Cancer Prevention and Early Detection for Community Health Centers

Cervical Cancer Prevention & Screening: Pathways to Greater Access

January 22, 2026

This session is being recorded

Welcome

Gabrielle Darville-Sanders, PHD, MPH, CHES

Strategic Director, National HPV Vaccination Roundtable

Agenda

1. **Why Access Matters: The Public Health Landscape**
   Speaker: Rebecca Landy, PhD

2. **Cervical Cancer Screening and HPV Self Collection Guidelines**
   Speaker: Sarah Temkin, MD

3. **Strategies and Tools to Increase Access**
   Speaker: Sarah Temkin, MD

4. **Best Practice: Primary HPV Testing in a Mobile Clinic**
   Speaker: Tom Hutch, MD, FAAFP, FASAM

5. **Q & A**
   Gabrielle Darville-Sanders, PHD, MPH, CHES

Poll

1. Almost all cases of cervical cancer are caused by high-risk types of human papillomavirus (HPV).
2. The 5-year relative survival rate is over __% for cervical cancer diagnosed at a localized stage.
3. How would you describe your knowledge of cervical cancer prevention and screening?
4. How would you describe your knowledge of self-collection HPV testing?
5. My clinic has implemented HPV self-collection screening.

Welcome To

Rebecca Landy, PhD

Principal Scientist, Risk Factors & Screening Research

American Cancer Society

Sarah Temkin, MD

Senior Director, Early Detection

American Cancer Society

Tom Hutch, MD, FAAFP, FASAM

Medical Director, We Care Daily Clinics

Clinical Assistant Professor

University of Washington Department of Family Medicine

American Cancer Society®

Rebecca Landy, PhD

Principal Scientist, Risk Factors & Screening Research

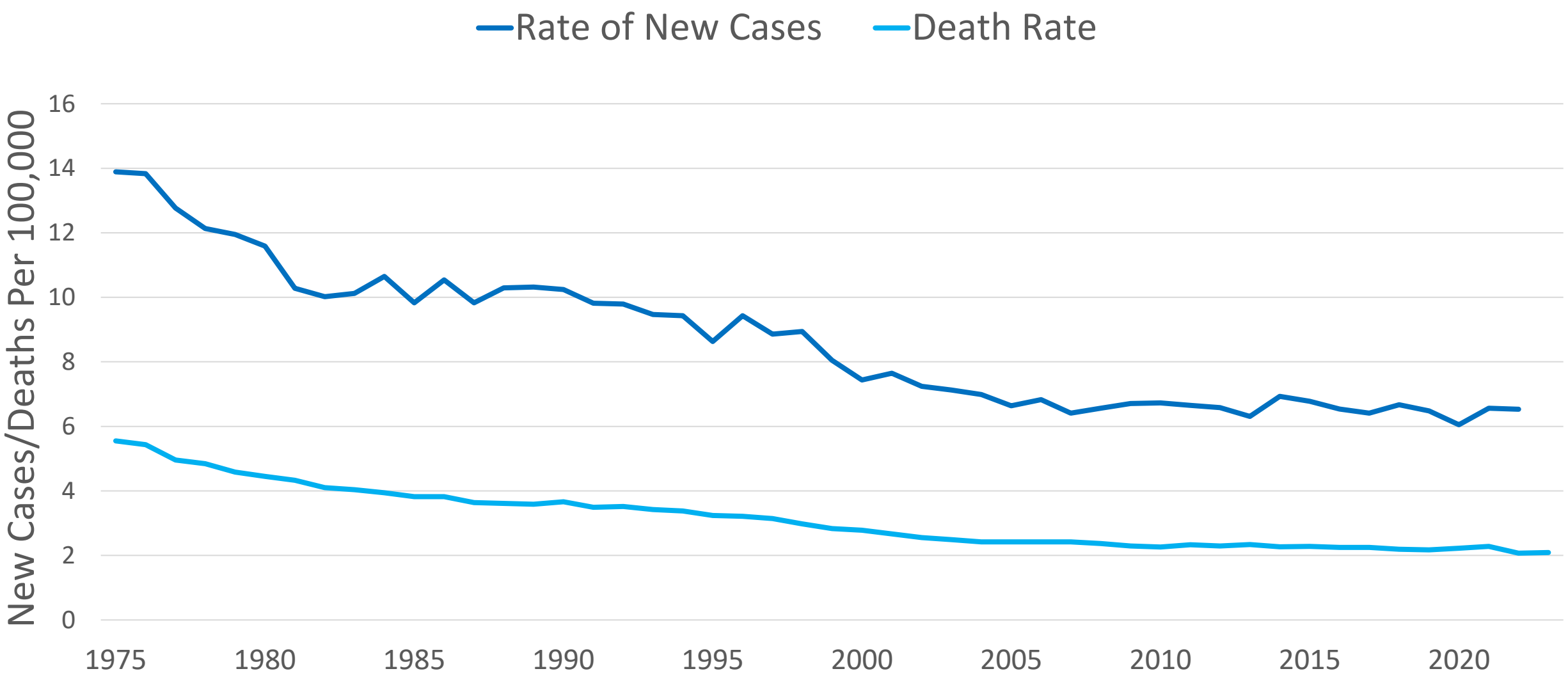
American Cancer Society

CERVICAL CANCER **AT A GLANCE**

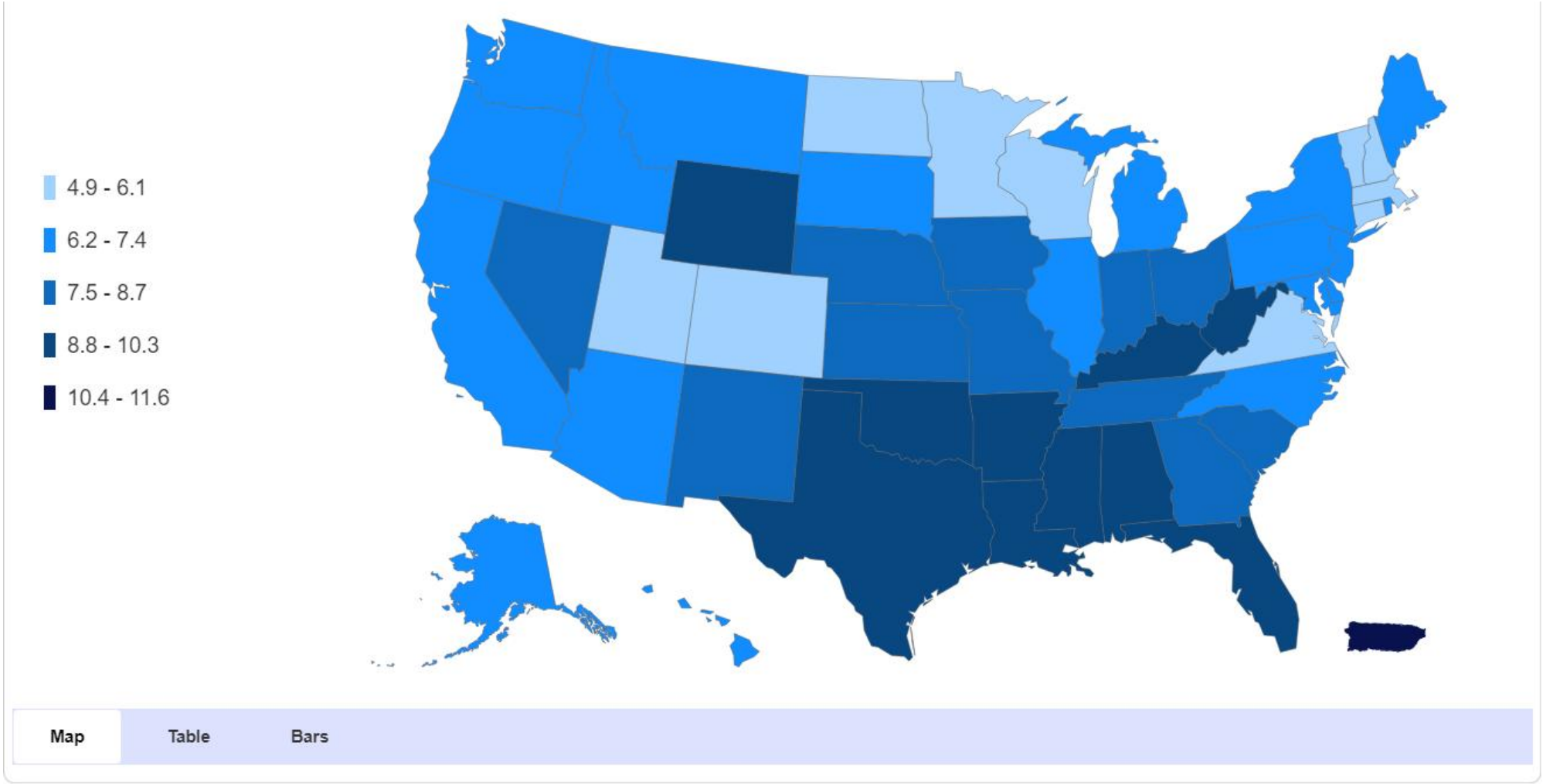
Estimated new cases, 2026	Estimated deaths, 2026	Incidence rates, 2018-2022	Mortality rates, 2019-2023
13,490	**4,200**	**9.7**	**3.0**
		Average annual rate per 100,000, age adjusted to the 2000 US standard population, corrected for hysterectomy prevalence	

SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/types/cervix | Accessed 1/20/2026.

Cervical Cancer Incidence and Mortality



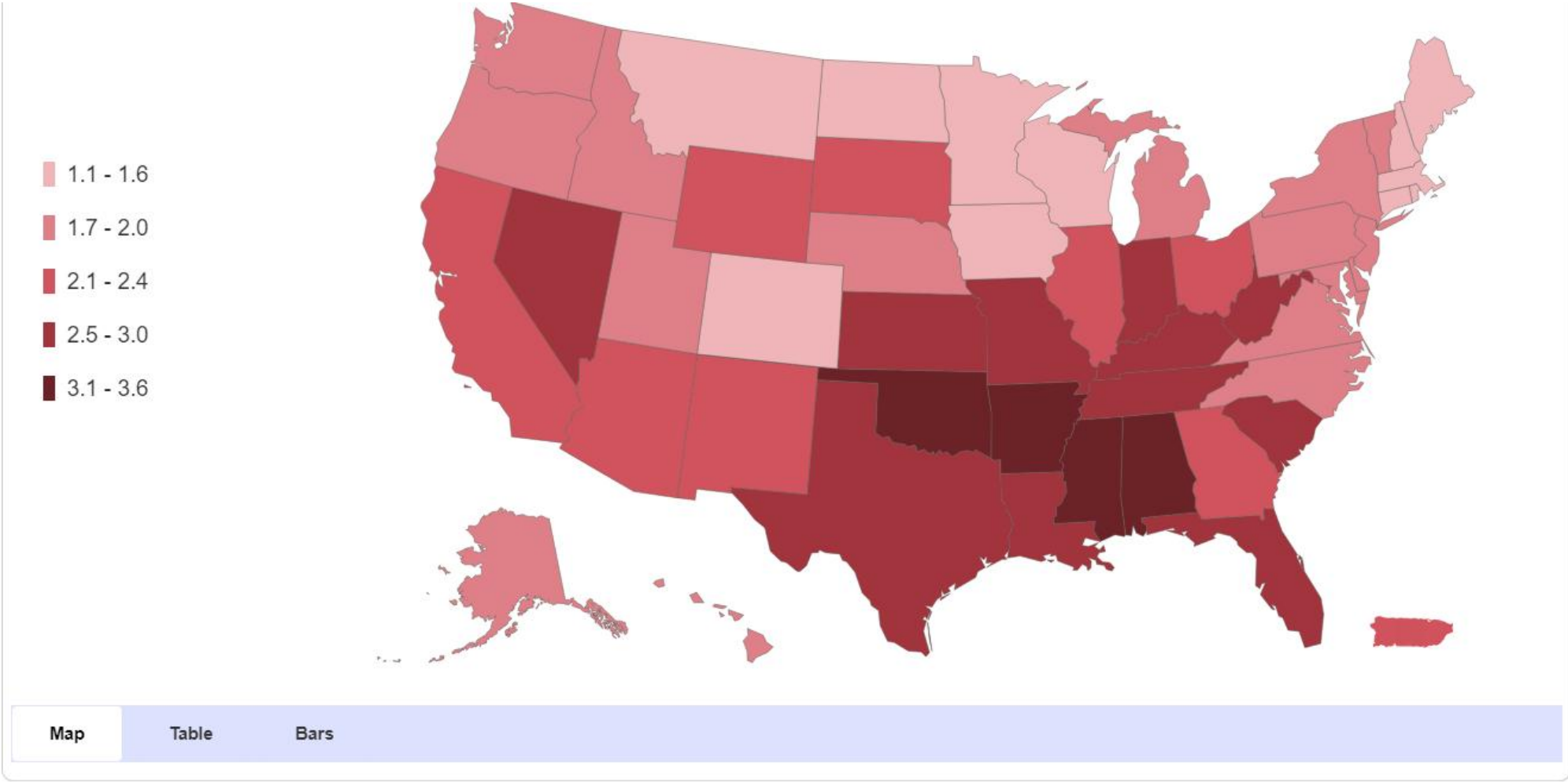
Cervix Cancer **Incidence Rates** by State, 2017-2021



Data Source: North American Association of Central Cancer Registries, 2024
Rate per 100,000, age-adjusted to the 2000 US standard population. Incidence is adjusted for delays when possible.

SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/types/cervix | Accessed 3/29/2025.

Cervix Cancer **Mortality Rates** by State, 2018-2022

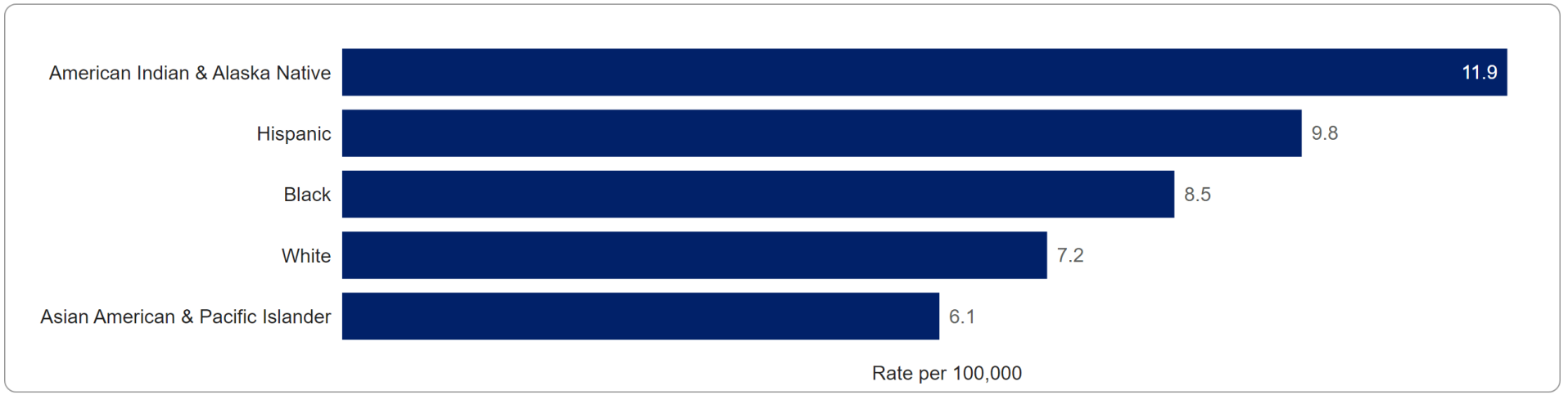


Data Source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2024
Rate per 100,000, age-adjusted to the 2000 US standard population.

