The Women's Health Network: Reviewing the Past, Planning the Future

Project Report

Russell K. Schutt, Ph.D.[1]
Project Director

with the assistance of

Elizabeth R. Cruz[2]
Project Administrative Assistant

and the Project Executive Steering Committee

John Z. Ayanian, MD, MPP
JudyAnn Bigby, MD
Brooke S. Harrow, PhD
Gail Gall, MS, RN
Maryjoan Ladden, RN, PhD
John Lowe, PhD
Keith Merlin, MD
Mary Neagle, MSW
Cathy Romeo
Rachel Wilson, MPH

We are grateful for funding from the Massachusetts Department of Public Health and for the consistent support and advice of Mary Lou Woodford, RN, BS, CSSM, Director, Women's Health Network and Elizabeth Irvin, MSW, PhD, Special Projects Director.

[1]Professor of Sociology, University of Massachusetts Boston and Lecturer on Sociology, Department of Psychiatry (Beth Israel/Deaconess Medical Center), Harvard Medical School.
[2]MA Candidate, Graduate Program in Applied Sociology, University of Massachusetts Boston.

Recommendations and rationales were written by the chairs and co-chairs of the seven project Task Forces, assisted by Task Force consultants and members (listed separately).

John Z. Ayanian, MD, MPP
Chair, Medical Knowledge & Health Care Technology: CVD Screening & Intervention Task Force
Department of Health Care Policy
Harvard Medical School

JudyAnn Bigby, MD
Chair**,** Health Care Disparities & Barriers to Health Care Access Task Force
Office for Women, Family, and Community Programs,
Brigham and Women's Hospital and Harvard Medical School

Brooke S. Harrow, PhD
Co-Chair, Fiscal Management & Business Operations Task Force
College of Nursing and Health Sciences
University of Massachusetts Boston

Gail Gall, MS, RN
Co-Chair, Case Management Task Force
College of Nursing and Health Sciences
University of Massachusetts Boston

Christine Judge, MS
Consultant, Health Care Delivery Systems Task Force
Harvard School of Public Health

Howard Koh, MD, MPH
Consultant, Health Care Delivery Systems Task Force
Harvard School of Public Health

Keith Merlin, MD
Chair, Medical Knowledge & Health Care Technology: Breast & Cervical Cancer Screening & Intervention Task Force
Obstetrics/Gynecology
Brockton Hospital

Mary Neagle, MSW
Co-Chair, Fiscal Management & Business Operations Task Force
DF/ PCC Breast and Cervical Screening Collaborative
MGH Community Health Associates

Cathy Romeo
Consultant, Health Care Disparities & Barriers to Health Care Access Task Force
Cultural Competency and Minority Health
VNA Care Network, Inc.

Rachel Wilson, MPH
Chair, Education, Outreach, & Education Task Force
Mary Horrigan Connors Center for Women's Health and Gender Biology
Brigham and Women's Hospital

Task Force chairs were assisted by Research Assistants who prepared literature reviews and described other programs. We are grateful for the contributions of:

Elizabeth R. Cruz, Robin Estabrook, Gina Gentile, Andrea Gnong, Sophy Nun-Hoeger, Maria Rocha-Tracy (Graduate Program in Applied Sociology, University of Massachusetts Boston), Rachelle Pierre (Harvard Medical School and Kennedy School of Government) and Swapna Reddy (Connors Center on Women's Health and Gender Biology).

Department of Public Health data were provided in part by Ellen Kramer, ScD, Women's Health Network, with assistance from Ruthie Birger (Department of Statistics, Harvard University).

The names of Task Force members and Women's Health Network staff who assisted the Task Forces are listed in the body of the report. Their contributions to this project were essential to its success.

We are also grateful for the many exceptional contributions of Dan Salvati to budgeting, administration, and web site design. Jeffrey Epperly also helped with invitations for the first Expert Panel meeting.

Executive Summary

The Massachusetts Department of Public Health funded the Women's Health Network Project: Reviewing the Past, Planning the Future in order to review critically the past and plan the future of the Women's Health Network (WHN). The goals of the review project (RPPF) were to provide information that could help improve the quality, cost effectiveness, and accessibility of WHN services and prepare for re-contracting the Women's Health Network beginning in FY 2007. This is a report of that review.

Project Overview

The Women's Health Network (WHN) provides breast cancer and cervical cancer screening and early detection services for uninsured and underinsured women, and heart disease and stroke prevention screening services. It is administered by the Massachusetts Department of Public Health (DPH) and funded in part by the U.S. Centers for Disease Control's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and the Well-Integrated Screening and Evaluation for Women Across the Nation Program (WISEWOMAN). Massachusetts provides additional funds for the NBCCEDP component. WHN contracts with 26 organizations to deliver NBCCEDP services, six of which also deliver WISEWOMAN services through the Massachusetts Heart Disease and Stroke Prevention Program.

The RPPF Project Executive Steering Committee was formed in January 2005, chaired by Russell Schutt, Ph.D. Eight-four heath care experts and program leaders were then recruited to participate in an Expert Panel that met between March and June 2005. Expert Panel members met in one of seven Task Forces to review current WHN operations, recent research evaluations of WHN, relevant published literature and descriptions of related programs and programs in other states. They also reviewed their own clinical and management experience, consulted other experts, and examined other data. Through this process of review, consultation, and deliberation, the members of each Task Force formulated recommendations about particular aspects of WHN operations. These recommendations, listed in the appendix, were then shared with the entire Expert Panel for further discussion and integration.

This report describes the RPPF process, summarizes the evidence reviewed, and presents the product of each task force's deliberations: a description of current operations, recommendations for maintaining or changing these operations, and the rationale underlying the recommendations. The recommendations are presented as the foundation for the Department of Public Health to use in designing specific procedural and management changes that can lead to a more effective and efficient program within the context of long-term departmental goals, currently available funding, and alternative resource opportunities.

Overview of Recommendations

The Expert Panel recommendations developed by the seven Task Forces are presented in the report's last section. This initial summary is an overview of the recommendations that highlights major common issues as well as points emphasized by the task forces, and takes into account overlapping recommendations developed by different task forces.

Connections with Clients and Prospective Clients

Recommendations concerning recruiting and serving clients focus attention on problems arising from the limited health focus of the program and the need for more effective outreach activities. Although the federal legislation establishing both the NBCCEDP and WISEWOMAN programs restricts their focus to a particular group of women and to specific health problems, Expert Panel members felt women would be better served if eligibility for the program and services available through the program were expanded, so as to allow a more integrated approach to women's health problems. Expert Panel members also suggested a community-based model of program outreach tailored to linguistic and cultural diversity among clients.

Expand Eligibility. Expert Panel members urged continued supplementary state funding in order to allow participation of more women 40-49, and others at high risk, than would be possible with only CDC funding (75% of mammograms paid with federal funds must be for women 50-64). However, Task Force members also urged expanding eligibility to women under age 18 in particular circumstances and advocating for undocumented aliens to receive free treatment, after diagnosis. Changes in eligibility processing were recommended to facilitate concurrent determination of eligibility for WHN and other programs, so as to increase the number of eligible women referred to WHN and the number of WHN clients who receive help with other needs.

Use Community-Based Outreach Model. The primary recommendation for enhancing outreach was to emphasize a "community-based" outreach model. This would mean making more intensive efforts to collaborate with community groups, rely on local outreach workers, use more oral rather than printed communication methods, and use specialized methods to reach hard-to-reach groups. In addition, Expert Panel members recommended marketing strategies and materials that would inform prospective clients about the program's limitations and would also correct misconceptions that result in fear of being billed for free services.

Broaden Breast & Cervical Cancer Services. Expert Panel physicians found that the diagnostic and service criteria for WHN were appropriate. However, they were troubled by their inability to treat non-covered conditions disclosed during examinations. They recommended expanding covered services, at least to include any gynecologic condition detected. More generally, they recommended a more primary-care-based client-centered service model that integrated WHN services into the larger health care system. An integrated screening model was proposed, so that multiple health problems could be identified at the time of screening and appropriate referrals made. The physicians also

recommended convening a panel annually that would be charged with reviewing technological developments and considering new approaches.

Refine Testing and Tracking for Heart Disease & Stroke Prevention Services. Additional CVD-diagnostic tests were recommended for improving diagnoses and an enhanced tracking system was proposed to monitor and help high-risk participants. Panel members also proposed tailoring services to the particular needs of individual clients identified by diagnostic tests and giving special attention to the needs of women with concurrent depression.

Relations with Contracting Organizations and Medical Providers

Improve Connections for Contracting Organizations. Recommendations for changes in relations with the organizations that contract with WHN focused on increasing collaboration and sharing about best practices between organizations, medical providers, and staff on a regional basis. Expert Panel members also recommended improving billing procedures by identifying staff to help with bills and helping providers to avoid billing women for non-covered services. They also stressed the importance of communicating more clearly program expectations for case management support to the contracting organizations.

Expand Medical Providers. Recommendations concerning relations with the medical organizations and individuals who deliver diagnostic and other medical services focused on means of expanding the numbers and types of providers. Specific suggestions included involving all Mass Health providers, increasing incentives for participation, locating sites in the neediest communities, including providers with longer hours and adding more HDSPP sites.

Information Systems

Many recommendations sought to take advantage of the capacity of new information systems—particularly, the Virtual Gateway--to improve client monitoring, centralize enrollment management, and separate administrative from programmatic activities. An overarching concern was to focus WHN resources on activities that truly add value for achieving public health goals and to leverage other preexisting resources to handle administrative functions.

Increase Client Monitoring. Expert Panel members recommended measuring referrals, outreach contacts and methods and tracking referred women to determine whether they enroll. Changes in the program's information systems were recommended to allow complete and consistent monitoring of clients by case managers throughout the program.

Centralize and Streamline Information Processing. Centralized processing and verification of enrollment was urged so that clients could receive WHN services at any participating site. The Virtual Gateway was highlighted as providing the key tool for

implementing this recommendation. The need of the WISEWOMAN program for streamlined reporting and data collection systems was given special attention.

Decouple Administrative and Programmatic Activities. In order to allow providers to focus on service provision, Expert Panel members recommended outsourcing routine business operations to MassHealth, decoupling administrative and programmatic processes and data, and de-linking the collection of data from payment for services.

Staffing

Expert Panel members recommended shifting from a single case manager model in which all case managers are nurses to a team model of service delivery in which nurses are an essential part of the team. Also highlighted was the need for increasing staff diversity and using community health workers. Numerous suggestions were also made for increasing staff training.

Use a Team Model. As urged in DPH's recent report on community health workers, Expert Panel members recommended increasing the role of client navigators—broadening their responsibilities to include those pertaining to community-based outreach workers and making them an essential part of the service team. They also urged WHN to use DPH outreach coordinators to oversee, evaluate, coordinate, convent and support local community outreach workers. Nurses were seen as an essential part of that team, but not as the sole providers of case management services, as they are now. Current WHN regulations permit individuals holding current licensure in Massachusetts or national case management certification to serve as case managers, as long as they have at least a BA/BS in health and human services or an RN (with some additional qualifications), but this broader conception of case manager requirements has not been reflected in actual hiring practices. The Expert Panel members recommended that, in order to develop a more community-based and culturally sensitive case management work force than is possible when all case managers are RNs, Contracting Organizations should be encouraged to recruit from this broader pool.

Add Community Health Workers. Expert Panel members suggested multiple strategies to increase staff diversity and enhance the effectiveness of service delivery in culturally diverse areas. They emphasized the importance of developing a more diverse staff and of requiring service sites to demonstrate how they would improve staff diversity. Community Health Workers, subsuming the Client Navigator role whenever possible, were seen as critical to this process of improving diversity and enhancing outreach, education, enrollment, re-screening and follow-up.

Increase Staff Training. Expert Panel members recommended the creation of an Orientation Program and a Professional Development Program for case managers and to require certification of case managers. They also emphasized the importance of cross-training all WHN staff at each site so that they could substitute for each other and understand client issues in a more holistic fashion. They also recommended emphasizing training all staff to increase their ability to deal with diverse cultural and linguistic issues.

Table of Contents

Introduction

The Massachusetts Department of Public Health's Women's Health Network (WHN) provides screening services to income-eligible uninsured women for the early detection of breast cancer and cervical cancer, as well as treatment referrals on an as-needed basis. In some locations, the WHN program also provides diagnostic testing for cardiovascular disease risk and risk reduction education and lifestyle counseling to decrease that risk. WHN is administered by the Massachusetts Department of Public Health (DPH) and funded by the U.S. Centers for Disease Control's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) and Well-Integrated Screening and Evaluation for Women Across the Nation Program (WISEWOMAN) and by the Commonwealth of Massachusetts.

Between January and June 2005, the Department of Public Health sponsored a project to improve WHN's quality, cost effectiveness, and accessibility: Reviewing the Past, Planning the Future (RPPF). Project participants examined the past ten years of WHN program operations and developed recommendations to help the program maximize adherence to Department, WHN, and CDC guidelines, increase enrollment, improve client choice, decrease provider burden, and facilitate client navigation through the system. This report presents the recommendations that emerged from the RPPF project.

Program Background

Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States. Screening for and early detection of breast and cervical cancer reduces death rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of certain racial and ethnic minorities and among under- or uninsured women, which creates a wide gap in health outcomes between such women and other women in the United States.

In 1990, Congress authorized the National Breast and Cervical Cancer Early Detection Program to address this health disparity, giving CDC the ability to implement a national strategic effort to increase access to mammography and Pap test screenings for women in need. The NBCCEDP is directed to low-income, uninsured women aged 18–64 from priority populations. The legislation authorizing the NBCCEDP also provided for public and professional education, quality assurance, and surveillance and evaluation systems to monitor program activities. In 2000, Congress gave the states the option to provide medical assistance for treatment through Medicaid for women diagnosed with cancer in the NBCCEDP. This program was implemented in Massachusetts in January 2004.

The CDC also offers a cardiovascular disease risk reduction program, the Heart Disease & Stroke Prevention Program, in conjunction with the NBCCEDP. According to

the American Heart Association, coronary heart disease is the leading cause of death for American women. One in five women has some form of heart or blood vessel disease and, in 2001, 498,900 women died from heart attacks and other coronary events. In 1993, Congress authorized the WISEWOMAN program in order to enable NBCCEDP participants at selected sites to receive standard cardiovascular disease preventive services including blood pressure and cholesterol testing, as well as counseling and education to help women develop a healthier diet, increase physical activity, and quit using tobacco.

The Massachusetts Department of Public Health's Women's Health Network (WHN) offers both the NBCCEDP and WISEWOMAN programs, as well as referrals for Medicaid-funded cancer treatment. The Commonwealth of Massachusetts adds funds to those provided by the CDC in order to allow women between the ages of 40 and 49 to receive NBCCEDP services. Massachusetts eligibility criteria for the Women's Health Network are: (1) Massachusetts residency; (2) household income less than 250% of the Federal Poverty Level; (3) no other insurance that covers the services; (4) age between 40 and 64 years old, except when specific other high-risk factors are present.

