# THE KRAFT CENTER

#### for Community Health Leadership

#### Trefler Program for Cancer Equity: Two Year Progress Report

August 3, 2017

With the generous support of the Trefler Family Foundation, the Kraft Center for Community Health Leadership has lead three projects to address cancer-related inequities in uniquely marginalized communities. The updates below outline the efforts that are underway at Boston Healthcare for the Homeless, MGH Charlestown HealthCare Center and Fenway Health.

#### Addressing cancer disparities by improving cervical cancer screening at Boston Health Care for the Homeless Program (BHCHP): Cassis Henry, MD

**The Problem:** Cervical cancer is more common and more deadly in homeless women. The starting point of this past year's work, funded by the Trefler Foundation, is research that demonstrated that homeless women have a four-fold higher risk of developing cervical cancer and that they are six times more likely to die from it. Our program has been unable to maintain the strides we had previously made in increasing cervical cancer screening (from 19% to 54% of eligible patients in six years), despite numerous initiatives. We recognized that a new approach was needed, based in a clearer understanding of the barriers to achieving this goal. Understanding both the need for and difficulty of screening more women, the goal of this project has been to improve cancer screening rates by improving both access to screening and the quality of the screening. By doing this, we hope to identify earlier women who may need follow-up and treatment for cervical lesions and, by doing so, increase their survival.

**Project Overview:** First, I aimed to understand provider and nurse perceptions regarding current barriers to cervical cancer screening in our program, as well as competing priorities for providers and patients at the clinical level. I interviewed 15 physicians, nurse practitioners and registered nurses at the Pine Street Inn, the MGH Homeless Clinic, the Woods-Mullen Shelter, the Shattuck Shelter and the Southampton Street Shelter. This group included clinicians achieving high rates of screening amongst their patients and clinicians with the lowest screening rates, in order to understand their approach to the patient and the perceived barriers to screening. With the five highest-performing clinicians, I focused on learning about their particular strategies for screening patients thoroughly with the same limited resources shared across the studied locations.

Second, I developed research protocols with researchers from the Dana Farber Cancer Institute and Harvard School of Public Health for qualitative interviews, which will be completed with 50 patients at a variety of sites, looking at their knowledge of cervical cancer, their experience of barriers to being screened, and their willingness to accept an alternative to the standard Pap smear—a non-invasive, painless and self-administered test called the "self-swab"—which could be adapted as an alternative for women who do not consent to Pap testing. The protocols developed include further and more in-depth interviews with primary care clinicians across the program.

As a test case, I focused on Pine Street Inn —one of the shelter-based women's clinics where I work with a current cervical cancer screening rate of 46% — to develop process improvements within the clinic which might be generalizable.

**Progress to Date:** We have focused on: 1) increasing pre-visit outreach to women identified as in need of screening, and 2) working with the shelter staff to increase its guests' knowledge of and use of the clinic's services. The shelter collaboration has allowed us to offer a guaranteed shelter bed, among other incentives, to women who are screened.

I organized and led a Grand Rounds with continuing medical education (CME), accredited by Boston Medical Center, and attended by 50 clinicians. The Grand Rounds related to trauma-informed approaches to the Pap smear, and focused on helping clinicians to approach and perform Paps in a manner that is more likely to achieve consent, and which recognizes and respects our patients' trauma experience.

Interest in my project generated through the presentation of my Trefler work at our General Staff meeting for 150 employees helped motivate the rebirth of the Women's Health Initiative at BHCHP, of which I am the sole psychiatry representative. Through this initiative, BHCHP "champions" work to identify PDSA cycles for improvement — which includes developing a plan to test the change (Plan), carrying out the test (Do), observing and learning from the results (Study), and determining what adjustments should be made to the test (Act) —for both cervical cancer screening at heterogeneous sites and for a weekly women's health clinic that provides behavioral health and access to cervical screening in a woman-friendly environment. Through these continuing efforts, I have participated in improving the screening of the more than 2,000 women served by our program.

