

NAPCRG 52nd Annual Meeting — Abstracts of Completed Research 2024.

Submission Id: 6693

Title

Pap-HPV co-testing adoption trends for cervical cancer screening in a multi-state Practice Research Network (PBRN) 2012-2017

Priority 1 (Research Category)

Health Care Disparities

Presenters

Michelle Shin, PhD, MPH, MSN, RN, Imara West, MPH, Chialing Hsu, MS, Maria Prado, MPH, Jennifer Tsui, PhD, MPH, Linda Ko, PhD, Rachel Winer, PhD, MPH, Allison Cole, MD, MPH

Abstract

Context: In 2012, the United States cervical cancer screening (CCS) guidelines changed to add co-testing (Papanicolaou [Pap] and human papillomavirus [HPV] test) to Pap-only. Little is known about variation in adoption of CCS modalities in federally qualified health centers (FQHCs) in communities where cervical cancer disparities persist. Objective: Describe adoption of co-testing as a CCS modality in FQHCs serving socioeconomically disadvantaged populations. Study design and analysis: In this observational study, we compared the distribution of screening modalities by 1) FQHC and year and 2) patient characteristics by screening modalities using chi-squared and t-tests. Setting or dataset: Electronic health record data from 25 primary care clinics in 3 FQHCs in Washington and Idaho PBRN from 2012-2017. Population Studied: Average-risk females ages 21-64 with ≥ 1 medical encounter and ≥ 1 routine CCS during 2012-2017. Intervention/instruments: N/A Outcome measures: Proportion of CCS with Pap-only, co-testing (Pap and HPV testing occurring within 30 days), and HPV-only. Results: From 2012-2017, 19,555 CCS were performed across 3 FQHCs, and the proportion of CCS with Pap-only decreased from 99.6% to 52.5%, co-testing increased from 0.4% to 46.7%, and HPV-only from 0.1% to 0.8%. Though co-testing increased steadily across 3 FQHCs, the proportion varied across organizations, ranging from 19.7% to 60.8% in 2017. Among 12,506 screened average-risk individuals, the mean age was 39.0 and 86.3% were White, 16.0% Hispanic or Latino, 30% rural and 27% not insured. Compared to individuals screened with Pap-only, those screened with co-testing were significantly older and more likely to be American Indian or Alaska Native (1.5% vs 0.6%, $p < 0.001$), Black or African American (3.4% vs 2.5%, $p < 0.001$), multiple race (0.3% vs 0.1%, $p < 0.001$) and Hispanic or Latino (28.5% vs 11.6%, $p < 0.001$), live in urban areas (87.3% vs 59.4%, $p < 0.001$), and be insured (83.5% vs 69.3%, $p < 0.001$). Conclusions: Significant variation in

adoption of co-testing across multi-state PBRN may reflect disparate access to CCS and HPV testing among subpopulations and FQHCs. Failure to adopt HPV testing, which is more sensitive than Pap-only for detecting cervical precancers, may exacerbate existing disparities. As new screening modalities emerge (e.g., HPV self-sampling), multilevel interventions that are tailored for both clinic and patients' needs will be critical to advance equitable access to CCS.

Downloaded from the Annals of Family Medicine website at www.AnnFamMed.org. Copyright © 2024 Annals of Family Medicine, Inc. For the private, noncommercial use of one individual user of the Web site. All other rights reserved. Contact copyrights@aafp.org for copyright questions and/or permission requests.