



# Women's Wellness Connection

Prevention Services Division

## Report and Recommendations on Strategic Directions for the Women's Wellness Connection Program

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## Introduction

As health care reform is implemented through the Affordable Care Act (ACA), many clients receiving breast and cervical cancer screenings through the Women's Wellness Connection (WWC) have become eligible for other funding streams, including Medicaid expansion and private health insurance. In light of this shifting health care environment, WWC continues to explore the best role for the program in: 1) reducing breast and cervical cancer morbidity and mortality rates, and 2) increasing equity in screening, identification, and treatment of breast and cervical cancer.

As a public program with multiple partners, WWC highly values its stakeholders and sought feedback through an online survey, key informant interviews and focus groups to help determine funding priorities for fiscal year 2015 (June 30, 2014 – June 29, 2015) and the strategic directions for the future of the program.

The objectives of the project were to:

- Identify changes affecting direct service providers during the period of health care reform transition, including breast and cervical cancer screening and diagnostics trends.
- Learn about agencies' overall needs and gaps in service that could better inform the strategic direction of the WWC program.
- Gain insight about stakeholder's priorities for the WWC program.

## Background

WWC is a nationally recognized program responsible for screening thousands of low-income Colorado women each year for breast and cervical cancer. WWC is funded by the Centers for Disease Control and Prevention's (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) as well as State of Colorado tobacco tax (Amendment 35) funds.

The mission of the WWC is to provide, promote and ensure quality breast and cervical cancer screening for underserved women in Colorado and connect them to resources. WWC provides breast and cervical cancer screenings (clinical breast exams, mammograms, pelvic exams, and Pap tests) and follow up to eligible women statewide through contractual agreements with 44 agencies that include federally qualified health centers, local health departments, rural hospitals, safety net clinics, private physicians and nonprofit organizations.

In addition, the program provides funding for case management to provide broader care for women with abnormal screening results, including enrollment in Medicaid if a woman is diagnosed with breast or cervical cancer. Women who meet WWC age and income eligibility criteria (whether or not they were served through WWC), and Medicaid's citizenship and creditable coverage requirements qualify for treatment under the Breast and Cervical Cancer Medicaid Program (BCCP Medicaid).

Enrollment in the WWC program is voluntary and based on eligibility criteria:

- Family income (self-report) at or below 250 percent of the [Federal Poverty Level](#).<sup>1</sup>
- Lawful presence in the United States
- Between the ages of 40 and 64 years
- No health insurance or client is underinsured (self-report)
  - *Underinsured* is defined as “individuals and families with public or private insurance that does not cover all necessary health care services, resulting in out-of-pocket expenses that may affect their ability to pay for or gain access to health care.” (HealthWords 2, Colorado Health Institute, 2009)
- Clients with Medicare Part A only and/or Colorado Indigent Care Program (CICP) are eligible. (Clients with Medicare Part B<sup>2</sup> or Medicaid as health insurance are not eligible for WWC services.)

## Problem/Need

In anticipation of the transition to health care reform, the WWC team began thinking about the strategic direction of WWC well before ACA implementation and the start of this project. Initial reviews of the women historically served through WWC suggested that as many as 75 percent of all WWC clients could fall below the 138 percent of the Federal Poverty Level, which would qualify them for Medicaid expansion. In fact, the number of WWC screenings paid per month between January and May 2014 has decreased by 40 to 50 percent compared to the same time period in 2013 (eCaST<sup>3</sup>), suggesting that more women are enrolled in Medicaid.

In 2013 and 2014, the WWC team, based on informal conversations with key stakeholders, identified strategic options for the future of WWC, including: 1) outreach to hard-to-reach populations, 2) Human Papillomavirus (HPV) vaccines, 3) mitigating barriers to care (such as language and transportation), 4) facilitating eligibility/application assistance for Medicaid and/or the health exchange, 5) infrastructure development, 6) health systems change, and 7) expanding current exploratory efforts, such as the Care Coordination Pilot Project.<sup>4</sup> They also identified more challenging options, such as expanding eligibility to include undocumented women or younger women specifically for cervical cancer screenings.

Additionally, WWC identified women likely still in need of Women’s Wellness Connection services even with the ACA, including:

- Women who are eligible for other programs, but not enrolled
- Women who are exempt from the individual mandate
- Uninsured or underinsured women between 138 and 250 percent of the Federal Poverty Level (FPL)
  - In 2012, there were approximately 34,440 (+/- 4891)<sup>5</sup> women in Colorado aged 40-64 who were uninsured and between 138 and 250 percent of the FPL (Census Bureau Small Area

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<sup>1</sup> Because WWC is a payor of last resort, and Medicaid clients are ineligible for the WWC program, it can be assumed that,

<sup>2</sup> <http://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html>

<sup>3</sup> The Electronic Cancer Surveillance and Tracking web application is used by WWC to collect and report to the CDC encounter-level data about WWC-funded services. The application is also a billing system used to pay for services.

<sup>4</sup> The WWC program implemented a Care Coordination Pilot Project from April – June 2014 with two participating agencies to pilot a program in which WWC paid for patient navigation and case management for clients with non-WWC payor sources who would otherwise be eligible for WWC.

<sup>5</sup> Census data include some undocumented women.

Health Insurance Estimates). Between July 1, 2012 and June 30, 2013, WWC clinics served 4,256 women in this age and income group, indicating that there were many women in Colorado in need of services who were not screened.

- Some insurance does not cover certain diagnostic services, or does so with a high cost. These women can be referred into the WWC to cover their diagnostic services.

In April 2014, the WWC team employed a consultant to reach out to stakeholders for their feedback. This report is the culmination of that effort. It includes an overview of the project methods and findings, and offers a set of recommendations for further consideration.

## Methodology Overview

The purpose of this project was to better understand WWC stakeholders' (WWC service providers and other key individuals and organizations) needs and preferences in order to help determine strategic directions, including funding priorities, for the WWC program. Though WWC cast a wide net, this effort was not a comprehensive community needs assessment.

This report is, by and large, subjective in nature. The qualitative approach was intended to paint broad brushstrokes of the current climate among WWC agencies and others who provide breast and cervical cancer screenings or have a stake in cancer prevention. Data based on perception are subject to the biases of all participants, including the researcher. Thus, the results here are not definitive. They represent a snapshot of the opinions and perspectives of a self-selected group of individuals passionate about their work during a period of significant change. What the WWC can glean from this project are the intentions, reflections, and broader attitudes about the value and viability of the WWC program.

To review the complete methodology for this project, see Appendix A.

## Data Collection

WWC used multiple methods to gather data through convenience sampling: an online survey, key informant interviews and focus groups. WWC utilized a single protocol with slight variations for all three methods, culminating in a key question about WWC priorities with a predefined set of options. WWC administered the online survey using *Survey Monkey* from May 22 – June 6, 2014 and collected 99 valid responses. WWC also conducted key informant interviews or focus groups from May 23 – June 12, 2014 with 30 unique participants. Though not documented, other informal activities contributed to the final results of this project, including recent research as well as conversations about and reports from WWC pilot projects in the areas of care coordination and outreach.

## Survey Respondents

A total of 99 respondents completed the survey. About three-quarters of survey respondents (n=75) represented an agency that provided direct services, 19 respondents were affiliated with organizations interested in cancer prevention, and 5 respondents identified themselves as unaffiliated individuals. About 70 percent of survey respondents overall (n=69) received WWC funding, including 84 percent (n=63) of direct service providers and 25 percent (n=6) of non-direct service providers. Survey respondents funded by WWC were reasonably representative of current WWC grantees by agency type, though there were variations in geographical representation. WWC did not ask survey respondents to report on population density (e.g., urban, rural, frontier). Non-direct service providers represented a

wide range of organizations including community or cultural centers, foundations, universities, advocacy groups, and other non-profits.

## **Interview and Focus Group Participants**

A total of 30 unique individuals participated in an interview or focus group, or both. The vast majority (87%, n=26) represented an agency that provided direct services, and 4 participants were affiliated with organizations interested in cancer prevention. More than four-fifths of all participants (87%, n=26) received WWC funding, including 96 percent (n=25) of direct service providers and 25 percent (n=1) of non-direct service providers. Interview and focus group participants funded by WWC slightly over represented Federally Qualified Health Centers (FQHC) and Local Public Health Agencies, and slightly under represented hospitals, safety net clinics, and private practitioners. Geographical representation varied as well. WWC was able to identify population density among direct service providers who participated in interviews and focus groups. Urban agencies were overrepresented and both rural and frontier agencies were underrepresented. Non-direct service providers represented advocacy organizations and a government agency.

## **Key Findings**

The results presented herein reflect selected findings from the data collected. For a detailed summary of findings, see Appendix B.

## **Trends in the Health Care Reform Environment**

WWC was able to confirm that the trends in eCaST billing data were, indeed, reflective of what WWC agencies were experiencing. That is, the numbers of WWC-eligible women, and the subsequent number of screenings paid through the WWC program, have been significantly declining since the implementation of the Affordable Care Act on January 1, 2014. The majority of potential WWC clients now fall among the ranks of the newly eligible for Medicaid, and many clinics have shifted the payor source for their prior WWC clients to Medicaid. Some agencies, particularly those who do not accept Medicaid clients, have been more impacted by this change and report that their overall client populations are significantly smaller. WWC was also able to rule out the possibility that the capacity to serve WWC-eligible women had decreased due to a temporary shift in priorities related to health reform (e.g., focusing on enrollment versus providing screening services).

Most agencies are experiencing surges in their Medicaid client populations, but some newly eligible Medicaid clients are struggling to find providers and timely appointments, particularly among agencies that cannot act as a medical home. Anecdotal evidence suggests that some agencies providing comprehensive care may be seeing an influx of younger women, mostly new Medicaid clients, with more extreme conditions, including breast and cervical cancers. This trend may be reflective of women who previously delayed care due to high costs.<sup>6</sup>

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<sup>6</sup> Colorado may expect higher numbers of abnormal screening results as well as higher than normal incidence rates of cancer, which is typical during major guideline and insurance eligibility changes (interview with Randi Rycroft, Colorado Central Cancer Registry, May 29, 2014).

## Needs and Gaps

With rare exception, the vast majority of participants identified the need to serve undocumented and younger clients as their biggest challenges, citing a lack of resources. Consensus also emerged about the need for care coordination and client identification/outreach.

Focus group participants frequently indicated a need for funding to provide screening mammograms to women under 50, though the Centers for Disease Control and Prevention’s NBCCEDP guidelines clearly point to *The Guide to Clinical Preventive Services*, based on recommendation of the U.S. Preventive Services Task Force (USPSTF). Both the NBCCEDP and the USPSTF recommend that mammography screenings should be routinely provided for women over the age of 50 and suggest conditional or discretionary screening for women as young as 40.<sup>7</sup> The NBCCEDP program further defines women ages 50 – 64 as a “priority population” and indicates that “a minimum of 75% percent of all NBCCEDP-reimbursed mammograms should be provided to program-eligible women who are 50 years of age and older...” (*NBCCEDP Program Guidance Manual*, p. 9).

This disconnect may arise from that fact that many providers follow Komen recommendations, which point to American Cancer Society and other guidelines that suggest routine screening mammograms begin at age 40.<sup>8</sup>

Additional needs identified by focus group participants included: improved/expanded education and outreach to non-WWC providers [e.g., increased relationship-building with providers who might be able to refer screened clients for diagnosis, and also increased education about BCCP Medicaid eligibility], messaging/awareness campaigns about the availability of WWC services to the general population, and increased inter-agency collaboration and networking opportunities. Region-specific or agency-specific needs included access to diagnostic services (colposcopies, biopsies, etc.) and transportation services to enable women to access screening and diagnostic services in other regions. Rural communities cited unique challenges, including privacy concerns in small communities (which increase demand for transportation even when clinical services are available locally) and an attitude of resistance to programs perceived as “government assistance.”

## WWC Priorities

WWC asked participants to select their priorities for WWC based on the following options:

- Identify potential clients from the local community who are likely eligible for WWC;
- Expand evidence-based outreach and education to hard-to-reach and underserved populations who are likely eligible for WWC;
- Mitigate barriers to accessing care (such as funding transportation, language services, dependent care, expanded clinic hours, mobile clinics, etc.);
- Assess eligibility and refer or enroll clients into the appropriate payor source for covered breast and cervical cancer screening (e.g. Medicaid, insurance subsidy, WWC, etc.);
- Expand care coordination (client navigation for women with normal results and/or case management for women with abnormal results) for eligible women who are otherwise insured for clinical procedures (e.g. Medicaid pays for Pap tests and mammograms);

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<sup>7</sup> See: <http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/guide/index.html>

<sup>8</sup> See Komen’s review of The Mammography Debate: <http://ww5.komen.org/BreastCancer/TheMammographyDebate.html>

- Enhance clinic infrastructure to bill Medicaid and private insurance;
- Implement health systems change<sup>9</sup> (for WWC and/or non-WWC clinics) to improve overall screening rates;
- Fund preventive services such as HPV vaccination;
- Reduce WWC age eligibility to women ages 30-39 (or possibly ages 21-39) for cervical cancer screening and diagnostics. (Note: This type of effort may require legislative change and should be considered as a possibility for after FY 2015.)

WWC agencies reported that they want to help current clients transition to screening services provided Medicaid and/or private insurance through better care coordination. Because most WWC agencies are experiencing a significant decline in WWC-eligible women seeking services, many agencies noted the importance of identifying and reaching out to potentially eligible women. Those agencies engaged in or considering outreach recognized that the shift to a narrower slice of the population (women whose household income fell between 128-250 percent of the Federal Poverty Level) due to Medicaid expansion requires a change in how they (and WWC) should approach this effort. The traditional methods of identification and outreach are simply no longer effective.

Some agencies strongly preferred to prioritize resources to better serve women already in their clinic populations, particularly women under age 40 and undocumented women who lack resources.

Though participants were not asked directly about undocumented women, participants frequently raised the issue. This was clearly a top priority for the vast majority of WWC stakeholders, including survey respondents who made the effort to comment about this priority for their agencies.

WWC stakeholders perceived other issues as lower priorities as a whole, but individual agencies may have higher priorities for specific needs. Rural agencies in particular desired better access to mammography and follow-up diagnostics. Where there was little agreement or low priorities, participants noted that their agencies already addressed the presented options or they had concerns about the amount of work required to implement a particular activity. These sometimes-competing priorities are reflective of the wide variety of WWC agencies and the diversity of their client populations. Moving forward, it may be important to consider the needs and priorities of individual agencies through directed efforts, such as mini-grants.

## Challenges

As a taxpayer-funded program, WWC follows rigorous state and federal regulations and requirements. It came as no surprise then that the perception of WWC requirements as onerous was a recurring theme throughout interviews and focus groups. Several agencies pointed out that the WWC program was staff-intensive and that compensation failed to cover the actual time/resources spent, particularly around care coordination. Even Care Coordination Pilot Project participants currently receiving compensation for non-WWC clients indicated that the work they did to meet program requirements exceeded the value of payment received. This potential barrier previously reduced or eliminated participation among some clinics serving small numbers of women, particularly in rural areas. Such unwillingness or lack of ability/resources to adhere to strict program requirements could present a roadblock to WWC program

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<sup>9</sup> For the purpose of this project, “health systems change” refers to the quality improvement process at the agency level that is based on evidence-based practice and utilizes population-based strategies to increase screening rates. See: <https://drive.google.com/file/d/0B5R4o4hXSQzxSXC1SzJZjBNR0k/edit?usp=sharing>

expansion, especially among agencies where WWC clients represent a small proportion of their overall client population or smaller agencies without staff capacity.

State legislation and federal guidelines also present barriers to program modification. State laws, for instance, prohibit the provision of breast and cervical cancer screening, diagnosis, and treatment to undocumented women, despite the need for such services. Federal program guidelines also limit the types of services available to women, such as routine breast cancer screenings for women under age 50.

## Recommendations

The shifting health care landscape demands further exploration and the ability to develop a flexible and adaptive response from the WWC program. Changes to the program should be incremental, coordinated, and build long-term sustainability with regard to funding and capacity. Leveraging existing evidence-based options (such as the Request for Applications to add additional WWC service delivery providers) to increase access to the current WWC program among underserved communities is a good place to start. Such actions, however, will likely have a limited effect without also launching simultaneous services that serve a larger community in need.

The following recommendations reflect the trends, needs, gaps in service, and challenges presented by WWC stakeholders in the current healthcare environment. WWC must determine the viability of all options, and a cost analysis and implementation plan will need to be completed before proceeding with any or all of the suggested changes. Any of these activities could be implemented individually, but they will have the greatest reach and impact if implemented in some combination.

- 1. Provide cervical cancer screening services to younger women.** Current federal guidelines support Pap tests beginning at age 21 and HPV co-testing at age 30. Cervical cancer incidence rates for women ages 30-39 are nearly as high as those 40-64.<sup>10</sup> An incremental roll-out would be most prudent in order to gauge the actual need and cost of women seeking services in this age range. WWC could initially expand services to women ages 30-39 and review annually to determine if age expansion to 21 is viable.
  - Further consideration of this recommendation may require that WWC continue conversations with the Department of Health Care Policy and Financing (BCCP Medicaid) to explore the parameters and ability to implement age expansion, given the relationship between WWC for screening and diagnostics and BCCP Medicaid for treatment.
  - Clarification of state statutes would better enable WWC to align program requirements with federal guidelines and evidence-based practice. The replacement of existing vague language (about state eligibility requirements for breast cancer screening), with a pointer to federal guidelines and authority for state programs to set their own eligibility requirements, would allow the WWC program to be more responsive to updated guidelines and evolving needs.
- 2. Expand the Care Coordination Pilot Project** to include a representative sample of agencies, or to all agencies. Create a more accessible consent form and re-evaluate the payout amounts for each level before expanding this option to more agencies. Review possibility of revising program requirements to accommodate outreach/education activities that better reflect the new federal family planning

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<sup>10</sup> Incidence rates for cancer are 17 per 100,000 among women ages 30-39 and 20 per 100,000 among women ages 40-64 (conversation on June 6, 2014 with Jack Finch, Colorado Central Cancer Registry).

guidelines, which indicate that Pap tests and pelvic exams are not needed annually.<sup>11</sup> Note: This option may not benefit all WWC agencies without also expanding eligibility requirements.

