Cervical Cancer Screening Practices of Volunteer Providers in Faith-based Clinics

Vicki Denson, PhD, WHNP-BC, and Rebecca Keele, PhD, PHCNS-BC

ABSTRACT

Hispanic women are at an increased risk of developing cervical cancer. Many of these women seek care at safety net clinics. The aim of this study was to examine the relationship between the characteristics of volunteer health care providers serving Hispanic women in faith-based safety net clinics and cervical cancer screening (CCS) practices. Findings revealed that volunteer nurse practitioners were more likely to document CCS recommendations ($P < .01$) and perform screenings ($P < .01$) than volunteer physicians. All types of volunteer providers improved in providing guideline-consistent screening recommendations despite screening guideline changes in 2009 and 2012 ($P < .05$).

Keywords: cervical cancer screening, faith based, Hispanic, safety net, volunteer

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Cervical cancer is a preventable disease if regular screenings are obtained, yet the Hispanic population continues to experience an increased risk of developing invasive cervical cancer in comparison with the non-Hispanic white population.[1] This disparity is especially high along the United States—Mexico border.[2] An underlying problem contributing to the disparity is underutilization of cervical cancer screening (CCS).

A Healthy People 2020 objective is to reduce the number of new cases of invasive cervical cancer in Hispanic women from 11.4 (2007 baseline) to 7.9 (age adjusted per 100,000 population) and to reduce death rates from 3.0 (2007 baseline) to 2.2 deaths per 100,000 Hispanic women.[3] Similarly, the Healthy Border 2010/2020 Strategic Framework to the Border objective is to reduce the death rate from cervical cancer by 30% in women ages 25 years or older in the United States and by 20% in Mexico.[4] Secondary prevention, such as the use of CCS, can identify women at risk for cervical cancer, subsequently providing early intervention to reduce morbidity and mortality.[5,6] Studies exploring the barriers to screening reveal a lack of physician recommendation as a predominant factor.[2,7-10] Failure to follow standard screening guidelines has also been documented[11,12] and may be caused by provider confusion related to differing recommendations by various national organizations in the past.[11]

BACKGROUND

The 2010 National Healthcare Disparities Report showed that screening measures result in cost-effectiveness.[13] In 2009, 3.3% of all human papilloma virus (HPV)-associated cancer cases were among women; 53.4% of these were cervical cancer.[14] Treatment costs for HPV-related diseases are in "excess of $5 billion annually, with the majority of the financial expenditure used for follow-up care from abnormal Pap test results."[15(p23)]

Health care providers participating in a survey study, including physicians, nurse practitioners (NPs), and nurse midwives, reported reasons for missing opportunities to screen women included lack of staff support, lack of a reminder system, feeling rushed, and lack of confidence in performing a gynecologic examination.[16] Intervention studies for CCS have vastly relied on the self-reports of physicians and Hispanic women,[12,16-18] which are known to have limitations.[19] Of the sparse studies using both chart audits with surveys and interviews to confirm that health care providers were accurately providing CCS recommendations, the documentation of preventive

screenings and recommendations by primary care physicians was low.[20,21] Physicians also tended to overestimate their performance on self-report compared with chart documentation.[20] Of the studies that have explored the CCS practices and characteristics of health care providers, most have targeted physicians in private urban practices, despite the fact that many low-income underserved women seek care at community health centers and charitable clinics[22,23] that also use NPs as providers of care.

Safety Net Programs

Safety net programs exist to serve low-income, uninsured, and vulnerable populations.[24,25] Community health centers offer preventive services, which are a requirement of the Affordable Care Act.[24] Although approximately 1,000 federally qualified health centers exist, many of which use paid staff in addition to volunteers,[23] it is projected that as many as 29 million people will continue to lack access to health care[25]; thus, free and charitable clinics remain an important part of safety net programs and are in an ideal position to increase recommendations for preventive screenings such as CCS.

Approximately 1,200 free and charitable clinics exist in the United States.[25] Unlike federally qualified health centers that receive federal funding, charitable and faith-based clinics receive little if any state or federal funding. Charitable and faith-based clinics must rely on foundations, grants, and private funding in addition to volunteer NPs, physician assistants (PAs), and physicians (MDs) to provide acute and preventive care for their clients.[25,26] These clinics recognize that their volunteers have varied educational and specialty backgrounds, which may impact performance or recommendation of preventive screenings such as CCS.[27]

According to a study conducted by Chattopadhyay et al,[28] the majority of NPs (56.7%) reported working in ambulatory settings, and of the ambulatory settings, only 13% of NPs reported their main practice setting as a clinic that provides care to the underserved population. Only 55% of NPs reported provision of preventive care, including screenings, as services they provide to most of their clients.[28] Because NPs play a pivotal role in providing preventative care to the public,[29] these statistics are concerning. If the majority of NPs have little experience working with underserved populations and only half reported provision of preventive screening practices to most clients, how will this impact NPs volunteering at charitable clinics for recommending CCS?

CCS Guidelines

Guidelines for CCS recommendations remained stable from 2003 until 2009 although there were notable differences in the guidelines between national organizations. In 2009, significant changes were made to the guidelines, which could explain reports in the literature of a lack of uniformity in CCS practices among health care providers as well as inconsistency for following guidelines. For example, previous to 2009, the American Cancer Society recommended that conventional cytology screening be performed annually for women < 30 years old, whereas the US Preventive Services Task Force recommended at least every 3 years. Guidelines for average-risk women released in March 2012 reflect more uniformity between organizations as follows:

1. Screening should begin at age 21
2. Women ages 21 to 29: cytology alone (conventional or liquid-based Papanicolaou test) every 3 years
3. Women ages 30 to 65: cytology alone every 3 years (acceptable) or screening with cytology and HPV testing every 5 years (preferred)
4. Women older than 65 years with evidence of adequate negative prior screenings and no history of cervical intraepithelial neoplasia 2 in the last 20 years should not be screened
5. Women with a history of hysterectomy, removal of the cervix, and no prior history of cervical intraepithelial neoplasia 2 should not be screened[6]

For this study, the guidelines of the American College of Obstetricians and Gynecologists (ACOG) were used in determining providers' guideline consistency with CCS.

PURPOSE/RESEARCH QUESTIONS

The purpose of this study was to examine the relationship between the characteristics of volunteer health care providers (VHCPs) and their CCS

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