

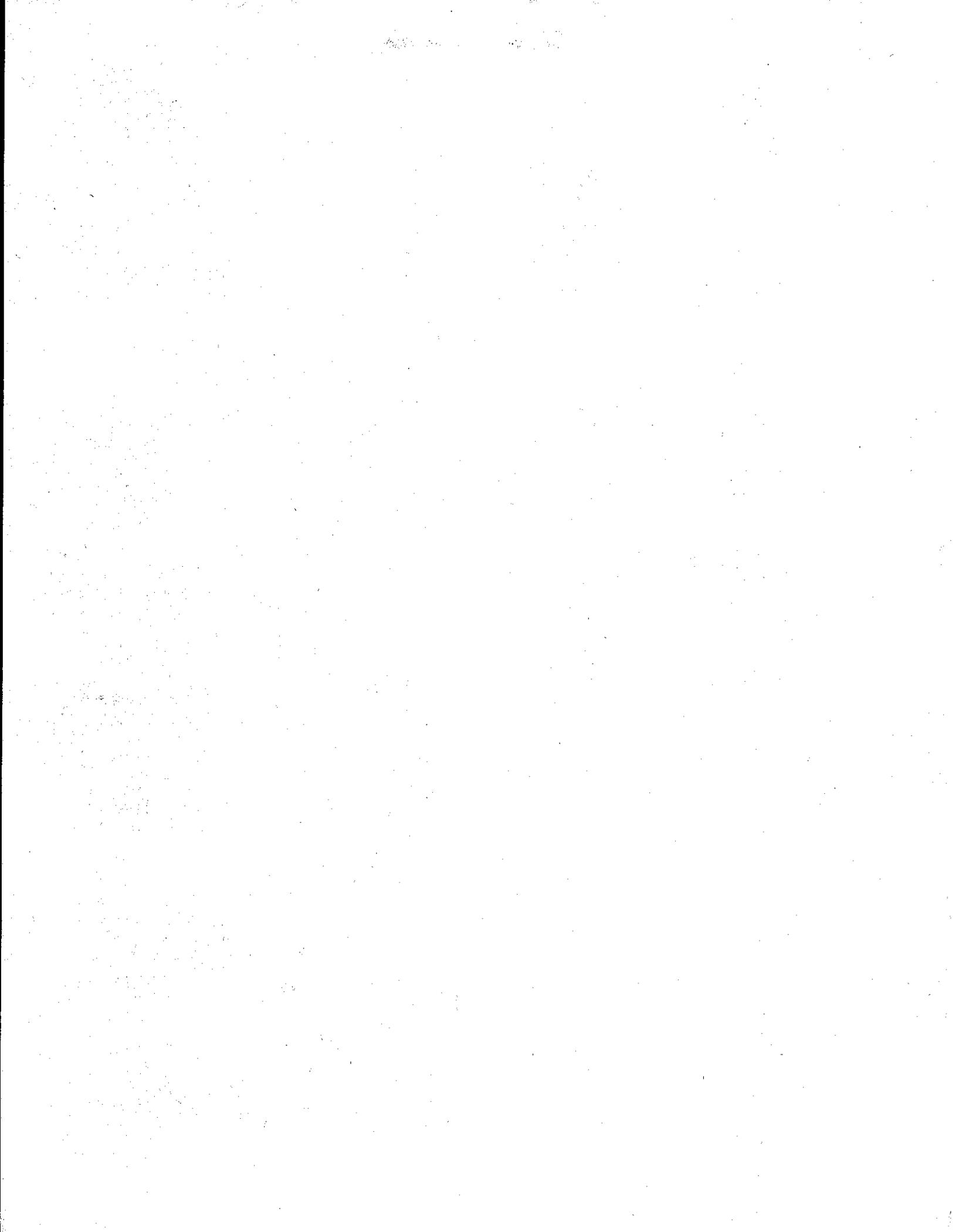
Chairman Becker and members of the House Human Services committee:

Thank you for the opportunity to address this committee on SB 328. As a surgeon who has confronted cancer in the operating room, I oppose this legislation. It will NOT significantly change the impact of cancer on Montanans. As an individual working hard to reduce the burden of cancer in Montana through a comprehensive collaborative approach, I ask that you oppose this legislation that will weaken the comprehensive efforts. I appreciate your concern and support on cancer related issues and policy. Cancer is a disease that crosses all boundaries. However this legislation is not needed to improve the cervical cancer burden in Montana and would be an unproductive use of resources.

I am Dr. Barbara Lloyd, a general surgeon who represented Montana for 6 years to the American College of Surgeons' Commission on Cancer. I would like to share some information with you. There is a nationwide collaborative effort to improve cancer related morbidity, mortality and quality of life. (See attachments 1 & 2 that describe the National and Montana comprehensive cancer control programs.) The Commission on Cancer, the American Cancer Society, the CDC and numerous other organizations support the comprehensive cancer control program. In Montana many experts, individuals and organizations have collaborated and worked hard to develop a Comprehensive Cancer Control plan for our state. For more progress to be made against the onslaught of cancer, the 'disease of the month' categorical mindset must change to a comprehensive approach. Starting with cervical cancer and working up the ranking list each session, it would take 40 years before we focus on the most common cancer. This legislation is counterproductive to cancer control and is not an efficient use of funds.

SB 328 would provide for a task force to study and report on cervical cancer. There is no medical reason for a cervical cancer task force and special study is not needed. Here is your report. The prevalence, care, causes and nature of cervical cancer are not a mystery. In 2002 there were 36 cases of invasive cervical cancer in Montana, this is less than 1% of the total 5191 cancer cases and is comparable to the United States rates. While cervical cancer worldwide is second only to breast cancer, in Montana it is ranked 20th. (See attachment 3 for the ranking of 2002 cancer cases, attachment 4 for a graph on MT cancer incidence & 5 for a graph of cervical cancer's decreasing incidence over 20 years for Montana and the US.) Mortality from cervical cancer is also decreasing yearly; it is down to 9 out of 1901 cancer deaths in 2002. That is 2.3 per 100,000 in Montana compared to 2.9 per 100,000 in the United States; it was 4.5 per 100,00 in 1977. In contrast, mortality from lung cancer in Montana is 54.1 per 100,000 and rising. (See attachment 6 for the graph of decreasing cervical cancer mortality & attachment 7 for mortality in MT from the most common cancers compared to cervical cancer.)

