HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, DC 20301-1200

DEC 9 1996

MEMORANDUM FOR: SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: FY 97 Breast Cancer Education, Diagnosis, and Prevention Program

The National Defense Authorization Act of 1997 allocated $25 million which will provide for the continuation of the FY 96 breast cancer education, diagnosis, and prevention program. Funds will be allocated to you for your military medical treatment facilities (MTFs) with coordination of plans and activities through the TRICARE Lead Agents. The Regional Action Teams developed under the FY 96 initiative should continue to serve as the interdisciplinary coordinating body for regional breast cancer plans and activities.

Substantial interest was shown for the 1996 Breast Cancer Initiative and excellent program ideas are being developed to benefit DoD women beneficiaries. I commend those Lead Agents and MTFs that executed creative and oftentimes complex programs in an extremely short time period. While I am confident that the goals outlined in the business plan will be accomplished, performance measures will need to be assessed to determine the overall successful outcomes.

The FY 97 funding plan will utilize a performance based weighting method for disbursing funds to MTFs and Lead Agents. The FY 97 Strategy, Progress, and Future Directions document (attachment) was discussed at the video teleconference held on November 22, 1996 and will be available on the worldwide web. It includes the FY 97 Business Plan. Funding for FY 97 will be allocated through a three-phased approach. Phase I will be distributed to the MTFs for beneficiary access to breast cancer screening, diagnosis, and treatment; Phase II will be distributed to MTFs for training of primary care managers; and Phase III will be distributed to the Lead Agents for a coordinated merit-based region-wide education program.

Each MTF and Lead Agent is required to submit quarterly progress reports, starting March 3, 1997, to OASD(HA) via Service chain-of-command. Phase I reports should start with baseline (pre FY 96 funding) data and note changes, on the following performance indicators:

a. increase in demand for mammography services

b. increase in number of beneficiaries accessing services

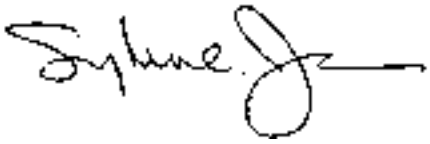
c. increase in availability of mammography appointments

d. reduction in average waiting time to obtain appointment

e. increase in number of beneficiaries screened

f. increases in number of beneficiaries educated and number of technicians trained.

Other information or ideas may be added that are consistent with the overall objectives of the program. Phase II and III performance indicators are included in the Strategy document.



Stephen C. Joseph, M.D., M.P.H.

Attachment:
As stated

Department of Defense

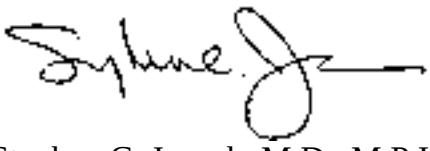
Breast Cancer Prevention, Education, and Diagnosis Initiative

Fiscal Year 1997
Strategy, Progress & Future Directions

27 NOVEMBER 1996

Preface

The Breast Cancer Prevention, Education and Diagnosis Initiative is intended to provide increased access and education on breast cancer to all eligible Department of Defense (DoD) women beneficiaries. The fiscal year funds for 1996 were allocated in two phases. Phase I, capitated funds, were distributed to all military treatment facilities (MTFs) for access and hardware, and Phase II, merit-based funds, were distributed to the Lead Agents for region-wide education programs. Funding authorizations were disbursed through the Offices of the Surgeons General to military treatment facilities and TRICARE Lead Agents. Each Surgeon General was able to redirect funds to provide the greatest coverage for breast cancer education, diagnosis, and treatment for their beneficiaries. It was imperative to obligate the FY 1996 funds by 30 September 1996 on items and areas that would increase access to breast cancer care for eligible women beneficiaries. We are appreciative of the efforts and innovative programs inaugurated during FY 96 and look forward to making significant inroads towards increased awareness, early detection, prevention, and successful treatment of breast cancer for our beneficiaries.



Stephen C. Joseph, M.D., M.P.H.
Assistant Secretary of Defense for Health Affairs

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Executive Summary

Breast cancer is the most commonly diagnosed cancer among United States women, with 184,300 new cases expected to be diagnosed in 1996. It is the leading cause of cancer deaths for women aged 15 to 54 years and the second leading cause of cancer deaths overall among women in the U.S. with about 46,250 deaths anticipated in 1996. The diagnosis of breast cancer has grown 2% each year since 1980. The lifetime risk of developing breast cancer has gone from 1 in every 20 women two decades ago to 1 in every 8 women today. The majority of women diagnosed with breast cancer, about 80% of all cases, are over the age of 50. The mortality rate in Caucasian women has dropped since 1992 but the mortality rate in African-American women has increased. It is believed by cancer experts that the overall decline in breast cancer seen in recent years is partly due to increased mammography screening, while the increase in African-American women could reflect the fact that fewer women in this group have mammograms. Screening for breast cancer is lowest among minority, low income, and older women. The percentage of minority women in the military is 40% (the majority of which are African-American), increasing the importance for DoD to emphasize increased awareness and education to military women in an effort to decrease the overall mortality rate. Breast cancer screening has resulted in a shift towards detection of breast cancer at earlier stages, when treatment is more effective and survival is likely to be higher.

The combined number of DoD women beneficiaries age 30 and above approximate about two million and represents about 26% of all Military Health Services System (MHSS) beneficiaries. Thirteen percent of the active

forces are women. Each year nearly 18,000 new cases of breast cancer are diagnosed in the MHSS. It is through education and awareness of the importance of clinical examinations, mammography, and monthly breast self-examinations (BSE) that breast cancer mortality can be decreased while positively affecting the morale of the DoD workforce.

The DoD Breast Cancer Work Group (WG), a Tri-Service interdisciplinary team composed of representatives nominated by the Services and the Office of the Assistant Secretary of Defense for Health Affairs (OASD (HA)), provides guidance and oversight for the Defense Health Program (DHP) on breast cancer. The Work Group advises the Tri-Service Executive Committee on utilization of FY 1996 and FY 1997 DHP breast cancer funds. The WG is responsible for the development of program guidelines and reviews implementation plans, which will aid in improving early diagnosis, education, and prevention of breast cancer for women beneficiaries.

The detailed Business Plan states the goals, objectives, strategies, and performance measures for the FY97 Program. The execution strategy includes the specific roles for the OASD (HA), the WG, the Service Surgeons General, the TRICARE Lead Agents, and the medical treatment facilities (MTFs), and the funding and execution methods, in addition to recommended reporting formats (see Appendices). The Business Plan is available via the World Wide Web at: http://www.tricare.osd.mil/policy/fy96/brcncr40.html#Attachment.

The FY97 Program will utilize a **three-phased approach**. **Phase I** will be implemented by the MTFs with coordination of the Lead Agents. Phase I focuses on **beneficiary access** to breast cancer screening, diagnosis, and treatment. **Phase II** will be implemented by the MTFs with coordination of the Lead Agents. Phase II focuses on **training programs** for all MTF Primary Care Managers on clinical breast cancer examinations and BSE techniques for beneficiaries. **Phase III** funds will be allocated to the Lead Agents for coordination and implementation of the programs. Phase III focuses on coordinated **region-wide education programs**. These will consist of (1) continuation of successful FY96 programs, (2) design of new merit-based programs, and/or (3) exporting of those FY96 regional programs, deemed worthy of implementing, throughout the MHSS.

Each TRICARE Lead Agent should have established a Regional Action Team during FY96 to design and coordinate the implementation of the Regional Implementation Plan. The Action Team will develop the implementation plan and operational guidelines for Phase III of the FY97 Program. Phase I and II implementation plans will be developed by the MTFs. These plans should explain how Phases I, II, and III programs will be accomplished. All plans will be submitted to the OASD (HA). Each MTF will implement the Phase I and II components. Phase III plans must be approved by OASD (HA). Once approved, the Lead Agents will implement the Phase III components. Each MTF shall be required to prepare a **quarterly** Progress Report concerning Phase I and II activities. These reports are to be sent to the OASD (HA) through the Service normal chain of command, with a coordination copy to their Lead Agent. Each Lead Agent will be required to prepare a **quarterly** Progress Report concerning Phase III programs and forward it to the OASD (HA) via the respective chain of command to the Service Surgeon General.

SECTION 1. INTRODUCTION AND BACKGROUND

1.1. Demographics Scope of the Problem

The total number of active duty and reserve women in the Armed Forces is nearly 350,000 and growing. This represents 13% of the active forces. Women beneficiaries (including those on active duty) of the Military Health Services System (MHSS) who are age 30 or older total 2.1 million, which is 26% of all MHSS beneficiaries. Nearly 18,000 cases of breast cancer are diagnosed in MHSS facilities each year. Breast cancer affects not only the women who develop the disease and undergo treatment, but also their spouses, families, employers, and peers. In the case of women who are either on active duty or in a reserve status, breast cancer is a readiness issue. The actual treatment for breast cancer, plus the loss of work time (and in certain cases, loss of life), has a significant and far-reaching impact economically and emotionally on the military and the Nation.

