

Cervical Cancer Mortality in Low Income Women-Inevitable or Avoidable Transcript

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MR. GIVEN: Very good. I want to thank Dr. Kerner and the folks who invited me and really glad to be here to share with you a little bit of information. As I have been saying to somebody at my table today, anybody that goes away from here without a feeling a data overload is probably really hard core. I noticed by even 11:30 or so, I was beginning to fade a bit, and I'm somebody who loves data. So, in that spirit, I'm going to keep going here. What we're just keep loading it up and see what happens. Anyway, what I want to do today is talk with you a little bit about a relatively unique program that we have in Michigan, where we've been able to link the Medicaid eligibility files with the cancer registry and cancers death certificate data in Michigan. And so what I'm going to be talking with you today about is the cervical cancer diagnosis treatment -- a bit about treatment and mortality. And as we go along, I'll have some comments that hopefully try to integrate, at least very briefly, what some other people have said this morning so at least maybe we can begin to build some themes out of this.

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So what I also want to mention are my collaborators in this project, Dr. Bradley, from the Department of Medicine, and Carolee Roberts, who is part of a private consulting group that has been doing the analysis of these data.

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We have several questions that we're going to try to address today. First of all, are cancers detected at early stages, and what are the demographics, some of the help, co-morbidity, nursing home residence, and other characteristics of women on Medicaid who we want to examine

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Are low income women getting appropriate treatment And again, we really are not going to answer that in any very definitive way. I think that becomes one of the... (remainder lost on tape turnover).

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MR. GIVEN: (beginning lost on tape turnover) . we stage. So, basically what we have so far is we find women 65 years of age and older are at higher risk. We do not find, so far, at least, anything that is in the state that is, at least in the Detroit area, so far as poverty is concerned, does not seem to have a big impact.

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And here it is, we see in a graphic form for the county of residence. And there we looked at, again, tried to look at breaking this up, fairly similarly, about the percent of poverty. And again, you just don't see that poverty itself, even on the statewide basis, is having a particularly, strong relationship with stage at diagnosis.

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This slide is a bit busy, but what I really wanted to point out here is a couple of things. First of all, what we've seen so far is Medicaid patients alone with non-Medicaid. Those folks who are under 65, particularly the 25 to 44 and the 45 to 64 age groups they were primarily diagnosed at early stage, and the percent diagnosed at later stage, obviously increases as you move to the 65 years of age and older. Now, when you are comparing by race, again, we did not find that Medicaid did any worse with the -- by race than non-Medicaid and again, this is for the State of Michigan we find that about 28 percent of all the people diagnosed at early stage; 28 percent were black, were Medicaid, and similarly, the bottom right-hand cell were about 10 percent of the non-Medicaid of those diagnosed at early stage. So again, if you compare the whites and blacks, the percent of - - diagnosed at early stage between Medicaid and non-Medicaid, you really don't see too remarkable a difference. Certainly there is something that puts blacks at a bit higher risk for a later stage diagnosis, but not anything too remarkable.

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What type of Medicaid plan So we wanted to look at that to see if that really had any impact. And again, what you see within Medicaid is the managed care plans, and then the managed care plan which is the physician service plan, which is basically a fee for service with a bit of premium cap on top of that for the provider doing some management. Has almost identical rates of stage at diagnosis, being really early stage. What we do see is those people and I think this is where it's really important to begin to understand you have older people, those 65 years of age and older, and then you have those people who are in long term care. And those are really, you notice there, that only about 40 percent of those patients are diagnosed in early stage. So what you begin to get is kind of a confluence of the age and then the location where they were residing at the time of diagnosis, which begins to really give you some idea that these are people probably with numerous co-morbid conditions who are in -- some in an institutionalized setting.

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This particular slide is troublesome. It's troublesome because we had a lot of difficulty trying to tease out of the claim files what we really had in the way of treatment programs for patients. This is something that, I think, almost everybody this morning has made reference to at some time or another, and I'm not sure that we can put a lot of stake in these data. I'm particularly troubled in the Medicaid setting, because although we did have people who we had continuous enrollment in Medicaid, many of them also had, periodically, other forms of insurance. And we went through and there is in the Medicaid claim files -- they have a little box where they check those and so you have to go through them very carefully, trying to tease out periods of time when they may have had other insurance. But in any case, what we do see is the difference between Medicaid and non-Medicaid in our ability to make some comparisons as to types of treatment. And again, we

were limited here to the SEER registry because this was the only place where we really could feel like we had any ability to look for particularly -- hysterectomies, we had some D and Cs -- and then, "no surgery" was kind of by inference. But again, I think that more than really looking at these numbers, I think what this really points out, and what I would like you take home for the message from this, is that really we need to begin to get some systematic way, ongoing treatment data. For cervical cancer patients, but for all cancer patients. We really need to know more about that.

