NBCCEDP Program Guidance Manual

Book 2

Policies and Procedures
Program Management
Partnerships

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NBCCEDP Program Guidance Manual

Policies and Procedures

Version 2

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I. INTRODUCTION TO THE CHAPTER

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is authorized Public Law 101-354, regulated by the federal government, and administered by Centers for Disease Control and Prevention (CDC). Therefore, it has several layers of regulations with which grantees must comply. This chapter distinguishes

- requirements based on the law,
- requirements based on regulations of the Federal Government,
- policies established by CDC's Division of Cancer Prevention and Control (DCPC)

There are two significant amendments to Public Law 101-354:

- Public Law 103-183—the Preventive Health Amendments of 1993—was enacted on December 14, 1993. It specifically allowed NBCCEDP funds to be awarded to tribes and tribal organizations.
- Public Law 105-340—the Women's Health Research and Prevention Amendments of 1998—was enacted on October 31, 1998. It specified that appropriate follow-up services included support services, such as case management.

The law and its amendments specify the necessary activities of any NBCCEDP grantee. These functions include the following:

- Screening women for breast and cervical cancer, with priority to low-income women
- Providing appropriate follow-up services and support services, such as case management and referrals for medical treatment
- Developing and disseminating public information and education programs
- Improving the education, training, and skills of health professionals
- Monitoring the quality and interpretation of screening procedures
- Evaluating the above activities

II. REQUIREMENTS BASED ON LAW

Public Law 101-354 specifies clinical breast exams (CBEs), pelvic examinations, Papanicolaou (Pap) tests, and mammograms as approved screening tests, and it requires that if a superior procedure becomes widely available and is recommended for use, the program will provide reimbursement for this procedure.

Public Law 101-354 and its amendments outline several unique requirements for the NBCCEDP with which programs must comply. Regulations described in this chapter that are derived from law are labeled with "L" prefixes. Those that come from federal regulations bear an "F" prefix. Policies developed by CDC are labeled with "P" prefixes. These distinctions clarify the basis of various regulations and policies for

users of this manual. The full text of Public Law 101-354 (and its amendments), the Breast and Cervical Cancer Mortality Prevention Act of 1990, which established the NBCCEDP can be found in Attachment A.

The most frequently referenced requirements are described below and are identified by the prefix "L" to highlight their basis in law rather than CDC policy.

L.1: Contracts and Consultants

Programs are allowed to contract with nonprofit and for-profit entities. If a nonprofit entity and a for-profit entity compete for a contract and they are determined to be equally qualified, the program may give priority to the nonprofit entity.

L.2: Matching Funds

Programs are required to match $1 of non-federal resources for each $3 of federal funds that they receive. Programs must identify, secure, ensure, and budget the resources and allowances of non-federal contributions for the program. Official notification of the required amount of matching funds is provided to programs in the Notice Of Award (NOA) issued by the Procurement and Grants Office (PGO). The basis for determining this match is the total amount of federal monies (financial assistance) awarded to the program. Further guidance regarding matching funds is provided in Attachment B.

L.3: Maintenance of Effort

Matching funds must be in excess of the amount that the program was contributing prior to its initial award of federal funds. In determining the amount of non-federal contributions to credit toward the matching funds requirement, the program can only use funds over and above the average annual amount the program had contributed toward breast and cervical cancer programs and activities for 2 years prior to the first fiscal year of federal funding for NBCCEDP.

L.4: Medicaid as It Relates to Maintenance of Effort or Matching Funds

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.

L.5: Medicare Reimbursements for Screening and Diagnostic Services

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 and a single rural rate or the various regional Medicare rates approved by CMS.

L.6: Payor of Last Resort

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. Attachment C provides greater detail about the payor of last resort as applied to IHS clinics and tribally operated clinics.

L.7: 60/40 Percent Distribution Requirement

Sixty-percent distribution–At least 60% of program funds must be used for direct clinical services. Costs allowable in the 60% category are allocated for: screening, diagnostic workup, referral for treatment, and essential support services (e.g., case management/patient navigation).

Forty-percent distribution–No more than 40% of program funds may be allocated to other required program functions, such as

- management activities,
- development and dissemination of information for public education and targeted outreach,
- improvement of the education, training, and skills of health professionals (professional development),
- establishment of mechanisms through which programs can monitor the quality of screening procedures and their interpretation (data management, quality assurance, and quality improvement),
- development and maintenance of partnerships,
- implementation of population-based activities that embrace environmental, policy, and systems change approaches,
- surveillance and evaluation activities.

The basis for calculating the 60/40 distribution is the total amount of federal monies awarded to the program. It does not apply to non-federal matching funds. Further guidance regarding 60% allowable costs can be found in Attachment D.

L.8: Ten-Percent 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% administrative costs will be considered part of the 40% budget distribution used to support infrastructure activities. 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.

L.9: Restrictions on Use of Grant

Other legal requirements of programs include the following stipulations:

- NBCCEDP funds may not be used to provide inpatient hospital services for any individual.
- Grantees 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.
- Grantees must establish fiscal control and fund accounting procedures that are subject to audit.

Further details about these restrictions and requirements are provided in the full text of the law in Attachment A.

III. Requirements Based on Federal Regulations

The following regulations apply to all federal grants including CDC grants. They are not specific to the NBCCEDP. These regulations are prefaced with the letter "F" to reflect their basis in federal policy.

F.1: Notice of Awards (NOA)

In addition to the legislative requirements detailed above, a grantee's activities are governed by the provisions of its NOA. Programs are subject to any terms and conditions noted in the "remarks" section of the NOA, as well as 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 grantee when funds are drawn or otherwise obtained from the grant payment system. A sample NOA with

explanatory text is provided in Attachment E. More information on grants is available at http://www.cdc.gov/about/ funding.htm.*

F.2: Competitive Application or Interim Progress Report (IPR)

All programs must submit an annual request for funding for CDC review and approval. If it is a competitive year (the first year of a new program announcement), a competitive application must be submitted. If it is a noncompetitive, continuation year, an IPR must be submitted. Both types of applications should include all information and data specified in the program announcement and its amendments. The competitive application or IPR for the NBCCEDP also must outline proposed reimbursement rates.

If applicable, the application should also include the information requested on the Clinical Cost Worksheet (CCW) (Attachment F), which is used by the grantee to estimate the number of women to be served and the screening and diagnostic services to be provided during that budget period.

The date for the receipt of these applications will be established by CDC's PGO.

F.3: Federal Financial Report (FFR)

An FFR is due to CDC's PGO 90 days after the end of each budget period. However, adjustments may be made up to 15 months after the end of the budget period. An FFR is the mechanism by which unobligated financial assistance funds are officially reported to CDC. Programs also should submit documentation of their current year's "estimated" unobligated dollars on Standard Form 424A or via letter prior to the end of the project or the approved no-cost or cost extension period. Further information is available at the PGO Web site (http://www.cdc.gov/about/business/funding.htm).

F.4: Prior Approval

Recipients are allowed a certain degree of latitude in making postaward programmatic changes and budget revisions. The grantee is permitted to rebudget within and between budget categories in the approved direct cost budget of the project to meet unanticipated requirements or to accomplish certain programmatic changes. Nevertheless, federal grants require that certain program changes receive prior approval from PGO. Failure to obtain prior approval, when required, may result in disallowance of costs. Examples of these prior approval items include

- a change in the principal investigator or other key personnel,
- spending funds that have been restricted,
- subcontracting a substantial amount of work,
- spending unobligated funds,

* Because of the evolving nature of the Internet, Web sites noted in this chapter may no longer exist. In such cases, a global Internet search or search from the noted entity's homepage may be needed to locate specific documents and resources.

- continuing operations through cost or no-cost extensions,
- establishing or changing contracts or consulting agreements,
- making significant budget changes (i.e., those of $1,000,000 or more or those exceeding 30% of the award, whichever is less).

F.5: Contractor and Consultant Approval Process

To obtain approval for a contractor or consultant, a program is required to submit the elements listed below to PGO.

Required Elements: Contractor

- **Name of contractor**—This element identifies the name of the proposed contractor.
- **Method of selection**—This element indicates whether the contract is sole source or a competitive bid. The program should describe the qualifications of the contractor and identify whether the contractor is a private, for-profit organization.
- **Period of performance**—This element specifies the beginning and ending dates of the contract. It also indicates whether this is a new or continuation contract.
- **Scope of work**—This element is used by the program to describe, in outcome terms, the specific services/tasks to be performed by the contractor as related to the accomplishment of program objectives (e.g., screen 250 program-eligible women for breast and cervical cancer). Deliverables (e.g., development of a curriculum, design of a survey questionnaire) should be clearly defined. For screening services where multiple providers have the same contract, only a single description of the required information is needed. The program does not need to send a copy of the actual or individual contracts to CDC.
- **Method of accountability**—This element is used to describe how the progress and performance of the contractor will be monitored during and at the close of the contract period. The program should identify who will be responsible for supervising the contract. If the contractor has been used previously, the program should describe the contractor's previous performance.
- **Itemized budget and justification**—This element is used by the program to provide an itemized budget with appropriate justification. Indirect costs paid under the contract must be itemized and included when the program calculates its overall administrative costs. These costs must not exceed 10% of the award.

If the above information is unknown for any contractor at the time the application is submitted, funds may be restricted until the required information is submitted. The information may be submitted at a later date as a revision to the budget. The body of the budget request should include a summary of the proposed contractors and amounts for each.

Required Elements: Consultant

- **Name of consultant**—This element identifies the name of the consultant and describes his or her qualifications.
- **Organizational affiliation**—This element identifies the organizational affiliation of the consultant, if applicable.
- **Nature of services to be rendered**—The program uses this element to describe, in outcome terms, the consultation to be provided, including the specific tasks to be completed and specific deliverables. The program does not need to send a copy of the actual consultant agreement to CDC.
- **Relevance of service to the project**—This element is used to describe how the consultant services relate to the accomplishment of specific program objectives.
- **Number of days of consultation**—This element specifies the total number of days of consultation.
- **Expected rate of compensation**—This element specifies the rate of compensation for the consultant (e.g., rate per hour, rate per day). The program should include a budget showing other costs, such as travel, per diem, and supplies.
- **Method of accountability**—This element is used to describe how the progress and performance of the consultant will be monitored. The program should identify who is responsible for supervising the consultant agreement. In addition, for continuation consultants, the program should describe their previous performance.

If the above information is unknown for any consultant at the time the application is submitted, the information may be submitted at a later date as a revision to the budget. The body of the budget request should include a summary of the proposed consultants and amounts for each.

IV. CDC-BASED PROGRAM POLICIES

Data Management Policies

The following policies were developed by CDC's DCPC specifically for the NBCCEDP. They include the prefix "PD" for program data management policies.

PD.1: Inclusion of Data in the Minimum Data Elements (MDEs)

MDEs are a set of standardized data elements used to collect demographic and clinical information on women screened with NBCCEDP funds. The MDEs should include screening and/or diagnostic data for eligible women in either of the following scenarios:

- Services solely paid for by NBCCEDP funds

- Services paid for in part by NBCCEDP funds and any other funding source (e.g., state, private, or other federal funds) with the ability to distinguish the funds contributed by the NBCCEDP

Screening and diagnostic data collected on women reported in the MDEs must meet all data quality standards set by CDC. Programs should not submit data on women for whom clinical services are covered solely by state, private, or other federal funds; this includes women for whom clinical services are used as a source of matching funds. Programs can refer to Attachments E and G (Data Management Orientation Web Conferences), as well as the Data Management chapter of this manual, to determine what data to report in the MDEs.

PD.2: Data Sharing

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 residents 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 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.

PD.3: Data linkages with Central Cancer Registry

Grantees 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.

Clinical Management and Reimbursement Policies

The following policies were developed by CDC's DCPC specifically for the NBCCEDP. They include the prefix "PC" for program clinical policies.

The eligible population for breast and cervical cancer screening in the NBCCEDP includes low-income (up to 250% of the federal poverty level), uninsured, and underinsured women (whose health insurance does not fully cover screening services). Once a woman is enrolled in the NBCCEDP, the grantee is responsible for the provision of rescreening mammograms and Pap tests at appropriate, recommended screening intervals.

Clinical Management and Reimbursement Policies for Breast Cancer Screening

The NBCCEDP reimburses for mammograms provided to program-eligible women; that is, mammography is provided to women age 40 to 64 every 1 or 2 years. However, the priority population for NBCCEDP mammography services is women between the ages of 50 and 64 who are low-income (up to 250% of the federal poverty level), who have not been screened in the past year, and who have no other source of health care reimbursement, such as insurance. Recruitment efforts should be concentrated on the priority population.

PC.1: Mammography for Women 50 Years of Age or Older

A minimum of 75% percent of all NBCCEDP-reimbursed mammograms should be provided to program-eligible women who are 50 years of age and older and not enrolled in Medicare Part B.

- If a woman is eligible to receive Medicare benefits but is not enrolled, she should be encouraged to enroll. Women enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services.
- Women aged 50 years or older who are not eligible to receive Medicare Part A and B are eligible to receive mammograms through the NBCCEDP. Mammograms provided to these women will be counted in the 75%.
- Medicare-eligible women with low incomes (up to 250% of the federal poverty level) who cannot pay the premium to enroll in Medicare Part B are eligible to receive mammograms through the NBCCEDP. Mammograms provided to these women will be counted in the 75%.

PC.2: Mammography for Women Under 50 Years of Age

Mammograms provided to program-eligible women less than 50 years of age should not exceed 25% of all mammograms provided by the NBCCEDP.

- **Asymptomatic women aged 40 to 49**—This population may be screened in the program, subject to the restriction noted above.
- **Symptomatic women under the age of 40**—NBCCEDP funds can be used to reimburse CBEs for women under the age of 40. If the findings of the CBE are considered to be abnormal, including a discrete mass, nipple discharge, and skin or nipple changes, a woman can be provided a diagnostic mammogram by the program and/or referred for a surgical consultation.
- **Asymptomatic women under the age of 40 at increased risk for breast cancer**—NBCCEDP funds cannot be used to screen asymptomatic women under the age of 40, even if they are considered to be at high risk (e.g., women who have a personal history of breast cancer or first-degree relative with premenopausal breast cancer) for breast cancer.

PC.3: Screening Males

Men are not eligible to receive NBCCEDP screening and/or diagnostic services.

PC.4: Mammography

The NBCCEDP will reimburse for both film and digital mammography up to the Medicare reimbursement rate.

PC.5: Computer-Aided Detection (CAD) and Magnetic Resonance Imaging (MRI)

Reimbursement of CAD and MRI is not permitted.

PC.6: Managing Women With Abnormal Breast Cancer Screening Results

The management of women whose mammogram and/or CBE yielded abnormal results relies on a body of scientific literature that is constantly growing and changing. Clinical management strategies also may vary by geographic region and by provider. Grantees are urged to develop their clinical policies in close consultation with their medical advisory board and in consideration of the 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/).

Clinical Management and Reimbursement Policies for Cervical Cancer Screening

The NBCCEDP reimburses for cervical cancer screening services provided to women between the ages of 21 and 64 who have low incomes (up to 250% of the federal poverty level) and no other source of health care reimbursement, such as insurance. The priority population includes women who have never been screened or have not been screened in the past 5 years. Recruitment efforts should be concentrated on the priority population.

PC.7: Increasing Screening for NBCCEDP-Eligible Women Never or Rarely Screened

Twenty percent of all clients *newly* enrolled for cervical cancer screening should be women who have never been screened for cervical cancer or who have not been screened for cervical cancer in the past 5 years.

PC.8: Cervical Cancer Screening for Women 21 to 64 Years of Age

The NBCCEDP funds may be used to reimburse cervical cancer screening following the 2012 United States Prevention Services Task Force (USPSTF) recommendations. Federal funds can be used for reimbursement of cervical cancer screening among women aged 21 to 64 years old, regardless of sexual activity.

- Women aged 21 to 29 years — NBCCEDP funds can be used to reimburse for Pap testing alone every 3 years.
- Women aged 30 to 64 years — NBCCEDP funds can be used to reimburse for Pap testing alone every 3 years or co-testing with the combination of Pap testing with human papillomavirus (HPV) testing every 5 years. Grantees must make both cervical cancer screening options (i.e., Pap testing every 3 years and Pap testing with HPV testing every 5 years) available.

- NBCCEDP funds can be used for annual cervical cancer screening among women who are considered high-risk (e.g., in-utero DES exposure, immunocompromised such as HIV infection, or history of cervical cancer).

- NBCCEDP funds cannot be used to reimburse for cervical cancer screening in women under the age of 21.

PC.9: Cervical Cancer Screening for Women Over 64 Years of Age

Cervical cancer screening is not recommended for women older than age 65 who have had adequate screening and are not high risk. If a woman over 64 needs to be screened and is eligible to receive Medicare benefits, but is not enrolled, she should be encouraged to enroll. Women enrolled in Medicare Part B are not eligible for the NBCCEDP clinical services.

Women who are eligible for Medicare Part B but have low incomes (up to 250% of the federal poverty level) and cannot pay the premium to enroll in Medicare Part B are eligible to receive services through the NBCCEDP.

PC.10: Cervical Cancer Screening Following Hysterectomy or Other Treatment for Cervical Neoplasia or Cancer

NBCCEDP funds CANNOT be used to reimburse for cervical cancer screening in women with 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.

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

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

- For women whom the reason for the hysterectomy or that there was no neoplasia or 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.

The presence of a cervix can be determined with a physical examination. NBCCEDP funds CAN be used to reimburse for an initial examination (i.e., pelvic examination) to determine if a woman has a cervix.

PC.11: Policy on Liquid-Based Cytology (LBC) Technologies for Primary Cervical Cancer Screening

Programs may reimburse for liquid-based cervical cytology for primary cervical cancer screening, up to the allowable Medicare rate. The screening interval is same for both the use of liquid-based tests and the conventional Pap tests.

The specific cervical cancer screening method must be indicated in the MDEs, so that the number of liquid-based tests can be distinguished from the number of conventional Pap tests performed. This will provide a means by which the test-specific diagnostic outcomes can be compared.

PC.12: Use of Automated Screening Technologies for Quality Assurance

NBCCEDP funds may not be used to reimburse automated technologies when they are used as a secondary assessment of Pap testing for quality assurance purposes. These quality assurance costs are included in the pricing of tests and are paid by the cytopathology laboratories.

PC.13: Managing Women With Abnormal Cervical Cancer Screening Results

The management of women whose cervical cancer screening tests yield abnormal results relies on a body of scientific literature that is constantly growing and changing. Clinical management strategies also may vary by geographic region and by provider. Grantees are urged to develop their clinical policies in close consultation with their medical advisory board and in consideration of the standards established by such organizations as the American Society for Colposcopy and Cervical Pathology (http://www.asccp.org) and the American College of Obstetricians and Gynecologists (http://www.acog.org/).

