

Standards of Care for Case Management October 2013

**Maryland Department of Health and Mental Hygiene
Center for Cancer Prevention and Control
Cigarette Restitution Fund Program
Cancer Prevention, Education, Screening and Treatment Program**

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Guidelines: Standards of Care for Case Management October, 2013

I. Introduction

This Guidance *replaces* Health Officers (HO) Memos #04-47, #07-35, #08-39, and #12-09.

The purpose of these guidelines is to provide local programs with minimum standards of care for case management of clients who are enrolled for screening, diagnosis, and/or treatment of targeted cancers (colorectal cancer (CRC), prostate cancer, oral cancer, skin cancer) in the Cigarette Restitution Fund/Cancer Prevention, Education, Screening and Treatment (CRF/CPEST) Program.

A. CRF/CPEST Program Conditions of Award

Local programs receive CRF/CPEST Program funds to conduct screening, diagnosis, and/or treatment. As part of the CRF/CPEST Program grant, the Conditions of Award include:

1. Each local program should utilize the appropriate “Minimal Elements” as the clinical standards for that cancer’s screening, diagnosis, and treatment.
2. Each local program shall assure that individuals with positive screening diagnostic tests are aggressively case managed in order to provide these individuals with needed diagnostic and/or treatment services.
3. Each local program shall collect and submit data on the services provided under this grant in the format and intervals specified by the program.

B. Local Program Responsibilities

1. Activities and responsibilities of case management include, but are not limited to the following:
 - a. Providing initial client assessment including determination of eligibility, intake and enrollment, as well as to provide ongoing assessment of client needs;
 - b. Coordinating services for screening, diagnosis, and treatment as necessary;
 - c. Providing case management including education, appointment reminders, scheduling, and communication with providers;
 - d. Assuring the client is aware of results and the recommendations made for follow-up;
 - e. Assuring each client receives appropriate services, provided either by the program or by linkage to services and,
 - f. Assuring every client in the CRF/CPEST Program diagnosed with cancer for which they are screened or who has findings that need follow-up care receives appropriate treatment and care in a timely manner.

2. These responsibilities for appropriate and timely enrollment, case management, and documentation for all clients screened, diagnosed, and/or treated in the cancer programs rest with the local programs.
3. These responsibilities lie ultimately with the Health Officer of the local health department or the Commissioner of Health in Baltimore City. For the Baltimore City University of Maryland Medical System (UMMS), these responsibilities lie with the UMMS CRF/CPEST Program Director.
4. Each local program should follow policies, procedures, and guidelines developed and distributed by the Center for Cancer Prevention and Control (CCPC).
5. Each local program should assure that case management, including management by contracted providers including Medical Case Managers, meets standards of care as well as standards set forth in the Minimal Elements for colorectal, oral, prostate, breast, and cervical cancers;
6. Health Officers and local Program Directors should develop and implement policies and procedures that address case management. These include:
 - a. Written policies, protocols, and procedures with scheduled reviews and revisions,
 - b. Internal management systems such as quality assurance activities and record reviews, and
 - c. Systems for evaluation, quality assurance, and record review at the local program level.

C. Center for Cancer Prevention and Control Responsibilities

CCPC provides guidance on case management through written sample policies, procedures, and template letters, and verbally through teleconferences and telephone consultation. CCPC also conducts verbal and written quality assurance activities through quality reviews of the CCPC databases, site visits, record reviews, and benchmarks reports.

1. Quality Review of Client Database

- a. Before a site visit, generally on an annual basis, CCPC reviews the local program cancer Client Database (CDB) entries to identify certain data entry errors and potential case management problems.
- b. CCPC documents and communicates issues identified in the CDB and record review in e-mails, at the site visits, and in site visit reports.

2. CCPC Site Visits and Record Reviews

- a. During a site visit, CCPC reviews a **sample** of client clinical records (approximately 10).
- b. In review of the **sample** of clinical records, CCPC identifies, reports, and documents any concerns found, for example:
 - i. Findings on cancer screenings that have not been followed-up;
 - ii. Recalls for repeat screenings that have not taken place;
 - iii. Recalls for procedures that are not at recommended intervals; and
 - iv. Recommended diagnosis and treatment services that were not completed timely.
- c. Limitations of CCPC record reviews include:
 - i. CCPC checks only a **sample** and does not check every client record to assure the completeness and quality of each cancer screening, diagnosis, treatment service, and related case management.

- ii. The CCPC review of a sample of records identifies issues that local programs should investigate in their entire client population. For example, if problems are noted about client notification, recalls not being completed, treatment not initiated promptly, the CCPC review will note that; however, it is the responsibility of the program to use this information to investigate the possibilities of broader issues with notification, recall, timely initiation of treatment that should be evaluated within the program for *all* clients.

3. CDB Benchmarks

CDB Benchmarks assess appropriateness of enrollment, case management, and notification of CRF/CPEST clients. CCPC prepares CDB benchmarks reports and sends them to local programs on a quarterly basis for review. For more information on benchmarks, see section *CDB Benchmarks for CRC and Prostate Cancer*.

4. Definitions

Administrative Case Manager: the person (usually a local program nurse but can be another employee or a contractor's employee), herein referred to as the 'case manager,' who, at a minimum, performs the following steps in case management:

- oversees the patient's care through the steps of screening, diagnosis, and treatment;
- sees that barriers are overcome;
- discusses medical management issues with the medical case manager(s);
- assures that results have been received, recorded (in medical chart and Client Database) and relayed, forms are sent, appointments are made; and
- ensures linkage to care for initiation of treatment, if needed.

Medical Case Manager: ("decision maker—taking liability"): the medical provider (e.g., physician or nurse practitioner) who makes medical decisions about the patient and who will assume liability for those decisions. This role can be played by one provider or by several providers for a single patient, e.g., the internist who does the physical exam and recommends colonoscopy; the gastroenterologist who performs the colonoscopy; the surgeon who decides which operation to perform, the radiation oncologist who calculates the radiation dose, and the oncologist who decides on the chemotherapy.

Local Program Medical Overseer/Manager: a physician/nurse practitioner (e.g., Health Officer, Deputy Health Officer, Medical Director) at the local program who:

- answers medical questions and gives guidance to staff as needed;
- writes/approves medical protocols;
- works on/reviews policies and procedures for referral and linkages to care;
- gives guidance to staff on reimbursement for medical screening, diagnosis, and treatment charges;
- may review the entire case record on the patient from the various medical and administrative case managers for quality assurance, etc.; and/or
- may oversee the entire program.

Contracted Provider: a medical provider with whom you have a signed contract to perform procedures and/or service. This can include a physician or nurse practitioner colonoscopist, dentist, pathologist; the contracted provider often serves as the Medical Case Manager.

