March 2006

Strategic Management and Evaluation Plan of the National Breast and Cervical Cancer Early Detection Program

Final Report

Prepared for

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Contents

1. OVERVIEW

In spring 2002, RTI International (RTI) began working with staff in the Program Services Branch (PSB) of the Centers for Disease Control and Prevention's (CDC's) Division of Cancer Prevention and Control (DCPC) to develop a comprehensive 5-year evaluation plan for the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The purpose of this plan was to specify prioritized outcomes for NBCCEDP, identify gaps in the current outcomes, and recommend ways to evaluate the program on an ongoing basis. The project team quickly realized the need for consensus among DCPC staff about future directions of the program so that the evaluation plan could be informed by internal key stakeholders and their beliefs about important indicators to incorporate into this plan. From the start, the evaluation plan has focused on the national program, rather than on grantees, and was meant to provide DCPC staff with a tool for identifying priority outcomes for the program and effectively allocating resources to evaluate program components of greatest importance. Therefore, the key stakeholders in this evaluation planning process have included DCPC staff across the Division, as well as external stakeholders who have close ties to NBCCEDP (e.g., Federal Advisory Committee).

To accomplish comprehensive evaluation planning (2002 to date), a number of processes and tools had to be developed to allow for ongoing key stakeholder input and to provide a system for implementing the plan. Appendix A summarizes the process followed to create this plan. Through a series of stakeholder sessions and using a variety of group processes, a comprehensive evaluation planning matrix (EPM) was created that specifies NBCCEDP goals, objectives, and accompanying activities and their relationship to identified program outputs and outcomes over the next 5 years (Appendix B). Using this information, DCPC now hopes to implement this strategic plan to prioritize evaluation activities. The outcomes have been divided into two types: health outcomes and program outcomes. Health outcomes are those measures specific to the women served by NBCCEDP and are generally collected through the minimum data element (MDE) system. Program outcomes focus on setting benchmarks to assess program performance and on establishing improved oversight by DCPC of individual programs. The following sections provide an overview of these two types of outcomes specific to NBCCEDP.

2. HEALTH OUTCOMES

Health outcomes are those measures related to the care provided to women served by NBCCEDP, including services delivered, timeliness of those services, and results of tests provided. DCPC has done an outstanding job identifying and monitoring health outcomes for NBCCEDP. This work began with the creation of MDEs that each grantee was required to collect and provide to CDC on a quarterly basis. Over time, measures from MDEs have been used to create data quality indicator guides (DQIGs) that DCPC uses to monitor whether individual programs have met specific measures of quality or timeliness of care. In addition, MDEs provide the basis for the NBCCEDP Government Performance Rating Act (GPRA) measures, as described below (Appendix C):

1. Increase the number of women screened (by mammogram or clinical breast exam [CBE] for breast cancer, and by Papanicolaou [Pap] test for cervical cancer).
2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years.
3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening (for breast cancer, abnormal results include abnormal mammogram [suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete] and/or abnormal CBE; for cervical cancer, abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells).
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis.
5. Increase the percentage of women with precancerous cervical lesions who start treatment within 90 days of diagnosis (includes CIN II, CIN III, and CIS).

The health outcomes specified in the EPM (see Appendix D) build on the MDE measures by focusing attention on the following:

- the characteristics of women screened to ensure that the majority of women screened fall within the prioritized age range of 50 to 64 years, are non-White, or are considered to be rarely or never screened
- the quality of screening, rescreening, and diagnostic services; the timeliness of these services; and access to treatment of those diagnosed with cancer

With the EPM work completed, three outcomes were specified that are not already a part of the GPRA and/or DQIG measures; all other outcomes represented in the EPM are tracked regularly through GPRA and DQIG mechanisms. These outcomes relate to the proportion of non-White women receiving services and potential overscreening for cervical cancer. Specific outcomes are as follows:

- (Objective 1.1) By 2007, increase to 52% the proportion of non-White women who receive a Pap test (by 2010, increase proportion to 53%).
- (Objective 1.1) By 2007, increase to 60% the proportion of non-White women who receive a mammogram (by 2010, increase proportion to 61%).
- (Objective 2.3) By 2007, move 25% of women with three consecutive normal Pap tests to a 3-year screening cycle (by 2010, move 40% of women).

3. PROGRAM OUTCOMES

As noted previously, program outcomes focus on setting benchmarks to assess program performance and on establishing improved oversight by DCPC of individual programs. As shown in Appendix E, the program outcomes for each goal have been separated from the EPM. These program outcomes fall into three general categories:

1. specific indicators for monitoring individual program performance,
2. improved oversight and management of grantee outcomes and financial management by DCPC staff, and
3. increased technical assistance to grantees and increased professional development of PSB staff.

The EPM includes several program outcomes related to increasing the number or proportion of funded programs that are meeting minimum criteria. Although the national program meets and often exceeds particular criteria on average, few individual programs do. For example, although many programs are meeting the NBCCEDP goal of screening 75% of women between ages 50 and 64, several individual programs are falling well below this goal and may need additional support and technical assistance from DCPC to achieve it. Through discussions related to this EPM, it was decided that DCPC should focus more on identifying programs that are falling below expectations so that consultation and action plans can be developed to improve their performance. Outcomes in this category focus on setting benchmarks to assess program performance and on establishing improved oversight by DCPC of individual programs:[1]

- Monitoring of the proportion of programs falling within a specified range related to program performance, including for the following program indicators:
  - increasing the proportion of women screened in the 50 to 64 age range (1.3)
  - meeting program screening projections for breast and cervical cancers (2.1)

[1]The numbers in parentheses correspond to the objectives in the EPM, which are listed in Appendices B and E.

  - having active medical advisory committees (2.2) and regularly attending professional development activities (2.3, 4.7)
  - meeting national clinical standards of care (3.3, 3.4, 3.5, 3.6)
  - managing data activities (4.5)
  - ensuring effective overall program management (6.2)
- General oversight and monitoring of programs to ensure ongoing improvement in performance indicators (2.6, 4.1, 4.2, 4.3, 4.4, 4.6, 4.8, 6.1)

During this process, it was recognized that there are gaps in the types of information available to grantees and DCPC staff to better monitor programs in relation to specific program performance indicators and to address issues more aggressively and communicate DCPC expectations more accurately. Two types of outcomes were created specific to this issue:

- provision of resources and information by DCPC for grantee use, such as through materials available on the Web site or via partners (2.4, 2.5, 4.9, 5.1, 5.2, 5.3, 5.5, 5.6, 6.5)
- provision of resources and/or training to internal DCPC staff (4.6, 6.3, 6.4)

4. LIMITATIONS

NBCCEDP is a highly complex program with extensive requirements mandated by Congress. Given all the intricacies and nuances of the program (which has been in existence since the Breast Cancer Mortality Act of 1990 was passed), as well as all the different people involved in program implementation, it has been difficult to create a comprehensive evaluation plan. However, this process has yielded a very useful set of outcomes that can now be used to better monitor and track program performance over time, ultimately resulting in improved health outcomes.

Completing the EPM was arduous and involved numerous iterations, which became tedious for staff and resulted in uneven participation among staff who had expertise in areas that may have been of benefit to the plan had they been involved throughout the process. The process lasted nearly 4 years and could have benefited from a shorter timeline and a clearer understanding of how the end result of this plan will be used. In addition, the process of obtaining information on outputs needed to complete the matrix was difficult and time-consuming. While it was initially an objective of this project to better coordinate the work being done by numerous staff to address NBCCEDP needs, maintaining an ongoing list of outputs as shown in the EPM may not be the best mechanism for achieving this objective.

5. RECOMMENDATIONS

The primary goal of this project was to systematically create an evaluation plan for the whole of NBCCEDP that could be used to better assess accomplishments and better coordinate efforts within DCPC. The EPM was created as a tool to guide that process, but it will need to be used over time to help set DCPC priorities for improving the NBCCEDP. Next steps include strategically using the EPM to link activities conducted by DCPC to program outcomes and systematically evaluating program components to achieve ongoing program improvement. The following sections outline specific strategies for moving this Plan forward.

5.1 Recommendations Related to Evaluation of Health Outcomes

Health outcomes of the NBCCEDP were established at the beginning of program implementation and have been refined over time. DCPC has done an excellent job of using these data to disseminate findings about the program, identify populations that were not being effectively reached, and guiding program development in how they can better address patient needs. For example, analysis of the MDEs indicated early in program development that a large proportion of women under age 50 were receiving services through the program. Based on this finding and the knowledge that older women are at greater risk of developing breast and cervical cancers, DCPC moved to establish a benchmark among programs where at least 75% of the women screened are age 50 or older. Through the DCPC's active MDE Committee, issues identified from the MDEs are continuously assessed and program indicators changed when needed. With the EPM, three outcomes were specified that are not currently being monitored: one focused on better monitoring of potential overscreening for cervical cancer, and two focused on increasing the proportion of non-White women screened by grantees. To address the potential for overscreening, an algorithm will need to be created to assess the baseline proportion of women who are currently being overscreened. Using this baseline, outcomes can be established to increase or maintain the benchmark so that screening can be monitored over time. The second measure of assessing the proportion of women by race/ethnicity who are receiving NBCCEDP services could now be added to the DQIGs to enable Program Consultants and others with direct contact with the programs to better monitor this indicator. While the average or baselines of these measures are rather high (59% of non-White women receiving mammograms and 51% receiving Pap tests in FY 2005), a number of programs could likely improve how well they are reaching out to women of color and benefit from technical assistance to address their public education and recruitment needs.

