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Implementation Of Cervical Cancer Screening Protocol (CCSP): A Quality Improvement Project

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Abstract

Background and significance: Cervical cancer is the fourth most commonly occurring cancer in women and the eighth most commonly occurring cancer overall (WCRF, 2020). Papanicolaou (Pap) testing is the primary screening for cervical cancer. In the past 40 years the number of cases and deaths from cervical cancer has decreased significantly, resulting from cervical cancer screenings (CDC, 2021). Healthy People 2030 reports to increase the proportion of females ages 21-65 who receive a cervical cancer screening based on the most recent guidelines. The 2030 target is 84.3%. Human papillomavirus (HPV) is a virus that is transmitted through sexual contact and is the leading cause of cervical cancer. **Purpose:** The purpose of this quality improvement (QI) project is to support the implementation of the Women's Health Cervical Cancer Screening Protocol (CCSP) in Primary Care Practices within a federal qualified health center (FQHC) serving the underserved residents in Southwestern PA. The goal of the CCSP is to review the current pap workflow in comparison to the ASCCP guidelines, HPV vaccine, and correct documentation. **Methods:** This project utilized the Model of Improvement and the PDSA approach in the implementation of the CCSP in a selected primary care clinic. A program charter was developed with the FQHC stakeholders that guided the CCSP implementation and evaluation. After training sessions with the staff and providers the CCSP workflow processes was implemented, Audits of the EHR documentation reviewing compliance with ASCCP guidelines and HPV vaccine guidelines. **Results:** After completion of CCSP, EHR documentation audits compliance with the CCSP improved by 75% as compared to pre-implementation EHR documentation. The CCSP workflow was adopted with the recommendation that the NextGen Clinical Care Guidelines module to be implemented to

support compliance and monitoring of the CCSP process. This will result in improved UDS cervical cancer screening performance measures.

Keywords: cervical cancer screening, cervical cancer guidelines, HPV, cervical cancer tracking, EHR, HIT, HIT/cancer

Implementation of Cervical Cancer Screening Protocol (CCSP): A Quality Improvement Project

Cervical cancer is the fourth most common cancer among women globally, with an estimated 570,000 new cases in 2018 (WHO, 2020). According to Ravikumar et al. (2018), the United States diagnosed approximately 12,000 women with cervical cancer each year and 4,000 women die each year from cervical cancer. With increase in cervical cancer screening and current guidelines, the incidence of and mortality is decreasing in the United States. It was once, one of the most common causes of cancer in women. Several organizations have recommended new guidelines for cervical cancer screening, the organizations include The American Cancer Society (ACS), the American College of Obstetricians and Gynecologists (ACOG), the United States Preventative Services Task Force (USPSTF), the American Society for Clinical Pathology (ASCP), and the American Society for Colposcopy and Cervical Pathology (ASCCP).

More than 99% of cervical cancers and cervical precancerous lesions are associated with chronic infections with high-risk HPV (Elliot, 2020). Human papillomavirus (HPV) is a virus that is transmitted through sexual contact and is the leading cause of cervical cancer. Almost all cervical cancers are caused by persistent infections with one of 12-14 HPV types (Schiffman et al., 2016). HPV is acquired by women shortly after the engagement of sexual intercourse and other sexual activity, but is nearly all cleared by the immune system within 1-2 years without producing neoplastic changes (Practice Bulletin, 2016). There are three different strategies to screen through a pap smear, they are: cytology alone, HPV alone, or a combination of both cytology and HPV or “co-testing”. Comprehensive cervical cancer control includes primary prevention (vaccination against HPV), secondary prevention (screening and treatment of pre-cancerous lesions), tertiary prevention (diagnosis and treatment of invasive cervical cancer) and

palliative care (WHO, 2020). The CDC reports screening tests and the HPV vaccine can help prevent cervical cancer. When cervical cancer is found early, it is highly treatable and associated with long survival and good quality of life.

According to the Pennsylvania Department of Health (PADOH) here were 535 cases of cervical cancer diagnosed, a rate of 7.8 cases per 100,000 Pennsylvanian women in 2016 (Pennsylvania Department of Health, 2019). Hispanic women had the highest incidence rate of cervical cancer (10.6 per 100,000), followed by black (10.1 per 100,000) and white women (7.5 per 100,000) in 2016 (2019).

Healthcare Problem

FQHC's are community-based health care providers that receive funds from the HRSA Health Center Program to provide primary care services in underserved areas (HRSA, 2018). The Health Resources & Service Administration (HRSA) supports the Women's Preventive Services Initiative (WPSI) that recommends cervical cancer screening for average-risk women aged 21 to 65 years. The purpose of the Women's Preventive Services Guidelines is to improve women's health across the lifespan by identifying preventive services and screenings to be used in clinical practice (HRSA, 2020).

The Uniform Data System (UDS) is the standardized reporting system within HRSA that monitors performance measures within community health centers. This system provides consistent patient outcomes and clinical performance data regarding services provided in FQHC's and other funded community health centers. This includes patient volumes by age and other socio-demographic characteristics. Staffing levels and services provided are also reported annually. Cervical cancer screening is one of the 18 UDS clinical quality measures. The national goal in 2020 for the UDS cervical cancer screening was 51% (HRSA, 2021).