#### Colorectal Cancer Screening at the Charlestown HealthCare Center: Carolina Abuelo, MD, MSc

**The Problem:** There are significant disparities in cancer screening rates in patients with mental health (MH) disorders and/or substance use disorder (SUD) who receive care at the Mass General Charlestown HealthCare Center. Patients with these conditions are much less likely to be screened for cancer. For example, 85% of all female patients receiving care in the Mass General Charlestown location have had their Pap smears, but only 59% of female patients with MH or SUD who visit the Charlestown HealthCare Center are up to date with their Pap. Similarly 84% of patients at the Charlestown HealthCare Center have had their mammogram in the last two years, but that statistic drops to 54% for patients with MH and/or SUD. Perhaps the most startling statistic relates to colorectal cancer screening: 80% of the Charlestown HealthCare Center's patients who are due for a screening, received one, but that statistic drops to 30% for patients of the same Center with MH and or SUD.

**Project Overview:** The colorectal cancer disparity is particularly impressive and there is not a great deal of experience navigating this population. In addition, little is published about navigation with peer support personnel, who are very active with our patients with SUD in Charlestown. Therefore, with the generous support of the Kraft Center, we cross-trained our SUD peer support specialist in colorectal cancer navigation. The goal of this cross training was to enable this individual to navigate SUD patients who need colorectal cancer screening. Additionally, this generous award, along with support from navigators in the MGH Chelsea HealthCare Center, also allowed the team to enhance the training of the three new patient navigators at the Charlestown HealthCare Center to include colorectal cancer screening. This process lead to a pilot effort to extend navigation services to other patients from the

Charlestown HealthCare Center. These additional services were provided by the skilled group of patient navigators already working at that location.

According to our preliminary data, there were approximately 700 patients with MH and/or SUD, of which 380 are eligible for colorectal cancer screening. Our experience in prior patient navigation interventions for colorectal cancer screening is that one, full-time patient navigator can reach approximately 300 patients over a nine-month period. For this pilot, we anticipated enrolling 200 patients and navigating them to colorectal cancer screening. The remainder would be navigated at the end of the study. We then assess rates between groups.

First, this part of the study received institutional review board (IRB) approval in 2016. Then, the peer support specialist and the Charlestown HealthCare Center patient navigators received further training with the experienced cancer navigators in Chelsea. We anticipated some challenges with navigation of this population, which is often difficult to reach. To address this, I met with our navigators on a weekly basis to both review cases, including the medical background, and to practice motivational interviewing skills and.

**Progress to Date:** Our collaboration with the peer support staff at the **Chelsea** HealthCare Center was helpful in both extending the reach of our services, as it allowed us to screen more vulnerable patients and decrease disparities, and it exposed our navigators to best practices for successful navigation, including: strategy of contacting patients at odd hours – Saturdays and Wednesday evenings — in order to make the first contact necessary to accompany them to their appointments. We also discovered strategies for operational improvement, for example, using a driver from the Charlestown HealthCare Center to pick up the fecal occult blood cards that we sent out to patients who declined a colonoscopy, but agreed to at-home screening. Through this process, and after reviewing patient charts, we became aware of the high risk population we were serving. . During the pilot period, one patient died of a drug overdose, another was sent to prison, another four individuals were diagnosed with other cancers. Unfortunately, one of those four individuals died of his cancer.

The preliminary results of the pilot program are included below:

- 21 colonoscopies were completed
- 6 patients completed fecal occult blood testing
- The SUD peer support specialist reached out to five patients, however none accepted his offer of support

**Next Steps:** Our next steps are offering navigation to the remaining patients and to disseminate our results. In fact, we just got a poster accepted for Community Research Day in Chelsea this fall regarding our findings.

