Wisconsin WISEWOMAN Provider Organization Implementation Manual

The creation of this document was made possible by cooperative agreement DP-23-0003 from the Centers for Disease Control and Prevention/Division for Heart Disease and Stroke Prevention/WISEWOMAN Program. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the CDC.

WISCONSIN DEPARTMENT of HEALTH SERVICES

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Purpose of this Manual

This manual is designed to give the provider organization the information, guidelines and resources needed to implement the WISEWOMAN program. Program staff are available to assist you by e-mail, phone, and on-site visits.

The programs and website links are identified as a public service to direct the reader to clinical resources, national guidelines and protocols, and relevant programmatic behavior change support information. The resources in this guide were current as of the publication date but are always subject to change.

Materials Development Overview and Guidance

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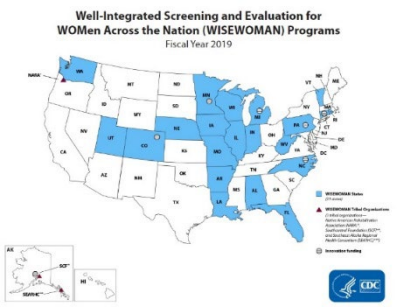
To increase name recognition and awareness of the WISEWOMAN Program, provider organizations are to use the name **WISEWOMAN** (all capital letters, as it is an acronym) on written materials.

Section 1: Program Overview

Introduction and Background



The **W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation **(WISEWOMAN)** Program was a result of the 1993 legislation that expanded the services offered within the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). In Wisconsin, NBCCEDP is called the Well Woman Program. The WISEWOMAN program helps women understand and reduce their risk for heart disease and stroke and promotes lasting heart-healthy lifestyles. Wisconsin has had a WISEWOMAN Program since 2008. The current cooperative agreement DP23-0003 extends from September 30, 2023 through September 29, 2028. The focus of this funding period is to expand WISEWOMAN services to NBCCEDP participants aged 35-64.

The NBCCEDP (called Well Woman in Wisconsin) and WISEWOMAN Program are "sister" programs offering two distinct health services. The table below gives a comparison of each program's health services.

TOPIC	NBCCEDP	WISEWOMAN
Year Funded	1990	1995
# of Funded Programs	50 states, District of Columbia, 5 territories and 12 tribal organizations	32 states and 2 tribal organizations and 1 territory
Program Administration	CDC's Division of Cancer Prevention and Control Program, Services Branch, National Center for Chronic Disease Prevention and Health Promotion	CDC's Division of Heart Disease and Stroke Prevention, Program Development and Services Branch
Program Focus	Early detection of breast and cervical cancer; population-based approaches to improve systems that increase high quality breast and cervical cancer screening and management consistent with current guidelines	Public health practice approach that focuses on delivery of evidence-based strategies to reduce risks, complications, and barriers to the prevention and control of heart disease and stroke

Services Provided	• Cancer screening:
	  ◦ Breast exam and mammography
	  ◦ Pap test
	  ◦ HPV testing
	• Diagnostic tests to pinpoint problems
	• Referrals to health care providers for medical management of conditions for women with abnormal or suspicious test results
	• Funds cannot be used for treatment
	• *In Wisconsin treatment may be provided by Well Woman Medicaid
		• CVD risk factor screening including:
		  ◦ Blood pressure, blood lipids
		  ◦ Blood glucose or A1c (if known to have diabetes), optional A1c to screen high-risk clients
		  ◦ Height/weight, BMI, waist circumference
		  ◦ Depression screening
		• CVD history, healthy lifestyle habits and readiness to change status assessments
		• Social services and support assessment
		• Bi-directional referrals
		• Hypertension management, evidence-based healthy behavior support services, and social services and support referrals
		• Funds cannot be used for treatment

TOPIC	NBCCEDP	WISEWOMAN
Where Clinical Services Are Provided	• Health care providers are recruited to offer regular pelvic, pap, and clinical breast exam screening tests and procedures • Providers must be willing to coordinate the care of women enrolled in the program from screening and clinical follow-up to a final diagnosis • Mammography facilities and clinical laboratories are recruited to provide services	• Health care providers are recruited from those offering NBCCEDP screening services • Health care facilities that employ clinical systems of care with demonstrated success in hypertension management, such as through use of electronic health records, medication therapy management, clinic staff training, team-based care, and quality assurance processes • Providers with staff skilled in providing patient-centered risk counseling and chronic disease management support

Burden of Cardiovascular Disease (CVD) in Wisconsin[1]

While showing moderate improvements in CVD mortality through medical treatment and evidence-based interventions, heart disease, stroke and diabetes remain among the leading causes of death and disability among women of all racial and ethnic groups in Wisconsin. Wisconsin data indicates that African Americans, Hispanic/Latinos and Native Americans are unequally burdened with the health effects of higher prevalence, morbidity, and mortality of CVD compared to White women.

Differences in access to primary care and preventive services, healthy and affordable food, transportation, safe and affordable housing, and other social determinants of health (SDoH) drive persistent CVD health disparities and inequities. For those with chronic conditions, socioeconomic factors are even mor crucial because they hinder lifestyle changes that are often first-line treatments for those conditions.

Hypertension – Hiding in Plain Sight

It is estimated that there are 1.3 million Wisconsin adults with hypertension, but less than half of them are in control.

- 44% are aware and treated but still not controlled
- 16% are aware that they have hypertension, but are untreated
- 40% are unaware that they even have hypertension

Diabetes/Pre-Diabetes

Two out of five adults are expected to develop type 2 diabetes in their lifetime. Nine percent of Wisconsin adults have been diagnosed with diabetes. One out of four adults with diabetes do not know they have it. Approximately one in three adults have prediabetes, but only about 10% have been diagnosed.

[1] https://www.dhs.wisconsin.gov/disease/chronic-disease.htm

Obesity/Physical Inactivity, Diet

Wisconsin obesity rates are consistent with the national average which indicates that 64% of adults are either overweight or obese.

In Wisconsin, little more than 5 out of 10 adults are meeting the physical activity recommendation of at least 150 minutes of moderate activity per week.

Only 1 out of 6 adults meet the recommended consumption of five or more fruits and vegetables a day.

Cigarette Smoking

While the use of tobacco is continuing to decrease, 17% of adults currently smoke. Smoking rates vary among racial and ethnic groups with Native Americans having the highest rate at 37% and Hispanic/Latinos recording the lowest at 12%.

WISEWOMAN (Purpose, Goals, Framework)

Individuals with heart disease and diabetes are at risk for serious complications, many of which can be prevented or delayed by early detection, medical control, self-management, and evidence-based healthy support services. The American Heart Association notes that clinicians should consider factors that affect individuals, such as the social determinants of health to inform treatment decisions and public health interventions that focus on advancing health equity.

The purpose of the WISEWOMAN program is to extend preventive health services and support activities to women who are participants in the Well Woman program. These extended preventive services include assessment of cardiovascular risk factors and provision of social services and support needs to reduce those risks through improved diet, physical activity, tobacco cessation, blood pressure monitoring and medication adherence support

Goals

The goals of the WISEWOMAN program are to:

- Reduce cardiovascular risk factors among high-risk women.
- Assure that cardiovascular screening is provided to women ages 35-64 who are participants in the Well Woman Program.
- Work with community-based organizations to provide evidence-based prevention services to those women in need of them through bi-directional referral and linkages.
- Improve the management and control of hypertension by integrating innovative health system-based approaches, such as team-based care, blood pressure self-monitoring (BPSM), pharmacy medication management programs, and strengthening community-clinical linkages.
- Gather and report program-related evaluation data, including impact measures.

Framework

The WISEWOMAN Program framework is based on the CDC's National Chronic Disease Prevention and Health Promotion Center's four domains; 1. Health Systems, 2. Community Clinical Linkages, 3. Epidemiology and Surveillance, and 4. Environmental Approaches. The WISEWOMAN Program activities are focused primarily in the health systems and community

clinical linkage domains. The Epidemiology and Surveillance and Environmental activities are intended to support all the program components.

Glossary of Key Terms for WISEWOMAN

Bi-directional Referral Process
Includes both the referral information going from the WISEWOMAN provider organization to the evidence-based healthy behavior support service and the information flowing back to the provider organization on patient participation and outcomes, e.g., weight loss, blood pressure change.

Blood Pressure Control
Having a Systolic Blood Pressure (SBP) below 130 mm Hg and a Diastolic Blood Pressure (DBP) below 80 mmHg for most people with hypertension. If multiple readings were taken in one visit, the average of all readings are used to obtain the final blood pressure value. With our adoption of the 2017 ACC guidelines, we are not focusing on the term "Uncontrolled HTN," rather we are looking more at thresholds and goals.

Community-Clinical Referral System
Includes any electronic, telephonic, fax-based, web-based, or paper-based system that tracks and receives data for all women who have been referred to a healthy behavior support service.

Healthy Behavior Support Service (HBSS)
Evidence-based interventions, e.g., Lifestyle Programs (LSP), Health Coaching (HC) and community resources.

Health Disparities
Differences in health outcomes and their determinants among segments of the population as defined by social, demographic, environmental, or geographic category.

