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Final Report of the TASK FORCE TO STUDY CERVICAL CANCER PREVENTION, DETECTION AND EDUCATION

November 2006

Members:
Sen. Nancy Sullivan, Chair
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Dr. Jonathan Fanburg
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Dr. Susan Mieslfeldt
Janet Miles
Dr. James Raczek
Dr. Molly Schwenn
Dr. James Wilberg

Staff:
Anna Broome, Legislative Analyst
Lucia Nixon, Legislative Analyst
Office of Policy & Legal Analysis
Maine Legislature
(207) 287-1670

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Executive Summary

Less than a century ago, cervical cancer was the number one cancer killer of women in the U.S. With the advent of the Pap test in the 1940s, cervical cancer became a largely preventable disease. Incidence and mortality rates for cervical cancer have fallen significantly since that time, but the disease has yet to be eliminated. The American Cancer Society has estimated that approximately 9,710 cases of invasive cervical cancer will be diagnosed and 3,700 women will die from cervical cancer in the U.S. in 2006. The Maine Cancer Registry reports that 58 women in Maine were diagnosed with invasive cervical cancer in 2003, and 15 women in Maine died from the disease in that year.

While Maine has done relatively well with respect to cervical cancer prevention and early detection efforts and while cervical cancer incidence and mortality rates in Maine are comparable to national rates, the fact that this preventable disease exists at all is evidence that more can be done. Recognizing the opportunity for the State to make significant progress toward complete eradication of cervical cancer, the 122nd Legislature established the Task Force to Study Cervical Cancer Prevention, Detection and Education ("Task Force") by Resolves 2005, Chapter 121. The Task Force was specifically created to examine the prevalence and incidence of cervical cancer in Maine, to review preventive strategies and new technologies, to assess existing laws, programs and services, and to develop a statewide cervical cancer prevention plan and strategies for plan implementation and coordination.

The 16-member Task Force included one member of the Senate, two members of the House of Representatives, eight members representing different medical organizations, associations and specialties, one member representing the health insurance industry, one member representing communications consultants, one member representing cervical cancer survivors and two representatives of the Maine Department of Health and Human Services. The Task Force convened on November 16, 2005 and held a total of 6 meetings to fulfill its duties. The final meeting was held on October 17, 2006.

Summary of Task Force Recommendations

- ***Increase public awareness and education regarding cervical cancer prevention, the connection between the human papillomavirus and cervical cancer, and the importance of screening.*** Strategies include a statewide public education campaign on cervical cancer prevention and screening undertaken by the Maine Breast and Cervical Health Program and school-based cervical cancer education initiatives developed by the Maine Center for Disease Control and Prevention in coordination with the Maine Department of Education.

- ***Increase provider knowledge of cervical cancer screening guidelines and emerging technologies in cervical cancer prevention and early detection.*** Strategies include expanding continuing medical education offerings for medical professionals that

address clinical issues in cervical cancer prevention and detection and updating the Maine Breast and Cervical Health Program's clinical guidelines for cervical cancer screening.

- ***Increase the number of Maine women who receive cervical cancer screening at recommended intervals.*** Strategies include expanding access to screening for low-income and uninsured women through the Maine Breast and Cervical Health Program and the state family planning system, providing incentives for insured individuals to get screened for cancer, and implementing systems to assist and support health care providers in the delivery of cervical cancer screening consistent with clinical guidelines.

- ***Implement the recommendations of the United States Centers for Disease Control and Prevention for the new human papillomavirus vaccine.*** Strategies include increasing state funding to the Maine Immunization Program, monitoring the vaccination rate and funding needs of that program and providing coverage for the vaccine under the state's MaineCare (Medicaid) program.

- ***Conduct public health research to improve and evaluate cervical cancer prevention efforts.*** Strategies include examining cervical cancer incidence and prevention issues among racial and ethnic minority populations in Maine, examining geographic variation in cervical cancer within the State and the higher rates of cancer in Somerset and Washington Counties, and, finally, conducting an evaluation of the state's progress in cervical cancer prevention, detection and education in response to the work of this Task Force.

I. INTRODUCTION

The Task Force to Study Cervical Cancer Prevention, Detection and Education was established in the First Regular Session of the 122nd Legislature by Resolves 2005, Chapter 121.[1] The Task Force was created to examine the prevalence and incidence of cervical cancer in Maine, to review preventive strategies and new technologies, to assess existing laws, programs and services, and to develop a statewide cervical cancer prevention plan and strategies for plan implementation and coordination. Specifically, the Task Force was charged with the following six duties:

1. Review statistical and qualitative data on the prevalence and incidence of cervical cancer in Maine;

2. Review preventive strategies and new technologies, including newly introduced vaccines and their effectiveness in preventing and controlling the risk of cervical cancer, as well as their relative costs;

3. Identify and examine the strengths and limitations of existing laws, regulations, programs and services regarding coverage and awareness of cervical cancer;

4. Consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations and other public and private organizations statewide to learn more about their contributions to cervical cancer diagnosis, prevention and treatment and their ideas for improving prevention, diagnosis and treatment in Maine;

5. Develop, in consultation with the Department of Health and Human Services, a statewide comprehensive cervical cancer prevention plan and strategies for plan implementation and for promoting the plan and awareness of the causes, risk factors, prevention, early detection and treatment of cervical cancer to the general public, state and local elected officials and various public and private organizations, associations, businesses, industries and agencies; and

6. Recommend strategies for coordination and communication among state and local agencies and organizations regarding their involvement in achieving the aims of the cervical cancer prevention plan.

The 16-member Task Force included one member of the Senate, two members of the House of Representatives, eight members representing different medical organizations, associations and specialties, one member representing the health insurance industry, one member representing communications consultants, one member representing cervical cancer survivors and two representatives of the Maine Department of Health and Human Services (DHHS).[2]

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[1] Resolves 2005, Chapter 121 is provided in Appendix A.

[2] The Task Force Membership list is provided in Appendix B. The position representing the Maine Osteopathic Association has been vacant in 2006.

Appointments to the Task Force were completed on October 19, 2005, and the Task Force convened for its first meeting on November 16, 2005. At the first meeting, members discussed the motivation for the study and identified the following justifications for undertaking this work:

- While Maine is doing relatively well in the areas of cervical cancer prevention, detection and education, there is an opportunity for the State to further reduce the rate of cervical cancer given the current technology and to move toward complete eradication of cervical cancer with the development and introduction of new technology, and

- There are gaps in the current system of cervical cancer prevention, detection and education in the State that need to be addressed.

To fulfill its duties, the Task Force held a total of 6 meetings between November 2005 and October 2006.[3] The Task Force submitted an initial report to the Joint Standing Committee on Health and Human Services and the Governor in December 2005. The present report is the final report of the Task Force. Pursuant to Resolves 2005, chapter 121, the joint standing committee of the Legislature having jurisdiction over health and human services matters in the First Regular Session of the 123rd Legislature is authorized to report out legislation on cervical cancer prevention, detection and education.[4]

[3] Meeting dates were: November 16, 2005; December 20, 2005; July 18, 2006; August 24, 2006; September 26, 2006; and October 17, 2006. Agendas for the Task Force meetings are provided in Appendix C. In accordance with the authorizing legislation, the Task Force did not meeting during the 2006 Legislative session.

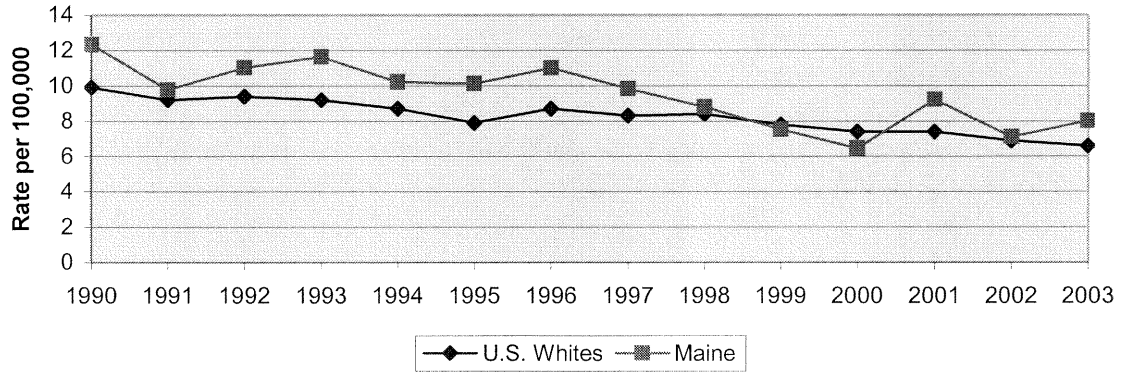
[4] Draft legislation to implement the recommendations of the Task Force is provided in Appendix D.

II. CERVICAL CANCER INCIDENCE

Less than a century ago, cervical cancer was the number one cancer killer of women in the U.S.[5] With the advent of the Pap test in the 1940s, cervical cancer became a largely preventable disease. Incidence and mortality rates for cervical cancer have fallen significantly since that time, but the disease has yet to be eliminated. The American Cancer Society has estimated that approximately 9,710 cases of invasive cervical cancer will be diagnosed and 3,700 women will die from cervical cancer in the U.S. in 2006.[6]

Cervical cancer incidence rates and mortality rates for Maine are similar to those for the U.S. white population, particularly in recent years (see Figure 1 and Figure 2).[7] In 2003, the approximately 8 per 100,000 women in Maine (58 women statewide) were diagnosed with invasive cervical cancer, and 1.8 per 100,000 women in Maine died from the disease (15 deaths statewide).

Figure 1 - Age-Adjusted Cervical Cancer Incidence Rates, 1990-2003

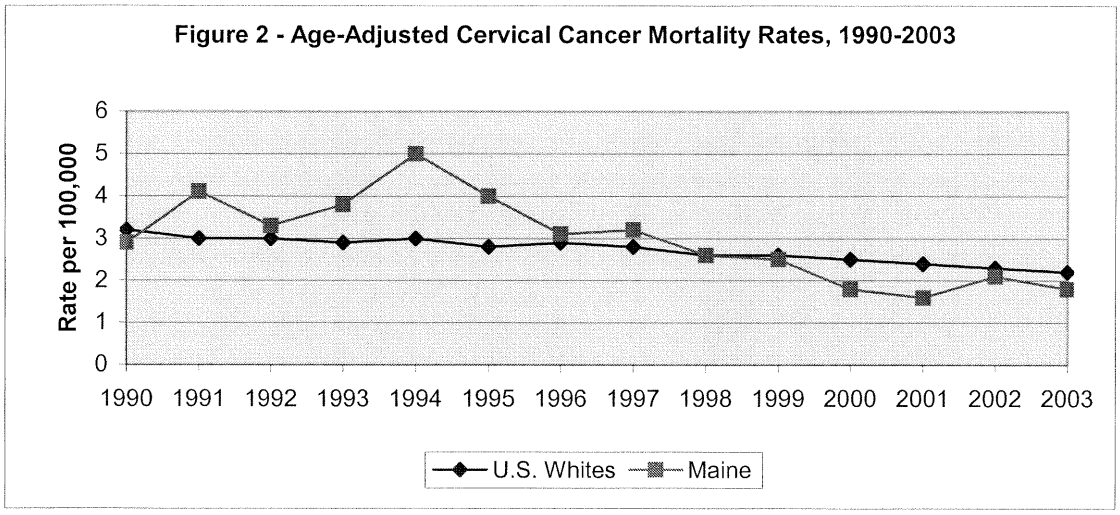


Source: Maine Cancer Registry and National Cancer Institute

[5] "Cervical Cancer Prevention and HPV DNA Test," Health & Sexuality 19(1) 2005.