The team hopes to capitalize on the training and experience the patient navigators and SUD peer support specialist received in the last year. We are now hoping to apply the innovative techniques learned through this pilot to increase cervical cancer screening in populations in Charlestown that are difficult to reach. The Charlestown patient navigators and SUD peer support specialist are poised to address disparities in Pap testing by offering an at-home test for Human Papilloma Virus (HPV), which is the cause of abnormal Pap tests and cervical cancer. If patients can provide a sample by obtaining it in the comfort of their own home, we may be able to dramatically increase screenings. We have gained

some momentum by obtaining the support of Dr. Jim Morrill, our medical director, and Dr. Josh Metlay, who is Chief of the Division of General Internal Medicine. We are happy to discuss our progress and lessons learned in greater detail. Again, we are grateful for the support of the Trefler Foundation.

#### Enhancing human papillomavirus (HPV) screening and vaccination to prevent squamous cell carcinoma among sexual and gender minority patients at Fenway Health: Alex Keuroghlian, MD, MPH

The Problem: Screening for anal HPV and pre-cancer is limited in the absence of evidence-based guidelines. Cervical cancer, for which there are evidence-based screening guidelines, has an annual incidence in the United States of 12,990 and causes 4,120 deaths per year. In contrast, anal and oropharyngeal cancer, for which there are no consensus guidelines, have annual incidences in the United States of 8,080 and 48,330, respectively, and respectively cause 1,080 and 9,570 deaths each year. Unlike cervical cancer, for which incidence has been steadily declining in recent years, HPV-associated anal and oropharyngeal cancer incidences are on the rise, particularly among sexual and gender minority patients. There is variability among Fenway Health providers in anal cancer screening practices, and poor screening adherence among Fenway Health patients. Uptake of the HPV vaccine is especially low among sexual and gender minority patients, despite higher risk for HPV-associated cancers. The goal of this project is to develop, implement, and evaluate a combined patient- and systems-level intervention at Fenway Health that will increase anal HPV screening and HPV vaccination rates among our patients.

#### Progress to Date:

- Designed a multi-component protocol approved by Fenway Health's institutional review board (IRB), which includes:
  - Electronic Health Record (EHR) audit
  - o Eight focus groups
  - Electronic Primary Care Provider (PCP) survey.
- Built a database with two cohorts of Fenway Health patients from the EHR:
  - One cohort of patients who are HPV vaccine-eligible,
  - One cohort of patients who have anal high-grade squamous intraepithelial lesion (HSIL) precancerous change to the skin of the anal canal or perianal area.
- Eight focus groups with a total of 29 participants were completed on September 2016. Qualitative data to identify patient-, provider- and systems-level barriers to anal cancer screening and vaccination uptake was collected. The results of these focus groups are currently being prepared for dissemination in the scientific journals listed below:
  - Apaydin, K.Z., Panther, L., Shtasel, D., Dale, S. K., Latham, C., Mayer, K., Keuroghlian, A. *Anal HPV* Screening Facilitators and Barriers among Men who Have Sex with Men (In Preparation)
  - Apaydin, K.Z., Fontenot, H., Shtasel, D., Dale, S. K., Latham, C., Mayer, K., Keuroghlian, A. Facilitators and Barriers of HPV Vaccination among Sexual and Gender Minority Patients (In Preparation)

- The electronic PCP surveys of 33 providers were completed on November 10, 2016. The survey assessed the providers' rationale for their individual anal cancer screening practices, their perspectives about barriers to anal cancer screening adherence, and individual differences in practice regarding HPV vaccine recommendations. The results of these surveys are currently being prepared for dissemination in scientific journals.
  - Apaydin, K.Z., Gonzalez, A., Shtasel, D., Latham, C., Mayer, K., Keuroghlian, A. *Perceptions and Practices of Primary Care Providers on HPV-related Cancer Prevention Utilization at an Urban Community Health Center* (In Preparation)
- The EHR Audit assessing patient-, provider-, and systems-level predictors of adequate HPV vaccination and HPV screening among patients was completed on December, 2016. Factors assessed by chart audits include psychiatric, addictions-related, and structural variables, as well as the overall level of engagement in primary care. The data is currently being analyzed.
  - Apaydin, K.Z., Borba, C., Panther, L., Shtasel, D., Latham, C., Mayer, K., Keuroghlian, A. Predictors of Adherence to Recommended High Resolution Anoscopy Among MSM who are at High Risk for Anal Cancer (In Preparation)
  - Apaydin, K.Z., Borba, C., Fontenot, H., Shtasel, D., Latham, C., Mayer, K., Keuroghlian, A. Predictors of HPV Vaccine Completing among Sexual and Gender Minority Patients at an Urban Community Health Center (In Preparation)