5.2 Recommendations Related to Evaluation of Program Outcomes

DCPC has monitored program performance very effectively, but less has been done to develop a standardized approach for setting benchmarks and improving individual program performance. Setting benchmarks can be a highly politicized process because grantees tend

to worry that their funding will be reduced or eliminated if they are unable to meet the standards. However, even though NBCCEDP is reaching many of the health outcomes for the program, individual programs are clearly having difficulty doing so and need help to actively address their problems in a more systematic way. As an example, through the EPM outcomes, it has been determined that only 16 of the current 68 NBCCEDP programs (23.5%) met or exceeded performance standards in FY 2005 (outcome for Objective 4.3, Appendix B). These performance standards have been established by PSB management as the essential elements for each program component, with each standard representing program priorities. Three steps are recommended to systematically address program outcomes:

1. PSB management prioritizes outcomes to address immediately as opposed to over time.
   - As shown in Appendices B and E, a large number of program outcomes have been stated that are not currently in the DQIG printout that Program Consultants receive for the individual programs they are assigned to assist (see Objectives 2.1, 2.2, 4.3, and 6.2 for examples). Because there are so many newly stated outcomes and because DCPC includes very busy staff, it would be worthwhile for PSB management to review these outcomes (see Appendix E).
   - Management could prioritize both the outcomes and the programs falling below specific levels (e.g., all programs that are at the lowest percentile of an outcome) that they think should be the focus of effort for the first year. Those priorities could help guide Program Consultants in knowing which issues to address with grantees first. It would also give Program Consultants guidance in which grantees to focus attention on if standards of performance are set. For example, for the outcome related to ensuring that 75% of the women receiving mammograms from programs fall between 50 and 64 years of age, it is noted that while this proportion is close to being achieved nationally, only 57% of programs were reaching that goal in program year 2004. In addition, it could be that only five grantees are performing well below expectation such that attention should be focused on them. If this outcome is viewed by PSB management as a priority for the first year, then tools and technical assistance strategies can be systematically developed to target this area of program performance. As this proportion is shown to increase over time, effort can then be shifted toward improving other outcomes.
2. Tools are created, perhaps by an internal committee, to standardize how programs are provided technical assistance to address the prioritized outcomes.
   - A few tools are available to Program Consultants to ensure standard delivery of technical assistance. However, the Program Consultants have different

communication styles and different perspectives on what they see as being important indicators to address. The EPM can be used to set priorities so that all Program Consultants are addressing the same outcomes systematically, and tools can be developed to assist in that effort. To follow the example from above, if it was agreed that the focus for the first year of implementing the EPM should be on increasing the proportion of women screened who are 50 to 64 years of age, then tools could be created that would assist Program Consultants in assessing how well a program is currently doing that and identifying areas of technical assistance that would be most helpful to provide. This tool could include a standard set of questions that the Program Consultant needs to obtain answers to in order to understand the barriers that programs are encountering in achieving this outcome and the assistance they believe they need. This form could include a place for specifying what proportion of women fall in this age range for the program, as well as a guide for asking the same set of questions to each site to help determine what is needed to systematically address this outcome. It may be that what is found through asking these questions is that there are limited health education materials available that specifically target this group of women. If this is the case, then DCPC could work with national partners such as ACS to ensure that more materials are developed and provided to grantees. Another reason this could be happening is that grantees have had varying levels of success in reaching this age group and have attempted a limited number of strategies. If this is identified as a priority measure, time could be devoted at the next Program Directors' meeting for programs that are performing well in this area to provide training on what has worked for them and to share materials they have developed that could be adapted by individual grantees. All of this would be best achieved by having a more standardized process for identifying issues grantees are facing in reaching performance indicators and how DCPC can systematically improve performance across the programs over time. Given that people are very busy and have varied perspectives on what would be helpful, it may be useful to create a Work Group or Committee of Program Consultants and others who, with guidance on what the priority outcomes are initially and then over time, can work together to develop these tools for standardized assessment and systematic provision of assistance.

3. Program Consultants and others with direct contact with individual programs are trained on assessing programs for the prioritized outcomes and using available tools accordingly.

   – If the above described process is followed, there will be an established set of priorities for each of the coming years and tools and/or strategies developed to impact related outcomes. Program Consultants and others providing direct

support to programs will then need to be trained on what the priorities are for their work and how they can best improve the program performance for grantees they are assigned to assist.

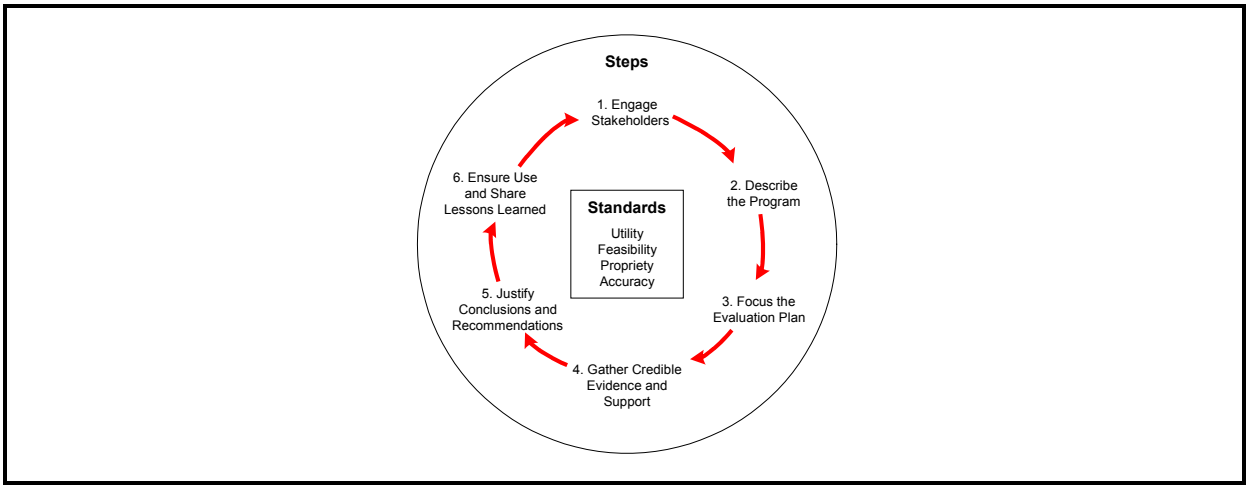
5.3 Recommendations Related to Overall Evaluation of the NBCCEDP

Overall, DCPC has done a thorough job of monitoring whether programs are reaching national benchmarks for delivering care to a specific population of women. As DCPC moves forward with its comprehensive NBCCEDP evaluation, it will be important to shift some of the focus onto what individual programs are accomplishing and how best to improve the performance of programs that are not meeting expectations. Establishing program outcomes in this EPM should help DCPC begin to shift the focus. Although there has been a concerted effort to identify programs performing poorly on certain indicators, NBCCEDP would benefit from a more systematic approach to addressing and monitoring these indicators over time and across programs. In order to focus more on program outcomes, baseline measures for each of the outcomes stated in the EPM will need to be provided and assessed. Some of the baseline measures are not currently in the EPM and will need to be added. Once these baselines are known, PSB management can then review each and develop a list of prioritized outcomes to focus on first, followed by outcomes that are long-term and considered less important to address immediately. Based on these priorities, DCPC can then develop a strategic effort for making decisions about efforts that should be funded and focusing Program Consultants' and other staff's attention on the areas of improvement that can best be addressed systematically and in a standardized way. The EPM should be viewed as a tool for DCPC to use in the ongoing assessment of activities that are underway, the prioritization of each, and the outcomes that can best lend themselves to overall program improvement. In addition, outcomes in the EPM can now be used to establish program performance measures for the upcoming revisions to the Program Announcement for renewal funding of NBCCEDP.

APPENDIX A:
SUMMARY OF THE PROCESS FOR CREATING THE NBCCEDP EVALUATION PLAN

In this appendix, we describe the process that was followed in creating an evaluation plan and presents the tools for implementing the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) evaluation in the future. Using principles introduced by Dr. Michael Quinn Patton's Utilization-Focused Evaluation (Patton, 1997), RTI began working with the Division of Cancer Prevention and Control (DCPC) in February 2002 to initiate a process for developing the 5-year evaluation plan for NBCCEDP. To ensure that evaluations are useful, this approach emphasizes involving many potential stakeholders in the planning process and implementing strategies to address the array of possible uses for the evaluation. Exhibit A-1 presents a model of effective evaluation planning using a framework adapted from CDC's "Framework for Program Evaluation in Public Health" (1999). Principles from this model were applied during "Development of a 5-Year Plan for Program Evaluation for NBCCEDP." The following section describes the process for creating the draft strategic management and evaluation plan for NBCCEDP.

Exhibit A-1. CDC's Framework for Program Evaluation—Adapted Steps for Evaluation Plan Development of NBCCEDP



Source: Centers for Disease Control and Prevention (CDC). 1999. "Framework for Program Evaluation in Public Health." *Morbidity and Mortality Weekly Report* 48(RR11):1-40.

A.1 Steps to Developing a Comprehensive Strategic Management and Evaluation Plan

A.1.1 Program Description, including History of Evaluation Work

Before developing the evaluation plan, RTI worked in spring 2002 to thoroughly understand what the program was doing, who the key stakeholders were, and what level of the plan needed to be developed. As a first step, RTI systematically reviewed NBCCEDP reports and other government documents to fully familiarize ourselves with the program. To ensure maximum use of these materials, we compiled a library of these resource materials, which included policies and procedures manuals, data users' manuals, and other program training materials and summary reports.

In March 2002, we met with key staff from across DCPC to present our approach to developing this plan and to obtain their initial input. We quickly realized that although DCPC had done a lot of work in the past to establish clear program goals and components for the implementation of NBCCEDP, goals needed to be identified for the national program office itself. With key stakeholders, we acknowledged that a strategic plan stating the program's goals, objectives, and activities was needed, and we decided to focus this plan on the national program.

In addition, we compiled an inventory of all evaluation activities that had occurred since initiation of NBCCEDP. This inventory provided an overview of the studies that were completed, results, and how the findings were used. The inventory also provided a foundation from which to build the "new" evaluation plan.

RTI conducted a thorough literature search in summer 2002 to identify and compile an inventory of publications based on NBCCEDP data. To make the information most accessible and useful to NBCCEDP staff, RTI proposed storing the data in a Microsoft Access database. Database components included

- a data entry form to allow users to easily add new publication records,
- a set of 12 queries designed to automatically pull up meaningful subsets of records (e.g., all publications that relate to goal 1), and
- a global report to automatically pull data on all records into a user-friendly format.

The database was designed to facilitate maximum use of the data by allowing users to organize and query the records in a manner that best suited their individual needs. RTI conducted a series of usability trainings with NBCCEDP staff to ensure utility of the database. Queries and reports were designed and finalized based on feedback from these trainings.

In addition to compiling this library of resource materials, RTI worked with NBCCEDP staff to develop an up-to-date inventory of publications based on NBCCEDP data. Our familiarity with these materials gives us insight into the program, which will help facilitate our efforts to help NBCCEDP finalize and effectively implement the program evaluation efforts.

Obtain Iterative Key Stakeholder Input

Using CDC's framework for program evaluation (1999), we worked with key stakeholders to identify the primary and overarching goals for NBCCEDP. Through a series of brainstorming and consensus-building group sessions, DCPC management staff across the program areas (e.g., Program Services Branch [PSB]) worked together in fall 2002 and agreed on six goals for the national program and identified how these national goals overlapped with the existing NBCCEDP program areas (Exhibit A-2).

