Executive Summary

IN-BCCP Overall Evaluation Results

The primary goal of the IN-BCCP is to ensure underinsured women ages 30 through 64 who are medically underserved due to financial constraints have access to timely breast and cervical cancer screening, diagnostic, and treatment services. Statewide, the IN-BCCP operates direct screening services through three regional offices (See Appendix A.) The Indiana Department of Health (IDOH) employs two full-time nurse case managers to support the regions. The IN-BCCP also seeks to increase the use of evidence-based initiatives (EBI) to increase breast and cervical cancer screening, and to foster community-clinical linkages and environmental approaches to improve women's health.

Despite the challenges posed by the COVID-19 pandemic, the IDOH and the IN-BCCP continued efforts to improve processes and strengthen program management throughout PY3. Additionally, the IN-BCCP partnered with three health systems to build their capacity to implement EBIs to increase breast and cervical cancer screening among rarely or never screened women. Finally, while not yet able to fully implement community-clinical linkages as described by the CDC, the program leveraged many opportunities to influence breast and cervical cancer screening rates through additional funding obtained by regional offices and the WISEWOMAN Program.

PY3: Evaluation Results:

- 3,417 breast and cervical cancer screenings – down only slightly from 3,551 in PY2. (See Appendix B.)
    - 1,858 breast cancer screenings – an increase over PY1 and PY2.
    - 1,559 cervical cancer screenings – fewer than PY2 but more than PY1.
- 46% of Indiana's 92 counties had an active IN-BCCP provider in PY3 (See Appendix C.)
    - 27% (25 counties) offered IN-BCCP-provided mammography
    - 24% (22 counties) offered IN-BCCP-provided colposcopy.
- Three (3) clinics participated in the Health System Intervention (HSI) initiative. One of these clinics completed their HSI engagement during PY3. The other two clinics provided baseline demographic, screening, and EBI data and partnered with IDOH to develop an implementation plan just before COVID-19 changed clinical practices in the state. One additional clinic enrolled in the HSI initiative in PY4.
- 1,221 additional visits were funded through non-BCCP funds raised by the Northern and Central Regions to serve women who fall slightly outside of the age or income parameters of the IN-BCCP. (See Appendix D.)
- 209 IN-BCCP participants engaged in health coaching to improve health behaviors using community-clinical linkages through the IDOH WISEWOMAN program.
- Approximately 26,000 people were reached through a variety of outreach and education efforts aimed at increasing awareness of screening guidelines and to provide information about how to access screening services.

How Results are Being Used

Evaluation of the IN-BCCP is overseen by an Evaluation Advisory Group (EAG) and supported by Community Solutions, Inc. (CSI). The EAG meets quarterly to identify key annual evaluation questions, interpret evaluation findings and implement evaluation recommendations. The evaluation consultant is part of the IN-BCCP team, allowing for ongoing input of evaluation findings for formative use by the program.

PY3 Lessons Learned and Recommendations for PY4

- The COVID-19 pandemic presented many challenges that IN-BCCP partners worked to overcome.
    - PY3 screening numbers remained high and likely would have exceeded PY1 and PY2 numbers.
    - COVID-19 stalled progress on implementation of the HSI initiative as the clinics responded to the challenges of COVID-19 response and women were more hesitant to engage in screening visits.
- IN-BCCP continues to work to fill gaps in women's healthcare services, but many opportunities remain.
    - There is a gap in services in several counties, especially among diagnostic services providers. The program should target outreach efforts to recruit providers in areas of greatest unmet need.
    - IN-BCCP is helping to fill the gap created by low insurance coverage rates among Hispanic women in Indiana. Among women ages 40 to 64 in Indiana, 41% of Hispanic women are uninsured compared with 14% of white and Black women. The Hispanic population represents 7% of the overall state population but in PY3 represented 65% of the IN-BCCP clients served. (Appendix E.)
- Priorities for PY4 include:
    - The IDOH and regional offices should work together to ensure that limited data are reported for non-BCCP paid clients being navigated by Regional Office staff for breast and cervical cancer services.
    - The development of a Community-Clinical Linkages Implementation Plan, including a rubric for selecting resources and tools for performance measurement, data collection, and evaluation.
    - Development of a process to evaluate the impact of outreach efforts on IN-BCCP participation.

Strategy: Program Management, Monitoring and Evaluation

The role of program management, monitoring and evaluation is to assure that the program has the resources it needs for success, to monitor the program implementation, and to provide feedback for program improvement.

The evaluation assessed how program management, monitoring, and evaluation support the outcomes of the IN-BCCP. The questions included; 1) Does the IN-BCCP have the proper contracts in place to effectively administer the program? 2) Does the IN-BCCP have the proper staff in place to effectively administer the program? and 3) Are there any issues that impact the relationship between the program and medical service providers?

The evaluation used a mixed-methods approach for the program management, monitoring and evaluation strategy.

Data and Analysis Include			
Type of Data	Source	Year	Purpose of the Analysis
Qualitative	Process observations	PY1, PY2, PY3	Describe program management
Qualitative	Key informant interviews	PY3	Describe program and identify program obstacles
Quantitative	IN-BCCP billing data	PY1, PY2, PY3	Document timeliness of billing and provider reimbursement

The analysis of program management, monitoring and evaluation has revealed several findings:

- Program and contractor staffing remained stable in in PY3 as staffing issues that previously impacted the program were resolved
  - The IN-BCCP had a director during most of PY3 (starting in July 2019).
  - The program had two nurse case managers (NCM) during all PY3. One is an IDOH staff position the other an IDOH contract position.
  - IDOH has had longstanding contracts with MaxTrac for data services and CSI for evaluation. Both were engaged for all PY3.
- PY3 saw an increase in satisfaction among the regional staff regarding IDOH leadership and program standardization.
- The billing and reimbursement processes continued to be a source of concern and frustration, but overall payment authorization was 25 days faster in PY3 compared to PY2. (See Appendix F.)
- The cost per patient rose during PY3 due to the CDC guidance allowing for screening MRIs. The IDOH was concerned that program screening may need to stop before the end of PY3. This was not necessary, as services were interrupted by COVID-19.

