IA BCC Program Manual

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IOWA CARE FOR YOURSELF PROGRAM

INTRODUCTION

Increasing cancer screening rates among at risk individuals could reduce the number of deaths from breast and cervical cancers. Deaths from these diseases occur disproportionately among individuals who are uninsured or underinsured. Those who have no regular source of health care, individuals without health insurance and those who immigrated to the United States within the past 10 years underuse mammography and Pap tests\(^1\).

Congress, recognizing the value of screening and early detection, passed the Breast and Cervical Cancer Mortality Prevention Act of 1990. This legislation authorized the Centers for Disease Control and Prevention (CDC) to create the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). This program was created “to ensure that every woman for whom it is deemed appropriate receives regular screening for breast and cervical cancers, prompt follow-up if necessary and assurance that the tests are performed in accordance with current recommendations for quality assurance.” Presently, the NBCCEDP funds all 50 states, the District of Columbia, six U.S. territories and 13 American Indian/Alaska Native tribes or tribal organizations to provide screening services for breast and cervical cancer. The program helps low-income, uninsured and underinsured individuals gain access to breast and cervical cancer screening and diagnostic services. These services include

- Clinical breast examinations
- Mammograms
- Pap tests
- Pelvic examinations
- Human papillomavirus (HPV) tests
- Diagnostic testing for abnormal results
- Referrals to treatment
- Patient Navigation

The Iowa Care for Yourself (CFY) Breast and Cervical Cancer Early Detection Program (BCC) was initially funded by the CDC in 1993 and began screening participants in August of 1995. The BCC program’s priority population serves individuals age 50 to 64 years. Individuals of other ages may be eligible for some services.

Even with adequate health insurance, many individuals still face substantial barriers to obtaining breast and cervical cancer screening such as geographic isolation, limited health literacy or self-efficacy, lack of provider recommendation, inconvenient times to access services and language barriers.

In 2015, the CDC expanded the program’s focus to increase breast and cervical cancer screening rates among all individuals of appropriate screening age. This includes those who have:

- Health insurance, especially the newly insured
- Publicly funded insurance, such as Medicare or Medicaid
- Access to Indian Health Service or tribal health clinics
- Coverage through other programs or services

To provide services for the BCC program, local Boards of Health must have a signed contract with the Iowa Department of Public Health’s BCC program and designate an agency to provide recruitment, enrollment, patient navigation, tracking, follow-up and case management services. The designated agency is known as the local program and is expected to follow program policies and protocols. The local program designates a coordinator to implement the program’s activities.

Changes in the BCC program policies may be made without advance notice. Healthcare providers, facilities, staff and/or billing agencies will receive notification of pertinent program updates via mail.
POLICIES AND PROCEDURES

The purpose for these policies and procedures is to:

1. Establish and maintain written documents to provide consistency and accuracy of services being offered to eligible and enrolled participants.
2. Maintain program services if a local program coordinator or other BCC representative is unable to perform their duties.

Each local program is to maintain and follow the program’s written policies and procedures addressing the following participant elements:

- Eligibility and enrollment
- Patient navigation
- Tracking and follow-up
- Case management of participants with abnormal screening results
- Recall of participants for screening at appropriate intervals
- Healthcare provider recruitment, enrollment and orientation
- Obtaining and reporting data
- Submission of claims for reimbursement of services
- Outreach strategies

CONFIDENTIALITY STATEMENT

The BCC program endorses the health care standards of patient confidentiality. These standards apply to all individuals and agencies representing or working in any capacity with the BCC program. All information gathered belongs to the Iowa Department of Public Health (IDPH). It will be used only for program purposes, and no participant will be identified by name without written permission.

Confidentiality is both an ethical and legal responsibility. State and federal courts uphold the common patient confidentiality standards such as the American Medical Association (AMA) ‘Code of Ethics.’ Divulging medical information to a third party without appropriate permission from a participant is considered a breach of confidentiality. Revealing such information may include any or all types of communication (verbal, written, phone, fax, electronic, etc.) and is considered a breach of confidentiality whether intentional or unintentional.

All local programs and coordinators must uphold confidentiality practices. Participant records and information must be secured in a manner accessible only to BCC program representatives. This includes but is not limited to locking files, private areas for verbally communicating with participants (face to face or by telephone) and a method for securing participant information at an agency’s or representative’s workstation (desktop, computer, mail, etc.).
PROGRAM ELIGIBILITY

To qualify for the BCC program, each participant must meet age and income eligibility criteria.

Priority Population

Direct efforts should be made to identify and screen uninsured, underinsured and underserved individuals between the ages of 50 and 64 years. Refer to Table 1: BCC Program Screening Services Guideline for which services the participants are eligible for by age group.

Eligibility for Services

Age criteria:
- Individuals age 40 and over
- Individuals under age 40 with breast cancer symptoms

Income criteria:
- Net household income\(^2\) at or below 250 percent of the federal poverty level based on household size (refer to BCC program income guidelines found at [www.idph.iowa.gov/CFY](http://www.idph.iowa.gov/CFY))
- No proof of income is required
- Assets do not affect income status

Insurance criteria:
- Has no medical insurance
- Has medical insurance but is underinsured
- Has medical insurance but has at least one barrier to receiving services

Residency criteria:
- Iowa residency is not required
- Individuals residing in a state other than Iowa may receive services if their state of residence’s Medicaid Breast and Cervical Cancer Treatment (BCCT) option accepts participants screened/diagnosed with NBCCEDP funds.

NOTE: Individuals residing in a state who’s BCCT does not accept participants screened with another state’s NBCCEDP funds should be referred for services to the BCCEDP in their state of residence. A participant wanting to enroll in the CFY-BCC services must be informed that the BCCT Medicaid option in their state of residence may not be available should they need financial assistance for treatment.

Transgender individuals need to receive screening services. We provide services to:
- A transwoman who has taken or is taking hormones
- A transman who has not had a bilateral mastectomy or total hysterectomy.
- Some individuals may not identify as a woman but may still need to be screened, or may identify as a woman but may not need to be screened. As a general rule, if an individual has a certain body part (breast and/or cervix) and otherwise meets criteria for screening based on risk factors or symptoms, screening should proceed regardless of hormone use.

\(^2\) Net household income refers to take home pay or the amount of money earned after payroll withholding such as state and federal income taxes, social security taxes and pretax benefits like health insurance premiums. If enrolled in a flexible spending account to pay for medical costs, the amount withheld from each check is also on a pre-tax basis. Net Household Income is net income of each person living in that household whether or not they are related.
PROGRAM SERVICES
SCREENING POLICIES

The CDC screening policies for the NBCCEDP result from careful review of scientific research, analysis of many complex program issues and input from partners in the healthcare field. The BCC program implements the CDC’s recommendations.

The following must be assessed during enrollment for all participants:

- Personal history of high risk for breast cancer
- Personal history of high risk for cervical cancer
- Smoking behavior
  - All participants who currently smoke are to be provided information on smoking cessation and offered referral to the Quitline Iowa
  - For more information about Quitline Iowa, visit [https://iowa.quitlogix.org](https://iowa.quitlogix.org)
- Environmental secondhand tobacco smoke exposure
- Blood pressure measurements – two systolic/diastolic measurements taken at least two minutes apart must be recorded
- Height (inches)
- Weight (pounds)
- Personal medical history
  - Breast cancer
  - Hysterectomy and the reason for having the hysterectomy
- Brief family history of breast cancer

Table 1: BCC Program Screening Services Guideline

<table>
<thead>
<tr>
<th>Age</th>
<th>Blood Pressure, Height, Weight</th>
<th>Clinical Breast Exam</th>
<th>Mammogram</th>
<th>Pelvic/Pap test³</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>ONLY if reporting symptoms of breast cancer⁴</td>
<td>ONLY if reporting symptoms of breast cancer</td>
<td>ONLY if CBE is abnormal</td>
<td>ONLY if reporting symptoms of breast cancer</td>
</tr>
<tr>
<td>40 – 49</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually Symptomatic</td>
<td>Per BCC program protocol</td>
<td>Per BCC program protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>Symptomatic</td>
<td>Symptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>As indicated</td>
<td>As indicated</td>
</tr>
<tr>
<td>50 – 64</td>
<td>Annually</td>
<td>Asymptomatic</td>
<td>Asymptomatic</td>
<td>As indicated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annually Symptomatic</td>
<td>Per BCC program protocol</td>
<td>Symptomatic</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As needed</td>
<td>Symptomatic</td>
<td>As indicated</td>
</tr>
</tbody>
</table>

Over 64

Participants over age 64 who do not have Medicare Part B and meet income guidelines will receive services as above for ages 50 – 64 years.

³ Refer to Table 2: Recommendations and Rationale for Cervical Cancer Screening Protocol and Payment for Pap test Following Hysterectomy section.

⁴ Examples of breast cancer symptoms include but are not limited to an abnormal CBE, breast skin dimpling or retraction, palpable mass or nipple discharge, inversion or scaliness.
Breast Cancer Screening Services Protocol

Program eligible individuals may receive breast cancer screening services reimbursed by the BCC program. Refer to Table 1: Care for Yourself Program Screening Services Guideline for clinical breast exam and mammogram recommendations.

