ScreenWise New Forms Training

Call in for audio! (888)636-3807

Participant code: 143095

New form training webinar for the ScreenWise Program providers and partners.

Forms Valid 01/01/2019

Oregon Health Authority

SCREENWISE PROGRAM
Public Health Division

ScreenWise

- Program of the Oregon Health Authority
- Uses federal, state and non-profit funding
- Helps low-income, uninsured and medically underserved women gain access to lifesaving breast and cervical cancer screening and diagnostic services.
- Network of providers throughout Oregon

Responsibilities of Enrolling Providers

- Providing quality care
- Providing care coordination and referrals to needed services
- Submitting all patient data on approved forms to ScreenWise
- Connecting to cancer treatment when diagnosed

ScreenWise Patient Eligibility

A patient must meet the following requirements to be enrolled in ScreenWise:

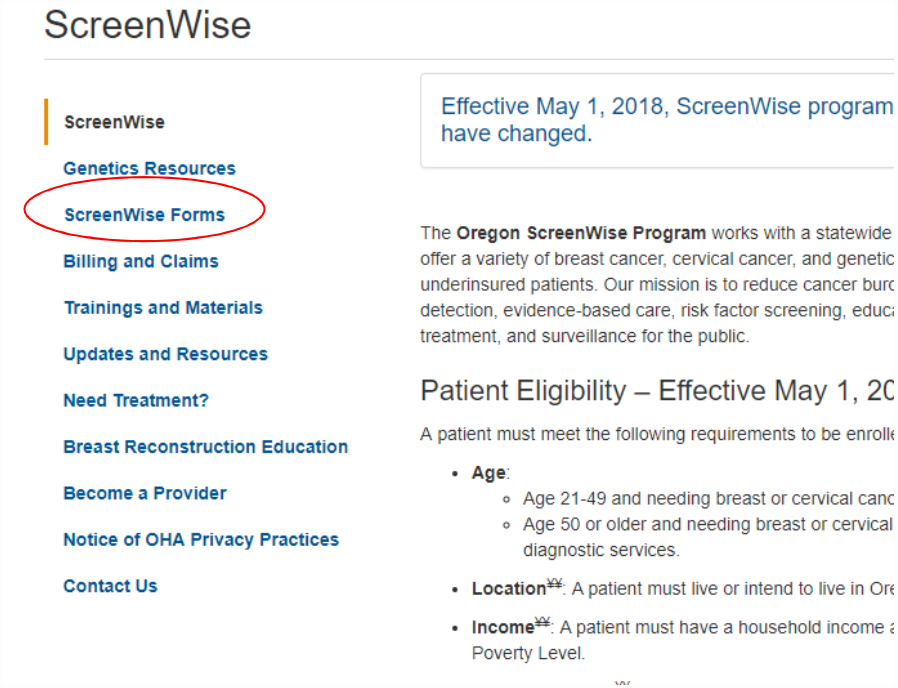
- **Age**:
  - Age 21-49 and needing breast or cervical cancer diagnostic services¥.
  - Age 50 or older and needing breast or cervical cancer screening or diagnostic services.
- **Location**¥¥: A patient must live or intend to live in Oregon.
- **Income**¥¥: A patient must have a household income at or below 250% of Federal Poverty Level.
- **Insurance status**¥¥: A patient must either have no health insurance OR have health insurance, but not enough to cover their needs.
- ¥ Need for diagnostic services to be determined by clinician
  ¥¥ Location, Income and Insurance information is self-declared by client

