Improving Access: A Training Series on Cervical Cancer Screening and Prevention for Health Centers

Session 4: Care Coordination and Linkages to Support Services

NATIONAL NURSE-LED CARE CONSORTIUM
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March 24th, 2026 | 3 pm EST

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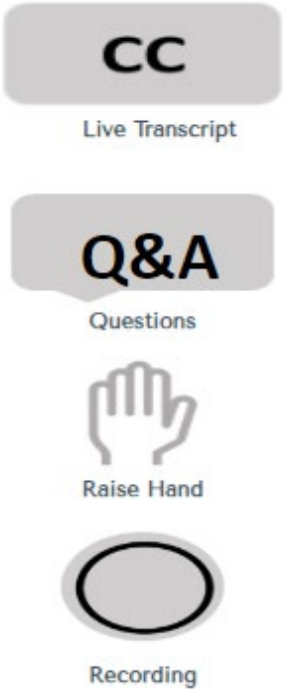

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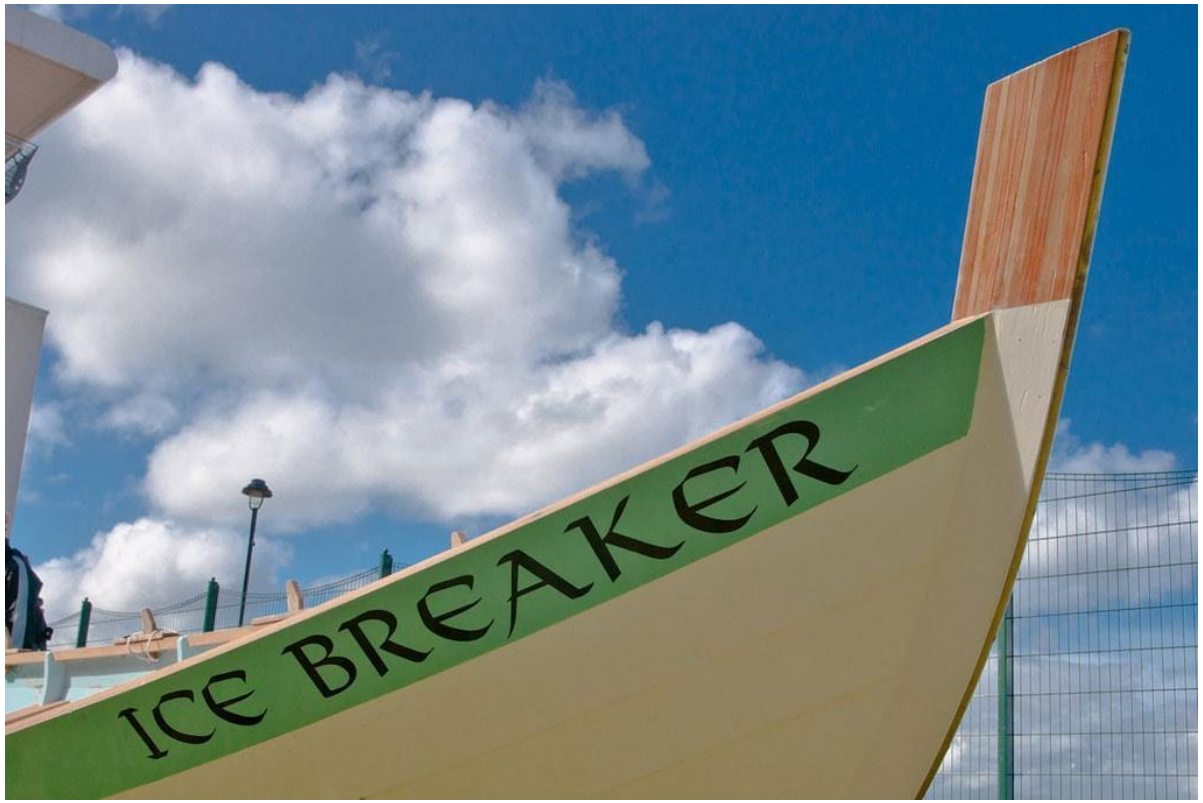

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Jillian Bird, MSN, RN
Senior Director of Strategic Initiatives

Matt Beierschmitt, MPP
Assistant Director of Training and Technical Assistance

Fatima Smith, MPH, CHES
Project Manager

Regina Brecker, MPH, CHES
Project Coordinator

Lucy Lunay
Program Intern

Anna Fry, MPH, BSN, RN
Clinical Nurse Educator

Today's Agenda

5 min - Welcome

20 min – Factors Affecting Screening Completion and Follow-Up - Karen Hacker, MD, PhD

- Factors affecting cervical cancer screening and follow-up in public housing residents
- Addressing barriers to screening through community partnerships and support services

20 min – The Potential for HPV Self-Sampling to Increase Cervical Cancer Screening, Access, and Uptake - Rachel L. Winer, PhD, MPH

- Screening in health centers
- Self sampling trials and results

10 min - Questions & Wrap-Up

Subject Matter Expert

Karen Hacker, MD, MPH
Adjunct Professor and Health Policy Fellow in Residence, Health Policy, and Management
Emory, Rollins School of Public Health

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Factors Affecting Cervical Cancer Screening and Follow-Up for Public Housing Residents

Karen Hacker, MD MPH

Emory University, Rollins School of Public Health

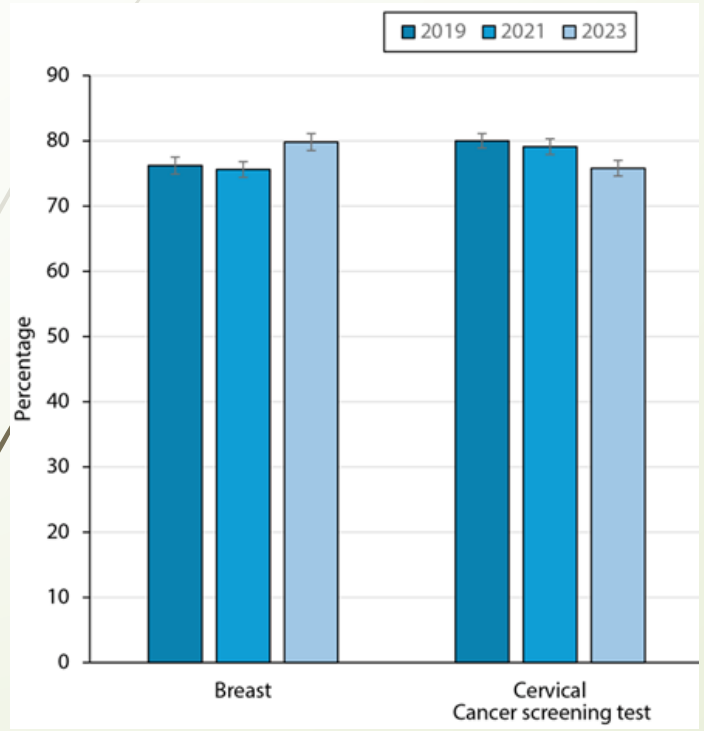
March 24, 2026

Public Housing Resident Characteristics

- Low income, 70% very low income
- 40% of households headed by someone >62 or with a disability
- 40% have children
- Large medically underserved populations
- Majority women led households
- Health insurance: Medicaid, Medicare
- Medically underserved populations with high levels of chronic disease and mental health issues

https://usafacts.org/answers/how-many-people-live-in-subsidized-housing/country/united-states/?utm_source