Exhibit A-2. NBCCEDP Goals and Corresponding Program Areas

Goal	Corresponding Program Areas
1. Conduct recruitment and outreach to provide screening and rescreening to low income, medically underserved women.	Recruitment Outreach
2. Provide enrolled women with quality screening and rescreening services.	Screening Quality assurance Rescreening Professional development
3. Assure enrolled women receive timely diagnostic and treatment services.	Diagnosis Treatment Case management
4. Conduct monitoring, evaluation, and research activities for program and policy improvement.	Evaluation
5. Enhance partnerships through effective communication and coordination.	Communication Dissemination Partnerships
6. Provide sound fiscal and programmatic management of the NBCCEDP.	Management

For each goal, key stakeholders then worked to specify all current activities. This process was fairly time intensive and resulted in spending more than a year compiling the necessary information. These and other details were incorporated into an evaluation planning matrix (EPM) that specified the following:

- objectives for each goal
- program area/component related to each objective
- program activities specific to each objective
- outputs (immediate products of an activity completed within 1 year)
- intermediate outcomes (measurable within 1 to 3 years)
- long-term outcomes (measurable after 3 or more years)
- available baseline measures (e.g., 2003 baseline measures for each specified intermediate or long-term outcome)
- current indicators (i.e., whether the outcomes are already required by Office of Management and Budget [OMB] or others)
- data source (i.e., whether the data for each outcome were already available or would need to be collected)

Through this process, some key terms were defined; for example, it was decided that objectives would be stated as an overarching step that, in combination with other objectives, would lead to achievement of their corresponding goal. We made a conscious decision not to state the objectives as specific, measurable, achievable, realistic, and time-bound (SMART) because we wanted to clearly state the outcomes in measurable terms. We knew if we presented both the objectives and outcomes this way, it would be difficult to distinguish between them. We also decided to specify outputs, instead of short-term outcomes. It was believed that outputs were more important to specify because they were deliverables or products of activities and would help DCPC later generate to-do lists for staff involved in completing activities. Intermediate and long-term outcomes were differentiated by the period of time in which they were expected to be achieved, because this provided a more obvious way to track if and when outcomes were achieved.

In addition, the EPM was created to comprehensively link a variety of sources within DCPC. To do this, we included information specifying which of the outcomes were current program indicators (e.g., whether they were Government Performance and Results Act [GPRA] indicators), what the current baseline measure was for each outcome, and what potential data sources would be for any outcomes specified in the plan.

In the EPM (see Appendix B for the final version), the four columns on the left embody the strategic management plan for NBCCEDP by specifying the objectives that staff should be focusing on and the proposed activities to achieve each objective. Outputs were viewed as part of the strategic management plan because they state actual products or deliverables to be developed by DCPC to meet each specified objective. The columns on the right, from intermediate outcomes and beyond, embody the evaluation plan by specifying the outcomes for each objective. This design allows people to begin forming linkages between activities and outcomes so that the evaluation will ultimately provide feedback into continued program planning and improvement.

Once we had this structure, we began specifying objectives and activities for each of the six identified goals. With input from key DCPC staff, all available information was used to specify objectives for each goal, such as by identifying current projects and/or priorities for NBCCEDP and incorporating them into the plan. Exhibit A-3 lists the finalized goals and their corresponding objectives. The numbers in parentheses after each objective area correspond to the number assigned to the objective in the EPM (see Appendix B).

Exhibit A-3. NBCCEDP Goals and Accompanying Objectives

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women

Objectives focus on

- recruiting rarely/never screened women, those 50 years or older, and/or from priority populations (1.1–1.3); and
- increasing grantee capacity to reach eligible populations (1.4).

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services

Objectives focus on

- providing resources for breast and cervical cancer screening (2.1),
- ensuring high-quality screening and rescreening services (2.2),
- promoting breast and cervical cancer rescreening according to clinical recommendations (2.3),
- providing professional development activities (2.4–2.5), and
- conducting evaluation and/or research on provider practices (2.6).

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services

Objectives focus on

- providing timely and adequate diagnostic and treatment services for both breast (3.1, 3.3, 3.4) and cervical cancers (3.2, 3.3, 3.4),
- supporting NBCCTA (3.5), and
- providing timely and adequate case management (3.6).

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement

Objectives focus on

- maintaining and monitoring evaluation plan (4.1),
- determining appropriate outcome measures (4.2) and performance indicators (4.3),
- maintaining data systems (4.4) and evaluating data quality (4.5),
- monitoring program performance (4.6),
- building evaluation capacity among grantees (4.7),
- conducting priority evaluation and research (4.8), and
- providing information on intervention strategies that work (4.9).

Exhibit A-3. NBCCEDP Goals and Accompanying Objectives (continued)

Goal 5: Enhance Partnerships through Effective Communication and Coordination Objectives focus on ❖ disseminating information about NBCCEDP to the public, targeted audiences, CDC, and national leaders (5.1, 5.3); ❖ translating research to practice (5.2); ❖ maintaining effective partnerships (5.4) and coordinating with them to address screening needs (5.6); and ❖ participating in Community Guide development (5.5).
Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP Objectives focus on ❖ developing and maintaining a strategic management plan (6.1), ❖ managing NBCCEDP cooperative agreements (6.2), ❖ establishing standards for providing technical assistance to grantees (6.3) and training PSB staff accordingly (6.4), and ❖ providing TA for grantees (6.5).

Prioritize Activities and Outcomes

Once the EPM was initially drafted, we identified key staff within DCPC to provide input into and comment on comprehensive development of each program area of the matrix. DCPC management supported this step and encouraged key staff to participate and respond. After providing the EPM for review, each identified staff member was interviewed in spring 2003 to obtain detailed input on each of the following issues, with an attempt to meet the standards set forth by CDC and the American Evaluation Association (AEA) (as shown in parentheses):

- What is your overall impression of the breadth and depth of the information provided in the matrix (i.e., what is the utility of each statement)?
- What would you change about the statements made within the matrix for your area of expertise (i.e., how accurate is the information)?

- What else would you like to see included in the matrix in terms of developing your area of expertise (i.e., to what extent could the information in the matrix show more propriety)?
- Which of the statements in the matrix do not seem feasible to complete (i.e., how feasible do the outcomes seem)? Why?

The CDC and AEA standards suggest that evaluations should serve the information needs of intended users (i.e., utility); be realistic, diplomatic, and frugal (i.e., feasible); behave legally, ethically, and with regard for the welfare of those involved and those affected (i.e., propriety); and reveal and convey technically accurate information (i.e., accuracy) (CDC, 1999). By using these standards early in the evaluation planning process, we ensured that the resulting plan would be applicable to DCPC and NBCCEDP.

After each step, the EPM was revised and appropriate comments were incorporated so that key management staff could then further review and refine the matrix. At this stage of development, we also asked the NBCCEDP Council's Strategic Planning Committee to review and comment on the plan. To accomplish this, we attended one of their meetings in July 2003 and facilitated a group process to obtain their comments. The plan was also presented to the NBCCEDP Federal Advisory Council for review and comment in December 2004. The plan was revised after each set of comments were reviewed.

APPENDIX B:
NBCCEDP STRATEGIC MANAGEMENT AND EVALUATION PLAN

Appendix B: NBCCEDP Strategic Management and Evaluation Plan

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Recruit-ment	1.1 Promote the recruitment of women from priority populations for screening.	1.1.a Develop population-based estimates of eligible women by race/ethnicity and age for each state.	Goals established for each grantee program on the percentage of eligible and priority women to screen for Pap test/ mammogram.	By 2007, increase to 52% the proportion of non-White women who receive a Pap test.	By 2010, increase to 53% the proportion of non-White women who receive a Pap test.	*PY05 = 51%*		MDE	PSB
				By 2007, increase to 60% the proportion of non-White women who receive a mammogram.	By 2010, increase to 61% the proportion of non-White women who receive a mammogram.	PY05: 59%			
				By 2007, increase the number of women screened for breast cancer to 550,000.	By 2010, increase the number of women screened for breast cancer to 575,000.	Breast FY02: 394,146 *FY03: 537,619*	GPRA, DQIG		
				By 2007, increase the number of women screened for cervical cancer to 350,000.	By 2010, increase the number of women screened for cervical cancer to 375,000.	Cervical FY02: 280,330 FY03: 304,407	GPRA, DQIG		

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women										
					Outcomes					
Program Area	**Objectives**		**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Recruitment	1.2	Promote the increased recruitment of rarely and never (R/N) screened women for cervical cancer screening.	1.2.a Identify effective strategies for recruiting R/N screened women. 1.2.a.1 Identify geographic areas where R/N women are likely to reside. 1.2.a.2 Establish partnership with USDA/NCI to increase cervical and breast cancer screening in high mortality counties.	Plan for expanded GIS use as appropriate. Update GIS state-specific maps Web-based GIS tools for grantees. Web-based Clearinghouse for recruitment strategies/tools. Report for grantees of effective outreach strategies for R/N screened women.	By 2007, at least 20% of women screened for cervical cancer are rarely/ never screened among 95% of grantees.	By 2010, at least 22% of women screened for cervical cancer are R/N screened among 95% of grantees.	R/N screened women: FY00: 21.7% FY01: 22.9%	GPRA; DCPC Goal 1.D, 2.D, 8.D, 10.B	MDE	EARB
					By 2007, maintain the percentage of R/N screened women for cervical cancer at or above 22.5%.	By 2010, increase the % of R/N screened women for cervical cancer to 26%.		DQIG 6a		
Recruitment	1.3	Promote the recruitment of women aged 50–64 for breast cancer screening.	1.3.a Identify effective strategies for recruiting women aged 50–64. 1.3.a.1 Identify geographic areas where women aged 50–64 who are program eligible reside.	Update GIS state-specific maps. Web-based Clearinghouse for recruitment strategies/tools. Report for grantees of effective outreach strategies for women aged 50–64	By 2007, increase to 75% the percentage of women aged 50–64 receiving mammograms.	By 2010, maintain CDC target of 75% of women aged 50–64 receiving mammograms.	PY03: 73% PY04: 71%	DQIG 19e DCPC Goal 8.D	MDE	PSB EARB
					By 2007, increase to 85% or more the proportion of grantees that reach the target goal of 75% for proportion of women aged 50–64 receiving mammograms.	By 2010, increase to 88% or more the proportion of grantees that reach the target goal of 75% for proportion of women aged 50–64 receiving mammograms.	PY03: 41/68, 60% PY04: 39/68, 57%	DQIG 19e		