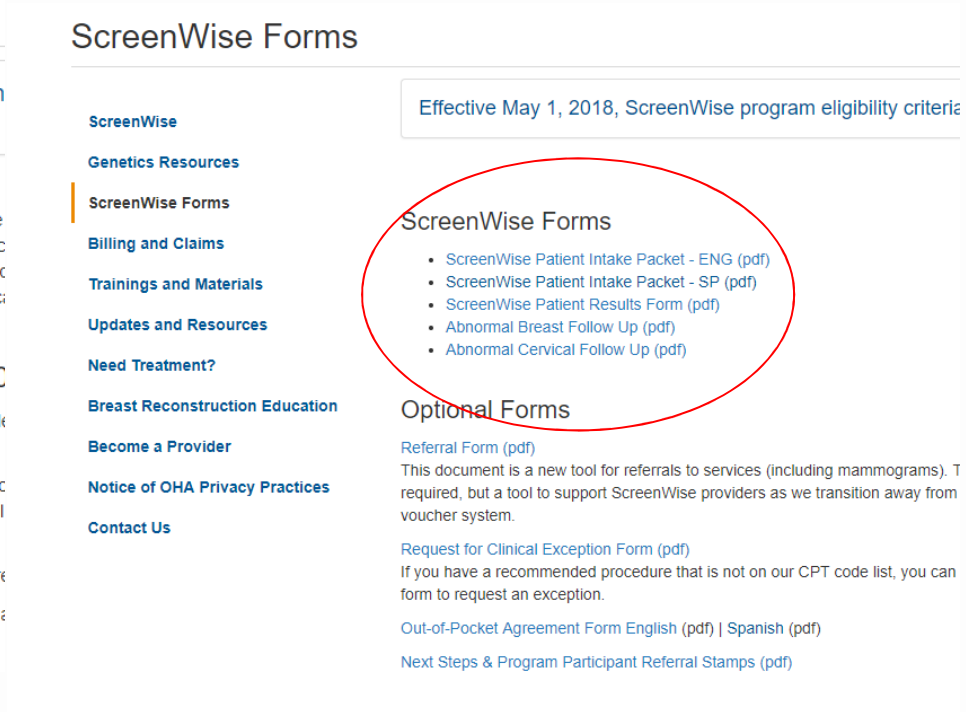
Forms Submission

- Forms can only be submitted by enrolling providers with current medical service agreements (MSAs) with the ScreenWise program.
- Forms must be submitted through the ScreenWise secure portal. Fax submissions are not recommended as receipt is not guaranteed. Send the forms via our secure portal https://secureemail.dhsoha.state.or.us/encrypt to the following e-mail address: Screenwise.info@state.or.us
- Providers must determine eligibility prior to providing ScreenWise services. ScreenWise does not provide eligibility confirmation.
- All forms are manually entered into the ScreenWise database by ScreenWise staff members
- Before submitting forms check for legibility and completion: The use of fillable PDFs are highly recommended

Form Locations

You can find our programs required patient data forms on our website: www.healthoregon.org/screenwise and clicking on “ScreenWise Forms”





Intake Packet Submission Specifics

- Intake Packets must be submitted within 5 days of the date of service.
- All 3 pages must be submitted for enrollment into the ScreenWise program. The absence of pages will delay or prevent patient enrollment.
- All fields must be answered. Otherwise a patient can not be enrolled into the program.
- Dates of service must be current, not back dated or pre-dated.
- Patients cannot be enrolled presumptively (i.e. a patient must have services ordered, not assumed)
- *Reminder* patients under 50 years of age are not eligible for screening services and must receiving diagnostic services (ordered and determined by a provider) necessary to rule out cancer..

Intake Packet Submission Specifics

Breast Cancer Risk Definition:

- "Yes" answer deems a patient "high risk"
  - Defined as a patient with BRCA mutation, a first-degree relative who is a BRCA carrier, a lifetime risk of 20-25% or greater as defined by risk assessment models, radiation treatment to the chest between ages 10-30, or personal or family history of genetic syndromes like Li-Fraumeni syndrome.
- "No" answer deems a patient not "high risk" by the above definition
- "Unknown" deems no assessment was done

Cervical Cancer Risk Definition:

- "Yes" answer deems a patient "high risk"
  - Defined as patients with prior DES exposure and immunocompromised patients.
- "No" answer deems a patient not "high risk" by the above definition
- "Unknown" deems no assessment was done

PUBLIC HEALTH DIVISION
ScreenWise Program

ScreenWise Program
Patient Intake Packet

Oregon Health Authority

Enrolling agency: _____ Site name: _____

Medical record number: _____ Date of enrollment: _____

Patient full name:		
Date of birth:	Sex: ☐ Female ☐ Male ☐ Other	☐ Homeless or unstable housing? (*If so, check box and only write ZIP code and county below*)
Home address:	Apartment number:	
City:	State:	ZIP:
Phone:		County:

Do you have health insurance or Medicaid?:	☐ Yes ☐ Yes, but not enough to cover my needs ☐ No
What is your **gross monthly household income?** (*This is the total income before taxes for all household members*):	$_____ monthly
How many people live in your household (*including yourself*)?:	_____ people

Hispanic or Latino origin?:	☐ Yes ☐ No ☐ Don't know/not sure ☐ Don't want to answer
Race (*check one or more*):	☐ American Indian or Alaska Native ☐ Asian ☐ Black or African-American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Don't know/not sure ☐ Don't want to answer
In what language do you prefer to read?	☐ English ☐ Spanish ☐ Other:

*** Submit all intake packet information to ScreenWise within 5 business days**

Patient consent

The Oregon ScreenWise program (*ScreenWise*), a program of the Oregon Health Authority, aims to reduce breast and cervical cancer, by promoting prevention and early detection.

ScreenWise may pay for:

- Screening and diagnostics for breast or cervical cancer
- Screening for hereditary cancer using genetic counseling and testing for BRCA 1 and 2 to identify high-risk patients
- Patient navigation and support

ScreenWise will not pay for breast or cervical cancer treatment. If treatment is needed, patients may apply for the Medicaid Breast and Cervical Cancer Treatment Program (BCCTP).

By signing this form, I **understand** that:

- My enrollment may start up to three months before the date signed below, allowing ScreenWise to pay for eligible claims during that period.
- I will remain enrolled in ScreenWise for one year while I am still eligible and do not ask to be taken out of the program.
- My provider will assess my eligibility to remain in the program every year.
- ScreenWise, my medical care providers, clinics and/or hospitals may share information with one another about my health care and any related medical care I receive through ScreenWise; and may organize my care and involvement in appropriate screening and/or diagnostic services, genetic counseling, and testing related to breast and cervical cancer.
- My information will not be shared with anyone outside of the Oregon Health Authority, its contracted providers and funders; and any published report will not use my name.
- I may receive written, telephone or electronic communications related to ScreenWise services.
- My provider must tell me in writing about any services that are not covered by ScreenWise.

