ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672
10534 SENATE HEALTH EDUCATION & SOCIAL SERVICES

Participation of Territories. Territories that operate Medicaid programs (Puerto Ricc Virgin Islands, American Samoa, Guam and the Northern Marianas Islands) may choo this new option. However, federal payments to those territories are capped by statute. the extent that these territories already receive the maximum federal payment permit the new law would not result in any additional federal funding. If the cap on federal payments has not been reached, federal funds at the enhanced matching rate could b available for the new eligibility group.

Treatment of American Indian and Alaska Native (AI/AN) Women. Under Secti 2701(c) of the Public Health Service Act, a medical care program of the Indian Health Service (IHS) or an Indian tribal organization is considered creditable coverage, as the term is used under HIPAA. But not all AI/AN women are "covered under" this creditabl coverage. The term "covered under" implies reasonable access to such a program. In consultation with IHS and the tribes, we intend to develop standards to determine whether individuals are "covered under" such a program.

Overview of Implementation

Successful implementation of the new benefit will require a coordinated effort betweer state Medicaid and public health agencies. State breast and cervical cancer programs been in place for several years so they may be able to provide to state Medicaid agenc important data on the numbers of women screened and diagnosed within a state.

At the federal level, HCFA will be working closely with CDC to help facilitate implementation of the new coverage group. To assist states as they move forward, we developing the state plan materials, instructions and more detailed questions and ans regarding the new benefit.

We believe that states will be able to design application procedures that are simple an that are closely tied to the case management services offered by most state breast an cervical cancer programs. A simple process will help ensure that women with cancer receive the treatment they need.

We encourage you to submit state plan amendments to your HCFA regional office as quickly as possible. HCFA staff will gladly offer technical assistance to any state that requests it. If you have questions about issues not addressed in this letter, please con Marlene Jones at HCFA (410) 786-3290 for Medicaid-related issues and Steve Reynold CDC (770) 488-3075 for issues concerning NBCCEDP.

Sincerely,

/s/

Timothy M. Westmoreland
Director

Footnotes:

(1) A woman is considered to have been screened under the CDC program and eligible the new Medicaid optional group if she has received a screening mammogram, clinical breast exam, or Pap test; or she has received diagnostic services following an abnorm clinical breast exam, mammogram, or Pap test; and she has received a diagnosis of b or cervical cancer or of a pre-cancerous condition of the breast or cervix as the result the screening or diagnostic service.

(2) Public Law 106 - 554, included the Medicare, Medicaid and SCHIP Benefits

Improvement and Protection Act of 2000 which, at section 710, provides a technical correction that the limitation under section 1903 (f) of the Social Security Act which li federal matching funds to individuals with incomes below 133 1/3% of the payment ordinarily made under the former Aid to Families with Dependent Children (AFDC) program to a family of the same size does not apply to this eligibility group. The effec date of the technical correction is October 1, 2000. States may cover all women who a screened through the CDC program and determined eligible for the new Medicaid optic regardless of income.

Enclosure

cc:
HCFA Regional Administrators
HCFA Associate Regional Administrators for Medicaid and State Operations
Centers for Disease Control and Prevention Grantees
Nancy Lee - Centers for Disease Control and Prevention
Steve Reynolds - Centers for Disease Control and Prevention
Kathy Cahill - Centers for Disease Control and Prevention
Don Shriber - Centers for Disease Control and Prevention, State Chronic Disease Direc
Lee Partridge - Director, Health Policy Unit, American Public Human Services Associati
Joy Wilson - Director, Health Committee, National Conference of State Legislatures
Matt Salo - Director of Health Legislation, National Governors' Association
Heather Mizeru - Director of State Affairs, National Association of Community Health Centers, Inc.

DRAFT

ATTACHMENT 2-2-A
PAGE 23b

STATE:_____

Citation Group Covered

B. Optional Coverage Other Than the Medically Needy (Continued)

1902 (a) (10) (A)
(ii) (XVIII) of the Act ____[24]. Women who:

a. have been screened for breast or cervical cancer under the Centers for Disease Con and Prevention Breast and Cervical Cancer Early Detection Program established under XV of the Public Health Service Act in accordance with the requirements of section 15(that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix;

b. are not otherwise covered under creditable coverage, as defined in section 2701 (c) the Public Health Service Act;

c. are not eligible for Medicaid under any mandatory categorically needy eligibility gro and

d. have not attained age 65.

1920B of the Act ____ [25]. Women who are determined by a "qualified entity" (as defined in 1920B (b) based on preliminary information, to be a woman described in 19 (aa) the Act related to certain breast and cervical cancer patients.

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman's eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the mo in which the determination of presumptive eligibility was made, the presumptive perio ends on that last day.

TN No._____ Approval Date:_____ Effective Date:_____

Supersedes
TN No._____

The National Breast and Cervical Cancer Early Detection Program

Program Announcement 99052

Alaska's Proposal

Project Period: 9/30/00 – 9/29/01

Submitted By:

State of Alaska
Department of Health & Social Services
Division of Public Health
Section of Maternal, Child and Family Health
1231 Gambell Street
Anchorage, AK 99501

Table of Contents

OMB Approval No. 0348-0043

APPLICATION FOR FEDERAL ASSISTANCE

2. DATE SUBMITTED: May 26, 2000		Applicant Identifier
1. TYPE OF SUBMISSION: Application [ ] Construction [ ] Non-Construction; Preapplication [ ] Construction [X] Non-Construction	3. DATE RECEIVED BY STATE: March 30,2000	State Application Identifier
	4. DATE RECEIVED BY FEDERAL AGENCY	Federal Identifier

5. APPLICANT INFORMATION

Legal Name: STATE OF ALASKA Department of Health & Social Services	Organizational Unit: Division of Public Health Section of Maternal, Child & Family Health
Address (give city, county, state, and zip code) 1231 Gambell Street Anchorage, AK 99501	Name and telephone number of the person to be contacted on matters involving this application (give area code) Pam Muth, MPH, Chief Section of Maternal, Child & Family Health (907) 269-3400

6. EMPLOYER IDENTIFICATION NUMBER (EIN): 92-6001185

7. TYPE OF APPLICANT: (enter appropriate letter in box) [A]

A. State H. Independent School District
B. County I. State Controlled Institution of Higher Learning
C. Municipal J. Private University
D. Township K. Indian Tribe
E. Interstate L. Individual
F. Intermunicipal M. Profit Organization
G. Special District N. Other (Specify)

8. TYPE OF APPLICATION: [ ] New [X] Continuation [ ] Revision

If Revision, enter appropriate letter(s) in box(es) [ ] [ ]
A Increase Award B Decrease Award
C Increase Duration D Decrease Duration
Other (specify)

9. NAME OF FEDERAL AGENCY: Centers for Disease Control and Prevention

10. CATALOG OF FEDERAL DOMESTIC ASSISTANCE NUMBER: 93-919

TITLE: National Breast & Cervical Cancer Early Detection Program

11. DESCRIPTIVE TITLE OF APPLICANT'S PROJECT: Alaska Breast & Cervical Cancer Early Detection Program

12. AREAS AFFECTED BY PROJECT (cities, states, etc.): State of Alaska

13. PROPOSED PROJECT: Start Date	Ending Date	14. CONGRESSIONAL DISTRICTS OF: a. Applicant	b. Project:
9/30/99	9/29/04	Alaska Congressional District	Alaska

15. ESTIMATED FUNDING:	
a. Federal	$ 1,837,492
b. Applicant	$ 0
c. State	$
d. Local	$
e Other	$ 824,401
f. Program Income	$ 0
g. TOTAL	$ 2,661,893

16. IS APPLICATION SUBJECT TO REVIEW BY STATE EXECUTIVE ORDER 12372 PROCESS?

a. YES THIS PREAPPLICATION/APPLICATION WAS MADE AVAILABLE TO THE STATE EXECUTIVE ORDER 12372 PROCESS FOR REVIEW ON: DATE:

b. NO [X] PROGRAM IS NOT COVERED BY E.O. 12372

[ ] OR PROGRAM HAS NOT BEEN SELECTED BY STATE FOR REVIEW

17. IS THE APPLICANT DELINQUENT ON ANY FEDERAL DEBT?

[ ] Yes If "Yes" attach an explanation. [X] No

18. TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL DATA IN THIS APPLICATION/PREAPPLICATION ARE TRUE AND CORRECT. THE DOCUMENT HAS BEEN DULY AUTHORIZED BY THE GOVERNING BODY OF THE APPLICANT AND THE APPLICANT WILL COMPLY WITH THE ATTACHED ASSURANCES IF THE ASSISTANCE IS AWARDED.

a Typed Name of Authorized Representative	b Title	c Telephone Number
Karen Perdue	Commissioner Department of Health & Social Services	(907) 465-3030
Signature of Authorized Representative		e Date Signed
[signature]		5/19/2000

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Standard Form 424 (REV 4-88)
Prescribed by OMB Circular A-102

OMB Approval No. [illegible]-0044

BUDGET INFORMATION - N[illegible]-Construction Programs

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. BCCEDP		$ 350,000	$	$ 1,837,492	$ 824,401	$ 2,661,893
2.						
3.						
4.						
5. TOTALS		$ 350,000	$	$ 1,837,492	$ 824,401	$ 2,661,893

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total (5)
	(1) 40%	(2) 60%	(3) Total	(4) Match	
a. Personnel	$ 290,943	$ 186,233	$ 477,176	$	$ 477,176
b. Fringe Benefits	87,283	55,870	143,153		143,153
c. Travel	41,115	10,260	51,375		51,375
d. Equipment					
e. Supplies					
f. Contractual	44,000	937,674	981,674		981,674
g. Construction					
h. Other	84,861		84,861	824,401	909,262
i. Total Direct Charges (sum of 6a - 6h)	548,202	1,190,037	1,738,239	824,401	2,562,640
j. Indirect Charges	99,253		99,253		99,253
k. TOTALS (sum of 6i and 6j)	$ 647,455	$ 1,190,037	$ 1,837,492	$ 824,401	$ 2,661,893
7. Program Income	$	$	$	$	$

Standard Form 424A (4-88)
Prescribed by OMB Circular A-102

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e) TOTALS
8. BCCEDP	$	$	$ 824,401	$ 824,401
9.				
10.				
11.				
12. TOTALS (sum of lines 8 and 11)	$	$	$ 824,401	$ 824,401

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 1,837,492	$ 459,373	$ 459,373	$ 459,373	$ 459,373
14. Non-Federal	824,401	206,100	206,100	206,100	206,101
15. TOTAL (sum of lines 13 and 14)	$ 2,661,893	$ 665,473	$ 665,473	$ 665,473	$ 665,474

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (Years)			
	(b) First	(c) Second	(d) Third	(e) Fourth
16. Breast and Cervical Cancer Early Detection	$ 1,837,492	$ 1,837,492	$ 1,837,492	$ 1,837,492
17.				
18.				
19.	$ 1,837,492	$ 1,837,492	$ 1,837,492	$ 1,837,492
20. TOTALS (sum of lines 16 - 19)				

SECTION F - OTHER BUDGET INFORMATION

(Attach additional Sheets if Necessary)

21. Direct Charges: $1,738,239

22. Indirect Charges: 16% Personnel + Fringe Benefits = $99,253

23. Remarks

CHECKLIST

NOTE TO APPLICANT: This form must be completed and submitted with the original of your application. Be sure to complete both sides of this form. Check the appropriate boxes and provide the information requested. This form should be attached as the last page of the signed original of the application. This page is reserved for CDC staff use only.

Type of Application: ☐ NEW ☒ Noncompeting Continuation ☐ Competing Continuation ☐ Supplemental

PART A: The following checklist is provided to assure that proper signatures, assurances, and certifications have been submitted.

	Included	NOT Applicable
1. Proper Signature and Date for Item 18 on SF 424 (FACE PAGE)	☒	
2. Human Subjects Certification, when applicable (45 CFR 46)	☐	XX

PART B: This part is provided to assure that pertinent information has been addressed and included in the application.

	YES	NOT Applicable
1. Has a Public Health System Impact Statement for the proposed program/project been completed and distributed as required?	☐	XX
2. Has the appropriate box been checked for item # 16 on the SF-424 (FACE PAGE) regarding intergovernmental review under E.O. 12372 ? (45 CFR Part 100)	XX	
3. Has the entire proposed project period been identified in item # 13 of the FACE PAGE?	XX	
4. Have biographical sketch(es) with job description(s) been attached, when required?	XX	
5. Has the "Budget Information" page, SF-424A (Non-Construction Programs) been completed and included?	XX	
6. Has the 12 month detailed budget been provided?	XX	
7. Has the budget for the entire proposed project period with sufficient detail been provided?	☐	XX
8. For a Supplemental application, does the detailed budget address only the additional funds requested?	☐	XX
9. For Competing Continuation and Supplemental applications, has a progress report been included?	XX	

PART C: In the spaces provided below, identify the applicant organization's administrative official to be notified if an award is made and the individual responsible for directing the proposed program/project.

Name, title, organization, address, E-mail address (if any), FAX, and telephone number of the administrative official to be notified if an award is to be made.

Orlando Moskito
Revenue Unit Supervisor
Dept. of Health & Social Services
P.O. Box 110650
Juneau, Alaska 99811-0650/(907) 465-3131

Name, title, organization, address, E-mail address (if any), FAX, and telephone number of the program director/project director/principal investigator designated to direct the proposed project or program.

Pam Muth, Chief
Section of Maternal, Child, & Family Health
1231 Gambell Street
Anchorage, Alaska 99501 / (907) 269-3400

APPLICANT ORGANIZATION'S 12-DIGIT DHHS EIN (if already assigned)

SOCIAL SECURITY NUMBER: 503-84-6465

HIGHEST DEGREE EARNED: MPH

(OVER)

NEW OR SIGNIFICANTLY REVISED INFORMATION

The program anticipated increasing the percent of Alaska Natives served from 1.5% to 10% by December 31, 2000. It is unlikely this projection will be reached, primarily because the program has not yet been in a position to work with Native health agencies. During the past year, the program has had to define and clarify its policies and procedures. The program has been diligent in its commitment to complete this undertaking before working with new screening providers. We anticipate establishing partnerships with Native health agencies within the next year. The percent of Alaska Natives served by the program should increase to the 10% goal by 12/2001.

