

WI Department of Health Services

Division of Public Health



Wisconsin Well Woman Program

New Model Proposal - Recommendations from Local Public Health Work Group

November 14, 2014

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1 WWWP NEW MODEL PROJECT

1.1 WWWP BACKGROUND

The Wisconsin Well Woman Program (WWWP) provides preventive health screening services to women with little or no health insurance coverage. Well Woman pays for mammograms, Pap tests, certain other health screenings, and multiple sclerosis testing for women with high risk signs of multiple sclerosis. The program is administered by the Wisconsin Department of Health Services, Division of Public Health, and is available in all 72 Wisconsin Counties and 11 tribes. Well Woman pays for certain screenings for some of the most common women's health concerns at no charge to eligible women.

The program is administered by local Coordinating Agencies that work directly with women. As of 2014, there are over 85 coordinating agencies located within county and municipal public health organizations and the 11 tribes, and over 1000 providers.

1.2 NEW MODEL

The organizational structure will change to a multi-jurisdictional model of 5 – 10 areas. Fewer coordinating agencies are expected to improve the efficiency of the program and increase consistency and coordination between Coordinating Agencies. Coordinators will be able to spend the majority of their time on the program.

The second area of change will be to decrease the provider network. There are over 1000 providers, many of whom do only a few screenings per year. The new provider network will be a subset of the current providers, with geographic coverage included to ensure that all areas of the state retain coverage. Eligibility will be limited to providers that are in one of these four categories:

- Health systems;
- Federally qualified health centers (FQHC);
- Outpatient hospital clinics;
- Rural health clinics.

The intent of this project is to create a new administrative model that will enable the WWWP to continue operating for years to come. The services provided by WWWP are not changing, nor are eligibility criteria.

The organizational changes described here will not affect the 11 tribes or the city of Milwaukee. The WWWP new model organizational changes will not include the City of Milwaukee Health Department and the Wisconsin tribes as they are unique in their operational structure within the Program.

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The *City of Milwaukee Health Department* is a full-time program devoted exclusively to the WWWP with administrative, clinical, and support staff. The Health Department functions as both a coordination agency and a screening provider. Their mobile mammography unit is supported by WWWP funding required by Wisconsin Statute 255.06(2)(c). More than 20% of all WWWP clients annually (an average of 1,570 women) are served by the Health Department's WWWP, which includes the coordination of follow-up and diagnostic services with multiple health systems in the metropolitan Milwaukee area.

The Health Department's client population is the most diverse in the state, with the majority of African American and Hispanic women served by the Program. During 2013, 2,360 women received screening services, with 977 African American women accounting for 76% of the statewide total for African Americans served during that year. Collaborative efforts are maintained with organizations, such as the Milwaukee Consortium on Hmong Health, to assure that culturally appropriate programming is provided to all clients.

The current *tribal WWWP service coordination model* will be maintained as it aligns with the longstanding working relationship of the Department of Health Services' Tribal Affairs Office to coordinate funding and program requirements with the tribes. It fulfills the need to coordinate payment between the WWWP and the IHS (Indian Health Service) funding for clinical services. The organizational structure of the WWWP tribal model supports the cultural, structural, and funding aspects of the 11 tribes in Wisconsin. The geographic locations of the reservations and tribal clinics are well-positioned to provide culturally appropriate education and screening services to tribal members. This WWWP tribal model sustains the unique role that tribal community health workers play in helping women access WWWP services.

1.3 WORK GROUP CHARGE

The Department of Health Services requested the Wisconsin Association of Local Health Departments and Boards (WAHLDB) to identify members to form a work group to make recommendations on the new multi-jurisdictional areas and the coordinating agency for each area, as well as to review and provide recommendations on the New Model plan.

The group comprised a representative from each of the five regions:

Western Region: Kelli Engen, Barron County

Northern Region: Joan Theurer, Marathon County

Southern Region: Barb Theis, Juneau County

Southeastern Region: Sally Nusslock, City of West Allis

Northeastern Region: Doug Gieryn, Winnebago County

The formal charter for the Work Group can be found in [§ 3.1](#).

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The recommendations included in this document were generated by the Work Group through discussions and meetings held from June 2014 through November 2014. The Work Group based their conclusions on the information available at that time. This information did not include which providers would comprise the new provider network.

2 NEW MODEL RECOMMENDATIONS

2.1 IDENTIFICATION OF MULTI-JURISDICTIONAL AREAS

The first recommendation proposes 10 Coordinating Agencies:

Oneida and Portage (Northern Region);
Winnebago and Brown (Northeastern Region);
Dane and Juneau (Southern Region),
Racine and Kenosha (Southeastern Region);
La Crosse and Eau Claire .

The list of counties by coordinating agencies in this recommendation is shown here.

- Southern Region
 - Dane
Dane, Rock, Jefferson
 - Juneau
Juneau, Adams, Richland, Sauk, Columbia, Dodge, Grant, Iowa, Lafayette, Green
- Southeastern Regionⁱ
 - Racine
Racine, suburban Milwaukee
 - Kenosha
Kenosha, Walworth
- Northeastern Region
 - Brown
Brown, Marinette, Oconto, Shawano, Door, Kewaunee, Manitowoc
 - Winnebago
Winnebago, Waupaca, Outagamie, Waushara, Calumet, Marquette, Green Lake, Fond du Lac, Sheboygan
- Northern Region
 - Oneida
Oneida, Bayfield, Ashland, Iron, Vilas, Forest, Florence, Sawyer, Price

ⁱ Washington, Ozaukee and Waukesha Counties are not included in this list as there is not yet a decision from them. Washington and Ozaukee could stay in the Southeastern Region or move to the Northeastern Region. Waukesha County is not currently assigned to a Multi-Jurisdictional Region.

