

Welcome

Presentation will start at
5 minutes past the hour

Women's and Men's Health Programs Today 2014

Every Woman Matters and
NE Colon Cancer Screening Program

Department of Health & Human Services



We've Come A Long Way

- Every Woman Matters
 - First woman Screened in 1992
 - Was called "It's Woman's Work"
 - Enrolled over 94,000 Women
 - Screened almost 80,000 women with a total of 192,000 visits
 - Performing
 - 125,840 mammograms
 - 142,811 Pap Smears

New Programming

- WiseWoman in 2000
 - CVD and Diabetes Screening
 - Lifestyle Interventions
- Nebraska Colon Cancer Screening Program 2004
 - Colon Cancer Screening
 - Men and Women 50 years of age and older
- State Pap Program 2009
 - Cervical Cancer Screening for women under 40
- State Pap Plus Program 2013
 - STD testing office Visits for women

Influencing Factors

- Medicaid Treatment Act 2001
 - Medicaid access for women dx with breast and cervical cancer
- LB 403 Passed in 2011
 - Program only available to US citizens and legal aliens
- Affordable Care Act signed in 2010
 - Many preventive screening and coverage mandates in place by 2014
 - 49,000 previously uninsured Nebraskans have insurance coverage
- EWM/NCP makes major program changes 2014

Impact

Diagnosed

Breast Cancer

- 888 Invasive Breast Cancers
- 192 Ductal Carcinoma, in situ
- 23 Lobular Carcinoma, in situ

Cervical Cancer

- 78 Invasive Cervical Cancers
- 1254 Carcinoma in situ
- 4 Adenocarcinoma/Squamous cell Carcinoma

Impact

Colon Cancer

- 10,807 colon cancer screenings
- 14 Colon Cancers
- 14 high grade polyps

CVD/Diabetes

- 26,967 screened for CVD and Diabetes
- 3064 new diagnosed cases of Hypertension
- 2036 new diagnosed cases of Hyperlipidemia
- 633 new diagnosed cases of Diabetes

Major Program Changes

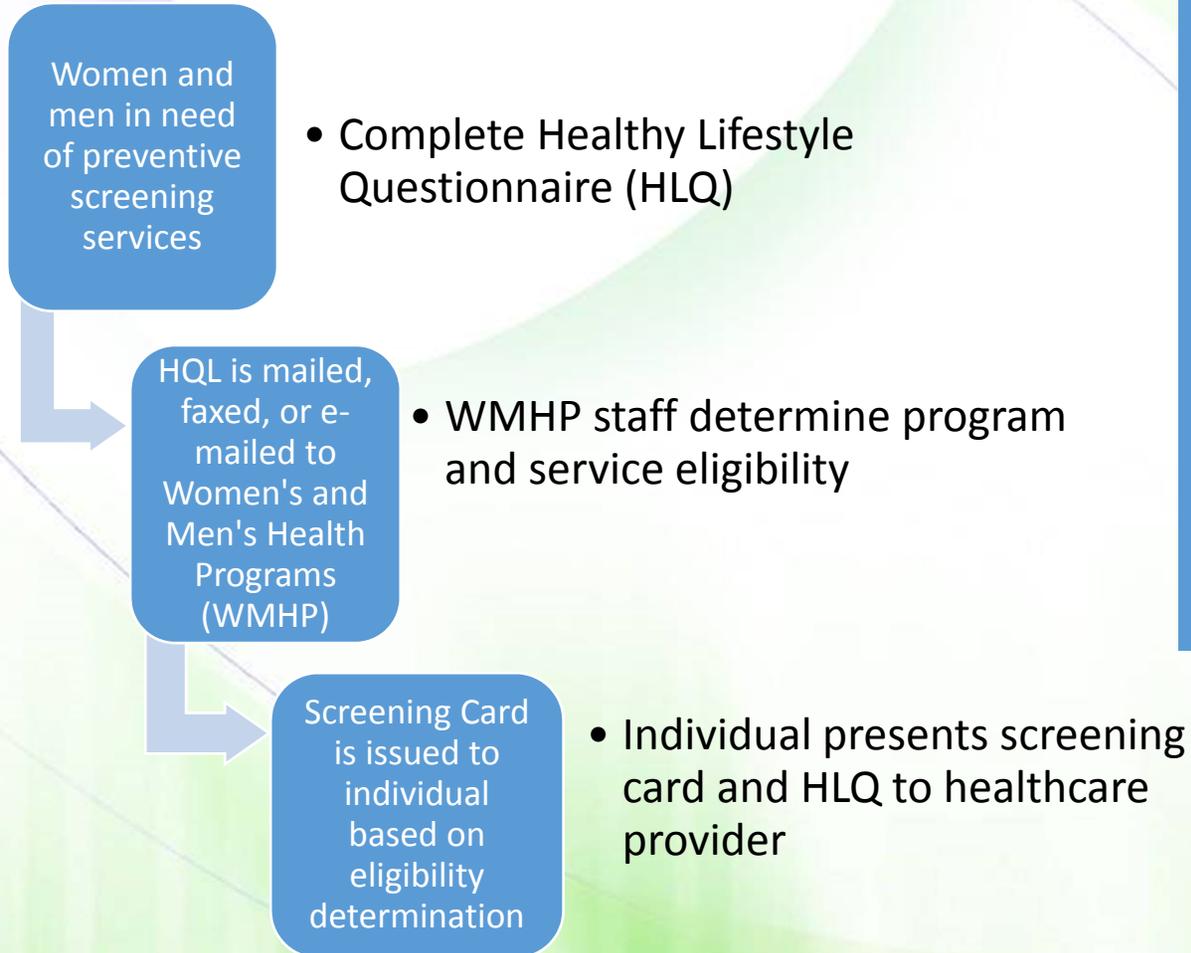
As of July 1, 2014 the Every Woman Matters Program and the NE Colon Cancer Screening Program will implement new procedures for enrolling women and men into the screening programs.

Eligibility Determination Role

- Women 40 and up will no longer be able to be enrolled for **screening services** through presumptive eligibility
- Eligibility determinations for **screening services** for women age 40 and up will be determined by the program.
- Eligibility determinations for colon cancer **screening services** for men age 50 and up will be determined by the program.
- Referrals and assistance in enrolling in the screening programs can be done within the clinic with completion of the Healthy Lifestyle Questionnaire, HLQ. (found on program material order form)

Enrolling and Determining Service Eligibility

Preventive Screening



How can I assist my patients to access the WMHPs?

