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Pap Smear Study at Wagner Indian Health Service

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Federal healthcare clinic improves ability to provide patients with needed services

The Wagner Indian Health Service (Wagner-IHS) is a direct-care facility that provides healthcare services to members of the Yankton Sioux Tribe, Santee Sioux Tribe of Nebraska, and Rosebud Sioux Tribe. Wagner-IHS is located on the Yankton Sioux Reservation in Wagner, South Dakota, where approximately 5,000 of the 12,700-member Yankton Sioux Tribe reside. Wagner-IHS also services patients from surrounding reservations and communities throughout South Dakota, Iowa, Minnesota, and Nebraska, and, like all federal IHS facilities, provides free care to any Native American.

As a federally funded facility, Wagner-IHS is subject to Government Performance Results Act (GPRA) measures, developed by the Congressional Budget Office in 2003 to measure budgetary results for annual fiscal-year appropriations. GPRA requires federal agencies to demonstrate that they are using their funds effectively toward meeting their missions, and requires a five-year strategic plan; submission of annual performance plans describing how agencies will achieve goals with their annual budget request; and performance measures with specific annual targets. IHS annually reports results for GPRA performance measures.¹

Wagner-IHS monitors 27 GPRA measures each fiscal year in the areas of diabetes, dental, immunizations, cancer screening, behavioral health, and other specialties (including cardiovascular disease). Any patient that enters the Wagner-IHS facility twice within a three-year span gets added to the GPRA measurement pool, and Wagner-IHS is scored on its ability to provide applicable care to those eligible patients. Each year the GPRA goals may rise, forcing providers to improve their quality of care. For a majority of the GPRA measures, Wagner-IHS was having trouble achieving its 2017 goals (the GPRA year runs July through June).

Wagner Indian Health Service

Indian Health Service is an agency within the Department of Health and Human Services and is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes was established in 1787.

The patient-based Wagner Indian Health Service clinic in Wagner, South Dakota, provides daily care (including weekends and holidays) from 7:00 am to 11:00 pm, with seven primary care providers, two physician assistants, and approximately 70 employees. The clinic contains 10 exam rooms as well as a lab, X-ray, pharmacy, dental, lactation consultant, dietician consultants, maternal child health program, healthy heart program, diabetes program, public health nursing, behavioral health services, tribal health representatives, fitness program, physical therapy, and optometry services. Other medical providers — obstetrics, cardiology, wound care, podiatry, and nephrology — are contracted and provide monthly services at Wagner-IHS.

¹ GPRA and Other National Reporting, Indian Health Service.

Lean Learning at AEH

CEO Michael Horned Eagle has been championing lean improvements at Wagner-IHS. When a quality-improvement leader at IHS headquarters sent out an email describing the Academy for Excellence in Healthcare (AEH) at The Ohio State University, Horned Eagle saw it as something new, exciting, and in line with the improve patient care (IPC) initiative underway at IHS. Horned Eagle applied for and received a scholarship for Wagner-IHS staff to attend AEH.

The CEO's initial intent was for the team heading to Columbus to work at improving the cancer-screening bundle of GPRA measures: pap smear rates, mammogram rates, colorectal cancer screen, and tobacco cessation. Wagner-IHS had met the national goals set by IHS for those measures in recent years, he says, "but we were always scrambling in the last couple of months to try and get our patients in to meet that goal." Horned Eagle was encouraged by Beth Miller, AEH Program Director, to focus on a single measure and expand the learning from the project out to other measures. "So I looked at all of them, and in reviewing the yearly data, determined that pap smears was the one that we struggled with the most, especially in the last two months to reach the national goal."

Horned Eagle says that the IHS area office and headquarters had identified the Wagner center as performing well, but he and staff saw "an opportunity to improve. Even though we're doing good, we could always do better, and we can meet that goal ahead of time rather than scrambling in the last couple of months of the GPRA year."

Horned Eagle assembled a cross-functional improvement team, which attended AEH training in January 2017 and learned about and improved their understanding of lean tools and techniques, such as standardized work, mapping process workflows, 5S organization, and daily management systems. Wanda Dally, Lab Supervisor, says, "We went into it not really knowing what to expect when we got there. The lean process is kind of a new concept for a lot of us. But, once we got there, we [thought], 'We can make this work back at our facility.' We liked the 5S, the 'no blame, no shame' [approach to problem solving], and breaking down our silos and working more as a team rather than independent departments."

