

State of Michigan

**Governor's Task
Force on Cervical
Cancer
Report**

September 30, 2006

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Executive Summary

THE PROBLEM

Although rates of cervical cancer in both the United States and Michigan have fallen significantly in the 70 years since the introduction and wide adoption of the Pap test, women continue to develop and die from invasive cervical cancer. Up to 70 percent of women who die from cervical cancer have either never had a Pap test or have not had a Pap test in the five years prior to the development of cancer. Many of the women developing invasive cervical cancer are older, may be members of minority groups, and are likely to not have a regular source of health care. The following data underscore these issues:

- According to the 2004 Special Cancer Behavioral Risk Factor Survey, of Michigan women age 40 and older who had not had a Pap test in the past 5 years, nearly 25% listed “not knowing they needed one” as their reason.
- Only 65% of women age 19-64 enrolled in Medicaid had Pap testing in a 3-year period. This is a combined figure for Fee-for-Service (FFS) and Managed Care Plans.
- The Michigan Behavioral Risk Factor Survey found that women in the youngest age group (18-24) and those in the oldest group (65+) have the lowest screening rates.
- According to the Michigan Cancer Surveillance System, at the same localized stage of diagnosis (a stage with better prognosis), the survival rate for African American women with cervical cancer was lower compared to whites (88.4% vs. 92.8%).
- The Human Papillomavirus is responsible for 99+% of cervical cancer, and is sexually transmitted.
- Fifty percent of all sexually active persons will be infected with Human Papillomavirus (HPV), with most infections clearing quickly.
- Eighty percent of women 50 and older have been exposed to HPV.

CERVICAL CANCER TASK FORCE

In response to this problem, Governor Jennifer Granholm commissioned a statewide Cervical Cancer Task Force (CCTF). The Task Force was charged with developing and promoting a comprehensive statewide prevention plan for cervical cancer, including recommendations for public awareness of the importance of cervical cancer screening, appropriate HPV testing, and the Human Papillomavirus (HPV4) Vaccine.

The Task Force is composed of representatives from both the Michigan House of Representatives and the Senate; the American Cancer Society; a health maintenance organization; health insurers; the American College of Obstetricians and Gynecology; and a women’s health organization. Other members include an oncologist, a nurse-practitioner, an epidemiologist from the Michigan Department of Community Health, the Michigan Surgeon-General, a member of the Michigan Cancer Consortium’s Cervical Cancer Advisory Committee,

and the Department of Community Health's Medical Services Administration Director of Medicaid management (see Page 5 for a complete list of Task Force Members).

SUMMARY: TASK FORCE RECOMMENDATIONS

To develop and promote a comprehensive statewide prevention plan for cervical cancer, the CCTF, over the course of three meetings, created a plan and recommendations for cervical cancer control in Michigan. Components of this plan include recognition of programs and activities currently underway to improve cervical cancer early detection, and recommendations on statewide public awareness of the importance of cervical cancer screening and the HPV4 Vaccine. The CCTF also made recommendations to several existing groups and agencies who are currently working in the area of cervical cancer control in Michigan.

The following is a summary of recommendations by the CCTF; please refer to the full report for the complete recommendations, background information, and supporting data.

The Michigan Cancer Consortium's Cervical Cancer Advisory Committee (CCAC) should:

- Collaborate with the Michigan Advisory Committee on Immunizations (MACI) to develop age-appropriate, culturally sensitive provider and patient education messages about the use and limitations of the HPV vaccine.
- Work with the Primary Care Initiative (PCI) to develop provider and age-appropriate, culturally sensitive patient education messages, that stress the need for continued Pap and appropriate Human Papillomavirus (HPV) testing, and the need for protection against other sexually-transmitted infections, regardless of vaccination status.

The Primary Care Initiative (PCI) should:

- Develop effective strategies to increase both appropriate cervical cancer screening and follow-up for abnormal screenings in accordance with Michigan Cancer Consortium (MCC) guidelines, including strategies to reduce provider, health system and patient barriers to quality health care.
- Work with the CCAC to develop and coordinate cost-effective, on-going provider and public education on the need for regular Pap and appropriate HPV testing.

The Michigan Department of Community Health (MDCH) should:

- Recognize the Michigan Cancer Consortium's Cervical Cancer Advisory Committee as the medical experts for issues relating to cervical cancer and as the advisory committee on cervical cancer for the state of Michigan.
- Support the MCC *Guidelines for the Early Detection of Cervical Cancer* (See Page 36), which contain recommendations for Pap and HPV testing.
- Develop strategies together with the MCC and CCAC to reduce health disparities related to cervical cancer.

- Develop strategies for the Michigan Medicaid Program to increase Pap testing rates among its enrollees (FY05 rates were 22.2%).
- Work with the Michigan Cancer Consortium to submit an annual report to the Governor and the Michigan Legislature on Michigan cancer incidence and mortality, including the status of cervical cancer control in Michigan.
- Require that all publicly funded programs in Michigan adopt the ACIP recommendations for the HPV vaccine.
- Utilize January as Cervical Cancer Awareness Month to develop and promote age-appropriate, culturally sensitive public education messages directed to all women and health care providers about the importance of regular cervical cancer screening, appropriate HPV testing, and the HPV Vaccine
- Promote Plan First! as a valuable resource for cervical cancer screening for eligible women; Plan First! enrollment should be especially promoted to Michigan women and health care providers in urban areas.
- Support continuation of Behavioral Risk Factor Survey (BRFS) and Special Cancer BRFS in Michigan, with a county-level focus when possible, and an understanding of the benefits as well as limitations of these surveys.
- Increase awareness of the MI-Child Program.
- Assure that women with abnormal Pap tests who are clients of Title X/Family Planning have appropriate and affordable follow-up and diagnostic services.
- Assure that publicly funded programs offering cervical cancer screening services provide the continuum of services: screening, diagnostic testing, and treatment as may be needed.
- Assure immunizations are recorded into the Michigan Care Improvement Registry (MCIR), including HPV vaccinations.

State and Federal Government should:

- Support and adequately fund the MCC's Cervical Cancer Strategic Plan (Page 31) for improving cervical cancer early detection, including age-appropriate, culturally sensitive targeted public education.
- Educate Michigan employers and health care purchasers about the importance of prevention services, and encourage purchase of inclusive insurance packages for their employees.
- Increase funding to expand the Breast and Cervical Cancer Control Program (BCCCP) to serve more eligible women.
- Assure access to the HPV4 vaccine to all sixth grade girls, including funding for wide distribution.
- Recognize the essential function of, and support full funding for, the Michigan Cancer Registry.
- Support development and implementation of the Michigan First Healthcare Plan.
- Support Congress's reauthorization of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the addition of funds to the current budget.

The goal of the Cervical Cancer Task Force (CCTF) is to reduce cervical cancer incidence and mortality for Michigan women through policies that promote primary and secondary prevention. By 2010, it is expected that public policies will be in place that assure HPV vaccination for all sixth grade girls and that promote appropriate screening for all women.

The CCTF requests the Governor to reconvene the Task Force in September 2007 so that status reports on the recommendations can be presented by appropriate representatives from the Michigan Department of Community Health, the Primary Care Initiative, and the Michigan Cancer Consortium.

Task Force Members

Task Force Chair	Senator Deborah Cherry
Chair of the Senate Health Policy committee	Senator Beverly Hammerstrom
Chair of the House Health Policy committee	Representative Edward Gaffney
A representative of the American Cancer Society	Vicki Rakowski Executive Vice President of Medical Activities, ACS, Great Lakes Division
A representative of a health maintenance organization	Thomas Petroff, DO Gynecologist Medical Director, McLaren Health Plan, Lansing
Representative of the health insurance industry	Deborah P. O’Neal MD Blue Cross/Blue Shield of Michigan
Representative of the American College of Obstetrics and Gynecology	Lauren Zoschnick, MD Obstetrician/Gynecologist Assistant Professor, University of Michigan Health System
Representative of a women’s health organization	Melva Craft-Blacksheare CNM
Representative of Breast and Cervical Cancer Control Program	Robert Burack MD, MPH Karmanos Cancer Institute
Nurse practitioner	Nancy Berman, MSN, APRN, BC Michigan Council of Nurse-Practitioners
Epidemiologist from the Department of Community Health	Corrine Miller PhD, DDS State Epidemiologist and Bureau Director, Bureau of Epidemiology.
Surgeon General or designee	Kimberlydawn Wisdom MD
Oncologist and Member of the Michigan Cancer Consortium’s Cervical Cancer Advisory Committee	Carolyn Johnston, MD Gynecologist/Oncologist Chair, Cervical Cancer Advisory Committee Associate Professor, University of Michigan Health System
Department of Community Health’s Medical Services Administration director of Medicaid management or a designee	Paul Reinhart Medicaid Director

Staff	
Jean Chabut, MPH, BSN	Deputy Director Public Health Administration
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Coordinated Plan for Cervical Cancer Control in Michigan

Michigan Groups Working on Cervical Cancer:

- Michigan Cancer Consortium's Cervical Cancer Advisory Committee (CCAC)
- Michigan Primary Care Initiative (PCI)
- Governor's Task Force on Cervical Cancer (CCTF)

Issue:

The Cervical Cancer Advisory Committee of the Michigan Cancer Consortium (MCC), the Michigan Primary Care Initiative, and Governor's Task Force on Cervical Cancer should coordinate their cervical cancer control activities to enhance and coordinate their statewide efforts.

Background:

The MCC is a statewide, inclusive, broad-based partnership of public and private organizations that provides a forum for collaboration (i.e., communication, coordination, and the sharing of resources) to reduce the burden of cancer among the citizens of Michigan by achieving the Consortium's research-based and results-oriented cancer prevention and control priorities. The *Michigan Cancer Consortium Initiative 2005 Strategic Plan* addresses the most pressing cancer control and prevention priorities that exist in Michigan today. It encompasses what Michigan cancer control experts believe to be the most important actions that can be undertaken during the next few years to reduce the toll taken by the cancers that currently pose the greatest burden to Michigan citizens.

- The Cervical Cancer Advisory Committee of the Michigan Cancer Consortium (MCC) plan represents the collective wisdom of a wide range of individuals and organizations in Michigan, including nationally recognized cancer experts, state health care leaders, health care providers, insurers and representatives of community-based organizations, all working together to achieve a common objective: to eliminate mortality from cervical cancer in Michigan women. Strategies to address MCC priorities, including those related to cervical cancer control, have been implemented.

The Primary Care Initiative is a statewide, broad-based group of key stakeholders and other interested participants gathered to collaborate and to improve the system of delivery of prevention services and the management of chronic disease and/or other conditions in primary care settings throughout Michigan.

- The Governor's Task Force on Cervical Cancer is charged with promoting cervical cancer screening awareness in Michigan. The group, whose charge ends on September 30, 2006, will make recommendations on statewide public awareness on cervical cancer and the importance of cervical cancer screening. This includes the understanding of the cost and disease burden of cervical cancer in Michigan; the progress and activities underway to address cervical cancer in Michigan; recommendations on statewide public

awareness on the importance of cervical cancer screening and the HPV Vaccine; and the recommendation of state policy issues related to cervical cancer.

Objectives for consideration by the CCTF included:

- Encourage provider focus on preventive medicine
- Increase public awareness
- Develop and/or support statewide policies to focus on increased screening, increased public awareness and encourage changes in medical payment systems to increase focus on primary care prevention efforts.
- Identify and pursue additional funding sources for prevention efforts

Summary and Proposed Recommendations:

Each group is addressing issues that relate to cervical cancer control.

Once prioritized issues are agreed upon, a coordinated collaborative response or strategy could be developed. MDCH's Cancer Prevention and Control Section staff these three groups and will facilitate coordination and collaboration as needed. In addition, CCAC, CCTF, and PCI have community members in common.

The CCTF supports the Michigan Cancer Consortium's Cervical Cancer Advisory Committee and recommends that this group be recognized as both the medical experts for issues relating to cervical cancer and as the advisory committee for the state of Michigan. The Task Force recommends that there be an annual report from the Michigan Cancer Consortium to the Legislature and Governor on Michigan cancer incidence, mortality and rate trends. This report will include advances in cervical cancer diagnosis and treatment in Michigan. Furthermore, the Task Force recommends that MCC's Cervical Cancer Priority Strategic Plan for improving cervical cancer early detection should be supported and funded adequately for implementation.

The CCTF recognizes and supports the work of the Primary Care Initiative to improve the primary care service delivery system in Michigan, ultimately resulting in high quality care for all Michigan residents, including cervical cancer screening for women.