- Have EWM/NCP HLQ packets available in your office
- Assist patients in completing forms if needed
- Fax or e-mail HLQs to WMHP for patients

Screening Card



Screening Card for ALL Services

Screening Card Label
Client Name/DOB/Demographics

NOTE TO CLIENTS:

Thank you for recently filling out the Health Lifestyle Questionnaire (HLQ) Form from Every Woman Matters (EWM) and the Nebraska Colon Cancer Screening Program (NCP). When you filled out the form, it gave us enough information to know what types of services you can get. All services listed on this card are services that you can get.

WHAT YOU NEED TO DO NEXT:

1. **CALL** a contracted provider to make an appointment for the services listed on this card. EWM providers can be found at:
http://dhhs.ne.gov/publichealth/Pages/womenshealth_ewm_ewm_providers.aspx
2. **TAKE** these items with you to your appointment:
 - This Screening Card
 - Healthy Lifestyle Questionnaire
 - Nebraska Tobacco Quitline Fax Referral, if you are a tobacco user
3. **FAST** if you are having blood work done. Fasting will give better results. Fasting means you do not eat or drink anything besides water for 9 hours before your lab work. **Lab work for cholesterol and diabetes cannot be paid for by itself; it must be done at the same time as breast and/or cervical services.**
4. **GIVE** the clinic this card and they will submit it to our office for payment. If you are referred for a mammogram, the clinic will give you a Mammography Order Form.
5. **SEND** your Fecal Occult Blood Test (FOBT) kit back to our lab in the envelope marked "Physicians Laboratory."
 - Do not take the kit with you to your appointment.**
 - If you did not receive a kit, you are not able to get one at this time.

NOTE TO PROVIDERS:

This client has been approved for all services listed inside this card based upon answers given on the Healthy Lifestyle Questionnaire (HLQ), income, insurance, citizenship status and age. The HLQ has been returned to the client so that health care providers can review the form with the client.

Need to know:

- Women will bring the Screening Card
- Completed HLQ for the clinic to keep
- Will come with fax referral for tobacco quit line if smoker
- **Should not** bring in the FOBT kit if issued. This is for home use only

Fax Referral Form



Nebraska Tobacco Quitline Fax Referral Form (Non-Medicaid) (800) 483-3114

****PROVIDER: Please PRINT CLEARLY, Hard-To-Read Handwriting Delays Services****

1. Print Patient Name (Last, First): _____ 2. Date: _____
3. DOB: ____ / ____ / ____ 4. Check if pregnant: _____ 5. Check if Spanish speaking: _____
6. Check if referred by: _____ Physician's Office/Clinic _____ Every Woman Matters _____ VA _____ Other
7. Provider Name: _____
8. Provider Address (Street/City/State/Zip): _____
9. Provider E-mail: _____ 10. Provider Phone: (_____) _____ - _____
11. Provider Fax: (_____) _____ - _____

PLEASE GIVE A COPY TO THE PATIENT BEFORE FAXING TO THE NEBRASKA TOBACCO QUITLINE AT: (800) 483-3114

 Patient initials

I give permission to my health care provider and/or Every Woman Matters to fax this information to the Nebraska Tobacco Quitline. I understand that a Quitline staff person will call me. I understand this is a free service.

 Patient initials

I agree to allow the Nebraska Tobacco Quitline to send information about my Quitline enrollment to my health care provider and/or Every Woman Matters as listed above.

Patient Signature: _____ Date: _____

Patient Address - Street: _____

City: _____, NE Zip: _____

The Quitline will call you. Please circle the best times to reach you.

Patient Phone: (_____) _____ - _____ Best Time to Call (Circle): AM PM Evenings Weekend

Alternate Phone: (_____) _____ - _____

If you are unavailable when we call, may we leave a message, identifying ourselves as the Nebraska Tobacco Quitline? _____ Y _____ N

If we are unable to reach you after three attempts, may we send a letter to you at the address above? _____ Y _____ N

(FOR PROVIDER USE ONLY)

ASK	ADVISE	ASSESS	ASSIST	ARRANGE
Date _____ Initial _____ # of cigarettes per day _____	Discussed: o Relevance o Risks o Rewards o Roadblocks	o No Interest o Quit Later o Ready o Quit < 6 mos o Maintain > 6 mos o Relapse	Set quit date _____ o Counsel o Quitline materials o Pharmacotherapy	o Referral to Quitline o Call o Referral to cessation group o Follow-up appt. given

Provider Patient Provider

Screening Card

All Services Screening Card

PROVIDER NOTE:

In order to receive reimbursement, **General Clinical Services/Risk Reduction Counseling, CVD/Diabetes Screening, Mammography/Clinical Breast Exam, Screening Pap/Pelvic Exam, and Colon Cancer Screening** boxes must be completed.

General Clinical Services / Risk Reduction Counseling

Height: (with shoes off) ____/____ feet/inches Refused
 Weight: _____ lbs. Refused
 Waist Circumference: _____ inches Refused
 Hip Circumference: _____ inches Refused
 Blood Pressure (1): ____/____ mm Hg Refused
 Blood Pressure (2): ____/____ mm Hg Refused

2 Blood Pressure readings **MUST** be taken at this visit.
 CDC & JNC VII Guidelines **REQUIRE 2 blood pressures**

Is the client taking blood pressure medication? Yes No
 If no, is it because of:
 Cost → Was client referred to low cost medication sources? Yes No
 Side Effects
 Patient Refused Medication
 NA → Client does not have high blood pressure

Completion of this box is equivalent to submitting a claim for Risk Reduction Counseling

Nutrition Counseling
 *Goal: _____
 Physical Activity Counseling
 *Goal: _____
 Tobacco Cessation Counseling
 *Goal: _____
 Client Referred to Statewide Quitline at 1-800-QUIT-NOW
 Fax Referral to Statewide Quitline at 1-800-QUIT-NOW
 Discussed with Client and Client Refused
 Medication Access/Adherence Counseling
 *Goal: _____
 Total time spent: 10 minutes
 20 minutes
 30 minutes

* Please refer to back page for additional information

CVD/Diabetes Screening

Labs can only be done in conjunction with breast and/or cervical screening services

Bloodwork Ordered: Yes No Blood Draw Date: ____/____/____ Fasted 9 hours: Yes No Don't Know
 (blood draw needs to be within 30 days of today's visit)

Total Cholesterol*: _____ mg/dl Refused
 *MUST be completed
 HDL (value not ratio): _____ mg/dl Refused
 LDL (value not ratio): _____ mg/dl Refused

Is the client taking cholesterol medication? Yes No
 If no, is it because of:
 Cost → Was client referred to low cost medication sources? Yes No
 Side Effects
 Patient Refused Medication
 NA → Client does not have high cholesterol

Triglycerides: _____ mg/dl Refused
 Blood Glucose: _____ mg/dl Refused
 OR
 A1c **only** if Client has Diabetes: _____ Refused

Is the client taking diabetes medication? Yes No
 If no, is it because of:
 Cost → Was client referred to low cost medication sources? Yes No
 Side Effects
 Patient Refused Medication
 NA → Client does not have diabetes

What about the Green Box?

