

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
National Center for Chronic Disease Prevention and  
Health Promotion  
Division of Cancer Prevention and Control**



**Virtual Meeting of the  
Breast and Cervical Cancer  
Early Detection and Control Advisory Committee  
February 3, 2014**

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**Record of the Proceedings**

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**BREAST AND CERVICAL CANCER  
EARLY DETECTION AND CONTROL ADVISORY COMMITTEE  
February 3, 2014**

**Minutes of the Virtual Meeting**

The U.S. Department of Health and Human Services (HHS) and the Centers for Disease Control and Prevention (CDC), National Center for Chronic Disease Prevention and Health Promotion, Division of Cancer Prevention and Control (DCPC), convened the first virtual meeting of the Breast and Cervical Cancer Early Detection and Control Advisory Committee (BCCEDCAC). The proceedings were held on February 3, 2014.

BCCEDCAC is formally chartered to provide advice and guidance to the HHS Secretary and the CDC Director regarding the early detection and control of breast and cervical cancer. BCCEDCAC's recommendations focus on national program goals and objectives, implementation strategies, and program priorities (including surveillance, epidemiologic investigations, education and training, information dissemination, professional interactions and collaborations, and policy).

Information for the public to access the BCCEDCAC virtual meeting via teleconference or webinar was published in the *Federal Register* in accordance with Federal Advisory Committee Act regulations. All sessions of the BCCEDCAC virtual meeting were open to the public (*Attachment 3: Participants' Directory*).

**Opening Session**

**Jameka R. Blackmon, MBA, CMP**

Public Health Advisor, Division of Cancer Prevention and Control  
Centers for Disease Control and Prevention  
BCCAC Designated Federal Officer

Ms. Blackmon conducted a roll call and announced that the voting members and *ex-officio* members who were attending the virtual meeting constituted a quorum for BCCEDCAC to conduct its business (*Attachment 2: Roster of the BCCEDCAC Membership*). She called the proceedings to order at 9:13 a.m. EST on February 3, 2014 and welcomed the participants to the first BCCEDCAC virtual meeting. None of the BCCEDCAC voting members declared conflicts of interest for the record for any of the items on the published agenda (*Attachment 1: Published Meeting Agenda*).

Ms. Blackmon explained that CDC was hosting the first BCCEDCAC virtual meeting in response to the President's Proficient Spending Policy requiring all federal agencies to reduce the number of in-person meetings to decrease travel expenses. She encouraged the BCCEDCAC members to submit e-mail messages to [gwr4@cdc.gov](mailto:gwr4@cdc.gov) with feedback on the current virtual meeting and suggestions to improve future virtual meetings.

Ms. Blackmon asked the participants to join her in welcoming Dr. David Espey, Acting Director of DCPC. Dr. Marcus Plescia, the former Director of DCPC, was appointed as the new Health Director of the Mecklenburg County (North Carolina) Health Department. The participants wished Dr. Plescia well in his new position.

**Jewel M. Mullen, MD, MPH, MPA**

Commissioner  
Connecticut Department of Public Health  
BCCEDCAC Chair

Dr. Mullen also welcomed the participants to the meeting and particularly thanked the BCCEDCAC members for setting aside time on their busy schedules to attend the first virtual meeting. She was pleased that the federal budget issues had been resolved in order for CDC to reschedule the BCCEDCAC 2013 meeting to the current virtual meeting.

Dr. Mullen highlighted several ongoing, new and emerging topics that would continue to be relevant and important to the BCCEDCAC over the next two years.

- Full implementation of the Affordable Care Act (ACA)
- New prevention opportunities for breast and cervical cancer (BCC)
- Continuous evolution of the CDC's National Breast and Cervical Cancer Early Detection Program (NBCCEDP) as public health and health care become more integrated
- CDC's ongoing activities to meet the needs of the population of women who have insufficient prevalence for and inadequate access to BCC screening, detection and treatment

Dr. Mullen pointed out that biographical sketches and photographs would be displayed on the screen as the BCCAC members introduced themselves. She concluded the opening session with a review of the agenda.

### **Update on the CDC National Breast and Cervical Cancer Early Detection Program**

**Faye Wong, MPH**

Chief, Program Services Branch, DCPC  
Centers for Disease Control and Prevention

Ms. Wong began her update by emphasizing that Dr. Plescia provided outstanding leadership during his tenure as the Director of DCPC from July 2009 to January 2014. Dr. Espey and senior management will continue to assure strong leadership of DCPC and excellent oversight of NBCCEDP and CDC's other cancer prevention and control programs until the permanent DCPC Director is appointed.

The NBCCEDP budget included a final appropriation of ~\$184 million in fiscal year (FY) 2012, an operating budget of ~\$175 million in FY2013, and an Omnibus budget of ~\$184 million in FY2014. These figures exclude WISEWOMAN Program funding of ~\$20 million for each of the three fiscal years, reflect Congressionally-mandated sequestration cuts in FY2013, and include \$104 million from the Prevention and Public Health Fund in FY2014.

Congress maintained the 60/40 requirement for allocation of NBCCEDP funds. BCC Programs must allocate 60% of their NBCCEDP funding to pay for screening services, patient navigation, care coordination; no more than 10% for administrative costs; and 30% for other programmatic issues (e.g., support for data collection systems, public education, outreach, professional education, surveillance and quality assurance).

NBCCEDP has served >4.4 million women since 1991 and diagnosed 59,457 breast cancers, 3,367 cervical cancers, and 158,772 pre-malignant cervical lesions with 40% being high grade. In program year 2012 alone, NBCCEDP screened 340,505 women for breast cancer and diagnosed 5,905 breast cancers. NBCCEDP also screened 273,533 women for cervical cancer, diagnosed 268 cervical cancers, and diagnosed 12,479 pre-malignant cervical lesions with 34% being high grade.