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Outreach	1.4 Increase grantee ability/capacity to reach the eligible population.	1.4.a Provide outreach training to grantees. 1.4.b Maintain listserv and Web forum for outreach coordinators. 1.4.c Disseminate effective outreach strategies included in the Community Guide. 1.4.d Partner with national organizations to support outreach activities.	Biennial training on outreach to 68 grantees. Quarterly conference calls of outreach coordinators. Maintain Web forum with public education information/resources. Dissemination plan. Formal partnerships maintained or established.	By 2007, increase to 18% the proportion of eligible women aged 40–64 screened by the NBCCEDP.	By 2010, increase to 20% the proportion of eligible women aged 40–64 screened by NBCCEDP.	Breast (age 40-64) CY00-01: 12% CY01-02: 13% Cervical (age 18-64) CY99-01: 16% CY00-02: 16%	DCPC Goal 10.C	MDE: population estimate	PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Screening	2.1 Provide resources for breast and cervical cancer screening.	2.1.a Develop national projections for delivery of screening services based on available resources and infrastructure type. 2.1.a.1 Conduct a study to assess how costs of programs can be measured. 2.1.a.2 Develop technical assistance tools to track and estimate costs. 2.1.b Monitor screening services provided through semiannual MDE reviews. 2.1.b.1 Identify deficiencies and address with each grantee as needed.	Report on study results. Cost measures for monitoring programs. Ongoing technical assistance to grantees. Annual review of Clinical Cost Worksheet (CCW). Other technical assistance tools to track and estimate costs. Action plan to address deficiencies.	By 2007, 50% of grantees will provide a minimum of 90% of projected Pap tests and mammograms annually. Breakdown of national data includes 1. the number of programs meeting projections, and 2. the percentage of national projection reached by all programs.	By 2010, 70% of grantees will provide a minimum of 95% of projected Pap tests and mammograms.	FY00—Not available FY01 Breast: 77%/nat'l (16/67 grantees—29%) FY01 Cervical: 83%/nat'l (21/67 grantees—31%)	GPRA "Indicators" DCPC Goal 2.C, 5.A	MDE	PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Quality Assurance	2.2 Ensure grantees provide high-quality screening and rescreening services.	2.2.a Participate in national meetings and dialogue with national groups (e.g., ACOG) about clinical practice issues as needed. 2.2.b Develop, promote, and disseminate through Breast and Cervical Cancer expert panels relevant policies reflecting current clinical practice as needed. 2.2.c Support grantees' use of their Medical Advisory Boards or Advisors.	Ongoing updates of algorithms and clinical guidelines about diagnostic services. Revised NBCCEDP policies and procedures manual.	By 2007, 90% of all grantees will have an active Medical Advisory Committee (MAC).	By 2010, 100% of grantees will have clinical guidelines reviewed annually by MAC and revised if needed.		DCPC Goal 2.B, 6.B, 6.C, 8.E, 9.D, 9.E	Could be STAR, MDE	PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Quality Assurance		2.2.d Monitor quality of screening services through semiannual MDE review. 2.2.d.1 Identify deficiencies and address with each grantee as needed. 2.2.e Conduct study (TO) to assess the extent to which program infrastructure and practices may contribute to or reduce disparities between service experiences of White versus non-White women screened by NBCCEDP.	Ongoing technical assistance to grantees. Action plan to address deficiencies.						

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Re-screening	2.3 Promote breast and cervical cancer rescreening according to clinical recommen-dations.	2.3.a Monitor breast and cervical cancer rescreening rates. 2.3.a.1 Identify deficiencies and address with each grantee as needed. 2.3.b Develop a screening algorithm to assess rates of rescreening and overscreening for cervical cancer in light of new clinical guidelines. 2.3.c Revise DQIG to include re-screening measures and targets for breast and cervical cancer.	Ongoing technical assistance to grantees. Action plan to address deficiencies.	By 2007, 25% of women with three consecutive normal Pap tests moved to a 3-year screening cycle.	By 2010, 40% of women with 3 consecutive normal Pap tests will move to a 3-year screening cycle.	Algorithms need to be reviewed and then baseline figures can be calculated and targets validated.	None	MDE	MDE Committee

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Professional Development	2.4 Promote professional education activities of grantees.	2.4.a Maintain professional education Web forum to share resources and support. 2.4.b Conduct an inventory of provider training topics, including materials and strategies, currently used by grantees.	Web forum with professional education resources. Inventory of provider training curricula/topics/ materials.	By 2007, disseminate a completed evaluation of NBCCEDP Web site usage by grantees.			DCPC Goal 6.A, 11.D	Could be STAR	PSB
		2.4.c Coordinate quarterly professional education conference calls. 2.4.d Coordinate meetings of grantees' professional education coordinators. 2.4.d.1 Use meetings to address deficiencies identified in Objective 2.2.	Quarterly professional education calls. Professional education meetings for grantees.	By 2007, 75% of grantees will participate in the professional education quarterly conference calls at least twice per year. On an annual basis, disseminate two new available and appropriate curricula/ training resources.	By 2010, 80% of grantees will conduct a professional education needs assessment among their providers. Sustain available and appropriate training curricula and resources to grantees.				

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 2: Provide Enrolled Women with Quality Screening and Rescreening Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Professional Development	2.5 Provide national training and technical assistance on priority clinical areas.	2.5.a Develop professional education training for follow-up of abnormal breast exams and clinical practice standards for CBE. 2.5.b Develop standardized tools as needed to support professional development.	Dissemination of national clinical practice standards and teaching manual for CBEs. Four modules for PCPs on follow-up of abnormal imaging and clinical findings for breast cancer detection. Other breast and cervical cancer tools yet to be determined.	National standards for CBE promoted by other national organizations. Increase in trainers using national standards.	Increase in the number of medical schools adopting the national standards. Increase in PPV of CBE in the national program.				PSB
Professional Development	2.6 Conduct evaluation and/or research regarding provider practices.	2.6.a Implement findings from focus group study report of MD and non-MD providers.	Other breast and cervical cancer tools yet to be determined.	Conduct annual survey of providers assessing their knowledge, attitudes, and behaviors toward B&C practices.	Increase in the amount of research directly related to provider B&C practices.				PSB/EARB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Diagnosis	3.1 Among women screened, diagnose breast cancer at an early stage.	3.1.a Monitor stage of diagnosis for initial and rescreened breast cancer cases. 3.1.a.1 Identify disparities in stage of diagnosis across racial/ethnic groups. 3.1.a.2 Develop a measure that would reflect changes in disparity of cancer stage across racial groups. 3.1.b Develop practice guidelines for collecting stage information for breast cancer and a protocol for linkage with cancer registry.	Practice guidelines for gathering stage data and protocol for linkage with cancer registry. Report on results from Linkage Study. Ongoing technical assistance to grantees.	By 2007, excluding breast cancers diagnosed in an initial screening, at least 70% of women aged 40 and older will be diagnosed at the localized stage. **2-year reporting lag	By 2010, excluding breast cancers diagnosed in an initial screening, at least 75% of women aged 40 and older will be diagnosed at the localized stage. (For internal use, not GPRA.) **2-year reporting lag	CY02 = 79% CY03 = 74% CY04 = 65%	GPRA DQIG (14)	MDE	PSB
				By 2007, 90% of the reported cervical stage data will have stage reported.	By 2010, 95% of the reported cervical stage data will have stage reported.	NEED BASELINE			
				At least 75% of grantees will link MDE to cancer registry data by 2007.	At least 90% of grantees will link MDE to cancer registry data by 2010.	NEED BASELINE			

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Diagnosis	3.2 Among women screened, diagnose cervical cancer at an early stage.	3.2.a Monitor age-adjusted rate of cervical cancer annually. 3.2.b Keep abreast of changing testing technologies and make appropriate policy recommendations to grantees. 3.2.b.1 Integrate new technologies into policy recommendations as appropriate. 3.2.c Convene expert panels on cervical policy and on breast policy that will lead to recommendations.	Assess new technologies through research as available and provide relevant guidance to grantees. Report on policy recommendations.	By 2007, excluding invasive cervical cancers diagnosed on an initial screen, maintain the age-adjusted incidence rate of invasive cervical cancer in women aged 18 and older to not more than 15/100,000 tests.	By 2010, excluding invasive cervical cancers diagnosed on an initial screen, lower the age-adjusted incidence rate of invasive cervical cancer in women aged 18 and older to not more than 13/100,000 tests.	FY02 = 15/100,000 FY03 = 15/100,000 FY04 = 17/100,000	GPRA DCPC Goal 8.E	MDE	PSB
				By 2007, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 18–29.	By 2010, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 18–29.	NEED BASELINE			

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
Diagnosis				By 2007, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 30 and older.	By 2010, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 30 and older.	NEED BASELINE			
				By 2007, 90% of the reported cervical stage data will have stage reported.	By 2010, 95% of the reported cervical stage data will have stage reported.	NEED BASELINE			
				By 2007, at least 75% of grantees will link MDE to cancer registry data.	By 2010, at least 90% of grantees will link MDE to cancer registry data.				

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
Diagnosis	3.3 Provide timely and adequate diagnostic services to women receiving abnormal breast and/or cervical cancer screening results.	3.3.a Monitor the time between abnormal screening results and final diagnosis. 3.3.a.1 Identify deficiencies and address with each grantee as needed. 3.3.b Conduct study to assess the extent to which program infrastructure and practices may contribute to or reduce disparities between service experiences of white versus non-white women screened by NBCCEDP. 3.3.c Develop strategies to address the challenges of providing timely diagnostic services.	Ongoing technical assistance to grantees Action plan to address deficiencies Breast and cervical cancer tools yet to be determined	By 2007, 86.5% of women with breast and 64% of women with cervical abnormalities will receive a final diagnosis within 60 days.	By 2010, 92% of women with breast and 66% of women with cervical abnormalities will receive a final diagnosis within 60 days.	**Breast—** FY00 = 82.2% FY01 = 83.6% FY03 = 81.8% **Cervical—** FY00 = 61.2% FY01 = 61.9% FY03 = 61.4%	GPRA DQIG (16d, 25d) DCPC Goal (10.A)	MDE	PSB
				By 2007, 85% of funded programs will meet CDC standards for timeliness of diagnostic follow-up of women with an abnormal screen result.	By 2010, 90% of funded programs will meet CDC standards for timeliness of diagnostic follow-up of women with an abnormal screen result.	Breast: Py03: 63/38, 93% Cervical: Py03: 41/68, 60%	DQIG (10, 11a, 16d, 20a, 25d, 26)		
Treatment	3.4 Provide timely access to treatment services for women diagnosed with cancer or pre-cancer.	3.4.a Monitor the time between diagnosis to treatment initiation. 3.4.a.1 Identify deficiencies and address with each grantee as needed. 3.4.b Develop strategies to address the challenges of providing timely treatment services.	Ongoing technical assistance to grantees Action plan to address deficiencies Breast and cervical cancer tools yet to be determined	By 2007, 95% of programs will meet CDC standards for timeliness to treatment following a diagnosis of cancer.	By 2010, 97% of programs will meet CDC standards for timeliness to treatment following a diagnosis of cancer.	Breast: PY04: 68/68, 100% Cervical: PY04: 63/68, 93%	DQIG (17, 18d, 18g, 27d)	MDE	PSB
				By 2007, 94% of women with precancerous cervical lesions (CINII, CINIII, CIS) will initiate treatment within 90 days.	By 2010, 94.5% of women with precancerous cervical lesions will initiate treatment within 90 days.	FY03 = 90.6% for cervical; 93.8% for breast	GPRA		