- Every Women is eligible to receive services in the green box
- Completing the green box in its entirety including risk reduction counseling is the same as submitting a claim for risk reduction counseling
- Patient should be fasting to receive blood work
- Please complete grey medication adherence questions if applicable** This is a priority for our funder

Screening Card

Mammography

USPSTF:
Biennial Mammography (every 2 years) for women 50-74. Women 40-49 based on risk and values.

Mark if:

- Mammogram ordered
Give client Mammography Order Form
- Mammogram not ordered
If not performed, mark or list reason:
 - Not age appropriate
 - Client not at risk (client 40-49)
 - Other _____

Clinical Breast Exam

Mark if:

- Client reports breast symptoms

Mark finding:

- Negative/Benign
- Suspicious for BREAST Malignancy
Immediate follow up is required beyond mammogram
- Not Performed
(list reason) _____

Screening Pap

USPSTF:
Clients 30-65 years of age only eligible for Pap test every THREE years with cytology or every FIVE years with co-testing (cytology/HPV).

Pap test performed

(place red & white EWM sticker on lab requisition)

- Co-testing with HPV performed
- No co-testing performed

Pap test not ordered *If not performed, mark or list reason*

- Hysterectomy *(with cervix removed)* not due to cervical cancer
- _____

Pelvic Exam

Mark finding:

- Negative/Benign
- Visible Suspicious CERVICAL lesion
- Not Performed
(list reason) _____

Colon Cancer Screening

- Client is not eligible for any NCP services due to being under age 50 or over age 74
- Client is 50-74 but not eligible based on personal and/or family history
- Client is 50-74 and was sent a FOBT kit with this card
- Client is 50-74 and NCP is working with client to schedule a colonoscopy

CLINICIAN:

Discussed with client the importance of:

- Completing the FOBT kit at home
- Returning the kit in the envelope provided that is marked "Physicians Lab"

Reminders to Clinician:

- Do not give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.

****MUST be an approved contracted provider to receive reimbursement.**

Date of Service for Office Visit

Clinician Name *(PRINT full name-do not abbreviate)*

Clinic Name *(PRINT full name-do not abbreviate)*

City

What is my patient eligible for?

- All services listed on her screening card
- Eligible services are based on current and previous history, both self reported and previous clinical documentation received by the program



The Healthy Lifestyle Questionnaire (HLQ) was included with this Screening Card and includes specific questions related to the client's current health behaviors. **The HLQ is a tool that can be utilized for Risk Reduction Counseling purposes.** Please review the HLQ with the client, as the HLQ is the clinics to keep for chart copy.

***CONVERSATION STARTERS TO CONSIDER FOR PROVIDERS:**

- **Make Healthy Food Choices.** Eat a variety of foods low in fat, like fruits, vegetables, whole grains, and low-fat dairy products, and reduce portion sizes. Avoid foods with trans-fat and foods high in cholesterol or salt. (HLQ Page 6 "Diet & Physical Activity" Q1-Q7)
- **Be Active.** Be moderately active for at least 30 minutes most days of the week or at least 150 minutes (2.5 hours) a week. (HLQ Page 6 "Diet & Physical Activity" Q8-Q9)
- **Aim for a Healthy Weight.** For those overweight, losing just 7% of body weight will reduce risk of heart disease and diabetes and improve overall health.
- **Avoid Tobacco.** If you don't smoke, don't start! Avoid second-hand smoke. If you smoke, consider quitting or cutting back. Call the Nebraska Tobacco Quitline at 1-800-QUIT-NOW (784-8669) or go to www.quitnow.ne.gov for more information. (HLQ Page 7 "Smoking Status" Q1-Q3)
- **Limit Alcohol Use.** This means drinking no more than 2 alcoholic drinks per day for men, or 1 alcoholic drink per day for women. (HLQ Page 7 "Safety & Wellness" Q1-Q2)

***QUESTIONS TO CONSIDER FOR HEALTHY LIFESTYLE CHANGE:**

On a scale of 1 to 10, how **important** is it for you right now to . . . ? (ex: getting regular physical activity)
On a scale of 1 to 10, how **confident** are you that you would succeed at . . . ? (ex: quitting smoking)
On a scale of 1 to 10, how **ready** are you to start making a change at . . . ? (ex: making healthy food choices)

EWM/NCP follows the U.S. Preventive Services Task Force (USPSTF) guidelines regarding screening intervals/recommendations. USPSTF information can be found at: www.uspreventiveservicestaskforce.org/recommendations.htm

If you have questions, please contact the Nebraska Women's & Men's Health Programs:
Nebraska Women's & Men's Health Programs
301 Centennial Mall South ~ P.O. Box 94817
Lincoln, NE 68509-4817

Toll Free: 800-532-2227
In Lincoln: 402-471-0929
Fax: 402-471-0913

Websites: www.dhhs.ne.gov/womenshealth
www.dhhs.ne.gov/crc or www.StayInTheGameNE.com

Email: dhhs.ewm@nebraska.gov (Every Woman Matters)
dhhs.nccsp@nebraska.gov (Nebraska Colon Program)

Every Woman Matters



#1U58/DP003928-01; #5U58/DP001421-05; #5U58/DP002043-04

What's on the back of the Screening Card?

- Useful points to dialogue with patient about modifiable risk factors
- How to contact the program



Screening Card

Mammography

USPSTF:
Biennial Mammography (every 2 years) for women 50-74. Women 40-49 based on risk and values.

Mark if:

- Mammogram ordered
Give client Mammography Order Form
- Mammogram not ordered
If not performed, mark or list reason:
 - Not age appropriate
 - Client not at risk (client 40-49)
 - Other _____

Clinical Breast Exam

Mark if:

- Client reports breast symptoms

Mark finding:

- Negative/Benign
- Suspicious for **BREAST** Malignancy
Immediate follow up is required beyond mammogram
- Not Performed
(list reason) _____

Colon Cancer Screening

- Client is not eligible for any NCP services due to being under age 50 or over age 74
- Client is 50-74 but not eligible based on personal and/or family history
- Client is 50-74 and was sent a FOBT kit with this card
- Client is 50-74 and NCP is working with client to schedule a colonoscopy

CLINICIAN:

Discussed with client the importance of:

- Completing the FOBT kit at home
- Returning the kit in the envelope provided that is marked "Physicians Lab"

Reminders to Clinician:

- Do not give the client a clinic FOBT kit or Digital Rectal Exam (DRE). If a clinic FOBT kit is given or a DRE performed and test results come back positive, NCP cannot enroll the client for a colonoscopy.