To arrive at a definitive diagnosis for a woman with an abnormal cervical cancer screening test, programs may use NBCCEDP funds to reimburse 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. Grantees are asked to formulate methods by which the use of these procedures may be closely monitored so that they are used appropriately.

PC.14: Reimbursement of HPV DNA Testing

HPV DNA testing is a reimbursable procedure when used for screening with Pap testing (i.e., cotesting) and for follow-up of abnormal Pap results as per ASCCP algorithms. Providers should specify the high-risk HPV DNA panel. Reimbursement for low-risk HPV DNA panel and HPV genotyping is not permitted.

Policies for Adequacy and Timeliness of Follow-up for Women With Abnormal Screening Results

Public Law 101-354 requires programs to take all appropriate measures to ensure the provision of necessary follow-up services required by women who have abnormal screening results and whose clinical services are paid for in whole or in part by NBCCEDP funds.

PC.15: Adequacy of Follow-up for Women With Abnormal Screening Results

A woman whose breast or cervical cancer screening was abnormal or suspicious must receive appropriate diagnostic procedures (as defined by the program's medical advisory consultants) to arrive at a final diagnosis.

Women with a diagnosis of breast or cervical cancer must be referred for appropriate treatment.

PC.16: Timeliness of Follow-up for Women With Abnormal Screening Results

The interval between initial screening and diagnosis of abnormal breast cancer screenings should be 60 days or less. The interval between initial screening and diagnosis of abnormal cervical cancer screenings should be 90 days or less.

The interval between diagnosis and initiation of treatment for breast cancer and invasive cervical cancer should be 60 days or less.

The interval between diagnosis and initiation of treatment for cervical intraepithelial neoplasia should be 90 days or less.

PC.17: Case Management/Patient Navigation

All NBCCEDP-enrolled women with an abnormal screening result must be *assessed* for their need of case management and patient navigation services and provided with such services accordingly. Examples of screening results which would require a case management assessment would be BIRADS 3, 4, 5 for mammograms; and ASC-H, LSIL, and HSIL results for Pap tests. These services conclude when a client initiates treatment, refuses treatment, or is no longer eligible for the NBCCEDP. When a woman concludes her cancer treatment, has been released by her treating physician to return to a schedule of routine screening, and continues to meet NBCCEDP eligibility requirements, she may return to the program and receive all its services.

General Clinical Management and Reimbursement Policies for NBCCEDP

PC.18: Office Visits Reimbursement Policy

The allowable reimbursement rates for office visits will be based on the type of service. Applicable CPT codes are as follows:

- Office Visit—New Patient (CPT codes 99201 and 99202) and Office Visit—Established Patient (CPT codes 99211 and 99121) shall continue to be reimbursed at no higher than the applicable Medicare rates.
- Office Visit—New Patient (CPT codes 99203, 99386, 99387) shall be reimbursed at no higher than the 99203 Medicare rate.
- Office Visit—Established Patient (CPT codes 99213, 99396, 99397) shall be reimbursed at no higher than the 99213 Medicare rate.

NBCCEDP funds cannot be used for services that are unrelated to breast and/or cervical cancer screening including time and materials needed to assess and manage problems unrelated to breast and cervical cancer. Grantees that have the ability and willingness to screen for and manage other health problems (e.g., STD testing, blood glucose testing, hemocult, etc.) may do so at their own discretion at the time of the woman's visit to the breast and cervical cancer screening provider. However, these grantees should

have a protocol to appropriately educate, manage, and pay for the additional provider time and materials required to conduct these unrelated services with non-NBCCEDP funds.

Policy for Tobacco Screening and Cessation

PC.19: Tobacco Screening and Cessation

Grantees must develop a policy requiring all providers to assess the smoking status of every woman screened by the NBCCEDP and refer those who smoke to tobacco quit lines. It is well known that tobacco use is associated with many cancers and chronic diseases that impact the health of our nation. As a chronic disease prevention priority, our public health cancer screening programs are able to promote the health of our patients by providing this great service with little additional effort. CDC wants to encourage providers to assess all women as a standard of practice, whether or not they are NBCCEDP-paid women. Each grantee is required to address this new requirement and progress regarding assessment of tobacco use and quitline referrals for smokers in their annual work plans. Providers should document assessments and referrals in the client's medical chart.

ATTACHMENTS

ATTACHMENT 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 disbursal 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].

ATTACHMENT B

MATCHING FUNDS

Generally, if federal monies are allowed for a service or activity, then non-federal contributions for the same service or activity may be allowed as a source of matching funds. Non-federal contributions may be made directly from grantee or through donations from public or private entities. Contributions from private for-profit entities are allowable sources of matching funds. The types of contributions may be cash or in kind, including equipment, services, or clinical services. Treatment, indirect, and overhead costs are disallowed as a source of matching funds. In addition, programs are restricted by maintenance of effort and Medicaid provisions in the law for determining the amount of their non-federal contributions. Tribal organizations contracting under the authority of Title I and compacting under the authority of Title III are permitted to use funds received under the Indian Self-Determination Act as matching funds.

Details must be provided on each source of cash resources. Examples of non-federal cash resources and amounts:

- State, tribal, territorial, and local program appropriations for screening, tracking, and follow-up
- State Medicaid payments for breast and cervical cancer screening (above maintenance of effort)
- State tobacco tax revenue used to support program activities
- Cash donations (each contributor and the dollar amount must be listed)
- Community fund-raising (each event and the amount raised must be listed)

For noncash resources, an itemized breakdown must be provided for each source, describing the method used to determine its value. Examples of non-federal noncash resources and amounts:

- Donated vehicles and equipment (e.g., vans for transportation, laboratory equipment, computers)
- Donated services (e.g., screening tests, diagnostic tests, transportation, volunteer time, services from organizations like ACS or YWCA) (If using the difference between the Medicare rate and the usual and customary provider charge document how the usual and customary charge was determined.)
- Donated supplies (e.g., educational materials, promotional materials)
- Donated media time (e.g., television, radio, print)
- Donated professional time (e.g., service on coalitions, advisory committees, and advertising/marketing consultation)

ATTACHMENT C

PAYOR OF LAST RESORT AS IT APPLIES TO IHS CLINICS AND TRIBALLY OPERATED CLINICS

This interpretation of 42 CFR 136.61 (2002) was provided by Clayton F. Old Elk of IHS (from e-mail communication, September 9, 2005).

IHS provides health services to more than 1.8 million American Indians/Alaska Natives through 155 IHS and tribally operated service units composed of over 600 direct health care delivery facilities, 49 hospitals, 231 health centers, 5 school health centers, and 309 health stations. Within this system, Indian tribes deliver IHS-funded services to their own communities with approximately 50% of the IHS budget in 13 hospitals, 172 health centers, 3 school health centers, and 260 health stations. The range of services includes traditional inpatient and ambulatory care. Because IHS programs are not fully funded, the Contract Health Services program relies on specific regulations relating to eligibility, notification, residency, and the IHS medical priority system. This system renders the CHS program to authorize care at restricted levels and results in a rationed health care system that provides services on the basis of the most relative medical need.

IHS is designated as the payor of last resort, meaning that all other available alternate resources, including IHS facilities, must first be used before payment is expected. According to 42 CFR 136.61 (2002), IHS is the payor of last resort for persons who have an alternate resource, notwithstanding any State or local law or regulation to the contrary. Accordingly, IHS will not be responsible for or authorize payment for medical services to the extent that an alternate resource is available. Alternate resources are defined as health care resources other than those of IHS, including but not limited to programs under title XVIII and title XIX of the Social Security Act (Medicare and Medicaid), State or local health care programs, and private insurance. IHS will not pay for medical bills when any of the following situations exist: (1) the patient was eligible for alternate resources when the medical services were provided; (2) the patient would have been eligible for alternate resources if the person had applied for them; or (3) the patient would have been eligible for alternate resources under State or local law or regulation but for his/her eligibility for CHS or other health services from IHS or an IHS-funded program. These mechanisms allow IHS to stretch the limited CHS dollars and help extend services throughout the year, as well as operate within budget.

ATTACHMENT D

FRAMEWORK AND GUIDELINES FOR DETERMINING 60% ALLOWABLE COSTS

FRAMEWORK

LAW (60%)	CDC INTERPRETATION (60%)	CDC INTERPRETATION (40%)	LAW (40%)
Screening tests: ▪ Clinical breast examination ▪ Mammogram ▪ Pelvic examination ▪ Pap test Follow-up and support services: ▪ Client case management/patient navigation	Office visits Laboratory fees Diagnostic services: ▪ Diagnostic mammogram ▪ Fine-needle aspiration ▪ Ultrasound ▪ Cyst aspiration ▪ Breast biopsy ▪ Endocervical curettage ▪ Colposcopy ▪ Colposcopy with biopsy ▪ Surgical consultation Others as determined by medical advisory consultants Client Interpretation Services Client Transportation Client intake Client counseling One-to-one recruitment By exception only (requires program consultant's approval): ▪ Clinical supplies and equipment ▪ Incentives	Management and planning Partnership development Data management/entry/ analysis Promotional materials Administrative costs Billing	Public education Professional development Quality assurance Evaluation Surveillance

Guidelines

The Breast and Cervical Cancer Mortality Prevention Act of 1990, Public Law 101-354, and its amendments authorize grantees to spend federal monies to

1. screen women for breast and cervical cancer as a preventive measure;
2. provide appropriate referrals, follow-up services, and support services such as case management;
3. develop and disseminate public information and education programs for the detection and control of breast and cervical cancer;
4. improve the education, training, and skills of health professionals in the detection and control of breast and cervical cancer;
5. establish mechanisms through which grantees can monitor the quality of screening procedures for breast and cervical cancer, including the interpretation of such procedures;
6. evaluate activities conducted in paragraphs (1) through (5) through appropriate surveillance or program-monitoring activities.

The Law stipulates that an award may not be made to a grantee unless the grantee agrees that not less than 60 percent of the grant is to be expended to provide the services or activities described in paragraphs (1) and (2) above and not more than 40 percent of the grant is to be expended to provide the services and activities described in paragraphs (3) through (6) above.

The basis for calculating the 60/40 percent distribution is the total amount of federal monies (financial assistance) awarded to the program. It does not apply to the non-federal matching funds.

The following guidance is intended to clarify and define costs that are allowable in the 60 percent category and supersedes all prior guidance. All other reasonable and well-justified costs associated with the implementation of the NBCCEDP will be considered allowable in the 40 percent category, including costs for program management, data management, and partnerships that are not specifically mentioned in bullets (3) through (6) above. The maximum 10 percent allowed for administrative costs is also included in the 40 percent category.

Screening, Follow-up, and Support Services—Allowable 60 Percent Costs

Allowable 60 percent costs include costs incurred to screen clients for breast and cervical cancer, as well as follow-up and support services for clients with abnormal screening results. These services are defined by the following subcategories:

- **Screening and follow-up services—**Costs of screening and diagnostic procedures incurred for breast and cervical cancer. In the case of breast cancer, screening procedures include both a physical examination of the breast and mammography. With cervical cancer, screening procedures include pelvic examination and Pap smear. Payment for screening procedures includes reimbursement of health care provider time (e.g., salary) or fees for office visits that are capped at the Medicare rate. Also

included are costs incurred at the program level to send out individual client recall/reminders (at appropriate screening intervals), if and when this service is not already part of the screening or primary care provider's standard operating procedures.

- **Laboratory services**—Cost of laboratory services, performed either on-site or off-site, for evaluation of cytology and tissue specimens from diagnostic procedures that are approved for reimbursement through the NBCCEDP.
- **Essential client support services**—Costs for ancillary screening and follow-up services include:
  - **Recruitment**—Costs incurred to conduct activities specifically designed to recruit *individual* clients for screening services through the NBCCEDP and address individual client barriers to breast and cervical cancer screening. Examples of these activities include door-to-door recruitment by a community outreach worker or other direct contact with a potential client for recruitment into the program.
  - **Client intake**—Costs incurred to determine *individual* client eligibility such as age, income, and insurance status and if determined eligible, to enroll the client into the NBCCEDP at the program level.
  - **Client case management/patient navigation**—Costs incurred to identify abnormal screening results and assess whether an *individual* client with an abnormal test result requires assistance to obtain diagnostic and/or treatment services and to provide that assistance as needed.
  - **Client transportation**—Costs incurred to provide transportation to *individual* clients to assist them in keeping their appointments at screening and diagnostic provider sites.
  - **Client interpretation services**—Costs incurred to provide interpretation services to assist *individual* clients in communicating with providers regarding screening, diagnostic, and support services as outlined in the categories listed above.

Points to Consider in Determining the Classification of a Program Cost as Part of the 60-Percent Distribution Category

As specified by law, 60% of program funds are to be devoted to providing direct clinical services, particularly screening, for eligible women. The law specifies that funds are not to be used to pay for treatment, but it is silent on the topic of diagnostic procedures. CDC's DCPC has determined that diagnostic services are integral to the NBCCEDP, and fees for these services should be considered as part of the 60% category.

Other program components, such as management and planning, public education, professional development, quality assurance, evaluation, surveillance, and administrative costs, while necessary to the functioning of an individual program, must not exceed 40% of the overall program budget. Regardless of the inherent value of any support services, grantees must ensure that their programs—and, therefore, their budgets—remain focused on screening.

Costs associated with tracking and data entry are not allowable as 60% activities. Also, incentives, in general, are not allowable under the 60% costs. Programs can request that client incentives be considered as part of the 60% category when the incentives are clearly part of the screening (and not marketing or

outreach) process. The CDC program consultant must approve the inclusion of these incentives in the 60% category.

The following questions may help grantees clarify whether a particular expense falls into the 60% or 40% category.

What Is the Intent of This Activity?

Example: Are you contacting an individual woman to address barriers to screening and follow-up (60%) or to resolve billing issues (40%)?

Example: Are you using a translator to help women communicate with their health provider at a screening site (60%), or are you using a translator to develop a new brochure (40%)? The costs to develop and duplicate an educational brochure, even if used for one-on-one recruitment, are not considered in your 60% budget category.

What Documentation Is Available to Support the Purpose of This Activity?

Example: Do you have staff timekeeping records or activity reports that can verify the amount of time a staff member spent calling an individual woman to schedule a follow-up appointment (60%) rather than to gather data/information missing from her enrollment form (40%)?

What Are Program Funds Actually Paying for?

Example: A program is designed to train community volunteers to recruit individual women for screening. The final outcome is one-to-one recruitment, but the program funds are actually paying to train volunteers (40%) not to conduct one-to-one recruitment (60%).

Exceptions: Clinical Supplies and Equipment

Clinical supplies and equipment, in general, are considered to be included in the reimbursement structure in a fee-for-service reimbursement system; they should not be reimbursed separately. Clinical supplies CAN be justified in situations where the grantee provides the direct clinical services and pays for the professional fees in an hourly fashion. Clinical supplies also can be requested as a one-time expense with appropriate justification for the need.

Equipment can be justified in rare instances where it is clear that such purchases are absolutely necessary for screening services to be available for program-eligible women. In such cases, allowances for decreasing future fee-for-service charges should be made.

Exceptions: Incentives

Generally, "giveaway items" are not allowable in the 60% category because they are used for marketing purposes. Promotional materials (e.g., tote bags, nail files) are intended to attract *potential clients.* They are marketing tools used to interest women in enrolling in the program. As such, these expenditures fall in the 40% category. Occasionally, rewards/gifts such as $15 gift cards are given to *program clients* upon

completion of a screening exam, particularly in cultural settings in which gifting is expected. These incentives would be considered tools for screening; the program consultant could approve their inclusion in the 60% category. There are increasingly stricter regulations on use of promotional items. Use of such items should be pre-approved by the Program Consultant and CDC's Procurement Grants Office.

ATTACHMENT E

SAMPLE NOTICE OF AWARD

2 05/13/2004 | 93.938

. SUPERSEDES AWARD NOTICE DATED

XCEPT THAT ANY ADDITIONS OR RESTRICTIONS _____

REVIOUSLY IMPOSED REMAIN IN EFFECT UNLESS SPECIFICALLY RESCINDED.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION

NOTICE OF COOPERATIVE AGREEMENT

AUTHORIZATION (LEGISLATION/REGULATION)

301A311BANDC317K242U.S.C.241A,243B/C247

. GRANT NO. 3
U87/CCU323766-01

5. ADMINISTRATIVE CODES
CCU87

. PROJECT PERIOD
FROM 05/15/2004 THROUGH 05/14/2006 4

. BUDGET PERIOD
FROM 05/15/2004 THROUGH 05/14/2005 5

. TITLE OF PROJECT (OR PROGRAM)
PROGRAMS TO IMPROVE THE HEALTH, EDUCATION,AND WELL-BEING OF YOUNG PEOPLE. 6

. GRANTEE NAME AND ADDRESS
NEA HEALTH INFORMATION NETWORK
NEA HEALTH INFORMATION NETWORK
1201 16TH STREET N.W.
WASHINGTON, DC 20036

10. DIRECTOR OF PROJECT (PROGRAM DIRECTOR/PRINCIPAL INVESTIGATOR)
JERALD NEWBERRY, EXECUTIVE DIRECTOR
NEA HEALTH INFORMATION NETWORK
1201 16TH STREET N.W.
WASHINGTON, DC 20036 7

1. APPROVED BUDGET (EXCLUDES PHS DIRECT ASSISTANCE) 8

PHS GRANT FUNDS ONLY
I TOTAL PROJECT COSTS INCLUDING GRANT FUNDS AND ALL OTHER FINANCIAL PARTICIPATION
(PLACE NUMERAL ON LINE) I

. SALARIES AND WAGES	108,818
. FRINGE BENEFITS	34,822
TOTAL PERSONNEL COSTS	143,640
. CONSULTANT COSTS	37,560
. EQUIPMENT	0
. SUPPLIES	600
. TRAVEL	19,080
. PATIENT CARE-INPATIENT	0
. PATIENT CARE-OUTPATIENT	0
. ALTERATIONS AND RENOVATIONS	0
. OTHER	13,896
. CONSORTIUM/CONTRACTUAL COSTS	15,120
. TRAINEE RELATED EXPENSES	0
. TRAINEE STIPENDS	0
. TRAINEE TUITION AND FEES	0
. TRAINEE TRAVEL	0
TOTAL DIRECT COSTS	229,896
. INDIRECT COSTS (21.00 % OF S&W/TADC)	45,103
. TOTAL APPROVED BUDGET	274,999
. SBIR FEE	0
. FEDERAL SHARE	274,999
. NON-FEDERAL SHARE	0

12. AWARD COMPUTATION FOR FINANCIAL ASSISTANCE 9

A. AMOUNT OF PHS FINANCIAL ASSISTANCE (FROM 11.U)	274,999
B. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIODS	0
C. LESS CUMULATIVE PRIOR AWARD(S) THIS BUDGET PERIOD	0
D. AMOUNT OF FINANCIAL ASSIST.THIS ACTION	274,999

13. RECOMMENDED FUTURE SUPPORT (SUBJECT TO THE AVAILABILITY OF FUNDS AND SATISFACTORY PROGRESS OF THE PROJECT)

BUDGET YEAR	TOTAL DIRECT COSTS	BUDGET YEAR	TOTAL DIRECT COSTS
A. 2	274,999	D. 0	0
B. 0	0	E. 0	0
C. 0	0	F. 0	0

14. APPROVED DIRECT ASSISTANCE BUDGET (IN LIEU OF CASH)

A. AMOUNT OF PHS DIRECT ASSISTANCE	0
B. LESS UNOBLIGATED BALANCE FROM PRIOR BUDGET PERIODS	0
C. LESS CUMULATIVE PRIOR AWARDS FROM THIS BUDGET PERIOD	0
D. AMOUNT OF DIRECT ASSISTANCE THIS ACTION	0

15. PROGRAM INCOME SUBJECT TO 45 CFR PART 74.SUBPART F,OR 45 CFR 92.25, SHALL BE USED IN ACCORDANCE WITH ONE OF THE FOLLOWING ALTERNATIVES: (SELECT ONE AND PUT LETTER IN BOX.)