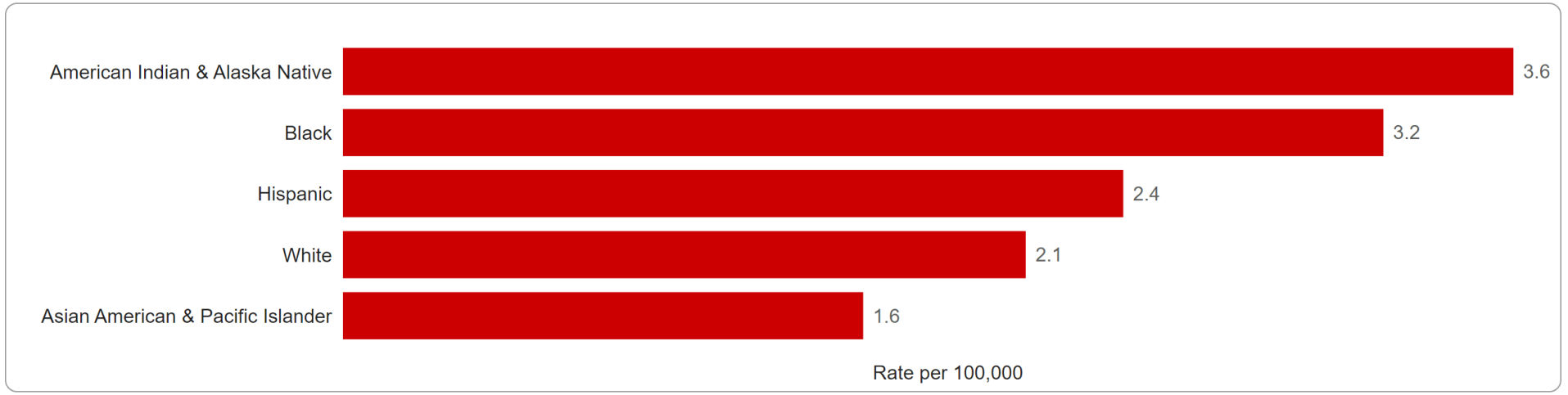
SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/types/cervix | Accessed 3/19/2025.

Cervical Cancer Incidence & Mortality Rates by Race & Ethnicity

Incidence Rates, 2017 - 2021



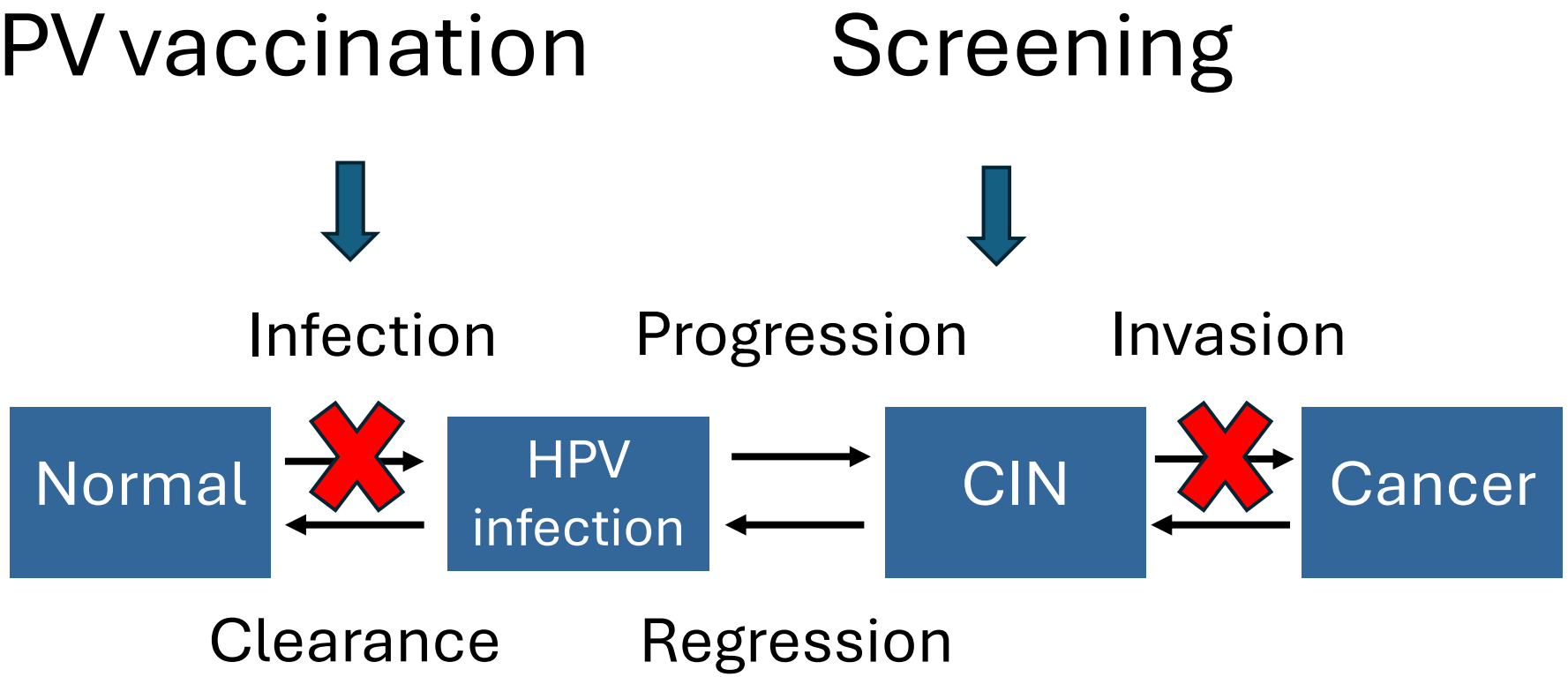
Mortality Rates, 2018 - 2022



 Rates per 100,000, age-adjusted to 2000 US standard population. Incidence is adjusted for delays when possible. Race is exclusive of Hispanic origin. Data source: National Center for Health Statistics, Centers for Disease Control and Prevention, 2024.
SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/ | Accessed 3/19/2025.

Prevention & Early Detection

The Natural History of Cervical Cancer



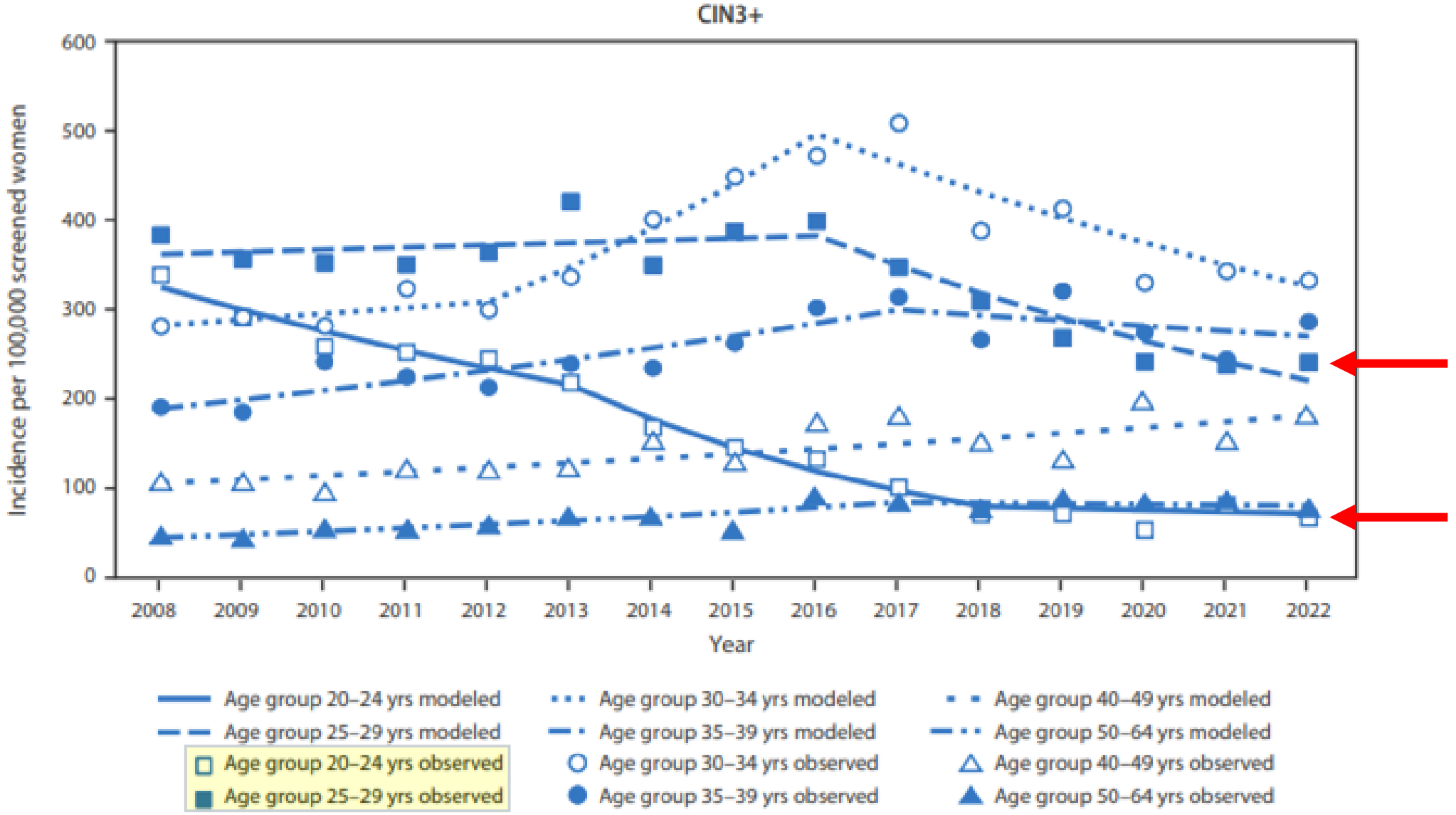
Adapted from: Schiffman M, Solomon D. N Engl J Med 2013;369:2324-2331. DOI: 10.1056/NEJMcp1210379

HPV vaccination

- Approved in the US since 2006
- Currently recommended for everyone aged 9-26, shared decision making ages 27-45 years
- In 2023, 65% of females and 61% of males aged 13-17 had received at least 1 dose before their 13th birthday [1]
- In 2022, 52% of female and 31% of male individuals aged 19-26 reported ever having received at least one dose [2]
- Estimated to reduce lifetime risk of cervical cancer by 85% if vaccinated by age 12 [3]
- Cancer Facts and Figures 2026: The rate of cervical cancer in women aged 20-24 years decreased by 11% per year since 2012

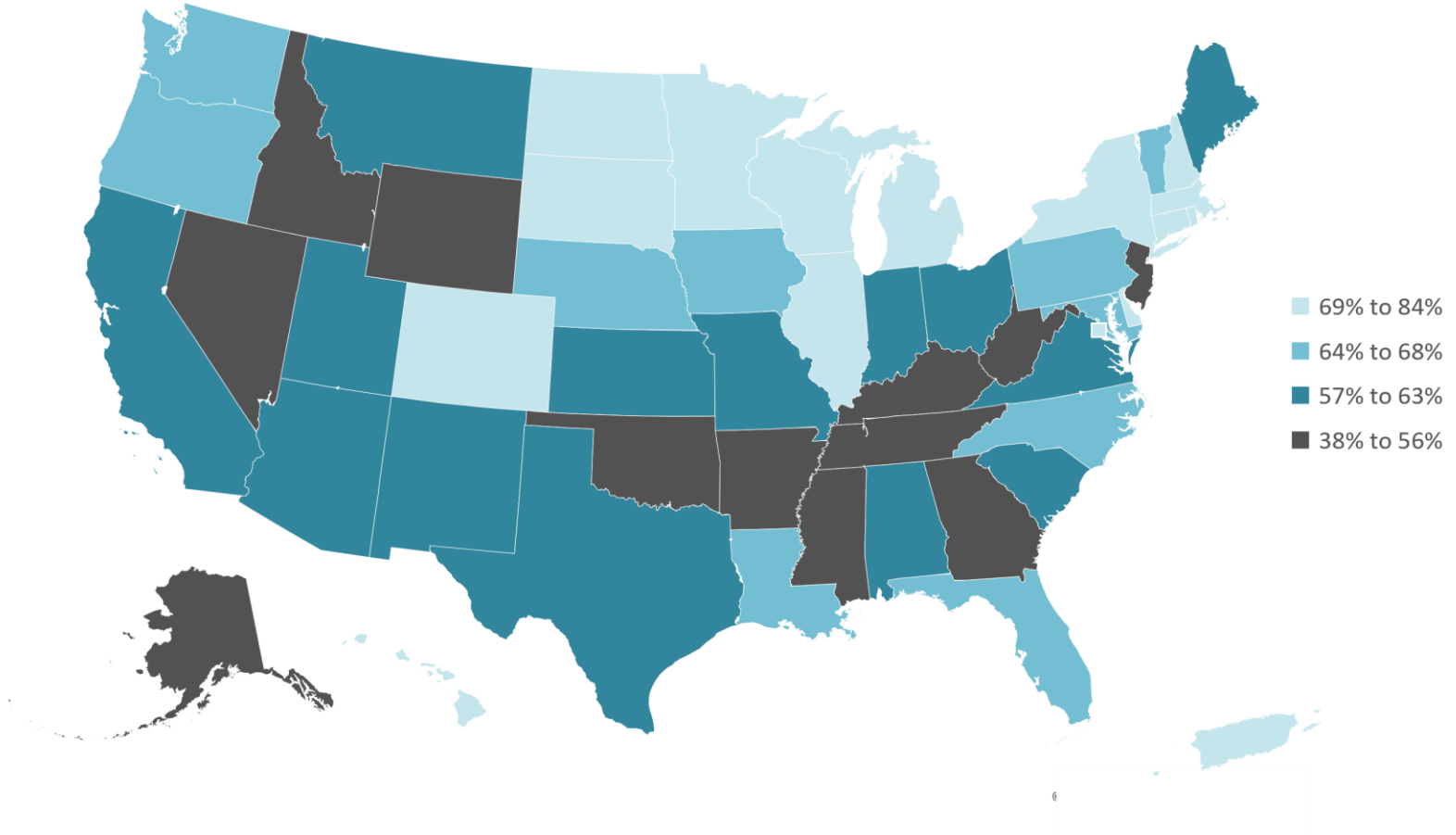
[1] National Immunization Survey-Teen, 2023; [2] National Health Interview Survey, 2022; [3] Kim et al, JNCI, 2017

FIGURE. Incidence (cases per 100,000 screened women)[*] of cervical precancers[†] — Human Papillomavirus Vaccine Impact Monitoring Project,[§] five sites, United States, 2008–2022[¶]



SOURCE: Morbidity and Mortality Weekly Report, Gargano et al (2025), vol 74

Up-to-date Human Papillomavirus Vaccination (%), Youth 13-17 Years, by State, US, 2023



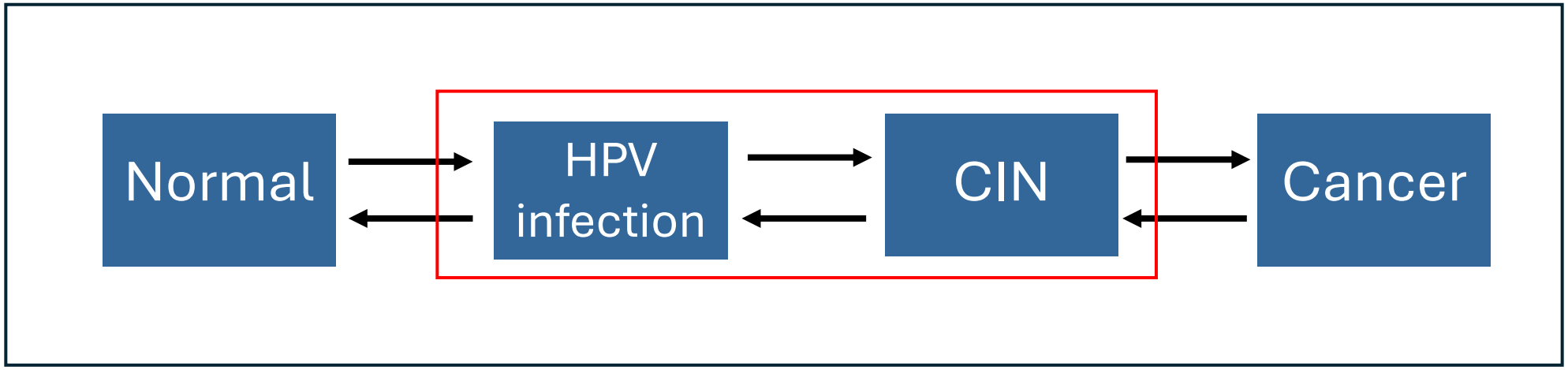
American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2025*. Atlanta: American Cancer Society; *2025-2026*.
https://www.cancer.org/research/cancer-facts-statistics/cancer-prevention-early-detection.html

