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Clinical services under the Women’s Wellness Connection (WWC) program may be carried out by a WWC agency or through subcontracts with other agencies. However, a WWC agency must perform basic breast and cervical cancer screening services on-site. Basic screening services include breast and cervical health history assessment, breast and cervical health education, clinical breast exams, pelvic exams and Pap tests. These services are covered in more detail below. A WWC agency must be the agency ultimately responsible for the care and follow-up of the clients it enrolls in the WWC program. In other words, each agency must “own” and “manage” the clients it enrolls in WWC. WWC clinical policies are not intended to limit client care or interfere with clinical decision-making of individual providers. However, agencies must adhere to WWC clinical policies in order to ensure appropriate use of program funding and procedure reimbursement for WWC enrolled clients. Provider discretion may be used to provide services beyond the WWC clinical policies, but WWC is not able to reimburse for these services.

Breast Cancer Screening Guidelines

WWC breast cancer screening guidelines are based on nationally recognized clinical guidelines from organizations such as the U.S. Preventive Services Task Force (USPSTF), American College of Obstetricians and Gynecologists (ACOG), National Cancer Institute (NCI), American Cancer Society (ACS), and with advice from the WWC medical director and Medical Advisory Board. National guidelines and recommendations do not replace clinical judgment based on individual circumstances of the client.

1. Breast Health History
   
   A breast health history must be recorded in the client’s chart. Breast health history should include, at a minimum, questions about:
   
   - Personal history of breast cancer.
   - First degree relative with breast cancer (e.g. mother/father, sister/brother, daughter/son).
   - New breast symptoms during the past three months.

   Collecting a comprehensive family history to assess for breast cancer risk is highly encouraged. This may include family history of prostate cancer, ovarian cancer, and BRCA1 or 2 gene mutations).

2. Breast Health Education

   Breast health education must be provided and documented in the client’s chart and eCaST if the agency wishes to receive reimbursement for breast services that do not go beyond level B1 of the Bundled Payment System (BPS) and do not include a clinical breast exam (See the Reimbursement section). Education must be provided in the context of an office visit. Education may be provided by the provider or other trained staff to the client in verbal or written form. Breast health education should include, at a minimum, information about:
   
   - Breast cancer screening intervals.
• The risks and benefits of mammogram screening.
• Risk factors for developing breast cancer.
• Symptoms of breast cancer.
• How to reduce risk of breast cancer (stay physically active with regular exercise; maintain a healthy weight; limit use of combination (estrogen + progesterone) hormone therapy, or know the risks and benefits of HRT and if it is the right option for the client; and limit the amount of alcohol consumed).
• NBCCEDP’s Breast Cancer Facts client handout can be used to meet this education requirement. This handout can be found here: http://www.cdc.gov/cancer/nbccedp/pdf/toolkit/NBCCEDP_2011_BCFacts_Gen_508.pdf.

3. Clinical Breast Exams
A clinical breast exam (CBE) may be provided yearly at the discretion of the provider. Yearly CBEs are considered optional by WWC and may be performed based on the provider’s and the client’s determination of need. Performance of a CBE is not required to receive reimbursement for breast cancer screening services. However, an office visit is required.

4. Annual Breast Health/Breast Education Visit
Agencies may be reimbursed for returning clients, who have an office visit and are determined by a mid-level, or higher, provider to not need a breast screening after review of the client’s health history, who have a visit that includes breast health history and education. Breast health history and education (as detailed in #1 and 2 above) must be completed and documented in the chart and eCaST in order to receive reimbursement in absence of a breast procedure (i.e. CBE/mammogram).

