MCC
Michigan Cancer Consortium

Building bridges with communities and organizations to fight cancer

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2011 Spirit of Collaboration Awards

Every year since 2001, the Michigan Cancer Consortium (MCC) has presented its highest honor — the Spirit of Collaboration Award — to member organizations that have done outstanding collaborative work to significantly move comprehensive cancer control activities forward in our state.

The MCC is pleased to announce the 2011 Spirit of Collaboration award recipients:

American Cancer Society Body and Soul Blue Challenge
Great Lakes Cancer Institute Colorectal Cancer Screening Task Force
Great Lakes Cancer Institute Patient Connect in Collaboration with the American Cancer Society Patient Referral Form
Josephine Ford Cancer Prevention and Treatment Demonstration Project
Kin Keeper SM Cancer Prevention Intervention
Michigan Smoke Free Apartment Initiative
Northwest Michigan Cancer Prevention and Awareness Coalition
Sister and Sister Free Mammogram Program
Value Partnerships: Oncology-Focused Collaborative Quality Initiatives

The following initiatives received honorable mention recognition:
Breast Cancer Safety Net; C-3 Community Garden and Beautification Project; Feet and Friends Fighting Colon Cancer and; Maria Mencia Cancer Caregiver Network.

Congratulations to all! For more information, please go to:
http://www.michigancancer.org/AboutTheMCC/AwardsByYear.cfm

MCC Co-Chairs Chuck Sherwin and Carolyn Johnston present Karen Patricia Williams (holding award) and Hiam Hamade of the Kin Keeper SM Cancer Prevention Intervention, with the Spirit of Collaboration Award.

MCC Co-Chairs, Chuck Sherwin and Carolyn Johnston, present Irene Balowski of the Northwest Michigan Cancer Prevention and Awareness Coalition with the Spirit of Collaboration Award.

Managing the pain associated with cancer

Pain is a common symptom in people with cancer. At the time of diagnosis, 30% to 40% of people experience pain. If the cancer has spread, 65% to 85% of people experience pain, and up to 95% of cancer pain can be treated successfully. Pain can make other aspects of cancer seem worse, such as fatigue, weakness, shortness of breath, nausea, constipation, sleep disturbances, depression, anxiety, and mental confusion.

However, not all people with cancer benefit from pain relief strategies because they don't share the symptoms with their health care team or have worries about the medications used to relieve pain. It is therefore important for providers to communicate with patients about pain so that together they can develop a plan to relieve it.

For more information, go to the American Society of Clinical Oncology website at: http://bit.ly/tkgbXO

Source: American Society of Clinical Oncology website

ACS Great Lakes Update

By Judy Stewart, ACS, Great Lakes Division

State Update:

Obesity

Bills to require minimum hours of physical and health education were introduced, HB 5139-5141, and referred to the House Committee on Education on November 1st. The American Cancer Society and Healthy Kids, Healthy Michigan support these bills.

Affordable Care Act – Health Insurance Exchange

On Nov. 8th, SB 693, a bill to create a health insurance exchange, the MIHealth Marketplace, passed the Senate Committee on Health Policy 5-3. On Nov. 10th the bill passed the full Senate 25-12.

SB 693 is an excellent start to ensure that cancer patients, and patients with other chronic diseases, have the best choices possible when it comes to selecting their health insurance. The American Cancer Society and the MI Consumers for Healthcare supported the bill as a framework for the exchange but did make recommendations to ensure seamless auto-enrollment into Medicaid for those who are eligible, assure the exchange a stable source of funding, and to allow the exchange to be active purchasers.

The House is expected to introduce its own version of an exchange bill but the Speaker of the House has said he doesn't plan to move an exchange bill through the House until June.

Speaker Bolger and members of his caucus are stating that they want to wait to act until the Supreme Court ruling -- which is expected mid-June. It appears that there is a fundamental misunderstanding on what exactly the Supreme Court will be ruling on. The Supreme Court will not be ruling on whether or not states have to set up a health insurance exchange. That part of the law is not being challenged. What they will be reviewing is the constitutionality of the individual mandate and the expansion of Medicaid.

Oral Chemo Parity

The Senate Committee on Insurance held a public hearing on oral chemotherapy access bills, SB 540-541. The bills, supported by the American Cancer Society, ensure cancer patients living in Michigan receive the physician-recommended care needed to fight their disease by eliminating disparities in health insurance coverage between oral and intravenous chemotherapy.

The bill was voted out of committee unanimously on November 8th and awaits a full Senate vote.

