

CERVICAL CANCER ELIMINATION INTERIM COMMITTEE

Mountain States Tumor Institute Group Room
St. Luke's Regional Medical Center Campus
100 East Idaho Street
Boise, Idaho
August 9, 2005

MINUTES

(As Approved by the Committee)

The Committee was called to order by Co-chair Senator Joyce Broadsword at 9:00 a.m. Other members present were Co-chair Representative Robert Ring, Senator Kate Kelly and Representative Donna Pence. Staff present were Maureen Ingram, Paige Alan Parker and Charmi Arregui.

Others present were Luana Lamkin and Keri Ann Rodgers, St. Luke's MSTI; Dan Heincy, R.Ph., Merck Human Health; R. Scott Burns, Merck Vaccine Division; Mike Brassey, Givens Pursley/St. Luke's Regional Medical Center; Dr. Lee Parsons, American College of Obstetricians & Gynecologists (ACOG); Scott Pugrud, Connelly and Smyser Ltd; Courtney Washburn, Idaho Women's Network; Nina Eng, Congressman Otter's Office; Dr. Christine Hahn, State Epidemiologist, Idaho Department of Health & Welfare, Division of Health; Minnie Inzer Muniz, Department of Health and Welfare; Molly Steckel and Ron Hodge, Idaho Medical Association; Chris Johnson, Cancer Data Registry of Idaho; Dr. A. Patrice Burgess, Idaho Medical Association; Kent Kunz, Office of the Governor; Brad Hoaglund, American Cancer Society; Dr. Leigh Morse, Family Practice Medical Center; Dr. Michael Myhre, IDX Pathology; Dr. Jerry Perez, Program Administrator for Gynecology Oncology, St. Luke's Regional Medical Center and St. Alphonsus Hospital; Mr. Richard Schultz, Administrator, Division of Health, State Department of Health & Welfare; and Betsy Russell, the Spokesman Review.

Co-chair Senator Broadsword and **Co-chair Representative Ring** gave introductory remarks, thanked the Mountain States Tumor Institute for hosting the committee, and introduced committee members. The committee was established pursuant to SCR 110, 2005, which directed the committee to review data regarding cervical cancer and human papillomavirus (HPV) in women within Idaho and to evaluate current methods used to provide women with information regarding cervical cancer, access to regular screening and options for increasing screening accuracy. In addition, the duties of the committee shall include the identification of pockets of need, priority therapies and preventive vaccines which are effective in preventing and controlling the risk of cervical cancer.

Dr. Lee Parsons, Chairman, Idaho Section, American College of Obstetricians and Gynecologists, began with a short historical review, stating that about twenty years ago it was thought that there was a correlation between the use of birth control pills and cervical cancer. Then some data suggested that herpes and cervical cancer were linked. Smoking does not cause cervical cancer, but

women who smoke compromise their immune system which results in a higher risk of cervical cancer. **Dr. Parsons** said that cervical cancer is not a random event. He said there will never be a study that scientifically proves that the HPV virus causes cervical cancer. From the data available, however, it is strongly suggested that HPV virus does cause cervical cancer. **Dr. Parsons** said that women who get HPV are those who have had many sexual partners and women who were sexually active at a younger age. At a young age, a woman's cervix has a mucous-producing lining; as women age, the lining changes. At a young age, if a woman becomes infected, she will be more susceptible to getting cervical cancer. **Dr. Parsons** said a 40 year old woman contracting HPV for the first time will be less susceptible to getting cervical cancer than an 18 year old woman getting HPV for the first time.

As an example of transmission of the virus, **Dr. Parsons** cited Evita Peron, wife of Argentine dictator Juan Domingo Peron. She died of cervical cancer at age 37. The Argentine dictator's first wife also died of cervical cancer. Widowers of women dying of cervical cancer tend to give cervical cancer to the next wife. Sixty to seventy-five percent of North Americans over the age of 20 years will be exposed to HPV. Most of the HPV's don't cause cervical cancer, but cause other infections. A person can contract HPV from sexual contact and from close contact. It is not something that most people know they have. The virus has many genes, but two specific genes, E6 and E7, are most likely to cause a problem.

Dr. Parsons said HPV is not an equal opportunity disease; it does not attack both genders. HPV doesn't show up in men, but men can spread the virus. Some HPV infections cause warts. Less than 1% of women infected with the highest risk type of HPV will get cervical cancer. **Dr. Parsons** said Pap smears are very important for early detection. HPV in Idaho affects 60-75% of all adults, the same percentage as affects HPV in all of North America. Most infections go unnoticed; some infections lead to abnormal Pap smears. In 2003, there were 42 new cases of cervical cancer in Idaho; 25 cases were curable with simple treatment; there were 14 deaths. For the last ten years, the cervical cancer rate statistically has remained the same, there being a 60% decrease from 1950, when Pap smears were not readily available.

In the last six years there have been 6 cases of cervical cancer per 100,000 women. Cervical cancer rates have diminished markedly because of preventive screening, also known as the annual Pap smear, where pre-cancerous lesions are discovered and treated before progressing to cancer. Providing incentives, or removing barriers, in order to encourage women to receive annual screening will further reduce the rate of cervical cancer.

Dr. Parsons said when women have pre-cancer symptoms, destruction by cryosurgery or removal by biopsy is the treatment. Early cervical cancer treatment can include a radical hysterectomy or radiation therapy. Metastatic cervical cancer is treated with chemotherapy and radiation therapy combined. **Dr. Parsons** said over one-half of the cervical cancer cases in Idaho last year were in women who had not had a Pap smear in five years, so women need to be encouraged to undergo annual Pap tests, even though some women can't afford to see a physician.