At the national level, CDC is continuing its strong focus on understanding the implications of ACA on the NBCCEDP and the complexities related to the changing healthcare environment, such as states that will and will not expand Medicaid coverage under ACA. The HealthCare.gov website was launched on October 1, 2013 for persons to enroll in ACA for Medicaid expansion or in Health Insurance Marketplaces for new insurance products.

At the state level, NBCCEDP grantees are making efforts to understand the impact of ACA on their individual BCC Programs. CDC is providing guidance and technical assistance (TA) to help NBCCEDP grantees resolve a number of key challenges related to ACA.

- NBCCEDP eligibility for women who are not enrolled in Medicaid expansion states or Health Insurance Marketplaces
- Operational issues, such as identifying and linking eligible women to ACA enrollment processes in each state
- Elimination in some states of coverage under the Breast and Cervical Cancer Prevention and Treatment Act for treatment of women who were screened by NBCCEDP
- Partial coverage of diagnostic services for women with abnormal screening results

CDC is aware that ACA will result in fewer women being directly screened by NBCCEDP, but this change will provide a tremendous opportunity to refocus efforts toward population-level interventions and increase screening for both insured and uninsured women. In the 2012-2017 NBCCEDP funding opportunity announcement (FOA), CDC encouraged BCC Programs to expand their activities to include more population-level, evidence-based interventions that are aligned with the *Community Guide*.

CDC also recognizes that the 60/40 requirement to allocate BCC resources will limit the ability of NBCCEDP grantees to take aggressive actions in this area. In response to a Congressional request, CDC will administer a survey in FY2014 to determine the needs of NBCCEDP grantees regarding the 60/40 requirement and propose potential strategies to make improvements in this area. CDC will report the survey findings to the House and Senate Appropriations Committees.

CDC is closely collaborating with state Medicaid programs and Federally Qualified Health Centers (FQHCs) to ensure that adequate screening and follow-up are provided to the NBCCEDP population. CDC also is collaborating with other partners to expand the NBCCEDP population-based strategies beyond women who we traditionally have been screening.

CDC has been relatively successful in anticipating unknown or uncertain issues related to ACA at the national level, but NBCCEDP grantees also have been identifying major ACA-related issues in their individual states. Decision trees have been designed to determine potential outcomes for each NBCCEDP-enrolled woman based on a particular circumstance. These decision trees have been enormously helpful in CDC learning about state-specific challenges and opportunities in ACA implementation. These lessons learned will place CDC and BCC Programs in a much better position to link eligible women to insurance coverage in the next ACA enrollment cycle in October 2014.

BCCEDCAC made two key comments on the need to demonstrate the continued importance of NBCCEDP even with transformations of the current healthcare system and payment models. First, BCCEDCAC should submit formal recommendations to assist CDC in responding to Congress about the NBCCEDP 60/40 requirement in light of the changing healthcare system. BCCEDCAC could describe precedents that have been established in this regard. For example, if CDC offered a degree of flexibility and creativity in interpreting the 60/40 requirement, NBCCEDP grantees will be allowed to use the 60% proportion to provide case management and patient navigation for women screened by other funding sources.

Second, a recent *Morbidity and Mortality Weekly Report* article concluded that utilization of Title X Family Planning Clinics in Massachusetts and demand for these services, including those offering BCC screening, have not changed even after health reform was fully implemented in the state. CDC should use the Massachusetts data to justify the need to sustain NBCCEDP over time regardless of full ACA implementation nationwide.

## Overview of New NBCCEDP Reimbursement Policies

### **Jacqueline Miller, MD, Capt. USPHS**

Medical Officer, Program Services Branch, DCPC  
Centers for Disease Control and Prevention

Dr. Miller presented an overview of two new NBCCEDP reimbursement policies CDC initiated in January 2014. The first new reimbursement policy is breast magnetic resonance imaging (MRI) that NBCCEDP grantees can now use in two specific circumstances: (1) screening performed in conjunction with a mammogram and (2) better assessment of areas of concern on a mammogram or evaluation of a client with a past history of breast cancer after completion of treatment. However, the new policy explicitly states that breast MRI can never be performed alone as a sole breast cancer screening tool and cannot be reimbursed for by NBCCEDP to assess the extent of disease in women who have just been diagnosed with breast cancer.

CDC's new policy is aligned with breast MRI screening criteria developed by the American Cancer Society. The client should have a known BRCA mutation, a first-degree relative who is a BRCA carrier, or a lifetime risk of 20%-25% or greater as defined by risk assessment models that are largely dependent on family history. Facilities with dedicated breast MRI equipment

and the capacity to perform MRI-guided breast biopsies are critical for maximum effectiveness of breast MRI screening.

The second new reimbursement policy is screening of male-to-female transgender women who have taken or are taking hormones and meet all NBCCEDP eligibility requirements. Although transgender women are now eligible to receive NBCCEDP breast cancer screening and diagnostic services, CDC will not issue routine screening recommendations due to limited data regarding the risk of breast cancer in this population. CDC has advised all BCC Programs to discuss individual risk factors of all eligible women, including transgender women, to determine the benefits and harms of screening and decide whether screening is medically indicated for the client.

CDC's new policy is adopted from consensus-based, preventive health recommendations by the Center of Excellence for Transgender Health. The guidance recommends breast-screening mammography for "transwomen" >50 years of age with past or current hormone use and additional risk factors (e.g., estrogen and progestin use >5 years, a positive family history of breast cancer, and a body mass index >35). However, individual assessments and clinical judgment will play a critical role because the recommendations do not provide guidance on intervals for breast-screening mammography.