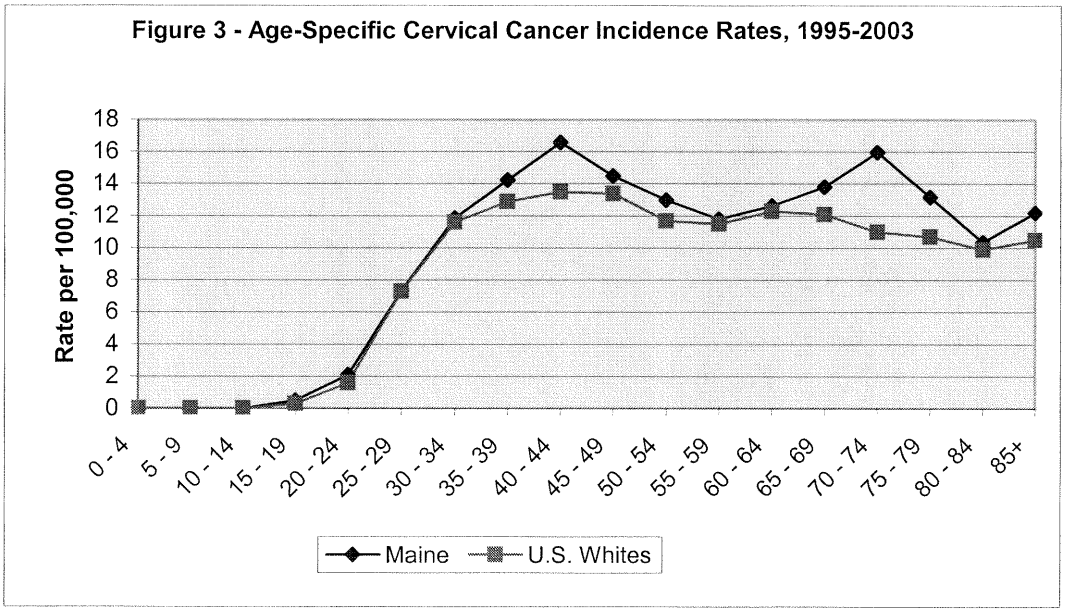
[6] American Cancer Society, "Detailed Guide: Cervical Cancer," Revised August 2006, http://www.cancer.org/docroot/cri/cri_2_3x.asp?dt=8

[7] The difference between cervical cancer incidence and mortality rates for Maine and U.S. whites are not statistically significant. The National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) collects cancer information from 13 population based registries representing approximately 14% of the U.S. Population; because the Maine population is 98% white, the Maine Cancer Registry uses the SEER U.S. white population data as a national comparison.



Source: Maine Cancer Registry and National Cancer Institute

The incidence of invasive cervical cancer increases dramatically among women in their mid-20s and early 30s (see Figure 3). This is consistent with the scientific evidence that cervical cancer develops over a relatively long period of time following exposure to HPV (typically 10-15 years if HPV or precancerous cells are not detected or treated). The incidence of invasive cervical cancer among Maine women peaks for women ages 40-44 years and again for women ages 70-74 years. This data suggests that targeting prevention efforts toward Maine girls and young women would prove effective in decreasing cervical cancer incidence in the future. The data also provide an important reminder that women over 60 years of age should not be neglected in prevention and early detection efforts.



Source: Maine Cancer Registry and National Cancer Institute

Within Maine, the highest rates of invasive cervical cancer are found in two geographically separate areas: Somerset County in western Maine and Washington County in eastern Maine (see Table 1). The age-adjusted incidence rates in these two counties are significantly higher than the statewide rate. While the differences are not statistically significant, lower rates of invasive cervical cancer are observed in southern and mid-coast counties, including Cumberland, York, Sagadahoc and Knox counties.

Table 1 - Age-Adjusted Cervical Cancer Incidence Rates by Maine County, 1995-2003

County	9-Year Count	Age Adjusted Rate per 100,000
Androscoggin	43	8.7
Aroostook	33	9.0
Cumberland	82	6.2
Franklin	12	8.6
Hancock	26	10.2
Kennebec	50	8.6
Knox	13	6.0
Lincoln	15	9.0
Oxford	33	11.9
Penobscot	75	10.7
Piscataquis	6	7.2
Sagadahoc	9	5.5
Somerset	38	15.6
Waldo	21	11.4
Washington	26	15.0
York	59	6.4
Maine	**542**	**8.6**

Source: Maine Cancer Registry.

Although racial and ethnic minority populations in Maine are presently too small to allow for statistical analysis of racial and ethnic differences in cervical cancer within the state (and guarantee the confidentiality of individuals), these populations are growing and such analysis will likely be possible in the future. National data provide clear evidence of variation in cervical cancer incidence by race and ethnicity. In 2002, the incidence rate per 100,000 was 8.2 among white women in the U.S., 12.4 among Black women and 13.1 among Hispanic women.[8] Historically, Vietnamese American women have had the highest rates of cervical cancer, at approximately five times the national rate (43 per 100,000 women during the period 1988-1992).[9]

[8] National Cancer Institute, State Cancer Profiles, 2002, http://statecancerprofiles.cancer.gov

[9] President's Advisory Commission on Asian Americans and Pacific Islanders, "Asian Americans and Pacific Islanders Addressing Health Disparities: Opportunities for Building a Healthy America," 2003, http://www.aapi.gov/Commission_Final_Health_Report.pdf

III. PREVENTION STRATEGIES AND NEW TECHNOLOGIES

A. Cervical Cancer Screening

Cervical cancer is a highly preventable disease through regular screening. The cornerstone of prevention for the last 60 years has been the Pap test. Developed by Dr. George Papanicolaou, the Pap test is credited for producing a greater than 70% drop in the death rate from cervical cancer since its introduction.[10] In 2004, nearly 89% of Maine women reported having had a Pap test within the last three years, 3 percentage points higher than the national median of 86%.[11] In addition to the Pap test, human papillomavirus (HPV) testing technology has recently emerged as an additional tool for cervical cancer screening.

1. Pap Testing

The Pap test is used to detect abnormal changes in cervical cells that may lead to the development of cervical cancer. Today, there are two key Pap test technologies: (1) the conventional Pap smear, which involves "smearing" cervical cells onto a glass slide, and (2) the newer thin-layer liquid-based Pap test approved by the FDA in 1996, which involves placing a sample of cervical cells in liquid.[12] The newer liquid-based technology has proven to have several advantages over the conventional Pap, including: higher quality sample; greater effectiveness in detecting low-grade and high-grade intraepithelial lesions; and the ability to conduct follow-up HPV testing without requiring the patient to return for another procedure. Given these advantages, health care providers are increasingly choosing to use the liquid-based Pap test over of the conventional Pap test. It is important to note that the liquid-based test is more expensive, because of the associated laboratory work.[13]

The state of Maine requires coverage for Pap tests through both law and program regulations. In the case of private health insurance, state law requires that all group health insurance policies and health maintenance organization (HMO) contracts cover "screening Pap tests recommended by a physician."[14] Under the state Medicaid program, MaineCare, the Pap test procedure and associated laboratory services are covered, except that laboratory services are not covered for women in program's the "non-categorical" eligibility category (non-disabled, childless adults).[15] Under the Maine Breast and Cervical Health Program, Pap tests are covered for participating women (see section IV of this report for details on this program).

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[10] "Cervical Cancer Prevention and HPV DNA Testing," Health & Sexuality 10(1) 2005

[11] U.S. CDC, Behavioral Risk Factor Surveillance System (BRFSS), http://apps.nccd.cdc.gov/brfss/

[12] "Human Papilloma Virus Testing in Cervical Cancer Prevention," Medscape, http://www.medscape.com/viewarticle/467126_6

[13] The two largest independent laboratories serving Maine currently charge $37.10-$42.00 for the liquid-based test and $22.80-$25.00 for the conventional Pap. Source: Maine DHHS.

[14] 24-A MRSA §§2837 and 4242.

[15] See MaineCare Benefits Manual sections on Physician Services (Chapters II and III, Section 90), Family Planning Agency Services (Chapters II and III, Section 30), and Laboratory Services (Chapters II and III, Section 55). See also Non-categorical Adults List of Covered Services (Chapter I, Appendix 3).

2. HPV Testing

HPV testing is increasingly being used to augment Pap testing in the diagnosis of cervical cancer. The HC2 High-Risk HPV DNA test manufactured by Digene Corporation (HPV test) was first approved by the U.S. Food and Drug Administration (FDA) in 2000 for use in the evaluation of abnormal Pap tests results.[16] At that time, the test was specifically indicated for use following an abnormal Pap to determine whether to proceed to a colposcopy, a procedure in which the outer portion of the cervix is examined using an instrument called a colposcope to magnify and illuminate the area. In 2003, the FDA approved expanded use of the HPV test in women over 30 years. Specifically, it approved the use of this test in primary screening of women over 30 years for cervical cancer, when used in conjunction with the Pap test.[17] Used in this way, the HPV test presents the opportunity to extend the cervical cancer screening intervals for women over 30 years with negative Pap tests and negative HPV tests.

3. Screening Guidelines

Cervical cancer screening guidelines are provided by three national medical organizations: (1) the American Cancer Society (ACS), (2) the U.S. Preventive Services Task Force[18] (USPSTF), and (3) the American College of Obstetricians and Gynecologists (ACOG). As shown in Table 2, the recommended starting point for screening is similar across the three guidelines, but the guidelines different somewhat regarding the time between screening tests, screening interval, and when to stop screening. While annual screening is common practice today, it is important to note that the guidelines advise less frequent screening in specific situations.

4. Cervical Cancer Screening Failure

Given the existing screening technology, it is estimated that 95% of cervical cancer could be prevented under perfect conditions.[19] In reality, 30% of cervical cancer cases are not prevented as a result of imperfections, or failures, in the screening system. Screening failures can be divided into two major types:

1. *Insufficient screening.* Approximately 65-70% of screening failures are the result of women not being screened. This includes women who have never been screened and women who are screened less frequently than is recommended, and

2. *False negative screening.* Approximately 30-35% of screening failures are the result of "false negative" screening, in which a woman is screened but still develops cervical cancer.

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[16] U.S. Food and Drug Administration, http://www.fda.gov/cdrh/pdf/P890064s009b.pdf
[17] U.S. Food and Drug Administration, http://www.fda.gov/cdrh/pdf/p890064s009a.pdf
[18] The USPSTF, sponsored by the U.S. DHHS Agency for Healthcare Research and Quality (AHRQ), is an independent panel of experts in primary care and prevention that reviews the scientific evidence of effectiveness and develops recommendations for clinical preventive services.
[19] Presentation of Dr. Michael Jones to the Task Force on December 20, 2005.

