



Opinion

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Cervical Cancer Screening and Prevention for Vulnerable Women Who Receive Care in The Safety Net

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It is widely accepted that patients in vulnerable circumstances such as those with mental illness or incarceration often have more difficulty prioritizing their basic primary care needs and are thus at risk for conditions that are preventable. Women with histories of mental illness, substance abuse and incarceration are more highly associated with having a diagnosis of cervical cancer.

Their work further provides support to the recommendations that providers who work with vulnerable populations be informed that risk histories such as incarceration and mental illness absolutely influence follow-up behaviors [1]. We have seen this in our own tracking of no-shows to colposcopy clinic for both our incarcerated patients as well as our patients with hospitalizations for mental illness.

There have been a number of studies highlighting rates of cancer and screening among mentally ill patients. Some studies have shown higher rates, some lower, and some with no difference when compared with the general population [2]. However, in California, among Medicaid recipients, where our programs are located James [3], found that only 20% of women with severe mental illness were screened. Further, the ACOG practice bulletin [4], has suggested that an increase in cancer screening may be more largely attributable to the streamlining of consensus guidelines by major national organizations. The same increases could also be explained by an expansion of clinicians using evidence-based practice or even to screening being linked to reimbursements in some settings and not have much to do with mental illness itself as a risk. Regardless of whether screening is increasing, Colton & Mandersheid [5] have found that people with severe mental illness are still at higher risk of mortality, often 25 years earlier than the

general population, from chronic and preventable conditions, with cancer being the second leading cause of death.

It is not uncommon for patients with psychiatric illness to have difficulties feeling comfortable with providers or obscure their medical histories or chief concerns. The healthcare systems' own limitations, access issues and appointment requirements can be especially difficult to navigate for patients with mental illness. They are often struggling with concurrent co-morbidities as well as the social determinants of health whose effects are often more prevalent for them.

Consequently, women with moderate to severe mental illness are often unable to access gynecologic care and family planning services appropriately. However, those same women are often receiving public health services in mental health settings. James et al suggest there may be benefits to the creation of specialized services for women's health in mental health settings or even a specialized registry. According to Weinstein et al, primary care providers can reduce the disparities in this population by understanding the specific risks and their common psychiatric and medical issues.

According to the Alameda County Community Health data profile assessment [6], adults with severe mental illness, especially for racial/ethnic minorities may be disproportionately high due to barriers in obtaining proper diagnosis, treatment, and management of mental illness. Barriers may include stigma, limited English proficiency, cultural understanding of health care services, lack of transportation, fragmented services, cost, co-morbidity of mental illness and other chronic diseases, and incarceration. These barriers may lead to exacerbations of mental illnesses and their symptoms, which may result in more hospitalizations. Self-harm, depression, and psychotic episodes are among some of the events

and conditions that lead to hospitalizations.

In Alameda County, the overall rate of severe mental illness hospitalizations has been steady from 1999 to 2011. There were 11,347 mental health hospitalizations in Alameda County from 2009 through 2011, at the age-adjusted rate of 236.3 per 100,000. Using this data and comparing it to screening data already discussed, if even one-third of these patients are women, that number would be 3,782. If only half of them are within the age ranges for cervical cancer screening, that number is still significant at 1,891. Finally, if only 20% of them are screened, that still leaves at least 1,513 women unscreened.

John George Psychiatric Pavilion (JGPP) is a public inpatient psychiatric hospital located in Northern California, in Alameda County. The patients that are cared for at JGPP have mental health issues ranging from substance abuse to untreated mental illness, homelessness and are often struggling with overwhelming trauma. Among them are a significantly underserved population of women struggling with a multitude of issues. Many have very limited access to and little knowledge of reproductive health services.

In early 2018, the inpatient psychiatric team along with a family nurse practitioner begun a pilot program for women receiving care at JGPP. Based on the data that this population is far behind the general population in screening tests, we believed this population would benefit immensely from the provision of family planning services, gynecological exams, cervical cancer screening and linkage to aftercare. The primary goal was to empower women who are often lost to follow-up or not receiving care within the traditional healthcare system. It stands to reason that screening for cervical cancer follows a similar trajectory as many other preventable diseases with regard to screening and that the women seen by the JGPP reproductive health service could bridge the gap in cervical cancer screening. John George's healthcare services are currently covered by Alameda County Behavioral Health services. These services are limited to psychiatric and related services which include initial medical evaluation but have not traditionally included cervical cancer screening, HPV testing and contraception and other forms of primary care. These reasons include the lack of regular preventive care and primary care, barriers in their access to utilization to these services beyond the usual access issues cited for vulnerable populations, and issues around consent and reimbursement during acute hospitalizations.

We offer a self-selecting GYN consult service for patients who are preparing for discharge from John George. Since early 2018, we average 2.8 visits weekly. We have done pap smears (some necessitating closer or colposcopic follow-up and even treatment for dysplasia). Of the cervical screening we have done, the vast majority had not had or could not recall recent screening at other outpatient facilities in the previous year. In fact, many had never had any reproductive health care or screening ever at 37 years old.

In addition to patients with mental illness, women who are incarcerated have traditionally lacked access to cervical cancer

screening and cervical cancer literacy, making prevention beyond episodic care difficult. [7] As already documented, the significant differences noted among mentally ill and incarcerated patients in screening and follow-up suggest the need for innovative approaches that addresses the challenges to cervical cancer screening and preventive health in these groups. Further, according to Clarke, et al., [8] among women with histories of having been in the criminal justice system those who have had pap smears showing ASCUS (atypical squamous cells of undetermined significance) were even less likely to have had a colposcopy than those in the general population, and their biopsy results often had significant pathology.