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
Treatment	3.5 Address implementa-tion challenges of the National Breast and Cervical Cancer Treatment Act (NBCCTA).	3.5.a Facilitate grantee dialogue regarding the NBCCTA. 3.5.b Assess the impact of the NBCCTA in collaboration with CMS and GWU. 3.5.b.1 Evaluate the fiscal and resource impact of the NBCCTA. 3.5.c Assess % and timeliness of women with cancer accessing treatment before or after NBCCTA. 3.5.d Monitor % and number of states that change and/or restrict adoption of the NBCCTA. 3.5.d.1 Develop strategies to address restrictions in state policies through current partnerships.	Web site resources Profiles of NBCCTA implementation in 51 states Report on implementation of NBCCTA in 16 states Report on findings from seven case studies Update inventory of states with active NBCCTA Strategies to work with partners to impact state implementation of NBCCTA	By 2007, 100% of states will maintain NBCCTA.	States will maintain NBCCTA By 2010, assess the efficiency of resources for women screened in the program.	FY04 = 100% grantees	DCPC Goal 10.B	Could be STAR	PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services									
Case Manage-ment	3.6 Support the provision of timely and adequate case management (CM) to women with abnormal screening results.	3.6.a Provide CM training and information to grantees. 3.6.b Coordinate quarterly conference calls for case managers. 3.6.c Manage and facilitate CM resources on Web forum. 3.6.d Evaluate the implementation of CM in collaboration with U of Michigan.	One CM training each 2 years for grantees Quarterly conference calls for grantees CM literature review Web forum CM materials Results of CM implementation study	By 2007, at least 90% of programs will have CM protocols consistent with CDC case management policy.		Need baseline regarding CM protocols/policy	DQIG 26, 18g	Could be STAR, MDE	PSB, OPPI
				By 2007, 95% of programs will meet CDC standards for timeliness to treatment following a diagnosis of breast or cervical cancer.	By 2010, 97% of programs will meet CDC standards for timeliness to treatment following a diagnosis of breast or cervical cancer.	Breast: PY04: 68/68, 100% Cervical: PY04: 63/68, 93%			

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Evaluation	4.1 Maintain a monitoring and evaluation plan for NBCCEDP.	4.1.a Develop and disseminate strategic and evaluation plan with identified priorities. 4.1.b Update strategic and evaluation plan annually. 4.1.c Conduct evaluation activities as specified.	Comprehensive monitoring and evaluation plan in the Access database Key stakeholders made aware of plan Annual updated strategic and evaluation plan	By 2007, 10% of CDC internal use NBCCEDP resources will be allocated to monitoring and evaluation activities.	By 2010, 12% of internal use NBCCEDP resources will be allocated to monitoring and evaluation activities.		DCPC Goal 8.B		PSB
Evaluation	4.2 Determine outcome measures for NBCCEDP.	4.2.a Revise the current RTI TO for the evaluation plan to develop new/revised outcome measures through input from key stakeholders.	New outcome measures Revised policy and program changes Publication of NBCCEDP outcomes	By 2007, 75% of objectives reflected in this Plan will have specific outcomes. By 2007, 95% of PSB staff will be knowledgeable of NBCCEDP Plan objectives and outcomes.	By 2010, 80% of objectives reflected in this Plan will have specific outcomes. By 2010, all new existing PSB staff will be knowledgeable of NBCCEDP Plan objectives and outcomes. Future outcome measures for NBCCEDP will be updated and revised as appropriate.	34/35 objectives (97%) have at least one outcome.	N/A	MDE STAR Budget	DCPC

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Monitoring	4.3 Maintain indicators of program performance that reflect program priorities.	4.3.a Annually revise set of indicators used to assess program performance. 4.3.a.1 Meet with PD Council to determine performance-based program indicators.	Annual summaries of grantee performance based on indicators.	By 2007, PSB management to develop a list of indicators of program performance for the "essential elements" for each program component that reflect program priorities.	By 2010, we will use the 11 core DQIG performance indicators and the national spend rate to determine the improvement in priority program performance areas.	16/68 (23.5%) programs met or exceeded performance standards in 2005.	"Indicators" DCPC Goal 5.B, 8.A, 8.B	MDE STAR Budget	OD, EARB, PSB
				By 2007, increase proportion of grantees to 26% that meet/exceed performance measures.	By 2010, increase proportion of grantees to 28% that meet/exceed performance measures.				
Monitoring		4.3.b Assess grantees on specific data quality indicators and other performance measures. 4.3.c Develop strategies for tying program performance to allocated funding.	Action plan with grantee to address issues Strategies for program accountability	By 2007, PSB management has set up performance-based funding and improves both individual program and national performance by assessing the 11 core DQIG indicators and national spend rate.	By 2010, performance-based budgeting is being used for all NBCCEDP programs.				

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Evaluation	4.4 Maintain data sets/ systems for NBCCEDP.	4.4.a Revise STAR data set. 4.4.b Maintain MDE data set. 4.4.c Secure IRB and OMB approvals 4.4.c.1 Obtain updated IRB/OMB approval as needed.	Revised STAR data set Annual revision of MDE variables Bimonthly MDE committee meetings IRB/OMB approvals	By 2007, 100% of data collected are reported and used by DCPC and/or grantees. Revise systems to ensure data necessary to manage and monitor programs.	Change reporting requirements as program performance indicators are defined and/or revised.		DCPC Goal 8.A	Could be STAR	PSB, MDE committee
Research Activities	4.5 Evaluate MDE data quality.	4.5.a Conduct Validation Study to verify MDE data in selected states in collaboration with SAIC. 4.5.b Conduct Linkage Study to match MDE data to Cancer Registry data. 4.5.c Conduct regular data quality checks and feedback through semiannual MDE review. 4.5.c.1 Identify deficiencies and address with each grantee as needed. 4.5.d Collaborate with MDE committee on an ongoing basis.	Report on study findings Publication of study results Report on study findings Revised guidance to grantees on linkage with registries Publication of study results Ongoing technical assistance to grantees Action plan to address deficiencies	By 2007, 75% of grantees will conduct linkages with cancer registry.	By 2010, 90% of grantees will conduct linkages with cancer registry.	Approximately 70% of programs have done "some" type of linkage with registry at "some point in the past" (49 of 68). Approximately 46% of programs have done "some" type of linkage with registry within last year (21 of 68).	DCPC Goal 8.B	MDE, Registry data	EARB/PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Evaluation	4.6 Monitor NBCCEDP program performance.	4.6.a Conduct semiannual MDE reviews. 4.6.a.1 Identify deficiencies and address with each grantee as needed. 4.6.b Conduct annual STAR reviews. 4.6.c Conduct annual aggregate performance indicator for PART and GPRA reviews.	Summary progress reports Action plan to address deficiencies	By 2006, a common approach to monitoring performance will be described and implemented within PSB. By 2007, PCs are using tools and trained in monitoring 100% of grantees (i.e., PMA, DQIG, and PBD processes).	New PCs are trained on tools and monitoring performance during their orientation.		DCPC Goal 8.C	MDE, could be STAR	PSB
				By 2007, 100% of grantee program performance monitoring will be maintained.	By 2010, maintain performance monitoring for all grantees.				
Evaluation	4.7 Build the evaluation capacity of grantees.	4.7.a Develop a Web-based training series on program evaluation. 4.7.b Ensure that system complies with National Chronic Disease Surveillance System (NCDSS).	Evaluation training series	By 2006, provide evaluation training to 100% of grantees.			DCPC Goal 8.C		PSB
				By 2006, 90% of grantees can demonstrate evaluation of program activities.	By 2010, 100% of grantees are conducting evaluation in accordance with evaluation guidance.				

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Research Activities	4.8 Conduct priority evaluation and research as identified by Division.	4.8.a Establish systematic means to identify evaluation priorities, including:	Reports on results from each study	By 2006, program priorities will guide the selection of competing proposals for discretionary funding. Program management and strategic priorities will inform division proposals for discretionary funding decisions.	By 2010, priorities of the NBCCEDP are supported.		DCPC Goal 2.B		PSB
Research Activities		4.8.a.1 Quality of care study to compare NBCCEDP services to those received by women through other funding sources. 4.8.a.2 Develop study to demonstrate the value added to a grantee's infrastructure through NBCCEDP funding.							

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	Objectives	DCPC Program Activities	Outputs/Products (FY '05)	Intermediate (1–3 years)	Long-Term (>3 years)	Measure	Current Indicator	Data Source (MDE, STAR, Budget, Census)	Accountability
		4.8.a.3 Determine service delivery systems that are most effective in delivery of NBCCEDP.							
		4.8.a.4 Conduct secondary data analysis to examine stage at diagnosis, cancer treatment, determinants of screening behavior, and survival of cancer patients.							
		4.8.a.5 Conduct research on interventions to promote cancer screening or impact informed decision making.							
		4.8.b Conduct a study to assess how costs of programs can be measured.	Report on study findings				PART DCPC Goal 2.C, 5.A		EARB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
		4.8.b.1 Determine factors influencing the cost of specific diagnostic and treatment procedures.							
Research Activities		4.8.b.2 Assess relationship between grantee program infrastructure, volume of women screened, and costs. 4.8.b.3 Determine cost measures to be collected by grantees. 4.8.b.4 Revise current data collection strategies as needed.							
Research Activities	4.9 Provide information on inter-vention strategies that work.	4.9.a Conduct studies on innovative interventions. 4.9.b Evaluate interventions to determine if they work. 4.9.c Conduct intervention research to determine what works.	Dissemination of findings	By 2007, at least four avenues of information resources will be available to grantees (i.e., Community Guide and needs assessment for evaluating interventions).	By 2010, two additional information sources have been developed for grantees (for a total of six).				PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 5: Enhance Partnerships through Effective Communication and Coordination									
				Outcomes					
Program Area	Objectives	DCPC Program Activities	Outputs/Products (FY '05)	Intermediate (1–3 years)	Long-Term (>3 years)	Measure	Current Indicator	Data Source (MDE, STAR, Budget, Census)	Accountability
Communi-cation	5.1 Provide information about NBCCEDP to U.S. public and other targeted audiences.	5.1.a Determine action plan for strategically presenting display and other materials about NBCCEDP to reach broadest audience of public health professionals.	Listing of conferences and channels for marketing program nationally Strategic plan of NBCCEDP marketing efforts	Increased public knowledge of services available through NBCCEDP	By 2010, have concerted national media campaign with national partners related to availability of screening services through NBCCEDP.		DCPC 11.A	MDE for Epi data	OPPI, PSB
		5.1.b Maintain NBCCEDP Web site.	Number of hits on NBCCEDP Web site Number of hits to NBCCEDP screening summary data pages on the CDC Web site	By 2007, the NBCCEDP home page will be receiving 17,100 hits/quarter. By 2007, increase hits to screening summary data pages to 650 visits/month.	By 2010, expand data content on the Web summaries to meet new requirements for information.	CY05: 5,697 hits/month CY05: 550 visits/month			
		5.1.c Evaluate DCPC's breast and cervical cancer-related Web sites.	Evaluation report of Web sites with recommendations						
		5.1.d Develop annual program report with comprehensive epidemiology data.	Published report of NBCCEDP epidemiology data every 5 years						
		5.1.e Collaborate with grantees to develop public reports of key performance indicators.	Biannual report on NBCCEDP						

