The Connecticut Cancer Screening Program (CCSP)

Policy and Procedure Manual

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Connecticut Department of Public Health
Community Health and Prevention Section
Comprehensive Cancer Programs
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Section I: Program Management

Overview

Centers for Disease Control and Prevention

The Centers for Disease Control and Prevention (CDC), based upon acts of Congress, funds the State of Connecticut, Department of Public Health (DPH) to provide breast and cervical cancer and colorectal cancer screening services to underserved populations throughout the State. The State of Connecticut, Department of Public Health, is accountable to the CDC for the appropriate use of these funds.

Connecticut Department of Public Health

The Connecticut Department of Public Health disseminates CDC funds to healthcare agencies throughout the State to provide services to underserved populations through a competitive grant process and is responsible for ongoing oversight of funded agencies. DPH ensures that contracted providers use established CDC and state approved clinical practice guidelines and protocols for clinical service delivery performed under this contract. Funded agencies are accountable to the DPH for the appropriate use of these funds.

CDC provides mandates, a conceptual framework, and guidelines that the State of Connecticut is charged with following as a recipient of CDC funds. These CDC mandates, conceptual framework, and guidelines are implemented through the DPH in combination with DPH fiscal and programmatic requirements and guidelines and establish the basis for funded agencies to plan, implement, and evaluate the provision of the services of the Connecticut Cancer Screening Program (CCSP).

In addition to providing financial support, the DPH Comprehensive Cancer Program, which has oversight of the CCSP, will assist participating providers under their contract by providing:

- A web-based CCSP Policy and Procedure Manual;
- Professional education, program development trainings, data management trainings, and provider meetings for contracted provider staff;
- Technical assistance with program planning, development, implementation, operations, and evaluation in accordance with federal and state government directives;
- Program guidance in implementing and maintaining an electronic tracking, follow-up, and referral system for the delivery of program services;
- Technical assistance with quality improvement activities;

- Assistance with enhancing and/or developing public/participant education activities;
- Assistance with program promotion and recruitment of eligible participants;
- Standardized forms and templates for all mandatory fiscal and programmatic reporting requirements;
- List(s) of allowable CPT codes and reimbursement rates for program services;
- Annual updates of eligibility guidelines including income eligibility; and,
- Regular program information/updates via e-mail, conference calls, trainings, webinars, meetings, and site visits.

Mission

The mission of the Connecticut Cancer Screening Program (CCSP) is to provide low income, underinsured, uninsured women with breast and cervical cancer screening for women ages 21-64 with a focus on women rarely or never screened and population-based colorectal cancer screening among average-risk, uninsured or underinsured men and women ages 50-64.

The intent of the Program is to increase the early detection and prevention of breast, cervical and colon cancer through screening and early detection at the earliest stages when treatment is most likely to be successful and the prognosis optimal. All program components are related to the support and delivery of screening and diagnostic services to those in need.

Conceptual Framework, Purpose, Definitions, and Essential Elements of CCSP Screening and Diagnostic Services

The screening and diagnostic services components of the program are represented as the core program. Assuring the availability and quality of these services to undeserved women and men is the intent of the program. All other program components are related to and support the delivery of screening and diagnostic services.

The purpose of screening and diagnostic services is to detect: 1) precancerous or cancerous lesions of the breast and cervix in women ages 21-64 years at the earliest stage and refer them for treatment; and, 2) detect precancerous or cancerous colon polyps in men and women ages 50-64 years and refer them for medical treatment. This is accomplished by establishing and maintaining a comprehensive provider network for screening and diagnostic services and treatment referrals that will maximize access to and provide quality care for program participants and will ensure that rescreening is provided at regular intervals for all program participants.
Screening and diagnostic services can be defined as specific and appropriate clinical services to detect breast and/or cervical abnormalities and colorectal abnormalities.

Services include screening, diagnosis, case management for breast and cervical cancer, patient navigation for colorectal cancer screening participants and referral for medical evaluation and treatment. Program funds do not pay for medications or medical evaluation and treatment for any of the screening services nor do they pay for smoking cessation programs or education programs.

Providers collect essential information on program participants such as demographics, symptoms, screening history, assessments of lifestyle, screening test results, diagnostic evaluation, final diagnosis and referral for treatment. DPH provides for provider documentation of information on a web-based data management system called Med-IT® and on an electronic Tri-annual Progress Report which includes expenditure reports and a program narrative section. The information identified in Med-IT and in the Tri-annual Progress Report establishes a basis for continuous evaluation of provider performance.

Cultural, Linguistic, and Literacy Competency

CCSP services need to be delivered in an atmosphere of cultural, linguistic, and literacy competency. Cultural competency allows health professionals to work effectively in cross culture situations. It allows individuals and organizations to function effectively within the context of cultural beliefs, behaviors, and needs presented by consumers and their communities. Health care services that are respectful of and responsive to the health beliefs, practices, cultural, linguistic, and literacy needs of diverse patients can help bring about positive outcomes.

The CCSP provides for the recognition of cultural practices, linguistic and literacy competency through DPH and its providers in the provision of provider education, screening services, translation services, bilingual staff, and program and education materials in a variety of foreign languages.

CLAS Standards

DPH has adopted the National Standards for Culturally & Linguistically Appropriate Services in Health and Health Care (CLAS standards, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15-). The CLAS standards are intended to advance principles of health equity, improve quality of care and services, and help eliminate health care disparities in concrete and practical ways.

Several of the CLAS standards are based in U.S. civil rights laws.

Inclusion

Providers will be inclusive of specific populations who can benefit from programmatic strategies. These populations include groups such as people with disabilities, non-English speaking populations, Lesbian, Gay, Bisexual, and Transgender (LGBT)

populations, appropriate age groups or other populations who might be otherwise missed by the program.

Program Management

Grantee's Contract Requirements and Responsibilities

Requirements: All grantees of CCSP must enter into a legally binding contract with DPH in order to provide program services to eligible participants in the State of Connecticut. Grantees may deliver program services directly or through fee-for-service providers in sub-contractor capacities to the grantee. The CCSP contract contains a summary description of services the grantee has agreed to deliver and includes the target number of participants that will be screened within a fiscal year by the grantee and their fee-for-service providers. Each contract has specific language and requirements that will be covered in the following subsections.

Legislative Requirements, Regulations, and Funding Distribution

The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354 and its amendments P.L. 103-183 and P.L. 105-340) specifies the required functions of breast and cervical cancer screening services.

CT. General Statutes Chapter 368g, Sec. 19a-266 enacts legislative authority for Connecticut's Breast and Cervical Cancer screening services. This law identifies the components and requirements of comprehensive breast and cervical cancer screening services.

The Connecticut Breast and Cervical Cancer Prevention and Treatment Act provides coverage with Medicaid through the Connecticut Department of Social Services for women found to have a precancerous condition or cancer of the breast or cervix and have no means of payment for treatment services. Information that explains this act can be found in the next section of this document titled the Medicaid Breast and Cervical Cancer Prevention and Treatment Act, Public Law 106-354.

Grantees and their fee-for-service providers are required to comply with National Clinical Guidelines as specified in the following subsections.

The Clinical Laboratory Improvement Amendments (CLIA) Certification: Use of Bethesda 2001 Reporting System (Paps). All cervical cytology interpretation must be performed on the premises of a qualified laboratory. These facilities must meet the standards and regulations described by the federal Centers for Medicare and Medicaid Services under the Clinical Laboratory Improvement Act of 1988. Cytopathologists should record their Pap test findings using the 2001 Bethesda System, which specifies specimen adequacy and is a descriptive diagnostic system that provides specific categories for abnormal findings, which in turn promote specificity in treatments. A

licensed certified pathologist must interpret all Pap tests conducted under this program. http://www.cancer.gov/newscenter/bethesda2001
CCSP grantees and fee-for-service providers laboratory services testing must be performed by a CLIA-Certified Laboratory, according to the requirements of 42 CFR Part 493, Laboratory Requirements Clinical and Laboratory Improvement Amendments (CLIA), Public Health Service Act, Subpart 2, Chapter 3535 Clinical Laboratories, located at .http://wwwn.cdc.gov/clia/regs/default.aspx

The CCSP requires all imaging results to be reported using the BI-RADS lexicon, a system designed by the American College of Radiology (ACR) http://www.acr.org/SecondaryMainMenuCategories/quality_safety/BIRADSAtlas.aspx to standardize language and categories. Mammography should only be performed in facilities certified by the United States Department of Agriculture accreditation under the Mammography Quality Standards Act referenced at http://www.fda.gov/Radiation-EmittingProducts/MammographyQualityStandardsActandProgram/default.htm. A licensed radiologist must interpret all mammography tests under this program.

CDC Guidelines require the provision of the promotion (advertising) of colorectal cancer screening services to the population at large and the provision of colorectal cancer screening services to uninsured and underinsured adults aged 50-64 years at or below 250% of the federal poverty level as of January 2014.

Guidance: Functions specified by law and amendments for breast and cervical cancer and colorectal cancer screening include but are not limited to the following:

- Providing early cancer detection services through screening of women ages 21-64 years of age for breast and cervical cancer with priority to low-income women, that includes a clinical breast exam, pelvic exam, Pap test, and mammography as indicated, providing appropriate diagnostic/follow-up services and support services such as case management, and referrals for medical treatment;

- Providing for the promotion (advertising) of the benefits for breast and cervical cancer and colorectal cancer screening services to the population at large regardless of insurance status;

- Providing colorectal cancer screening services to men and women ages 50-64 years of age, including assessments of candidates for colon cancer risk which may include a physical examination, patient education, bowel prep and colonoscopy preparation instructions, colonoscopy, patient navigation services, and medical referral to a primary care physician for follow-up services;

- Contracting with nonprofit and for-profit entities;

- Breast and cervical and colorectal cancer screening funds are the payer of last resort. This means that program funds cannot be used to pay for any services that are covered by a state compensation program, an insurance policy, a federal

or state health benefits program, or an entity that provides health services on a pre-paid basis;

- At least 70% of program funds must be used for direct clinical services. Costs allowable in the 70% category are allocated for screening, diagnostic exams, referral for treatment, and essential support service such as case management;

- No more than 30% of funds may be allocated to other required program functions such as management activities, recruitment and outreach activities, professional development, data management, quality assurance, quality improvement, development and maintenance of partnerships, travel, surveillance, and evaluation activities;

- Spend no more than 10% of Federal funds annually for administrative expenses;

- Do not use funds to pay for inpatient hospital services for any individual;

- Do not balance bill participants for services provided and reimbursable by the CCSP;

- Providing appropriate referrals for medical evaluation, follow-up services, and 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; and,

- Utilizing funds in the most cost efficient manner.

Medicaid Breast and Cervical Cancer Prevention and Treatment Act

Public Law 106-354

Requirement: All women diagnosed with cancer or precancerous lesions through the program are eligible for treatment of breast or cervical cancer through the *Medicaid Breast and Cervical Cancer Prevention and Treatment Act*, *Public Law 106-354* through the Department of Social Services (DSS).

Guidance: Under this Act, a woman can be granted presumptive eligibility status while her application for full Medicaid benefits is being processed. The designation of presumptive eligibility refers to the process of granting temporary Medicaid benefits to properly screened program participants while their application for Medicaid is pending.

It facilitates the prompt enrollment and immediate access to services for women who are in need of treatment for breast and/or cervical cancer. The Department of Social Services has no income or asset requirements required of participants to participate in the program.

- A woman is not eligible for the Medicaid Treatment Act if she has creditable health insurance or is not a citizen of the United States or if she is not a qualified alien.

- If a woman turns age 65 during her period of coverage, her eligibility will terminate as of the date of her birthday. As of the age of 65, the Department of Social Services will explore other categories of Medicaid coverage and will assist the woman to continue coverage under Medicare. Women 65+ who are not enrolled in Medicare Part B may be eligible to receive program services.

- The Department of Social Services may vest certain medical providers with the authority to accept applications and grant Medicaid presumptively on its behalf. These providers are called Qualified Entities. CCSP provider sites can serve as Qualified Entities for the Breast and Cervical Cancer Medicaid coverage group.

- If a CCSP provider is interested in becoming a Qualified Entity the procedure to become a Qualified Entity, the W-1BCC Fast Form- Breast and Cervical Cancer Medicaid Coverage Group —Fast Form" Application/Redetermination is to be completed and submitted to the Department of Social Services, allowing the Department of Social Services to start Medicaid coverage immediately. Forms are available upon request from DSS. If assistance is needed to complete the form, contact the Medical Eligibility Specialist at the Department of Social Services at 860-424-5305.

- Once the woman has been found presumptively eligible for Medicaid, the Department of Social Services will guarantee payment for medical services rendered for a five day period from the date presumptive eligibility was established. The woman is given a BCC Coverage Group Certification and Guarantee of Payment voucher or form W-538BCC that can be used to obtain medical services until she receives a regular Medicaid CONNECT card.

Grantees' Fee-for-Services Provider Requirements and Responsibilities

Requirements: Grantees must establish and maintain a comprehensive network of fee-for-service providers who will provide screening and diagnostic services and treatment referrals to maximize access and provide quality care for participants enrolled in the program. Grantees are required to establish and maintain a comprehensive provider network for: 1) breast and cervical cancer screening, diagnostic and treatment referral services; and 2) board certified gastroenterologists who will perform colonoscopies and to ensure treatment referral for any colorectal cancer diagnosed through the program. A comprehensive provider network includes a balance between providers with a high

volume of cases and providers who deliver care to a specialized subgroup of women such as providers who are multilingual and care for non-English speaking women and men. Grantees are responsible for the delivery of timely, appropriate, and quality CCSP services; including the oversight and provision of services provided through their fee-for-service network. All grantees and their fee-for-service providers are required to follow the CDC and DPH approved California Breast Cancer Diagnostic Algorithms the American Society for Colposcopy and Cervical Pathology (ASCCP), the current Consensus Guidelines for the Management of Women with Cervical Cytological and Histological Abnormalities, and the Manual for Gastroenterologists Participating in the Connecticut Colorectal Cancer Control Program.

Grantees are allowed to provide services directly through their own organizations and/or through fee-for-service provider arrangements with nonprofit and for-profit entities in their service region. Grantees are responsible for oversight of their respective fee-for-service providers.

Grantees should contract only with health care practitioners who agree to comply with the provision of care as identified through program protocols, national clinical care guidelines and algorithms, and to provide appropriate integrated services at the annual office visit.

Breast and Cervical Cancer Screening: Fee-for-Service Providers must seek pre-authorization from the DPH nurse consultant or designee when cancer screening recommendations do not adhere to approved algorithms and protocols. The Breast and Cervical Cancer screening component has two Medical Advisory Boards; one for Breast Cancer Screening and one for Cervical Cancer Screening. The Medical Advisory Boards address policy, provide guidelines, and make rulings concerning departure from approved algorithms and protocols. The rulings of the Medical Advisory Boards are final.

Colorectal Cancer Screening: The Colorectal Cancer screening component has a Medical Advisory Board. The Medical Advisory Board addresses policy, provides guidelines, and makes rulings concerning departure from approved algorithms and protocols. The rulings of the Medical Advisory Board are final.

In the event that a colorectal cancer screening participant presents without referral from a medical home, providers must assist the participant in obtaining a primary care provider.

Guidance: Providers can develop a check list of criteria that can be used to evaluate the extent to which an interested fee-for-service provider is capable of providing program services according to program policies, algorithms, and procedures. The check list can also be used to identify service gaps which can be addressed to facilitate compliance with programmatic requirements.

Providers must routinely orient new fee-for-service providers to program services and requirements and must up-date sub-contractors on a rolling basis, as changes occur in the program, in order to maintain compliance with Program protocols.

Grantees are required to follow the DPH Contractor Financial Reporting Guidelines in Appendix A which set forth the financial reporting requirements for the CCSP. These guidelines include information regarding expenditure reporting, sub-contractor reporting, budget revision requests, audit information and the necessary forms for fiscal management.

Guidance: In the event that a situation arises resulting in the provider's non-compliance with one or more contractual obligations, such as a staff vacancy or the suspension of screening services, the project director must inform the DPH program coordinator by email within five days of the action and include what actions are underway to address the situation.

Grantees' Contract Requirements and Responsibilities

Requirements: All grantees that provide CCSP services must enter into a legally binding contract with DPH in order to provide program services to eligible participants in the State of Connecticut. Grantees may deliver program services directly or through fee-for-service providers in sub-contractor capacities to the grantee. The contract contains a summary description of services the grantee has agreed to deliver, including the target number of participants that will be screened by the grantee and their fee-for-service providers, within a fiscal year.

Budget and Financial Management Requirements and Responsibilities

Requirements: Grantees are required to adhere to their approved budget and budget procedures and to periodically report budget and financial expenditures to DPH on a timely basis according to the DPH Contractor Financial Reporting Guidelines in Appendix A. The DPH Contractor Financial Reporting Guidelines include the following forms:

- Financial Expenditure Report Form;
- Salary Detail Sheet and Sample Salary Detail Sheet;
- Equipment Report Form;
- Budget Variance Justification;
- Sub-contractor Financial Expenditure Report Form; and,
- Budget Revision Request and Sample Budget Revision Request.

CCSP funds cannot be used to pay for any service for which payment has been made or can be made by any other payer. CCSP funds can be used only after all of the other sources of funds are exhausted and as such is the payer of last resort.

Guidance: Requests for payments that exceed budgeted amounts will not be paid. This must not result in balance billing to program participants.

Provider fiscal officers and provider program staff need to communicate and interact regularly to track the timely and appropriate use of program funds.

Distribution of Funds

Requirement: DPH requires that at least 70% of grant funds must be used for expenses that can be tied directly to individual program participant clinical services. The basis for determining the funding distribution is the total amount of federal funds awarded to the grantee. Costs allowable in the 70% category are those that benefit the woman directly such as:

- Screening;
- Diagnostic workup;
- Medical eligibility assessment;
- Referral for treatment;
- Patient navigation and case management;
- Transportation; and,
- Translation services.

No more than 30% of grant funds can be used for activities/services that do not directly benefit the participant such as:

- Management activities;
- Recruitment and outreach;
- Professional development;
- Data management, quality assurance, and quality improvement;
- Development and maintenance of partnerships

- Community engagement;
- Surveillance and evaluation activities; and,
- Travel.

No more that 10% of grantee funds can be used for administrative costs. The 10% administrative costs are considered to be part of the 30% distribution.

Site Visits

DPH conducts site visits to provider sites annually or as needed as part of performance monitoring and evaluation. The site visit provides DPH staff with the opportunity to learn more about the provider facility, program, personnel, and community, and to obtain constructive feedback from provider staff concerning different aspects of the program. This also provides an opportunity for DPH consultation and technical assistance to the provider. Site visit reports based upon the site visit are prepared and sent to providers. The report may request a documented plan of corrective actions with submission to DPH on an as needed basis.

Provider Meetings and Trainings

DPH sponsors provider meetings quarterly throughout the year. Generally meetings are held at the DPH Conference Center at 470 Capitol Avenue in Hartford and can also be held at other sites throughout the state. Provider meetings offer an opportunity for CCSP providers to get together with DPH staff for purposes of discussing programmatic business and changes in policy and procedures, sharing information, sharing best practices, and for training concerning data collection, quality assurance, networking, and other topics. Provider staff is required to attend all provider meetings and training sessions.

Professional Development and Education

Professional development and education enhance grantee and fee-for-service providers' knowledge, attitudes, and behaviors to support high quality breast and cervical cancer and colorectal cancer early detection services.

Requirements: Grantees are required to participate in all DPH sponsored provider meetings, training sessions, and education conferences in order to remain up-to-date concerning the current CCSP services.

Guidance: Grantees should consider participation/collaboration/sponsoring of professional development that will increase providers' fee-for-service providers'/partners' knowledge of information related to quality screening for breast, cervical and colorectal cancer screening and early detection.

Professional education methods may include lectures, conferences, informal group meetings, annual meetings, or workshops with dissemination of reports and literature.

Providers can work through their respective Cancer Community Advisory Councils to promote education events in their region.

Grantees are requested to attend at least one education event annual that will add to their professional development, knowledge and skills as it relates to the CCSP.

Provider Staffing Requirements and Responsibilities

Requirement: CCSP grantees are required to staff the program with an in-kind project director, site coordinator, case manager, outreach coordinator, patient navigator, and data-entry specialist. All staff are required to attend DPH sponsored provider meetings, trainings, site visits, and provider education conferences and to document program activities in the Tri-annual Progress Report.

CCSP services need to be delivered in an atmosphere of cultural, linguistic and literacy competency. All provider staff and fee-for-service providers need to provide screening services that are respectful of and responsive to the health beliefs, practices, cultural, linguistic, and literacy needs of the diverse participants served by the CCSP.

Guidance: Grantees can provide for additional in-kind staff and volunteers to assist in the provision of program services.

Providers can apply for grants to assist in providing additional personnel to support the program.

All staff work collaboratively to ensure contracted mandates, program policies, and components are being met in a timely fashion.

All staff assists in the navigation of participants through the health care delivery system in a timely fashion.

All staff document required information into the web-based data system Med-IT® in a timely and accurate fashion.

Project Director: (In-kind)

The project director is directly accountable to DPH for the oversight and direction of all aspects of the CCSP and for the submission of the Tri-annual Progress Report to DPH at predetermined intervals. Specific core functions include but are not limited to the oversight of the following:

- Demonstrate leadership and communicate effectively with state agency administrators;

- Administration, implementation, fiscal management, data management, quality improvement activities, and evaluation of the CCSP at the facility;

- Compliance with all contractual mandates, performance indicators, program guidelines and associated deadlines;

- Assurance that clinical follow-up takes place in a timely fashion;

- Compliance of fee-for-service providers with contractual mandates and deadlines;

- Providing for the full complement of staff, notification of the DPH program coordinator within five working days of staffing changes, and providing for backup staffing when extended periods of absence occur;

- Monitoring the utilization of services and screening and diagnostic expenditures through the review of Med-IT data reports;

- Development and ongoing support of the CCSP Cancer and Community Advisory Council;

- Reviewing and approving the CCSP Tri-annual Progress Report and submitting it to DPH with a signed cover letter by the pre-determined due dates;

- Ensuring that the required data collection and reporting systems are in place and functioning; and,

- Holding regularly scheduled staff meetings at least once a month.

Site Coordinator

The site coordinator is responsible for the day-to-day operations of the program and works closely with the project director and other program staff in this capacity. Specific core functions include but are not limited to the following:

- Coordination of all program services to ensure all program contracted mandates, components, policies, and guidelines are being met in a timely fashion and according to established time lines;

- Participation in the monitoring and utilization of services and screening and diagnostic expenditures using data reports;

- Development and monitoring of tracking to ensure participants will make and keep the variety of medical appointments that are part of the screening process;

- Liaison between provider and fee-for-service providers to ensure effective and efficient program operations;

- Enrollment of participants based upon eligibility criteria and referral of participants who are not eligible for the program to appropriate screening services;

- Obtaining, coordinating and submitting complete and accurate participant data for services rendered by the provider and its fee-for-service providers in accordance with data submission guidelines;

- Developing and maintaining of a computer or manual participant tracking and reminder database for the follow-up of abnormal results and for rescreens to ensure timeliness and completeness of follow-up;

- Participation in the development and ongoing support of the CCSP Cancer Community Advisory Council;

- Effective ongoing communication and collaboration with the project director, program staff, clinical providers, DPH, and others;

- Providing orientation/training to new staff and fee-for-service providers; and,

- Documenting program progress in the CCSP Tri-annual Progress Report.

Case Manager

Each CCSP is required to have a case manager who is a Connecticut registered nurse or licensed social worker. The case manager is directly responsible for the management of participants who have abnormal screening results, including the tracking and conducting of timely clinical follow-up on all breast and cervical cancer screening participants with abnormal screening results. Specific core functions include but are not limited to the following:

- Collaborate with the site coordinator to develop a standardized system to identify and track participants with abnormal test results, who require case management, linking them to treatment services or insurance when needed, and ensuring that follow-up is completed;

- Conduct an assessment on all participants screened for breast and cervical cancer who have abnormal results; based upon the results of the needs assessment, formulate a written care plan only for those participants who desire or are in need of assistance to facilitate care;

- Work with the colorectal cancer patient navigator to arrange the direct provision of medical care as determined by the site participating gastroenterologist and other medical care provider to address the complications and/or the treatment of colorectal cancer;

- Develop resources and promote participant self-determination and self-sufficiency as they are navigated through the provider's health care system;

- Comply with the CCSP Case Management Policy;

- Document activities in the CCSP Tri-annual Progress Report; and,

- Participate in the development and ongoing support of the CCSP Cancer Community Advisory Council.

Outreach Educator/Marketing Assistant

The outreach educator is responsible for providing public education, outreach, and inreach in the community environment, concerning breast and cervical cancer and colon cancer screening for the purpose of increasing the number of underserved participants who receive CCSP services. The recruitment of underserved participants into the CCSP is achieved through activities that occur in economically disadvantaged neighborhoods where the target population resides. The marketing of CCSP services through mass media channels such as radio, television, large newspapers, and the web such as social media are essential to successful recruitment efforts. Specific core functions include but are not limited to the following:

- Collaborate with the provider facility communications office and the Cancer Community Advisory Council to promote CCSP education and recruitment, in particular using electronic media channels (radio, television, cable television, websites, and social media), large newspapers, and small media such as local radio stations, small newspapers, and community newsletters;

- Target CCSP media and public education and outreach recruitment activities to participants and organizations associated with economically disadvantaged neighborhoods;

- Develop and maintain collaborative partnerships with community agencies to support public education, outreach, and inreach activities for recruitment into the CCSP and to support healthy lifestyles in the community;

- Work with the Cancer Community Advisory Council to achieve public education, outreach, and inreach recruitment objectives;

- Promote CCSP key screening messages and program information into existing forums such as provider newsletters, medical grand rounds, and scheduled standing meetings;

- Document activities in the CCSP Tri-annual Progress Report*;*

- Participate in the development and ongoing support of the CCSP Cancer Community Advisory Council; and,

- Identify sources of screening services in the area for referral of individuals who are not eligible for CCSP services.

Patient Navigator

A patient navigator is defined as a trained, culturally sensitive healthcare worker who provides support and guidance throughout the cancer care continuum; whose duties include helping patients to —navigate" through the maze of doctors' offices, clinics, hospitals, outpatient centers, insurance and payment systems, patient-support organizations, and other components of the health care system.

Patient navigation of colorectal cancer screening services is designed to achieve timely delivery of colorectal cancer screening services and patient satisfaction with their respective encounters with the cancer care system. Specific core functions include but are not limited to the following for each participant:

- Provide culturally appropriate education regarding the need for colorectal cancer screening;
- Interacts with women in the context of their culture, language, and literacy;
- Schedule and confirm colonoscopy appointments;
- Provide participants with both verbal and written instructions for adequate bowel preparation prior to colonoscopy screening and confirm that participants understand and adhere to these instructions;
- Confirm participants mode of transportation back to residence following the colonoscopy screening procedure; and,
- Arrange the direct provision of medical care as determined by the site participating gastroenterologist and other medical care provider to address complications and/or the treatment of cancer.