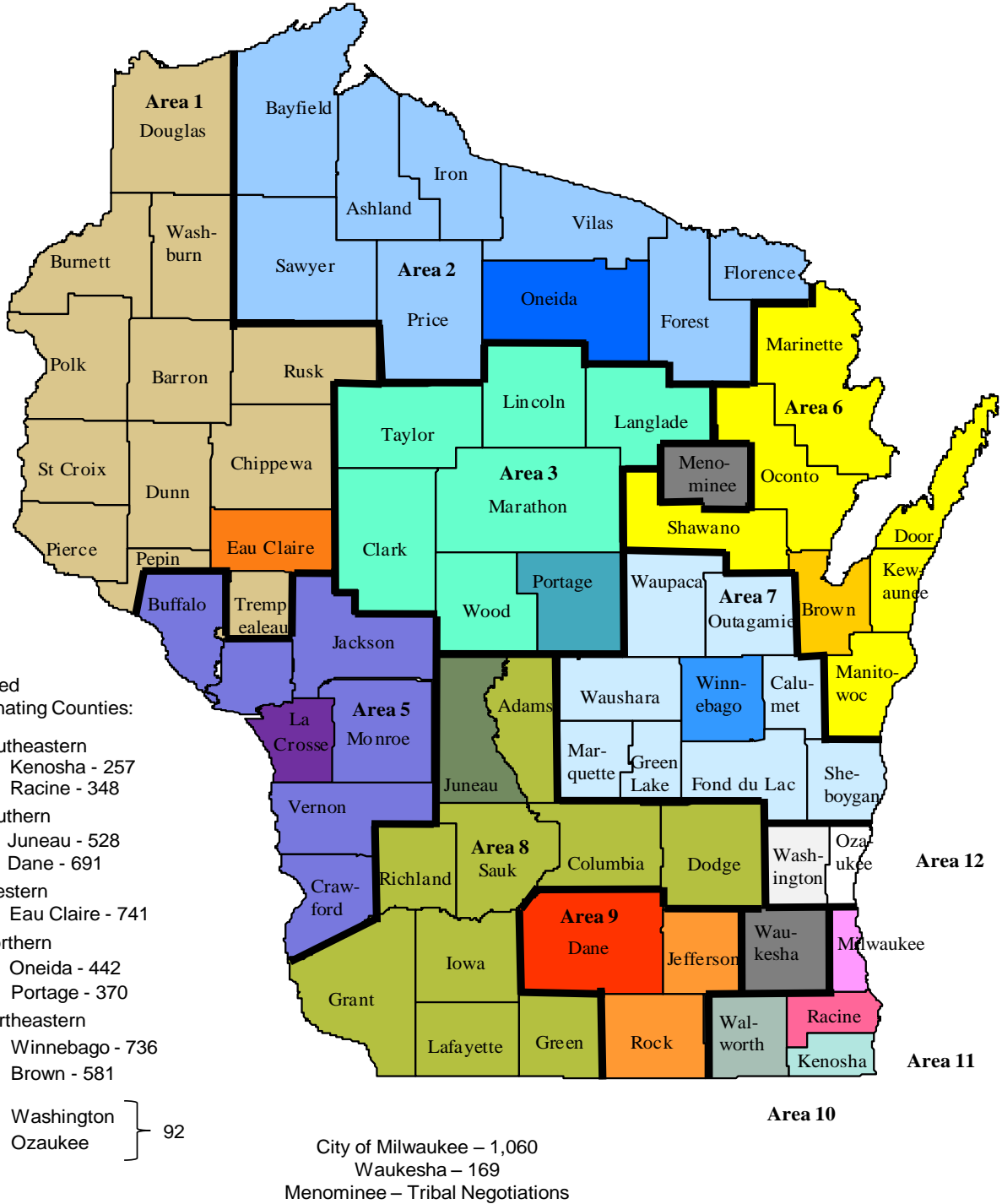
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- Portage
Portage, Taylor, Lincoln, Langlade, Clark, Marathon, Wood
- Western Region
 - Eau Claire
Polk, St. Croix, Eau Claire, Trempealeau (northern half), Pepin, Pierce, Dunn, Chippewa, Polk, Rusk, Barron, Burnett, Washburn, Douglas
 - La Crosse
La Crosse, Vernon, Monroe, Trempealeau (southern half), Jackson, Buffalo, Crawford



As of 11/12/2014

Multi-Jurisdictional Areas and Coordinating Agencies
Contract Numbers Calendar Year 2013
Version 1



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The second recommendation proposes 11 Coordinating Agencies, with the change occurring in the Western Region:

La Crosse, Polk, and Eau Claire;

