

# **Breast and Cervical Cancer Program Allocation Steering Committee Minutes Portland State Office Building, April 24, 2009**

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## Committee Members:

- Dr. Michelle Berlin; representing Oregon Health and Science University (OHSU Center for Women's Health)
- Gail Brownmiller; representing Susan G. Komen for the Cure
- Pat Crozier; representing Conference of Local Health Officials (CHLO)
- Beth Epstien; representing DHS Women's and Reproductive Health Section
- Mandi Poltl; representing American Cancer Society
- Julie McFarlane; representing DHS WISEWOMAN (WW) program
- Dr. Elizabeth Steiner; representing the Knight Cancer Center

Breast and Cervical Cancer Program (BCCP) staff in attendance: Amy Manchester Harris, Anna Meddaugh, Elvin Yuen, Maureen Hinman, Mary Kate Brousseau, and Kate Schmidt

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## **Welcome – Amy Manchester Harris**

Amy welcomed the Allocation Steering Committee back and also Beth Epstien who was not able to attend the first meeting. Beth is the Medical Consultant for the DHS Office of Family Health. Also introduced was Anna Meddaugh the newest BCCP team member. Anna is the new Research Analyst and comes from working for the Clark County Health Department and Washington State Department of Health.

Amy reviewed the desired outcome of the meeting, CDC funding, timeline and survey results.

- a. Desired outcome of this meeting is to have clear plans to implement the allotments because the new fiscal year is approaching quickly on July 1, 2009.
- b. BCCP heard from the CDC that we will most likely have level funding for the next fiscal year. This means we'll probably be able to serve 7,000 women.
- c. Allocation notifications to providers will probably go out in the middle of May so providers can start scheduling appointments.
- d. Survey online that allows for feedback on the March meeting. It has received 4 responses.

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## **Overall Criteria – Anna Meddaugh and Amy Manchester Harris**

Anna Meddaugh went over the criteria application methodology and maps for each of the criterion (see Power Point slides for more details).

- I. The criteria seem simple but incorporating them into a formula required very complicated steps.
- II. Uninsured and unemployment(Variable 1).
  - a. Uninsured data
    - i. Data used is from 2005, concern was expressed that it could have drastically since 2005. This is the only current data available to the level of specification (e.g., county level and age) that is available.
    - ii. From the Census Bureau, used Small Area Health Insurance Estimates, more recent data did not go down to counties below 65,000 in population.

- iii. Because of a small sample size, for many counties, there was no difference in rate of uninsurance if the margin of error is taken into account.
  - b. Unemployment data
    - i. This was more recent so makes up for uninsured data being from 2005.
- III. Breast/Cervical Cancer Incidence (Variable 2)
  - a. Data for breast cancer incidence does not include DCIS.
  - b. Breast cancer incidence
    - i. One county has a rate statistically significantly higher than the state overall rate.
    - ii. Four counties have a rate lower.
    - iii. One county did not have a rate calculated due to small sample size.
  - c. Cervical cancer incidence
    - i. Half of all counties didn't have rates calculated due to small sample size.
  - d. Could one look at trends over time?
    - i. For breast cancer, only one county had a statistically significant upward trend over time—Crook.
    - ii. For cervical cancer, only one county had a statistically significant downward trend over time—Multnomah.
  - e. County stages of cancer look differently? Komen has looked at this data for breast cancer and have found it to be pretty much the same.
- IV. Race/Ethnicity (Variable 3)
  - a. To determined number of race=non-white, needed to use three data sets from three periods of time.
    - i. This might have caused over-representation in of minorities.
    - ii. The Hispanic population tends to be younger than other ethnicities or the general population. Therefore....
- V. Steps
  - a. Ranked all counties from 36 (highest) to 1 (lowest) on each criterion.
  - b. For any criterion that needed to be combined into one variable, the average of the ranking was calculated.
  - c. Based on the ranking, broke the entire list into for quartiles.
    - i. Q1=lowest group
    - ii. Q4=highest group
  - d. For each variable in a certain quartile, assigned a score.
  - e. Each county was then given a score and then the scores for the three variables were added together.
  - f. With the total scores, the counties were again ranked, then broken into quartiles.
  - g. The quartiles were given specific multipliers such that the higher quartile has a higher multiplier so they'd be given more allotments.
- VI. Starting point (baseline)
  - a. Baseline number was calculated based on the BCCP eligible population.
  - b. When looking at a smaller part of the population, the margin of error increased.
  - c. How is the total number of women served (7000) calculated?
    - i. The estimates are based on the program's past performance, looking at the number of clients that required more expensive diagnostic services in addition to the basic screening services. With that, one can use the CDC-provided clinical cost worksheet that takes these factors into account and then projects a number of women that can be served based on a given funding level.

