# MINIMAL REQUIREMENTS FOR A

# CANCER SCREENING VISIT

|  |  |  |
| --- | --- | --- |
| **ASSESSMENT** | **INITIAL VISIT** | **ADDITIONAL VISITS** |
| **Comprehensive Health History to include:**   * Family history of breast/genital/colon-rectal cancers * LMP or date of menopause * Contraceptive method if childbearing age * Documentation of HRT or ERT if menopausal * Date of last Pap/mammogram and results * Previous abnormal Pap, diagnostics, treatments * Previous breast problems, diagnostics, treatments * Assessment: breast/cervical cancer risk factors, tobacco use | Required  (Health History and Physical Examination Form) | Required  (Interval Health History and Physical Examination  Form) |
| **Physical Examination to include:**   * Documentation of general appearance and mental status * Height/Weight/BMI * Blood pressure * Clinical breast examination for women aged 40 or older (as indicated for others) * Pelvic examination that includes visualization of the vulva, vagina, cervix/vaginal cuff and thorough bimanual including adnexae * Rectal exam (age 50 and as indicated for others) * Other as needed | Required | Required  (Exception: Pelvic exams are not required unless the patient is also getting a Pap test, but may be performed at clinician’s discretion. |
| **Laboratory:** Pap test (as indicated by age guidelines) | Required | Pap tests are not required annually; routine cervical cancer screening Paps are repeated q. 3-5 years, as indicated. |
| * Fecal occult blood testing (i.e., FIT, Guaiac) (age 50 and older or 45 and older for African American or family history)   + Follow manufacturer’s instructions   + If positive, refer to M.D. | Required | Required |
| * Hemoglobin | If indicated | If indicated |
| * STD testing | If indicated by history/exam | If indicated by history/exam |
| **Referral for annual or biennial mammogram (age > 40), based on provider’s recommendation** | Required | Required |
| **Counseling:** (Documentation in medical record required)  - ACH-40 (“Improving Health for Women”) – CSEM given/counseled and patient verbalized understanding   * Breast Self-Awareness (optional teaching sheet),/CBE as indicated * Benefits and risks of mammography (optional teaching sheet) * Pap/Mammogram rescreening recommendations * Regular exercise * Adequate diet (low fat, high fiber, 5 fruits/vegetables daily) * Osteoporosis/prevention and bone density testing * Risks/Benefits of HRT if menopausal * Contraception if needed * Smoking risks/cessation and referral * Immunization needs/update * STD risk counseling if indicated * Ovarian Cancer Screening at age 50 (age 25 if family history) (Locations: UKMC; Hardin, Mason, Floyd, McCracken, Greenup and Pulaski County Health Centers) call 1-800-766-8279 for appt. | Required | Required |
| **Documentation of Return Clinic Appointments** | Required | Required |
| Follow-up of Abnormal Test Results | Required | Required |

# BREAST CANCER SCREENING

Early diagnosis of breast cancer offers women more treatment options and greatly reduces mortality. Early diagnosis is aided by the triad of breast self-awareness and when indicated or age appropriate, a clinical breast exam (CBE) and regular mammography screening.

1. **BREAST CANCER RISK FACTORS:**
   1. Female age 40 or older; risk increases with age
   2. First degree relative (mother, sister, daughter) with history of breast cancer before the age of 50 (pre-menopausal) or a *close relative* with a male breast cancer or with a known BRCA (Breast Cancer Susceptibility gene) mutation, or if the patient herself has a known BRCA mutation. (See E. GENETIC COUNSELING/TESTING for definition of *close relative*.)
   3. Personal history of a benign breast condition
   4. History of radiation treatments to the chest wall
   5. Early menarche (prior to age 12)
   6. Late menopause (after age 52)
   7. No pregnancies or first pregnancy after age 30
   8. Hormone use: some oral contraceptives and combination (estrogen and progestin used together) hormone replacement therapy
   9. Use of the drug diethylstilbestrol (DES) or intrauterine exposure to it.
   10. Overweight/Obese (especially after menopause)
   11. Lack of physical activity
   12. Alcohol consumption – risk increases with amount of alcohol consumed

1. **BREAST SCREENING HISTORY:**
   1. Include dates and results of previous mammograms
   2. Elicit personal history of breast symptoms including pain, tenderness, nipple discharge, palpable mass or skin changes
   3. Document any personal history of breast cancer and previous biopsies or treatments
   4. Screen for risk factors (listed above)
2. **CLINICAL BREAST EXAMINATION AND MAMMOGRAPHY**
   1. All females should be counseled on breast self-awareness beginning at age 21. Counseling shall be documented in the medical record (e.g. “Breast Self-Awareness counseling provided”) at the initial and annual visits.
   2. A clinical breast exam (CBE) should be ***offered*** \*annually to females beginning at age 21 through age 39. A CBE should be done annually on women age 40 and older, high-risk women or any woman who presents with symptoms. During their cancer screening visits, women shall be informed to report any changes in their breasts noticed between visits to the Nurse Case Manager (NCM) at the Local Health Department (LHD) as soon as possible. Also, see *Accepting Referrals from Outside Providers* in the section *TRACKING AND FOLLOW-UP REQUIREMENTS.* If the previous CBE was performed by an outside provider, thorough documentation of the exam done by that provider must be obtained, reviewed by the examining nurse at the LHD and placed in the patient’s chart.

\****Offered*** *in the context of informed decision-making, recognizing the uncertainty of additional benefits/harms of CBE beyond screening mammography. (Adapted from ACOG Practice Bulletin 179, July 2017)*

* 1. The required method for performing the CBE is using the principles of positioning, three levels of palpation, and the vertical strip search pattern.
  2. Routine screening mammograms will begin at age 40 and are recommended every 1 to 2 years based on a woman’s history and clinical presentation. Any women age 40 or older who wishes to have an *annual* mammogram shall be provided one, regardless of history or presentation. In menstruating women, the mammogram should be scheduled about 2 weeks after the LMP.
  3. Transgender women (male-to-female) have different routine screening recommendations. For this population, it is recommended that screening mammography be performed every 2 years once the woman has reached the age of 50 **and** has been on feminizing hormones at least 5 years.

*Note: Transgender breast screening guidelines adopted from consensus recommendations from The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health:* [*http://transhealth.ucsf.edu/trans?page=protocol-screening#S2X*](http://transhealth.ucsf.edu/trans?page=protocol-screening#S2X) *.*

* 1. A woman with breast implants will follow a routine (non-high risk) screening schedule, unless she is symptomatic.
  2. Women under the age of 40 who are either symptomatic, or asymptomatic but have been determined to be high-risk, can be evaluated with CBE, **diagnostic** mammogram and/or a surgical consult. These services can be reimbursed with KWCSP funds for eligible women.
  3. Women who are at high risk of developing breast cancer should be screened with both an annual mammogram and annual breast MRI, beginning at age 40, earlier if otherwise noted (below). A woman is considered high risk if **any** of the following are true:
* She has a lifetime risk of 20% or more for development of breast cancer, based on risk assessment models, such as BRCAPRO, Claus, or Tyrer-Cuzick (IBIS), that are largely dependent on family history. (Risk assessment *tools* will not routinely be used, but as an option, a simple one can be found at: <http://ibis.ikonopedia.com> )
* She has a first degree relative (mother, sister, daughter) with a history of premenopausal (before age 50) breast cancer or who is known to have a BRCA

mutation, or if the woman herself has a known BRCA mutation. (Begin annual screening 10 years earlier than the age of family member at time of her breast cancer diagnosis, but not younger than age 25; if family member’s age at diagnosis is unknown, begin annual screening at age 35.)