Recommendations Developed through Formative Evaluation Activities and **Corresponding Program Changes**

- Maintain program staff. **All IDOH program staff positions are currently filled.**
- Continue to engage contractors in a timely manner. **PY4 contracts have been executed.**
- Engage regional staff in the development of standard operating procedures. **IDOH staff is continuing to refine HSI, Environmental Approaches, Community-Clinical Linkage (CCL) and Patient Navigation (PN) procedures.**
- Continue to identify ways to streamline the provider reimbursement system. Missing patient signature(s) is an obstacle for timely payment. **The program is working to identify ways to get an electronic signature from women so they don't have to return to the provider's office to physically complete missing signatures.**
- Utilize evaluation feedback to the IN-BCCP program staff on the direct screening and diagnostic service provision on a regular basis. **This is being done on an ongoing basis.**

The evaluation findings are presented at quarterly EAG meetings. Process reflections are shared regularly by the evaluator with the IDOH program staff to use for formative program adjustments. The evaluator is also involved in the ongoing efforts to collect data to understand and reduce the time between provider services and reimbursement.

Strategy: Direct Screening Services

The IN-BCCP continued to prioritize direct screening and diagnostic services for under- and uninsured women who earn at or below 200% of the FPL.

To assess the extent to which the program is effectively and equitably reaching the target populations, the following evaluation questions were asked and answered: 1) What is the overall need in the state? 2) What proportion of women in need are being served by the program? 3) What are the demographic characteristics need by region, and the number of women screened by each region? 4) Where are providers located and what services are provided? 5) Is that adequate to meet the population needs? and 6) What are the outcomes of the women screened and diagnosed by the program?

The evaluation used a mixed-methods approach for the direct screening services strategy.

Data and Analysis Include			
Type of Data	Source	Year	Purpose of the Analysis
Qualitative	Key Informant data	PY2	Process and satisfaction
Quantitative	SAHIE Data	2019	Describe areas of need
Quantitative	IN-BCCP Client Data	PY1, PY2, PY3	Participant location and program outcomes
Quantitative	Provider Agreements	PY2, PY3	Providers location and services provided
Quantitative	Provider Survey	January 2019	Practice type and year in the IN-BCCP
Quantitative	Cancer Registry Data	2012-2017	Compare cancer by stage statewide compared to IN-BCCP

The analysis of direct screening services revealed several findings:

- COVID-19 impacted the program due to most clinics halting screenings. From March through the end of the program year, few of the IN-BCCP provers were scheduling regular screening either due to a combination of clinic restrictions and low consumer demand for preventive care and screening services.
- The program performed 3,417 screenings in PY3 down slightly from 3,551 in PY2 and up from 3,005 in PY1.
- There are almost 42,000 women in ages 40-64 who earn 200% of the FPL or below. The program operated at capacity and was only able serve about 9% of those women. (See Appendix G.)
- Regions are not providing services proportionate to the need within the region. The Northern Region providers tend to see a higher proportion of their population, the Southern Regions lower. (See Appendix G.)
- Statewide, black women are diagnosed at later stages for both breast and cervical cancer and are more likely to die from both cancers than non-black women. (See Appendix H.)
- Low-income Hispanic women ages 40 to 64 are less likely to be insured than white or black women and comprise a large percent of IN-BCCP participants. (See Appendix D.)
- Of Indiana's 92 counties, 50 did not have an active IN-BCCP provider in PY3, 67 did not perform IN-BCCP provided mammography, and 70 did not perform IN-BCCP provided colposcopy. (See Appendix C.)
    - Women receiving services from IN-BCCP came from 79 Indiana Counties.
        - Many women had to drive to other counties to receive IN-BCCP services.
        - The lack of mammogram sites can be a barrier for low income women, especially those that may have limited access to transportation, childcare or time off work.
    - Women with abnormal screening results often travel long distances for diagnostic and treatment services due to the lack of specialty providers for both cervical and breast cancer.
- During PY3, regional staff participated in 175 education and outreach events, reaching more than 26,000 people. There is currently not a process for tracking people from those events to see if they participated in the IN-BCCP or followed through with breast or cervical cancer screening.

Recommendations Developed through Formative Evaluation Activities and **Corresponding Program Changes**

- Target outreach efforts to recruit new providers throughout the state, especially providers in areas of greatest need and providers of diagnostic services for both breast and cervical cancer. **All regional coordinators and the program staff are working to recruit new providers in underserved areas.**
- Increase the capacity of the Southern Region to ensure they can serve a proportionate number of women. **The southern region staff have been working to increase the capacity by engaging new providers.**
- Utilize available data to make program modifications to encourage screening participation by Black women to identify cancer at an earlier stage. **The IDOH is working with the regional coordinators to identify CCL and other efforts to engage underserved women in the IN-BCCP.**

The evaluation findings are presented at quarterly EAG meetings. Process reflections are shared regularly by the evaluator with the IDOH program staff and regional staff to use for formative program adjustments.

Strategy: Health System Initiative (HSI): Enhancing Service Delivery Using Evidence-Based Initiatives

The IN-BCCP partnered with three health systems that serve primarily people earning less than 250% of the FPL to reach underserved women through the implementation of evidence-based interventions (EBI).

The evaluation questions for health systems intervention for PY3 included; 1) What is the baseline screening rates and EBIs being used at each clinic? 2) What EBIs have the HSI sites engaged in to improve breast and cervical cancer screening rates? and 3) Have breast and cervical cancer screening rates improved as a result of increased use of EBIs?

The evaluation used a process approach for the HSI strategy.

Data and Analysis Include			
Type of Data	Source	Year	Purpose of the Analysis
Qualitative	Process observations	PY2 and PY3	Describe the process the IDOH used to engage HSI sites
Quantitative	Clinic cervical cancer screening rate	2018 and 2019 Annual	Establish the baseline cervical cancer screening rates for each clinic
Quantitative	Clinic breast cancer screening rate	2018 and 2019 Annual	Establish the baseline breast cancer screening rates for each clinic
Qualitative	Clinic EBIs	2018 and 2019 Annual	Establish the EBIs in use at each clinic

The analysis of HSI sites revealed the following findings:

- COVID-19 impacted the program due to most clinics halting screenings. From March through the end of the program year, few of the IN-BCCP provers were scheduling regular screening either due to a combination of clinic restrictions and low consumer demand for preventive health and screening services.
- The Riggs Women's Clinic concluded their HSI work during PY3. They were challenged because the breast and cervical cancer screening rates for the clinic were already above the state average.
    - The staff implemented an EBI of providing Pap screening when a woman presented for other issues, thus eliminating the need for an additional visit. The provider was encouraged by the increased uptake in Paps she had in her patient panel.
    - Overall, the screening rates for breast and cervical cancer remained at the same level, including the months of March through May which saw a decline in other clinics due to COVID-19. (See Appendix I.)
- NorthShore Portage and NorthShore Lake station became HSI sites in PY3.
    - Both clinics' baseline screening rates were below the statewide screening rate as reported in the BRFSS.
    - The work kicked off at the end of February and stalled almost immediately because of COVID-19. During the kickoff meeting the NorthShore staff identified several opportunities to improve the use of existing EBIs.
    - Both NorthShore clinics are using patient navigation, have expanded hours to reduce screening barriers, utilize provider reminders, patient reminders and provider assessment and feedback.
    - IDOH staff has continued to meet with the NorthShore staff monthly to help them strategize for when they return to normal operations.