**** MUST be an approved contracted provider to receive reimbursement.**

Screening Pap

USPSTF:
Clients 30-65 years of age only eligible for Pap test every **THREE** years with cytology or every **FIVE** years with co-testing (cytology/HPV).

Pap test performed

(place red & white)

- Co-testing
- No co-testing

Pap test not performed

(list reason)

- Hysterectomy
- Cervical excision
- _____

Mark finding:

- Negative
- Visible Squamous Cell
- Not Performed
(list reason) _____

Client NOT eligible this year

Date of Service for Office Visit

Clinician Name *(PRINT full name-do not abbreviate)*

Clinic Name *(PRINT full name-do not abbreviate)*

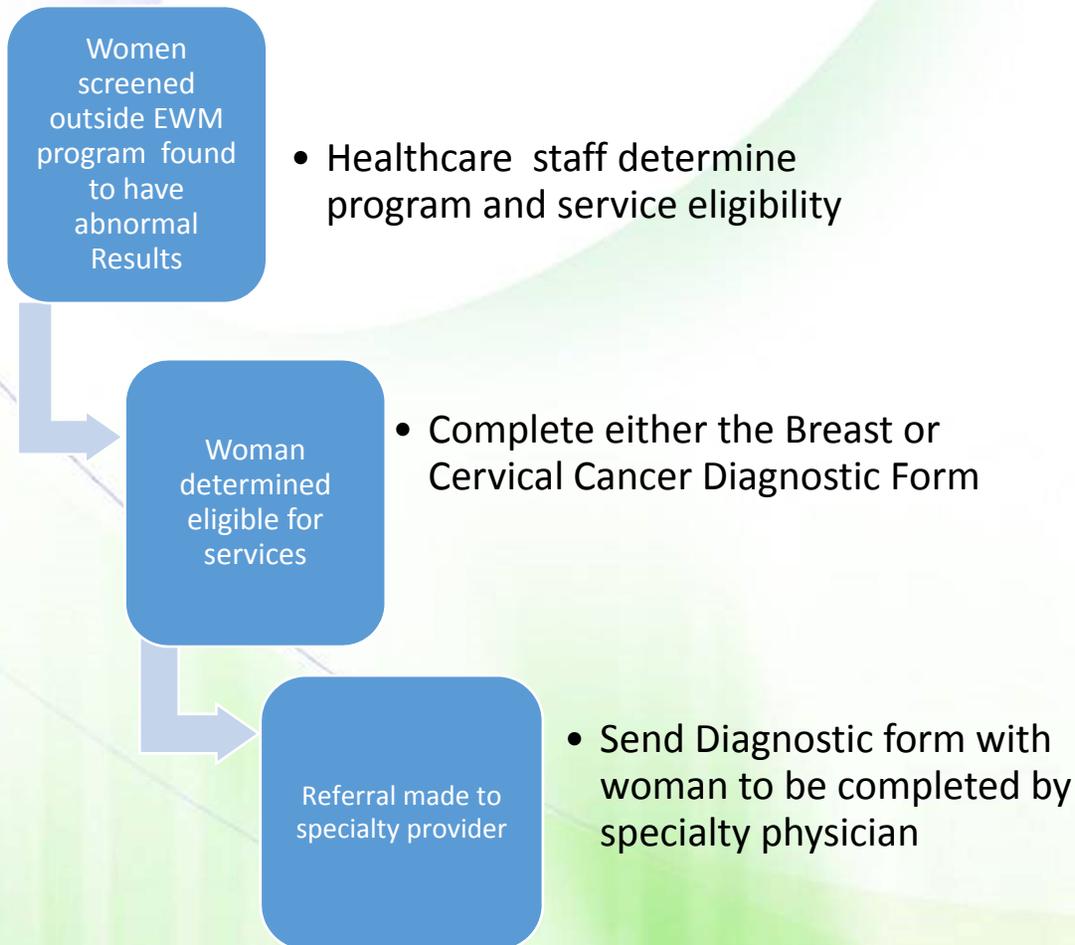
City

How will clinic know if a woman is not eligible for all services?

- Screening section will be grayed out and clearly say Client not eligible this year
- Colon Cancer Screening Box is informational and lets clinic know what if any colon cancer screening was reimbursable by the program.

Enrolling and Determining Service Eligibility

Diagnostic Services



How can I assure services are covered for my patients?

- Follow Guidance regarding Presumptive Eligibility
- Complete the diagnostic form in its entirety
- Make sure screening results are included
- Follow standards of care as noted on the diagnostic form

Diagnostic Forms

Follow Up & Treatment Plan

First Name MI Last Name Date of Birth month / day / year

Screening Provider Name MI Last Name Date of Birth month / day / year

Diagnostic Provider Name MI Last Name Date of Birth month / day / year

Date of Clinical Breast Exam

Age CBE Findings: Suspicious CBE Suspicious CBE or Diagnostic mammography findings (contribution by surgeon preferred)

Service: Surg Breast Fin Br B

Enrollment Date: Request Approved Yes No Funding Available Yes No EWI
 Program Signature Date of Signature *Approval is good for one month after Date of Signature

Breast Cancer Treatment

Client referred to another provider who will take over care

Referral Clinician Information - clinician name, clinic name, city name (do not abbreviate clinic name)
 *Consultations can only be reimbursed if provider normally brings clients into the office for consultation
 Consultation Date / / To give client treatment options

Treatment Regimen consist of _____ (do not abbreviate regimen)
 Date Treatment started/initiated _____ (date of surgery, chemotherapy, radiation, etc.)
 Client refused diagnostic workup Date of refusal / / Did client make Inf Procedure Refused _____ Reason Refused _____

Breast Cancer Treatment - to be completed by the provider who initiated

Name and Address of Clinic initiating/completing (do not abbreviate clinic name) Date

Surveillance / Follow Up

History of Prior Breast Screening, Diagnostic Tests and Treatment
 Last Clinical Breast Exam Result/Finding _____
 Last Screening or Diagnostic Mammogram Result/Finding _____
 Last Breast Ultrasound Result/Finding _____
 Last Treatment _____

6 Month Follow Up (only for clients 40+)

Client reports symptoms
 Clinical Breast Exam (Clinical Breast Exam strongly recommended and reimbursable by E) Negative/Benign Probably Benign
 Mammogram Negative/Benign Probably Benign
 Breast Ultrasound Negative/Benign

NOTE: If client has findings other than negative or benign refer to Page 3 of this form for further required follow up

Surveillance/Follow Up - to be completed by the provider who initiated

Name and Address of Clinic initiating/completing (do not abbreviate clinic name) Date