In healthcare today, health information technology (HIT) is key in promoting better care, affordable care, healthy populations and communities, and care of the provider within inter professional teams (McBride & Tietze, 2019). The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 invested $30 billion to stimulate the adoption and "meaningful use" of electronic health records (EHR) and related infrastructure. The effective use of health information technology by primary care practices to facilitate quality improvement (QI) can help practices improve their ability to deliver high quality care and improve patient outcomes (Higgins et al., 2015).

The CDC (2021) defines **c**linical decision support systems (CDSS) as computer-based programs that analyze data within EHRs to provide prompts and reminders to assist health care providers in implementing evidence-based clinical guidelines at the point of care. Sutton, et al., (2020) report the scope of functions by the CDSS is many, including improves on patient safety, clinical management, cost containment, administrative function, diagnostic support (imaging, laboratory, and pathology), patient decision support, better documentation, and workflow improvement are some of advantages. HIT plays a key role in providing healthcare providers and clinical services staff with health maintenance guidelines and tracks the patient's compliance with those guidelines. In doing so, the health care center can assist the patient in obtaining the needed screening in order to reduce their risk for cancer and other diseases as well and maintain optimum health. This DNP quality improvement seeks to increase the timely completion of cervical cancer screenings utilizing national clinical guidelines for females ages 21-65. The improvement of the health center's utilization of their EHR, NextGen, will be central in improving patient outcomes.

Literature Review

The Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model is a powerful problem-solving approach to clinical decision-making and is accompanied by user-friendly tools to guide individual or group use. The goal of the model is to ensure that the latest research findings and best practices are quickly and appropriately incorporated into patient care (Johns Hopkins Medicine, 2021).

The databases searched for this literature review included PubMed, Cumulative Index of Nursing and Allied Health Literature (CINAHL), Google Scholar, and EBSCO. The following search terms where included: cervical cancer screening, cervical cancer guidelines, HPV, cervical cancer tracking, EHR, HIT, and HIT/cancer. Searches were limited to articles from 2010-2021, and 24 articles were chosen. Information from national organizations including The American College of Obstetricians and Gynecologists (ACOG), American Society for Colposcopy and Cervical Pathology (ASCCP), the American Society for Clinical Pathology (ASCP), and The U.S. Preventative Services Task Force (USPSTF). These three organizations recommend women aged 21-65 receive cervical cytology alone every 3 years.

Recommendations for Screening

The American College of Obstetricians and Gynecologists (ACOG), the United States Preventative Services Task Force (USPSTF), and the American Society for Clinical Pathology (ASCP), and the American Society for Colposcopy and Cervical Pathology (ASCCP) recommend routine cytology screening every 3 years starting at age 21, with an option to switch to cytology and HPV “contesting” every 5 years starting at age 30 years (Moyer, 2012; Sawaya, et al., 2019; Practice Bulletin, 2016.)

Interventions to Increase Screening

Cervical cancer remains prevalent thought the world. Assisting women to be screened and continue to follow guidelines and recommendation for cervical cancer is very challenging. Kurt, et al. (2019) found that of three intervention that included 1.) one-on-one training accompanied by an educational brochure; 2.) providing the educational brochure only, and 3.) giving an invitation without any relevant information, one-on-one training and an educational brochure was most effective in increasing participation in cervical cancer screening.

Barriers to Screening

Akinlotan, et al. 2017 reports that women of low income and low educational attainment, are less likely to be screened, or follow up with results of abnormal cytology. Participants identified potential barriers to receiving a pap smear where: fear of finding cancer; anxiety about the procedure; feelings of embarrassment; anticipation of pain, and cost of care. Hispanics women also identified language barrier and male providers as a barrier listed. Other barriers identified in this study were lack of health insurance; not having a regular source of primary care; lack of knowledge of risk factors; recent immigration status; lack of transportation; chronic diseases; taking time off of work; and lack of childcare. It was also reported that cervical cancer screenings were reported higher among younger women regardless of race/ethnicity. Understanding these barriers and assisting women in overcoming them may increase their participation in cervical cancer screening and reducing their risk of cervical cancer.

Reminder/Recall System

Thomson, et al. (2020) described an effective patient recall system for cervical cancer screening in Honduras was phone calls for one year follow up of HPV testing. Of 558 women

who were initially HPV positive, 98% were contacted and 75% completed the repeat HPV screening.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

The Agency for Healthcare Research and Quality (AHRQ) provides a program called Consumer Assessment of Healthcare Providers and Systems (CAHPS). Its purpose is to advance our scientific patient experience with healthcare. One area studied was reminder systems for immunizations and preventative services (AHRQ, 2017). In a study comparing the effectiveness of different approaches to improve immunizations and screening, patient reminder systems were the fifth most effective method, with an improvement of 150 percent compared to control groups. Also reported was strong evidence from meta-analytic studies that physician reminder system for preventative care are effective at increasing preventative procedures.

Electronic Health Record Documentation

Sittig and Classen (2010) developed a comprehensive EHR monitoring and evaluation framework that emphasized the importance of safe and effective EHR. The framework identified the five essential components: reporting EHR safety issues, enhanced EHR certification, self-assessment of EHR use, on-site accreditation of EHR and a national EHR adverse event investigation board. The article identified examples of meeting these five components and their relationships with quality improvement.

Feldman et al. (2017), also focused the use of the EHR in improving identification of patients that are overdue for cervical cancer screening. Prior to implementation of a cervical cancer screening registry only 60% of females were up to date with cervical cancer screening guidelines. After implementation of the registry the rate at 70% of females were up to date with cervical cancer screening guidelines after one year of this study. This article utilized the Sittig

and Singh's eight-dimensional model in creating this system which integrated socio-technical elements that lead to this improvement.