Table 2 - Cervical Cancer Screening Guidelines[20]

Recommendation	American Cancer Society (Nov. 2002)	U.S. Preventive Services Task Force (Jan. 2003)	American College of Obstetricians and Gynecologists (Aug. 2003)
When to Start Screening	Approximately 3 years after onset of vaginal intercourse, but no later than age 21	Within 3 years of onset of sexual activity or age 21, whichever comes first	Approximately 3 years after onset of sexual intercourse, but no later than age 21
Screening Interval			
If conventional Pap smear test	a) Annually b) Every 2-3 years for women ≥30 yrs with 3 negative cytology tests	At least every 3 years	a) Annually b) Every 2-3 years for women ≥30 yrs with 3 negative cytology tests
If liquid-based cytology test	a) Every 2 years b) Every 2-3 years for women ≥30 yrs with 3 negative cytology tests	Insufficient evidence	a) Annually b) Every 2-3 years for women ≥30 yrs with 3 negative cytology tests
If HPV testing used	Every 3 years if HPV negative, cytology negative	Insufficient evidence	Every 3 years if HPV negative, cytology negative
When to Stop Screening	Women ≥ 70 yrs with ≥ 3 recent, consecutive negative tests and no abnormal tests in prior 10 years	Women > 65 yrs with negative tests, who are not otherwise at high risk for cervical cancer	Inconclusive evidence to establish upper age limit

B. Cervical Cancer Vaccines

The newest technology in the fight against cervical cancer is the HPV vaccine. Infection by HPV is well-established as the most important risk factor for cervical cancer, and research has shown the presence of HPV in over 93% of cervical cancers.[21] HPV is a very common infection. The U.S. Centers for Disease Control and Prevention (CDC) has estimated that 20 million people in U.S. were infected with HPV in 2005 and 80% of women have been infected by HPV by age 50.[22] Most HPV infections are transient and resolve on their own without medical intervention and do not develop into cervical cancer.[23] However, when HPV does not go away on its own,

[20] "Summary Tables of Cervical Cancer Screening Guidelines and Recommendations for New Technologies," U.S. Department of Health and Human Services (DHHS), Centers for Disease Control and Prevention (CDC), http://www.cdc.gov/std/hpv/ScreeningTables.pdf

[21] National Cancer Institute. "Cervical Cancer: Backgrounder," http://rex.nci.nih.gov/massmedia/backgrounders/cervical.html

[22] "CDC's Advisory Committee Recommends Human Papillomavirus Virus Vaccination," U.S. CDC, http://www.cdc.gov/od/oc/media/pressrel/r060629.htm

[23] Presentation of Dr. Michael Jones to the Task Force on December 20, 2005.

certain types of the virus can develop into cervical cancer. There are more than 100 types of HPV, but only certain types have been linked to the development of cervical cancer, including HPV 16 which is estimated to account for 50% of cervical cancer, and HPV 18, 31 and 45, which together are estimated to account for 30% of cervical cancer.[24]

Given the strong link between HPV and cervical cancer, vaccines that protect against HPV have the potential to play an important role in preventing cervical cancer, particularly among women who are not getting screened at the recommended intervals. It is important to note that even once vaccines are available, screening will remain critical to cervical cancer prevention for a number of reasons, including the fact that the vaccines do not protect against all strains of HPV that cause cervical cancer, the vaccines do not treat existing HPV infection, and there are many women today who will not receive the vaccines. It is also important to recognize that there will be a significant lag period between the introduction of HPV vaccines and a reduction in cervical cancer incidence and mortality rates, due to the latency associated with this cancer. Additionally, acceptance of the vaccines among health care providers and consumers is an important practical challenge that will need to be addressed to fully realize the potential of these vaccines.

1. Gardasil

On June 8, 2006, the FDA approved Gardasil, for use in females ages 9-26 for the "prevention of cervical cancer and other diseases caused by HPV."[25, 26] Manufactured by Merck and Co, Inc., Gardasil is the first vaccine approved by the FDA for cervical cancer prevention. Gardasil targets four types of HPV: 6, 11, 16 and 18. HPV types 16 and 18 are leading causes of cervical cancer, accounting for 70% of all cervical cancer cases.[27]

On the basis of Merck's clinical trials, involving 21,000 women worldwide, the FDA concluded that:

> Gardasil was nearly 100 percent effective in preventing precancerous cervical lesions, precancerous vaginal and vulvar lesions, and genital warts caused by infection with the HPV types against which the vaccine is directed. While the study period was not long enough for cervical cancer to develop, the prevention of these cervical precancerous lesions is believed highly likely to result in the prevention of those cancers.[28]

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[24] Shah, Keerti V. (1997). "Human Papillomaviruses and Anogenital Cancers." The New England Journal of Medicine, 337(19) 1386-1388.

[25] "FDA Licenses New Vaccine for Prevention of Cervical Cancer and Other Diseases in Females Caused by Human Papillomavirus," FDA, http://www.fda.gov/bbs/topics/NEWS/2006/NEW01385.html

[26] Merck is currently conducting clinical trials with women aged 27-45 years and with men. Dr. Liana Clark, Merck, presentation to the Task Force, August 24, 2006.

[27] Merck is developing a vaccine that will cover 8 types of HPV; the company hopes to have that drug approved by 2010. Dr. Liana Clark, Merck, presentation to the Task Force, August 24, 2006.

[28] "FDA Licenses New Vaccine for Prevention of Cervical Cancer and Other Diseases in Females Caused by Human Papillomavirus," FDA, http://www.fda.gov/bbs/topics/NEWS/2006/NEW01385.html

Following the FDA's approval of Gardasil on June 8, the CDC's Advisory Committee on Immunization Practices (ACIP) voted on June 29, 2006, to recommend routine vaccination with three doses of Gardasil for all girls ages 11-12 years, as well as "catch-up" vaccination of girls and women ages 13-26 years who have not received the vaccine or completed the 3-injection series. Routine vaccination at ages 11-12 years is designed to catch most girls prior to any exposure to HPV, so that the vaccine can have its maximal effect. These recommendations were posted by the CDC as "Provisional Recommendations" in August 2006 and final publication of the recommendations is expected in November 2006.[29]

2. Cervarix

GlaxoSmithKline (GSK) is currently seeking FDA approval for its HPV vaccine, Cervarix. Cervarix is a bivalent vaccine that targets HPV types 16 and 18. Phase III clinical trials of Cervarix are currently in progress, and GSK submitted its Biologics License Application (BLA) in 2006. Like Gardasil, Cervarix has been shown to be highly effective in preventing persistent HPV infection and HPV type-specific associated lesions.[30]

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[29] "ACIP Provisional Recommendations for the Use of Quadrivalent HPV Vaccine," U.S. CDC, http://www.cdc.gov/Nip/recs/provisional_recs/hpv.pdf

[30] Diane M. Harper, MD, MPH, MS. Presentation, Conference on "The Status of Cervical Cancer Vaccine Research", Women's Policy, Inc., Washington, DC, December 6, 2005.

IV. EXISTING PROGRAMS AND SERVICES

The Task Force reviewed and examined the strengths and limitations of current programs and services in the State that contribute to cervical cancer prevention, detection and education. Through reports, presentations and discussions, the Task Force developed the following inventory of key state agencies and organizations involved in various aspects of cervical cancer.

A. Maine Breast and Cervical Health Program

The Maine Breast and Cervical Health Program (MBCHP) provides free cervical cancer (and breast cancer) screening and related diagnostic services for low-income and uninsured women in the state. This program operates within Maine DHHS under authorization and funding from the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) of the U.S. CDC. The NBCCEDP, which was established by Congress under the Breast and Cervical Cancer Mortality Prevention Act of 1990, is the first and only national cancer screening program. Maine is one of over 60 states and tribal organizations that have received funding from the CDC to implement a comprehensive breast and cervical cancer health program. Key features of the program are as follows:

- ***Funding.*** MBCHP currently receives nearly $1.8 million in annual funding from the U.S. CDC. These federal funds are supplemented with approximately $370,000 in state General Fund dollars.

- ***Eligibility.*** Eligibility for MBCHP is based on age, income, insurance status and residence. Under current MBCHP rules, women who are 40 years and older, have income at or below 250% of the federal poverty level, are uninsured or underinsured, and reside in Maine or New Hampshire are eligible.[31]

- ***Enrollment.*** Since its inception, MBCHP has enrolled over 16,700 women, provided 25,820 Pap tests and diagnosed 61 cases of cervical cancer, including 5 cases of invasive cervical cancer and 56 cases of carcinoma in situ of the cervix.[32] Current program enrollment is over 5,300 women, with approximately one-third age 40-49 years and the remaining two-thirds age 50 years and older.[33] Enrollment rates vary from 43% of eligible women in Washington County down to 7% of eligible women in Cumberland County.[34]

- ***Covered clinical services.*** For enrollees, the MBCHP provides an annual exam, including a clinical breast exam, pelvic exam and a Pap test. An HPV test is

[31] The U.S. CDC gives the option of eligibility starting at age 18; due to the limited funding for MBCHP and the availability of family planning services for younger women, Maine decided to begin eligibility at age 40.
[32] Carcinoma in situ is noninvasive; cancer cells are in the first layer of cells lining the cervix only and have not invaded the deeper tissues. Source: National Cancer Institute.
[33] As of October 6, 2006, MBCHP reports 5,329 women enrolled.
[34] Source: Maine Department of Health and Human Services, Maine Breast and Cervical Health Program.

covered following an abnormal result on a Pap test. Cancer treatment is not covered by MBCHP but, in most cases, is covered by MaineCare pursuant to the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000.

- ***Service delivery system and outreach.*** MBCHP funds more than 300 sites to provide clinical and educational services. These include: primary care provider sites which provide clinical exams and pap tests; other health care professionals who provide diagnostic services on referral; laboratory facilities that provide cytology and pathology services; and six community partnerships that provide public education and other support services in six counties. In 2005, the MBCHP distributed 70,000 brochures and 1,900 posters to 441 sites across the state.

B. MaineCare and the Treatment Act

Since 2001, Maine has provided Medicaid (MaineCare) coverage for cancer treatment to women diagnosed with cervical cancer, or breast cancer, under the MBCHP. This coverage was established in accordance with the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 (the Treatment Act), through Maine Public Law 2001, chapter 439, Part TT, which required DHHS to amend its rules to provide full MaineCare coverage to eligible women diagnosed with breast or cervical cancer by the MBCHP. Approximately two years following this rule change, Maine applied for and received federal approval for a less restrictive option allowed under the federal Treatment Act, under which the state provides MaineCare coverage to eligible women who are not enrolled in MBCHP but who: (a) meet MBCHP eligibility requirements and (b) are screened or diagnosed at a participating MBCHP site.[35]

To be eligible for MaineCare under the Treatment Act provisions, a woman must be under age 65, not covered by credible health insurance, and have income less than 250% of the federal poverty level.[36] MaineCare coverage under these rules is continuous for at least one year as long as the woman is receiving cancer treatment. Since 2001, a total of 103 women with cervical cancer or pre-cancer have enrolled in MaineCare under these rules.

C. Maine Cancer Registry

The Maine Cancer Registry (MCR) has an important role in cervical cancer prevention as the source of statewide data and expertise regarding cancer incidence. The MCR was established by the Legislature in 1983 to provide a population-based cancer surveillance system for the state.[37] The registry, which operates within the Maine CDC, DHHS, receives federal funding

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[35] This change was motivated by LD 143, Resolve, to Improve Access to Breast and Cervical Cancer Treatment, which was proposed in the 121st legislature. Ultimately, LD 143 was not enacted after the department agreed to make the changes without legislation.

[36] Specifically the individual must have no "credible coverage" as defined in Section 2701(a) of the federal Public Health Service Act.

[37] 22 MRSA §1404.

under the National Program of Cancer Registries, a program of the U.S. CDC. These federal dollars are matched with state funds, at a ratio of $3 federal to $1 state.