5. Screening Mammography
• WWC follows the United States Preventive Services Task Force (USPSTF) recommendations. Although USPSTF recommends (Grade B) biennial screening, annual screening mammograms are covered for clients’ age 50-64 years in WWC. Annual screening is defined as 10 months or greater from the initial or previous screening.
• WWC covers targeted screening mammograms for clients ages 40-49. In order to be compliant with USPSTF guidelines, providers must avoid offering routine screening in this age group and instead, discuss potential benefits and harms of mammography screening in order to assist clients in making an informed choice. Women who place a higher value on the potential benefit than the potential harms may choose to begin screening between the ages of 40 and 49 years (USPSTF Grade C recommendation).
  o Counseling prior to scheduling a screening mammogram for a client ages 40-49 should consist of a detailed conversation and agreement between a
clinical staff member and client that includes discussion of benefits and harms of screenings, a client’s preference and breast cancer risk profile. Clinical staff may use the WWC Targeted Screening Client Handout found on the WWC website to provide this counseling. This counseling is more detailed and specific than the typical breast health education (described in #1, above). However, the more detailed counseling described here will also meet the requirements of the breast health education.

- The counseling should include specific information regarding:
  1) Risks, including: false-positive and false-negative rates, rates of additional diagnostics, the detection of tumors that may not progress to cancer, anxiety/discomfort, and over diagnosis (i.e., tumors detected on screening that never would have led to clinical symptoms).
  2) Benefits, including: a decreased risk in breast cancer mortality and if diagnosed with breast cancer, the need for less aggressive treatment.

- Some women with no family history of breast cancer will elect to wait until age 50 to start screening mammography; others may not be comfortable doing so.

- WWC encourages agencies to utilize one or more of the following three tools to assist providers and clients in determining whether a client 40-49 years old is an appropriate candidate for a screening mammogram.
  1) The USPSTF recommendations on Shared Decision-making About Screening and Chemoprevention.
  2) The National Cancer Institute's Breast Cancer Risk Assessment Tool.
3) WWC's quick reference table

<table>
<thead>
<tr>
<th>Reasons a 40-49 year old client may be recommended to have a screening mammogram</th>
<th>Reasons a 40-49 year old client may not be recommended to have a screening mammogram</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Personal history of breast cancer.</td>
<td>• Has no identifiable factors for increased risk.</td>
</tr>
<tr>
<td>• Family history of breast cancer.</td>
<td>• Hesitant about the possible harms of screening mammography.</td>
</tr>
<tr>
<td>• Previous breast biopsy.</td>
<td>• Feels the possible harms are greater than the benefits in her case.</td>
</tr>
<tr>
<td>• Known genetic mutations.</td>
<td></td>
</tr>
<tr>
<td>• Unknown family history.</td>
<td></td>
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<tr>
<td>• Excessive alcohol use, defined as 2 or more drinks daily.</td>
<td></td>
</tr>
<tr>
<td>• Ashkenazi Jewish decent.</td>
<td></td>
</tr>
<tr>
<td>• Nulliparity (never had children).</td>
<td></td>
</tr>
<tr>
<td>• First child born after the age of 30.</td>
<td></td>
</tr>
<tr>
<td>• Breast density noted on previous mammogram of 51% or higher.</td>
<td></td>
</tr>
<tr>
<td>• History of chest mantle radiation for Hodgkin Lymphoma or non-Hodgkin Lymphoma.</td>
<td></td>
</tr>
</tbody>
</table>

- Meeting the Centers for Disease Control and Prevention’s Screening Core Performance Indicator for mammograms (at least 75 percent of all mammograms performed should be provided to clients who are 50 years of age and older) continues to be a priority of the WWC program. Recruitment efforts should continue to be focused on this priority population.

- Breast Ultrasound or Automated Whole Breast Ultrasound is not covered by WWC when used as a screening method.

- 3D tomography (tomosynthesis) is not a covered screening procedure under WWC (USPSTF Grade I recommendation).

6. Breast Diagnostics and Management of Abnormal Breast Findings

Breast diagnostic services are covered for all clients eligible for WWC if they have breast symptoms, abnormal CBEs, abnormal screening mammograms, or referrals for diagnostic work-ups.

