Bree Collaborative | Cervical Cancer Screening Workgroup
March 3rd, 2021 | 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Laura Kate Zaichkin, MPH, Director of Health Plan Performance and Strategy, SEIU 775 Benefits Group
Virginia Arnold, DNP, ARNP, Nurse Practitioner, Pike Place Market Neighborcare
Diana Buist, PhD, MPH, Senior Investigator,
Colleen Haller, MPH, Director of Quality, Community Health Plan of Washington
Beth Kruse, CNM, Public Health Seattle King County
Jordann Loehr, MD, OB/GYN, Yakima Valley Farmworkers Clinic
Rachel Winer, PhD, Professor of Epidemiology, Director of Research and Strategic Partnerships, Kaiser Research Institute
LuAnn Chen, MD, Family Physician, Senior Medical Director, Community Health Plan of Washington
Leslie Edwards, CNM, Nurse Midwife
Connie Mao, MD, Professor of Obstetrics and Gynecology, University of Washington Medical Center
Michelle Sullivan, Chief Quality and Compliance Officer, Yakima Neighborhood Health
Sandra White, MD, Pathologist, Cellnetix University of Washington

STAFF AND MEMBERS OF THE PUBLIC

Ginny Weir, MPH, Bree Collaborative
Amy Etzel, Bree Collaborative
Nick Locke, MPH, Bree Collaborative

WELCOME

Laura Kate Zaichkin, MPH, Director of Health Plan Performance and Strategy, SEIU 775 Benefits Group welcomed members to the workgroup and those present introduced themselves.

Motion: Approval of February 3rd, 2021 minutes
Outcome: Passed with unanimous support

GENERAL DISCUSSION: STARTING A DRAFT OF THE RECOMMENDATIONS

Ginny Weir, MPH, Bree Collaborative opened the discussion to define the problem.

- What to do with a million+ dollars. Helpful to think about impacts of last mile follow-up with a nurse navigator vs. spending more time on outreach to those who have not been screened. Thinking of the continuum of care for different populations and thinking about holes are in populations.
    - People move to problem solve without understanding their problem. Part of cancer screening framework – are you focused on HEDIS to get a rate up? Or are you focused on people. What are we trying to solve – reduce mortality?
- Screening rates in WA, we are in the top third of states for screening overall. One of the big issues that we see is follow-up. How much attention to put on those who didn't get a screen at all vs those who need follow-up. Overdue screen vs. follow-up. Trying to get them coordinated to see gynecology is even more difficult.
- Interpretations are difficult also for primary care providers – gap in understanding need for follow-up.
    - ASCCP app is available but may not be used. One-time $10 fee. It is not integrated into systems. Epic does a good job telling you when your next pap is due. Pops up in notifications for care gaps.

    - Guidelines can be confusing without the app.
    - Many clinicians are not aware of cervical pathology. Non-follow-up problems, you have to actively see if that patient is due.
- We change the guidelines frequently as there are changes in the guidelines all the time. We need better systems in place to help providers.
- When is self-swab coming? Changes ongoing, more pressure due to COVID for FDA to approve it. You may be able to buy in drug store then your PCP would never see it.
- When there is an abnormality people sometimes disappear. Work on people's fear of finding cancer. Then access to colposcopes is an issue. This might be a stranger so a person is even less likely to want to see them.
- Should we include language of how to talk to patients? Could be further testing.
    - Are there handouts that are officially made for patients. Lot of handouts not written in the right reading level for patients – the EPIC-generated paperwork is not helpful.
    - Finding resources at the right reading level. Some might speak Spanish but not read Spanish.
- If you look at epidemiology, people who are not screened at all are more at risk. Our goal should be to focus on reducing mortality but also anyone.
- Holes in our population and roles in screening and referral are different across the state.
- Fear of cancer
    - Is cervical cancer screening inherently different? The procedure needed to do this screening is so much more invasive than a mammogram. Pelvic exam is the issue. Can be a conversation over several visits.
    - Sexual trauma can also lead to hesitancy
    - Hesitancy due to hygiene (e.g., pubic hair)
    - Can also feel like a lot of false alarms – positives that lead to colposcopy that don't lead to cancer.
    - Conversation starts with prevention
    - Lifetime worth of conversation – starting with HPV.
- HPV – most recent guidelines do not show a change enough to account. Expecting a change over time to the risk. Vaccine has not been out that long in the grand scheme of things.
- Different age groups need different messaging – bimodal education.
    - Home trial – trying to understand in people with access to health insurance what is causing them to not come in. Why do I need to be screened for an STI? Why do I need to be screened 20 years after I stopped having sex?
    - They don't understand why they need to be screened? This is complicated.
    - Depends on what problem you are trying to solve.
    - Population with a high prevalence of sexual trauma may be a whole different conversation.
- What is the most important thing to do first. Not well served by saying HPV is an STI.
- Only cancer that we have a primary prevention for. We will be doing many fewer screenings.
- Navigators help with getting people to the referral sites but they still didn't go into their appointments.
- How we communicate results to patients. If you have an abnormal lab a message to a nurse to call the patient. It is out of the provider's hands. What the next step is for the likelihood they will have a follow-up? Many different issues.
    - Obesity leading to not easily accessible cervix.
    - Sexual trauma.

