NH Healthy Lives

Heart Program Pilot

Manual

Division of Public Health Services

NH Department of Health & Human Services

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ABBREVIATIONS AND ACRONYMS

The following is a list of abbreviations and acronyms commonly used by the NH Healthy Lives Heart Program.

A1C Test	Glycosylated Hemoglobin Test
ADA	American Diabetes Association
BCCP	Breast and Cervical Cancer Program
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
CHD	Coronary Heart Disease
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CVD	Cardiovascular Disease
DASH	Dietary Approaches to Stop Hypertension
DBP	Diastolic Blood Pressure
DHHS	Department of Health and Human Services
DSMES	Diabetes self-management education and support
EHR	Electronic Health Record
FPG	Fasting Plasma Glucose Test
HBP	High Blood Pressure
HBSS	Healthy Behavior Support Service
HDL-C	High-Density Lipoprotein Cholesterol
HTN	Hypertension
IOM	Institute of Medicine
IOV	Integrated Office Visit
LDL-C	Low-Density Lipoprotein Cholesterol
MDE	Minimum Data Element
MNT	Medical Nutrition Therapy
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
NHHL-BCCP	New Hampshire Healthy Lives Breast and Cervical Cancer Program
NHHL-HP	New Hampshire Healthy Lives Heart Program
SBP	Systolic Blood Pressure
SMBP	Self-Measured Blood Pressure
TIA	Transient Ischemic Attack
TLC	Therapeutic Lifestyle Changes

SECTION 1: INTRODUCTION

NH Healthy Lives Heart Program (NHHL-HP) Background

The Centers for Disease Control and Prevention (CDC) funded NHHL-HP (as known as WISEWOMAN, **W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) was created to serve low-income, uninsured, and underinsured people ages 40 to 64 years, by providing them with heart disease and stroke risk factor screenings and services promoting healthy behaviors.

NHHL-HP serves participants in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP), which helps ensure a full range of health services. New Hampshire Department of Health and Human Services (NHDHHS) administers the grant.

Heart disease and stroke are among the leading causes of death in New Hampshire. The NHHL-HP aims to improve the delivery of diabetes, heart disease, and stroke prevention and management services by focusing on cardiovascular disease (CVD) risk factors, specifically improving blood pressure control. NHHL-HP helps integrate innovative and evidence-based approaches to heart disease and stroke prevention within health care systems and throughout communities.

Examples of this include:

- Using a team-based care approach, which includes the patient, the primary care provider, nurses, pharmacists, and community health workers, to provide care for patients with high blood pressure and other risk factors.
- Supporting clinicians by providing tools and resources to help their patients regularly measure their blood pressure at home.
- Providing tools to pharmacists to work with patients to help them take their blood pressure medications as directed.
- Providing skill-based trainings to encourage participants to improve their diet and increase physical activity.
- Referring tobacco users to quit lines or other tobacco cessation resources.
- Supporting community-based farmers' markets and other programs to increase access to healthy, fresh food options.
- Providing access to community-based physical activity options such as YMCA memberships.
- Increasing the number of evidence-based lifestyle programs offered in communities such as the National Diabetes Prevention Programs and programs through the YMCA.

Centers for Disease Control and Prevention Cooperative Agreements			
Topic	**National Breast and Cervical Cancer Early Detection Program (NBCCEDP)**	**Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)**	**Improving the Health of Americans Through Prevention and Management of Diabetes, Heart Disease, and Stroke (DP18-1815)**
New Hampshire Specific Name for Branding and Promotional Purposes	NH Healthy Lives-Breast and Cervical Cancer Program (NHHL-BCCP).	For the pilot rollout, this is referred to as NH Healthy Lives-Heart Program (NHHL-HP).	Commonly referred to as the "1815 grant" with no specific branding.
Focus of Program	Early detection of breast and cervical cancer; population based approach to improve systems that increase breast and cervical cancer screening and management.	Improve control of high blood pressure and other heart disease and stroke risk factors.	Through policy, systems, and environmental changes: -Prevent or delay development of type 2 diabetes in people at high risk and improve the health of people living with diabetes. -Prevent and manage cardiovascular disease, with a focus on high blood pressure and high cholesterol.
Target Audience	Cervical cancer screening: for patients aged 21 to 64 years, with a focus on patients who have rarely or never been screened.	Individuals aged 40 to 64 years eligible or enrolled in the NHHL-BCCP.	High-burden populations/communities affected disproportionately due to socioeconomic or other characteristics, including inadequate access to

	Mammography screening for patients aged 40 to 64 years, with a focus on patients aged 50 to 64 years.		care, poor quality of care, or low income.
Services Provided	Cancer screening through mammography and pap test; Diagnostic tests to target problems; Referrals to health care providers for medical management of conditions.	Screenings for heart disease and stroke risk factors including blood pressure, cholesterol, prediabetes, diabetes, BMI, and smoking. Counseling to reduce risk for heart disease and stroke. Patient referrals for medical evaluation and management of health condition(s) when needed. Follow-up appointment for uncontrolled high blood pressure, diabetes, and high cholesterol. Patient referrals to healthy lifestyle programs, other healthy behavior support options, and low-cost medication resources. Track and monitor clinical measures shown to improve healthcare quality and identify patients at	<u>Support health systems and community organizations to increase:</u> Reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high cholesterol. Community-clinical linkages that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high cholesterol. Participation in evidence-based lifestyle interventions among patients with high blood pressure and high cholesterol. Use of pharmacists in providing diabetes self-management education and support (DSMES) and in helping people with diabetes, high blood pressure and high

		risk for and with high blood pressure. Implement team-based care to reduce CVD risk. Link community resources and clinical services that support bi-directional referrals, self-management, and lifestyle change for patients at risk for CVD.	cholesterol manage their medications. Access to, coverage for, and enrollment & retention of people with prediabetes in the National Diabetes Prevention Program (National DPP). Access to, coverage for, and participation of people with diabetes in DSMES programs.
Who Provides Clinical Care	Health care providers who offer Pap tests and regular pelvic and clinical breast exam screening tests. Providers must be willing to coordinate the care of patients enrolled in the program from screening and clinical follow-up to a final diagnosis. Laboratories and mammography facilities are recruited to provide services.	Health care providers must also offer the NHHL-BCCP screening services. Providers must have staff skilled in screening for cardiovascular disease and providing patient-centered counseling to reduce risk for heart disease and stroke.	Direct clinical services are not funded through this cooperative agreement.

Program Mission

The mission of the NHHL-HP is to manage and reduce cardiovascular disease risk factors among underserved New Hampshire participants, ages 40 to 64. The program will provide comprehensive CVD risk factor screenings for these participants receiving breast and cervical cancer screenings through NHHL-BCCP. All program components are related to the delivery of screening and diagnostic services, and delivery of support to those in need.

NHHL-HP Strategies

Every screening site is required to apply the NHHL-HP strategies:

1. Track and monitor clinical measures shown to improve healthcare quality and identify patients at risk for and with hypertension (HTN).
2. Implement team-based care to reduce cardiovascular disease risk with a focus on hypertension control and management.
3. Link community resources and clinical services that support bi-directional referrals, self-management, and lifestyle change for those at risk for CVD.

SECTION 2: AGENCY RESPONSIBILITIES

NH DHHS Responsibilities

As a recipient of CDC funds, NH DHHS must follow CDC guidelines. CDC provides a framework for implementation, and ongoing technical assistance provided by a team of project officers. DHHS is responsible to ensure providers give quality patient care in all facets of the program, including integrated office visits, follow-up services and rescreening services.

DHHS ensures contracted providers use established CDC approved protocols for service delivery. Contracted providers are accountable to NH DHHS for the appropriate use of funds. Supervision of NHHL-HP staff will be per institutional guidelines and in compliance with state licensure requirements. In addition to providing financial support, DHHS will assist contracted providers through:

- Guidance in training a Health Coach where needed.
- Professional education, program development trainings, data management trainings, and meetings for contracted provider staff.
- Technical assistance with program planning, development, implementation, operations, and evaluation in accordance with federal and state government directives.

- Program guidance in implementing and maintaining an electronic tracking/follow-up referral system for the delivery of program services.

- Technical assistance with quality assurance and improvement activities.

- Assistance with enhancing and/or developing public/participants education activities.

- Assistance with program promotion and recruitment of eligible participants.

- List(s) of allowable Current Procedural Terminology (CPT) codes and reimbursement rates for program services.

- Regular program information/updates via e-mail, conference calls, trainings, webinars, meetings, and site visits.

Program Site Responsibilities

1. Identify one person as the Site Coordinator. A Site Coordinator is responsible for:
    - Acting as the main point of contact between the site and DHHS.
    - Ensuring adherence to all NHHL-HP requirements, including policies, procedures, and protocols.
2. Meet or show significant progress toward meeting performance measures established by the CDC.
3. Train all staff members involved in the implementation of the NHHL-HP prior to their participation in the program.
4. Provide attestation documentation to DHHS that program policies and procedures will be followed by each staff member involved in the implementation of the program.
5. Inform the DHHS NHHL-HP Program Coordinator of any program staff changes (including extended sick leave) within one week of change.
6. Collect all data elements required by DHHS using Med-IT or the site EHR.
7. Actively participate in the Quality Improvement (QI) Process.
8. Use reports to assist in the QI process and to identify participants requiring follow-up.
9. Client Confidentiality: All sites must have a written policy that outlines methods to protect the confidentiality of participants. Confidentiality must be maintained for each participant, in all aspects of the program. This policy must be in compliance with HIPPA regulations. All envelopes and faxes containing participant identifying information must be marked “Confidential” before submitting. All electronic correspondence (i.e. email) of confidential information containing personal identifiers must be transferred and/or exchanged via a secure electronic system.

Participant's Rights

Contracted sites are required to:

- Protect the use/disclosure of any participant's medical or social information of a confidential nature.
- Consider medical services and information contained in medical records as confidential.
- Disclose the participant's medical records to contracted NHHL-BCCP providers or medical facilities accepting the participant.
- Disclose the participant's medical records to NHHL-BCCP State Office.
- Disclose, in summary or other form, information which does not identify individuals or providers, if such information is in compliance with applicable federal and state regulations, and the exchange of medical record information is in keeping with established medical standards.

Informed Consent

Participants of the program agree to have personal and family history information collected and shared with DHHS via the NHHL-HP Informed Consent Form:

- By either written or digital consent forms, the participant grants permission to health care providers to report all information concerning screening tests and procedures, treatment, and any related care or activity to DHHS.
- The consent form must be signed (written or digitally) at the time of enrollment into the NHHL-HP.
- A new consent form must be signed (written or digitally) at each annual rescreening.