The most effective way to decrease the devastating effects of breast cancer is by increasing the knowledge that physicians and beneficiaries have concerning clinical examinations, mammograms, and monthly breast self-examinations (BSE). Early breast cancer detection and education can increase survival rates. Initiatives to advance a broad range of activities to promote the health and well-being of women, plus efforts to assist women in making more informed choices about their health, can lead to a reduced incidence and prevalence of breast cancer.

1.2. Purpose of the Initiative

In FY 1996, Congress directed the Assistant Secretary of Defense for Health Affairs (ASD (HA)) to develop and implement this program to improve early diagnosis, education, and prevention of breast cancer for women beneficiaries of the MHSS. The National Defense Authorization Act of FY 1997 allocated $25M to the Defense Health Program for this Initiative.

1.3. Tri-Service Interdisciplinary Work Group

In response to the FY96 legislation, the ASD (HA) chartered a Tri-Service interdisciplinary team called the DoD Breast Cancer Work Group (WG). The purpose of the WG is to provide guidance and oversight for the Defense Health Program (DHP) breast cancer program and to develop an implementation plan to improve prevention, early diagnosis, and education on breast cancer for women beneficiaries. Specifically, the WG advises the Tri-Service Executive Committee (TEC) on utilization of the DHP Breast Cancer funds. The WG meets monthly, or more frequently, as needed.

The WG is comprised of representatives from the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)) and from each Service. These representatives come from appropriate disciplines such as medical, surgical and radiation oncology, general surgery, gynecology, radiology, nursing, and family practice. Colonel Doris Browne, M.D., MPH, Director of Prevention and Standards, OASD (HA)/Clinical Services, chairs the WG, which consists of the following members:

OASD (HA) Representative and Work Group Chair	COL Doris Browne, MC
Office of the Army Surgeon General (OTSG)	COL David Jaques, MC COL Julia Williams, NC LTC Yvonne Andejski, MC

Office of the Navy Surgeon General (BUMED)	CAPT Kathleen O'Farrell, MC CDR Cary Goepfert, MC CDR Steven Remmenga, MC
Office of the Air Force Surgeon General (AFMOA)	Lt Col Ray Cunningham, MC Maj Michael Freckleton, MC Lt Col Tom Bradley, MC
Deputy Assistant Secretary of Defense (Health Budgets & Programs) Representative	Mr. Bernard McGill

For FY97, the WG has expanded its membership to include each Surgeon General's women's health consultant and breast cancer survivors as ad hoc (non-voting) representatives. In order to increase communication and coordination for implementation of the FY97 Strategy, each Service will also have non-voting representatives from the financial arenas on the WG. The FY97 Work Group Charter (see Appendix A) delineates the roles and responsibilities of the WG.

SECTION 2. IMPLEMENTATION PLAN

2.1. Phase I, II, and III Concepts

In FY96, the Breast Cancer Work Group (WG) developed a two-phased plan for executing the $25 million budget item appropriated by Congress. This phased approach will continue in FY97. The purpose of dividing the plan into phases is to highlight the areas of concern in the Congressional language access and education. In FY97, Phase I will focus on MHSS beneficiary access to breast cancer care, particularly screening, and will be managed by the military Medical Treatment Facilities (MTFs). Phase II will focus on education for MHSS beneficiaries and health care providers and will be managed by the MTF. Phase III will focus on developing merit-based education programs or exporting successful Phase II programs from the FY96 Initiative and will be coordinated by the TRICARE Lead Agents.

2.1-A. PHASE I. The goal of Phase I is to increase awareness of screening, diagnosis, and treatment options, improve clinical outcomes and patient satisfaction, and decrease the loss of work time. Phase I funding, representing 40% of the FY97 $25M allocation, will be distributed to the MTFs based on the number of MHSS women beneficiaries over the age of 30 within the MTF's catchment area. Funding allocation for non-catchment area population will be included in Phase I distribution to Surgeons General for designation at their discretion. Phase I funds will be used to increase beneficiary access to breast cancer care via a variety of means, including the purchase of hardware (not more than 10% of Phase I allocation) that would have a direct impact on increasing access to breast cancer screening. See Appendix B for a partial list of recommendations for expenditures for Phase I. Examples of appropriate items funded under the FY96 Phase I Initiative are:

- Extended clinic hours
- Upgrades for ultrasound and mammography equipment

- Overtime for civilian personnel
- Extension/expansion of contracts to increase turnaround of mammography results
- Enhancement/upgrade of stereotactic & ultrasound biopsy services
- Mammography multi-loader processor
- BSE training tapes and models.

Some suggested Phase I performance measures to be utilized by the MTF are as follows:

- Percent change in demand for mammography services
- Percent change in number of beneficiaries accessing services
- Percent change in availability of mammography appointments
- Percent change in average waiting time to obtain appointment
- Percent change in number of beneficiaries screened
- Percent change in number of beneficiaries educated
- Percent change in number of technicians trained.

2.1-B. PHASE II. Phase II funding, representing 20% of the FY97 $25M allocation, will be used by the MTFs solely for education of the Primary Care Managers (PCMs) in breast care, which includes clinical breast examinations and BSE techniques and for training beneficiaries in BSE. For the purpose of the breast cancer initiative, PCMs are identified as physicians (internists, family practitioners, general practitioners, and obstetricians/gynecologists), nurse practitioners, nurses, certified nurse midwives, physician assistants, and some independent duty corpsmen. As stated in the FY97 Business Plan, the WG is committed to pursuing the following primary strategy in 1997:

"Train all TRICARE primary care managers (PCMs) through funding for, and sponsorship of, a short course in clinical breast examination techniques."

The WG believes that training all PCMs about breast care, including BSE and clinical examinations will enable them to conduct screening clinical examinations for breast cancer and teach all women beneficiaries in their care how to do BSE. In addition, it is expected that this training will enable PCMs to identify "high risk" women beneficiaries who need additional education and counseling on early breast cancer detection and management. The PCMs will then be able to provide access to these services.

The WG further recommends that training of the PCM will consist of office counseling techniques and skills development workshops on cancer prevention, early detection technologies, and state-of-the-art treatment options. In addition, the PCM should be taught which behaviors impact breast cancer risk, how to identify "high risk" women, and how to counsel women about modifying behaviors which can affect breast cancer risk.

Prior to initiating the PCM training program, each MTF will establish a baseline, i.e., how many women report being taught BSE during a visit with a PCM within a 12 month period. After the PCM training program is completed, the MTF will record how many women report being taught BSE during a visit with a PCM, within the last 12 month period, to determine if change has occurred.

Some suggested performance measures for Phase II are as follows:

- Percentage of pcms trained in clinical breast examination techniques
- Percentage of active duty/other MHSS women who have been instructed in BSE
- Percentage of active duty/other MHSS women over the age of 40 who have ever had a screening mammogram
- Percentage of active duty/other MHSS women who have been given breast cancer care educational materials.

2.1-C. PHASE III. Phase III funding, representing 40% of the FY97 $25M allocation, will have three purposes:

- Continue FY96 Phase II education program
- Start a new merit-based regional program of education for providers and/or beneficiaries
- Export merit-based FY96 Phase II programs to other TRICARE regions.

(1) FY97 Phase III funds may be used to continue successful FY96 Phase II programs or to create a new regional education program for providers and/or beneficiaries. In all cases, the program must be able to demonstrate that it has merit and the potential for moving the MHSS towards realization of the goals and objectives of the FY97 Initiative.

TRICARE Lead Agents should continue to measure the success of their Phase III programs, utilizing FY96 Phase II performance measures, such as the following:

- Percent change of breast cancer cases diagnosed at early clinical stage
- Percent change in percent of beneficiaries adhering to breast cancer screening recommendations
- Percent change in beneficiaries attending breast cancer educational outreach programs, accessing educational kiosks, and/or using educational cd-roms
- Correlation between patient education and early detection rates.

(2) FY97 Phase III funds may be used to export successful merit-based FY96 Phase II programs to other TRICARE regions. The WG will decide which FY96 Phase II programs will be exported after review of proposals from TRICARE Lead Agents to the OASD (HA).