The program projected adding screening providers in three communities that already had screening providers, and in seven additional communities that did not have screening providers. The timeline for accomplishing this has been pushed back because, again, the program had to define and clarify its policies and procedures before working with new providers. We should begin adding new providers by July 2000 and reach our projected goal by the end of FY2001.

The program will continue to strive to improve the rate of appropriate follow-up of abnormal CBEs toward 100%. According to the most recent MDE submission, we are making progress toward that goal (58.6 % to 63.6%), however, it is unlikely we will reach 100% by September 30,2000. Rates are monitored on a semi-annual basis in conjunction with MDE submissions.

The program budgeted to screen 4,500 women in FY 2000 while the projected timeline for reaching this figure was not until December 31, 2001. The program is steadily increasing the numbers of women screened and should reach its projection as planned.

The program has found that having a large statewide coalition does not efficiently or effectively support program services. The program, therefore, has moved in the direction of working with community-based groups on a regional basis. This information was included in the April 2000 progress report to PGO and is discussed in further detail under section 3 of this continuing grant application, Partnership Development and Community Involvement.

Case management initiatives will be expanded beyond the description in the FY2000 application and are addressed in the attached plan. Related to this issue, the program has found that at this time, the only tribal grantee with which we have a need to coordinate services to women screened is SEARHC. We are working to coordinate services on an ongoing basis and will work toward establishing a memorandum of agreement. At this time, there is no apparent need for this type of collaboration with the other tribal grantees.

The public health nursing position to be funded half-time by the program has not been filled. The position is still being negotiated and hiring for that position is dependent, in part, upon action that must be taken by Public Health Nursing. The budgeted Administrative Clerk II position has not yet been filled; however, we anticipate filling the position by the end of FY2000.

Rescreening Operational Plan and Protocol

Each woman who is enrolled in AK-BCCEDP must be tracked and recalled for an annual Pap test, pelvic exam, CBE, and, if she is 50 to 64 years old, a mammogram. Each provider is responsible to maintain a system for identifying and notifying AK-BCCEDP clients who are due

for clinical breast and pelvic exams, mammograms, and Pap tests. AK-BCCEDP will pay for annual rescreening [including screening mammography (for all women age 50 to 64 and 10% of women age 40 to 49), clinical breast exam (CBE), Pap test, and pelvic exam] that occurs no sooner than eleven (11) months from the service date of the previous annual screening. Contact must be made with the program consultant if annual screening needs to take place sooner than eleven months from the previous annual screening.

To assist with client recall, each provider will receive from the AK-BCCEDP a monthly list of clients who are due for annual screenings, approximately one (1) month before these clients are due to be rescreened. For example, in May 2000, the AK-BCCEDP will send the provider a list of clients due for annual screening in June 2000. If the client does not return for rescreening, she will not be on the list again in subsequent years.

Minimum Requirements for Recalling Clients

1. The screening provider sends personalized reminders to clients three to six weeks before the anniversary date of the previous year's exam.
2. If no appointment has been made, call the client one to four weeks prior to the screening anniversary date and schedule an appointment if the client agrees to rescreening. Verification of the woman's continuing eligibility should be made during this call. If the client is no longer eligible, refer her to other resources for ongoing screening and follow-up.
3. Make a second telephone call within three weeks after the annual screening date if no appointment has been scheduled or if the client has failed to keep a scheduled appointment.

If no appointment has been made, or if the client has failed to keep a scheduled appointment, record your attempts to contact the client in the client's medical record.

PROGRESS REPORT

A. Management. The Alaska BCCEDP changed management in February 1999. One of the primary activities following the change, and of this grant year, has been to develop, define and clarify policies and procedures for the program. This has been a major undertaking, but one which has significantly improved the program. We have also had many personnel management challenges in the program to include staff vacancies. In addition, the program has been laying the groundwork necessary to increase screening and diagnostic services in both communities currently without participating screening providers and in communities with screening providers but not enough to serve to the potentially eligible population. We plan to increase the number of women screened to 4,500 by December 31, 2001. The program had to delay plans to add new screening providers because the program lacked clear, consistent, documented policies and procedures that needed to be developed before adding new providers. During this grant year the following has occurred or been accomplished:

- Increased the number of diagnostic providers who have agreements with program by five
- Revised program Policies and Procedures Manual for providers. Task included having to develop and define many policies and procedures contained therein.
- The program's women's health nurse practitioner (NP) position was vacant for six months (10/99-3/00) resulting in some program activity deadlines being pushed back. Priority for the NP consultant's time will be re-convening the Clinical Advisory Committee, participating in the overall quality assurance process, monitoring and addressing abnormal clinical breast exam (CBE) follow-up needs, implementing new cervical cancer and case management policies, and improving the overall quality of, and standardizing, CBE techniques.

- The program's public education/marketing position was vacant for three months (11/99-2/00). Several major activities have been undertaken and/or achieved since filling that position (see Public Education, Information and Outreach).
- The program Accounting Technician position was vacant for three months (8/99-11/99) during a state hiring freeze and following the implementation of a new system for program billing. Program billing got two or more months behind. The Accounting Technician position was filled in November 1999 and program bills are now typically processed within one week of their receipt in the billing office.
- The program Public Health Nurse liaison position (half-time) and Administrative Clerk II position remain vacant. The program is taking steps to fill the clerk position. The nursing position is still being negotiated and hiring for that position is dependent, in part, upon action that must be taken by Public Health Nursing.

B. Surveillance

Women Screened. From 3/95-9/30/99, the AK-BCCEDP screened a total of 8,748 women. The following tables show the breakdown of enrolled women by age group, race and ethnicity. The number of new women enrolled increased from 1,840 in year four to 2,276 in year 5 (FY99). The majority of women served by the program continue to be white, non-Hispanic women. Sixty-nine percent of screening mammograms go to women ages 50-64. Based on our data runs, the program is now almost meeting the 75% minimum for screening mammograms and we are continuing to work with providers on this issue. The number of women receiving initial mammograms has steadily increased each year, from 24 in FY95 to 1,524 in FY99.

Age of Enrolled Women 3/95 – 9/30/99

Age Group	Frequency	Percent
<20	357	4
20-29	1951	22
30-39	2198	25
40-49	2187	25
50-64	1769	20
>65	286	3

Race and Ethnicity of Enrolled Women 3/95 – 9/30/99

Race	Hispanic	Non-Hispanic	Unknown	Total
AK Native/ Am Ind (1.6%)	9	122	7	138
Asian/Pacific Island (5.2%)	16	430	9	455
African American (6.7%)	36	539	7	582
White (79.3%)	614	6180	147	6941
Other (3.4%)	228	58	12	298
Unknown (3.8%)	33	46	255	334
Total (100%)	936 (11%)	7375 (84%)	437 (5%)	8748

Insurance Status. The AK-BCCEDP collects information on insurance status as part of its eligibility determination process. Currently, eligibility forms are retained by the provider in the enrolled woman's medical chart and are reviewed during monitoring site visits. This information is not reported to AK-BCCEDP at this time. Information concerning insurance status, however, is often obtained by the program through the AK-BCCEDP billing office through the routine submission of bills by providers seeking reimbursement for services. In March 2000, we began to enter insurance information into the database used for bill processing. The program receives notification from providers when women have met or not met their deductible, when Medicaid has paid all or a portion of a bill, or when providers make a special notation that a patient does or

does not have insurance. Because we have only very recently begun to enter this information, we are unable to break out screening by insurance status at this time.

Rescreening. The formula for the rescreening rates was the one detailed in the handouts provided to the program managers at their annual meeting in 2/17/00.

Race and Ethnicity of Rescreened Women. For the period 3/93-12/97, rescreening of women has occurred most among the white, non-Hispanic women enrolled in the program. This is to be expected as they are the largest group of women enrolled. A breakdown by age group is provided below describing rescreened women.

Race/Ethnicity of Rescreened Women	40-49 years	50-64 years
White	87.5%	76%
Black	6.25%	10%
Asian	6.25%	6%
Alaska Native/American Indian	N/A	2%
Other	N/A	4%
Unknown	N/A	2%
Non-Hispanic	87.5%	13%
Hispanic	6.25%	82%
Unknown	6.25%	5%

Abnormal Findings. Abnormal findings are reported for the period 3/95 – 9/30/99.

Mammograms. Abnormal findings include all women with a finding of probably benign short-term follow-up indicated, highly suspicious, suspicious for malignancy and assessment incomplete (BIRADS 3, 4, 5 or 6). As expected, women with abnormal screening mammogram findings are more likely to be older women (50-59), the percentage increasing with increasing age. One-fourth of women with abnormal mammogram results reported never having a mammogram. Race and ethnicity of abnormal mammograms reflect percentages similar to that over the overall population screened.

Clinical Breast Exams. The following tables give the breakdown of results for clinical breast exams by age and race.

CBE Results by Age Group, 3/95 - 9/30/99

Result	<20	20-29	30-39	40-49	50-64	>64	Total
Normal/ Benign	161 (3%)	1125 (18%)	1425 (23%)	1659 (27%)	1518 (25%)	210 (3%)	6098
Abnormal Suspicious	4 (1%)	36 (9%)	106 (28%)	134 (35%)	87 (23%)	11 (3%)	378

CBE Result by Race, 3/95 - 9/30/99

Result	White	Black	Asian	AK Native	Other	Unknown	Total
Normal/ Benign	4807 (79%)	416 (7%)	287 (5%)	88 (2%)	300 (5%)	200 (3%)	6098
Abnormal Suspicious	320 (85%)	24 (6%)	6 (2%)	7 (2%)	8 (2%)	13 (3%)	378

Eighty-nine percent (89%) of abnormal suspicious CBEs are among non-Hispanic women. Only 6% of abnormal suspicious CBEs are in Hispanic women which is consistent with our overall program demographics.

Pap Tests. Abnormal Pap test results (final diagnosis of high grade SIL and squamous cell cancer combined) reflect the race, ethnicity and age percentages of all women screened in the program. The rate of abnormal Pap tests decreases with increasing age, from 31% for women under 30 to 15% for women 50-64.

The mean time elapsed from screening to diagnosis for Pap tests is 45 days, and for screening mammograms is 49 days. The mean time elapsed from diagnosis of cervical dysplasia or cancer to treatment is 24.5 days, and for diagnosis of breast cancer to treatment is 38 days. Forty-one breast cancers and eight cervical cancers have been detected through the program since 1995.

C. Partnership Development and Community Involvement

Partnership development is now more purposefully focused on matching local resources to the service needs of program women. As availability of services varies by state geographic region, the program has started working with local grass roots service provider groups. In order to expand screening activity statewide we are developing tools and protocols for initiating services in new communities as well as expanding services in existing communities, assessing diagnostic capacity, resources, and referral patterns. During this year, we have accomplished the following:

- The Matanuska-Susitna Agency Partnership has recruited diagnostic specialists in preparation for the increased need for program women who will be entering the program with newly recruited screening providers in the summer of 2000. Several providers have expressed interest in becoming screening providers for the program.
- In the Central Kenai area similar efforts are being initiated under leadership of community members in partnership with the program. Kenai-area activity has included assessment of community resources and the need for additional screening and diagnostic providers.
- In Anchorage, the program is formalizing partnerships by facilitating agreements between outreach and screening providers, formalizing partnerships with other funding agencies for screening mammography for women 40-49, and monitoring the effectiveness and efficiency of rotating consultants for diagnostic services. As program case management services develop and expand, the value of these partnerships will grow.
- In Southeast Alaska we have collaborated with tribal grantee, SEARHC, and Public Health Nursing to ensure non-beneficiaries (non-Natives) living in major SE Alaska communities (Juneau, Ketchikan) and some remote SE communities have access to breast and cervical screening services. We continually work together to ensure that services are not duplicated and are coordinated. The programs have worked together on several outreach and public education efforts, as well as professional education opportunities.

D. Professional Education.

The program has moved away from its tradition of offering one large statewide conference on breast and cervical cancer early detection issues as a means of delivering professional education to providers to offering opportunities more targeted to improving specific skills and knowledge of our screening providers. Activities and plans in place include promotion of self-study on *Follow up of Abnormal CBE and Mammographic Findings* and *Mammacare* training. We also

plan to provide focus group training to state staff and grantee outreach staff before the end of the year. Program nurses provide ongoing technical assistance to screening providers on program policies and procedures and clinical guidelines. During this year we have also:

- Surveyed providers on program satisfaction and professional education needs.
- Held quarterly teleconferences for screening providers on program policy updates and issues.
- Coordinated downlink sites and disseminated information on satellite broadcasts relevant to BCCEDP.
- Determined abnormal CBE follow-up as the professional education priority for program providers this year. To date, 12 screening sites and 18 non-screening providers have requested 53 *Follow up* self-study manuals indicated an intended viewing audience of 59.
- Developed a booth for the Alaska Nursing Association, Alaska Nurse Practitioner, and Issues in Women's Health conferences to promote the self study packet, *Followup of Abnormal CBE and Mammographic Findings*.
- Put plans for *Mammacare* CBE training in place. Program nurse practitioner will become a certified trainer by 9/30/2000; instruction will be offered to program screening providers.

E. Quality Assurance and Improvement

Experts in the management of breast and cervical disease have been selected and retained on contract to advise the program on complex medical management issues.

Clinical guidelines of the AK-BCCEDP will be reviewed and revised with input from a reorganized Clinical Advisory Committee (CAC). The committee will convene by June 2000 and complete a review of current guidelines by September 30, 2000. Updated guidelines will be completed by December 2000 and printed and distributed to all program providers as soon as possible after that date. The CAC will continue to meet at least semi-annually to address other program concerns, with priority given to implementation of the cervical cancer screening policy and appropriate abnormal CBE follow-up.

