WISEWOMAN Colorado

Program Manual

Colorado Department of Public Health and Environment
Health Services and Connections Branch

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PURPOSE OF THIS MANUAL

This manual is designed to give you the information needed to run a successful WISEWOMAN program. It is organized into sections that generally follow the flow of a client – starting with background and recruitment and ending with reimbursement and subcontracting. If you do not find the information you need in this manual, please do not hesitate to contact a member of the state WISEWOMAN team.

WISEWOMAN PROGRAM BACKGROUND

In 1993, Congress authorized the Centers for Disease Control and Prevention (CDC) to establish the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program to extend services provided to women as part of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). In Colorado, the NBCCEDP funded program is Women's Wellness Connection (WWC). WISEWOMAN provides NBCCEDP clients with access to additional preventive health services, including screenings for cardiovascular disease risk factors, referrals for medical evaluation, and lifestyle programs.

In 2013, the CDC released Funding Opportunity Announcement (FOA) DP13-1302, which began a new 4-year cooperative agreement with 19 state and 2 tribal organizations. Through this FOA, the Colorado Department of Public Health and Environment was funded to provide the WISEWOMAN Program for four years beginning June 30, 2013. WISEWOMAN is administered in the same unit at CDPHE as WWC.

The priority of the WISEWOMAN Program is cardiovascular disease risk reduction, with a focus on hypertension control. This focus aligns with and supports Million Hearts®, a national initiative to prevent one million heart attacks and strokes by 2017 (http://millionhearts.hhs.gov). Through WISEWOMAN services, low-income, underinsured, or uninsured 40-64 year-old women are provided the knowledge, skills, and opportunities to improve their diet, physical activity, and other life habits to prevent, delay, or control cardiovascular and other chronic diseases.

The three major categories of healthy behavior support options include:

- Evidence-based lifestyle programs delivered either in the health care setting or through community-based organizations.
- Health coaching delivered either in the health care setting or through community-based organizations.
- Referrals to community-based resources that support healthy behaviors.

The long-term objectives for the WISEWOMAN Program include the following:

1. Develop systems that monitor, improve, and sustain the cardiovascular health of the population served.
2. Collect, analyze, report, and use high quality program data and information to plan, monitor progress, perform evaluation, track outcomes, and improve program effectiveness.
3. Partner with organizations to support physical activity, healthy food choices, smoking cessation, and elimination of exposure to second-hand smoke.
4. Support clinical systems of care to improve access to and delivery of cardiovascular disease preventive health services, with an emphasis on control of hypertension.
5. Leverage existing resources provided through chronic disease programs, community-based organizations, and the health care system to reduce cardiovascular risk factors in the population served; risk factors of focus include high blood pressure, diabetes, cholesterol, overweight/obese, and smoking.
6. Implement evidence-based clinical preventive services and utilize evidence-based community resources to improve cardiovascular health in the population served.

7. Build or strengthen community-clinical linkages to increase access to community-based lifestyle programs and services that promote self-management of healthy behaviors and/or chronic disease in the population served.

ELIGIBILITY, ENROLLMENT AND RECRUITMENT OF CLIENTS

Client Eligibility

Client Eligibility Requirements

Agencies must ensure that WISEWOMAN clients meet all of the following eligibility criteria annually. Each woman served must be:

- **Enrolled and remain eligible to participate in the Women's Wellness Connection (WWC) program***
- **In the priority age range of 40-64 years old.**
- **Low income (250% or less of the federal poverty guidelines).**
- **Underinsured or uninsured.**
- **Unable to pay the premium to enroll in Medicare, Part B (if eligible for Medicare).**

***To participate in WISEWOMAN, women must first meet all WWC eligibility criteria including age, income and lawful presence.**

Client Eligibility Guidance

Agencies should develop plans to recruit Women's Wellness Connection (WWC) clients into WISEWOMAN.

Recruitment plans should reflect the following WISEWOMAN objectives:

- Serve as many eligible women as possible by using the most efficient means.
- Reach groups/populations that are at disproportionate risk for cardiovascular disease.

Client Enrollment

Client Enrollment Requirements

Women who become WISEWOMEN clients must first be enrolled in the Women's Wellness Connection program. WISEWOMAN clients are screened for cardiovascular disease risk and receive risk reduction counseling at the WWC/WISEWOMAN integrated office visit.

Enrollment and participation in the WISEWOMAN program is voluntary. WWC clients enroll in the WISEWOMAN program by completing three required forms: 1) WWC/WISEWOMAN Consent Form; 2) WISEWOMAN Patient Information Form; and 3) WISEWOMAN Risk Reduction Counseling & Referral Form. If any of the required forms are omitted, a client is not enrolled in the WISEWOMAN program, and no services performed will be reimbursed. These three forms must be updated annually and kept in the client's file. These forms can be found on the Colorado WISEWOMAN website at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources.

1. **WWC/WISEWOMAN Consent Form**
   When a client signs this form, she is affirming that she understands WWC and WISEWOMAN eligibility rules and coverage and has knowingly agreed to participate in both the WWC and WISEWOMAN programs. The client may complete this form on her own or a clinic staff member may assist her in

doing so. The client must be the one who signs the form.

2. **WISEWOMAN Patient Information Form**
   The WISEWOMAN Patient Information Form contains questions regarding a client's cardiovascular history and current behaviors that may increase her cardiovascular disease risk. The information collected is confidential. The client may complete this form on her own or a clinic staff member may assist her in doing so.

3. **WISEWOMAN Risk Reduction Counseling & Referral Form**

   The WISEWOMAN Risk Reduction Counseling & Referral Form contains questions regarding a client's readiness to change and participate in a healthy behavior support option. This form may be continuously updated as health coaching sessions are completed or as a Diabetes Prevention Program reports new services were provided to the client. The information collected is confidential.
   A clinic staff member should complete this form.

INTEGRATED OFFICE VISIT POLICY

The initial WISEWOMAN screening office visit must occur at the same visit as the woman's annual (WWC) office visit. This is referred to as the integrated office visit. The rescreening visit should be an integrated office visit to the extent possible. WISEWOMAN funds cannot be used to pay for the integrated office visit. The integrated office visit must be paid for by the WWC program. However, WISEWOMAN will pay for the cardiovascular laboratory tests, risk reduction counseling, and any WISEWOMAN associated administrative fees that are incurred during the integrated office visit.

Exceptions to this are:

1) A small proportion of WISEWOMAN Screening Office Visits can be conducted at a later date than the initial WWC Screening Office Visit. Agencies are granted an exception where **up to 10%** of WISEWOMAN screening office visits offered during a fiscal year are allowed to occur outside of an integrated office visit. A date field has been added to the patient information form as well as into eCaST to capture the WISEWOMAN screening visit date. This will allow for calculation of those WISEWOMAN visits offered outside of the integrated office visit. CDPHE may implement performance improvement plans or other corrective actions if an agency is exceeding the 10% limit.
   a) Lab tests for WISEWOMAN screening may be done within 30 days (or longer, at the discretion of the agency's Medical Director) of the WISEWOMAN Screening Office Visit. This exception applies to:
      i. Eligible WWC clients (who have received a breast and cervical cancer visit in the last 11 months) that are called back to do labs prior to their initial WISEWOMAN visit
      ii. WISEWOMAN clients who don't have time to do the WISEWOMAN screening office visit on the same day as their breast and cervical cancer visit or the agency didn't have staff available conduct the WISEWOMAN screening office visit on the same day
      iii. agencies that send labs out to a third party lab prior to completing the risk reduction counseling initiated at the screening visit
   b) Note that agencies will **not** be able to enter WISEWOMAN data into eCaST until a WWC screening office visit has been completed.

In an agency's first year of WISEWOMAN implementation in Colorado, an exception is granted, which allows for the provision of non-integrated screening visits for existing WWC clients who have been previously screened. This permits agencies to provide cardiovascular disease screening and WISEWOMAN services to clients that were seen for their WWC annual breast and/or cervical cancer screening as early as July 1 of the current contracted fiscal year.

CLIENT CONSENT REQUIREMENTS

Agencies must have a process in place to obtain women's consent to participate in the WISEWOMAN Program. Agencies must use the consent form provided by the Colorado Department of Public Health and Environment. For efficiency, the consents for WISEWOMAN and Women's Wellness Connection (WWC) program have been combined.

CLINICAL SERVICES

Baseline Screenings and Rescreenings

BASELINE SCREENINGS AND RESCREENINGS OVERVIEW

The clinical screening component assesses the presence of chronic disease risk factors and must include the following measurements:

- Blood pressure
- Laboratory tests to assess the client's cholesterol and glucose levels and
- Body mass index.

BASELINE SCREENINGS AND RESCREENINGS REQUIREMENTS

Agencies must comply with the following screening requirements:

- **Conduct baseline screenings as part of an integrated office visit (see page 5 for the Integrated Office Visit policy).**
- **Rescreen WISEWOMAN clients who return for their WWC annual exam within 12-18 months* after their previous screening WISEWOMAN screening. The rescreening visit should be an integrated office visit to the extent possible.**
- **Collect the client's demographics and complete both the Patient Information and Risk Reduction Counseling & Referral forms prior to or at the baseline visit.**
- **Conduct screenings in accordance with national clinical guidelines.**

*Note: Although a rescreening visit should occur 12-18 months following the previous visit, an 11-month cutoff has been established to allow flexibility for women who return just before the one-year mark.

BASELINE SCREENING AND FOLLOW-UP ASSESSMENT GUIDANCE

Time Frame for Completing Screening Services

Health professionals need complete screenings and health risk assessments to evaluate a client's cardiovascular risk, provide client-centered risk reduction counseling, and determine appropriate next steps. Therefore, all screening services should be completed at the screening visit or within as short a time frame as possible after the initial visit. It is ideal to collect all this information at the integrated office visit, but CDC recognizes that this may not always be possible.

Labs should be done within 30 days before or after the screening office visit. In cases where labs were done prior to 30 days, the Medical Director at the agency should determine the length of time labs are considered valid.

VALID SCREENINGS

In order for WISEWOMAN screenings, including baseline screenings and rescreenings to be considered valid, they should, at a minimum, include:

- Blood pressure date
- Month and year of birth
- Race and ethnicity

- Previous cardiovascular disease risk [high cholesterol, hypertension, diabetes, coronary heart disease/chest pain, heart attack, heart failure, stroke/transient ischemic attack, vascular disease, or congenital heart defects]
- Use of medications to lower cholesterol, blood pressure, or blood sugar
- Diet [consumption of fruits, vegetables, fish, whole grains, and beverages with added sugar]
- Physical activity [moderate and vigorous physical activity]
- Smoking status
- height and weight
- first systolic blood pressure
- first diastolic blood pressure
- total cholesterol
- fasting glucose or A1C

Vitals, Lab Tests and Interpretation of Results

Blood Pressure Measurement Technique

Accurate blood pressure measurements are critical for detecting and managing high blood pressure. Blood pressure measurements should be done using the following proper technique:

- Clients should not smoke, exercise, or have caffeine for at least 30 minutes before their blood pressure is measured.
- Clients should be seated quietly for at least 5 minutes in a chair (rather than on an exam table), with feet on the floor and arms supported at heart level.
- An appropriate sized cuff should be used (cuff bladder encircling at least 80% of the arm).
- A mercury sphygmomanometer, a recently calibrated aneroid manometer, or a validated electronic device should be used.
- At least two measurements should be taken and recorded, separated by a minimum of five minutes. If the first two readings differ by more than 5mmHg, additional measurements should be taken.

Body Mass Index Measurement Technique

Body Mass Index (BMI) is used as a screening tool to identify possible weight problems for adults. BMI is a number calculated from a person's weight and height. The use of BMI allows people to compare their own weight status to that of the general population.

- Obtain the client’s weight in pounds (lbs) and height in inches (in).
- Calculate BMI using a standard BMI chart or table.
- To use the table, find the appropriate height in the left-hand column labeled “height”. Move across to a given weight (in pounds). The number at the top of the column is the BMI at that height and weight.

HIP AND WAIST CIRCUMFERENCE MEASUREMENT TECHNIQUE**

The 1997 World Health Organization (WHO) Expert Consultation on Obesity recognized the importance of abdominal fat mass (referred to as abdominal, central or visceral obesity), which can vary considerably within a narrow range of total body fat and body mass index (BMI). It also highlighted the need for other indicators to complement the measurement of BMI, to identify individuals at increased risk of obesity-related morbidity due to accumulation of abdominal fat (WHO, 2000a). Waist–hip ratio (i.e. the waist circumference divided by the hip circumference) was suggested as an additional measure of body fat distribution. The ratio can be measured more precisely than skin folds, and it provides an index of both subcutaneous and intra-abdominal adipose tissue (Bjorntorp, 1987). In women, BMI was associated with increased risk of cardiovascular disease; however, waist–hip ratio appeared to be a stronger independent risk factor than BMI (Lapidus et al., 1984).