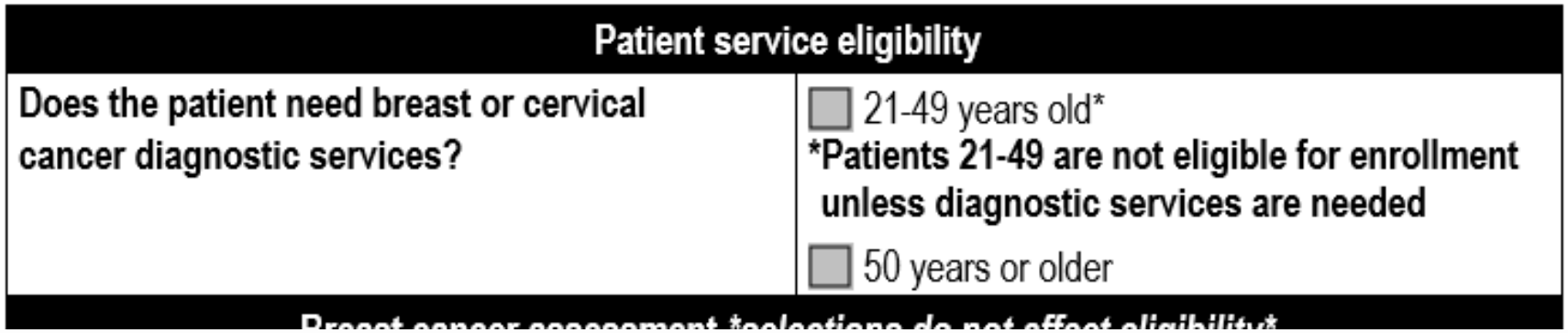
By signing this form, I **confirm** that:

I meet all of the following eligibility requirements for the program:

- ✓ I live in or intend to live in Oregon
- ✓ My household income is at or below 250% of the Federal Poverty Level
- ✓ I do not have insurance or my insurance does not fully cover my needs

Patient signature: Date:

Patient name (*printed*):



Patient service eligibility	
Does the patient need breast or cervical cancer diagnostic services?	☐ 21-49 years old* ***Patients 21-49 are not eligible for enrollment unless diagnostic services are needed** ☐ 50 years or older
Breast cancer assessment *selections do not affect eligibility*	

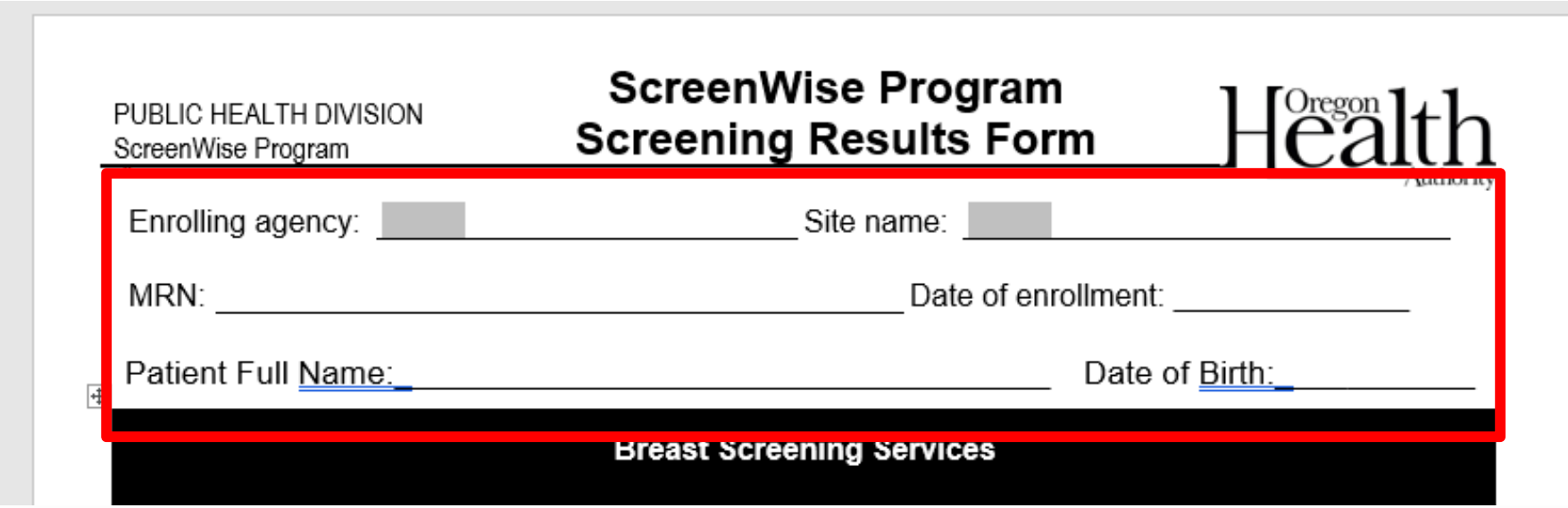
- Patients 21-49 must be enrolled only after a provider has determined that they require breast or cervical cancer diagnostic services.
- If this box is omitted patients 21-49 will not be enrolled until the paperwork has been submitted with the correct selection
- If diagnostic services have not yet been determined as necessary patients should not be preemptively enrolled.