3. **Enhance outreach and education activities for hard-to-reach populations.** Targeted marketing may require a multi-pronged, multi-stage approach, and could include:
  - A. **Contract with a data analyst to identify the target WWC audience based on the most current datasets.** This may include client-level and/or provider-level data, including analyses by region/zip code (household income, age, gender, legal presence, etc.), as well as employer and/or primary care and other non-WWC clinics.
  - B. **Provide technical assistance in the areas of communication, marketing, and other types of outreach** to service delivery providers and other organizations with expertise in community outreach. Share learned information from outreach pilot projects<sup>12</sup> and national evidence-based practice for outreach to narrow target markets. Consider a stronger statewide effort to market the WWC program to the general population. This may require an additional WWC role, suitable for an individual with both a community health and marketing background.
  - C. **Fund pilot grants** for WWC service delivery providers and other organizations with expertise in community engagement to provide local outreach to WWC-eligible women and non-WWC providers.
4. **Create additional opportunities for WWC agency collaboration and training.** Health reform has produced many opportunities, but it has also upset the status quo. This transition period is a critical time for community-building to solidify and strengthen the WWC program. Though not specifically discussed, the focus groups made apparent a current, substantial need for more in-person networking and increased opportunities for training. Either of these activities could be leveraged to include programmatic training, presentations on projects, trends, best practices, etc., and opportunities for productive work groups to solve region-specific or agency-specific problems:
  - A. **Regional conferences, such as the already-planned “WWC Road Shows”** that go beyond training to include workgroups on hot topics. Encourage wide participation among WWC agency staff, and incentivize if necessary.
  - B. **An annual conference** could be beneficial to the WWC program. Ideally, this would be a useful culmination to the regional conferences at the end of FY 2015 or early FY 2016.
5. **Ongoing program evaluation for the purpose of quality assurance and quality improvement** would be especially beneficial during this transition period and could include:
  - A. **The creation of a Lean workgroup to streamline WWC procedures**, thereby making the program more accessible to agencies. Include stakeholders in this process.
  - B. **Create opportunities to meet agency-specific and/or region-specific needs** that fall outside of the aggregate priorities identified by stakeholders. Rural and frontier areas have particularly

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<sup>11</sup> See: <http://www.hhs.gov/opa/program-guidelines/family-planning-services/index.html>

<sup>12</sup> WWC contracted with three organizations in June 2014 to learn from their experiences with outreach to hard-to-reach populations. As these projects are not yet complete at the time of this report, no citation is available.

unique needs, such as transportation or mobile providers.<sup>13</sup> It may be most fruitful to offer a one-time grant that enables individual agencies to address specific needs and deficiencies, such as equipment, data infrastructure, transportation, etc. Increased collaborative activities suggested above could also provide creative solutions to local barriers to care.

- C. **Continuous needs assessment and program evaluation** to allow WWC to adapt the program and procedures based on fluctuating needs.
  - A. **A comprehensive community needs assessment** at the end of FY 2015, or at a time that makes most sense for the WWC program. Allow sufficient time (e.g., 6-9 months) to ensure both agency and regional representation. In-person focus groups could be attached to regional conferences. Given the transitional nature of the health care environment, regularly engaging stakeholders would allow WWC to be most flexible and responsive to change.
  - B. **Continued evaluation of overall needs beyond the scope of the WWC program**, by agency, region, and statewide. Having a clear and intentional vision of how WWC is positioned could help to ensure that underserved communities are most effectively reached without overlap of other state programs.

## Conclusion

Undoubtedly, there are significant changes occurring as a result of health care reform. Increased access to Medicaid and insurance subsidies has resulted in fewer WWC-eligible women. This is a good problem to have. But increased access to health care does not guarantee increased access to breast and cervical cancer screenings.

The health care system is complex and confusing, and the transition period of health care reform remains uncertain. Patients—especially those newly eligible for Medicaid and private insurance—still need help navigating the system. Underserved women continue to need breast and cervical cancer screenings. There is a large pool of potentially eligible women who simply do not know that they qualify for WWC, and many more seeking services who do not meet current eligibility requirements.

There remains a need for the WWC breast and cervical cancer screening program, and there is a valuable opportunity to leverage current resources to build long-term sustainability. By adjusting program parameters, the Women’s Wellness Connection can remain a viable resource for women in need and continue to positively impact breast and cervical cancer prevention in the State of Colorado.

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<sup>13</sup> See page 56, under “Emerging Issues” for a focus group conversation about a possible mobile cervical screening service.

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## Appendix A: Methodology

### Participant Identification

The aim of this project was to gather information from a broad set of WWC stakeholders, including those who provided service delivery and those who did not. WWC relied on convenience sampling for all data collection activities. There were no screening mechanisms to determine eligibility. The WWC team identified internal and external stakeholders for key informant interviews and contacted them by email to participate. Targeted individuals and groups were encouraged to widely share the survey link:

- 2014 WWC Grantees (Appendix C)
- WWC Contractors
- WWC eConnect Newsletter Recipients
- WWC’s Breast and Cervical Cancer Screening Program (BCCSP) Advisory Board
- CDPHE Office of Health Equity
- CDPHE Colorectal Cancer Control Program
- CDPHE Comprehensive Cancer Control Program
- Colorado Central Cancer Registry
- Title X Family Planning Program
- Colorado Cancer Coalition, including the Breast Cancer Task Force
- BCCP Medicaid
- Komen Colorado
- Komen of Southeastern Colorado
- American Cancer Society

Survey participants had the option to leave contact information to participate in a focus group. Links to the survey and focus group sign-ups were also published in the WWC’s weekly email newsletter, *eConnect*, which is widely distributed. WWC conducted one targeted focus group at the 2014 Title X Family Planning Conference, in which invited registered participants affiliated with current WWC-funded agencies were invited. (See Appendix D for a list of focus group participants.)

### Instrument Development

Data were gathered using a single protocol, with slight variations, for three methods: an online survey, key informant interviews and focus groups.

The survey instrument included a total of 17 questions of various types, including multiple-choice, rating scales, open-ended, and a forced-rank matrix. The WWC program and data teams contributed questions and helped to refine the final instrument. Most questions also included a “Comments” or “Other” open-ended response. Skip logic was enabled for some questions. The survey was divided into two main sections. The first question filtered respondents either into a section of 15 questions for direct service providers or a section of 4 questions for non-direct service providers.<sup>14</sup>

Survey questions for direct service providers addressed agency and individual demographics, including regional location, individual role, agency type, and WWC funding received. They were also queried about their experiences with changes in the post-health care reform environment, including trends on

<sup>14</sup> See the survey instrument here: <https://drive.google.com/file/d/0B5R4o4hXSQzxE5HUUI2Z0R6dms/edit?usp=sharing>

the numbers of clients served and screening rates. Questions also addressed agency needs and gaps in service as well as current practice. Questions for non-direct service providers addressed the type of organization and WWC funding received. All survey participants were directed to a final question about options for WWC funding priorities. At the end of the survey, participants also had the opportunity to leave contact information if they were interested in participating in an interview or focus group.

The interview and focus group protocol mirrored the key survey questions, but drilled down deeper to allow participants to discuss each potential option for WWC program expansion. (See Appendix E for a sample Interview/Focus Group protocol.)

### **Implementation and Analysis**

The online survey was tested internally with WWC and data staff, and was administered using *Survey Monkey* from May 22 – June 6, 2014. No incentives for completion were offered.

The purpose of the survey was to better understand stakeholders' strategic priorities for the WWC program. Specifically, WWC direct service providers were asked to report on the changes they were experiencing since the implementation of the Affordable Care Act on January 1, 2014, their current needs and practices, and their priorities for WWC. All participants were queried about WWC priorities.

Raw data collected through Survey Monkey was cleaned and coded. A total of 99 valid responses were collected, though not all respondents answered all questions. Sample size is noted in figures and tables. Of the 125 total survey responses, 26 were removed from the dataset as incomplete. Responses were considered "incomplete" when participants did not answer any questions about agency need or WWC priorities. Summary statistics were calculated for each question using total number and percentage of responses. Inferential tests were not run for this dataset.

Additionally, a total of 30 unique participants were interviewed as key informants (n=8) and/or participated in one of five focus groups (n=24) between May 23 – June 12, 2014.<sup>15</sup> One focus group was conducted in-person at the Title X Family Planning conference on June 4, 2014. The remaining focus groups were convened remotely as call-in conferences. Four of the focus groups were recorded and transcribed. All other interviews and focus groups were summarized from notes. Transcripts and other notes were coded and categorized manually.

### **Limitations and Lessons Learned**

There are a number of limitations to the survey. WWC did not enable restrictions to IP address or email, so that multiple individuals from the same agency could complete the survey from the same location. As a result, survey responses were anonymous and a response rate could not be determined. Due to the small sample size and anonymity, the survey may not be representative of all WWC stakeholders.

The survey was initially constructed with mandatory response options for direct service providers, restrictions which were removed after noticing a high incomplete rate among early respondents. Unfortunately, the highest survey access rate also occurred during this timeframe, so the high number of incompletes likely affected the overall completion rate of 79 percent. A pilot survey would have mitigated some of the barriers to survey completion.

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<sup>15</sup> Two interview participants opted into the focus groups as well.

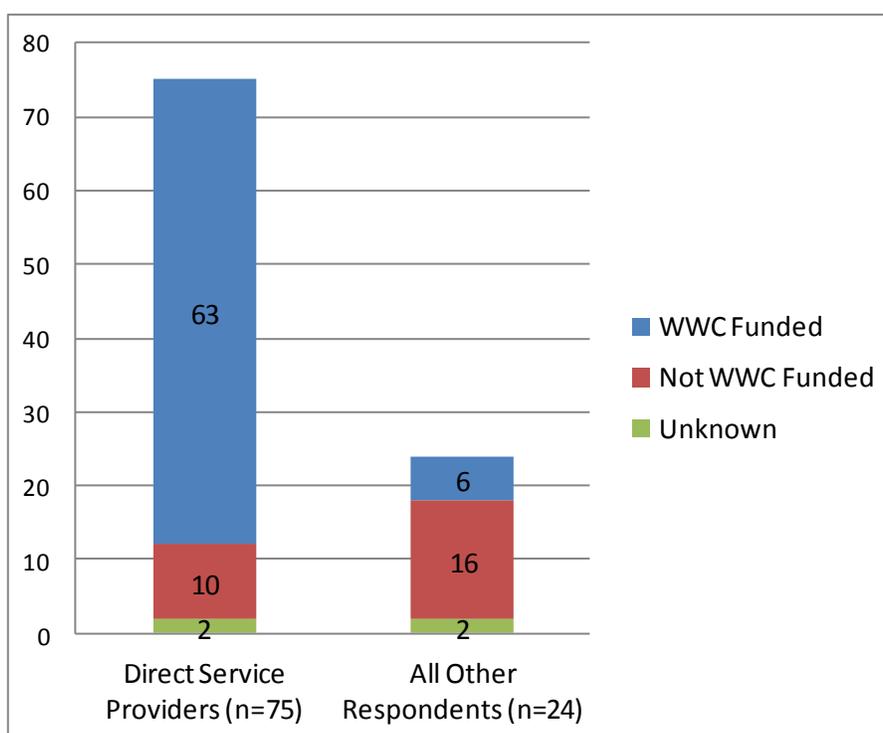
The condensed timeline of the project effectively limited the number and scope of interviews and focus groups. Structured focus groups with representative samples by agency type, size, and geographic region would have been a preferable measure, and may be worth considering at the as a follow up to gauge the WWC environment at the end of fiscal year 2015.

### Participant Demographics

A total of 99 respondents completed the survey. Of those, 75 respondents represented an agency that provided direct services, 19 respondents were affiliated with organizations interested in cancer prevention, and 5 respondents identified themselves as unaffiliated individuals.

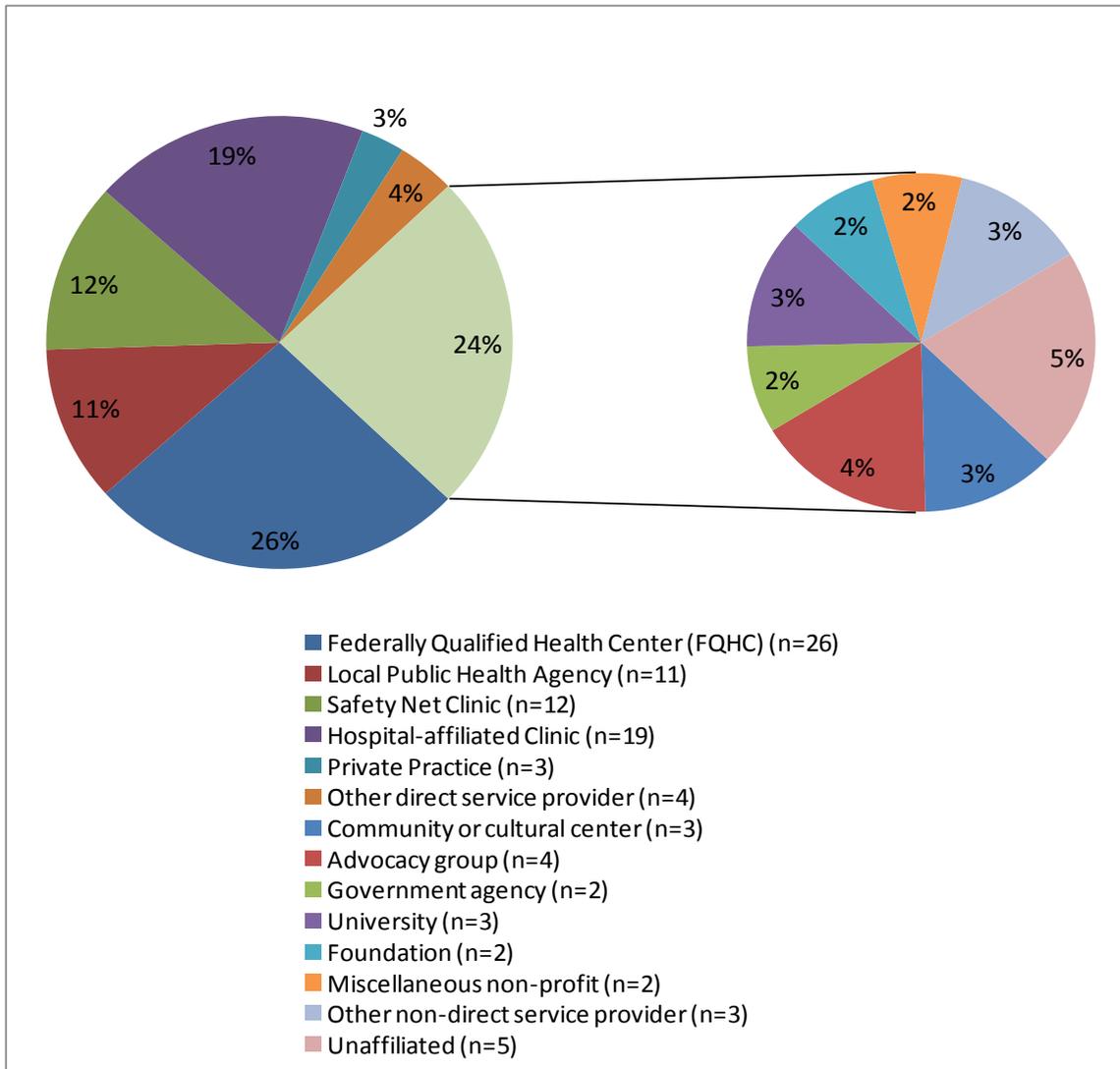
About 70 percent of survey respondents (n=69) received WWC funding, and the vast majority (n=63) were direct service providers (see Figure 1).

**Figure 1. Survey Respondents by WWC Funding (n=99)**



Survey respondents also represented a variety of organization types (see Figure 2). Among direct service providers (n=75), more respondents represented Federally Qualified Health Centers (FQHC) (n=26) and Hospital-affiliated Clinics (n=19) than other types of agencies. Respondents who represented non-direct service providers (n=18) reported affiliation with a wide range of organizations. Five (5) respondents reported no affiliation with any kind of organization or agency.

Figure 2. Survey Respondents by Organization Type (n=99)



Among direct service providers who responded to the survey (n=75), 61 percent (n=46) were affiliated with agencies that have multiple clinical sites. These providers were also distributed geographically according to their Regional Care Collaborative Organization (RCCO) regions, as shown in Figure 3. Figure 4 shows a RCCO Region Map.<sup>16</sup>

<sup>16</sup> For an explanation of RCCO Regions, see: <http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application/pdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251705316405&ssbinary=true>

Figure 3. Direct Service Providers by Regional Care Collaborative Organization (RCCO) (n=75)

