Comprehensive Cancer Control
Collaborating to Conquer Cancer

COMPREHENSIVE
CANCER CONTROL PLAN

TIP SHEET

CERVICAL CANCER SCREENING

The Comprehensive Cancer Control National Partnership (CCCNP) is a 20+ year collaboration of diverse national organizations working together to build and strengthen Comprehensive Cancer Control (CCC) efforts across the nation.

This Tip Sheet is part of a series offered through the CCCNP to assist CCC programs charged with developing, implementing, and evaluating cancer control plans tailored to their state/tribe/territory/jurisdiction. CCC Plans focus coalition efforts on evidence-based interventions (EBIs) that impact cancer prevention and control across the cancer continuum.

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How to Use This Tip Sheet

Use When Updating Your CCC Plans

Tip Sheets can be used to help CCC program staff, coalition staff, and volunteers update CCC plans. Each tip sheet focuses on a specific topic (e.g., colorectal cancer screening, tobacco control, risk factors for cancer survivors). Follow the steps throughout the Tip Sheet to help guide your process in updating your cancer plan for that specific topic area. Some ideas:

- Incorporate the Tip Sheet into your plan update process – share it with your coalition workgroups and use it to help guide your decisions.
- Identify a lead person to ensure that the Tip Sheet is used by the workgroup or team assigned to update the plan section that addresses each Tip Sheet topic.
- Use the Tip Sheet to check that the topic is appropriately addressed in your plan and that the elements outlined on the next page are covered (objective, data, strategies).
- Use the **worksheet** at the end of this document with your partners to ask and answer critical questions related to the topic as you update your plan.

Use When Implementing Your CCC Plan

Tip Sheets can be used while you are implementing the priorities in your plan. The partners and resources listed in each sheet can help ensure your coalition work stays on track and is of high quality. Some ideas:

- Use with coalition leadership and workgroups as they implement the plan, to find resources, data, and to think about partners that could be engaged in implementing specific strategies from the plan.
- Engage coalition members and reactivate workgroups that have been inactive or need a renewed sense of direction.
- Orient new CCC program staff and coalition members or leaders, to help them better understand the importance of the Tip Sheet topics to CCC efforts, and to provide access to relevant information and resources
- Use the Tip Sheets to help with decision making when identifying priorities from the CCC plan.
- Help a priority workgroup who is just forming to help find an area to focus in on, especially by using the questions at the end of the Tip Sheets.
- Use as a tool to check progress in implementing the plan's priorities, especially focusing on data being collected, EBI's being used and the engagement of key implementation partners.
- Share them with partners (community organizations, FQHCs, Primary Care Associations, etc.) as a resource about a specific topic including sources of information, data, and evidence-based interventions.

Definitions

- **SMART Objective** – is an objective in the cancer plan that is Specific, Measurable, Achievable, Relevant, and Time-bound.
- **Evidence-Based Strategy** – is a specific activity that is designed to achieve the objective and is based on evidence that the strategy is expected to work in your situation, i.e., it has been evaluated and shown to work.
- **Crude vs. Age-adjusted Rates** – Crude rates are influenced by the age distribution of the state's population. Even if two states have the same age-adjusted rates, the state with the relatively older population will generally have higher crude rates because incidence or death rates for most cancers increase with age. Age-adjusting the rates ensures that differences in incidence or deaths from one year to another, or between one geographic area and another, are not due to differences in the age distribution of the populations being compared. Find out more **here**.
- **Populations of Focus** – are those groups experiencing the greatest cancer disparities in your region. Disparities might include higher cancer incidence or mortality; greater challenges accessing cancer screening, treatment, and/or survivorship care services; or populations experiencing bias in society and the healthcare system.
- **Health Equity** – occurs when every person has the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.
- **Health Disparity** – is a type of difference in health that is closely linked with social or economic disadvantage. Health disparities negatively affect groups of people who have systemically experienced greater social or economic obstacles to health. These obstacles stem from discrimination or exclusion that is historically linked to characteristics such as race or ethnicity, socioeconomic status, disability, sexual orientation, and many other factors.[1]
- **Social Determinants of Health (SDoH)** – are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[2]

[1] U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020 [Internet]. Section IV: Advisory Committee findings and recommendations [cited 2010 January 6]. Available from: **http://www.healthypeople.gov/sites/default/files/PhaseI_0.pdf**.