A participant with an abnormal breast screening result should receive timely and appropriate diagnostic testing and treatment as defined by the clinical guidelines endorsed by the Commission on Cancer of the American College of Surgeons, the American College of Obstetrics and Gynecology and the National Cancer Institute. Refer to Table 2: Algorithm for Breast Cancer Screening Follow-up Adequacy.

Cervical Cancer Screening Services Protocol

These guidelines are developed to address cervical cancer screenings in the BCC program general population. Every effort should be made to ensure that participants are screened at the recommended intervals. Refer to Table 3: Recommendations and Rationale for Cervical Cancer Screening Protocol.

A participant with an abnormal cervical screening result should receive timely and appropriate diagnostic testing and treatment as defined by the American Society for Colposcopy and Cervical Pathology algorithms: http://www.asccp.org/asccp-guidelines. When recommended follow-up and treatment are completed, the participant may receive cervical cancer screening paid for by the BCC program following Table 3: Recommendations and Rationale for Cervical Cancer Screening Protocol.

Payment for Pap test Following Hysterectomy:

- BCC program funds may pay for an initial pelvic examination to determine whether the participant has a cervix after a hysterectomy has been done. It is reimbursed as part of the office visit.
  - If a cervix (or cervical cuff) is present, BCC program funds may pay for a cervical cancer screening following the Cervical Cancer Screening Protocol.
  - If a cervix is not present, BCC program funds will not pay for cervical cancer screening.
- BCC program funds may pay for cervical cancer screening in participants with complete hysterectomy (no cervix remains) if the participant does not know if the reason for the hysterectomy was cervical cancer. Refer to Table 3: Recommendations and Rationale for Cervical Cancer Screening Protocol.

Exceptions to Cervical Cancer Screening Protocol

- These guidelines do not address high-risk populations who may need more intensive or alternative screening. These populations include individuals with:
  - A history of cervical cancer or history of CIN2⁵, CIN3⁶ or HSIL⁷
  - Human immunodeficiency virus (HIV) infection
  - Organ transplantation
  - Had diethylstilbestrol (DES) exposure in utero or
  - Immunocompromised from other health conditions.
- Participants who express concern about their cervical health or indicate changes in gynecological health status to the healthcare provider will be reviewed for reimbursement of cervical cancer screening services sooner than three (or five) years on a case-by-case basis.

⁵ Cervical intraepithelial neoplasia grade 2
⁶ Cervical intraepithelial neoplasia grade 3
⁷ High-grade squamous intraepithelial lesion
Table 2: Algorithm for Breast Cancer Screening Follow-up Adequacy

<table>
<thead>
<tr>
<th>CBE RESULT</th>
<th>MAMMOGRAM RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal/Benign (including fibrocystic, lumpiness or nodularity)</td>
<td>• Normal</td>
<td>• No work-up required</td>
</tr>
<tr>
<td></td>
<td>• Benign</td>
<td>• If work-up is planned, at least one diagnostic procedure must be done and a final diagnosis recorded</td>
</tr>
<tr>
<td></td>
<td>• Probably Benign (Short term follow-up indicated)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Suspicious Abnormality</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td>• High Suggestive of Malignancy</td>
<td>• Surgical consult for repeat breast exam</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Ultrasound</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Biopsy/Lumpectomy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fine Needle/Cyst Aspiration</td>
</tr>
<tr>
<td></td>
<td>Note: A mammogram or additional mammogram views only are not considered adequate</td>
<td></td>
</tr>
<tr>
<td>Abnormal (suspicious for cancer)</td>
<td>• Negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Benign</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Probably Benign (Short term follow-up indicated)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assessment Incomplete</td>
<td></td>
</tr>
</tbody>
</table>

8 This algorithm is inappropriate as a tool for clinical decision-making for individuals to determine whether certain providers are performing according to accepted national practices.

9 Clinical interventions based on clinical guidelines endorsed by the Commission on Cancer of the American College of Surgeons, the American College of Obstetrics and Gynecology and the National Cancer Institute.
### Table 3: Recommendations and Rationale for Cervical Cancer Screening Protocol

<table>
<thead>
<tr>
<th>Abbreviations</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC-US Atypical squamous cells of undetermined significance</td>
<td>HPV Human papillomavirus</td>
</tr>
<tr>
<td>ASCCP American Society for Colposcopy and Cervical Pathology</td>
<td>LSIL Low-grade squamous intraepithelial lesion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommended Screening Method</th>
<th>Management of Screening Results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages &lt; 21 Years</td>
<td>No cervical screening</td>
<td>HPV-positive ASC-US or Pap cytology of LSIL+(^{10}): Refer to ASCCP guidelines</td>
<td>HPV testing should not be used for screening or management of ASC-US in this age group.</td>
</tr>
<tr>
<td>Ages 21-29 Years</td>
<td>Pap cytology alone every three years</td>
<td>Pap cytology negative or HPV-negative ASC-US: Rescreen with Pap cytology in three years</td>
<td>HPV testing should not be used for screening in this age group.</td>
</tr>
<tr>
<td>Ages 30-65 Years</td>
<td>Cotest(^{11}) Screening every five years</td>
<td>HPV-positive ASC-US or Pap cytology of LSIL+: Refer to ASCCP guidelines</td>
<td></td>
</tr>
<tr>
<td>Preferred</td>
<td></td>
<td>HPV-positive, Pap cytology negative:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 1: 12-month follow-up with cotesting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 2: Test for HPV16 or HPV16/18 genotypes</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If HPV16 or HPV16/18 positive: refer for colposcopy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If HPV16 or HPV16/18 negative: 12-month follow-up with cotesting</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HPV-negative ASC-US: Rescreen with cotesting in three years.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cotest negative: Rescreen in five years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Primary HPV Test(^{12})Screening every five years</td>
<td></td>
</tr>
<tr>
<td>Acceptable</td>
<td>Screening with Pap cytology alone every three years</td>
<td>HPV Type Positive: Refer to ASCCP guidelines</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>HPV negative: Rescreen in five years with Primary HPV Test Screening.</td>
<td></td>
</tr>
<tr>
<td>Ages &gt; 65 Years</td>
<td>No screening if a participant has had an adequate prior negative screening history</td>
<td>Consult with a healthcare provider for individualized case-by-case follow-up care (reimbursement may not be covered by the BCC program)</td>
<td>Individuals with a history of CIN2/HSIL+ should continue screening every three years for at least 20 years after a period of frequent screening</td>
</tr>
<tr>
<td>After hysterectomy</td>
<td>No screening</td>
<td>Consult with a healthcare provider for individualized case-by-case follow-up care (reimbursement may not be covered by the BCC program)</td>
<td>Applies to individuals who no longer have a cervix and do not have a history of CIN2+ in the past 20 years or cervical cancer ever</td>
</tr>
</tbody>
</table>

\(^{10}\)“+” means Pap test results equal to or more severe than the original pathology of Pap test result listed

\(^{11}\)Pap test + HPV test = cotest

\(^{12}\)Primary HPV test = HPV test only
Table 4: Algorithm for Cervical Cancer Screening Follow-up Adequacy\(^{13}\)

NOTE: Pap Specimen Adequacy must be “Satisfactory” for Pap test results to be recorded.

<table>
<thead>
<tr>
<th>PAPANICOLAOU (PAP) TEST RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY(^{14})</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BETHESDA (TBS) 2001</strong></td>
<td></td>
</tr>
<tr>
<td>Negative for Intraepithelial Lesion or Malignancy</td>
<td>• No work-up required</td>
</tr>
<tr>
<td>ASC-US (Atypical Squamous Cells – Undetermined Significance)</td>
<td>• No work-up required, but follow-up at one year required</td>
</tr>
<tr>
<td></td>
<td>• If HPV test negative, co-testing follow-up at 3 years</td>
</tr>
<tr>
<td></td>
<td>• If HPV test positive, colposcopy required</td>
</tr>
<tr>
<td></td>
<td>• If work-up is planned, colposcopy must be done</td>
</tr>
<tr>
<td>Low Grade SIL encompassing:</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td>• HPV</td>
<td>• Negative HPV, repeat co-testing at 1 year</td>
</tr>
<tr>
<td>• Mild Dysplasia/CIN 1</td>
<td>• Negative HPV, colposcopy (with or without biopsy)</td>
</tr>
<tr>
<td></td>
<td>• No or Positive HPV, colposcopy (with or without biopsy)</td>
</tr>
<tr>
<td>ASC-H (Atypical Squamous Cells – Cannot exclude High Grade Squamous Intraepithelial Lesion [SIL])</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td>• Colposcopy</td>
</tr>
<tr>
<td></td>
<td>• Colposcopy with biopsy</td>
</tr>
<tr>
<td>High Grade SIL encompassing (with features suspicious for invasion):</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td>• Moderate &amp; Severe Dysplasia</td>
<td>• Colposcopy</td>
</tr>
<tr>
<td>• CIS/CIN 2 &amp; CIN 3</td>
<td>• Colposcopy with biopsy</td>
</tr>
<tr>
<td></td>
<td>• Loop Electrode Excision Procedure(^{15})</td>
</tr>
<tr>
<td></td>
<td>• Conization (^{1})</td>
</tr>
<tr>
<td>Squamous Cell Carcinoma</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td></td>
<td>• Colposcopy</td>
</tr>
<tr>
<td></td>
<td>• Colposcopy with biopsy</td>
</tr>
<tr>
<td>Abnormal Glandular Cells</td>
<td>One or more of the following:</td>
</tr>
<tr>
<td>Adenocarcinoma in situ (AIS)</td>
<td>• Colposcopy</td>
</tr>
<tr>
<td>Adenocarcinoma</td>
<td>• Colposcopy with biopsy</td>
</tr>
<tr>
<td></td>
<td>• Cold knife Conization (^{1})</td>
</tr>
<tr>
<td></td>
<td>• Endometrial Biopsy (^{1})</td>
</tr>
</tbody>
</table>

