The National Capital Area Regional Breast Healthcare Improvement Initiative

The Primary Care Coalition of Montgomery County (PCC) and the Regional Primary Care Coalition (RPCC) are collaborating to improve the efficiency and effectiveness of breast cancer screening, referral, and follow-up for low-income women in the National Capital Area. The PCC/RPCC Project will build upon the successes of the PCC Breast Healthcare Process Improvement Project. The PCC Project, anchored in community-based primary care clinics serving as medical homes, uses a model for improvement developed by Tom Nolan, PhD, Associates in Process Improvement (API). The long-term goal of the Regional Initiative is to position clinics throughout the region to provide 100 percent of low-income women residents 40 and over with access to high-quality, timely breast healthcare. The Regional Initiative consists of:

- **Phase I, 2010:** Current State Analysis; Build Partnerships and Plan Replication
- **Phase II, 2011:** Develop, Implement, and Monitor Specific Process Improvement Initiatives
- **Phase III, 2012:** Sustain, Evaluate, and Spread

The success of the project will be measured based on the following:

- Increase in breast cancer screening referral rate and in breast cancer screening rate.
- Decrease in cycle times from referral to screening, screening to diagnosis, diagnosis to treatment.
- Increase in the coordination of breast healthcare by participating safety-net clinics, and new and enhanced collaborative relationships.
- Changes in procedures and relationships that eliminate identified barriers to breast healthcare in efforts to achieve standards of excellence.
- Improved clinic charting and reporting of data on breast healthcare of clients.

State of the Region Breast Healthcare Assessment

Phase I included a State of the Region Assessment, carried out by Mosaica: The Center for Nonprofit Development and Pluralism. The assessment, which included data review, key informant sessions and interviews, and a survey of 22 safety net clinics, provides an in-depth analysis of the state of breast healthcare for low-income women in the National Capital Area. It helps establish a knowledge base for the regional replication and expansion of the PCC model from Montgomery County to other jurisdictions.

The following highlights some of the assessment's key findings and implications:

- **Demographics**: Some 120,000, or 15% of the region's population of women 40-64 are low-income. Of these, almost 39% are uninsured; however the percent of low-income uninsured varies dramatically by jurisdiction. In Northern Virginia, 53% of low-income women 40-64 are uninsured. In Suburban Maryland it is about 42% and in DC about 17%. (*Source: Estimates from the U.S. Census Bureau and Small Area Health Insurance Estimates (2007)*. The difference is largely attributable to differences in state Medicaid eligibility requirements and extent of local programs that provide coverage to low income residents. The DC estimate is probably high due to Census data limitations.

- **Breast Cancer Screening, Incidence, and Mortality Rates:** Annual screening rates in DC, Maryland, and Virginia are between 62% and 64%, all slightly above the national average of 59.7%.(American Cancer Society Research 2009) Breast cancer incidence rates are highest in DC, Montgomery County, and Fairfax County, while breast cancer mortality is highest in DC, Prince George's County, and Prince William County. Obtaining data for screening incidence and mortality among the low-income and low-income uninsured in the region was beyond the scope of the assessment; however, data from the American Cancer Society show that the aggregate screening rate among uninsured women (34.9%) is far lower than the rate for insured women (59.7%).

- **Safety Net Clinics:** The region has 31 safety-net clinics that serve as medical homes to women 40 and over, spread almost equally among Washington, DC (10), Northern Virginia (11), and Suburban Maryland (10). Together they operate 92 facilities providing primary health care to people who might otherwise be unable to obtain it. Two clinics located in DC have facilities in Montgomery County. About 55% of clinics provide services to people who live in other jurisdictions. These clinics provided care to an estimated 59,800 women 40 and over in

2009, about 55,650 of them low-income and 34,000 low-income and uninsured. However, the number of patients served (and clinic capacity) and the number of uninsured needing care vary dramatically by jurisdiction. The safety-net clinics in the District are serving about 8,000 low-income uninsured women 40 and over, the Northern Virginia clinics about 16,050, Prince George's County's one clinic about 1,300, and Montgomery County clinics about 8,650. The majority of low-income patients in DC clinics are insured, while less than 10% in Northern Virginia have coverage. Many clinics in Northern Virginia and the Prince George's county clinic sometimes have waiting lists.

- **Challenges**: Financial issues are important in every jurisdiction (though in different ways), as are patient issues, from language and cultural barriers to limited knowledge about breast cancer or available services to transportation problems. Some of the most important and challenging barriers are systemic. They involve narrowly defined program eligibility, limited access points, extremely complex and sometimes irresolvable documentation requirements for program access, and varied and demanding administrative regulations and procedures for pre-service authorizations that can prevent timely diagnosis and treatment. While many entities work together effectively to provide timely, comprehensive services for their low-income and uninsured patients, none of the jurisdictions has a coordinated system of breast healthcare services. All jurisdictions struggle with arranging and coordinating charity care and especially with identifying specialists to serve low-income uninsured women with breast cancer.

  Among the greatest challenges to timely and high quality breast health care for low-income women 40 and over throughout the region, as identified by clinics, hospitals, community-based outreach groups, and other providers, are the following:
  - Lack of service coordination.
  - Limitations in scope or funding of National Breast and Cervical Cancer Early Detection Program (NBCCEDP), a CDC program that funds states to provide access to breast and cervical cancer screening services to underserved women with limited access to screening, diagnostics, and/or treatment for some low-income, uninsured women and differences in the extent to which each jurisdiction makes its own state or local funding available.
  - Great differences in the availability of federal, state, and local public funding for diagnosis and treatment.
  - Administrative complexities in helping patients obtain charity care, apply for state-supported diagnostic or treatment services, or get timely approval for diagnosis or treatment for women served through Medicaid MCOs.
  - Lack of access to specialty care, especially oncology and surgery.
  - Lack of affordable care for women with incomes just above 200% of the federal poverty level.

- **Implications for Breast Healthcare in the Region:**
  - Need for systems change and service integration throughout the region.
  - Need for better data collection and tracking of low-income population health data.
  - Need for stronger provider coordination:
    - Community-based outreach and education providers need to be linked to safety-net clinics.
    - Clinics and mammography providers need to develop close relationships.
    - Hospitals need to establish a coordinated process for arranging hospital-based charity care.
    - The role of patient navigators should be enhanced so they can arrange patient access to a continuum of services.
  - Need for a regional perspective and strategy as well as funding coordination from both public and private funders.
  - Need to consider the social determinants of health, which may be a factor in mortality rates.

Safety-net clinics have indicated a high level of interest in participating in the Regional Process Improvement Initiative. Several clinics would like to serve as targeted replication sites, others to be part of a group of involved clinics, still others to participate in jurisdiction-specific or regional learning communities. Some navigators and other staff of non-clinical providers would also like to be part of knowledge-sharing sessions.