- d. The population uninsured might not actually be uninsured if they are partnered and the partner has health insurance.
- e. Instead of just incidence of cancer, should we take into acct staging to weight allotments towards counties with a higher proportion of diagnoses in later stages.
- f. When comparing the map of Oregon, by county, of BCCP Eligible population to the map of BCCP Weighted Allocation, the maps look very similar.
- g. Might need to look at the scores to see the difference between the highest score and the lowest score. If the different is huge, then the weighting between the quartiles needs to be increased. This goes for the scores for each variable and perhaps the aggregated scores.
- h. Looking at the scores for each variable and county, the spread between the scores seems proportional to the weighting.

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**Provider Criteria – Maureen Hinman and Amy Manchester Harris**

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Amy went over the priority population criterion issues and Maureen Hinman went over the Safety Net and Medically Underserved Area definition and criterion.

- I. Priority Populations Criterion
  - a. State ran into issues in operationalizing this criterion because as the number of slots per provider got smaller, the number of minority patients seen made a bigger impact on the percentage.
  - b. Could aggregate, per county, the total number of clients allotted and out of those, who were minority. Then take that minority number and use that as a baseline. So it becomes...a provider saw what percentage of clients out of the minority number of clients in that county.
  - c. Find out from providers what their overall patient mix is
  - d. If the State will be telling providers to concentrate on priority populations, the BCCP needs to give providers very explicit algorithms on how to triage allotments towards priority populations (and passing up not-priority populations). The burden should not be on the providers to come up with a way to triage the allotments.
- II. Safety Net Clinic
  - a. Different organizations have different definitions for this, and the definitions also differed based on the reason the definition was being utilized. So BCCP to included as many designations as possible in order to cast the net as widely as possible.
- III. Medically Underserved Area
  - a. Rural health designations included good criteria such as distance traveled to hospital. However, it covered only rural areas. So BCCP included all three criteria to create a list of providers in Medically Underserved Area-type providers.
- IV. Provider Distribution Criteria Table
  - a. If one provider who was granted a lot of slots, but this provider is in an unpopulated area of the county, perhaps some of their allocations should be shifted towards a population center.
  - b. For WW, some provider could not be a WW site because their main client base is not the priority population. So that would limit WW's ability to grow.
  - c. The State might need to tweak some numbers, especially if a provider has a characteristic. For example, Native American Rehabilitation Association of the Northwest (NARA) has numerous slots under the current distribution but is only contracted to serve under-40 BCCP clients.