The MCR collects patient demographic, diagnosis and initial treatment data on cases of cancer diagnosed in Maine. With respect to cervical cancer, the MCR collects data on cases of invasive cervical cancer (cervical cancer that has invaded surrounding tissues); it does not collect data on cervical carcinoma in situ (noninvasive).[38] The data is collected by MCR comes from hospitals, health care facilities, physicians and other health care providers who diagnose or treat cancer patients. The MCR law requires health care providers and facilities to report new cases of cancer within six months of diagnosis.[39] The MCR uses the data it collects to monitor and evaluate cancer trends in Maine, to identify areas in need of public health interventions and to improve cancer prevention, treatment and control. The MCR publishes an annual cancer incidence report that includes statistical comparisons between Maine and the nation for various cancer types, including invasive cervical cancer.

D. Maine Immunization Program

With the recent introduction of the HPV vaccine, the Maine Immunization Program (MIP) within DHHS is positioned to become an important player in the state's cervical cancer prevention efforts. Under its "universal purchase policy," Maine purchases and distributes to public and private health care providers statewide all of the CDC-recommended vaccines for all children aged 0 to 18 years, as well as influenza, pneumococcal and first dose measles, mumps, rubella for adults. Currently, the MIP distributes approximately 300,000 doses of vaccine annually to over 700 health care providers in the state.[40] In addition to its vaccine purchase and distribution functions, the MIP also measures immunization rates, provides education and information regarding immunization issues, monitors vaccine usage and maintains an electronic immunization registry.

Funding of the MIP emerged as an important issue of concern to the Task Force. The MIP currently receives funding to purchase vaccine from the following sources:

- ***Vaccines for Children (VFC).*** Vaccines for Children is a federal entitlement program that provides vaccines recommended by the U.S. CDC's Advisory Council on Immunization Practices (ACIP) at no cost for children aged 0-18 years in the following categories: Medicaid-eligible; uninsured; insured but insurance does not cover childhood immunizations (these children must go to a Federally Qualified Health Clinic or Rural Health Clinic); and Native American or Alaskan Native. In 2005, the U.S. CDC awarded $3.2 million in VFC-purchased vaccines for Maine children who qualify for VFC. On

[38] The MCR also does not collect data on basal cell and squamous cell carcinoma of the skin.
[39] 22 MRSA §1402.
[40] Source: Maine Immunization Program, http://www.maine.gov/dhhs/boh/mip/vaccine_related.html

November 1, 2006, Merck announced that the U.S. CDC added Gardasil to the VFC contract.[41]

- ***Section 317 Grant Program.*** The Section 317 program is a federal grant program that provides funding for vaccines for underinsured children not covered under VFC, and for adults. This is a discretionary annual appropriation at the federal level. In 2005, the U.S. CDC awarded $2.9 million in Section 317 funding to Maine.

- ***Private Health Insurance Plans.*** Under an oral agreement between the State and six HMOs under the umbrella of the Maine Association of Health Plans, six HMOs make an annual contribution to support the state's purchase of vaccine for children.[42] In 2005, the six HMOs contributed $700,000 to the state for vaccine purchase for children.

- ***Fund for a Healthy Maine (FHM).*** Under a recent Maine law, certain FHM (tobacco settlement) dollars have been allocated specifically for the purchase of influenza vaccine for adults.[43] In 2005, $1.2 million in FHM dollars were made available for this purpose.

There is currently no General Fund support for the purchase and distribution of vaccines. The lack of General Fund support for this program poses a significant challenge to the MIP in its efforts to carry out the state's universal purchase policy. This challenge increases with each year as new vaccines are recommended, the prices for vaccines increase and federal appropriations for the Section 317 grant program fail to keep up with these recommendations.[44] Even before the addition of the new HPV vaccine, the MIP has estimated that to cover 80% of Maine children with the CDC recommended vaccines, the program needs an additional $2.5 million per year for vaccines for children aged 0-10 years, and an additional $1.5 million for vaccines for children aged 11-18 years.[45]

E. Maine Cancer Consortium

The Maine Cancer Consortium was established in 1999 to develop and implement a state cancer control plan. Today, the consortium is a statewide partnership including 300 individuals representing over 130 public and private organizations. The Consortium relies on its members to seek and provide funding which comes from variety of public and private sources. Membership in the Consortium is open to anyone interested in its mission, which is "to reduce the burden of cancer in Maine by working collaboratively to optimize quality of life by improving access to care, prevention, early detection, treatment, rehabilitation, survivorship, palliation and end of life

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[41] "Product News: Merck's Cervical Cancer Vaccine, Gardasil®, Added to the CDC Vaccines for Children Contract," Merck, http://www.merck.com/newsroom/press_releases/product/2006_1101.html

[42] The amount of the contribution is based on the HMO's self-reported number of children within specific age groups.

[43] PL 2003, c. 451, Pt RR.

[44] Cochi, Stephen L. MD, MPH. "Vaccine Financing from the National Immunization Program's Perspective," National Immunization Program, U.S. CDC, June 2004.

[45] Source: Maine Immunization Program, data provided to the Task Force, September 2006.

care."[46] The focus of the Consortium's work continues to be the development and implementation of the state cancer plan. In May 2006, the Consortium released the Maine Cancer Plan 2006-2010. The plan includes a specific section on cervical cancer, as well as a section on sexual health that addresses HPV prevention.[47]

F. Maine Comprehensive Cancer Control Program

The Maine Comprehensive Cancer Control Program, or Comp Cancer, was established by the Legislature in 2003 to coordinate Maine's cancer control efforts, including prevention, research and treatment activities.[48] Comp Cancer is a participating program of the U.S. CDC National Comprehensive Cancer Control Program, and is entirely supported by federal funds at this time. Current objectives of Comp Cancer include: expanding collaborative efforts in place through the Maine Cancer Consortium; increasing use of the Maine Cancer Plan; providing technical assistance to state and local organizations; conducting public awareness projects; and evaluating implementation of the Maine Cancer Plan.[49] In the area of screening, Comp Cancer has launched a public awareness campaign for colorectal cancer screening.[50]

G. Family Planning Services

The state family planning system has an important clinical and educational role in cervical cancer prevention. At the center of the system is the Family Planning Association of Maine (FPA), which was founded in 1970. The FPA is the Maine grantee for federal family planning funding under Title X of the Public Health Services Act. As the Title X grantee for the state, the FPA provides funding and assistance to a network of 11 delegate agencies that operate a network of 45 family planning clinic sites statewide, which provide comprehensive reproductive health services, including cervical cancer screening and related tests. In 2005, Maine family planning clinics served over 30,000 clients. More than half of these clients (52%) had income at or below the federal poverty level and just under half of the clients were 18 to 24 years of age (46%).[51] In addition to clinical services, the FPA also provides outreach and education, including family life education programs, and works to advance the cause of reproductive freedom.

The FPA is a private non-profit organization. In addition to federal funds, FPA receives state funds, including approximately $1.3 million from the General Fund to support clinical services and family life education and $0.4 million from the Fund for Healthy Maine to conduct outreach to high-risk populations. Additional revenue sources include fees, reimbursement by third-party insurance, private fund-raising, grants from private foundations, and investments.

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[46] Maine Cancer Consortium, http://www.mainecancerconsortium.org/welcome.html
[47] These sections of the Maine Cancer Plan are provided in Appendix E.
[48] PL 2003, c. 215; 22 MRSA §1407.
[49] Maine Comprehensive Cancer Control Program, http://www.maine.gov/dhhs/boh/ccc/index.htm
[50] Screen Me materials can be viewed on line at http://www.maine.gov/dhhs/boh/ccc/screenme.htm
[51] Presentation of Evelyn Kietlyka, Family Planning Association of Maine, to the Task Force on August 24, 2006.

V. CERVICAL CANCER PREVENTION PLAN - RECOMMENDATIONS

Based on its review and assessment of cervical cancer incidence, prevention technologies, the current array of programs and resources available in the state and the recommendations of the Maine Comprehensive Cancer Control Plan 2006-2010, the Task Force has developed its recommendations for a plan of action to eliminate cervical cancer in Maine. The Task Force recommendations, including specific actions and strategies, are organized around the following objectives:

- Increase public awareness and education regarding cervical cancer prevention, the connection between HPV and cervical cancer, and the importance of screening;
- Increase provider knowledge of cervical cancer screening guidelines and emerging technologies in cervical cancer prevention and early detection;
- Increase the number of Maine women who receive cervical cancer screening at recommended intervals;
- Implement the recommendations of the U.S. CDC for the new HPV vaccine; and
- Conduct public health research to improve and evaluate cervical cancer prevention efforts.

The Task Force recognizes that there are costs attached to each of its recommendations and further recommends that the State appropriate and allocate the funds necessary to implement its proposals, as outlined below.

A. Public Awareness

Objective: Increase public awareness and education regarding cervical cancer prevention, the connection between HPV and cervical cancer, and the importance of screening.

Recommended strategies:

1. Direct the Maine Breast and Cervical Health Program (MBCHP) to implement a statewide public education campaign on cervical cancer prevention and screening, as follows:

    a. Develop and distribute printed informational materials to all sites that currently receive MBCHP brochures,[52] plus additional locations statewide

[52] In 2005, MBCHP brochures were distributed to 441 sites, including DHHS offices, hospitals, primary care providers and mammography facilities.

including libraries, shopping malls, grocery stores, hair salons, pharmacies and health care facilities; offer these materials to faith-based organizations.

b. Coordinate specific educational outreach initiatives for racial and ethnic minorities in the state, particularly in Portland, Lewiston, and Bangor, and develop multi-lingual fact sheets and informational materials, as appropriate.[53]

c. Collaborate with organizations representing senior citizens and retired persons to ensure the public awareness campaign reaches women over 60 years.

d. Increase the broadcast of MBCHP public service announcements from the current 4 months (January-April) to all 12 months of the year.

2. Direct the Maine CDC to implement school-based cervical cancer education initiatives, as follows:

a. Develop printed educational materials appropriate for posting at middle and secondary schools and universities, including multi-lingual versions as appropriate. Partner with the Department of Education (DOE) and the University of Maine System to coordinate the distribution and posting of materials at public schools and universities. Include restrooms as a site for posting these materials. Offer the materials to private schools and universities.

b. Develop an educational pamphlet for 5th grade students regarding the availability of the HPV vaccine.[54] Work with DOE health education staff, school nurses and health coordinators to facilitate distribution of the pamphlet in public schools. Provide copies of the pamphlet to all pediatricians and family physicians licensed in the state. Offer the pamphlet to private schools.

c. Develop, in collaboration with DOE health education staff, a "speakers' network" consisting of medical professionals willing to speak about cervical cancer prevention in health education classes or other school forums.

d. Seek grant funding to implement an activity-based cervical cancer education initiative in Maine schools.[55]

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[53] Cancer Care Ontario (Canada) has a fact sheet "HPV and Cancer of the Cervix" in English and 14 other languages. See for example: http://www.cancercare.on.ca/pdf/ocsp_somali_hpv.pdf (Somali) http://www.cancercare.on.ca/pdf/FSHPVE.QXD.pdf (English)

[54] Fifth grade was selected because the federal CDC recommendation is to begin vaccination at 11-12 years.