* She has a history of radiation treatments to the chest wall. (Begin annual screening 10 years after radiation was completed, but not younger than age 25.)
* She has a history of pre-cancer/cancer of the breast. (Post-mastectomy women will have a **diagnostic** mammogram of the opposite breast.)
  1. Any woman with an abnormal CBE should be referred for either a **diagnostic** mammogram (usually for women age 30 and older) or ultrasound (often preferred for woman under the age of 30 due to their typically dense breasts, but the radiologist may choose to do a diagnostic mammogram for the younger age woman as well.).

1. **MAGNETIC RESONANCE IMAGING (MRI)**

*Women in the high risk category will be screened with an annual MRI as well as an annual mammogram. Otherwise, determination of the need for a MRI for patients will be made by the contracted breast surgeon or radiologist.*

* KWCSP will reimburse Breast MRI when performed in conjunction with a mammogram when a client is considered “high risk” as determined in the previous section (Section C). However, KWCSP will not reimburse Breast MRI when performed alone as a screening tool.
* KWCSP will reimburse Breast MRI when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment.
* KWCSP will not reimburse Breast MRI when performed to assess the extent of disease in women who are already diagnosed with breast cancer.

**E. GENETIC COUNSELING/TESTING**

*The information below is adapted from the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin 182, September 2017. (Replaces Practice Bulletin 103, April 2009.)*

A woman affected by at least one of the following is at increased risk for having an inherited predisposition to breast and ovarian, tubal or peritoneal cancer. She should be advised of the need for genetic counseling and consideration of genetic testing:

* Epithelial ovarian, tubal or peritoneal cancer
* Breast cancer at age 45 years or less
* Breast cancer and has a *close relative\** with breast cancer at age 50 years or less or close relative with epithelial ovarian, tubal or peritoneal cancer at any age
* Breast cancer at age 50 years or less with a limited or unknown family history
* Breast cancer and has two or more *close relatives* with breast cancer at any age
* Breast cancer and has two or more *close relatives* with pancreatic cancer or aggressive prostate cancer (Gleason score equal to or greater than 7)
* Two breast cancer primaries with the first diagnosed before age 50 years
* Triple-negative breast cancer at age 60 or less
* Breast cancer and Ashkenazi Jewish ancestry at any age
* Pancreatic cancer and have two or more *close relatives* with breast cancer; ovarian, tubal or peritoneal cancer; pancreatic cancer; or aggressive prostate cancer (Gleason score equal to or greater than 7)

A woman unaffected with cancer, but with one or more of the following has increased likelihood of having an inherited predisposition to breast and ovarian, tubal, or peritoneal cancer and should receive genetic counseling and be offered genetic testing:

* A first-degree or several *close relatives* that meet one or more of the conditions listed above
* A *close relative* carrying a known BRCA1 or BRCA2 mutation
* A *close relative* with male breast cancer

*\*Close relative means: parent, sibling or offspring (1st degree); grandparent, grandchild, uncle, aunt, nephew, niece, half-sibling (2nd degree); first cousin, great-grandparent or great-grandchild (3rd degree).*

LHDs are not required to *refer*, only to *recommend* genetic counseling/testing to those patients for whom it is indicated. KWCSP funds cannot be used for genetic counseling/testing.

**F.** **PATIENT EDUCATION ON BREAST HEALTH**

1. Counseling with documentation at the initial and annual visits shall include teaching breast self-awareness, individual breast cancer risk factors/risk reduction, benefits/risks of mammography and the importance of regular screenings.
2. Patients with an abnormal CBE, mammogram, ultrasound or MRI will have documented counseling done as appropriate.

**BREAST CANCER FOLLOW-UP**

**POST BREAST DIAGNOSTICS OR TREATMENT**

Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment (if applicable), thecontracted qualified clinician (breast surgeon, radiologist, etc.) will provide anorder for the patient’s next screening**.** If this is not received,the NCM must contact thecontracted qualified clinician **to** obtain an order**.** Even if the patient has a diagnosis with abenign finding, **the clinician *must* give an order for the patient’s next screening schedule after follow-up of an abnormal screening test result.**

**A.** **SURGICAL REFERRALS**

1. Women with an abnormal CBE must be referred for surgical consultation regardless of diagnostic mammogram or ultrasound results unless CBE is done by radiologist and found to be negative/benign. Thorough documentation by the radiologist shall be required.
2. Any patient with a *bloody* nipple discharge (unilateral or bilateral) requires a referral to a surgeon for evaluation.
3. Any patient with a *spontaneous* (without nipple stimulation) and/or *unilateral* nipple discharge requires a referral to a surgeon for evaluation.
4. *Bilateral non-bloody* *discharge that occurs* *only with nipple stimulation* does notneed referral to a surgeon. This type of nipple discharge may be due to fibrocystic changes (usually greenish), hormonal imbalance, pregnancy, lactation and some medications (oral contraceptives, phenothiazides, anti-hypertensives, tranquilizers). If the clinician (MD or ARNP) determines the need for further evaluation of this type of nipple discharge, it typically is to either a gynecologist or endocrinologist.
5. If a patient presents with a “breast lump” that she has discovered on BSE but both the CBE and mammogram (or ultrasound) are normal, she may be referred to a surgeon for a second opinion. The patient may also be referred to another contracted provider for a second opinion for other concerns she may have regarding her care during screening. For KWCSP eligible patients, the second opinion will be reimbursed by the program for services listed on the approved CPT codes list found in the CCSG.
6. A patient who has a personal history of breast cancer shall be scheduled for a surgical consult with her annual mammogram/MRI regardless of CBE, mammogram or MRI results. This will be reimbursed by the KWCSP for program eligible women.
7. After an initial abnormal finding, when there is an order from a contracted qualified clinician (breast surgeon, radiologist, etc.) for frequent follow-up mammograms, ultrasounds, CBEs or surgical consults, these services will be paid for by the KWCSP until the patient has been released into normal routine screening by this provider.  These follow-up services may show normal or abnormal findings.  However, the continued frequent screening services will be reimbursed by the program until the patient is released to routine screening.  National standards recommend frequent follow-up to continue for up to 2-3 years for specific original findings on radiology testing and clinical findings.  This determination will be made by the contracted qualified clinician (radiologist or breast surgeon).

**B.** **FOLLOW-UP**

1. Patients with an abnormal mammogram, MRI or ultrasound result shall be notified by the health department within 10 working days of receiving the result or within 30 days of the procedure, whichever comes first.
2. Referrals for a surgical consult or requests for additional imaging must be made within 3 weeks (21 days) of abnormal CBE or receipt of abnormal mammogram.
3. Copies of results from consults & diagnostic procedures (including pathology reports) will be received and placed in the medical record within 30 days of the consult or diagnostic procedure.
4. The month and year the next mammogram is due will be documented on the CH3A. A patient with normal screening results will follow the appropriate routine screening guidelines unless there is a reported change in her breasts. For patients who have been scheduled for abnormal test follow-up with a contracted provider, the order for the next mammogram or other future screening and diagnostic procedures shall be provided by the contracted qualified clinician (breast surgeon, radiologist, etc.) and noted in the patient’s chart. The NCM shall inform the patient of her next screening or diagnostic procedure that is ordered.
5. The interval between abnormal breast screening (date of screening) and final diagnosis should be 60 days or less. The interval between diagnosis (date of diagnosis) and initiation of treatment should also be 60 days or less.

