Breakout Topic D:

Cervical Screening Health Equity

11:00 AM – 12:30 PM

American Cancer Society®

NATIONAL HPV VACCINATION ROUNDTABLE

American Cancer Society®

NATIONAL ROUNDTABLE ON CERVICAL CANCER

Breakout Topic D:
Cervical Screening Health Equity

Rebecca Landy, PhD
American Cancer Society

Trisha Amboree, PhD
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Cervical Screening Health Equity

Rebecca Landy, PhD

June 9, 2026

American Cancer Society®

Disclosures and Acknowledgements

Nothing to disclose

Collaborators on the work I'll show at the end:

Sarah Phillips (Hospital of the University of Pennsylvania)

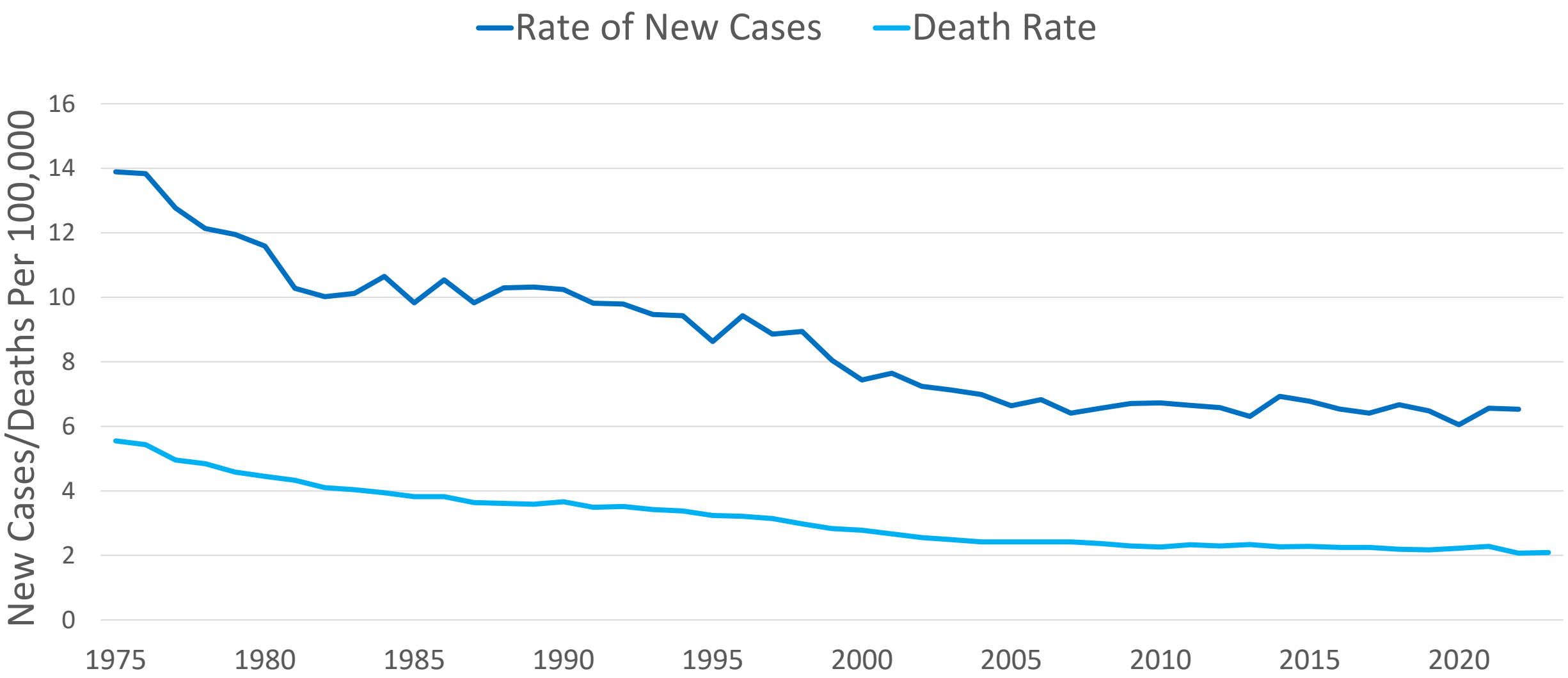
Priti Bandi (ACS)

Jessica Star (ACS)

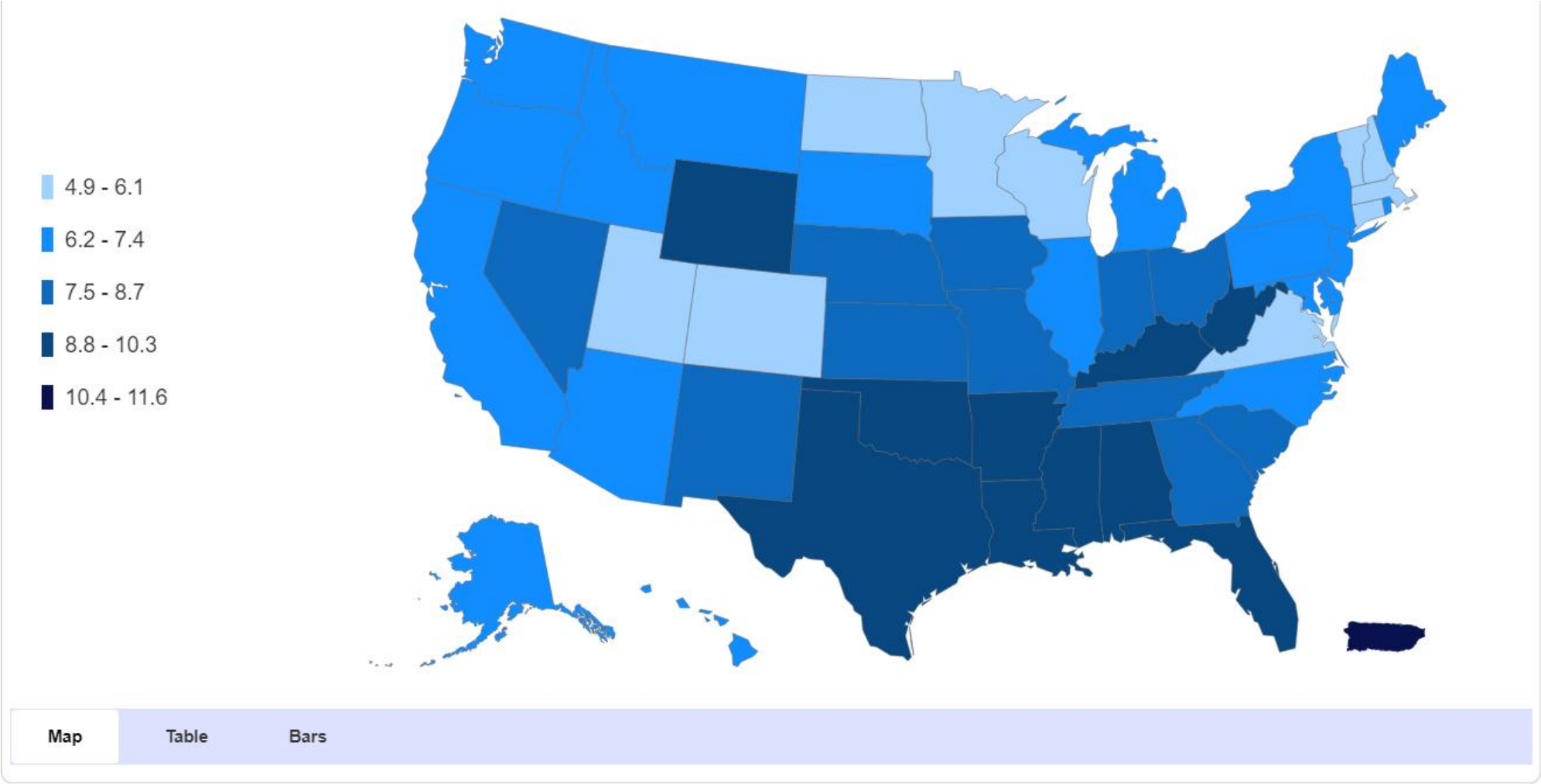
Sarah Temkin (ACS)

Bob Smith (ACS)

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.

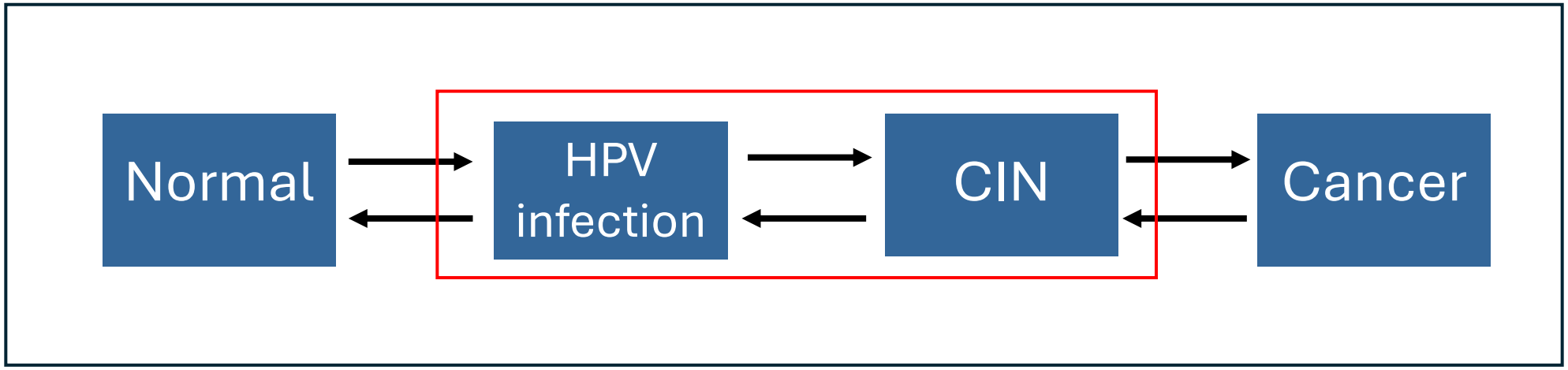
SOURCE: American Cancer Society. Cancer Statistics Center. https://cancerstatisticscenter.cancer.org/types/cervix | Accessed 3/29/2025.

Cervical Cancer Screening

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

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

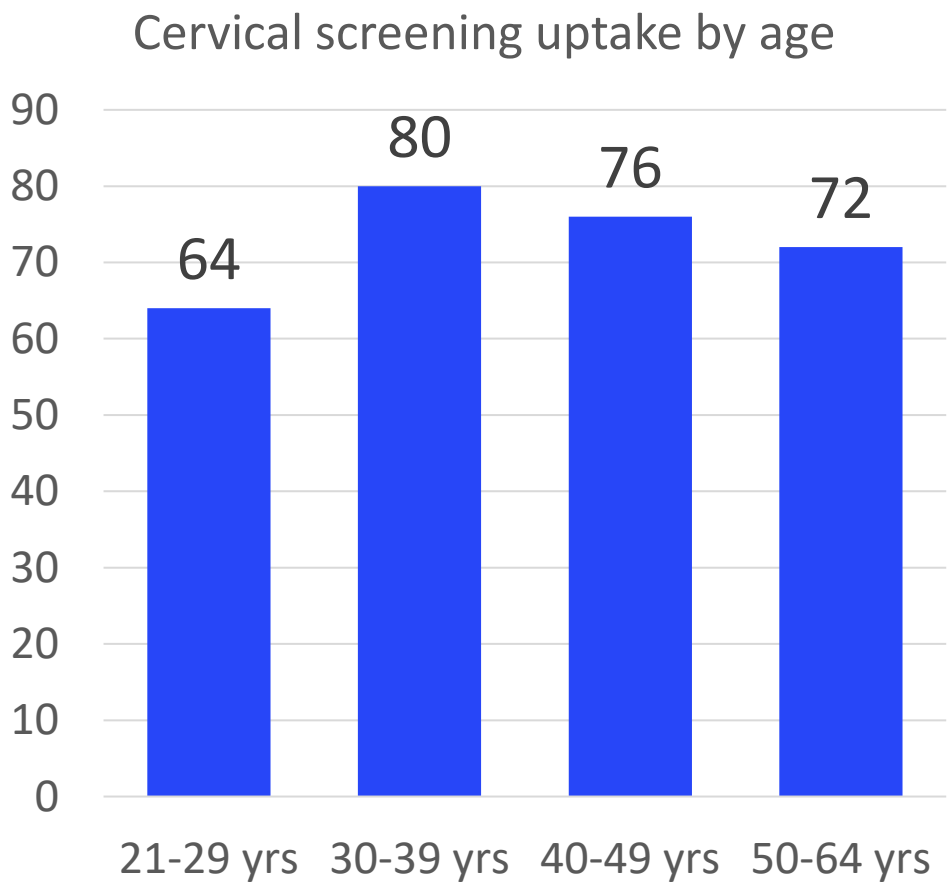
Cytology/Pap testing – detect abnormal cells, 3-year screening interval

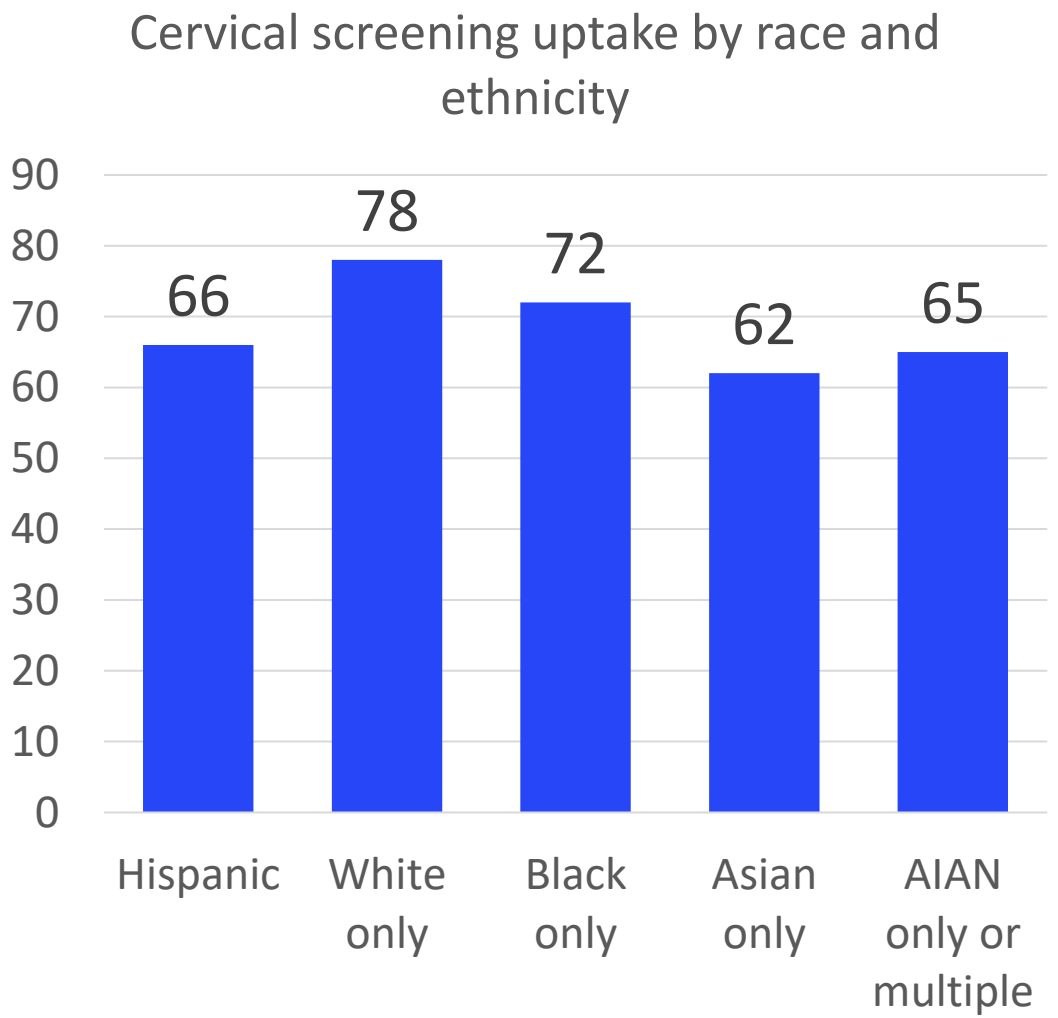


ACS guidelines updated in December 2025 to include self-sampling. Attending screening regularly is estimated to reduce the risk of cancer by 70%[1]

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

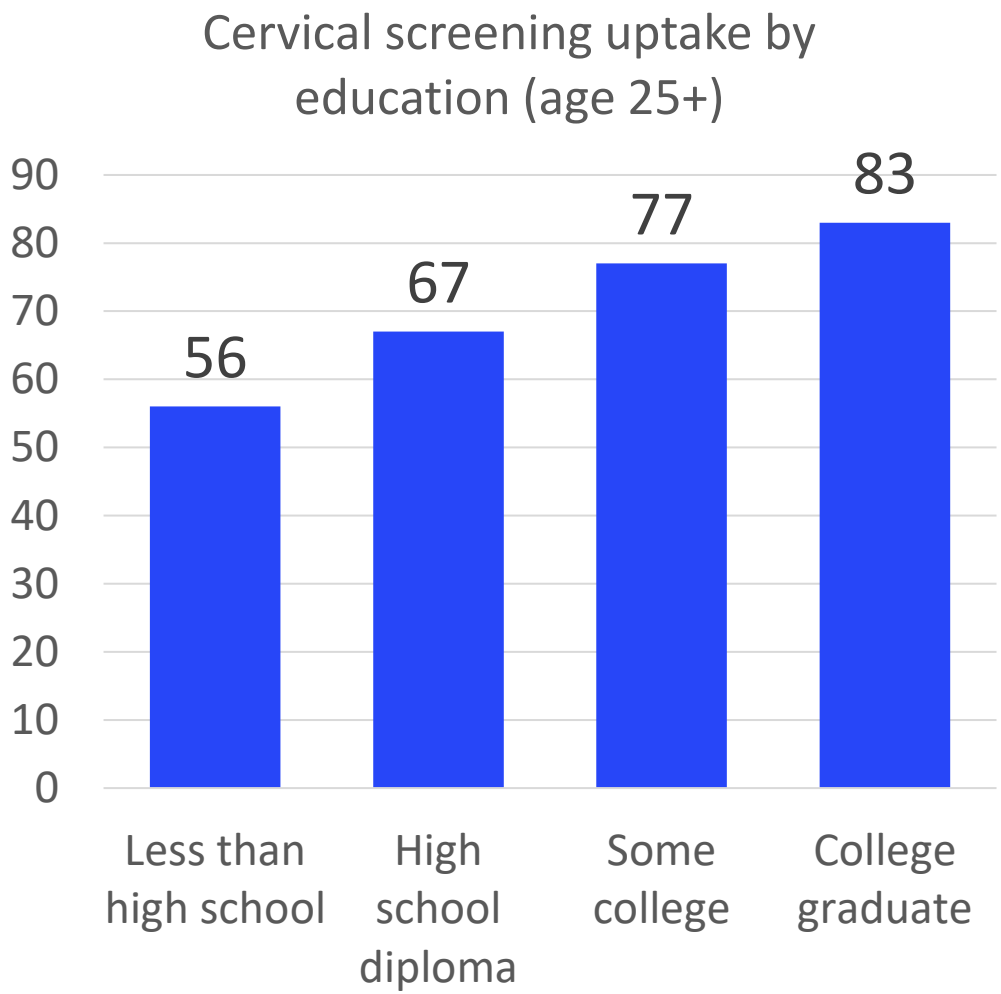
Cervical screening uptake (75% in 2021)

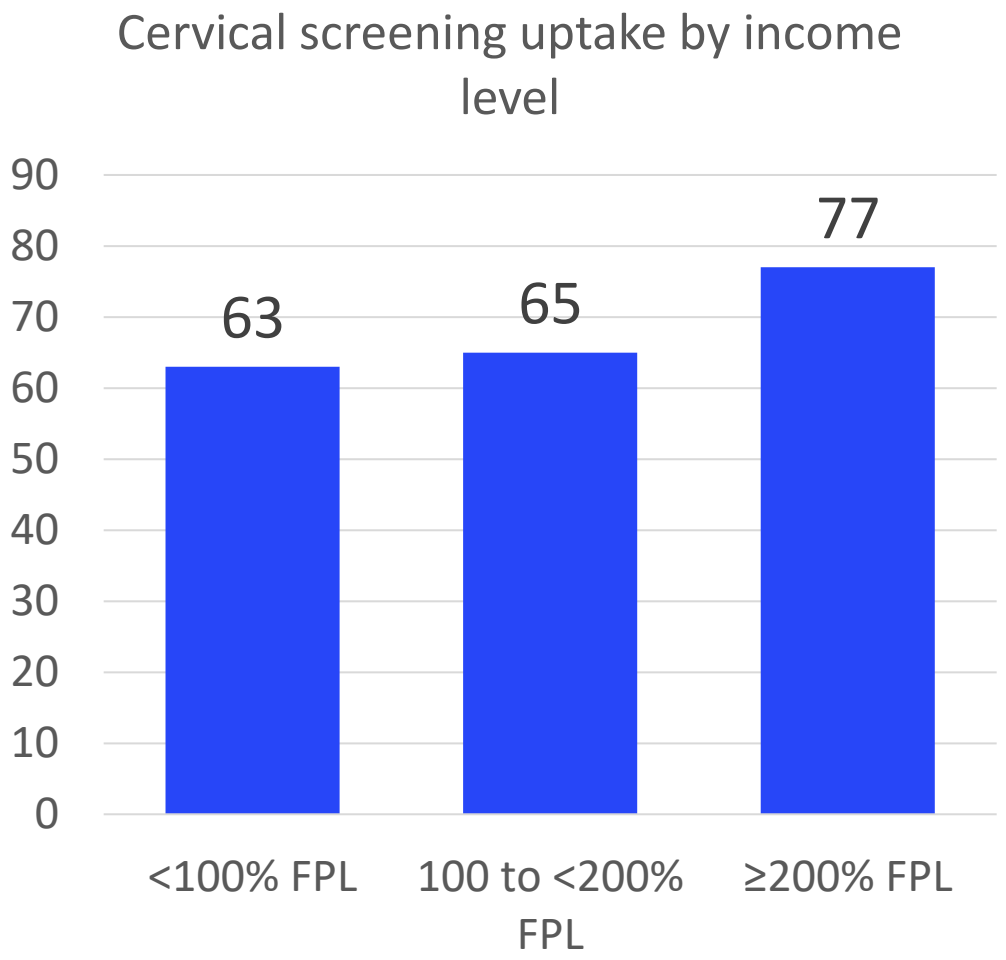




American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2025*. Atlanta: American Cancer Society; *2025-2026*.
https://www.cancer.org/research/cancer-facts-statistics/cancer-prevention-early-detection.html

Cervical screening uptake (2021)





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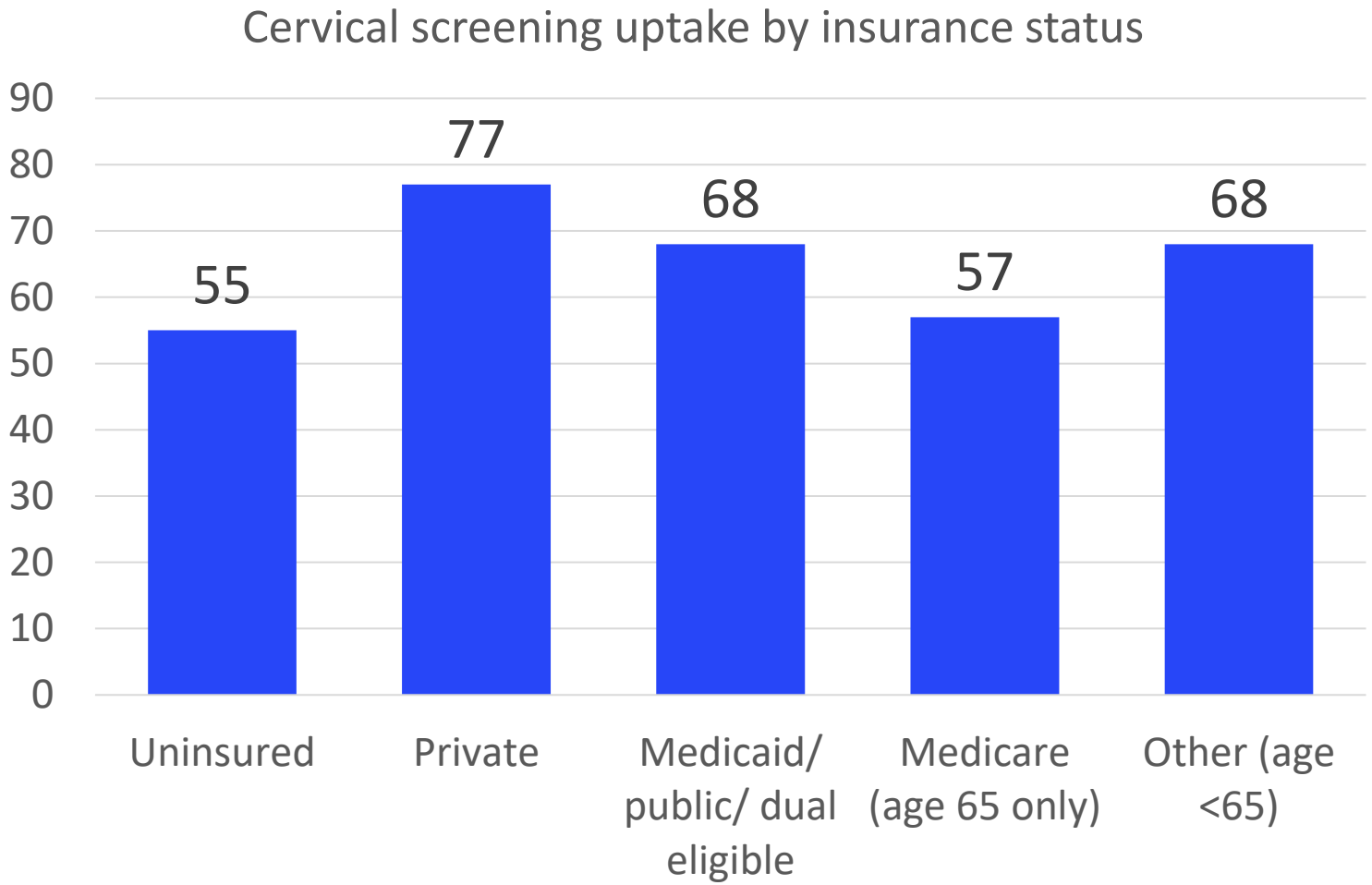
Cervical screening uptake (2021)



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

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

3 studies showing a reduction in cervical cancer incidence among vaccinated women

CONCLUSIONS

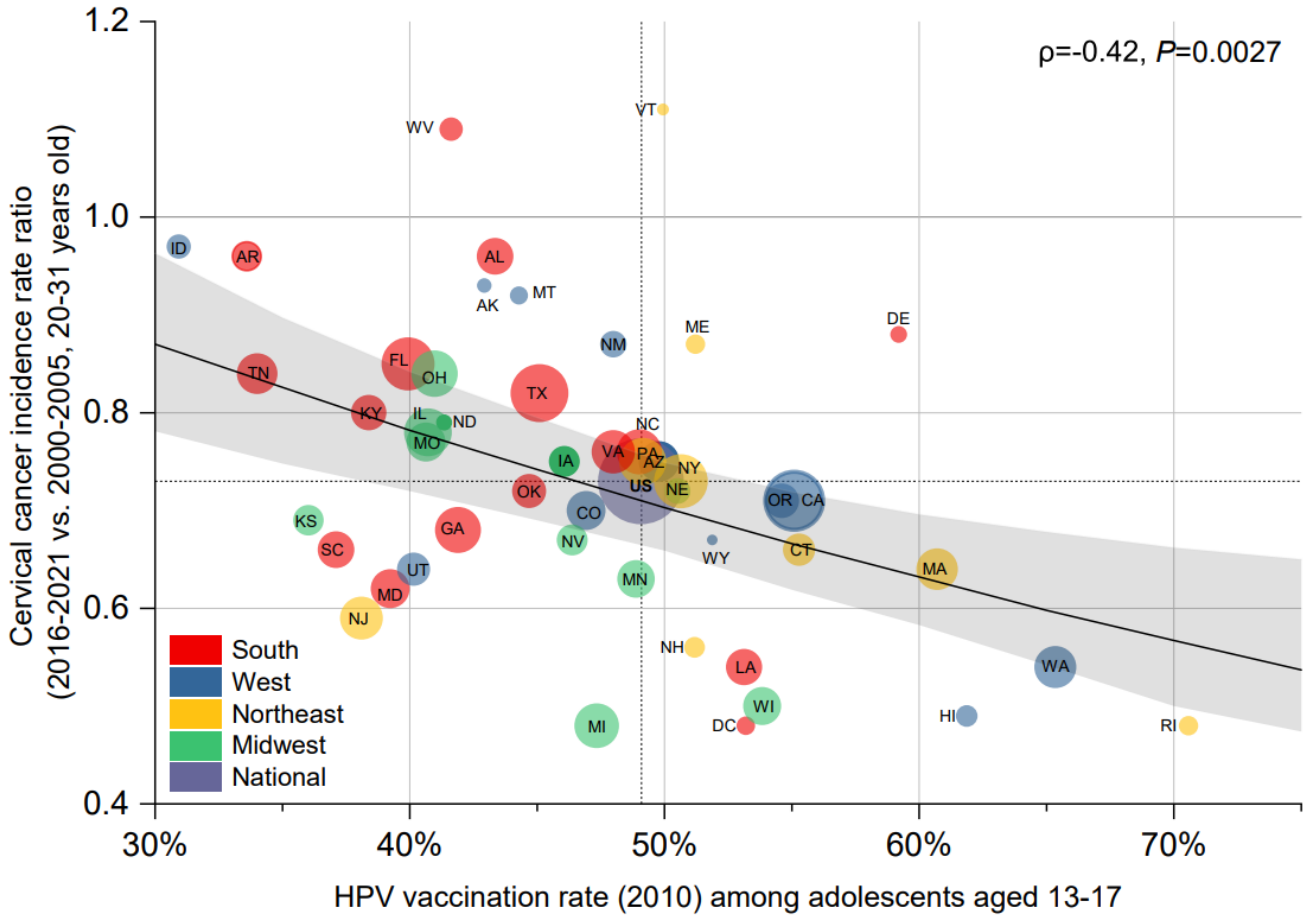
Among Swedish girls and women 10 to 30 years old, quadrivalent HPV vaccination was associated with a substantially reduced risk of invasive cervical cancer at the population level. (Funded by the Swedish Foundation for Strategic Research and others.)

creased with increasing buffer period (IRR = 0.85, 95% CI = 0.55 to 1.32, with 4-year buffer period). **Conclusion:** HPV vaccine effectiveness against cervical cancer at the population level is high among girls vaccinated younger than age 20 years. The lack of immediate effect in women vaccinated at age 20-30 years points to the importance of early age at vaccination.