Another example, Khullar et al. (2014), reviewed EHR documents of overdue cervical cancer screening and compared them with the findings of a manual review the charts in an urban health center. The study found that 65 patients that were thought to be up to date (UTD) by EHR review but were overdue with manual review. The study found that the difference was due to the data in the EHR was non-extractable. The authors recommended the development of mechanisms to capture reports from outside facilities and incorporate accurate documentation processes into the medical team's workflow to optimize EHR documentation in primary care practices. This article demonstrates the need to evaluate all EHR's for limitations within their documentation and to be aware of the impact it can have on clinical outcomes.

Socio-Technical Framework

Sociotechnical perspectives explore the relationships between humans and technology within an environment. Sittig and Singh's Eight-Dimensional Model was intended to be used as a guide or tool to assist practitioner/researcher to seek interrelationships among various human, technical, and contextual elements in the environment, which may influence elements of HIT (McBride & Tietze, 2019). The eight dimensions include: hardware and software, system measurement and monitoring, people, workflow and communication, clinical content, internal organizational policies and procedures, external rules-regulations-and pressures, and human-computer interface (McBride & Tietze, 2019). These eight dimensions are interrelated and should be used together to generate insight on how HIT is used for healthcare purposes and generating a desired outcome. Figure 1 shows the complex interrelationships among the eight dimensions.

Sittig & Singh's model is the study of design, development, use, implementation, and evaluation of HIT. HIT plays key role in health maintenance in preventing cervical cancer. Clinical decision support systems (CDSS) is comprised of software designed to be a direct aid to clinical-decision making, CDSS has been endorsed by the US Government's Health and Medicare acts, financially incentivizing CDS implementation into EHRs. CDSS can assist with managing patients on research/treatment protocols, racking and placing orders, follow-up for referrals, as well as ensuring preventative care. CDSS also includes monitoring clinical practice standards (cervical cancer screening), alarm systems, drug control, order sets, clinical workflow tools, and so much more.

Description of the Project

The purpose of this quality improvement (QI) project is to support the implementation of the Women's Health Cervical Cancer Screening protocol (CCSP) in primary care practices within a FQHC serving the underserved residents in Southwestern PA. The goal of the CCSP is to increase cervical cancer screening rates to improve early identification and management.

Specific Aims

Aim #1: Evaluate CCSP for compliance with ASCCP recommendations.

1.1: Compare protocol with EB guidelines

1.2: Review EHR documentation system for compliance with ASCCP guidelines

1.3: Identify areas requiring review based upon evaluation

1.4: Review with Stakeholders

Aim #2: Revision of CCSP 2019 CCSP

2.1: Evaluate CCSP 2019 workflow including staff activity and identify changes in CCSP related to staff activities

2.2: Expand CCSP to include EHR

2.3: Identify changes in patient follow-up

Aim #3: Implement PDSA Cycle 1 of CCSP

3.1: **Plan**: Development staff training modules including performance and EMR documentation

3.2: **Do:** Implement: Implement CCSP according to timeline and rollout

3.3: **Study**: Complete documentation audits utilizing the CCSP protocol 1 month prior to implementation and 1 month after implementation

3.3.1 Compare and analyze audit data

3.4: **Act**: Discuss study finding with stakeholders and choose one of the following:

- Adopt the protocol and process and roll-out to other clinics
- Adapt the protocol and process and repeat another PDSA cycle
- Abandon the protocol and process

Overview of Methodology: Quality Improvement

The IHI's Model for Improvement (2021) was identified by HRSA as the quality improvement framework for all FQHC quality improvement projects (HRSA, 2011). Guidance documents for FQHC's include implementation guidelines for all QI project which start by asking three questions: 1. What are we trying to accomplish?; 2. How will we know that a change is an improvement?; 3. What changes can we make that will result in improvement? (IHI, 2021).

The Plan-Do-Study-Act (PDSA) cycle was used to test the effects of small changes, make them, and ultimately spread the effective changes through the practice or organization. A Project Charter was developed with organizational providers and staff that guided the development of

the PDSA and its evaluation. Figure 2 provides an overview of activities taken in each step of this process.

Setting

The organization involved in this project is a FQHC with 13 clinics in the 4 counties in mid-west and southwestern regions of Pennsylvania. The services provided are adult and pediatric primary care, women's health, dental, eye and mental health in Pennsylvania. Also, there is a mobile unit that provides some services through Pennsylvania and Northern West Virginia.

Community Health Centers provide comprehensive, culturally competent, high-quality primary health care services to the nation's most vulnerable individuals and families. This organization accepts commercial insurance plans, participates in federal-state programs [e.g., National Breast and Cervical Cancer Early Detection Program (NBCCEDP)] that pay for screening and diagnostic services. Also, the organization offers a sliding scale fee based on the patient's ability to pay which is a program for uninsured and underinsured.

Implementation

In 2019 a CC workgroup was developed to create a CCSP protocol based upon the updated national guidelines noted previously. A protocol was written but the project was not implemented due to the COVID 19 pandemic. The 2019 CCSP protocol was used as the foundation of this quality improvement project. The timeline of these activities are noted in Figure 3.