The following programs received Phase II funding during FY96 and could potentially be exported to other TRICARE regions:

- Quality management and nurse care manager
- Mobile education units
- Genetic counseling and testing
- Tracking and mail-out education module
- Interactive cd-rom education program
- Focus group module
- Patient tracking and case management training
- Wellness education interactive kiosk
- Youth and elderly education program
- Centralized tumor board/tumor registry.

2.1-D. Regional Action Teams. Each TRICARE Lead Agent under the FY96 Initiative was to have formed a Regional Action Team led by a senior physician specialist in either oncology, family practice, internal medicine, general surgery, or gynecology. The senior physician specialist will be the point of contact and responsible for coordination (including progress reports) of the Regional Plan. Action teams should include representation from the disciplines of primary care, general surgery, oncology (medical, surgical and radiation), gynecology, preventive medicine, radiology, nursing, and physical therapy. In addition, representatives from beneficiary support and breast cancer advocacy groups may be members.

The Regional Action Team will be responsible for recommending to the Lead Agent the best utilization of the money allocated for the Breast Cancer Initiative and for developing implementation plans. The Lead Agents will forward the proposals, including an implementation plan, to the OASD (HA) for review and awarding of funds, based upon the merit of their plans.

The Regional Action Team should be expanded to include representatives from the MTF. The team is responsible for developing a regional plan for increasing access to education.

2.1-E. Summary

Phase I The focus is **access to care**. The Phase I plan will be designed by the MTF.

Phase II The focus is **education of PCM and beneficiaries in clinical breast examinations and BSE**. The Phase II plan will be designed by the MTF.

Phase III The focus is **education of health care providers and beneficiaries in breast care**. The Regional Action Team at the Lead Agent will design the Phase III Plan. One or more of three options can be proposed:

- Continue the FY96 Phase II Program
- Design a new merit-based program
- Export a successful merit-based FY96 Phase II Program to another TRICARE region.

SECTION 3. FY97 BUSINESS PLAN

3.1 Background for the Initiative

The total number of active duty and reserve women in the Armed Forces is nearly 350,000 (13%) of the Active Forces and growing. If we add to this number all other women Military Health Services System (MHSS) beneficiaries who are age 30 or older, the total is 26% of the Active Forces. This is important because it means that breast cancer is a readiness issue. Breast cancer affects not only the woman diagnosed with the disease, but also her spouse, family, employer, friends, and peers. If the woman is on active duty, she will lose time at work for treatment and therapy. In addition, her concentration may be focused entirely on her treatment and immediate future. If the woman's husband is on active duty, he likely will lose time at work caring for her or accompanying her to treatment. Most importantly, he may find it difficult to concentrate on his work. If the active duty woman or husband is in an operational role, this difficulty with concentration can have devastating effects on national

security.

There are three available screening tests for breast cancer that are considered to be effective. They are the clinical breast examination, mammography, and the breast self-examination (BSE). The Department of Defense recommends in its policy guidelines that an annual clinical breast examination for all women and a baseline screening mammogram be obtained for women at age 40. In addition, mammography should be provided every two years for women between ages 40 and 50. Annual screening mammograms are recommended for women beginning at age 50. If clinically indicated, a baseline screening mammogram should be accomplished at an earlier age. Monthly BSEs are strongly encouraged.

Early breast cancer detection and education can reduce the more serious effects of breast cancer and increase survival rates. Initiatives to advance a broad range of activities promoting the health and well-being of women, plus efforts to assist women in making more informed choices about their health, can lead to a reduced incidence and prevalence of breast cancer. The most effective way to decrease the devastating effects of breast cancer is by increasing the knowledge of physicians and beneficiaries about clinical examinations, mammograms, and monthly BSE.

3.2. Legislative Background

The FY 1996 Defense Appropriations Act provided an increase of $100M for breast cancer. It designated $75M for the continuation of the Army's peer-reviewed research program and $25M to the Department of Defense for increased recruitment, training and education for military cancer specialists, diagnostic equipment and improved detection technologies, and prevention and education efforts for the military community. The FY 1997 Defense Appropriations Act provided an additional $25M to continue the education and prevention program initiated with the FY96 funds.

3.3. Goals and Objectives for the FY97 Initiative

3.3-A. Goals

- Ensure MHSS health care providers and beneficiaries are knowledgeable about state-of-the-art breast cancer detection and treatment options.
- Ensure MHSS health care providers and beneficiaries have access to state-of-the-art breast cancer detection and treatment options.

3.3-B. Objectives

- Provide MHSS health care providers training in early detection, minimization of breast cancer risk, and state-of-the-art treatment options.
- Optimize access for MHSS beneficiaries to state-of-the-art breast cancer treatment and follow-on options.

3.4. Strategies for the FY97 Initiative.

The FY97 Initiative will have as its centerpiece **three interrelated components**:

- MHSS women beneficiaries aged 18 and above will be instructed in and/or provided self-instructional material in breast examination and encouraged to practice monthly BSE.
- MHSS primary care managers (PCMs), identified for purposes of this breast cancer initiative as physicians (internists, family practitioners, general practitioners, and obstetricians/gynecologists), nurse practitioners, nurses, certified nurse midwives, physician assistants, and independent duty corpsmen will be educated in breast care.
- MHSS women beneficiaries diagnosed with breast cancer will have increased access to the full range of treatment options.

The strategy with the highest priority for FY97 is to train all TRICARE primary care managers (PCMs) through funding for, and sponsorship of, a short course in clinical breast examination techniques. The intended outcomes are the following:

- The PCM will be able to teach BSE to all MHSS women beneficiaries who visit them for health care of any nature.
- The PCM will be able to identify "high risk" women beneficiaries who need additional education and counseling on early breast cancer detection and management; and the PCM will provide access to these services.

The training of the PCM will consist of office counseling techniques and skills development workshops on cancer prevention, early detection technologies, and state-of-the-art treatment options. In addition, the PCM will be taught which behaviors impact breast cancer risk, how to identify "high risk" women, and how to counsel women about modifying behaviors which can affect breast cancer risk.

Prior to initiating the PCM training program, the medical treatment facility (MTF) will establish a baseline, i.e., how many women have been taught BSE during a visit with a PCM. After the PCM training program is completed, the MTF will record how many women report being taught BSE, to determine if change has occurred.

- Support studies on the epidemiology of breast cancer, specifically for premenopausal breast cancer in MHSS active duty and reserve women.
- Facilitate increased patient participation in choice of treatment by providing MHSS women beneficiaries exposure to, access to, and education on all elements of breast care, including specialty care available from radiology, surgery, and oncology. Facilitate the participation of MHSS women beneficiaries in clinical trials, including chemoprevention trials, when the benefits and risks of the therapy have been thoroughly explained.
- Provide psychosocial support for MHSS women beneficiaries diagnosed with breast cancer. Provide psychosocial family member support.
- Train interested military oncologists in breast cancer risk assessment and genetic counseling. Approved DoD guidelines will specify who the "high risk" patients are and how they will be identified, screened, and appropriately counseled by military oncologists and medical geneticists.
- Develop or obtain health education information and interactive modules specific to breast cancer screening, management, and treatment for educating women MHSS beneficiaries aged 18 and older.
- Identify and pursue other worthwhile activities within the guidelines of the Breast Cancer Prevention, Education, and Diagnosis Initiative.

3.6. Performance Measures for FY97

The rate-based indicators for the performance measurements for Phase I shall be based upon the Defense Medical Information System (DMIS) data for MTF catchment and non-catchment areas (see Appendix C). The following are some performance measures that will be used to track progress towards attainment of the FY97 Goals and Objectives:

- Percentage of active duty women who have been given breast cancer care educational materials
- Percentage of other MHSS women beneficiaries who have been given breast cancer care educational materials
- Percentage of active duty women who have been instructed in BSE
- Percentage of other MHSS women beneficiaries who have been instructed in BSE
- Percentage of active duty women over the age of 40 who have ever had a screening mammogram
- Percentage of other MHSS women beneficiaries who have ever had a screening mammogram.

3.7. FY97 Initiative Execution Strategy

The FY97 Initiative will be a Tri-Service execution effort, involving a partnership of the three Services, at all echelons. Communication, cooperation, and coordination will be essential for successful achievement of the Goals and Objectives.

3.7-A. Role of OASD (HA) Director, Prevention and Standards

- Provides program management for the Breast Cancer Prevention, Education and Diagnosis Initiative
- Provides oversight and coordination for all FY97 Initiative activities
- Provides guidance and funding to the MTFs and Lead Agents via the Surgeons General
- Reviews and approves all Phase I, II, and III plans
- Reviews all progress reports
- Chairs Tri-Service Work Group
- Advises the Principal Deputy and Tri-Service Executive Committee (TEC) on progress and issues associated with the execution of the Initiative.