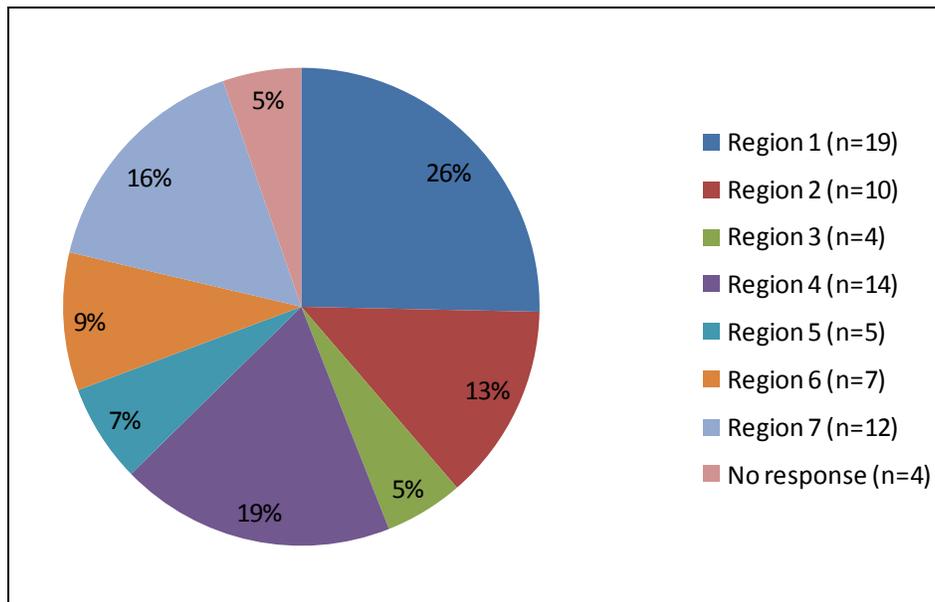
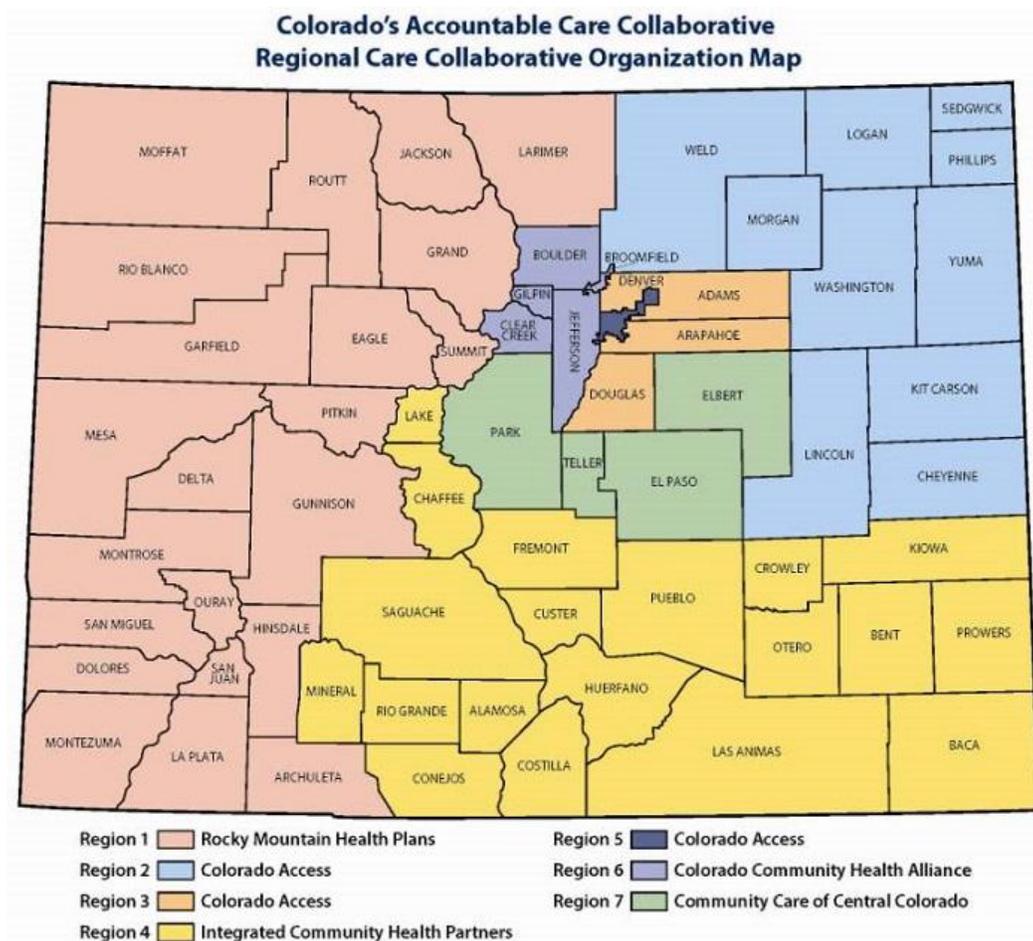
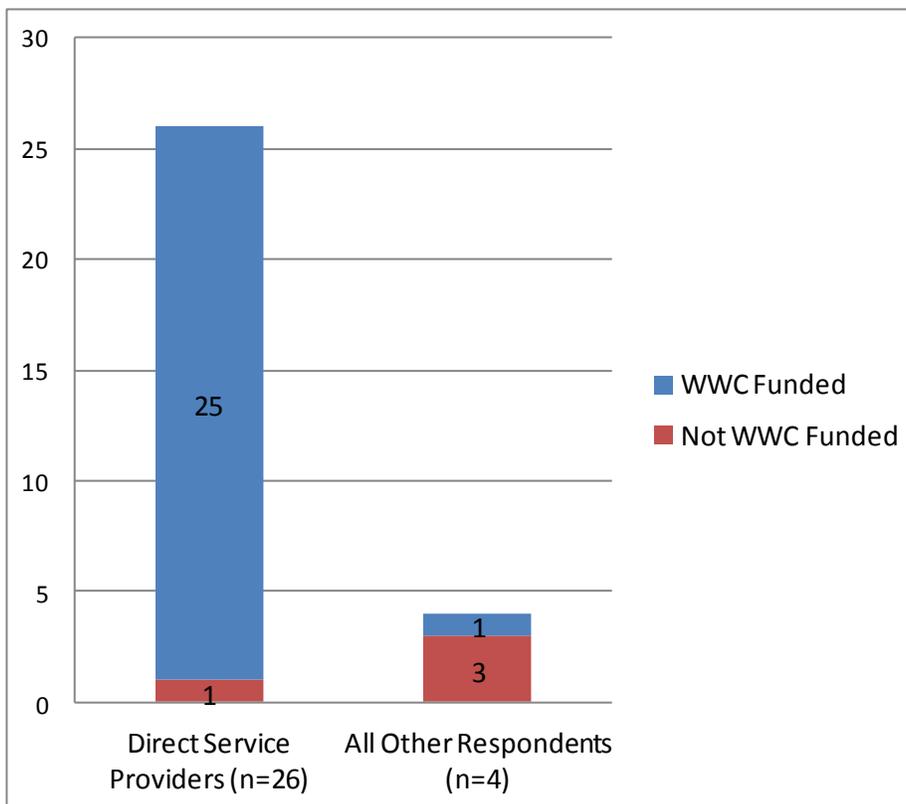


Figure 4. RCCO Map



A total of 30 unique individuals, representing 26 direct service providers, and four non-direct service providers, participated in a key informant interview or focus group, or both (see Figure 5).

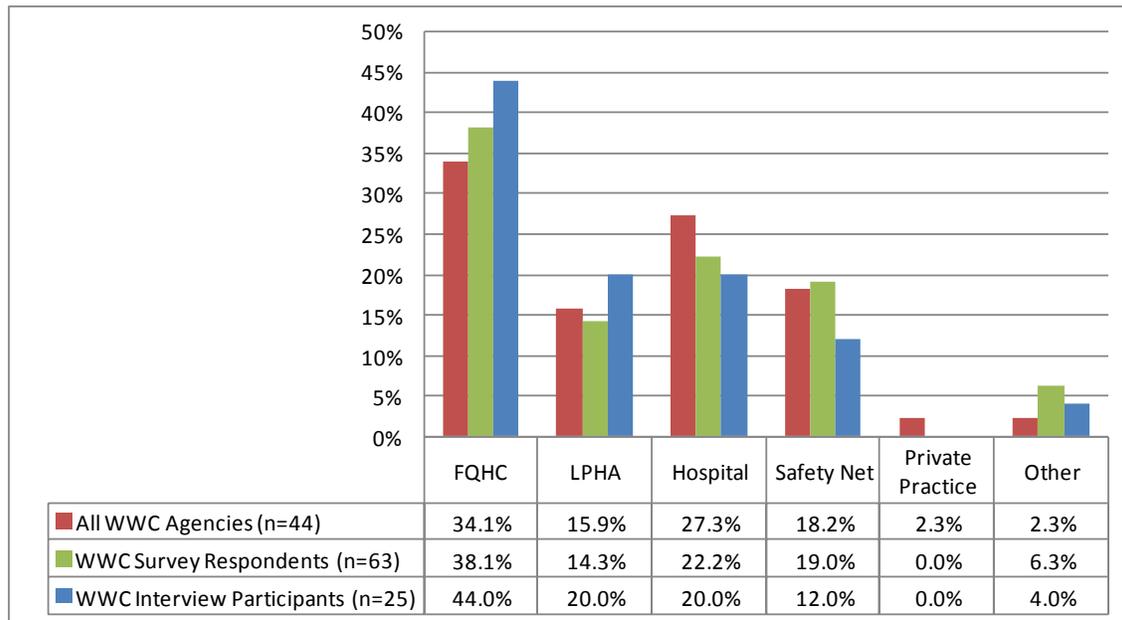
**Figure 5. Interview and Focus Group Participants by WWC Funding (n=30)**



**WWC Representation**

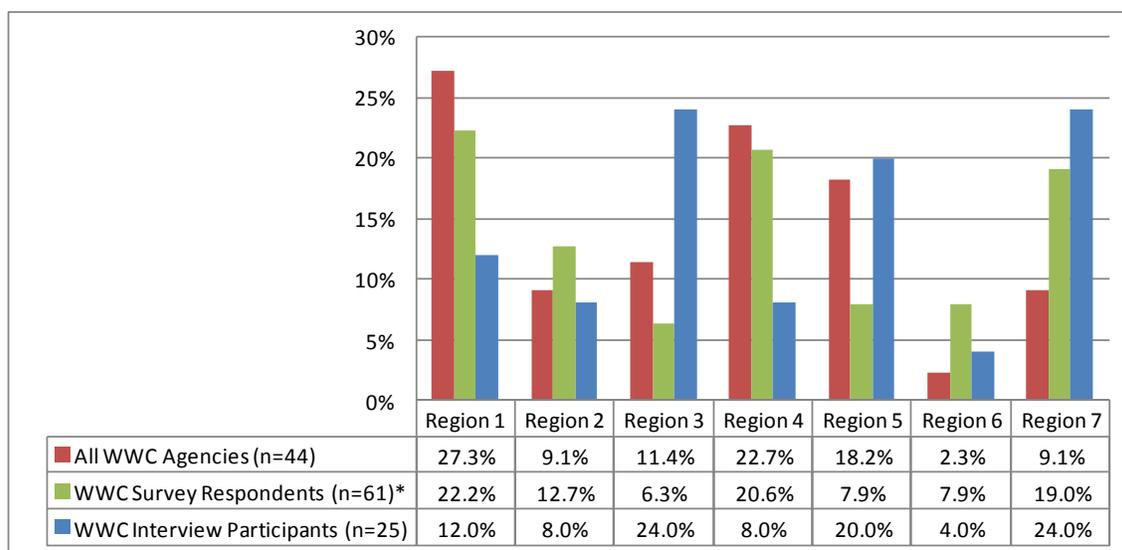
Because WWC relied on convenience sampling for data collection, and multiple individuals from specific agencies participated, representation was difficult to measure. Looking at descriptive measures, there was overrepresentation among FQHCs, underrepresentation of hospitals and private practitioners in both the survey and interviews/focus groups, and slight overrepresentation of Local Public Health Agencies (LPHA) in the interviews/focus groups (see Figure 6).

**Figure 6. WWC Agency Representation by Agency Type**



There was also variation based on geographical region (see Figure 7). Looking at RCCO regional breakdowns, Regions 1, 3, and 5 were underrepresented and Regions 2, 6, and 7 were overrepresented in the survey. Regions 1, 4, and 6 were underrepresented and Regions 4 and 7 were overrepresented in interviews and focus groups. Unfortunately, some RCCOs serve urban, rural, and/or frontier communities, so these designations tell us little beyond geographic region.

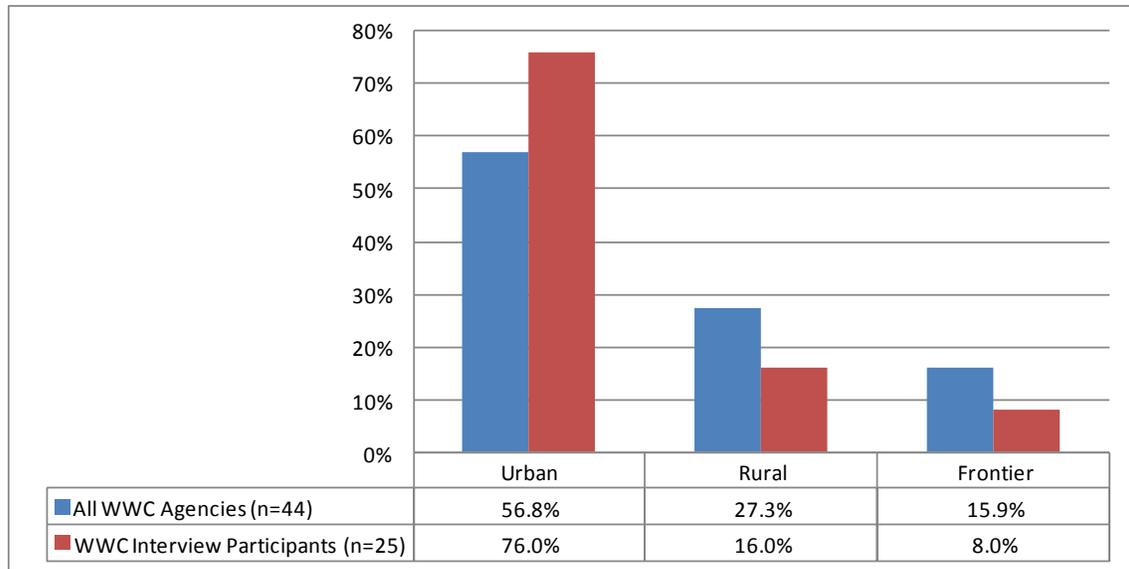
**Figure 7. WWC Agency Representation by RCCO Region**



\*Two survey respondents did not answer this question.

More interview and focus group participants represented agencies located in urban areas than those in rural or frontier areas (see Figure 8).

**Figure 8. WWC Agency Representation by Population Density**



## Appendix B: Summary of Results (Survey, Focus Groups and Interviews)

The following summary represents all data collected from the WWC Strategic Planning Survey as well as interviews and focus groups. Participant responses are clustered by topics and, for the most part, reflect the order of the questions in the original protocol.

### Trends in the Post-ACA Environment

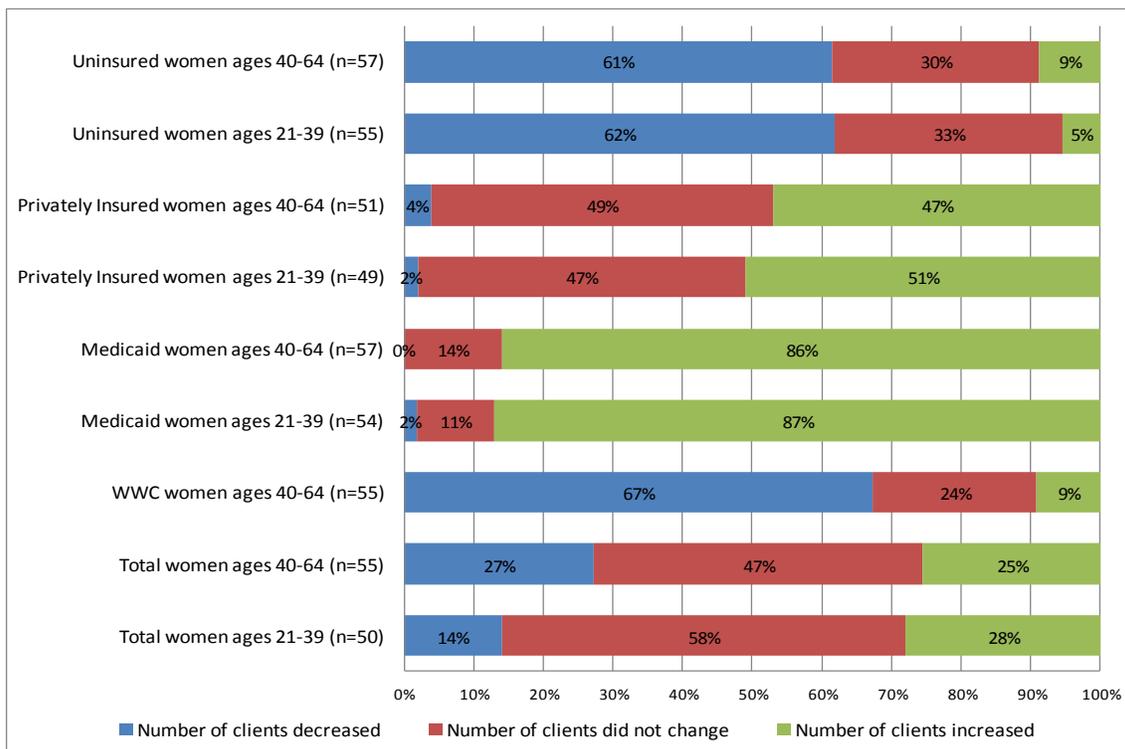
WWC wanted to better understand the changes that direct service providers were experiencing in their agencies in the post-health reform environment. Question 7 on the survey asked respondents to indicate if the number of women served—by age and payor source—was increasing, decreasing, or staying the same.

A total of 59 respondents answered Question 7, though fewer respondents may have completed individual categories. All N/A responses were eliminated from the figures below. Percentage is based on the n for each question and response category.

Figure 9 shows that more respondents perceived changes in client populations based on payor source than age groupings. Most respondents reported declining numbers of women served in WWC-eligible and uninsured populations, and the vast majority of respondents reported an increase in the number of Medicaid clients. Specifically, most respondents who serve WWC clients (67%, n=37) reported a decrease in WWC-eligible women. Similarly, most respondents (61%, n= 35) reported a decline of uninsured women ages 40-64. A vast majority of respondents (83%, n= 49) also reported an increase in women with Medicaid ages 40-64. Respondents' perception of change among privately insured women of all ages was split between no change versus an increase in numbers; very few respondents reported a decrease. Similar results are shown for younger women by each payor source.

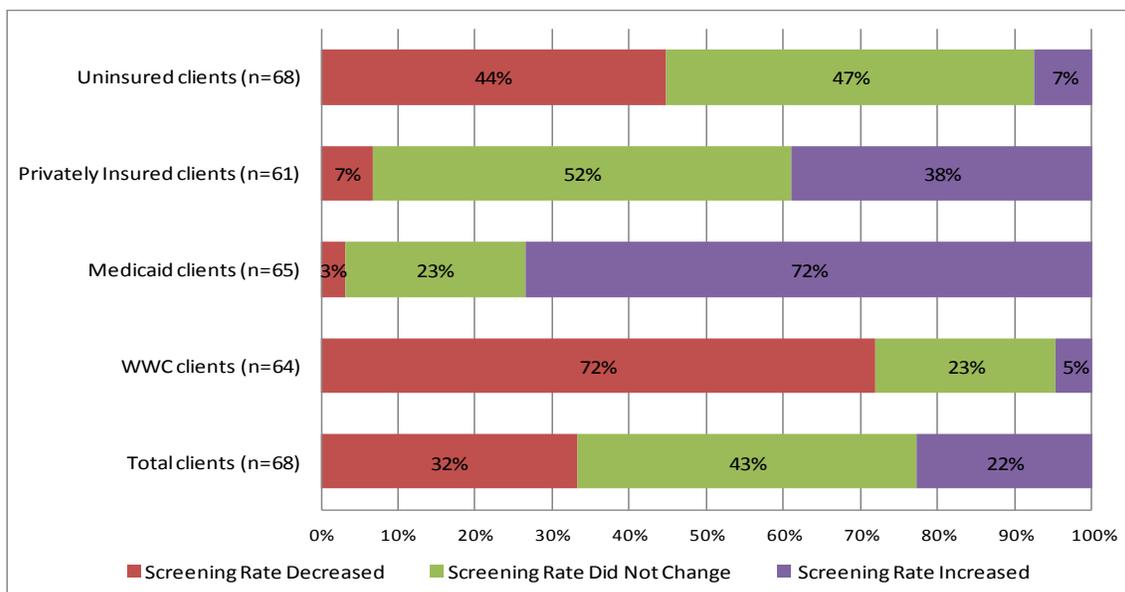
When considering their overall population of women served, 47 percent of respondents (n=26) reported no change in the number of women ages 40-64 that their agencies serve, with the remaining respondents split in reporting either an increase (25%, n=14) or decrease (27%, n=15) in client numbers. For all women ages 21-39 served, a greater number of respondents (58%, n=29) reported no change in the number of clients and fewer respondents (14%, n=7) reported a decrease.

**Figure 9. Perceptions of Change in Client Populations by Age and Payor Source (n=59)**



Survey Question 8 addressed perceived changes in breast and cervical cancer screening rates among different client populations. Most respondents (72%) reported a decrease in screenings among WWC clients and an increase in screenings among Medicaid clients (see Figure 10).

**Figure 10. Perceptions of Change in Screening Rates (n=71)**



Lower screening rates could identify possible changes in program priorities. It is also possible that the question was unclear to survey respondents. In fact, survey comments and follow up focus group conversations suggest that it is more likely that survey respondents intended to report that the *quantity* of screenings is changing (as a result of shifts in client payor sources), but it is unlikely that rates have changed. Agency data could clarify the actual rates.

Comments suggest that agencies may have differing experiences based on their client populations.