**C****.** **TREATMENT FOR PRE-CANCER/CANCER OF THE BREAST:**

Patients that have been screened/diagnosed through KWCSP may be eligible for the treatment fund if diagnosed with pre-cancer/cancer of breast. For more information and forms related to the Breast and Cervical Cancer Treatment Program (BCCTP), please refer to their website at <http://chfs.ky.gov/dms/bcctp>.

Below are some conditions that are considered precancerous conditions when found on a biopsy. If a patient receives one of these diagnoses or a diagnosis of cancer, she is eligible for the BCCTP. The NCM is responsible for initiating the BCCTP application.

Breast Pre-cancerous Conditions:

* Lobular carcinoma-in-situ
* Atypical hyperplasia
* Benign Phylloides tumors
* Some types of papillomatosis
* Radial scar, sometimes referred to as sclerosing lesions

**For more in-depth information on enrolling patients in treatment through the BCCTP see the section *BREAST/CERVICAL CANCER TREATMENT THROUGH MEDICAID’S BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP).***

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**D.** **BI-RADS CLASSIFICATION OF MAMMOGRAM RESULTS AND MANAGEMENT**

Category 0: **Assessment Incomplete**

This category indicates the need for additional imaging, which will be recommended by the radiologist or old films required for comparison.

Category 1: **Negative**

Recommendation should be made for routine follow-up according to the screening guidelines. Notify the patient when it is time for re-screening.

(Refer to surgeon if CBE is abnormal)

Category 2: **Benign Finding**

Recommendation should be made for routine follow-up according to the screening guidelines. Notify the patient when it is time for re-screening.

(Refer to surgeon if CBE is abnormal)

Category 3: **Probably Benign**

Follow-up should be provided according to the radiologist’s recommendation. Usually the radiologist will recommend a repeat mammogram in six months. Counsel the patient on the results of the mammogram and provide a re-screening appointment. (Refer to surgeon if CBE is abnormal)

Category 4: **Suspicious Abnormality**

A biopsy should be considered. Refer to a surgeon for further evaluation. Counsel the patient on the results of the mammogram and assure that arrangements are made for the surgical consultation.

Category 5: **Highly Suggestive of Malignancy**

There is probability of cancer. Refer to a surgeon for further evaluation. Counsel the patient on the results of the mammogram and assure that the arrangements are made for the surgical consultation.

Category 6: **Known Biopsy-Proven Malignancy-Appropriate Action Should Be Taken**

This category is reserved for lesions identified on the imaging study with biopsy proof of malignancy prior to definitive therapy.

# ALGORITHM FOR BREAST CANCER SCREENING FOLLOW-UP

ANNUAL CLINICAL BREAST EXAMINATION

**ABNORMAL CBE**

(Discrete mass or abnormal thickening)

**NORMAL & BENIGN FINDINGS ON CBE**

(Includes fibrocystic changes & normal nodularity)

**1. REPEAT CBE IN ONE YEAR IF 40 OR OLDER, HIGH RISK OR PER PATIENT REQUEST**

2. ANNUAL OR BIENNIAL SCREENING MAMMOGRAM IF

AGE 40 AND OLDER

1. IF SCREENING MAMMOGRAM IS ABNORMAL, PATIENT TO BE NOTIFIED WITHIN 10 DAYS OF RECEIVING THE RESULT OR WITHIN 30 DAYS OF THE PROCEDURE (whichever comes first)
2. A FINAL DIAGNOSIS OBTAINED WITHIN 60 DAYS OF DETECTION OF THE ABNORMALITY (from date screened)

5. OBTAIN SCREENING MAMMOGRAM

WRITTEN REPORT WITHIN 60 DAYS OF THE PROCEDURE

THE PROCEDURE

**1. BREAST ULTRASOUND (ages 29 and under)**

1. DIAGNOSTIC MAMMOGRAM (ages 30 & older)

and ultrasound if needed

3. SURGICAL REFERRAL APPOINTMENT WITHIN 3

WEEKS OF DISCOVERY OF ABNORMAL CBE

(Regardless of ultrasound and/or mammogram results-

unless CBE repeated by radiologist and normal/benign result- must have thorough documentation from radiologist)

4. FINAL DIAGNOSIS OBTAINED WITHIN 60 DAYS OF DETECTION OF ABNORMALITY (from date screened)

5. RECORDS TO BE RECEIVED WITHIN 30 DAYS OF

CONSULT/PROCEDURES

6. FOLLOW RECOMMENDATIONS OF SURGEON AND/OR RADIOLOGIST

# CERVICAL CANCER SCREENING

Routine periodic screening encourages early identification of precancerous conditions of the cervix and early stage diagnosis of cervical cancer. Most cervical cancer can be PREVENTED with detection and early treatment of precancerous lesions.

**A.** **Cervical Cancer Risk Factors**

This is an overall list of factors and/or behaviors which may increase the risk for cervical cancer. Some factors on this list are not considered when making the determination for a patient’s Pap screening interval. See “Cervical Cancer Screening Guidelines” for factors that are used to determine when a patient is considered “high-risk” and not eligible for increasing the time interval between screenings.

1. History of HPV and/or Dysplasia
2. Multiple (3 or more) sexual partners in lifetime
3. A sex partner with multiple sex partners
4. A sex partner who has had a partner with HPV/dysplasia/cervical cancer
5. Cigarette smoking (any amount)
6. Beginning sexual intercourse at a young age (age 18 or less)
7. History of 2 or more sexually transmitted infections
8. Intrauterine exposure to diethylstilbestrol (DES)
9. Infrequent screening (>5 years since last Pap)
10. Immunosuppressed (HIV/AIDS, diabetes, transplant recipient, chronic steroid use, auto-immune disorders)

**B. CERVICAL SCREENING HISTORY**

1. Elicit date and result of last Pap test

2. Determine if a previous history of an abnormal Pap and/or HPV

3. Determine if history of a previous colposcopy & biopsy and/or treatment

4. Screen for risk factors (listed above)

5. Screen for history of abnormal bleeding patterns

**C. PELVIC EXAMINATION**

The purpose of this section is to outline components of a pelvic exam, when to start screening, and how often to continue screening.

The pelvic examination serves multiple purposes, including the assessment of the ***vulva, vagina, cervix, uterus*** *and* ***adnexa*.** The pelvic examination includes:

* inspection of the***external******genitalia, urethra*** and ***introitus;***
* examination of the***vagina***and ***cervix;***and
* bimanualexamination of the***uterus, cervix, adnexa*** and ***ovaries*.**

If indicated, rectovaginal examination is performed as a part of the examination. Some health care providers incorporate the rectovaginal examination as part of the routine examination.

**A pelvic examination may be performed as preventive care for all women 21 years of age and older,** but it is not required annually. It is required as part of the cervical cancer screening visit when a Pap test is done.\* A bimanual pelvic examination is generally not necessary at the initial reproductive health visit. A general physical examination, including an external genital examination, may be done because it allows assessment of secondary sexual development, reassurance and education. A “teaching” external-only genital examination can provide an opportunity to familiarize adolescents with normal anatomy, assess adequacy of hygiene and allow the health care provider an opportunity to visualize the perineum for any anomalies. Pelvic examination need only be performed in adolescents when it is likely to yield important information regarding conditions such as amenorrhea, abnormal bleeding, vaginitis, presence of a possible foreign body, pelvic pain, pelvic mass or a sexually transmitted

disease (STD). If the patient has had sexual intercourse, screening for STDs is important. Refer to STD Guidelines.

RNs must refer any abnormal finding on the pelvic examination to a midlevel or higher clinician or a contracted gynecologist for further evaluation.

