



# **NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM**

**DP22-2202 Program Manual: Part I  
Program Implementation**

Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion  
Division of Cancer Prevention and Control  
Program Services Branch

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# OVERVIEW



## Background and History of the NBCCEDP

Breast and cervical cancer effects thousands of women each year across the United States with greater impact on those with limited access to care. Early detection and treatment of breast and cervical cancer through screening reduces mortality rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of racial and ethnic minorities and among those who are under- or uninsured, which creates a wide gap in health outcomes. To address this health inequity, Congress authorized the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) through the Breast and Cervical Cancer Mortality Prevention Act of 1990, directing the Centers for Disease Control and Prevention (CDC) to implement a national strategic effort for increasing access to breast and cervical cancer screening and diagnostic services for women in need (See [Appendix A](#)). For the purpose of our program, the term "women" (and the pronouns "she" and "her") includes those who do not self-identify as women, such as non-binary individuals and transgender men.

The goal of the NBCCEDP is to decrease cancer incidence, morbidity, and mortality by focusing on populations who are underserved and who have increased cancer risk due to health inequities. CDC has developed this NBCCEDP Program Manual Part 1 to provide award recipients an understanding of the NBCCEDP expectations. This manual is intended to assist recipients in meeting the requirements of the NBCCEDP as set forth in both the federal law and CDC guidance (including the Funding Opportunity Announcement DP22-2202). This will be a living document that will be updated as required during the 5-year funding period. NBCCEDP Program Manual Part II: Monitoring and Evaluation, is a companion document addressing recipient policies related to evaluation, required data collections, and CDC's national evaluation plan.

The NBCCEDP has been administered by CDC's Division of Cancer Prevention and Control (DCPC) through cooperative agreements since 1991. The program has grown to include all 50 U.S. states, the District of Columbia, 13 tribes or tribal organizations, 5 US territories, and 2 freely associated states. Those who are diagnosed with cancer through this program may be eligible for treatment through Medicaid coverage as authorized by the Breast and Cervical Cancer Treatment and Prevention Act passed by Congress in 2000.

## Priority Populations

The NBCCEDP eligible population includes those who are uninsured or underinsured, at or below 250% of the federal poverty level, aged 40 to 64 years for breast cancer services, and aged 21-64 years for cervical cancer services. Those who are symptomatic or high-risk under the age of 40 years and those over the age of 64 who do not have Medicare Part B may also receive services through the program. Recipients are required to describe their priority populations and those populations of focus who are experiencing disparities based on available data such as race, ethnicity, disability, gender identity, sexual orientation, geography, socioeconomic status, health literacy, screening rates, and cancer incidence and mortality. Recipients are responsible for educating and motivating individuals to seek screening; ensuring that services are convenient, accessible, and provided in a respectful, culturally competent manner; effectively communicating results; and assisting women who need additional services.

Those who are underinsured have out-of-pocket cost sharing required by their health insurance plans that they cannot afford. This is often a barrier for getting appropriate testing. These persons may be eligible to receive support from NBCCEDP to cover their out-of-pocket expenses. However, by law, CDC funds may not be used to pay for any portion of a test or procedure that would be paid for by another source (e.g., Medicaid or private insurance) under any circumstance and the total reimbursement paid must be limited to the Medicare rate. Recipients have the flexibility to determine whether to serve the underinsured within their program population and to define their program eligibility requirements for underinsured.

While all segments of society are affected by cancer, there are certain populations that are disproportionately burdened by the increased risk of cancer or by the lack of adequate healthcare options for prevention and/or treatment. Among the populations that will benefit from this funding are those living in rural and frontier geographic areas; culturally isolated; incarcerated or institutionalized; medically underserved; from minorities defined by race, religion, ethnicity, or culture, including African Americans, Alaska Natives, American Indians, Asian Americans, Pacific Islanders and Hispanics; lesbian, gay, bisexual, transgender, or queer; with low literacy or non-English speaking language barriers; and disabilities. Recipients should seek to achieve health equity by targeting efforts to populations disproportionately affected by cancer such as having higher mortality or rate of late-stage disease. Relevant data should be utilized to identify these populations and to select culturally appropriate and evidence-based interventions for implementation.

## NBCCEDP Eligibility

CDC established eligibility criteria for breast and cervical cancer screening in the NBCCEDP to include low-income (<250% FPL), uninsured, underinsured (i.e., whose health insurance does not fully cover screening and diagnostic services), appropriate age requirements as per screening guidelines. More specific details on age requirements can be found in the Clinical Services section of this manual. Recipients may have more restrictive eligibility criteria based upon their jurisdictional regulations. However, criteria may not expand beyond CDC's criteria. Recipients are responsible for establishing and maintaining a process to determine eligibility and enrolling eligible individuals for NBCCEDP-funded services. In addition, recipients are responsible for the provision of rescreening as per the recommended screening intervals for those who remain enrolled in the program.

## Healthy People 2030 Objectives

In accordance with the Healthy People 2030 core objectives for the nation, this program focuses on addressing the national cancer burden. Measurable outcomes for awardees will be in alignment with the following performance objectives:

- Reduce the female breast cancer death rate (C-04)
- Increase the proportion of females who get screened for breast cancer (C-05)
- Increase the proportion of females who get screened for cervical cancer (C-09)

More information about Healthy People 2030 objectives is available here:

<https://health.gov/healthypeople/objectives-and-data/browse-objectives>.

## NBCCEDP Focus

The focus of the NBCCEDP is to increase breast and cervical cancer screening. The program provides direct screening and diagnostic services for breast and cervical cancer, assists with implementation of evidence-based interventions to increase screening within partner clinics, works with community partners to actively outreach and link women to clinical services. Ultimately, a comprehensive public health approach is needed to increase breast and cervical cancer screening and follow-up. This expanded focus will help to reduce disparities and missed opportunities during patient encounters.

For NBCCEDP, this emphasis is reflected within 5 strategies:

- 1) Use of cancer and surveillance data to identify program-eligible populations and specific populations of focus who experience health disparities.
- 2) Support partnerships with community-based organizations, community health workers, cancer coalitions, and other chronic disease programs to reach populations of focus and maximize access to screening.
- 3) Deliver breast and cervical cancer screening and diagnostic services with a prioritization on populations that experience high mortality and rates of late-stage disease at diagnosis. Also assist individuals into and through the screening and diagnostic continuum using community health workers, patient navigators, and local partners to overcome barriers and address social determinants of health.
- 4) Work with partner clinics where you are providing screening and diagnostic services to implement evidence-based interventions which increase access to, delivery of, and demand for breast and cervical cancer screening.
- 5) Monitor efforts and evaluate outcomes to assess program effectiveness. Results of these assessments should be reported to CDC and shared as lessons learned.

**Recipients are required to implement all strategies to achieve program success.** Expected activities for each strategy are described in more detail in this manual. The NBCCEDP Logic Model depicts the work of the strategies in achieving intended outcomes. (See [Appendix B](#)).

# STRATEGIES

The background of the page features a complex, abstract design. It includes several overlapping, semi-transparent rectangular shapes in shades of light blue, grey, and white. A network of thin, colored lines (blue, orange, red) crisscrosses the space, some connecting to small square nodes. On the left side, there is a detailed technical diagram resembling a circuit board or a flowchart, with various symbols, dots, and colored squares (orange, purple, blue) connected by black lines.

## Cancer Data and Surveillance

Use of state and local data is required for identifying the population that is eligible for the program. Data should also be used to identify populations who are disproportionately burdened by breast or cervical cancer where services should be prioritized. Recipients are expected to manage data-driven programs. Identifying, using, and monitoring data should drive program decisions. Recipients should work with researchers, epidemiologists, and others to use current state and local-level data with Geographic Information System (GIS) mapping or other information systems to identify and describe priority populations and/or communities of need. These same data should be reviewed periodically to assess the impact of program activities. Data can be highly valuable for program monitoring, program improvement, quality assurance and evaluation, as well as for communicating program efforts and successes to the public, legislators, and advocates.

## Supporting Partnerships for Cancer Control and Prevention

Partnerships can be defined as groups of individuals brought together by an established reciprocal agreement for sharing resources and responsibilities to achieve common goals and derive mutual benefits. The basic assumption of a partnership is that when individuals or organizations work together, they will be more successful in their collective efforts than they could be as individual players. A partnership can be a relationship between as few as two parties, or it can involve a larger number of individuals and organizations.

Recipients are expected to develop or continue strategic partnerships in order to support the implementation of cancer program priorities and activities. Recipients should serve on cancer coalitions and help set breast and cervical cancer screening and health equity goals within cancer control plans which help to inform program planning. Collaboration with community organizations, other cancer programs, and chronic disease programs can improve the reach to the priority population and reduce redundancies. Recipients should work in partnership with other programs, including other NBCCEDP-funded programs in the same jurisdictions, to organize and address interrelated health issues and strategies that increase breast and cervical cancer screening, enhance cancer prevention and risk reduction activities, and ultimately decrease cancer burden among NBCCEDP populations of focus. Recipients should also routinely engage partners to monitor progress, provide support, and adjust activities to ensure relationships are yielding desired outcomes.

Key areas of collaboration include working with:

- State cancer coalitions and coalition partners for program planning and identification of priority populations
- Other chronic disease and health promotion programs on prevention and risk reduction activities, identifying high-risk populations, informing policies that support cancer prevention and control, and use of public health surveillance data
- Central cancer registries for reporting and use of cancer burden data
- Immunization programs to disseminate information to women screened through the NBCCEDP about HPV vaccination for adolescents to prevent cervical cancer and provide referrals to appropriate immunization programs for their children
- Other programs to help advance health equity.

The purpose of developing partnerships is to help recipients reach their goals by maximizing use of resources and coordinating program activities. To ensure program success, recipients should establish partnerships with entities such as

- Local health care facilities (e.g., community health centers and hospitals)
- Non-traditional agencies (e.g., USDA-funded Cooperative Extension Service, Bureau of Prisons, and the Housing and Urban Development)
- National organization affiliates (e.g., National Urban League, American Cancer Society, Susan G Komen)
- Professional organizations
- State and local governments
- Tribal governments
- Tribally designated organizations
- Primary care associations
- Employers
- Community organizations
- Community advocates.

MOUs, contracts, or some other formal written document should be established with these partners to delineate activities, roles, and expected outcomes. See [Appendix C](#) for MOU requirements.

## Deliver Cancer Screening and Diagnostic Services

Recipients are expected to provide **1) breast and cervical cancer screening and diagnostic services, 2) patient navigation support to program-eligible women, and 3) assistance with connecting women to needed services through community outreach.**

## Screening and Diagnostic Services

All NBCCEDP recipients are required to provide breast and cervical cancer screening and diagnostic services. Recipients should provide timely and appropriate services to women who are uninsured or underinsured and meet NBCCEDP eligibility criteria of at or below 250% FPL, and age appropriate per screening guidelines. Risk assessments should be performed so that those who are high risk can get enhanced services per national recommendations. Recipients should also provide timely referral to treatment services for women diagnosed with breast or cervical cancer or pre-cancers.

Recipients must maintain a service delivery system of clinical providers, a reimbursement system, and a data reporting system. Recipients are expected to set annual and 5-year projections for the number of women who will receive screening and diagnostic services. To help reduce the morbidity and mortality of breast and cervical cancer, the NBCCEDP is focusing on increasing services to eligible women. Each recipient is expected to increase the number of women served each year by 5%.

See [Clinical Services](#) section for details on clinical management of screening and diagnostic services.

## Service Delivery Projections

Over the last 10 years of the NBCCEDP, there has been a continued decrease in the number of women served by the program, although the number of eligible women remains much higher than the number served. Beginning with DP22-2202, recipients are expected to increase the number of women who receive breast and/or cervical cancer services by 5% from the previous year, with Program Year 1 as baseline. Each recipient should increase efficiency and reach more women in need. Recipients are required to submit annual projections on the total number of women who will be served overall, number served for breast cancer, number served for cervical cancer, and number who will receive only patient navigation services (if any). Recipients should

provide projections by race and ethnicity and rurality for each group. Projections should be developed using available data and reflect a focus on populations who are disproportionately burdened by breast or cervical cancer (e.g., having higher mortality or rate of late-stage disease). Recipients may also submit projects for additional populations of focus such as a religious group or LGBTQ+ population. Projections will be submitted electronically as per CDC guidance. Corresponding objectives should also be included in annual workplans. CDC will monitor progress towards reaching the projections at least quarterly throughout the program year.

## Patient Navigation

For purposes of the NBCCEDP, patient navigation is defined as individualized assistance provided to women to help overcome barriers and facilitate timely access to quality screening and diagnostic services, as well as initiation of timely treatment for those diagnosed with cancer. Women often face significant barriers to accessing and completing cancer screening and diagnostic services. NBCCEDP recipients are required to provide patient navigation as a strategy aimed to reduce disparities by helping women overcome those barriers, when needed.

Recipients are **required** to:

- Provide patient navigation services to assist women receiving NBCCEDP-paid clinical services in overcoming barriers to complete screening, diagnostic services, and initiation of cancer treatment. All women enrolled in the NBCCEDP **must** be assessed for barriers and need of patient navigation services. When needed, women should be provided any necessary services to help overcome barriers. Not all women will need or accept help overcoming barriers; however, all must be assessed so a determination can be made.

Recipients have the **option** to also:

- Provide patient navigation services to assist low-income women from recipients' priority populations who are being served in screening clinics, but who have other payment sources (e.g., state funds, Medicaid) for screening and/or diagnostic services. CDC refers to this service as "navigation-only".

### *Required Patient Navigation Activities*

Although patient navigation services vary based on an individual's needs, at a minimum, patient navigation for women served by the NBCCEDP must include the following activities:

1. Assessment of individual patient barriers to cancer screening, diagnostic services, and initiation of cancer treatment
2. Patient education and support
3. Resolution of patient barriers (e.g., transportation, translation services)
4. Patient tracking and follow-up to monitor patient progress in completing screening, diagnostic testing, and initiating cancer treatment
5. A minimum of two, but preferably more, contacts with the patient, due to the centrality of the patient-navigator relationship.
6. Collection of data to evaluate the primary outcomes of patient navigation -- cancer screening and/or diagnostic testing, final diagnosis, and treatment initiation if needed.
7. Linking women to other needed health, community, and social services.

### ***Optional Patient Navigation-Only Services***

Recipients may provide "patient navigation-only" services to women whose screening and diagnostic services are paid by other sources and who reflect NBCCEDP age and income eligibility requirements. Delivery of patient navigation-only services should occur in clinics where NBCCEDP-paid clinical services are provided. The target population for navigation-only services should be predominantly low-income women ( $\leq 250\%$  FPL) and be of appropriate age per USPSTF screening guidelines. For example, a recipient could support patient navigation in a partner clinic, such as an FQHC, that serves low-income populations. Recipients must collect CDC-required minimum data elements (MDEs) that are specified in the MDE data dictionary for navigated-only women who complete screening and/or diagnostic services. This requirement should be discussed with the clinic prior to starting the navigation services. When appropriate, navigators should assist in obtaining required patient-level clinical data.

### ***Terminating Patient Navigation***

Depending on screening and diagnostic outcomes, patient navigation services are terminated when a client (1) completes screening and has a normal result; (2) completes diagnostic testing and has normal results; (3) initiates cancer treatment; or (4) refuses treatment.

## **Connecting Women to Clinical Services through Community Outreach**

The goals of this strategy are to reach individuals in the community, facilitate their access to clinical services, and ensure screening completion. Recipients should strive to meet individuals where they are. Data should be used to identify 1) where they live; 2) where they work; 3) where they access care, and 4) what community services they use. Coordination of services among health systems, communities, and public health using community-based and/or clinic-based health workers can increase access to clinical care and promote health behaviors.

Recipients may use community-based and/or clinic-based health workers/lay advisors, s, or health educators for community outreach to identify women for screening, provide patient education about risk factors and preventive health behaviors, and address barriers to care. These health workers may also refer individuals to health insurance enrollment or other needed health or social service resources. The ultimate goal of the activity is to link women to community resources, medical homes, and/or health care systems/clinics for cancer screening, diagnostic, genomics, and/or treatment resources. The best way to achieve this is often by working with community and national affiliate partners to set goals, determine strategies to reach populations experiencing disparities, and use culturally appropriate interventions tailored to communities.

Recipients are required to develop processes to link individuals to health systems within the community where they live and work. The first step is to use available data to identify priority populations experiencing disparities and/or communities of need and identify the available resources for that community. Use of community-based workers (lay or professional) can help link individuals to health systems by providing outreach, education, and/or navigation services.

Recipients should identify and collaborate with key community-based organizations and other community partners that can help reach these disparate populations using culturally appropriate communications and interventions. These organizations may be able to integrate screening messages into their existing outreach, serve as access ports to reach priority populations, and assist with referring or navigating individuals to screening sites. Recipients should develop a partnership agreement (e.g., Memorandum of Understanding (MOU)) with these organizations that clearly defines the activities, roles, and expected outcomes.

The goals of these activities are to

- **Inform** individuals and community partners about your program (e.g., what it covers, screening sites, referral process).
- **Educate** individuals and community partners about cancer screening.
- **Link** individuals to health systems through community-based referrals.

Recipients are required to develop an evaluation and performance measurement plan (see Policy Manual Part II: Monitoring and Evaluation). This plan should address monitoring to ensure priority women are identified, linked or navigated to screening, and screened. This may require development of monitoring and tracking tools in conjunction with your partners that can be used to assess the quality and outcomes of all efforts. Recipients should:

- **Document and report** community activities conducted to include how many individuals were reached as part of the activity **and** how many of these individuals completed screening.
- **Review** activity to determine if goals were met, if the effort was implemented as planned, if processes worked well, whether it was worth the investment, and lessons learned.
- **Revise** activity as needed to improve efforts or determine if it should be terminated.
- **Share** any successes or challenges that can be helpful to others and any promising practices.

In planning activities with community partners, consider these questions to ensure that you will be able to monitor and evaluate your activities:

- How will individuals reached in the community be followed or tracked to confirm screening completion?
- What data can be collected to monitor how well the activities are being delivered (e.g., number of individuals reached, number of individuals referred for clinical services)?
- Did the activities focus on the right individuals (those in the priority populations) and did they reach those individuals?
- Will individuals reached through these activities receive CDC-funded screening and/or CDC-funded navigation? If so, are processes in place to collect Minimum Data Elements?
- How will confirmation of screening completion be collected for individuals who do not receive CDC-funded screening or navigation (i.e., more than self-report)?

As you explore these strategies, consider:

- Developing agreements between all involved organizations (e.g., your program, community-based partner, and health system/clinic) that support linking individuals to clinical services (screening), sharing client information for referral purposes, and collecting MDE data.
- Collecting reliable evaluation data that will support continuous feedback for program improvement and help to demonstrate outcomes (e.g., screening completion, meeting health equity goals).

See [Appendix D](#) for examples of recipient CCL activities that align with this guidance.

## Implementation of Evidence-based Interventions (EBIs)

Health systems are important partners for NBCCEDP recipients. A health system is any “system for delivering healthcare that may include, for example, hospitals, clinics, health maintenance organizations (HMOs), and community health centers.” By working with a health system to improve its breast and cervical cancer screening process, a recipient can reach many people who need to be screened for breast and cervical cancer.

Recipients should partner with health clinics to increase the overall number of women screened, improving clinic-level breast and cervical cancer screening rates, and strengthening the delivery of cancer screening services. To do this, recipients should partner with clinics to conduct a comprehensive assessment of the partner health care delivery system. The assessment should include breast and cervical cancer screening rates, data/electronic health record (EHR) functionality, patient/health system process flow, policies/standing orders for cancer screening, provider/health system adherence to clinical cancer screening guidelines, patient navigation/community health worker/support services, health equity strategies in place and/or opportunities to initiate or expand, and use of EBIs or other strategies that support cancer screening. Recipients, in partnership with the health care system, should use these data to identify priority populations and to identify appropriate interventions for implementation.