    - Challenge of finding a colposcopist. Encouraging people to do a colposcopies, give resources on how to become certified.
    - Could state put together of colposcopists? Does extend beyond OBGYNs but people don't know where to send someone. Low insurance coverage in a population.
    - Likely only centers for colposcopists – needs to be better tracked. Likely to see decreasing cervical cancer rates.
- Trauma informed pelvic exam/gynecology
    - Have you had any painful pelvic exams in the past?
    - You can change your mind at any point. You can stop or pause at any point.
    - Open the floor for them to be in control.
- There is come data about a self-swab. Depending on type of HPV test may be more or less accurate. Currently no approved test. Using it at some UW clinics for people who might not otherwise be screened. Most of the problem is that the lab might not run it. High 80s for sensitivity.
    - Self-sampling is being used in other countries.
    - National cancer institute is planning a large clinical trial.
- Follow-up
    - Usually on the individual provider to follow-up. To do with system resources. Have had a decrease in ancillary staff to support tracking of patients. Other systems like Kaiser have resources. Barrier to getting people back in.
    - Return rate is about 60% failure to return. Lots of room for improvement.
    - Radiologists are managing mammography from screen to diagnostic.
- Pre-ASCCP guidelines we used to send out reminder letters for people who had an abnormal result but it became a non-contributory standard. Don't put it on the pathologist, they don't have history on prior pap or other biopsies. Not same setup as with breast cancer.
- Pediatricians recommend the HPV vaccine less than other vaccines. Not required by schools, done in adolescence.
    - UW has online CME course for providers about cultural barriers (e.g., east African families)
    - Immunization action coalition of Washington
    - Insurance coverage is only up until 45 – Apple Health. CHPW does not require prior-auth for vaccines.
    - Only recommended or specific individuals so there is a copay for people.
    - Cost of vaccine is $600 + admin. So close to $1000.
- Add language about vulnerable groups (e.g., LGBTQ, disability, focus on healthy sexuality), about trauma-informed care, and about not shaming people such as those with a high BMI.

  Action Items:
    - Ginny reach out to immunization action coalition of WA.
    - Ginny to reach out to school-based health.

Summary of Issues:

- Population that is are overdue for screening
    - Self-swab is not currently available, is being tested for efficacy.
- Population that have had a positive screen and need follow-up
    - Access to colposcopists – how are we arranging this
    - Challenging for a provider to follow-up – is tasked back to the individual provider.
- Talking to people about cancer broadly

    - Not wanting to address a positive due to fear - Abnormal results – how to communicate
    - Addressing the screening and follow-up needs of those who have had sexual trauma
- Activities to address mortality
    - HPV
    - Education
        - Older adults vs. younger adults
        - How to communicate after a positive test
    - Need for colposcopists
        - List of those who are trauma-informed
    - Paying for HPV vaccines
        - Uniform insurance coverage until age 45

GOOD OF THE ORDER

Ms. Zaichkin thanked all for attending and adjourned the meeting.