*Requirements for Management of Abnormal Breast Exams or Imaging Results:*

The 2011 Breast Cancer Diagnostic Algorithms for Primary Care Providers (4th Ed.) must be used by WWC agencies to guide clinical decision-making in the work-up of breast abnormalities. These algorithms may also be used to assess risk of breast cancer. Also included in the algorithms are clinical tools including core competencies of a clinical breast exam, CBE results documentation form, and a breast cancer history and risk assessment client information form. Copies of the algorithms can be downloaded at:
Document all client contacts and attempted contacts regarding abnormal breast cancer screening and diagnostic tests in the client’s chart.

- Breast Biopsy
  1) WWC will cover breast biopsy of a suspicious breast mass or lesion whenever it is indicated or recommended by a physician. WWC will not cover surgical procedures on benign breast masses for cosmetic or pain management reasons.

  2) WWC may provide additional reimbursement when additional breast biopsies are required to complete a diagnosis. The amount will be in addition to the level B4 BPS reimbursement. WWC will reimburse second breast biopsies performed on the same day. Please email the nurse consultant once all biopsy results are entered in eCaST in order to ensure timely reimbursement.

- Clinical Concordance
  1) Both a diagnostic mammogram and an ultrasound should be ordered to help complete a diagnostic evaluation for clients with a suspicious CBE or suspicious breast symptoms. An abnormal CBE even in the presence of a BI-RADS® 1 or BI-RADS® 2 finding on a screening or diagnostic mammogram requires further investigation.

  2) The CBE and diagnostic imaging results must be concordant before a diagnostic evaluation is considered complete. WWC recognizes that there are cases in which a client with an abnormal CBE is sent for diagnostic imaging and only a mammogram is completed by the radiologist. Although the radiologist may consider his or her diagnostic work-up complete, this does not mean that the work-up is complete. Clinical concordance is typically achieved by:

     o Repeating the CBE within 30 days to make sure the finding has either resolved or is consistent with the mammogram results, or,

     o The ordering clinician comparing the imaging findings with the abnormal CBE results to ensure that the abnormality is explained by the imaging.

     o Please email the nurse consultant once the provider has reviewed the case for clinical concordance and recommends no further follow-up of the abnormal CBE or a repeat CBE to reassess the abnormal finding has been completed. Please review the “Abnormal CBE Clinical Concordance” policy found on WWC’s website.
• Ductograms are covered when the procedure is being performed to rule out breast cancer.

• Magnetic Resonance Imaging (MRI)
  1) Breast MRI must have preapproval from the WWC nurse consultant.
  2) WWC will reimburse for screening breast MRI performed in conjunction with a mammogram when a client has:
     ▪ A positive BRCA1 or BRCA2 gene mutation test.
     ▪ A first-degree relative who is a BRCA carrier.
     ▪ A lifetime risk of 20-25 percent or greater as defined by risk assessment models such as BRCAPRO that are largely dependent on family history.
  3) Breast MRI can also be reimbursed when used to better assess areas of concern on a mammogram or for evaluation of a client with a past history of breast cancer after completing treatment.
  4) Breast MRI should never be done alone as a breast cancer screening tool. Breast MRI cannot be reimbursed by WWC to assess the extent of disease in women who have already been diagnosed with breast cancer.
  5) Providers should discuss risk factors with all clients to determine if she is at high risk for breast cancer. To be most effective, it is critical that breast MRI is done at facilities with dedicated breast MRI equipment and that can perform MRI-guided breast biopsies.

7. Health First Colorado’s Breast and Cervical Cancer Program (BCCP) for the Treatment of Eligible Diagnoses

All clients enrolled in WWC with an eligible diagnosis may apply for Health First Colorado’s BCCP if they are in need of active treatment. Clients who are under close surveillance only (e.g. follow-up or repeat mammogram) are not eligible for Health First Colorado’s BCCP

• Active treatment is defined as a client in need of surgical interventions, chemotherapy or radiation, or chemoprevention (e.g. Tamoxifen).