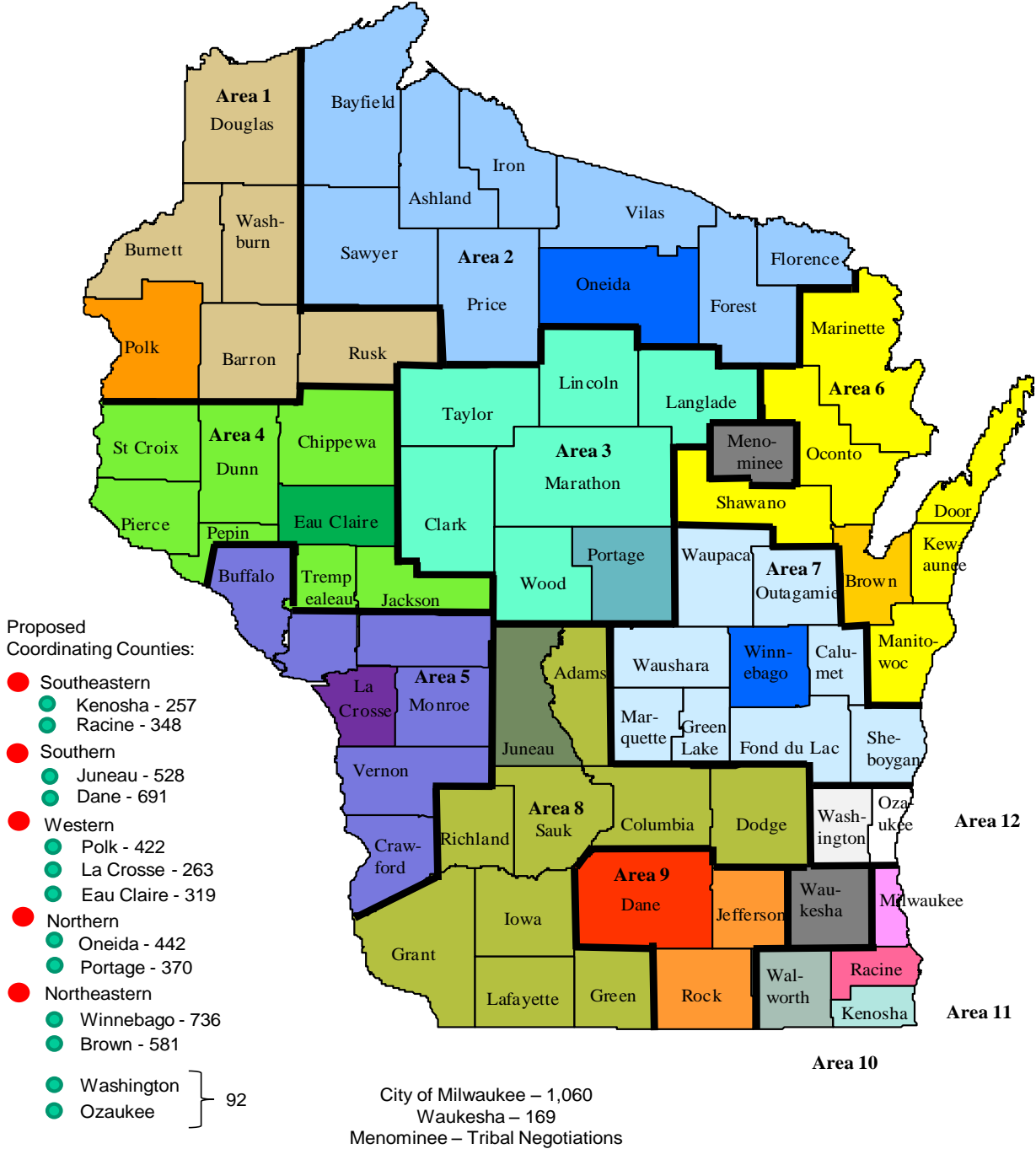
The list of counties by coordinating agencies in this recommendation differs only in the Western Region, where 3 coordinating agencies are being proposed:

- Western Region
 - La Crosse
La Crosse, Vernon, Monroe, Trempealeau (southern half), Jackson (southern half), Buffalo, Crawford
 - Polk
Polk, Barron, Rusk, Washburn, Burnett, Douglas
 - Eau Claire
St. Croix, Eau Claire, Pepin, Pierce, Chippewa, Trempealeau (northern half), Jackson (northern half), Dunn



As of 11/12/2014

Multi-Jurisdictional Areas and Coordinating Agencies
 Contract Numbers Calendar Year 2013
 Version 2



2.2 GUIDELINES FOR FUNDING ALLOCATIONS

The New Model is expected to be fully in place on 7/1/2015, for the start of year 4 of a 5-year cooperative grant on 7/1/2015.

The Well Woman Program is funded to deliver services within a set budget. CDC, the main funder, does not consider Well Woman to be an entitlement program, meaning that the number of women served may be less than the number of eligible women. Wisconsin's Well Woman Program went over budget every year in fiscal year 2012 and 2013, with the Department providing additional funds from its General Revenue to make up the difference.

Moving to a model with fewer coordinating agencies and providers is expected to improve efficiency and decrease total operating costs for the program over time. In addition, enrollment in ACA marketplace insurance programs and BadgerCare Plus is expected to decrease the number of women enrolling in the Well Women Program.