Protocol:

- Measure the waist circumference at the end of several consecutive natural breaths, at a level parallel to the floor, midpoint between the top of the iliac crest and the lower margin of the last palpable rib in the mid axillary line.
- Measure the hip circumference at a level parallel to the floor, at the largest circumference of the buttocks.
- Make both measurements with a stretch-resistant tape that is wrapped snugly around the subject, but not to the point that the tape is constricting. Keep the tape level and parallel to the floor at the point of measurement.
- Ensure that the subject is standing upright during the measurement, with arms relaxed at the side, feet evenly spread apart and body weight evenly distributed.

**These measurements are not REQUIRED elements for a valid screening, but are strongly suggested to help support the understanding of cardiovascular disease risk factors of individual clients and the overall WISEWOMAN population.

Abdominal Obesity Measurement Guidelines

Organization	Measurement used	Definition of abdominal obesity
American Heart Association, National Heart, Lung and Blood Institute	Waist circumference	Women: > 88 cm (35 inches)
International Diabetes Federation	Waist circumference	Women: > 80 cm (31.5 inches), Men: > 90 cm (35.5 inches)Different cut-points for different ethnic groups
World Health Organization	Waist-to-hip ratio	Women: > 0.85

References:

Waist Circumference and Waist-Hip Ratio: Report of a WHO Expert Consultation
http://whqlibdoc.who.int/publications/2011/9789241501491_eng.pdf

Glucose and Cholesterol Fasting Laboratory Tests

- Fasting laboratory tests are preferred over non-fasting, in accordance with national clinical guidelines.
- Women should fast a minimum of 9 hours prior to fasting tests.
- Consistent with National guidelines, the WISEWOMAN program recommends a complete lipoprotein profile (total cholesterol, LDL cholesterol, HDL cholesterol and triglycerides) as the preferred screening test.
- If the client presents in a non-fasting state, only the values for total cholesterol and HDL will be useable. In such a case, if total cholesterol > 200mg/dL or HDL is <40mg/dL, a follow-up fasting lipoprotein profile is needed.
- When fasting laboratory tests are not feasible, agencies may use non-fasting point of service laboratory tests to maximize screening opportunities.
- In clients with pre-existing diabetes, or for those who are non-fasting, the A1C should be performed for glucose testing.

CLIA Waived Point of Service Laboratory Tests

CLIA regulations are based on laboratory test complexity, and are classified as waived, moderate complexity, or high complexity. Facilities performing only waived tests have no routine oversight or personnel requirements and are only required to obtain a Certificate of Waiver, pay fees and follow the manufacturer's requirements. Health Departments and other facilities must follow the requirements of the policies of their laboratory director.

The point of service devices provided for clinic use through the WISEWOMAN program are in the waived

category. All users of waived tests are required to register with CMS and obtain a CLIA Certificate of Waiver. If the laboratory modifies the test instructions, including quality control, the test will no longer meet the requirements for waived categorization. A modified test is regarded as highly complex and is subject to all applicable CLIA requirements. The application for the Certificate of waiver can be obtained through the CMS website: http://www.cms.hhs.gov/clia/.

Clinical Screenings References/Resources

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) can be found at:

http://www.nhlbi.nih.gov/files/docs/guidelines/express.pdf

JNC7 Physician Reference Card:
http://www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf

2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline:
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation
Guideline on the Assessment of Cardiovascular Risk Slide Set

American Diabetes Association Standards of Medical Care in Diabetes—2014:
http://care.diabetesjournals.org/content/37/Supplement_1/S14.extract

2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation

Interpretation and Classification of Blood Pressure, Glucose, Cholesterol and Body Mass Index Values

Blood Pressure Classification

Normal (mmHg)	**Prehypertension (mmHg)**	**†Uncontrolled Hypertension (mmHg)**		**†Alert Values**
		Stage 1	**Stage 2**	Medical evaluation and treatment immediately or within ***7 days.***
<120 Systolic ***and*** <80 Diastolic	120-139 Systolic ***or*** 80-89 Diastolic	140-159 Systolic ***or*** 90-99 Diastolic	≥ 160 Systolic ***or*** ≥ 100 Diastolic	>180 Systolic ***or*** >110 Diastolic

Note: Guidelines recommend that the diagnosis of hypertension be based on 2 or more blood pressure readings on at least separate occasions.

†Disease-level values

References:

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) http://www.nhlbi.nih.gov/files/docs/guidelines/express.pdf

AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Clients With Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and American College of Cardiology Foundation.
http://circ.ahajournals.org/content/early/2011/11/01/CIR.0b013e318235eb4d.citation

Lipid and A1C Values: Non-fasting Values

Measurement	Normal	Abnormal	
Total Cholesterol* (mg/dL)	<200 **(desirable)**	**Borderline High (Predisease-Level Values)** 200-239	**†High** ≥240
HDL Cholesterol* (mg/dL)	≥40 ≥60 **(optimal)**	**Low** <40	
A1C	<5.7%	**Prediabetes** 5.7% – 6.4%	**†Diabetes** ≥ 6.5%

Note: HDL and Total Cholesterol classification is the same regardless of fasting status.

†Disease-level values

Cholesterol Recommendations

Adult Treatment Panel (ATP) III recommends a complete lipoprotein profile (total cholesterol, LDL cholesterol, HDL cholesterol, and triglycerides) as the preferred initial test. If the testing opportunity is non-fasting, only the values for total cholesterol and HDL cholesterol are usable.
When non-fasting total cholesterol is >200 mg/dL or HDL is <40 mg/dL, a follow-up lipoprotein profile is needed for appropriate management based on LDL.

A1C Test

The A1C (Glycosylated Hemoglobin) test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP) certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay.

Lipid Values: *Fasting* Values (fasting for ≥ 9 hours)

Measurement	Normal	Abnormal		
LDL Cholesterol* (mg/dL)	<100 **(optimal)** 100-129 **(near optimal/ above optimal)**	**Borderline High (Predisease-Level Values)** 130-159	†**High** 160-189	†**Very High** ≥190
Triglycerides (mg/dL)	< 150	**Borderline High (Predisease-Level Values)** 150-199	†**High** 200-499	†**Very High** ≥500
Total Cholesterol (mg/dL)**	<200 **(desirable)**	**Borderline High (Predisease-Level Values)** 200-239	†**High** ≥240	
HDL Cholesterol (mg/dL)**	≥40 ≥60 **(optimal)**	**Low** <40		

Note: The optimal LDL values are lower for individuals at high risk (or with known Coronary Artery Disease)
****Note:*** HDL and Total Cholesterol classification is the same regardless of fasting status.

†Disease-level values

Reference:

Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III).
http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm

Glucose Values: *Fasting* Values (fasting for ≥ 8 hours)

Measurement	Normal	Abnormal	
Fasting Plasma	FPG <100	**Prediabetes**	†**Diabetes**

Glucose(mg/dL)		FPG 100-125	FPG ≥126
Oral Glucose Tolerance Test (OGTT) (mg/dL)	OGTT <140	**Prediabetes** OGTT 140-199	**†Diabetes** OGTT ≥200

†Disease-level values

Reference:
American Diabetes Association Standards of Medical Care in Diabetes—2014.
http://care.diabetesjournals.org/content/37/Supplement_1/S14.full

Body Mass Index (BMI) Classification

	Underweight	Normal Weight	Overweight	Obesity (Class 1)	Obesity (Class 2)	Extreme Obesity (Class 3)
Height and Weight – BMI (kg/m^2)	<18.5	18.5-24.9	25-29.9	30-34.9	35-39.9	≥40

Reference:
Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report.
http://www.ncbi.nlm.nih.gov/books/NBK2003/

Referral for Medical Evaluation of Alert Values, Uncontrolled Hypertension and other Abnormal Findings

Referral for Medical Evaluation Overview

WISEWOMAN Alert values are laboratory results that indicate the need for immediate attention. They are based on current clinical practice and risk to the individual's health.

Measurement	WISEWOMAN Alert Values
Blood Pressure	Systolic >180 mmHg **OR** Diastolic >110 mmHg
†Blood Glucose	≤50 mg/dL **or** ≥250 mg/dL

† Blood glucose alert levels are the same regardless of fasting status.

Reference:
Martin R. Huecker, MD, Daniel F. Danzl, MD. Chapter 43. Metabolic & Endocrine Emergencies**;** CURRENT Diagnosis & Treatment Emergency Medicine, 7e. Accessed online June 4, 2013 through CDC Electronic-Books.

Fasting vs. Non-Fasting Abnormal Values:

- Fasting laboratory tests are preferred over non-fasting, in accordance with national clinical guidelines.
- Fasting abnormal screening values may be repeated at the discretion of the health care provider**.**
- Women should fast a minimum of 9 hours prior to fasting tests.
- Agencies may use A1C tests (point-of-care or laboratory).

Uncontrolled Hypertension:

Improving control of hypertension is a major focus of the WISEWOMAN Program. WISEWOMAN agencies are expected to conduct additional preventive services for WISEWOMAN clients who have uncontrolled hypertension.

WISEWOMAN Abnormal Findings:

Agencies must ensure that women with abnormal screening results should have appropriate medical evaluation in accordance with national guidelines and WISEWOMAN Program guidelines.

REFERRAL FOR MEDICAL EVALUATION REQUIREMENTS

Agencies must ensure the following:

- **All women with WISEWOMAN alert values must receive:**
  - **medical evaluation and treatment immediately or within 7 days of the alert measurement, in accordance with national standards of care and the judgment of the agency's Medical Director;**
  - **case management to assist women with accessing indicated medical care.**

- **All women with abnormal blood pressure measurements must receive further attention as appropriate, based on the individual situation**

- **All women with disease-level blood pressure or laboratory values, must be referred for medical evaluation if not currently being treated.**

- **All women with uncontrolled hypertension must receive case management and other appropriate follow-up (refer to the Hypertension Control and Medication Access section and the Case Management sub-section below).**

- **All women must have access to free or low-cost medical care and medication, as needed.**

- **Health care providers must have an effective referral process for abnormal findings.**

Note: **It is not necessary to confirm follow-up on every case (except for alert values) but agencies must have a process to ensure the referral system works.**

Referral for Medical Evaluation Guidance

Timeframe for Alert Value Referrals:

The Medical Director of the agency or clinic should determine whether a particular alert value needs immediate attention or follow-up within seven days.

Follow-up of Uncontrolled Hypertension:

Agencies should refer to their organizational policies and/or consult with their medical director to establish standard protocols for follow-up of uncontrolled hypertension. The protocol will vary depending on the capacity of the health care facility, but at a minimum should include medication counseling. The protocol may include team-based care with pharmacists, nutritionists, nurse educators, community health workers or others. It may include use of electronic reporting and tracking of blood pressure trends, and self-measured blood pressure monitoring among other strategies. The aim is for agencies to establish or strengthen practical methods to track and improve control of hypertension.

Participants with uncontrolled hypertension should be encouraged to set medication adherence as a priority area. The Case Manager at the WISEWOMAN agency will provide the following to all participants who choose medication adherence support:

- Monitoring of participant compliance using an evidence-based protocol

OR

- Referral to an agency or organization that provides participant follow-up using an evidence-based protocol

Medication Adherence Guidance

Medication adherence refers to the act of conforming to the recommendations made by the provider with respect to timing, dosage and frequency of medication taking[1]. Medication adherence is associated with decreased utilization and hospitalization rates, cost benefits, improved quality of care and improved health outcomes.

[1] Cramer JA, Roy A, Burrell A, Fairchild CJ, Fuldeore MJ, Ollendorf DA, Wong PK. Medication compliance and persistence: terminology and definitions. *Value Health.* 2008; 11:44–47.

Primary Non-adherence:

- Prescription not filled
- Prescription not started

Secondary Non-adherence:

- Prescription not finished
- Prescription not taken as prescribed

Common Barriers to Medication Adherence:

Patient-Related Barriers

- Forgetfulness
- Value of therapy
- Lack of knowledge
- Concern/denial
- Cultural beliefs
- Health Literacy
- Financial

Medication-Related Barriers

- Perceived side effects
- Complex regimens
- Length of therapy

Provider-Related Barriers

- Poor relationship and/or communication with provider
- Lack of provider feedback and reinforcement

Proactive Solutions and Tools

B-SMART Appropriate Medication Use Process

B-SMART (Barriers, Solutions, Motivation, Adherence Tools, Relationships, and Triage) is a multifaceted, systematic adherence checklist. It can improve concordance at the beginning of therapy compliance to the regimen and persistence over time.

Reference:

Oyekan, E., Nimalasuriya, A., Martin, J., Scott, R., Dudl, R. J., & Green, K. (2009). The B-SMART Appropriate Medication-Use Process: A Guide for Clinicians to Help Patients— *Part 1: Barriers, Solutions, and Motivation*. *The Permanente Journal*, *13*(1), 62–69.