High Blood Pressure (HBP)
Have a SBP of 130 mm Hg or higher or DBP of 80 mm Hg or higher. See ACC/AHA Task Force 2017 Guideline for Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults.

Integrated Office Visit (IOV)
An IOV is defined as providing WISEWOMAN and Well Woman screening services during the same office visit.

Known High Blood Pressure
Clients with multiple abnormal blood pressure values, e.g., SBP ≥130 mm Hg or DBP ≥80 mm Hg, recorded in the medical record with report of a provider diagnosis code for hypertension according to ICD 10-codes.

Multi-disciplinary team approach (also referred to as team-based care)
Each team includes the client, the client's primary care provider, and other non-physician professionals such as nurses, pharmacists, dietitians, social workers, health coaches, patient navigators, and/or community health workers. Team members provide process support such as team huddles and share responsibilities of care to complement the activities of the primary care provider. These responsibilities include medication management, patient follow-up and adherence, and self-management support

Policies or Systems
These includes laws, regulations, procedures, protocols, quality improvement processes, structures, arrangement, administrative actions, incentives, or voluntary practices of governments and other institutions to encourage a multi-disciplinary team approach to blood pressure control. These may be set by the provider, payer, Accountable Care Organizations, Medicaid, or Medicare.

Social Services and Support
The Social Services and Support Network is comprised of social service and support partner organizations which address social risk factors that inhibit a participant's involvement and completion of HBSS. Social services and support referrals are based on care coordination systems that link program participants to social services and support that contribute to optimal health outcomes. It should be noted that these do not always occur linearly but can occur at different phases of the program. These services should address the needs identified by the participant and care team members and include, but not be limited to, services that address social risk factors broadly within the programmatic jurisdiction, such as inadequate housing, food assistance, and lack of transportation

Undiagnosed Hypertension
Patients with multiple abnormal values, e.g., systolic blood pressure equal to or greater than 130 mmHg, or diastolic blood pressure equal to or greater than 80 mmHg recorded in the medical record without report of a provider diagnosis code ICD-10.

Validation of the Client's Diagnosis
CDC requires that the client's diagnosis of hypertension be evident by an ICD code(s) recorded in the client's medical record. The program cannot accept a client's self-reporting alone, even if she is on medication. In addition to hypertension validation, Wisconsin requires confirmation by ICD code(s) for diabetes, or high cholesterol, in addition to the client self-reporting. This could be either a previously established diagnosis or a new diagnosis based on their current screening results.

Section 2: Eligibility and Recruitment

Client Eligibility Criteria

To be eligible for the WISEWOMAN Program the woman must:

- Be enrolled in the Well Woman Program.
- Live in Wisconsin.
- Be age 35-64 years.
- Be under-insured or un-insured.
- Have income at or less than 250 percent of the federal poverty level and meet all Well Woman Program Income Eligibility Guidelines.
- Sign a WISEWOMAN Client Consent form.

Client Enrollment

The provider organization should develop plans to recruit clients from women who are new to the Well Woman Program and women who are scheduled for their Well Woman breast and cervical cancer screening office visit. The provider organization will initiate the enrollment form for the Well Woman Program.

Enrollment and participation in the WISEWOMAN Program are voluntary. Provider organizations should remember the core objective of WISEWOMAN is to help those clients who are in the contemplation stage of readiness to become informed and activated participants for cardiovascular disease risk reduction and self-management. WISEWOMAN is not just a screening program. The aim of WISEWOMAN should be clearly promoted before enrollment. If an eligible client indicates that she is not ready to engage in healthy behavior change (pre-contemplation stage) or that she might be interested in the future (contemplation stage) the provider should contact her in the future and not enroll the client into the WISEWOMAN Program.

Enrollment Requirements

For a client to be enrolled in the WISEWOMAN Program she must:

1. Be enrolled in the Well Woman Program.
2. Be willing to make changes in her lifestyle that support the prevention, delay, or control of cardiovascular, diabetes, and other chronic diseases.
3. Complete the WISEWOMAN Program Client Consent form.
4. Participate in an Integrated Office Visit (IOV) whenever possible with the Well Woman Program screening visit.
6. Complete all WISEWOMAN program assessments, including the Health History, Healthy Lifestyle and the Social Services and Support.
7. Be willing to be tested for cholesterol and blood glucose levels. The client must come to her appointment fasting for at least nine hours prior to the blood draw. If she has not fasted, her appointment must be rescheduled.
8. Have blood pressure, height, weight, and waist measured.

Client Recruitment Process

Reaching eligible and motivated women to take part in WISEWOMAN is critical to the success of the program. Women who are enrolled or eligible to be enrolled in Well Woman services can have additional preventative services through WISEWOMAN. Clients who enroll in WISEWOMAN **should be ready to make lifestyle behavior changes, no matter how small, to improve, prevent, delay, or control cardiovascular, diabetes, and other chronic diseases**. Remember, clients making small changes in eating and physical activity can improve their health and start down the path to living a healthy lifestyle for life. Recruitment strategies may include:

Health System

1. Review Electronic Medical Records to identify new clients.
2. Promote the WISEWOMAN program services when sending Well Woman annual rescreen reminder letter or email.
3. Place promotional and/or engaging tools and materials in waiting rooms.

Community

1. Participate in community events including health fairs, community forums and community organization meetings to promote Well Woman and WISEWOMAN services.
2. Use WISEWOMAN clients as ambassadors to promote the program to other women.

Media

1. Utilize radio talk shows to promote women's wellness screenings.
2. Submit personal stories to community newspapers.
3. Ask a community partner (grocery store or laundromat) to post program flyers.
4. Use these key months to promote program services:
    - January: Cervical Cancer Awareness
    - February: Heart Health Awareness
    - March: Nutrition Awareness
    - April: Minority Health
    - May: Mother's Day
    - October: Breast Cancer Awareness
    - November: Diabetes Awareness

Client Termination

The client must remain eligible with the Well Woman Program to maintain eligibility in the WISEWOMAN Program. If a client is terminated from the Well Woman Program for any reason, she is simultaneously terminated from the WISEWOMAN Program and is not eligible for any WISEWOMAN screening and Healthy Behavior Support Services. WISEWOMAN clients who are participating in an approved lifestyle program in which the reimbursement has been paid in full, e.g., Take Off Pounds Sensibly (TOPS), Diabetes Prevention Program (DPP), can continue until the completion of the lifestyle program service.

Section 3: Program Roles and Responsibilities

Wisconsin Department of Health Services

Program Management and Implementation

1. Develop and execute program contracts.
2. Establish partnerships that support WISEWOMAN cardiovascular disease management, healthy behavior support program and social and support services .
3. Monitor expenditure reports and authorize reimbursement based on accurate provider reports.
4. Develop guidelines and reporting requirements based on national CDC guidelines.
5. Maintain ongoing communications with provider organizations regarding annual work-plans, program policies, procedures, screening and diagnostic data, community scans and other issues as they arise.
6. Gather and document provider organization standardized protocols to:
   a. Provide team-based care.
   b. Identify hypertensive clients.
   c. Provide hypertension management
   d. Provide clinical, social services and support bi-directional referrals.
7. Provide WISEWOMAN Program materials (forms, publications).
8. Support provider assessment, planning, training, implementation, and sustainability of care teams to support CVD improvements.
9. Provide training, technical assistance, and professional education resources.
10. Set, monitor, and maintain quality assurance standards.
11. Maintain client confidentiality.
12. Maintain the WISEWOMAN Med-IT® data management system for program evaluation and reporting Minimum Data Elements (MDE) to CDC.
13. Provide educational tools, literature, and other educational materials as needed.
14. Support state and CDC-led program evaluation.

Provider Organization Team

All staff involved in implementing program services are considered a member of the team. Each team will depend on the provider organization and may include data entry, billing personnel, clinical intake staff, clinical screening staff (taking biometrics and clinical values, medical providers performing risk counseling and clinical follow-up (alert, abnormal, HTN management), and healthy behavior, and social services support services referral staff.

Training/Orientation/Continuing Education

1. Participate in WISEWOMAN Program orientation: training sessions, chronic disease management, e.g., blood pressure, diabetes, high cholesterol programs and other professional education opportunities as needed.
2. Maintain skills in conducting appropriate screening services such as use and maintenance of point-of-care testing and lab equipment, accurate blood pressure, waist measurement, biometric testing procedures, PHQ2 depression screening, social services and support assessment, and client-centered risk counseling using Motivational Interviewing (MI) techniques.
3. Meet licensing and certification requirements.
4. Document annually, training and/or CE activities that support WISEWOMAN program using the WISEWOMAN Provider Assurance and Training Checklist form.

Program Services

1. Perform medical evaluation (baseline, follow-up, and rescreening services) based on the National Clinical Care guidelines pertaining to blood pressure, cholesterol and diabetes, and lifestyle recommendations for obesity, diet, physical activity, and tobacco cessation. Utilize the client's screening information in subsequent years for comparison and to appropriately confer with the client.
2. Utilize client-centered risk counseling for all clients screened. This includes:
   a. Providing screening results both verbally and in writing.
   b. Explaining each client's health risk based on screening results,
   c. Providing bi-directional referrals to support medical follow-up, healthy behavior support services, social services and support needs and community resources to help reduce their risk of heart disease, stroke, and diabetes.

