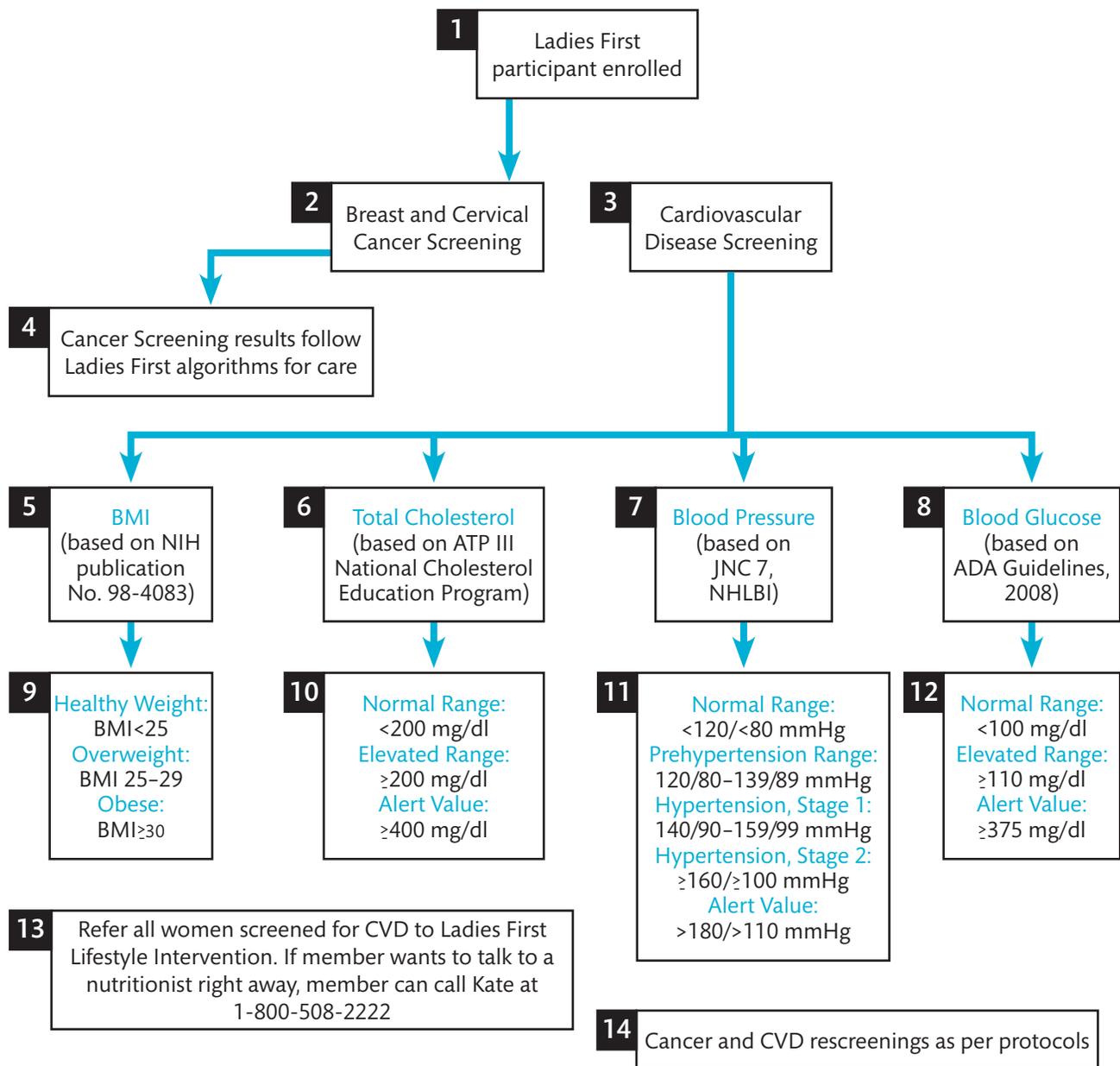


Summary of Cancer and CVD Screening Protocols



1 Patient Enrolls in Ladies First Screening Program
All women enrolled in Ladies First should be offered the breast and cervical cancer screening services and cardiovascular disease risk factor screening services.

2 Breast and Cervical Cancer Screening
All women in the Ladies First program will be offered breast and cervical cancer screening as outlined in the breast and cervical cancer screening protocols.

3 Cardiovascular Disease Risk Factor Screening
These services include screening for cholesterol (total, HDL, LDL and triglycerides), systolic and diastolic blood pressure, diabetes mellitus, BMI and waist measurement, and must be available to every Ladies First member.

4 Cancer Screening Results

Information detailing the services, follow-up, treatment, and billing in the Ladies First Program are found in the Ladies First Resource Manual.

5 BMI

The BMI screening protocol is based on the Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults; National Institutes of Health; National Heart, Lung and Blood Institute (NHLBI), September 1998.

6 Total Cholesterol

The cholesterol screening protocol is based on the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III), National Institutes of Health, July, 2004.

7 Blood Pressure

The blood pressure protocol is based on the recommendations of the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7), National Institutes of Health, 2003.

8 Blood Glucose

The blood glucose protocol is based on the American Diabetes Association Clinical Practice Recommendations, 2008 and Recommendations for Management of Diabetes in Vermont, 2004.

9 BMI Ranges

The ranges for healthy weight, overweight and obesity follow NHLBI recommendations.

10 Total Blood Cholesterol Ranges

The ranges for total normal and elevated blood cholesterol follow ATP III guidelines. The alert range, ≥ 400 mg/dl, has been defined by the CDCP to designate those women who must receive immediate diagnostic work-up and case management services.

11 Blood Pressure Ranges

The ranges for normal, prehypertension, and hypertension stages 1 and 2 blood pressure follow JNC 7 recommendations. The alert range, $>180/110$ mmHg (either systolic or diastolic level elevated), has been defined by the CDCP to designate those women who must receive immediate diagnostic work-up, pharmacological and case management services.

12 Blood Glucose Ranges

The ranges for normal and elevated blood glucose follow ADA Clinical Practice recommendations. The alert range of ≥ 375 mg/dl has been defined by the CDCP to designate those women who must receive immediate pharmacological and case management services.

13 Refer all women screened for CVD to Ladies First Lifestyle Intervention

14 Rescreen for cancer and CVD as per protocols

References

Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (ATP III). National Institutes of Health, 2004.

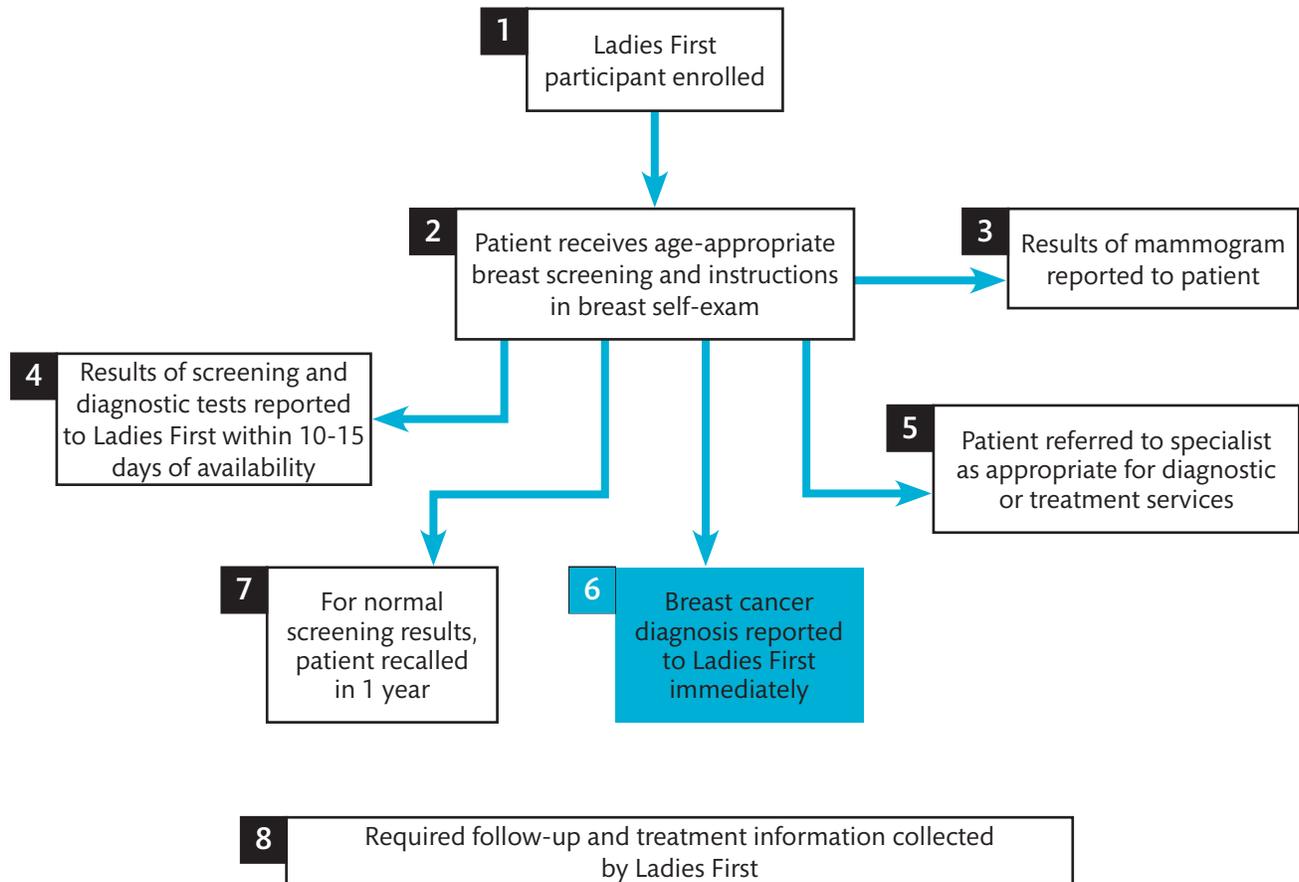
Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure, (JNC 7). National Institutes of Health, 2003.