Cervical Cancer Screening

Recommended for ages 21-65 (USPSTF) or 25-65 (ACS)

HPV testing – detect high-risk HPV infection, 5-year screening interval

Cytology/Pap testing – detect abnormal cells, 3-year screening interval

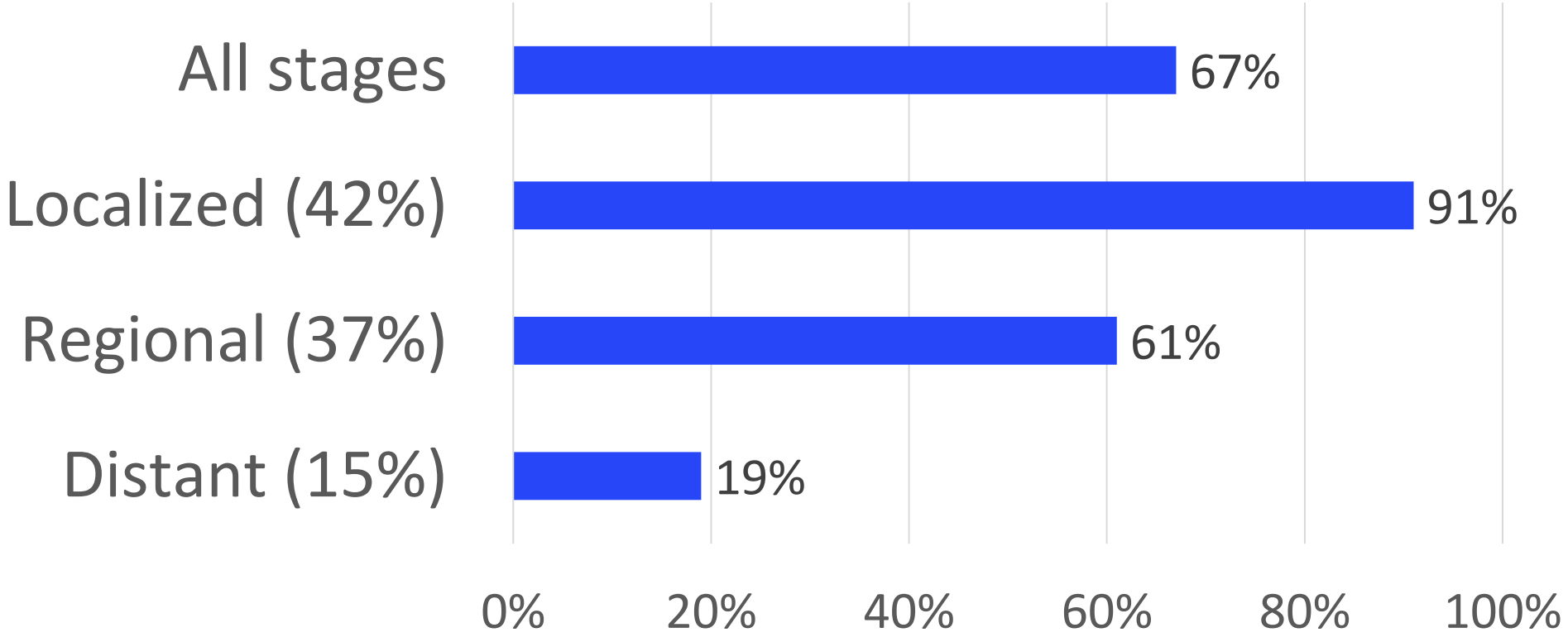


ACS guidelines updated in December 2025 to include self-sampling. Attending screening regularly is estimated to reduce the risk of cancer by 70%[1]

[1] Landy et al, International Journal of Cancer, 2020

Early detection saves lives

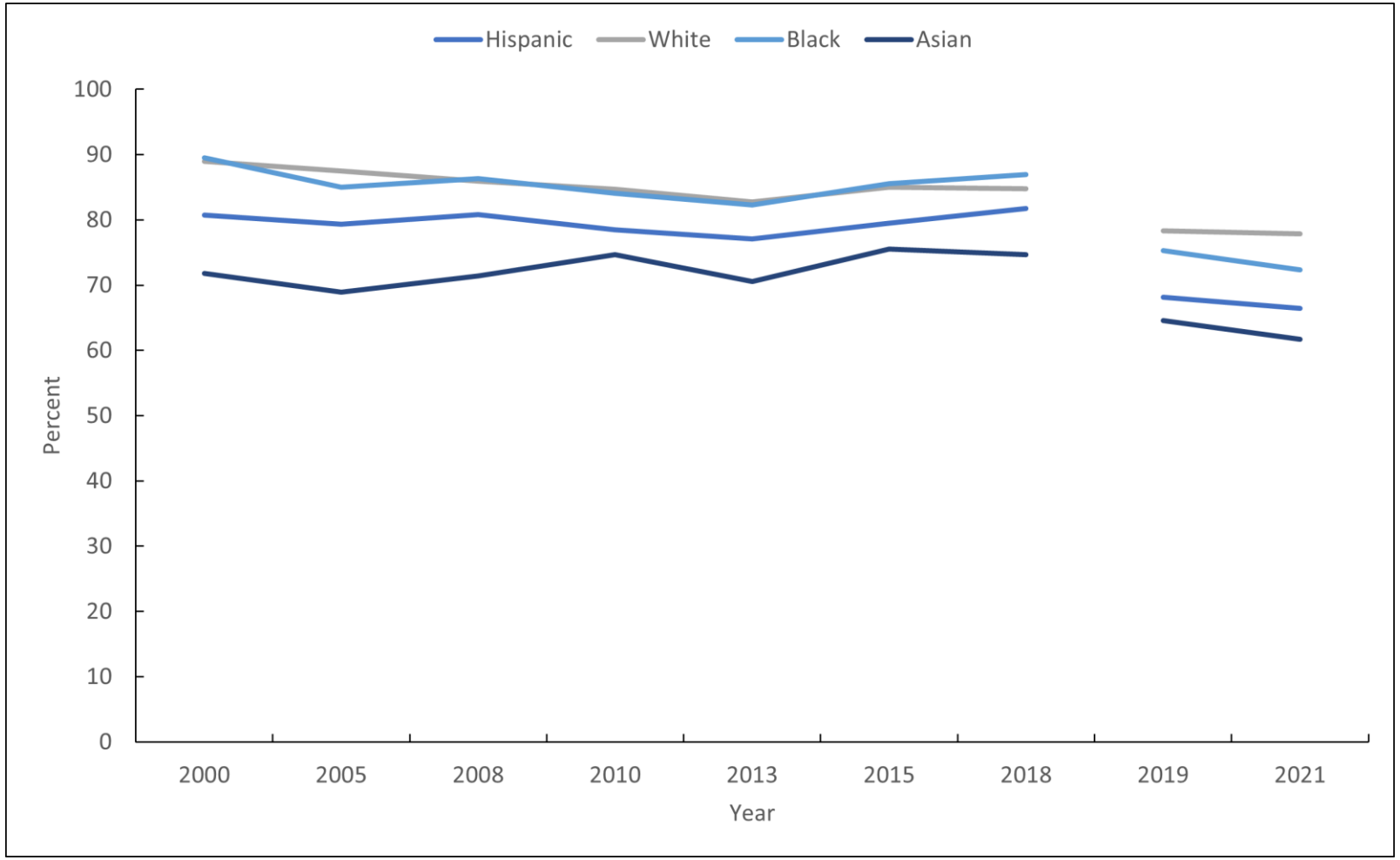
5-year relative survival by stage at diagnosis, 2014-2020



Data source: Surveillance, Epidemiology, and End Results 22 registries, National Cancer Institute, 2024
Survival is adjusted for normal life expectancy and based on cases diagnosed 2014-2020 and followed through 2021.

SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/types/cervix | Accessed 3/19/2025.

Trends in Cervical Cancer Screening*(%) by Race/Ethnicity, Women 21 to 65 Years and Older, US, 1987–2021



Up-to-date with cervical screening (USPSTF) 2021: 73% overall:

56% for people with less than high school education, 83% for college graduates

63% for <100% federal poverty level (FPL). 77% for ≥200% FPL

55% uninsured, 77% private insurance

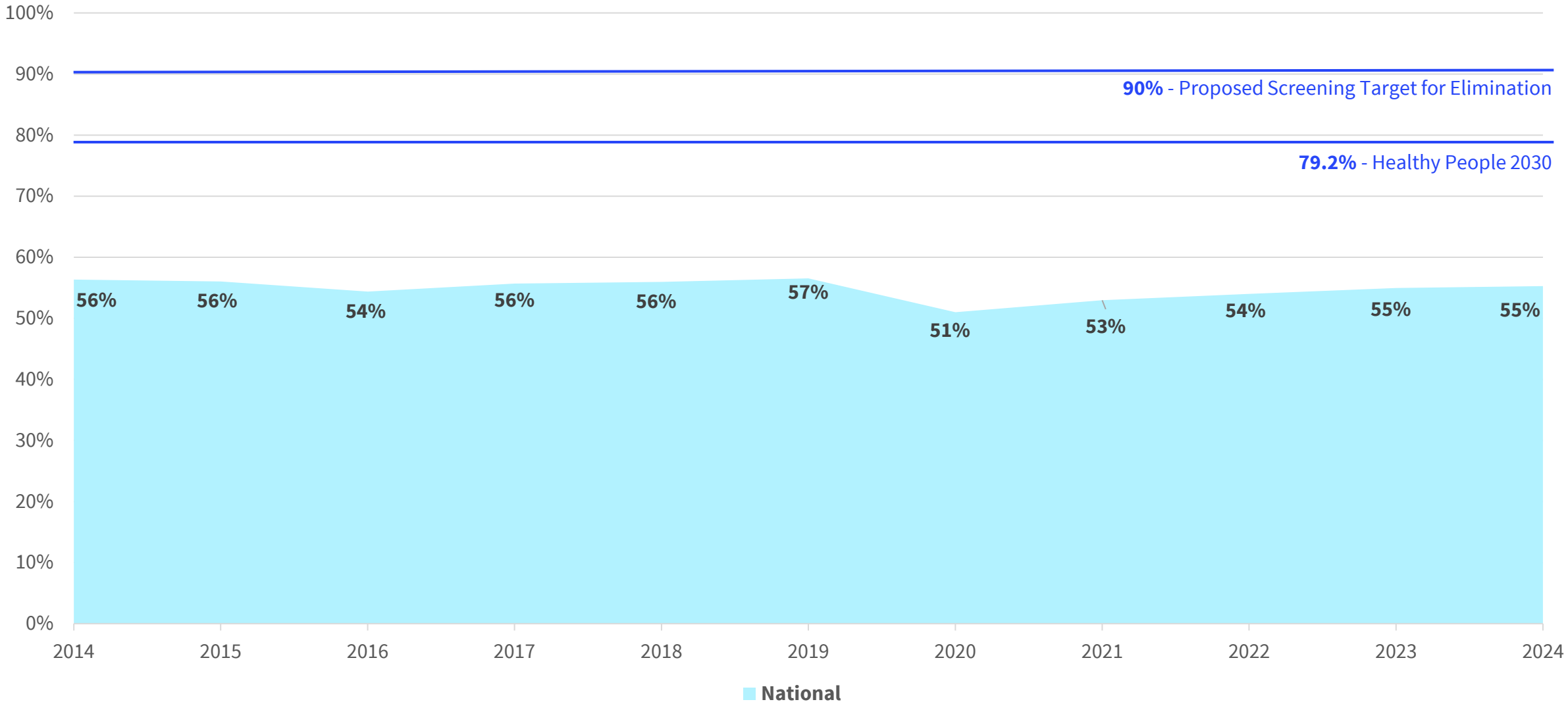
Estimates are age adjusted to the year 2000 US population standard using 4 age groups: 21-29, 30-39, 40-49, and 50-65 years. The National Health Interview Survey (NHIS) underwent a significant redesign in 2019, preventing comparability to prior years indicated by the line break. *Cervical cancer screening is defined as Pap test in the past 3 years (2000-2021) among females 21-65 years or HPV and Pap co-testing in the past 5 years (2015-2021) among females 30-65 years who have not had a hysterectomy; hysterectomy data not available in 2003. Up-to-date cervical cancer screening data not available in the NHIS 2023. Primary HPV testing estimates are not available due to questionnaire limitations.

Source: National Health Interview Surveys, 2000-2021.

American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2025*. Atlanta: American Cancer Society; *2025-2026*. https://www.cancer.org/research/cancer-facts-statistics/cancer-prevention-early-detection.html

FQHC Cervical Cancer Screening Trends 2014 – 2024 | National

HRSA Uniform Data System (UDS) Data



Source: HRSA Health Center Program Uniform Data (UDS) Data, 2024. https://www.hrsa.gov/foia/electronic-reading . Accessed 9/1/2025. Calculations and data visualization by the American Cancer Society.

Sarah Temkin, MD, FACS

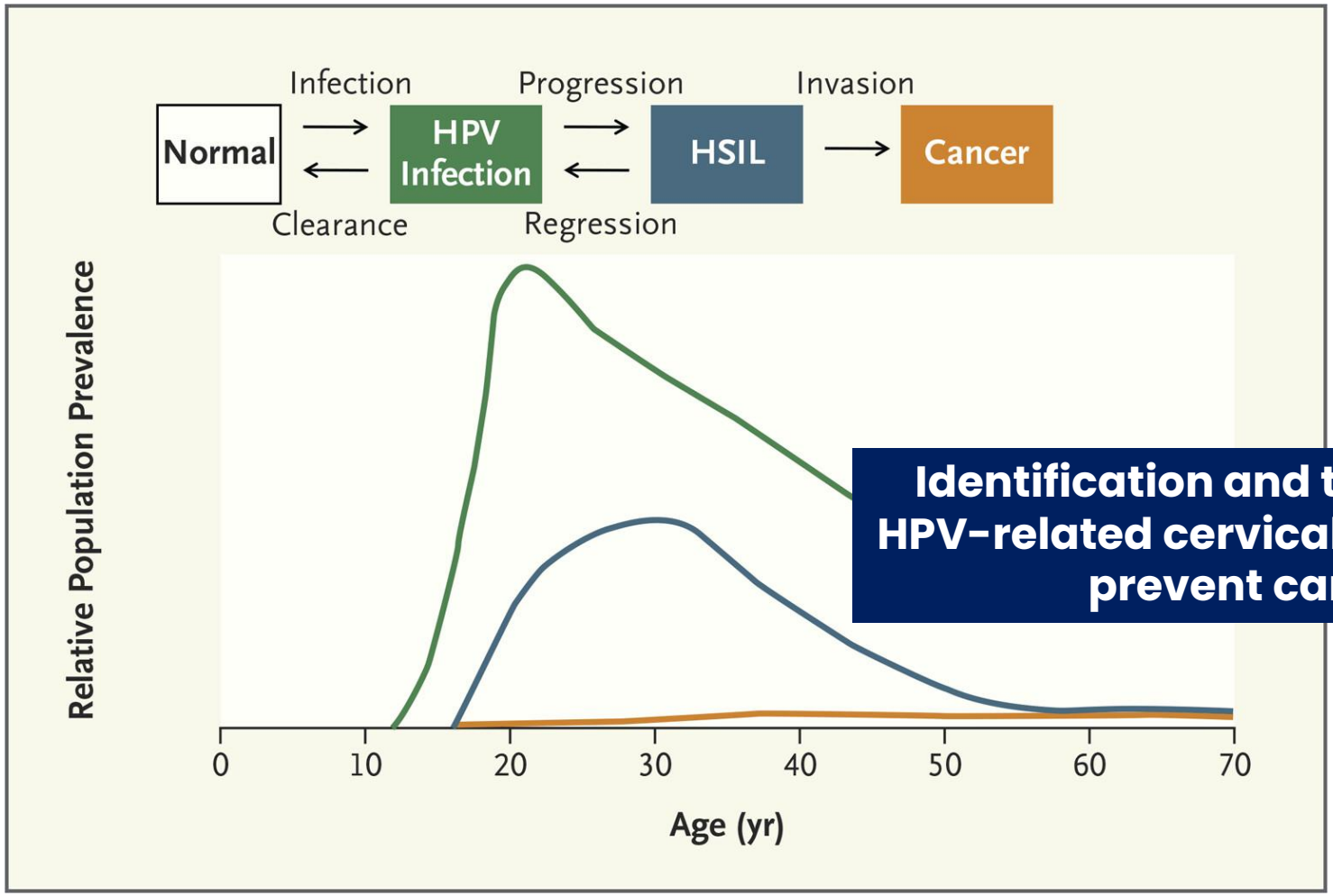
Senior Director, Early Detection

American Cancer Society

The Natural History of Cervical Cancer

Almost all cases of cervical cancer are caused by high-risk types of human papillomavirus (HPV)