Data Entry Specialist

The data entry specialist, working with program staff, is responsible for the organization and processing of CCSP data. Specific core functions include but are not limited to the following:

- Compile, sort, and verify the accuracy of data prior to data entry;
- Obtain further information for incomplete documents;
- Enter data from source documents into prescribed computer database;
- Check completed work for accuracy;

- Store completed documents in designated locations;
- Comply with data integrity and security policies; and,
- Generate data reports as required.

Personnel and Volunteers (In-kind)

Providers can assign in-kind facility staff and volunteers to assist in the provision of program services as required. Additional staff can also be added through obtaining grants for that purpose.

Grantees' Staff Orientation to the CCSP

Requirements: Grantees need to identify a system for the routine orientation of all new employees to the CCSP and its services, protocols, documentation, and financial and billing procedures upon employment and periodically, as needed, when updates and/or staff changes occur.

Guidance: Knowledge of, compliance with, and continuity in the delivery of program services, including financial and billing procedures and data management are essential to program operations. This is accomplished through timely orientation of new personnel to the program, as needs arise. DPH staff can assist in the orientation of new personnel.

The **CCSP Policy and Procedure Manual** serves as a resource to plan and implement a new staff and provider orientation to the program.

Partnerships

Requirement: Grantees are required to establish partnerships with individuals, organizations, and groups to recruit participants, to share resources and responsibilities, to achieve common goals and to derive mutual benefits in the provision of CCSP services to the community. To achieve this goal, providers need to embrace a framework such as the Social Ecologic Model provided in Appendix B and to work with and support the Cancer Community Advisory Council.

Guidance: Grantees can seek out and establish partnership organizations willing to assist the provider to meet program goals, objectives, and activities including sources of free or discounted medical care and medications and to support program participants in adopting and maintaining a healthy lifestyle in the community.

Partnerships can assist in identifying women in the community who are rarely or never screened for breast and cervical cancer, and men and women for colon cancer.

Grantees can identify and collaborate with community based organizations that provide diabetes education and smoking cessation programs.

Grantees can identify local community organizations and businesses to create or provide access to low-cost resources and activities that promote healthy behaviors and appropriate chronic disease management in the community.

Cancer Community Advisory Council

Requirement: All CCSP grantees are required to develop, maintain, and support a Cancer Community Advisory Council (CCAC) with an identified chairperson who is not from the provider agency.

Guidance: The purpose of the CCAC is to complement the knowledge and skills of the CCSP through representation of key stakeholders in the community service area who can provide an external perspective on the program, advocate for the program, seek additional funds, increase its visibility, provide guidance, communicate opinions, share expertise, support the coordination of services among community agencies, and contribute to improving the health of the community as a whole through participation in the identification of evidence-based lifestyle programs.
The CCAC serves in an advisory capacity. It does not have formal authority to govern the CCSP nor does it have fiduciary responsibility. CCAC advice and recommendations are non-binding.

CCAC membership needs to support the purpose of the CCSP with particular attention to linkages that connect screened participants with medical evaluation and treatment services and to medication access. CCAC membership can include partner organizations, health professionals, and other community members who can enhance and contribute to the mission of the CCSP.

Health departments and federally qualified health centers should be invited to participate on the CCAC. Membership should reflect the diversity of the community and should include representatives from the community's cultural and ethnic minority organizations.

Providers need to provide an orientation for the CCAC membership to its role and purpose and to the CCSP mission and services. Providers document CCAC meetings and activities on the Tri-annual Progress Report.

Recruitment: Public Education, Outreach, and Inreach

Recruitment is the act of seeking to educate and enroll eligible men and women into the CCSP by raising awareness, educating, addressing barriers, and motivating eligible men and women to complete their screening exams as part of their routine health care. Recruitment may consist of three types of activities: public education, outreach, and inreach.

Public education involves the delivery of clear and consistent advertising messages about breast and cervical cancer screening and colon cancer screening. Outreach relies on comprehensive, tailored, population specific strategies, designed to reach and bring men and women from priority populations into clinical screening services. Inreach involves approaching program eligible priority men and women who are using other health care services and recruiting them for enrollment into the CCSP.

The recruitment of men to receive colorectal cancer screening services can include the topics mentioned below but can also include the recruitment of men through informing the women who become enrolled into the CCSP of the availability of colorectal cancer screening services for the men in their family.

Requirement: Grantees are required to promote breast and cervical cancer and colorectal cancer screening services and to establish partnerships with community groups to actively advertise and recruit and enroll program eligible participants from priority populations using public education, outreach and inreach strategies.

Guidance: To accomplish public education, outreach, and inreach providers can:

- Work with the Cancer Community Advisory Council;
- Work with the provider agency communications office to implement a variety of media coverage on a rolling basis, including electronic media;
- Use large and small mass media which includes PSAs, advertisements, radio, television, newspapers, and magazines, social media, and incentives such as fans, pencils, water bottles, etc.;
- Use targeted media which is designed to reach specific segments of the population including newsletters, videos, computers, and direct mail campaigns;
- Use the provider web site home page to advertise services and events and use social media as well;
- Identify places for inreach activities such as provider clinics, community clinics, Federally Qualified Health Care Centers; etc.
- Offer community events for interaction with individuals;
- Work with other community providers to reduce screening barriers; and,
- Target faith-based organizations and churches in low income communities.

Providers document media, outreach, and inreach activities on the Tri-annual Progress Report.

Materials Development

Requirements: CDC retains an unrestricted right to use, reproduce, adapt, and disseminate for its own purposes, products that may be developed using Federal funds by cooperative agreement recipients, contractors, subcontractors, vendors, or consultants. These products may include, but are not limited to the following: program curriculum, program participant materials, graphic designs, educational and other informational materials, fact sheets, newsletter templates, and manuals.

Guidance: Grantees working with contractors or consultants to develop program materials will want to make sure that the contractor or consultant is aware of this requirement.

Section II: Direct Services

Description of CCSP Direct Services

Integrated program services include the specific screening services and procedures identified below, and are provided at no-cost to program participants**. Participants who receive CCSP services are not to receive balance bills.** Financial counseling services should be offered to all program participants in need of it.

Breast and cervical cancer screening for women 21-64 years of age include:

- Enrollment;
- Assessment of tobacco use;
- Clinical breast examination and age-appropriate mammography;
- Pelvic examination and interval-appropriate Papanicolaou (Pap) Test;
- Case management of abnormal values to facilitate essential support services for participants who are assessed to need support services;
- Diagnostic services where appropriate;
- Referral for treatment services; and,
- Rescreening services.

Colorectal cancer public education/awareness initiative and screening services for men and women ages 50-64 include:

- Providing patient navigation services;
- Determining initial program eligibility;
- Determining medical eligibility (medical clearance for the procedure);
- Providing patient education and counseling regarding the need for colorectal cancer screening;
- Enrolling participant;
- Scheduling a colonoscopy appointment with a board certified gastroenterologist;
- Informing/assisting participant with the need for transportation;

- Conducting patient education regarding proper bowel preparation for the colonoscopy;

- Performing the colonoscopy;

- Providing for colonoscopy follow-up;

- Assisting in the coordination of appropriate follow-up care in regard to any abnormal or incomplete colonoscopy findings or complications; and,

- Rescreening every ten years for individuals with normal screening results.

Participant Eligibility Criteria

Requirements: Providers are required to develop a systematic approach for determining the eligibility of each potential program participant for each of the two screening services offered: breast and cervical cancer screening, and colorectal cancer screening, utilizing the list of eligibility criteria identified in Appendix C. Additional eligibility criteria are identified below for colorectal cancer screening. Recruit and enroll participants into the program until the screening funds for each particular type of screening services are depleted.

Breast and Cervical Cancer Screening: Actively recruit women ages 21-64 into the breast and cervical cancer screening program in accordance with the list of eligibility criteria.

Colorectal Cancer Screening: Providers are required to determine both Program Eligibility and Medical Eligibility (average or moderate risk) for all potential participants, men and women, between the ages of 50-64 years for colorectal cancer screening.

Guidance: Fee-for-service providers are to screen potential participants for eligibility for one or more of the screening services.

Breast and Cervical Cancer Screening: Providers can recruit program participants through public education, outreach and inreach activities which can include the use of media such as public service announcements, advertising, and social media, targeting women who are rarely or never screened.

Colorectal Cancer Screening: Initial Eligibility Determination: Providers determine initial eligibility based upon the client meeting all of the following four criteria. If one or more of the criteria are not met the client is not eligible for colorectal cancer screening services.

- Men and women between the ages of 50 and 64 years:
  Asymptomatic and at average or increased risk for colorectal cancer (risk levels identified below).

Risk Levels for Colorectal Cancer Eligibility Determinations

Asymptomatic: Screening for colorectal cancer is testing for the presence of colorectal cancer precursors in the absence of symptoms.

Average Risk: Screening efforts should focus on the priority target population, people between the ages of 50 and 64 years who are at average risk for colorectal cancer.

Average risk is generally defined as:

- No personal or family history of colorectal cancer;
- No history of inflammatory bowel disease (Ulcerative Colitis or Crohn's Disease); and,
- No history of genetic syndromes such as Familial Adenomatous Polyposis (FAP) or Hereditary Non-Polyposis Colorectal Cancer (HPNCC).

Increased Risk**:** Please note that individuals at increased risk may be considered for screening. For example, people at increased risk for colorectal cancer due to family history of colorectal cancer or adenomatous polyps. People at increased risk for colorectal cancer include those with:

- A personal history of adenomatous polyps on a previous colonoscopy, or a family history of colorectal cancer or adenomatous polyps. Family history is defined as: a single first-degree relative with colorectal cancer or advanced adenoma ≥ 1 cm in size, or with high-grade dysplasia or villous elements.

Uninsured/Underinsured: Participants who have no health insurance or whose health insurance does not cover a colonoscopy.

Low income: Participants whose income is at or below 250% of the Federal Poverty Level.

People who are symptomatic or are at high risk for colorectal cancer are not eligible for colorectal cancer screening through the CCSP.

Symptomatic: People presenting with symptoms need a complete evaluation by a clinician to determine the cause of their symptoms. While gastrointestinal symptoms may be indicative of an underlying colorectal cancer or polyp, they may also be caused by many other conditions. This evaluation and any potential subsequent treatment are beyond the scope of the CCSP. If a client has been medically evaluated and cleared for colorectal cancer screening, then the client may enroll in the program if all eligibility criteria are met.

Significant gastro intestinal symptoms that would preclude eligibility for the program include but are not limited to:

- Rectal bleeding, bloody diarrhea or blood in the stool within the past six months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving colorectal cancer screening services);
- Prolonged change in bowel habits (e.g. diarrhea or constipation for more than two weeks that has not been clinically evaluated);
- Persistent abdominal pain;
- Symptoms of bowel obstruction (e.g. abdominal distension, nausea, vomiting, severe constipation; and,
- Significant unintentional weight loss of 10% or more of starting body weight.

High Risk: People at high risk for colorectal cancer are those with:

- A personal history of colorectal cancer; or,
- A genetic diagnosis of familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (HNPCC); or,
- A clinical diagnosis or suspicion of FAP or HNPCC; or,
- A history of inflammatory bowel disease (ulcerative colitis or Crohn's disease).

People at high risk for colorectal cancer generally require genetic counseling and/or intensive clinical and surveillance services that are beyond the scope of the CCSP. If individuals at high risk for colorectal cancer present to the program for screening they must be referred into the medical health care system for appropriate services.

The decision to be screened after age 75 should be made on an individual basis. If an individual 75 years of age and older presents to the program for screening, he or she must be referred into the medical health care system for appropriate services.

Colorectal Cancer Screening: Medical Eligibility Determination: Providers determine medical eligibility based upon medical clearance by a clinician. Generally, the required medical history and physical exam, to determine if the patient is medical eligible for colorectal cancer screening services, should be brief. Previous experience indicates that the quicker the patient completes the screening process and is scheduled for the colonoscopy, the more likely it is that the patient will actually undergo the colonoscopy.

If the initial screening occurs face-to-face at the health care facility, the medical eligibility determination should be conducted the same day. Provider clinical staff will obtain a relevant medical history and perform a brief physical exam to determine if the patient is medically eligible to undergo the colonoscopy procedure. The medical history and physical exam are intended to answer four important questions:

- Is the patient having current intestinal problems? If the patient is having current intestinal problems, then he or she needs to have these problems diagnosed and treated before being considered for a screening colonoscopy.

- Does the patient have a history of medical problems? The presence of medical problems does not necessarily mean that the patient cannot safely undergo a colonoscopy. If they are not under good control, certain medical problems such as heart disease may be a reason why the patient should not undergo a colonoscopy. The doctor may decide to delay the colonoscopy until the patient's medical problems are better controlled.

- Is the patient taking any medications? Certain medications, such as blood thinners, may increase the risk of problems during or after a colonoscopy. Sometimes, the patient will be asked to make changes in his or her medications before undergoing the procedure.

- Does the patient have a family history of cancer? The doctor performing the colonoscopy will want to know the patient's family history of colorectal and other types of cancer in order assess the patient's own risk of developing this disease**.** If the patient has a personal history of colorectal cancer the patient is not eligible for program services.

Once the individual has been found to be initially eligible and medically eligible, enrollment can take place.

Participant Enrollment and Re-Enrollment

Requirement: Program participants who meet the eligibility requirements for any of the screening services offered through the CCSP are enrolled into the program using criteria identified on the CCSP Enrollment Form or by entering that data directly into the Med-IT system. The enrollment form was designed to collect Minimum Data Elements (MDEs) and other supporting documentation necessary for the management and reporting of client services. The form contains patient contact information, a primary care physician reference, client demographics, and previous health history.

By entering a screening record directly into the Med-IT system, a unique identifier is auto-generated and may be used in conjunction with Medical Record numbers, Social Security numbers, or any other identifier used for patient identification at the service location.

Requirement: Re-enrollment is the process by which participants are determined eligible for another cycle of screening services. Participants are to be deemed eligible for services (re-enrolled) prior to the initiation of a new screening cycle.

Requirement: Providers need to identify a procedure for systematic review of completed enrollment data to ensure accuracy and completeness.

Tobacco Use Assessment

Requirement: Providers are required to carry out a tobacco use assessment annually on every participant enrolled in the CCSP. Based upon the participant's reply, providers are required to refer participants to the Connecticut Quitline for smoking cessation counseling or to any other community smoking cessation programs, to confirm their arrival and to document this information appropriately for inclusion into the Med-IT® system. Refer to the Tobacco Cessation Policy in Appendix D.

Written Consent

Requirement: Providers must have a process in place to obtain written consent from participants in order for them to participate in the program prior to service delivery. Verbal consent is not sufficient. A new consent form must be signed annually or for each re-enrollment into the program.

Guidance: Program consent forms written in English can be found in Appendices G-J. Upon request, DPH can provide electronic versions of consent forms in English, Portuguese or Spanish for providers to use on site. Use the consent form that is appropriate to the services the participant will be receiving. Providers need to review the content of the consent form with participants to ensure it is understood and to answer any questions the participant may have. If consent forms have been mailed to the participant for signature the provider should ensure that the consent is reviewed with the participant at the time of the office visit. Translation services should be provided for participants who need it.

Office Visit Appointment for Screening Services

Requirements: Once the provider has determined that the participant is eligible to receive one or more of the screening program services and the participant agrees to participate, the provider then schedules the office visit and other related appointments. An office visit is defined as time spent with a patient for the evaluation and management of CCSP screening services provided in the provider's outpatient or other ambulatory facility or in a fee-for-service physician's office. Refer to the Office Visit Policy in Appendix F. Documentation of direct services provided can be captured on the CCSP Clinical Data Collection and Reporting Forms found in Appendix T or may be entered directly into the Med-IT system. Providers are required to offer access to services at times other than regular business hours at least once each week. Examples of this are weekday evening hours or Saturdays hours.

Providers are required to recognize, respect and make accommodations for differences in cultural practices and linguistic and literacy competency by providing appropriate provider education, screening services, translation services, bilingual staff, and program and education materials. **(Please refer to CLAS Standards on Page 6).** References for Internet Resources and Free Patient Education Materials containing foreign language resources can be found in Appendix G.

Breast and Cervical Cancer Screening: Every attempt should be made to synchronize screening services into one integrated office visit per year per eligible participant. This is the allowable standard. There may be exceptions to this practice when screening results are found to be abnormal and services follow recommended algorithms for diagnostic and/or follow-up care.

Colorectal Cancer Screening: Once a patient has been formally enrolled for colorectal cancer screening, providers are required to educate the participant concerning colorectal cancer, test procedures, written and verbal information concerning bowel preparation, and prevention strategies. Providers are required to make an appointment with a participating gastroenterologist once a participant has been educated concerning colorectal cancer screening and has agreed to undergo a colonoscopy. Providers must verify transportation arrangements at this time.

Due to medications that are used for the colonoscopy procedure, the patient will not be able to drive him or herself to and from the colonoscopy procedure. Arranging transportation to and from the colonoscopy appointment may be one of the most difficult tasks for the patients enrolled in the CCSP to accomplish. Therefore, at the time that the appointment for the colonoscopy is made, it is essential to review and plan with the patient how he or she will get to and from the appointment.

Arriving to the scheduled appointment on time is also important, as colonoscopy facilities often operate under very tight schedules. A week prior to the scheduled colonoscopy, the provider should check in with the patient to make sure that the transportation arrangements are in place. If not, provider staff should arrange for appropriate transportation. **Ensuring that another individual drives the patient home in a personal car or taxi is an acceptable arrangement. Giving the patient a bus token or pass is unacceptable.**

A brochure about colon cancer developed by the American Cancer Society (ACS) can be accessed at http://www.cancer.org/downloads/PRO/They_Know_How.pdf. The ACS brochure includes basic information about colon cancer and how to prevent it and may serve as a useful outline for your colorectal cancer patient education efforts. One aspect of the ACS brochure deserves emphasis. Toward the end the brochure, various tests used to detect colorectal cancer are reviewed. For the purposes of colorectal cancer screening services, the important point is that only a colonoscopy both examines the entire colon and has the potential to prevent colorectal cancer. The other tests either examine only part of the colon or only aid in detecting cancer that already exists.

The DPH has identified a variety of patient education materials on colorectal cancer that are available in English and Spanish.

After reviewing the patient education materials on colorectal cancer screening and bowel preparation, the patient may decide against continued participation in the program. If this situation occurs, a notation must be entered to the Med-IT online data system.

Guidance: Providers need to plan the appropriate amount of time for the office visit, based upon the screening services that will be delivered. Additional time for the office visit needs to be allowed for colorectal cancer education as required.

Providers need to ensure that appointments are made at times amenable to participants as much as clinic schedules allow. Participant transportation and translation services needs may be determined at this time as well.

Providers need to establish a tracking system that includes reminders to participants to keep their appointments for the office visit, mammography, laboratory blood tests, colonoscopy, and other related screening tests or procedures.

Eligible clients enrolled in the CCSP may transfer between contracted provider sites within the state without subsequent interruption of screening services. Refer to Inter-Program Client Transfer Policy found in Appendix H.

Screening, Rescreening and Follow-up Activities

Requirements: Provide integrated breast and cervical and colorectal cancer screening services, to eligible participants as appropriate, who have been formally enrolled into the program. Providers must seek approval from DPH staff for any variation from program algorithms and protocols as needed, on an individual case-by-case basis.

Breast and Cervical Cancer Screening: Providers are required to adhere to the breast and cervical cancer clinical protocols (policies, procedures, and algorithms), the CT-DPH approved California Breast Cancer Diagnostic Algorithms, the American Society for Colposcopy and Cervical Pathology (ASCCP), and the current Consensus Guidelines for the Management of Women with Cervical Cytological and Histological Abnormalities. These algorithms were adopted by the DPH, approved by the CDC for use in Connecticut and are referenced in the legally binding contracts between DPH and health care providers. These protocols are established to provide guidance and to assist contractors with the management of clinical services rendered through the CCSP.

Documentation: Providers are required to document on the Breast and Cervical Cancer Diagnosis and Treatment Form.

Breast and Cervical Cancer Rescreening: Provide integrated rescreening services 12-18 months after the baseline screening visit, including the same assessments, screening, follow-up services for breast and cervical cancer screening participants.

Colorectal Cancer Screening: Providers and their subcontractors are required to adhere to the colorectal cancer screening protocols mandated by CDC as part of the CDC grant award and promulgated through DPH policies and procedure to providers and as referenced in the legally binding contracts between DPH and health care providers.

Colorectal Cancer Rescreening: If the patient successfully completes the colonoscopy with no abnormalities or complications, the usual recommendation is that he or she under goes another screening colonoscopy in 10 years.

Patients who had a biopsy or polyps removed during the colonoscopy may be asked to repeat the procedure in anywhere from a few months to five years, depending on what was found when the biopsy specimens are examined in a laboratory.

Providers should develop systems for identifying, tracking, and reminding participants about their screening/rescreening office visits and related diagnostic tests and procedures.

Guidance: Breast and cervical cancer rescreening services are the same as those provided at the annual or original screening office visit.

Breast and Cervical Cancer Screening/Rescreening Services

Provide breast and cervical cancer screening services to eligible women 21-64 years of age to include both a clinical examination of the breasts, mammography, pelvic examination and Pap test. In cases where women have either breast or cervical services independent of the other, (i.e., because of menstruation at the time of the office visit) a return office visit may be required to complete the appropriate screening services.

Clinical breast and cervical cancer screening services can be provided by a Connecticut licensed physician (MD) or Connecticut licensed advanced practice registered nurse (APRN).

Providers should develop and implement a recall/reminder system for the purpose of contacting program participants to remind them about their appointments related to the screening process.

Clinical Breast Examination: The clinician performs a clinical breast examination (CBE) during the office visit. Providers should schedule the CBE between days 6 and 10 after the patient's menstrual cycle.

Mammography: Providers need to schedule mammography following the CBE and provide the participant with an appointment card. Asymptomatic women under the age of 40 may not receive screening mammograms regardless of family or personal history.

Pelvic Exam-Pap test: The clinician performs a pelvic examination during the office visit and performs a Pap test.

- Women aged 21 through 29 should receive a Pap test every 3 years if the test results are negative.

- Women aged 30 through 64 with a history of negative test results may elect to extend the 3 year screening intervals to every 5 years if high risk HPV co-testing is performed along with the Pap test and the results are negative.

- For women with a history of CIN 2, CIN 3 or adenocarcinoma in situ; they should continue routine age-based screening for at least 20 years.

The following women do not need regular Pap tests:

- Women over age 65 who have had adequate negative screening results from prior Pap tests of satisfactory quality. (Women with a history of CIN2, CIN3, or adenocarcinoma in situ should continue routine age-based screening for at least 20 years.)

- Women who have had a total hysterectomy for benign disease (Note: not due to cervical cancer.) This applies to women without a cervix and without a history of CIN2, CIN3, adenocarcinoma in situ, or cancer in the past 20 years.

High-risk HPV Testing: Women ages 30 to 64 years can be offered cervical cancer screening with a combination of Pap testing and High Risk HPV testing every 3 years and may choose to extend the cervical cancer screening interval to every 5.

Breast Cancer Screening and Diagnostic Clinical Protocols: Providers must deliver appropriate and timely breast cancer screening and diagnostic services in accordance with CDC-approved *Breast Cancer Diagnostic Algorithms* developed by the California Department of Public Health Cancer Detection Section that were approved and adopted by the CT DPH. These algorithms were established to guide clinicians in assessing a woman's risk of developing breast cancer during each routine screening visit and to aid clinicians in determining the work-up for various breast abnormalities or suspicious findings detected during screening. The seven (7) breast cancer algorithm flowcharts, available at: Breast Cancer Diagnostic Algorithms, address the following:

Algorithm 1. Assessment of Risk;

Algorithm 2. New Palpable Mass;

Algorithm 3. Abnormal Screening Mammogram with Normal CBE;

Algorithm 4. Spontaneous Unilateral Nipple Discharge;

Algorithm 5. Breast Skin Changes/Nipple Retraction;

Algorithm 6. Breast Pain in a Non-Lactating Woman; and,

Algorithm 7. Management of Breast Biopsy Results.

Fine needle aspiration should be considered only when clinicians seek to rule out or identify cancer in a suspicious breast mass and not for ongoing cyst management nor as a screening tool. Utilization of Fine needle aspiration is allowable under program auspices when employed as intended: to diagnose or rule out breast cancer. Refer to the Fine Needle Aspiration Policy in Appendix I.

Cervical Cancer Screening and Diagnostic Clinical Protocols: CCSP contracted health care providers must deliver appropriate and timely cervical cancer diagnostic services in accordance with DPH protocols and policies including Cervical Cancer Screening Policy in Appendix J and, Diagnostic Excisional Procedures Policy in Appendix K and CCSP Pre-Authorization Form found in Appendix L, included in and with policies that may be developed in the future. Providers must also deliver cervical cancer screening and follow-up of women with abnormalities that are in compliance with nationally recognized guidelines developed by the American Society for Colposcopy and Cervical Pathology (ASCCP). This guidance with accompanying algorithms was established to guide clinicians in the management of women with various cervical abnormalities and can be found at Updated Consensus Guideline Algorithms.

Breast and Cervical Cancer Screening Declaration of Lost to Follow-Up Protocol: The following are the necessary steps to document that a participant is declared lost to follow-up. The steps outlined in the following protocol must be taken by providers when a participant's screening results are abnormal and/or when a precancerous or cancer has been diagnosed. Once this process has been completed and the participant has not been successfully located, this will result in the closure of the screening cycle. The protocol is as follows:

The Provider Must:

1. Notify the participant within two weeks of receipt of the abnormal finding, via telephone.

2. If step 1 is unsuccessful, mail the participant a letter by the end of week three, requesting the participant to contact the Provider.
3. If the participant has not responded by the end of week five, mail a second letter by the end of week six, via certified mail with a return receipt, again requesting the participant to contact the Provider.

4. If the certified letter does not evoke a response by the end of week eight, the participant is considered —Lost to Follow-Up" and,
5. The Provider must document steps 1-4 and include the documentation in the participant's medical chart. In addition, the clinical cycle must be closed with the date of the last notification attempt noted and all data entered into Med-IT.

In order to reduce the number of women who will not accept a certified letter, it is suggested that providers educate women during the enrollment process about the possibility of receiving a certified letter if they do not keep appointments. It is also suggested that the return address on the certified letter contain the name of the screening program and/or a program logo so that the woman can recognize the source of the certified letter.

Colorectal Cancer Screening-Rescreening Services**:** Provide colorectal cancer screening services for eligible men and women ages 50-64. Recruit women who have been enrolled into the CCSP and target the men in their families as well. Also recruit men and women outside of the CCSP through public education, inreach and outreach.

Determine "Initial Program Eligibility": Providers determine the individual's initial eligibility for the program and document findings on the Enrollment Form. Indicate whether or not the individual is eligible for the procedure and the date the procedure will be performed.

Determine "Medical Eligibility" (medical clearance for the procedure): Provider clinical staff determines whether or not the individual is medically able to undergo the colonoscopy procedure. If the initial screening process occurs ~~-in~~ person" at the health care facility, the medical eligibility determination should be conducted by a clinician the same day.