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 5: Enhance Partnerships through Effective Communication and Coordination									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Dissemination	5.2 Establish mechanisms to help translate research findings into practice.	5.2.a Develop an index of NBCCEDP-related studies for posting on Web site. 5.2.b Provide presentations to grantees on studies at Program Director meetings. 5.2.c Identify effective interventions through Community Guide, etc., for dissemination. 5.2.d Provide training to program consultants about interventions that work. 5.2.e Facilitate meetings with experts regarding "best practice."	Index of studies updated biannually Information on studies through Web sites and conferences Ongoing technical assistance to grantees Meetings on best practice	By 2007, interventions from the Community Guide will be disseminated to our grantees • RTIPS • grantee training • assess grantee interventions • PRC cancer network By 2007, CPCRN will have provided two in-services to our grantees.	By 2010, increase availability of evidence to grantees and partners. By 2010, increase availability of intervention tools provided to grantees and partners. By 2010, increase use of research findings as documented by evidence-based proposals funded through NBCCEDP.		DCPC Goal 11.A, 11.D	MDE, Inventory	OPPI, PSB
Communication	5.3 Provide information about NBCCEDP to CDC and national leadership.	5.3.a Participate in CDC annual program review process held by Center. 5.3.b Conduct annual aggregate performance indicator for PART and GPRA reviews. 5.3.c Respond to Congressional inquiries.	Annual program review report GPRA/PART reports Reports to Congress	By 2006, improve PART score from 2004. By 2007, increase the number of presentations above the division level.	By 2008, improve PART assessment to indicate results achieved. By 2010, increase understanding among internal partners.	FY2004 (PART score): 100% program purpose/ design; 71% strategic planning; 64% program mgmt; 25% program results; Average 65%[2]	DCPC Goal 11.A	MDE Budget	PSB, OPPI

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 5: Enhance Partnerships through Effective Communication and Coordination									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Partner-ships	5.4 Maintain effective partnerships with key stakeholders and establish new partnerships to help extend reach and effectiveness of NBCCEDP and reduce disparities.	5.4.a Develop partnership framework to manage partnerships. 5.4.a.1 Work to improve relationships with partners (e.g., ACS, NCI). 5.4.b Maintain cooperative agreements with key external partners (e.g., ACS, NCI). 5.4.c Maintain partnerships with internal CDC programs (e.g., WISEWOMAN, comprehensive cancer control [CCC]). 5.4.d Participate via subcommittee liaisons in monthly communication with NBCCEDP Council. 5.4.e Facilitate NBCCEDP National Advisory Council meetings.	Approved partnership framework Tools for developing partnerships Written agreement with external partners Conduct joint annual meetings Annual meeting				DCPC Goal 10.C, 11.A. 11.C		PSB, OPPI

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 5: Enhance Partnerships through Effective Communication and Coordination									
				Outcomes					
Program Area	**Objectives**	**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Partner-ships	5.5 Participate in development of Community Guide to identify evidence-based cancer interventions.	5.5.a Participate in Community Guide Work Group meetings. 5.5.b Develop a "best practice" agenda to discuss with grantees. 5.5.c Promote specific evidence-based interventions.	Recommendations for best practice. Materials and trainings on specific interventions.	By 2007, cancer component of Community Guide is published.	By 2010, revise current cancer component of Community Guide (adding new sections—e.g., IDM).				PSB
Partner-ships	5.6 Coordinate with partners to effectively address the needs of women that NBCCEDP does not have the resources to screen.	5.6.a Enhance communication with partners to educate them on effective recruitment strategies. 5.6.b Assess grantee legitimate interaction with CCC programs.		By 2007, develop multi-year joint strategies (i.e., communication, advocacy, field collaboration, recruitment/outreach, data sharing, quality improvement, and patient navigation) with ACS to identify additional resources to address unmet need among priority populations.	By 2010, funding equal to 1/3 of the NBCCEDP budget is made available through partnerships and other resources to address unmet needs.				PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP										
					Outcomes					
Program Area	**Objectives**		**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Management	6.1	Develop and maintain a strategic management plan for NBCCEDP.	6.1.a Collaborate with key stakeholders to develop a 5-year strategic plan and incorporate into a computer system for ongoing use. 6.1.b Monitor and assess emerging issues with partners.	Produce logic models with stakeholder input. Prepare planning matrix for ongoing review and updates.	By 2007, Management and Evaluation Plan (MAEP) is approved by mgmt and matrix is created.	Improve PART score. By 2010, key partners share common understanding/ expectations of NBCCEDP performance.	PART score (see Objective 5.3)			PSB
					By 2007, MAEP is reviewed and revised on an annual basis. MAEP is communicated to key partners.	By 2010, MAEP is used by all management staff on an annual basis.				
Management	6.2	Manage NBCCEDP cooperative agreements.	6.2.a Facilitate annual application process.	RFP/continuation guidance document Technical reviews on applications	By 2007, 80% of grantees submit accurate FSRs by 11/1/05.	By 2010, 90% of grantees submit timely component-specific FSR.	FY05: 33% with accurate FSRs			PSB
			6.2.b Respond to formal grantee requests (e.g., unobligated requests, redirection of funds, release of restrictions) within ___ (#) days.	Update NBCCEDP Policy and Procedure manual.	Reduction of unobligated funds through performance-based criteria for funding.					
			6.2.c Track unobligated balances in collaboration with PSB/OD and PGO for NBCCEDP grantees.	–Track # of revisions. –Track % of total change.						
			6.2.d Assure 60/40 compliance.							

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP										
					Outcomes					
Program Area	**Objectives**		**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Management			6.2.e Identify grantee programs in the low range of MDE and fiscal information measures. 6.2.e.1 Address deficiencies with grantees as needed.	Action plans developed with grantees to address issues in consultation plan.	Ensure performance-based distribution of funds through increase in programs that qualify through the following 3 criteria: 1. PMA score increase 2. Spending ratio and unobligated balance available 3. Increase in key MDE indicators		Need baseline			
Management	6.3	Establish standards for technical assistance provided to grantees.	6.3.a Develop tools to assist program consultants in providing standardized technical assistance.	Maintain and revise site visit monitoring tool. Training package for program consultants	By 2007, all programs have a current consultation plan. By 2007, establish standard response protocol for programs with significant deficiencies in performance. By 2007, 100% of deficient programs get scrutiny at higher level.	By 2010, maintain that all programs have a consultation plan and are receiving standard help in addressing deficiencies.				PSB

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP										
					Outcomes					
Program Area	**Objectives**		**DCPC Program Activities**	**Outputs/Products (FY '05)**	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	**Measure**	**Current Indicator**	**Data Source (MDE, STAR, Budget, Census)**	**Accountability**
Management	6.4	Provide training to PSB Program staff.	6.4.a Provide orientation to new program consultants. 6.4.b Train program consultants on developing consultation plan. 6.4.c Support training opportunities annually for DCPC staff.	Updated consultation plan	By 2007, 100% of the program consultants complete a customized training within the first 6 months of hire.	By 2010, maintain training expectations for program consultants.				PSB
					By 2007, 100% of staff have taken grants management training.					
					By 2007, staff are available with skills in AI/AN, cultural competency, and territories.	By 2010, maintain cultural-competency skills in multiple cultures.				
					By 2007, 80% of staff completed an IDP.	85% of staff have taken a course identified on their IDP.				

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP										
					Outcomes					
Program Area	Objectives		DCPC Program Activities	Outputs/Products (FY '05)	Intermediate (1–3 years)	Long-Term (>3 years)	Measure	Current Indicator	Data Source (MDE, STAR, Budget, Census)	Accountability
	6.5	Provide technical assistance to grantees.	6.5.a Coordinate monthly conference calls with grantees.	Site visit every 18 months	Increase in participation in subject matter conference calls.		Need baselines			PSB
			6.5.b Provide additional technical assistance via e-mail/telephone as needed.		By 2007, establish lead technical experts in the following B&C program components: • Quality assurance and improvement • Recruitment • Partnerships • Data Management • Management • Evaluation • Professional development • Screening	By 2010, maintain technical expertise in each of the eight B&C program components.				
					Increase to X% the PDs using the Web forum.	Increase to X% the PDs using the Web forum.	Need baseline			

Appendix B: NBCCEDP Strategic Management and Evaluation Plan (continued)

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP									
				Outcomes					
Program Area	Objectives	DCPC Program Activities	Outputs/Products (FY '05)	Intermediate (1–3 years)	Long-Term (>3 years)	Measure	Current Indicator	Data Source (MDE, STAR, Budget, Census)	Accountability
		6.5.c Conduct, at a minimum, biennial site visits to grantees to provide technical assistance and discuss issues on Consultation Plans. 6.5.d Work with grantees to improve data quality and program quality. 6.5.e Conduct technical reviews of applications. 6.5.f Develop new NBCCEDP manual with specific guidance on program components. 6.5.g Develop and update consultation plan for each grantee. 6.5.h Develop standard reports that can be used by the program consultants to identify and address grantee program deficiencies.	Site visit monitoring tool Data assessment tool provided to grantees every 6 months. Technical reviews to grantees with recommendations. Annual feedback letters to all grantees. Updated consultation plan Standard reports.	By 2007, 100% of programs will have an agreed upon consultation plan implemented. By 2007, 100% of programs with significant deficiencies receive a site visit annually, with other programs visited at least every 3 years.	By 2010, maintain that all programs have a consultation plan and are receiving standard help in addressing deficiencies.				