A complete revision of the site review and monitoring process is currently underway. Routine site reviews were postponed during the last year while the program undertook a major review of policies, procedures and processes. A plan for biennial reviews was initiated in April 2000. New providers will have a site review after their first year of participation and biennially thereafter. Site monitoring reviews will continue with priority for immediate review of sites with the greatest need for technical assistance. Additional accomplishments during this grant year include:

- New guidelines and tools for conducting a screening provider site visit are being developed; adjusted time for completion 11/00.
- Program consultants continue to offer technical assistance to providers where needs have been identified through MDEs or upon provider request.
- Contract ANP protocols and contract being developed to review abnormal CBEs at all sites.
- Diagnostic reports are monitored for consistency with data reported by screening providers
- Data reports are developed and distributed to screening providers as a means for providing feedback on program enrolled women (e.g. numbers screened, percents of abnormal results, percents of mammograms to women 50-64)

F. Public Education, Information and Outreach.

During this grant year the program has accomplished the following:

- Conducted a review of the literature on one-to-one outreach interventions; developed request for proposal (RFP) for Breast and Cervical Outreach Demonstration Projects. Projects are scheduled to begin in August 2000 in applicant communities where BCCEDP services exist.
- Negotiated, implemented and monitored grant with YWCA ENCOREplus program. Provided technical assistance to increase the numbers of women recruited in the Anchorage area and to recruit more women ages 50 to 64.
- In-progress assessment of the 800 line as an enrollment method.
- Developed new marketing materials, established relationships with other agencies that serve low-income populations, and decided on a new program name, Breast and Cervical HEALTH CHECK. Working on new program logo. Advertised program in screening communities statewide (posters, coupons, newspaper ads).
- Pilot project in Central Kenai Penninsula has reliably evaluated personal door to door recruitment during the past year. Impact to date:
  - increase in #s program women ages 40-49 & 50-64 who were screened from prior to the project to after project implementation
  - increase in % of program screened women ages 50-64 receiving screening mammography to over 80%
  - able to evaluate outreach efforts reliably

G. Screening, Referral, Tracking, Follow-Up

One of the major challenges in this area is the lack of secure funding for diagnostic and treatment services not covered by the BCCEDP. We continue to pursue partnerships to ensure diagnostic and treatment services are available to women screened through the program. A variety of donated resources, pro bono work or extended payment arrangements are used to cover costs not covered by the BCCEDP.

- The program developed a protocol for referral, tracking and follow-up of abnormal results by providers. Follow up of abnormal screening results is done monthly per program protocol developed 1/00; protocols are revised as needed
- Program consultants track women with abnormal results monthly to promote timely and appropriate diagnosis & treatment of all abnormal screening results by providers
- Clinical forms have been revised to be more user-friendly and capture new MDE requirements
- Program services have been coordinated with Public Health Nursing family planning services

H. Evaluation

The program has not developed a new plan or significantly modified the current plan to assess the implementation and effectiveness of each program component.

Alaska Breast and Cervical Health Check Case Management Plan

Goal

Alaska BCHC's case management goal is to assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervical cancer. The measure of success will be that all women will complete diagnostic services within 60 days of an abnormal screening result and women diagnosed with cancer will initiate treatment within 60 days.

Background and Assessment

Alaska BCHC staff have worked diligently over the past 18 months to improve the quality of reporting and recording of provider-client data to ensure accurate clinical findings are entered in the CaST database. Part of this important exchange between the program staff and provider network has been an improved understanding of the importance of the role of follow-up and care coordination in assisting women to access needed services. The ability to generate an accurate estimate of the number of women who will need case management services depends on accurate data sources. Criteria for case management clients has not yet been finalized. However, staff discussion indicates a consensus that priority case management populations would include those with highly suspect CBE, mammography, or Pap results; women who have missed needed diagnostic or rescreening appointments; and women needing short term follow-up. Case closure criteria would also be data dependent and will be enhanced by "cleaning up" some remaining inconsistencies in our data for "lost to follow up" and "refused" clients.

The cumulative MDE data on mammograms indicate a relatively high percentage of missing (15.3) or pending (1.2) status of final diagnosis. The cumulative percentage refused (9.5) and lost to follow-up (4.7) seem to be improving per the most recent data submission (4.8 and 4.0 respectively), but are still well above the expected minimum of 2-3%. Similarly, MDE Pap screening data for 4/98-3/99 indicate higher than expected lost to follow-up percentages (7.4; $\leq$3 expected) and a percentage of complete follow-up (89.5) that is a near miss ($\geq$90 expected).

Implementation

Locally based clinical providers will be expected to provide case management enhancement of their current follow-up and tracking efforts. BCHC staff will assist by providing guidance on policy, technical assistance, systems development, enhanced data and tracking reports, needs assessment and intake criteria, resource directories, revised forms/consents, and financial assistance. Information is currently being collected on payment options, amounts, and allowable services. One model under consideration is that of the Alaska Division of Medical Assistance, which is a fee for service model covering screening, initial assessment, care plan development, re-assessment, and a per month fee for active "care coordination services".

State program staff responsible for oversight of the case management plan is primarily the program coordinator, with assistance from the clinical nurse consultant for quality assurance and monitoring processes, data manager for evaluation component, regional

program consultants for site work, review and technical assistance. The outreach coordinator is developing a model for community resource inventory which, when expanded to a statewide inventory will assist in locating and directing clients to care givers. Attention to services for disabled women will be given special emphasis.

An ambitious timeline has been developed with the detailed workplan. Work is in progress on case management definitions, provider needs assessment, and estimation of staff capacity and number of patients in need. Tools and forms will be developed and tested later this year. Evaluation/monitoring and billing systems will be pretested and redesigned in early 2001, with implementation scheduled for fall, 2001.

Monitoring and evaluation of the success of the case management effort will be done through analysis of CaST data and site review. The expected number of cases compared to the actual number of cases, the number/percent of women completing their recommended follow-up for diagnosis or treatment initiation, and the expected reduction in the number/percent of women lost to follow-up will be monitored on a regular basis.

AK-BCCEDP Case Management Work Plan – Systems Level

Case Management Goal: To assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervi[illegible]cer.
Measure of Success: Women will complete diagnostic services within 60 days of an abnormal screening result; women diagnosed with cancer will initiate treatment within 60 days.
Goal for process of assessment: To determine the extent of the program's need for case management and the availability of resources needed to implement planned case management services.
Objective 1: Beginning 1/27/00 and continuing on an ongoing basis, program staff will define the target client population with potential need for case management to enable timely access into diagnostic, treatment, and re-screening services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Define eligibility and case closure criteria for case management clients and set appropriate protocol based on past two years of program data.	In Progress	MDEs	5/11/00 & ongoing	Clinical QA Coordinator – CK
B. Assess the extent of the program's need for case management based on CaST [illegible]ta and selected chart audit [illegible]ts based on criteria developed in protocol above.	In Progress	CaST data	05/01/00	Data Manager Program Coordinator – SCB Clinical QA Coordinator – CK
C. Work with program site case managers to develop estimates of time and cost for case management services based on established eligibility criteria and current client utilization of existing services.	In Progress	CaST data	6/11/00 & ongoing	Data Manager Program Coordinator – SCB Clinical QA Coordinator – CK

Objective 2: Beginning 9/30/99 and continuing on an ongoing basis, program staff will inventory existing case management resources available to the program from regional social and health care agencies.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Review the Alaska Department of Community and Economic Development's community profiles to develop a resource list of program service delivery areas by geographic region.	In Progress	Local and state data	5/26/00	Health Planner – MB Pub.Ed. Coordinator – LS
B. Identify key players for social service referrals and other case management needs in partnership with local service delivery providers including public health centers.	In Progress	N/A	5/26/00	Health Planner – MB Pub.Ed. Coordinator – LS
C Assess the diagnostic and [illegible]reatment capacity by geographic region	In Progress	CaST data Local & state data	Ongoing	Program Coordinator – SCB Data Manager

D. Inventory existing site case manager resources available to the program; evaluate current skill and expertise level of site case managers.	In Progress		7/31/00	Program Coordinator – SCB Program Consultants SSB & SH

Goal for process of planning: To assure that resources are in place prior to implementing the case management system at a client level.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff will assess adequacy of provider staff at each site to deliver quality case management services for all program eligible women.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. With the estimate of the number of women at each site who will need case management, develop skills and task list for site case managers.	In Progress	CaST data	9/1/00	Program Coordinator – SCB Clinical QA Coordinator – CK
B. Develop training and skills enhancement plan for each site.	In Progress	N/A	05/01/2001	Health Planner – MB Program Coordinator – SCB
C. Develop protocol and program materials defining both systems level and client level accountability and reporting requirements for case management services.	In Progress	N/A	02/01/01 & ongoing	Clinical QA Consultant – CK Program Coordinator – SCB Program Consultants – SSB & SH
Design protocols and tools to document: • Needs assessment • Individual case management plan • Completion of case management • Refusal of care • Referral Form • Follow-Up Form • Lost to follow up • Assurance of confidentiality & consent to participate in case management	In Progress	N/A	07/11/00 & ongoing	Clinical QA Consultant – CK Program Coordinator – SCB Program Consultants SSB & SH
E. Continue to develop a marketing plan by geographic region to continue recruiting diagnostic and treatment providers	In Progress	N/A	03/01/00 & ongoing	Pub Ed Coordinator-LS
F. Develop a plan for AK-BCCEDP staff to assure case management services at sites found to have inadequate resources.	In Progress	N/A	07/11/00	Program Coordinator –SCB Clinical QA Coordinator – CK

Goal for process of **coordination**: To optimize services available to the client by developing and coordinating standardized sy avoid duplication of services at the local level.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff will establish formal and informal agreem maximize availability and access to necessary diagnostic, treatment, and support services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Working with local partnerships and providers determine the needs for formal agreements.	In Progress	N/A	9/30/99 & on-going	Program Coordinator – SCB Health Planner – MB
B. Work with local service providers to establish community partnerships to assist in the coordination of services and reduce duplication of services.	In Progress	N/A	6/11/01	Health Planner – MB
C. Develop a standardized client referral tool and algorithm of the referral process for each identified program service delivery area to assure reliable tracking of clients.	In Progress	N/A	8/31/00	Clinical QA Coordinator – CK
D. Define role of provider and program staff in facilitating coordination of all case management activities between providers and in the management of the referral tracking system.	In Progress	N/A	8/31/00	Program Coordinator – SCB

Goal for the process of **monitoring**: To provide ongoing re-assessment of the case management system and, when appropriate management and operational plan.

Objective 1: Program staff will implement a case management monitoring plan by 1/1/02

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a case management quality-monitoring plan.	In Progress	CaST data	11/15/00	Clinical QA Coordinator – CK
B. Monitor the number of case management clients who fail to receive case management services according to the plan.	In Progress	CaST data	4/1/02 & semi-annually thereafter	Program Coordinator – SCB Data Manager
C. Review trends of the failed cases for evaluation and modification of current case management systems and plan.	In Progress	CaST data	7/1/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK
D. Modify current systems and plan based on trends identified.	In Progress	CaST data	7/01/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK
E. Apply evaluation results to redesign of the system and perating plan.	In Progress	CaST data	7/1/02	Program Coordinator – SCB Data Manager Clinical QA Coordinator- CK

Goal for process of **resource development:** To develop adequate provider resources at both local and state level to maximize diagnostic, and treatment services.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff in collaboration with site case managers, diagnostic and treatment services available in all program service areas.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Hire marketing and public education staff person.	Complete 2/7/00	N/A		Program Coordinator – SCB
B. Develop and implement marketing plan. Market the program.	In Progress	N/A	3/24/00 & monthly thereafter	Pub Ed Coordinator – LS
C. Recruit and establish agreements with diagnostic providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
D. Recruit and provide continuing support to gratis treatment providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
E. Develop and maintain a statewide directory of resources by geographic region utilizing current annual "Provider Update" tool.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB

Objective 2: Staff will implement a reimbursement system for case managementby 8/31/00.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a case management budget for the program based on estimated number of women eligible for case management at each site and estimated cost of serving each woman.	In Progress	CaST data	9/1/00	Program Coordinator – SCB
B. Select reimbursement mechanism.	In Progress	Billing data	5/1/00	Program Coordinator – SCB
C. Design algorithm and specify necessary elements for processing & paying a case management bill.	In Progress	Billing data	6/1/00	Program Coordinator – SCB
D. Program staff will develop and document a reimbursement protocol & system for case management	In Progress	Billing data	7/1/00	Program Coordinator – SCB

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

Goal for process of **resource development:** To develop adequate provider resources at both local and state level to maximize diagnostic, and treatment services.

Objective 1: Beginning 9/30/99 and continuing on an ongoing basis, program staff in collaboration with site case managers, diagnostic and treatment services available in all program service areas.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Hire marketing and public education staff person.	Complete 2/7/00	N/A		Program Coordinator – SCB
B. Develop and implement marketing plan. Market the program.	In Progress	N/A	3/24/00 & monthly thereafter	Pub Ed Coordinator – LS
C. Recruit and establish agreements with diagnostic providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
D. Recruit and provide continuing support to gratis treatment providers.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB
E. Develop and maintain a statewide directory of resources by geographic region utilizing current annual "Provider Update" tool.	In Progress	N/A	5/1/00 & monthly thereafter	Program Coordinator – SCB

Objective 2: Staff will implement a reimbursement system for case managementby 8/31/00.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a case management budget for the program based on estimated number of women eligible for case management at each site and estimated cost of serving each woman.	In Progress	CaST data	9/1/00	Program Coordinator – SCB
B. Select reimbursement mechanism.	In Progress	Billing data	5/1/00	Program Coordinator – SCB
C. Design algorithm and specify necessary elements for processing & paying a case management bill.	In Progress	Billing data	6/1/00	Program Coordinator – SCB
D. Program staff will develop and document a reimbursement protocol & system for case management	In Progress	Billing data	7/1/00	Program Coordinator – SCB

Objective 1: By 10/1/01 program staff will implement an evaluation process that includes the use of MDEs, client and provider satisfaction surveys to measure the adequacy of individual case management services.
Goal for the process of **evaluation:** To evaluate the effectiveness of the case management system and its sustaining ability to assure timely and high quality case management services that positively impact the program MDEs, providers, and clients.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Identify criteria to be included in the evaluation including outcome measures of the adequacy of individual case management service.	In Progress	CaST data	11/1/00 & on-going	Clinical QA Coordinator – CK
B. Design a protocol and process for submission and quality assessment of case management tools and activities documented by the tools.	In Progress	N/A	11/1/00 & on-going	Clinical QA Coordinator – CK
C. Design tool & process to capture desired information including client satisfaction survey.	In Progress	N/A	11/1/00 & on-going	Clinical QA Coordinator – CK
D. Assess timeliness and adequacy of individual case management services using MDEs, needs assessment, referral systems, and documentation of refused care & lost to follow up tools.	In Progress	CaST data	11/01/01	Data Manager
E. Assess numbers of providers leaving the program because of new requirements.	In Progress	N/A	8/31/01	Program Coordinator – SCB
F. Assess provider satisfaction with case management using survey.	In Progress	Satisfaction Survey	1/15/02	Program Coordinator – SCB
G. Assess number of case managed women entering a re-screening cycle.	In Progress	MDE's	11/01/02	Data Manager
H. Assure continued assessment of need for, and provision of, training	In Progress	CaST data	7/01/01	Program Coordinator – SCB Program Consultant – SSB Clinical QA Consultant – CK Data Manager

AK-BCCEDP Case Management Work Plan—Client Level

Case Management Goal: To assure continuous improvement in the status of the medical outcomes of all program clients with abnormal screening results, as well as all those diagnosed with breast or cervical cancer.