Recipients should work with partner clinics to make these interventions become a part of the patient flow for long term sustainability. Many factors can effect whether interventions continue long-term (e.g., organizational capacity and adequate staffing). To improve the chances that an intervention will continue, recipients should work with partners to incorporate

elements upfront that promote adoption and sustainability by clinic staff, like securing leadership buy-in and support; identifying a champion; involving all of the staff in selecting EBIs and making adaptations that are a fit for how the clinic operates; documenting practices and processes; conducting booster trainings to refresh knowledge; monitoring and evaluation; and creating a feedback loop for improvements.

By working with health systems, NBCCEDP recipients can expand their reach through implementing EBIs recommended in *The Guide to Community Preventive Services* (aka *The Community Guide*) and increasing screening among all women in the clinic/health system. The following table lists recommended EBIs to increase breast and cervical cancer screenings.

Approach	Intervention*	Breast	Cervical
<b>Increasing Client Demand</b>	<b>Client Reminders</b>	<b>Recommended</b>	<b>Recommended</b>
	<b>Group Education</b>	<b>Recommended</b>	Insufficient evidence
	<b>One-On-One Education</b>	<b>Recommended</b>	<b>Recommended</b>
	<b>Small Media</b>	<b>Recommended</b>	<b>Recommended</b>
<b>Increasing Client Access</b>	<b>Reducing Structural Barriers</b>	<b>Recommended</b>	Insufficient evidence
	<b>Reducing Out-of-Pocket Costs</b>	<b>Recommended</b>	Insufficient evidence
<b>Increasing Provider Delivery</b>	<b>Provider Assessment and Feedback</b>	<b>Recommended</b>	<b>Recommended</b>
	<b>Provider Reminders</b>	<b>Recommended</b>	<b>Recommended</b>
<b>Engage Community Health Workers</b>		<b>Recommended</b>	<b>Recommended</b>

\*If an intervention is recommended for one cancer but has insufficient evidence for the other cancer, CDC will allow the intervention to be implemented for both cancers.

*The Community Guide* also recommends use of interventions from multiple approaches as an effective strategy to increase cancer screening. Research showed that combining EBIs from approaches that increase client demand with those that increase provider delivery or combining EBIs from all three approaches (increasing client demand, increasing client access, and increasing provider delivery) resulted in significant increases in screening among the community compared to the implementation of single EBIs.

Recipients should document EBIs selected for each clinic in their workplans. Additionally, recipients should work with providers and health systems clinics to strengthen the capability

and use of health information technology systems, particularly the EHRs, to 1) monitor clinic-level screening rates, 2) identify populations who need to be screened, 3) implement EBIs, and 4) track completeness and timeliness of screening services. CDC is providing an Evidence-based Intervention Clinic Review Tool to assist recipients in organizing information about each clinic that is gathered during clinic assessments, process mapping, and implementation planning. The information can be used for program planning and during technical assistance discussions with the Program Consultant.

## Description of EBIs

*The Community Guide* serves as a resource to help select interventions to improve health and prevent disease in your state, community, community organization, business, healthcare organization, or school. The descriptions of EBIs recommended for increasing breast and/or cervical cancer screening are below and can be found at <https://www.thecommunityguide.org/topic/cancer>.

CDC developed individual logic models for all EBIs, patient navigation, and community outreach. An additional 'meta-logic model' illustrates how these activities work together to achieve desired outcomes. Recipients are encouraged to use these logic models in designing their own evaluation plans. See [Appendix E](#) for EBI Logic Models.

### *Client Reminders*

Client reminders are written (letter, postcard, email) or telephone messages (including automated messages) advising people that they are due for screening. Client reminders may be enhanced by one or more of the following:

- Follow-up printed or telephone reminders
- Additional text or discussion with information about indications for, benefits of, and ways to overcome barriers to screening
- Assistance in scheduling appointments

These interventions can address the overall priority population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment.

### ***Group Education***

Group education conveys information on indications for, benefits of, and ways to overcome barriers to screening with the goal of informing, encouraging, and motivating participants to seek recommended screening. Group education is usually conducted by health professionals or by trained lay people who use presentations or other teaching aids in a lecture or interactive format, and often incorporate role modeling or other methods. Group education can be given to a variety of groups, in different settings, and by different types of educators with different backgrounds and styles.

### ***One-On-One Education***

One-on-one education delivers information to individuals about indications for, benefits of, and ways to overcome barriers to cancer screening with the goal of informing, encouraging, and motivating them to seek recommended screening. These messages are delivered by healthcare workers or other health professionals, lay health advisors, or volunteers, and are conducted by telephone or in person in medical, community, worksite, or household settings.

These messages can be untailed to address the overall target population or tailored with the intent to reach one specific person, based on characteristics unique to that person, related to the outcome of interest, and derived from an individual assessment. One-on-one education is often accompanied by supporting materials delivered via small media (e.g., brochures), and may also involve client reminders.

### ***Small Media***

Small media include videos and printed materials such as letters, brochures, and newsletters. These materials can be used to inform and motivate people to be screened for cancer. They can provide information tailored to specific individuals or targeted to general audiences.

Recipients should make effort to use existing materials such as [Make It Your Own \(MIYO\)](#) when implementing small media. Recipients should also consider appropriate adaptations to tailor materials to the population of focus (e.g., using culturally appropriate images, gender inclusive language).

### ***Reducing Structural Barriers***

Structural barriers are non-economic burdens or obstacles that make it difficult for people to access cancer screening. Interventions designed to reduce these barriers may facilitate access to cancer screening services by:

- Reducing time or distance between service delivery settings and target populations
- Modifying hours of service to meet client needs
- Offering services in alternative or non-clinical settings (e.g., mobile mammography vans at worksites or in residential communities)
- Eliminating or simplifying administrative procedures and other obstacles (e.g., scheduling assistance, patient navigators, transportation, dependent care, translation services, limiting the number of clinic visits)

Such interventions often include one or more secondary supporting measures, such as:

- Printed or telephone reminders
- Education about cancer screening
- Information about screening availability (e.g., group education, pamphlets, or brochures)
- Measures to reduce out-of-pocket costs to the client (though interventions principally designed to reduce client costs are considered a separate class of approaches)

### ***Reducing Out-of-Pocket Costs***

Interventions to reduce client out-of-pocket costs attempt to minimize or remove economic barriers that make it difficult for clients to access cancer screening services. Costs can be reduced through a variety of approaches, including vouchers, reimbursements, reduction in co-pays, or adjustments in federal or state insurance coverage. Efforts to reduce client costs may be combined with measures to provide client education, information about program availability, or measures to reduce structural barriers.

### ***Provider Assessment and Feedback***

Provider assessment and feedback interventions both evaluate provider performance in delivering or offering screening to clients (assessment) and present providers with information

about their performance in providing screening services (feedback). Feedback may describe the performance of a group of providers (e.g., mean performance for a practice) or an individual provider, and may be compared with a goal or standard.

### ***Provider Reminder/Recall Systems***

Reminders inform health care providers it is time for a client's cancer screening test (called a "reminder") or that the client is overdue for screening (called a "recall"). The reminders can be provided in different ways, such as in client charts or by e-mail.

### ***Engaging Community Health Workers***

Community health workers are trained to connect the community with the healthcare system. Interventions that increase community demand and improve community access are effective when community health workers are engaged alone or as a part of a team.

## **Program Monitoring and Evaluation**

Evaluation, or the systematic collection of information about how a program operates and its impact, is an important part of program management. A good evaluation enables you to monitor program implementation, demonstrate the success of programmatic activity in achieving outcomes, and identify areas for improvement. Please see NBCCEDP Program Manual, Part II: Monitoring and Evaluation for related policies, data collection and reporting requirements, and CDC's plan for leading the national evaluation of the NBCCEDP.

## **Quality Assurance /Quality Improvement**

Quality assurance and quality improvement (QA/QI) support the quality of clinical service delivery. QA is the process of monitoring the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. QI is the commitment and approach used to continuously improve every process in every part of an organization, with the intent of meeting and exceeding customer expectations and outcomes. The QI process can be used to identify and improve any aspect of the program that impedes its

function, such as bottlenecks in claims payments, and timely and complete submission of data by providers. QA/QI processes in the NBCCEDP are intended to 1) improve screening and diagnostic services; 2) link structure and process and include standards, measurement, and actions; 3) identify and remedy root causes of quality problems; 4) meet customer needs; and 5) focus on high-volume, costly, high-risk, or problem-prone aspects of care.

These aims are achieved by assessing performance, making changes based on the assessment, and monitoring improvement. Steps to QA/QI include:

- **Quality monitoring**—The planned, systematic, and ongoing collection, compilation, and organization of data about the quality or appropriateness of an important aspect of care, as well as the comparison of those data to an established level of performance (e.g., target). The NBCCEDP core performance indicators (e.g., timeliness to diagnosis, timeliness to treatment initiation) are designed specifically for this purpose and represent aspects of care that align with the purpose of the NBCCEDP. Therefore, they are important to monitor.
- **Quality assessment**—The measurement of the level of quality at a given point in time. Assessing quality provides organizations with an opportunity to measure performance against standards (targets or benchmarks). Quality assessment creates a bridge between monitoring and improvement by establishing a common understanding of the quality of services provided and identifying opportunities for improvement. In setting priorities, assessment of clinical services is a key activity. QA above and beyond the NBCCEDP core indicators (e.g., client satisfaction) is also encouraged.
- **Quality improvement**—This is the commitment and approach used to improve the process continuously with the intent of meeting and exceeding set expectations and outcomes. QI strives to find strategies that will institute a change and continuously improve quality.

Additionally, it should be noted that activities to ensure quality services must maintain patient confidentiality.

# CLINICAL SERVICES



## Clinical Management and Reimbursement Policies for Breast Cancer Assessment

### *Breast Cancer Priority Population*

Efforts to reduce breast cancer disparities should focus on populations with high rates of late-stage disease and high mortality. Recipients should focus recruitment efforts on these populations using available data.

### *Average Risk Screening*

The NBCCEDP reimburses for breast cancer screening that are provided every 1 to 2 years to those age 40 and older who are at or below 250% of the federal poverty level and have no source of health care reimbursement. Testing should be based on history and clinical presentation. Recipients should determine their populations of focus for health disparities based on available data and concentrate efforts on reaching those populations.

### *High-Risk*

All women should undergo a risk assessment to determine if they are at high risk for breast cancer. NBCCEDP funds can be used for annual breast cancer screening among those who are considered at **high-risk** for breast cancer. “High risk” includes those who have a known genetic mutations, first-degree relatives with premenopausal breast cancer or known genetic mutations, a history of radiation treatment to the chest area before the age of 30 (typically for Hodgkin’s lymphoma), and a lifetime risk of 20% or more for development of breast cancer based on risk assessment models that are largely dependent on family history. Providers can choose whichever method they prefer to determine if someone is at high risk for breast cancer. Those at high risk for breast cancer should be screened with both an annual mammogram and an annual breast MRI.

### *Mammography Reimbursement*

The NBCCEDP will reimburse for film, digital, and 3-D mammography up to the Medicare reimbursement rate. All individuals should be counseled on the benefits and risks of mammography. If 3-D mammography is an option, everyone should be counseled on the benefits and risks of 3-D mammograms versus 2-D mammograms to make an informed decision.

Recipients should refer to the CDC's CPT Allowable List for appropriate reimbursement CPT codes.

### ***Magnetic Resonance Imaging (MRI) Reimbursement***

NBCCEDP will reimburse for screening breast MRI performed in conjunction with a mammogram when a client has been determined to be high risk (e.g., has a BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20% or greater as defined by risk assessment models). Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment. Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed for by the NBCCEDP to assess the extent of disease for staging in women who were recently diagnosed with breast cancer and preparing for treatment. Providers should discuss risk factors with all clients to determine if the person is at high risk for breast cancer. To be most effective, it is critical that breast MRI is done at facilities with dedicated breast MRI equipment and that can perform MRI-guided breast biopsies.

### ***Breast Cancer Screening for Women Over 64 Years of Age***

If a person is eligible to receive Medicare benefits and is not enrolled in Medicare, they should be encouraged to enroll. Those who are enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services. Those who are not eligible to receive Medicare Part B and those who are Medicare-eligible but cannot pay the premium to enroll in Medicare Part B may receive mammograms through the NBCCEDP.

### ***Breast Cancer Screening and Diagnostics for Women Under 40 Years of Age***

NBCCEDP funds can be used to evaluate women under the age of 40 who are symptomatic. If someone is symptomatic due to breast mass, nipple discharge, breast pain, etc., they can be provided a clinical breast examination, diagnostic testing, and/or a surgical consultation through the program.

NBCCEDP funds can be used to evaluate someone under the age of 40 who is asymptomatic and has been determined to be at high risk (see above high-risk definition) for breast cancer.

***Breast Cancer Screening for Transgender Women***

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through the NBCCEDP. Therefore, federal funds may be used to screen transgender women. While CDC does not make any recommendation about routine screening among this population, recipients and providers should counsel all eligible women, including transgender women, about the benefits and harms of screening and discuss individual risk factors to determine if screening is medically indicated.

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus recommendations on preventive care services for the transgender population. Those recommendations include “for transwomen with past or current hormone use, breast-screening mammography in patients over age 50 with additional risk factors (e.g., estrogen and progestin use for 5-10 years, positive family history, BMI > 35).” Those preventive care recommendations can be found at <http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-women>.

***Breast Cancer Screening for Transgender Men***

Transgender men (female-to-male), who have not undergone a bilateral mastectomy and meet all program eligibility requirements, are also eligible to receive breast cancer screening and diagnostic services through the NBCCEDP. Guidance on breast cancer screening for transgender men from the Center of Excellence for Transgender Health can be found at <http://transhealth.ucsf.edu/trans?page=guidelines-breast-cancer-men>.

***Breast Cancer Screening for Men***

Men are not eligible to receive breast cancer screening and/or diagnostic services through the NBCCEDP.

***Breast Cancer Screening or Surveillance for Women with History of Breast Cancer***

Those with a known history of breast cancer may be evaluated through the NBCCEDP for screening or surveillance if they meet program eligibility requirements. Follow-up should be based on their providers assessment and depend on their stage of disease and treatment course. NBCCEDP funds cannot be used to reimburse for any form of treatment.

### ***Managing Women with Abnormal Breast Cancer Screening Results***

The management following an abnormal mammogram and/or CBE relies on a body of scientific literature that is constantly growing and changing. Recipients are urged to develop clinical policies in close consultation with their medical consultants in consideration of the diagnostic standards established by such organizations as the National Comprehensive Cancer Network (<http://www.nccn.org/>) and the American College of Radiology (<http://www.acr.org/>).

To arrive at a definitive diagnosis after an abnormal breast cancer screening test, programs may use NBCCEDP funds to reimburse for additional testing such as ultrasound, breast MRI, image-directed biopsy, fine needle aspiration, core biopsy, etc., as well as associated pathology. Recipients are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

## **Clinical Management and Reimbursement Policies for Cervical Cancer Assessment**

### ***Cervical Cancer Priority Population***

The majority of those with invasive cervical cancer have never been screened for cervical cancer. These individuals are a priority in order to decrease cervical cancer diagnoses. Recruitment efforts should be concentrated on this population. As such, a minimum of 35% of all NBCCEDP-reimbursed cervical cancer screenings should be provided to program-eligible women who have never been screened for cervical cancer or not been screened within the past 10 years.

### ***Average-Risk Screening***

The NBCCEDP reimburses for cervical cancer screening and diagnostic services provided to those between the ages of 21 and 64 who are at or below 250% of the federal poverty level and have no other source of health care reimbursement, such as insurance.

The NBCCEDP funds can be used to reimburse for Pap testing alone every 3 years for those aged 21 to 29 years. For those aged 30 to 64 years, funds can be used to reimburse for either 1) Pap testing alone every 3 years, 2) co-testing with the combination of Pap testing with human

papillomavirus (HPV) testing every 5 years for those aged 40-64, or 3) primary HPV testing every 5 years. NBCCEDP funds cannot be used to reimburse for cervical cancer screening in those under the age of 21.

### ***High-Risk Screening***

Those who are at high risk for cervical cancer need to be screened more frequently. This includes those with HIV infection, who have had an organ transplantation, who may be immunocompromised from another health condition, or who had DES exposure in utero. In general those under the age of 30 should undergo annual Pap testing and those age 30 years and older should have co-testing every 3 years or annual Pap testing.

### ***Cytology Reimbursement***

Recipients may use either conventional or liquid-based cytology.

### ***HPV DNA Testing Reimbursement***

HPV DNA testing is reimbursable when used for screening or follow-up of abnormal Pap results. HPV genotyping is reimbursable when used for follow-up of abnormal cervical cancer screening results as per ASCCP algorithms. Providers should specify the high-risk HPV DNA panel only. Low-risk HPV DNA panel is not reimbursable. NBCCEDP may reimburse for high-risk DNA testing and genotyping using any FDA-approved test.

### ***Cervical Cancer Screening for Women Over 64 Years of Age***

Cervical cancer screening is not recommended for those older than 65 years of age who have had adequate screening and are not high risk. If a person over 64 needs to be screened and is eligible to receive Medicare benefits but is not enrolled, they should be encouraged to enroll. Those enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services. Those who are not eligible to receive Medicare Part B and those who are Medicare-eligible but cannot pay the premium to enroll in Medicare Part B may receive clinical services through the NBCCEDP.

### ***Cervical Cancer Screening for Transgender Men***

Transgender men (female-to-male) who have not undergone a total hysterectomy (i.e., still have a cervix) and meet all other eligibility requirements are eligible to receive cervical cancer screening and diagnostic services through the NBCCEDP.

### ***Cervical Cancer Screening or Surveillance Following Hysterectomy or Other Treatment for Cervical Neoplasia or Cancer***

NBCCEDP funds CANNOT be used to reimburse for cervical cancer screening in women who have had total hysterectomies (i.e., those without a cervix), unless the hysterectomy was performed because of cervical neoplasia (precursors to cervical cancer) or invasive cervical cancer.

Those with a known history of cervical cancer may be evaluated through the NBCCEDP for screening or surveillance if they meet program eligibility requirements. Follow-up should be based on their providers assessment and depend on their stage of disease and treatment course. All required testing for surveillance may be reimbursed by the program. NBCCEDP funds cannot be used to reimburse for any form of treatment.

For those with a history of cervical neoplasia or in situ disease, NBCCEDP funds can be used to reimburse for routine cervical cancer surveillance for 20 years post treatment.

For those with a history of invasive cervical cancer, NBCCEDP funds can be used to reimburse for cervical cancer surveillance indefinitely, as long as they are in good health.

For those whom the reason for the hysterectomy or final diagnosis of no neoplasia or invasive cancer cannot be documented, NBCCEDP funds can be used to reimburse for cervical cancer screening. For these women, cervical cancer screening should continue until there is a 10-year history of negative screening results, including the documentation that the Pap tests were technically satisfactory.

If it is unknown if the cervix was removed at the time of the hysterectomy, a physical examination can be done to determine if the cervix is present. NBCCEDP funds can be used to reimburse for an initial examination to determine if the cervix is still present.

### ***Managing Women With Abnormal Cervical Cancer Screening Results***

The management of abnormal cervical cancer screening results relies on a body of scientific literature that is constantly growing and changing. Recipients are urged to develop their clinical

policies in close consultation with their medical consultants and in consideration of the standards established by such organizations as the American Society for Colposcopy and Cervical Pathology (<http://www.asccp.org/asccp-guidelines>), the American College of Obstetricians and Gynecologists (<https://www.acog.org/Clinical-Guidance-and-Publications/Search-Clinical-Guidance>), and the Society of Gynecologic Oncologist (<https://www.sgo.org/clinical-practice/guidelines/>). The ASCCP provides a free on-line web application to assist with management.