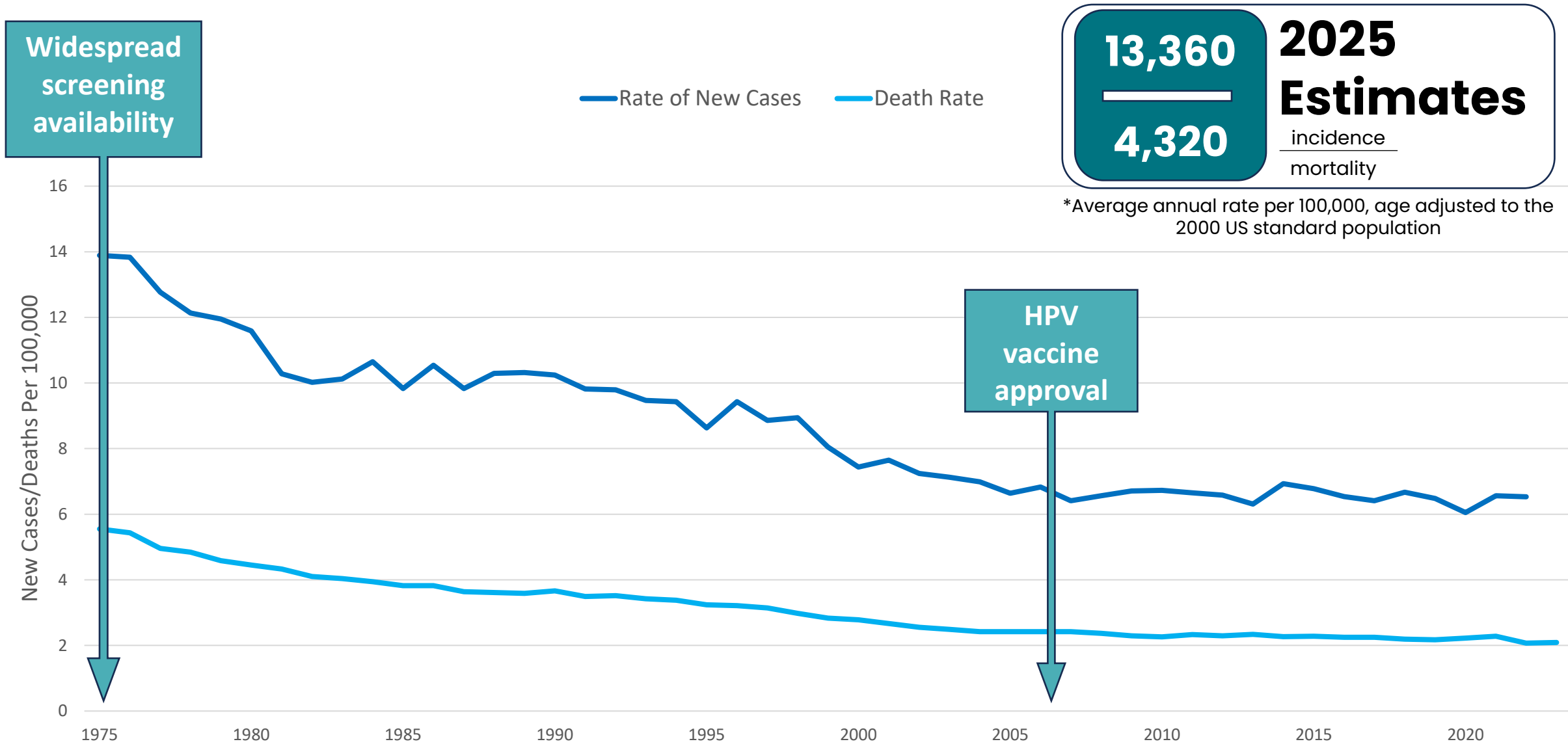
HPV-Related Cervical Disease



Identification and treatment of HPV-related cervical changes can prevent cancer

Schiffman M, Solomon D. N Engl J Med 2013;369:2324-2331. DOI: 10.1056/NEJMcp1210379

Cervical Cancer Incidence and Mortality



2025 Estimates

13,360 incidence

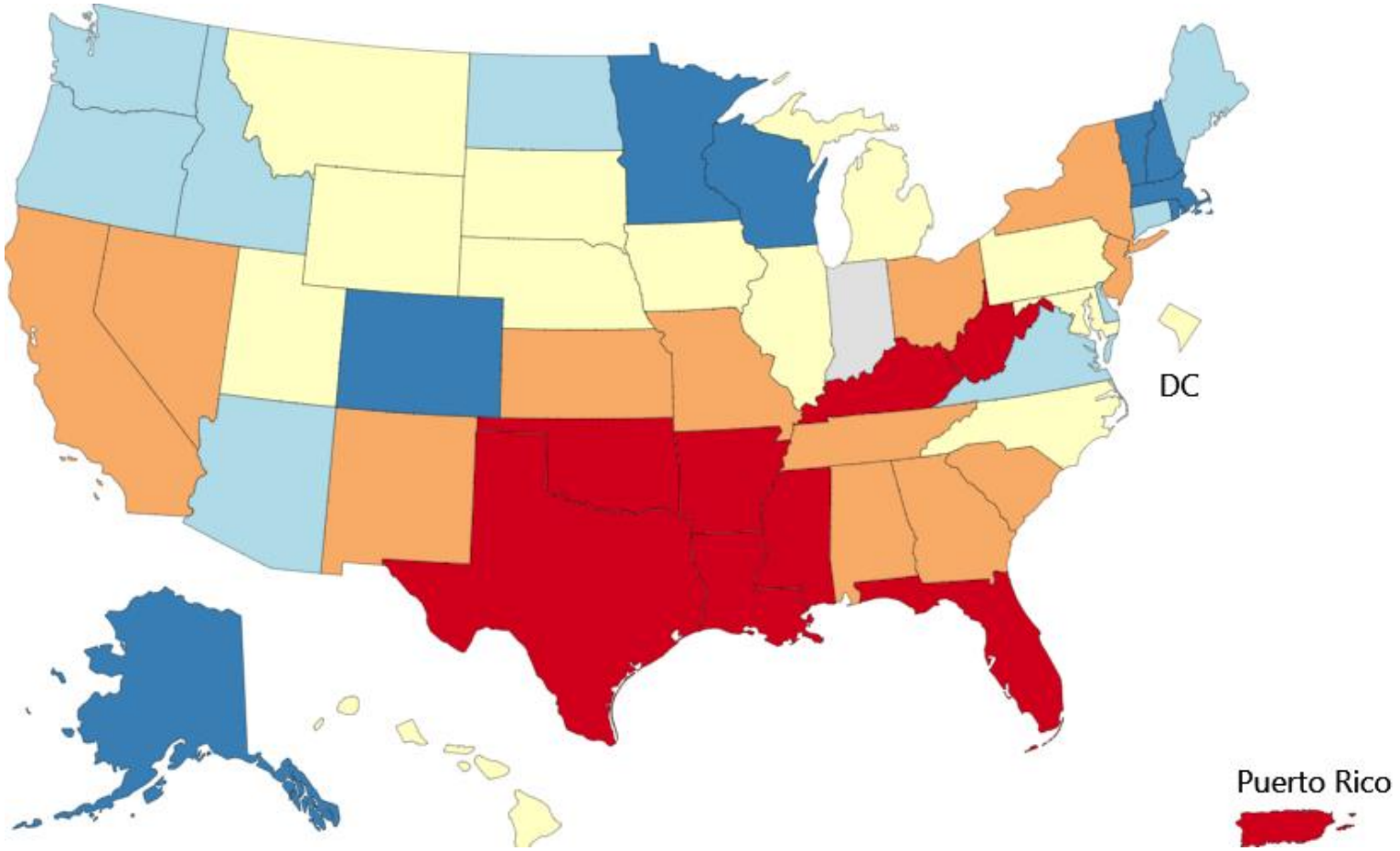
4,320 mortality

*Average annual rate per 100,000, age adjusted to the 2000 US standard population

Most Cervical Cancers Are Diagnosed Late

American Cancer Society

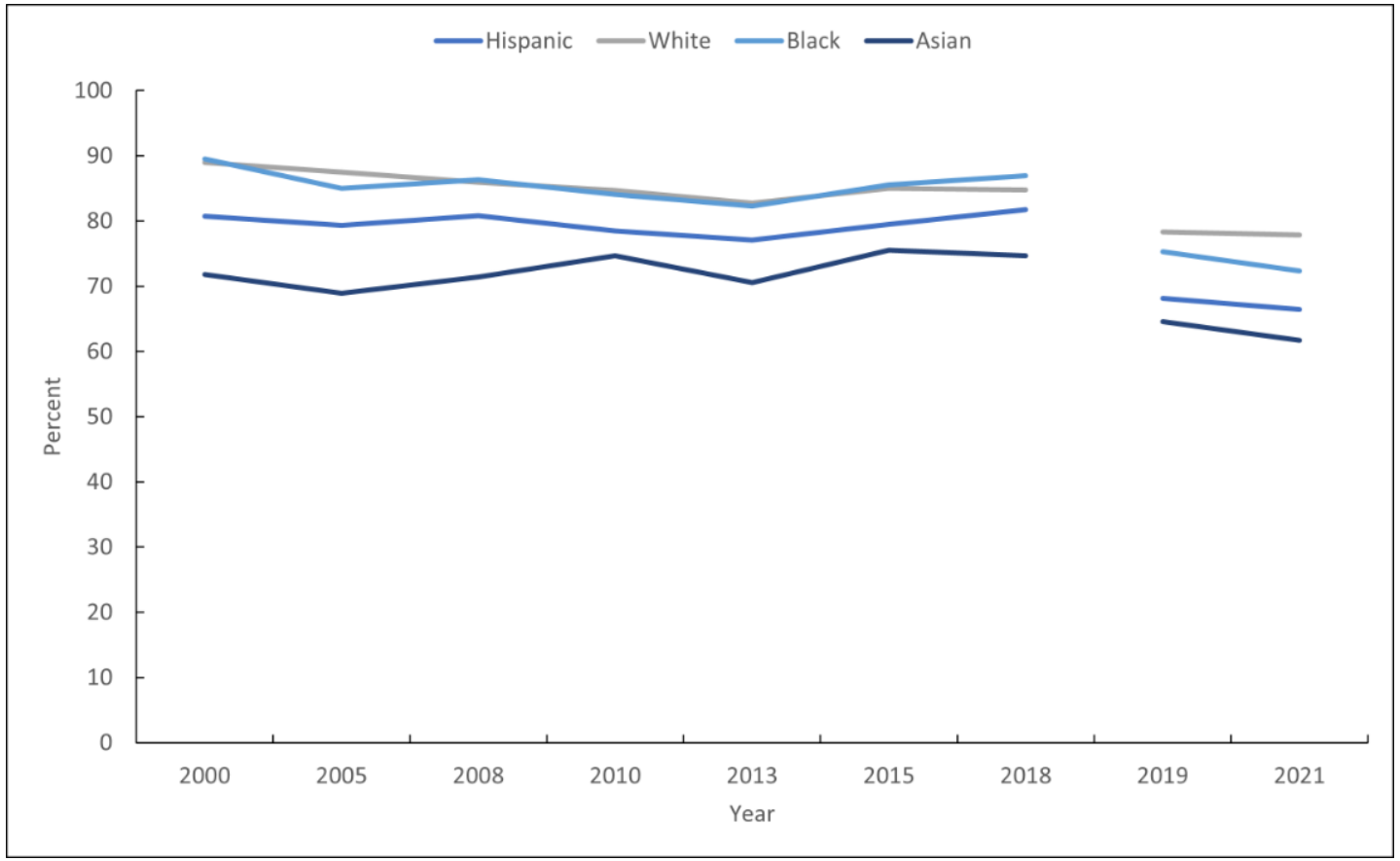
Incidence Rates: Cervix (Late Stage^), 2017-2021
All Races (includes Hispanic), All Ages



https://statecancerprofiles.cancer.gov/incidencerates/index.php

Up To Date Cervical Cancer Screening

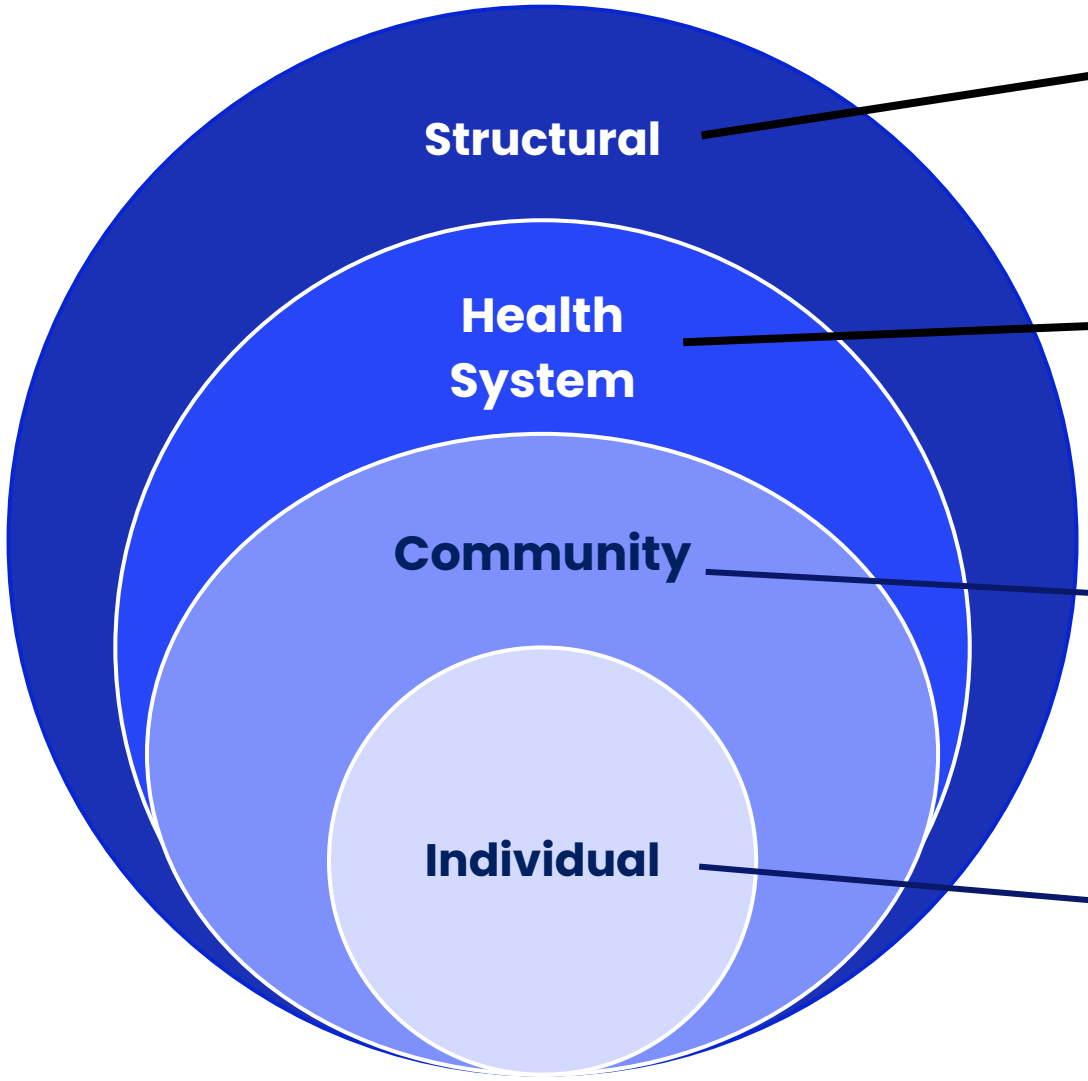
Trends in Cervical Cancer Screening*(%) by Race/Ethnicity, Women 21 to 65 Years and Older, US, 1987-2021