3.7-B. Role of Tri-Service Work Group

- Provides guidance and oversight for the Initiative
- Develops an implementation plan for the Initiative
- Advises the TEC on utilization of the FY97 funds.

3.7-C. Role of Surgeons General

- Distribute funds to the Lead Agents and MTFs
- Forward guidance from the OASD (HA) to the Lead Agents and MTFs
- Forward reports from the Lead Agents and MTFs to the OASD (HA).

3.7-D. TRICARE Lead Agents

- Receive guidance and Phase 3 funding from the OASD (HA) via the Lead Agent's Service Surgeon General
- Chair and coordinate activities of the Regional Action Team, including the development of regional plans for Phase III
- Coordinate design and implementation of Phase I and II activities
- Coordinate the exportation of successful FY96 Phase II programs to other TRICARE regions
- Forward quarterly Phase III progress reports to the OASD (HA) via the Lead Agent's Service chain of command.

3.7-E. Medical Treatment Facility (MTF)

- Receives guidance and funding from Service Surgeon General
- Actively participates in regional planning as a member of the Regional Action Team
- Implements the Phase I and II components of the breast cancer initiative
- Coordinates Phase I and II activities with the Lead Agent and Regional Action Team
- Provides quarterly progress reports of Phase I and II activities to their appropriate Service chain of command to the OASD (HA) with a coordinating copy to their Lead Agent.

3.8. Phase I and Phase II Plans

- The purpose of Phase I funding is to increase beneficiary access to breast cancer care, including screening, diagnosis, and treatment. The Phase I Plan will include a section explaining the strategy each MTF in the TRICARE region will use to increase access to breast cancer screening, diagnosis, and treatment. This plan will also include an explanation of how FY97 Phase I activities will complement and build upon the FY96 activities. The recommended format is provided in Appendix D.

- The purpose of Phase II funding is to increase knowledge of the PCM of clinical breast examination and BSE techniques. All PCMs will be trained in clinical breast examinations and BSE. After training, PCMs are expected to train all women beneficiaries in their care in BSE techniques. The Phase II plan is to include a section explaining the strategy each MTF will use to establish a baseline for the number of women who have received BSE training prior to the time the training program for PCMs is completed. Another section will describe the method that will be used to record how many women report having had BSE training by the PCM after the training program is completed. The recommended format is provided in Appendix E.

3.9. Regional Plans

Each TRICARE Lead Agent is responsible for establishing a Regional Action Team. The team should consist of representatives from MTFs in the TRICARE region. In addition, the team should include representatives from the disciplines of primary care, general surgery, internal medicine, oncology (surgical, medical, and radiation), gynecology, radiology, preventive medicine, nursing, and physical therapy. Representatives from the beneficiary population and breast cancer advocacy groups should also be included on the team.

Each Regional Action Team will develop, submit for approval to OASD (HA), and coordinate the implementation of a Regional Plan for Phase III of the FY97 Initiative. The plan will follow the following guidelines:

a. The Regional Action Team will use the FY97 Business Plan, particularly the sections on Goals and Objectives, Strategies, and Performance Measures, as a guide.

b. The purpose of Phase III funding is to increase DoD beneficiary and physician training and education about breast care. This can be accomplished by the continuation of FY96 Phase II programs, designing new educational programs, or exporting successful FY96 Phase II programs to other TRICARE regions. The recommended format is provided in Appendix F.

(1) For proposals to continue FY96 program the plan will describe the program, cite specific accomplishments (using the performance indicators), and the rationale for continuation through FY97.

(2) For proposals for new merit-based programs the plan will describe the proposed program (including specific detail about methods), cite specific reasons for NOT continuing the FY96 program, cite specific reasons for proposing the new program, and cite specific expected outcomes.

(3) For proposals to export successful FY96 Phase II programs describe the program, explain WHY it should be exported, describe in detail HOW it would be exported, and cite specific expected outcomes.

c. The Lead Agent will forward the Phase III plan to the OASD (HA) via the Lead Agent's Service Surgeon General.

d. The Regional Phase III Plan is due to the OASD (HA) no later than 3 February 1997. The OASD (HA) will notify the Lead Agent via the Surgeon General of the approval/disapproval of the plan no later than 3 March 1997. Note that submitting the plan does NOT assure "approval." Phase III funds will NOT be disbursed until the Lead Agents receive notification of "approval."

e. The plan will include a schedule for routine and regular Regional Action Team meetings and timelines for implementation of all aspects of the plan.

3.10. Funding Procedure

Funding will occur in three phases:

a. Forty percent of the $25M will be allocated by the OASD (HA) to the Surgeons General, for Phase I activities. This allocation will be based upon a capitated rate for all women MHSS beneficiaries over the age of 30 in the TRICARE region. The funding allocation for the MTF is based on the catchment area population (see Appendix C). Funding for non-catchment area populations is to be designated at the discretion of each Surgeon General. Lead Agents may be an ideal designee for utilizing non-catchment area funds. It is anticipated that Phase I funding allocation will be made by December 1996.

b. Twenty percent of the $25M will be allocated by the OASD (HA) to the MTFs, via the Surgeons General, for Phase II. Phase II spending will be solely for the training of PCMs in clinical and BSE examination techniques. After the training, PCMs will train all women beneficiaries in their care about BSE.

c. Forty percent of the $25M will be allocated by the OASD (HA) to the TRICARE Lead Agents, via the Surgeons General, for Phase III programs. Phase III will consist of (1) continuation of FY96 Phase II programs, (2) starting new merit-based educational programs, and/or (3) exporting successful FY96 Phase II programs to other TRICARE regions.

SECTION 4. FY97 PROGRAM EVALUATION

The system-wide performance measures (section 3.6 above) will be the primary means of evaluating effectiveness of the Initiative. Quarterly MTF Phase I and II and quarterly Phase III Progress Reports will provide information about each facility's and TRICARE region's breast cancer activities. These should be summarized by the Surgeons General to obtain a MHSS system-wide profile of changes in the performance measures, and therefore, progress towards accomplishment of the FY97 Goals and Objectives of the Initiative.

4.1. Progress Reports

The purpose of progress reports is to document progress towards the FY97 Goals and Objectives (section 3.3 above). The method for estimating progress will be to document changes in the FY97 performance measures from the pre-funding baseline (that is, prior to FY96 funding).

Each MTF will provide two quarterly progress reports through their Surgeon General to the OASD (HA), with a coordination copy to their Lead Agent. These will be two separate progress reports, one for Phase I and one for Phase II. The first set of reports is due to the OASD (HA) by close of business on 3 March 1997.

Each Lead Agent will provide a quarterly Phase III progress report to the OASD (HA) via the Lead Agent's Service Surgeon General. The first report is due to the OASD (HA) by close of business on 1 May 1997.

The recommended format for the MTF Phase I progress report can be found in Appendix G; the recommended format for the MTF Phase II Progress Report can be found in Appendix H; and the recommended format for the Lead Agent Phase III Progress Report can be found in Appendix I.

The MTFs will provide a final (end-of-FY97) Phase I and II report to OASD (HA). The Lead Agent will provide a final (end-of-FY97) Phase III regional progress report to the OASD (HA) via the Lead Agent's Surgeon General. These reports will be a status report of Phases I, II, and III as of 30 September 1997. They are due at the

OASD (HA) no later than close of business 1 November 1997.

APPENDIX A. DoD BREAST CANCER WORK GROUP CHARTER

APPENDIX B. RECOMMENDED PHASE I EXPENDITURES

Recommended:

- Contract personnel (e.g., radiologists, mammography technicians, administrative/clerical staff)
- Extending clinic hours, personnel overtime costs
- Enhancement of existing mammography and ultrasonography equipment
- Equipment (e.g., sequential pumps, ultrasound probes, spring-loaded guns)
- Mail-out notification of mammography results
- Technician continuing education course(s) (but not travel costs)
- Additional supplies, film
- Beneficiary education materials (e.g., pamphlets, shower cards)
- Marketing and advertising for MTF's increased access programs
- Other items (e.g., fax machine for mammography coordination, sleeves for mammogram films, biopsy chair, ultrasound transducer, view boxes)
- Chemotherapy drugs (must be approved by waiver).

Not Recommended:

- New mammography and/or ultrasonography units
- Books

- Professional seminars, conferences, and similar events
- Travel costs.