Alert and/or Abnormal Values Clinical Follow-up Services

1. Provide timely and appropriate medical follow-up (unless the client refuses) including fasting lab tests and/or diagnostic office visits as indicated by the assessment and screenings.
   a. Conduct Diagnostic Office Visits (DOV) for clients who have alert values immediately or within **seven calendar days.**
   b. Conduct optional DOVs for eligible clients who have abnormal values within a reasonable time frame.
   c. Refer clients with abnormal blood pressure to a hypertension management program and track their involvement.

Community—Clinical Linkages

Provide community and clinical bi-directional referrals for self-management and lifestyle change for clients at risk for cardiovascular disease, e.g., low cost or free medications, chronic disease management programs, medical home provider, evidence-based healthy behavior support interventions (lifestyle programs, health coaching), and social services and support needs e.g., food security, housing, childcare.

Program Data and Reports

Document all WISEWOMAN services using the Wisconsin program Med-IT® data management system within three working days after the client is seen or as soon as possible after receiving information from the health care provider.

1. Participate in quality assurance reviews and monitoring by the staff office.
2. Support state and Centers for Disease Control and Prevention (CDC)-led program evaluation as needed.

Provider Organization Manager/Coordinator

Staff responsible for overseeing the implementation of the WISEWOMAN Program by acting as the point of contact between the provider organization and the program state office staff.

Program Implementation

1. Assist state office in obtaining baseline performance measure data.
2. Assure the provider organization meets or shows significant progress toward meeting performance measures established by CDC.
3. Assure WISEWOMAN Program protocols for service delivery, bi-directional referrals, hypertension identification, management, and documentation are being followed.
4. Assure WISEWOMAN team staff have needed skills for effective program implementation.
5. Participate and support WISEWOMAN Program orientation and training sessions.
6. Assure that laboratory services used for screening meet Clinical Laboratory Improvement Amendments of 1998 (CLIA) or are CLIA-waived. Assure adherence to the manufacturer's guidelines in the use of laboratory technology.
7. Assure that providers are engaged in team-based care.

8. Assure providers are skilled in implementing appropriate screening services, such as use and maintenance of point-of-care testing and lab equipment, accurate blood pressure measurement, accurate biometric testing procedures, waist measurement, depression screening, and client-centered risk counseling using motivational interviewing techniques, etc.
9. Assure that all WISEWOMAN service data are entered into the Med-IT® data management system within 3 working days after the client is seen or as soon as possible after receiving information from the health care provider.

10 Document team members' training and orientation on WISEWOMAN program services, according to their role and responsibilities. Documentation must be recorded using the Program Assurances and Training Checklist form. Send copies to the state office staff annually.

11 Provide and regularly update staff contact information.

Client Recruitment

1. Recruit clients from the Well Woman Program for WISEWOMAN services.
2. Coordinate recruitment efforts to ensure that eligible women are enrolled in both programs.
3. Enroll clients for WISEWOMAN services using the Well Woman Enrollment form.
4. Support clients to return for baseline, follow-up screening, and annual rescreen visit(s).
   a. Schedule women for annual screenings at 12–18-month intervals. Provider must have the client's previous screening information (health history, healthy lifestyle and social services and support assessments, screening activity form, healthy behavior support service form, etc.) available for comparison and appropriately confer with the client.
   b. Schedule women for follow-up screening 4–6 weeks after completion of their healthy behavior support service.

Program Services

1. Assure client-centered risk counseling and health coaching are delivered in accordance with program protocols.
2. Assure clients are notified of whether recommended services are covered or not covered by the WISEWOMAN Program prior to receiving them, and clients are not billed for any service that is covered by the WISEWOMAN Program.

Alert and/or Abnormal Values Clinical Follow-Up Services

1. Assure clients receive timely and appropriate medical follow-up (unless the woman refuses), including fasting lab tests and/or diagnostic office visits as indicated by the assessment and screenings.
   a. Assure that clients who have alert values have access to medical evaluation and treatment **immediately** or **within seven calendar days.**
   b. Assure that eligible clients who have abnormal values are referred for a DOV if deemed necessary by the provider within a reasonable time frame.
   c. Assure documentation of three attempts to contact clients for follow-up of alert findings, DOV visits and/or selected healthy behavior support services before designating the client as "lost to follow-up."
2. Assure that clients with abnormal blood pressure are referred to a hypertension management program and track their involvement.
3. Assure case management services as needed.

Community - Clinical Linkages

1. Assure clients needing ongoing management are linked using bi-directional referral to free or low-cost ongoing medical treatment as indicated based on screening or DOV visit recommendations. Feedback should provide information on referral status and identified barriers to accessing those services**.**
2. Assist clients in gaining access to low-cost or free medications if they require medication therapy.
3. Assure and document whether clients in need of medication resources were linked to these services.

4. Conduct an annual community scan. The scan should identify existing resources in the community that support healthy lifestyle changes, social services and support needs, and clinical resources.
5. Utilize bi-directional referrals to community resources to help clients achieve their lifestyle behavior change goals.

Program Data and Reports

1. Assure client confidentiality and protection of medical records as required by law.
2. Assure WISEWOMAN data are entered in the WISEWOMAN Med-IT® data system within three working days after the client is seen or as soon as possible after receiving information from the health care provider. The WISEWOMAN Med-IT® data system is not an Electronic Medical Records system (EMR) and should not be used to gather any information beyond the required data elements used for cardiovascular screening surveillance.
3. Conduct "real time" quality and error data entry checks.
4. Review validation reports sent by the data manager. These validation reports capture any data errors and quality issues that should be reviewed and corrected by the provider organization before the WISEWOMAN Minimum Data Elements (MDEs) are submitted to the CDC twice each fiscal year.
5. Conduct program management activities using client data reports, e.g., WW Abnormal Assessment, LSP/HC, Clients By Provider, Social Services and Support. Providers can also run client data queries.

Section 4: Program Services

Types of Screenings

1. Baseline Screening: The initial client screening; establishes starting point for WISEWOMAN program.
2. Follow-Up Screening: Post healthy behavior support service (must occur within four to six weeks of completion of LSP/HC and not later than 11 months after the client's baseline screening or last rescreening).
3. Rescreening: Subsequent screening occurring 12–18 months after a client's baseline screening or last rescreening.

Program Delivery

WISEWOMAN baseline screening services begin a one-year cycle. The visit must occur as part of an IOV in conjunction with the Well Woman Program breast and cervical cancer early detection office visit. The rescreening visit should be an integrated office visit to the extent possible. WISEWOMAN funds may pay for limited additional office visits based on specific program criteria [see Section 8, Diagnostic and Hypertension Management Office Visits].

The provider organization must utilize bi-directional referrals to link clients who need additional diagnostic services, ongoing management, referral to low-cost or free medical care, medication assistance, or community-based social services and support resources as appropriate.

Referral to a Healthy Behavior Support Service (HBSS), health coaching, lifestyle programs, or other support services will be based on the readiness to change and risk factors. However, all clients must agree to receive at least one health coaching session. This session occurs at the IOV following risk counseling.

The WISEWOMAN CVD risk reduction efforts will focus on identifying undiagnosed hypertension, as well as hypertension control and management. This includes:

- Support for strategies such as team-based health care.
- Medication Therapy Management (MTM).
- Health systems changes (e.g., electronic health record tracking of clients with hypertension, blood pressure self-monitoring, medication management counseling, clinic staff training, and quality assurance processes).

The WISEWOMAN state office staff will work with the provider organization to document standard protocols for identification, management, and treatment of hypertension. The aim is to help the provider organization establish or strengthen practical methods to identify, track and improve control of hypertension. The protocol will vary depending on the capacity of the provider organization, but at a minimum should include:

- Team-based care with pharmacists, nutritionists, nurse educators, community health workers, or others.
- Use of electronic reporting and tracking of blood pressure trends.
- Self-measured blood pressure monitoring.
- Other strategies. [see Section 8, Diagnostic and Hypertension Management Office Visits].

Counseling Framework

The CDC WISEWOMAN Program has adopted the use of client-centered risk counseling and health coaching using motivational interviewing techniques. The primary goal of motivational interviewing is to guide the client in understanding the reasons for her mixed feelings about a desired behavior change and to identify internal motivations that will help her move past her hesitance or unwillingness to make a behavior change.

With motivational interviewing, the provider seeks to understand the client's perspective, recognizing that clients who need to make changes are at different levels of readiness to do so. It affirms that the client has the freedom to choose whether to make behavior changes and that the way changes are made is self-directed by the client. Motivational interviewing is non-judgmental and involves collaboration, not confrontation, evocation, not education, autonomy rather than authority, and exploration rather than explanation. Effective processes for change focus on goals that are client-identified, specific and realistic.

Motivational Interviewing

An initial motivational interviewing (MI) training is required for all WISEWOMAN staff who have no previous MI training. The one to two-day training may be provided through collaboration with state partners, e.g., Department of Health Services Chronic Disease Prevention and Tobacco Prevention and Control programs, and other local or state organizations.