To arrive at a definitive diagnosis after an abnormal cervical cancer screening test, recipients may use NBCCEDP funds to reimburse for colposcopy, colposcopy-directed biopsy, endocervical curettage, and, in unusual cases, diagnostic excisional procedures (such as LEEP and cold-knife excisions), as well as associated pathology. Recipients are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

### ***HPV vaccination***

NBCCEDP funds cannot be used to reimburse for HPV vaccination. However, recipients should collaborate with immunization and other chronic disease programs to education individuals about HPV vaccination for prevention of cervical cancer and where they may take their children to receive HPV vaccination or get vaccinated if they are in the catch-up age group.

## **Adequate and Timely Follow-up**

### ***Adequacy of Follow-up for Women with Abnormal Screening Results***

Public Law 101-354 requires recipients to take all appropriate measures to ensure the provision of necessary follow-up services required after abnormal screening results. If a breast or cervical cancer screening test is abnormal or suspicious, appropriate diagnostic procedures to arrive at a final diagnosis must be performed. Those with a diagnosis of breast or cervical cancer must be referred for appropriate treatment. Referral may be made to your state Medicaid Treatment Act Program based on state guidelines.

### ***Timeliness of Follow-up for Women with Abnormal Screening Results***

The interval between abnormal breast and cervical cancer screening results and final diagnosis should be no more than 60 days.

### *Timeliness of Treatment for Women Diagnosed with Cancer*

The interval between diagnosis of invasive breast or cervical cancer and initiation of treatment should be no more than 60 days.

## **Tobacco Screening and Cessation**

Recipients must develop a policy requiring all participating providers to assess the smoking status of every person screened by the NBCCEDP and refer those who smoke to tobacco quit lines. As a chronic disease prevention priority, our public health cancer screening programs are able to promote the health of our patients by providing this service with little additional effort. Each recipient is required to address this requirement in their annual work plan.

It is well known that tobacco use is associated with many cancers and chronic diseases that impact the health of our nation. CDC wants to encourage providers to assess all individuals as a standard of practice. Providers should document assessments and referrals in the medical chart.

## **Integrated Office Visit with WISEWOMAN**

CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) offers an established framework that provides the opportunity to target other chronic diseases among women, including heart disease. The authorization of the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program is an extension of the NBCCEDP to expand the preventive services being offered to women served by the NBCCEDP. The intent of the WISEWOMAN legislation is to provide chronic disease risk factor screening and health education interventions to women enrolled in the NBCCEDP, in an effort to lower their risk of heart disease and stroke. All office visits for WISEWOMAN screenings are expected to be integrated into the NBCCEDP screening office visit. The CDC's NBCCEDP and WISEWOMAN programs have developed joint policies to provide guidance for this integrated office visit.

The intent and benefit of coupling the two programs is to create a stronger link to ensure that as many women aged 40-64 as possible who are enrolled in the NBCCEDP also receive appropriate cardiovascular disease risk assessment and risk reduction in states that have both NBCCEDP and WISEWOMAN programs.

### ***WISEWOMAN Integrated Screening Services***

The following WISEWOMAN clinical screening services are expected to be integrated into the NBCCEDP screening exam office visit for new and established women aged 40-64:

- Blood Pressure Measurement (must record two systolic and two diastolic measurements)
- Height and Weight Measurement to calculate Body Mass Index
- Smoking Assessment and referral for cessation (also expected as part of the NBCCEDP office visits)

### ***Integrated Office Visits***

Integrated office visits should occur for women aged 40-64 who are enrolled in the NBCCEDP. Both programs must appropriately reimburse for screening visits and services using the following guidance:

- NBCCEDP funds should be used to reimburse for the integrated office visit. WISEWOMAN funds should not be used to pay for these office visits unless they have received CDC approval to conduct non-integrated office visits.
- WISEWOMAN funds should be used to reimburse providers for the costs associated with measuring cholesterol, lipids, glucose, HgA1C, or any other applicable labs.
- When rescreening for NBCCEDP and WISEWOMAN coincide, then this should be an integrated office visit, with reimbursement for the office visit using NBCCEDP funds. Any non-integrated rescreening or diagnostic office visits for WISEWOMAN services should be paid for with WISEWOMAN funds.

### ***Referral to WISEWOMAN***

Women who are determined by their provider to be at risk for cardiovascular disease (e.g., elevated blood pressure, obesity, smoking, family history of cardiovascular disease, etc.) should be referred to WISEWOMAN for appropriate services. It is expected that state NBCCEDP and WISEWOMAN programs collaborate to develop procedures and policies to ensure needed services are received.

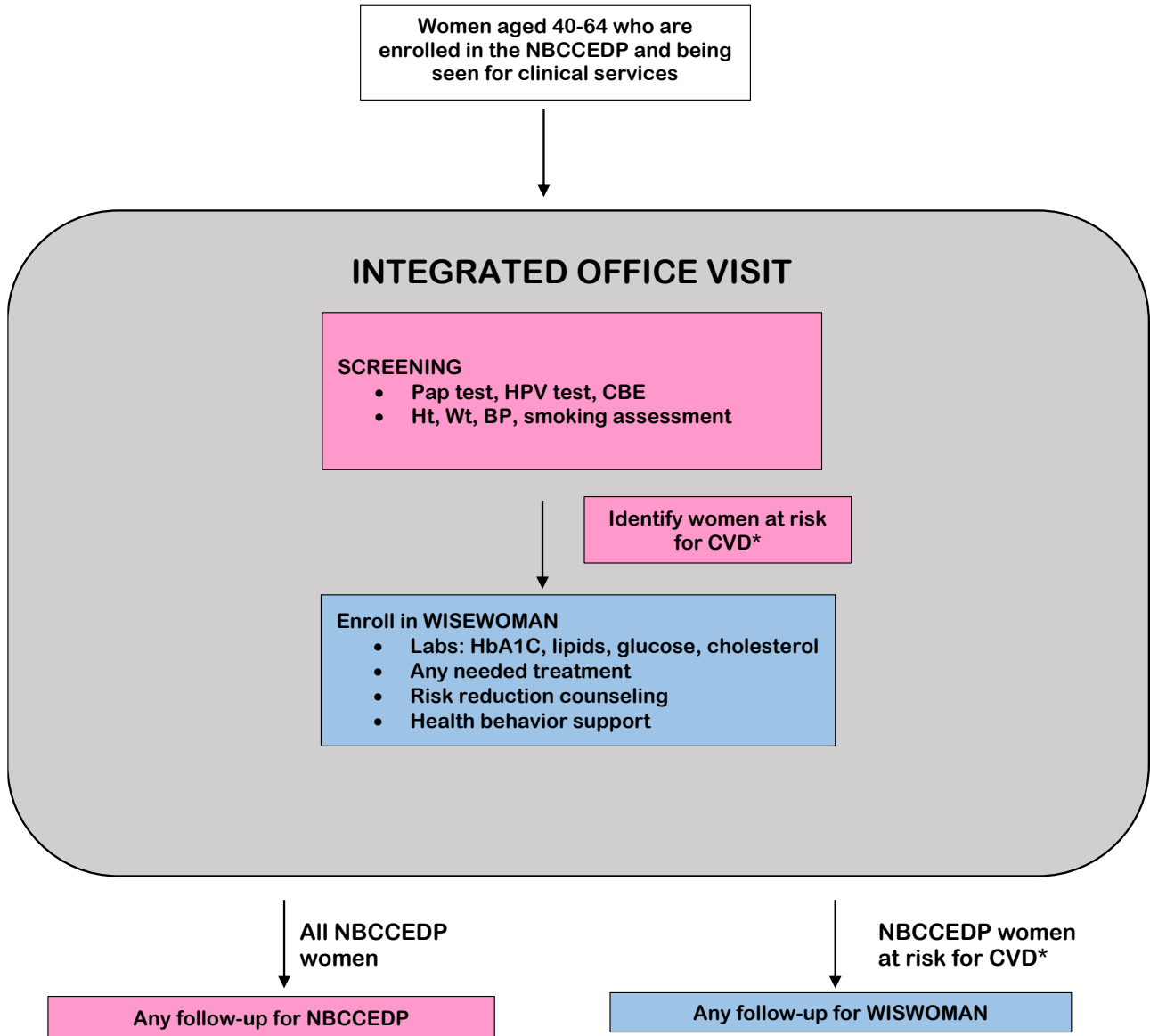
***Risk Reduction Counseling***

Women who are found to be at risk for cardiovascular disease (i.e., elevated blood pressure, obesity, tobacco use, family history of cardiovascular disease, etc.) should be referred for risk reduction counseling through WISEWOMAN. Risk reduction counseling services can take place on the same day as the screening office visit or on a different day, depending on the funded program structure, but must be billed appropriately. If women are referred for WISEWOMAN services on a different day, the programs must ensure that there is an adequate system in place to ensure follow-up. Funded WISEWOMAN programs are expected to reimburse providers for the time spent conducting the risk reduction counseling services. This reimbursement should be billed separate from the time spent conducting the clinical screening services that are part of the integrated office visit. The duration of the counseling should be appropriate to the level of counseling needed to convey the woman's screening results, interpretation of the results, and appropriate recommendations.

***Follow-Up Services***

Any needed follow-up services for NBCCEDP or WISEWOMAN should be scheduled as appropriate. These services may occur simultaneously or consecutively depending upon the nature of care needed. Both programs must ensure that a system is in place to monitor the follow-up recommended.

## Integrated Office Visit for Co-Located Providers

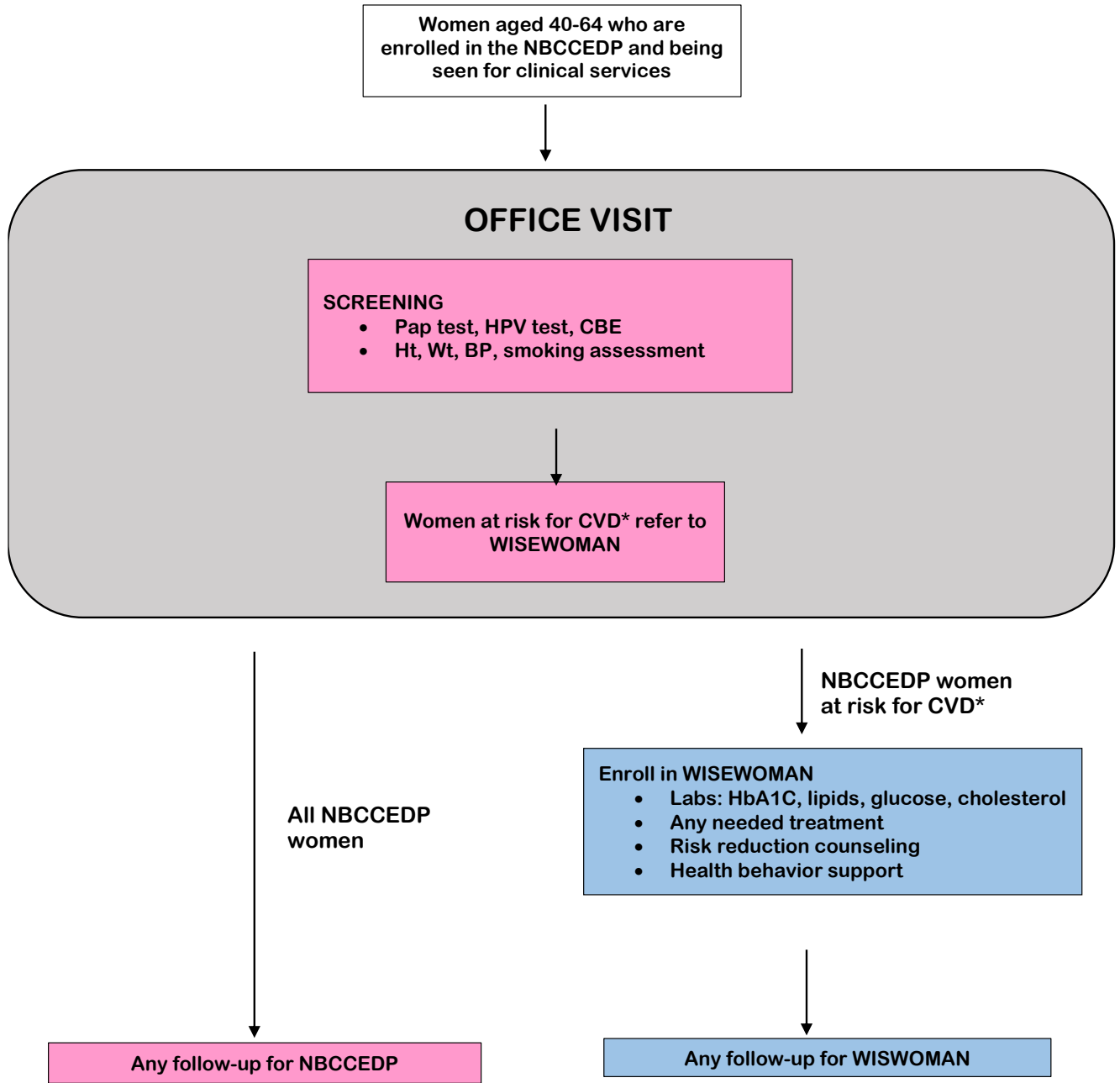


■ NBCCEDP funds for reimbursement

■ WISEWOMAN funds for reimbursement

\*At risk for CVD = elevated blood pressure, obesity, smoking, family history for CVD, etc.

### Office Visit for Provider Not Co-Located



- NBCCEDP funds for reimbursement
- WISEWOMAN funds for reimbursement

\*At risk for CVD = elevated blood pressure, obesity, smoking, family history for CVD, etc.

# DATA REQUIREMENTS



## MDE Data Systems and Related Software

CDC provides an optional database known as CaST. The Cancer Screening and Tracking (CaST) system is a database management system used to track women screened for breast and cervical cancer. CaST supports collection of patient-level screening and follow-up data items and allows for the creation of the MDE file that is submitted twice annually to CDC. CaST also helps recipients create linked systems for billing, enrollment, and patient navigation; supports streamlining data entry; and allows for remote data entry via a secured connection and SQL server option. CaST has user defined fields and formats and has the capability to develop queries and reports.

The MDE Data Users' Manual provides detailed information on CaST and is available at <https://nbccedp.cdc.gov>

## Patient-level Data (Minimum Data Elements)

Minimum Data Elements (MDEs) are a set of standardized data elements used to collect demographic and clinical information on women screened with NBCCEDP funds. The MDEs are reported to CDC twice a year and represent a subset of data required by CDC to monitor screening performance. Each MDE record describes a screening cycle that starts with a screening test and tracks the women through any immediate follow-up of abnormal findings needed to complete diagnostic evaluation and initiate treatment. A unique patient identification number facilitates tracking screening services to a woman over time. Screening and diagnostic data collected on women reported in the MDEs must meet all data quality standards set by CDC. The MDE Data Users' Manual provides detailed information on the MDEs and is available at <https://nbccedp.cdc.gov>

The MDEs include screening and/or diagnostic data for program-eligible women in any of the following scenarios:

- Screening and/or diagnostic testing solely paid for by NBCCEDP funds
- Screening and/or diagnostic testing paid for in part by NBCCEDP funds and other funding sources (e.g., state, private, or other federal funds) with the ability to distinguish the funds contributed by the NBCCEDP

- Patient-navigation only services paid for by NBCCEDP funds and screening and/or diagnostic testing paid solely by other funding source. Recipients will report an abbreviated MDE record in this scenario.

## Data Linkages with Central Cancer Registry

Recipients are required to perform data linkages with the state central cancer registry in accordance with CDC specifications, to enhance the completeness and quality of MDEs and registry data systems. Results from the linkages should be used to update the MDEs with registry-standardized diagnosis and stage data, identify missing cancer cases in the central cancer registry, and reconcile differences between the two data sources. The MDE Data Users' Manual provides additional information on the data linkage process and is available at <https://nbccedp.cdc.gov>

## Clinic-level Data

Recipients will submit baseline and annual clinic data for each partner clinic where EBIs are implemented. Data elements include unique health system and clinic IDs that allows for tracking over time, health system and clinic characteristics; patient population demographics; clinic partnership status; screening rates; monitoring and quality improvement activities; EBI implementation; patient navigation; and strategies for supporting community clinical linkages (e.g., community health work). Recipients can use optional Baseline and Annual Clinic Data Collection Forms to collect and compile relevant clinic data elements. The NBCCEDP Clinic Data Users' Manual provides additional information on clinic data and is available at <https://nbccedp.cdc.gov>.

## Recipient Survey and Quarterly Program Updates

The annual NBCCEDP recipient survey collects additional information on program management, clinic service delivery, partnerships, provider networks, and program challenges. The survey is administered electronically each August. Survey data will be used to describe recipient programs and to inform CDC about training/technical assistance needs of recipients.

CDC also leads the Quarterly Program Update, a short survey completed by recipients at the end of each quarter. This survey collects monitoring data related to service provision, spending, staffing, and program challenges. CDC will use the updates to inform technical assistance and help recipients make any corrective action plans needed.

The NBCCEDP Program Manual II: Monitoring and Evaluation provides information on these surveys, including the instruments, and is available at <https://nbccedp.cdc.gov>.

## Data Sharing and Approvals

As part of the IRB agreement for collection and analysis of data elements from the NBCCEDP, CDC maintains a data sharing policy regarding requests for MDE data for research use by CDC or external investigators. Data requests must include a research proposal which is subject to requirements of confidentiality, human subject's protection, and clearance procedures. Proposals are reviewed and approved through CDC's MDE committee. The policy calls for the removal of personal identifiers and geographic indicators to provide "national level" data. Other than the program-specific data presented on CDC's public web site, which is provided so the public can view statistics for their state, CDC does not release program-specific data for use outside of CDC without notifying the program. This policy does not apply to data inquiries from the Office of Management and Budget (OMB), Congress, or similar entities, or to aggregate data shared with the general public to describe results of the NBCCEDP. CDC's legal counsel has determined that MDE data are subject to the Freedom of Information Act.

# PROGRAM MANAGEMENT AND CDC MONITORING

## Program Management

Program management is the process of leading, facilitating and ensuring the strategic planning, implementation, coordination, integration, and evaluation of programmatic activities and administrative systems to ensure efficiency and effectiveness.

### Monitor program activities and ensure that all CDC requirements are met

Recipients are expected to:

- Establish and enhance program infrastructure and capacity to increase breast and cervical cancer screening rates and navigation services to priority populations over the length of the project period.
- Hire or retain adequate and qualified staff to manage the program. Essential staff, at the minimum includes 0.5 FTE program director, 0.5 FTE data manager, and 0.5 FTE evaluator.
- Hire staff with adequate knowledge and expertise in health systems interventions and patient navigation.
- Acquire medical advisor(s) with relevant expertise in breast and cervical cancer screening and diagnostics to provide clinical consultation throughout the project period.
- Develop an annual work plan containing specific, measurable, achievable, realistic, time-phased, inclusive, and equitable (SMARTIE) objectives, as well as activities and performance measures for each program strategy.
- Establish contracts, grants, or memoranda of understanding (MOU) with program partners to assure timely clinical service delivery, implement evidence-based interventions, and provide effective community outreach.
- Develop and maintain a fiscal system that tracks and monitors program expenditures, ensures the timely reimbursement of services, and provides detailed fiscal reporting to CDC on time.
- Prepare and submit required reports (e.g., annual progress reports and FFRs) and updates (i.e., Quarterly Recipient Update Tool) to CDC on time.
- Develop an evaluation plan with CDC guidance based on program identified strategies. The plan should be updated, as needed, throughout the project period. The plan must include stakeholders, program description, evaluation questions, process/outcome measures, data collection methods, analytic methods, and reporting methods.
- Participate in required CDC meetings and trainings to facilitate the accomplishment of proposed objectives.