BCCEDCAC discussed the following topics in the question/answer session with Dr. Miller on the two new NBCCEDP reimbursement policies.

- The feasibility of using existing BCC Program data systems to estimate breast cancer risk among transgender women.
- Retention of NBCCEDP's longstanding reimbursement policy to screen female-to-male transgender men who have not undergone a bilateral mastectomy and hysterectomy.
- CDC's communications with multiple advocacy groups to assure strong outreach to the transgender community to raise awareness of the new reimbursement policy.

## Overview of Cervical Cancer Screening in U.S.-Associated Pacific Island Jurisdictions

### **Mona Saraiya, MD, MPH**

Assistant Director of Global Cancer, Epidemiology and Applied Research Branch, DCPC  
Centers for Disease Control and Prevention

Dr. Saraiya presented an overview of recent activities by CDC and its partners to address the high cervical cancer mortality rate in U.S.-Associated Pacific Island (USAPI) jurisdictions. Cervical cancer is a leading cause of cancer mortality in USAPI jurisdictions. Several U.S. government entities provide cervical cancer screening, but frequently act in silos.

CDC directly funds four of the six USAPI jurisdictions through NBCCEDP: American Samoa, Commonwealth of Northern Mariana Islands (CNMI), Guam, and Republic of Palau. The HHS Office of Population Affairs (OPA) funds all six USAPI jurisdictions through Title X Family Planning Clinics. The Health Resources and Services Administration funds most of the USAPI jurisdictions through Community Health Centers (CHCs).

The Federated States of Micronesia and Republic of the Marshall Islands independently created cervical cancer screening guidelines that recommend routine visual inspection with acetic acid (VIA). However, the guidelines have received inconsistent support because three other agencies in the USAPI jurisdictions predominantly perform cytology-based screening. Pap test coverage is persistently low in the four NBCCEDP-funded USAPI jurisdictions: <40% in American Samoa and Palau, 13.5% in Guam, and 12% in CNMI. Data on follow-up Pap tests are minimal as well.

Several important developments have occurred in cervical cancer screening over the past five years. In November 2013, the World Health Organization (WHO) issued new “Guidelines for Screening and Treatment of Precancerous Lesions for Cervical Cancer Prevention” along with new algorithms and screen-and-treat strategies. WHO minimized the focus on cytology-based screening and only recommended this strategy if the program met certain quality indicators (e.g., training, high coverage and follow-up). WHO recommended VIA-based screening alone or primary human papillomavirus (HPV) screening in settings with low coverage, insufficient resources and poor follow-up. A GRADE-based review was conducted to evaluate the quality and strength of the WHO guidelines.

Other key milestones in cervical cancer screening include increased availability of HPV testing and utilization of HPV vaccine for prevention of HPV infection in younger women in the USAPI jurisdictions. Moreover, point-of-care testing with “careHPV” is being piloted in several countries, while primary HPV testing is occurring in several European countries. Self-collected HPV testing is successfully reaching women who traditionally have not been screened, but the accuracy of this test is lower.

A survey and focus groups were recently conducted to determine the acceptability of and barriers to using newer technologies among USAPI programs and providers. Programs and providers expressed a strong interest in newer technologies, particularly to address challenges in providing screening and treatment in the outer islands. The survey and focus group results will be released within the next two months.

An “Expert Panel on Cervical Cancer Screening in the U.S. Territories and Pacific Island Jurisdictions” was convened in September 2013 with representation by CDC, OPA, WHO, Pan American Health Organization, and the American Society of Colposcopy and Cervical Pathology (ASCCP). The 40-member expert panel placed several important items on its meeting agendas: overviews for all six USAPI jurisdictions to present their specific issues; CDC’s overview of NBCCEDP; OPA’s overview of the Title X Program; WHO’s overview of its new cervical cancer screening and treatment guidelines; and a presentation by Puerto Rico. Several BCCEDCAC members also attended the expert panel meetings.

The expert panel agreed to take the following actions. ASCCP and the American Congress of Obstetricians and Gynecologists will develop a committee opinion paper to review the cervical cancer problem in the USAPI jurisdictions overall and recommend appropriate screening technologies. The committee opinion will serve as the first step in initiating a series of demonstration projects to determine next steps in the USAPI jurisdictions. The paper is expected to be released in the next few months and published in various journals.

The USAPI demonstration projects will be designed to answer the following questions: (1) Is one approach suitable for the main island versus the outer islands? (2) What opportunities are available to develop standard operating procedures that would be consistent with the WHO

algorithms? (3) What methods or tools are needed to evaluate the acceptability, feasibility and cost of covering all age-eligible women? (4) Should a single-visit approach using VIA or HPV screening followed by cryotherapy be considered (e.g., a “see and treat” strategy)?

The expert panel agreed that in order to strengthen and streamline the three disparate data systems, a coordinated approach will need to be implemented in close collaboration with the three agencies in the USAPI jurisdictions, other federal partners and WHO. The expert panel hopes that some of its proposed strategies will be reimbursable in the future.

BCCEDCAC discussed the following topics in the question/answer session with Dr. Saraiya on cervical cancer screening in the USAPI jurisdictions.

- Coverage of HPV vaccine through NBCCEDP and other funding sources for specific populations (e.g., women only or both men and women).
- The ability of the expert panel’s proposed interventions to focus on behavioral issues that successfully promote the use of screening in the United States (e.g., general screening education and follow-up), while addressing USAPI’s unique health system barriers to screening (e.g., severe geographical disparities, extreme logistical challenges, and overwhelming barriers to the use of electronic technology for tracking and follow-up in the outer islands).
- Extremely limited Medicaid coverage and services for cervical cancer treatment in the USAPI jurisdictions.