Dr. Patrice Burgess, President of the Idaho Medical Association, and a faculty member at the Family Medicine Residency of Idaho, talked about access issues and barriers. She said Idaho has four counties that have no physicians whatsoever. Some counties do not have access to obstetrics and

gynecology (Ob/Gyn) and Idaho has only one gynecological oncologist. **Dr. Burgess** said much of the care in rural areas is provided by nurse practitioners, physician assistants and family practice physicians. Other barriers to getting treatment are finances or lack of insurance; some people don't seek precautionary tests, but rather wait until there is a serious problem. **Dr. Burgess** also said there is a significant substance abuse problem in Idaho and a significant lack of access to mental health facilities. Consequently, people with substance abuse or mental health issues are less likely to go in for preventive treatment.

Dr. Burgess said a lot of abnormal Pap smears don't necessarily turn into cervical cancer. The next test, after a Pap smear, is a colposcopy, a sophisticated instrument designed to facilitate visual inspection of the vagina and cervix. Once a biopsy is taken, the pathologist interprets the findings. If a person has a pre-cancerous condition, several treatment options are available. These may include freezing the area, similar to freezing a wart, or minor surgery can be performed. Not all family physicians perform these types of surgeries to remove a portion of the cervix that is abnormal. A more advanced surgery excises a cone-shaped portion higher in the cervix. **Dr. Burgess** said these are all steps that can be taken before there is a need for an advanced cancer surgery.

Dr. Burgess said that if a woman has an abnormal Pap smear, she needs to be followed up every three to four months until there are three or four normal Pap smears within one year; then annual Pap smears are sufficient. **Dr. Burgess** said it is very challenging to get even motivated, financially well-off women to undertake these steps; if a woman is dealing with substance abuse, mental illness or financial hardship, the chances of seeking treatment decrease substantially.

Dr. Burgess said there are many counties in Idaho which do not have a physician who is trained in techniques used to treat women with abnormal Pap smears. **Dr. Burgess** said in the physician's case, he has to evaluate how often a piece of equipment will be used before he can purchase it, if the purchase requires a substantial capital outlay. Physicians also need to keep their skills updated on some of the more sophisticated procedures, especially with regard to interpretations and treatments. **Dr. Burgess** said there are continual changes, making it necessary to constantly update technical skills. Often times in rural areas, patients with abnormal Pap smear results are sent to Boise, Twin Falls, Idaho Falls, Pocatello, Lewiston or Coeur d'Alene.

Dr. Burgess said pregnancy is a golden opportunity to get a Pap smear. Many 16-18 year old pregnant patients have an abnormal Pap smear. These pregnant patients are followed until the end of their pregnancy. **Dr. Burgess** finds it difficult to maintain continuing contact with some patients after they give birth because of the way Medicaid is structured.

Dr. Burgess said the good news about cervical cancer is that it is completely preventable with regular Pap smears and appropriate follow-ups. **Dr. Burgess** said cervical cancer is 100 percent treatable, but the patient has to follow certain steps. She said any barriers that can be removed, allowing better access to health care, would be of great benefit to the state.

Senator Broadsword asked what the protocol is for doctors to continue checking on a woman with an abnormal Pap smear. **Dr. Burgess** said it depends on the degree of the abnormality; she said Pap smears are graded on the degree of the abnormality, or another test may be done as well. If the Pap

smear is minimally abnormal, it might be repeated every three or four months; if the first one is quite abnormal, a follow-up colposcopy can be done. In a related question, **Senator Broadsword** asked if insurance companies are reluctant to pay for more frequent testing. **Dr. Burgess** said they are pretty good about preventive care. There are problems if a person does not have insurance and does not qualify for Medicaid; such women may be reluctant to have the initial procedure done or the follow-ups, due to cost. The problem is not with third party payers, but is with the non-insured, cash-paying patients. **Dr. Burgess** added there are well-accepted protocols in place, so there are not payment issues with third party payers. **Dr. Burgess** continued, explaining that substance abusers and mentally ill people often times make poor choices regarding sexual behavior and may do things that compromise their immune systems, putting them at greater risk for exposure to HPV. Also, it is difficult to educate people that birth control pills will not protect them from sexually transmitted diseases, including HPV.

Senator Kelly asked what is being done to educate patients. **Dr. Burgess** answered that when doctors prescribe birth control pills, they take that opportunity to educate about sexually transmitted diseases (STD's). **Dr. Burgess** said they need to be specific when telling pregnant teenage girls that if they have an abnormal Pap smear, they need to follow the recommended treatment plan.

Legislative Services staff asked if a Pap smear will show anything other than cervical cancer. **Dr. Burgess** said it can show inflammation, infections and other conditions, but is generally designed to show the presence of cervical cancer.

Dr. Leigh Morse, Family Practice Medical Center of Idaho, explained that the center serves many of the so-called medically indigent population in Southwest Idaho; in just over 3 years, they have done 3,300 Pap smears. Before reporting those results, it helps to understand that cervical cancer develops in the lining of the cervix, the lower part of the uterus (womb) that enters the vagina (birth canal). This condition usually develops over time. Normal cervical cells may gradually undergo changes to become precancerous and then cancerous. Cervical intraepithelial neoplasia (CIN) is the term used to describe these abnormal changes. CIN is classified according to the degree of cell abnormality. Low-grade CIN indicates a minimal change in the cells and high-grade CIN indicates a greater degree of abnormality. So, of the 3,300 Pap smears, there were over 50 cases rated at CIN 1, over 20 with a CIN 2, 61 rated at CIN 3, and 5 malignant neoplasms.

