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b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

1995 Mammography Campaign
Provider Group Meeting

Monday, April 3, 1995
3 PM - 4 PM
Room 476 OEOB

AGENDA

1).	Welcome/Introduction	Marilyn Yager
2).	Mammography Campaign Overview	Helen Smits, M.D.
3).	Provider Participation Opportunities	Helen Smits, M.D.
4).	Discussion	
5).	Wrap-up/Next Steps	Marilyn Yager

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Booklet, "Things to Know About Quality Mammograms," 16 pages

A Woman's Guide

Quality Mammography

Things To Know About Quality Mammograms

Consumer Version
Clinical Practice Guideline
Number 13

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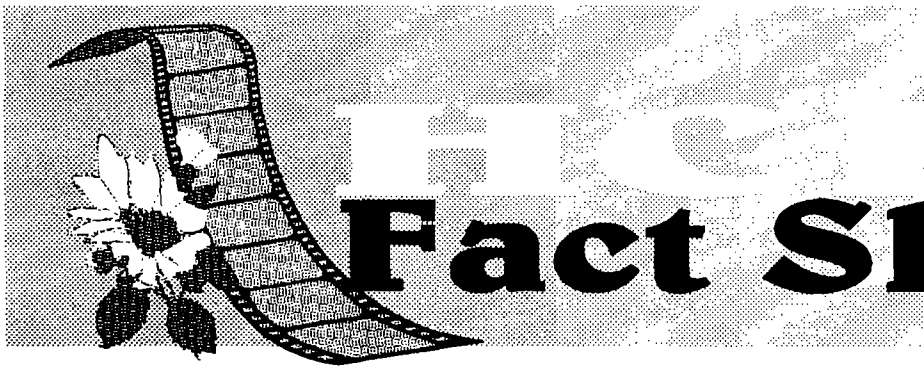
Booklet, "Get a Mammogram," 6 pages

Get A Mammogram

A Picture That Can Save Your Life!

Medicare Covers Mammograms!

The Department of Health and Human Services



Fact Sheet

Get a Mammogram....a picture that can save your life

March 1995

MEDICARE COVERAGE OF MAMMOGRAMS

Medicare is a federal health insurance program for people 65 and older and certain individuals with disabilities or end stage renal disease (ESRD). It is run by the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

Screening Mammograms:

Since January 1, 1991, Medicare has covered mammography screening for the early detection of breast cancer. *Screening mammograms*, together with a physician's interpretation of the results, are covered by Medicare. The following table describes the conditions under which Medicare will pay for screening mammograms.

AGE	MEDICARE COVERAGE FOR SCREENING MAMMOGRAMS
Under 35	No Coverage
35 to under 40	Only One Screening Mammogram
40 to under 50*	One Annual Screening Mammogram
40 to under 50	One Screening Mammogram Every 2 Years
50 to under 65	One Annual Screening Mammogram
65 and above	One Screening Mammogram Every 2 Years

*Women with a high risk of developing breast cancer (for example, a woman with a mother, sister or daughter who has had breast cancer).

Medicare also covers *diagnostic mammograms* when the patient shows signs or symptoms of having cancer. Medicare will cover these diagnostic mammograms for Medicare beneficiaries when the patient's physician has a specific reason for ordering the test, no matter what the age of the patient.

Payment for Screening Mammograms:

In 1995, a beneficiary's share of the costs will vary depending on the type of mammogram, whether her physician's Medicare claim is assigned or unassigned, and whether her Part B deductible has been met.

MORE

For screening mammograms, Medicare will pay a maximum of 80 percent of the 1995 Medicare approved amount (that is, $60.88 x .80 = $48.70). A physician who does not accept assignment of a Medicare claim may charge a beneficiary no more than 115 percent of the Medicare approved amount.

For diagnostic mammograms, Medicare will pay a maximum of 80 percent of the fee schedule amount. The fee schedule amount is approximately $67.16. The exact amount varies based on location and whether a physician is a Medicare participating physician. A physician who does not accept assignment of a Medicare claim may charge a beneficiary no more than 115 percent of fee schedule amount.

Quality Standards:

The Mammography Quality Standards Act (MQSA) of 1992 went into effect on October 1, 1994, requiring all mammography facilities seeking Medicare payment for mammography screening to meet quality standards defined by regulations of the Food and Drug Administration (FDA). To lawfully perform either screening or diagnostic mammography under MQSA, facilities must obtain a certificate from the FDA by meeting quality standards for personnel, equipment, quality assurance and record keeping.

To retain the certificate, a facility must successfully complete an annual inspection by an MQSA inspector trained by the FDA. HCFA has ceased performing inspections. Instead, HCFA has agreed to accept FDA's certification as evidence that the facility is qualified for Medicare reimbursement, thereby minimizing duplication of inspections.

Statistics:

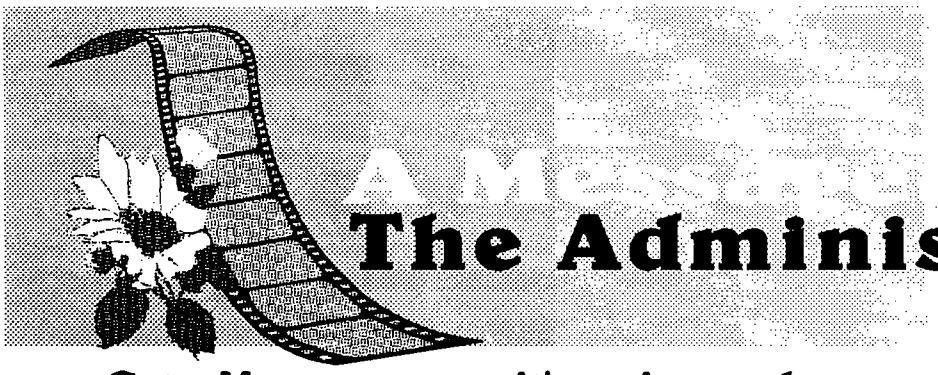
- *The American Cancer Society (ACS) estimates there will be 182,000 new cases of invasive breast cancer in 1995 and that 90,100 of these cases will be in women age 65 and older.*

- *ACS estimates there will be 46,000 deaths in females from breast cancer in 1995 and that 25,700 of these deaths will be in women age 65 and older.*

For More Information:

For more information about breast cancer and mammograms, call the Cancer Information Service's toll free telephone number, ***1-800-4-CANCER*** *or* ***(1-800-422-6237)****.*

For more information about Medicare coverage of mammograms, call Medicare's toll-free telephone number, ***1-800-638-6833****.*



A Message From The Administrator

Get a Mammogram....it's a picture that can save your life

Dear Colleague:

We hope you will join us in a campaign to encourage more women age 65 and older to protect themselves by obtaining mammography screenings. Although Medicare covers screening mammograms for the early detection of breast cancer, Medicare data indicate that more than 60 percent of older women do not take advantage of this benefit. A successful campaign can prevent thousands of unnecessary deaths.

The Health Care Financing Administration (HCFA) is undertaking the mammography campaign as the second step in the agency's "Consumer Information Strategy." This national strategy will help Medicare and Medicaid beneficiaries participate with their physicians in making decisions on prevention and treatment options.

Preventing breast cancer deaths with timely mammograms is a prime target for our attention. Breast cancer will affect one of every eight women born in the United States. The risk of breast cancer increases with age. National data show that in 1994, approximately 50 percent of new cases of breast cancer were in women age 65 and older; and about 56 percent of the deaths from breast cancer were in women age 65 and older. For women age 65 or older, getting a mammogram every two years can save lives.

We need your assistance in publicizing the life-saving value of mammograms and Medicare coverage of this procedure.

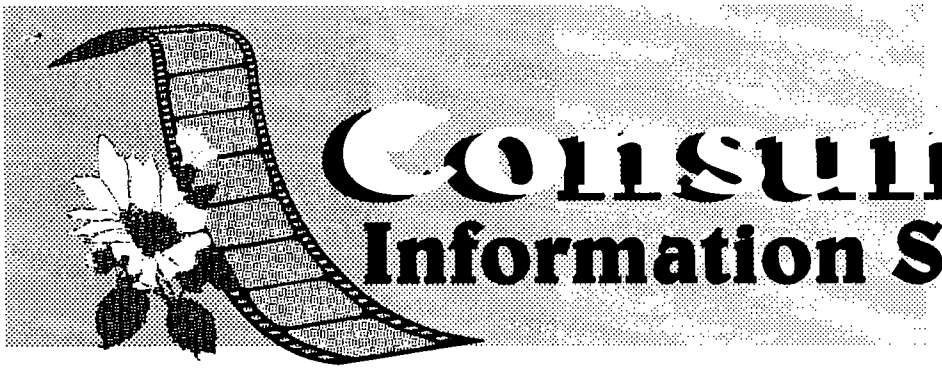
The following materials should be helpful to you:

- Medicare claims data showing 1992 - 1993 mammography utilization rates by state and by race;
- A HCFA brochure, in English and Spanish, telling older Americans about the benefits of the Medicare-covered mammograms;
- Posters encouraging regular mammograms;
- A fact sheet on HCFA's Consumer Information Strategy;
- A HCFA fact sheet on the Medicare mammography benefit; and
- A Woman's Guide on Quality Mammograms from the Agency for Health Care Policy and Research.

We look forward to working with you. If you need additional information, please call HCFA's Office of Public Liaison at (202) 690-6616. For information about HCFA's state and county mammography utilization data, please call (410) 597-3933.