II. Standards

A. Overarching Responsibilities

The goals of case management including linkage to care are: 1) to save lives from cancer, 2) to eliminate barriers to care, and 3) to ensure timely delivery of services. The outcome goals are: 1) to meet benchmarks including to assure that all clients who have a suspicious or confirmed cancer get resolution/treatment through more timely diagnosis and treatment, and 2) to obtain specific stage and treatment information.

1. Case Manager Responsibilities

- a. Determine eligibility for program services (see section *Eligibility Determination*).
- b. Educate the client on available program services and on screening and cancer information (see section *Education*).
- c. Navigate the client through the screening, diagnosis, and treatment process as appropriate and continually assess client needs such as medical management and special needs (see section *Navigation and Assessment of Client Needs*).
- d. Work with your providers to manage administration of roles and responsibilities as specified in your provider contracts. Ensure that the provider is aware of, agrees to accept and carries out all provisions of the contract (see section *Provider Oversight*).
- e. Notify the client of the results either verbally and/or in writing as per your policies and procedures regarding notification and document attempts and outcome (see section *Results Notification and Tables 1 and 2*).
- f. Recall the client at appropriate intervals for screening and/or follow-up (see section *Recall Notification and Table 3*).
- g. Provide treatment or link the client to care if the client has findings requiring further diagnostic work-up or treatment of the targeted cancer found during screening, based on determination of eligibility for those services per your program's policies/procedures (see sections *Linkage and Eligibility Determination*).

2. Eligibility Determination

The CRF/CPEST Program requires that local programs assess client eligibility for the program on at least *two occasions* as appropriate: for screening **and** for diagnostic work-up and/or treatment services beyond screening. Local programs might also confirm eligibility just prior to paying for clinical services in case the client has recently obtained insurance coverage, such as Medicaid/Medical Assistance (MA), etc.

a. Screening

Your program may enroll both uninsured and **underinsured** people for screening if they also meet the income and other eligibility requirements of your program.

- i. Define eligibility of clients for your CRF/CPEST program in your Policies and Procedures manual (including symptoms, age, health insurance (uninsured and **underinsured**), income, and residency).

- ii. Decide methods of ascertaining eligibility and type of documents needed for screening and diagnosis (for example, verbal documentation of income vs. copies of tax forms).
- iii. Document in your grant application to CCPC these eligibility policies and procedures.
- iv. Obtain information (verbal or written documents, if required) from the client.
- v. For chargeable screening procedures, determine income eligibility using household income and family size, compared to the Federal Poverty Guidelines (FPG) updated annually that include the income for each family size for various percentages at and above the 100% federal poverty level (FPL). The CRF/CPEST Program **does not** require written documentation of household income or family size to determine eligibility for screening or diagnosis. If your program does not require written documentation for screening eligibility, the client may verbally report household income and family size information for screening and/or diagnostic procedures. See the following sections *Household Income* and *Family Size (or Family Unit)* for definitions.
- vi. For non-chargeable screening procedures, e.g., oral cancer screening exam, verification of income eligibility is not required for screening procedures; however, for diagnostic procedures, verbal income eligibility information is required, whereas for treatment, written verification is required.
- vii. People known to have MA coverage are ineligible for chargeable screening procedures in the program and should not be screened in CRF/CPEST Program. Utilize the Electronic Verification System (EVS) to check for MA coverage for the individual.
- viii. Before January 1, 2014, people with Primary Adult Care (PAC) were possibly eligible for CRF/CPEST screenings depending on the screening service needed. After January 1, 2014, clients with PAC will have Expanded MA benefits and are ineligible for chargeable screening procedures in the program.
- ix. Assure that all staff know and understand your program eligibility criteria/guidelines.
- x. As CRF is the payer of last resort, specify in your provider contracts that the provider will first bill other health insurers (if any) and send you the Explanation of Benefits so you know how much has been covered before you pay bills. Additionally, a contract should be executed for diagnosis and/or treatment services if/when your program plans to provide for diagnosis and/or treatment services to eligible clients.
- xi. Accurately and fully document eligibility in the client's medical record and in the CDB Core form, including the Health Insurance field. Update the information at the start of each cycle to reflect the client's status at that time.
- xii. Enter **eligibility determination** in the CDB (refer to CDB Forms Guidance documents for location of specific fields needed for each cancer).
- xiii. Accurately and fully complete the portion of the appropriate CDB Screening Form that ask for "**Screening/Diagnosis Payer (check all that apply)**" to include **all** the payers for basic screening and diagnostic services in the cycle. (*Diagnostic and Treatment payers for clients referred for further work-up or treatment are entered on the post screening form*) When health insurance status changes or expected payment of procedures in a cycle changes, please update the payer field in the CDB to include all sources that paid for the procedures. **Do not update the Core form Health Insurance field if the insurance changes during a cycle** because that field reflects their insurance status when they *entered or started* the cycle. You may note the change in health insurance in Nurses Notes for that cycle.
- xiv. Do not enter screening procedures in the CDB if you did not pay for the procedure (for example, procedures such as physical exam, colonoscopy, FOBT) or for whom you only pay for bowel preparation solutions and no procedures. Screening procedures may need to be removed if you paid nothing for that particular procedure (and cycle closed as "No Screening"). You may also contact CCPC staff to request that cycles be deleted

by CCPC for cycles that you have already entered but later determine that you did not pay for any procedures.

Household Income

Household income is used to assess eligibility along with family size. It is a field in the CDB. The client's household income must not exceed 250% of the FPL (see chart provided by the CRF/CPEST Program, annually, for amounts); programs may choose a lower FPL for eligibility to their program. If the client's income is greater than 250% of the FPL, the client is not eligible to receive clinical service in the CRF/CPEST Program, including screening, diagnosis and/or treatment services. Household is defined and described as family size or family unit, in the following section.

Family Size (or Family Unit)

Family size is used to assess eligibility along with household income; it is captured in the CDB as 'Number in persons in household, including self.' The 'family' (i.e., household) is defined as the unit comprised of the applicant ('self') and one or more of the following dependents:

- Spouse
- Financially dependent child
- Financially dependent relative (by blood, marriage, or adoption)

Family size is defined as the number claimed on the client's most recent Income Tax Return (including self, spouse, financially dependent child(ren) and relative(s)).

b. Additional Diagnostic Work-up and/or Treatment Services

On January 15, 2007, new regulations for the CRF Program under COMAR 10.14.06.01-07 became effective. These regulations apply to the local health departments and statewide academic health centers that receive CRF funds and allocate a portion of their grant award to pay **for cancer treatment** services for eligible clients. The new regulations can be found at: <http://www.dsd.state.md.us/comar/SearchTitle.aspx?scope=10> (add search criteria: Subtitle 14). The regulations establish that each local health department and statewide academic health center allocating CRF funds for cancer treatment services must:

- i. Develop written financial eligibility criteria for uninsured and underinsured individuals to receive treatment services funded by the CRF/CPEST Program;
- ii. Submit the written financial eligibility criteria for cancer treatment services to CCPC when the criteria is initially developed and when any changes in the financial eligibility criteria are made; and
- iii. Provide an updated copy of the Financial Eligibility Criteria for Cancer Treatment Services form with the CRF/CPEST grant application.