Recommendations Developed through Formative Evaluation Activities and **Corresponding Program Changes**

- Since the program will never have enough funding to provide direct screening services to all un- and underinsured women who earn at or below 200 percent of the FPL, encourage the use of EBIs at the HSI clinics and support community-clinical linkages to increase screening rates. **Two NorthShore facilities have committed to the HSI work and in PY4 LifeSpring clinic in Jeffersonville will begin an HSI.**
- Continue to support the HSI sites with a practice coach to provide technical assistance so that as they are able screening again, they are prepared to implement EBI changes. **The IDOH practice coach and IN-BCCP staff have continued to meet with the HSI sites monthly.**
- Continue to collect performance measures for the EBIs implemented by the HSIs and provide regular feedback and support to the HSI sites and technical assistance providers. **In addition to the monthly TA meetings, clinic screening rates are being collected monthly and qualitative data is being collected quarterly from the HSI sites to assist them with the identification of effective EBIs.**

The evaluator is imbedded in the HSI along with the practice coach to collect all quantitative and qualitative data and regularly assess the data to provide feedback for practice improvement and assessment of successful EBIs.

Strategy: Community-Clinical Linkages: Environmental Approaches for Sustainable Cancer Control

The IN-BCCP did not implement any new strategies to increase community-clinical linkages during PY3, but instead continued to leverage the partnership with the IN-WISEWOMAN (WW) program and efforts of the Regional Offices to provide resources to increase community-clinical linkages for un- and underinsured low-income women.

The PY3 evaluation analyzed data WW, collected information about the women served from each of the regions that have additional resources, and identified other opportunities the regions had used to engage women in the IN-BCCP. Evaluation questions included: 1) What community-clinical linkages are currently being used to increase breast and cervical cancer screening rates? 2) What are the community-clinical linkages that can be expanded to link women to clinical services and measure there screening participation?

The evaluation used a mixed-methods approach for the community-clinical linkages strategy.

Data and Analysis Include			
Type of Data	Data/Source	Year	Purpose of the Analysis
Qualitative	Key Informant data	PY2, PY3	Identification of community-clinical linkages by regional staff
Quantitative	Regional staff outreach events	PY3	Identification of the number of outreach events and audience reached by regional staff
Quantitative	WW program data	WW PY1 and PY2	Health coaching of WW/IN-BCCP participants
Quantitative	Women provided with breast and cervical cancer services not paid by IN-BCCP	PY2, PY3	Identification of community-clinical linkages by regional staff

The analysis of community-clinical linkages revealed several findings:

- The WW program provides an opportunity to engage IN-BCCP participants in lifestyle improvements.
  - Almost 80% of women screened by the WW program accept health coaching services.
- The Central Region engaged in two partnerships where they were onsite to enroll women in the IN-BCCP. At two events, they were able to engage 8 women, three qualified and received IN-BCCP services the others were able to be served using other funding sources.
- The regional offices reach over 26,000 people during outreach events.
- The Southern Region coordinator does regular outreach at food pantries but has not been able to connect those women to the IN-BCCP program.
- The Northern and Central Region has non-BCCP funds that they use to provide breast and cervical serves to over 900 women annually.
- The IDOH reengaged with the Employer Gold Standard Committee of the Indiana Cancer Consortium and had two meetings.
- The IN-BCCP staff engaged Indiana University (IU) to participate in a breast and cervical cancer screening initiative with their employees.

Recommendations Developed through Formative Evaluation Activities and **Corresponding Program Changes**

- Leverage partnerships within the IDOH to connect IN-BCCP women with community health improvement programming, including using WW to improve lifestyle habits. **The IN-BCCP staff continues to work with the WW program.**
- Develop a process to connect and track women engaged at outreach events to breast and cervical cancer screening. **During PY4, the IDOH will develop protocols for regional coordinators to track community clinical linkages and measure the women who engaged in IN-BCCP.**
- The regions that have funding to serve women not paid by IN-BCCP sources should be counted for the patient navigation of those women. **The IN-BCCP staff and regional offices are working to collect the required abbreviated MDE data to count the patient navigated women they serve.**
- The IDOH will continue to meet with the Employer Gold Standard Committee of the Indiana Cancer Consortium. **Additional meetings are planned for PY4.**
- IN-BCCP staff should establish a formal agreement with IU to increase breast and cervical cancer screening among employees. **IN-BCCP staff have sought IDOH legal guidance for the development of the MOU.**

Evaluation findings were shared in report form to the regional staff and IDOH. These findings have been used to inform program changes.

