CASE MANAGEMENT

Case Management (CM) is mandated program component for the Georgia Breast and Cervical Cancer Program. The Women's Health Research and Prevention Amendments of 1998 call for the assurance “to the extent practicable, the provision of appropriate follow-up services and support services such as case management.” The following policy guidelines are referenced from the NBCCEDP Case Management Workshop Manual. The CDC-generated NBCCEDP Case Management policies are intended to serve as a road map and will be used by the State of Georgia to further build its CM program. There will be further, more specific, policy updates as the state and local public health districts partner in designing a system of CM that will align federal policy with the local needs of the Georgia Breast and Cervical Cancer Program population.

Definition of Case Management

Case Management (CM) is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual’s health needs through communication and available resources to promote quality cost-effective outcomes. Case Management involves establishing, brokering, and sustaining a system of available clinical (screening, diagnostic, and treatment) and essential support services for all Breast and Cervical Cancer Program eligible women who would ultimately be assessed to need case management services. Case Management is described as the most intensive intervention in the continuum of care. It is a proactive process in which barriers to accessing needed services are anticipated and minimized. The effect of case management and the progress towards reaching this goal initially will be measured by the timeless and adequacy guidelines (listed under Case Management Measures of Effectiveness) as referenced in NBCCEDP Policies and Procedures Manual and the Minimum Data Elements.

Purpose of Case Management

To provide a mechanism to reduce barriers to screening, diagnostic, and treatment services for the BREAST AND CERVICAL CANCER PROGRAM target population.
Goal of Breast and Cervical Cancer Program Case Management

The goal of Case Management is to assure to women enrolled in the Georgia Breast and Cervical Cancer Program receive screening, diagnostic and treatment services with appropriate timeliness as defined by the CDC Case Management measures of effectiveness on the next page.

Case Management Objectives

The Case Management measures of effectiveness are as follows:

- No more than 10% (5% lost to follow-up or refused and 5% pending follow-up) of women with abnormal screening results should fail to complete a diagnostic work up for breast and cervical cancer.
- 75% of women who have had abnormal breast and/or cervical screening results will receive diagnostic services within 60 days.
- 80% of women who receive a breast cancer or cervical cancer/pre-cancer diagnosis will begin treatment within 60 days or 90 days, respectively.
- Refusal of diagnostic services and refusal of treatment should be kept to a minimum, the CDC standard is that 3% or less will be lost to follow-up and 2% or less will refuse diagnostic or treatment services.
- Case Management continues for up to 6 months for cases that follow-up is delayed past the designated time frame. These cases are closed administratively at 5 months Data forms are updated and submitted when follow-up occurs.

Case Management versus Tracking and Follow-up

Case management, tracking and follow-up are three distinct processes. Case Management is client based and an integral portion of clinical standards. Tracking and follow-up are support services. The CDC defines these terms as follows:

CASE MANAGEMENT

A system for supporting individual client care services.
TRACKING

Use of a data system to monitor a woman's receipt of screening/re-screening, diagnostic, and treatment procedures. It is a reactive process to ensure a woman's compliance with the recommended screening/re-screening, diagnostic and treatment protocols.

FOLLOW-UP

Provision of appropriate and timely clinical services following an abnormal test result and/or diagnosis of cancer. Follow-up can occur as part of case management or tracking because it involves the actual provision of clinical services following an abnormal screening result and/or diagnosis of cancer.

When follow-up is delayed past the designated time frames. These cases are closed administratively at 5 months. Data forms are updated and submitted when follow-up occurs.

Breast and Cervical Cancer Program Case Management Requirements

WHO:

1. All Breast and Cervical Cancer Program enrolled women with an abnormal screening result or with the diagnosis of cancer must be assessed for their need of case management services and provided such services accordingly.

Abnormal screening results are:

- Clinical Breast Exam- Abnormal, suspicious for cancer. This includes clinical categories: (1) discrete palpable mass; (2) spontaneous unilateral bloody, clear or serosanguinous nipple discharge; (3) nipple or areolar scaliness; (4) skin dimpling or retraction; and (5) breast pain.
- Mammography- Abnormal results include American College of Radiology (ACR) categories: suspicious abnormality, biopsy should be considered; highly suggestive of malignancy, appropriate action should be taken; and assessment is incomplete, need additional imaging evaluation.
• Pap Test- Abnormal results include an atypical squamous cell (ASG), abnormal glandular cells (AGUS) and high-grade squamous intraepithelial lesion (HSIL) squamous cell carcinoma.