**Next Steps:** From these three project components and their publications:

- Develop standardized health center-wide guidelines for HPV vaccination and anal HPV screening (anal Paps and HRA recommendations) for Fenway Health's PCPs
- Disseminate above guidelines nationally through Fenway Health's National LGBT Health Education Center,
- Develop patient education and awareness materials on HPV vaccination among young SGM and anal HPV screening among SGM,
- Disseminate screening guidelines nationally through Fenway Health's National LGBT Health Education Center.

# CASE PRESENTATION: CERVICAL CANCER SCREENING IN HARD-TO-REACH POPULATIONS

Cassis Henry, MA, MD Kraft Practitioner--Trefler Trainee



# OUTLINE

Cervical cancer and homeless women

# 

Boston Health Care for the Homeless Program & Family Team at BHCHP

- Patient story
- Lessons learned

# Cervical cancer, screening and homeless women

- $\Box$  Cervical cancer incidence: 4.4x higher than the general population<sup>\*</sup>
- Mortality: 6 x more likely to die from cervical cancer than those in the general population
  - Low rates of cervical cancer screening
    Delayed diagnosis ->increased mortality
    Barriers
  - Barriers to treatment

\*Baggett et al., Disparities in Cancer Incidence, Stage and Mortality at Boston Health Care for the Homeless Program . Am J Prev Med 2015;49(5):694–702.





**BHCHP** □ Since 1985 ■ 12,000 individuals a year, 60+ sites Family Team Outreach



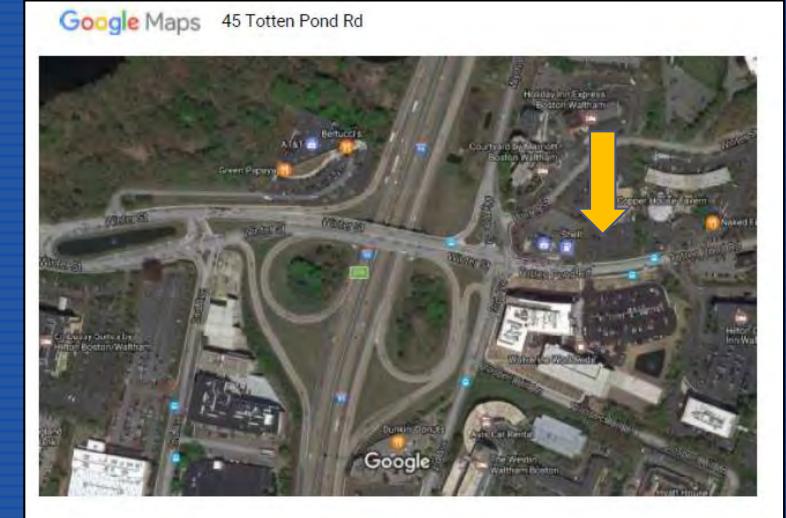






- Integrated team: Case managers, MDs, NP, PA, RN, behavioral health
- 11 locations: family shelters, DV shelters in Boston and hotel/motel shelters in suburbs
- Treating adults and children

# Context of care: Motel





# Context of care: clinic/motel room



# Patient story

- □ 39 yo refugee from DRC, single mother of 8, homeless with her family
- Latent TB infection, DM
- Engagement with health care
  PAP SMEAR
- Next steps
- Present