(ACS Great Lakes Update continued on page 5)

Michigan Cancer Genetics Alliance Corner

Breast Cancer Risk Models: A Review

Submitted by Xinxin (Shirley) Yao, Genetic Counseling Student, Wayne State University and the Michigan Cancer Genetics Alliance

When estimating a woman's risk for developing breast cancer, genetics specialists typically consider two separate risk questions.

- What is her risk for developing breast cancer in the future? ***and***
- What is the chance that she carries an inherited gene change in a breast cancer related gene (such as BRCA1 or BRCA2)?

In an attempt to answer these two questions, a number of cancer risk assessment models are typically used during a genetic counseling session. These models try to answer either one or both of the questions above using several cancer risk factors regarding personal and family health history.

Table 1. Gail Model Risk Factors

- Age
- Race
- Age at menarche
- Age at first live birth
- Number of previous breast biopsies (up to two)
- Presence of atypical ductal hyperplasia
- Number of first-degree relatives with breast cancer

One of the most widely used (and validated) risk models for estimating lifetime breast cancer risk is the Gail Model, which was developed in 1989 by Mitchell Gail et al. The Gail model was developed using data obtained from the Breast Cancer Detection Demonstration Project (BCDDP) involving 2,852 cases (those with cancer) and 3,146 controls (those without cancer). The BCDDP data involved mostly Caucasian women who were being routinely screened for breast cancer by mammography. The modified Gail model (also called Gail 2) is currently used in practice today and incorporates several risk factors (Table 1) and also incorporates data from SEER (Surveillance, Epidemiology and End Results registry) which allows other races to be considered in the risk assessment model. The Gail 2 model is easy to access and use, incorporates reproductive factors, adjusts for race, and it is well-validated on a US population. However, the Gail 2 model does not incorporate paternal family history of breast cancer, second-degree relatives with breast cancer, relatives' age at cancer diagnosis, or the presence of ovarian cancer in the family. It has also been shown to overestimate risk in women with non-proliferative breast growths, it has lower accuracy for individual risk prediction.

Similarly, the Claus model, developed by Claus and colleagues, estimates a woman's risk of breast cancer in the future. This model is based on data from a large population-based, case-control study conducted by the Centers for Disease Control (called the Cancer and Steroid Hormone study or CASH study) that included 4,730 histologically confirmed breast cancer patients and 4,688 matched controls. This model provides age-specific risk estimates in women with a family history of breast cancer, using combinations of affected relatives. The Claus model accounts for moderate and strong genetic risk factors and has been validatedusing data from a large case-control study population in the US. However, the Claus model does not incorporate non-familial risk factors and or account for certain affected relative combinations (e.g. mother and maternal grandmother affected with breast cancer).

Table 2. Claus Model Risk Factors

- Age
- First-degree relatives with breast cancer
- Both maternal and paternal family history
- Second-degree relatives with breast cancer
- Ages at diagnosis of affected family members
- **Extended Claus adjusts for:** bilateral breast cancer, ovarian cancer, and more than 2 relatives with breast cancer

The BRCAPRO model is a Bayesian model used to estimate the risk of inherited changes in the BRCA1 and/or BRCA2 genes. It incorporates published BRCA1 and BRCA2 mutation carrier frequencies, cancer penetrance in mutation carriers, cancer status, and age at diagnosis of the client's first-degree and second-degree relatives. Using information on both affected and unaffected relatives, BRCAPRO provides the chance of carrying a BRCA1 or BRCA2 mutation and chance of developing breast cancer as well. However, this model weighs in situ breast cancer much lower than invasive breast cancer and can underestimate the BRCA1/2 risk in some families. This model also does not estimate the risk of having an inherited susceptibility to breast cancer from rarer genes, such as *TP53*, *PTEN*, and *STK11*. - more -

Breast Cancer Risk Models: A Review *(continued from page 3)*

The IBIS or Tyrer-Cuzick model, developed by Tyrer and Cuzick in 2005, is based on the International Breast Intervention Study and other epidemiological studies. It incorporates features of both the Gail and Claus models as well as estimates the chance of carrying a BRCA1 or BRCA2 mutation in addition to age-adjusted breast cancer risk. While it incorporates many unique risk factors such as height, BMI, age at menopause, use of hormone replacement therapy, 3rd degree relatives, and presence of lobular carcinoma in situ (LCIS), it has not been validated/calibrated in a US population and is therefore not widely used in clinical practice in the US.

Several interesting and user-friendly risk assessment models exist to estimate both the risk of breast cancer and/or chance of identifying *BRCA1* and/or *BRCA2* mutation. It is important to remember that the models differ substantially in their assumptions and thus in their applicability for specific patients. Because the models do not incorporate every risk factor, the estimates they provide on breast cancer risk and BRCA1/2 risk are considered guides rather than absolutes. These models should be used in conjunction with clinical judgment during a formal cancer risk evaluation by a trained cancer genetics specialist.