Patient Enrollment

For enrollment into NHHL-HP, the screening staff must complete the following:

- Confirm eligibility of participant for NHHL-BCCP.

Record-Keeping

- Copies of the signed NHHL-HP Informed Consent Form, the NHHL-HP Clinical Data Collection Form: Baseline/Risk Reduction, and the NHHL-HP HBSS Form are to be entered into the patient's permanent medical record/EHR maintained by the primary provider.

- The clinical team must document all education provided to participants.
- The clinical team must establish a system for tracking participants, which notifies them when it is time for routine screening, follow-ups, rechecks, and rescreening visits.

- Ensure all participants found to have ALERT values are referred for medical evaluation and treatment immediately or within 7 days, the integrated office visit counting as DAY 1 and that ALERT workups are completed and documented in the EHR.
- Ensure all participants found to have ABNORMAL/DISEASE-LEVEL values are referred for medical evaluation and treatment within 30 days, the integrated office visit counting as DAY 1, and that, this follow-up is complete and documented in the EHR.

Reporting Requirements

To receive reimbursement from DHHS, the clinical team will submit the following:

- NHHL-HP CVD Health Risk Assessment
- NHHL-HP HBSS Form
- NHHL-HP Follow Up Assessment (completed once participant has had a minimum of 3 Health Coaching sessions in a minimum of a 6 month period)
- Health Insurance Claims (HCFA 1500) complete with all service codes and dates through e-billing

Contract/Reimbursement

- NHHL-HP clinical team must maintain current and applicable federal and/or state licenses.
- The clinical team must agree to accept the program-approved reimbursement fee as payment in full for services rendered. That reimbursement, by law, cannot be over the current Medicare reimbursement rate.

Quality Assurance/Quality Improvement

The clinical team is required to participate in quality assurance and quality improvement activities as deemed appropriate by DHHS. This includes compliance with contractual performance measures, participation in scheduled site visits, and professional development trainings.

SECTION 3: SCREENING SERVICES

Participant Eligibility

Eligibility for patient participation in the NHHL-HP include:

1. Individual* between the ages of 40 and 64
2. Household income at or below 250% of the federal poverty level

3. Eligible for the NH BCCP (a patient does NOT have to be enrolled, but enrollment is strongly encouraged)
4. Underinsured or uninsured
    - Insurance does not cover these services
    - Unable to pay a co-payment or have a high deductible
    - No Medicaid or Medicare Part B coverage
5. New Hampshire resident (exception: those that live in York County, Maine are allowed to enroll in BCCP/NHHL-HP)

**Women, transgender men and transgender women*.

Participant Enrollment

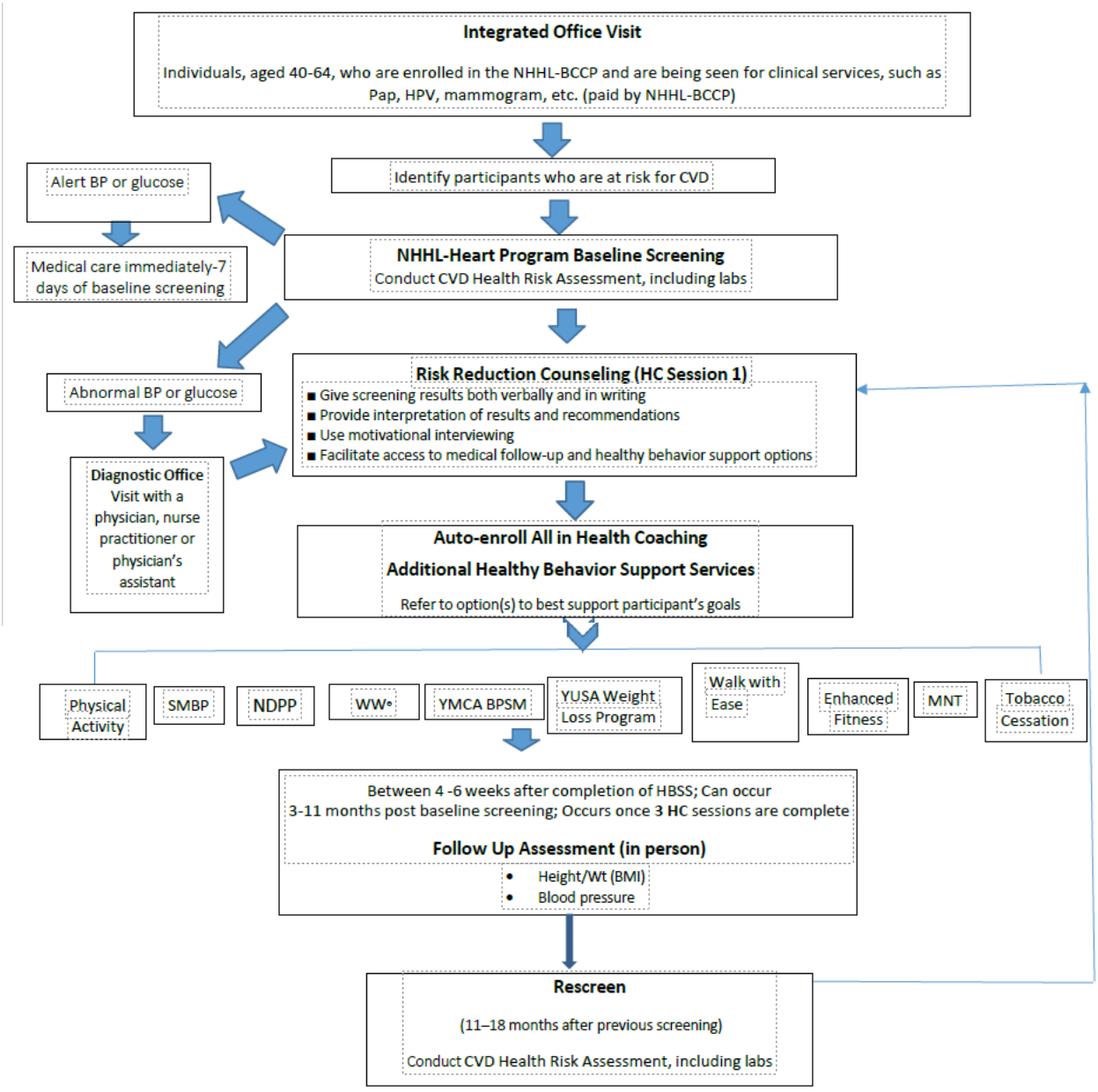
Enrollment and participation in the NHHL-HP is voluntary. All enrolling NHHL-HP participants must have a completed:

1. NHHL-HP Informed Consent Form
2. NHHL-HP CVD Health Risk Assessment
3. NHHL-HP HBSS Form
4. NHHL-HP Follow-Up Assessment Form

If the Informed Consent or the CVD Health Risk Assessment forms are omitted, a participant is not enrolled in the NHHL-HP and no services performed will be reimbursed. All forms must be updated annually as part of each screening visit and kept in the participant's file.

When a participant signs the NHHL-HP Informed Consent Form, they are affirming that they understand NHHL-HP eligibility rules and coverage and have knowingly agreed to participate in the NHHL-HP. The participant may complete this form on their own or a clinic team member may assist them in doing so. The participant must be the one who signs the form. The NHHL-HP CVD Health Risk Assessment contains questions regarding a participant's cardiovascular history and current behaviors that may increase their cardiovascular disease risk. The information collected is confidential. The participant may complete this form on their own or a clinic team member may assist them in doing so. The clinical team is strongly encouraged to review the form with the participant to ensure clear understanding of the questions asked and to capture the most accurate responses possible. The NHHL-HP HBSS Form contains questions regarding a participant's readiness to change and participate in a healthy behavior support option. This form is completed by the clinical team in conjunction with the NHHL-HP participant. It may be continuously updated as needed. The information collected is confidential.

SECTION 4: PROGRAM FLOW



The Integrated Office Visit

The integrated office visit consists of all of the following:

- Annual breast and cervical cancer screenings (paid for by NHHL-BCCP)
- CVD Health Risk Assessment
- Laboratory tests; fasting preferred, but not required (paid for by NHHL-HP):
    - Total cholesterol, HDL, LDL
    - Triglycerides
    - Fasting glucose or HgbA1c

  ***Non-fasting lipid profiles must meet the following criteria**:
    - The participant has not indicated a previous history of elevated cholesterol **AND**
    - Is not currently taking a statin **AND**
    - Can attest that they have not eaten a meal with high fat-content within the last 8 hours
- Risk reduction counseling to help participants understand their risks (considered Health Coaching Session #1)
- Auto-enrollment into Health Coaching
- A HBSS referral in addition to HC, if deemed necessary, to support participants' engagement in healthy lifestyle behaviors to prevent, minimize, or delay the onset of chronic disease

NHHL-HP screenings can be offered outside of the integrated office visit when:

- A participant is eligible for both NHHL-BCCP and NHHL-HP but has yet to receive NHHL-BCCP services.
- A participant received NHHL-BCCP-paid breast or cervical cancer screening services through another NHHL-BCCP provider/agency.
- A participant is eligible for NHHL-BCCP but declines/refuses breast and cervical cancer screening services.
- A participant is not due for breast and cervical cancer screening services and did not receive breast or cervical health education.
- A participant receives NHHL-BCCP -paid breast or cervical cancer clinical screening after NHHL-HP services.

The CVD Health Risk Assessment Component

This component evaluates the participant's medical history and current health behaviors including:

- Body Mass Index (BMI), using the participant's height and weight
- Waist circumference (not required, but recommended)

- Blood Pressure Assessment
- Cholesterol Assessment : Total cholesterol, HDL, and LDL cholesterol and Triglycerides
- Fasting glucose or Hgb A1c
- Participants who are identified with a disease level value will be referred for additional blood work (if needed) and to a health care provider for a Diagnostic Office Visit
- Any medication to lower cholesterol, lower blood pressure or lower blood sugar
- Home blood pressure measurement
- Healthy Lifestyle questions, includes intake of fruits and vegetables, whole grains, sugar sweetened beverages, sodium
- Physical Activity, accounting for moderate and vigorous physical activity
- Tobacco Use

If the health risk assessment is completed prior to the integrated office visit, please use the date of the actual office visit as the date of enrollment, **NOT** the date the health risk assessment was completed.

Time Frame for Completing Screenings

All screening services should be completed at the integrated office visit or within as short a time frame as possible after the initial visit. It is ideal to collect all this information at the office visit, but CDC recognizes that this may not always be possible. Labs (total cholesterol, HDL, LDL, Triglycerides, fasting glucose (or HgbA1C)) should be done within 30 days of the office visit. In cases where labs were done prior to 30 days, Medical Directors should determine the length of time labs are considered valid.