Follow Up & Treatment

First Name MI Last Name Date of Birth month / day / year

Screening Provider Name MI Last Name Date of Birth month / day / year

Diagnostic Provider Name MI Last Name Date of Birth month / day / year

Address

First Name MI Last Name Date of Birth month / day / year

Age Cytology and co-testing covered on

Screening Tests: Negative/Benign with Cervical Lesion Unsatisfactory and no HPV

Ages 21-29: ASC-US LSIL ASC-H HSIL

Ages 30-74: Unsatisfactory HPV- Cytology HPV+ ASC-US HPV unknown or HPV+ LSIL HPV- HSIL HPV+ ASC-H regardless of HPV HSIL ASC (Initial workup) **All Subcategories Atypical Endometrial Cells

Squamous Cell Carcinoma Consultation (only reimbursed if provider normally brings clients into the office for consultation) **This includes unexplained vagin

Final Diagnosis Date or Pathology Check One:
 Normal/Benign Inflammation
 HPV/Condylomata/Atypia Treatment Not Indicated
 Inconclusive Results Date _____

Clinic Name and Address: _____ Date _____

History of Prior Breast Screening, Diagnostic Tests and Treatment

Last Pap Test Result/Finding _____
 Last HPV Result/Finding _____
 Last Colposcopy with biopsy Diagnosis _____
 Last Treatment _____

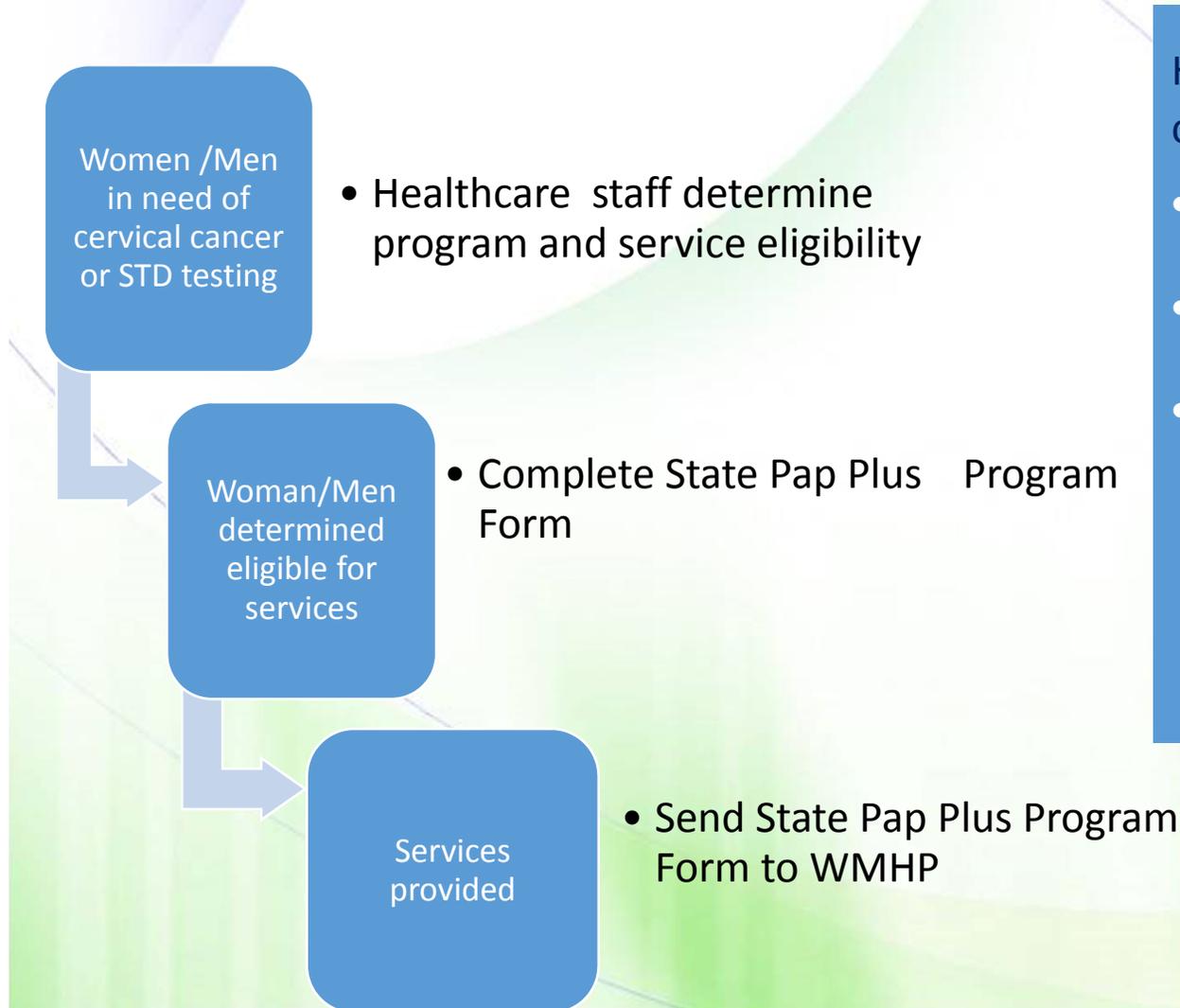
Cytology @ ECC @ 6 months (if CIN 2, 3 is identified at the margins of an excisional procedure)
 Colposcopy and Cytology Observation @ 6 months (for women diagnosed with CIN 2, 3 when no treatment has been done)
 Colposcopy with ECC @ 6 months (for women diagnosed with CIN 2, 3 when no treatment has been done)
 Colposcopy & Cytology Observation @ 6 month intervals for 2 years for ages 21-24 (no CIN 2 or 3 after ASC-H, HSIL)
 Cervical Cancer Treatment - to be completed by the provider who initiated

Name and Address of Clinic initiating/completing (do not abbreviate clinic name) Date

**Guidelines for reimbursable diagnostic testing and frequency is noted clearly on each form. This documentation must be complete prior to payment being made.

Enrolling and Determining Service Eligibility

State Pap Plus Program



How can I assure services are covered for my patients?

- Follow Guidance regarding Presumptive Eligibility
- Complete the State Pap Plus Form in its entirety
- Providers who intend to see greater than 50 patients in a year under this program must enter all data on line

State Pap Plus Service Documentation



State Pap Plus Program

Please fill out this form. Filling out this form will help The State Pap Plus Program determine what services are best for you.

The State Pap Plus Program is only for Nebraska Residents

Ages 18+: STD Screening Only for Women and Men

Ages 21-39: STD and Cervical Cancer Screening Only for Women

WHAT YOU NEED TO KNOW:

- Please answer ALL questions. If you don't we will call you or send the form back to you and this could delay important health screenings.
- If you have insurance, The State Pap Plus Program will only pay after your insurance pays.