The WHN contracts with 26 organizations across the state to provide services related to screening, diagnosing and treating breast and cervical cancer. In addition the HDSPP program funds screening for cardiovascular disease risk factors and education about risk factor reduction in six organizations. Several different staff participate in the WHN and HDSPP programs including a program coordinator, case manager, client navigator, and risk reduction educator (for HDSPP only). The roles of the staff vary somewhat across sites but the same functions appeared to be addressed collectively across all of the sites. The case managers are key to the WHN program.

Specific NBCCEDP services offered are mammograms, clinical breast exams, Pap tests and pelvic exams; when needed, diagnostic services can also include radiology, biopsy, pathology, and anesthesia. At the locations that also offer WISEWOMAN services, women receive free screening for cardiovascular risk factors—hypertension, cholesterol, and diabetes. These locations also provide risk reduction education and counseling about healthy lifestyles.

The WHN serves a diverse group of women – 56% are white-NH, 31.5 % are Hispanic, 8.8% are black and 2.1% are Asian. Only 55.7% speak English as their first language. Spanish and Portuguese are the most common languages spoken after English. Approximately 30% have less than a high school education.[1]

Project Overview

Since 1993, the Women's Health Network has delivered screening and diagnostic services to more than 77,000 Massachusetts women. Between 2000 and 2001, 67% of WHN-eligible women ages 40-64 received a screening mammogram in Massachusetts,

[1] Health Brief. Women's Health in Massachusetts. Department of Public Health April 2005.

compared to just 12% of comparable women throughout the United States. Between 1999 and 2001, 42% of the eligible women in Massachusetts received a Pap test, compared to just 15% nationally. In FY 2004 alone, WHN screened over 11,000 women and these women tended to have less education than the entire state population and were much more likely to come from racial, ethnic, and linguistic minority groups. This record of accomplishment suggests that the WHN has been successful in reducing morbidity and mortality due to breast and cervical cancer among the target populations (WHN, 4/12/2005).

The 2005 WHN review and planning project was designed to develop procedures for an even more successful program. In spite of WHN's success in delivering needed diagnostic services to thousands of women, it is estimated that in FY 2004 at least 36,000 eligible women were not served. In addition, after a decade of increase, the rates of participation in both mammograms and Pap testes declined in 2002-2003 among uninsured Massachusetts women. Delivery of cardiovascular risk reduction services was more limited: in 2004, only six of the 26 organizations that contracted to deliver WHN services could be funded to provide WISEWOMAN services.

The Review and Planning Process

Improving program effectiveness requires consideration of the multiple, interrelated factors that influence program functioning and client behavior (Zapka et al., 2003). The WHN Review and Planning Project focused on seven key factors: medical knowledge and available health care technologies for the screening and diagnosis of both breast and cervical cancer and cardiovascular disease; the operation of health care delivery systems; the design of case management; strategies for education, outreach, and enrollment; sources of disparities between social groups in health care behaviors and outcomes; options for fiscal management and business operations.

These different factors and the individuals who specialize in them intersect with each other and change over time. In addition, identification of their implications for practice must be guided by knowledge of the WHN program and its effectiveness. These considerations led to a review process that engaged experts from a variety of disciplinary and programmatic backgrounds and that provided multiple opportunities for considering diverse perspectives and new additions to knowledge.

The RPPF project was guided by Project Director Russell Schutt and an Executive Steering Committee comprised of experts in the seven different areas who each had experience with the WHN program (see Appendix). Executive Steering Committee members chaired Task Forces of experts in one of the seven areas and also met regularly to share insights and coordinate efforts. At least one graduate Research Assistant and one WHN staff member was assigned to each Task Force chair. Research Assistants recorded minutes of Task Force meetings, searched and summarized relevant literature, and searched the Web for information on comparable programs.

Eighty-four health care policy experts and program leaders served on the larger project Expert Panel and one of its seven Task Forces, chaired by one or two Executive

Steering Committee members (see lists later in this report) and assisted by at least one DPH staff member and one graduate research assistant. Each Task Force was charged with developing recommendations about specific aspects of the WHN program. The entire Expert Panel met first in March 2005 in order to learn about the WHN program and to develop specific objectives and work plans. For the next three months, the Task Forces met separately, in order to review research literature, program experience, and relevant data and to formulate recommendations that reflected this review. Every Expert Panel member received evaluation research reports on the WHN program and most task force chairs attended a special presentation about the key findings in these reports. The entire Expert Panel convened again in June 2005 in order to share insights and integrate recommendations.

Identification and implementation of efficacious changes requires careful review of research findings, relevant theory and programmatic experience as well as informed translation of this body of work into new program policies and procedures. In order to fulfill these requirements, the RPPF project drew upon prior Department of Public Health-sponsored research about WHN; other research about comparable programs in other states and about related public health problems; and the insights of academic and program experts. During the project, reports from five different evaluation studies of the Massachusetts WHN program were inspected (see Appendix), 700 person-hours were spent in a total of 34 Task Force meetings, more than 500 scholarly articles were inspected, and information was obtained for comparisons with 25 other programs.

In a supplementary investigation, information was collected from WHN staff and program directors concerning contracting organizations that have left the WHN program. In addition, special analyses were conducted of data available from state and federal sources when needed to resolve questions arising during task force deliberations.

Evaluation Research Summaries

The five evaluation studies sponsored by WHN generated analyses of data from multiple sources: interviews with WHN case managers, program coordinators, and DPH contract managers, focus groups with WHN staff, two phone surveys of WHN clients, an analysis of client records, and summaries of chart audits.

The Case Management Study

The Case Management evaluation used a mixed methods design with data collected from WHN staff, WHN records, and WHN clients: (1) Interviews with DPH contract managers (N=3); (2) Interviews with all WHN case managers and program coordinators (N=52); (3) Secondary analyses of service use data (N=3182); (4) Phone survey of stratified random sample of WHN service recipients seen for breast or cervical cancer test results (N=204, with oversampling of those who had received test results indicating a high probability of cancer) (Schutt et al., 2005). Measures collected with these methods are listed in an appendix.

- Overall, clients were very satisfied with the WHN program and WHN case managers.
- Clients who were less educated and/or in poorer physical and more depressed were less satisfied.
- Case managers were very satisfied with their jobs and their service delivery.
- Case managers rated their workload as heavy, particularly at HDSPP sites.
- Primary service barriers reported by both clients and case managers were fear of bills and language problems.
- Case managers reported difficulties in finding clients and maintaining contact.
- Case managers desired more training and computer support.
- Hispanic women had lower rates of cervical cancer screening than other participating women.
- Several contracting organizations that participate in the HDSPP program had very long times from trigger to diagnosis for their breast and cervical cancer clients.
- There was significant regional variation in the time it takes to make a diagnosis after an abnormal finding, with Boston having the longest time (>30 days) and Cape Cod and Southeastern Massachusetts having the shortest time (<10 days).
- The time from diagnosis to treatment was similar across Massachusetts regions, except that women served by one contractor in the Metro West region take nearly twice as long as other women to get into treatment after diagnosis (>50 days).
- WHN women using community health centers had a longer time to diagnosis after an abnormal finding than women who don't use community health centers.

The WHN Services Study

The goal of this evaluation was to systematically solicit feedback from staff of the 26 contracting organizations with regard to the strengths and weaknesses of the current Women's Health Network (WHN) service delivery model. Medical Service Sites were stratified with regard to their primary organization type, as follows: a collaborative site, decentralized service sites, community health centers, and hospital-based programs. Representative staff from each type of organization were invited to participate. Key informant interviews and group discussions were conducted at community locations throughout the state over an 8 month period. Discussions were audio taped and analyzed using Ethnograph. 18 client navigators, 16 program

coordinators, 4 risk reduction educators, and 8 case managers were interviewed in various groupings. (Suri, 2005)

- Staff reported high levels of commitment and satisfaction with their work
- Unique advantages of different types of contracting organizations were identified: the collaborative model reduces administrative burden on medical service sites; the centralized model facilitates provision of more comprehensive care; while the decentralized model and individual health centers model facilitate community outreach
- High turnover rates among medical service site staff were a problem.
- Contracting organizations reported excessive paperwork and slow payment of bills.
- Some staff at contracting organizations felt there was insufficient training for WHN and a lack of appreciation at the sites for the client navigator role.
- Client-level barriers to effective service delivery included client transiency, cultural and linguistic differences, fear of screening, client fear of bills, lack of transportation and low literacy.
- Contracting organizations found that BCCEDP screening requirements were at odds with HDSPP requirements for risk reduction education and lifestyle counseling.
- Many participants indicated a need for collaboration between contracting organizations.

Eligible Women Analysis

The analysis of eligible women and participation Women's Health Network was conducted with data from five sources: (1) all WHN participants from 1993 to 2004; (2) Massachusetts data from the U.S. Census Current Population Survey from 1999 to 2001; (3) health care data collected in the annual survey by the Massachusetts Division of Health Care Finance and Policy in 2002 and 2004; (5) mammography screening data reported to WHN in 2003 (Kramer, 2005). Findings include:

- The 85% rate of mammography screening among MA women in 2003 within the past two years exceeds the federal Healthy People 2010 target of 70%, while the 88% rate of Pap testing within the past three years almost meets the federal Health People 2010 target of 90%.
- The rate of mammography screening among MA women in all racial/ethnic groups exceeds the federal target; the rate of Pap testing is within five percentage

points of the federal target of 90% among MA women who are white, African-American, and Hispanic, but it is only 66% among Asian women.

- A large number of eligible women are still not served and the number served has declined in recent years.

The DPH Satisfaction Surveys

A client satisfaction survey was conducted by DPH staff in the summer of 2003. A proportionate stratified random sample was drawn from the entire WHN client population, with clients who had at least 12 years of formal schooling sent a mailed questionnaire and those with fewer years of schooling interviewed by phone. The overall response rate was 30%, resulting in an N of 1348 clients (Ooi, 2003). The survey analysis revealed that…

- Clients reported high levels of satisfaction.
- Many clients did not recognize the WHN program name.
- Family members and friends were primary sources of program awareness
- There seemed to be insufficient explanations of privacy rights to clients

The Women's Health network (then called "the Massachusetts Breast and Cervical Cancer Initiative") also surveyed client satisfaction in February 1998. This short survey was mailed to 881 clients at 11 of the 36 BCCI sites at that time. These eleven sites were selected to represent clients from diverse geographic and demographic backgrounds as well as different types of sites. The overall response rate was 62%, resulting in an N of 533 clients. Results were consistent with those obtained in the 2003 survey.

- More than 90% of the respondents indicated satisfaction in response to about half of the 13 satisfaction questions, including those pertaining to respectful treatment, quality of care, and agreement to return again for screening.
- Satisfaction was somewhat lower with processing procedures, including explanations about exams and understanding test results, with 75-80% indicating satisfaction.
- White respondents were more likely to state that they would return for screening the next year than were African American respondents.
- Clients felt respected by their physicians, but 35% had not received information on the importance of Pap smears and 28% had not received information on breast self-exams.
- Several respondents reported poor treatment by staff in relation to testing procedures and several had received unexpected bills for their medical services.

Chart Audits

The audit of client service charts was based on a 5% sampling of records from March 2003 to November 2004, with the criterion that at each service site, at least 10% of the records, but no more than 30 records were reviewed (Karacek, 2005).

- More than 90% of service sites were in compliance with almost all documentation requirements.
- ¾ of the NBCCEDP cases have the required written clinical referral; 4/5^{ths} of those at the HD&SPP sites have the required Healthy Heart participation form.
- 3/4ths of sites have case manager education, evaluation, and discharge documents.
- Overall, documentation is less adequate for HDSPP cases.
- 3/4ths of clients have most of their lab test results and 3/4ths have an ATPIII risk score, but just half have a smoking assessment in their file.
- 2/3rds of HDSPP clients had a signed risk reduction document in their files and 2/3rds had a doctor's evaluation, but only 1/3rd had a 6-month followup document.
- The rates of screening and followup were somewhat below program standards, with almost a 20% point gap for followup after abnormal Pap test result.
- The timelessness of breast cancer diagnoses exceeded standards, but timelessness was below standards for cervical cancer diagnosis and for both breast and cervical treatment (although findings differed between 2003 and 2004).
- 7 sites with Heart Disease & Stroke Prevention services were below standard in screening and intervention, but met the timeliness standards for case management.

Additional investigations were conducted in response to questions raised during the RPPF process.

Former WHN Vendors

Women's Health Network staff and some Contracting Organization representatives were interviewed to learn about the reasons that some Contracting Organizations left the WHN program. Additional information was obtained from available records. Twenty Contracting Organizations have left the WHN program, and five others have been subsumed within larger contracts. Several reasons for leaving WHN were cited frequently; some of these differed by type of Contracting Organization (Gall, 2005).

- A large multi-site Contracting Organization left WHN due to inadequate reimbursement for outreach and other services, as well as difficulties in securing the data required by WHN from an immigrant population served at multiple sites.

- Several small community hospitals reported inadequate staff to meet the requirements of the WHN program.

- Many community health centers reported problems with processing bills as required by WHN.

- Community health centers reported difficulty in recruiting and retaining registered nurses as case managers.

- Community health centers were able to allocate only a fraction of a staff member's time to the WHN program, and so there was no single strong advocate for the program.

- Some community health centers had difficulty serving sufficient numbers to meet WHN requirements.

- Several community health centers joined a multi-site program alliance that reduced the administrative burden of the program.

- WHN offers WISEWOMAN sites insufficient training and support to provide lifestyle behavior change.

- WISEWOMAN service guidelines conflict with the practice standards of some local providers.

- Case managers have difficulty negotiating for needed services identified in the WISEWOMAN program when these are not reimbursable through WHN.

- Considerable administrative burden created by WISEWOMAN requirement of multiple service appointments during the year.

- Clients are often deterred by complex scheduling and long hours required for WISEWOMAN services.

- Multiple health and family problems and fear of incurring unpaid bills diminish client participation in WISEWOMAN.

Contract manager interviews

Three DPH staff managed WHN contracts in 2004 with 26 organizations. All three contract managers were interviewed in late spring and summer 2004, in order to

learn about their experiences in managing the contracts and the types of issues that arose with contracting organizations that they identified as relatively successful and unsuccessful. Although these interviews were conducted in order to provide background required by the Case Management Evaluation project, they were analyzed separately for the RPPF project (Gall, 2005).

- Successful contractors are able to adapt program requirements to agency characteristics, such as by integrating enrollment and billing functions and in relations with primary care providers.

- Successful contractors understand the role of WHN, are willing to meet DPH standards, and maintain good records.

- Successful contractors are able to recruit and train sufficient numbers of staff who meet DPH standards and are culturally and linguistically competent and who are flexible and willing to learn.

- Successful contractors provide clear role definitions and integrate staff functions as useful.