Referral for Medical Evaluation of Uncontrolled Hypertension and Other Abnormal Findings (Including Alerts)

Individuals with abnormal screening results must have appropriate medical evaluation in accordance with standards of care and NHHL-HP guidelines. Sites must ensure that all participants with NHHL-HP 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 Medical Director
- Case management to assist participants with accessing indicated medical care

All participants with abnormal blood pressure measurements must receive further attention as appropriate, and participants with disease-level blood pressure or laboratory values must be referred for medical evaluation if not currently being treated. Participants with uncontrolled hypertension must receive case management and other appropriate follow-up, as well as access to free or low-cost medical care and medication, as needed. Health care providers must have an effective referral process for abnormal findings.

Alerts set by the NHHL-HP are:

- Blood Pressure: Systolic>180 mmHg **OR** Diastolic >110 mmHg
- Fasting blood glucose: 250 mg/dL
- For the purposes of NHHL-HP, there are no alert values for cholesterol or A1C. However, if the initial non-fasting lipid profile reveals a triglycerides level of 400 mg/dL or higher, a repeat lipid profile in the fasting state should be performed for assessment of fasting triglyceride levels and baseline LDL.

Diagnostic Office Visit

A diagnostic visit is when a client is seen due to an abnormal value discovered during the NHHL-HP screening visit. The NHHL-HP will reimburse for one office visit (per occurrence) for evaluation of alert values or other abnormal or disease-level values. This must be completed by either a physician, nurse practitioner or physician's assistant.

The NHHL-HP will cover the cost of case management associated with providing appropriate attention to abnormal blood pressure measurements**.** Height, weight and blood pressure should be recorded at all case management visits.

Risk Reduction Counseling (Health Coaching Session #1)

Participants who are found to be at risk for cardiovascular disease should be referred for risk reduction counseling through NHHL-HP. Risk reduction counseling services **can take place on the same day as the integrated office visit or on a different day,** but must be billed appropriately. NHHL-HP will reimburse providers for the time spent conducting the risk reduction counseling services. This reimbursement should be billed separate from the time spent conducting the clinical screening services that are part of the integrated office visit. The duration of the counseling should be appropriate to the level of counseling needed to convey the participant's screening results, interpretation of the results, and appropriate recommendations.

The Risk Reduction Counseling Session is considered the 1st Health Coaching session for all participants. Risk Reduction Counseling Session may include:

- Medical history, lab, and clinical results review.
- Discussion of CVD risk and importance of a healthy lifestyle to reduce risk.

- Determine target blood pressure reading for hypertensive patients.
- Determine if participant is a candidate for SMBP.
- Discuss diet.
- Determination of ability to participate in physical activity.
- A referral an additional Healthy Behavior Support Service (HBSS), if deemed necessary.
- Obtain permission to check back in 30-60 days to follow-up if participant is either not ready or interested in healthy support options.

SECTION 5: HEALTHY BEHAVIOR SUPPORT SERVICE OPTIONS

Healthy Behavior Support Services (HBSS) are available to all NHHL-HP participants who are interested in making positive changes in their lives. HBSS offerings vary based on local availability to sites. Examples may include gym memberships, WW (formerly known as Weight Watchers), yoga studios, etc. All sites are required to provide participants with Health Coaching as a HBSS option.

Health Coaching (HC)

HC is offered as a HBSS to **all** participants of the NHHL-HP Program, as it has been shown to be a promising intervention improving physical activity and nutrition, tobacco cessation, weight loss, medication management and hypertension control[1]. In addition to HC being a HBSS on its own, gym memberships, Weight Watchers, and all other HBSS offerings MUST be paired with Health Coaching.

HC is centered on evidenced-based interventions such as Motivational Interviewing (MI) and goal setting to facilitate healthy and sustainable behavior change. Health Coaches are usually social workers, dietitians, CHW, or any other non-physician team member who have met the NHHL-HP requirements to provide health coaching. NHHL-HP funds may be used for HC professional development. Certain HC training offerings are tailored to certain professions, so staff should choose the training that aligns best with their professional training.

Health Coaches take a holistic view, and understand that participants have established work/home routines and personal relationships, all which play an important part in overall health. Because “one size doesn’t fit all” for health coaching, each session must be individualized for participants, focusing on small steps/changes based on participant’s unique goals and needs. HC are supportive allies who help track a participant’s progress, help identify and access available resources, and help to break down barriers standing between the participant and better health.

In order to provide support, HC will include:

- Motivational interviewing techniques
- Supportive counseling
- Goal setting
- Follow-up on progress toward goals
- Referrals to appropriate community referrals
- **Minimum of three sessions within a minimum of a 6 month period are required to complete HC and proceed with the Follow-Up Assessment** (due to the variability in length of other HBSS programs, the scheduling of Follow-Up Assessments will be based off of when **HC is complete**; participants should continue with any additional HBSS programs they may be participating in and complete those sessions/memberships as well.)

The *Risk Reduction Counseling* session is counted as the **first** Health Coaching session. During the risk reduction counseling, the HC will assess the participant's readiness to make changes. Those who are ready to change will be enrolled in health coaching to assist them in making healthy lifestyle behavior changes. Participants who are not ready to change should be encouraged to make a small step towards change and be offered health coaching. However, if the participant still does not want to set a goal (i.e., do a small step and plan) document that HC (HBSS) was offered but participant refused in the EMR/Med-IT. The participant may be rescreened in one year.

Setting Small Steps for Participants in Health Coaching

For participants who are ready to make a change, the Health Coach will:

- Talk with the participant using Motivational Interviewing techniques
- Encourage the participant to identify one priority area
    - Medication Adherence
    - Nutrition
    - Physical activity
    - Smoking cessation
    - Blood Pressure Management
- Work with the participant to set a small step related to their chosen priority area

- Encourage the participant to focus on setting a small step they are interested in achieving. The small step should be:
    - Specific (focus on one priority area)
    - Measurable (i.e., eat one more vegetable a day, walk 10 minutes a day
    - Attainable (make it a small step, not a huge leap)
    - Relevant (it should be something the participant wants to do)
    - Time-Bound (i.e., do it every day for two weeks)
- Help the participant set a plan that covers who, where, when, what, and how.

For participants who have set a small step, the Health Coach will:

- Make regular contact with the participant to encourage success with the small step (outreach a minimum of two times)
- Document each contact as a HC visit
- Help the participant overcome barriers to successfully reaching the small step. NHHL-HP may be able to provide help/guidance with transportation, clothing/sneakers, child care options, etc.
- Help the participant set a new small step as the participant reaches and feels comfortable with the previous small step
- Provide additional educational materials and referrals to appropriate community resources related to the small step

Sessions 2 and 3 can be either face-to-face, by phone, teleconferencing or interactive email, with no minimum time limit.

Training of Health Coaches

NHHL-HP sites may opt to have staff trained as Health Coaches. In order to receive reimbursement for these trainings, the following criteria must be met.

1. **Motivational Interviewing**. All HC must be trained in Motivational Interviewing and provide documentation of completed training. An "Introduction to Motivational Interviewing" course is acceptable to meet this requirement. In NH, a MI trainer can be found through the Motivational Interviewing Network of Trainers (MINT), such as North Country Health Consortium.

2. **Health coaching certification** or training that incorporates health coaching core competencies. Examples:

- National Society of Health Coaches (NSHC) awards the credential of Certified Health Coach (CHC) to clinical health care or allied health care providers

- American Council on Exercise (ACE) Health Coach Certification
- American Fitness Professionals and Associates (AFPA) Health and Wellness coach
- National Diabetes Prevention Program Lifestyle Coach Training
- Association of Diabetes Care and Education Specialists (ADCES) Career Path Certificate (options for providers, allied health, Community Health Workers and others)
- Community Health Worker Training – also for recovery coaches, patient navigators, health assisters, etc.

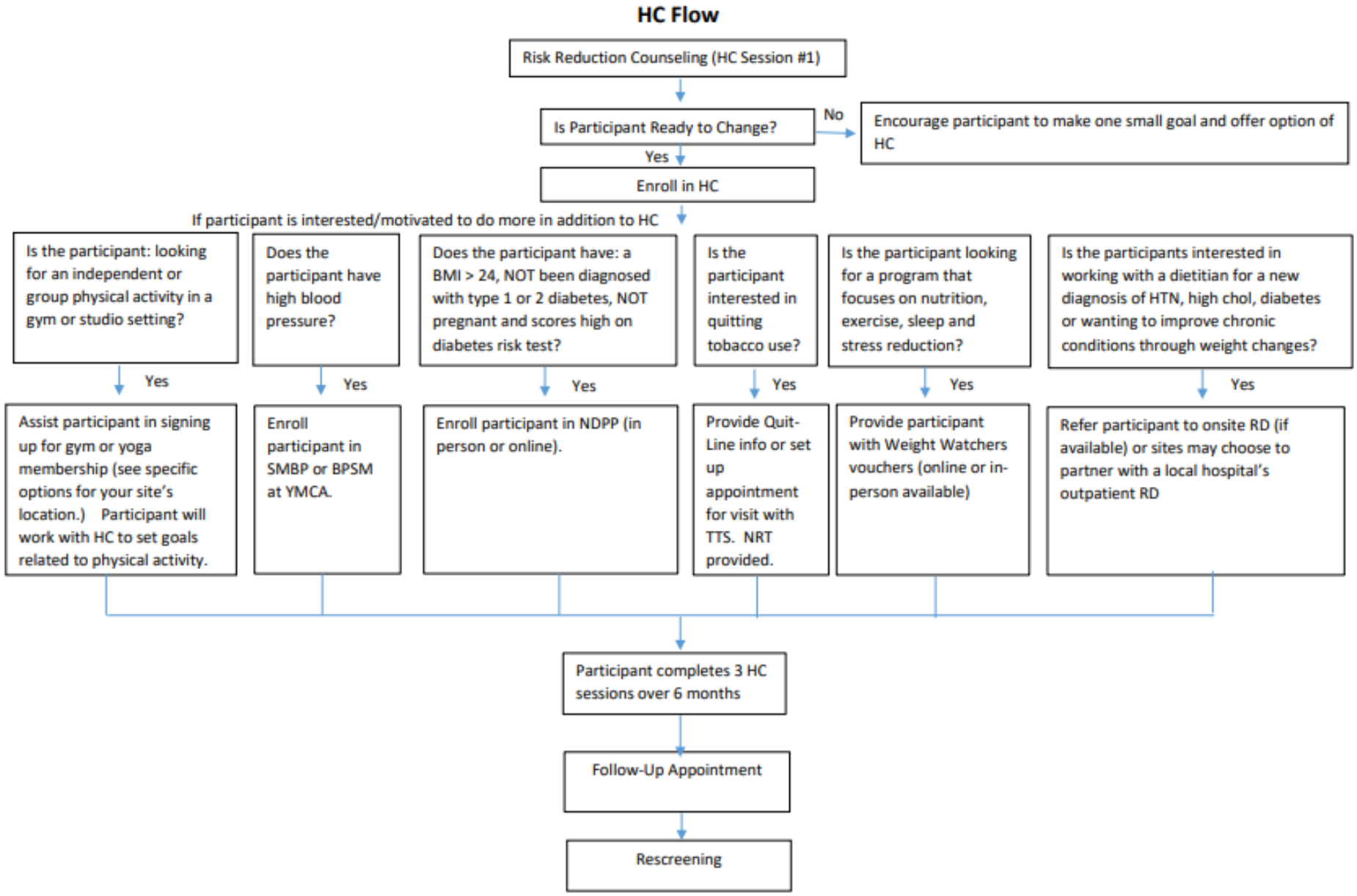
Core competencies for health coaches are based on theoretical principles, science, and clinical practice guidelines and include:

- Active, unencumbered professional license to practice in a clinical setting
- Code of Ethics and Standards of Practice
- Shared decision making regarding treatment plan
- Spirit of the health coaching relationship as a 50/50 patient-provider partner in health
- Active Listening
- Communication
- Transtheoretical Model of Change
- Generational and Societal Influences on Behavior Change
- Cultural Competence
- Goal-setting
- Guiding the Agenda
- Mindfulness
- Motivational Interviewing
    - Open-ended questions
    - Affirmation
    - Reflection
    - Summary
    - Avoiding discord/managing resistance
    - Client Empowerment
- Telephonic Coaching
- Evidence-based clinical practice interventions for wellness and prevention

Med-It codes for HC are: Individual coaching-21NHHCG001; Group-21NHHCG002

A separate guide detailing Health Coaching will be provided to each site.

Health Coaching Work Flow



Self-Measured Blood Pressure Monitoring with Clinical Support/Health Coaching

SMBP is defined as regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere. The health care team will provide SMBP with additional support that includes determining patient's target blood pressure parameters, regular one-on-one counseling, telephone or web-based support tools, and educational materials. NHHL-HP will provide monitors and reimburse for SMBP.

Each site will have a SMBP protocol in place, which is reviewed and updated annually. Protocol will outline how participants will be monitored and timeline for follow up.

In addition to SMBP, participants will be required to see a Health Coach. Participants should be made aware that they will be asked for their most recent blood pressure readings at each health coaching session.

Pairing SMBP with HC, The Health Coach will:

- Educate participant on how to take an accurate measurement of blood pressure
- Make sure the participant knows how to use the machine's history function or use a paper log to record each measurement.
- Provide education on lifestyle changes that can help lower blood pressure.
- Work with the participant to set a goal related to blood pressure.
- Maintain regular contact with the participant to encourage them to record blood pressure.
- Discuss barriers to participation if patient is not recording BP
- During each health coaching session, record blood pressure readings in EMR/Med-It

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Med-It code for SMBP with HC is 21NHHCGSMB.

Diabetes Prevention Program (DPP) Paired with HC

Referral to DPP participation for NHHL-HP participants is most appropriate for those who:

- Are overweight (body mass index above 24, or 22 if patient is Asian)
- Have **NOT** been diagnosed with type 1 or type 2 diabetes
- Are **NOT** pregnant
- Scores high on the diabetes risk test (https://www.cdc.gov/diabetes/takethetest/)

The focus of the DPP is to prevent type 2 diabetes among people who are at risk. This lifestyle intervention was developed to increase physical activity to a minimum of 150 minutes per week and reduce weight by a minimum of 5-7% percent. The program consists of a total of 25 sessions; weekly sessions for first 16 weeks of the core curriculum, and then either once or twice per month of the remainder of the program.

Pairing DPP with HC, The Health Coach will:

- Work with the participant to set a goal related to diabetes prevention
  -Goal could be to complete the DPP
- Refer the participant to the local DPP using the established referral process
- Maintain regular contact with the participant to encourage them to attend all sessions
- Discuss barriers to participation if they have trouble attending
- Enter data from each session into EMR/Med-IT

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of DPP is not required prior to the follow up appointment, completion of the DPP is defined as 9 sessions in the first 16 core sessions, 3 sessions in the Maintenance phase (last 6 months). Referral to DPP and completion of program must be documented in Med-It.

New Hampshire's recognized Diabetes Prevention Program are listed here: https://preventdiabetesnh.org/new-hampshire-national-diabetes-prevention-program-locations/

DPP sites will bill DHHS directly for reimbursement of participants in the program. For Med-It program tracking purposes, please use 21HNLSPDPP for In-Person and 21HNLSPDPV for on-line/virtual NDPP.

WW® (Offered in person or Online) Paired with HC

WW® (formerly known as Weight Watchers) is a program that is helpful for participants looking for a lifestyle change program that focuses on nutrition, exercise, sleep and stress. Each participant will receive vouchers (provided to the sites by DHHS) that will allow them to attend in-person or virtual workshops that meet at a set times weekly. In addition, participants will have access to the digital WW program, which is an online app. Sites will be required to track the name and date of the participant that received the vouchers.

Pairing WW with HC, the Health Coach will:

- Work with participant to set a realistic weight loss goal, goal related to improved nutrition or realistic movement goals
- Assist participant in creating a WW digital account using the provided digital voucher
- Maintain regular contact with the participant to encourage regular engagement using the WW mobile app
- Discuss barriers to participation if they have trouble using the app
- Enter data from each session into EMR/Med-IT

- Check in with participants at weeks 7 and 10 (approximately) and document their participation in the program into Med-It. This documentation will include a self-reported weight as available.

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of WW membership is not required prior to the follow up appointment, completion is defined as attending 6 WW sessions over the 14 week period. Please track these appointments in the EMR/Med-It. For Med-It program tracking purposes, please use 21NHLSPWWO if the participant only partakes in online classes and 21NHLSPWWP if the participant partakes in in-person classes.

YMCA BPSM Paired with HC

The BPSM program offered by the YMCA is an approved lifestyle program for the NHHL-HP. The goal of the YMCA BPSM program is to reduce blood pressure and improve blood pressure management in participants, while enhancing knowledge in regards to developing healthier eating habits. Participants must be diagnosed with high blood pressure, not experienced a recent cardiac event, not have atrial fibrillation or other arrhythmias and not be at risk for lymphedema. BPSM is a 4-month-evidence-based program where participants will:

- Attend 10-minute personalized consultations
- Learn measuring techniques and record blood pressure at home to share during consultations
- Attend monthly nutrition education workshops to develop healthier eating habits

Pairing BPSM with HC, The Health Coach will:

- Confirm participant can accurately measure blood pressure (will have been shown through BPSM classes)
- Make sure the participant knows how to use the machine's history function or use a paper log to record each measurement
- Provide education on lifestyle changes that can help lower blood pressure
- Work with participant to set realistic goal in relation to blood pressure values
- Maintain regular contact with the participant to encourage them to record blood pressure/attend classes
- Discuss barriers to participation if patient is not recording BP or attending BPSM classes
- During each health coaching session, record blood pressure readings in EMR/Med-It
- Engage in bidirectional feedback from BPSM program

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of BPSM is not required prior to the follow up appointment, completion of BPSM is defined as attending:

- 2 Heart Health Ambassador (HHA) consultations per month; 8 sessions over 4 months
- 3 out of 4 nutrition education sessions over the 4 month period

These session must be tracked via Med-It.

The YMCA will bill DHHS directly for services rendered. The Med-It tracking code for YMCA BPSM is 21NHLSPYBP.

YUSA Weight Loss Program Paired with HC

This HBSS is intended for those who are not eligible to enroll into YMCA's Diabetes Prevention Program, but are interested in a lifestyle change program or those who are not ready to commit to the DPP program due to time or other barriers, but are still looking for a program in a group setting. Through this 12 week program, groups will meet one hour per week, where facilitator-lead discussions will focus on goal setting, balanced eating, physical activity, stress, mindfulness and more. Participants track their daily food intake and physical activity, as well as develop weekly action plans that incorporate concepts learned during each session.

Pairing YUSA Weight Loss Program with HC, The Health Coach will:
- Work with the participant to set a goal related to weight loss/realistic movement goals
- Refer the participant to the YUSA Weight Loss Program using the established referral process
- Maintain regular contact with the participant to encourage them to attend all sessions
- Discuss barriers to participation if they have trouble attending
- Engage in bidirectional feedback from YUSA Weight Loss program
- Enter data from each session into EMR/Med-IT

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of YUSA Weight Loss Program is not required prior to the follow up appointment, completion of YUSA Weight Loss Program is defined as attending 8 out of 12 sessions. YMCA will bill DHHS directly for reimbursement of classes. The Med-It code is 21HNLSPYWL.

Walk with Ease (WWE) Paired with HC

Walk with Ease is an evidence-based program that has been proven to help people with arthritis or other related conditions reduce pain, increase balance, strength and walking pace, and improve overall health. Participants receive an Arthritis Foundation certification, a leader's manual filled with exercise illustrations, health education information, and a 6-week walking plan.

Pairing WWE with HC, The Health Coach will:
- Work with the participant to set realistic movement goals

• Refer the participant to Walk With Ease using the established referral process
• Maintain regular contact with the participant to encourage them to attend all sessions
• Discuss barriers to participation if they have trouble attending
• Engage in bidirectional feedback from WWE
• Enter data from each session into EMR/Med-IT

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of WWE is not required prior to the follow up appointment, completion is defined as attending 8 WWE classes over the 6 weeks. If the program is taken through the YMCA, Heath Coach will consult with Y to confirm attendance of classes. YMCA will bill DHHS directly for reimbursement of WWE. The Health Coach will bill DHHS directly for their services using approved CPT codes. The Med-It code for program tracking purposes is 21NHHCGWWE.

Enhance® Fitness at the YMCA Paired with HC

Enhance® Fitness is an evidence-based group exercise and falls prevention program that helps older adults at all levels of fitness become more active, energized, and empowered to sustain independent lives. Older adults who may have arthritis, MS, Parkinson's, issues with balance, those who are have a BMI ≥25, or are new to exercise would benefit from the Enhance® Fitness program. Sessions meet three times a week for 1 hour.

Pairing Enhance® Fitness with HC, The Health Coach will:
• Work with the participant to set a goal realistic movement goals
• Refer the participant to Enhance Fitness using the established referral process
• Maintain regular contact with the participant to encourage them to attend all sessions
• Discuss barriers to participation if they have trouble attending
• Engage in bidirectional feedback from YMCA
• Enter data from each session into EMR/Med-IT

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of Enhance® Fitness is not required prior to the follow up appointment, completion of this program is defined as attending 12 classes over a 16 week period.