Appendix A: IN-BCCP Regional Map

Northern Region

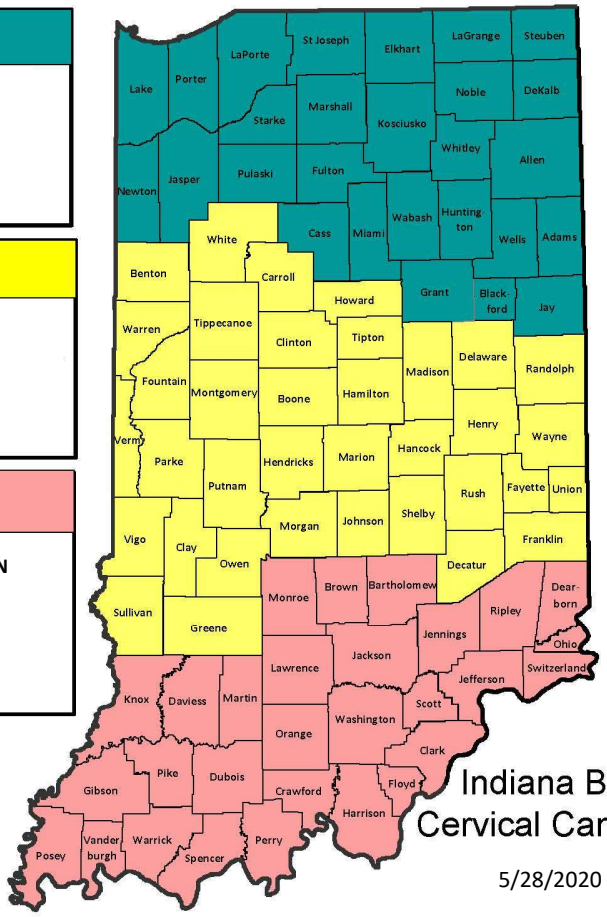
United Health Services
Mary Heck, Executive Director
mheck@uhs-in.org
574-247-6047 ext. 122

Central Region

YWCA
Amber Thurman, Senior Director
athurman@ywcalafayette.org
765-742-4375

Southern Region

Family Health Centers of Southern IN
Alicia Swank, Regional Coordinator
aswank@fhcenters.org
812-283-2792