- Contractors judged by contract managers to be unsuccessful do not value the role of WHN, are unable to adjust usual procedures to WHN requirements, and have difficulty meeting reporting requirements. Community health centers have particular problems in these areas.

- Unsuccessful contractors have difficulty meeting capacity targets and/or have easier access to alternative programs.

- Unsuccessful contractors have difficulty recruiting and retaining appropriate staff.

- Unsuccessful contractors have high levels of WHN staff turnover, schedule insufficient time for the program activities, and do not provide opportunities for professional orientation and development.

- Unsuccessful contractors have difficulty connecting with medical providers and gaining required data from them.

- Funding for lifestyle interventions for HDSPP clients needs to be increased to cover more than just tobacco cessation.

- Contracting organizations need more orientation and training about WHN is needed.

- Several client-level barriers impede service delivery linguistic and cultural differences, immigration status, poverty, and competing demands due to work and family.

Depression interview

The UMass Boston Center for Survey Research phone survey of WHN clients revealed substantial levels of depressive symptoms (Schutt et al., 2005). RPPF staff interviewed a psychiatric oncologist at Beth Israel/Deaconess Medical Center in order to learn about ways to improve referrals for women with symptoms of depression (Cruz, 2005). Her observations, summarized below, informed several Task Force recommendations.

- Low motivation and suicidal thoughts associated with depression reduce the likelihood of follow-up.
- Screen new clients for depression with a simple paper and pencil test—the Beck Depression Inventory--that can be distributed in the waiting room of medical providers.
- Depression is a treatable illness.
- Some cultures don't talk about mental illness, which impedes treatment.
- Educating patients and other family members is the best way to reduce service barriers due to stigma.
- Provide WHN staff with a one–hour training session about depression, how to respond to it, and where to refer women for it.
- Mental health services for low income women can be covered by free care, sliding fee scales at community mental health centers, and pharmaceutical company programs.

Service data analyses

Data were also analyzed from the Massachusetts Behavioral Risk Factor Surveillance Survey and the Cancer Registry. They provided more information about program coverage and women's needs.

- Asian women have lower rates of cervical cancer screening than white, black and Hispanic women (66.5% vs. 88% all women).
- Boston has higher age adjusted-rates of cervical cancer than all other regions of Massachusetts.
- Death rates from cervical cancer for the years 1998-2002 were 4.5 per 100,000 for NH-black women and 1.8 for NH-white women.
- Black women in Massachusetts have the highest death rates from breast cancer.

- Women with less than a HS education, with less than $25,000 in income, from Western Massachusetts and from Boston have the highest rates of cardiovascular disease risk factors and cardiovascular disease.

- Black women have the higher death rates from cardiovascular disease than all other Massachusetts women.

Research Literature Highlights

Task Force members reviewed more than 500 research articles and reports as they formulated recommendations. This review process identified influences on health care behavior, highlighted effective program approaches, and specified options for system operations.

A large body of literature on breast and cervical cancer screening indicates that the effectiveness of different methods varies, in part in relation to client characteristics.

- Older women are less likely to have their cancers detected through clinical breast exams (Bobo and Lee, 2000; Bobo, Lawson, and Lee, 2003).

- Women in the WHN have slightly longer times from diagnosis to treatment than other breast cancer patients and are less likely to receive radiation therapy after partial mastectomy (Liu et al., 2005).

- Disparities in cancer screening are widening among groups with no usual source of care (Swan et al., 2003).

- Women referred for atypical glandular cells due to severe cervical lesions (CIN 2 or worse) should be tested for HPV DNA in order to rule out HSIL, AIS, or carcinoma (Derchain et al., 2004).

- Screening results vary between racial and ethnic groups (May et al., 2000; Schootman and Fuortes, 2001; Bernard et al., 2001).

- Film mammography is the currently most cost effective method, compared to digital mammography, CAD, MRI, and ultrasound.

A growing body of research on WISEWOMAN projects identifies some of the bases of program effectiveness.

- WISEWOMAN has been effective in reaching disadvantaged and minority women at high risk of cardiovascular and other chronic diseases (Will et al., 2004).

- Comprehensive screening lowers the prevalence of hypertension (Stoddard et al., 2004).

- Lifestyle counseling can result in increased physical activity (Stoddard et al., 2004).

- Lifestyle counseling produces only a statistically insignificant reduction in coronary heart disease risk after one year, in spite of higher cost (Finkelstein, et al., 2002).

- Integration of WISEWOMAN services within community health centers would improve the centers' effectiveness (Mays et al., 2004).

- Research is necessary for monitoring and improving programs but can create burdens on program staff (Viadro, Farris, and Will, 2004).

Literature on breast and cervical cancer services has identified several sources of socioeconomic disparities and has emphasized the value of several strategies for reducing barriers to health care.

- African-American and Hispanic women underutilize mammography and women of low SES are less likely to be diagnosed with early stage breast cancer.

- Misconceptions about screening procedures reduced participation by many Hispanic women.

- Low income women in a mammography and Pap test screening and follow-up program with depressive or anxiety disorders had more characteristics that create barriers to screening and follow-up testing.

Providers should use multiple strategies for reducing these disparities:

- Provide cultural competency training to all health care professionals (Wolff et al., 2003).

- Use contextually appropriate methods of delivering health care information (Wolff et al., 2003).

- Recruit, retain and promote a diverse health care staff (Wolff et al., 2003).

- Use community-based patient navigators to help underserved populations engage with the health care system (Freeman, 2002; Frelix et al., 1999; Freeman, Muth, and Kerner, 1995; Psooy et al., 2004).

- Engage lay community leaders and peers in health promotion programs (Horowitz et al., 2004; Wolff et al., 2003; Kiger, 2003).

- Collect sociodemographic data to allow measurement of health disparities (Wolff et al., 2003).

Literature on reducing disparities in cardiovascular disease morbidity and mortality identifies similar strategies as effective.

- Provide culturally sensitive and targeted health education materials (Para-Medina et al., 2004).
- Focus educational materials on patients' about misconceptions concerning health (Association of Black Cardiologists, Inc., 2004).
- Educate providers about health care disparities (Lurie et al., 2005).
- Support lifestyle changes to improve health (Stoddard, 2004).
- Use vouchers and discount programs to encourage exercise and weight loss (Will et al., 2004).
- Involve community members in developing and delivering health promotion programs (Becker et al., 2005).

Research on enrollment, outreach and education in cancer screening programs has highlighted the effectiveness of several particular approaches:

- Use community health workers who come from similar cultural backgrounds as the prospective patients (Centers for Disease Control and Prevention, 1997; Kiger, 2003; Navarro et al., 1998).
- Use group activities to encourage women to discuss health concerns
- Use one-to-one outreach involving cancer survivors and other peers
- Partner with religious groups (Centers for Disease Control and Prevention, 1997; Kiger, 2003).
- Develop media campaigns that target the desired social groups (Amhad et al., 2004; Centers for Disease Control and Prevention, 1997; Kiger, 2003).
- Send mobile mammography units to places in the community frequented by the target groups, with particular attention to reaching women who have limited access to fixed screening sites
- Collaborate with supermarkets and other popular stores to deliver information as part of the shopping experience
- Include in outreach materials such incentives as discount coupons

Literature reviewed about case management provided some background about the WHN case management program as well as some indicators of the effectiveness of particular case management approaches.

- Congress added case management services were added to the NBCCEDP in 1998. These services are to be provided by credentialed or licensed staff (Women's Health Network, 2005).

- The Women's Health network uses standards developed by the Case Management Society of America. These standards emphasis a holistic and client-centered approach focused on effective linkage of clients to needed services (Women's Health Network, 2005; Case Management Society of America, 2002).

- Poor women are particularly in need of case management services due to lack of knowledge about and access to the health care system (Kasper and Ferguson, 2000).

- Research indicates that nurse case managers improve follow-up for breast abnormalities by reducing barriers and improving patient trust (Bastani, Yabroff, and Glenn, 2004).

- Case managers can reduce ethnic and income disparities in health behaviors and outcomes (Engelstad et al., 2001).

- "Full service case management" involving provision of all needed clinical and support services and a personal relationship with clients is more effective in engaging clients in treatment and improving outcomes than is broker case management or a hybrid model (Bedell, Cohen, and Sullivan, 2000).

- A case management team approach increases service efficiency and cost-effectiveness, particularly for chronic disease patients (Galvin and Baudendistel, 1998).

- Older breast cancer patients have special needs for managing coexisting medical conditions and activities of daily living (Jennings-Sanders and Anderson, 2003).

Research on health care systems has several implications for the WHN program.

- Centralization and integration of health care networks is associated with improved service delivery, higher levels of system performance and greater efficiency in operations (Bazzoli et al., 2001).

- An integrated information system improves health care program management (Shapleigh, 1993).

- Well-planned outcome evaluations should be a component of WISEWOMAN programs (Finkelstein and Wittenborn, 2004).

- WISEWOMAN programs impose difficult burdens in terms of research and reporting, and work requirements (Viadro, Farris, and Will, 2004.)

- WISEWOMAN requirements are difficult to integrate with BCCEDP programs. Planning, training and support re essential (Viadro, Farris, and Will, 2004).

Alternative Program Highlights

Although federal regulations mandate some common features in NBCCEDP and WISEWOMAN programs throughout the United States, specific administrative and service delivery elements can vary among states, territories, and tribes. Task Force members examined NBCCEDP programs in several other states in order to consider alternative approaches to achieving particular program goals. Other public health programs that used different techniques for outreach and enrollment were also examined.

Case Management

Models of case management used for the NBCCEDP differ among states, although there is little evidence concerning the efficacy of the alternatives.

- Case management models vary in the degree of centralized control, ranging from decentralized program (eg. Michigan and New York), to regionally or locally controlled case management programs (eg. Nebraska), to centralized (Maine), and mixed models (Washington). Case management models also vary in the number of contracting organizations responsible for case management and in the method of reimbursement for case management—payment per client or by program capacity.

- NBCCEDP case management programs across the nation encounter similar challenges (Lantz, 2004): the desire of case managers to deliver a broader range of services than client tracking, complaints about caseload size and inadequate CDC funding; and the need for case managers to wear multiple "hats." Programs also report difficulties in finding qualified and experienced staff and providing sufficient training.

Outreach, Enrollment, Education

Programs throughout the country have used innovative methods to reach, enroll, and educate uninsured, low-income women in need of breast and cervical cancer screenings. One method is partnering with local corporations.

- Safeway supermarkets worked with California programs by printing mammography screening information on grocery sacks and Stop and Shop supermarkets collaborated with Rhode Island by setting up booths with

program information. Michigan coordinated a sweepstakes campaign with Kmart for women who had gotten a mammogram.

- Several grantees used coupons or vouchers to encourage women to get mammograms, keep appointments, or fill out surveys. Gas coupons were particularly effective as they rewarded and motivated clients and reduced the cost of their transportation. Providing coupons also provided a means to track clients. In South Carolina clients filled out a 2-part coupon with their contact information and detached $5 for groceries or Burger King.

Several states rely on lay health workers or volunteers to get the message out.

- Maryland trains employees working in the community, such as at laundry facilities and hair salons, to be able to answer program questions and give provider referrals.

- New Mexico coordinates with community residents to host "Home Health Parties," where program staff deliver presentations about cancer and cancer screenings. These parties have been successful with communities of color and other special populations because they offer flexibility to adjust the style, message, setting, and approach to accommodate cultural preferences.

- Washington D.C.'s programs employ lay health navigators (LHN), who live in community and share the same language, culture, and beliefs. These navigators work with women who might not other complete scheduled appointments, encouraging them to attend screening appointments, accompanying them appointments (when necessary), providing counseling, listening to fears, and giving appointment reminders. Research shows women served by the LHN were 5 times more likely to complete breast cancer screening exams on the scheduled appointment date than women not served by the program.

Others look to media outlets, especially for targeted populations.

- California utilizes multiple diverse sources. Television, billboards, in-store promotions, and press events entice women over 40 to get free screenings by portraying breast cancer a relentless time bomb. For the Latina community a local Spanish radio station produces a monthly talk show, which reinforces messages and includes testimonials of survivors, family members, and physicians. For the Vietnamese community a video was created that uses Vietnamese actors and themes, opposed to dubbing an English video, and tells a story of how one woman who gets regular screenings convinces another to overcome her fear and embarrassment. Additionally, a free Vietnamese newspaper publishes no-cost articles

written by program staff that explains screening, testing types, and service sites.

- Connecticut allied with a credible, visible local disc jockey to reach an African American target audience in New Haven. The DJ has hosted program directors and gives weekly updates on the total number of women getting screened and urges women to take advantage of the program.

- Nebraska runs television and radio commercials about the consequences of women who only focus on taking care of their family, and neglect taking care of their own health.

- Washington created the first screening effort directed at lesbians by including partnerships with lesbian press and involving visible, respected, and vocal members of the local lesbian community.

Placing mobile mammography has also proved to be an effective method.

- An outreach and portable screening program was created in New Jersey. Here program staff make monthly visits educating women at such settings as senior housing complexes, beauty parlors, and supermarkets. During the visits staff schedule mammography appointments for when the portable mammography returns 2 weeks later.

- New York funded 5 new mobile mammography units that travel the state visiting churches, grange halls and other community sites. This has been particularly helpful for reaching geographically isolated women who are unable to use fixed service sites.

Another documented way to reach target populations is through collaborating with religious organizations.

- Minnesota sponsors a church-based even to discuss women's fears and encourage the African American community to get screened and/or tested. This past year 38 churches participated in "Cancer Awareness Sunday".

- South Carolina sponsors "Pink Ribbon Sunday," where church members are encouraged to wear ribbons with an attached card detailing state specifics on breast cancer, ways to detect it, and the public health screening program's phone number. Churches are also given a guide on how to approach breast cancer as a family issue.

States employ multiple strategies to reduce disparities in screening by race/ethnicity and language and by removing financial barriers. For example:

- Hawaii's program uses culturally attuned outreach workers to educate and persuade them to use the free services.

- Ohio's program partners with advocacy groups to target underserved populations, such as Asians, migrant workers, Hispanics, and African-Americans. These organizations provide translation, outreach and transportation services.

- Montana's program has created an American Indian women's health task force to represent reservations and urban communities and grassroots coalitions in each community. With the representatives meeting regularly and the formation of the grassroots coalitions in several communities, screening rates for this population has increased threefold.

Some other public health program examples are:

- The Special Service for Groups, Inc. and Orange Country Asian and Pacific Islander Community Alliance in California provide health education to community members, provide cultural sensitivity information to health care providers, share cultural and health practices of the respective communities, assist with culturally and linguistically appropriate patient navigation, and education communities on the impacts of policy changes on health access.

- Access Community Health Network in IL collaborates with African American and Latino churches to provide comprehensive, bi-lingual educational sessions.