A. DEDUCTION
B. ADDITIONAL COSTS
C. MATCHING
D. OTHER RESEARCH(ADD/DEDUCT OPTION)
E. OTHER (SEE REMARKS)

B 10

THIS AWARD IS BASED ON AN APPLICATION SUBMITTED TO, AND AS APPROVED BY, THE PHS ON THE ABOVE TITLED PROJECT AND IS SUBJECT TO THE TERMS AND CONDITIONS INCORPORATED EITHER DIRECTLY OR BY REFERENCE IN THE FOLLOWING: A.THE GRANT PROGRAM LEGISLATION CITED ABOVE. B.THE GRANT PROGRAM REGULATION CITED ABOVE. C.THIS AWARD NOTICE INCLUDING TERMS AND CONDITIONS,IF ANY,NOTED BELOW UNDER REMARKS. D.PHS GRANTS POLICY STATEMENT INCLUDING ADDENDA IN EFFECT AS OF THE BEGINNING DATE OF THE BUDGET PERIOD. E.45 CFR PART 74 OR 45 CFR PART 92 AS APPLICABLE. IN THE EVENT THERE ARE CONFLICTING OR OTHERWISE INCONSISTENT POLICIES APPLICABLE TO THE GRANT. THE ABOVE ORDER OF PRECEDENCE SHALL PREVAIL. ACCEPTANCE OF THE GRANT TERMS AND CONDITIONS IS ACKNOWLEDGED BY THE GRANTEE WHEN FUNDS ARE DRAWN OR OTHERWISE OBTAINED FROM THE GRANT PAYMENT SYSTEM. 11

REMARKS (OTHER TERMS AND CONDITIONS ATTACHED - ___ YES X NO)

SPONSOR: NATL. CTR. FOR CHRONIC DISEASE PREV. & HEALTH PROMOTION
*IDC RATE BASE: SEE ATTACHED

PHS GRANTS MANAGEMENT OFFICER: (SIGNATURE) 1 (NAME-TYPED/PRINT) CARLOS SMILEY (TITLE) GRANTS MANAGEMENT OFFICER

7. OBJ. CLASS. 41.51 | 18. CRS.EIN: 1-581898631-A1 | 19. LIST NO.: CO-120-L04

FY-CAN	DOCUMENT NO.	ADMINISTRATIVE CODE	AMT.ACTION FIN.ASST	AMT.ACTION DIR.ASST
0.A 04-11282 04-9213202	B. CCU323766	C. CCU87	D. 274,999	E. 0
1.A	B.	C.	D.	E.
2.A	B.	C.	D.	E.

HS-5152-1 (REV.7/92) (MODIFIED CDC VERSION 10/92)

Guide to Key Features of the NOA

1. **Signature**—A signature is required; if the NOA is not signed by a PHS Grants Management Officer, it is not a legal document.
2. **Date on previous award**—This NOA replaces that award.
3. **Grant number**—This number should be referenced in any communication with PGO, and with the submission of all documentation.
4. **Project period**—This range refers to the duration of the overall program (1 to 5 years).
5. **Budget period**—This is only 1 year, specific to the current year's budget only.
6. **Title of the project**—This is the title as supplied by the grantee and recorded by PGO.
7. **Name and title of the program director or principal investigator**—CDC approval is required before the program can make changes in either position.
8. **Approved budget**—This section reflects results from budget discussions and negotiations. This amount is monitored to ensure that funds are being spent in accordance with the plan.
9. **Award computation for financial assistance**—New money and carryover funds are reflected here.
10. **Program income alternatives**—Deductions, additional costs, and matching funds are reflected here.
11. **The fine print (regulatory guidance)**—Programs should read this section carefully!

ATTACHMENT F

SAMPLE CLINICAL COST WORKSHEET

2006-2007 QUESTIONNAIRE	Andalusia	AA
CLINICAL & CASE MANAGEMENT SERVICES		**Your Forecast:**
How many new screening mammograms?		2,100
How many re-screening mammograms?		1,400
How many screening CBEs?		6,000
How many Pap tests?		3,500
How many HPV tests?		30
How many anesthesia units/charges?		65
How many facility fees?		0
How many loop electrode excision procedures?		6
How many diagnostic conization procedures?		4
How many endocervical curretage procedures?		2
How many office visits - new patient?		2,000
How many office visits - established patient?		2,400
How many office visits - problem focused?		1,000
How many women referred in for breast diagnostics?		100
How many women referred in for cervical diagnostics?		250
CLINICAL PROCEDURES:	**CPT Code(s):**	**Reimbursement Rate:**
Screening Mammogram	76092	$78.75
Pap Test	88164	$14.76
HPV Test	87621	$49.04
Anesthesia	00400	$78.00
Facility Fees	N/A	$0.00
Loop Electrode Excision Procedure (LEEP)	57522	$233.75
Diagnostic Conization	57461	$330.75
Endocervical Curretage	57505	$91.78
Office Visit: New Patient	99202	$61.54
Office Visit: Established Patient	99213	$49.79
Office Visit: Problem Focused	99241	$47.25
Diagnostic Mammogram	76091	$89.86
Ultrasound	76645	$64.39
FNA	10022, 88172, 88173, 76942	$446.57
Non-Excisional Biopsy	19103, 19295, 76098, 76090	$1,065.20
Excisional Biopsy	19125, 19126, 19290, 19291, 76096	$848.97
Surgical consult	99243	$115.48
Breast Pathology	88305	$95.74
Colpo-directed Biopsy	57454	$149.73
Colposcopy alone	57452	$103.99
Cervical Pathology	88305	$95.74
Case Management Cost Unit:	**Number of Units:**	**Reimbursement Rate:**
FTE	1	$52,675.00

2006-2007 CLINICAL COST WORKSHEET: Andalusia

INPUT FROM QUESTIONNAIRE

SCREENING		CPT CODE	COST PER
Mammograms: New Screenings	2,100	76092	$78.75
Mammograms: Re-Screenings	1,400	76092	$78.75
Screening CBEs	6,000		
Pap Tests	3,500	88164	$14.76
Office Visits: New Patients	2,000	99202	$61.54
Office Visits: Established Patients	2,400	99213	$49.79
Office Visits: Problem Focused	1,000	99241	$47.25
Referred In for Breast Diagnostics	100		
Referred In for Cervical Diagnostics	250		

PROGRAM:

AA

RATES BASED ON PROGRAM-SPECIFIC MDE EXPERIENCE

Rate of abnormal mammograms new screenings	18.5%
Rate of abnormal mammograms rescreenings	9.3%
Rate of abnormal CBEs (with normal mammogram)	14.3%
Rate of ASCUS Paps	5.4%
Rate of LSIL Paps	3.3%
Rate of AGCUS / HGSIL / SqCa Paps	1.5%

MDE Data Extraction Period:	
Screening:	Jul 03 - Dec 03
Diagnostics:	Jul 03 - Jun 04
MDE Submission:	April 2005

RATE OF EACH PROCEDURE FOLLOWING: ABNORMAL MAMMOGRAM		CPT CODE	COST PER
Diagnostic Mam	52.3%	76091	$89.86
Ultrasound	54.0%	76645	$64.39
FNA	4.4%	10022, 88172, 88173, 76942	$446.57
Non-Excisional Biopsy	11.1%	19103, 19295, 76098, 76090	$1,065.20
Excisional Biopsy	22.2%	19125, 19126, 19290, 19291, 76096	$848.97
Surgical consult	21.9%	99243	$115.48
Pathology	37.8%	88305	$95.74

RATE OF EACH PROCEDURE FOLLOWING: ABNORMAL CBE		CPT CODE	COST PER
Diagnostic Mammogram	11.6%	76091	$89.86
Ultrasound	73.3%	76645	$64.39
FNA	3.4%	10022, 88172, 88173, 76942	$446.57
Non-Excisional Biopsy	2.1%	19103, 19295, 76098, 76090	$1,065.20
Excisional biopsy	4.3%	19125, 19126, 19290, 19291, 76096	$848.97
Surgical Consult	49.8%	99243	$115.48
Pathology	9.8%	88305	$95.74

RATE OF EACH PROCEDURE FOLLOWING: ASCUS PAP TEST		CPT CODE	COST PER
Colpo-directed Biopsy	90.0%	57454	$149.73
Colposcopy alone	10.0%	57452	$103.99
Pathology	90.0%	88305	$95.74

RATE OF EACH PROCEDURE FOLLOWING: LSIL PAP TEST		CPT CODE	COST PER
Colpo-directed Biopsy	90.3%	57454	$149.73
Colposcopy alone	9.7%	57452	$103.99
Pathology	90.3%	88305	$95.74

RATE OF EACH PROCEDURE FOLLOWING: AGCUS / HGSIL / SQCA PAP TEST		CPT CODE	COST PER
Colpo-directed Biopsy	74.8%	57454	$149.73
Colposcopy alone	9.9%	57452	$103.99
Pathology	74.8%	88305	$95.74

2006-2007 CLINICAL COST WORKSHEET: Andalusia (Continued)

CALCULATIONS USING ABOVE RATES					
PRELIMINARY CALCULATIONS	**SCREENING:**	**REFERRED IN:**	**TOTAL:**		
Abnormal Mammograms	520	100	620		
Abnormal CBEs (norm mamm)	857		857		
ASCUS Paps	191		191		
LSIL Paps	116		116		
AGCUS/HGSIL/SqCa Paps	53	250	303		
LINE ITEM COUNTS AND COSTS	**Number**	**Line Item Cost**	**% of Total**	**Federal Funds**	**Other Funds**
Screening Mammogram	3,500	$275,625	22.6%	$250,625	$25,000
Pap Tests	3,500	$51,660	4.2%	$41,660	$10,000
Office visits	5,400	$289,826	23.8%	$289,826	
Colpo-directed Biopsy	504	$75,464	6.2%	$75,464	
Colposcopy alone	61	$6,343	0.5%	$6,343	
Diagnostic Mammogram	425	$38,191	3.1%	$38,191	
Ultrasound	963	$62,008	5.1%	$62,008	
FNA	57	$25,454	2.1%	$25,454	
Biopsy(non excisional)	88	$93,738	7.7%	$93,738	
Excisional biopsy	175	$148,570	12.2%	$148,570	
Surgical consult	563	$65,015	5.3%	$65,015	
Pathology; breast	319	$30,541	2.5%	$30,541	
Pathology cervical	504	$48,253	4.0%	$48,253	
HPV Testing	30	$1,471	0.1%	$1,471	
Anesthesia	65	$5,070	0.4%	$5,070	
Facility Fees	0	$0	0.0%	$0	
Loop Electrode Excision Procedure	6	$1,403	0.1%	$1,403	
Diagnostic Conization	4	$1,323	0.1%	$1,323	
Endocervical Curretage	2	$184	0.0%	$184	
CLINICAL SUB-TOTAL:	16,154	$1,217,229	100%	$1,185,138	$35,000
CASE MANAGEMENT COSTS					
COST UNIT:	**Number**	**Line Item Cost**		**Federal Funds**	**Other Funds**
FTE	1	$52,675		$52,675	$0
OTHER CLINICAL OR DIRECT SERVICE COSTS					
Procedure/Activity/Ancillary Charge	**(Related) CPT:**	**Number**	**Unit:**	**Cost Per Unit:**	**Total Cost:**
Pap Test Requiring Physician Interpretation	88141	60	Test	$21.44	$1,286.40
				OTHER SUB-TOTAL:	$1,286.40
GRAND TOTAL:					
$1,239,099					

Data Extracted from MDEs (see note below)	Andalusia
Sorted By Program Row:	AA
Abnormal Mammograms (new) Numerator	530
Abnormal Mammograms (new) Denominator	2858
Abnormal Mammograms (new) Rate	0.1854
Abnormal Mammograms (subsequent) Numerator	122
Abnormal Mammograms (subsequent) Denominator	1312
Abnormal Mammograms (subsequent) Rate	0.0930
Abnormal CBEs (with normal mammograms) Numerator	576
Abnormal CBEs (with normal mammograms) Denominator	4037
Abnormal CBEs (with normal mammograms) Rate	0.1427
Number of Mammogram Referrals	182
ASCUS Pap Tests Numerator	530
ASCUS Pap Tests Denominator	9746
ASCUS Pap Tests Rate	0.0544
LSIL Pap Tests Numerator	322
LSIL Pap Tests Denominator	9746
LSIL Pap Tests Rate	0.0330
AGCUS, HSIL and Squamous Cancer Pap Tests Numerator	146
AGCUS, HSIL and Squamous Cancer Pap Tests Denominator	9746
AGCUS, HSIL and Squamous Cancer Pap Tests Rate	0.0150
Number of Pap Test Referrals	155
Dx Mam following an Abnormal Mammogram Numerator	248
Dx Mam following an Abnormal Mammogram Denominator	474
Dx Mam following an Abnormal Mammogram Rate	0.5232
Ultrasound following an Abnormal Mammogram Numerator	256
Ultrasound following an Abnormal Mammogram Denominator	474
Ultrasound following an Abnormal Mammogram Rate	0.5401
FNA following an Abnormal Mammogram Numerator	21
FNA following an Abnormal Mammogram Denominator	474
FNA following an Abnormal Mammogram Rate	0.0443
Biopsy following an Abnormal Mammogram Numerator	158
Biopsy following an Abnormal Mammogram Denominator	474
Biopsy following an Abnormal Mammogram Rate	0.3333
Surgical Consult following an Abnormal Mammogram Numerator	104
Surgical Consult following an Abnormal Mammogram Denominator	474
Surgical Consult following an Abnormal Mammogram Rate	0.2194
Dx Mam following an Abnormal CBE Numerator	51
Dx Mam following an Abnormal CBE Denominator	438
Dx Mam following an Abnormal CBE Rate	0.1164
Ultrasound following an Abnormal CBE Numerator	321
Ultrasound following an Abnormal CBE Denominator	438
Ultrasound following an Abnormal CBE Rate	0.7329
FNA following an Abnormal CBE Numerator	15
FNA following an Abnormal CBE Denominator	438
FNA following an Abnormal CBE Rate	0.0342
Biopsy following an Abnormal CBE Numerator	28
Biopsy following an Abnormal CBE Denominator	438
Biopsy following an Abnormal CBE Rate	0.0639
Surgical Consult following an Abnormal CBE Numerator	218
Surgical Consult following an Abnormal CBE Denominator	438
Surgical Consult following an Abnormal CBE Rate	0.4977
Colpo-directed Biopsy following ASCUS Pap Test Numerator	18
Colpo-directed Biopsy following ASCUS Pap Test Denominator	20
Colpo-directed Biopsy following ASCUS Pap Test Rate	0.9000
Colposcopy Alone following ASCUS Pap Test Numerator	2
Colposcopy Alone following ASCUS Pap Test Denominator	20
Colposcopy Alone following ASCUS Pap Test Rate	0.1000
Colpo-directed Biopsy following LSIL Pap Test Numerator	121
Colpo-directed Biopsy following LSIL Pap Test Denominator	134
Colpo-directed Biopsy following LSIL Pap Test Rate	0.9030
Colposcopy Alone following LSIL Pap Test Numerator	13
Colposcopy Alone following LSIL Pap Test Denominator	134
Colposcopy Alone following LSIL Pap Test Rate	0.0970
Colpo-directed Biopsy following HSIL/SqCa Pap Tests Numerator	98
Colpo-directed Biopsy following HSIL/SqCa Pap Tests Denominator	131
Colpo-directed Biopsy following HSIL/SqCa Pap Tests Rate	0.7481
Colposcopy Alone following HSIL/SqCa Pap Tests Numerator	13
Colposcopy Alone following HSIL/SqCa Pap Tests Denominator	131
Colposcopy Alone following HSIL/SqCa Pap Tests Rate	0.0992

Screening Data Time Period:	Jul 03 - Dec 03
Diagnostic Data Time Period:	Jul 03 - Jun 04
MDE Submission:	April 2005

ATTACHMENT G

DATA MANAGEMENT ORIENTATION WEB CONFERENCES

The following sessions related to data management are available through Web conference replay files, accessible at the NBCCEDP Resources Web site (http://www.nbccedp.org). New sessions will be added as they become available.