Sincerely,

Bruce C. Vladeck, Ph.D.
Administrator
Health Care Financing Administration



Consumer Information Strategy

Get a Mammogram....a picture that can save your life

THE HEALTH CARE FINANCING ADMINISTRATION's
CONSUMER INFORMATION STRATEGY

OVERVIEW

The Health Care Financing Administration's (HCFA) Consumer Information Strategy (CIS) will help Medicare and Medicaid beneficiaries stay healthy. Using information from a variety of sources, the new initiative encourages greater use of health care services and assists beneficiaries in making informed choices about health care.

Medicare and Medicaid data on the use of services and patterns of care is the primary source of information for the initiative. Medicare alone pays more than 700 million claims a year for services to beneficiaries. Data on patterns of care provide useful information on treatment options. Analysis of claims data also identifies underserved localities to which special outreach efforts may be targeted.

HCFA plans to use its network of communications with consumers and physicians to promote use of important existing Medicare benefits and to help consumers choose wisely among alternative treatments. The first full scale campaign in 1994 promoted use of covered flu shots.

Screening mammography is the second campaign. Later campaigns will help beneficiaries choose among treatment options for localized prostate cancer and early stage breast cancer. All campaigns make use of HCFA's claims data to highlight current practice and to monitor effectiveness.

HCFA's 1995 SCREENING MAMMOGRAPHY CAMPAIGN

Among American women, breast cancer is the most commonly diagnosed cancer and the second leading cause of death. The incidence of breast cancer is highest in the over-65 population served by the Medicare program. Although Medicare covers screening mammograms for the early detection of breast cancer, Medicare data indicate that more than 60 percent of elderly women do not take advantage of this benefit.

In *Healthy People 2000*, the Department of Health and Human Services (DHHS) set a goal that 60 percent of women in the Medicare age group should have a mammogram every two years. The current level is 37 percent. Reasons for the gap include lack of knowledge of the benefit, lack of physician support for mammograms in this age group, fear of pain or harm from the mammogram, fear of detecting an untreatable disease, modesty, and a general sense that it is possible to be "too old" to need screening.

MAMMOGRAPHY CAMPAIGN MATERIALS

- *Materials for the campaign have been developed in collaboration with DHHS components, such as the National Cancer Institute, the Office of Women's Health, the Centers for Disease Control and the Agency for Health Care Policy and Research on material content; with the Food and Drug Administration on issues of safety and effectiveness of the screening; and with the Administration on Aging on the best ways to reach the elderly.*

- *Campaign materials include an analysis of recent claims data on a state-by-state basis; availability of county data to interested parties; brochures in English and Spanish that encourage screening mammography and educate Medicare beneficiaires on the benefit; a kit with fact sheets, newsletter articles, Medicare data charts, posters, and magazine and newspaper "slicks".*

- *The campaign will kickoff May 1, 1995, with special emphasis centered around Mother's Day, and will continue through the remainer of the year. Also, additional emphasis will be placed on the campaign during Breast Cancer Awareness Month in October.*

DISSEMINATION

Dissemination for the screening mammography campaign is handled through HCFA's ten regional offices. The basic elements of communication and outreach include:

- *Medicare carriers and intermediaries, working through their medical advisory committees and newsletters, to reach the medical community and beneficiaries.*

- *Peer Review Organizations in each State, working directly with physicians and beneficiaries. Four PROs have already undertaken mammography promotion campaigns and will take the lead in replicating their experiences.*

- *Health Insurance Information, Counseling and Assistance programs, funded in each state by grants from HCFA, working through volunteers to inform and educate beneficiaries.*

- *Coordination with Area Agencies on Aging and State Health Departments.*

COLLABORATION WITH OUTSIDE GROUPS

The success of this project is dependent on the support and enthusiasm of outside groups. Collaboration is extensive, involving both consumer-oriented and professional groups. Interaction takes place at many levels. For example, HCFA is working nationally with senior groups, cancer organizations, and many provider groups. Our regional offices and State agents are developing collaborative relationships with beneficiary, provider, and cancer organizations throughout their own local areas.

Beneficiary Newsletter

Get a Mammogram....it's a picture that can save your life

MAMMOGRAMS SAVE LIVES!
THE FACTS ABOUT OLDER WOMEN AND BREAST CANCER

The Health Care Financing Administration (HCFA), the federal agency responsible for the Medicare and Medicaid programs, is conducting a nationwide public information campaign to encourage women aged 65 and older to get a screening mammogram. Breast cancer will affect one of every eight women born in the United States, and the risk increases with age. Mammograms can detect breast cancer early when it can be treated. Mammograms save lives.

Breast cancer is the most commonly diagnosed cancer and the second leading cause of death among women. Breast cancer is most common among women over age 65. National data show that in 1994, approximately 50 percent of new cases of breast cancer were in women age 65 and older; and about 56 percent of the deaths from breast cancer were in women age 65 and older.

Although Medicare covers screening mammograms for the early detection of breast cancer, Medicare data indicate that more than 60 percent of older women do not take advantage of this benefit. Rates for African American women are even lower.

For women age 65 and older, Medicare helps pay for one screening mammogram every two years. Medicare's interval for screening is consistent with the National Cancer Institute (NCI) statements. It is important for women to return for a mammogram every two years (sooner if symptoms develop) because cancer can show up at any time. A mammogram can find breast cancer that is too small for anyone to feel, including doctors and nurses.

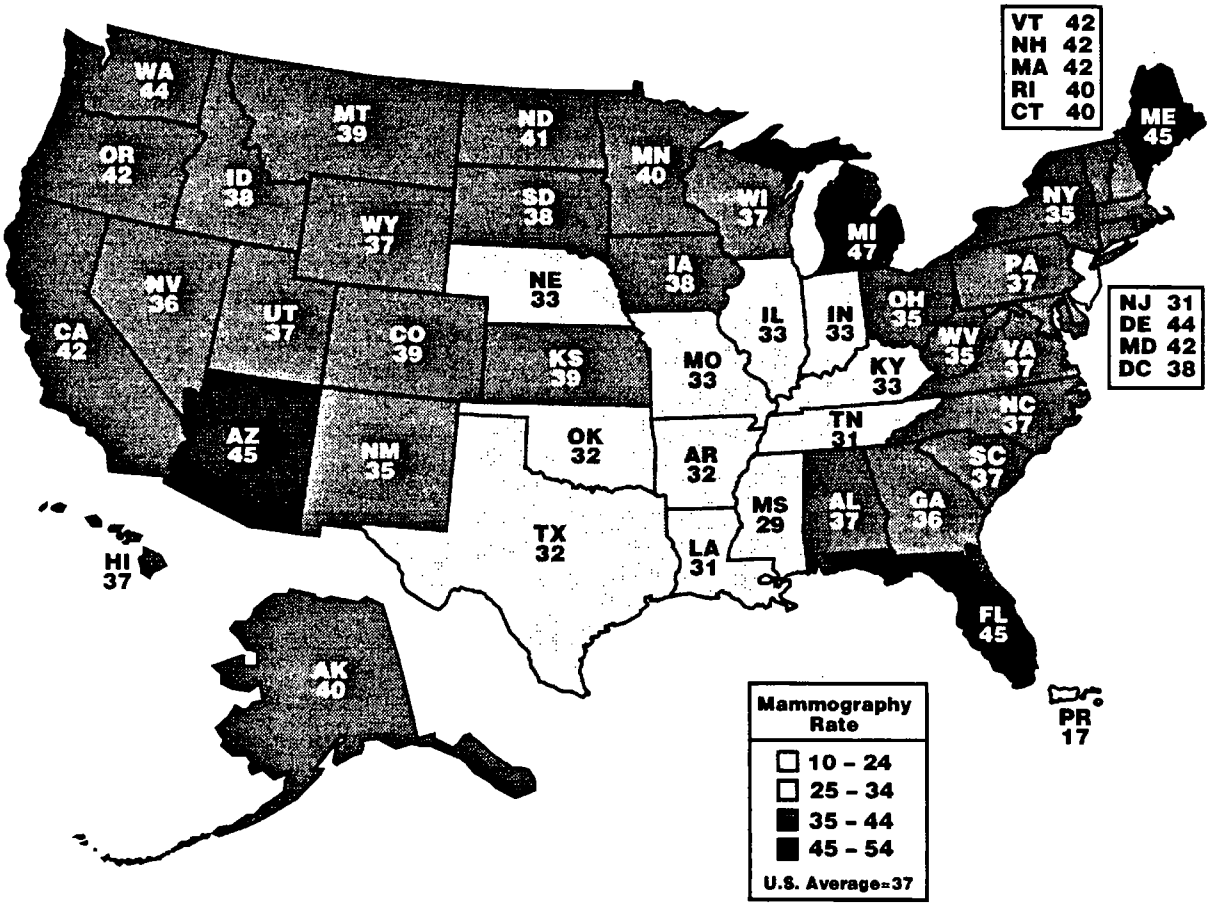
Medicare also helps pay for a mammogram when an individual is being treated by a physician for cancer or shows signs or symptoms of having cancer. In such cases, Medicare helps pay for as many diagnostic mammograms as a physician finds necessary. Medicare also helps pay for mammography screenings for certain other at risk women who are receiving Social Security disability benefits.

Individuals who are Medicaid eligible should contact their state or local medical assistance (Medicaid) agency, social services office, or welfare office to find out about Medicaid coverage of mammography screenings.

This article is suggested for use in your organization's newsletter.