Oyekan, E., Nimalasuriya, A., Martin, J., Scott, R., Dudl, R. J., & Green, K. (2009). The B-SMART Appropriate Medication-Use Process: A Guide for Clinicians to Help Patients-Part *2: Adherence, Relationships, and Triage*. *The Permanente Journal*, *13*(4), 50–54.

Morisky Medication Adherence Scale

The Morisky 4-Item Self-Report MEASURE of Medication-taking Behavior

[MMAS-4]		***Yes***	***No***
1.	Do you ever forget to take your (name of health condition) medicine?	0	1
2*.	Do you ever have problems remembering to take your (name of health condition) medication?	0	1
3.	When you feel better, do you sometimes stop taking your (name of health condition) medicine?	0	1
4.	Sometimes if you feel worse when you take your (name of health condition) medicine, do you stop taking it?	0	1
*Revised items. Morisky, DE & DiMatteo, MR. *Journal of Clinical Epidemiology*. 2011; 64:262-263			

Rating scale:

HIGH adherence= 0 or all "no "responses

MEDIUM Adherence= 1-2

LOW Adherence- 3-4

HYPERTENSION CONTROL AND MEDICATION ACCESS

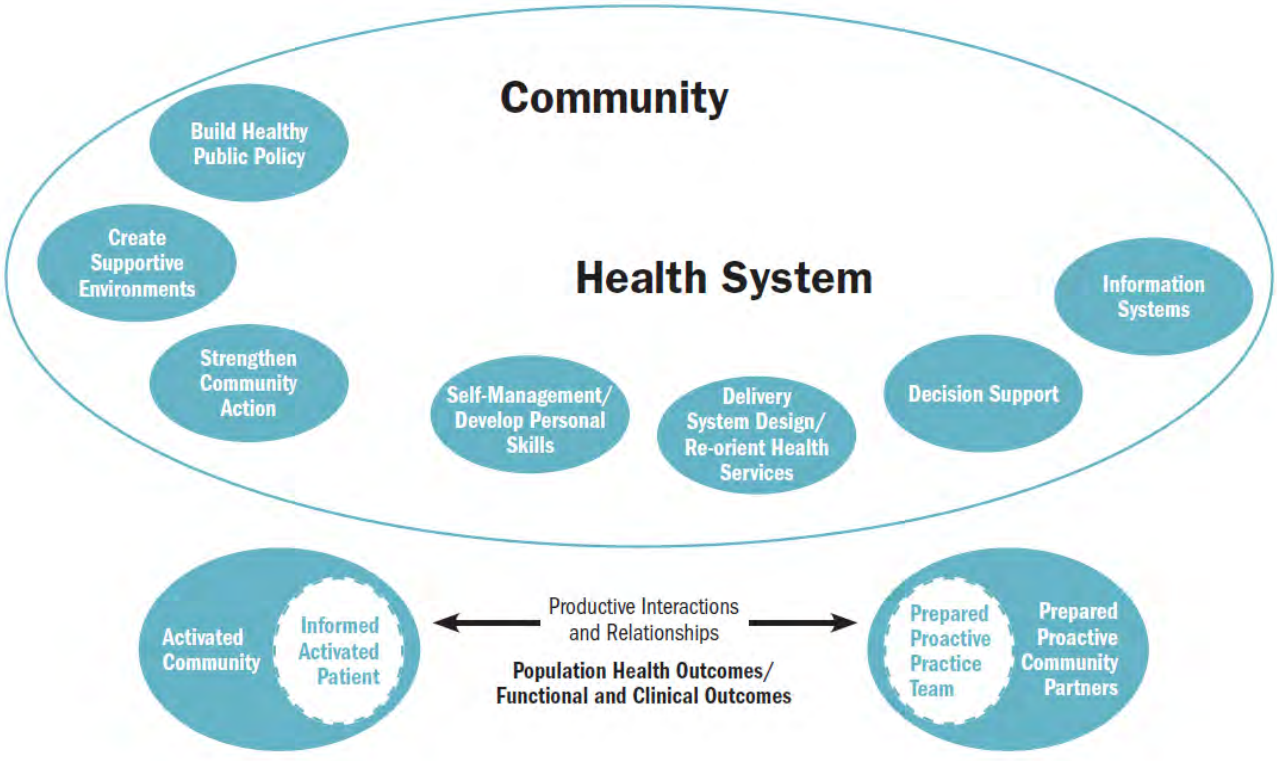
HYPERTENSION CONTROL REQUIREMENTS

Improving control of hypertension is a major focus of the WISEWOMAN Program. WISEWOMAN agencies are expected to conduct additional preventive services for WISEWOMAN clients who have uncontrolled hypertension.

WISEWOMAN agencies must meet the following criteria:

- **Be current Women's Wellness Connection (WWC) providers.**
- **Employ clinical systems of care with demonstrated success in hypertension management, such as through use of electronic health records, medication therapy management, clinic staff training, team-based care, and quality assurance processes.**
- **Reduce barriers to understanding the treatment regimen and receiving medication, particularly for hypertension.**
- **Provide chronic disease self-management support.**

The Expanded Chronic Care Model below has been widely adopted to show the key components of effective health care and prevention rather than disease management approaches. This framework shows how the health care delivery system fits in a socio-ecological model. The WISEWOMAN Program aligns conceptually with the Expanded Chronic Care Model, and with many of the activities outlined in CDC's Funding Opportunity Announcement (FOA) DP13-1305, State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.



Barr VJ, Robinson S, Marin-Link B, Underhill L, Dottas A, Ravensdale D, et al. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. Hosp Q. 2003;7(1);73-82.

HYPERTENSION CONTROL GUIDANCE

WISEWOMAN services should be delivered in health care settings that will:

- be user-friendly for clients (culturally and linguistically appropriate and easy to navigate);
- be efficient for clients and staff in terms of cost and time;
- use treatment protocols to improve control of hypertension;
- have mechanisms to ensure that all clients receive complete WISEWOMAN services;
- have quality assurance processes in place;
- use multi-disciplinary health care teams;
- have effective training procedures;
- have mechanisms to track information through electronic health records;
- have mechanisms to communicate information to the client, and the client's primary care team.

HYPERTENSION DEFINITIONS

Normal Blood Pressure
Systolic <120 mmHg *and* Diastolic <80 mmHg

Pre-Hypertension
Systolic 120-139 mmHg or Diastolic 80-89 mmHg

Stage 1 Hypertension
Systolic 140-159 mmHg or Diastolic 90-99 mmHg

Stage 2 Hypertension
Systolic ≥160 mmHg or Diastolic ≥100 mmHg

Control of hypertension: Managing hypertension to maintain blood pressure readings of <140 mmHg systolic and < 90 mmHg diastolic.

Uncontrolled hypertension: Cases where treatment for hypertension has not achieved these target blood pressures.

Hypertension Control

Managing hypertension to maintain blood pressure readings of <140 systolic and < 90 diastolic mmHg. For diabetic clients, or clients with chronic kidney disease, adequate control is <130/80 mmHg.

Uncontrolled hypertension

Cases where treatment for hypertension has not achieved these target blood pressures.

BROAD STRATEGIES TO IMPROVE PRIMARY CARE[1]		
STRATEGY/APPROACH	**DESCRIPTION**	**EXAMPLES**
Delivery System Design (sometimes called Clinical Practice Design or Redesign)	Processes to: ■ be efficient for patients and staff ■ consistently deliver quality care ■ reliably document care	■ Prescribing anti-hypertensive medication consistent with national guidelines ■ Streamlining patient registration processes to minimize waiting time
Self-Management Support	Activities to increase patients' skills in managing their own health	■ Teaching patients how to measure and track their blood pressure
Decision Support	Automated messages for clinicians	■ Using computer-generated prompts to remind a clinician that a patient's blood pressure is abnormal and to consider adjusting medication
Health Information Technology (Health IT) Note: Health IT can be used to implement Decision Support or Delivery System Design.	Storage, retrieval, sharing, and use of health care information, and data for communication and decision making[2]	■ Using health IT reports to determine which patients with hypertension are not well-controlled ■ Using heath IT reports to determine which patients have not returned for follow-up
APPROACHES SHOWN TO BE EFFECTIVE IN CONTROLLING HYPERTENSION		
Evidence-Based Treatment Protocols[3]	Simple, evidence-based treatment protocols can have a powerful impact in improving control by clarifying titration intervals and treatment options, and by expanding the types of staff that can assist in timely follow-up with patients. When embedded in electronic health records, protocols can serve as clinical decision support at the point of care so no opportunities are missed to achieve control.	Veterans Affairs (VA)/Department of Defense (DOD) Kaiser Permanente (KP)
Self-Measured Blood Pressure Monitoring with Support[4]	Blood pressure readings (taken by patient outside of a clinical setting) reported to the health care team who advise or take action as indicated.	Patient measures blood pressure at home and emails readings to health care team who then provide advice or make needed adjustments in medications.
Team-Based Care[5]	The use of a multi-disciplinary team to improve the quality of hypertension management for patients	Physician diagnoses hypertension and prescribes anti-hypertensive medication and refers to nutritionist to counsel on DASH diet.
Medication Adherence and Access Support	Medication adherence and access support can include the following: ■ Explaining what the medication is intended to do and the correct way to take medication ■ Assessing tolerance and appropriateness of medication for a particular patient ■ Assuring access to affordable medication	When a patient is prescribed a new anti-hypertensive medication, (1) pharmacist provides Medication Therapy Management services[6] and (2) a case manager helps find an affordable source of medication.
References/Resources	[1]Adapted from the Expanded Chronic Care Model. Barr VJ, Robinson S, Marin-Link B, Underhill L, Dottas A, Ravensdale D, et al. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. Hosp Q. 2003;7(1);73-82. [2]Healthit.gov Tools & Resources/Glossary http://www.healthit.gov/policy-researchers-implementers/glossary [3]Evidence-based Treatment Protocols for Improving Blood Pressure Control Resources from Million Hearts® http://millionhearts.hhs.gov/resources/protocols.html [4]The Agency for Healthcare Research and Quality Self-Measured Blood Pressure findings: "Self-Measured Blood Pressure Monitoring: Comparative Effectiveness." Agency for Healthcare Research and Quality. January 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm [5]Community Guide. Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control. http://www.thecommunityguide.org/cvd/teambasedcare.html [6]Medication Therapy Management (MTM) as defined by the American Pharmacists Association are a broad range of services that pharmacists provide that optimize therapeutic outcomes for individual patients. Pharmacists provide MTM to help patients get the best benefit from medication by actively managing drug therapy and resolving medication-related problems.	

Hypertension Control References/Resources

Improving Chronic Illness Care. The Chronic Care Model
http://www.improvingchroniccare.org/index.php?p=The_Chronic_CareModel&s=2

Strategies to Improve Hypertension Control

- The Million Hearts® Blood Pressure Toolkit.
  http://millionhearts.hhs.gov/resources/toolkits.html#bpToolkit

- Million Hearts® Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians.
  http://millionhearts.hhs.gov/Docs/MH_SMBP_Clinicians.pdf

- Institute for Healthcare Improvement: Partnering in Self-Management Support: A Toolkit for Clinicians.
  http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx

Medication Access Overview

Most people with hypertension require medication to control and maintain their blood pressure at recommended levels. In populations that are uninsured or underinsured, paying for medication can be problematic. Cost can be a major factor in non-adherence to treatment plans and high rates of uncontrolled hypertension.

Medication Access Requirements

Agencies must ensure access to affordable medication for women who require it, particularly, for hypertension.

Medication Access References/Resources

The following are potential resources for free or low-cost medications:

340B Drug Pricing Program & Pharmacy Affairs
Health Resources and Services Administration (HRSA) requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices.
http://www.hrsa.gov/opa/index.html

Partnership for Prescription Assistance
The Partnership brings together America's pharmaceutical companies, doctors, other health care providers, client advocacy organizations and community groups to help clients obtain free or low-cost medicines.
http://www.pparx.org/en/prescription_assistance_programs

Federal Trade Commission (FTC)
FTC provides useful consumer information regarding prescription savings programs and generic drugs.
http://www.consumer.ftc.gov/articles/0063-generic-drugs-and-low-cost-prescriptions

Medicare Information
Information about the specific drug plans available in a particular area and about Medicare drug plans in

general are available at 1-800-MEDICARE (1-800-633-4227).
www.medicare.gov

NeedyMeds
NeedyMeds keeps up-to-date information from pharmaceutical companies on client assistance programs.
http://www.needymeds.org/

RxAssist
Funded by The Robert Wood Johnson Foundation, RxAssist is a web based medication resource center for providers, advocates, consumers, and caregivers.
http://rxassist.org/providers

Rx Hope
RxHope contracts directly with pharmaceutical companies to provide an electronic application process for their client assistance programs. RxHope provides this service to physicians and clients free of charge.
https://www.rxhope.com/

State Pharmaceutical Assistance Programs
This website identifies states that have programs to provide pharmaceutical coverage or assistance, primarily to low-income older people or people with disabilities who do not qualify for Medicaid.
http://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx

HEALTH RISK ASSESSMENTS

HEALTH RISK ASSESSMENTS OVERVIEW

A health risk assessment is a health questionnaire that provides individuals with an evaluation of their health risks and quality of life. The information from the assessments helps providers work collaboratively with clients to make decisions and improve their health.