The risk factors for cervical cancer include smoking, early first sexual experience, multiple sex partners, and genital warts also known as Human Papillomavirus infection. The medical provider community is aware of these factors but continuing education focusing on all cancer risks is helpful. The public is aware of the screening available for cervical cancer. The PAP test is probably the best-known screening test that we have. It is low cost and well utilized. More than 84% of Montana women over 18 have had a PAP test in the last 3 years. There is no public health need for a task force on cervical cancer. Programs are ongoing to continue increasing the screening rates. Strategies to improve screening for cervical and other cancers are included in the forthcoming cancer control plan. In contrast, only 47% of Montanans 50 or older reported ever having had a sigmoidoscopy or colonoscopy for colon cancer screening. Public and medical provider education programs should include prevention and early detection for all cancers.



Diagnosis and treatment of pre-cancer of the cervix are successful, cost effective and readily available. Prognosis for cervical cancer is quite good. The uninsured have access through the MT Breast and Cervical Health program, Community Health Centers and Title X clinics. Coverage and awareness issues exist for all cancers and are not unique to cervical cancer.

Companies manufacturing new technologies are well able to market their products without the need of a task force to pave the way. There are new tests and a new vaccine for genital warts. Warts are common in sexual active people with multiple partners throughout their life. Nationally the sexually transmitted disease section of the CDC may support of this type of legislation, as cervical cancer is associated with some subtypes of HPV infection. However, the cancer control section of the CDC is promoting the comprehensive approach. At this time the US Preventive Services Task Force concludes that there is insufficient evidence for routinely testing for HPV. (See attachment 8 for evidence-based recommendations on cervical cancer) The vaccine is not yet FDA approved and is not ready for public health programs. Such research and advances will contribute to the long-term control of sexually transmitted diseases and cervical cancer. Researchers are our partners in cancer control. When evidence shows that an emerging technology has become state-of-the-art then strategies will be considered for the comprehensive cancer control plan in areas of determined need. Language addressing emerging technologies is included in the draft plan. The Montana Cancer Control Coalition has a process for prioritizing issues and strategies. This legislation will preempt that process and seriously disrupt the evidence-based cooperative collaborative approach that is needed for a successful comprehensive plan. Please don't undermine our hard work.

While facilitation, coordination and communication are always a laudable ideal; it is not clear how adding a third party, such as a task force, would accomplish improvement. It will confuse communication about cancer control if it is presented one disease site at a time. The comprehensive approach is more effective.

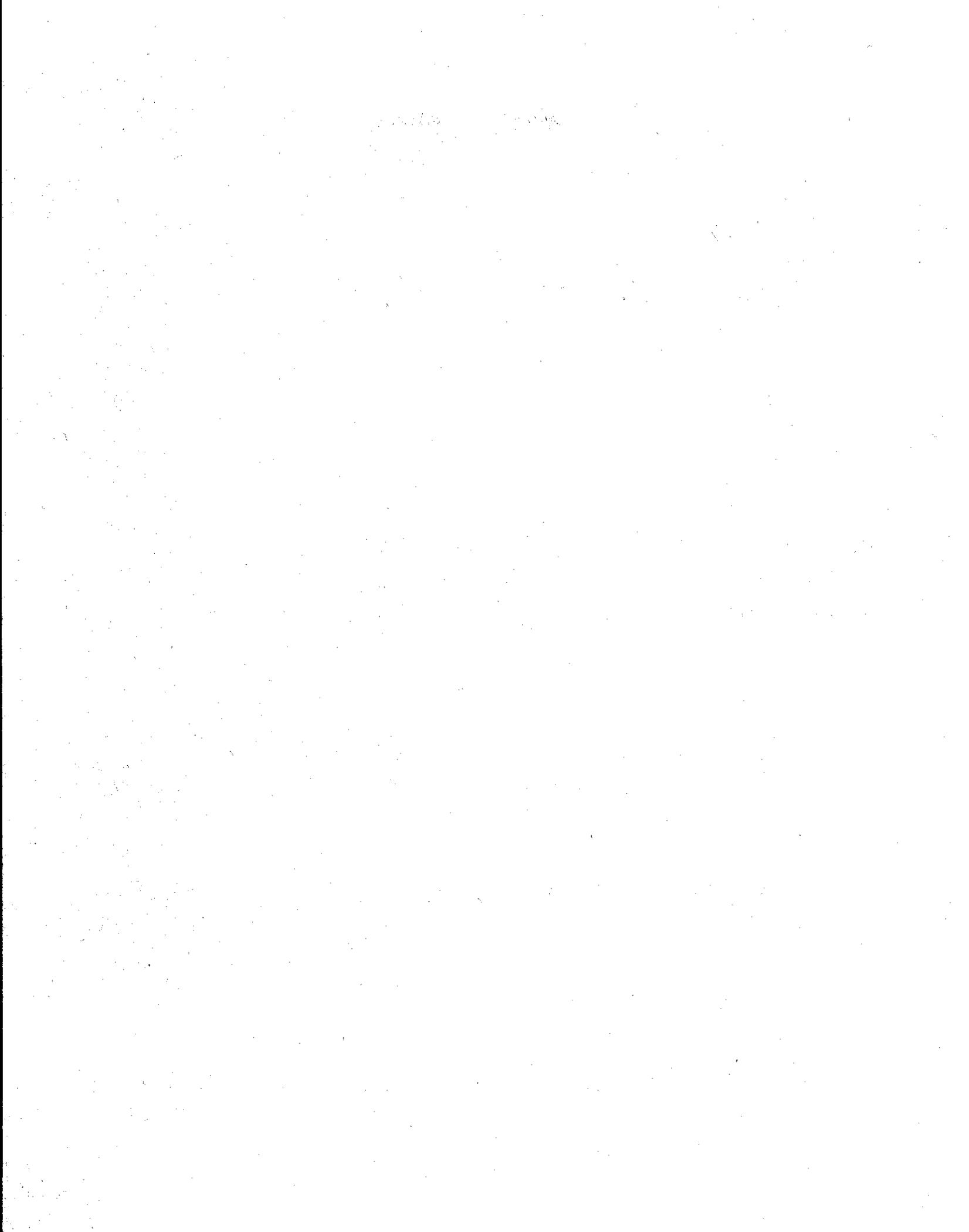
Increased screening and early diagnosis are part of ongoing public health programs. To reduce the burden and costs of cancer in Montana, the cancers that contribute the majority of incident cases need to be addressed. This includes lung, breast, prostate and colorectal. Focusing on a site that has less than 1% of our cancers will have minimal to NO effect on the cost and burden of cancer in Montana. It will neglect the majority of Montanan's affected by cancer. A more efficient approach is to comprehensively study all cancers in Montana including assessing barriers, gaps and disparities. Adequate funding is not presently available for a complete study of cancer burden in Montana. The funds spent for this unnecessary task force would be wasted. Funding is limited.

In summary, this legislation will not change the impact of cervical cancer on Montanans, it is a misuse of limited cancer control resources, it is not needed, and it is damaging to the ongoing comprehensive cancer control process. I ask you to please vote against SB328, defeat this legislation.