*Adapted from ACOG Committee Opinion, Number 431, May 2009.*

*\*For guidance on when to perform a pelvic exam, apart from the cancer screening Pap test, see the algorithm entitled “Algorithm for Deciding if a Pelvic Exam is Necessary During a Family Planning Visit”, found in the FP section of the CCSG.*

* 1. **Cervical Cancer Screening Guidelines**

Routine cervical cancer screening begins at age 21 with the Pap test, to be repeated every 3 years. At age 30, a woman can choose to continue with the Pap test only, or have a co-test (Pap test and HPV test) every 5 years. Abnormal test results can alter the screening schedule.

Patients with a cervical history of CIN2, CIN3 or cervical cancer, in utero exposure to DES or who are immunocompromised, as stated above, are considered **high-risk patients** whendetermining their cancer screening interval options**. These women should be screened according** **to orders from the contracted gynecologist.**

***Note: The physician who treats a patient’s CIN2, CIN3 or cervical cancer will determine the interval between future screenings and the length of screening surveillance, including possible extension of screening past the age of 65.***

**FOR ALL PATIENTS WHO ARE SENT TO A CONTRACTED GYNECOLOGIST OR COLPOSCOPIST:**

**Once her diagnostic procedures are complete and she has a diagnosis and treatment if applicable, the contracted clinician (gynecologist or colposcopist) who diagnoses and/or treats will provide an order for the patient’s future screening schedule.** If this is not received, the NCM must contact this provider to obtain an order. If a patient has a history of colposcopy at another provider’s office, the records and order for future screening schedule should be obtained from that office.

1. **WOMEN AGES 21-29:**

without a history of CIN2, CIN3 or cervical cancer, or in utero exposure to DES and who are not immunocompromised (non high-risk patient) should have cytology screening every 3 years. Also, see notes above for patients who have a history including colposcopy. Pap tests should begin at 21 years of age (may be done earlier at clinician’s discretion based on abnormal clinical findings. KWCSP funds cannot be used for cervical cancer screening for anyone younger than the age of 21 years). If the patient is a minor with a potentially life-threatening test result (includes “Adenocarcinoma-In-Situ”, “HSIL” or “ASC-H” result) and cannot be contacted, the parent or guardian may be contacted (KRS 214.185(6)).  Minors shall be made aware of this policy at the screening visit.

**2. WOMEN AGES 30-65:**

without a history of CIN2, CIN3, cervical cancer, or in utero exposure to DES and who are not immunocompromised (non high-risk patient) have two options for cervical cancer screening and must be offered both options by the LHD. Also, see notes above for patients who have a history including colposcopy. One recommendation for screening is cytology every 3 years. Another option for women in this age group, who want to lengthen the screening interval, is screening with a combination of cytology and HPV testing every 5 years (“co-testing”).

Screening by co-testing which includes Pap test and HPV High Risk DNA testing is the preferred standard for non-high risk patients in this age group and all grantees of the CDC NBCCEDP grant must offer this option to patients who do not have any contraindications listed in the previous paragraph. The decision will be made by the patient. “Women choosing co-testing to increase their screening interval should be aware that positive screening results are more likely with HPV-based strategies than with cytology alone and that some women may require prolonged surveillance with additional frequent testing if they have persistently positive HPV results.  The percentage of U.S. women undergoing co-testing who will have a normal cytology test result and a positive HPV test result (and who therefore require additional testing) ranges from 11% among women age 30 to 34 years to 2.6% among women age 60 to 65 years.” A percentage rate was not reported for women ages 35-59.

**\*The High Risk HPV DNA panel will only be covered by the KWCSP when testing meets the criteria stated in the notes on the “Approved CPT Codes” listing in the CCSG. Low-risk HPV DNA panel will not be reimbursed by KWCSP.**

**SPECIAL** **POPULATIONS:**

Women with the following high-risk conditions should be screened according to orders from the contracted gynecologist regardless of their age: immunosuppression (i.e., renal transplant, etc.), HIV infection, history of CIN2, CIN3, cervical cancer or DES exposure in utero.  If uncertain of whether a patient’s condition/disease would cause immunosuppression, consult your medical director or contracted clinician. KWCSP funds can be used for annual cervical cancer screening among women who are considered high-risk.

The NCM shall contact the contracted provider to determine screening guidelines for patients with a history of pre-cancer or cancer of the cervix. The type of follow-up will often be determined by the provider according to the extent of the cancer. KWCSP funds can be used to reimburse for routine cervical cancer surveillance for 20 years post-treatment for women with a how history of cervical neoplasia or in situ disease, or can reimburse indefinitely for screening of women with a history of invasive cervical cancer, as long as the woman is in good health.

**WOMEN FOLLOWING HYSTERECTOMY**

* + Women at any age following a hysterectomy with removal of the cervix who *do not* have a positive history of CIN2, CIN3 or cervical cancer should not be screened for vaginal cancer using any modality according to the ACS-ASCCP-ASCP screening guidelines released in Nov. 2012.
  + Women at any age following a hysterectomy with removal of the cervix who *do have* a positive history of CIN2, CIN3 or cervical cancer should be screened as stated in the preceding section, titled “Special Populations”. Vaginal/vulvar/labial Pap tests or biopsies shall be performed by the LHD contracted clinician (gynecologist or colposcopist) for patients with a history of CIN2, CIN3, cervical cancer or for an abnormal physical finding during an exam performed at the LHD. KWCSP funds can be used to reimburse for the vaginal Pap tests and/or diagnostic follow-up for eligible women in this situation.
  + Women for whom the reason for the hysterectomy or final diagnosis of no neoplasia or invasive cancer cannot be documented, should continue cervical cancer screening until there is a 10-year history of negative screening results, including documentation that Pap tests were technically satisfactory.

**VULVAR. LABIAL, OR VAGINAL ABNORMALITIES**

* If a vulvar or labial lesion is found during an examination, the patient shall be informed that this abnormal finding will need follow-up to rule out cancer. Vulvar and labial screening/diagnostic follow-up will be performed by the contracted clinician (gynecologist or colposcopist). Vulvar or labial procedures will not be reimbursed by the KWCSP.
* Follow-up for any abnormal findings of the vagina, vulva or labia will be determined by the gynecologist who performs the screening and/or diagnostic procedures for the patient.

**WOMEN OLDER THAN 65**

Women older than 65 with documentation of adequate negative prior screening, who are not otherwise at high risk for cervical cancer and have no history of CIN2, CIN3 or cervical cancer within the last 20 years should not be screened.  Adequate negative prior screening is three consecutive negative cytology results or two consecutive negative co-tests within the 10 years before cessation of screening, with the most recent test occurring within the past 5 years.

**WOMEN IN ABNORMAL FOLLOW-UP**

Guidance for follow-up of an abnormal Pap test result is found under the heading of MANAGEMENT OF ABNORMAL PAP TEST RESULTS in the CCSG. This should be referenced when planning case management. However, the contracted qualified clinician (gynecologist, colposcopist, etc.) who provides the colposcopy and/or treatment will direct patient care. Services that can be reimbursed are found on the approved CPT code list found in the CCSG. Medical providers and patients shall be made aware of services that **can be** reimbursed. **Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment if applicable, the contracted clinician who diagnoses and/or treats will provide an order for the patient’s next screening. If this is not received, the NCM must contact this provider to obtain an order.**

**WOMEN WHO HAVE RECEIVED HPV VACCINE**

Women who have received the HPV vaccine should continue to be screened according to the age-appropriate guidelines.