MDE Orientation

Three sessions present a comprehensive orientation to MDE data collection and reporting:

- MDE Orientation Session 1, Overview of the Web Conference Series, MDEs, and Screening Cycles
- MDE Orientation Session 2, Submission Requirements and Feedback Reports
- MDE Orientation Session 3, Maintaining a Screening, Tracking, and Follow-up Program

MDE Algorithms

Technical presentations describe the algorithms commonly used in MDE feedback and reporting:

- Standard terminology and algorithms used by CDC/IMS to quantify services funded through the program (e.g., women screened, women served, screening tests provided)
- Algorithms used to compute DQIG core indicator percentages
- Hypothesis test used in determining if the CDC performance standard was met on DQIG core indicators

Orientation to NBCCEDP Web Resources

Overviews are available at the following two Web sites:

- NBCCEDP Partners (http://www.cdc.gov/cancer/nbccedp/partners.htm)
- NBCCEDP Resources Web site (http://www.nbccedp.org)

Centers for Disease Control and Prevention
National Center for Chronic Disease
Prevention and Health Promotion
Division of Cancer Prevention and Control
Program Services Branch
770-488-4880

NBCCEDP Program Guidance Manual

Program Management

Version 2

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ATTACHMENTS

Attachment A: Framework for Determining 60/40 Distribution

I. INTRODUCTION

Overview of the Chapter

This chapter contains guidance, sample strategies, and resources to assist in the development of thoughtful approaches to managing the program at the state, tribal, or territorial level. The overall intent of the chapter is to help program managers focus program resources (e.g., human, fiscal, informational) on improving access to quality screening and diagnostic services for breast and cervical cancer.

Conceptual Framework

The Program Management and Evaluation components are represented by a sphere that symbolizes their all-encompassing nature. The placement of management on top represents how all other parts of the program fall under this leadership. Managing these components requires a systems approach, understanding the bigger picture of how and why the program components interrelate to achieve optimal results.

Purpose of Program Management

The purpose of program management is to

- maximize available resources to implement all program components according to established policies and procedures;
- identify and leverage non-federal resources;
- provide leadership in program planning, implementation, and evaluation; and
- coordinate and administer program activities and supportive management systems.

Definition of Program Management

Program management is the act of

- leading, facilitating, and ensuring the strategic planning, implementation, coordination, integration, and evaluation of efficient and effective programmatic activities and administrative systems;
- developing, cultivating, and maintaining productive working relationships among staff members and with partners through the creation of supportive communication channels and feedback mechanisms.

CDC Administrative Requirements That Influence Program Management

These include policies related to the following:

- **60/40 percent distribution requirement**—specifies that no less than 60% of total federal funding must be spent on direct clinical services to program eligible women.
- **10 percent administrative costs**—is considered a portion of the "40%" budget and specifies a 10% limitation on use of federal funds for administrative expenditures.
- **Contracts and consultants**—specifies requirements for contracting with public and non-profit or for-profit private entities.
- **Contractor and consultant approval process**—specifies elements that must be submitted to CDC prior to obtaining approval of a contractor or consultant.
- **Federal Financial Report (FFR)**—specifies requirements for reporting on the expenditure of federal funds. Unobligated funds are reported here.
- **Interim Progress Report (IPR) or competitive application**—specifies requirements for submitting periodic reports to CDC for continuation or new funding.
- **Maintenance of effort**—specifies how to determine the amount of non-federal contributions to credit toward the matching funds requirement.
- **Matching funds**—specifies expectations for securing matching funds in the form of non-federal resources.
- **Medicaid as it relates to match**—specifies how to account for Medicaid contributions in relation to matching funds.
- **Medicare reimbursements for screening and diagnostic services**—specifies that reimbursement to program providers of clinical services may not exceed Medicare rates for corresponding procedures.
- **Prior approval**—specifies examples of program changes requiring prior approval from CDC and consequences for failure to obtain such approval.

Essential Elements of Program Management

To meet NBCCEDP's expectations in the area of program management, a grantee should

- identify a staff person to serve as a program director or coordinator;
- recruit and develop a qualified and technically diverse staff;
- develop an annual work plan containing specific, measureable, achievable, realistic, and time-phased (SMART) objectives as well as activities and performance measures for each program component to increase evidence-based screening promotion services at the population level and to provide screening provision services to priority populations;
- implement all NBCCEDP components;
- develop an accurate budget request that corresponds with the program's work plan and meets the administrative requirements and guidelines of the NBCCEDP;
- establish and maintain a sound fiscal system that tracks and monitors program expenditures and ensures the accurate and timely reimbursement of services contracted by the program;
- prepare and submit reports (e.g., progress reports, FFRs) to CDC in a timely manner; and

- develop mechanisms for consultation with tribal governments and native people to enhance breast and cervical cancer screening activities in tribal communities.

Competencies Needed to Implement Program Management

Staff members responsible for management need the ability to

- develop and nurture a strong, cohesive team of qualified and technically diverse staff;
- assume a leadership role by inspiring and mobilizing others;
- build partnerships with other cancer and chronic disease programs, organizations, agencies, and individuals;
- communicate effectively with staff, program partners, agency management teams, CDC program staff, and providers;
- initiate and guide long- and short-term planning processes; and
- develop, track, report, and manage complex budgets;

Staff members responsible for management need knowledge in

- NBCCEDP policies, procedures, and requirements;
- administrative and fiscal requirements and practices of the state, territory, or tribe; and
- methods for evaluating program performance and outcomes.

II. ROLE OF THE PROGRAM DIRECTOR

Responsibilities

The state, tribal, or territorial 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 do the following:

- Recruit and develop a qualified and technically diverse staff
- 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 work plan containing SMART 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 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

Characteristics of Effective Managers

Characteristics of a good manager include the manager's ability to

- communicate and articulate,
- empower others,
- develop trust,
- "read" situations and know when to act (have a good sense of timing),
- focus and self-motivate (have personal drive), and
- handle the emotional aspects of change.

Key Message

A grantee's infrastructure model should be appropriate for the tasks to be accomplished, the resources available, and the costs. Furthermore, once a grantee settles on a particular infrastructure, the grantee should regularly examine the configuration to be sure that it is still "working" for the program. Changes in funding, resources, providers, programmatic priorities, and mandates may make infrastructure adjustments prudent. As a grantee learns about other programs and their accomplishments, it should recognize that another program's success may be due to its unique infrastructure—what works for one program may not work for all.

Organizational Context

The NBCCEDP does not exist in a vacuum; rather, it is part of a larger public health environment, including the following entities:

National Comprehensive Cancer Control Program (NCCCP)—Comprehensive cancer control is defined by CDC as a collaborative process through which a community and its partners pool resources to promote cancer prevention, improve cancer detection, increase access to health and social services, and reduce the burden of cancer. These efforts will contribute to reducing cancer risk, detecting cancers earlier, improving treatments, and enhancing survivorship and quality of life for cancer patients. Effective cancer prevention and control planning and programming should address a continuum of services ranging from primary prevention and early detection through effective, quality care to survivorship and end-of-life issues. A comprehensive approach involves experts from many

disciplines and professional backgrounds, and it addresses major cancer priorities identified with local cancer data through collaborative strategies that maximize available resources. The BCCEDP should be a key player in comprehensive cancer control activities and initiatives. Information on CDC's NCCCP is available at http://www.cdc.gov/cancer/ncccp/.*

Cancer registries—Registries collect information about incidence, diagnoses, treatment, and mortality. Data collected by cancer registries enable NBCCEDP planners to understand and address the breast and cervical cancer burden better, as well as evaluate the effectiveness of efforts to prevent, control, and treat the cancers. CDC's National Program of Cancer Registries (NPCR), established in 1994, supports and promotes the collection and use of registry data in 45 states, the District of Columbia, Puerto Rico, and the U.S. Pacific Island Jurisdictions. The NPCR currently collects surveillance data for all cancers, including cancers of the breast and cervix, as reported for the general population, whites, African Americans, Asians/Pacific Islanders, Hispanics/Latinos, and American Indians/Alaska Natives. The CDC's NPCR complements National Cancer Institute's Surveillance Epidemiology and End Results (SEER) registries. Together, the NPCR and SEER Program collect cancer data for the entire U.S. population. These data are provided annually in the national United States Cancer Statistics report, which is available at http://www.cdc.gov/cancer/npcr/uscs/.

Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)—This CDC-funded program helps uninsured women gain access to screening and lifestyle interventions that can reduce their risk for heart disease and other chronic diseases. This program was established through 1993 legislation that authorized the expansion of services offered through the NBCCEDP to include screenings and interventions for chronic disease risk factors. NBCCEDP participants aged 40 to 64 also may qualify for WISEWOMAN services. WISEWOMAN currently operates 21 CDC-funded WISEWOMAN programs in 20 states (two programs in Alaska) and tribal organizations. More information about WISEWOMAN can be found at http://www.cdc.gov/wisewoman/.

Colorectal Cancer Control Program (CRCCP)—This CDC-funded program helps individuals gain access to colorectal cancer (CRC) screenings through both provision and promotion activities. This program was established in 2009 and funds 29 grantees (25 states and 4 tribal programs). The major focus of the CRCCP is to work with communities, healthcare systems, employers and other organizations to increase age appropriate CRC screening among the population to 80%. The program's priority population for provision of screening is low-income, uninsured individuals aged 50-64 years.

Other programs—These programs include women's health programs (e.g., maternal and child health, reproductive health) and general health promotion programs (e.g., coordinated chronic disease) and offices.

In addition, the nature of the BCCEDP infrastructure design may pose unique management opportunities and challenges. This infrastructure, which can vary by program component, is either centralized, decentralized, or a blend of the two. Typically, these models can be characterized as follows:

Centralized—Actual clinical services are provided in satellite locations, such as clinicians' offices and health centers. All other program components and management roles are located in central units, most often the headquarters of state health departments. The grantee performs all activities.

Decentralized—The grantee contracts with local or regional health departments, private hospitals, or other entities to implement the BCCEDP components. Oversight and policy roles remain with the grantee, but strategic and operational roles are delegated to local or regional entities. One or more contractors (individuals or firms) usually perform these activities.

Blended—The grantee and contractors share responsibility for performing the activities. Clinical services are provided in satellite locations, with oversight in a central office. Management functions (e.g., assessment, strategy, policy) are located in a central office, but other core program activities (e.g., recruitment, professional development) may be delivered by providers or contractors.

The following table outlines some of the major advantages of centralized and decentralized infrastructures.

Infrastructure Model	Advantages
Centralized	By gathering all staff members and resources in one place, economies of scale permit focus and specialization. The variety of activities and required experience leads to more career paths and opportunities for professional growth. Simpler, direct lines of authority make it easier to manage, control, and coordinate activities. Common organizational culture, policies, and procedures streamline communication and decisionmaking.
Decentralized	Influence of the local community is increased. Greater flexibility and innovation are possible. Opportunity for involvement among providers and stakeholders is enhanced. When resources are dedicated to a particular specialized activity, subject matter expertise tends to become more focused and have greater depth.
Blended	Any combination of the advantages of both centralized and decentralized models is available. Community influence is increased as the common organizational culture, policies, and procedures streamline communication and decision-making.

Range of Tasks

The specific tasks of the program director in several critical areas are described below.

Staffing

Developing and nurturing a strong, cohesive team involves the following activities:

- Recruiting a qualified and technically diverse staff
- Developing staffing plans, position descriptions, performance plans, and individual development plans
- Identifying outside sources to augment existing staff members
- Orienting, training, and nurturing staff members
- Supervising, monitoring, and evaluating the performance of staff members

Communication

Positive interaction with others establishes a trusting relationship with employees, program partners, agency management teams, CDC program staff members, and providers. Schoonover describes the interpersonal skills for successful interactions as follows:

- **Attention**—The ability to be receptive to a variety of perspectives
- **Empathy**—The ability to identify clearly with the thoughts, feelings, and actions of others (e.g., to "put yourself in another's shoes")
- **Rapport**—The ability to make a firm, ongoing emotional connection with another person
- **Respect**—The ability to take an abiding, nonjudgmental stance toward others

Strategic Planning

As noted by Bryson, "strategic planning is a set of concepts, procedures, and tools to help leaders, managers, and others think and act strategically on behalf of their organizations and their organizations' stakeholders."[3] Strategic planning includes the following activities:

- Developing mission statements, measurable objectives, strategies, performance measures, and measurement strategies
- Identifying and interpreting data sources for use in decision making
- Securing sufficient resources to support program efforts
- Maintaining the vision for the program and consistently taking actions to move the program forward
- Ensuring the evaluation of program activities and the use of evaluation results and other data to shape and guide the program

Fiscal and Administrative Management

Being fiscally responsible and accountable entails the following:

- Developing, tracking, reporting, and managing complex budgets
- Monitoring the use of program funds to support program activities
- Understanding and adhering to federal and state, tribal, or territorial cooperative agreement requirements, contract and grants policies and procedures, and other applicable policies and procedures
- Developing a positive relationship with the fiscal office in the grantee's agency to facilitate communication about expenditures, charges, regulations, and required reports

Reporting

Program directors share progress with federal and state stakeholders through the following activities:

- Supervising and ensuring the accuracy of complex data reporting systems
- Preparing and submitting required reports accurately and completely, according to timelines specified by the national program
- Preparing other reports as appropriate (but not necessarily required) (e.g., feedback/quality assurance reports to providers, performance reports to partners and elected officials)

Leadership and Partnership Building

"Public leadership is the inspiration and mobilization of others to undertake collective action in pursuit of the common good." The early detection of breast and cervical cancer is a mission beyond the scope of one lone public health program. It requires the participation and involvement of a host of other organizations and providers, working in concert. Leadership includes the following:

- **Envisioning**—Being concerned with the organization's basic purpose and general direction; being a vision-directed, agenda-driven, and results-oriented person
- **Communicating**—Inventing images, metaphors, and models that provide a focus for new attention; often challenging conventional wisdom; exercising the capacity to influence and organize meaning for the members of the organization
- **Establishing trust**—Being predictable, reliable, and accountable; using a clear and consistent style to drive and reinforce the basic vision for the future
- **Empowering**—Achieving the highest potential through a shared vision and a mutual sense of trust

(See the Partnerships chapter for detailed guidance on building relationships with specific partners.)

Evaluation

Program directors are responsible for evaluating the achievement of short-term, intermediate, and long-term outcomes. Effective managers are not afraid to be introspective and to ask the hard questions about the program's performance: Are we on track? If not, why not? How can we do better?

(See the Evaluation chapter for guidance on designing and carrying out program evaluations.)

III. COMPONENTS OF PROGRAM MANAGEMENT

Staffing and Personnel Management

Hiring Staff

Human Resource Planning

The questions listed below relate to hiring barriers, the legislative requirements of the national program, budgetary limitations, and interpersonal factors that should be considered.

- What staff members are needed to achieve program goals and expectations?
- What are the job descriptions for the necessary positions? How do they relate to the program's 60/40 distribution requirements?
- How much funding is available to support staffing, considering the program's 60/40 distribution requirements?
- What internal hiring barriers exist (e.g., hiring freezes, position misclassifications, monetary restrictions) that make it difficult to fill staff positions?

- What are desirable characteristics for each staff position (e.g., educational level, training background, relevant past experience, cultural competence)?
- What interpersonal characteristics are needed (e.g., skilled communicator, detail oriented, analytical)?
- What other mechanism exists for the program to obtain staff members without having to hire them as state, tribal, or territorial employees (e.g., contracts, memoranda of agreement or understanding with key partners, interns, students for practicum experience)? What are the advantages and disadvantages of each mechanism (e.g., issues of continuity, supervision, short- vs. long-term time commitment)?
- Are there multiple program components that can be managed by the same individual? Which ones, why, and how?
- Should the majority of a program's staffing resources be placed internally (e.g., central office, centralized program) or externally (e.g., region, district, county)? What are the advantages and disadvantages of each? Are there state, tribal, or territorial restrictions to either?
- What are the lines of supervision of each staff person? Has the program developed an organizational chart that describes these lines of authority? Are supervisors prepared to guide and direct staff members appropriately?

When hiring staff members to meet the requirements of the program, the grantee should review the program components and current policies to identify the types of staff members needed. Often, a staff member must assume responsibility for two or more roles. It is important that responsibility for each program component be clearly delineated in staff job descriptions.

Key Message

Grantees must take the needed time and effort to hire the "right" person for each job. The upfront investment will be well worth it later on.

Justifying Staff Requests

The requirement that 60% of the budget be directed to the provision of direct services makes the careful allocation and tracking of staff even more essential. Funding for staff members who do not have face-to-face or one-on-one contact with the women served by a program should come out of the 40% portion of a program's budget. For each requested position approved by CDC, programs are required to provide the following information:

- Name of the staff member occupying the position
- The staff member's annual salary
- The percentage of time budgeted for the program
- The total number of months of salary budgeted during the year
- The total amount of salary requested (percentage of annual salary)
- The position as it relates to the 60/40 distribution requirements

Programs should organize a list of requested positions by program component. They also should provide a justification and description of the duties and responsibilities for each new position, relating it to the accomplishment of specific program objectives.

Consultants may be used to accomplish some aspects of the program, particularly if the tasks are relatively short term, the expertise is highly specialized, additional staff members are needed quickly, or hiring freezes or other internal barriers prohibit the hiring of staff.

(See Contracts and Consultants in the Policies and Procedures chapter.)

Job Descriptions

Job descriptions should be well written to inform potential applicants about a job's requirements and expectations. Many management experts believe that one of the most important steps for recruiting the right person is to give the applicant a realistic preview of the job—one that is not apt to scare the person away but rather provides an honest view of what the job will be like.

The Interview

The interview will help the program to identify the most qualified individual to fill a vacant position. The interview process generally has three stages: establishing rapport, exchanging information, and closing the interview.

Establishing rapport—Create a pleasant environment, call the applicant by his or her first name if that is office protocol, and tell the applicant that you are taking notes to ease tension for both the applicant and the interviewer.

Exchanging information—Helpful information can be obtained by asking questions, listening carefully, being straightforward, not hesitating to ask "Why?," observing body language, and being consistent (e.g., asking the same questions of each applicant).

Closing the interview—Keeping an open mind, avoiding judging a candidate on the basis of his or her level of agreement with your views, remaining cordial and unhurried, thanking the applicant for his or her time and effort, and standing and showing the applicant out can leave the applicant with a feeling of being respected and appreciated.

The Americans with Disabilities Act of 1990 and the Civil Rights Act of 1991 are two major legislative initiatives that must be followed in the interview and selection process. The Federal Government created guidelines for avoiding discrimination, the Uniform Guidelines on Employee Selection Procedures (http://www.uniformguidelines.com/). This material should be available from state, tribal, or territorial agency human resources offices.

Key Message

Past performance is the best predictor of future performance.

John Kador, in his book *The Manager's Book of Questions: 751 Great Interview Questions for Hiring the Best Person*, surveyed the country's leading recruiters for Fortune 500 companies and compiled a top-ten list of the best and toughest interview questions. In the experts' opinion, the best questions are those that appear to elicit answers that provide good insight about the applicant as well as his or her capabilities with respect to the qualifications required of the position. The toughest questions are designed to be difficult and thought provoking, much like the problems an employee will encounter in the workplace.