The Work Group was given a high and low budget to use in deliberations:

- A budget of \$200,000 statewide base funding, with \$75 @ woman;
- A budget of \$500,000 statewide base funding, with \$75 @ woman.

The budget amount does not include transportation costs, but should include interpreting and translation costs. The base funding represents an amount that will be distributed to the Coordinating Agencies regardless of the number of clients served by the agencies. A high (\$500,000) and a low (\$200,000) estimate were provided. The \$75 amount is the money allocated per client and is separate from the base funding amount.

Recommendations from the Work Group:

- Consider a formula based on the population being served. This is similar to what many other DPH programs do. Consider the impact of these specific attributes when determining the funding amount for a Coordinating Agency:
 - Disparate needs;
 - Interpreting and translation needs;
 - Number of women served by the WWWP;
 - Geographic size of the multi-jurisdictional area;
 - Number of women eligible;
 - General population;
 - Number of women living in poverty.
 - ;
- Whenever possible, create standard, state-wide services for things such as translations, outreach, trainings, and data collection.
- Create a separate set-aside in budgeting for translation and transportation services.
- During the transition period, have some extra funding available to assist the new Multi-jurisdictional agencies for unanticipated costs.

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- Guarantee a stable plan for 3 – 5 years. This is recommended to provide stability to local public health organizations that are going to act as the new multi-jurisdictional agencies.
- As this new breakout of agencies matures, include some local participation in any recalculation of funding formulas.

2.3 STRATEGIES TO ASSIST WITH ROLE CLARIFICATION FOR COORDINATORS AND COORDINATING AGENCIES

The Work Group was presented with a formal document outlining a proposal. This document can be viewed in [§ 3.2](#). The proposal had 2 sections: an introduction and a section on specific coordinator responsibilities.

Discussion centered on one sentence from the introduction. That sentence is shown below.

Due to the clinical nature of the responsibilities, the designated coordinator(s) must be a registered nurse, physician assistant or Licensed Clinical Social Worker (LCSW).

The Work Group proposed modifications to this statement:

- Add “public health nurse” and “health educator” to the list of specifically defined job classifications.
- Eliminate the requirement that a coordinator must be a nurse, LCSW or physician assistant. Replace this with a list of minimum requirements that a coordinator should have.

.Additional recommendations

- Create an estimate of the number of women or number of client interactions that an FTE coordinator can be expected to work with, based on the average time periods for initial and follow-up visits. The estimate should include these considerations:
 - Skill level of the coordinator;
 - Percent of time that the coordinator and/or administrative staff is expected to spend on clerical/back-office activities.
- Work with Providers to review and verify the feasibility of having Coordinators make medical appointments.

2.4 TRANSITION PLAN TO FUTURE PROGRAM MODEL

The Work Group was presented with a formal document outlining a proposed timeline for transitioning to the New Model for referrals. This document can be viewed in [§ 3.3](#).

Data

- Research to determine if there any legal issues regarding the transfer of data and/or records from county agencies or other entities to the new MJA coordinating agencies. Specific concerns to research include record retention requirements and HIPAA rules.

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- Research to determine if there are any HIPAA or other privacy/sharing issues in transfer of data
- Identify what needs to be transferred (beyond just records) from current coordinating agencies to new MJA agencies
- Establish a process to ensure that MJA coordinators be able to see records from other jurisdictions
- The State needs to set parameters/expectations for data sharing and then share these with counties

Communication during the transition

- Provide a single contact point, such as a phone number, for local agencies to use for questions
- Schedule a face-to-face meeting for providers and coordinators
- Consider having meetings between current coordinators and new coordinators
- Continue to have regular conference calls/meeting between coordinators after new model in place

During and immediately after implementation

- Consider doing some strategic or long-range planning with the coordinator group
- Identify and plan for the special needs of border areas; e.g., may want to build in some form of cooperation/consultation for coordinators
- Make sure there is a system in place to provide backups for coordinators

Interpretation & Translation

- Expect a need to create new contracts for interpretation and translation needs – which will require approval by county boards – and some guarantee of funding
- Consider translation needs – MJA coordinators will be working out of county offices – and may need to bring in resources that are not currently under contract with the county (e.g., a multi-county area may require use of a HMONG translator that was not previously needed in the county hosting the MJA)
- Consider creating some playable modules in different languages and having them on the website

Big picture thoughts

- Evaluate if the transition timeline is realistic. The current timeline begins with the announcement of the new MJA on 12/31/14. The actual transition period is planned for 4/1/15 to 6/30/15. Having enough time for the local county board and organization hosting the new MJA coordinating agency to gain all needed approvals is critical. Local Health Departments may need to go through multiple county boards and committees to secure approval to be a MJA coordinating agency. County boards and committees often meet only monthly, and may want to hold off on granting approval until all

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questions regarding funding for incurred expenses are answered. Estimate given that it could take from 45 to 90 days to get the needed approvals.

- Transportation concerns should be directly addressed during transition planning as this is a big issue for rural areas
- Provide funding to Coordinating Agencies to assist with costs incurred during the transition period
- Post-transition – establish in a formal, periodic and coordinated approach for counties to request transfers to different Coordinating Agencies, while safe-guarding the ability of Coordinating Agencies to manage their budgets and Multi-jurisdictional areas.