Percent of Screening – Eligible Adults Who Were Up to Date with U.S. Preventive Services Task Force (USPSTF) Cervical Cancer Screening Recommendations - 2023



Characteristic	Cervical Cancer Screening	
	Number	Percent
Overall (age standardized)	8,727	75.8
Race		
Asian	640	67.8
Black/African American	1080	72.7
White	6039	77.5
Other	162	78.1
Missing	614	78.1
Education		
Less than high school	585	62.3
High School/GED	1788	67.2
Some College	2341	74.7
College	3971	83.5
% Federal Poverty Threshold		
<138	1681	65.5
>138-250	1577	69.1
>250-400	1800	74.6
>400	3669	83.2

National Center for Health Statistics, National Health Interview Survey, 2023. CDC https://www.cdc.gov/nchs/nhis/documentation/2023-nhis.html

Screening for Cervical Cancer: The Challenges for Public Housing Residents

Exam

Access

- Location of Services
- Safety
- Transportation
- Clinic Hours
- Childcare

Discomfort with exam itself

- Challenges for disabled residents

Shifting Guidelines

TABLE 1

Screening for Cervical Cancer: Clinical Summary of the USPSTF Recommendations

Population	Women aged 21 to 29 years	Women aged 30 to 65 years	Women younger than 21 years, women older than 65 years with adequate prior screening, and women who have had a hysterectomy
Recommendations	Screen for cervical cancer every 3 years with cytology alone. Grade: A	Screen for cervical cancer every 3 years with cytology alone, every 5 years with hrHPV testing alone, or every 5 years with cotesting. Grade: A	Do not screen for cervical cancer. Grade: D
Risk assessment	All women aged 21 to 65 years are at risk for cervical cancer because of potential exposure to hrHPV types through sexual intercourse and should be screened. Certain risk factors further increase risk for cervical cancer, including HIV infection, a compromised immune system, in utero exposure to diethylstilbestrol, and previous treatment of a high-grade precancerous lesion or cervical cancer. Women with these risk factors should receive individualized follow-up.		
Screening tests	Screening with cervical cytology alone, primary testing for hrHPV alone, or both at the same time (cotesting) can detect high-grade precancerous cervical lesions and cervical cancer. Clinicians should focus on ensuring that women receive adequate screening, appropriate evaluation of abnormal results, and indicated treatment, regardless of which screening strategy is used.		
Treatment and interventions	High-grade cervical lesions may be treated with excisional and ablative therapies. Early-stage cervical cancer may be treated with surgery (hysterectomy) or chemotherapy.		

Note: These recommendations apply to individuals who have a cervix, regardless of their sexual history or HPV vaccination status. These recommendations do not apply to individuals who have been diagnosed with a high-grade precancerous cervical lesion or cervical cancer, those with in utero exposure to diethylstilbestrol, or those who have a compromised immune system (e.g., individuals living with HIV).

Note: For a summary of the evidence systematically reviewed in making this recommendation, the full recommendation statement, and supporting documents, go to https://www.uspreventiveservicestaskforce.org/.

HIV = human immunodeficiency virus; hrHPV = high-risk HPV; USPSTF = U.S. Preventive Services Task Force.

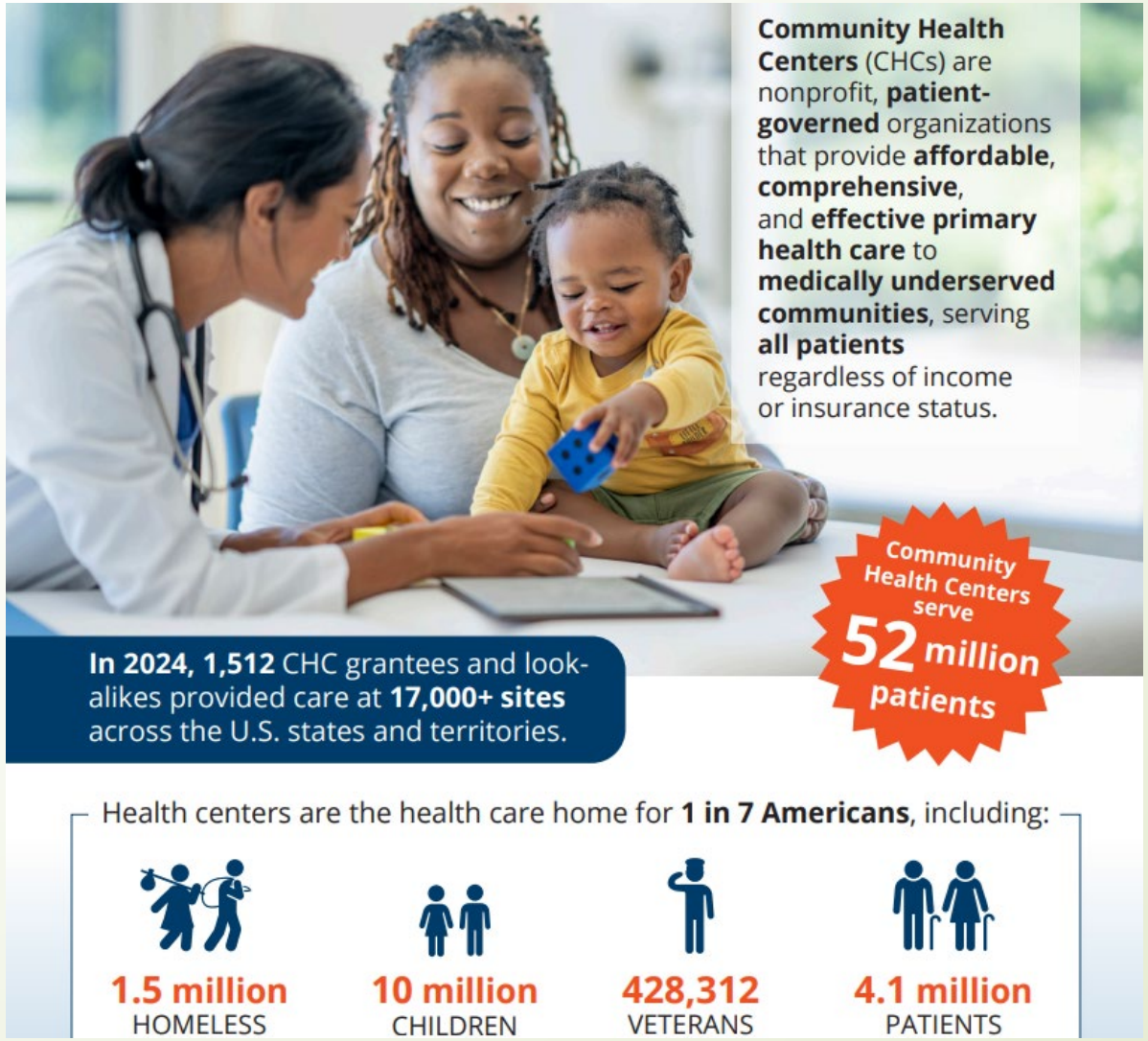
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening

Trust and communication

Follow-Up

- What is the patient's responsibility
- What is the provider's responsibility
- Follow-through breakdown
- Unique issues for public housing residents

Partnership: Health Centers



https://www.nachc.org/resource/americas-health-centers-by-the-numbers/

- Located near or co-located within public housing developments
- Work with community health workers
- Sponsor programs for cancer screening
- One-stop shop
- Geared to low-income populations

Community Health Workers

- From and of the community
- May be residents of public housing
- Assist in navigating the health system
- Provide support for health-related needs
- Certified and trained

New Screening Options

- FDA Approved in Early 2026
- Primary high-risk Human Papillomavirus (hrHPV) testing via self collection
- If hrHPV is negative move to screening every 5 years
- Starting in January 2027, private insurance plans will cover new screening options.

The teal wand

HPV Vaccination Prevents Cancer

Misconceptions

Availability

Recommended use

Next Steps

- Understand the problem
  - Rates of screening, specific challenges to screening
- What interventions will help
  - Programs in housing developments
  - Health Center relationships
  - Community health workers
  - Self-administered testing

Subject Matter Expert

Rachel L. Winer, PhD, MPH
Professor of Epidemiology
University of Washington

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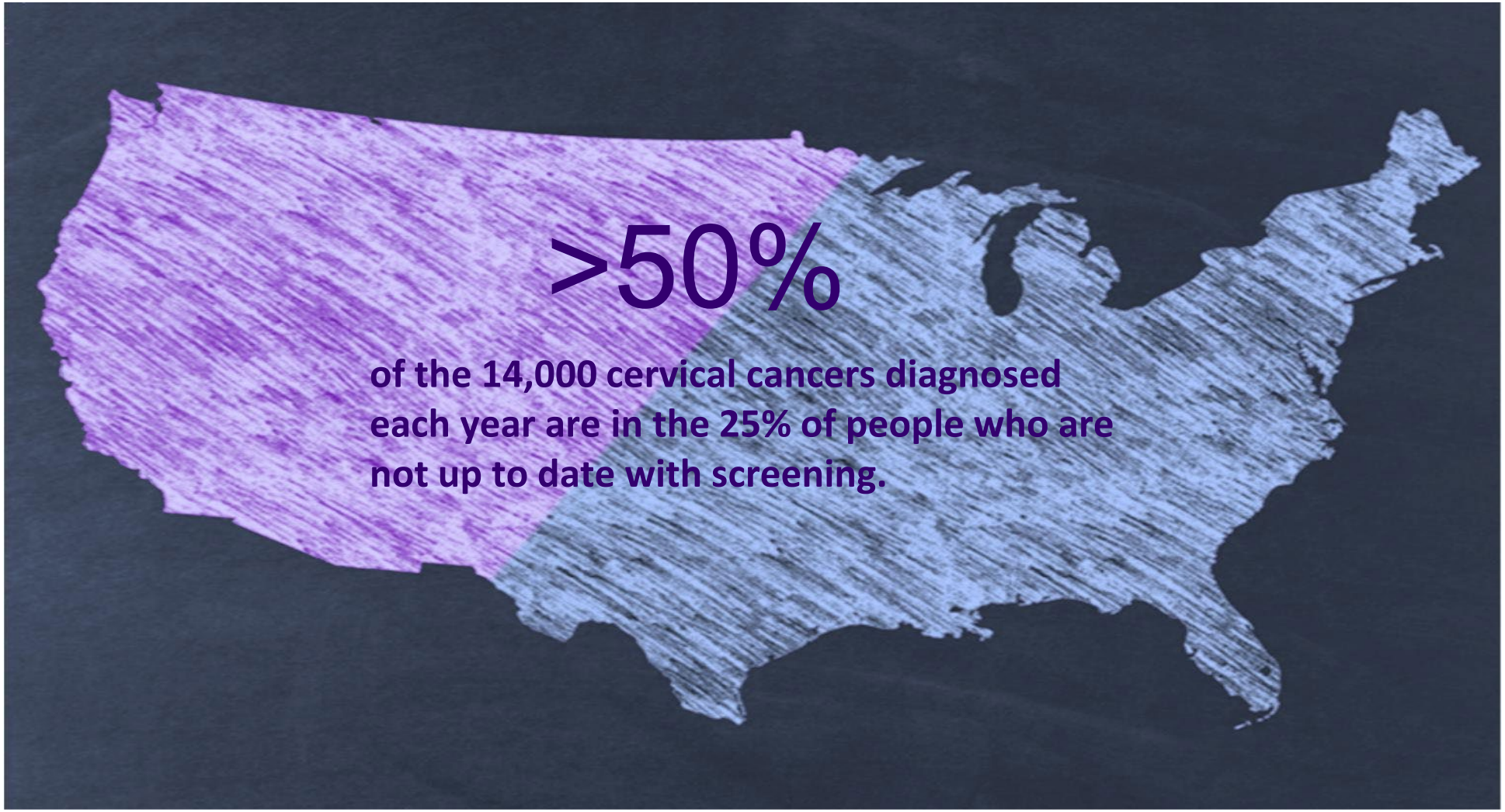
DEPARTMENT OF EPIDEMIOLOGY
UNIVERSITY of WASHINGTON
School of Public Health

THE POTENTIAL FOR HPV SELF-SAMPLING TO INCREASE CERVICAL CANCER SCREENING ACCESS AND UPTAKE

Rachel Winer, PhD, MPH
Department of Epidemiology
University of Washington


>50%
of the 14,000 cervical cancers diagnosed each year are in the 25% of people who are not up to date with screening.