If the client needs additional services for work-up or treatment beyond screening, the case manager should:

- iv. Determine criteria for eligibility and methods of ascertainment of eligibility for treatment in your grant, and ensure they are consistent with internal policies and procedures. Note that the CRF/CPEST Program does require written documentation of household income and family size information from a client prior to using CRF/CPEST

Program funds to provide treatment services, including treatment for complications that may arise during screening procedures, and at least verbal documentation of information for diagnostic work-up.

- v. Obtain written verification of eligibility criteria (required) from the client prior to services.
- vi. Determine income eligibility using household income and family size, compared to the Federal Poverty Guidelines that include the income for each family size for various percentages above the 100% FPL. See sections Household Income and Family Size (or Family Unit) above for definitions.
- vii. Determine income.
- viii. Determine if client is eligible for treatment services and enter eligibility in the CDB (refer to CDB forms guidance for location of specific fields needed for each cancer), defined as “Is client eligible for additional work-up, treatment, or case management services by Program?” (Page 1 of Post Screening form) in the CDB as follows:

CDB Field:

Eligible for Additional CRF Work-up, Treatment, or Case Management Services?

CDB category	Meaning
Yes, funds available	<ul style="list-style-type: none"> • Client meets income, insurance, and residence eligibility of program, • Client has signed "long form" consent, and • CRF funds are available and being used to pay part or all of the medical care. (This may include clients who have no coverage, or those, for example, who have their bills paid by CRF/CPEST fee-for-service or those who get Medical Assistance (MA) but on whom you are spending CRF/CPEST funds for services not covered by MA or other insurance.
Yes, but funds are not available	<ul style="list-style-type: none"> • Client meets income, insurance, and residence eligibility of program, • Client has signed "long form" consent, and • CRF funds are NOT available to pay for any part of their medical care so you have linked the client to another payment source, e.g., MA, Maryland Cancer Fund (MCF), Charity Care or some other source of funding to cover the expenses incurred for diagnosis and/or treatment. <p>Checking "Yes, but funds not available" allows you to reflect your case management efforts required to link a client to care and guide them through the process and to document the findings and outcomes (e.g., stage, type of treatment) on clients you case manage.</p> <p>Note: This category includes a client who met the program eligibility criteria for screening endoscopy and then obtains full coverage, e.g., MA or the Health Benefits Exchange, for further work-up or treatment via linkage through your program.</p>
No	<ul style="list-style-type: none"> • Client does not meet income, insurance, or residence eligibility of program (usually this means that the client is above program eligibility for income or insurance). • Client is referred for medical care paid for by private insurance, Medicare, MA (if they had it prior to enrollment) or self-pay, and is not linked to treatment through your program. <p>Example: if your program does not require written documentation of eligibility for screening and the client got a colonoscopy for CRC Screening and cancer was found. Upon request for written documentation to determine</p>

	<p>eligibility for treatment, you discover that the client is over-income and is therefore not eligible for treatment funds.</p> <p>Example: a client had a positive FOBT in your program but has private medical insurance that will cover diagnosis and treatment.</p> <p>Note: if the client was screened by colonoscopy in your program and is now insured due to linkage done by your program to assist the client in covering diagnosis and treatment costs then the client should be entered as "Yes, funds not available" for eligibility, rather than as "No" because this field should reflect the client's status <i>at the time of initial eligibility assessment</i>—when the client was determined to be eligible.</p>
Unknown	<ul style="list-style-type: none"> • Client declines to provide the program with the information necessary to determine eligibility. • Program is unable to obtain necessary eligibility information, e.g., client is lost to follow-up before eligibility is determined.

3. Education

Staff in the local programs should ensure that the client is educated regarding the cancer(s) for which the client is being screened, the screening procedure (including any necessary preparation for the procedures, e.g., bowel prep, and possible complications), what services the programs will/will not cover, and that the client consents to participating in the program.

Staff should also ensure that providers in their jurisdiction (and neighboring jurisdiction[s], if desired) are knowledgeable about program services.

4. Navigation and Assessment of Client Needs

Staff in the local programs should navigate a client through the screening, diagnosis, and/or treatment process. This involves activities such as scheduling appointments, reviewing insurance coverage information, assisting the client with applying for alternative insurance plans, providing transportation or language services, discussing medical management with physicians or physician office staff.

Staff in the local programs should interview the client and assess the client’s needs such as:

- Medical management: assess if the client is taking medications or has underlying conditions that might affect or interfere with any aspect of a procedure. Examples include a client who is taking Coumadin before a colonoscopy, is diabetic, or is taking a medication that would be contraindicated with bowel prep.
- Special provisions: assess if the client needs services such as transportation or language services.
- Health insurance: educate the client on health care coverage options including the Maryland Health Benefits Exchange and Expanded MA and encourage the client to enroll for health insurance.

5. Oversight of Contracted Providers

Staff in the local program should develop relationships and work with contracted providers to ensure communication and continuity of care with clients.

- a. Use the CCPC template contracts for contracts with providers/Medical Case Managers. These templates require them to report results back to the program and adhere to program guidelines
- b. Verify, as included in provider contracts, that the provider is aware of, and agrees to accept provisions including but limited to:
 - i. Sending results of testing to the local program according to the contract as a condition for reimbursement;
 - ii. Informing/notifying the local program of the recommendations for follow up, recall interval, and/or treatment; and
 - iii. Complying with the current Minimal Elements including the Standardized Colonoscopy Reporting and Data System (CORADS) for colonoscopy results.
- c. Obtain findings and the provider recommendation(s).
- d. Determine what the provider communicated with the client about the findings and recommendations, including recommendations for recall/next procedure.
- e. Request that the provider wait to review pathology (if applicable) before finalizing his/her results and recommendations for recall/follow up.
- f. Compare the provider's findings and recommendations with the Minimal Elements to determine whether the provider recommendations agree with the Minimal Elements; follow the policies and procedures for your program for recalls that are not in agreement with the Minimal Elements. Consult with the provider regarding management that is not in agreement with the Minimal Elements (see section *Standards Specific to Case Management for Colorectal Cancer*) or treatment not in line with the standards of care for treatment (if known).

6. Results Notification/Recall Notification

This section deals with guidance related to results notification and recall notification. Case managers should:

- a. Develop policies and procedures regarding client notification that consider:
 - o Frequency and type of contact;
 - o Screening procedures findings/results;
 - o Recalls that are due for subsequent screening cycles; and
 - o Documentation.
- b. Determine what the provider told the client about the findings and recommendations including recall/next procedure.
- c. Refer to and/or follow minimum standards/recommendations based on the specific cancer type and findings/results and recall in:
 - Table 1 Results Notification Case Management for CRC (page 20);
 - Table 2 Results Notification Case Management for Oral and Skin Cancer (page 24);
 - Table 3 Recall Case Management (page 27).
 - i. Notify the client of the results either verbally and/or in writing per your program's policies and procedures. Refer to Tables 1 and 2.
 - ii. If the client has a **positive or abnormal** result, make additional efforts to assure that the client is made aware of the result. Refer to Tables 1 and 2.
 - iii. If the local program does not have sufficient funding to pay for further diagnosis and/or treatment of targeted or non-targeted cancers found during screening for those clients who are eligible for services by their income and insurance, then determine your procedures for "linking" a client to care. Refer to the following section **7. Linkage to Care**, below.

