

CDC Vital Signs Town Hall Teleconference

Cervical Cancer Prevention: State Perspectives on Screening and HPV Vaccination
November 12, 2014
2:00 pm (EST)

Coordinator: Welcome and thank you for standing by. At this time all participants will be in a listen-only mode until the question and answer session. At that time if you would like to ask a question you may press star 1 on your touch-tone phone. Today's call is being recorded. If you have any objections you may disconnect at this time. Now I would like to turn the call over to Steve Reynolds.

Steve Reynolds: Hi, good afternoon, everyone. I'm Steve Reynolds, the deputy director for CDC's Office for State, Tribal, Local and Territorial Support. I want to welcome you to the call and I'm glad you could join us here today. We'll be discussing the latest *Vital Signs* report on cervical cancer prevention. Before we get started, let's go over some housekeeping details. You can go online and download today's PowerPoint presentation so you can follow along with the presenters. Hopefully you've already done so.

But if not, the web address is www.cdc.gov/stltpublichealth. That's S-T-L-T public health, all one word. There is a link directly to the *Vital Signs* Town Hall web page under highlighted products and resources on the lower right side of the page. On this web page you can also view vitals for the presenters. This is also where we will add the audio recording and transcript for today's teleconference. They should be available sometime next week.

Now back to our topic of the day, cervical cancer prevention is an important public health issue. There's 12,000 women that get cervical cancer every year, and more than 4,000 of those women die from it each year, and that

number has not changed for a long time, at least a decade or so, and that's unfortunate. On today's call we're going to hear from three of our colleagues.

First we will hear from Dr. Vicki Benard, an epidemiologist and team lead in the Epidemiology and Applied Research Branch of the Division of Cancer Prevention and Control at the National Center for Chronic Disease Prevention and Health Promotion, here at CDC. She will provide a summary of this month's *Vital Signs* report. Then we'll hear from Cheley Grigsby, and she will present.

She is a program director for the Alaska Breast and Cervical Health Check at the Alaska Department of Health and Social Services. She will discuss partnering with federally qualified health centers to increase cancer - cervical cancer screening. She will then hand the call over to Heather Hirsch, who is the program coordinator for the Comprehensive Cancer Control Program at the Minnesota Department of Health.

She will discuss the strategies, successes, and lessons learned in increasing HPV vaccines to prevent cervical cancer in Minnesota. There will be a time for questions after our presentations, but you can get in the queue at any time to ask a question. Just press star 1 and record your name when prompted. And now, let me turn this - the call over to Dr. Vicki Benard.

Dr. Vicki Benard: Okay, good afternoon. It's my pleasure today to give you an overview of our work in cervical cancer, examining three national datasets for cervical cancer incidence, mortality, and screening. Slide 5, with the understanding of the ideological role of human papilloma virus (HPV) in cervical cancer, we have seen many changes in cervical cancer prevention. We now have both primary and secondary prevention tools.

The HPV vaccination helps prevent infection with the human papilloma virus types that cause most cervical cancers. The Pap test is a screening test that has been around since the 1950s, and screens for abnormal cells that if left untreated could cause cervical cancer. The HPV test screens for the HPV virus that causes these cell changes, and I will discuss all of these in more detail throughout the presentation.

Slide 6, our main message for the *Vital Signs* is that cervical cancer is largely preventable, that no woman should die of cervical cancer. Yet as you heard from Steve, our sobering statistics show that 12,000 women develop and 4,000 women die of this disease each year. Unlike other cancers we have the preventative measures with screening and vaccination that as many as 93% of cervical cancers could be prevented.

Yet in 2012, 8 million women in the United States had not been screened for cervical cancer at all or within the last five years. Slide 7, almost all cervical cancers begin with an infection with a high risk type of HPV. This infection must persist in order to become pre-cancer, and it may be decades before pre-cancer becomes invasive. Most HPV infections clear within two years and never become precancerous.

There are two opportunities for intervention including vaccination at 11/12 years before HPV exposure and then with screening beginning at age 21 to detect pre-cancers before they become invasive or to catch invasive cancer early. Slide 8, current recommendation for the HPV vaccine is 11 to 12 year olds prior to HPV exposure or girls ages 13 to 26 and boys 13 to 21 can get the vaccine if they have not already received it.

For an average risk women, ages 21 to 29, a Pap test is recommended every three years, and for an average risk women 30 to 65 years, she can discuss her options with the doctor of either a Pap test at every 3 years, or a Pap test with an HPV test every five years. Slide 9, for this MMWR we examine screening patterns using behavioral risk factor surveillance system for 2012 and examine the percentage of women who had not been screened at all or in the past five years.