Thank you for taking time for your health!



Version: July 2014

****Only the office visit in which a STD test was done is reimbursable. STD test kits or lab processing is not reimbursable through the program.**

State Pap Plus Program Services

<p>STD Test(s)</p> <p>Client is 18+ *Office visit covered when an STD test is performed for men and women 18+</p> <p>Test(s): <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis</p> <p>Is this a Pelvic Inflammatory Disease (PID)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Screening Pap</p> <p>Client is 21-39 years of age: <input type="checkbox"/> Screening Pap test performed every 3 years</p> <p>Client is 30-39 years of age: <input type="checkbox"/> Screening Pap and HPV co-testing every 5 years</p>	<p>Clinical Breast Exam</p> <p>Mark if: <input type="checkbox"/> Client reports breast symptoms</p> <p>Mark finding: <input type="checkbox"/> Negative/Benign <input type="checkbox"/> Suspicious for BREAST Malignancy Immediate follow up is required beyond mammogram <input type="checkbox"/> Not Performed (list reason) _____</p>
<p>Pelvic Exam</p> <p>Mark finding: <input type="checkbox"/> Negative/Benign <input type="checkbox"/> Visible Suspicious CERVICAL lesion <input type="checkbox"/> Not Performed (list reason) _____</p>		<p>US Preventive Services Task Force (USPSTF) Guidelines:</p> <ul style="list-style-type: none"> It is now recommended that cervical cancer screening begin at 21 years of age, regardless of sexual activity or other risk factors. Screening with cytology is recommended every 3 years for women 21-29 years of age. Clients 30-65 years of age only eligible for Pap test every THREE years with cytology or every FIVE years with co-testing (cytology/HPV).
<p>Surveillance / Follow Up</p> <p>6 month follow up must follow 2012 ASCCP Guidelines. Does this request follow 2012 ASCCP Consensus Guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>		
<p>History of Prior Breast Screening, Diagnostic Tests and Treatment</p> <p>Last Pap Test Result/Finding _____ Date ____/____/____</p> <p>Last HPV Result/Finding _____ Date ____/____/____</p> <p>Last Colposcopy with biopsy Diagnosis _____ Date ____/____/____</p> <p>Last Treatment _____ Date ____/____/____</p>		
<p><input type="checkbox"/> Cytology @ ECC @ 6 months Date ____/____/____ <input type="checkbox"/> Negative/Benign If CIN 2, 3 is identified at the margins of an excisional procedure</p> <p><input type="checkbox"/> Cotesting and _____ Date ____/____/____ <input type="checkbox"/> Negative/Benign</p> <p><input type="checkbox"/> Colposcopy with ECC Re-evaluation @ 6 months (for women diagnosed with AIS when margins involved or ECC Positive)</p> <p><input type="checkbox"/> Colposcopy & Cytology Observation Date ____/____/____ <input type="checkbox"/> Negative/Benign @ 6 month intervals for 12 months (for young women with CIN2, 3 when no treatment has been done)</p> <p><input type="checkbox"/> Colposcopy & Cytology Observation Date ____/____/____ <input type="checkbox"/> Negative/Benign @ 6 month intervals for 2 years for ages 21-24 (no CIN 2 or 3 after ASCH, HSIL)</p>		

General Clinical Services / Risk Reduction Counseling

Height: (with shoes off) ____/____ feet/inches Refused

Weight: _____ lbs. Refused

Waist Circumference: _____ inches Refused

Hip Circumference: _____ inches Refused

Blood Pressure (1): ____/____ mm Hg Refused

Blood Pressure (2): ____/____ mm Hg Refused

2 Blood Pressure readings MUST be taken at this visit. CDC & JNC VII Guidelines REQUIRE 2 blood pressures

Is client a smoker? Yes No

Client Referred to Statewide Quitline at 1-800-QUIT-NOW

Fax Referral to Statewide Quitline at 1-800-QUIT-NOW

Discussed with Client and Client Refused

The office visit reimbursement allows for breast screening and general clinical services to be provided at the same time as STD or Pap test, however, a client **cannot** enroll just to receive these services.

Clinician Name _____ Please write full name - do not abbreviate

Clinic Name _____

Date of Service for Office Visit _____

City _____

Presumptive Eligibility Check Lists

Diagnostic Services

- **Citizenship:** Patient is a US citizen or qualified alien under the Federal Nationality Act
- **Income:** Income falls within Income Eligibility Scale
- **Insurance:** Patient cannot have Medicare part B or Medicaid

- **Age:** Women ages 18 and up for breast and cervical cancer diagnostics after abnormal screening results
- **Services:** Services provided follow program guidelines; Guidelines are printed on Diagnostic Forms

Diagnostic Forms

Cervical Diagnostic Enrollment, Follow Up & Treatment Plan for Women 18-74

- PROVIDER NOTES:**
- If client currently enrolled for screening services complete ONLY the name and date of birth on pages 3 and 4.
 - Male clients are NOT eligible for screening or diagnostic procedures.



Cervical Diagnostic Enrollment, Follow Up & Treatment Plan for Women 21-74

- PROVIDER NOTES:**
- If client currently enrolled for screening services complete ONLY the name and date of birth on pages 3 and 4.
 - Male clients are NOT eligible for screening or diagnostic procedures.



Version: July 2014



301 Central Mall North - P.O. Box 94817
Lincoln, NE 68509-4817 Fax: 402-471-6913
1-800-532-2229
www.dhs.ne.gov/neomindhealth

INSTRUCTIONS: Please answer each question and PRINT clearly!

First Name: _____ Middle Initial: _____ Last Name: _____
 Maiden Name: _____ Marital Status: Single Married Divorced
 Birthdate: month / day / year Gender: Female Male Social Security #: _____
 Address: _____ Apt. # _____
 City: _____ County: _____ State: _____
 Home Phone: () Work Phone: () Cell Phone: ()
 Yes I want to receive program information by email. Email: _____
 In case we can't reach you: _____ Relationship: Spouse Family/Friend
 Contact person: _____
 Phone: () State: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Are you of Hispanic/Latina(o) origin? Yes No Unknown Country of origin: _____
 What is your primary language spoken in your home? English Spanish Vietnamese Other
 What race or ethnicity are you? (check all boxes that apply)
 American Indian/Alaska Native Black/African American Mexican American
 White Asian Pacific Islander/Native Hawaiian
 Other Unknown
 Are you a Refugee? Yes No ODK* If yes, where from: _____
 Highest level of education completed: 1 2 3 4 5 6 7 8 9 10 11 12
 13 14 15 16 16+ GED Don't know Don't
 How did you hear about the program: Doctor/Clinic Family/Friend I am a Current/Previous Client
 Newspaper/Radio/TV Other

INSTRUCTIONS: Please answer each question and PRINT clearly!