APPENDIX C:
CURRENT VERSION OF THE GOVERNMENT PERFORMANCE RATING INDICATORS FOR THE NBCCEDP

GOAL 1: INCREASE EARLY DETECTION OF BREAST AND CERVICAL CANCER BY BUILDING NATIONWIDE PROGRAMS IN BREAST AND CERVICAL CANCER PREVENTION, ESPECIALLY AMONG HIGH-RISK, UNDERSERVED WOMEN.			
Performance Measure	Targets	Actual Performance	Ref
Excluding invasive cervical cancers diagnosed on an initial screen in NBCCEDP, lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older.	**FY 2006:** <14/1000† **FY 2005:** <14/10,000† **FY 2004:** 15/100,000† **FY 2003:** 16/100,000† **FY 2002:** 22/100,000	**FY 2006:** 2/2008† **FY 2005:** 2/2007† **FY 2004:** 2/2006† **FY 2003:** 15/100,000 **FY 2002:** 15/100,000 (Exceeded)	[Do not update this column]

†FY rate based on 3 years of data (see narrative text below).

Performance Measure: *Excluding invasive cervical cancers diagnosed on an initial screen in National Breast and Cervical Cancer Early Detection Program (NBCCEDP), lower the age-adjusted rate of invasive cervical cancer in women aged 20 and older.*

CDC continues to meet the established target for an age-adjusted rate of invasive cervical cancer in women aged 20 and older to not more than 22 per 100,000 Pap tests provided. For FY 2002, the age-adjusted rate was 15 per 100,000, based on cumulative data from the beginning of the program. Beginning in 2003, CDC moved to calculating this rate based on a rolling 3-year time frame rather than cumulative data (for instance, the FY 2003 rate will reflect data for 2001–2003). Using a 3-year period provides more current information while ensuring statistical stability in the estimate. An age-adjusted rate of 15 per 100,000 continues in FY 2003.

GOAL 2: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Performance Measure	Targets	Actual Performance	Ref
1. Increase the number of women screened. Breast: mammogram or CBE Cervical: Pap test	**FY 2006:** Breast 401,000; Cervical 280,000 **FY 2005:** Breast 401,000; Cervical 280,000 **FY 2004:** Breast 381,682; Cervical 275,000	**FY 2006:** 2/2008 **FY 2005:** 2/2007 **FY 2004:** 2/2006 **FY 2003:** Breast 537,619 Cervical 304,407 **FY 2002:** Breast 394,146; Cervical 280,330	[Do not update this column]

GOAL 2: EXPAND COMMUNITY-BASED BREAST AND CERVICAL CANCER SCREENING AND DIAGNOSTIC SERVICES TO LOW INCOME, MEDICALLY UNDERSERVED WOMEN. FOR WOMEN DIAGNOSED WITH CANCER OR PRE-CANCER, ENSURE ACCESS TO TREATMENT SERVICES.			
Performance Measure	Targets	Actual Performance	Ref
2. Increase the percentage of newly enrolled women who have not received a Pap test within the past 5 years.	**FY 2006:** 25% Cervical **FY 2005:** 25% Cervical **FY 2004:** 22.5% Cervical	**FY 2006:** 2/2008 **FY 2005:** 2/2007 **FY 2004:** 2/2006 **FY 2003:** 21,3% **FY 2002:** 22.2%	
3. Increase the percentage of women with abnormal results who receive a final diagnosis within 60 days of screening. Breast: abnormal mammogram (suspicious of abnormality, highly suggestive of malignancy, or assessment incomplete) and/or abnormal CBE Cervical: abnormal Pap includes high grade SIL, squamous cancer, or abnormal glandular cells	**FY 2006:** Breast 87.5%; Cervical 64.5% **FY 2005:** Breast 87.5%; Cervical 64.5% **FY 2004:** Breast 86.5%; Cervical 64%	**FY 2006:** 2/2008 **FY 2005:** 2/2007 **FY 2004:** 2/2006 **FY 2003:** Breast 81.4% Cervical 62.0% **FY 2002:** Breast 82.8%; Cervical 63.0%	
4. Increase the percentage of women with cancer who start treatment within 60 days of diagnosis.	**FY 2006:** Breast 95.5%; Cervical 92.5% **FY 2005:** Breast 95.5%; Cervical 92.5% **FY 2004:** Breast 95%; Cervical 92%	**FY 2006:** 2/2008 **FY 2005:** 2/2007 **FY 2004:** 2/2006 **FY 2003:** Breast 93.0% Cervical 91.9% **FY 2002:** Breast 92.9%; Cervical 88.6%	
5. Cervical: Increase the percentage of women with precancerous lesions who start treatment within 90 days of diagnosis (includes CIN II, CIN III, and CIS).	**FY 2006:** 94.5% **FY 2005:** 94.5% **FY 2004:** 94%	**FY 2006:** 2/2008 **FY 2005:** 2/2007 **FY 2004:** 2/2006 **FY 2003:** 89.0% **FY 2002:** 90.3%	

APPENDIX D:
NBCCDP STRATEGIC MANAGEMENT AND EVALUATION PLAN: HEALTH OUTCOMES

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women			
Objectives	**Outcomes**		**Data Source (MDE, STAR, Budget, Census)**
	Intermediate (1–3 years)	**Long-Term (>3 years)**	
1.1 Promote the recruitment of women from priority populations for screening.	By 2007, increase to 52% the proportion of non-White women who receive a Pap test. By 2007, increase to 60% the proportion of non-White women who receive a mammogram. By 2007, increase the number of women screened for breast cancer to 550,000. By 2007, increase the number of women screened for cervical cancer to 350,000.	By 2010, increase to 53% the proportion of non-White women who receive a Pap test. By 2010, increase to 61% the proportion of non-White women who receive a mammogram. By 2010, increase the number of women screened for breast cancer to 575,000. By 2010, increase the number of women screened for cervical cancer to 375,000.	MDE
1.2 Promote the increased recruitment of rarely and never (R/N) screened women for cervical cancer screening.	By 2007, at least 20% of women screened for cervical cancer are rarely/never screened among 95% of grantees. By 2007, maintain the percentage of R/N screened women for cervical cancer at or above 22.5%.	By 2010, at least 22% of women screened for cervical cancer are R/N screened among 95% of grantees. By 2010, increase the percentage of R/N screened women for cervical cancer to 26%.	MDE
1.3 Promote the recruitment of women aged 50–64 for breast cancer screening.	By 2007, increase to 75% the percentage of women aged 50–64 receiving mammograms.	By 2010, maintain CDC target of 75% of women aged 50–64 receiving mammograms.	MDE
1.4 Increase grantee ability/capacity to reach the eligible population.	By 2007, increase to 18% the proportion of eligible women aged 40–64 screened by the NBCCEDP.	By 2010, increase to 20% the proportion of eligible women aged 40–64 screened by NBCCEDP.	MDE: Population estimate

Goal 2: Provide Enrolled Women with Quality Screening, Rescreening, and Diagnostic Services			
	Outcomes		**Data Source (MDE, STAR, Budget, Census)**
Objectives	**Intermediate (1–3 years)**	**Long-Term (>3 years)**	
2.3 Promote breast and cervical cancer rescreening according to clinical recommendations.	By 2007, 25% of women with 3 consecutive normal Pap tests moved to a 3-year screening cycle.	By 2010, 40% of women with three consecutive normal Pap tests will move to a 3-year screening cycle.	MDE

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services			
Objectives	**Outcomes**		**Data Source (MDE, STAR, Budget, Census)**
	Intermediate (1–3 years)	**Long-Term (>3 years)**	
3.1 Among women screened, diagnose breast cancer at an early stage.	By 2007, excluding breast cancers diagnosed in an initial screening, at least 70% of women aged 40 and older will be diagnosed at the localized stage. **2-year reporting lag.	By 2010, excluding breast cancers diagnosed in an initial screening, at least 75% of women aged 40 and older will be diagnosed at the localized stage. (For internal use, not GPRA.) **2-year reporting lag.	MDE
3.2 Among women screened, diagnose cervical cancer at an early stage.	By 2007, excluding invasive cervical cancers diagnosed on an initial screen, maintain the age-adjusted incidence rate of invasive cervical cancer in women aged 18 and older to not more than 15 per 100,000 tests. By 2007, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 18–29. By 2007, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 30 and older.	By 2010, excluding invasive cervical cancers diagnosed on an initial screen, lower the age-adjusted incidence rate of invasive cervical cancer in women aged 18 and older to not more than 13 per 100,000 tests. By 2010, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 18–29. By 2010, excluding women screened for first time by NBCCEDP, reduce the age-adjusted rate of CIN II and III to X/100,000 tests among women aged 30 and older.	MDE
3.3 Provide timely and adequate diagnostic services to women receiving abnormal breast and/or cervical cancer screening results.	By 2007, 86.5% of women with breast and 64% of women with cervical abnormalities will receive a final diagnosis within 60 days.	By 2010, 92% of women with breast and 66% of women with cervical abnormalities will receive a final diagnosis within 60 days.	MDE
3.4 Provide timely access to treatment services for women diagnosed with cancer or precancer.	By 2007, 94% of women with precancerous cervical lesions (CINII, CINIII, CIS) will initiate treatment within 90 days.	By 2010, 94.5% of women with precancerous cervical lesions will initiate treatment within 90 days.	MDE

APPENDIX E:
NBCCDP STRATEGIC MANAGEMENT AND EVALUATION PLAN: PROGRAM OUTCOMES

Goal 1: Conduct Recruitment and Outreach to Provide Screening and Rescreening to Low Income, Medically Underserved Women		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
1.3 Promote the recruitment of women aged 50–64 for breast cancer screening.	By 2007, increase to 85% or more the proportion of grantees that reach the target goal of 75% for proportion of women aged 50–64 receiving mammograms.	By 2010, increase to 88% or more the proportion of grantees that reach the target goal of 75% for proportion of women aged 50–64 receiving mammograms.

Goal 2: Provide Enrolled Women with Quality Screening, Rescreening, and Diagnostic Services		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
2.1 Provide resources for breast and cervical cancer screening.	By 2007, 50% of grantees will provide a minimum of 90% of projected Pap tests and mammograms annually. Breakdown of national data includes 1. the number of programs meeting projections, and 2. the percentage of national projection reached by all programs.	By 2010, 70% of grantees will provide a minimum of 95% of projected Pap tests and mammograms.
2.2 Ensure grantees provide high-quality screening and rescreening services.	By 2007, 90% of all grantees will have an active Medical Advisory Committee (MAC).	By 2010, 100% of grantees will have clinical guidelines reviewed annually by MAC and revised if needed.
2.4 Promote professional education activities of grantees.	By 2007, disseminate a completed evaluation of NBCCEDP Web site usage by grantees. By 2007, 75% of grantees will participate in the professional education quarterly conference calls at least twice per year. On an annual basis, disseminate two new available and appropriate curricula/training resources.	By 2010, 80% of grantees will conduct a professional education needs assessment among their providers. Sustain available and appropriate training curricula and resources to grantees.
2.5 Provide national training and technical assistance on priority clinical areas.	National standards for CBE promoted by other national organizations Increase in trainers using national standards	Increase in the number of medical schools adopting the national standards. Increase in PPV of CBE in the national program.
2.6 Conduct evaluation and/or research regarding provider practices.	Conduct annual survey of providers assessing their knowledge, attitudes, and behaviors toward the B&C practices.	Increase in the amount of research directly related to provider B&C practices.