HEALTH RISK ASSESSMENTS REQUIREMENTS

Agencies must comply with the following requirements:

- **Conduct cardiovascular health risk assessments for each WISEWOMAN client during screening visits. Health risk assessment results and screening values provide the basis for risk reduction counseling tailored to each individual.**
- **Ensure completion of assessments for all clients prior to risk reduction counseling. ***
- **Ensure that the assessments and results are delivered in a culturally competent manner.**
- **All clients receive assessment form in language which they comprehend, or a trained translator completes the form with the client**
- **Clients with lower literacy levels are assisted in completing the assessment form.**

Agencies must use the WISEWOMAN Patient Information and Risk Reduction Counseling & Referral forms provided by CDPHE to complete the health risk assessment. These forms can be found on the WISEWOMAN website at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources**.**

***If assessments are completed prior to the screening office visit, the information must be available to the clinician/counselor and incorporated into risk reduction counseling.**

HEALTH RISK ASSESSMENTS GUIDANCE

Clients may complete the Risk Reduction & Counseling Form in the health care setting at the time of screening, or they may complete it before their initial visit. Providers should review health risk assessment questions with clients to ensure they are accurate and complete.

Health risk assessments are used to:

- Provide data to calculate individual cardiovascular risk;
- Monitor the risk reduction counseling interaction and goal setting process;
- Establish baseline health behaviors to measure any changes at interim visits and rescreening;
- Identify health needs among the population.

TOBACCO USE ASSESSMENT POLICY

The Centers for Disease Control and Prevention (CDC) requires all National Breast and Cervical Cancer Early Detection Program (NBCCEDP) grantees assess all enrolled clients for tobacco use status and promote tobacco cessation services. WISEWOMAN is committed to promoting tobacco cessation to all clients enrolled in the program.

All clients enrolled in WWC should be evaluated for tobacco use. All clients who screen positive for tobacco use should be provided with QuitLine materials. Clients that express interest in quitting should be given a **referral to the Colorado QuitLine**.

WISEWOMAN suggests using the Ask, Advise, and Refer method for agencies that do not already assess clients for tobacco use and promote quitting:

- ASK every client at each encounter about tobacco use and document status.
- ADVISE every tobacco user to quit with a clear, strong personalized health message about the benefits of quitting.
- REFER clients who are ready to quit tobacco within the next 30 days to the Colorado QuitLine directly at 1-800-QUIT-NOW (1-800-784-8669) or use the Fax-To-Quit form.

QuitLine Referral Process

For clients who express interest in a referral, a QuitLine Fax-To-Quit form should be completed and faxed to the QuitLine. Once this form has been completed and faxed to the QuitLine, a QuitLine employee will call the client to provide tobacco cessation counseling services. The QuitLine Fax-To-Quit form with fax number can be downloaded from:
https://www.coquitline.org/providers_partners/default.aspx.

Other Tobacco Cessation Resources

- WISEWOMAN funds can be used for other tobacco cessation programs, especially if the QuitLine does not address language and other cultural barriers.
- WISEWOMAN funds cannot be used for nicotine replacement therapies. Many quit lines and other tobacco cessation resources offer these therapies at little or no cost.

RISK REDUCTION COUNSELING

RISK REDUCTION COUNSELING OVERVIEW

Client-centered risk reduction counseling (RRC) is a major component of the WISEWOMAN Program. RRC, when skillfully provided, can help WISEWOMAN clients become effective and informed managers of their health and health care. Studies indicate that clients who are engaged and actively participate in their own care have better health outcomes. The Expanded Chronic Care Model relies on an informed and activated patient interacting with a prepared, proactive practice team.

RISK REDUCTION COUNSELING REQUIREMENTS

Agencies must comply with the following requirements:

- **Provide RRC to all WISEWOMAN clients face-to-face at the time of their screening visits*.**
- **Clients must receive screening results, interpretation of the results, and recommendations in accordance with national guidelines. This information must be provided both verbally and in writing.**
- **During the face-to-face counseling, counselors must:**
  - **Discuss client's screening and health risk assessment results**
  - **Assure client understands her CVD risk as compared to other women her age.**
  - **Consider a client's language, healthy literacy, and cultural background in the interaction.**
  - **Use motivational interviewing skills.**
  - **Collaboratively identify goals and strategies to support goals (e.g., lifestyle programs and other healthy behavior support options).**
  - **Facilitate access to healthy behavior support options.**
  - **Obtain permission to check back in 30-60 days to follow-up if not interested or ready for a healthy behavior support option.**
  - **Arrange follow-up for women with uncontrolled hypertension**
  - **Reduce barriers to understanding the treatment regimen and receiving medication, particularly for hypertension.**
  - **Provide chronic disease self-management support.**

Note: **Chronic disease self-management support refers to generic self-management support methods as depicted in the Expanded Chronic Care Model and should not be construed as recommending any specific programs.**

***** If laboratory results are not available at the time of the screening visit, agencies must provide counseling based on available information. Agencies must complete risk reduction counseling when laboratory results are available. This can be provided by phone or in-person and a written copy sent to the client.**

WISEWOMAN RRC must be initiated in person at the initial WISEWOMAN screening office visit and should be completed the same day or within 30 days of the screening date.

Initiation of WISEWOMAN risk reduction counseling includes at a minimum, the following:

- **WWC/WISEWOMAN Consent Form is completed**

- **Two blood pressure measurements (within five minutes of each other) are taken**
- **BMI is calculated based on measured height and weight**
- **Tobacco use and cessation screening and counseling (using the Ask, Advise, and Refer method) is conducted**
- **Available Patient Information Form responses and clinical results are reviewed**
- **Verbal and written explanation of values and the client's relative risk for heart disease based on responses and values are communicated**

Exceptions to completion the same day are:

1) Completion of the RRC by telephone
2) Completion of the RRC once lab values become available

Risk Reduction Counseling Guidance

Developing a Client-Centered Risk Reduction Plan

A client-centered risk reduction plan should be developed collaboratively by the client and counselor. Counselors should offer options not directives. Steps should be acceptable to the client, explicit, and achievable. The plan should recognize the counselor's limited role and focus on increasing the client's skills and providing resources needed to achieve behavior change.

Risk Reduction Counseling Skills

There are a number of approaches and curricula designed to provide the necessary skills for effective client-centered counseling. Common elements include:

- talking with, rather than to, the client;
- responding with sensitivity and considering health literacy or cultural issues that may emerge;
- maintaining a non-judgmental attitude, using active listening, asking open ended questions;
- supporting positive risk reduction changes already made by the client;
- assisting the client in identifying barriers to risk reduction (e.g., knowledge gaps, skills needed, socio-economic and other life circumstances that are barriers to being healthy).

Materials Development Overview

Agencies may want to use existing materials or develop their own materials to explain screening results. Agencies may also wish to employ additional educational materials to support discussion around client-centered goals and healthy behaviors.

Materials Development Requirements

CDC retains an unrestricted right to use, reproduce, adapt and disseminate products developed using WISEWOMAN federal funds. These products may include program participant materials, graphic designs, educational and other informational materials, fact sheets, newsletter templates and manuals.

Materials Development Guidance

Agencies working with subcontractors or consultants to develop program materials should ensure that the subcontractor/consultant is aware that any materials that they produce with WISEWOMAN funds will be the property of CDC.

The funding source should be noted on any material or publication developed using WISEWOMAN funds. An appropriate citation would be:

> *The creation of this [insert material name or description] was made possible by cooperative agreement DP13-1302 from the Centers for Disease Control and Prevention/Division for Heart Disease and Stroke Prevention/ WISEWOMAN Program. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of CDC.*

To increase name recognition and awareness of the WISEWOMAN Program, agencies are encouraged to use the name WISEWOMAN (all capital letters, as it is an acronym) whenever possible on written materials.

Sample Materials to explain screening results for use during counseling

- All WISEWOMAN lab values and measurements (Know Your Numbers handout)
  - https://www.colorado.gov/pacific/sites/default/files/HPF_WW_WISEWOMAN_my-health-info.pdf
- BMI
  - http://catalog.nhlbi.nih.gov/pubstatic//06-5831/06-5831.pdf
- Blood pressure
  - http://www.nhlbi.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html.
  - http://millionhearts.hhs.gov/Docs/BP_Toolkit/BP_Toolkit_Fact_Sheet.pdf
  - http://millionhearts.hhs.gov/Docs/BP_Toolkit/BP_Wallet_Card.pdf
  - http://millionhearts.hhs.gov/Docs/4_Steps_Forward_English.PDF
  - http://millionhearts.hhs.gov/Docs/4_Steps_Forward_Spanish.PDF
  - http://www.fda.gov/downloads/ForConsumers/ByAudience/ForWomen/FreePublications/UCM282311.pdf
- Blood cholesterol
  - http://www.nhlbi.nih.gov/health/public/heart/chol/wyntk.pdf
  - http://www.heart.org/HEARTORG/Conditions/What-Your-Cholesterol-Levels-Mean_UCM_305562_Article.jsp.
- Controlling Sodium Intake
  - http://www.cdc.gov/salt/pdfs/sources_of_sodium.pdf
  - http://millionhearts.hhs.gov/Docs/novella_spanish.pdf
  - http://millionhearts.hhs.gov/Docs/promotora_guide_spanish.pdf
- Healthy Food Choices
  - http://www.choosemyplate.gov/print-materials-ordering.html
- Risk Calculation
  - 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation
- Assessment of Cardiovascular Risk
  http://mylifecheck.heart.org/
  http://50.56.33.51/hart01/main_en_US.html
  http://circ.ahajournals.org/content/97/18/1837.full.pdf+html

Additional materials and related handouts can be found under the Colorado WISEWOMAN website: https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources.

HEALTHY BEHAVIOR SUPPORT OPTIONS

Diabetes Prevention Program (DPP)

Each WISEWOMAN program across the nation implements a lifestyle program as part of a strategy to improve the health statuses of individuals participating in WISEWOMAN. The Colorado WISEWOMAN Program has chosen to integrate the Diabetes Prevention Program (DPP), as an evidence-based intervention strategy.

REFERRAL TO DPP

Referral to DPP participation for WISEWOMAN clients is most appropriate for clients who:

- Indicate a readiness to change
- Agree DPP is an appropriate behavior support option
- Have access to a local DPP
- Meet the DPP eligibility requirements as outlined in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures:

1) Have a body mass index (BMI) of ≥24 kg/m2 (≥22 kg/m2, if Asian).

2) A minimum of 50 percent of a program's clients must have had a recent (within the past year), documented, blood-based diagnostic test indicating they have prediabetes, or a history of gestational diabetes mellitus (GDM), according to one of the following specifications:
   a. Fasting plasma glucose of 100 to 125 mg/dl
   b. Plasma glucose measured 2 hours after a 75 gm glucose load of 140 to 199 mg/dl
   c. A1C of 5.7 to 6.4
   d. Clinically diagnosed GDM during a previous pregnancy (may be self-reported)

3) A maximum of 50 percent of a program's clients may be considered eligible without a blood-based test or history of GDM only if they screen positive for prediabetes based on the CDC Prediabetes Screening Test, which was validated for prediabetes using 2007–2008 National Health and Nutrition Examination Survey data.

PURPOSE OF THE DPP

The focus of the Diabetes Prevention Program is to prevent type 2 diabetes among people at-risk for diabetes. This successful standardized lifestyle intervention was developed to increase physical activity to a minimum of 150 minutes per week and reduce weight by a minimum of 7 percent (5-7 percent achievement range in the field) for population meeting eligibility criteria.

Individual "lifestyle coaches" work with program clients to help them in achieving individualized clearly defined weight loss and physical activity goals. The program focuses on self-management to achieve long-term improvements in diet and physical activity.

The program consists of two phases: a 16-session core curriculum and a 6-session maintenance/post-core phase. This 16-session core curriculum courses are each typically delivered once per week and must be

completed within 26 weeks. The remaining six classes (the post-core classes), are each usually delivered once per month. These 60-minute, in-person sessions include:

1) A private weigh-in and review of self-monitoring records;
2) Discussions on various topics, identification of barriers and
3) Action planning, in a group setting.

Completion of the DPP is defined as 9 (of 16) core sessions and 3 (of 6) maintenance/post-core.

If a WISEWOMAN agency has a client interested in DPP participation but a class isn't going to start soon, the agency may choose to refer clients interested in DPP to one Health Coaching session in the interim (See "Health Coaching" section).