- The Boston Public Health Commission in MA created "The Breast Friends Program" to increase awareness of the importance of breast cancer early detection, especially among African American women. "Parties" are conducted in women's homes, churches, schools, and health centers that provide a safe and supportive setting to discuss strategies to detect breast cancer at an early stage and learn where to seek help if necessary. Community women are trained in basic breast health education, including breast cancer risk factors and early detection methods. The party leaders spread the word of breast health and refer women to free mammography services on the city of Boston's mobile mammography van.

Systems and Fiscal Operations

Massachusetts's NBCCEDP program is similar to that offered in several other New England states:

- Connecticut, Rhode Island, Maine, and New York have basically the same eligibility criteria.
    - Rhode Island's additional state funding also permits focusing on age groups not prioritized by the CDC.

- Rhode Island and New York clients may also apply for Medicaid to cover treatment services.

NBCCEDP programs in different states provide some alternative models for system operations and fiscal management. Program directors from four other states provided information to the RPPF.

- Michigan has a decentralized program, in which the state contracts with local agencies that provide screening services themselves or contract with local providers for screening. Outreach and improvement is centralized, with the state dealing directly with 700 clinical providers throughout the state. However, billing is handled centrally, with the state processing all claims and submitting them to a national organization. Program representatives feel that transmitting data to the national provider to determine if a woman is in the system is costly and would prefer to do it themselves.

- Maine has a very centralized program. Medical providers contract directly with approximately 125 primary care sites, but there is central enrollment for almost all clients through a toll free line, which gives consumers the option of selecting a provider. This method has been found to work well. Case management services are also very centralized, with just one full time case manager for the entire state (another has been requested). Medicaid is used to process claims, although with diminishing success. The claims payments and database reports are not linked and missing data reports are often sent from providers.

- Nebraska's program has over 600 contracts with private providers. The state uses centralized billing and data processing, with the 4 biggest providers entering claims and data online and the others doing it by hand. Provider-specific case management services are supplemented by six individuals who are paid to provide case management services when needed to manage larger caseloads. There is no active outreach program, due to insufficient program capacity for additional clients.

- Washington state's program is decentralized. Six prime contractors manage contracts with providers, who then subcontract with community health sites. Different private contractors use different approaches to case management. Each private contractor is responsible for oversight of administration and for case management services. Difficulties are reported in timely processing of claims for payment. Seventy-four percent of the funds is for care and 26% for case management, rather than the preferred 60% - 40% formula.

- New York's program is decentralized, contracting with 53 local contractors. Local health departments and hospitals are responsible for coordinating a local partnership for services that involves coordination, outreach, data management, fiscal management, and case management. Most service providers use an online system to enter data. A report is generated each month to request reimbursements for contractors. The state provides more than twice as much funding for the program than does the CDC, but program representatives feel the program is underfunded and overburdened with paperwork.

The Task Force Recommendations and Rationales

The next sections begin with summaries of program procedures and requirements pertinent to the work of each task force and then present the detailed recommendations of each task force as well as the rationales for each recommendation.

Medical Knowledge & Health Care Technology: Breast and Cervical Cancer

Chair: Keith Merlin, MD, Brockton Hospital

RA: Andrea Gnong, University of Massachusetts Boston

DPH: Ruth Karacek, RN, MPH, CCM, Department of Public Health

Members:

Ronald Burkman, MD, Baystate Medical Center

Barbara Cashavelly, RN, MSNT, Massachusetts General Hospital

Linda Clayton, MD, MPH, Executive Office of Health & Human Services

Sarah Feldman, MD, MPH, Brigham & Women's Hosptial

Karen Freund, MD, MPH, Boston Medical Center

Gerald Garlitz, RT, Dana Farber Cancer Institute

Annekathryn Goodman, MD, Massachusetts General Hospital

Judi Hirshfield-Bartek, RN, MS, OCN, Beth Israel Deaconess Med Center

Daniel Kopans, MD, Massachusetts General Hospital

Manlio LoConte, MD, Saints Memorial Hospital

Lisa McCoy, MD, MPH, American Cancer Society

Doris Moore, Department of Public Health

Sylvie Ratelle, MD, MPH, Department of Public Health

Shali Sanders, NP, Health & Continence Institute

Susan Schwarz, RN, Great Brook Valley Health Center

Susan Troyan, MD, Beth Israel Deaconess Med Center

Current Procedures and Requirements

- Program guidelines mandate prompt follow-up of all women with abnormal screening results. WHN funds case management services to support this requirement. Women who were screened for and found to have breast or cervical cancer, including pre-cancerous conditions, through the Women's Health Network, are eligible to apply for the MassHealth Breast and Cervical Cancer Treatment Program, a Medicaid program.

- Eligibility criteria: Massachusetts residency, **and** 40-64 years of age, **and** uninsured (have no health insurance) or underinsured (insured but insurance does not cover breast and cervical cancer screening services, **and** not eligible for MassHealth (Medicaid), **and** meet income guidelines (an income at or below 250% of Federal poverty guidelines), **and** are willing to enroll in the program.

- Under certain circumstances, some **younger women** (18+) and **older women** (65+) who are at high risk may qualify for enrollment. Under certain circumstances, **men** may qualify for enrollment if they are referred by a physician who, based with an abnormal clinical finding, has referred the man to rule out breast cancer.

- Citizenship and Immigration status will <u>not</u> be used as criteria to include or exclude women from enrolling in WHN who are otherwise determined eligible under these guidelines. All applicants will be asked, however, and must provide, information about their citizenship and immigration status as part of the WHN application process.

- Citizenship and Immigration status will be used as criteria to include or exclude women from enrolling in the MassHealth Breast and Cervical Cancer Treatment Program.

- WHN-BCCEDP funds may be used to **reimburse** for one annual screening office visit for each participant. The annual screening office visit should include a clinical breast exam (CBE) and pelvic examination, a Pap test and mammogram at appropriate intervals as described in the relevant *clinical guidelines*, and teaching of breast self-exam (BSE). In addition, the program funds screening tests (mammogram and Pap test) and diagnostic tests (diagnostic imaging, biopsy, and pathology).

- WHN contracts with 26 health care organizations statewide to deliver program services. Contracting organizations must ensure that women with **abnormal screening** examinations or test results (abnormal findings) are referred to a medical provider for appropriate diagnostic examination(s) and clinical follow-up in accordance with clinical guidelines. This is assured through the provision of professional case management services and clinical tracking services.

- Organizations contracting with WHN must have a **tracking system** that ensures that eligible BCCEDP women are screened for breast and cervical cancer services, that all screening test results are reported to the project, that women obtain medical referrals for needed diagnostic services, that women complete all diagnostic tests.

Breast & Cervical Cancer Recommendations

Screening and Diagnostic Criteria and Procedures

1) Present criteria and procedures relevant and appropriate

- Abnormal Pap or significant cervical lesion
- Abnormal mammogram or abnormal CBE findings

Rationale: The present criteria and procedures utilized in the WHN for the diagnosis and management of cervical and breast cancers are consistent with evidence-based guidelines promulgated by recognized nation professional organizations. In addition, they are in agreement with the recent Centers for Disease Control statement position on these issues. The present criteria for entering at the diagnostic stage remain relevant and appropriate. They are consistent with CDC and other professional guidelines. In summary, for cervical diagnostics, an abnormal Pap smear or significant cervical lesion would qualify. In breast disease, an abnormal Mammogram or abnormal findings on clinical breast examination would meet diagnostic criteria. This present criteria for cervical and breast cancer are sufficient in light of recent CDC reviews of the program.

2) Maintain priority for high-risk groups, i.e.:

- Infrequently or never screened women
- Cervical: > 5 lifetime partners, smoking, STD history
- Breast: family history, nulliparity

Rationale: Continued emphasis on high-risk groups, especially those who have not received screening or those women have not been recently screened remains a priority. The risk factors for cervical cancer are well established and include more than 5 sexual partners over a lifetime, smoking, and history of sexually transmitted disease. Similarly for breast cancer, family history and nulliparity are known risk factors.

3) Continue annual cervical and breast exams

Rationale: An annual examination is considered an integrally important part of the assessment of women for cervical and breast cancer. As such it should remain a requirement.

Eligibility

4) Request additional funding and policy changes from legislators to allow inclusion of adolescents and undocumented aliens (long term):

Rationale: There should never be a woman in the Commonwealth of Massachusetts who cannot get care for breast or cervical disease because of her age or residency status. The committee strongly recommends that funding be available and policy changes made so that age and residency requirements are dropped for entrance at the diagnostic or treatment stage.

- Include women younger than 18 for screening and treatment when they are not eligible for screening and treatment when they are not eligible through other programs.

Rationale: At present, the program has a minimum age of 18. Yet there are women under 18 who do not qualify for MassHealth and require diagnostic and treatment services. Therefore, age requirements for entry at the diagnostic level should be removed.

- Recommend that MassHealth regulations be changed to allow treatment services for undocumented aliens.

Rationale: The MassHealth Breast and Cervical Cancer Treatment program does not provide services to undocumented aliens.

5) Request additional funding to treat and manage any gynecologic condition detected (long term):

- Consider specific legislative budgetary line item
- Consider coverage of other serious conditions

Rationale: The annual examination allows additional opportunity to diagnose and treat issues related to breast and cervical disease, not to mention other medical disorders. This opportunity does present some challenges however. The Women's Health Network was and is designed to only address issues related to breast and cervical disease. In the course of an examination other serious medical conditions may be identified. These medical problems may require further testing and treatment. The limitations of the program preclude coverage for these services. The providers in the program face ethical, medical, legal, and logistical problems in insuring these problems are properly addressed. The committee would strongly recommend requesting additional funding for the treatment and management of, at a minimum, any gynecologic condition discovered during the screening and diagnostic evaluation. To effect these needed changes, legislative action may be required to create fiscal support for such activities. Consideration for a specific legislative budgetary line item has been offered as a possible mechanism to permit funding and to monitor cost.

Certainly a major consideration in the implementation of the program revolves around cost considerations. As a public health program, the committee strongly recognizes the need to do the greatest good for the largest number of women possible in the most cost effective method. Yet the strength of the program lies in the individual attention given to each woman who participates in it. As pressures on cost-containment rise, we must not forget our primary mission to improve the health of each individual woman who entrusts us with her care.

Technology

6) Attend to latest technologies, i.e.:

- HPV testing, either stand-alone or as adjuvant test to Pap
- HPV vaccines
- Breast imaging techniques such as MRIs

Rationale: Our current protocols need to continue to be reevaluated in light of new scientific advances and technologies to insure the women in the program continue to receive high quality cost-effective care. As evidence of new technologies such as Human Papilloma Virus vaccine or Breast Magnetic Resonance Imaging emerge, the program must be flexible enough to adopt evidence-based proven advances in a timely fashion.

7) Offer genetic testing to all appropriate patients (long term):

- National Comprehensive Cancer Network Guidelines
- Offer enrollment to all identified as high genetic risk
- Only opportunity to empower highest risk women
- Expensive but effective in reducing future costs

Rationale: At the present time, there is genetic testing available for appropriate women who develop breast cancer or who may be at risk for the development of disease. The committee believes that genetic testing, in accordance with the National Comprehensive Cancer Network guidelines, should be offered to all appropriate patients. Individuals identified as high risk for genetic cancer should be offered enrollment in the Women's Health Network program. While it is recognized that genetic testing is a potentially expensive endeavor, it provides the only opportunity to empower women who may be at the highest risk of developing breast or ovarian cancer a chance to proactively address their genetic risk thereby decreasing future costs – emotional and financial. The committee understands the limitations of the present program but does believe genetic testing is cost-effective and a standard of care in appropriately selected patients.

8) Keep up with evidence-based technologies and approaches by:

- Creating expert panel to review guidelines at least annually

- Including cervical and breast disease experts, clinicians, technologists, DPH representatives

Rationale: Medicine is constantly changing and there are new technologies and therapies on the horizon. Human Papilloma viral testing as either a stand-alone or adjuvant test to a Pap smear is now clinically available. Vaccines for HPV are now in clinical trials. New modalities for breast imaging such as Magnetic Resonance show potential promise. To insure the Women's Health Network incorporates the latest evidence-based technologies and approaches, the committee recommends the DPH create an expert panel to review the guidelines at least annually. The panel should include experts in cervical and breast disease, clinicians, technologists, and representatives from the DPH. The broadest possible perspective on the issues will provide the best vision for the future.

Medical Knowledge & Health Care Technology: Heart Disease and Stroke Prevention

Chair: John Ayanian, MD, MPP, Harvard Medical School

RA: Gina Gentile, University of Massachusetts Boston

DPH: Mary Lou Woodford, RN, BSN, CCM, Department of Public Health

Members:

Chava Chapman, MD, Boston Medical Center

Anita Christie, RN, MHA, CPHQ, South Shore Medical Center

Paula Johnson, MD, MPH, Brigham & Women's Hospital

Jewel Mullin, MD, MPH, Mason Square Neighborhood Health Center

Nancy Norman, MD, MPH, Fenway Community Health Center

Laurel Radwin, PhD, University of Massachusetts Boston

Theresa Trainor, LPN, BS, CPHQ, Mass PRO

Heather Ursini, RNC, Mary Lane Hospital

Janet Yardley, MD, Framingham Community Health Center

Current Procedures and Requirements

- The **Heart Disease and Stroke Prevention Program (**HDSPP) requires that the women are between the ages of 40 and 64 and already enrolled in the Breast and Cervical Cancer Early Detection Program (BCCEDP).
- Patients are **screened** using National evidence-based clinical guidelines aimed at modifiable cardiovascular disease (CVD) risk factors. These risk factors focus include hypertension, abnormal cholesterol, poor dietary intake, low levels of physical activity, overweight and obesity, tobacco use and diabetes.
- HDSPP **funds may be used to pay for** one screening office visit and up to two follow-up office visits per year for each woman enrolled. The following tests will be reimbursed by the program: resting pulse, screening blood pressure, confirmatory blood pressure, height and weight measurements, automated blood chemistry, fasting blood glucose, fasting lipid panel, urinalysis, paper and pencil tests, interviews or computerized methods that measure level of physical activity, dietary intake and smoking status. If the woman is diabetic, hemoglobin A1C testing is also covered.
- **Women with abnormal findings** require both clinical follow-up and clinical tracking. Case management services are required for all women identified with ATP III risk scores of ≥20%. Women are notified of test results and at least 3 attempts at notification must be documented in the WHN record.
- **For all enrollees**, contracting organizations must arrange for referral to medical services, provide clinical tracking services, provide risk reduction education services, and report the following data using the Department's automated information system (AIS): screening test, date of test, findings for each test; risk reduction education (RRE) session date, length of session, and topic of session; ATP III risk score, lifestyle assessment scores and date; lifestyle intervention plans and date; and other lifestyle interventions by date and topic.
- All women enrolled in the HDSPP program are offered **risk reduction educa**tion services annually. 100% of enrollees are expected to receive risk reduction services. There is a 6-month reassessment and follow-up of lifestyle intervention.
- Contracting organizations must have a system in place to track and remind enrollees to return for annual re-screens. Lifestyle assessments must be conducted and individualized intervention plans must be developed and documented.