SCREENING DISPARITIES IN HRSA-FUNDED HEALTH CENTER PATIENTS

- **More than 1200 health centers provide comprehensive health services to ~29.3 million patients**
  - **Patients are predominantly in medically underserved populations, have incomes below the federal poverty level, use Medicaid, or are uninsured**
- **Patients in health centers have lower screening rates than national averages (55% up to date in 2023)**

https://data.hrsa.gov/topics/healthcenters/uds/overview/national

ALTERNATIVE SCREENING STRATEGIES

- **U.S.-based cervical cancer screening guidelines endorse Pap testing, HPV testing (on clinician-collected or self-collected samples), or Pap/Human Papillomavirus co-testing.**

- **HPV self-sampling has potential to increase access & eliminate need for a clinic visit for a majority of people with a cervix.**

SELF-SAMPLING FOR HPV

- Highly acceptable & increases participation in cervical cancer screening
- Comparable diagnostic accuracy to clinician-collected sampling for detecting cervical precancer
- Several countries include HPV self-sampling options
- US FDA approval for use in healthcare settings (2024), and at home (limited) (2025)
- US guideline endorsement (ACS, HRSA) (2025)

OPPORTUNITIES WITH HPV SELF-SAMPLING

- **Potential to address poor health outcomes (exacerbated by the pandemic)**
- **Potential utility for underscreened/medically underserved populations**
- **Flexible distribution methods (mail, in-clinic)**

CONSIDERATIONS FOR HEALTH CENTERS

- **Health centers have limited resources for adopting and sustaining new preventive care services like HPV self-sampling.**
- **Health centers will need guidance, education, training, and support to integrate HPV self-sampling.**
- **Implementation strategies will also need to support the transition from Pap to primary HPV screening.**
- **Workflows and patient tracking systems will need to adjust for managing follow-up.**
  - **Self-sampled tests that are positive for non-HPV-16/18 types require a clinic visit for a clinician to perform a Pap.**

HPV SELF-SAMPLING TRIALS

> HOME (2014-2018) and STEP (2020-2022) trials

- Kaiser Permanente Washington
- Pragmatic Randomized Controlled Trials (RCTs) of mailed HPV self-sampling; individual-level randomization

> Isbaar project (2021-2025)

- Community-based primary care clinics in Minneapolis, MN
- Effectiveness-implementation study of in-clinic HPV self-sampling; difference-in-difference design

> STEP-2 (2024-2030)

- health centers and medicaid health plans in WA and OR
- Pragmatic RCT of in-clinic and mailed HPV self-sampling; clinic-level randomization

JAMA | Original Investigation

Strategies to Increase Cervical Cancer Screening With Mailed Human Papillomavirus Self-Sampling Kits
A Randomized Clinical Trial

Rachel L. Winer, PhD, MPH; John Lin, BA; Melissa L. Anderson, MS; Jasmin A. Tiro, PhD; Beverly B. Green, MD, MPH; Hongyuan Gao, MS; Richard T. Meenan, PhD, MPH, MBA; Kristina Hansen, BA; Angela Sparks, MD; Diana S. M. Buist, PhD, MPH

https://jamanetwork.com/journals/jama/fullarticle/2812323

THE STEP TRIAL: BACKGROUND

- **Mailing HPV self-sampling kits to underscreened individuals increases adherence.**
  - Meta-analysis of 25 trials[1]: 13% absolute increase vs. control
  - U.S. HOME trial[2]: 9% absolute increase vs. control

- **Randomized trials have not evaluated offering self-sampling to previously-adherent individuals.**

- **Optimal strategies for increasing cervical cancer screening may differ by patient screening history and healthcare setting.**

https://pubmed.ncbi.nlm.nih.gov/36517552/

STUDY OVERVIEW

- **Study setting: Kaiser Permanente Washington – a large, integrated healthcare delivery system in Washington State, USA**

- **Pragmatic trial to evaluate effectiveness of different outreach approaches for offering HPV self-sampling, by screening history (previously-adherent, overdue, unknown)**

OUTREACH APPROACHES

- ***Education***: **Mailed educational material + Usual care screening reminders**
- ***Direct Mail:*** **Directly-mailed home HPV kit + educational material + Usual care**
- ***Opt-In:*** **Option to request a home HPV kit + educational material + Usual care**

STUDY DESIGN

- **Electronic medical records to identify and randomize eligible individuals, Nov 2020 - Jan 2022**
- **Screening completion outcome tracked for 6-months post-randomization as either:**
  - **In-clinic screening**
  - **Kit return with negative or HPV16/18+ results**
  - **Kit return with in-clinic reflex cytology when results were other HR-HPV+ or unsatisfactory**
- **Intention-to-treat analysis**

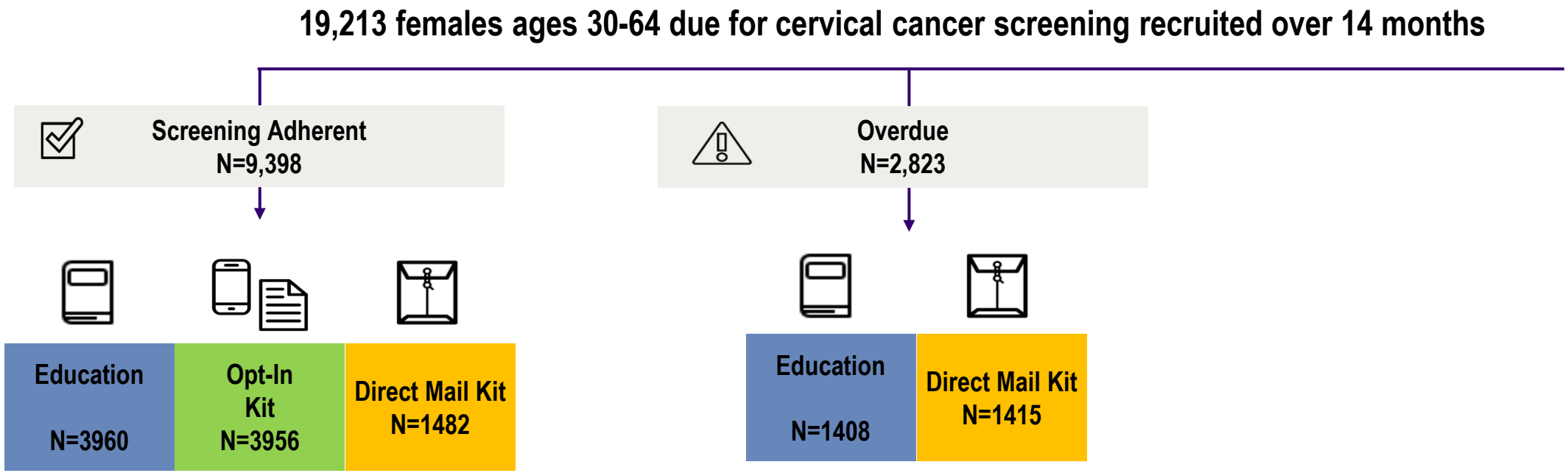
STUDY DESIGN

19,213 females ages 30-64 due for cervical cancer screening recruited over 14 months

