Bree Collaborative | Cervical Cancer Screening Workgroup
May 5, 2021| 8:00 – 9:30 a.m.
Virtual

MEMBERS PRESENT

Laura Kate Zaichkin, MPH, SEIU 775 Benefits Group
Diana Buist
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

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 April minutes
Outcome: Passed with unanimous support

CERVICAL CANCER PREVENTION

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

- Awkward language that communication is "not pathology"
- NCQA metrics will change rapidly and may become antiquated. As providers do more HPV testing having a pap as a measure of success will not be applicable. Need to put away the pap smears. Backwards thinking.
    - UW has moved to doing HPV testing predominantly.
    - KP's guidelines just came out that primary HPV is the default.
    - Add following ASACCP guidelines.
    - Those who are under 30? How to address
    - Most now are starting to look at screening those over 25 for only HPV test. Not using Pap at all as metric.
    - USPSTF needs to change their starting age and that HPV is the primary testing method.
- Issue of rapidly changing guidelines – especially around age.
- Should have patient-facing language broken out by age.
- HPV vaccination rate is up to 80% in some age groups but 60% for others. Higher for female adolescents than male. There is an assumption that vaccination will continue.
    - Should keep co-test as vaccination rates are not as high as in other countries.
- Reinforcing that providers, payers should pay attention to the evolving science and pathways to access and barriers to access and working on those depending on their lane.
- Can use existing guidelines that recommend co-testing but acknowledge that HPV testing is most likely the future.
- Whether we want to differ from the USPSTF guidelines by age and testing type.

- Also need to include HEDIS metric as that is how everyone is graded. They may need to pause the measure for a few years. They will need to add-in more codes that will satisfy the science.
- The HPV test is the code, not particular to cervix. Up to plan to decide whether they will count vaginal HPV as screening. Plan would not know if the screen is vaginal or cervical.
    - Anal screen is a different reimbursement rate and a different code.
    - Once FDA approves self-swab, it will be more available. This is only available by some labs. We can't recommend this yet.
    - Many delivery sites self-collect in the office and process as a routine cervical/vaginal specimen.
    - Pathology will know whether cervical or vaginal as causes different follow-up. They will also get last menstrual period and whether they have been treated for HPV in the past. Whether patient has a cervix.
- Self-swab
    - Whether FDA approval means the test will need to be validated in the lab.
    - Add that this should be recommended by national quality organizations.
    - Some organizations have less agency to decide their own testing mechanism. We do not want to punish providers who are being graded by a particular type of cervical cancer screening. Don't want to be doing wild-west treatment.
    - This will go far for populations who do not feel comfortable with a pelvic exam.
- A guideline-concordant HPV-only test of a 25-year-old will not satisfy HEDIS and will unfairly punish evidence-following providers.
- ASACCP
    - Need to put in results from cytology or you can't go on.
    - LabCorp policy unknown.
- Pathway
    - CC screen will vary based on mechanism for screening. Some groups won't do primary HPV screen.
    - Add double arrow between abnormal result and CC screen.
    - Will people be testing at home without interacting with their provider at all? Or with the FIT kit? One can buy HPV testing kits online. Hard to get FIT tests back. Could do self tests at the office (no timing of bodily functions that is involved). Would patients get the results themselves or would they go through a provider. Don't want to lose someone who doesn't know what to do with the result.
- Self-purchase STI tests
    - Recommend against ordering HPV tests online for consumers.
    - Not available in New York (must be legislation barring self-purchased tests).
- CLIA regulates laboratories. You should not do testing in a non-CLIA lab. Test only in CLIA-regulated lab.
- Should not be ordering a lab test unless you know what it means. How to communicate with patients.
- Communication best practices
    - Need to add that communication is guideline consistent.
    - Need wholistic communication.
    - Person-centered – they have time to have all their questions answered.
- Robust enough language about talking to patients from a trauma-informed perspective.

GOOD OF THE ORDER

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