References:

Evans, D., & Howell, A. (2007). Breast cancer risk-assessment models. *Breast Cancer Research*, *9*(5), 213-220.
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Gail et al. (1989). Projecting Individualized Probabilities of Developing Breast Cancer for White Females Who Are Being Examined Annually. Journal of the National Cancer Institute, 81(24): 1879-1886.
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Public Health Genomics 2012–2017 Report Released

The Centers for Disease Control and Prevention, Office of Public Health Genomics (CDC/OPHG), has announced its priorities to advance the field of public health genomics.

To develop the priority recommendations, the CDC/OPHG initiated three activities: (1) consultation of public health genomics stakeholders conducted by the Center for Public Health and Community Genomics at the University of Michigan School of Public Health, including a) analysis of a Request for Information (RFI) issued by the Department of Health and Human Services/ CDC, b) interviews of key informants from the public health system and c) informal discussions with community-and practice-based public health practitioners; (2) interviews of key informants from the non-profit and for-profit sectors conducted by Genetic Alliance; and (3) an all-day meeting held in Bethesda, MD on September 14, 2011, attended by over 70 leaders in the field of public health genomics (academic, public health, health care organizations, and community-based organizations). Michigan stakeholders are prominently featured in the report.

For more information: http://genomicsforum.org/

Centers for Disease Control and Prevention Posts Cancer Registry Success Stories

The CDC announces that many of the success stories (including Michigan's), submitted by the registries in CDC's National Program of Cancer Registries (NPCR), are now posted on NPCR's web site at: http://1.usa.gov/ujKdg5. Additional stories will be added as the review process is completed. The stories posted are those that in some measure have impacted public health.

Several stories related to breast or colorectal cancers have been translated for Spanish-speaking readers. These stories illustrate how the data collected throughout the nation through central cancer registries are of great importance and value in addressing the needs of public health at local and national levels. For more information, go to: http://1.usa.gov/uQ6nsT

ACS Great Lakes Update *(continued from page 2)*

Federal Update:

Super Committee and Appropriations

Shortly before its November 23 deadline, the bipartisan Joint Select Committee on Deficit Reduction, better known as the "super committee," announced it was unable to devise a deficit reduction plan that a majority of the committee's members could support. Under the Budget Control Act, the legislation that created the super committee, automatic across-the-board spending cuts are scheduled to begin in calendar year 2013. Cuts are to be shared equally between domestic discretionary and defense programs. Social Security, Medicaid, veterans' benefits, and other essential programs are exempt from the automatic cuts. Reductions to Medicare would be limited to 2 percent and impact providers only, with no cuts for beneficiaries. The across-the-board cuts are in addition to an earlier round of cuts to domestic discretionary spending called for in the Budget Control Act, which total $900 billion over 10 years. No cuts were made to Medicare and Medicaid. Funding for cancer research, prevention and early detection programs is not likely to suffer serious cuts in fiscal year 2012, but what happens in the following years is more difficult to predict.

Medical Loss Ratio

The Affordable Care Act requires insurers to spend at least 80 percent of their premium revenue on health care claims and quality improvement costs. Beginning this year, insurers who miss the target are required to rebate the difference to policy holders. Recently, the Department of Health and Human Services (HHS) released the final rule governing medical loss ratio (MLR) calculations, the percentage insurers spend on benefits versus administrative costs. Overall the rule is favorable to consumers and maintains the inclusion of insurance broker and agent fees in the calculation as administrative expenses. The American Cancer Society Cancer Action Network (ACS CAN) strongly supports this aspect of the rule, believing that classifying fees and commissions as administrative expenses more accurately reflects the proportion of spending by insurers on health care.

Public Health and Prevention Fund

Congress continues to turn toward the Public Health and Prevention Fund that was created under the Affordable Care Act to pay for a range of non-prevention budget items. The intent of the fund was to finally make prevention a national priority, after years of spending a mere four cents of every dollar trying to keep people well. If Congress succeeds in channeling this critical funding elsewhere, we risk reverting to a health care system that only focuses on treating people once they get sick.

ACS CAN is working to defend the fund and urging Congress to use the money to improve public health. To that end, ACS CAN joined dozens of other public health groups for a lobby day on December 15. Representatives from the groups attended meetings on Capitol Hill to encourage members of Congress to protect the prevention funding and use it as it is intended, to make an historic investment in the health of this country.

