

ELIMINATING DISPARITIES IN CARE

Case Study: Preventing, Diagnosing and Treating Breast Cancer in Minority Populations

Project goal: To improve mammography screening rates for women ages 50 – 69.

Reason for project: Overall screening rates were low, with recent declines among certain language groups. Reaching those key groups of CHA patient populations became a priority and the Breast Health Initiative was created.

Demonstrable outcome: When the Initiative began, screening rates were below 60 percent; they are now above 80 percent. Among Spanish and Portuguese speakers, rates are above 90 percent.

Sustained accomplishments: Improved cross-departmental communication; improving access to mammography screenings has become a system goal – not just Initiative goal.

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Organization: Cambridge Health Alliance

Program: Breast Health Initiative

Location: Boston, MA

Summary:

The Breast Health Initiative is a collaborative project of the Cambridge Health Alliance (CHA) departments of Radiology, Medicine/Primary Care and Community Affairs, with support from the Avon Foundation. The program targets the all women 50-69, including English, Haitian, Portuguese and Spanish-speaking populations.

The Initiative aims to improve mammography-screening rates among CHA patients through:

- Enhanced CHA breast health services
- Patient outreach
- Patient education

NOTE: Some programs are in the initial stages for data collection and reporting, while others are small in scope and have not yet established benchmarks. Where there is data available, it is provided in the questions and answers below.

Q&A:

1. How did the organization's leadership know there were disparities in care (i.e., clinical data outcomes, HCAHPS survey, some other mechanism)?

Our 2004 data showed that some patients experienced long waits for mammogram appointments. At the same time, community leaders were advocating for improved women's health, especially breast cancer screening and treatment. Regarding disparities, our data also indicated that screening rates were low, with particular recent declines for certain language groups after a large outreach grant ended.

2. Is this program part of CHA's quality improvement goals?

Yes, the work of the Breast Health Initiative supports CHA's quality improvement goals. Several members of the Breast Health Initiative Working Group also sit on CHA's quality improvement teams. As an organization, CHA has set a system-wide goal of increasing the rate of mammogram screenings – the purpose of the Breast Health Initiative.

There is a consistent message across the system – mammogram rates are an important quality indicator. CHA's data reports and computerized medical record reminders are consistent with the clinical guidelines that CHA set for mammography screening. As a health system, CHA is committed to providing assistance and culturally competent, individualized care for patients as needed.

3. How did the organization plan interventions and implement the program?

Early on work focused on three main areas: Developing IT and patient tracking systems, building radiology capacity to increase access, and specialized outreach to unscreened and hard to reach patients. Originally, a patient registry was developed from the target population of patients who were overdue for breast cancer screening. Regularly updated, accurate screening rate reports were also established. While the development of good data systems was not a strong part of the original project conception, the importance of this area has grown continuously since the beginning of the project. The Initiative is continually developing, monitoring, and reviewing/cleaning its data.

IT

To affect change at a population level, useful, timely, and accurate data is needed. The Initiative works with 15 clinics in different locations, as well as the Department of Radiology, so it is essential that providers easily know which patients are due for screening so they can communicate within and across departments. Data was improved for accuracy and better analysis and IT systems were improved to facilitate timely communication.

After looking at screening rates and how they were measured by different departments, the Initiative streamlined data collection creating consistency and eliminating duplicity. Data reports are fewer and complementary with definitions clearly defined. One important task for a safety net system with a somewhat transient population was uniformly defining who was the targeted “patient.” Was it someone who visited once or someone with whom there was an established relationship? In order to engage the right patients and monitor progress reliably there had to be a common definition.

The electronic medical record became an important tool that supports accurate data collection and the promotion of preventative screenings at time of patient visit. In 2004, because of system delays, some patients went outside the CHA system for annual mammograms. These patients were up to date on screening but internally there was no record of it. CHA’s e-record enables providers to now record when women are screened outside the CHA system; this data is accurately incorporated in CHA’s screening rates and outreach lists.

INCREASING ACCESS & CAPACITY

In 2004, some patients experienced a six-month wait for mammography screening appointments. To improve access and decrease wait time, CHA invested substantial resources that resulted in improved capacity and communication, including an all digital mammography system, a voice activated dictation system, and an overall increase in the number and type of available breast imaging equipment at three sites.

As a result, CHA can now accommodate same day screenings and has doubled the number of mammograms provided since the program began in 2004.

While the Breast Health Initiative focuses on screening, parallel improvements were made to CHA’s breast cancer diagnostic and treatment capacity with the establishment of a multidisciplinary Cambridge Breast Center (CBC) in 2005, also with support from the Avon Foundation. Before the CBC, CHA’s multicultural patients often

experienced significant delays moving across disciplines after abnormal tests. Now, there is a seamless transition from the identification of a suspicious lesion to diagnosis to treatment with strong support from a coordinated, multidisciplinary and multilingual staff.

OUTREACH

Staff and patient education are important components of the Initiative’s outreach work. Outreach staff work individually with the 15 clinics, reviewing their breast health screening rates and lists of patients due for mammograms, and identifying factors that contribute to unscreened patients. This review helps the Initiative and clinic staff better understand the clinic population. The clinic and outreach staff collaborate to send unscreened patients a personalized letter from their primary care provider that encourages them to come in for a screening. The letter is followed up with a personal phone call – up to three calls total – offering to schedule, and occasionally transport, women to the clinic for their screening. Letters and phone calls are provided to patients in their own languages.