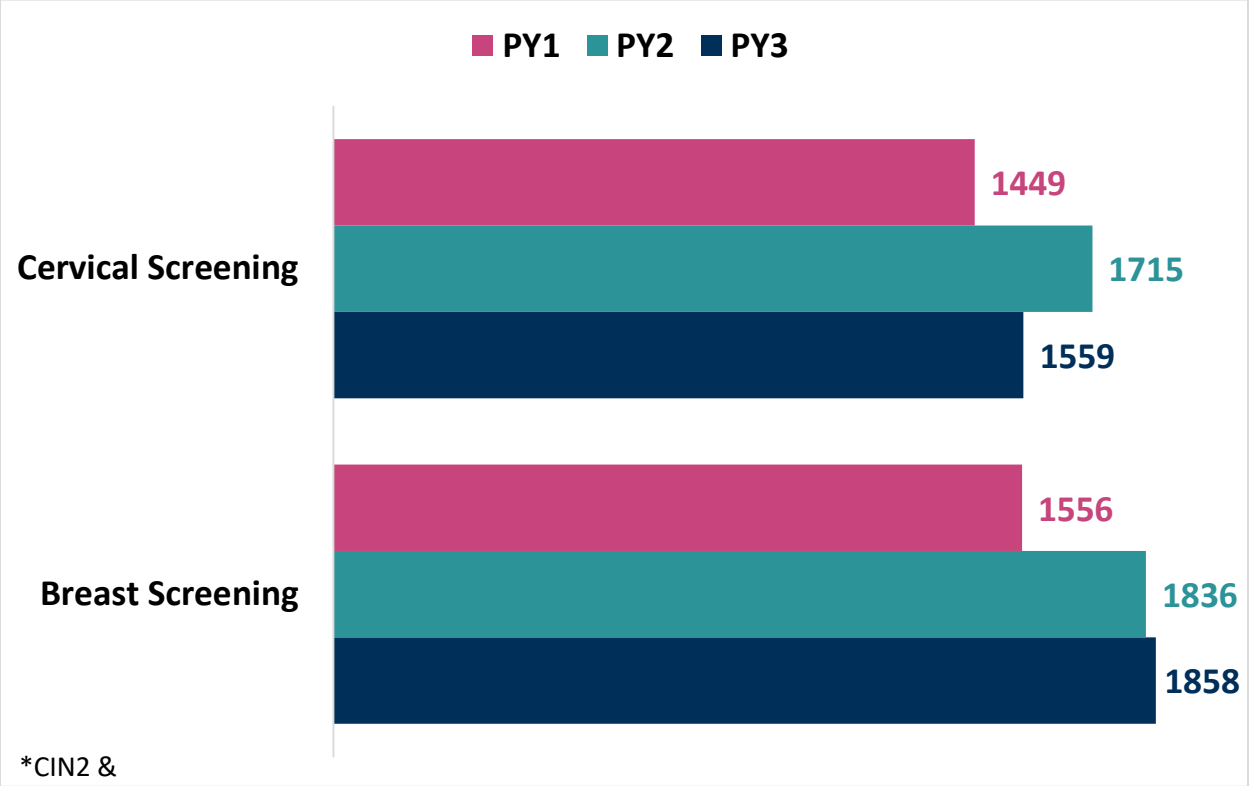


Indiana Breast and Cervical Cancer Program

5/28/2020

Appendix B: IN-BCCP Screenings by Program Year

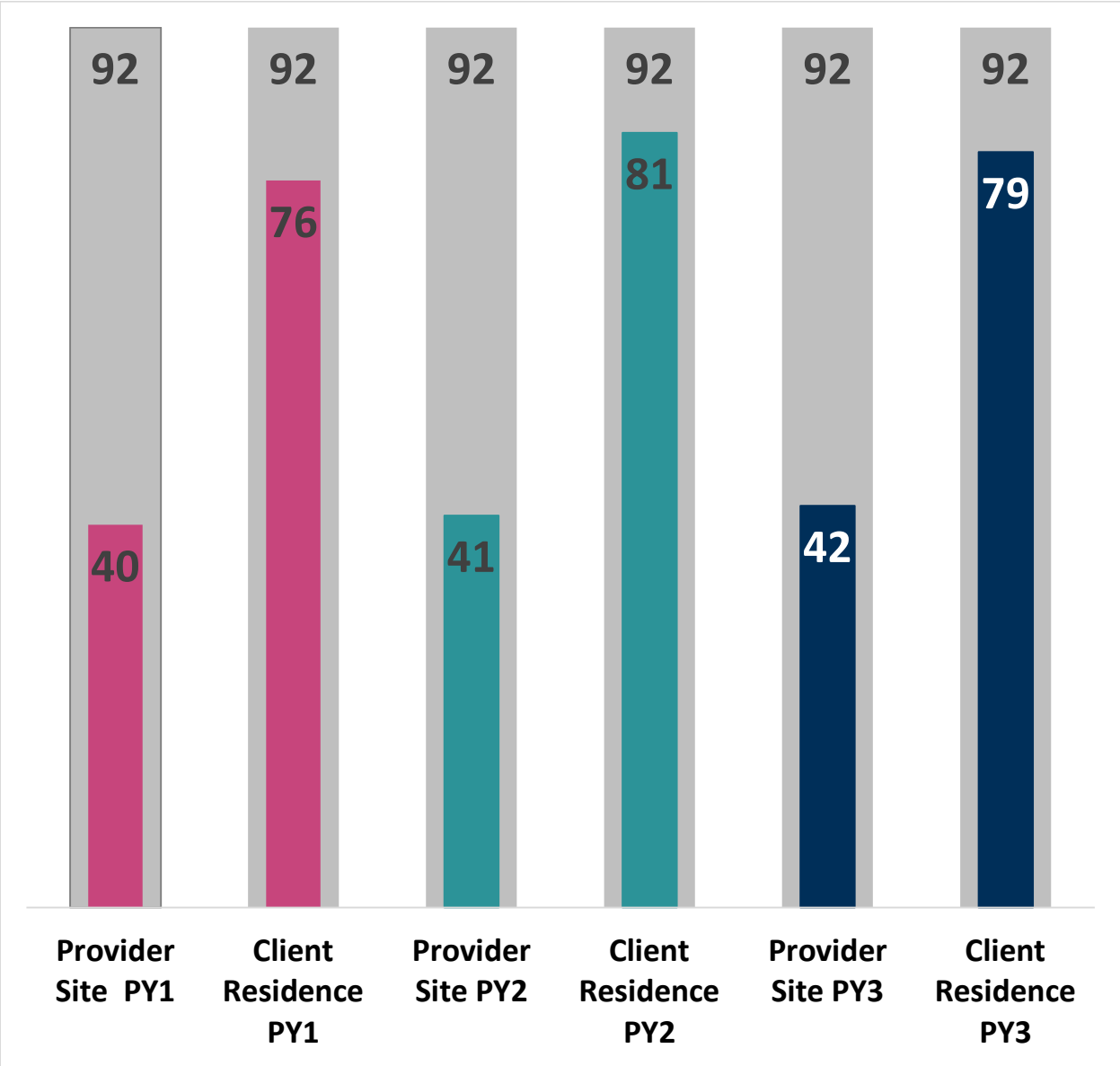
IN-BCCP Screenings completed by program year.



*CIN2 &

Appendix C: IN-BCCP Presence and Usage by County

Counties with IN-BCCP active providers and client residence counties by program year



IN-BCCP Services by number of counties where they were provided in 2019-2020

Service	Breast	Cervical
Screening Services	41	38
Diagnostic Services	25	22
Source: IN-BCCP data (2019-2020)		

Appendix D: Women Served with Non-BCCP Funding

Women Served by Non-BCCP Funding Sources in PY2

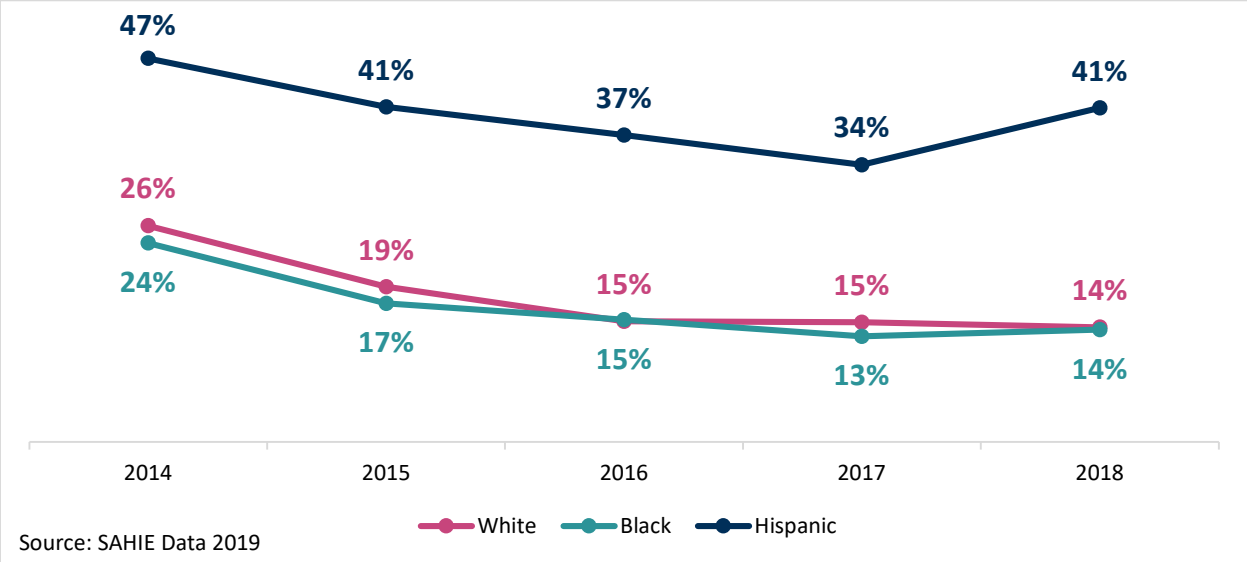
Region	Screening Mammograms	Breast Diagnostics	Cervical Services	Total Services
Northern	396	97	4	497
Central	171	132	102	405

Women Served by Non-BCCP Funding Sources in PY3

Region	Screening Mammograms	Breast Diagnostics	Cervical Services	Total Services
Northern	348	104	0	452
Central	402	259	108	769