MAMMOGRAPHY SERVICES PAID BY MEDICARE

Percentage of All Women Beneficiaries Age 65 or Older With At Least One Medicare-Paid Mammogram in 1992 or 1993

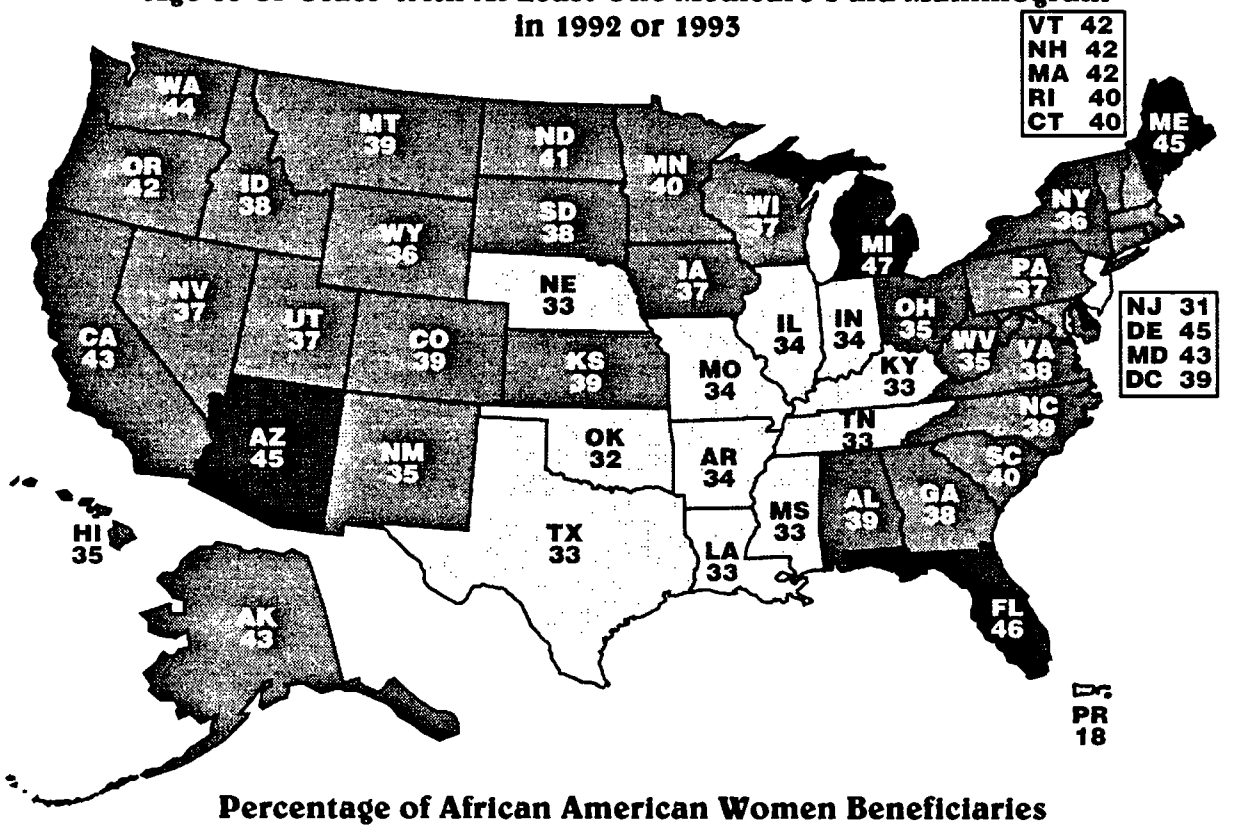


These data reflect claims paid by Medicare for non-HMO beneficiaries only. Total mammography rates may be higher in those areas with free or subsidized programs.

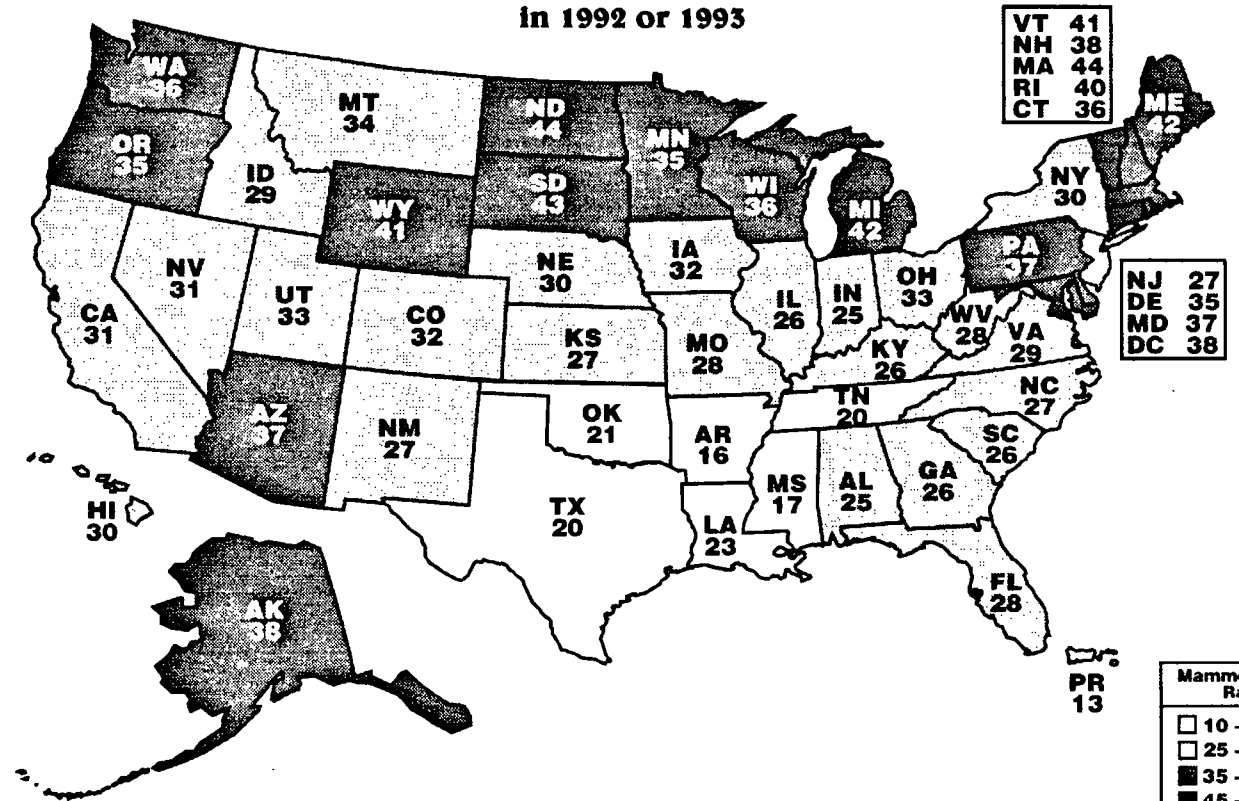
Source: **Health Care Financing Administration (HCFA),** administrative claims data files, January 1, 1992 – December 31, 1993. See page 4 for notes.

MAMMOGRAPHY SERVICES PAID BY MEDICARE

Percentage of Caucasian Women Beneficiaries Age 65 or Older With At Least One Medicare-Paid Mammogram in 1992 or 1993



Percentage of African American Women Beneficiaries Age 65 or Older With At Least One Medicare-Paid Mammogram in 1992 or 1993



Source: **Health Care Financing Administration (HCFA),** administrative claims data files, January 1, 1992 – December 31, 1993. See page 4 for notes.

MAMMOGRAPHY SERVICES PAID BY MEDICARE
State Rates (%) for Elderly Medicare Women by Race in 1992 or 1993

State	All	Caucasian	African American	State	All	Caucasian	African American
Alabama	37	39	25	Nebraska	33	33	30
Alaska	40	43	38	Nevada	36	37	31
Arizona	45	45	37	New Hampshire	42	42	38
Arkansas	32	34	16	New Jersey	31	31	27
California	42	43	31	New Mexico	35	35	27
Colorado	39	39	32	New York	35	36	30
Connecticut	40	40	36	North Carolina	37	39	27
Delaware	44	45	35	North Dakota	41	41	44
D.C.	38	39	38	Ohio	35	35	33
Florida	45	46	28	Oklahoma	32	32	21
Georgia	36	38	26	Oregon	42	42	35
Hawaii	37	35	30	Pennsylvania	37	37	37
Idaho	38	38	29	Puerto Rico*	17	18	13
Illinois	33	34	26	Rhode Island	40	40	40
Indiana	33	34	25	South Carolina	37	40	26
Iowa	38	37	32	South Dakota	38	38	43
Kansas	39	39	27	Tennessee	31	33	20
Kentucky	33	33	26	Texas	32	33	20
Louisiana	31	33	23	Utah	37	37	33
Maine	45	45	42	Vermont	42	42	41
Maryland	42	43	37	Virginia	37	38	29
Massachusetts	42	42	44	Washington	44	44	36
Michigan	47	47	42	West Virginia	35	35	28
Minnesota	40	40	35	Wisconsin	37	37	36
Mississippi	29	33	17	Wyoming	37	36	41
Missouri	33	34	28				
Montana	39	39	34	**US Total**	**37**	**38**	**28**

National Rates for Elderly Medicare Women by Age and Race in 1992 or 1993

	Number of Women Having Mammography	Number of Non-HMO Part B Enrollees	Medicare-Paid Mammography Rate (%)
All Women	5,569,463	14,907,870	37
65 - 69	1,730,605	3,520,992	49
70 - 74	1,817,349	4,001,577	45
75 - 79	1,185,464	3,167,832	37
80 - 84	595,477	2,253,383	26
85 or over	240,568	1,964,086	12
Caucasian Women	4,951,492	12,969,903	38
65 - 69	1,498,827	2,957,428	51
70 - 74	1,622,633	3,471,296	47
75 - 79	1,071,435	2,787,475	38
80 - 84	540,695	1,997,478	27
85 or over	217,902	1,756,226	12
African American Women	311,490	1,107,742	28
65 - 69	99,350	272,928	36
70 - 74	99,537	298,838	33
75 - 79	63,836	230,864	28
80 - 84	32,828	159,731	21
85 or over	15,939	145,381	11

Source: **Health Care Financing Administration (HCFA),** administrative claims data files, January 1, 1992 – December 31, 1993. See page 4 for notes. * Not included in national totals.