Dr. Morse said the at-risk population includes teens and women with sexual abuse histories, teens with multiple sex partners, women with unstable relationships and multiple sex partners, women with HIV and women with poor access to screening. Women ages 20-30 years have the highest rate of CIN. Women younger than 30 should undergo annual cervical cytological screening. Recommendations to use the more sensitive test -ThinPrep/HPV- are not as applicable to this population, and costs of screening would more than double if ThinPrep/HPV were routinely used. **Dr. Morse** said the diagnostic rate of CIN 1 would increase, and that CIN 1 is common in young women. Approximately 60% of CIN 1 lesions regress within 6 years, unlike the 10% to 20% of CIN 3 patients who progress to develop invasive cancer. ThinPrep is more sensitive, but potential decrease in specificity can result in increased false positives. Aggressive work with CIN 1 patients has morbidity/cost issues.

Dr. Morse next discussed atypical squamous cells of undetermined significance, ASCUS, in other words, a way for a pathology laboratory to say: "We don't know exactly why, but these cells aren't typical." The vast majority of women with ASCUS do not have cancer or a significant disease, although a few may. A pathology laboratory may label a Pap smear as ASCUS based on changes due to the following: improper drying; blood on the slide; inflammation; actual changes in the cells themselves, as occurs in dysplasia (abnormally developing, precancerous cells); and cancer. **Dr. Morse** said they routinely stratify the occurrence with high risk HPV in young or pregnant patients. If it is positive, they do a colposcopy. All cancers associated with high risk HPV do not develop disease. If the test comes back negative, a Pap smear should be repeated annually.

Dr. Morse said that a pregnant CIN 1 patient, or a patient with high risk HPV, would generally be given a colposcopy within the window of Medicaid. **Dr. Morse** discussed how to improve access for screening, stating that an expansion needs to occur for Women's Health Check (WHC) or other funding to include younger women. **Dr. Morse** said insurance or Medicaid should encourage a "medical home" so that physicians can get to know patients and counsel them about high risk behaviors. She also said that awareness campaigns regarding the role of HPV and cervical disease would help to improve access to treatment throughout the state. **Dr. Morse** discussed barriers to treatment which include economic, logistical access, fear/denial and medical management.

Dr. Morse discussed issues with outside referral, including Pap smear or colposcopy or both, delay of treatment, timely referral, repeat colposcopy, biopsy and treatment. **Dr. Morse** said that treatment issues included timely access to treatment, costs of pathology, costs of rescreening, and assurance of follow-up visits. **Dr. Morse** has a goal to decrease incidence of and improve treatment of pre-cancers. These include access to treatment, reimbursement to treatment centers, gathering data on high grade dysplasia and high risk HPV, vaccinating teenagers when and if vaccination is available, and educating teenagers on the role of HPV and risk factors of multiple sex partners.

Dr. Michael Myhre, founder and owner of IDX Pathology, President-elect of the Ada-Canyon Medical Society, and Trustee District 4 of the Idaho Medical Association, discussed the pathology of cervical cancer, admitting that he had some strong opinions on how Pap smears should be administered, and indicated that not everyone shares his view. **Dr. Myhre** said that IDX does about 45,000 Pap smears annually, most being done in the Central District Health Department, adding that they do not profit financially from these Pap smears. **Dr. Myhre** said that generally, poor women with poor or infrequent access to health care, are more likely to get cervical cancer.

Dr. Myhre explained how cells inside and outside the cervix turn precancerous or cancerous, and also how a Pap smear is administered. **Dr. Myhre** said the process is highly subjective on false negatives and false positives, having a range of possible outcomes; the reason for testing is to look for formation of abnormal cells, pointing out that a conventional Pap smear will accurately identify only 51% of women who have abnormal cells. **Dr. Myhre** said Pap smears work best in situations where the Pap smear gets repeated; if it is repeated three years in a row, 90% of women with abnormal cells will be diagnosed.

Dr. Myhre said there will be 4,000-5,000 deaths in the country this year from cervical cancer. Mortality has not been impacted (has not declined) in this country during the past 20 years because

the lack of access to medical care by poorer members of the population has remained constant. When these patients with cervical cancer finally do go to a doctor, they usually have late-stage cancer. **Dr. Myhre** said the State of North Carolina and Blue Cross /Blue Shield of Hawaii have conducted studies to compare the cost of managing their Pap smear one-year and two-year programs. They saved from seven to ten dollars per patient in year two of the two-year because of the repeat administration, adding that the Pap smear is very effective in prevention. In response to a question, **Dr. Myhre** said it is important to be both sensitive and specific in a Pap smear test.

Dr. Myhre said that it is important to see a patient multiple times and discussed alternatives to a colposcopy. If a Hybrid HPV/DNA test comes back negative, a patient probably doesn't need to have a colposcopy examination. **Dr. Myhre** believes that cervical pathology is effective. Even though women don't like to have Pap smears, they are a very necessary diagnostic test. Regarding costs, **Dr. Myhre** referred to Blue Cross/Blue Shield of Hawaii and the State of North Carolina studies. The conventional Pap smear reimbursement was boosted to about \$14 per smear, very close to cost of service, and ThinPrep Pap is reimbursed by Medicare at the rate of \$25. ThinPrep Paps result in lower operational costs in total patient care: fewer unsatisfactory tests, fewer less-than-optimal Pap smears and fewer repeats, resulting in fewer patient visits and fewer patients needing a colposcopy.