Interpretation **We observed a substantial reduction in cervical cancer and incidence of CIN3 in young women after the introduction of the HPV immunisation programme in England, especially in individuals who were offered the vaccine at age 12–13 years. The HPV immunisation programme has successfully almost eliminated cervical cancer in women born since Sept 1, 1995.**

Lei et al, NEJM 2020; Kjaer et al, JNCI 2021; Falcaro et al, Lancet 2021

State Level Vaccination Rates are Associated with Cervical Cancer Incidence



Jiang C, et al. *JNCI: Journal of the National Cancer Institute*, 2026; https://doi.org/10.1093/jnci/djag051

Cervical screening by HPV vaccination status

- Screening rates are not presented by HPV vaccination status, despite knowing that cervical cancer risk varies dramatically by vaccination status.
- This makes it hard to assess the population-level protection against cervical cancer that is being achieved by cervical screening.
- Data from NHIS 2019, females aged 21-39 years who did not report a hysterectomy (N=4000)
  - Self-reported HPV vaccination status, self-reported cervical screening status/time since last screen
- Assumptions:
  - HPV vaccination reduces the risk of cervical cancer by 85%[1]
  - Being up-to-date with cervical screening reduces the risk of cervical cancer by 70%[2]
  - The effects of vaccination and screening are independent, i.e. vaccinated females who are up-to-date with screening have 95.5% lower risk
  - Ignores herd immunity

[1] Kim et al, JNCI, 2017, [2] Landy et al, IJC, 2019

Conclusions

- Cervical screening rates are higher among women who self-reported receiving the HPV vaccine
- High risk subgroup – 15% (1 in 7) females aged 21-39 are both unvaccinated and unscreened
- Population-level benefit of increasing screening uptake varies by whether the additional people being screened have been vaccinated
  - Highlights the importance of both screening and vaccination
- Knowing vaccination status helps inform where to focus prevention efforts and interventions
- Knowing screening uptake by vaccination status helps better understand population-level protection

There is very limited published data looking at observed screening rates by vaccination status

- Results I presented are based on self-report for both vaccination and screening

Do you have access to data where this could be explored?

If so, please be in touch! Rebecca.Landy@cancer.org

American Cancer Society | National HPV Vaccination Roundtable | American Cancer Society | National Roundtable on Cervical Cancer

Thank You

Uncovering Gaps in Screening and Charting a Path Toward Targeted Improvement

Trisha L. Amboree, PhD MPH
Assistant Professor, Public Health Sciences
Cancer Prevention & Control Program

American Cancer Society Roundtable National Meeting
Screening Equity Session
June 9, 2026

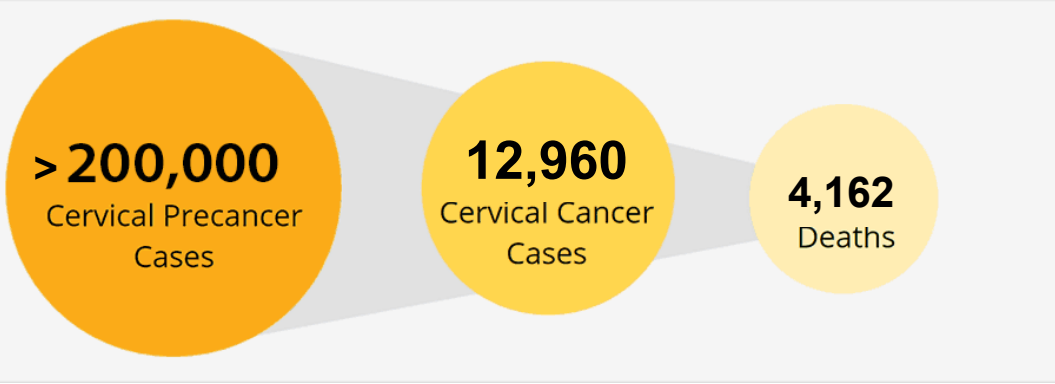
Disclosures

My travel and lodging was covered to give this talk.

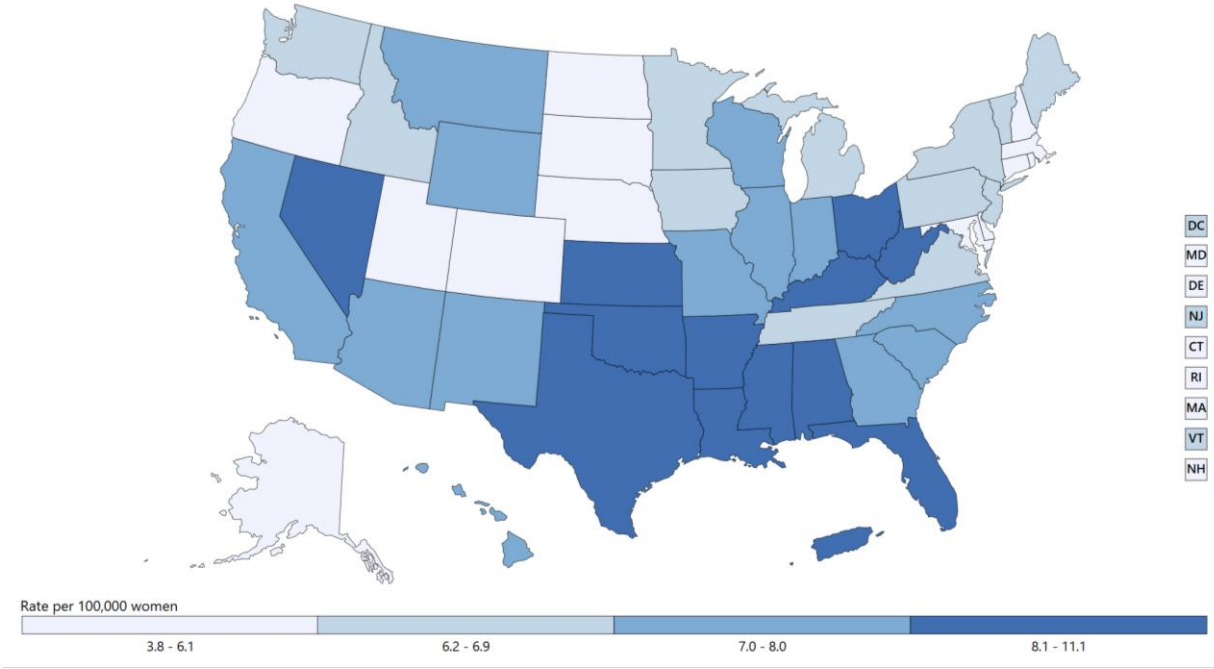
Some of the work I'll discuss was funded through an NIMHD supplement.

I have no other financial relationships or conflicts of interest to disclose.

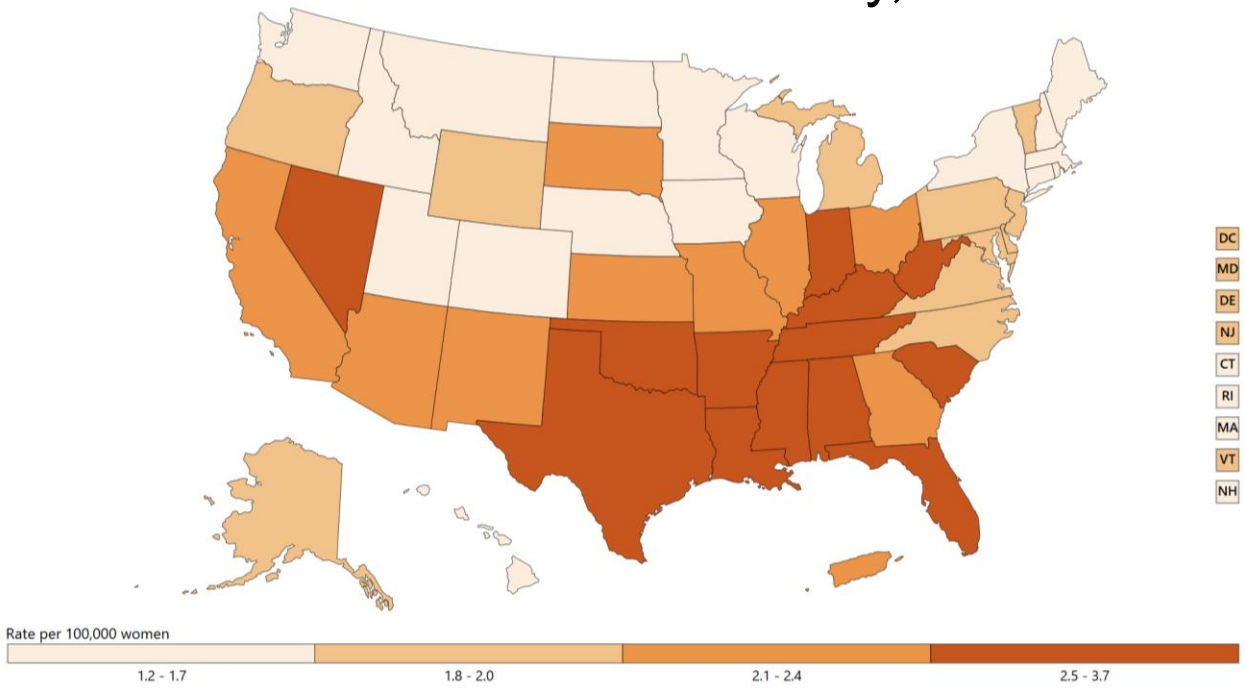
The ideas presented in this talk are my own and do not necessarily represent my funder or employer.



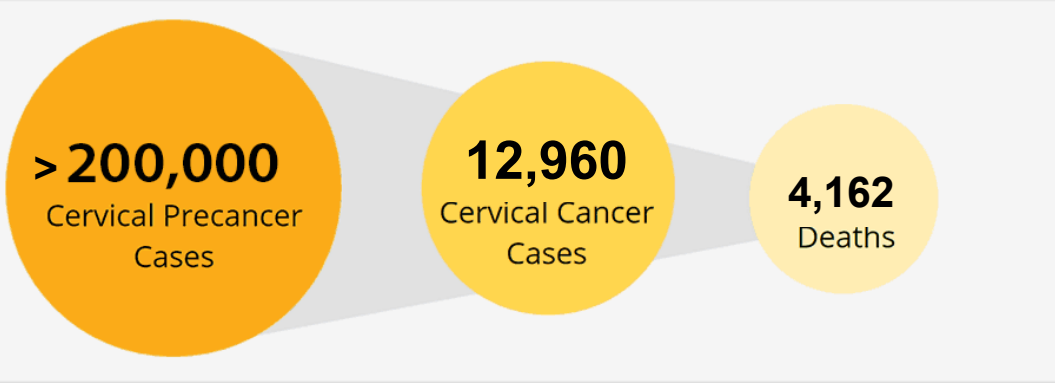
Annual Incidence, 2022



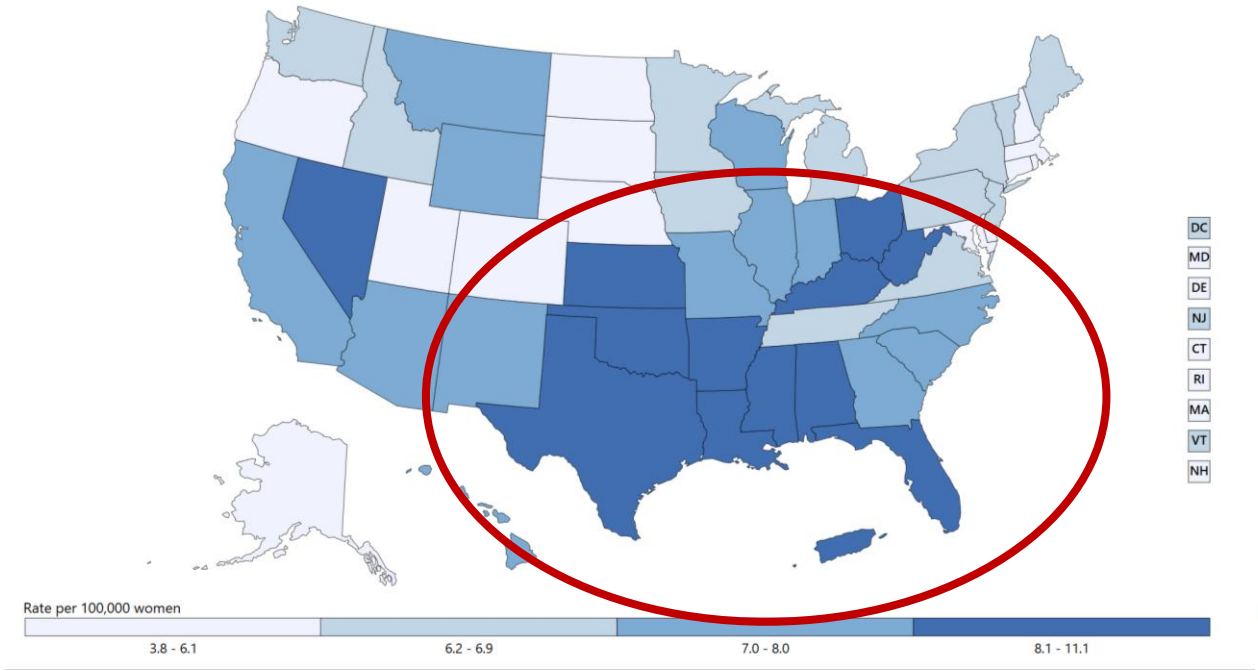
Mortality, 2019-2023



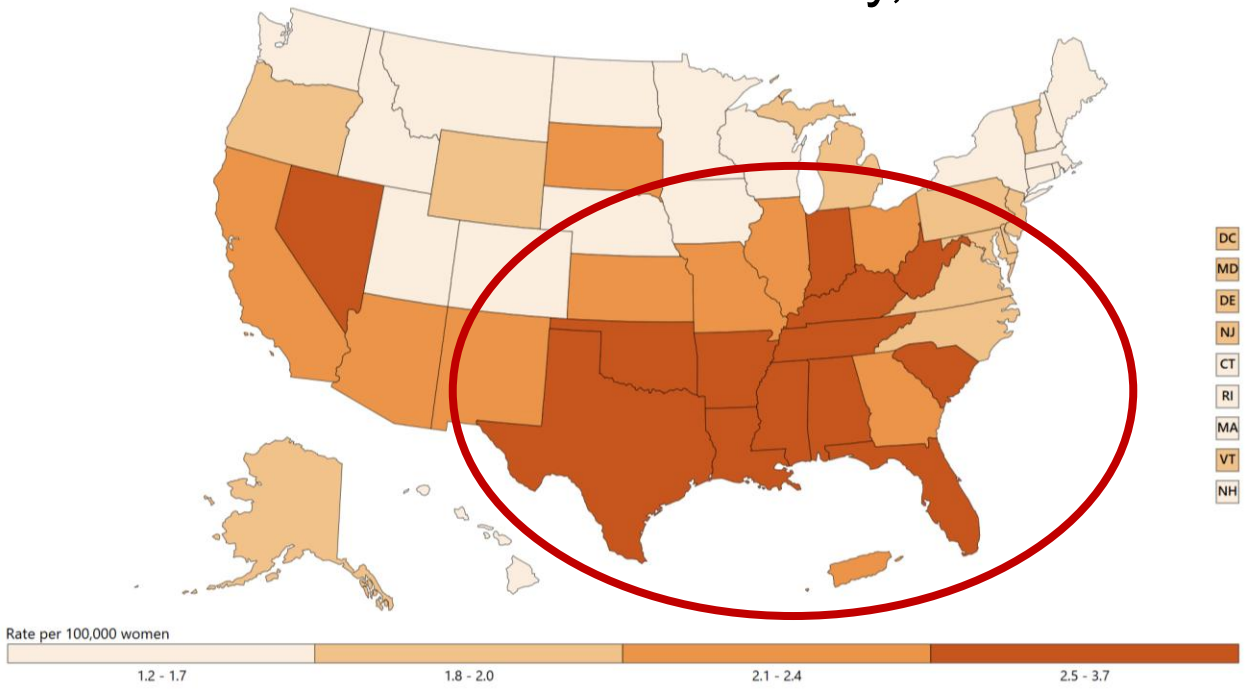
USCS Working Group, NCI, 2025 **[1]**



Annual Incidence, 2022



Mortality, 2019-2023



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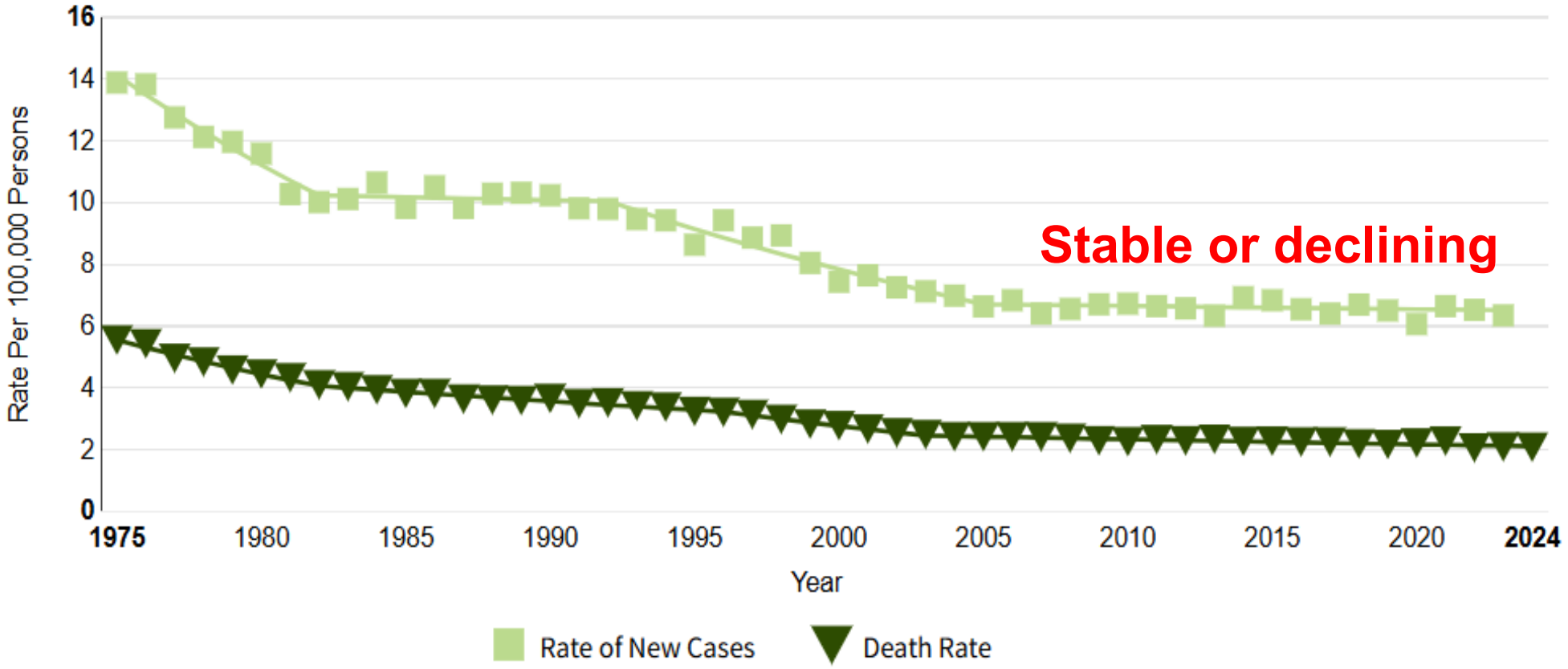


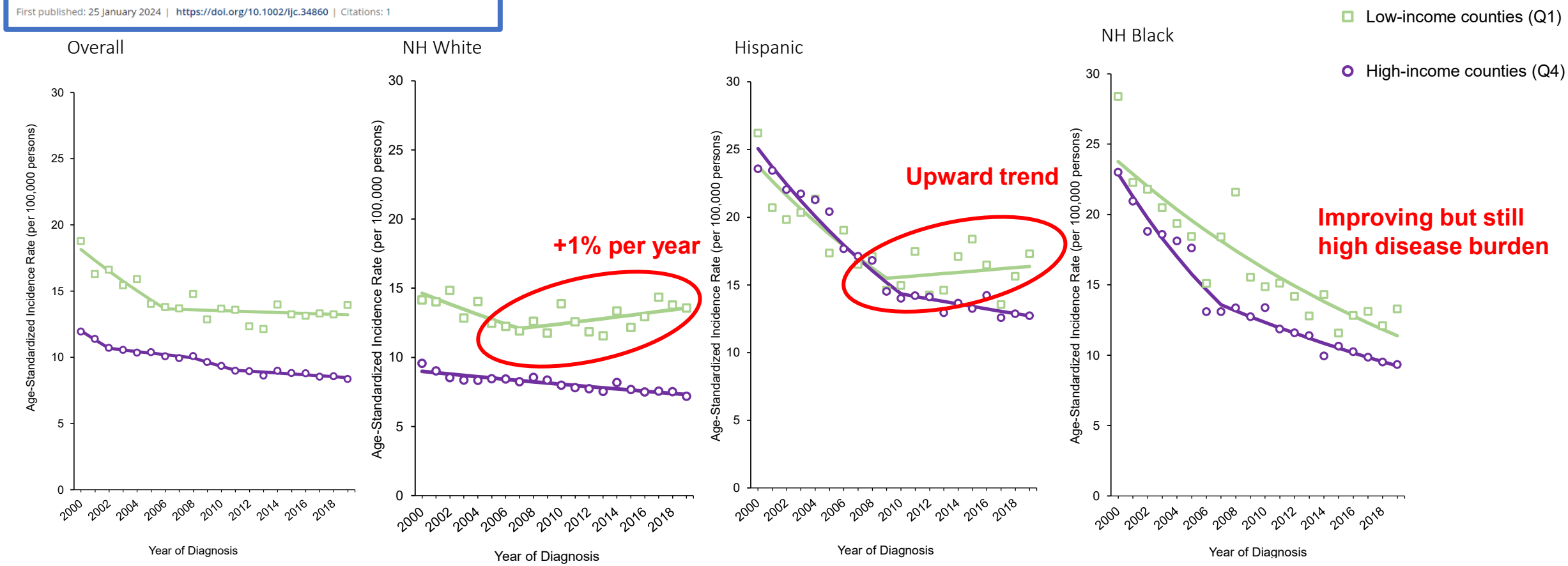
NCI SEER, 2026 **[2]**

SHORT REPORT | Full Access

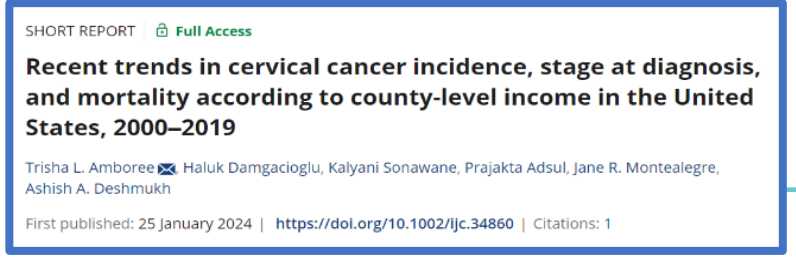
Recent trends in cervical cancer incidence, stage at diagnosis, and mortality according to county-level income in the United States, 2000–2019

Trisha L. Amboree, Haluk Damgacioglu, Kalyani Sonawane, Prajakta Adsul, Jane R. Montealegre, Ashish A. Deshmukh

First published: 25 January 2024 | https://doi.org/10.1002/ijc.34860 | Citations: 1



Amboree et al., *Int J Cancer*, 2024 **[3]**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Troubling increase of distant-stage diagnoses within low-income quartile

Race and ethnicity	Year	APC	(95%CI)
All	2004-2019	1.5%	-0.3% to 3.6%
NH White	2004-2019	**4.4%** *	1.7% to 7.5%
Hispanic	2004-2019	1.5%	-0.6% to 4.1%
NH Black	2004-2019	**-4.1%** *	-7.8% to -0.5%