American Diabetes Association Clinical Practice Recommendations, 2008 .

Recommendations for Management of Diabetes in Vermont, 2004.

The Practical Guide, Identification, Evaluation and Treatment of Overweight and Obesity in Adults, National Institutes of Health Publication 02-4084.

Breast Screening Protocol



1 Patient Enrolls in Ladies First Screening Program

- Patient meets age and income eligibility requirements, or
- Patient is age 18-39 with breast symptoms

2 Patient Receives Age-Appropriate Breast Cancer Screening and Instruction in Breast Self-Exam

3 Results of Mammogram Reported to Patient

- Primary care provider reports both normal and abnormal results to patient

4 Results of Screening and Diagnostic Tests Reported to Ladies First within 10-15 days of availability.

- CBE results reported on Screening Report by primary care provider.
- Mammography and ultrasound results reported directly by mammography facility
- Breast biopsy results reported directly by laboratory
- All other services reported by provider

5 Patient Referred to Specialist as Appropriate for Diagnostic or Treatment Services

- Primary care providers may refer to participating specialists who have agreed to accept Ladies First reimbursement for diagnostic services and consultations
- The patient may not be billed for any Ladies First covered service, (refer to Annual Schedule of Fees for Covered Services)
- Diagnosis and follow-up should be provided as per clinical guidelines, (refer to Breast Diagnostic Algorithms for Primary Care Clinicians in this resource manual or on the Ladies First web page)

6 Breast Cancer Diagnosis Reported to Ladies First Immediately

- Provider notifies Ladies First of patient diagnosed with breast cancer by telephone or confidential fax (Provider Support Line 1-800-510-2282, fax 802-657-4208)
- Patients enrolled by Ladies First in the Breast and Cervical Cancer Prevention Treatment Act Program (BCCPTA) per eligibility guidelines.
- Case management services available to assist members with barriers to care
- Documentation of lost to follow-up and refused status reported to Ladies First.

7 For Normal Screening Results, Patient Recalled in 1 Year

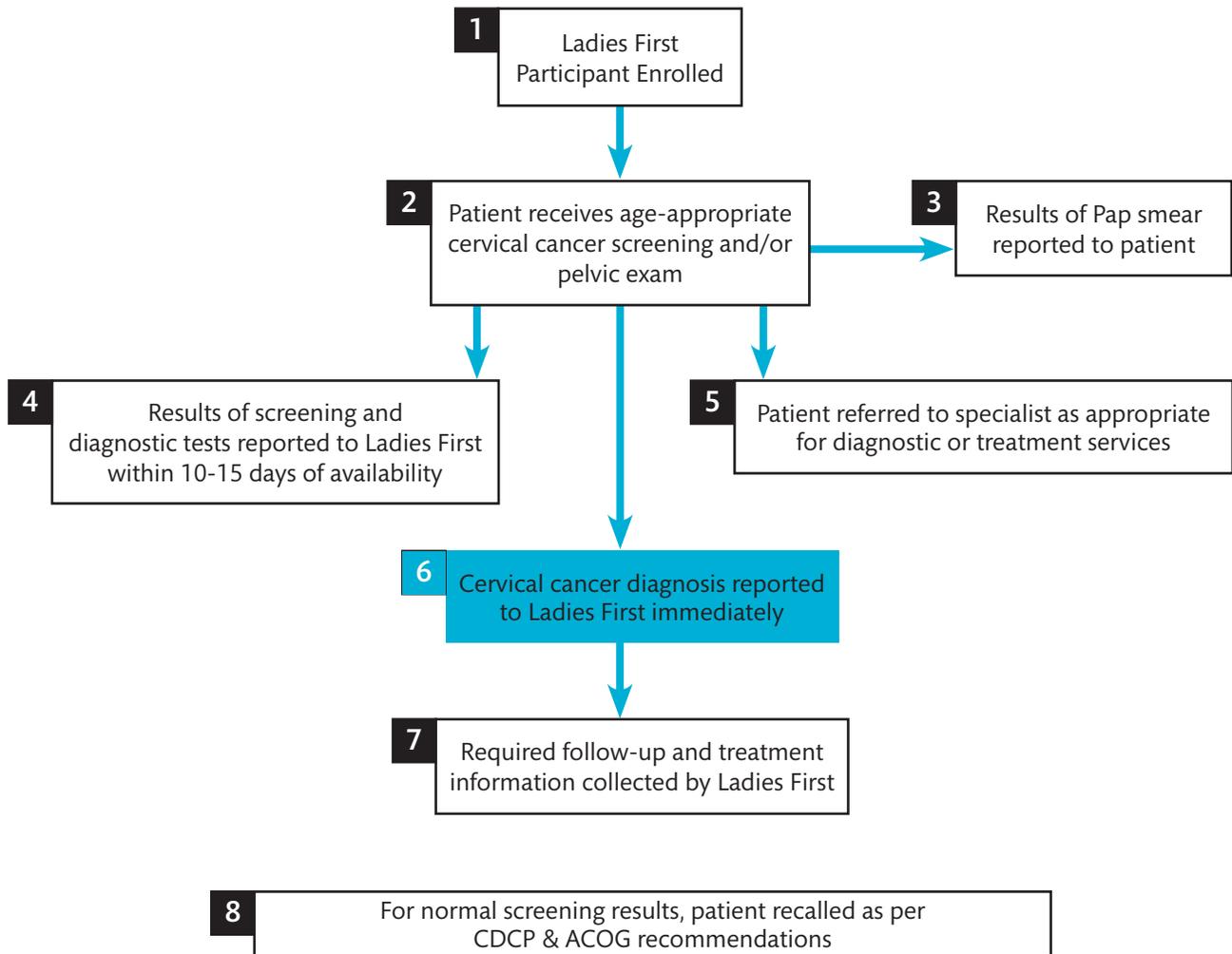
8 Required Follow-up and Treatment Information Collected by Ladies First

- Providers will send Follow-up reports to Ladies First for each woman with abnormal screening results. Information required for CDCP reporting is collected. This includes final diagnosis, date of diagnosis, follow-up recommendations, treatment initiation date, stage of disease, and tumor size as appropriate.

9 Recall patient for annual screening

Providers will receive a phone contact when this information is not submitted in a timely matter.

Cervical Screening Protocol



1 Patient Enrolls in Ladies First Screening Program

- Patient meets age and income eligibility requirements, or
- Patient is age 18–39 with history of abnormal cervical Pap smear (within the last 2 years).

2 Patient Receives Age-Appropriate Cervical Cancer Screening and Pelvic Exam

- American College of Obstetrics and Gynecology Recommendations:
- Cervical Pap smear screening annually (3 years after onset of vaginal intercourse, vaginal sexual activity, sexual activity, or no later than age 21).