Senator Kelly questioned whether **Dr. Myhre's** presentation was more focused on **Dr. Myhre's** opinion that one test was better than another, asking if there was one company who backed this ThinPrep test? Is there any business involvement? **Senator Kelly** was concerned about legislators evaluating this data in their decision-making process, without a medical background. **Dr. Myhre** answered that ThinPrep was first offered by one company in 1996; it was approved by the FDA. Since that time, there have been two other liquid-based cytology products that have been FDA approved for the Pap smear screening process. **Dr. Myhre** believes that the conventional Pap smear will be gone in the next ten years. Part of the reason is the liability issue for pathologists. Doctors profit about 25 cents on a conventional Pap smear, with great risk due to malpractice claims. The newer test is more reliable, in his opinion. **Senator Kelly** asked if there is another side to this? **Dr. Burgess** confirmed that there is a difference of opinion in the cost effective data of the various tests and which populations are best served by which test, but agreed that the ThinPrep test was of better quality, stating that there is no controversy over that point.

Dr. Myhre said oncologists have identified cigarette smoke as a risk factor for developing cervical cancer. **Representative Ring** asked about HPV/DNA testing and the cost as compared to a colposcopy. **Dr. Myhre** said that for the HPV/DNA test, the Medicare reimbursement rate is \$60 per test and appears to be cost effective. **Senator Broadsword** asked about the reimbursement from Medicaid to the pathologist and asked if the reimbursement from Medicaid to the practice was higher for an HPV/DNA test as well. **Dr. Myhre** answered that Medicare/Medicaid laws specify that the laboratory performing the test must bill for the test, and that reimbursement rate is set annually by Medicaid.

Dr. Myhre noted that women often avoid Pap smears until they are long overdue; early detection is key. Two studies have been well done, in his opinion, but going 100% to ThinPrep saved Blue Cross/Blue Shield in Hawaii \$7.07 per patient per year in administering ThinPrep. The first year, one facility in North Carolina that converted to using ThinPrep 100%, saved \$1 million in their central laboratory.

In **Dr. Myhre's** opinion, the women also got better health care.

Dr. Jerry Perez, Program Administrator for Gynecology Oncology at St. Luke's and St. Alphonsus Regional Medical Centers, said he is the only gynecological oncologist in Idaho, Wyoming and Montana, there being about 500 board certified in the U.S. **Dr. Perez** said that cervical cancer is unique in that it is a slow-developing cancer, making it very difficult to detect at very early pre-cancer stages. Cell sample progression from normal to cancer stage is very slow, taking about seven years for most patients. Pap smears have about a 40% false-negative rate, so dysplasia is sometimes missed. However, if women get yearly Pap tests, chances are dysplasia will be caught, and early treatment is key.

Dr. Perez stated that the problem with HPV is that it is everywhere. In a study done at Rutgers University of young women 17-18 years of age seeking birth control means for the first time, 26% of these women were already HPV positive; by their junior year of college, 60% of the women had HPV. HPV is a skin virus which attacks the cervix, and when a young girl reaches puberty, an area of the cervix becomes cellularly active; it is during that time of cellular activity that those cells are incredibly susceptible to HPV. **Dr. Perez** emphasized that if young women delay sexual activity for even one year after entering puberty, the statistics for HPV can be decreased dramatically. Girls who are exposed to HPV through sexual activity during that year after starting to menstruate are 26 times more likely to contract HPV which becomes cervical cancer, than those who remain chaste for that year.

Dr. Perez stated that HPV is a sexually transmitted disease. Sometimes HPV will spontaneously regress to normal, but some of these viral infections progress to pre-cancerous lesions called dysplasia. Of those who experience low-grade dysplasia, 68% will eventually overcome the virus and have normal cervix cells, but about 14% will progress to cervical cancer. Early dysplasia developing to cervical cancer probably takes about seven years, unless immuno-compromised, in which case it will progress faster. The Pap test screening is a method to target this 14% of the female population. **Dr. Perez** reiterated the risk factors for cervical cancer because of the exposure to HPV: early onset first intercourse, smoking, having multiple sex partners, and not being tested annually.

Dr. Perez addressed the subject of HPV vaccines, noting it is incredibly complex because other non-medical factors are of concern. If a vaccine works, and if a vaccine is given for STD's, is sexual activity being condoned? What about administering the vaccine to infants, prior to risk, with the question remaining about whether or not a booster may be required? Also, men are the major carriers of HPV, but they do not get cancer from HPV. They carry the virus and transmit HPV to women. So, do you save the expense and not vaccinate men and thereby miss the opportunity to decrease the rate of transmission, or do you just vaccinate females? There are certainly ethical considerations that must be dealt with in this area of treatment.

The committee viewed a live, nationally-aired Webcast sponsored by the Centers for Disease Control and Prevention entitled "HPV and Cervical Cancer: An Update on Prevention Strategies." This presentation is available for credit viewing on the website: www.phppo.cdc.gov/phtn/hpv-05. The course number for the program is "wd0075" and a contact phone number is 1-800-41-TRAIN or (404) 639-1292.

Because more than 10,000 women nationally develop cervical cancer annually, and more than half of those women never had a Pap smear, and over 3,000 die, four medical doctors presented information which:

1. Identified the two types of genital HPV infection (high and low-risk)
2. Discussed the epidemiology of genital HPV infection in the United States
3. Described the natural history of genital HPV infection
4. Identified methods used to detect cervical cellular abnormalities for the prevention of cervical cancer (clinical uses of the HPV/DNA test in the context of test screening and management)
5. Summarized appropriate patient counseling messages for genital HPV infection
6. Identified methods for preventing genital HPV infection

The committee recessed for lunch, followed by a guided tour of MSTI facilities, prior to reconvening for the afternoon session.