*Since many of our new patients have never been screened, there may be a dip in our panel screening rates till we can get them caught up with delayed preventive care.*

*Most of the uninsured clients we serve cannot utilize WWC because they are undocumented.*

*We are still seeing many WWC clients, regardless of ACA.*

*It's too soon to see a big impact from ACA in the uninsured population. I think the next enrollment period will have bigger impact.*

*We screen many more insured (Medicaid and commercial) now, but the "rate" has not changed.*

Question 9 asked what might be causing any changes: "If there has been a change to your agency's breast and cervical cancer screening and diagnostic rates since January 1, 2014, what do you think is influencing that change? Please address by client populations if possible." A total of 47 respondents answered this question. The overwhelming majority attributed changes to the Affordable Care Act. This response reflects the sentiments shared by most survey participants:

*WWC rates have decreased as more women are using Medicaid or private insurance to pay for screening. I have enrolled one woman with private insurance into WWC to pay for diagnostics. The rate of women over 40 being screened has probably not changed significantly because they could have used WWC previously, but women under 40 who were previously uninsured, have probably increased their screening rate due to now being able to access Medicaid to pay for screening.*

Overall, the vast majority of respondents reported a decrease, sometimes significant, in WWC-eligible women and a simultaneous drastic increase in Medicaid or Medicaid-eligible women among their current client populations. Interview and focus group participants shared similar results and were able to confirm that many of the newly eligible women on Medicaid were former WWC clients, but some agencies noted that their overall client populations are increasing as a result of more clients seeking care.

*More patients are seeking care overall. Some Medicaid patients are moving to Kaiser because they have the most affordable of all private insurance.*

*We've seen a 4% overall increase in patient load since ACA. The shift has mainly been in funding centers. This varies 2-10% by clinical site.*

*We've had a tremendous decrease in patients who are eligible for WWC specifically. In first 4 months of 2014, we had 3,600 WWC patients. That's gone down to 1,200 patients: so a sharp*

*decline. We had a pretty robust enrollment system for CICP<sup>17</sup> clients, so a lot of those turned into not-CICP clients, so that's great.*

*All providers [in my region] are reporting decreases in numbers of WWC clients as expected, especially clinics that take Medicaid, but this varies by provider. FQHCs are not seeing declines overall, more of a shift in funding streams.*

*Our numbers are down in WWC.*

*And our WWC has gone way down. A lot of them are on Medicaid. Because of FP and stuff, we've been seeing some in Family Planning, the Medicaid ones, and having mammograms billed through Medicaid. We've been transitioning a little bit.*

*We're really rural...It's pretty poor. But a lot of our WWC patients are now on Medicaid. Because we also had a huge push to get people enrolled...So we're not seeing as many WWC patients because most of them are eligible for Medicaid and have done that. We have a huge undocumented population. In a regular day when we see 16 patients, probably 50% of them are undocumented. So about 50%.*

*We've been very robust getting all of our CICP ladies on Medicaid. So what happens? WWC goes down.*

*We used to have a lot more women who would qualify for WWC but who are now qualifying for Medicaid to pay for services. In the last few months, our ladies are disappearing to insurance and Medicaid.*

*We have seen a lot of our patients go into Medicaid. We haven't had the same numbers in the past for WWC.*

*Our numbers from WWC-eligible women have dropped greatly.*

*I think we're getting more patients, but with Medicaid. The number of WWC-eligible women that has dropped.*

*It seems I'm experiencing the same thing as other agencies. We're seeing an increase in patients enrolling in Medicaid.*

*What we're seeing...is definitely a dramatic increase in patients that are eligible for Medicaid expansion, probably 1/3 to 1/2 of patients are getting enrolled into Medicaid. And then as far as what we're seeing in WWC; we're seeing an increase in those women who are just now turning 40 and it's time for them to start their big-time screening.*

*We've seen our population of WWC-eligible women drop by about half since Jan...And we're looking at outreach.*

Though many participants identified this transition period as a change in payor source, others felt more impacted.

*The Affordable Care Act, as wonderful as it is, it has absolutely devastated the numbers here. And so I know I'm not the only one. But it's very hard to get people in the door because they're on Medicaid now. So, it's been hard to keep numbers up.*

<sup>17</sup> For more information about the Colorado Indigent Care Program (CICP), see: <http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1214299805914>

*We've seen a decrease in numbers on our waitlist. For example, in the past, women had to wait about 4 weeks for an appointment. Now they can get in about a week. Cancellations are mostly among women who now qualify for Medicaid. Overall, it's slowed down a little.*

*We're seeing about half of the expected number of clients since January. We were on track before ACA. Changes are consistent across the board: call center, scheduling, and family planning numbers are down too. The numbers of clients referred in for diagnostics also down. We were previously filling 120 monthly appointment slots across 4 sites and now we're filling less than 50. At the last clinic, we had only one client and this client had Medicaid.*

*There are a few sites where WWC-dedicated staff are worried about their jobs.*

*I can tell you what I've seen is less patients at the clinic because most patients have qualified for Medicaid by the time I get them into the clinic for WWC.*

Some participants noted an increase in younger women in their client populations since the beginning of the year, many who have advancing conditions. This may be partially attributed to the fact that clients who previously did not seek regular care due to a lack of funds now have access through increased coverage through Medicaid or private insurance. As a result, it's possible that Colorado will see an initial increase in abnormal diagnoses until this previously underserved population is more thoroughly screened. (Randi Rycroft, CCCR)

*The thing is we're seeing younger and younger women through the clinic, a decrease, by about 10% among women in their 40s and 50s. We're also seeing an increase in weird stuff: some skin cancers, some lymphoma, some cervical cancer that has spread. Also younger women who haven't seen a doctor or gotten a Pap in awhile.*

*We're seeing more younger women as well. An increase in the women who have been holding off, but now they're covered and they're coming in.*

*We're seeing more of these younger women that are taking advantage of things but we also seem to have more Medicare-type patients for some reason.*

There are a few exceptions to this trend, especially among agencies that primarily serve undocumented women.

*There is such a small percentage that are affected by health care reform at [our clinic], so we're not affected a whole lot. If they are WWC eligible, they are probably eligible for Medicaid.*

*I know that, on the Western Slope, Komen grantees are underutilizing WWC funds but running out of Komen funds because of the large undocumented population.*

*Some clinics are experiencing no decrease in screenings, but a switch in payor source. They're seeing more women with private insurance and an increase in younger women with cancer. Just a handful, but still rare and surprising. The younger women are not necessarily on Medicaid, but participate in their discount program. The number of Pap tests they provide are decreasing due to the new guidelines.*

Outreach and relationship-building was also cited by a few survey respondents as a crucial component of their agency's service, either as a marker of success or a need for improvement:

*As more and more patients are served, there has been growing awareness among communities and subsequent referrals made by family members and friends.*

*We receive a much higher percentage of diagnostic referrals than the average WWC due to several relationships in the community.*

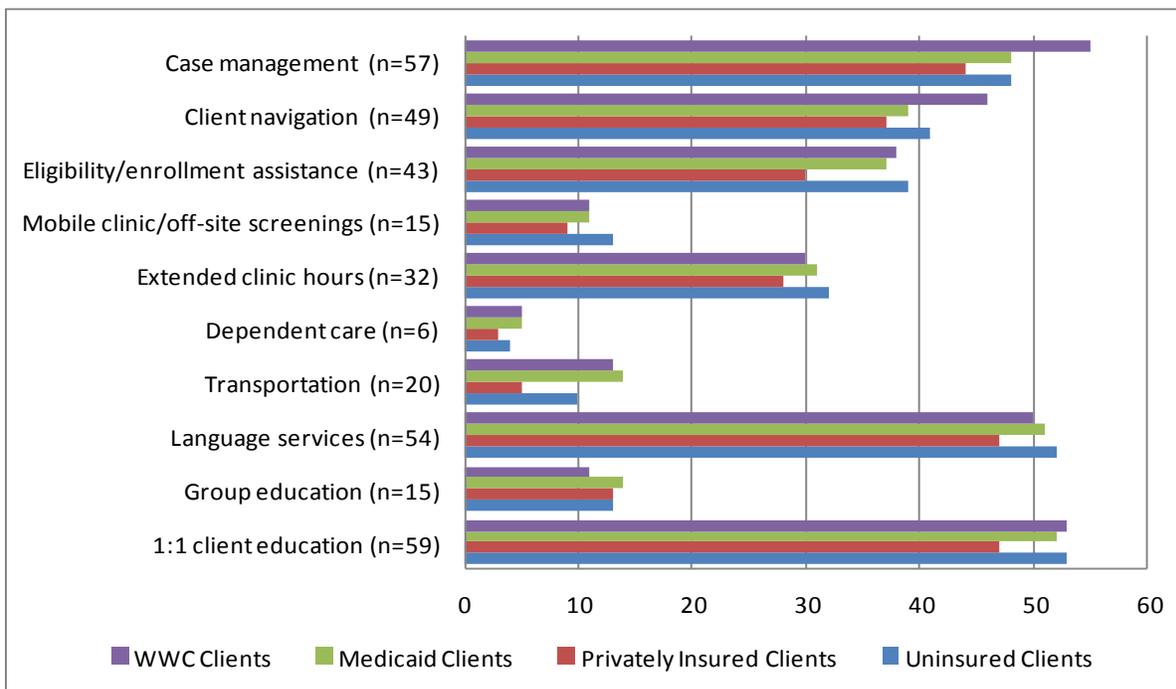
*ACA implementation is part of it and also the lack of outreach in our county.*

Question 10 asked respondents if they had data to support their experience. Nearly half of respondents (48%, n=34) reported that data was available to support the changes they perceived, 25 percent (n=18) were unsure, and 27 percent (n=19) reported that data was not available.

**Current and Planned Service Delivery**

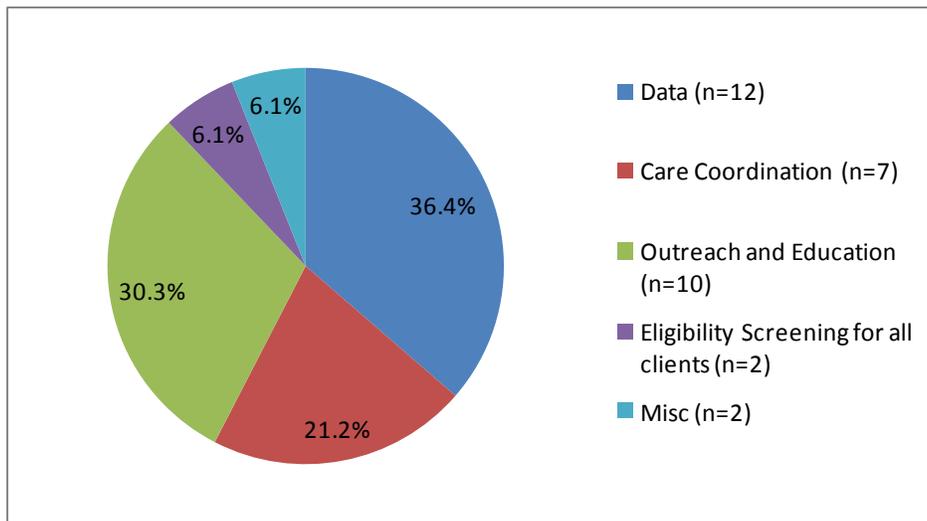
To gauge the types of services that agencies provided, WWC asked survey participants if they currently or planned to provide certain support services to their client populations. Responses show little variation of services provided across client populations, though there is variation of available services (see Figure 11).

**Figure 11. Agency Services Offered (Current or Planned), by Client Population (n=63)**



In Question 12, survey participants were asked if they were engaged in any quality improvement activities to increase breast and cervical cancer screenings. A total of 68 respondents answered Question 12. More than half (53%, n=36) reported that their agencies were engaged in quality improvement practices, 27 percent (n=18) were uncertain, and 20 percent (n=14) were not. Thirty-three of the respondents provided comments (see Figure 12). Of those, 36 percent of respondents (n=12) reported that their agencies used data to improve practices, 30 percent (n=10) engaged in client education and community outreach, and 21 percent (n=7) referred to reminder calls and other care coordination activities.

**Figure 12. Self-Reported Quality Improvement Activities (n=33)**



**Needs and Gaps**

WWC asked survey respondents to describe their agency’s greatest needs in Question 10, “Based on your experience since implementation of the ACA (January 1, 2014), what do you anticipate are your agency’s most pressing needs related to breast and cervical cancer screenings and diagnostics?” A total of 56 respondents replied. Most respondents (73%, n=41) expressed the need for additional funding to serve uninsured or underinsured clients. Of those, nearly half (46%, n=19) specifically mentioned the high need for funding to serve undocumented women, and 27 percent (n=11) specifically noted the need for funding to serve women younger than 40 or to focus on outreach and recruitment in some way. Nine percent of all respondents (n=5) also mentioned the need for funding in the areas of care coordination, eligibility/payor source determination, or follow-up diagnostics for breast cancer. Several respondents noted multiple needs.

**Uninsured and Underinsured Clients**

For some survey participants, finding a way to manage uninsured or underinsured clients with high co-pays or deductibles was a challenge.

*Our most pressing needs are how to capture patients who are ever so slightly above the income cutoffs who have yet to enroll in any ACA coverage or are deciding to pay the penalty. In addition, we have several patients without proof of residency. Often Spanish Speakers who don't have any resources, this is perhaps our most in-need population.*

*Funding for those who still fall into the loop of not being able to afford healthcare.*

*Increased amount of deductible, so patients are having to pay out of pocket for diagnostic imaging studies and biopsies.*

*Funding sources for screening the uninsured women who do not qualify for Medicaid, and cannot afford private insurance. Also, lack of transportation for needed diagnostics not available within our service areas.*

*We continue to have women without insurance and are still in need. Many are undocumented, but many are not.*

*Payment for direct services for screenings and diagnostics for uninsured and undocumented women. There are still women who might be eligible for either Medicaid or private insurance who refused to apply/obtain either one. Additionally the Medicaid population continues to fluctuate and people are enrolled and unenrolled for various reasons. Funding resources for the undocumented are almost non-existent.*

*Screening and diagnostics for undocumented patients, and those who are unable to obtain insurance due to other reasons. For instance, our county has some of the highest premiums in the nation, as we have patients at the clinic who will choose the penalty over the purchasing a monthly premium. Others will have high deductibles and if their screening comes back positive, they will be unable to afford the cost of the diagnostics.*

Focus group participants also mentioned the underinsured issue:

*Private insurance covers mammogram, but patients can't afford co-pay...*

*That's just the simple one. "It's paid for by my insurance" the screening mammogram, but then you need a diagnostic and they can't afford it because it's \$500 out of pocket and they have this deductible. The other piece is the high deductibles. Not all the [insurance] programs pay for preventive. They [the patients] got the cheapest one. So I've been seeing a lot of those people. They can't even afford their screenings.*

*Another thing I've heard from nurses and seen. Sometimes these women who aren't eligible for Medicaid, and haven't gotten health insurance through the exchange, they end up being almost like they're going to fall through the crack. They can't get insurance on the exchange until it opens up next year but they have a breast lump now. Those are the women that we are having to scramble to help. That's the challenge we face.*

### **Younger Women and Undocumented Clients**

The need to expand services to younger and undocumented women is a pressing concern for some survey respondents:

*Our largest need is in women from 30-39 who need detection for early breast and cervical cancer. We have seen a notable uptick in cancer diagnoses in this age group.*

*Covering women under 40 for BCCP Medicaid. We have so many women getting diagnosed earlier. Also, opening up funding to undocumented women.*

*Undocumented folks and women under 40 are desperately in need of funding for these services.*

*We have seen an increase in women younger than 40 with abnormal mammograms requiring biopsy. The lack of financial resources for these women is daunting for clinic staff responsible for case management.*

*Getting clients a colpo and paying for short term follow up. Also getting the younger than 40 yr. olds follow up/dx mammogram/ultrasounds paid for. Our population that is not lawfully present also needs to have a program in which they can get services. Also clients must travel a distance at times to get the proper care, i.e., Denver, Montrose or Grand Junction.*

*I believe the most pressing need is for women who are not permanent residents or citizens (i.e., undocumented women). The second most pressing need would be for cervical screening for women under 40 who remain uninsured.*

Likewise, nearly every interview and focus group addressed, without prompting, that their biggest need was a lack of funding sources for both younger and undocumented women.

*The biggest challenge that we are facing is a lack of funding for undocumented and younger women, so ineligible for WWC. Komen's funding was decreased this year and will decrease as years go on....We are getting some Medicaid, but we're seeing a huge influx of clients who don't have anything else and we need to figure out how to pay for those clients.*

*There would be women who, if not for their age, would qualify for WWC. So we're using Komen funding and that takes away Komen funding that could be used for women who are undocumented, or men.*

*For us, undocumented and younger women, we could also use funding in those areas. We also as an agency don't bill Medicaid across the board. We do for some programs, but our infrastructure system at this point is not set up to bill Medicaid and third party payors, so that's a huge huge change that would need to happen for us to see those ladies.*

*We also get younger women, younger than 40. We diagnose a lot of cancers for young women. We get a lot of referrals for younger women from outside agencies. We may start with the screenings. Often time they're referred in for the diagnostic piece. Even [another agency] is sending us patients that they think are cancer patients, right before the biopsy. You guys have said before that you can't pay for undocumented..., so boy would it help [to pay for younger women].*

*In terms of needs, we are seeing a lot of cancer in women under 40. This isn't new. But there just isn't funding out there to serve these women.*

*I think our biggest challenge is that we have a lot of undocumented patients...so we have to figure out funding for them, so luckily I have some through our hospital. And, even now though they're looking at MRIs, they're difficult because they're still expensive no matter how we look at it.*

*I'm hearing from my nurses all the same stuff. And the other thing that I've encountered along with the undocumented, we're not a Komen site, so for our undocumented, we use private donation money that runs out really quickly so we're really stingy with it. I was able to offer payment for some of those undocumented, or at least the women under 40 who have a breast lump that we've referred out.*

*We're facing similar challenges of the other agencies. We have a lot of undocumented patients. We do have Komen money and a couple of other sources of grant funds. But those funds only go so far. So I can [provide] a whole lot of screening mammograms, but then if they need any type of diagnostics, I'm really scrambling to find funds for women who don't qualify for WWC funds.*

*So, let's say an [undocumented] Mexican woman comes in and I get her screened and she has a lump and she needs a biopsy, she's not going to get it because she doesn't have the money to go get it. There's nowhere in [our county] to get it so they have to go to [a different county]. So, there are all these barriers to going there. And it costs thousands of dollars to get a biopsy.*

*We have a lot of undocumented people coming through who are needing assistance. We also have a privately funded grant that helps with some of that, but only up to \$500. So, like someone else said, once they get to diagnostics, it can be a hairy situation.*

*And younger women who need Pap smears or gynecology. To help them out. It's just that we have a very specific group [for WWC] and there are a few people who fall outside of that.*

*More patients with known breast issues are coming in, perhaps because it's known for catering to these needs. We need more funding for diagnostics, especially among younger women. Also, there is a lot of confusion around when mammos can be available to younger women.*

*Komen can't fund all the need. There is not enough money for undocumented clients. There is not enough understanding of population that doesn't get mammograms every 2 years.*

With rare exception, agencies noted that their undocumented clients accounted for about 20 percent of their overall populations, though at least two agencies served primarily (80% or more) undocumented clients.