Renewing the War on Cancer

Forty years ago, President Nixon signed the landmark National Cancer Act and launched what came to be known as the "war on cancer." The signing of the act signified that Congress and the President were making cancer a national priority.

On December 13th, the Senate honored that historic moment by introducing a resolution commemorating the anniversary. The resolution, co-sponsored by Sens. John Kerry (D-MA), Jerry Moran (R-KS) and Bob Casey (D-PA), celebrates the fact that people with cancer stand a far better chance of surviving the disease today than they did 40 years ago.
Much of the progress we've made over the past 40 years is thanks to the law's creation of a National Cancer Program conducted through the National Cancer Institute (NCI). Today, there are 66 NCI-designated cancer centers in 33 states, and NCI is the world's largest funder of cancer research.

Of course, there is still so much work to be done. With 1 in 2 men and 1 in 3 women projected to be diagnosed with cancer in their lifetime, it is critical that the elected officials make it a national priority to eliminate death and suffering from this disease. This anniversary is the perfect time to reinvigorate the war against cancer and commit to sustain federal investments in cancer research, prevention and early detection programs and access to care.

2012 Survivorship Research Conference and Survivor Advocate Program – registration open

The National Cancer Institute's Office of Cancer Survivorship, the American Cancer Society, LIVESTRONG, and the Centers for Disease Control and Prevention are bringing together diverse groups of stakeholders for the 6th Biennial Cancer Survivorship Research Conference, entitled "Cancer Survivorship Research: Translating Science to Care," that will be held on June 14-16, 2012, at the Crystal Gateway Marriott in Arlington, Virginia.

Applications are now being accepted for the Survivor Advocate Program, which provides scholarships for up to 20 advocates to attend the conference. Advocates will learn first-hand about translating cancer survivorship advances from early-stage research to survivor care, interact with other advocate leaders and researchers, and develop tools to educate communities about key survivorship issues.

Applicants should have direct experience with cancer - either as a survivor, family member or caregiver of someone with cancer, or health care professional with direct patient/survivor contact. ***The deadline to submit a scholarship application is January 17, 2012, at 11:59 p.m. EST.***

Please visit http://www.cancer.org/subsites/Survivorship2012/survivor_advocate_program for more information about, and to submit an application for, the Survivor Advocate Program. For more information about the 6th Biennial Cancer Survivorship Research Conference, go to: http://www.cancer.org/subsites/Survivorship2012/survivorship-conference-2012 or contact Kalina Duncan at kalina.duncan@nih.gov .

Five Michigan practices make QOPI® certified list of practices

The American Society of Clinical Oncology's (ASCO) Quality Oncology Practice Initiative (QOPI®) is an oncologist-led, practice-based quality improvement program. The goal of QOPI® is to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. The process employed for improving cancer care includes measurement, feedback and improvement tools for hematology-oncology practices. QOPI® also collects many measures around pain and symptoms, including referrals to palliative care and hospice services.

ASCO's QOPI® certification program is relatively new, launching in January 2010. Practices have to be in the QOPI® initiative in order to be eligible to apply for certification. The five Michigan practices that are certified by QOPI are:
Northern Michigan Hematology/Oncology (2010) - Petoskey, MI
Southwest Michigan Oncology Associates (2011) - Battle Creek, MI
Sparrow Regional Cancer Center - Sparrow Medical Oncology (2010) - Lansing, MI
University of Michigan Cancer Center (2011) - Ann Arbor, MI
West Michigan Cancer Center (2010) - Kalamazoo, MI

Congratulations to these five Michigan QOPI® certified practices. For more information, see: http://qopi.asco.org/certifiedpractices

For more information on QOPI®, please see: http://qopi.asco.org/program.

January

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1 ***January is... Cervical Health Awareness Month***	2	3	4	5	6	7
8	9	10	11 ***MCC Challenge Informational Call***: Conference #: 1-877-336-1828 Passcode: 3288992# (1:00 – 2:00 p.m. ET)	12	13	14
15	16	17	18	19	20	21 Free PAP/Cervical Cancer Screening For eligible women; 1:00 – 4:00 p.m.; Call U-M Cancer Answer Line to make appointment 1-800-865-1125
22	23	24 *Webinar* Ensuring the delivery of patient-centered cancer care (2:00 – 3:00 p.m. ET)	25	26	27	28
29	30	31				

2012

Febuary

Sun	Mon	Tue	Wed	Thu	Fri	Sat
			1 *Webinar* "Working with Physician Advocates on Tobacco Free Policies" To register: call 517-241-1195 or email: lyone@michigan.gov 11:00 a.m. – 12:00 noon	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29			

2012