**PRIMARY HUMAN PAPILLOMAVIRUS (HPV) SCREENING ALGORITHM**

<table>
<thead>
<tr>
<th>HPV TEST RESULT</th>
<th>DIAGNOSTIC PROCEDURES REQUIRED FOR ADEQUACY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>• Routine Screening</td>
</tr>
<tr>
<td>12 Other High Risk HPV (hrHPV) Positive</td>
<td>• Cytology Required</td>
</tr>
<tr>
<td></td>
<td>• If Pap test negative, HPV test in 12 months</td>
</tr>
<tr>
<td></td>
<td>• If Pap Test greater than or equal to ASC-US, colposcopy required</td>
</tr>
<tr>
<td>Type 16/18 Positive</td>
<td>• Colposcopy</td>
</tr>
</tbody>
</table>

\(^{13}\) This algorithm is inappropriate as a tool for clinical decision making for individuals or to determine if certain providers are performing according to accepted national practices.


\(^{15}\) Must be preauthorized with BCC program state staff.
PATIENT NAVIGATION SERVICES

The CDC defines patient navigation as “individualized assistance offered to clients to help overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of treatment services for persons diagnosed with cancer.”

Participants often face significant barriers to accessing and completing cancer screening and diagnostics. Patient navigation is a process that the local program coordinator uses to guide participants through barriers in the healthcare system. Barriers to screening, diagnostics and treatment may include but are not limited to:

- Financial and economic
- Language and cultural
- Communication
- Healthcare system
- Transportation
- Fear
- Bias based on culture/race/age
- Need for child/elderly/family care
- Comfort level with provider/facility
- Disability

Policy

Patient navigation services are to be provided to all participants who enroll in the BCC program.

Patient navigation begins before anyone gets screened according to the CDC and ends when a participant completes screening and has a normal result, completes diagnostic testing and has normal results, initiates cancer treatment or refuses treatment.

Required Patient Navigation Activities

Patient navigation activities vary based on the participant’s barriers. At a minimum, patient navigation must include the following activities as well as a minimum of two contacts with the participant:

- Written assessment of individual barriers to cancer screening, diagnostic testing or initiation of cancer treatment
  - A barriers assessment form will be completed by the local program coordinator and the participant to obtain specific information identifying barriers and concerns
  - Local program coordinators will actively ensure that each participant receives services
- Resolution of barriers
  - If local program coordinators are unable to resolve barriers, the Health Services Coordinator should be contacted for assistance
- Participant education and support
- Participant tracking and follow-up to monitor participant progress in completing screening, diagnostic testing and initiating cancer treatment in a timely manner
- Collection of data to evaluate the primary outcomes of patient navigation, such as participant adherence to cancer screening, diagnostic testing and treatment initiation for all participants receiving navigation services
CASE MANAGEMENT SERVICES

Case management is a type of patient navigation. The CDC defines case management as “establishing, brokering and sustaining a system of essential support services for enrolled participants to identify and overcome barriers to definitive diagnosis and treatment.”

Participants with an abnormal breast or cervical screening result must be assessed further to determine need for case management services. If additional needs are identified, services to address the needs are to be provided. Abnormal breast or cervical screening results are as follows:

Clinical Breast Exam (CBE) – Abnormal results (suspicious for cancer) not limited to:
- Discrete Mass (Cystic or Solid)
- Bloody or Serous Nipple Discharge
- Skin Dimpling or Retraction
- Nipple/Areolar Scaliness

Mammography – Abnormal results of the following American College of Radiology categories:
- BIRADS III – Probably benign (short-term follow-up indicated)
- BIRADS IV – Suspicious Abnormality (consider biopsy)
- BIRADS V – Highly Suggestive of Malignancy

Pap Test – Abnormal results include:
- Atypical squamous cells – undetermined significance (ASC-US)
- Atypical squamous cells – Cannot exclude High Grade SIL (ASC-H)
- Low Grade squamous cells intraepithelial lesion encompassing: HPV, Mild dysplasia/CIN 1
- High Grade squamous cells intraepithelial lesion encompassing: moderate and severe dysplasia, CIS/CIN 2 and CIN 3
- Squamous cell carcinoma
- Atypical glandular cells
- Adenocarcinoma in situ (AIS)
- Adenocarcinoma

Duration of Case Management Services

Case management begins with an abnormal breast or cervical screening result as defined by CDC. Case management ends with:
- A completed diagnostic process with breast or cervical disease not diagnosed,
- Initiation of treatment for a diagnosed breast or cervical cancer,
- Refusal of treatment, or
- When the participant is no longer eligible for the BCC program.

A participant may re-enter the case management process with a new abnormal breast or cervical screening/diagnostic result or with the participant’s request for assistance.

Case Management Activities
- A barrier assessment form will be completed by the local program coordinator and the participant to obtain specific information to identify barriers and concerns.
- Local program coordinators will actively ensure that each participant receives appropriate services.
- If local program coordinators are unable to resolve problems for meeting barriers, the Health Services Coordinator will be contacted for assistance immediately.
Flow Chart for Abnormal Test Results

Abnormal test results

Local CFY-BCC staff notified

Local CFY staff follow & document process to contact participant

Additional barriers identified

None identified

Plan established, actions taken

Barrier Assessment plan revisited

PARTICIPANT CONTACTED

Reassess/monitor

UNABLE TO CONTACT PARTICIPANT

Identified resources contacted

Complete diagnostic results form; document as ‘Lost to Follow-Up’ or ‘Work-Up Refused’

Appointment(s) for diagnostic testing made

Diagnostic tests performed & documented

Cancer diagnosed

Cancer not diagnosed

Submit diagnostic results in electronic data system

Referred & entered in appropriate treatment
DIAGNOSTIC SERVICES

Enrolling for Diagnostic Services

- Individuals aged 40 and over with a recent abnormal CBE, mammogram, Pap test or HPV test may be enrolled in the BCC program for diagnostic breast and cervical cancer screening services. A person must meet eligibility criteria and the abnormal results must be documented in the program’s database.
- A participant under age 40 is not eligible for BCC program diagnostic services unless they have breast cancer symptoms and have received screening services provided by the BCC program.

Table 5: BCC Program Diagnostic Services Guideline

<table>
<thead>
<tr>
<th>AGE</th>
<th>BREAST</th>
<th>CERVICAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td>Diagnostic services are available if:</td>
<td>Diagnostic services are available if:</td>
</tr>
<tr>
<td></td>
<td>1. CBE and/or mammogram is abnormal and</td>
<td>1. Pap or HPV test was abnormal and</td>
</tr>
<tr>
<td></td>
<td>2. Screening services received through the BCC program</td>
<td>2. Screening services received through the BCC program</td>
</tr>
<tr>
<td></td>
<td>Services same as 50 – 64 year old</td>
<td>Services same as 50 – 64 year old</td>
</tr>
<tr>
<td>40 – 49</td>
<td>Same as 50 – 64 year old</td>
<td>Same as 50 – 64 year old</td>
</tr>
<tr>
<td>50 – 64</td>
<td>Diagnostic services are available if CBE and/or mammogram is abnormal.</td>
<td>Diagnostic services are available if Pap or HPV test is abnormal.</td>
</tr>
<tr>
<td></td>
<td>BCC program funds will reimburse for:</td>
<td>BCC program funds will reimburse for:</td>
</tr>
<tr>
<td></td>
<td>1. Surgical consultation visit for repeat CBE</td>
<td>1. Surgical consultation</td>
</tr>
<tr>
<td></td>
<td>2. Mammogram</td>
<td>2. Colposcopy (with or without biopsy)</td>
</tr>
<tr>
<td></td>
<td>3. Biopsy/Lumpectomy</td>
<td>3. Pathology fees</td>
</tr>
<tr>
<td></td>
<td>4. Ultrasound</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Fine needle/cyst aspiration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. Pathology fees</td>
<td></td>
</tr>
<tr>
<td></td>
<td>7. Pathology consult during surgery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>8. Anesthesia time</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If a breast MRI is preauthorized, BCC program funds will pay for the procedure.</td>
<td>If the procedure is preauthorized BCC program funds will reimburse for:</td>
</tr>
<tr>
<td></td>
<td>BCC program funds cannot be used to reimburse for any treatment or to determine the extent of breast cancer or pre-cancer.</td>
<td>1. LEEP or conization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Endometrial biopsy (for AGC Pap results only)</td>
</tr>
<tr>
<td>Over 64</td>
<td>BCC program diagnostic services are not available if an individual has Medicare Part B. If an individual does not have Medicare Part B, they should receive services as 50 – 64 year old.</td>
<td>BCC program funds cannot be used to reimburse for any treatment or to determine the extent of cervical cancer or pre-cancer.</td>
</tr>
</tbody>
</table>
Preauthorization

Authorization for reimbursement of certain procedures must be obtained prior to the procedures being performed. Preauthorization can be obtained by calling the Health Services Coordinator at (515) 242-6200.