Enroll Participant for Colorectal Cancer Screening Services: Once the patient agrees to have the colonoscopy and the initial and medical eligibility procedures are completed, the participant can be formally enrolled for screening services. The information on the *Enrollment Form* needs to be completed.

Provide Colorectal Cancer Patient Education: Providers educate the patient about colon cancer and how to prevent it, including a review of the colonoscopy procedure, and provide the patient with education materials.

Schedule Colonoscopy Appointment: Once the patient has agreed to undergo the colonoscopy, an appointment needs to be made with a participating gastroenterologist.

Verify Transportation Arrangements: Due to the medications used for the colonoscopy procedure the patient cannot drive. Providers need to assist the patient in making transportation arrangements, reminding them of it a week before the appointment date and emphasizing the need to arrive for the appointment on time.

Preparation for a Colonoscopy: Performing a successful colonoscopy, which means that the doctor is able to view the entire length of the colon, requires that the bowel be cleared of all fecal material prior to the exam. Failure to completely clean the bowel will mean that the colonoscopy will need to be rescheduled, and the patient will have to repeat the whole bowel prep process. As most patients regard the bowel prep as the most unpleasant part of the whole screening colonoscopy process, ensuring that the bowel prep is done properly the first time is important.

Preparing the bowel is accomplished with the use of a laxative, which is relatively strong. During the bowel prep process most patients experience some discomfort and will need to use the bathroom frequently. An important part of preparing the patient for the procedure is making sure that the patient has access to bathroom facilities on the day before the colonoscopy is scheduled.

In addition to the use of laxatives to cleanse the bowel, preparation for a colonoscopy includes some dietary restrictions and may include the discontinuation of certain medications. Each component of the colonoscopy preparation process is described in detail below.

Medications to Avoid before a Colonoscopy: Some medications (prescription and over-the-counter) can reduce the body's ability to form blood clots. Taking these before a colonoscopy may increase the risk of bleeding during and after the exam. For this reason, it is generally recommended to temporarily stop certain drugs before a colonoscopy.

The decision about whether to stop any medication is always based on an estimate of the relative risk of having a significant medical problem during the short time that the patient is off the medication compared to the risk of bleeding complications from the colonoscopy. The provider clinician will make this decision.

Dietary Restrictions Prior to a Colonoscopy: On the day prior to the day on which the colonoscopy is scheduled, the patient should stop eating all solid foods and restrict his or her intake to clear liquids. The patient should not drink liquids that are red or purple in color, as their presence in the bowel may be confused with blood. Typical clear liquid choices are shown in the table below.

Clear Liquid Choices

Apple Juice
Popsicles (orange, lemon-lime)
Tea
Coffee (honey, sugar, and sugar substitutes can be used but **no milk**)
Jell-O (**No red or purple**)
Gatorade (orange, lemon-lime)
Clear soup, broth
White grape juice

Hard candy

Beginning at bedtime or midnight, whichever is earlier, of the evening before the colonoscopy is scheduled; the patient should not eat or drink anything. The only exceptions to this are in the case of a colonoscopy scheduled in the afternoon of the next day or if the patient must take essential medications. If the patient is scheduled for an afternoon colonoscopy, he or she may drink clear liquids up to five hours before the exam. Essential medications may be taken with a sip of water the morning of the colonoscopy.

Generally, a normal diet many be resumed after the colonoscopy is completed and the sedative has worn off. Patients who had a biopsy performed during the colonoscopy may have some dietary restrictions after the exam, such as avoiding nuts and popcorn for three days.

Prep Medications for a Colonoscopy: A variety of laxatives are used to cleanse the bowel of fecal material prior to the colonoscopy. Providing the laxatives to some patient at no cost will be essential to ensure the success of the program. The medications will be provided to the patient in one of two ways: either the provider can supply them to the patient at the time of the medical eligibility exam or the patient can be given a prescription to be filled at a pharmacy. Either way, the patient needs to obtain the prep medications at least three days before the colonoscopy is scheduled. Each provider will need to decide on the best method of getting the medications into the hands of their particular patients.

Colonoscopy Preparation Instructions: A copy of typical Patient Instructions for Bowel Preparation is shown in Appendix Q. Copies of this prep instruction are available in other languages, for example Spanish, and can be accessed at http://www.salix.com/products/moviprep/patient-instructions-fgn.aspx

Because bowel preparation is vital to a successful colonoscopy, ensuring that the patient understands and follows the instructions is extremely important. The patient navigator or another provider staff person should review the prep instructions with the patient at the time that the colonoscopy appointment is made. In reviewing the prep instructions with the patient, several points are particularly important.

Make sure the patient either receives the prep medicines at the time of the visit to the provider site. Without using medicines for proper bowel preparation, no screening colonoscopy will occur.

Make sure that the patient has access to fresh water or other clear liquids (for example, ginger ale, apple juice, Gatorade, and broth). In addition, the patient should have access to a refrigerator where the mixed solution can be stored safely.
Make sure that the patient will be able to be near a bathroom the day before the colonoscopy. While drinking the solution, the urge to go to the bathroom will come on quickly.

Going to the bathroom frequently can cause a sore bottom. The use of plain or aloe baby wipes, Desitin ointment, A&D ointment, or toilet paper with aloe can help relieve a sore bottom.

As the date of the patient's colonoscopy approaches, the patient navigator or another assigned staff will need to contact the patient and go over the following check list. The participant:

- Has obtained the bowel prep.
- Understands how to prepare the Moviprep solution.
- Has access to a refrigerator to store the Moviprep solution.
- Understands how to take all of the Moviprep solution the day before the exam.
- Has stopped any vitamins with iron or vitamin E.
- Is prepared to stop or has stopped all blood thinning medications.
- Has obtained special instructions on continuing or not continuing medications prior to the colonoscopy from the prescribing physicians.
- Understands the dietary restrictions (clear liquids only the day before the colonoscopy, and nothing by mouth the day of the colonoscopy).
- Is aware of the date, time, and place for the colonoscopy.
- Has firm arrangements for transportation to and from the colonoscopy appointment.

On the day before the colonoscopy the patient navigator should conduct a final check with the patient to ensure that the bowel prep has been completed and that transportation to and from the colonoscopy appointment remains in place. This will help reduce the no show rate.

Colonoscopy is Performed: When the patient arrives at the facility where the colonoscopy is to be performed, the gastroenterologist will assess whether the patient was able to follow all of the instructions for preparing the bowel for the colonoscopy examination. If the gastroenterologist determines that the patient is not medically ready or has not completed the bowel preparation, the patient may need to be rescheduled for a colonoscopy at a later date.

If this should happen, the gastroenterologist or his or her staff members will contact the provider with instructions on what should take place before the patient returns for the colonoscopy. In some instances, the patient's primary care provider will need to see the

patient to get his or her medical conditions under better control. The patient will need to go through the process of determining if he or she is medically eligible for the colonoscopy procedure once again. For those patients with inadequate bowel prep, the colonoscopy should be repeated as soon as the patient is medically eligible to tolerate the prep. The patient will need to be issued another bowel prep kit and greater efforts made to ensure that the bowel prep instructions are followed carefully.

Colonoscopy Follow-up: The final consideration in the colorectal cancer screening process is appropriate follow-up to the colonoscopy. Follow-up falls into two general areas: 1) follow-up of any complications for the colonoscopy itself and 2) managing any abnormalities that might have been detected on the exam.

Complications after a colonoscopy: In a large majority of cases, the colonoscopy procedure will be completed successfully without complications. Serious complications, such as perforating the wall of the intestine, are rare, occurring in less than 1 in 1000 patients.

Regardless of whether or not the exam was normal, the patient must be checked for possible complications. Most complications become apparent in the days following the procedure, but some may be delayed for up to 30 days. Each of the participating gastroenterologists will have his or her own instructions for the patient after the colonoscopy is completed. The providers at your institutions should be aware of the specific post-procedure instructions used by the gastroenterologist who sees your patients. In addition, some gastroenterologist or one of their staff members will call and check to see how the patient is doing 1 or 2 days after the exam. Other gastroenterologists may prefer to have one of the provider's staff take responsibility for checking on the patient after the exam. The important point is that everyone is clear on who will have this responsibility.

Because the patient may call your site with concerns after the colonoscopy exam, knowing what to expect after a colonoscopy is important.

Because air is put into the colon during the exam, patients may experience some bloating and cramps afterward. Passing gas relieves these symptoms. Drinking warm liquids, walking, and taking a warm bath can help to pass the gas more quickly. The sedative that is used during the exam may cause some patients to feel tired or drowsy for 1 or 2 days after the exam. Strenuous exercise should be avoided for 12 hours after the exam. Most patients resume normal activities within a day of the exam. Patients who had a colonoscopy without a biopsy may resume a normal diet and their usual medications (including blood thinners) after the exam.

Patients who had a polypectomy performed during the colonoscopy may have some dietary restrictions after the exam, such as avoiding nuts and popcorn for 3 days. In addition, patients who had a biopsy should consult their physician regarding the use of blood-thinning medications such as Coumadin, aspirin, and ibuprofen after the exam.

A small amount of bleeding may occur after the exam. This may be noticed on the toilet paper after wiping or in the toilet bowl. If the bleeding increases or continues for more than 24 hours after the colonoscopy, the patient should contact the GI specialist or the Provider, or go to the emergency room.

If at any time in the 30-day period after the colonoscopy a patient develops a fever over 100° F; pain in the abdomen, chest, or shoulder; or black or bloody stools, the patient should contact the GI specialist or Provider, or go to the emergency room.

Managing abnormalities found during the colonoscopy: Regardless of whether the patient's colonoscopy was totally normal or if abnormalities were found, the GI specialist should send a complete report of the colonoscopy, including the pathology reports for any biopsy specimens that might have been sent to a laboratory, to the site coordinator at the referring provider. The colonoscopy report should contain a recommendation for when the patient should have a repeat colonoscopy in the future. Because the colonoscopy and pathology reports may contain important recommendations for follow-up care, the patient's primary care provider should review these reports as soon as they come into the facility.

Rescreening: If the patient successfully completes the colonoscopy with no abnormalities or complications, the usual recommendation is that he or she under goes another screening colonoscopy in 10 years. Patients who had a biopsy or polyps removed during the colonoscopy may be asked to repeat the procedure in anywhere from a few months to five years, depending on what was found when the biopsy specimens are examined in a laboratory.

If cancer or some other bowel disease was diagnosed on the basis of the colonoscopy or pathology report, the patient should be referred to the appropriate physician for follow-up and treatment. The program director at each of the participating sites along with all pertinent staff will be responsible for making the appropriate referral for the patient based on established guidelines/protocols for treatment referrals.

Referrals: Provide participants with abnormal colorectal cancer screening results with referrals to a medical home or to their primary care provider for follow-up for a cancer diagnosis.

Documentation: Providers document colorectal cancer screening information on the Enrollment Form, the CRC Screening Results form and the Additional Polyps Form and/or into the on-line Med-IT System.

Patient Navigation Services: The patient navigator provides support and guidance in helping patients to navigate through the maze of doctors' offices, clinics, hospitals, outpatient centers, insurance and payment systems, and education services in order to achieve timely delivery of colorectal cancer screening services and patient satisfaction.

Clinical Follow-up-Systems for Referral

Requirement: Breast and Cervical Cancer Screening: Providers must develop a system that will ensure that the necessary procedures to complete a timely and adequate diagnostic work-up for an abnormal screening result or for the referral of a participant to treatment for a cancer diagnosis takes place. Clinical follow-up can also refer to short term clinical follow-up for a BI-RADS 3 category, which generally consists of a follow-up clinical breast exam or mammogram at six months. The adequacy and timeliness of clinical follow-up for breast and cervical participants must be consistent with or exceed CDC policy and benchmark indicators.

Colorectal Cancer Screening: Participants screened for colorectal cancer with abnormal results must be referred to a medical care home or to the primary care provider for follow-up care in accordance with screening protocols.

Guidance: Breast and Cervical Cancer Screening: A woman whose breast or cervical cancer screening is abnormal or suspicious must receive appropriate diagnostic procedures (as defined by the program's clinical protocols) to arrive at a final diagnosis. Women with a diagnosis of breast or cervical cancer must be referred for appropriate treatment. The interval between initial screening and diagnosis of abnormal breast and cervical cancer screenings should be 60 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.

If resources for the continued enrollment of women for screening of breast and cervical participants are limited, priority for the use of these limited funds should be directed toward diagnostic follow-up for women already screened by the program and waiting for diagnostic follow-up services.

Diagnostic testing: When screening results are abnormal for breast and cervical participants, the CCSP provider must ensure that the screening service providers have a protocol for referral of participants to diagnostic service providers who are also CCSP providers. CCSP providers can work with screening providers to identify their normal referral providers and recruit them into the CCSP as necessary.

Treatment: With the enactment of the Breast and Cervical Cancer Prevention and Treatment Act of 2000, referral to Medicaid is available for most women who are diagnosed with cancer through the CCSP. Providers must negotiate treatment services from alternative resources for those women who are not eligible for treatment services through Medicaid.

Colorectal Cancer Screening: If cancer or some other bowel disease was diagnosed on the basis of the colonoscopy or pathology report, the participant is referred to the appropriate physician for follow-up and treatment. Provider staff are responsible to assist the participant in making the appropriate referral.

Providers can identify flow diagrams, with associated detailed narratives including timelines, to identify the specifics of each type of follow-up system. The flow diagram can be used to support evaluation of the effectiveness of the follow-up system.

Providers need to refer participants for financial counseling services when needed to facilitate access to medical care and treatment and to medications.

Case Management/Patient Navigation

Case management services are intended to ensure complete and timely clinical follow-up according to specific program protocols for program participants who had abnormal screening results for breast and cervical cancer screening.

Patient navigation services assist the colon cancer screening participant in navigating the health care system through the screening process.

Requirement: Breast and Cervical Cancer Screening Services**:** Providers must offer case management services, by a Connecticut licensed registered nurse or licensed social worker, to women screened and found to have abnormal screening results for breast and cervical cancer. The *Case Management Policy/Needs Assessment Form* is located in Appendix R.

Colorectal Cancer Screening: The patient navigator is responsible for assisting the participant in navigating through the complexities of the health care system in order to have the colonoscopy procedure performed. The patient navigator also ensures arrangement of the direct provision of medical care as determined by the site participating gastroenterologist and other medical care providers to address complications and/or treatment of cancer.

Guidance: Breast and Cervical Cancer Screening: The provider must ensure that the case manager tracks and conducts —clinical follow-up" for all participants screened for breast and cervical cancer and collects abnormal screening results from screening providers in a timely fashion according to specific time lines identified in the program protocols.

Colorectal Cancer Screening**:** The patient navigator must ensure that arrangements have been made for participants, as determined by the site participating gastroenterologist and other medical care providers, to address complications and/or the treatment of cancer.

Section III: Data Management, Quality Assurance/Quality Improvement, and Evaluation

Overview

This section provides guidance and resources for collecting, analyzing, and reporting a structured data set for characterizing screening, diagnostic follow-up, and treatment efforts; monitoring data collection and analysis efforts, using results for program evaluation and improvement, and reporting results to the Connecticut Department of Public Health in compliance with contract mandates.

Data Management

Purpose: The purpose of data management is to ensure the availability of high quality data for program planning, quality assurance, and evaluation.

Requirement: Providers are required to develop and manage data collection and electronic documentation according to CDC and DPH mandates, policies and guidelines.

Guidance: Federal —Early Detection Programs" like the NBCCEDP and the CRCCP are grounded in Public Law, regulated by Federal Government, and administered by grantees under the direction of the CDC.

CDC requires documentation of accountability for these programs through the management of data in a structured format. Data, especially the results of screening and diagnostic services, should be used to evaluate and inform each of the other program components.

To meet expectations in the area of data management, providers are to:

- Establish and maintain a data system to collect, edit, manage, and continuously improve the data needed to track a participant's receipt of screening/rescreening, diagnostic, and treatment services;

- Establish a system that provides routine and ad-hoc reports for program management;

- Establish mechanisms for reviewing and assessing the completeness, accuracy and timeliness of data collected by the grantee; and,

- Establish protocols to ensure the security and confidentiality of all data collected.

The Clinical Data Collection and Reporting Requirements Manual is available as a separate document for guidance on data collection and reporting.

Confidentiality-The Privacy Rule and HIPAA

Requirement: Providers are required to follow the U.S. Department of Health and Human Services Privacy Rule and implement the requirements of the Health Insurance Portability and Accountability Act of 1996 (―HIPAA").

Guidance: The Standards for Privacy of Individually Identifiable Health Information (―Privacy Rule") establishes a set of national standards for the protection of certain health information. The U.S. Department of Health and Human Services (―HHS") issued the Privacy Rule to implement the requirement of the Health Insurance Portability and Accountability Act of 1996 (―HIPAA"). The Privacy Rule standards address the use and disclosure of individuals' health information—called ―protected health information" by organizations subject to the Privacy Rule — called ―covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used. Within HHS, the Office for Civil Rights (―OCR") has responsibility for implementing and enforcing the Privacy Rule with respect to voluntary compliance activities and civil money penalties.

A major goal of the Privacy Rule is to assure that individuals' health information is properly protected while allowing the flow of health information needed to provide and promote high quality health care and to protect the public's health and well-being. The Privacy Rule strikes a balance that permits important uses of information, while protecting the privacy of people who seek care and healing. Given that the health care marketplace is diverse, the Privacy Rule is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed.

Participants of the CCSP must agree or consent to have personal and family history information collected and shared with the DPH. By signing a program consent form, the participant grants permission to any and all health care providers to report all information concerning screenings tests and procedures, treatment, case management, and any related care or activity to the CCSP state office. This form must be completed at the time when the participant enrolls in the CCSP. A new consent form must be signed at each annual rescreening. Verbal consent at the time of annual rescreening is not acceptable.

Minimum Data Collection and Electronic Documentation

Requirement: Providers are required to collect and electronically document a minimum amount of program information referred to by the CDC as Minimum Data Elements (MDEs) and Colorectal Cancer Clinical Data Elements (CCDEs). Data collection and electronic documentation is to be done according to program policies and guidelines.

Guidance: MDEs/CCDEs are a set of standardized data elements established by the CDC to report demographic and clinical information on participants served with CCSP funds. MDEs/CCDEs are the minimum data items considered necessary for CDC and grantees to be able to monitor and evaluate program performance. MDEs/CCDEs are

used to establish policies and practices, access program outcomes, and respond to the informational needs of stakeholders and partners.

The CCSP must show a positive impact to public health from the funds awarded and expended in pursuit of program goals. Compliance with the collection and electronic documentation of MDEs/CCDEs allows for routine evaluation of the performance and the value of each funded program, demonstrating accountability, and providing a solid basis for decision-making that will lead to stronger and more effective programs. Accurate electronic documentation of appropriate clinical practices allows for the financial reimbursement of services provided with program funds.

Online Medical Information Tracking (Med-IT) System

Requirements: Providers are required to develop and manage data collection and electronic documentation of MDEs/CCDEs according to CDC and DPH mandates, policies and guidelines. This is to be done using the online medical information tracking system Med-IT®.

Guidance: DPH uses the OxBow Data Management Systems, LLC, Online Medical Information Tracking System (Med-IT) to manage clinical, demographic and financial program data. Med-IT is designed for HIPAA compliancy and meets all current CDC requirements of the CCSP. The Med-IT system can be used to assist providers in maintaining complete and timely records.

Pursuant to contractual agreement, providers must submit data as mandated by the CDC and shall do so using the Med-IT system available online at https://www.med-itweb.com. Data collection forms have been developed by DPH and approved for use by CDC to aid providers in collecting all required fields. The following data collection forms can be accessed through the Med-IT system:

- CCSP Enrollment Form;
- CCSP Screening and Assessment Form; and,
- CCSP Breast and Cervical Cancer Diagnosis and Treatment Form.

Med-IT users have real-time access to data for program planning, quality assurance, and evaluation. Programs are encouraged to run routine reporting functions inherent in the Med-IT system to ensure the availability of high quality data and to evaluate and inform each of the other program components for continuous improvement. A document called Optimizing Program Performance Using Med-IT Reports can be found in (Appendix V) to aid in these activities.

Example data to be gleaned from these reports include:

- Counts/rates of services provided and counts/rates of the outcome of those services, supporting grantees to manage program resources;

- A listing of clinically appropriate services that are not documented as having been completed, supporting the provider to ensure compliance with clinical protocols;

- A listing of clients coming due for an interval-appropriate screening services, for patient and provider reminder services; and,

- Real-time accounting of claim reimbursement status to aid in responsible stewardship of program funds.

Data from Med-IT can be extracted for use with other software such as Microsoft Office to generate such output as spreadsheets and mail merges for creating patient reminder notifications for participants who have yet to completed/update their enrollment forms, sign their medical release forms, obtain a scheduled service, or who will be due for a re-screening visit.

Documentation of Clinical Accountability/Performance Indicators

Requirement: The complete and accurate accounting of all program-funded services provided to participants enrolled in the CCSP is further measured by the CDC with compliance to specific —Performance Indicators.” All grantees are required to perform in compliance with these indicators.

Guidance: Specific performance indicators (outcome evaluation criteria) have been identified by CDC as having the most impact to program performance. They are referred to by several different names and are listed below. Providers are encouraged to meet and exceed these performance indicators.

Performance Indicators for Breast Cancer Screening:

- At a minimum, 75% of all participants receiving a mammogram with funds provided under this contract must be 50 years of age or older.
- At a minimum, 90% of abnormal clinical breast examinations and abnormal mammograms identified with funds provided under this contract must have complete diagnostic follow-up.
- At a minimum, 75% of abnormal clinical breast examinations and abnormal mammograms identified with funds provided under this contract must have less than 60 days from date of screening to date of diagnosis.
- At a minimum, 90% of all diagnoses of CIS, other, DCIS, or Invasive Breast Cancer obtained with funds provided under this contract must have treatment initiated.

- At a minimum, 80% of all Invasive Breast Cancer diagnosed with funds provided under this contract must have less than 60 days from date of diagnosis to date treatment is initiated.

Performance Indicators for Cervical Cancer Screening:

- At a minimum, 20% of all participants provided a Pap test on the first breast and cervical cancer screening program encounter, with funds provided under this contract, must have never had a Pap test or not have had a pap test within the last five years.
- At a minimum, 90% of abnormal Pap tests performed with funds provided under this contract must have complete diagnostic follow-up.
- At a minimum, 75% of abnormal Pap tests performed with funds provided under this contract must have less than 60 days from date of screening to date of diagnosis.
- At a minimum, 90% of all diagnoses of HSIL, CIN II, CIN III, or Invasive Cervical Cancer obtained with funds provided under this contract must be referred for and have treatment initiated.
- At a minimum, 80% of all diagnoses of HSIL, CIN II, or CIN III/CIS, obtained with funds provided under this contract must have an interval of less than 90 days from date of diagnosis to date treatment is initiated.
- At a minimum, 80% of all diagnoses of Invasive Cervical Cancer must have less than 90 days from date of diagnosis to date treatment is initiated.

Performance Indicators for Colon Cancer Screening:

- At a minimum, 75% of new participants screened are at average risk for colorectal cancer.
- At a minimum, 95% of all Program participants who receive colonoscopies must be 50 years of age or older.
- At a minimum, 90% of all Program participants whose colonoscopies result in an abnormality must have complete diagnostic follow-up.
- At a minimum, 95% of all Program participants diagnosed with colorectal cancer must have treatment initiated.
- At a minimum, 80% of Program participants diagnosed with colorectal cancer must have an interval of less than 60 days from date of diagnosis to date treatment is initiated.

Documentation of Financial Accountability

Requirement: Grantees are required to track expenditures for clinical reimbursement in the Med-IT system. Grantees are also required to submit a Contract Balance Report

from the Med-IT system with each Expenditure Report that is submitted under contractual mandate. Both reports must balance.

Guidance: Med-IT provides a complete audit trail within the customized billing function of this online medical information tracking system. PARAMOUNT to financial accountability is the complete, accurate, and timely recording of program-funded services provided to a participant.

Reimbursement of clinical service claims (charges) with program funds cannot be processed if the clinical data is not in line with clinical protocol and if the clinical data does not coincide with the claims data. Examples of this include:

Cases where the service is not due (instances of over screening);

Cases where the service is not reimbursable (inappropriate use of funds); and,

Cases where the date of service, the service provider, or the Current Procedural Terminology (CPT) code in the clinical record does not match the claims record.

Grantees will be provided with a list of allowable procedures, relevant CPT codes, and reimbursement rates for each fiscal year. The Med-IT system is programmed to reimburse only those claims for services as defined by clinical protocol and on the allowable procedures and CPT codes list. This includes age eligibility for services rendered and compliance with recommended screening intervals. The Med-IT® system will check for duplicate billing and alert the user if a claim has been previously entered.

The Med-IT system will provide a detailed invoice (billing authorization report) for each contractor or their subcontractors, to be submitted with physical reimbursement for clinical services provided.

Current Procedural Terminology (CPT Codes)/Reimbursement

Requirement: Providers are required to use appropriate CPT Codes from the CCSP Allowable Procedures and Relevant CPT Codes document to identify screening procedures and tests and to identify appropriate reimbursement rates. Providers are not to bill CCSP participants for any out-of-pocket expenses incurred for services that are covered in the program.

Guidance: Current Procedural Terminology (CPT) is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose for the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effect means for reliable nationwide communication among physicians, patients and third parties.

CCSP funds can only be used to reimburse services approved by the CDC. The Connecticut Allowable Procedures and Relevant CPT Codes document provided in Appendix T contains those CDC-approved services with rates effective from July 1, 2014 to June 30, 2015. Services are reimbursed at the Connecticut adjusted Medicare rates. Allowable CPT codes have been grouped by program and service type for the purpose providing an explanation of how each CPT code is to be utilized. As mentioned above, grantees will be provided with an updated list of allowable procedures, relevant CPT codes, and reimbursement rates for each fiscal year.

Quality Assurance/Quality Improvement

Purpose: The purpose of quality assurance and improvement is to ensure the quality of services delivered through the CCSP, to monitor performance and identify opportunities for improvement, and plan effective strategies for improving services. Quality assurance and improvement functions in concert with data monitoring and evaluation to assess, and improve program outcomes.

Requirement: Providers are required to participate in quality assurance and quality improvement activities as deemed appropriate by the DPH. This includes compliance with contractual performance measures and participation in scheduled site visits and professional development trainings.

Guidance: Quality assurance (QA) includes retrospective assessment of the level of quality at a point in time. It provides an opportunity to measure performance against standards or benchmarks. Ideally it creates a bridge between monitoring and quality improvement by establishing a common understanding of the quality of services provided and identifying opportunities for improvement. Quality improvement (QI) is the commitment and approaches used to proactively and continuously improve every process in every part of an organization, with the intent of meeting current professional knowledge and standards and exceeding expectations and health outcomes. QA and QI are designed to increase the likelihood of desired health outcomes.

MDE/CCDE data and the Med-IT system can be used to ensure quality services both prospectively and retrospectively. QA examples include tracking the current screening status of an individual participant to provide routine reminders for promoting regular rescreening or to provide inquiries to subcontractors about obtaining pending test results. QA refers to that which has been done, and identifies overall program trends of timeliness and adequacy. Running evaluation of current data can help ensure retrospective QA is favorable. A document called Optimizing Program Performance Using Med-IT Reports can be found in Appendix V to aid in these activities.