To decrease the burden of cancer for your constituents there are three important steps you can take:

- 1) Do NOT pass this single cancer site legislation
- 2) Join the cooperative comprehensive effort to improve Montana's cancer morbidity, mortality and quality of life by becoming a member of the Montana Cancer Control Coalition.
- 3) In 2007, consider legislation that will add state funding to the basic CDC funds to support implementation of Montana's Comprehensive Cancer Control plan.

Thank you.



National Comprehensive Cancer Control Program



CDC's mission is to develop and to provide an integrated and coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation.

CDC is a leader in nationwide cancer prevention and control, working with national organizations, state health agencies and other key groups to develop, implement, and promote effective cancer prevention and control practices.

Why Comprehensive Cancer Control?

The significant growth of cancer prevention and control programs within health agencies has resulted in recognizing that improved coordination of cancer control activities is essential to maximize resources and achieve desired cancer control outcomes. Comprehensive cancer control (CCC) results in many benefits including increased efficiency for delivering public health messages and services to the public.

"To be efficient and effective, we must work with our partners to change the categorical cancer mindset into one comprehensive strategy. It is important that we use all we know in one concerted effort to improve cancer prevention and control for all those in need."

James S. Marks, MD, MPH, Director
National Center for Chronic Disease Prevention and Health Promotion

Action Opportunities for Comprehensive Cancer Control

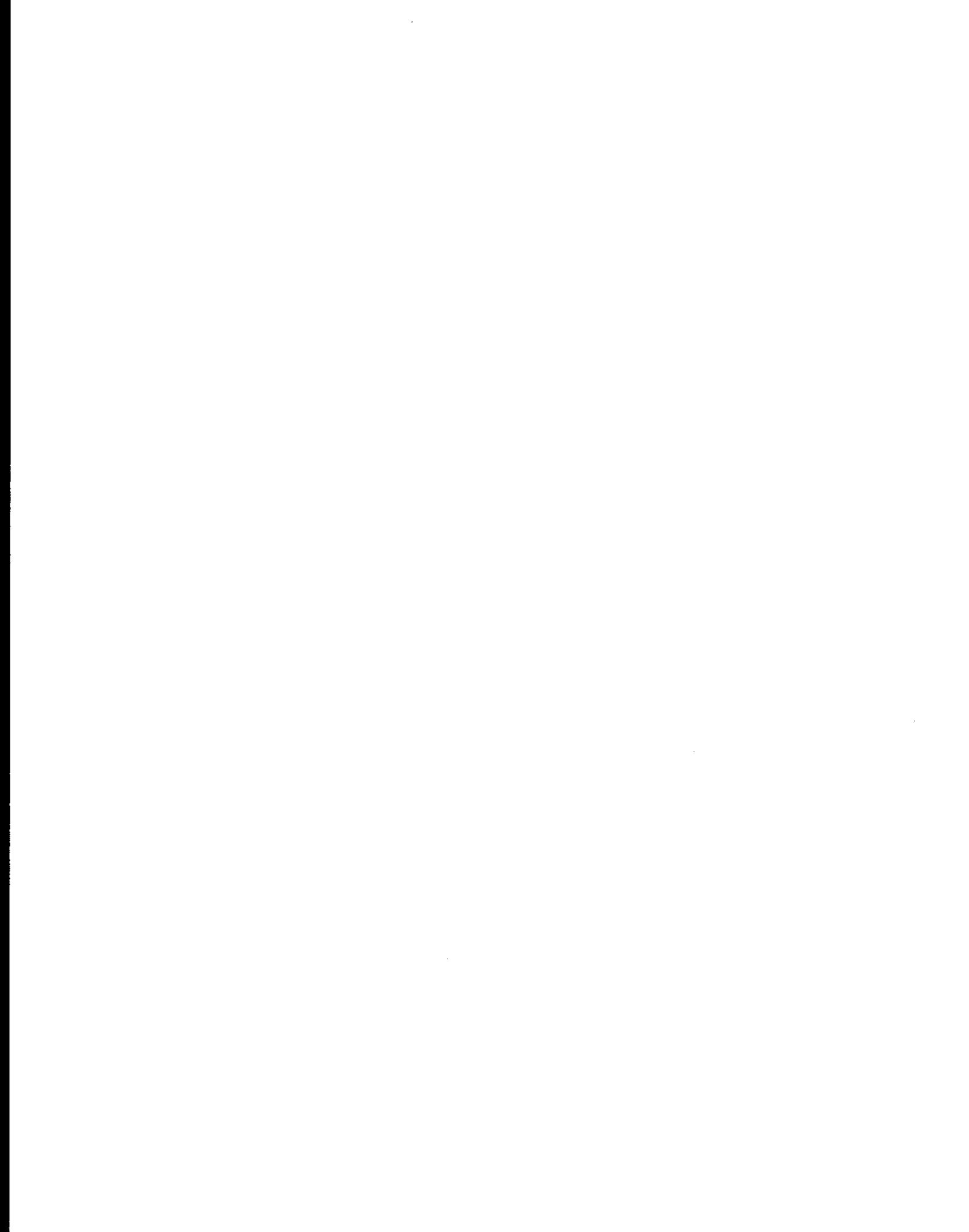
CDC's National Comprehensive Cancer Control Program (NCCCP) is a national resource for supporting CCC efforts. Since 1998, the number of programs participating in CDC's NCCCP has grown from 6 to 61. With this support, state and tribal health agencies continue to establish broad-based CCC coalitions, assess the burden of cancer, determine priorities for cancer prevention and control, and develop and implement CCC plans.

Cancer plans are the stepping-stones for advancing CCC programs—to put the program into action. Each state or tribal health agency develops an individual cancer plan to address its unique cancer burden. As states or tribal health agencies implement cancer plans, they integrate expertise and efforts from many disciplines: basic and applied research, evaluation, health education, program development, public policy, surveillance, clinical services, and health communications.

Cancer Burden

- One of every four U.S. deaths is due to cancer
- Over 19 million new cases diagnosed since 1990
- Over 1.3 million new cases will be diagnosed in 2005

Cancer Facts & Figures 2005, American Cancer Society, 2005



Rationale for Comprehensive Cancer Control

Cumulative Public Health Benefit

During the last decade there has been tremendous growth in the scope and number of programs designed to reduce the burden of cancer, these programs generally address a particular cancer site (breast, prostate, etc.) or reducing specific risk factors (e.g., tobacco use).

The experience and knowledge gained from these categorical programs provide a solid basis for a more comprehensive approach to cancer prevention and control.

Partnership Benefit

Many stakeholders involved in cancer prevention and control activities have recognized that coordination among categorical programs is uncommon. This may lead to duplicating efforts and missed opportunities.