As staffing and fiscal resources allow, additional circumstances for which expanding the initiation of case management services could include:
• Lack of response to re-screening reminder system after normal screen.
• Previous history of abnormal screening results.
• Results requiring short-term follow-up (e.g. ASC-US, LSIL, ACR3-probably benign, short interval follow-up indicated).
• Lack of timely response at any stage of the screening and diagnosis process.
• Request by the client or provider.

At any point in the continuum of care, the client may need regular or intensive case management (see chart on the following pages).

Assure that the following clients are top priority for receiving intensive case management services. Those who:
• Refuse diagnostic services for breast and cervical cancer
• Refuse treatment for breast or cervical cancer or pre-cancer.
• Had treatment delayed beyond 60 days after a breast cancer diagnosis.
• Had treatment delayed beyond 90 days after a cervical cancer diagnosis.
• Are lost to follow-up after diagnosis and before treatment of breast or cervical cancer.

2. All women referred to a Breast and Cervical Cancer Program provider for presumptive eligibility for WHMP must be assessed for their needs of case management services and provided such services accordingly. If the treating physician’s care team will be providing case management services then document this in the client’s chart.
WHEN:

Breast and Cervical Cancer Program case management should begin when an abnormal screening result or diagnosis of cancer is obtained, and concludes when a client initiates treatment or is no longer eligible for the Breast and Cervical Cancer Program. Local public health districts may give consideration to continuing case management services beyond the initiation of treatment based on the client’s demonstration of need, and as staffing and fiscal resources allow.

Assure that current Breast and Cervical Cancer Program clients with abnormal screening and diagnostic results receive continued case management in the event the provider terminates their agreement with the state office to provide Breast and Cervical Cancer Program services. It is the responsibility of the originating screening coordinator to complete and submit required data forms.

WHAT:

There are six key elements of the case management program component that represent the minimum elements to be incorporated into Breast and Cervical Cancer Program case management activities. These key elements are present at both the program and client levels and consist of assessment, planning, coordination, monitoring, evaluation, and resource development. These key elements are described as interdependent complementing one another to successfully provide case management services.
### Difference between Program and Individual Client Case Management Components

