
Bree Collaborative | Cervical Cancer Screening Workgroup

March 3rd, 2021 | 8:00 – 9:30 a.m.

Virtual

MEMBERS PRESENT

Laura Kate Zaichkin, MPH, SEIU 775 Benefits

Group

LuAnn Chen, MD, Community Health Plan of
Washington

Colleen Haller, MPH, Community Health Plan of
Washington

Beth Kruse, CNM, Public Health Seattle King

County

Jordann Loehr, MD, Yakima Valley Farmworkers
Clinic

Connie Mao, MD, University of Washington
Medical Center

Sophia Shaddy, MD, CellNetix Pathology

Sandra White, MD, CellNetix Pathology

STAFF AND MEMBERS OF THE PUBLIC

Amy Etzel, Bree Collaborative

Ginny Weir, 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 March minutes

Outcome: Passed with unanimous support

CERVICAL CANCER PREVENTION

Ginny Weir, MPH, Bree Collaborative asked for reactions to the table of barriers and solutions:

- Revise the infographic
 - Revise so all arrows do not go to death (show interventions)
 - Arrow from treatment/management back to screening
- In the table, to replace the term pap smear with cervical cancer screening
 - HPV test is part of the screening
- Much of what we do is about education.
- HPV vaccine
 - Stigma, general social attitudes toward sex and sexually transmitted diseases. Some states do require HPV vaccine as a requirement for school enrollment as for other vaccines. Unsure how many other states require this.
 - Some countries require this.
 - About 80% of girls have had one dose and 60% of boys, but lower for whole series.
 - Tracking – is a state registry. Workflow would be to check this registry for those under 18. If you are over 18 there is no way to transmit information. MAs look up WA state insurance registry to see if HPV is in that. Problem is if there is an error with the person's name in the registry but is only for those who have received vaccines in the state. This can be used in for adults as well. Swedish for example requires providers to check the registry. You can also see what a person is due for.
 - Vaccines document in the registry. Pharmacies do this too. They used to not document when vaccines were provided.
 - Is included in some EHRs – such as Epic – the link to WSIS. Not uniform. Small private clinics have difficulty tracking.

- Whether religiously-affiliated delivery sites have policy-barriers to HPV vaccination – this is unlikely.
- Swedish is graded on how many patients have vaccine.
- As of April 2020, at least four jurisdictions (Rhode Island, Virginia, Washington, D.C. and Puerto Rico) require HPV vaccination for school attendance. Hawaii will require the vaccine starting July 1, 2020.
- Cervical cancer screen
 - Many people get this screening at a family planning clinic and do not have a PCP or a care home.
 - People are uninsured and those who are undocumented have a fear of coming in for any care.
 - Cost esp copays
 - Cannot just say you need to get a pelvic exam the day-of as people tend to need to be psychologically ready for an uncomfortable exam. Hard to measure 5 years, has become more confusing as is not annually.
 - Often say come in at 25, 30, 35 etc.
 - There and the five year thing makes it seem like it is not a big deal. When it is annual it seems more a big deal like blood pressure. The message gets diluted.
 - Unscreened people are those who are not in a system or enrolled in a plan. The solutions are more difficult.
 - People with health insurance whose insurance changes every year or every two years. Health plans cannot share information. In Seattle King County more and more systems are on Epic.
 - Age-based is a good way to think about it – 20-25-30. Public health message.
 - Complicated when you get above 65, for a 67 year old person who you don't know what their last exam result was. New ACCP guidelines are clear but a lot of clinical judgement. Hopefully as a better vaccinated population comes through a population needs less screens. Recommendation that to discontinue screenings you have two negative tests or a negative HPV screen. If you don't know you do a co-test and then make a judgment about whether to bring them back to do another test at 70. Hard to stop at 65 unless you keep your records with you. Lot of debate about whether to screen when people whoa re older but you do get a lot of false positives and can cause harm as it is uncomfortable due to atrophic changes.
 - Stuck with residual HPV that won't cause cancer. Relies on that person having to figure that out. People might not know they have had an abnormal pap. Getting providers to say this out loud to confirm with the person and that they do have history of abnormal pap. People may think no news is good news.
 - Addressing fear of cancer – see a lot in prenatal care where people don't want to know. Talk a lot about birth preparation. Rarely to change a mind. In cervical cancer not expecting to find cancer, you are looking for pre-cancerous conditions. Shifting from you are looking to cancer to you are preventing cancer. Education – when there are abnormal results, education about addressing fear and anxiety. Black/white thinking about cancer.
 - Trajectory of people you are reminding and calling. As time goes by the messaging gets more dire. When people don't seem to be listening or hearing, elevated language. How else would you do this. Need to document that the person was aware of the possible nature of the risk.

- You say that you are screening to prevent cancer, but then they have an abnormal result, and you don't need to do anything, mixed message.
- If they had a colposcopy a couple years ago, they might not want to come in but are highest risk with persistent disease.
- HPV is difficult to understand, that a positive does not mean that you will get cancer. Not a yes/no screening.
- Significant cost for anyone who is not on Medicaid.
- Cost information to the person. The provider won't know how much any procedure will cost.
- If a women enrolls in the BCCHP program before an abnormal pap everything else is covered. This is for anyone who is here without a social security number. Covers all cervical or breast screening but only if they are enrolled in the program.
- Payment is low and not a lot of OBGYNs accept that payment.
- Lot of administrative time to do consenting etc. Is a mess administratively. They can be enrolled after an abnormal pap.
- They do not know how many people they will be able to find at any time.
- Missing from table
 - Not enough hourly employees (MAs, people who call registries) Overall staffing
 - Tracking is the most difficult. Some people come in and out of having an abnormal pap multiple times over time. Who needs to come back for a pap in 6 mos. This is piled onto the provider. Don't have people who are doing the tracking and that is critical. Has to be done manually, not a function of EHR. Not reimbursed in FFS.
- No state registry but cancer cases are recorded in SEERs data.
 - Could require that all providers used the CDR that has all cancer screening results.
 - All MCOs have to pay to support it.
 - NM has cervical cancer registry. Every pathologist is required to record every pap etc. Across all systems and types of cancer.
 - <https://hpvprevention.unm.edu/nmhvpr/selected-publications.html>
 - <ibis.health.state.nm.us/indicator/view/CancerIncidCervix.Year.html>
- Epic in a system is not the same as Epic in another system.
 - In a large system it can take up to 12 months to make any change with limited IT and Epic.

GOOD OF THE ORDER

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