ACS: Women who are age 70 and older with an intact cervix and who have 3 or more documented, consecutive,

technically normal/negative Pap screenings and no abnormal/positive Paps within a 10 year period prior to age 70, may elect to decline cervical cancer screening.

3 Results of Pap Smear Reported to Patient

- Provider reports both normal and abnormal results to patient

4 Results of Screening and Diagnostic Tests Reported to Ladies First

- Pelvic exam results reported to Ladies First on Screening Report Form by primary care provider within 10 days of date of service
- Pap smear and cervical biopsy results reported to Ladies First directly by laboratory

5 Patient Referred to Specialist as Appropriate for Diagnostic or Treatment Services

- Primary care providers may refer to participating specialists who have agreed to accept Ladies First reimbursement for diagnostic services and consultations
- The patient may not be billed for any Ladies First covered service, (refer to Annual Schedule of Fees for Covered Services)
- Diagnosis and follow-up should be provided as per clinical guidelines (refer to ASCCP Guidelines for the management of abnormal cervical cancer screening in Health Care Provider Toolkit)

6 Cervical Cancer Diagnosis Reported to Ladies First Immediately

- Provider notifies Ladies First of patient diagnosed with cervical cancer by telephone (Provider Support Line 1-800-510-2282, or confidential fax 802-657-4208)
- Patients enrolled in Breast and Cervical Cancer Treatment Medicaid Program (BCCT) per eligibility guidelines, (refer to Covered Services)
- Case management services available to assist health care providers with barriers to care
- Documentation of lost to follow-up and refused status reported to Ladies First per guidelines

7 Required Follow-up and Treatment Information Collected by Ladies First

- Providers will receive a Follow-up Form in the mail to complete for each woman with abnormal screening results. Information required for CDCP reporting is collected. This includes final diagnosis, date of diagnosis, follow-up recommendations, treatment initiation date, stage of disease, and tumor size as appropriate.

8 Recall patient for screening as per ACOG Recommendations

References:

American College of Obstetrics and Gynecology, Committee Opinion. *Primary and Preventive Care: Periodic Assessments.*

*High risk factors for sexually transmitted disease include history of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with persons with culture-proven STD, history of repeated episodes of STDs, attendance at clinics for STDs.

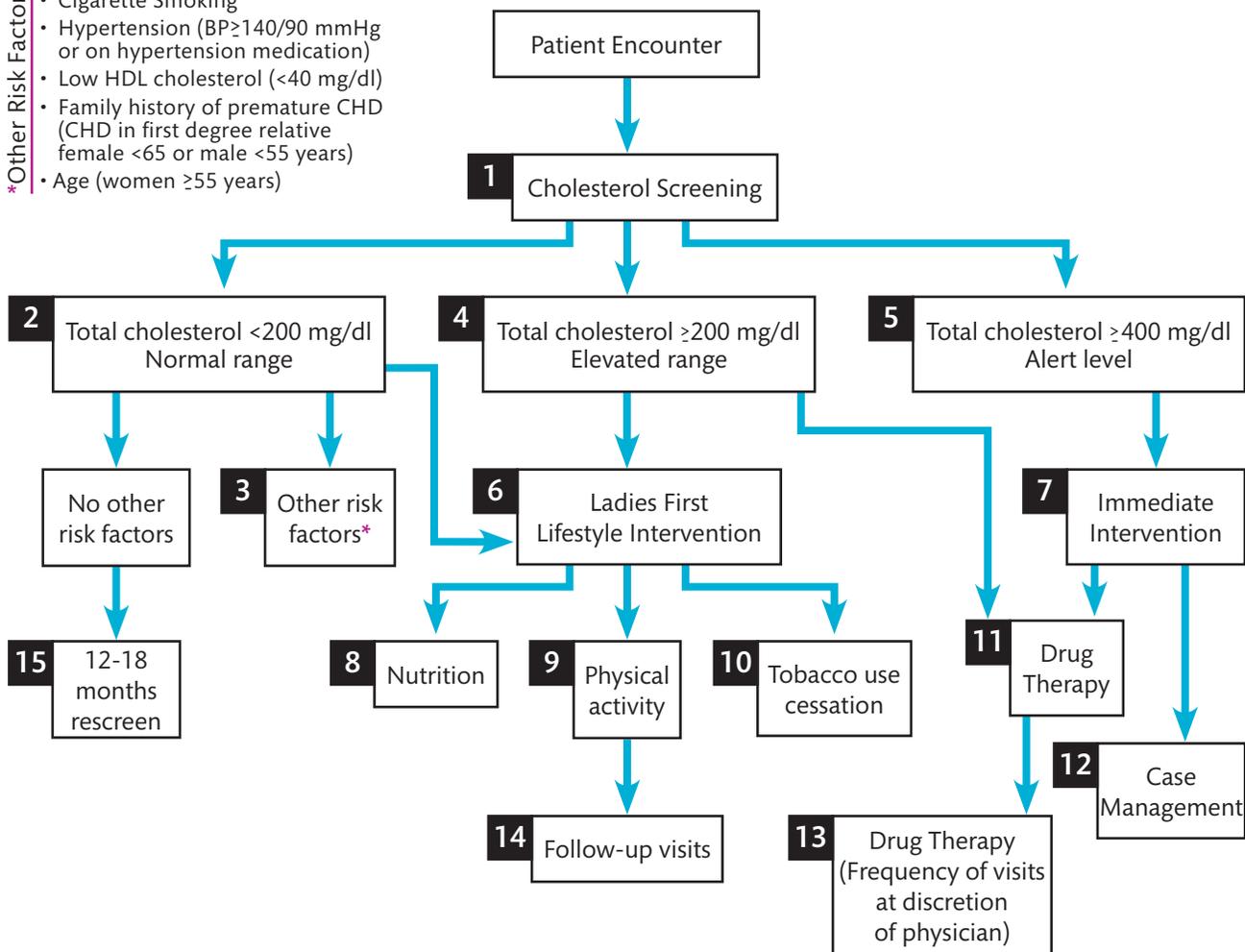
**Ladies First covers annual Pap smear screening for women age 40 years and over or women age 18–39 years with a history of an abnormal Pap. The program covers annual Pap smear screening for 3 consecutive satisfactory Pap smears, after which Pap smears will be reimbursed every 3 years. If physician discretion indicates patient is at high risk for cervical cancer, Pap smear screening will be covered annually.

Cholesterol Screening Protocol

Based on ATP III (Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults), National Cholesterol Education Program, National Institutes of Health, 2004.

*Other Risk Factors

- Cigarette Smoking
- Hypertension (BP \geq 140/90 mmHg or on hypertension medication)
- Low HDL cholesterol (<40 mg/dl)
- Family history of premature CHD (CHD in first degree relative female <65 or male <55 years)
- Age (women \geq 55 years)



1 Cholesterol Screening

- Determine lipoprotein levels - obtain complete lipoprotein profile after 9 to 12 hour fast.

HDL Cholesterol mg/dl

<40	low
\geq 60	high

ATP III Classification of LDL, Total, and HDL Cholesterol, mg/dl:

Total Cholesterol mg/dl

<200	desirable
200-239	borderline high
\geq 240	high

LDL Cholesterol mg/dl

Primary Target of Therapy

<100	optimal
100-129	near optimal/above optimal
130-159	high
\geq 190	very high

2 Total Cholesterol: Normal Range (<200 mg/dl)

- All women in the Ladies First Program will be re-screened in one year. The Ladies First Program will pay for annual rescreening for their members. All Ladies First members may participate in Lifestyle Interventions.

3 Other Risk Factors

- In the presence of other risk factors, the LDL goals should be modified and women should be referred to one or more of the Lifestyle Interventions. Providers should use the Lifestyle Intervention Rx Pad to refer women to the Ladies First Lifestyle Intervention program.
- Major risk factors exclusive of LDL cholesterol:
 - ◆ Cigarette smoking
 - ◆ Hypertension (BP ≥140/90 mmHg or on antihypertensive medication)
 - ◆ Low HDL cholesterol (<40 mg/dl) (if ≥60, count as a positive risk factor)
 - ◆ Family history of premature CHD (CHD in female first degree relative <65 years, or male first relative <55 years)
 - ◆ Age (women 55 years)

4 Total Cholesterol: Elevated Range (≥200 mg/dl)

- Identify presence of clinical atherosclerotic disease that confers high risk for coronary heart disease (CHD) events (CHD risk equivalent):
 - ◆ Clinical CHD
 - ◆ Symptomatic carotid artery disease
 - ◆ Peripheral arterial disease
 - ◆ Abdominal aortic aneurysm
 - ◆ Patients should be educated on goals for lipid levels based on their risk factors

5 Total Cholesterol: Alert Level (≥400 mg/dl)

- Pharmacological therapy and case management services must be provided immediately. Recommend Lifestyle Interventions simultaneously with pharmacological therapy.
- Patient should be referred to low cost medication program.