<table>
<thead>
<tr>
<th>Key Element</th>
<th>Program Perspective</th>
<th>Individual Client Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment</td>
<td>Determination of your program's need for and preparedness to implement, oversee, and manage a case management system.</td>
<td>A cooperative effort between the client and case manager to examine the client's need for re-screening, diagnostic, treatment, and support services through a process of gathering critical information from the client. This assessment should include the necessary procedures for obtaining client's consent to reveal personal information and assurance of confidentiality between the client, the case manager, and the provider team.</td>
</tr>
<tr>
<td>Assessment Activities</td>
<td><strong>Example:</strong> Appraise available community resources. Examine staff and agency capacity for providing case management. Evaluate current MDEs to determine a baseline for assessing improvement in measures of effectiveness as described in the section titled “Case Management Measures of Effectiveness” in this section.</td>
<td><strong>Example:</strong> Evaluate the Breast and Cervical Cancer Program client's need for case management services. Assess barriers to completion of recommended care. Obtain consent from the client to share information with the provider team. Provide assurance of confidentiality between the client, the case manager, and the provider team. Document consent and assurance of privacy in the client's medical records.</td>
</tr>
<tr>
<td>Planning</td>
<td>Assurance that adequate program resources are available to meet needs of individual Breast and Cervical Cancer Program clients.</td>
<td>Development of an individual client plan for meeting immediate, medium, and long-term needs as identified in the assessment.</td>
</tr>
<tr>
<td>Planning Activities</td>
<td><strong>Example:</strong> Determine number of clients that may require case management services in your district. Use data on timeliness of diagnostic and treatment services, as well as demographic, and behavioral knowledge of the clients in your public health district. Assess preparedness of nurses, client navigators and other case management providers. Define a beginning and ending point for delivery of case management services. Determine activities for each key element, including development of protocols, and program materials. Decide who will be accountable for case management activities.</td>
<td><strong>Example:</strong> The individual client plan should be documented in the client's medical records, and should include the following:</td>
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<tr>
<td></td>
<td>3. Goals and related activities with time frames.</td>
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<tr>
<td></td>
<td>4. Delineation of who is responsible for meeting what goals.</td>
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<tr>
<td></td>
<td>5. Consistently revisit and revise plan as needed throughout the case management process.</td>
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<table>
<thead>
<tr>
<th>Key Element</th>
<th>Program Perspective</th>
<th>Individual Client Perspective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordination</td>
<td>The establishment of standardized systems to track various aspects of case management.</td>
<td>The brokerage, coordination, and referral of services to meet the needs of the client as outlined in the client plan.</td>
</tr>
<tr>
<td>Coordination</td>
<td>Example: Development of a standardized written referral process; development of a system of tracking to assure timely receipt of needed services.</td>
<td>Example: Provision of active assistance by the case manager to ensure that the client’s plan. This may include educating and counseling the client about needed clinical services and about supportive services (e.g., transportation vouchers to doctors’ offices).</td>
</tr>
<tr>
<td>Monitoring</td>
<td>The re-assessment and, if necessary the re-design of the program’s case management system and operational plan. In other words, is our case management system operating as planned?</td>
<td>The ongoing re-assessment of the client’s needs. The re-assessment of the quality of care and services provided to the client to determine if new and continuing needs are being met. Client plans should be updated based on routine reassessments.</td>
</tr>
<tr>
<td>Monitoring</td>
<td>Example: Relocation of case management responsibilities among staff as needed, review of case management documentation.</td>
<td>Example: Follow-up with client to determine if client has received needed services, reminder cards for appointments, and whether new barriers to receiving screening and diagnostic services have developed.</td>
</tr>
<tr>
<td>Resource Development</td>
<td>The establishment of formal and informal agreements to maximize availability and access to essential screening support services, diagnostic and treatment resources.</td>
<td>Promoting self-sufficiency and self-determination among clients by assuring that women gain the knowledge, skills, and support needed to obtain necessary services.</td>
</tr>
<tr>
<td>Resource Development</td>
<td>Example: Contact the Latin American Association to obtain a list of Spanish speaking providers who will provide screening and diagnostic services to Breast and Cervical Cancer Program enrolled Latinas. Partner with local churches to provide transportation to diagnostic and screening services, or free/low cost childcare while receiving services if needed.</td>
<td>Example: Provide client with a language friendly resource list to contact organizations for assistance (e.g. a list and schedule for mobile mammograms).</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Develop outcome measures that at a minimum measure the timeliness and adequacy of individual case management services, case management provider satisfaction, and effectiveness of referral systems. These measures should be tied to the Minimum Data Elements (MDEs).</td>
<td>Assessing client satisfaction, access and timeliness of referral services, and quality of individual case management client plans.</td>
</tr>
</tbody>
</table>
Documentation Guidelines

- Document all case management assessments, plans, actions and outcomes.
- Assure that each client’s initial intake process includes an overview of Breast and Cervical Cancer Program services and expectations including case management, as well as an explanation of informed consent and release of medical information.
- Assure that every new client signs a release of information in order to obtain diagnostic, treatment, or staging information from private or tertiary providers. Client must sign release on 3151 Form. Document client’s refusal of recommended services on a Refusal of Care Form.
- Complete and submit all Breast and Cervical Cancer Program- required data to the state office according to submission policy. This includes having staff initiate a Breast and Cervical Cancer Program Diagnostic and Treatment Form, 3154B or 3154C, for each woman requiring diagnostic services.

The Role of Client Navigators in Case Management

Assisting with case management of Breast and Cervical Cancer Program clients is within the scope of position responsibilities of Client Navigators. Under the supervision of the designated nurse case manager the Client Navigator may assist with phone calls to make appointments, home visits and linking clients to appropriate resources. Refer to Section V for a detailed listing of Client Navigator responsibilities concerning case management.
# Individual Case Management Follow-up Requirements