Wagner-IHS Improvement Team

- Michael Horned Eagle, CEO
- Dr. Grisel Rodriguez, Clinical Director
- CAPT Judy Cuka, Director Public Health Nursing
- Wanda Dally, Lab Supervisor
- LCDR Joan Fillaus, Registered Dental Hygienist

The Wagner-IHS team was coached at AEH and onsite in South Dakota by Margaret Pennington, AEH Faculty Director. The team reported their initial improvement-project findings to AEH in May 2017.

While at AEH, the improvement team worked at scoping their project to one GPRA score — eligible patients receiving a pap smear. Wagner-IHS had not met the annual GPRA goal three years in a row, despite previously meeting the goal five years in a row. In the past, last-minute efforts to improve the pap smear score created many capacity problems in the clinic. The Wagner-IHS vision for the project was to provide the best patient care to eligible women of 24-65 years old, which would involve increasing pap

smear testing from 53 percent of eligible women to 56 percent by June 30, 2017. There were 1,159 eligible patients for pap smears at the beginning of the current GPRA year, and that number could increase throughout the year.

When arriving back at the clinic, the improvement team immediately conducted meetings and communicated with staff the project’s objectives and key learnings from AEH. “The first thing we did when we got back to South Dakota was that Monday we met with all of the nurses and then all of the providers,” says Dally. “Those guys are the frontline staff. They see it. They live it. We wanted to get their opinion. We wanted to get their buy-in. We wanted to see what did they think would be some of those stumbling blocks that were hindering us from moving forward with this. They were really receptive, and were firing out things that they thought that they could improve on.” She adds that bringing ideas back from AEH helped to rejuvenate staff and jumpstart IPC activities.

Lieutenant Commander Joan Fillaus, Registered Dental Hygienist, says the flow mapping done at AEH helped the team to engage staff and immediately put their off-site planning into action. The team had further scoped their effort to identify where they could make the most impact with pap smear screenings, and chose to focus on walk-in patients that come to the clinic (rather than the entire population of eligible patients missing the pap smear or patients that do not make appointments to the clinic and have not been a

Pap Smear Offered — Worksheet

Wagner IHS Possible PAP - Smear Study
From _____ To _____ (only 10 pt.s per week or 2 per day)

Medical Record Number	Date Of Visit	Provider Sdr Nurse	Age	Not Asked	Refused	Made An Appt.	PAP Completed	Other or Explain Why?
N/A	2-13	Radita	41		X	X		appt made - in pain
N/A	2-13	SN	27		X			refused completely
N/A	2-14	Kimmy	27		X			Appt made
N/A	2-14	Radita	33	X				would call back for a pap
N/A	2-15	Radita	42		X	X		made appt 3/16/17
N/A	2-15	Pisa	62				X	
N/A	2-16	Lisa	16		X			to sick
N/A	2-16	N/A	N/A	N/A	N/A	N/A	N/A	N/A
N/A	2-17	htc	21			X		
N/A	2-17	hime	44		X	X		made appt for pap at home
N/A	2-17		24		X			February 13 th - 17 th - to nurse pain

Source: Wagner Indian Health Service

walk-in to the clinic). With Wagner-IHS staff they examined in more detail the four steps in a patient’s flow — registration, triage, exam, and follow-up appointment — relative to pap smears.

A medical assistant was asked to review two weeks of walk-in patients and record if they had been offered a pap smear at registration, and then also recorded going forward what occurred with eligible walk-ins on a weekly basis: if they were offered a pap smear, if they chose to have one performed or scheduled an appointment for one, and if they declined and the reasons why (see *Pap Smear Offered — Worksheet*).

Addressing walk-ins could provide the biggest immediate return on the team’s effort because staff had immediate access to the patient. Dr. Grisel Rodriguez, Clinical Director, says Wagner-IHS has an average between 40 percent and 50 percent of no-shows on the appointments. “So we try to take advantage of the patients when they’re here to get the most out of the visit. If you identify that you’re missing your pap smear or in a male that you’re missing your PSA (prostate-specific antigen test) or that we haven’t done your lipids or we haven’t seen you in our diabetic clinic in over six months, we want to get the max out of

that visit. We do not know when we will see our patient again because of the high no-show rate for appointments.”

Data compiled by the medical assistant for the two-week period showed that only 15 percent of eligible walk-in patients had a pap smear. More than 50 percent of walk-ins were not flagged as needing a pap smear, 20 percent of patients made a future appointment for a pap smear, and 15 percent refused to have a pap smear and did not make an appointment.