6 Lifestyle Intervention

- Interventions are tailored to the patient's need, and goals are established with the patient's input. All women with abnormal cholesterol levels must be referred to the Ladies First Lifestyle Intervention program.

7 Immediate Intervention

- Intervention should begin during the office visit or within one week for women with cholesterol ≥400 mg/dl. The CDC sets alert values for immediate treatment.

8 Nutrition

- Goals are determined by each patient's need, with patient input. Goals should include but not be limited to:
 - ◆ Weight loss if BM>25
 - ◆ Limiting the intake of saturated fat to <7% a day
 - ◆ Limiting the intake of cholesterol to <200mg/day
 - ◆ Consider increased soluble fiber 10–25g/day and plant stanols/sterols (2g/day)

9 Physical Activity

- 30 minutes of moderate physical activity on most, preferably all, days. Moderate physical activity includes any activity that causes an increase in heart rate. Activities can include:
 - ◆ Brisk walking 2 miles in 30 minutes
 - ◆ Pushing a stroller 1 mile in 30 minutes
 - ◆ Stair walking for 15 minutes
 - ◆ Gardening for 30–45 minutes
 - ◆ Washing windows or floors for 45–60 minutes
 - ◆ Dancing fast (social) for 30 minutes
 - ◆ Bicycling 5 miles in 30 minutes

10 Tobacco Use Cessation

- Participant should quit smoking to reduce cardiovascular risk. Refer to Vermont Quit Network 1-800-QUIT-NOW (784-8669) or vtquitnetwork.org

11 Drug Therapy

- (See ATP III Guidelines for specific information.)
Drugs affecting lipoprotein metabolism: *Ladies First will not pay for prescription medications.* Patients should be referred to low cost medication programs.
 - ◆ HMG CoA reductase inhibitors (statins):
Lovastatin, Pravastatin, Simvastatin, Fluvastatin, Atorvastatin
 - ◆ Bile acid sequestrants:
Cholestyramine, Colestipol, Colesevelam
 - ◆ Nicotinic acid:
Immediate release (crystalline) nicotinic acid, extended release nicotinic acid, sustained release nicotinic acid
 - ◆ Fibrates:
Gemfibrozil, Fenofibrate, Clofibrate

12 Case Management

- Case management services including assessment of barriers to making lifestyle changes and maintaining drug regimen, monitoring success toward making lifestyle changes, and support for therapeutic interventions are available to patients through the Ladies First central office.

13 Frequency of Return Visits

- Frequency of return visits for the monitoring of drug therapy is at the discretion of the provider and should be followed according to the ATP III guidelines.

14 Follow-up Visits

- ATP III guidelines recommend that after 3 months of treatment with therapeutic Lifestyle Intervention changes, patients should be screened for metabolic syndrome and treated as necessary.

Clinical Identification of Metabolic Syndrome in Women. Any three of the following:

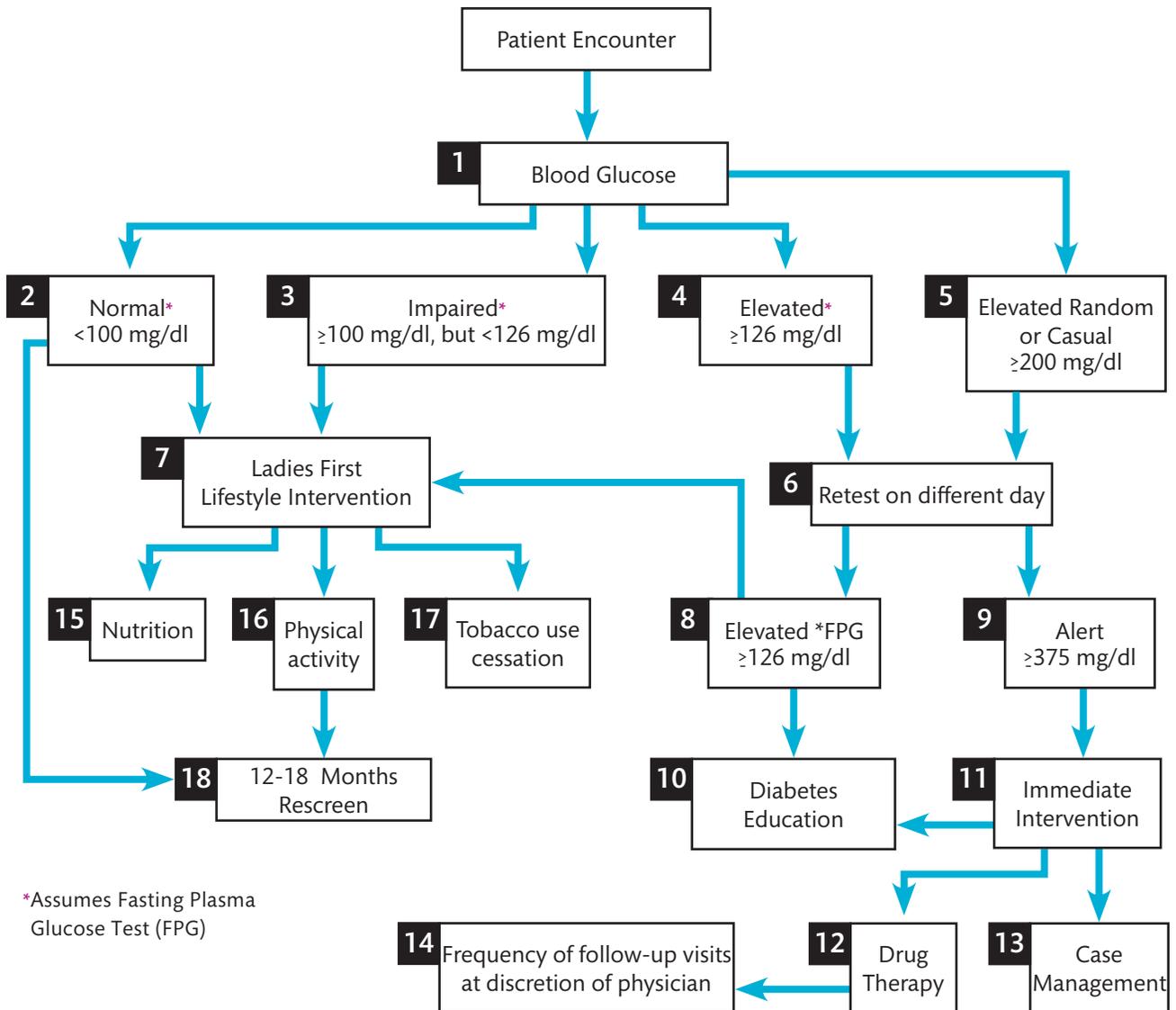
Risk Factor	Defining Level
Abdominal obesity: waist circumference	>88 cm (>35 in)
Triglycerides	>150 mg/dl
HDL cholesterol	<50 mg/dl
Blood pressure	>130/>85 mmHg
Fasting glucose	≥100 mg/dl

15 Rescreen Visit

- All women in the Ladies First Program must be re-screened annually. Ladies First will pay for an annual rescreening.

Diabetes Screening Protocol

Based on American Diabetes Association *Clinical Practice Recommendations, 2008* and *Recommendations for Management of Diabetes in Vermont, 2004*



1 Blood Glucose

Fasting Plasma Glucose (FPG) performed after an eight-hour fast is preferred. Casual Plasma Glucose (CPG) may be used if patient is not fasting. An Oral Glucose Tolerance Test (OGTT), performed after a 75g dose of anhydrous glucose in water, may be used if special circumstances exist.

2 Normal Range

If less than 100 mg/dl, no further action is required. All Ladies First members will be re-screened 12-18 months.

3 Impaired Range (Pre-Diabetes)

If the FPG is ≥ 100 but < 126 mg/dl, individuals have impaired fasting glucose (IFG). IFG is a risk factor for future diabetes and individuals should be referred to the Ladies First Lifestyle Intervention program.

4 Elevated Range (Diabetes)

If the FPG is ≥ 126 mg/dl, a retest should be scheduled. A confirmatory FPG or OGTT should be completed on a different day if the clinical condition of the patient permits. Patients should be educated on goals for glucose values.