**\*Pap Screening Guidelines Reference: 2012, American Society for Colposcopy and Cervical Pathology *Journal of lower Genital Tract Disease, Volume 16, Number 3, 2012, 00-00.***

**Age – Delineated Cervical Cancer Screening Schedule** 

# CERVICAL CANCER FOLLOW-UP

**A. The Bethesda 2001 System**

The Bethesda System for reporting cervical and/or vaginal cytology is the recognized system for reporting results. The LHD is required to contract with a laboratory that uses this system of reporting. The state computerized reporting options for Pap test findings and the protocols for management of abnormal findings are based on the Bethesda 2001 System.

Specimen Adequacy

Satisfactory

Unsatisfactory

## General Categorization

Negative for Intraepithelial Lesion or Malignancy (NIL)

Epithelial Cell Abnormality

###### Negative for intraepithelial lesion or malignancy

## Negative for Intraepithelial Lesion or Malignancy with:

Presence of Organisms

Trichomoniasis

Candida

Shift in vaginal flora suggestive of bacterial vaginosis

Bacterial morphology consistent with Actinomyces

Cellular changes consistent with Herpes simplex virus

Reactive cellular changes

Inflammation

Radiation effects

IUD effects

Metaplasia (normal)

Atrophy

## Epithelial Cell Abnormalities present

Squamous Cell Abnormality

### Atypical Squamous Cells of Undetermined Significance (ASC-US)

Atypical Squamous Cells cannot exclude a High-Grade Lesion (ASC-H)

Low Grade Squamous Intraepithelial Lesion (LSIL)

High Grade Squamous Intraepithelial Lesion (HSIL)

Squamous Cell Carcinoma

Glandular Cell Abnormality (AGC)

Atypical endocervical, glandular or endometrial cells

Adenocarcinoma-In-Situ or Adenocarcinoma

**B. PATIENT EDUCATION ON CERVICAL HEALTH**

1. Counseling on cervical cancer risk factors, Human Papillomavirus (HPV) testing and risk reduction (including smoking cessation) during screening visits is required. Smokers must be offered referral to the Quit Now Kentucky tobacco quit line and/or Freedom from Smoking classes.
2. Counseling on the HPV vaccination shall be provided to the patient and the parent of minors when applicable.
3. Patients must have documented counseling as appropriate.

**C. FOLLOW-UP**

1. Refer patient if abnormal cervix or polyps visualized.
2. Patients with abnormal Pap test shall be notified within 10 working days from the date the Pap test is received at the clinic.
3. Referral appointments must be made within 3 weeks (21 days) of the clinic receiving the abnormal Pap test result. Any delay in meeting this timeframe must be documented in the patient’s medical record, including any “1st available” appointment
4. A final diagnosis must be made within 60 days of the Pap test screening. The final diagnosis is based on colposcopy and biopsy results. Treatment should be initiated 60 days or less from the date of diagnosis of a pre-cancer or cancer of the cervix.
5. Results of referrals including colposcopy, biopsy path reports, cryotherapy, Loop electrosurgical excision procedure (LEEP) procedure and pathology reports, Cold Knife Conization (CKC) procedure and pathology reports and Laser treatment documentation must be received within 30 days of the procedure.
6. The month and year the next Pap test is due is to be documented on the progress note. The nurse’s note should include the doctor’s or colposcopist’s name, date and source of the order (verbal order, doctor’s office note in chart, etc.) for the next screening or diagnostic procedure.

# D. MANAGEMENT OF ABNORMAL PAP TEST RESULTS

(Numbers correspond to PSRS submission)

Follow-up for any abnormal findings of the vagina, vulva or labia will be determined by the contracted clinician (gynecologist or colposcopist) who performs the screening and/or diagnostic procedures for the patient. Also, see SCREENING AND REIMBURSEMENT INFORMATION FOR VAGINAL, LABIAL OR VULVAR PROCEDURES

**#1 SATISFACTORY / NEGATIVE FOR INTRAEPITHELIAL LESION**

**Refer patient if abnormal cervix or polyps visualized**

**Management of Women Age 30 and older with Co-Testing:**

**CYTOLOGY NEGATIVE- HPV NEGATIVE (COTESTING)**

* SEE CERVICAL CANCER SCREENING GUIDELINES AT THE BEGINNING OF THE CERVICAL CANCER SCREENING SECTION for scheduling patient’s next screening unless she is currently in abnormal follow-up. If the current Pap result was part of follow-up for a previous abnormal, refer to physician’s order for next screening.

**CYTOLOGY NEGATIVE-HPV POSITIVE (CO-TESTING)**

* According to the 2012, American Society for Colposcopy and Cervical Pathology Journal of Lower Genital Tract Disease, Volume 16, Number 3, 2012, 00-00 and 2013, American Society for Colposcopy and Cervical Pathology *Journal of Lower Genital Tract Disease, Volume 17, Number 5, 2013, S1-S27.*

Women co-testing HPV positive, cytology negative should be followed with either:

**Option 1)** Repeat Co-testing in 1 year **if this was her first co-test**.

**If this was her second follow-up co-test**, with result of ASCUS OR HPV positive, she should be referred for colposcopy. If the second follow-up co-test is Cytology Negative and HPV Negative, then Repeat Co-Testing @ 3 years.

OR

**Option 2)** perform immediate HPV DNA Typing / genotype-specific testing for HPV16 alone or for HPV 16/18. **AT THIS TIME CDC POLICY ONLY ALLOWS REIMBURSEMENT FOR HPV PANEL.**

If HPV 16and HPV 18 is negative, rescreen in 1 year with co-testing. If HPV 16 or HPV 18 is positive, refer for colposcopy.

**CYTOLOGY NEGATIVE BUT EC/TZ ABSENT/INSUFFICENT**

* **AGES 21-29: routine screening (HPV testing is unacceptable)**
* **AGES 30 and OLDER:**

1. **HPV Negative:** routine screening
2. **HPV Positive:** Cytology plus HPV testing in 1 year OR Genotyping
3. **HPV Unknown:** HPV testing (Preferred) OR Repeat Cytology in 3 years (Acceptable). If HPV testing is negative then can return to Routine screening but if HPV is positive then will need to repeat Cytology and HPV test in 1 year OR Genotyping

**SATISFACTORY/ NEGATIVE FOR INTRAEPITHELIAL LESION WITH PRESENCE OF ORGANISMS OR REACTIVE CELLULAR CHANGES:**

* Clinician consult to decide if treatment is indicated
* Repeat Pap test at next scheduled screening

**ENDOMETRIAL OR GLANDULAR CELLS PRESENT ON A NEGATIVE PAP:**

When there is a result of “endometrial cells in a woman past age 40” on a negative Pap test result, the NCM shall contact the contracted provider. The NCM will provide all pertinent medical history to the physician including past cervical history and test results, age, and current Pap results. The physician will determine follow-up for the patient. If the patient is KWCSP eligible, services on the approved CPT code list in the CCSG will be reimbursed by the program.

**#2 ATYPICAL SQUAMOUS CELLS OF UNDETERMINED SIGNIFICANCE (ASC-US)**

According to the 2012, American Society for Colposcopy and Cervical Pathology Journal of Lower Genital Tract Disease, Volume 16, Number 3, 2012, 00-00 and 2013, American Society for Colposcopy and Cervical Pathology Journal of Lower Genital Tract Disease, Volume 17, Number 5, 2013, S1-S27.

**Women ages 21-24:**

1. Repeat Cytology @ 12 months (Preferred)

* **NEG, ASCUS, LSIL results: need to Repeat Cytology @ 12 months and if Negative x 2 then return to routine screening** If this repeat is ASCUS or greater refer to colposcopy.
* **On the first repeat cytology if result is ASCUS-H, AGC, HSIL need to Refer for Colposcopy**

1. Reflex HPV Testing (Acceptable)

* If HPV Negative then return to Routine screening (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)
* If HPV Positive then Repeat Cytology at 12 months (See two bullets under #1 for follow-up).