Measure of Success: Women will complete diagnostic services within 60 days of an abnormal screening result; women diagnosed with cancer will initiate treatment within 60 days.

Goal for process of assessment: To determine the extent of each client's need for case management and the availability of resources needed to implement planned case management services at each provider site.

Objective 1: By 9/1/00, based on the definition of the target client population with potential need for case management, each provider will assess the characteristics and numbers of individuals in the program who are at risk for, or have not achieved timely access to diagnostic, treatment, and re-screening services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Develop a risk assessment tool based on eligibility and case closure criteria for case management of clients.	In Progress	CaST Data	6/30/00 and monthly thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.
B. Assess the extent of each provider's skills and knowledge for assessing clients' needs for diagnostic, treatment and essential support services.	In Progress	N/A	8/31/01 & annually thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.
C. Develop guidelines and process for re-assessment of client's continued need for case management or criteria for closure of case.	In Progress	N/A	8/31/01 & biannually thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.

Goal for process of **planning**: To develop standardized care plans to assure that each client's individual short term and long term needs for receiving diagnostic, treatment, and re-screening services are met in a consistent and timely manner.

Objective 1: By 10/1/01 the designated site case manager for each provider site will have in place an individualized care plan for each client assessed and found to be in need of case management services

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Provide training and ongoing technical assistance in use of the risk assessment tool and standardized sample case management plans that set goals, activities, time elements, and clearly designate responsibility for each element.		CaST Data	9/1/00 On-going	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K. Program Consultants-S.B. & S.A.H.
B. Implement the state level plan for case management at provider sites without resources to provide case management services.		N/A	8/31/00	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.
C. Provide local sites with a tool to document referrals, follow up, and revisions of case management plans.		N/A	8/31/00	Program Coordinator – S. Burn. Clinical QA Coordinator - C.K.

Goal for process of **coordination:** To optimize coordination of services and resources between provider and regional helper agencies to assure that resources meet clients' needs while reducing duplication of effort.

Objective 1: Beginning 9/30/99 program staff & site case managers will work with local providers, coalitions and public health centers to coordinate and maintain resources and support services to meet client needs as specified in the client case management care plan.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Establish formal and informal agreements to maximize availability and access to necessary diagnostic, treatment and support services.	In Progress	N/A	10/01/99 and monthly thereafter	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
B. Provide active assistance in reviewing the case management process at provider sites to ensure all clients receive the services identified in their case management plan.	In Progress	N/A	10/01/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
C. Guide site case managers in appropriate documentation needed to coordinate services in each client's case management plan.		N/A	10/1/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.
D. Provide training and technical assistance for site case managers to assure appropriate use of tracking tools, and timely and reliable tracking of clients.		CaST Data	10/1/99	Program Coordinator—S.Burn. Program Consultants-S.B. & S.A.H.

Goal for the process of **monitoring:** To provide ongoing re-assessment of case management operating plan and, when appropriate, to modify the program's case management operating plan to assure each client receives appropriate, timely services.

By 11/1/01 site case managers will review each client's needs and re-assess the quality of care and timeliness of services provided based upon that review.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Review CaST data and individual case management plans of clients receiving case management with the site case managers on at least a monthly basis.		CaST Data	11/01/01 and monthly thereafter	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H.
B. Re-assess and re-design the individual case management care plan if necessary.		N/A	11/01/01	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H.

Goal for process of **resource development:** To increase the client's ability to use support, diagnostic, and treatment services in an appropriate and timely manner.

Objective 1: By 11/1/00 site case managers will document the knowledge, skills and support offered to clients to promote their self-sufficiency and self-determination.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Training and ongoing technical assistance will be provided to assure site case managers understand and follow expected protocols.		CaST Data	11/01/01 and monthly thereafter	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H.
B. Case management plans, involving the client at every step, will be signed and dated by both the client and the case manager.		N/A	11/01/01 and monthly thereafter	Site Case Managers
C. Conduct annual inventory of resources available and utilized by clients.		N/A	11/01/01	Clinical QA Coordinator – C.K. Program Consultants – S.B. & S.A.H., Site Case Managers

Goal for the process of **evaluation:** To evaluate whether clients receive diagnostic, treatment and rescreening services in a timely and appropriate manner according to program protocol.

Objective 1: By 12/1/01 program staff will review outcome measures of the adequacy of individual case management services.

Activities	Status	Data	Time Frame for Assessing Progress	Staff Responsible
A. Monthly review of site specific CaST data and submitted case management plans, adequacy will be assessed based on timeliness of access to diagnostic and treatment services.	In Progress	CaST Data	11/01/01 and monthly thereafter	Program Coordinator – S. Burn. Clinical QA Coordinator – C.K. Data Manager
B. All clients will have their case management plan reviewed for quality, appropriateness and timeliness of services accessed following closure of their case.	In Progress	CaST Data	Bienneial site visits	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
C. Client satisfaction will be reviewed following closure of every case.	In Progress	CaST Data	Monthly	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
D. Documented refused care & lost to follow up clients will have their medical records reviewed during each standard QA site visit.	In Progress	CaST Data	Bienneial site visits	Clinical QA Coordinator – C.K. Program Consultants—S.B. & S.A.H.
E. Provide feedback to site case managers on the quality of services and performance	In Progress	CaST Data	4/01/02 & biannually thereafter	Program Coordinator – S. Burn. Data Manager Clinical QA Coordinator—C.K. Program Consultants—S.B. & S.A.H

Overview of Cervical Cancer Operational Plan for Alaska BCHC

Background / Data Review and Assessment

The Alaska BCHC's improved infrastructure and support for providers has resulted in an increase of women served over the past 18 months, or since the program was moved to the Maternal, Child, and Family Health section. Considerable attention has been devoted to improving the quality of clinical breast examination and follow-up. The program is now moving to develop a more comprehensive and standardized quality assurance plan. MDE data indicate increases can be anticipated for both breast and cervical screening: Paps (04/98-03/99) 3,830; projected (04/99-03/00) 4,000; and screening mammogram results (04/98-03/99) 1,647; projected (04/99-03/00) 1,800.

The Alaska BCHC serves women aged 18-64 who are un- or underinsured and have incomes <250% of the Federal Poverty Level (FPL). Review of MDE data through 9/30/99 show that of women 50-64 years of age, only 36% have received a program funded Pap test. The ethnicity of women with abnormal Pap tests reflects the demographics of our program enrollment.

Cervical cancer mortality rates in Alaska are low relative to other states. For the five year period of 1992-96 the average annual mortality rate for Alaska was 1.8 per 100,000 women - the fourth lowest among the 50 states (SEER, 1999). Only a decade earlier (1986-87), Alaska's cervical cancer mortality rate was tenth highest in the nation at 3.8 per 100,000 (MMWR 1992:41;SS-2). Continued improvement in cervical cancer mortality is especially marked among Alaska Natives. Between 1980 and 1998, the cervical cancer mortality rate for Alaska Natives declined by 87%. By 1993-97, the average annual cervical cancer mortality rate for Alaska Native women was 2.5 per 100,000 and, while higher than the non-Native rate for that time period, was not statistically different. Only three cervical cancer deaths occurred among Alaska Natives during 1994 to 1998, preventing calculation of a reliable mortality rate -- but the continued decline in mortality due to cervical cancer indicates that this racial disparity for cervical cancer mortality in Alaska may have been eliminated (Schoellhorn, unpublished, 2000).

Background / Data Review for Women Rarely or Never Screened

Alaska Behavioral Risk Factor Surveillance System (BRFSS) data for 1998 indicate that 96.9% of women have ever had a Pap test, and 92.3% have had a Pap test in the last five years. Women reporting lower incomes and fewer years of education report lowest rates of Pap screening within the last five years. By age, the lowest rates of Pap screening within the last five years occur in the 60-64 yr. (17.5%) and over 65 yr. old (15.6%) age groups. Women who are retired or unable to work report having received the least screening in the last three years. Racial pattern data obtained for blacks from BRFSS may be skewed by small sample size. "Other" race reports a high rate of recent Pap screening, possibly because of access to Native Health Corporation services by Alaska Native populations. State race-specific data show that Alaska Natives report the highest rates of Pap test screening in the past three years and, consistent with that, the "Other" group is the most likely to have been screened in the last three years.

Of the women that have received pap tests through our program, 3.5% (206 of 5,865) have never had a Pap test and an additional 10 % (575 of 5,591) received their last Pap test five or more years ago. Only 1.2% of women said the did not know or did not indicate they had ever had a Pap test and another 7% said they had had a Pap but did not recall when the last one occurred. Women received both Pap and breast screening on entrance into the program 35% of the time. Only 13.9% of our program clients have received three annual Pap screenings where the results were all Negative/WNL.

Background / Data Review Re: Decreasing Over-screening Among Enrolled Women
We use the patient reminder system in CaST that provides annual and short term follow-up reminders. The reminder lists are sent to our providers. These reminder/recall systems are currently capable of accepting modification to generate recall data for Pap test cycles other than on an annual basis and on a result-dependent basis. Providers have their own recall systems that may require modification to incorporate the new guidelines. Questions have arisen as to whether or not women will continue to come for annual breast screening when Pap screening is not offered or encouraged as appropriate for them.

Hysterectomy is reported on 19% of program clients compared to 14.4% statewide (BRFSS data). Of the program clients, 2% of the reported hysterectomies were in women with a history of cervical cancer; 3% were in women with a history of severe cervical dysplasia. The program has had a policy of not encouraging Pap smears for women with previous hysterectomy for non-cancerous reasons but has continued to pay providers for Pap smears when the client is uncertain as to reason for hysterectomy, or for provider discretionary reasons. The program also pays for an initial exam to determine whether or not a woman has a cervix. The program has collected hysterectomy data but will be adding a question to specifically address whether or not the woman has an intact cervix.

There are 18 women who are currently in the program who have returned for a fourth Pap after having three normal Paps by our providers. There are 91 women who have received three normal Pap tests who will not be eligible for a fourth. There are 656 women who have had two normal Paps who may need to be counseled about not returning on an annual basis if their next test is normal. The program has only been screening for five years, so we are only now at a point where we can begin to monitor overscreening.

The program's clinical guidelines will be updated to include recommendations for Pap screening on a result-driven basis. Key experts from the clinical advisory committee will be called upon to assist the program in re-educating providers about the change in policy and practice. Program eligibility and screening forms will be revised to assist providers in identifying women who are not in need of Pap screening due to having had three consecutive normal results in the last 5-year period.

Revised Cervical Cancer Screening Policy Workplan
Alaska BCHC (Rev. 05/08/00)

Program Goal: Increase cervical cancer screening for AK-BCHC program eligible women who have never or rarely received screening.

Measure of Success: At least 20 % of new program clients will meet the criteria of having been never or rarely screened for cervical cancer.

Objective 1A: By 10/01/2000, staff will develop a plan and timeline for identifying and reaching program eligible women who have never or rarely been screened for cervical cancer.

Activities	Data	Time Frame to Assess Progress	Staff Member(s) Responsible
a. Review and document current program capacity and activities to identify and screen never and rarely screened program eligible women.	Program	12/00	Clinical nurse consultant, Data analyst, Program coordinator
b. Review program data to determine the number & percent of women never and rarely screened (current and new enrollees).	Program Minimum Data Elements (MDE), BRFSS	12/00	Data analyst
c. Review program and other data to identify high-risk populations or geographic areas.	Program MDE, Cancer Registry, Mortality,	12/00	Epidemiologist
d. Assess the need for intensified outreach, specific strategies, and screening efforts to reach identified sub-populations.	BRFSS	12/00	Epidemiologist, Data analyst
onduct key informant interviews, focus groups or surveys to determine women's reasons for rare or never screening		02/00	Marketing analyst, Regional reps.
f. Meet with providers to identify key contacts for outreach into identified sub-populations and elicit assistance from those key contacts		02/00	Regional reps. ,Clinical nurse consultant, Program coordinator
g. Develop and pretest program materials for outreach to the rarely or never screening population		03/00	Marketing consultant

Objective 1B: By 10/01/2001, staff will implement the program plan to identify, reach, and screen program eligible women who have never or rarely been screened for cervical cancer.

a. On-going review of current program data and progress toward objectives. Plans will be revised as appropriate.	Program MDE	On-going	Program coord., Clinical nurse cons., Regional reps., Data analyst, Epidemiologist

Program Goal: Implement the revised cervical cancer screening policy. Decrease over screening among enrolled women (10/01/01).

Measure of Success: At least 75% of program clients with three consecutive, normal Pap tests within a 5 year period are transitioned to a 3-year cervical re-screening interval.

Objective 2A: By 01/01/2001, staff will develop draft cervical cancer screening policy and plan for dissemination to program providers.