* denotes statistical significance

Amboree et al., *Int J Cancer*, 2024 **[3]**

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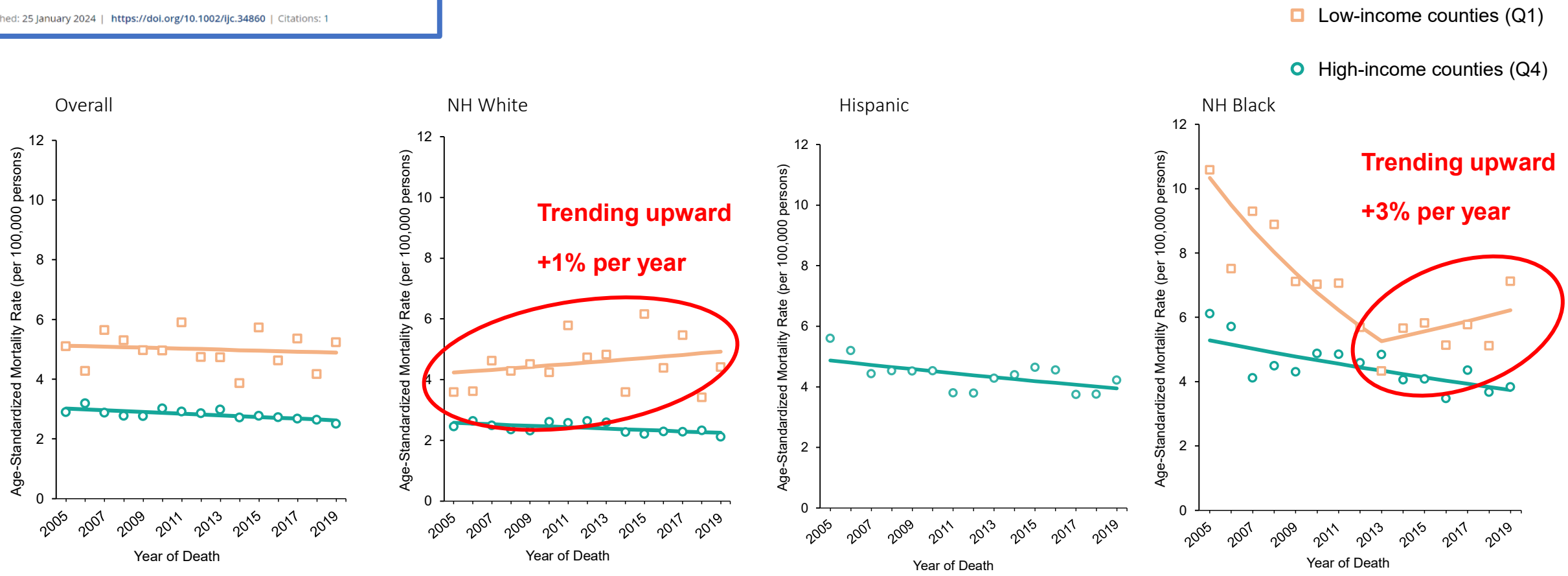


Amboree et al., *Int J Cancer*, 2024 **[3]**

Research Letter | Oncology

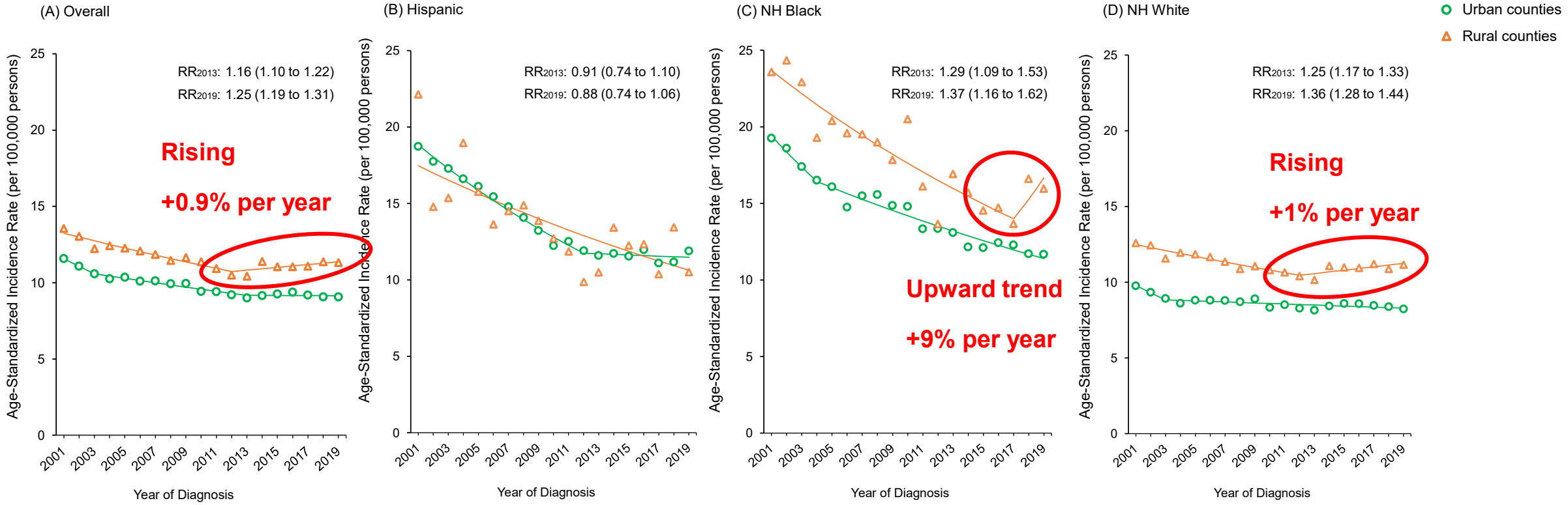
March 3, 2025

Rural-Urban Disparities in Cervical Cancer Incidence and Mortality Among US Women

Trisha L. Amboree, PhD, MPH[1,2,3]; Haluk Damgacioglu, PhD[1,2]; Elizabeth Y. Chiao, MD[4,5]; Kathleen M. Schmeler, MD[6]; Kalyani Sonawane, PhD[1,2]; Ashish A. Deshmukh, PhD[1,2]; Jane R. Montealegre, PhD[3]

Author Affiliations | Article Information

JAMA Netw Open. 2025;8(3):e2462634. doi:10.1001/jamanetworkopen.2024.62634



Amboree et al., *JAMA Netw Open*, 2025 **[4]**

Research Letter | Oncology

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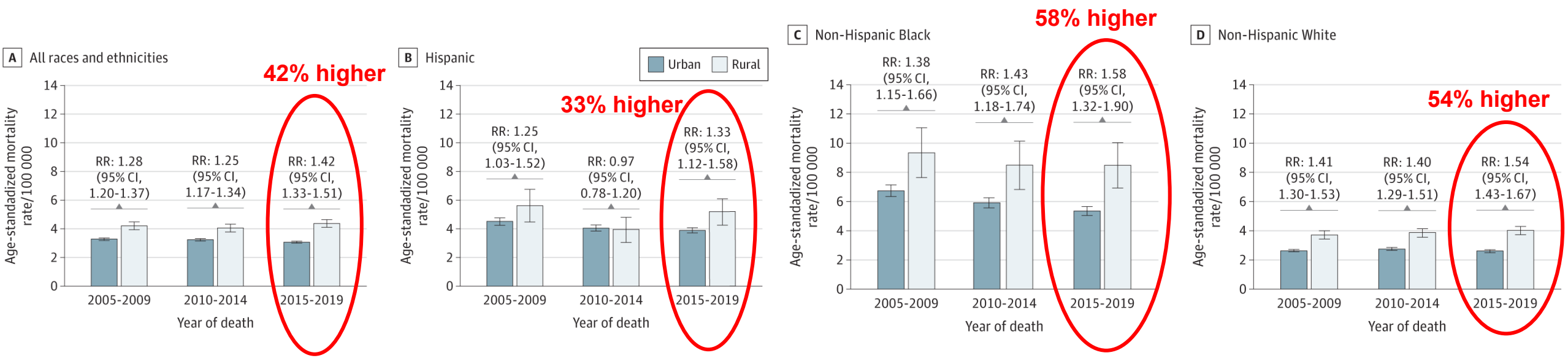


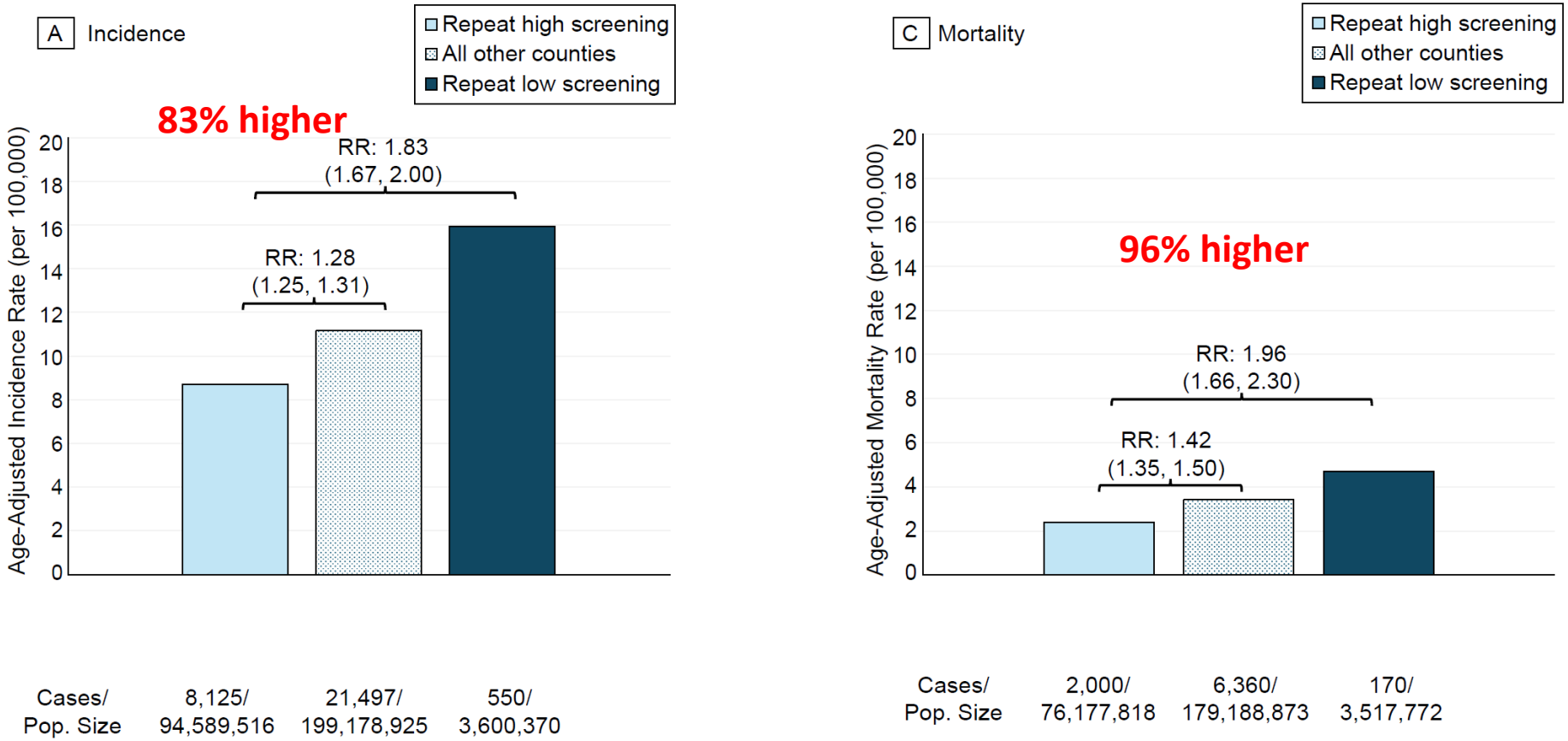
Amboree et al., *JAMA Netw Open*, 2025 **[4]**

JAMA Network Open

Research Letter | Oncology

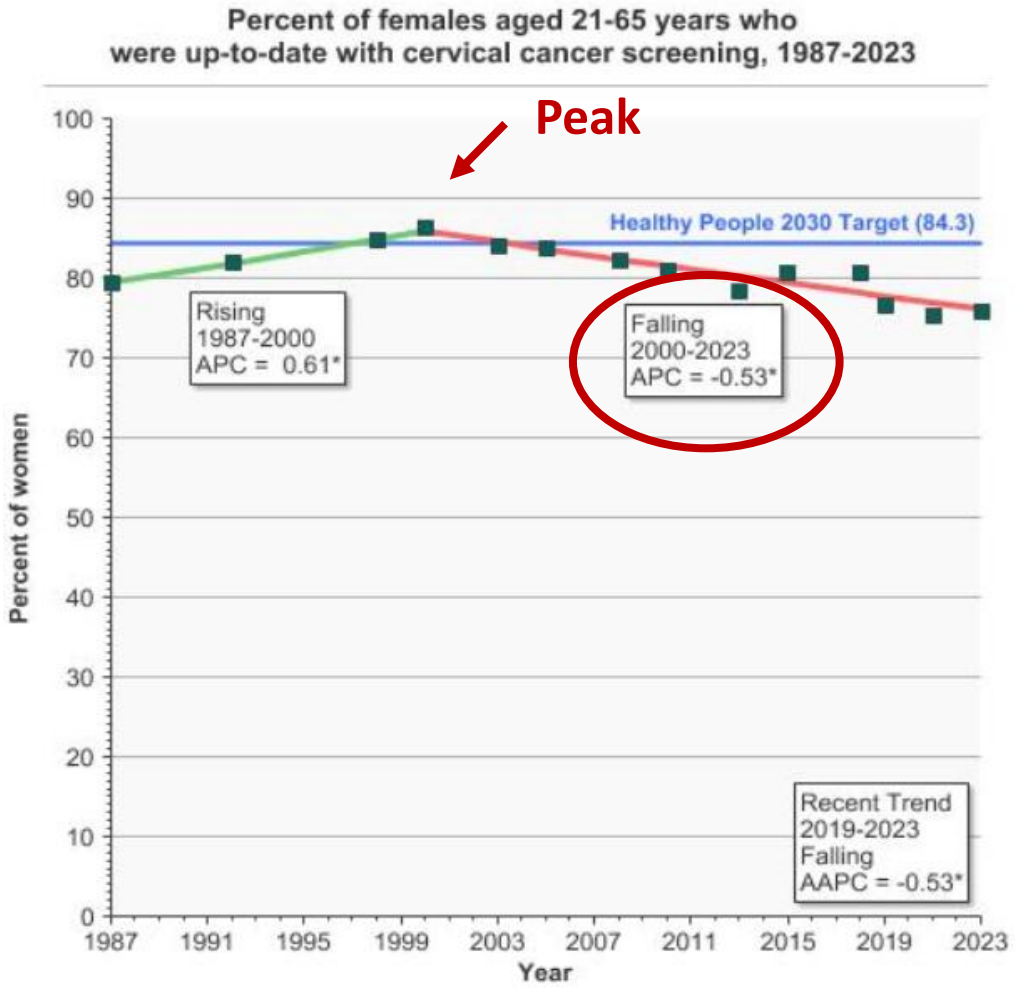
County-Level Cervical Cancer Screening Coverage and Differences in Incidence and Mortality

Trisha L. Amboree, PhD, MPH; Jane R. Montealegre, PhD; Haluk Damgacioglu, PhD; Brian Orr, MD; John Wrangle, MD; Kalyani Sonawane, PhD; Ashish A. Deshmukh, PhD



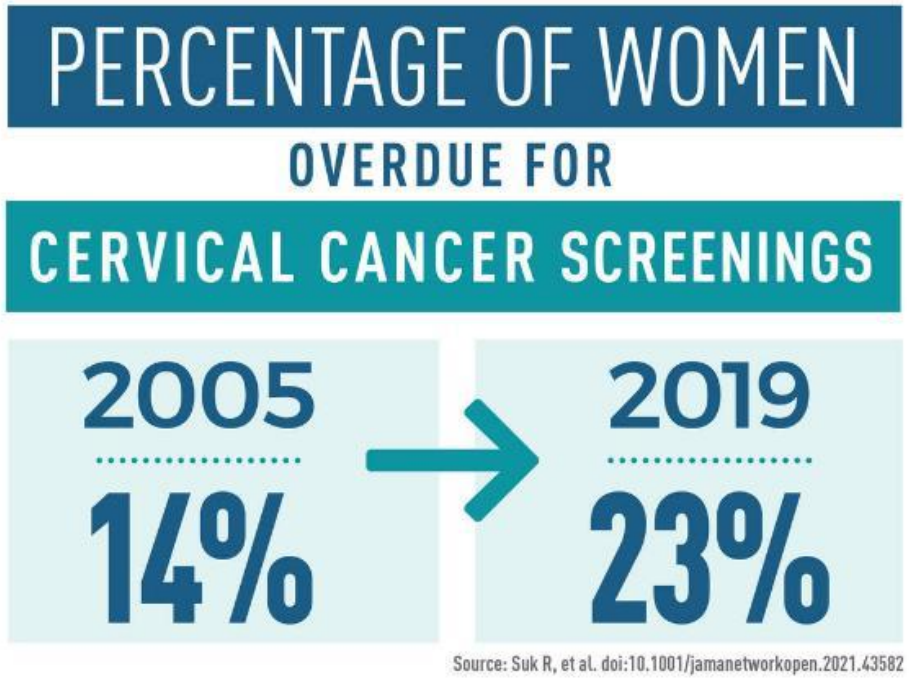
Amboree et al., *JAMA Netw Open*, 2025 **[5]**

Low Screening Uptake



NCI DHHS, 2025 **[6]**

Low Screening Uptake



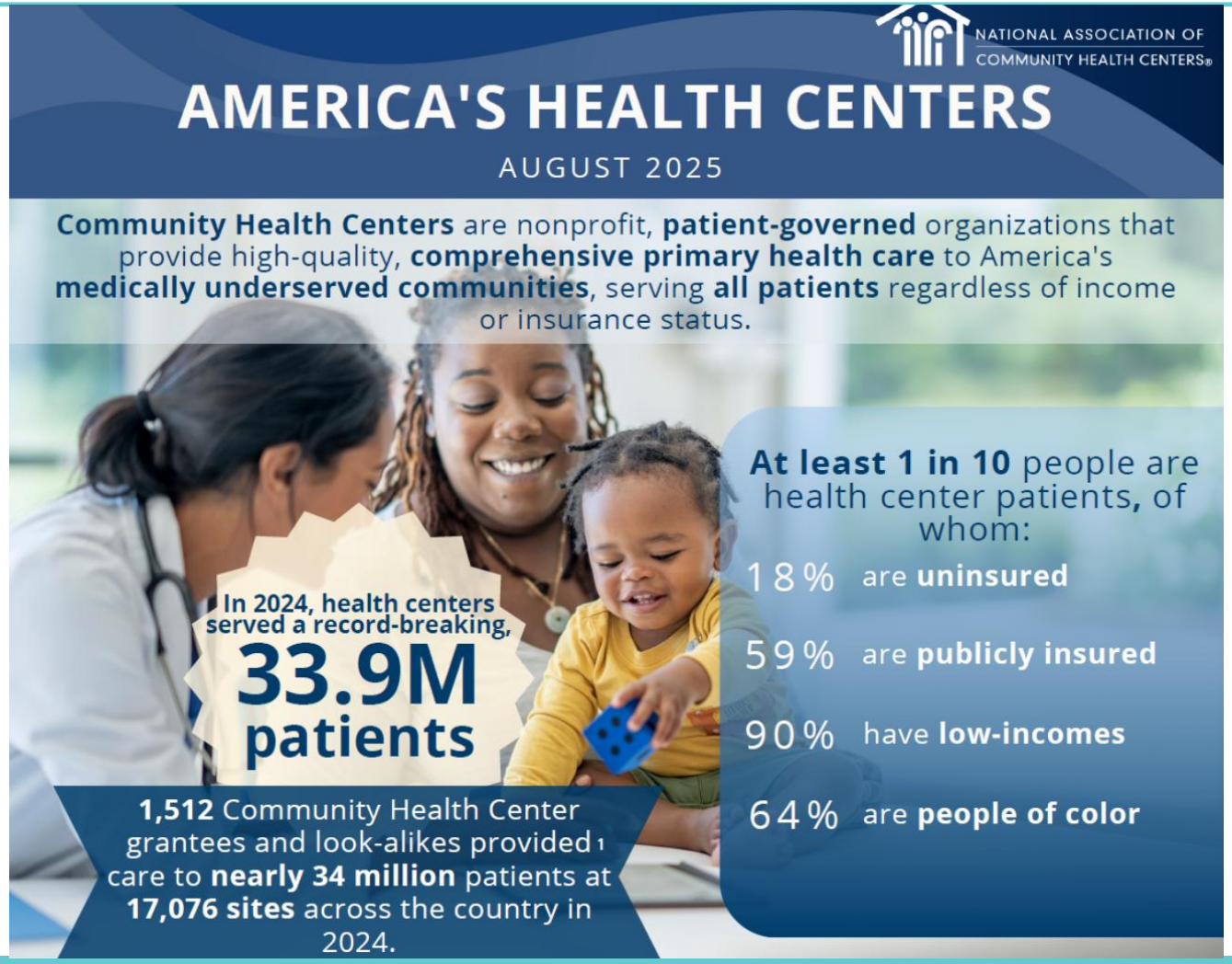
Predicted Probability of Overdue Screening

	Age 21-29y	Age 30-65y
Asian	36%	36%
Hispanic	31%	30%
NH Black	23%	21%
NH White	22%	21%
Other	28%	29%

	Age 21-29y	Age 30-65y
Private	20%	20%
Public	28%	28%
Other	24%	23%
None	41%	41%

Suk et al., *JAMA Netw Open*, 2024 **[7]**

Settings servicing low-resourced populations



NACHC, 2025 **[8]**

Original Investigation

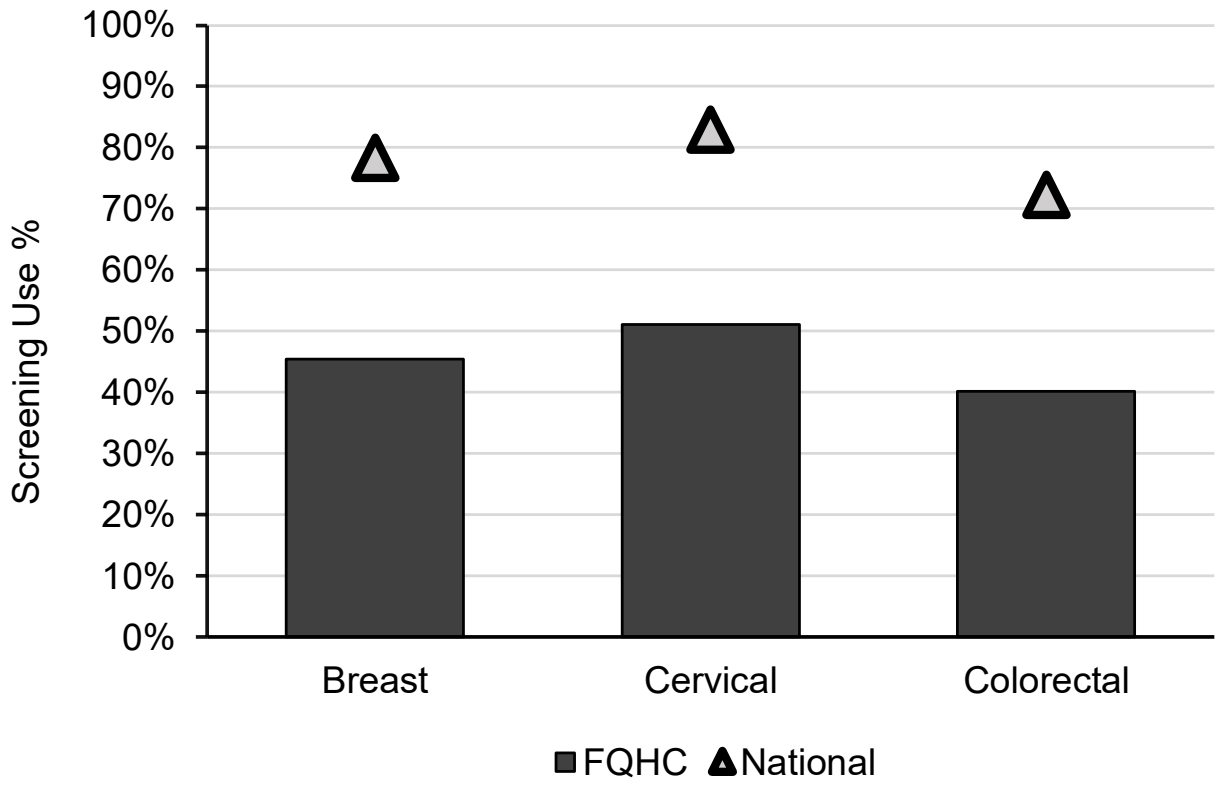
April 29, 2024

National Breast, Cervical, and Colorectal Cancer Screening Use in Federally Qualified Health Centers

Trisha L. Amboree, PhD[1]; Jane R. Montealegre, PhD[1]; Susan L. Parker, MPH[1]; Ashvita Garg, PhD[2,3]; Haluk Damgacioglu, PhD[2,3]; Kathleen M. Schmeler, MD[4]; Elizabeth Y. Chiao, MD[5,6]; Elizabeth G. Hill, PhD[2,3]; Kalyani Sonawane, PhD[2,3]; Ashish A. Deshmukh, PhD[2,3]; Prajakta Adsul, MBBS, MPH, PhD[7,8]

» Author Affiliations | Article Information

JAMA Intern Med. 2024;184(6):671-679. doi:10.1001/jamainternmed.2024.0693



Amboree et al., *JAMA Int Med*, 2024 **[9]**

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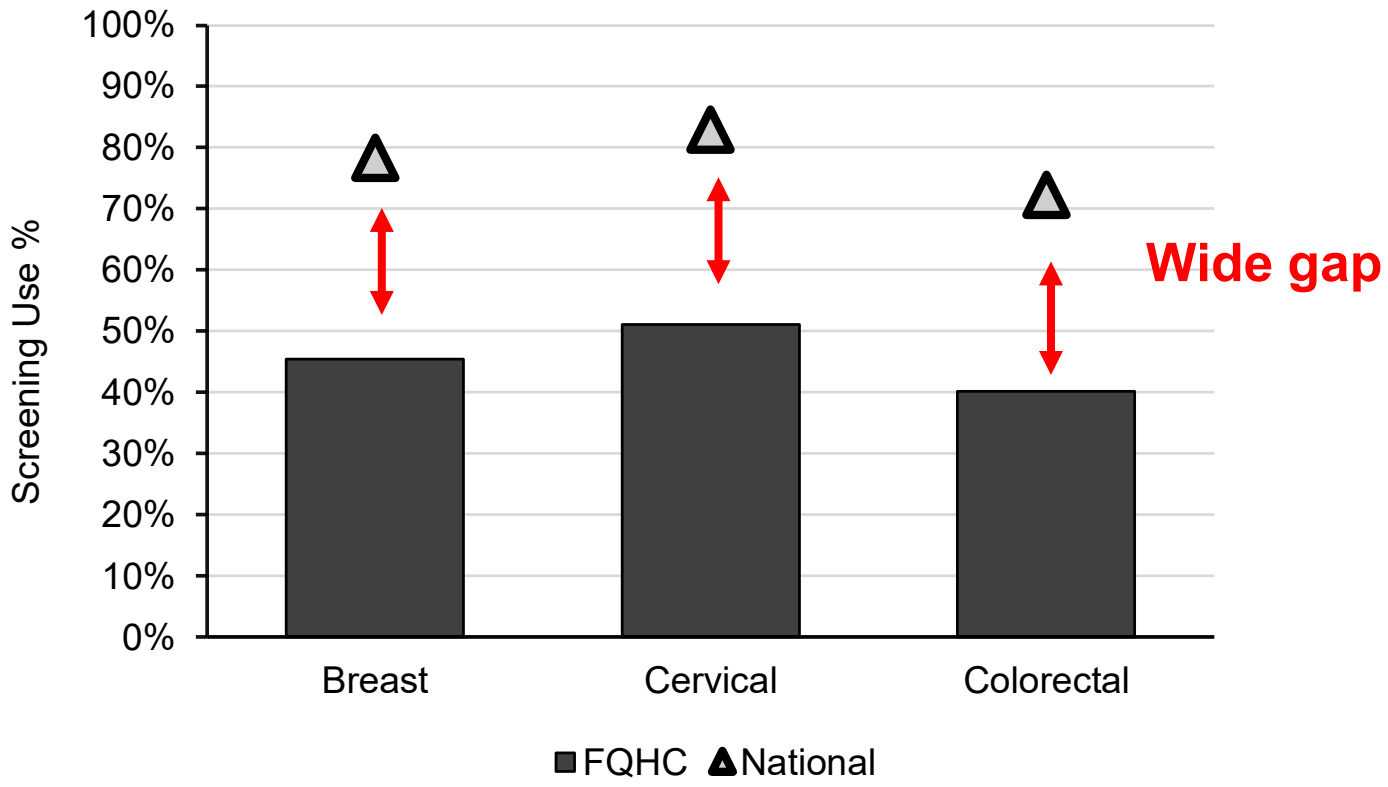