[2] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved 12/04/2020, from **https://health.gov/healthypeople/objectives-and-data/social-determinants-health**.

Tips for Updating Your CCC Plan

- **Use your current cancer plan as a starting point:** Think of this process as updating the current plan instead of starting a new plan from scratch.
- **Be systematic:** Assign workgroups to review and update certain sections of the plan. Create a process that is common across all workgroups tasked with updating the plan, which should include a standard set of criteria for the inclusion of plan goals, objectives, and strategies.
- **Focus workgroups on assessing and updating the core aspects of the plan:** the goals, objectives, and strategies.
- **Identify someone to take the lead** on writing the introduction, connecting text, and putting the document together for publication.
- **Use data to determine the focus of the plan:** Which cancers are most prevalent in the population? What subpopulations experience the most disparities?
- **View through a health equity lens:** Be intentional and proactive in keeping health equity issues at the forefront in every step of the cancer plan process – when engaging partners, collecting data, and setting goals. Include representatives from your population of focus in the writing of your cancer plan.

Use these resources to explore more cancer control planning tips and examples:

- **Nine Habits of Successful CCC Coalitions**
- **CCC Implementation Building Blocks** (see page 7 of the Appendices for more tips on updating your plan)

Additional resources you can use:

- Search other CCC plans to get ideas – **CDC's CCC Plan Map and Search Tool**
- **CDC Cancer Plan Self-Assessment Tool**
- **GW State Cancer Plans Priority Alignment Resource Guide and Tool**
- **A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease**

Checklist for Updating Your CCC Plan

- ☐ **Ensure that your workgroup is familiar with your current cancer plan.**
- ☐ **Create a systematic process for the workgroup to follow that is intentional about addressing health equity.**
- ☐ **Use data to focus on the populations with the highest cancer burdens.**
- ☐ **Focus workgroups on assessing and updating goals, objectives, and strategies.**
- ☐ **Identify someone to write the introduction and assemble the final document.**