Heart Disease and Stroke Prevention Recommendations

Data Collection & Patient Tracking

1) *The WHN should provide case managers with basic tracking systems to support more complete and consistent program-wide monitoring of key information, including participants':

- Initial and follow-up CVD risk score and its risk factor components
- Completion of follow-up risk re-assessments and counseling visits
- Source of primary care
- Eligibility & enrollment in MassHealth, Free Care, and/or drug assistance programs

Rationale: This data system would expand on the currently collected "Minimum Data Elements" (MDE) database to allow more complete monitoring of program participants.

2) *The WHN should provide case managers with a data system for tracking whether each participant who has hypertension, hyperlipidemia, diabetes mellitus and/or is a current smoker has:

- A primary care provider
- A program for obtaining free or reduced cost medications for hypertension, hyperlipidemia, diabetes mellitus, and/or smoking cessation
- A program for obtaining free or reduced cost supplies for glucose monitoring (i.e. glucometer, lancets, test strips) if a participant has diabetes mellitus

Rationale: Each participant in the WHN Heart Disease & Stroke Prevention program with one or more established CVD risk factors (hypertension, hyperlipidemia, diabetes mellitus, and/or current smoking) should be tracked in a local site database with summary reporting to the WHN program. This database should record their primary care provider, access to medications, and ability to diabetes supplies if relevant.

Risk Stratification & Intensity of Follow-up Services

3) *The frequency of follow-up visits for risk re-assessment and risk reduction counseling services should be explicitly tailored to participants' initial level of CVD risk:

- High-risk patients (e.g. 10-year CVD risk score >10%) contacted every 2-3 months
- Medium-risk patients (e.g. CVD risk score 5-10%) contacted every 6 months

- Low-risk patients (e.g. CVD risk score <5%) contacted every 12 months

Rationale: The WHN manual stipulates that Heart Disease & Stroke Prevention programs must provide annual risk reevaluation sessions for all clients and also a 6 month re-assessment of the lifestyle interventions for nutrition and physical activity. For those with ATP III risk groups scores ≥20%,, case management and tracking services are also required, but frequency of contact is not stipulated. High-risk patients would benefit from more frequent follow-up visits (every 3 months) to assess their ongoing risk status, and low-risk patients may only require annual follow-up to determine whether their risk status has worsened.

Clinical Services

4) *A *brief screening tool for depression* should be added to the initial CVD evaluation for all program participants.

Rationale: Depression is an important comorbid condition that can adversely affect CVD outcomes and impair individuals' ability to follow lifestyle modifications and treatments to reduce CVD risk. Brief screening tools are readily available and could guide referrals for primary care or mental health services (e.g. MHI-5 survey questions from Berwick et al. 1991).

5) **Glycosylated hemoglobin testing* should be retained as a covered Heart Disease & Stroke Prevention service for women with diabetes mellitus or glucose intolerance.

Rationale: Recent studies have shown that glycosylated hemoglobin levels are an independent predictor of CVD risk among women with diabetes mellitus or glucose intolerance.[Ann Intern Med 2005 refs] The Massachusetts WHN program has previously received CDC approval to include this test as a covered service, so this coverage should be retained.

6) **Liver function testing (e.g. ALT)* should be added as a covered service for women with hyperlipidemia who may require lipid-lowering medications.

Rationale: Women with hyperlipidemia may be eligible for lipid-lowering medications that could have higher risk or be contraindicated in patients with chronic liver disease, such as hepatitis C or alcoholic hepatitis. Basic liver function testing will identify most of these women.

7) ***C-reactive protein (CRP) testing* should be considered as an additional covered service in the initial CVD risk assessment.

Rationale: If ongoing randomized clinical trials demonstrate that women age 40-64 with elevated CRP levels and normal lipid profiles benefit from treatments to lower CVD risk

(e.g. lipid-lowering therapy, aspirin), CRP may be a useful screening test to add for risk stratification.

Referrals for Primary Care, Medications, and Medical Supplies

8) *Each site participating in the Heart Disease & Stroke Prevention program should provide the WHN with a written summary of local primary care providers (e.g. community health centers, hospital-based clinics, and/or private physicians' offices) to which participants with CVD risk factors can be referred for medical evaluation and treatment. This summary should be updated annually and reviewed by WHN staff in the Massachusetts Department of Public Health.

Rationale: WHN sites participating in the Heart Disease & Stroke Prevention program have a varied set of arrangements for helping participants obtain needed primary care and medications. Case managers and program staff are actively focused on arranging primary care referrals and access to medications through a series of ad-hoc arrangements. At a program based at a community health center, for example, primary care services are readily available on site. In contrast, a VNA-based program works with both community health centers and private physicians' offices for needed referrals. As part of the WHN Heart Disease & Stroke Prevention program oversight, these arrangements for primary care services, medications, and medical supplies should be explicitly documented by participating sites and reviewed with WHN central staff, and WHN central staff should assist sites in ensuring that adequate referral resources are in place.(Mays et al. 2004)

Heart Disease & Stroke Prevention Program Expansion

9) **State funds should be sought for expanding the Heart Disease & Stroke Prevention program beyond the current 7 participating WHN sites to allow more WHN sites to provide CVD risk assessment and counseling services.

Rationale: The current WHN sites are making strong efforts to enroll as many women as possible, but they can screen only a small proportion of potentially eligible women state-wide [could add some BRFSS data here].

Footnotes

*Short-term recommendation to be implemented within 1 year
**Longer-term recommendation to be implemented with 3-5 years

Case Management

Co-chairs:

Gail Gall, MS, RN, University of Massachusetts Boston

MaryJoan Ladden, PhD, RN, Harvard Pilgrim Health Care

RA: Elizabeth R. Cruz, University of Massachusetts Boston

DPH: Gail Chaffee, RN, CCM, Department of Public Health

Members:

Nashira Baril, Boston Public Health Commission

Maura Lessard, RN, BSN, CRRN, CCM, Marketing Educational Management Services

Eileen Manning, RN, BS, Dana Farber/ Partners Community Care Breast & Cervical Screening Collaborative

Lois McCloskey, DrPH, Boston University School of Public Health

Sharleen Moffatt, RN, BSN, Franklin County Home Care Corporation

Beth Paronich, MSW, LICSW, Jordan Hospital

Donna Peltier-Saxe, RN, MSN, Dana Farber/ Partners Community Care Breast & Cervical Screening Collaborative

The Case Management Task Force reviewed current procedures and regulations concerning the delivery of case management services and formulated recommendations for changes concerning both the Breast and Cervical Cancer program and the Heart Disease and Stroke Prevention Program.

Current Procedures and Requirements

- Contracting organizations have the responsibility to ensure that women with abnormal findings are referred to a medical provider for appropriate clinical follow-up in accordance with clinical guidelines. Case management is the program component that links patients with the broader health care and social support systems. Timely and adequate follow-up of abnormal results is assured through the provision of case management services.

- The process of case management involves identifying, brokering and sustaining diagnostic and treatment resources that ensure the provision of essential medical services to at-risk WHN-enrolled women. These activities include assessment of the barriers to receive timely and appropriate care, and development of a case management plan to address and attempt to resolve these barriers.

- Women must agree to the provision of case management services and this consent must be documented in their WHN medical record.

- Case management is a WHN-covered service that is paid for through the cost reimbursement portion of the DPH contract with the contracting organization; they cannot be billed by a medical provided or women cannot be billed for these services.

- Case managers must link women with cancer to the MassHealth Breast and Cervical Treatment Program. If the woman is not eligible for this, the case manager must link her to free or low-cost treatment services within the same expected time frame.

- Termination of case management services:

    - For BCCEDP: No cancer diagnosis; Initiation of treatment for cancer or precancerous condition; Successful enrollment in the MBCCTP; Refusal of services; Moved out of state; Lost to follow-up; Ineligible for services

    - For HDSPP: ATP III 10 year Risk score falls below 20%; Refusal of services; Moved out of state; Lost to follow-up; Ineligible for services

- Case management is a professional service provided by credentialed and/or licensed staff. "Case manager" shall mean a person or entity holding current licensure in Massachusetts or national case management certification, **and either have** a BA/BS or higher in health and human services **or be** a registered nurse,

licensed in Massachusetts, with an associate degree, a 3 year hospital diploma, or a bachelor degree or higher

Case Management Recommendations

Case Management structure

1) Create a client-centered model, adaptable to a variety of health care organizations, so that case management service can meet the unique needs of WHN clients.

- Case management services should continue to be decentralized and managed by contracting agencies.

Rationale: WHN clients come from diverse ethnic and cultural backgrounds and have multiple health, mental health, and social needs. Case managers need partnerships with providers/ organizations in that community to facilitate client access. Sites need the flexibility, within specific parameters of CDC and DPH guidelines, to implement case management services that best fit the needs of their population.

- Case management services should be team structured.

Rationale: Team structure provides opportunity to maximize the personnel resources of the contracting agency to provide services. For contracting agencies in which there are more than one staff members providing case management, program coordination, and client navigation, the teamwork should provide the clients a range of resources including clinical and cultural competencies as well as access to brokerage services.

2) Clearly describe the expectations for case management service to WHN vendors. The expectations to be described in the contract include:

- Administrative support for CM
- Minimum time for CM services based on enrollment capacity and client caseload characteristics.
- Qualifications of CM
- Training requirements to be supported by the site, such as site specific orientation, ongoing training, and team development.

Rationale: Because each WHN site will meet the needs of their clients differently, the expectations for case management services should be clearly described in the contract so that supports are standard across the network and sites are accountable for these components.

3) Create regional case management networks to enhance collaboration and stimulate best practices.

Rationale: Maximize the experience and skills of the case managers and client navigators by encouraging them to share resources, encourage collaboration, and develop best practices in WHN case management. This network would benefit from client participation.

Case Manager Qualifications

4) WHN Case Managers should be licensed health care professionals with a set of defined core competencies and skills. Case managers without a nursing background should be part of a team that includes a health professional able to make decisions based on clinical data. In small provider sites, where the team approach cannot work, the nurse is the key to successful CM

This differs from the current DPH statement of criteria. The TF recommends deleting the phrases: "and either BA/BS or higher in health and human services, or RN licensed in MA, with AD, diploma, or BS or higher" from the 2005 Policy and Procedure Manual.

The case managers should have a defined set of core competencies and skills including:

- Ability to interpret medical/ health data related to clients
- Ability to integrate cultural and ethnic disparities into assessment, plan, and intervention
- Computer skills, including Excel, Access, and web searches
- Communication skills; verbal, written, in person, and by telephone
- Problem solving skills with creativity and flexibility
- Ability to effectively interface with PCPs and specialists on behalf of the client
- Ability to identify and secure relevant site/organizational, community, and state resources for the client and her family
- Ability to lead and work as part of a team
- Ability to advocate for WHN services within the organization

Rationale: While many would argue that nurses are the optimal case managers for the WHN program, Massachusetts faces challenges in recruitment and retention of nurses. WHN sites need flexibility in recruiting from a larger pool of eligible, licensed case management staff (social workers, nutritionists, health educators, etc). Consideration should be given to increase recruitment from members of WHN target populations. If the case manager is not a nurse, she/he should function as part of a team to ensure medical or nursing supervision of clinical decision making.

Case Management Training and Resources

5) Create a case management orientation program (WHN 101) that is multimodal and has separate tracks for each level of staff (case managers and client navigators). Additionally, establish a mentoring program that connects experienced staff and newcomers. Topics include:

- How CM operates in WHN
- Awareness and respect for the unique needs of women in WHN
- Clinical issues related to breast and cervical cancer, and CVD
- Expectations and responsibilities of case managers, client navigators, and program coordinators
- Standard assessment techniques, including general and mental health
- Local, regional, and state resources
- DPH and other case management specific supports
- Working as a team including delegation, supervision, and role issues.

6) Establish a professional development series that includes the voices of, and is intended for all who work with WHN clients (case managers, client navigators, outreach staff, DPH and agency staff). The series should be interactive and driven toward improving case management services, job satisfaction, staff retention, and client satisfaction. Professional development topics include:

- Professional development topics:
- Best practices in case management for breast and cervical cancer and heart disease & stroke prevention
- Understanding how clients' experiences and backgrounds, including racism and disparities, influence their health care choices
- Cultural competence
- Assessment of psychosocial response to potential cancer and CVD diagnoses.
- Enhancing clients' self management skills
- Integrating clients' perspective into care
- Negotiating care boundaries
- Refining communication skills for various situations
- Negotiating with providers
- Managing time and prioritizing work areas
- Managing stress
- Brokering access to wider health, social, and financial support services.
- Behavior change theory and practice
- Evaluation strategies at the agency level

Rationale for items 5 & 6: The success of the WHN depends of the effectiveness of case management services. To optimize their skills, case managers and client navigators need not only a basic orientation to case management and WHN but also mentoring, training, and resources across the professional development continuum.

<u>Heart Disease & Stroke Prevention Case Management</u>

7) Increase funding for the WISEWOMAN program to pay for recommended diagnostic testing, adequately reimburse providers, and support continued intervention for client behavior changes.

Rationale: The program cannot be effective at the current level. It has experienced significant loss of contracted service providers and is unable to attract new contractors as presently designed. Enhanced funding is needed to connect patients to primary and specialty care. Because fear of bills is an important issues deterring participation, the program needs to guarantee reimbursement of a broader range of services

8) Provide training for WISEWOMAN staff to support their roles as lifestyle coaches. Support nutrition and behavior change counselors at DPH for the entire program to access.

Rationale: Coaching clients on lifestyle change is a critical part of the WISEWOMAN program and role of case managers and client navigators. To enhance effectiveness, they need specific skills in behavior change theory, client empowerment, and self-management for the particular cultures represented by WHN clients. Community health workers with skills in specific behavior change coaching may be best utilized at specific sites.

9) Streamline WISEWOMAN reporting and data collection based on clinical and field-service needs.

Rationale: These activities should support rather than drive the program and not detract from the case management staff's ability to delivery quality and timely services. Each agency has its own paper work as well as WISEWOMAN records. For many in the field, the paperwork is repetitive and not clinically valuable, thus a barrier to effective services. New systems should be developed in consultation with those in the field who will use the systems.

<u>Additional Recommendations</u>

10) Establish a quality improvement and innovation fund to test new ideas in care improvement.

Rationale: Case managers in the field have a unique and valuable perspective. Innovation usually comes from within the field. New ideas need support to be tested and evaluated. Such investments cold add to the quality of services as well as satisfaction of both clients and staff.

11) Encourage and support case manager certification

Rationale: Establishes a baseline credential and competency for the program and serves to support the Case Managers in the field and give them access to further resources for professional development

12) Support the designation of client navigators as community health workers (CHWs).