<table>
<thead>
<tr>
<th>Action</th>
<th>Time frame</th>
<th>Documentation</th>
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</thead>
<tbody>
<tr>
<td>Nurse or Case Manager contacts client to inform of screening results.</td>
<td><strong>Normal Screening Results:</strong> Contact within 30 days. Recall for re-screening at appropriate interval. <strong>Abnormal Screening Results:</strong> First attempt within 5 working days of clinic receiving the abnormal screening result. See Breast and Cervical Procedure Manuals for clinically specific follow-up protocol for clients with findings suspicious of breast and cervical cancer: at least 2 telephone calls or letters, a certified letter and a home visit.</td>
<td>6. Record screening results and all follow-up attempts/outcomes in client’s chart. 7. Document that client has signified understanding of abnormal screening results and recommended diagnostic procedures, including: options, possible outcomes, financial resources, and importance of participation in further testing.</td>
</tr>
<tr>
<td>Conduct Case Management Needs Assessment and Use it to Develop Plan of Care.</td>
<td>1. Complete case management assessment tool within 14 days of clinic receiving the abnormal screening result. 8. Case Manager and client design and agree to follow-up plan of care within 30 days of clinic receiving the abnormal screening result.</td>
<td>1. Add Case Management assessment and follow-up plan to client’s chart.</td>
</tr>
</tbody>
</table>

- **Monitoring:** A process of ongoing tracking and documentation to determine whether client has received needed services in a timely manner.

<table>
<thead>
<tr>
<th>Monitoring</th>
<th>Time frame</th>
<th>Documentation</th>
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</thead>
<tbody>
<tr>
<td>1. Make first attempt to verify service delivery within 30 days of client’s agreement to the plan of care, and at least monthly thereafter until diagnosis/treatment is achieved.</td>
<td>1. In client’s chart, record each monitoring action and status of client’s completion of service. 11. When documentation of service delivery and results from the physician, lab or other provider is obtained, add these to the client’s chart.</td>
<td></td>
</tr>
<tr>
<td>10. Obtain written test results/diagnosis within 3 working days of the procedure, if results are abnormal and within 10-15 working days if results are normal.</td>
<td>12. Complete/submit Form 3154B or 3154C.</td>
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</table>

- **Implement intensive Case Management**

<table>
<thead>
<tr>
<th>Implement intensive Case Management</th>
<th>Time frame</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Initiate when client is resistant or unable to follow-up on recommendations; frequently does not keep appointments.</td>
<td>1. All case management actions and outcomes must be documented in the client’s chart.</td>
<td></td>
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</tbody>
</table>
Action  
**Client Care Conference**  
Clinic Nurse meets with Case Manager or District Coordinator to determine if all case management options have been explored and to plan future client contacts, including annual re-screening.

**Nurse or Case Manager** contacts client to counsel and educate about having recommended test or treatment.

If client moves to another state or another district in Georgia.

**Time Frame**

Initiated as part of intensive case management plan. To be done as soon as necessary and prior to administrative closeout. With client’s permission, family members, friends, or a Client Navigator may be used to assist client in completing plan of care.

These guidelines are applicable to both regular and intensive case management. Attempt to contact client within 5 days of missed appointment and continue at least monthly for a least 90 days after the abnormal screening or diagnostic result. Methods should include phone calls, letters, and certified letters. Home visits should be done where findings are highly suspicious for cancer and the client has not responded to other contact measures. Intensive case management efforts may continue even if screening cycle is administratively closed. Include client in recall system.

If information needed to locate client is available then contact client and refer to that state’s NBCCEDP/ other provider and send client’s records to provider.

**Documentation**

- Record occurrence and outcome of staff meeting in client’s chart.

13. Document client’s consent to include others in plan of care.

- After exhausting all attempts to contact client and refer to intensive case management assessment, close the screening cycle for this particular visit by completing/submitting Form 3154B or 3154C, within 5 months after the date of the abnormal screening or diagnostic test.

- If able to reach client, provide her with written referral information for contacting accessible clinic for breast and cervical cancer follow-up.


15. Document referral and/or attempts to contact client in client’s chart.

16. Request state of residence to send follow-up information to state office.
## Comparison of Regular vs. Intensive Case Management