We examined United States cancer statistics for 2007 to 2011 covering 99% of the US population to calculate incidence rates by state and region. We also examined the National Vital Statistics Systems for 2007 to 2011 to calculate death rates by state, region, and overall. Slide 10, there were 8 million women who had not been screened for cervical cancer in the past 5 years. Disparities were present in the findings including 23% of women not screened did not have health insurance and 25% of women not screened did not have a regular health care provider.

Additionally, older women and Asian Pacific Islanders were more likely to be inadequately screened. Slide 11 shows the cervical cancer incidence rate by state for 2011. DC had the highest incidence rate of 13.7 per 100,000 women while New Hampshire had the lowest rate of 4.5. Note the darker colors in the southern region. Slide 12 shows cervical cancer death rate by state for 2011, West Virginia had the highest death rate at 4.8 while Minnesota had the lowest rate at 1.2. Again, note the darker colors in the southern states.

Slide 13, overall we reported up screening in 2012, the range of not screened by state was 6.9 to 18.7%. The southern states had the highest percent not screened. There were over 62,000 women diagnosed with cervical cancer from 2007 to 2011, and overall there was a 1.9% decrease per year over this time with the south having the highest incident rate at 8.5. Over 19,000

women died of cervical cancer over this time period, and the rates remain stable at 2.3

The south, again, had the highest death rate at 2.7. Slide 14, if we look back from 1975, you'll see the dramatic decreases in cervical cancer deaths. This was mostly due to the widespread use of the Pap test. However in 2007 to 2011 the death rate remained fairly stable. National surveys presenting screening trends found a slight decrease in cervical cancer screening from 2000 to 2010. We believe the real key to moving the mark in cervical cancer is to reach these women who are not being screened as we know that over 50% cervical cancers are in women who have never or rarely been screened.

Slide 15, what can be done to address cervical cancer? Well from our state and local health programs, we can find women who need screening by working with state Medicaid programs, community health centers, and community based groups, help women get screened, get to their medical appointments, and get treated as needed. We can promote a reminder recall system for screening and HPV vaccination, and promote recommended screening options and HPV vaccines to the public.

Our next speakers are going to share some of their great work in the states that are addressing some of these recommendations. Slide 16, thank you, and next we'll hear from Cheley Grigsby.

Cheley Grigsby: Hi, Vicki. Thank you. Can you hear me okay? This is Cheley Grigsby with the state of Alaska's Breast and Cervical Health Check program, and the presentation I'm going to be doing is going to demonstrate how we can partner with federally qualified health centers to increase cervical cancer screening rates. This is slide 17, so first I want to give you a little bit of information about Anchorage Neighborhood Health Center (ANHC), slide 18.

And about Anchorage in itself, ANHC is the largest federally qualified health center in Alaska. It's located in Anchorage, and it's our most populated community in the state. ANHC serves 14,477 patients in 2013, and their screening rate at that time was 42%. The majority of their patients are under 100% of the federal poverty level, and their - 70% of those patients are between the ages of 20 to 64, so it just made sense to work with this group.

So what we did was Anchorage Neighborhood Health Center decided that they were going to put this pilot project together and work with funding that they had from BCHS as well since we could pay for the screening for these low income women. Slide 19, they used their UDS data to identify what their current screening rate was, it was at 42%. So and if anyone is unfamiliar with UDS data, it's the uniform data system that the federally qualified health centers are reporting to HRSA.

Slide 20, they wanted to identify barriers both for the patient and the clinician. So from the patient standpoint, the patients said they didn't have time, they couldn't afford it, and they didn't know when they were supposed to get screened, but they also had barriers from the providers as well, and the providers were saying that they're dealing with patients with chronic issues, and so they're waiting for the patients to make appointments specifically about screening.

And when the patient comes in and screening is not why they're coming in, they don't really have time to address their screening needs. Slide 21, so ANHC applied for HRSA funding to help them support some of the efforts they were going to use for this pilot project. Then they used BCHC to pay for the low income women, and then they enrolled - they used a local outreach

group, the YWCA Encore program to help them reach those rarely or never screened women.

Slide 22, since ANHC had a new center, it was divided into three pods. They used - they took that as an advantage, and they set up a tracking system in each one of those pods that were like their individual clinics. They each had their own clinician and nurses supporting them. So they could use whatever system that they felt was best for reminding, and it gave them a chance to evaluate how those worked as well.

Slide 23, so one of the options was the nurse would call the patients and try to set up an appointment. Another pod had the staff just mail reminder letters, and the third pod would have the staff call and try to schedule appointments. Slide 24, all pods had one change that they had to implement, and that was that they would check the medical records of patients who were coming in, women 21 to 64, and identify if they were in need of a Pap.

If they were, they set up the room up so the clinician didn't have to stop what they were doing in order to go get stuff to take the Pap at that time, and they would have the patient prepared by disrobing and for whatever reason they were there. When the clinician came in then, they could take that opportunity to say "oh, and by the way, you haven't had a Pap, so if you're - you know, here's why you need a Pap, and if we can do that right now, if you want to just lean back."