On-site Provision and/or Off-site Referral for DPP

Colorado WISEWOMAN agencies must offer DPP on-site and/or have at least one referral source for DPP through a sub-contract or memorandum of understanding with an existing DPP site (refer to the Subcontracting section below for guidance on subcontracting for WISEWOMAN services). The WISEWOMAN clinic and existing local DPP site will determine referral protocols. WISEWOMAN clinics will collect MDE-required data from DPPs through the creation of data feedback loops. This data will be entered by the WISEWOMAN clinic into the eCaST data system. The WISEWOMAN clinic will be responsible for follow-up and rescreening.

Colorado's recognized Diabetes Prevention Program are listed here:
https://nccd.cdc.gov/DDT_DPRP/State.aspx?STATE=CO

Criteria and Training to provide the DPP On-site

Personnel must meet specific criteria for the responsibilities, skills, knowledge and qualities to become a DPP Lifestyle Coach. Lifestyle coaches may have other credentials (RD, RN, MA) but credentials are not required. Additionally, a Diabetes Prevention Coordinator is designated to implement the program, supervise daily operations, provide support and guidance to coaches and ensure the program activities achieve quality performance outcomes. The coach and coordinator may be the same individual.

Although attendance is not required, the DPP Lifestyle Coach training is offered periodically in Colorado and WISEWOMAN agencies have the opportunity to participate in order to be trained in delivering the National DPP curriculum on-site. To become a nationally-recognized program, agencies should complete the application at the following link. http://www.cdc.gov/diabetes/prevention/recognition/application.htm

Reimbursement for DPP Provision

Participating WISEWOMAN clinics will be reimbursed according to the bundled payment system criteria. The bundled payment system can be found on the Colorado WISEWOMAN website at:
https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources

Bundled payment system structure will incentivize and motivate recognized DPPs to encourage enrollment, retention and completion of program. The bundled payment system also includes some funding for incentives and reduction of barriers (for example: assisting with transportation costs).

Participating DPPs will be reimbursed by WISEWOMAN agencies for each session that clients complete. WISEWOMAN agencies will be reimbursed according to the bundled payment system. It will be up to the WISEWOMAN agency to negotiate payment rates with their local DPPs through subcontracts or memoranda of understanding, unless they choose to offer the DPP on-site. The bundled payment system is based on an average rate of $350 for 22 DPP sessions (approximately $15 per session).

Health Coaching

Health coaching is a WISEWOMAN healthy behavior support option to reduce a women's cardiovascular risk. Health coaching uses a collaborative, client-focused approach to enable participants to take responsibility for their health and well-being. Preliminary studies indicate that health coaching can improve management of diabetes, hyperlipidemia, cancer pain, asthma, weight loss and physical activity.

Health coaching differs from risk reduction counseling and the Diabetes Prevention Program (DPP). Risk reduction counseling precedes health coaching and lays the groundwork for what the woman chooses to prioritize in the health coaching sessions to follow. DPP is a lifestyle program with a focus on prevention of type 2 diabetes among persons at-risk. Refer to the WISEWOMAN Program Comparison Tables document found at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources for more information on distinguishing these three program elements.

Because health coaching differs from risk reduction counseling, health coaching must be distinct and separate from Risk Reduction Counseling (RRC). Exceptions to this are:

1) A health coaching session delivered immediately following risk reduction counseling
    a. The agency will determine if this Health Coaching session following the RRC should be counted as Enhanced risk reduction counseling (an extended version of the regular risk reduction counseling) or as the first health coaching session
        i. For clients that show readiness for engagement and motivation to change, and that commit to complete two additional HC sessions, then the first HC session provided immediately after the RRC is counted as "**HC session 1**".
        ii. If the client decides she does not want to participate in additional HC sessions after the session is conducted, then this session counts as "**enhanced RRC**".
            1. The W1 level of the WISEWOMAN Bundled Payment System has built in padding to cover an additional counseling time and effort for a sub-set of clients.
            2. A check box will be added to the risk reduction counseling form and eCaST to allow easier tracking of enhanced RRC visits. This tracking will allow CDPHE to determine if the padding included in the Bundled Payment System is sufficient.
2) Health coaching conducted as an interim healthy behavior support option to keep the client engaged and motivated until a DPP group becomes available.
    a. This option should be used if the client's screening visit is not conducted around the time that a new DPP class will begin the course.
        i. The W1 level of the WISEWOMAN Bundled Payment System has built in padding to cover an unofficial health coaching session for select WISEWOMAN clients.

Referral to Health Coaching

Health coaching is most appropriate for WISEWOMAN clients who:

- Indicate a readiness to change
- Agree that health coaching is an appropriate behavior support option for themselves
- Prefer to individualize their healthy behavior support option
- Desire a condensed program delivery timeline
- Are ineligible or decline to participate in the Diabetes Prevention Program (DPP)

Health Coaching Fundamentals

Health coaching is a client-centered, whole-person approach to behavior change. It is an appropriate option for clients who express a desire to explore modifying a health related behavior. Using Motivational Interviewing and other skills, the goal of health coaching is to help clients increase readiness and gain confidence to make lasting changes for improved health. In collaboration with their health coach, clients will use cognitive behavioral and Motivational Interviewing strategies, such as SMART (specific, measurable, attainable, realistic and timely) goal-setting, encouraging self-efficacy and self-monitoring, and identifying support sources.

Women will work collaboratively with their health coach to determine a priority area(s) of focus for the brief coaching interventions, such as physical activity, nutrition, weight loss, tobacco cessation or medication management. Motivational Interviewing techniques will be effectively utilized to elicit and strengthen motivation for changing behaviors related to the priority area. Drawing on core components of this counseling approach, health coaches will employ open ended questions, affirmative statements, reflective listening skills and summarizations to effectively capture and resonate change talk and self-motivational statements communicated by the client.

Principal tenets and features of the Colorado WISEWOMAN health coaching healthy behavior support option:

- Client-centered
    - Interaction is collaborative; non-directive
- Client-tailored
    - Clients choose the goals that they want to address
    - Quantity and duration of sessions can vary based on client's needs and desires
    - Coaching can be done in person or by telephone to eliminate barriers to participation
- Whole-Person Approach
    - All health risks and conditions of an individual are taken into consideration
    - To ensure a continuum of care, women are linked to additional community-based resources as necessary, to address specific challenges they are facing

Session Dosage and Delivery

Clients should be encouraged to set an initial health coaching session within two weeks of referral, but ultimately may propose a dosing schedule informed by personal goals, learning style and schedule availability. Health coaching sessions should be staggered in intervals to ensure that clients have sufficient time to institute behavior change, maximize opportunity for application without loss of momentum and support self-efficacy.

The minimum number of required sessions a client can be offered is three (3). The maximum number of sessions a client can receive is eight (8), delivered over a period of time to be co-determined by the health coach and client. The recommended number of coaching sessions will be based on client preference, readiness to change and complexity of client goals. **Clients must participate in a minimum of three health coaching sessions to be considered to have completed health coaching.** Health coaching sessions must range from 20-60 minutes in length. NOTE: The risk reduction counseling provided at the screening visit does not count as health coaching or a health coaching session (For more information, refer to Risk Reduction Counseling section of manual).

Studies identify distance and cost as being among the major factors that constrain women's ability to access services. To minimize known barriers to client access and maximize client choice, health coaching must be offered both face-to-face and over the telephone. Options for health coaching settings and formats (a combination of the below is acceptable):

- Individual, face-to-face health coaching – Must be provided at a minimum in a private exam, counseling or conference room located at a clinic or community agency.
- Individual, telephonic health coaching – Health coach must be at a minimum conducting counseling from a private or semi-private room or office in a clinic or community agency.
- Group, face-to-face health coaching – Must be provided at a minimum in a private conference room at a clinic or community agency.

Health coaching sessions conducted by WISEWOMAN agencies will be documented using the Risk Reduction Counseling and Referral form. The form will be incorporated into the WISEWOMAN eCaST database to further support documentation and program evaluation processes.

Client Follow-Up and Case Management

Health coaches must follow up with all clients within four weeks of completion of health coaching, as defined by client participation in a minimum of three health coaching sessions over a recommended four month period, to assess progress and reinforce goals. This follow-up should include standard elements, including:

- Review of client priority area and motivation for change
- Reassessment of readiness to change and confidence measures
- Recognition and celebration of successes
- Discussion of challenges and barriers to progress
- Use of community resources and provision of additional resources as needed
- Reminder of rescreening visit

Clinical measures (cholesterol, glucose, blood pressure, height, weight) must be collected at initial screening visit and at the client's rescreening appointment 12-18 months after the initial screening visit, but not during the follow-up assessment. Case management must be documented using the Risk Reduction Counseling & Referral Form. The follow-up assessments must be documented using the Follow-up Assessment form. Data from the form must be entered into the WISEWOMAN eCaST database.

Criteria and Training to Provide Health Coaching

To carry out the responsibilities and gain the skills, knowledge and qualities required for health coaching delivery, personnel must meet specific criteria. All individuals delivering health coaching services to WISEWOMAN clients must have received training and/or demonstrate core competencies in the following areas:

- Chronic disease prevention/ Health Promotion knowledge base

- Cardiovascular Disease
- Motivational Interviewing (MI)
- Capacity Building skills
- Cultural competency
- Advocacy skills
- Patient confidentiality
- Verbal and written communication skills

The minimum training required for health coaches will be Motivational Interviewing competency training (self-study viewing of Motivational Interviewing DVD series and successful completion of post-test), attendance at a one day, face-to-face Motivational Interviewing workshop and participation in a 1.5 hour cardiovascular disease 101 training covering the health topics on which WISEWOMAN clients will likely focus. For the in-person Motivational Interviewing component, workshop activities will focus on expansion of skills related to the strategic use of questions and reflections to build upon and deepen client change talk. Health coaches will practice application of complex and focused reflective listening skills designed to reduce client resistance.

Although attendance is not required, health coaches will also be strongly encouraged to attend Patient Navigator Fundamentals, a four day, intensive program offered free of charge to Colorado residents through the Patient Navigator Training Collaborative. Topics covered in the training include health literacy, ethics, health promotion, conflict resolution and a half day Motivational Interviewing principles and practice module. This program provides health coaches with comprehensive training that supports their ability to prompt client engagement and activation, enhances the continuity of client care and improves the overall WISEWOMAN client experience.

More information about the Patient Navigator Fundamental course may be found on the Patient Navigator Training Collaborative website: http://patientnavigatortraining.org/courses/level1/.

Health coaches will be required to maintain skills through ongoing education and training opportunities provided by the Colorado Department of Health and Environment. WISEWOMAN program staff will ensure Motivational Interviewing skills and knowledge of agency staff providing direct Health Coaching through the following:

- Health coach self-assessments
- Peer learning groups
- Observational opportunities during trainings and site visits

Reimbursement for Health Coaching Provision

Participating WISEWOMAN agencies will be reimbursed for each health coaching session a client completes according to the WISEWOMAN Bundled Payment System. The WISEWOMAN Bundled Payment System can be found on the WISEWOMAN section of the WWC website at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources

The WISEWOMAN Bundled Payment System is based on an average Medicare rate for individual counseling (CPT Codes: 99401-99404). The WISEWOMAN Bundled Payment System also includes some funding for incentives and reduction of barriers (for example: assisting with transportation costs). One health coaching session plus additional costs for case management, incentives/barrier reduction and administration totals $55 per session.

References:

The National Community Health Advisor Study, Chapter 3: Core Roles and Competencies of Community Health Advisors pp. 11–17; May 1998 University of Arizona, Tucson, Arizona

John Bongaarts and Judith Bruce. The Causes of Unmet Need for Contraception and the Social Content of Services. *Studies in Family Planning* 26, no. 2 (1995): 57-75.

Christine Bechtel and Debra L. Ness, "If You Build It, Will They Come? Designing Truly Patient-Centered Health Care," *Health Affairs*, 29, no.5 (2010):914-920
Sallit J, Ciccazzo M, Dixon Z. A Cognitive-behavioral weight control program improves eating and smoking behaviors in weight-concerned female smokers. Journal of the American Dietetic Association. 2009; 109:1398-1405.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people for change.* New York: Guilford Press.

Community Based Resources

Referral to community-based resources is a WISEWOMAN healthy behavior support option to reduce a woman's cardiovascular disease risk. Community-based resources supplement other healthy behavior support options (i.e., lifestyle programs such as the DPP, and health coaching) and other preventive services that may be available in the clinic, such as medication counseling. For an individual woman, referral to community-based resources may be the most appropriate healthy behavior support option.

Agencies should develop partnerships to offer community-based resources at low or no cost to women.

WISEWOMAN participants should be referred to community-based resources to support identified goals. These resources may include self-management programs that support chronic disease management, physical activity, nutrition, and tobacco cessation. Typically initial referral occurs during risk reduction counseling. These referrals may also occur during lifestyle programs or health coaching sessions.