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Now, we talked quite a bit about the issues that Medicaid faces and what kinds of services they provide. And I think this slide tries to point out some of the issues that are raised by trying to deal with Medicaid claim files. If you noticed back early on, we told you that we got the date of the diagnosis which for each of our cervical cancer patients. And then we compared that with the date on which they were enrolled into the Medicaid program. And what you see here is for people who had no prior coverage prior to diagnosis. Now there were not a great number of those there were only 90 but what you begin to see there is about 38 percent of those were late stage at diagnosis; about 43 percent had surgery; and about half had no cervical cancer treatment. Again, this is probably -- has a lot to do with the fact of when they got the diagnosis, when they were able to get them onto Medicaid, and this probably -- a lot of the issues around treatment, the appropriateness of care which they were provided probably had a lot to do with the fact of the timing of the diagnosis and the timing of enrollment onto Medicaid. What you see on the farthest column there, is where there was complete coverage. You see that only about 16 percent of those people were diagnosed with late stage, and much higher -- about 20 percent had surgery, and about 20 percent less had no cervical cancer treatment. And only about half as many died within six months of diagnosis. So again, that doesn't say a lot about the kinds of care that people in poverty are receiving, but I think it does say something about the fact is that we really those people who are getting no coverage prior to the time of diagnosis are really the most vulnerable in our population, and one can only speculate, but one would have to wonder, if we would be better off to just have continuous coverage given the fact of what we invest in these people with late stage and fairly high cost.

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The characteristic of cervical cancer patients who died in Michigan. Dr. Kerner asked me to try to talk a little bit about this. And there were 69 of those cases during the two-year period that we could identify off the death certificate data when we matched them up. And what we find was about -- you can see the mean age there and the racial breakdown. Obviously, the most important thing is 75 percent of them were late stage. Types of plan: is nothing terribly remarkable there. What you see is the months enrolled prior to diagnosis was about four, with a big standard deviation, you need to know. And then they were not enrolled fairly long, only about 10 months after they were diagnosed. So again, these are people who died. These were people who were not enrolled in health care so far as we knew prior to the time of their diagnosis, or if they were, it was very shortly prior to, and they were not enrolled long following their diagnosis. And what we're doing now is looking at the -- some of the cost for those patients, which so far, support what you might suspect. They spent a lot of money in a fairly short amount of time dealing with the situation that while not hopeless, is not certainly terribly hopeful either.

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What are some of the reasons why care may not have typical Well, as other people have pointed out this morning, some of these people died of a different cancer. They had, had one or more months of other insurance during that time. Some had less than five months of valid coverage under Medicaid. Only four of them had coverage started three months after diagnosis. And one of the three of them had considerable claim files suggesting mental

health, substance abuse, and a variety of psychological co-morbidities.

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One of the things that was also interesting to us was we looked at what were the stages of these women who died during our two-year period of '96 - '97. What we found was: You can see that, not all of them, but most of them were stage II and III cancers. They were all pretty young, and the months that they survived there are in the third column. What we noticed about this is, if you go back and, for example, look at the five-year survival rates for women with stage II cervical cancer, these women were, by and large, did not make the average five-year survival rate. So, one has to assume that -- doesn't have to assume, but one could assume that these were particularly aggressive cancers that probably came on quickly, were probably very rapidly progressing, very aggressive. And so, as a result of that, one can wonder what could be done about those. And probably the most important thing would have been try to have diagnosed them earlier. Obviously, but again, these were people who had fairly aggressive disease and were under the five-year survival rates.

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Some of the main results that I would like to just summarize, is that racial differences and stage treatment and death were not terribly apparent. Older patients tend to be diagnosed at late stage. Women with no coverage prior to cervical cancer diagnosis and subsequent Medicaid coverage, were certainly more likely to die.

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I think there are a number of policy implications that I would like to just go into. The first one, certainly we need to improve their screening, but that's fairly obvious, and I think we're all aware of that. The question of expanding insurance coverage. Again, the whole issue and debate about national health insurance and expanding coverage goes on and on. But certainly, I think these data support the fact that, certainly, people who are in continuing coverage, even though it is Medicaid coverage, are really going to do better than those people who are simply receiving some kind of coverage shortly before or following the time of their diagnosis. A couple of other things that I think. There are some real opportunities that we have now. During this past year, with the states now coming in line and passing legislation to enroll women who are diagnosed with breast or cervical cancer into the state Medicaid program, I think this is a real opportunity for somebody. I know we're taking up this project in Michigan. But, in general, I think it's very, very important that we begin to try to follow this program from the time of its inception. We need to understand the processes -- not only we know that there's probably an arduous process from the time of getting diagnosed. I know in Michigan, people who are diagnosed under Title XV have obviously not a -- it's not a easy route because you have to find a physician who is treating the people, who is really doing the test this month. Then you have to get there. Then if you have an abnormal Pap smear, then you have to get back to them, but they may not be the physician of record when you're doing the repeat Pap. So, there really is a real process there. But then, the next question is, once you're diagnosed, how easy is it for you to get on Medicaid. What is that interval of time between diagnosis and the time you get on Medicaid. One of the other things that's very interesting is that, I know that our state, the Medicaid agency is very interested in tracking, since you're on Medicaid, what other coverage and what other claims do you make while on Medicaid. So what other services are you receiving. So what is the total burden of costs of care that go beyond just being treated for cervical, or in this case, cervical and breast cancer. So, I would encourage us to really think about this as something as a project or possibly projects for each of the states. We're in the process of negotiating this with our Title XV program, and linking that up with our state Medicaid projects, so that we can begin to follow women. I think they're a lot of interesting issues that come up. What happens following treatment once recurrence comes. Do people get back on. How do all of these things sort of unfold. And I don't think we know