# Lessons learned





# Acknowledgements

- BHCHP Family Team
- Harriet Tolpin & Derri Shtasel
- Jessie Gaeta & Esther Valdez
- Trefler Family Foundation
- Kraft Foundation

Navigation with peer support to address disparities in colorectal cancer screening

> Carolina Abuelo MD MSc 1/2017

- Charlestown
- Navigation
- Current project
- Challenges and future directions



# Origins

- Thomas and Jane Walford
- Mishawam
- 1775
- 1860's Irish



# Charlestown

- population 16,439
- 1.4 mile square



- minority population :23.5% up from 4.9% in 1990.
- community health assessment (2012):
  - Substance use and its impact on violence and public safety
  - Cancer prevention described as access to screening.

# Screening rates in patients with MH or SUD

- Cervical CA: 59% vs 85%.
- breast CA: 54% vs 84%
- CRC: < 30% vs 80%

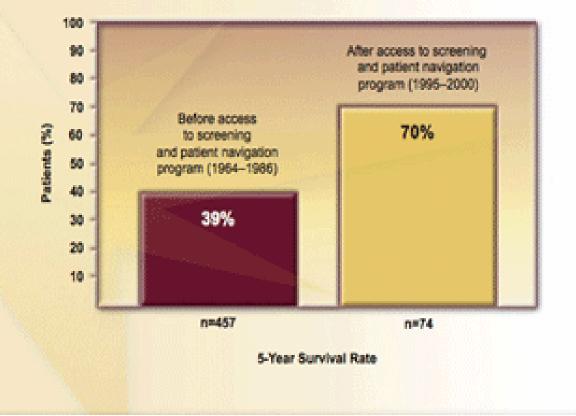


# **Patient Navigation**

- Initially piloted in the 1990s in Harlem
- Typical barriers
  - Financial
  - Communication
  - Medical system barriers
  - Psychological barriers
  - Other
    - transportation
    - child care

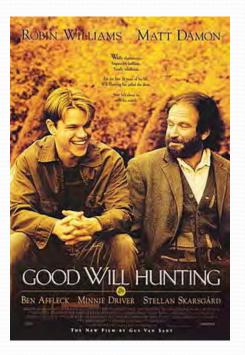


## Harlem Hospital Center: Improved Access to Screening and Patient Navigation<sup>13</sup>



# 700 patients with mental illness and/or SUD

- 380 eligible for CRC
- 175 for cervical
- 155 for breast



# **Peer Navigator**



# Thanks!

- Jim Morrill MD
- Sanja Percac Lima MD
- James Meigs MD
- Mallory Collins
- Colleen Daly
- Karen Winkfield MD
- The Kraft Center
- Carmen Horne and Anthony DeFilippo

- Silvestre Valdez
- JosepVicente
- Debbie Merowski
- Efrain Lozada
- Jeannie Bernhart
- Lorenzo Lewis
- Dr. Derri Shtasel
- Harriet Tolpin



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# Enhancing HPV Screening and Vaccination to Prevent Cancer among Sexual and Gender Minorities

Alex S. Keuroghlian, MD MPH

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# Background:

- Among sexual and gender minorities (SGM), anal and oropharyngeal HPV is highly prevalent;
- High-risk HPV (HR-HPV) associated with majority of anal (90%) and oropharyngeal (70%) cancers;
- U.S. incidence (56,400) and mortality (10,600) increasing, particularly among SGM;
- Cervical cancer annual incidence is 13,000 and mortality rate is 4,100.

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# Background:

- No evidence-based guidelines for anal HPV screening;
- Variability among Fenway providers in anal cancer screening;
- Poor anal cancer screening adherence among patients;
- Young SGM have lower HPV vaccine uptake, despite higher risk.

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# Proposed Cancer Prevention Initiative:

To develop, implement, and evaluate patient-, provider- and systems-level interventions at Fenway that will increase HPV screening and vaccination among sexual and gender minorities.