% UP TO DATE
76%

https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/cancer-prevention-and-early-detection-facts-and-figures/2025-cped-files/cped-cff-2025-2026.pdf

Barriers to Screening are Multifactorial



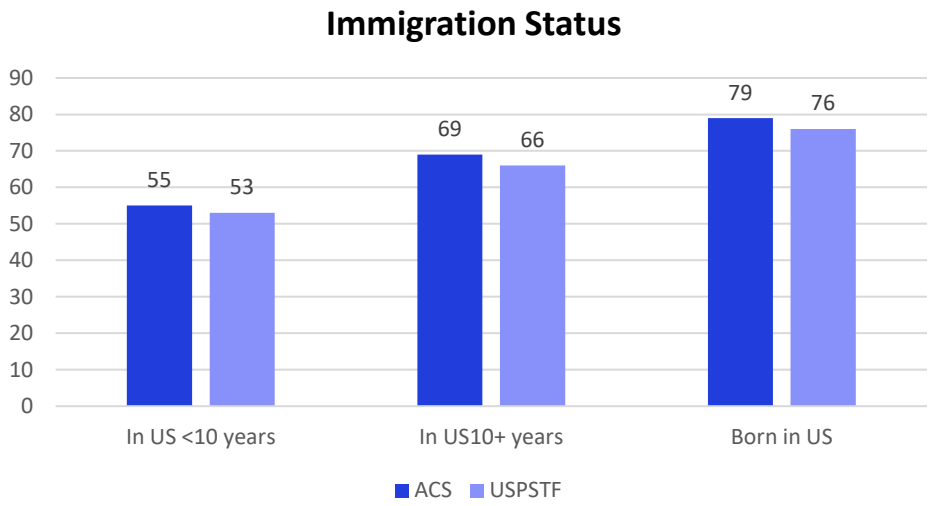
Insurance coverage
Out-of-pocket costs
Availability of transportation

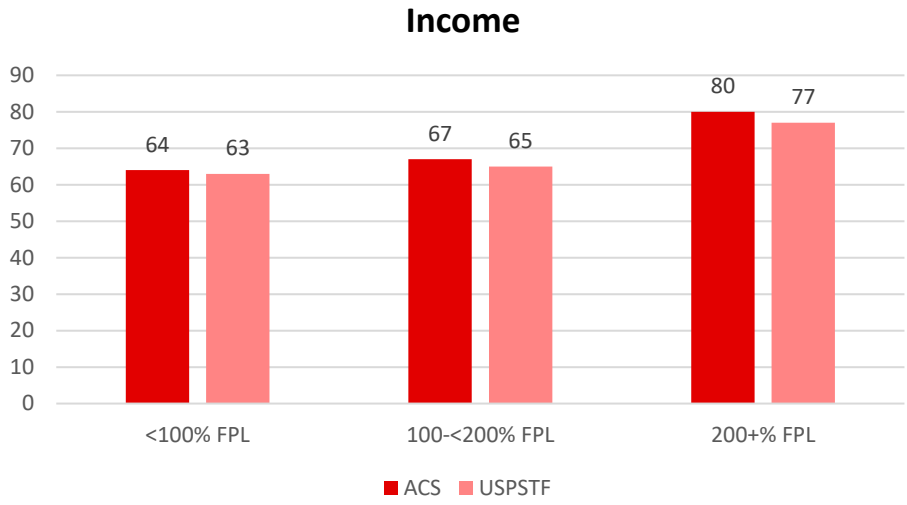
Lack of Provider Recommendation
Insufficient Care Coordination
Inflexible Scheduling

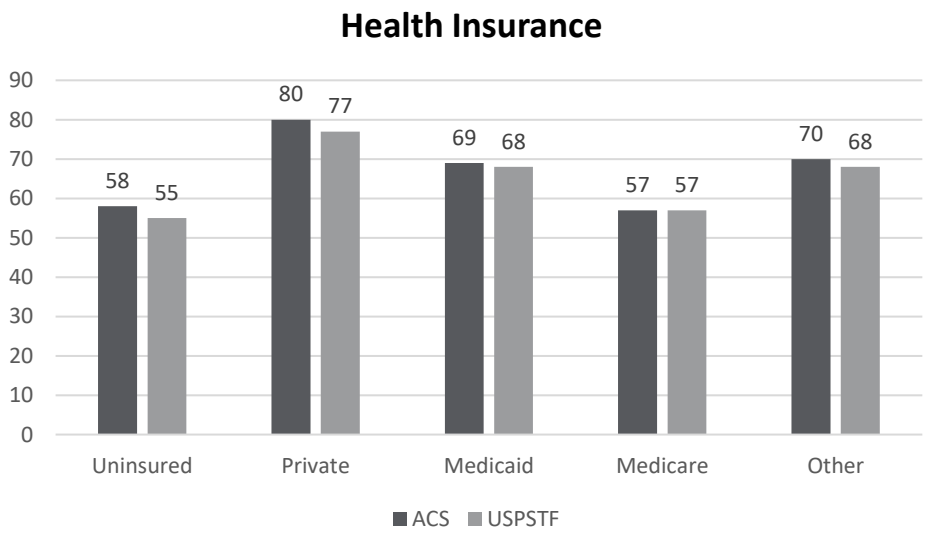
Social isolation
Language and Health Literacy
Stigma

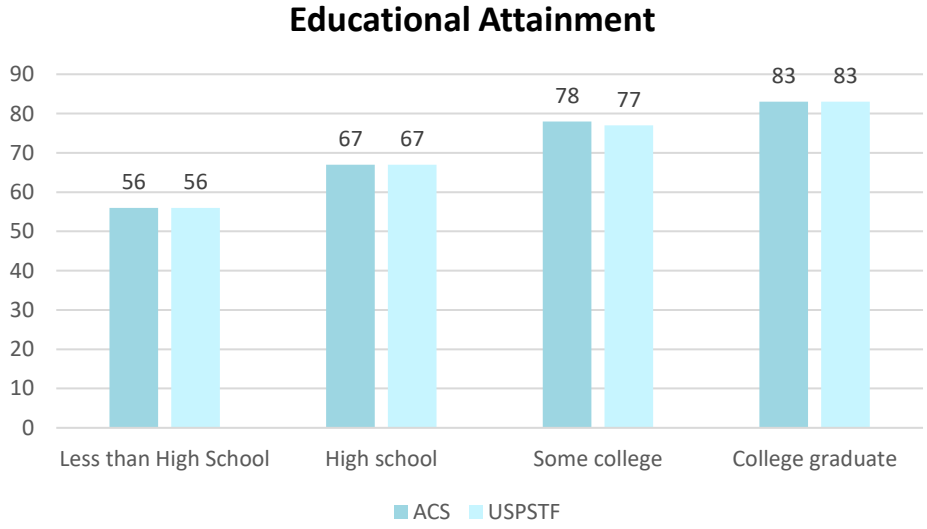
Fear / Mistrust
Lack of Education
Time off from Work
Financial Considerations

Social Factors & Cervical Cancer Screening





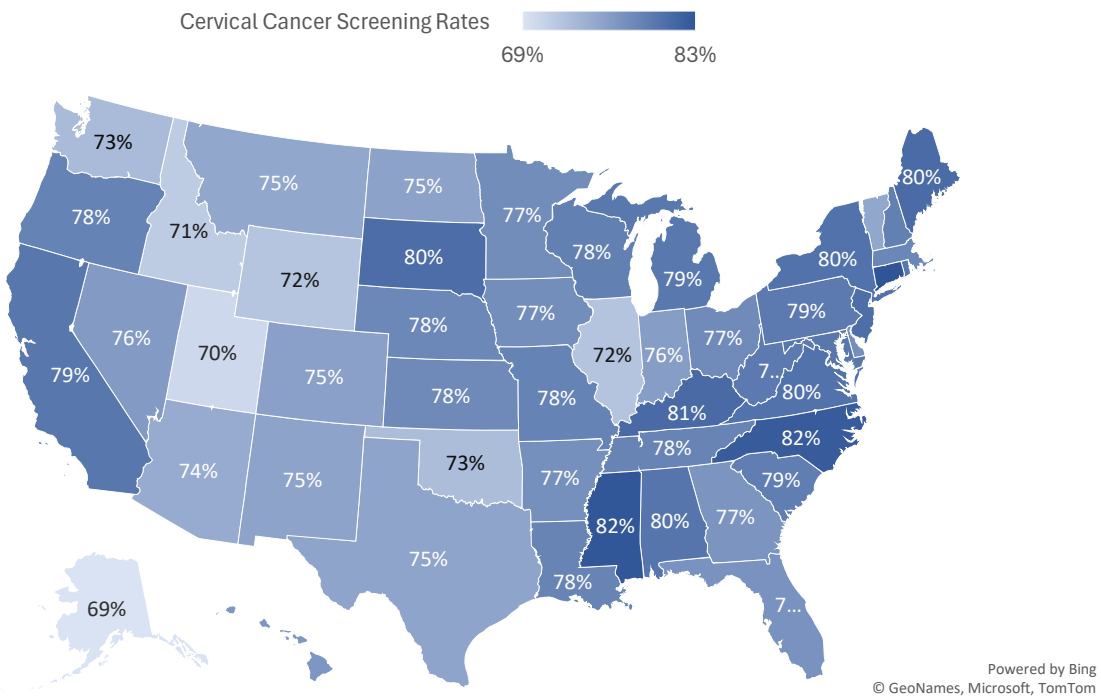




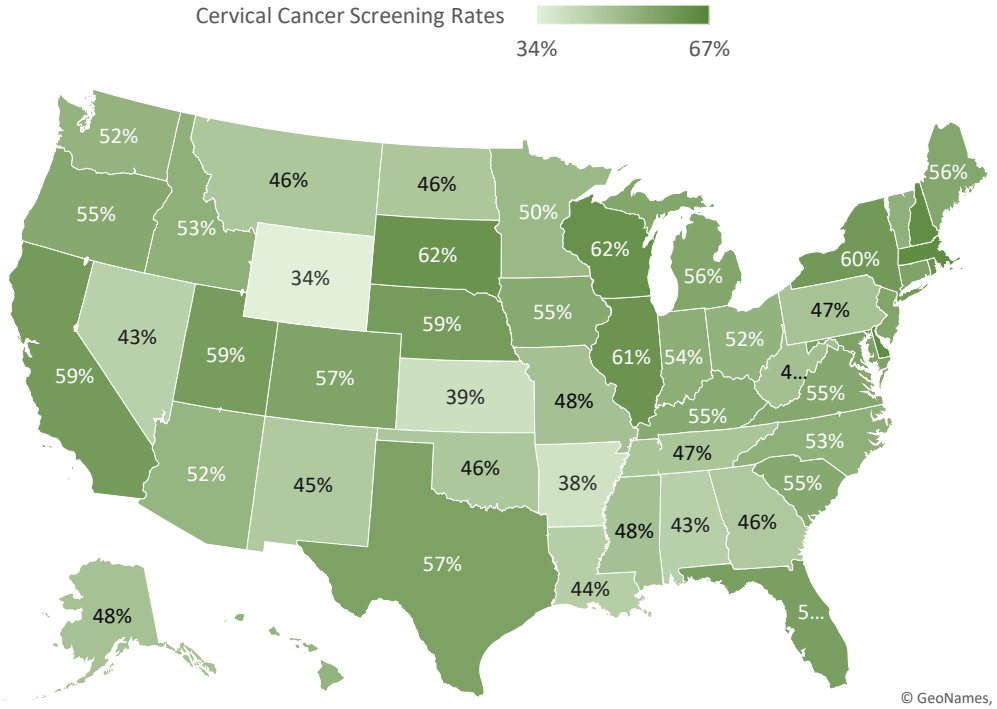
American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2025*. Atlanta: American Cancer Society; *2025-2026*. https://www.cancer.org/research/cancer-facts-statistics/cancer-prevention-early-detection.html