Screening Adherent
N=9,398

Education	Opt-In Kit	Direct Mail Kit
N=3960	N=3956	N=1482

STUDY DESIGN



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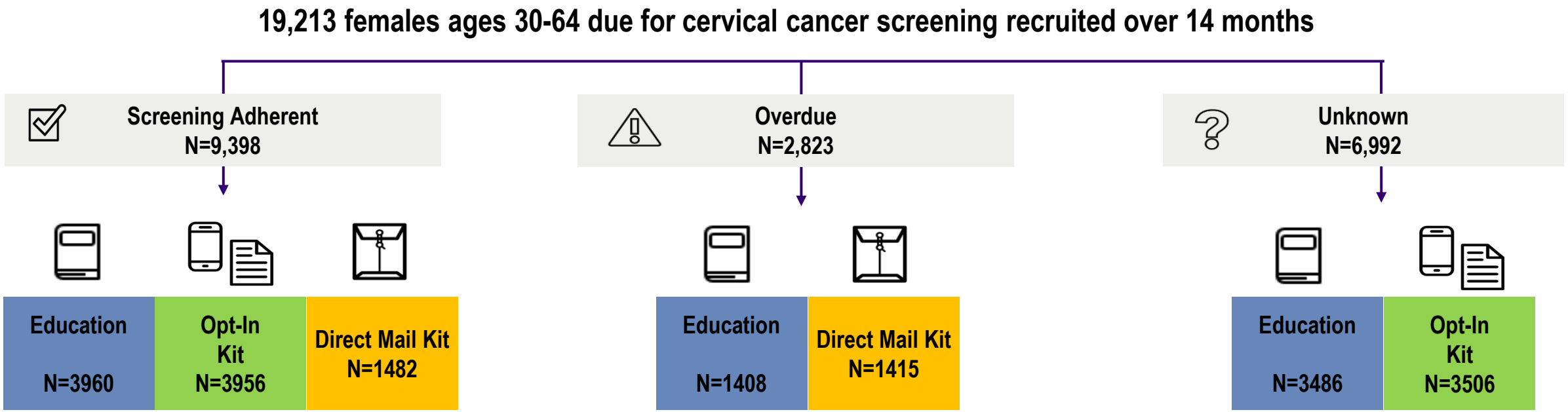
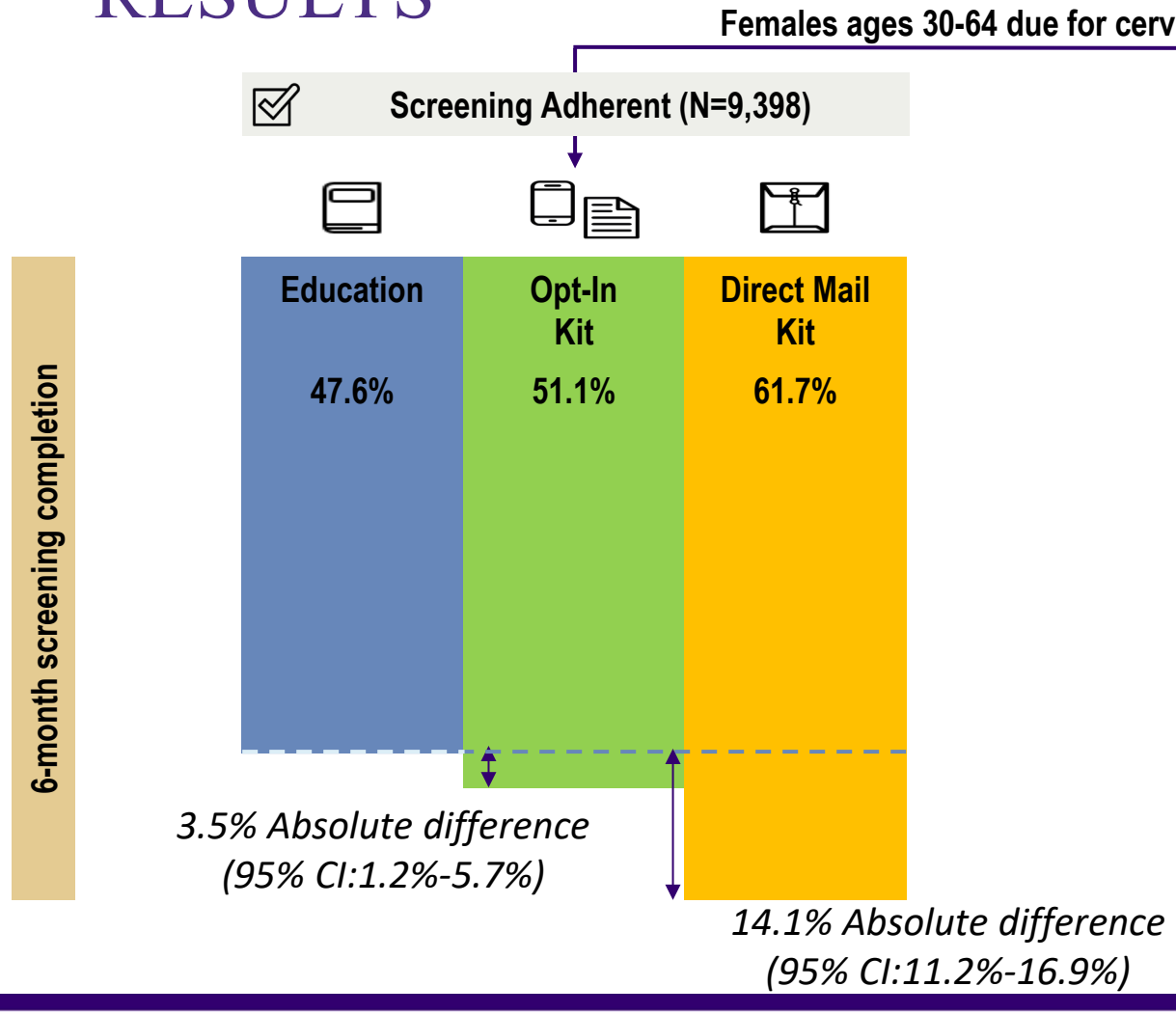