MAMMOGRAPHY SERVICES PAID BY MEDICARE

Percentage of Women Beneficiaries Age 65 or Older With At Least One Medicare-Paid Mammogram in 1992 or 1993

Key Findings

Older women face a greater risk of developing breast cancer than younger women. Yet older women do not take full advantage of the life-saving potential of mammograms to detect breast cancer early, when it may be cured. The Department of Health and Human Services (DHHS) goal for the Year 2000 is for at least 60 percent of all older women to receive a mammogram and a clinical breast exam every two years.

During the 1992 – 1993 period no state had reached the Year 2000 goal of 60 percent. Biennial rates of mammography by State ranged from 29 to 47 percent. Generally, Caucasians had higher biennial rates (range: 31 to 47 percent) than African Americans (range: 16 to 44 percent).

When applied to the approximately 18 million elderly women on Medicare who receive services in the fee-for-service sector, these percentages imply over 10 million elderly women have not received a mammogram in the past 2 years. When translated by race, these data imply approximately 9 million Caucasian women and nearly 1 million African American women did not receive this important Medicare-covered preventive service.

HCFA Data

Reflect the most current biennial data on total mammography use by Medicare women aged 65 and older who are enrolled in the Part A and Part B programs.

Are based on all mammography claims submitted by providers under Medicare Part B .

Include Caucasians, African Americans, members of all other racial groups, and persons of unknown race in the category "all".

Exclude approximately 6% of elderly women enrolled in managed care settings, such as HMOs. Managed care settings do not submit claims for individual services.

What HCFA Mammography Data Represent

The mammography rates reported here include the two types of mammograms, those that were done preventively (screening type) and those that were done because the woman had suspicious signs or symptoms of breast cancer (diagnostic type). Both types are included because the codes used to bill Medicare for mammograms are not used uniformly by all providers. Because of this variation, Medicare claims cannot reliably distinguish screening and diagnostic mammograms.

Medicare claims miss some elderly women who have had mammograms. Women who receive care in managed care settings (like HMOs), or who otherwise obtain an unbilled or free mammogram cannot be counted via Medicare claims. Free or unbilled mammograms may be provided by public and private programs administered in hospitals, clinics, mobile vans, or local organizations such as the YWCA.

The 1995 DHHS Medicare Mammography Campaign

1995 marks the first year of an ongoing HCFA commitment to improve mammography use by Medicare beneficiaries. Another major HCFA release under this initial effort is a brochure reminding women and their health care providers that mammography is a covered Medicare benefit. Numerous public, private, and consumer organizations were instrumental in the launching of this campaign.

Sources of Additional Information

HCFA has a comprehensive mammography data book that contains county and state data for the combined years 1992-1993, and for the single year 1993. The book also includes information on female Medicare beneficiaries aged 50 to 64. To obtain a copy, please contact the Statistical Information Hotline, (410) 597-3933 or the Press Office, (202) 690-6145 (media representatives only).

Source: **Health Care Financing Administration (HCFA),** administrative claims data files, January 1, 1992 – December 31, 1993.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: January 5, 1995

FROM: Bruce C. Vladeck
Administrator, Health Care Financing Administration

SUBJECT: Mammography for Medicare Beneficiaries

TO: Hillary Rodham Clinton
First Lady, White House

Chris Jennings asked me to drop you a note about Medicare's coverage of mammograms.

The Medicare benefit for screening mammography for women age 65 and older is set at one test every two years. Our interval for screening is consistent with that in the HSA and is supported by a variety of organizations including both the National Cancer Institute and the American Geriatric Society. There are no limits on the frequency of diagnostic mammograms other than the usual requirement that they be medically necessary.

Our real problem with the Medicare benefit is underuse. Our latest figures show that fewer than 30% of all elderly women on Medicare have a claim submitted for a mammogram, diagnostic or screening, in any given year. Rates for African American women and those poor enough to be eligible for Medicaid are even lower. I am enclosing a chart which summarizes the data.

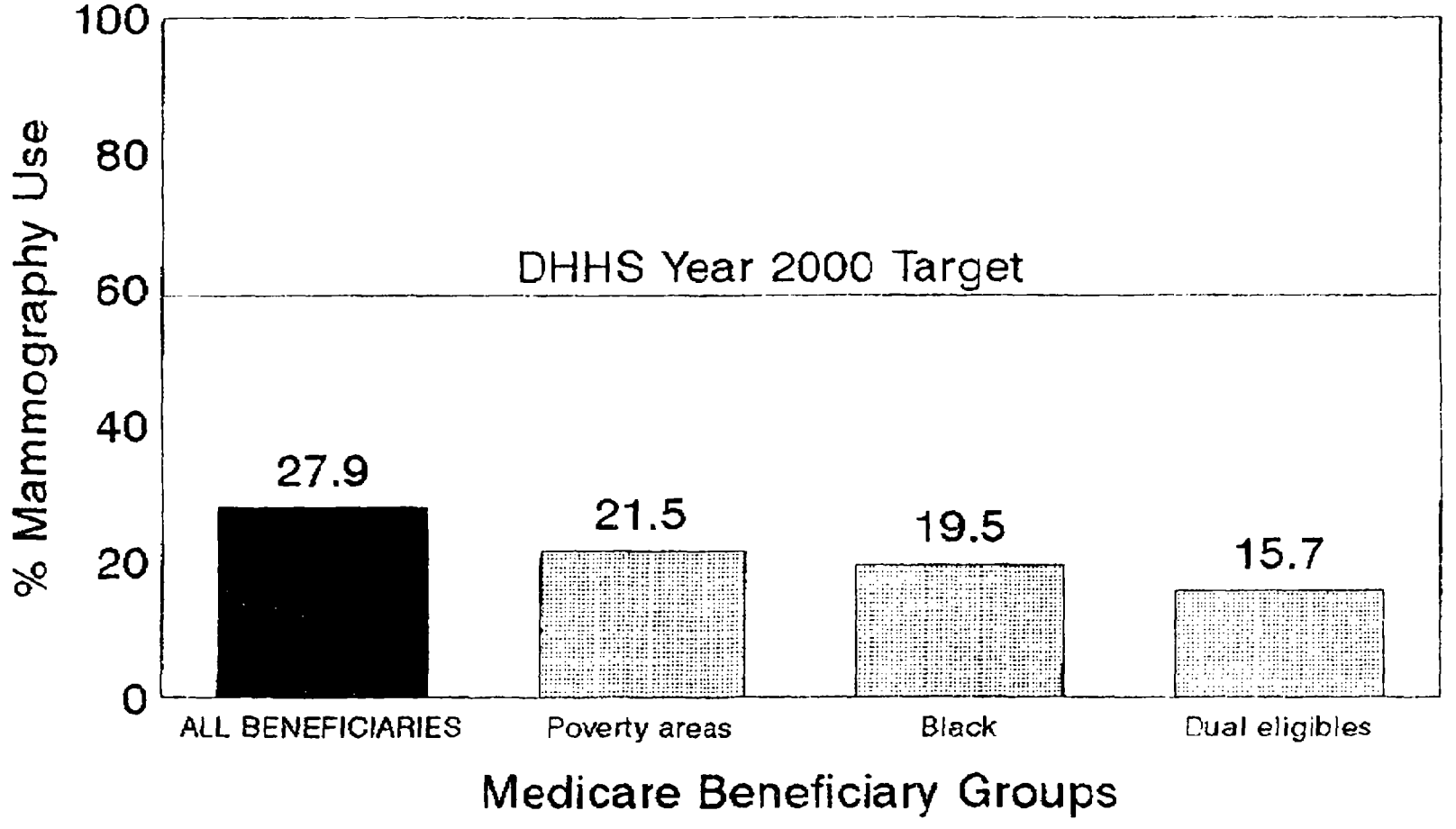
Later this spring we plan to launch a major initiative to increase the use of screening mammograms by Medicare beneficiaries. Using consumer information material prepared by the National Cancer Institute and various outside organizations, we will contact a wide variety of beneficiary groups to remind them that Medicare does pay for mammograms and that women do not outgrow the need for this test.

As part of this initiative, we will contact physicians both through professional societies and our Carriers and Intermediaries. Our aim will be to be sure that physicians serving Medicare beneficiaries are informed about the availability of the screening benefit and that they understand the importance of distinguishing between diagnostic and screening tests in the billing process. Carriers will also be reminded that properly coded diagnostic mammograms should not be denied on the basis of frequency screens intended only for screening procedures.

I am very excited about this initiative which can, if successful, make a real difference to the health of our beneficiaries. We are still in the early planning phases and would be very appreciative if you could be directly involved.

If you have any further questions, please feel free to contact me.

Annual Mammography Use By Medicare Beneficiaries: 1991 (Percent By Group)



Notes: The DHHS Year 2000 target is for women 50 years of age and over.
Dual eligibles are entitled to both Medicare and Medicaid.

Source: Medicare Part B claims and enrollment database: 199

January 17, 1995

VISIT TO THE BETH ISRAEL MEDICAL CENTER'S COMPREHENSIVE BREAST SERVICE PROGRAM

DATE:	**Wednesday, January 18**
TIME:	**10:00 am**
LOCATION:	**Beth Israel Medical Center New York, NY**
FROM:	**Liz Bowyer**

I. PURPOSE

To learn about Beth Israel Medical Center's breast cancer program, one of the most aggressive breast cancer facilities in New York, and meet with a small group of older women to discuss the importance of mammograms and the barriers that prevent women from using the Medicare mammography benefit.