**Women ages 25 and older:**

1. HPV Testing (Preferred)

* HPV Positive needs Referral for Colposcopy
* HPV Negative will need Repeat Co-Testing @ 3 years (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)

1. Repeat Cytology at 1 year (Acceptable)

* If Repeat is Negative go to Routine Screening (Cytology in 3 years if she is not considered high risk according to the criteria found under Cervical Screening Guidelines in the CCSG)
* If Repeat is ASCUS or worse needs Referral for Colposcopy

**#3 ATYPICAL SQUAMOUS CELLS CANNOT RULE OUT HIGH GRADE (ASC-H)**

**Women ages 21-24:**

* Refer for colposcopy (immediate LEEP is unacceptable)

**Women ages 25 and older:**

* Refer for colposcopy evaluation regardless of HPV status

**For patients under 21 who were screened prior to the 2009 ACOG screening guideline changes, refer patient to your contracted provider for ASC-H Pap results.**

**#4 LOW GRADE INTRAEPITHELIAL NEOPLASIA (CIN I, Mild dysplasia, HPV) (LSIL)**

**Women ages 21-24:**

1. Repeat Cytology @ 12 months (Preferred)

* **NEG, ASCUS, LSIL results: need to Repeat Cytology @ 12 months and if Negative x 2 then return to routine screening** If this repeat is ASCUS or greater refer to colposcopy.
* **On the first repeat cytology if result is ASCUS-H, AGC, HSIL need to Refer for Colposcopy**

1. Reflex HPV Testing (Acceptable)

* If HPV Negative then return to Routine screening (if she is not considered high risk according to the criteria found under Cervical Cancer Screening Guidelines in the CCSG)
* If HPV Positive then Repeat Cytology at 12 months (See two bullets under #1 for follow-up).

**Women ages 25 and older:**

With Negative HPV Test: Repeat Co-Testing @ 1 year (Preferred) OR refer for Colposcopy (Acceptable). If Repeat Co-Testing is done and Cytology is Negative and HPV is Negative then may repeat Co-Testing @ 3 years. If Repeat Co-Testing is done and Cytology is ASCUS or worse OR HPV Test is Positive then would refer for Colposcopy.

1. With No HPV Test: Refer for Colposcopy
2. With Positive HPV Test: Refer for Colposcopy

**For patients under 21 who were screened prior to the 2009 ACOG screening guideline changes, no follow-up required and patient should return for annual Pap screening until age 21.**

**#5 HIGH GRADE INTRAEPITHELIAL NEOPLASIA (CIN II, CIN III, Moderate-Severe dysplasia, or carcinoma-in-situ) (HSIL)**

**Women ages 21-24:**

* **Refer for Colposcopy evaluation (Immediate LEEP is unacceptable)**

**Women ages 25 and older:**

* Refer for colposcopy evaluation or LEEP.
* The contracted provider shall perform a review of the cytology, colposcopy, and histology results when no lesion or only biopsy-confirmed CIN 1 is identified after colposcopy in women with HSIL Pap test reports. If the review yields a revised interpretation, management should follow guidelines for the revised interpretation; if a cytological interpretation of HSIL is upheld or if review is not possible, a diagnostic excisional procedure (e.g., LEEP) is preferred in nonpregnant patients.

**For patients under 21 who were screened prior to 2009 ACOG screening guideline changes, refer patient to your contracted provider for HSIL Pap results.**

**#6 SQUAMOUS CELL CARCINOMA**

* Refer to a qualified provider

**#7 ADENOCARCINOMA OR ADENOCARCINOMA-IN-SITU**

* Refer to a qualified provider

**#8 UNSATISFACTORY**

1. HPV unknown (any age): Repeat Cytology after 2-4 months
2. HPV Negative (age 30 and older): Repeat Cytology after 2-4 months
3. HPV Positive (age 30 and older): Repeat Cytology after 2-4 months OR Refer for Colposcopy (either is Acceptable)

\*If Repeat Cytology is:

Abnormal: Manage per ASCCP guidelines (See Management of Abnormal Pap Test Results per CCSG)

Negative: Routine Screening (HPV negative or unknown) OR Cotesting @ 1 year (HPV positive)

Unsatisfactory: Refer for Colposcopy

**#9 ATYPICAL GLANDULAR CELLS OF UNDETERMINED SIGNIFICANCE (AGC)**

* Contact contracted provider for order of follow-up. The NCM will provide all pertinent medical history to the physician including past cervical history and test results, age, and current Pap results. The physician will determine follow-up for the patient. If the patient is KWCSP eligible, services on the approved CPT code list in the CCSG will be reimbursed by the program.

**The Consensus Guidelines updated 2012-2013 for cervical follow-up are on the American Society for Colposcopy and Cervical Pathology website at** [**http://www.asccp.org/**](http://www.asccp.org/). Due to copyright restrictions, we are unable to include the ASCCP algorithms in the CCSG. However, LHD nurses are encouraged to print the cytology follow-up algorithms from the ASCCP website for their own use.

1. **POST COLPOSCOPY EVALUATION OR TREATMENT**

**Once a patient’s diagnostic procedures are complete and she has a diagnosis and treatment (if applicable), the contracted qualified clinician (gynecologist, colposcopist, etc.) providing the colposcopy and/or treatment will provide an order for the patient’s next screening. If this is not received, the NCM must contact this provider to obtain an order. Even if the patient has a diagnosis with a benign finding, the contracted clinician who provided this diagnosis must give an order for the patient’s next screening schedule after follow-up of an abnormal screening test result.**

**LOOP ELECTRICAL EXCISION PROCEDURE (LEEP), Diagnostic vs Treatment**

A local surgical procedure known as a LEEP or a [cone biopsy](http://en.wikipedia.org/wiki/Cervical_conization) can be considered either a diagnostic or treatment procedure.

A patient’s colposcopy biopsy may be benign, show mild dysplasia or a biopsy may not be performed. However, a physician may determine that it is necessary to perform a LEEP to obtain a more comprehensive or accurate specimen.

* When a patient’s colposcopy biopsy is benign, mild or a biopsy was not performed, a LEEP would be considered a **diagnostic** procedure and would be covered under the **KWCSP**.
* When a LEEP procedure is performed on a patient who had a colposcopy diagnosis of HSIL, the LEEP would be considered **treatment** and should be covered under the **BCCTP**.

The NCM shall ensure that the patient begins the application process for the BCCTP after receiving the colposcopy diagnosis of cancer or pre-cancer.

1. **TREATMENT FOR PRE-CANCER/CANCER OF THE CERVIX**

Patients that have been screened or diagnosed through KWCSP may be eligible for the Breast and Cervical Cancer Treatment Program (BCCTP) if diagnosed with pre-cancer/cancer of cervix (includes endocervical). For more information and forms related to BCCTP, please refer to their website at <http://chfs.ky.gov/dms/bcctp>.

Below are some conditions that are considered pre-cancerous conditions when found on a biopsy. If the patient receives one of these diagnoses or a diagnosis of cancer, she is eligible for the BCCTP.

Cervical Pre-cancerous Conditions:

* High grade squamous epithelial lesions (HSIL)
* Adenocarcinaoma-in-Situ

**For more in-depth information on enrolling patients in treatment through the BCCTP, see the section *BREAST/CERVICAL CANCER TREATMENT THROUGH MEDICAID’S BREAST AND CERVICAL CANCER TREATMENT PROGRAM.***

**BREAST/CERVICAL CANCER TREATMENT THROUGH MEDICAID’S BREAST AND CERVICAL CANCER TREATMENT PROGRAM (BCCTP):**

Once a woman is screened or diagnosed through the KWCSP and is found to have a pre-cancer or cancer of the breast or cervix, the NCM shall begin the application process for the BCCTP.