APPENDIX C. REGIONAL AND SERVICE DEMOGRAPHICS

REGION 1

FACILITY NAME	INSTALLATION	SVC	REG	ST	POP*
WALTER REED AMC	WASHINGTON DC	A	1	DC	14,550
KIMBROUGH ACH	FT. MEADE	A	1	MD	22,984
KELLER ACH	WEST POINT	A	1	NY	7,363
DEWITT ACH	FT. BELVOIR	A	1	VA	37,063
436th MEDICAL GROUP	DOVER AFB	F	1	DE	7,484
89th MEDICAL GROUP	ANDREWS AFB	F	1	MD	17,075
NH GROTON	GROTON	N	1	CT	9,059
NNMC BETHESDA	BETHESDA	N	1	MD	27,023
NH PATUXENT RIVER	PATUXENT RIVER	N	1	MD	3,655
NH NEWPORT	NEWPORT	N	1	RI	9,103
305TH MEDICAL GROUP	MCGUIRE AFB	F	1	NJ	21,505
ARMY OUTCATCHMENT		A	1		47,080
NAVY OUTCATCHMENT		N	1		31,673
AIR FORCE OUTCATCHMENT		F	1		35,194
	REGION 1 TOTAL				**290,811**

REGION 2

FACILITY NAME	INSTALLATION	SVC	REG	ST	POP*
WOMACK AMC	FT. BRAGG	A	2	NC	31,426
MCDONALD ACH	FT. EUSTIS	A	2	VA	12,566
KENNER ACH	FT. LEE	A	2	VA	11,294
4th MEDICAL GROUP	SEYMOUR JOHNSON AFB	F	2	NC	7,546
1st MEDICAL GROUP	LANGLEY AFB	F	2	VA	19,013
NH CAMP LEJEUNE	CAMP LEJEUNE	N	2	NC	12,987
NH CHERRY POINT	CHERRY POINT	N	2	NC	6,280
NH PORTSMOUTH	PORTSMOUTH	N	2	VA	63,891
ARMY OUTCATCHMENT		A	2		13,575
NAVY OUTCATCHMENT		N	2		10,481
AIR FORCE OUTCATCHMENT		F	2		10,408

	REGION 2 TOTAL				**199,467**

REGION 3

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
EISENHOWER AMC	FT. GORDON	A	3	GA	14,921
MARTIN ACH	FT. BENNING	A	3	GA	17,168
WINN ACH	FT. STEWART	A	3	GA	11,230
MONCRIEF ACH	FT. JACKSON	A	3	SC	14,431
6th MEDICAL GROUP	MACDILL AFB	F	3	FL	34,479
45th MEDICAL GROUP	PATRICK AFB	F	3	FL	17,136
347th MEDICAL GROUP	MOODY AFB	F	3	GA	4,524
78th MEDICAL GROUP	ROBINS AFB	F	3	GA	9,197
20th MEDICAL GROUP	SHAW AFB	F	3	SC	7,050
NH JACKSONVILLE	JACKSONVILLE	N	3	FL	34,193
NH CHARLESTON	CHARLESTON	N	3	SC	19,021
NH BEAUFORT	BEAUFORT	N	3	SC	5,304
ARMY OUTCATCHMENT		A			41,139
NAVY OUTCATCHMENT		N			34,450
AIR FORCE OUTCATCHMENT		F			36,834
	REGION 3 TOTAL				**301,077**

REGION 4

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
FOX ACH	REDSTONE ARSENAL	A	4	AL	10,137
NOBLE ACH	FT. MCCLELLAN	A	4	AL	6,788
LYSTER ACH	FT. RUCKER	A	4	AL	9,311
502nd MEDICAL GROUP	MAXWELL AFB	F	4	AL	11,650
96th MEDICAL GROUP	EGLIN AFB	F	4	FL	20,800
325th MEDICAL GROUP	TYNDALL AFB	F	4	FL	8,968
81st MEDICAL GROUP	KEESLER AFB	F	4	MS	13,917
NH PENSACOLA	PENSACOLA	N	4	FL	19,658
NH MILLINGTON	MILLINGTON	N	4	TN	10,269
ARMY OUTCATCHMENT		A			24,265
NAVY OUTCATCHMENT		N			17,343
AIR FORCE OUTCATCHMENT		F			20,208
	REGION 4 TOTAL				**173,314**

REGION 5

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***

BLANCHFIELD ACH	FT. CAMPBELL	A		5	KY	14,014
IRELAND ACH	FT. KNOX	A		5	KY	14,464
375th MEDICAL GROUP	SCOTT AFB	F		5	IL	16,496
74th MEDICAL GROUP	WRIGHT-PATTERSON AFB	F		5	OH	15,615
NH GREAT LAKES	GREAT LAKES	N		5	IL	11,380
ARMY OUTCATCHMENT		A				38,627
NAVY OUTCATCHMENT		N				23,695
AIR FORCE OUTCATCHMENT		F				32,533
	REGION 5 TOTAL					**166,824**

REGION 6

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
BAYNE-JONES ACH	FT. POLK	A	6	LA	5,656
REYNOLDS ACH	FT. SILL	A	6	OK	11,670
BROOKE AMC	FT. SAM HOUSTON	A	6	TX	31,025
DARNALL ACH	FT. HOOD	A	6	TX	24,612
314th MEDICAL GROUP	LITTLE ROCK AFB	F	6	AR	10,798
2nd MEDICAL GROUP	BARKSDALE AFB	F	6	LA	9,631
72nd MEDICAL GROUP	TINKER AFB	F	6	OK	15,495
97th MEDICAL GROUP	ALTUS AFB	F	6	OK	2,604
7th MEDICAL GROUP	DYESS AFB	F	6	TX	5,112
82nd MEDICAL GROUP	SHEPPARD AFB	F	6	TX	5,768
47th MEDICAL GROUP	LAUGHLIN AFB	F	6	TX	1,173
59th MEDICAL WING	LACKLAND AFB	F	6	TX	26,786
NH CORPUS CHRISTI	CORPUS CHRISTI	N	6	TX	6,609
ARMY OUTCATCHMENT		A			37,539
NAVY OUTCATCHMENT		N			25,091
AIR FORCE OUTCATCHMENT		F			53,301
	REGION 6 TOTAL				**272,870**

REGION 7

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
BLISS ACH	FT. HUACHUCA	A	7	AZ	6,161
WILLIAM BEAUMONT AMC	FT. BLISS	A	7	TX	17,593
56th MEDICAL GROUP	LUKE AFB	F	7	AZ	23,851
355th MEDICAL GROUP	DAVIS MONTHAN AFB	F	7	AZ	14,612
99th MEDICAL GROUP	NELLIS AFB	F	7	NV	18,503
377th MEDICAL GROUP	KIRTLAND AFB	F	7	NM	13,053
49th MEDICAL GROUP	HOLLOMAN AFB	F	7	NM	3,914
27th MEDICAL GROUP	CANNON AFB	F	7	NM	2,892
ARMY OUTCATCHMENT		A			4,752

NAVY OUTCATCHMENT		N			7,338
AIR FORCE OUTCATCHMENT		F			5,649
	REGION 7 TOTAL				**118,318**

REGION 8

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
FITZSIMONS AMC	DENVER	A	8	CO	18,628
EVANS ACH	FT. CARSON	A	8	CO	17,709
IRWIN ACH	FT. RILEY	A	8	KS	6,382
MUNSON ACH	FT. LEAVENWORTH	A	8	KS	11,148
L. WOOD ACH	FT. LEONARD WOOD	A	8	MO	6,231
10TH MEDICAL GROUP	USAF ACADEMY	F	8	CO	13,890
366th MEDICAL GROUP	MOUNTAIN HOME AFB	F	8	ID	2,273
509th MEDICAL GROUP	WHITEMAN AFB	F	8	MO	3,284
55th MEDICAL GROUP	OFFUTT AFB	F	8	NE	12,450
319th MEDICAL GROUP	GRAND FORKS AFB	F	8	ND	2,473
5th MEDICAL GROUP	MINOT AFB	F	8	ND	2,299
28th MEDICAL GROUP	ELLSWORTH AFB	F	8	SD	3,899
75th MEDICAL GROUP	HILL AFB	F	8	UT	9,510
90th MEDICAL GROUP	F.E. WARREN AFB	F	8	WY	3,290
ARMY OUTCATCHMENT		A			24,711
NAVY OUTCATCHMENT		N			17,995
AIR FORCE OUTCATCHMENT		F			29,235
	REGION 8 TOTAL				**185,407**

REGION 9

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
WEED ACH	FT. IRWIN	A	9	CA	2,370
30th MEDICAL GROUP	VANDENBERG AFB	F	9	CA	5,459
95th MEDICAL GROUP	EDWARDS AFB	F	9	CA	5,062
NH CAMP PENDLETON	CAMP PENDLETON	N	9	CA	25,069
NH SAN DIEGO	SAN DIEGO	N	9	CA	64,214
NH TWENTYNINE PALMS	TWENTYNINE PALMS	N	9	CA	3,290
ARMY OUTCATCHMENT		A			10,639
NAVY OUTCATCHMENT		N			25,923
AIR FORCE OUTCATCHMENT		F			21,430
	REGION 9 TOTAL				**163,456**