2.5 REFERRAL PROCESS TO BADGERCARE PLUS AND MARKETPLACE

The Work Group was presented with a formal document outlining a proposed approach for referrals. This document can be viewed in [§ 3.4.](#)

The group was supportive of this document with the addition of these changes and recommendations:

- Change wording in this sentence “Refer the client to the internet site HealthCare.gov, the Healthcare.gov toll-free telephone number 1-800-318-2596, or the appropriate agency in your area” to emphasize that not all women have internet access.
- Add additional resource information to this document. Multi-jurisdictional areas should create a version that has local resource information.
- Create a document listing contact information that can be given to the woman to take with her.
- Add language to the Responsibility/Role section stating that coordinators need to have knowledge of who provides these services in their area.

2.6 TRANSLATION AND INTERPRETATION SERVICES

- Create standard materials at the State level, and have those translated into different languages.
- Create a separate set-aside in budgeting for interpretation and translation services.

2.7 IDENTIFICATION OF POTENTIAL RISKS AND CHALLENGES

The intent in this area was to do risk planning. Work Group members were asked to come up potential issues and a strategy or suggestion that could be applied to either mitigate or minimize the impact of the issue. As part of the process, a strategy or recommendation to mitigate the challenge was also developed.

Topic Area	Challenge or Barrier	Recommendation or Strategy
All	Coming up with a single model that will work for everyone	Come up with an ‘umbrella approach’ that will allow for customizable options by area
§ 2.3 Funding	How to hire and keep qualified staff when funding is only guaranteed a year at a time.	Guarantee a stable plan for 3 – 5 years

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Topic Area	Challenge or Barrier	Recommendation or Strategy
§ 2.4 Transition	Separate data systems create challenges in sharing data between coordinating agencies	Have a single State-wide electronic data system that can be shared by all coordinating agencies across all multi-jurisdictional areas
All	Need an infrastructure capable of dealing with a diverse client group including citizens and non-citizens, rural and urban, and English speaking and non-English speaking women.	<ul style="list-style-type: none"> - Data being compiled on projected client base will help in selecting the multi-jurisdictional areas (MJA) - WG needs to establish boundaries for MJA very carefully - Coordinating agencies will need to establish and maintain strong, ongoing communication with DPH central office - Coordinating agencies will need to work with each other – which should be easier with fewer agencies
All	Counties take pride in providing a “localized” community presence – how do we keep that personal touch when providing services to a much larger area?	
All	Establishing and maintaining good communication with local Public Health at the county level	<ul style="list-style-type: none"> - Careful management during the transition period - Plan the transition to contain a period of time when both new MJA and current county-based coordinating agencies are active - Include providers in transition plan
§ 2.6 Role Clarification	Defining the role of MJA and coordinators in dealing with cancer prevention, education, and outreach.	<ul style="list-style-type: none"> - The role of MJA and coordinators will continue to evolve - Encourage cooperation with local health agencies served in the Multi-jurisdictional area - Use implementation of New Model as an opportunity for training and tools, and to work together to create a State-based approach that will ensure that women receive the same information and support regardless of which coordinating agency they use
All	Ensure that as we move to fewer providers/systems this doesn’t conflict with the goal of creating health homes (health home concept is to have all aspects of health care be coordinated.)	<ul style="list-style-type: none"> - Facilitate partnerships between smaller clinics and larger clinics – so information is not lost during transition period - Require WWWP providers to send information on screenings to a woman’s main health care provider
§ 2.6 Role Clarification § 2.3 Funding	Will the program provide any assistance to women for traveling to a provider? Fewer providers may mean a greater need for transportation assistance.	<p>(This information was given by DPH WWWP)</p> <ul style="list-style-type: none"> -New model is keeping with the current requirement that every woman will be able to receive cervical cancer and breast cancer screenings within 50 miles of where they live – that has not changed. -Multiple Sclerosis screenings are only available at 4 locations, so while very few women receive them, they will continue to require a greater travel distance for many women. -As is done currently (in the MS component, for example), program will be able to provide assistance as needed such things as a gas card, bus ticket, or even providing a driver.
	Simplify the process by which women enrolled in the Well Woman Program can provide proof to their provider/system that they are in the program	<ul style="list-style-type: none"> - If there was a single, State-wide database it could transmit the forms directly to providers -Providers currently have the ability to go into the Forward-Health portal and look up this information (information given by DPH WWWP) -Smaller number of providers will make it easier to work with them on establishing protocols/processes to accomplish this
§ 2.4 Transition	Women currently in the program may be forced to switch to a different provider/clinic	<ul style="list-style-type: none"> -The transition plan will need to include time to work with women on the transition. Estimated time for coordinators to spend with clients should anticipate additional time during the transition period.