DNP Project Findings

AIM 1 Finding

This aim was to evaluate CCSP for compliance with ASCCP recommendations which involved reviewing the 2019 CCSP and comparing with all clinical management

recommendations. After obtaining consensus on the 2021 CCSP with stakeholders which include CC QI staff, providers and clinical staff members, the protocol was compared with the current cervical cancer processes.

After reviewing current practice with stakeholders, the CCSP Workflow was developed as seen in Figure 4. In this process it was noted that a clinical decision support (CDS) module of NextGen, CC's electronic health record was not being used. This module known as Care Guidelines provides alerts and updates each patient in compliance with national healthcare maintenance guidelines. This CDS could assist clinical staff and providers to identify gaps in their patient's preventative health including pap testing, immunizations, and follow-up to abnormal screening tests results. Implementation of this CDS was supported by stakeholders and will be included in the project's recommendations.

AIM 2

This aim was to revise the CCSP (workflow) made in 2019 to current CCSP to evaluate. The stakeholders approved the reviewed and revised 2021 CCSP. The 2021 CCSP was emailed to all providers, clinical staff, and quality improvement staff. Also in the email was the workflow document that includes documentation guidelines for pap smear results with return dates. Identifying dates of pap smears completed outside of CC is the responsibility of clinical staff and training was completed regarding this process and documentation. Again, NextGen's patient recall module is not currently being utilizing and was approved by stakeholders as part of the future workflow. This will be included in the project's recommendations.

AIM 3

This aim was implementation of PDSA cycle 1 of CCSP. A comparison chart is provided in Figure 5 which displays the improvement between the documentation audits one month prior

to the CCSP implementation and one month during implementation. Even though the audit was a small number of charts the during implementation demonstrated a 75% improvement in compliance with the 2021 CCSP process. Future evaluation of this change will include ongoing audits at 3, 6 and 9 months and a 100% review of charts as part of the UDS annual reporting of cervical cancer screenings.

Figure 6 shows a comparison of cervical cancer screenings that are compared yearly to the UDS clinical quality measures national average in women 23-64 compared to my organization CC women ages 24-64. Year 2019 was not able to be present in this chart because of missing data. This chart demonstrated the need for improvement in CC's cervical cancer processes and will be compared to 2021 data that includes 100% of charts of women 23-64.

The final step in the PDSA is to act. The stakeholders review the 2021 CCSP protocol and PDSA findings and agree that the CC should implement the CCSP to all other CC offices. A PDSA process will be utilized, and the Study will include documentation audits as well as UDS performance measures. Provider and clinical staff training will continue as well as obtaining their feedback through the CAHPS system.

Recommendations for future PDSA's utilized in the CCSP roll-out include implementation of NextGen's Care Guidelines CDS offered through NextGen as well as implementation of their Patient Recall scheduling system. UDS performance measures could be used in the quarterly evaluation of the change in practice as well as continuing the documentation audit at 3, 6, and 9 months after all PDSA implementations. It is also recommended that orientation programs include CCSP protocols as well as NextGen CDS and patient recall systems.

Interpretation/Sustainability

This DNP project implemented a new cervical cancer screening process in a FQHC in SW Pennsylvania and found a significant increase in correct documentation. The plan will be to expand the CCSP to other offices in the organization and implementation of NextGen Care Guidelines and Patient recall systems. On-going stakeholder meetings will be held every 3 months. Increasing provider and staff engagement is a strategy to improve use of the CCSP and implementing the NextGen Care Guidelines and Patient recall systems. Consistent and effective use of the CCSP using the NextGen Care Guidelines CDS and recall system can lead to increased cervical cancer screening and decrease morbidity and mortality.

Limitations

These results and recommendations for this DNP project are specific to the CC organization. The short implementation and evaluation of documentation timeline for evaluation of change was only three months but the organization is committed to continuing the evaluation through the documentation audits and UDS performance measures.

Conclusion

FQHC's are committed to improving the health of their patients through primary care services that include preventive health practices compliant with evidence based national guidelines. Cervical cancer is the fourth most commonly occurring cancer in women and the eighth most commonly occurring cancer overall (WCRF, 2020) and has a successful prevention strategy that focuses on the Papanicolaou (Pap) testing which is the primary screening for cervical cancer. This approach has resulted in significant decreases in cervical cancer nationally.

CC has not reached national levels of cervical cancer prevention in the level of pap testing among their patients ages 23-65. This quality improvement (QI) project focused on the implementation of the Women's Health Cervical Cancer Screening Protocol (CCSP) in one primary care that involved consensus of the ASCCP guidelines, HPV vaccine, and correct documentation into the 2021 CCSP. Through the use of the PDSA approach in the implementation of the CCSP which resulted in a 75 % improvement in documentation of CCSP activities related to cervical cancer prevention. It was found that two important tools within NextGen, CC's electronic health record, was not being utilized and plans are being made to implement the Care Guidelines CDS and the patient recall system in the next PDSA implementation as the CCSP is rolled out to all CC clinics. This will result in improved UDS cervical cancer performance measures and improved patient outcomes.