Michigan Cancer Surveillance Program (Cancer Registry) and Cervical Cancer

Background:

The Michigan Cancer Surveillance Program is part of the National Program of Cancer Registries (NPCR). Cancer registries collect information about the occurrence (incidence) of cancer, the types of cancers diagnosed and their locations within the body, the extent of cancer at the time of diagnosis (disease stage), method of diagnosis, and the kinds of treatment that patients receive. These data are reported to a central statewide registry from various medical facilities, including hospitals and laboratories, physicians' offices, other state registries. Mortality data is obtained from reviews of death certificates.

Michigan's statewide registry, which was established in 1985, reports the following information: Cancer data (incidence, stage at diagnosis, survival and mortality) by age, sex, race/ethnicity and geographic area. Data can be viewed on the registries' website at www.michigan.gov/mdch select "Statistics."

Data collected by state cancer registries enable public health professionals to better understand and address the cancer burden. These registries are designed to:

- Monitor cancer trends over time.
- Determine cancer patterns in various populations.
- Guide planning and evaluation of cancer control programs (e.g. determine whether prevention, screening, and treatment efforts are making a difference).
- Help set priorities for allocating health resources.
- Advance clinical, epidemiologic, and health services research.
- Provide information for the national database of cancer incidence.

Another surveillance system, the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) registry program complements NPCR. Together, NPCR and the SEER program collect cancer data for the entire U.S. population. The SEER program gathers in-depth data on cancer cases diagnosed in California, Connecticut, Hawaii, Iowa, Kentucky, Louisiana, New Mexico and Utah, as well as in six metropolitan areas (including the Detroit Metropolitan area – Wayne, Oakland and Macomb counties) and several rural/special population areas. The six metropolitan SEER registries submit data to NPCR's state registries. The major difference between the State Registry and SEER is that SEER conducts active follow-up on patients to assess on-going treatment and survival. Their website is <http://seer.cancer.gov>

CDC has established national standards to ensure the completeness, timeliness, and quality of cancer registry data. In addition, CDC recommends that central cancer registries incorporate standards for data quality and format as described by the North America Association of Central Cancer Registries (NAACCR). Those registries' are reviewed to determine their ability to produce complete, accurate and timely data. Registries that meet the highest standards receive NAACCR certification. Forty-four CDC-supported NPCR state registries (including Michigan)

achieved these high standards for their 2003 data, the most recent year for which cancer incidence data are available.

Summary and Recommendations:

Michigan's Cancer Registry is long standing and has maintained the highest standards serving as a model for others. The registry has proven to be an important tool for Michigan's cancer control efforts and a reliable source of data for use in cancer research. Michigan operates one of the lowest cost registries in the nation. The recent elimination of all state general fund dollars for the registry has raised some concern for the future stability of the registry.

The Governor's Task Force on Cervical Cancer recommends that adequate state funding for the Cancer Registry be provided. Ideally, with additional funds, the registry could provide even greater assistance with cancer prevention and control efforts by tracking back on cancer deaths to identify preceding screening practices, the cost of care, insurance status, health behaviors and other factors which provide critical information in developing public education, provider education and other public health funding priorities to improve the public's health and prevent deaths.

The CCTF recognizes the essential function of the Cancer Registry and supports the increase of state funding for the cancer registry. The CCTF supports groups such as the Women in Government (WIG) and the National Governor's Association (NGA) in advocating for increased funding for cancer registries.

Cervical Cancer in Michigan: Women Who Die From Cervical Cancer

Background:

According to the Centers for Disease Control and Prevention (CDC), 50–60% of the women who die from invasive cervical cancer are “rarely – or never screened.” Despite improvements in cervical cancer incidence and mortality rates there are still many years of life lost unnecessarily to this cancer. In fact, the average years of life lost (24 years per death) are higher for cervical cancer than for any other cancer. Rarely- or never-screened women have either never had a Pap test or have not had a Pap test for at least 5 years. Another 5-10% of women who die from invasive cervical cancer have “false-Negative” Pap test results. 10-15% of women have an abnormal Pap test, but are “lost to follow-up” and do not receive needed diagnostic testing. Additionally, 10-15 percent is medically mismanaged, 9-12 percent has an “uncommon cancer, which is difficult to detect” and 5-10% have a rapidly progressive form of cervical cancer. (The latter two categories do not lend themselves to easy intervention.) Therefore, the most serious factor contributing to cervical cancer incidence and mortality, and the one that can be most readily addressed, is lack of screening.

Michigan Incidence: In 2003, 399 women developed invasive cervical cancer. Age, race and some geographic information for these women are provided in the chart below.

Cervical Cancer Incidence 2003	Total	%	White	%	Black	%
Age 19 and under	1	0.25%	1	0.25%	0	0
Age 20 - 39	120	30.1%	82	20.55%	26	6.51%
Age 40-64	209	52.4%	153	38.34%	47	11.78%
Age 65-79	56	14.0%	43	10.78%	9	2.25%
Age 80 and over	13	3.25%	9	2.25%	2	0.50%
Total	399	100%	288	72.18%	84	21.05%
Wayne County	111		46		60	

Michigan Mortality: In 2004, 118 women died from invasive cervical cancer. Their age, race, and some geographic information are provided.

Cervical Cancer Deaths 2004	Total	%	White	%	Black	%
Age 39 and under	14	11.86%	10	8.47%	4	3.38%
Age 40-64	53	44.91%	41	34.74%	12	10.16%
Age 65-79	35	29.66%	28	23.72%	9	7.62%
Age 80 and over	16	13.56%	11	9.32%	2	1.69%
Total	118	100%	90	76.27%	27	22.88%
Wayne County	35		16		19	

Summary:

Michigan women who develop (and die from) invasive cervical cancer are of varied racial and age groups. A large number of them are either or both African-American women and women who live in Wayne County. Elderly women diagnosed with cervical cancer are more likely to die from it. It might be assumed that more than half of the women who die from invasive cervical cancer have never (or rarely) received Pap testing. These women are more likely to be minority women, who have low SES, may be born outside the United States, and have no usual source of health care.

Recommendations:

Utilizing January as Cervical Cancer Awareness Month, public education messages should be directed to all women about the importance of cervical cancer screening and the HPV Vaccine. Education strategies should be broadened to include older women and their health care providers.

Administration of the HPV Vaccine to girls age 11-12 should be promoted as part of “Back-to-School” messages. The CCAC is in the process of developing messages for patients, parents and providers about the HPV4 Vaccine and the need for continued cervical cancer and STD screening.

The CCTF endorses the Michigan Cancer Consortium’s Cervical Cancer Priority Strategic Plan, which calls for targeted public education (directed at women in high risk groups such as those who are rarely or never screened for cervical cancer, minorities, low SES, foreign born, and those women with no usual source of health care) via culturally specific messages and using community leaders as spokespersons.

The PCI should develop and implement effective strategies to increase both cervical cancer screening and adequate follow-up for abnormal screenings. These strategies need to include strategies to reduce provider, health system and patient barriers to quality health care.

The PCI and CCAC, along with other organizations, will develop and support neutral media campaigns educating the public on the need for regular screening Pap tests.

Develop effective strategies to increase both appropriate cervical cancer screening and follow-up for abnormal screenings in accordance with MCC guidelines, including strategies to reduce provider, health system and patient barriers to quality health care.

Increase awareness of the MI Child Program.

Develop strategies together with the MCC and CCAC to reduce health disparities related to cervical cancer.

Cervical Cancer Screening Behaviors

Background:

The national Behavioral Risk Factor Surveillance System (BRFSS) consists of annual surveys conducted independently by the states, District of Columbia and U.S. Territories and is coordinated through a cooperative agreement with the Centers for Disease Control and Prevention (CDC). The annual Michigan surveys follow the CDC telephone survey protocol and use the standardized core questionnaire.

The Michigan Behavioral Risk Factor Survey (BRFS) is a statewide telephone survey of Michigan residents, aged 18 years and older and is the only source of state-specific, population-based estimates of the prevalence of various behaviors, medical conditions and preventive health care practices among Michigan adults.

The first Special Cancer Behavioral Risk Factor Survey (SCBRFS) was conducted in 2001-2002. The SCBRFS is an ongoing surveillance designed to measure progress towards achieving several priorities of the Michigan Cancer Consortium (MCC). A second SCBRFS was conducted in 2004. The results from the 2004 and future surveys will be compared against 2001-2002 baseline data in order to evaluate progress in cancer-related behaviors and knowledge within the Michigan adult population. There are 20 questions on the SCBRFS and two on the annual BRFS that address Pap testing and cervical cancer. (See Attachment)

Concerns related to the BRFS process and the potential of error due to “Self-Reported” Data are addressed in an article titled: *“Validation of Self-Reported Chronic Conditions and Health Services in a Managed Care Population”* By Linda M. Martin, MS, Marilyn Leff, MSPH, Ned Calonge, MD, Carol Garrett, PhD, David E. Nelson, MD. It known that there is some error due to the self-report process; however, the conclusion of this article is that the BRFS Pap indicator is ‘reasonably accurate.’

Additional concerns involve potential statistical challenges to BRFS data due to people that 1) do not have telephones, 2) speak foreign languages, or 3) have low literacy levels. A State of Michigan epidemiologist stated that “If people who live in households without phones are different ... compared with people who live in households with phones, and if the proportion who live in households without phones is large, this can result in biased estimates... approximately 4% of Michigan households do not have a working phone, so this would minimize the impact of phone non-coverage on state-level estimates. But, it may still be a problem in certain geographic or demographic subpopulations in which the telephone non-coverage rate is higher.” She also stated that non-response based on language does happen in the MI BRFS, but at a fairly low frequency; and literacy is not an issue since it is a telephone survey.

Summary and Recommendations:

Data gathered from the Michigan Behavioral Risk Factor Surveys provide valid and valuable information pertaining to the population-based estimates of the prevalence of various behaviors, medical conditions and preventive health care practices among Michigan adults.

- Continuation of Behavioral Risk Factor Surveys in Michigan with the understanding of its benefits as well as its limitations.
- Continuation of Special Cancer Behavioral Risk Factor Surveys in Michigan, especially at the county level.
- Continued use of these data for evidence-based statewide strategic planning through the CCAC.
- Objective studies of screening behavior in Michigan women using strategies as noted in the MCC's Cervical Cancer Priority Strategic Plan.

Availability and Accessibility of Pap and HPV Testing

Pap testing as a screen for cervical dysplasia and cervical cancer is paid for by multiple sources throughout Michigan. Pap testing is available but limited for women without insurance. HPV (Human Papillomavirus) testing is usually available to women who receive Pap testing.

- About 12.6% of Michigan women are uninsured. It is estimated that approximately 388,488 women ages 18 to 64 are without insurance¹.
- Both private insurance providers and other programs provide Pap testing to Michigan women.²
- Blue Cross/Blue Shield of MI provides prevention services to clients whose employer purchases those services. For local Michigan employer groups (not including automotive groups), Pap testing is covered for 73% of employer groups and is in 72% of contracts.
- Health Maintenance Organizations (HMOs) provide Pap testing as part of preventative services. Michigan HEDIS rates for Pap testing range from 81.83% to 93.02% with a mean of 83.97%
- Medicaid provides Pap Testing to women ages 20 – 64. In FY05, 442,029 Michigan women, age 19-64, received Medicaid; 98,378 of them had Pap testing. 6,363 women received HPV testing. Women move in and out of Medicaid FFS and Managed Care Plans on a monthly basis, but at any point, the membership is evenly distributed and up to 65 percent of these women receive a Pap smear in the 2-3 year time frame recommended.
- Clients of Family Planning are mostly age 15-44, and Title X/Family Planning programs provide Pap testing as part of Family Planning services; in 2005, 74,764 Pap tests were provided. Women who had abnormal Pap tests could be referred to Michigan's Breast and Cervical Cancer Control Program (BCCCP) for diagnostic services; in 2005, 1,133 Family Planning women were referred to the BCCCP.
- Plan First!, the Medicaid waiver program for Family Planning services, started July 1, 2006. This program expands Medicaid eligibility for women, ages 19 – 44, to receive family planning services including Pap testing paid for through Medicaid. It is anticipated that up to 200,000 women will qualify for this program.
- Title XV, the Michigan Breast and Cervical Cancer Control Program, provided 23,187 Pap tests to women age 40-64 in 2005. In the same year, six (6) BCCCP women were diagnosed with invasive Cervical Cancer and five (5) with invasive Adenocarcinoma. Because of limited funding, a waiting list of up to 5,000 women is expected in FY06.
- Various county health plans are available; they refer women ages 40- 64 to BCCCP for screening and diagnostic services. They also provide Pap testing to women age 19 – 39.
- The Michigan First Healthcare Plan will include prevention services., This program is expected to start in April 2007.