• Health First Colorado’s BCCP eligible diagnoses of Atypical Lobular Hyperplasia (ALH), Atypical Ductal Hyperplasia (ADH), Lobular Carcinoma in Situ (LCIS)/Lobular Neoplasia and Benign Phyllodes Tumor may not require active treatment, especially if the diagnosis was made by an excisional biopsy. If one of these diagnoses is made by an excisional biopsy, verification that a client is in need of active treatment is required by WWC before a client will be approved for BCCP.
Cervical Cancer Screening Guidelines

WWC cervical cancer screening guidelines are based on nationally recognized clinical guidelines from organizations such as the American College of Obstetricians and Gynecologists (ACOG), American Society for Colposcopy and Cervical Pathology (ASCCP), American Society for Clinical Pathology, U.S. Preventive Services Task Force, and with advice from the WWC medical director and Medical Advisory Board. Cervical cancer screenings may be covered for women ages 21 to 64. National guidelines and recommendations do not replace clinical judgment based on individual circumstances of the client.

1. Cervical Health History

A cervical health history should be recorded in the client’s chart and in eCaST, if applicable and should include:

- History of Cervical Intraepithelial Neoplasia (CIN) 2/3 or cervical cancer.
- Human Immunodeficiency Virus (HIV) status.
- History of diethylstilbestrol (DES) exposure in utero (DES exposure factsheet).
- History of conditions resulting in a compromised immune system, such as organ transplantation, chemotherapy or chronic corticosteroid treatment.
- Hysterectomy status.

2. Cervical Health Education

Cervical health education must be provided and documented in the client’s chart and eCaST to receive reimbursement for cervical cancer screening services in absence of a pelvic exam and/or Pap/HPV Test. Education may be provided by the provider or other trained staff to the client in verbal or written form. Cervical health education should include, at a minimum, information about:

- Cervical cancer screening intervals.
- Options for cervical cancer screening.
- Risk factors for developing cervical cancer.
- Symptoms of cervical cancer.
- How to reduce risk of cervical cancer (Get the HPV vaccine, follow up with your doctor if your Pap test results are not normal, don’t smoke, use condoms.
during sex, and limit your number of sexual partners).

- NBCCEDP’s Cervical Cancer Facts client handout can be used to meet this education requirement. This handout can be found here: http://www.cdc.gov/cancer/nbccedp/pdf/toolkit/NBCCEDP_2011_CCFacts_Gen_508.pdf.

3. Pelvic Exams

A pelvic exam may be provided yearly at the discretion of the provider. If a pelvic exam is not being performed as a component of collecting a Pap test, it is considered optional by WWC and may be performed based on the provider’s and client’s determination of need. Performance of a pelvic exam is not required to receive reimbursement for cervical cancer screening services.

The USPSTF’s definition of a pelvic exam is a check of a woman’s pelvic organs, including her vagina, vulva, cervix, uterus, fallopian tubes, and ovaries. If a pelvic exam is being performed, it should include examination of each of these organs.

Annual Cervical Health/Cervical Education Visit

Returning clients, who have an office visit and are determined by a midlevel, or higher, provider to not need cervical screenings after review of the client’s health history may be reimbursed for a visit that includes cervical health history and education. Cervical health history and education (as detailed in #1 and 2 above) must be completed and documented in the chart and eCaST in order to receive the reimbursement in absence of a cervical procedure (i.e. Pelvic/Pap/HPV).

4. Screening for Cervical Cancer

Screening for clients 21 to 64 years at average risk for cervical cancer will be covered by WWC at routine screening intervals, every three years with a Pap test alone. For clients 30-64, the option of providing cervical screening every five years with Pap and HPV co-testing is highly recommended.