Activities	Data	Time Frame to Assess Progress	Staff Member Responsible
a. CHC Clinical Advisory Committee to review, revise, recommend cervical cancer screening policy, define clinician discretion, incorporate into guidelines.		10/00	Clinical nurse consultant

b. Identify key supporters willing to work with Project Staff to assist with provider education and implementation of this policy.		11/00	Project Coordinator, Clinical nurse consultant, Regional reps.
c. Develop a plan and timeline for dissemination of the policy to providers.		11/00	Project Coordinator, Clinical nurse consultant
d. Review program materials and program contracts to determine need for revisions due to policy/ procedural change.		02/01	Project coordinator, Marketing consult., Outreach coordinator

Objective 2B: By 10/01/2001, staff will coordinate the dissemination, training on and implementation of the revised cervical cancer plan.

a. Disseminate policy to providers.		04/01	Clinical nurse cons.,
b. Monitor provider feedback and requests for assistance in implementing the policy.		On-going	Clinical nurse cons., Outreach coord., Regional reps.
c. Assess success of strategies implemented; revise as necessary.		On-going	Project coordinator, Clinical nurse cons.
d. Develop plan to evaluate impact of policy on the return rate of women needing breast screening but not Pap/pelvic under the Program's guidelines.		09/01	Clinical nurse cons., Data analyst, Regional reps.

Objective 2C: By 10/01/2001, staff will coordinate efforts to inform/educate program eligible women of the revised cervical cancer screening policy.

a. Develop and disseminate client messages and qualitatively analyze effectiveness of messages and media used.		04/01	Marketing cons., Project coordinator, Data analyst
b. Ongoing assessment of success of strategies as implemented. Revise as necessary.		On-going	Project coordinator

Objective 2D: By 10/01/2001, staff will coordinate efforts for a program review of clinical systems to determine frequency at which program providers are scheduling Pap tests for NBCCEDP-enrolled women.

a. Develop and document plans to promote provider compliance with new policy.	Program	01/01	Data analyst, Clinical nurse cons., Regional reps.
b. Review and document aggregate program data to identify provider agencies that have historically provided Pap tests to women after documentation of three consecutive, normal, annual results.	Program	06/01	Data analyst
c. Meet with providers to discuss, reinforce scientific basis for, and encourage compliance with policy.		06/01	Project coordinator, Clinical nurse cons., Regional reps.
d. Develop a method to identify individual clinicians within provider agencies.		09/01	Data analyst
e. Assess progress toward meeting objective.	Program, site visits	On-going	Project coordinator

Objective 2E: By 10/01/2001, staff will review and revise the current reminder/recall system and educate contractors to ensure that eligible women are reminded of appointments at the appropriate intervals.

a. Review/revise current reminder policies and procedures as needed.		06/01	Project coordinator
b. Review/revise program materials as needed.		06/01	Outreach coord., Regional reps
c. Develop standardized cue cards and reminder cards for use by providers to emphasize recommended Pap screening schedule.		06/01	Outreach coord., Marketing consultant
d. Review and document program data regarding the Project's rescreening rate.	Program MDE	04/01	Data analyst, Regional reps.
e. Test modified reminder/recall system to ensure clients will be recalled at the appropriate intervals.	IMS	09/01	Project coordinator, Data analyst, Regional reps.
f. Ongoing review of rescreening rates, program materials, reminder/recall systems with revision as necessary.	Program	On-going	

Program Goal 3: Implement the policy on screening women with hysterectomy for reasons unrelated to cancer (10/01/00)

Measure of Success: No more than 2% of program clients with absent cervix due to non-cancer related hysterectomy will receive Pap screening

Objective 3: By 10/01/01, systems to monitor compliance with the Project's hysterectomy policy will be reviewed and revised as necessary.

Activities	Data	Time Frame to Assess Progress	Staff Member Responsible
a. Current program policy will be reviewed to assure consistency with CDC policy.		10/00	Project coordinator
b. Clinical Advisory Committee will review and revise clinical guidelines as necessary to clarify policy for providers.		10/00	Clinical nurse consultant
c. Assure billing edits are accurate and effective.	Program records	On-going	Data analyst, Billing clerk, Data entry clerk
d. Review CaST data	CaST	10/01/01	Data analyst

rev. 05/08/00

BUDGET JUSTIFICATION
9/30/2000 – 9/29/2001

PERSONNEL

40% Distribution:	**$290,943**
60% Distribution:	**$186,233**
TOTAL	**$477,176**

	Position Title/Name	Annual Salary	% Time	Months	Amount Requested
1.	Program Director Linda Vlastuin	$68,496	50%	12	0
2.	Program Coordinator Sandy Burnham	$56,388	100% (40%)	12	$56,388
3.	Clinical Consultant/QA/NP Chris Knutson	$55,788	15% (40%) 35% (60%)	12	$ 8,368 $19,526
4.	Liaison/Clinical/Prof Ed Sally Bowers	$54,420	25% (40%) 75% (60%)	12	$13,605 $40,815
5.	Liaison/Clinical Sherrell Holtshouser	$55,650	25% (40%) 75% (60%)	12	$13,913 $41,738
6.	Outreach/Coalition Micki Boling	$51,971	75% (40%) 25% (60%)	12	$38,978 $12,993
7.	Public Ed/Outreach/Mktg Lisa Simono	$47,760	75% (40%) 25% (60%)	12	$35,820 $11,940
8.	Programmer/Analyst Grace Reynolds	$52,824	25% (40%) 75% (60%)	12	$13,206 $39,618
9.	Admin Clerk II Jeanne Della-Maggiore	$27,060	75% (40%) 25% (60%)	12	$20,295 $ 6,765
10.	PHN/NP Liaison Vacant	$51,352 (6 mos)	(40%) 50% (60%)	12	 $12,838
11.	Admin Clerk III Sue Layton	$32,952	100% (40%)	12	$32,952
12.	Admin Clerk II Vacant	$ 26,604	100% (40%)	12	$26,604
13.	Accounting TechnicianI Julie Bristol	$30,814	100% (40%)	12	$30,814

FRINGE BENEFITS — **40% Distribution $87,283**
($ Amount x .30) — **60% Distribution $55,870**
TOTAL $143,153

Personnel: Administration
$290,943 x 30% = $87,283
Personnel: Outreach/Screening/Referral/Follow-up
$186,233 x 30% = $55,870

INDIRECT COST — **40% Distribution** — S 99,253
$620,329 x 16% = $99,253
The indirect rate used by the State of Alaska is approximately 16% of personnel costs and fringe benefits.

TRAVEL

40% Distribution: $41,115
60% Distribution: $10,260
TOTAL $51,375

Out of State — **(40% Distribution) Total $12,075**

Conference/Meeting	# Personnel	$/Person/Trip	Total Cost
Chronic Disease Conference	1	$1,725	$1,725

1 trip x $1,000 r/t airfare x 1 person = $1,000
5 days per diem x $42/day x 1 person = $210
4 nights lodging x $110/night x 1 person = $440
Shuttle, airport parking, mileage @ $75
One Program staff will travel to CDC sponsored Chronic Disease Conference in Atlanta, GA.

NTC Conference — 2 — $1,725 — $3,450
1 trip x $1,000 r/t airfare x 2 people = $2,000
5 days per diem x $42/day x 2 people = $336
4 nights lodging x $110/night x 2 people = $660
Shuttle, airport parking, mileage @ $75
Two Program staff will attend one National Training Center training as required by CDC.

Program Directors' Meeting — 1 (x 2trips) — $1,725 — $3,450
2 trips x $1,000 r/t airfare x 1 person = $2,000
10 days per diem x $42/day x 1 person = $420
8 nights lodging x $110/night x 1 person = $880
Shuttle, airport parking, mileage @ $75/trip
Program Coordinator will travel to lower 48 to two CDC Program Directors meetings.

Data Managers — 1 — $1,725 — $1,725
1 trip x $1,000 r/t airfare x 1 person = $1,000
5 days per diem x $42/day x 1 person = $210

4 nights lodging x $110/night x 1 person = $440
Shuttle, airport parking, mileage @ $75
Data manager will travel to lower 48 for CDC mandated data managers' meeting.

Cancer Control Conference	1	$1,725	$1,725

1 trip x $1,000 r/t airfare x 1 people = $1,000
5 days per diem x $42/day x 1 people = $210
4 nights lodging x $110/night x 1 people = $440
Shuttle, airport parking, mileage @ $75
One Program staff will travel to lower 48 for CDC required cancer control conference.

Cervical Cancer Public Education Conference	1	$1,725	$1,725

1 trip x $1,000 r/t airfare x 1 person = $1,000
5 days per diem x $42/day x 1 person = $210
4 nights lodging x $110/night x 1 person = $440
Shuttle, airport parking, mileage @ $75

In State - Staff **(40% Distribution) Total $29.040**

Outreach/Screening Referral/Follow-up	No. of Personnel	Cost per Person/Trip	Total Cost
Various Locations	2	$726	$29,040

20 trips x $350 average r/t airfare x 2 people = $14,000
3 days per diem x $42/day x 2 people x 20 trips = $5,040
2 nights lodging x $100/night x 2 people x 20 trips = $8,000
Rental car, airport parking, etc @$50/person x 20 = $2,000
Justification
To be used by the Program Coordinator, Clinical Liaisons and Outreach personnel to enroll providers, conduct site quality assurance reviews, technical assistance and individual client case management at screening sites. Trips will require two people. New sites may require two trips during their first year of screening for the program.

In State - Patient **(60% Distribution) Total $10.260**

Patient	# Clients	$/Person/Trip	Total Cost
Rural Areas	15	$684	$10,260

1 trip x $400 r/t airfare per patient x 15 patients = $6,000
2 days per diem x $42/day x per patient x 15 trips = $1,260
2 nights lodging x $100/night x per patient x 15 trips = $3,000
Justification
The Program is expanding into rural areas of the State and patient travel will be needed to obtain diagnostic services.

CONTRACTUAL

40% Distribution:	**$ 44,000**
60% Distribution:	**$ 937,674**
TOTAL	**$ 981,674**

Clinical Services **(60% Distribution) Total $675,287**

4,500 Clients x $150 per client = $675,287

Payments to screening and diagnostic providers for procedures. Screening and diagnostic calculation worksheet estimates a higher cost per woman than the program has ever experienced in the past. We estimate cost per woman for clinical services to be $150 per woman. Based on historical program data, cost for clinical services per woman has been $135.

Eligibility Determination/Follow-up/Supplies **(60% Distribution) Total $135,000**

4,500 clients at $30/client = $135,000

Payment to screening providers for above services.

Case Management **(60% Distribution) Total $ 86,387**

Payment for case management services per case management plan.

Outreach/Follow-up **(40% Distribution) Total $24,000**
(60% Distribution) Total $36,000

Grant to YWCA for recruiting women, determining eligibility, and conducting follow-up in the Anchorage area.

Medical Consultation **(40% Distribution) Total $ 5,000**
(60% Distribution) Total $ 5,000

50 hours x $200/hour = $10,000

Contract with women's health specialist for consultation on pap smear follow-up/cervical diagnostic services and provider training. Contract previously approved.

Billing Database Maintenance and Updating **(40% Distribution) Total $ 5,000**

Contract with programmer to provide maintenance and updates on customized billing database as needed by the program. Contract previously approved.

Professional Education **(40% Distribution) Total $10,000**

5 trainer/speakers x $2,000 per speaker = $10,000

(Includes airfare, lodging, per diem and/or honorarium)

Provide continuing education and skills building opportunities on breast and cervical cancer screening to medical providers statewide by providing speakers for 5 statewide professional conferences including the Alaska Nurse Practitioners Association, Alaska Medical Association, Radiology Associates, Physicians Assistants, and Mammography Technology Associates.

OTHER

40% Distribution:	**$ 84,861**
60% Distribution:	**$ _____**
TOTAL	**$ 84,861**

In State Travel **(40% Distribution) Total $3,804**

Conference/Meeting	No. of Personnel	Cost per Person/Trip	Total Cost
BCCEDP Medical Advisory Committee Meeting	6	$634	$3,804

1 trip x $400 average r/t airfare x 6 people = $2,400
2 days per diem x $42/day x 6 people x 1 trip = $504
1 night lodging x $100/night x 6 people x 1 trip = $600
Cab, airport parking, etc. @$75 each = $300

Justification

Travel for six BCCEDP Medical Advisory Committee members to travel to Anchorage for one Medical Advisory Committee meeting to revise protocols.

Advertising/Marketing **(40% Distribution) Total $40,000**

Television/radio adds to broadcast Public Service Announcements, adds on city buses, statewide and local newspaper adds in 19 communities for outreach and public education.
Average expense = 19 Communities x $2,105 per community

Printing **(40% Distribution) Total $20,835**

Poster/display board for program $500

Orientation packets for screening & diagnostic providers. $2.50/packet x 200 packets = $500

Marketing packets for screening providers. $2.50/packet x 200 packets = $500

Updated clinical guidelines for medical providers. $3/booklet x 1,000 booklets = $3,000

Resource guide. $1/booklet x 2500 booklets = $2,500

Client reminder cards for follow-up screening services. .30¢/card x 5,000 cards = $1,500

Program forms (eligibility, data reporting, Vouchers). $1250 per quarter x 4 quarters = $5,000

Program handout to explain program to enrolled women. .50 x 5000 = $2,500

Direct mailing event stuffers 60,000@ .025 each = $1,500

Posters, sticky pads, gift certificates $3,335

Postage **(40% Distribution) Total $10,122**

Provider orientation packets. $3/packet x 200 packets = $600

Marketing packets. $3/packet x 200 packets = $600

Resource Guides. .75¢/booklet x 2.500 booklets = $1,875

Clinical Guidelines. $2.50/booklet x 1,000 booklets = $2,500

Mailing program forms to providers. $250 per quarter x 4 quarters = $1,000

Policy and procedure manuals. $5/manual x 200 manuals = $1,000

Postage for mailing program posters, brochures, etc. = $2,547

Telephone **(40% Distribution) Total $ 3,000**

Medical Advisory Committee
4 teleconference meetings per year x 2 hours per meeting x $200 hour = $1,600

Screening Provider Teleconference
4 teleconference meetings per year x 1 hour per meeting x $200 hour = $800

1-800 Telephone Line for Client Outreach
$50 per month x 12 months = $600

Supplies **(40% Distribution) Total $5,000**

Purchase file folders, envelopes, pocket folders, mailing boxes, etc. = $3,000

Purchase self-study materials and videos for medical providers = $2,000

Miscellaneous **(40% Distribution) Total $2,100**

Conference participation fees 2 @ $250 = $500

Staff training. $200 per training x 8 staff = $1,600. Provide job related professional education to BCCEDP staff.

