

# CDPHE WISEWOMAN SERVICE DELIVERY FLOW DIAGRAM

Eligible Women (breast and/cervical office visit through WWC, age 40 to 64) – Integrated Office Visit

## Screenings and Medical Support

- Forms: WISEWOMAN Consent/Patient Information/ Risk Reduction Counseling & Referral/Medical Evaluation & Workup
  - CVD screenings (BP; Cholesterol; Glucose; BMI) – preferably fasting for 9 hrs.
  - Provide medical support/Address uncontrolled hypertension
- Patient-Centered Risk Reduction Counseling (Begun at time of office visit)**
- Give screening results both verbally and in writing
  - Provide interpretation of results and recommendations
  - Use motivational interviewing
  - Facilitate access to medical follow-up and healthy behavior support options

Rescreen (12-18 months after previous screening)

<p><b>Predisease-Level Values</b></p> <p><b>Cholesterol</b></p> <ul style="list-style-type: none"> <li>Total Cholesterol = 200-239</li> <li>HDL Cholesterol &lt; 40</li> <li>Fasting LDL Cholesterol = 130-159</li> <li>Triglycerides = 150-199</li> </ul> <p><b>Glucose (Prediabetes)</b></p> <ul style="list-style-type: none"> <li>A1C = 5.7-6.4%</li> <li>Fasting Plasma Glucose = 100-125</li> </ul> <p><b>BMI (Overweight and Obese)</b></p> <ul style="list-style-type: none"> <li>BMI &gt; 25</li> </ul> <p><b>BP (Prehypertension)</b></p> <ul style="list-style-type: none"> <li>120-139 Systolic</li> <li>80-89 Diastolic</li> </ul> <p><b>HISTORY/BEHAVIORS</b></p> <ul style="list-style-type: none"> <li>Smoking;</li> <li>Physical Inactivity;</li> <li>Poor Nutrition</li> <li>Medication Adherence &amp; Access</li> </ul>
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<p><b>Disease-Level Values</b></p> <p><b>Cholesterol<sup>†</sup></b></p> <ul style="list-style-type: none"> <li>Total Cholesterol ≥ 240</li> <li>Fasting LDL Cholesterol ≥ 160</li> <li>Triglycerides ≥ 200</li> </ul> <p><b>Glucose<sup>†</sup></b></p> <ul style="list-style-type: none"> <li>A1C ≥ 6.5%</li> <li>Fasting Plasma Glucose ≥ 126</li> </ul> <p><sup>†</sup> Refer for medical evaluation if not currently being treated</p>
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<p><b>Uncontrolled Hypertension<sup>†</sup></b></p> <p><b>Stage 1</b></p> <ul style="list-style-type: none"> <li>140-159 Sys</li> <li>90-99 Dias</li> </ul> <p><b>Stage 2</b></p> <ul style="list-style-type: none"> <li>≥ 160 Sys</li> <li>≥ 100 Dias</li> </ul> <p><sup>†</sup> Refer for medical evaluation if not currently being treated</p>
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<p><b>Alert Values</b></p> <ul style="list-style-type: none"> <li>Systolic BP &gt; 180 or Diastolic &gt; 110</li> <li>Blood Glucose &lt; 50<sup>†</sup> or ≥ 250<sup>†</sup></li> </ul> <p>Medical evaluation and treatment immediately or within <b>7 days</b></p> <p><sup>†</sup> Blood glucose alert levels are same regardless of fasting status</p>
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<p><b>Refer for medical evaluation</b></p> <ul style="list-style-type: none"> <li>Medication Adherence and Access Support</li> </ul>
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Ready

Not Ready

Call back at a later date

<p><b>Healthy Behavior Support Options – Referrals to and participation in option(s) that best support woman’s goals.</b></p>			Case management
<p><b>Health Coaching</b></p> <p>Ongoing coaching sessions that improve/maintain health.</p> <p>Motivational Interviewing</p> <ol style="list-style-type: none"> <li>Trained staff to offer on-site</li> <li>Refer to Colorado Heart Healthy Solutions (CHHS)</li> </ol>	<p><b>Diabetes Prevention Program</b></p> <p>Referral of eligible women to accessible DPP</p> <ol style="list-style-type: none"> <li>Train staff to offer DPP on-site</li> <li>Refer to local DPP</li> </ol>	<p><b>Community-Based Referrals</b></p> <p>Resources that support healthy behaviors, including tobacco cessation</p>	

<p><b>Follow-Up Assessment – 4 weeks after completion of Health Coaching or DPP</b></p> <p>Min. = Medications, BP self-monitoring, Diet, Physical Activity, Smoking, Quality of Life</p>
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