Effective interviewing involves systematically developing questions that will assist the interviewer in objectively gauging the candidate's ability to do the job and his or her likelihood of fitting into the organizational structure. Questions should probe the candidate's performance on previous jobs, as past performance is often the best predictor of future performance. Asking open-ended questions will often elicit more information about a candidate and allow the interviewer to gather more complete and detailed information. This behavioral interviewing process involves five steps:

- **Skills analysis**—Determine the skills necessary for the job
- **Skill definitions**—Identify what needs to be assessed about the candidate's skills and abilities
- **Structured interview**—Create open-ended structured questions about the candidate's experience
- **Gaining examples**—Elicit specific examples of the candidate's use of skills necessary to perform job tasks
- **Rating the evidence**—Rate the examples provided by the candidate against the skills necessary to perform the job

Orienting Staff

Planning for Orientation

A good orientation program and adequate training for new staff members can help lessen the potential for premature staff turnover, program disruption, poor morale, and complaints related to employee relations. A study conducted by Ohio State University researchers demonstrated that new employees who completed a 3-hour orientation program showed a higher level of commitment to their employer than did those who skipped the program. The study also showed that those who attended the orientation also reported an increase in informal contact and social relationships with their peers.

An orientation program for new staff members generally includes the following:

- An explanation of the organizational structure and function (lines of authority)
- Staff member introductions
- A review of Public Laws 101-354, 103-183, and 105-340, as well as any other relevant federal and state laws or regulations
- A tour of the program areas
- Explanation of the equipment and resources available
- Explanation of the critical duties of other staff members
- Explanation of the new staff member's duties and responsibilities
- Familiarization with the written and unwritten policies of the program
- Explanation of the program's relationship to, and with, other divisions and offices

The following tools and processes may assist a program's orientation of new staff members:

- A copy of the Policies and Procedures chapter
- A locally developed orientation manual
- The assignment of a mentor, who provides special attention and guidance to the new person
- A mechanism for tracking what the employee has and has not learned

- Regularly scheduled meetings to answer questions, provide guidance and support, and identify any looming problems or difficulties that may lead to employee anxiety or disenchantment
- A chance for new employees to connect with others doing similar work at the agency or with others working on the NBCCEDP; programs should feel free to use CDC's program consultants to help facilitate this process

The Orientation Process

For an effective orientation program, the grantee must have a process for compiling and maintaining relevant materials. Some programs develop orientation manuals; others keep materials in a centrally located area for staff acquisition; and others use the NBCCEDP Policies and Procedures Manual, augmenting it with additional information when necessary.

State, tribal, or territorial orientation programs can be organized in a number of ways. It may be helpful for grantees to use existing materials, such as the NBCCEDP's Framework, Social Ecological Model, Policies and Procedures Manual, Data User's Manual, and various other training tools developed by CDC. These resources can be found on the NBCCEDP Resources Web site at www.NBCCEDP.org.

The Orientation Checklist

An orientation checklist can help grantee staff members track the program elements that the new employee has mastered. The checklist lists all job aspects that the employee must learn, including such items as telephone protocol, computer and e-mail policies, and how to use office equipment. The checklist should include the date on which orientation to a specific task or feature of the program was completed and a signature or initialing area for both the new employee and person orienting to sign. If the checklist is completed accurately and honestly, it serves as a measure of new employee introduction and training to a specific facet of the organization or the job.

Developing and Retaining Staff Members

Staff Training

The trainer's approach to training and attitude about the training can have a tremendous influence on how an employee benefits from the training experience. Discussing expectations of what the employee will learn from training and how it will be applied to his or her job, as well as discussing the training with the employee upon his or her return from it, can make a difference in transforming the skills and knowledge learned into skills and knowledge applied in the job setting.

Key Message

Grantees should allow sufficient time for training new employees and then document what training takes place. When program staff members leave and new employees are hired, grantees should be patient—it can take months for a new employee to be fully trained.

The NBCCEDP encourages ongoing staff training and provides several opportunities throughout the program period for grantee staff members to participate. These opportunities can be either formal courses or more informal opportunities, including the following:

- **Trainings**—These sessions are specific to certain components of the NBCCEDP. Trainings have been developed and offered for program directors, data managers, recruitment coordinators, professional development coordinators, case managers, and quality assurance and quality improvement coordinators. Schedules of upcoming trainings are posted on the NBCCEDP Programs and Partners Web Forum. In addition, CDC staff members arrange and manage regularly scheduled calls on the topics of recruitment, professional development, and case management.
- **Regional trainings**—These sessions are often planned by program directors, through support from CDC. Regional trainings provide current program information on various program components, as well as the opportunity for attendees to share experiences, and they promote the development and increased use of comprehensive approaches to addressing the burden of cancer.
- **NBCCEDP meetings**—These meetings bring together program directors and other relevant staff members to discuss pertinent issues. Grantee participation at these annual meetings is essential to the effective implementation of the NBCCEDP. This is a time for sharing among programs, hearing about new initiatives, and networking with colleagues.
- **NBCCEDP listservs**—These listservs, operated and maintained by CDC, provide an efficient means of sharing information and networking among grantees, including posting of grantee questions and notices, changes in policy, updates on science issues, and information about upcoming meetings. Program consultants can provide information about how to access these listservs.
- **CDC's Cancer Conference**—This conference is held periodically. It offers programs the opportunity to gain knowledge and skills, and network with a broad set of partners.
- **Continuing education opportunities**—Continuing education is available for physicians and nurses, and general continuing education is available through CDC's *MMWR* series. Selected publications may be downloaded from http://www.cdc.gov/mmwr.
- **Educational materials**—These training materials are available on the Internet, at http://www.cdc.gov/cancer/nbccedp/training/. Materials include the self-study packet *Work plans: A Program Management Tool*, community health worker programs materials, and outreach strategies and interventions.
- **Professional publications**—These materials, along with information, abstracts, and program descriptions from national, state, and local programs are available through the CDC Chronic Disease Prevention databases (http://www.cdc.gov/chronicdisease/). The databases also contain technical reports, proceedings, papers, policy documents, and legislation. Full text is provided for selected publications.

Turnover

Strategies for reducing staff turnover include clearly outlining job responsibilities and job expectations. Equally important are allowing professionals the autonomy to do their job well and providing them with a sense of confidence in their capabilities. Inherent to the concept of trust and confidence in the employee's ability is allowing differences in approaching problems and in achieving outcomes.

Typical complaints that lead staff members to leave include

Key Message

No matter how satisfied staff members are, grantees should expect some turnover—and prepare for it. Strategies for handling turnover include developing protocols, documenting procedures, and cross-training staff members so that vacancies do not create large "holes" and difficult transitions.

those related to their lack of the following: involvement in decisions, information from management, recognition, and opportunities for promotion and training. Elements that help retain employees include the following: exciting and challenging work, career growth opportunities, learning and development opportunities, coworkers that respect others, fair pay, supportive management, and a caring boss.

Possible strategies to reduce turnover and maintain good employee morale include being flexible with travel to key conferences, workshops, and training programs, and rewarding staff in intangible ways. These intangibles can include management doing the following: frequently reinforcing good work, showing empathy when workloads are heavy, providing words of encouragement and understanding, having occasional staff office gatherings (e.g., an unannounced 20-minute group meeting for coffee, juice, and pastries), sending congratulatory e-mails on birthdays and other special occasions, and stopping by unannounced just to say "hello" and "thank you." Exit interviews are often helpful in gaining an honest picture of the circumstances and factors affecting employee morale and turnover.

Communicating With Staff Members

Meetings

Grantees should establish a staff meeting schedule that is consistent and convenient. Written agendas help to keep meetings focused and on track. Topics typically covered at staff meetings include the following: program activity updates, pertinent planning or evaluation issues, personnel items (e.g., birthdays, retirements), and upcoming events (e.g., trainings, meetings, conference calls). Agreement on ground rules for these meetings can be very helpful, and preparation of minutes or summaries provides a historical record of decision and action items needing further attention.

E-mail and Other Communication Methods

Much exchange of information takes place through e-mail. However, grantee staff members should avoid using e-mail when personal, face-to-face interactions are more appropriate or effective. Often, e-mail messages can be misinterpreted; thus, they should not be used to communicate any information of a sensitive nature.

Program Planning and Operations

Program planning involves the use and development of actions and policies that will affect an organization's or agency's ability to survive in the long run. Planning is oriented to the future.

Key Message

Grantees should not develop plans in a vacuum, and then market them to—or impose them on—others. Involving those affected by the plan in its creation will make for a better plan AND increase its chances of being implemented as intended.

Preparing Strategic Plans

"Strategic planning is a set of concepts, procedures, and tools to help leaders, managers, and others think and act strategically on behalf of their organizations and their organizations' stakeholders." Strategic planning is essential to

effective leadership and program management. It is the continuous process of systematically evaluating the organization, defining its long-term objectives, identifying quantifiable goals, developing strategies to reach those objectives and goals, and allocating resources to carry out the strategies. Strategic plans typically cover a 3- to 5-year time period.

Elements for Planning

Elements of strategic planning include the following: development of an organizational vision and mission, formulation of goals, development of objectives to reach those goals, identification of strategies to achieve those objectives, and development of an evaluation plan that effectively measures performance. This process allows the grantee to assess its strengths and weaknesses, elicit and examine continuous feedback, and identify opportunities to make adjustments to plans as needed.

Vision statements—A vision defines the desired future of an issue or an organization. The vision is the broad conceptual framework that should be strong enough to guide the planning process. The CDC vision—Health Protection…Health Equity—provides this framework. A shared vision and long-term commitment among diverse groups assist in mobilizing energy and resources. They also serve as a rallying point for planners and facilitate the development of specific, measurable, achievable, realistic, and time-phased objectives.

Mission statements—Mission statements are statements of organizational purpose; that is, why does the organization exist, and what does it do? Mission statements describe the following:

- Information on the program (e.g., the NBCCEDP)
- The intended beneficiaries of the program (e.g., program-eligible women)
- The main services to be provided (e.g., breast and cervical cancer screening)
- The program's geographic boundaries
- The program's desired outcomes (e.g., to reduce morbidity and mortality, to detect cancer in its earliest stages)
- A concept that expresses the program's identity

Goals and objectives—Goals and objectives follow the development of the mission statement.
The goal statement provides a big picture of the intended outcome and is taken from performance areas identified in the mission statement. For example, a goal statement might read as follows: "to reduce the number of new cancer cases as well as the illness, disability, and deaths caused by

Key Messages

- ***Vision—How would a perfect world look?***
- ***Mission—What is the program's particular contribution to achieving the vision?***
- ***Goals—What will happen as a result of the program fulfilling its mission?***
- ***Objectives—Within the time period selected, what will the program do?***
- ***Activities—What smaller steps will the program take to meet its objectives?***

cancer."

Objectives list the steps necessary to reach the overall goal. For example, an objective might read as follows: By the year 2020, the death rate from cancer of the uterine cervix will be reduced from 2.4 per 100,000 females to 2.2 deaths per 100,000.

There is often confusion between goals and objectives. As used in *Work Plans: A Program Management Tool* (available at http://www.cdc.gov/cancer/nbccedp/training/workplans/), goals tend to be broad and general, and they often do not include a timeframe. Objectives, however, capture how a goal will be achieved and should be SMART:

Specific—Identify who, what, and where
Measurable—Identify how many
Achievable—Can be attained
Realistic—Can be attained given the time and resources available
Time-phased—Identify when
Activities—Activities are the steps that a program undertakes to accomplish its objectives.

The following factors are important in determining activities:

- Identifying organizational strengths and weaknesses
- Determining public health environment opportunities and constraints
- Matching organizational strengths and weaknesses with environmental opportunities and constraints
- Setting policies and parameters to frame the boundaries of the program

Using Logic Models

Logic models link program inputs (e.g., resources) and activities to program products and outcomes (e.g., goals and objectives) while communicating the logic (theory) behind the program (its rationale for existing). Grantees can use logic models to do the following:

- Identify the products, and short-term, intermediate, and long-term outcomes for the program
- Link outcomes to each other and to program activities using the identified logic, theory, and/or model for the program (i.e., illustrate cause and effect)
- Incorporate findings from research and demonstration projects
- Select indicators to measure outcomes, depending on the program's stage of development
- Illustrate why the program is important as well as its fundamental purpose
- Depict what intermediate products and outcomes must occur before long-term outcomes will be evident
- Make midcourse adjustments and improvements in the program
- Form a common reference point for staff members, stakeholders, constituents, and the funding agency

Logic models will communicate underlying theory (logic) as well as why selected activities are a good solution to the problems identified. Some logic models read left to right, others top to bottom with intermittent circles and squares, and others follow a winding path; all are designed to demonstrate the

link (logic/theory) of what leads to what. What are the links between resources, activities, products and outcomes? Why and how will the program work?

(For more detail on logic models and their use, see the Evaluation chapter.)

Designing Work Plans

CDC requires NBCCEDP grantees 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 SMART objectives for each program component. The essential elements for each program component should be addressed in the program's work plan. The work plan also should list the staff members who are responsible for each activity and include a description of the evaluation measures to determine the program's progress toward achieving objectives. These evaluation measures should include specific time intervals for reviewing progress. Programs are encouraged to use the NBCCEDP work plan template as a guide for developing their individual work plans. This template is part of *Work plans: A Program Management Tool*, which can be downloaded from http://www.cdc.gov/cancer/nbccedp/training/workplans/.
Work plans have the following components:

Key Message

A good manager engages staff members in the development of a workplan. Reviewing the performance of the past and current years' strategies is a first step. If the program's application was not fully funded, the manager, with the staff, should prioritize strategies and revise the workplan to match the award level.

- Goals
- Measures of success
- Measurable objectives
- Activities
- Data
- Timeframe for assessing progress
- Team members responsible
- Progress report

Grantees 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 that address progress and deficiencies
- Assist with training key staff members to plan, implement, monitor progress, and assess program activities

Linking Program Planning and Evaluation

Program development can be informed by evaluation. The program is informed by ongoing needs assessment and surveillance to determine what resources are available, where gaps exist, the characteristics of the program's location, and the needs of the priority populations of women. Using this information, grantees can develop overall program goals and objectives. The work plan describes program component activities to meet these goals and objectives. The evaluation of these overall program and component activities helps grantees to make regular adjustments and mid-course corrections, as well as revise and develop the work plan as the program progresses. This cycle is ongoing and continuously repeated.

Program monitoring is the systematic documentation of program performance, which indicates whether the program is functioning as planned or according to self-defined measures of success. During the development phase of an activity, program monitoring can help identify problems and suggest beneficial changes to ensure future activity and program success. For activities and programs beyond the development phase, program monitoring also can provide the grantee with information that can be used to successfully achieve program objectives, track the program's progress, and assess the performance of component activities over time.

Evaluation and monitoring data should be reported and shared regularly, such as at program staff meetings. These data should also be shared with clinical providers and networks that provide services for programs with decentralized systems.

(See the Data Management chapter for examples of program monitoring systems, including provider feedback mechanisms.)

Securing Financial Resources

NBCCEDP Award Process

Grantees are required to submit a request for funding to CDC annually. If it is a competitive year (i.e., the first year of a new funding opportunity announcement), a program's request for funding is included in its competitive application. If it is a noncompetitive, continuation year, a request for funding is included in

the program's IPR. In addition to a justifiable budget request, both types of submissions (competitive application or IPR) should contain background information, data reviews and assessments, and a work plan that includes activities and strategies for planning, implementing, and evaluating success in meeting stated programmatic goals and strategies. (Additional information about the IPR is provided later in this chapter.) Procurement and Grants Office (PGO) offers guidance for preparing *a budget request* at www.cdc.gov/od/pgo/funding/grants/Budget_Guidelines.doc.

Key Message

Management staff members should read the grantee's award notice very carefully and keep it handy throughout the budget and project period. The notice includes important information on how much funding the grantee can expect from CDC, as well as what CDC expects from the grantee in return to account for those funds.

Grantees must submit applications electronically at http://www.grants.gov, a unified site for interaction between grant applicants and the U.S. Federal agencies that manage grant and cooperative agreement funds. Before submitting a grant application electronically to CDC, an organization applying for the grant must complete a one-time registration at Grants.gov. All registration formalities must be completed prior to submission.

CDC uses a systematic, performance-based approach for making funding decisions to ensure uniformity and equity in the data and information that are considered in the process. Funding recommendations are based on a careful review of the IPRs, individual program performance, realistic screening projections, reasonable and well-justified budget requests, and compliance with the 60% legislative requirement of the NBCCEDP. CDC's performance-based approach considers several criteria, including the following:

Ability to spend awarded funds
Ability to make realistic screening projections on the basis of prior performance and meet those projections
Ability to provide appropriate high-quality and timely services to clients
Compliance with requirements (particularly the 60/40 distribution requirement, the 10% limit on administrative charges, and the required match)
Ability to increase the number of women screened
Ability to accomplish objectives and outcomes outlined in the work plan.

Preparing Program Budgets by Projecting Clinical Costs

When preparing program budgets, grantees should do the following:

- Work with CDC program consultants.
- Know and understand all pertinent budget requirements and guidelines.
- Review program expenditures from the previous year. How do expenditures for the past year match up to the projected budget? What accounts for the differences?
- Review the current work plan and the past year's accomplishments and performance. Are some tasks complete and no longer in need of fiscal support? Did the program achieve what it intended from

program activities? For example, did the targeted outreach strategy bring in the appropriate number of women? What activities need to be discontinued or altered during the coming year?

- Accurately project the number of women the program can serve in a year and build on screening projections. If the program has been meeting the CDC performance-based funding criteria, staff members should talk with the program consultant about the possibility of receiving additional funds. If the program has not met its projections, is it likely to do so during the coming year? Is the program currently out of compliance with the 60/40 requirement because it did not meet projections? Does the budget request need to be revised downward to reflect more realistic projections?
- A critical budget projection is the estimate of the cost of clinical (and other direct) services. To help grantees make this projection, CDC has created a clinical cost worksheet (CCW). The CCW is a standardized tool for estimating clinical and other direct service costs. The worksheet helps grantees to project the number of new screening and rescreening mammograms, clinical breast exams, Pap tests, office visits (for new patients, established patients, and problem-focused visits), and referrals for breast and cervical diagnostics that are likely to need reimbursement in the coming year. It also records the number of unique, unduplicated women who are expected to receive services.
- Appropriately account for staff positions the grantee has filled or wishes to fill in the coming year.

BCCEDP managers should be aware of the following factors that can affect budget requests and the achievement of objectives:

- A reduction in federal appropriations
- A redirection of funds to meet a critical need elsewhere within the budget
- Changes in legislation with respect to allowable screening services
- State, tribal, or territorial agency restrictions on using funds
- Differences between federal and state agencies on the interpretation of allowable expenditures
- Sudden increases in local provider costs

Management of Fiscal and Administrative Systems

Program managers' fiscal responsibilities do not end with budget preparation, submission, and approval. Once budgets are approved, program managers are responsible for tracking expenditures, identifying problems, and making adjustments in a timely and responsible manner.