RESULTS



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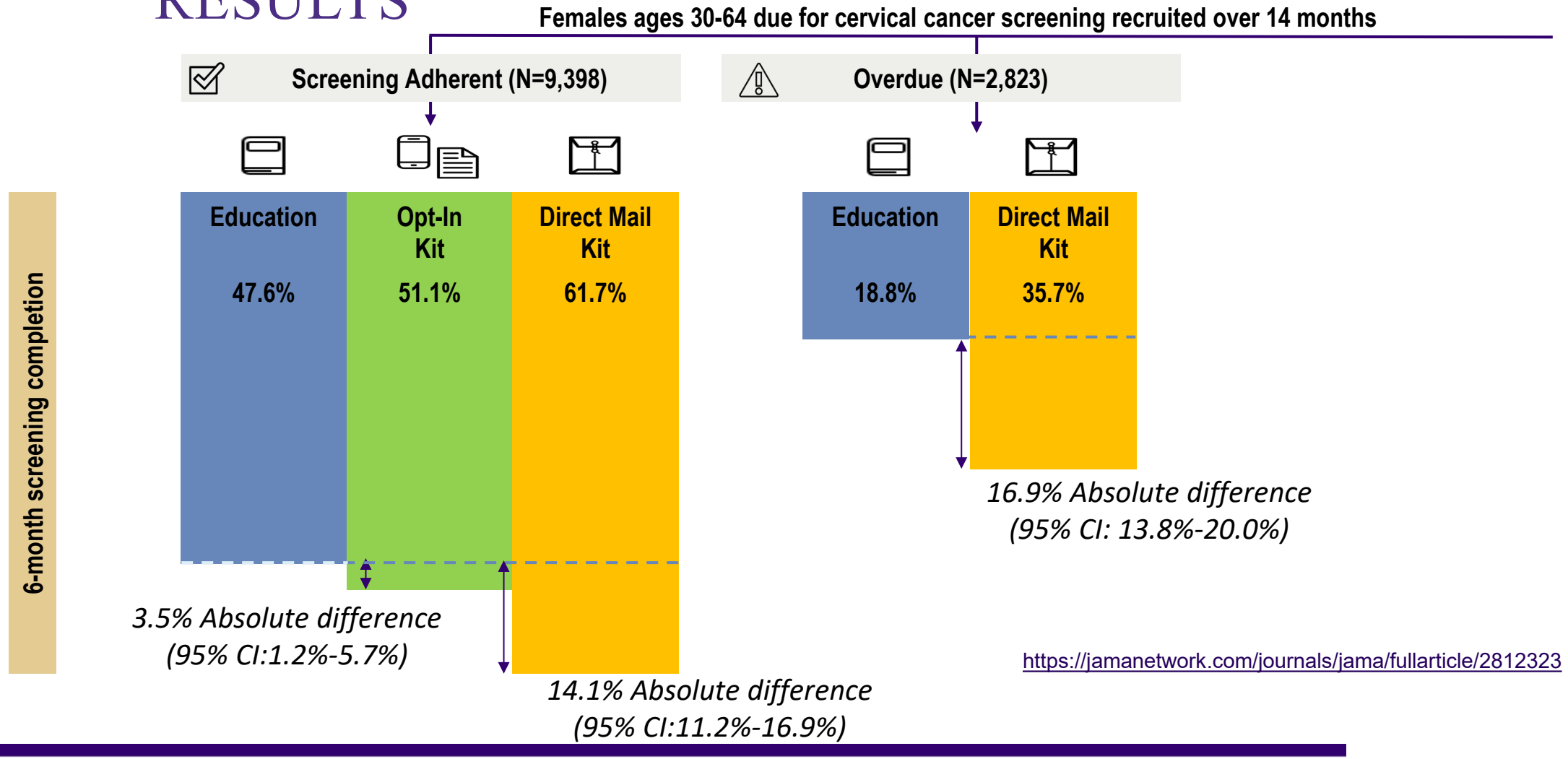
RESULTS



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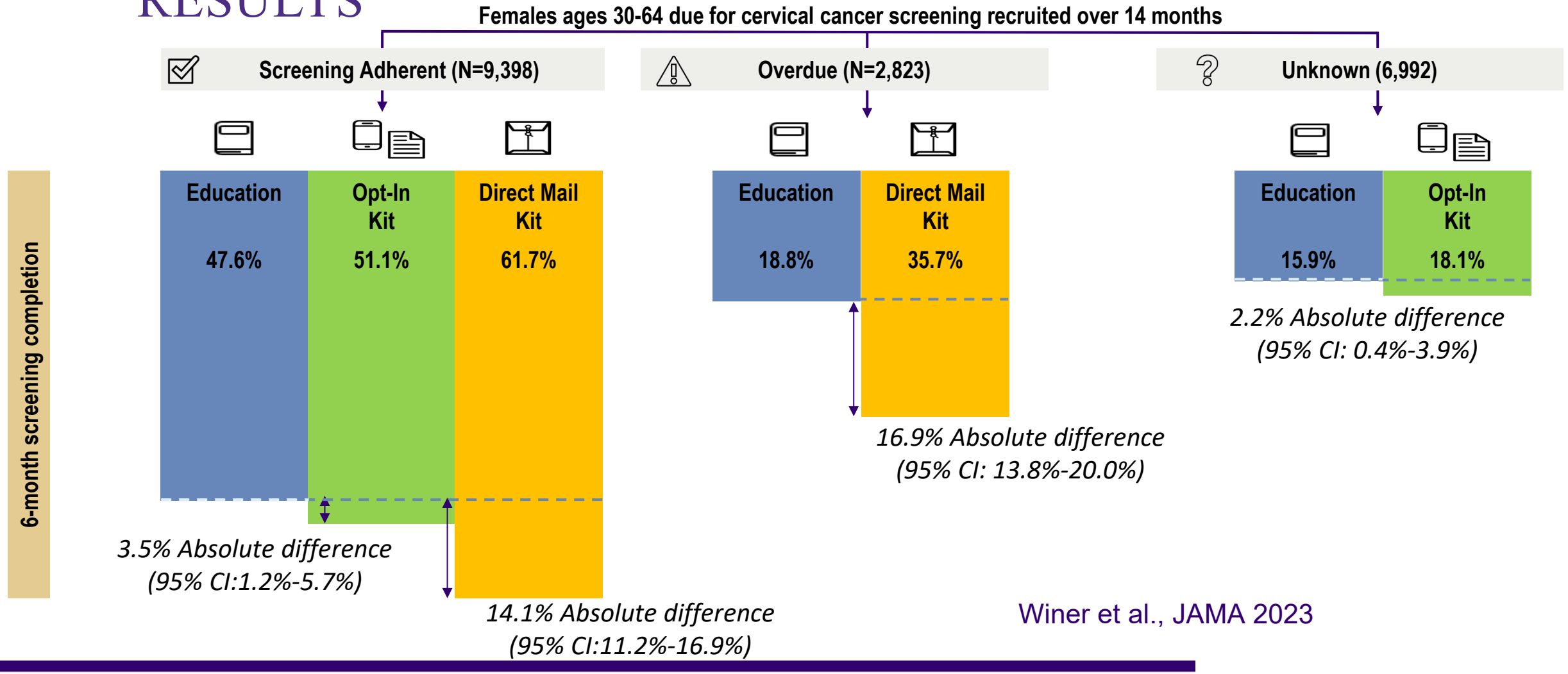
RESULTS



Winer et al., JAMA 2023

DISCUSSION

- **Direct-mail self-sampling increased screening by >14% in both due and overdue individuals, and was economically dominant over other strategies.**
  - **Opt-in approach minimally increased screening.**

- **Our trial was fielded during the pandemic**
  - **Results show that direct-mail outreach can mitigate impact of missed in-clinic screening as well as reach underscreened individuals.**

DISCUSSION

- **U.S. health systems implementing HPV self-sampling should prioritize direct-mail outreach for due and overdue individuals.**