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# Project Components in 2016:

- Electronic health record (EHR) chart audit
- Patient focus groups
- Primary care provider electronic survey

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# EHR Chart Audit:

- To evaluate predictors of HPV screening adherence among Fenway patients with anal High-Grade Squamous Intraepithelial Lesions (HSIL);
- To evaluate predictors of HPV vaccine uptake by eligible Fenway patients.

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HPV Screening Cohort (227 charts completed):

- diagnosed with HSIL by Pap smear, High
  Resolution Anoscopy (HRA) and/or biopsy
- had an HRA appointment between 4/1/2011
  and 3/31/2016 (1,900 patients)
- identify as lesbian, gay, bisexual, something else and/or transgender

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HPV Vaccine Cohort (319 charts completed):

- offered HPV vaccine between 4/1/2011 and
  3/31/2016 (22,000 patients)
- ages 18 to 26
- identify as lesbian, gay, bisexual, something else and/or transgender

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# **Built New Database to Assess:**

- Demographics
- Behavioral health
- Social history
- Engagement in care
- Sexual risk
- HPV vaccination
- Anal Pap history
- HRA history

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# **Demographics:**

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Demogr	aphics	Beha	vioral	Health	Soci	al History	Engag	gemen	t in Care	s	exual	Risk	HP	V Vax	Anal Pa	p	HRA				
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# **EHR Information Assessed:**

Current:		Diagnoses:	
Alcohol use	Disorder diagnosis	Posttraumatic stress disorder diagnosis?:	
Tobacco use	Disorder diagnosis	Anxiety disorder diagnosis?:	
Amphetamines Use	Disorder diagnosis	Mood disorder diagnosis?:	
Crack/Cocaine Use	Disorder diagnosis	Personality disorder diagnosis?:	
Opiates Use	Disorder diagnosis		
Benzodiazepines Use	Disorder diagnosis	Service Utilization:	
🔲 IVDU Use	Disorder diagnosis	Psychotherapy (MSW/LMHC)?:	
Cannabis Use	Disorder diagnosis	Psychopharmacology Prescription?:	
Other Use	🔲 Disorder diagnosis	Psychiatrist?:	
Specify:		Substance Abuse Treatment Program?:	-
None Indicated		Residential/PHP/IOP?:	
ver:		Suboxone/Buprenophrine/Methadone/	
Alcohol use	Disorder diagnosis	Naltrexone prescription?:	
Tobacco use	Disorder diagnosis	In-patient mental health treatment?:	
Amphetamines Use	Disorder diagnosis		
Crack/Cocaine Use	Disorder diagnosis	History of suicide attempt?	
Opiates Use	Disorder diagnosis		
Benzodiazepines Use	Disorder diagnosis	Notes about substance use:	
IVDU Use	Disorder diagnosis		
Cannabis Use	Disorder diagnosis		
Cther Use	Disorder diagnosis		
Specify:			

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# Social History:

emographics Behavioral Hea	th Social History	Engagement in Care	Sexual Risk	HPV Vax	Anal Pap	HRA
History of unstable housing?:						
Employment status:	-					
Education level:		•				
Income by FPL%:	1	-				
History of sex work?:		•				
History of physical abuse?:		-				
History of sexual abuse?:						
Health Insurance:		-				
Accessed case management services at Fenway:		•				

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# **Engagement in Care:**

emographics Behavioral Health Social History Engagement in Care	Sexual Risk HPV Vax Anal Pap HRA
Primary Care Appointments:	
Number of primary care appts in the study period:	
# of primary care appts marked "complete":	
# of primary care appts cancelled by patient:	Cancel %:
# of primary care appts where patient DNKA:	DNKA %:
Behavioral Health Appointments:	
Number of BH appts in the study period:	
# of BH appts marked "complete":	
# of BH appts cancelled by patient: Cancel %	6:
# of BH appts where patient DNKA: DNKA %	
Number of times came in for an STI screen (days had and HIV, chlam gonorrhea, syphilis tests in the study period):	ydia,
Vaccinations:	
Did the patient receive any of the Hep B Vaccinatons?	
If yes, was the series completed (all 3 shots administered)?	<b></b>
Did the patient receive any of the Hep A Vaccinatons?	
If yes, was the series completed?	