[55] See for example, the "Make the Connection" campaign and bracelet activity recently conducted by the Cancer Research and Prevention Foundation and Step Up Women's network, with support from Merck and Co.; see: www.maketheconnection.org

B. Provider Knowledge

Objective: Increase provider knowledge of clinical guidelines for cervical cancer screening and emerging technologies in cervical cancer prevention and early detection.

Recommended strategies:

1. Direct the Maine CDC to work with the Maine Medical Association's Committee on Continuing Medical Education and Accreditation to increase continuing medical education (CME) offerings regarding cervical cancer. Recommend that the content of these offerings include, but not be limited to:

    - Current clinical guidelines for cervical cancer screening, including new developments in screening and situations in which the guidelines recommended screening less frequently than annually;

    - HPV vaccines, including status of vaccine development and U.S. CDC recommendations; and

    - Emerging issues and technologies in prevention, detection and treatment of cervical cancer.

    Recommend that the expanded offerings include self-study options, such as on-line CME programs.[56] Encourage the Maine Medical Association to conduct outreach efforts to promote cervical cancer CME offerings and to inform providers of insurance coverage for the HPV vaccine.

2. Direct MBCHP to review and update the program's clinical guidelines for cervical cancer screening, taking into account the most recent guidelines published by the American Cancer Society, the American College of Obstetricians and Gynecologists and the U.S. Preventive Services Task Force. Direct MBCHP to offer a professional education program on this subject after the review and update is complete.

C. Screening

Objective: Increase the number of Maine women who receive cervical cancer screening at recommended intervals, with a primary focus on increased screening among women who are screened less frequently than recommended, and a secondary focus on decreased screening among women who are screened more frequently than recommended.

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[56] See for example, existing on-line courses designed by American Society of Colposcopy and Cervical Pathology (ASCCP) in collaboration with American Social Health Association (ASHA), http://www.asccp.org/edu/home_study.shtml

Recommended strategies:

1. Implement the recommended "public awareness" and "provider knowledge" strategies to increase understanding of the importance of screening for cervical cancer and the recommended screening intervals.

2. Expand access to cervical cancer screening for low-income and underserved women as follows:

    a. Expand the MBCHP program to provide cervical cancer screening to women under 40 years; the first priority must be to add women ages 35-39 years to the program and target services to those women who have never been screened or only rarely screened for cervical cancer.[57]

    b. Direct the MBCHP to collaborate with the Family Planning Association of Maine (FPA) to develop ideas for outreach and coordination to increase cervical cancer screening among women ineligible for MBCHP, particularly women ages 18-35 years.

    c. Direct the MBCHP to expand its "special screening day" program, at which women who are newly enrolled in MBCHP receive their Pap tests and mammograms at a single site.[58] Direct MBCHP to consider new locations and as well as additional days in existing locations as potential expansion strategies.

    d. Direct DHHS, Office of MaineCare Services, in consultation with MBCHP and FPA, to evaluate the possibility of applying for a federal Medicaid Family Planning Waiver in order to extend coverage for cervical cancer screening to more low-income women in Maine.

3. Direct the MBCHP in consultation with Maine Comprehensive Cancer Control Program, the Maine State Employee Health Commission, the American Cancer Society and private insurance companies and to explore options for encouraging insured individuals to make and attend medical appointments for cancer screenings, including cervical cancer.[59]

4. Direct the Maine Quality Forum (MQF) to identify and assess the status of current efforts and initiatives by health insurers and health care providers that may enhance the delivery of cervical cancer screening and follow-up care, including but not limited to:

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[57] Eligibility currently begins at 40 years.

[58] Task Force member, Dr. James A. Raczek, representing the Academy of Family Physicians voted against this recommendation.

[59] Examples may include giving employees time off from work for cancer screening appointments.

- Computer-based clinical improvement tools designed for health care providers to track and manage patient care, including cervical cancer screening.

- Provider incentives to conduct cervical cancer screening at recommended intervals, including health care quality and performance measures.

D. HPV Vaccine

Objective: Implement recommendations of the U.S. CDC for the new HPV vaccine.

Recommended strategies:

1. Make funding for the HPV vaccine a high priority. Specifically, increase state funding to the Maine Immunization Program (MIP), including a General Fund appropriation. Require that a portion of the appropriation be designated for the HPV vaccine, including purchase, distribution and associated operational costs.

2. Direct the MIP to report to the joint standing committee of the Legislature having jurisdiction over health matters regarding program funding and vaccination rates, including:

   - The overall program budget for the current year and previous two years, including specific information regarding the HPV vaccine expenditures;

   - State and national immunization rates for childhood vaccines, including HPV; and

   - An update on the funding gap, specifically the additional funds needed to vaccinate 80% of Maine children with CDC recommended vaccines, including HPV.

   Require the MIP to submit an initial report no later than January 30, 2008, and a follow-up report no later than January 30, 2010.

3. Direct DHHS to provide coverage under the state MaineCare (Medicaid) program for the HPV vaccine consistent with U.S. CDC recommendations.

4. Integrate HPV vaccine information into "public awareness" and "provider knowledge" strategies outlined above.

E. Further Research and Evaluation

Objective: Conduct public health research to improve and evaluate cervical cancer prevention efforts.

Recommended strategies:

1. Direct the Office of Minority Health to work with the Maine Cancer Registry, the Maine Comprehensive Cancer Control Program and the Office of Multicultural Affairs to examine cervical cancer incidence and prevention issues among racial and ethnic minority populations in Maine, including:

    - Available data on cervical cancer among racial and ethnic minorities;
    - Barriers to screening and treatment across different racial and ethnic minorities; and
    - Best practices in education and outreach to racial and ethnic minorities.

2. Direct the Maine Cancer Registry and the Maine Breast and Cervical Health Program to examine the geographic variation in cervical cancer rates within Maine, focusing on the higher rates of cervical cancer in Washington County and Somerset County and why the rates in these locations are higher than in other areas of the state. Direct the MCR and MBCHP to collaborate with the American Cancer Society, community organizations and health care providers to develop recommendations for reducing the incidence of cervical cancer in these counties.

3. Direct the Maine CDC to monitor and evaluate the state's progress in cervical cancer prevention, detection and education in response to the work of the Task Force. Require the Maine CDC to review the status and outcome of each Task Force recommendation and report its findings and recommendations, including any legislation, to the joint standing committee of the Legislature having jurisdiction over health services. Require an initial and final evaluation report as follows:

    - Initial report no later than January 30, 2009, and
    - Final report no later than January 30, 2011.

F. Addendum

The following two recommendations were made after the final meeting of the Task Force and were not endorsed by the group as a whole.

1. Direct the Maine CDC to convene a stakeholder group in 2010 to evaluate the progress of HPV vaccination in Maine and examine the potential costs and benefits of adding the HPV vaccine to the immunizations required for school attendance. Require the Maine CDC to report its findings and recommendations to the joint standing committee of the Legislature having jurisdiction over health and human services matters by January 15, 2011.[60]

2. Target additional cervical cancer prevention, detection and education efforts to Somerset and Washington Counties as follows:[61]

    a. Direct the MBCHP to conduct specific educational outreach initiatives for women in Somerset and Washington Counties.

    b. Direct the Maine CDC, working with the Maine Medical Association's Committee on Continuing Medical Education, to target medical professionals in Somerset and Washington Counties when expanding CME offerings regarding cervical cancer (as described under "provider knowledge" recommendations).

    c. Prioritize Washington and Somerset Counties in efforts to increase cervical cancer screening rates.

[60] Task Force members, Rep. Lisa T. Marrache, Co-Chair of the Task Force, and Dr. Jonathan T. Fanburg, representing the American Academy of Pediatrics, made this recommendation.
[61] Task Force member, Dr. Molly Schwenn, Director, Maine Cancer Registry, made this recommendation.

APPENDIX A

Authorizing Legislation, Resolves 2005, Chapter 121

CHAPTER 121
H.P. 899 - L.D. 1302

Resolve, Establishing The Task Force To Study Cervical Cancer Prevention, Detection and Education

Emergency preamble. Whereas, acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, this resolve establishes the Task Force to Study Cervical Cancer Prevention, Detection and Education; and

Whereas, the study must be initiated before the 90-day period expires in order that the study may be completed and a report submitted in time for submission to the next legislative session; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Task force established. Resolved: That the Task Force to Study Cervical Cancer Prevention, Detection and Education, referred to in this resolve as "the task force," is established; and be it further

Sec. 2. Task force membership. Resolved: That the task force consists of the following 16 voting members:

1. Seven members appointed by the President of the Senate as follows:

   A. One member of the Senate;
   B. One representative of a women's health organization;
   C. One communications consultant;
   D. One representative of the American Academy of Pediatrics;
   E. One representative of the American Academy of Family Physicians;
   F. One licensed registered nurse; and
   G. One representative of the Maine Medical Association or its successor;

2. Seven members appointed by the Speaker of the House of Representatives as follows:

   A. Two members of the House of Representatives;
   B. One representative of the American Cancer Society who is an oncologist;
   C. One representative of the health insurance industry;
   D. One representative of the American College of Obstetricians and Gynecologists;
   E. One member of the Maine Osteopathic Association or its successor; and
   F. One person who has survived cervical cancer;

3. The medical director of the Maine Cancer Registry or the medical director's designee; and

4. The Director of the Maine Breast and Cervical Health Program within the Department of Health and Human Services, Bureau of Health and other members of the Bureau of Health, as

necessary to the work of the task force, who serve as ex officio nonvoting members of the task force.

When making appointments to the task force, each appointing authority shall ensure that appointees reflect the composition of the State's population with regard to ethnicity, race and age; and be it further

Sec. 3. Chair. Resolved: That the Senate member shall serve as chair and the first-named House member shall serve as vice-chair; and be it further

Sec. 4. Appointments; convening of task force. Resolved: That all appointments must be made no later than 30 days after the effective date of this resolve. The appointing authorities shall notify the Executive Director of the Legislative Council once all appointments have been completed. The chair shall call and convene the first meeting of the task force by August 1, 2005; and be it further

Sec. 5. Quorum. Resolved: That a majority of the task force constitutes a quorum for the transaction of its business; and be it further

Sec. 6. Committees. Resolved: That the task force chair may establish committees for the purpose of making special studies pursuant to its duties and may appoint persons who are not members of the task force to serve on each committee as resource persons. Resource persons are voting members of the committees to which they are appointed. Committees may meet with the frequency needed to accomplish the purposes of this resolve; and be it further

Sec. 7. Duties. Resolved: That the task force shall:

1. Review statistical and qualitative data on the prevalence and incidence of cervical cancer in Maine;

2. Review preventive strategies and new technologies, including newly introduced vaccines and their effectiveness in preventing and controlling the risk of cervical cancer, as well as their relative costs;

3. Identify and examine the strengths and limitations of existing laws, regulations, programs and services regarding coverage and awareness of cervical cancer;

4. Consider reports and testimony from individuals, local health departments, community-based organizations, voluntary health organizations and other public and private organizations statewide to learn more about their contributions to cervical cancer diagnosis, prevention and treatment and their ideas for improving prevention, diagnosis and treatment in Maine;

5. Develop, in consultation with the Department of Health and Human Services, a statewide comprehensive cervical cancer prevention plan and strategies for plan implementation and for promoting the plan and awareness of the causes, risk factors, prevention, early detection and treatment of cervical cancer to the general public, state and local elected officials and various public and private organizations, associations, businesses, industries and agencies; and

6. Recommend strategies for coordination and communication among state and local agencies and organizations regarding their involvement in achieving the aims of the cervical cancer prevention plan; and be it further