Mr. Chris Johnson, Epidemiologist, Cancer Data Registry of Idaho, prepared a PowerPoint presentation with **Dr. Christine Hahn, State Epidemiologist, Idaho Department of Health & Welfare**. This PowerPoint presentation entitled "Idaho Cervical Cancer Statistics" is available as an attachment to these minutes at: www.legislature.idaho.gov.

Mr. Johnson stated that one in three women and one in two men will be diagnosed with cancer sometime in their lives, cancer being the #2 cause of death, behind heart disease; in Idaho, about 22% of deaths are from cancer. More than 10 years can go by between the beginning of carcinogenesis (the process by which normal cells are transformed into cancer cells) and the diagnosis of cancer. Cancer can occur at any age, but is a disease of aging; about 77% of cancers are diagnosed at age 55 or older, and people are living longer, so more cases of cancer can be expected in the future, placing a greater burden on the health care system.

In Idaho in 2003, breast cancer was the most prevalent cancer in females, with 801 cases, and 42 patients were diagnosed with cervical cancer, 13th in cancer cases; 172 women died from breast cancer that metastasized, and 14 died from cervical cancer. Cancer survival depends on cancer site and the stage at which the cancer is diagnosed and treated; cervical cancer, if caught at an early stage, has a very high survival rate, but at late-stage, survival is very poor. Lung cancer death was the #1 cause of death among women in Idaho and cervical cancer was ranked #14. The five-year survival rate for cervical cancer in Idaho was 60% from 1994-2003.

Mr. Johnson distributed the "Annual Report of the Cancer Data Registry of Idaho, Cancer in Idaho - 2003, dated April 2005," a copy of which is available in the Legislative Services Office. The Cancer Data Registry of Idaho is a state-wide cancer registry established in 1969 that collects incidence (new case data) and survival data, meaning they follow up patients over time after diagnosis, on all cancer patients residing in Idaho, or who are diagnosed or treated in Idaho. They are currently funded from a small portion of the Idaho cigarette tax and also a grant from the Centers for Disease Control and Prevention (CDC). **Senator Kelly** said that HPV is not a reportable diagnosis, and obviously cancer is, and asked where these instructions to report occur. **Mr. Johnson** answered that it is in Idaho law and rule within the reportable diseases section, confirming that cancer is listed as a reportable disease, but HPV is not reportable. CIN 1, which is cancer on a tissue but has not yet invaded the tissue, is

reportable. *In situ* cervical cases are not reportable. There is a system for grading pathology slides, and pathologists changed the systems they used, which changed the reportable status of *in situ* disease. **Senator Kelly** asked who reports cases. **Mr. Johnson** answered that data comes from hospitals, outpatient surgery centers, free standing radiation centers, physicians, death certificates, and other state cancer registries. The vast majority of data comes from hospitals; information on one patient could come from 3 or 4 different sources, but the registry consolidates this information into one record.

Demographically, in comparison with worldwide data, the U.S. has a very low rate of cervical cancer, specifically due to an effective, well established Pap screening process. In contrast, Mexico has the highest incidence of cervical cancer in the world, due to having no effective screening process; Africa is second highest. Cervical cancer progresses very rapidly in women who have immune deficiencies such as those who have HIV or have had transplants; it also spreads much more rapidly in women who smoke.

Cervical cancer generally occurs in younger women than other types of cancer overall. In Idaho, going back to 1970, about 38,000 people have a history of cancer; 600-700 of those have been cervical cancer. According to the American Cancer Society, about 30% of cancers are related to tobacco, another 30% to adult diet and obesity, and the culprit for cervical cancer is HPV. Worldwide, cervical cancer is the 5th most common cancer in humans, 2nd most common cause of cancer in women after breast cancer worldwide. Many deaths occur, the majority in resource-poor settings.

Cervical cancer is still the leading cause of cancer death among women in parts of the world where Pap tests are not available. The majority of cervical cancer cases come from HPV; several types of HPV are most closely related to malignancies. HPV is incredibly common; cervical cancer is not. Pap tests are the greatest success story for cancer screening; in the U.S., cervical cancer was the leading cause of cancer deaths in women, but in Idaho cervical cancer ranks #14 for cancer deaths in women. **Mr. Johnson** showed a cervical cancer incidence table for Idaho, showing that by age 30, 1 in 4,117 women develop invasive cervical cancer; by age 50, 1 in 400; and by age 80, 1 in 187.

There is no U.S. cancer registry; one does not exist. Abstract statistics only are given to the Centers for Disease Control, but no confidential information. **Mr. Johnson** showed a graph of cervical cancer incidence by health districts in Idaho, pointing out to legislators the importance of making available Pap tests in certain areas where rates of incidence may be higher. Idaho's adjusted rate of cervical cancer for the years 1999-2003 was about 22% lower than SEER (National Cancer Institute) rates for whites in the U.S. The highest rates of cervical cancer are among Hispanic women and the lowest rates are among American Indian and Alaska native women (all rates are age adjusted). There are distinct regional differences with rates of cervical cancer, and maps of the U.S. and Idaho were shown. From 1970 to 2005, there has been about a 3% decrease per year average of cervical cancer incidence, due to success in Pap screenings.