- **For individuals with unknown history, testing alternative outreach approaches and/or additional efforts to document screening history are warranted.**

THE ISBAAR STUDY: BACKGROUND

- **Cervical cancer screening rates are lower in Somali-American women than women in the general US population.**
- **Prior research showed that HPV self-sampling is acceptable to Somali-American women.[1]**
- **Offering HPV self-sampling in-clinic in primary care is understudied and has potential to increase screening and increase health outcomes for all.**

1. Sewali et al., Cancer Medicine 2015

STUDY DESIGN

- **Implement in-clinic HPV self-sampling in 3 primary care clinics serving high volumes of Somali-American women.**

- **Using difference-in-difference methods, compare 12-month pre- and 12-month post-implementation changes in screening completion in intervention clinics to changes in 37 control clinics over the same time period.**
  - **https://pubmed.ncbi.nlm.nih.gov/39561921/**

INTERPRETATION

- **Offering in-clinic HPV self-sampling in primary care is associated with increased cervical screening overall and in Somali Americans.**
- **Higher baseline screening rate in control compared to intervention clinics is a limitation.**
- **This is the first U.S. evaluation of an in-clinic HPV self-sampling strategy to increasing screening.**
- **Given U.S. FDA approval of HPV self-sampling in healthcare settings, results are applicable to other U.S. clinics implementing HPV self-sampling.**

STEP-2 TRIAL OVERVIEW

- **Collaborate with Medicaid health insurance plans & health centers in WA & OR to implement and evaluate 2 HPV self-sampling intervention strategies (in-clinic distribution with or without mailed distribution)**

STEP-2 TRIAL OVERVIEW

> 2-year pilot

- **Develop, test, and refine HPV self-sampling interventions & implementation strategies in 2 health centers & 2 health plans**

> 4-year full trial

- **Clinic randomized pragmatic trial in 42 health center clinics**
- **Clinics randomized to Usual Care, in-clinic distribution *only*, or in-clinic *plus* mailed distribution**
- **Evaluate comparative effectiveness; cost effectiveness; and acceptability, adoption, implementation & maintenance**

IMPLEMENTATION STRATEGIES

Clinic Readiness Tool
- Champion & clinic team assess available resources & current staff roles/ responsibilities supporting cervical cancer screening delivery

-Strengths & weaknesses of current protocols / workflows; what must be adjusted to integrate HPV self-sampling?

Practice Facilitators & Facilitation Guide

- Options on how to modify workflows/ protocols based on clinic team preference

Patient-Centered materials (BCT)
- Pamphlet about HPV role in cervical cancer, importance of screening, new screening modality (self sampling)

- Kit Instructions (for use in clinic & in mailings)

- Staff instructions, Text reminders

Clinician / Staff Webinars
- Basic cervical cancer facts, new modality (accurate, equivalent to clinician-collected tests), adjusted follow-up protocols

- Communication skill building (screening recommendation, answering patient questions (difference Pap vs. HPV tests), explaining test results

Implementation Toolkit for mailing

- Instructions on how health plans & clinics can collaborate to maximize mailed kit reach

https://dcricollab.dcri.duke.edu/sites/NIHKR/KR/STEP-2%20Collaboratory%20Onboarding%20Presentation%20FINAL.pdf?utm_source=chatgpt.com

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Collaborators at the University of Washington, Kaiser Permanente Washington Health Research Institute, Kaiser Permanente Washington, Kaiser Permanente Center for Health Research, University of Chicago, University of Minnesota:

Melissa Anderson
Tara Beatty
Christina Bliss Barsness
Susan Carol Bradford
Diana Buist
Margaret Chin
Annie Chun
Barbara Detering
Caitlin Dorsey
John Dunn
Anna Edelmann
Huda Farah
Hongyuan Gao
Rahel Ghebre
Beverly Green
Dina Greene
James Greene
Kristina Hansen
Anisa Ibrahim
AJ Jose
Sony Kilgore-Martin
Kilian Kimbel
Sarah Levy
John Lin
Richard Meenan
Diana Miglioretti
Imam Sharif Mohamed
Amanda Petrik
Rebekah Pratt
Tim Ramer
Jen Rivelli
Wendy Robinson
Judy Rose
Brandie Sevey
Susan Shortreed
Liz Shuster
Angela Sparks
Adam Szpiro
Chris Tachibana
Chris Thayer
Jasmin Tiro
Jamie Thompson
DT Tran
Catherine Troja
Theresia Tutt
Bryan Weiner
Sophie Yohe

Questions?