Sec. 8. Staff assistance. Resolved: That the Legislative Council shall provide necessary staffing services to the task force; and be it further

Sec. 9. Compensation. Resolved: That legislative members of the task force are entitled to receive the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses for their attendance at authorized meetings of the task force. Public members not otherwise compensated by their employers or other entities that they represent are entitled to receive reimbursement of necessary expenses and, upon a demonstration of financial hardship, a per diem equal to the legislative per diem for their attendance at authorized meetings of the task force; and be it further

Sec. 10. Report. Resolved: That, no later than December 7, 2005, the task force shall submit an initial report to the Joint Standing Committee on Health and Human Services and the Governor. The task force is not authorized to meet from December 21, 2005 to April 25, 2006 or to introduce legislation. The task force shall submit its final report to the joint standing committee of the Legislature having jurisdiction over health and human services matters by November 1, 2006. The joint standing committee of the Legislature having jurisdiction over health and human services matters in the First Regular Session of the 123rd Legislature may report out legislation on cervical cancer prevention, detection and education; and be it further

Sec. 11. Task force funding. Resolved: That the task force shall seek outside funds to fully fund all costs of the task force. If sufficient outside funding has not been received by September 15, 2005 to fully fund all costs of the task force, no meetings are authorized and no expenses of any kind may be incurred or reimbursed. Contributions to support the work of the task force may not be accepted from any party having pecuniary or other vested interest in the outcome of the matters being studied. Any person, other than a state agency, desiring to make a financial or in-kind contribution must certify to the Legislative Council that it has no pecuniary or other vested interest in the outcome of the study. Such certification must be made in the manner prescribed by the Legislative Council. All contributions are subject to approval by the Legislative Council. All funds accepted must be forwarded to the Executive Director of the Legislative Council along with an accounting record that includes the amount of funds, the date the funds were received, from whom the funds were received and the purpose of and any limitation on the use of those funds. The Executive Director of the Legislative Council shall administer any funds received by the task force. The executive director shall notify the chair of the task force when sufficient funding has been received; and be it further

Sec. 12. Appropriations and allocations. Resolved: That the following appropriations and allocations are made.

LEGISLATURE

Miscellaneous Studies 0444

Initiative: Provides an allocation of Other Special Revenue Funds in the event outside funding is collected to support the activities of the Task Force to Study Cervical Cancer Prevention, Detection and Education. If sufficient outside funding has not been received by September 15, 2005 to fully fund all costs of the task force, no meetings are authorized and no expenses of any kind may be incurred or reimbursed.

OTHER SPECIAL REVENUE FUNDS	2005-06	2006-07
Personal Services	$880	$880
All Other	$3,600	$3,600
OTHER SPECIAL REVENUE FUNDS TOTAL	$4,480	$4,480

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

Effective June 21, 2005.

APPENDIX B

Task Force Membership List

Task Force to Study Cervical Cancer Prevention, Detection and Education

Resolve 2005, Ch. 121

Appointment(s) by the President

Sen. Nancy B. Sullivan - Chair 20 Westwood Drive Biddeford, ME 04005 207 282-5594	Senate Member
Kolawole Adewale Bankole M.D., M.S. Amanda Lane, Lot #10 PO Box 5642 Ellsworth, ME 04605	Representing Communications Consultants
Dina Cole BSN, RN, CPAN 9 Lemon Street Veazie, ME 04401	Representing Licensed Registered Nurses
Jonathan T. Fanburg M.D., M.P.H. PO Box 1420 Ellsworth, ME 04605	Representing the American Academy of Pediatrics
Michael A. Jones M.D. 152 Morton Road Yarmouth, ME 04096	Representing the Maine Medical Association
Evelyn G. Kieltyka MSN, MS, FNP Family Planning Assoc. of ME P. O. Box 587 Augusta, ME 04332-0587	Representing a Women's Health Organization
James A. Raczek M.D., FACFP 489 State St., - Webber 1 Bangor, ME 04401 207 945-6573	Representing the Academy of Family Physicians

Appointment(s) by the Speaker

Rep. Lisa T. Marrache - Chair 109 Silver Street Waterville, ME 04901 207 861-0154	House Members
Rep. James J. Campbell Sr. P.O. Box 29 West Newfield, ME 04095	House Members
Carrie Bolander, D.O. 24 Miles Center Way Damariscotta, ME 04543	Representing the Maine Osteopathic Association
Bob Downs RR 1, Box 1580 Pittsfield, ME 04967	Representing the Health Insurance Industry
Susan Miesfeldt, M.D. Maine Center for Cancer Medicine 100 U.S. Route 1 Scarborough, ME 04074 207 885-7600	Representing the American Cancer Society (Oncologist)

Janet Miles

PO Box 3205
Auburn, ME 04212-3205

Representing Cervical Cancer Survivors

James Wilberg, M.D.
35 Stapleford Drive
Falmouth, ME 04105

Representing the American College of Obstetricians & Gynecologists

Medical Director, Maine Cancer Registry

Dr. Molly Schwenn, Medical Director
Maine Cancer Registry
State House Station 11 4th Floor, Key Plaza
Augusta, ME 04333
207 287-8945

Director, Maine Cancer Registry

Other

Sharon Jerome Program Director
MBCHP, Key Plaza, 4th Floor
11 State House Station
Augusta, ME 04333
207 287-6895

Director, Maine Breast & Cervical Health Program, DHHS

APPENDIX C

Meeting Agendas

Task Force to Study Cervical Cancer Prevention, Detection and Education

November 16, 2005, 1:00pm to 4:00pm
Room 427, State House

AGENDA

1:00pm Welcome and Introductions

1:30pm Overview of Task Force Legislation, Duties and Requirements

2:00pm Where are we now? Overview of Cervical Cancer Incidence and Prevention, Detection and Education Initiatives in Maine

- Dr. Molly Schwenn, Director, Maine Cancer Registry
- Sharon Gerome, Director, Maine Breast and Cervical Health Program

3:00pm Task Force Planning

- Establishing Priorities and Goals
- Developing Work Plan / Schedule
- Planning for Initial Report due December 2005

4:00pm Adjournment

Next Meeting: December 16, 2005 at 1:00pm in State House Room 427

Task Force to Study Cervical Cancer Prevention, Detection and Education

December 16, 2005, 1:00pm to 4:00pm
Room 427, State House

AGENDA

1:00pm Introductions

1:15pm Clinical Guidelines – *Dr. Razcek*

1:30pm Technology Issues – *Dr. Jones*
- HPV/vaccine development
- Thin prep vs. conventional pap
- Women who are screened but for whom screening fails

2:00pm MaineCare coverage of cervical cancer screening/treatment
Linda Schumacher and Maura Howard, DHHS

2:30pm Western Maine Community Action Program, "At Your Cervix"
Nancy Audet, Program Manager, Tri-County Health Services

3:00pm Report Back on the Cervical Cancer Summit, *Rep. Marrache*

3:15pm Initial Report (Due December 23) – Staff review of outline / report drafting

4:00pm Adjournment

Task Force to Study Cervical Cancer Prevention, Detection and Education

July 18, 2006, 1:00pm to 4:00pm
Room 214, Cross Office Building

AGENDA

1:00pm	**Introductions**
1:15pm	**Review and Updates** ▪ Review of Initial Report ▪ Updates – Recent News, Reports and Resources
1:45pm	**Task Force Discussion/Work Session** ▪ Remaining Duties and Schedule ▪ Developing a Statewide Cervical Cancer Prevention Plan – Next Steps
2:30pm	**Break**
2:45pm	**Presentation / Maine Health Data Organization - Overview of Available Data** *(Al Prysunka)*
3:15pm	**Presentation / Family Planning Association of Maine – Pap Test Data** *(Evelyn Kieltyka)*
3:45pm	**Planning for Next Meeting**
4:00pm	**Adjournment**

Next Meeting -- August 24, 2006, 9:30am-12:30pm
Cross Office Building, Room 214

Task Force to Study Cervical Cancer Prevention, Detection and Education

August 24, 2006, 9:30am-12:30pm
Room 214, Cross Office Building

AGENDA

9:30am	**Introductions**
9:45am	**Merck / Gardasil**
10:30am	**Maine Immunization Program** *Sally Lou Patterson, Director, Division of Infectious Disease, DHHS*
11:00am	**Family Planning Association / Pap Test Data** *Evelyn Kieltyka, Senior Vice President of Program Services*
11:30am	**Task Force Discussion & Work Session**
12:15pm	**Planning for Next Meeting**
12:30pm	**Adjournment**

Next Meeting – September 19, 2006, 1:30am-4:30pm
Cross Office Building, Room 214

Task Force to Study Cervical Cancer Prevention, Detection and Education

September 26, 2006, 1:30-4:30pm
Room 214, Cross Office Building

AGENDA

1:30pm	**Introductions**
1:45pm	**Task Force Work Session – Development of Recommendations**
4:15pm	**Planning for Next Meeting**
4:30pm	**Adjournment**

Next Meeting – October 17, 2006, 1:30-4:30pm
Cross Office Building, Room 214

Task Force to Study Cervical Cancer Prevention, Detection and Education

October 17, 2006, 1:30-4:30pm
Room 214, Cross Office Building

AGENDA

1:30pm	**Introductions**
1:45pm	**Task Force Work Session – Review of Draft Report**
4:30pm	**Adjournment**

APPENDIX D

Draft Legislation to Implement Task Force Recommendations

An Act to Implement the Recommendations of the Task Force to Study Cervical Cancer Prevention, Detection and Education

Be it enacted by the People of the State of Maine as follows:

Part A

Sec A-1. State funding for the human papillomavirus vaccine. Beginning with state fiscal year 2006-07, the Maine Legislature shall provide funding to the Maine Immunization Program to support the purchase and distribution of the human papillomavirus vaccine and associated program operation costs. The Legislature shall appropriate the funds necessary to provide the human papillomavirus vaccine to all 11 and 12 year old females in the state after utilizing all available federal funding and federally-purchased vaccine.

Sec. A-2. Maine Immunization Program to report on program funding and vaccination rates. The Maine Immunization Program shall report to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding the status of program funding and vaccination rates. The program shall submit an initial report to the committee no later than January 30, 2008, and a second report no later than January 30, 2010. Each report must include the following:

1. Program budget information for the current year and previous two years, including specific information regarding expenditures on the human papillomavirus vaccine;

2. Documentation of any funding shortage that exists between available funds and the expenditures required to vaccinate 80% of Maine children with the human papillomavirus vaccine and the other vaccines on the federal Centers for Disease Control and Prevention recommended childhood and adolescent vaccine schedule; and

3. State and national immunization rates for the human papillomavirus vaccine and the other vaccines on the federal Centers for Disease Control and Prevention recommended childhood and adolescent vaccine schedule.

Sec. A-3. MaineCare coverage of the human papillomavirus vaccine. The Department of Health and Human Services shall amend the rules for the MaineCare program to provide coverage for the human papillomavirus vaccine in accordance with the federal Centers for Disease Control and Prevention's current recommended childhood and adolescent immunization schedule and current recommended adult immunization schedule as published in the Morbidity and Mortality Weekly Report. The Office of MaineCare Services shall provide information regarding human papillomavirus

vaccination among MaineCare members to the Maine Center for Disease Control and Prevention for inclusion in the initial and final evaluation reports required under Section D-3.