Goal 3: Assure Enrolled Women Receive Timely Diagnostic and Treatment Services		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
3.1 Among women screened, diagnose breast cancer at an early stage.	By 2007, 90% of the reported cervical stage data will have stage reported. At least 75% of grantees will link MDE to cancer registry data by 2007.	By 2010, 95% of the reported cervical stage data will have stage reported. At least 90% of grantees will link MDE to cancer registry data by 2010.
3.2 Among women screened, diagnose cervical cancer at an early stage.	By 2007, 90% of the reported cervical stage data will have stage reported. By 2007, at least 75% of grantees will link MDE to cancer registry data.	By 2010, 95% of the reported cervical stage data will have stage reported. By 2010, at least 90% of grantees will link MDE to cancer registry data.
3.3 Provide timely and adequate diagnostic services to women receiving abnormal breast and/or cervical cancer screening results.	By 2007, 85% of funded programs will meet CDC standards for timeliness of diagnostic follow-up of women with an abnormal screen result.	By 2010, 90% of funded programs will meet CDC standards for timeliness of diagnostic follow-up of women with an abnormal screen result.
3.4 Provide timely access to treatment services for women diagnosed with cancer or precancer.	By 2007, 95% of programs will meet CDC standards for timeliness to treatment following a diagnosis of cancer	By 2010, 97% of programs will meet CDC standards for timeliness to treatment following a diagnosis of cancer.
3.5 Address implementation challenges of the National Breast and Cervical Cancer Treatment Act (NBCCTA).	By 2007, 100% of states will maintain NBCCTA.	States will maintain NBCCTA. By 2010, assess the efficiency of resources for women screened in the program.
3.6 Support the provision of timely and adequate case management (CM) to women with abnormal screening results.	By 2007, at least 90% of programs will have CM protocols consistent with CDC case management policy. By 2007, 95% of programs will meet CDC standards for timeliness to treatment following a diagnosis of breast or cervical cancer.	By 2010, 97% of programs will meet CDC standards for timeliness to treatment following a diagnosis of breast or cervical cancer

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
4.1 Maintain a monitoring and evaluation plan for the NBCCEDP.	By 2007, 10% of CDC internal use NBCCEDP resources will be allocated to monitoring and evaluation activities.	By 2010, 12% of internal use NBCCEDP resources will be allocated to monitoring and evaluation activities.
4.2 Determine outcome measures for NBCCEDP.	By 2007, 75% of objectives reflected in this Plan will have specific outcomes. By 2007, 95% of PSB staff will be knowledgeable of NBCCEDP Plan objectives and outcomes.	By 2010, 80% of objectives reflected in this Plan will have specific outcomes. By 2010, all new existing PSB staff will be knowledgeable of NBCCEDP Plan objectives and outcomes. Future outcome measures for NBCCEDP will be updated and revised as appropriate.
4.3 Maintain indicators of program performance that reflect program priorities.	By 2007, PSB management to develop a list of indicators of program performance for the "essential elements" for each program component that reflect program priorities. By 2007, increase proportion of grantees to 26% that meet/exceed performance measures. By 2007, PSB management has set up performance based funding and improves both individual program and national performance by assessing the 11 core DQIG indicators and national spend rate.	By 2010, we will use the 11 core DQIG performance indicators and the national spend rate to determine the improvement in priority program performance areas. By 2010, increase proportion of grantees to 28% that meet/exceed performance measures. By 2010, performance-based budgeting is being used for all NBCCEDP programs.
4.4 Maintain data sets/ systems for NBCCEDP.	By 2007, 100% of data collected are reported and used by DCPC and/or grantees. Revise systems to ensure data necessary to manage and monitor programs.	Change reporting requirements as program performance indicators are defined and/or revised.
4.5 Evaluate MDE data quality.	By 2007, 75% of grantees will conduct linkages with cancer registry.	By 2010, 90% of grantees will conduct linkages with cancer registry.

(continued)

Goal 4: Conduct Monitoring, Evaluation, and Research Activities for Program and Policy Improvement (continued)		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
4.6 Monitor NBCCEDP program performance.	By 2006, a common approach to monitoring performance will be described and implemented within PSB. By 2007, PCs are using tools and trained in monitoring 100% of grantees (i.e., PMA, DQIG, and PBD processes). By 2007, 100% of grantee program performance monitoring will be maintained.	New PCs are trained on tools and monitoring performance during their orientation. By 2010, maintain performance monitoring for all grantees.
4.7 Build the evaluation capacity of grantees.	By 2006, provide evaluation training to 100% of grantees. By 2006, 90% of grantees can demonstrate evaluation of program activities.	By 2010, 100% of grantees are conducting evaluation in accordance with evaluation guidance.
4.8 Conduct priority evaluation and research as identified by Division.	By 2006, program priorities will guide the selection of competing proposals for discretionary funding. Program management and strategic priorities will inform division proposals for discretionary funding decisions.	By 2010, priorities of the NBCCEDP are supported.
4.9 Provide information on intervention strategies that work.	By 2007, at least four avenues of information resources will be available to grantees (i.e., Community Guide and needs assessment for evaluating interventions).	By 2010, two additional information sources have been developed for grantees (for a total of six).

Goal 5: Enhance Partnerships through Effective Communication and Coordination		
	Outcomes	
Objectives	**Intermediate (1–3 years)**	**Long-Term (>3 years)**
5.1 Provide information about NBCCEDP to U.S. public and other targeted audiences.	Increased public knowledge of services available through NBCCEDP By 2007, the NBCCEDP home page will be receiving 17,100 hits/quarter. By 2007, increase hits to screening summary data pages to 650 visits/ month.	By 2010, have concerted national media campaign with national partners related to availability of screening services through NBCCEDP. By 2010, expand data content on the Web summaries to meet new requirements for information.
5.2 Establish mechanisms to help translate research findings into practice.	By 2007, interventions from the Community Guide will be disseminated to our grantees. ▪ RTIPS ▪ grantee training ▪ assess grantee interventions ▪ PRC cancer network By 2007, CPCRN will have provided two in-services to our grantees.	By 2010, increase availability of evidence to grantees and partners. By 2010, increase availability of intervention tools provided to grantees and partners. By 2010, increase use of research findings as documented by evidence-based proposals funded through NBCCEDP.
5.3 Provide information about NBCCEDP to CDC and national leadership.	By 2006, improve PART score from 2004. By 2007, increase the number of presentations above the Division level.	By 2008, improve PART assessment to indicate results achieved. By 2010, increase understanding among internal partners.
5.4 Maintain effective partnerships with key stakeholders and establish new partnerships to help extend reach and effectiveness of NBCCEDP and reduce disparities.		
5.5 Participate in development of Community Guide to identify evidence-based cancer interventions.	By 2007, cancer component of Community Guide is published.	By 2010, revise current cancer component of Community Guide (adding new sections, e.g., IDM).

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Goal 5: Enhance Partnerships through Effective Communication and Coordination (continued)		
	Outcomes	
Objectives	**Intermediate (1–3 years)**	**Long-Term (>3 years)**
5.6 Coordinate with partners to effectively address the needs of women that NBCCEDP does not have the resources to screen.	By 2007, develop multi-year joint strategies (i.e., communication, advocacy, field collaboration, recruitment/outreach, data sharing, quality improvement, and patient navigation) with ACS to identify additional resources to address unmet needs among priority populations.	By 2010, funding equal to one-third of the NBCCEDP budget is made available through partnerships and other resources to address unmet needs.

Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP		
	Outcomes	
Objectives	**Intermediate (1–3 years)**	**Long-Term (>3 years)**
6.1 Develop and maintain a strategic management plan for NBCCEDP.	By 2007, Management and Evaluation Plan (MAEP) is approved by mgmt and matrix is created. By 2007, MAEP is reviewed and revised on an annual basis. MAEP is communicated to key partners.	Improve PART score. By 2010, key partners share common understanding/ expectations of NBCCEDP performance. By 2010, MAEP is used by all management staff on an annual basis.
6.2 Manage NBCCEDP cooperative agreements.	By 2007, 80% of grantees submit accurate FSRs by 11/1/05. Reduction of unobligated funds through performance-based criteria for funding. Ensure performance-based distribution of funds through increase in program that qualify through the following three criteria: 1. PMA score increase 2. Spending ratio and unobligated balance available 3. Increase in key MDE indicators.	By 2010, 90% of grantees submit timely component-specific FSR.
6.3 Establish standards for technical assistance provided to grantees.	By 2007, all programs have a current consultation plan. By 2007, establish standard response protocol for programs with significant deficiencies in performance. By 2007, 100% of deficient programs get scrutiny at higher level.	By 2010, maintain that all programs have a consultation plan and are receiving standard help in addressing deficiencies.
6.4 Provide training to PSB Program staff.	By 2007, 100% of the program consultants complete a customized training within the first 6 months of hire. By 2007, 100% of staff have taken grants management training. By 2007, staff are available with skills in AI/AN, cultural competency, and territories. By 2007, 80% of staff completed an IDP.	By 2010, maintain training expectations for program consultants. By 2010, maintain cultural-competency skills in multiple cultures. 85% of staff have taken a course identified on their IDP.

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Goal 6: Provide Sound Fiscal and Programmatic Management of the NBCCEDP (continued)		
Objectives	**Outcomes**	
	Intermediate (1–3 years)	**Long-Term (>3 years)**
6.5 Provide technical assistance to grantees.	Increase in participation in subject matter conference calls By 2007, establish lead technical experts in the following B&C program components: ▪ Quality assurance and improvement ▪ Recruitment ▪ Partnerships ▪ Data Management ▪ Management ▪ Evaluation ▪ Professional development ▪ Screening Increase X% of PDs using the Web forum. By 2007, 100% of programs will have an agreed upon consultation plan implemented. By 2007, 100% of programs with significant deficiencies receive a site visit annually, with other programs visited at least every 3 years.	By 2010, maintain technical expertise in each of the eight B&C program components. Increase to X% the PDs using the Web forum. By 2010, maintain that all programs have a consultation plan and are receiving standard help in addressing deficiencies.