The NBCCEDP has evolved from a startup program focused on increasing screening services for women nationwide to a more competitive program supporting efforts based on need and performance as well as grantees' ability to successfully engage in screening promotion activities. In such a performance-based environment, CDC expects both fiscal management and fiscal accountability.

The NBCCEDP grant requirements mandated by law are clearly delineated:

- Priority must be given to providing screening services to low-income women.
- Not less than 60% of the grant funds shall be used for screening and follow-up services.
- Funds cannot be used to pay for cancer treatment services, research, or in-hospital care.
- Not more than 10% of the grant may be used for administrative expenses (in lieu of indirect costs).

- A program must contribute the equivalent of $1 (cash or in-kind) for each $3 of federal funds (the match) it receives.
- In determining the amount of non-federal contribution to credit toward the matching funds requirement, programs may only use funds over and above the annual amount the program had contributed toward breast and cervical cancer programs and activities for the 2-year period preceding the first fiscal year of federal funding for the NBCCEDP.

(*See Introduction chapter.*)

60/40 Distribution Requirement

The mandates also stipulate that a grantee must use a minimum of 60% of federal funds to provide direct services to women (referred to in this manual as the 60/40 distribution requirement). These direct services include clinical and nonclinical services. Reimbursement for clinical services, individual outreach encounters, case management, patient translation services (not for brochures and other printed material, but to facilitate communication between a client and a health professional or NBCCEDP staff), and the costs of transportation subsidy for individual women to be able to keep their appointments are all allowable in the 60% category. The nonclinical services are often described as "essential support services."

(See Attachment: Framework for Determining 60/40 Distribution.)

The grantee may spend the remainder of CDC funding on all other activities, including management, partnerships, recruitment, professional development, evaluation, data management, and quality assurance/quality improvement. A maximum of 10% of a grantee's total award may be used for administrative expenses, as defined in Federal OMB Circular A-87 (available at http://www.whitehouse.gov/omb/circulars_a087_2004/). Because the NBCCEDP does not allow support of indirect costs, grantees should check with their fiscal offices to find out what administrative expenses are included in the state's or territory's negotiated indirect cost rate with the regional Health and Human Services (HHS) office.

(See the Policies and Procedures chapter.)

Required Match and Maintenance of Effort

Programs are required to contribute matching funds—non-federal resources (cash, in-kind, or donated services or equipment)—in the amount of $1 for each $3 of federal money received through CDC agreements. Specific guidance has been established on how to determine the match requirement and what constitutes allowable sources of that match. Matching funds may not include the following: (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.

Matching resources range from in-kind contributions, such as space, volunteers, time, and equipment, to substantial grants or investments by private or public agencies, foundations, or organizations. Strategic plans, work plans, and reports can be extremely useful in identifying, seeking, and justifying additional support from a variety of funding sources. Some grantees receive state dollars to satisfy the match

requirement; other programs must find more creative ways to meet this mandate. Documentation must be kept to show the source of the match, the estimated dollar value, and way in which the value was derived. This is particularly true if the matching contributions are noncash resources.

Examples of Cash and Noncash Sources for Required Match	
Non-federal cash resources	Program appropriations for screening, tracking, and follow-up State Medicaid for breast and cervical cancer screening (above maintenance of effort) State tobacco tax revenue Cash donations Community fundraising
Non-federal noncash resources	Donated vehicles and equipment (e.g., vans for transportation, laboratory equipment, computers) Donated services (e.g., screening tests, diagnostic tests, transportation, volunteer time) Donated supplies (e.g., education materials, promotional materials) Donated media time (e.g., television, radio, print) Donated professional time (e.g., service on coalitions, advisory committees, advertising/marketing consultation) Cost differential between reimbursed rates and usual and customary fees

In addition to the matching contribution, each program must identify its maintenance of effort (MOE). MOE is 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 the NBCCEDP. Only those non-federal contributions in excess of the MOE amount may be considered matching funds. Supplanting, or replacing, existing program efforts that are currently paid with federal or non-federal sources is not allowable.

(See Matching Funds in the Policies and Procedures chapter.)

Fiscal Management and Reporting Requirements

Programs are responsible for all grant requirements and reports. Generally, reports that are fiscal in nature are submitted to CDC's PGO. Grantees must fully understand what is allowable, what needs prior approval, what reports are required, and what protocols must be in place. Specific reporting requirements for NBCCEDP awards are described in the Terms and Conditions section of each program's Notice of Grant Award. A good *basic* resource for understanding these requirements is the *Grantee's Financial Reference Guide for Managing CDC Grants and Cooperative Agreements* (available at http://www.cdc.gov/od/pgo/funding/grants/policymain.shtm). This document is intended for use by nonprofit organizations and state and local governments as a reference guide to the regulatory and procedural requirements that govern CDC's grants process. It supplements, but does not replace, established federal policies or regulations governing the NBCCEDP. The guide contains basic information, such as definitions, frequently used acronyms and abbreviations, financial management systems requirements, rules for allocating indirect costs, matching and cost sharing requirements, prior approval protocols, and mandates reports.

Monitoring Budgets

Budget monitoring is an ongoing responsibility and answers three critical questions: (1) Is the funding being spent on activities or items that are most likely to result in the accomplishment of program objectives? (2) Is the money being spent as intended or budgeted? (3) Are current expenditures the most efficient and effective use of these resources?

Establishing an ongoing and positive working relationship with the fiscal officer responsible for management of a BCCEDP budget is one key to successful budget management. Establishing a routine system for tracking how funds are spent (and to which line item expenditures are assigned) and accounting for over- and under-spending requires a good system for communicating with agency fiscal staff. Program offices may or may not be closely tied to financial offices. However, ensuring concurrence between funds spent is important for both offices. This is one reason CDC requires signatures from both the fiscal and business offices. CDC strongly encourages program directors to develop productive relationships with their fiscal office.

Ultimately, it is the BCCEDP director who is responsible for the expenditure of funds, for the content of the FFR, and for having immediate knowledge of where and how funds are allocated and spent.

While monitoring program budgets, grantees may discover the need to redirect funds from one line item to another in order to meet screening needs or to reallocate unused funds from a vacant position, for example. Redirection may require "prior approval" from PGO. The BCCEDP director should discuss these actions and options with the program consultant for specific guidance.

If it is likely that funds will not be spent by the end of the year, the BCCEDP director should discuss options for spending unobligated funds with the program consultant. The director should also maintain a list of special initiatives that could be undertaken with these funds or any additional supplemental funds that may become available.

One good way to monitor expenses is to review expenditure reports monthly. Questions to ask in that review include the following:

- Is money being spent as planned?
- Is the program using the same definitions of specific budget items as the state, territory, or tribal budget office (e.g., for equipment, supplies, travel)?
- What is the billing and reimbursement cycle for providers? Are bills submitted in a timely fashion?
- Are providers being paid promptly?
- Is the program screening on track? On the basis of projects and history, is the program where it would expect to be by this time of year?
- If spending continued at the current rate, is it likely that the program will be over budget, under budget, or right on target? Are 60% or more of expended funds being used to pay for screening tests, diagnostic services, laboratory fees, and essential screening support services?

Key Message

A good practice is to pay providers AFTER they submit all of the required program data for a woman.

- Are all staff positions filled? If not, how long are they expected to be vacant?

(See Competitive Application or IPR in the Policies and Procedures chapter.)

Field Example

To increase the submission of forms with complete data, one program offers opportunities to train provider staff and makes its manual available on the Web. In addition, the program does not pay for services until the proper data forms are submitted and entered.

Contracting and Billing Processes

Programs are permitted and encouraged to contract with public and private entities for screening and diagnostic services or other programmatic activities. However, the amounts paid for screening and diagnostic procedures are not to exceed the Medicare reimbursement rates.
(See the Quality Assurance/Quality Improvement chapter.)

Administrative Reporting Requirements and Data Mechanisms

The scope and complexity of the NBCCEDP require that grantees keep accurate records and provide periodic reports to CDC. With input from program directors, CDC has developed several reporting mechanisms that make data collection and the generation of results more efficient and streamlined. CDC has documented most of the NBCCEDP administrative requirements in the Policies and Procedures chapter of this manual.

Field Example

In FY 2008–2009, one program conducted an evaluation study of the current capitation rate that is reimbursed to clinical providers to determine if it is adequate to cover clinical expenses. The outcome of this analysis will help determine if the capitation rate will be changed and implemented in FY 2011 or if the capitation system in its entirety should be evaluated and changed for an alternative system.

Reporting is necessary for a variety of reasons, because it provides the following:

- Key information for monitoring program progress, expenditures, and data quality

- Key information for developing reports to Congress, including the Congressional Budget Committee; to the media; and to NBCCEDP stakeholders, partners, and other key constituents
- A source for identifying research needs
- A source for identifying trends and issues that may be relevant to program success on a national level
- Surveillance information that contributes to measuring reductions in morbidity and mortality

Reports to CDC have varying due dates. CDC generally shares these due dates via a variety of communication vehicles, including official correspondences, blast e-mail messages, Web conferences, www.nbccedp.org, and program consultants.

Interim Progress Reports (IPR)

Each grantee must submit an IPR, previously referred to as a noncompetitive application, midway through the budget period. CDC's PGO typically provides guidance and relevant due dates to each grantee 45 to 60 days before the IPR due date. The IPR generally provides a review of program activities, as well as accomplishments and challenges for the first 6 months of the program year.

When preparing an IPR, grantees must estimate unobligated funds at the end of the current budget period and request that these funds be carried over into the next budget period. CDC may use up to 75% of these estimated unobligated funds to support the continuation award. Programs may also request and/or CDC may use unobligated funds from preceding budget periods to support the continuation award. These unobligated funds must have been reported on an FFR. Requests for unobligated or estimated unobligated funds can be included with the IPR, or they can be submitted later at the end of year with the FFR (see below).

Key Message

Grantees should be sure that the amount of estimated unobligated funds is fairly accurate because they will be responsible for making up the difference for any shortfalls in the estimate.

Programs should also understand that if they request 100% of the unobligated balance and the FFR is subsequently revised to reflect a lesser amount, their next awards will be reduced by the difference between the amount awarded and the revised unobligated balance. Unobligated dollars may be used for any legitimate activity or items related to the NBCCEDP scope of work, and they are subject to the 60/40 distribution requirement.

End-of-Year Progress Report or Annual Progress Report (APR)

These reports are due 90 days after the end of a budget period. They generally describe program activities, as well as accomplishments and challenges during the last 6 months of the program year.

Federal Financial Report (FFR)

All CDC grantees are required to submit a report of expenditures for each budget period. An annual FFR is due 90 days after the end of a budget period or program year. Grantees may request up to 100% of unobligated funds if there is a bona fide need. Grantees should work closely with their program consultant to develop an appropriate request. Grantees are encouraged to submit such requests as early as possible (i.e., with the IPR) and to be mindful of PGO submission deadlines. Requests for unobligated funds should be submitted no later than December 31 of the year in which they are reported. This timeframe increases the likelihood that requests will be processed in sufficient time for funds to be obligated before the end of the budget period. In collaboration with the program consultant, the decision to carry funds forward is made by the PGO Grants Management Officer/Grants Management Specialist.

If an unobligated balance remains at the end of the budget period, the Grants Management Officer/Grants Management Specialist (GMO/GMS), in conjunction with the program consultant, will determine the appropriate disposition of the unobligated balances. Depending on the outcome of the assessment, as the designated fiscal officer, the GMO/GMS may:

- Withdraw the excess funds by issuing an amendment to the NGA for the current budget period; or,
- Authorize some or all of the unobligated balance to be carried forward.
- The carryover may be used as an offset (reduction) to new funding (e.g., the budget and activity for the budget period remains as previously approved); or offset (reduction) to new funding (e.g., the budget and activity for the budget period remains as previously approved); or,
- Addition to the full level of previously approved funding (e.g., activities remaining from the prior budget are added to those of the current budget period and the budget are added to those of the current budget period and the budget is increased accordingly.

CDC accepts revised FFRs from grantees at any time (regardless of when the original FFR was due or submitted). If errors are discovered or unliquidated obligations were reported, programs have up to 15 months after the end of the budget period to submit a revised FFR. If no revised FFR is submitted within the 15 month timeframe, the last FFR submitted will be considered to be the final FFR.

Minimum Data Elements (MDE)

The MDEs are a set of standardized data elements, developed in collaboration with funded programs, for reporting demographic and clinical information on women served using NBCCEDP funds. The MDEs consist of information on women screened or diagnosed using program funds, including the following:

- Program enrollment location
- Patient demographic characteristics
- Patient-reported symptoms and screening history
- Screening services and results
- Diagnostic procedures and final diagnosis result
- Treatment initiation data
- Indication of NBCCEDP as a funding source by screening procedure, and diagnostic procedures

The MDEs are the data items considered to be minimally necessary for grantees and CDC to monitor and evaluate the program. Grantees are expected to report these data to CDC semiannually through MDE submissions.

(See the Data Management chapter for more information on the MDEs.)

Accessing Data Sources

In addition to the MDEs, grantees are encouraged to use other surveillance systems to review and augment data information (e.g., cancer registry programs for cancer incidence and mortality data). Linkages with and, in some cases, enhancements of these systems can help a grantee to

- compare cancer outcomes for women screened in the program with those of women in other regions;
- identify segments of the population at higher risk for disease, as well as populations at risk for not being screened;
- monitor the number, distribution, and quality of breast and cervical cancer screening resources, including mammography facilities, cytology laboratories, and providers who offer diagnostic services.

(See the Data Management chapter for more detail on using data sources for program planning, management, and evaluation.)

WORKING WITH CDC

Program Consultants

The primary role of CDC program consultants is to provide technical assistance and consultation, to be a resource, and to ensure good stewardship of federal funds.

Program consultants communicate regularly with programs through site visits, phone or conference calls, e-mails, and other means. Specific expectations of program consultants include the following:

- Monitoring cooperative agreements through ongoing review of program work plans and feedback regarding progress in meeting work plan objectives, ensuring program compliance with the cooperative agreement requirements
- Reviewing progress reports to determine that programs are meeting CDC-established performance expectations
- Monitoring progress toward meeting program objectives and helping grantees develop appropriate plans for improving and/or enhancing program performance
- Serving as a liaison to keep CDC management informed of program progress and issues, help develop and share program success stories and best practices, and provide funding recommendations
- Connecting programs with resources at CDC, in other states, in other federal agencies, and elsewhere
- Providing technical assistance on collaborations with priority populations, such as tribal representatives

Regular planned or scheduled communication with program consultants works well for some grantees. Grantees are always welcome to contact their program consultants by phone or e-mail to ask operational questions, seek policy clarification, or to strategize and solve problems.

Site Visits

CDC conducts routine site visits to stay current on program activities and progress. On occasion, problem-focused visits also are planned to address specific issues or concerns. In general, site visits have the following purposes:

- Orienting state, tribal, or territorial staff members
- Providing an opportunity for program consultants to gain an understanding of program operations, to visit provider sites, and to meet partners
- Solving problems and providing technical assistance in specific areas
- Addressing data quality and providing specific technical assistance for data management, collection, and analysis

The more the program consultant understands what a program does, how it operates, and what challenges it faces, the better he will be able to provide technical assistance and serve as an effective advocate.

To prepare for site visits, program directors work jointly with the program consultant to

- identify the purpose of the visit,
- specify site visit objectives,
- identify participants,
- develop an agenda and schedule,
- gather needed materials for review prior to the site visit.

Opportunities also will be sought to combine site visits with other related programs, such as the NPCR, NCCCP, and WISEWOMAN.

IV. EVALUATING PROGRAM MANAGEMENT

Measurable Objectives

Evaluation of program management should be guided by specific and measurable objectives that reflect a program's interests and priorities. Suggested objectives include the following:

- By [IPR submission date], budget review will have taken place, and reallocation of any unencumbered resources will be complete.
- By [date], all available staff positions will be filled with qualified individuals who collectively reflect the racial/ethnic diversity of the client population.
- All staff members will use data in preparing for their participation in quarterly retreats.

- Within XX months of IPR submission, tribal consultations will have been held (as appropriate).

Evaluation Questions

Once measurable objectives for program management are established, each of those objectives should be converted into a set of evaluation questions. Having identified these questions allows grantees to determine the best process for collecting needed data to answer them. The table below shows examples of evaluation questions for program management and suggested methods for answering those questions.

Evaluation Question	Uses of Evaluation Findings	Processes	Data Collection Strategy
Are there program objectives for each component?	Identify additional, and/or changes in, objectives	Review the work plan	Review the work plan
Have contracts and memoranda of agreement been developed for providers, consultants, and partners?	Identify gaps, and/or changes needed, in contracts and agreements Suggest additional contracts that may be useful	Review contracts and agreements	Locate and review contracts and agreements
Have qualified, technically diverse staff members been recruited and trained?	Identify needed staff members Guide recruitment efforts	Conduct performance reviews Identify work not being performed adequately and likely causes for this	Elicit thoughts and suggestions from existing staff members and partners about staffing needs and configuration

In evaluating program management, grantees should first start with the BCCEDP work plan then consider other questions of interest that were not included in the work plan. Additional questions to consider include the following:

1. Are there timelines with specified activities, lead person(s), and performance measures?
2. Are there administrative systems in place to identify, monitor, and report progress and delays?
3. Is there a system in place to document and update program and administrative guidelines and to maintain procedures to keep everyone informed of changes?
4. Does each staff person have a current position description?
5. Do program staff members use their time productively, and are they satisfied with their workloads, accomplishments, and work environment?
6. Was last year's budget request developed to correspond with the work plan and meet the administrative requirements and guidelines of the NBCCEDP?
7. Is the program over- or under-spending its budget? Why? What adjustments can be made to bring expenditures in line with the budget? How can the program project a more realistic budget next year?
8. Have strategies been identified to maximize available resources?

9. Has a schedule of allowable fees and charges for covered services been developed that is in compliance with federal requirements?
10. Are contracts and memoranda of agreement in place for providers, consultants, and partners?
11. Do women recruited into the program meet eligibility criteria?
12. Do partners feel that their affiliation with the program is positive and productive?
13. Have relationships been established and/or maintained with other key programs, such as Medicaid and Medicare?
14. Have fiscal accounting and billing procedures and referral services been established with Medicaid and Medicare?
15. Have all required reports been submitted?
16. Have the required reports been used for making decisions?
17. Have strategies been established to effectively engage in screening promotion activities?