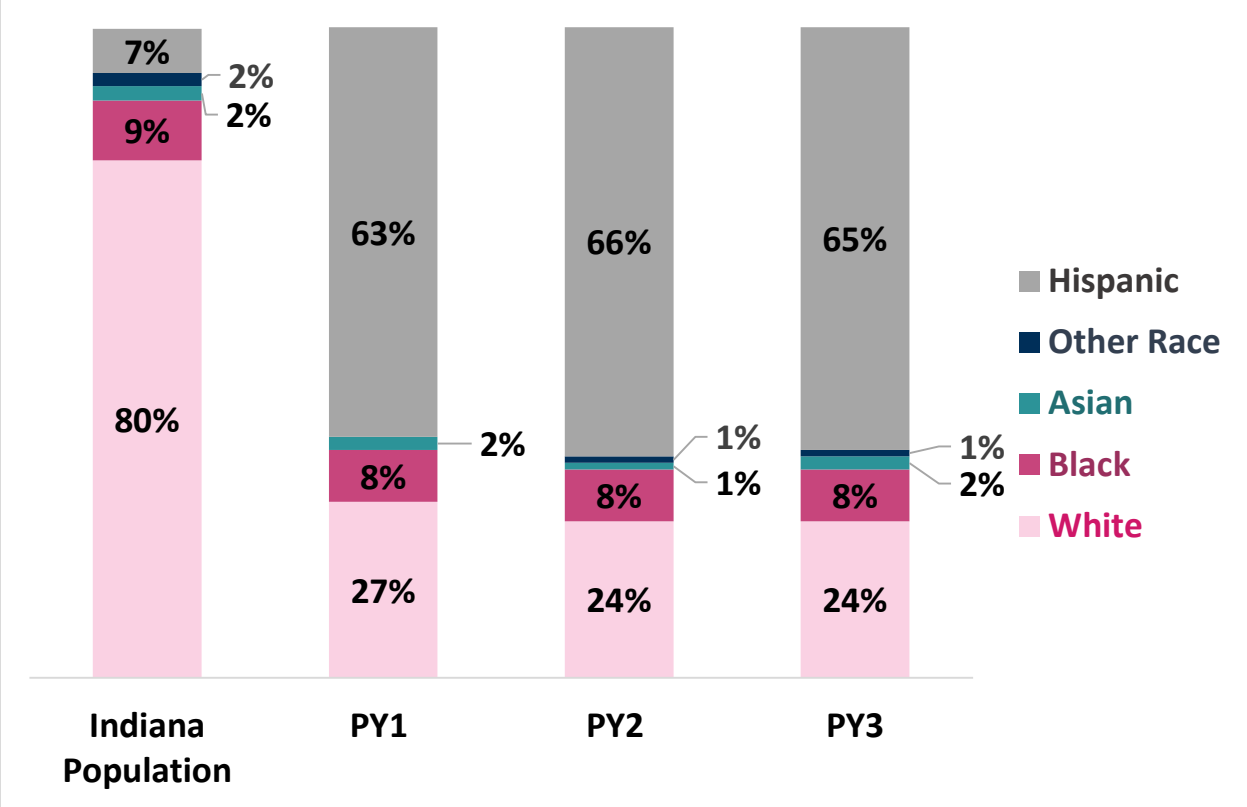
Appendix E: Hispanic Population

Percent Uninsured Women Ages 40 to 64 by Race and Ethnicity in Indiana, 2014-2018



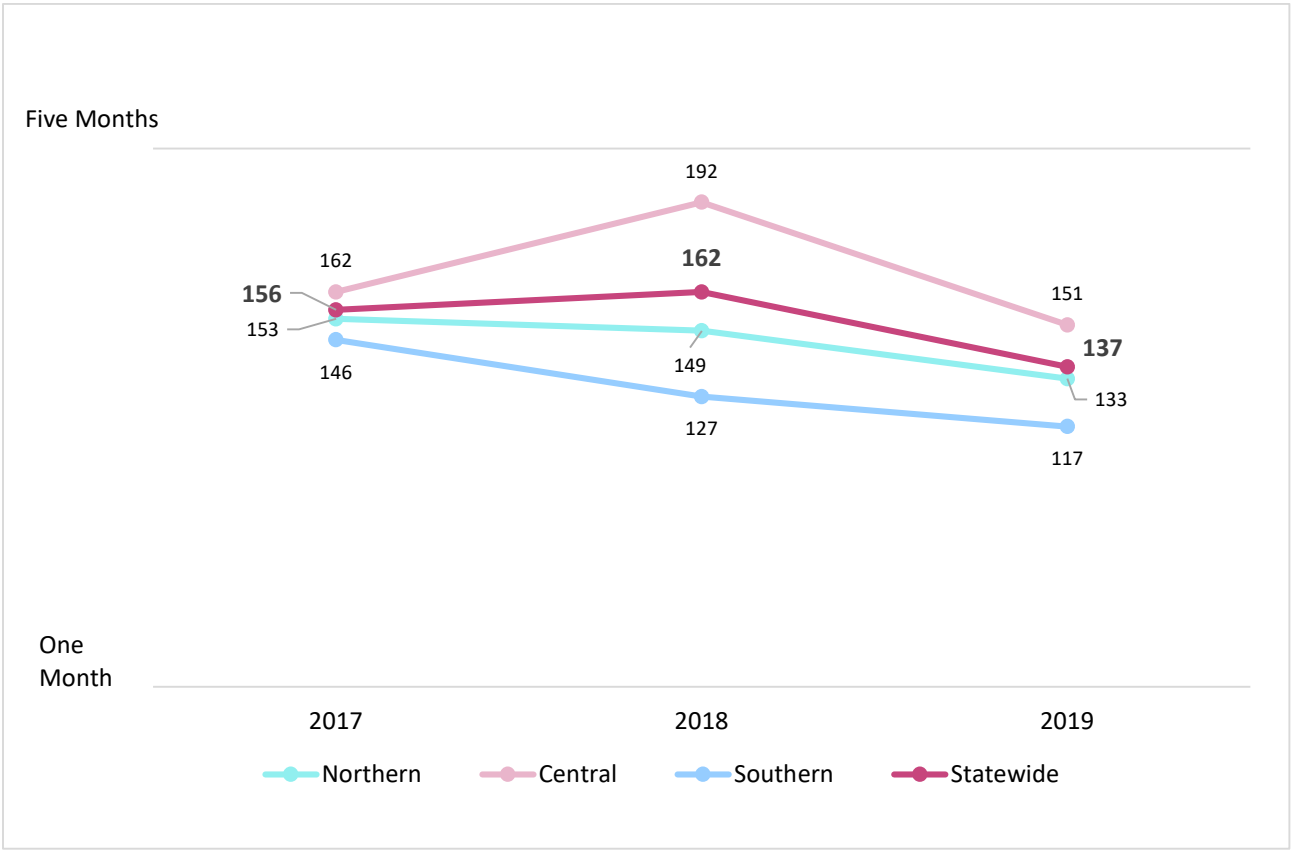
Source: SAHIE Data 2019

Percent of state population by race and ethnicity of IN-BCCP clients by program year