- Participate on the state or territorial-wide cancer coalitions for the development of cancer control plans and collaboration with coalition partners to achieve program goals.
- Collaborate across CDC cancer programs and with chronic disease partners to achieve cancer program goals and advance health equity

## **Role of the Program Director**

The program director has a wide range of administrative and program management responsibilities requiring strong leadership abilities and the capability to simultaneously organize and manage multiple tasks. He or she must:

- Recruit and develop a qualified and technically diverse staff
- Provide strategic direction to guide program planning, implementation, and evaluation.
- Demonstrate leadership and communicate effectively with federal and state agency administrators and legislators
- Establish, maintain, and nurture partnerships
- Work with community, local, state, tribal, and national groups and organizations, as well as special interest groups and others
- Develop an annual workplan containing SMARTIE objectives, as well as activities and performance measures for each program component
- Develop an accurate and realistic budget request that corresponds with the program's work plan and meets the administrative requirements and funded tier guidelines of the NBCCEDP
- Establish a sound fiscal system that tracks and monitors program expenditures and ensures the accurate and timely reimbursement of services contracted by the program
- Coordinate and manage the operation of all program components
- Anticipate and solve problems
- Negotiate, mediate, and serve as a catalyst for partners, providers, staff members, and others
- Coordinate task forces and work groups on the state and, sometimes, national level
- Participate actively, and make presentations, at national, state, and local meetings and conferences
- Prepare and submit timely required reports.
- Serve as primary point of contact for CDC-assigned program consultant.

## CDC Monitoring

Monitoring activities by CDC will include routine and ongoing communication between the CDC and recipients, site visits, and recipient reporting [including work plans, evaluation plans, screening projections, success stories, data reporting (i.e., MDE, clinic data, recipient survey), and financial reporting]. These activities provide CDC with periodic data to examine recipients' overall performance and progress toward meeting the NBCCEDP goals and outcomes. Reporting identifies successes and challenges that recipients encounter throughout the project period. Reporting is a requirement for recipients who want to apply for yearly continuation of funding.

To assess and support recipient performance, CDC will:

- **review** work plans and screening projections to ensure feasibility based on the budget and consistency with the requirements of the funding opportunity announcement.
- **confirm** that recipients are performing at a satisfactory level to achieve outcomes within stated timeframes.
- **work** with recipients to adjust work plans, budgets, and other application materials based on achievement of outcomes, evaluation results, and final award.
- **monitor** data, including performance measures (programmatic and financial), to assure satisfactory performance levels.
- **monitor** and report consistency with grant regulations and policies along with the identification, notification, and management of financial issues.

## Workplan

CDC requires NBCCEDP recipients to develop annual work plans to assist in planning a course of action for the coming year, guided by national program goals and based on individual program needs and resources. The work plan is a management tool that provides direction and guidance for the overall program as well as for each program component; it can serve as a blueprint for program management. It should include SMARTIE objectives for each program component (**See Appendix F**). The essential elements for each program component should be addressed in the program's work plan. The workplan also should list the staff members who are responsible for each activity and include a description of the performance measures to determine the program's progress toward achieving objectives. These measures should include numeric values that quantify progress towards achieving activities.

Workplans should have the following components:

- Proposed objectives
- Activities
- Performance measures
- Start and end dates
- Personnel assigned
- Progress report

Recipients can use work plans to do the following:

- State the goals and objectives of each program component and the strategies that will be used to attain them
- Help the staff members who are responsible for different program components determine priorities for planning and a timeline for implementation
- Help align program objectives and activities with the budget request
- Provide a template for organizing and monitoring the program implementation process
- Establish measures of success by which to gauge program effectiveness
- Provide a mechanism for making revisions as a result of progress and deficiencies
- Assist with training key staff members to plan, implement, monitor progress, and assess program activities

Recipients are encouraged to use the NBCCEDP work plan template as a guide for developing their work plans (See [Appendix G](#)). A description of each component with examples can be found in the template. Recipients will develop workplans and progress reports in CDC's [Award Management Platform \(AMP\)](#). Hard copies of workplans and progress reports generated in AMP should be submitted to GrantSolutions, as outlined in continuation guidance.

## EBI Implementation Clinic Review Guide

Recipients must meet with your CDC Program Consultant to discuss findings from the clinic's needs assessment and other critical aspects of planning before moving forward with EBI implementation. CDC has developed a Clinic Review Guide (See [Appendix H](#)) that may be used to assist with program planning and to guide technical assistance calls with your Program Consultants. Information in the review guide captures:

- Process flow maps for patients which identifies any gaps

- Clinic characteristics such as staffing, existing clinical policies, screening rates, and quality assessment/quality improvement initiatives
- Population served by the partner clinic
- EBIs chosen or process changes needed to address gaps
- Details of how EBIs will be implemented
- Notes to assist with TA discussions

# NBCCEDP LEGISLATIVE REQUIREMENTS



## Matching Funds

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 Public Health Services (PHS) Act, as amended, requires matching funds from non-Federal sources in an amount not less than one dollar for every three dollars of Federal funds awarded under this program. However, Title 48 of the U.S. Code 1469a (d) requires DHHS to waive matching fund requirements up to \$200,000 for Guam, U.S. Virgin Islands, American Samoa and the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

Matching funds may be cash, in-kind or donated services or equipment. 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 to use funds received under the Indian Self-Determination Act as matching funds.

Applicants may also designate as State/Tribal/Territorial/Pacific Island Jurisdiction matching funds any non-Federal amounts spent pursuant to Title XIX of the Social Security Act for the screening and case management of women for breast and cervical cancers.

Matching funds may not include: (1) 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. All costs used to satisfy the matching requirements must be documented by the applicant and will be subject to audit.

## Maintenance of Effort

Maintenance of Effort is required for this program in accordance with the authorizing legislation PL 101-354. The average amount of non-Federal contributions toward breast and cervical cancer programs and activities for the two-year period preceding the first Federal fiscal year of funding for NBCCEDP is referred to as Maintenance of Effort (MOE). Only those non-Federal contributions in excess of the MOE amount may be considered matching funds. Supplanting, or replacing, existing program efforts currently paid with Federal or non-Federal sources is not allowable.

Non-federal Medicaid amounts are allowable as sources of matching funds. However, the State Medicaid contribution is subject to the maintenance-of-effort requirement, must be program related, and cannot be used for any other program.

## Reimbursement for screening and diagnostic services capped at the Medicare rate

The amount paid by a program to an entity for screening and follow-up services may not exceed the amount that would be paid under Part B of title XVIII of the Social Security Act (maximum Medicare rates in the State).

For each of the screening and diagnostic services paid for by the NBCCEDP, the program may choose to reimburse providers at either a single rate based on the Medicare rates approved by the Center for Medicare and Medicaid Services (CMS) for that State or using multiple rates, such as a single urban rate, a single rural rate, or the various regional Medicare rates approved by CMS.

## 10% administrative costs

No more than 10% of the federal monies may be used for administrative expenses. The total dollar amount of federal monies awarded to the program should be used as the basis for determining the 10% administrative costs. The 10% limitation on administrative costs is in lieu of indirect costs. Each program may define the basis for its administrative costs. However, administrative expenses (i.e., indirect costs) associated with all contracts are considered part of the limitation placed on the overall total administrative costs under the cooperative agreement award.

## Payor of last resort (except for IHS)

NBCCEDP funds cannot be used to pay for any service for which payment has been made or can be made by a state compensation program, under an insurance policy, under a federal or state health benefits program, or by an entity that provides health services on a prepaid basis. This use of NBCCEDP funds only after all other sources have been exhausted means that the NBCCEDP is the “payor of last resort.”

The exception to this rule is clinics or offices that are operated by Indian Health Service (IHS) or individual American Indian tribes. IHS is the payor of last resort for persons who have an alternate resource (42 CFR 136.61 [2002]); the NBCCEDP has historically been considered such an alternative resource.

## Restrictions on use of grant funding

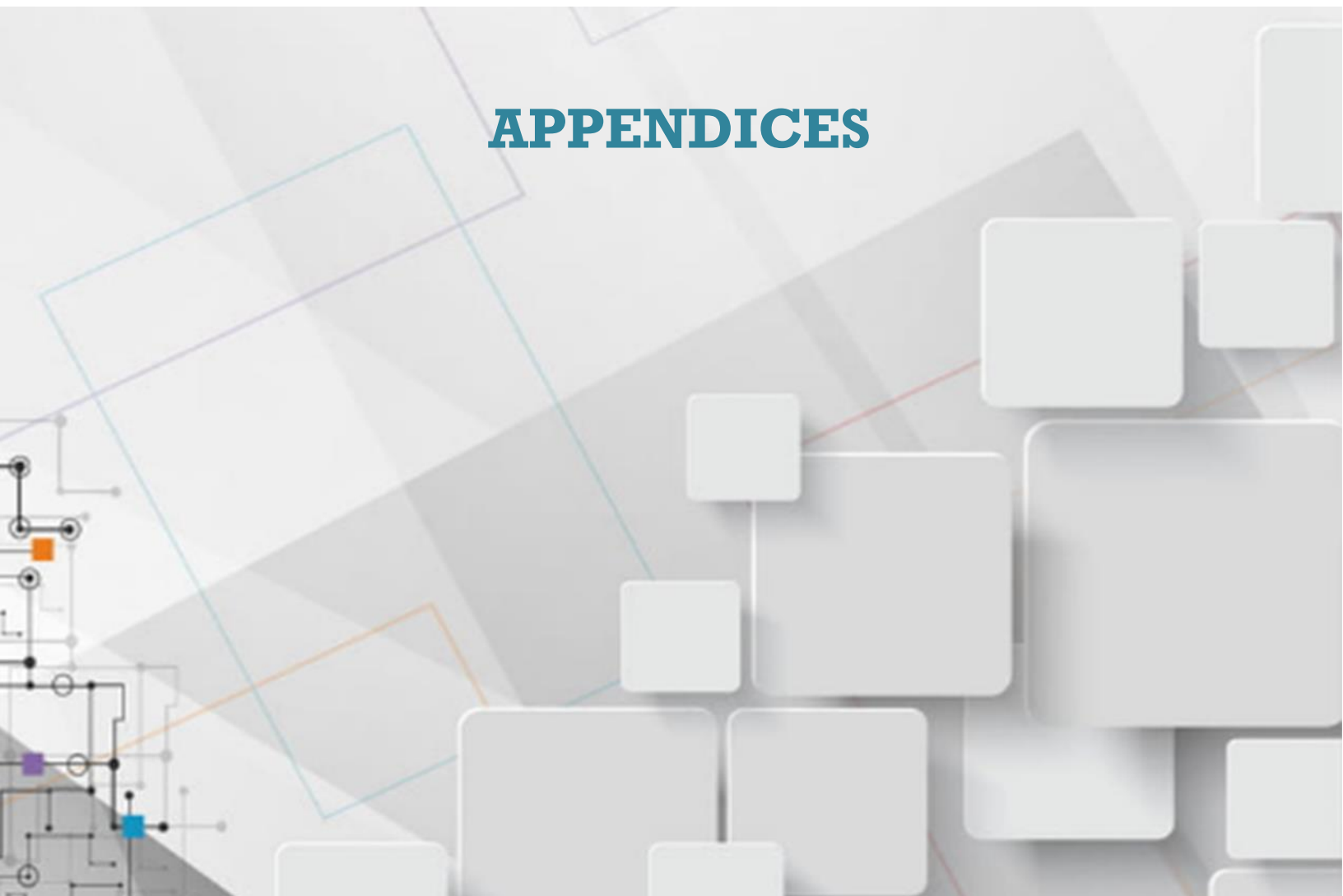
Other legal requirements of programs include the following stipulations:

- NBCCEDP funds may not be used to provide inpatient hospital services for any individual.
- Recipients must agree to give priority to low-income women in their provision of program services.
- Imposition of fees for services must be limited.
- Program services must be available to women throughout the state, tribe, or territory.
- Program activities must be coordinated with other federal, state, tribal, and local programs operating in the jurisdiction.
- Recipients must establish fiscal control and fund accounting procedures that are subject to audit.
- NBCCEDP funds may not be used for research.
- NBCCEDP funds may not be used for any lobbying activity to influence or induce members of the public to contact their elected representatives to influence support or opposition to proposed or pending legislation.

## Notice of Awards (NOA)

In addition to the legislative requirements detailed above, a recipient's activities are governed by the provisions of its official NOA. Programs are subject to any terms and conditions noted in the NOA, as well as the Public Health Services (PHS) grants policy statements that are in effect as of the beginning of the budget period. Acceptance of the grant terms and conditions is acknowledged by the recipient when funds are drawn or otherwise obtained from the grant payment system. Recipients should follow the terms outlined in the NOA regarding reporting requirements and approval processes. For questions regarding the grants management process, recipients should contact the Grants Management Specialist in CDC's Office of Grants Services.

# APPENDICES



## Appendix A: Public Law 101-354 and Its Amendments (P.L. 103-183 and P.L. 105-340)

Title 42. The Public Health and Welfare  
Chapter 6a. The Public Health Service  
Preventive Health Measures With Respect to Breast and Cervical Cancers  
42 U.S.C. § 300k

Note: Amendments to Public Law 101-354 are indicated in bold and italics, followed by a reference to the amending law in parentheses.

### § 300k. Establishment of program of grants to States

(a) In general. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to States on the basis of an established competitive review process for the purpose of carrying out programs—

- (1) to screen women for breast and cervical cancer as a preventive health measure;
- (2) to provide appropriate referrals for medical treatment of women screened pursuant to paragraph (1) and to ensure, to the extent practicable, the provision of appropriate follow-up services ***and support services such as case management (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***;
- (3) to develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;
- (4) to improve the education, training, and skills of health professionals (including allied health professionals) in the detection and control of breast and cervical cancer;
- (5) to establish mechanisms through which the States can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures; and
- (6) to evaluate activities conducted under paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

(b) Grant and contract authority of States.

- (1) In general. A State receiving a grant under subsection (a) may, subject to paragraphs (2) and (3), expend the grant to carry out the purpose described in such subsection ***through grants to public and nonprofit private entities and through contracts with public and private entities (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)***.
- (2) ***Certain applications. If a nonprofit private entity and a private entity that is not a nonprofit entity both submit applications to a State to receive an award of a grant or contract pursuant to paragraph (1), the State may give priority to the application***

***submitted by the nonprofit private entity in any case in which the State determines that the quality of such application is equivalent to the quality of the application submitted by the other private entity (Women’s Health Research and Prevention Amendments of 1998, Public Law 105-340).***

(3) Payments for screenings. The amount paid by a State to an entity under this subsection for a screening procedure under subsection (a)(1) may not exceed the amount that would be paid under part B of title XVIII of the Social Security Act [42 U.S.C. §§ 1395j et seq.] if payment were made under such part for furnishing the procedure to a woman enrolled under such part.

(c) Special consideration for certain States. In making grants under subsection (a) to States whose initial grants under such subsection are made for fiscal year 1995 or any subsequent fiscal year, the Secretary shall give special consideration to any State whose proposal for carrying out programs under such subsection—

- (1) has been approved through a process of peer review; and
- (2) is made with respect to geographic areas in which there is—
  - (A) a substantial rate of mortality from breast or cervical cancer; or
  - (B) a substantial incidence of either of such cancers.

[(d)](c) Coordinating committee regarding year 2000 health objectives. The Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish a committee to coordinate the activities of the agencies of the Public Health Service (and other appropriate federal agencies) that are carried out toward achieving the objectives established by the Secretary for reductions in the rate of mortality from breast and cervical cancer in the United States by the year 2000. Such committee shall be comprised of federal officers or employees designated by the heads of the agencies involved to serve on the committee as representatives of the agencies, and such representatives from other public or private entities as the Secretary determines to be appropriate.

### **§ 300l. Requirement of matching funds**

(a) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees, with respect to the costs to be incurred by the State in carrying out the purpose described in such section, to make available non-federal contributions (in cash or in kind under subsection (b)) toward such costs in an amount equal to not less than \$1 for each \$3 of federal funds provided in the grant. Such contributions may be made directly or through donations from public or private entities.

(b) Determination of amount of non-federal contribution.

(1) In general. Non-federal contributions required in subsection (a) may be in cash or in kind, fairly evaluated, including equipment or services (and excluding indirect or overhead costs). Amounts provided by the federal government, or services assisted or subsidized to any significant extent by the federal government, may not be included in determining the amount of such non-federal contributions.

(2) Maintenance of effort. In making a determination of the amount of non-federal contributions for purposes of subsection (a), the Secretary may include only non-federal

contributions in excess of the average amount of non-federal contributions made by the State involved toward the purpose described in section 1501 [42 U.S.C. § 300k] for the 2-year period preceding the first fiscal year for which the State is applying to receive a grant under such section.

(3) Inclusion of relevant non-federal contributions for Medicaid. In making a determination of the amount of non-federal contributions for purposes of subsection (a), the Secretary shall, subject to paragraphs (1) and (2) of this subsection, include any non-federal amounts expended pursuant to title XIX of the Social Security Act [42 U.S.C. § 1396 et seq.] by the State involved toward the purpose described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

### **§ 300l-1. Requirement regarding Medicaid**

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] for a program in a State unless the State plan under title XIX of the Social Security Act [42 U.S.C. §§ 1396 et seq.] for the State includes the screening procedures specified in subparagraphs (A) and (B) of section 1503(a)(2) [42 U.S.C. § 300m(a)(2)(A), (B)] as medical assistance provided under the plan.

### **§ 300m. Requirements with respect to type and quality of services**

(a) Requirement of provision of all services by date certain. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees—

(1) to ensure that, initially and throughout the period during which amounts are received pursuant to the grant, not less than 60 percent of the grant is expended to provide each of the services or activities described in paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)], including making available screening procedures for both breast and cervical cancers;

(2) subject to subsection (b), to ensure that—

(A) in the case of breast cancer, both a physical examination of the breasts and the screening procedure known as a mammography are conducted; and

(B) in the case of cervical cancer, both a pelvic examination and the screening procedure known as a Pap smear are conducted;

(3) to ensure that, by the end of any second fiscal year of payments pursuant to the grant, each of the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)] is provided; and

(4) to ensure that not more than 40 percent of the grant is expended to provide the services or activities described in paragraphs (3) through (6) of such section.

(b) Use of improved screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if any screening procedure superior to a procedure described in subsection (a)(2) becomes commonly available and is recommended for use, any entity providing screening procedures pursuant to the grant will utilize the superior procedure rather than the procedure described in such subsection.

(c) Quality assurance regarding screening procedures. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the State will, in

accordance with applicable law, assure the quality of screening procedures conducted pursuant to such section

***(Preventive Health Amendments of 1993, Public Law 103-183).***

**§ 300n. Additional required agreements**

(a) Priority for low-income women. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that low-income women will be given priority in the provision of services and activities pursuant to paragraphs (1) and (2) of section 1501(a) [42 U.S.C. § 300k(a)].

(b) Limitation on imposition of fees for services. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that, if a charge is imposed for the provision of services or activities under the grant, such charge—

- (1) will be made according to a schedule of charges that is made available to the public;
- (2) will be adjusted to reflect the income of the woman involved; and
- (3) will not be imposed on any woman with an income of less than 100 percent of the official poverty line, as established by the Director of the Office of Management and Budget and revised by the Secretary in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981 [42 U.S.C. § 9902(2)].