YMCA will bill DHHS directly for reimbursement of classes. The Med-It code for program tracking purposes is 21NHLSPYEF.

Medical Nutrition Therapy (MNT) Paired with HC

MNT is nutrition-based treatment provided by a registered dietitian. Patients with newly diagnosed or uncontrolled with hypertension, hypercholesterolemia, diabetes or those in need of weight reduction, in order to improve chronic conditions, would be ideal participants to see a RD. If RD is in-house, participant can be referred internally or sites may choose to partner with a local hospital's outpatient RD.

Dietitians will be required to document visits and give visit summaries to primary care providers. (For on-site dietitians, EHR documentation would meet this requirements.) Dietitians will bill DHHS for payment, using CPT codes for MNT.

Pairing MNT with HC, the Health Coach will:

- Work with participant to set a realistic weight loss goal, goal related to improved nutrition or realistic movement goals
- Maintain regular contact with the participant to encourage plan set forth by Registered Dietitian
- Discuss barriers to participation
- Enter data from each session into EMR/Med-IT
- Check in with participants and document their participation in MNT sessions into EMR/Med-It.
- Engage in bidirectional feedback from RD

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of MNT is not required prior to the follow up appointment, completion is defined as four sessions (once a month for 4 months).

Physical Activity Membership Paired with HC

Participants who are interested in physical activity may receive a membership to a gym or yoga studio. Each participating site will have gym or yoga studio membership options specific to their geographical area. Memberships may last anywhere from 3 -6 months.

Pairing PA with HC, the Health Coach will:

- Work with participant to set a realistic movement goals
- Assist participant in signing up for the membership (may require completion of online forms)
- Maintain regular contact with the participant to encourage regular attendance to the gym
- Discuss barriers to participation if they have trouble attending
- Enter data from each session into EMR/Med-IT
- Check in with participants and document their participation in the program into Med-It.
- Engage in bidirectional feedback from sites

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months.

Tobacco Cessation Resources Paired with HC

Participants who are interested in quitting tobacco use, including electronic nicotine delivery systems, may benefit from tobacco cessation resources. QuitNow-NH is comprised of phone and on-line services.

1-800-QUIT-NOW (Adults/young adults)

www.QuitNowNH.org (Adults/young adults)

There is $0 cost to NH residents to use the QuitNow-NH program. QuitNow-NH mails cessation medications directly to the individual participating in weekly coaching. Quit Coaches are highly skilled in transtheoretical model of behavior change and are nationally certified in motivational interviewing. QuitNow-NH tracks data from the very first interaction for 12 months, regardless of the number of services provided for that individual. Participants will be contacted six months post enrollment to assess tobacco abstinence and satisfaction with the services they received. A referral to the program will be captured through EMR/Med-It.

If a NHHL-HP site would prefer to have an On-Site Tobacco Treatment Specialist, NHHL-HP funds may be used in order to have staff appropriately trained through the UMASS Center for Tobacco Research and Training. Staff such as registered dietitians or CHW would be ideal candidates for TTS, since many of these staff members are also health coaches, allowing numerous healthy behaviors to be addressed at once.

NRT can be provided to participants through the state Tobacco Program. An order form from the Tobacco Program must be completed in order to receive NRT. In addition, in order to receive NRT, sites must be willing to:

- Provide a protocol regarding NRT
- Engage in NRT tracking. This must include:
  a. Date of Receipt of NRT
  b. Name of Medication
  c. Strength
  d. Amount
  e. Lot number
  f. Date of expiration

Pairing tobacco cessation with HC, the Health Coach will:

- Work with participant to set a realistic quit goals
- Maintain regular contact with the participant to encourage smoking cessation
- Provide option of NRT via TTS if appropriate
- Discuss barriers if they have trouble
- Enter data from each session into EMR/Med-IT
- Check in with participants and document their participation in the program into Med-It.

Completion of the Health Coach requirements is defined as a minimum of 3 visits over 6 months. Although completion of a tobacco cessation program is not required prior to the follow up appointment, completion is defined as a minimum of 3 sessions. TTS can bill DHHS using appropriate CPT codes for reimbursement.

SECTION 6: FOLLOW-UP ASSESSMENT

Follow-up assessments provide an opportunity to evaluate short-term health outcomes in women who participate in HBSS. They can also provide valuable information about how a program is working and indicate the need for revisions. Sites must conduct a formal follow-up assessment for all participants that complete a HBSS. **Follow-ups should occur within four (4) weeks (and up to 4 month) once a participant has met with a health coach a minimum of 3 times over a 6 month period.**

Follow-up assessments should include:

- Height and weight measurements to calculate BMI
- Blood pressure measurement(s)
- Completion of the *Follow-up Assessment form* with the participant

If the follow-up assessment appointment is too close to the participant's annual integrated office visit, the follow-up visit may be skipped, as long as all required data is obtained once the participant restarts the NHHL-HP cycle.

If an in-person follow-up screening is a hardship for a participant, a telehealth follow-up screening may be completed. (Sites are strongly encouraged to reduce barriers and have in-person visits as feasible.)

If a participant has an elevated or disease level lipid at their baseline/returning screening, they may not be eligible for the telehealth follow-up screening, as a labs may need to be drawn. This decision is up to the medical provider.

If it is determined that the follow up visit will need to be done via telehealth, the following steps will be taken:

At the **initial screening** visit during the integrated office visit, sites must:

• Ensure participants have access to a reliable scale (scales can be provided as needed)

• Ensure participants have access to a blood pressure monitor (to confirm cuffs are calibrated and validated, please provide participants with ones purchased through grant funds)

• Demonstrate proper blood pressure technique and provide SMBP resources

This includes instructing a patient on the following when taking blood pressure at home:

- **Don't** measure blood pressure within half an hour of eating, smoking, drinking caffeinated drinks, or exercising.
- If on blood pressure medication, measure BP before you take your medication.
- If needed, use the bathroom before measuring blood pressure.
- **Wear loose-fitting clothes.**
- **Rest for five minutes before taking a BP reading.** Sit somewhere quiet, in a seat with back support, where your arm can rest on a firm surface and feet can be flat on the floor. Stay in this position while taking your blood pressure.
- **Make sure your arm is supported and at the same level as your heart.** Keep your arm and hand relaxed, not tensed.
- Take two or three measurements, one minute apart.

(If a participant decides that enrolling in Health Coaching or another HBSS is not feasible at this time, no cuff or scale will be provided to that participant)

At the **telehealth follow-up** visit, sites must:

• Collect answers to questions on Follow-Up Assessment form

• Record self-reported weight and blood pressure

- Before patient takes **blood pressure**, instruct patient on the following when taking blood pressure at home:
    - Don't measure blood pressure within half an hour of eating, smoking, drinking caffeinated drinks, or exercising.
    - If on blood pressure medication, measure BP before you take your medication.
    - If needed, use the bathroom before measuring blood pressure.
    - Wear loose-fitting clothes.
    - Rest for five minutes before taking a BP reading. Sit somewhere quiet, in a seat with back support, where your arm can rest on a firm surface and feet can be flat on the floor. Stay in this position while taking your blood pressure.

    - Make sure your arm is supported and at the same level as your heart. Keep your arm and hand relaxed, not tensed.
    - Take two or three measurements, one minute apart.
- For accuracy of **weights**, instruct patient on the following when weighing themselves at home:
    - Place scale on a flat surface. Avoid placing it on uneven or bumpy tiles, rugs, or carpet.
    - Stand still on the scale with both feet even and flat. Don't touch or hold on to anything, as that will affect the weight displayed by the scale
    - Weigh yourself on the same day of the week**.** If you plan to keep track of your weight, weigh yourself once per week on the same day each time.
    - Avoid weighing yourself every day.
    - Measure your weight at the same time of day, such as first thing in the morning. This will eliminate fluctuations from weighing yourself on an empty stomach versus just after a large meal.
    - Weigh yourself after going to the bathroom in the morning for the most accurate result.
    - Weigh yourself before eating or drinking anything.
    - Wear the same type of clothes, such as shorts and a t-shirt), each time you weigh yourself. You can also weigh yourself naked, if preferred.
    - Use the same scale. Different scales will give you different readings.

- Ideally, telehealth visits should be completed with video capacity when available, so site staff can watch the participant take their measurement and confirm accurate methods
- In Med-It, blood pressure and weight must be designated as self-reported. Under the "measurement" tab, there will be a box to check that designates that the weight and BP were self-reported.
- An excel spreadsheet will be used to track which participants were seen through the virtual follow up method. This spreadsheet will be provided to sites. Items tracked will include participants ID and date of self-reported blood pressure at follow up appointment.

SECTION 7: DATA COLLECTION FORMS

NHHL-HP has mandatory reporting requirements and data elements that are required by the CDC. The data collected from the NHHL-HP forms provides evidence to the funding agencies that monies used by NHHL-HP are used to:

- Ensure participants receive cardiovascular disease screening tests in conjunction with NHHL-BCCP screenings.

- Ensure participants with alert values and disease-level values are followed according to CDC guidelines.
- Ensure the program is reaching the in-need segment of the population.
- Evaluate the effectiveness of the NHHL-HP.
- Ensure the availability of high quality data for program planning as well as quality assurance of the program.

General Information Concerning All Forms

- All forms should be complete and accurate.
- The original forms will be sent to the Program Manager with an invoice by the 15th of each month.
- All forms can be printed from Med-IT.
- Copies of all forms must be kept in the medical record.
- The results of the lab tests should be carefully recorded so that participants receive adequate follow-up and providers receive proper payment.

- The NHHL-HP Informed Consent Form must be signed before any services are rendered, and the signed document must be maintained in the patient's medical record.
- Forms are currently available in English, Spanish, Portuguese and Brazilian Portuguese. Please let DPHS know if additional translations are needed.

SECTION 8: BILLING AND REIMBURSEMENT

NHHL-HP funds can only be used to reimburse for services outlined by CDC as approved procedures and up to the current Medicare reimbursement amounts. HBSS are also reimbursable services.

NHHL-HP Paid Services:

- Clinical laboratory tests at initial screening
- Risk reduction counseling session with medical professional
- A medical follow-up visit with provider regarding screening issues
- Nutritional counseling sessions (MNT) with a registered dietitian
- A follow-up office visit with medical provider following HBSS

• **CPT/ HCPCS Code**	**Description**	**Non-Facility Fee**	**Facility Fee**
Laboratory Tests			
36415	Collection of venous blood by venipuncture	$3.00	$3.00

*Either 90832 **OR** 90834 can be billed for **one** time only.