**USPSTF and ACS/ASCCP/ASCP**

<table>
<thead>
<tr>
<th>Age to begin screening</th>
<th>Age 21, regardless of the age of initiation of sexual intercourse or the presence of other behavior-related risk factors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>When to discontinue screening</td>
<td>At greater than 65 years old if the woman has had adequate negative prior screening. Women with a history of CIN2 or more severe diagnosis should continue routine screening for at least 20 years.</td>
</tr>
<tr>
<td>Screening intervals, Ages 21-29</td>
<td>Pap testing alone every 3 years.</td>
</tr>
<tr>
<td>Screening Intervals for women 30-65 years old</td>
<td>Pap testing alone every 3 years or Pap testing with high risk HPV testing every 5 years.</td>
</tr>
</tbody>
</table>
Screening intervals for women with total hysterectomy

<table>
<thead>
<tr>
<th>Use of high risk HPV Testing in conjunction with Pap test screening and follow-up in specific circumstances.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For further recommendations for the use of high risk HPV testing in the management of abnormal Pap or biopsy results, please refer to the American Society for Colposcopy and Cervical Pathology algorithms.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>No Pap test screening if the woman has had adequate negative prior screening and the woman does not have a cervix and does not have a history of CIN2 or a more severe diagnosis in the past 20 years or cervical cancer ever.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should not be used for screening in women under 30 years.</td>
</tr>
<tr>
<td>HPV co-testing can be used in women 30 years old or older, every 5 years.</td>
</tr>
<tr>
<td>If co-testing HPV positive and Pap test negative then repeat co-testing in 12 months or do immediate HPV DNA typing for HPV16/18.</td>
</tr>
<tr>
<td>1. If co-testing is repeated at 12 months:</td>
</tr>
<tr>
<td>a. If positive HPV or Pap &gt;ASC refer to colposcopy.</td>
</tr>
<tr>
<td>b. If Pap and HPV negative repeat co-testing in 3 years.</td>
</tr>
<tr>
<td>2. If HPV DNA typing:</td>
</tr>
<tr>
<td>a. If HPV 16 and 18 negative, then repeat co-testing in 1 year.</td>
</tr>
<tr>
<td>b. If HPV 16 or 18 positive, then refer for colposcopy.</td>
</tr>
<tr>
<td>If co-testing HPV is negative and the Pap test is ASC-US, repeat co-testing in 3 years.</td>
</tr>
</tbody>
</table>

(Source: ASCCP Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors © 2013)

- WWC recommends that agencies screen eligible clients between the ages of 30 and 64 with Pap and HPV co-testing every five years.
- WWC recommends that agencies screen eligible clients between the ages of 21 and 29 with cytology alone. Women younger than 30 years should not be screened with HPV alone or in combination with cytology (cotesting).
- Please note that the follow-up of abnormal results for women 21 to 24 years old may be different than for women 25 years and older.
- Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated.
- WWC strongly recommends that clients who have never been screened for cervical cancer or who have not been screened in the past five years, be screened using Pap and HPV co-testing. If both tests are normal, these clients may proceed with routine screening intervals.
For average risk clients, WWC will not reimburse for Pap and/or HPV testing obtained earlier than the recommended routine intervals. If a Pap and/or HPV obtained prior to the routine screening interval are abnormal, WWC will reimburse for subsequent diagnostic testing (colposcopy/LEEP).

HPV testing alone is not an approved WWC screening strategy and will not be reimbursed.

Exceptions to Routine Screening Guidelines:

WWC will reimburse for cervical cancer screenings in women with any of the following risk factors that may require more frequent cervical cancer screenings than recommended in the routine screening guidelines (which were intended for average-risk women).

- Clients who are infected with HIV or who are otherwise immunocompromised.
- Clients who were exposed to DES in utero.

WWC will cover annual screening for clients after treatment for CIN 2/3 for at least two years or as determined by the provider’s plan of care. The ASCCP recommends Pap and HPV co-testing at 12, 24 and 60 months, then routine testing for 20 years.