Annually, WISEWOMAN team members' MI skills will be assessed by the provider organization and further training/refresher opportunities will be provided as needed. Providers are also strongly encouraged to access self-study online MI and health coaching training opportunities such as those listed below whenever possible. Some of these trainings offer CEUs and have pre- and post-assessments.

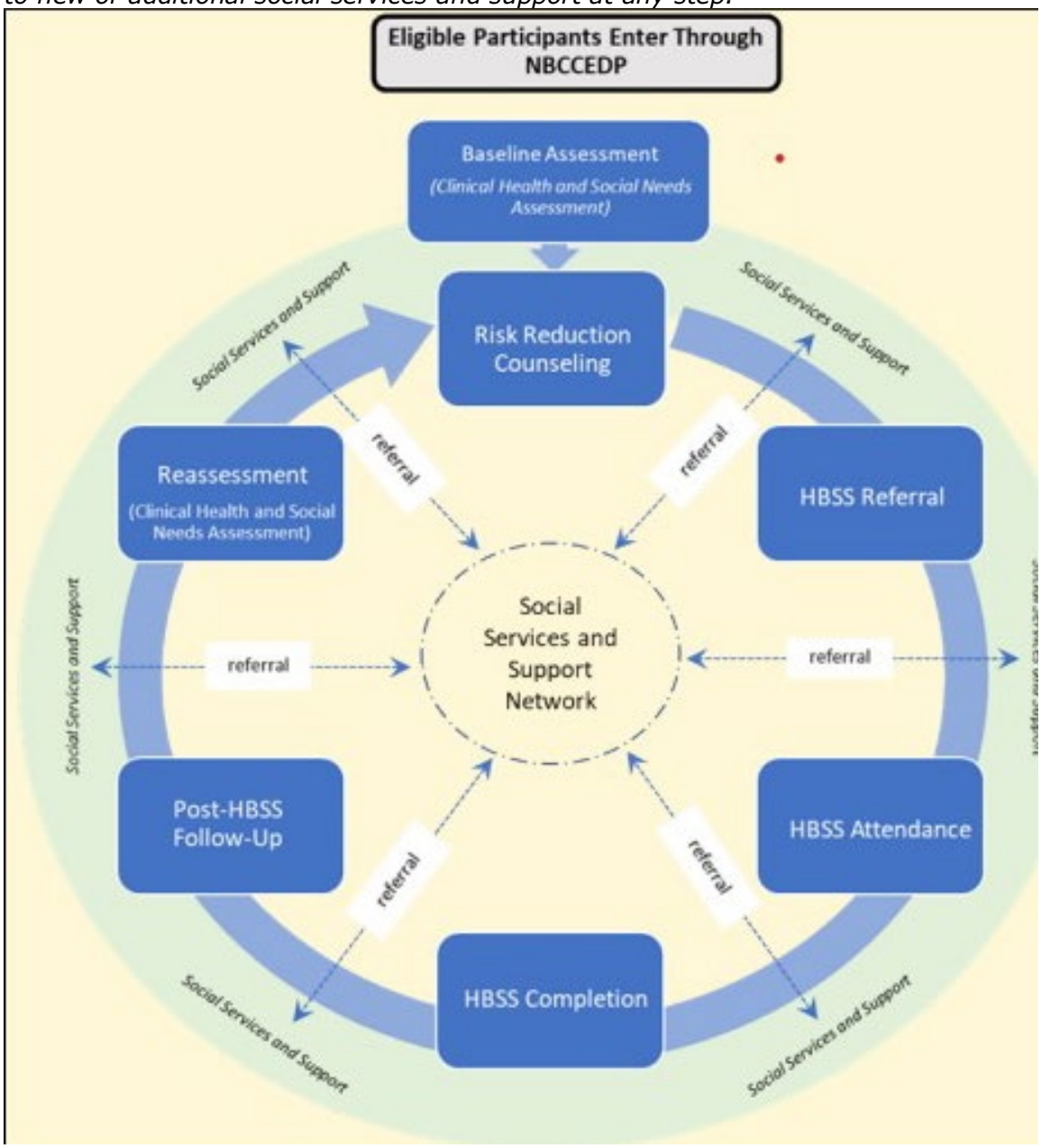
Motivational Interviewing Resources

- **University of Wisconsin, Center for Tobacco Research and Intervention**
  Free Videos for Health Care Providers
- **Copies of training videos you can access on YouTube**
  - Ineffective Physician
  - Effective Physician
  - Mr. Smith's Smoking Evolution
  - Coaching with Compassion (describes brain research that supports using a compassionate approach to teaching; also useful for MI spirit – 2½ minutes long).
- **Videos that are not specific to chronic disease management but show examples of MI and basic MI skills**
  - Scenario One (23 min.)
  - Scenario Two (16 min.)
  - Scenario Three (18 min.

Section 5 Service Flow

Flow Diagram for WISEWOMAN Program Services

WISEWOMAN is a direct services program, which requires providers to follow a specific program flow in order to ensure an appropriate identification, assessment, and referral of participants. The following program flow chart describes the process of providing WISEWOMAN CVD risk assessments and access to healthy behavior support services to those enrolled in the program. As the participant progresses through the program flow, the participants' clinical and social needs are assessed. *The participant may be referred to new or additional social services and support at any step.*



Office Appointment Process

1. Remind client of the appointment time, date, and location of the IOV at least one week prior to the appointment date. This will help to prompt the client to fast nine hours prior to the appointment for best results. The provider organization can use any of the following reminder methods:
   a. Phone
   b. Mailing
   c. Text messaging
2. The provider organization should also arrange to call the client on the telephone or text message her the day prior to the appointment date to again remind her of the time and location of the IOV and fasting needs.
3. If the client is on medication for blood pressure or cholesterol, the client is strongly advised to take her medication with a sip of water (non-caloric intake) prior to the appointment. However, the client should always comply with her doctor's directions related to taking her medication.
4. If needed, the provider organization should arrange for assistance with transportation and/or onsite childcare to help the client participate in WISEWOMAN services.
5. If the client does not keep her appointment, attempts to reach her to reschedule the appointment by phone, mail or text messaging should be implemented.

Screening - Integrated Office Visit (IOV)

Client Consent

The WISEWOMAN provider organization must have the client review and sign the WISEWOMAN client consent form prior to receiving services. The program consent form will give clients information on the services provided, including screening, rescreening, community resource and social services and support referrals, medical follow-up (if required), possible risks and the potential benefits of their involvement in the program, protection of identifiable information, and use of information for monitoring and evaluation. When a client signs the form, she is acknowledging that she understands the WISEWOMAN services and has knowingly agreed to participate in the program. A copy of the form should be given to the client.

Health Risk Assessments (Health History and Healthy Lifestyle and Social Services and Support Assessment)

The cardiovascular health, lifestyle and social services and support assessments are completed and entered in the program data system at baseline, rescreening, and follow-up screening visits. Social services and support assessments can occur at any encounter visit to ensure clients have access to identified needs.

For the cardiovascular conditions, in addition to the client self-reporting, the program will need to know whether the client has a confirmed diagnosis of either hypertension, diabetes, or high cholesterol, evident by an ICD code recorded in the client's medical record. This could be either a new diagnosis or an already established diagnosis.

Health risk assessments are used to provide data to calculate individual cardiovascular risk and support the patient-centered risk counseling interaction and health coaching process and any socioeconomic factors that may impact the client's ability to address her cardiovascular risks. The assessments also establish baseline health behaviors and practices to measure any changes at follow-up screening and rescreening. The following forms should be used: WISEWOMAN Client Health History Assessment form, WISEWOMAN Client Healthy Lifestyle Assessment form, and WISEWOMAN Social Services and Support Assessment form . The information should be entered in the Med-IT® data management system.

The WISEWOMAN provider organization must make sure that the client has answered all the relevant questions during the assessment intake as specifically as possible so the answers will provide meaningful program data. Answers such as "don't know," "don't want to answer," or those left blank do little to contribute to outcome data analysis and overall evaluation of the program. If answers seem inappropriate, conduct further clarification with the client to attain a more accurate response. Responses to the health and social services and support risk assessments must be available to the WISEWOMAN screening provider at the time of the IOV.

Clinical Screening Measurements

Ideally the client will get her blood tests and lab results the same day, during the Integrated Office Visit. If "point of service" testing is not available, the provider may have the client's blood drawn prior to the visit. However, the provider still must comply with conducting IOV procedures, (e.g., reviewing health history, healthy lifestyle, performing social services and support, and tobacco assessments, following lab and clinical procedures, patient-centered risk counseling, and making appropriate referrals as needed) all at the same visit. **Fasting tests are required**. Clients should fast a minimum of nine hours prior to fasting tests. If fasting lab procedures are performed prior to the WISEWOMAN screening office visit, the labs must have been completed within the past 30 days. However, for the A1c test, values can be collected anytime within the past 90 days.

Time Frame for Completing Screening Services

Since all screening measurements and assessments are to be used to determine participation in healthy behavior support service linkages and/or bi-directional referrals to community-based resources, it is expected that all labs and other screening services will be completed within **as short a time frame as possible**.