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Topic Area	Challenge or Barrier	Recommendation or Strategy
§2.3 Funding	What if a multi-jurisdictional agency needs more funding than what was planned for?	-The Work Group can provide recommendations on formulas for funding
§ 2.3 Funding	How to hire and keep qualified staff when funding is only guaranteed a year at a time.	Guarantee a stable plan for 3 – 5 years
§ 2.4 Transition	Women currently in the program may be forced to switch to a different provider/clinic	-The transition plan will need to include time to work with women on the transition. Estimated time for coordinators to spend with clients should anticipate additional time during the transition period.
All	Ensuring data integrity in a multi-jurisdictional environment	- At the State Level, work with the individual Coordinating Agencies to establish quality standards and regular quality improvement reviews

3 WISCONSIN WELL WOMAN NEW MODEL PROJECT DOCUMENTS

3.1 WORK GROUP CHARTER

CHARTER

WISCONSIN WELL WOMAN PROGRAM (WWWP)

FUTURE PROGRAM MODEL

Purpose

The Department of Health Services (DHS) is establishing a WWWP Future Program Model Work Group to ensure that the WWWP remains strong and available for eligible women who need breast and cervical cancer screening.

Composition of the Work Group

The Work Group comprises the five local health officers recommended and provided by the Wisconsin Association of Local Health Departments and Boards (WALHDAB). These members represent each of the five Division of Public Health (DPH) regions. Members are:

- Kelli Engen (Barron County, Western Region)
- Joan Theurer (Marathon County, Northern Region)
- Barb Theis (Juneau County, Southern Region)
- Sally Nusslock (City of West Allis, Southeastern Region)
- Doug Gieryn (Winnebago County, Northeastern Region)

Functions

The Work Group will:

1. Provide recommendations on the organizational structure for the future WWWP model for the service coordination component. The following bullet points list areas where recommendations are needed; additional areas can be added.

For planning purposes, the State is asking that the Work Group consider if the number of clients being seen would have an impact on its recommendations, and if so to add separate recommendations for large (8,000 women per

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year), medium (6,000 women per year) and small (4,000 women per year) client bases. For each bulleted area, the Work Group should consider the impact of a large client base (8,000 women), a medium-sized client base (6,000 women), and a small client base (4,000 women).

- Organizational structure with identification of the multi-jurisdictional areas within the state to include the geographic distribution of providers and coordinating agencies. The State is asking that the Work Group produce at least one recommendation that includes no fewer than 5 multi-jurisdictional areas, and no more than 10.
 - Selection process, determination, and recommendations of local health departments who will serve as lead agencies for service coordination within a defined multi-jurisdictional area.
 - Guidelines for funding allocations for coordinating agencies
 - Transition plan to future program model including communication to existing clients and community and health care partners and agencies, transition of program and client data (electronic, paper files, etc.) from current coordinating agencies, and identification of strategies to communicate progress and challenges
 - Identification of potential challenges and barriers for service coordination under the new model and recommendations and strategies to address them
 - Strategies to assist with role clarification for providers and coordinating agencies
 - Inclusion of proper referral process to BadgerCare Plus and the Marketplace for lead agencies and their partners health departments
 - Assurance and inclusion of translation and interpretation services for lead agencies
2. Communicate with local public health officers and WWWP coordinators within their respective regions to provide information and updates on work group progress and to gather feedback for inclusion in work group discussions
 3. Provide recommendations on the provider network transition as directly linked to service coordination, and
 4. Submit a document with recommendations for the future WWWP model to the DPH Administrator for consideration by November 15, 2014

Any recommendation made is advisory to the DHS, which will make the final decision on the WWWP Future Program Model.

Frequency of Meetings

The Work Group will meet from June 2014 through November 2014 with a frequency determined by the DPH in consultation with work group members based on calendar and member availability.

Meeting Facilitation and Administrative Support

The Work Group meetings will be facilitated by Paula Sherman, Project Manager, Division of Enterprise Services, and Department of Health Services.

The following administrative support will be provided to the Work Group:

- Meeting scheduling, locations, and teleconference arrangements
- Meeting note taking and distribution (to include items discussed, decisions made, and next steps)
- Assistance with preparation of final recommendation document.

Data, resource documents, survey summaries, and technical assistance will be provided to the Work Group.

WWWP Program Requirements

When developing the recommendations for the multi-jurisdictional service coordination component, the Work Group must consider and adhere to the:

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- 1) CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) policies, procedures, and guidelines,
- 2) WWWP Policies and Procedures Manual,
- 3) Coordinator Responsibilities (Case Management & Service Coordination), and
- 4) WWWP Provider (Clinical) Case Management Responsibilities (of abnormal results).

3.2 LEAD AGENCY AND COORDINATOR RESPONSIBILITIES



Proposal for Discussion on July 21, 2014 LEAD AGENCY AND COORDINATOR RESPONSIBILITIES

I. Introduction

The lead agency must be a local health department.

The lead agency will assume full responsibility for the defined WWWP contract, work plan and service coordination responsibilities, including case management, within its jurisdiction.

Each lead agency must hire or contract for one part time (at least 20 hours per week dedicated to WWWP) designated coordinator responsible for all programmatic activities. Additional WWWP time will be determined based on the WWWP funding and the projected number of clients to be served. The lead agency must also ensure there is an alternate staff person to serve in the absence of the designated coordinator who meets the same qualifications and requirements.

Due to the clinical nature of the responsibilities, the designated coordinator(s) must be a registered nurse, physician assistant or Licensed Clinical Social Worker (LCSW).

- The designated coordinator must have significant medical knowledge in order to function in the capacity of case manager to meet the CDC National Breast and Cervical Cancer Early Detection Program (NBCCEDP) time-specific requirements, to ensure appropriate clinical follow-up, to minimize litigation concerns, and for quality assurance purposes.
- Delayed diagnosis of breast cancer has been one of the leading causes of malpractice lawsuits.
- Use of standard clinical protocols ensures that high quality care is provided in an appropriate and timely manner.