Rationale: The DPH has just issued a report on CHW, defining the role and reporting on characteristics of CHWs in MA. Designating the client navigators as CHWs would reinforce their value as members of the case management team and keep the WHN program in alignment with DPH policies.

Health Care Disparities and Barriers to Health Care Access

Chair: Judy Ann Bigby, MD, Brigham & Women's Hospital

Consultant:
Cathy Romeo, VNA Care Network, Inc.

RAs: Elizabeth R. Cruz, University of Massachusetts Boston

Rachelle Pierre, Harvard Medical School

DPH: Janice Mirabassi, MA, Department of Public Health

Members:

Jane Cloutterbuck, PhD, RN, University of Massachusetts Boston

Dora Gutierrez, MD, Latin American Health Institute

Nancy Keating, MD, MPH, Harvard Medical School

Karen Lasser, MD, MPH, Cambridge Health Alliance

Lidia Schapira, MD, Massachusetts General Hospital

Darrell Smith, Brigham & Women's Hospital

The Disparities and Barriers Task Force considered the sources of health care disparities and barriers to health care access as well as techniques that could reduce disparities and barriers.

Healthcare Disparities & Barriers to Access Recommendations

Categorical Nature of Program

1) The WHN should coordinate with other DPH programs to meet the needs of women with depression.

Rationale: In WHN, women with depressive symptoms are less likely to follow-up with abnormal results.

2) The WHN program should evolve into a primary care based model of comprehensive women's health for those uninsured. The CDC and MA DPH should increase funding for diagnostic and treatment services (long term).

Rationale: The categorical nature of the program requires several administrative structures that are burdensome or difficult to implement. Women present with health needs that are not related to the WHN or WiseWoman covered services and providers respond to these needs because they want to ensure that women get the care they need and they feel an ethical obligation to do so.

Cultural competence

3) WHN contracts should require providers to demonstrate an awareness of disparities, especially the issues unique to women, and describe the programs and policies that encourage and sustain cultural competence. Sites should demonstrate how they will meet unique needs of specific populations (e.g. availability of interpreters).

Rationale: There are cultural differences in health risk, incidence, mortality, patterns of health care use, and health values. Policies need to be attentive and sensitive to in order to effectively reduce such disparities.

4) Clinical site evaluations should include benchmarks that adequately assess cultural competence.

Rationale: It is important to collect data on race/ethnicity, country of birth, length of residence, socioeconomic status, and language preference to measure any gaps in health outcomes and to measure any reduction in health disparities. These data must be shared with the community and incorporated into program changes.

5) The WHN program should diversify staff to better reflect the population being served. This includes have specific recruiting strategies to open up positions and exploring a model of case management not requiring nurse case managers.

Rationale: There is a lack of racial/ethnic/linguistic concordance between case managers and the population serviced. The nursing pool lacks racial/ethnic/linguistic diversity and many duties assigned to the case manager do not require nursing skills or training.

6) The WHN should regularly assess patient experiences and use these results to improve programs.

Rationale: Research shows that patient satisfaction is a predictor for returning for care and recommending services to others. Recent WHN evaluations show that non-English speakers are less satisfied and clients were less likely to recommend the program to non-English speakers and disabled women.

7) The WHN should use community health workers/patient navigators for outreach, follow-up, and re-screening.

Rationale: Research shows that patient navigators who are racially and culturally similar to the clients they serve and are familiar with patients' communities have been shown to have a significant effect of rates of biopsies for abnormal findings and timeliness of diagnosis.

<u>Fear of bills</u>

8) The WHN should develop marketing strategies that address fear of bills up front so more women will participate.

Rationale: Task Force members believe that women's experiences with free health care has caused them to be skeptical of programs that are free. Women inform others in their community about their experiences in the health care system. Learning that some women get bills even though the program is free deters others prom participating.

9) The WHN should screen women for other programs upon intake.

Rationale: Women who are eligible for WHN may be eligible for other programs as well. Additional coverage would help to prevent women getting bills for services that are not covered by WHN.

10) The WHN should develop materials that adequately inform women of the limitations of the program and covered services. Such materials should be language and literacy appropriate.

Rationale: Women are not adequately informed of which services are covered and they are fearful of receiving bills for non-covered services.

11) The WHN should improve access to WHN staff that can help problem solve when women receive bills.

Rationale: This would prevent women from being so fearful to receive bills, help them find methods to pay for a bill they cannot afford and ultimately not dissuade them from continuing services.

12) The WHN should work with providers to identify ways to deliver non-covered services without women getting a bill.

Rationale: Providers are not educated about all the limitations of the program and consequences of providing non-covered services. Also, there is a lack of resources to address CVD risk factors.

13) The WHN should evolve into a primary care based model of comprehensive women's health (Long term).

Rationale: A comprehensive care model would eliminate many of the barriers to getting service including fear of bills for non-covered services.

Logistics

14) The WHN should mandate providers to include hours on the week-ends or evenings. An option includes exploring ways to encourage those with extended hours to participate.

Rationale: Most clients cannot get services during normal business hours (Monday – Friday, 9 – 5) because they need to work and do not have sick time.

Limited number of sites; administrative burden

15) The WHN should set up processes to streamline systems.

Rationale: Reports from drop-out vendors suggest the need for a more "user friendly" model.

16) The WHN should increase incentives for site participation, including increasing reimbursement (Long term).

Rationale: Enrollment in WHN has declined even though the uninsured have increased in number. 25 programs dropped out of the WHN program (with 5 subsumed into other contracts) for a variety of reasons. While not all reasons can be directly attributed to WHN, changes in the program such as upgrading screening to include case management services, adding the WISEWOMAN program with risk reduction education, and updates in technology (information, billing, and enrollment) contributed to the decrease in participating vendors. Reports from case managers state that administering the

WISEWOMAN program is extremely labor intensive and that DPH does not adequately fund their programs.

Outreach and transient population

17) The WHN should increase outreach efforts, such as including in site contracts, targeting specific populations, and strengthening the role of the community health workers. Additionally outreach workers should reassure immigrant populations of program intent.

Rationale: In 2000 the WHN programs were forced to discontinue its outreach program. Since then screening and re-screening rates are lower than desirable. Even though there has been an increase in the number of uninsured and under-insured women, the numbers of clients have declined over several consecutive years. In FY 2004, it is estimated that only 23% of eligible women were screened. For example, between 1999 and 2001, only 42% of eligible women 40-64 years old received a Pap test and between 2000-2001 only 31% of eligible women 40-64 years old received a mammogram. Only 66.5% of Asian women reported having a Pap test in 2002, compared to the 88% of all MA women. Within the program there is a significant transient population. Immigrants need to verify their status and provide SSN for new the new enrollment process.

Efforts to reach underserved populations that focus on using existing community and social networks (such as faith based organizations) are often more effective in recruiting underserved women for screening procedures than efforts that are developed solely out of a health care institution. Identifying trusted community members to outreach helps to build trust.

Education, Outreach, & Enrollment

Chair: Rachel Wilson, MPH, Brigham & Women's Hospital

RAs: Sophy Nun-Hoeger, University of Massachusetts Boston

Swapna Reddy, JD, MPH, Brigham & Women's Hospital

DPH: Heather Nelson, PhD (ABD), MPH, Department of Public Health

Members:

Gayle Bagley, American Cancer Society

Carol Brayboy, Boston Public Health Commission

Jennifer Cochran, Department of Public Health

Sally Fogerty, MEd, BSN, Department of Public Health

Gail Fortes, YWCA Southeastern MA

Sally Hooper, MSW, LICSW, Massachusetts General Hospital

Donaldo Macedo, PhD, University of Massachusetts Boston

Susan Madden, Division of Health Care Finance & Policy

Janet McGrail-Spillane, American Cancer Society

Lisa Renee Sicilano, Massachusetts Public Health Association

Karen Webber, VNA Care Network, Inc.

John Wei, MD, Lahey Clinic

Current Procedures and Requirements

- Women can call the toll free line to learn more information about the program and about participating sites.

- Medical providers in the community are encouraged to refer income-eligible women into the program.

- Through the WHN Training Institute there are free and low-cost professional education programs for outreach staff, client navigators, community health workers, clinicians, and medical professions.

- A representative list of training offerings from previous years include: Breast self exam; Clinical breast exam; Outreach strategies; Conducting effective peer-education sessions; Cultural competence; Breast, cervical and cardiovascular health for community health workers; CME/CEU; AIS.

- The WHN develops and distributes free health promotion materials through the Massachusetts Health Promotion Clearinghouse. These materials are appropriate for clinic waiting areas, to distribute to medical providers and in the community; and as handouts to patients. Formats include posters, pamphlets, and electronic media. These materials are free of charge. Selected publications are available in several languages.

Education, Outreach and Enrollment Recommendations

Outreach Structure Recommendations

1) The primary focus and funding for WHN outreach should be targeted toward community outreach at the local level, using the below 3-tiered strategies:

Rationale: The number of clients served by the WHN has declined steadily since 2000. While other factors may have contributed to this decline, it is important to note that this was also the year that funding for outreach was eliminated. When government funding streams change, outreach is often the first program component to be reduced. When outreach is conducted locally, instead of centrally, outreach activities may be more likely to be sustained.

- Use site specific outreach by Community Health Workers (CHWs) and Peer Educators. This involves each medical service site being responsible for and funded to specifically conduct (or subcontract) outreach to the communities serviced by their center. To address previous problems of outreach referrals made only to the site conducting the outreach, language should be included in each contract that specifically requires sites to refer clients to agencies that have the capacity and infrastructure to best address the specific needs of the

clients (i.e. geography, language, specific services offered). This should also be reiterated in trainings and regional meetings and assessed through evaluation. [Note: WHN site subcontracts for outreach should be processed centrally by DPH, but managed locally by the site.]

- *Rationale: CHWs are recognized consistently in research and practice as the most effective method of outreach. Peer educators can be an effective supplemental tool for CHWs to convey messages through oral networks in the community. Additionally, the use of CHW's can help to reduce cultural and linguistic barriers and alleviate client fears of breast and cervical cancer screening that may prevent women from enrolling or re-enrolling.*

- *Rationale: Currently, WHN sites that subcontract out to others are overburdened by the administration and paperwork necessary. Centralized subcontracting can help to reduce this burden and streamline processes.*

Enlist community programs to reach target populations that may be particularly high-risk and/or hard to reach through other methods. This method should only be utilized if evaluation indicates that a population is not being reached and that the local outreach workers do not have the capacity to do so.

- *Rationale: An aggressive strategy is needed to assure that sites are located in ways that maximize access by target populations. The importance of site location can be seen in the reduction in Chinese speaking clients from 2003-2004 following the discontinued participation of a primarily Chinese-speaking WHN site.*

Have a DPH Outreach Coordinator(s) to oversee local outreach staff and coordinate their work to maximize effectiveness. Responsibilities should include, but not be limited to: convening regular mandatory regional meetings for outreach (and other) WHN staff, coordinating outreach to assure that all target populations are being reached, collecting evaluation data, and providing technical assistance, training, and support to outreach staff. They should also be responsible for working with central WHN staff to assess progress in reaching statewide outreach goals.

- *Rationale: WHN site surveys report that there is a great need and desire to meet regionally, especially to discuss and share outreach methods.*

2) Strategically locate medical sites in the communities where target populations seek care. DPH must review and actively purse such targeted participation.

Rationale: Local ties, cultural/linguistic diversity, and community partnerships are fundamental to conduct the most effective community outreach.

- *The number of clients served by the WHN has declined steadily since 2000. While other factors may have contributed to this decline, it is important to note that this was also the year that funding for outreach was eliminated.*
- *Local ties, cultural/linguistic diversity and community partnerships are fundamental to conduct the most effective community outreach.*
- *CHW's are recognized consistently in research and practice as the most effective method of outreach. Peer educators can be an effective supplemental tool for CHW's to convey messages through oral networks in the community.*
- *The use of CHW's can help to reduce cultural and linguistic barriers and alleviate client fears of breast and cervical cancer screening that may prevent women from enrolling or re-enrolling.*
- *WHN site surveys report that there is a great need and desire to meet regionally, especially to discuss and share outreach methods.*
- *When government funding streams change, outreach is often the first program component to be reduced. When outreach is conducted locally, instead of centrally, outreach activities may be more likely to be sustained.*
- *Currently, WHN sites that subcontract out to others are overburdened by the administration and paperwork necessary. Centralized subcontracting can help to reduce this burden and streamline processes.*
- *An aggressive strategy is needed to assure that sites are located in ways that maximize access by target populations.*
- *The importance of site location can be seen in the reduction in Chinese speaking clients from 2003-2004 following the discontinued participation of a primarily Chinese-speaking WHN site.*

Educational Materials Recommendations

Education of potential clients should rely less on written materials and more on oral networks and "word of mouth". This will require a reallocation of funds to support the education methods recommended below. Business sized cards with a local WHN phone number, available in multiple languages, should be the primary written material used by outreach workers and other community groups. An assessment of how the WHN toll-free number is being utilized and its cost-effectiveness should be conducted and compared to reliance on local phone numbers.

Rationale

- *27% of WHN clients have less than a high school education.*

- *20-30% of WHN clients surveyed heard of the program through a family member or friend, particularly among Portuguese and Spanish speakers.*
- *Surveys report that almost all WHN medical sites expressed concern about MDPH's toll-free number not being answered and delays in responding.*

Educational Methods Recommendations

The primary methods recommended for public education include:
(1) The use of community health workers and peer educators
(2) Partnerships with local social, community and religious organizations
(3) Local, targeted, culturally specific media campaigns (i.e. Latino radio)

Rationale

- *Research indicates that these are the most effective outreach methods available.*
- *See rationale for outreach structure re: CHW's above.*
- *These methods are relatively lower in cost than other options, such as large media campaigns.*

Evaluation Recommendations

Because some clients may enroll in WHN after contact with more than one outreach worker, evaluation of outreach should be measured in a way that recognizes and records all contacts that lead to a client's enrollment. Outreach should be evaluated based on simple reports submitted to outreach coordinators on a regular basis, which include the following data:

(1) Description of referrals made, with information on race, ethnicity and language of referrals, as well as where the woman was referred to, and the reason for the referral (which will allow for outreach coordinators to assess whether referrals are being made to sites with the capacity and infrastructure that best serve the client).
(2) Type and method of outreach methods, appropriate category indicated (i.e. initial contact, follow-up).
(3) Number of contacts made through outreach methods, by whom and through what role.

It should be the responsibility of outreach coordinators to gather this information. WHN central staff should use this information to compare the outreach contacts and referrals to the pool of eligible women to determine who is still not being reached and who is being reached most effectively. Women referred to WHN should also be tracked to determine if they ultimately enroll in the program. Successful outreach and methods should be shared at regional outreach meetings.

It is important to recognize that local community outreach is a long-term investment that involves building relationships and networks. Therefore, the new outreach structure will

most probably not show immediate results and assessment must take place over a period of years.