Both individuals and organizations working on specific cancer prevention and control efforts support coordination and integration to enhance existing programs. They are committed to helping define strategies to promote programs and services that are available across the full spectrum of cancer prevention and control (prevention, early detection, diagnosis and treatment, palliation, survivorship, and end of life).

Collective Empowerment

No single organization or agency has the capacity to address all the cancer control needs within a state.

Individual leaders are willing to join together to focus time, resources, and staff on a comprehensive cancer control approach. They can make decisions and take actions that affect cancer control across the whole community.

Gap Reduction

While many accomplishments have been made in cancer prevention and control, disparities among racial and ethnic minority and medically underserved populations still exist.

A comprehensive approach to cancer prevention and control requires leaders to create a holistic vision that addresses the gaps in cancer control within their state.



Montana's Comprehensive Cancer Control Planning Process

- There is a strong national initiative to include Cancer Control in public health activities. The national "Dialogue on Cancer" began several years ago and ultimately led to CDC funding a formal programmatic approach to Comprehensive Cancer Control nationwide. Each state is tasked with developing and implementing a Comprehensive Cancer Control plan.
- Comprehensive Cancer Control is broadly defined as "a coordinated approach to reduce the incidence, morbidity, and mortality of cancer through prevention, early detection, treatment, rehabilitation, and palliation."
 - This approach integrates multiple disciplines including administration, research, clinical services, evaluation, health education, program development, grassroots services, data analysis, public policy, surveillance, and health communications in a coordinated cooperative effort.
 - Because of the broad definition, it is important to include a broad spectrum of organizations and partners to share a global perspective of the cancer burden, needs, and issues in Montana.
- The Montana Cancer Control Coalition (MT CCC) is a group that represents all Montanans. The Coalition is developing the comprehensive cancer control plan for Montana. Your organization has an important stake in Montana's planning efforts for cancer control. The MT CCC is continuing the process of recruiting to the Coalition. We would like to invite you or a representative from your organization to participate in this effort.
- Reorganization of the Chronic Disease Prevention and Health Promotion Bureau in the Montana Department of Public Health and Human Services created the Cancer Control Section bringing together programs that are related to cancer control. The new section includes:
 - The Montana Central Tumor Registry,
 - The Montana Breast and Cervical Health Program
 - The Comprehensive Cancer Control Program, a newly funded program July 2004.
- The next statewide MT CCC meeting will be held in Helena late May 2005. Our goal is to have a draft plan written by July 2005. There will be biannual statewide meetings until the plan is completed and implemented. There are frequent small workgroup meetings to provide input on the details for the priority goals, objectives, and strategies and evaluation of Montana's Comprehensive Cancer Control plan. At this time priority issues are being established and the Goals, Objectives, Strategies and Evaluation plan formulated for the draft Comprehensive Cancer Control plan for Montana.
- If you are able to participate or you can appoint a representative from your community/organization, please contact Sue Miller at 444-3624. She will send you meeting information and help get your community involved in the planning process. (Travel will be reimbursed).

Montana Comprehensive Cancer Control Plan

Vision:

A statewide comprehensive approach to reduce the burden of cancer in Montana; evidence-based and motivated by compassion, an investment in the future.

Mission:

- Reduce cancer incidence, morbidity, and mortality in Montana through a collaborative partnership of private and public individuals and organizations.
- Develop, implement, promote and advocate a statewide coordinated integrated approach to control cancer for all Montanans that ensures quality of life through research, prevention, early detection, treatment, rehabilitation, and palliation.

Purpose of the Montana Comprehensive Cancer Control Plan:

The plan is intended to serve as a guide for conducting a Comprehensive Cancer Control Program for Montana. This plan supports an evolving and participatory approach that allows flexibility and creativity for responding to emerging needs or particular circumstances. It has been designed to engage all individuals and groups touched by cancer, to encourage statewide community participation, and to promote collaboration for comprehensive cancer control for all Montanans.

Values:

- Evidence-based
- Data-driven and best practice
- Culturally sensitive
- Outcome oriented
- Comprehensive
- Respectful of individual's rights and dignity
- Respectful of individual's privacy and safety
- Evolutionary and responsive
- Disparity responsive
- Cost sensitive

Overall Montana Comprehensive Cancer Control Plan GOALS:

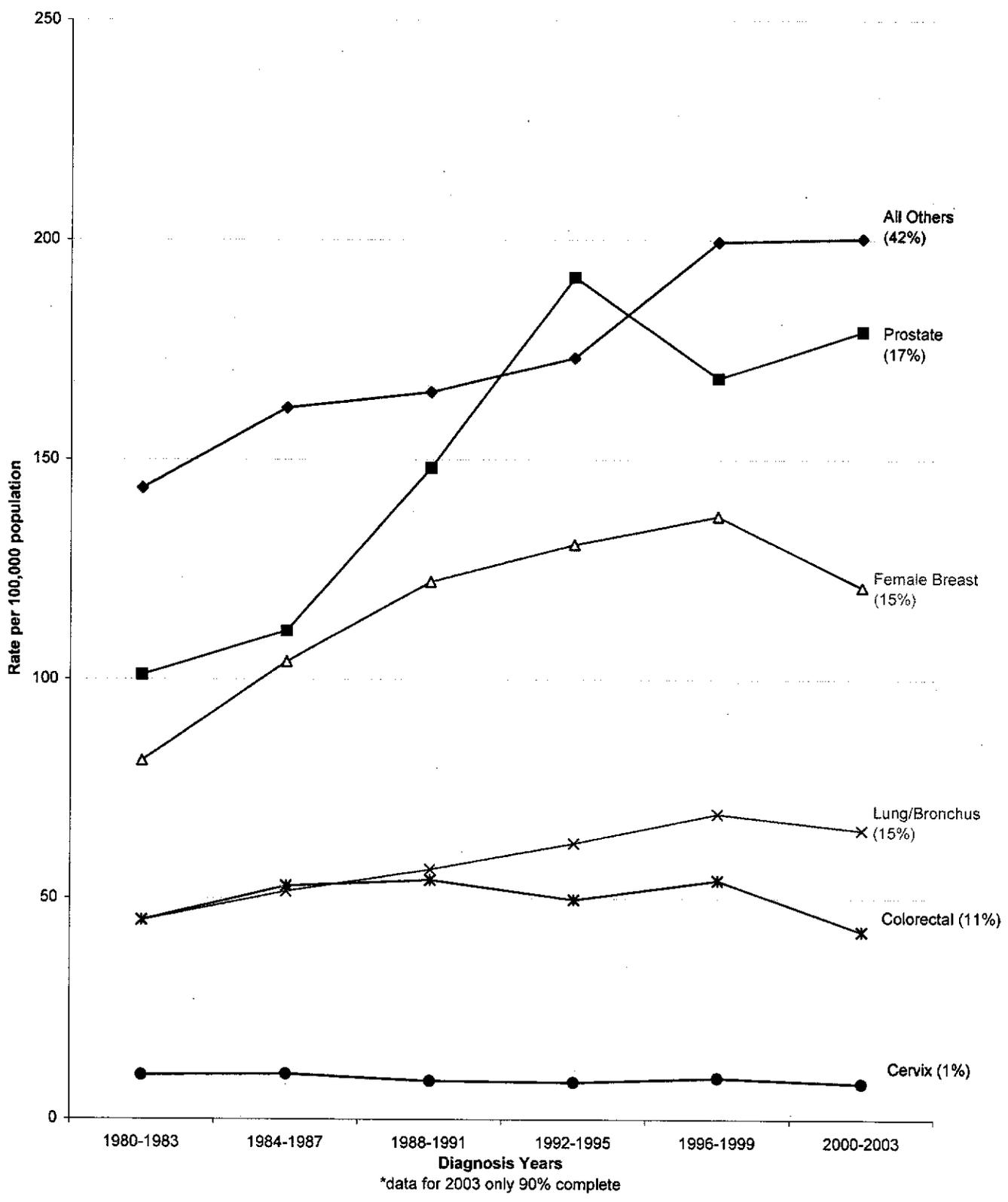
1. Actively work to prevent cancer by reducing the risk of developing cancer.
2. When cancer occurs, detect it at the earliest stage possible.
3. When cancer is found, promote access to quality comprehensive cancer care.
4. Optimize the quality of life along the health-related continuum of care for those affected by cancer and their support networks.
5. Monitor, disseminate, and utilize data while improving consistency, coordination, and completeness of cancer data reporting and surveillance.
6. Support research to best improve cancer control for Montana.
7. Develop and support policies and initiatives that enable cancer control in Montana.
8. Fully inform the public about cancer control information.