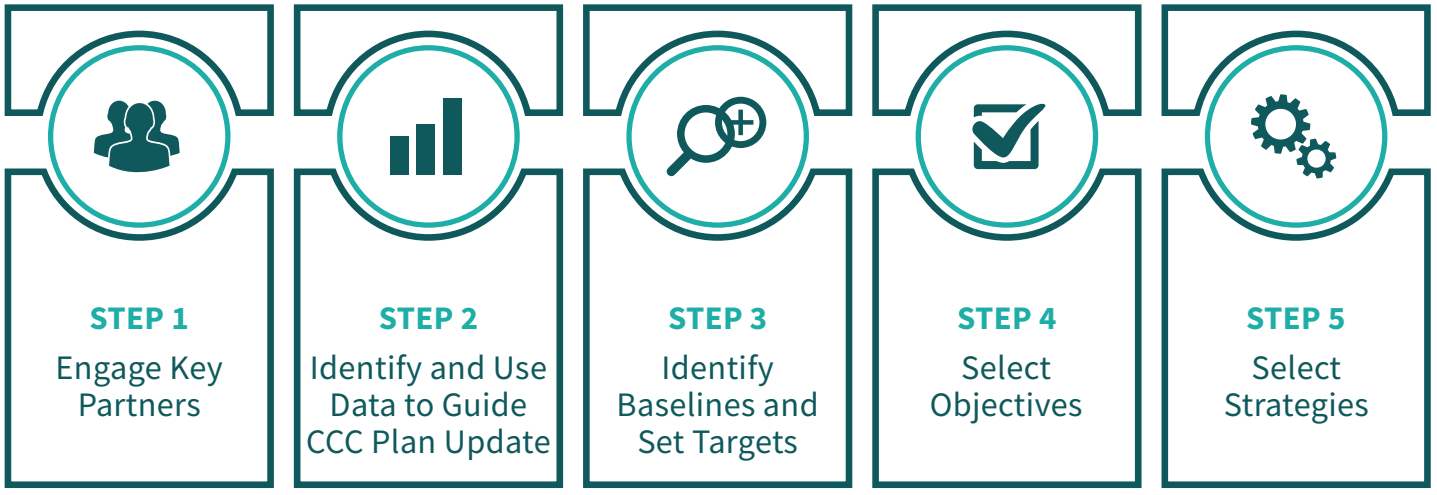
COMPREHENSIVE CANCER CONTROL PLAN UPDATE TIP SHEET

Cervical Cancer Screening

Why Cervical Cancer Screening is an Important Part of Your CCC Plan[3]

- Both cervical cancer incidence and deaths have dropped by more than half since the mid-1970s due to cervical cancers being detected earlier through widespread screening with the Pap test.
- Despite this progress and the introduction and advances in finding cervical cancer early, the disease persists in the US, causing disparities in both incidence and mortality for American Indian/Alaska Native, Hispanic/Latino, and non-Hispanic Black populations.
- CCC coalitions have an opportunity to collaborate with key partners, such as CDC-funded National Breast and Cervical Cancer Early Detection Program (NBCCEDP) recipients and community-based organizations to increase cervical cancer screening and appropriate management after abnormal test results, and address disparities caused by disease. CCC coalitions can also work with vaccination programs and coalitions to increase HPV vaccination, and prevent cervical cancer as well at five other types of cancer.

Cervical cancer can be prevented. CCC coalitions can work to help accelerate efforts in the US and worldwide to eliminate cervical cancer. CCC coalitions are uniquely positioned to bring partners together to address disparities that cause cervical cancer to persist.