¹ MDCH, Characteristics of the Uninsured and Select Health Insurance Coverage in Michigan, Nov 2003

² There are ~3,083,245 women age 18 - 64 in Michigan. Source: Census 2000

Summary and Recommendations:

Despite the availability of resources for Pap testing for many women without insurance, some women age 19-64 do not receive Pap screening, HPV testing, or follow-up diagnostic studies, as may be indicated. The Governor's Task Force encourages that programs assure the provision of a continuum of services, from screening, through diagnostic testing and incorporating treatment, as may be indicated. The CCTF recognizes that the Michigan First Healthcare Plan and Plan First! are valuable resources for cervical cancer screening and should be widely promoted to Michigan women and providers.

Michigan Medicaid should develop strategies that increase Pap testing rates among women receiving Medicaid

Women who are clients of Title X/Family Planning and have abnormal Pap tests must be assured of appropriate follow-up and diagnostic services, as needed.

Michigan employers must be educated about the importance of prevention services in order that they may purchase inclusive insurance packages for their employees.

The PCI should develop strategies that remove health care barriers to both screening and follow-up, with a focus on promoting available, affordable and acceptable care.

The CCTF supports the Michigan Cancer Consortium's Cervical Cancer Advisory Committee's *Guidelines for the Early Detection of Cervical Cancer* containing recommendations for Pap and HPV testing.

CCTF recognizes that the Breast and Cervical Cancer Control Program (BCCCP) is only able to serve 15 percent of eligible women in any year and urges that this program be expanded to serve more eligible women.

Increase funding to expand the Breast and Cervical Cancer Control Program (BCCCP) to serve more eligible women.

Support Congress's reauthorization of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the addition of funds to the current budget.

Plan First! Medicaid Waiver for Family Planning Program

“Traditional” Medicaid is available to

- United States citizens and certain “non-citizens” who have been in the US for five years or more.
- Individuals who are blind, disabled or pregnant, or who are the caretaker of a dependent child.
- Persons who are not disabled and who have an income at 50% of poverty may also receive Medicaid.
- Women diagnosed with cervical cancer or “precancer” (CIN2) through the Breast and Cervical Cancer Control Program (BCCCP) are also eligible to apply for Medicaid.

Michigan applied for and was recently granted a waiver to provide Family Planning Services, including Pap testing, for up to 200,000 women ages 19 - 44.

- Enrollment in Plan First! begins July 1, 2006.
- Citizenship rules for Medicaid will apply.
- To qualify, women may have a family income no greater than 185% of poverty.
- Women who are not eligible for Plan First! (income, citizenship) may still receive care at Title X/Family Planning agencies.
- Women “aging out” of MI Child or who have recently been covered by Healthy Moms and current Title X/Family Planning clients will be the first to be enrolled in Plan First!
- Certain limited services – birth control and testing and treatment for sexually-transmitted diseases - will be covered.
- Pap testing will be covered; follow-up diagnostic testing will not be covered through Plan First!
- Women who are clients of both Plan First! and of Title X/Family Planning and who have an abnormal Pap test indicating a possible cervical cancer diagnosis are eligible to be referred to the BCCCP for follow-up diagnostic testing.
- Providers who take Medicaid and provide well-woman services may be Plan First! providers.

Summary and Recommendations:

Many more women at risk for cervical cancer will be able to receive Pap testing through the Medicaid Waiver program for Family Planning, Plan First!

The CCTF recommends that enrollment in Plan First! be widely promoted by the Michigan Department of Community Health to both Michigan women and health care providers, especially in urban areas.

Assure that affordable colposcopy services are available to Family Planning clients in every county.

Michigan Public Education Campaigns for Cervical Cancer Awareness

Background:

A Public Health media campaign can have multiple objectives including:

- Raising Awareness
- Providing Health Information
- Providing Health Program Information
- Increasing Participation in a Health Program
- Increasing the Use or Practice of Identifiable Healthy Behaviors

Methods:

Strategies utilized in public health campaigns include use of *broadcast media* via television and radio advertisements (paid and Public Service Announcements), interviews and personal interest stories; *print media* campaigns via newspapers, magazines, billboards and bus boards); and *small print media* initiatives including brochures, pamphlets, flyers, informational letters, videos, posters, mail inserts or newsletters and fact sheets.

Recent MDCH campaigns relating to Cervical and/or Breast and Cervical Cancer:

The “*Happy Pap Day*” and “*Dates*” campaign ran from January 2005 to September 2005. The campaign strategy involved 4,000 Television Ads that ran statewide and 17,000 radio ads. Also, 117,000 postcards were mailed in the Detroit area to African American, Hispanic, and Arab American female-headed households with incomes of less than \$25,000. Focus groups were used to test the messages.

The goal of the campaign was to increase general awareness of cervical cancer screening and to encourage women to obtain Pap tests.

During the period of the “*Happy Pap Day*” marketing campaign, the following results were realized, in comparison to the same period in 2004:

- There was a 48% increase in calls to the MDCH clearinghouse.
- There was a 72% increase in BCCCP brochure orders from the clearinghouse, and
- There was a 24% increase in BCCCP enrollment (an increase of 1,643 women)

This was not a sustained increase over time after the campaign ended.

Additional evaluation will be done using HEDIS and BRFSS data to determine if more women received a Pap test during the course of the campaign. This data is not yet available.

Another marketing campaign titled “**FREE2BE**” ran from late September 2002 through March 2003. This campaign was developed as collaboration between the American Cancer Society (ACS) Great Lakes Division and the Michigan Department of Community Health (MDCH). The objectives of this campaign were:

- To raise awareness regarding breast and cervical cancer and the importance of screening.
- To inform eligible women about BCCCP.
- To let women know that in the event a breast or cervical cancer was diagnosed by the BCCCP, a woman would be eligible to apply for Medicaid to cover treatment.
- To increase the number of women enrolled in BCCCP.

Results:

During the six-month campaign period, 2,850 calls from throughout Michigan were made to the special toll free FREE2BE number at ACS. At least one call was received from nearly every Michigan county. Of the 2,850 calls, 1,198 referrals were made to local BCCCP agencies.

Of the 1,198 referrals, 405 women enrolled in the program as a result of the promotional campaign.

The methods by which the enrolled women heard about the program are:

Medicaid Flyer/Insert	67.8%
Family Member/Friend	11.4%
Billboard/Transit Ad	9.7%
Other	6.7%
Newspaper	2.5%
Television	1.0%
Radio	0.7%

Summary and Recommendations:

Multi-faceted media campaigns have proven to be effective ways to reach women and promote the importance of screening for, and early detection of breast and cervical cancer. CCTF recognizes ongoing awareness is important. Media campaigns can be effective in raising awareness but with short-term effects. In view of the high cost of statewide media campaigns (TV, radio), CCTF recognizes the need for ongoing public awareness methods as stated in the MCCI Strategic Plan.

- Support the development of ongoing statewide public awareness campaigns as one strategy to achieve the *Michigan Cancer Control Initiative’s Cervical Cancer Priority* goals.
- Support the development of media messages that help reach women never or rarely screened for cervical cancer.

- The CCAC and PCI should coordinate cost-effective, on-going public education on Pap and HPV testing, as indicated, using the MCC Theme Calendar, “Back-to-School,” and Mother-Daughter themes.

Vaccine for Human Papillomavirus (HPV)**

- The Human Papillomavirus (HPV) is responsible for 99+% of cervical cancer, and is sexually transmitted.
- HPV is usually acquired soon after the first sexual intercourse.
- 25% of US teens have sex by age 15 years and 48% by age 17 years.
- Eighty percent of women 50 and older have been exposed to HPV.
- It is assumed that 50% of all sexually active persons will be infected with HPV, with most infections clearing quickly.
- Infection with HPV is asymptomatic; there is no culture for HPV (rather, DNA detection is used in Hybrid Capture II™).
- In the US, the highest prevalence (40%) of High-Risk HPV is among 14-19 year olds. Prevalence decreases with increased age.³
- HPV strains #16 and 18 are responsible for 70% of invasive cervical cancer in the United States; there are at least 13 high-risk (for cancer) types of HPV.
- Several vaccines against HPV have been developed:
 - The vaccine developed by Merck is a quadrivalent (covers strains 16 and 18 as well as 6 and 11, strains responsible for most warts)
 - GlaxoSmithKline's vaccine (yet to be FDA-approved) is bivalent (strains 16 and 18).
- The HPV4 vaccine will cost \$360/series.
- FDA approval occurred June 8, 2006 for the quadrivalent vaccine (HPV4); approval for the bivalent HPV2 from GSK is expected in 2007.
- The [Advisory Committee on Immunization Practices](#) (ACIP) provisional recommendations for HPV4 include:
 - routine vaccination for 11-12 year-old girls
 - catch-up vaccination for 13-26 year-old females
 - girls age 9-10 may receive the vaccine at provider discretion
- Medicaid and MI Child will pay for the vaccine.
- Vaccinated women will continue to need Pap testing on a regular basis.
- Michigan Cancer Consortium's Cervical Cancer Advisory Committee, together with MACI, will develop messages for patients and providers, as well as health policy recommendations.

** See Page 47 for an overview of the Division of Immunization and Page 50 for the MDCH fact sheet on HPV.

³ Dunn, Eileen. "HPV Epidemiology is the U.S." in presentation to the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, Feb 21, 2006.

Summary and Recommendations:

The HPV Vaccine should be promoted as a cancer prevention mechanism and be made generally available to young women, using guidance developed by the Michigan Cancer Consortium's Cervical Cancer Advisory Committee (CCAC) and Michigan's Immunization Advisory Committee. MDCH will endorse the guidance document. Adequate funding must also be included from appropriate sources to assure wide distribution and availability of the vaccine.

The CCTF supports the development of patient education messages by the CCAC, in collaboration with the Michigan Advisory Committee on Immunization (MACI), that stress the need for continued Pap and HPV testing, as indicated, and the need for protection against other STDs regardless of vaccination status.

Collaborate with MACI to develop age-appropriate, culturally sensitive provider and patient education messages about the use and limitations of the HPV vaccine.

The CCTF recommends that all publicly funded programs adopt the ACIP recommendations for the HPV4 vaccine.

Assure immunizations are recorded into the Michigan Care Improvement Registry (MCIR), including HPV vaccinations.

Appendices

Status of Cervical Cancer in Michigan

Mortality and Incidence in Michigan Compared to the U.S.

According to SEER national cancer registry data, the state of Michigan had the 21st lowest incidence rate of cervical cancer in 2001 and the 8th lowest mortality rate in 2002 among states. Rates for both incidence and mortality related to cervical cancer are generally declining for both Michigan and the United States. Although incidence rates for Michigan are similar to those of the U.S., mortality rates are lower for Michigan and the estimated annual percent change (EAPC) in mortality in Michigan is -4.4%, while in the U.S. the EAPC is -3.3%.

Michigan Incidence and Mortality Compared to the U.S.

		Michigan Rate*	U.S. Rate* (SEER)
Mortality	N=104 (# of deaths)	1.9	2.5
Incidence	N=382 (# of new cases)	7.3	7.2

*Age Adjusted Rate per 100,000

Knowledge of Risk Factors for Cervical Cancer among Women in Michigan

Many women are unaware of the risk factors for cervical cancer. Behavioral risk factors for cervical cancer include sexual practices that may lead to infection with Human Papilloma Virus (HPV), smoking, and not getting screened for cervical cancer. According to the 2004 Special Cancer Behavioral Risk Factor Survey (SCBRFS), among Michigan women ages 40 and older only 3.3% named having HPV as a risk factor, 13% said that cigarette smoking was a risk factor, and 19.2% said that not having regular pap tests was a risk factor. The 2004 Five City African American Behavioral Risk Factor Survey also found extremely low rates for awareness of risk factors for cervical cancer. Knowledge of HPV and cigarette smoking as a risk factor was less than 4% in all five cities. In Flint and Pontiac, awareness of HPV as a risk factor was almost null and as low as 0.3% and 0.4% respectively. Among the five cities included in the study, rates of knowledge regarding lack of regular screening as a risk factor ranged from 18.4%-37.5%. According to the 2004 SCBRFS 3.9% of Michigan women age 40 and older who did not have a pap test in the past year listed not knowing that they needed one as their reason as did 24.5% of women who had not had a pap test in the past 5 years.

Screening Practices for Cervical Cancer among Michigan Women

Although HPV is the main causative factor for cervical cancer, regular screening is extremely important for the reduction or mortality related to cervical cancer. When cervical cancer is detected in the early stages it is almost completely treatable and yet many women are dying unnecessarily because they fail to get regular Pap smear tests. Findings from the 2004 Cervical Cancer Follow-Back Study of Invasive Cervical Cancer showed that of all the women surveyed 60% had not had a Pap test within 36 months prior to their diagnosis.