Amboree et al., *JAMA Int Med*, 2024 **[9]**

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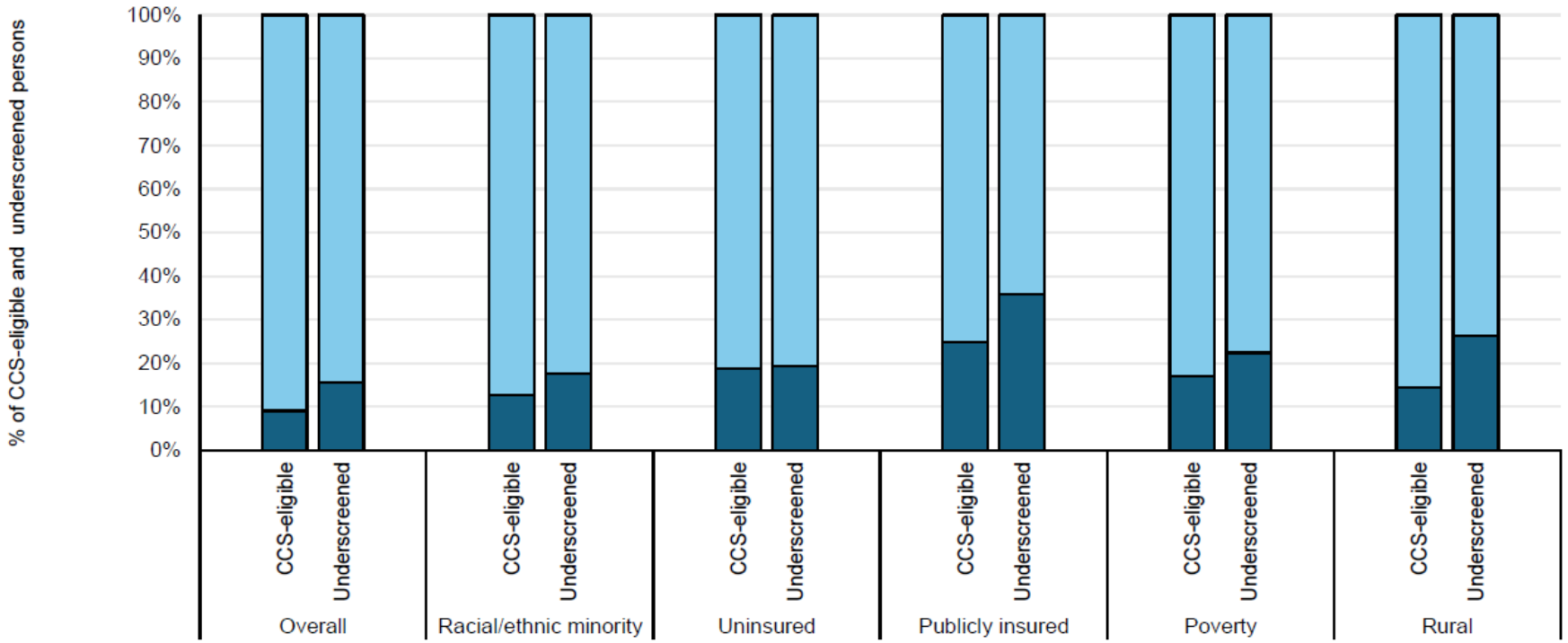
Original Investigation | Obstetrics and Gynecology

National Outcomes of Increasing Cervical Cancer Screening in Federally Qualified Health Centers

Trisha L. Amboree, PhD[1,2]; Prajakta Adsul, MBBS, PhD[3,4]; Haluk Damgacioglu, PhD[1,2]; Kathleen M. Schmeler, MD[5]; Elizabeth Y. Chiao, MD[6]; Roxana Cruz, MD[7]; Kalyani Sonawane, PhD[1,2]; Ashish A. Deshmukh, PhD[1,2]; Jane R. Montealegre, PhD[8]



Amboree et al., *JAMA Netw Open*, 2025 **[10]**

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Original Investigation | Obstetrics and Gynecology

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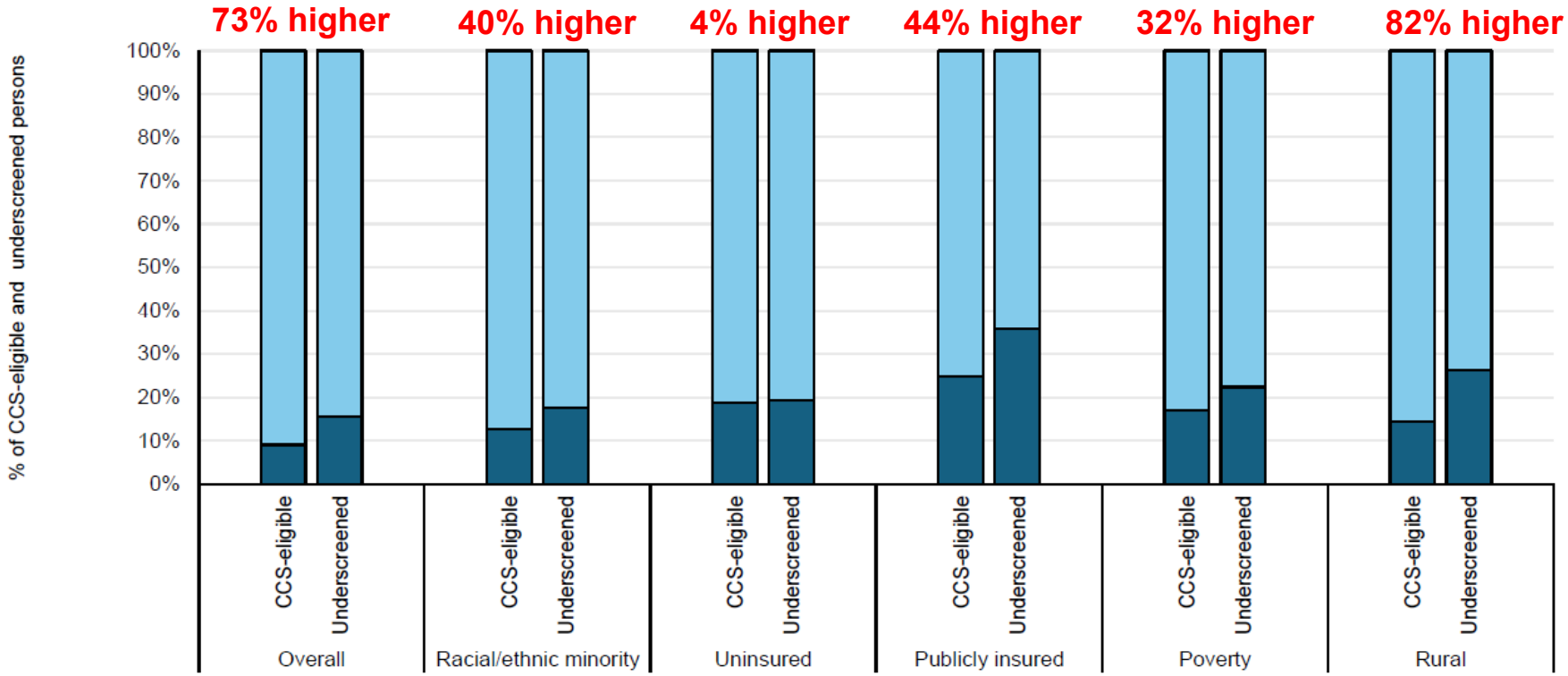

Amboree et al., *JAMA Netw Open*, 2025 **[10]**

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Current	HP2030
55.1%	79.2%

Table 2. Estimated Outcomes of Improving Screening in Federally Qualified Health Centers on National Cervical Cancer Screening

Subgroup[a]	Population, % (95% CI)			Percentage point increase in screened (95% UI)	Increase in screened, No. (95% UI)
	Screened (status quo)	Reference	Screened (after improvement)		
Overall	74.0 (72.7-75.3)	NA	76.2 (75.5-76.9)	2.2 (1.5-3.0)	1 872 367 (1 255 829-2 503 321)
Racial and/or ethnic minority group	67.8 (65.8-69.8)	78.7 (77.2-80.2)	70.9 (70.1-71.7)	3.1 (2.0-6.8)	1 186 202 (767 146-1 610 107)
Uninsured	56.6 (52.6-60.7)	76.2 (75.0-77.5)	61.2 (60.0-62.5)	4.5 (2.6-6.6)	386 231 (206 576-560 309)
Publicly insured	68.8 (65.9-71.7)	78.6 (77.2-79.9)	74.8 (73.5-76.3)	6.0 (4.4-7.6)	1 045 421 (766 597-1 327 638)
≤200% of Federal poverty level	65.9 (63.6-68.2)	77.5 (76.1-78.8)	70.0 (69.0-71.1)	4.1 (2.9-5.4)	1 682 596 (1 149 685-2 174 653)
Rural	71.9 (68.3-75.5)	74.3 (72.9-75.7)	76.3 (73.9-78.9)	4.4 (2.0-6.8)	656 158 (274 486-1 041 013)

Amboree et al., *JAMA Netw Open*, 2025 **[10]**

Targeted improvements in low-resourced settings

- FQHCs
- Safety net health settings
- Rural and low-income areas

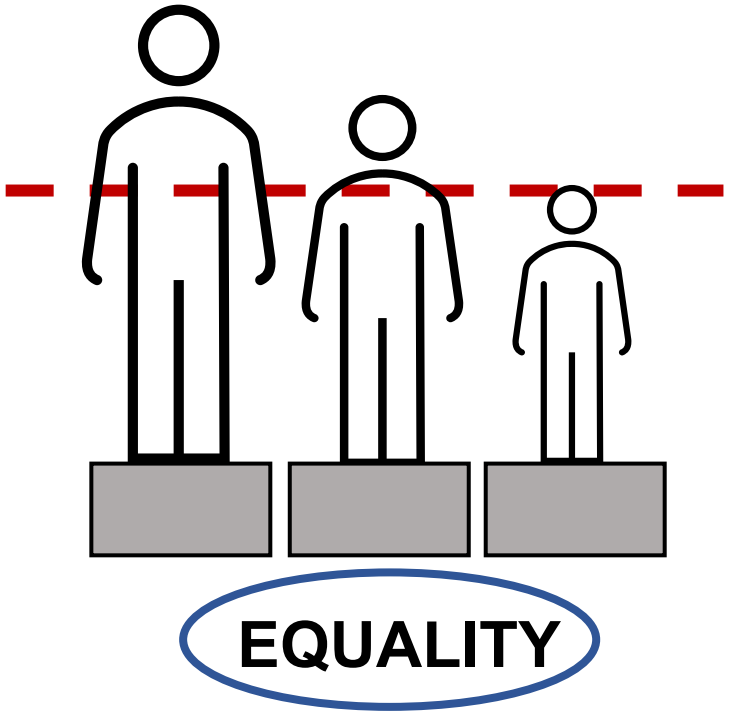
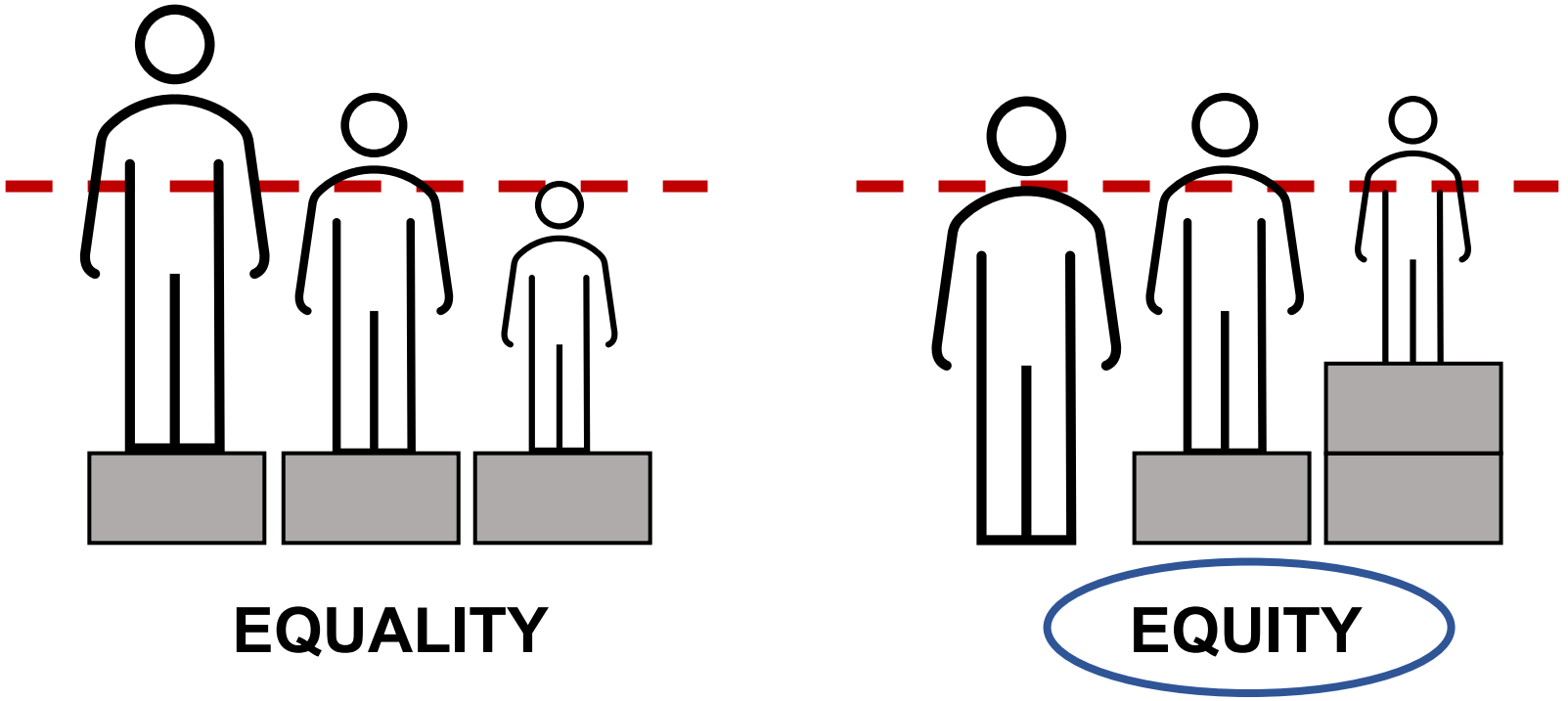


Image inspired from: *https://www.acpdecisions.org/health-equity-what-it-means-and-why-it-matters/*



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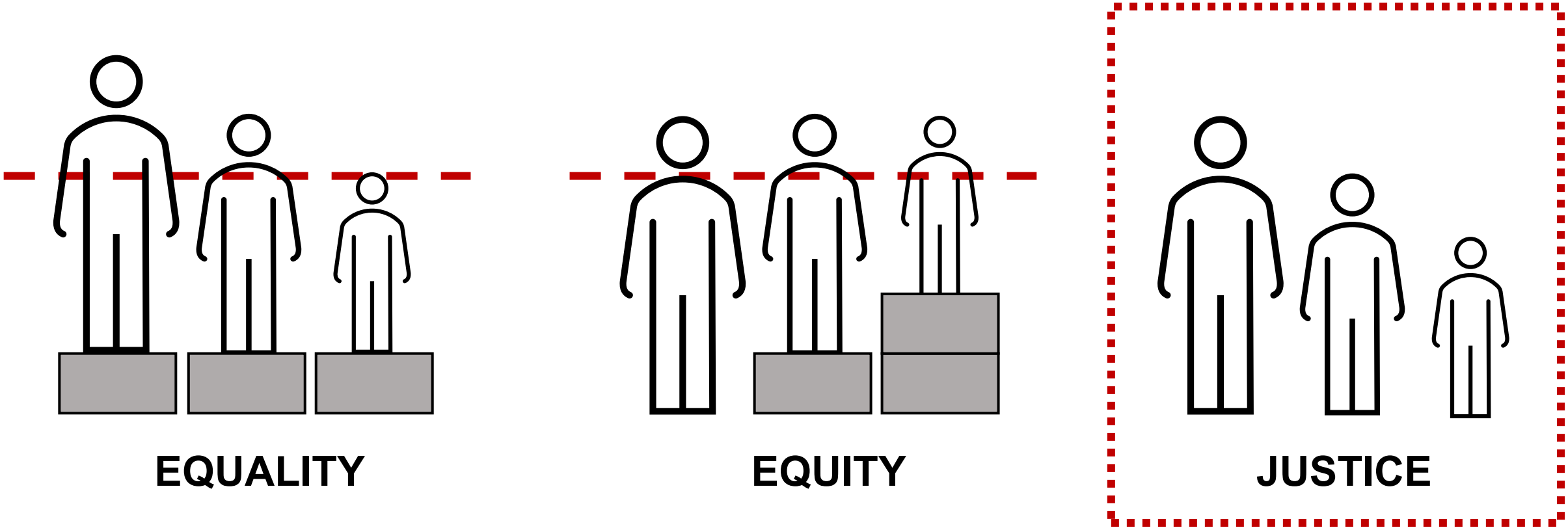

Image inspired from: *https://www.acpdecisions.org/health-equity-what-it-means-and-why-it-matters/*

Funding on the cited publications:

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HCC Scholars in Health Impact and Access Award

Collaborators on the cited publications:

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Kathleen Schmeler, MD

Ashvita Garg, PhD

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Prajakta Adsul, PhD, MBBS

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[10] Amboree TL, Adsul P, Damgacioglu H, Schmeler KM, Chiao EY, Cruz R, Sonawane K, Deshmukh AA, Montealegre JR. National Outcomes of Increasing Cervical Cancer Screening in Federally Qualified Health Centers. *JAMA Netw Open*. 2025 Oct 1;8(10):e2538593. doi: 10.1001/jamanetworkopen.2025.38593. PMID: 41123893; PMCID: PMC12547585.

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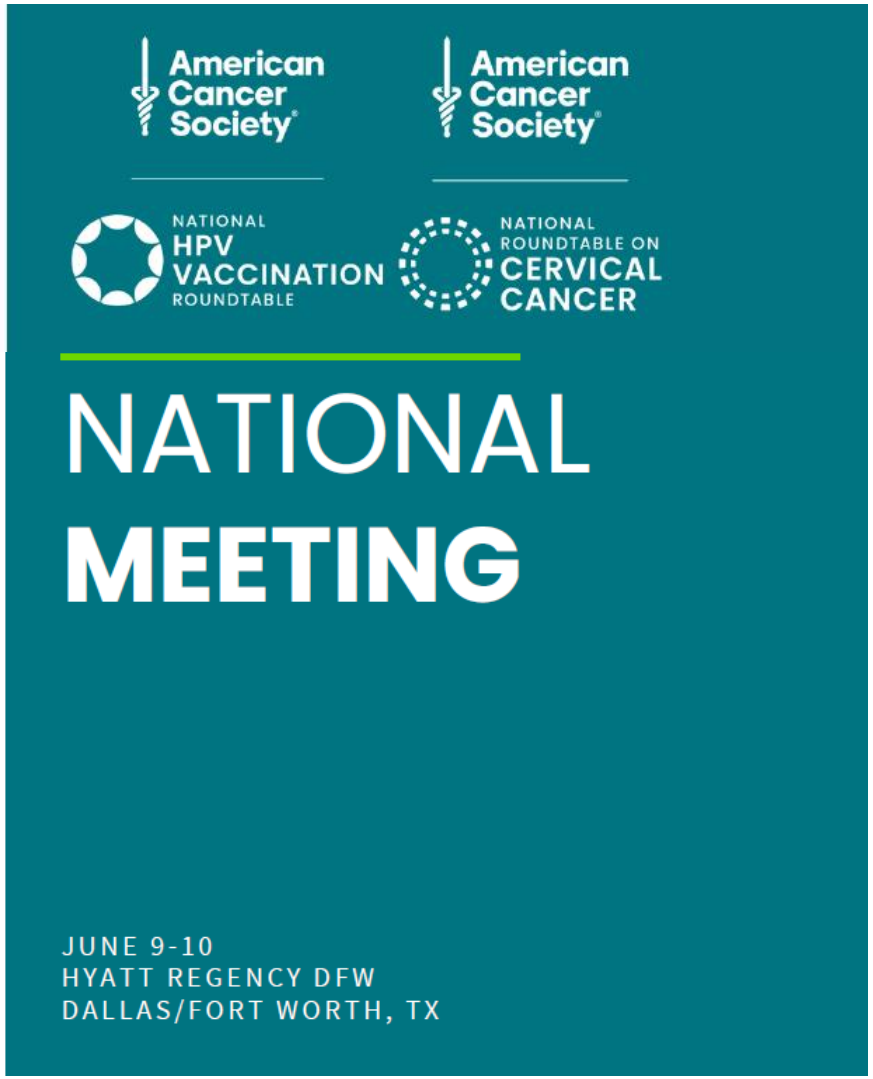
Thank You



From Potential to Priority: Scaling Up Screening in Safety Net Settings

Jane Montealegre, PhD

Associate Professor of Behavioral Science

MD Anderson Cancer Center

June 9, 2026

Cancer
UT MD Anderson

Disclosures

No financial conflicts of interest to disclose.

Grant funding:

National Institutes of Health

Cancer Prevention and Research Institute of Texas

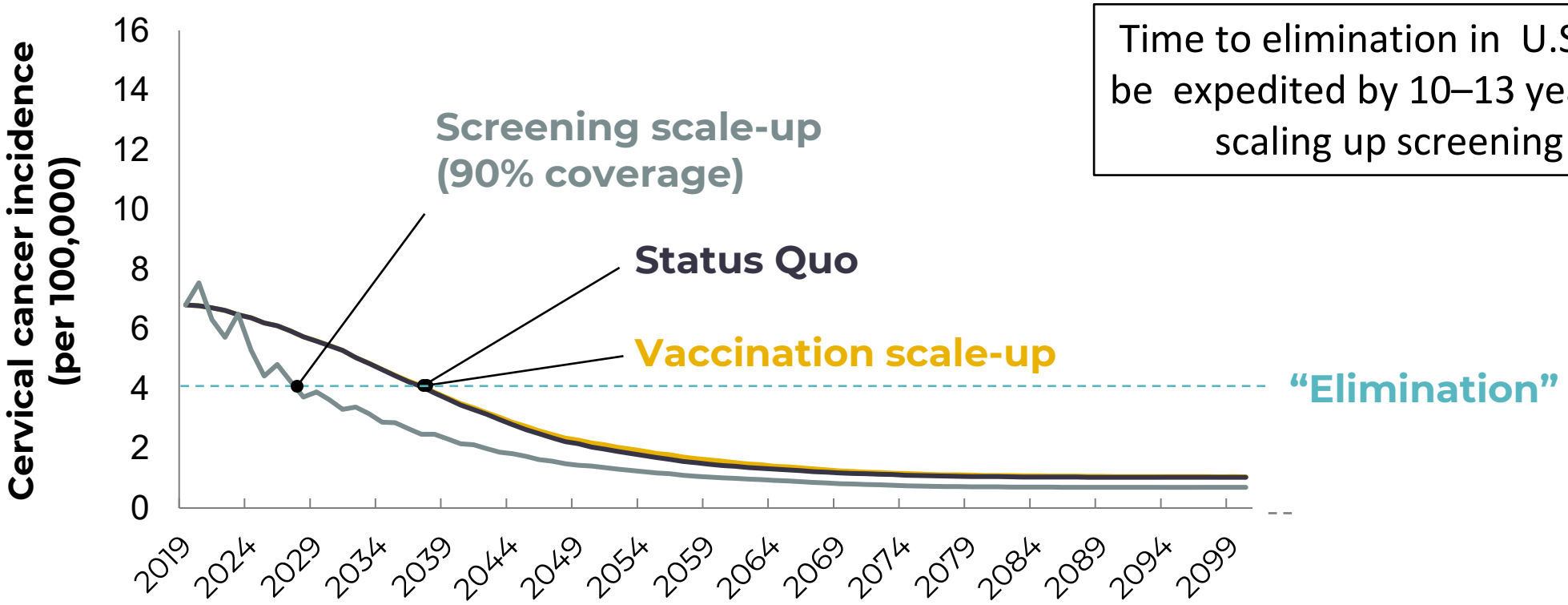
In kind donation from BD/Waters for HPV testing for uninsured patients in Project ACCESS partner clinics

Background

We have an unprecedented opportunity to eliminate a cancer.

90% **70%** **90%**

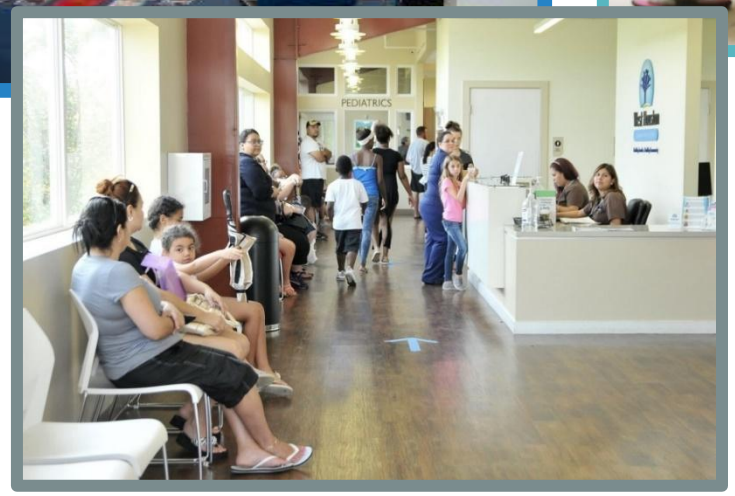
Background



Time to elimination in U.S. can be expedited by 10–13 years by scaling up screening

Burger et al, Lancet Public Health, 2020

How are we going to scale up?



