Reaching the Underserved With a Preventorium

Health clinic effectively bridges cultures to offer at-risk group a proactive approach to health care.

BY GINA SHAW
Contributing Writer

NEW YORK — When Elmer E. Huerta, M.D., left his oncology practice in Peru to come to the Washington, D.C., area in 1987, "I thought I was going to the heavens," he recalls. In Peru, 85% of breast and cervical cancers are found at stage III or IV, he told physicians at a cancer symposium.

But when he arrived in the United States, Dr. Huerta found pockets of poverty and lack of access, where people were horribly underserved and where diagnosis of disease came much too late, just as it did in Peru. He treated women with breasts horribly swollen and disfigured by tumors, who hadn't sought care until their symptoms were overwhelming, and their cancers so far advanced that they were almost untreatable.

"I saw women who could not bring themselves to do breast self-exams, because their mothers and grandmothers told them never to touch their breasts," Dr. Huerta said at the symposium, which was sponsored by New York University and the Lynne Cohen Foundation for Ovarian Cancer Research.

Dr. Huerta realized that cultural barriers—as well as unfamiliarity with the health care system, a lack of insurance coverage, and linguistic isolation—were keeping many Hispanic men and women in the United States from seeking preventive health care. Many would go to the doctor only when they were sick, which meant that diseases that could have been caught and treated early were being diagnosed in late, deadly stages. "The challenge I faced was how to convince people to seek care when they had no symptoms," he said.

The answer came through television and radio. He asked a patient with an advanced case of cervical cancer why she had not had a Pap smear before, and she responded, "What's that?" Seeking to lighten the mood during the same visit, he asked her what she thought of the goings-on on a popular soap opera appearing on a Spanish-language television network. She was instantly engaged, telling him what she thought the characters would do next. So, "I thought, why can't we sell health like we sell shoes—through the media?"

In 1989, Dr. Huerta created his first radio program, "Cuidando Su Salud [Taking Care of Your Health]," selling not pills, potions, and products, but prevention. The show has run daily ever since, and now Dr. Huerta has added a weekly, nationally syndicated call-in talk show and a local live television program to his roster. Together, the programs are estimated to reach 90% of Hispanics in the United States.

In 1993, a health clinic in Maryland's Montgomery County learned about the power of Dr. Huerta's message. In an average quarter, the clinic saw perhaps 20 Hispanic women for mammograms and Pap smears. During the first quarter of 1993, for example, 23 Hispanic women came to the clinic. But in the following 3 months, that number skyrocketed to 118—more than 5 times as many Hispanic patients as the clinic had seen in any quarter.

Dr. Huerta also persuaded his listeners to participate in clinical trials, which have struggled with low rates of accrual in the Spanish-speaking community. When he promoted one National Institutes of Health–sponsored trial on the radio, 325 listeners signed up, compared with no Hispanic participants in the previous month. He broadcasts clear, easy to understand information on topics such as how clinical trials work, why men should examine their testicles regularly, and the importance of wearing seat belts.

Once people got the message about preventive care and screening, they were left to seek affordable care. This is one reason Dr. Huerta founded the Cancer Preventorium more than a decade ago at the Washington (D.C.) Hospital Center. The affordable clinic allows low-income people to go for screening tests and get referrals for treatment. It's the opposite of the sanatoriums that sprang up in the early part of the 20th century, which hosted people with long-term illnesses. You don't go to the Preventorium if you're sick, he says. You go because you're well and want to stay that way.

Three weeks after its opening, the Preventorium had appointments booked through the end of the year. Patients pay $64 a visit, and the collection rate is almost 100%. "Even poor people will pay if you give them something of value," he said. ■

Medicare Part D Benefit May Facilitate Formulary Appeals

BY JENNIFER SILVERMAN
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WASHINGTON — Patients may find it easier to appeal denials of payment for medications under Medicare's new Part D prescription drug benefit than they do under other health programs, an analyst said during a meeting of the Medicare Payment Advisory Commission.

Specifically, the new benefit offers quicker alternatives to getting formulary exceptions for nonpreferred drugs than private plans or Medicaid, Joan Sokolovsky, Ph.D., a MedPAC senior analyst indicated. The new prescription drug benefit, a part of the Medicare Modernization Act of 2003, goes into effect in January.

MedPAC analysts reviewed the appeals processes in several private plans and in Medicaid to see how they compare with the upcoming Part D prescription drug benefit. The commission queried a number of stakeholders in these markets, including physicians, pharmacists, consumer advocates, health plan representatives, and pharmacy benefit manager representatives.

While Medicare's regulations on appeals generally support the processes of Medicaid and private health plans, MedPAC did find some fundamental differences, Dr. Sokolovsky said.

More situations are considered "coverage determinations" under the Part D benefit and may be appealed, she said. For example, Medicare beneficiaries will be able to appeal an increased copayment if they are prescribed a nonpreferred drug as opposed to a preferred drug. Dr. Sokolovsky said that private plans reported having little experience with this kind of adjustment.

The time frame for handling exception requests is also shorter under Part D, Dr. Sokolovsky continued. "If under an urgent request for an exception, a [Medicare Part D] plan must handle these determinations within 24 hours. That's typically faster than required for most [private insurers] now."

Shorter, expedited time frames and the ability to appeal copays, however, may lead to an increased volume of appeals, and possibly higher premiums, she said.

To minimize appeals, Part D plans may put fewer restrictions on separate, tiered cost sharing on nonpreferred drugs.

In some cases, physicians under Part D must get prior approval or authorization before nonpreferred drugs are covered.

From interviews with stakeholders, MedPAC learned prior authorization often creates burdens for beneficiaries and providers in commercial and Medicaid plans.

Prior authorization should ideally take place before the prescription is written—but often doesn't, Dr. Sokolovsky said.

"Physicians frequently don't know what the drugs are on their patients' formularies, or which ones require prior authorization." Patients often become aware of the need for prior authorization when the pharmacist tries to process the prescription and gets a notice the drug is not covered, but lists others that would be covered.

Private plans tend to keep detailed information on the disposition of exception requests; however, some information never comes back to a plan, she said. ■