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Table 1

Summary of Cervical Cancer Screening Recommendations

Summary of Cervical Cancer Screening Recommendations:

Age	ACS (2020)	ACOG (2016, 2018)	USPSTF & AAFP (2018)
<21 years	Not recommended	Not recommended	Not recommended
21-29	***Start at 25 years*** Primary HPV testing alone every 5 years (preferred) **OR** Co-testing every 5 years **OR** Cytology alone every 3 years	***Start at 21 years*** Cytology alone every 3 years	***Start at 21 years*** Cytology alone every 3 years
30-65	Primary HPV testing alone every 5 years (preferred) **OR** Co-testing every 5 years **OR** Cytology alone every 3 years	Co-testing every 5 years (preferred) **OR** Cytology alone every 3 years **OR** Primary HPV testing alone every 5 years [b] (alternative)	Cytology alone every 3 years **OR** Primary HPV testing alone every 5 years **OR** Co-testing every 5 years (alternative)
>65	Not recommended [a]	Not recommended [c]	Not recommended [c]
Hysterectomy (with no history of cervical cancer or high-grade pre-cancerous lesion)	Not recommended	Not recommended	Not recommended

[a] No CIN 2 or greater within 25 years ***and*** documented negative screening in prior 10 years

[b] Acceptable in women ≥ 25 years

[c] History of adequate screening: 3 consecutive negative cytology results or 2 consecutive negative co-testing results within 10 years with the most recent test within 5 years