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# Sexual Risk:

Demographics	Behavioral Health	Social History	Engagement in Care	Sexual Risk	HPV Vax	Anal Pap	HRA		
Sexual Part Number of Condom or sexual inter PrEP Utiliza HIV Diagnos HIV Diagnos HIV Ser reportin HIV Diag	mer History: sexual partners: barrier use during rcourse: tion: sis and Viral Load		Engagement in Care	STI	Diagnos Chlamy Gonorri Syphilis Human Genital Hepatit Pelvic I Anogen Trichon None	es: dia hea Papillomav Herpes dis C (HCV) nflammato nital warts noniasis diagnose b results	rirus (HPV ry Disease s come f	e (PID) from	
Most Re Detecta	ecent Viral load Date ble Viral load during dy period?								

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# **HPV Vaccination:**

emo	graphics	Behav	ioral Health	Soc	cial History	Engagement in Car	e Sexual R	sk	HPV Vax	Anal Pa	ap	HRA
$\angle$	HPVVaxDa	nte 👻	HPVNum	-	Vac	cine Name 🛛 👻	Reviewe	-				
*												

## Anal Pap:

Demographics Behavioral Health Social History Engagement in Care Sexual Risk HPV Vax Anal Pap HRA

🕗 AnalPapDate 👻	PapDiagnosis	-	PapDiagnosis_other	*	
*		-			

# HRA:

Demographics Behavioral Health Social History Engagement in Care Sexual Risk HPV Vax Anal Pap HRA

1	HRADate 🚽	Benign 👻	Anal Wart 👻	Anal Wart 🕞	· LSIL 👻	LSIL 👻	HSIL 👻	HSIL 👻	AIN2 -	AIN2 👻	AIN3 -	AIN3 👻	Other -	Other -	Other I 👻
*		III 🔲			- 🔳										

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# Patient Focus Groups (8 in total):

Heard from Fenway patients with high vaccine uptake and screening adherence, as well as patients with low uptake/adherence, to identify patient-, provider- and systems-level barriers.

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# Screening Focus Groups (4 in total):

"It would be nice to have a specific setup for that, because it seemed like I was just free floating, and if they had to take a biopsy, that would sting a little bit, and you would move out of position. But if it had some kind of table or something that would hold you in place, I just felt uncomfortable. Like, a GYN doctor has the stirrups and they're in place. It's kind of like you're just on -- happen to be on a table. And I think there was nothing to hold on to. And so I think of it as not very comfortable, but they have to take a biopsy. So, but it'd be nice if they had some kind of position, a better position that would be more consistent."

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# Vaccine Focus Groups (4 in total):

"I think it was -- it was first marketed as towards, you know, cis[gender] women, right? You know, biological females born as female sex. And later on, it came out as, you know, it can help biological males, too. And I think with that, it just applies to human beings in general. Anyone who is susceptible to the various cancers that it could maybe prevent can benefit from it. [...] maybe people have this sort of, this view of HPV and Gardasil vaccine as being for women only. And maybe they could do a better job at kind of tailoring that towards more of a universal, you're a human being, and people have cancer risks. You want to protect yourself."

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Primary Care Provider Electronic Survey and In-person Meeting (33 PCPs):

Assessed the rationale for PCP's individual HPV screening and vaccination practices, as well as their perspectives about barriers/facilitators for screening and vaccination.

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# Next Steps:

- Dissemination of results
- Developing standardized HPV screening protocol through convening of PCPs
- Implementing and evaluating patient health education program
- Additional systems-level interventions

# THANK YOU!