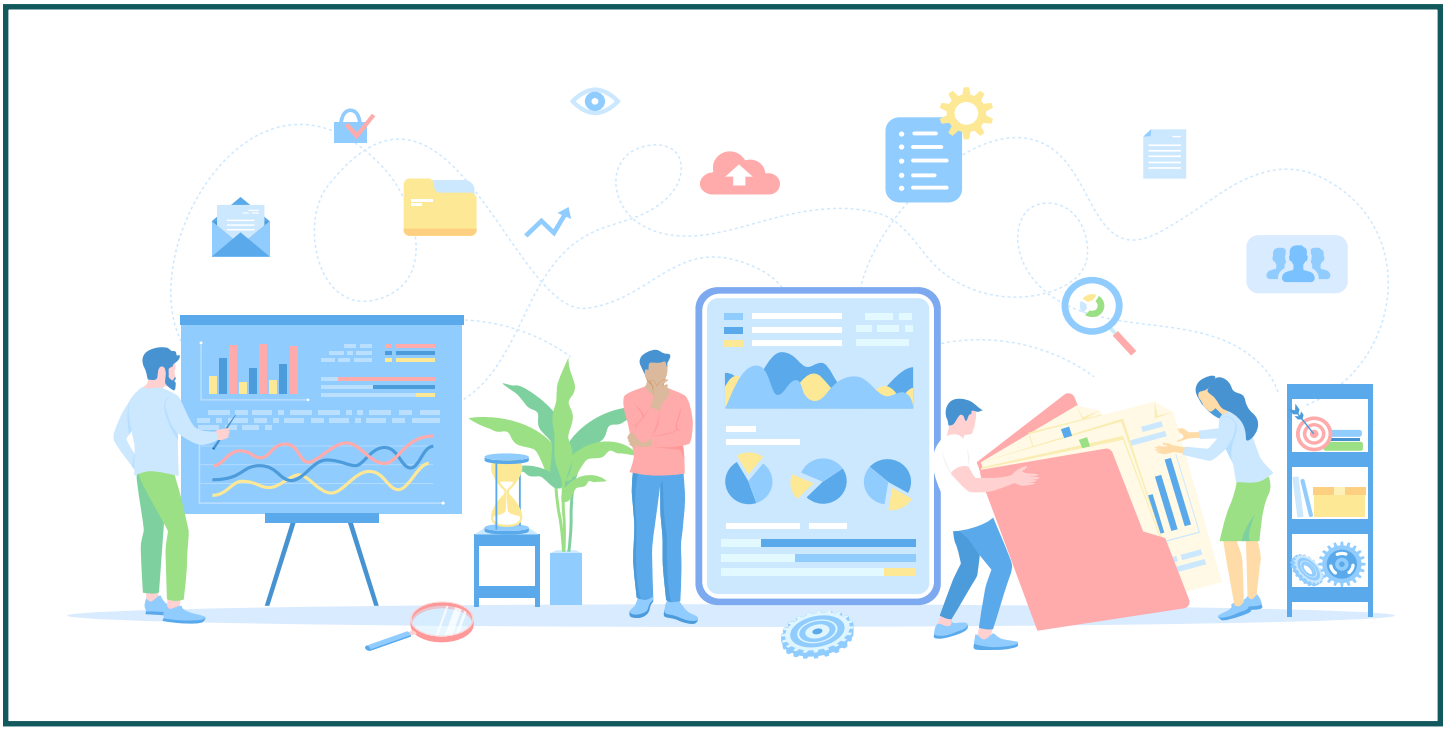


[3] ACS Cancer Facts & Figures 2022: **https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2022/2022-cancer-facts-and-figures.pdf**. Accessed 10.24.22.

STEP 1
Engage Key Partners

Engage experts in cervical cancer screening. Organizations and agencies that have access to the data you need and partners who will be critical to implementing your cervical cancer screening strategies include:

- Your federal tribal, territorial, or state-funded cervical cancer screening program staff and providers, including CDC's **NBCCEDP** recipients
- **ACS Cancer Action Network**
- **American Cancer Society**
- **American College of Surgeons** (ACOS) Commission on Cancer (CoC) State Chair, along with the Cancer Liaison Physicians and the health systems they work in
- Cancer centers and academic partners interested in cervical cancer-related research, including **NCI Designated Cancer Centers**
- **Community Health Centers**
- Current coalition workgroup or advisory group members focused on cervical cancer screening
- Immunization coalitions or HPV vaccination roundtables/coalitions
- **Immunization programs**
- Those with lived experience with cervical cancer
- Medical coders/billers – as they are a link between patients, providers, and insurers
- Organizations and individuals that represent communities experiencing disparities in cervical cancer, including American Indian/Alaska Native, Hispanic/Latino, and non-Hispanic Black populations
- Policy-makers and legislative champions
- Primary care provider representatives – perhaps from your state or regional **primary care association**
- Provider champions
- State health insurance commissioner's office
- Your central cancer registry [**National Program of Cancer Registries (NPCR)**] and **Surveillance, Epidemiology, and End Results (SEER)**



STEP 2

Identify and Use Data to Guide CCC Plan Update

Data is essential to your cancer plan in several ways, including:

- Identifying populations that have higher incidence and mortality rates of cervical cancer and lower screening rates. It is helpful to examine this by race, ethnicity, health insurance status, social determinants of health, and geographic area.
- Identifying your cervical cancer screening rate, progress, and trends over time to identify specific areas for focus
- Working with health systems to examine data on positive HPV tests and pre-cervical cancer diagnosis and follow up
- Identifying the availability and type of providers, cancer services, and ancillary supports (survivor programs, etc.) in different geographic areas and population groups to inform your objectives and strategies in this topic area, including identification of providers with high screening rates or referrals to screening.
- Comparing local data with national data to highlight screening best practices, as well as, key areas of need, or lagging progress
- Laying a foundation to measure progress over the life of the plan (e.g., baselines and targets)

It's best to use data from your own state, tribe, jurisdiction, or territory. But national data can help you set targets by letting you compare your data with other locations and the nation as a whole.