REGION 10

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***
60th MEDICAL GROUP	TRAVIS AFB	F	10	CA	17,201

9th MEDICAL GROUP	BEALE AFB	F	10	CA	5,721	
77th MEDICAL GROUP	MCCLELLAN AFB	F	10	CA	21,531	
NH LEMOORE	LEMOORE	N	10	CA	6,235	
ARMY OUTCATCHMENT		A			12,818	
NAVY OUTCATCHMENT		N			9,558	
AIR FORCE OUTCATCHMENT		F			8,461	
	REGION 10 TOTAL					**81,525**

REGION 11

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***	
MADIGAN AMC	FT. LEWIS	A	11	WA	36,791	
92nd MEDICAL GROUP	FAIRCHILD AFB	F	11	WA	8,926	
NH BREMERTON	BREMERTON	N	11	WA	12,066	
NH OAK HARBOR	OAK HARBOR	N	11	WA	6,625	
ARMY OUTCATCHMENT		A			9,773	
NAVY OUTCATCHMENT		N			14,457	
AIR FORCE OUTCATCHMENT		F			10,861	
	REGION 11 TOTAL					**99,499**

REGION 12

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***	
TRIPLER AMC	FT. SHAFTER	A	12	HI	27,870	
ARMY OUTCATCHMENT		A			816	
NAVY OUTCATCHMENT		N			449	
AIR FORCE OUTCATCHMENT		F			346	
	REGION 12 TOTAL					**29,481**

EUROPE

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***	
95TH CSH-HEIDELBERG	HEIDELBERG	A	EU	GM	6,548	
LANDSTUHL REGIONAL MEDCEN	LANDSTUHL	A	EU	GM	6,827	
65th MEDICAL GROUP	LAJES FLD	F	EU	PO	446	
48th MEDICAL GROUP	RAF LAKENHEATH	F	EU	UK	4,506	
39th MEDICAL GROUP	INCIRLIK AB	F	EU	TU	699	
52nd MEDICAL GROUP	SPANGDAHLEM AB	F	EU	GM	1,724	
NH NAPLES	NAPLES	N	EU	IT	1,420	
NH ROTA	ROTA	N	EU	SP	1,019	
BH SIGONELLA	NAS SIGONELLA	N	EU	IT	743	
NH KEFLAVIK	KEFLAVIK	N	OS	IC	641	
ARMY OUTCATCHMENT		A	EU		13,364	
NAVY OUTCATCHMENT		N	EU		3,273	

AIR FORCE OUTCATCHMENT		F	EU		6,749	
	EUROPE TOTAL					**47,959**

PACIFIC

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***	
BASSETT ACH	FT. WAINWRIGHT	A	AK	AK	3,410	
121st GENERAL HOSPITAL	SEOUL	A	OS	KO	3,453	
3rd MEDICAL GROUP	ELMENDORF AFB	F	AK	AK	8,834	
8th MEDICAL GROUP	KUNSAN AB	F	OS	KO	348	
51st MEDICAL GROUP	OSAN AB	F	OS	KO	2,170	
35th MEDICAL GROUP	MISAWA	F	OS	JA	1,732	
374th MEDICAL GROUP	YOKOTA AB	F	OS	JA	2,308	
NH GUAM	AGANA	N	OS	GU	4,086	
NH OKINAWA	OKINAWA	N	OS	JA	4,862	
NH YOKOSUKA	YOKOSUKA	N	OS	JA	3,040	
ARMY OUTCATCHMENT		A	OS		8,317	
NAVY OUTCATCHMENT		N	OS		1,884	
AIR FORCE OUTCATCHMENT		F	OS		1,967	
ARMY OUTCATCHMENT		A		AK	458	
NAVY OUTCATCHMENT		N		AK	274	
AIR FORCE OUTCATCHMENT		F		AK	285	
	PACIFIC TOTAL					**47,428**

MISCELLANEOUS

FACILITY NAME	**INSTALLATION**	**SVC**	**REG**	**ST**	**POP***	
		A			12	
		N			655	
		F			4	
NH GUANTANAMO BAY	GUANTANAMO BAY	N	OS	CA	254	
NH ROOS ROADS	CEIBA	N	OS	PR	1,840	
GORGAS ACH	GORGAS	A	OS	PM	2,941	
	MISCELLANEOUS TOTAL					**5,706**

TOTAL INCATCHMENT	**1,397,253**
TOTAL OUTCATCHMENT	**785,889**
GRAND TOTAL	**2,183,142**

FACILITY NAME	**INSTALLATION NAME**	**SVC**	**REG**	**ST**	**POP***	
WALTER REED AMC	WASHINGTON DC	A	1	DC	14,550	

KIMBROUGH ACH	FT. MEADE	A	1	MD	22,984
KELLER ACH	WEST POINT	A	1	NY	7,363
DEWITT ACH	FT. BELVOIR	A	1	VA	37,063
WOMACK AMC	FT. BRAGG	A	2	NC	31,426
MCDONALD ACH	FT. EUSTIS	A	2	VA	12,566
KENNER ACH	FT. LEE	A	2	VA	11,294
EISENHOWER AMC	FT. GORDON	A	3	GA	14,921
MARTIN ACH	FT. BENNING	A	3	GA	17,168
WINN ACH	FT. STEWART	A	3	GA	11,230
MONCRIEF ACH	FT. JACKSON	A	3	SC	14,431
FOX ACH	REDSTONE ARSENAL	A	4	AL	10,137
NOBLE ACH	FT. MCCLELLAN	A	4	AL	6,788
LYSTER ACH	FT. RUCKER	A	4	AL	9,311
BLANCHFIELD ACH	FT. CAMPBELL	A	5	KY	14,014
IRELAND ACH	FT. KNOX	A	5	KY	14,464
BAYNE-JONES ACH	FT. POLK	A	6	LA	5,656
REYNOLDS ACH	FT. SILL	A	6	OK	11,670
BROOKE AMC	FT. SAM HOUSTON	A	6	TX	31,025
DARNALL ACH	FT. HOOD	A	6	TX	24,612
BLISS ACH	FT. HUACHUCA	A	7	AZ	6,161
WILLIAM BEAUMONT AMC	FT. BLISS	A	7	TX	17,593
FITZSIMONS AMC	DENVER	A	8	CO	18,628
EVANS ACH	FT. CARSON	A	8	CO	17,709
IRWIN ACH	FT. RILEY	A	8	KS	6,382
MUNSON ACH	FT. LEAVENWORTH	A	8	KS	11,148
L. WOOD ACH	FT. LEONARD WOOD	A	8	MO	6,231
WEED ACH	FT. IRWIN	A	9	CA	2,370
MADIGAN AMC	FT. LEWIS	A	11	WA	36,791
TRIPLER AMC	FT. SHAFTER	A	12	HI	27,870
95TH CSH-HEIDELBERG	HEIDELBERG	A	EU	GM	6,548
LANDSTUHL REGIONAL MEDCEN	LANDSTUHL	A	EU	GM	6,827
BASSETT ACH	FT. WAINWRIGHT	A	AK	AK	3,410
121st GENERAL HOSPITAL	SEOUL	A	OS	KO	3,453
REGION 1 OUTCATCHMENT		A			47,080
REGION 2 OUTCATCHMENT		A			13,575
REGION 3 OUTCATCHMENT		A			41,139
REGION 4 OUTCATCHMENT		A			24,265
REGION 5 OUTCATCHMENT		A			38,627
REGION 6 OUTCATCHMENT		A			37,539
REGION 7 OUTCATCHMENT		A			4,752
REGION 8 OUTCATCHMENT		A			24,711

REGION 9 OUTCATCHMENT	A	10,639
REGION 10 OUTCATCHMENT	A	12,818
REGION 11 OUTCATCHMENT	A	9,773
REGION 12 OUTCATCHMENT	A	816
EUROPE OUTCATCHMENT	A	13,364
PACIFIC OUTCATCHMENT	A	8,775
MISCELLANEOUS	A	2,953
ARMY TOTAL		784,620