Figure 1

Sittig and Singh's Eight-Dimensional Sociotechnical Model

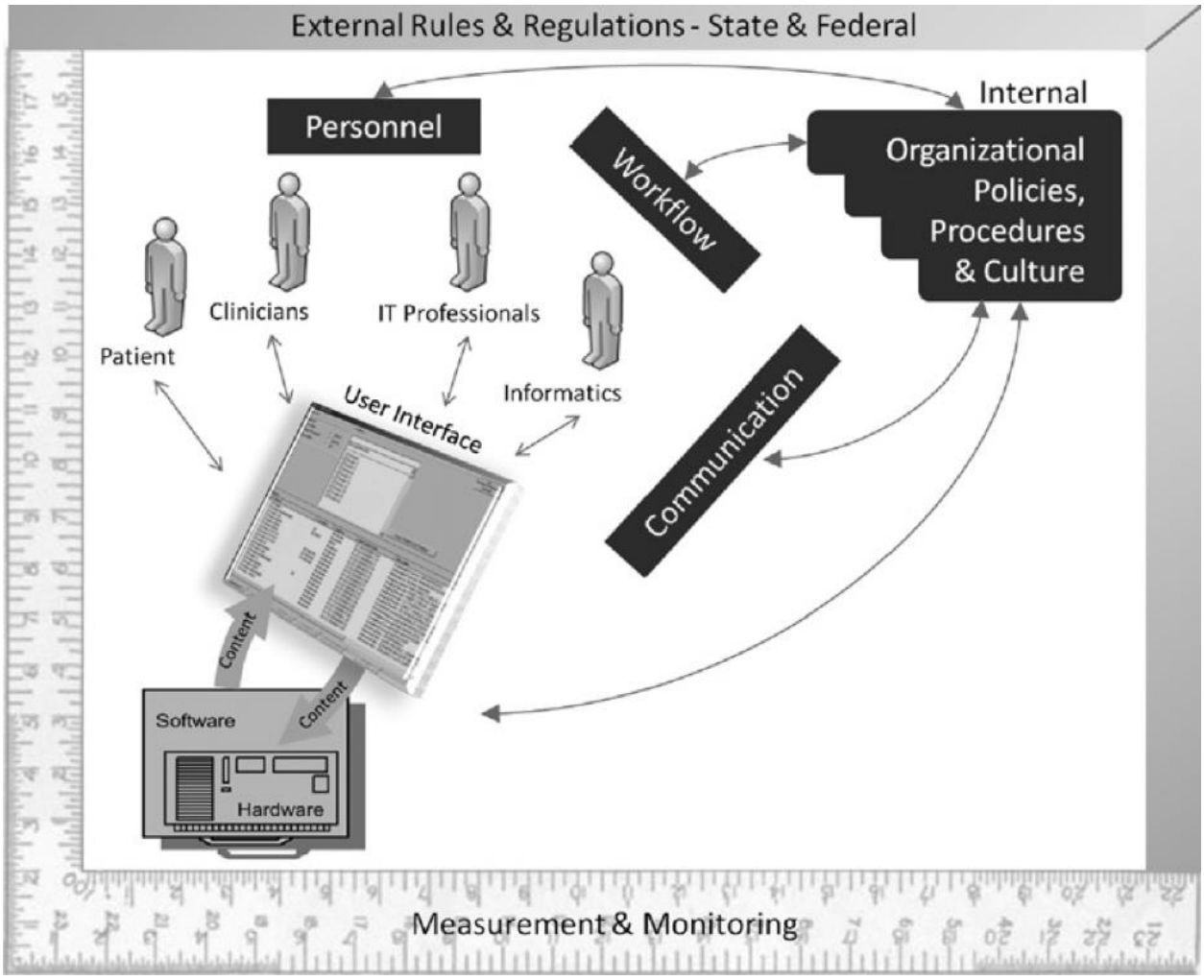


Figure 2

Sample Implementing the PDSA Cycle

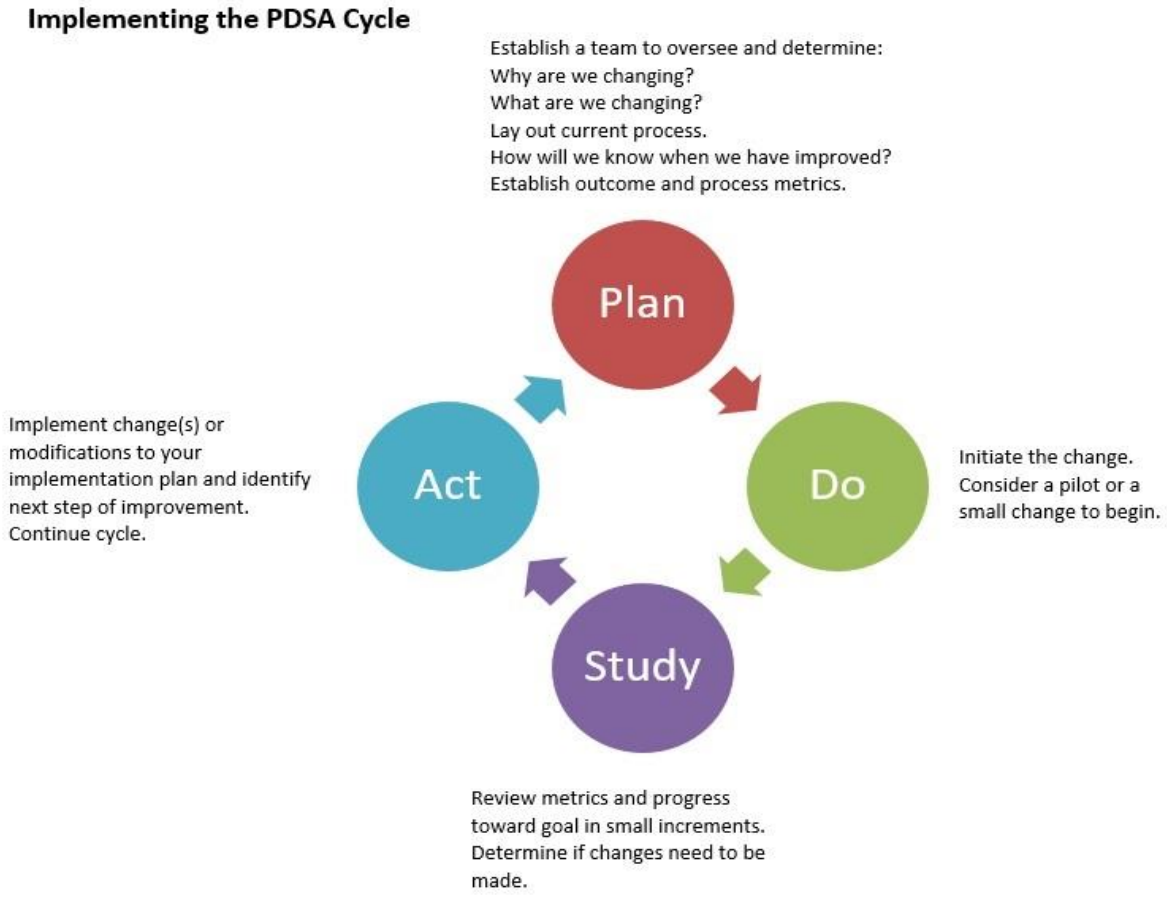


Figure 3