The CCSP is actively involved in ensuring that participants receive quality, timely and appropriate clinical services by monitoring clinical service delivery and performance of contracted providers, identifying areas for improvement in care, and assisting with planning and implementation of effective strategies for improved service delivery.

To meet expectations for QA/QI, grantees should:

- Collaborate with the DPH nurse consultant and the medical advisory boards (MABs) to ensure the quality of clinical services being delivered;
- Ensure all service providers use established clinical practice guidelines and protocols that have been endorsed by the CDC and the MAB;
- Establish a system for monitoring program services to identify potential problems and capitalize on best practices;
- Regularly assess program data for opportunities to improve outcomes of participants serviced by the program; and,
- Initiate improvement strategies and ensure a continuous cycle of monitoring until outcomes demonstrate that improvement has been sustained.

Evaluation

Purpose: The purpose of evaluation is to assess quality, implementation, effectiveness, and efficiency of program activities, including population based activities.

Requirement: Providers are required to engage in evaluation activities as deemed appropriate by the DPH. This includes routine submission of contractual progress and expenditure reports as well as participation in site visits, conference calls, surveys, workshops and tri-annual narratives assessing program progress toward goals and objectives.

Guidance: Program evaluation is —the systematic collection of information about program activities, characteristics, and outcomes to make judgments about the program, improve program effectiveness, and/or make decisions about future program development." Through evaluation, one can examine the effectiveness and efficiency of the program overall. Evaluation data emphasizes areas of program strength and highlights areas that are in need of improvement. Evaluation findings help to monitor progress toward desired outcomes, improve program operations, and demonstrate to stakeholders how the program maximized the use of resources. All providers should participate in evaluating the impact of their programs in their respective communities. Providers are encouraged to:

- Design evaluation activities with the explicit purpose of providing quality, effectiveness and efficiency to program operations;
- Integrate evaluation activities within all program components; and,

- Use evaluation findings as the foundation for overall program planning and program improvement.

Elements of program evaluation include the ability to describe the program in a functional, diagrammatic flow process so that individual processes could be evaluated for their effectiveness and productivity. Evaluation plans use a combination of qualitative and quantitative methods to establish a foundation for overall program planning and improvement.

Evaluation aims to better serve program staff members, participants, and partners by making judgments about the program or its components, improving effectiveness, and informing others about program accomplishments.

Process Evaluation focuses on how a program or intervention works to attain specific goals and objectives. Process evaluation answers the question: Are we doing what we said we would do? Process evaluation often provides insight into why a goal or objective is or is not met. Examples of a process evaluation question would be:

How well do the subcontractors understand clinical protocol and guidance documents?

- How quickly do we get test results from service providers?
- How likely is the participant to comply with clinical recommendations?
- How effective are we at navigating participants through the system?

Outcome Evaluation focuses on what effect the program actually has on those directly, or indirectly experiencing the program (i.e. clients, providers, communities). Outcome evaluation provides information about whether the program has been able to meet its short-term and intermediate goals and objectives. Examples of an outcome evaluation question would be:

- To what extent has the program met its screening targets?
- To what extent has the program delivered appropriate and timely services?
- How have community partners contributed to increasing screening rates?
- Are providers actually following clinical guidelines for screening?

Impact Evaluations focus on the effects the program has on participants, health systems, and communities. Examples of an impact evaluation question would be:

- Is the program detecting more disease in earlier stages of development?

- Are participants receiving and benefiting from appropriate treatment for their diagnoses?

- Are more participants aware of the importance to screen for early detection?

- To what extent has a program delivered appropriate and timely services to a community?

- How have community partners supported the delivery of services to eligible populations?

The CDC has a Framework for Program Evaluation that DPH staff are readily familiar with. It is important to work with DPH staff to ensure each program functions at its optimal and makes the best use of resources available to reduce the burden of disease in our communities.

I. Introduction

1. Overview:

This guidance document is presented to facilitate understanding of the financial requirements associated with holding a service contact issued by the Department of Public Health (Department). While the majority of the guidance contained herein relates to contractor financial reporting obligations there is information, notably in this introduction Section, to assist with preparation of acceptable contract budget information.

2. Universal Chart of Accounts:

a. The Department and other State Human Service Agencies, under the leadership of the Office of Policy and Management (OPM), have developed a Universal Chart of Accounts (UCOA) for use with all POS Contracts and PSA contracts where possible. Implementation of the new UCOA will be phased in beginning with new contracts, contract renewals, and changes in contract Funding Periods effective July 1, 2014.

b. In conjunction with the UCOA, an integrated MS Excel UCOA Workbook has been developed that utilizes linked spreadsheets to minimize duplicate entries, reduce errors and simplify budget development and contract reporting activities. For many if not most Department contracts, the UCOA Workbook will replace other electronic reporting formats being used by the Department.

c. Guidance on use of the UCOA Workbook exists as:

i. Account definitions included within the Workbook;

ii. Usage Instructions incorporated directly within the Workbook;

iii. Training overview webinars posted to the OPM and State Agency websites;

iv. Direct assistance from State Agency Support staff.

State Agency may also implement special training sessions for Providers, as needed.

d. As the UCOA becomes implemented, guidance regarding its use shall be available in these forms/formats. The information contained herein does not apply to the new UCOA Workbook format. All instructions in this guide refer to current forms in use (or planned for use) by the Department. At a future date, as current tools become obsolete, these Guidelines will be revised accordingly.

3. Administrative and General (A&G) Costs:

a. Overview:

A&G costs are those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective.

i. Because of the diverse characteristics and accounting practices of organizations, it is not possible to specify the types of cost that may be classified as A&G costs in all situations. In addition, there is no universal definition of A&G costs in federal OMB circulars, GAAP, or other cost accounting standards. Therefore, for the purposes of these cost standards, A&G is defined as those costs that have been incurred for the overall executive and administrative offices of the organization or other expenses of a general nature that do not relate solely to any major cost objective of the organization. They are costs that by their nature are administrative in support of the overall organization. This category must also

include its allocable share of fringe benefit costs, operation and maintenance expenses, depreciation, and interest costs.

ii. For the purposes of clarification, examples of A&G costs include, but are not limited to, the following:

1) Business or office management;

2) Salaries and other expenses (e.g., payroll, taxes, benefits, travel) of executive directors, administrative personnel, or secretaries for portion of time spent administering the general organization's affairs;

3) Salaries and other expenses (e.g., payroll, taxes, benefits, travel) of employees whose duties consist primarily of general legal services; personnel administration; budget and planning; finance; accounting, auditing or financial reporting; business services; safety or risk management; management information systems; library; record keeping; filing, mail distribution, or other general services;

4) Providing executive direction and organization planning;

5) Attending general board, committee, or staff meetings (unless held in connection with specific programs or fundraising activities);

6) Annual meeting;

7) Preparation, publication, or distribution of an annual report;

8) Proportion of costs of training conferences, workshops, or seminars that deal with administration or general topics;

9) General legal services;

10) Personnel administration;

11) Budget and planning;

12) Finance;

13) Accounting, auditing or financial reporting;

14) Business services (purchasing, accounts payable, etc.);

15) Safety or risk management;

16) Management information systems;

17) Library;

18) Record keeping;

19) Filing, mail distribution, or other general services;

20) In addition to staff expenses, proportional office costs (e.g., building occupancy, telephone, office supplies, equipment).

b. Cost Allocation Plans (CAP):

i. The purpose of the cost allocation plan (CAP) is to summarize, in writing, the methods and procedures the organization uses to allocate costs to benefiting programs and activities. Only costs that are allowable, in accordance with the State of Connecticut Cost Standards shall be allocated to the State award. The CAP must include provisions for allocating A&G costs. The plan must be initially

approved by the Board of Directors for inclusion in the organization's official policies and procedures.

ii. All costs and other data used to distribute costs in the CAP must be supported by accounting and other records that ensure the propriety of costs assigned to the State award. Once an organization establishes an allocation methodology, it must be used consistently over time. The CAP must be retained on file for audit and made available to State agencies, upon request.

iii. Revisions to the Plan

The CAP must be reviewed on an annual basis and updated, as necessary, to reflect any changes in the allocation methodology. Significant changes to the allocation methodology require approval of the Board of Directors. Such changes must result in a more equitable distribution of costs. Justification for changes must be documented and supported by actual cost data.

c. Allocation Methodology:

i. Although there are different methodologies available for allocating costs, the methodology used must result in a reasonable and equitable distribution of costs to programs and activities based upon the benefits received.by the State-funded program and other activities.

ii. The organization must document its allocation methodology for A&G costs in the CAP. The CAP must identify each type of A&G cost and each A&G cost pool that allocates costs to the organization's programs and activities. The CAP must document the specific method used to allocate each type of cost or specific cost pool.

iii. The use of cost pools to distribute A&G costs is an allowable method to allocate costs to State-funded programs. The cost pool methodology must result in an allocation of costs to both State-funded programs and other activities and must be equitable and reasonable to the benefits received.

iv. Direct costs that are applicable to an organization's programs or activities must not be included in any A&G cost pool that results in a charge to a State-funded program.

4. <u>Fringe Benefits:</u>

a. Overview:

A contract that authorizes the payment of employee Salaries and Wages also allows for reasonable and acceptable charges for the recovery of Fringe Benefits paid to those employees. Fringe Benefits are defined as:

i. regular compensation paid to employees during periods of authorized absences from the job (such as vacation, sick, or military leave);

ii. employer contributions or expenses for social security, health insurance, retirement plans, workers' compensation, short-term or long-term disability, life insurance, health savings account, training, or tuition reimbursement;

iii. provisions for a reserve under self-insurance for unemployment compensation, workers' compensation, or health insurance;

iv. life insurance costs are the costs of insurance on the lives of trustees, officers, or other employees holding positions of similar responsibility.

b. Allowable Costs:

Contracts employing State funds must comply with the State of Connecticut Cost Standards, established by OPM, to determine whether individual cost components are allowable for inclusion in Fringe Benefits, unless more restrictive regulations exist for a particular Program. Federal grants may employ different standards for acceptability of Fringe Benefit cost components. Per the State of Connecticut Cost Standards, the following are allowable Fringe Benefit costs:

i. Fringe benefits in the form of regular compensation paid to employees during periods of authorized absences from the job are allowable, provided such costs are in accordance with established written organizational policies and are distributed to all organizational programs and activities in proportion to the relative amount of time or effort actually devoted to each.

ii. Fringe benefits in the form of employer contributions are allowable in accordance with the provisions of the standards, provided such benefits are granted in accordance with established written organizational policies and are distributed to all organizational programs and activities on an equitable basis.

iii. Costs incurred for a reserve under self-insurance for unemployment, workers' compensation, or health insurance are allowable to the extent that (a) the provisions represent reasonable estimates of the liabilities for such compensation, and (b) the types of coverage, extent of coverage, and rates and premiums would have been allowable had insurance been purchased to cover the risks. However, provisions for self-insured liabilities that do not become payable for more than one year after the provision is made must not exceed the total projected loss as calculated by an independent third party.

iv. Life insurance costs are allowable only to the extent that the insurance represents additional compensation for personal services.

v. Costs of the organization's retirement plan that are incurred in accordance with the established written policies of the organization are allowable, provided:

1) Such policies meet the test of reasonableness; and

2) The methods of cost allocation are equitable for all programs and activities; and

3) The cost assigned to each fiscal year is determined in accordance with GAAP; and

1) The costs assigned to a given fiscal year are paid or funded for all plan participants within applicable IRS and Employee Retirement Income Security Act (ERISA) of 1974 (PL 93-406) guidelines;

vi. Retirement plan termination insurance premiums paid pursuant to ERISA are allowable.

c. Unallowable Costs:

Per the Connecticut Cost Standards, the following Fringe Benefit costs are unallowable:

i. Any Items of costs claimed for reimbursement on a "Salary and Wages" line-item cannot also be include in the Fringe Benefit Category.

ii. Costs of insurance on the lives of trustees, officers, or other employees holding positions of similar responsibility when the organization is named as beneficiary are unallowable.

iii. Increases to normal or past service retirement costs caused by a delay in funding the actuarial liability beyond contractual or regulatory standards are unallowable.

iv. Late payment charges on retirement plan termination insurance premiums paid pursuant to ERISA are unallowable.

v. Excise taxes on accumulated funding deficiencies, prohibited transactions of pension plan fiduciaries, and other penalties imposed under ERISA are unallowable.

d. Justification of Requests:

Any request for contractual reimbursement of Fringe Benefit shall include a justification. That justification shall include a breakdown of the overall composition of the Fringe Benefit Cost Pool and indicate either percentage or actual amount that each component comprises of the total Fringe Benefit amount being requested.

e. Fringe Benefit Budgeting:

Fringe Benefit expenses for employee Salary and Wages shall be included on the budget for which the Salary and Wages Expenses are requested. In other words, If there are multiple budgets, representing multiple Programs or activities within a single contract, the Salary and Wages cannot appear on one budget and the Fringe Benefits on a different one.

II. Monthly Cash Management System

All contractors (subgrantees) awarded DPH prepayment grants that are managed in accordance with Monthly Cash Management System procedures shall submit monthly Financial Reporting and Cash Needs Reports. Submission of these reports will be done using either the UCOA Excel Workbook discussed in the Introduction or a similar DPH Financial Reporting and Cash Needs Workbook (FRCN) consisting of linked spreadsheets to facilitate accurate and timely reporting. Receipt of the Financial Reporting and Cash Needs Reports of the Workbook will allow the Department of Public Health (Department) to effectively monitor the actual cash balances of subgrantees prior to issuing payments subsequent to the initial contract payment(s). This prerequisite is pursuant to 45CFR92.20(b)(7) of the Code of Federal Regulations which requires that grantees must monitor cash drawdowns by their subgrantee to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees. In addition, 45CFR92.21(c) provides that subgrantees shall be paid in advance, provided they demonstrate the ability to minimize the time elapsing between the transfer of funds and the subsequent disbursement.

1. <u>Reporting:</u>

Contractors shall submit the Financial Reporting and Cash Needs Reports to the Department in addition to any other contractually required reports. With the exception of the final Financial Reporting and Cash Needs Report, all reports for the current contract Funding Period are due by the 15th day of the month for the expenditures incurred by the contractor for the entire preceding month. The **Final** Financial Reporting and Cash Needs Report is due by the last day of the second month following the close of the contract Funding Period. For example, if the contract Funding Period is July 1 – June 30:

Financial Reporting and Cash Needs Report for the Period:	Due Date:
July 1 – July 31	August 15
August 1 – August 31	September 15
September 1 – September 30	October 15
October 1 – October 31	November 15
November 1 – November 30	December 15
December 1 – December 31	January 15
January 1 – January 31	February 15
February 1 – February 28	March 15
March 1 – March 31	April 15
April 1 – April 30	May 15
May 1 – May 31	June 15
June 1 – June 30	August 31

2. Payment:

a. Contract payments are made prospectively upon contract execution and at the beginning of each month, or as indicated in the contract payment schedule, and are calculated using a base equal to a one month proportional distribution of funds for the contract Funding Period and applying an adjustment based on the variance between the last submitted expenditures and a one month proportional distribution of funds. For example, assuming the contract Funding Period is twelve months duration and the Funding Period total amount is $120,000:

i. The first payment for the contract Funding Period is payable no earlier than contract execution and the beginning of the first month of the contract Funding Period in the amount of 1/12th of $120,000, or $10,000. Note that there are no reported expenditures at this time upon which to base an adjustment.

ii. The second payment for the contract Funding Period will be made no earlier than contract execution and the beginning of the second month of the contract Funding Period in the amount of 1/12th of $120,000, or $10,000. Note again that there are still no reported expenditures upon which to base an adjustment.

1) On the 15th of the second month of the contract Funding Period a Financial Reporting and Cash Needs Report is received showing expenditures for the first month of the contract Funding Period equal to $9,000, of which no amount is disallowed by the Department.

2) The difference between $10,000 (1/12th of the contract Funding Period amount) and the reported $9,000 is $1,000.

iii. The third payment for the contract Funding Period will be made no earlier than contract execution and the beginning of the third month of the contract Funding Period in the amount $10,000 minus $1,000 for a net payment of $9,000.

iv. Payment shall continue in the manner until all funds for the contract Funding Period have been allocated or the final Financial Reporting and Cash Needs Report is received, whichever occurs first.

v. A final reconciliation will be performed after receipt of the final Financial Reporting and Cash Needs Report and may result in an additional payment to

the contractor if total allowable expenditures exceed the amount of funding paid to the contractor or a refund required from the contractor if the amount of funding paid exceeds the allowable expenditures reported.

b. Except in the case where the funding source is non-lapsing funds each contract Funding Period is accounted for separately. Therefore the Financial Reporting and Cash Needs Report for the second, and each subsequent contract Funding Period will begin again with no reported expenditures for the first two month periods of the new Funding Period. Also the final Financial Reporting and Cash Needs Report for any Funding Period must close out that reporting period resulting in a final reconciliation. Normally, neither funds nor expenditures span multiple years.

3. Workbook Organization:

The remainder of the discussion of the Monthly Cash Management System focuses on use of the FRCN. Separate training aids, instructions, and definitions are associated with the UCOA Workbook and available separately. The FRCN consist of a group of related and integrated worksheets organized into colored tabs for ease of recognition as follows:

a. **Yellow** tabbed worksheets include the following informational, budgetary, budget schedules, and budget revision information:

i. **Contract Data Sheet** (FRCN only) – a collection of static contract information defining the contractor, contract, contract funding and contract period dates.

ii. **Positions** (FRCN) or **Schedule A Salaries** (UCOA) – a contract position schedule accounting for the positions, individuals, rates of pay, hours worked, and fringe benefits, budgeted to be charged to the contract. This tab is a schedule of personnel salary and fringe benefit expenses that are rolled-up to consolidated Salary/Wages and Fringe Benefit budgetary line items.

iii. **Contractual** – subcontractor schedules accounting for services budgeted to be provided by subcontractors employed by the contractor reflecting funding that will be provided through the contract to support those services.

iv. **Budget Services** – a schedule of primary and/or support services budgeted to be funded through the contract and rolled-up to consolidated budgetary line items. The Budget Services are a detail schedule of these items similar to the Position tab containing the Position Schedule.

v. **Budget** – a complete budgetary representation of all funding authorized by the contract separated by, and allocated to, appropriate budgetary line items (categories). Some of the budgetary line items include high-level roll-up amounts from appropriate schedules i.e., Positions, Contractual, and Budget Services. In those cases a separate line is for the schedule amount is displayed on the budget and is maintained separate from the approved budget amount. This is to allow for the collection of changed schedule amounts within the Department's budgetary variance allowance prior to submission/approval of a budget revision.

vi. **Budget_Rev** – a collection of suggested and/or requested reallocation of funds from one budgetary line item to another.

b. **Green** tabbed worksheets include the expenditure **reporting** data and periodic line item detail required for submission to the Department. The darker shaded tabs represent the Expenditure Report data and the lighter shaded tabs represent the supporting detail as described in the following:

i. **Program Expenditure Report(s)** – reporting form(s) to record monthly expenditures in each of the budgetary line items comprising the contract budget. There may be multiple expenditure reporting forms if the contract contains multiple Programs and/or funding sources requiring separate reporting. The Expenditure Report forms also include information indicating the payment request that will result from the expenditures, trend information to assist with distribution of expenditures uniformly throughout the Period, and an area for the contractor to submit any other Program income information required by the Department but not used to offset contract expenditures. Program Expenditure Report form worksheet tabs names include the Program label and the funds source label for ease of identification.

ii. **Subcontractor Expenditure Report(s)** – reporting forms to record expenditures incurred by subcontractors employed by the contractor to provide services funded by the contract. Subcontractor expenditures are reported in the same manner as for the contractor's Program Expenditures with a separate report for each subcontractor employed. These report amounts comprise the detail of the Contractual line item expenditures reported by the contractor on its Program Expenditure Report and when combined should normally equal that amount. The Subcontract Expenditure information may be included and submitted monthly but is mandatory for submission at the end of each period identified as the end date of each period. When reported monthly, the amounts are to be adjusted each month to represent the cumulative amount for the period covered.

iii. **Salary Detail** – a periodically required breakout of Salary/Wages and Fringe Benefit amounts for each contractor employed individual funded by the Contract. This form provides the position and person level detail supporting the Salary/Wages and Fringe Benefits budgetary line items and the total(s) from this form must equal the amount reported on the contractor's Program Expenditure Report(s). There is a separate Salary Detail reporting grid for each Program funding via the contract. The Salary Detail information may be included and submitted monthly but is mandatory for submission at the end of each period identified as the end date of each period.

iv. **Service Detail** – a periodically required breakout of budgeted Service amounts for each Budget Service funded by the contract, as represented on the Budget Service tab. This form provides detail supporting the Service budgetary line item(s) and the total(s) from this form must equal the amount reported on the contractor's Program Expenditure Report(s). There is a separate Salary Detail reporting grid for each Program funding via the contract. The Salary Detail information may be included and submitted monthly but is mandatory for submission at the end of each period identified as the end date of each period.

c. **Blue** tabbed worksheets include the contractor and subcontractor budgets in a printable format as described in the following:

i. **Contract Budget** – a printable version of the consolidated contract budget. This budget presentation is available and should be printed at any time there is a change in the contract budget such as after the acceptance by the Department of a budget revision. The printed document should be incorporated into any printed version of the contract being maintained.

ii. **Subcontractor Budget 1** – if subcontractors are employed, this tab contains a printable version of subcontractor budgets for subcontractors one through three.

This budget presentation is available and should be printed at any time there is a change in the budget amounts for subcontractors one, two, or three such as after the acceptance by the Department of a budget revision. The printed document should be incorporated into any printed version of the contract being maintained.

iii. **Subcontractor Budget 2** – if more than three subcontractors are funded by the contract this tab contains a printable version of subcontractor budgets for subcontractors four and five. This budget presentation is available and should be printed at any time there is a change in the budget amounts for subcontractors four or five such as after the acceptance by the Department of a budget revision. The printed document should be incorporated into any printed version of the contract being maintained.

4. **Form Completion and Use:**

Forms within the Financial Reporting and Cash Needs Report Excel Workbook are completed as follows:

a. **Prior to contract execution and/or to set up the contract:**

i. **Completed by the Department:**

1) **Contract Data Sheet** – The Department will complete the entries on this sheet to reflect contract related information such as contractor name, contract number, contract term, contract Programs, contract fund sources, funding period start and end dates.

2) **Budget Services** – If a schedule supporting budgetary line-items (Services) is required, the Budget Services will be listed on this sheet under the name of the Budgetary line item for which they will consolidate to on the budget.

3) **Budget** – Any specifically required budgetary line items will be listed on this sheet by the Department. Four line items will always appear on the budget and are associated with the consolidated amounts from the Yellow schedule tabs. These are easily identified by the spreadsheet row being split into two sub-rows to the right of the line-item name with the word Schedule appearing in green on the topmost of the sub-rows. If line items are listed in addition to the ones resulting from schedules, they will could be suggested budgetary line-items, required budgetary line-items, or line-items to which funding is limited. Guidance will be provided by the Department.

The Workbook with information completed as above will be provided to the Contractor via e-mail to have the remaining required information completed.

ii. **Completed by the Contractor:**

1) **Positions** (Position Schedule) – This is an electronic version of the Position Schedule 2a that was previously completed on paper. Total amounts from this schedule will determine the budgetary line item amounts for “Salary & Wages” and “Fringe Benefits”. The Position sheet has separate sections for each Program funded under the contract and for each funding source within each Program. Entries should be made as follows:

(a) From left to right enter the Position Title; followed by the name of the individual filling the position (if not yet filled enter "TBD"); followed by the rate of pay earned by the person filling, or to be filling, the position; followed by the Fringe Benefit rate to be paid to the person filling the position. If you budget fringe benefits as a defined absolute amount vs. a rate, leave the Fringe Benefit Rate column blank and enter an amount in the column labeled "Fringe Benefit (Absolute)". If you budget a combination of rate based Fringe Benefits plus a define absolute amount you may use both columns and enter the appropriate rates and amount. The total Fringe Benefits will be the result of the applied rate plus the absolute amount.

(b) In the appropriate fund source columns for each Program included in the contract enter the hours per week and weeks per funding period to be worked for each of the employees entered on the sheet. If you plan to fund an employee position from multiple fund sources and/or to work supporting multiple Programs in the contract the time must be split among the Programs and fund sources in accordance with the amount of time that will be budget to each. Grayed out columns cannot be used because they are either calculated values or have no Program and/or funding associated with them.

All employee hours and dollars associated with the entries will be displayed in the Total columns on the right-hand side of the sheet. The total hours budgeted for each employee/position cannot exceed the actual scheduled hours per week i.e., if an employee works forty hours per week the total of all hours distributed among the Programs and funding sources cannot exceed forty. Totals for all employees will be displayed in the bottom row of the sheet.

2) **Contractual** (Subcontractor) – This sheet contains electronic versions of the Subcontractor Schedule A – Detail previously completed on paper. One schedule must be completed for each subcontractor budget under the contract. Entries should be made as follows for each subcontractor to be employed:

(a) Place an "X" in one of the boxes defining the Funding Basis (Budget, Fee for Service, or Hourly Rate). Do not mark more than one Funding Basis for each subcontractor. "X" is the only acceptable entry to make in these cells.

(b) Place an "X" in one of the Set-Aside designations. Do not mark more than one Set-Aside designation. "X" is the only acceptable entry to make in these cells.

(c) In the "line-Item Description" section of the sheet list the budgetary line-item for which you intend to budget expenses consistent with the Budget Basis i.e., "Medical Supplies", "Travel", "Postage" for Budget Basis; "Rental of Conference Facility" for Fee for Service; "Medical Follow-Up 20h/w x 40 weeks" for Hourly Rate.

(d) Within each funding source and Program enter the amount of funds budgeted to that Program and funding source for each line-item. Grayed out columns cannot be used because they are either calculated values or have no Program and/or funding associated with them.

3) **Budget Services** – If line-items exist on this schedule it is because the Department must budget and monitor at a finer level of detail specific items that roll up to consolidated budgetary line-items. This schedule could be used to break-out specific medical services or other budgetary items where a standardized budget format does not permit the Department to meet its monitoring and reporting needs. Specific guidance will vary based on the individual contract.

For each subcomponent of each budgetary line-item enter the amount budgeted for that subcomponent in the column of the appropriate Program and funding source. Grayed out columns cannot be used because they are either calculated values or have no Program and/or funding associated with them. Program totals and contract totals for each subcomponent and for all subcomponents combined are calculated automatically.

4) **Budget** – All requested contract budget amounts must be listed on this sheet. All budget line-items with associated detail schedules (Positions, Contractual, Services) will have the total amounts from the schedules displayed on the upper row of the line-item.

(a) Enter the amount of funds you request to budget in the column of the Program and fund source for each of the line-items listed on the Budget sheet.

(b) For line-items with associated schedules, the schedule amount will be displayed on the Budget Worksheet for reference. The same amount displayed from the schedule must be entered directly below the scheduled amount. Entry of a different amount would result in a requested budgetary amount that does not agree with scheduled amount. The discrepancy will turn red (unless you use an outdated version of MS Excel). Any such red entries must be reviewed and corrected by either matching the entry in the budget to the schedule amount or correcting an erroneous entry in the schedule.