WWC will cover annual Pap testing for clients with a history of cervical cancer.

WWC will cover one year follow-up Pap and/or HPV testing when it is recommended by the ASCCP Updated Consensus Guidelines for Managing Abnormal Cervical Cancer Screening Tests and Cancer Precursors (2012).

Screening Clients Who Have Had a Hysterectomy:

- WWC will cover Pap testing alone every three years for clients who have had a hysterectomy for treatment of CIN 2/3, or who have a history of CIN 2/3 prior to having a hysterectomy.
- WWC will cover annual Pap testing for clients with a hysterectomy for cervical cancer.
- Clients who have had a hysterectomy with complete removal of the cervix for benign reasons and who have no history of CIN 2 or worse are not eligible for WWC cervical cancer screening services.

5. Management and Follow-Up of Abnormal Cervical Cancer Screening

• Document all client contacts and attempted contacts regarding the abnormal cervical cancer screening and diagnostic tests in the client’s chart.

• WWC will cover diagnostic excisional procedures such as LEEP when they are among acceptable options according to current ASCCP guidelines, such as follow-up for HSIL Pap test results in women over age 24.

• WWC will cover endometrial biopsy (EMB) in addition to colposcopy for evaluation of Atypical Glandular Cells (AGC). WWC will not cover EMB for reasons other than follow-up of an AGC Pap test. Please email the nurse consultant when management of a client includes both a colposcopy and EMB to ensure reimbursement for both procedures. Pre-approval is not necessary.

• WWC will cover a colposcopy and/or polypectomy regardless of the Pap test result for cervical lesions, cervical polyps, or other suspicious cervical findings as determined by the provider. A normal Pap test cannot be used as a diagnostic indicator for a suspicious cervical finding on visual exam.

• WWC may provide additional reimbursement when more than one cervical diagnostic procedure is required to complete a diagnosis. The amount will be in addition to the level C4 bundled payment system reimbursement. Please email the WWC nurse consultant once the biopsy results are entered in eCaST in order to receive timely reimbursement.

6. Health First Colorado’s BCCP for the Treatment of Eligible Diagnoses

All clients enrolled in WWC with an eligible diagnosis may apply for BCCP through Health First Colorado if they are in need of active treatment. Clients who are under close surveillance only (e.g., follow-up Pap testing) are not eligible for BCCP.

• Active treatment is defined as a client in need of any of the following: surgical treatment (e.g. hysterectomy, LEEP, cone, cryotherapy), chemotherapy or radiation.

• Clients diagnosed with certain cervical precancerous conditions (e.g. CIN 2/3) may not require active treatment, especially if the diagnosis is made by an excisional procedure. Verification from the provider that a client is in need of active treatment is required by WWC before a client will be approved for Health First Colorado’s BCCP.

References


Tobacco Use Assessment and Referral Policy

Background

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. WWC is committed to improving the health of its clients through improving screening, diagnosis, treatment and referral for tobacco cessation. The goal is to ensure that every client is screened for tobacco use, their tobacco use status is documented, and clients who use tobacco are advised to quit.

Assessment of Tobacco Use Status

All clients enrolled in WWC should be evaluated for tobacco use at each visit. The United States Preventive Service Task Force (USPSTF) found reliable evidence that brief smoking cessation interventions, including screening, brief behavioral counseling (less than 3 minutes), and pharmacotherapy delivered in primary care settings are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after one year.