II. BACKGROUND

Beth Israel Medical Center

Beth Israel is a private voluntary hospital in Manhattan, founded by Eastern European immigrants over 100 years ago to serve the Jewish community of the Lower East Side. Today, Beth Israel is one of the largest and best hospitals in New York -- it has the fourth largest admissions rate of any hospital in the nation -- with a high Medicaid and Medicare load, and a strong ethnic patient mix. Beth Israel Hospital is comprised of two acute care facilities -- a 940-bed hospital in downtown Manhattan, which you will visit; and a 240-bed hospital on the Upper East Side. The hospital also serves as a teaching hospital for the Albert Einstein College of Medicine.

The Comprehensive Breast Service at Beth Israel Medical Center

Beth Israel has one of the largest and most comprehensive breast cancer programs in the state. With over 800 breast cancer patients treated each year, Beth Israel is second only to Sloan Kettering in size. The hospital has breast service facilities on both of its hospital campuses. The downtown campus is the larger facility and offers a comprehensive range of inpatient and outpatient breast services, including surgery, mammography, clinical breast exams, education and community outreach programs. Each facility also employs a nurse coordinator, who helps patients address the emotional side of breast cancer screening and/or treatment.

A high percentage (41%) of Beth Israel's cancer patients are Medicare recipients. The

breakdown of the remaining patients is: 12% Medicaid, 20% Blue Cross; 15% HMO, 11% commercial insurance and 1% self-pay. Beth Israel's cancer patient breakdown is 57% Caucasian, including a substantial number of Russian immigrants; 16% African American, 12% Hispanic, 3% Asian and 13% unknown.

New York

In 1992 - 93, approximately 35% of all women Medicare beneficiaries in New York had at least one Medicare-paid mammogram (about average nationwide). Thirty-six percent of white Medicare recipients and 30% of black Medicare recipients used the benefit.

Patients

Your visit to Beth Israel will include two patient meetings: a private meeting with a woman who is preparing to undergo a surgical biopsy; and a discussion on the Medicare benefit with approximately 10 older women who have had a range of experiences with breast cancer and mammography (see attached descriptions and suggested follow-up questions). The discussion will be open to the press, and will also include Dr. Susan Blumenthal, Ann Trontell from HCFA, two experts on seniors issues and several members of the Beth Israel medical staff.

III. PARTICIPANTS

Meet and Greet with Hospital Administrators
-See attached list

Visit with Maria Mateo
-HRC
-Maria Mateo
-Heddy Irizarry, mother
-Dr. Burton Surik, doctor
-Dr. Natalie Strutynsky, radiologist

Discussion
-See attached list

IV. SEQUENCE OF EVENTS

-HRC arrives Beth Israel Medical Center
-HRC proceeds to meet & greet with hospital administrators (10 min.)
-HRC proceeds to visit with Maria Mateo (40 minutes)
-HRC proceeds to discussion (1 hour, 15 minutes)
-HRC departs Beth Israel Medical Center

V. PRESS

Meet & greet: Closed press
Private visit: Closed press
Discussion: Open press

VI. REMARKS

Talking points prepared by Lissa Muscatine.

January 21, 1995

MEDICARE MAMMOGRAPHY BENEFIT LISTENING SESSION
AT THE SOUTHEAST FOCAL POINT SENIOR CENTER / JOSEPH MEYERHOFF SENIOR CENTER

DATE:	**Sunday, January 22**
TIME:	**2:00 pm**
LOCATION:	**S.E. Focal Point Senior Center/Joseph Meyerhoff Senior Center Hollywood, FL**
FROM:	**Liz Bowyer**

I. PURPOSE

To participate in a listening session on the Medicare mammography benefit with a group of local older women, physicians and HHS officials, and to discuss the importance of mammography, the concerns that older women have about mammography, and the barriers that prevent them from using the Medicare benefit.

II. BACKGROUND

This event will be similar to the listening session at Beth Israel Hospital in New York, except that this session will be open entirely to the press and will include an audience of approximately 200 people, primarily local older women. The stage will be set for a discussion with you, Dr. Blumenthal, Helen Smits from HCFA, two local physicians, a seniors expert and eight local women who have had a wide range of experiences with mammography and breast cancer. The eight women were selected from the local memberships of Church Women United, the AARP, the Older Women's League and the National Council of Negro Women (descriptions attached).

The audience will include seniors and board members from the senior center where the event is taking place, and older women selected from the membership of the organizations listed above. We will provide the audience with White House folders containing four handouts on mammography, including:

- booklet on "Things to Know About Quality Mammograms"
- list of questions women ask about mammography
- fact sheet on the Medicare benefit
- information sheet with phone numbers women can call to find out where to get mammograms in Florida, how to learn more about mammograms and the Medicare benefit, etc.

The pamphlets will be on the coffee table near your seat at the discussion. You

might want to mention the pamphlets in your remarks and encourage the audience to pick up copies as they leave the event. (Pamphlets are also in your binder pocket.)

Note: The American Cancer Society is paying for the costs of the event.

Florida Statistics

- In 1993, there were 2,687 Florida women who died from breast cancer, and 27 men.

- In 1991, 9,906 Florida women were diagnosed with invasive breast cancer, 57% of whom were age 65 and over.

- In Florida, 45% of all women Medicare beneficiaries age 65 and over received at least one Medicare-paid mammogram in 1992 or 1993. Forty-six percent of all white recipients used the benefit; 28 percent of all African American recipients used the benefit.

- Of 1.1 million elderly women in Florida enrolled in fee-for-service Medicare, about 600,000 have gone more than two years without a mammogram. Approximately 40,000 elderly African American women and 540,000 elderly white women have not taken advantage of the benefit.

The Southeast Focal Point Senior Center/Joseph Meyerhoff Senior Center

The Southeast Focal Point Meyerhoff Senior Center is a federally-funded, locally-administered senior center in Broward County that provides a comprehensive range of social services to people 60 years and older. The center is financed primarily by federal funds appropriated through the Older Americans Act (OAA), a piece of Great Society legislation that serves as the primary vehicle for providing services to the nation's elderly. The center is administered by the Jewish Federation of South Broward, a private non-profit organization.

The center is one of four programs or "focal points" in Broward County designated by the Area Agency on Aging to receive federal funds. Each "focal point" provides a continuum of community-based services -- including meals and nutrition services, transportation, adult day care, preventive health programs and screenings, counseling and support groups and social activities -- aimed at helping older people stay in their own homes and communities, instead of institutions, for as long as possible. In addition to funding through the Older Americans Act, the center also receives state and local funds and private funds from the Jewish Federation.

The Southeast Focal Point Meyerhoff Center provides services to approximately 3,000 seniors in southeast Broward County every year. Programs under the Older Americans Act are not means-tested, so there are no requirements for participation except that beneficiaries must be 60 years and older. The core of the center's services

is its meals program -- each day, the center serves a kosher lunch to approximately 150 - 175 seniors, along with home-delivered meals. The center's dining/multipurpose room will be the site of the mammography listening session.

"Contract with America"

The Republican's Personal Responsibility Act would repeal the congregate and home-delivered meals provisions of the Older Americans Act, along with other federal nutrition programs like Food Stamps and School Lunch, and replace them with a new Food Assistance Block grant program to the states administered by the USDA. The block grant funds could only be used to provide food assistance to the economically disadvantaged.

This issue is of great concern to the local Area Agency on Aging officials in Broward County, and to many seniors who participate in the Focal Point Meyerhoff Center's meals program.

III. PARTICIPANTS

Stage Participants
-HRC
-Susan Blumenthal
-Helen Smits
-Dr. Fleur Sack, Chief of the Department of Family Practice, Baptist Hospital of Miami
-Dr. Glenda Huston, University of Miami, Family Practice
-Alice von Suskil, American Cancer Society, senior expert
-Eight women Medicare beneficiaries (see attached list)

IV. SEQUENCE OF EVENTS

- HRC arrives and proceeds to hold (5 minutes)
- HRC proceeds to community room for Discussion
- HRC delivers remarks and opens discussion with participants on stage
- If time permits, HRC has option to take questions from the audience and the press
- Program closes and HRC exits stage left, working ropeline on departure
- HRC proceeds to anteroom to film HHS video news release

V. PRESS

Open press.

VI. REMARKS

Prepared by Lissa Muscatine.

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DOCUMENT NO. AND TYPE	SUBJECT/TITLE	DATE	RESTRICTION
001. bios	Stage Participants (2 pages)	01/21/1995	b(6)

COLLECTION:
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Jennifer Klein
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FOLDER TITLE:
[Mammography] Campaign

2014-0536-S
kc1559

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

P1 National Security Classified Information [(a)(1) of the PRA]
P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
P3 Release would violate a Federal statute [(a)(3) of the PRA]
P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [a)(5) of the PRA]
P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

C. Closed in accordance with restrictions contained in donor's deed of gift.
PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).
RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

b(1) National security classified information [(b)(1) of the FOIA]
b(2) Release would disclose internal personnel rules and practices of an agency [(b)(2) of the FOIA]
b(3) Release would violate a Federal statute [(b)(3) of the FOIA]
b(4) Release would disclose trade secrets or confidential or financial information [(b)(4) of the FOIA]
b(6) Release would constitute a clearly unwarranted invasion of personal privacy [(b)(6) of the FOIA]
b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

January 25, 1995

MEDICARE MAMMOGRAPHY BENEFIT LISTENING SESSION AT KIMBALL SENIOR CENTER

DATE:	**Thursday, January 26**
TIME:	**1:00 pm**
LOCATION:	**Kimball Senior Center**
	National City, CA
FROM:	**Liz Bowyer**

I. PURPOSE

To participate in a listening session on the Medicare mammography benefit with a group of local older women, physicians and HHS officials, and discuss the importance of mammography, the concerns that older women have about mammography, and the barriers that prevent them from using the Medicare benefit.