According to the 2004 SCBRFS, of the Michigan women ages 40 and older, only 58.7% reported to have had a Pap test in the past year and 80.5% reported to have had a Pap test within the past 3 years.

Disparities in Cervical Cancer and Screening Practices

Disparities in screening practices, in mortality, and incidence rates have also been observed within studies conducted in Michigan. The Michigan Cancer Surveillance System provides data on stage at diagnosis of all cancer cases in Michigan. Of cervical cancer cases that were diagnosed at the same localized stage, a stage with better prognosis, survival rate for African American women was lower compared to whites (88.4% vs. 92.8%). The Michigan Behavioral Risk Factor Survey (BRFS) found that women in the youngest group (18-24) and those in the oldest group (65+) have the lowest screening rates of 77.7% and 74.5% respectively. The age group with the highest screening rates (93.2%) was the 25-34 year old group; there was a decline in screening with increasing age. Education also appears to have a noticeable impact on screening rates. Screening Pap test rates increased with increasing education. Those with a college education had the highest rates (92.1%), while those with less than a high school degree had the lowest rates of screening (79.6%). Disparities were also found among certain racial and ethnic groups. The 2004 SCBRFS found that rates of screening within the past year were lowest for Arab Americans (36.4%) and Asian American (33.7%). These two groups also had the lowest rates of screening over the past 3 years. Even though African Americans reported the highest rates of screening within the past year and the past 3 years, higher age-adjusted incidence (white=6.7; black=10.9) and mortality rates (white=1.7; black=3.1) per 100,000 are seen in African Americans compared to whites. There are also disparities in the percentage of abnormal cervical findings among population groups. Hispanics are the most likely to report having an abnormal finding upon screening within the past 10 years (33.6%), followed by American Indians (22.6%) while the rate of abnormal findings in the general population is 15.2%.

Breast and Cervical Cancer Control Program

Since 1991, the Michigan Department of Community Health (MDCH) has implemented a comprehensive breast and cervical cancer control program (BCCCP), through a multi-year grant from the U.S. Centers for Disease Control and Prevention. With these funds, low-income women have access to life-saving cancer screening services and follow-up care. The BCCCP has screened over 112,800 women and diagnosed over 1900 breast cancers and 790 cervical cancers.

Through this program, women who have breast and cervical cancer will be identified at earlier stages of these diseases, when treatment is less expensive and the survival rate is more favorable. Working together, medical providers and local health agencies can ensure that the highest quality breast and cervical cancer control services are available to all women in their communities.

Who Is Eligible?

To be enrolled in the BCCCP the woman must:

- Have an **income** \leq **250%** of federal poverty level
- Be **uninsured or underinsured**
- Be **age 40 - 64** for breast/cervical cancer screening and for diagnostic follow-up of breast/cervical abnormalities **OR**
- Be **age 18 – 39**, have been identified with a cervical abnormality through the **Title X Program, and referred to the BCCCP** for cervical cancer diagnostic follow-up.

This program can also serve low-income women with some types of insurance, but their insurer must be billed first, for services provided. If their insurance does not cover one or more of the services, they may be eligible for free services. Women enrolled in a managed care program, health maintenance organization or Medicare Part B are not eligible for the BCCCP.

Services Available:

Through these local public health programs, women aged 40-64 can receive screening services such as clinical breast exams, mammograms, Pap tests, and pelvic exams.

If a breast and/or cervical abnormality is identified from the screening test/exam, the woman will be referred to community providers for follow-up. Over 75 diagnostic services are provided free of cost through the BCCC program. Some of these include:

- Diagnostic mammograms
- Ultrasounds
- Breast Biopsy
- Colposcopy services
- Colposcopy-directed biopsy services
- Medical Consultations
- Selected anesthesia services

Family Planning women enrolled in the BCCCP are eligible to receive cervical diagnostic services. Although the BCCCP doesn't pay for treatment services, women diagnosed with breast or cervical cancer through the program may be eligible to apply for Medicaid coverage.

Where Are These Services Available?

Women throughout Michigan may seek these services from over 700 contracted BCCCP providers across the state. Services are also available through tribal health clinics of seven federally recognized Indian tribes.

Any Michigan woman age 40 through 64 can call 1-800-922-MAMM to obtain a local phone number to talk to the BCCCP coordinating agency closest to her home. The local agency will assess each woman for program eligibility based on age and income, and provide an appointment to a health care provider or clinic near her home.

Provider Participation:

BCCCP services are coordinated through 19 local health departments across Michigan as well as the Karmanos Cancer Institute in Detroit. These agencies have enlisted the cooperation and participation of physicians, hospitals, and other health care organizations in their communities to assure that all necessary follow-up services are provided.

Local agencies are required to provide or arrange for basic screening services, i.e., clinical breast exams, screening mammograms, pelvic exams, Pap smears, and patient education.

Some local agencies are delivering these basic services through their existing or expanded department staff. Others are providing the basic services through subcontracts with community providers. Local agencies usually contract with radiology facilities to provide mammography services to enrolled women, as well as with clinical laboratories to analyze Pap smears.

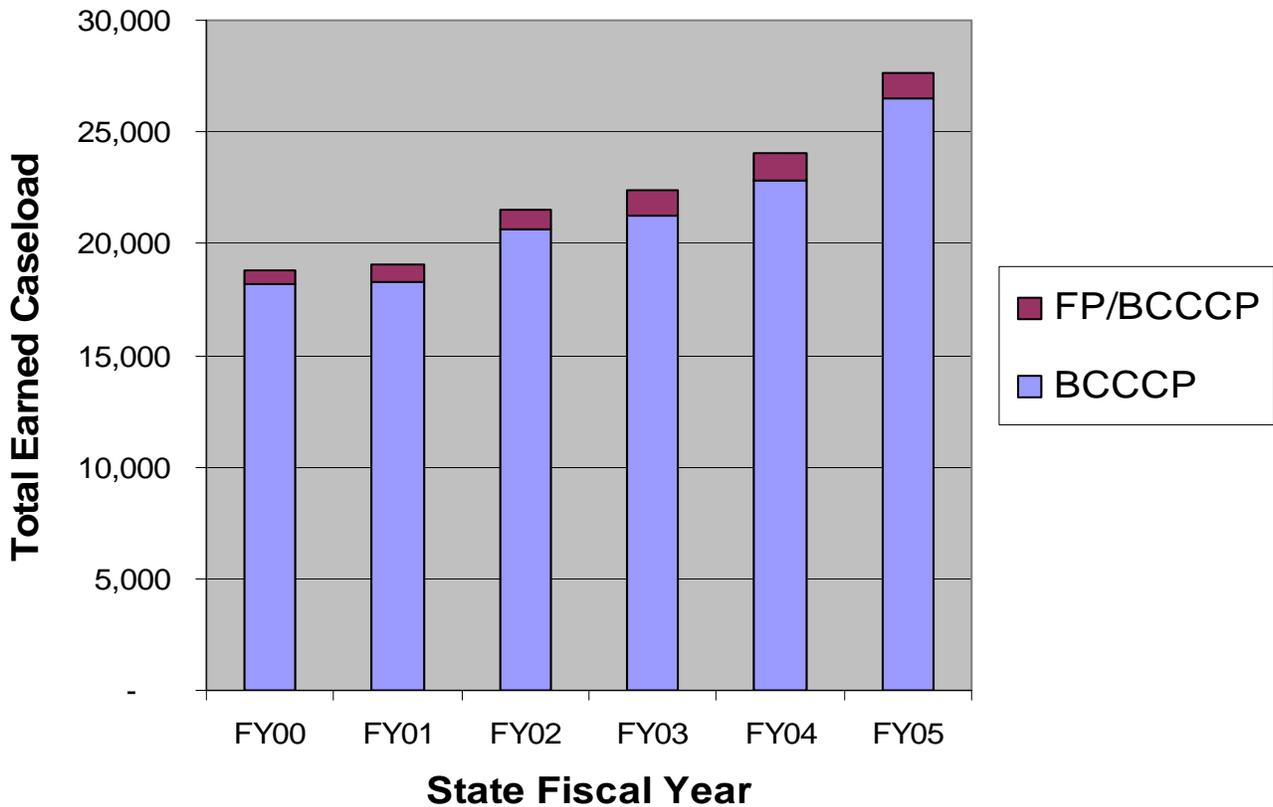
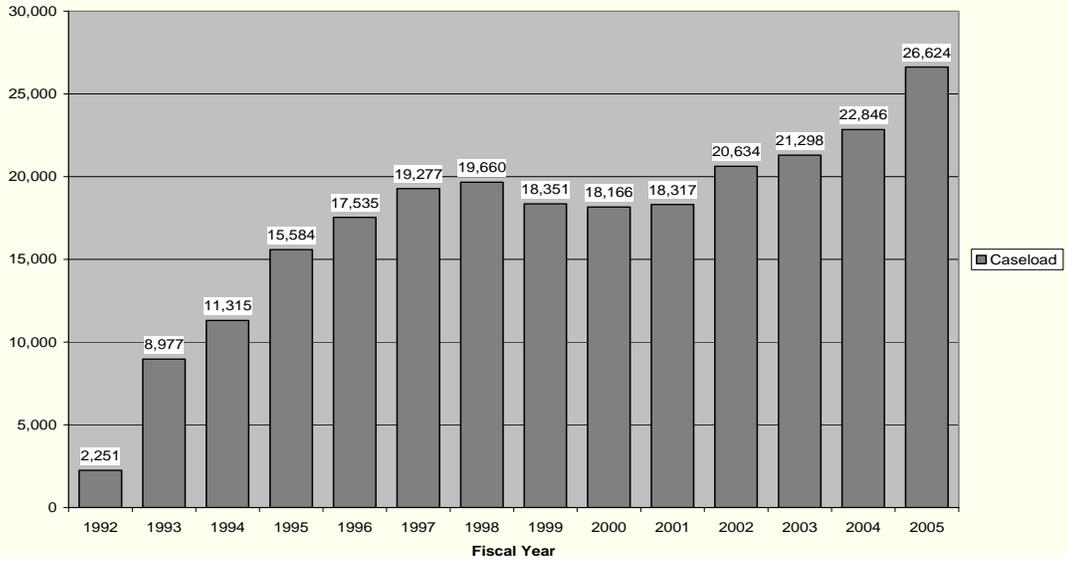
Program Growth

Since the establishment of the program in 1991, the BCCCP has experienced a significant growth in the number of women served by this program. As can be seen in Graph 1, the program has grown to serve well over 26,000 women per year. The caseload is restricted to available funds and can vary from year to year. Figure 2 shows the caseload increases due to the women served initially through Title X/ Family Planning. This number could at least double in the next fiscal year due to Plan First!



Yearly Caseload Increase

BCCCP Caseload by FY



Federal and State Programs: Eligibility Criteria and Services								
Program	Gender	Age	Must be U/S Citizen?	Income	Cervical Screening services	Cervical Diagnostic services	Treatment	Other
BCCCP	F	40-64	Not necessary	<250% FPL*	yes	yes	via Medicaid Treatment Act	
Title X/Family Planning	F	14-45	Not necessary	Sliding scale	yes	Refer to BCCCP	via Medicaid Treatment Act	Family-Planning related
Plan First!	F	18-44	Yes, or resident > 5 years	<185% FPL*	yes	Refer to BCCCP	via Medicaid Treatment Act	Family-Planning related
Traditional Medicaid	M/F	18+	Yes, or resident > 5 years	35-52% of FPL* depending on program	yes	yes	yes	>age 21 w/ children, or blind or disabled
Adult Benefit Waiver	M/F	18+	Yes, or resident > 5 years	33% of FPL*	yes	yes	yes	> age 21 w/o children, neither blind, disabled or pregnant
MOMS	F	none	Not necessary	<185% FPL*	yes	yes	no	Pregnancy up to 2 months PP
Healthy Kids	M/F	Pregnant women and children <19	Yes, or resident > 5 years	0-1 year old or pregnant: 185% FPL* age 1-18: 150% FPL*	Yes, if indicated	yes	yes	Pregnancy/childhood – ESO if not a resident
MI-Child	M/F	<19	Yes	150-200% of FPL*	Yes, if indicated	yes	yes	Children – families pay \$5/month for coverage

***FPL = Federal Poverty Level**



Overview: Michigan Cancer Consortium and Cervical Cancer Advisory Committee

Since 1996, a statewide partnership of public and private organizations, the Michigan Cancer Consortium (MCC) www.michigancancer.org, has collaborated to reduce the burden of cancer on Michigan citizens. In 1996, there were 52 MCC Member Organizations; currently, there are 85 MCC Member Organizations.