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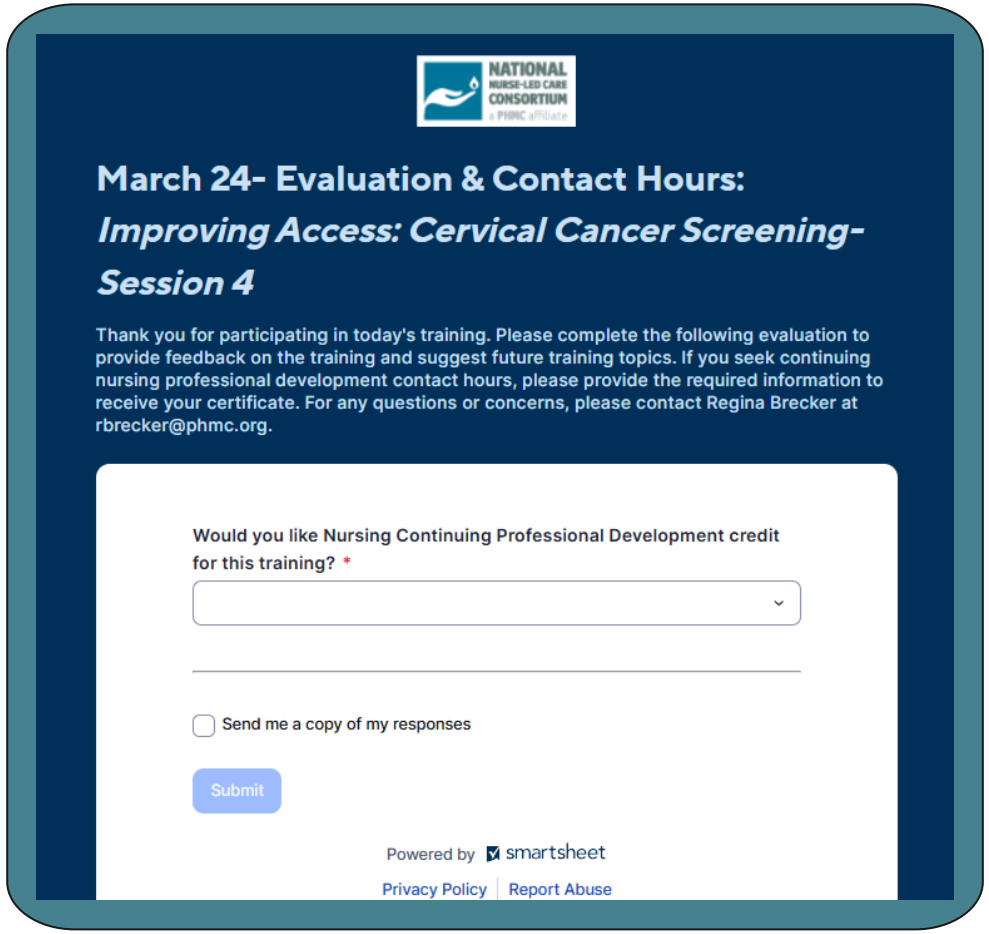
Evaluation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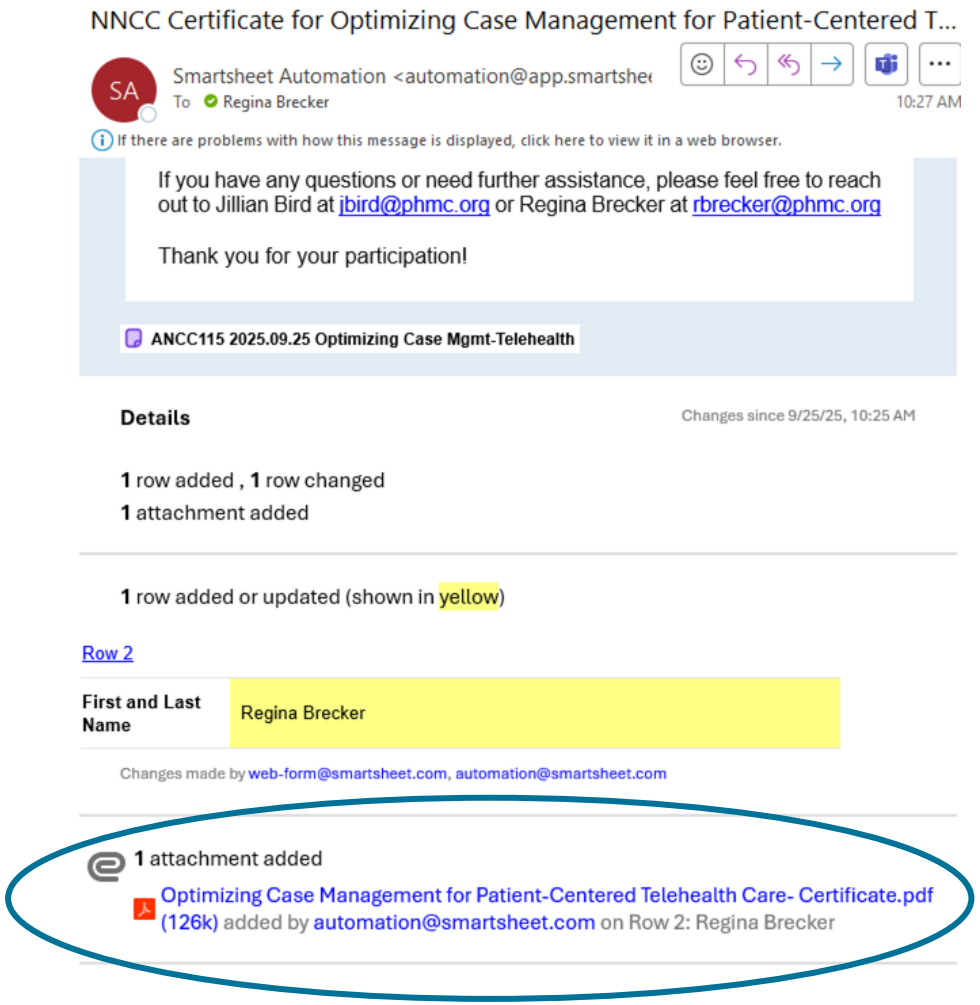
NNCC Certificate for Optimizing Case Management for Patient-Centered T...

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To Regina Brecker 10:27 AM

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If you have any questions or need further assistance, please feel free to reach out to Jillian Bird at jbird@phmc.org or Regina Brecker at rbrecker@phmc.org

Thank you for your participation!

ANCC115 2025.09.25 Optimizing Case Mgmt-Telehealth

Details Changes since 9/25/25, 10:25 AM

1 row added , **1** row changed

1 attachment added

1 row added or updated (shown in yellow)

Row 2

First and Last Name	Regina Brecker

Changes made by web-form@smartsheet.com, automation@smartsheet.com

1 attachment added

Optimizing Case Management for Patient-Centered Telehealth Care- Certificate.pdf (126k) added by automation@smartsheet.com on Row 2: Regina Brecker

Access Health Center Resources

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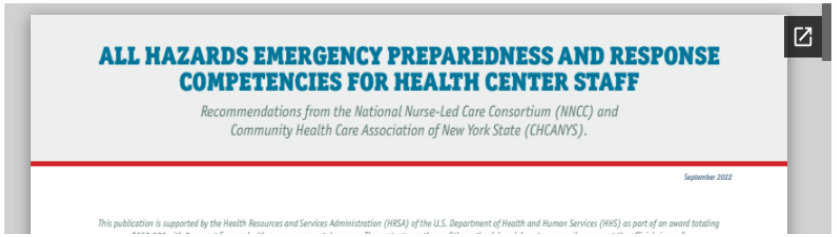
All Hazards Emergency Preparedness and Response Competencies for Health Center Staff

To successfully perform their assigned emergency/disaster roles, health center staff must understand how their organization will respond to hazards, including the use of altered management structures and modified operations. The National Nurse-Led Care Consortium (NNCC) and the Community Health Care Association of New York State (CHCANYS) created a set of competencies to improve the emergency and disaster preparedness of all health center staff. This publication provides a comprehensive overview of those competencies and sub-competencies, as well as a description of their development process. The competencies are intended to form the foundation of health center staff education and preparedness for all-hazards emergency and disaster response and will allow health centers to direct their limited training time and resources to cover the most essential preparedness aspects.



Upcoming Trainings

March 25, April 1, & April 8, 2026 - 2 pm EST

- Sessions 2, 3, 4: *Treating More Than the Disease: Whole Person Approaches to Managing Chronic Conditions*
- Registration: https://us02web.zoom.us/webinar/register/WN_wvZhXfg_RImOTI02fyUdfA

April 14 & 21, 2026 - 3 pm EST

- *From Outreach to Outcomes: Community-Driven Strategies to Improve Colorectal Cancer Screening*
- Registration: https://us02web.zoom.us/webinar/register/WN_yJE2BOaNT5uLCimBP1y-Jw

April 16, 2026 - 2 pm EST

- *The Effective Use of Z-Codes for Non-medical Factors Screening & Documentation*
- Registration: https://us02web.zoom.us/webinar/register/WN_Jig2SL-gRNasga7ajhWuig

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