The team found that patient records frequently were not checked at triage to see if a patient was eligible for a pap smear. In addition, a computer program issue did not trigger a reminder during the triage to ask patients about a pap smear, and physicians did not ask a patient during the exam if she was eligible. Even when asked, many walk-in patients declined a pap smear; reasons included unavailability of a female provider to conduct the exam or the time it would take for a screening. Dr. Rodriguez says the data also helped the team identify and support staff who were least likely to ask patients to submit to a pap smear.

Developing and Implementing Countermeasures

The team reported to staff how many missed opportunities occurred on a weekly basis, says Dr. Rodriguez, and this eventually led to the implementation of weekly huddles as a means to regularly communicate GPRA performance and other conditions. And instead of getting GPRA reports on a monthly basis, Horned Eagle began to produce those on a weekly basis, which are posted at a visual board and reviewed by staff on Monday morning. With a clearer view of why walk-in patients were not having pap smears, the team and Wagner-IHS staff developed countermeasures that could quickly be put in place:

- *Triage issue:* The team implemented standard work for the triage process to flag patients as eligible for a pap smear, and, if eligible, communicate that information to the physician.
- *Computer issue:* To support the triage countermeasure, the team needed to correct the reminders tab in the clinic’s computer program. Since the team was conducting lean meetings/huddles with staff weekly, the nurse in charge of the clinic’s software programming quickly took action and was able to fix the glitch within one week.
- *Exam issues:* Only female providers in the clinic (two of seven) had been performing pap smears, despite all providers being qualified to do so. In April, all physicians went through an in-service training on how to perform a pap smear, which was provided by an OB/GYN. With more physicians available, this could reduce wait time for an exam.

In a nurse meeting, it was noted that only three of the 10 exam rooms had privacy screens used for pap smear exams, which could create a delay if those three rooms were in use. The team notified Horned Eagle, and privacy screens were immediately ordered to standardize all rooms for pap smears. Nurses also created pap-smear kits and stocked a cabinet in each exam room with the kits. The nurse working with each doctor is responsible for ensuring kits are in the two rooms that

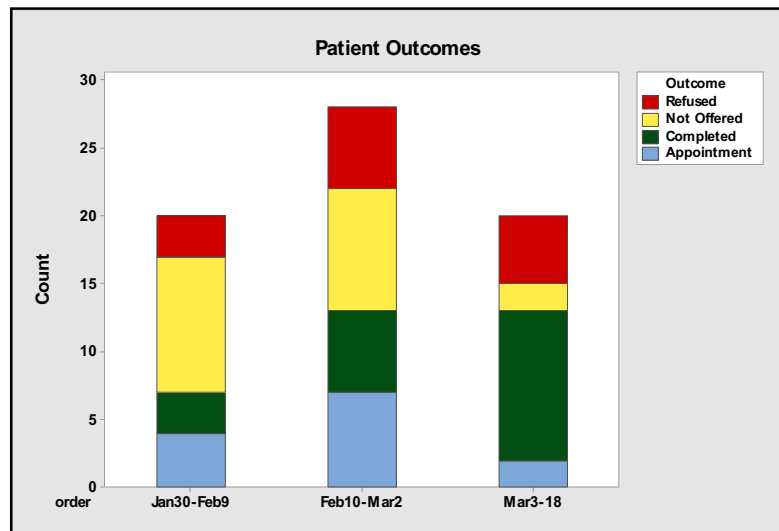
their doctor uses as well as general 5S of the rooms. (Most of the nurses understood the clinic’s lean objectives, understood why the concepts were being implemented, and were engaged and willing to help.) The kits could reduce time looking for supplies, reduce the time it takes to perform an exam, and improve patient flow in the clinic.

- *Patient refusals:* Patients typically refused the pap smear because they wanted to do it when they felt prepared for the exam; did not feel well enough for the exam (they came to clinic because they were sick); or because they were culturally sensitive to such exams and/or not concerned about their health. With help from AEH coach Pennington, the team worked to differentiate the “soft no” patients (those that make an appointment but often do not show up) from the “hard no” patients (not even a \$50 gift card could influence these patients into making an appointment for a pap smear). The team would try to change the cultural perspective of patients via education, and nurses and physicians would encourage and reinforce the need for patients to undergo the exams.
- *Checkout and follow-up issues:* Follow-up appointments were rarely made, and so the checkout process was changed to request appointments for all eligible patients that did not receive the pap smear during their walk-in visit. But even when an appointment was made, cancellation and no-show rates were high. Reasons included the patient forgot, transportation issues, and other priorities. Medical assistants planned to call patients and remind them of their appointments.