Preauthorization is needed for the following procedures:
- Breast magnetic resonance imaging (MRI) - screening and diagnostic
- Cervical
  - Loop Electrode Excisional Procedure (LEEP)
  - Cervical conization
  - Endometrial biopsy

Breast Services

Individuals at high risk for breast cancer should get annual mammograms and annual screening breast MRIs. It is normal practice that the screenings are done six months apart. The MRI is done no matter the results of the mammogram.

A participant is considered high risk for breast and qualifies for a screening MRI in conjunction with a mammogram when the participant has:
- Tested positive for a BRCA mutation
- A close relative that has tested positive for a BRCA mutation
- A first degree relative with breast cancer (parent, sibling or child)
- A history of radiation treatment to the chest area before the age of 30
- A lifetime risk score of 20 percent or greater for development of breast cancer based on risk assessment models that are largely dependent on family history.

Preauthorization for reimbursement of a diagnostic MRI of the breast must be obtained before performing the procedure. The Health Services Coordinator is responsible for granting preauthorization. Reimbursement of an MRI may be possible:
- If the participant has a past history of breast cancer
- The radiologist is recommending MRI to assess areas of concern

The breast MRI will not be reimbursed by the BCC program if it is being used as a screening tool for average-risk participants or to assess the extent of disease of a participant who was recently diagnosed with breast cancer.
Cervical Services
Preauthorization for reimbursement of a LEEP, cervical conization or endometrial biopsy as a diagnostic procedure must be obtained before performing the procedure. The Health Services Coordinator is responsible for granting preauthorization. These include:

- High Grade Squamous Intraepithelial Lesions
  Reimbursement of a LEEP or conization of the cervix for diagnosis is based on the ASCCP algorithm for *Management of Women with High-grade Squamous Intraepithelial Lesions*.

- Atypical Glandular Cells
  Reimbursement of a cold conization of the cervix for diagnosis is based on the ASCCP algorithm for *Management of Women with Atypical Glandular Cells*.

- Atypical Glandular Cells
  Reimbursement of an endometrial biopsy for diagnosis is based on the ASCCP algorithm for *Management of Women with Atypical Glandular Cells*. 
REFUSAL OF SERVICES OR LOST TO FOLLOW-UP

In some cases, participants do not follow through with recommended screening, diagnostic and/or treatment services. Every attempt should be made to ensure participants have adequate diagnostic and/or treatment follow-up required by the BCC program. The following processes are only required after an abnormal screening result or breast/cervical precancer/cancer result if the participant is not getting further services.

Refusal Of Services

A participant should be documented as “Refused” when:
1. The participant verbally refuses any recommended follow-up care.
2. The participant refuses in writing any recommended follow-up care.

It is recommended that participants be notified verbally, if possible, and in writing of what type of follow-up is needed, when it is needed and what may happen if the follow-up does not occur. A draft letter can be obtained from the Health Services Coordinator. Documentation of the informed refusal should be kept in the participant’s file. This can be done either by documentation quoting the verbal conversation that occurred with the participant or by having the participant sign a form that states specifically what is being refused and acknowledges the risks involved if not completing the recommended follow-up.

Lost To Follow-Up

A participant should be documented as “Lost to Follow-Up” when:
1. At least three contacts are attempted and documented in the participant’s file. This documentation should include the type of contact attempted, date and the outcome.
2. The last contact attempt is by certified mail with a return receipt. A draft letter can be obtained from the Health Services Coordinator. A copy of the certified letter and the return receipt should be kept in the participant’s file. If the letter is returned without signature, the letter and unsigned receipt should be kept in the participant’s file.

Methods for Contact Attempts

It is recommended that different methods be used to contact an individual for completion of any follow-up services. This includes:
- Telephone,
- Written communication,
- Call the contact person listed on the last enrollment, but maintain confidentiality
- Contact the healthcare provider for additional contact information or
- Other options identified and documented.

Local program staff may continue to follow or track a participant’s progress for quality of care issues, but documentation of the participant’s refusal or lost to follow-up status needs to be done in the live web-based database.
TREATMENT SERVICES

In 2001, Iowa Legislators enacted federal legislation called the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000. During the 2013 Iowa Legislative session, the eligibility criteria of the Iowa law changed. The changes provided access to Medicaid benefits during the treatment period to male and female Iowans diagnosed with pre-cancerous or cancerous breast conditions and individuals diagnosed with precancerous or cancerous cervical conditions not paid for with NBCCEDP funding.

Eligibility for Referral to the IA Breast and Cervical Cancer Treatment (BCCT) Option of Medicaid
1. An individual (male or female) is eligible for the BCCT option of Medicaid if the individual:
   a. Is not covered by a mandatory category of Medicaid
   b. Has not reached age 65
   c. Received breast or cervical cancer screenings or related diagnostic services provided or funded by:
      i. A National Breast and Cervical Cancer Early Detection Program
      ii. Family planning centers
      iii. Community health centers
      iv. Non-profit organizations
   d. Does not have creditable insurance coverage for breast or cervical cancer treatment
2. The individual must meet the income eligibility requirements established by the BCC program
3. The individual must be diagnosed with a precancerous/cancerous breast or cervical condition and require treatment for the diagnosis

Presumptive Eligibility (PE)
Presumptive Eligibility offers immediate health services access by providing temporary health insurance through Medicaid. The Department of Human Services (DHS) authorizes local employees to make BCCT PE determinations.

PE Rules
1. Must be an Iowa resident
2. Must be a US citizen or qualified alien
   Exceptions: Pregnant Women and BCCT applicants
3. Must not have received PE in the last 12 months for the same condition
   Exceptions: Pregnant Women and BCCT applicants

Notes:
- PE is granted on a day-by-day basis.
- An individual may only have PE once during a 12-month period.
  Exceptions:
  An individual is diagnosed with breast or cervical cancer/precancer, has treatment and then has a new diagnosis.
  A woman is pregnant, delivers and is pregnant within the same 12-month period.
- If the individual’s treatment is expected to exceed 45–60 days, the person will need to complete a full DHS Health Services Application (HSA). The application is available from DHS.
Presumptive Eligibility Provider (PEP)

The DHS authorizes certain individuals to make BCCT PE determinations. This person is known as the Qualified Entity.

1. The Qualified Entity can help the individual to fill out the necessary information on the DHS’s HSA form. To have a valid PE application, the following information is needed:
   - First name, middle initial and last name
   - Full address with county of residence
   - Application Date (date application is entered online on the Iowa Medicaid Presumptive Eligibility Portal)
   - Gender
   - Date of Birth
   - Applying for PE
   - Type of PE
   - Had PE in last 12 months
   - Receiving Medicaid
   - Resident of Iowa
   - Signature and date

2. The Qualified Entity will complete the PE application online with the above information.

3. The Qualified Entity should print and make copies of the:
   - Notice of Action
   - Application for Benefits

   These forms provide the individual’s assigned Medicaid identification number. The original Notice of Action is for the individual to show to providers, and the copy is for your files.

Non PEP

If a local organization does not have an individual authorized from the DHS to make BCCT PE determinations, the local organization needs to:

1. Assist the individual with completing a full DHS HSA,
2. Complete a Medicaid Treatment Option Eligibility Verification form. This form is available from the Health Service Coordinator.
3. Refer the individual to the DHS office for their county of residence. Ongoing Medicaid may start on the first day of the month approved for Medicaid by DHS.

ASSISTANCE:

Once an individual is enrolled for BCCT Medicaid services, the person has access to full Medicaid benefits for the duration of treatment for a precancerous/cancer breast or cervical diagnosis.

STATE CONTACTS:

Department of Public Health
  Care for Yourself Program:
  Jolene Carver
  (515) 242-6200
  jolene.carver@idph.iowa.gov

Department of Human Services:
  Amelia Alibasic
  (515) 281-4521
  AAlibas@dhs.state.ia.us
RESCREENING SERVICES

Rescreening is the process of returning for a screening test at a predetermined interval. The yearly interval for the NBCCEDP is 10 to 18 months. Screening at regular intervals decreases a person’s risk of dying from breast cancer or developing cervical cancer.

Recall Reminder System
Responsibilities

- The BCC program data manager generates the rescreening reminder lists from the database.
- BCC program state and local program staff are responsible for:
  - Reviewing information that is sent to individuals as a yearly reminder that it is time for screening, including the importance of regular screening leading to early detection and a better outcome if diagnosed with breast or cervical cancer.
  - Implementing the reminder system determines when an individual is due for screening services based on the last dates of CBE, mammogram and Pap or HPV test.
- Local program staff are responsible for:
  - Indicating whether their local program or the state program will be responsible for sending the yearly reminder to the individual.
  - Determining if an individual is still eligible for BCC program services.
    - If the person is not eligible, document the reason in the live web-based data system. A copy of this form is to be kept in the individual’s file.
      - Note: A person is determined to be ineligible if they have:
        - Insurance to pay for services and no barriers
        - Moved without forwarding address
        - Age (< 40 years without breast issues)
        - Net household income > 250 percent of the federal poverty guidelines
        - Lost to follow-up
        - Deceased
        - Declined re-enrollment
      - Documentation must be changed later if the individual becomes eligible to receive services again. A copy of the form is kept in the individual’s file.
  - Document the date of the reminder contact(s) in each individual’s file.
- The Health Services Coordinator administers the rescreening process. This includes: training, verifying local program compliance, reviewing, and updating the policy and evaluating barriers.