Appendix F: Days from Visit to Authorization to Pay

Average days between visit date and payment authorization



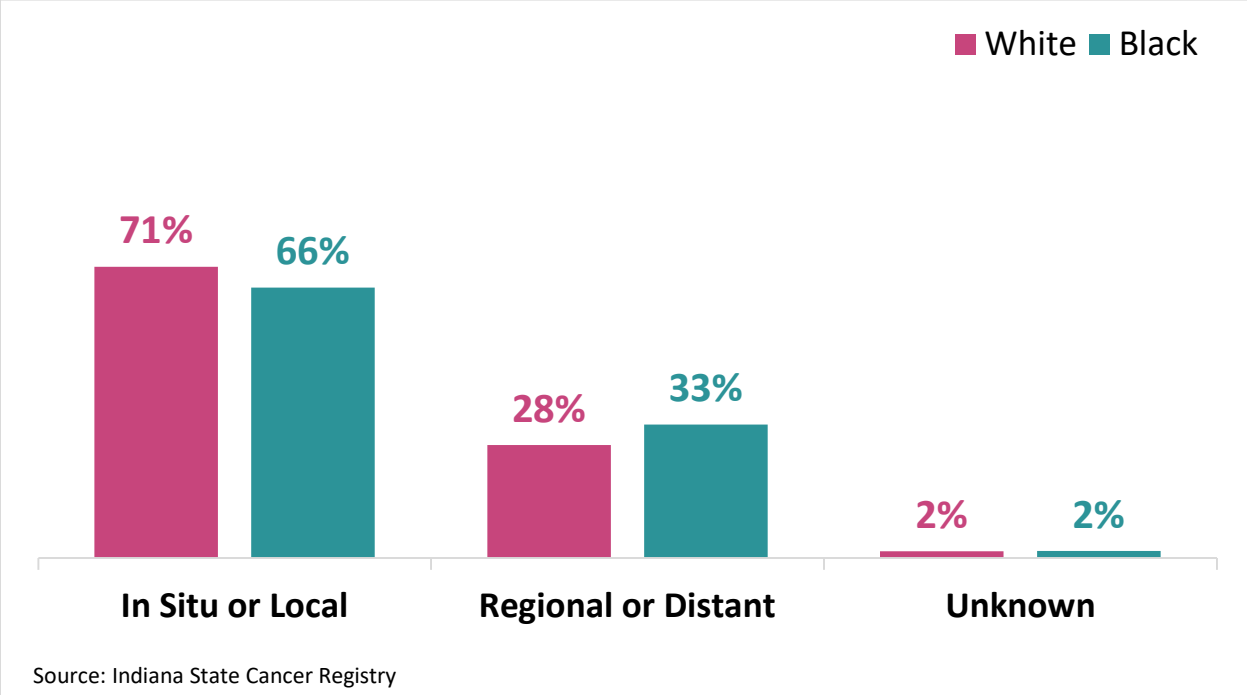
Appendix G: Potential IN-BCCP Population and Population Served by Region

Population of women ages 40-64 earning <= 200 FPL (2018) and women served by IN-BCCP, (2018-2019)

Region	Total # of women ages 40-64	# of uninsured women ages 40-64 earning <= 200% FPL	Unduplicated count of women enrolled in the IN-BCCP 2018-2019 Program Year	IN-BCCP participants as a % of uninsured women ages 40-64 earning <= 200% FPL
Indiana	*1,065,936*	*41,905*	*3,696*	*9%*
Northern	375,309	15,755	1,864	12%
Central	484,269	18,798	1,476	8%
Southern	201,367	7,188	359	5%
Source: SAHIE, 2019 and IN-BCCP data (2018-2019)				

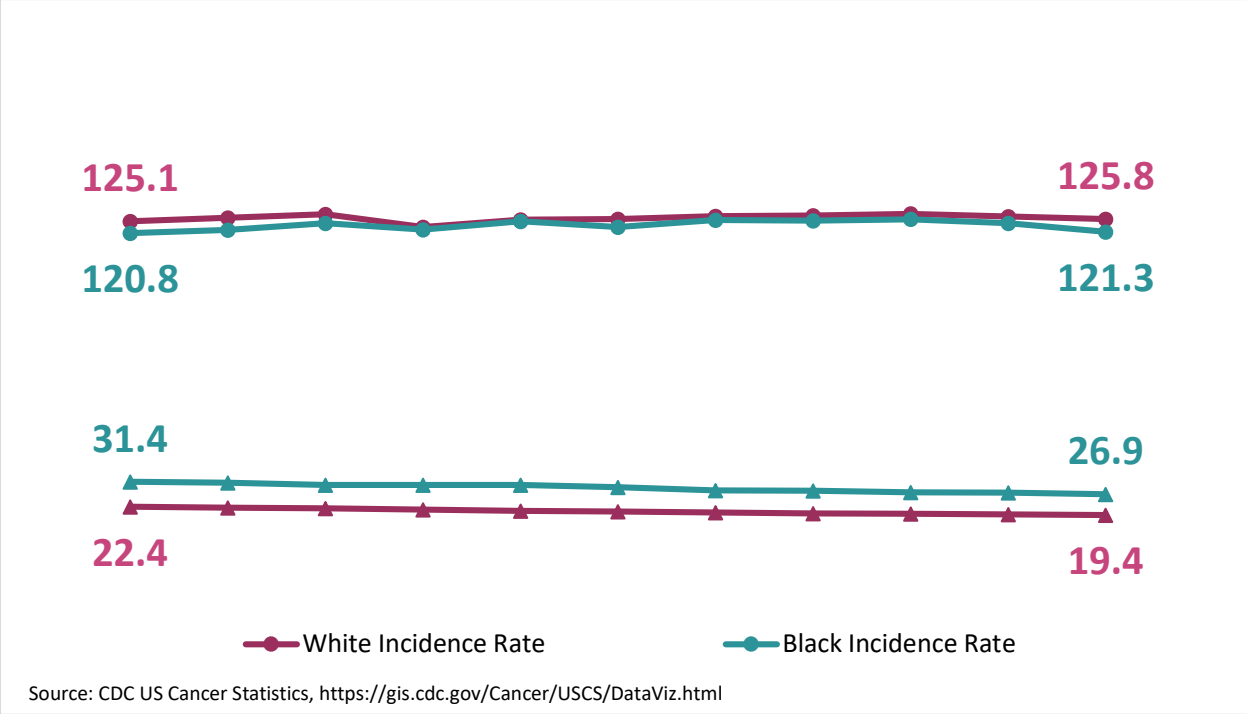
Appendix H: Race

Percent of female breast cancer cases in Indiana by stage of diagnosis and race, 2006-2015