Physical Activity/Nutrition Resources

- Hunger-Free Colorado Hotline: (1-855-855-4626)
- Supplemental Nutrition Assistance Program (SNAP):
- Expanded Food and Nutrition Education Program (EFNEP)
- TOPS
- Cooking Matters
- Recreation departments
- Local parks
- Walking/Biking trails
- Mall walking programs
- Gardening programs
- Food coupon programs
- Farmers' markets
- Nutrition classes

Tobacco Cessation Resources

- Colorado Quitline: 1-800-QUIT-NOW (1-800-784-8669)
  - WISEWOMAN funds can be used for other tobacco cessation programs, especially if the QuitLine does not address language and other cultural barriers.
  - WISEWOMAN funds cannot be used for nicotine replacement therapies. Many quit lines and other tobacco cessation resources offer these therapies at little or no cost.

Other Resources

Agencies should refer women to additional resources that offer support for specific challenges that the woman is facing. These resources may include:

- Mental health services
  - Metro Crisis Line: (1-888-885-1222)
  - National Suicide Prevention Lifeline: (1- 800-273-TALK (800-273-8255)
  - Pueblo Suicide Prevention Center: (719-564-6642)
- Temporary Assistance for Needy Families (TANF)
  - Colorado Department of Human Services Division of Colorado Works (303) 866-6210)
- Translation services
- Job training
- Violence prevention services
- Transportation services
- Discount/free cost medication programs
- Faith-based programs

Follow-up Assessments

Follow-up Assessment Overview

Follow-up assessments provide an opportunity to assess short-term health outcomes in women who participate in health coaching or lifestyle programs. They can also provide valuable information about how a program is working and indicate the need for revisions.

Follow-up Assessment Requirements

- **Agencies must conduct follow-up assessments for all women that complete health coaching and lifestyle programs.***
- **Follow-up assessments should occur within four weeks of completing health coaching or DPP sessions.**
- **Assessments must be conducted using the Follow-up Assessment form located on the WISEWOMAN website: https://www.colorado.gov/cdphe/wisewoman, and documented in eCaST.**

***If a woman receives rescreening within 3 months of completing health coaching or a lifestyle program, then the follow-up assessment requirement is met.**

Case Management

Case Management Overview

WISEWOMAN requires that clients who have abnormal screening results receive the follow-up services they need. This is achieved through case management. Case management is a short-term intensive support service used to ensure that clients receive appropriate and timely medical care. Case management also assists clients in understanding the treatment regimen, obtaining affordable medication, attending medical appointments, and/or reducing other barriers. The goal of case management is to coordinate timely and appropriate medical care for women with alert screening values for blood pressure and glucose or for uncontrolled hypertension. Case managers also help ensure that women participate in applicable healthy support options for which they are eligible and interested.

- All women with WISEWOMAN **alert** values must receive:
  - medical evaluation and treatment immediately or within seven days of the alert measurement, in accordance with national standards of care and the judgment of the Medical Director;
  - case management to assist women with accessing indicated medical care.

Case management may be provided by non-clinical professionals, but a qualified health care professional (Registered Nurse, Physician Assistant or Physician, in good standing to provide healthcare in the state of Colorado) must have oversight when clinical expertise is required.

Lost to Follow-Up/Refused Service Policy

Background

Funding received from the Centers for Disease Control and Prevention's (CDC) Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) program is contingent upon the Colorado WISEWOMAN program meeting or exceeding several quality assurance parameters and performance measures. Therefore, case managers must ensure the following indicators are met for all WISEWOMAN clients with abnormal screening results. Agencies must ensure that their:

1. Program follows-up with 100% of women with abnormal blood pressure values.

2. Program ensures that 80% of women referred to the Diabetes Prevention Program or health coaching participate in the program.

3. Program ensures that 60% of women who participate in the Diabetes Prevention Program or health coaching complete the program.

4. Program meets or exceeds 95% of its CDPHE approved screening goal. Screening goal includes baseline and rescreening.

Policy

Tracking and Documentation

A WISEWOMAN client contact and tracking system must be in place to notify clients of abnormal results. Clients should be notified in writing and verbally, of their screening and lab results. Contacts should be clearly documented in the client's medical record and should include what type of follow-up is needed, the recommended timeframe for follow-up, and the clinical implications if the follow-up does not occur. Contact should continue until one of the following occurs and is documented in the medical record:

1. Recommended follow-up evaluation has been completed and the client has been referred for treatment (if indicated).

2. Three documented attempts in contacting the client have been made. If the client has a valid address, one of these attempts must be in writing and sent as a certified letter.

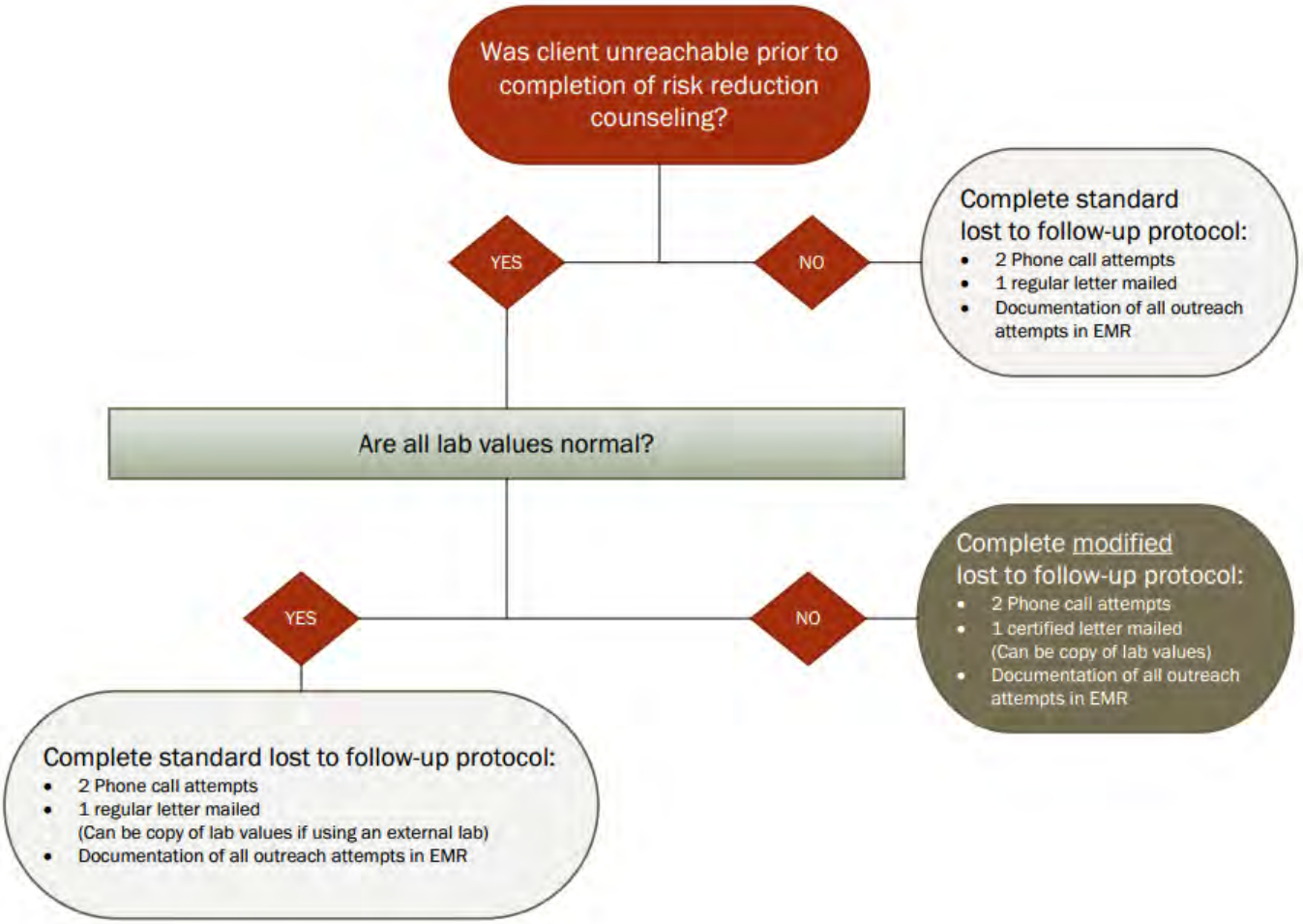
3. An informed refusal is documented in the client's medical record.

Lost to Follow-Up

1. A client can be considered lost to follow-up when at least three contact attempts have been made and documented in the client's medical record.
2. The third contact attempt should be in writing, via either regular or certified* letter. Certified letter circumstances are outlined below.

3. This documentation should include the type of contact attempted, the date, and the outcome.

4. Agencies are encouraged to complete lost to follow-up procedures for a case within 60 days of the first unsuccessful attempt to reach the client.



Risk Reduction Counseling

ALL WISEWOMAN screening results (BMI, BP, Glu or hbA1c, lipids, tobacco usage) must be provided BOTH verbally and in writing. It is strongly recommended that as many components of RRC that are available be discussed with women on the integrated office date are completed on that date, to minimize case management and lost to follow up processes.

Risk reduction counselors will typically deliver RRC by the following means:

- in person- integrated office date and/or later date (both verbally and in writing)
- telephonically (verbally and via a mailed* copy of the lab results)
    - *if blood glucose lab result is in alert range a CERTIFIED* letter must be sent to patient
    - *if woman has uncontrolled or alert range blood pressure and systolic/diastolic numbers are NOT provided to her in writing on the day of the integrated office visit, a CERTIFIED* letter must be sent to patient communicating these numbers
    - A noncertified letter may be sent for all other non-alert values, unless woman returns in person to complete RRC, in which case she may be handed her values in writing (either copy of lab results or My Health Information handout)

A regular letter may be sent with lab values if the values are below these alert values.

However, if a letter with lab results is sent (whether letter is certified or not certified); if there is no *verbal* contact with the patient then RRC (W1) cannot be completed. A W1 will always be paid if the clinic properly completes (and documents) the lost to follow up policy and follows the criteria below:

- WISEWOMAN screening results do NOT contain alert values or uncontrolled hypertension values that were NOT provided verbally and in writing on the screening date
    - 2 phone calls + noncertified letter
- WISEWOMAN screening results contain alert range or uncontrolled hypertension values that were NOT provided verbally and in writing on the screening date OR woman did not receive required medical evaluation & medication counseling
    - 2 phone calls + CERTIFIED* letter

Refused Service

1. A client is considered to have refused service when one of the following has been carefully documented in the client's medical record:
    a. She has verbally refused the follow-up care recommended.
    b. She has refused in writing the follow-up care recommended.

2. Documentation of the informed refusal should be kept in the client's medical record. Documentation should include what is being refused and that the client has been informed of the risks involved if recommended follow-up is not completed.

NATIONAL CLINICAL, DIET, AND LIFESTYLE GUIDELINES

NATIONAL GUIDELINES OVERVIEW

National clinical, diet, and lifestyle guidelines translate the best available science to practice. National guidelines assist clinicians and clients in making health care decisions. Guidelines do not take the place of the health care provider's judgment.

Clinical practice guidelines on Hypertension, Cholesterol, Overweight and Obesity are developed through collaborative efforts of national organizations. Additional guidelines on diseases and lifestyle are developed by national organizations such as the American Heart Association, American Diabetes Association and the American College of Cardiology. All the national guidelines are based on a rigorous review process.

NATIONAL GUIDELINES REQUIREMENTS

Agencies must ensure that WISEWOMAN service providers follow standard care practices, generally the current national guidelines. Each WISEWOMAN agency should have a Medical Director or Board that establishes which specific set of guidelines that facility will follow and also provides guidance for situations not addressed by guidelines.

NATIONAL GUIDELINES GUIDANCE

Agencies should assure the quality of all WISEWOMAN services provided by using standards of care when delivering clinical and preventive services. Agencies should employ nationally recognized standards and methods for ensuring quality in the delivery of WISEWOMAN services. The following are examples:

- When subcontracting with other organizations for services, agencies should specify expectations regarding adherence to national guidelines in contractual agreements, training, and program policies.
- Agencies should provide ongoing professional development and technical assistance on national guidelines and quality assurance regarding the use of national guidelines to their subcontractors or encourage them to attend CDPHE recommended professional development.
- Agencies should ensure subcontractors participate in professional development and technical assistance regarding national guidelines provided by CDPHE.
- Agencies should participate in site visits, chart audits and/or data audits conducted by CDPHE and should conduct their own audits to assess quality in the delivery of services.

CDC and CDPHE recognize that national guidelines are not fixed protocols that must be followed and that a licensed practitioner's judgment remains paramount.