The discussion resulted in BCCEDCAC proposing several suggestions for CDC and its partners to consider in their ongoing efforts to further decrease the high cervical cancer mortality rate in USAPI by addressing the unique barriers to screening in these jurisdictions.

- More investments should be targeted to improving health outcomes in the USAPI jurisdictions. Most notably, cervical cancer mortality rates in some USAPI populations rival those in second- and third-world countries. Additional resources should be allocated to the development of novel evidence-based strategies for USAPI women, particularly those on the outer islands, to more easily access cervical cancer screening. The funding also should be used to help USAPI programs and providers better understand and address the psychosocial, geographical and other barriers that are unique to USAPI residents.
- Initiatives and interventions to further decrease the USAPI cervical cancer mortality rate should be designed to be flexible to actually meet the needs of USAPI women as well as realistic and feasible in light of the constraints and barriers in these jurisdictions.
- The National Cancer Institute’s (NCI) strong body of evidence on innovative outreach strategies should be thoroughly reviewed to compile experiences and lessons learned from other parts of the world. Most notably, an NCI-funded study will soon be published highlighting a successful outreach program in India that publicizes, supports and affirms the use of VIA screening along with an organized screening approach. Based on the outcomes of this study, CDC should determine the level of flexibility in NBCCEDP for administrative and other responsibilities to be redistributed. For example, BCC Program staff in the USAPI jurisdictions could strengthen cooperation, collaboration and partnerships with local hospitals and clinics to coordinate and organize community-based outreach programs. Instead of women overcoming tremendous geographical and other barriers to report to BCC Program sites for care, staff would travel to the USAPI jurisdictions and outer islands to perform screening and provide treatment as needed.

## Update on CDC's African American Women and Mass Media Intervention

### Ingrid Hall, PhD, MPH

Epidemiologist, Epidemiology and Applied Research Branch, DCPC  
Centers for Disease Control and Prevention

Dr. Hall presented an update on CDC's evaluation of a community-based intervention to increase breast cancer screening and early detection among low-income African American women. The purpose of the African American Mass Media (AAMM) Campaign was to raise local awareness of NBCCEDP in Georgia, increase mammography utilization among NBCCEDP-eligible African American women 40-64 years of age, and decrease breast cancer mortality rates among African American women.

CDC piloted the AAMM intervention from August 2008 to July 2009. The multimedia component was launched in Macon and Savannah, Georgia and included 30- and 60-second radio broadcasts of testimonials from breast cancer survivors and monthly 60-minute public affairs shows. The broadcasts were aired on radio stations with predominantly African American audiences. The community presence component was launched in Savannah only and included print media and community events. Columbus, Georgia served as the control site and only conducted its routine BCC outreach activities.

CDC's evaluation plan was designed to assess changes in awareness and behavior by monitoring three areas: (1) changes in calls to 1-800-4CANCER, (2) the number of callers who reported radio as their source of information, and (3) the number of African American women in Macon and Savannah who received mammography screening from the Georgia BCC Program compared to Columbus.

The key findings of the evaluation are summarized as follows. The percent of calls by African American women who obtained the 1-800-4CANCER toll-free number from radio broadcasts increased each month in the Macon and Savannah intervention sites, while the Columbus control site reported no calls. By race, African American women accounted for the majority of calls in Macon (60%) and Savannah (57%), while white women accounted for the majority of calls in Columbus (50%). By type, the general public accounted for the majority of calls in Macon (57%) and Savannah (54%), while friends and relatives accounted for the majority of calls in Columbus (34%).

By health insurance status, 44% of callers in Macon and 41% of callers in Savannah were uninsured compared to 20% of uninsured callers in Columbus. By information source, 31% of callers in Macon and 26% of callers in Savannah learned of the 1-800-4CANCER toll-free number from radio broadcasts, while 30% of callers in Columbus learned of the number from the telephone book or directory assistance.

To assess the full impact of the AAMM Campaign on mammography screening of African American women by BCC Programs, CDC extended the evaluation period until December 2009 to account for waiting lists, scheduling conflicts or other delays. The 36% average increase in the number of African American women in Savannah who obtained mammography screening from the BCC Program each month was statistically significant (e.g., a monthly average of 129 mammograms in the first six months of the AAMM Campaign compared to a monthly average of

176 mammograms in the last six months plus the additional five months of the AAMM Campaign).

The 22% average increase in the number of African American women in Macon who obtained mammography screening from the BCC Program each month was not statistically significant. This finding indicates that the community presence component in the Savannah site played a critical role in changing both awareness and behavior. The number of African American women in Columbus who obtained mammography screening from the BCC Program each month remained fairly stable over the course of the AAMM Campaign.

Pre-intervention data collected from July 2007-July 2008 showed that BCC Programs at all three sites performed an average of 117 mammograms on African American women per month compared to an average of 161 mammograms per month during the intervention. The 37% average increase was statistically significant.

Overall, the evaluation showed that compared to the Columbus control site, the Macon and Savannah intervention sites accounted for more African American callers, a greater proportion of callers from the general public, a larger percentage of uninsured women, more callers who learned of the 1-800-4CANCER toll-free number from radio broadcasts, and an increase in the average number of African American women who obtained mammography screening by BCC Programs each month.

The evaluation further demonstrated that a community-based radio and print materials public health campaign appeared to be a viable communication method to reach and change knowledge, awareness and behavior among African American women. Moreover, the campaign has the potential to reduce breast cancer health disparities. Additional details on the AAMM Campaign in Georgia can be obtained from the [CDC.gov/cancer](http://CDC.gov/cancer) website. CDC plans to generate and release more data after completing the AAMM Campaign in North Carolina in March 2014.