(c) If you have received permission to add custom budgetary line-items to the Budget, begin entering the item descriptions immediately below the last appearing line-item description in the column and immediately to the right of the line-item number. Enter the associated budgetary amount requested in the column of the Program and fund source for each of the line-items listed on the Budget sheet.

(d) The total of all budgetary line-items cannot exceed the amount of contract funding available. All Program and contract totals are automatically calculated and displayed.

The Workbook with information completed as above must then be submitted to the Department via e-mail for review and acceptance of the budget and supporting documents for the proposed contract. The Workbook shall be submitted/returned directly to the CGMS staff person from whom it was received.

b. Post contract execution:

i. Activities Performed by the Department:

1) **Budget Acceptance** – At the conclusion of any budget negotiations, clarifications, and review the Department will trigger an automated process to accept the providers' budget if it meets all funding/contractual requirements and conforms to the State of Connecticut Cost Standards published by OPM and available for review at http://www.ct.gov/opm/cwp/view.asp?a=2981&q=382994&opmNav_GID=1806. Acceptance of the budget shall result in:

(a) Acceptance date stamps being placed on the printable contract budget and the printable subcontractor budgets.

(b) Transfer of all position (Position Schedule 2a) information to appropriate places on the Salary Detail reporting form to facilitate easy reporting by providers.

2) **Delivery of Reporting Package** – The Department shall send the completed and accepted Financial Reporting and Cash Needs Report Excel Workbook to the Contractor via e-mail in preparation for use and submission of required financial expenditure reports/information.

3) **Review of Submitted Financial Documents** – The Department shall review, in accordance with Contract Terms and Conditions, submitted expenditure report, detail listing, justification, and/or budget revision Worksheets. Approval of such information shall be conditional upon accurate completion and evidence that all funding has been used, or is proposed to be used, in accordance with contract requirements and/or funding authorizations.

4) **Return of Submitted Financial Reporting and Cash Needs Report Excel Workbook** – The Department shall return the Financial Reporting and Cash Needs Report Excel Workbook to the Contractor upon completion of its review/approval process.

ii. Activities Performed by the Provider:

1) **Expenditure Report and Detail Listing Submission** - At the conclusion of each financial reporting period as defined in the contract, providers shall submit financial expenditure reports to the Department, no later than the report due dates listed in the contract. The required reports include the providers' financial Expenditure Report, any subcontractor financial Expenditure Reports, provider Salary Detail report, and provider Service Detail report. All of the reports are included in the Financial Reporting and Cash Needs Report Excel Workbook, which shall be submitted as a whole. Note that not all of these reports are required with every contract and the reporting periods for some of the reports may vary from the overall contract report periods as follows:

(a) Subcontractor Expenditure Reports are to be completed separately and submitted in accordance with the frequency identified on the reporting Worksheet, but information may be submitted on a monthly basis and updated over the course of the identified period, if desired.

(b) Detail listings shall be completed according to the frequency identified in the Contract, but information may be submitted on a monthly basis and updated over the course of the identified period, if desired.

2) **Position Schedule 2a Maintenance** – The "Salary and Wages" and "Fringe Benefit" budgetary line items are roll-ups of the information that is maintained on "Position Schedule 2a". These roll-up amounts appear for reference on the Budget Worksheet. Providers shall maintain this information current as workforce composition changes throughout the term of the Funding Period. Changes to Position Schedule 2a will automatically generate entries on the Budget Revision Request Worksheet and be available for submission when and as required by contract Terms and Conditions and/or State policy.

3) **Budget Revision Requests** – If it is anticipated that spending within any particular Budgetary Line-Item will exceed the amount allowed in the contract and per State policy the Provider may consider requesting a Budget Revision. Any changes made to Position Schedule 2a will be accumulated on the Budget Revision Worksheet. Any additional movement of funds shall be entered on the same Worksheet for each affected Program. The Department must be notified when a Provider requests consideration of a completed Budget Revision and such revision may be submitted concurrently with a periodic Expenditure Report for review. If the Department approves the requested revision, figures in the Workbook will be revised when it is returned to the Provider. **Note that expenditures that exceed the budgeted Line-Item amount by more than the allowed variance amount upon Funding Period close are subject to disallowance.**

4) **Budget Variance Justification** – In the event a Budget Revision has not been approved and any Line-Item expenditures exceed the budgetary amount by more than the allowed variance, the Provider may request consideration of the over-expenditure for payment by completing and submitting a Budget Variance Justification form. Such form shall provide complete justification of the need for the over-expenditure and the reason advance permission was not requested. Acceptance of the request shall be considered by the Department on a case by case basis. Final Contract expenditures exceeding the contractual variance amount that do not receive approval by the Department shall be disallowed.

5) All Workbook submission of Financial Expenditure and related reports shall be made to the CGMS central reporting e-mail box at **"DPH-CGMS-FinReports@ct.gov"**

III. Bi-Monthly Cash Management System

All contractors (subgrantees) awarded DPH prepayment grants that include funds managed via Bi-monthly Cash Management System shall submit bi-monthly cash needs statements to the DPH using the **PH111 Bi-Monthly Cash Management Report** form. Receipt of the PH111 will allow the Department of Public Health (Department) to effectively monitor the actual cash needs of its subgrantees prior to issuing payments subsequent to the initial contract payment and throughout the Contract term. This prerequisite is pursuant to 45CFR92.20(b)(7) of the Code of Federal Regulations which requires that grantees must monitor cash drawdowns by their subgrantee to assure that they conform substantially to the same standards of timing and amount as apply to advances to the grantees. In addition, 45CFR92.21(c) provides that subgrantees shall be paid in advance, provided they demonstrate the ability to minimize the time elapsing between the transfer of funds and the subsequent disbursement.

1. Reporting:

a. For convenience the Department has developed MS Excel based report formats for most of the standard reports that must be submitted. The individual reports are contained on separate Worksheet tabs within a single MS Workbook that is available to contractors for reporting. Contractors shall submit the PH111 form to the Department in addition to any contractually required expenditure reports. The PH111 is due by the 1st of the month preceding the payment date. For example, if the contract period is July 1 – June 30:

PH111 for the Period:	PH111 Due Date:	Payment Date:
July 1 – August 30	June 1	July 1
September 1 – October 31	August 1	September 1
November 1 – December 31	October 1	November 1
January 1 – February 28	December 1	January 1
March 1 – April 30	February 1	March 1
May 1 – June 30	April 1	May 1

b. The expenditures reported on the PH111 are those that appear on the last expenditure report submitted to the Department.

c. The periodic projections include expected expenditures beginning on the date of the last submitted expenditure report and through the last date of the reporting period for which funds are being requested and should be estimated as accurately as possible. The contractor's estimations shall be based upon documentation including but not limited to purchase orders, employee schedules with estimated salary needs, contracts for professional services, rental fee schedules, etc. The amount reported on the PH111 should reflect the amount of total projected cash outlay, not the incurrence of a liability. For example, if educational materials are ordered in July for delivery in September, and the payment will not be made until after delivery, the projected cash disbursement would be included on the PH111 covering cash needs for the period including September, not July.

d. Except in the case where the funding source is non lapsing funds, each contract year is accounted for separately. Therefore the PH111 for the period beginning the second, and each subsequent contract budget year must begin with an indication of no reported expenditures and only include projected cash needs for the first two month period of the

new financial reporting period. Also the final PH111 for any budget year must close out that reporting period. Normally, neither funds nor accounting span multiple years.

(a) The MS Workbook containing the PH111 should be submitted to the Department's Contracts and Grants Management Section (CGMS) via email to: **"DPH-CGMS-FinReports@ct.gov"**

2. Payment:

Contract payments are made on a bi-monthly basis, or as indicated in the payment schedule, and are calculated using cumulative actual expenditures and projected data as reported by the subgrantee. The initial payment on a prepayment contract is equal to the projected cash needs reported on the PH111 but not to exceed the scheduled maximum payment amount. Subsequent bi-monthly payments are equal to the PH111 cumulative actual reported expenditures plus projections of additional funds needed through the end of the requested period less any prior payments but not to exceed the scheduled maximum payment amount.

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SAMPLE PH111 BI-MONTHLY CASH MANAGEMENT REPORT

PH111 Bi-Monthly Cash Management Report - (Cash Needs Statement)

CONTRACTOR:	ABC Corporataion	Contract Log #	1-2345		
		Funding Period:	1/1/2013	To	12/31/2013
		Contract Period:	1/1/2013	To	12/31/2014
PROGRAM:	HIV Surveillance	SID:	12345		

	Column 1	Column 2	Column 3	Column 4 (Total of Column 2 & 3)		Column 5	Column 6 (Column 4 minus Column 5)
#	Program/Fund	Expenditures reported as of last expenditure report for period ending: _____	Needs from end date of expenditure report in Column 2 through period ending: _____	Cumulative Cash Required Through End of Request Period Identified in Column 3		Less Amt Paid to Date (Note: this amount will be reduced by DPH for any payments in process but not received as of report date)	Requested Payment Amount (This cannot exceed scheduled maximum except if previous payments were reduced)
1				$ -			$ -
2				$ -			$ -
3				$ -			$ -
4				$ -			$ -
5				$ -			$ -
6				$ -			$ -
7				$ -			$ -
8				$ -			$ -
9				$ -			$ -
10				$ -			$ -

IV. Contractor Financial Expenditure Reporting Guidelines

1. Overview:

There are terms in the contract that state that Financial Expenditure Reports and subcontractor reports are due on a periodic basis. Most contracts require contractors to submit reports to the Department's Contracts and Grants Management Section (CGMS) 30 days after the end of the Budget Reporting Period (typically a one to four month period), except for the final Expenditure Report, which is normally due 60 days after the end of the Contract Budget Period. Actual report due dates are listed in each contract.

a. Refer to the contract for exact Reporting Periods and the respective due dates. Expenditures shall be reported for the current period and cumulatively.

b. **Multiple Budgets:** When contracts include more than one Program (such as a contract which includes a Genetics Program as well as a Sickle Cell Program) or restricted funding sources, funds provided for each program or fund source must be kept separate and cannot be commingled. Budgeting, accounting, reporting and final contract settlement shall be by Program/Funding.

c. The contractor must submit Financial Expenditure Reports on a timely basis. If there is to be an unavoidable delay in submitting a report, the contractor must notify the CGMS and explain the reason for the delay and provide the expected submission date.

d. If no program activities are conducted or if no money is spent during any given Report Period, the Financial Expenditure Report(s) must still be submitted indicating such.

e. Financial Expenditure Reports are due as specified in the contract. The final cumulative Expenditure Report is due to the Department no later than 60 days after the end of the Contract Period or as specified in the contract. A report that shows Unpaid Obligations will not be considered final until all Unpaid Obligations are paid.

f. For convenience the Department has developed MS Excel based report formats for most of the standard reports that must be submitted. The individual reports are contained on separate Worksheet tabs within a single MS Workbook that is available to contractors for reporting. The Worksheets have standard formulas included to minimize errors.

2. Form Completion and Use:

Refer to the following instructions for guidance in preparation of the Financial Expenditure Report(s):

a. The **"Contractor"** name and Contract Log # must be listed exactly as they appear on the contract.

b. The **"Program"** name appears on the Contract Budget for which you are reporting expenditures. If the contract contains multiple Programs, multiple budgets will be included with the corresponding Program name listed for each Budget. A separate Expenditure Report shall be submitted for each separate budget included in the contract.

c. The **"Funding Period"** is the period for which the financial expenditures are being compiled. The periods are identified in the contract and correspond to the Funding Period identified in each contract budget. Due dates for periodic reports within each Funding Period are also identified in the contract, typically in a section

entitled “Reports and Report Schedule” or something similar. Both the start and end dates of the Funding Period must be included.

d. The **“Contract Period”** is the total period covered by the contract and can span multiple fiscal and/or calendar years as well as multiple Funding Periods and Reporting Periods. It represents the full maximum Term of the contract. The contract start and end dates are indicated on the Contract as a Term and Condition.

e. The **“Budget Line Items”** column MUST list budgetary items exactly as they appear on the approved budget that was in effect at the end of the **Reporting Period**.

i. The **“Salary and Wages”** line item is used to list the total salary of all individuals who are funded by the contract. Individual salary detail must be provided separately as described in **Section V** using the Salary Detail Sheet provided.

ii. The **“Fringe Benefit”** line item is used to list the total fringe benefits of all individuals who are funded by the contract. If different fringe benefit rates are applied to various individuals, the differing rates and amounts must also be detailed on the **Salary Detail Sheet** as described in **Section V**.

f. The following guidance describes the individual columns that appear on the Financial Expenditure Report:

i. Column 1

“Contract Award”-- awarded amount for contract line items as per approved budget in effect at the end of the Report Period. The budget in affect at the end of the period is the later of the fully executed Contract Budget, a fully executed Amendment Budget, or a fully approved Budget Revision Request executed in accordance with instruction in **Section VII**. Amounts included on any amendment or Budget Revision Request in process, but not yet fully executed, do not represent awarded amounts.

ii. Column 2

“Period # Expenses”-- amounts actually disbursed or encumbered in each Reporting Period per budgeted line items.

iii. Column 3

“Expenses to Date”-- total amounts actually disbursed or encumbered in the current and all prior Reporting Periods as defined by the contract.

iv. Column 4

“Unpaid Obligations”--items purchased, contracted for, or ordered prior to the expiration of the contract or contract Funding Period, for which moneys have not yet been disbursed. Note: this column normally is only applicable if your organization is reporting expenditures on a Cash Basis rather than Accrual Basis.

v. Column 5

“Total Obligations and Expenditures”- columns 4 added to column 3 indicates the total amount of expenditures applicable to the contract.

vi. Column 6

"Balance Remaining"-- column 5 subtracted from column 1 indicates the balance of funds available for line-item expenditures. Note: a remaining balance is only available if the funding period has not ended.

Column 7 (Information Only)

"Variance"—indicates the percentage by which the **Total Obligations and Expenditures** (Column 5) exceeds the budgetary allowance for the line item.

vii. **Column 8** (Information Only)

"Action Needed"—indicates the action that should be taken in response to the variance, if any, indicated by the Variance (Column 7). If other than **"Ok"** is displayed the possible actions are completion of either a **"Budget Revision Request"** (**Section VII**) or a **"Budget Variance Justification Form"** (**Section IV.4**)

viii. **TOTAL** (Bottom Row)

Displays the total of each Expenditure Report column.

g. The final cumulative Financial Expenditure Report for any Budget Period cannot include any Unpaid Obligations. All outstanding Unpaid Obligations must be liquidated prior to submission of the final Financial Expenditure Report.

h. To expedite processing the MS Excel Financial Expenditure Reports require no signatures and can be submitted electronically to the CGMS Central Reporting Mailbox at **"DPH-CGMS-FinReports@ct.gov"**. A scanned or computer generated reproduction of the appropriate report may be e-mailed in the same manner. **Note: e-mail submission of unsigned Expenditure Reports requires that the Contractor has provided the Department with the names of individuals authorized to submit such reports.**

i. Contractors should discontinue the use of superseded forms that contain signature lines. The use of such superseded report forms that contain signature lines shall continue to require signatures as indicated on the form. The financial officer and the Project Director (or the person responsible for contract compliance) must sign and date these Financial Expenditure Reports. The financial officer is generally the Treasurer of the corporation, the Controller, or some other designated official who is responsible for the funds. The Project Director is attesting that funds were expended in accordance with the contract Terms and Conditions and for approved items. The financial officer is attesting to the accuracy of the recorded and submitted financial record keeping information.

j. If you require matching contractor funds to be shown, or if you want to show use of your own funds, then reports must be submitted in accordance with an approved Department format. If no format has been specified, separate forms must be used, e.g., one for contract funds, a second for matching contractor funds and a third totaling the first two separate **Financial Expenditure Reports**.

3. **Equipment:**

Capital equipment is defined as having a useful life of more than one year and a cost of $5,000 or more. Contractors are required to complete and submit the Department's Equipment Report form for all capital equipment purchased approved and made under the terms of the contract. The Equipment Report Form must be submitted with the periodic reports for the period in which the equipment purchase occurred.

If the contract specifies that equipment purchased with Department funding shall remain the property of the Department, such equipment must be returned to the Department or disposed of in accordance with Department instructions upon determination that the use of such equipment by the contractor is no longer required.

4. Expenditure Variance:

Providers may vary individual line item expenditures by as much as twenty (20) percent for any particular budget line-item without approval from the Department. All variances must be budget neutral so any variance exceeding the line-item budgetary amount must be offset by decreases on other line-items. Any variance exceeding the twenty percent limit must be approved by the Department. Approval will not be considered without submission of a **Budget Variance Justification** form explaining the variance. A Budget Variance Justification form must be submitted with any expenditure report that contains such a variance. Variances occurring prior to the end of the contract Funding Period may be more appropriately handled via a **Budget Revision Request** (**Section VII**). Consideration for requested approval of any variance will be based on Department procedures and Program needs/requirements. Any disallowed over-expenditures must be refunded to the Department upon request.

5. Payments:

Contract payments are made accordance with the contract terms and conditions and the contract payment schedule. If a scheduled payment table has any required deliverables, reports, or activities associated with it, those conditions will be indicated in the payment schedule. All payment dates listed in payment schedules represent the earliest date that payment will be available. Payment will only be made when the indicated conditions of payment have been satisfactorily met. All payment amounts listed in payment schedules are maximum available payment amounts. Individual payments are subject to reduction in accordance with the contract terms and conditions.

6. Refunds:

The CGMS shall review the contractor's final Financial Expenditure Report to ensure the accuracy submitted information and to ensure that funds were expended for approved purposes. The Department's Program staff must approve spending and/or overspending of funds. A letter shall be sent from the CGMS to the contractor requesting the return of funds if it is determined that a refund of is due to the Department as a result of unexpended contract funds or disallowance by the Department of any contract expenditures.

Note: Sample Financial Expenditure Report, Equipment Report, and Budget Variance Justification forms follow:

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SAMPLE FINANCIAL EXPENDITURE REPORT

EXPENDITURE REPORT FORM

CONTRACTOR: ABC Corporataion

Contract Log # 1-2345

Funding Period: 1/1/2013 To 12/31/2014

FINAL REPORT Yes √ No

Contract Period: 1/1/2013 To 12/31/2014

PROGRAM: HIV Surveilance

SID: 12345

Budget Line Items	1	(2a)	(2b)	(2c)	(2d)	(2e)	(2f)	3	4	5	6		
	Award	Period 1 Expense	Period 2 Expense	Period 3 Expense	Period 4 Expense	Period 5 Expense	Period 6 Expense	Expenses To Date	Unpaid Obligations	Obligations & Expenses	Balance Remaining	% Variance	Action Needed
								$ -		$ -	$ -		
								$ -		$ -	$ -		
								$ -		$ -	$ -		
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TOTALS:	$ -					$ -	$ -	$ -	$ -	$ -	$ -		

CERTIFICATION: ABC Corporataion certifies that the above financial report has been reviewed for accuracy and that the expenditures shown are consistent with the terms and conditions set forth in the Department of Public Health's contract as identified herein.

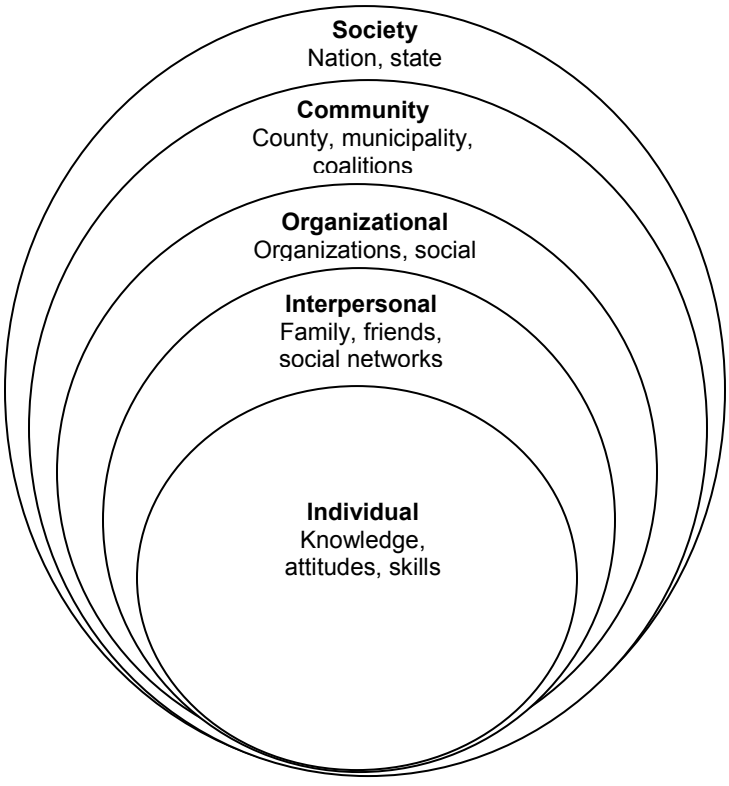
Appendix B: Social Ecologic Model

Delivering CCSP services requires partnerships linking people to needed personal health services and assuring the provision of health care when otherwise unavailable and to also work with the community to influence the environments of the CCSP participants that will support a healthy lifestyle.

To achieve this goal, providers need to embrace a framework such as the Social Ecologic Model. This model encourages public health action at the individual, interpersonal, organizational, community, and societal levels. The socio-ecological model recognizes the interwoven relationship that exists between the individual and their environment. The development and support of the Cancer Community Advisory Council facilitates this process.

While individuals are responsible for instituting and maintaining the lifestyle changes necessary to reduce risk and improve health, individual behavior is determined to a large extent by social environment, e.g. community norms and values, regulations, and policies.

Barriers to healthy behaviors are shared among the community as a whole. As these barriers are lowered or removed, behavior change becomes more achievable and sustainable. The most effective approach leading to healthy behaviors is a combination of the efforts at all levels--individual, interpersonal, organizational, community, and public policy.



CCSP Projects Are Encouraged to Take Public Health Action at Many Different Levels. Examples of CCSP Activities That Promote Women's Health at Multiple Levels

Social Ecologic Level	Examples of Activities
Individual (Participant)	Provide screening, diagnosis, referral, case management, medical follow-up, one-on-one risk reduction counseling, and lifestyle counseling.
Interpersonal	Offer health education classes to individual, family, and friends.
Organizational	Offer clinic services on evenings and weekends. Identify referral sites for free or sliding scale medical evaluation and treatment.
Community	Work with community partners to: develop a community garden; support farmers markets; identify or develop bicycle trails, walking trails, and parks; and, promote breast and cervical, heart disease, and colon cancer screenings.

Appendix C: CCSP Participant Eligibility Criteria

Potential program participants need to meet the eligibility criteria listed below.

- Women who are at or below 250% of the Federal Poverty Level (FPL) are uninsured, or underinsured, with a focus upon African American and Hispanic women for breast and cervical cancer and heart disease screening;

- Women ages 40-64 years qualify for mammography with a priority focus on women ages 54-64 and with a focus on women who are rarely or never screened;

- Women ages 35-39 may qualify for a mammogram when symptoms and/or specific risk factors for breast cancer are present;

- Program funds can be used to reimburse clinical breast exams for women under the age of 40 years if the findings of the clinical breast exam are considered to be abnormal, including a discrete mass, nipple discharge, and skin or nipple changes, a woman can be provided with a diagnostic mammogram by the program and /or referred for a surgical consultation;

- Program funds cannot be used to screen asymptomatic women under the age of 40;

- A minimum of 75% of all reimbursed mammograms must be provided to women ages 50 years of age and older who are not enrolled in Medicare Part B;

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

- Women ages 21-64 qualify for a pelvic examination and Pap. test;

- If a woman is eligible to receive Medicare benefits but is not enrolled, she should be encouraged to enroll;

- Women who have Medicare Part B are not eligible for breast and cervical cancer screening through the program;

- Women ages 65 and older may qualify for mammography and heart disease screening if they are eligible for Medicare Part B but are unable to pay for it; and,

- Women ages 40-64 years qualify for heart disease screening tests who have received a mammography and/or Pap. test and/or a blood pressure measurement.

-

- Men and women ages 50-64 who have never been screened for colon cancer qualify for colonoscopies;

    - Potential participants who have insurance with a deductible of $1,000 or greater or whose health insurance does not cover services provided through this program qualify for program services.

    - Potential participants for a colonoscopy cannot be enrolled into the program if they have the following conditions:
        - Personal history of colorectal cancer;
        - Gastrointestinal symptoms;
        - Inflammatory bowel disease and genetic syndromes associated with the development of colorectal cancer.

- If potential participants do not meet program criteria and cannot be enrolled, refer them to other resources in the community.

Appendix D: Tobacco Screening and Cessation Policy

Purpose

- To support the CBCCEDP and Integrated Programs mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure quality care standards for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.
- To encourage cessation of smoking and tobacco use.

Policy

Every client screened by the Connecticut Cancer and Heart Disease Integrated Health Screening Program is required to have assessment of smoking status and, for those who smoke, referral to the Connecticut Quitline must be provided.

Protocol

1. Determine the client's smoking status during enrollment into the program and update annually.
2. Document the status of current tobacco use in the Med-It® system.
3. For smokers, document the age at which smoking was started if known.
4. Provide client with contact information to Connecticut Quitline. Quitline brochures and information are available by contacting The Department of Public Health, Tobacco Use Prevention and Control Program (860) 509-8251.
5. Document the provision of Quitline referral in the client record.

Appendix E: CCSP Consent Forms

Connecticut Department of Public Health
Breast, Cervical, and Colorectal Cancer Screening Consent Form

Purpose: The Integrated Program provides early detection, screening, and diagnostic services for breast, cervical, and colorectal cancer, free of charge to eligible participants, to identify breast, cervical, and/or colorectal cancer in its earliest stages so that it can be prevented and/or treated.

Screening Tests/Side Effects/Discomfort of Lab Tests: I agree to have personal and family history information collected, a breast examination; an X-ray called a mammogram; a pelvic examination that will include taking a sample of cells from the opening of the uterus (cervix) called a Pap test, a check for polyps or cancer inside the rectum and lower part of the colon (colonoscopy), and my height, weight, and blood pressure taken.

The screening tests, possible side effects, potential complications, and/or any physical discomfort that may be experienced have been explained to me.

Return for Rescreening: If I continue to meet program eligibility requirements, I agree to return in 12-18 months for my breast and cervical annual screening examinations. The same screening tests and paperwork will be carried out and completed at that appointment.

Abnormal Screening Results: It has been explained to me that the program will provide selected diagnostic follow-up and/or refer me to a health care provider for medical follow-up if I have abnormal screening results. Support will be provided to me, if needed, to assist me in obtaining needed medical care.

Release of Medical Information-Confidentiality Statement-Withdrawing from Program: I give permission to any and all health care providers to report all information concerning screenings tests and procedures, treatment, case management, and any related care or activity to the Connecticut Department of Public Health's Connecticut Cancer Screening Program. Any information reported to the program will remain confidential. Information submitted to CDC and associated program partners or in published reports will not identify any participant by name. Participation in this program is voluntary. I may drop out at any time by notifying the program staff. I may withdraw my permission to release information at any time.