FACILITY NAME	**INSTALLATION NAME**	**SVC**	**REG**	**ST**	**POP***
436th MEDICAL GROUP	DOVER AFB	F	1	DE	7,484
89th MEDICAL GROUP	ANDREWS AFB	F	1	MD	17,075
4th MEDICAL GROUP	SEYMOUR JOHNSON AFB	F	2	NC	7,546
1st MEDICAL GROUP	LANGLEY AFB	F	2	VA	19,013
6th MEDICAL GROUP	MACDILL AFB	F	3	FL	34,479
45th MEDICAL GROUP	PATRICK AFB	F	3	FL	17,136
347th MEDICAL GROUP	MOODY AFB	F	3	GA	4,524
78th MEDICAL GROUP	ROBINS AFB	F	3	GA	9,197
20th MEDICAL GROUP	SHAW AFB	F	3	SC	7,050
502nd MEDICAL GROUP	MAXWELL AFB	F	4	AL	11,650
96th MEDICAL GROUP	EGLIN AFB	F	4	FL	20,800
325th MEDICAL GROUP	TYNDALL AFB	F	4	FL	8,968
81st MEDICAL GROUP	KEESLER AFB	F	4	MS	13,917
375th MEDICAL GROUP	SCOTT AFB	F	5	IL	16,496
74th MEDICAL GROUP	WRIGHT-PATTERSON AFB	F	5	OH	15,615
314th MEDICAL GROUP	LITTLE ROCK AFB	F	6	AR	10,798
2nd MEDICAL GROUP	BARKSDALE AFB	F	6	LA	9,631
72nd MEDICAL GROUP	TINKER AFB	F	6	OK	15,495
97th MEDICAL GROUP	ALTUS AFB	F	6	OK	2,604
7th MEDICAL GROUP	DYESS AFB	F	6	TX	5,112
82nd MEDICAL GROUP	SHEPPARD AFB	F	6	TX	5,768
47th MEDICAL GROUP	LAUGHLIN AFB	F	6	TX	1,173
59th MEDICAL WING	LACKLAND AFB	F	6	TX	26,786
56th MEDICAL GROUP	LUKE AFB	F	7	AZ	23,851
355th MEDICAL GROUP	DAVIS MONTHAN AFB	F	7	AZ	14,612
99th MEDICAL GROUP	NELLIS AFB	F	7	NV	18,503
377th MEDICAL GROUP	KIRTLAND AFB	F	7	NM	13,053
49th MEDICAL GROUP	HOLLOMAN AFB	F	7	NM	3,914
27th MEDICAL GROUP	CANNON AFB	F	7	NM	2,892
10th MEDICAL GROUP	USAF ACADEMY	F	8	CO	13,890

366th MEDICAL GROUP	MOUNTAIN HOME AFB	F	8	ID	2,273
509th MEDICAL GROUP	WHITEMAN AFB	F	8	MO	3,284
55th MEDICAL GROUP	OFFUTT AFB	F	8	NE	12,450
319th MEDICAL GROUP	GRAND FORKS AFB	F	8	ND	2,473
5th MEDICAL GROUP	MINOT AFB	F	8	ND	2,299
28th MEDICAL GROUP	ELLSWORTH AFB	F	8	SD	3,899
75th MEDICAL GROUP	HILL AFB	F	8	UT	9,510
90th MEDICAL GROUP	F.E. WARREN AFB	F	8	WY	3,290
30th MEDICAL GROUP	VANDENBERG AFB	F	9	CA	5,459
95th MEDICAL GROUP	EDWARDS AFB	F	9	CA	5,062
60th MEDICAL GROUP	TRAVIS AFB	F	10	CA	17,201
9th MEDICAL GROUP	BEALE AFB	F	10	CA	5,721
77th MEDICAL GROUP	MCCLELLAN AFB	F	10	CA	21,531
92nd MEDICAL GROUP	FAIRCHILD AFB	F	11	WA	8,926
65th MEDICAL GROUP	LAJES FLD	F	EU	PO	446
48th MEDICAL GROUP	RAF LAKENHEATH	F	EU	UK	4,506
39th MEDICAL GROUP	INCIRLIK AB	F	EU	TU	699
52nd MEDICAL GROUP	SPANGDAHLEM AB	F	EU	GM	1,724
8th MEDICAL GROUP	KUNSAN AB	F	OS	KO	348
51st MEDICAL GROUP	OSAN AB	F	OS	KO	2,170
35th MEDICAL GROUP	MISAWA	F	OS	JA	1,732
374th MEDICAL GROUP	YOKOTA AB	F	OS	JA	2,308
3rd MEDICAL GROUP	ELMENDORF AFB	F	AK	AK	8,834
305th MEDICAL GROUP	MCGUIRE AFB	F	1	NJ	21,505
REGION 1 OUTCATCHMENT		F			35,194
REGION 2 OUTCATCHMENT		F			10,408
REGION 3 OUTCATCHMENT		F			36,834
REGION 4 OUTCATCHMENT		F			20,208
REGION 5 OUTCATCHMENT		F			32,533
REGION 6 OUTCATCHMENT		F			53,301
REGION 7 OUTCATCHMENT		F			5,649
REGION 8 OUTCATCHMENT		F			29,235
REGION 9 OUTCATCHMENT		F			21,430
REGION 10 OUTCATCHMENT		F			8,461
REGION 11 OUTCATCHMENT		F			10,861
REGION 12 OUTCATCHMENT		F			346
EUROPE OUTCATCHMENT		F			6,749
PACIFIC OUTCATCHMENT		F			2,252
MISCELLANEOUS		F			4
AIR FORCE TOTAL					800,147

FACILITY NAME	INSTALLATION NAME	SVC	REG	ST	POP*
NH GROTON	GROTON	N	1	CT	9,059
NNMC BETHESDA	BETHESDA	N	1	MD	27,023
NH PATUXENT RIVER	PATUXENT RIVER	N	1	MD	3,655
NH NEWPORT	NEWPORT	N	1	RI	9,103
NH CAMP LEJEUNE	CAMP LEJEUNE	N	2	NC	12,987
NH CHERRY POINT	CHERRY POINT	N	2	NC	6,280
NH PORTSMOUTH	PORTSMOUTH	N	2	VA	63,891
NH JACKSONVILLE	JACKSONVILLE	N	3	FL	34,193
NH CHARLESTON	CHARLESTON	N	3	SC	19,021
NH BEAUFORT	BEAUFORT	N	3	SC	5,304
NH PENSACOLA	PENSACOLA	N	4	FL	19,658
NH MILLINGTON	MILLINGTON	N	4	TN	10,269
NH GREAT LAKES	GREAT LAKES	N	5	IL	11,380
NH CORPUS CHRISTI	CORPUS CHRISTI	N	6	TX	6,609
NH CAMP PENDLETON	CAMP PENDLETON	N	9	CA	25,069
NH SAN DIEGO	SAN DIEGO	N	9	CA	64,214
NH TWENTYNINE PALMS	TWENTYNINE PALMS	N	9	CA	3,290
NH LEMOORE	LEMOORE	N	10	CA	6,235
NH BREMERTON	BREMERTON	N	11	WA	12,066
NH OAK HARBOR	OAK HARBOR	N	11	WA	6,625
NH NAPLES	NAPLES	N	EU	IT	1,420
NH ROTA	ROTA	N	EU	SP	1,019
BH SIGONELLA	NAS SIGONELLA	N	EU	IT	743
NH KEFLAVIK	KEFLAVIK	N	OS	IC	641
NH GUAM	AGANA	N	OS	GU	4,086
NH OKINAWA	OKINAWA	N	OS	JA	4,862
NH YOKOSUKA	YOKOSUKA	N	OS	JA	3,040
REGION 1 OUTCATCHMENT		N			31,673
REGION 2 OUTCATCHMENT		N			10,481
REGION 3 OUTCATCHMENT		N			34,450
REGION 4 OUTCATCHMENT		N			17,343
REGION 5 OUTCATCHMENT		N			23,695
REGION 6 OUTCATCHMENT		N			25,091
REGION 7 OUTCATCHMENT		N			7,338
REGION 8 OUTCATCHMENT		N			17,995
REGION 9 OUTCATCHMENT		N			25,923
REGION 10 OUTCATCHMENT		N			9,558
REGION 11 OUTCATCHMENT		N			14,457

REGION 12 OUTCATCHMENT	N	449
EUROPE OUTCATCHMENT	N	3,273
PACIFIC OUTCATCHMENT	N	2,158
MISCELLANEOUS	N	2,749
NAVY TOTAL		598,375
GRAND TOTAL		2,183,142

*Population of women beneficiaries over age 30.

Data Source: Defense Medical Information System, 1996

APPENDIX D. RECOMMENDED FORMAT FOR THE PHASE I PLAN.

1. MTF NAME: **2. DATE SUBMITTED:**

3. MTF POC NAME:

a. DSN PHONE: **b. COMMERCIAL PHONE:**

c. EMAIL: **d. COMMERCIAL FAX NUMBER:**

4. PHASE I FUNDING FOR THIS MTF:

a. FY96 DOLLARS OBLIGATED FOR PHASE I ACTIVITIES:

b. FY97 DOLLARS ALLOCATED TO PHASE I:

5. NARRATIVE DESCRIPTION OF THE PHASE I PLAN FOR YOUR MTF:

[NOTE: must provide all details for the OASD (HA) to make an informed decision]

a. How will you increase beneficiary access to screening, diagnosis, and breast care?