Special Saturday events help working women set up and keep appointments and often they can attend a session with friends. The Saturday sessions combine group education with individual screenings.

4. What was the time frame, from conception to full implementation?

The Initiative has evolved considerably since it began in 2004 but the primary goal has remained the same: to improve mammography screening rates for women ages 50-69. In 2007, the Initiative expanded its target population to include women ages 40-50 to reflect changes in CHA’s clinical standards.

The Initiative still continues. From the first year screening rates have continued to improve but much has happened in the Initiative’s evolution. In 2005, CHA also created the Cambridge Breast Center, part of CHA’s commitment to increase breast health screening rates and treatment for underserved women. Mammography rates are also a key quality improvement indicator for the Ambulatory Services.

5. What were the results?

In 2004, screening rates (two year rates for women 50-69) started below 60 percent and are now up to 86 percent. The Initiative continues to assess rates by language group breaking it down by English, Spanish, Portuguese, Haitian Creole and “Other”. In 2004, “Other”, at 54 percent, was the lowest rate. Now, all rates for all language groups are above 80 percent. The two highest language groups are now Spanish speakers, with a screening rate of 92 percent, and Portuguese speakers, with a rate of 94 percent.

6. How did the organization assess the outcomes?

An interdepartmental work group meets monthly with representatives from radiology, primary care, community affairs, quality improvement, marketing and CHA’s Breast Center. A goal of the Breast Health Initiative is to improve departmental collaboration. This was not part of the original project concept but an example of the Initiative’s evolution. To address these mammography screening issues successfully requires different disciplines and departments in order to engage patients collaboratively.

The working group analyzes the data and success rates. They identify systems issues and barriers and strategize successful methods for improving rates.

In specific clinics, patient chart reviews were done to help better understand why women aren’t being screened. At the same time, the Initiative collaborates with CHA’s planned care model. These two projects complement each other and are a direct result of team-based care utilizing the support of non-clinical, non-licensed care “navigators”, such as those who call patients on the phone to proactively set up appointments for them.

7. Has there been a sustained improvement since implementation?

Screening rates continue to be above 80 percent. Success has allowed the Initiative to focus on sub-population data and work to better understand challenges in reaching the entire patient population.

For example, screening rates among non-English speakers continue to climb but understanding the diverse English-

speaking population has proved challenging. It may be that English-speaking patients go more frequently outside the CHA system for a mammogram and that fact is not always apparent on their e-record. Additionally, CHA primary care sites see many English-speaking psychiatric patients, who have their own population-specific barriers to preventative health care. CHA is working to better identify these sub-population groups with data reports that allow a deeper understanding.

Since the Initiative began, the CHA system has set a goal for increasing breast health screening rates among women ages 40-69, a broader clinical goal than the Breast Health Initiative which targets women ages 50-69.

8. What challenges or obstacles were overcome?

A big challenge is fostering communication in order to avoid duplicity. CHA is a large system offering all services – from mammography screening to diagnosis to treatment to continuing primary care. Disciplines differ and departments differ therefore it was essential that there be strong internal communication. Creating a working group was a great solution for that. Everyone knew what others were doing and together, they informed the process.

It is also important to keep the people who do the work day-in and day-out engaged and to acknowledge their contributions. Celebration and acknowledgement of steady progress has served as an effective means for engagement.

9. What was the cost of the program and how was it funded (grant, etc.)?

Since 2004, Avon Foundation grants have provided sustained project funding to supplement the support from CHA. Initially, CHA invested \$1.8 million in capital improvements to increase Radiology capacity and efficiency.

10. What other stakeholders (i.e., community groups) were involved?

The Volunteer Health Advisor (VHA) Program was key to actively involving the community. VHAs are community leaders trained and supported by CHA to act as a bridge between the community and the CHA health care system. Roughly 200 VHAs representing the Haitian, Brazilian, Latino, South Asian and African American communities provide routine health education and outreach to CHA communities. A subset of these VHAs supports Breast Health outreach.

The Initiative involved the VHAs in less traditional ways as well. In response to challenges reaching certain language groups, CHA conducted focus groups of women from different language groups to discuss their views of breast health and mammography screening. Using data from these groups, Initiative staff identified culturally tailored communications messages and developed outreach materials specific to different language groups. They then invited the VHAs to participate in focus groups to review these materials for language as well as image suggestions. From this process, outreach materials were tailored for each language group with culturally appropriate language and pictures of women from specific ethnic groups – often with VHAs themselves as models.

11. What advice would you give other organizations wanting to improve care in similar ways?

It takes both institutional and care giver commitment as well as a respectful willingness to work together across disciplines. Leadership must be engaged in improving community health and support those doing the every day work in a way that promotes larger health improvement goals.

Communication is important. Facilitating communication across disciplines is challenging, but essential when tackling a big quality improvement goal.

Don't underestimate the importance of accurate and timely data. Good data on patient population and outcomes as well as more qualitative data on what others are doing and what's working can help make a case for and direct action.

Rather than focusing on disparities as a “special topic”, commit to understanding and working with your patient population or populations and ask how the best patient-centered care can be provided to them. That shift in focus can cause disparities to drop away.

Quality care is collaborative care. This type of care also includes an ongoing partnership with the community and an understanding of public health principles. Including these aspects in clinical care design allows clinical care to be tailored to the needs of the populations we serve.