A telephone survey on a variety of health topics, including cancer screening, revealed that in Idaho, half of all women with cervical cancer had *not* had a Pap test within the past 3 years. No health district in Idaho is currently meeting its objectives for healthy cancer screening. Higher income, higher education, better insurance, and younger age all relate to higher screening statistics. Women

over 55 have a much greater rate of late-stage cervical cancer than younger women.

Senator Broadsword asked if menopausal women become less likely to get annual screenings and if this were also true of breast cancer screening. **Mr. Johnson** confirmed this was probably true, adding there is supporting data. Utah and Idaho had the lowest rates of Pap screening in the U.S. in 2004. For breast cancer screening, Idaho ranks *lowest* in the U.S. **Mr. Johnson** suggested that the committee look at age groups to see which populations would best be targeted for enhanced screening.

Dr. Hahn and **Mr. Johnson** said there is some discrepancy in screening rates that cannot yet be explained without more data on HPV in Idaho. **Senator Kelly** asked how screening could be improved, and asked if we need to increase emphasis on screening at this point, knowing that there is beginning to arise a new, more invasive type of HPV in Idaho than has been typical. **Mr. Johnson** answered that it all takes money, and that is the screening barrier right now. The difference between screening and disease reporting are really two different issues; screening looks at the current stage of women's health relative to their cervix, and the disease reporting data leads to predicting what may come in the future. From a cost effectiveness standpoint, trying to increase screening when there is low mortality, may not be cost effective. It may be more cost effective to start evaluating when these more invasive strains start entering Idaho and really target those women who may be affected by that strain in future years, using a 10-20 year prediction. **Mr. Johnson** stated that he would be hesitant to ask for greater emphasis to be placed on HPV reporting because that would lead to differentiating what kind of HPV was being identified, and that would be very costly. Screening is probably most cost effective in the long-term; it is a matter of identifying those women who would benefit most from that screening and making fiscal resources available for those women who do not currently have that screening paid for.

Mr. Brad Hoaglund, American Cancer Society, stated that it was an interesting oddity that Utah and Idaho are ranked number one and two for lowest rate of smoking in the nation; he wondered if Idaho is seeing some benefit from that in women who may have low screening rates, but less tobacco use. Cigarette smoke is considered by gynecological oncologists to be a really significant co-carcinogen; HPV is clearly the cause of cervical cancer, but carcinogens can be identified by tobacco smoke secreted by the endocervical glands.

Ms. Minnie Inzer Muniz program manager of Women's Health Check (WHC), Bureau of Clinical and Preventive Services, Division of Health, Idaho Department of Health and Welfare, said the Women's Health Check program is similar to sixty other programs throughout the country, is funded by the Centers for Disease Control and Prevention (CDC), and is a highly regulated program with respect to population as well as the specific tests that can be done. WHC provides annual Pap smears, clinical breast exams and diagnostic tests. Ten years ago an infrastructure was begun for WHC, screening began very slowly, and through the years, diagnostic tests have been added. Women are screened, and if diagnosed with cervical cancer, can qualify for the Breast and Cervical Cancer (BCC) Medicaid program, which means they can be treated for cancer using public funds. While there are still many gaps, this has helped.

Eligibility varies from state to state, but in Idaho, to qualify, one must have no health coverage, must meet 200% federal poverty level criteria, and be aged 50-64 years. This program, then, supports

screening for cervical and breast cancer to cover the older population which is at the greatest risk. The dollars available will cover less than 15% of the eligible population, so WHC tries to focus public money where they think it will be best spent, thus the age restrictions. WHC, for the fiscal year ending June, 2005, was more efficient than resources allowed, having screened about 3,400 women. WHC is at capacity with the level of federal funding they receive, and they know that of the women they screen, only about 1,600 to 1,800 will have Pap tests. This is because many of them have had hysterectomies. Unless such a woman has had a prior cervical cancer, she is ineligible for a Pap test.

BCC Medicaid has a few additional requirements: women must be under age 65, not otherwise eligible for Medicaid, without creditable health care coverage, screened through WHC, and found to need treatment for breast and/or cervical cancer. The age limit is mandated by Medicaid law which does not allow Medicaid to treat anyone over 65. During fiscal year 2005, 71 women were diagnosed through WHC and referred to Medicaid for treatment; 47 were diagnosed with breast cancer, 24 with cervical cancer or precancerous lesions needing treatment; some patients carried over from prior years, still in active treatment; and total BCC Medicaid expenditures were \$2,076,200 (80% from federal funds and 20% state funds).

When a woman is on the BCC Medicaid program, she is eligible for full Medicaid coverage for the duration of her active treatment. Starting in 1996, WHC partnered with the Cancer Data Registry, ACS, and others to try to begin to pool efforts to better educate (without duplication) and do outreach, so efforts continue as does growth. The purpose of Idaho Breast and Cervical Cancer Alliance (IBCCA) is to reduce the risk and impact of breast and cervical cancer. The federal government combined these two cancers in a single program because there are tests for early detection in both, and if either breast or cervical cancer is detected at an early stage, treatment can be successful. As of June 30, 2005, Idaho became a comprehensive cancer planning state, meaning that a group will have the responsibility at the state level to look at testing, screening and management of all cancers to ensure that there is no duplication or unnecessary overlap.

WHC has worked for 8 years to get screening at current capacity; it takes a great deal of effort for health districts and others to find eligible women who have never had annual screenings. Identified gaps include social and cultural barriers. Offering free screening is the first step, but getting women to that screening is a big issue. Pap tests are available through the Reproductive Health Program managed through health districts, but they don't have funds for diagnostic tests, so a big gap exists. Education is critical; smoking is definitely increasing the risk for cervical cancer and women of all ages need to be educated about HPV prevention. Any recommendation to prevent and eliminate cervical cancer should address access for low income women and the uninsured who are at increased risk. If they don't have insurance, these women are not going to seek any procedure; even if the best procedure is recommended, some women can't access that test.