(c) Statewide provision of services.

(1) In general. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that services and activities under the grant will be made available throughout the State, 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 [25 U.S.C. § 450b]).

(2) Waiver. The Secretary may waive the requirement established in paragraph (1) for a State if the Secretary determines that compliance by the State with the requirement would result in an inefficient allocation of resources with respect to carrying out the purpose described in section 1501(a) [42 U.S.C. § 300k(a)].

(3) Grants to tribes and tribal organizations.

(A) The Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to tribes and tribal organizations (as such terms are used in paragraph (1)) for the purpose of carrying out programs described in section 1501(a) [42 U.S.C. § 300k(a)]. This title applies to such a grant (in relation to the jurisdiction of the tribe or organization) to the same extent and in the same manner as such title applies to a grant to a State under section 1501 [42 U.S.C. § 300k] (in relation to the jurisdiction of the State).

(B) If a tribe or tribal organization is receiving a grant under subparagraph (A) and the State in which the tribe or organization is located is receiving a grant under section 1501 [42 U.S.C. § 300k], the requirement established in paragraph (1) for the State regarding the tribe or organization is deemed to have been waived under paragraph (2) ***(Preventive Health Amendments of 1993, Public Law 103-183).***

(d) Relationship to items and services under other programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to make payment for any item or service to the extent that payment has been made, or can reasonably be expected to be made, with respect to such item or service—

- (1) under any State compensation program, under an insurance policy, or under any federal or state health benefits program; or
- (2) by an entity that provides health services on a prepaid basis.

(e) Coordination with other breast and cervical cancer programs. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the services and activities funded through the grant shall be coordinated with other Federal, State, and local breast and cervical cancer programs.

(f) Limitation on administrative expenses. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that not more than 10 percent of the grant will be expended for administrative expenses with respect to the grant.

(g) Restrictions on use of grant. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that the grant will not be expended to provide inpatient hospital services for any individual.

(h) Records and audits. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees that—

- (1) the State will establish such fiscal control and fund accounting procedures as may be necessary to ensure the proper disbursement of, and accounting for, amounts received by the State under such section; and
- (2) upon request, the State will provide records maintained pursuant to paragraph (1) to the Secretary or the Comptroller of the United States for purposes of auditing the expenditures by the State of the grant.

(i) Reports to Secretary. The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless the State involved agrees to submit to the Secretary such reports as the Secretary may require with respect to the grant.

#### **§ 300n-1. Description of intended uses of grant**

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless—

- (1) the State involved submits to the Secretary a description of the purposes for which the State intends to expend the grant;
- (2) the description identifies the populations, areas, and localities in the State with a need for the services or activities described in section 1501(a) [42 U.S.C. § 300k(a)];
- (3) the description provides information relating to the services and activities to be provided, including a description of the manner in which the services and activities will be coordinated with any similar services or activities of public and nonprofit private entities; and
- (4) the description provides assurances that the grant funds will be used in the most cost-effective manner.

**§ 300n-2. Requirement of submission of application**

The Secretary may not make a grant under section 1501 [42 U.S.C. § 300k] unless an application for the grant is submitted to the Secretary, the application contains the description of intended uses required in section 1505 [42 U.S.C. § 300n-1], and the application is in such form, is made in such manner, and contains such agreements, assurances, and information as the Secretary determines to be necessary to carry out this title [42 U.S.C. §§ 300k et seq.].

**§ 300n-3. Technical assistance and provision of supplies and services in lieu of grant funds**

(a) Technical assistance. The Secretary may provide training and technical assistance with respect to the planning, development, and operation of any program or service carried out pursuant to section 1501 [42 U.S.C. § 300k]. The Secretary may provide such technical assistance directly or through grants to, or contracts with, public and private entities.

(b) Provision of supplies and services in lieu of grant funds.

(1) In general. Upon the request of a State receiving a grant under section 1501 [42 U.S.C. § 300k], the Secretary may, subject to paragraph (2), provide supplies, equipment, and services for the purpose of aiding the State in carrying out such section and, for such purpose, may detail to the State any officer or employee of the Department of Health and Human Services.

(2) Corresponding reduction in payments. With respect to a request described in paragraph (1), the Secretary shall reduce the amount of payments under the grant under section 1501 [42 U.S.C. § 300k] to the State involved by an amount equal to the costs of detailing personnel (including pay, allowances, and travel expenses) and the fair market value of any supplies, equipment, or services provided by the Secretary. The Secretary shall, for the payment of expenses incurred in complying with such request, expend the amounts withheld.

**§ 300n-4. Evaluations and reports**

(a) Evaluations. The Secretary shall, directly or through contracts with public or private entities, provide for annual evaluations of programs carried out pursuant to section 1501 [42 U.S.C. § 300k]. Such evaluations shall include evaluations of the extent to which States carrying out such programs are in compliance with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

(b) Report to Congress. The Secretary shall, not later than 1 year after the date on which amounts are first appropriated pursuant to section 1509(a) [42 U.S.C. § 300n-5(a)], and annually thereafter, submit to the Committee on Energy and Commerce of the House of Representatives, and to the Committee on Labor and Human Resources of the Senate, a report summarizing evaluations carried out pursuant to subsection (a) during the preceding fiscal year and making such recommendations for administrative and legislative initiatives with respect to this title [42 U.S.C. §§ 300k et seq.] as the Secretary determines to be appropriate, including

recommendations regarding compliance by the States with section 1501(a)(2) [42 U.S.C. § 300k(a)(2)] and with section 1504(c) [42 U.S.C. § 300n(c)].

#### **§ 300n-4a. Supplemental grants for additional preventive health services**

(a) Demonstration projects. In the case of States receiving grants under section 1501 [42 U.S.C. § 300k], the Secretary, acting through the Director of the Centers for Disease Control and Prevention, may make grants to not more than 3 such States to carry out demonstration projects for the purpose of—

- (1) providing preventive health services in addition to the services authorized in such section, including screenings regarding blood pressure and cholesterol, and including health education;
- (2) providing appropriate referrals for medical treatment of women receiving services pursuant to paragraph (1) and ensuring, to the extent practicable, the provision of appropriate follow-up services; and
- (3) evaluating activities conducted under paragraphs (1) and (2) through appropriate surveillance or program-monitoring activities.

(b) Status as participant in program regarding breast and cervical cancer. The Secretary may not make a grant under subsection (a) unless the State involved agrees that services under the grant will be provided only through entities that are screening women for breast or cervical cancer pursuant to a grant under section 1501 [42 U.S.C. § 300k].

(c) Applicability of provisions of general program. This title [42 U.S.C. §§ 300k et seq.] applies to a grant under subsection (a) to the same extent and in the same manner as such title applies to a grant under section 1501 [42 U.S.C. § 300k].

(d) Funding.

- (1) In general. Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated \$3,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 **through 2003 (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)**.
- (2) Limitation regarding funding with respect to breast and cervical cancer. The authorization of appropriations established in paragraph (1) is not effective for a fiscal year unless the amount appropriated under section 1510(a) [42 U.S.C. § 300n-5(a)] for the fiscal year is equal to or greater than \$100,000,000.

#### **§ 300n-5. Funding for general program**

(a) Authorization of appropriations. For the purpose of carrying out this title [42 U.S.C. §§ 300k et seq.], there are authorized to be appropriated \$50,000,000 for fiscal year 1991, such sums as may be necessary for each of the fiscal years 1992 and 1993, \$150,000,000 for fiscal year 1994, and such sums as may be necessary for each of the fiscal years 1995 **through 2003 (Women's Health Research and Prevention Amendments of 1998, Public Law 105-340)**.

(b) Set-aside for technical assistance and provision of supplies and services. Of the amounts appropriated under subsection (a) for a fiscal year, the Secretary shall reserve not more than 20 percent for carrying out section 1507 [42 U.S.C. § 300n-3].

## Appendix B: DP22-2202 National Breast and Cervical Cancer Early Detection Program Logic Model

<p><b>Strategies and Activities</b></p> <p><b>Cancer Data and Surveillance (Strategy 2)</b></p> <ul style="list-style-type: none"> <li>Use state and local data to identify and describe the population who is eligible for the program. Prioritize populations disproportionately burdened by breast or cervical cancer (i.e., populations of focus) for service delivery.</li> </ul> <p><b>Support Partnerships for Cancer Control and Prevention (Strategy 3)</b></p> <ul style="list-style-type: none"> <li>Work with the cancer coalition, Colorectal Cancer Control Program (CRCCP), National Comprehensive Cancer Control Program (NCCCP), National Program of Cancer Registries (NPCR) and other organizations to help set breast and cervical cancer screening and health equity goals within cancer control plans.</li> <li>Serve on the cancer coalition.</li> <li>Collaborate with community-based organizations to increase screening among populations of focus.</li> <li>Collaborate with other chronic disease and public health programs to disseminate information to women served across programs.</li> <li>Collaborate with other cancer programs, including other NBCCEDP-funded programs, to maximize screening access and share lessons learned.</li> </ul> <p><b>Deliver Breast and Cervical Cancer Screening (Strategy 4)</b></p> <ul style="list-style-type: none"> <li>Set annual and 5-year service delivery projections for breast and cervical cancer.</li> <li>Establish and maintain a screening delivery system to provide breast and cervical cancer screening and diagnostic services to program-eligible women. Prioritize populations that experience higher mortality and late-stage cancer.</li> <li>Conduct outreach to identify program-eligible women and connect them to screening and diagnostic services in partner clinics.</li> <li>Engage local partners and community health workers to identify women in need of support to access services and monitor through screening completion.</li> <li>Provide patient navigation to women who receive NBCCEDP-paid clinical services.</li> <li>Provide patient navigation to women who meet some NBCCEDP eligibility requirements whose clinical services are paid by other sources (OPTIONAL).</li> <li>Partner with organizations to link program-eligible women to other needed health, community, and social services.</li> <li>Establish formal partnerships with organizations that show expertise in and access to populations of focus.</li> <li>Collaborate with organizations with expertise in providing technical assistance to clinics.</li> <li>Conduct ongoing quality improvement for timely and appropriate screening and follow-up services.</li> <li>Collect and report minimum data element (MDE) records for all women receiving NBCCEDP-paid services.</li> </ul> <p><b>Implement Evidence-Based Interventions (Strategy 4)</b></p> <ul style="list-style-type: none"> <li>Work with partner clinics that provide NBCCEDP-paid clinical services to implement evidence-based interventions (EBIs).</li> <li>Identify an EBI champion in each partner clinic.</li> <li>Provide ongoing technical assistance to support EBI implementation, adaptation, and data monitoring.</li> <li>Collect and report baseline and annual clinic-level data.</li> </ul> <p><b>Program Monitoring and Evaluation (Strategy 5)</b></p> <ul style="list-style-type: none"> <li>Participate in CDC-led monitoring, evaluation, and dissemination efforts.</li> <li>Develop an evaluation plan.</li> <li>Evaluate processes and outcomes.</li> <li>Establish and maintain MDE systems to collect and report patient data.</li> <li>Monitor, report, and use MDE and clinic-level data.</li> <li>Submit annual evaluation reports to describe program monitoring, effectiveness, and use of findings.</li> <li>Share evaluation findings with appropriate partners.</li> </ul>	<p><b>Short Term Outcomes</b></p> <ul style="list-style-type: none"> <li>Increased access to breast and cervical cancer screening among program-eligible women, prioritizing populations of focus.</li> <li>Increased partnerships with clinics serving women with lower income.</li> <li>Increased access to healthy/community/social services among program-eligible women through partnerships.</li> <li>Increased use of data to inform program planning and improvement.</li> <li>Increased EBI implementation to improve screening within partner clinics.</li> <li>Improved provider knowledge of breast and cervical cancer screening recommendations and diagnostic guidelines.</li> <li>Improved effectiveness of outreach to populations experiencing health inequities for breast and cervical cancer.</li> </ul>	<p><b>Intermediate Outcomes</b></p> <ul style="list-style-type: none"> <li>Increased number of women receiving NBCCEDP-paid screening and follow-up services.</li> <li>Increased number of women served who experience higher mortality and late-stage cancer.</li> <li>Increased early detection of breast and cervical cancer.</li> <li>Increased adherence to timely diagnostic follow-up.</li> <li>Increased timely cancer treatment referral.</li> <li>Increased clinic-level breast and cervical cancer screening rates in partner screening clinics.</li> <li>Increased utilization of needed health, community, and social services among program-eligible women.</li> <li>Decreased inequities in screening and follow-up services among populations of focus.</li> </ul>	<p><b>Long-Term Outcomes</b></p> <ul style="list-style-type: none"> <li>Decreased cancer incidence, morbidity, and mortality.</li> <li>Reduced cancer disparities.</li> </ul>
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## Appendix C: DP17-1701 MOU and MOA Requirements

The purpose of each Memorandum of Understanding (MOU) or Memorandum of Agreement (MOA) is to clearly define the mutual goals and the working relationship between partners. Further, it outlines the responsibilities of the recipient and each participating health system partner, or other entity, to conduct work directly funded by this funding opportunity announcement. The MOU/MOA must be between the recipient and the partner. A separate, additional agreement or contract is required between the recipient and any intermediaries. The MOU/MOA must be detailed, specific, and binding and outline who, what, and when.

The MOU/MOA must include:

- 1) Names of parties/agencies/organizations entering the agreement.
- 2) An effective **date range** that spans the length of the proposed project.
- 3) Commitment of the participating partner to work with the recipient and other collaborative partners to address program requirements and implement project activities. **Must delineate specific roles of partner in achieving the goals of the FOA.**
- 4) Commitment to collaboratively
  - **assess the needs and existing capacity** to achieve goals
  - **select and implement activities** described in the FOA
  - **monitor implementation progress**
  - **evaluate outcomes and success** of the partnership
  - **participate in data reporting and evaluation activities** required by CDC
- 5) Commitment of the recipient to work with the partner and other collaborative partners to address project requirements, including the **designation of point(s) of contact** within the recipient organization and the partner **with authority to make program-related decisions** and dedicated to the implementation of the proposed applicant activities.
- 6) While this is not a contract, if an exchange of funds is involved, the budget and justification should be outlined here along with deliverables/services to be provided. (Do not insert the contract.)
- 7) Counter-signatures for both parties by authorized representatives

The MOU outline might include Purpose, Background and Objectives, Terms of the Memorandum including dates, Responsibilities of the (recipient), Responsibilities of the (partner health system), Funding, Authorized Representatives, Amending/Terminating the Agreement.

## Appendix D: Examples of Community Clinical Linkage (CCL) Activities

Below are a few promising examples of CCL activities. Hopefully they can stimulate thinking about how to implement CCL strategies.

### **CHWs at Health Department Conduct Community Outreach and Refer Women**

The Nebraska program conducts statewide outreach through a network of 19 “Community Health Hubs,” which are mostly local health departments. Community Health Workers (CHWs), funded through the hubs or local health departments, connect with women in the community and navigate them to more than 400 screening providers. They document contacts and risk assessments for each woman in an electronic CHW Encounter Registry. If a woman is deemed eligible for Nebraska’s program, the CHW assists her in completing an enrollment form, which is then sent to the program for review and follow-up. The program uses the Encounter Registry data to assess the type of outreach or navigation provided to non-program eligible women and determines if they complete screening at one of their provider sites. The program has a CHW training curriculum for program-affiliated CHWs and manages the Encounter Registry to monitor community outreach progress.

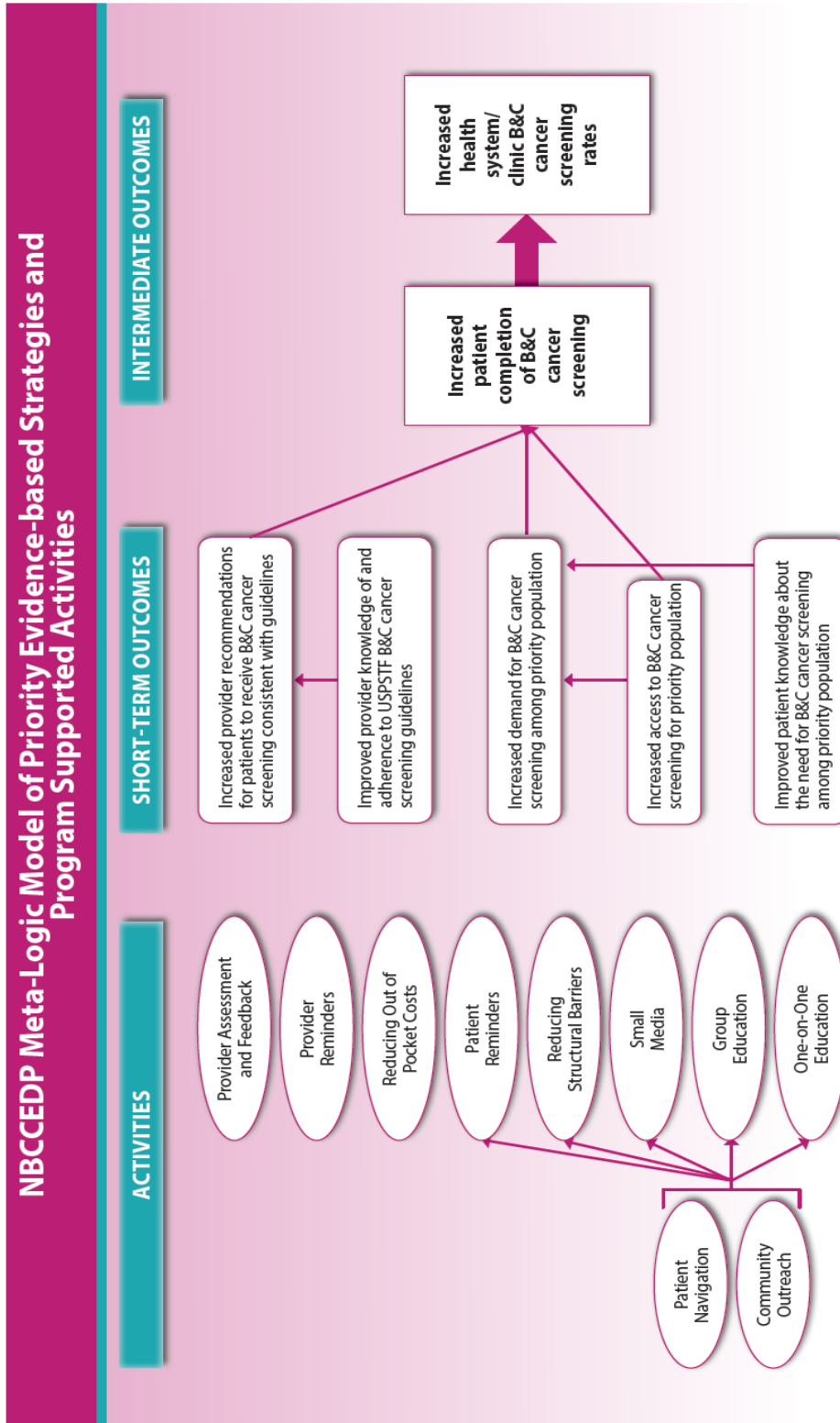
### **Staff Conduct Outreach and Navigation at Community-Based Organization**

The Louisiana State University program partners with six Second Harvest Food Bank pantries in New Orleans. The program’s navigator and nurse practitioner conduct outreach and education, navigating eligible women to four breast and cervical cancer screening providers in the area. Methods for education and outreach depend on the pantry’s food distribution operations and may include group and/or 1:1 education activities, stationed in or near the waiting area. The program initially conducted an assessment at each pantry. Among the information collected was the number of women and federal poverty level served, the best days to conduct outreach, the availability of space (for education and outreach), and whether the women had a primary care provider. Since grantee personnel are providing the navigation, they are able to enter data into the program’s data management system, Catalyst, used to report MDEs and PN-Only MDEs. The community navigation program will be expanding to additional parishes in 2019.