- d. BCCP waiting list
  - i. How should one decide to bring on providers?
  - ii. If a county doesn't have a provider, then it needs providers waiting list would be reviewed first.
  - iii. Level of care provision should be a factor. Can provider give specialized care?
    - 1. Ancillary providers are not subject to the waiting list.
  - iv. Which provider can provide more comprehensive care. Which leads to a diagnosis in shorter amount of time.
- e. If bringing on a new provider in a county, which (should) an existing provider be taken off? If so, which one?
- f. This decision is made difficult because of a lack of data about all providers in area or on the waiting list. By next year, the data that is lacking should have been collected for current providers. .
- g. Potential process:
  - i. Pick out providers in the list who HAVE to get in because there are no providers or 2 few providers in an area.
  - ii. Then pick out providers who would not add value to the provider network.
  - iii. It was suggested to send survey out to 77 providers to get simple information.
- h. Who this year has used their slots?
  - i. If not used them all their slots, shouldn't give them as many this time.
  - ii. Do they even want to continue to be a provider?
  - iii. Do they not have enough capacity to use up their slots?
- i. Map the locations of where the slots are to ensure coverage.
- j. Steering committee knows that there are factors involved which will require manual adjustment to slots from one provider to another. The Steering Committee trust BCCP to make those adjustments based on difference with provider and area needs.
- k. Should there be a minimum number of slots that providers need to have? When adding providers from the waiting list, it drives down allocations for all the other providers.
  - i. Look to see the geographic spread. Maybe providers right next to each other means one can be eliminated.
  - ii. Not all safety-net clinics are optimally to be a BCCP provider, if they don't have the capacity to do all other work involved in processing BCCP clients.

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## **Eligibility Criteria**

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### **I Underinsured**

- a. Because the number of underinsured clients served is only 0.6% of clients served in calendar year 2008, then a change or not doesn't affect the clients seen that much.
- b. So perhaps it's better to not change the criterion to follow the advice of the survey. DO NOT CHANGE this criterion.

### **II Federal Poverty Level change**

- a. WW is at 250%. Therefore this would affect them.
- b. Because a change wouldn't significantly affect the type of clients seen, DO NOT CHANGE criterion.
- c. Age Change
- d. Providing divided services is an interesting option. For example, for some states, women under 50 only get a pap, pelvic and CBE and no mamm.

- e. So many states have different criterion.
  - (1) For WISEWoman, age criterion starts at 40 even though they'd like to focus on 50 and over.
- f. Because of funding priorities, only 25% of mammograms done can be for women 40-49. Because of these changes already happening, DO NOT CHANGE criterion.

### III. Mammography frequency

- a. CDC has a priority for clients to be re-screened.
- b. No national organizations making a clinical recommendation for screening every 2 years. For those orgs making a recommendation for 1-2 years, they add caveats that the frequency must be individualized for the individual patient.
- c. If going to every 2 years, there is concern that BCCP is saying that mammogram every 2 years is the clinical recommendation. Therefore, if going to every 2 years, there must be clear communication that there is a difference between what BCCP will *pay for*, but that this is not a clinical recommendation.
  - i. The difference between what BCCP will pay for and what is clinically recommended has never been separated.
  - ii. Implication is that the patient who needs a mammogram every one year for individual reasons will be responsible for the cost.
- d. If going to every two years, then will be able to save funds going to diagnostics for false positives, which is higher for women 40-49 versus 50+.
  - i. But looking at years of life saved and other broader measures, then the cost benefit of funds going to screen 40-49 versus 50+ starts to even out.
- e. The efficacy of a well-done Clinical Breast Exam (CBE) on 40-49 is just as good as a mammogram.
- f. Question posed to the MAC was to change the breast screening interval instead of the interval between mammograms.
- g. Recommendation: Pay for mammogram (and CBE) every 2 years, with some flexibility.
- h. Going to 2 years would reduce number of women who want just the mammogram.
- i. Implementation of going to 2 years would have to be carefully planned out and may be phased in over time.
- j. Recommendation: While CBEs can be done annually, BCCP will only pay for screening mammograms every 2 years (22 months). Team should propose a plan for how to operationalize the policy. Communication should make it clear that this policy is not a clinical recommendation.

### II Allocating allocations?

- a. Recommendation: Allocations should be quarterly
- b. This will allow program manage allocations through out the year, especially if there are providers who don't use up their allotments for two quarters in a row.
- c. This gets the program to be running all year long, instead of petering out at the end of the fiscal year.
- d. Providers if out of allocations for the quarter would refer clients to new quarter for appointments.

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### WRAP UP

BCCP staff will work to set up a conference call to go over final provider numbers with the Allocation Steering Committee in May. They will map providers, develop key messages for providers and a plan for implementing the mamm policy.