CDC does not currently allow WHC to pay for liquid-based cytology referred to earlier in the meeting as ThinPrep, although cost studies are being done. All factors are being compiled, compounded with dollars available for public health, and **Ms. Muniz** believes that there may be more recommendations for liquid-based cytology every 2-3 years for the over 30 population. Changes are taking place, but cost is often the issue. **Ms. Muniz** added that there is a "211" Idaho Care Line. This is a telephone access line to the Department of Health & Welfare where citizens can receive referrals to local care

providers and other health and/or welfare issues. The line is accessed by simply dialing "211" from any telephone.

Ms. Muniz distributed a packet of information entitled "Women's Health Check," a copy of which is available in Legislative Services Office.

Mr. Richard Schultz, Administrator, Division of Health, State Department of Health and Welfare, reiterated that HPV is a sexually transmitted disease (STD), and that screening for the consequences of infection have been primarily addressed at this meeting. **Mr. Schultz** believes that emphasis really needs to be on prevention, trying to get young people to realize that STD's are not all cured by seeing a physician, taking a pill, or getting a shot. Whether an STD is HPV or HIV, there are a number of STD's causing very long-term consequences, from a public health care perspective, and much more emphasis needs to be placed on motivating young people to change their high-risk behaviors.

Mr. Schultz said there will be some very controversial ads coming out soon both on radio and in print, targeted at 18-24 year olds. There is narrative in these ads which tries to connect with this young population to make them realize that there are long-term risks associated with contracting STD's. Legislators may hear complaints from constituents about the graphic nature of some of these ad campaigns or the placement of these ads, such as in the Boise Weekly, but these ads are deliberately trying to target places and times when the young people will see and read this information. The Department of Health and Welfare is trying to prevent HPV in the first place. There was a survey done recently in the north Idaho health district which showed that 30% of the women coming in to the STD family planning clinic were coming in with HPV infections. It is becoming almost an indigenous disease and the emphasis needs to be on prevention of HPV.

Representative Ring suggested changing the target age of 18-24 year olds to a younger group, even to those as young as 12 years of age, which is when sexual activity is starting to occur. **Mr. Schultz** stated that some schools do not want this information given to their students, adding that church groups have been the most responsive. The young people most at risk, however, are not in those church groups, so how to get the message to those youth practicing at-risk behaviors becomes the challenge. These are not just sexually active young people, but may be abusing substances as well. He said he is well aware of the risks of running such aggressive ads, but when STD outbreaks are rampant, something must be done to address that.

Senator Kelly asked how these ad campaigns were being funded. **Mr. Schultz** stated that these ads are funded through general funds to the Department of Health and Welfare.

Representative Ring added that there is a high correlation between drug usage and STD's. This is a cultural issue and, as with the increasing methamphetamine problem, these issues become intertwined. **Senator Kelly** asked how the legislature could help with Health & Welfare's aggressive, pro-active ad campaigns. **Mr. Schultz** answered that money is necessary, but what is really needed is the moral support of the legislature, to encourage those constituents who are offended by these graphic ads to accept the value in the message; it is not the intent to target moral conservatives, but targeting another part of the at-risk population is necessary. **Mr. Schultz** asked that legislators refer

constituents who are having especially unhappy with the ads to contact Health & Welfare so that the department can give them more information and justification. **Mr. Schultz** asked that legislators do *not* get offended by the ads, but rather give flexibility to Health & Welfare to target this at-risk population. **Mr. Schultz** said he intends to report to the legislature a year from now on the effectiveness of these ads. Hopefully, he will be able to verify that the ads are having some impact on that at-risk population, or at least creating a shift in attitude. Change will come slowly, but awareness of the problems and attitudes can then lead to different behaviors; fear *can* be a motivator.

Representative Pence asked if Health & Welfare were receiving resistance to these ad campaigns in schools, and if that was legislatively dictated or school board dictated. **Mr. Schultz** responded that it was school districts, and some are willing to be more aggressive than others; this can be done more successfully at the school district level, without legislative intervention. Good health should also be an important part of every child's education, to learn and live productive lives. **Representative Pence** pointed out that she has had great success working with school administration. **Mr. Schultz** emphasized that the moral support of legislators is critical. Health & Welfare spent \$200,000 last year and another \$200,000 this year for ads; they will measure the effects of these ad campaigns, and if they have the desired effect, the legislature may be asked for more funds for 2008 to broaden the campaign, after fully evaluating the success of the campaign.

Senator Kelly asked how that success would be measured. **Mr. Schultz** said that surveys can be done on attitude changes, as well as compiling statistics on the number of young people going to STD clinics for treatment. Focus target groups are being monitored and evaluations will be made as to the success of the ad campaigns. The bottom line will eventually be how many STD's are being treated in clinics. Legislators at this meeting encouraged **Mr. Schultz** to remain steadfast with these ads, and he again stated that their support is critical to success of the ad campaign, since Health & Welfare has already run into roadblocks and been criticized.