Source: Indiana State Cancer Registry

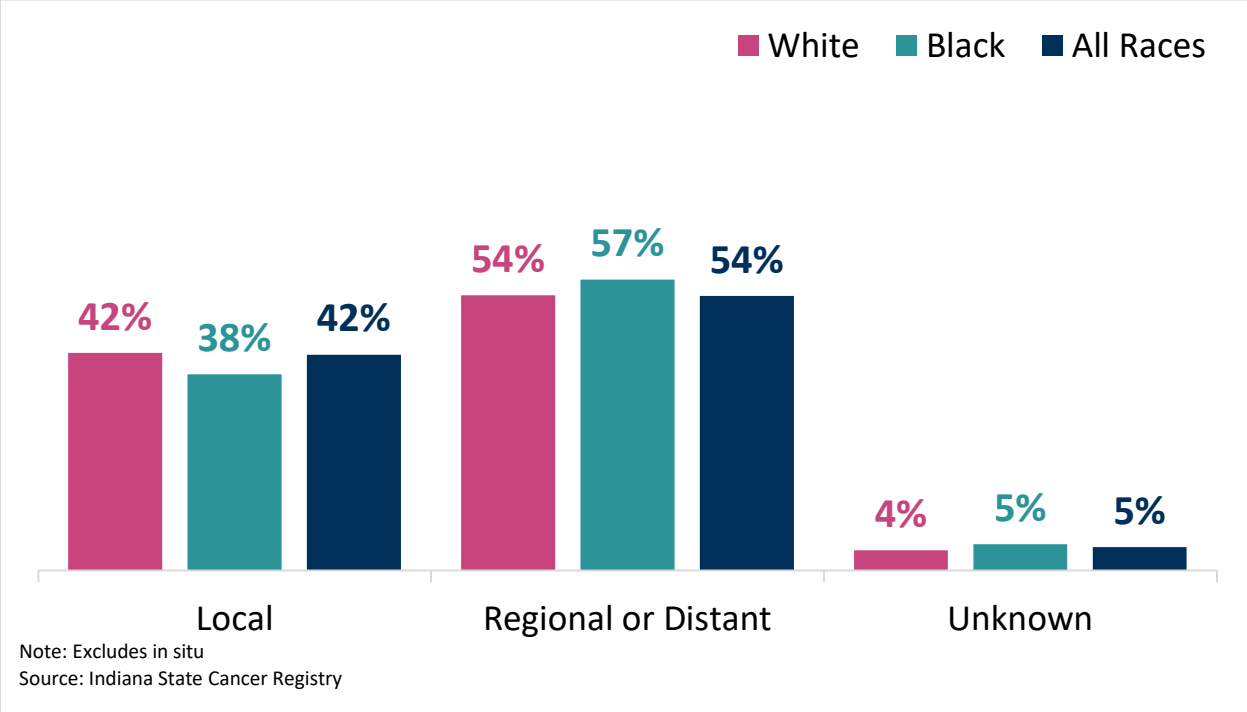
Indiana female age adjusted breast cancer incidence and death rates by race, 2007-2017



Source: CDC US Cancer Statistics, https://gis.cdc.gov/Cancer/USCS/DataViz.html

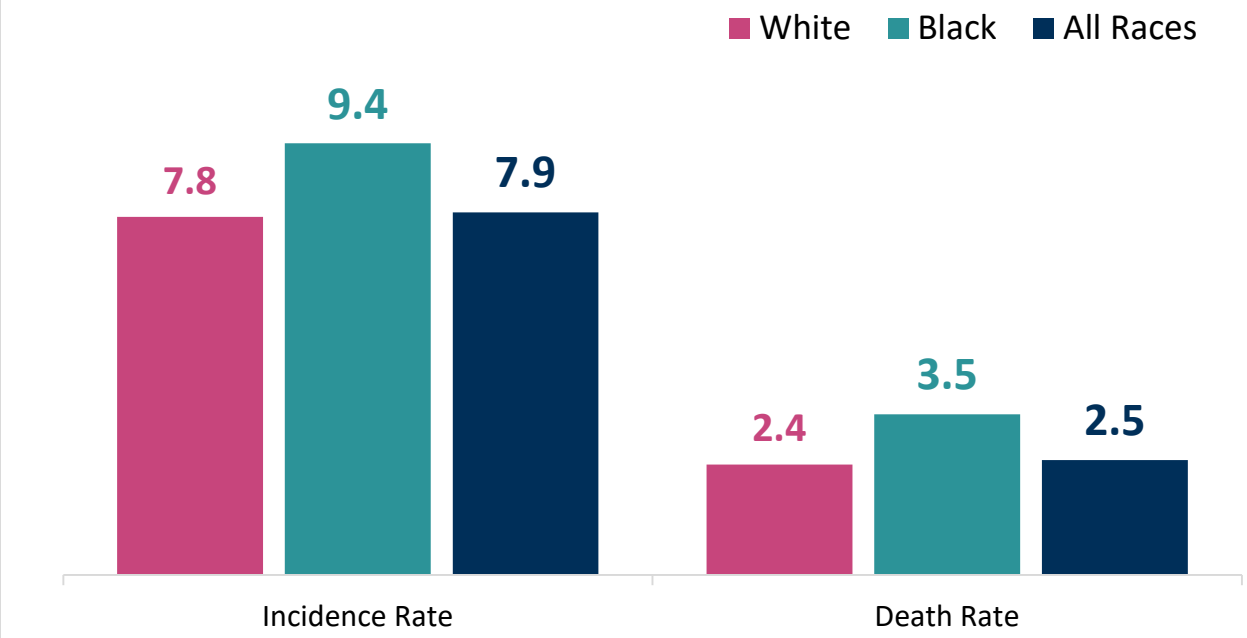
Appendix H: Race

Percent of female cervical cancer cases in Indiana by stage of diagnosis and race, 2006-2015



Note: Excludes in situ
Source: Indiana State Cancer Registry

Indiana cervical cancer age-adjusted* incidence and death rates by race, 2006-2015



*Age-adjusted to the US 2000 standard population
†Rate among Black females is significantly higher (P<05) than the rate among white females
Source: Indiana State Cancer Registry

Appendix I: Riggs Women's Health Screening Rates

Women screened at Riggs Women's Health in PY3