80061	Lipid panel	$13.39	$13.39
82465	Cholesterol, serum or whole blood, total	$4.35	$4.35
83718	Lipoprotein, direct measurement; high density cholesterol (HDL cholesterol)	$8.19	$8.19
Tests to Assess Glucose and Diabetes			
80048	Basic metabolic panel	$8.46	$8.46
80053	Comprehensive metabolic panel	$10.56	$10.56
81002	Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents	$3.50	$3.50
82947	Glucose; quantitative	$3.93	$3.93
82948	Glucose; blood, reagent strip	$5.04	$5.04
82951	Glucose tolerance test (GTT), three specimens	$17.99	$17.99
83036	Hemoglobin glycated (A1c)	$9.71	$9.71
85025	Complete Blood Count	$10	$10
Behavioral Health			
90832	Psychotherapy services rendered for 30 minutes by a licensed mental health provider*	$76.04	$66.56
90834	Psychotherapy services rendered for 45 minutes by a licensed mental health provider*	$100.57	$88.28
Nutrition Services Provided by a Registered Dietitian			
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	$37.58	$33.01
97803	Re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	$32.76	$27.84
97804	Group (2 or more individuals), each 30 minutes	$17.20	$15.80
Pharmacist Services			
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient	$45.00	$45.00
99606	Initial 15 minutes, established patient	$20.00	$20.00
99607	Each additional 15 minutes (List separately in addition to code for the primary service) (Use 99607 in conjunction with 99605, 99606)	$10.00	$10.00
Education and Training for Patient Self-Management (prescribed by a physician or other qualified health professional)			

98960	Individual - Education and training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient; Bill in 30-minute units: limit 4 units per 24 hours; no more than 8 units per calendar month per recipient.	$19.44	$19.44
98961	Group - Education and training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; **2-4 patients**	$9.09	$9.09
98962	Group - Education and training for patient self-management by a qualified nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; **5-8 patients**	$6.56	$6.56
Telephone Services and Other Non-Face-to-Face Services			
98966	Telephone assessment and management service provided by a qualified non-physician health professional to an established patient: 5-10 minutes of medical discussion	$13.34	$11.24
98967	11-20 minutes	$24.23	$22.12
98968	21-30 minutes	$33.75	$31.30
Chronic Care Management Services			
99490	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$63.42	$50.78
99491	Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month	$85.85	$76.02

99487	Complex chronic care management services, with the following required elements: ● Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient ● Chronic conditions place the patient at significant risk of death, acute exacerbation/ decompensation, or functional decline ● Establishment or substantial revision of a comprehensive care plan ● Moderate or high complexity medical decision making ● 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$136.53	$93.43
99489	Each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month	$71.67	$51.56
Chronic Care Remote Physiologic Monitoring			
99453	Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment Remote monitoring physiologic parameter setup	$19.92	$19.92
99454	Device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	$51.92	$51.92
99457	Remote patient monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes	$49.64	$30.33
99458	Remote patient monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes	$40.16	$30.33
99473	SMBP using a device validated for clinical accuracy; patient education/training and device calibration	$13.30	$13.30
99474	separate self-measurements of two readings one minute apart, twice daily over a 30-day	$15.54	$8.87

	period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient		
99091	Collection and interpretation of physiologic data (e.g. ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified healthcare professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days.	$54.48	$54.48
Office Visits			
99202	New Patient - expanded history, exam, straightforward decision-making; 15-29 minutes	$74.00 (BCCP covered code as well)	$48.37
99203	New Patient - detailed history, exam, straightforward decision-making; 30-44 minutes	$114.21 (BCCP covered code as well)	$83.32
99204	New Patient - comprehensive history, exam, moderate complexity decision-making; 45-59 minutes	$169.25 (BCCP covered code as well)	$134.15
99205	New Patient - comprehensive history, exam, high complexity decision-making; 60-74 minutes	$223.27(BCCP covered code as well)	$182.20
99211	Established Patient - evaluation and management, may not require presence of physician; 5 minutes	$23.96 (BCCP covered code as well)	$8.87
99212	Established Patient - history, exam, straightforward decision-making; 10 minutes	$57.86 (BCCP covered code as well)	$35.75
99213	Established Patient - expanded history, exam, straightforward decision-making; 20-29 minutes	$92.06 (BCCP covered code as well)	$66.44
99214	Established Patient - expanded history, exam, straightforward decision-making; 30-39 minutes	$130.10 (BCCP covered code as well)	$98.15
Medical Team Conference and Consultation			

99366	Medical team conference, Direct (Face-to-Face) contact with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional. Team conference services of less than 30 minutes duration are not reported separately	$45.01	$44.75
Preventive Medicine Services - Office Visits			
99386	New patient: Initial comprehensive preventive medicine evaluation and management - history, examination, counseling/guidance, risk factor reduction, ordering of appropriate laboratory/diagnostic procedures - 40 -64 years	$103.37 (BCCP covered code as well)	$103.37
99396	Established patient: Periodic comprehensive preventive medicine evaluation and management - history, examination, counseling/guidance, risk factor reduction, ordering of appropriate laboratory/diagnostic procedures - 40 -64 years	$84.78(BCCP covered code as well)	$84.78
99401	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual: 15 minutes	$35.00	$35.00
99402	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual: 30 minutes	$65.00	$65.00
99403	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual: 45 minutes	$90.00	$90.00
99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual: 60 minutes	$120.00	$120.00
99406	Preventive Medicine Tobacco Use Cessation: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	$15.07	$11.91
99407	Preventive Medicine Tobacco Use Cessation: Smoking and tobacco use cessation counseling visit; intermediate, greater than 10 minutes	$28.00	$25.19
99411	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; 30 minutes	$13.10	$5.99
99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; 60 minutes	$22.69	$16.07
Other Preventive Services, Telephone and Internet Services			
99420	Administration and interpretation of health risk assessment instrument	$75.00	$75.00

99441	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion	$57.25	$35.13
99442	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion	$92.06	$66.44
99443	Telephone evaluation and management service by a physician or other qualified health professional who may report evaluation and management services provided to an established patient, not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion	$129.49	$97.54

ICD-10 Codes

The following ICD-10 codes are approved for NHHL-HP use:

E10.8 Type 1 diabetes mellitus: Type 1 diabetes mellitus with unspecified complications

E10.9 Type 1 diabetes mellitus: Type 1 diabetes mellitus without complications

E11.42 Type 2 Diabetes Mellitus With Diabetic Polyneuropathy

E11.65 Type 2 diabetes mellitus with hyperglycemia

E11.69 Type 2 diabetes mellitus with other specified complication

E11.8 Type 2 diabetes mellitus with unspecified complications

E11.9 Type 2 diabetes mellitus without complications

E13.65 Other specified diabetes mellitus with hyperglycemia

E13.69 Other diabetes mellitus with other specified complication

E13.8 Other diabetes mellitus with unspecified complications

E13.9 Other specified diabetes mellitus without complications

E66.01 Morbid (severe) obesity due to excess calories

E66.09 Other obesity due to excess calories

E66.1 Drug-induced obesity

E66.3 Overweight

E66.8 Other obesity

E66.9 Obesity, unspecified

E75.6 Lipid storage disorder, unspecified

E78.00 Pure hypercholesterolemia

E78.1 Disorders of lipoprotein metabolism and other lipidemias: Pure hyperglyceridemia

E78.2 Mixed hyperlipidemia

E78.3 Hyperchylomicronemia

E78.4 Other hyperlipidemia

E78.5 Hyperlipidemia, unspecified

E78.6 Lipoprotein deficiency

E78.70 Disorder of bile acid and cholesterol metabolism, unspecified

E78.9 Disorder of lipoprotein metabolism, unspecified

F17.200 Nicotine dependence, unspecified, uncomplicated

F17.201 Nicotine dependence, unspecified, in remission

F17.203 Nicotine dependence unspecified, with withdrawal

F17.208 Nicotine dependence, unspecified, with other nicotine-induced disorders

F17.209 Nicotine dependence, unspecified, with unspecified nicotine-induced disorders

F17.210 Nicotine dependence, cigarettes, uncomplicated

F17.211 Nicotine dependence, cigarettes, in remission

F17.213 Nicotine dependence, cigarettes, with withdrawal

F17.218 Nicotine dependence, cigarettes, with other disorders

F17.219 Nicotine dependence, cigarettes, with unspecified disorders

F17.220 Nicotine dependence, chewing tobacco, uncomplicated

F17.221 Nicotine dependence, chewing tobacco, in remission

F17.223 Nicotine dependence, chewing tobacco, with withdrawal

F17.228 Nicotine dependence, chewing tobacco, with other disorders

F17.229 Nicotine dependence, chewing tobacco, with unspecified disorders

F17.290 Nicotine dependence, other tobacco product, uncomplicated

F17.291 Nicotine dependence, other tobacco product, in remission

F17.293 Nicotine dependence, other tobacco product, with withdrawal

F17.298 Nicotine dependence, other tobacco product, with other disorders

F17.299 Nicotine dependence, other tobacco product, with unspecified disorders

I10 Essential (primary) hypertension

I47.1 Supraventricular tachycardia

I49.2 Junctional premature depolarization

R03.0 Elevated blood-pressure reading, w/o diagnosis of htn

R63.1 Symptoms and signs concerning food and fluid intake: Polydipsia

R73.01 Impaired fasting glucose

R73.02 Impaired glucose tolerance (oral)

R73.03 Prediabetes

R73.09 Other abnormal glucose

R73.9 Hyperglycemia, unspecified

Z00.00 Encounter for general adult medical exam w/o abnormal findings

Z00.01 Encounter for general adult medical exam with abnormal findings

Z01.30 Encounter for other special examination without complaint, suspected or reported diagnosis: Encounter for examination of blood pressure without abnormal findings

Z01.31 Encounter for other special examination without complaint, suspected or reported diagnosis: Encounter for examination of blood pressure with abnormal findings

Z13.1 Encounter for screening for diabetes mellitus

Z13.220 Encounter for screening for lipid disorders

Z13.6 Encounter for screening for cardiovascular disorders

Z71.9 Counseling, unspecified

Z72.3 Lack of physical exercise

Z72.4 Inappropriate diet and eating habits

Z82.41 Family history of certain disabilities and chronic diseases (leading to disablement): Family history of ischemic heart disease and other diseases of the circulatory system: Family history of sudden cardiac death

Z82.49 Family history of certain disabilities and chronic diseases (leading to disablement): Family history of ischemic heart disease and other diseases of the circulatory system

Z83.3 Family history of other specific disorders: Family history of diabetes mellitus

Z86.32 Personal history of certain other diseases: Personal history of endocrine, nutritional and metabolic diseases: Personal history of gestational diabetes

Z87.891 Personal history of nicotine dependence

NH Healthy Lives Heart Program (NHHL-HP) Informed Consent

NH Healthy Lives

NH Healthy Lives Heart Program (NHHL-HP) Informed Consent

You may receive NHHL-HP services if you are a NHHL-CP participant and are between the ages of 40-64. The Program's aim is to help you reduce your risk for developing cardiovascular disease and/or stroke. As a participant, you will receive screening tests to identify your cardiovascular disease risk factors and help in reducing or controlling them. Tests include: 1) blood pressure measurements, 2) taking a small amount of blood (this may cause you some minor discomfort) to check your fasting glucose or A1C level and your cholesterol/lipid levels, 3) taking your weight, height, and determining your body mass index (BMI), and 4) you will be asked if you use tobacco products. You will also be asked health questions to determine if you are healthy enough to participate in physical activity.

