



Cancer Detection Programs:  
Every Woman Counts

## California Breast and Cervical Cancer Advisory Council Meeting (Teleconference)

1616 Capitol Avenue, Building 174, 4th Floor – Room 74.463 (Kings River Room)  
Sacramento, CA 95814

### MINUTES November 8, 2007 3:00 p.m. to 5:00 p.m.

#### **Members Present:**

Bloom, Joan  
Cordeiro, Janna  
Howell, Lydia  
Policar, Michael

Robinson, Sandra  
Rodriguez, Beverly Diane  
Wagman, Larry

#### **Members Absent:**

Brooks, Sally West  
Carr, Diane  
Gruder, Larry  
Kavanaugh-Lynch, Marion

Mills, Claire  
Shinagawa, Susan  
Somkin, Carol

#### **CDPH Staff Present:**

Bullock, Jean  
DeLeon, Josephine  
Fox, Serra  
Kohatsu, Neal

Lyman, Donald  
Pellegrini, Deborah  
Shimizu, Robin  
Smalley, Sherie

#### **Welcome and Roll Call**

Membership introduction was taken followed by Larry Wagman, BCCAC Chair, calling the teleconference to order at 3:00 p.m. This “urgent” teleconference was in lieu of the regularly scheduled, but cancelled Council meeting. The floor was turned over to Sherie Smalley, Chief of CDS, for presentation of the agenda and items for discussion.

#### **Report by Department of Public Health**

Sherie Smalley presented agenda issues, options, and explained handout materials.

**Problems Identified** - For Fiscal Year 2007/08 and 2008/09 there are financial pressures because there is no viable mechanism to increase funding, while there are increased numbers of women (caseload) seeking services. As shown on a graphic handout provided, and explained by Sherie Smalley, caseload has been increasing 8% per year. In 2006/07 an estimated 20% of those eligible for breast cancer screening were served and less than 10% were screened for cervical cancer. This year liquid based pap and HPV tests are being implemented and digital mammography will significantly increase costs.

**Options Provided** - To stay within budget, services must be limited or the budget increased. Any strategy to increase the budget cannot be done in a timely manner,

and may not keep up with continuing increases in expenses. The present budget's inability to pay for all the services projected could result in closing doors in late February/early March if a decision is deferred too long.

**Alternatives Presented** – The following five alternatives were outlined:

1. No new women enrolled from January to June 30, 2008 with continuing care for women already enrolled.
2. Limiting breast cancer screening services to those 50 years and older.
3. Changing from 200% to 135% or 100% of the federal poverty level.
4. Changing guidelines for screening intervals from 12 to 18 months.
5. Reducing cervical services.

### **Council and CDPH Discussion**

Following a review and discussion of the outlined alternatives, Sherie Smalley explained that in the absence of increased funding, the Advisory Council would be asked to make a recommendation.

**Alternative No. 1:** No new women enrolled from January to June 30, 2008, only continuing care for women already enrolled. (Point of clarification – This means everyone who is enrolled will be served, regardless of age group.) Discussion included:

- o The issue of enrollment, which generally occurs the same day a woman enters a provider's office or community clinic. Usually, if she has no third party insurance and is determined eligible for EWC, she is enrolled that day, she receives a breast exam, and a mammogram is requisitioned. That woman is then considered an enrolled member for the 12 months following that day.
- o The last enrollment date under this option would be on or about 12/31/07.
- o Any current enrollee should be able to be re-screened within 18 months, and 6 months is a reasonable delay period, depending on the long-term plan.
- o What will happen when EWC money is unavailable? For new patients during the January to June period, Michael Policar pointed out that women generally will either go to a county clinic, where other funding sources may be available (sometimes with a sliding scale share of cost), or a woman will go to a private practitioner thus limiting her choice to paying the entire amount out-of-pocket.
- o Establishing a definitive diagnosis is necessary for that subset of women in the middle of a work-up, so they remain "in the loop" of continuing services.
- o To improve the Council members comfort level in decision making it would be helpful to know how many women go to county clinics versus how many visit private practitioners.