Signature: _____ Date: _____

Print Name_____
(Last) (First) (Middle Initial)

Connecticut Department of Public Health

Breast and Cervical Cancer Screening Consent Form

Purpose: The Program provides early detection, screening, and diagnostic services for breast and cervical cancer, free of charge to eligible women, to identify breast or cervical cancer in its earliest stages so that it can be prevented and/or treated.

Screening Tests/Side Effects/Discomfort of Lab Tests: I agree to have personal and family history information collected, a breast examination; an X-ray called a mammogram; a pelvic examination that will include taking a sample of cells from the opening of the uterus (cervix) called a Pap test, and my height, weight, and blood pressure taken.

Abnormal Screening Results: It has been explained to me that the program will provide selected diagnostic follow-up and/or refer me to a health care provider for medical follow-up if I have abnormal screening results. Support will be provided to me, if needed, to assist me in obtaining needed medical care.

Return for Rescreening: If I continue to meet program eligibility requirements, I agree to return in 12-18 months for my breast and cervical cancer annual screening examinations. The same screening tests and paperwork will be carried out and completed at that appointment.

Release of Medical Information-Confidentiality Statement-Withdrawing from Program:
I give permission to any and all health care providers to report all information concerning screenings tests and procedures, treatment, case management, and any related care or activity to the Connecticut Department of Public Health's Connecticut Cancer and heart Disease Integrated Health Screening Program. Any information reported to the program will remain confidential. Information submitted to CDC and associated program partners or in published reports will not identify any woman by name. Participation in this program is voluntary. I may drop out at any time by notifying the program staff. I may withdraw my permission to release information at any time.

Signature: _____ Date: _____

Print Name_____
(Last) (First) (Middle Initial)

Connecticut Department of Public Health
Connecticut Colorectal Cancer Control Program (CCRCP)
(For Men, or For Women Receiving Colorectal Cancer Screening Services Only)

CONSENT

Purpose: The Program provides early detection, screening, and referral for diagnostic and/or treatment services for colorectal cancer, free of charge to eligible participants, to prevent or identify colorectal cancer in its earliest stages when it is most treatable.

Screening Tests/Side Effects/Discomfort of Lab Tests: I agree to have personal and family history information collected, a check for polyps or cancer inside the rectum and lower part of the colon (colonoscopy), and my height, weight, and blood pressure taken.

Abnormal Screening Results: It has been explained to me that the program will provide referral for diagnostic follow-up if I have abnormal screening results, and/or refer me to a health care provider for medical treatment if colorectal cancer is diagnosed. Support will be provided to me, if needed, to assist me in obtaining needed medical care.

Release of Medical Information-Confidentiality Statement-Withdrawing from Program: I give permission to any and all health care providers to report all information concerning screenings tests and procedures, treatment, patient navigation, and any related care or activity to the Connecticut Department of Public Health's Connecticut Colorectal Cancer Control Program. Any information reported to the program will remain confidential. Information submitted to CDC and associated program partners or in published reports will not identify any participant by name. Participation in this program is voluntary. I may drop out at any time by notifying the program staff. I may withdraw my permission to release information at any time.

Signature: _____ Date: _____

Print Name_____
(Last) (First) (Middle Initial)

Appendix F: Office Visit Policy

Purpose

- To support the CCSP mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CCSP with abnormal screening results or diagnoses of cancer have access to timely, comprehensive and appropriate follow-up.
- To ensure quality care standards for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.

Policy

It is the policy of the CCSP to reimburse one office visit per year per eligible enrolled participant with normal screening tests.

Definition

An office visit is time spent with a patient for the evaluation and management services provided in a physician's office or in an outpatient or other ambulatory facility. The visit is considered part of screening and diagnostic services incurred to detect or rule out breast and cervical cancer. As recommended by CDC, 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.

Protocol

For breast cancer screening, procedures should include both clinical examination of the breast and mammography. With cervical cancer screening, procedures should include both pelvic examination and Pap test. Office visits must be comprehensive and should include provision of both breast and cervical screening. For cases when women have either breast or cervical services independent of the other, effort must be towards synchronizing routine services into an ***annual integrated visit***.

Follow-up of abnormal screening results may include further diagnostic measures. Approval of variation from this protocol should be sought as needed, on an individual case-by-case basis, through contact with DPH CBCCEDP staff.

Appendix G: Internet Resources and Free Patient Education Materials

Smoking Cessation

American Cancer Society (ACS)
http://www.cancer.org/Healthy/StayAwayfromTobacco/GuidetoQuittingSmoking/index

Centers for Disease Control and Prevention (CDC)
Smoking and Tobacco Use: Quit Smoking
http://www.cdc.gov/tobacco/quit_smoking/index.htm

Department of Health and Human Services (HHS)
www.BeTobaccoFree.gov

National Cancer Institute (NCI)
Tobacco Control Research Branch
www.Smokefree.gov

Cultural and Linguistic Competency
HHS: Quick Guide to Health Literacy
http://www.health.gov/communication/literacy/quickguide/factsbasic.htm

The Office of Minority Health: What is Cultural Competency?
http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=11

MedlinePlus: Health Information in Multiple Languages
http://www.nlm.nih.gov/medlineplus/languages/languages.html

Disease-Specific Resources

National Cancer Institute (NCI)
www.cancer.gov

Other
Centers for Disease Control and Prevention (CDC)
www.cdc.gov

The Community Guide – What Works to Promote Health
The Community Preventive Services Task Force
http://www.thecommunityguide.org/index.html

The Department of Health and Human Services (HHS)
www.hhs.gov

Health Finder
www.healthfinder.gov

MedlinePlus
http://www.nlm.nih.gov/medlineplus/

National Center for Complementary and Alternative Medicine (NCCAM)
http://nccam.nih.gov/

The National Institutes for Health (NIH)
www.nih.gov

The National Women's Health Information Center
www.womenshealth.gov

Appendix H: Inter-Program Client Transfer Policy

Purpose

- To support the CCSP mission, vision and values.

- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CCSP with abnormal screening results or diagnoses of cancer have access to timely, comprehensive and appropriate follow-up.
- To ensure continuity of quality care standards for all enrolled participants.

- To promote contractual, clinical and fiscal compliance.

Policy

Eligible clients enrolled in the CCSP may transfer between contracted Provider sites within the state without subsequent interruption or dissimilarity of screening services.

Definition

Transfer occurs when a client, previously determined eligible for services in the CCSP, relocates residence or for other reason desires to obtain services through a contracted provider site other than the one where currently enrolled.

Protocol

The referring Provider site (where the client is enrolled) is to contact the receiving Provider site (where future screening services will be provided), explain the circumstances of the transfer, provide relevant clinical information adequate to ensure continuity of services, and document the process in the client's electronic record.

The receiving Provider site must contact DPH to request the client's electronic data tracking record be made accessible. DPH will enact the electronic transfer of access rights in the web-based Med-It® medical information tracking system and inform the receiving Provider site of completion. This action also restricts the client's record access to the provider site actually servicing the client.

The receiving Provider site must verify the client's eligibility status is current, that services are due and timely.

Appendix I: Fine Needle Aspiration Policy

Purpose

- To support the CBCCEDP and Integrated Programs mission, vision and values.

- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CBCCEDP and Integrated Programs with abnormal screening results or diagnosis of cancer have access to timely, comprehensive and appropriate follow-up.

- To ensure quality care standards for all enrolled participants.

- To promote contractual, clinical and fiscal compliance.

Policy

It is the policy of the Connecticut Breast and Cervical Cancer Early Detection Program to reimburse fine needle aspiration (FNA) procedures that are necessary to diagnose (determine the presence of) cancer in a breast mass or clinically suspicious lesion.

1. **Definition**
   Fine-needle aspiration is a method of collecting cells to look for signs of cancer. A doctor inserts a thin needle into a lump and withdraws a sample of cells or fluid. The material is then examined under a microscope.

2. **Protocol**
   Fine needle aspiration should be considered only when clinicians seek to rule out or identify cancer in a suspicious breast mass and not for ongoing cyst management nor as a screening tool. Utilization of Fine needle aspiration is allowable under program auspices when employed as intended: to diagnose or rule out breast cancer.

Appendix J: Cervical Cancer Screening Policy

Purpose

- To support the Connecticut Cancer Integrated Health Screening Program (CCSP) Programs mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure quality care standards for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.

Policy

Women enrolled in the Connecticut Cancer Integrated Health Screening Program (CCSP) are screened for cervical cancer according to the most updated recommendations approved by the Centers for Disease Control and Prevention.

Protocol

Updated clinical protocols for cervical cancer screening guidelines in CT include:

- Women under the age of 21 years may not be screened for cervical cancer regardless of the age of sexual initiation or other risk factors.
- Women who are referred to the CCSP and are aged younger than 21 years may not be screened for cervical cancer regardless of the risk factors.
- The annual office visit for program participants should include clinical breast exam, and speculum and bimanual pelvic examination even if no cervical cancer screening is performed.
- Women ages 21 to 64 years may receive screening for cervical cancer with cytology (Pap test) every 3 years. Pap testing may be performed using either liquid-based cytology or conventional Pap test.
- Women ages 30 to 64 years may receive screening for cervical cancer with cytology and co-testing for High Risk Human Papilloma Virus (HR-HPV) every 5 years if both tests are negative. **All HPV testing is restricted to High Risk strains of the virus only.**
- Unsatisfactory Pap tests should be repeated after 2 to 4 months. If due to obscuring inflammation with an identified organism, specific treatment may be given prior to repeating the Pap test. For repeatedly unsatisfactory due to obscuring blood, inflammation, or necrosis, additional clinical evaluation, such as colposcopy or biopsy may be helpful.

- Absent endocervical cells/transformation zone (EC/TZ) for women aged 21 – 29, continue with routine screening. For women aged 30 and older with cytology negative and no HPV testing/unknown HPV status, then HPV testing is preferred with an acceptable option of repeat cytology in 3 years—routine screening. When there are no EC/TZ cells, the cytology is negative and the HPV is positive, repeating both cytology and HPV in 1 year **or** colposcopy are acceptable follow-up actions.
- The recommendations no longer include having 3 consecutive negative Pap tests before increasing the screening interval. If a woman is over the age of 30 and has not been screened in many years, she would benefit from having Pap test with an HPV test. If this screening is negative, she does not need rescreening for 5 years.
- Women younger than 30 and all women may receive reflex HR-HPV testing in follow-up of ASC-US cytology results. **All HPV testing is restricted to High Risk strains of the virus only**.
- Women who have received the HPV vaccine should continue cervical cancer screening according to the current guidelines.
- Women who are immune-compromised, have undergone hysterectomy for cervical cancer or high-grade pre-cancerous lesions, or were exposed to Diethylstilbestrol (DES) in utero may be screened annually with Pap testing only.
- Women who have undergone hysterectomy for cervical cancer or with colposcopy results of CIN 2 or greater may receive Pap tests for 20 years, and follow-up diagnostic testing according to guidelines published by the American Society for Colposcopy and Cervical Pathology, available online at http://www.asccp.org .
- Women older than age 64 who have evidence of adequate negative prior screening and no history of CIN 2 or greater in the previous 20 years should not be screened for cervical cancer. If no adequate history can be documented, a Pap test or Pap/HPV co-test is encouraged. Once screening is discontinued, it should not be started for any reason, even if a woman reports having a new sex partner.
- Clinicians should educate all women about the components of the pelvic exam, including whether cervical cancer screening is performed and whether or not the woman is being tested for STDs, including HPV. Given the recommended increase in screening interval, consideration should be given to providing women with copies of their Pap and Pap/HPV test results.

An informational patient fact sheet about the new guidelines is available from the USPSTF at: http://www.uspreventiveservicestaskforce.org/uspstf11/cervcancer/cervcancerfact.pdf.

The CDC and Department of Public Health will continue to monitor the science regarding new technology and protocols for cancer screening as they emerge. Rev. 6/20/2012, 4/5/2013

Appendix K: Diagnostic Excisional Procedures (LEEP/Conization)

Purpose

- To support the CBCCEDP and Integrated Programs mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CBCCEDP and Integrated Programs with abnormal screening results or diagnosis of cancer have access to timely, comprehensive and appropriate follow-up.
- To ensure quality care standards for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.

Policy

It is the policy of the Connecticut Breast and Cervical Cancer Early Detection Program to closely monitor the reimbursement of Diagnostic Excisional Procedures (Loop Electrode/Electrosurgical Excision Procedure or LEEP and Cervical Conization). Pre-authorization is required for these procedures.

Definition

LEEP uses a thin wire loop that acts like a scalpel (surgical knife) with an electric current that is passed through the loop. The electrified wire cuts away a thin layer of the cervix. It is an excisional procedure performed on women with CIN 3 findings on colposcopy and in whom the diagnosis of invasive cervical cancer must be ruled out.

Conization of the cervix is defined as excision of a cone-shaped or cylindrical wedge from the cervix uteri that includes the transformation zone and all or a portion of the endocervical canal. It is used for the definitive diagnosis of squamous or glandular intraepithelial lesions, for excluding microinvasive carcinomas, and for conservative treatment of cervical intraepithelial neoplasia (CIN).

LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations according to their algorithm on the management of women with HIS.

Protocol

In accordance with CDC guidance, and recommendations from the American Society for Colposcopy and Cervical Pathology (ASCCP), LEEP and Cervical Conization, diagnostic excisional procedures, may be reimbursed ***in unusual cases*** to arrive at a definitive diagnosis for women in whom CIN 3 or HSIL has been found on colposcopy, and for whom the diagnosis of invasive cervical cancer must be ruled out.
When a provider opts to perform a Diagnostic Excisional Procedure, pre-authorization for reimbursement is required in advance and on individual basis.

The Case Manager must ensure accurate completion of information on a pre-authorization request form, phone to advise the CT DPH BCCEDP, and fax the form to the Nurse Consultant or Program Coordinator promptly after a procedure is recommended.

DPH staff will review the request and consult with the Medical Advisory Committee or designated clinical representative(s) as indicated, communicate approval or denial to the provider by return fax, and record the determination in the Administrative Notes section of the Med-IT online data tracking system. Advance approval of departure from the protocol should be sought through DPH BCCEDP as soon as possible, when needed, on a case-by-case basis.

When the review process is complete, the pre-authorization form will be filed with the patient's plan of care.

Reimbursement for diagnostic excisional cervical procedures performed without pre-authorization will require review by the Medical Advisory Board prior to the claim being approved.

Appendix L: CCSP Pre-authorization Form

Diagnostic Excisional Procedures

Med-IT #:_____ Age: _____ Colposcopy Date: _____

Colposcopy Results: _____ LEEP Recommended by: _____

Brief Relevant Contributory Health History (include dates):_____

_____

_____

_____

_____

_____

Submitted by: _____ Date: _____

DPH Fax: (860) 509-7855

M.A.B. Approval: ❒N/A (Compliant with ASCCP algorithms) Verbal ❒ E-Mail ❒ Fax ❒

DPH Authorization/Denial Communicated by: _____

To: _____

Date: _____

Return Fax: _____

Appendix M: Blood Pressure Measurement Procedure

The JNC-7 Report recommends the following steps for accurately measuring blood pressure:

- The auscultatory (listening) method of blood pressure measurement with a properly calibrated and validated instrument should be used.
- Participants should not smoke, exercise, or have caffeine for at least 30 minutes before their blood pressure is measured.
- Participants should be seated quietly for at least 5 minutes in a chair (rather than an exam table), with feet on the floor and arms supported at heart level.
- To ensure accuracy, use the appropriate size cuff (cuff bladder encircling at least 80% of the arm). Some adults may require a large adult cuff.
- Use a mercury sphygmomanometer, a recently calibrated aneroid manometer, or a validated electronic device to measure blood pressure.
- Measure and record at least two measurements, separated by a minimum of 2 minutes.
- Systolic blood pressure (SBP) is the point at which the first of two or more sounds is heard (phase 1), and diastolic blood pressure (DBP) is the point before the disappearance of the sounds (phase 5).
- Providers should give each participant specific blood pressure numbers and goals verbally and in writing.

Appendix N: Connecticut Tobacco Quitline Fax Referral Forms and Related Instructions

March 2014

Dear Providers:

The Centers for Disease Control and Prevention (CDC) is interested in collecting the number of client referrals made to the Connecticut Quitline. To provide this information the Connecticut Department of Public Health (DPH) Breast and Cervical Cancer Program, and Colorectal Cancer Program have worked with the DPH Tobacco Prevention and Control Program to establish procedures which will permit collection of Connecticut Quitline referral data.

The Tobacco Prevention and Control Program developed a toolkit for use by healthcare providers. Providers can use the toolkit to refer interested patients to the Connecticut Quitline. The toolkit is enclosed for your site's use and includes an introductory letter from Dr. Jewel Mullen, DPH Commissioner; a Connecticut Quitline Fact Sheet for health professionals; several Connecticut Quitline brochures; and, two Connecticut Quitline Fax Referral Forms, one in English and one in Spanish. Both forms are personalized to contain the agency name, program name, and zip code.

It is very important to use only the personalized fax referral forms when making referrals to the Connecticut Quitline. The personalized information supports data collection (number of referrals made to the Quitline by a particular agency). These data will be reported to CDC. An electronic copy of the personalized English form and the Spanish form will be emailed to you. **Use only these forms for referrals to the Quitline.**

Fax referral procedure: The agency completes the fax referral form and has client sign it. The agency faxes the form to the telephone number identified on the form. The Connecticut Quitline will contact the patient directly to set-up counseling sessions once the form is received. The Connecticut Quitline does not accept hard copies by mail.

All provider sites are required to begin using the Connecticut Quitline Fax Referral Forms, effective immediately, when referring patients to the Connecticut Quitline.

Thank you for your attention in this matter. Please do not hesitate to contact the DPH with questions.

Sincerely,

Connecticut Department of Public Health
410 Capitol Avenue MS 11-CCS
Hartford, CT 06134
Telephone: 860.509.8166

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

Jewel Mullen, M.D., M.P.H., M.P.A.
Commissioner

Dannel Malloy
Governor

February 2012

Dear Healthcare Provider:

Helping your patients become tobacco free is easier with the assistance of the Connecticut Quitline. This is an important service to offer your patients because smoking harms nearly every organ of the body. Currently in Connecticut, 16.7% of adults use tobacco, and 70% of them want to quit.

When you refer your patients to 1-800-QUIT-NOW, they will be offered a telephone-based counseling program, which is funded by the Connecticut Department of Public Health and currently provided via a contract with Alere Wellbeing.

I encourage you to take a proactive approach to eliminating tobacco use by following "the 5 A's" recommended by the U.S. Department of Health and Human Services:

1. **Ask** patients about tobacco use at every visit
2. **Advise** patients who use tobacco to quit
3. **Assess** patients' readiness to quit*
4. **Assist** patients in quitting*
5. **Arrange** for follow up contact*

The process is straightforward: identify your tobacco users and advise them to quit. Statistics show that people are more likely to try to quit when advised by a health care provider. *The tobacco treatment specialists who staff the Connecticut Quitline will assess your patient's readiness to quit, assist in the quitting process and arrange for follow up contact. When you use the enclosed fax referral form, you will receive a status report of your patient's quit attempts.

Referrals to the Connecticut Quitline will help to reduce the burden of tobacco use within our state. For patients who are ready to quit, fax their information by using the enclosed Fax Referral Form and a specialist will contact them, or your patient can call 1-800-QUIT-NOW 24 hours a day, 7 days a week or register online at www.quitnow.net/connecticut.

If you have questions or would like more information, please call the Connecticut Department of Public Health Tobacco Use Prevention and Control Program at 860-509-8251.

Sincerely,

Jewel Mullen, M.D., M.P.H, M.P.A.
Commissioner

PHONE: (860) 509-7101 FAX: (860) 509-7111
410 CAPITOL AVENUE - MS#13COM, P.O. BOX 340308, HARTFORD, CONNECTICUT 06134-0308
Affirmative Action / Equal Employment Opportunity Employer

Consent Obtained In-Person Form

CONNECTICUT QUITLINE
1-800-QUIT-NOW

CONNECTICUT QUITLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: _____/_____/_____

Provider Information:

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE) YES ☐ NO ☐ DON'T KNOW ☐

Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER MALE FEMALE

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER HM ☐ WK ☐ CELL ☐

SECONDARY PHONE NUMBER HM ☐ WK ☐ CELL ☐

LANGUAGE PREFERENCE (*PLEASE CHECK ONE*) ENGLISH ☐ SPANISH ☐ OTHER

_____ I am ready to quit tobacco and request the Connecticut Quitline contact me to help me with my quit plan.
(Consent via phone)

_____ I **DO NOT** give my permission to the Connecticut Quitline to leave a message when contacting me.
(Consent via phone) ***** By not initialing, you are giving your permission for the quitline to leave a message.***

PATIENT SIGNATURE: _ _____ DATE: _____/_____/_____

The Connecticut Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.***

☐ **6AM – 9AM** ☐ **9AM – 12PM** ☐ **12PM – 3PM** ☐ **3PM – 6PM** ☐ **6PM – 9PM**

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (*CHECK ONE*): ☐ **Primary #** ☐ **Secondary #**

Consent Obtained by Phone Form

CONNECTICUT QUITLINE
1-800-QUIT-NOW

CONNECTICUT QUITLINE FAX REFERRAL FORM

Fax Number: 1-800-483-3114

FAX SENT DATE: _____/_____/_____

Provider Information:

CLINIC NAME

CLINIC ZIP CODE

HEALTH CARE PROVIDER

CONTACT NAME

FAX NUMBER

PHONE NUMBER

I AM A HIPAA COVERED ENTITY (PLEASE CHECK ONE) YES ☐ NO ☐ DON'T KNOW ☐

Patient Information:

PATIENT NAME

DATE OF BIRTH

GENDER MALE FEMALE

ADDRESS

CITY

ZIP CODE

PRIMARY PHONE NUMBER HM ☐ WK ☐ CELL ☐

SECONDARY PHONE NUMBER HM ☐ WK ☐ CELL ☐

LANGUAGE PREFERENCE (*PLEASE CHECK ONE*) ENGLISH ☐ SPANISH ☐ OTHER

_____ I am ready to quit tobacco and request the Connecticut Quitline contact me to help me with my quit plan.
(Consent via phone)

_____ I **DO NOT** give my permission to the Connecticut Quitline to leave a message when contacting me.
(Consent via phone) ***** By not initialing, you are giving your permission for the quitline to leave a message.***

PATIENT SIGNATURE: **ON FILE AND OBTAINED BY:** _____ DATE: _____/_____/_____

The Connecticut Quitline will call you. Please check the BEST 3-hour time frame for them to reach you. ***NOTE: The Quitline is open 7 days a week; call attempts over a weekend may be made at times other than during this 3-hour time frame.***

☐ 6AM – 9AM ☐ 9AM – 12PM ☐ 12PM – 3PM ☐ 3PM – 6PM ☐ 6PM – 9PM

WITHIN THIS 3-HOUR TIME FRAME, PLEASE CONTACT ME AT (*CHECK ONE*): ☐ Primary # ☐ Secondary #

Appendix O: Connecticut FQHCs

Federally Qualified Health Care Centers in Connecticut

Hartford County and Tolland County

Community Health Center of Enfield
5 N. Main Street
Enfield, CT 06082-3339
(860) 347-6971
www.chc1.com

Charter Oak Health Center
401 New Britain Avenue
Hartford, CT 06106-3833
(860) 550-7500
www.thecharteroak.org

Charter Oak Health Center, Inc.
21 Grand Street
Hartford, CT 06191-1541
(860) 550-7500
www.thecharteroak.org

Community Health Services, Inc.
500 Albany Avenue
Hartford, CT 06120-2508
(860) 249-9625
www.chshartford.org

Charter Oak Health Center
401 New Britain Avenue
Hartford, CT 06106-3833
(860) 550-7500
www.thecharteroak.org

Charter Oak Health Center, Inc.
21 Grand Street
Hartford, CT 06191-1541
(860) 550-7500
www.thecharteroak.org

Community Health Services, Inc.
500 Albany Avenue
Hartford, CT 06120-2508
(860) 249-9625
www.chshartford.org

East Hartford Community HealthCare
94 Connecticut Blvd.
East Hartford, CT 06108-3013
(860) 528-1359
www.ehchc.org

Manchester Community Health Services
150 North Main Street
Manchester, CT 06042
(860) 646-8117
www.ehchc.org

Community Health Center of Bristol
395 North Main Street
Bristol, CT 06010
860-585-5000
www.chc1.com

Community Health Center of New Britain
85 Lafayette Street
New Britain, CT 06051
(860) 224-3642
www.chc1.com

Vernon Community Health Services
3 Prospect Street
Vernon, CT 06066-3216
(860) 896-1616
www.ehchc.org

Windham County

Generations Family Health Center, Inc.
40 Mansfield Ave.
Willimantic, CT 06226-1948
(860) 450-7471
www.genhealth.org

Generations Family Health Center, Inc.
54 Reynolds Street
Danielson, CT 06239-1101
(860) 774-7501
www.genhealth.org

UCFS Health Center – Jewett City
70 Main Street
Jewett City, CT 06351
(860) 376-7040
www.ucfs.org

Generations Family Health Center, Inc.
202 Pomfret Street
Putnam, CT 06260
(860) 963-7917
www.genhealth.org

UCFS Health Center – Plainfield
120-122 Plainfield Road
Moosup, CT 06354
(860) 822-4938
www.ucfs.org

New London County

Generations Family Health Center - Norwich
W.W. Backus Medical Office Bldg. Suite 510
330 Washington Street
Norwich, CT 06360-2733
(860) 450-7456
www.genhealth.org

UCFS Health Center
47 Town Street
Norwich, CT 06360
(860) 892-7042
www.ucfs.org

UCFS - Rock Nook
77 East Town Street
Norwich, CT 06360
(860)892-7042
www.ucfs.org

Community Health Center of Groton
481 Gold Star Highway
Groton, CT 06340-3823
(860) 446-8858
www.chc1.com

Community Health Center of New London
1 Shaws Cove
New London, CT 06320-4902
(860) 447-8304
www.chc1.com

UCFS - New London
400 Bayonet Street, Suite 103
New London, CT 06320
(860) 442-4319
www.ucfs.org

UCFS - Colchester
212 Upton Road, Suite C
Colchester, CT 06415
(860) 537-7676
www.ucfs.org

New Haven County

Cornell-Scott Hill Health Center
226 Dixwell Avenue
New Haven, CT 06511-3456
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center
400-428 Columbus Avenue, New Haven
New Haven, CT 06519-1233
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center
Grant Street Partnership
62 Grant Street
New Haven, CT 06519-2514
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center
State Street Health Services
911 State Street
New Haven, CT 06511-3926
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center
South Central Rehabilitation Center
232 Cedar Street
New Haven, CT 06510-3219
(203) 503-3000
www.hillhealthcenter.com

Fair Haven Community Health Center
374 Grand Avenue
New Haven, CT 06513
(203) 777-7411
www.fhchc.org

Cornell-Scott Hill Health Center West Haven
285 Main Street
West Haven, CT 06516-7307
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center Ansonia
121 Wakelee Avenue
Ansonia, CT 06401-1198
(203) 503-3000
www.hillhealthcenter.com