II. BACKGROUND

This event will be similar to the listening session in Florida, except that this session will have a more diverse panel and a smaller, more diverse audience. The stage will be set for a discussion with you, Dr. Blumenthal, Dr. Smits, two surgeons, a general internist, a seniors expert and seven local women who have had a wide range of experiences with mammography and breast cancer. The women were selected from the memberships of eight local organizations (list and descriptions attached).

The audience of approximately 120 will include seniors from the Kimball Senior Center and the eight local organizations. We will provide the audience with pamphlets on mammography and Medicare, translated into Spanish and with California-specific information (copies in binder pocket).

Note: The Susan Komen Breast Cancer Foundation is paying for the event. Darice Caswell, president of the San Diego Komen chapter, will be seated in the front row.

<u>California Statistics</u>

- In California, 42% of all women beneficiaries age 65 and older had at least one Medicare-paid mammogram in 1992 or 1993. Forty-three percent of all white women beneficiaries and 31% of all black beneficiaries used the Medicare benefit.

- There are approximately 2.1 million eligible female Medicare beneficiaries in California. Of the 1.8 million elderly women in California in fee-for-service Medicare, it is estimated that over one million have gone more than two years without a mammogram. Approximately 900,000 elderly white women and 60,000 elderly black women have not taken advantage of the Medicare benefit.

- In San Diego County, there are 177,080 eligible female Medicare beneficiaries. Of those, approximately 76,490 or 43% enrolled in HMOs.

- Approximately 650,000 (31%) of the total female Medicare beneficiaries in California are enrolled in a managed care plan. (Medicare beneficiaries enrolled in managed care plans are entitled to the same benefits as Medicare fee-for-service beneficiaries. At this time, there is no data to demonstrate the number of women who receive mammograms in managed care plans. However, starting this year, HCFA has asked that managed care plans voluntarily collect and report information regarding the use of mammogram services by their Medicare enrollees).

- According to the Centers for Disease Control, 19,966 women in California died of breast cancer from 1988 - 1991. In 1995, an estimated 5,010 women will die of breast cancer, and 20,105 new cases of breast cancer will be diagnosed in California women.

Kimball Senior Center

The Kimball Senior Center is an adult recreation center located in National City, an ethnically diverse, lower-income community just outside San Diego. Each week, the center offers recreation programs and classes, health prevention programs and referral services to approximately 700 - 1000 seniors ages 55 and older. Generally, the Kimball Center reflects the diverse population of National City, which is comprised of approximately 50% Hispanics, 16 % Asians, and 8% African Americans. The center was built in 1987 with Community Development Block Grant funds, and is now completely funded and operated by the city.

The Kimball Senior Center is located next to a federal nutrition site funded by the Older Americans Act, and two elderly housing units subsidized by HUD. The center is located in Kimball Park, the site of a Clinton campaign rally in August 1992. Congressman Filner suggested the Kimball Center for this event; he has used the site periodically for constituent meetings, including a health care forum last year.

Note: The Kimball Center holds an annual health fair for seniors in conjunction with local hospitals. On several occasions, the center has offered $5 mammograms as part of the health fair. While the center has no immediate plans to offer the mammograms again, administrators say they might be willing to do so in the future.

III. PARTICIPANTS

Onstage
-HRC
-Dr. Susan Blumenthal
-Dr. Helen Smits
-Helen Beebe (bee-bee), American Cancer Society, senior expert
-Dr. Margaret McCracken, general internist
-Dr. Dava Gerard, surgeon
-Dr. Sheryl Cramer, surgeon
-7 local women

IV. SEQUENCE OF EVENTS

- HRC arrives, proceeds to hold/briefing
- HRC proceeds to stage for panel discussion
- HRC delivers remarks and begins open discussion with participants on stage
- Option of taking questions from audience
- HRC departs stage and works ropeline upon departure

V. PRESS

Open press.

VI. REMARKS

Talking points provided by Lissa Muscatine.

FIRST LADY HILLARY RODHAM CLINTON
MAMMOGRAM ROUNDTABLE
KIMBALL SENIOR CENTER
NATIONAL CITY, FLORIDA
JANUARY 26, 1995

TALKING POINTS

INTRODUCTION

* Nearly every family in America is touched at one time or another by breast cancer. We all know someone -- a grandmother, mother, sister, aunt, daughter, niece or, in my case, a mother-in-law -- who has suffered or is suffering from the disease.

* The numbers are shocking: about 1 in 8 women in this country will contract breast cancer during her lifetime. The rates are getting higher every year. And older women are the most vulnerable because the chances of getting breast cancer increase with age.

* While these numbers are distressing, it is equally distressing that many older women who are eligible for breast cancer screenings don't take advantage of them.

* Medicare covers regular screenings for women over 65 and diagnostic screenings whenever a doctor thinks it is medically appropriate. Yet nearly two-thirds of women eligible under Medicare don't get mammograms. Many women don't get mammograms because they think they are safe until a problem arises. In other cases, women don't get screened because their doctors never recommend it. Some women are afraid of mammograms, or embarrassed at the idea of having a breast screening. In fact, mammograms are safe and those administering them are trained professionals.

* Over the past 2 years, many older women have conveyed their concerns about breast cancer to me. Their anxieties and problems in dealing with the disease prompted me to learn more about programs that might help. Through officials at the Department of Health and Human Services, I learned that too few older women were taking advantage of the Medicare mammography benefit. I hope that my visit to Beth Israel today will help raise awareness about

this issue.

THE MEDICARE BENEFIT FOR BREAST SCREENINGS IS AN EXAMPLE OF GOVERNMENT WORKING FOR YOU

* The whole point of government is to make it work for people. Medicare coverage for breast screenings is one of a number of ways the federal government is involved in the fight against breast cancer. Along with research at NIH and other agencies, this program offers a direct benefit to a segment of the population at high risk for a deadly disease.

WE HAVE A PROGRAM IN PLACE THAT CAN SAVE LIVES

* We have a program in place. We have a program that can save lives. Now we have to make sure that patients, doctors, and all health care providers are aware of the importance of regular mammograms, particularly for older women.

THIS PROGRAM IS AN EXAMPLE OF HOW PREVENTIVE CARE WORKS

* Over the last two years, we talked a lot about preventive care as part of health care reform. This is a perfect example of how a small investment today can pay off down the road. A mammogram is much less costly -- in dollars and emotions -- than surgery or serious illness. By taking advantage of this Medicare benefit, thousands of older women cannot only be given the hope of life, they can be given a higher quality of life. It's a win-win-win situation -- for patients, providers, and for all of us collectively who prosper from living in a healthier society.

###

MEMORANDUM

Date: April 9, 1996

To: Barbara Wooley

From: Nancy Chupp

Re: CWU contacts for the Mammogram Awareness Campaign

Greetings! I called all CWU contacts today and was able to reach five out of seven of them. When talking to them I continually stressed that think of activities which directly resulted from your campaign. Below is a summary of these calls:

1. Lillian Anderson - Ft. Lauderdale, FL
   Nothing new to report for her personally or for her local CWU unit.

2. Madie Scales - Lakeland, FL
   No answer

3. Zennie Cummins - Pomona, CA
   No answer Jennifer Castellan

4. Dorothy Bjornson - Rock Island, IL
   She says she has been talking to lots of people she knows about the importance of mammograms. She and Clara Calwell organized a program on mammogram awareness and the White House campaign for their local AAUW chapter. Twenty one women came (in 18 below 0 degree weather!) She has another awareness program scheduled for October to the Augustana College Endowment Society, a society of all women, many of whom are over 60.

5. Clara Calwell - Rock Island, IL
   She "tells everyone she meets!" She says she constantly brings it up both to people she knows and people she doesn't. She is amazed at how many people do not know Medicare covers mammograms and frequently is the one to educate them about it. She is also surprised how many times Medicare mistakenly charges women for mammograms. Along with Dorothy Bjornson she organized the forum for the AAUW chapter on this topic.

   Clara has been a long time supporter of the Cancer Society but gained more steam from the White Houses efforts and in the last year, she has agreed to take a fund raising role for the Society. Whenever she speaks at Society sponsored events she raises the mammogram issue to both men and women. With men, she tells them to tell their wives,

mothers, and sisters about the Medicare coverage. She also does a lot of fund raising by phone for the Cancer Society in her new role. Even if people make pledges or not, she always ends her conversation with, "Before you hang up, I want to remind you to get your mammogram."

6. Dorothy Mason - Chicago, IL
Before the White House Awareness Campaign Dorothy had had only one mammogram (5-6 years ago). It was painful enough that she was scared to go back. The First Lady's challenge that "we have to take charge of our own lives," convinced her to make an appointment. She has since had her second mammogram.

7. Mary Crisman - Binton, IA
Mary has set up a forum at the church to do awareness on this issue. As part of the educational forum they had a worship service appreciating the people who had been involved in the awareness campaign. They also brought in a women from the Red Cross to do demonstrations on self exams and explain the importance. Mary took photos of the IA event with the First Lady and takes her photo book everywhere. She took it to the CWU regional event in Wisconsin where 200 women attended and used it as a conversation starter on the topic. At this regional event, many participants wrote letters to their congressmembers, particularly to Senator Harkin, thanking him for his support for women's health and for supporting funding for mammograms.

Hope this is helpful. I will call any additional information I receive in to you before Thursday.

AMERICAN CANCER SOCIETY® DISTRICT OF COLUMBIA DIVISION, INC.