5 Elevated Range, Random or Casual

A casual plasma glucose level ≥ 200 mg/dl with symptoms of diabetes such as polyuria, polydipsia, and unexplained weight loss is considered diagnostic of diabetes. A confirmatory FPG or OGTT should be completed on a different day if the clinical condition of the patient permits.

6 Retest on a Different Day

Generally, two abnormal test results using any of the three tests on two different days are necessary for a diagnosis of diabetes.

7 Ladies First Lifestyle Intervention

Regardless of abnormal values, only women age 40 or over may participate in the Lifestyle Intervention Program. Individuals with IFG (pre-diabetes) as well as those with a diagnosis of diabetes should be referred to the Lifestyle Intervention program.

8 Elevated Glucose ≥ 126 but < 375 mg/dl

With the official diagnosis of diabetes, the patient should be referred to a program for comprehensive diabetes education. Drug therapy may also be considered.

9 Alert Level ≥ 375 mg/dl

Any patient with glucose at the alert level should receive immediate intervention services. Levels for alert values are recommended by the CDCP to begin immediate treatment.

10 Diabetes Education*

A comprehensive diabetes education program assesses the educational needs of the individual and should be prepared to provide instruction related to the following:

- Describing the diabetes disease process and treatment options
- Incorporating appropriate nutritional management into lifestyle
- Incorporating physical activity into lifestyle
- Utilizing medications (if applicable) for therapeutic effectiveness
- Monitoring blood glucose, urine ketones (when appropriate), and using the results to improve control
- All women should be informed of their optimum glucose, lipid and blood pressure levels
- Preventing, detecting and treating acute complications
- Preventing (through risk reduction behavior), detecting and treating chronic complications
- Goal setting to promote health and problem solving for daily living
- Integrating psychosocial adjustment to daily life
- Promoting preconception care, management during pregnancy, and gestational diabetes management when applicable

11 Immediate Intervention

Intervention should begin at the clinic visit

**Ladies First cannot reimburse for diabetes education.*

12 Drug Therapy

Appropriate drug therapy using access programs for patients without insurance should be initiated simultaneously with diabetes education program referral and case management for individuals with a diagnosis of diabetes

13 Case Management

Case management, including assessment of barriers to making lifestyle changes and support for therapeutic interventions, should be made available to all patients through the clinic or through the Ladies First staff.

Ladies First will provide case management for women with alert values.

14 Frequency of Follow-up Visits

Frequency of visits is at the discretion of the provider and should be according to the

Recommendations for Management of Diabetes Mellitus in Vermont, 2004

15 Nutrition

The goals of nutrition therapy for patients with diabetes are:

- Maintain blood glucose levels in a normal range, or as close to normal as is safely possible, to prevent or reduce the risk for complications of diabetes
- Maintain blood lipid levels that reduce the risk for macrovascular disease
- Maintain blood pressure levels that reduce the risk for vascular disease
- Improve health through healthy food choices and physical activity
- Prevent and treat the acute complications of insulin-treated diabetes such as hypoglycemia, short-term illness and exercise related problems
- Prevent and treat the long-term complications of diabetes such as renal disease, neuropathy, retinopathy, hypertension and cardiovascular disease

16 Physical Activity

Exercise is an important therapeutic tool for people with diabetes. Exercise programs should be individualized to maximize benefit and minimize risk. Refer to the *Recommendations for Management of Diabetes in Vermont, 2004* for guidelines for increasing physical activity in patients with diabetes.

17 Tobacco Cessation

All individuals who use tobacco products should be counseled on cessation and instructed to call the Vermont Quit Network 1-800-QUIT-NOW (784-8669) or vtquitnetwork.org *Please advise patients to inform Quit Line that they are Ladies First members.*

18 12-18 Month Rescreen

All women participating in the Ladies First program should be rescreened at 12-month intervals. Annual screening will be paid for by the Ladies First program.

Screening for Diabetes Mellitus

The objective of screening for elevated blood glucose is to identify participants likely to have undiagnosed diabetes. Diabetes is often asymptomatic in its early stages and can remain undiagnosed for many years. The chronic hyperglycemia of diabetes is associated with long-term dysfunction, damage, and failure of various organs; especially the eyes, kidneys, nerves, heart and blood vessels. Individuals with undiagnosed diabetes are also at significantly higher risk for stroke, coronary heart disease, and peripheral vascular disease than the nondiabetic population. They also have a greater likelihood of having dyslipidemia, hypertension, and obesity.

Screening of high-risk (see the table below) individuals should be considered by their health care provider at three-year intervals beginning at age 45. The rationale for this interval is that false negatives will be repeated before substantial time elapses. There is little likelihood of an individual developing any of the complications of diabetes to a significant degree within three years of a negative screening test result.

The Ladies First program will pay for annual diabetes screening for all women 40+ enrolled in Ladies First.

Table 1.10
Major Risk Factors for Type 2 Diabetes

• Age ≥45 years
• Family history of diabetes (i.e., parents or siblings with diabetes)
• Overweight BMI ≥25 kg/m ²)
• Habitual physical inactivity
• Race/ethnicity (e.g., African-Americans, Hispanic-Americans, Native Americans, Asian-Americans, and Pacific Islanders)
• Previously identified IFG (Impaired Fasting Glucose) or IGT (Impaired Glucose Tolerance)*
• Hypertension (≥140/90 mmHg in adults)
• HDL cholesterol ≤35 mg/dl and/or triglyceride level >250 mg/dl (282 mmol/l)
• History of GDM (Gestational Diabetes Mellitus) or delivery of a baby weight >9 lbs.
• Polycystic ovary syndrome
• History of vascular disease

*Now called pre-diabetes

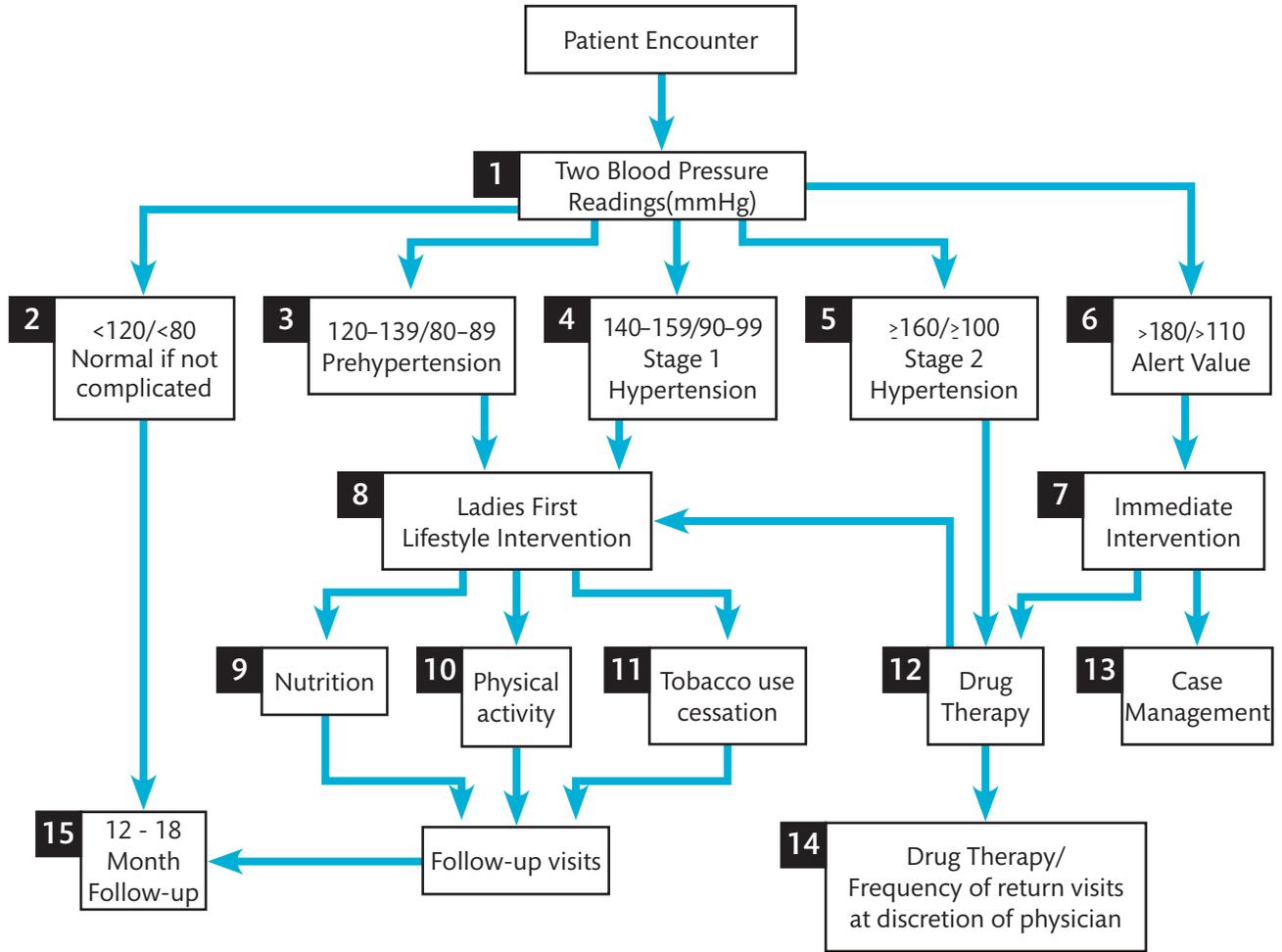
Tests for participants who have not previously been diagnosed with diabetes