During 1996, the MCC convened six expert advisory committees focusing on breast, cervical, colorectal, lung and prostate cancers and on the primary prevention of cancer. The charge to the advisory committees was to develop a cancer control plan for each cancer site, and include recommendations that would reduce morbidity and mortality from that particular cancer. The MCC Cervical Cancer Advisory Committee used an evidence-based process to consider the problem of cervical cancer within the cancer continuum – prevention, early detection, treatment and issues of quality of life and survivorship. The CCAC then identified the 10 objectives they believed would have the greatest impact on cervical cancer morbidity and on mortality reduction. The objectives were ranked using criteria which considered the impact on incidence reduction, mortality reduction, relative survival and feasibility of implementation.

In June 1998, the MCC first reviewed the recommendations from each Advisory Committee and then further prioritized the objectives, using the criteria of feasibility, importance, and the benefit of collaboration. They identified an objective for each cancer site, an objective for each arena (such as prevention or early detection), and also identified objectives they termed “cross-cutting” – those that addressed clinical trials or end-of-life issues. In conclusion, ten cancer control priorities for Michigan were then identified as the “Michigan Cancer Consortium Initiative Strategic Plan.” Three of the ten cancer control priorities address early detection: breast, cervical and colorectal cancer.

The current MCC Cervical Cancer Advisory Committee consists of health care providers from around Michigan; these include primary care providers (physicians, nurse practitioners and nurse-midwives), specialists in gynecology and oncology, pathologists and providers of colposcopy services. The American Cancer Society, Great Lakes Division sends a representative; there are representatives from professional organizations such as the Michigan Section of the American College of Obstetrics and Gynecology. The Michigan Department of Community Health has representatives from Cancer Prevention and Control, Family Planning, STD/HIV, Immunizations, Medicaid, Teen Clinics and Laboratories.

The Cervical Cancer Advisory Committee developed Guidelines for the *Early Detection of Cervical Cancer* in 2003 and the updated the Cervical Cancer Priority Strategic Plan in 2005 (See Page 34 for the guidelines). Messages, for patients, parents and providers about the new HPV Vaccine, are currently being developed. One of the Strategic Plan strategies, to “Explore feasibility of laboratories mailing Pap test reports to patients,” was discussed by a CCAC Workgroup and “piloted” during 2006. The CCAC plans to update the *Guidelines* in early 2007, and as needed.



Cervical Cancer Priority Strategic Plan

Cervical Cancer Priority:

- By 2010, the incidence of invasive cervical cancer in Michigan women will be reduced by 50%.
- Ninety-seven percent of women over age 21, or 3 years after the onset of sexual activity, will have had a Pap test at least once in their lifetime.
 - Ninety percent of women over the age of 21 will have had a Pap test within the last 2 years.

Progress Markers

How will the MCC know if progress is made toward achieving the Cervical Cancer Priority? The following markers will be measured by Behavioral Risk Factor Surveys, Cancer Registry data, and other assessments to evaluate progress toward the priority:

- Invasive cervical cancer incidence rate.
- Number of women age 21, or 3 years after the onset of sexual activity, who have had a Pap test at least once in their lifetime.
- Number of women over age 21 who have had a Pap test within the last 2 years.
- Number of patient education efforts.
- Number of provider education efforts.
- Number of health care policies initiated by legislature.

Why This Priority Is Important

Death from cervical cancer is considered to be preventable, and no one should die from cervical cancer. Yet, 114 women in Michigan died of the disease in 2002.

During 2001, 428 women in Michigan were diagnosed with invasive cervical cancer. Approximately 23 percent of these women were between the ages of 25 and 39; 27 percent were between 40 and 49; 27 percent were between 50 and 64 years old; and 22 percent were 65 years of age or older.

During the Year 2002, Michigan women lost a total of 2,917 person-years of life to cervical cancer, with an average of 25.6 years of life lost per person.

The Pap test is the most efficient cancer screening procedure known to medicine. Although very effective, it is not perfect. Most precancerous abnormalities affecting the uterine cervix are very slow in developing. Pap tests can detect cellular abnormalities before they develop into cancer.

Evidence strongly suggests that regular screening with Pap tests decreases mortality from cervical cancer, as about sixty percent of women who die of cervical cancer have not had a Pap test in the last five years.

Experts believe that virtually all cervical cancer deaths could be prevented by a combination of safe sex practices, routine Pap tests, and appropriate follow-up and treatment of abnormal screening results. Yet, research indicates that certain groups of women do not get regular Pap tests.

What Needs To Be Done

To lower cervical cancer incidence and mortality rates, the barriers to screening must be addressed. These barriers include patient, provider, and/or health care system aspects. There is also a need to understand why cervical cancer is developing in particular individuals and what is unique to those individuals.

More than 96 percent of Michigan women age 18 and older have received at least one Pap test during their lifetime. But only 85 percent of Michigan women age 18 and older have received a Pap test within the past three years. Women less likely to receive cervical cancer screening within the past three years include those with low incomes, those with less than a high school education, and those who are over the age of 60.

The MCC Cervical Cancer Advisory Committee has identified specific objectives and strategies that need to be implemented to achieve this priority.² These objectives and strategies are as follows:

Objective #1

Increase patient education efforts regarding cervical cancer screening.

Strategies:

- From within targeted communities, identify and train male and female peer spokespersons to help develop and disseminate prevention messages to community members.
**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*
- Identify unique community leaders and educate them in order to increase screening rates.
**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*
- To promote screening, develop a narrowly targeted message that is culturally specific and disseminate through small, local, culturally specific media.

**Organizations representing or Serving Hard to Reach Special Populations can participate in this strategy.*

- Provide education through media, targeting January (Cervical Cancer Awareness Month)
 - Education should follow the Breast Cancer model of awareness.
 - Education should be in the medical sections of newspapers and use cancer support groups to educate the public.
 - Increase screening efforts to women in substance abuse treatment centers and homeless/domestic violence centers.

**All MCC organizations can participate in this strategy.*

- Before college admission physical, provide information to university students to ask provider about Pap test.

**MCC Key Partner organizations can participate in this strategy.*

Objective #2

Increase provider education efforts regarding cervical cancer screening.

Strategies:

- Educate all Michigan health care providers on MCC cervical cancer screening guidelines early and often.
 - Mail MCC cervical cancer screening guidelines to all Michigan providers.
 - Review cervical cancer screening guidelines in health care provider curriculum.
 - Provide MCC cervical cancer screening guidelines to all health care provider students.
 - Include one-page MCC cervical cancer screening guidelines summary in professional organizations' newsletter.

**All MCC member organizations can participate in this strategy.*

- Provide information to Emergency Department physicians regarding the suggestion to include information on possible need for Pap testing on Emergency Department Discharge Instructions.

**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*

- Encourage providers to offer Pap testing, as appropriate, to women who present for STI screening.

**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*

- Provide education through media, targeting January (Cervical Cancer Awareness Month)
 - Education should follow the Breast Cancer model of awareness.
 - Education should be in the medical sections of newspapers.

- Increase screening efforts to women in substance abuse treatment centers and homeless/domestic violence centers.

**All MCC organizations can participate in this strategy.*

Objective #3

Influence health care policy reform.

Strategies:

- Require that Medicaid Managed Care contracts have a mechanism for incentives for adherence to MCC cervical cancer screening guidelines.
**Health Care Insurance Plans can participate in this strategy.*
- Create voucher-type program for uninsured/underinsured women who do not qualify for federal program to “purchase” Pap tests at lower costs.
**Health Care Insurance Plans and Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Request funding for ongoing cervical cancer education for both providers and patients.
**All MCC member organizations can participate in this strategy.*
- Strongly recommend that pathologists provide correlation between the index Pap and the biopsy result on the report.
**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Explore feasibility of laboratories mailing Pap test reports to patients (similar in procedure to the mailing of mammogram reports).
 - Convene Cervical Cancer Advisory workgroup to evaluate current effectiveness of mammogram mailing data and determine baseline data on follow-up of abnormal Pap tests.
**Cervical Cancer Advisory Committee workgroup members can participate in this strategy.*
- Mandate that hospitals in Michigan offer Pap testing during hospital admissions for all eligible women who have not been screened within previous 18 months.
**Health Care / Primary Care Delivery Systems and Practices can participate in this strategy.*
- Address non-coverage by traditional third-party payment sources of prevention services such as Pap and HPV testing.
**Health Care Insurance Plans can participate in this strategy.*

- Provide uniformity in Cervical Cancer screening recommendations.
 - Medicaid and the Michigan Department of Community of Health should promote MCC screening guidelines to providers.
- *The Michigan Department of Community Health can participate in this strategy.*

Objective #4

Participate in Cervical Cancer Research Projects.

Strategies:

- Measure cervical cancer screening rates at the county level.
 - Analyze counties where screening rates are low.
 - Analyze demographics of non-screened populations and administer targeted surveys in those counties.
 - Target “low-screening” counties for intervention based on county level demographics and associated factors.
 - Use next iteration of Behavioral Risk Factor Surveys to evaluate impact of interventions.
 - Disseminate research results to interested parties.
- *Health Care Insurance Plans can participate in this strategy.*

Endnote

1. Whenever possible, the data quoted in this strategic plan are the most recent available. Frequently there is a 12- to 18-month interval between the time a cancer is diagnosed and the time that information is available from the Michigan Cancer Registry. However, cancer mortality data for any given year generally are available from the Registry within several months after the close of that calendar year. Hence, the cancer-related mortality data that are available often are more recent than the available cancer-related incidence data.
2. For a complete list of the Cervical Cancer Advisory Committee members and the references used to determine these strategies, please visit the MCC website at <http://www.michigancancer.org>.

Michigan Cancer Consortium
**Recommendations for the
Early Diagnosis of Cervical Cancer, 2003**

In 1996, the Michigan Department of Public Health (now the Michigan Department of Community Health) released a 98-page document entitled *Cervical Cancer Screening & Detection in Michigan: Recommendations to Reduce Mortality*.

The guidelines were the result of several years of research and the collective expertise of professionals from the fields of public health, medicine, nursing, and epidemiology. They were written by members of the Cervical Cancer Advisory Committee, a subcommittee of the Department's Michigan Cancer Consortium (MCC), to guide the practice of health care providers in conducting cervical cancer screening examinations and follow-up of abnormalities.

In December 2000, in recognition of the changed state of science, the MCC (now an independent body comprised of organizational members) reconvened Michigan clinical experts from a variety of disciplines, installing them as members of a new MCC Cervical Cancer Advisory Committee and charging them with revising the 1996 recommendations, based upon the current knowledge and best practice.

In March 2001, the MCC Board of Directors reviewed and approved these updated consensus guidelines, publishing them as *MCC Recommendations for the Early Diagnosis of Cervical Cancer* and disseminating a summary of them in a laminated, tri-fold document to primary care providers throughout Michigan.

In 2002, the MCC again assembled its Cervical Cancer Advisory Committee, this time to address recently released changes in the Bethesda System (a national, uniform framework of pathology classification for reporting the results of Pap tests) and the American Cancer Society guidelines for the initiation of Pap smear screening and the management of abnormal Pap smears.

Committee members met in late 2002 and again in early 2003 to review and revise the MCC recommendations to ensure that they were consistent with the changes at the national level and adhered to the best current clinical evidence and expert opinions. The group submitted its completed revisions to the MCC Board of Directors, which approved them in April 2003. The guidelines have been pilot-tested in several locations and are being disseminated to providers and health care systems throughout the state.

Notes About the 2003 MCC Guidelines

In their revision of the MCC guidelines, members of the MCC Cervical Cancer Advisory Committee strove to meet two goals: 1) to maximize the delivery of cervical cancer screening techniques and 2) to minimize over-treatment of low-grade disease that often resolves spontaneously, while at the same time identifying and treating significant cervical disease.

The *2003 MCC Recommendations for the Early Diagnosis of Cervical Cancer* speak to several points of concern expressed by Cervical Cancer Advisory Committee members during the guideline revision process.

The first concern was to ensure the appropriate follow-up of abnormal Pap smears by seeking to minimize, as much as possible, both the over-management and the over-treatment of less serious cervical abnormalities, especially among young women who wish to retain fertility.

A second concern was to ensure, as much as possible, that women who were, for whatever reason, not able to easily access either cervical cancer screening and/or follow-up diagnostic services would not, as a result, be placed at undue risk of developing invasive cervical cancer.

A third concern involved the possibility of promoting liquid-based cytology as the standard of care. Although this technology can potentially be used to screen women less frequently, it is more costly than a conventional Pap test. As such, it currently is much more likely to be available to providers in larger health systems than to providers working in public health and family planning agencies.

Lastly, the Advisory Committee members were concerned about the fact that the test for Human Papillomavirus is becoming more widely available and, therefore, that the appropriate use of this test should lead to more targeted follow-up.