### **Partnering with the Hepatitis C Program to Schedule Screening at their Outreach Event**

The Cherokee Nation program is in the early phases of partnering with the Hepatitis C Program. The latter program is piloting a project to provide education and screening at food distribution centers. Referred to as “food warehouses”, low-income people shop for free at these grocery-like stores. The breast and cervical program’s health educator and clinic-based case manager will work alongside the Hepatitis program staff. While screening will be provided on-site for various health maintenance screenings such as HbA1c, cholesterol, Hepatitis C, and HIV, the breast and cervical program will schedule appointments on the spot for cancer screening.

## Appendix E: Evidence-based Interventions Logic Models

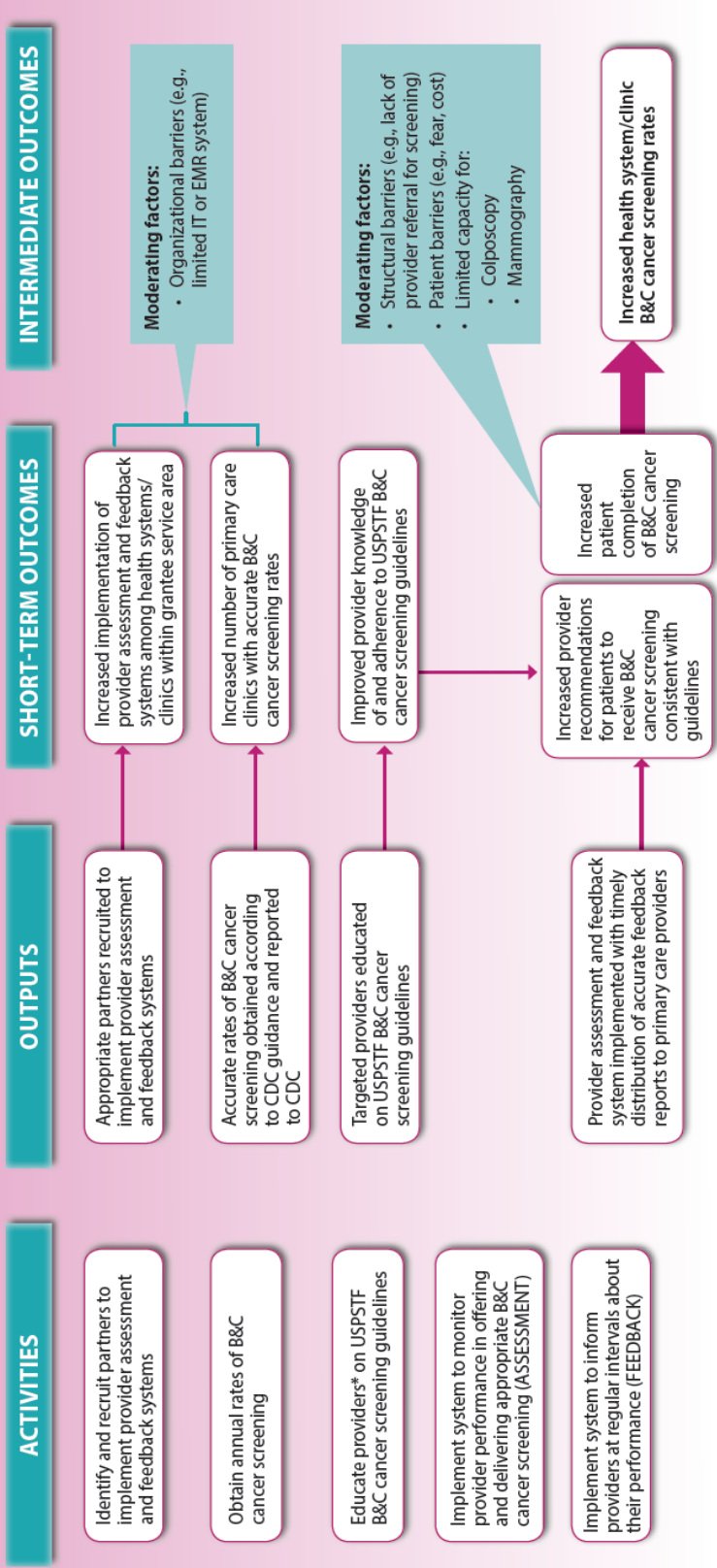


**Definitions/Abbreviations**  
 USPSTF = United States Preventive Services Task Force  
 EMR = Electronic Medical Records  
 MVO = "Make It Your Own" www.myooworks.org  
 Research-tested messages and designs for health communications materials  
 CHWs = Community Health Workers

August 2017

# Provider Assessment and Feedback for the NBCCEDP – Logic Model

## EVIDENCE-BASED STRATEGY



\*The term "providers" refers to any/all clinical staff involved in implementation/use of the provider assessment and feedback system.

Monitoring and Evaluation by Grantee

### Definitions/Abbreviations

- USPSTF = United States Preventive Services Task Force
- MIYO = "Make it Your Own" [www.miyoworks.org](http://www.miyoworks.org)
- Research-tested messages and designs for health communications materials
- EMR = Electronic Medical Records
- PN = Patient Navigation
- CHWs = Community Health Workers



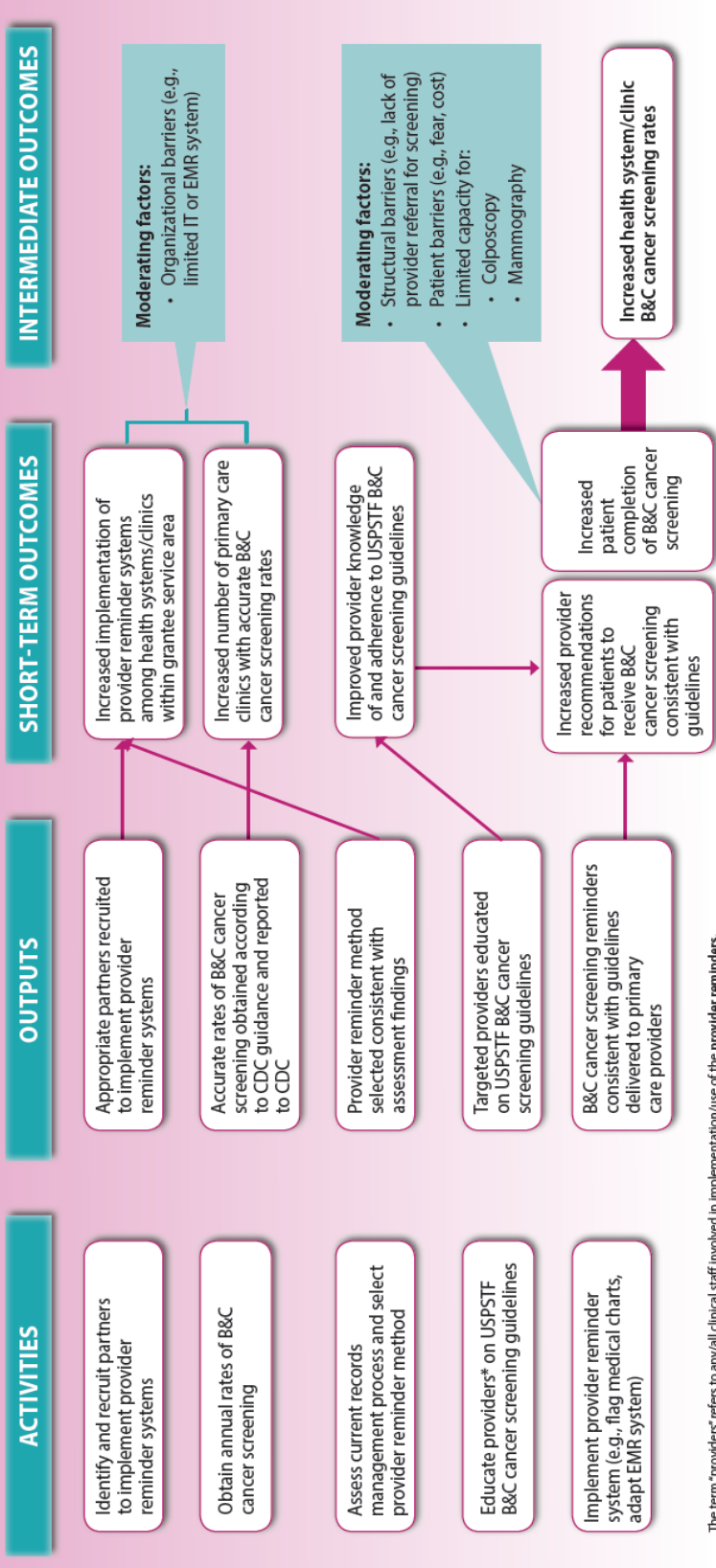
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion

August 2017

C25962A

# Provider Reminders for the NBCCEDP – Logic Model

## EVIDENCE-BASED STRATEGY



The term "providers" refers to any/all clinical staff involved in implementation/use of the provider reminders.

Monitoring and Evaluation by Grantee

### Definitions/Abbreviations

USPSTF = United States Preventive Services Task Force  
 EMR = Electronic Medical Records  
 PN = Patient Navigation  
 CHWs = Community Health Workers



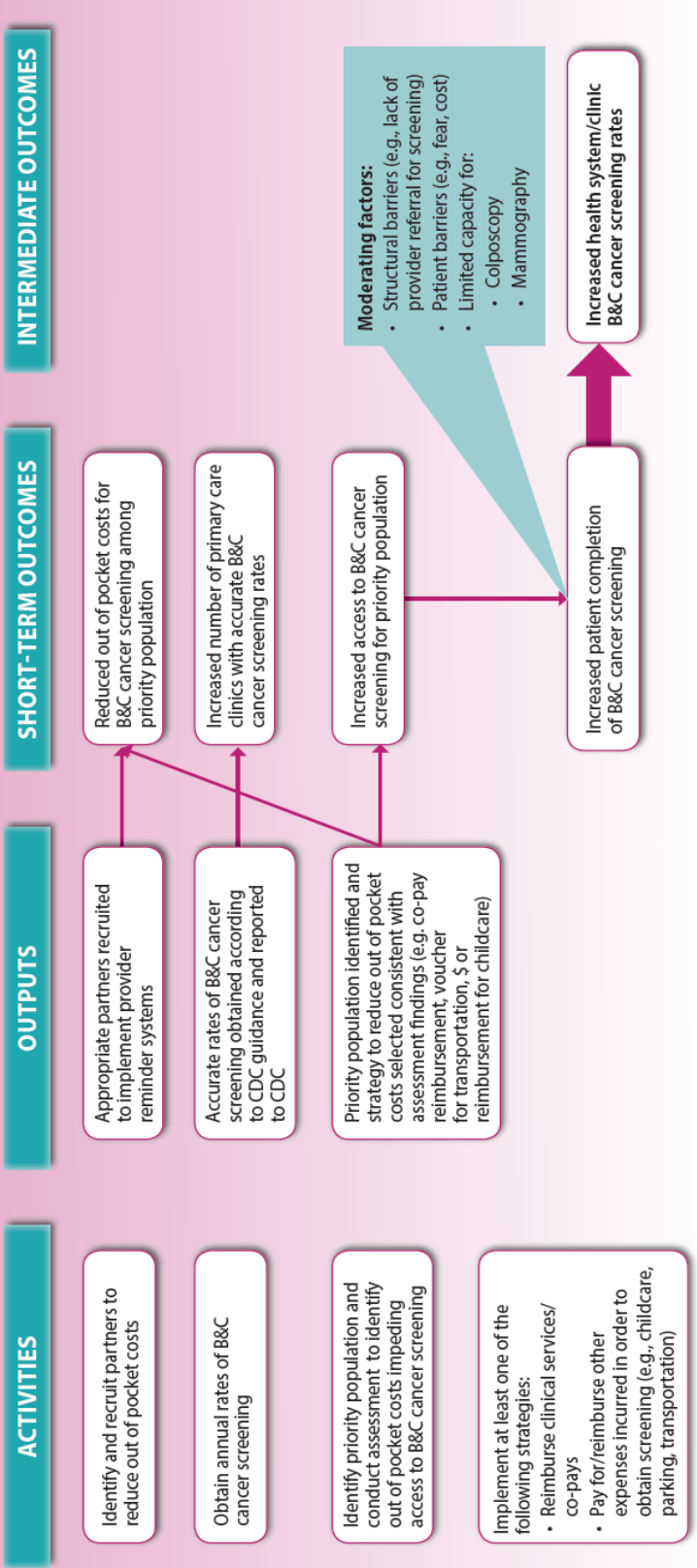
Centers for Disease Control and Prevention  
 National Center for Chronic Disease Prevention and Health Promotion

August 2017

CC2042A

# Reducing Out of Pocket Costs for the NBCCEDP – Logic Model

## EVIDENCE-BASED STRATEGY



Monitoring and Evaluation by Grantee

**Definitions/Abbreviations**

USPSTF = United States Preventive Services Task Force  
 MMYO = "Make it Your Own", [www.miyoworks.org](http://www.miyoworks.org)  
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records  
 PN = Patient Navigation  
 CHWs = Community Health Workers

August 2017

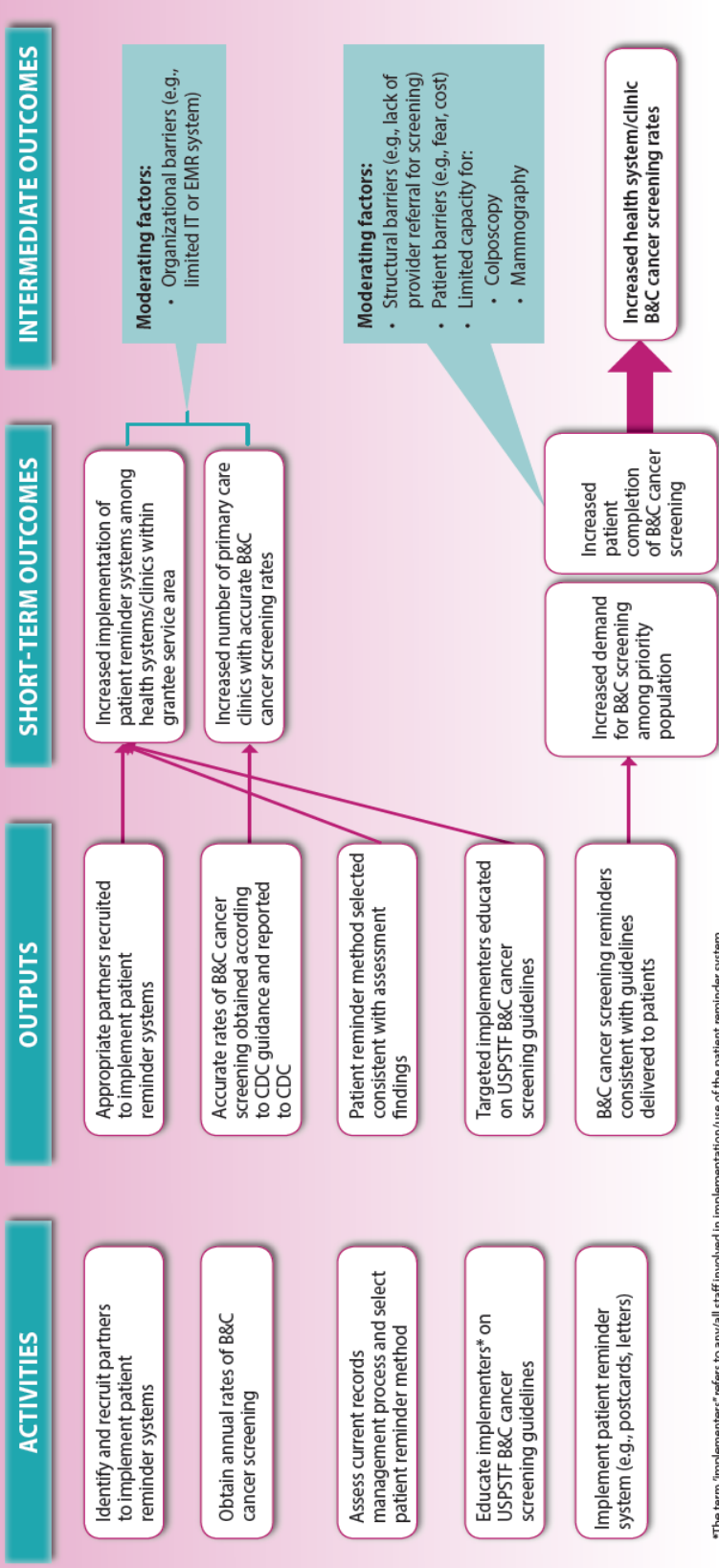


Centers for Disease Control and Prevention  
 National Center for Chronic Disease Prevention and Health Promotion

C230624.8

# Patient Reminders for the NBCCEDP – Logic Model

## EVIDENCE-BASED STRATEGY



\*The term "implementers" refers to any/all staff involved in implementation/use of the patient reminder system.