- iv. Assure that the client’s primary care provider (PCP), as applicable, is informed of the results/recommendations. This can be accomplished by copying the PCP (adding a cc:) on your results letter to the client or confirming that the PCP was copied on the procedure results to the client from the doctor.
- d. Recall the client at the appropriate interval.
 - i. Refer to Table 3 regarding recall and documentation.
 - ii. For follow-up and future screenings (recall) of clients who have NOT been discharged from your program, run the “Recall Report” from the CDB for the specified module, (i.e., CRC, oral, skin) to identify clients due for recall.

For additional standards, see sections *Standards Specific to Case Management for Colorectal Cancer* and *Additional Standards for CRC, Oral, and Skin Cancer Based on Results of Cancer Screening and Eligibility for Service* (pages 17 and 19).

7. Linkage to Care: “Linking” Clients to Additional Diagnosis and Treatment

The Cigarette Restitution Fund (CRF) Program legislation states:

Health—General Article, §13-1109 (d) A comprehensive plan for cancer prevention, education, screening, and treatment shall: ...

- (6) demonstrate that any early detection or screening program that is or will be funded under a local public health cancer grant provides necessary treatment or linkages to necessary treatment for uninsured individuals who are diagnosed with a targeted or non-targeted cancer as a result of the screening process;

Local programs should determine if there are funds to pay for additional diagnosis and/or treatment services such as with suspected or confirmed cancer cases.

- a. If the client is found **eligible** for further diagnostic work-up or treatment and your local program **has CRF funds**, proceed with case management and arrangements for care.
- b. If the client is found eligible for further diagnostic work-up or treatment but your local program **does not have funds**, “link” the client to care outside of the program per the program’s procedures for linkage and CCPC recommendations.
- c. Linkage, or linking a client to care, involves exploring alternative payment options for the client and assisting the client with applying for the most appropriate alternative and using available method(s) for payment. Linkage, or linking a client to care, means ensuring the client has a health care provider who will provide needed care, not just locating alternative payment options. Recommendations for linkage to necessary diagnosis and/or treatment services for uninsured individuals diagnosed in the program include communicating with clients and providers, initiating the process for exploring options/applying for payment, and providing continued case management when providing linkage while assuring client receives care as follows:

Client Communication

- a. Document your program’s procedures for determining eligibility for payment for additional diagnosis and/or treatment (income levels, insurance status, family/personal assets, etc.).
- b. Develop a sheet/pamphlet that explains what services your program will, will not, and may cover for additional diagnosis and treatment (see example in HO Memo # 02-26).
- c. Before screening, assure that the client understands what your program *will*, *will not*, or *may* be able to pay for, if an abnormality is found or a complication occurs during cancer

screening. Document this by having the client sign the appropriate consent form acknowledging his/her understanding.

- d. Give the sheet/pamphlet of services to clients of the program and provide assistance in locating a willing provider(s) to those who need additional diagnosis or treatment.

Provider Communication

- a. Develop a list of hospitals and providers by specialty in your jurisdiction (or possibly in close proximity to your jurisdiction as well) that provide the additional diagnosis and treatment services.
- b. Describe your screening program to the providers.
- c. Query the providers as to their willingness to see uninsured clients including: what services would be provided, whether they would put the client on “uncompensated care” including charity care (hospitals), and whether a payment plan can be arranged with the client, etc.
- d. If no providers are available in certain specialty areas, consider providers in other jurisdictions.

Process for Exploring Options/Applying for Payment

The process for linkage may require that the program explore various options of payment and help the client apply for multiple options **simultaneously** in the event that the client is not eligible for one or more options, including, but not limited to:

Medicaid/Medical Assistance (MA)
Maryland Health Benefits Exchange (HBE)
Maryland Cancer Fund (MCF)
CRF/CPEST Program funds
Hospital Uncompensated Care (charity care)
Other local or national funds

- a. MA: Develop a relationship with the local department of social services and/or the MA liaison in your local health department, and learn basic criteria for MA eligibility. Direct and/or assist the client to apply or reapply for MA. Use the Electronic Verification System (EVS) to check whether the client already has MA.
- b. HBE: **In FY14, the Maryland Health Benefits Exchange will become available and case managers may assist the client in understanding the client’s options.**
- c. MCF: If/when CRF-CPEST funds are not available, case managers may assist the client by collecting the needed information to apply for a MCF grant. The program will need to call CCPC MCF Coordinator regarding availability of funds and, as applicable, obtain required information from the client in order to apply for a MCF grant on behalf of the client. The MCF awards funds on a first come, first served basis until funds are exhausted (http://phpa.dhmdh.maryland.gov/cancer/SitePages/mcf_home.aspx).
- d. CRF/CPEST: When it is determined by a client’s medical case manager that immediate treatment is needed or when a client does not have coverage, CRF/CPEST grant funds may be used to pay for necessary diagnosis and/or treatment for targeted cancers per the program’s **approved** grant award. Examples of no coverage include if the client is not eligible for MA or if client does not have other insurance that covers the needed diagnosis or treatment. Determine if your program can pay for any or all of the treatment. This might involve a budget modification and/or reallocation of funds. CRF/CPEST funds can be encumbered at the end of a fiscal year to pay for treatment services in the next fiscal year

with approval of CCPC and with completion of a Treatment Plan per Health Officer Memo #05-29.

CRF/CPEST funds may be used to pay bills “fee-for-service” until the MA application is processed and client is enrolled in MA, or to pay the MA “spend down” amount if required by MA. CRF/CPEST funds may **not** be used for additional diagnosis and treatment services for non-targeted cancers found during screening for a targeted cancer.

The CRF/CPEST Program may pay for treatment services for clients who were previously diagnosed with a targeted cancer.

- e. If **no** source of funding, payment plans, or uncompensated care, etc. can be identified for the patient to begin needed treatment, the case manager should notify the Local Health Officer about the situation and request guidance.
- f. If a non-targeted cancer is found during screening (for example, ovarian cancer found during CRC screening), the case manager should assist the client to know about and make application for MA, an MCF Treatment Grant, or other available health insurance, as applicable. If client is ineligible for MA, or for MCF Treatment Grant funding, refer the client to the local hospital charity care program, sliding fee scale provider, and/or local and national organizations such as Cancer Care.
- g. Document all case management efforts to “link” the client to care in the client’s medical record; programs may also document in the CDB Nurse’s Notes.
- h. If client is **not eligible** for further services in your local program, inform the client of his/her results and your program’s/the provider’s recommendations; make at least one additional call to the client to assure that the client followed through with the recommendations.