Total Grant 40/60 Summary	
40% (includes $99,253 in administrative costs)	**$ 647,455 (35%)**
60%	**$1,190,037 (65%)**
Total Request	**$1,837,492 (100%)**

Unobligated Funds

The program anticipates having approximately $350,000 in unobligated funds at the close of FY 2001 (October 29, 2000). This is the result of: several staff vacancies during the year, a delay in enrolling new providers and conducting site visits, coalition activities that were not conducted because of a change in direction with those plans, and because we have not yet achieved our goal of screening 4,500 women per year (targeted for December 2001). We have also made an effort to work with the American Cancer Society and YWCA ENCORE Plus program to fund screening mammograms for women 40-49, so we have had a reduction of program funded mammograms for that age group. This effort was initiated in order to work toward the CDC requirement of 90% of program funded mammograms going to women age 50-64.

MAINTENANCE OF EFFORT
9/30/2000 – 9/29/2001

Personnel: $ 20,892

This represents a portion of the salaries (including benefits of the following state employees who are actively involved in this project.

Pam Muth, MPH Section Chief	15%	$14,302
Jay Newgaard, Admin. Assistant	10%	$ 6,590

Equipment: $132,249

This represents the State's cost for the computer hardware/software Necessary to conduct BCCEDP's activities and LAN support.

Contractual: $ 25,939

Telephone costs to support BCCEDP's activities.

TOTAL STATE SUPPORT $179,080

SUMMARY OF MATCH

Category	Amount
Public Health Nursing – Women's Health Services	$263,398
Alaska Run For Women	$ 49,500
Donated Mammograms – Providence Imaging Center	$ 5,000
Donated Mammograms – Alaska Regional Hospital	$ 5,000
Donated Mammograms – Health South Diagnostics	$ 5,000
Donated Mammograms – Breast Cancer Detection Center	$213,888
Uncompensated Care – Medical Providers	$225,000
Breast Cancer Focus Inc. – Education	$57,615
Total	**$824,401**

SCREENING AND DIAGNOSTIC WORK-UP CALCULATIONS SHEET

CALCULATIONS INPUT

NUMBER OF WOMEN SCREENED		AK-BCCEDP	Cost of each procedure
New Screens: mammograms	1,200		
Subsequent mammograms	600		
Total mammograms	1,800		$ 67.81
Number of screening CBE's	1,800		
New Screens: PAPs	2,500		
Subsequent PAPs	2,000		
Total PAPs	4,500		$ 14.60
New office visits	2,560	New Pt	$ 143.88
Subsequent office visits	2,250	Established Pt	$ 81.56
Total office visits	4,810		

ASSUMPTIONS REGARDING RATES OF ABNORMALS AND PROCEDURES

Rate of abnormal mammograms new (5-10%)	5.3%
Rate of abnormal mammograms - subsequent	3.6%
Rate of abnormal CBE's (with normal mammogram)	8.0%
Rate of ASCUS Paps	6.0%
Rate of LSIL Paps	3.0%
Rate of HGSIL and SqCa Paps	1.0%

Rate of each procedure following an abnormal mammogram		Cost of each procedure
Diagnostic Mam (addt'l mam views)	56%	$ 79.33
Ultrasound	31%	$ 80.35
FNA	9%	$ 97.30
Biopsy (non excisional)	9%	$ 372.89
Excisional biopsy	19%	$ 403.60
Surgical consult	30%	$ 103.23
Pathology charges: breast		$ 86.97

Rate of each procedure following an abnormal CBE (with normal mam)	
Diagnostic Mam (addt'l mam views)	33%
Ultrasound	50%
FNA	7%
Biopsy (non exc.)	0%
Excisional biopsy	7%
Surgical Consult	93%

Rate of each procedure following ASCUS Pap smear		
Colpo-directed Biopsy	15%	$ 117.75
Colposcopy alone	5%	$ 91.12
Repeat Pap smears	100%	$ 28.93
Pathology charges: cervical		$ 86.97
Rate of each procedure following LSIL Pap smear		
Colpo-directed Biuopsy	35%	$ 117.75
Colposcopy alone	15%	$ 91.12
Repeat Pap smears	100%	$ 28.93
Pathology charges: cervical		$ 86.97
Rate of each procedure following HGSIL and SqCa Pap smear		
Colpo-directed Buipsy	90%	$ 117.75
Colposcopy alone	10%	$ 91.12
Repeat Pap smears	100%	$ 28.93
Pathology charges: cervical		$ 86.97

CALCULATIONS USING ABOVE RATES

Total abnormal mams	85.2
Total abnormal CBE's (normal Mam)	144
Total ASCUS Paps	270
Total LSIL Paps	135
Total HGSIL and SqCa Paps	45

TOTAL NUMBERS AND COSTS OF SCREENING AND DIAGNOSTIC PROCEDURES

Mammogram	1,800	$ 122,058	14.6%
Pap smears	4,500	$ 65,700	7.9%
Office visits	4,810	$ 551,843	66.2%
Colposcopy/biopsy	128.25	$ 15,101	1.8%
Colposcopy alone	38.25	$ 3,485	0.4%
Diagnostic Mam (addt'l mam views)	95	$ 7,555	0.9%
Ultrasound	98	$ 7,907	0.9%
FNA	18	$ 1,727	0.2%
Biopsy (non excisional)	8	$ 2,859	0.3%
Excisional biopsy	26	$ 10,602	1.3%
Repeat pap smear	450	$ 13,019	1.6%
Surgical consult	159	$ 16,463	2.0%
Pathology; breast	52	$ 4,495	0.5%
Pathology; cervical	128	$ 11,154	1.3%
TOTALS	12,311	$ 833,968	100%

Appendices

Alaska BCCEDP CPT Codes for 2000

DESCRIPTION OF SERVICE	CPT CODE	AK FEE 2000	TECH-NICAL	PROFES-SIONAL
CERVICAL				
Screening				
Pap Smear, reported in Bethesda System	88164	$14.60		
Diagnostics				
Pap Smear, reported in Bethesda System requiring interpretation by physician	88141	28.93		
Colposcopy Biopsy Interpretation	88305	86.97	36.90	50.07
Colposcopy without Biopsy (surgical procedure only)	57452	91.12		
Colposcopy with Biopsy and/or endocervical curettage (surgical procedure only)	57454	117.75		
OFFICE VISITS				
New Patient - Office Visit (10 minutes face to face)	99201	46.12		
New Patient - Office Visit (20 minutes face to face)	99202	71.28		
New Patient - Office Visit (30 minutes face to face)	99203	99.89		
New Patient - Office Visit (45 minutes face to face)	99204	143.88		
New Patient - Office Visit (60 minutes face to face)	99205	177.95		
Established Patient - Office Visit (5 minutes face to face)	99211	23.07		
Established Patient - Office Visit (10 minutes face to face)	99212	38.82		
Established Patient - Office Visit (15 minutes face to face)	99213	52.97		
Established Patient - Office Visit (25 minutes face to face)	99214	81.56		
Established Patient - Office Visit (40 minutes face to face)	99215	121.35		
Consultation Visit - 15 minutes face to face with patient	99241	63.23		
Consultation Visit - 30 minutes face to face with patient	99242	103.23		
Consultation Visit - 40 minutes face to face with patient	99243	131.26		
PREVENTIVE MEDICINE SERVICES				
New Patient – Initial Preventive Medicine Visit, 40-64 Years	99386	104.48		
New Patient – Initial Preventive Medicine Visit, 65 – Years	99387	120.87		
Established Patient – Periodic Preventive Medicine Visit, 40-64 Years	99396	99.89		
Established Patient – Periodic Preventive Medicine Visit, 65 – Years	99397	109.88		

Alaska BCCEDP CPT Codes for 2000

DESCRIPTION OF SERVICE	CPT CODE	AK FEE 2000	TECH-NICAL	PROFES-SIONAL
BREAST				
Screening				
Screening mammogram	76092	$67.81	$46.12	$21.69
Diagnostics				
Diagnostic/Follow-up- Unilateral Mammogram	76090	79.33	49.19	30.14
Diagnostic/Follow-up- Bilateral Mammogram	76091	97.62	60.49	37.13
Stereotactic localization for breast biopsy, each lesion, radiological supervision and interpretation	76095	424.91	331.91	93.00
Preoperative placement of needle localization wire, breast, radiological supervision and interpretation	76096	92.85	60.49	32.37
Radiological examination, surgical specimen	76098	29.39	19.59	9.79
Ultrasound - Echography, Breasts(unilateral or bilateral) B -scan and/or real time image documentation	76645	80.35	49.19	31.16
Ultrasonic guidance for cyst aspiration, radiological supervision and interpretation	76938	109.99	71.06	38.93
Ultrasonic guidance for needle biopsy, radiological supervision and interpretation	76942	110.42	71.06	39.36
Aspiration of Cyst of Breast (surgical procedure only)	19000	70.12		
Aspiration of Cyst of Breast, Additional	19001	40.36		
Biopsy of breast; needle core (surgical procedure only)	19100	134.36		
Incisional biopsy of breast.	19101	372.89		
Excision of cyst, fibroadenoma, or other benign or malignant tumor aberrant breast tissue, duct lesion or nipple lesion	19120	403.60		
Excision of breast lesion identified by pre-operative placement of radiological marker - single lesion	19125	440.47		
Excision of breast lesion identified by pre-operative placement of radiological marker - each additional lesion	19126	188.43		
Preoperative placement of needle localization wire, breast	19290	157.03		
Surgical Tray. Reimbursed only in conjunction with 19101, 19120, 19125, 19126, 76095	A4550	19.04		
Fine Needle Aspiration with/without preparation of smears	88170	97.30	21.01	76.29
Evaluation of Fine Needle Aspiration	88172	70.26	31.62	38.65
Interpretation and Report of Fine Needle Aspiration	88173	112.44	32.05	80.40
Breast biopsy interpretation	88305	86.97	36.90	50.07

Billing Code: 4163-18-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 99052]

Cooperative Agreement for 1999 National Breast and Cervical Cancer Early Detection Program

Notice of Availability of Funds

A. Purpose

The Centers for Disease Control and Prevention (CDC) announces the availability of fiscal year (FY) 1999 funds for a cooperative agreement program for the National Breast and Cervical Cancer Early Detection Program. This program addresses the "Healthy People 2000" priority area(s) related to cancer.

The purpose of this program is to establish a State/territorial/tribal comprehensive public health approach to reduce breast and cervical cancer morbidity and mortality through screening, tracking, follow-up and case management, public education, information, and outreach, professional education, quality assurance and improvement, surveillance, evaluation, partnership development and community involvement. The program is established to eliminate disparity and provide comprehensive breast and

cervical cancer screening services for all women at or below 250 percent of the official poverty line as established by the Director of the Office of Management and Budget(OMB) and revised by the Secretary of DHHS in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1991 [Section 1504(b)(3) of the PHS Act, as amended]. Criteria for priority populations are uninsured or under-insured older women who are racial, ethnic and cultural minorities, such as American Indians, Alaska Natives, African-Americans, Hispanics, Asian/Pacific Islanders; Lesbians; women with disabilities; and for women who live in hard-to-reach communities in urban and rural areas. Priority populations, as defined above, will be used throughout this document.

B. Eligible Applicants

Assistance will be provided only to the official health departments of States and Territories or their bona fide agents or instrumentalities and to Indian Tribal governments (including Indian Tribes, Tribal organizations, Alaska Natives and Urban Indian organizations, hereafter referred to as Tribes). This includes the Commonwealth of Puerto Rico, the Federated States of Micronesia, Guam, and the Republic of the Marshall Islands, and federally recognized tribes.

1. The following States and territories are excluded:

   a. American Samoa, California, Colorado, Maryland,

Michigan, Minnesota, Missouri, New Mexico, North Carolina, South Carolina, Texas, and West Virginia, which were funded in August 1997, under Program Announcement 718 entitled National Breast and Cervical Cancer Early Detection Program.

b. Alabama, Commonwealth of the Northern Mariana Islands, Delaware, Hawaii, Idaho, Indiana, Kentucky, Mississippi, Montana, Nevada, New Hampshire, North Dakota, Republic of Palau, South Dakota, Tennessee, Virgin Islands, Virginia, Washington, DC, and Wyoming, which were funded in September of 1996, under Program Announcement 623 entitled 1996 National Breast and Cervical Cancer Early Detection Program.

2. The following Tribes are excluded:

a. Consolidated Tribal Health Project, Inc., CA, and Southeast Regional Health Consortium, AK, which were funded August 1997, under Program Announcement 718 entitled National Breast and Cervical Cancer Early Detection Program.

b. Hopi tribe, AZ; Native American Rehabilitation Association of the NW, OR; Indian Community Health Service; AZ; and the Navajo Division of Health, AZ, which were funded in September of 1996, under Program Announcement 623 entitled 1996 National

Breast and Cervical Cancer Early Detection Program.

States currently receiving CDC funds under Program Announcement 321 and 474, entitled Early Detection and Control of Breast and Cervical Cancer, are eligible to apply for funding under this announcement. Tribes currently receiving CDC funds under Program Announcement 442, entitled Early Detection Program American Indian Initiative, are eligible to apply for funding under this announcement. Additionally, Puerto Rico, currently funded under Program Announcement 425, entitled Capacity Building for Core Components of Breast and Cervical Cancer Prevention and Control, is eligible to apply under this announcement.

C. Availability of Funds

1. Approximately $53,000,000 is available in FY 1999 to fund approximately 23 States. It is expected that the average award will be $2,100,000, ranging from $1,000,000 to $4,500,000.

2. Approximately $3,500,000 is available in FY 1999 to fund approximately 12 Tribes/Territories. It is expected that the average award will be $300,000, ranging from $200,000 to $500,000.

It is expected that the awards will begin on September 30, 1999, and will be made for a 12-month budget period within a

project period of up to five years. Funding estimates may change.

Continuation awards of funded projects within an approved project period will be made on the basis of satisfactory progress and the availability of funds.

Direct Assistance

You may request Federal personnel, equipment, or supplies as direct assistance, in lieu of a portion of financial assistance.