Breast cancer assessment *selections do not affect eligibility*	
Ashkenazi Jewish origin?	☐ Yes ☐ No ☐ Unknown ☐ Refused
Has patient, or any of their close blood related relatives ever been diagnosed with breast, fallopian tube, male breast, melanoma, ovarian, pancreatic, peritoneal, or prostate cancers?	☐ Yes ☐ No ☐ Unknown ☐ Refused
Breast cancer risk?	☐ Yes ☐ No ☐ Unknown
Breast cancer services	
CBE date: _____ (MM/YYYY)	☐ Normal exam/benign finding ☐ Abnormal/suspicious for cancer ☐ Not performed
Mammogram ordered?	☐ Yes ☐ No ☐ Sent directly for diagnostics (*e.g. ultrasound, etc.*)

Cervical cancer assessment *selections do not affect eligibility*	
Previous pap?	☐ Yes, date (*if known*): _____ (MM/YYYY) ☐ No ☐ Unknown
Cervical cancer risk?	☐ Yes ☐ No ☐ Unknown
Cervical cancer screening services	
Pap date: _____ (MM/YYYY)	☐ Routine screening ☐ Surveillance ☐ Pap elsewhere, referred in for diagnostics ☐ Pap after primary HPV+ ☐ No pap done ☐ No cervical services performed
HPV ordered?	☐ Yes ☐ No

ScreenWise Results Form Specifics

- Results forms need to be completed in full and returned once all initial results have been received.
- Enrolling providers, not ancillary providers, are responsible for submitting results to ScreenWise.
- Dates must be provided for all services.
- The results form is 2 pages. **The form will be denied if both pages are not submitted.**
- In order for this form to be considered complete, all results and follow-up recommendations need to be completed for the current date of service.
- Sections shaded in grey require the completion of the Final Outcome form.
- Dates of service must be current, not back dated or pre-dated.