WWC providers are encouraged to screen* for tobacco use status using the “5 A’s” intervention:

<table>
<thead>
<tr>
<th>ASK</th>
<th>Identify and document tobacco use status for every client at every visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVISE</td>
<td>In a clear, strong, and personalized manner, urge every tobacco user to quit.</td>
</tr>
<tr>
<td>ASSESS</td>
<td>Is the tobacco user willing to make a quit attempt at this time?</td>
</tr>
<tr>
<td>ASSIST</td>
<td>For the client willing to make a quit attempt, refer to the Colorado QuitLine directly at 1-800-QUIT-NOW (1-800-784-8669) or use the Fax-To-Quit form.</td>
</tr>
<tr>
<td>ARRANGE</td>
<td>Schedule follow-up contact, in person or by telephone, preferable within the first week after the quit date.</td>
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</tbody>
</table>

*Dependent upon client need, provider capacity, and clinic preference, the ASK, ADVISE, REFER (AAR) intervention model may also be used to assess for tobacco use.

<table>
<thead>
<tr>
<th>ASK</th>
<th>Identify and document tobacco use status for every client at every visit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADVISE</td>
<td>In a clear, strong, and personalized manner, urge every tobacco user to quit.</td>
</tr>
<tr>
<td>REFER</td>
<td>Connect 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.</td>
</tr>
</tbody>
</table>

QuitLine Referral Process

CDPHE strongly recommends that clients are referred to the Colorado QuitLine for free telephonic counseling and support during each quit attempt or other evidence-based cessation program or resource. Clients will receive help from trained quit coaches, which has been shown to increase the success of their quit attempt.

To refer a client to the Colorado QuitLine, print out the Fax-To-Quit form (also available in Spanish) and fax it to 1-800-261-6259. Once this form has been completed and faxed to the QuitLine, a QuitLine staff member will contact the client. Clients can also visit the online program at Colorado QuitLine or call 1-800-QUIT-NOW (1-800-784-8669).

The Asian QuitLine provides services in Chinese, Korean, and Vietnamese.

For the Client Unready to Quit

For clients not ready to make a quit attempt at the time, clinicians should use a brief intervention designed to promote the motivation to quit. Such clients may respond to brief motivational interventions that are based on principles of Motivational Interviewing (MI), a directive, client-centered counseling intervention. The content areas that should be addressed in a motivational counseling intervention can be captured by the “5 R’s”: relevance, risks, rewards, roadblocks, and repetition. More information on these clinical interventions may be found in Treating Tobacco Use and Dependence: 2008 Update - Clinical Practice Guideline at http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/index.html.

Marijuana Resources

CDPHE marijuana resources: https://www.colorado.gov/cdphe/marijuana-clinical-guidelines

Transgender Coverage

Transgender women (male-to-female), who have taken or are taking hormones and meet all program eligibility requirements, are eligible to receive breast cancer screening and diagnostic services through WWC. Although there are limited data regarding the risk for breast cancer among transgender women, evidence has shown that long term hormone use does increase the risk for breast cancer among women whose biological sex was female at birth. While CDC does not make any recommendation about routine screening among this population, transgender women are eligible under federal law to receive appropriate cancer screening. CDC recommends that providers counsel all eligible women, including transgender women, about the benefits and harms of screening and discuss individual risk factors to determine if screening is medically indicated.

The Center of Excellence for Transgender Health and the World Professional Association for Transgender Health have developed consensus guidelines for the primary and gender-affirming care of transgender and gender nonbinary people. Those guidelines include for “transgender women with past or current hormone use, breast-screening mammography in clients over age 50 with additional risk factors (e.g., estrogen and progestin use > 5 years, positive family history, BMI > 35).” These specific preventive care recommendations can be found for:
Breast cancer screening in transgender men.

Screening for breast cancer in transgender women.

Screening for cervical cancer in transgender men.

WWC funds may be used to cover cervical and breast screening and diagnostic services for eligible transgender men (female-to-male) who have not yet undergone a complete hysterectomy or bilateral mastectomy or who meet the “screening clients who have had a hysterectomy” guidance above.

**Transgender Resources (National)**


- CDC - LGBT Health: [http://www.cdc.gov/lgbthealth/about.htm](http://www.cdc.gov/lgbthealth/about.htm).


**Colorado Transgender Resources**