As part of the Advisory Committee's discussions, a cytopathologist member shared this statement from the College of American Pathologists' *Policy on Frequency of Cervical Cancer Screening, 2003*:

"The College of American Pathologists encourages annual pelvic exams and regular cervical cancer screening for all women. Regular cervical cancer screening should begin three years after women become sexually active or by the age of 21. Current data indicate that most women under the age of 30 will benefit from annual cervical cancer screening. Lengthened intervals of cervical cancer screening may be appropriate for some women depending upon specific clinical circumstances.

"Regardless of age, the appropriate screening interval should be determined by each patient in consultation with her physician taking into account detailed patient history and risk factors. A woman's Human Papillomavirus status may be a contributing factor in determining cervical cancer screening frequency. When accuracy or completeness of the historical record is in doubt, annual screening should be the default screening interval."

In light of the Committee's desire to reconcile these issues, the *2003 MCC Recommendations for the Early Diagnosis of Cervical Cancer* promote **annual** screening for cervical cancer. The recommendations also encourage providers to develop office-based systems that will notify women of abnormal Pap tests, encourage them to schedule follow-up diagnostic testing, and remind them to schedule a Pap test on a regular basis.

The Michigan Cancer Consortium would like to thank all those involved for their significant contributions of time and effort to ensure that Michigan's guidelines continue to reflect the best of scientific evidence and expert opinions regarding the early detection of cervical cancer.

April 17, 2003

Bibliography

Anttila T, Saikku P, Koskela P, Bloigu A, Dillner J, Ikaheimo I, Jellum E, Lehtinen M, Lenner P, Hakulinen T, Narvanen A, Pukkals E, Thoresen S, Youngman L, Paavonen J. Serotypes of *Chlamydia trachomatis* and risk for development of cervical squamous cell carcinoma. *JAMA* 2001;285:47-51

Ho GYF, Bierman R, Beardsley L, Chang CJ, Burk RD. Natural history of cervicovaginal Papillomavirus infection in young women. *NEJM* 1998;338:423-428

Miller MG, Sung HY, Sawaya GF, Kearney KA, Kinney W, Hiatt RA. Screening interval and risk of invasive squamous cell cervical cancer. *Ob/Gyn* 2003;101:29-37.

Munoz N, Bosch FX, de Sanjose S, Herrero R, Castellsague X, Shah KV, Snijers PJF, Meijer CJLM. Epidemiologic classification of Human Papillomavirus types associated with cervical cancer. *NEMJ* 2003;348:518-527.

Nash JD, Burke TM, Hoskins WJ. Biologic course of cervical Human Papillomavirus infection. *Ob/Gyn* 1987;69:160-162.

Saslow D, Runowicz CD, Solomon D, Moscicki AB, Smith RA, Eyre HJ, Cohen C. American Cancer Society guideline for the early detection of cervical neoplasia and cancer. *CA* 2002;52:342-362.

Shepherd J, Peersman G, Weston R, Napuli I. Cervical cancer and sexual lifestyle: A systematic review of health education interventions targeted at women. *Health Ed Res* 2000;15:681-694.

Soloman D, Davey D, Kurman R, Moriarty A, O'Connor D, Prey M, Raab S, Sherman M, Wilbur D, Wright T, Young N. The Bethesda 2001 System. *JAMA* 2002;287:2114-2119.

Soloman D, Schiffman M, Tarrone R. Comparison of three management strategies for patients with atypical squamous cells of undetermined significance. *JNCI* 2001;93:293-199.

Wright TC, Cox JT, Massad LS, Twiggs LB, Wilkinson EJ. 2001 Consensus guidelines for the management of women with cervical cytological abnormalities. *JAMA* 2002;287:2120-2129.

Section A

Michigan Cancer Consortium
Cervical Cancer Early Detection Guidelines for Primary Care Providers
Spring 2003

Screening Tests

A Pap test and speculum exam should be used for routine cervical cancer screening.

Age to Initiate Screening

Screening for cervical cancer should begin at age 21 or three years after the onset of sexual activity, whichever occurs first.

Screening Frequency

Women should be encouraged to have annual gynecologic exams and not be discouraged from seeking Pap tests or annual screening unless they have none of the following risk factors:

- History of sexual intercourse
- No previous routine Pap smear (never been screened or have not been screened in 5+ years)
- Women who are infected with high-risk HPV
- Women with a history of cervical or vaginal dysplasia or cervical, endometrial, vaginal, or vulvar cancer
- Women who were exposed to DES *in utero*
- Women who currently have, or have had, more than one sexual partner
- Women whose sexual partners have had more than one partner.
- Women whose sexual partners have had other sexual partners with cervical cancer or with high-risk HPV
- Women and women whose sexual partners have a history of substance abuse or HIV/AIDS
- Women who began sexual intercourse at ≤ 15 years of age
- Women with a history of sexually transmitted diseases, other than HPV
- Women who are immunosuppressed
- Smokers and abusers of other substances, including alcohol
- Women without risk factors: After 3 consecutive annual negative Pap tests, the screening interval may be increased to every 2 years.
- Women without a cervix, and without a prior history of gynecologic malignancy, are at low risk of cervical cancer.

Upper Age Limit for Screening

There is no upper age limit at which cervical cancer screening should be discontinued. A woman should be screened as long as she is at risk for HPV exposure/infection. Therefore, age should not be the sole factor in determining when screening is no longer appropriate. Provider discretion should be used with consideration of: 1) whether the woman is sexually active and therefore at risk for HPV exposure; 2) existence of other co-morbid conditions which are likely to decrease life expectancy; and 3) if she is HIV+. Women over age 70 may consider not being screened if they have had three (3) documented negative Pap tests and no abnormal Pap tests in the last 10 years.

Reminder and Tracking Systems

Clinicians should be encouraged to develop a system which will notify women of abnormal Pap tests, ask them to schedule follow-up diagnostic testing, and remind them to schedule a Pap test.

Patient Education

Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV.

Section B

SPECULUM EXAM

Findings	Action
Abnormal gross appearance Perform Pap test	Immediate referral for colposcopy with biopsy, as indicated (Do not rely on cervical cytology results alone)

Indications for Referral to Qualified Healthcare Provider

- Women who are pregnant and have an abnormal Pap test and/or abnormal cervix, including a planned referral for postpartum management
- Women with recurrent or persistent dysplasia who have a desire for fertility
- Pap test results of AGC or AIS
- Women who are immunocompromised with abnormal Pap test \geq ASC-US
- HSIL Pap test not confirmed by biopsy or ECC
- ASC-H with negative work-up
- Women whose Pap smear specimen is “unsatisfactory for evaluation due to Atrophy with Inflammation” and in whom the use of estrogen is contraindicated (Page B-5)
- Pap test result of “LSIL for low-risk, postmenopausal women with a history of negative Pap tests” and in whom the use of estrogen is contraindicated (Page B-6)
- **It is recommended that women with any gynecologic cancer should be referred to a GYN oncologist**

HPV Management

Perform HPV (high-risk) testing 1 year after colposcopy	If results of high risk HPV test +, repeat colposcopy
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Pap Testing on Women Who Have Had Complete Hysterectomies

- Perform yearly speculum and bimanual exam
- There is no indication for Pap testing in most instances
- History of CIN/CIS where this was the reason for hysterectomy, DES exposure *in utero*, or immunocompromised status: Continue vaginal sampling
- Woman with a history of abnormal cervical biopsies (CIN2/CIN3): Pap test of vagina until 3 negative tests are achieved within 10 years, then Pap testing may be discontinued
- Women with a cervix (supra-cervical hysterectomy) should continue Pap tests based on screening guidelines

Glossary

HPV: Human Papillomavirus

ASC-US: Atypical Squamous Cells — Uncertain Significance

ASC-H: Atypical Squamous Cells — Cannot Exclude High-grade Lesion

LSIL: Low-grade Squamous Intraepithelial Lesion (mild dysplasia)

HSIL: High-grade Squamous Intraepithelial Lesion (moderate/severe dysplasia)