National Guidelines References/Resources

Cardiovascular Risk and Blood Pressure

Million Hearts® Evidence-based Treatment Protocols for Improving Blood Pressure Control
http://millionhearts.hhs.gov/resources/protocols.html

Go AS, Bauman MA, Coleman King SM, Fonarow GC, Lawrence W,
Williams KA, Sanchez E. An effective approach to high blood pressure control: A Science Advisory From the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention. *Hypertension*. 2014;63:878–885.
http://hyper.ahajournals.org/content/63/4/878

Centers for Disease Control and Prevention. *Hypertension Control: Action Steps for Clinicians.* Atlanta, GA: Centers for Disease Control and Prevention, US Dept. of Health and Human Services; 2013.
http://millionhearts.hhs.gov/resources/action_guides.html

2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk: A Report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation
Guideline on the Assessment of Cardiovascular Risk Slide Set

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).
http://www.nhlbi.nih.gov/guidelines/hypertension/

Cholesterol

2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation
Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults Slide Set

Diabetes

American Diabetes Association Standards of Medical Care in Diabetes—2014.
http://care.diabetesjournals.org/content/37/Supplement_1/S14.full

Overweight and Obesity

2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults: A Report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines and The Obesity Society.
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee
Guideline for the Management of Overweight and Obesity in Adults Slide Set

Tobacco Use

Best Practices for Comprehensive Tobacco Control Programs—2014; Centers for Disease Control and Prevention
http://www.cdc.gov/tobacco/stateandcommunity/best_practices/

National Diet & Lifestyle Guidelines

The 2013 AHA/ACC Guideline on Lifestyle Management to Reduce Cardiovascular Risk: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines.
http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437740.48606.d1.citation

Million Hearts. Healthy Eating & Lifestyle Resource Center.
http://recipes.millionhearts.hhs.gov/

Dietary Guidelines for Americans, 2010.
http://www.cnpp.usda.gov/DGAs2010-PolicyDocument.htm

Your Guide to Lowering Your Blood Pressure With DASH: DASH Eating Plan
http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf

2008 Physical Activity Guidelines for Americans.
http://www.health.gov/paguidelines/guidelines/default.aspx

Position Stand: American College of Sports Medicine (ACSM) Quantity and Quality of Exercise for Developing and Maintaining Cardiorespiratory, Musculoskeletal, and Neuromotor Fitness in Apparently Healthy Adults: Guidance for Prescribing Exercise.
http://journals.lww.com/acsmmsse/Fulltext/2011/07000/Quantity_and_Quality_of_Exercise_for_Developing.26.aspx

GET THE FACTS: Sodium and the Dietary Guidelines.
http://www.cdc.gov/salt/pdfs/sodium_dietary_guidelines.pdf

The U.S. National Physical Activity Plan, 2010.
http://www.physicalactivityplan.org/theplan.php

(eCaST) DATA ENTRY AND DOCUMENTATION

Agencies are required to manually enter WISEWOMAN data in the Electronic Cancer Surveillance and Tracking (eCaST) web application. eCaST is a program management and public health surveillance tool. It is not an electronic health record (EHR) and should not be used to gather any information beyond required data elements used for cardiovascular screening surveillance. Based on data entered, agency grant activity statements are generated within the eCaST application, making eCaST data entry the only way WISEWOMAN service delivery agencies can access grant funds.

eCaST was developed by the Colorado Department of Public Health and Environment (CDPHE) in 2005. It is updated and maintained by CDPHE to meet U.S. Centers for Disease Control and Prevention (CDC) WISEWOMAN reporting and documentation requirements.

Data for other public health screening programs are also collected in eCaST. Client demographic data is shared across grant programs, but clinical information is accessible by program only. It is possible that your agency may use eCaST for other public health programs. Programs using eCaST include:

- WISEWOMAN
- Women's Wellness Connection (WWC)
- Colorectal Cancer Screening Program
- Colorectal Cancer Control Program

Data Collected and Reported in eCaST

All WWC agencies must collect and store data on WISEWOMAN-funded cardiovascular screenings. The program provides a set of paper forms. Information gathered on paper forms represents all data that must be reported via eCaST. Data must be entered within thirty (30) days of providing cardiovascular services to a Women's Wellness Connection client.

Forms can be found on the website at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources.
Information collected on each form is summarized below.

1. **WISEWOMAN Patient Information Form**

   The WISEWOMAN Patient Information Form contains questions regarding a client's cardiovascular history and current behaviors that may increase her cardiovascular disease risk. The information collected is confidential. The client may complete this form on her own or a clinic staff member may assist her in doing so.

2. **WISEWOMAN Risk Reduction Counseling & Referral Form**

   The WISEWOMAN Risk Reduction Counseling & Referral Form contains questions regarding a client's readiness to change and participate in a healthy behavior support option. This form may be continuously updated as health coaching sessions are completed or as a Diabetes Prevention Program reports new services were provided to the client. The information collected is confidential.
   A clinic staff member should complete this form.

Uses of Data

eCaST data replace many standard reporting requirements, such as progress reports and grant invoicing. Your agency should use the eCaST application to:

1. **Ensure client eligibility**
   Because a WISEWOMAN client must meet Women's Wellness Connection eligibility criteria to be enrolled in WISWEWOMAN, WWC eligibility criteria are embedded in the eCaST application. Clients not meeting demographic and clinical eligibility requirements are flagged and reimbursement is withheld if entered into eCaST in error.

2. **Monitor quality of clinical services**
   eCaST is used to monitor adherence to WISEWOMAN clinical algorithms on individual client, agency and state levels. Abnormal screening results per these clinical algorithms are embedded in eCaST, and clients requiring follow up are automatically flagged in the system. If follow-up recommendations are made which do not follow WISEWOMAN clinical algorithms, payment will be withheld; unlike the Women's Wellness Connection, client services will become reimbursable upon entry into eCaST, rather than completion of all lifestyle interventions, given the length of time needed to complete recommended interventions. In addition to client-specific eCaST features, reports assessing agency performance on CDC indicators are also available. Agencies should use eCaST in addition to other clinic processes to ensure all clients are receiving appropriate services.

3. **Reimburse for grant activity.**
   Grant activity is assessed each month based on clinical services entered into eCaST. A grant activity statement is generated for agencies with valid cardiovascular screening cases containing no data entry errors. Statements are available from the eCaST application.

4. **Monitor grant spending and screening goals.**
   eCaST has a report available to help an agency monitor grant fund expenditures. This can be used to project funds needed through the remainder of the fiscal year. The WISEWOMAN program requires that agencies monitor spending of allocated funds, ensuring there is enough funding available throughout the fiscal year to provide services to women in need of them.

WISEWOMAN state staff uses eCaST to:

1. Monitor data across all service delivery agencies to ensure volume of data entry errors is low.
2. Ensure clinical quality of services provided meet CDC indicators.
3. Ensure each agency is on pace to draw down 100 percent of grant funds over the contract period.
4. Identify agencies in need of funding increases or decreases.

eCaST data are submitted to the CDC for review two times each fiscal year – on April 1 and October 1. WISEWOMAN minimum data elements (MDEs) are a set of standardized data variables needed to ensure that consistent and complete information is collected for each WISEWOMAN participant. MDEs serve the purposes of describing, monitoring and assessing individual and program progress. Some MDEs are captured using eCaST data.

There are limitations to eCaST data entry and use. Because eCaST is a public health surveillance tool, WISEWOMAN agencies may not enter data on non-WISEWOMAN funded cardiovascular screenings.

Data Cleaning and Data Quality

DataCON is a data cleaning project completed in March and September in preparation for CDC data submissions. Agencies are required to review all screenings performed over the previous one and a half years that do not meet a CDC clinical indicator or contain data errors. Agencies must review such screenings to confirm accuracy, review completeness and correct errors.

WISEWOMAN staff provides a listing of screenings requiring review to the agency's eCaST Coordinator. Typically, listings are provided via an Excel spreadsheet in early to mid-March and September. Agencies are given two to four weeks to complete, depending on volume of screenings for review.

Other data cleaning and data quality projects are conducted as needed after identifying concerning data trends or at CDC's request. Projects can be focused on specific agencies or may be implemented statewide. Agency participation is required.

Communication regarding specific clients is primarily sent via unencrypted email. Clients are referenced to by eCaST ID number alone so that no Personal Health Information (PHI) is exposed. Fax, encrypted email, and file transfer protocol sites may be used when WISEWOMAN must communicate PHI. Information shared with WISEWOMAN is confidential.

eCaST Location and Software Requirements

The eCaST application is located on CDPHE's Health Informatics Portal at:
https://www.phi.dphe.state.co.us/nonauthenticated/default.aspx?

Agencies do not need to install additional software beyond a web browser. eCaST data entry is a WISEWOMAN contract requirement; therefore, it is important that eCaST users at each agency have access to an eCaST-supported web browser. eCaST runs most efficiently on Google Chrome (download at https://www.google.com/intl/en/chrome/browser/); however, Mozilla Firefox and Internet Explorer version 9+ are also supported. **Note that eCaST does not function on, and is not supported on Internet Explorer version 8 or earlier versions**.

Accessing eCaST

All staff requesting new access to eCaST are required to attend an eCaST Basics training session before they are given access. These are held on the first Wednesday of each month from 9:30 to 11:30 a.m. Contact the WISEWOMAN data manager to RSVP.

When an existing eCaST user no longer needs access for WISEWOMAN data entry, an agency must report to WISEWOMAN program staff within 15 days.

Data Security and Confidentiality

All eCaST users are required to agree to the Colorado Department of Public Health and Environments (CDPHE) "Data use, security, and confidentiality" agreement prior to accessing the eCaST application. A copy of this agreement and CDPHE's security policy can be found at:
http://www.phi.dphe.state.co.us/NonAuthenticated/Documents/HI%20Portal%20Confidentiality%20and%20Use%20Agreement%202014.11.10.pdf

Authority for Data Collection

WISEWOMAN receives authority to collect client data through the CDC's WISEWOMAN program.

The WISEWOMAN Statement of Work in service delivery agency contracts includes the requirement for collecting and submitting cardiovascular screening and lifestyle intervention data.

CDPHE is not a HIPAA entity but is a public health authority pursuant to HIPAA. According to Title 45 CFR 164.512, however, "A covered HIPAA entity may disclose protected health information to a health oversight agency for oversight activities authorized by law." Thus, CDPHE can receive protected health information as it relates to health oversight activities. Additional information regarding CDPHE and the HIPAA privacy rule language can be found in each agency's WISEWOMAN contract with CDPHE.

REIMBURSEMENT

How does WISEWOMAN Reimburse?

WISEWOMAN reimbursement is dependent on case outcome. As a case becomes more complex, the reimbursement amount increases. WISEWOMAN has identified ten levels of increasing case complexity marked by the number of Diabetes Prevention Program (DPP) or Health Coaching sessions the client attends. These levels make up the Bundled Payment System (BPS). **In the BPS, each level builds on preceding levels.** BPS reimbursement rates are based on Medicare rates for procedures likely to be completed in a given level and on the typical cost for a DPP class or health coaching session. Rates are set based on current Medicare CPT code rates at the beginning of each fiscal year. (See Bundled Payment System Chart at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources).

Cardiovascular screening reimbursement for includes:

Unlike the Women's Wellness Connection, WISEWOMAN levels are reimbursable immediately upon achieving the minimum requirements for any give level. For example, a Level One is reimbursable after screening services are submitted into eCaST but before completion of recommended lifestyle interventions. Similarly, Level Two is reimbursable after completion of one DPP session and Level Three is reimbursable after completion of a client's fourth DPP session.

What does WISEWOMAN Reimbursement Cover?

Agencies will be paid according to the fiscal year's BPS Chart as information on a client's WISEWOMAN cycle has been entered, completely and accurately, into eCaST. In order to be considered for payment, WISEWOMAN services must be entered into the eCaST data system within **thirty (30)** days of the service being performed. Agencies will only be paid for cases that meet eligibility, performance and data requirements. The WISEWOMAN program will provide reimbursement for a client's completed cardiovascular screening, laboratory test and risk reduction counseling. Additional reimbursement will be provided as each client completes additional healthy behavior support options classes, as outlined in the Bundled Payment System. The completion of health coaching and Diabetes Prevention Program (DPP) classes determines additional payments to be made, once the data entered in eCaST meet the benchmark requirements for each subsequent level.

WISEWOMAN agencies accept these fees as payment in full.

Reimbursement should cover costs associated with:

- Enrollment of clients in WISEWOMAN
- Cardiovascular screening laboratory tests
- Cardiovascular screening and risk reduction counseling services as outlined in those respective sections of this manual.
- A follow-up visit for alert values, untreated disease-level values and uncontrolled hypertension
- Client navigation and case management services
- Participation in DPP or Health Coaching

- Incentives and barrier reduction
- Administrative procedures to ensure access to affordable medication for women who require it
- Entry of all information into eCaST

Clients should not be billed for services described in the WISEWOMAN CPT Code List. Moreover, should there be a difference between an agency's standard rate for a given service and the WISEWOMAN rate for that service, it is not payable by WISEWOMAN, and the difference should not be billed to the client. If services not on the CPT Code List and outside of the WISEWOMAN program scope are provided, agencies may bill the client for these services. However, clients must be notified and advised of the costs before services are provided. The CPT Code List can be found here: https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources.