Variations by Geography and Clinical Setting

2020 State Level Cancer Screening Rates
BRFSS Data

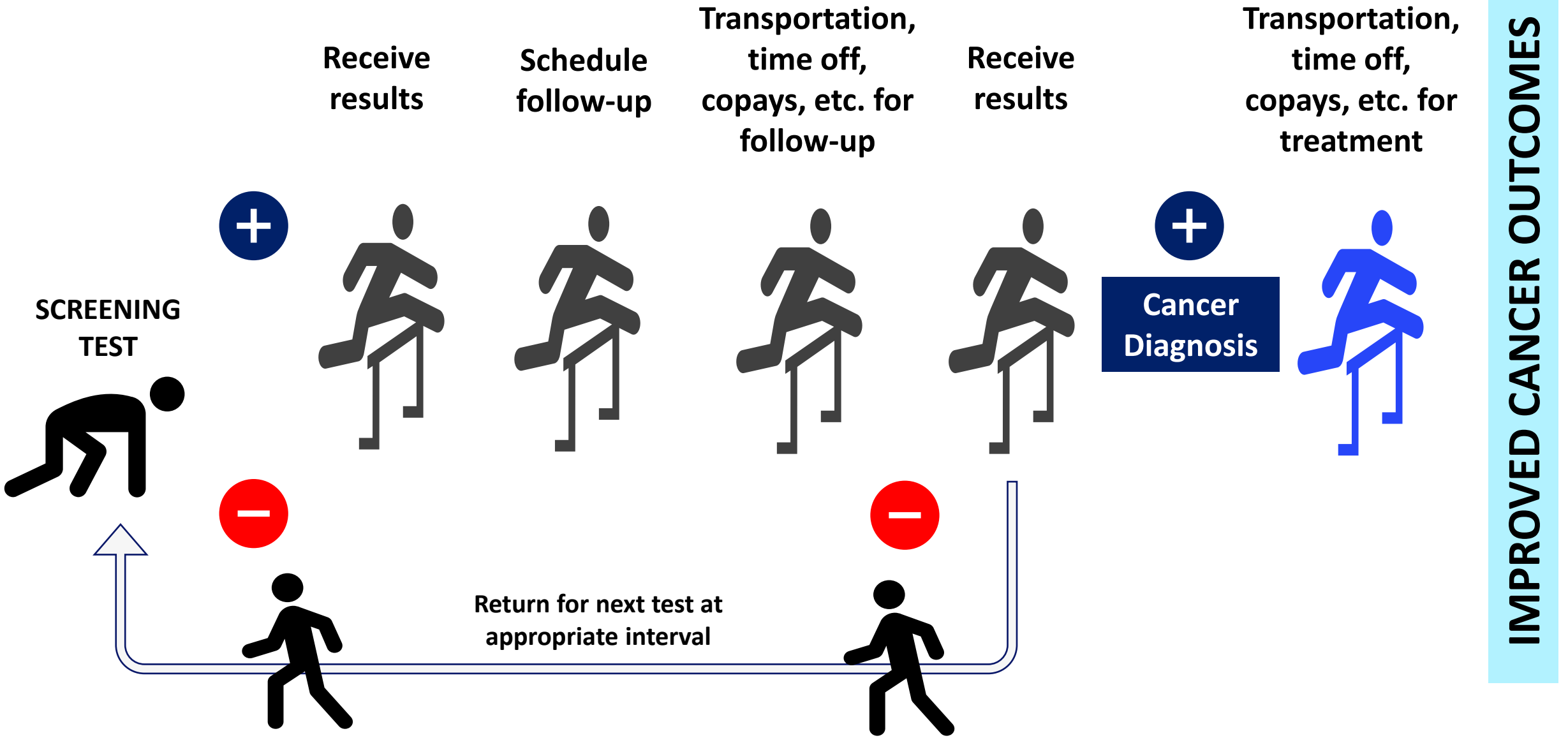


2024 FQHC Cervical Cancer Screening Rates
HRSA Uniform Data System (UDS) Data

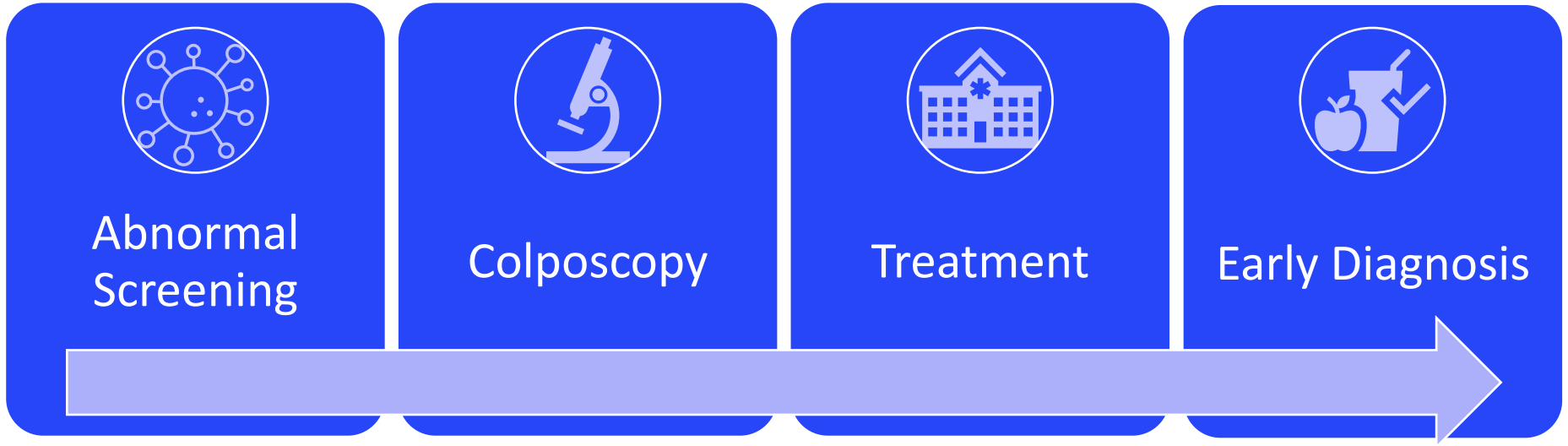


Calculations and data visualization by the American Cancer Society.

Multiple Barriers to Screening Along the Process



The Cervical Cancer Screening Process



76% of eligible patients are up to date on screening

47% with abnormal cervical cancer screen receive colposcopy within 3 months

Median time from biopsy to cancer treatment initiation 68.5 days

Opportunity to improve cancer outcomes

https://cancerstatisticscenter.cancer.org/screening-and-risk/hpv-test
Alimena S, et al. Obstet Gynecol. 2023 Nov 1;142(5):1125-1134. doi: 10.1097/AOG.0000000000005313.
Liang, Jessica et al. American Journal of Obstetrics & Gynecology, Volume 233, Issue 3, 186.e1 - 186.e9

Self-Collection Provides an Opportunity to Improve Early Detection

ACS Recommendations Include Self-Collection

American Cancer Society

Under Age 25

Screening is not recommended.

Cervical cancer is rare before age 25.

Ages 25 to 65

Get screened using a primary HPV test (HPV test alone) either:

- On a cervical sample collected by a health care provider every 5 years (preferred) **or**
- On a self-collected vaginal sample every 3 years.

If primary HPV testing is not available, screening may be done with a co-test (both HPV and Pap) **every 5 years**, or a Pap test **every 3 years**.*

**Getting screened regularly is the most important thing, no matter which test you get.*

Over Age 65

Talk to your health care provider about stopping screening if you've been getting screened regularly.

People can stop cervical cancer screening at age 65 if their most recent screening tests have been normal. This depends on the type of screening test that was used.

Perkins RB, et al. CA Cancer J Clin. 2026;e70041. doi:10.3322/caac.70041

Women's Preventive Services Guidelines

Type of Preventive Service	Current Guideline	Updated Guideline Beginning with Plan Years Starting in 2027
Screening for Cervical Cancer	The WPSI recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, the Women's Preventive Services Initiative recommends cervical cancer screening using cervical cytology (Pap test) every 3 years. Cotesting with cytology and human papillomavirus testing is not recommended for women younger than 30 years. Women aged 30 to 65 should be screened with cytology and human papillomavirus testing every 5 years or cytology alone every 3 years. Women who are at average risk should not be screened more than once every 3 years.	The WPSI recommends cervical cancer screening for average-risk women aged 21 to 65 years. For women aged 21 to 29 years, cervical cancer screening using cervical cytology (Pap test) every 3 years is recommended. Co-testing with cytology and human papillomavirus (hrHPV) testing is not recommended for women younger than 30 years. Women aged 30 to 65 years should be screened with primary hrHPV testing every 5 years (preferred) or cytology and hrHPV testing (co-testing) every 5 years. If hrHPV testing is not available, continue screening with cytology alone every 3 years. Women who are at average risk should not be screened on the initial screening. If additional testing (e.g., cytology, biopsy, colposcopy, extended genotyping, dual stain) and pathologic evaluation are indicated, these services also are recommended to complete the screening process for malignancies.

Patient-collected hrHPV testing is an appropriate method and should be offered as an option for cervical cancer screening in women aged 30 to 65 years at average risk.

https://www.hrsa.gov/womens-guidelines

FDA-approved self-collection tests for primary HPV screening?

American Cancer Society | National Roundtable on Cervical Cancer

Self-collection kits for the healthcare settings

Roche
cobas®
with Copan 522C.80 swab or Evalyn® Brush

BD
Onclarity™
with Copan 522C.80 swab

Abbott
Alinity M
with simpli-COLLECT™ HPV Collection Kit or Evalyn® Brush

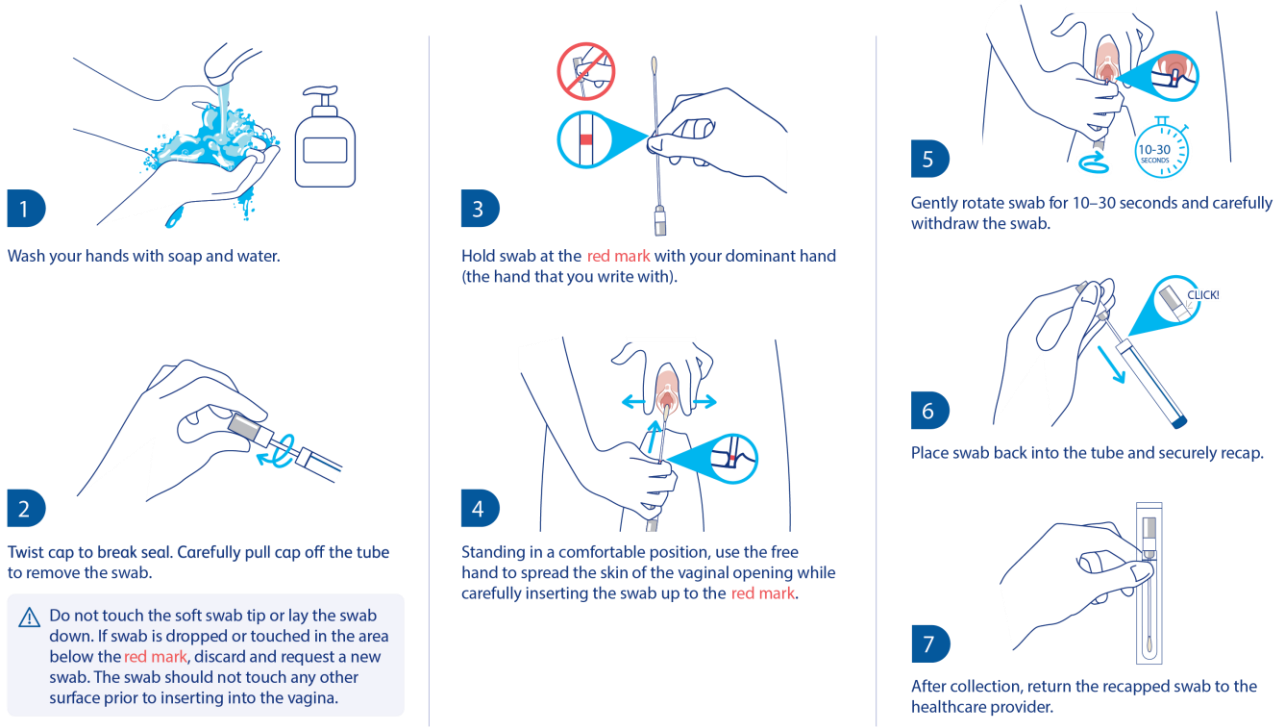
Device for home collection

Teal Health
Teal Wand™
**in select states*

How is HPV self-collection test done?

In-clinic Patient Self-collection Steps for Copan Swab (device partnered with BD and Roche)

1. Wash hands
2. Open the swab carefully. Avoid touching the area below the red mark towards the tip.
3. Hold the swab at the red mark.
4. Use your other hand to spread the skin of the vaginal opening and carefully insert the swab into the vagina up to the red mark.
5. Gently rotate the swab for 10-30 seconds and then remove the swab.
6. Place the swab back in the tube and make sure the cap is secured.
7. Give your healthcare provider the recapped swab.



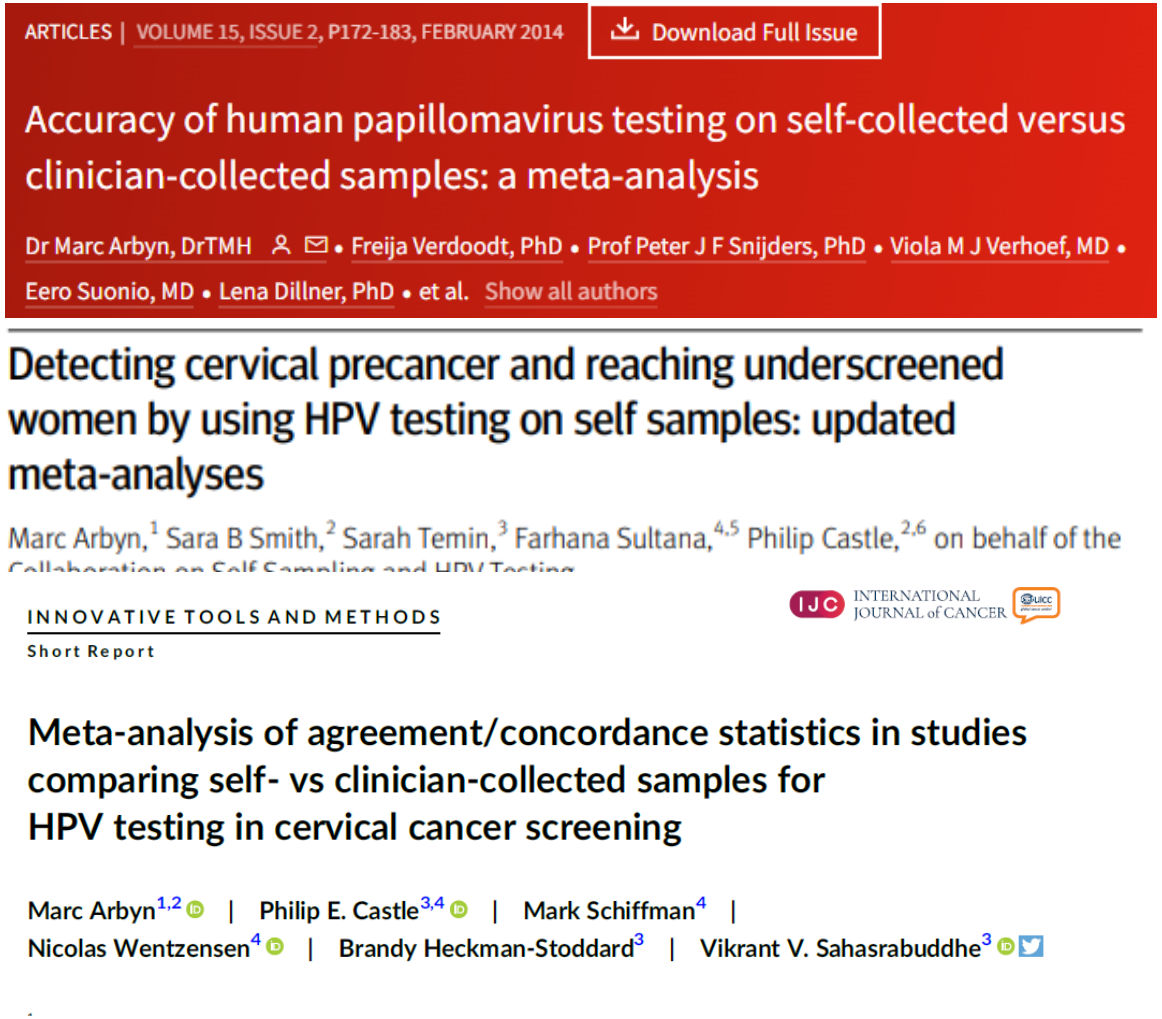
Pictures: adapted from Becton, Dickinson and Company (BD)

Not shown: Evalyn® brush approved for use with Roche

HPV Self Collection Test Performance

Three meta-analyses have been done to evaluate HPV self-collection testing

- ***More sensitive*** at detecting CIN2+ than cytology alone in the first round of screening*
- ***Comparable sensitivity*** *and* ***high agreement*** with clinician-collected primary HPV testing samples



ARTICLES | VOLUME 15, ISSUE 2, P172-183, FEBRUARY 2014 Download Full Issue

Accuracy of human papillomavirus testing on self-collected versus clinician-collected samples: a meta-analysis

Dr Marc Arbyn, DrTMH • Freija Verdoodt, PhD • Prof Peter J F Snijders, PhD • Viola M J Verhoef, MD • Eero Suonio, MD • Lena Dillner, PhD • et al. Show all authors

Detecting cervical precancer and reaching underscreened women by using HPV testing on self samples: updated meta-analyses

Marc Arbyn,[1] Sara B Smith,[2] Sarah Temin,[3] Farhana Sultana,[4,5] Philip Castle,[2,6] on behalf of the

INNOVATIVE TOOLS AND METHODS

Short Report

IJC INTERNATIONAL JOURNAL of CANCER

Meta-analysis of agreement/concordance statistics in studies comparing self- vs clinician-collected samples for HPV testing in cervical cancer screening

Marc Arbyn[1,2] | Philip E. Castle[3,4] | Mark Schiffman[4] | Nicolas Wentzensen[4] | Brandy Heckman-Stoddard[3] | Vikrant V. Sahasrabuddhe[3]

although less specific, so better suited to a screening test; a more sensitive test is better at ruling out a condition-a negative result is likely a true negative, while a more specific test is better at ruling in a condition- a positive result is more likely to be a true positive