(1) Give specific details of the program you want to put into place.

(2) Is this a continuation of your FY96 program, or a new program?

(3) How does your FY97 Plan complement and build upon your FY96 activities?

b. How will you spend Phase I money? List each item and cost per item. Give as many details as

you think necessary for the OASD (HA) to make aninformed decision.

6. TIMETABLE FOR THE FY97 PHASE I PROGRAM AT YOUR MTF:

APPENDIX E. RECOMMENDED FORMAT FOR THE PHASE II PLAN

1. MTF NAME: **2. DATE SUBMITTED:**

3. MTF POC NAME:

a. DSN PHONE: **b. COMMERCIAL PHONE:**

c. EMAIL: **d. COMMERCIAL FAX:**

4. PHASE II PLAN:

a. Each MTF will establish a "baseline" for the number of women who report having received BSE training from their PCM during their last visit. Describe the methodology to be used to obtain the baseline data.

b. Describe the training program that will be provided to the PCMs in your MTF. Be specific about course content, how, total hours, etc. Describe the plan for ensuring that ALL PCMs in your MTF receive the training. Describe the testing and evaluation methods to be used. List the faculty, including vitae.

c. After the PCMs have completed the training, all women beneficiaries who have visits with the PCMs thereafter will be asked if they received BSE training during their visit. This number will be recorded and a report will be filed every two months with the TRICARE Lead Agent, who will forward the data (via the Service Surgeon General) to the OASD (HA). Describe the methodology to be used to obtain these data, how they will be recorded, by whom, and when.

d. How will you spend the Phase II money? Give specific details of each item and its cost. Give as many details as you think necessary for the OASD (HA) to make an informed decision.

5. TIMETABLE FOR THE FY97 PHASE II PROGRAM AT YOUR MTF:

APPENDIX F. RECOMMENDED FORMAT FOR PHASE III REGIONAL PLAN.

1. REGION: **2. DATE SUBMITTED:**

3. LEAD AGENT POC NAME:

a. DSN PHONE: **b. COMMERCIAL PHONE:**

c. EMAIL: **d. COMMERCIAL FAX NUMBER:**

4. LIST OF REGIONAL ACTION TEAM MEMBERS (name and location):

5. HOW OFTEN DOES THE REGIONAL ACTION TEAM MEET?

6. FY96 PHASE II FUNDING:

a. FY96 DOLLARS OBLIGATED FOR PHASE II ACTIVITIES:

7. FY97 PLAN FOR PHASE II:

[NOTE: it is essential that you provide all details for the OASD (HA) to make an informed decision]

a. CONTINUE FY96 PHASE II PROGRAM

(1)
Summarize the Program.

(2)
Cite specific accomplishments, using the performance indicators.

(3)
Provide the rational for continuation. What is expected to be accomplished by continuing the Program for one more year?

b. DESIGN A NEW PROGRAM

(1)
Describe the proposed Program (including specific detail about methods).

(2)
Cite specific reasons for NOT continuing the FY96 Program.

(3)
Cite specific reasons for proposing this new Program.

(4)
Cite specific expected outcomes.

c. EXPORT A SUCCESSFUL FY96 PHASE II PROGRAM TO ANOTHER TRICARE REGION

(1)

Explain WHY the Program should be exported.

(2)

Describe, in detail, HOW it will be exported.

(3)

Cite specific expected outcomes.

d. HOW DOES YOUR FY97 PLAN COMPLEMENT AND BUILD UPON YOUR FY96 ACTIVITIES?

e. HOW WILL YOU SPEND PHASE III MONEY? LIST EACH ITEM AND COST PER ITEM. GIVE AS MANY DETAILS AS YOU THINK NECESSARY FOR THE OASD (HA) TO MAKE AN INFORMED DECISION.

8. TIMELINE FOR THE FY97 PHASE III PROGRAM:

APPENDIX G. FORMAT FOR MTF PHASE I QUARTERLY PROGRESS REPORTS.

1. MTF NAME: **2. POC NAME:**

3. POC DSN: **4. POC COMMERCIAL PHONE:**

5. POC EMAIL: **6. DATE OF REPORT:**

7. COMMERCIAL FAX NUMBER:

8. PROGRESS - FY97 PERFORMANCE MEASURES:
(See section E of the FY97 Business Plan)

	BASELINE PERCENT	THIS MONTH PERCENT	PERCENT CHANGE (increase or decrease)
ACTIVE DUTY - GIVEN EDUCATIONAL MATERIALS			
OTHER WOMEN BENEFICIARIES - GIVEN EDUCATIONAL MATERIALS			
ACTIVE DUTY - INSTRUCTED IN BSE			
OTHER WOMEN BENEFICIARIES - INSTRUCTED IN BSE			

ACTIVE DUTY - BASELINE SCREENING MAMMOGRAM			
OTHER WOMEN BENEFICIARIES - BASELINE SCREENING MAMMOGRAM			
AVAILABILITY OF MAMMOGRAPHY APPOINTMENTS			
AVERAGE WAITING TIME FOR MAMMOGRAPHY APPOINTMENTS			

9. ISSUES, PROBLEMS WITH IMPLEMENTATION:

APPENDIX H. FORMAT FOR MTF PHASE II QUARTERLY PROGRESS REPORTS.

1. MTF NAME: **2. POC NAME:**

3. POC DSN: **4. POC COMMERCIAL PHONE:**

5. POC EMAIL: **6. DATE OF REPORT:**

7. COMMERCIAL FAX:

8. PROGRESS:

a. BASELINE number of women who report receiving BSE training =

b. DATES PCMs RECEIVED TRAINING =

c. NUMBER OF WOMEN WHO REPORT RECEIVING BSE TRAINING =

d. IS "C" AN INCREASE FROM BASELINE? HOW MUCH?

9. ISSUES, PROBLEMS WITH IMPLEMENTATION:

APPENDIX I. FORMAT FOR REGIONAL PHASE III QUARTERLY PROGRESS REPORTS

1. MTF NAME: **2. POC NAME:**

3. POC DSN: **4. POC COMMERCIAL PHONE:**

5. POC EMAIL: **6. DATE OF REPORT:**

7. COMMERCIAL FAX NUMBER:

8. PROGRESS FY97 RECOMMENDED PERFORMANCE MEASURES: (See section IIIE of the FY97 Business Plan)

a. Number of and percent change in number of patients participating in choice of treatment

b. Percent change in number of MHSS women beneficiaries diagnosed with breast cancer and participating in psychosocial support program

c. Number of and percent change in number of military oncologists receiving training in breast cancer risk assessment and genetic counseling

d. Number of and percent change of breast cancer cases diagnosed at early clinical stage

e. Percent of beneficiaries adhering to breast cancer screening recommendations

f. Percent change in beneficiaries attending breast cancer educational outreach programs, accessing educational kiosks, and/or using educational CD-ROMs

g. Correlation between patient education and early detection rates.

9. ISSUES, PROBLEMS WITH IMPLEMENTATION:

APPENDIX J. RECOMMENDED FORMAT FOR REQUEST FOR WAIVER

[all information is necessary for approval]

[Date]

MEMORANDUM FOR THE DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) FOR CLINICAL SERVICES

SUBJECT: Breast Cancer Prevention, Education And Diagnosis Initiative Waiver Request

1. Conditional approval was granted for **[put the name of your MTF here]**'s proposed actions for increasing

access to breast cancer screening and treatment (Phase I of the Breast Cancer Prevention, Education and Diagnosis Initiative, as per the 1996 Defense Authorization Act). Because our proposal includes a provision for **[state whether you are seeking a waiver for equipment/hardware costs which exceed 10% of the total money allocated or for chemotherapy drugs]**, we request a formal waiver of the applicable regulations.

2. **[In this paragraph, give a clear and specific rationale for the equipment/hardware or chemotherapy drugs you are requesting. Include specific expected outcomes which make the equipment/hardware or chemotherapy drugs important to increasing access of DoD beneficiaries to breast cancer screening and/or treatment.]**

3. **[Give the name of a point of contact, DSN phone number, commercial phone number, commercial fax number, and email address. This is VERY important in case we need to ask questions prior to granting approval.]**

[Name of CO/XO]
[Title]

Recommendation:

_____Approved/Disapproved_____Date_____

J.F. Mazzuchi
Deputy Assistant Secretary
for Clinical Services