So slide 25, the outreach group for the YWCA specifically was looking for these women who are rarely or never screened, and they were making phone calls to anyone who hadn't been in for more than three years trying to schedule appointments for all three pods this way, just to reach that rarely or never screened population. So slide 26, the evaluation portion of this.

At the end of one year, ANHC had increased their screening rates 56%, so that was an increase of 12% in the calendar year of 2013. There was no significant difference in the three pods and how they used the reminder system and so they decided that it didn't matter how they reminded those patients as long as they were using one of the evidence-based practices. They were within the same - they were very similar.

But they did have a problem with the rarely or never screened women who were being contacted by the YWCA. That particular group still just didn't want to be contacted, so they went back to having the nurse call those patients. Slide 27, one year later, so this was done in 2013. We did have the opportunity to go back in 2014 and see how you know, if there was a change. The quality integration managers, Heidi Baines over at ANHC, and I asked her what she felt the difference was.

In 2014 their screening rates dropped a little bit to 50% again and when she was asked why she thought that was, she was doing - there was a competition between those three pods, and constant updates with all clinicians and reminders being to the front desk to don't forget those charts, to check those charts to see if a woman needed a Pap. Without that constant reminder from the quality integration manager, their cancer screening rate dropped a small amount, but it didn't go down to what it was before.

So keeping it in the radar is something that they have to do to keep those screening rates up. And slide 28, here's my contact information and Heidi Baines as well at ANHC. If you have any questions you can contact her as well and thank you for your time and Heather's next.

Heather Hirsch: Thank you, Cheley. My name is Heather Hirsch and I have the slides over on each side, 29, I am the comprehensive cancer control program coordinator for the Minnesota Department of Health and the presentation that I'm giving you is going to be about the work that we are doing in partnership with our coalition, the Minnesota Cancer Alliance, and our other partners which include the Minnesota Department of Health Immunization Program and several others that I'm going to mention throughout the call.

One of the first activities that we undertook in partnership with the Immunization Program was in sending a joint letter from the Minnesota Cancer Alliance and the Minnesota Department of Health to 253 clinics that were identified through the vaccine for children program ordering records, and we were looking for clinics who were not ordering an adolescent vaccine ratio that we would expect.

So if they were giving TDAP for meningococcal, they should also be giving the HPV vaccine so if we weren't seeing a three to one ratio, because they needed three doses of HPV for every adolescent they're giving the vaccines to, to every one dose of TDAP, we put them in the list of clinics that needed some more prompting, and the letter included information about the HPV associated cancer rates in the state of Minnesota, as well as CDC materials on how to increase your vaccine rates.

So as we go to slide 31, the Minnesota Cancer Alliance which is our coalition in Minnesota identified increasing the HPV vaccine rate as a priority back in 2001 when they initially added it to the state cancer control plan. The state cancer plan goes through 2016 and the coalition also added increasing HPV vaccine as a systems approach to their policy agenda in 2011 as well. And it has been identified by the cancer alliance steering committee in 2011 and '12 and then continued work has gone on since then.

A work group which was chartered by the committee is developing a work plan in that changing the messaging around HPV, moving away from HPV as an STD and really framing the message around cancer prevention. The strategy includes recruiting physicians to write editorials in provider publications, host provider education webinars, and conduct clinic visits.

Slide 32, the policy agenda for the Minnesota Cancer Alliance is really around getting a state reported clinic level measure of HPV vaccination rates. In Minnesota we have an organization called Minnesota Community Measurement that collects and publicly reports a set of state identified measures. At the clinic, group or at the medical group level and at the clinic group - at the clinic level for certain measures.

This strategy is really aimed at allowing parents to know how well their provider is doing in terms of giving the vaccines and other health indicators, and also to allow targeted interventions with clinics that are struggling with their HPV vaccination rates compared to their other adolescent vaccines. Slide 33, the Minnesota Cancer Alliance also is working to develop culturally appropriate educational materials and this year was awarded a grant from the Prevent Cancer Foundation in the amount of \$10,000 to do just that.

Working on the grants is the American Indian Cancer Foundation, the Fond du Lac Comprehensive Cancer Control Program, the Minnesota Wisconsin Inter-tribal Cancer Council, the Minnesota Department of Health, and the purpose is really to develop and test culturally specific mailing and educational material for HPV vaccinations that can be used in Minnesota's American Indian population. It is also used to distribute the educational materials and reminder mailings to the clinics and American Indian serving

organizations throughout the northern plains tribes, which includes Minnesota, parts of Wisconsin, North and South Dakota, and Iowa.

So far they have successfully conducted 7 focus groups with parents, are compiling the results, and beginning to develop materials which will be printed and disseminated this winter. We've also been working with Indian Health Services to get data on HPV vaccination rates from tribal clinics so that we can have an idea as to where the tribes are which HPV vaccination.