The medical provider will assess the following during the IOV using the WISEWOMAN Screening Activity form. The information should be entered in the Med-IT® data management system.

1. Client Health History (CVD risk or current disease level, medication adherence, aspirin therapy, blood pressure self-monitoring).
2. Healthy Lifestyle (food groups, eating patterns, physical activity levels, tobacco use, alcohol use, depression).
3. Social Services and Support (Socioeconomic factors impacting CVD and lifestyle changes).
4. Blood Lipids: CPT code: Fasting 80061 (lipid profile). *
5. Blood Glucose: CPT code: Fasting 82947.
6. A1c: CPT code: 83036.
7. Height and weight measurements to calculate Body Mass Index (BMI) and waist measurement.
8. At least two blood pressure measurements separated by one to two minutes with the average recorded. See Section 7 Hypertension Management-Checklist for Accurate Measurement of Blood Pressure.

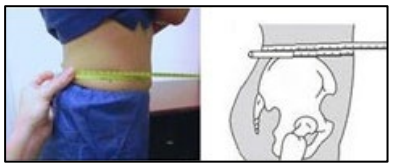
*__If Cholestech cannot calculate an LDL, the provider must do an LDL direct lab test. The lab results must be entered into the program data base and communicated to the client.__

Waist Circumference[2] (Optional)

According to the National Institutes of Health, waist circumference is associated with obesity or overweight and insulin sensitivity. Waist circumference can be used as a screening tool but is not diagnostic of BMI or the health of an individual. If most of the fat is around the waist rather than the hips, the client is at a higher risk of heart disease and type 2 diabetes. Although waist circumference and BMI are interrelated, waist circumference provides an independent prediction of risk over and above that of BMI.

[2] NIH "The Practical Guide- Identification, Evaluation, and Treatment of Overweight and Obesity in Adults"

The waist circumference measurement is particularly useful in clients who are categorized as normal or overweight in terms of BMI. The risk goes up in women who have a waist size that is greater than 35 inches (88 cm).To correctly measure waist circumference:



1. Have the client stand, locate the upper hip bone and the top of the right iliac crest.
2. Place the tape in a horizontal plane around the client's bare abdomen at the level of the iliac crest.
3. Make sure tape is horizontal around the waist and is parallel to the floor.
4. Keep the tape snug around the waist, but not compressing the skin.
5. The measurement is made at the end of a normal expiration (after she breathes out).

Waist Circumference Resources

- Waist Circumference Measurement Guidelines
- Navy Body Composition Assessment (BCA) (You will need to fast forward to the waist measurement portion of the video.)

Depression Screening[3]

Depression is one of the leading causes of disability in adults. Depression has a major impact on a person's quality of life and can increase the risk of suicide. It can make it more difficult for people to care for other health conditions they may have. Depression also can affect family members, especially children. The U.S. Preventive Services Task Force recommends screening in adolescents and adults in clinical practices that have systems in place to ensure accurate diagnosis, effective treatment, and follow-up. The Patient Health Questionnaire PHQ2 and PHQ9 are commonly used validated screening tools. The goal of screening is to identify WISEWOMAN clients who may have depression. The PHQ-2 is a short questionnaire that asks clients to: report how often over the past two weeks they are bothered by:

a. problems such as a lack of pleasure in doing things.
b. sad or hopeless feelings.
c. sleep problems.
d. trouble concentrating.

The PHQ-2 also asks whether these problems are having an impact on the client's ability to carry out daily activities.

The responses to each of these questions are given a score as follows:

Score	Frequency
0	**Not at all**
1	**Several days**
2	**More than half**
3	**Nearly every day**

Interpretation

The PHQ-2 score is obtained by adding the score for each question, then totaling points. A PHQ-2 score ranges from 0-6. A score of 3 is considered as the optimal cut point when using the PHQ-2 to screen for depression. If the PHQ-2 screening is positive for depression, the client should be given a PHQ-9 screening. If this screening is positive, the provider organization should have resources in place to refer the client for further evaluation.

The WISEWOMAN provider will review the screening results, provide risk counseling, arrange for medication needs, and make necessary referrals. This may include the need for medical follow-up for hypertension management or referrals for a diagnostic office visit or to an outside

[3] https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/depression-in-adults-screening

provider for abnormal screening results [see Section 6 Follow-up on the WISEWOMAN Screening Activity form].

The provider organization must have an effective referral system in place to ensure access to appropriate clinical-community resources [see Details in Sections 8 and 9].

Section 6: Risk Counseling

Risk Counseling Using Motivational Interviewing

Client-centered risk counseling is a major component of the WISEWOMAN program. Risk counseling skillfully provided can help WISEWOMAN participants become effective and informed managers of their health and health care. Risk counseling should be conducted by the medical provider.

Studies indicate that clients who are engaged and actively participate in their own care have better health outcomes. During the face-to-face counseling, the medical provider should:

1. Consider the client's language, health literacy, and cultural background in the interaction.
2. Discuss the client's screening health risk and social services and support assessment results using the WISEWOMAN Screening and Healthy Behavior Support guide to give the results in writing.
3. Assure the client understands her cardiovascular risk(s).
4. Determine the client's readiness to make behavior change(s).[See the WISEWOMAN Stages of Change Tip sheet.
5. Ask the client what changes she is ready to make.
6. The health coach meets with the client to:
   a. Conduct the initial Healthy Behavior Support Service by collaboratively identifying a SMART goal and action steps to support the client's priority goal (e.g., nutrition, physical activity, smoking cessation, blood pressure control, weight loss, reducing risk of diabetes).[See Section 11, Healthy Behavior Support Services].
   b. Facilitate access to Healthy Behavior Support Service option(s) (Lifestyle Program or Health Coaching) through bi-directional referral and reporting.
   c. Facilitate access to clinical services e.g., hypertension management, diagnostic office visit, smoking cessation, social services, and support resources and indicate any referrals.
   d. Indicate which Healthy Behavior Support Service option the client selected.

Some conversation comments/questions to get you started.

- *Today's screening will help you identify your risks at this time. Let's review the results of your screening.*
- *If it is OK with you, I would like to explain a little more about your results.*
- *What do these results mean to you?*

The information should be entered in the Med-IT® data management system.

Section 7: Hypertension Management

AHA/ACC 2017 Guidelines

The 2017 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults changes the definition of hypertension, which is now any systolic blood pressure measurement of 130 mm Hg or higher, or any diastolic blood pressure measurement of 80 mm Hg or higher.[4] Because the new definition sets a lower threshold for hypertension diagnosis, 46% of US adults will be classified as having hypertension vs 32% based on the JNC7 definition. Other statistics in the updated guidelines show that only about 20% of people with hypertension followed their treatment plan well enough to improve, and up to 25% of them fail even to fill their initial prescription.

The 2017 Guidelines are intended to define practices in meeting the needs of patients in most, but not all, circumstances and should not replace clinical judgment. The guidelines focus on targets and goal-oriented blood pressure treatment that are based on the patient's health history, health status, and risk assessment. Several different blood pressure thresholds and goals for the long-term treatment of hypertension with pharmacological therapy are recommended.

Blood Pressure Categories

American Heart Association | American Stroke Association

BLOOD PRESSURE CATEGORY	SYSTOLIC mm Hg (upper number)		DIASTOLIC mm Hg (lower number)
NORMAL	LESS THAN 120	and	LESS THAN 80
ELEVATED	120 – 129	and	LESS THAN 80
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 1	130 – 139	or	80 – 89
HIGH BLOOD PRESSURE (HYPERTENSION) STAGE 2	140 OR HIGHER	or	90 OR HIGHER
HYPERTENSIVE CRISIS (consult your doctor immediately)	HIGHER THAN 180	and/or	HIGHER THAN 120

heart.org/bplevels

Focus of 2017 Guidelines

1. New definitions for hypertension
2. New blood pressure goals
3. New targets for people with comorbidities
4. Updated recommendations for special populations
5. Accuracy of measurement
6. Benefits of lifestyle therapy
7. New recommendations for treatment protocols and follow-up
8. Pharmacological recommendations
9. Quality improvement activities and system changes
10. Assessing the 10-year risk for heart disease and stroke using the atherosclerotic cardiovascular disease risk calculator
11. Self-monitoring of blood pressure with clinical support
12. Team-based care interventions
13. Motivational techniques and 1:1 counseling
14. Value of social and community support services
15. Information technology-based strategies to promote control

[4] 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

Validation of the Client's Diagnosis

In addition to the client self-reporting, the program will need to know whether the client has a confirmed diagnosis of hypertension, evident by an ICD code recorded in the client's medical record. This could be either a new diagnosis or an already established diagnosis.

Recommendations for Accurate Blood Pressure Measurements

Accurate blood pressure measurements are critical for detecting and managing high blood pressure.