Once your provider has your lab results, you will meet with a medical professional to discuss the results. All participants will be referred to Health Coaching, free of charge. If your test results are elevated or if you smoke, you may be eligible to enroll in a Healthy Behavior Support Service designed to reduce your risk factors; this program will be provided to you, free of charge.

You will also be asked to return for rescreening 4 to 6 weeks following the completion of the Healthy Behavior Support Service. This visit will be at no cost to you.

☐I understand that the NHHL-HP will help me determine my risk of getting cardiovascular disease (also known as heart disease), having a heart attack, having a stroke, or getting diabetes or high blood pressure.

☐The NHHL-HP will work with me to make changes that may help manage my risk for getting these diseases.

☐My information will be kept private, and will not be shared with anyone outside the NHHL-HP, within the clinic, and the NH Department of Health. The NH Medicaid Office and the US Centers for Disease Control and Prevention (CDC) will receive NHHL-HP data in the aggregate, and will not have my name, therefore the information they receive will be anonymous.

☐I understand the above mentioned test will be performed. I understand these tests do not take the place of a medical exam, and may not reveal if I have a medical problem.

☐I understand I may experience minor discomfort from blood sample collection.

☐If any of my results are elevated, I may be referred to a provider who will help me manage these health concerns.

☐I accept the responsibility for following up with a health care provider, if it is suggested that I do so.

☐I will answer questions about my health history and my family's health history.

☐I will answer questions about what I eat, how active I am, and if I smoke.

☐I understand that physical activity may be part of the NHHL-HP Program. I will discuss starting an exercise program with medical staff and/or alert medical staff if I have any concerns about my ability to safely increase my current physical activity level.

☐I agree to participate in both the screening tests and the NHHL-HP lifestyle education sessions.

☐I understand that I will be contacted to return following the completion of my healthy behavior support service and again, in 1 year, to see if my health status related to these services has changed.

☐I understand that my health is my responsibility. I am responsible for keeping my appointments.

☐I understand that the NHHL-HP services will be available to me at no cost.

☐I have read or had the above read to me. I agree that all the information above is correct.

I fully understand the information on this form and agree to join the NHHL-HP Program. I may revoke my authorization and withdraw from the program at any time by submitting a written request to my provider.

_____ _____

Participant's Name Date

For further information about the NHHL-HP, please email Lisa Corman at lisa.h.corman@dhhs.nh.gov

NHHL-HP CVD Health Risk Assessment

NH Healthy Lives

ORGANIZATION	DATE OF SCREENING ___/___/_____	CLIENT ID	DATE OF BIRTH
LAST NAME	FIRST NAME	CITY ADDRESS AND ZIP CODE	

TYPE OF SCREENING: ▯ INITIAL ▯ ANNUAL RESCREENING

PATIENT INSTRUCTIONS: Please fill in each part below.

DEMOGRAPHICS

What is your highest grade of **education** completed?

- ▯ < 9 grade
- ▯ Some high school
- ▯ High school graduate or equivalent
- ▯ Some college or higher
- ▯ Don't know/Not sure

Are you of Hispanic or Latino origin?

▯ Yes ▯ No

Race:_____

What is the **primary language** spoken in your home?

▯ English ▯ French ▯ Japanese ▯ Russian ▯ Creole

▯ Spanish ▯ Chinese ▯ Korean ▯ Tagalog ▯ Portuguese

▯ Arabic ▯ Italian ▯ Polish ▯ Vietnamese ▯ Hmong

▯ Other Language _____

CHOLESTEROL

Have you ever been diagnosed with **high cholesterol**?..... ▯ Yes ▯ No ▯ DK*

- Was a statin medication prescribed to lower your **cholesterol**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
- Was a medication other than a statin prescribed to lower your **cholesterol**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
  - If yes, during the past 7 days (including today), on how many days did you take prescribed medication to lower your **cholesterol**? ..... _____ Days

HYPERTENSION

Have you ever been diagnosed with **hypertension (high blood pressure)**?..... ▯ Yes ▯ No ▯ DK*

- Was medication prescribed to lower your **blood pressure**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
- If yes, during the past 7 days, on how many days did you take prescribed medication (including diuretics/water pills) to lower your **blood pressure**?..... _____ Days
- Do you measure your **blood pressure** at home or using another calibrated sources?..... ▯ Yes ▯ No ▯ DK* ▯ NA
- If no, provide reason:
  - ▯ Never told to measure ▯ Don't know how to measure ▯ Don't have equipment to measure
- If yes, How often do you measure your **blood pressure** at home or using other calibrated sources?
  - ▯ Multiple times per day ▯ Daily ▯ A few times per week ▯ Weekly ▯ Monthly ▯ DK*
- Do you regularly share **blood pressure** readings with a health care provider for feedback? ▯ Yes ▯ No ▯ DK* ▯ NA

DK- Don't know/Not Sure; NA-Not applicable

NHHL-HP CVD Health Risk Assessment

NH Healthy Lives

LAST NAME	FIRST NAME	CLIENT ID

PATIENT INSTRUCTIONS (continued): Please fill in each part below.

DIABETES

Have you ever been diagnosed with **Diabetes**? (Either Type 1 or Type 2) ?…….... ▯ Yes ▯ No ▯ DK*

- Was medication prescribed to lower your **blood sugar**? ……..... ▯ Yes ▯ No ▯ DK* ▯ NA
- If yes, during the past 7 days (including today), on how many days did you take prescribed medication to lower your **blood sugar**? ……..... _____ Days

HEART ATTACK

Are you taking **aspirin** daily to help prevent a heart attack or stroke? ..... ▯ Yes ▯ No ▯ DK*

Have ever had any of the following **conditions**? (Mark all that apply)

▯ Stroke/transient ischemic attack (TIA) ▯ Heart attack ▯ Coronary heart disease ▯ Heart failure

▯ Vascular disease (peripheral arterial disease) ▯ Congenital heart disease and defects

HEALTH BEHAVIOR

How many cups of fruits and vegetables do you eat in an average day?..... Cups

Do you eat **fish** at least two times a week?..... ▯ Yes ▯ No

Thinking about all of the servings of grain products you eat in a typical day, how many are **whole grains**?

▯ Less than half ▯ About half ▯ More than half

Do you drink less than 36 ounces (450 calories) of **beverages** with **added sugars** weekly?..... ▯ Yes ▯ No

Are you currently watching or reducing your **sodium** or **salt** intake?..... ▯ Yes ▯ No

How many minutes **physical activity** (exercise) do you get in a week? ..... _____ Minutes

Over the past 7 days, how often did you have a drink containing **alcohol**? _____

..... Days On average, how many **alcoholic drinks** do you consume per _____ day?

..... Drinks

Do you **smoke**? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)?

▯ Current Smoker ▯ Quit (1-12 months ago) ▯ Quit (More than 12 ago) ▯ Never Smoked

MENTAL HEALTH

Over the past 2 weeks, how often have you felt **little interest** or **pleasure** in doing things?

▯ No days (not at all) ▯ Several days ▯ More than half ▯ Nearly every day

Over the past 2 weeks, how often have you felt **down**, **depressed** or **hopeless**?

▯ No days (not at all) ▯ Several days ▯ More than half ▯ Nearly every day

DK- Don't know/Not Sure; NA-Not applicable

NH Healthy Lives

NHHL-HP
Healthy Behavior Support Services Form

This form is to be filled out by the provider or health coach, NOT the participant

Provider Name	Date	Med-It#

Last Name	First Name	M.I.	Date of Birth
			/ /

Participant Goal:

- ❑ Drink more water
- ❑ Get blood pressure under control
- ❑ Lose weight
- ❑ Exercise more
- ❑ Decrease A1C
- ❑ Eat more fruits and vegetables
- ❑ Lower cholesterol
- ❑ Quit smoking

Barriers to Achieving Goal:

- ❑ Transportation
- ❑ Financial issues
- ❑ Family/Social Support Issues
- ❑ Food Insecurity
- ❑ Lack of Motivation/Commitment
- ❑ Education/Health Literacy
- ❑ Unrealistic Goal Setting
- ❑ Other_____

Successes to Achieving Goal:

Participant Stage of Change:

❑ Pre-contemplation ❑ Contemplation ❑ Preparation ❑ Action ❑ Maintenance

Was participant referred to any of the following HBSS?

❑ Health Coaching ❑ BPSM ❑ WW ❑ MNT ❑ SMBP ❑ DSMES ❑ Other YMCA Program ❑ National Diabetes Program (NDPP)

❑ Physical Activity ❑ Health Coaching

SMBP (if applicable)

Date: / /	Session Length (mins):		Will participant: ❑ Keep BP Log ❑ Report values back to provider
Was cuff given to participant for at home use? ❑ Yes ❑ No (if no, please explain)	1st Blood Pressure	/	
	2nd Blood Pressure	/	Was participant given information on lifestyle changes? ❑ Yes ❑ No
	Average Blood Pressure		
❑ Was participant trained on how to accurately measure BP at home?	❑ Was cuff calibrated? ❑ Yes ❑ No		MTM Visit? ❑ Yes ❑ No

TOBACCO CESSATION (if applicable)

Referral Date	Type (check one)	Completion
/ /	❑ Quitline ❑ Community-Based Tobacco Program ❑ Other_____	❑ Yes – Completed ❑ No – Partially Completed ❑ No – Withdrew ❑ No – Participant Could Not Be Reached
Completion Date		
/ /		

Notes:

Clinician Signature:_____ **Date:** _____

Provide copies to provider and participants

NHHL-HP Follow Up Assessment

NH Healthy Lives

ORGANIZATION	DATE OF SCREENING ___/___/_____	CLIENT ID	DATE OF BIRTH
LAST NAME	FIRST NAME	CITY ADDRESS AND ZIP CODE	

TYPE OF SCREENING: ▯ FOLLOW-UP

PATIENT INSTRUCTIONS: Please fill in each part below.