V. RESOURCES

OTHER RESOURCES
CDC, Engaging, Building, Expanding: An NBCCEDP Partnership Development Toolkit, http://www.cdc.gov/cancer/nbccedp/pdf/toolkit/NBCCEDP_Toolkit.pdf
National Council for Public-Private Partnership, For the Good of the People: Using Public-Private Partnerships To Meet America's Essential Needs, http://www.ncppp.org/presskit/ncpppwhitepaper.pdf
Partnership for Prevention, 2005, Leading by Example: Improving the Bottom Line Through a High Performance, Less Costly Workforce http://www.prevent.org/Initiatives/Leading-by-Example.aspx
Public Health Foundation Learning Resource Center. (http://bookstore.phf.org) A Web site well worth browsing for video or computer training programs that can be purchased for a nominal charge and to which medical, nursing, or general continuing education units are attached. For example, the following are available: ***Management perspectives for public health practitioners.*** Through computer-based training, this course introduces new managers to basic concepts and practical tips for leading, motivating, and problem solving in the workplace. ***Selected literature of performance management.*** Comprehensive annotated bibliography that provides information and examples from scientific and other literature about performance management. It also provides a listing of "hot picks"—articles, books, or reports considered to be the most relevant and useful resources.
National Diabetes Education Program, Community Partnership Guide, http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=121
Meade, C., Menard, J., Luguu, J., Martinez-Tyson, D, and Gwede C. (2011). **Creating Community-Academic Partnerships for Cancer Disparities Research and Health Promotion**

Web Site *	
Cancer Prevention and Control Database, CDC	http://www.cdc.gov/chronicdisease/index.htm Contains references and program descriptions useful for training or general information.
Cancer Publications, CDC	http://www.cdc.gov/cancer/dcpc/publications/ Contains resources and training materials from DCPC and others.
***Uniform Guidelines for Employee Selection Procedures*, Equal Employment Opportunity Commission**	http://www.eeoc.gov/
***Morbidity and Mortality Weekly Report*, CDC**	http://www.cdc.gov/mmwr/
Management Concepts	https://www.managementconcepts.com/portal/server.pt/community/home/314 Offers specific courses on managing grants and cooperative agreements.
Federal Register	http://www.gpoaccess.gov/fr/index.html
45 CFR 92—Uniform administrative requirements for grants and cooperative agreements to state and local governments (A-102)	http://www.access.gpo.gov/nara/cfr/waisidx_99/45cfr92_99.html - Bing
45 CFR 74—Uniform administrative requirements for awards and subawards to institutions of higher education, hospitals, and other nonprofit organizations, and commercial organization; and certain grants and agreements with states, local governments and Indian tribal governments (A-110)	http://www.gpoaccess.gov/fr/index.html
HHS Payment Management System	http://www.dpm.psc.gov/access_pms/system_status.aspx
CDC Home Page	http://www.cdc.gov

* Because of the evolving nature of the Internet, Web sites noted in this chapter may no longer exist. In such cases, a global Internet search or search from the noted entity's homepage may be needed to locate specific documents and resources.

ATTACHMENTS

ATTACHMENT A

FRAMEWORK FOR DETERMINING 60/40 DISTRIBUTION

Points to Consider in Determining the Classification of a Program Cost as Part of the 60% Distribution Category

What is the intent of the activity? Example: Are you using a translator to help women communicate with their health provider at a screening site (60%), or are you using a translator to develop a new brochure (40%)?

What documentation is available to support this activity as a screening or diagnostic support or essential support services activity? Example: Do you have staff timekeeping records or activity reports that can verify that a staff member's time has been spent calling individual women for a referral or specific follow-up (60%) rather than for general data management activities (40%)?

How would an auditor view your classification of this activity?

What are program funds actually paying for? Example: An outreach program is designed to train community volunteers to recruit individual women for screening. The final outcome is one-to-one outreach/recruitment, but the program funds are actually paying for training services (40%), not for the volunteers' costs to conduct one-to-one outreach (60%).

Does the data management system serve primarily to retrospectively monitor and ensure the timeliness and adequacy of clinical services (40%), or does this system primarily serve to prompt case management/follow-up staff to contact individual women with abnormal screening results for referral and follow-up (60%)?

Law (60%)	Guidelines (60%)	Guidelines (40%)	Law (40%)
Screening tests Clinical breast exam Mammography Pelvic exam Pap test Follow-up and support services Client case management of abnormal results	Office visits Laboratory fees Diagnostic services Diagnostic mammogram Fine-needle aspiration Ultrasound Cyst aspiration Breast biopsy Endocervical curettage Colposcopy Colposcopy with biopsy Surgical consultation Others as determined by CDC and local medical advisory consultants Individual client services Translation Transportation Client intake Client counseling * By exception only (requires program consultant's prior approval) clinical supplies and equipment and incentives	Management and planning Partnership development Data management and analysis Promotional materials Administrative costs Billing	Public education Professional development QA/QI Evaluation Surveillance

Centers for Disease Control and Prevention
National Center for Chronic Disease
Prevention and Health Promotion
Division of Cancer Prevention and Control
Program Services Branch
770-488-4880

NBCCEDP Program Guidance Manual

Partnerships

Version 2

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Attachment A: Partnership Toolkit

I. INTRODUCTION TO PARTNERSHIPS

Overview of the Chapter

This chapter contains sample strategies and resources to assist in the development or enhancement of key partnerships. The chapter will provide guidance about how to expand and engage partners and sustain and evaluate their efforts.

Conceptual Framework

The Partnership component is represented as an extension to show that partnerships expand the reach, capacity, and resources of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Partnerships influence all components, and partners play a key role in advancing the broader goals of the NBCCEDP—enhanced access and quality for all women.

(See the Introduction to the Manual, NBCCEDP Conceptual Framework.)

Definition of Partnerships

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 join 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. These larger groups are often referred to as a network, coalition, consortium, or collaboration. The strongest partnerships occur when both mutual and individual goals are served by the joint agreement.

Purpose of Partnerships

The purpose of developing partnerships is to help programs reach their goals by

- expanding and maximizing resources;
- coordinating program activities;
- overcoming obstacles to the recruitment of NBCCEDP priority populations;
- promoting the delivery, improvement, and evaluation of breast and cervical cancer screening services.

Partnerships can offer the following:

- Additional skills and expertise (e.g., planning, design, and implementation of community assessments; provision of training and technical assistance; development and distribution of educational materials; planning, design, and implementation of program evaluation)
- Increased understanding of, and access to, priority populations for enhanced outreach, in-reach, and public education

- Increased understanding of and access to insured women for enhanced outreach and public education
- Increased opportunities for promotion of the NBCCEDP
- Coordination of public education about the issues related to breast and cervical cancer as they relate to other cancers and/or chronic diseases
- Advice on key medical and community issues (e.g., participation on medical advisory board, community advisory groups; assistance with guideline development)
- Increased access to data and interpretation of data
- Links to diagnostic services, treatment, survivorship counseling, and care
- Support for shaping policy change
- Individualized support for patients (e.g., transportation, translation)
- Additional venues through which quality screening can be provided
- Staffing, facilities, or other requirements for meetings

Essential Elements of Partnerships

To meet NBCCEDP's expectations in the area of partnerships, a grantee should seek out and establish partnerships and coalitions with, and among, entities such as cancer and chronic disease programs within your agency, external public health agencies, healthcare plans and networks, public and private businesses, service and social groups, nonprofit agencies and institutions, and interested individuals and representatives of priority populations who are willing to share their resources to extend the scope and impact of breast and cervical cancer screening activities and to increase population level screening. In general, the program should always look for partners with appropriate knowledge, skills, and resources on the basis of current and anticipated program needs. To increase population based screening, the grant recipient should:

- Develop and maintain collaborative partnerships with diverse agencies and organizations in the community and with clinical providers to conduct targeted outreach to ensure patient support, improve quality, and enhance coordination across all program components.
- Develop and maintain collaborative partnerships with other health jurisdictions in your area (e.g., districts, counties, states, and tribal organizations, as applicable) to increase the program's geographic coverage, provide or receive technical assistance, and gain or provide access to eligible populations in need of services.
- Develop and maintain collaborative relationships and data sharing agreements with central cancer registries to link the program's clinical data with cancer registry data and utilize these data in program planning, implementation, and evaluation.

To extend the scope and impact of breast and cervical cancer screening activities, the grant recipient should:

- Collaborate and actively engage with the Comprehensive Cancer Control Program (CCC) and coalition to increase awareness of effective policy, systems, and environmental (PSE) approaches that support cancer screening activities in the cancer plan.
- Execute formal agreements with key external partners organizations (e.g., Medicaid, federally qualified health centers (FQHCs), Medicare, health care systems, health insurers, and large workplaces) that reach large populations to support policy and health systems improvements, efficient use of resources, and increase high-quality cancer screening.

Competencies Needed to Implement Partnerships

Staff members responsible for developing effective partnerships need the ability to

- work effectively with diverse groups of people, which include both professional and community partners from a variety of cultural and educational backgrounds,
- facilitate meetings in an organized and efficient manner,
- help others organize and accomplish complex tasks, and
- focus on both the task (accomplishing the goals and mission of the partnership) and process (how the partners relate to each other).

Staff members responsible for developing effective partnerships need knowledge in

- stages in the development of partnerships and coalitions,
- methods for facilitating groups in developing a common mission,
- group dynamics,
- group problem solving techniques,
- reciprocity and how to work within that framework,
- conflict management and resolution strategies,
- data and assessment tools needed for action planning, and
- cultural differences and disparities.

II. DETERMINING THE NEED

Partnerships should be initiated to meet specific strategic needs. A program might ask the following questions to assess its partnership needs:

- Where is the program having difficulties reaching its goals and objectives? Is the program having trouble reaching priority populations, enlisting providers, developing population-based strategies,

conducting community assessments or accessing and interpreting other data, or evaluating the effectiveness of outreach efforts?
- What could be done more effectively with strategic partners?
- How might strategic partnerships assist in program efforts?
- To what extent do the perceived benefits of partnerships outweigh the perceived costs?

Programs also should consider the following factors when assessing the need for a particular partnership:

- Benefits or enticements to offer the partner. Possibilities include increased visibility, increased access to priority populations, increased networking opportunities, staff development, technical assistance, connections to key stakeholders, increased funding, and improved image.
- Shared goals. In a reciprocal partnership, there is both a common goal that is advanced by partners working together and individualized benefits for each partner.

Benefits of partnership, as well as potential benefits most often cited in the literature. These benefits include

- increased networking,
- increased information sharing,
- access to resources,
- access to the priority population,
- attainment of the desired outcomes from the partnership's efforts, and
- personal recognition and enhanced skills.

Costs of partnership. Some potential costs are

- time expenditure,
- loss of autonomy in shared decision making,
- expenditure of scarce resources,
- lack of direction in the partnership, leading to frustration,
- perceived lack of appreciation or recognition,
- burnout,
- lack of necessary skills, and
- perceived pressure for additional commitment.

Assessing Potential Partnerships

Finding the right partners is critical. Programs should consider the following:

- What potential partners have been identified?
- What is the expected outcome of the partnership?

- Has the program sought out new and nontraditional partners (e.g., organizations serving priority populations, such as lesbians, women with disabilities, and women from racial and ethnic minority communities)?
- Has the program sought out or strengthened partnerships with the kinds of partners required, such as Medicaid and Medicare, Federally Qualified Health Centers, and large workplaces?
- Which partners could help the program better achieve its goals and objectives?
- Does the program have a history of good relations with these potential partners?
- What specific resources will these potential partners contribute to the outcomes or products expected from the partnership?
- What might be some potential drawbacks in partnering with this organization?
- What resources would be valuable? Who has those resources?
- Could collaboration reduce costs or make reallocating funds possible?
- Does the organization understand and support our priorities or have similar priorities?
- Is there a person (a champion) who will work to make sure the partnership is successful?

Developing the Partnership

A number of steps are useful in initiating a partnership. The following steps are offered as suggestions, but each program will need to assess its own situation to determine which steps will be most useful.

1. Determine the appropriate level of partnership (networking, coordinating, cooperating, or collaborating) between the program and each potential partner:

- **Networking**—Exchanging information for mutual benefit.

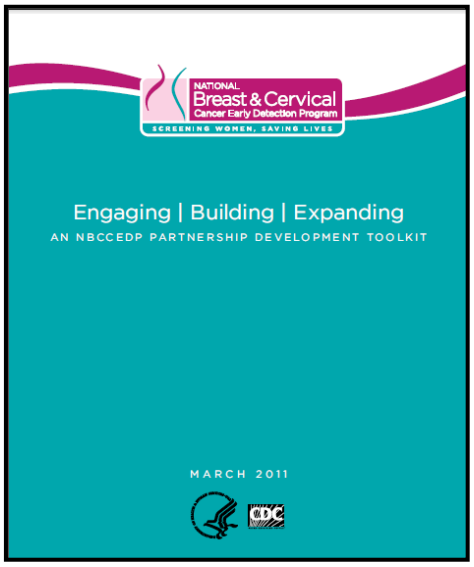
- **Coordinating**—Exchanging information and altering activities for mutual benefit to achieve a common purpose.

- **Integrating**—Exchanging information, altering activities, and sharing resources (e.g., staff, financial, technical) to achieve a common purpose for mutual benefit.

- **Collaborating**—Exchanging information, altering activities, sharing resources (e.g., staff, financial, technical), and enhancing each other's capacity for mutual benefit and a common purpose.

2. Determine the available resources the program can contribute to the partnership. Shared resources can include a variety of human, financial, and technical contributions, including program or community knowledge, staffing, stakeholder time, physical property, and access to people and/or funding.

3. Develop a document that outlines the mutual benefits of partnership. (See *Why You Should Partner with NBCCEDP Programs* in *Engaging, Building, Expanding: An NBCCEDP Partnership Development Toolkit* (Partnership Toolkit) found at www.NBCCEDP.org and www.cdc.gov/cancer/nbccedp/toolkit.htm.



4. Know your program and be able to describe it in a succinct manner. You should be able to answer: What does your program do? Why does it matter? How has your program been successful previously? (Review the *Sample Elevator Speech* and *Sample Answers to Common Partner Questions* in the Partnership Toolkit.

5. Meet with the partner in person if possible. Because a critical component of partnerships is relationship building, in-person meetings are always preferable.

6. Take the time to establish rapport and build trust. Building strong relationships takes time.

7. Give a general overview of the program (if the potential partner is unfamiliar with the NBCCEDP. (Refer to *Talking Points* in the Partnership Toolkit. Also have on hand your customized and updated *Program Profile Template* and the *About the Program* fact sheet to present to the potential partner.)

8. Explain the program's specific needs and why the partner would be helpful. (See *Making Your Case* in the Partnership Toolkit or *Sample Pitch Letter* if unable to meet in person.)

9. Ask about the partner's organization and perspective.

10. Learn about the culture of this potential partner, that is, the values, beliefs, etc., that should be taken into consideration when working together. This information can be gleaned by observing communication styles, asking direct questions, listening carefully, and asking others who have worked with this partner in the past. Based on your research, adapt your outreach and communications to "speak their language," fit their style and preferences, and ensure it is relevant to their organization.

11. Ask what needs the partner has, and discuss how the program might help meet those needs. Bring ideas from your preparatory research.

12. Make a clear and specific "ask" of the partner. If possible, your "ask" should be task-oriented with a beginning and an end. Don't expect partners to know what is needed. Make it as easy for them as possible to partner with you.

Formalizing the Partnership

Once an organization has agreed to partner with your program, it is important to formalize the relationship. The following steps are suggested.

1. Develop a shared vision, mission statement, and goals for the partnership.

2. Develop shared goals and objectives for the partnership, and design an action plan.

3. Discuss roles and responsibilities, and clarify the following:

- Who will do what
- Who will be the contact person for regular communications
- Timelines as appropriate
- Communications chain of command for media and external stakeholders

4. Agree on decision making procedures (e.g., who will decide what and how).

5. Brainstorm to set other ground rules for effective ways of working together.

6. Discuss anticipated problems or "rough spots," and identify strategies for addressing them.

7. Discuss conflict management styles and strategies.

8. Identify additional resources that are needed to accomplish the goals that are mutually agreed on. Ask if other partners need to be included in this partnership.

9. Discuss requirements for documentation or paperwork (e.g., progress reports), if appropriate.

10. Outline ways to evaluate the effectiveness of the partnership and its efforts.

11. Consider formalizing the partnership through a Memorandum of Understanding, contract, or some other written document. Consult the program's legal department for advice on exact wording.

12. Accommodate changes to strategies when and where necessary by being flexible.

Key Message

A program should review its need for each partnership on a regular basis and assess the partnership's effectiveness.

Maintaining and Sustaining a Partnership

A professional partnership takes time, nurturing, and respect. Programs should consider the following suggestions for working effectively with NBCCEDP partners:

1. Communicate regularly. Agree on a mutually convenient time and method for "checking in" with the partner. Check-ins can be verbal or written. Discuss what is working well, talk about problems, and develop strategies for resolving them.

2. Develop a feedback loop for assessing how the partnership is working for all partners. Build on successes, address problems, and explore ways to enhance the partnership.

3. Ensure that the action plan is being used for partnership activities.

4. Respect the partners' boundaries, structure, procedures, and processes.

5. Express appreciation through verbal or written comments.

6. With their permission, give partners credit and recognition in public forums (e.g., in meetings with key stakeholders and with the media). (See *Thank You Letter and Recognition Certificate* as well as the *Introduction to Public and Media Relations* in the Partnership Toolkit.)

7. Be flexible and open to change as the partnership develops.

8. Formalize a review of the partnership by creating an evaluation form that measures satisfaction with the partnership. A review should be done at least annually.

9. Discuss and use the results of the partnership evaluation to improve the partnership.

10. Discuss each of the partner's goals for the partnership over the long term and what criteria will be used for continuing the partnership.

11. Keep track of partnership activities, and evaluate progress and accomplishments.

12. Communicate results of partnership activities to partners and stakeholders to show areas of success and areas for improvement.

Reviving Faltering Partnerships

Sometimes the grantee has had a partnership or collaboration that did not function effectively—or at all. If this is the case, it may be important for the program to diagnose the difficulty and then generate ideas for addressing the problems. A review of studies examining the factors that lead to successful collaborations determined that the following factors were important for effective collaboration.