April 9, 1996

Memorandum

TO : Karrie Wilson, National Vice President
Government Relations

FROM : Lisa Burris
Director, Medical Affairs &
Assistant Executive Vice President
D.C. Division, Inc.

RE : Issue of Medicare Coverage for Mammograms

Here are examples of how the District of Columbia Division is highlighting the issue of the Medicare Benefit for mammograms.

Maggie Williams is the D.C. Division Reach to Recovery Volunteer who participated last year in the panel session with the First Lady, Hillary Clinton, on the issue of Medicare coverage for mammograms. She remains dedicated to our mission in the fight against breast cancer.

Since that time, the D.C. Division's Breast Cancer Detection Team has conducted a 1995 Survey of Primary Care Physicians on Breast Cancer Early Detection Attitudes and Behaviors and subsequent physician focus group. The purpose of the study was to learn what physicians believe would motivate more women to go for mammograms or participate in other early detection screening practices for breast cancer. The Medicare reimbursement provision was discussed at length by physician focus group members.

Community based programs on the early detection of breast cancer are conducted at local senior citizen centers. Information is provided on the Medicare covered benefit for obtaining mammograms.

The District of Columbia Division's Making Strides Against Breast Cancer Fundraising Event will be held on Saturday, September 28, 1996 and will spotlight the issue of mammogram coverage by Medicare in this public forum. Participants can walk, jog, or stroll along the five mile course to celebrate the strides we have already made against breast cancer and re-dedicate ourselves to the strides we have yet to make.

Thank you.

For Barbara Woolley

Sola Lett attended the Town Hall Meeting in Hollywood, Florida in January, 1995 and heard the testimonies by the panelists about the barriers to breast cancer screening for older women. Since the event she has made a commitment to reach older women in Florida, especially those at highest risk, with information and education about screening.

During 1995, she participated in various organizations on both the State level in Florida, and in the community in which she lives, Pensacola, Florida.

As the leader of Health Advocacy Services volunteers in Florida, she participates on the Breast and Cervical Cancer Coalition sponsored by the Florida Medical Quality Assurance and the State Health Department. She also serves on the Breast Cancer Initiative Work Group of the Florida Division of the American Cancer Society.

Because of her work in Florida, she was invited by the University of South Florida College of Public Health and the Florida Medical Quality Assurance to participate on the Mammography Awareness Team which targets older women in churches in minority communities in the Tampa area.

In Pensacola, she serves as Chair of the Breast Cancer Initiative for the Pensacola unit of the American Cancer Society, and also chairs the Minority Involvement Committee of Pensacola Unit.

On the national level, she served on the Work Group that developed the training materials for AARP's National Breast Care Campaign.

In addition to her individual efforts to promote breast cancer screening, she directs the work of 15 local volunteers in the state of Florida. These volunteers conducted more than 60 presentations, health fairs and screenings that reached almost 6,000 older persons with information about the importance of breast cancer screening.

M E M O R A N D U M

To: Jennifer Klein

From: Karen Guss

Date: August 31, 1995

Re: Medicare HMO Report Cards

I think the quality report card is a great idea because it gives consumers more information. In U.S. Healthcare's version the information is helpful and not misleading because it is presented as a percentage of people obtaining the service rather than as some sort of quality indicator the HMO makes up itself. Of course, there would always the concern that an HMO producing its own quality report card would give into the temptation to exaggerate its performance.

HCFA could be an honest broker, but it does not now have a quality report card initiative in place. Although HCFA is interested in the idea, it does not yet have the capability to compile a report card that compares all of the HMOs in the industry to one another. I was told that the person at HCFA who knows the most about HCFA's work in this area is Gary Bailey, a member of HCFA's Beneficiary Access and Education Team. He has been out of the office on vacation (along with everyone else in the Administration besides the two of us) but he can normally be reached at 410 786-4297.

US HEALTHCARE®

What do you think of what U.S. Health care is doing? Let me know.
Ann Marie Hummel
401 7438 fax
410 786 3194
Jen

July 10, 1995

Jennifer Klein
The White House
Second Floor, West Wing
Washington, DC 20500

Re: Mammography Screening for Medicare Enrollees

Dear Jennifer:

Enclosed is some information regarding the work done at U.S. Healthcare to measure and report the results of programs which encourage screening for breast cancer among women enrolled in our Medicare program. We provided this information in the form of a "Medicare Quality Report Card" for the first time last year (see enclosed). We have recently issued our second report card so that results are now reported for 1993 and 1994. Each reports a percentage of women who received mammographic screening in the previous two years.

Also enclosed is an article, co-authored by three of our physicians, which discusses the importance of mammography screening and an article which reports on a breast examination training program for primary care physicians in the U.S. Healthcare network.

I hope that this information will give you and others a sense of the work that we have done in the area of mammography screening and breast cancer awareness, and our ability to measure results. I would appreciate hearing from you after you have had a chance to review the enclosed materials. As we discussed, a meeting would seem to be an appropriate next step.

Very truly yours,

Dennis Oakes
(215) 654-5964

Enclosures

i\gr\95oakes\fed\klein.doc

Karen -
Is HCFA doing anything with a "quality report card"? If not, what do they think of this?

CORPORATE HEADQUARTERS
980 JOLLY ROAD □ P.O. BOX 1109 □ BLUE BELL, PA 19422 □ (215) 628-4800 □ FAX (215) 283-6858

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Number 4 January 27, 1995

USQA® Report — a quality measurement report for U.S. Healthcare®

U. S. Healthcare® Develops Quality Report Card for its Medicare Enrollees

In order to demonstrate its commitment to quality, and care for Medicare enrollees, U.S. Healthcare® has developed the Medicare Quality Report Card. The Report Card was developed by U.S. Quality Algorithms®, Inc. (USQA), a leader in the development of methodologies to measure and improve the performance of the health care delivery system. It took the lead in enabling U.S. Healthcare to produce the first Quality Report Card to meet HEDIS 2.0 (Health Plan Employer Data and Information Set Version 2.0) specifications for its HMO•PA® (Southeastern Pennsylvania Region) health plan reporting on calendar year 1992. USQA has used similar methods in its recent development of the indicators in the Medicare Quality Report Card.

The USQA Medicare Quality Report Card is divided into several sections including quality of care measures and access and satisfaction measures. The quality of care measures have been chosen based on process and outcome measures of care that are important to Medicare enrollees.

The first group of measures relate to preventive services. The influenza vaccine is recommended for all members

1993 Medicare Quality Report Card — HMO•PA®

	Quality of Care Measure	Description	Result
	PREVENTIVE SERVICES		
1	**Influenza Vaccination Rate**	members age 65 or older receiving an influenza vaccine based on patient's self-report	63.2% *
2	**Mammography Screening Every Two Years (65-75 age)**	women age 65-75 who received a mammogram in calendar years 1992 or 1993	72.1% *
3	**Biennial Eye Examination**	members receiving an eye exam in previous 2 years	63.6%
	ACUTE and CHRONIC DISEASE		
4	**Diabetics Receiving Hemoglobin $A1_C$ Test**	members with diabetes who received an annual glycated hemoglobin test	50.3%
5	**Survival to Discharge for Patients Admitted with an Acute Myocardial Infarction**	members discharged alive after admission for an acute myocardial infarction (not treated by PTCA or CABG)	89.8%
6	**Chronic Obstructive Pulmonary Disease (COPD)**		
	a. COPD Admission Rate	members hospitalized with COPD	0.62%
	b. COPD Readmission Rate	members admitted more than once for COPD	0.09%
	c. COPD Readmission Rate Ratio	ratio of members admitted more than once for COPD compared to members admitted only once	.149
7	**Congestive Heart Failure (CHF)**		
	a. CHF Admission Rate	members hospitalized with CHF	1.29%
	b. CHF Readmission Rate	members admitted more than once for CHF	0.28%
	c. CHF Readmission Rate Ratio	ratio of members admitted more than once for CHF compared to members admitted only once	.215
	MENTAL HEALTH		
8	**Ambulatory Follow-up after Hospitalization for Depression**	Ambulatory follow-up of members within 30 days of discharge after a hospitalization for depression	81.5%
	MEMBER ACCESS and SATISFACTION		
9	**Member Access**	members who visited a USHC participating provider	95.9%
10	**Satisfaction Measures**		
	a. Overall Medical Care	response of good or better to survey question concerning "overall medical care"	98.5%
	b. Primary Care Physician	responded that would recommend their primary care physician to a family member	96.7%
	c. U.S. Healthcare	responded that would recommend U.S. Healthcare to a family member	99.0%