Have you ever been diagnosed with **high cholesterol**?..... ▯ Yes ▯ No ▯ DK*

- Was a statin medication prescribed to lower your **cholesterol**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
- Was a medication other than a statin prescribed to lower your **cholesterol**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
  - If yes, during the past 7 days (including today), on how many days did you take prescribed medication to lower your **cholesterol**? ..... _____ Days

Have you ever been diagnosed with **hypertension (high blood pressure)**?..... …▯ Yes ▯ No ▯ DK*

- Was medication prescribed to lower your **blood pressure**?..... ▯ Yes ▯ No ▯ DK* ▯ NA
- If yes, during the past 7 days, on how many days did you take prescribed medication (including diuretics/water pills) to lower your **blood pressure**?..... _____ Days
- Do you measure your **blood pressure** at home or using another calibrated sources?..... ▯ Yes ▯ No ▯ DK*
- If no, provide reason:
  ▯ Never told to measure ▯ Don't know how to measure ▯ Don't have equipment to measure
- If yes, How often do you measure your **blood pressure** at home or using other calibrated sources?
  ▯ Multiple times per day ▯ Daily ▯ A few times per week ▯ Weekly ▯ Monthly ▯ DK*
- Do you regularly share **blood pressure** readings with a health care provider for feedback? ▯ Yes ▯ No ▯ DK* ▯ NA

Have you ever been diagnosed with **Diabetes**? (Either Type 1 or Type 2)?…… ▯ Yes ▯ No ▯ DK*

- Was medication prescribed to lower your **blood sugar**? ▯ Yes ▯ No ▯ DK* ▯ NA
- If yes, during the past 7 days (including today), on how many days did you take prescribed medication to lower your **blood sugar**? ……..... _____ Days

DK -Don't know/Not Sure; NA-Not applicable

NHHL-HP Follow Up Assessment

NH Healthy Lives

LAST NAME	FIRST NAME	CLIENT ID

PATIENT INSTRUCTIONS (continued): Please fill in each part below.

Are you taking **aspirin** daily to help prevent a heart attack or stroke? ..... ▯ Yes ▯ No ▯ DK*

Have ever had any of the following **conditions**? (Mark <u>all</u> that apply)

▯ Stroke/transient ischemic attack (TIA) ▯ Heart attack ▯ Coronary heart disease ▯ Heart failure

▯ Vascular disease (peripheral arterial disease) ▯ Congenital heart disease and defects

How many cups of fruits and vegetables do you eat in an average day?..... Cups

Do you eat **fish** at least two times a week?..... ▯ Yes ▯ No

Thinking about all of the servings of grain products you eat in a typical day, how many are **whole grains**?

▯ Less than half ▯ About half ▯ More than half

Do you drink less than 36 ounces (450 calories) of **beverages** with **added sugars** weekly?..... ▯ Yes ▯ No

Are you currently watching or reducing your **sodium** or **salt** intake?..... ▯ Yes ▯ No

How many minutes **physical activity** (exercise) do you get in a week? ..... _____ Minutes

Over the past 7 days, how often did you have a drink containing **alcohol**? _____

..... Days On average, how many **alcoholic drinks** do you consume per _____ day?

..... Drinks

Do you **smoke**? Includes cigarettes, pipes, or cigars (smoked tobacco in any form)?

▯ Current Smoker ▯ Quit (1-12 months ago) ▯ Quit (More than 12 ago) ▯ Never Smoked

Over the past 2 weeks, how often have you felt **little interest** or **pleasure** in doing things?

▯ No days (not at all) ▯ Several days ▯ More than half ▯ Nearly every day

Over the past 2 weeks, how often have you felt **down**, **depressed** or **hopeless**?

▯ No days (not at all) ▯ Several days ▯ More than half ▯ Nearly every day

DK -Don't know/Not Sure; NA-Not applicable

FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

The Granite YMCA | Healthy Living Initiatives

HEALTH CARE PROVIDER REFERRAL FORM

Healthy Living Initiative programs are for ages 18 and over and are offered at the five branches of The Granite YMCA: YMCA of Downtown Manchester, YMCA Allard Center of Goffstown, YMCA of Greater Londonderry, YMCA of Strafford County, and the YMCA of the Seacoast. *Specific program offerings may vary based on location.*

Select applicable program.

- ☐ Tai Ji Quan™: Moving for Better Balance, Fall Prevention Program
- ☐ LIVE**STRONG** at the YMCA, Cancer Survivorship Program
- ☐ YMCA's Blood Pressure Self-Monitoring Program
- ☐ Enhance®Fitness, Older Adult Fitness Program
- ☐ Walk with Ease, Arthritis Foundation Program
- ☐ YMCA's Diabetes Prevention Program

For the YMCA's Diabetes Prevention Program:

Do you have one of the following lab values or diagnosis? Please check each box that is true, and provide a value if possible:

- ☐ A1c (must be 5.7%-6.4%) _____
- ☐ Fasting plasma glucose (must be 110-125 mg/dL)_____
- ☐ 2-hour (75 gm glucola) plasma glucose (must be 140-199 mg/dL) _____
- ☐ Prediabetes determined by clinical diagnosis of gestational diabetes (GDM)_____

Send referrals to:
ATTN: Cindy Lafond, Association Director of Healthy Living Initiatives
Email: health@graniteymca.org | Phone: 603.232.8668 | HIPAA Secure Fax: 1.978.616.4513

OFFICE USE ONLY:

YMCA of Downtown Manchester ☐ YMCA of Greater Londonderry ☐ YMCA of Strafford County ☐
YMCA Allard Center of Goffstown ☐ YMCA of the Seacoast ☐

PATIENT INFORMATION

Patient Name _____ D/O/B _____

Phone _____ Patient Email _____

I consent to and authorize _____ to release to The Granite YMCA, my health information containing my ability to participate in the _____ program.

I consent to and authorize The Granite YMCA to release to _____ my pre and post health assessment at the conclusion of the _____ program. Authorization is not valid beyond one year from date of signature.

Patient Signature _____ Date_____

TO BE COMPLETED BY THE PROVIDER

Physician Name_____ Physician Phone_____

Referring Hospital _____ Address _____

Please indicate the level of participation and any limiting activities.

_____Cleared to exercise

_____Cleared to exercise with the following restrictions and/or recommendations_____

_____

Physician Signature _____ Date_____

PROGRAM DESCRIPTIONS & ELIGIBILITY

The YMCA's Diabetes Prevention Program focuses on small, measurable, reasonable goals to give participants confidence they can make the necessary changes to reduce their risk for type 2 diabetes and live healthier lives. In a classroom setting, a trained lifestyle coach will facilitate a small group of participants in learning about healthier eating, physical activity and other behavior changes over 25 sessions.

PREDIABETES RISK TEST

Write your score in the boxes below

How old are you? Younger than 40 (0 points) 50 - 59 (2 points) 40 - 49 (1 point) 60 or older (3 points)	
Are you a man or a woman? Man (1 point) Woman (0 points)	
If you are a woman, have you ever been diagnosed with gestational diabetes? Yes (1 point) No (0 points)	
Do you have a mother, father, sister, or brother with diabetes? Yes (1 point) No (0 points)	
Have you ever been diagnosed with high blood pressure? Yes (1 point) No (0 points)	
Are you physically active? Yes (0 points) No (1 point)	
What is your weight category? (See chart at right)	

IF YOU SCORED A 5 OR HIGHER then you may be at risk for prediabetes or diabetes, and may qualify for the program. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition where blood sugar levels are higher than normal but not high enough for a type 2 diabetes diagnosis.

AT RISK WEIGHT CHART

HEIGHT	WEIGHT (lbs.)		
4'10"	119 - 142	143 - 190	191+
4'11"	124 - 147	148 - 197	198+
5'0"	128 - 152	153 - 203	204+
5'1"	132 - 157	158 - 210	211+
5'2"	136 - 163	164 - 217	218+
5'3"	141 - 168	169 - 224	225+
5'4"	145 - 173	174 - 231	232+
5'5"	150 - 179	180 - 239	240+
5'6"	155 - 185	186 - 246	247+
5'7"	159 - 190	191 - 254	255+
5'8"	164 - 196	197 - 261	262+
5'9"	169 - 202	203 - 269	270+
5'10"	174 - 208	209 - 277	278+
5'11"	179 - 214	215 - 285	286+
6'0"	184 - 220	221 - 293	294+
6'1"	189 - 226	227 - 301	302+
6'2"	194 - 232	233 - 310	311+
6'3"	200 - 239	240 - 318	319+
6'4"	205 - 245	246 - 327	328+
	1 Point	2 Points	3 Points
	You weigh less than the 1 Point column (0 pts)		

The YMCA's Blood Pressure Self-Monitoring Program is designed to help adults with hypertension lower and manage their blood pressure. The four-month program focuses on regular home self-monitoring of one's blood pressure using proper measuring techniques, one-on-one consultations with a trained Healthy Heart Ambassador, support and group-based nutrition education for better blood pressure management.

WHO QUALIFIES?

- Be at least 18 years old
- Diagnosed with high blood pressure
- Not have experienced a recent cardiac event
- Not have atrial fibrillation or other arrhythmias
- Not be at risk for lymphedema

LIVE**STRONG** at the YMCA is a FREE 12 week, small group program for adult cancer survivors, family members, and caregivers. in the transitional period between completing their cancer treatment and the time of feeling physically and emotionally strong enough to return to their normal life.

Tai Ji Quan™: Moving for Better Balance aims to improve balance, coordination, and stability using gentle, low-impact movements based on the forms of Tai Chi. This progressive, evidence-based, 24-week program has been shown to increase confidence, reduce the risk of falling, and enhance overall fitness for participants. All levels are welcome.

Walk with Ease, is proven to reduce the pain of arthritis and improve overall health. This six-week program is for those who need relief from joint pain or those who would just like to become more physically active. Participants are taught how to safely make physical activity part of their everyday lives. Walk with Ease is nationally recognized by the Centers for Disease Control and Prevention.

Enhance®Fitness is a proven community-based senior fitness and arthritis management program. It helps older adults become more active, energized, and empowered for independent living. This program has been nationally recognized by the Centers for Disease Control and Prevention, US Department of Health and Human Services, Administration for Community Living, and the National Council on Aging.

References

1. Gordon NF, Salmon RD, Wright BS, Faircloth GC, Reid KS, Gordon TL. Clinical Effectiveness of Lifestyle Health Coaching: Case Study of an Evidence-Based Program. *Am J Lifestyle Med*. 2016;11(2):153-166. Published 2016 Jul 7. doi:10.1177/1559827615592351
2. https://www.cdc.gov/NHHL-HP/about.htm
3. https://www.cdc.gov/NHHL-HP/docs/ww_technical_assistance_guidance.pdf