Cornell-Scott Hill Health Center Derby (Dental)
30 Elizabeth Street
Derby, CT 06418-1802
(203) 503-3000
www.hillhealthcenter.com

Staywell Health Care, Inc.
80 Phoenix Avenue
Waterbury, CT 06702-1418
(203) 756-8021
www.staywellhealth.org

StayWell Health Center – South End
1302 South Main Street
Waterbury, CT 06706
(203) 597-9044
www.staywellhealth.org

Middlesex County

Community Health Center of Meriden
134 State Street
Meriden, CT 06450
(203-237-2229
www.chc1.com

Community Health Center of Clinton
114 East Main Street
Clinton, CT 06413-2112
(860) 347-6971
www.chc1.com

Community Health Center of Old Saybrook
263 Main Street
Old Saybrook, CT 06475-2326
(860) 388-4433
www.chc1.com

Litchfield County

Community Health and Wellness Center of Greater Torrington
157 Litchfield Street
Torrington, CT 06790
(860) 489-0931
www.chwctorr.org

Community Health and Wellness Center of Greater Torrington
469 Migeon Avenue
Torrington, CT 06790-4643
(860) 489-0931
www.chwctorr.org

Fairfield County

Community Health Center of Danbury
8 Delay Street
Danbury, CT 06810
(203) 797-8330
www.chc1.com

Greater Danbury Community Health Center
57 North Street
Danbury, CT 06810
(203) 743-0100
http://www.ct-institute.org/health.html

Stratford Community Health Center
727 Honeyspot Rd
Stratford, CT, 06415-7180
(203) 375-7242
www.optimushealthcare.org

Southwest Community Health Center, Inc.
986 Fairfield Avenue
Bridgeport, CT 06605-1116
(203) 330-6000
www.swchc.org

Southwest Community Health Center, Inc.
(OB/GYN)
510 Clinton Avenue
Bridgeport, CT 06605
(203) 366-4000
www.swchc.org

Southwest Community Health Center, Inc.
(Mental Health/Substance Abuse)
1046 Fairfield Avenue
Bridgeport, CT 06605
(203) 330-6054
www.swchc.org

Fairfield County (continued)

Southwest Comm. Health Center, Inc.
743 South Avenue
Bridgeport, CT 06604
(203) 330-6010
www.swchc.org

Southwest Community Health Center, Inc.
361 Bird Street
Bridgeport, CT 06605
(203) 330-6000
www.swchc.org

Optimus Health Care Main Office
982 East Main Street
Bridgeport, CT, 06608-2409
(203) 696-3260
www.optimushealthcare.org

Hollow Community Health Center
82-88 George St
Bridgeport, CT, 06605
(203) 576-3881
www.optimushealthcare.org

JP Morgan Chase Wellness Center
1071 East Main Street
Bridgeport, CT, 06608
(203) 330-2783
www.optimushealthcare.org

Bridgeport Community Health Center
471 Barnum Avenue
Bridgeport, CT, 06608-2409
(203) 333-6864
www.optimushealthcare.org

Park City Primary Care Center
64 Black Rock Avenue
Bridgeport, CT, 06605
(203) 579-5000
www.optimushealthcare.org

Ralphola Taylor Community Health Center
790 Central Ave
Bridgeport, CT, 06607
(203) 332-4567
www.optimushealthcare.org

Community Health Center of Norwalk
49 Day Street
Norwalk, CT 06854
203-854-9292
www.chc1.com

Norwalk Community Health Center
120 Connecticut Avenue
Norwalk, CT 06854
(203) 899-1770
www.norwalkchc.org

Franklin Street Community Health Center
141 Franklin Street
Stamford, CT 06901
203-969-0802
www.chc1.com

Integrated Care Program F.S. Dubois Center
780 Summer Street
Stamford, CT, 06905
(203) 348 1648
www.optimushealthcare.org

Optimus Washington Boulevard
1351 Washington Blvd
Stamford, CT, 06902
(203) 621-3700
www.optimushealthcare.org

Stamford Community Health Center
805 Atlantic St
Stamford, CT, 06902
(203) 327-5111
www.optimushealthcare.org

Fairgate Community Health Center
138 Stillwater Ave
Stamford, CT, 06902
(203) 357-0277
www.optimushealthcare.org

Clinic @ Woodland
8 Woodland Place
Stamford, CT, 06902
(203) 348-4444
www.optimushealthcare.org

Appendix P : Patient's Instructions for Bowel Preparation

Patient's Instruction for Bowel Preparation

Proper Preparation is the key to a successful colonoscopy

Procedure Date: Arrival Time:

Procedure Time:

NOTE: The MoviPrep carton contains 4 pouches and a disposable container for mixing. You must complete the entire prep to ensure the most effective cleansing.

One week prior to the procedure, avoid all aspirin or arthritis medication such as Advil, Motrin, Aleve or Ibuprofen. Tylenol is allowed if a pain medication is needed. Also, if you take iron (ferrous sulfate), stop it one week before the procedure.

If you take blood thinners of any kind or are a diabetic, please let the physician know for special instructions on their use.

Medication will be given at the time of your colonoscopy. You will need to have someone available to drive you home. Plan on being at the center for 2 hours. You will NOT BE ALLOWED to drive yourself. Public transportation is not allowed. You will not be able to go to work the day of your procedure.

DAY BEFORE THE PROCEDURE:
1. You may have clear liquids only for breakfast, lunch and dinner. Drink clear liquids throughout the day. Clear liquids allowed are: water, clear broth, bouillon, soda, clear fruit juice such as apple or grape, coffee or tea, popsicles. You may have Jell-O (NO ORANGE OR RED JELLO!!) NO MILK OR MILK PRODUCTS!!! **NO RED OR ORANGE liquids. Any juice you can see through and has NO PULP is acceptable. We encourage you to drink as much fluid as possible until bedtime to avoid dehydration.

DAY OF THE PROCEDURE:
1. NOTHING BY MOUTH 4 HOURS BEFORE THE PROCEDURE.
2. If you take medications that were allowed, take them in the morning of the procedure with a SMALL amount of water. If they can wait until AFTER the procedure then wait to take those meds until after.

RISK OF POLYPECTOMY: If a polyp is removed, there is always the risk of either making a hole in the bowel (perforation) or causing a significant amount of bleeding. These risks are very low, but you must be aware of them. Either problem, i.e., bleeding or perforation could require abdominal surgery.

IF EXCESSIVE RECTAL BLEEDING, FEVER, VOMITING OR UNUSUAL PAIN EXIST AFTER THE PROCEDURE PLEASE CALL OUR OFFICE AT **(_____)_____**.

Patient Instructions - Split Dose Regimen

The MoviPrep carton contains 4 pouches and a disposable container for mixing. You must complete the entire prep to ensure the most effective cleansing.

The day before your colonoscopy beginning at: _____

STEP 1
MIX FIRST DOSE

- Empty 1 Pouch A and 1 Pouch B into the disposable container
- Add lukewarm drinking water to the top line of the container. Mix to dissolve

If preferred, mix solution ahead of time and refrigerate prior to drinking.
The reconstituted solution should be used within 24 hours.

STEP 2
DRINK FIRST DOSE

- The MoviPrep container is divided by 4 marks. Every 15 minutes, drink the solution down to the next mark (approximately 8 oz.), until the full liter is consumed
- Drink 16 oz. of the clear liquid of your choice. This is a necessary step to ensure adequate hydration and an effective prep.

The evening before or the morning of your colonoscopy beginning at: _____

STEP 3
MIX SECOND DOSE

- Empty 1 Pouch A and 1 Pouch B into the disposable container
- Add lukewarm drinking water to the top line of the container. Mix to dissolve

If preferred, mix solution ahead of time and refrigerate prior to drinking.
The reconstituted solution should be used within 24 hours.

STEP 4
DRINK SECOND DOSE

- The MoviPrep container is divided by 4 marks. Every 15 minutes, drink the solution down to the next mark (approximately 8 oz.), until the full liter is consumed
- Drink 16 oz. of the clear liquid of your choice. This is a necessary step to ensure adequate hydration and an effective prep.

Colonoscopy prep causes the body to lose a significant amount of fluid and can result in sickness due to dehydration. It's important that you prepare your body by drinking extra clear liquids before the prep. Stay hydrated by drinking all required clear liquids

during the prep. Replenish your system by drinking clear liquids after returning home from your colonoscopy**. If you have any questions, please call our office at**

_____

Appendix Q: Case Management Policy/Needs Assessment Form

CT Department of Public Health Comprehensive Cancer Programs staff are available for assistance with interpreting program policies.

Purpose:

- To support the CCHDIHSP mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CCSP with abnormal screening results or diagnoses of cancer have access to timely, comprehensive and appropriate follow-up.
- To ensure a favorable quality of care for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.

Definition

Case Management is defined as establishing, brokering, and sustaining a system of essential support services for participants to identify and overcome barriers to definitive diagnosis and treatment. The function is distinguishable in the utilization of collaborative assessment, planning and coordination processes between the client, the Case Manager and the providers of services. It also includes monitoring and evaluation of options and services to meet the health needs of clients through communication and available resources to promote quality, cost-effective outcomes.

Case Management refers to a broad system of providing services to patients with abnormal results and should be provided promptly. That is, once patients with abnormal screening result are identified, they should be assessed for medical and social services needs as well as barriers impeding their access to diagnostic and/or treatment services.

Function

A Connecticut licensed Registered Nurse or Licensed Social Worker is required for the position of Case Manager. The Case Manager shall have a working knowledge of the CCSP, its target populations, breast, cervical and colorectal cancer, and cardiovascular

risk reduction resources available in the community. In addition, the Case Manager shall have good verbal and written communication skills and the ability to organize and maintain systems (e.g., fiscal management, participant data, tracking, and follow-up).

The Case Manager should be able to demonstrate the ability to conduct an assessment and formulate a written plan of care for those participants needing additional care.

This position shall be directly responsible to:

- Ensure Case Management services are offered and provided to those participants who have abnormal results, as specified, and need Case Management to facilitate care.

- Ensure participants receive assistance with navigation through the health care delivery system.

- Link the participant to treatment services when needed including notifying the primary care physician of abnormal results.

- Work collaboratively with DPH staff, the Project Director and Outreach Educator to ensure all program components, policies, and contracted mandates are being met.

- Attend all CCHDISHP sponsored meetings and training sessions.

- Perform other related duties as necessary.

Protocol

All participants with an abnormal screening result must be assessed for the need of Case Management services and provided with such services accordingly. Examples of screening results that would require a Case Management assessment would be:

- discrete palpable breast mass;
- BI-RADS 3, 4, 5 for mammograms;
- adenocarcinoma on colonoscopy; and,
- ASC-US and above for Pap tests.

Currently, the Med-It system creates Case Management lists for program participants with abnormal screening results. The following Case Management services must be provided to all such participants:

For each participant:
 Conduct individual participant assessment of need for services using the DPH Connecticut Breast, Cervical and Colorectal Cancer Early Detection Program Needs Assessment form

 Based on the assessment, develop and implement a “plan of care” for each participant in need of or desiring assistance and support using the DPH Case Management Care Plan form as follows:

- Schedule appropriate diagnostic follow-up;
- Make referrals for provision of appropriate and timely clinical services following any abnormal test result and/or diagnosis of cancer;
- Provide for assistance through the health care delivery system utilizing appropriate community resources;
- Document all measures promptly; and,
- Use the Med-It data system to document and monitor patients’ receipt of screening/re-screening, diagnostic, and treatment procedures.

Case Management services conclude when a participant initiates treatment, refuses treatment, or no longer meets eligibility criteria for the Early Detection Integrated Programs.

Connecticut Breast, Cervical and Colorectal Cancer Early Detection Programs
Needs Assessment Form

Connecticut Breast & Cervical Cancer Early Detection Program

- Client Name:
- Date of Birth:
- Phone #: (1)
- Phone #: (2)
- Med-IT#: Cycle #:
- Date Client notified of abnormality:

Reason for assessment:
☐ Abnormal Clinical Breast Exam
☐ Suspicious/malignant mammo. (BI-RADS 3 or higher)
☐ Incomplete assessment mammo. (not resolved in 15 workdays)
☐ HSIL, LGSIL, ASCUS +HPV, AGC or carcinoma
☐ Abnormal colorectal screen

- Date of assessment: (must be within 10 days of client notification) ☐ By phone ☐ In Person
- Confidentiality was assured: ❒ Yes No ❒(explain)
- Case Management **NOT Indicated** ❒ Dx. Workup complete ❒ Lost to F/U ❒
- CBCCEDP Contracted Site: Client learns best by:

A. DEMOGRAPHICS

1. Marital Status ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Widowed
2. Number in Household: _____
3. Insurance: ☐ Yes ☐ No
   If Yes, Type: _____
4. Monthly Income:_____
5. Primary Language:
   _____
6. Highest Level of Education: _____
7. Occupation:
   _____
8. Do you work during the day? ☐ Yes ☐ No ☐ N/A
9. Can we contact you at work? ☐ Yes ☐ No ☐ N/A

B. SOCIAL RESOURCES

1. Support Person ☐Yes ☐No
2. Name and Relationship: _____
   _____
3. If no phone, how can we reach you? ☐ N/A
   _____
4. Do you have problems with transportation?
   ☐ Yes ☐ No
5. Do you have problems with child or elder care?
   ☐ Yes ☐ No
6. Name someone who is not in your household who would always know your location:
   Name: _____
   Phone: _____
7. Are you followed by any other Case Manager?
   ☐ Yes ☐ No If Yes:
   Name:

C. HEALTH STATUS

1. Health History _____
   _____
   _____
2. Where do you go for health care: Physician_____
   Hospital or Clinic_____ Self-Treat_____
   Alternative Medicine (i.e. herbs, aromatherapy etc.) ____
   Other _____
3. Who is your regular health care provider?
   Name: _____
   Phone: _____
4. Date last seen: _____
5. Why were you referred for testing or treatment?
   _____
   _____
   _____
6. What are your concerns about testing or treatment?
   _____
   _____

D. Barriers to Diagnostic and Follow-up Care

☐ Language/Cultural ☐ Religious Beliefs
☐ Disabilities ☐ Sexual Concerns
☐ Transportation ☐ Discomfort of Procedures
☐ Making Appointment ☐ Fear of:
☐ Leaving Work ☐ Cancer
☐ Child/Elder Care ☐ Loss of Intimacy
☐ Relationships with S.O. ☐ Loss of Employment
☐ Understanding of Medical Needs
☐ Finances ☐ Confusion about covered services
☐ Other: _____
_____
_____

Case Management Needed: No❒ Provided ❒ Refused ❒

Next Scheduled Contact _____ **Case Manager Signature/Date**_____

Appendix R: Case Management Policy/Needs Assessment Form

CT Department of Public Health Comprehensive Cancer Programs staff are available for assistance with interpreting program policies.

Purpose:

- To support the CCHDIHSP mission, vision and values.
- To comply with Centers for Disease Control and Prevention (CDC) national guidance, state statutes, and federal laws.
- To ensure equitable and consistent access to treatment referral for all enrolled participants.
- To ensure all women enrolled in the CCSP with abnormal screening results or diagnoses of cancer have access to timely, comprehensive and appropriate follow-up.
- To ensure a favorable quality of care for all enrolled participants.
- To promote contractual, clinical and fiscal compliance.

Definition

Case Management is defined as establishing, brokering, and sustaining a system of essential support services for participants to identify and overcome barriers to definitive diagnosis and treatment. The function is distinguishable in the utilization of collaborative assessment, planning and coordination processes between the client, the Case Manager and the providers of services. It also includes monitoring and evaluation of options and services to meet the health needs of clients through communication and available resources to promote quality, cost-effective outcomes.

Case Management refers to a broad system of providing services to patients with abnormal results and should be provided promptly. That is, once patients with abnormal screening result are identified, they should be assessed for medical and social services needs as well as barriers impeding their access to diagnostic and/or treatment services.

Function

A Connecticut licensed Registered Nurse or Licensed Social Worker is required for the position of Case Manager. The Case Manager shall have a working knowledge of the CCSP, its target populations, breast, cervical and colorectal cancer. In addition, the Case Manager shall have good verbal and written communication skills and the ability to organize and maintain systems (e.g., fiscal management, participant data, tracking, and follow-up).

The Case Manager should be able to demonstrate the ability to conduct an assessment and formulate a written plan of care for those participants needing additional care.

This position shall be directly responsible to:

- Ensure Case Management services are offered and provided to those participants who have abnormal results, as specified, and need Case Management to facilitate care.
- Ensure participants receive assistance with navigation through the health care delivery system.
- Link the participant to treatment services when needed including notifying the primary care physician of abnormal results.
- Work collaboratively with DPH staff, the Project Director and Outreach Educator to ensure all program components, policies, and contracted mandates are being met.
- Attend all CCHDISHP sponsored meetings and training sessions.
- Perform other related duties as necessary.

Protocol

All participants with an abnormal screening result must be assessed for the need of Case Management services and provided with such services accordingly. This includes enrollees who have been referred into the program for diagnostic follow up of abnormal results obtained prior to enrollment. Examples of screening results that would require a Case Management assessment would be:

- discrete palpable breast mass;
- BI-RADS 3, 4, 5 for mammograms;
- adenocarcinoma on colonoscopy; and,
- ASC-US and worse for Pap tests.

Currently, the Med-It system creates Case Management lists for program participants with abnormal screening results. The following Case Management services must be provided to all such participants:

For each participant:

 Conduct individual participant assessment of need for services using the DPH Connecticut Breast, Cervical and Colorectal Cancer Early Detection Program Needs Assessment form

 Based on the assessment, develop and implement a "plan of care" for each participant in need of or desiring assistance and support using the DPH Case Management Care Plan form as follows:

- Schedule appropriate diagnostic follow-up;
- Make referrals for provision of appropriate and timely clinical services following any abnormal test result and/or diagnosis of cancer;
- Provide for assistance through the health care delivery system utilizing appropriate community resources;
- Document all measures promptly; and,
- Use the Med-It data system to document and monitor patients' receipt of screening/re-screening, diagnostic, and treatment procedures as close to real time as possible.

Case Management services conclude when a participant is diagnosed, initiates treatment, refuses treatment, or no longer meets eligibility criteria for the Early Detection Integrated Programs.

2014-2015 Connecticut Allowable Procedures and Relevant CPT Codes
Connecticut Cancer Screening Program (CCSP)
Appendix S: CPT Code Reimbursement Rates

CODES		ALLOWABLE CPT CODES & RATES	REIMBURSEMENT RATES			
MED-IT Codes	**CPT Codes**	**Procedure/Description**				
Section 1		**INTEGRATED OFFICE VISITS (Clinical Office Visits Starting a New Screening Cycle) Must include Breast or Cervical and Colorectal**	**Global**	**Professional**	**Technical**	**Facility**
BR204	99204	**Initial Breast and Cervical and Colorectal Patient**; *comprehensive* history, exam, decision-making of moderate complexity; 45 minutes	178.42	140.04		38.38
BR386	99386	**Initial Breast and Cervical and Colorectal Patient**; *comprehensive* preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 40-64 years of age	178.42	140.04		38.38
BR214	99214	**Established Breast and Cervical and Colorectal Patient**; *detailed* history, exam, decision-making of moderate complexity; 25 minutes	115.81	83.83		31.98
BR396	99396	**Periodic Breast and Cervical and Colorectal Patient:** *comprehensive* preventive medicine evaluation and management; history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc; 40-64 years of age	115.81	83.83		31.98
Section 2		**OFFICE VISITS PROVIDING CCSP SERVICES ONLY (Clinical Office Visits)**	**Global**	**Professional**	**Technical**	**Facility**
BC201	99201	**Initial Patient**; history, exam, straightforward decision-making; 10 minutes	46.96	28.17		18.79
BC202	99202	**Initial Patient**; *expanded* history, exam, straightforward decision-making; 20 minutes	80.39	53.60		26.79
BC203	99203	**Initial Patient**; *detailed* history, exam, straightforward decision-making of low complexity; 30 minutes	116.60	81.82		34.78
BC211	99211	**Established Patient**; evaluation and management, may not require presence of physician; 5 minutes	21.84	9.84		12.00
BC212	99212	**Established Patient**; history, exam, straightforward decision-making; 10 minutes	47.36	26.97		20.39
BC213	99213	**Established Patient**; *expanded* history, exam, straightforward decision-making of low complexity; 15 minutes	78.65	54.67		23.98
Section 3		**OFFICE VISITS PROVIDING CCSP SERVICES ONLY (Clinical Office Visits)**	**Global**	**Professional**	**Technical**	**Facility**
CR201	99201	**New Patients**, *expanded* history, exam, straightforward decision-making; 10 minutes	46.96	28.17		18.79
CR202	99202	**New Patients**, *expanded* history, exam, straightforward decision-making; 20 minutes	80.39	53.60		26.79
Section 4		**CCSP BREAST SCREENING PROCEDURES (Starting Annual Breast Screening Cycle)**	**Global**	**Professional**	**Technical**	**Facility**
77057	77057	Screening Mammogram, Bilateral (2 view film study of each breast)	90.25	37.84	52.41	
77056	77056	Mammography, Diagnostic Follow-up, Bilateral	126.92	46.92	80.00	
G0202	G0202	Screening Mammogram, Digital, Bilateral	148.62	37.44	111.18	
G0204	G0204	Diagnostic Mammogram, Digital, Bilateral	181.29	46.92	134.37	

Rates Effective July 1, 2014 to June 30, 2015

2014-2015 Connecticut Allowable Procedures and Relevant CPT Codes

Section 5		ADDITIONAL CCSP BREAST IMAGING PROCEDURES (For Use When Screening Test Results are Inconclusive)	Global	Professional	Technical	Facility
77055	77055	Mammography, Diagnostic Follow-up, Unilateral	98.65	37.84	60.81	
77056	77056	Mammography, Diagnostic Follow-up, Bilateral	126.92	46.92	80.00	
G0204	G0204	Diagnostic Mammogram, Digital, Bilateral	181.29	46.92	134.37	
G0206	G0206	Diagnostic Mammogram, Digital, Unilateral	142.63	37.44	105.19	
76645	76645	Ultrasound, breast(s), unilateral or bilateral, B-scan and/or real time with image documentation	109.97	29.57	80.40	
Section 6		**ABNORMAL CCSP BREAST SURGICAL CONSULTATIONS (Diagnostic Services for Abnormal Screening Test Outcome Only)**	**Global**	**Professional**	**Technical**	**Facility**
BX201	99201	**Initial Patient**; history, exam, straightforward decision-making; 10 minutes	46.96	28.17		18.79
BX202	99202	**Initial Patient**; *expanded* history, exam, straightforward decision-making; 20 minutes	80.39	53.60		26.79
BX203	99203	**Initial Patient**; *detailed* history, exam, straightforward decision-making of low complexity; 30 min.	116.60	81.82		34.78
BX204	99204	**Initial Patient**; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	178.42	140.04		38.38
BX205	99205	**Initial Patient**; *comprehensive* history, exam, high complexity decision-making; 60 minutes	221.73	180.55		41.18
BX211	99211	**Established Patient**; evaluation and management, may not require presence of physician; 5 min.	21.84	9.84		12.00
BX212	99212	**Established Patient**; history, exam, straightforward decision-making; 10 minutes	47.36	26.97		20.39
BX213	99213	**Established Patient**; *expanded* history, exam, straightforward decision-making of low complexity; 15 minutes	78.65	54.67		23.98
Section 7		**ABNORMAL CCSP BREAST DIAGNOSTIC SERVICES (Diagnostic Services for Abnormal Screening Test Outcome Only)**	**Global**	**Professional**	**Technical**	**Facility**
10021	10021	Fine needle aspiration without imaging guidance	164.61	77.86		86.75
10022	10022	Fine needle aspiration with imaging guidance	153.88	71.52		82.36
19000	19000	Puncture aspiration of cyst of breast	124.03	48.07		75.96
19001	19001	Puncture aspiration of cyst of breast, each additional cyst, *used with 19000*	29.21	23.61		5.60
19081	19081	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, stereotactic guidance, first lesion	753.43	201.33		552.10
19082	19082	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, stereotactic guidance, each additional lesion	610.44	95.12		515.32
19083	19083	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous ultrasound guidance, first lesion	748.56	188.47		560.09
19084	19084	Breast biopsy, with placement of localization device and imaging of biopsy specimen, percutaneous, ultrasound guidance, each additional lesion	602.29	89.37		512.92
19100	19100	Breast biopsy, percutaneous, needle core, not using imaging guidance	165.58	76.03		89.55
19101	19101	Breast biopsy, open, incisional	373.05	241.92		131.13
19120	19120	Excision of cyst, fibroadenoma or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion; open; one or more lesions	540.06	452.51		87.55
19125	19125	Excision of breast lesion identified by preoperative placement of radiological marker; open; single lesion	598.57	502.22		96.35
19126	19126	Excision of breast lesion identified by preoperative placement of radiological marker, open; *each additional lesion separately identified by a preoperative radiological marker*	176.78	176.78		0

Rates Effective July 1, 2014 to June 30, 2015

19281	19281	Placement of breast localization devise, percutaneous, mammographic guidance, first lesion	268.46	111.35		157.11
19282	19282	Placement of breast localization devise, percutaneous, mammographic guidance, each additional lesion	187.13	52.80		134.33
19283	19283	Placement of breast localization devise, percutaneous, stereotactic guidance, first lesion	305.64	112.55		193.09
19284	19284	Placement of breast localization devise, percutaneous, stereotactic guidance, each additional lesion	225.11	53.20		171.91
19285	19285	Placement of breast localization devise, percutaneous, ultrasound guidance, first lesion	521.99	95.42		426.57
19286	19286	Placement of breast localization devise, percutaneous, ultrasound guidance, each additional lesion	439.09	45.70		393.39
76098	76098	Radiological examination, surgical specimen	21.15	6.71	12.44	
76942	76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	80.76	44.82	35.94	
88172	88172	Cytopathology, evaluation of fine needle aspirate; immediate cytohistologic study to determine adequacy of specimen(s)	58.58	38.15	20.43	
88173	88173	Cytopathology, evaluation of fine needle aspirate; *interpretation and report*	159.54	75.94	83.60	
88305	88305	Surgical pathology, gross and microscopic examination	76.37	40.35	36.02	
88307	88307	Surgical pathology, gross and microscopic examination; requiring microscopic evaluation of surgical margins	316.80	88.88	227.92	
Section 8		**CCSP CERVIAL SCREENING PROCEDURES (Starting New Cervical Screening Cycle)**	**Global**	**Professional**	**Technical**	**Facility**
88141	88141	Cytopathology (conventional Pap test), cervical or vaginal, any reporting system, *requiring interpretation by physician*	34.32			
88142	88142	Cytopathology (liquid-based Pap test) cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening under physician supervision	27.64			
88143	88143	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; manual screening and rescreening under physician supervision	27.64			
88164	88164	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening under physician supervision	14.42			
88165	88165	Cytopathology (conventional Pap test), slides cervical or vaginal reported in Bethesda System, manual screening and rescreening under physician supervision (redo)	14.42			
88174	88174	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system, under physician supervision	27.64			
88175	88175	Cytopathology, cervical or vaginal, collected in preservative fluid, automated thin layer preparation; screening by automated system and manual rescreening, under physician supervision	27.64			
87621	87621	Papillomavirus, Human, Amplified Probe ▪ Hybrid Capture II from Digene - HPV Test [High Risk Typing, only] ▪ Cervista HPV HR	47.87			
Section 9		**ABNORMAL CCSP CERVIAL SURGICAL CONSULTATIONS (Diagnostic Services for Abnormal Screening Test Outcome Only)**	**Global**	**Professional**	**Technical**	**Facility**
CX201	99201	**Initial Patient**; history, exam, straightforward decision-making; 10 minutes	46.96	28.17		18.79
CX202	99202	**Initial Patient**; *expanded* history, exam, straightforward decision-making; 20 minutes	80.39	53.60		26.79
CX203	99203	**Initial Patient**; *detailed* history, exam, straightforward decision-making of low complexity; 30 minutes	116.60	81.82		34.78