Factors Related to the Environment	**History of collaboration or cooperation in the community—**A history of collaboration or cooperation exists in the community and offers the potential collaborative partners an understanding of the roles and expectations, thus enabling them to trust the process. **Collaborative group seen as a leader in the community—**The collaborative group (including the agencies in the group) is perceived within the community as a leader—at least related to the goals and activities it intends to accomplish. **Political/social climate favorable—**Political leaders, opinion makers, persons who control resources, and the general public support the mission of the collaborative group.
Factors Related to Membership Characteristics	**Mutual respect, understanding, and trust—**Members of the collaborative group share an understanding and respect for each other and their respective organizations—how they operate, their cultural norms and values, limitations, and expectations. **Appropriate cross-section of members—**The collaborative group includes representatives from each segment of the community that will be affected by its activities. **Members see collaboration as being in their self-interest—**Collaborating partners believe that the benefits of collaboration will offset costs, such as loss of autonomy and turf. **Ability to compromise—**Collaborating partners are able to compromise, since the many decisions within a collaborative effort cannot possibly fit the preferences of every member perfectly.
Factors Related to Process and Structure	**Members share a stake in both process and outcome—**Members of a collaborative group feel "ownership" of both the way the group works and the results or products of its work. **Multiple layers of decision making—**Every level (upper management, middle management, operations) within each organization in the collaborative group participates in decision making. **Flexibility—**The collaborative group remains open to varied ways of organizing itself and accomplishing its work. **Development of clear roles and policy guidelines—**The collaborating partners clearly understand their roles, rights, and responsibilities, as well as how to carry out those

	responsibilities. **Adaptability—**The collaborative group has the ability to sustain itself in the midst of major changes, even if it needs to change some major goals, members, etc., in order to deal with changing conditions.
Factors Related to Communication	**Open and frequent communication—**Collaborative group members interact often, update one another, discuss issues openly, and convey all necessary information to one another and to people outside the group. **Established informal and formal communications links—**Channels of communication exist on paper so information flows smoothly. In addition, members establish personal connections, producing a better, more informed, and cohesive group working on a common project.
Factors Related to Purpose	**Concrete, attainable goals and objectives—**Goals and objectives of the collaborative group are clear to all partners and can realistically be attained. **Shared vision—**Collaborating partners have the same vision, with clearly agreed-on mission, objectives, and strategy. The shared vision may exist at the outset of collaboration, or the partners may develop a vision as they work together. **Unique purpose—**The mission, goals, or approach of the collaborative group differs, at least in part, from the mission, goals, or approach of the member organizations.
Factors Related to Resources	**Sufficient funds—The collaborative group has an adequate, consistent financial base to support its operations.** **Skilled convener—The individual who convenes the collaborative group has organizational and interpersonal skills and carries out the role with fairness. Because of these characteristics, the convener is granted respect or legitimacy from the collaborative partners.**

Field Example

One BCCEDP program reactivated a coalition by sending a letter to all previous members. Many responded that they were interested in continued participation. For those who were not interested or did not have time, a letter was sent to let them know that if their interest or time commitments changed, they would be welcomed by the coalition. The small core group met and had original members provide information on the coalition's history and continuity to support the new members.

Ending Partnerships

Sometimes programs outgrow the need for particular partnerships, or the needs change and the existing partnerships are no longer crucial. Grantees should not feel timid about discontinuing partnerships that are no longer needed. It is important that they thank the partner for his or her efforts, acknowledge and explain the reason for discontinuing the partnership, and make sure that the parting is amicable and mutually agreed on. If the partner expresses the desire to continue the partnership, the parties should work together to figure out ways to continue a relationship, perhaps at a less formal or intensive level.

Examples of NBCCEDP National Partners

CDC's Division of Cancer Prevention and Control (DCPC) has a number of national partners that promote its mission through programmatic implementation and activities that put research findings into action. These partners may or may not receive CDC funding. National partners may have regional, state, or local chapters or affiliates that assist grantees in accomplishing their goals. National organizations also may have useful materials or strategies that might be helpful to programs at the state, tribal, or territorial

level. (See *Working with Our National Partners* in the Partnership Toolkit for notes from partners on how to effectively work with them.) Examples of national partners are listed below.

American Cancer Society (ACS)—ACS works with NBCCEDP to (1) promote a standard cancer screening; (2) sponsor numerous recruitment strategies; (3) support women diagnosed with cancer; and (4) help increase awareness of the NBCCEDP.

Asian and Pacific Islander American Health Forum (APIAHF)—The APIAHF project was designed to improve cancer prevention, early detection, and survivorship among the Asian and Pacific Islander population.

Avon Foundation Breast Care Fund—The foundation collaborated with CDC to develop the Avon/CDC Foundation Mobile Access Program. Through this program, seven community organizations have been awarded grants to implement mobile mammography screening programs to reach underserved women.

Health Resources and Services Administration (HRSA)—HRSA houses the federally funded Community Health Centers program. CDC participates in a series of collaboratives designed to develop and implement quality improvement practices in cancer screening in community and migrant health centers. In addition, CDC funds a case management component of the Migrant Clinicians' Network, which ensures that migrant and mobile clients of the Community Health Centers program get the cancer screening follow-up they need, regardless of their location.

Field Example

To bring breast and cervical cancer education into correctional facilities within one State, the State's department of public health, the Avon Foundation Breast Care Fund, and the State Sheriffs' Association formed a partnership in January 2004. This partnership, known as The Butterfly Project, educates women about the importance of early detection of breast and cervical cancer. Working with the county sheriff's departments, women who are eligible for the State BCCEDP are transported for screening to their local health departments.

Indian Health Service (IHS)—IHS conducts a biannual Cancer Survivors Support Group Leadership Training Course for American Indian/Alaska Native cancer survivors who wish to start support groups in their communities. IHS also trains primary care providers in colposcopy.

Intercultural Cancer Council (ICC)—ICC developed a communications network that links health professionals, organizations, and individuals who work with underserved communities. ICC provides them with information about cancer prevention and control among those populations. DCPC uses this national network as a vehicle for disseminating information and for gathering feedback from member organizations and individuals on their cancer prevention experience with ethnic minority and medically underserved communities.

Lance Armstrong Foundation (LAF)—LAF develops and disseminates culturally relevant and linguistically appropriate materials and programs to improve cancer survivorship among African Americans, American Indians, Alaska Natives, Spanish speakers, and rural Americans. LAF also creates cancer awareness and education materials and programs.

National Cancer Institute (NCI)—NCI worked with CDC and ACS to create Cancer Control PLANET, a resource for planning, implementation, and evaluation. This resource serves as a portal to cancer-related data and new evidence-based tools that can help communities better understand and address their cancer burden. NCI collaborates with CDC on many activities. One such activity is co-leading and managing the Healthy People 2020 Cancer Goals and Objectives. Healthy People 2020 is a statement of national health objectives designed to identify the most significant preventable threats to health and establish national goals to reduce these threats. As co-leaders in the cancer area of Healthy People 2020, CDC and NCI are responsible for undertaking activities to move the Nation toward achieving the Healthy People 2020 goals and for reporting progress on the focus area objectives over the course of the decade.

Native CIRCLE—The Mayo Clinic's American Indian/Alaska Native Cancer Information Resource Center and Learning Exchange is a resource center that provides cancer-related materials to health care professionals and lay people involved in the education, care, and treatment of American Indians and Alaska Natives.

North American Association of Central Cancer Registries (NAACCR)—NAACCR develops resources to address cancer registration issues, including completeness, timeliness, and quality of the collection of data. NAACCR also develops educational materials and provides guidance and forums that promote the use of cancer registry data for cancer prevention and control.

Field Example

Partnerships often result in mutual benefits. The BCCEDP works with the state affiliate of the Susan G. Komen Breast Cancer Foundation. When the local Komen affiliate was ready to move from an all-volunteer organization to having a paid staff, it approached the state department of health for guidance. To support the foundation's mission to fund research grants and support education, screening, and treatment projects in communities, the BCCEDP recommended that it start by hiring a grants administrator. BCCEDP also assisted in the development of the grant request for proposal and grant evaluation tool. A BCCEDP employee works with the grants coordinator to present three annual grant writing workshops for community groups interested in applying for a Komen grant. All community grant applications to the foundation are reviewed by at least one member of the BCCEDP staff.

Another Komen Affiliate also has supported the BCCEDP by continually advocating for State funding to increase screening for women 40 to 50 years of age and to support the State Breast and Cervical Cancer Diagnosis and Treatment Program for women of all ages. Representatives from Komen are members of the Community Agency Committee, which assisted with the development of the State cancer plan's chapter on breast cancer and provided breast cancer literature to local programs. Through this strong partnership, Komen and the BCCEDP grantee were able to accomplish their own objectives, which ultimately benefited the women in their communities.

Susan G. Komen For the Cure—The foundation publishes educational breast cancer materials, directs women to CDC programs (including CDC's BCCEDP), and raises funds for breast cancer research and projects. It also supports community-based organizations (CBO) that are associated with BCCEDP by funding special projects.

United States Conference of Mayors (USCM)—USCM provides information about cancer prevention and control to all mayors, who can use the information to promote cancer awareness in their communities, paying special attention to underserved and high-risk populations. The Mayors' Campaign Against Breast Cancer raises awareness about breast cancer and breast cancer screening, and it refers eligible women to CDC's State-based screening programs.

United States Department of Agriculture (USDA)—USDA collaborates with CDC, NCI, some NBCCEDP grantees, and other community partners to increase the probability that women in areas of persistently high cervical cancer mortality will receive cervical and, if appropriate, breast cancer screening services and follow-up.

(For more information about other national partners and their activities, see http://www.cdc.gov/cancer/nbccedp/partners.htm.)

Regional and Local Partners

Grantees should establish collaborations with chronic disease programs within their agencies and other federally funded programs, such as the regional office of NCI's Cancer Information Service (CIS), HRSA's Office of Women's Health, Community and Migrant Health Centers, Title X Family Planning Programs, state offices for aging and minority health, IHS, and the Medicare program. In addition to local chapters of national organizations, there are many partners that are specific to particular grantees, regions, or communities.

Linkage and active collaborations are strongly encouraged with private-sector organizations, such as ACS; Young Women Christian Association; the Susan G. Komen Breast Cancer Foundation; CBOs serving ethnic and racial minority communities; organizations serving women with disabilities; professional organizations; local universities and other institutions of learning; survivors of breast and cervical cancer; local women's support groups; religious and civic groups; community leaders (both informal and formal) and members of the intended audience; managed care organizations; and other agencies and businesses in the community. Below are ways that worksites, medical professional organizations, and health systems may be valuable partners. (See *Ways to Work With Partners* in the Partnership Toolkit for additional ways that particular partner types may be useful to your efforts.)

Worksites are particularly important settings for health promotion and disease prevention. Employers not only have an obligation to provide a safe working environment, but also an opportunity to significantly improve the overall health and well-being of employees through worksite-based programs and policy changes. To increase quality screening, employers may:

- Implement worksite policies to support screening, including health care benefits that include coverage (and eliminate cost as a barrier to screening), time off for screening, and other worksite policies that enable access to quality screening.
- Increase general awareness of the need for screening through worksite wellness activities, including small media interventions and on-site education sessions.

(See *Increasing Quality Colorectal Cancer Screening: An Action Guide for Engaging Employers and Professional Organizations* (Increasing Quality Action Guide), Section 2 found at www.NBCCEDP.org for tips on working with employers.)

Medical professional organizations are also important access points for reaching a wide variety of health care providers. These organizations can represent different types of medical providers (physicians, physician assistants, nurse practitioners, patient navigators, and community health workers) and specialty care providers (family practitioners, general practitioners, internists, obstetricians, and gynecologists) as

well as organizational settings where care is delivered (public health departments, primary care clinics, and hospitals). To increase quality screening, professional organizations may

- Provide education to their members regarding recommended screening guidelines.
- Provide opportunities for training to increase skills related to delivery of quality screening.
- Assist members with incorporating system changes within their practices that support provision of quality screening, such as patient reminder systems.
- Influence policy makers and systems to incorporate changes that support quality cancer screening.

(See Increasing Quality Action Guide, Section 3 for tips on working with professional organizations.)

Health systems provide an avenue for reaching many individuals who need to be screened. Successfully working with these health systems to assist them in improving their screening processes allows the program to reach more people than it would by reaching out to these people individually. This cascading or multiplier effect makes for more efficient use of resources.

The following examples illustrate partnerships that have been forged by BCCEDP grantees.

Forming a medical advisory board—A medical advisory board is one example of a local collaboration of medical consultants that assists BCCEDP grantees by providing advice on such issues as screening and diagnostic guidelines or interpretation of program data.

Developing a community advisory group—Some programs have a community advisory group that, for example, helps the program better understand the priority populations, assists the program in reviewing educational materials, and gives feedback on program providers.

Establishing a coalition—Most states have already established comprehensive cancer control coalitions and do not need to establish new coalitions on a statewide level. However, some programs have also established regional or local coalitions. Another example might be an agreement by a group of oncologists to take nonpaying patients on a rotating basis.

Integrating the BCCEDP agenda into the work of ongoing coalitions or collaborations—Sometimes it is not necessary to form another coalition; instead, a grantee can look for opportunities to fold the program's agenda and needs into the work of an existing coalition. For example, the BCCEDP grantee could advance its goals through a working group or subcommittee of the state CCC coalition. All comprehensive cancer control plans include strategies aimed at increasing breast and cervical cancer screening and improving care for breast and cervical cancer patients and their families. The BCCEDP and the women it serves are the key beneficiaries of successful implementation of the breast and cervical cancer strategies outlined in the cancer plan. In addition, by working through CCC coalitions, BCCEDP grantees can increase access to additional partners to support program goals. For example, a CCC partner may be able to provide in-kind support for BCCEDP outreach and professional development activities and trainings (e.g., resources for meetings, professional expertise). This support may allow the BCCEDP grantee to shift outreach resources toward screening additional women.

Field Example

One BCCEDP has sought innovative strategies that stretch federal money to overcome barriers and reach uninsured women within the state. Through numerous collaborations with such organizations as the CCC coalition, the Appalachia Cancer Network, NCI's CIS, the Rural Health Education Partnerships Program, and many small community groups, including churches and aging groups, the program now reaches a larger proportion of the state's eligible population annually. On a larger scale, strategic partnerships with the Cancer Center, the Susan G. Komen Breast Cancer Foundation, ACS, the Mautner Project, and Avon have increased the program's ability to reach underserved minority populations and has increased its visibility.

As a result of the hard work involved in establishing collaborations with community organizations, this BCCEDP provided more women with potentially lifesaving free or low-cost screening services. These types of collaborations illustrate the importance of community involvement as an effective way to reach underserved populations.

III. EVALUATING PARTNERSHIPS

Programs must evaluate their partnerships to ensure that they are meeting the goals and objectives that led to their creation. For example, if a partnership was developed to increase access to a particular group of women, then the program should assess whether those women are being reached and enrolled for screening. Assessment of partnerships may encompass several areas, depending on the reason for establishing the partnership:

Expanding and maximizing resources—Partnerships can enhance both human and material resources available to the program and improve efficient use of those resources. Staff should evaluate whether or not additional resources have been acquired or resource expenditures have decreased (or not increased) as a result of the partnership.

Coordinating program activities—Partners can assist in conducting targeted outreach to ensure patient support, improve quality screenings, and enhance coordination across all program components. Staff should assess whether partners are working collaboratively to assist in these activities.

Overcoming obstacles to the recruitment of BCCEDP priority populations— Partners can play a key role in increasing the program's geographic coverage and in providing or receiving technical assistance that results in program improvement. Program staff should assess the increase in effectiveness of the program overall by assessing reach and quality improvement.

Promoting the delivery, improvement, and evaluation of breast and cervical cancer screening—Partners can be helpful in publicizing the BCCEDP services and giving feedback about the effectiveness of the program and its providers. The program director should evaluate whether partners are providing information and insights that can lead to program improvement.

Increasing awareness – Partners can broaden the reach when promoting effective policy, systems, and environmental approaches and improvements that support cancer screening. Staff should assess increased reach in these areas.

Measurable Objectives

Partnership evaluation should be guided by specific and measurable objectives that reflect a program's interests and priorities. Some suggested objectives are the following:

Key Message

Programs should remember that reciprocity is a key principle of sustainable and effective partnerships. They should always think about how each partner can benefit from the partnership.

Expanding and Maximizing Resources–By [date], two partners will assist in the development of an evaluation plan for the recruitment element of the program.

Coordinating Program Activities–By [date], two partners will assist the BCCEDP recruitment coordinator in recruiting participants in a Bells for Remembrance event.

Overcoming Obstacles to Recruitment of BCCEDP Priority Populations–By [date], the number of women recruited from the ["X"] population will increase from 50 to 100.

Promoting the Delivery, Improvement, and Evaluation of Breast and Cervical Cancer Screening–By [date], three partners will include information about the BCCEDP in their educational efforts (e.g., workshops, brochures).

Increasing Awareness–By [date], a partner will improve their internal policies or systems or will have actively influenced a policy, system, or environmental factor.

Evaluation Questions

Once measurable objectives for the partnership are established, each of those objectives should be converted into a set of evaluation questions. The table below shows examples of evaluation questions for partnerships and suggested methods for answering those questions.

Evaluation Questions	Uses of Evaluation Findings	Processes	Data Collection Strategies
Have we increased our human and other resources through partnerships?	Expand the reach of the BCCEDP through resource sharing	Review partnership meeting minutes	Conduct a document review
Have partners assisted us in coordinating any program activities?	Enhance program activities through increased participation	Review meeting minutes for key program activities Observe partner attendance at program activities	Conduct a document review
Has there been an increase in program or specific provider quality as a result of partnership efforts?	Enhance quality throughout the program	Review data Patient feedback forms	Review MDEs and track the need for follow-up or corrective actions
Have our partners promoted BCCEDP screening services? Are mechanisms for feedback in place?	Improve visibility and effectiveness of BCCEDP screening services	Interview partners Review small media	Conduct a document review of partner materials Review feedback from partners
Has awareness of the need for policy, systems, and environmental change increased through partnership efforts?	Broaden promotion activities beyond program eligible women	Interview partners Observe population-based strategies	Review screening rates across the state

In evaluating partnerships, the grantee should start with some evaluation questions related to the objectives and measures of success for partnerships described in the BCCEDP workplan. Then, the grantee should consider other questions of interest that were not included in the workplan.

The following questions also should be considered:

- How satisfied are all partners with the accomplishments of the partnership?
- Has the partnership identified challenges and ways to overcome obstacles?
- Have the partners completed an assessment tool and used the findings of the evaluation to improve partnership functioning?

V. RESOURCES

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* Because of the evolving nature of the Internet, Web sites noted here may no longer exist. In such cases, a global Internet search or search from the noted entity's homepage may be needed to locate specific documents and resources.

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