FY 1997 COOPERATIVE AGREEMENT GUIDANCE NON-COMPETING CONTINUATION APPLICATIONS

THE NATIONAL PROGRAM OF CANCER REGISTRIES

THE CENTERS FOR DISEASE CONTROL AND PREVENTION

Consistent with the Centers for Disease Control and Prevention's (CDC) intent to streamline the grant and cooperative agreement process, only the following items are required:

I. Application Form PHS-5161-1 (Revised 7/92).

II. Annual certification of Compliance with the Cancer Registries Amendment Act. This form is enclosed with the application kit.

III. A. A progress report which succinctly describes program accomplishments and progress made in meeting project objectives. This report will replace the second quarterly report due April 30, 1997, for the period January 1, 1997 through March 31, 1997. The program narrative should not exceed **20 pages** and should be concisely written and focus on the following program objectives:

1. **Legislation and regulations**--The State has a law authorizing formation of a Statewide registry and legislation or regulation in support of all 8 criteria outlined in Public Law 102-515 (PL 102-515).

2. **Uniform data elements**
Information collected on cancer cases includes all required data items as described in PL 102-515. Note that additional items are recommended but not required. Please also refer to the February 27, 1995 letter from Daniel S. Miller, M.D., M.P.H. and Mary D. Hutton, R.N., M.P.H. for the required and recommended items for NPCR-funded central registries (See enclosure).

For each data item collected, the central registry uses standard codes as promulgated by the [North] American Association of Central Cancer Registries ([N]AACCR) and stated in the "Data Standards and Data Dictionary", Volume II, February 14, 1994, as updated with replacement pages, dated April 4, 1995. (A revision is expected in 1997.) In addition, the central registry uses standard definitions and codes for occupation and industry as promulgated by the NAACCR Uniform Data Standards Committee. (See enclosure)
The central registry uses the 1994, 1995, or 1996 version of the [N]AACCR Data Exchange Record Layout for Record Type A. Record Type A is a full case abstract record type including text summaries (see [N]AACCR Standards for Cancer Registries, Volume I, Data Exchange Standard and Record Description, February 14, 1994 and the April 1996 revision.)

3. **Completeness of reporting**

95% of expected unduplicated cases of invasive cancer occurring in State residents in a diagnosis year are reported to the central registry.
The State assures complete reporting of cancer cases to the central registry by inpatient and outpatient hospitals, laboratories, and other facilities providing screening, diagnostic, or therapeutic services; **and** by physicians and surgeons, and all other health care practitioners diagnosing or providing treatment for cancer patients except for cases directly referred to or previously admitted to a hospital or other facility providing screening, diagnostic, or therapeutic services.
The central registry initiates death certificate clearance and follow-back within 6 months of the close of the diagnosis year. Note: Early linkages may be performed with incomplete death or registry files; however, additional linkages must then be performed when the registry considers its case file to be at least 85% complete and the death file is considered complete for the same diagnostic year by the vital statistics' office.
The percentage of cases diagnosed by "death certificate only" is less than 3% of all cancers registered in a given year <u>after</u> follow-back.

The State has documentation of the method used to estimate expected number of unduplicated cases of invasive cancer occurring in State residents in a diagnosis year.
The State has case-sharing agreements with all bordering States and with all other relevant States.

4. **Timeliness of reporting**--cancer cases are reported to the central registry within 6 months from the date of diagnosis.

5. **Data quality**
The central registry has a section or unit that is responsible for an overall program of quality assurance. The quality assurance program is formally defined and consists of carefully planned activities for monitoring quality.
The central registry employs at least one certified tumor registrar.
The central registry has written documentation of policies and procedures for assuring data quality. Documentation is usually in the form of procedure manuals, coding manuals, and other manuals.
The central registry provides training, based on an annual reassessment of training needs, to central registry staff, staff in hospitals, laboratories, clinics, physicians' offices, and all other facilities where staff are responsible for cancer case identification, abstracting, and quality control. For example, the following areas are addressed during training activities: reporting requirements (i.e., frequency of reporting, mechanism of reporting, etc.); data collection (i.e., reportable neoplasms, casefinding procedures, abstracting requirements, etc.); quality control, and data processing.
The central registry applies standard computerized data edits (e.g. EDITS NAACCR or SEER Metafile) to all records to check for item validity, internal consistency, and inter-record consistency.
The central registry has on-site electronic data storage and retrieval.
Reporting facilities in the State use personal computers and standardized data collection software for abstracting and coding. Data, including codes and text, are submitted in standardized electronic form, via network, modem, diskette, or magnetic tape.

Text information is included in the central registry's data set in computerized form.
Internal and external casefinding and reabstracting audits are performed. All audits are planned and executed according to a formal, written protocol.

6. **Monitoring completeness, timeliness, and quality**--the central registry monitors completeness, timeliness, and quality of reporting from the state reporting facilities on a regular basis and takes corrective action when problems are identified.

   For example, States compare every month the **expected** number of cases from each reporting facility with the **actual** number received. In addition, at least quarterly, the State compares the **expected** number of unduplicated cases of invasive cancer occurring in State residents in a diagnosis year with the **actual** number of such cases reported to the central registry.

7. **Central Registry Computer System**--the central registry computer system meets the recommendations in "Overview: A Model Central Cancer Registry Computer System" (see enclosure) and NAACCR Standards.

8. **Annual Report**--the central registry publishes an annual report of cancer incidence within 12 months of the end of the diagnosis year. At a minimum, the report includes age-adjusted incidence rates and age-adjusted mortality rates for the diagnosis year by anatomic site and gender. However, the Central Registry can also provide age-adjusted rates by anatomic site, race, and gender, if such rates are available.