*There is no slowdown in need for the undocumented population.*

*We need to find resources to help undocumented women, especially in the 30-39 year old range for cervical.*

*ANY help with undocumented resources would be welcome.*

*We still have 16% of our population that is undocumented, so it's a pretty large percentage.*

*We serve a lot of undocumented. It's close to 20% in the city, so that's what I would encourage money to go to.*

*Expanding eligibility to include undocumented clients would be a benefit to our agency. Undocumented clients account for nearly 50% of our client population, so this would be an in-reach effort.*

*We continue to see many many women who don't qualify for WWC because they are undocumented. That would be a huge help for us.*

One participant noted that some refugees have a gap period with no access to health coverage.

*The refugee population is undocumented and ineligible for Medicaid for a period of time. So, that's an untapped resource for WWC. And they have a high incidence of cervical cancer. In between being an undocumented and getting their citizenship, they lose it.*

Participants noted that treatment resources were limited for this population, but argued that hindrance should not be a driver in the decision to screen.

*The other big, terrible thing is that they're never going to qualify for Medicaid, and there are no treatment dollars. But I don't know if that's a good enough excuse not to do the screenings. They could go home to Mexico and get some treatment...It might increase their [the charity hospital] burden a little. I can't get them treatment. I can get them a colpo because we do them so cheaply. And I can get them to St. Joe's but I don't know if that would increase terribly. Cervical cancer cases are so low. There are only 12,000 cases annually in the US.*

### **Screening Mammograms for Younger Women**

Many focus group and interview participants also addressed their perceived need for screening mammograms for younger women, especially in the 40-49-age range, and follow-up breast diagnostics for women under 40.

*I would like to see equitable access to care for breast and cervical screenings.*

*Open breast screening to all ages and provide more diagnostic and treatment coverage.*

*Fund screening mammograms for 40-49 year olds.*

*We see, and think the data shows, that there is a need for regular screening mammograms for women 40-49.*

*We are the only mammography location in our region, which is a pretty large region. Is there any way to get some assistance with a mobile mammography?*

*I wonder if WWC is considering opening up and starting to provide payment for mammography for women ages 40-49. Has that been talked about at all? At least at our clinic, that's the reason we need the mobile mammography van, it's to provide Komen services. We're not a Komen provider.*

*Also, we're seeing younger women who come in and do not have a family history or anything that would trigger them to be in 40-49 category, or even younger, but they're trying to get their screenings done. And they just don't have the resources to do it.*

*For screening, 40-49. I know we use task force guidelines, but there are other guidelines out there and so many of our providers follow those guidelines. Also for younger women who are needing diagnostics work.*

*I do see in the future, Komen funding potentially decreasing further as people have Medicaid or insurance to be able to pay for these services, "I don't have to give to this cause," so I only see this becoming a bigger issue for Komen.*

*What we've seen with our patients that are eligible for WWC, someone is showing up with breast cancer and they don't qualify because they haven't been in the US for more than 5 years, so they don't qualify for WWC and they wouldn't be covered under emergency Medicaid.*

*We have funds left over for WWC versus, it's a whole different story, we actually have a waitlist for mammograms, for Komen.*

*Komen covers all those patients we can't get into WWC. Well, yeah, the majority of that would be [undocumented], but also women 40-49.*

*Mine is under 40. Those people with those abnormal lumps and bumps. Some of which turn out not to be cancer, but also those that turn out to be cancer, pre-cancer, but they're under 40. And undocumented. That's the biggest population.*

*I think that's the thing for [our agency]. The patients under 40 or 40-49 who are documented, but they can't qualify for WWC.*

*Some of our grantees restrict screenings to women 50-64, but we would prefer that they include women 40-64.*

*It is important for agencies to begin to think about the possibility of decreased Komen funding in the future - we all have to figure out a way to continue to cover undocumented clients (or those not eligible for WWC) and cannot rely on only a few agencies to cover all those ineligible for WWC or Medicaid. We all need to take shared responsibility for our indigent populations who rely on us for their breast and cervical care.*

Additionally, participants also noted the lack of funds for breast diagnostics among women of all ages and payor sources.

*Is no one else having issues with breast MRI completed. I know there's some funding available now.*

*We also have an issue with that [MRIs]. The only women who have needed it have not been WWC eligible, which was an absolute nightmare. Even if there are WWC eligible, it's not as simple as just writing an order and just faxing it to the hospital.*

*Once you get to the biopsies [for younger women], that's where we don't have funds. If WWC could cover the breast biopsies... I have screening, diagnostic mammos, and surgical consults, and ultrasounds. But biopsy, we don't have it. There was somebody who was a 35-year old who needs a biopsy, and there are no funds either. She might be documented, but we still have no funds for biopsy.*

Some respondents wanted to expand outreach and education efforts to reach underserved women potentially eligible for WWC.

*We need a good way to inform women and their providers that the WWC can help women pay for diagnostic services after they've had their 100% insurance-covered screenings.*

*Outreach and coordination remain key, especially since our target population faces financial, cultural, and linguistic barriers.*

*Marketing to the working poor who do not qualify for Medicaid but cannot afford health insurance or have a high deductible*

*PR: find the women out in the boonies who are not accessing care.*

### **Outreach and Education**

Focus group participants also addressed the need for outreach and education.

*The other thing I'm seeing is because people know that they're not qualified for Medicaid, they assume that they're not qualified for WWC and the income requirements are different. So, some way...so they've just assumed. "I've tried to get Medicaid and I couldn't, so there's nothing available for me." I don't know how to reach that population. Until they're a problem.*

*Right now, the biggest challenge is getting the word out. Previously, we had no need to market as we had more women coming in than we could serve. Now we need to go after eligible women who we know are out there. We just don't have the capacity to do that with such a small staff.*

*I'd say one of our biggest challenges is getting people to take responsibility for their personal health and well-being in just getting people out there and getting people more engaged.*

*With the guidelines changes, people think they don't need to get mammograms anymore. With the whole change with Paps... If you don't have to get a Pap, you're not going to get one for 20 years. You're going to wait.*

### **Care Coordination**

Some survey respondents addressed the need for care coordination at all levels. One provider noted the difficulty some women face when transitioning from one payor source to another.

*Not only the financial support offered by WWC but also the case management/navigation services we offer are needed by our patients. It is hard for women that previously used WWC and were guided through the process and had a list of specific providers they could see under the program to now be on their own to find a provider that accepts their insurance/Medicaid, schedule their appointments and understand the flow of health care. We also have a high demand for cervical services. [Our agency] performs between 50-60 colpo procedures in Colorado each month (although these are not all WWC eligible women) so there is a true need for those diagnostic services. For any given month. At least half of the women who need a colpo after an abnormal pap test are under age 40.*

*Clients need navigators to assist with applying for ACA.*

*We also need funding for navigation of women being seen for breast and cervical screening and diagnostics regardless of payer source.*

*Receiving case management/navigation reimbursement for all ages who are receiving screenings through another payor.*

Focus group participants also address the need for care coordination, both in terms of navigating a shifting health care landscape and in dealing with client-specific needs.

*My biggest concern is people getting lost. That they're getting their screenings covered and then they need a diagnostic. They qualify for WWC but they are not with us to start with. So, getting that word out. You guys were talking about patient navigation. That's my big thing: case management, patient navigation. For people that even have insurance or Medicaid, so that they get to the diagnosis and treatment as quickly as possible. You know, the goals of WWC, to reduce morbidity and mortality. ...How do I intervene, and educate, and get them in the door, and get them to treatment? I don't know why they're getting breast cancer more in my county, but it doesn't matter. I don't want—because they don't qualify for WWC anymore—I don't want these people to be lost. I'm spending a lot of time on the phone, a lot of time doing case management, a lot of time doing a lot of things that are not being reimbursed, by anyone. And that's not just with B&C, but in general, across the board.*

*I think one our biggest challenges in our population is not having a case manager who can actually hold hand of our very abused women who have no trust in anybody for anything all the way through the system. Because once they leave our front door of any of our facilities, or walk off the van, if we weren't trauma informed in the first place, they're gone. And we are very successful with those that we can actually pick up, arrange everything for, and walk through whole process. We have very good outcomes for those of course. But we need money for case managers.*

## Medicaid Issues

Survey respondents pointed out logistical challenges for clients who are actively seeking care, such as Medicaid clients who cannot find providers willing to accept them.

*Not necessarily our needs but with the expansion of Medicaid, I see a growing need for primary care able to provide overall health and health screening utilizing mid-levels as this population has increased and we continue to receive significantly lower than cost reimbursement from Medicaid. It's great to have coverage, but not if no one will take you. There is still a huge gap and need in this space.*

*Finding physician specialists who will accept Medicaid or uninsured patients for diagnostics or treatment.*

*Also, Medicaid has a low diagnostic MRI rate, so it's hard to find willing providers.*

*There is one clinic where 95% of clients are eligible for Medicaid, but they are not necessarily finding providers.*

Focus group and interview respondents were also attuned to these bigger issues around Medicaid, and echoed survey respondents' concerns.

*Some of these populations that now are receiving Medicaid, we have to think about them turning "on" and "off" Medicaid, maybe to the marketplace, and the gaps that are going to happen, and that's going to be really hard to manage for some of us.*

*We need more providers. And we're hoping to increase from about 40 providers to 60 by the end of the year.*

*It's a provider shortage, not for WWC necessarily, but for insured and Medicaid [clients]. Now they're getting insurance – insurances too. But how do you find these women [who have received an abnormal result at a non-WWC provider], especially in a rural area. But we have no radio station, no TV. How do you find these people so that they don't stop doing things? Because I feel that they aren't even doing their screenings because the education isn't there. The promotion isn't there. You know. I think, yeah they have insurance now, but they don't know what to do with it necessarily. And we're not out there saying "Get your mammograms!" because they have insurance that's going to pay for it, but nobody is working with them to make sure that they do their screenings, and then if something is abnormal...*

*There are not providers. Not WWC, but in general for women. Because that's our goal from a public health perspective.*

*Getting appointment slots. So the majority of our patients are family planning. And we do the best of our efforts, are backed up and we're having a hard time getting the patients seen...for new patients, return visits. Providers are booked up 4-5 weeks. It's rough.*

*Also those women on Medicaid, we're also seeing pretty big turnaround times for them to get their procedures done. So, when we refer for mammograms, we're having to call several times before they get it done. So just because they have insurance doesn't mean they're going to follow through...with what they were asked to do.*

### **Community Partnerships**

Focus group participants noted the need for improved opportunities to partner with providers related to WWC and BCCP Medicaid expansion, as illustrated in this discussion:

*And even if you've talked to them [non-WWC providers] they still don't remember when it gets to that point. I worked directly with and talked to [a provider] and there was a gal who came into my office with an open gaping wound in her breast. And she had already gone to [this provider] three months ago before she got to my office. And they knew that she could get into BCCP... We could have gotten her into treatment quicker and care quicker.*

*It sounds to me like there needs to be a different entry point besides screening. It sounds like if someone has a gaping wound in their breast, then they need help. That should be an entry point.*

*It goes back to having to have those partnerships within the communities we're serving to help fill that gap. And the funding to do it.*

One focus group participant addressed the need for more interagency collaboration:

*With Komen, I can be a little more creative, because we do do undocumented. I will help out other agencies. I don't care where they're at. If they need something for their undocumented person, because obviously we don't have as many up here. So if they need those diagnostics. I'm working with [another agency in another county] to help them with vouchers for that. And that keeps growing a bit. And just supporting each other if you're slightly close to each other.*

### **Social Determinants of Health**

Focus group participants noted that, even with Medicaid and insurance, clients still face barriers to care that are often exacerbated by social determinants:

*All women at our clinic face the issue that just because they have Medicaid doesn't reduce other barriers for screening/follow-up. Those barriers might include transportation, scheduling (work hours conflict), childcare, and the associated challenges with rescheduling. Also, we need help with women who don't qualify for Medicaid because they are over 138 FPL.*

*Durango is completely the opposite of everywhere else. You can find any kind of specialist you want but there is a shortage of PCPs. More rural areas are opposite: they have primary care providers but no specialists, which means that they often have to travel far for specialty care. Some transportation is available. We have a monthly medical van.*

*I think one of our biggest issues across the board is follow up. And it's not a matter of us not having the resources to be able to follow up with these patients. It's a matter of our patients can't afford their cell phone bill this month, so it gets shut off. They get a new cell phone, they get a new number. They move and we don't have their address any more. They don't come back into the clinic to get test results. They do get test results and have to go see a specialist and refuse to go see them. Ours is more a matter of patients' unwillingness for follow up rather than our resources. We do have some patients who it's a resource issue. But we get a lot of money from a lot of places that we can get a lot things paid for, for our patients. It's their unwillingness to come and get their results and talk about what needs to be the next step and come every three months for their [Nuvaring] and stuff like that... They're in and out of prison all the time. They're going back to Mexico for 6 months at a time and then come back. We have a patient who goes to Russia for 2 years and then randomly shows back up and wants us to take care of her again. It's more of a lifestyle issue than a government, political perspective. We don't have the dueling*

*banjos. With our Hispanic females, yes [there are cultural barriers], definitely. Definitely with them. Even some of our Hispanic males. Because they're the people who bring home the money. They're the ones that work. They take care of the family. And they don't have time to be sick. They don't have time to be hurt. They don't come in. A lot of Hispanics I find, at least in our population, that when you finish your lisenipril, you need to come back in for a refill because you need to stay on that medication. Just because it says no refills, doesn't mean that you're done. ... We need to find better ways to follow up with that. It [follow through] depends on the age group. And follow up for birth control. The older women, between 20 - 40, are really good about coming in and following up. Our girls under 20 are not, at all, any way shape or form good about coming in and showing up until they need Plan B. And then there they are. And it's like, "Here's some more birth control. Come back." And they just don't follow up. It's sad to say, but the communities we serve, you kind of grow up drinking and having sex. That's what you do when you get into high school. And it's just the culture out there.*

Several interview and focus group participants also noted problems with the perception of government assistance, as this comments illustrates:

*I just saw a woman today, not yet 65, but she doesn't want free services through Medicaid. There is a stigma with government assistance. People are less willing to come forth and seek assistance. Once at the clinic, they are more willing to accept help, but they sure don't want their neighbors to find out.*

### **Agency and Program-Level Barriers**

One focus group participant mentioned agency-specific challenges that prevent them from serving a larger client population:

*Our funders will give us money to build buildings. We get all kinds of toys. Capital investment. However, it takes people to run the shelter. So fundraising for people to actually do the work would be lovely. And pay them high enough so that it's a competitive wage...Our benefits are pretty fabulous. But the base range for starting [positions], all the way through all of our health services, are not competitive. So that's one of our challenges. Without competitive salaries, you can't fill all the openings. And if you don't have enough people, you can't fill up all the slots. So, we're building a new building. And when we open, we'll only have enough people to use half the building. And how are we going to see all the people who want or need, unfortunately, our services?*

*From our perspective...has always been, there should be more dollars for treatment. There should be a cost shift of dollars from screening to treatment. There's never been dollars for treatment for certain populations. So, since there are more people being covered by Medicaid, there should be a shift of dollars from screening to treatment.*

One interviewee noted that WWC requirements are a barrier to clinics that serve a small client population.

*Small clinics often have no capacity to commit to WWC. They could bill just a few (~10) clients a year but it's not worth the extra effort. The rub is that the few women who might receive services are women who wouldn't be served otherwise.*

Of all interview and survey participants, only one felt that there was little need or identifiable gaps in service, in part because their agency served a primarily undocumented population and was funded by non-state sources to do so:

*Our women’s health program is really robust, so there are no real gaps; it’s heavily funded. 70% of patients are women to begin with. Mainly we’re focusing on getting eligible women into Medicaid and improving efficiency, but we’re already taking steps in that direction.*

**Stakeholder Priorities**

Ultimately, the goal of this project was to gauge stakeholder priorities for WWC fiscal year 2015 funding. In the survey, this culminated with Question 16, a matrix with forced ranking for nine (9) options: “Which of the following services related to breast and cervical cancer screening and diagnostics should WWC prioritize (in addition to current WWC services) for FY 2015 (June 30, 2014 - June 29, 2015)? Please rank in order of importance to you [1 = highest priority; 9 = lowest priority]. Each number may be selected only once.”

Responses to this question were analyzed using a simple [Borda Count](#), a weighted method to assist in consensus-based decision-making. Each option was assigned a number of points that corresponded to the number of options ranked lower. Since nine options were presented, the option ranked first received 9 points<sup>18</sup>, the second received 8 points (n – 1), the third received 7 points (n – 2) and so on, with the last option receiving 1 point (n – 8). The points were then totaled to determine an aggregate ranked order.

A total of 79 respondents completed Question 16. Of these, 75 percent (n=59) were direct service providers. The remaining 25 percent (n=20) were either individuals who represented organizations involved in cancer prevention (n=12) or unaffiliated individuals (n=8). Each respondent group reported different overall priorities among the presented options, though all groups highly ranked the need for care coordination. Notably, funding HPV vaccines and infrastructure development were low priorities for all groups. Table 1 shows the total points and rankings for all respondent groups.

**Table 1. WWC Priorities by Overall Rank and Points (n=79)**

	Direct Service Providers (n=59)		Non-Direct Service Providers (n=20)				All Respondents (n=79)	
	Rank	Points	Organizations (n=12)		Individuals (n=8)		Rank	Points
Care Coordination	2nd	353	2nd	74	2nd	54	1st	481
Identify Clients	1st	364	3rd	67	6th	34	2nd	465
Outreach/Education	3rd	334	5th*	59	4th	45	3rd	438
Mitigate Barriers	6th	290	1st	78	1st	55	4th	423
Reduce Age Eligibility	4th	315	4th	66	7th	33	5th	414
Enrollment Assistance	5th	300	5th*	59	3rd	48	6th	407
Health Systems Change	7th	241	7th	56	5th	39	7th	336
HPV Vaccine	8th	230	8th	51	9th	25	8th	306
Infrastructure Development	9th	228	9th	30	8th	27	9th	285

\* Non-Direct Service Organizations equally ranked Outreach/Education and Enrollment Assistance.

<sup>18</sup> n was determined by the total number of options presented.

Overall, direct service providers prioritized those activities that would most likely increase their client base (e.g., client identification and outreach, reducing age eligibility) or improve outcomes (e.g., care coordination, barrier mitigation). Table 2 shows rankings ordered by respondent groups.