Multiple outside forces can contribute to blood pressure variability. The following is a list of common actions that result in inaccurate blood pressure readings that can easily be controlled.[5]

Cause	Systolic Effect
1. The cuff is too small (one of the most common causes of error in clinical practice).	+10-40 mmHg
2. The cuff is too large (one of the most common causes of error in clinical practice).	-5-25 mmHg
3. The artery line is not centered.	+4-6 mmHg
4. The arm is above heart level.	+2 mmHg per inch
5. The arm is below heart level.	- 2 mmHg per inch
6. Patient's feet are not flat on the floor.	+5-15 mmHg
7. Patient's back is not supported.	+5-15 mmHg
8. Legs crossed	+ 5-8 mmHg

Cause	Systolic Effect
9. Patient in pain	+10-30 mmHg
10. Patient talking	+10-15 mmHg
11. Patient has full bladder.	+10-15 mmHg
12. Patient has difficulty breathing.	+5-8 mmHg
13. Patient does not rest 3-5 minutes.	+10-20 mmHg
14. White Coat Syndrome	+11-20 mmHg
15. Tobacco or caffeine use	+6-11 mmHg
16. Cuff is placed over clothing.	+/-10-40 mmHg

Aneroid devices that are out of calibration most often read too low.

[5] Improving the Screening, Prevention & Management of Hypertension – An Implementation Tool For Clinic Practice Teams, Washington State Department of Health

Checklist for Accurate Measurement of Blood Pressure[6]

Key Steps for Proper BP Measurements	Specific Instructions
Step 1: Properly prepare the patient.	1. Have the patient relax, sitting in a chair (feet on floor), back supported for >5 minutes. 2. The patient should avoid caffeine, exercise, and smoking for at least 30 minutes before measurement. 3. Ensure patient has emptied his/her bladder. 4. Neither the patient nor the observer should talk during the rest period or during the measurement. 5. Remove all clothing covering the location of cuff placement. 6. Measurement made while the patient is sitting or lying on an examining table do not fulfill these criteria.
Step 2: Use the proper techniques for BP measurements.	1. Use a BP measure device that has been validated, and make sure that the device is calibrated periodically. 2. Support the patient's bare arm, (e.g., resting on a desk palm up). 3. Position the middle of the cuff on the patient's upper arm at the level of the right atrium (the midpoint of the sternum). 4. Use the correct cuff size, such that the bladder encircles 80% of the arm, and note if a larger – or smaller-than-normal cuff size is used. 5. Either the stethoscope diaphragm or bell may be used for auscultatory readings.
Step 3: Take the proper measurements needed for diagnosis and treatment of elevated BP/hypertension.	1. At the first visit, record BP in both arms. Use the arm that gives the higher reading for subsequent readings. 2. Separate repeated measurement by 1–2 minutes. 3. For auscultatory determinations use a palpated estimate of radial pulse obliteration pressure to estimate SBP. Inflate the cuff 20-30 mm Hg above this level for an auscultatory determination of the BP level.
Step 4: Properly document accurate BP readings.	1. Record SBP and DBP. If using the auscultatory technique, record SBP and DBP as onset of the first Korotkoff sound and disappearance of all Korotkoff sounds, respectively, using the nearest even number. 2. Note the time of most recent BP medication taken before measurements.
Step 5: Average the readings.	1. Use an average of $\geq$ 2 readings obtained on multiple occasions to estimate the individual's level of BP.
Step 6: Provide BP readings to patient.	1. Provide clients the SBP/DBP readings both verbally and in writing.

Recommended Cuff Sizes

Recommended cuff sizes	
Arm Circumference	**Adult Cuff Size**
22 to 26 cm	Small adult (12x22 cm)
27 to 34 cm	Adult (16x30 cm)
35 to 44 cm	Large adult (16x36 cm)
45 to 52 cm	Adult thigh (16x42 cm)

Manufacturers' cuff sizes differ widely as to what they consider a large/small size, etc. Providers are encouraged not to rely solely on the manufactures' markings as to cuff size. Instead, they should measure the bladder of each cuff before placing it into initial service.

[6] 2017ACC/AHA/AAPA/ABCA/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults

Accurate Blood Pressure Measurement Resources

- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
- MetaStar Health Care Improvement
- American Medical Association
- Target: BP
- Maine Health
  - Wisconsin Department of Health Service web portal provides resources and information on cardiac health initiatives in Wisconsin.
  - Validated Blood Pressure self-management blood pressure devices.
  - https://www.validatebp.org/
-

Undiagnosed Hypertension Resources

Million Hearts Undiagnosed Hypertension Partner Toolkit

Other Resources

Screening and Management of Diabetes

https://diabetes.org/

Diagnosis and management of diabetes should be done according to the current American Diabetes Association's Standards of Medical Care for Diabetes Mellitus. These guidelines are reviewed and updated annually.

Screening and Management of Cholesterol

Diagnosis and management of blood cholesterol should be done according to the 2018 Cholesterol Clinical Practice Guidelines.
2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

Section 8: Referrals for Diagnostic, Hypertension Management, and Medical Follow-Up Office Visits

Diagnostic Office Visit (DOV)(s) Protocols

1. The WISEWOMAN medical provider will review the results from the Health History, Healthy Lifestyle Assessment, blood pressure assessment, anthropometric screening, and lab values to determine the client's current health status and whether there is a need for a DOV referral for medical follow-up for abnormal screening results, or for additional office visits for hypertension management.
2. Diagnostic Office Visits are covered only for limited circumstances. The medical provider will determine the need for follow-up visits based on criteria as indicated in this section.

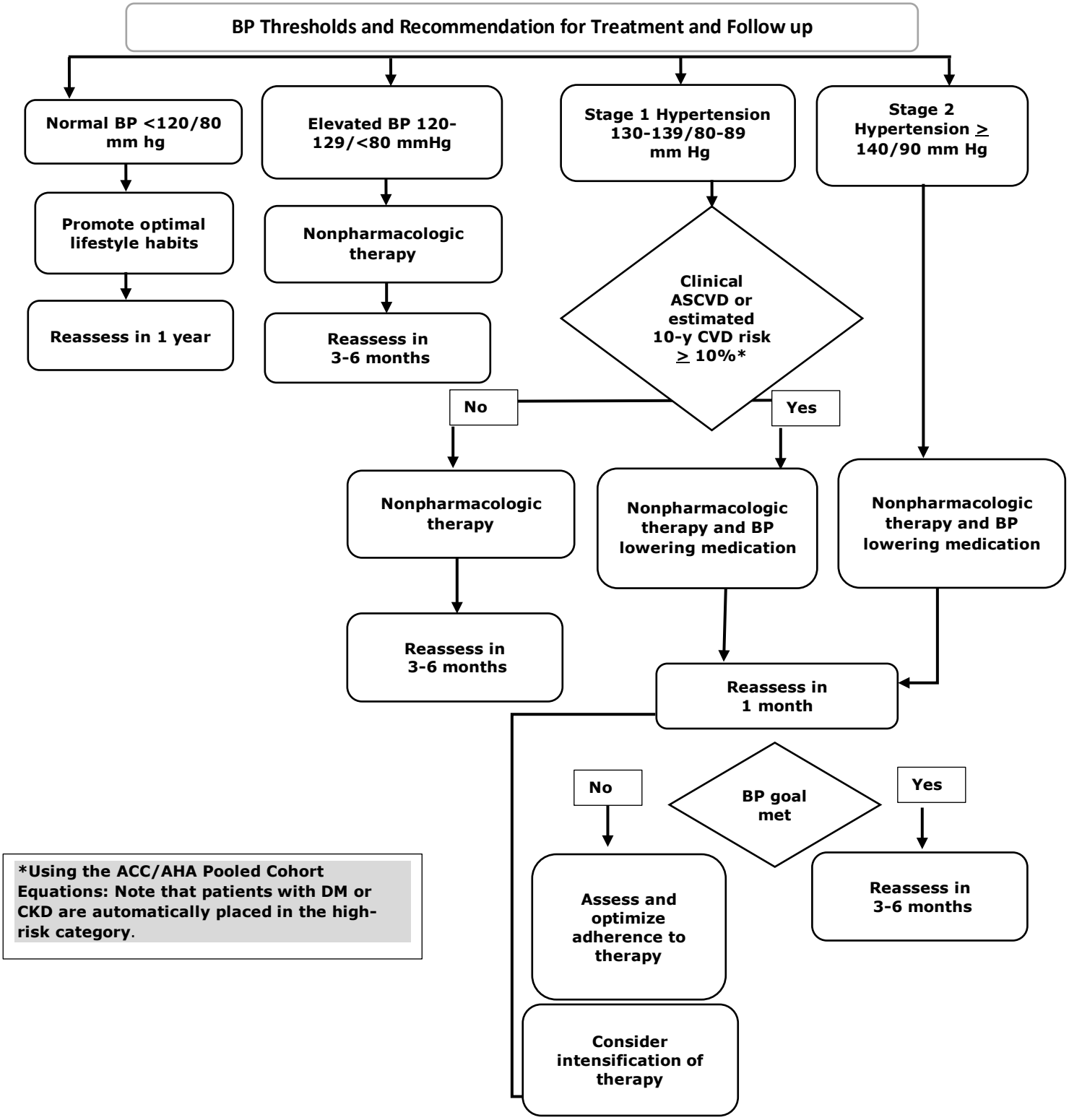
Mandatory Visits for Alerts

WISEWOMAN alert laboratory values indicate the need for immediate attention. They are based on current clinical practice and risk to the individual's health. The provider organization must ensure these clients receive medical evaluation and treatment either **immediately or within seven calendar days** of the alert measurement, in accordance with national standards and the judgment of the WISEWOMAN medical provider.