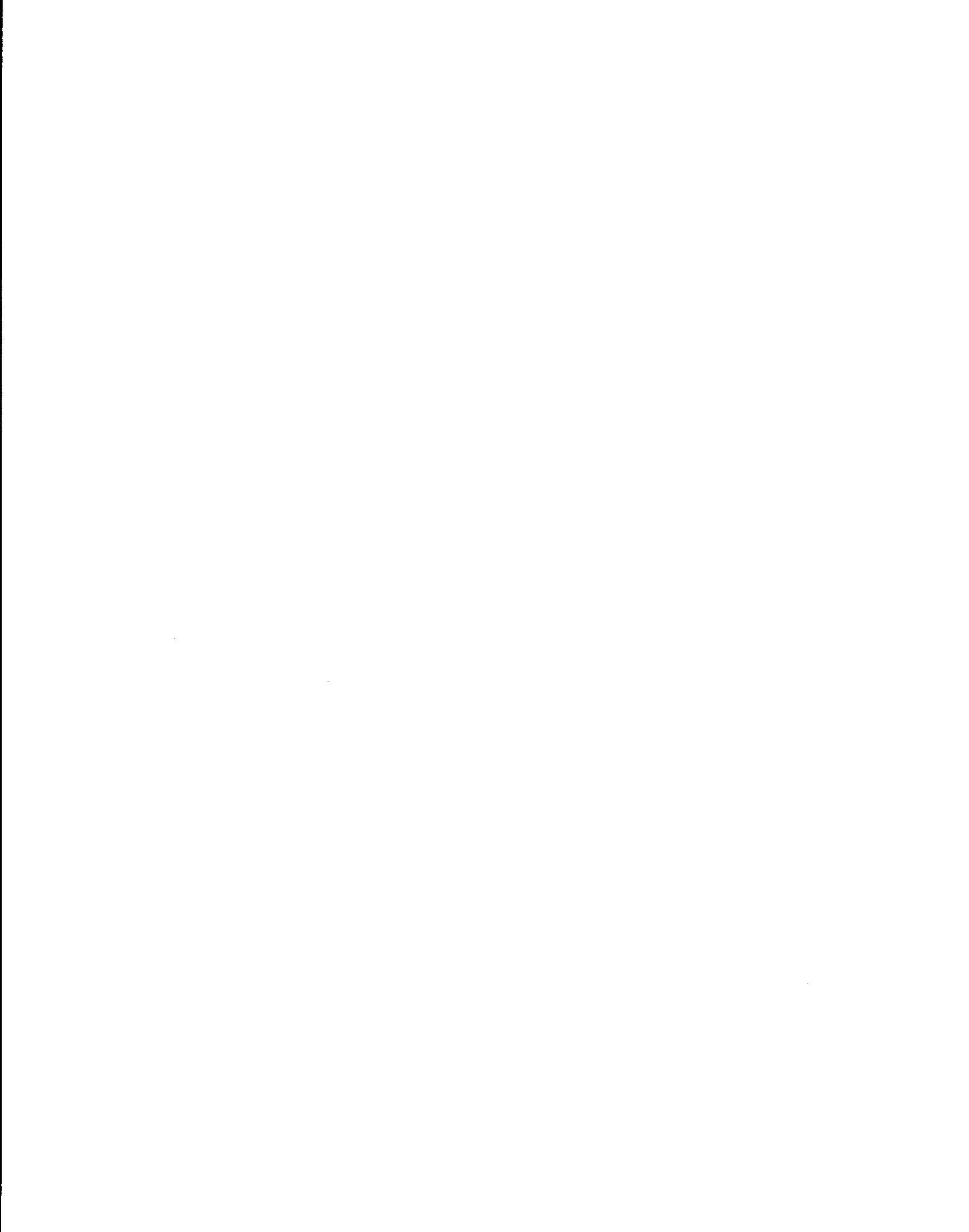
Montana Cancer
Number of Cases
Ranked 2002

Cancer site	Mortality	Incidence
TOTAL (all cancers)	1901	5191
Lung and bronchus	527	631
Colorectal	184	501
All Lymphomas	171	140
Breast	152	762
Prostate	110	932
Pancreas	89	79
Leukemia	69	123
Ovary	64	80
Kidney	51	122
Esophagus	50	37
Central Nervous System	46	87
Liver & Bile ducts	42	54
Stomach	42	86
Bladder	39	243
Skin (melanoma & other)	34	240
Uterine	31	121
Soft tissue	23	17
Oral	17	71
Thyroid	9	104
Cervix uteri	9	36