Local data sources include:

- Your central cancer registry **National Program of Cancer Registries (NPCR)** and **Surveillance, Epidemiology, and End Results (SEER)** and **Behavioral Risk Factor Surveillance System (BRFSS)**
- Health systems or EHR data networks (if available)
- **Health Center Program Uniform Data System (UDS) cervical cancer screening rates**

National data sources include:

- **US Cancer Statistics**
- **State Cancer Profiles**
- **American Cancer Society Facts and Figures**
- **Health Information National Trends Survey (HINTS)**
- **HEDIS**
- **National Cancer Institute (NCI) Cancer Trends Progress Report**
- **CDC**
- **County Health Rankings and Roadmaps**
- **CDC National Environmental Public Health Tracking Network Data Explorer** (while there are no cervical cancer incidence rates published here, you will find useful data on the social determinants of health)

STEP 3
Identify Baselines and Set Targets

The questions in the worksheet below can guide you to think through data gathering, decision-making and priority-setting processes. Think about the following topics as you work through the questions:

- Set targets for increases in cervical cancer screening and decreases in cervical cancer deaths based on your data, partner input, and local/national targets.
- Identify if there are priority areas based on data in specific populations.
- Consult **Healthy People** 2030 goals, your health department's chronic disease plan, and **BRFSS data** to see what baselines and targets are already being used by your partners; remember to cite your data sources.
- See **CDC's NBCCEDP screening program summaries** to better understand current screening rates among populations eligible for the program.

STEP 4
Select Objectives

It is helpful to show how your CCC plan goals contribute to national goals. Create a **primary objective** that mirrors national priorities, such as those in Healthy People 2030, and identify 1-2 other **health equity objectives** that support specific needs within your communities, including a special focus on subpopulations that experience health disparities.

Healthy People 2030 Cervical Cancer Screening Objective

Increase the proportion of females who get screened for cervical cancer based on the most recent guidelines.

	BASELINE	TARGET
Percent of females aged 21 to 65 years received a cervical cancer screening in 2018 (age-adjusted to the year 2000 standard population).	**80.5%**	**84.3%**

Note: The American Cancer Society now recommends those aged 25 to 65 should have a primary HPV test every 5 years. If primary HPV testing is not available, screening may be done with either a co-test that combines an HPV test with a Papanicolaou (Pap) test every 5 years or a Pap test alone every 3 years. These recommendations differ from those of the US Preventive Services Task Force.

EXAMPLES OF PRIMARY OBJECTIVES

By 2027, increase the percentage of women aged 21 – 65 years who are up to date with a cervical cancer screening test from X% to X% (defined as a Pap test within the past 3 years for women aged 21 – 65 years, or HPV co-test for women aged 30 – 65 years within the past 5 years, or primary HPV test for women aged 30 – 65 years) (BRFSS).

Increase risk-appropriate screening for breast, cervical and colorectal cancers, with a separate baseline and target for each cancer, e.g., by 2027, increase cervical cancer screening among women from X% to X% (BRFSS).

Decrease the incidence of new cases of invasive cervical cancer from X cases per 100,00 to X cases per 100,000 by 2027.

Decrease the incidence of late-stage invasive cervical cancer from X cases per 100,000 to X cases per 100,000 by 2027.

EXAMPLE OF A HEALTH EQUITY OBJECTIVE

Increase cervical cancer screening among women and persons with a cervix who are uninsured or underinsured from X% to X% by 2027 (BRFSS).

STEP 5
Select Strategies

When choosing strategies that can help address needs you have identified, think about what existing networks, programs, and services you can leverage, enhance, or expand; if the strategy is realistic and feasible given the political will around this issue and available resources; and the impact the strategy will have on achieving the objective you have set.

For cervical cancer screening, ensure that your strategies are supportive of nationally recognized cervical cancer screening guidelines, such as the **US Preventive Services Task Force recommendations** and **American Cancer Society recommended screening guidelines**.

The following strategies are examples of evidence-based strategies found in CCC plans:

Client-oriented screening intervention strategies	Provider-oriented/health system intervention strategies
• Increase the use of client reminders for cervical cancer screening. • Use community health workers or lay patient navigators, especially in underserved communities, to provide one-on-one education, appointment scheduling, and translation services. • Develop a statewide education campaign that includes 1:1 and small media patient education that can be tailored by partners. • Reduce barriers to accessing screening by offering non-clinical settings for screening (communities, worksites) and modifying clinic hours to offer evening screening options.	• Remind providers so that they are aware of which patients are due or overdue for screening or follow-up after an abnormal test result. • Assess provider screening baselines and provide feedback about how well they are doing, along with provider education about the best ways to offer screening.