Monitoring and Evaluation by Grantee

**Definitions/Abbreviations**

USPSTF = United States Preventive Services Task Force  
 EMR = Electronic Medical Records  
 MHO = "Make it Your Own" www.mjoworks.org  
 PN = Patient Navigation  
 CHWs = Community Health Workers  
 Research-tested messages and designs for health communications materials



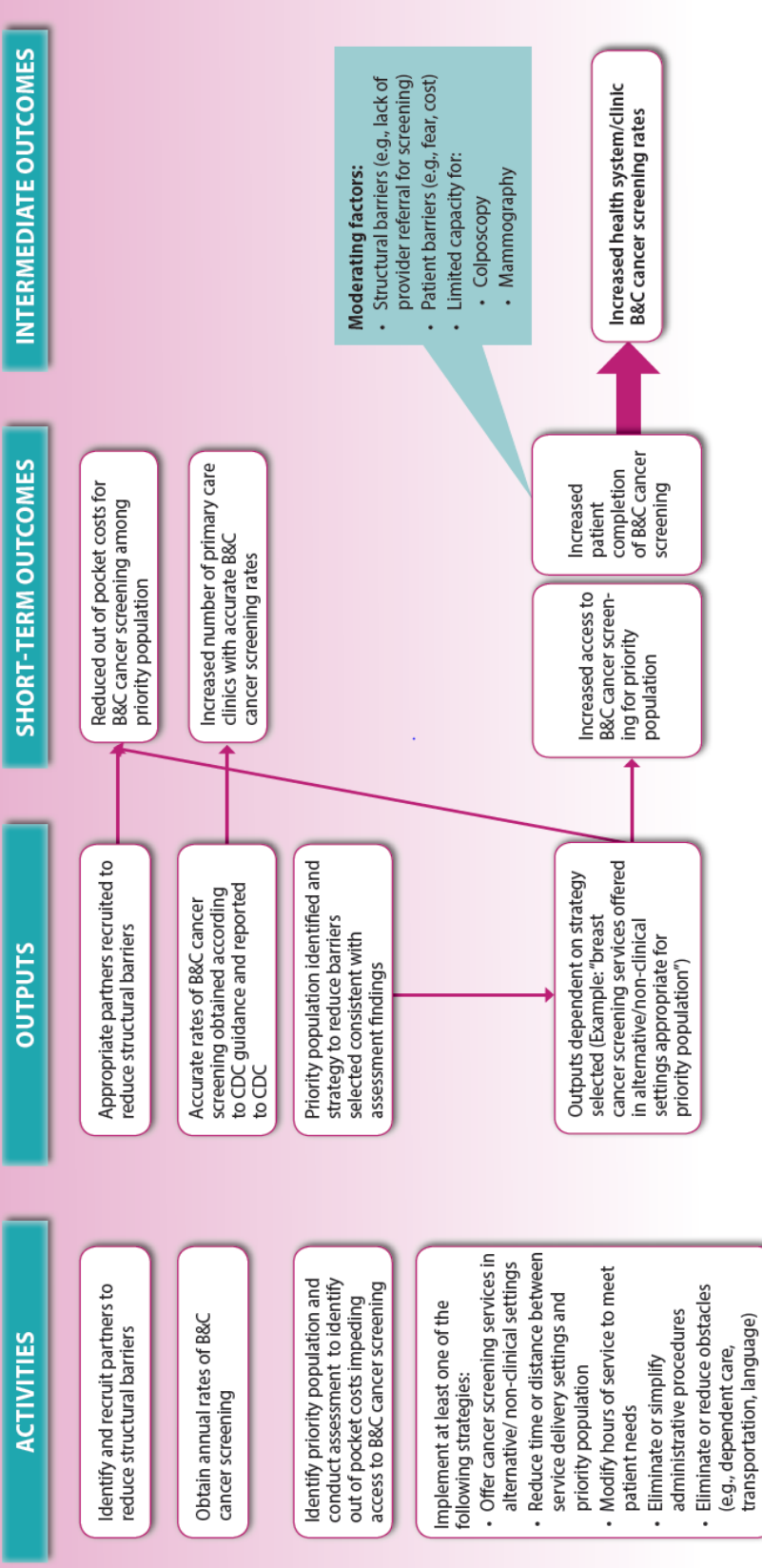
Centers for Disease Control and Prevention  
 National Center for Chronic Disease Prevention and Health Promotion

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ccs202a

# Reducing Structural Barriers for the NBCCEDP – Logic Model

## EVIDENCE-BASED STRATEGY



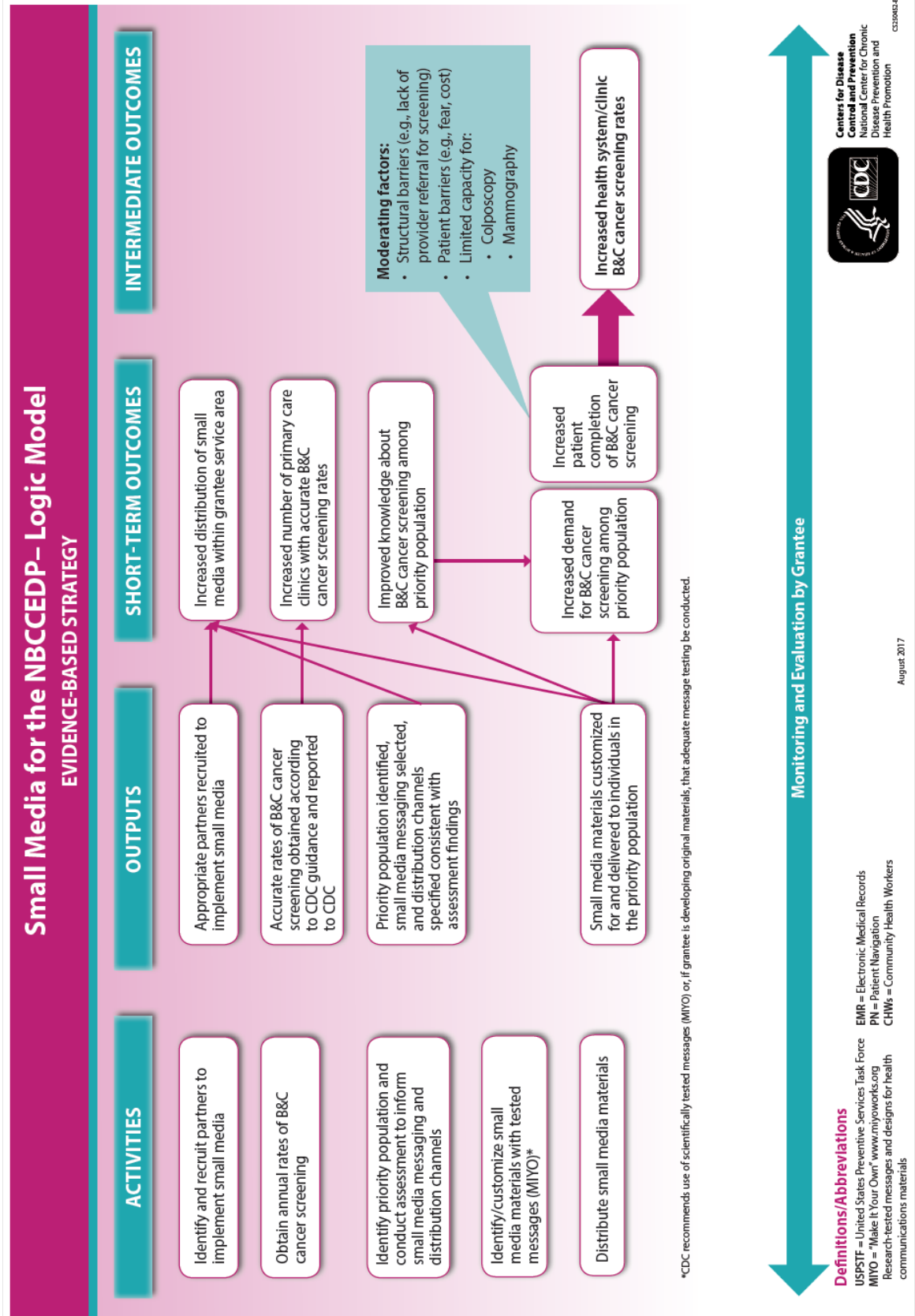
Monitoring and Evaluation by Grantee

**Definitions/Abbreviations**  
 USPSTF = United States Preventive Services Task Force  
 MHO = "Make It Your Own" www.myooworks.org  
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records  
 PN = Patient Navigation  
 CHWs = Community Health Workers

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 National Center for Chronic Disease Prevention and Health Promotion  
 C3296524



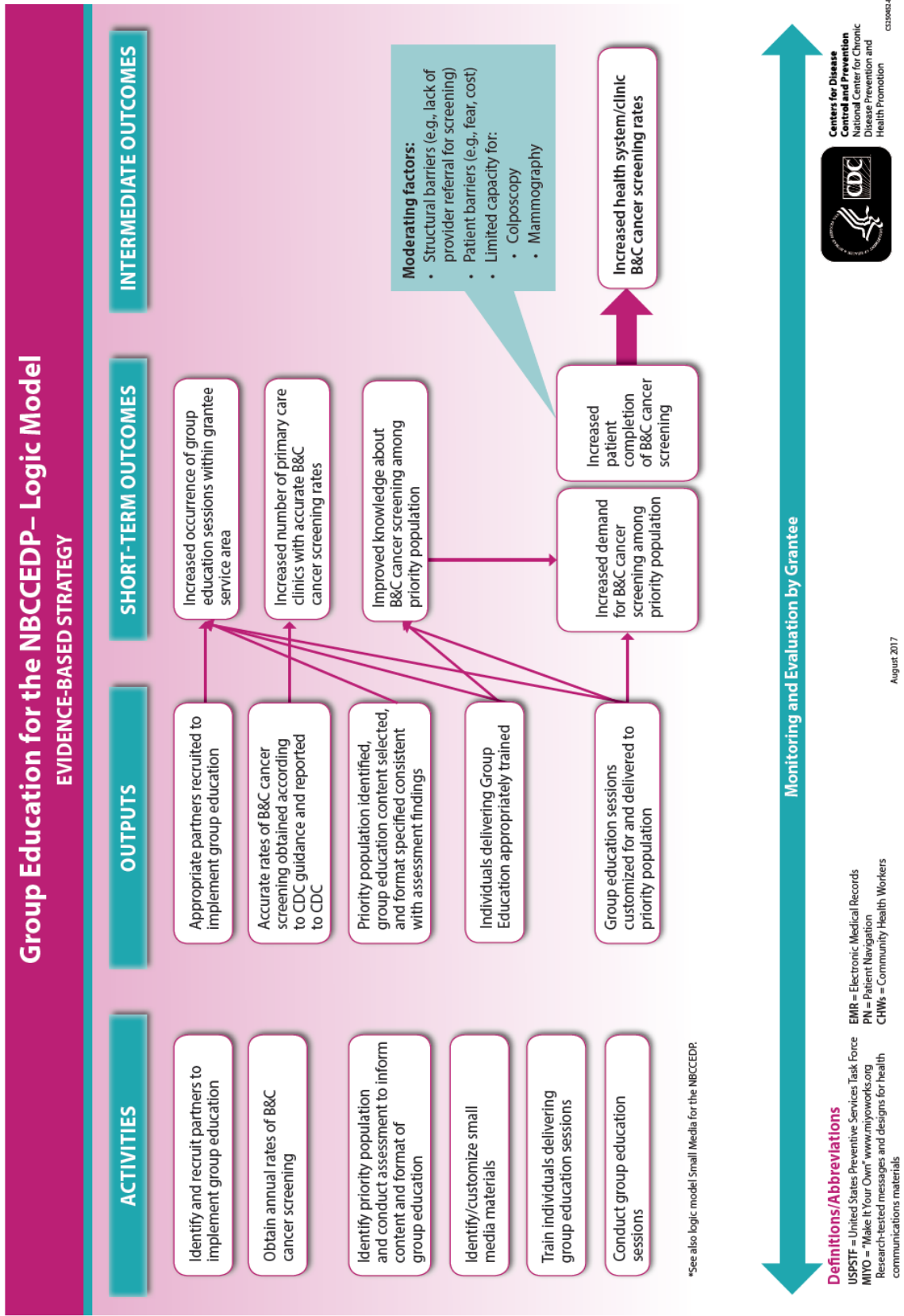
Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention and Health Promotion

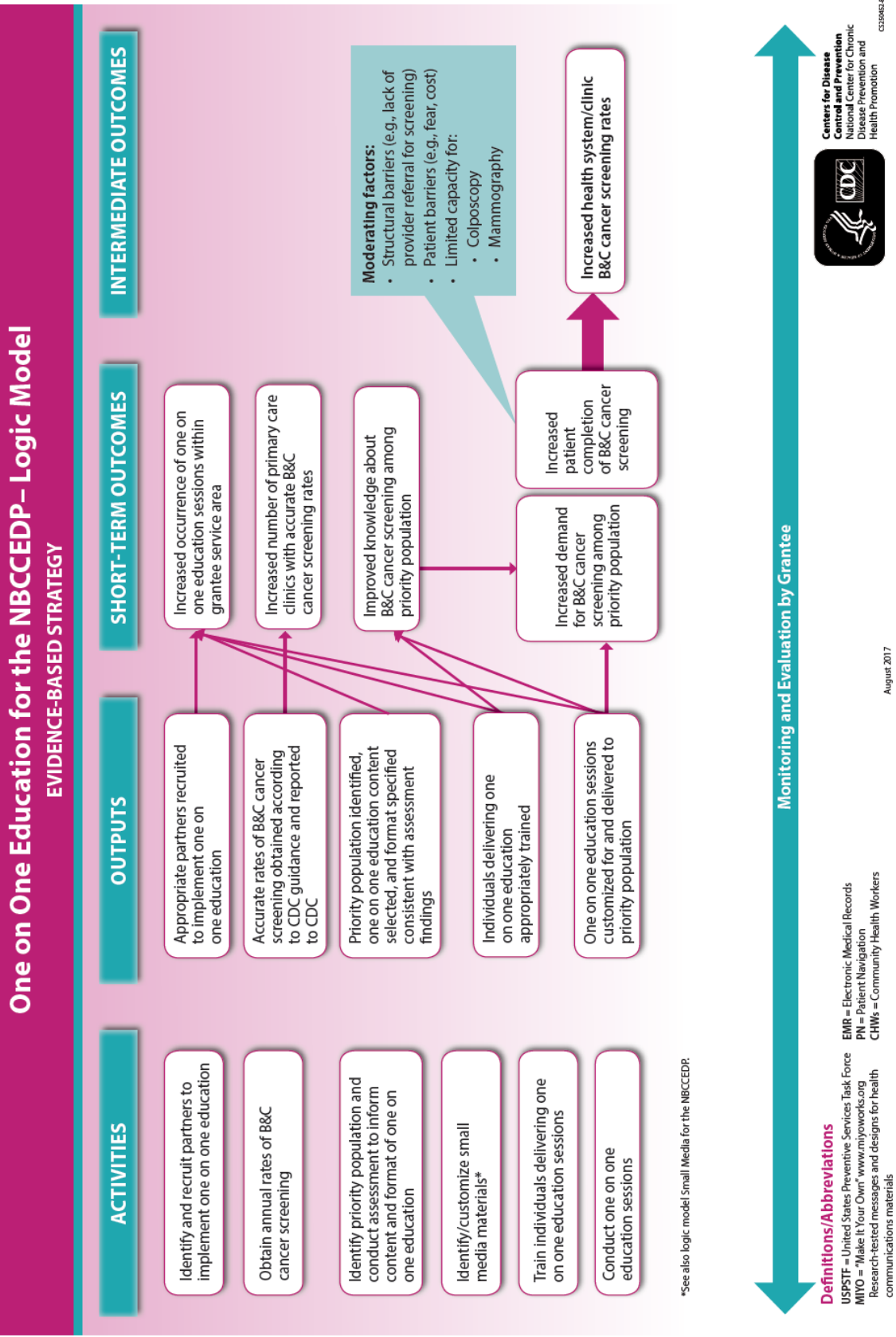
**Definitions/Abbreviations**  
 USPTF = United States Preventive Services Task Force  
 MIYO = "Make It Your Own" www.miyoworks.org  
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records  
 PN = Patient Navigation  
 CHWs = Community Health Workers

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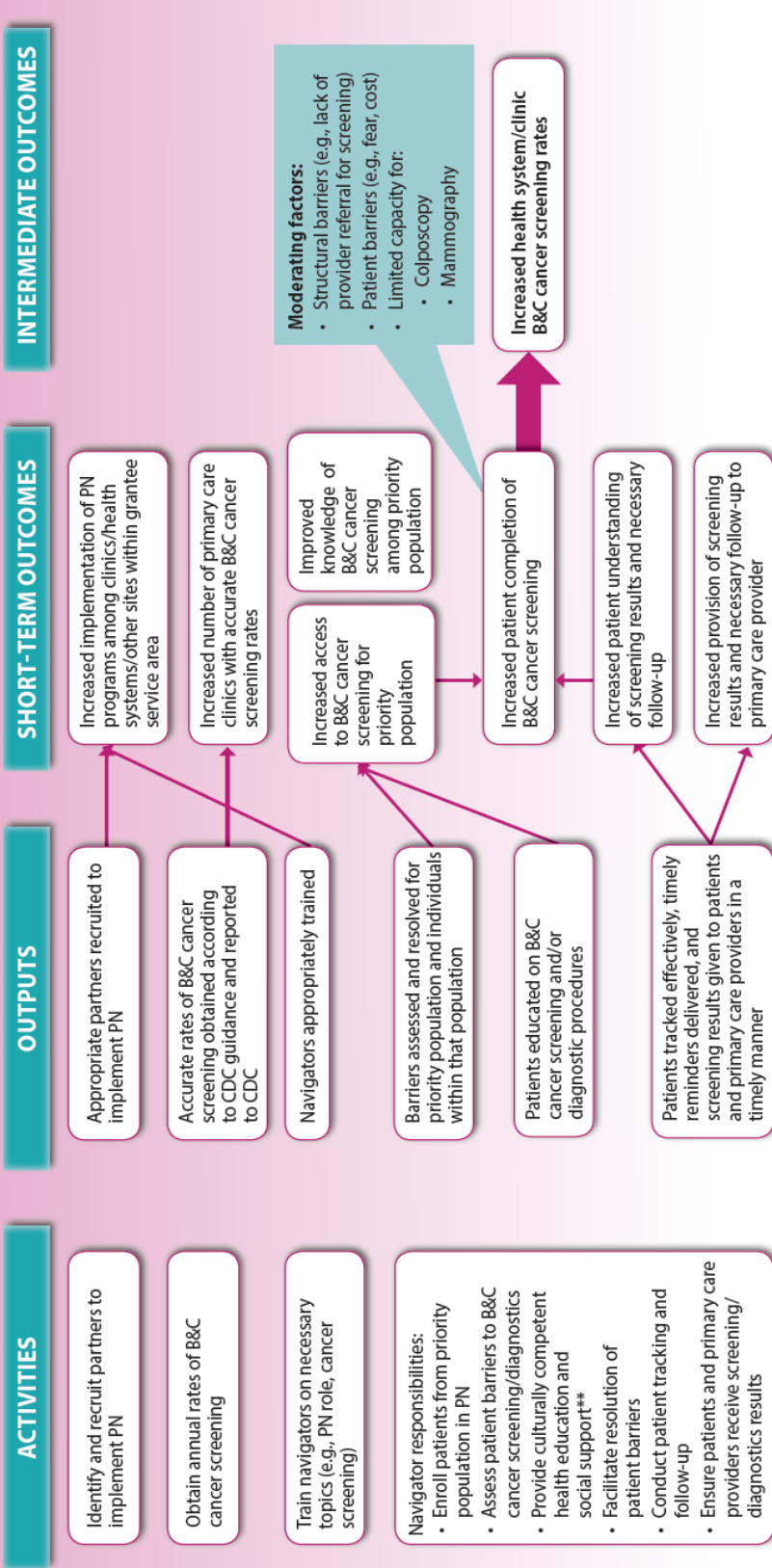
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## Patient Navigation (PN) for the NBCCEDP – Logic Model

### PROGRAM SUPPORTED ACTIVITY



\*NBCCEDP Policies Manual for PN Policy  
 \*\*See also logic models for One on One and Group Education for the NBCCEDP

### Monitoring and Evaluation by Grantee

#### Definitions/Abbreviations

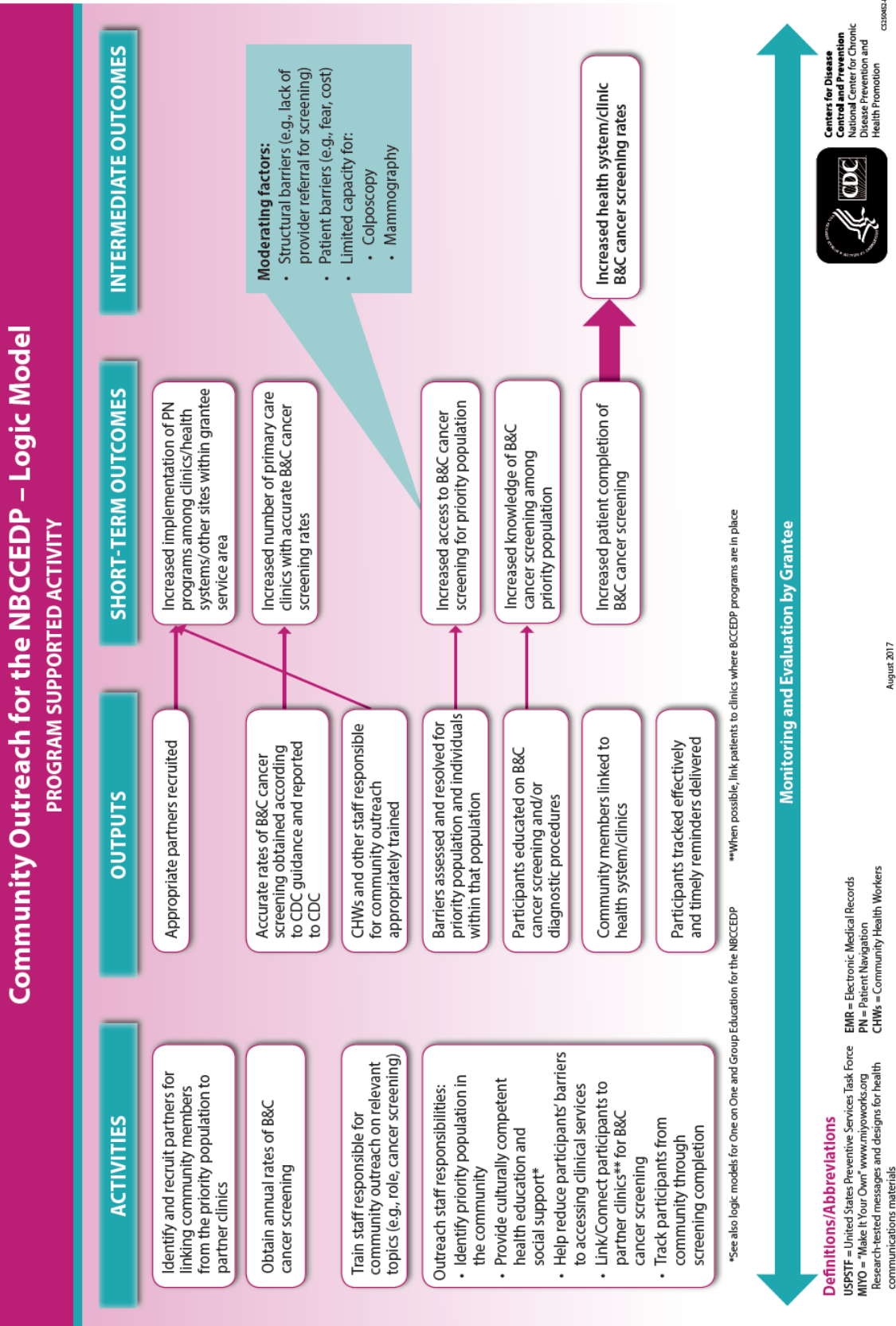
USPSTF = United States Preventive Services Task Force  
 MHO = "Make It Your Own" www.myooworks.org  
 Research-tested messages and designs for health communications materials

EMR = Electronic Medical Records  
 PN = Patient Navigation  
 CHWs = Community Health Workers



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## Appendix F: Writing SMARTIE Objectives

Well-written objectives will give you a roadmap to plan, put into action, and evaluate your program outcomes and activities. You may have written “SMART” objectives before. This document expands on that concept by introducing two new elements—inclusive and equitable—to form a “SMART-IE” objective.