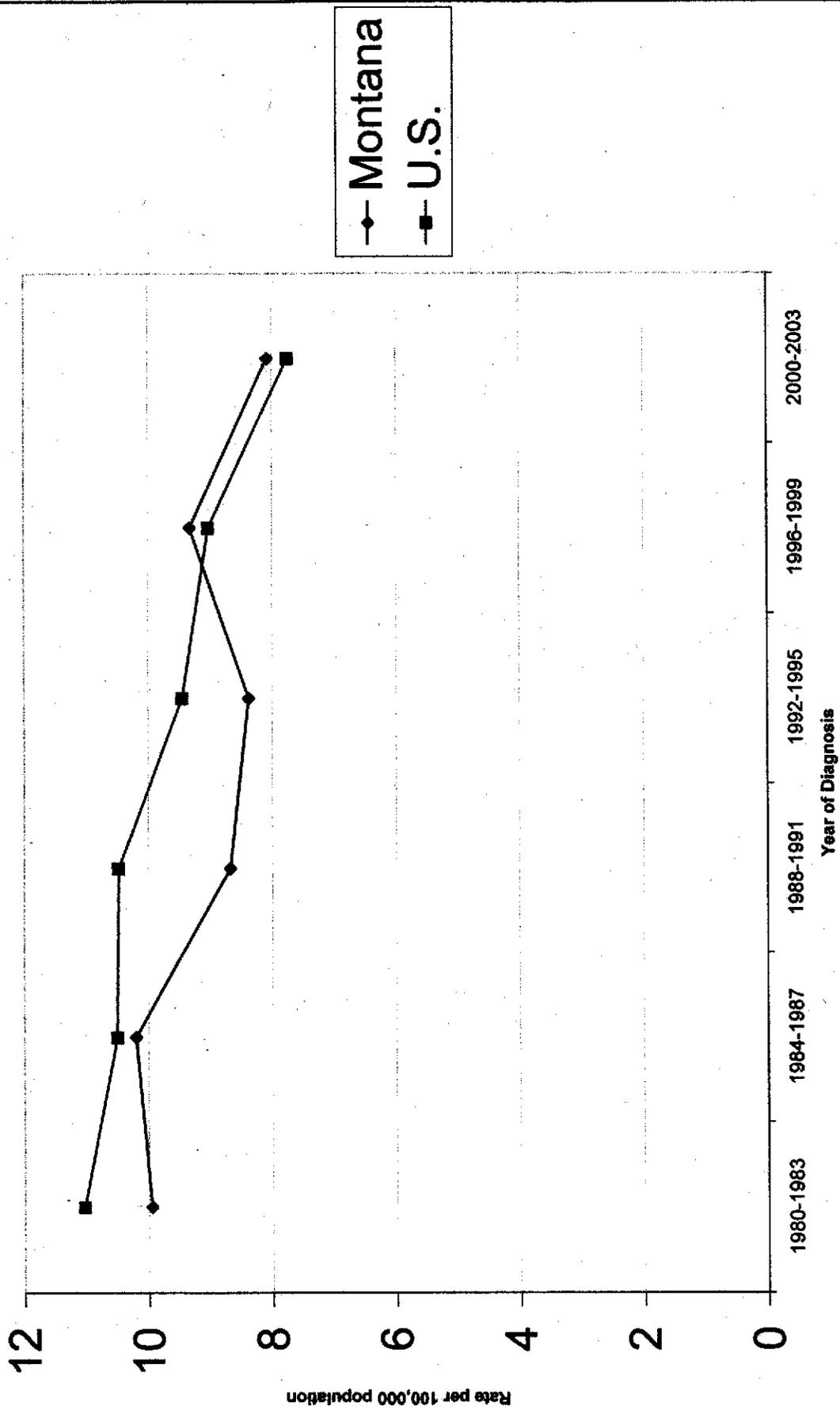


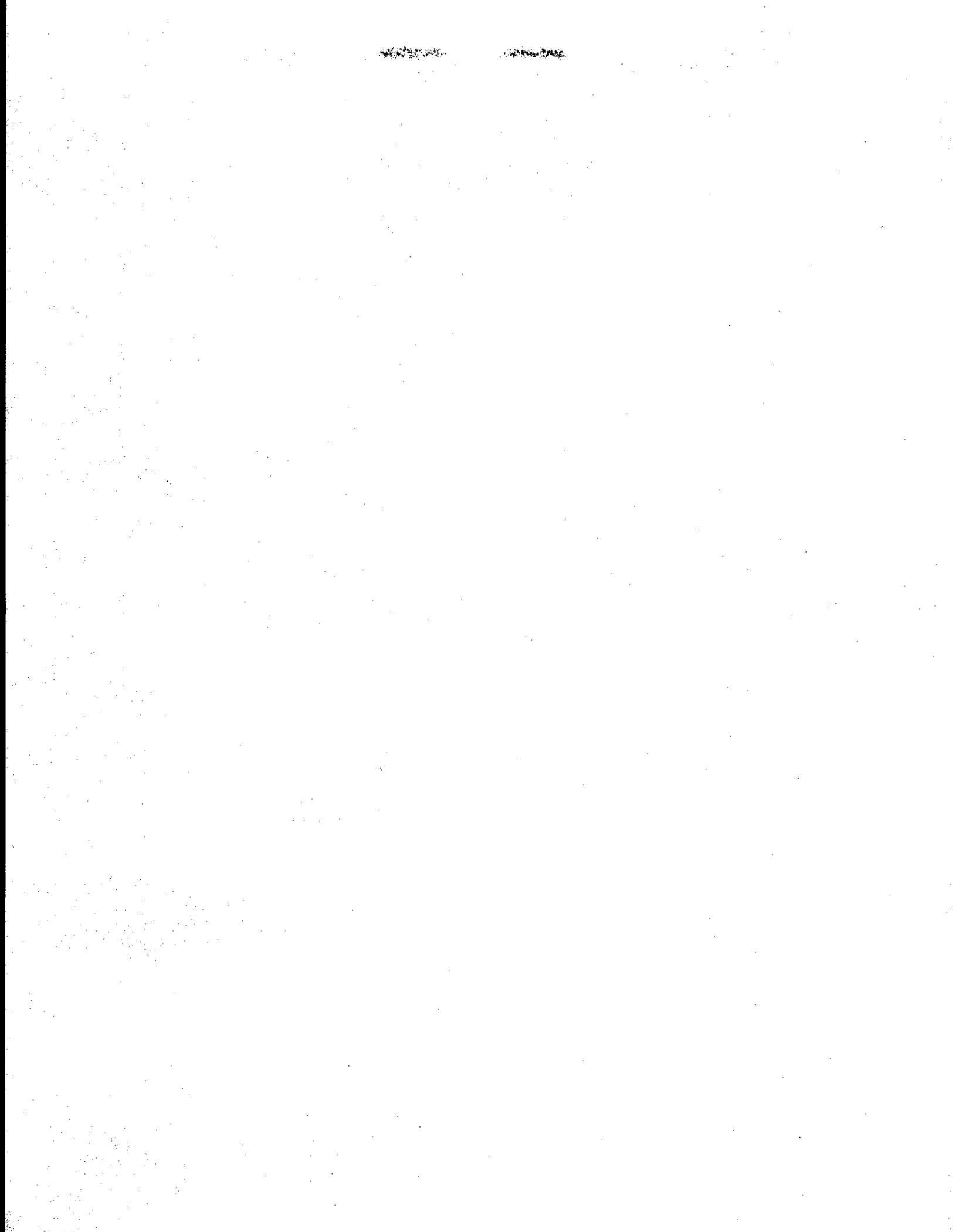
Cancer Incidence in Montana, 1980-2003





Cervical Cancer Incidence Rate, 1980-2003