Part B

Sec. B-1. Statewide public education campaign regarding cervical cancer. The Maine Breast and Cervical Health Program, referred to in this section as "the program," shall develop and implement a statewide public education campaign regarding cervical cancer prevention and early detection, including the importance of cervical cancer screening and the availability of the human papillomavirus vaccine. In carrying out the campaign, the program shall:

1. Broadcast public service announcements, including information about cervical cancer prevention and early detection, for all 12 months of the year;

2. Distribute printed information materials regarding cervical cancer to all sites that currently receive program brochures and to additional locations statewide including, but not limited to, libraries, shopping malls, grocery stores, hair salons and health care facilities. The program must also offer these informational materials to faith-based organizations;

3. Collaborate with the Office of Minority Health to develop specific outreach initiatives for racial and ethnic minority populations in the state. Informational materials developed pursuant to subsection 2 must be translated into languages other than English, as appropriate; and

4. Consult with state and local organizations representing senior citizens and retired person to develop specific outreach initiatives to reach women over 60 years.

The program shall report its progress and results in implementing this section to the Maine Center for Disease Control and Prevention for inclusion in the initial and final evaluation reports required under Section D-3.

Sec. B-2. School-based cervical cancer education initiatives. The Maine Center for Disease Control and Prevention, referred to in this section as "the center," shall coordinate the development and implementation of school-based cervical cancer education initiatives in accordance with this section.

1. The center shall develop printed materials on cervical cancer prevention and early detection appropriate for students in grades 6-12 and college students to be posted at schools and universities. The center shall collaborate with the Maine Department of Education and the University of Maine System to coordinate the distribution and posting

of materials at public schools and universities. The center shall offer these materials to private schools and colleges;

2. The center shall develop an educational pamphlet regarding the HPV vaccine for students in the fifth grade. The center shall collaborate with health education staff within the Department of Education, school nurses and health coordinators to facilitate the distribution of the pamphlet in public schools. The center shall provide copies of the pamphlet to all pediatricians and family physicians licensed in the state and shall offer the pamphlet to private schools;

3. The center shall collaborate with health education staff of the Department of Education to develop a listing of medical professionals willing to speak about cervical cancer prevention in health education classes or other appropriate forums in public schools on a voluntary basis; and

4. The center shall seek grant funding to implement an activity-based cervical cancer educational initiative in schools. The center shall seek input from the Department of Education in developing its proposal and applying for grant funding.

The center shall report its progress and results in implementing this section in the initial and final evaluation reports required under section D-3.

Sec. B-3. Continuing medical education regarding cervical cancer. The Maine Center for Disease Control and Prevention shall collaborate with the Maine Medical Association's Committee on Continuing Medical Education and Accreditation to identify and implement strategies to expand continuing medical education opportunities regarding cervical cancer, including but not limited to: current clinical guidelines for cervical cancer screening; human papillomavirus vaccines; and emerging issues and technologies in cervical cancer prevention, detection and treatment. The Maine Center for Disease Control and Prevention shall encourage the Maine Medical Association to conduct outreach efforts to promote cervical cancer continuing education offerings to its members and inform them of the current status of the human papillomavirus vaccines, including availability, cost and insurance coverage. The Maine Center for Disease Control and Prevention shall report its progress and results in implementing this section in the initial and final evaluation reports required under section D-3.

Part C

Sec C-1. Medicaid waiver for family planning services. The Department of Health and Human Services, including representatives of the Office of MaineCare Services and the Maine Breast and Cervical Health Program, in consultation with the Family Planning Association of Maine, Inc., shall examine the potential costs and benefits of obtaining a state Medicaid family planning waiver to provide cervical cancer screening and related services to individuals who do not otherwise qualify for the state

MaineCare program. The examination must include an assessment of the potential value of such a waiver to the state's efforts to cervical cancer prevention and early detection. No later than January 1, 2008, the department shall make a recommendation to the joint standing committee of the Legislature having jurisdiction over health and human services matters regarding whether the state should apply to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services for a waiver.

Sec. C-2. Maine Breast and Cervical Health Program eligibility expansion. The Department of Health and Human Services shall amend the rules regarding eligibility for the Maine Breast and Cervical Health Program to grant eligibility for cervical cancer screening and related services to women ages 35 to 39 years who meet all other eligibility criteria for the program. The program shall report its experience under this rule change to the Maine Center for Disease Control and Prevention for inclusion in the initial and final evaluation reports required under section D-3.

Sec. C-3. Maine Breast and Cervical Health Program screening initiatives. The Maine Breast and Cervical Health Program shall implement the following initiatives to increase and improve cervical cancer screening:

1. The program shall collaborate with the Family Planning Association of Maine, Inc., to develop ideas for outreach and coordination to increase cervical cancer screening among women who are ineligible for the program, with particular attention to women under 35 years of age;

2. The program shall expand its special screening days. The expansion may include adding more sites, adding more screening days at current sites or a combination of these strategies, based on the program's assessed need and demand for services;

3. The program shall update its clinical guidelines for cervical cancer screening, based on a review of the most recent clinical guidelines for cervical cancer screening published by the American Cancer Society, the American College of Obstetricians and Gynecologists and the United States Preventive Services Task Force. The program shall offer a professional education program on clinical guidelines for cervical cancer screening after it has completed the update; and

4. The program shall coordinate a stakeholder group including representatives of the Maine Comprehensive Cancer Control Program, the State Employee Health Commission, the American Cancer Society, and health insurance carriers operating in the State to explore options for encouraging insured individuals to make and attend medical appointments for cancer screening including, but not limited to, cervical cancer screening.

The program shall report its progress and results in implementing this section to the Maine Center for Disease Control and Prevention for inclusion in the initial and final evaluation reports required under section D-3.

Sec. C-5. Maine Quality Forum review and report on health care system initiatives affecting the delivery of cervical cancer screening services. The Maine Quality Forum shall identify and assess current initiatives within the state health care system that may enhance the delivery of cervical cancer screening and follow-up medical care, including computer-based clinical improvement systems to track and manage patient care, provider incentives and health care quality and performance measures. The forum shall report its findings, and any recommendations, to the Maine Center for Disease Control and Prevention for inclusion in the initial evaluation report required under section D-3.

Part D

Sec. D-1. Cervical cancer incidence and prevention in racial and ethnic minority populations. The Office of Minority Health shall, in collaboration with the Maine Cancer Registry, the Office of Multicultural Affairs and the Maine Comprehensive Cancer Control Program, examine cervical cancer incidence in racial and ethnic minority populations in the State and develop recommendations to improve cervical cancer prevention and early detection in these populations. The project must consider:

1. Available data on cervical cancer incidence among racial and ethnic minorities;

2. Barriers to cervical cancer screening and treatment across different racial and ethnic minorities; and

3. Best practices in public health education and outreach to racial and ethnic minorities.

The Office of Minority Health shall report its findings and recommendations to the Maine Center for Disease Control and Prevention for inclusion in the initial evaluation report required under section D-3.

Sec. D-2. Geographic variations in cervical cancer rates. The Maine Cancer Registry shall, in collaboration with the Maine Breast and Cervical Health Program, examine geographic variation in cervical cancer rates within the state, with particular attention to the higher rates of cervical cancer observed in Washington County and Somerset County, and shall explore reasons for the variation. The Maine Cancer Registry and the Maine Breast and Cervical Health Program shall consult with the American Cancer Society, community organizations and health care providers to develop recommendations for reducing the incidence of cervical cancer in Washington County

and Somerset County. The Maine Cancer Registry shall report its findings and recommendations to the Maine Center for Disease Control and Prevention for inclusion in the initial evaluation report required under section D-3.

Sec. D-3. Evaluation of cervical cancer prevention, detection and education initiatives. The Maine Center for Disease Control and Prevention shall monitor and evaluate the State's progress in cervical cancer prevention, detection and education in response to the work of the Legislature's Task Force to Study Cervical Cancer Prevention, Detection and Education. The center shall submit two evaluation reports to the joint standing committee of the Legislature having jurisdiction over health and human services matters. The reports must address the progress, status and outcomes of each recommendation contained in the final report of the Task Force including, but not limited to, each initiative required under this Act. The initial evaluation report must be submitted no later than January 30, 2009, and the final evaluation report must be submitted no later than January 30, 2011. After review of the initial report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out legislation regarding cervical cancer prevention, detection and education to the First Regular Session of the 124th Legislature. After review of the final report, the joint standing committee of the Legislature having jurisdiction over health and human services matters may report out legislation regarding cervical cancer prevention, detection and education to the First Regular Session of the 125th Legislature.

SUMMARY

This bill implements the recommendations of the Task Force to Study Cervical Cancer Prevention, Detection and Education.

Part A of the bill relates to the human papillomavirus vaccine. It specifically does the following:

1. It requires the Maine Legislature to provide funding to the Maine Immunization Program for purchasing and distributing the human papillomavirus vaccine to all 11 and 12 year old females.

2. It requires the Maine Immunization Program to report to the joint standing committee of the Legislature having jurisdiction over health and human matters on the status of program funding and vaccination rates, including specific information on the human papillomavirus vaccine, by January 30, 2008 and again by January 30, 2010.

3. It requires the Department of Health and Human Services to amend the rules for the MaineCare program to include coverage for the vaccine.

Part B of the bill relates to improving public awareness and education regarding cervical cancer prevention. It specifically does the following:

1. It requires the Maine Breast and Cervical Health Program to develop public education materials regarding cervical cancer prevention and the human papillomavirus vaccine to be distributed to sites that currently receive the program's materials, as well as locations that include libraries, malls, health care facilities and others. It requires the materials to be translated into languages other than English when necessary.

2. It requires the Maine Center for Disease Control and Prevention to coordinate with the Maine Department of Education and the University of Maine System to develop educational materials for schools and universities, including a 5th grade pamphlet. In addition, the Center must develop a voluntary speakers group for health and other classes.

3. It requires the Maine Center for Disease Control and Prevention to collaborate with the Maine Medical Association to develop and expand continuing medical education units related to cervical cancer, including appropriate screening guidelines and vaccination materials.

Part C of the bill relates to expanding cervical cancer screening opportunities. It specifically requires the following:

1. It requires the Department of Health and Human Services to consult with MaineCare, the Maine Breast and Cervical Health Program, and the Family Planning Association of Maine to determine the potential costs and benefits of obtaining a federal Medicaid family planning waiver to provide cervical cancer screening and related services to individuals that do not currently qualify for MaineCare.

2. It requires the Maine Breast and Cervical Health Program to expand eligibility to include women ages 35-39 years who meet all other eligibility criteria for the program.

3. It requires the Maine Breast and Cervical Health Program to: coordinate with the Family Planning Association of Maine to increase cervical cancer screening among women under 35 years of ages; expand screening days to new sites or additional days; update screening guidelines; and work with the Maine Comprehensive Cancer Control Program, the State Employee Health Commission, the American Cancer Society, and health insurance carriers to explore options for encouraging people to attend cancer screenings.

4. It requires the Maine Quality Forum to identify and assess current initiatives within the state health care system that may enhance delivery of cervical cancer screening and follow-up care.

Part D relates to future research in cervical cancer. It specifically does the following:

1. It requires the Office of Minority Health to collaborate with the Maine Cancer Registry, the Office of Multicultural Affairs, and the Maine Comprehensive Cancer

Control Program to examine cervical cancer incidence in racial and ethnic minorities in the state and study barriers to screening and treatment and best practices for overcoming those barriers.