Rationale

- *Evaluation is necessary to determine what methods are most effective, what populations are being reached and not reached, to share successful methods, and to provide oversight to determine if referrals are being made to the sites with the capacity and infrastructure that best serve the client.*
- *Evaluation can help to identify trends in referral patterns and changes in community demographics.*
- *Evaluation is important for effective coordination, oversight, and accountability.*
- *Collection of data from all points of outreach and referral can help to reduce the competition that has been a problem in the past.*

Staff Training & Support

Staff Role Recommendation: Outreach/Navigator Role

The roles of the Client Navigator and Outreach Worker should be clearly defined and recognized as part of the health care team. Given the similar roles and background required of outreach workers and client navigators, we **strongly recommend** that these roles be combined whenever possible. This would result in continuity through initial contact, referral, enrollment, health care services navigation, follow-up, and re-enrollment.

Rationale

- *WHN staff, particularly client navigators, reported a lack of appreciation and recognition by their teams for their contributions and confusion about the appropriate boundaries between their role and that of the case managers. This boundary could become even less clearly defined with the inception of an outreach worker, if the roles are not combined.*
- *Outreach workers may be more likely to feel integrated in the medical services delivery team if their role is combined with the client navigator, where she will have more interaction with medical site staff.*
- *The combination of the client navigator and outreach worker roles will most likely increase enrollment, enhance client trust, streamline care, and could result in increased repeat visits and re-enrollment.*

WHN staff training

All staff at participating WHN sites that are involved in client enrollment must be fully trained in WHN and in cultural and linguistic competency. This includes training for financial and registration staff at each site, as well as providers and administrators who

may refer women into the program (for improved "in-reach"). Cross training should also be conducted, in order to protect against gaps in service during staff transitions and to foster an appreciation for other WHN site staff roles.

Rationale

- *Without knowledge of the program, it will be difficult for financial and registration staff to effectively recruit women into the program and answer their questions, especially if the Virtual Gateway is to be used increasingly as a recruitment tool.*
- *Virtually all contracting organization staff reported the need for more consistent training of staff to maximize the understanding of WHN Program guidelines and foster more collaborative relationships.*
- *Almost all medical site staff reported challenges in getting adequate WHN training to stay current and conveyed interest in cross-role training.*
- *28-45% of WHN patients reported referral by a health care worker; however some site staff report that providers sometimes fail to understand the WHN program restrictions so that women get charged for services they can not afford.*

Regional Meetings

Regional meetings with outreach workers and others involved in WHN enrollment and care should be held at least quarterly. Meetings should be coordinated by the DPH outreach coordinator(s). Meetings should be interactive, as opposed to presentation and reporting format, to stimulate active participation to address barriers and facilitate more collaborative relationships. The meetings should be mandatory and can provide a forum for:

- Identification of staff training needs
- Providing staff trainings
- Sharing of information, techniques, and resources
- Staff recognition, support and technical assistance
- Regional coordination
- Evaluation data collection, dissemination, and discussion

Once a year, this meeting should be opened up to other outreach workers in the community that may be working on other issues with the same population.

Rationale

- *Medical site staff report significant variations in the approaches to "in reach and outreach" activities used at various sites and little opportunity to share approaches.*
- *Medical site staff have recommended that MDPH should seek ways (verbally and in writing) to acknowledge the work of particular contracting*

organization staff and to ensure that client navigators are well integrated into their medical service sites.
- *In the past, attendance by WHN site staff at regional meetings was not mandatory and was therefore limited.*

Enrollment

Information Collection Recommendation

Continue to collect client information at each individual medical site. When possible, Client Navigators or Outreach Workers should assist in the collection of information from potential WHN clients for submission and processing. The person collecting information from the client should inform her that the information will be shared with government agencies responsible for funding the program, but that it will be kept private and will not be used against them in any way (i.e. immigration, billing).

Rationale

- *Clients report fear of bills, dealing with insurance, distrust of the system, lack of system knowledge, scheduling, and transportation as barriers to services.*
- *Clients are asked for sensitive and private information, such as citizenship and income.*
- *For these reasons, it is best to have information processed locally, and not by a centralized authority that may be less trusted.*
- *It is ideal to have the enrollment process facilitated through a personal interaction, where trust can be established, as opposed to the more impersonal method of enrollment by phone or computer.*
- *Client Navigators/Outreach Workers are likely to come from a similar background and speak the language of the client, thus engendering the trust of the client and putting her more at ease than someone of a different background/role.*
- *Non-English speaking clients with less education are more likely to report feeling that their privacy rights were not adequately explained to them.*

Enrollment Processing Recommendation

While eligibility should continue to be determined by the site at which the woman presents, the client enrollment information that is collected should be submitted and processed centrally, through electronic means whenever possible. In order to avoid delays in scheduling and the provision of care to clients that may result from centralized approval, "presumptive eligibility" should be determined immediately at the medical site so services can proceed without disruption.

Rationale

- *Currently, verification and enrollment take place at each individual site, which restricts the client from receiving care at any other sites. Central processing will allow women to receive care at any participating WHN site, providing increased flexibility and thus patient satisfaction.*
- *Centralized enrollment processing will allow for centralized data collection, tracking and evaluation.*
- *The current practice of site-specific enrollment processing has resulted in a lack of standardized verification procedures across institutions. Centralized enrollment can help to standardize operations and streamline procedures, which can result in improved efficiency, reduced duplication and paperwork, and ultimately cost-savings.*

Virtual Gateway Recommendations

The Virtual Gateway should be used to outreach to and enroll eligible women who are receiving care at a WHN medical site but have not yet been introduced to the program. Ideally, when a person is asked to provide enrollment information for MassHealth/Free Care via the Virtual Gateway, the computer will prompt the person entering the information to screen for eligibility in **all** state assistance programs listed, including WHN. At a minimum, registration and financial staff at WHN sites should be trained about WHN and prompted to ask women who are completing the MassHealth/Free Care application if they are willing to also check for WHN eligibility.

Rationale

- *All uninsured women will be required to complete an application for MassHealth/Free Care, creating a new opportunity to introduce WHN to potential new clients.*
- *WHN eligibility questions can be added to the MassHealth/Free Care questions with little extra effort.*
- *Virtual gateway can outreach to women who otherwise might not be reached.*

Health Care Delivery Systems

Separate task forces considered the operation of the WHN within the context of the larger health care delivery system and the specific procedures and regulations concerning fiscal management and business operations.

Chair: John Lowe, III, PhD, Simmons College

Consultants:

Howard Koh, MD, MPH, Harvard School of Public Health

Christine Judge, MS, Harvard School of Public Health

RA: Maria Tracy, MA, University of Massachusetts Boston

DPH: Hillary Sugrue, Department of Public Health

Liz Welch, Department of Public Health

Members:

Karen Edlund, Department of Public Health

James Fitchett, MA, ProVentive, Inc.

Oscar Gutierrez, PhD, University of Massachusetts Boston

Craig Johnson, MS, Executive Office of Health & Human Services

Deborah Klein-Walker, PhD, MEd, Abt Associates, Inc.

Phyllis Kornguth, MD, PhD, Harvard Medical School

Anne Levine, Dana Farber Cancer Institute

Tracy Miller, JD, Department of Public Health

Laurie Robinson, MTS, U.S. Department of Health & Human Services

Goals, Objectives and Strategies for Improving Current Procedures

The Health Care Delivery Systems Task Force developed a framework that is designed to realign provider and WHN policy, process, plan and information technology initiatives to better serve women participating in the WHN. The framework organizes the recommendations by goals, objectives and strategies, in response to the problems identified by participants, and services to introduce the specific Task Force recommendations.

The Health Systems Workgroup identified four primary goals for the Women's Health Network. These goals state in general terms the direction that the WHN should follow to improve the service experience for women and make it easier for providers (physicians, hospitals, health centers, VNAs, etc) to deliver services.

1. Improve Access/Choice – Women in WHN should have access to a broad array of WHN providers. Improved access would be characterized by improved administrative convenience for providers as well as an expanded choice of providers for women participating in the program.

2. Improve Continuity – Women should be able to obtain services from alternative WHN provider sites without a loss of continuity of services under the WHN program. Women also should be able to obtain all needed primary care services at the point of service; and providers should be paid for all services rendered.

3. Enhance Quality – Women should receive high-quality, evidence-based services from appropriately credentialed health service providers.

4. Enhance Cost Effectiveness – WHN providers should receive timely payments for the full cost of participating in the program. WHN should ensure that the greatest possible number of eligible women receive WHN services based on available resources.

In order to achieve the goals identified above, the WHN must successfully implement the following critical success factors.

1. Decouple administrative and programmatic processes and data - Administrative overhead is often cited as a barrier to provider participation. WHN must establish a model that encourages more providers to participate.

2. Timely Payment for Service (De-link Data and Payment) - The current process requires the completion of all diagnostic services in a case prior to paying a claim for any component piece. Many providers cannot absorb delayed payment. WHN needs to develop capability to reimburse for services rendered closer to date of service for component pieces, implying a change in protocol, guideline etc.

3. Flexibility to Absorb new programs – The WHN system must be designed in a way to integrate and support new CDC categorical programs, such as colorectal cancer screening. The addition of such programs will further the goal of continuity of services.

Objectives

The Task Force specified objectives -- specific targets -- that the WHN should achieve *by 2008*. Upon adoption, these objectives can be elaborated on to identify WHN requirements including the need for collection of additional data as well as the need for integration of information with WHN and non-WHN programs and other agencies.

- Increase the % eligible women served by 15%
- Increase the # visits/screenings by 15%
- Increase access to primary care (# WHN women with a PCP)
- Decrease the % provider administrative cost
- Decrease the time between bill and payment by 50%
- Decrease the time from diagnosis to treatment by 25%
- Decrease the time for State-program eligibility determination by 50%
- Cover the provider cost of doing business with the WHN

The following matrix can be used to demonstrate the relationship of strategies and objectives, including key strategies in support of multiple objectives. This along with other factors was used to assess the "criticality" of individual strategies.

Goals Access/Choice Capacity Cost Effectiveness Quality		Objectives								
		□ % Eligible Women Served	□ # Visits/Screenings	□ # Providers in System	□ Access to Primary Care	□ % Admin Cost to Provider	□ Time to Pay	Treatment	Determination	□ Cover the Cost of Doing
Strategies	Administrative Simplification	↑	↑	↑	↑					
	Streamline/Integrate Business Processes	↑	↑	↑		↓	↓	↓	↓	
	Broaden Access to Virtual Gateway	↑	↑	↑		↓	↓	↓	↓	
	Staffing Alternatives	↑	↑	↑		↓				↑
	Prime Contractor Model	↑			↑	↓	↓	↓		
	Link to Primary Care Provider	↑	↑	↑				↓		

The strategies developed by the Task Force are the pattern of objectives, policies, functions, processes and plans that indicate how the WHN should function over time. Upon adoption, the strategies the Task Force identified can be further developed into specific actions to realize the strategy and achieve WHN objectives.

Strategy	Criticality	Planning Horizon
Evaluate and Implement Administrative Simplification	High	Tactical
Evaluate the impact of administrative simplification on the overall financial impact on providers participating in the WHN program. Develop and implement strategies to simplify and integrate transaction processing, to make doing business with WHN seamless/transparent to participants and providers. Realign existing state business processes, including eligibility determinations and evaluation of alternative claims processing… Leverage the Virtual Gateway for Provider Access to Information		
Evaluate and Implement Staffing Alternatives	High	Tactical
Evaluate the opportunity to redefine staffing requirements including the requirement for Case Management staff (e.g. staffing patterns related to outcomes). Identify alternative staffing models for Case Management… Assess the potential positive impact of administrative simplification initiatives … -- funds/reimburses full cost of participation in program.		
Replicate the Prime Contractor Model	Low	Strategic
Investigate whether a prime contractor model can be used for transactional services, including data collection, case management and outreach.		
Link Participants to Primary Care Providers	Medium	Strategic
Need to go beyond breast and cervical cancer screening and WISEWOMAN…. Including one annual physical and/or other categorical programs.		

Health Care Delivery Systems Recommendations

Government Financing

1) The Commonwealth of Massachusetts should continue to supplement its match of the CDC contribution to WHN.

Rationale: Massachusetts's performance on percentage of eligible women screened by the WHN is greatly enhanced by this supplement (in 2001 for women aged 40-64 67% in MA compared to 12% in US), compared to the national average. The state should increase this supplement if outreach successfully increases the number of eligible women enrolled in the program.

Government Administrative

2) The Commonwealth of Massachusetts should continue to streamline its administrative processes via the Virtual Gateway.

Rationale: Rapid determination of eligibility for and enrollment in state programs, particularly MassHealth and WHN, improves women's access to primary care, screening, and continuity to care. This rapid determination of eligibility for and enrollment in state programs also enhances provider payments for services rendered and may increase the number of state participating providers.

3) The Commonwealth should require women applying for enrollment in state programs to apply for all programs (i.e. MassHealth, WHN, Uncompensated Care Pool).

Rationale: This policy would enable the system to assign women to the appropriate program based on percentage of poverty guidelines, which may free up additional resources to target uninsured and underinsured women.

<u>WHN System Tactical (shorter term)</u>

4) Decouple administrative and programmatic processes and data.

Rationale: Administrative overhead is often cited as a barrier to provider participation and a cause of providers leaving the program. Simplified and integrated transaction processing (billing and claims) should expedite provider payments for services rendered and may increase the number of providers participating in state programs. Also, DPH and WHN need a flexible system to be prepared to support potential new CDC categorical programs such as colorectal cancer screening.

5) Evaluate alternative claims processing vendors, e.g. MassHealth and/ or Blue Cross.

Rationale: Several states successfully employ an "insurance" model for NBCCEDP and WISEWOMAN billing and payment (e.g. ME, MI). This would also expedite provider payment for services rendered and may increase the number of providers participating in state programs. DPH would be able to maintain control over programmatic aspects f the program (case management, data collection, and outreach).

6) De-link data collection and payment.

Rationale: Many providers cannot absorb delayed payment due to WHN data reporting requirements. Other states have done this and maintained CDC performance requirements for data reporting. Additionally, de-linking is consistent with the separation of claims and program elements, discussed above.

7) Evaluate impact of proposed "Reform" legislation on MassHealth eligibility and Uncompensated Care Pool payment policy.

Rationale: A dramatic increase in MassHealth eligibility may decrease the number of women eligible for WHN. If this decrease is realized, it may require a shifting in strategy to underinsured or to uninsured populations that are more reluctant to medical

consumers, including the undocumented population. Fewer eligible women and more interest in provider participation may enable WHN to target services to areas or populations of service disparities. Also capping Uncompensated Care Pool payments may dissuade providers from billing that and push them to look to alternative payment sources for WHN covered services.

8) Evaluate and implement staffing alternatives for case management related to outcomes.

Rationale: Varied staff (licensed and non-licensed) carriers out case management functions. Providers should have flexibility based on performance rather than degree. The cost of licensed staff unnecessarily increases administrative costs.