**Table 2. WWC Priorities, Ranked by Respondent Group (n=79)**

Rank	Direct Service Providers (n=61)	Non-Direct Service Providers (n=20)		All Respondents (n=79)
		Organizations (n=12)	Individuals (n=8)	
1st	Identify Clients	Mitigate Barriers	Mitigate Barriers	Care Coordination
2nd	Care Coordination	Care Coordination	Care Coordination	Identify Clients
3rd	Outreach/Education	Identify Clients	Enrollment Assistance	Outreach/Education
4th	Reduce Age Eligibility	Reduce Age Eligibility	Outreach/Education	Mitigate Barriers
5th	Enrollment Assistance	Outreach/Education*	Health Systems Change	Reduce Age Eligibility
6th	Mitigate Barriers	Enrollment Assistance*	Identify Clients	Enrollment Assistance
7th	Health Systems Change	Health Systems Change	Reduce Age Eligibility	Health Systems Change
8th	HPV Vaccine	HPV Vaccine	Infrastructure Development	HPV Vaccine
9th	Infrastructure Development	Infrastructure Development	HPV Vaccine	Infrastructure Development

\* Non-Direct Service Organizations equally ranked Outreach/Education and Enrollment Assistance.

Beyond barrier mitigation and care coordination, organizations and individuals reported differing priorities. Respondents representing organizations more highly ranked a reduction in age eligibility and health systems change while unaffiliated individuals more highly ranked enrollment assistance and outreach/education. The responses of non-direct service providers, both organizations and individuals, should be considered with caution as the respondent pool was particularly small.

**Care Coordination**

For the purpose of this project, Care Coordination includes:

- **Client navigation** (e.g., patient navigation) services are provided to eligible clients who have **normal** breast and/or cervical screening outcomes to assist clients through the screening process. In general, navigation services assist clients to move through a complex health insurance system and a complex health care system.
- **Case management** services are provided to eligible clients who have an **abnormal** breast and/or cervical screening up to the point of a definitive cancer diagnosis. This includes helping them to understand their abnormal result(s).

Survey respondents collectively ranked Care Coordination as a higher priority for the WWC. Interview and focus group participants also saw a gap that needed to be filled.

*[Our agency] offers case management to all of our patients, and we have historically for years. ...Aside from lowering the age range and providing direct services to patients who need breast and cervical screening, [care coordination] would be a great second focus. Even though [our agency] provides the service to everyone, one of the things I found out is that not all [agencies] are able to case manage their patients. That came as a big surprise. I think for agencies that are not able to case manage all of their patients, this would be a really good option for them to pick and choose who needs the case management.*

*This is a priority. We've had a couple of grants focused on specific populations, e.g., Latinas, women with disabilities, and we found care coordination to be extremely helpful. We saw a big improvement in our outcomes. Our outcomes have decreased since grants expired. This is really important, especially with the longer 5-year Pap test. We still do a little of this, but we only have staffing for phone reminders. The problem is that addresses change a lot. We're not as active with this without the grants.*

*Patient navigation is important, especially here. Women have no idea where to go and trying to keep women local and in their own environment is important. We do this, but it would be really nice to have support. Trying to find where to send women outside of our clinic can take a lot of effort. ...We use the RCCO for case management with Medicaid, but it's really for ER abuse/overuse, ER imaging, and readmission. It's not for everyday patient navigation or case management.*

*I'd say that care coordination is our biggest need in terms of program management.*

*Case management funds could create buy-in to the Medicaid Program and help to support needed infrastructure development for [our agency] to expand to use Medicaid. It could pay for FTE time and help to sustain the program existence.*

Many agencies provided some level of case management, but not client navigation.

*We definitely don't have anyone who does that [PN]. We do call back anyone who is required to come back. We follow up on them. We call them back. That's split up among whoever has time: the screeners, the technologist. We do have a certified breast health nurse navigator who works with our cancer patients, but we have no one that does that [navigation to screenings]. The only navigation we have is after diagnosis.*

*Patient navigation works in depth with diagnostics, but not the general patient population. This is a strong area for us, but we would benefit from another position. We expanded, added in a role the previous year, a personal health coach. And we've had amazing results.*

*Clinical staff are required to do follow up with all abnormal patients across client population, regardless of program/payor source, but we do not have dedicated patient navigators or case managers. We have hired one RN in Denver to handle some of this, though other clinics don't have a person in this role. While [our agency] may not be able to implement something like [a care coordination program] because of labor/time costs (they would need extensive ed/training too), we recognize the value in providing services, especially since the Affordable Care Act. Providing care coordination to newly eligible Medicaid or private insurance, including younger women, would be great. Younger women especially need assistance as they just don't have the experience with managing their own health yet. So, both navigation and education are really important.*

*[Our] case management is primarily reserved for higher risk patients...but we have about 20 clinics, so we have a couple of different case managers, so they do it based on need. Not everyone gets case managed.*

Even those who already provide client navigation acknowledged that much of what they did was not sufficient to meet the needs of their clients.

*I would handle the patient navigation. We have two referral specialists who receive referrals from the provider. However, they're not doing the level of patient navigation that I do. They might say, "here's the number of where you should go." In theory, they're supposed to check back in a*

*month or two, but they are handling all the referrals that come through our clinics, so in practice that doesn't actually happen.*

*I think it would be really nice. Right now, our nurses help take care of the diagnosis, but they are really busy with many other things, seeing patients, doing walk-ins, they do fall behind – not too behind – but I think it would be a great use to just stick with the WWC diagnostics or just mammogram diagnostics. It would be a great help for community partners to have that help.*

*For us, it's [case management] mostly related to breast services. Cervical cancer is mostly done in house. We do up to LEEP in office. So, it's the breast cancer. Because nobody in our organization has surgical credentialing anyway. It's all out of house. ...Then when they have cancer, the BCCP takes over. And they go to an organization for care. Once you have a diagnosis of cancer, they do a lot of case management. I think it's just up to that point. But at least for [our agency], cervical cancer is less common and we can treat that in house, so there's less need.*

Most participants acknowledged that their outcomes improved and clients appreciated reminders, but that feedback was not universal.

*And just those phone calls. It's part of outreach and education. I'll call up out of the blue and they're like, "Oh I'm so glad you called. I was going to do that." They need that. Because life happens. Think of ourselves. We're not in the same situation, but time goes really fast and I'm realizing that "I didn't get my mammogram. I didn't go to my annual appointment."*

*... A lot times I'll call a patient and she'll say, "ah, I'm so glad you called. I totally forgot. Can I have the number for the hospital?" and I'll get her results two weeks later. But that phone call does need to happen.*

*Doing [care coordination] is definitely taking more time. We're calling the ones even ordered to have screening mammograms to remind them to get their screening mammograms done. Patients don't always appreciate getting calls for screening mammograms.*

One participant saw a bigger possibility for care coordination during the health reform transition period:

*What I'd like to see is finding some way to navigate clients to medical homes, regardless of care need. What I'm hearing is that there are waiting lists for new patients except those with symptoms. So, while this wouldn't be directly related to breast and cervical screening, this could be a global public health priority that may ultimately have an impact on screening rates and getting people access to care.*

Others noted the need to develop provider partnerships, which care coordination could foster.

*But again, then we're seeing it with non-WWC people. I get call from providers, from other people, "Ok how are we going to figure this out?" And it's not even a client of mine at the time. Or they'll come and see them once. Or I'll call them on the phone and we'll see what we can connect them with. ... Now that they have insurances, they still need the management. It's the same with family planning. We have this expertise in this area (breast and cervical) just like with family planning. The primary care providers who are supposed to do all this stuff now, don't have [the expertise]. So, it's working with, partnering with your local providers.*

Some participants had specific needs around care coordination, particularly as a result of language barriers:

*What we could use is a Spanish speaking case manager. That would assist us quite a bit. To be able to fund a case manager to work with our Hispanic population specifically so that they do get the follow-up and they do come back, and if they do have cancer, that person could work with our nurse navigator. Even though we have a Spanish-speaking scheduler, what we do find is that our Spanish-speaking clients are lost to follow up more than anyone else. It has a lot to do with the fear piece. But we'll call and call and send letters, but we lose those ladies. So, that's something: a culturally responsive person who could work with those clients who are lost to follow up.*

*There is a real struggle with how to pay for staff time for patient navigation. This is particularly difficult for non-English speaking clients. Care coordination is often very time-intensive, particularly for LEP clients. CC has to explain medical condition but also has to help patient get care at another provider and explain that HIPAA has to be signed at every provider.*

Some participants saw a need for more consistency in care coordination. There was some concern about the quality of care outside of the agency.

*I do know that [our agency], getting people in, they have one person who case manages all those women who need it. But it's case management that gets handed off, rather than one person stays with the same case manager.*

*Is there any way to assess the quality of care? One thing about WWC providers is that you know that they're providing really quality care because they have metrics/milestones they have to adhere to. When patients shift providers, is care the same (e.g., Medicaid)?*

*It's my understanding that the RCCO has a different focus than the type of case management provided for WWC clients. I think they use claims-level prompts to focus energies on reducing costs to high-volume clients (the 10% who take up all of the resources). I'm not sure they have knowledge base for managing WWC clients.*

A couple of participants suggested a statewide or regional effort:

*I don't know if it would be possible, but if the patient is going to have to be out of the agency anyway, could we have a state-funded case manager who gets assigned to that person, and be totally outside of the clinic setting, like a regional case manager? Again, that stuff is out of house for most organizations. Breast biopsies are not going to be in the organization.*

*With the expansion of BCCP, I think you could comfortably expand WWC. There's an opportunity for relationship building with private providers. I would love to see WWC/BCCP establish its own care coordination network. There would be less confusion across providers.*

Participants pointed out potential challenges to implementing care coordination. Many cited the need for additional resources in sufficient proportion to the workload.

*The main thing is [the WWC care coordination] requires agencies to be able to provide case management to more people. It's time and money, like everything else. For an organization that has 20 clinics... In order to meet that demand, I can see how more staff people and a kickback per patient could add up to a salary for someone new, who specifically deals with patients A-M, and N-Z or something like that.*

*Within WWC, we have one RN and a huge portion of her job is doing care coordination for patients. It's a huge financial drain. WWC payments don't cover the actual time/cost involved. In fact, we are considering the value of WWC given our limited capacity. We would need additional funds for just care coordination. An FTE would dramatically increase our services.*

*That's [the case management] the more time-consuming. And it takes more expertise, clinical background.... It debatable, but it definitely needs clinical input no matter. ...it doesn't have to be a provider. It can be a nurse. ...But there has to be definite clinical input.*

*I know that we can't get any more people here. I've been told that this is my staff and... that's it. So we're not allowed to use anything you give us to leverage it for more people. I do think though that having a person who can assist, even a half-time FTE, would be a huge help to see more screening patients for sure. We're self-limiting the number of patients we can see because of our staffing.*

*It's really hard to say [if we would take advantage of care coordination] because that's looking at staffing restructuring. We couldn't ask our referral specialists to take on more work with patient navigation and eCaST data entry. They're already so overtaxed. So I suppose the agency could look at hiring an additional coordinator, but that's an agency decision I couldn't answer. It would also depend on the level of reimbursement and whether it was sufficient to fund that person's role.*

*We do have a centralized call center that is extremely time consuming to go through all the screening requirements to see if these people qualify, and that's not something that's rolled into anything we get reimbursed for. We do have a system that does reminder calls and that's pretty time intensive as well. Having patients come in to fill out paperwork can be pretty slow if you don't have that all set to go. We do have it spread across a couple of different places, so it's interesting to think about. We do have a couple of nurse case managers that do assist with abnormal and calling patients back and following up and that sort of thing. We do have people to do that, but we don't have what we need to really cover the cost of those services. We have seen – not as much in the last couple of months – clients who qualified for WWC then 2 weeks before their appointment, their Medicaid comes through, and we were trying to help them navigate that. But we felt kind of stuck trying to manage this person who didn't have a PCP. It does feel like an extra work load we previously didn't have.*

Some participants pointed out that it takes more than just funding to create a successful care coordination program.

*It would be a multi-pronged need. Multiple changes would have to happen for us to leverage that. There would have to be some kind of expand of eligibility, either for undocumented or young women for us to consider changing our infrastructure to bill. Because at this point, we don't even have a patient load that would come close to making that something we need.*

*Release of records could be an issue across payor sources.*

### **Client Identification and Recruitment**

Client Identification was difficult to parse out from outreach and education in the focus groups and interviews despite defining it as preliminary data analysis to inform the next steps of outreach and education. So it is likely that survey respondents experienced the same difficulty in differentiating the two options. Regardless, focus group and interview participants had a lot of say about the process of client recruitment at all steps.

Many participants indicated that they would like state-level assistance for this early research:

*I think it would feel to me that we would need some assistance on a larger level to help identify these ladies. We've been trying to do some outreach. And it's difficult to find these ladies. So getting some help with outreach marketing, whether it's zip codes, neighborhoods, or whatever, from the state, would be extremely helpful.*

*I think this is an area where it takes a lot of time and energy and we don't have the resources at the clinic to do this. So if WWC could help with finding them and informing them of the program that would be super helpful. When our numbers decreased this year, we knew that there are women out there, but how do we find the time to reach out to them?*

*I think it is an area where we need help identifying where those areas are. We can do the outreach if we know the organization, but we don't always know where those organizations are.*

*We live in a small area, and identifying women is not as easy as it is as if we were in a more metropolitan areas. [...] Locally, that would be extremely helpful.*

*It would be helpful if the state identified WWC-eligible clients. If you do, that would be helpful.*

*We would love help with this [identifying potential clients]. We don't have the capacity and could not implement.*

Participants were also quick to point out the challenges they faced in finding potentially WWC-eligible women:

*They're too hard to find, and the issue [accepting "government assistance"] is really about pride.*

*We have been doing a lot of outreach events recently in all kinds of different locations, including supermarkets, beauty salons, and of course the more traditional places, health fairs, food banks, rec centers. We're not finding a lot of the WWC-eligible women so far in any of these locations.*

*One of the things that, in rural areas, is still getting mammography to women who can't get to mammography. And so I don't know how much of an inter relationship exists between informing qualified women that they need the service and how much of it is the availability of the service of women in areas where WWC qualified services aren't available easily.*

Many agencies did engage in some level of outreach, but agreed that much more could be accomplished through directed funding.

*It [outreach] would be extremely beneficial. We definitely don't have the capacity to do this. If we had to be responsible for this, we would struggle without staff support.*

*We have our own outreach department (1:1, group classes)...I'd recommend [funding outreach] for others who might not have that.*

Though most participants agreed that outreach needed to be localized, one agency saw the need for statewide outreach:

*I think for some agencies, like the agency I work for, having some of that outreach done by people that aren't affiliated with any particular agency can be more helpful so that if those patients don't want to come to us, they still know that they can access that grant through other providers. That might be something that only my agency deals with. I just think that it's important for us all*

*to come together and promote the program as a whole, not just that we, as individual agencies, have that program.*

*We would be concerned about a state effort [at outreach] as centralized attempts have the potential to lose the local focus. But working with community agencies with a health focus would be ideal. I'm a little skeptical about working with community agencies that aren't focused on health.*

*We feel strongly that outreach efforts should happen at a grassroots community level, not the state level. ACS did not provide any positive benefit for us.*

*I would say that [our agency] is really good at inreach. I have some staff who would say that outreach is more challenging...We don't do a good job at marketing. If you could tie that piece of outreach and education to market WWC so that we're getting the information out there. So that we've got brochures and flyers to put out at health fairs and community fairs where we are partnering with other agencies. That's what we need from our perspective...More money so that we could actually do it. [Statewide outreach] doesn't work. It's kind of interesting how that's all played out.*

Though some agencies felt that outreach efforts were strong, some focus group participants felt that there was a dearth of general knowledge about the WWC program.

*I have to wonder how much awareness is out there with a lot of women, with the program in general. [...] For TV commercials, radio ads, Google ads, and that kind of stuff, just making women aware of what's available to them, even at the diagnostic level even if they're insured would probably do a lot of good.*

*There is a need for more marketing to the general public, not just the people are looking for it. The people who are just passing by, non-clinical, not sitting in doctor's office, but the general population. Just getting them thinking about screening...because they don't know what they don't know.*

Several participants mentioned that they were already partnered with community organizations and coalitions as part of their outreach efforts. One participant suggested that there were untapped opportunities to leverage.

*We don't really have a lot of choices. We have to work together.*

*I think it's an ongoing situation where you just continue to be there, continue to be in people's faces. Out of sight, out of mind.*

*The representation in our community is among the coalitions and leagues and boards that we are involved in. We go quarterly just to remind them that our services exist.*

*I do [partner with local community organizations to help with outreach and education] already but there is a need for more. I'm just seeing it. But for me, the numbers have dropped so drastically, but I am so concerned that because of our high risk for breast cancer that we're going to have a lot more mortality and morbidity for breast cancer in our small county. Because these people don't know that the resources are there.*

*There is a huge opportunity to build relationships with community-based organizations that may not be directly connected with healthcare systems, but have the capacity and experience educating their populations and connecting them with providers, e.g., churches, advocacy orgs,*

*etc. CREA, for example, does breast health education, helps clients schedule appointments, and navigates patients to care.*

*And that's probably what's missing in all of this. When you talk about care coordination and outreach/education, maybe, we're huge organizations. We have education to do amongst our own organization to know who does what and how to get to them. Let alone education with a community partner.*

Other participants felt that the target audience needed to be expanded to women with a higher income level.

*I think it's important to remember that, yes, we need to continue with these organizations. But they're not the only underserved population.*

*I think we maybe need to broaden our horizons on who we're outreaching to. I go to different events, and a lot of times I'm preaching to the choir. I'm already reaching women who know about the program, who are previously enrolled, or who are Medicaid eligible. I constantly feel like I'm preaching to the choir. It would be nice to have ideas on how to reach these other pockets of people who aren't aware of the program who may be eligible.*

Several focus group participants identified perhaps the key challenge to outreach in the post-healthcare reform environment:

*I think in some ways that identification goal is important, but I think the difficulty that in rural areas where the screening percentages are so much lower, we as medical providers may identify different groups of women who might really need WWC or needing screening, but they might not have identified themselves in that population. So there's kind of a disconnect between the people we, as medical providers, see so clearly as "needing screening" but that the education for the women about the program, about breast cancer screening intervals isn't there. So I think that kind of patient education and outreach is needed.*

*There's a large population that doesn't fit into this group. Up to 250 of the FPL, that's a family that's probably doing ok. Not rolling in money, probably not a lot of savings for health care. But they're doing ok. THEY feel that they're doing ok. But they may think that they're not qualified for these programs because they're not poverty-stricken, according to them. So they may. So someone who has insurance, they don't feel that they qualify for these things. They think they're for women who are very very underserved, and they're not that.*

*I agree with that. I think some of those women that are at these other doctor's offices that aren't going to [our clinic] are these women who think "no, we're ok," so they don't realize that they qualify for things.*

*So, I'm thinking that we need to advertise differently to reach out to the working poor because those are going to be the ones that fit more into this category.*

Some focus group participants shared those own experiences and possible creative solutions to reaching out to this working population.

*I don't think we always know what people make...I discovered that part of our housekeeping is contracted and part of it is employed. Those people that are employed have insurance. Those people that are contracted don't. I was not aware that we had contracted employees. Now, they are all eligible [for WWC], but that's not a thing that I was aware of. So, it's finding those pockets of people...*

*So, maybe trying to outreach, not to individuals, but to local businesses, because it depends on the insurance coverage they offer their employees, and if they don't.*

Several focus group participants felt as though there was the opportunity to outreach and educate non-WWC providers rather than the clients themselves. They were able to share examples of how building provider partnerships can have successful results, but they also see a need to do more of this.