* Exceeds *Healthy People 2000* goal of 60%

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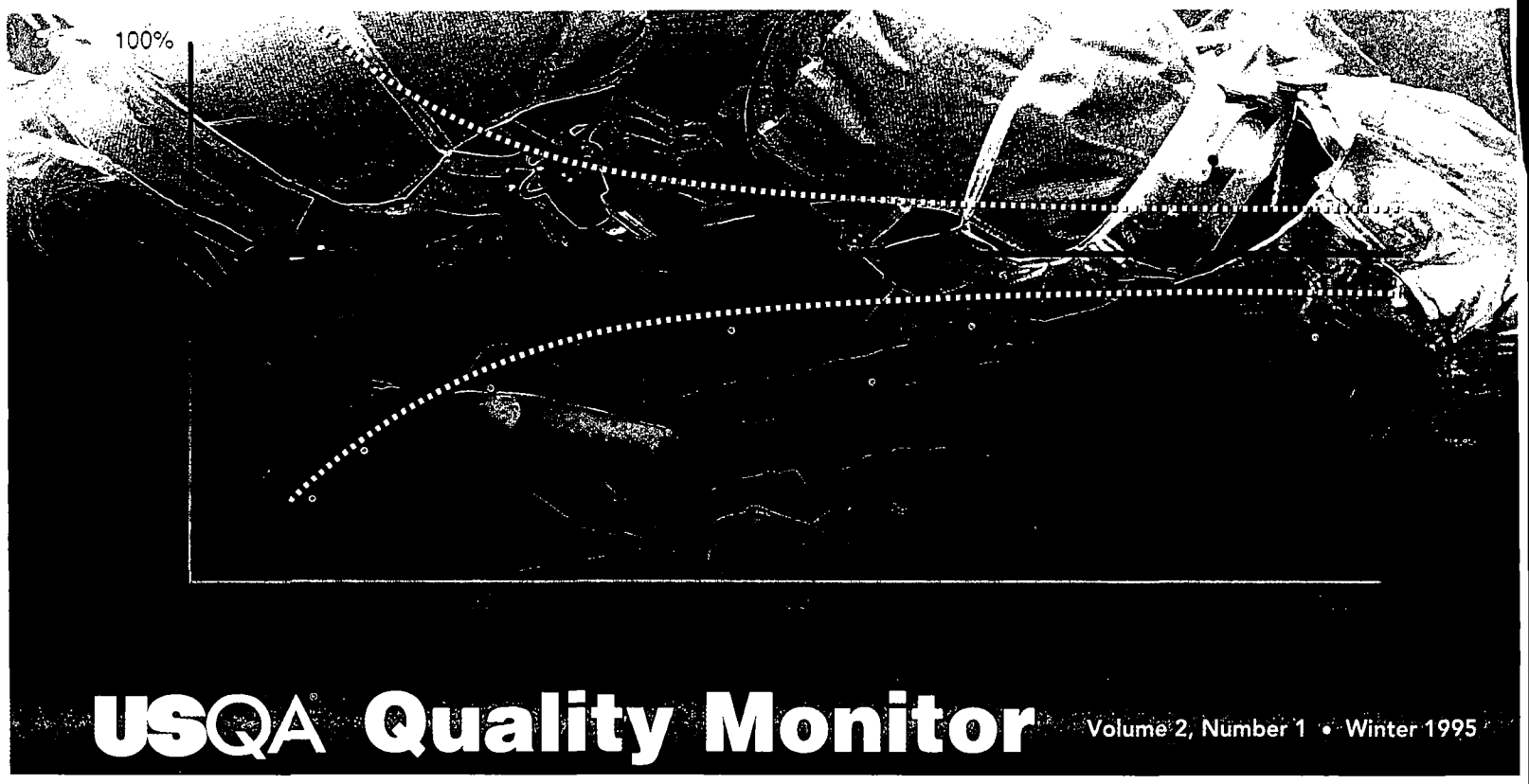

USQA Quality Monitor

Volume 2, Number 1 • Winter 1995

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Number 6 April 21, 1995

USQA Report a quality measurement report for U.S. Healthcare®

Evaluation of U.S. Healthcare Check™ Clinical Breast Exam Education Program for Physicians

Background

Breast cancer is the most prevalent cancer in women. The benefits of early detection through mammography screening, clinical breast examination, and patients' breast self-examination are well-documented. U.S. Healthcare initiated its breast cancer screening program, U.S. Healthcare Check™, in 1987 to encourage early detection of breast cancer to reduce the morbidity and mortality from breast cancer in its members. The breast cancer screening program consists of several components, which are listed in figure 1.

figure 1

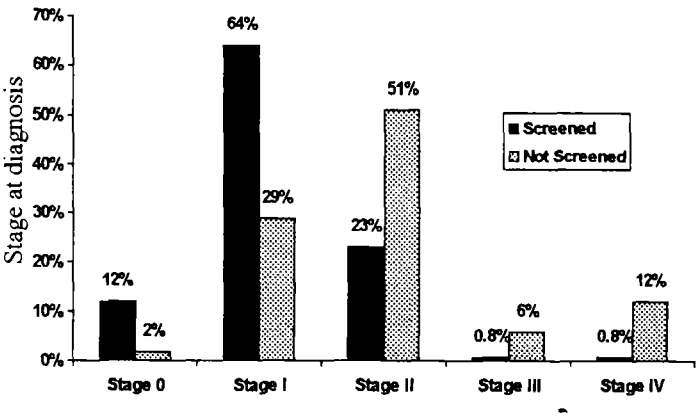
Program Components

- Fully covered mammography screening to all age-eligible members
- Risk assessment of all U.S. Healthcare female members 40 and over
- Certification program for participating radiologists to perform mammography – ACR accreditation and FDA certification
- Educational material for members
- Educational materials for U.S. Healthcare Primary Care Physicians including a continuing education course developed jointly with Fox Chase Cancer Center
- Instructional course on clinical breast examination with the use of silicone breast models
- Tracking and follow-up of abnormal mammograms
- Prompt notification of results to physician and participant
- Case management of members with newly diagnosed breast cancer

Previous research performed by USQA and U.S. Healthcare has demonstrated improved outcomes in women who have participated in our mammography screening program.

figure 2

Stage of disease by screening status



For women diagnosed with breast cancer in 1989 and 1990, there was a significant down-staging of breast cancer at the time of diagnosis for women participating in the screening program as compared to those who did not participate. Only 1 percent of the breast cancers detected in screened women were found at clinical stages III and IV versus 6 percent (Stage III) and 12 percent (Stage IV) in unscreened women (figure 2, Solin et al, Breast Disease, 1995). In addition, this down-staging had a demonstrated impact on the eligibility of breast-conserving surgery (88 percent versus 60 percent) in screened versus unscreened women. This eligibility further led to increased use of breast conservation surgery and definitive irradiation in those who participated in screening (44 percent versus 37 percent).

Clinical Breast Examination Training Program

In 1992, U.S. Healthcare began an office-based clinical breast examination training program for Primary Care Physicians in Southeastern Pennsylvania, Southern New Jersey, and Delaware. Hester Bloom, an educator from U.S. Healthcare's Health Education Department, visits physicians in their offices to conduct the program. During the visit, the following screening recommendations of the American Cancer Society are reviewed.

① Monthly breast self-exam (BSE) by female patients 20 and older

② Annual clinical breast examination by the physician: age 20-39– at least every three years; age 40 and over– annually

③ Periodic mammography: age 40-49– every 1 or 2 years, dependent on risk; age 50 and older– every year.

A major component of the one-hour training session is the review of the clinical breast exam by the use of the MammaCare® method, which uses lump-bearing silicone breast models as demonstration and instructional tools. This method involves 45 minutes of hands-on,

(continued on page 2)

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ORIGINAL INVESTIGATION

The Importance of Mammographic Screening Relative to the Treatment of Women With Carcinoma of the Breast

Lawrence J. Solin, MD; Antonio Legorreta, MD, MPH; Delray J. Schultz, PhD; Steven Zatz, MD; Robert L. Goodman, MD

Background: The use of mammographic screening for the early detection of breast cancer has been shown to reduce the mortality from breast cancer. However, the impact of mammographic screening relative to the local treatment of the breast (ie, breast-conservation treatment vs mastectomy) is not well established.

Methods: An analysis was performed of 206 newly diagnosed and treated breast cancers in 201 women identified in 1989 from a health maintenance organization (US Healthcare, Blue Bell, Pa). The 206 breast cancers were evaluated for eligibility for and actual local treatment of the breast with breast-conserving surgery and definitive breast irradiation as a function of mammographic screening for the early detection of breast cancer.

Results: Eligibility for local treatment of the breast with breast-conserving surgery and definitive breast irradiation was significantly increased for the breast cancers detected in women who had undergone mammographic screening compared with the breast cancers detected in women who had not undergone mammographic screening (88% vs 60%, respectively; $P<.0001$). For the breast cancers that were eligible on chart review for treatment with breast-conserving surgery and definitive breast irradiation, there was no significant difference in the actual local treatment of the breast with breast-conserving surgery and definitive breast irradiation for the eligible breast cancers detected in women who had undergone mammographic screening compared with the eligible breast cancers detected in women who had not undergone mammographic screening (44% vs 37%, respectively; $P=.40$); however, there was a statistically significant difference for the subgroup of women aged 50 years or more (49% vs 21%, respectively; $P=.016$).

Conclusions: These results show that breast cancers detected in women who had undergone mammographic screening were more likely to be eligible for breast-conserving surgery and definitive breast irradiation compared with breast cancers detected in women who had not undergone mammographic screening. For women aged 50 years or more, there was a significant increase in the use of breast-conserving surgery and definitive breast irradiation for eligible breast cancers detected in women who had undergone mammographic screening compared with eligible breast cancers detected in women who had not undergone mammographic screening.

(Arch Intern Med. 1994;154:745-752)

From the Department of Radiation Oncology, University of Pennsylvania School of Medicine, Philadelphia (Dr Solin); US Healthcare, Blue Bell, Pa (Drs Legorreta, Zatz, and Goodman); and Department of Mathematics, Millersville (Pa) University, and University of Pennsylvania Cancer Center, Philadelphia (Dr Schultz).

THE USE OF mammographic screening for the early detection of carcinoma of the breast has two potential benefits: (1) a reduction in breast cancer mortality from earlier detection and (2) an increased potential for breast-conservation treatment because of the increased detection of smaller and earlier-staged carcinomas.[1-4] The first benefit from the use of mammographic screening, a reduction in breast cancer mortality, has been well established in multiple prospective, randomized trials. However, studies of mammographic screening programs have typically reported outcome in terms of survival, not local treatment of the breast. Therefore, the second potential benefit from the use of mammographic screening, an increase in the potential for breast-conservation treatment instead of mastectomy, has not been well studied.

See Patients and Methods on next page

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