Quality Improvement Timeline

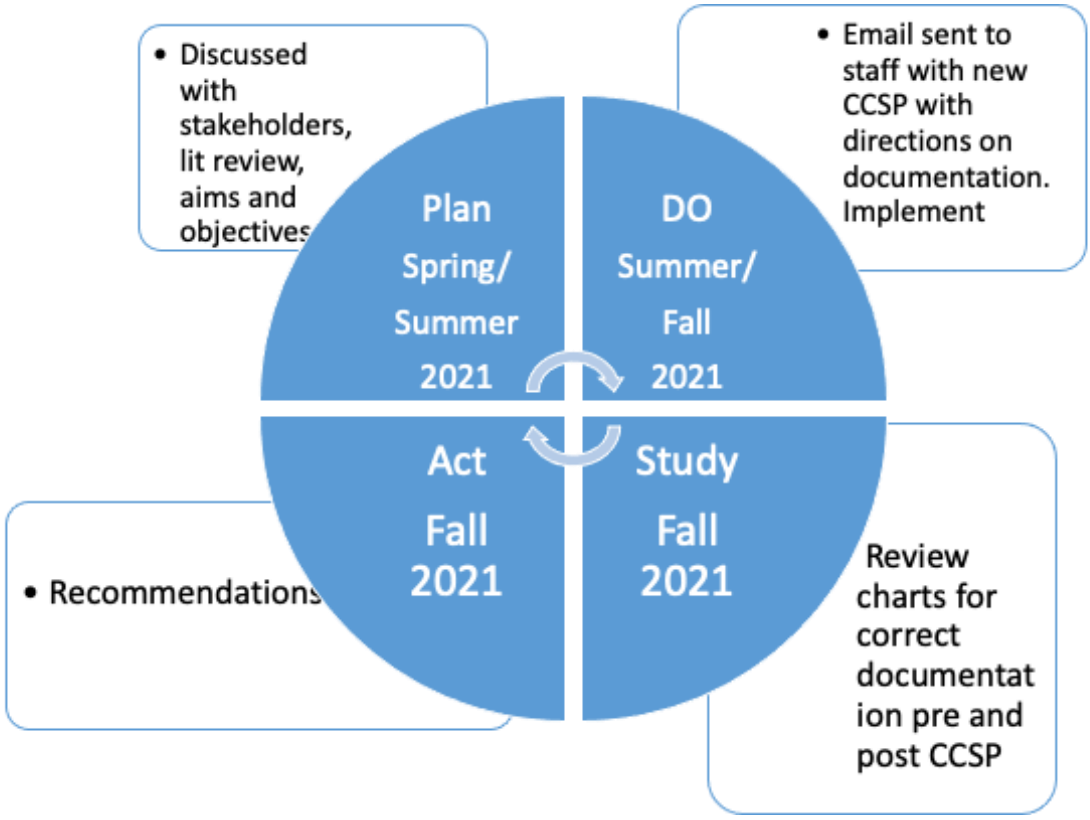


Figure 4

CCSP Workflow

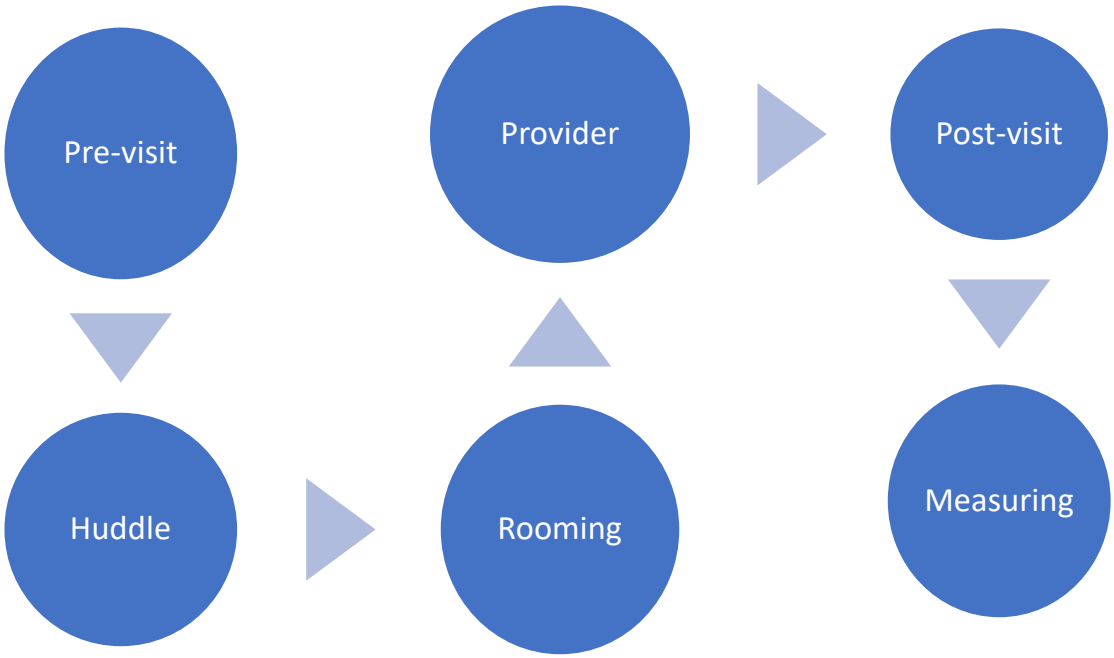


Figure 5

Correct vs Not Correct Documentation (pre and during implementation)