The most frequently used screening test for diabetes is the Fasting Plasma Glucose (FPG) because it is easier and faster to perform in the clinic setting, more acceptable to patients and less expensive.

- An FPG ≥126 mg/dl is an indication for retesting.
- Testing should be repeated on a different day to confirm a diagnosis.
- Casual plasma glucose (food or drink has been taken shortly before testing) may be performed if necessary. A casual plasma glucose level ≥200 mg/dl with symptoms of diabetes is considered diagnostic of diabetes.
- A confirmatory FPG test or OGTT (Oral Glucose Tolerance Test) should be completed on a different day if the clinical condition of the patient permits.

Hypertension Screening Protocol

Based on *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)*. National Institutes of Health, 2003.



1 Blood Pressure

- Patient should rest 5 minutes and refrain from smoking or ingesting caffeine for 30 minutes prior to initial measurement.
- Appropriate size cuff for the patient must be used. Some adults may require a large adult cuff.
- Two or more readings, separated by at least 2 minutes should be recorded.

2 Normal Range: <120/80 mmHg

If there are no complicating risk factors, no further action is indicated. All Ladies First members will be rescreened annually.

3 Prehypertension Range:

120–139/80–89 mmHg complicated by diabetes, target organ damage, CVD
Lifestyle intervention should be considered for participants who have complications and blood pressure over 120/80.

4 Stage 1 Hypertension: 140–159/90–99 mmHg

Clinicians should consider drug therapy as initial therapy plus lifestyle modifications for patients with multiple risk factors. Patients should be educated on goals for blood pressure values.

5 Stage 2 Hypertension: $\geq 160/\geq 100$ mmHg
Drug therapy should be initial therapy along with lifestyle modifications.

6 Alert Value: $>180/>110$ as defined by CDCP
Women should receive immediate pharmacological and case management services.

7 Immediate Intervention
Pharmacological and lifestyle intervention should be initiated at the office visit. Educate patient and family about disease. Involve them in measurement and treatment. Teach patient what her optimum BP should be. Maintain communications with patient. Keep care inexpensive and simple.

8 Lifestyle Interventions

- If there are no major risk factors (diabetes mellitus, smoking, dyslipidemia, age >60 , postmenopausal, family history in women <65), lifestyle interventions should be initiated and followed for 6 to 12 months. For patients with multiple risk factors, clinicians should consider drugs as initial therapy plus lifestyle modifications.
- Set a clear goal of therapy based on patient's risk. Control blood pressure to below:
 - 140/90 mmHg for patients with uncomplicated hypertension; set a lower goal for those with target organ damage or clinical cardiovascular disease.
 - 130/80 mmHg for patients with diabetes, renal failure, heart failure.
- Encourage lifestyle modifications.

9 Nutrition

- Lose weight, if needed (BMI >25)
- Follow recommendations of the DASH diet
- Restrict sodium intake to 100 mmol per day (2.4 g sodium or 6 g sodium chloride)
- Limit alcohol intake to less than 1 drink per day
- Maintain adequate potassium intake – about 3,500 mg per day
- Maintain adequate intakes of calcium and magnesium for general health

10 Physical Activity

- Thirty minutes of moderate physical activity on most, preferably all, days. Moderate physical activity includes any activity that causes an increase in heart rate. Activities can include:
 - ◆ Brisk walking 2 miles in 30 minutes
 - ◆ Pushing a stroller 1 mile in 30 minutes
 - ◆ Stair walking for 15 minutes
 - ◆ Gardening for 30–45 minutes
 - ◆ Washing windows or floors for 45–60 minutes
 - ◆ Dancing fast (social) for 30 minutes
 - ◆ Bicycling 5 miles in 30 minutes

11 Tobacco Use Cessation
Cessation of all tobacco use.
Refer to Vermont Quit Network 1-800-QUIT-NOW (784-8669) or vtquitnetwork.org

12 Drug therapy

- Favor once-daily, long-acting formulations.
- Use combination tablets, when needed.
- Consider using generic formulas or larger tablets that can be divided. This may be less expensive.
- Be willing to stop unsuccessful therapy and try a different approach.
- **The Ladies First program cannot pay for drug therapy. Patients should be referred to low cost medication programs.**
- Refer to JNC 7 for recommendations for mitral drug choices.

Recommended Initial Drug Choices

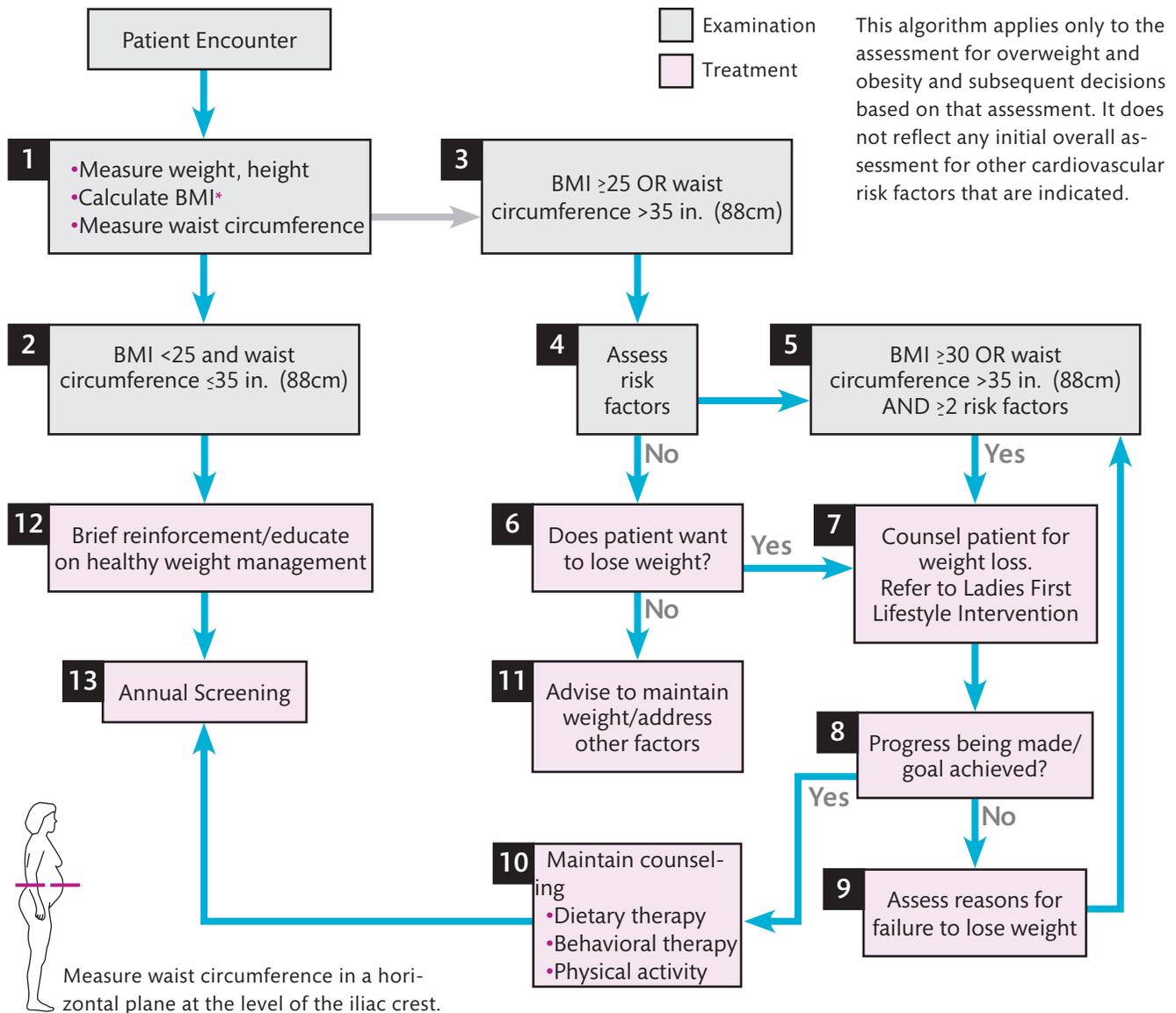
Uncomplicated Hypertension	Compelling Indications		Specific Indications for the Following Drugs
Diuretics; Beta-blockers	Diabetes type I	Start with ACE inhibitor if proteinuria is present	ACE inhibitors; Angiotensin II receptor blockers; Alpha-blockers
	Heart failure	Start with ACE inhibitor or diuretic	Alpha-Beta-blockers; Beta-Blockers; Calcium antagonists
	Myocardial infarction	Beta-blocker (non-ISA); ACE inhibitor for LV dysfunction	Diuretics
	Isolated systolic hypertension (older patients)	Diuretics (preferred); Calcium antagonists (long-acting DHP)	