GPRA Results and Next Steps

By mid-March, most eligible walk-in patients to Wagner-IHS had been identified and offered a pap smear (up from 50 percent at the start of the project), and 50 percent of those offered had either completed a pap smear during the walk-in visit or scheduled an appointment (see *Improved Pap Smear Completion Rates*). Patient refusals for the period rose from 15 percent to 25 percent because more patients were being asked. By the end of May, the GPRA measure for pap smears was at 59.2 percent, well above the national goal of 56.1 percent, and was rising in June.

Improved Pap Smear Completion Rates



Source: Wagner Indian Health Service

Dr. Rodriguez says that improvements were rapidly achieved “by those little changes that we were focusing on: just asking the patient, having the room prepared, having the kits already in there, just saving

a lot of time, and sometimes not even giving the patient the option — ‘You know, you’re due for your pap smear, so we’re going to get it done today.’”

As the weeks went by, the team saw the pap smear measure improve significantly from week to week (rather than month to month as it had previously been tracked), which was a visual recognition for the staff and kept enthusiasm high, adds Dr. Rodriguez: “‘This is working. This can be done. We don’t have to be in the month of June and doing Saturday clinics to get our GPRA numbers up.’... Everybody automatically goes and looks how well we’re doing and how much we went up from the week before. It is a constant reminder that we have to keep doing this because it does work.”

The team believes the improvements are sustainable, yet they also continue to examine how to address challenges that remain. For example, pap smears have been conducted by each of the Wagner-IHS male providers, but not as many as the team would like; this remains an issue of patient preference. In addition, medical assistants have encountered wrong phone numbers and disconnected phones when trying to reach patients who made an appointment for a pap smear during their walk-in visit. “We’ve tried to figure out a way to keep our phone numbers better updated, addresses better updated,” says Dally, and have worked with IT staff to get calls to display as “IHS” rather than “Unknown” on patients’ phones to improve communications and, thus, minimize no-shows.

Wagner-IHS staff have independently developed ways to positively impact GPRA measures. As the team began shifting their attention to the eligible patients that do not make appointments and who are not walk-ins, nurses took the initiative to send letters and educational materials to 100 women eligible for a pap smear. This effort resulted in one provider performing 15 exams because of the letter. Unlike phone calls, the patients were responsive to mail. In addition, some patients reported back to the clinic that they had the exam done elsewhere, which enables the clinic to enter this as a historical record that counts toward the GPRA scorecard. Nurses have also begun using letters to encourage other GPRA services. “Since they were already checking to see if the pap smear was due, they were checking to see if the mammogram was due, and then they were checking to see if the colorectal cancer was due,” says Dr. Rodriguez. “So they created this letter of a reminder, with all three of these measures as well. And as a result of that, all three of these measures that we struggled with for the past couple of years are all in the green as of right now.”

These and other practices applied to the pap smear initiative are improving other GPRA measures as well through mid-June (see *Complementary Effects from Pap Smear Project* on next page). For example, *daily* team huddles were started and have become mandatory, during which staff are taking their “no shame, no blame” approach to identifying problems more frequently. Huddles and the visual tracking board have continued to increase awareness of all GPRA rates and help to align staff to improve them.