To be eligible for Medicaid, an applicant or recipient shall be a citizen of the United States as verified through documented evidence presented during initial application as required in 907 KAR 1:011. The LHD shall verify patient’s identity and citizenship by viewing the patient’s driver license and birth certificate. For patients who were born in Kentucky and do not have a copy of their birth certificate or for more information about the citizenship documentation requirement, contact the Department for Medicaid Services at 1-800-635-2570. Other patients will need to contact Vital Statistics in their state of birth in order to obtain an original birth certificate. A passport may also be used for documentation of both identity and citizenship.

Complete the Pre-screening Eligibility Form using the Medicaid web application. Then, complete application and call Medicaid for confirmation number. The original signed application, Pre-screening Eligibility Form and proof of identity and citizenship should be maintained in the patient’s chart in the administrative section.

As stated on the Department for Medicaid Services BCCTP website, some patients may require longer than the standard period of treatment and may be granted a Medicaid eligibility extension. An eligibility extension form ([MAP - 813D](http://chfs.ky.gov/NR/rdonlyres/BEB8C3CD-9F59-40D0-9332-7F3C934FB514/0/MAP813D.pdf) Breast and Cervical Cancer Treatment Program Extension) can be obtained from the department's website or by calling toll-free 1-800-807-1232.

During the initial BCCTP application process, the **NCM shall inform the patient to contact the NCM two weeks prior to the end of her Medicaid eligibility period** if her treatment plan will extend past that eligibility period. Extension requests must be initiated by the treating physician. **The NCM will assist the physician in obtaining an extension form to complete on the patient’s behalf.**

When extension request review is completed, recipients will receive a notice of their new eligibility status.

**TREATMENT PROGRAM ELIGIBILITY INFORMATION**

* A Pap test, mammogram, ultrasound or MRI does not provide a definitive diagnosis of pre-cancer or cancer. These are considered screening tests.
* A patient must have a **biopsy** that confirms either a diagnosis of **cancer or pre-cancer** of the cervix or breast for her to be eligible for the BCCTP.
* Cancer or pre-cancer of the vagina, vulva, labia or uterine/endometrial lining do not make a patient eligible for the BCCTP. The BCCTP is for cancer or pre-cancer treatment of the breast or cervix for women screened or diagnosed through the KWCSP.
* A result of HSIL on a biopsy of the cervix (CIN II or greater) is required for a patient to be considered eligible clinically for the BCCTP.
* Once the biopsy diagnosis is confirmed, the NCM will begin the process of ensuring that an application is completed for the patient to be enrolled with Medicaid (BCCTP).
* The NCM is responsible for initiating the BCCTP application when a final diagnosis has been received and patient eligibility determined. Support staff at the LHD may assist or perform the application process.

# TRACKING AND FOLLOW-UP REQUIREMENTS

The Local Health Department (LHD) is accountable for tracking KWCSP patients with abnormal screening test results to ensure these women receive the necessary re-screening or diagnostic follow-up services to reach a timely final diagnosis and begin treatment. This includes those patients where the screening occurred in another program such as family planning, pediatrics, or prenatal. Insured women with abnormal results should be referred to their primary care physician/medical home for necessary follow up. Each clinic site is responsible for assigning this tracking responsibility to a Registered Nurse, Advanced Registered Nurse Practitioner or Licensed Practical Nurse. The nurse that assumes this responsibility is referred to as the Nurse Case Manager (NCM).

**Prior to assuming the role and responsibilities of NCM with the KWCSP, the nurse must complete the following educational modules on TRAIN:**

* **How to Best Utilize the State’s Breast and Cervical Cancer Screening and Treatment Programs** **(Course # 1009091)**
* **Cancer Screening and Follow-Up Using the Core Clinical Service Guide** **(Course # 1044117)**
* **Kentucky Public Health** **Nurse Case Management: Helping Women with Abnormal Breast and Cervical Cancer Screening Results** **(Course # 1013696)**
* **Documentation: Kentucky Public Health Nurse Case Management for Abnormal Breast and Cervical Cancer Screening Follow-up (Course # 1020005)**

**The following modules are highly recommended**:

* **Who are the Never and Rarely Screened? Kentucky Women Share Insights about the Impact of their Care and How You Can Make the Difference** **(Part 1 Course # 1010683, Part 2 Course # 1010684)**

**TRAINING IN ADDITION TO MODULES FOR NEW NURSE CASE MANAGERS**

When there is a staff change for the NCM position, the Nursing or Clinical Supervisor must notify the Clinical Coordinator of the KWCSP at 502-564-3236, as soon as possible. One-on-one training will be provided to each new NCM by the QA Nurse Consultant.. This training may be provided by ITV, telephonically or in person.

**BACKUP NURSE CASE MANAGERS**

There must also be another RN, LPN or APRN, a back-up NCM, who is knowledgeable about cancer screening follow-up and is available to assume the Nurse Case Manager’s (NCM) role and responsibilities in the event the NCM is absent for more than seven calendar days. A timely diagnosis is crucial to creating positive outcomes in cancer screening. Completion of the modules listed above are also required of the backup NCM prior to assuming NCM duties; the one-on-one training is optional.

**NURSE CASE MANAGER DUTIES**

Tracking and follow-up can be time consuming and therefore it is recommended that professional and support staff work as a team toward this effort. The NCM is required to provide patient contact, counseling, tracking, and follow-up while the support staff may assist the case manager by scheduling appointments, obtaining records, and electronic entry of data. The NCM shall review all patient appointment arrangements and medical records to provide detailed documentation in the Progress Notes of the patient’s medical chart. Administrative time is imperative for NCMs to meet program requirements. The NCM should assure that all aspects of the case management process are appropriately documented in the patient’s service record.

The NCM must have an organized manual or electronic tracking system in place to assure that patients receive appropriate and timely intervention. It is also strongly recommended that the ACH-58 Case Management Form side (in this section) be used to assist staff with this required tracking and follow-up. (See Administrative Reference for instructions on Data Collection side of form.)

It is the responsibility of the KWCSP Nurse Case Manager (NCM) to contact the patient, surgeon or oncologist to ensure the patient has begun treatment for a cancer or pre-cancerous condition. The patient must have had a service that either removed part or all of her cancer or received chemotherapy or radiation to reduce her cancer for her treatment to be considered started. The NCM does not continue to provide case management for treatment once a patient is on the treatment program (BCCTP). The patient’s care will be managed by her Kentucky Medicaid health care providers. The NCM does not need to request treatment records. However, the NCM must document on the CH-3 nursing notes, the type of treatment that began the patient’s care and the date that it was performed. The NCM shall document the source of this information (doctor’s name and specialty, patient, etc.).

For further testing and management after the initial abnormal result, patients who qualify for KWCSP should be case managed by the local health department according to program guidelines. However, when a patient has a medical home, the patient may be referred back to the primary care physician for follow-up management, after the patient is informed of the abnormal test and need for follow-up. Health departments should have good communication with local medical home providers so that each provider’s role and expectations are clear.

A flowchart outlining the case management guidelines can be found at the end of the Cancer Screening/Follow-up Section.