These requirements are subject to review annually on the basis of continued need.

The lead agency may be terminated for failure to meet these requirements.

The final selection of lead agencies must be approved by the Department of Health Services.

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The WWWP Policy and Procedures Manual outline the policies, guidelines, requirements, and procedures for participating in the Wisconsin Well Woman Program as a health care provider or a Local Coordinating Agency.

II. Coordinator Responsibilities

The designated coordinator is responsible for service coordination, including case management. Please see the WWWP Policy and Procedures Manual, PPH 43029 (revised 2/23/10) Chapter 2, page 2.1, for information on Service Coordination Agreements.

- All WWWP local coordinating agencies are expected to meet the WWWP Boundary Statement objectives and Performance-based Contract Quality Criteria established by the Division of Public Health.

CASE MANAGEMENT is a shared responsibility between the provider and the designated coordinator. However, the coordinating agency bears the ultimate responsibility to assure that women with abnormal screening results obtain further diagnostic testing and depending on the diagnosis, receive subsequent treatment.

The Centers for Disease Control and Prevention (CDC), National Breast and Cervical Cancer Early Detection Program defines case management as: establishing, brokering, and sustaining a system of essential support services for NBCCEDP-enrolled women. It is a cooperative process between the local coordinator, client, and provider.

Case Management involves a system of assessment, planning, coordination, monitoring, evaluation, and resource development to assure timely diagnostic and treatment services, as well as re-screening. The CDC policy for case management requires that, at minimum, case management is offered to all women with abnormal screening results.

The coordinator must assure that case management is provided according to the WWWP Policy and Procedure Manual protocols that are based on the CDC NBCCEDP requirements and national guidelines.

The following responsibilities are what the designated coordinator will do in the new model effective in 2015.

1. Determine eligibility and enroll clients. (Current WWWP requirement)

Please see the WWWP Policy and Procedures Manual, Chapter 2, Local Coordinating Agencies and Chapter 3, Eligibility and Enrollment. This describes the coordinator responsibilities for determining eligibility and enrollment.

2. Maintain a file of every enrolled client. (Current WWWP requirement)

3. Maintain a confidential database or system for tracking all enrolled clients. (Current WWWP requirement) Please see the WWWP Policy and Procedures Manual, Chapter 2, Local Coordinating Agencies, page 2.2 for more information.

4. Refer clients to appropriate health care providers and schedule initial appointments. Remind clients of their follow up appointments and re-screening dates. Scheduling initial client appointments and reminding clients of follow-up appointments is a new requirement.

5. Assure there is a system for effective communication with health care providers for case management and follow-up for clients who have abnormal screening results. (Current WWWP requirement) Each woman must be notified in a timely manner of both her screening and diagnostic results. Tracking systems function as a safety net to ensure clients receive timely results.

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6. Contact the provider if results of breast or cervical cancer screenings have not been received. (Current WWWP requirement)
7. Assist the providers in contacting the client for recommended follow-up, if needed. (Current WWWP requirement) Appropriate and timely clinical services following an abnormal test result and/or diagnosis of cancer are very important.
8. Document in the client's record whether follow-up information is received, the date it was received, whether the information was received from the provider or client, and the results of the follow-up. (Current WWWP requirement) Please see the WWWP Policy and Procedures Manual, Chapter 2, Local Coordinating Agencies and Chapter 5, Case Management for more information.
9. Specify whether there is a final disposition or whether additional follow-up is required and ensure that a final diagnosis is recorded for breast and cervical abnormalities. (Current WWWP requirement)
10. Assist clients when necessary, to obtain treatment and social support for abnormal WWWP screening and diagnostic services. Provide client navigation as needed and ensure communication with other coordinators when indicated. (Current WWWP requirement)
11. Develop and maintain a resource guide that includes a written *Essential Treatment Plan* and necessary services, such as transportation, translation, and support services. (Current WWWP requirement)
12. Participate in orientation and continuing education activities relevant to breast and cervical cancer screening services. Participate in the Breast Cancer Task Force. Participate in population-based health education, planning and implementation activities to increase breast and cervical cancer screening rates among all women of appropriate screening age. The tasks for orientation and outreach are not new. Local coordinators have been responsible for these since the beginning of the Program. The remaining tasks relating to the Breast Cancer Task Force and population-based health screening activities are new requirements. Partnerships, one of the eight NBCCEDP components, requires WWWP to extend the scope and impact of population-based breast and cervical cancer screening activities through partnerships with key external organizations that reach large population groups and health care systems.
13. Facilitate the application process for Wisconsin Well Woman Medicaid, if the client is diagnosed with and needs treatment for breast or cervical cancer. (Current WWWP requirement) Please see the WWWP Policy and Procedures Manual, Chapter 7, for more information on Wisconsin Well Woman Medicaid.
14. Participate in WWWP quality assurance activities, including the provision of reports and cooperation with site visits. This includes notifying and consulting with health care providers and central office to resolve quality concerns. (Current WWWP requirement) The coordinator is ultimately responsible for assuring that clients receive timely and complete screening, rescreening, and diagnostic services and treatment.
15. Be responsible for the WWWP Multiple Sclerosis component of the program. (Current WWWP requirement)

REFERENCES

1. Public Law 101-354 and its Amendments
2. Breast and Cervical Cancer Mortality Prevention Act of 1990, including Public Law 101-354 and its Amendments <http://www.cdc.gov/cancer/nbccedp/legislation/law.htm>

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3. WWWP Policy and Procedures Manual, PPH 43029 (revised 2/23/2010) (The Manual will be updated to reflect new service delivery and coordination models.)