Safety Nets

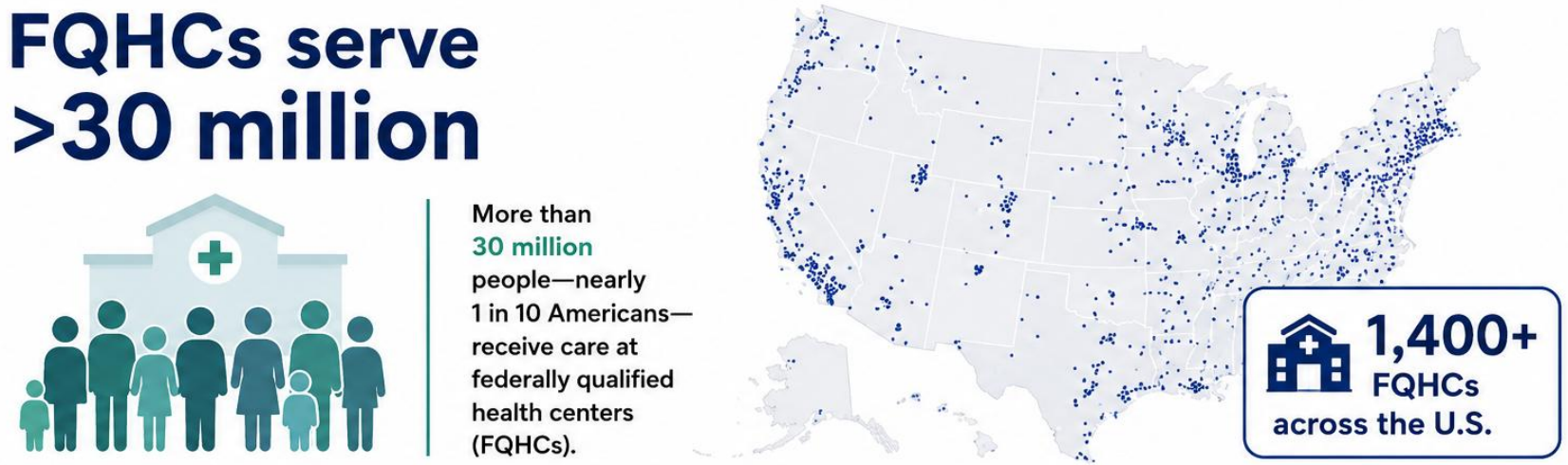
What are the safety nets

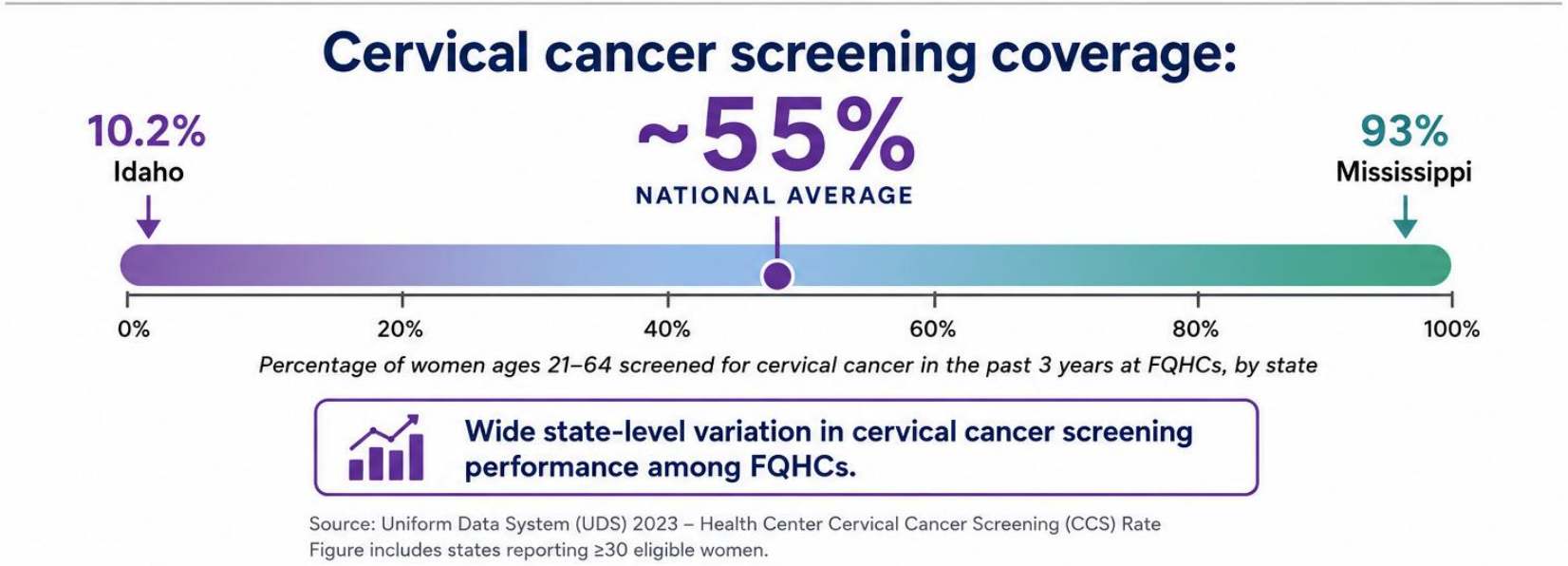
County safety net systems	Federally qualified health centers (FQHCs) and look-alikes	Rural Health Clinics	Charitable clinics	Health department clinics

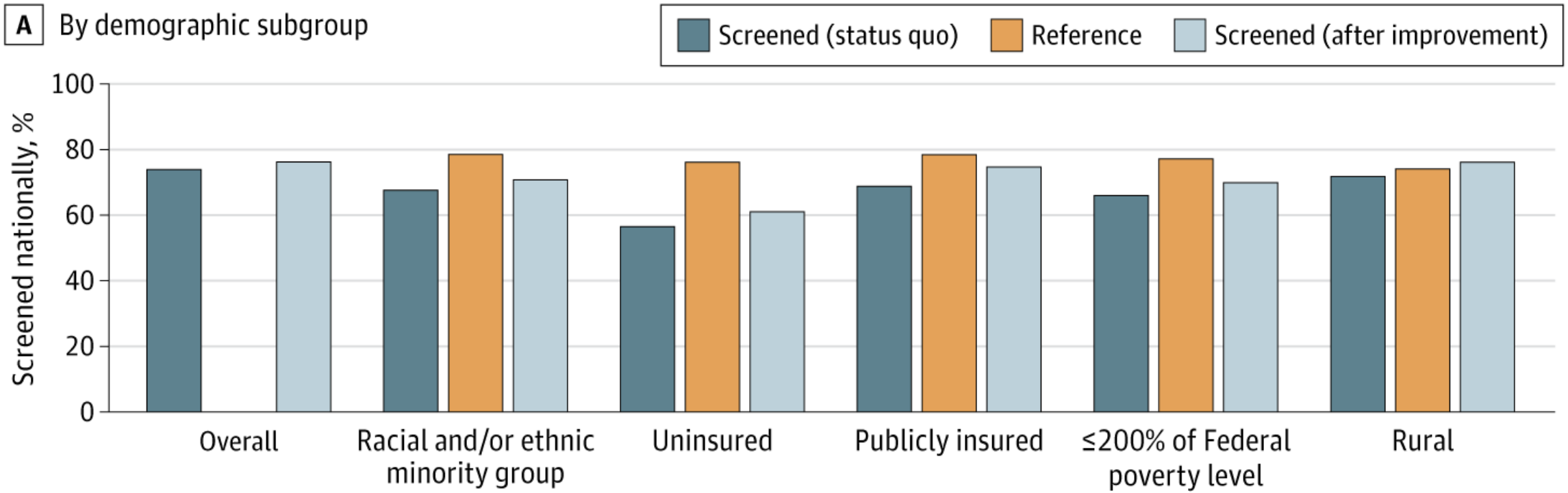
Safety net health settings provide services to populations disproportionately burdened by cervical cancer:

Rural	Racial/ethnic minorities	Low SES	Uninsured

The Opportunity of Safety Nets







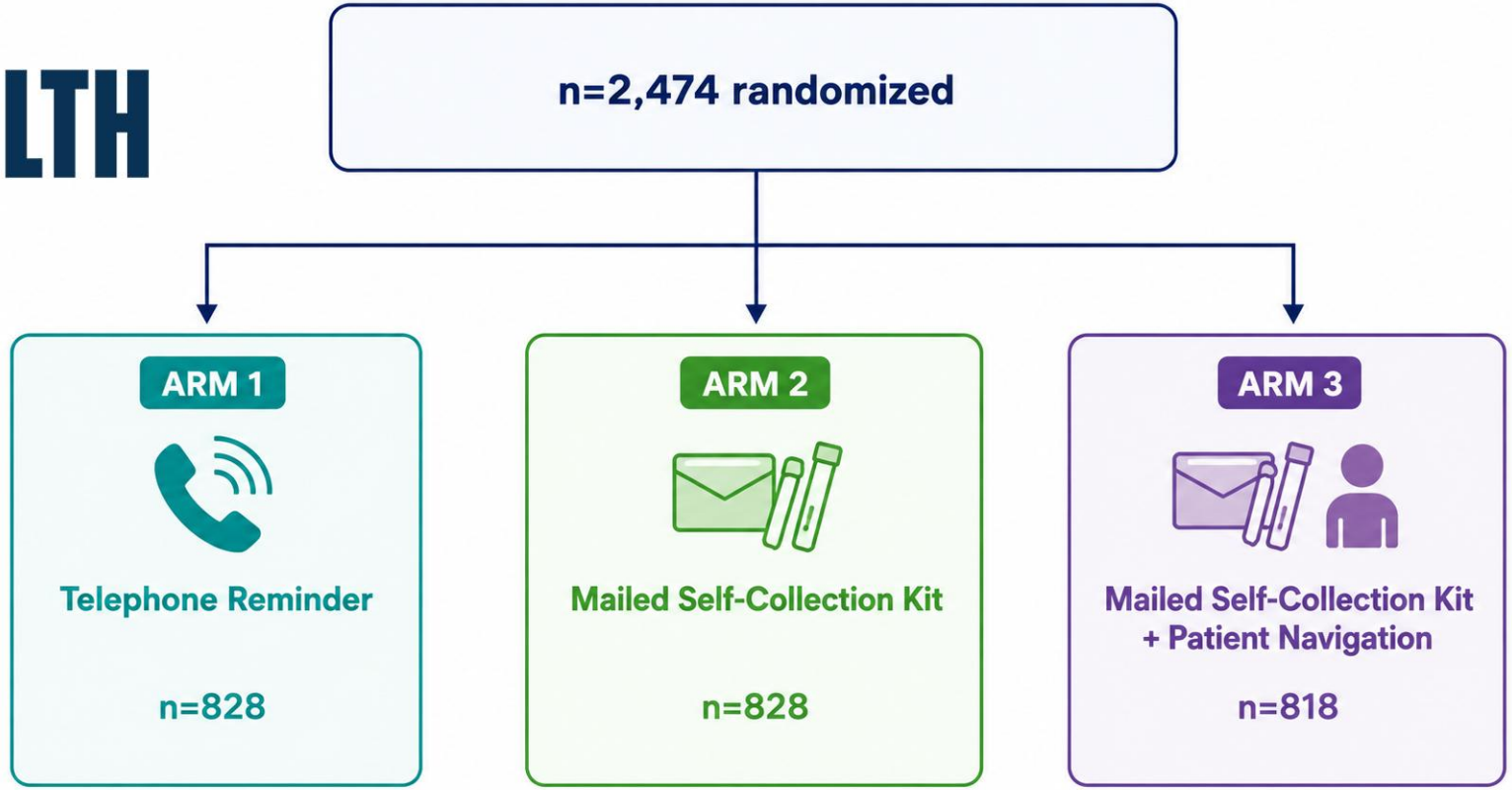
The Opportunity of Safety Nets

Amboree... Montealegre, JAMA Netw Open, 2025

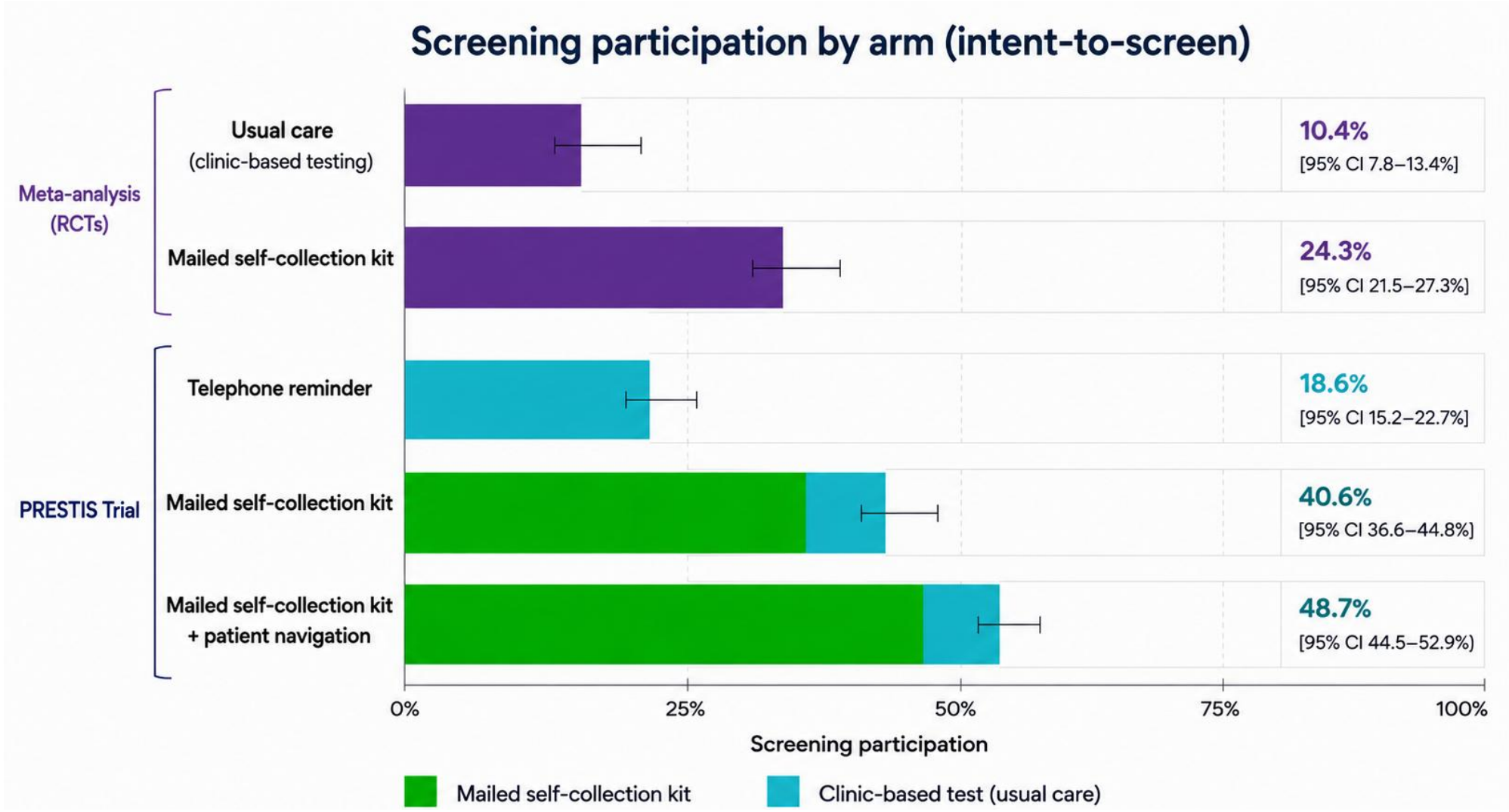
Self-collection is particularly effective in safety net health settings

PRESTIS Study

HARRISHEALTH



Montealegre et al, JAMA Int Med, 2025



PRESTIS Study

Montealegre et al, JAMA Int Med, 2025

From potential to priority:
Accelerating implementation of self-collection in safety net health systems

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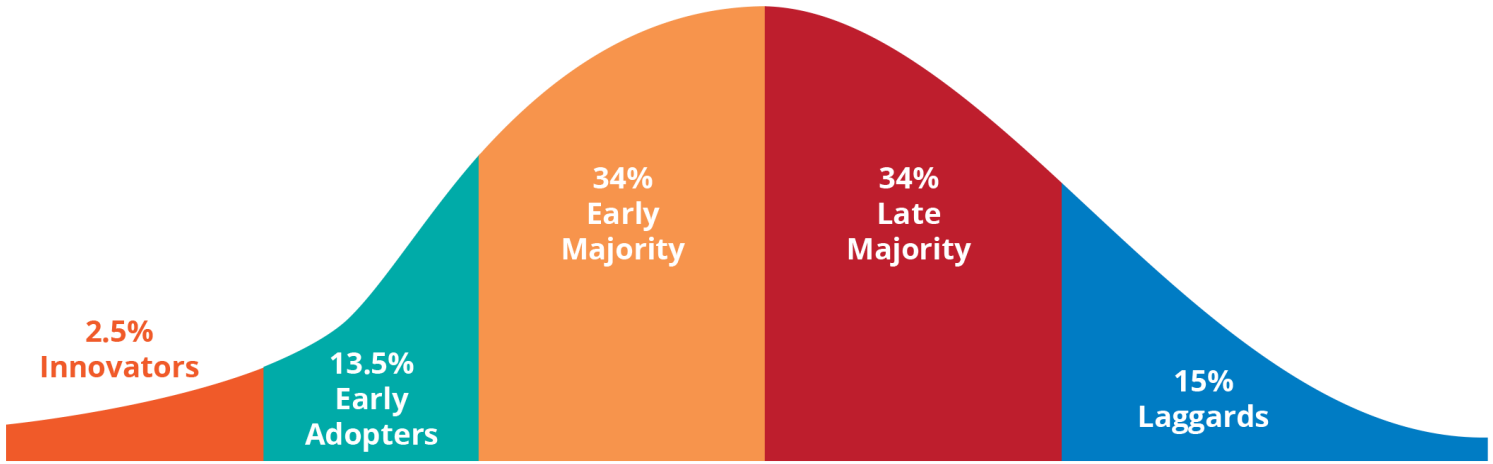

American Cancer Society | NATIONAL ROUNDTABLE ON CERVICAL CANCER

Self-Collection Workgroup

From potential to priority:
Accelerating implementation of self-collection in safety net health systems

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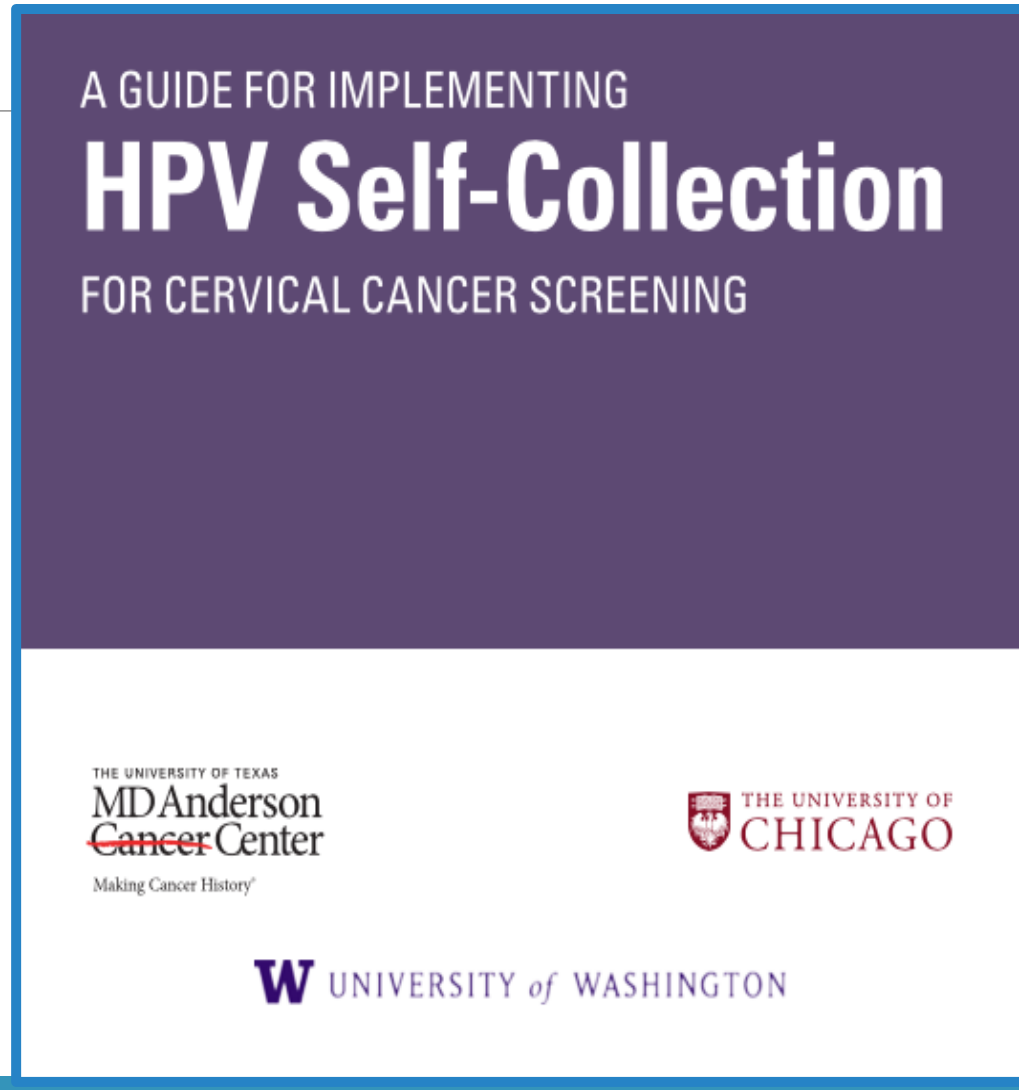
Scan me!



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From potential to priority:
Accelerating implementation of self-collection in safety net health systems

Cancer UT MD Anderson

Su Clínica

HARRISHEALTH

ACCESS

- Self-collection integrated into primary care workflow
- Self-collection offered as an option, particularly for under-screened patients
- Patients self-collect on site
- Referral to cytology/colposcopy within same system
- Bilingual, culturally-concordant patient navigation to follow-up

Cancer Prevention and Research Institute of Texas (CPRIT): PP240017 (mPIs: Montealegre, Schmeler)

From potential to priority:
Accelerating implementation of self-collection in safety net health systems

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SCREEN-UP
HOUSTON
CERVICAL CANCER SCREENING PROGRAM

Healthcare for the Homeless Houston

- Self-collection integrated into primary care and street medicine workflow
- Self-collection offered as an option
- Patients self-collect on site (in clinic) or private area (street medicine)
- Currently: referral for follow-up; Future: in-house colpo and LEEP
- Case managers provide navigation to follow-up

Mila Salcedo, MD PhD

SCREEN-UP: CPRIT PP260042 (mPIs: Salcedo, Montealegre)

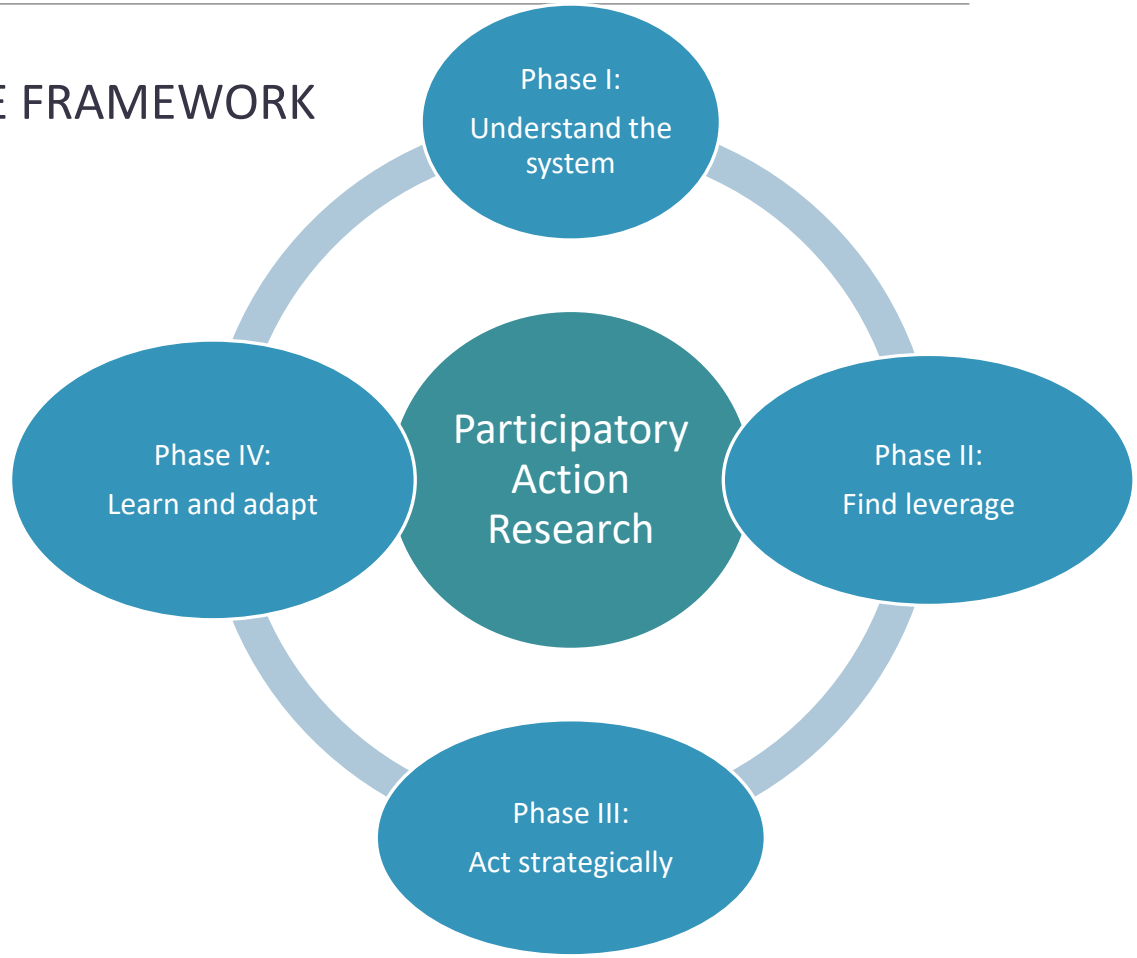
From potential to priority:
Accelerating implementation of self-collection outside the safety net

- Community Health Workers organize screening events
- CHWs provide education via flipchart and offer self-collection kit
- Patients self-collect in restroom on-site
- Referral to partner AHEC Clinic for follow-up
- CHWs provide navigation to follow-up

Integrating Self-Collection in Safety Net Primary Care Workflows

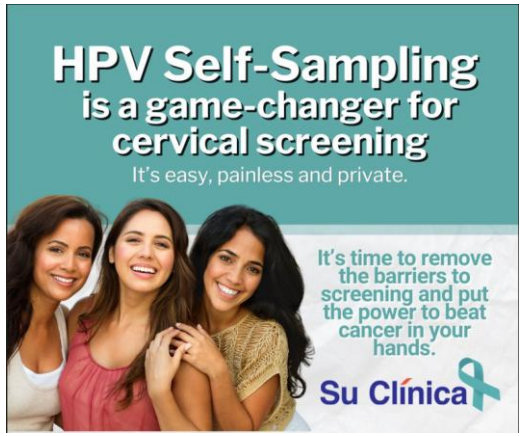
- Co-Create
- Implement
- Evaluate
- Disseminate

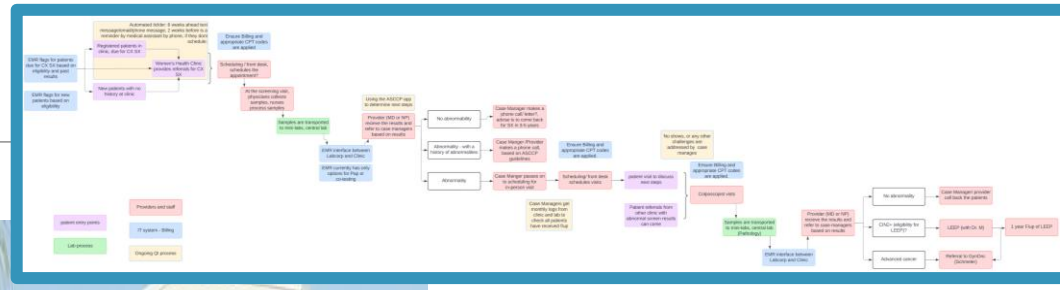
INSPIRE FRAMEWORK



Gravitt et al, Cancer Epi Biomarkers Prev, 2020

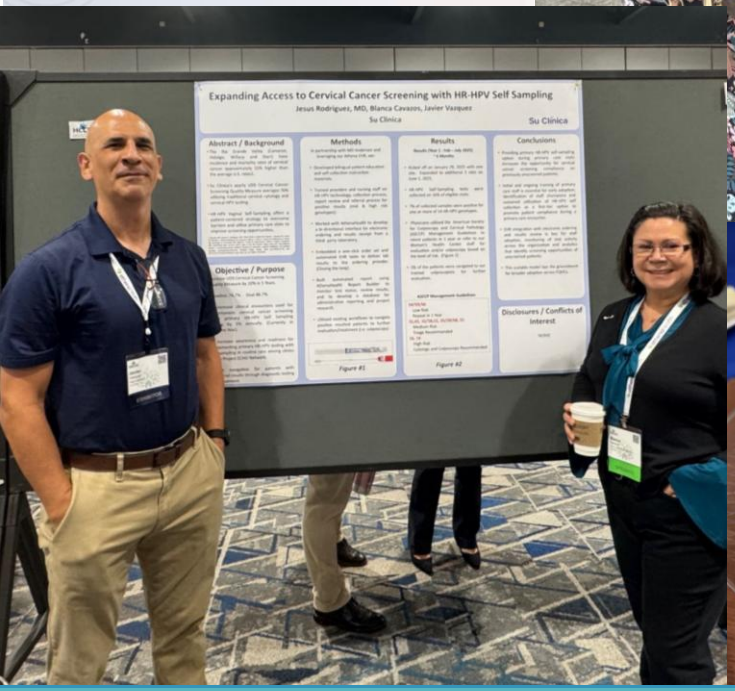
Integrating Self-Collection in Safety Net Primary Care Workflows





Gravitt et al, Cancer Epi Biomarkers Prev, 2020

The joy and pride of co-created programs



Thank you!