PUBLIC HEALTH DIVISION
ScreenWise Program

ScreenWise Program Screening Results Form

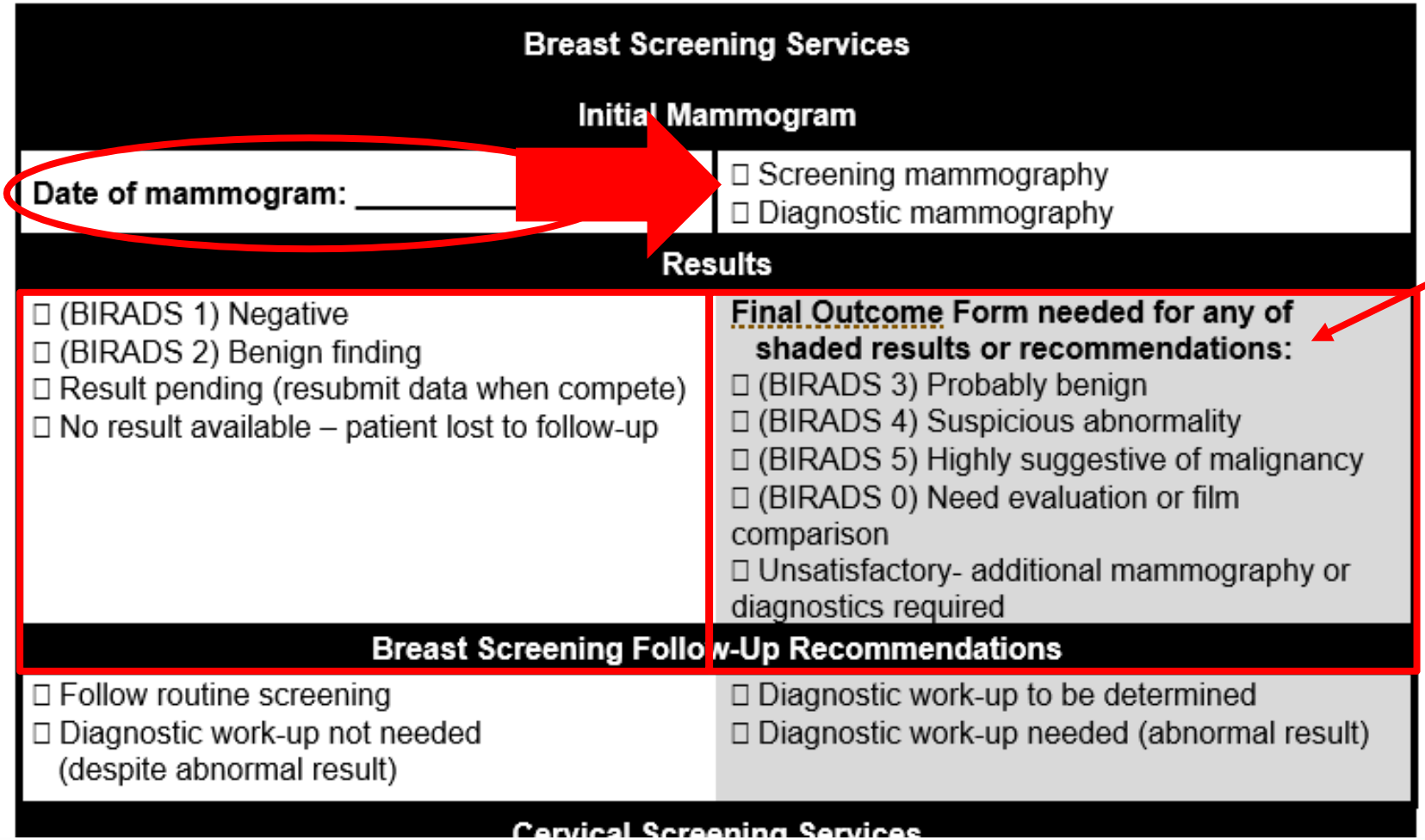
Oregon Health Authority

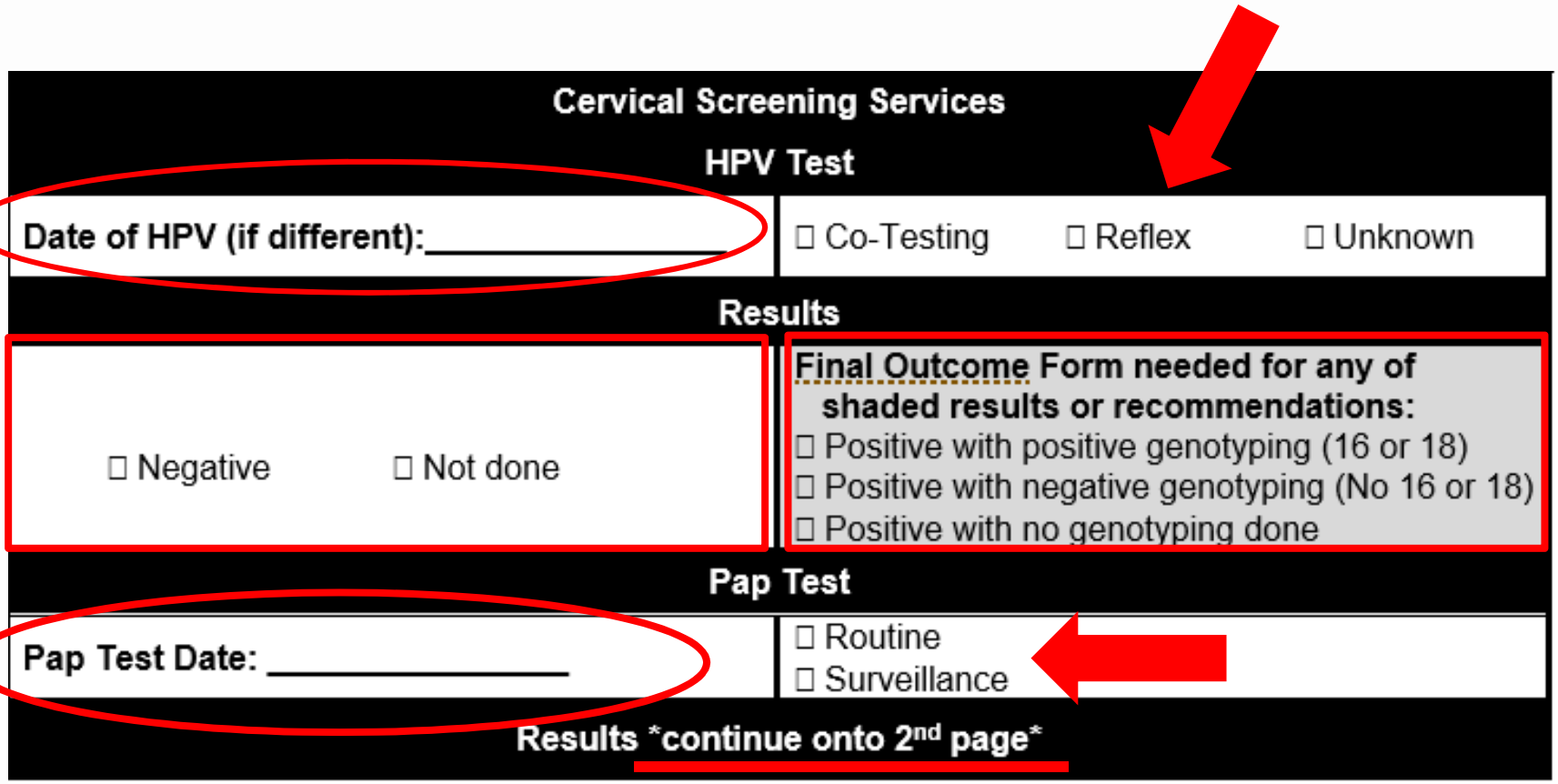
Enrolling agency: _____ Site name: _____