First Name: _____ Middle Initial: _____ Last Name: _____
 Maiden Name: _____ Marital Status: Single Married Divorced
 Birthdate: month / day / year Gender: Female Male Social Security #: _____
 Address: _____ Apt. # _____
 City: _____ County: _____ State: _____
 Home Phone: () Work Phone: () Cell Phone: ()
 Yes I want to receive program information by email. Email: _____
 In case we can't reach you: _____ Relationship: Spouse Family/Friend
 Contact person: _____
 Phone: () State: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Are you of Hispanic/Latina(o) origin? Yes No Unknown Country of origin: _____
 What is your primary language spoken in your home? English Spanish Vietnamese Other
 What race or ethnicity are you? (check all boxes that apply)
 American Indian/Alaska Native Black/African American Mexican American
 White Asian Pacific Islander/Native Hawaiian
 Other Unknown
 Are you a Refugee? Yes No ODK* If yes, where from: _____
 Highest level of education completed: 1 2 3 4 5 6 7 8 9 10 11 12
 13 14 15 16 16+ GED Don't know Don't Want to Answer
 How did you hear about the program: Doctor/Clinic Family/Friend I am a Current/Previous Client
 Newspaper/Radio/TV Other Agency Community Health Worker

INCOME & INSURANCE

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.
 What is your household income before taxes? Weekly Monthly Yearly Income: \$ _____
 Please Note: Self employed are to use net income after taxes.
 How many people live on this income? 1 2 3 4 5 6 7 8 9 10 11
 Do you have insurance? Yes None/No Coverage If yes, is it: Medicare (for people 65 and over)
 Part A and B Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement (please list)

INCOME & INSURANCE

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.
 What is your household income before taxes? Weekly Monthly Yearly Income: \$ _____
 Please Note: Self employed are to use net income after taxes.
 How many people live on this income? 1 2 3 4 5 6 7 8 9 10 11
 Do you have insurance? Yes None/No Coverage If yes, is it: Medicare (for people 65 and over)
 Part A and B Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement (please list)

BREAST & CERVICAL

1. Have you ever had any of the following tests?:
 Pap test Yes No ODK* Most Recent Date: ____/____/____ Th
 Mammogram (breast x-ray) Yes No ODK* Most Recent Date: ____/____/____ Th
 2. Have you ever had a hysterectomy (removal of the uterus)?
 2a. Was your hysterectomy to treat cervical cancer?
 3. Has your mother, sister or daughter ever had breast cancer? No Yes
 4. Have you ever had breast cancer? No Yes
 5. Have you ever had cervical cancer?

BREAST & CERVICAL

1. Have you ever had any of the following tests?:
 Pap test Yes No ODK* Most Recent Date: ____/____/____ Th The result: Normal Abnormal
 Mammogram (breast x-ray) Yes No ODK* Most Recent Date: ____/____/____ Th The result: Normal Abnormal
 2. Have you ever had a hysterectomy (removal of the uterus)?
 2a. Was your hysterectomy to treat cervical cancer?
 3. Has your mother, sister or daughter ever had breast cancer? No Yes ODK*
 4. Have you ever had breast cancer? No Yes ODK*
 5. Have you ever had cervical cancer? No Yes ODK* When: ____/____/____
 No Yes ODK* When: ____/____/____

Informed Consent and Release of Medical Information

Version: July 2014

■ You must read and sign this page to be a part of the Every Woman Matters Program.

How can I assist my patients to access Diagnostic Services?

- Complete all applicable sections of diagnostic forms
- Utilize checklist for presumptive eligibility determination
- Check that referral to specialty clinician's are to those participating in the program

- I want to be a part of the Every Woman Matters (EWM) Program. I know:
 - I can only receive breast diagnostic tests if I am under the age of 40
 - I cannot be over income guidelines
 - If I have insurance, EWM will only pay after my insurance pays
 - I must be a female (per Federal Guidelines)
 - I will notify EWM if I do not wish to be a part of this program anymore
- I know that if I am under 40 years of age, I will not be a part of EWM after I have had my breast cancer diagnostic tests.
- I know that if I am 40-74 years of age, I may be eligible for full screening services which may include: breast and cervical cancer screening, screenings for blood pressure, cholesterol, diabetes, and obesity based upon US Preventive Services Task Force and Program Guidelines. I have talked with my health care provider about the screening test(s) and understand possible side effects or discomforts.
- I understand that I may be asked to increase my level of physical activity and make changes to my diet as part of the health education offered to me. I understand that before I make these activity and/or diet changes I am encouraged to talk to my health care provider about any related concerns or questions.
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by EWM.
- I may be given information to learn how to change my diet, increase activity, and/or stop smoking. EWM may remind me when it is time for me to schedule my screening exams and send me mail to help me learn more about my health.
- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to EWM, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and/or cervical cancer screening, follow up exams, diagnostic tests and/or treatment to EWM.
- To assist me in making the best health care decisions, EWM may share clinical and other health care information including lab results and health history with my health care providers.
- My name, address, email, social security number and/or other personal information will be used only by EWM. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by EWM and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

♦ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front and back copy of my USCIS documentation. (**permanent resident card**)

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Your Name (first, middle, last)

Your Signature

month / day / year

month / day / year

Date of Your Signature

Your Date of Birth

Fields for Eligibility Determination

INCOME & INSURANCE

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your **household income** before taxes? Weekly Monthly Yearly Income: \$ _____

Please Note: Self employed are to use net income after taxes.

How many **people** live on this income? 1 2 3 4 5 6 7 8 9 10 11 12

Do you have **insurance**? Yes None/No Coverage If **yes**, is it: Medicare (for people 65 and over)
 Part A and B Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement
(please list)

personal information.