HPV self-collection eligibility

Patients who are eligible

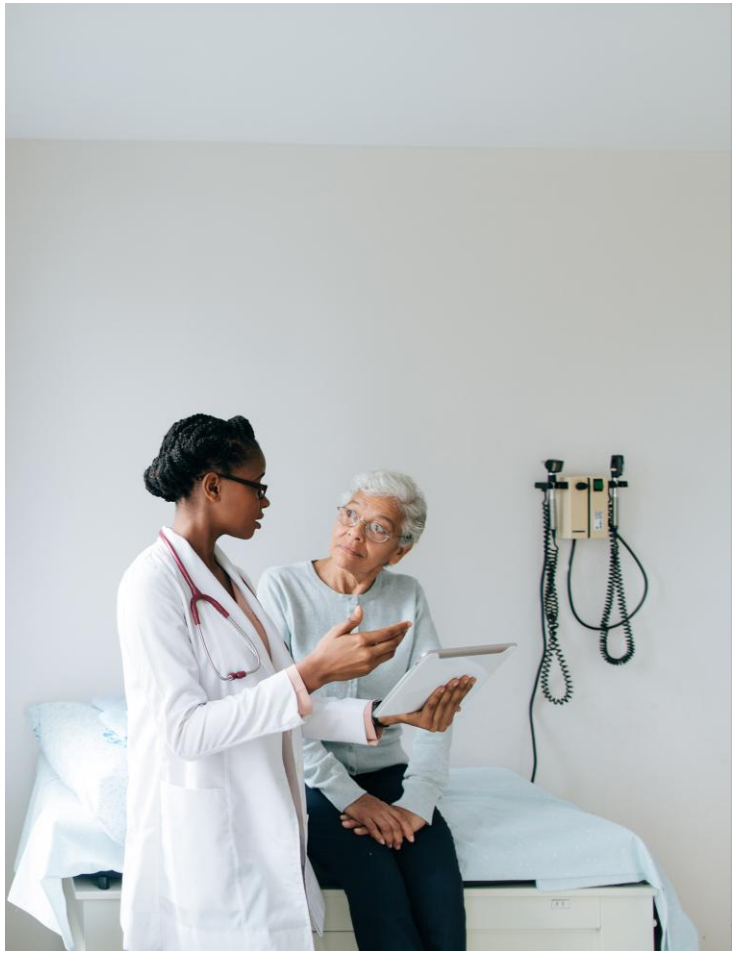
- Must be eligible for primary HPV testing

Patients who should still have a clinician collected screening test

- HIV+ or other immunosuppression
- History of in utero DES exposure
- Other patients at high risk

Other considerations

- Age under 30
- Medicare coverage



Source: ACS NRTCC Preparing for Self-Collection: Clinician Communication Guide

Acceptability of Self Collection

Patients report high acceptability of vaginal specimen collection across multiple settings

Benefits

- Easy to perform
- No or less pain
- Privacy

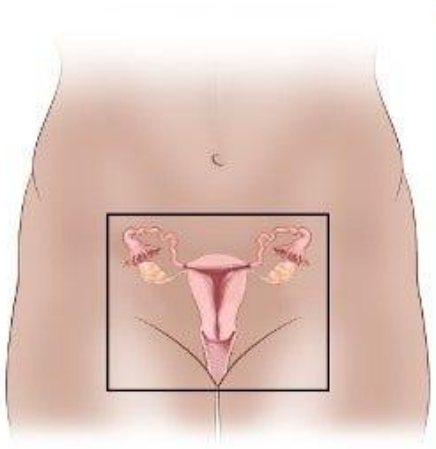
Harms

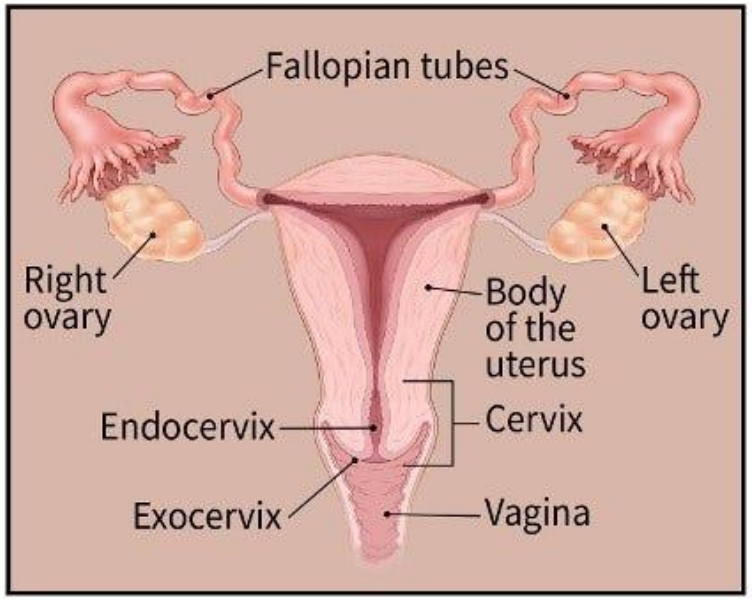
- Potential to miss physical exam findings

Morgan K, et al. Journal of Lower Genital Tract Disease 23(3):p 193-199, July 2019. | DOI: 10.1097/LGT.0000000000000476

Symptoms Still Need Clinical Evaluation

- Abnormal vaginal bleeding
  - post-coital
  - post-menopausal
  - irregular menses
  - menorrhagia
- Abnormal vaginal discharge
- Hematuria
- Dyspareunia
- Other pelvic pain





Where cervical cancer screening can be performed

Before Self-Collection

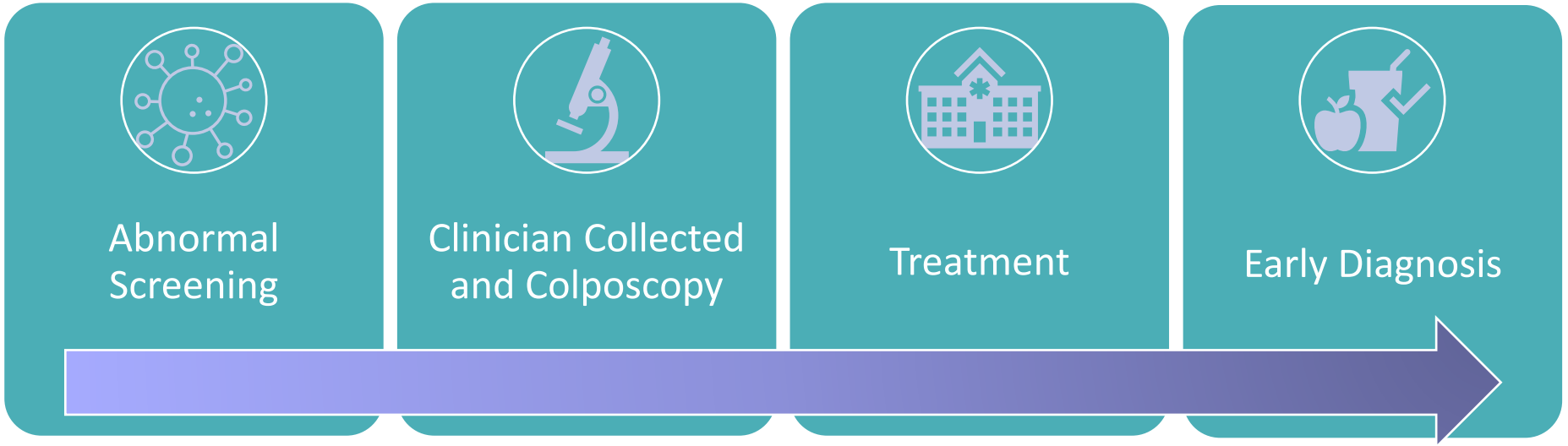
- Healthcare professional with training to do a pelvic exam
- Specialized office equipment
- Often required a standalone appointment

After Self-Collection

- Any healthcare professional
- Can be part of another screening appointment, lab or radiology visit
- Any private setting

Source: ACS NRTCC Preparing for Self-Collection: Clinician Communication Guide

The screening process with self-collection



More abnormal screenings may be identified

Referral needs will change within the system. Patient assistance must be available.

Opportunity to improve cancer outcomes

https://cancerstatisticscenter.cancer.org/screening-and-risk/hpv-test
Alimena S, et al. Obstet Gynecol. 2023 Nov 1;142(5):1125-1134. doi: 10.1097/AOG.0000000000005313.
Liang, Jessica et al. American Journal of Obstetrics & Gynecology, Volume 233, Issue 3, 186.e1 - 186.e9

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- NIH/NCI Cancer Center Support Grant P30 CA015704
- Clinical collaboration between We Care Daily Clinics and the Swisher Lab at University of Washington

Project Setting

- Opioid Treatment Program (OTP) – An outpatient clinic offering medical services, counseling, and dispensed medication for opioid use disorder (such as methadone and buprenorphine) to people with substance use disorder (SUD)
- Ideal setting to provide cervical cancer screening to an under-screened, at-risk population
- Perceived stigma among those with SUD has often generated avoidance of healthcare interactions, leading to low receipt of primary preventive care[1,2]
- Individuals with SUD may have other risk factors for cervical cancer including tobacco use, non-vaccination for HPV, history of transactional sex, and history of sexual abuse[3,4]

Project Setting

- We Care Daily Clinics
  - OTPs with brick-and-mortar and mobile clinics in Seattle region
  - Patients come to clinic with frequencies ranging from daily to monthly to receive medication and services

Project Setting

- We Care Daily Clinics
  - Medical management of SUD, hepatitis C, HIV, other STIs
    - Some procedures such as Nexplanon, but no facilities for gynecological services or exams
  - Counseling services from SUD Professionals and Certified Peer Support Specialists
  - About 1800 patients total, 200 of whom are served by mobile clinics

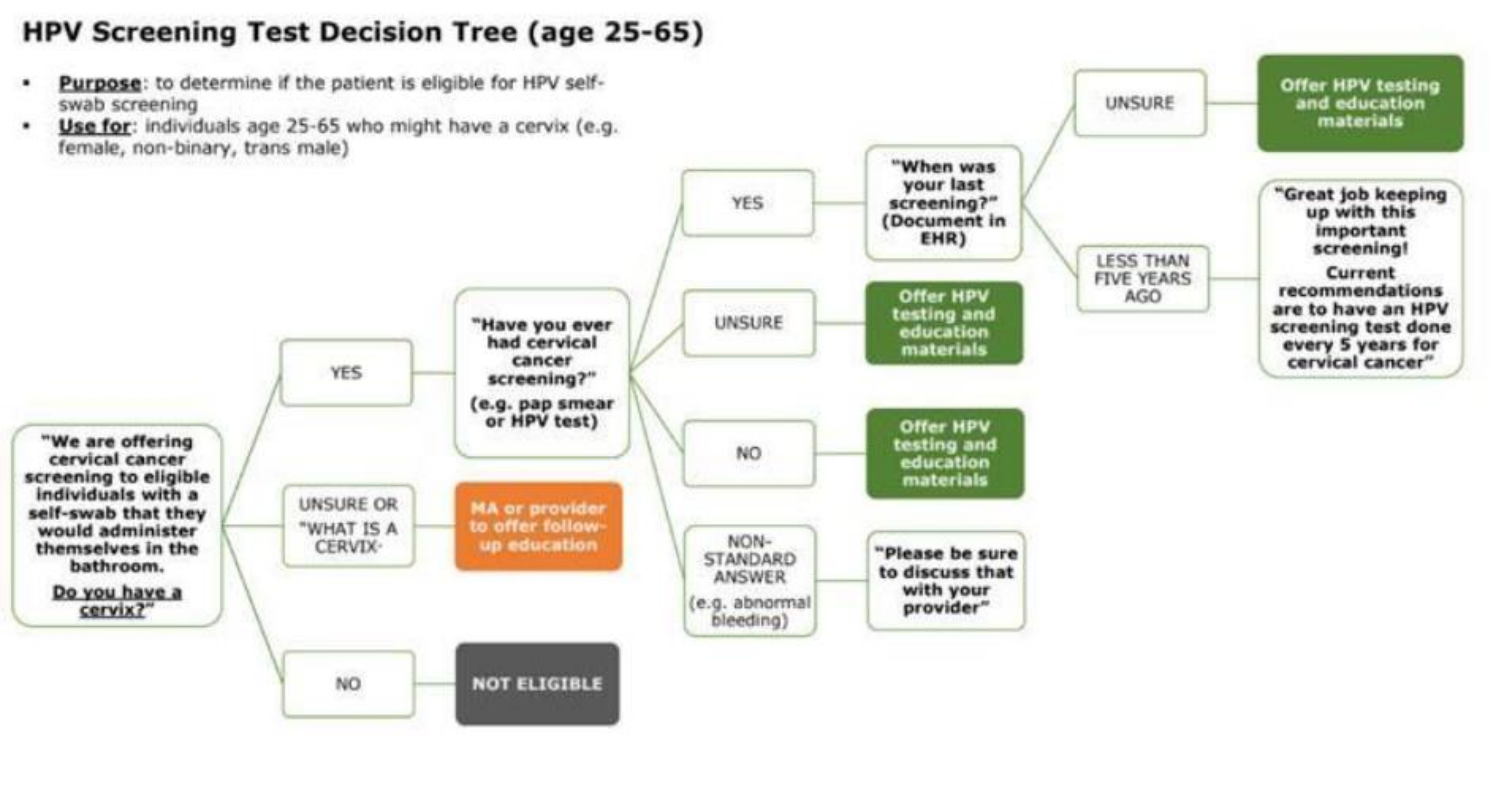
We Care Daily Clinics Patient Demographics	
n=1775	
Characteristic	%
Female	47
Female age 25-65 years	44 (n=726)
Race	
Asian	1
Black	8
American Indian/Alaska Native	9
Native Hawaiian/Pacific Islander	1
White	72
Declined/other	8
Hispanic Ethnicity	5

Project Goals

- Introduce and evaluate a low-barrier model for integrating HPV self-collect cervical cancer screening into an opioid treatment program
- Measure current rates of screening and testing outcomes
- Assess acceptability to clients
- Facilitate referral and follow-up