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Funding:

CPRIT PP24007, PP260074

NIMHD R01MD30175

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Thank You

Promoting Health Equity in Alaska Native Communities: Primary HPV Screening

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Disclosures

- None

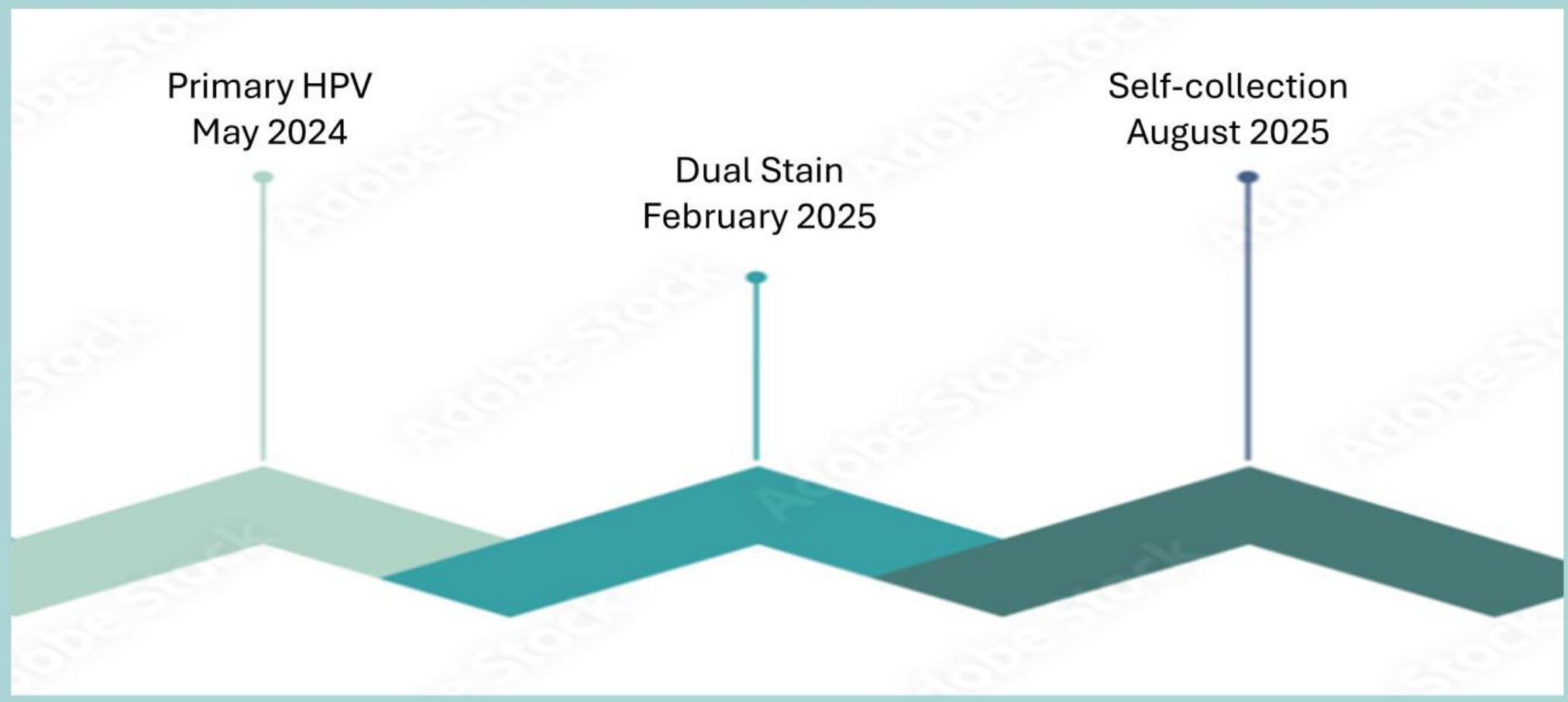
Objectives

To share the journey with the implementation of Primary HPV and Dual Stain at the Alaska Native Medical Center

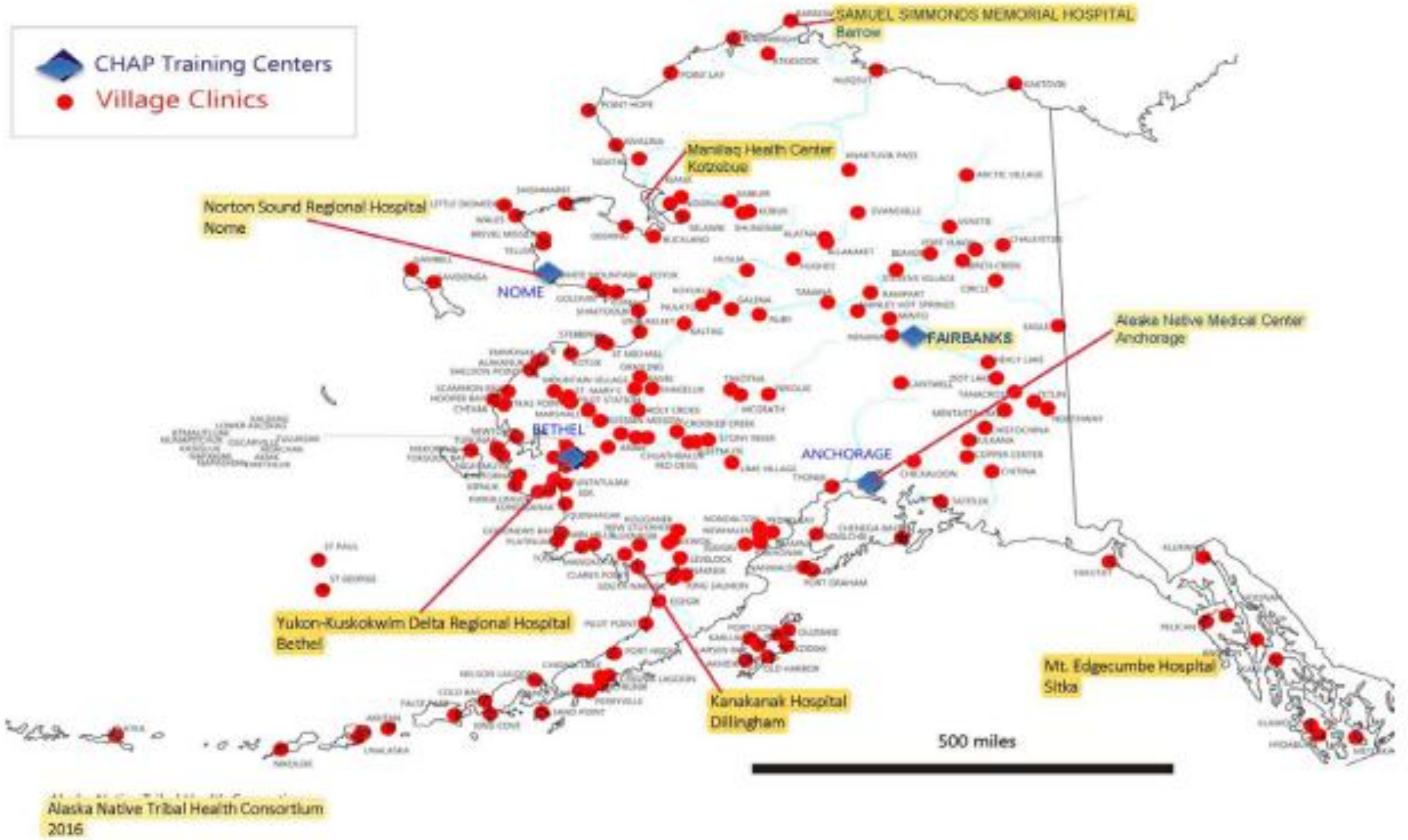
To share insight into the integral components necessary for system-wide screening change for cervical cancer.

To understand what the successes and the challenges have been.

Primary HPV Cervical Cancer Screening Implementation Timeline at ANMC



Community Health Aide/Practitioner Village Clinics



Health Equity Lens

Geography

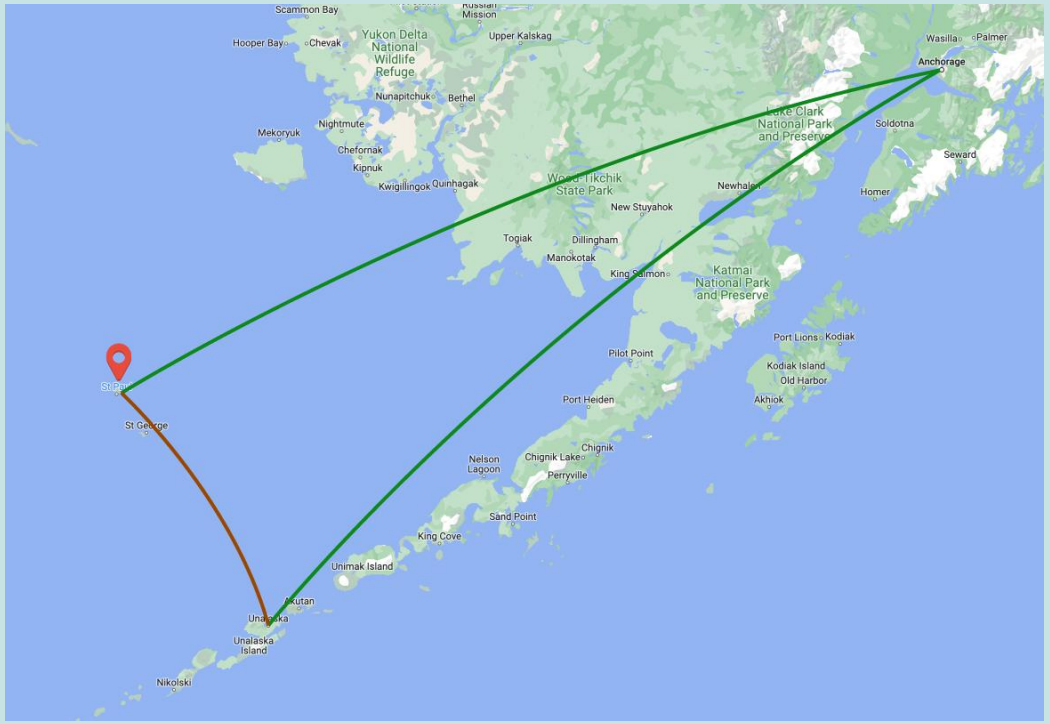
Transportation

Rural vs Urban

Language

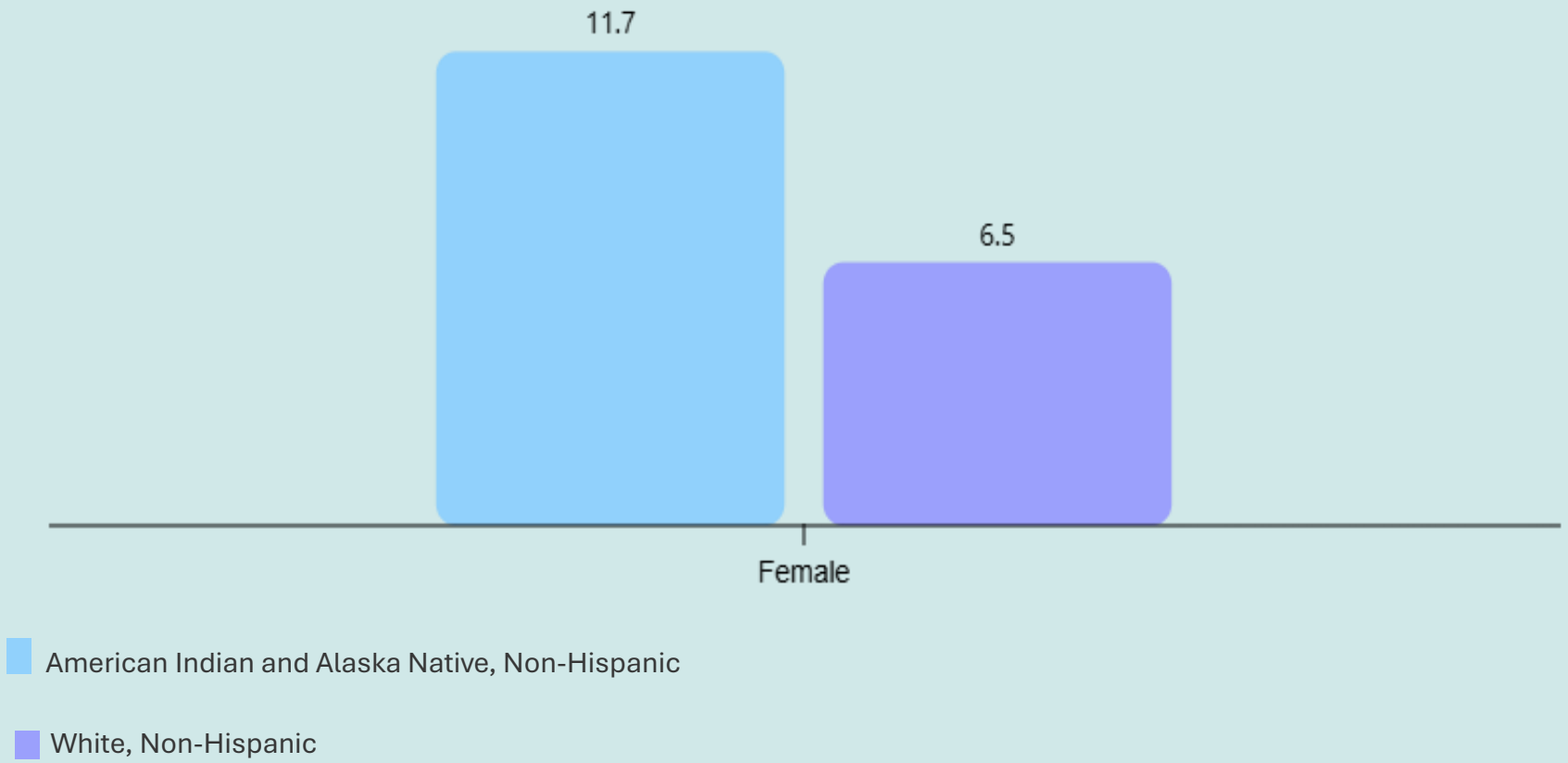
Weather

Poverty



Rate of New Cervical Cancers, United States, 2018-2022

Rate per 100,000 women

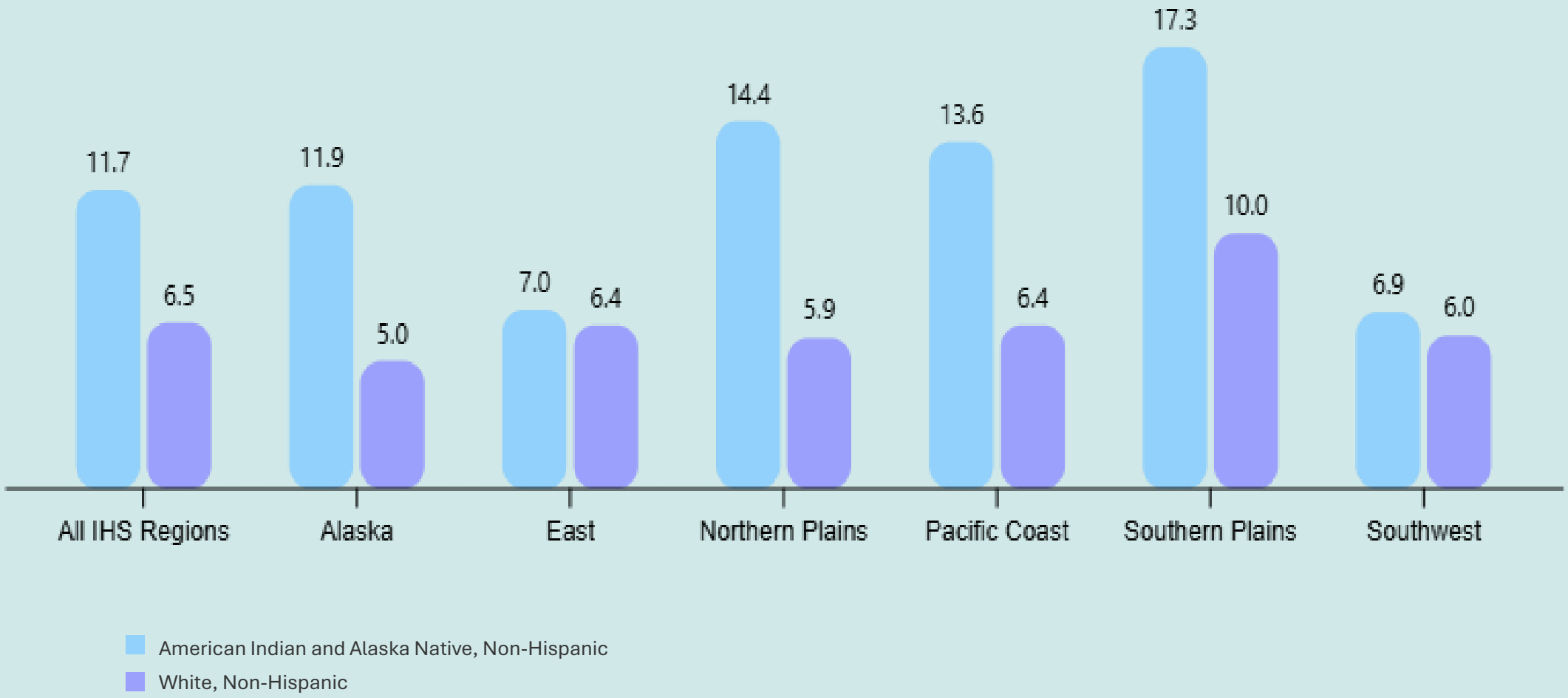


Source - U.S. Cancer Statistics Working Group. U.S. Cancer Statistics Data Visualizations Tool. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention and National Cancer Institute;https://www.cdc.gov/cancer/dataviz, released in June 2025.

Rate of New Cervical Cancers, United States, 2018-2022

American Indian and Alaska Native, Non-Hispanic* and White, Non-Hispanic

Rate per 100,000 women



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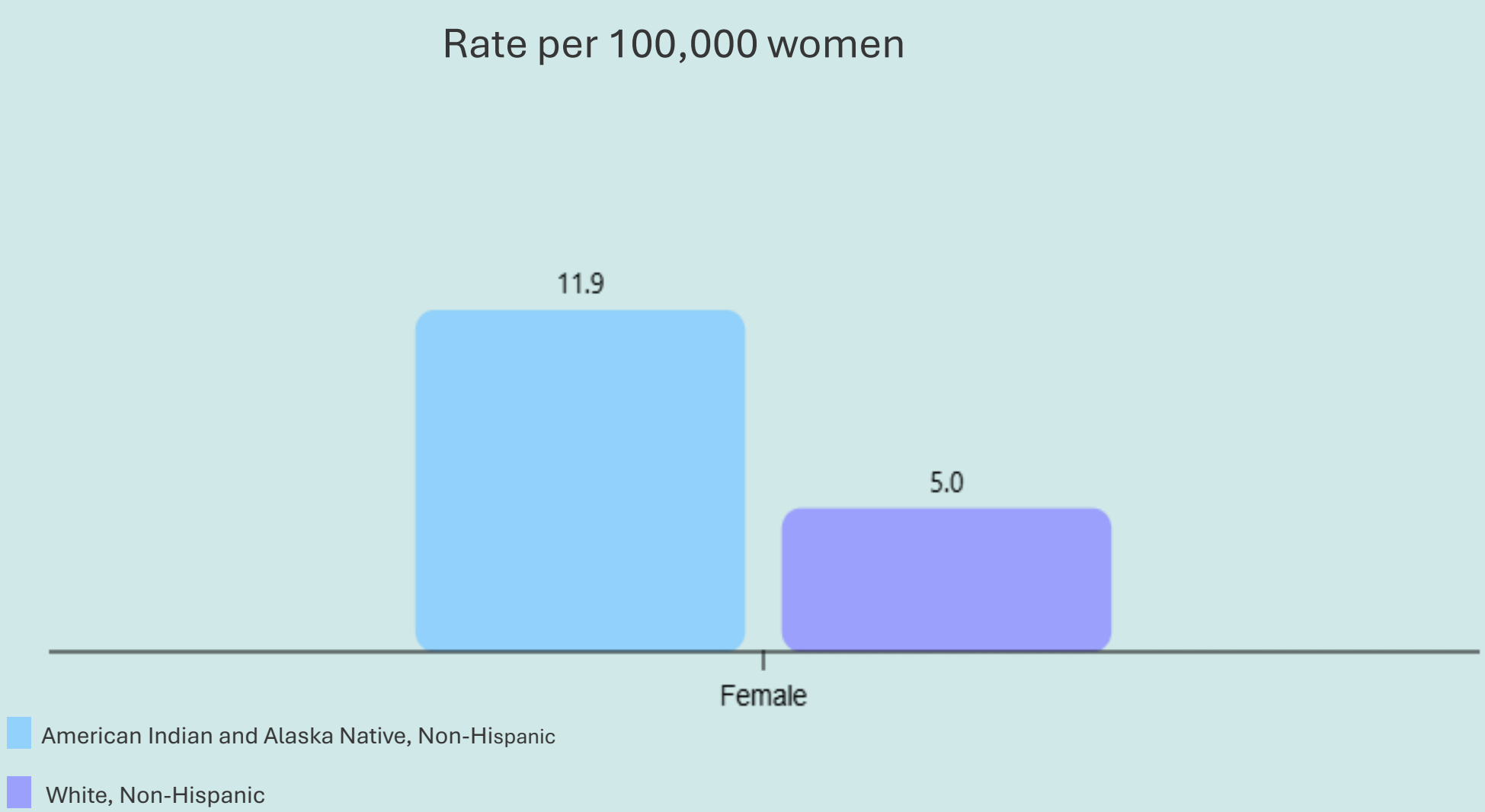
Rate of New Cervical Cancers, Alaska, 2018-2022



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Cervical Cancer Demographics, Alaskan Residents

Incidence by Region, 2015 - 2019

Behavioral Health Region	Age-Adj Rate
Anchorage	8.2
Fairbanks	4.0*
Interior^	
Juneau	10.0*
Kenai Peninsula	9.4*
Mat-Su	5.6*
Northwest	18.7*
Southeast	7.7*
Southwest	11.3*
Y-K-Delta^	

Incidence by Race/Ethnicity, 2015 - 2019

Race / Ethnicity	Age-Adj Rate
White	6.8
Alaska Native	12.5
Black^	
Asian/Pacific Islander	10.0*
Hispanic^	

Rates are per 100,000 and age-adjusted to the 2000 US Std Population
Hispanic persons can be of any race.
^ Indicates statistic not displayed due to fewer than 6 cases.
* Rates based on <20 events are statistically unreliable and should be used with caution.