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute

Overweight Screening

Based on *The Practical Guide, Identification, Evaluation, and Treatment of Overweight and Obesity in Adults*, National Institutes of Health Publication 00-4084, October 2000.



*Calculate BMI as follows:
 $BMI = \text{weight (lbs.)} \times 703 \div [\text{height (in.)} \times \text{height (in.)}]$

1 Weight Screening

- Measure weight and height. Weight should be obtained with the patient wearing undergarments and no shoes.
- Calculate body mass index (BMI). Use a BMI chart or calculate manually.

2 BMI <25 and Waist Circumference ≤35 Inches (88cm)

- Rescreen in one year

3 BMI ≥25 OR Waist Circumference >35 Inches (88cm)

- These cutoff values divide overweight from normal weight and are consistent with other national and international guidelines
- Elevated waist circumference indicates an increased proportion of abdominal fat and is a risk factor for cardiovascular disease. All Ladies First members should have waist circumference measured upon initial screening and at the one year rescreening visit.

4 Assess Risk Factors

- Risk assessment for CVD and diabetes in a person who is overweight will include special considerations for the medical history, physical examination, and laboratory examination. Although there is no direct evidence that addressing risk factors increases weight loss, treating the risk factors through weight loss is a recommended strategy.
- Risk factors include:
 - ◆ Established coronary heart disease or other atherosclerotic disease
 - ◆ Type 2 diabetes or impaired fasting glucose
 - ◆ Sleep apnea
 - ◆ Smoking
 - ◆ Hypertension
 - ◆ Elevated LDL cholesterol
 - ◆ Low HDL cholesterol
 - ◆ Family history of premature CHD ≥55 yrs. (F)

5 BMI ≥30 OR BMI 25–29 and ≥2 Risk Factors OR Waist >35 Inches and ≥2 Risk Factors

- The Expert Panel on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults recommends that all patients who meet these criteria should attempt to lose weight.
- It is important to ask the patient whether or not she wants to lose weight. Those with a BMI between 25 and 29.9 and who have one or no risk factors should work on maintaining their current weight rather than embark on a weight reduction program, unless they desire to lose weight.

6 Does the Patient Want to Lose Weight?

- Patients who do not want to lose weight but who are overweight (BMI 25–29.9), without a high waist circumference and with one or no cardiovascular risk factors, should be counseled regarding the need to maintain their weight at or below its present level
- Patients who wish to lose weight should be guided according to boxes 7 and 8

7 Clinician and Patient Devise Goals

- All Ladies First members who are overweight should be referred to the Ladies First Lifestyle Intervention program
- The decision to lose weight must be made jointly between the clinician and patient. Patient involvement and investment is crucial to success. The patient may choose as a goal not to lose weight but rather to prevent further weight gain.
- As an initial goal for weight loss, the panel recommends the loss of 10 percent of baseline weight at a rate of 1 to 2 pounds per week, and the establishment of an energy deficit of 500 to 1,000 kcal/day
- For individuals who are overweight, a deficit of 300 to 500 kcal/day may be more appropriate, providing a weight loss of about 1/2 pound per week. Also, there is evidence that an average of 8 percent of body weight can be lost over 6 months. Since this observed average weight loss includes people who do not lose weight, an individual goal of 10 percent is reasonable. After 6 months, most patients will equilibrate (caloric intake balancing energy expenditure); thus, they will require an adjustment of their energy balance if they are to lose more weight.

- The three major components of weight loss therapy are dietary therapy, increased physical activity, and behavior therapy
- These lifestyle therapies should be attempted for at least 6 months before considering pharmacotherapy. In addition, pharmacotherapy should be considered as an adjunct to lifestyle therapy for patients with a BMI ≥ 30 with no concomitant obesity-related risk factors or diseases. Pharmacotherapy may also be considered for patients with a BMI ≥ 27 who have concomitant obesity-related risk factors or diseases. The risk factors or diseases considered important enough to warrant pharmacotherapy at a BMI of 27 to 29.9 are hypertension, dyslipidemia, CHD, type 2 diabetes, and sleep apnea. **Note that the Ladies First program will not pay for the cost of pharmacotherapy. Patients should be referred to low cost medication programs.**
- Two drugs approved for weight loss by the FDA for long-term use are sibutramine and orlistat. However, sibutramine should not be used in patients with a history of hypertension, CHD, congestive heart failure, arrhythmias, or history of stroke. Certain patients may be candidates for weight loss surgery.
- Each component of weight loss therapy should be introduced to the patient briefly. The selection of weight loss methods should be made in the context of patient preferences, analysis of past failed attempts, and consideration of the available resources. These components will be addressed with the patient and a registered dietitian during the Lifestyle Intervention program.

8 Progress Being Made/Goal Achieved?

- During the acute weight loss period and at the 6-month and 1-year follow-up visits, patients should be weighed, their BMI should be calculated, and their progress should be assessed
- If at any time it appears that the program is failing, a reassessment should take place to determine the reasons. If pharmacotherapy is used, appropriate monitoring for side effects is recommended. If a patient can achieve the recommended 10 percent reduction in body weight within 6 months to 1 year, this change in weight can be considered good progress.

9 Assess Reasons for Failure to Lose Weight

- If a patient fails to achieve the recommended 10-percent reduction in body weight within 6 months or 1 year, a re-evaluation is required

10 Maintenance Counseling

- Evidence suggests that more than 80 percent of the individuals who lose weight will gradually regain it. Maintenance includes continued contact with the health care provider for education, support, and medical monitoring.

11 Advise to Maintain Weight/Address Other Risk Factors

Those patients who are overweight but not obese, and who wish to focus on maintenance of their current weight, should be provided with counseling and advice so their weight does not increase

12 Brief Reinforcement/Educate on Weight Management

Patients who are now at an appropriate body weight should be advised of the importance of staying in this category.

13 Annual Rescreening

Patients should receive periodic monitoring of their weight and BMI. All women in the Ladies First program will be rescreened annually. Only the annual rescreening will be paid by the Ladies First program.