One of our early victories, our early successes in partnership was getting - was partnering with the Minnesota State High School League and the Minnesota Department of Health Immunization Program to change the language on the physical assessment form that all student athletes need to have on file to participate in state high school sports of Minnesota. So the old State High School League did not mention HPV, so we got them to add both meningococcal and HPV.

And then we also got them to - it's sort of a newer version - not make any distinction between recommended and school required vaccines, so they just lump all of the vaccines for adolescents together under the same category. Slide 35, another project - so we are also working with the immunization program to co-fund a reminder recall project. There was a suburban pediatric practice and a greater Minnesota family practice, and the combined adolescent cohort of about 19,000.

We funded the two clinic systems to do three rounds of mailings. To date they've completed two rounds successfully and the third round is nearly completed. The mailings were recall reminders to come in for their HPV vaccinations. Challenges that the clinics encountered were data quality. They had a really difficult time determining what adolescents were still in their

practice; clinic staff turnover, the clinic staff that we started working with at the beginning of the project aren't necessarily all still in place.

And the lessons that we've learned so far, the patients responded enthusiastically. In the first round of mailings we sent out all 15,000 letters reminding parents to bring their kids in for vaccinations at the same time and unfortunately that meant that several thousand parents were calling to schedule appointments, and that clinics weren't able to accommodate that, so in rounds two and three, we took a tiered approach and went through - one clinic system went through alphabetically and another clinic system just went through chunks of a couple hundred at a time so that they could accommodate the patient volume.

We also found that the clinics were willing to use the Immunization Information System, which is based out of the Department of Health to develop the reminder recall tools after they'd been demonstrated. Initially they weren't very receptive to using the tools that we had developed through the department of health, but after a demonstration and really understanding how they would be used, the clinics were willing to do that.

And then that was a service that we could offer to them. Slide 36, we've also worked with our immunization program and several interested stakeholders to develop some provider videos. These provider videos are complete and they are housed on state website called www.leadvaccines.org, and this website - the videos, really, the goal is to increase providers' comfort in recommending HPV, to suggest easy, realistic responses to common questions or hesitations, to show them not tell them how to talk to patients, and to model the case methodology which is corroborate, make it about we, make it about science, and explain and advise model.

And we use this in the Prevention and Public Health Funded grants that our immunization program receives this year as well as part of the provider education project. And so I apologize when I gave this talk the last time, we had not finished shooting but we have finished shooting the videos and they are edited and ready for prime time and have - we've begun disseminating them. We've had them reviewed by pediatricians and family physicians as well as other clinic staff who are working and we've showed them successfully to several audiences and gotten great response.

Slide 37 is really going to talk about our PPHS grant. First slide, #37, shows you the variety of organizations that are involved in our project, which is specifically aimed at increasing HPV vaccination reach in the state of Minnesota. So we've got broad participation from our cancer organizations, from our health plans, from oral health, from cancer screening organizations, medical organizations, provider organizations, as well.

So go on to slide 38, one of the first steps of the grant was to do a reminder recall and public awareness campaign, so the first part of the reminder recall, we did a mailing out of the department of health to 123,000 adolescent - 11 to 12 year olds in the state of Minnesota. The letters were addressed to their parents, and the photograph that you see on the slide is the front and back of the card.

We also followed up and did regional reminders for those who were due for the - any dose of HPV, so first, second, or third dose in specific regions of the state where we did some additional mailings and we also did some auto-dialing. We had all the addresses verified and so we had a return rate of less than 8% which we felt pretty good about. And the message on the postcards was really about the full platform of adolescent vaccines, but emphasized HPV.

Slide 39 starts to talk about our provider education and assessment and feedback visits that were conducted as part of the PPHS grant. So the provider education, we did on demand webcasts, which is available on the website from CME for physicians. We plan to do five lectures and 10 clinic visits. We actually did over a dozen lectures throughout the state of Minnesota and paired as many as we could with clinic visits.

And again, the conversation discussed the full adolescent platform but really focused on hesitations, barriers, and concerns about giving the HPV vaccine. We had a retired family physician from Burrell, Minnesota, give the presentation, which I think also added a lot of credibility to the presentation and then we paired those with possible with assessment and feedback visits which were done by the immunization staff at the Department of Health.

And those are really quality improvement planning, that clinic visit, looking at their clinic specific adolescent vaccine rates and helping develop a plan to develop an intervention specific to that clinic and do some targeted follow-up after the fact. And slide 40 has my contact information. I'll be happy to share any of the materials that we've developed with anyone who's interested and answering further questions, and now I believe I'm turning it back to Steve to facilitate the question and answer and the resources.

Steve Reynolds: Thank you so much, thank you for those outstanding presentations.