**A. Informing the Patient of Abnormal Results**

Patients with an abnormal Pap test or mammogram result must be notified within 10 working days from receipt of the abnormal test result or within 30 days from the test date (whichever comes first) following this plan of action:

1. Whenever possible, the NCM shall contact the patient by telephone and have her come to the clinic for face-to-face counseling for abnormal test results. It is expected that the clinic has emergency numbers for all “no home contact” patients. Guidance for “no home contact” patients and minors is found in KRS 214.185.
2. When the patient comes in to the Health Department for counseling, test results and recommendations for follow-up are reviewed with the patient, options discussed and a letter explaining the result in writing is given to the patient. Arrangements for follow-up are then made (see Section B). The visit shall be documented in the patient chart.
3. If the NCM is unable to make verbal contact with the patient by phone then an attempt to contact the patient by letter on the same day as the unsuccessful phone call is necessary. The letter shall inform the patient about the abnormal test result with instructions to contact the NCM at the health department.
4. If the patient does not respond within 10 working days after the letter is mailed, the nurse shall then send a certified letter to the patient informing her of her abnormal test results with instructions to contact the health department.

Once the above has been completed with no response then it is appropriate to document the patient as lost to follow-up.

**B. Follow-up for Abnormal Test Results**

All patients with abnormal lab tests need follow-up. Patients who meet eligibility criteria for KWCSP must be referred according to program guidelines to contracted specialists for further testing/evaluation. Other patients may have a medical home (regular source of medical care) outside of the local health department (LHD). The patient’s medical home/PCP can be determined at registration.

Medical homes may include private physicians, Passport providers, Primary Care Centers, FQHC’s, and Community Health Centers. These providers will be responsible for arranging and providing follow-up care for their patients. Each local health department should maintain open communication with primary care providers in their area to be sure there is agreement on roles and expectations for follow-up of patients with abnormal results.

**B1. Follow-up Arrangements for KWSCP-eligible Patients**

1. The NCM will schedule an appointment for the patient with a KWCSP contracted provider for the appropriate follow-up testing or evaluation. A referral letter and reports of the abnormal test results are sent to the contracted provider who will be seeing the patient.
2. The NCM tracks to see that the patient showed for the appointment and documents the visit in the patient’s chart.
3. The NCM collects reports from the contracted provider and makes arrangements for further diagnostic testing as ordered.
4. If the patient does not keep an appointment for a scheduled consult appointment, diagnostic procedure, treatment, or follow-up/repeat Pap, a certified letter will be sent to the patient within 10 working days of the missed appointment. No further follow up tracking is needed for these patients. If the patient reschedules a missed appointment after receiving a certified letter and then does not keep that appointment, a second certified letter is not necessary.
5. All attempts of patient contact shall be documented in the progress notes (CH3A).
6. If the patient is a minor with a potentially life-threatening test result (includes a “HSIL” or “ASC-H” result on a Pap test or a “Suspicious Abnormality” or “Highly Suggestive of Malignancy” mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit.

**B2. Follow-up Arrangements for Patients with a Medical Home**

1. The NCM will schedule an appointment for the patient with their PCP for the appropriate follow-up testing or evaluation. A referral letter and reports of the abnormal test results along with past pertinent abnormal cervical cancer screening/diagnostic tests and results are sent to the Primary Care provider who will be seeing the patient. Document in the progress notes (CH3A) all transfer of care actions provided for the patient.

**NOTE:** It is imperative that the PCP is informed of any of their patient’s abnormal test results. This will allow the PCP to assure that the patient receives the appropriate follow-up care.

1. If the patient is a minor with a potentially life-threatening test result (includes a “HSIL” or “ASC-H” result on a Pap test or a “Suspicious Abnormality” or “Highly Suggestive of Malignancy” mammogram or ultrasound result) and cannot be contacted, the parent or guardian must be contacted. Minors shall be made aware of this policy at the screening visit.
2. All attempts of contact with the patient and PCP shall be documented in the patient’s progress notes (CH3A).

**C. Other Situations:**

Patients who are not KWCSP eligible and do not have a medical home: Local Health Departments may screen some patients who are not eligible for KWCSP and do not have a medical home. Efforts should be made to find the patient a medical home. If that is not possible, then the LHD may manage these patients following KWCSP protocols and providers. Efforts should be made to find other resources for financial assistance in these circumstances as they would not be covered by the KWCSP.

Work-up Refused: occurs when a patient has been notified and counseled (by phone or in person) regarding an abnormal result and either fails to keep a referral appointment for diagnostics/treatment or verbalizes her desire not to seek follow-up. The date of final contact should be noted in the service record (CH3A) and on ACH-58 Data Collection Form side.

Lost to Follow-up: occurs when unable to inform and counsel the patient, either by phone or in person, regarding an abnormal test result. The date of the final contact attempt should be noted in the service record (CH3A) and on ACH-58 Data Collection Form side.

**ACCEPTING REFERRALS/FOLLOW-UP REFERRAL REQUIREMENTS:**

Healthcare providers should be encouraged to refer uninsured women to the local health department as soon as possible to determine eligibility for the Kentucky Women’s Cancer Screening Program (KWCSP).

In the event a KWCSP *eligible* woman presents to the LHD for cancer-screening services, but has had a physical examination within the past 12 months that included CBE, Pelvic and Pap test from another healthcare provider, the following are requirements of the Kentucky Women’s Cancer Screening Program.

1. The woman must meet the eligibility requirements of the program and provide consent for services.
2. The patient is responsible for bringing her records at time of visit or having them sent to LHD prior to the visit.  This will enable the LHD provider to assess if all the minimum requirements were met.  These records must include copies of the actual physical examination (including CBE and pelvic examination) and a copy of the Pap test result as well as any other pertinent laboratory work such as stool for occult blood, hemoglobin, blood sugar, and cholesterol results. (A note from a physician such as “normal CBE needs mammogram” is not acceptable for medical record documentation).
3. The comprehensive health history form must be completed and reviewed with the patient. The height, weight, BMI and blood pressure should be obtained and recorded.
4. If the physical examination portion of the visit was completed elsewhere (within past 12 months) the nurse or clinician shall document on the physical exam form “See incoming records for the physical examination.”
5. If the provider has failed to provide documentation of ANY of the minimal requirements on the patient, the LHD is responsible for completing these components prior to referral for screening or diagnostic services.
6. It is the responsibility of the LHD to educate providers as to the minimal referral requirements of the program in order to accept patients for screening and possibly follow-up diagnostic services.

Able to contact pt by phone within 10 working days of receipt of abnormal test result or 30 days from procedure.

YES

NO

Schedule counseling appointment.

Send letter to pt. w/ regarding abnormal results & need to contact LHD.

Pt. shows for counseling appt.

Counsel, give letter w/ result & schedule follow-up. Refer to LHD/Dx contracted provider or PCP.

Did pt. contact LHD within 10 working days of letter being mailed?

YES-Schedule counseling appointment. See left side of diagram

NO-Send certified letter to pt.

Did patient keep appointment?

Assure that results are obtained & documented. Evaluate results for further need of diagnostic services.

YES-Schedule appointment. See left side of diagram.

NO-Document lost to follow-up

Send certified letter within 10 working days of missed appt. & document pt. refused.

Does pt. require further diagnostics per report?

NO-Contact pt. & counsel regarding further screening recommendation.

YES-Notify pt. & coordinate further dx procedures.

Did pt. keep secondary dx follow-up appointments for services?

NO

YES-Assure that results are obtained & documented. Contact pt. by phone within 10 working days of receipt or 30 days from procedure date to discuss further screening/dx results.

NO

Send copy of results, hx to LHD contracted provider.

Send copy of results, hx to PCP.

Could patient be reached by phone?

YES-Assure that pt. understands further screening recommendations.

YES

NO

NO

Yes-PCP follows pt.

Response from pt. within 10 working days of certified letter.