Reminder Process

- Contact an individual approximately 11 months following a screening procedure date and encourage them to re-enroll for services.
- If the individual has not contacted the local program approximately one month following the first contact, the local program staff will attempt a second contact to individuals 50 years or older. Participants aged 49 years and younger do not need a second contact.
- If these contacts fail to produce re-enrollment of an individual, send a letter to the participant’s last known mailing address approximately two weeks following the second reminder. The letter will inform the individual that they are due for rescreening, explain the importance of regular screening and ask them to contact the local program. If the person does not respond to the final reminder within approximately 30 days, document the individual as “not interested.”
- Each program may choose to enroll individuals aged 40 – 49 if they contact the program but the program must meet the core indicator that 75 percent of the federally funded mammograms are provided to participants age 50 and over.
• Use various methods to contact an individual for rescreening. This includes:
  o Telephone
  o Written communication (letter or reminder card)
  o Contact the individual’s healthcare provider for additional information
  o Call the contact person listed on the individual’s last enrollment but maintain the individual’s confidentiality or
  o Other options identified and documented
• Attempts to contact the individual should be documented in the individual’s BCC program file. It is not necessary to document a reason for not contacting an individual under age 50 for rescreening.

Transfer Of Participant Between Programs

If a participant was screened by a local program in a prior year and enrolls for services in a different program in a subsequent year, the participant’s screening and/or diagnostic information will need to be transferred into the database.
• To start the transfer of information, determine if the participant is currently enrolled in the program by using the University of Iowa (UI) web-based database: [https://careforyourselfiowa.com](https://careforyourselfiowa.com). All participants previously or currently enrolled are listed with the program identified.

<table>
<thead>
<tr>
<th>Client Name</th>
<th>ID #</th>
<th>Prog#-Client#</th>
<th>Date of Birth</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>MARY SMITH</td>
<td>9940</td>
<td>77-1943</td>
<td>09/03/1948</td>
<td>Transfer</td>
</tr>
<tr>
<td>MARY SMITH</td>
<td>8101</td>
<td>74-7542</td>
<td>12/11/1954</td>
<td>Transfer</td>
</tr>
<tr>
<td>MARY SMITH</td>
<td>7966</td>
<td>74-7316</td>
<td>11/17/1946</td>
<td>Transfer</td>
</tr>
</tbody>
</table>

• If the participant is enrolled with another program or has been in the past, contact the program coordinator to check current enrollment status. *The most current enrollment information may not be entered in the UI database.*
• Once the participant transfer is agreed upon, use the UI database to process the request. Login to the website and do the participant search. Verify that it is the correct participant and click “Request a Transfer”.
• A transfer of the participant’s information from one program to another must be initiated through the data reporting system. The request needs to be completed by the 25th day of each month to allow adequate processing time.
• Once the UI staff have completed the transfer in the database, you will receive an email.
REIMBURSEMENT SERVICES

The BCC program contracts with a third party payer to process claims and reimburse healthcare providers for covered services.

Reimbursable Services

Federal law requires that reimbursement with federal funds may not exceed Iowa Medicare Part B rates. Medicare and BCC program reimbursement rates are updated annually after the rates are released by the Centers for Medicare and Medicaid Services (CMS). Updated information is available on the BCC program website at https://www.idph.iowa.gov/cfy/information-for-healthcareproviders.

Claims for payment of BCC program services will only be accepted for reimbursement for one year following the individual’s date of service. Claims received after the filing deadline will be entered into the Billing System and denied for not being filed in a timely manner. Claims denied for late filing may not be billed to the client.

The BCC program is the payer of last resort. An Explanation of Benefits (EOB) must be obtained from an insurance company when appropriate. The BCC program will reimburse for copay and deductibles up to the amount indicated on the BCC Program Reimbursement Schedule for the portion not covered by insurance.

An individual enrolled in the BCC program should not be billed for:

- Any program-covered service.
- Claims denied for not filing in a timely manner.
- Collection and transportation of specimens. These costs are to be covered by the office visit reimbursement. They should not be billed separately.

Note: The participant may be billed for services not covered by the BCC program. The participant must be made aware before the service is provided that the BCC program will not cover the procedure and the cost will be her responsibility.

Claims Reimbursement Report

When claims payment is made, the third party payer will enclose a list of participating patient/participants with the payment. The list will include the individual’s name, date of birth, date of service, the CPT and ICD-10 codes, amount billed, amount allowed and the amount paid. An individual may not be billed for BCC program-covered services.

If reimbursement is denied, an explanation of denial will be included on the list. A BCC program participant may be billed for services not covered by the program.

QUESTIONS

Questions about claims should be directed to:

Medical Billing Services
Iowa Screening Programs
500 East Court Ave Suite 305
Des Moines, IA 50309-2057
(515) 237-3974

Questions about Cooperative Agreements should be directed to the Iowa Department of Public Health’s Care for Yourself Program at 1-866-339-7909.
CORE INDICATORS

A set of standardized data elements, Minimal Data Elements (MDEs), are used to collect demographic and clinical information on women screened with BCC funds. The MDEs are reported to CDC twice a year and represent a subset of data required by CDC to monitor screening performance. Screening and diagnostic data collected on women reported in the MDEs must meet all data quality standards set by CDC.

Part of the MDEs are the Core Indicators that help CDC and the BCC staff monitor the quality and performance of the BCC program. The Core Indicators are reviewed by the BCC program Data Manager and Health Services Coordinator monthly. Local program coordinators are contacted to make the changes or for clarification of the care provided if changes in documentation are not needed.

Listed below are the eleven Core Indicators that have been set by CDC to monitor and compare the 70 NBCCED Programs. The first six monitor cervical screening and the last five monitor breast screening. The following examines each Core Indicator individually.

Cervical Core Indicators

Core Indicator 1:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 6.a - Percentage of initial program Pap tests provided to never/rarely</td>
<td>221</td>
<td>981</td>
<td>22.5</td>
<td>YES</td>
</tr>
<tr>
<td>screened women (goal: &gt;= 20%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The threshold goal for Core Indicator 1 is greater than or equal to 20%. Another way to describe this goal is that one out of five new participants enrolled and screened by the program must be never or rarely (not screened within the last five years) screened. This Core Indicator can be difficult to manage as most participants enter the BCC program for mammography services. Looking at the above example, out of the 981 new participants enrolled in the program, 221 (22.5%) were considered never or rarely screened; therefore this Core Indicator was met.

Core Indicator 2:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 11.a - Percentage of abnormal Pap tests with complete follow-up (goal:</td>
<td>22</td>
<td>23</td>
<td>95.7</td>
<td>YES</td>
</tr>
<tr>
<td>&gt;= 90%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Core Indicator 2 has a threshold goal of greater than or equal to 90%. This indicator measures the timeliness of diagnostic testing and diagnosis of abnormal Pap tests, as described by CDC. This example shows that there was one participant that did not have a complete follow-up, putting the program at 95.7% or met. There may specific barriers that would prevent a program from meeting this follow-up goal including: participant refusal, loss of contact with the participant, or provider guidance to extend follow-up. The local program coordinator would be responsible for reporting the reason for the incomplete or late follow-up.
Core Indicator 3:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 16.d. - Percentage of abnormal Pap tests where the time between the Pap test and final diagnosis was &gt; 90 days (goal: &lt;= 25%)</td>
<td>2</td>
<td>20</td>
<td>10</td>
<td>YES</td>
</tr>
</tbody>
</table>

A threshold goal of less than or equal to 25% is expected to meet Core Indicator 3. The NBCCEDP has quality standards for timeliness of follow-up for cervical cancer screening when diagnostic work-up is indicated. The time from screening to a final diagnosis must be no more than 90 days. This core indicator typically has smaller abnormal results, making meeting the threshold difficult. In looking at this denominator, only 20 participants had diagnostics done. Two (10%) of the participants were outside the 90 days. The indicator was met but it did give the BCC program a higher percentage.

Core Indicator 4:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 17 - Percentage of final diagnosis of HSIL, CIN II, CIN III/CIS, or invasive cervical carcinoma where treatment has been started (goal: &gt;= 90%)</td>
<td>23</td>
<td>24</td>
<td>95.8</td>
<td>YES</td>
</tr>
</tbody>
</table>

Core Indicator 4 has a threshold goal of greater than or equal to 90%. The NBCCEDP has quality standards for timeliness of follow-up for cervical cancer screening if cancer is diagnosed, the time from diagnosis to the start of treatment must be no more than 90 days. This example shows there were 24 participants that were diagnosed with cervical cancer with 23 (95.8%) having started treatment for the finding, making this Core Indicator met. The BCC program database does not document specific treatment options, only that treatment was started. Treatment is defined by CDC as standard treatment for the diagnosis. Examples would include LEEP, conization, cryosurgery, laser surgery or hysterectomy.

