HPV Self Sampling Symposium Facilitated Brainstorming Session Results

Moderated by Baingroup Consulting

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October 2016

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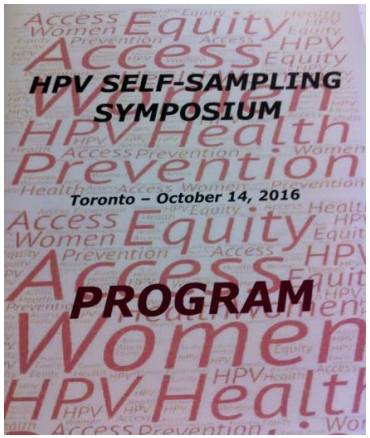


Rational Aim of Dialogue: To determine what is needed to adopt HPV self-sampling across Canada.

Experiential Aim of Dialogue: For participants to explore the research evidence and experience of other jurisdictions in utilizing HPV self-sampling and to discuss what is needed to implement HVP self-sampling across Canada.

Timing: 1 hour

Process: In groups, two tables per group, participants will move around the room answering a series of 6 questions posted on the walls. Participants will have large markers and 20cm x 15cm post-it notes to write down their ideas in answer to the questions. Each group will be assigned a beginning question. For the first question groups will have 10 minutes to discuss the question, document their ideas on the post-its and stick them on the template reporting chart. The Facilitator will ask groups to move clock-wise around the room to the next question, they will be given 7 minutes to read the comments made by the last group and add their own new ideas. This process will continue with groups having 5 minutes at each remaining chart, until each group has input their thoughts on each question chart. At the end, groups will be asked to return to their original chart and review all of the ideas that have been posted. The Facilitator will then ask each group to summarize the group's collective ideas regarding that question.

Documentation: The group responses documented on each question chart have been transcribed below for inclusion in the final report.

Q1: What are the knowledge gaps and what further research is needed to advance the use of HPV self-sampling across Canada?

- economic analysis of self-sampling
- optimal and responsive triage testing - keeping pace with new technologies, e.g. biomarkers
- how to provide follow-up for remote communities
- role of different funders, re indigenous populations
- is HPV self-screening non-inferior to clinician HPV screening?
- training of NP and GP colposcopists - virtual coloposcopy?
- delivery of self-sampling kits
- how to scale the top and spread implementation strategies
- feasibility of self-sampling within an organized programmatic setting - screening program
- implementation strategies to maximize benefits while minimizing harms - e.g. within organized programs
- stability of sampling kits - temperature, humidity, travel time
- economic analysis – primary HPV screening versus PAP versus clinicians screen
- follow-up of abnormal after positive self-test in a Canadian setting
- HPV types beyond IGC13, can be regional
- flow cytotechs will respond to HPV positive samples
- knowledge / impatience for screening uptake
- engagement and understanding of different communities
- one community can have one recommendation while others might have 10
- what are the opportunities with other technologies? What is the difference using RNA DNA?
- what is the optimal way to communicate to women?
- women who get self-sample what is lost in the process?
- not enough economic research in HPV self-sampling

Q2: What resources are needed to implement HPV self-sampling in your province or program?

- timely follow-up for positive results
- more clarity on the data
- resources are present, especially the cytology ones but there is still evidence and need more data
- in British Columbia, like most provinces, need centralized life cancer data. We can extend the screening intervals. If data is available properly
    - automated data
    - practitioners and population understanding HPV, women should engage properly
    - location of cancer registry and HPV screening
- having people committed to screening, who never had the test before
- more organization
- government needs to provide support nationally and regionally
- funding
- increase capacity and system to process
- increased volume of testing and follow-up of abnormal results
- central coordination of translation for materials
- better EMR system that integrates with registries *
- indigenous peoples engagement and support (OCAP)
- buy-in from other marginalized communities (indigenous, immigrant, etc.)
- include sociodemographic data
- logistics data – temperature, dry versus wet sample
- KTE with other jurisdictions
- fee disincentives, fee incentives for guideline adherence *
- simple and clear instructions for collecting owns sample *

- public and clinician engagement and education - this is very hard - where and how
- centralized lab services *
- first adoption of primary HPV screening in Canada
- organized colposcopy services that work with screening programs
- better information systems - registries with linkages
- fully organize screening programs
- follow-up algorithms with five follow-up rates
- ability to identify eligible populations - i.e. unscreened women

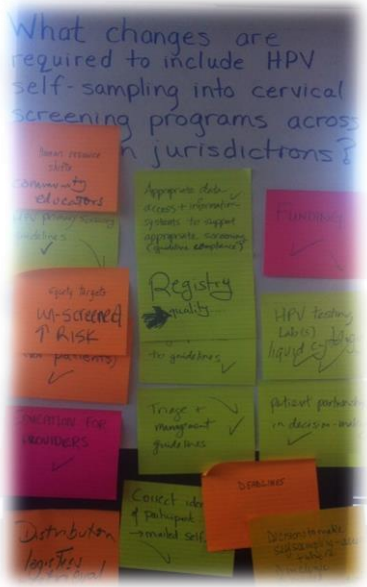
Q3: What changes are required to include HPV self-sampling into cervical screening programs across Canadian jurisdictions?

- Human Resource shifts
- community educators
- distribution logistics and retention evaluation
- equity targets
- unscreened increased risk
- HPV screening guidelines **
- education for patients **
- education for providers *
- triage and management guidelines **
- correct identification of participants - mailed self-samples *
- funding **
- deadlines
- decisions to make self-sampling - access and where
    - in clinic
    - mailed

  - other community sites, e.g., pharmacy
- patient partnership in decision-making *
- HPV testing labs - liquid cytology **
- registry quality
- strategies to align practiced guidelines *
- appropriate data access and information systems to support appropriate screening - guideline compliance *

Q4: What are the main takeaways from today and what are the next steps to move HPV self-sampling forward across Canada?

- gathering stakeholders in building consensus among cytopathologists, primary care, OBs, women's groups and others is important
- hard-to-reach greatest benefit
- importance of knowledge sharing
- better understanding of unscreened populations
- what about women who self-sampling can't reach?
- confident, with evidence to date for self-sampling
- who do we not need to reach
- clear pathways to colposcopy for those screening positive
- all women want self-testing
- education for women and providers, including self-efficacy
- next steps
  - clear guidelines - whose to follow
  - address the different settings in Canada
  - determine age, interval, who to target, triage
  - no more efficacy studies
  - implementation studies



    - meaningful engagement of clinicians
    - peer educators/community health workers – well-resourced and engaged
- family medicine resident education – EBM, practice
- not opportunistic, organized
- net benefit
- strong evidence
- increased uptake balances decreased sensitivity
- over screening is a danger
- will cervical cancer incidence be lower? Need surveillance, outcomes, evaluation
- all women in Canada need access to the same standard of HPV screening
- co-testing
- guidelines and evidence for HPV testing for primary care
- need to focus, who cannot be reached, not those who have been reached
- self-collection is a way for immigrant women, low income women and less educated women by looking at today's presentation
- how you can advocate for HPV sampling for women from low or high income countries?
- over screening by healthcare practitioners is an issue