CX204	99204	**Initial Patient**; *comprehensive* history, exam, moderate complexity decision-making; 45 minutes	178.42	140.04		38.38
CX205	99205	**Initial Patient**; *comprehensive* history, exam, high complexity decision-making; 60 minutes	221.73	180.55		41.18
CX211	99211	**Established Patient**; evaluation and management, may not require presence of physician; 5 minutes	21.84	9.84		12.00
CX212	99212	**Established Patient**; history, exam, straightforward decision-making; 10 minutes	47.36	26.97		20.39
CX213	99213	**Established Patient**; *expanded* history, exam, straightforward decision-making of low complexity; 15 minutes	78.65	54.87		23.98
Section 10		**CCSPP CERVIAL DIAGNOSTIC PROCEDURES (Diagnostic Services for Abnormal Screening Test Outcome Only)**	**Global**	**Professional**	**Technical**	**Facility**
57452	57452	Colposcopy of the cervix	120.76	102.37		18.39
57454	57454	Colposcopy of the cervix, with biopsy and endocervical curettage	170.15	151.76		18.39
57455	57455	Colposcopy of the cervix, with biopsy	158.71	123.92		34.79
57456	57456	Colposcopy of the cervix, with endocervical curettage	150.29	115.51		3478
57460	57460	Endoscopy with loop electrode biopsy(s) of the cervix	314.84	182.51		132.33
57461	57461	Endoscopy with loop electrode conization of the cervix	356.06	210.14		145.92
57500	57500	Biopsy, single or multiple, or local excision, with or without fulguration (separate procedure)	141.97	84.80		57.17
57505	57505	Endocervical curettage (not done as part of a dilation and curettage)	113.22	102.42		10.80
57520	57520	Conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser	339.01	304.23		34.78
57522	57522	Loop electrode excision procedure (LEEP)	293.08	271.49		21.59
58100	58100	Endometrial sampling (biopsy) with or without endocervical sampling (biopsy), without cervical dilation, any method (separate procedure)	121.55	98.36		23.19
58110	58110	Endometrial sampling (biopsy) performed in conjunction with colposcopy (List separately in addition to code for primary procedure)	53.10	45.50		7.60
88305	88305	Surgical pathology, gross and microscopic examination	76.37	40.35	36.02	
88331	88331	Pathology consultation during surgery, first tissue block, with frozen section(s), single specimen	106.50	66.08	40.42	
88332	88332	Pathology consultation during surgery, first tissue block, with frozen section(s), each additional specimen	46.91	32.88	14.03	
G0461	G0461	Immunohistochemistry or immunocytochemistry, per specimen; first stain	96.90	32.49	64.41	
G0462	G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional stain	75.65	13.24	62.41	
Section 11		**COLONOSCOPY SCREENING PROCEDURES**	**Global**	**Professional**	**Technical**	**Facility**
G0121	G0121	Screening colonoscopy on average risk individual	431.17	237.67		Section 14
I0121	G0121 -53	Interrupted screening colonoscopy on average risk individual	151.70	69.75		Section 14
45378	45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression (separate procedure)	431.17	237.67		Section 14
I5378	45378 -53	Interrupted colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection of specimen(s) by brushing or washing, with or without colon decompression	151.70	69.75		Section 14
45380	45380	Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple	513.02	283.54		Section

						14
45381	45381	Colonoscopy, flexible, proximal to the splenic flexure; with directed submucosal injection(s), any substance.	515.64	268.97		Section 14
45384	45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery	512.82	296.93		Section 14
45385	45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique	578.27	336.80		Section 14
Section 12		**COLONOSCOPY-RELATED ANESTHESIOLOGY**	**Global**	**Professional**	**Technical**	**Facility**
00810	00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum* (if using this code, facility fee is capped at 280.35	119.65			
Section 13		**COLONOSCOPY-RELATED PATHOLOGY**	**Global**	**Professional**	**Technical**	**Facility**
88300	88300	Surgical Pathology, gross examination only (surgical specimen)	16.21	11.24	4.98	
88302	88302	Surgical pathology, gross and microscopic examination (level II)	33.24	7.61	25.63	
88305	88305	Surgical pathology, gross/microscopic examination, colon,/colorectal polyp biopsy (level IV)	76.37	40.35	36.02	
G0461	G0461	Immunohistochemistry or immunocytochemistry, per specimen; first stain	96.90	32.49	64.41	
G0462	G0462	Immunohistochemistry or immunocytochemistry, per specimen; each additional stain	75.65	13.24	62.41	
Section 14		**COLONOSCOPY-RELATED FACILITY FEE**	**Global**	**Professional**	**Technical**	**Facility**
00158	00158	Colorectal Cancer Screening; Colonoscopy for hospital based outpatient facility	400		119.65	280.35
121SG	G0121 -SG	Colorectal Cancer Screening; Average Risk Colonoscopy for ambulatory surgery center	400		119.65	280.35
Section 15		**COLONSOCOPY-RELATED ELECTROCARDIOGRAM**	**Global**	**Professional**	**Technical**	**Facility**
93000	93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	18.31			
Section 16		**COLONOSCOPY-RELATED BLOOD WORK**	**Global**	**Professional**	**Technical**	**Facility**
80048	80048	Basic metabolic panel (Calcium, total) This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)	11.54			
85610	85610	Prothrombin time	5.37			

2014-2015 Connecticut Allowable Procedures and Relevant CPT Codes

PROCEDURES SPECIFICALLY NOT ALLOWED	
Any	Treatment of breast cancer, cervical intraepithelial neoplasia and cervical cancer.
Any	Computer Aided Detection (CAD) in breast cancer screening or diagnostics
Any	Magnetic Resonance Imaging (MRI) in breast cancer screening or diagnostics
Any	Treatment of colorectal cancer or any other cancer diagnosed as a result of participation in the program
Any	Treatment of medical conditions diagnosed as a result of participation in the program or that existed prior to entry into the program
Any	Care and services for complications that result from screening or diagnostic test provided by the program
Any	Evaluation of symptoms for clients who present to CRC screening but are found to have gastrointestinal symptoms
Any	CRC Diagnostic services for clients who had an initial positive screening test performed outside the program
Any	CT Colonography (or virtual colonoscopy) as a primary screening test
Any	Computed Tomography Scans (CTs or CAT Scans) requested for staging or other purposes.

END NOTES
All consultations should be billed through the standard "new patient" office visit CPT codes: 99201-99205. These codes (99204-99205) are not appropriate for NBCCEDP screening visits. CPT codes 99201-99205 are coded as BX201-BX205 for breast surgical consultations and CX201-CX205 for cervical surgical consultations in MED-IT. Consultations billed as BX-204 or CX-204 and as BX-214 or CX-215 must meet the criteria for the 99204 and 99205 codes respectively.
The type and duration of office visits should be appropriate to the level of care necessary for accomplishing screening and diagnostic follow-up within the NBCCEDP. Reimbursement rates should not exceed those published by Medicare. While the use of 993XX-series codes may be necessary in some programs, the 993XX Preventive Medicine Evaluation visits themselves are not appropriate for the NBCCEDP. 9938X codes shall be reimbursed at or below the 99203 rate, and 9939X codes shall be reimbursed at or below the 99213 rate.
CDC reimbursement for cytopathology may be made when following the new United States Prevention Services Task Force (USPSTF) recommendations for women to receive either Pap testing alone every 3 years or Pap testing with HPV testing every 5 years. Cervical cytopathology codes 88143, 88174 and 88175 must be reimbursed at the applicable 88142 Medicare reimbursement rate (or less). [Source: NBCCEDP Blast Email, Dated 9/27/06]
HPV DNA testing is a reimbursable procedure if used for screening in conjunction with Pap testing or for follow-up of an abnormal Pap result or surveillance as per ASCCP guidelines. It is not reimbursable as a primary screening test for women of all ages or as an adjunctive screening test to the Pap for women under 30 years of age. Providers should specify the high-risk HPV DNA panel only. Reimbursement of screening for low-risk HPV types is not permitted. The CDC will allow for reimbursement of Cervista HPV HR at the same rate as the Digene Hybrid-Capture 2 HPV DNA Assay. CDC funds cannot be used for reimbursement of genotyping (e.g., Cervista HPV 16/18).
Codes 19081-19086 are to be used for breast biopsies that include image guidance, placement of localization device, and imaging of specimen. These codes should not be used in conjunction with 19281-19288.
Codes 19281-19288 are for image guidance placement of localization device without image-guided biopsy. These codes should not be used in conjunction with 19081-19086.
A LEEP or conization of the cervix, as a diagnostic procedure, may be reimbursed based on ASCCP recommendations. Grantees are strongly encouraged to develop policies to closely monitor these procedures and should pre-authorize this service for reimbursement by having its medical advisory board or designated clinical representative(s) review these cases in advance, and on an individual basis.
Medicare's methodology for the payment of anesthesia services are outlined in the Medicare Claims Processing Manual, Chapter 12, pages 99-107, available here: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf The carrier-specific Medicare anesthesia conversion rates are available here: http://www.cms.hhs.gov/center/anesth.asp
If the colorectal cancer screening client fails standard moderate sedation, anesthesia may be used to complete the endoscopic procedure. Documentation should be provided to support the use of anesthesia on a case-by-case basis.

closely monitor these procedures and should pre-authorize this service for reimbursement by having its medical advisory board or designated clinical representative(s) review these cases in advance, and on an individual basis.
Medicare's methodology for the payment of anesthesia services are outlined in the Medicare Claims Processing Manual, Chapter 12, pages 99-107, available here: http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf The carrier-specific Medicare anesthesia conversion rates are available here: http://www.cms.hhs.gov/center/anesth.asp
If the colorectal cancer screening client fails standard moderate sedation, anesthesia may be used to complete the endoscopic procedure. Documentation should be provided to support the use of anesthesia on a case-by-case basis.

Rev 3-5-14-NoWW

Appendix T **Connecticut Cancer Screening Program**

☐ New Client

☐ Returning Client

Enrollment Form

(Page 1)

Med-IT #:_____

Chart #: _____

Patient Enrollment Information

Name: _____ _____ _____

Last Name First Name MI

Date of Enrollment Status: _____ [mm/dd/yyyy]

(This is the date of new or updated enrollment data to coincide with services)

Enrolling Provider: _____

Eligibility

Household Income (**Before Taxes**): _____ __ weekly __ monthly __annually Number of people living on this income:_____

Insurance: __ No Insurance __ Not enough because of: __ High Deductible __ Yes, I have: __ Private Insurance

__ Low Coverage __ Medicaid Coverage

__ Medicaid Spend-down

Tobacco Use: Do you smoke or chew tobacco? __ Yes __ No

Do you want information on quitting? __ Yes __ No

Client **is requesting** the following services:

- ☐ Clinical breast & cervical exam
- ☐ Papanicolaou (Pap) Test
- ☐ Repeated Papanicolaou Test (previous unsatisfactory)
- ☐ Annual mammogram
- ☐ Follow-up mammogram
- ☐ Screening Colonoscopy
- ☐ Diagnostic follow-up

Client **is eligible for** the following services:

- ☐ Clinical breast & cervical exam
- ☐ Papanicolaou (Pap) Test
- ☐ Repeated Papanicolaou Test (previous unsatisfactory)
- ☐ Annual mammogram
- ☐ Follow-up mammogram
- ☐ Screening Colonoscopy
- ☐ Diagnostic follow-up

Primary Care Physician

Name of Practice:_____ Name of Doctor:_____

City:_____ State:_____ Telephone:_____

Patient Contact Information

Name: _____ _____ [Last Name, First Name, MI] Gender: __ Male __ Female

Maiden Name: _____ Date of Birth: _____ [mm/dd/yyyy]

Address: _____ Address 2: _____

How long will you be at this address: _____

Zip Code:_____ City: _____

County:_____ State: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Do you have a home computer __ Yes __ No Do you have e-mail access: __ Yes __ No Email:_____

Backup Patient Contact Information That Will Likely Not Change Over Time

Name:_____ Relationship:_____

Address:_____ Address 2:_____

Zip Code:_____ City:_____ State:_____

Home Phone:_____ Cell phone:_____ Work Phone:_____

Connecticut Cancer Screening Program

Enrollment Form

(Page 2)

Med-IT #:_____

Chart #: _____

Cultural Characteristics

Country of Birth:_____

Are you Hispanic? __ Yes __ No __ Unknown

__ Cuban
__ Mexican
__ Puerto Rican
__ South or Central American
__ From Other Spanish culture/origin regardless of race:

Are you Haitian __ Yes __ No __ Unknown

What is / are your race(s)? [Choose all that apply]

__ White
__ Asian __ *Asian Indian* __ *Korean* __ *Taiwanese*
__ *Chinese* __ *Filipino* __ *Vietnamese*
__ *Japanese* __ *Other:*
__ Native America / Alaskan Native
__ Black / African American
__ Hawaiian or Other Pacific Islander
__ *Native* __ *Guamian or Chamorro*
__*Samoan* __ *Other*:

Demographics

How well do you speak English __ Very Well __ Well __ Not Well __ Not at all

In what language do you prefer to read health information? _____

In what language do you prefer to hear about health information? _____

When did you come to live in the United State? _____[mm/dd/yyyy]

Employment Status? __ Employed for Wages __ Out of work more than 1 year __ Homemaker __ Retired
__ Self - employed __ Out of work less than 1 year __ Student __ Other, specify:_____

How did you learn about the program?

__ Friend / Family __ State Health Department / Website __ Mailing / Coupon
__ Church __ Local Health Department / Website __ Television / Radio
__ Social Group __ Women's Services / Outreach Worker __Newspaper
__ Work __ Family Doctor / Clinic __ Brochure / Poster

Last School Grade Completed? ___ Less than 9th Grade __ Some High School __ HS Grad or GED ___ Some College ___ No Answer

Breast Health History ---------- [If you are male, no need to answer] ----------

Prior Mammogram? __ Yes __ No (last mammogram before coming to the program)

Date of Prior Mammogram: _____ Result of prior Mammogram: __ Normal __ Abnormal __ Don't Remember
[dd/mm/yyyy]

Cervical Health History ---------- [If you are male, no need to answer] ----------

Prior Pap test? __ Yes __ No (last pap test before coming to the program)

Date of prior Pap tests: _____ [mm/dd/yyyy] Result of prior Pap test: __ Normal __ Abnormal __ Don't Remember

Have you ever had a hysterectomy? __ Yes __ No Was the hysterectomy due to cancer? __ Yes __ No

Previous Colorectal Cancer Screening History

__ Had a take-home fecal test (FOTB or FIT) __ normal (negative test) __ abnormal (positive test) __ Unknown
Date: _____(mm/yyyy)

__ Had a previous sigmoidoscopy? __ Normal / Negative / Results other than polyps, tumors, or cancer __ Incomplete test
Date: _____ (mm/yyyy) __ Polyp(s) / Tumor(s) / Cancer __ Unknown

__ Had a previous colonoscopy? __ Normal / Negative Results other than polyps, tumors or cancer __ Incomplete test
Date: _____ (mm/yyyy) __ Polyp(s) / Tumor(s) / Cancer __ Unknown

Connecticut Cancer Screening Program

Enrollment Form

Med-IT #:_____

Chart #: _____

Current Colorectal Health History

__ Yes __ No **Have you ever been diagnosed with colorectal cancer?** Year of Diagnosis: _____

__Yes __ No **Have you ever been diagnosed with a pre-cancerous colorectal polyp(s)?**

If so, what is the largest number of polys diagnosed during a single procedure? : _____

__ Yes __ No Were any of these polyps adenomatous (a benign tumor)?

__ Yes __ No **Have you ever been diagnosed with a genetic syndrome such as:**

__ Familial adenomatous polyposis (FAP)? ___ Hereditary non-polyposis CRC (NHPCC) or Lynch Syndrome

__Yes __No **Have you ever had a history of Inflammatory Bowel Disease (IBD)?**

__ Ulcerative colitis __ Crohn's Disease (colitis) __ Other colitis,: specify: _____

__ Yes __ No **Are you currently experiencing any rectal bleeding?**

__Yes __ No **Do you now, or have you ever had any of the following medical problems:**

__ change in bowel habits	__ hypertension	__ Sleep Apnea
__ anemia	__ coronary artery disease (CAD)	__ asthma
__ diabetes mellitus	__ congestive heart failure	__ COPD*
__ liver cirrhosis	__ artificial heart valve	__ Defibrillator / Pace Maker

__ Yes __ No Has any family member (mother father, sister, brother, grandmother, grandfather) been diagnosed with colorectal cancer or a precancerous polyp(s)**?**

*Chronic Obstructive Pulmonary Disease

Client eligible for screening colonoscopy ? **__ No __ Yes** **Date of scheduled procedure: _____**

[mm/dd/yyyy]

Notes for Colonoscopy:

Barriers for Access to Continuing Health Care

- ☐ Language Issues
- ☐ Cultural Differences
- ☐ Lack of Transportation
- ☐ Getting Time from Work
- ☐ A Disability or Impairment
- ☐ Other: _____
  _____
- ☐ Religious Beliefs
- ☐ Concerns about Sex
- ☐ Child/Elder Care
- ☐ Finances / Money
- ☐ Making the Appointment
- ☐ Potential Discomfort of Procedure
- ☐ Relationship with Significant Other
- ☐ Understanding of the Medical Need
- ☐ Confusion about Covered Services
- ☐ Fear:
  - ☐ Of Being Diagnosed with Cancer
  - ☐ Of Losing Intimacy after Procedure
  - ☐ Of Losing Employment if Diagnosed with Illness

Client Notes

Rev 3-5-2014

Connecticut Cancer Screening Program

Screening and Assessment Form

(Page 1)

Med-IT #:_____

Chart #: _____

Client **REQUIRES NEEDS ASSESSMENT ☐ YES ☐ NO**

Name: _____ , _____ [Last Name, First Name, MI]

Screening Provider: _____ Screening Date _____

Clinical Office Visit Documentation: (Reason for initiation of screening cycle)

Breast Cancer Screening ___	**Cervical Cancer Screening ___**	**Colorectal Cancer Screening ___**
1) Routine Mammogram	1) Routine Pap Test	1) First screening test (Cycle 1)
2) Surveillance of abnormal	2) Surveillance of Abnormal	2) 2nd screening test (Cycle 1)
3) Non-program-referred in	3) Non-program-referred in	3) 3rd screening test (Cycle 1)
4) Not done, CBE or dx only	4) Not done, dx only	4) 4th screening test (Cycle 1)
5) Cervical cancer screening only	5) Breast cancer screening only	

Clinical Breast Exam (CBE): Symptoms being reported by client? ___ No ___ Yes Symptoms: _____

CBE: ☐ Normal/Benign Findings ☐ Abnormality Suspicious for Cancer ☐ Not Needed ☐ Needed, but not performed

Date: ___/___/____ Date: ___/___/____ Why not:_____

***** Abnormality suspicious for cancer requires diagnostic follow-up*****

Breast Self-Exam ____ Taught ____ Knows ____ Did Not Teach Date: ___/___/____

Initial Mammogram (not diagnostic follow-up): Date of Mammogram: ___/___/____ Facility: _____

Dense Breast Ultrasound Recommended ___Yes ___No

Type of Mammogram: ___Conventional Screening ___Conventional Diagnostic ___Digital Screening ___Digital Diagnostic

Radiologist's Comments: **Findings: BIRADS _____**

Pap and HPV Tests:

HPV Test: ___ Yes ___No

Date of HPV Test ___/___/____

HPV Result: ___Pos. ___Neg.

Date of Pap test: ___/___/_____

Findings (Bethesda 2001)_____

Lab: _____

Adequacy: __Satisfactory __Unsatisfactory

Date of Pelvic Exam ___/___/_____

Cervix present: ___Yes ___No

Post-Menopausal: ___Yes ___No

Exam Note: _____

_____

Notes

Connecticut Cancer and Heart Disease Integrated Health Screening Program

Screening and Assessment Form

(Page 2)

Med-IT #:_____

Chart #: _____

CRC Screening Procedure: Screening Test # ____

Screening Exam Date ___/___/_____ Recommended Test Procedure _____

Provider _____ Provider Specialty _____

Consultation Comments:

Consult Date ___/___/_____

Outcome Summary

Adequate bowel prep	__ Yes __ No	Cecum reached	__ Yes __ No
Biopsy performed	__ Yes __ No	Polypectomy performed	__ Yes __ No
# Specimens sent to pathology	_____	Pathology report received	__ Yes __ No

***** If bowel prep or cecum reached is no, the test cannot be considered complete and must be repeated *****

Complications? __ Yes __ No If yes, what were they _____

Was this the initial screening test? __ Yes __ No **Test Performed?** __ Yes __ No if no, why not_____

Test Results ___ Normal/Neg ___Suspicious ___Inadequate/Incomplete ___ Other / Not polyps

Test Outcome: ___ Complete ___Incomplete

Test Recommendation: ___ None/Complete ___Repeat Colonoscopy ___Sigmoidoscopy ___ DCBE

___ Surgery to complete diagnosis ___Other, specify _____

***** If initial test is complete, there should be no additional recommendations for screening tests *****

Total # Polyps/Specimens? _____

Polyp #	Location*	Size (cm)	Procedure 1	Procedure 2	Procedure 3	Complt Rmvl	Histology**
1							
2							
3							
4							

*Location Choices	Rect	RecSig	Sig	Desc	Sple	Trans	Hep	Asc	Cec	App	OverLap	Unknown
**Histology Choices	Norm	NonAd	Hyper	AdNOS	AdTub	AdMix	AdVill	AdSerr	AdDysp	AdCanc	Canc	Unknown

Surgery Summary

Was surgery / surgical resection needed to compete diagnosis? __ Yes __ No If yes, **date of surgery** _____/_____/_____

Histology** from surgical resection (most severe) _____ ___Surgery recommended but not performed

Pathology Summary

Histology of most severe polyp or lesion _____ Total number_____ Largest Size (cm)_____

Final Diagnosis

Date of diagnosis ___/___/_____ Status of diagnosis: ___ Complete ___ Refused ___ Lost to Follow-up

Final Diagnosis: ____ Normal/Neg ____Hyperplastic ____ Polyp, no HGD ____ Polyp with HGD ___ Cancer

Complications from screening test #1 _____

Complications from screening test #2 _____

Future Screening

Recommended Procedure _____ for: ___ Surveillance or ___ Screening at interval of_____ months

Treatment

Cancer Type: ___ New Primary Site ___Recurrent Primary Site ___Metastasis from other organ __ Unknown

Date of treatment: ___/___/_____ Status of treatment: ___ Complete ___ Refused ___ Lost to Follow-up

Connecticut Cancer Screening Program

Breast and Cervical Cancer Diagnosis and Treatment Form

Med-IT # _____

(Page 1)

Chart #: _____

Client Name: _____ , _____ [Last Name, First Name, MI] Date of Screening: ____/____/_____

Breast Imaging Procedures

___Film Comparison	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Unilateral Diagnostic Mam (Digital/Conv)	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Bilateral Diagnostic Mam (Digital/Conv)	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Diagnostic Breast Ultrasound	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ CT Dense Breast Ultrasound	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____

Final Imaging Outcome: BI-RADS_____ **Date of Final Imaging Outcome ___/___/_____**

Breast Diagnostic Procedures

___CBE with Breast Specialist	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Biopsy / Lumpectomy	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Fine Needle / Cyst Aspiration	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____
___ Other⇨	Date: ___/___/____	Outcome: BI-RADS ___	Provider:_____

Specify: _____

Diagnostic Disposition:_____ **Final Diagnosis_____** **Date of Final Dx ___/___/_____**

Breast Cancer Treatment

Treatment Needed: ___Yes ___ No

Recommended Treatment: _____

Disposition:_____ Date: __/___/_____ Why refused: _____

Cervical Diagnostic Procedures

___Colpo without biopsy	Date: ___/___/____	Outcome: _____ ___	Provider:_____
___ Colpo with biopsy and/or ECC	Date: ___/___/____	Outcome: _____	Provider:_____
___ Loop Electrode Excision	Date: ___/___/____	Outcome: _____ ___	Provider:_____
___Cold Knife Cone	Date: ___/___/____	Outcome: _____ ___	Provider:_____
___ ECC Alone	Date: ___/___/____	Outcome: _____ ___	Provider:_____
___ Other⇨	Date: ___/___/____	Outcome: _____ ___	Provider:_____

Specify: _____

Diagnostic Disposition:_____ **Final Diagnosis_____** **Date of Final Dx ___/___/_____**

Cervical Cancer Treatment

Treatment Needed: ___Yes ___ No

Recommended Treatment: _____

Disposition:_____ Date: __/___/_____ Why refused: _____

Notes

Appendix U: Optimizing Program Performance Using Med-IT Reports

There are many options to help drive program performance using Med-IT reports. Routine monitoring of your program's various activities using the reports recommended below can be of great benefit for meeting and exceeding your program's objectives. Access to these reports for each program can be found on the navigation menu under each program heading.

CLINICAL MONITORING:

- *__Follow-Up (Missing Follow-Up) Report__: Provides a listing of clinically appropriate services that are not documented as having been completed and supports the provider to ensure compliance with clinical protocols.

- ***Case Management Follow-Up Report**: Provides Case Managers with a real-time listing of clients with abnormal screening results that require assessment, follow-up or closure of their
clinical case.

- ***Rescreening Notification Report**: Provides a listing of clients coming due for an interval-appropriate screening service in support of reminder and advanced scheduling activities to ensure women receive routine screening services.

- *__Tickler Report__: Provides a time-sensitive listing of reminders that you create for yourself in efforts to stay on top of open issues.

FISCAL MONITORING:

- ***Billing Authorization**: Provides real-time accounting of a program's claims status and stands as back-up for payment to service providers.

- ***Contract Balance**: Provides a real-time accounting of expended (authorized) funds in reference to each annual funding award(s).

- ***Missing Claims Report:** Provides a listing of services rendered which are missing an associated claim. This report will help ensure all providers are being fully reimbursed for their participation in these programs.

PERFORMANCE MONITORING:

- *__SRS__ (Screening Rate Summary Report): Provides counts and rates of services provided and counts and rates of the outcome of those services.

- *__Tickler Report__: Provides a time-sensitive listing of reminders that you create for yourself in efforts to stay on top of open issues.

Appendix V: References

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