Use of Funds

1. Not less than 60 percent of cooperative agreement funds will be expended for screening, tracking, follow-up, and the provision of appropriate support services such as case management. The remaining 40 percent will be expended to support public education, information, and outreach; professional education; quality assurance and improvement; surveillance; program evaluation; partnership development and community involvement. [Section 1503(a)(1) and (4) of the PHS Act, as amended].
2. Cooperative agreement funds will not be expended to provide inpatient hospital or treatment services. [Section 1504(g) of the PHS Act, as amended.] Also, cooperative agreement funds will not be used for the

specific diagnostic procedure of Loop Electrosurgical Excisional Procedure (LEEP).

3. Not more than 10 percent of funds will be expended annually for administrative expenses. These administrative expenses are in lieu of and replace indirect costs. [Section 1504(f) of the PHS Act, as amended.]

   Note: Treatment is defined as any medical or surgical intervention recommended by a clinician, and provided for the management of a diagnosed condition.

4. Matching funds are required from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program. [Section 1502 (a) and (b) of the PHS Act, as amended.]

5. Costs used to satisfy matching requirements are subject to the same prior approval requirements and rules of allowability as those which govern project costs supported by Federal funds. (OMB Circular A-87 "Cost Principles for State, Local and Indian Tribal Governments" and PHS Grants Policy Statement, Section 6).

6. All costs used to satisfy matching requirements must be documented by the applicant and will be subject to audit.

Recipient Financial Participation

Recipient financial participation is required for this program in accordance with the authorizing legislation. Section 1502(a) and (b)(1), (2), and (3) of the PHS Act, as amended, requires matching funds from non-Federal sources in an amount not less than $1 for each $3 of Federal funds awarded under this program. However, The Omnibus Territories Act requires DHHS to waive matching fund requirements for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands.

The matching funds may be in cash or its equivalent in-kind or donated services, including equipment, fairly evaluated. The contributions may be made directly or through donations from public or private entities. Public Law 93-638 authorizes tribal organizations contracting under the authority of Title I and compacting under the authority of Title III to use funds received under the Indian Self-Determination Act as matching funds.

In States/territories/tribes, non-Federal funds from a variety of sources may presently be used to support one or more of the breast and cervical cancer early detection activities described in this program announcement.

Maintenance of Effort (MOE) - The average amount of non-Federal dollars expended for breast and cervical cancer programs and activities made by a State/territory/tribe for

the two year period preceding the first Federal fiscal year of the program funding for breast and cervical cancer early detection activities. Supplantation of existing program efforts funded through other Federal or non-Federal sources is not allowable. Applicants may also include, as State/territory/tribe matching funds, any non-Federal amounts expended pursuant to Title XIX of the Social Security Act for the screening, tracking, follow-up and case management of women for breast and cervical cancer. Matching funds may not include: (1) the payment for treatment services or the donation of treatment services; (2) services assisted or subsidized by the Federal government; or (3) the indirect or overhead costs of an organization.

D. Program Requirements

In accordance with Public Law 101-354:

1. States, territories and tribes are required to implement all the following program components:

   a. States and tribes presently receiving comprehensive funding: All program components should be operational at this time.

   b. Territory presently receiving capacity funding: Comprehensive breast and cervical cancer screening, follow-up, tracking services and other support services such as a case management should

be initiated within the first twelve months of the first budget year. The capacity building program components (not the screening, tracking, follow-up and case management systems) should be fully operational at this time.

c. Territories/tribes not presently receiving capacity funds and applying for comprehensive funding: The application should outline plans for the operation of all program components. The screening, tracking, follow-up and case management systems should be initiated within twelve months of the award date. [Section 1503 (a)(1) and (3) of the PHS Act, as amended.]

2. If a new or improved, and superior, screening procedure becomes widely available and is recommended for use, this superior procedure will be utilized in the program. [Section 1503(b) of the PHS Act, as amended.]

3. An award may not be made unless the State/Territorial Medicaid Program provides coverage for:

a. In the case of breast cancer, a clinical breast examination and screening mammography.

b. In the case of cervical cancer, both a pelvic examination and Pap test screening. [Section 1502A of the PHS Act, as amended.]

For those Territorial Departments of Health not

receiving Medicaid, this program requirement would be non-applicable.

4. In 1993, Congressional amendments to the National Breast and Cervical Cancer Early Detection Program included the following changes:

   a. The amount paid by a State/territory/tribe for a screening procedure may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act (Medicare) [Section 1501(b)(3) of the PHS Act, as amended].

   b. All facilities conducting mammography screening procedures funded by the Prcgram must meet the regulations for mammography quality assurance developed by the Food and Drug Administration (FDA), most recently reauthorized and finalized October 31, 1998.

   c. For cervical cancer activities, facilities will meet the standards and regulations developed by the Health Care Financing Administration (HCFA) implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988.

5. In 1998, Reauthorization language for the National Breast and Cervical Cancer Early Detection Program included the following change:

   a. States/territories/tribes may enter into contracts

with public and non-profit private entities and through contracts with public and private entities to provide screening, tracking, follow-up, and case management services, as well as for public education, information, and outreach activities, professional education activities, establish mechanisms to monitor quality of screening procedures, and to evaluate such activities. If a non-profit private entity and a private entity that is not a non-profit entity both submit applications to a State/tribe/territory, the State/tribe/territory may give priority, based on a competitive review process, to the application submitted by the non-profit private entity in any case in which the State/tribe/territory determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity [Section 1501(b) of the PHS Act, as amended].

In accordance with Section 1504 (c)(2) of the PHS Act, as amended, CDC may waive the requirements for specific services/activities if it is determined that compliance by the State/territory/tribe would result in an inefficient allocation of resources with respect to carrying out a comprehensive breast and cervical cancer early detection

program (as described in Section 1501(a)). A request from the recipient outlining appropriate and detailed justification would be required before the waiver is approved.

In conducting activities to achieve the purpose of this program, the recipient will be responsible for the activities under "Recipient Activities", and CDC will be responsible for conducting activities under "CDC Activities".

Recipient Activities

1. **Establish a system for screening and rescreening women for breast and cervical cancer as a preventive health measure. [Section 1501(a)(1) of the PHS Act, as amended.]**

   This program is to increase the access to and use of screening services for breast and cervical cancer among all women with emphasis being given to identified priority populations as described under the "Purpose" section.

   a. Ensure that screening and rescreening procedures are available for both breast and cervical cancer and provided to women participating in the program, including a clinical breast exam, mammography, pelvic exam, and Pap smear.

[Section 1503(a)(2)(A) and (B).]

b. Screening services should be made available according to the following guidelines:

(1) Provide priority for screening, tracking, follow-up and other support services such as case management to women who are low-income and uninsured or under-insured. [Section 1504(a) of the PHS Act, as amended.]

An award may not be made under this announcement unless the State/territory/tribe involved agrees to give priority to the provision of screening, tracking, follow-up, and other support services such as case management to low-income women who are underserved or uninsured.

Note: Low income is defined as at or below 250 percent of the official poverty line. The official poverty line is established by the Director of the OMB and revised by the Secretary of the DHHS in accordance with Section 673(2) of the Omnibus Budget Reconciliation Act of 1991 [Section 1504(b)(3) of the PHS Act, as amended.]

(2) Establish breast and cervical cancer screening services throughout the

State/territory/tribe. [Section 1504(c)(1) of the PHS Act, as amended.]

Funds may not be awarded under this announcement, unless the State/territory/tribe involved agrees that services and activities will be made available throughout the State, territory, or tribe, including availability to members of any Indian tribe or tribal organization (as such terms are defined in Section 4 of the Indian Self-Determination and Education Assistance Act).

(3) Provide allowances for items and services reimbursed under other programs. [Section 1504(d)(1) and (2) of the PHS Act, as amended.]

Funds may not be awarded under this announcement, unless the State/territory/tribe involved agrees that funds will not be expended to make payment for any item or service that will be paid or can reasonably be expected to be paid by:

(a) Any State/territory/tribe compensation program, insurance policy, or Federal or State/territory/tribe health benefits program.

(b) An entity that provides health services on a prepaid basis.

(4) Establish a schedule of fees/charges for services. [Section 1504(b)(1), (2), and (3) of the PHS Act, as amended.]

Funds may not be awarded under this announcement unless the State/territory/tribe involved agrees that if charges are to be imposed for the provision of services or program activities, the fees/charges for allowable screening and diagnostic evaluation will be:

(a) Made according to a schedule of fees that is made available to the public. [Section 1504(b)(1) of the PHS Act, amended.]

(b) Adjusted to reflect the income of the woman screened. [Section 1504(b)(2) of the PHS Act, as amended.]

(c) Totally waived for any woman with an income of less than 100 percent of the official poverty line.

Additionally, the schedule of fees/charges should not exceed the maximum allowable charges established by the Medicare Program administered by the Health Care Financing Administration (HCFA). Fee/charge schedules should be developed in accordance with guidelines described in the interim final rule (42 CFR Parts 405 and 534) which implements Section 4163 of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508) which provides limited coverage for screening mammography services.

Breast Health: The most important risk factors for breast cancer are being female and older age. Priority for mammograms should be given to eligible women 50 years and older not enrolled in Medicare Part B previously screened in the NBCCEDP. Specific policies that outline eligibility criteria and authorize screening and diagnostic services are provided in the NBCCEDP PPM.

Cervical Health: Women who are 18 years and

older, with an intact cervix, are eligible for an annual Pap test and pelvic examination. While the incidence of precancerous lesions are higher among younger women, older women have higher rates of invasive cancer and cervical cancer mortality and are less likely to be screened regularly. Hence, programs should provide a balanced distribution in the ages of wome· receiving Pap tests. Women who have had a total hysterectomy that was performed for cervical neoplasia are eligible to receive Pap screening. Priority for Pap tests should be given to eligible women previously screened in the NBCCEDP. The following exception applies:

> After a woman has had three consecutive, normal, annual examinations, the Pap test may be performed less frequently at the discretion of her health care provider.
>
> For diagnostic services following an abnormal screening result, cooperative agreement funds may be

expended for colposcopy, colposcopy-directed biopsy, and endocervical curettage.

2. **Provide appropriate referrals for medical treatment of women screened in the program and ensure, to the extent practicable, the provision of appropriate and timely diagnostic and treatment services. [Section 1501(a)(2) of the PHS Act, as amended.]**

A system for providing the appropriate and timely diagnostic and treatment services for women whose screening test results are abnormal or suspicious is an essential component of any comprehensive breast and cervical cancer early detection program. Priority for diagnostic services should be given to women provided a screening procedure by the program who have abnormal screening results. The implementation plan and budget for diagnostic services should reflect the projected number of women to be screened by the program annually and the estimated number of abnormal screening exams expected. Programs are encouraged to use the Screening and Diagnostic Worksheet included in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Policies and Procedures Manual (PPM) to report their projections.

3. **Develop, implement and maintain a proactive system for the timely and appropriate tracking, follow-up, and case management of women with abnormal or suspicious screening tests [Section 1501(a)(6) of the PHS Act, as amended].**

Systems should include the regular updating of information on local resources available in the community to which health care providers can refer women for additional diagnostic procedures, as well as treatment services. Clients in need of treatment services should be assisted with obtaining eligibility for public-supported third party reimbursement programs or private donated services.

Tracking the women screened is essential to identify those women who have abnormal results and ensure they receive appropriate and timely follow-up for short-interval rescreening, diagnostic procedures, and treatment. Tracking also includes reminders and outreach to women with normal or benign results to return for timely rescreening. A proactive tracking system is one that can be effectively integrated into the State/territory/tribe health care delivery system. The tracking system should provide women with a unique identification number and to document the outcome of

individual screening tests, regardless of the screening cycle or site. It should also provide information on needed diagnostic follow-up. Confidentiality of a woman's clinical procedure results must be assured. To meet the intent of Pub. L. 101-354 in ensuring the appropriate follow-up of women with abnormal screening results, the State/territory/tribe tracking and follow-up system must include information on screening location (e.g., county, city), demographic characteristics (e.g., race, date of birth), and screening procedures and results (e.g., mammography, Pap tests) for all women in the program. For women identified with abnormal screening results, information on diagnostic procedures (e.g., colposcopy) and final diagnoses, treatment (e.g., date initiated), and stages of cancer must be included.

4. **Develop and disseminate public information, education and outreach programs for the early detection and control of breast and cervical cancer. [Section 1501 (a)(3) of the PHS Act, as amended.]**

Public information, education, and outreach include the systematic design and sustained delivery of clear and consistent health messages to women using a variety of methods and strategies that contribute to the early detection of breast and cervical cancer. Successful

public education and outreach programs are those that increase women's knowledge, and ultimately have an impact on attitudes and screening behavior.

Public information, education, and outreach activities should increase the number of women screened especially those who are identified as priority populations as defined in the "Purpose" section.

State/territory/tribe and local programs should clearly demonstrate, through evaluation, the relationship of public information, education, and outreach strategies to the number of women screened through the program.

The program should develop a plan that defines the scope (content, priority populations, methods, strategies outcomes, resources) of the public information, education, and outreach efforts.

5. **Improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer. [Section 1501(a)(4) of the PHS Act, as amended.]**

The purpose of professional education activities is to affect health care providers' knowledge, attitudes, and behaviors to ultimately result in more women, who are identified as priority populations as defined in the

"Purpose" section, in the intended audience being screened appropriately.

Professional education refers to the education of physicians, nurses, case managers, cytotechnologists, radiologists, radiologic technologists, health educators, outreach workers, support staff members, and other health professionals. It includes preprofessional, postgraduate, and continuing education. Professional education includes developing knowledge, attitudes, and skills to enable professionals to perform their jobs more effectively. It involves the identification of resources and needs and planning, implementing, and evaluating training for the health care provider. Professional education includes promoting the development and implementation of systems of health care delivery that provide positive clinical outcomes for patients, as well as the development and dissemination of clear recommendations and guidelines.

A plan should be developed that defines the scope (i.e., content, provider populations, strategies, methods, outcomes, resources) of professional education, including a prioritized list of professional groups to be trained.

Training should be based on adult learning principles with a focus on skill-based training.