Data Source: Alaska Division of Public Health, Alaska Cancer Registry

Cervical Cancer Demographics, Alaskan Residents

Mortality Rates by Region, 1996 - 2020

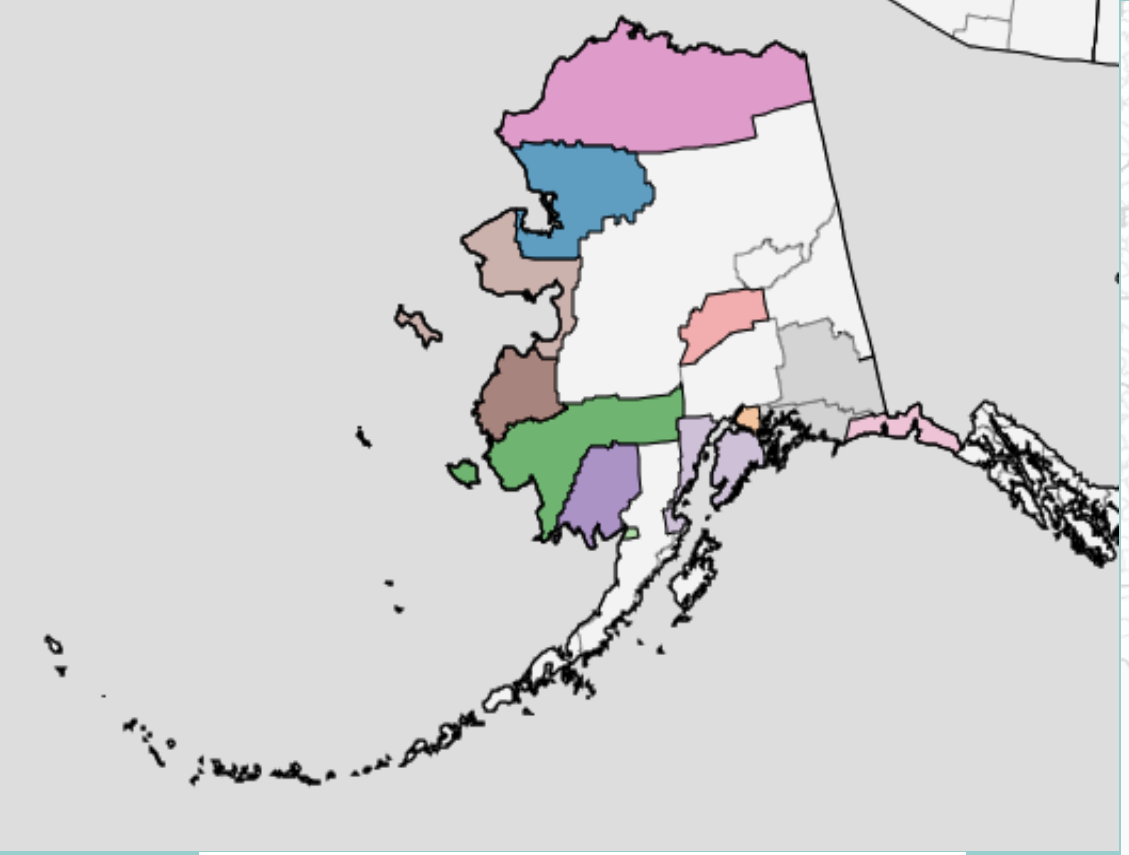
Behavioral Health Region	Age-Adj Rate
Anchorage	1.7
Fairbanks	1.6*
Interior^	
Juneau	2.0*
Kenai Peninsula	1.8*
Mat-Su	2.1
Northwest	2.6*
Southeast	1.3*
Southwest^	
Y-K-Delta	6.6*

Mortality by Race/ Ethnicity, 1996 - 2020

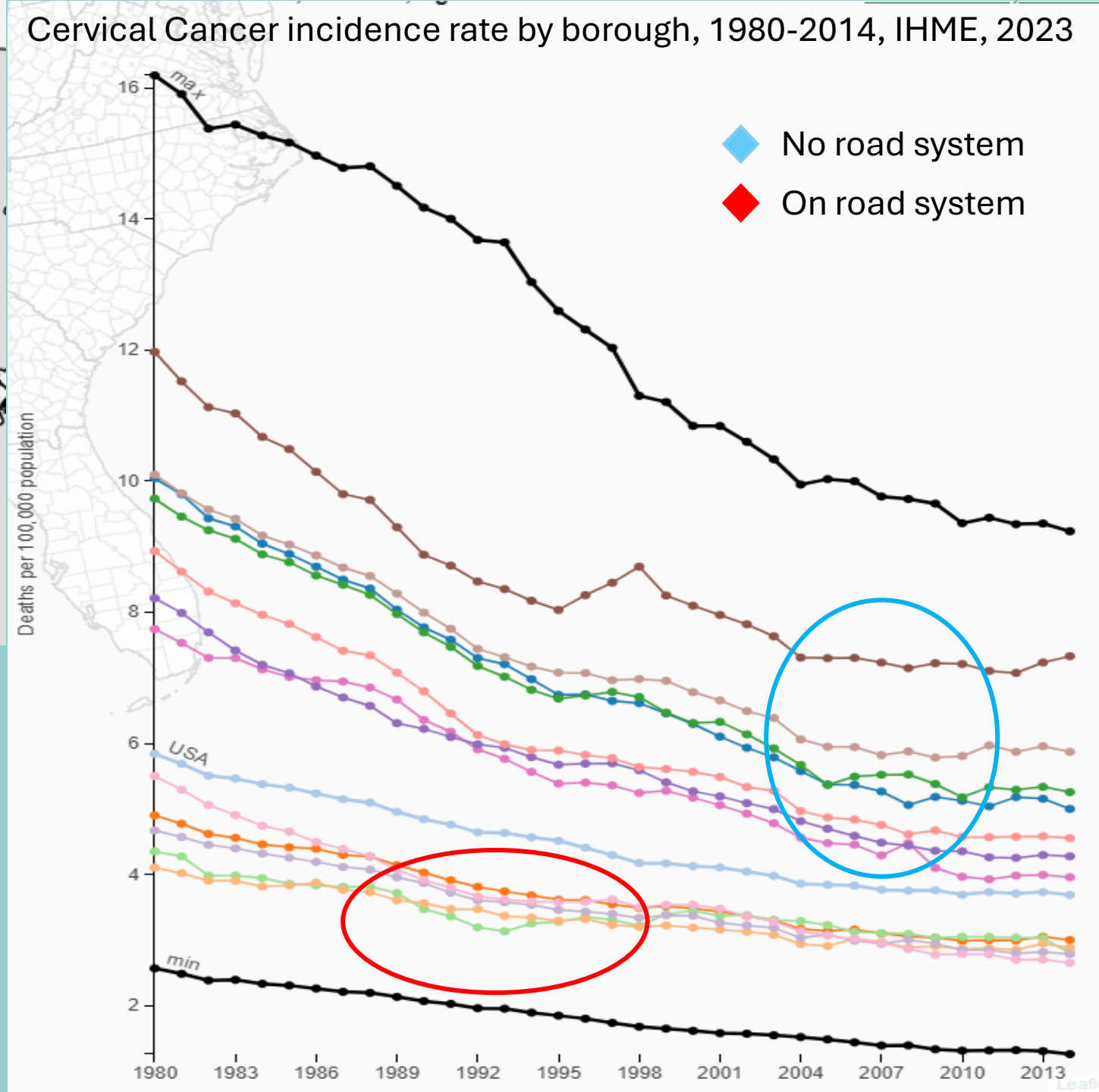
Race / Ethnicity	Age-Adj Rate
White	1.7
Alaska Native	3.3
Black^	
Asian/Pacific Islander	1.3*
Hispanic/Latino^	

Rates are per 100,000 and age-adjusted to the 2000 US Std Population
Hispanic/Latino persons can be of any race.
^ Indicates statistic not displayed due to fewer than 6 cases.
* Rates based on <20 events are statistically unreliable and should be used with caution.

Data Source: Alaska Division of Public Health, Alaska Cancer Registry



- Max
- Min
- United States of America
- United States of America - Alaska
- United States of America - Alaska - Northwest Arctic Borough
- United States of America - Alaska - Anchorage Municipality
- United States of America - Alaska - Kenai Peninsula Borough
- United States of America - Alaska - Bethel Census Area
- United States of America - Alaska - Bristol Bay Borough
- United States of America - Alaska - Denali Borough
- United States of America - Alaska - Dillingham Census Area
- United States of America - Alaska - Kusilvak Census Area
- United States of America - Alaska - Nome Census Area
- United States of America - Alaska - North Slope Borough
- United States of America - Alaska - Yakutat City and Borough



Alaska ranks 49th out of 50 states for cervical cancer screening with rates remaining stable ~60%

Who's not getting screened?

- Rural, geographic barriers
- Transportation, childcare, work challenges
- History of sexual trauma
- People struggling with addiction
- People who don't think they are at risk
- Non-binary individuals
- Unhoused
- Un- and Underinsured

What is Primary HPV Screening

- ✓ Primary HPV screening is testing for high-risk HPV first, followed by a triage test such as cytology and/or HPV genotyping if the initial test is positive.

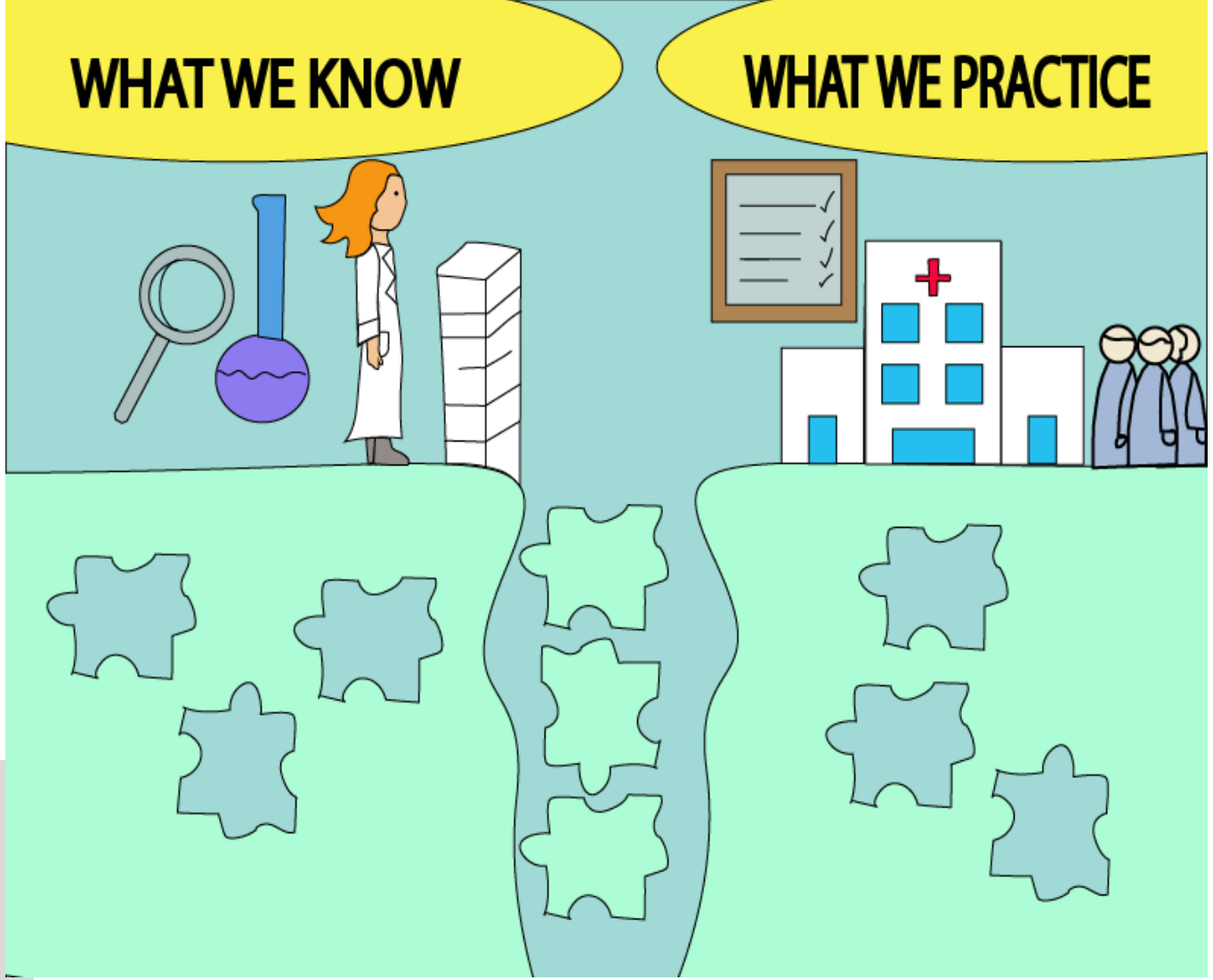
- ✓ The presence of a high-risk HPV type indicates a risk for developing a cervical pre-cancer or cancer**-especially if the HPV test remains positive over time (years).**

- ✓ Biggest advantage is ability for self-collection

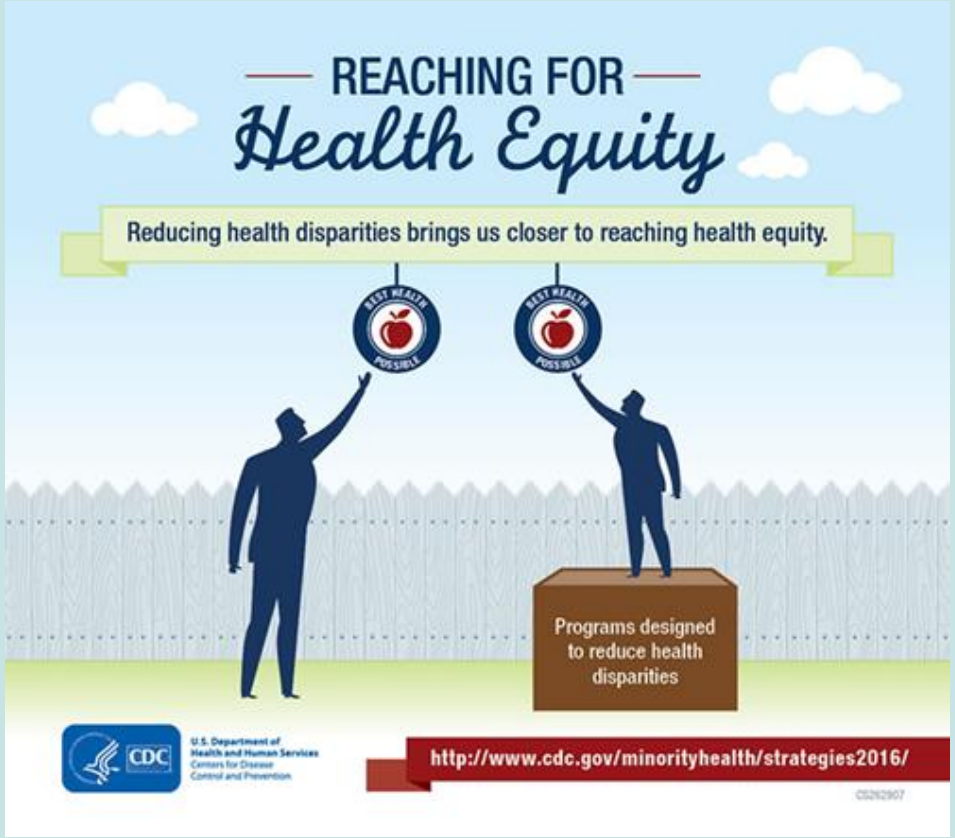
Self-collection HPV tests

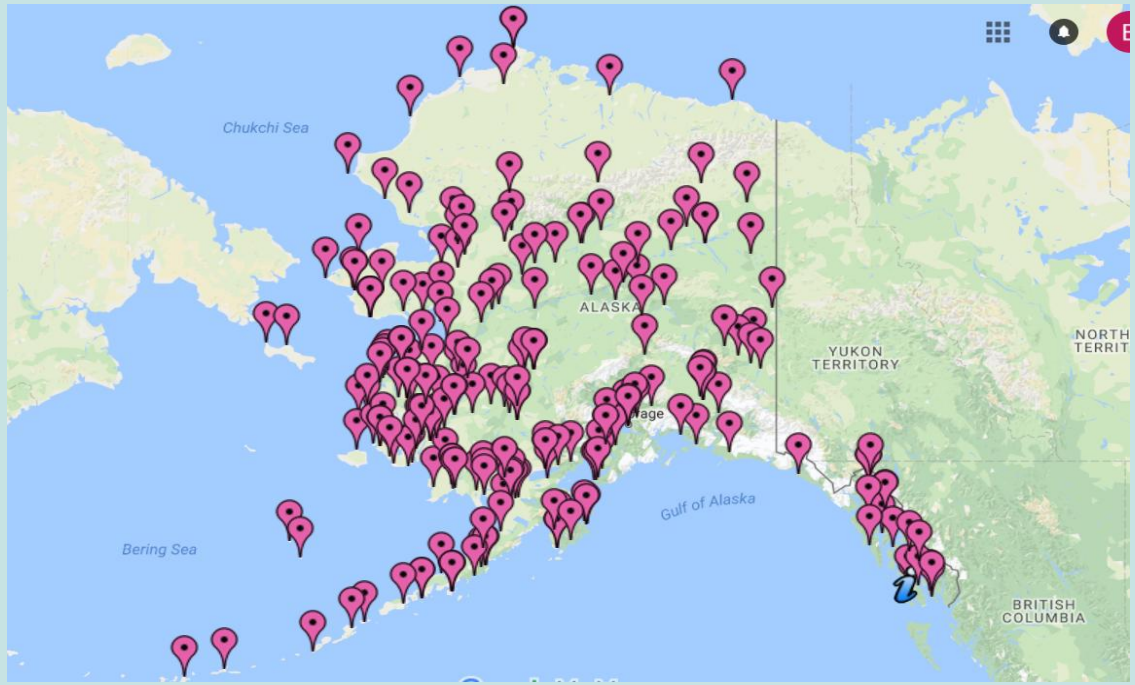
- Multiple studies have shown that self-collection is effective, is cost-effective, and is acceptable to people, especially among under-screened populations.
- High agreement with clinician- collected samples

Here we go…



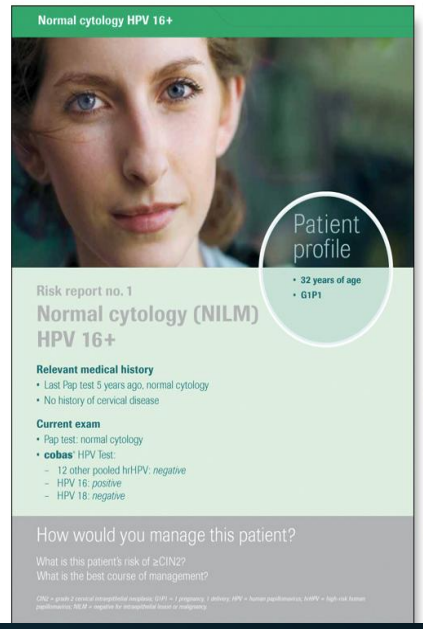
Using a Health Equity Lens

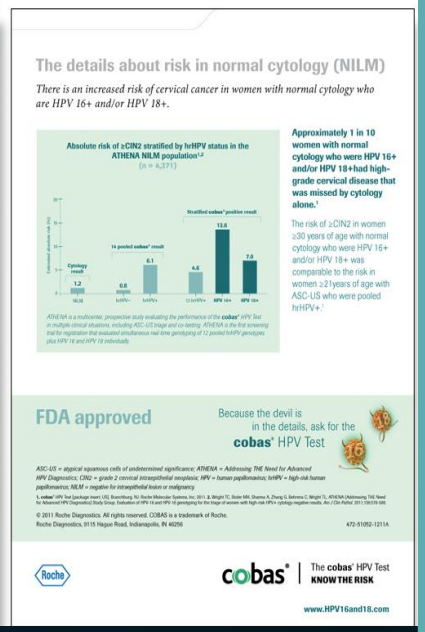




Goal: Bring Primary HPV screening to Alaska Native people to address health disparities that exist.

Road to Primary HPV





2022-2023 Historical Context for Cervical Cancer Screening in AK

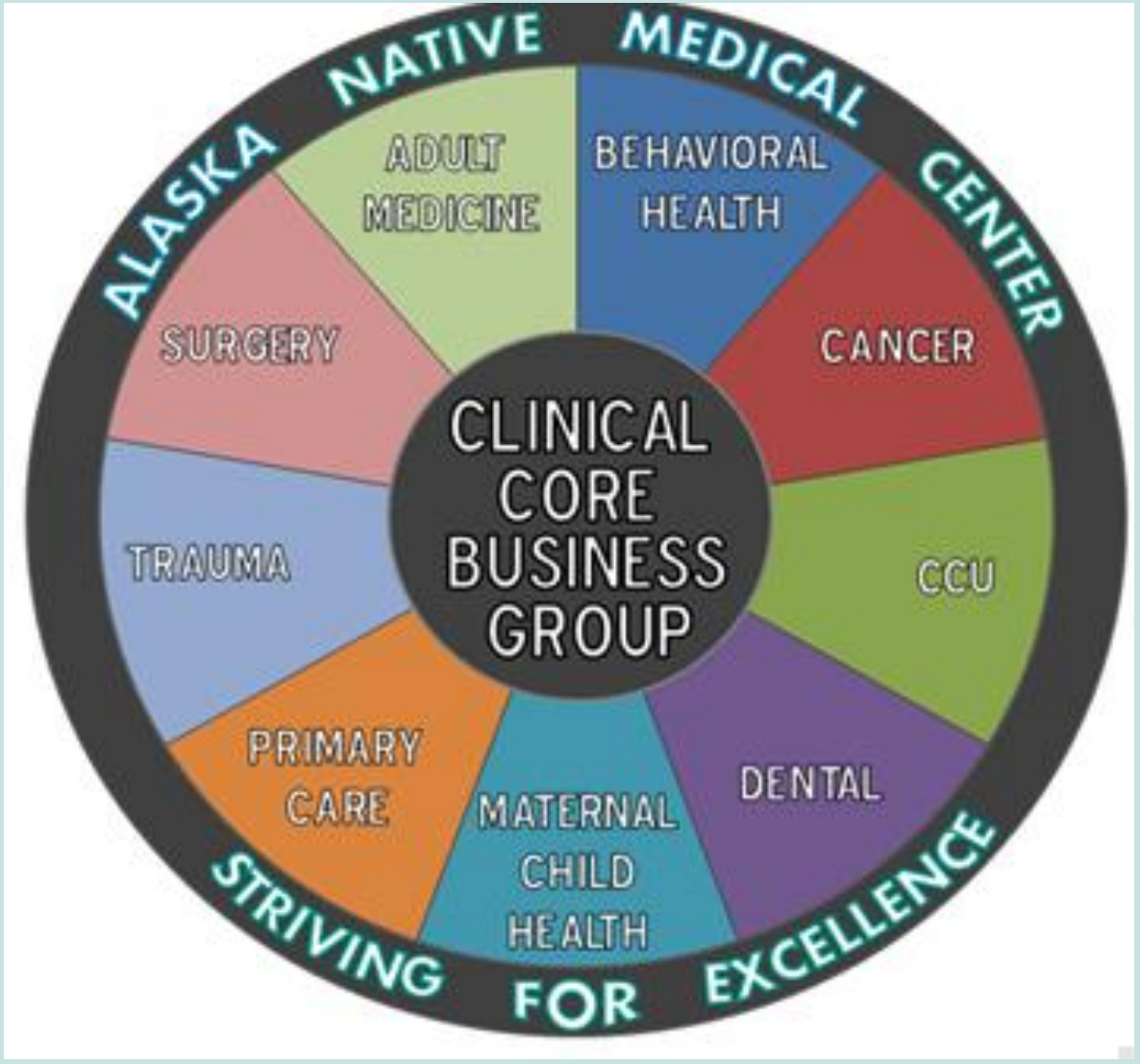
- Barriers to in-state testing, with *all* PAP / HPV testing referred outside
- American Cancer Society's endorsement of primary HPV testing in 2020: opportunity for ANMC Laboratory's expansion of in-house molecular testing during the COVID-19 pandemic.

This led to…

- 2023 Statewide contract for referred PAP/HPV testing was up for renegotiation, able to change to Primary HPV testing
- Cervical cancer became the top priority for ANMC's Cancer Committee 2023-24 Agenda
- Secured the **cobas®** HPV test system for in-house testing

#1 Identify Stakeholders

- **Administrators**
- **Clinicians**
  - Medical Directors of OBGYN
  - GYN ONC providers
  - WH/Primary Care Providers
  - Health Aides
  - Early Detection Program
- **Clinical Core Business Groups**
  - Cancer
  - Maternal Child Health
  - Primary Care
- **Medical Executive Committee**
- **Clinical Quality Council**
- **Customer Owners**



Implementation in action: Collaborating on the transition to primary HPV screening for cervical cancer in the United States

Levi S. Downs Jr MD[1] | Ritu Nayar MD[2] | Jane Gerndt MPH[3] | Debbie Saslow PhD[3] | for the American Cancer Society Primary HPV Screening Initiative Steering Committee

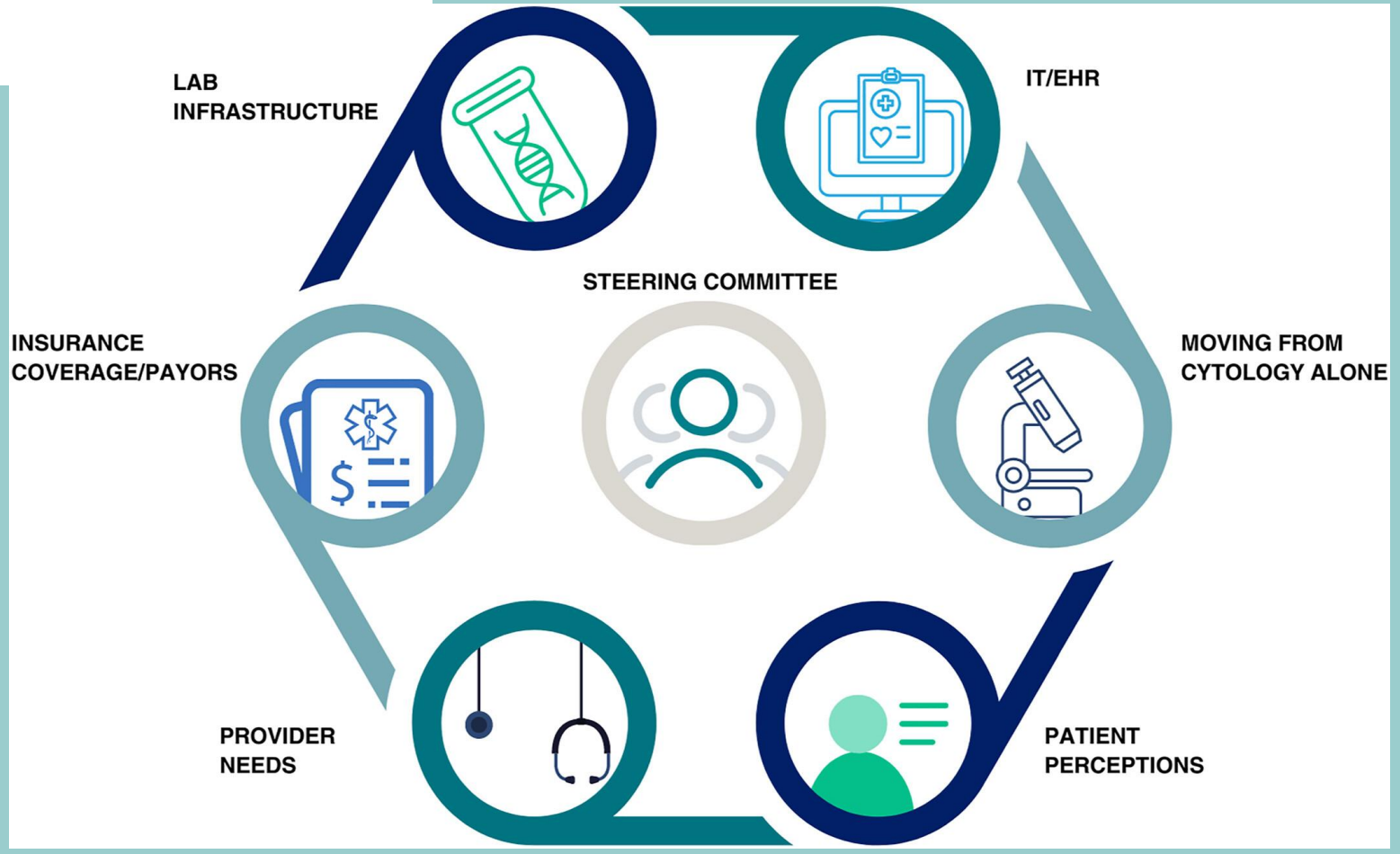
[1]Park Nicollet Health Services, Minneapolis, Minnesota, USA

[2]Northwestern University, Feinberg School of Medicine, Chicago, Illinois, USA

[3]American Cancer Society, Atlanta, Georgia, USA

American Cancer Society's resources for transition to Primary HPV

https://cervicalroundtable.org/



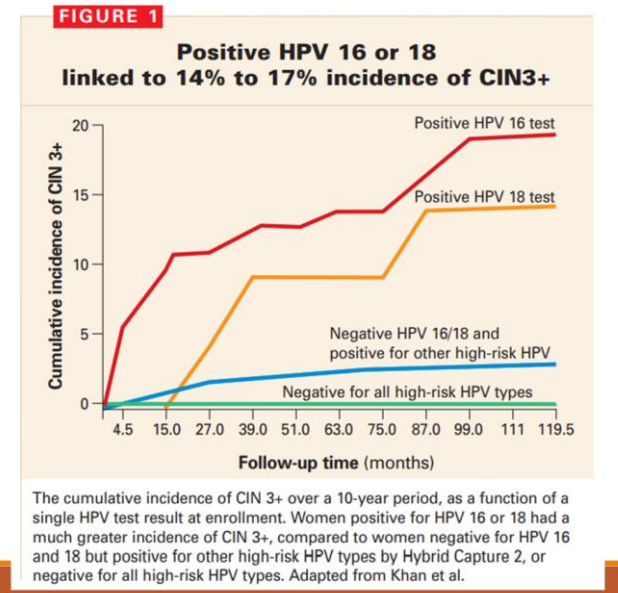
American Cancer Society | NATIONAL ROUNDTABLE ON CERVICAL CANCER

#2 Provider Needs

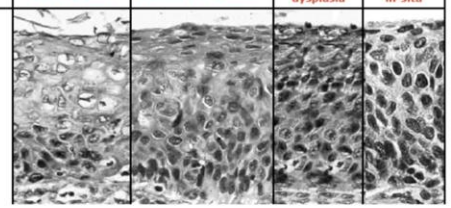
What is HPV?