Mr. Dan Heincy, Merck Pharmaceutical Company, stated that programs were running at CDC for different screenings, prescribing what technology to use as far as Pap screens go; studies are being done in at least two states with regard to saving money on liquid-based techniques. He asked: "Are you aware of other states, possibly Texas, using newer technology, and if so, how are they doing this, under some type of waiver?" **Ms. Muniz** answered that none of the federally-funded moneys can be used to pay for liquid-based technology to date because they are looking at reaching a broad base of the population. A panel of experts at CDC has been convened to make recommendations. Those two studies were limited to probably state or other outside funds; they did not use federal funds. CDC is likely to make a change this year in its recommendation for annual screening for women over age 30; she expects that liquid-based technology will soon be allowed every 2-3 years. **Ms. Muniz** commented that CDC moves very slowly; however, they look at issues from all perspectives instead of allowing an issue to be market driven. CDC is also very supportive of using vaccine when it becomes available, but it will step back and take a broad-based look at the entire population and how it impacts low-income people before final recommendations are made or before federal funds are allowed to be used. **Representative Ring** observed that in the first instance, a standard Pap is cheaper; however, a liquid-based Pap becomes more cost effective when you factor in the additional costs of a standard Pap, plus colposcopy, and a direct biopsy.

Senator Broadsword asked **Mr. R. Scott Burns, Region Manager, Health Policy, Merck Vaccine Division, Cedar Hills, Utah**, for an update on the HPV vaccine and if and when trials will be completed. **Mr. Burns** responded that the vaccine has not been submitted to the Federal Drug Administration (FDA) for approval yet. A specific time line is not known; however, results of clinical studies have been published and are readily available.

In the committee discussion which followed the presentations, members noted the importance of education in increasing awareness of the disease and emphasizing the importance of regular Pap smear testing. One charge to the committee is to determine if there is a problem in Idaho and, from the information presented, cervical cancer is not as big a problem in Idaho as it is in other states. To prevent spread of the virus in the first place is preferable to dealing with the consequences of HPV and cervical cancer after the fact. It was noted that because of the lag time between exposure to HPV and the occurrence of cervical cancer, it is more difficult to educate on the connection between the two. And with increased sexual activity at a much younger age, as well as increased methamphetamine abuse, education and awareness could now be the key to successfully targeting elimination of cervical cancer in the future. It was pointed out that education on getting annual Pap smears is as important as education regarding abstinence and making the younger population aware of STD's and long-term effects of their behaviors. With the increases in population due to borders crossings, especially where there is little education about the necessity for Pap testing, new strains of STD's which are more virulent, are being brought into the U.S., and this could also impact HPV elimination.

Mr. Schultz suggested that it might be helpful for the committee to look at the burden placed on the public health system which is providing Pap smears through family planning clinics and STD clinics. This is where women who don't currently have access to an insured health care system go to get a Pap smear. Most are relying on district health departments as their primary source for receiving Pap smears. It might be important to evaluate how much more capacity public health districts have to provide Pap smears, since women are being encouraged to get them.

Senator Kelly asked if district health departments were keeping up now, and **Mr. Schultz** answered that they are keeping up, but that the waiting lists can be considerable, in some districts up to 3 weeks for a pregnancy check. That is part of the challenge that exists, not just motivating women, but once they get motivated, where do they go to get that test? Right now the public health system, one source for screening, is close to capacity from both a financial standpoint and logistically. The challenge is to be reimbursed for testing. **Senator Kelly** asked if that could be tied to breast exams. **Ms. Muniz** answered that could be a possibility in the future and, in fact, some partnerships between public and private clinics have been formed. In exchange for screening services, they are also given extra money to collect data and information. **Mr. Schultz** added that due to the restrictive nature of federal requirements for WHC, there are probably clinics that will not want to participate, simply because of the administrative burden placed on them; there could be other avenues to fund these clinics to do the testing, but not necessarily all the administrative reporting. WHC is a good program, but it can't be comprehensive enough to meet all needs; they must find a way to complement that need, and encourage all providers to participate.

Senator Broadsword noted this may present an opportunity for partnering or for complementary

programs being added to what is already being done with STD screening and awareness. If education is being done on prevention of STD's, then, in turn, women are less likely to get HPV, and hopefully thereby reducing the incidence of cervical cancer. **Senator Broadsword** asked if there were more education dollars available somewhere to complement what Health & Welfare is doing, to make that connection. **Mr. Schultz** answered that he didn't think there were any motivational dollars available; providers and parents can be educated, but he was not sure that the target population could be educated, stating that according to surveys done, young people need to be motivated. Young people acknowledge there is a risk, but they generally do not believe they will contract an STD. Therefore, a more aggressive approach is needed, to show the magnitude of the problem.

For example, these new ad campaigns ask: "When did you last have sex? Do you know that 1 in 4 people has an STD? Which one of you here has an STD?" As that "in their face" message gets out, resistance comes from parents who balk at the idea that the ad suggests that all young people are having sex. These ads are only trying to target those young people at greatest risk. Grade school children from approximately the age of 12 years, need education and motivation to further prevent STD's in the future, hopefully so they can make better decisions regarding their actions.

Senator Broadsword asked if colleges and universities had been approached and if they were accepting these ad campaign programs. **Mr. Schultz** responded that they have not been involved up to this point, and that colleges and universities have not been contacted yet. **Senator Broadsword** encouraged **Mr. Schultz** to talk to higher educational institutions, since their clinics see many patients, and this is a very good place for these ad campaigns. **Representative Ring** added that part of education and motivation should be the statement that cervical cancer is the new STD. **Mr. Schultz** reinforced that concept, noting the new chlamydia rates are just astronomical. Students need to be informed that infertility later in life is highly associated with having contracted an STD earlier in life, chlamydia, herpes and HPV being very damaging.

Senator Broadsword adjourned the meeting at 4:00 p.m.