Using a combination of these strategies is more effective than implementing a single strategy.

For health system interventions, it is helpful to consider the following:

- Find a clinical champion who can energize clinic staff and keep everyone focused on improving cervical cancer screening rates.
- Establish a clinic baseline cervical cancer screening rate and periodically monitor screening rates so approaches can be adjusted as needed.
- Electronic health record (EHR) data may need to go through a validation process to ensure screening estimates are accurate, given that most EHRs are not optimized to produce screening estimates. Clinics may need to work with their information technology (IT) or health informatics staff member to examine potential issues with data entry, documentation of completed screening, inclusion/exclusion criteria for numerators and denominators, and other issues.

Where to Find EBIs

Evidence-informed evaluations from your partners (e.g., NBCCEDPs), **The Community Guide**, **NCI's Evidence-Based Cancer Control Programs**, and **Cochrane Reviews**.

For information and tools on implementing and adapting strategies to fit your location, see the **CDC's Evidence-Based Intervention Planning Guides** and the training, "**Putting Public Health Evidence Into Practice.**"

More Cervical Cancer Resources

- **National Breast and Cervical Cancer Early Detection Program**
- **CDC's Inside Knowledge About Gynecologic Cancer Campaign**
- **CDC's Cervical Cancer Survivor Stories**
- **CDD's Face Your Health** an educational outreach program to encourage African American women to get screened for cervical cancer
- **Measuring Breast, Cervical, and Colorectal Cancer Screening Rates in Health System Clinics (CDC)**
- **ACS National Roundtable on Cervical Cancer**
- ACS **2021 Messaging Guidebook: Effectively Messaging Cancer Screening During the COVID-19 Pandemic**
- ACS **Promoting Cervical Cancer Screening During the COVID-19 Pandemic**
- President's Cancer Panel Closing Gaps in Cancer Screening: **Cervical Cancer Brief**
- **HPV and Pap Test Results: Next Steps after an Abnormal Cervical Cancer Screening Test - NCI**

Worksheet: Questions to Ask and Answer

Use this worksheet to help you and your coalition partners focused on cervical cancer to identify best pratices, gaps, opportunities, and challenges that should be reflected in your CCC plan objectives and strategies. Record your answers and use the information to help inform your selection of objectives and strategies for your updated plan.

1. Overall, how are we doing in cervical cancer screening compared to the national rates, our neighboring states, and our own rates in previous years?

- What primary objectives do we want to set, given our analysis of this data?

2. In what specific populations or communities are the screening rates lagging? Do we know why? If we do not know why, how do we find out?

- What health disparity objectives do we want to set, given our analysis of this data?

3. What partners can we engage to help implement policy and system changes to support cervical cancer screening uptake over time? Do we have existing connections with them? How can we engage these partners? Why will they want to be involved? What is the value proposition for them?

- What strategies should we select, given the answers to the questions?

4. Are cervical cancer screening services easily accessible to all populations? Is there a geographic area or sub-population with less convenient access or greater barriers to accessing services?

- What strategies should we select, given the answers to the questions?

5. What existing services, networks, or programs could we leverage to increase cervical cancer screening rates?

- What strategies should we select, given the answers to this question?

6. What policies do we want to advocate for or promote to help increase cervical cancer screening?

- What strategies should we select, given the answers to this question?

7. What gets measured is what gets done: How can we best track cervical cancer screening outcomes? How do we know we are making progress along the way?

- Are there strategies we should select related to the answers to these questions?

8. What and how do we communicate these results to policy-makers, along with a “one voice” recommendation for increasing rates?

- Are there strategies we should select related to the answers to this question?

9. How will the strategies we selected optimize health outcomes for those who have historically experienced health outcome disparities (or populations of focus)?