In order to be eligible for EWM you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

♦ For the purpose of complying with Neb. Rev. Stat. §§4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front and back copy of my USCIS documentation. (permanent resident card)

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Your Name (first, middle, last)

Your Signature

month / day / year

month / day / year

Date of Your Signature

Your Date of Birth

Eligibility Scale

Women's and Men's Health Programs Income Eligibility Scale for Every Woman Matters

Effective July 1, 2014 - June 30, 2015

Yearly Income

# of People in Household	FREE	\$5.00 Donation
1	0 - \$11,670	\$11,671 - 26,258
2	0 - \$15,730	\$15,731-35,393
3	0-\$19,790	\$19,791-44,528
4	0-\$23,850	\$23,851-53,663
5	0-\$27,910	\$27,911-62,798
6	0-\$31,970	\$31,971-71,933
7	call 1-800-532-2227	

Monthly Income

# of People in Household	FREE	\$5.00 Donation
1	0 - \$973	\$974 - 2,188
2	0 - \$1,311	\$1,312-2,949
3	0-\$1,649	\$1,650-3,711
4	0-\$1,988	\$1,989-4,472
5	0-\$2,326	\$2,327-5,233
6	0-\$2,644	\$2,645-5,944
7	call 1-800-532-2227	

Determining Household Income

Household income is self-reported to EWM. No verification or documentation of income is required. Enrolling clients report their gross annual income before deductions. All income coming into the home that supports the household is to be counted. This includes the following:

- Interest and Dividends
- Public Assistance
- Commissions and tips
- Other forms of supplementary income
- Alimony
- Disability
- Social Security

Those with farm incomes or non-farm self-employment are asked to record the amount of net income after deductions. This is determined by subtracting deductions and depreciation from gross receipts.

Determining Household Size

All persons living in the same house and being supported by the income are to be included in the number of people in the household. This includes grandchildren, guardianship, domestic partners, etc. who are supported by the same income. Roommates who do not share income do not have to be included in the number of people in the house nor towards the total annual income.

Presumptive Eligibility Check Lists

State Pap Plus

- **Citizenship:** Patient is a US citizen or qualified alien under the Federal Nationality Act
- **Income:** Income falls within Income Eligibility Scale
- **Insurance:** Patient **cannot have any insurance coverage**
- **Resident of Nebraska**

- **Age:**
 - Women and Men ages 18 and up for STD Office visit
 - Women 21 and up for cervical cancer screening

- **Services:** Services provided follow program guidelines; Guidelines are printed on State Pap Plus Form

State Pap Plus Booklet pg. 2-3

Informed Consent and Release of Medical Information Version: July 2014

■ You must read and sign page 2.

- I want to be a part of the **Women's and Men's Health State Pap Plus Program**. I know:
 - The State Pap Plus Program pays for the cost of an office visit in which STD testing is done. It does not pay for the cost of STD testing and handling, follow up or treatment
 - I cannot be over income guidelines
 - If I have insurance, EWM will only pay after my insurance pays
 - I will notify the State Pap Plus Program if I do not wish to be a part of this program anymore
- I have talked with the clinic about how I am going to pay for any tests or services that are not paid by the program.
- I have talked with my healthcare provider about the test(s) and understand possible side effects or discomforts.
- Based on my personal and health history, I may receive screening and/or health education materials. I know that if I move without giving my mailing address to the program, I may not get reminders about screening and education. I accept responsibility for following through on any advice my health care provider may give me.
- I understand that if my breast and cervical test results are abnormal that I will automatically be enrolled in the Every Woman Matters (EWM) Diagnostic Program in order to assist me in paying for diagnostic procedures that are allowed under EWM.
- I understand that the services provided adhere to national guidelines and recommendations for cervical cancer screening. If I have any questions about allowable services, I will talk with my health care provider or call the program at 1-800-532-2227.
- My health care provider, laboratory, clinic, radiology unit, and/or hospital can give results of my breast and cervical cancer screening exams, follow up exams, and/or treatment to EWM.
- To assist me in making the best health care decisions, the State Pap Plus Program may share clinical and other health care information including lab results and health history with my health care providers.
- My name, address, email, social security number and/or other personal information will be used only by the program. It may be used to let me know if I need follow up exams. This information may be shared with other organizations as required to receive treatment resources.
- Other information may be used for studies approved by the program and/or The Centers for Disease Prevention and Control (CDC) for use by outside researchers to learn more about women's and men's health. These studies will not use my name or other personal information.

In order to be eligible for EWM/NCP you must be a U.S. Citizen or a qualified alien under the Federal Immigration and Nationality Act. Please check which box applies to you.

- For the purpose of complying with Neb. Rev. Stat. §64-108 through 4-114, I attest as follows:

I am a citizen of the United States.

OR

I am a qualified alien under the federal Immigration and Nationality Act. I am attaching a front and back copy of my USCIS documentation. (permanent resident card)

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

Please Print Your Name (first, middle, last)

Your Signature

month / day / year

month / day / year

Date of Your Signature

Your Date of Birth

First Name: _____ Last Name: _____ Date of Birth: ____/____/____

Client Information & Healthy Lifestyle Questionnaire

INSTRUCTIONS: Please answer each question and PRINT clearly!

Version: July 2014

First Name: _____ Middle Initial: _____ Last Name: _____

Maiden Name: _____ Marital Status: Single Married Divorced

Birthdate: month / day / year Gender: Female Male Social Security #: _____ - _____ - _____

Address: _____ Apt. # _____

City: _____ County: _____ State: _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Yes I want to receive program information by email. Email: _____

In case we can't reach you: Spouse Family/Friend

Contact person: _____ Relationship: Other _____

Phone: (____) _____

Address: _____ City: _____ State: _____ Zip: _____

Are you of **Hispanic/Latina(o)** origin? Yes No Unknown Country of origin: _____

What is your **primary language** spoken in your home? English Spanish Vietnamese Other _____

What **race or ethnicity** are you? American Indian/Alaska Native Tribe _____
(check all boxes that apply)
 Black/African American
 Mexican American
 White
 Asian
 Pacific Islander/Native Hawaiian
 Other _____
 Unknown

Are you a **Refugee**? Yes No DK* If yes, where from: _____

Highest level of **education** completed: 1 2 3 4 5 6 7 8 9 10 11 12
 13 14 15 16 16+ GED Don't Know Don't Want to Answer

How did you **hear about the program**: Doctor/Clinic Family/Friend Agency
 Newspaper/Radio/TV I am a Current/Previous Client Community Health Worker
 Other _____

I will be required to show proof that my income is within the program income guidelines when I am contacted by program staff. If I am found to be over income guidelines, I will be responsible for my bills for services received.

What is your **household income before taxes**? Weekly Monthly Yearly Income: \$ _____
 Please Note: Self employed are to use net income after taxes.

How many **people** live on this income? 1 2 3 4 5 6 7 8 9 10 11 12

Do you have **insurance**? Yes None/No Coverage If **yes**, is it: Medicare (for people 65 and over)
 Part A and B
 Part A only
 Medicaid (full coverage for self)
 Private Insurance with or without Medicaid Supplement
 (please list) _____

First Name: _____ Last Name: _____ Date of Birth: ____/____/____ 3

Thank You

We appreciate all the hard work
you do as providers.

The programs would not be where we are today
or have served the number of men and women we
have without the work of dedicated providers
across the whole state.

Contact

Questions, concerns or suggestions:

Phone: 800-532-2227

E-mail: dhhs.EveryWomanMatters@Nebraska.gov