You can use SMARTIE objectives to increase and improve cancer screening among populations that have higher rates of breast and cervical cancer but less access to services.

To write these objectives, ask yourself the following questions:

- Who are the populations of focus in your program?
- What are their needs and barriers to screening?
- Where do they live?
- What community organizations serve them and have their trust?
- Which strategies are appropriate and likely to increase screening among people with the most need?

Ask your populations of focus and your partners for input on your objectives. Ask them what interventions they recommend and how they define success. Objectives that consider diversity, inclusion, and equity will help you share the power and responsibility for achieving desired outcomes and increase your chances of success.

### Is Your Objective a SMARTIE Objective?

#### Specific

Does the objective state the outcome that you aim to accomplish? Among what population, by when, and by how much?

#### Measurable

How will you track your progress and know when milestones have been reached and the objective achieved (for example, metrics or defined qualities)?

#### Attainable

Is the objective challenging but achievable within the capabilities of your program and the community being served? Do you have enough resources?

#### Relevant

Is the objective aligned with the priorities of your program and Notice of Funding Opportunity (NOFO) requirements? Is it meaningful to the population of focus and community being served?

#### Time Based

Is there a deadline to achieve the objective? Are there review points to assess progress?

#### Inclusive

Have you invited, considered, and incorporated input from the population of focus and your community partners where appropriate?

**Equitable**

Does the objective address the unique needs and circumstances of different populations, increase quality services where needed, and seek to address cancer screening disparities?

**Resources**

- The Management Center: [From SMART to SMARTIE: How to Embed Inclusion and Equity in Your Goals](http://www.managementcenter.org/resources/smart-to-smartie-embed-inclusion-equity-goals/) (www.managementcenter.org/resources/smart-to-smartie-embed-inclusion-equity-goals/)
- The Management Center: [SMARTIE Goals Worksheet](http://www.managementcenter.org/resources/smartie-goals-worksheet/) (www.managementcenter.org/resources/smartie-goals-worksheet/)
- Massachusetts Department of Public Health: [Racial Equity Data Road Map \(pages 52–53\)](http://www.mass.gov/service-details/racial-equity-data-road-map) (www.mass.gov/service-details/racial-equity-data-road-map)
- Giving USA: [Be a SMARTIE: An Equity-Forward Approach to Goal-Setting](https://alford.com/be-a-smartie-an-equity-forward-approach-to-goal-setting/) (https://alford.com/be-a-smartie-an-equity-forward-approach-to-goal-setting/)
- Idealist: [What’s Better than SMART Goals? Try SMARTIE Goals](http://www.idealists.org/en/careers/better-than-smart-smartie-goals) (www.idealists.org/en/careers/better-than-smart-smartie-goals)

**Examples**

NBCCEDP Strategy	Traditional Objective	SMARTIE Objective
<p><b>Strategy 2:</b> Use surveillance systems and population-based surveys to assess cancer burden and inform programmatic efforts</p>	<p>By 8/1/2022, use Small Area Health Insurance Estimates to identify and describe program-eligible populations in &lt;jurisdiction&gt;.</p>	<p>By 8/1/2022, use cancer late-stage diagnosis and mortality data to identify and prioritize populations most in need of cancer screening services.</p>
<p><b>Strategy 3:</b> Support partnerships for cancer control and prevention</p>	<p>By 6/29/2023, participate in all &lt;jurisdiction&gt; cancer coalition meetings.</p>	<p>By 10/1/2022, work within the &lt;jurisdiction&gt; cancer coalition to develop a health equity strategy to increase cervical cancer screening based on cancer health disparities and other burden data and input from &lt;the populations of focus&gt; and partners from the community. By 12/1/2022, work within the &lt;jurisdiction&gt; cancer coalition to recruit &lt;number&gt; community members from &lt;the prioritized population of focus&gt; to help identify strategies to increase and improve cancer screening in their communities.</p>
<p><b>Strategy 4:</b> Deliver screening and implement evidence-based interventions (EBIs)</p>	<p>By 11/1/2022, execute a memorandum of understanding with &lt;Clinic A&gt;, &lt;Clinic B&gt;, and &lt;Clinic C&gt; to select, adapt, and implement EBIs. By 12/1/2022, renew contracts with existing breast and cervical cancer screening providers.</p>	<p>By 12/1/2022, recruit &lt;number&gt; new health care providers and clinics close to &lt;the prioritized populations of focus&gt; to provide screening services. By 12/31/2022, work with &lt;community partner&gt; to provide technical assistance to &lt;number&gt; providers and clinics on how to increase and improve service delivery to &lt;the prioritized populations of focus&gt;. By 6/29/2023, work with at least two local organizations with demonstrated access to &lt;the prioritized population of focus&gt; in their community to refer at least 200 people to the program for services.</p>

		<p>By 6/29/2023, screen &lt;number&gt; women from &lt;population of focus&gt;.</p> <p>By 6/29/2023, increase screening among &lt;population of focus&gt; by 20% by the end of Program Year 2.</p>
<p><b>Strategy 5:</b> Conduct program monitoring and evaluation</p>	<p>By 12/30/2022, develop and submit a program evaluation plan that assesses program planning processes and outcomes, using high-quality data.</p>	<p>By 12/30/2022, develop a program evaluation plan that specifies the measures, sources of data or data collection planned, and methods of analysis to assess the achievement of breast and cervical cancer screening and other targets for &lt;each population of focus&gt;.</p> <p>By 6/29/2023, meet at least 95% of screening targets for &lt;each population of focus&gt;.</p>

## Appendix G: NBCCEDP Work Plan Template

A *work plan* is a document, often created in chart form, used as a program management tool to provide direction and guidance for the overall program. The following recommended components follow each other in the work plan development process and are designed to be used for program planning, implementation, and monitoring progress toward reaching program goals. Applicants are encouraged to use the template to document their detailed work plan for Year 1 of the award and provide a general summary of work plan activities for Years 2 through 5 in narrative form.

### 1. Notice of Funding Opportunity (NOFO) Strategy

The *NOFO Strategy* is a group of activities that, when executed, achieves the short-, intermediate-, and long-term outcomes of the NOFO. NBCCEDP work plans must align with the NBCCEDP strategies in CDC-RFA-DP22-2202. For the full list of NBCCEDP strategies, see *CDC Project Description, Approach, Strategies & Activities, Program 1: NBCCEDP*. Please note the applicant's work plan for Program 1 should include work in all Program 1 strategy areas included in the NOFO.\*

### 2. Objectives Proposed and Produced

The *objectives* are the main outputs or changes that will occur as a result of successfully implementing the strategy. List key SMART-IE objectives you will complete during Year 1. SMART-IE objectives are specific, measurable, attainable, relevant, time-based inclusive, and equitable. Please refer to the SMART-IE objectives document posted to the NOFO website. Each objective should include a planned date for completion and what is to be accomplished. Completion dates for objectives should vary according to how work should progress. Most objectives will contain a number indicating quantity, percentage, or other progress indicator. See the examples below and in the SMART-IE Objectives document. You may add boxes, as needed, for additional objectives and activities.

Example: By December 1, 2022, recruit new providers or clinics in proximity to Jackson County to expand access to screening services for American Indian women living in urban areas of the state.

### 3. Activities

An *activity* is a measurable step to achieve the strategy. It describes key activities you will complete during Year 1. Each activity should designate the person responsible for implementation. Note that Challenges and Successes are for completion during CDC's progress review. Activities can be used to determine a program's status at any point in time, and they can be measured during the period of performance. Activities answer, "What steps must be completed to achieve the strategy?"

Example: Complete assessments for Clinic A, Clinic B, and Clinic C to inform selection of evidence-based interventions to increase breast and cervical cancer screening rates.

### 4. Performance Measure

A *performance measure* quantifies progress towards achieving activities. They are realistic, measurable standards that a program sets for itself to gauge progress. Multiple performance measures may be required to assess progress of a particular strategy or activity. Performance measures should contain a numeric value or clearly observable behavior; for example, the percentage of women referred to screening or the number of technical assistance sessions provided to partner clinics.

### 5. Start and End Date

The time frame should include an *approximate start and end date* for the activity. To determine a reasonable time frame, consider how long it will take to assess progress, previous experience, and other activities you are planning.

**6. Personnel Assigned**

Determine which *team members* are responsible for each of the activities involved. Consider who is appropriate to complete the activity and staff constraints given other activities you are planning.

**7. Progress Report**

The final component of the work plan is the *progress report* that describes:

- Objectives completed to date.
- Successes and significant accomplishments.
- Challenges and major problems encountered.
- Progress status for each activity.
- Work plan revisions needed.

Complete this section and submit it at the designated time for progress reporting.

**8. What Is a SMART-IE Objective\*?**

See examples in the SMART-IE Objectives document on the NOFO website.

**Specific**

Does the objective state the outcome that you aim to accomplish? Among whom, by when, and by how much?

**Measurable**

How will you track your progress and know when milestones have been reached and the objective has been achieved (for example, metrics or defined qualities)?

**Attainable**

Is the objective challenging but achievable within the capabilities of your program and the community being served? Are resources adequate?

**Relevant**

Is the objective aligned with the priorities of your program and NOFO requirements, and meaningful to the population of focus and community being served?

**Time-Based**

Is there a deadline to achieve the objective? Are there review points to assess progress throughout the course of achieving the objective?

**Inclusive**

Has input from the population of focus and community partners been invited, considered, and incorporated where appropriate?

**Equitable**

Does the objective address the unique needs and circumstances of different populations, increase quality services where needed, and seek to address cancer screening disparities among populations with higher rates of late-stage disease and cancer mortality?

\*As outlined in the NOFO, Strategy 4 includes both activities related to delivering screening and activities related to implementing evidence-based interventions. The work plan template includes separate sections for each of these two broad types of activities. Additionally, the work plan includes a section for program management to include administrative, fiscal, reporting, and other similar activities that support implementation of the NOFO.

## NBCCEDP Templates

### Work Plan

Applicants are encouraged to use the below template for the work plan in the application. Awardees will be asked to complete future work plans and progress reports in the Award Management Platform (AMP)<sup>1</sup>. Use of this template will aid with future data entry. Additional reporting components may be added in the future.

<b>NBCCEDP Work Plan Template [insert year]</b>			
<b>NOFO Strategy:</b> Strategy 2: Use surveillance systems and population-based surveys to assess cancer burden, examine health disparities, focus program efforts, and inform efforts to address social determinants of health (SDOH).			
<b>Objectives Proposed:</b>			
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>

<b>NBCCEDP Work Plan Template [insert year]</b>			
<b>NOFO Strategy:</b> Strategy 3: Support partnerships for cancer control and prevention.			
<b>Objectives Proposed:</b>			
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>

<b>NBCCEDP Work Plan Template [insert year]</b>			
<b>NOFO Strategy:</b> Strategy 4. Deliver cancer screening and implement evidence-based interventions (EBIs) in primary care clinics that serve women impacted by health inequities.			
<b>Objectives Proposed:</b>			
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>

<b>NBCCEDP Work Plan Template [insert year]</b>			
<b>NOFO Strategy:</b> Strategy 5: Conduct program monitoring and evaluation to strengthen program processes and improve equitable outcomes.			
<b>Objectives Proposed:</b>			
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>

<b>NBCCEDP Work Plan Template [insert year]</b>			
<b>NOFO Strategy:</b> Program Management			
<b>Objectives Proposed:</b>			
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>

**Progress Report Template**

This section will be used for reporting future progress to NBCCEDP and will not be used for this application process. Progress Reports will be completed in AMP.

<b>NBCCEDP Progress Report Template [insert year]</b>				
<b>NOFO Strategy:</b>				
<b>Objectives Produced:</b>				
<b>Activities</b>	<b>Performance Measure(s)</b>	<b>Start and End Date</b>	<b>Personnel Assigned</b>	<b>Status</b>
<u>Successes:</u>				
<u>Challenges:</u>				

## Appendix H: Evidence-Based Intervention Clinic Review Guide

CDC has created this Clinic Review Guide to assist award recipients in organizing information for program planning and technical assistance. Considerations for assessing health equity processes are also provided. The table below captures a snapshot of findings from clinic assessments, process maps, and implementation planning and can be used as a starting point for discussion between you and your CDC Program Consultant. To share the updated document with CDC prior to program calls, upload it as a TA request in CDC's Award Management Platform (AMP). This guide replaces the CRCCP 2002 Clinic Implementation Plan Summary (CIPS) tool.

### Column Descriptions:

1. Clinic and Health System Name - If the information differs by clinic or groups of clinics under a health system, list them on separate rows. If the information is the same, list them all in one row.
2. Process Flow Maps – Note whether a process map has been completed, gaps are identified and used to drive EBI planning, and the document has been shared with CDC. Process flow maps should illustrate the patient appointment process for each health system or clinic. Include processes for determining eligible patients and outreach, barrier assessment, addressing missed appointments, and diagnostic follow-up.
3. Clinic Characteristics – select responses and/or describe clinic characteristics such as provider staffing, baseline screening rates, existing EBIs, leadership support, clinic champions, involvement in other QA/QI initiatives, participation in the NBCCEDP service delivery program, existing B&C or CRC policies, and EHR systems in place.
4. Population Served – share additional information on the populations of focus served by the partner clinic and how the clinic supports community inclusion. Examples include whether patient satisfaction is assessed, whether community representation is present through staffing (gender appropriate, language appropriate) and/or partners, whether community members are engaged in planning activities, and if the clinic uses stratified data to identify disparities in screening.

5. EBIs or Process Changes– Select “yes” or “no” based on the EBI’s and process changes identified for partner clinics. These should match gaps identified.
  
6. Implementation Details – Provide information on how EBIs will be implemented. For example, client reminders will include tailored mailed letters and multiple text message reminders. Consider how advancing health equity is accounted for in implementation. (See health equity questions included)
  
7. Notes – space for notes or comments on EBI implementation or on other information provided in the table during program calls or in general.

Clinic Name(s)	Patient and Screening Workflow(s) Attached	Clinic Characteristics	Population Served	EBI Selection or Process Changes to Address Gaps	Implementation Details	Notes for Discussion
	Is a Patient and/or Screening Process Workflow provided? Choose an item.	Number and types of providers (MDs, MAs, NPs, PA)	Which program populations of focus are served by this clinic?	Provider Assessment and Feedback Choose an item.	<p><b>Provider Assessment and Feedback Implementation Details</b></p> <p>How often do providers get feedback? Is feedback in aggregate or by provider?</p> <p>Is health equity data shared and discussed with providers/staff?</p> <p>How is patient satisfaction taken into consideration when assessing provider performance?</p>	

					How is the patient's level of understanding of the screening continuum process taken into consideration when assessing provider performance?	
	<p>Are gaps and missed opportunities identified in the workflows? Choose an item.</p> <p>Additional details:</p>	<p>Baseline Screening Rates Breast - Cervical - Colorectal -</p>	<p>Is patient satisfaction formally assessed? Choose an item.</p> <p>Additional details:</p>	<p>Provider Reminder Systems Choose an item.</p>	<p><b>Provider Reminder Systems Implementation Details</b></p> <p>How are providers reminded? Which providers receive the reminder?</p> <p>Are trainings offered to providers that focus on conducting culturally competent patient visits?</p>	
		<p>Existing EBIs Prior to Project Implementation Choose an item. Choose an item. Choose an item.</p> <p>Additional details:</p>	<p>Does staff represent membership of the populations of focus? Choose an item.</p>	<p>Client Reminder Systems Choose an item.</p>	<p><b>Client Reminder Systems Implementation Details</b></p> <p>Are mailers and text messages language appropriate?</p> <p>How often are reminders sent to a client?</p> <p>What modes are used for reminders?</p>	

		<p>Clinic leadership support Choose an item. Additional details:</p>	<p>Is there community representation within planning activities? Choose an item.</p>	<p>Reducing Structural Barriers Choose an item.</p>	<p><b>Reducing Structural Barriers Implementation Details</b></p> <p>How have operations been modified to reduce structural barriers?</p> <p>Are CHWs and/or PNs included in this approach?</p> <p>How is your patient navigation tailored?</p>	
		<p>Clinic screening champion in place Choose an item. Additional details:</p>				
		<p>Alignment with other QA/QI initiatives Choose an item. Additional details:</p>	<p>Does the clinic work with community partners that represent the population of focus? Choose an item.</p> <p>If yes, describe the partners and purpose of the partnership:</p>	<p>Other process changes based on identified gaps:</p> <p>EHR data validated?</p> <p>EHR changes supporting data collection and query?</p>	<p><b>Other Changes Implementation Details</b></p>	
		<p>NBCCEDP direct service provider Choose an item.</p>	<p>How have you assessed clinic efforts</p>			

		<p>Existing standard orders/policies for screening age-appropriate patients for B&amp;C or CRC Choose an item.</p>	<p>to identify disparities and advance health equity? For example: How are patients with late-stage diagnoses prioritized in screening efforts? Are navigators and providers addressing patient concerns around screening? Are providers and clinic staff aware of sexual orientation preferences of patients and tailor the health visit accordingly? How are your EBI interventions strengthened if evaluation reveals poor uptake/gaps</p>			
		<p>EHR system used: Additional details:</p>				

			/decreases in screening rates?			
--	--	--	--------------------------------------	--	--	--