## Overview of the NBCCEDP Implementation Survey

### **Amy DeGross, PhD**

Health Education Specialist, Program Services Branch, DCPC  
Centers for Disease Control and Prevention

Dr. DeGross presented preliminary results of a survey that CDC administered to the NBCCEDP grantees beginning in December 2013. In the 2012-2017 NBCCEDP FOA, CDC encouraged the BCC Programs to expand activities beyond their traditional priority populations to include broader population-level initiatives and evidence-based strategies that are aligned with the *Community Guide*.

This shift is being driven by healthcare reform and the potential for ACA to increase insurance coverage of BCC Program clients in the future, but new opportunities also will be available for NBCCEDP to reach wider audiences and strengthen its impact. However, CDC recognizes that the NBCCEDP 60/40 requirement will limit the ability of BCC Programs to conduct more population-based activities.

Due to significant changes that will occur over the five-year project period of the NBCCEDP FOA, CDC realized the importance of capturing data on current and future implementation strategies of the BCC Programs. CDC acknowledged that systematic data on NBCCEDP's non-screening/non-clinical activities have not been collected since 2003.

The overarching goals of the ongoing survey are to systematically assess the implementation of NBCCEDP within an evolving healthcare context over the five-year project period of the FOA; annually assess the training and TA needs of the BCC Programs during their transition to a health reform environment; and apply the survey findings to inform CDC's national planning process. CDC collected NBCCEDP data from June 30, 2012 to June 29, 2013 to establish program year (PY) 1 as a baseline for the survey.

From March-November 2013, CDC developed the survey questions, solicited broad stakeholder input from both DCPC and non-DCPC staff, identified nine BCC Programs to pilot the survey with extensive cognitive testing, designed a web-based application, and obtained approval from the Office of Management and Budget. The survey content addresses eight major areas: respondent information, non-clinical program activities, clinical service delivery, evaluation, non-screening partnerships, data use, training and TA needs, and program management (including participation in and the impact or challenges of health reform among grantees).

The 30-minute web-based survey asked the BCC Programs to report their PY1 activities from July 2012 to June 2013. The survey included ~70 closed-ended questions and 4 open-ended questions on the health reform experiences of the grantees to date. All 67 BCC Programs completed the survey by December 19, 2013. CDC completed the data validation process in January 2014 and currently is analyzing the data.

The aggregated preliminary findings from the PY1 survey are highlighted as follows. The 67 BCC Programs primarily targeted NBCCEDP providers and clients with six evidence-based interventions (EBIs): small media (98.5% of grantees), client reminders (89.5%), reduction in structural barriers (86.6%), provider reminders (62.7%), provider assessment and feedback (70%), and professional development/provider education (83.6%). Of the six EBIs, only small media (94%) and professional development/provider education (61.2%) were used by more than 50% of grantees to reach non-NBCCEDP providers and clients. CDC believes these outcomes might change if the NBCCEDP 60/40 requirement is revised with more flexibility in the future.

The 67 BCC Programs used a variety of provider facilities and networks to offer NBCCEDP services: FQHCs or CHCs (1-105 facilities used by 50 grantees); individual offices or clinics, excluding FQHCs (1-1,487 facilities used by 48 grantees); healthcare systems, hospitals or clinics associated with insurers (1-309 facilities used by 41 grantees), and Indian Health Service (IHS) or other Tribal Health Organization sites and clinics (1-25 facilities used by 33 grantees).

The 67 BCC Programs collaborated with a diverse group of non-screening partners: Cancer Coalitions (61 grantees), community-based non-profit organizations (50), hospitals, health systems and state insurers (41), local health departments (39), FQHCs (36), state Medicaid programs (36), CHCs (30), state employers or worksites (30), IHS or other Tribal Organizations (26), other agencies or organizations (18), accountable care organizations (3), and Medicare (3).

The 36 BCC Programs that partnered with FQHCs conducted a broad range of non-screening activities: implementation of EBIs to promote screening (25 grantees), special events (23), community health worker, patient navigation or case management activities (16), activities to improve the use of data (15), quality assurance/quality improvement (QA/QI) activities (11), health reform-related activities (5), worksite wellness programming (4), facilitation of insurance enrollment or third-party funding (4), mass media campaigns (4), and promotion of organizational change (1).

The 36 BCC Programs that partnered with state Medicaid programs conducted the same non-screening activities as those with FQHCs, but to a much lesser degree: facilitation of insurance enrollment or third-party funding (14 grantees), implementation of EBIs to promote screening (10), activities to improve the use of data (8), special events (8), health reform-related activities (8), QA/QI activities (7), community health worker, patient navigation or case management activities (6), worksite wellness programming (1), mass media campaigns (1), and promotion of organizational change (1).

The 67 BCC Programs rated their training and TA needs by highest level of priority as of the end of December 2012. Those ranked with the highest priority included health reform and covered preventive services (46.3% of grantees), systems changes (38.8%), Health Insurance Exchange and Marketplaces (37.3%), program monitoring and evaluation (34.3%), and QA/QI strategies (34.3%).

The 67 BCC Programs described their most common management challenges: staff turnover (43.3% of grantees), changes to clinical guidelines (34.3%), changes in administrative systems (31.3%), health reform implementation (28.4%), and the need to meet the NBCCEDP 60/40 requirement (26.9%).