Continued Case Management when Linking Client to Care

Examples of continued case management when linking a client to care for additional diagnostic and/or treatment services include:

- Assist with scheduling appointments.
- Work with community and service providers (e.g., local social services agency)
- Make frequent phone calls to the client to ascertain progress with applications, appointments, etc.
- Contact the provider to confirm appointments and to ensure that the provider has copies of any procedure and pathology reports needed to complete the requested consultation for diagnosis and/or treatment services.
- Arrange transportation, language, or other services as needed.
- Obtain information regarding the client on treatment (types and when the clients first started each treatment type), stage information, and pathology findings/reports.
- Make periodic attempts (monthly, at a minimum) to assess client’s status with the MA application process as applicable if services are needed for a long period of time and assist client as needed with the process.

Continue case management until services related to the diagnosis are no longer needed, treatment has been initiated, and program has obtained the necessary information concerning the client's outcome, treatment, stage information and payment source.

8. Clinical Record and Client Database (CDB) Documentation

All case management activities should be documented in the client's record and, as appropriate, through completion of the required fields CDB.

For documentation of case management in the client medical record and the CDB, the case manager should:

- a. Document contact with clients and providers, home visits, telephone calls, etc. in the client record.
- b. Sign and date in ink, client record entries including Nurse's Notes from the CDB if the case manager chooses to use the Nurse's Notes from the CDB for documentation.
- c. Maintain copies of results, referrals, letters sent to clients (including undeliverable letters) in the client record.
- d. Complete CDB forms (Core, Screening, and Post-Screening [if work-up indicated]) and enter data per the CDB Guidance Documents specific to the given cancer, being sure to complete all required fields.
- e. Note special guidance about CDB entry:
 - i. If your program pays for services not otherwise covered by other insurers that are needed for screening but **not** the screening service itself, such as physical exams or pre-screening exams, please enter in the CDB only those procedures paid for by the program. In the CDB, the client will be counted as receiving a 'service' but not as being 'screened' or having a colonoscopy, for example, in the program if they have only a physical exam or pre-screening visit paid for with CRF/CPEST funds.
 - ii. Accurately and fully document eligibility in the client's medical record and on the CDB Core form, including the Health Insurance field. Update the information at the start of each cycle to reflect the client's status as of the start of the cycle. Please be aware that the Core form should only be updated for returning clients found eligible for services. If upon recall the client is found to no longer be eligible for the program the Core should NOT be updated as the Core should reflect the client's status when last found eligible for the program.
 - iii. Accurately and fully complete the portion of the appropriate CDB Screening Form that ask for "Screening/Diagnosis Payer (check all that apply)" to include ALL the payers for services. When health insurance status changes or expected payment of procedures in a cycle changes, please update this field in the CDB cycle to include all sources that paid for the procedures. Do NOT update the Core form Health Insurance field if the insurance changes during the course of the cycle because that field reflects their insurance status when they *entered* the cycle. You may note the change in health insurance in Nurse's Notes for that cycle.
 - iv. Do not enter clients in the CDB for whom you pay for no procedures or for whom you only pay for bowel preparation solutions. Procedures may need to be removed (and cycle closed as "No Screening") for cycles that you have already entered but later determine that you did not pay for any procedures.

- v. Find additional information in the CDB Forms Guidance documents (refer to the Help menu in the CDB for the latest documents) or call the CCPC Surveillance and Evaluation Unit for assistance.
- vi. For cancer cases diagnosed in the program, enter the initial diagnostic and/or treatment procedures such as CT scans, surgical procedures, chemotherapy and/or radiation therapy (date of **first** chemo started--not every session), in Additional Procedures, regardless of whether or not the procedure was paid for by the program.
- vii. For cancer cases diagnosed outside of the program who have been referred into the program for Treatment Only, or for cancer cases diagnosed in the program who require new cycles specifically for documentation of continued CRF funded treatment services, enter only those procedures paid for by the program. (See in the CDB Help Menu-CDB Guidance-Diagnosis Treatment Only cycles.)
- viii. Complete the Post-Screening Form in the CDB on all clients who are referred for further procedures for the diagnosis and/or treatment of the targeted cancer or for the removal of colon polyps that requires surgical intervention.
- ix. Print CDB Core, Cycle, and Summary reports and save the latest versions in the client's medical record. When updates are made to the CDB, print the reports and replace the old versions in the client's medical record.
- x. Note: If the program chooses not to initiate CDB data entry until after all test results are received, this means that the program is not able to take advantage of any of the CDB case management tracking features. In addition, if the program chooses to use other "tracking systems" such as Excel spreadsheets, logs, etc., there is double data entry work and these other systems may not be secure and may not have built in data backup capabilities.

B. Standards Specific to Case Management for Colorectal Cancer

1. CRC Recall Intervals

Each local program should have written policies and procedures that specifically address how your program plans to handle recall recommendations that fall outside of those specified by the Minimal Elements. Management recommendations for recall intervals that are too long or too short for CRC follow:

- a. Case management if the recommended recall interval is **too long** for a client with findings:
 - i. Contact provider:
 - Discuss discrepancy between provider's recommendation and Minimum Elements,
 - Determine if the doctor had a reason for the longer interval, and
 - Document discussion and decision in client record and CDB cycle closure.
 - ii. Contact Local Program Medical Overseer/Manager with problems/concerns; consult with CCPC as needed who may discuss with the Medical Advisory Committee.
 - iii. If local program plans to allow providers to NOT follow the Minimal Elements (e.g., your program plans to set the recall for the client *whenever* the doctor recommends, not by the Minimal Elements), document this in your site's policy and procedure manual, and then document the information on each case that has an interval that falls outside the guidelines.

- b. Case management if the provider's recommended recall interval is **too short for average risk clients** who have no symptoms, an adequate colonoscopy, and no findings on their prior colonoscopy that would require an interval shorter than 10 years (for example, the provider always tells people to come back in 5-7 years, but the Minimal Elements say 10 years and our program has said we would only PAY for colonoscopy in 10 years):
 - i. Contact provider at least once to determine the provider's policy,
 - Determine if the doctor had a reason for the shorter interval,
 - Discuss discrepancy between doctor's recommendation and Minimum Elements and that the CRFP will only pay for the repeat colonoscopy in 10 years, and
 - Document the discussion and the decision in the client record and CDB cycle closure comments.
 - ii. Send the patient a letter saying that the doctor may recommend a shorter interval, but the program can only pay in 10 years unless the patient develops symptoms or develops new risk factors (see template letter in CCPC HO memo #13-08).
 - iii. If your local program plans to allow providers to NOT follow the Minimal Elements (for example, you plan to recall the client *whenever* the provider recommends), document this in your site's policy and procedure manual, and then document the information on each case that has an interval that falls outside the guidelines.