**ACTION ITEM: CDPH staff to provide Council members with data showing the numbers of EWC patients visiting private practices versus county or community-based clinics.**

- o **Alternative No. 2:** Limiting breast cancer screening services to those 50 years and older. Discussion included:

- If we currently eliminate women aged 40-49, per Sherie Smalley, there would not be a money shortage this fiscal year. But, there would not be enough savings to implement digital mammography.
- Joan Bloom pointed out that approximately 25% of the breast cancers diagnosed occur in women under the age of 50.
- Current guidelines of some organizations for baseline mammograms have moved downward from age 50 to 40 and consideration is being given to screening younger women.
- The use of breast cancer risk assessment models (those that include racial and ethnic groups representative of the EWC population) were suggested for determining the appropriateness of limiting services.
- Larry Wagman raised the possibility, that since CDC guidelines require 75% of those women screened should be over age 50, and we are now screening at 50/50, there be an exclusion (by time or by number) so that the metric of 75% may be met.
- Per Larry Wagman, if it is possible to differentiate women 40-49 and 50+, by first assessing risk, and next, define what level of risk is necessary to make it worthwhile to continue screening, risk levels could drive screening by age.
- Per Sherie Smalley, if we implement this alternative in January, there is the potential to disenroll a woman who is in the process of a diagnostic workup. Also, Debbie Pellegrini clarified that when the calculation was made with about 50% of the women aged 40-49, to make the necessary savings, services would need to stop to all women 40-49. This may result in “public backlash.”
- Per Joan Bloom this is not a “palatable” choice. This was the consensus of Council members.

**ACTION ITEM: Form a workgroup to define a risk level where there is benefit in screening vs. a risk level where there is not in the 40-49 age group. The intent is to develop considerations for the appropriate use of screening in this population.**

**Alternative No. 3:** Changing from 200% to the lower 135% or 100 % of the federal poverty level. (A handout showing patient income criteria was explained. Per Sherie Smalley this is not a good option because patients self-report and there is no way to verify income levels.) Discussion included:

- If we drop to 100% of the federal poverty level, per Sherie Smalley, we may stay within budget if all women are honest about income level. But, enforcement is not possible, and this may exclude some ‘high risk’ women. She pointed out that other states screen women at 200% of federal poverty level, and that federal guidelines allow screening women up 250% of the federal poverty level.
- Michael Policar mentioned this alternative may cause denial of an older (e.g., 50-60 y.o.) woman who is at 170% of poverty, who really needs services, compared to a very poor younger (e.g., 40 y.o.) woman who does not need services quite as much.

**Alternative No. 4:** Changing guidelines for screening intervals from 12 to 18 months. Discussion included:

- It is scientifically acceptable to go to an 18 month interval but that it could not be enforced through our current claims system, EDS.
- While edits could be made to EDS, so that screenings could be detected and second claims in less than a year could be denied, this would cost about \$650,000.
- Larry Wagman's suggestion to calculate the cost of systemic changes to see when there is a "break even" point.
- Sherie Smalley pointed out that our program providers refer patients to any Medi-Cal radiologist and that radiologist bills to EDS, but there is no current way to distinguish between their status as one of our providers. To implement this change, Medi-Cal would have to change its guidelines.
- Neal Kohatsu mentioned that this would also necessitate a reeducation of providers.
- For standards of care, best practices, and quality improvement this alternative is worthy of future discussion but will not help the current financial situation.

**Alternative No. 5:** Reducing cervical services.

This alternative will not have enough effect on costs and was not discussed.

**Alternative Selected: Alternative No. 1 was selected by consensus of the Council.**

**NOTE:** It was expressed by the Council that all alternatives were unacceptable solutions, but with ongoing analysis of the issues presented, and with the modification that there is continuing evaluation of program funds of the first 6 months of 2008, this is the best alternative of those available.

There was discussion interspersed throughout the above discussion about the impact to the budget of the inevitable need to pay for digital mammography. CDS is in the process of researching the actual location of digital vs. film mammography machines to determine the present and future barriers to care resulting from the lack of money to pay for digital mammography.

### **Advisory Council Structure**

Sherie Smalley addressed:

- Newest members of CDS
- Bylaws
  - A new ad hoc Bylaw Committee is to be formed. Bylaws will follow appropriate statutory rules, define membership, and content of standing workgroups. Bylaws will be distributed to Council members for review and final approval.
  - Term limits are to be included in the bylaws.
- Workgroups – The following types are to be formed:
  - A scientific, evidence-based, medical approach to cervical cancer issues.

- A scientific, evidence-based, medical approach to breast cancer issues.
- A group to study health disparity issues.

**ACTION ITEM:** Larry Wagman to send a note to Council members to identify members interest in workgroup participation.

**Additional Items to be addressed:**

**ACTION:** Per the request of Michael Policar, topics to be added to the next meeting agenda by CDS concern the convening of a committee to make recommendations on 1) Pap periodicity, and 2) making HPV + Pap testing available to Medi-Cal, Family PACT or EWC women.

**Adjournment:** 4:30 p.m.