Of the 67 BCC Programs, 11 reported CDC as their sole funding source and the remaining 56 described their non-CDC funding sources: federal funding (\$59,000--\$4.1 million awarded to 10 grantees); state funding (\$70,000-\$17 million awarded to 45 grantees); non-profit funding (\$2,000--\$2.6 million awarded to 31 grantees); and other funding sources (\$200--\$1.9 million awarded to 18 grantees). CDC will monitor state funding to BCC Programs over time to identify any reductions based on the assumption that ACA will provide insurance coverage to all NBCCEDP-eligible women.

CDC identified three major areas of NBCCEDP programming that most likely will be impacted by ACA over time based on ACA-related services the BCC Programs provided in PY1: 50 of 50 states offered NBCCEDP services through the Medicaid Treatment Act (100%); 59 of 67 BCC Programs extended enrollment to both uninsured and underinsured NBCCEDP clients (88.1%); and 24 of 67 BCC Programs facilitated insurance enrollment for NBCCEDP clients.

The BCC Programs responded to several qualitative questions regarding their experiences and management challenges with health reform to date, including lack of knowledge of NBCCEDP-eligible population size in an ACA environment, the uncertainty of federal and state funding, limited understanding of Health Insurance Marketplaces, and the future of NBCCEDP.

CDC reached a number of important conclusions based on the preliminary survey findings of strategies the BCC Programs used to implement NBCCEDP in PY1. EBIs primarily were targeted to NBCCEDP providers and patients, but small media initiatives also were successful in reaching non-NBCCEDP audiences. Collaborations were formed with an extensive provider

network, particularly FQHCs and CHCs. Efforts to facilitate insurance enrollment were made by only 24% of grantees. Partnerships with FQHCs and state Medicaid programs to conduct non-screening activities were established by ~50% of grantees. Several grantees expressed uncertainty regarding health reform implementation and the future of NBCCEDP.

CDC's next steps in the NBCCEDP survey will be to complete the detailed data analysis and disseminate the results to the BCC Programs through a webinar, grantee-specific reports, summary tables and publications. CDC will utilize its existing NBCCEDP mechanisms to respond to and address the training and TA needs of the BCC Programs, such as the Outreach and Education Workgroup, the Quality Assurance Workgroup, and the upcoming Program Director's meeting. The PY1 survey will be revised for implementation in the field after the PY2 activities are completed.

BCCEDCAC discussed the following topics in the question/answer session with Dr. DeGroff on the NBCCEDP implementation survey.

- The surprising result in which BCC Programs did not describe the requirement to match state funds as a challenge in implementing NBCCEDP.
- CDC's plans to include questions in the next iteration of the NBCCEDP implementation survey to respond to the Congressional request to determine the needs of BCC Programs regarding the 60/40 requirement.

### BCCEDCAC Moderated Discussion

#### **Jewel M. Mullen, MD, MPH, MPA**

Commissioner  
Connecticut Department of Public Health  
BCCAC Chair

Dr. Mullen moderated a discussion for the BCCEDCAC members to offer their insights, perspectives and feedback in response to CDC's two questions on the future direction of NBCCEDP. She emphasized that comments and suggestions by each individual BCCEDCAC member were equally valuable for CDC's consideration of next steps. To provide helpful and concrete input to CDC, she advised the BCCEDCAC members to apply their historical experiences with NBCCEDP, utilize their health reform knowledge, and consider the overviews that were presented during the virtual meeting.

#### **Question 1: *Should NBCCEDP focus on the limitations of coverage for diagnostic services?***

- CDC should expand the focus of NBCCEDP to assure that women who obtain BCC screening achieve diagnostic resolution. However, creative and realistic strategies should be implemented to ensure that NBCCEDP will not be responsible for covering diagnostic services for all eligible women.
- CDC should collect NBCCEDP data from each state to determine gaps between the number of women who have positive screening results (denominator) versus those who need coverage for diagnostic services (numerator). Available resources in each state also should be identified to assist in estimating the national burden.
- CDC should administer a survey for all 67 BCC Programs to report their existing sources to refer women with positive screening results to follow-up diagnostic services. CDC

also should consult with its Advisory Committee on Breast Cancer in Young Women to determine whether recommendations have been made on diagnostic services for young women at higher risk to inform BCCEDCAC's discussion of this issue.

- CDC should prioritize and systematically collect longitudinal data on the follow-up of women who received abnormal screening results from NBCCEDP, but were required to seek coverage of diagnostic services from other sources. NBCCEDP's current completion rate of 95% between BCC screening and diagnostic follow-up is outstanding, but a decrease in this rate in a health reform environment will be problematic.
- CDC should consider IHS's unique challenges in its decision-making process on whether to expand NBCCEDP's focus to include limitations of coverage for diagnostic services. For example, 34% of NBCCEDP-eligible, uninsured Native American women 15-44 years of age may or may not rely on IHS depending on their residence in urban areas or on Indian reservations. IHS receives funding for BCC referral, follow-up and treatment, but its role as a "low-resourced safety net system" results in immediate expenditure of these dollars. Anecdotal data from IHS clinicians show that Native American women are extremely reluctant to present for screening due to the intrusive nature of BCC examinations and the lack of female providers. Despite these barriers, IHS clinics report a 62% screening rate among NBCCEDP-eligible Native American women and notable follow-up success. However, completion of the full continuum of care from follow-up through treatment for Native American women with a BCC diagnosis remains problematic.
- CDC should establish a long-term goal for NBCCEDP in which a shift would be made to capitated screening rates. Because screening has the ability to predict a proportion of abnormal results, the new NBCCEDP reimbursement model would be based on predicted abnormal results. Funds for a complete diagnostic work-up also would be set aside at the outset as part of the screening fee. The new model would provide an opportunity for CDC to reconsider NBCCEDP reimbursement as payment for the overall process rather than payment for the specific screening test.
- CDC should take extreme caution in stretching NBCCEDP's limited budget even further to cover gaps in diagnostic services. The following concerns should be considered in establishing priorities.
  - Of all states, ~50% opted out of expanding Medicaid coverage under ACA. Women in these states who are below 100% of the Federal Poverty Level will be severely impacted.
  - At the state level, NBCCEDP has never achieved coverage of the majority of its eligible population. At the territorial level, the overview presented during the current meeting reported alarmingly low screening rates and disproportionately high cervical cancer mortality rates among women in NBCCEDP-funded USAPI jurisdictions.
  - CDC's goal to shift to population-based efforts to increase screening to all women, particularly low-income women, will significantly impact NBCCEDP's strained budget.
  - NBCCEDP's potential new role of covering diagnostic services for a new population of women who have health insurance through ACA, but still face barriers to meeting co-pays, deductibles or other cost-sharing requirements should be considered.
  - CDC recently implemented a new reimbursement policy for NBCCEDP to cover breast MRI, but this screening modality is extremely expensive, particularly if follow-up MRIs, additional imaging or biopsies are needed. Breast MRI screening also is associated with a large number of false-positive results.
- CDC should allow the BCC Programs to operate with a great deal of flexibility based on the specific needs of their client populations and the role of their states in ACA.