6. **Establish mechanisms through which the State/territory/tribe can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures. [Section 1501(a)(5) of the PHS Act, as amended.]** Cooperative agreement funds may not be awarded [under Section 1501 of the PHS Act, as amended, Pub. L. 101-354] unless the State/territory/tribe involved agrees to assure that the State/territory/tribe will, in accordance with applicable law, assure the quality of screening procedures conducted pursuant to Section 1503 (c) of the PHS Act, as amended.

   a. Develop and implement a quality assurance and improvement system for breast cancer screening. The mammography services provided to women screened in the program must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services.

      (1) All facilities conducting mammography screening procedures funded by the program must meet the requirements for mammography

quality assurance developed by the Food and Drug Administration (FDA), most recently Reauthorized and finalized October 31, 1998.

(2) Radiologists participating in the program will record their findings using the second edition American College of Radiology (ACR) Breast Imaging Reporting and Data System (BI-RADS). The BI-RADS' reporting categories are as follows: (1) Negative; (2) Benign finding; (3) Probably benign finding -- short interval follow-up suggested; (4) Suspicious finding; (5) Highly suggestive of malignancy; (6) Assessment incomplete -- additional imaging evaluation needed.

(3) A report of the results of a mammogram performed through this program will be placed in a woman's permanent medical records that are maintained by her health care provider.

b. Develop and implement a quality assurance and improvement system for cervical cancer screening. The laboratory services provided to women for cytological screening must be conducted in accordance with the following guidelines issued by the Secretary of the Department of Health and Human Services.

(1) All facilities providing laboratory services will meet the standards and regulations promulgated by the Health Care Financing Administration (HCFA) under the Clinical Laboratory Improvement Act (CLIA) of 1988.

(2) All cervical cytology interpretation is required to be done on the premises of a qualified laboratory.

(3) A report of the results of a Pap test performed through this program will be placed in the woman's permanent medical records that are maintained by her health care provider.

(4) Pathologists participating in the program will record their Pap test findings using the Bethesda System which specifies specimen adequacy and incorporates these categories: (1) Within Normal Limits; (2) Infection/Inflammation/Reactive Changes; (3) Atypical squamous cells; (4) Low Grade Squamous Intra epithelial Neoplasia (SIL); (5) High Grade SIL; (6) Squamous Cell Carcinoma; (7) Atypical glandular cells; (8) Other.

In addition to using only MQSA and CLIA certified providers, quality assurance and improvement efforts

should include use of:

(1) an active medical advisory group;

(2) established clinical guidelines; and,

(3) a system that assures that abnormal screening results are followed-up and that rescreening occurs.

7. **Establish mechanisms which enhance the State/territory/tribe cancer surveillance system (i.e., linkage to the Central Cancer Registry and other databases) and facilitate program planning and evaluation. [Section 1501(a)(5)) of the PHS Act, as amended.]**

Monitoring the distribution and determinants of breast and cervical cancer incidence and mortality is necessary to effectively plan, implement, and evaluate a comprehensive early detection program. Linkages and coordination with State/territory/tribe vital statistics, the Central Cancer Registry, the Behavioral Risk Factor Surveillance System and other State/territory/tribe and local surveys are needed to evaluate the status of a program's goals and objectives.

a. To do this, surveillance systems should be established or enhanced which will:

(1) Collect Statewide/territory/tribal population-based information on the demographics, incidence, staging at diagnosis, and mortality from breast and cervical cancer.

(2) Identify segments of the population at higher risk for disease and for the failure to be screened.

(3) Identify factors contributing to the disease burden, such as behavioral risk factors and limited or inequitable access to early detection and treatment services.

(4) Monitor the number and characteristics of women screened in the program and the outcome of screening by analyzing data from the State/territory/tribe tracking and follow-up system.

(5) Monitor screening resources, including the number of available mammography facilities, cytology laboratories, and providers of cervical cancer screening.

(6) When appropriate, develop linkages between the above-mentioned data bases.

b. Measuring the effectiveness of program activities to modify the screening behavior of women and the

effect on morbidity and mortality is important for the identification of successful intervention strategies for the early detection of breast and cervical cancer. Equally important is the evaluation or the assessment of factors that contributed to the successful or unsuccessful establishment and implementation of program activities.

The design of each program component should ensure that there can be meaningful evaluation. The evaluation plan should assess the implementation and effectiveness of each program component. At a minimum, the evaluation plan should identify those program activities that will be evaluated, the objectives to be measured, how they will be measured, the proposed program time-lines, and resources needed. In addition to evaluating progress in meeting goals and objectives, the program should develop performance indicators to use as a measure of program improvement and resource management and allocation.

Note: Indicator is defined as a performance measure used to track critical processes over time to signify progress toward a particular goal or outcome of the program.

8. **Ensure the coordination of services and program activities with other similar programs and establish a broad-based coalition to advise and support the program. [Section 1504(e) of the PHS Act, as amended.]**

Coordination with other similar programs maximizes the availability of services and program activities, promotes consistency in screening procedures and educational messages, and reduces duplication. An award may not be made under this program announcement unless the State/territory/tribe agrees that the services and activities provided in this program are coordinated with other Federal, State/territory/tribe, and local breast and cervical cancer early detection programs through the development of collaborative partnerships. [Section 1504(e) of the PHS Act, as amended.]

The success of a comprehensive breast and cervical cancer early detection program is improved by broad-based support in the community and active public and private sector involvement. Partnership development with a broad range of stakeholders, including consumers, brings valuable knowledge, skills, and financial resources to the program, and provides access to, and information about, populations of women who have been missed by traditional health service systems.

Linkages should be established with federally funded programs such as the Regional Offices of the National Cancer Institute/Cancer Information Service (NCI/CIS), the Health Resources and Services Administration (HRSA) community/migrant health centers, Title X Family Planning programs, State Offices for Aging and Minority Health, the Indian Health Service (IHS) and the Medicare Program of the Health Care Financing Administration (HCFA).

Linkages and active collaboration are strongly encouraged with private sector organizations such as the American Cancer Society (ACS), the Young Women's Christian Association (YWCA), the Susan G. Komen Breast Cancer Foundation, the National Breast Cancer Coalition (NBCC), the National Alliance of Breast Cancer Organizations (NABCO), the American Association of Retired Persons (AARP), local medical and nursing societies professional organizations, private physicians, survivors of breast and cervical cancer, local women's support groups, community leaders, managed care organizations, and other agencies and businesses in the community that provide health care and related support services to women.

9. Develop a work and management plan for the implementation of a comprehensive breast and cervical

cancer screening program.

The success of a comprehensive breast and cervical cancer early detection program is increased by the existence of a comprehensive, integrated, and realistic plan to address these diseases among all women, with emphasis given to women identified as priority populations under the "Purpose" section. All program components of the comprehensive program should be addressed.

A work plan should include goals, measurable objectives, strategies proposed to attain the goals and performance indicators (if applicable). The goals in the work plan should relate to the State, territory, or tribe Year 2000 Objectives and to the State, territory, and tribe Cancer Control Plan.

The management plan should reflect the development of qualified and diverse technical, program, and program/administrative staff, appropriate organizational relationships including lines of authority, adequate internal and external communication systems, and a system for sound fiscal management.

10. Representation or attendance at CDC sponsored trainings, meetings, site visits, and conferences.

CDC Activities

1. Convene a workshop of the funded Programs every one to two years for information-sharing and problem-solving and hold a Program Director's meeting at least once a year.

2. Provide consultation and technical assistance to plan, implement, and evaluate each component as described under Recipient Activities above, to include:

   a. Practical application of Public Law 101-354, including amendments to the law;

   b. Design and implementation of each program component (screening, tracking, follow-up and support services such as case management; public education and outreach; professional education; partnership development and community involvement; quality assurance and improvement; surveillance; and evaluation);

   c. Interpretation of current scientific literature related to the early detection of breast and cervical cancer;

   d. Nationally recognized clinical and quality assurance guidelines for the assessment and diagnosis of breast and cervical cancer;

   e. Evaluation of each program component through the analysis and interpretation of program outcomes,

screening data, and surveillance data;

f. Overall operational planning and program management.

3. Provide training opportunities on selected topics to State, territorial and tribal program staff through the National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control's National Training Center.

4. Conduct site visits to assess program progress and mutually resolve problems, as needed, and/or coordinate reverse site visits to CDC in Atlanta, Georgia.

G. Application Content

Use the information in the Program Requirements, Other Requirements, and Evaluation Criteria sections to develop the application content. Your application will be evaluated on the criteria listed, so it is important to follow them in laying out your program plan. The application, including budget, justification and appendices, should be no more than 125 double-spaced unbound pages, printed on one-side of 8 ½ x 11" paper, suitable for photocopying, with one inch margins, and 12 point font.

1. Executive Summary

The applicant should provide a clear, concise one or two page written summary to include: (1) the need for

goals, measurable, time-phased, and realistic objectives, and strategies to attain the goals for: (1) the overall program and (2) specific program components as described under the Recipient Activities. Project the number of women to be screened and rescreened annually by age, racial and ethnic groups, and areas or locality in the State/territory/tribe. [Section 1505(2) of the PHS Act, as amended.] Estimate the number of abnormal screening exams expected annually. Applicants are encouraged to include a completed Screening and Diagnostic Worksheet (sample included in the NBCCEDP PPM) in their application.

b. Describe the State/territory/tribe's: (1) health care delivery system; (2) proposed Statewide/territorial/tribal screening system; (3) proposed proactive tracking and follow-up system for women requiring diagnostic procedures and medical treatment not provided by the program; and (4) proposed tracking and follow-up system for women screened and rescreened by the program; and (5) proposed support services such as case management [Section 1501(a)(1) and (2) of the PHS Act, as amended.]

c. For those applicants previously receiving National

Breast and Cervical Cancer Early Detection Program Cooperative Agreement funding, describe, in detail, the operational plan related to rescreening efforts (including staff responsible for oversight, the process to monitor rescreening rates and the system to assess the strategies used) and rescreening protocol (including a systematic and comprehensive reminder system). Include the calculation of mammography and cervical cancer rescreening rates for clinical services previously provided to eligible enrolled NBCCEDP women.

d. Document available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid Program. [Section 1504 (d) of the PHS Act, as amended.]

e. Describe the ability to establish a screening program that meets FDA regulations for mammography screening; uses the American College of Radiology Breast Imaging Reporting and Data System (BI-RADS); meets the standards and regulations of the Clinical Laboratory Improvement Act (CLIA) for cervical cancer screening; and, uses the Bethesda System.

f. Provide a projected timetable for program implementation that displays dates for the accomplishment of specific proposed activities.

g. Describe the current or proposed plan for evaluating (1) the program's progress in meeting specific objectives outlined in the implementation plan by program component area, and (2) overall success based on performance indicators established by the applicant. Describe the types of indicators to be used to assess outcomes that will occur as a result of this funding. Baseline measures should be identified and assessed to allow for comparisons after implementation has begun. Specify the kind of data/performance indicator that will be used, how the data will be obtained, how information will be used to improve the overall efficiency and effectiveness of the program, as well as individual program components, who is responsible for each evaluation task, and a timeline for accomplishing each evaluation task.

h. Describe how the State/territory/tribe will assure that funds will be used in a cost-effective manner. [Section 1503 (4) of the PHS Act, as amended.]

4. Partnership Development and Community Involvement

The applicant should describe:

a. How the program will develop linkages and coordinate with other Federal, State and local programs, voluntary and professional organizations, private physicians, and mammography facilities and other groups, agencies, and businesses in the community that provide health care and related support services to women. [Section 1504(e) of the PHS Act, as amended.]

b. The current or proposed broad-based coalitions that will advise and support the breast and cervical cancer early detection program, including the identification of current members or proposed representatives, their charge, and their proposed roles and responsibilities. Specific subcommittees of the coalition should be described (e.g., Medical Advisory, public information education and outreach, and professional education).

c. Letters of support (dated within the last three months) from key partners, participants, and community leaders should be included in the application.

5. Management and Organizational Structure

The applicant should submit a Management plan. This plan should include a description of the structure to ensure the implementation of a comprehensive breast and cervical cancer program that includes development of qualified and diverse technical, program, and administrative staff, organizational relationships including lines of authority, internal and external communication systems, and a system for sound fiscal management. The information should also include the following:

a. A copy of the organizational chart indicating the placement of the proposed program in the department/organization.

b. Documentation of available resources in the State/territory/tribe for the payment or reimbursement of breast and cervical cancer screening, including the Medicaid and Medicare Programs. [Section 1504 (d) of the PHS Act, as amended.]

c. The proposed schedule of fees and charges for breast and cervical cancer screening and diagnostic services, consistent with maximum Medicare reimbursement rates, and include a description of its use in the program. In

States/territories/tribes where there are multiple Medicare rates and a single reimbursement rate is being proposed, the applicant must provide justification for approval. [Section 1504 (b) of the PHS Act, as amended.]

6. **Capability for Program Implementation**

The applicant should describe proposed activities as measured by:

a. Accomplishments of an existing breast and cervical cancer early detection program funded by CDC or relevant past experiences funded by other sources:

(1) States Currently Receiving CDC Comprehensive Funds:

Accomplishments in establishing a comprehensive breast and cervical cancer early detection program, including the total number, age and racial/ethnic distribution of women screened; percent of abnormal findings by age and race/ethnicity; rate of cancer age adjusted or age-group specific; follow-up time between screening and diagnosis and between diagnosis and treatment initiation; and, percent of women who are routinely rescreened by the program.

Accomplishments in establishing an infrastructure to support a breast and cervical cancer screening program and in resolving program challenges, such as mammography screening for Medicare Part B unenrolled women 50 years and older, the timely follow-up of women with abnormal screening and diagnostic results, or the use of the American College of Radiology BI-RADS by radiologists to report mammogram results.

(2) Territory currently receiving CDC Capacity Building Funds: Accomplishments in establishing a comprehensive infrastructure to support a breast and cervical cancer screening program including screening, tracking, follow-up and case management information, public education and outreach, professional education, quality assurance and improvement, surveillance, and partnership development and community involvement.

(3) Territories/Tribes not currently Receiving CDC Breast and Cervical Cancer Funds: Relevant past experiences of the applicant in conducting screening, tracking, follow-up, case management; public information,