*[There] are those women who go to other individual doctor's offices [besides a WWC clinic]. Even though we've gone out and told them [the provider] about this and given them information, they don't utilize it. It's that information to go to the office so that when women come in and say they're self pay...and now need this mammogram, and they don't know that there's funding out there. They don't know, so if it is finding the women, it is **how** to find them. That's one route to find them. I have patients who call in and say doctor 'so-and-so' said you might have funding. Well, there are probably a lot more women in that office that don't even get that information. Or other offices that don't give out that information.*

*We have someone at the [local hospital] that will occasionally go through the schedule and pluck out the women who are self-pay for their mammograms, and she'll give them a call and tell them to call [us]. And very often, we're able to enroll those women in WWC. So, we do have someone looking out for us, but it's true that we're just one clinic. And [we're in] a very metropolitan area, and there are lots of clinics that women go to. And not all of them are likely to be aware that both [our clinic and the other local] clinic have WWC funds.*

*I work in the mammography department. The women coming in, if the [staff] see that they're self pay, they might ask them and then they call me, but a lot of those women have a really high deductible, and they don't ask them. Those people that could maybe qualify don't. I think it would be easy to catch it at the doctor's office level.*

*I've wanted to do outreach to other doctor's offices, but it's all been on my own time because my work won't pay for that.*

*I think they're [Primary Care Providers] sometimes not aware of the program. They may or may not be. They'll refer them for mammo. A lot of times, that's where we identify that they [clients] are eligible for the mammos for WWC. I actually had a patient who was diagnosed who went to one agency during October because it was a \$49 mammogram. She had a large lump and lymph node. Then it took her a month-and-a-half to get the money to afford the diagnostic. It wasn't until she needed the biopsy that I even found out she existed because she was calling every clinic in town for how to get a biopsy. So it took us 4-5 months to get her in because of that. Not through any fault of our own. But nobody knew the resources out there... The outcome of this lady is that I did talk to this agency. We have a great dialogue now. And we actually did a multi-agency collaboration on a patient through a Komen grant that would not have been possible if it had not been for this other lady.*

*[Primary care agencies aren't all aware of BCCP expansion] I think people have gone and talked to them, but I don't think they're aware of it. Or they don't think of it. Or, as a nurse, I don't look at what my patients have. I take care of them. And unless they say "I can't afford it." But nurses aren't looking.*

*Maybe that's another avenue for outreach with family physicians. You know, a coordinated effort among breast cancer organizations to outreach. This is maybe something the breast cancer task force could assist with to really push an outreach effort around the state with family physicians. It seems to me that women who are Medicaid eligible, or eligible women, may see a family*

*physician somewhere...If they see a family physician, so that they say, "You need a mammogram and here is where you go."*

*The safety net clinics know about you. Indigent patients know about you. Everyone, especially with the high deductible, knows about you because you do the low-cost mammograms every October and May. And that is a period where we should all be asking, "Why are you doing this?" Do you have insurance? Are you eligible? And nobody asks. Because nobody has the time. But that is a perfect thing. Either because they have high deductible and they may or may not be eligible. Or they're doing it because they don't have insurance and they may or may not be eligible....And this should not be limited to two months out of the year, right?...Right. We all know that.*

*We do some follow up with these women, but once they are referred out, it's up to them. We don't follow them as closely as I would like. It would also be nice to have more definitive partnerships rather than a referral list.*

A few focus group and interview participants didn't see the need for outreach and education, either because they thought that outreach was already success (or was a tapped-out effort) or they felt that it was beyond the scope of their organization's mission.

*Outreach has been done so much. We've already reached the people we're going to reach that way. Latina women are an underserved group, but sometimes it feels misleading with Spanish-language materials, because then undocumented women think they're eligible.*

*It's not a priority in an urban area. We have already made this effort.*

*I feel like outreach is an area we currently are ok. We need help identifying women we could help...we already have all the call center staff to take care of patients calling in.*

*We're in middle of capacity building, adding some exam rooms. This might be more beneficial down the road but we're currently at capacity...*

*We don't have any outreach staff at all. That's just not our mission. We're hospital based. We don't have a community health work. So, aside from media marketing, we don't look for these patients.*

One participant noted that they were inundated with Medicaid clients, which prevented them from outreaching to underserved populations.

*We have quite a bit of capacity. We have plenty of screening openings...One thing I will tell you is that the majority of the outreach we'll be doing is with insured clients. And that's just because we can't continue with these Medicaid reimbursements for the vast majority of clients, it's just not a sustainable business model for us.*

Other participants felt that they already had a large enough demand among their existing client populations:

*It's so hard to look past the people who are already coming into our clinics. Be it the 25 year old. Be it the undocumented Mexican. It's so hard to see past them and hunt down the American citizens who could qualify for something but don't even show up. I'm sorry, but... I could spend that money tomorrow in my office with the patients who have already come through the door. I don't have to go looking for them.*

*I know we advertise big for WWC. It's in the newspaper every day. It's on the radio. [Our clinic] has always been, our free clinic, for everything. Just because of so many programs that we have. So even people with insurance will show up and say "free mammogram?" So, your insurance is going to pay for it, so we'll send you. So, because of our advertising, people know that they can come there and get what they need. For free. Be it through insurance, or this program, or whatever it is. I don't feel like identifying clients is the problem...We could use the money for patients that are already there.*

Most interview and focus group participants did not see the need to mitigate barriers as a strong area for WWC to focus their resources. In some cases, participants felt that they had ways to mitigate barriers already.

*Occasionally there's a need or barrier as far as transportation, but that's not the main concern we have at the clinic. The breast services through WWC we offer are pretty easily accessed. We have public transportation and we do have bus tokens available.*

*It's not a huge issue for us. We have such a wide service area that occasionally we have ladies for whom it's difficult to get to the clinic, but it's not a barrier to accessing care – it might just be a small delay. We've been able to help with that in the few cases that happen.*

*Sometimes we have women who can't get to a mammogram, but it's unusual. That would just be a very small number of women that would be in need of that service for our particular agency.*

*As far as the cost of transportation, we have gas cards. It just becomes a problem if they don't know anyone who has a car who can drive them there. And that's the rare person. Usually someone, if you say, we can give them gas, will drive them. There are always exceptions, but for the most part we have that covered.*

*We have a volunteer resource advocacy program that tries to work with patients to assess their barriers and connect them with community resources, but it's 100% volunteer and doesn't always reach as far as we'd like it to.*

*We have a resource center that will help women with transportation needs. There is no Medicaid access to transportation here. But we also find that our clients, once scheduled, consider their appointments a high priority. We don't have a lot of problems with no-shows because of transportation. In fact, I'm always surprised that people can afford the gas.*

Participants did acknowledge that, for some populations, particularly rural communities and the greatly underserved, that there were still specific challenges to overcoming barriers, such as language and transportation.

*There is a problem with language, especially when referring clients. I believe that the language barrier is causing a delay in access to care. The level of language skills across health care providers is not consistent. Sometimes interpreters are not asking the same questions, but patients think they are and will refuse to answer at the next step. Much of the problem is a misunderstanding about how the health system works, especially if the patient is from a country where there was not a system of accessing care from multiple places/providers....What if there was an interpreter who followed patients through the system?*

*We have a language line, so we're able to talk with our patients. It would be helpful for us to have a case coordinator that could help clients fill out paperwork, certified interpreter. We find that it stretches out an appointment past its scheduled time. So, for screening, we allow 15 minutes for a screening mammogram. So if we have a new patient and she has to fill out all the paperwork*

*and we have to go through a language line, so [language assistance] would help us. The other piece is just having someone to help deal with fear and focusing on the family. Because I agree, transportation is not the issue. I think that it's more that people are afraid to come and they make that conscious choice not to come.*

*So we have a multicultural resource office. We have a woman who will call ...a Spanish-speaking person who can find someone to take them, if they're going to go. If they even have the money or can pull together the resources. Sometimes I go talk to the multicultural resource person and there's no option. We have no idea if there ever going to go. Or if they'll go back to Mexico. So...*

*Transportation does not seem to be a recurring problem. Although in non-metro areas, ACS has no drivers and they're still recruiting, especially native-speaking drivers.*

*Mitigating barriers is a priority, especially transportation (bus tickets, gas cards, taxi vouchers). Even Medicaid patients with access to transportation services face barriers because of access to phones (e.g., homeless), long wait times. I was on a call with a client seeking transportation to chemo from Medicaid and they kept trying to talk her into taking the bus instead of requesting pick up. We need transportation assistance for clients regardless of payor source.*

*One of the things we did around the rural community, which is not ideal, but we committed one of our WWC clinic days to a rural community. We were part of a collaboration out there and they had a bus that bussed everybody in. And the clinic was dedicated to the population that day. And it was highly successful. ...It was another organization [that bussed in women]. They have a health collaborative where they're trying to get providers into that area because we don't have mobile mammography, this was the best we could do. The lady who was the chair of the collaborative, her husband was a bus driver and they borrowed the church bus. Some were in that community, which was about an hour away. Some drove to that community, which made it further to get to the bus. Because we didn't just keep it in that area. We included the outlying areas too..... The ideal thing would be to bring the whole clinic [to the women]. The only reason we couldn't was because we were going to do a skin screening and a head-and-neck screening, but it was how to do the mammography. Because our WWC clinic is a one-stop. And we were concerned that they wouldn't come in for the mammography. Ideal would be to have mobile mammography so that you could do the clinic right there.*

*But, we have no Medicaid providers for women's health in [our] county at all, so they have to go to [the neighboring] county. And, so, for some, depending on where they're at, that's an hour and a half. And transportation is an issue... We have no public transportation....we have a whole transportation committee, but it's very slow. Everything that happens, then it disappears again. It's [transportation] hard in rural... My RCCO is [in another county] and they try to do stuff. And we have providers here, but they don't take any new patients on Medicaid. They're maxed out, won't take any new adults. So, I don't see the benefit from RCCO. I appreciate RCCOs, don't get me wrong. But I don't see a direct benefit to my clients because they still have to get down to the [other county]. The RCCO doesn't know how to help us, or they're so busy, they're just overwhelmed.*

*We don't have the transportation.*

*Getting people to clinic is an issue. Mostly for people who don't have access to transportation.*

*We got a new hospital and I got a new contract for mammograms, our mammo screening rate just skyrocketed because they didn't have to go down to the springs to get their mammogram. Local access is there.*

For working clients, scheduling often presents a challenge, according to focus group participants.

*With the working poor, the hardest thing with them is literally they'll set up an appointment, but if they get called into work, they have to work. So that population...They weren't planning on working that day. But if they can, they're going to work. And they get called in. And that happens. A lot. And we don't know until that day.*

*It's something that may not be obvious, but our homeless population doesn't want that 8am appointment because that's when they serve breakfast at the shelter. They don't want that noon appointment because that's when they can get lunch.*

*I think being able to expand clinic hours. That's not a WWC issue, but an in-clinic issue. But not to be 8-5 or 9-5. We start seeing patients every day at 7:30. And we have one day a week where we're open until 7. And we have a lot of patients coming in during those hours because they can't take a day off work, but they can come in at 7:45 and see the doctor before they have to go to work. Or they can come in at 6 when they get off work.*

In one focus group, participants discussed the need to provide additional assistance to clients and how the culture of poverty does not instantly change with access to insurance coverage.

*The culture of poverty isn't changing just because they're insured. It's a big issue that these people still need help. I know we've been talking about that today but I don't know. We don't want to hand hold them. We want to help them grow up but at the same time we don't want the big consequences either.*

*Sometimes I feel like our patients need to be handheld... We have our driver from RCCO. He's going to pick you up. At your house. And drive to you this place. And that's, I feel like that's important sometimes....Our RCCO will pick our patients up even if they don't have Medicaid and take them to specialists or appointments at our clinic.*

Some participants also noted the potential disconnect between clinics and the communities that they're in, either because clients are worried about confidentiality or because they have an ideological concern.

*Also, people drive to [another county] or wherever because they don't want others to see their test results. Because they know everybody. EVERY body...Everybody knows your name. It's not a bar. It's the whole community.*

*I have heard more than once, this doesn't specifically relate to WWC, but getting any kind of public assistance is against their principles, or they won't get on Medicaid or "Obamacare" because it's against their principles, which basically means they're on the other side of the aisle, but they're fine with getting free birth control because it doesn't have Obama's name on it.*

*In most rural counties, there is one provider if any, but then the very conservative/proud community won't even use that one provider. And if that one provider is Planned Parenthood, some people will simply not go. Some people won't go because they perceive the provider as not being anonymous. In a small town, everybody knows everybody.*

*Small communities are often very conservative...A lot of people are very independent and won't participate in anything that smacks remotely as charity. They would rather save money and pay out of pocket because they are anti-government and anti-health reform and they don't want to participate. I'm not sure how closely clinics actually reflect the communities that they're in. Some communities have local coalitions that raise money for women who need health services rather than enroll in a "government program."*

### **Lowering the Age Eligibility for Cervical Cancer Screening**

Though survey respondents did not rank this option in the top tier of priorities, interview and focus group participants were overwhelmingly supportive and excited by the possibility.

*I love the idea expanding services to a broader age range... Let's use the money more effectively for those people who need it.*

*We've also had quite a few patients who aren't on Medicaid and we've had to put them into Komen. But it would be nice if we could put them into WWC because they meet all the requirements except the age requirements.*

*Philosophically, I have an issue with restricting funds on age period. I think age guidelines should be used for treatments of conditions and diseases, not who is eligible for what. "Oh wait, you're too old. Oh wait, you're younger than 40. You're too young. We can't help you." It's one of the things I'm opposed to because we have all kinds of girls who are dealing with past abuse. That's one more restriction, one more rule.*

*It would be easier clinically staffing if there were no age restrictions...These are the patients who are already there. We don't have to go look for them. They're already there for something else. So being able to provide this service and bigger picture philosophically, if we can catch a CIN2, at age 25, and do something about it, then that person becomes somebody who doesn't show up at 39 with full-blown cervical cancer because nobody did anything. I understand why there are guidelines for breast cancer. There's medical evidence for that. I think that cervical cancer specifically is a gap. And I don't think it's following medical guidelines either.*

*The highest risk population [those not getting regular exams] for cervical cancer is not getting screened.*

*Lowering the age for WWC services would be beneficial to us. We mostly have a younger population. 65% of our women are under 50. Also, most women for mammography are under 50.*

*Age eligibility could have a big impact, it would be easy to implement. The biggest challenge would be the work process. And, if there is no change to eligibility, we can expect a continued decline to the point that [our agency] won't be able to sustain all clinical sites.*

*But they're the ones [younger women], that group is going up and down on work and incomes. You're more steady when you're older. At that age group, they're the ones that get lost going on and off insurance.*

*This [lowering the age] is important. And, if you paid for LEEPs, there should be little burden to Medicaid (~1 month). Even with the LEEP, these women should only be on Medicaid for a couple of months. Check with Medicaid to see if they have systems in place to accurately end coverage for BCCP after treatment. If not, could you work with Medicaid to improve their systems? Plus, they're younger women who are less likely to have co-morbidities, so the cost burden to Medicaid should be less than among traditional WWC clients. It would also be good to partner around HPV vaccinations to beef up prevention efforts.*

Participants noted that a lack of funding sources for diagnostic services is often a hindrance to follow-up among younger women with abnormal results.

*I think definitely we have historically difficulty getting those women in after an abnormal Pap. Also, you see a bit more responsibility with the older population. I think from our data, it's about the same between 30-39 and 40-64.*

*I think there are women who would qualify for WWC apart from their age. They're a group that could use the funding.*

*We would be very happy to serve some of our younger women. We have FP patients who come in and get Paps through Title X, but Title X does not currently cover HPV testing. Also, they have to pay out of pocket if they need a colpo and most of our patients cannot afford that.*

*I think we definitely have, for younger women who need colposcopies after an abnormal Pap. That cost is a barrier to them. Komen can kick in for breast, but for cervical issues for younger ladies, that cost really is high. Our colpo is \$330 out of pocket, which is pretty low, but we can do payment plans, and we try really hard not to make it a barrier. But it's still a lot of money for young women.*

*Yes, yes, and yes. We are seeing a huge number of women in their early 30s with abnormal results and high-grade precancerous lesions. Many of these women are working but don't have the income to do follow up treatment (e.g., LEEPs). We do have an Ob-Gyn who does these for about 30% of cost (around \$500) when we refer to him. So, we see women declining treatment because they can't afford it.*

*This is our biggest priority area as this reflects our population. There is a high need for resources for cervical in younger women because there are no other funding sources out there.*

One participant also saw a great need for client education among younger women.

*So my feeling is that the women who are 40-64 are being more proactive about their health because they're starting to ache. It's the 25 year olds who are still in the middle and not bothered. They could qualify for WWC and never use it. Those 20-30 are a higher risk population because they don't have any medical issues yet. They're less likely to come in. They're less likely to get insurance. I may be wrong but I think that's going to be the group that's slowest to signing up.*

Some participants also suggested that there was a need for help among women over 64 who did not qualify for Medicare.

*You know, the other population I've had patients in is the over 64 is because you assume everyone has Medicare and they don't all have it. ...You have to put money into it. So if you have been employed at an agency that didn't take it out. If you have not worked, and your husband didn't include you, there are reasons. I did not know that until it started happening to co-workers of mine where I worked before. They assume that you'll pay for private insurance.*

*We've run into patients who are 70, 65. I think I've seen quite a few this year already.*

### **Eligibility/Enrollment Assistance**

Most survey respondents did not prioritize the need for funding enrollment assistance. Likewise, interview and focus group respondents noted that most agencies have onsite eligibility workers, and the ability to screen and refer clients. Even the smaller agencies that don't have the capacity to screen did not consider this a priority, though.