1. Alert Values
   a. Blood Pressure alert values: systolic >180 mm Hg or diastolic >120 mm Hg.
2. The WISEWOMAN diagnostic medical provider will conduct the diagnostic office visit for clients with **alert** values and document in the Med-IT® database. See the Diagnostic and Hypertension Management Referral form.
3. If the client cannot arrange to be seen by a medical provider within the allotted seven calendar day period, case management services must be implemented with attempts to get the client to return for follow-up. Case management services must be documented in the Med-IT® database in the client's Cycle Notes. See Case Management.
   a. Case management is a short-term intensive support service used to ensure that clients receive appropriate and timely medical care. Case management also assists clients in understanding the treatment regimen, obtaining affordable medication, and attending medical appointments and/or reducing other barriers.
4. If the client refuses a diagnostic office visit for alert values, the medical provider will inform the client of the benefits of receiving, and the health consequences of refusing, follow-up. The provider will complete the case management notes and enter in the Med-IT® database in the client's Recall Activity screen.

Referral Hypertension Protocols[7]

1. The WISEWOMAN medical provider will determine whether the client needs a referral for abnormal blood pressure according to the following blood pressure readings:



[7] 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults-Guidelines Made Simple, A Selection of Tables and Figures

2. Providers are expected to conduct additional services for hypertension management using established protocols and strategies, (e.g., medication therapy management, blood pressure self-monitoring).
3. The program will cover up to five hypertension management office visits, as well as up to five health coaching sessions.
4. The goal is to achieve the client's individual goal as discussed with the provider. This is usually less than 130/80.
5. In addition, the program will provide health coaching or lifestyle programs for health behavior modification for clients who have abnormal blood pressure.
6. Providers who conduct a Therapeutic Lifestyle Change (TLC) discussion during the visit can record the intervention as a health coaching encounter if the following activities take place:
   a. Discussion is done in the Spirit of MI and documentation supports the conversations addressing progress, barriers, and community resources.
   b. Conversation is at least 10-15 minutes.
   c. The client identifies or re-commits to a SMART goal.
7. The WISEWOMAN diagnostic medical provider will conduct the hypertension management visits and document them in the Med-IT® database. See the Diagnostic and Hypertension Management Referral form.
8. If the client receives a bi-directional referral back to her own provider for hypertension management, or referral for abnormal screening results, the medical system to which the woman is referred is then responsible for providing medical follow-up and ensuring treatment.
9. If the client refuses follow-up visits for hypertension management, or referral for abnormal screening results, the medical provider will inform the client of the benefits of receiving, and the health consequences of refusing, follow-up.

Diabetes and Hypertension Considerations

The American Diabetes Association Standards of Medical Care in Diabetes indicates the following:

1. For clients with diabetes and hypertension, blood pressure targets should be individualized through a shared decision-making process that addresses cardiovascular risk, potential adverse effects of antihypertensive medications and patient preference.
2. For individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease or 10-year ASCVD risk of > 15%), a blood pressure target of <130/80 mm Hg may be appropriate if it can be safely attained.
3. For individuals with diabetes and hypertension at lower risk for cardiovascular disease (10-year ASCVD risk <15%),typically treat to a blood pressure target of <140/90 mmHg.
4. ADA also recommends that all hypertensive clients with diabetes should monitor their blood pressure at home.
5. Refer to the ADA Clinical Practice Guidelines for recommendations and changes.

Hypertension Management Strategies

Improving control of hypertension is a major focus of the WISEWOMAN Program. Providers are expected to conduct additional preventive services for clients who need hypertension management by using established protocols or by strengthening their existing hypertension control protocols.

The following are examples of a wide variety of available evidence-based hypertension management resources.

Strategy	Description	Examples
Delivery system design	Processes to be efficient for clients and staff; consistently deliver quality care, reliably document care	Prescribing anti-hypertensive medication consistent with national guidelines Streamlining patient registration processes to minimize waiting time

Self-management support	Activities to increase clients' skills in managing their own health	Teaching clients how to measure and track their blood pressure
Decision support	Automated messages for clinicians	Using computer-generated prompts to remind a clinician that a patient's blood pressure is abnormal and to consider adjusting medication
Health information technology (Health IT) *Note: Health IT can be used to implement decision support or delivery system design.*	Storage, retrieval, sharing and use of health care information and data for communication and decision-making	Use Health IT reports to determine which clients with hypertension are not well controlled Use Health IT reports to determine which clients have not returned for follow-up

Approaches Shown to be Effective in Controlling Hypertension

Blood Pressure Self-Monitoring (BPSM)

BPSM are blood pressure readings taken by the client outside of a clinical setting. Readings are shared with the medical provider who then provides advice or makes needed adjustments in medications.

Blood pressure readings taken in community settings (church, pharmacy, etc.) do not fall under the definition of BPSM. Clients selecting BPSM must agree to the intervention guidelines and sign the WISEWOMAN Client Home Blood Pressure Self-Monitoring Agreement form.

Blood Pressure Self-Monitoring Resources

- **Target: BP**
  - **How to Use Your Home Blood Pressure Monitor**
    This patient-friendly video from the National Association of Community Health Centers (NACHC) outlines clear instructions for using home blood pressure monitors to measure and track blood pressure. The video is also available in Spanish and can be downloaded in English or in Spanish.
  - **SMBP Training Video**
    This educational video from the American Medical Association helps train care teams and clients on how to properly measure blood pressure. This video is also available in Spanish.
  - **Using Self-Measured Blood Pressure (SMBP) to Diagnose and Manage High Blood Pressure**
    This webinar reviews the benefits of using SMBP, illustrates techniques and protocols to help clients self-monitor their blood pressure, and describes how clinicians can set up SMBP programs in their practice.
  - **Self-Measured Blood Pressure Monitoring to Control Hypertension**
    This Medscape video highlights ways health care providers can help clients manage hypertension. (To view the video, you may have to register with Medscape.)
  - **SMBP Training Wisconsin Department of Health Services** training videos for providers and patients
  - https://www.dhs.wisconsin.gov/disease/chronic-training.htm

Team-Based Care (TBC)

The Community Prevention Task Force recommends TBC to improve BP control. Team-Based Care is a health system or an organizational intervention that integrates a multidisciplinary team to improve the quality of hypertension care for clients. Team-based care is established by adding new staff or changing the roles of existing staff to work with a primary care provider. Each team includes the client, the client's primary care provider and other professionals such

as nurses, pharmacists, dietitians, social workers, and community health workers. Team members provide process support and share responsibilities of hypertension care to complement activities of the primary care provider. These responsibilities include medication management, patient follow-up, and adherence and self-management support. [8]

Team-Based Care Resources

- Centers for Disease Control and Prevention - Promoting Team-Based Care to Improve High Blood Pressure Control https://www.cdc.gov/dhdsp/pubs/team-based-care.htm
- World Health Organization - HEARTS Technical package for cardiovascular disease management in primary health care — Team-Based Care

Medication Adherence and Access Support

Medication adherence refers to the client's act of conforming to the recommendation made by the provider with respect to timing, dosage and frequency of medication taking. Medication adherence is associated with increased control, lower hospitalization rates, improved cost benefits, improved quality of care, and improved health outcomes. Provider client discussions should also include explaining what the medication is intended to do, tolerance and appropriateness of medication, and ability to access affordable medication.

Medication Adherence and Access Resources

Million Hearts

This document provides tools and implementation guides to support evidence and practice-based medication adherence strategies for health practitioners. The website also includes an interactive module developed by the American Medical Association. The module helps providers identify and address medication nonadherence and change behaviors. Patient self-help videos on how to take medicine as directed, and tips for taking blood pressure medicines, are provided in English and Spanish.

Other Abnormal Screening/Laboratory Values

Diagnostic visits for abnormal findings are covered only under limited circumstances. The diagnostic office visit for abnormal findings is not intended to monitor the status of treatment or to provide patient education. WISEWOMEN abnormal values are laboratory results that indicate the need for follow-up attention. They are based on current clinical practice and risk to the individual's health. There are exceptions for hypertension management**.**

1. The WISEWOMAN Program will reimburse for **one** diagnostic office visit for abnormal findings when based on program-specified criteria. The diagnostic office visit may only be reimbursed when **one or both of the following two situations occur**:
   a. Further evaluation is needed to confirm whether the client has a new diagnosis of high blood pressure, dyslipidemia, or diabetes. The diagnosis must be validated (ICD code(s) in the client's medical record.
   b. Further evaluation is needed to determine if medication or other more immediate treatment is needed that could not be appropriately assessed/done during the IOV.
2. Lipids Abnormal Values – may refer for one DOV at provider's discretion for LDL ≥130 mg/dL.
   *If the Cholestech cannot calculate an LDL, the provider must do an LDL direct lab test. The lab results must be entered into the WISEWOMAN Med-IT® base and communicated to the client. This may or may not necessitate a DOV visit.
3. Blood Sugar Abnormal Values— may refer for one DOV at provider's discretion to assess a new diagnosis for diabetes.
   a. Fasting blood glucose value ≥ 126 mg/dL

[8] https://www.thecommunityguide.org/findings/cardiovascular-disease-team-based-care-improve-blood-pressure-control

b. A1c ≥ 6.5%

4. Stage 1 or higher blood pressure measurements status should be referred for hypertension management. Client may have up to five office visits for hypertension management.