Core Indicator 5:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 18.d. - Percentage of final diagnosis of HSIL, CIN II, or CIN III/CIS where the time between the date of final diagnosis and the date of treatment initiation is &gt; 90 days (goal: &lt;= 20%)</td>
<td>2</td>
<td>20</td>
<td>10</td>
<td>YES</td>
</tr>
</tbody>
</table>

The threshold goal for Core Indicator 5 is less than or equal to 20%. The indicator is determined by looking at dates from final diagnosis to beginning of treatment. The goal is to have the participants diagnosed with HSIL, CIN II, CIN III or CIS move from final diagnosis to standard treatment in 90 days or less. The above example shows 20 total diagnosed participants with two participants starting standard treatment outside the 90 days (10%); therefore the Core Indicator is met.
Core Indicator 6:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 18.g. - Percentage of final diagnosis of invasive cervical carcinoma where the time between the date of final diagnosis and the date of treatment initiation is &gt; 60 days (goal: &lt;= 20%)</td>
<td>2</td>
<td>3</td>
<td>66.7</td>
<td>Small #</td>
</tr>
</tbody>
</table>

The numbers for this core indicator can show how small numbers affect the percentage. The NBCCEDP has quality standards for timeliness of follow-up for cervical cancer screening if invasive cervical cancer is diagnosed, the time from diagnosis to the start of standard treatment must be no more than 60 days. With three participants being diagnosed with invasive cervical cancer and two of them not starting treatment within 60 days, the percentage for the Core Indicator is 66.7%. CDC does not consider this indicator met, but does take into consideration the small sample size.

Breast Core Indicators

Core Indicator 7:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 19.e. - Percentage of NBCCEDP funded mammograms provided to women 50 years of age and older (goal: &gt;= 75%)</td>
<td>2,212</td>
<td>3,450</td>
<td>64.1</td>
<td>NO</td>
</tr>
</tbody>
</table>

A threshold goal of greater than or equal to 75% is expected to meet Core Indicator 7. Local program coordinators hear a lot about this core indicator. The BCC program is expected to provide 75% of the BCC paid mammograms to participants 50 years of age and older. This example shows that 3,450 mammograms were paid with BCC funding, with 2,212 (64.1%) of the participants being 50 and older. In this example the ore Indicator was Not Met.

Examples of Calculating the 75/25 Core Indicator

To meet this indicator, each program must track the number of women under 50 years of age receiving BCC paid mammograms so that this age group does not exceed 25 percent of enrolled participants.

Example #1:
The “Alpha County” CFY Program begins the year with 190 participants to enroll. How many women under 50 years of age are able to have a mammogram paid using BCC funds if there is another source to pay for mammograms for 37 women under age 50?

- 190 Participants
- -37 Mammograms paid for by another source
- 153 Total number of BCC funded mammograms

The number used to calculate the 75/25 Core Indicator is 153.

- 153 BCC funded mammograms
- \( \times 0.25 \) percent
- 38.25 \( 38 \text{ (rounded)} \) mammograms
- 38 BCC funded mammograms
- +37 Mammograms paid for by another source
- 75 Women under 50 years of age
If the “Alpha County” CFY Program provides BCC funded mammograms to 115 women over the age of 50, they will be able to provide 75 mammograms to women under age 50. The Core Indicator is determined by looking at the number of mammograms reimbursed using only BCC funding.

Example #2:
The “Bravo County” CFY Program begins the year with 190 participants to enroll. It has no additional funding to pay for mammograms for women under age 50. In order to maintain the program’s 75/25 split, how many women under 50 years of age can have their mammograms paid using BCC funds?

190 Participants  
- 0 Mammograms paid by another source  
190 Total number of BCC funded mammograms

The number used to calculate the 75/25 Core Indicator is 190.

190 BCC funded mammograms  
0.25 percent  
47.50 47 (rounded) mammograms

47 BCC funded mammograms  
- Mammograms paid for by another source  
47 Women under 50 years of age

If the “Bravo County” program provides BCC funded mammograms to 143 women over the age of 50, they will be able to provide 47 mammograms to women under 50 years of age.

Key Point: Do not calculate how many women under 50 years of age can be screened using the number assigned to your program and screen all of the under 50 women without screening the women 50 years of age and over. If you don’t reach all of the women over 50 years of age, you will not meet the 75/25 Core Indicator.

Core Indicator 8:

<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.a.</td>
<td>Percentage of abnormal breast screenings with complete follow-up (goal: &gt;= 90%)</td>
<td>1,075</td>
<td>1,093</td>
<td>98.4</td>
<td>YES</td>
</tr>
</tbody>
</table>

Core Indicator 8 has a threshold goal of greater than or equal to 90%. This indicator looks at proper diagnostic and diagnosis documentation if the result of the clinical breast examination, mammogram or screening MRI was abnormal, as described by CDC. There may specific barriers that would prevent a program from meeting this follow-up goal including: participant refusal, loss of contact with the participant, or provider guidance to extend follow-up. The local program coordinator would be responsible for reporting the reason for the incomplete or late follow-up. If the participant was diagnosed with breast cancer, was treatment started. Treatment is defined by CDC as standard treatment for the diagnosis. Examples would include radiation therapy, lumpectomy or mastectomy. This example shows that there were 18 participants that did not have complete follow-up putting the program at 98.4% or met.
Core Indicator 9:

<table>
<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 Item 25.d. - Percentage of abnormal breast screenings where the time between the screening and final diagnosis was &gt; 60 days (goal: &lt;= 25%)</td>
<td>34</td>
<td>1,074</td>
<td>3.2</td>
<td>YES</td>
</tr>
</tbody>
</table>

A threshold goal of less than or equal to 25% is expected to meet Core Indicator 9. The indicator looks at the length of time from the date of screening to date of final diagnosis. The NBCCEDP has quality standards for timeliness of follow-up for breast cancer screening when diagnostic work-up is indicated. The time from screening (date of mammogram or if mammogram not performed, date of CBE) to a final diagnosis must be no more than 60 days. This example shows that 34 of the 1,074 (3.2%) participants were diagnosed outside the 60 days; therefore this indicator was met.

Core Indicator 10:

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<thead>
<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 Item 26 - Percentage of final diagnosis of breast cancer where treatment has been started (goal: &gt;= 90%)</td>
<td>62</td>
<td>65</td>
<td>95.4</td>
<td>YES</td>
</tr>
</tbody>
</table>

Core Indicator 10 has a threshold goal of greater than or equal to 90%. The indicator is determined by looking at dates from screening, diagnostics, and final diagnosis to beginning of treatment. This example shows that there were three participants out of 65 that did not complete follow-up putting the program at 95.4% or met. There may specific barriers that would prevent a program from meeting this follow-up goal including: participant refusal, loss of contact with the participant, or provider guidance to extend follow-up. The local program coordinator would be responsible for reporting the reason for incomplete follow-up.

Core Indicator 11:

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<tr>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Pct</th>
<th>Met?</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Item 27.d. - Percentage of final diagnosis of breast cancer where the time between the date of final diagnosis and the date of treatment initiation is &gt; 60 days (goal: &lt;= 20%)</td>
<td>7</td>
<td>62</td>
<td>11.3</td>
<td>YES</td>
</tr>
</tbody>
</table>

The threshold goal for Core Indicator 11 is less than or equal to 20%. The NBCCEDP has quality standards for timeliness of follow-up for breast cancer screening, if cancer is diagnosed, the time from diagnosis to the start of standard treatment must be no more than 60 days. With 62 participants in the category and seven participants starting treatment outside of the 60 days, the percentage for this core indicator is 11.3%. Core indicator 11 is met.
DISCLOSURES FOR PUBLIC HEALTH ACTIVITIES

[45 CFR 164.512(b)]

Background

The HIPAA Privacy Rule recognizes the legitimate need for public health authorities and others responsible for ensuring public health and safety to have access to protected health information to carry out their public health mission. The Rule also recognizes that public health reports made by covered entities are an important means of identifying threats to the health and safety of the public at large, as well as individuals. Accordingly, the Rule permits covered entities to disclose protected health information without authorization for specified public health purposes.

How the Rule Works

General Public Health Activities. The Privacy Rule permits covered entities to disclose protected health information, without authorization, to public health authorities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This would include, for example, the reporting of a disease or injury; reporting vital events, such as births or deaths; and conducting public health surveillance, investigations, or interventions. See 45 CFR 164.512(b)(1)(i). Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority. See 45 CFR 164.512(b)(1)(i). Covered entities who are also a public health authority may use, as well as disclose, protected health information for these public health purposes. See 45 CFR 164.512(b)(2).

A “public health authority” is an agency or authority of the United States government, a State, a territory, a political subdivision of a State or territory, or Indian tribe that is responsible for public health matters as part of its official mandate, as well as a person or entity acting under a grant of authority from, or under a contract with, a public health agency. See 45 CFR 164.501. Examples of a public health authority include State and local health departments, the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA).

Generally, covered entities are required reasonably to limit the protected health information disclosed for public health purposes to the minimum amount necessary to accomplish the public health purpose. However, covered entities are not required to make a minimum necessary determination for public health disclosures that are made pursuant to an individual’s authorization, or for disclosures that are required by other law. See 45 CFR 164.502(b). For disclosures to a public health authority, covered entities may reasonably rely on a minimum necessary determination made by the public health authority in requesting the protected health information. See 45 CFR 164.514(d)(3)(iii)(A). For routine and recurring public health disclosures, covered entities may develop standard protocols, as part of their minimum necessary policies and procedures, that address the types and amount of protected health information that may be disclosed for such purposes. See 45 CFR 164.514(d)(3)(i).