AGC: Atypical Glandular Cells

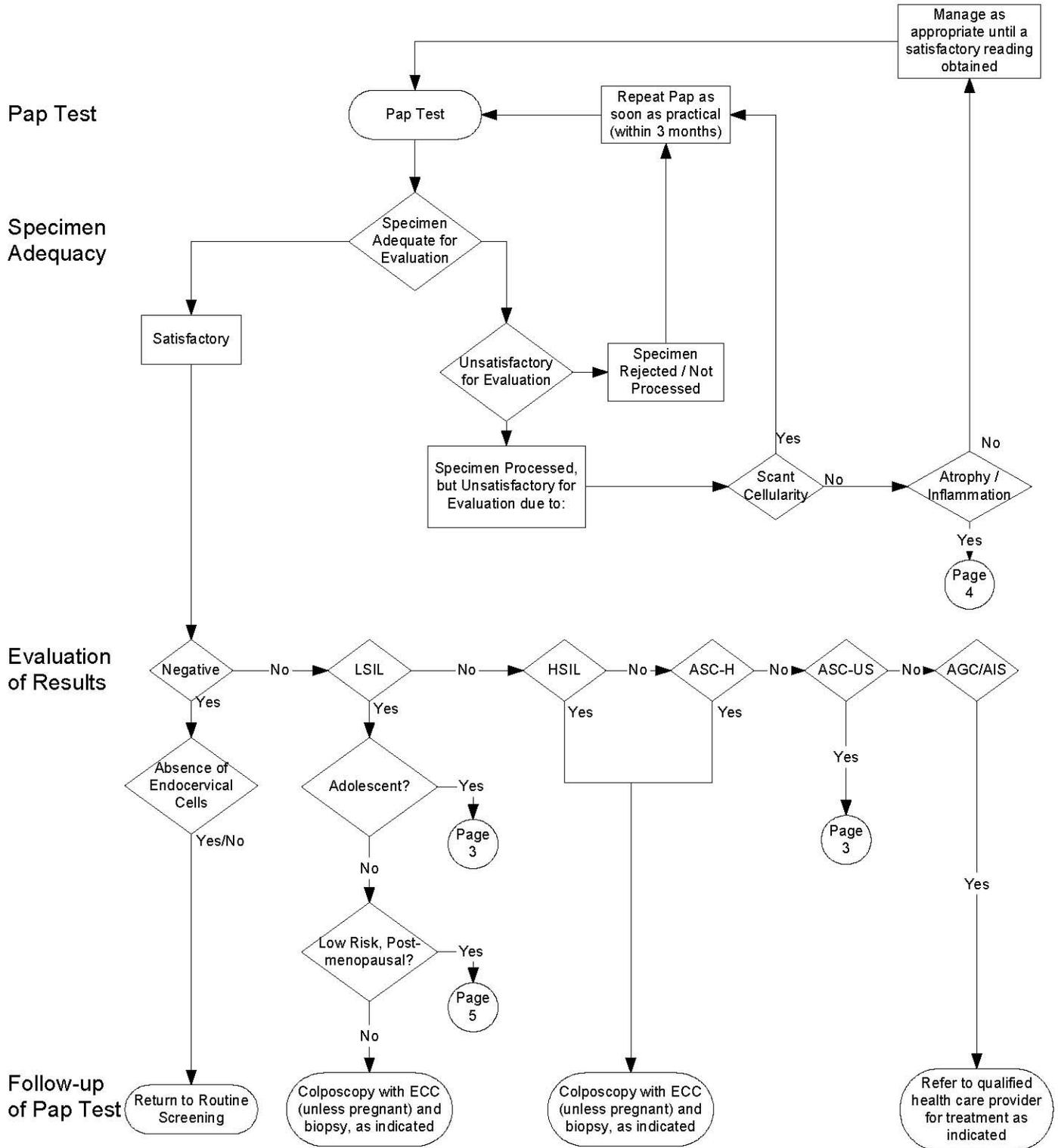
AIS: Adenocarcinoma *in Situ*

ECC: Endocervical curettage

CIN: Cervical Intraepithelial Neoplasia

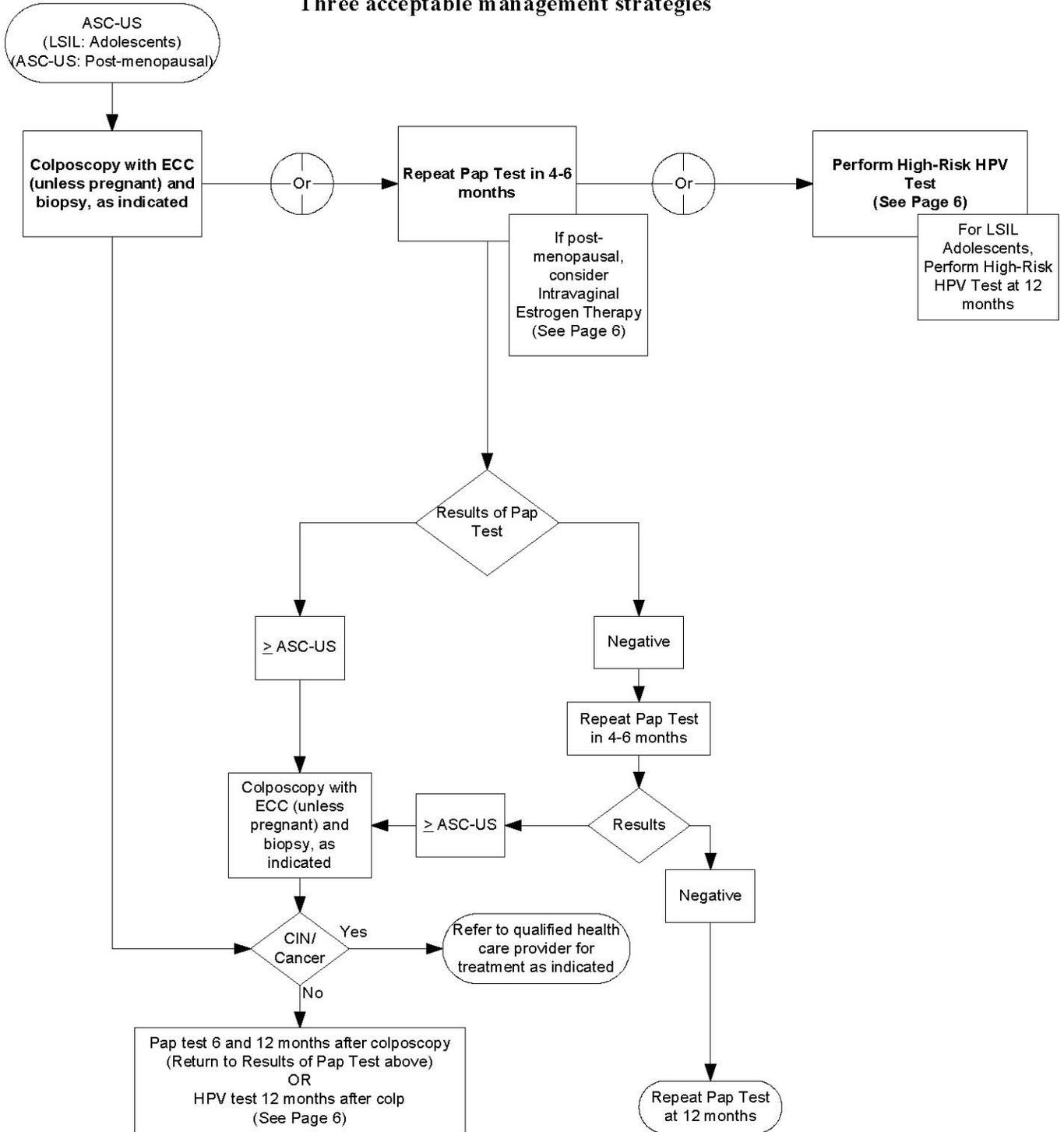
HIV: Human Immunodeficiency Virus

Management Overview of Pap Test Results

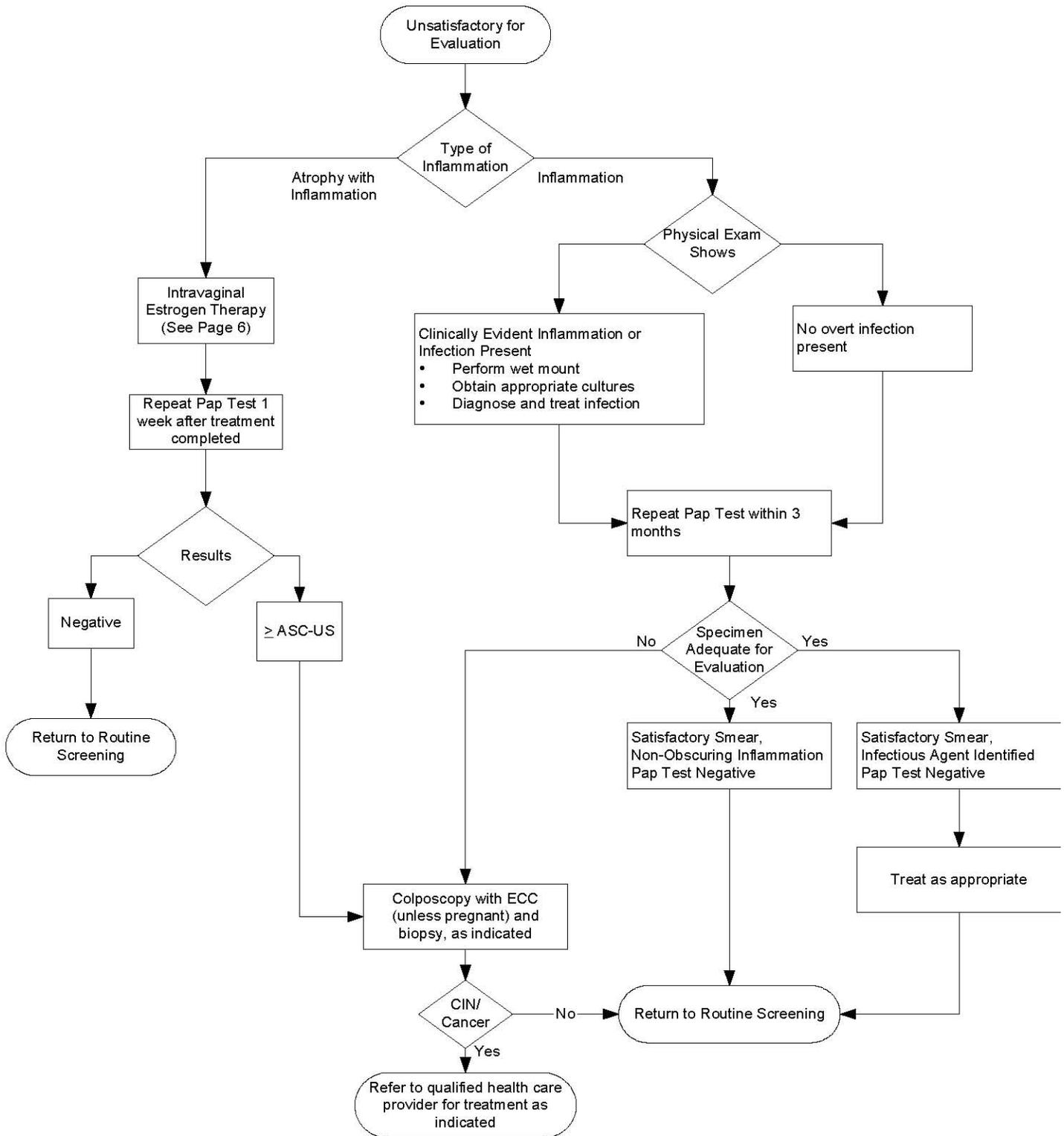


PAP TEST RESULTS
ASC-US (Atypical Squamous Cells-Uncertain Significance)
or LSIL (Special Circumstance: Adolescents)

Three acceptable management strategies



PAP TEST RESULTS
UNSATISFACTORY for Evaluation, due to INFLAMMATION*
(Causes: infection, atrophy/estrogen deficiency)

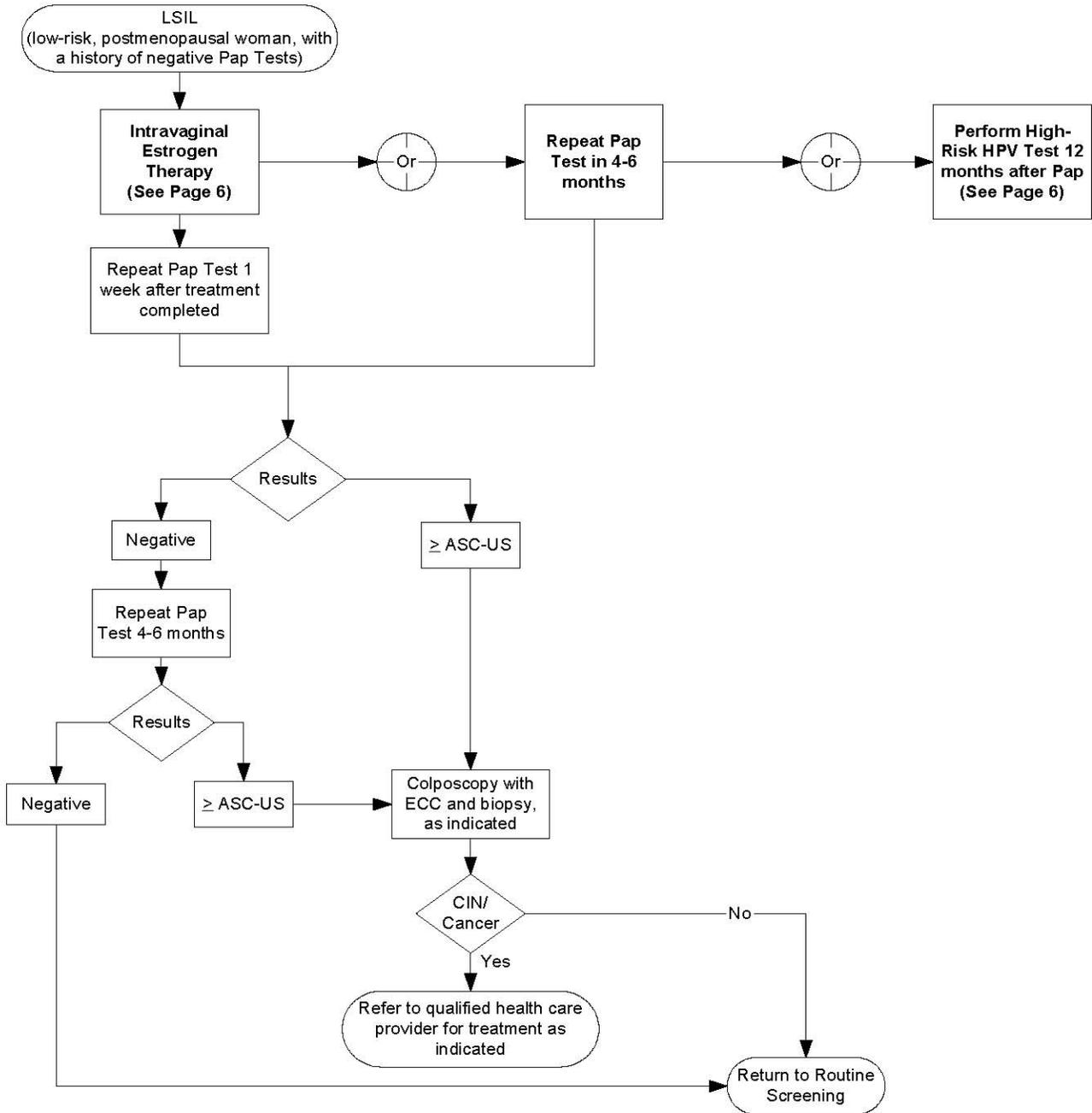


*inflammation is not indicative of a potential cancer *per se*, but inflammation may obscure the result

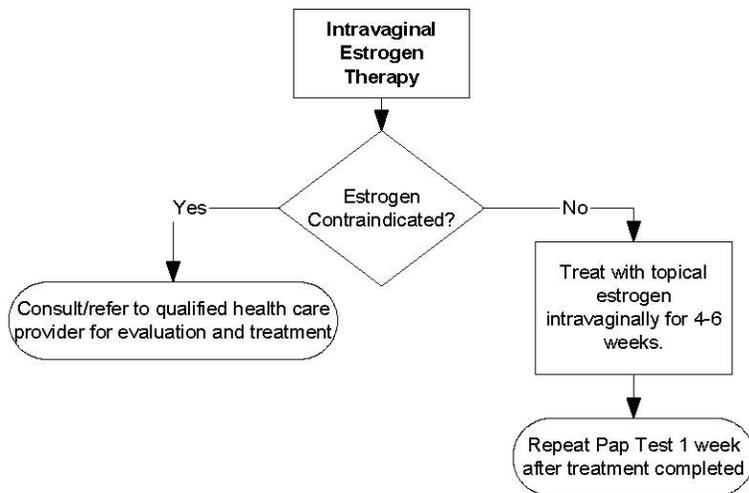
PAP TEST RESULTS

LSIL

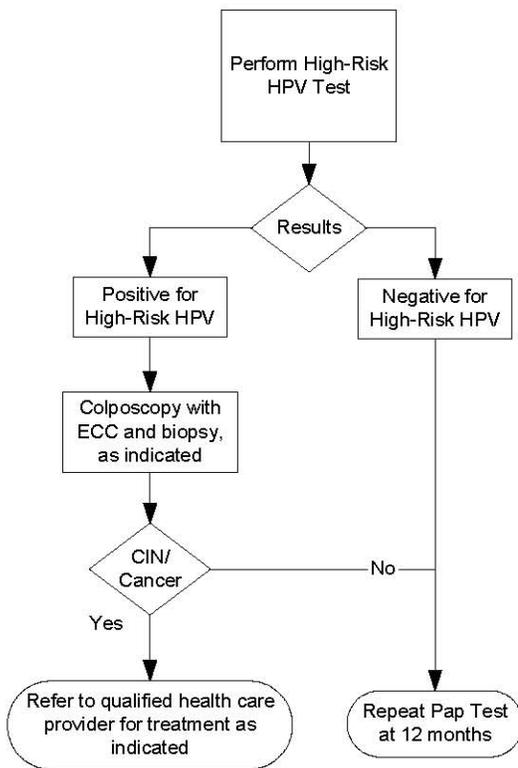
(Special Circumstance: low-risk, postmenopausal women, with a history of negative Pap Tests)



Intravaginal Estrogen Therapy, for postmenopausal women



High Risk HPV Testing



Division of Immunization Overview

The mission of the Division of Immunization of the Michigan Department of Community Health (MDCH) is to minimize and prevent the occurrence of vaccine-preventable diseases within our state.