In order to increase access for this population and to reduce barriers to cervical cancer prevention and treatment for dysplasia, the first two patients in our 4-hour clinic sessions are prioritized specifically for incarcerated women. We provide health care in our facility to Alameda County residents in the county jail, Santa Rita. Often when incarceration begins, there is a medical evaluation-similar to what occurs in a psychiatric hospitalization. In these evaluations, chronic health issues are often identified, and treatment initiated. However, beyond the immediate hospitalization/incarceration, linkages to ongoing screening and treatment can be limited.

Alameda Health System is a network of federally qualified health centers (FQHC) that provide primary and specialty care, three hospitals that provide a variety of community and emergency services, and a long-term care facility. AHS hold a contract to provide healthcare services for inmates of the county jail, Santa Rita. The jail has its own clinic, or infirmary, where patients are initially evaluated. The services provided include some screening including Pap Smears for women. When a pap smear requires a colposcopic evaluation, the inmates are referred to the colposcopy clinic at AHS' main ambulatory site, co-located next to the hospital. Just like inpatient psychiatric stays, the time incarcerated varies based on a number of factors including current charges, future and previous charges or other warrants. Consequently, it is often not known how long the incarceration will be upon initial evaluation. Security, comorbidities and reimbursement policies can further complicate plans for follow-up beyond screening such as colposcopy.

In order to address the disparities in follow-up evaluation and treatment for incarcerated women in Alameda County, our colposcopy clinic has initiated a method for incarcerated or formerly incarcerated patients to be seen. The first two colposcopy appointments of the weekly clinic are reserved for Santa Rita patients. This increases access for patients with shorter durations of incarceration and/or those who had previous abnormal paps without follow-up, those who were released prior to receiving any follow-up and re-incarcerated. AHS is reimbursed for colposcopy by the jail's healthcare payer at a rate that is equal or higher than the typical rate for these services, so offering them to incarcerated patients also does not result in a net loss. If those slots are not filled by the last day of the week before the next colposcopy clinic session, it will be filled by a patient with a more immediate need for

colposcopy such as a patient with a HSIL Pap.

The colposcopic providers at AHS have initiated regular communication with the Santa Rita clinic and secure pap screening results and colposcopies are handled both electronically using a secure email system and in-person via sheriff deputies who handle the paperwork for these services. This enables each system to map and track the need for such follow-up and the provision of such services. The colposcopy clinic has initiated two additional interventions that reduce barriers to post-incarceration follow-up. Those same first two appointments reserved for Santa Rita patients can also be filled by patients that were seen while incarcerated and subsequently released. This reduces the chance that a patient will not receive their results and make a follow-up plan. Security concerns make it impossible to give incarcerated patients appointments during the time they are incarcerated. By informing them that those appointments are always prioritized for them, they are able to drop in and receive results. If they drop in at times when colposcopy clinic is not in session, they are given the colposcopy clinic phone number, specifically created for patients to access colposcopy clinic providers and staff. The colposcopy clinic developed a "graduation letter," for patients as well, that documents their initiation to colposcopy care, their actual colposcopy date and result, any treatment such as LEEP or cryotherapy, and the follow-up paps and results done or needed. These letters are scanned into the electronic medical record, dictated by providers, and given to patients as they exit colposcopy clinic.

Women with serious mental illness and women who are incarcerated have unique challenges to health equity, health literacy and accessibility to healthcare services. As providers for these vulnerable populations, it is ours and the system we practice in's combined responsibility to ensure disparities are not perpetuated by bias or institutional barriers. Improving access alone will not eliminate barriers unless we address the connections between medical and social service providers and between institutions that serve women [9]. Williams et al., [10] rightly points to providers on all levels placing particular focus on the barriers associated with race, poverty, and structural inequities. Our jobs are to ensure

informed consent while at the same time acknowledging that "fair is not equal." It is our job to train ourselves and each other to recognize disparities, learn about them from each other, from our patients, and from our world and look tirelessly for ways they can be eliminated.

Acknowledgment

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Conflicts of Interest

No conflicts of interest.

References

1. Ramaswamy M, Simmons R, Kelly P (2014) The development of a brief jail-based cervical cancer health promotion intervention. *Health Promot Pract* 16(3): 432-442.
2. Weinstein L, Stefancic A, Cunningham A, Hurley K, Cabassa L, et al. (2016) Cancer screening, prevention, and treatment in people with mental illness. *CA Cancer J Clin* 66(2): 133-151.
3. James M, Thomas M, Frolov L, Riano N, Vittinghoff E, et al. (2017) Rates of cervical cancer screening among women with severe mental illness in the public health system. *Psychiatr Serv* 68(8): 839-842.
4. (2016) Practice Bulletin No. 157: Cervical Cancer Screening and Prevention. *Obstet Gynecol* 127(1): 185-187.
5. Colton C, Manderscheid R (2006) Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health client in eight states. *Prev Chronic Dis* 3(2): A42.
6. (2014) Alameda County Health Data Profile.
7. Kelly P, Allison M, Ramaswamy Megha (2018) Cervical cancer screening among incarcerated women. *PLoS One*. 13(6): e0199220.
8. Clarke J, Phipps M, Rose J, Hebert M, Rosengard C, et al. (2007) Follow-up of abnormal Pap Smears among incarcerated women. *Journal of Correctional Health Care* 13(1): 22-26.
9. Viron M, Baggett T, Hill M, Fruedenreich O (2012) Schizophrenia for primary care providers: How to contribute to the care of a vulnerable patient population. *Am J Med* 125(3): 223-230.
10. Williams A, Erb Downward J, Bruzelius E, Hara Cicero EO, Maling A, et al. (2013) Exploring cancer screening in the context of unmet mental health needs: A participatory pilot study. *Prog Community Health Partnersh* 7(2): 123-134.