<http://www.dhs.wisconsin.gov/womenshealth/WWWP/PolicyandProceduresManual.htm>

4. WWWP Boundary Statement (attached)

5. WWWP Quality Criteria (attached)

Draft for July 21, 2014 Workgroup Discussion

3.3 TRANSITION PLAN TIMELINE

WWWP NEW MODEL TRANSITION PLAN TIMELINE

DRAFT for discussion 9-26-2014

October 2014

- Work on transition plan
- Central Office WWWP staff will continue work on the RFA
- Central Office WWWP staff will update provider maps
- Identify new communication needs

November 2014

- Work on transition plan
- WWWP workgroup identifies jurisdictions for lead agencies for the new coordinator network
- Begin to develop communication letters and materials (e.g., clients to new model, discontinuation of old providers, etc.)
- Begin to update WWWP web page (continue to add to it as needed)

December 2014

- Work on transition plan
- Announce availability of Provider RFA through multiple channels – 12/1/14
- Hold meeting with HP
- Formal announcement of jurisdictions/lead agencies and coordinators - 12/31/14
- Meet with the Division of Access and Accountability

January 2015

- Work on transition plan
- Begin coordinator monthly teleconferences regarding transition
- Review data management needs for transition
- Develop draft language for new Provider Participation Agreement (PPA)
- Begin to revise WWWP Policy and Procedures Manual
- Finalize communication letters

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- RFA applications due – 1/30/2015

February 2015

- Work on transition plan
- Begin to develop contracts for lead agencies
- Meet with the appropriate parties to discuss toll-free number availability and process
- Continue monthly teleconference with coordinators regarding transition
- Send out PPAs for new provider network February 21st (need returned by 3/25/2015)
- Begin to send out client letters and old provider network letters announcing changes via local coordinators and HP regarding end dating old system
- Finalize new PPA materials

March 2015

- Continue monthly coordinator teleconference regarding transition
- Finalize WWWP Policy and Procedures Manual
- Finalize training materials
- Providers return new PPAs by 3/25/2015

April 2015

- Develop listing of new providers
- Announcement of new provider network
- Develop web-site for providers
- Update WWWP web-page for all users
- Transition period from current coordinator network to new coordinator network through June 30th
- Begin client record transfer period
- Continue monthly coordinator teleconferences

May 2015

- Begin new provider trainings
- Develop appropriate client listings
- Continue monthly coordinator teleconference regarding transition
- Begin teleconferences with new provider network regarding transition

June 2015

- Continue new provider and coordinator network orientation to the new model
- Continue new coordinator and provider network trainings on new policies and procedures
- Teleconferences with new coordinator network
- Teleconferences with new provider network
- Former coordinator and provider networks end: June 30th

September 2015

- Last day for old provider network to submit WWWP claims: September 30 (for services provided through 6/30/15)

3.4 REFERRALS TO BADGERCARE PLUS AND MARKETPLACE PLAN



Referral to BadgerCare Plus and the Federal Health Insurance Marketplace for Wisconsin Well Woman Program Participants (and Prospective Participants)

INTRODUCTION AND BACKGROUND:

Last summer, the CDC, Division of Cancer Prevention and Control held a webinar on the Affordable Care Act (ACA) for National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Directors. The webinar speakers provided an overview of the health insurance marketplace created through the Affordable Care Act. CDC also encouraged all of the state programs to work with NBCCEDP-clients to let them know about the new health care options available for comprehensive health care coverage.

The Wisconsin Well Woman Program is proposing to have coordinators refer women to BadgerCare Plus and the Affordable Care Act federal health insurance Marketplace in order to apply for the comprehensive health care coverage. We do not expect coordinators to be experts on these programs. However, we are asking them to encourage women to explore these comprehensive coverage options because the WWWP is a breast and cervical cancer screening program.

COORDINATOR RESPONSIBILITIES

1. Referral to BadgerCare Plus and the Federal Health Insurance Marketplace

- Ask the WWWP client (or prospective client) if she knows about the ACA federal Health Insurance Marketplace and BadgerCare Plus (Medicaid).
- Tell her that she may be able to enroll in BadgerCare Plus or apply for private health insurance through the federal Health Insurance Marketplace and receive comprehensive health care coverage.
 - For BadgerCare Plus Eligibility:
 - Wisconsin resident
 - US citizen or qualifying immigrant
 - Social Security Number
 - Household income at or below 100% of the federal poverty level
- Encourage the client to explore comprehensive health care coverage through BadgerCarePlus or the ACA Federal Health Insurance Marketplace.
- Refer the client to the internet site HealthCare.gov, the toll-free number 1-800-318-2596, or the appropriate agency in your area.
- Let the client know that the WWWP is not ending. The program will continue to be available for eligible women who need breast and cervical cancer screening services.