- The Nebraska BCC Program has estimated that the Health Insurance Exchange and Marketplaces will cover screening for ~500 of its potential clients only. For women who will continue to face barriers to the cost of diagnostic services, however, providers most likely will continue to refer these women to the BCC Program due to its role as a credible source of coverage. Moreover, the BCC Program has created a mechanism with support from both federal and state funding sources that allows uninsured and underinsured women to receive diagnostic services as long as NBCCEDP income requirements are met. The BCC Program also educates these women on obtaining preventive services through their other insurance coverage.
- Nebraska opted out of Medicaid expansion under ACA and has virtually no involvement in referring clients to the Health Insurance Exchange and Marketplaces. Although the Nebraska BCC Program covers diagnostic services, other states are unable to cover this service.

**Question 2:** *What sources should CDC explore to develop relationships with non-traditional partners for NBCCEDP?*

- *African American Populations*
  - Traditional African American men's health programs (e.g., barbershop programs and screening programs targeting heart disease and prostate cancer) that have a new interest in engaging and reaching African American women to address BCC issues
  - African American faith-based organizations. The Partnership Center for Community and Faith-Based Organizations has a national reach and conducts tremendous outreach in African American communities through webinars and other media. Dr. Lee offered to link CDC with this organization.
  - Teen pregnancy programs
  - Mental health programs
- *Native Americans/Other Small Populations*
  - The Community Health Aid Program. This excellent outreach program primarily is conducted by well-trained village women, but also includes some men. The program provides primary care 24 hours per day/7 days per week to persons who reside in the bush areas of Alaska.
  - The National Congress on American Indians. This advocacy group focuses on the needs of American Indian/Alaska Native women and tribes.
  - Tribal consultations to build partnerships with CDC on addressing issues that are important to tribes, including access to BCC screening, follow-up and treatment
  - Trained community health workers who are funded by tribes and used in the lower 48 states to address tribal health needs
  - Home visits by McVee grantees to Native Americans during the perinatal period. This initiative would provide a tremendous opportunity to increase awareness of and interest in preventive care among new Native American parents.
  - Title V Maternal and Child Health Programs that are located in every state and several U.S. territories. A partnership with CDC would help to minimize tasks of overburdened Title V Program Health Directors.
  - Health programs that are making strong efforts to increase screening rates in the lesbian/gay/bisexual/transgender community
  - Behavioral health programs that target prevention, screening and primary care to disabled and mentally ill populations
- *Other Potential Sources*
  - Community leaders and non-profit organizations that address health needs in the Hispanic community

- For-profit hospitals, private insurers and other payers that will cover prevention and screening services for the new Medicaid patient population under ACA
- Restaurant Associations and other professional organizations that are conducting outreach to young, healthy persons who will become new purchasers of insurance through the Health Insurance Exchange and Marketplaces
- Local programs that have extensive knowledge of and contact with non-traditional partners and communities at the local level
- Train-the-trainer programs. The Nebraska BCC Program provides a wealth of tools and resources (e.g., training and TA, data and EBIs) to empower small breast cancer groups to conduct their own activities and build their own partnerships with local communities. These groups have been instrumental in engaging non-traditional partners that the state of Nebraska would never have been able to reach.
- Integrated federal funding streams and programs (e.g., maternal/child health and chronic disease) that have a unified voice. True integration at the federal level will provide states with leverage to develop “non-competing” programs and partnerships at state and local levels.
- Mobile health programs, new applications and other technology (e.g., SmartPhones, tablets and social media) to reach underserved populations and emphasize the importance of BCC screening and follow-up
- Monitoring programs and electronic health records to track women with abnormal screening results who do not have cancer and do not present for follow-up

Dr. Mullen concluded the moderated discussion by confirming that the BCCEDCAC would routinely revisit the two questions to provide additional input to CDC as NBCCEDP evolves over time in an ACA environment.

### **Public Comment Session**

Ms. Blackmon opened the floor for public comments; none of the participants responded.

### **Closing Session**

Ms. Blackmon regrettably announced the passing of Dr. Handel Reynolds, a BCCEDCAC member, on June 14, 2013. A moment of silence was held in remembrance of Dr. Reynolds.

Ms. Blackmon announced that the terms of three BCCEDCAC members would expire in March 2014: Drs. Carol Brown, Mary Dolan and Hannah Linden. The participants joined Dr. Mullen in commending the three outgoing members for contributing their valuable time, expertise and input to CDC over the past four years. She confirmed that their roles as BCCEDCAC members had a tremendous impact on improving the lives of women throughout the country who are served by NBCCEDP.