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Regular Case Management</th>
<th>Intensive Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>CM Care Plan</td>
<td>Developed with client cooperation and client is able to implement with minimal nursing intervention.</td>
<td>Developed with as much client input as possible, but obstacles must be addressed in order to implement.</td>
</tr>
<tr>
<td>Client Status</td>
<td>Willing and able to follow-up on recommendations. Usually keeps appointments.</td>
<td>Resistant or unable to follow-up on recommendations. Frequently does not keep appointments.</td>
</tr>
<tr>
<td>Assessment</td>
<td>Evaluate all situational and/or functional variables for each client: physical, psychosocial (spirit; patient, family), and socioeconomic, (community capabilities, financial, environmental). Client is found to be able and likely to follow through with the needed diagnostic evaluation with minimal guidance.</td>
<td>Same assessment as for regular case management, however client is found to be unable or unlikely to follow through with the needed diagnostic evaluation without substantial support from the case manager and perhaps other staff.</td>
</tr>
<tr>
<td>Problem Identification</td>
<td>The client has no or minimal circumstances that will impede good client outcomes. Routine case management or other staff assistance is required, but limited. For example, staff time is needed to assist the client with a Cancer State Aid application, but the client is able to follow through on her own.</td>
<td>The client has more than one circumstance of moderate to high complexity that will result in poor client outcomes and require an intensive case management effort. Several issues are identified, addressed and resolved by providing education/consultation involving the appropriate partners and by locating needed resources.</td>
</tr>
<tr>
<td>Planning</td>
<td>Develop a plan and timeline to achieve diagnosis and, if needed, assure treatment.</td>
<td>Develop an extensive care plan to identify and address the client's immediate, short-term and long-term needs; promote decision-making; set goals and timeline; and assure resources to implement the care plan.</td>
</tr>
<tr>
<td>Resource Coordination and Requirements</td>
<td>Follow-up with client and provider who is performing diagnostic evaluation to determine final diagnosis and, if needed, assist client in finding resources for treatment and support.</td>
<td>Same initial process as for regular case management, but multiple resources and extensive coordination (meetings, phone calls, strategizing, and documentation) are required to reach care plan goals.</td>
</tr>
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</table>

Recommended Booklets (available from American Cancer Society):

- If Your Doctor Needs a Better Picture of Your Breast
- If You Need a Breast Biopsy
- If You Have Been Told You Have Breast Cancer
<table>
<thead>
<tr>
<th>Parameter</th>
<th>Regular Case Management</th>
<th>Intensive Case Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Monitoring</td>
<td>Within 1 month of completing the case management plan, verify that the plan was implemented. At least monthly, monitor service delivery and provide ongoing assistance to help the client resolve barriers until diagnosis and/or treatment is achieved. Measures the client's response to the services she had received, the effectiveness of the care plan and the quality of the services provided. Compare clients status to expected progress and proactively make needed adjustments.</td>
<td>In addition to monitoring described for regular case management, ongoing follow-up and unusual time and effort are required to track the plan of care. This includes ongoing updates from all relevant sources about the services and products. Determine if the goals of the care plan remain appropriate and are being achieved. The local Case Manager, District Coordinator and State Nurse Consultant work in partnership to identify and resolve case management issues.</td>
</tr>
<tr>
<td>Evaluation and Case Management Plan Revision</td>
<td>Evaluate and document the status of diagnostic or treatment service delivery. Obtain result(s) from the facility or private physician and place in the client’s medical record.</td>
<td>Same as for regular case management, plus additional ongoing reevaluation of strategies to resolve multiple service take place or all avenues have been exhausted.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Client completes plan of care or need for intensive case management is indicated.</td>
<td>Ongoing, persistent case management is needed for client to complete plan of care.</td>
</tr>
<tr>
<td>Documentation</td>
<td>Keep complete, timely and accurate documentation of case management actions and outcomes in the client’s chart. Initiate a Diagnostic/Treatment Form (3154B or 3154C) for each woman who requires diagnostic services. This form must be submitted to the state office according to the submission plan.</td>
<td>Same procedure as for regular case management, but the high level of complexity requires unusual time/effort for documentation.</td>
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<tr>
<td></td>
<td></td>
<td>A client is not considered “lost to follow-up” or “refused” unless required attempts to contact client and a client care conference are completed/documented. Submit Form 3154B or 3154C and the “Report Form for Refused and Lost to Follow-Up” to document these cases. If client contact is possible, request that they sign an Informed Refusal of Care form if client is refusing recommended services. This form documents unresolved issues that caused care refusal; it is placed in client’s chart.</td>
</tr>
<tr>
<td>Parameter</td>
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<td>Intensive Case Management</td>
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</tr>
<tr>
<td>Case Manager and/or</td>
<td>Initial assessment and plan by nurse, plus routine contact for follow-up appointments and</td>
<td>Multiple meetings, phone calls, home visits and follow-up, as well as extensive strategizing and documentation are required.</td>
</tr>
<tr>
<td>Other Staff Time Required</td>
<td>communicating results.</td>
<td></td>
</tr>
<tr>
<td>Administrative Close-out</td>
<td>Client Care Conference of clinic nurse and CM or District Coordinator is required before closeout decision is made. Also, see Documentation section above.</td>
<td>Multiple meetings, phone calls, and follow-up, as well as extensive strategizing and documentation are required.</td>
</tr>
<tr>
<td>CPT Codes</td>
<td>OCMGT 1</td>
<td>OCMGT 2</td>
</tr>
</tbody>
</table>