Cases where a lifestyle intervention is recommended but the client does not complete will be reimbursed at Level One. The WISEWOMAN program will only pay one agency for services provided for each woman, each fiscal year. If two agencies provide WISEWOMAN services to a client, the agency that provided the initial cardiovascular screening and referral will receive reimbursement.

Use of WISEWOMAN Funds for Clinical Services

Use of WISEWOMAN funds is allowed for the following services:

- Laboratory tests at the baseline/rescreening visit and first follow-up office visit, as needed.
- A second set of labs if the Medical Director determines they are indicated.
- Risk reduction counseling.
- Costs associated with WISEWOMAN referrals for support services such as medication adherence, self-measured blood pressure monitoring with support, health coaching, tobacco cessation support programs, or nutrition counseling.
- One office visit (per occurrence) for evaluation of alert values or other disease-level values.
- Case management as needed for women who have alert screening values for blood pressure and glucose or for uncontrolled hypertension.

Use of WISEWOMAN funds is not allowed for the following services:

- The integrated office visit. (WWC pays for integrated office visit)
- Laboratory tests other than those on the allowable CPT codes list.
- Medication or other medical treatment or procedures for clinical conditions (in accordance with Public Law 101-354 and its amendments).

Note: In accordance with Public Law 101-354 and its amendments, WISEWOMAN funds must be the payer of last resort. Grantees cannot use WISEWOMAN funds to pay for any services that are covered by a State compensation program, an insurance policy, a federal or state health benefits program, or an entity that provides health services on a prepaid basis. Exception: Indian Health Services is the payer of last resort if these funds are available.

Reimbursement for Case Management

Within the Bundled Payment System, agencies are reimbursed for case management services depending on the outcome of the case. In order to receive reimbursement for case management services, agencies must do the following:

1. Ensure that clients who have abnormal screening results receive the follow-up services they need*;
2. Assess and refer eligible women who indicate a readiness to change, to health coaching or the Diabetes Prevention Program (DPP);
3. Use WISEWOMAN approved algorithms to determine next steps;
4. Assess clients' barriers to completing recommended health coaching sessions or Diabetes Prevention Program classes;
5. Ensure intensive follow-up and reinforcement of goals for women that participate in DPP; and
6. The Follow-up assessment shall occur within four weeks after Health Coaching, Diabetes Prevention Program or other LSP program completion. The agency shall comply with the "Lost to Follow Up/Refused Service Policy" for clients who discontinue services (see Case Management sub-section, pages 26-28 of this manual).
    - Follow-up assessment may be completed directly by the agency or by the subcontractor).
    - This may be completed via telephone, face to face or by mail.
    - In cases where a client receives rescreening within 3 months of completion of healthy behavior support option programming, eCaST users must enter the appropriate Patient Information form data into both the initial health assessment portion of the rescreen, as well as the previous screening's follow-up assessment.

Exclusions and Exceptions for Reimbursements

- Agencies will **not** receive payment for Level One services if a client with medical alert values does not receive medical treatment immediately or within seven days, or if there is no documentation indicating that the client was advised to seek immediate medical attention.
- If the client cannot be reached for the follow-up services, this should be documented according to the Lost to Follow-up/Refused Service Policy.
- If a client is lost to follow-up before risk reduction counseling can be completed, agencies may request reimbursement at a level I. In these cases, WISWOMAN program staff must be contacted for administrative approval.

Adjustments to Reimbursements

Reimbursement will be ready each time a case reaches a higher level in eCaST; funds will be adjusted (credited or debited) on the agency's grant activity statement. Adjustments may occur in the following circumstances:

- Client information is updated, demonstrating ineligibility for the WISEWOMAN program.
- Services are added or removed from eCaST that change the case status from closed to open.
- Services are added to or removed from eCaST that cause the reimbursement level to change.
- Data are changed by data entry staff from a known to missing value.
- Reimbursement was made in error for duplicate clients identified.
- WISEWOMAN places a case on hold or administrative override because the case does not meet contractual requirements.

Agencies should work directly with WISEWOMAN program staff regarding non-payment of clients screened. If WISEWOMAN staff members are unable to rectify reimbursement issues, agencies may work with the WISEWOMAN fiscal officer.

When Does WISEWOMAN Reimburse?

Grant activity statements will be generated the 15th of each month or the first business day after the 15th on the agency's behalf according to services entered in eCaST. One reimbursement check for all completed screenings and health coaching or Diabetes Prevention Program (DPP) sessions that have met data and quality standards in eCaST as of the 14th of each month will be included in the billing cycle each month. The final grant activity statement is generated 30 days after the end of the fiscal year (i.e., 30 days after June 30).

Reimbursement checks are produced by and mailed from the state comptroller's office, not the Colorado Department of Public Health and Environment. Each check received will include a payment voucher number. This number is also listed on each Grant Activity Statement, the invoice generated in eCaST, so that agencies can verify clients associated with checks received.

Tracking Budgets

Each agency receives a funding amount that it can use to provide services under the WISEWOMAN program each fiscal year. Once an agency's total budget amount has been reached, the WISEWOMAN program may not pay for any additional expenses incurred by the agency.

Agencies that are under-spent in their budgets may have funds taken back and reallocated to other agencies at any time during the contract period.

SUBCONTRACTING

Screening and risk reduction counseling services must be provided directly by a WISEWOMAN agency. However, lab services, medical evaluation and follow-up and healthy behavior support option services (Diabetes Prevention Program and/or other Lifestyle Programs) may be delivered by a WISEWOMAN agency or through subcontracts with other entities. When a WISEWOMAN agency provides WISEWOMAN covered services by referring clients to another organization through a subcontract, that agency must maintain, at a minimum, a memorandum of understanding (MOU), or other binding contractual agreement with the subcontracting organization. This agreement must incorporate a mechanism for payment. A subcontractor is subject to all of the terms and conditions of the WISEWOMAN contract. Additionally, the WISEWOMAN agency remains ultimately responsible for the timely and satisfactory completion of all work performed by any subcontractor(s) under the WISEWOMAN contract.

The WISEWOMAN agency must provide a list of all current subcontracts to the WISEWOMAN program within 15 days of executing the contract and report all subcontractor changes to the WISEWOMAN program within 15 days of occurrence.

WISEWOMAN Subcontracting Requirements

Subcontracts must be secured with local organizations to the extent possible.

In addition, WISEWOMAN clients should not be billed or be made responsible for payment of any cardiovascular screening costs associated with services outlined on the Current Procedural Technology (CPT) Code List (https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources) and the WISEWOMAN Bundled Payment System. If services **not** on the CPT Code List or Bundled Payment System are provided, subcontractors may bill the client for these services. However, clients must be notified and advised of the costs before services are provided. The CPT Code List is updated annually based on information found on the Centers for Medicare and Medicaid Services website: http://www.cms.gov/apps/ama/license.asp?file=/physicianfeesched/downloads/pe_townhall_tables_pubuse.zip

Subcontracting Basics

It is each WISEWOMAN agency's responsibility to ensure that the subcontracts or MOUs are reviewed by its legal counsel.

Subcontracts should be signed by both parties, outline specific roles and responsibilities, and ensure that all financial obligations are defined and other terms/conditions included.
At a minimum, the following elements should be incorporated into an agreement:

- General description of the project, including an outline of the specific roles and responsibilities
- Deliverables (specific services to be provided)
- Signatures of both parties

BASELINE SCREENING ASSESSMENTS AND SYSTEMS/INFRASTRUCTURE CHANGE

The main focus of funding for WISEWOMAN agencies is to provide cardiovascular screening to women who are already eligible for breast and/or cervical cancer screening through the Women's Wellness Connection (WWC) program. The second focus of the WISEWOMAN project is to conduct baseline screening assessment and systems/infrastructure change within the implementing agency.

- *Baseline Screening Assessments:* Assess clinic-wide screening practices and determine clinic-wide baseline screening rates related to colorectal, breast, and cervical cancer services, as well as cardiovascular measures.

- *Systems/Infrastructure Change:* Based on baseline screening assessment data, policies and practices will be adjusted as needed towards providing sustainable, high quality cancer and cardiovascular screening services. Funds will be provided to establish systems which increase agency or clinic-wide screening rates.

Project Description:

This project will focus on building a sustainable infrastructure to increase preventative cancer and cardiovascular disease screenings among the entire clinic population (not just those served through the WISEWOMAN program). Based on baseline assessment data that will be collected through chart audits, policies and practices will be developed and adjusted towards providing sustainable, high quality cancer and cardiovascular disease screening services.

Each agency participating in the WISEWOMAN program will receive additional funding under a separate purchasing agreement to conduct systems change efforts to increase breast, cervical, and colorectal cancer and cardiovascular disease screening rates among the agency's entire clinic populations.

ENVIRONMENTAL APPROACHES

ENVIRONMENTAL APPROACHES OVERVIEW

Improvements in social and physical environments make healthy behaviors more feasible. The anticipated outcomes in the CDC Environmental Approaches Domain are environmental changes in communities that result in more places for physical activity, increased access to healthy food, smoking cessation services, and more smoke-free public places. Environmental approaches have broad reach, sustained health impact, and are best buys for public health.

Partnerships allow for more efficient use of resources and play a key role in advancing the broader goals of the WISEWOMAN Program. The purpose of developing strategic partnerships to support environmental approaches is to increase opportunities for physical activity, healthy food choices, smoking cessation, and smoke-free public places.

ENVIRONMENTAL APPROACHES REQUIREMENTS

As a WISEWOMAN grantee, Colorado must work with partners to increase options to reinforce healthful behaviors in the following areas: physical activity, healthy food choices, smoking cessation, and smoke-free environments in communities where WISEWOMAN participants live, work, play and receive screening services. These partnerships can include state, community-based, governmental and non-governmental entities.

WISEWOMAN agencies will be made aware of their role in any statewide or local activities related to the Environmental Approaches Domain.

WISEWOMAN PROGRAM EVALUATION

PROGRAM EVALUATION OVERVIEW

Evaluation of WISEWOMAN activities will (1) demonstrate program effectiveness in improving hypertension control and other cardiovascular risk among the target population, (2) provide useful information to drive continuous program improvement, (3) contribute to the evidence base for specific program activities, and (4) contribute to the evidence base for disparate populations.

PROGRAM EVALUATION REQUIREMENTS

As a WISEWOMAN grantee, Colorado must comply with the following evaluation requirements:

- **Conduct both process and outcome evaluation of their program activities.**
- **Develop an overarching 4-year evaluation plan and specific annual plans for each program year and submit them for CDC approval.**
- **Use evaluation findings to make revisions and improvements to the program.**
- **Report evaluation findings annually to CDC.**
- **Report cumulative evaluation findings for the 4-year project period in the Final Performance Report.**
- **Address the three priorities areas determined by CDC: (1) uncontrolled hypertension; (2) health coaching and/or lifestyle programs; and (3) one additional area.**

Agencies will be made aware of their role in the statewide evaluation of the WISEWOMAN program in Colorado. For more information on program evaluation, refer to the Colorado WISEWOMAN Evaluation Plan found at https://www.colorado.gov/pacific/cdphe/wisewoman-provider-resources

ABBREVIATIONS AND ACRONYMS

Below is a list of abbreviations and acronyms that are commonly used by the WISEWOMAN Program

A1C Test	Glycosylated Hemoglobin Test
ATP III	Adult Treatment Panel III Report (National Cholesterol Education Program, 2001)
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
CDPHE	Colorado Department of Public Health and Environment
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CVD	Cardiovascular Disease
DASH	Dietary Approaches to Stop Hypertension
DBP	Diastolic Blood Pressure
eCaST	Electronic Cancer Surveillance and Tracking
EHR	Electronic Health Record
FOA	Funding Opportunity Announcement
FPG Test	Fasting Plasma Glucose Test
HC	Health Coach/Health Coaching
HBP	High Blood Pressure
HDL-C	High-Density Lipoprotein Cholesterol
HTN	Hypertension
IOV	Integrated Office Visit
JNC 7	Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7, 2004)
LDL-C	Low-Density Lipoprotein Cholesterol
LSP	Lifestyle Program
MDE	Minimum Data Element
MTM	Medication Therapy Management
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
OGTT	Oral Glucose Tolerance Test
RRC	Risk Reduction Counselor/Risk Reduction Counseling
SBP	Systolic Blood Pressure
SMBP	Self-Measured Blood Pressure
TIA	Transient Ischemic Attack
TLC	Therapeutic Lifestyle Changes
USPSTF	U.S. Preventive Services Task Force
WISEWOMAN	Well-Integrated Screening and Evaluation for Women Across the Nation
WWC	Women's Wellness Connection