Ms. Blackmon announced that the next in-person BCCEDCAC meeting would be held in Atlanta, Georgia. The BCCEDCAC members described several issues that CDC should consider in planning the meeting: fiscal year-end on September 30, travel restrictions of federal employees in FY2014, and the holiday season and the potential for inclement weather in

December. Based on BCCEDCAC's feedback, Ms. Blackmon confirmed that CDC would circulate potential dates for the next meeting in either October or November 2014.

Dr. Mullen thanked the BCCEDCAC members for providing CDC with detailed, thoughtful and high-quality input over the course of the virtual meeting. She also thanked Ms. Blackmon, Ms. Wong and other DCPC staff for their continued stewardship and management in preparing, planning and organizing BCCEDCAC meetings.

With no further discussion or business brought before BCCEDCAC, Ms. Blackmon adjourned the virtual meeting at 12:06 p.m. EST on February 3, 2014.

I hereby certify that to the best of my knowledge, the foregoing Minutes of the proceedings are accurate and complete.

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Date

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Jewel Mullen, MD, MPH, MPA  
Chair, Breast and Cervical Cancer Early  
Detection and Control Advisory Committee



## **Attachment 1**

### **Published Meeting Agenda**

#### **MEETING OBJECTIVES:**

Committee members are charged with advising the Secretary of the U.S. Department of Health and Human Services (DHHS) and the Director of the Centers for Disease Control and Prevention (CDC) regarding the early detection and control of breast and cervical cancer. Committee members will discuss and make recommendations regarding national program goals and objectives; implementation strategies; and program priorities

### **Monday, February 3, 2014**

**9:00 A.M. - 9:05 A.M.**

#### **Opening: Welcome and Roll Call**

*Jameka R. Blackmon, MBA, CMP*  
Designated Federal Officer, DCPC, CDC

*Jewel Mullen, MD, MPH, MPA*  
Connecticut Department of Public Health  
BCCEDCAC Committee Chair

**9:05 A.M. - 9:15 A.M.**

#### **Call to Order & Introductions of BCCEDCAC Members**

*Jewel Mullen, MD, MPH, MPA*  
Connecticut Department of Public Health  
BCCEDCAC Committee Chair

**9:15 A.M. - 9:30 A.M.**

#### **CDC Updates**

*Faye Wong, MPH*  
Program Services Branch  
Branch Chief, DCPC, CDC

**9:30 A.M. - 9:45 A.M.**

#### **National Breast and Cervical Cancer Early Detection Program (NBCCEDP) Policy Updates**

*Jacqueline Miller, MD*  
Program Services Branch  
Medical Officer, DCPC, CDC

- 9:45 A.M. - 10:05 A.M.      Cervical Cancer Screening in the Pacific Islands**
- Mona Saraiya, MD, MPH*  
Epidemiology and Applied Research Branch  
Medical Officer, DCPC, CDC
- 10:05 A.M. - 10:20 A.M.      African American Women and Mass Media Campaign in Georgia**
- Ingrid Hall, PhD, MPH*  
Epidemiology and Applied Research Branch  
Epidemiologist, DCPC, CDC
- 10:20 A.M. - 10:45 A.M.      NBCCEDP Survey on Use of Evidence-based Interventions to Increase Cancer Screening and ACA Challenges**
- Amy DeGross, PhD*  
Program Services Branch  
Health Education Specialist, DCPC, CDC
- 10:45 A.M. - 11:15 A.M.      Limitations of Coverage for Diagnostic Testing: Should This be a Program Focus?  
Group Discussion**
- Jewel Mullen, MD, MPH, MPA*  
Connecticut Department of Public Health  
BCCEDCAC Committee Chair
- 11:15 A.M. - 11:45 A.M.      Developing relationships with nontraditional partners: Where should we be looking?  
Group Discussion**
- Jewel Mullen, MD, MPH, MPA*  
Connecticut Department of Public Health  
BCCEDCAC Committee Chair
- 11:45 A.M. - 12:00 P.M.      Public Comment**
- 12:00 P.M. - 12:05 P.M.      Wrap-Up/Announcements/Adjourn**
- Jewel Mullen, MD, MPH, MPA*  
Connecticut Department of Public Health  
BCCEDCAC Committee Chair



## Attachment 2

### Roster of the BCCEDCAC Membership

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## **Attachment 3** **Participants' Directory**

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Jacqueline Miller, MD

Mona Saraiya, MD, MPH

Faye Wong, MPH



## **Attachment 4**

### **Glossary of Acronyms**

AAMM	African American Mass Media
ACA	Affordable Care Act
ASCCP	American Society of Colposcopy and Cervical Pathology
BCC	Breast and Cervical Cancer
BCCEDCAC	Breast and Cervical Cancer Early Detection and Control Advisory Committee
CDC	Centers for Disease Control and Prevention
CHCs	Community Health Centers
CNMI	Commonwealth of Northern Mariana Islands
DCPC	Division of Cancer Prevention and Control
EBIs	Evidence-Based Interventions
FOA	Funding Opportunity Announcement
FQHCs	Federally Qualified Health Centers
FY	Fiscal Year
HHS	U.S. Department of Health and Human Services
HPV	Human Papillomavirus
IHS	Indian Health Service
MRI	Magnetic Resonance Imaging
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCI	National Cancer Institute
OPA	Office of Population Affairs
PY	Program Year
QA/QI	Quality Assurance/Quality Improvement
TA	Technical Assistance
USAPI	U.S.-Associated Pacific Island
VIA	Visual Inspection with Acetic Acid
WHO	World Health Organization