- The human papillomavirus is a small dsDNA virus, specific to humans, which infects epithelial cells.
- Once incorporated into cells, the viral proteins decrease apoptosis, leading to unregulated cell growth.
  - This can cause either benign or malignant tumors, depending on the infected location and the strain of virus.
- More than 100 types of HPV have been identified.
  - Over 40 types affect the anogenital area.

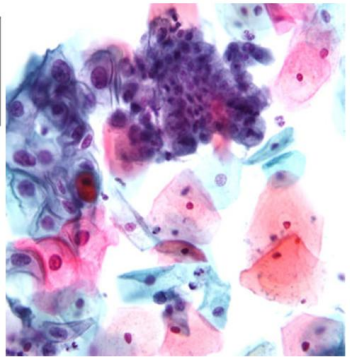
Not all HPV genotypes are the same



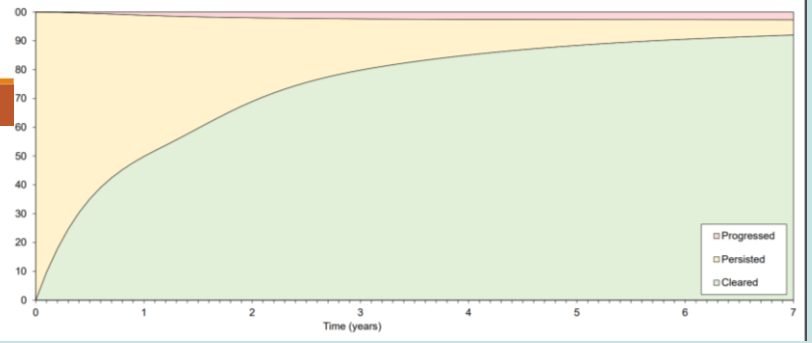
HPV Infection- What does it do?

LAST System[1]	Cytology	LSIL	HSIL		
	Histology	LSIL	p16 staining should be performed*	HSIL	
Bethesda Classification System[2]	Cytology	LSIL	HSIL		
	Histology	CIN 1	CIN 2	CIN 3	
Previous terminology		Mild dysplasia	Moderate dysplasia	Severe dysplasia	Carcinoma in-situ
Histologic images					

Detection of HPV Cervical Changes

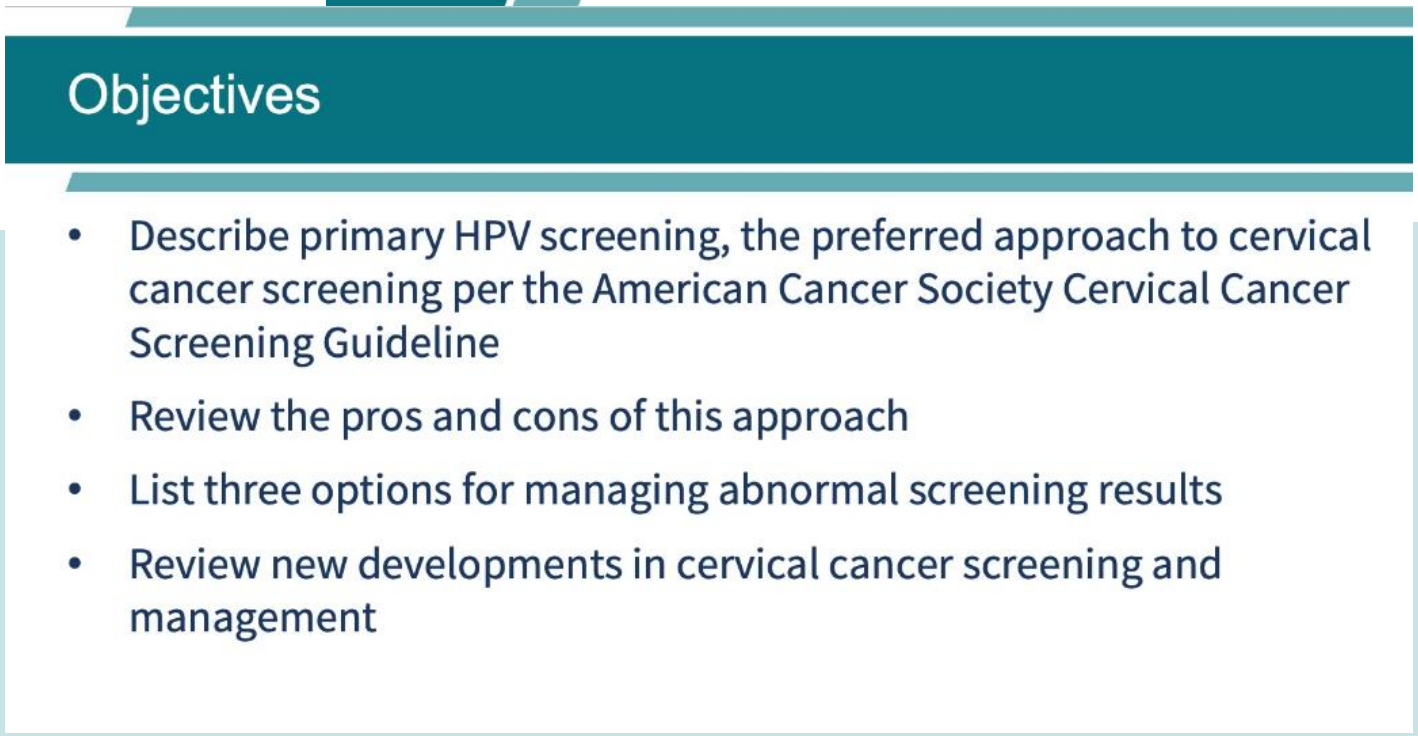


Most HPV infections become undetectable in 1-3 years
those that persist cause CIN3+ over time



First, the basics...

Then, the nuts and bolts…



Cervical Cancer Screening Trends Slide Deck (2024) This presentation was presented to provider groups and facilitated good discussions

Scripting
Guidelines
EHR order sets
Results

American Cancer Society | National Roundtable on Cervical Cancer

Talking to your Patients about Primary HPV Screening: A Script for Providers

For some patients, cervical cancer screening is stressful and confusing. For providers, talking about it can be complicated and time consuming, particularly given the stigma surrounding HPV infection and the different screening options.

This script provides a clear and accurate approach to explaining the advantages of primary HPV screening for cervical cancer screening. We hope it will save you time and reduce anxiety for provider and patient alike. Modification may be needed for your individual patients and patient population. [Alternative wording suggestions are in brackets.]

ANMC Cervical Cancer Prevention Guideline

Do's and Don'ts: Explaining Primary HPV Screening to Patients

American Cancer Society | National Roundtable on Cervical Cancer

DO'S

- DO highlight technology and research advancements to support moving towards primary HPV screening.
- DO explain that this is a test that detects the presence of a virus that can cause cancer.
- DO be sensitive to the stigma around HPV and use language that is not stigmatizing. One way to do this is to emphasize to patients that HPV is very common.
- DO be inclusive of LGTBQ+ persons with a cervix who still qualify for routine cervical cancer screening.

DON'TS

- DON'T stress that there is a test being taken away from the traditional screening paradigm (the Pap test).
- DON'T call attention to cost-saving as it is not a driver for the transition to primary HPV screening.
- DON'T couple HPV and sexually transmitted infections.
- DON'T forget to emphasize the importance of following up after a positive HPV test result.

This resource was developed by the Patient Perceptions Workgroup as a part of the American Cancer Society National Roundtable on Cervical Cancer's Primary HPV Screening Initiative which aims to support the transition and implementation of primary HPV screening across the United States.

#3 Consumer Needs – Education/Information

Preventing Cancer with HPV Screening

American Cancer Society | National Roundtable on Cervical Cancer

HPV stands for **human papillomavirus**. There are many types of HPV and some of these types cause cancer. Screening for HPV is an important way to help prevent cancer.

Most people will have an HPV infection at some point in their lives.

HPV and My Health

HPV is a very common virus—just like the common cold virus. Often, the infection clears up on its own and doesn't cause any health problems. But sometimes, the infection doesn't go away. This is why screening is so important. It helps find problems early, so they can be treated.

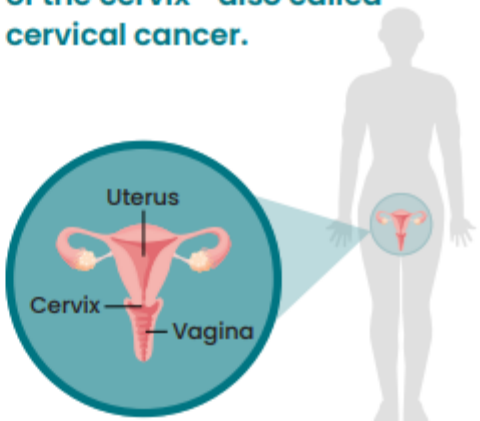
HPV and Cervical Cancer

There are different types of HPV. Some types of HPV cause warts on the hands, feet, or genitals. Other types of HPV cause cancer—these are the types that HPV screening looks for.

It often takes many years for cervical cancer to develop after a person gets these types of HPV. This gives time to discover the HPV infection and treat any problems before cancer develops.

This is why screening is so important.

One type of cancer caused by HPV is cancer of the cervix—also called cervical cancer.



Screening for HPV

Cervical cancer was once one of the most common causes of cancer death for American women. **Thanks to the development of cervical cancer screening tests**, this is no longer the case. Rates of cervical cancer and deaths from the disease have dropped significantly.

A screening test is used to find potential health problems early, before a person has any symptoms of disease.

The Pap test was the first test available to screen for cervical cancer. This test helps find cells on the cervix that are not normal and could develop into cancer. Infection with certain types of HPV can cause these cell changes.

HPV screening can identify if a person has one of these types of HPV before changes in the cells occur. Having one of these cancer-causing HPV types does not mean a person will surely get cancer, it just means they should be checked carefully to prevent cancer from developing.

We know that specific types of HPV cause cancer. Having a test that can find whether a person has one of these types is a great step forward in preventing cancer.

After Screening

Be Sure to Follow Up. Talking with your provider to learn about your results is very important.

If the test is negative...

- Low chance of cancer developing in the next 5 years
- You won't need screening again for 5 years (unless you've previously had an abnormal Pap or positive HPV test).

If the test is positive for any of the HPV types that can cause cancer...

- More testing will be needed
- A healthcare provider may need to take a closer look at your cervix and another HPV test may be needed sooner.

A positive result is an opportunity to prevent cancer, but only if you follow up with your provider!

It is so important to talk to your healthcare provider to get the extra care and testing needed to help prevent cancer.

asha
American Sexual Health Association

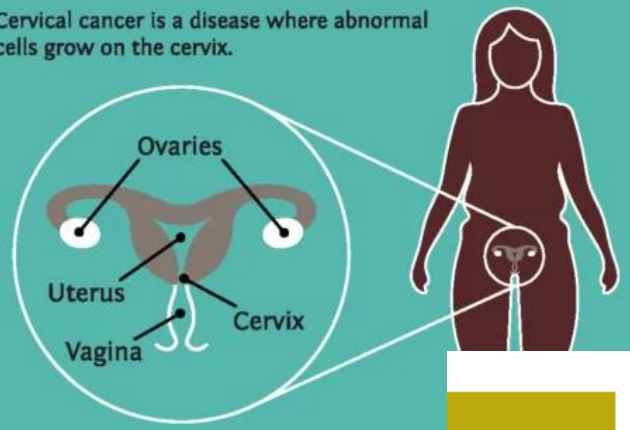
This resource was developed by the Patient Perceptions Workgroup as a part of the American Cancer Society National Roundtable on Cervical Cancer's Primary HPV Screening Initiative which aims to support the transition and implementation of primary HPV screening across the United States.

Screening and Prevention

End Cervical Cancer ▸▸▸▸ in Indian Country

What is cervical cancer?

Cervical cancer is a disease where abnormal cells grow on the cervix.



What can I do?

GET VACCINATED
The human papillomavirus (HP
recommended for everyone ag
against HPV cases that lead to
cancers. *Learn more at: AICAF.o*

PRACTICE SMART SEX
Use protection and talk w
partners: anyone who has
vaginal or oral sex can get

QUIT SMOKING
Smoking weakens the immune
harder for the body to fight HP
Learn more at: AICAF.org/quit

GET SCREENED
Cervical cancer is highly c
detected and treated early

to Quality

Cancer screenings at Southcentral Fou

By SCF Public Relations

Family wellness is essential to a thriving Alaska Native community. As part of the organization's commitment to family wellness, Southcentral Foundation's (SCF) strategic plan has been oriented around 12 family wellness objectives adopted by the SCF Board of Directors, including **"reducing the rate of preventable cancers and improving the management of cancers."**

Cancer can take a devastating toll on families and communities and, according to the Alaska Native Epidemiology Center, it was the leading cause of death among Alaska Native men and women from 2004 to 2008. Cancer was the cause of one out of every five Alaska Native

CERVICAL CANCER

Cervical cancer can be preventable. Since this cancer typically begins with pre-cancerous changes in the body, there are two ways of looking at preventing it in its invasive form. The first is "early detection" – to find and treat pre-cancers – and the second is to prevent the pre-cancers. A Pap test can help find abnormal cells of the cervix (pre-cancers) and cervical cancer at an early stage. Studies have shown that not smoking can lower your risk of cervical cancer, along with avoiding exposure to HPV, a very common sexually transmitted disease that is responsible for more than 90 percent of all cervical cancers. Fortunately the vaccine, Gardasil®, can help protect males and females against four different types of HPV. For the best protection, it is recommended that the vaccine

#4 IT/EHR

New order sets

Cytology ages 21-24 years old

HPV 16/18/other w/reflex cyto 25+ years (ACS)

Cotests for special populations*, 25+ years

Results Reporting

Issues with Screening and Prevention – finding work-arounds

Learned experiences

Need for a “cytology order” for certain patients (send-out)

Important to involve the data/grant person who reports to CDC

#5 **Laboratory**'s role

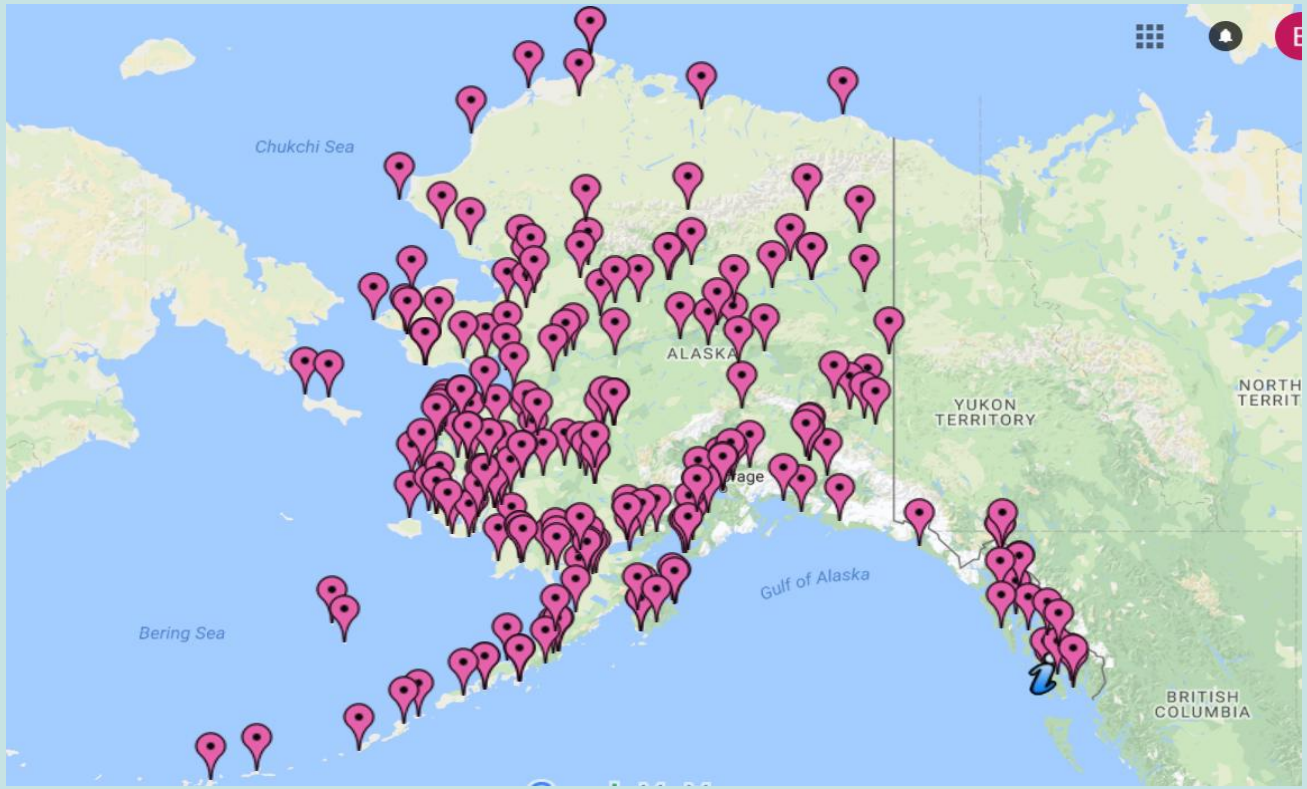
- Selecting the platform
- Ensuring the test is accurate and reliable ("validation")
- Developing standard operating procedures
- Training staff
- Establishing quality assurance metrics for ongoing performance,
- "Go-live" communication (i.e., orders, specimen requirements, etc.)

ANTHC launches first in-state lab for cervical cancer screening

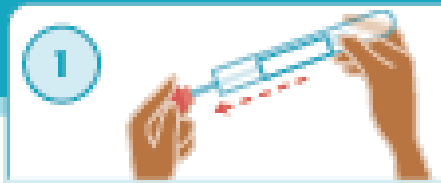
Alaska Public Media | By Rachel Cassandra
Published May 24, 2024 at 12:32 PM AKDT

For rural areas, HPV self-collection is Health Equity

- Clinic-based: What defines a clinic?
  - Walk in clinics, ERs, Mobile units, Home Visits, Treatment Centers, Health Fairs

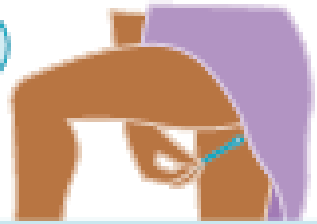


HPV Test Self-Collection Instructions



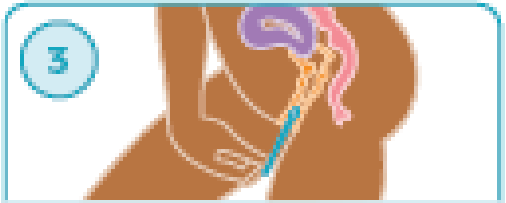
SWAB:

- Wash your hands with soap and water.
- Remove the swab from plastic tube, just twist and pull it.
- If possible, avoid taking the sample during your monthly period.



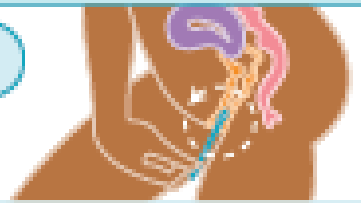
POSITION:

- Undress from the waist down.
- Get into a comfortable position as shown above while holding the swab in your hand.



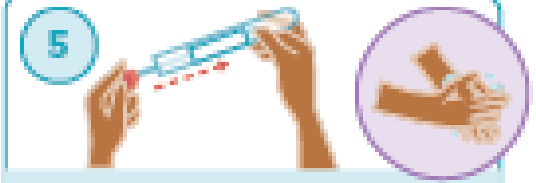
TAKING THE SAMPLE:

- Gently spread open the folds of skin at the vaginal opening with your other hand.
- Insert the swab into your vagina directed towards your lower back approximately two inches, half the length of a finger. This is similar to how you would insert a tampon.



TAKING THE SAMPLE (continued):

- Rotate the swab gently for 10-30 seconds.
- There should be no pain or discomfort.



RETURN TO PLASTIC TUBE:

- Place the swab into the plastic tube.
- Tightly screw the cap onto the tube.
- Finally, wash your hands with soap and water.

The HPV test is used to screen for cervical cancer. For more information about cervical cancer screening and prevention, please talk with your primary care team today.

ALASKA NATIVE MEDICAL CENTER

Suspension of self-collected specimen

Sample suspension instructions for Copan *FLOQSwabs*® #552C.RM

Sample handling instructions for self-collected sample using Copan FLOQSwabs® #552C.RM for testing with the **cobas®** 4800 HPV Test or **cobas®** HPV.

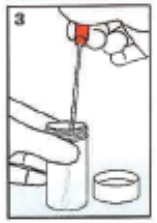
Self-collected sample must be placed into medium after sample has been collected.

- **Read all instructions before starting sample suspension.**
- For sample collection, follow the collection device manufacturer's Instructions for use.
- Once the sample has been collected, continue with the following instructions to preserve the sample:

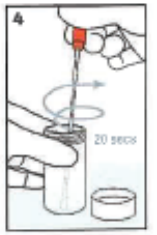
Handle the collected sample with care.

1. Carefully uncap the vial containing medium and place it on a stable, flat surface.

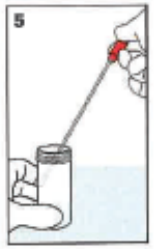
2. Slowly pull the FLOQSwab cap off to remove the swab from the tube. **Minimize touching the inner walls of the tube as you remove the FLOQSwab.**



3. Hold the vial with one hand then with the other hand place the FLOQSwab tip into the vial until the FLOQSwab **tip is fully immersed in the medium** and **touching the bottom** of the vial.



4. Holding onto the vial, **swirl the FLOQSwab along the inner vial wall** for **20 seconds** while **ensuring the swab remains immersed** in the medium. Be careful not to splash.



5. Carefully draw the FLOQSwab up along the inner vial wall until the tip is no longer immersed in the medium. **Hold the tip against the inner vial wall to drain fluid** off of the swab. Place the FLOQSwab into the tube and discard.

6. Re-cap the vial and tighten until **the lines on the cap and vial meet or slightly overlap** to prevent leakage. Store upright.

7. The sample can now be processed with the **cobas®** 4800 HPV Test or **cobas®** HPV.

Glossary

FLOQSwab/Swab: The self-collection device used to collect sample.

Tube: A protective container that the self-collected device will come in and can be used to temporarily store the collection device after the sample has been collected.

Vial: A container which contains 20 mL of clear solution. The specimen you collect will need to be transferred into this container and this container will be sent to the lab for processing.

Medium: What the liquid that comes in the vial is called.

Self collect staff and patient materials

Evaluation of Implementation:

1. Screening numbers
2. Patient satisfaction
3. Provider satisfaction
4. Incidence rates

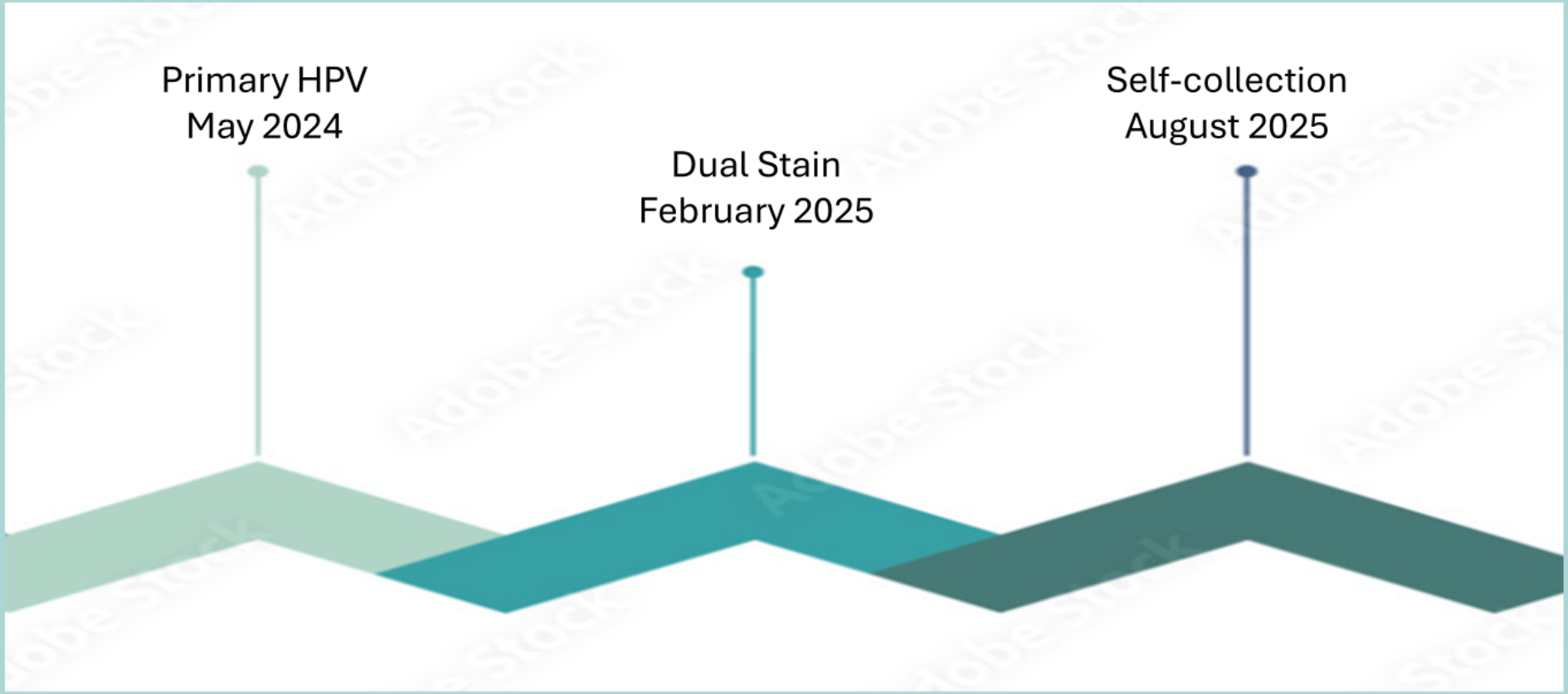
Things we couldn’t predict

- Some provider resistance
- 25-29 year-olds – Primary HPV not covered/not included with USPSTF guidelines (reimbursement issue)
- Initial issues with reporting data/Hedis measures
- EHR: orders and results

Things that went well

- Support from Tribal Health Leaders
- Cancer Committee Support for the Primary HPV instrument and willingness to trailblaze
- Provider satisfaction was high
- IT/EHR and provider collaboration
- Support and interest for self-collection

Primary HPV Cervical Cancer Screening Implementation Timeline at ANMC



Taikuu!
Inupiaq

Way Dankoo
Tsimshian

Tsin'aen
Ahtna Athabascan

Háw'aa
Haida

‘Awa'ahdah
Eyak

Qagaasakung
Aleut

THANK YOU!

Gunalchéesh
Tlingit

Igamsiqanaghhalek
Siberian Yupik

Благодарите Вас
Dena’ina Athabascan

Quyana!
Yup’ik

Thank You

Questions?