*We have several enrollment sites, so our patients when they are enrolling, they automatically fill out their Medicaid and CACP applications to see what they qualify for.*

*We also do have a Medicaid enrollment specialist, but if a patient receives a Medicaid denial, it's up to them to enroll in the exchange. We don't do anything for denials.*

*We help with Medicaid enrollment as well.*

*We're just helping them to get enrolled and supporting them if they need help with that. Referring them to social services. They're in the same building. The waiting time for approval is around 2 months and a half or almost 3 months, so they're getting a lot of applications right now.*

*I feel it's under control here.*

*We already do that. If we do get a patient that has no insurance and doesn't know what to do, which is usually in the same building. And we will have screeners who help them navigate and see what they qualify for.*

*Well, I feel like we've already navigated that. Our front staff is already educated. We have other problems. Other needs.*

*This whole Affordable Care Act...Everybody got up to speed. It took a lot of extra time, and still is, but not as bad as before it closed for awhile. It does take a lot of extra clinic time. We're all aware of it because we want people to get into coverage.*

*We're already doing this. Sometimes it takes a week to get an eligibility appointment, but a week isn't bad. I don't think this should be a priority.*

*We connect patients with other resources either within our agency or other community resources that determine eligibility, other partners.*

*This is something we currently do. We have a center in our building so we just refer people straight over there.*

*In an ideal world, yeah. Some sort of navigator of giving patients the help they need in the exchange would be lovely, but over at [our clinic] it seems to be going okay. People seem to be motivated to get health insurance if they are denied Medicaid.*

One agency felt that enrollment assistance is outside of their mission:

*As a safety net clinic, we feel that we are serving women outside of the Medicaid/insurance, so helping with application/eligibility falls outside the scope of what we do.*

A couple of participants felt that some help with navigating clients at this stage of seeking healthcare could be beneficial:

*We could really use the help because the people who are doing...the schedulers are the ones who are screening them for whatever program. And that takes a lot of time. What we do know is that we have a 10-15% abandoned call rate because of all the time it's taking to screen them and to fill out the paperwork with the women on the line. The way I envision it is that the scheduler could do the initial questions on income then transfer them to someone who could fill out all the paperwork so that they'd be all ready to go when they come in. It's just the staffing we could use. So, I'm really talking about our staffing problems.*

*I think historically WWC has always been a staff-heavy requirement kind of a program. It does take a lot at all levels in managing that. The BPS does assist but I can't imagine that we're the only ones who feel like it doesn't completely cover everything. So with all of these new challenges, so if they get Medicaid in the middle of the process and we're still managing it, then we don't get reimbursed for that. On the front end, it can be a really time-consuming process. Depending on*

*the size of your agency and your staffing, so whether it's an FTE or some sort of CM or enrollment eligibility reimbursement, that would be something interesting to consider.*

Participants also raised concern about putting responsibility for Medicaid enrollment in the hands of service providers:

*The patient responsibility amount may be bigger than the Medicaid rate, so there's a disincentive to enroll clients in the private marketplace.*

*One clinic is now taking Medicaid. They say that they lose money on every patient now. Most patients were previously self pay.*

### **Quality Improvement Through Health Systems Change**

Most direct service providers did not see immediate value in prioritizing health systems change either on the survey or in focus groups and interviews. A couple did not feel positioned to undergo a quality improvement process. Some focus group participants felt that they were already engaged in population-based in-reach activities and did not see a need to undergo such an endeavor.

*We're not there yet.*

*We already do in-reach.*

*We have to look at payor source. We have an EHR...And our records are systemwide, so we have access to all of those records. We're doing really great with that. We're looking at meaningful use...*

*We do pull reports and go through patients who are in need of screenings. Those patients who haven't had a mammogram for two years and we'll call those and we'll send a letter for the patients to come in. Every patient who walks into the clinic and if they're eligible for a mammogram, we'll give them the application to fill out for WWC, and we do get them through.*

*I was actually hired...specifically for process improvement... We have a large group of patients and clinical staff who are working on improving these things.*

*We do quite a bit of in-reach, but how we get a lot of patients screened ...is that process. You kind of have to, with as large and spread out as [our agency] is.*

*We've got a quality improvement director now.*

*We have a new billing vendor who only works with [our agency] and the vendor is leading the current change process.*

*Promotoras do a lot of in-reach. We're also undergoing clinic-wide improvement. We hired a new business manager and she's been following staff to help improve efficiencies.*

Some participants showed an interest in the health systems change, but also saw challenges.

*I think it's important to take the opportunity to fund any effort to help any health provider willing to build efficiencies, both with converting to EHR and improving procedural systems. Several—especially small—clinics don't have the ability, or don't know how, to access their data.*

*In term of systems change stuff, that kind of approach works well in some settings, but not in larger umbrella organizations, at least at local level. I work with local health dept meeting with 1-*

*2 people. Getting information standardized and transmitted through the health department seems nearly impossible. Planned Parenthood is going through ton of changes. It's worth pursuing systems change with larger organizations (especially Planned Parenthood) because that needs to happen from the top down.*

*We've done a little bit of this. I am all about anything to make us more efficient and better serve our clients. I'm not sure about the rest of the team. I'd have to ask. But I think this would be a valuable endeavor.*

*[Our agency] does not do any in-reach at this time, but it's something our director has been throwing around.*

*I believe we're already in talks with someone about improving our systems. I don't know if they're going to be able to do that. If WWC was willing to provide some kind of funding for this, that would incentivize us to participate.*

*Someone has been in touch with our medical director about this. I don't know if they've committed. If there was a carrot involved in terms of funding... They'd probably be willing to do it without the carrot, but it wouldn't hurt.*

Others were specifically interested in ways to launch patient portals as a way to improve efficiencies and outcomes.

*The thought is, and we're trying to look at patient portals now, through grant funding. How we implement that patient portal so that patients have immediate access to their results, making appointments. That might connect to something we were talking about earlier, that lack of follow through. So if they had access to it in the safety and comfort of it in their own home, would they be more likely to follow through? To check those results, and make follow up appointments, and therefore improving not only the quality of the organization, but their own health.*

*We are being pushed for meaningful use. Clearly patient portal is the next step. Level 2.*

*I know we're doing a big push for our patient portal and trying to get all of them. Our patients don't have computers to access the program....But many of them have much nicer phones than I do so they could access it there.*

### **Infrastructure Development for Billing Medicaid and Private Insurance**

Most participants represented agencies that already bill Medicaid and therefore did not have a need for infrastructure development. As such, they did not consider infrastructure development a priority for WWC. One agency had a demonstrated need for help with infrastructure development, but thought that the need was so high and dependent on so many other factors, that the value of such an undertaking would depend on other factors.

*And the need is there because although many of our patients now have Medicaid doesn't mean that they're getting in to see anyone. In fact, we're hearing that they're having a very hard time getting in to see anyone. And we have patients that call us all the time and would like to come in and see us, and they're not allowed to see us. When they call the call center, they're asked if they have Medicaid, and if they say yes, then they're told, "sorry we can't see you."*

*I think our agency is so far behind on infrastructure that – I won't say we'd decline a small pot of money – but that might be a question I can't answer for sure. It would depend on a number of factors as well, especially eligibility expansion.*

## HPV Vaccines

One focus group conversation raised the possibility of providing HPV vaccinations for younger clients, particularly among women ages 19-26. They noted that there is some public health grant funding to help pay for these vaccines, but the funding is limited and uncertain.

*It's \$150 a shot, 3 shots. Who's going to come up with \$450 for the series? Seriously once people are 19, they're no longer VFC [Vaccines for Children].*

*We have done that with special projects grants so that we've had free vaccines in that gap age group.*

*I don't know where we get it, but I can get funding for HPV vaccines...It would be nice to have. We don't know, and you wouldn't know, if you're going to get that funding again... And there was a gap. There was a time when I had some that were expiring but [clients] weren't finished [with the series]. And you have to make decisions. Do you borrow from Peter to pay Paul? Or do you just not do that third shot?*

*Well, we can get state-funded vaccines because we have public health in our facility. At the same time, you never know when you're going to get state funding for HPV.*

Some participants thought that HPV vaccines needed a bigger spotlight to clarify misconceptions about the vaccine.

*I think taking a position on it would put it in the spotlight. It is important I think. There's a reason our vaccination rates stink in the US. ...And then you tell a parent about it and they're like, 'oh, my child is never going to have sex.' And then they don't get it. And then their kid is 20 and has never gotten vaccinated.*

*I think some people think it's giving them permission to have sex.*

*You know, parents come in and tell me that, "Oh my kid's not having sex. She's 11." And I tell them "I don't care. She's going to have sex someday whether it's tomorrow, in 10 years, in 15 years. She needs to have this vaccine today so that in 15 years she doesn't get this [cancer]."*

*Most people have sex at sometime in their lives.*

*I say this from the perspective of a larger organization that's really crappy at HPV vaccinations. We're really good with the peds. Once they're out of peds, we forget. No primary care provider is going to offer HPV vaccines.*

*Well, our agency is much smaller than yours. I know all of our MAs set actions. So if I give you your first HPV shot today, I'm going to set an action to myself and it's going to pop up in a month to call this patient and say "hey you need to come in for your second shot. You need to come in."*

## Emerging Issues

### *Interagency Collaboration*

One focus group addressed the fact that some agencies could not provide cervical diagnostics on site or refer clients to a provider for a reasonable cost. The following (abridged) conversation describes a potential solution with a state-coordinated effort.

*I know there's one provider who ... just gives patients my extension and tells them, Call [sic] and tell her you need a colpo and she'll get you in. And I do. Because it's important. And a lot of them are coming to me as non-WWC and coming to me for colpo. And I help them. And it's great. And that's the way it should work. ...When I just said that, I thought, gosh, the state should know that we are able to do that we have access to colpo and LEEP and –I don't know how this would work with billing but—but we should be able to, that if somebody in your organization called and said that this patient needs a colpo, we'll get them in and do their colpo...there should be some resource.... I can see putting some effort into creating that. Creating the situation where somebody does colpos for WWC patients. Send somebody from a different town one day a month. Get them all done. Have that possibility. And have the state maybe put some effort into arranging that. I don't have the time to coordinate it. You don't have time coordinate. But I'm sure there are other people like myself who would be willing to come out there and do colpos for a day. For free even. The sort of coordination of who could do it, and who would organize that, and how that would happen. And I could argue that you could find people to do it on a volunteer basis even. I don't see any reason this couldn't be done. But you need the resource.*

*I've been entertaining that with [another agency] because they do colpos there and they do them for free. They do almost all their services for free, but they have WWC now. But she says "could I bring it up?" But there is a coordination thing, you and I do immunizations and communicable disease and everything else as well, how do we get everybody to herd the cats and get everybody in the same place in the same time to get their colpos?*

*If there was somebody at the state level who could coordinate it, that would be great.*

*Obviously we're still going to have to do at our own clinic to make it happen. And I've talked to a [community partner] about getting a bus to get everyone on a bus to go get their mammograms at the hospital. It wouldn't just be WWC people. It would be Komen people, WWC people, Medicaid, for any woman that needs a mammogram. But then I think of this logistical nightmare if I'm trying to do all this and there are all these women at the hospital who are waiting for their turn at the mammogram, doing their paperwork. So, it's bigger, but it's a great idea. This thing about the colpo, it's a great idea, but it needs some support. Staff support. FTEs.*

*But I agree with you. Out of all the facilities that have WWC providers able to do colpos, people are going to be willing to travel for a day, once a quarter. Switch it around. Go to different facilities. Craig is willing to go this day. Denver can go this day. Whatever you have to do. Then one person has to travel once a year. Then that service is in that area.*

*I think you could argue to any of the organizations participating in this that that's important. That's a worthwhile endeavor. Then maybe you could find a scope. Maybe you know someone who does \$300 colpos. And maybe they could be coerced into lending it to you for a day. It's not something that you're necessarily going to break or damage. People, it's not rocket science, really. It's just certainly not \$300 worth of rocket science. And then WWC would cover the lab costs on WWC clients. And the pathology costs aren't the big expense, it's the provider.*

*Well if you're talking rural, a van at the state. This is kind of crazy. If the state owned the equipment, I'd say it'd be around \$12-15K would get you all the equipment you needed. And there was a way, a method of getting it to a clinic and set it up. There's no reason you can't get it to other people's clinics and set up. It's not big. You can get it in the back of the car. The LEEP machine is a little box.*

*I think providers would be willing to give up an exam room for a day to get this stuff done.*

*I think it's a creative way to solve the problem. If your patients aren't going to go get a colposcopy, then can we bring the colpo to them? In the bigger picture, is there a way we could dodge the undocumented issue by doing really low-cost. If we had that mobile clinic and the scope was provided, the autoclaving was provided, the instruments, then, what else is there? The cost of people and gas.*

*Absolutely. We just started this thing. We have a backpack. If it's below 10 degrees in Aurora, we do care from 6-10 in the field who won't go to the shelter, we treat them there. If they will go we drive them. But we've got the backpack. We carry everything we need. Colposcopes can be pretty simple.*

*The biggest thing. They won't get their colpo done if there's no payor source. If there is a payor source, it takes longer than we're supposed to.*

*But it takes 15 minutes. If someone will donate their time. And if you have the instruments. They're expensive, but you use them over and over. It's easier to solve than the breast cancer situation because it's harder to get a mobile biopsy unit. You can't take the ...biopsy.*

*I think that's an excellent idea.*

## Miscellaneous

Focus group and interview participants raised other possible options and considerations, but these were not discussed:

*If there could be some way for any provider to bill WWC. If there could be some way for non-WWC providers in those rural areas to have a subcontractor provide initial exams. Not a large number, but reaching populations that don't have services. Some counties have one town.*

*Collaborate to create a universal HIPAA form.*

*It's important to note that it's not just ACA that may be causing some changes. The changes in recommended intervals in screening also have an impact. Many women equate Pap with office visit, so when the timeline extends to 5 years, it's very difficult to get women into the office for annual wellness visits. So not only are there fewer eligible WWC women in the pool of current clients, they also need fewer services.*

## Appendix C: FY 2014 WWC Grantees

Boulder Valley Women's Health Center  
Clinica Colorado  
Clinica Family Health Services  
Clínica Tepeyac  
Colorado Coalition for the Homeless  
Community Health Clinic (Dolores)  
Community Health Services  
Delta County Health Department  
Denver Health and Hospital Authority  
Denver Indian Health and Family Services  
Dream Centers Women's Clinic  
Exempla St. Joseph Community Clinics  
Grand River Health  
Gunnison County Public Health  
High Plains Community Health Center  
Hue N. Vo, M.D.  
Kit Carson County Health & Human Services  
Lake City Area Medical Center  
Marillac Clinic  
Metro Community Provider Network (MCPN)  
Mountain Family Health Centers  
Mt. San Rafael Hospital  
Northwest Colorado Visiting Nurses Association  
Parkview Adult Medicine Clinic  
Peak Vista Community Health Center  
Penrose St. Francis Hospital  
Planned Parenthood of the Rocky Mountains  
Prowers Medical Group  
Pueblo Community Health Center  
Salud Family Health  
San Juan Basin Health Department  
San Luis Valley Health  
Southern Colorado Family Medicine  
Spanish Peaks Outreach and Women's Clinic  
St. Mary's Family Medicine Center  
St. Thomas More Hospital  
Summit Community Care Clinic  
Sunrise Community Health Center  
Teller County Public Health  
Tri-County Health Department  
Uncompahgre Medical Center  
Valley-Wide Health Systems  
Weld County Department of Public Health & Environment  
Yuma District Hospital

## Appendix D: Interview and Focus Group Participants

**Sundari Birdsall**, Boulder Valley Women’s Health  
**Nikky Bresny**, Colorado Coalition for the Homeless  
**Laurie Broder**, Tri-County Health Department  
**Heather Brown**, Northwest Visiting Nurses Association  
**Debbie Channel**, Spanish Peaks Outreach and Women's Clinic  
**Esther Clark**, Planned Parenthood of the Rocky Mountains  
**Rebecca Daniels**, San Luis Valley Health  
**Karen Forest**, American Cancer Society  
**Jenniffer Gonzalez**, Summit Community Care Clinic  
**Jennifer Halfacre**, Clínica Tepeyac  
**Cindy Killip**, Yuma District Hospital  
**Laura Larson**, Metro Community Provider Network  
**Jane Lose**, Metro Community Provider Network  
**Claire McArdle**, Sunrise Loveland Community Health Center  
**Laura McLoughlin**, Gunnison County Public Health  
**Darlyn Miller**, Teller County Public Health  
**Jennifer Miller**, Dream Centers Women’s Clinic  
**Evi Molina**, Clinica Family Health Services  
**Wendy Nading**, Tri-County Health Department  
**Toni Panetta**, Komen Colorado  
**Beatriz Perez**, Metro Community Provider Network  
**Cynthia Quijas-Barker**, Peak Vista Community Health Center  
**Randi Rycroft**, Colorado Central Cancer Registry  
**Mary Scheid**, Northern Colorado Medical Center  
**Ashley Shurley**, Denver Health Mobile Clinic  
**Heather Sorensen**, Tri-County Health Department  
**Selena Sotelo**, Metro Community Provider Network  
**Peggy Thomas**, Penrose Cancer Center  
**Vicki Tosher**, Colorado Breast Cancer Coalition  
**Joanne Vermeulen**, Exempla Saint Joseph Hospital

## Appendix E: Sample Interview/Focus Group Protocol

### INTERVIEW & FOCUS GROUP QUESTIONS (Prompts in *italics*)

#### WHAT ARE YOU EXPERIENCING?

1. What are your experiences since implementation of the ACA on January 1st, at your agency?  
*Are you seeing any changes? If so, what do you think is causing those changes*  
*Are you seeing fewer un/underinsured patients since Jan? Are previous clients now insured*  
*Are total client numbers stable, but payor sources changing*  
*Is there anything else impacting your clients/your agency?*
  - a. If your agency has multiple clinical sites, are you seeing any variations by site?
  - b. Are you making any changes to the way you do business? If so, please explain.

#### WHAT DO YOU NEED?

2. What are the biggest challenges your agency is currently facing? What are your agency's most pressing needs? In relation to breast and cervical cancer screening/diagnostics, and overall.  
*What are your gaps in service, and the underlying causes? What needed breast and cervical screenings/diagnostics and/or treatments are not being funded? Why?*

#### HOW CAN WWC HELP?

3. I've listed some options that we've identified as priorities among WWC agencies. I'd like to spend a few minutes talking about the pros and cons of each option as it relates to your agency. *So, as you're thinking about each of these options, please consider (and feel free to comment on) these questions: Is there a need for this service at your agency? Do you currently have this service in place? If not, why not? Would you want this service at your agency? If so, what would it take to implement? (e.g., funding, training/TA, etc.)*
  - a. **Identifying potential clients** (e.g., hard-to-reach, un(der)served communities who are likely eligible for WWC) *What does this look like? Would CDPHE take the lead or who would have the most expertise?*
  - b. **Community outreach and education** e.g., WWC (CDPHE) partners with local community organizations that already work with hard-to-reach and/or underserved communities.  
*Is this something your agency would have the ability to do?*
  - c. **Mitigating barriers to get clients to clinic: language, transportation, etc.**  
*What kind of 1:1 data could you provide?*
  - d. **Determining eligibility/application assistance** (Medicaid, insurance, WWC, etc.)  
*Do you do this now? What would it take for you to do this?*  
*What would be the best payment structure (i.e. add level to BPS, or fund staff time?)*  
*What would you estimate the cost of this activity being per client?*
  - e. **Care coordination for clients regardless of payor source** (i.e. separate care coordination costs from procedure costs in BPS): patient navigation and case management  
*Do you partner with your RCCO? What role do they play?*  
*Do you already offer this for non-WWC clients? What is the funding source?*
  - f. **Infrastructure development to bill Medicaid/private insurance**  
*What support would be needed?*
  - g. **Health systems change/quality improvement practices**, e.g., establish foundational & sustainable practices to systematically reach entire clinic population to ensure every client receives appropriate screening (may not be at their clinic)
  - h. **WWC age eligibility to women 30-39 or 21-39 for cervical screening and diagnostics?**  
*This type of effort would likely require legislative change. Would you support that process?*  
*What are the current cervical cancer treatment (referral) options for this population?*
4. Do you have additional priorities for WWC other than those already mentioned? If so, what are they?  
*(Reiterate options)*
5. Is there anything else you'd like to add about the future of WWC services at your agency?
6. Who else should we talk to?