To the Editor:
Breast cancer is the most frequently diagnosed cancer in women in the United States, and it accounts for 1 out of 3 diagnoses of cancer.\(^1\) In the recent past, various studies have consistently shown poor breast cancer screening rates in the racial and ethnic minority populations, including African Americans, Native Indians, Asians, and Hispanics.\(^2-6\) It clearly indicates that the current strategies to increase awareness regarding breast cancer screening methods in the minority groups have not been up to the mark. Therefore, it becomes essential to highlight this issue and design effective strategies to increase the screening rates in the women belonging to minority groups.

Aside from the direct out-of-pocket costs of breast cancer examinations, poor screening rates in minority groups can be attributed to 2 principal reasons: (1) a lack of awareness about the importance of breast cancer screening and screening methods available and (2) culture-based embarrassment about screening methods such as mammography.\(^7\) Due to existing social and cultural barriers, many minority women feel reluctant to go for breast cancer screening. Language barriers further worsen the issue. Jacobs et al. have reported that the language barriers act as a hindrance to breast cancer screening by impeding adequate health communication.\(^6\) It is important to influence the social and cultural beliefs of these women and also decrease the existing language barriers in order to decrease their reluctance and, hence, increase the screening rates.

An effective way of increasing the screening rates for breast cancer in women belonging to minority groups can be achieved through proper counseling. Fox et al. have reported physician counseling as the most important variable that predicted whether women of all races had a mammogram.\(^7\) However, pharmacists are the health care providers who most often interact with these patients. The AMCP Framework for Quality Drug Therapy includes an assessment of quality pharmacy services in areas of health management and health promotion specific to measures such as the provision of support materials in languages that are predominant in the target population and are sensitive to cultural differences among ethnic populations.\(^8\) Therefore, it becomes essential that pharmacists take responsibility for providing counseling to these women.

Pharmacists can play an important role in increasing awareness of breast cancer screening among minority women. Pharmacists working in both community and hospital settings are the key drug information providers to patients since they are the ones who interact most frequently with them. They should provide more information to these women regarding mammography, clinical breast examination (CBE), and breast self-examination (BSE). This can be done by either providing individualized counseling or by organizing community-based education programs. Culturally targeted interventions can prove helpful in increasing awareness and screening rates.\(^9\)

Distributing self-risk assessment tools and pamphlets that provide information about mammography and CBE may also help in increasing awareness and screening rates. Regular screening and surveillance of women at increased risk for breast cancer may prove very useful in detecting disease at an early stage, thus decreasing the associated morbidity and mortality. Through counseling, pharmacists can provide these women with the essential knowledge they need to make rational and informed decisions about screening and prevention. It is, however, important that the pharmacists be provided education and training, at either the college level or at the pharmacies, regarding the cultural beliefs, customs, and language needs of these groups. That will immensely help in providing individualized care to each culturally diverse patient.

Literature suggests that 92% of [breast] malignancies can be cured with early detection and treatment.\(^1\) The National Committee for Quality Assurance (NCQA) 2005 report mentioned that a mammography can help in detecting breast cancer 1 to 3 years before a woman can feel the lump, and it helps in detecting approximately 85% of breast cancers.\(^10\) Giles et al. have investigated the outcomes of a community pharmacy-based breast cancer risk assessment and education program.\(^1\) In their study reported in 2001, they found significant improvements in the frequency of BSE and in the proportion of patients following American Cancer Society guidelines for BSE after pharmacist-based intervention. Currently, there is a lack of information highlighting the role of pharmacists in the breast cancer screening programs. Pharmacists working in public health settings should conduct more studies that focus on the role of pharmacists in educating women belonging to minority groups about the importance of breast cancer screening.

Racial disparities have also been observed in the quality of care provided in Medicare managed care. The Balanced Budget Act of 1997 requires that all health plans that enroll Medicare beneficiaries annually report quality-of-care data using a Medicare-specific version of the Health Plan Employer Data and Information Set (HEDIS).\(^11\) The HEDIS breast cancer screening measure (developed by NCQA) estimates the percentage of women between the ages 52 to 69 years enrolled in a health plan who had at least 1 mammogram in the past 2 years.\(^12\) The rationale is that mammography screening has been shown to reduce the mortality by about 20% to 40% in women aged 50 years and older.\(^12\) According to the NCQA 2005 report, screening rates for women enrolled in different plans are 73.4% for commercial plans, 74% for Medicare, and 54.1% for Medicaid.\(^10\) However, recent studies have shown that blacks enrolled in Medicare managed care are less likely to receive breast cancer screening (mammogram) as compared with white enrollees.\(^13,14\)

Pharmacists can assist in decreasing this gap and thus help managed care organizations to provide high-quality care to all
enrollees irrespective of their ethnicity. A timely detection of cancer through screening may also help in containing the costs that would otherwise have been incurred if the cancer was detected at a later stage. The total estimated direct and indirect costs associated with breast cancer in the United States are between $2.35 billion and $3.13 billion, and about $2 billion of this is for late-stage breast cancer treatment.14

With more than a 13% probability of a woman developing invasive breast cancer in her lifetime,15 it is important that pharmacists assume a professional and direct responsibility in the effort to inform women of this risk. Ethnic and language barriers should be overcome in this education effort.

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DISCLOSURES
The author discloses no potential bias or conflict of interest relating to this letter.

REFERENCES

Medicare Part D on the Front Line

To the Editor:
Here are some of my observations from the first 4 months of Medicare Part D, as a community pharmacist working in a chain pharmacy in the Southwest. I may be in the minority of pharmacists with regard to Medicare D observations. But then again, my chain employer understandably keeps us totally in the dark regarding all aspects of reimbursement, so I have no idea of the financial impact Medicare Part D has on my employer. I think, after a rocky start, the Medicare Part D program implementation has been relatively smooth.

The first week in January 2006 was a nightmare, with patients having no information about their enrollment. The issues with the Social Security Income (SSI) number not relaying information to the Centers for Medicare and Medicaid Services (CMS) for “extra help” eligibility are well known. Most of those patients were covered by Medicaid already, and there was difficulty in determining the proper copayment amounts for these dual eligibles. Even now, we simply bill Medicare D and the system does a split billing to the state Medicaid program for the copay amounts.

The payers were poorly staffed to handle our calls for claim processing assistance. Hold times were ridiculous. Some systems said, “We’re too busy, call back later.” After the first month, my chain pharmacy employer developed a Medicare D eligibility finder that is a Godsend. With just the patient’s Social Security number, we can transmit a claim to CMS, which, of course, rejects it. But the rejection gives you the BIN, PCN, ID and Group numbers. So the ID card is unnecessary. Also, if no eligibility is found, the patient knows the enrollment has not yet been processed.

The payers did a very poor job of informing patients about the “donut hole” portion of the benefit. Everyone was doing a happy dance when they got their first claims processed for just the “donut hole” portion of the benefit. Everyone was doing a happy dance when they got their first claims processed for just the “donut hole” portion of the benefit. Everyone was doing a happy dance when they got their first claims processed for just the “donut hole” portion of the benefit.

CMS did a great job designing the Medicare D Plan Finder