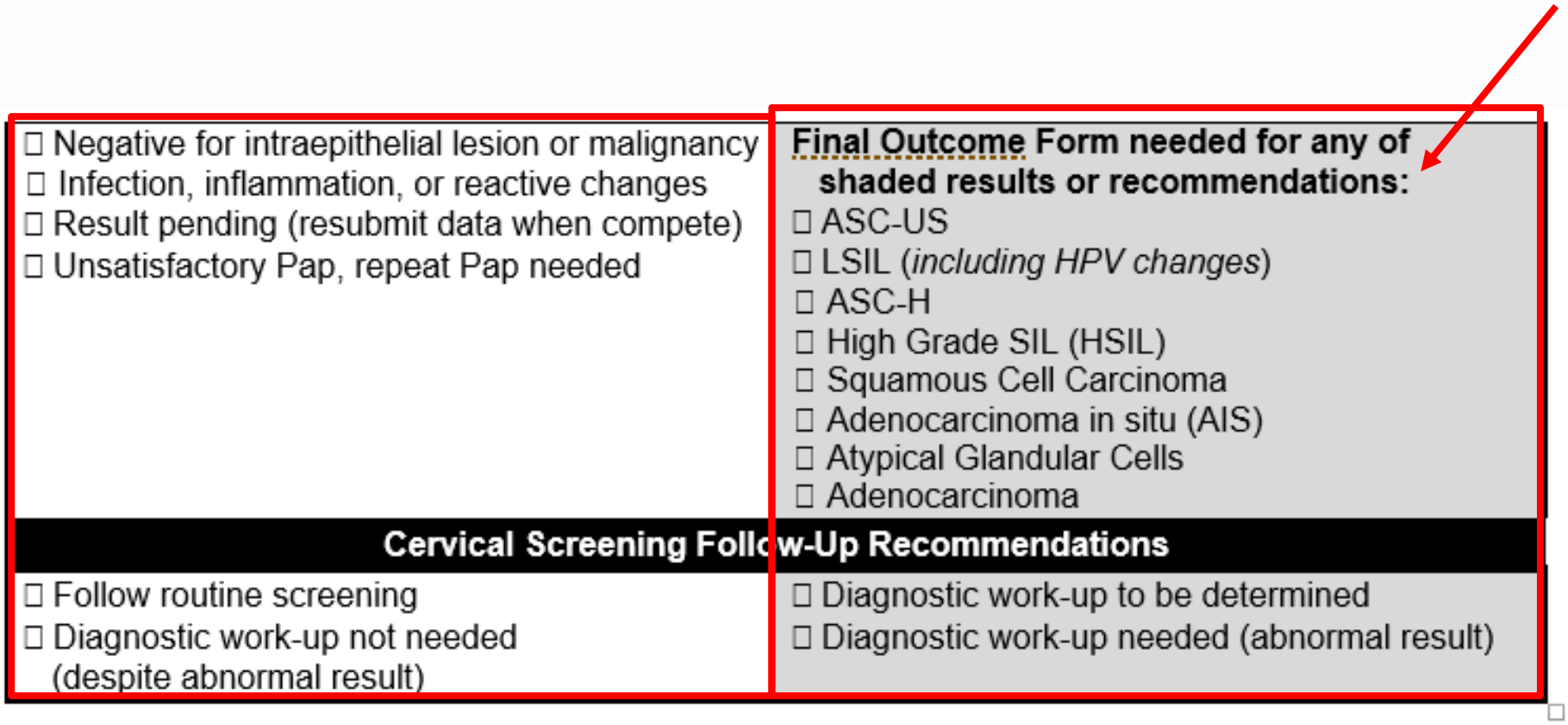
MRN: _____ Date of enrollment: _____

Patient Full Name: _____ Date of Birth: _____

Breast Screening Services


Breast Screening Services
Initial Mammogram
Date of mammogram: _____
☐ Screening mammography
☐ Diagnostic mammography
Results
☐ (BIRADS 1) Negative
☐ (BIRADS 2) Benign finding
☐ Result pending (resubmit data when compete)
☐ No result available – patient lost to follow-up
Final Outcome Form needed for any of shaded results or recommendations:
☐ (BIRADS 3) Probably benign
☐ (BIRADS 4) Suspicious abnormality
☐ (BIRADS 5) Highly suggestive of malignancy
☐ (BIRADS 0) Need evaluation or film comparison
☐ Unsatisfactory- additional mammography or diagnostics required
Breast Screening Follow-Up Recommendations
☐ Follow routine screening
☐ Diagnostic work-up not needed (despite abnormal result)
☐ Diagnostic work-up to be determined
☐ Diagnostic work-up needed (abnormal result)
Cervical Screening Services


Cervical Screening Services
HPV Test
Date of HPV (if different):_____
☐ Co-Testing ☐ Reflex ☐ Unknown
Results
☐ Negative ☐ Not done
Final Outcome Form needed for any of shaded results or recommendations:
☐ Positive with positive genotyping (16 or 18)
☐ Positive with negative genotyping (No 16 or 18)
☐ Positive with no genotyping done
Pap Test
Pap Test Date: _____
☐ Routine
☐ Surveillance
Results *continue onto 2nd page*