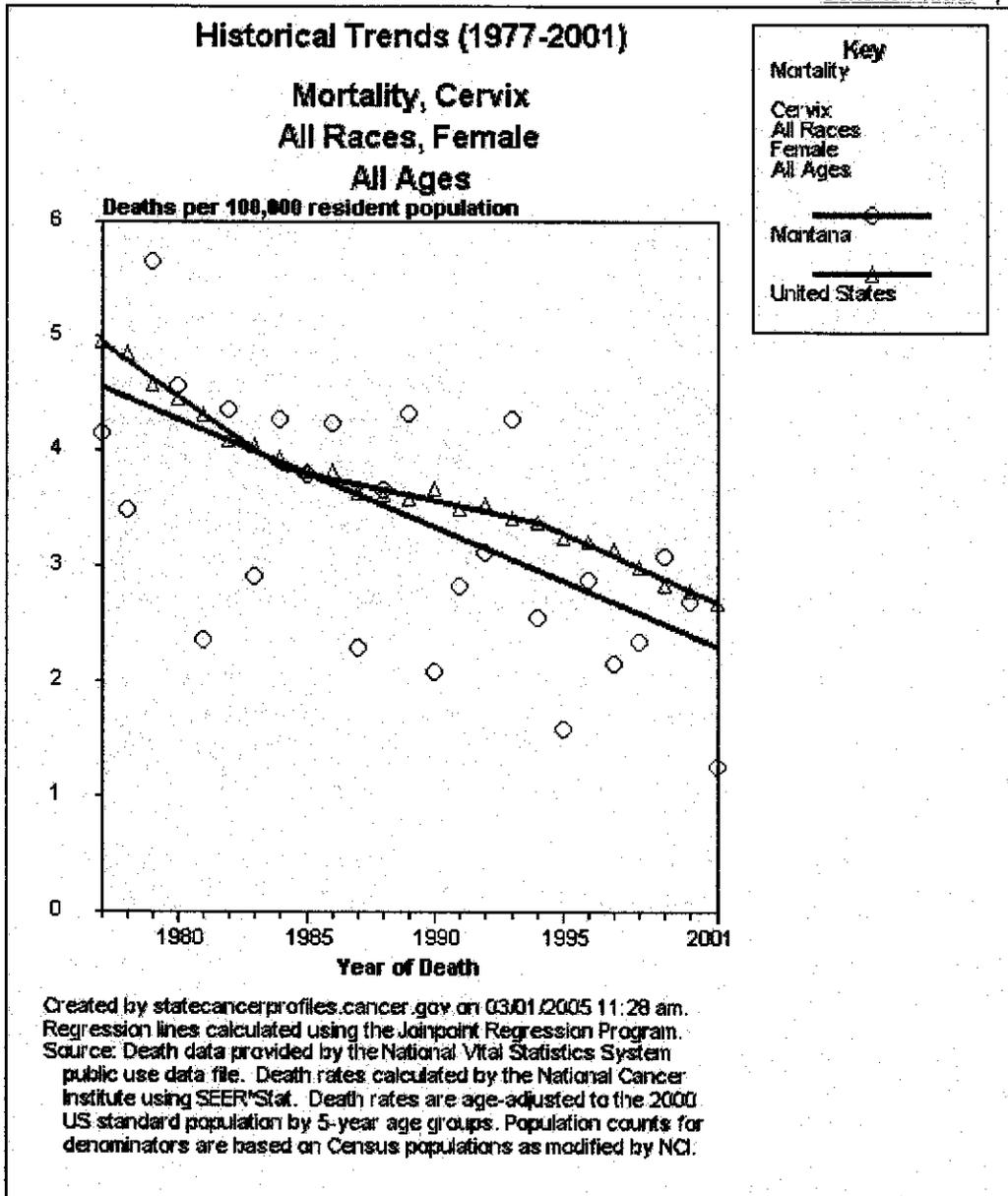




State Cancer Profiles

Historical Trends

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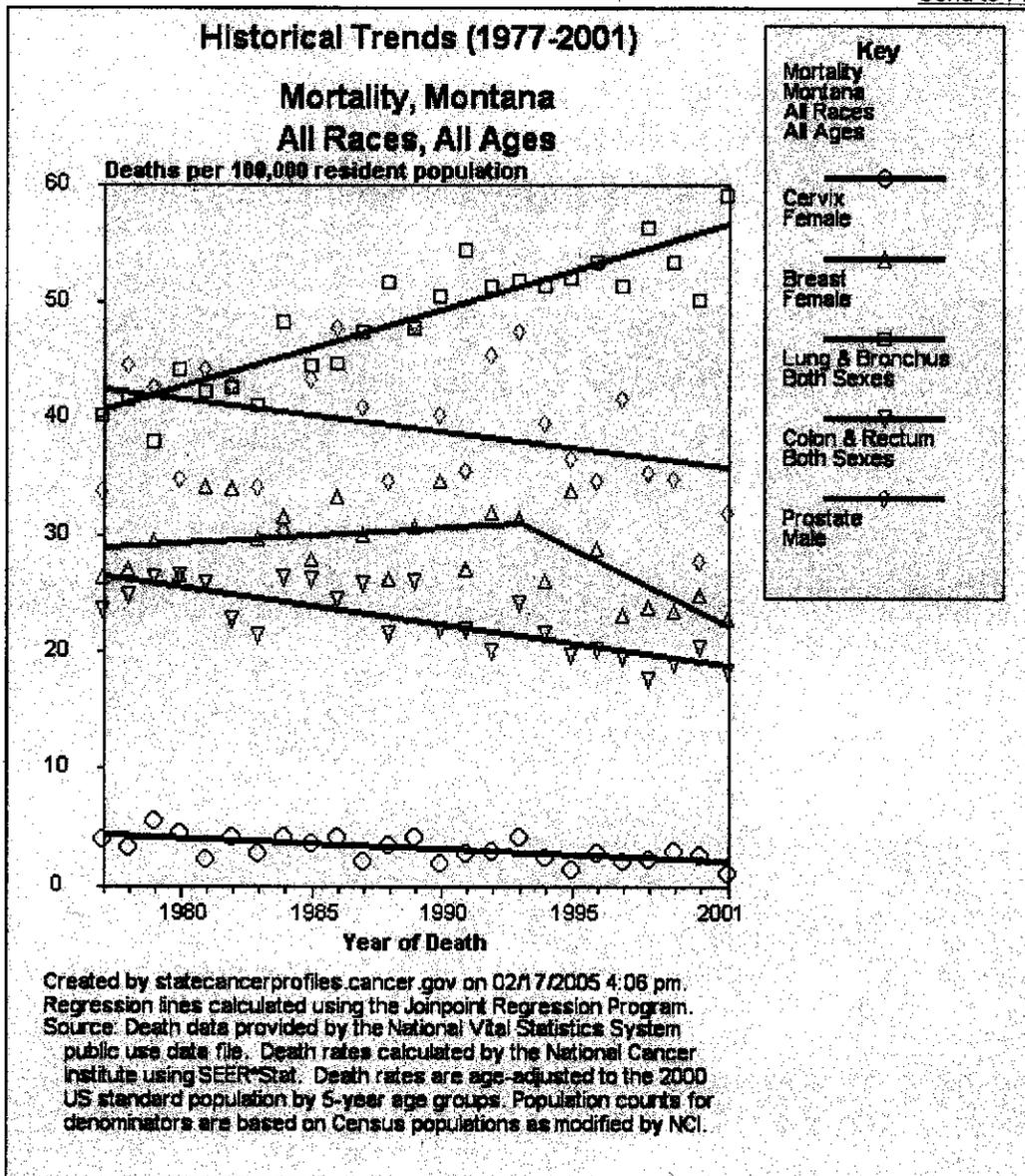