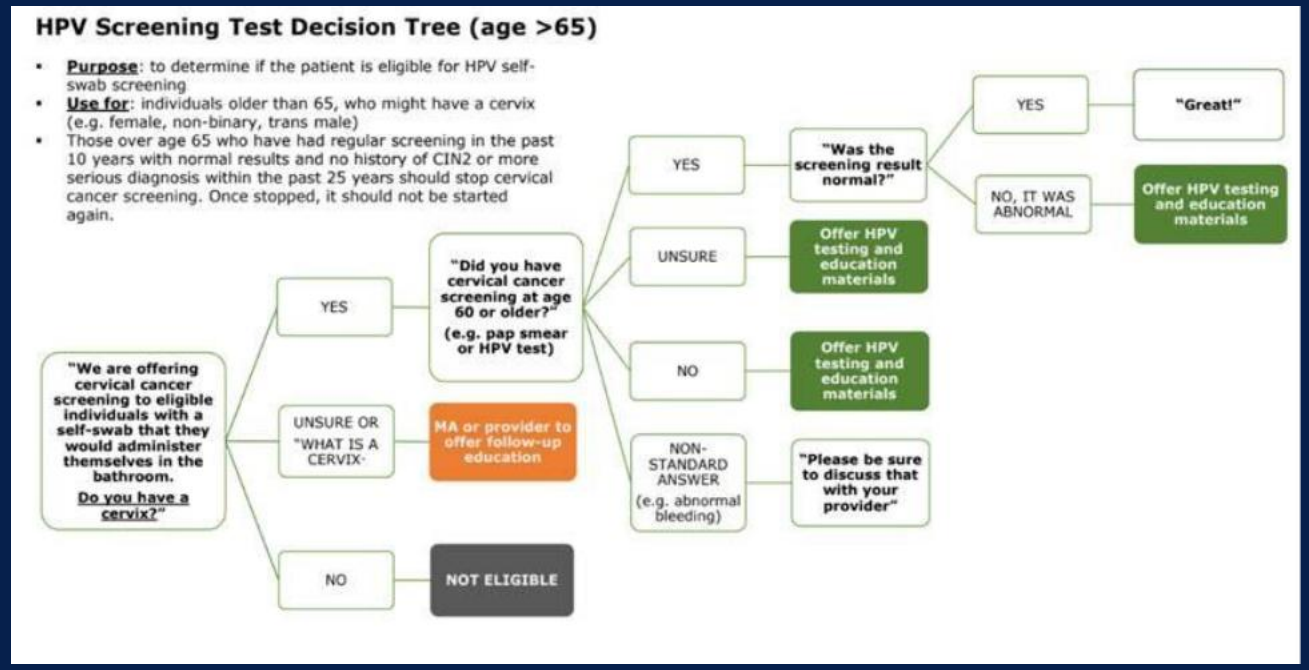
Project Workflows

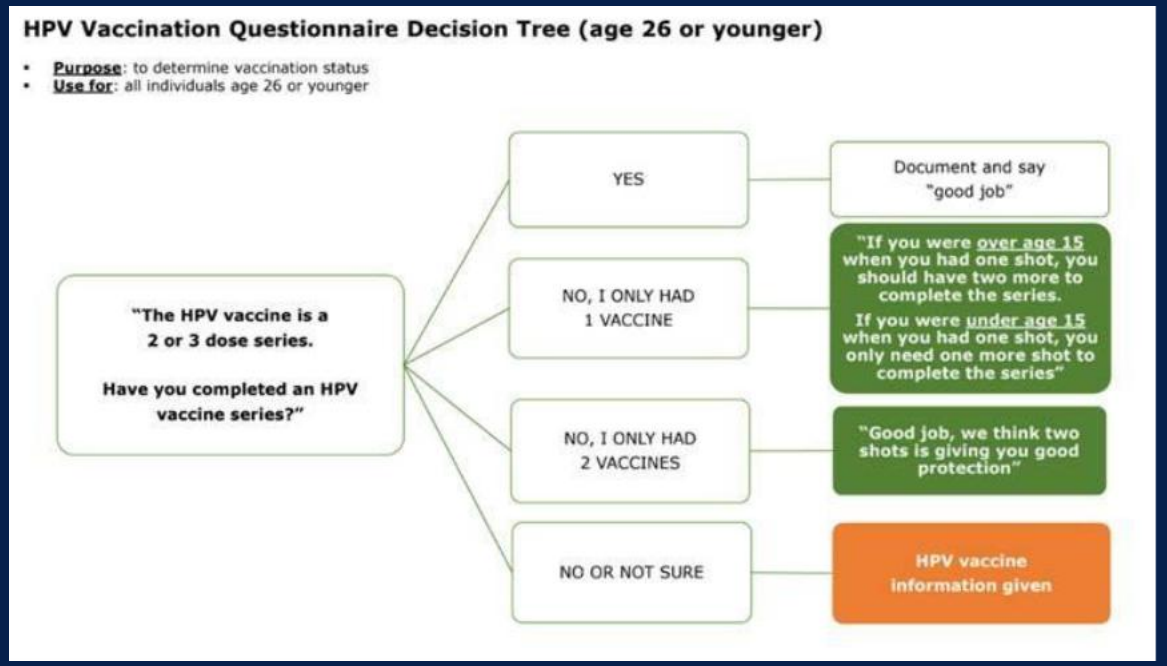
- Medical Assistants identify candidates ahead of Annual Medical Update visit, offer testing per decision tree:



Project Workflows

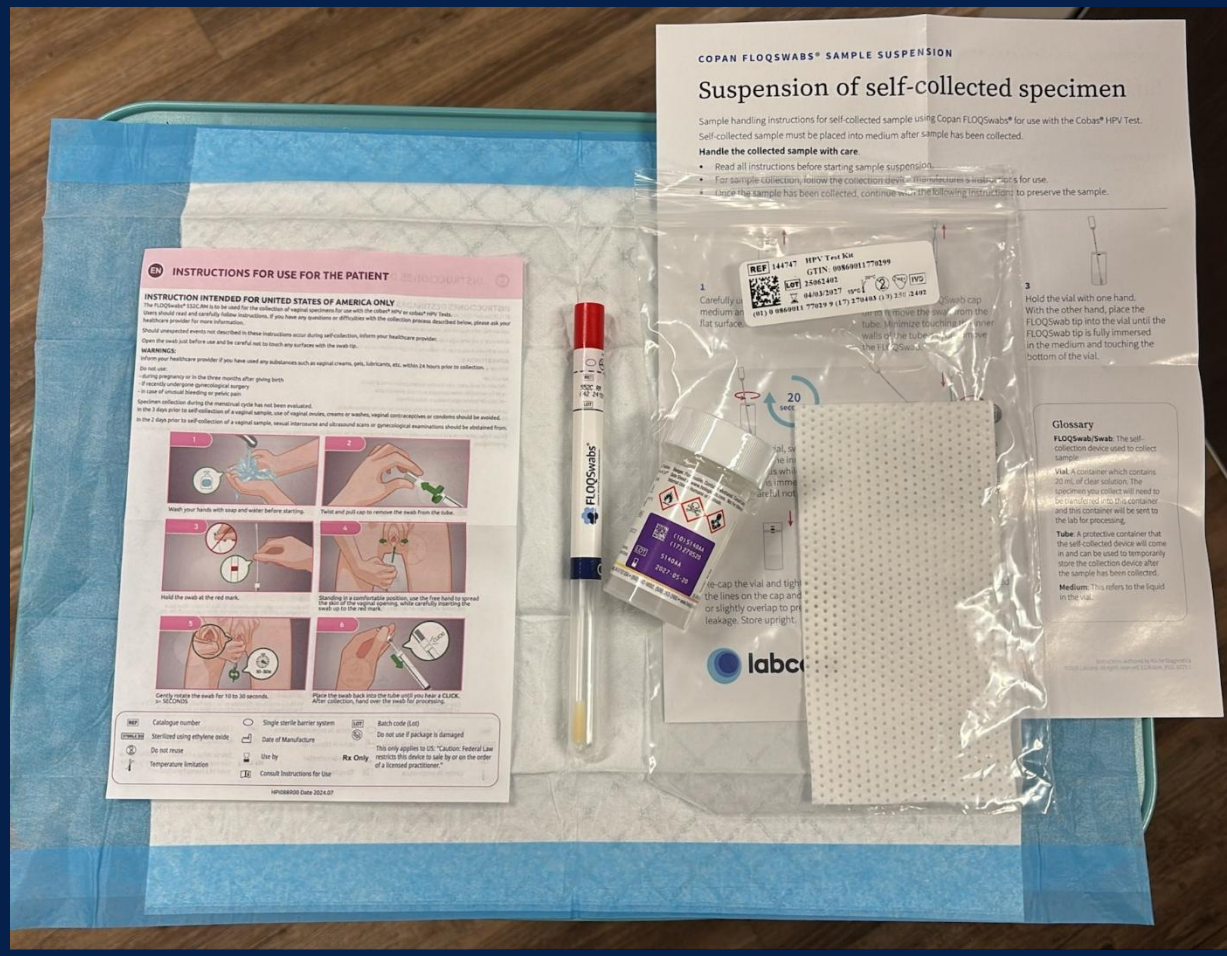
- Additional decision trees: Those >65 years old; vaccination questionnaire:





Project Workflows

- Eligible patients were offered a kit for self-collection, instructions in English or Spanish, and a diagram of collection technique
- Completed in facility restroom, concordant with routine urine testing
- Those who were eligible but uncertain about proceeding were encouraged to discuss further with medical provider at that day's visit
- Written info on HPV testing and cervical cancer screening from CDC was provided



Project Workflows

- HPV tests were sent to UW Molecular Diagnostics Laboratory in twice weekly batches (6/2024-8/2025) or to Labcorp (9/2025 – present) for testing with Roche cobas® HPV test (FDA-approved for self-collection within a healthcare setting 5/2024)

Project Workflows

- Negative results via personalized letters handed to patients during routine visits, typically within a week of result
- Positive results prompted in-person medical consultations, with multi-modal outreach (phone/text/email) for missed appointments
- Management followed ASCCP risk-based consensus guidelines, referring patients testing positive for HPV-16/18 directly to colposcopy, while those with other hrHPV types were referred for cervical cytology
- Navigation system using EHR reminders to prompt provider chart reviews at one and four weeks post-referral to verify appointment scheduling and attendance

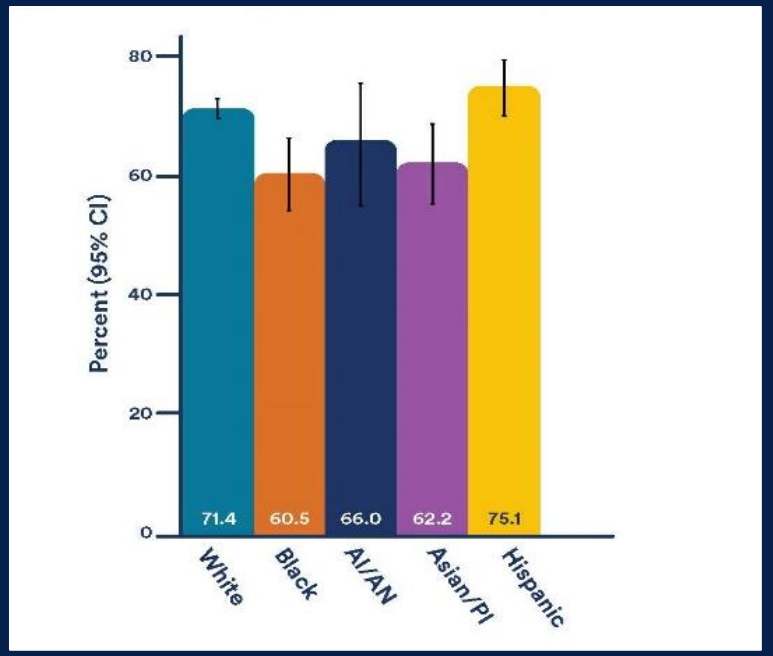
Linkage to Care

- Those with SUD report high rates of sexual abuse histories, which can make follow-up testing traumatic[3,4]
- We identified a list of trauma-informed gynecologic care providers in a variety of locations
- WCDC providers sent referrals detailing HPV results and request for follow-up testing
- To address logistical and psychosocial hurdles, the clinic provided free patient transportation to referral partners and offered Certified Peer Support Specialist accompaniment to off-site gynecologic appointments for emotional support

Addressing Health Equity

- Most HPV self-collect studies have taken place within healthcare systems that already provide cervical cancer screening with provider-collected samples[7]
- New clients with SUD often present with multiple medical and social issues including active withdrawal
- Bringing screening to patients in a setting where they already feel safe and respected can help to bypass structural barriers that lead to mortality disparities

Prevalence of up-to-date cervical cancer screening by race and ethnicity in WA[5]



Conclusion: You Can Do This!

- Incorporation of cervical cancer screening into a relatively small clinic with no gynecological services was feasible and acceptable with high patient eligibility and uptake
- HPV self-collect tests can expand cervical cancer screening into clinics to reach under-screened patients, which should reduce health care disparities and cervical cancer mortality

Questions and Acknowledgments

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  - Our patients
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    - including Mallory Davis, Andora Azabache, Krystelle Castillo, Karla Diaz, Jessica Iwuoha, Keira Jack, Kurt Kenoyer, Lamont Scott, Christina Walsh, Wendy Mironov, and Medical Assistant Team
  - University of Washington Molecular Diagnostics Laboratory
    - including Stephen L. Cherne and Eric Huang

References

- 1. Biancarelli DL, Biello KB, Childs E, et al. Strategies used by people who inject drugs to avoid stigma in healthcare settings. *Drug Alcohol Depend*. May 1 2019;198:80-86. doi:10.1016/j.drugalcdep.2019.01.037
- 2. Price O, Swanton R, Grebely J, et al. Vaccination coverage among people who inject drugs: A systematic review. *Int J Drug Policy*. May 2024;127:104382. doi:10.1016/j.drugpo.2024.104382
- 3. Owens L, Gilmore K, Terplan M, Prager S, Micks E. Providing reproductive health services for women who inject drugs: a pilot program. *Harm Reduct J*. Jul 14 2020;17(1):47. doi:10.1186/s12954-020-00395-y
- 4. Medina-Perucha L, Scott J, Chapman S, Barnett J, Dack C, Family H. A qualitative study on intersectional stigma and sexual health among women on opioid substitution treatment in England: Implications for research, policy and practice. *Soc Sci Med*. Feb 2019;222:315-322. doi:10.1016/j.socscimed.2019.01.022
- 5. Centers for Disease Control and Prevention. BRFSS Prevalence & Trends Data. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/brfss/brfssprevalence/index.html
- 6. Winer, R.L., J. Lin, J.A. Tiro, D.L. Miglioretti, T. Beatty, H. Gao, K. Kimbel, C. Thayer, and D.S.M. Buist, *Effect of Mailed Human Papillomavirus Test Kits vs Usual Care Reminders on Cervical Cancer Screening Uptake, Precancer Detection, and Treatment: A Randomized Clinical Trial.* JAMA Netw Open, 2019. **2**(11): p. e1914729. PMID:31693128.
- 7. Winer, R.L., J. Lin, M.L. Anderson, J.A. Tiro, B.B. Green, H. Gao, . . . D.S.M. Buist, *Strategies to Increase Cervical Cancer Screening With Mailed Human Papillomavirus Self-Sampling Kits: A Randomized Clinical Trial.* JAMA, 2023. **330**(20): p. 1971-1981. PMID:38015219.

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American Cancer Society®

Q&A

Poll

1. Almost all cases of cervical cancer are caused by high-risk types of human papillomavirus (HPV).
2. The 5-year relative survival rate is over __% for cervical cancer diagnosed at a localized stage.
3. After today's webinar, how would you describe your knowledge of cervical cancer prevention and screening?
4. After today's webinar, how would you describe your knowledge of self-collection HPV testing?

Resources

New Cancer Screening Resources

[Cancer Screening Resources For Healthcare Professionals]

[Cancer Screening Resources for Patients]

Screening Resources

- Cervical Cancer Screening Guidelines
- Cervical Cancer Fact Sheet for Health Care Professionals
- FAQs for Transitioning to Primary HPV Testing for Cervical Cancer Screening
- Preparing for Self-Collection: Clinician Communication Guide
- A Guide for Implementing HPV Self Collection for Cervical Cancer Screening
- Evidence Based Intervention Guide
- HRSA Screening Guidelines
- Coding and Billing / insurance coverage
- ACS Cancer Risk 360
- ACS Screening Disparity Atlas

2026 Promising Practices Series

American Cancer Society

Join us for this informative webinar series to learn about the latest evidence-based practices to improve HPV vaccination (among adolescents aged 9–13) and cervical cancer elimination efforts nationwide!

This series is scheduled on Thursdays from 2pm - 3pm ET:

Session 1:
20 Years of HPV Vaccination Safety & Impact
February 19th

Session 2:
HPV Vaccination QI Success Stories
April 16th

Session 3:
Partnering for HPV Vaccination Progress
June 18th

Session 4:
Provider Education for On-Time HPV Vaccination
August 20th

Session 5:
Provider & Team Champions for HPV Vaccination
October 15th

Session 6:
Cervical Cancer Elimination
December 10th

Register here!

2026 RURAL LEARNING COMMUNITY

The 2026 rural learning community will provide practical strategies and peer-based learning to help participants implement evidence-based interventions that strengthen cancer prevention and screening efforts in their clinics and communities.

Topics to be explored include:

- From Colon to Cervical: Best Practices with Self-Collection Testing
- Bridge the Gap: HPV Partnerships & Pathways That Work
- From Start to Finish: HPV Series Completion in Rural Communities
- Small Media, Big Impact: Boosting HPV Vaccination in Rural Communities
- Measuring What Matters: HPV Report Cards for Clinics and Provider

Register here

Sessions will occur the **2nd Wednesday of every month** (March-November 2026)
Time: 2-3pm EST
Location: Zoom meeting

If you have any questions about the learning community, please reach out to Ashley.Lach@cancer.org

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THANK YOU!