Other Public Health Activities. The Privacy Rule recognizes the important role that persons or entities other than public health authorities play in certain essential public health activities. Accordingly, the Rule permits covered entities to disclose protected health information, without authorization, to such persons or entities for the public health activities discussed below.
• **Child abuse or neglect.** Covered entities may disclose protected health information to report known or suspected child abuse or neglect, if the report is made to a public health authority or other appropriate government authority that is authorized by law to receive such reports. For instance, the social services department of a local government might have legal authority to receive reports of child abuse or neglect, in which case, the Privacy Rule would permit a covered entity to report such cases to that authority without obtaining individual authorization. Likewise, a covered entity could report such cases to the police department when the police department is authorized by law to receive such reports. See 45 CFR 164.512(b)(1)(ii). See also 45 CFR 512(c) for information regarding disclosures about adult victims of abuse, neglect, or domestic violence.

• **Quality, safety or effectiveness of a product or activity regulated by the FDA.** Covered entities may disclose protected health information to a person subject to FDA jurisdiction, for public health purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity for which that person has responsibility. Examples of purposes or activities for which such disclosures may be made include, but are not limited to:

  < Collecting or reporting adverse events (including similar reports regarding food and dietary supplements), product defects or problems (including problems regarding use or labeling), or biological product deviations;
  < Tracking FDA-regulated products;
  < Enabling product recalls, repairs, replacement or lookback (which includes locating and notifying individuals who received recalled or withdrawn products or products that are the subject of lookback); and
  < Conducting post-marketing surveillance.

See 45 CFR 164.512(b)(1)(iii). The “person” subject to the jurisdiction of the FDA does not have to be a specific individual. Rather, it can be an individual or an entity, such as a partnership, corporation, or association. Covered entities may identify the party or parties responsible for an FDA-regulated product from the product label, from written material that accompanies the product (know as labeling), or from sources of labeling, such as the Physician’s Desk Reference.

**C Persons at risk of contracting or spreading a disease.** A covered entity may disclose protected health information to a person who is at risk of contracting or spreading a disease or condition if other law authorizes the covered entity to notify such individuals as necessary to carry out public health interventions or investigations. For example, a covered health care provider may disclose protected health information as needed to notify a person that (s)he has been exposed to a communicable disease if the covered entity is legally authorized to do so to prevent or control the spread of the disease. See 45 CFR 164.512(b)(1)(iv).
C Workplace medical surveillance. A covered health care provider who provides a health care service to an individual at the request of the individual’s employer, or provides the service in the capacity of a member of the employer’s workforce, may disclose the individual’s protected health information to the employer for the purposes of workplace medical surveillance or the evaluation of work-related illness and injuries to the extent the employer needs that information to comply with OSHA, the Mine Safety and Health Administration (MSHA), or the requirements of State laws having a similar purpose. The information disclosed must be limited to the provider’s findings regarding such medical surveillance or work-related illness or injury. The covered health care provider must provide the individual with written notice that the information will be disclosed to his or her employer (or the notice may be posted at the worksite if that is where the service is provided). See 45 CFR 164.512(b)(1)(v).

Frequently Asked Questions

To see Privacy Rule FAQs, click the desired link below:

FAQs on Public Health Uses and Disclosures

FAQs on ALL Privacy Rule Topics
https://www.hhs.gov/answers/hipaa/where-can-i-find-information-about-health-information-privacy/index.html

(You can also go to http://answers.hhs.gov/cgi-bin/hhs.cfg/php/enduser/std_alp.php, then select "Privacy of Health Information/HIPAA" from the Category drop down list and click the Search button.)
HIPAA PRIVACY RULES AND THE RELEASE OF INFORMATION TO THE IOWA CARE FOR YOURSELF PROGRAM

The Health Insurance Portability and Accountability Act (HIPAA) regulations contain several major components. The Privacy Rule requires covered entities to obtain consent or authorization from an individual for certain uses and disclosures of identifiable health information. However, the Privacy Rule expressly permits covered entities to release identifiable health information to public health authorities under certain circumstances without obtaining consent or authorization from the patient.

First, although the requirements of HIPAA generally preempt state law, HIPAA provides for certain exceptions to this general preemption rule. One such exception applies when state statute and state administrative rules provide for "the reporting of disease or injury, . . . or for the conduct of public health surveillance, investigation, or intervention." 45 CFR 160.203. Iowa Code chapter 135 and 641 Iowa Administrative Code chapter 8 authorize the Iowa Care For Yourself Program (ICFYP) to have access to information from hospital records, physician records, and clinical charts for the purpose of ensuring service delivery and program and fiscal management. These provisions of law are not preempted by HIPAA and therefore a hospital, clinic, or health care provider is not required to obtain consent or authorization from a patient prior to releasing this information to the ICFYP.

HIPAA also provides for a number of "permitted disclosures," i.e. those disclosures of protected health information for which consent or authorization is not required. HIPAA authorizes such disclosures "to the extent that such use or disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law." 45 CFR 164.512(a). HIPAA further authorizes disclosures for public health activities to "a public health authority that is authorized by law to collect or receive such information for the purposes of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions[.]" 45 CFR 164.512(b)(1)(i). Hospitals, clinics, and health care providers are authorized by Iowa law to allow the ICFYP to have access to information about patients for purposes of preventing cancer. Hence, HIPAA does not require that covered entities obtain consent or authorization prior to releasing such information to the ICFYP. Additionally, ICFYP participants...
execute a release which authorizes health care providers, laboratories, and hospitals to provide the ICFYP with results of the screening and follow-up examinations and treatment.

In short, HIPAA provides no legal basis for hospitals, clinics, or health care providers to prohibit the ICFYP from obtaining information for the purpose of ensuring that women receive appropriate screening tests, confirmatory testing, and treatment.
CancerCare provides limited financial assistance to individuals affected by cancer. As a nonprofit organization, funding depends on the sources of support received at any given time. If funding is not available at the time needed, CancerCare counselors will work to refer to other financial assistance resources. With a gift from the Avon Foundation, CancerCare, Inc. established a special assistance fund for low income, under-, uninsured and underserved individuals (male and female) with a breast cancer diagnosis and their families. For complete information go to www.cancercare.org.

### Assistance from CancerCare

<table>
<thead>
<tr>
<th><strong>Financial</strong></th>
<th><strong>Limited assistance to be used for:</strong></th>
</tr>
</thead>
</table>
| All requests must be for current services (within one month) | - Transportation to and from treatment services  
- Childcare  
- Home care  
- Pain and anti-nausea medication, oral hormonal medication, lymphedema supplies and durable medical equipment |
| **Services not paid for:** | |
| | - Any screening or diagnostic services  
- Basic living expenses such as rent, mortgages, utility payments or food |
| **Eligibility:** | |
| | - Individuals with a diagnosis of breast cancer may qualify for assistance  
- Be in active treatment breast cancer  
- Meet eligibility guidelines based on the federal poverty guidelines (proof of income required)  
- Live in the US or Puerto Rico  
- No citizenship requirements |
| **Steps for Applying:** | 1. Call 800-813-HOPE (4673) and complete an interview with a social worker.  
2. If eligible to apply, an individualized bar-coded application and a request for documentation to verify income will be sent to the individual.  
3. The individual must submit a legible completed application. |

| **Professional** | Oncology social workers provide individual counseling, lead support groups, locate services that help with home care or transportation and guide people through the process of applying for Social Security disability or other forms of assistance. CancerCare’s oncology social workers are available to help online or on the telephone in the U.S., free of charge.  
**Our oncology social workers can help you:** |
|------------------|---------------------------------------------------------------|
| | - Better understand cancer and its treatment  
- Learn new ways to cope with cancer  
- Manage emotions such as anxiety or sadness  
- Improve communication with your health care team  
- Talk to your family about cancer  
- Find reliable information  
- Find useful resources in your community  
- Manage financial challenges |

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<tr>
<th><strong>Other</strong></th>
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</table>
| | - Provides easy-to-read booklets and fact sheets online or in print that include up-to-date reliable information on cancer-related topics.  
- Leading experts in oncology provide up-to-date information in one-hour educational cancer workshops over the telephone or online free of charge.  
- Spanish speaking staff available |
Definitions\(^\text{16}\):

“Abnormal screen” means a suspicion of breast or cervical cancer.

1. A suspicion of breast cancer includes
   - clinical breast examination findings of: palpable breast mass, breast dimpling, nipple retraction, bloody nipple discharge, palpable lymph nodes around clavicle or axilla, nipple erythema and scaliness,
   - a mammography result of breast imaging reporting and data system (BI-RADS) category 4 (suspicious abnormality suggesting need for biopsy) or category 5 (highly suggestive of malignancy), breast biopsy result of ductal cancer in situ, lobular cancer in situ, or breast or lymph node (or other) biopsy result of breast cancer.

2. Suspicion of cervical cancer is a Pap test result of
   - atypical squamous cells cannot exclude high-grade squamous intraepithelial lesions (ASC-H)
   - atypical glandular cells (AGC)
   - low-grade squamous intraepithelial lesion (LSIL)
   - high-grade squamous intraepithelial lesion (HSIL)
   - leukoplakia of the cervix
   - cervical biopsy result of cervical intraepithelial neoplasia II or III
   - cancer in situ

“BCCPTA” or “Breast and Cervical Cancer Prevention and Treatment Act of 2000” means a federal law that provides each state with the option of extending Medicaid eligibility to women who were diagnosed with breast or cervical cancer through the National Breast and Cervical Cancer Early Detection Program.