Complementary Effects from Pap Smear Project

IT/UGRA Monthly Report - GY 2017	2016 Final	Sept.	October	↑ or ↓ from 2017 Goal		IT/UGRA Monthly Report - GY 2017	2016 Final	6/12/17	6/19/17	↑ or ↓ from 2017 Goal	
DIABETES GROUP						DIABETES GROUP					
Good Glycemic Control < 8	38.40%	17.90%	17.40%	-31.00%	Red	Good Glycemic Control < 8	38.4%	35.5%	35.5%	-12.9%	Red
Controlled BP <140/90	75.70%	64.10%	65.20%	1.40%	Green	Controlled BP <140/90	75.9%	68.7%	69.2%	5.4%	Green
Statin Therapy	62.10%	62.20%	61.70%	-0.20%	Red	Statin Therapy	61.8%	65.0%	65.0%	3.1%	Green
Nephropathy Assessed	87.30%	44.60%	43.70%	-19.60%	Red	Nephropathy Assessed	87.1%	86.8%	87.1%	23.8%	Green
Retinopathy Exam*	64.70%	28.70%	33.30%	-29.80%	Red	Retinopathy Exam*	64.7%	63.3%	64.9%	1.8%	Green
DENTAL						DENTAL					
Access to Services	27.50%	10.70%	12.60%	-17.10%	Red	Access to Services	27.4%	27.4%	27.9%	-1.8%	Red
Sealants	15.80%	5.00%	6.10%	-10.50%	Red	Sealants	15.8%	18.1%	18.7%	2.1%	Green
Topical Fluoride pt count	30.20%	8.20%	9.40%	-20.50%	Red	Topical Fluoride pt count	30.2%	30.1%	30.9%	1.0%	Green
IMMUNIZATIONS						IMMUNIZATIONS					
Influenza 6 m - 17 years	52.10%	19.00%	28.20%	-8.90%	Red	Influenza 6 m - 17 years	52.2%	42.8%	42.7%	5.6%	Green
Influenza 18+	44.90%	24.60%	33.00%	-5.70%	Red	Influenza 18+	45.0%	47.5%	47.4%	8.7%	Green
Pneumovax 65+	90.70%	90.80%	91.30%	4.60%	Green	Pneumovax 65+	90.6%	91.3%	91.4%	4.7%	Green
Childhood Immunizations	N/A	61.80%	64.40%	-10.40%	Red	Childhood Immunizations	N/A	95.8%	95.8%	21.0%	Green
CANCER SCREENING						CANCER SCREENING					
Pap Smear Rates	56.20%	49.20%	49.90%	-6.20%	Red	Pap Smear Rates	56.1%	60.1%	60.1%	4.0%	Green
Mammogram Rates	57.60%	46.20%	46.20%	-10.50%	Red	Mammogram Rates	57.4%	60.9%	60.9%	4.2%	Green
Colorectal Ca Screen	38.70%	24.30%	24.50%	-15.70%	Red	Colorectal Ca Screen	38.8%	44.0%	43.0%	2.8%	Green
Tobacco Cessation	53.60%	15.90%	19.60%	-33.60%	Red	Tobacco Cessation	53.6%	50.8%	53.8%	0.6%	Green
BEHAVIORAL HEALTH						BEHAVIORAL HEALTH					
Alcohol Screening (FAS Prev)	73.70%	42.40%	49.30%	Baseline	Green	Alcohol Screening (FAS Prev)	73.8%	73.8%	74.1%	Baseline	Green
SBIRT 9-75	N/A	0.00%	0.00%	Baseline	Green	SBIRT 9-75	N/A	0.6%	0.6%	Baseline	Green
IPV/DV SCREEN 15-40	74.50%	47.80%	53.50%	-11.80%	Red	IPV/DV SCREEN 15-40	74.6%	77.0%	77.5%	12.2%	Green
Depression Screening 12-17	59.30%	37.60%	42.30%	Baseline	Green	Depression Screening 12-17	59.4%	64.3%	65.3%	Baseline	Green
Depression Screening 18+	76.50%	48.20%	54.00%	-16.00%	Red	Depression Screening 18+	76.7%	76.6%	77.0%	7.0%	Green
CVD RELATED/OTHER						CVD RELATED/OTHER					
Med. Mgmt. APT	32.10%	37.00%	38.70%	Baseline	Green	Med. Mgmt. APT	32.1%	40.3%	40.3%	Baseline	Green
Med. Mgmt. CONPT	18.90%	15.10%	14.70%	Baseline	Green	Med. Mgmt. CONPT	18.9%	19.4%	19.4%	Baseline	Green
Childhood Wt. Control	19.30%	17.30%	20.20%	2.60%	Green	Childhood Wt. Control	19.9%	22.2%	22.8%	0.0%	Green
Control High BP-MH	65.90%	46.30%	52.20%	-7.50%	Red	Control High BP-MH	66.1%	59.4%	59.7%	0.0%	Green
CVD Statin Therapy	52.40%	52.20%	51.60%	Baseline	Green	CVD Statin Therapy	52.2%	56.2%	56.4%	Baseline	Green
Prenatal HIV Testing	57.50%	57.30%	57.00%	15.10%	Green	Prenatal HIV Testing	57.4%	59.3%	59.3%	17.4%	Green
Breastfeeding rates @ 2Mo.	22.20%	46.90%	45.50%	9.10%	Green	Breastfeeding rates @ 2Mo.	22.2%	43.6%	43.6%	7.2%	Green