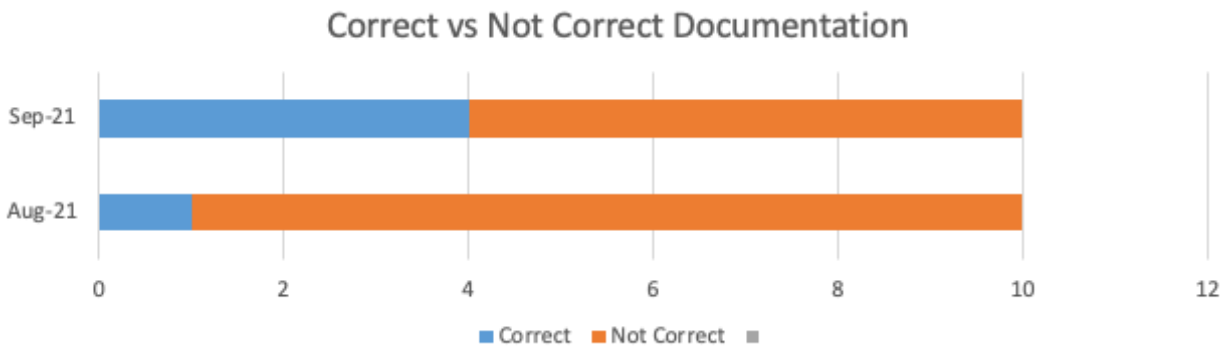
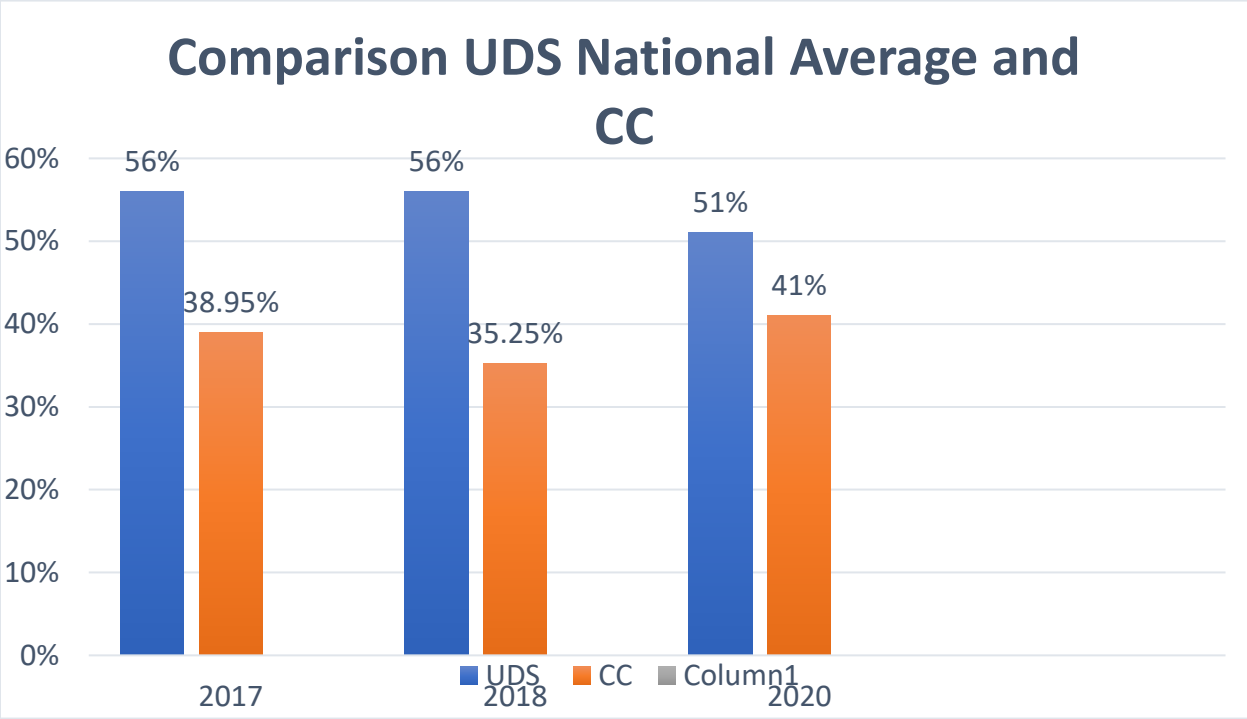


Figure 6

Comparison between UDS Clinical Quality Measures National Average (23-64) to CC (24-64)



Appendix

Cervical Cancer Screening Protocol (CCSP) 2021

Pre-visit

Check schedule the day before.
Identify women between 21 and 64 from the schedule.
Enter names of those women on the huddle sheet.
Look in orders management first under labs for previous pap.
If it is in orders management, make sure it's completed. (MA can do if not already signed off.)
If not there, go to categories for scanned in labs, under pap smear. If one is scanned in & current, add to orders module.
If not in either place, check in the chart for old ones to see who they saw previously, contact that office to see if a more current test is available. Also, you can check WHIN.
If none are found, you'll need to ask patient when rooming.
If one is found, use the "did you know guidelines" for ages and if pap is normal, if not normal, discuss with provider in huddle.
If you find documentation that the women had a ***hysterectomy*** please document in surgical histories and if you know the reason why, that needs documented as well. Discuss findings with provider in huddle. This must be documented in "surgical histories".

Huddle

Discuss findings from pre-visit in huddle with provider.
MA to notify provider if no pap or most recent pap was abnormal.
If none, patient needs a pap completed, unless they have already gone and we do not have a copy, will need to ask patient at rooming.

Rooming

If no pap asks the patient if they have had a pap recently.
If the patient goes somewhere else, ask and document the name of the gynecologist.
If the patient did have one recently, make a note on the huddle sheet to contact the gynecologist and get the results. Will be documented in the log book and the EHR.
If no pap, MA notifies patient they are due for a pap and we need to get that scheduled before they leave the office.
If time allows in the schedule, check with provider to see if they want to do pap while they are here. If not……
Decide if patient will schedule here or if she has a gynecologist. If here…..
MA to write on the bottom of the encounter form, "schedule for pap".
If patient wants a gynecologist, write on huddle sheet, under pap column with preferred provider name, to give to referral staff to set up.

Ask patient if between 21-45 if they have received the HPV vaccine, if not provide with information and to discuss with provider.
Notify provider that patient is due.

Provider
Confirms with patient that they are due for a pap. OR
Confirms with patient that we will complete today. OR
Confirms with patient that they will come back to see us to get pap (already on the bottom of encounter form).

Post Visit
If the patient is getting done outside of cc, the name is on the huddle sheet that the MA gives to the referral staff.
Referral is placed to gynecologist for pap. Order as referral, in details, type for pap.
When pap come in through the PAQ, provider should sign off with actions, "normal not due for 5 year" or whatever the results were and when they are due next. This will help staff when doing pre-visit on patients.
The results are entered in the orders module comment box, it will show up in the test tubes for all to see, without scrolling through PTA's, encounters, etc.
At check out-If patient does not want to schedule at the front when checking out, the front needs to copy the encounter form or keep a list of patients who need a pap and call weekly until it's done.
When scanned in, outside pap, provider will sign off and write due date in comment box.

Measuring
Measure if patient was due, did the patient schedule to come back or was a referral placed to gynecologist.
Measure completed paps weekly.
Numerator=completed pap and Denominator=women in the age group who have not had a hysterectomy due to non-cancerous reasons.
Was pap documented appropriately