that yet, but I think this is the time to really get some really good data about the process of treatment, which we have little of right now, to really begin to understand better than a particularly vulnerable sector of our population that is being diagnosed. And then, how are they being treated and managed So, with that, thank you very much. DR. KERNER: We have time for a couple of questions. Yes, go ahead. How did I know you were going to jump on that microphone DR. LOOK: Oh, I don't know. DR. KERNER: Right. Can we have the lights up, please SPEAKER: (inaudible). And you say I want more Medicaid dollars so that I can find the 55 patients in the State of Indiana that are going to die of cervix cancer who are over the 65, but the pot of money's only so big. Who should I take it away from, Dr. Given Do I take it away from little babies, from the moms who are about to give birth next week I don't want to take away from those ladies. I mean, how do you argue that If you look at -- there's 14,000 cases and 4,300 deaths I mean, if you round up the number. There is a certain percentage that happen in rural folks and there's a certain percentage in folks over 65. But any individual state, those are small numbers. You go into the governor who has a Medicaid pot of money that he thinks is way too big anyway compared to every other thing he has to do, so how do you argue -- how do you advocate for this to make the governor listen Because I know what's happening in Indiana, and they're going to cut back Medicaid. It's going to be really hard to go say give us more Medicaid dollars so we can go find the last 55 patients over the age of 65 who have cervix cancer. DR. KERNER: Want to take that on, Bill MR. GIVEN: Sure, why not. I should let you know I'm running for governor, so .. SPEAKER: You'll have my vote if you get this question right. MR. GIVEN: Good thing you live in Indiana, then. I don't have to worry about you. No, obviously, that is a question that everybody asks and is sort of the ultimate: What do you do How do you allocate I guess that one of the things that, to me, seems reasonable about this whole issue of, particularly, adding Medicaid services to this. Why, if you're going to have a program that is going to screen and diagnose and try to diagnose breast and cervical cancer, and then if you have no real way of effecting any kind of treatment, to me that seems like sort of the most perverse of social interests. That's my opinion. I'm not speaking as an economist. And I know every governor in probably every state, particularly in the Midwest, where the economics are going down, is saying, "Oh boy!" That's all I can really tell you. I could also tell you about some of the drugs I might want to take a second look at, eliminating from the formulary. I've -- remember, you asked this question, okay DR. LOOK: I'm from the Pharmaceutical Manufacturers Association. MR. GIVEN: Good for you. DR. LOOK: Have I got a whole bucket of money for you, sir. MR. GIVEN: That's right. I know that there was a flu medication -- came out about two years ago, where it was very effective if you took it within the first -- I don't remember, 36, 48 hours, something - - but if you waited beyond some time, it was sort of like, it didn't amount to having much use at all. And the director at that time said, "Well, I got pressured to putting that onto my Medicaid formulary," so there just went another, I don't know, 1,375,000. And he said, "I've have no idea where that money's coming from," but he said, "I know it's going to go out the door." I think, if you want to start to really getting down to how are we going to pick on some of these things. First, you don't create a kind of perverse, where you screen and diagnose and then offer few people the opportunity to be treated. And second of all, you may have to look in some of your other kind of formulary for some medications that may be marginal. DR. KERNER: Nancy, if you want to comment. DR. BREEN: Yeah. Let me talk a little bit about the Breast and Cervical Treatment Act because I'm hearing a few misconceptions here, and I want to just clear it up. I'm with the CDC, I'm the director of the division there that administers this program nationally. And, let me first say, that the B amp;C Program has been around for 11 years. And we've tracked the women getting treated following a diagnosis of cancer and over 90 percent have. But we never gave out money to any state, and we cover all 50 states now, without them having a plan for finding treatment for these women. We totally agree with you. You should not have a program unless treatment's provided. The B amp;C program, and that's a point I'm going to make in a second about your data, here. The B amp;C program has always been for women who have no insurance or not very much insurance, and therefore, women who have Medicaid have never been eligible for this

program. So all of the data you saw up there from Michig