**Addendum:** If it is determined that the BREAST AND CERVICAL CANCER PROGRAM client has a cancer diagnosis, receives presumptive eligibility for Women’s Health Medicaid, AND case management is continued by the public health clinic, the public health providers can bill DSPS for provision of case management services until the client is enrolled in a CMO (Care Management Organization).

**CASE MANAGEMENT RESOURCES**

Booklets and websites useful to case managers are included in the Resource Catalog CD.

**Client Counseling**

Counseling at the time of the client’s initial visit is key to her understanding of program recommendations and their participation in the program, including screening and the importance of re-screening and follow-up.

When counseling clients or providing ongoing case management services, it is essential to consider potential cultural, language, and literacy issues. Anything that creates a true barrier to health care constitutes a “special need”, whether physical, cultural, or psychosocial. Client counseling is important for meeting these special needs so client can receive needed screening and follow-up.

**Providers should counsel clients at the time of the initial visit regarding:**

a. BREAST AND CERVICAL CANCER
b. Screening guidelines.
c. The importance of regular screening.
d. Identification of potential barriers to qualify care.
e. The availability of support from nurses and resources.

Providers should counsel clients who have abnormal screening results regarding the:

a. Importance of receiving needed follow-up.
b. Importance of knowing about treatment and fiscal choices.
c. Availability of support from nurses, client navigators, and other resources.

BREAST AND CERVICAL CANCER PROGRAM recommends one-on-one counseling with clients using booklets and information guides, which can be ordered from the American Cancer Society, the National Cancer Institute, and the CDC.

Re-screening vs. Recall for Breast Screening

RE-SCREENING:
The CDC uses this term to describe women who are obtaining a mammogram within 18 months of their last mammogram date who possess the following characteristics:

- Between the age of 40-64 years of age.
- Previous mammogram (within last 18 month period) was normal or benign.
- Have not developed breast cancer since the last normal or benign mammogram.

The Georgia BREAST AND CERVICAL CANCER PROGRAM goal is 50% of these women will return for annual mammograms.

RECALL:
Concerns the process by which all women are brought back in to the clinic for appropriate clinical services based upon screening test results. In addition to the re-screening population, recall would include a woman with an abnormal mammogram who needs to return in 3 months for a repeat mammogram. Recall would also include a woman with a questionable CBE with short-term follow-up or mammogram suspicious for cancer who needs to return to the clinic for diagnostic services.

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The distinction between Recall and Re-screening is important to the public health nurse in devising both monitoring and case management strategies. Public health consists of two streams of focus: provision of individual client services and population based care. Recall is the client focused aspect of monitoring and case management in which the goal is to assure that each woman is returning for the appropriate services based upon her screening test results and subsequent plan of care.

Re-Screening drives the population-based aspect of public health monitoring and case management in which each public health district devises strategies (i.e. client navigator sends out colorful reminder cards) to promote the return of women who have had normal screening results annually for a mammogram. Both recall and re-screening are crucial in achieving the BREAST AND CERVICAL CANCER PROGRAM goals of reducing morbidity and mortality related to breast cancer. Those who are effectively recalled complete needed treatment sooner. Those who are rescreened increase their chances of detecting existing breast cancer at an earlier stage thus greatly improving prognosis.

Re-screening vs. Recall for Cervical Screening and Diagnostic Services

RE-SCREENING:

The CDC does not stipulate a re-screening definition for cervical screening and diagnosis. With cervical screening the more pressing issue is over screening in which women are obtained Pap smears more frequently than clinical guidelines recommend. See Cervical Procedure Manual and Section II, Policy and Procedure in this manual for recommended screening guidelines.

RECALL:

Similar to breast screening and diagnostic services, it concerns the process by which all women are brought back in to the clinic for appropriate clinical services based upon Pap smear screening test results.