“BCCT option of Medicaid” or “breast and cervical cancer treatment option of Medicaid” means the optional program of medical aid designed for individuals who are unable to afford regular medical service and are diagnosed with breast or cervical precancer or cancer through the National Breast and Cervical Cancer Early Detection Program, or through funds from family planning centers, community health centers, or non-profit organizations. The individuals that receive screening or services meet eligibility requirements established by the Iowa care for yourself program. The BCCT option of Medicaid is financed by federal and state payment sources and is authorized by Title XIX of the Social Security Act.

“Benign” means a noncancerous condition that does not spread to other parts of the body.

“Biopsy” means the removal of a sample or an entire abnormality for microscopic examination to diagnose a problem. Examples of a sampling would be a core biopsy or incisional biopsy; an example of entire removal would be an excisional biopsy.

“BI-RADS” or “breast imaging reporting and data systems” means a standardized reporting system for mammography, breast ultrasound, and breast MRI reports.

“Breast ultrasound” means an imaging technique commonly used to screen for tumors and other breast abnormalities. The ultrasound uses high-energy sound waves to produce detailed images of the inside of the breast.

“Cancer” means a group of diseases involving abnormal cell growth with the potential to invade or spread to other parts of the body.

“Carcinoma in situ” means a group of abnormal cells found only in the place where they first formed in the body.

“CBE” or “clinical breast examination” means complete examination of a woman’s breast and axilla with palpation by a health care provider trained to recognize many different types of abnormalities and warning signs.

\(^{16}\) Adapted from Iowa Administrative Code 641—Chapter 8
“Colposcopy” means a medical procedure that allows close examination of the surface of the cervix with a high-powered microscope.

“Community health centers” means a community-based organization that offers comprehensive essential primary and preventive care services to populations with limited access to health care.

“Cooperative agreement” means a signed contract between the department and another party, for example, a healthcare facility. This contract allows the department to pay the health care facility for providing services to IA CFY program participants.

“Creditable coverage” means any insurance that pays for medical bills incurred for the screening, diagnosis, or treatment of breast and cervical cancer. Creditable coverage as described by the Health Insurance Portability and Accountability Act of 1996 includes, but is not limited to, group health plans or health insurance coverage consisting of medical care under any hospital or medical service policy, health maintenance organization, Medicare Part A or B, Medicaid, armed forces insurance, or state health risk pool. An individual who has creditable coverage shall not be eligible for coverage under the breast and cervical cancer treatment option of Medicaid.

“Creditable coverage circumstances” means those instances in which an individual has creditable coverage but is not actually covered for treatment of breast or cervical cancer.
1. When there is a preexisting-condition exclusion or when the annual or lifetime limit on benefits has been exhausted, an individual is not considered to have creditable coverage for this treatment.
2. If the individual has limited coverage, such as a high deductible, limited drug coverage, or a limited number of outpatient visits, she is still considered to have creditable coverage and is not eligible for coverage under the breast and cervical cancer treatment option of Medicaid.
3. If the individual has a policy with a limited scope of coverage, such as dental, vision, or long-term care, or has a policy that covers only a specific disease or illness, she is not considered to have creditable coverage unless the policy provides coverage for breast and cervical cancer treatment.
4. For the purposes of this program, eligibility for Indian Health Services or tribal health care is not considered creditable coverage (according to P.L. 107-121, the Native American Breast and Cervical Cancer Treatment Technical Amendment Act of 2001).

“Cytology” means the branch of biology concerned with the structure and function of plant and animal cells.

“Cytopathology” means the branch of pathology that studies and diagnoses diseases on the cellular level.

“Diagnostic mammography” means a radiological examination performed for clinical indications, such as breast mass(es), other breast signs or symptoms (spontaneous nipple discharge, skin changes), or special cases, such as a history of breast cancer with breast conservation or augmented breasts.

“Family Planning clinic” means a Title X family planning program site dedicated to the provision of family planning and related preventive health services to low-income and underserved populations.

“Follow-up” means the IA CFY program component that involves a system for seeking information about or reviewing an abnormal condition, rescreening, or recall for annual visits.

“Health care provider” means any physician, advanced registered nurse practitioner, or physician assistant who is authorized to practice by the state and performing within the scope of their practice as defined by state law; provides care to IA CFY program-enrolled women.

“IA BCCEDP” or “Iowa breast and cervical cancer early detection program” means a comprehensive breast and cervical cancer screening program established and funded under Title XV of the federal Public Health Service Act and administered by the Iowa department of public health, with the delegated responsibility of implementation and evaluation from the CDC, Division of Cancer Prevention and Control.
“IA CFY program” or “Iowa care for yourself program” means an integrated comprehensive breast and cervical cancer screening program and cardiovascular risk factor screening and intervention program administered by the Iowa department of public health.

“IA WISEWOMAN” or “Iowa well-integrated screening and evaluation for women across the nation” means a cardiovascular-related risk factor screening and intervention program to provide standard preventive screening services, including blood pressure measurements, cholesterol testing, and lifestyle interventions that target poor nutrition, physical inactivity, and tobacco use. The program is authorized by the federal government and administered by the CDC to help reduce deaths and disability from heart disease and stroke.

“ICD-10” or “International Classification of Disease, 10th edition” means a standardized classification of diseases, injuries, and causes of death, by cause and anatomic localization, which is systematically put into a number of up to seven digits and which allows clinicians, statisticians, politicians, health planners and others to speak a common language, both in the United States and internationally.

“In need of treatment” means a medical or surgical intervention is required because of an abnormal finding of breast or cervical cancer or precancer that was determined because of a screening or diagnostic procedure for breast or cervical cancer or precancer.

“MDEs” or “minimum data elements” means a set of standardized data elements used to collect patient-level screening records on women served through the NBCCEDP in order to evaluate whether programs are meeting clinical standards and programmatic priorities.

“NBCCEDP” or “National Breast and Cervical Cancer Early Detection Program” means a program established with the passage of the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354). The law authorizes the CDC to establish a program of grants to states, tribes, and territories to increase the early detection of breast and cervical cancer, particularly among low-income, uninsured, and underserved women.

“Nonprofit organization” means a group organized for purposes other than generating profit and in which no part of the organization’s income is distributed to its members, directors, or officers.

“Outreach” means the IA CFY program component that involves recruiting targeted populations or women who never or rarely utilize preventive health services.

“Pap test” means the Papanicolaou screening test that collects cells from the cervix for examination under a microscope. The Pap test can detect abnormal cells or precancerous cells before cancer develops.

“Patient Navigation” means an IA CFY program component that offers assistance to overcome healthcare system barriers and facilitate timely access to quality screening and diagnostics as well as initiation of breast or cervical cancer treatment services for individuals.

“Precancerous” means a condition or lesion involving abnormal cells that are associated with an increased risk of developing into cancer.

“Program and fiscal management” means the IA CFY program component that includes planning, organizing, directing, coordinating, managing, budgeting for, and evaluating program activities.

“Rarely or never been screened” means, as defined for the NBCCEDP, that an individual has not had cervical cancer screening within the last five years or has never been screened for cervical cancer.

“Recruitment” means the IA CFY program component that involves enrolling targeted populations or women for preventive health services.

“Referral” means the IA CFY program component that involves directing women with abnormal screening results to appropriate resources for follow-up action.
“Screening mammography” means the use of X-ray of the breasts of asymptomatic women in an attempt to detect abnormal lesions of the breast when they are small, nonpalpable, and confined to the breast.

“Service delivery” means providing, either directly or through contractual arrangements, comprehensive breast and cervical cancer screening and heart disease and stroke risk factor screening, diagnosis, and treatment services through tracking of screening intervals, timeliness of diagnosis, and timeliness of treatment of women.

“Surveillance” means the IA CFY program component that involves the systematic collection, analysis, and interpretation of health data.

“TBS” or “the Bethesda system” means a system for reporting cervical or vaginal cytologic diagnoses, used for reporting Pap test results.
# Pink Ribbon Advisory Board (PRAB)

<table>
<thead>
<tr>
<th>Name</th>
<th>Program/Region</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
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Pink Ribbon Advisory Board (PRAB)

Member’s Role
- Serve in an advisory capacity to state program throughout the two-year term;
- Serve as a representative of local program staff from within the member’s region;
- Act as liaison and provide communications between local program staff in the member’s region and state program staff; and
- Help problems solve and initiate program ideas to state staff.

Communicate with local program staff within the member’s region
- Participate in scheduled quarterly PRAB conference calls;
  - Discuss and provide agenda items; questions, concerns;
  - Discuss program issues including barriers, comprehension, implementation;
  - Outcomes from PRAB meetings or conference calls held; and
  - Provide (as indicated) a summary of discussions, rationales, etc. of agenda items and program issues discussed.

Communicate with state program staff
- Propose agenda items
  - Input/feedback from local program staff of agenda topics; consensus of opinion, or various opinions that merit attention;
  - Provide ideas for Annual Meeting, Regional Meetings, Quarterly Meetings, and additional trainings as needed;
- Present local program staff concerns or questions on program issues; barriers, comprehension, implementation; and
- Proposals for solutions to barriers, comprehension, and implementation.