☐ Negative for intraepithelial lesion or malignancy ☐ Infection, inflammation, or reactive changes ☐ Result pending (resubmit data when compete) ☐ Unsatisfactory Pap, repeat Pap needed	**Final Outcome Form needed for any of shaded results or recommendations:** ☐ ASC-US ☐ LSIL (*including HPV changes*) ☐ ASC-H ☐ High Grade SIL (HSIL) ☐ Squamous Cell Carcinoma ☐ Adenocarcinoma in situ (AIS) ☐ Atypical Glandular Cells ☐ Adenocarcinoma
Cervical Screening Follow-Up Recommendations	
☐ Follow routine screening ☐ Diagnostic work-up not needed (despite abnormal result)	☐ Diagnostic work-up to be determined ☐ Diagnostic work-up needed (abnormal result)

Final Outcome Form Specifics

- Final outcome forms are required for anyone needing diagnostic services, have a screening result that is suspicious or inconclusive (as outlined in gray on the Results Form), or who receive(d) a cancer diagnosis.
- Final outcome forms need to be completed in full and returned once all patient services complete.
- Enrolling providers, not ancillary providers, are responsible for submitting final outcomes to ScreenWise.
- The final outcome form is 2 pages. **The form will be denied if both pages are not submitted.**
- Dates of service must be current, not back dated or pre-dated.
- In order for this form to be considered complete all indicated fields for the outcomes being provided (breast, cervical, or both) must be completed including date fields.

PUBLIC HEALTH DIVISION
ScreenWise Program

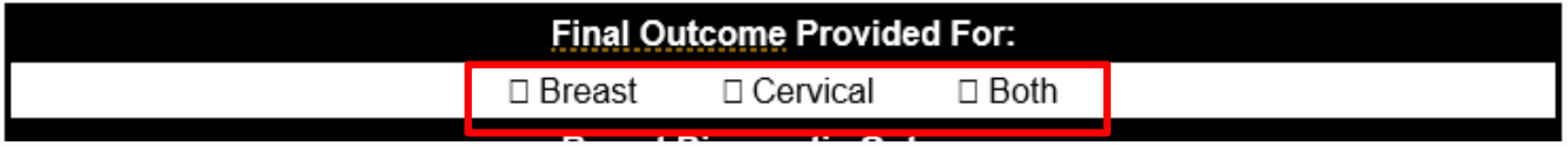
ScreenWise Program
Final Outcome Form

Enrolling agency: _____ Site name: _____

MRN: _____ Date of enrollment: _____

Patient Full Name: _____ Date of Birth: _____

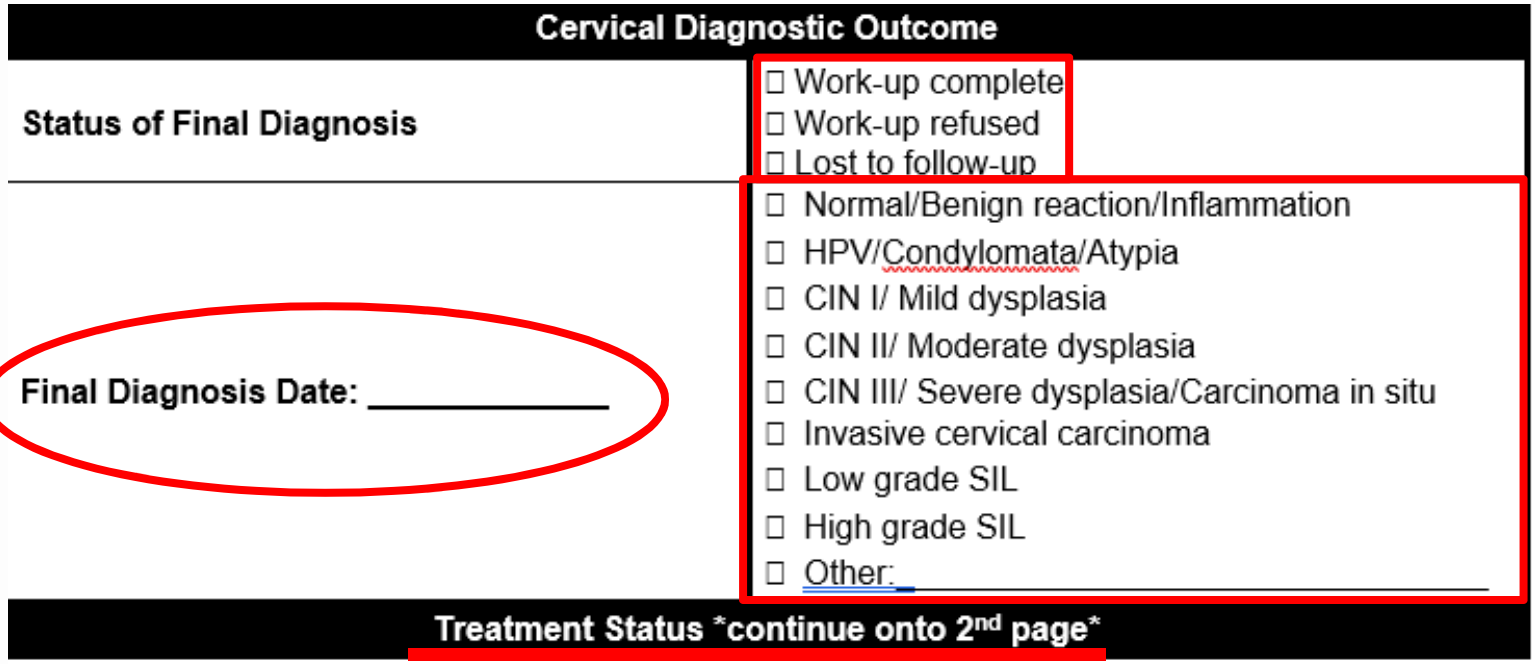
Final Outcome Provided For:

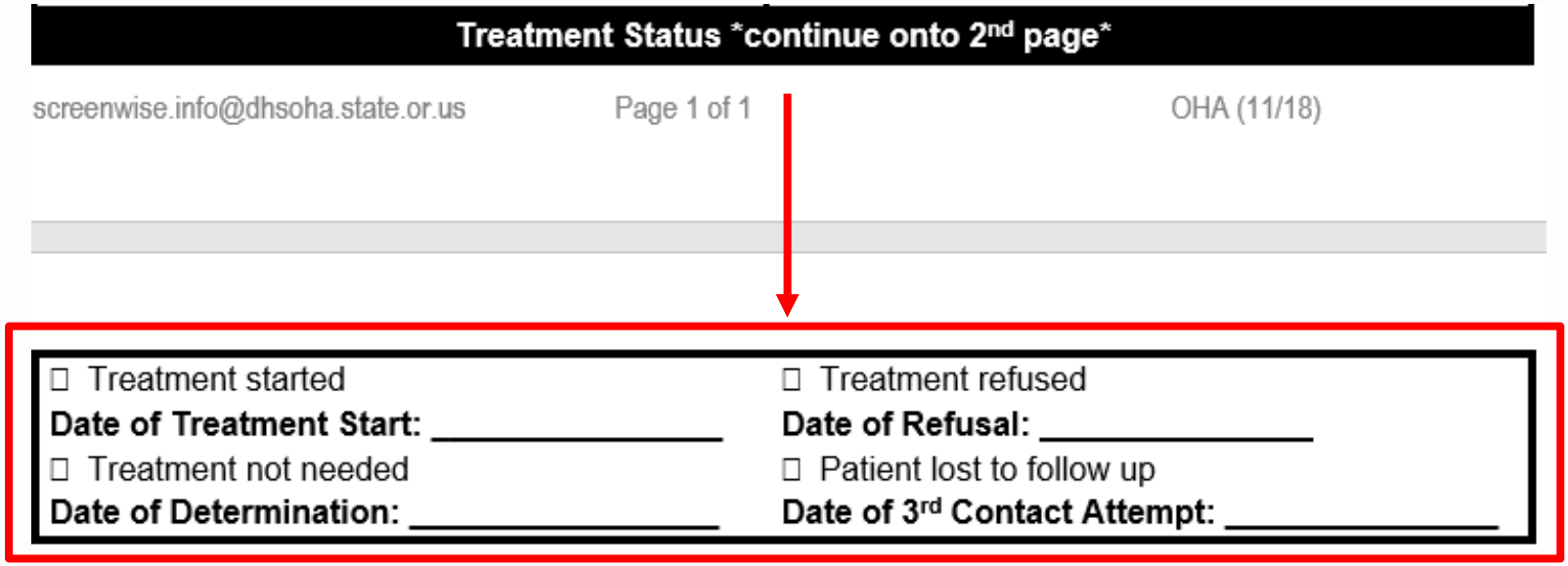


Breast Diagnostic Outcome	
Status of Final Diagnosis	☐ Work-up complete ☐ Work-up refused ☐ Lost to follow-up
Final Diagnosis Date: _____	☐ Carcinoma in Situ ☐ Invasive Breast Cancer ☐ Breast Cancer not diagnosed ☐ Lobular Carcinoma in situ (LCIS – Stage 0) ☐ Ductal Carcinoma in situ (DCIS – Stage 0) ☐ Other:

Breast Treatment Status	
☐ Treatment started **Date of Treatment Start: _____**	☐ Treatment refused **Date of Refusal: _____**
☐ Treatment not needed **Date of Determination: _____**	☐ Patient lost to follow up **Date of 3rd Contact Attempt: _____**

Surgical Diagnostic Outcome


Cervical Diagnostic Outcome
Status of Final Diagnosis
Work-up complete
Work-up refused
Lost to follow-up
Final Diagnosis Date: _____
Normal/Benign reaction/Inflammation
HPV/Condylomata/Atypia
CIN I/ Mild dysplasia
CIN II/ Moderate dysplasia
CIN III/ Severe dysplasia/Carcinoma in situ
Invasive cervical carcinoma
Low grade SIL
High grade SIL
Other: _____
Treatment Status *continue onto 2nd page*


Treatment Status *continue onto 2nd page*
screenwise.info@dhsoha.state.or.us
Page 1 of 1
OHA (11/18)
☐ Treatment started
Date of Treatment Start: _____
☐ Treatment not needed
Date of Determination: _____
☐ Treatment refused
Date of Refusal: _____
☐ Patient lost to follow up
Date of 3rd Contact Attempt: _____

To Ask A Question Via Phone Press *6

Please contact Wendy Jacobs with any questions or concerns about ScreenWise Forms

wendy.m.jacobs@state.or.us

THANK YOU!!

Oregon Health Authority