2. It requires the Maine Cancer Registry to collaborate with the Maine Breast and Cervical Health Program to examine the higher incidence of cervical cancer in Washington County and Somerset County to determine reasons for the variation and develop recommendations for reducing cervical cancer in those counties.

3. It requires the Maine Center for Disease Control and Prevention to monitor and evaluate state progress in implementing the Task Force recommendations and report to the joint standing committee of the Legislature having jurisdiction over health and human services by January 30, 2009, and again by January 30, 2011.

APPENDIX E

Excerpts from Maine Cancer Plan 2006-2010

SEXUAL HEALTH

Certain sexually transmitted diseases, including human papillomavirus (HPV), hepatitis B (HBV), and human immunodeficiency virus (HIV), are associated with cancer. Certain types of HPV, specifically HPV-16 and HPV-18, are the major causes of cervical cancer and may also play a role in cancers of the anus, vulva, vagina, and penis. Hepatitis viruses, particularly HBV, have been linked to liver cancers, and HIV has been linked with lymphoma, anal cancer, and Kaposi's sarcoma. Risk factors for sexually transmitted diseases (STDs) include unprotected sexual contact and multiple partners.

Currently, early detection of certain HPV types, such as HPV-16 and -18 is the standard for prevention of cervical cancer. However, with new technologies emerging for HPV-testing, the development of effective HPV vaccines, and increased awareness of HPV among the general public, there may be more emphasis on primary prevention of cervical cancer. Additionally, methods used to prevent other STDs will have some impact on reducing the incidence of HPV infection and, indirectly, the incidence of cervical cancer.

Goal: To reduce the risk of cervical and other cancers associated with sexually transmitted disease in Maine.

Objective 1: Reduce by 10% the incidence of sexually transmitted diseases associated with the development of cancer in Maine by 2010.

Baseline: 12 cases of Acute HBV incidence in Maine, Maine CDC STD Program, 2004; National HPV incidence estimate: 6.2 million.

Strategies

1. Provide health care/social service professionals with at least five opportunities for HPV education.
2. Promote public knowledge about HPV by developing and disseminating at least 500 fact sheets for females and health care professionals through collaboration between the Maine Breast and Cervical Health Program, the Maine Comprehensive Cancer Program and the Maine HIV, STD and Viral Hepatitis Program.
3. Increase the number of HIV and STD prevention interventions that target individuals at high risk for HPV, HBV and HIV infection.
4. Conduct at least two public education campaigns to promote safer sex and/or vaccines by 2010.
5. Seek funding for HPV vaccination.

Objective 2: Promote Hepatitis B vaccine for Maine children 19-35 months of age.

Baseline: 92% received 3 or more doses of hepatitis B vaccine, CDC National Immunization Survey, 2004.

Objective 3: Promote Hepatitis B vaccines for at-risk adults accessing STD clinics.

Strategies

1. Implement at least two interventions annually to increase the number of children who receive Hepatitis B vaccine by the time they enter kindergarten.
2. Provide at least two opportunities annually for people working with middle school children to learn more about viral hepatitis prevention and resources.
3. Increase the proportion of sexually active adults who receive free Hepatitis B vaccine by 2010.

Objective 4: Increase abstinence to 60% among sexually active 9 – 12th graders by 2010

Baseline: 55%, MYRBS, 2005.

Objective 5: Increase condom use at last intercourse to 63% among sexually active 9 - 12th graders by 2010.

Baseline: 59%, MYRBS, 2005.

Strategies

1. Implement Comprehensive School Health Education and a Coordinated School Health Program that includes an age appropriate comprehensive sex education curriculum.
2. Provide sexuality counseling and education.
3. Provide condoms and full family planning services through high school health center grantees.
4. Conduct public education to promote condom use as a social/community norm.
5. Seek funding to support and expand efforts.

ENVIRONMENTAL HEALTH

About 20 chemicals found in the environment, including arsenic, asbestos, benzene, cadmium, chromium, radon, and vinyl chloride, have been identified as known human carcinogens by national and international agencies. Many additional chemicals have been identified as being potential human carcinogens. The cancer burden posed by specific environmental carcinogens (aside from occupational exposure) has not been well defined. Despite the fact that the contribution of environmental carcinogens to the cancer burden is not as well understood as some of the other major causes of cancer, such as tobacco use, preventive measures should be initiated. Such measures are largely based on what is known at the present and include the reduction of exposure to hazardous chemicals in the workplace and the reduction of environmental pollution.

CERVICAL CANCER

Cervical cancer screening is important to detect significant abnormal cell changes that may arise before cancer develops. Since the introduction of the Papanicolaou (Pap) test, cervical cancer incidence and mortality rates have significantly declined in the United States and in Maine (Figures 22 & 23). Less than fifty women in Maine were diagnosed with cervical cancer in 2005. While the number of women affected by cervical cancer is relatively small compared to other cancers, it is one of the most preventable and treatable cancers.[60]

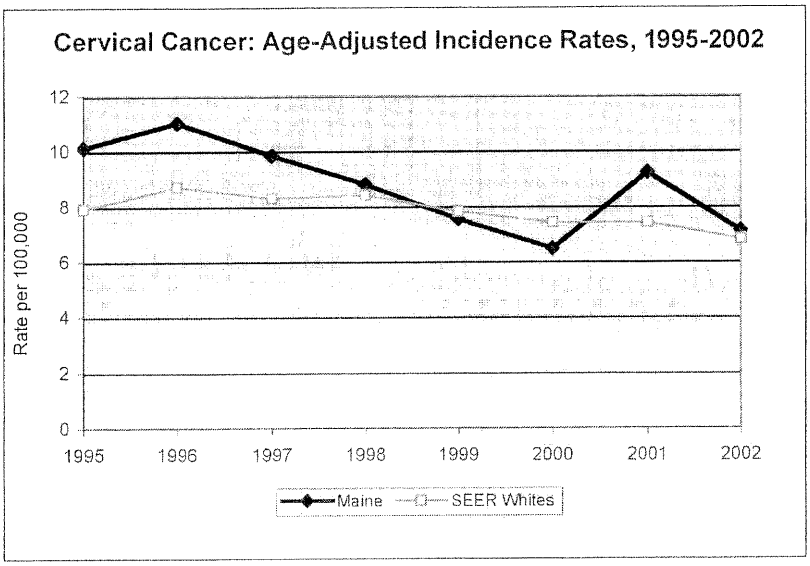

Figure 22: Age-Adjusted Cervical Cancer Incidence Rates, 1995-2002
Source: Surveillance, Epidemiology and End Results Program and the Maine Cancer Registry Program.

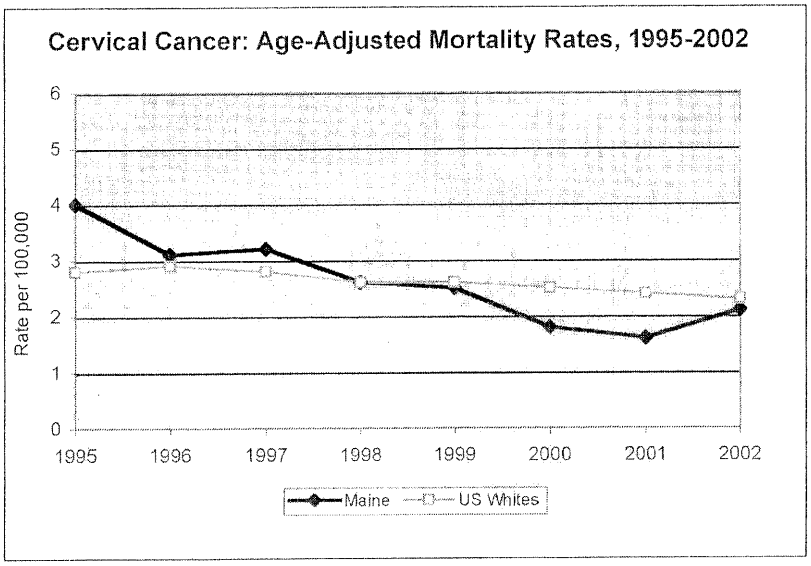

Figure 23: Age-Adjusted Cervical Cancer Mortality Rates, 1995-2002
Source: National Center for Health Statistics

The primary risk factor for cervical cancer is certain types of human papillomavirus (HPV). Other risk factors include smoking, poor nutrition, and immunosuppression.[61] Southeast Asian women have the highest invasive cervical cancer incidence rates. For example, cervical cancer incidence rates are five times higher among Vietnamese American women than white women.[62]

Additionally, after the age of 25, the incidence and mortality of invasive cancer in African American women increases rapidly with age, while in white women, it rises more slowly.

Studies have shown repeatedly that early detection is effective in reducing the number of women dying of cervical cancer. With routine screening, women significantly improve their odds of finding cervical cancer at its earliest and most treatable stages. Several national organizations have developed screening guidelines (Appendix D).

In 2004, almost 89% of Maine women had a Pap test within three years. This is one of the highest screening rates for cervical cancer in United States. This is due in part to the successful implementation of the Maine Breast and Cervical Health Program, which offers free mammography and Pap tests to income eligible women ages 40 and over. Advocacy and education efforts have also played an important role. Additionally, all Maine insurers are required to pay for cervical cancer screening, which helps to reduce the financial barrier to getting screened.

Goal: To reduce by 30% the rate of cervical cancer deaths by 2010.

Baseline: 2.1 per 100,000 deaths, Maine Cancer Registry, 2002.

Objective 1: Increase the proportion of Maine women with a uterine cervix who have ever received a Pap test to 98% by 2010.

Baseline: 96% of women aged 18 and older with a uterine cervix have ever received a Pap test, BRFSS, 2004.

Strategies

1. Provide advocacy for ongoing implementation of Maine Breast and Cervical Health Program.
2. Provide advocacy for ongoing funding of Title X (Family Planning) activities.
3. Provide continuing education programs about cervical cancer screening inclusive of HPV and vaccine education to health care professionals.
4. Collaborate with organizations that represent women with a higher prevalence of cervical cancer to develop and disseminate culturally and linguistically appropriate messages.

Objective 2: Increase the proportion of Maine women with a uterine cervix that received a Pap test within the preceding 1 to 3 years to 92% by 2010.

Baseline: 89% of women aged 18 and older with a uterine cervix have received a Pap test within the previous 3 years, BRFSS, 2004.

Strategies

1. Provide advocacy for ongoing implementation of Maine Breast and Cervical Health Program
2. Provide advocacy for ongoing funding of Title X (Family Planning) activities.
3. Provide continuing education programs about cervical cancer screening inclusive of HPV and vaccine education to health care professionals.
4. Collaborate with organizations that represent women with a higher prevalence of cervical cancer to develop and disseminate culturally and linguistically appropriate messages.

Objective 3: Maintain the proportion of patients diagnosed with invasive cervical cancer who receive or have access to appropriate treatment (within 60 days to treatment starting) by 2010.

Baseline: 100% Maine Breast and Cervical Health Program/April 2005 MDE Submission Data Quality.

Strategies

1. Develop a relationship with cancer treating hospitals to explore the collection of data on timely results.

Objective 4: Reduce the number of women who are diagnosed with regional or distant stage cervical cancer by 2010.

Baseline: 30% Regional and 6% Distant, Maine Cancer Registry, DHHS, 1995-2002.

Strategies

1. Conduct case studies of current cancer deaths.
2. Develop interventions based on the analysis of case studies.