   Note: For cases diagnosed in 1996, the annual report should be published by January 1, 1998. For cases diagnosed in 1997, the annual report should be published by January 1, 1999.

9. **Minimal Data Set**--the central registry prepares and maintains "in-house", a minimal data set which corresponds to the annual report, that meets uniform data standards recommended by NAACCR.

10. **Data Utilization**--the central registry has a comprehensive plan for analysis, interpretation, use, and dissemination of data.

    Analytical plans may include procedures for linking cancer registry data to secondary databases such as medical claims data, census data, other surveillance databases, and data from the National Breast and Cervical Cancer Early Detection Program. Data meeting minimum standards for completeness, timeliness, and quality are used to a) provide timely feedback for evaluating progress toward achieving cancer-control objectives that include the "Healthy People 2000" objectives; b) identify cancer incidence variation for ethnic groups and for regions within a State; c) evaluate State cancer-control activities; d) conduct epidemiologic research; e) improve planning for future health care needs; and f) guide health resource allocation.

B. Program Progress for Year 03

The application should describe "actual" and "projected" accomplishments since some activities will be completed after the application due date (May 5, 1997). For purposes of this application, assume that "actual" accomplishments refer to activities and the status of the data base as of March 31, 1997, allowing thirty days to process the application before submission. For example, the timeliness of reporting should reflect the actual number of cases in the database as of March 31, 1997. "Projected" accomplishments refer to proposed activities, including those related to collection of 1996 data, through the remainder of Year 03 (April 1-September 30, 1997). In addition, planned activities that will not be implemented during Year 03 should be noted.

1. Actual Accomplishments--For each program objective outlined in paragraph A. above, summarize the major activities accomplished during the period **October 1, 1996 - March 31, 1997**. For objectives related to reporting standards (i.e., timeliness, completeness, uniform data elements), recipients should describe the status of the data base for 1996 cases as of March 31, 1997 which allows 30 days for processing this application. In addition, recipients should complete Table 1 (See enclosure) which assesses completeness and timeliness for 1996 invasive cases of

cancer, a subset of reportable cases as defined in Program Announcement 426.

2. Projected Accomplishments--Describe activities that will be accomplished during the period **April 1, 1997-September 30, 1997**. Recipients should focus on activities related to cases diagnosed in 1996 and cases diagnosed in 1997.

   For example, Part I **and** Part II recipients should describe activities planned for ensuring all cases diagnosed from January 1, 1997 - March 31, 1997 are reported to the central registry by September 30, 1997 in compliance with the NPCR's standards for completeness, timeliness, and quality of data.

   In addition, **all recipients,** should describe activities planned for ensuring 1) that all 1996 cases are reported to the central registry by June 1997; 2) that death clearance procedures are initiated by July 1997 for diagnosis year 1996; etc.

3. Challenges and Problems Experienced--Describe each program objective that will not be achieved by September 30, 1997. Summarize specific challenges and problems experienced.

IV. A program narrative that describes any new or significantly revised items or information (objectives, scope of activities, operational methods, key personnel, evaluation, data sets, work plan, etc.) not included in the 01 year or subsequent annual noncompeting continuation applications.

V. A detailed budget must be submitted. Supporting justification should be provided where appropriate. You do not need to rejustify existing budget items that are unchanged from the FY 1996 approved budget; simply list the items in the budget and indicate that they are continuation items.

The following information must be submitted for any new requested contracts. (1) name(s) of contractor; (2) method of selection (competitive or sole source -- less than full competition must be justified); (3) period of performance; (4) description of activities; and (5) itemized budget with narrative justification. If this information is not available when the application is submitted, and the contract line-item is approved by the CDC,

then funds for the contract(s) will be restricted for expenditure on the award.

Note: Where approval to contract was previously provided and the activities are expected to continue without significant change during a subsequent budget period, the noncompeting continuation application need **not** repeat this detailed information but should indicate that the arrangements are expected to continue as previously approved and should reflect the related budgetary needs. Where previously approved contracted activities are expected to change significantly, complete information concerning the proposed changes must be provided. Requests to continue previously approved contract(s) should include the name(s) of the approved contractor and the anticipated itemized budget.

If indirect costs are requested, it is necessary to include a copy of your organization's current negotiated Federal indirect cost rate agreement or a cost allocation plan for those grantees under such a plan.

VI. Unobligated funds

A request to utilize unobligated funds may be submitted with the continuation application. However, any request to utilize unobligated funds must be accompanied by a **separate** programmatic narrative, a budget, and a budget justification. Please note that unobligated funds are subject to the matching requirements.

Please number all pages and print on one side only. Your application should be double spaced. Do not staple and/or bind your application.

A signed original and two copies of your application must be postmarked by ***May 5, 1997,*** and mailed to:

Sharron P. Orum
Grants Management Officer
Procurement and Grants Office
Centers for Disease Control and Prevention
255 East Paces Ferry Road, NE, Room 300, MS-E18
Atlanta, Georgia 30305

Please reference Program Announcement #426 "National Program of Cancer Registries" on the mailing envelope and on the application Standard Form 424, block 11. Please also make sure that block 16, regarding E.O. 12372, is completed correctly on Standard Form 424.

Refer to Program Announcement #426 for detailed information regarding the scope of this cooperative agreement and specific priority activities to be conducted. Cooperative agreement funds may be used to support personnel and to purchase equipment, supplies, and services directly related to project activities and consistent with the scope of the cooperative agreement.

Cooperative agreement funds may not be used to supplant state or local funds, to provide inpatient care or personal health services, support construction or renovation of facilities.