- c. Case management if the provider's recommended recall interval is **too short for client who had findings** of adenoma or colorectal cancer:

Local programs may discuss the findings and recall interval in the CRC Minimal Elements with the provider but programs may pay for a repeat colonoscopy using the recall interval recommended by the provider.

2. Recalls for Inadequate Colonoscopy

The indicators of adequacy for a colonoscopy include bowel preparation and cecum reached.

Definitions of **“Was bowel preparation adequate?”** include (as defined in the CDB):

Yes	If the colonoscopy procedure report explicitly states that the bowel preparation was “adequate,” “good,” “excellent,” “fair;” or If the provider indicates that despite a less than adequate prep, an adequate view was obtained after irrigation of the bowel; or If the colonoscopy report does NOT state the adequacy of bowel prep and the program and provider agree that this documentation indicates that this means the prep was adequate
No	If the procedure report indicates “poor prep,” “inadequate prep,” “small polyps may have been missed;” or If the provider states that the prep was “fair” but recommends a recall interval that is shorter than would be recommended per the Minimal Elements for the given risks and findings because of the prep
Unknown	If the bowel preparation adequacy is not stated in the report

Definitions of **“Was cecum reached?”** include (as defined in the CDB):

Yes	If the endoscopist documents having gotten to the cecum or otherwise describes having gotten a good look at the cecum to rule out lesions Note: If the client had prior surgery and has no cecum (for example, prior bowel resection, or hemicolectomy) but the colonoscope reached the end of the remaining colon, check “Yes.”
No	If the endoscopist describes the procedure as NOT having gotten a good look at the cecum to rule out lesions
Unknown	If reaching the cecum is not documented in the report

If either of these fields is No or Unknown, the colonoscopy is **inadequate or possibly inadequate**.

For these colonoscopies, the case manager should:

- Contact provider,
- Discuss with provider/Medical Case Manager to clarify and determine the provider’s recommendation for next steps, and
- Document whether the provider’s recommendation is or is not in agreement with the Minimal Elements.

The recommended management for inadequate or possibly inadequate is:

Complete the screening with repeat colonoscopy right away in this cycle (within 6 months),
OR

- If client is at average risk and had no findings on the colonoscopy that was performed, then complete screening with either an annual high sensitivity FOBT if the colon was visualized to at least the sigmoid, or with a DCBE; then repeat colonoscopy in 5 years.

Note: If possibly inadequate, recall per the provider’s recommendation, but recall should be no longer than the Minimal Elements for the client’s risk factors and screening findings.

C. Additional Standards for CRC, Oral, and Skin Cancer Based on Results of Cancer Screening and Eligibility for Services

Tables 1 and 2 list the Case Management Group (by results of screening tests), the recommendations for that Group, the Eligibility Group (program eligible for services or not) and the *Minimum* Case Management required under the CRF/CPEST Program. Programs may choose to do more, but should at least do the *minimum case management*. Programs should document their policies and procedures specifying how they follow these recommendations.

Table 3 provides the minimum recommendations of case management for recall.

D. CDB Benchmarks for CRC and Prostate Cancer

Tables 4 and 5 list the CDB benchmarks including the indicators and standards for CRC and prostate cancer, respectively.

CCPC produced CDB Benchmark reports are issued quarterly and address the following components of case management including eligibility, treatment/time to treatment for cancers diagnosed in the program, completeness of stage of cancer, and notification/timeliness of notification. The benchmarks, indicators, and standards are listed for CRC in Table 4 and for prostate cancer (as applicable to diagnosis and treatment) in Table 5.

When received, the local programs should review their benchmarks report(s), correct any data entry errors that may have led to not meeting a benchmark, evaluate performance of their program and providers, and make changes as necessary in order to meet the benchmarks.

Table 1. Results Notification Case Management: Colorectal Cancer

Case Management Group	Recommendation*	Eligibility Group	Minimum Case Management/Notification
Negative FOBT—Average risk, no symptoms	Complete screening with sigmoidoscopy or colonoscopy; recall if eligible per CRC Minimal Elements (ME)	Program eligible for more screening	<ol style="list-style-type: none"> 1. Telephone call or letter to notify client of results and recommendation and recall interval, if appropriate. 2. Document in record and CDB.
		NOT program eligible	<ol style="list-style-type: none"> 1. Telephone call or letter to notify client of results and recommendation and recall interval, if appropriate. 2. Document in record; discharge from program and CDB.
Negative FOBT—Increased risk or symptoms	For screening/work up, need colonoscopy or other work up; recall if eligible per CRC ME	Program eligible	<ol style="list-style-type: none"> 1. Telephone call or letter to notify client of results and recommendation. 2. Try to schedule colonoscopy for workup for symptoms. 3. Document in record and CDB.
		NOT program eligible	<ol style="list-style-type: none"> 1. Telephone call or letter to notify client of results and recommendation. 2. Make at least one additional attempt to determine whether client followed recommendation. 3. Document in record; discharge from program and CDB.
Positive FOBT	Complete screening/diagnostic work up with colonoscopy; recall if eligible per CRC ME	Program eligible	<ol style="list-style-type: none"> 1. Telephone call to notify client of results and recommendation; letter to notify client if not able to reach via telephone call. 2. Try to schedule for colonoscopy or additional workup. 3. Document in record and CDB.
		NOT program eligible	<ol style="list-style-type: none"> 1. Telephone call or letter to notify client of results and recommendation. 2. Follow up notice with a second call to see if client followed through with recommendation and the outcome, if available. 3. Document in record; discharge from program and CDB.
Sigmoidoscopy negative	Annual FOBT with repeat sigmoidoscopy in 5 years (or a colonoscopy in 5 years) if eligible per ME	Program Eligible	<ol style="list-style-type: none"> 1. Telephone call to client or letter to notify client of results, recommendation, and recall interval; letter to notify client if not able to reach via telephone call. 2. Try to schedule colonoscopy or additional workup. 3. Document in record and CDB.
Sigmoidoscopy finding: polyps or other suspicious finding	Complete screening with colonoscopy; recall per colonoscopy findings, Attachment 1B of CRC ME	Program Eligible	<ol style="list-style-type: none"> 1. Telephone call and/or letter to client to notify client of results and recommendation. 2. Schedule for colonoscopy or workup with a second and third call to client to see if client followed through with recommendation. 3. Document in record and CDB; discharge from program and CDB if not eligible.