Adult Body Mass Index (BMI) Chart



WEIGHT	95	100	105	110	115	120	125	130	135	140	145	150	155	160	165	170	175	180	185	190	195	200	205	210	215	220	225	230	235	240	245
5'0"	19	20	21	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48
5'1"	18	19	20	21	22	23	24	25	26	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	43	44	45	46
5'2"	17	18	19	20	21	22	23	24	25	26	27	27	28	29	30	31	32	33	34	35	36	37	37	38	39	40	41	42	43	44	45
5'3"	17	18	19	19	20	21	22	23	24	25	26	27	27	28	29	30	31	32	33	34	35	35	36	37	38	39	40	41	42	43	43
5'4"	16	17	18	19	20	21	21	22	23	24	25	26	27	27	28	29	30	31	32	33	33	34	35	36	37	38	39	39	40	41	42
5'5"	16	17	17	18	19	20	21	22	22	23	24	25	26	27	27	28	29	30	31	32	32	33	34	35	36	37	37	38	39	40	41
5'6"	15	16	17	18	19	19	20	21	22	23	23	24	25	26	27	27	28	29	30	31	31	32	33	34	35	36	36	37	38	39	40
5'7"	15	16	16	17	18	19	20	20	21	22	23	23	24	25	26	27	27	28	29	30	31	31	32	33	34	34	35	36	37	38	38
5'8"	14	15	16	17	17	18	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	33	33	34	35	36	36	37
5'9"	14	15	16	16	17	18	18	19	20	21	21	22	23	24	24	25	26	27	27	28	29	30	30	31	32	32	33	34	35	35	36
5'10"	14	14	15	16	16	17	18	19	19	20	21	22	22	23	24	24	25	26	27	27	28	29	29	30	31	32	32	33	34	34	35
5'11"	13	14	15	15	16	17	17	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	29	29	30	31	31	32	33	33	34
6'0"	13	14	14	15	16	16	17	18	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	31	31	32	33	33
6'1"	13	13	14	15	15	16	16	17	18	18	19	20	20	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	32	32
6'2"	12	13	13	14	15	15	16	17	17	18	19	19	20	21	21	22	22	23	24	24	25	26	26	27	28	28	29	30	30	31	31
6'3"	12	12	13	14	14	15	16	16	17	17	18	19	19	20	21	21	22	22	23	24	24	25	26	26	27	27	28	29	29	30	31
6'4"	12	12	13	13	14	15	15	16	16	17	18	18	19	19	20	21	21	22	23	23	24	24	25	26	26	27	27	28	29	29	30

Under healthy weight: BMI <18.5
Healthy weight: BMI 18.5–24.9
Overweight: BMI 25–29.9
Obese I: BMI 30–34.9
Obese II: BMI ≥40

Weight Loss Recommendations

- For people with a BMI ≥30, weight loss is recommended
- For people with a BMI between 25 and 29.9, or who have a waist circumference greater than 40" in men and 35" in women, and who have additional risk factors, weight loss is recommended
- For people with a BMI between 25 and 29.9 who have no risk factors and do not want to lose weight, prevention of further weight gain is recommended

Risk Factors

Disease conditions:

- Established CHD, other atherosclerotic diseases
- Type 2 diabetes
- Sleep apnea
- Gynecological abnormalities
- Osteoarthritis
- Gallstones & their complications
- Stress incontinence

Cardiovascular risk factors:

- Cigarette smoking
- Hypertension
- High LDL cholesterol (≥160 mg/dl)
- Low HDL cholesterol: Men <40 mg/dl; Women <50 mg/dl
- Impaired fasting glucose (110–125 mg/dl)
- Family history of premature CHD
- Men ≥45 years; Women ≥55 years (or postmenopausal)

Other risk factors:

- High serum triglycerides (>150 mg/dl)
- Physical inactivity

BMI is calculated by weight in pounds multiplied by 703 and divided by height in inches squared.

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- Overweight: BMI 25–299 (light gray area)
- Obesity: BMI 30 and above (dark gray area)

Weight Loss Recommendations

- For women with BMI ≥30, weight loss is recommended
- For women with BMI 25–299, or who have a waist circumference greater than 35 inches, and who have two or more risk factors,* weight loss is recommended
- Overweight women with a BMI ≤25–299 who have risk should prevent further weight gain

Disease conditions:

- Established CHD, other atherosclerotic diseases
- Type 2 diabetes
- Sleep apnea
- Gynecological abnormalities
- Osteoarthritis
- Gallstones & their complications
- Stress incontinence

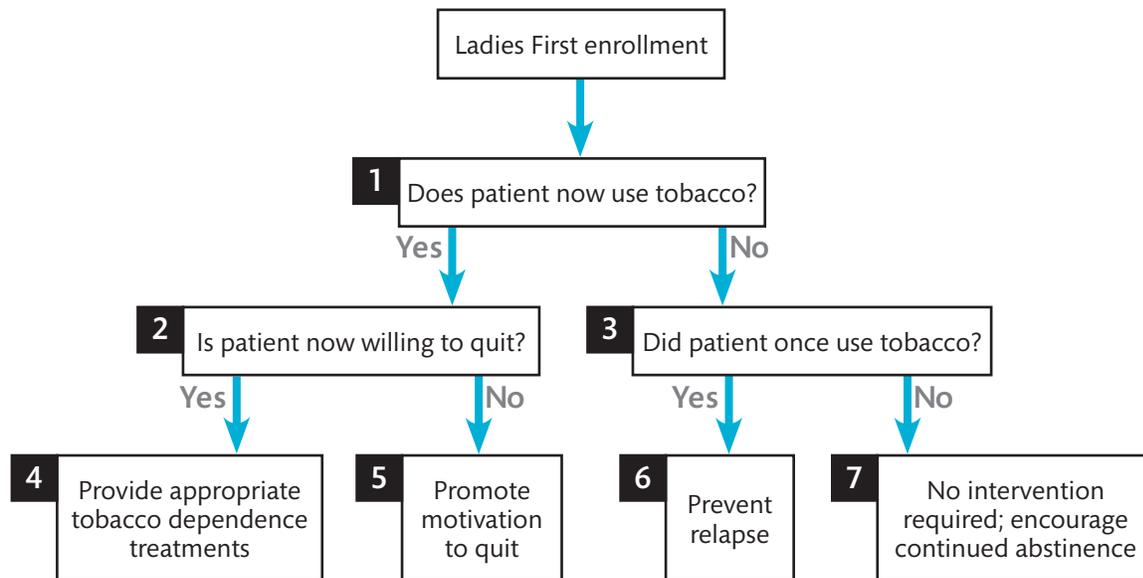
Cardiovascular risk factors:

- Cigarette smoking
- Hypertension
- High risk LDL-cholesterol (≥160 mg/dl)
- Low HDL cholesterol (≤35 mg/dl)
- Impaired fasting glucose (100–125 mg/dl)
- Family history of premature CHD
- ≥55 years (or postmenopausal)

Other risk factors:

- High serum triglycerides (>200 mg/dl)
- Physical inactivity

Tobacco Use Screening Protocol



1 Does the Patient Now Use Tobacco?

Upon enrollment all Ladies First members should be asked about tobacco use status

2 Is the Patient Now Willing to Quit?

Strongly urge all tobacco users to quit in a clear, strong, and personalized manner. Assess their willingness to quit. If the patient is willing to quit, refer her to the Vermont Quit Network 1-800-QUIT-NOW (1-800-784-8669). The QUIT network is available free of charge to all Vermont residents. Be sure to inform patients to let the Quit network know that they are Ladies First members.

3 Did the Patient Once Use Tobacco?

If the patient currently does not use tobacco, discuss past tobacco use. Ask how long it has been since the patient used tobacco. Most relapse occurs soon after quitting, however some people relapse months or years after their quit date.

4 Provide Appropriate Tobacco Dependence Treatments

- Appropriate treatments offered through the Vermont Quit Network include group or individual counseling sessions depending on the patient's preference
- Recommend Nicotine Replacement Therapies (NRT), if appropriate. NRT can double the patient's success of quitting. All methods of NRT (nicotine patch, gum, nasal spray, inhalers and bupropion hydrochloride) have been found to be equally effective.

5 Promote Motivation to Quit

- If patient is unwilling to quit at this time inform them of the health risks associated with smoking and provide the Quit Line number for future reference. The “5Rs” can be used to motivate patients to quit. Ask the patient to identify:
 - ◆ Relevance: why quitting is personally relevant to them
 - ◆ Risks: potential negative consequences of tobacco use
 - ◆ Rewards: potential benefits to stopping tobacco use
 - ◆ Roadblocks: impediments to quitting (note elements of treatment that can address these)
 - ◆ Repetition: repeat at each visit

6 Prevent Relapse

Congratulate and encourage patient to remain tobacco-free. Discuss the health benefits related to not smoking. Assess what is working for them to remain abstinent from tobacco. Assess and address potential problems that may threaten abstinence. These may include: lack of support to remain tobacco-free, negative mood/depression, strong/persistent withdrawal symptoms, weight gain.

- ## **7** No Intervention Required; Encourage Continued Abstinence
- For patients who have never smoked, encourage continued abstinence from smoking

References

Fiore MC, Bailey WC, Cohen SJ, et al. *Treating Tobacco Use and Dependence*. Quick Reference Guide for Clinicians. Rockville, MD: U.S. Dept. of Health and Human Services. Public Health Service. October 2000.