Source: Wagner Indian Health Service

Clinic leadership has moved beyond a system of putting sticky notes of “what we think needs to be done or a recommendation or a request” to having conversations with the people involved, adds Rodriguez. “The communication has really, really opened up. The huddles, as recommended from our last visit in Ohio, are not only now conducted by me, as Clinical Director, but a different member conducts the huddle each morning, whether it be nursing, whether it be lab, whether it be pharmacy, or whoever is there that has something to say. We usually start with where we are with GPRA. ‘What are we focusing on? We’re in the green in these numbers. These are the ones that are red. This is where we’re pulling our focus. We’re getting our lists. We’re calling our patients.’” She says “anything and everything” can be discussed, such as the medications requested by providers, lab order sets, or replenishing supplies. “Things come up in that morning huddle of how can we make not only life easier for each and every one of us but to improve the patient care.”

Fillaus says that Wagner-IHS will get a quantitative look at staff satisfaction by conducting a brief survey of providers about the improvement project and resulting changes. Captain Judy Cuka, Director Public Health Nursing, says that she expects the feedback to be favorable, and has heard from colleagues that they notice the positive impact on culture and attitude that the huddles and lean-focused improvements have fostered. “I think it happened because everybody had a part to play. I think the huddles really helped. They forced people — doctors and nurses — to talk to each other, because that wasn’t always the case. People felt like they could bring things up and get answers right away.”

Dr. Rodriguez adds that staff “weren’t being told what to do. They were being asked, ‘What do we need to do in whole so that we can improve this measure?’ And everybody had great suggestions and recommendations, and we followed through on them. They saw that they were heard.”

Captain Cuka agrees: “We let them solve the problems themselves. We just gave them some tools, and they took it and ran with it because they’re the ones doing the work there day in and day out... Give them the [lean] tools and let them do the work, figure it out, and just guide them through the processes.”

“From an administrative standpoint, IHS functions as a regular federal government or state government agency in that we’re usually delivering care from the top down,” explains Horned Eagle. “We get mandates and we get initiatives, and we’re told, ‘You will do this,’ without being given any tools or any resources to affect the outcome. I think it would be important for other federal or state agencies that adopt this measure to know that this is a complete reversal in that we’re giving all the tools and the decision-making to the people who are actually doing the work. It’s going to be a real process change for them.”

The Wagner-IHS project has been successful in large part because it not only “came from the top” but had the hands-on involvement of CEO Horned Eagle, notes Cuka: “He applied for the scholarship. He came with us to Ohio. Every meeting that we had with the doctors, the nurses, he was at. He supported the concept of lean management and said, ‘This is where we’re going to go. This is our vision.’”

AEH Commentary

The Wagner Indian Health Service (Wagner-IHS) project illustrates the power of a cross-functional team to assess and address a single problem that is reflective of a broader set of issues. By focusing intently on one measure and thoroughly identifying root causes (GPRA pap smear rates), the Wagner-IHS team was able to define and implement best practices, work standards, and a daily management system that are being applied to and improving the overall operations of the clinic and its performance to the larger, common set of objectives (all GPRA measures).

The project also highlights how the improvement team sought to better understand their customer — Native American patients — and the factors that helped or inhibited the team and Wagner-IHS to meet its performance objectives. For example, the team differentiated their patient base, developing methods that encouraged one population group to quickly get care (offering pap smears to walk-in patients to the clinic), while taking a longer-term approach for another population group (writing letters and distributing educational information to patients that have not come to the clinic but who likely need care).

Most healthcare providers that pursue lean improvements do so with at least some awareness of and support from senior leadership. That is always necessary, but rarely sufficient. At Wagner-IHS, CEO Michael Horned Eagle led the initiative and was actively engaged throughout all aspects of the project, from attending the training at AEH to helping the team implement changes. This level of engagement is unusual, even in a small healthcare organization such as Wagner-IHS, but team members attest to the direction and value it provides to improvement efforts.

About AEH

The Academy for Excellence in Healthcare blends in-person class time with hands-on project work, interactive simulations, and recurrent coaching, all aimed at helping healthcare teams spark actionable change at their organization. At the heart of this program is a real-world workplace problem each participant team selects and commits to solving through five intensive days on campus, followed several weeks later by two days of project report-outs and lean leadership training. This project-based approach pays immediate dividends and lays the groundwork for transformational change.



In collaboration with



Pap Smear Study

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