Case Management Group	Recommendation*	Eligibility Group	Minimum Case Management/Notification
<p>Colonoscopy-inadequate or uncertain removal of polyps ('positive/abnormal'): per colonoscopist, e.g., could not reach cecum; or poor bowel preparation and stool obscured view of colon polyps/lesions of 5 mm or larger</p>	<p>Complete screening with additional procedure(s) and recall at timing interval recommended by Medical Case Manager per CRC ME</p>	<p>Program Eligible</p>	<ol style="list-style-type: none"> 1. Telephone call to client: <ol style="list-style-type: none"> a. To discuss results, or b. To verify that the provider notified the client and assure client is aware of the results of screening and the recall recommendation. 2. For normal findings: Send a letter to client from your program giving results, recommendation, and recall interval. Complete CDB and file letter in client's medical record.
<p>Colonoscopy-no finding or a finding with recall more than 5 years per CRC ME ('normal findings'): For example, normal colonoscopy, low risk hyperplastic polyps, other polyps, recent diagnosis of inflammatory bowel disease, hemorrhoids, and/or diverticula</p>	<p>Recall for screening or surveillance per Attachment 1B of CRC ME and Medical Case Manager</p>	<p>Program Eligible</p>	<ol style="list-style-type: none"> 3. For positive/abnormal findings: Make additional efforts to assure that the client is made aware of the result: <ol style="list-style-type: none"> a. If the local program cannot notify the client about the positive/abnormal result verbally, then a home visit, letter or certified letter would be the next step to complete the minimum case management requirement for notification. If unable to reach client at home, send a letter (regular or certified) to notify client of the results and recommendations. b. If the client is sent a regular letter and the letter is returned, send a certified letter to assure that the client received the results. If the certified letter is returned and all other attempts fail, consider the client "not notified" and "lost to follow-up" for your documentation in the CDB and medical record. (Note some clients may not sign for certified letters so sending regular mail <i>and</i> certified may be more effective.)
<p>Colonoscopy finding ('positive/abnormal'): For example, adenomatous polyps/adenomas, certain hyperplastic polyps, sessile serrated polyps (with or without other findings) usually requiring recall within 5 years but no cancer</p>	<p>Recall for screening or surveillance per Attachment 1B of CRC ME and Medical Case Manager</p>	<p>Program Eligible</p>	<ol style="list-style-type: none"> 4. If there is a difference between the recall recommendation of the endoscopist and what your local program will pay for, include that in the letter (see sample letter in HO Memo #11-51) and discuss this with client verbally, if possible. 5. Schedule client for colonoscopy or additional screening procedure as indicated by colonoscopist/Medical Case Manager, such as procedures needed after an inadequate colonoscopy or after suspected cancer findings. 6. Document local policies and procedures regarding notification in your Local Program Policy/Procedure manual. For example, document how your program "assures that the client is aware of the results of screening and the recall recommendation." 7. Document notification and discussions in record and CDB.

Colonoscopy finding ('positive/abnormal'): cancer, suspect cancer, or other finding requiring surgery	Treatment per Medical Case Manager recommendations; Recall if eligible per CRC ME and Medical Case Manager recommendation	Eligible for additional CRF work-up, treatment or case management services? - Yes, and funds available to pay for diagnosis and/or treatment or - Yes, eligible, but no funds available (that is, eligible for case management but program will not pay for diagnosis or treatment); link client by assisting in applying for MA, MCF, or insurance as applicable Note: includes a client who subsequently got MA	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) to make sure client knows results and recommendations. 2. Assure that client has followed through with a provider for care, or, if not, that you have notified the client about the recommendations by certified letter/regular mail/home visit. 3. If you are paying for additional diagnostic work-up and/or treatment services, obtain at least verbal verification of income eligibility for additional diagnostic services and written verification for treatment services; assure that the client got the services for which you are being billed and that you approve the reimbursement rate. 4. If you are not paying for additional diagnosis and treatment, link the client to care by assisting the client in applying for MA, MCF, other insurance, and/or hospital charity care as appropriate. Notify Health Officer if treatment is needed and no source of payment for care has been found. 5. Complete at least the required elements in the CDB CRC Post-Screening Form for <i>Eligible</i> Clients and enter diagnostic and treatment procedures via Additional Procedures as per the CDB data entry form guidance. 6. Document case management in CDB Nurse's Notes and in the client medical record.
		NOT Eligible for additional CRF work-up, treatment, or case management services (for example, client has Medicare or MA and program will not do case management)	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) to make sure client knows results and recommendations. 2. Make second and third contacts as needed to determine outcome and to make sure that client has followed through with a provider for care, or, if not reached or if client has not followed through, that you have sent the client the recommendations by certified letter. 3. Complete at least the required elements in the CDB CRC Post-Screening Form for <i>Ineligible</i> Clients and close the cycle. Discharge client from the program and CDB if no longer eligible for any screening services in the program. 4. Document in client record.

*Recommendation: See appropriate Minimal Elements.

Table 2. Results Notification Case Management: Oral and Skin Cancer

Case Management Group	Recommendation*	Eligibility Group	Minimum case management
Normal screening exam	There are currently no recommendations for routine screening for oral or skin cancer so recall should be per your program’s policies and procedures.	Program eligible or NOT program eligible	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) and/or letter/written information to client to notify client of results, recommendation for subsequent screenings, and recall if eligible. 2. Document in record, and discharge from program and CDB if determined not program eligible.
Abnormal screening—NOT suggestive of cancer <i>being screened for</i> Examples: Oral: caries, herpes, voice change Skin: seborrhea, dermatitis, psoriasis	Follow recommendations of Medical Case Manager. Return for screening per Minimal Elements or per Medical Case Manager	Program eligible or NOT program eligible	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) with written confirmation to notify client of results, recommendation, and recall for routine screening if eligible. Results and recommendations may be given to the client in writing at the time of screening. 2. Document in client record and discharge from program and CDB if determined to be not program eligible.

Case Management Group	Recommendation*	Eligibility Group	Minimum case management
<p>Abnormal screening—suggestive of cancer being screened for Examples: Oral: lesion(s) suggestive of cancer; positive brush biopsy; brush biopsy with atypical cells or unsatisfactory and needs repeating Skin: Lesion suggestive of cancer</p>	<p>Follow recommendations of Medical Case Manager; Complete diagnostic work up or return for additional testing</p>	<p>Program eligible</p> <ul style="list-style-type: none"> - Yes, and funds available to pay for diagnosis and/or treatment <p>or</p> <ul style="list-style-type: none"> - Yes, eligible, but no funds available (that is, eligible for case management but program will not pay for diagnosis or treatment); link client by assisting in applying for MA, MCF, or other insurance, as applicable <p>Note: includes a client who subsequently got MA</p>	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) to make sure client knows results and recommendations. 2. Letter/written documentation to client giving results, and follow-up recommendations. 3. Schedule additional testing/work-up/follow-up. 4. If you are paying for additional diagnostic work-up and/or treatment services, obtain at least verbal verification of income eligibility for additional diagnostic services and written verification for treatment services; assure that the client got the services for which you are being billed and that you approve the reimbursement rate. 5. If you are not paying for additional diagnosis and treatment, you should link the client to care by assisting the client in applying for Medicaid, MCF, other insurance, and/or hospital charity care as appropriate. Notify Health Officer if treatment needed and no source of payment for care has been found. 6. Document in the CDB. Complete at least the required elements in the appropriate CDB Post-Screening Form for <i>Eligible</i> Clients and enter additional screening and diagnostic procedures via Additional Procedures as per the CDB data entry form guidance. 7. Document case management activities in Nurse’s Notes in CDB and client record.
		<p>NOT program eligible</p>	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) to make sure client knows results and recommendations. Letter/written documentation to client giving results, and follow-up recommendations. 2. Refer to provider who will take care of the client. 3. Make at least one additional contact to determine outcome and to make sure (by calling the client) that client has followed through with a provider for care, or, if not, that you have sent the client the recommendations by certified letter. 4. Document in the CDB. Complete at least the required elements in the appropriate CDB Post-Screening Form for <i>Ineligible</i> Clients. 5. Discharge from program and CDB when determined ineligible.