<u>WHN Systems Strategic (longer term)</u>

9) Leverage Virtual Gateway beyond determination of program eligibility to allow for provider access to information for facilitating the ability of women to move among providers and to simplifying and integrating the collection of data.

Rationale: This would improve continuity of care, patient choice, integration with MassHealth, particularly when a woman becomes eligible for MassHealth Treatment Act. In general, the state law is not going to limit the use of these data among EHHS agencies or within WHN provider agencies, provided it is shared for eligibility, provision of services, and care coordination. Also, in general, HIPAA is not going to limit the use of these data among providers, for treatment, payment, health care options, and health oversight. In circumstances where data sharing is not permitted under state law or by HIPAA, sharing can be effectuated with the consent of the women involved.

10) Replicate the Prime Contractor Model.

Rationale: The model may increase the number of providers able to participate in the program, if regional or prime contractors are available to complete some of the administrative components. Also contract alternatives for case management, data collection, and outreach may enhance WHN performance vis a vis CDC requirements.

11) Increase access of WHN participants to primary care.

Rationale: WHN is an effective mechanism to get women into the health care system. The public health philosophy to provide complete health coverage is imbedded within its model. By creating a flexible model that will absorb additional categorical programs, the WHN will move in the direction of more complete coverage.

Fiscal Management & Business Operations

Co-Chairs:

Brooke Harrow, PhD, University of Massachusetts Boston

Mary Neagle, MSW, Dana Farber/ Partners Community Care Breast & Cervical Screening Collaborative

RA: Robin Estabrook, University of Massachusetts Boston

DPH: Maria Arguedas, Department of Public Health

Liz Welch, Department of Public Health

Members:

Christine Ballas, Executive Office of Health & Human Services

Josie Bouvier, Visiting Nurse Association of Cape Cod

Barbara Farrell, MS, RN, Baystate Medical Center

Atilla Habip, MBA, ProVentive, Inc.

Sandra Johnson, Boston Medical Center

Susan Madden, Division of Health Care Finance & Policy

Caroline Washburn, Division of Health Care Finance & Policy

Current Procedures and Requirements

- Each contracting agency must bill on a monthly basis, submitting bills on the 15th of every month, for the previous month's expenses.

- Each contract agency must submit the following forms: Monthly Expenditure Report (MER); Personal Summary Report (PSR); Service Delivery Report (SDR); Payment Voucher (PV).

- Cost reimbursement is a set amount of funding that is awarded to a contract agency for the fiscal year. Each contractor has a distinct cost reimbursement award based on the services and/ or capacity they agreed to provide in their RFR application and in their contract. Cost reimbursement funds should be used to cover the following expenses: Staff including the program coordinator, client navigator, case manager(s), risk reduction educator(s) and lifestyle counselors; Travel; Supplies; Direct care consultants; and other program expenses.

- There are 26 WHN Contracted Medical Sites throughout the Commonwealth.

- WHN medical services contractors have open order contracts, and WHN reimburses for specific clinical services using a list of covered services that are reimbursed based on Medicare urban unit rates. Agencies receive reimbursement as services are provided and billed to WHN.

    - They cannot bill for medical services provided to more than the assigned annual capacity (programs that wish to exceed their annual capacity must receive prior written approval from WHN).
    - They cannot bill for a procedure until they receive a final result and bill from the clinician/agency rendering the services.
    - Programs must bill in accordance with the WHN Business Rules.
    - Programs must accept WHN unit rate reimbursement payment in full.
    - WHN funds cannot be used to balance the bill.

Fiscal Management and Business Operations Recommendations

WHN Mission

1) WHN should focus its own resources on truly "value adding" public health activities: outreach, education, case management, and quality of care.

Rationale: the administrative burden for WHN is overwhelming and is so burdensome that some medical sites are unable to participate. This leaves gaps in geographic, cultural and linguistic capacity. Focusing on public health activities instead of administrative tasks would allow for better care and more access for clients, ability to focus on care for providers, and more resources to focus on servicing clients for WHN/ DPH.

Intake, Enrollment, and Eligibility

2) WHN should outsource intake, enrollment, and eligibility to EOHHS via the Virtually Gateway system.

Rationale: This would enable clients to receive the program with the highest benefits for which they are eligible. This would enable providers to have a known, routine process and a common eligibility database. This would enable WHN/DPH to standardize processes for state funded programs, lower administrative costs, track women as they enter and leave programs, and receive maximum federal financing.

Billing

3) WHN should outsource claims processing. Process claims through MassHealth for appropriate payers.

Rationale: The current WHN fiscal and business operations are duplicative and have little capability to work with other state and federally funded programs that many WHN participants use. Processing claims through MassHealth would make for fewer bills to patients, standardized billing and faster payments to providers, and more accuracy and efficiency and maximum federal funding for WHN/DPH.

Contracting

4) WHN should expand its provider base to all MassHealth providers. In the short term this could be handled by adding an attachment to MassHealth provider contracts that potential WHN providers would fill out.

Rationale: This would result in more access and choice for clients. Additionally there decentralized medical sites could be associated with less time to diagnosis. Providers

would have simpler and centralized contracting. And there would be an elimination of redundant activities for WHN/ DPH.

Further Study

5) Test and evaluate the assumptions that: (a) medical data can be uncoupled from paying claims; (b) technical capacity is sufficient to meet the requirements of outsourcing; (c) providers will agree to these changes.

Rationale: The changes required to adopt these new approaches may exceed the capacity of current regulations and/or technology.

References

Ahmad, Farah, Jill I. Cameron & Donna E. Stewart. 2005. "A Tailored Intervention to Promote Breast Cancer Screening among South Asian Immigrant Women." *Social Science & Medicine* 60: 575-586.

Bastini, Roshan, K. Robin Yabroff, Ronald E. Meyers, and Beth Glenn. 2004. "Interventions to Improve Follow-Up of Abnormal Findings in Cancer Screening." Supplement to *Cancer* 101: 1188-1200.

Bazzoli, Gloria J., Stephen M. Shortell, Federico Ciliberto, Peter D. Kralovec, and Nicole L. Dubbs. 2001. "Tracking the Changing Provider Landscape: Implications for Health Policy and Practice." *Health Affairs* 20(6): 188-196.

Becker, Diane M., Lisa R. Yanek, Wallace R. Johnson, Jr, Diane Garrett, Taryn F. Moy, Stasia Stott Reynolds, Roger S. Blumenthal, Dhananjay Vaidya, and Lewis C. Becker. 2005. "Impact of a Community-Based Multiple Risk Factor Intervention on Cardiovascular Risk in Black Families with a History of Premature Coronary Disease." *Circulation* 111: 1298-1304.

Bedell, Jeffrey, Neal L. Cohen, and Ann Sullivan. 2000. "Case Management: The Best Practices and the Next Generation of Innovation." *Community Mental Health Journal* 36: 179-195.

Berwick D, Murphy J, Goldman P, Ware J, Barsky A, Weinstein M. 1991. "Performance of a five-item mental health screening test." *Medical Care* 29:169-176.

Bobo, J. K. and N. C. Lee. 2000. "Factors Associated with Accurate Cancer Detection During a Clinical Breast Examination." *Annals of Epidemiology* 7: 463.

Bobo, J. K., H. Lawson, and N. C. Lee. 2003. "Risk Factors for Failure to Detect a Cancer During Clinical Breast Examinations." *Cancer Causes & Control* 14: 461-468.

Case Management Society of American. 2002. *Standards of Practice for Case Management* (Revised, 2002). Little Rock, AK: Case Management Society of America

Centers for Disease Control and Prevention. 1997. *Reaching Women for Mammography Screening: Successful Strategies of National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Grantees.* Atlanta, GA: U.S. Department of Health and Human Services

Center for Women's Health. 2004. "Assessing Coronary Artery Disease in Women." Atlanta, GA: Association of Black Cardiologists, Retrieved July 5, 2005

(http://www.abcardio.org/women_learning.htm)

Derchain, S. F., S. H. Rabelo-Santos, L. O. Sarian, L. C. Zeferino, E. R. de Oliveira Zambeli, M. C. do Amaral Westin, L. A. de Angelo Andrade, and K. J. Syrjanen. 2004. "Human Papillomavirus DNA Detection and Histological Findings in Women Referred for Atypical Glandular Cells or Adenocarcinoma In Situ in Their Pap Smears." *Gynecologic Oncology* 95: 618-623.

Engelstad, Linda P., Susan L. Stewart, Bang H. Nguyen, Katherine L. Bedeian, Mary Rubin, Rena J. Pasick, and Robert A. Hiatt. 2004. "Abnormal Pap Smear Follow-Up in a High Risk Population." *Cancer Epidemiology, Biomarkers and Prevention* 10: 1015-1020.

Farris, Roseanne P., Dawn M. Haney, and Diane Dunet. 2004. "Expanding the Evidence for Health Promotion: Developing Best Practices for WISEWOMAN." *Journal of Women's Health* 13:634-643.

Finkelstein, Eric, Philip Troped, Julie Will, and Ruth Palombo. 2002. "Cost-Effectiveness of a Cardiovascular Disease Risk Reduction Program Aimed at Financially Vulnerable Women: the Massachusetts WISEWOMAN Project. *Journal of Women's Health and Gender-Based Medicine,* 11: 519-526.

Freeman, Harold P. 2002. "HANYS Breast Cancer Demonstration Project." Rensselaer, NY: Healthcare Association of New York State, Retrieved May 5, 2002 (http://www.hanys.org/bcdp/resource/kits/pnrsourcekit.cfm)

Freeman, Harold P., B. J. Muth, and J. F. Kerner. 1995. "Expanding Access to Cancer Screening and Clinical Follow-Up Among the Medically Underserved." *Cancer Practice* 3: 19-30.

Frelix, G. D., R. Rosenblatt, M. Solomon, and B. Vikram. 1999. "Breast Cancer Screening in Underserved Women in the Bronx." *Journal of the National Medical Association* 94: 195-200.

Galvin, Linda Crowley and Diane Baudendistel. 1998. "Case Management: A Team Approach." *Nursing Management* 29: 28-32

Jennings-Saners, A. and E. T. Anderson. 2003. "Older Women with Breast Cancer: Perceptions of the Effectiveness of Nurse Case Managers." *Nurse Outlook* 51: 108-114.

Kiger, Holly. 2003. "Outreach to Multiethnic, Multicultural, and Multilingual Women for Breast Cancer and Cervical Cancer Education and Screening." *Family and Community Health* 26: 307-318.

Liu, Melissa J., Helen Hawk, Susan T. Gershman, Suzanne M. Smith, Ruth Karacek, Mary Lou Woodford, and John Ayanian. 2005. "The Effects of a National Breast and Cervical Cancer Early Detection Program on Social Disparities in Breast Cancer Diagnosis and Treatment in Massachusetts." *Cancer Causes & Control* 1: 27-33.

Lurie, Nicole, Allen Fremont, Arvind K. Jain, Stephanie L. Taylor, Rebecca McLaughlin, Erica Peterson, B. Waine Kong, and T. Bruce Ferguson. 2005. "Racial and Ethnic Disparities in Care: The Perspective of Cardiologists. *Circulation* 111: 1264-1269.

Mays, Glen, Heather Hesketh, Alice Ammerman, Chris Stockmyer, Tamara Johnson, and Marcia Bayne-Smith. 2004. "Integrating Preventive Health Services Within Community Health Centers: Lessons from WISEWOMAN." *Journal of Women's Health* 13: 607-615.

Navarro, A. M., K. L. Senn, L. J. McNicholas, R. M. Kaplan, B. Roppe, and M. C. Campo. 1998. "Por La Vida Model Intervention Enhances Use of Cancer Screening Tests among Latinas." *American Journal of Preventive Medicine*. 15:32-41.

Parra-Medina, Deborah, Sara Wilcox, Melva Thompson-Robinson, Roger Sargent, and Julie C. Will. "A Replicable Process for Redesigning Ethnically Relevant Educational Materials. *Journal of Women's Health* 13: 579-588.

Psooy, F. J., D. Schreuer, J. Borgaonkar, and J. S. Caines. 2004. "Patient Navigation: Improving Timeliness in the Diagnosis of Breast Abnormalities." *Canadian Association of Radiologists Journal* 55: 145-150.

Schootman, M. and L. J. Fuortes. 2001. "Early Indicators of the Effect of a Breast Cancer Screening Program for Low-Income Women." *Cancer Detection and Prevention* 2: 138-146.

Stoddard, Anne M., Ruth Palombo, Philip Troped, Glorian Sorensen, and Julie Will. 2004. "Cardiovascular Disease Risk Reduction: The Massachusetts WISEWOMAN Project. *Journal of Women's Health* 13:539-546.

Swan, J., N. Breen, R. J. Coates, B. K. Rimer, and N. C. Lee. 2003. "Progress in Cancer Screening Practices in the United States: Results from the 2000 National Health Interview Survey." *Cancer* 6: 1528-1540.

Viadro, Claire, Rosanne Farris, and Julie Will. 2004. "The WISEWOMAN Projects: Lessons Learned from Three States." *Journal of Women's Health* 13: 529-538.

Will, Julie, Rosanne Farris, Charlene Sanders, Chrisandra Stockmyer, and Eric Finkelstein. 2004. "Health Promotion Interventions for Disadvantaged Women:

Overview of the WISEWOMAN Projects." *Journal of Women's Health* 13: 482-502.

Wolff, Marie, Tovah Bates, Barbra Beck, Staci Young, Syed M. Ahmed, and Cheryl Maurana. 2003. "Cancer Prevention in Underserved African American Communities: Barriers and Effective Strategies – A Review of the Literature." *Wisconsin Medical Journal* 102: 36-40.

Women's Health Network. 2005. "Policy and Procedure Manual." Boston, MA: Massachusetts Department of Public Health.

Zapka, Jane G. Stephen H. Taplin, Leif I. Solberg and M. Michele Manos**.** 2003 . "A Framework for Improving the Quality of Cancer Care: The Case of Breast and Cervical Cancer Screening." Cancer Epidemiology Biomarkers & Prevention 12:4-13.

Appendices

Project Timeline
Detailed Literature Reviews
Literature Summaries
Background on Other Programs
Detailed Recommendations with Priority Rankings
Background Presentations (March 9)
Research Presentations (April 7)
Virtual Gateway Presentation (April 7)
Task Force Presentations (June 1)
Task Force Meeting Minutes

Project Timeline

- Executive Steering Convened ~ January 26, 2005
- Expert Panel kick off meeting ~ March 9, 2005
- Expert Panel Data Presentation - April 7, 2005
- Task Force Meetings (March to May)
- Expert Panel Recommendations - June 1, 2005
- WHN Strategic Planning Committee Convenes - June 17, 2005
    - Review of Recommendations ~ Summer 2005
- Public Report of WHN changes _ (WHN Model design)
- Writing of RFR Fall 2005
- Release and Review of RFR ~ January to March, 2006
- Implementation of new contracts ~ July 2006