This mission is accomplished utilizing a multifaceted approach involving many programs such as provider quality assurance and education, surveillance for disease and monitoring vaccine uptake, and education and outreach to many groups. The Michigan Immunization program, through its partnerships with local health departments and private providers, works to assure that vaccines are made available and used appropriately.

Vaccine for Children Program:

The Vaccines for Children (VFC) program is a state-operated federal entitlement program that provides vaccines to enrolled public and private immunization providers at little or no cost to children under the age of 19.

VFC - Basic: Uses federal funds to provide vaccines for children less than 19 years of age who meet one of the following federal VFC eligibility requirements:

- are Medicaid eligible
- have no health insurance (uninsured)
- are American Indian or Alaskan Native
- are underinsured and served at a federally qualified health center (FQHC) or a rural health center (RHC) *

** In Michigan, local health departments (LHDs) operate under agreements that allow them to act on behalf of Federally Qualified Health Centers (FQHCs) for purposes of childhood immunizations.*

The VFC-Basic program primarily serves the Medicaid-eligible population and is considered an entitlement program. Federal appropriations for entitlement programs must be maintained because eligibility guidelines are a matter of federal law and funds must be provided to support vaccinations for all children falling within the guidelines.

VFC - Expanded: Uses a different source of federal funds - Section 317 money - to provide vaccines for children less than 19 years of age who are under-insured and served by a VFC-enrolled private provider. Not all VFC vaccines are available under the VFC-Expanded program.

Eligibility for the VFC-Expanded program is set by State policy, based on allocated federal funds. This funding has been gradually decreasing each year over the last decade. MDCH tries to assure that these funds are allocated among immunization activities in a way that best promotes the health of Michigan's citizens.

Insured: A child is considered insured for immunizations if all or a part of the vaccine is covered by insurance. Co-pays, deductibles, or other charges associated with the cost of the vaccine are considered to be routine costs of health care and the child would not qualify to receive VFC vaccines. A child with insurance that has a cap on preventive care is considered to be fully insured until the cap is fully depleted. An insured child (including MI-Child enrollees) is not eligible for either the VFC-Basic or VFC-Expanded program.

Under-Insured: For the purposes of determining eligibility for VFC, children are considered to be under-insured if the child's insurance does not include **any** reimbursement for the cost of the vaccine. A child with health insurance that has no immunization benefit at the time the child presents is considered to be under-insured and eligible to receive VFC vaccine. When a child's health insurance generally covers immunization, but a particular VFC vaccine is not covered, that child is VFC-eligible for purposes of that particular vaccine at that visit, but eligibility must be reviewed for future immunizations.

Administrative Fees: Federal policy has set the maximum administrative fee charged in Michigan at \$16.75 per injection. Providers using federally procured VFC vaccines cannot deny administration of these vaccines due to the inability of a child's parent or guardian to pay an administration fee.

For more information, see www.cdc.gov/nip/vfc

Michigan Care Improvement Registry (MCIR):

In accordance with Public Act 91 of the Public Acts of 2006, the Michigan Department of Community Health (MDCH) established the Michigan Care Improvement Registry (MCIR) to record information regarding immunizations administered by health care providers.

The MCIR consists of an electronic statewide database into which physicians, and other private and public health care providers submit data relative to the immunizations they provide.

Schools and Childcare Centers use the MCIR to do their immunization program (compliance) reporting to their local health departments.

Reporting methods

Immunization data may be submitted electronically or by using paper scan forms. Those providers submitting their data electronically may use the MCIR Web application to submit records interactively on an individual basis, or in groups through a batch transfer from an approved Electronic Medical Record (EMR) system. An optional Vaccine Inventory Module assists providers with management of their vaccine inventory and will generate the reports needed for documentation of the Vaccines For Children program.

Accessing methods

The data may be accessed only by authorized professionals to determine which immunizations are due for the children they see. Immunization providers can determine the immunization level

of their practice or community. Individual physicians and hospitals may access a child's record to determine the completeness of his or her immunizations. Authorized users have direct real-time access to the MCIR through the MCIR Web application. Public health officials utilize data from the system to determine the overall state of immunizations and to target remedial actions when necessary.

The State is divided into six MCIR regions with regional staff responsible for administering specific counties within the State. The regional staff assists public health agencies and private providers in utilizing the system. At the State level the registry is administered by the Michigan Department of Community Health's Division of Immunization.

Users of the system must refrain from employing the MCIR and data on the MCIR for any use other than that required to provide immunization or preventive health services. Access to the MCIR database is permitted under the provisions of MCL 540.9201, 9206 and 9227. For more information, see www.mcir.org.

Michigan Advisory Committee on Immunizations (MACI):

The Michigan Advisory Committee on Immunizations (MACI) was formed in 1992 to advise the Michigan Department of Community Health on immunization-related issues. Current membership includes twenty representatives from the Michigan Health and Hospital Association, the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Chapter of the American Academy of Family Physicians, and various other public health and health related organizations. MACI provides the Division of Immunization with guidance on state policy recommendations. Each organization's representative is asked to attend and participate in quarterly meetings, provide input from their organization, and take information back to their organization for consideration. The increased number of vaccines that are recommended for children, adolescents, and adults, and the challenges of financing vaccines make this committee's role essential to our state. A current list of members and meeting times can be obtained from taten@michigan.gov.

Human Papillomavirus Fact Sheet

Facts about the virus and the vaccine:

- The Human Papillomavirus is responsible for over 99% of cervical cancer, and is sexually transmitted.
- Human Papillomavirus (HPV) is very prevalent in the United States. Approximately 20 million people are currently infected with HPV, and at least 50 percent of sexually active men and women acquire genital HPV infection at some point in their lives. About 1 million sexually active adults in the U.S. have visible genital warts at any point in time. However, most infections are asymptomatic which means that people do not know they are infected yet they can still transmit the virus to a sex partner.
- 25% of US teens have sex by age 15 years and 48% by age 17 years.
- In the US, the highest prevalence (40%) of High-Risk HPV is among 14-19 year olds. Prevalence decreases with increased age.³
- Of the over 100 strains of HPV, more than 30 are sexually transmitted and can cause genital HPV infection. Some of the viruses causing genital HPV infection are “low risk types” and can cause genital warts or mild Pap test abnormalities. “High risk” types can cause abnormal Pap tests and may also lead to genital cancers. Persistent infection with “high-risk” types of HPV is the main risk factor for cervical cancer.
- Cervical cancer is the second most common cancer in women, worldwide. In the US as well as Michigan, rates of cervical cancer, as well as mortality caused by cervical cancer, are higher for African American and Hispanic women, when compared with white women. See “Facts about Cervical Cancer in Michigan” http://www.michigan.gov/documents/CervicalFacts_6648_7.pdf
- HPV strains #16 and 18 are responsible for 70% of invasive cervical cancer in the United States; there are at least 13 high-risk (for cancer) types of HPV
- Merck and GlaxoSmithKline have developed vaccines against HPV: Merck’s is a quadrivalent (covers strains 16 and 18 as well as 6 and 11, strains responsible for most warts) while GSK’s is bivalent (strains 16 and 18).
- The vaccine, Gardasil®, (HPV4) is manufactured by Merck and is licensed for use in females ages 9-26 years. Current studies are being done on the vaccine in males. GSK’s vaccine is under review, but is not yet licensed.
- HPV4 has been found to be 100% effective in preventing cervical pre-cancers caused by the targeted HPV types. It has also been found to be almost 100% effective in preventing pre-cancers of the vulva and vagina, and genital warts that are caused by the targeted HPV types.
- HPV4 vaccine has been tested in over 20,541 females (ages 16-26 years) in many countries around the world. There appear to be no serious side effects. The most common side effect is brief soreness at the injection site. There is no thimerosal or mercury in the vaccine. This vaccine is made up of proteins from the outer coat of the virus (HPV).

- HPV4 vaccine should be delivered through a series of three IM injections over a six-month period (at 0, 2, and 6 months). It may be given at the same time as other vaccines.
- Federal law requires that Vaccine Information Statements (VIS) be handed out whenever certain vaccinations are given, before each dose. A HPV4 VIS will be available soon.
- Vaccines administered to children and adults should be entered into the web-based immunization registry- the Michigan Care Improvement Registry (MCIR). See www.mcir.org.

Summary and Recommendations:

- The [Advisory Committee on Immunization Practices](#) (ACIP) provisional recommendations for HPV4 include:
 - routine vaccination for 11-12 year-old girls
 - catch-up vaccination for 13-26 year-old females
 - girls age 9-10 may receive the vaccine at provider discretion
- The HPV vaccine should be made generally available to young women, using guidance developed by the Michigan Cancer Consortium's Cervical Cancer Advisory Committee (CCAC) and the Michigan Advisory Committee on Immunizations (MACI).
- The Cervical Cancer Task Force recommends that all publicly funded programs adopt the HPV recommendations developed collaboratively by the CCAC and MACI.
- While the impact of an effective HPV vaccine on cervical cancer rates may not be realized for decades (since cervical cancer takes many years to develop), the impact of this vaccine on cervical cancer precursors (abnormal Pap test results) and genital warts may be realized sooner.
- Although an effective vaccine is a major advance in the prevention of genital HPV and cervical cancer, it will not replace other prevention strategies, such as cervical cancer screening for women or protective sexual behaviors.
- Pap tests will remain an important weapon in our arsenal against cervical cancer. Even if 100 percent vaccine coverage is achieved, the current HPV vaccine will not eliminate the need to continue cervical cancer screening in the United States because about 30 percent of cervical cancers are caused by viruses not in the current vaccine.

HPV4: Facts about Vaccine Cost and Financing

- Like other vaccines, HPV vaccine will be cost effective. It will save dollars as it saves lives and reduces suffering. The retail price for the private sector HPV vaccine is \$360 for the 3-dose series. The vaccine should be given before the onset of sexual activity to receive the full benefits of this vaccine but administration of the vaccine should still be considered for those following the onset of sexual activity.

- Federal health programs, such as Vaccines for Children (VFC), will cover the HPV vaccine. The VFC program provides free vaccines in private provider offices and public health clinics to children and adolescents age 18 and younger, who are either uninsured, Medicaid-eligible, American Indian, or Alaska Native. The underinsured (have insurance coverage that does not cover vaccination) have been covered for all vaccines in federally qualified health centers (FQHCs) or local health departments in Michigan. As of August 28, 2006, CDC has not yet finalized contract prices with the manufacturer and therefore the vaccine is not yet available through the VFC program.
- Insurance companies usually cover the cost of ACIP recommended vaccines. Private providers will be asked to assess which patients are covered by their health plans for this vaccine. There may be a lag time after the vaccine is recommended and when it is covered by health plans.
- Merck Corporation has a patient assistance program that will pay for the HPV4 Vaccine for uninsured adults who qualify financially.
- For more information, see www.cdc.gov/nip or www.cdc.gov/std/hpv

Glossary of Acronyms

ACIP:	CDC's Advisory Committee on Immunization Practices
CCAC:	Cervical Cancer Advisory Committee of the Michigan Cancer Consortium
CCTF:	Cervical Cancer Task Force (Governor appointed)
HPV:	Human Papillomavirus
HPV4:	Human Papillomavirus vaccine (quadrivalent)
MACI:	Michigan Advisory Committee on Immunizations
MCC:	Michigan Cancer Consortium
MCIR:	Michigan Care Improvement Registry
MDCH:	Michigan Department of Community Health
PCI:	Primary Care Initiative