Case Management Group	Recommendation*	Eligibility Group	Minimum case management
Cancer or other positive/abnormal finding requiring surgery/treatment	Treatment per Medical Case Manager recommendations and Minimal Elements	<p>Eligible for additional CRF work-up, treatment, or case management services?</p> <p>- Yes, and funds available to pay for diagnosis and/or treatment</p> <p>or</p> <p>- Yes, eligible, but no funds available (that is, eligible for case management but program will not pay for diagnosis or treatment); link client by assisting in applying for MA, MCF, and/or other insurance as applicable Note: includes a client who subsequently got MA</p>	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone) to make sure client knows results and recommendations. 2. Schedule additional testing/work-up/follow up. 3. Make sure that client has followed through with a provider for care, or, if not, send the client the recommendations by certified letter. 4. If you are paying for additional diagnostic work-up and/or treatment services, obtain at least verbal verification of income eligibility for additional diagnostic services and written verification for treatment services; you will need to be more involved and assure that the client got the services for which you are being billed and approve reimbursement rate. 5. If you are not paying for additional diagnosis and treatment, you should assist the client in applying for MA, MCF, or other insurance and/or charity care whichever is/are most appropriate. Notify Health Officer if treatment needed and no source of payment for care has been found. 6. Document in the CDB. Complete at least the required elements in the appropriate CDB Post-Screening Form for <i>Eligible</i> Clients and enter additional diagnostic and treatment procedures via Additional Procedures as per the CDB data entry form guidance 7. Document case management activities in Nurse’s Notes in CDB and client record.
		NOT Eligible for additional CRF work-up, treatment, or case management services (for example, client not found eligible by the provided written documentation of eligibility, e.g., over income or fully insured)	<ol style="list-style-type: none"> 1. Verbal communication (in person or by telephone), make sure client knows results and recommendations. 2. Letter/written documentation to client giving results, and follow-up recommendations. 3. Make at least one additional contact to determine outcome and to make sure (by calling the client) that client has followed through with a provider for care; or if not, send the client the recommendations by certified letter. 4. Document in the CDB. Complete at least the required elements in the appropriate CDB Post-Screening Form for <i>Ineligible</i> Clients per CDB form guidance. 5. Discharge from program and CDB.

*Recommendation: See appropriate Minimal Elements.

Table 3. Recall Case Management

Case Management Group	Recommendation	Eligibility Group	Minimum Case Management
<p>For recall: Need at least one notice of the need for repeat screenings for follow-up of clients who have NOT been discharged from your program</p>	<p>See appropriate Minimal Elements</p>	<p>Program eligible for more screening and not discharged from program</p>	<ol style="list-style-type: none"> 1. Document that you: <ol style="list-style-type: none"> a. Informed client of the recommendation for annual screening at the time of initial screening and to contact the program for annual screening; or b. Made one attempt to recall the client following negative FOBT, negative oral or negative skin cancer screening (for example, a copy of result letter in client medical record stating recommended follow-up screening, or a copy of new recall letter in medical record). 2. Document one successful or at least three attempts to contact client for repeat colorectal cancer screening after prior sigmoidoscopy or colonoscopy where no adenoma, serrated polyp, or colorectal cancer was found. 3. Document one successful or at least three attempts by different methods/different times of day to recall client after prior positive/abnormal screenings such as with finding of CRC, adenoma, serrated polyp, or abnormal skin or oral exam suggestive of cancer. <p>Note: The recall is an opportunity to notify the client of the need for recall screening; however, the client may have other insurance coverage (for example Medicare, MA or insurance) and may no longer be eligible for the CRF/CPEST Program.</p>

Table 4. Colorectal Cancer Benchmarks: Indicators and Standards

Category	No.	Indicator	Standard
Screening Priority Population	1	Percent of asymptomatic average risk clients screened who are age 50 years and older at first screening*	≥95%
Case Management Among Program-eligible Clients	2	Percent of adenocarcinoma and squamous cell carcinoma diagnosed with treatment started	≥80%
	3	Percent of adenocarcinoma and squamous cell carcinoma diagnosed with treatment started within 60 days of diagnosis among those who started treatment	≥80%
	4	Percent of adenocarcinoma cancers with stage information among eligible clients diagnosed with adenocarcinoma in program	≥80%
Notification	5	Percent of colonoscopy results received by program within 28 days of the procedure	≥80%
	6	Percent of clients ever notified of screening* results by program	≥95%
	7	Percent of clients who had colonoscopy, were notified of results, and were notified by program within 7 days of when results received by program	≥80%

*Screening means screened with fecal occult blood test, sigmoidoscopy, colonoscopy, or double contrast barium enema

Table 5. Prostate Cancer Benchmarks: Indicators and Standards

Category	No.	Indicator	Standard
Screening Priority Population	1	Percent of prostate cancer screenings with both PSA and DRE	≥80%
Case Management Among Program-eligible Men	2	Percent of prostate cancer screenings* with abnormal findings/needs further evaluation to rule out cancer with a diagnosis status of "Complete"	≥80%
	3	Percent of prostate cancer screenings* with abnormal findings/needs further evaluation to rule out cancer with date of diagnosis within 90 days of screening* among those with diagnosis status of "Complete"	≥80%
	4	Percent of prostate cancers diagnosed with treatment started	≥80%
	5	Percent of prostate cancers with treatment started within 60 days of diagnosis among those who started treatment	≥80%
	6	Percent of prostate cancers with stage information among clients diagnosed with cancer who had surgery	≥80%
Notification	7	Percent of PSA results received by the program within 28 days of test	≥80%
	8	Percent of men ever notified of screening* results by program	≥95%
	9	Percent of men with abnormal findings/needs further evaluation to rule out cancer, were notified of results, and were notified by program within 7 days of when screening* results received by program	≥80%

*Screening means screened with Prostate Specific Antigen (PSA) and/or Digital Rectal Exam (DRE)

Date of screening = if DRE only, if PSA only, if DRE and PSA done on same date, use the date of screening exam

if DRE and PSA done on different dates, use minimum PSA date

Cancer = positive transurethral ultrasound (TRUS)