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State Cancer Profiles

Historical Trends

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WHAT'S NEW

From the U.S. Preventive Services Task Force
An Overview of Recommendations

AHRQ Publication No. APIP03-0004

January 2003

Screening for Cervical Cancer

What Screening Is Recommended by the USPSTF?

- The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening women for cervical cancer if they are sexually active and have a cervix.
- The USPSTF recommends against routinely screening women older than age 65 if they have had adequate recent screening with normal Pap smears and are not otherwise at increased risk for cervical cancer.
- The USPSTF recommends against routine Pap screening for women who have had a total hysterectomy for benign disease.
- The USPSTF concludes that the evidence is insufficient to

recommend for or against new technologies (such as ThinPrep®) in place of conventional Pap tests.

- The USPSTF concludes that the evidence is insufficient to recommend for or against *human papillomavirus* (HPV) testing as a primary screening test for cervical cancer.

The Task Force concludes that screening should begin within 3 years of the start of sexual activity or age 21, whichever comes first, and should be done at least every 3 years. The risk for cervical cancer and the yield of screening decline through middle age. For women older than 65 who have had normal Pap smears, the benefits of continued screening may not outweigh the potential harms, such as false-positive test results and invasive procedures. The Task Force also concludes that the yield of detecting vaginal neoplasms is

too low to justify continuing screening after a total hysterectomy.

Most cases of cervical cancer occur in women who are not screened adequately.

Most cases of cervical cancer occur in women who are not screened adequately. Clinicians, hospitals, and health plans should develop systems to identify and screen women, including older women, who have had no screening or who have been screened inadequately in the past.

Why Aren't Annual Pap Tests or Newer Technologies Recommended?

The USPSTF found no direct evidence that annual screening is more effective

What's New from the U.S. Preventive Services Task Force is a series of fact sheets based on recommendations of the U.S. Preventive Services Task Force (USPSTF). The USPSTF systematically reviews the evidence of effectiveness of a wide range of clinical preventive services—including screening, counseling, and chemoprevention (the use of medication to prevent disease)—to develop recommendations for preventive care in the primary care setting. **This fact sheet presents highlights of USPSTF recommendations on this topic and should not be used to make treatment or policy decisions.**

More detailed information on this subject is available in several Systematic Evidence Reviews, a Summary of the Evidence, and the USPSTF Recommendations and Rationale, which can be found on the Agency for Healthcare Research and Quality's (AHRQ) Web site (<http://www.preventiveservices.ahrq.gov>) and through the National Guideline Clearinghouse (<http://www.guideline.gov>). The Summary of the Evidence and the USPSTF Recommendations and Rationale are available in print through the AHRQ Clearinghouse (1-800-358-9295, or ahrqpubs@ahrq.gov).

www.ahrq.gov



than less frequent screening in preventing cases of cervical cancer or death from cervical cancer. Cervical cancer usually progresses from precancerous lesions to invasive cancer over many years. Unless women are at increased risk for cervical cancer, screening less frequently is likely to be effective while reducing the number of false-positive results.

The available data are insufficient to determine whether newer, more expensive forms of Pap tests are better than conventional Pap tests. Although some data suggest new tests like ThinPrep® may detect more high-grade lesions, they may also increase false-positive results. HPV tests are not yet

approved for use as primary screening tests for cervical cancer but research is underway to determine whether HPV tests can identify women who need more or less frequent screening with Pap tests.

How Do These Recommendations Differ from Previous Task Force Recommendations?

These recommendations reinforce earlier recommendations that sexually active women get regular Pap testing at least every 3 years. The revised recommendations, however, raise the age at which routine screening should

begin, as a result of data suggesting that the risk for cervical cancer in adolescents is low and the risk for false-positive results is high. The recommendation against continuing routine screening in women after age 65, or after a total hysterectomy, are stronger than in 1996, reflecting new data on the low yield and potential harms of such screening.

For more information on screening for cervical cancer, contact the following organizations:

healthfinder™
<http://www.healthfinder.gov>

**National Cancer Institute
National Institutes of Health**
<http://www.nci.nih.gov>



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality
www.ahrq.gov



U.S. Preventive Services Task Force

Members of the USPSTF represent the fields of family medicine, gerontology, obstetrics-gynecology, pediatrics, nursing, prevention research, and psychology. Members of the USPSTF are:

Alfred O. Berg, MD, MPH
Chair

Janet D. Allan, PhD, RN, CS
Vice-chair

Paul S. Frame, MD

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Mark S. Johnson, MD, MPH

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Jeffrey F. Peipert, MD, MPH*

Nola J. Pender, PhD, RN*

Albert L. Siu, MD, MSPH

Steven M. Teutsch, MD, MPH

Carolyn Westhoff, MD, MSc

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*Members of the USPSTF at the time the recommendation on cervical cancer screening was finalized.



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