Abnormal Values That Do Not Qualify for a Diagnostic Office Visit

Clients with impaired fasting glucose or the elevated blood pressure designation according to the 2017 Hypertension Guidelines, DO **NOT** qualify for a DOV and should:

1. Receive risk factor counseling/education during the IOV.
2. Be referred for a Healthy Behavior Support Service option.
3. Be referred to a medical provider or community resources if in need of periodic blood glucose and/or blood pressure monitoring.

Provider Organization Responsibilities for Diagnostic or Hypertension Management Referral

The WISEWOMAN medical provider will determine whether the client needs a referral for a **diagnostic office visit** according to the following:

Normal Values	Abnormal Values	Alert/Crisis Values
Client **does not** receive a referral for a WISEWOMAN DOV.	The WISEWOMAN medical provider **may arrange** for one DOV appointment according to specified criteria for the client at his/her discretion. This visit must be completed within a reasonable time frame of the IOV. EXCEPTIONS: Clients with abnormal blood pressure (Stage 1 or higher) should be referred (unless they refuse) to a hypertension management program. **There may be exceptions to this based on the health care provider's clinical judgement**. Up to five office visits are allowed for this follow-up.	Client **will receive** a referral for a WISEWOMAN DOV. This visit must be completed immediately or within **one week (seven calendar days)** of the IOV.

Reimbursement guidelines are not a substitute for clinical guidelines or clinical judgment. Clients with disease level blood pressure or lab values needing ongoing care must be referred for further diagnostic services or for a medical service.

If the WISEWOMAN medical provider wants to conduct a DOV for a client with a combination of abnormal values that do not meet the criteria specified above, they may contact the WISEWOMAN program service delivery coordinator for guidance. The service delivery coordinator will consult with the WISEWOMAN medical director for possible authorization for further testing on a case-by-case basis.

Service Provider Responsibilities at the Diagnostic and/or Hypertension Management Office Visit

The WISEWOMAN diagnostic medical provider will:

1. Review the clinical information in the client's screening activity reporting module and provide additional WISEWOMAN covered assessment services and diagnostic tests as needed. See Diagnostic and Hypertension Management Referral.
2. Implement case management services if the client does not show up for the DOV or the hypertension management visit to determine reason(s) and attempt to get the client to come to the appointment.
3. If needed, help with obtaining access to prescribed medications, supplies and/or linkages for their continuing follow-up care.
4. If for HTN management, document blood pressure re-measurements including dates.
5. Assure WISEWOMAN clients with alert or abnormal values are linked to free or low-cost continuing care services when indicated unless the client refuses.
    a. The medical system to which the woman is referred to is responsible for providing medical follow-up and ensuring treatment.
    b. It is important to ensure women with alert or abnormal values who need ongoing care are directed to a health care provider who will see them regardless of their financial status or circumstances.
6. Providers who conduct a Therapeutic Lifestyle Change (TLC) discussion doing the DOV or hypertension management visits can record the intervention as a health coaching encounter if the following activities take place:
    a. Discussion is done in the spirit of MI and documentation supports the conversation addressing progress, barriers, and community resources.
    b. TLC conversation is at least 10-15 minutes.
    c. The client identifies or re-commits to a SMART goal.

Cardiovascular Disease Management Resources

- Target: BP American Heart Association
  This national initiative aims to reduce the number of Americans who have heart attacks and strokes by urging medical practices, health service organizations, and clients to prioritize blood pressure control. Target: BP supports physicians and care teams by offering access to the latest research, tools, and resources to reach and sustain blood pressure goal rates within the patient populations they serve.

- Target: Type 2 Diabetes American Health Association
  National initiative that aims to prioritize management of type 2 diabetes and cardiovascular risk factor in outpatient care. Target: Type 2 Diabetes and its related resources at Know Diabetes by Heart, provides clinicians and patients with access to a variety of resources to help them understand and manage chronic disease. The initiative offers state and national recognition for health care organizations that commit to, and achieve success, as defined by statistical benchmarks.

- Million Hearts® toolkits
  Practice and informational toolkits designed to help partners incorporate Million Hearts® into their everyday work and enhance community heart disease and stroke prevention efforts.

- Wisconsin Department of Health Services https://www.dhs.wisconsin.gov/heart-disease/million-hearts.htm
  Wisconsin Department of Health Service web portal provides resources and information on cardiac health initiatives in Wisconsin.

- CDC Sodium Reduction Resources
- Centers for Disease Control and Prevention, Division for Heart Disease and Stroke Prevention
  Provides data, training webcasts, and webinars and educational materials on a variety of heart disease and stroke topics.
- 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines
- Standards of Care in Diabetes 2024
  The diagnosis and management of diabetes should be done according to the current American Diabetes Association's Standards of Medical Care for Diabetes Mellitus. These guidelines are reviewed and updated annually.
- 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines

Section 9: Community–Clinical and Social Services and Support Resources

Identifying Community Resources and Social Services and Support Network and Referrals

The provider organization will conduct an annual community scan of each community they serve. The goal of the scan is to identify existing resources in the community that support healthy lifestyles, and social services and support networks which address risks factors that support chronic disease self-management and the client's involvement and completion of HBSS. When determining community-clinical resources, the provider should consider the likelihood of having a bi-directional referral procedure in place with the referring agency. However, not all the community resources will require a bi-directional referral procedure, e.g., walking in the mall or park.

This WISEWOMAN cooperative agreement will be collecting social services and support referral data on:

1. Food insecurity
2. Childcare
3. Transportation
4. Computer Use
5. Internet Access
6. Housing
7. Violence Prevention Services
8. Mental health
9. Translation Services
10. Substance Abuse
11. Medication Adherence

Community Referrals and Linkages

The WISEWOMAN client should be referred to community-based resources to support identified goals. Typically, initial referrals occur during risk counseling, but may also occur during other program services such as lifestyle programs, health coaching sessions, and/or follow-up diagnostic/management services.

Bi-Directional Referral Process

Successful bi-directional referral includes both the referral information going from the WISEWOMAN provider to the healthy behavior support service, community-clinical resources and the information flowing back to the health care provider on the client's participation, as well as any outcomes such as weight loss or blood pressure readings, or social services and support utilization. The referral system may include any electronic, telephonic, fax-based, web-based, or paper-based system that tracks and receives data for all clients that have been referred to a community-clinical service. Any bi-directional referrals should be entered in the Med-IT® data management system.

Healthy Behavior Support Services (HBSS)

The aim of HBSS is to provide skills, support and information that supports the client's ability to integrate healthy behaviors into her daily life.

Criteria for HBSS

1. Be evidence-based or viewed as "promising" (created on evidence-informed activities).

2. Show effectiveness in improving diet, physical activity, weight loss and chronic disease management with emphasis on hypertension.
3. Incorporate national diet and lifestyle recommendations.
4. Be culturally appropriate and delivered using easy-to-understand language.

All HBSS must be approved by CDC. The following are currently approved programs***:***
1. Health Coaching (HC)
2. Health Coaching with Blood Pressure Self-Monitoring (HCwBPSM)
3. Diabetes Prevention Program (DPP)
4. Take Off Pounds Sensibly (TOPS)
5. Health Coaching with Walk With Ease (HCwWWE)

If the provider organization has additional evidence-based/evidence-informed programs they would like considered, they must contact the WISEWOMAN program coordinator.

Assistance with Medication and Diabetes Supplies

Due to the federal funding requirements, WISEWOMAN funds cannot be expended on medication or diabetes supplies for clients. However, the WISEWOMAN provider organization should assist the client with obtaining access to necessary medications and supplies.

Smoking Cessation

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

- Clients who use tobacco should be provided Quit Line materials. Providers are encouraged to give clients information on tobacco risks and benefits of quitting, however, providing education materials is not a referral.
- Clients who express interest in quitting, including identifying smoking cessation as a priority during risk counseling and/or health coaching, should be given a referral to the Wisconsin Tobacco Quit Line. The referral requires that the provider contact the client to determine her activity/outcome status. The status should be recorded in the WISEWOMAN Med-IT® data management system.

Wisconsin Tobacco Quit Line: 1-800-QUIT-NOW (1-800-784-8669)

The Wisconsin Tobacco Quit Line offers free, confidential, non-judgmental coaching, and information about how to quit. Quit coaches help each caller develop an individualized quit plan, including selecting a quit date. The Quit Line also sends callers a free quit guide with information about quitting methods, medications, and other tips. The coach can also provide a list of community tobacco cessation programs.

Wisconsin Tobacco Quit Line— Fax to Quit Service

Fax to Quit is a program that links the services of the Wisconsin Tobacco Quit Line directly to the potential quitter with the help of health care providers. Tobacco users no longer have to take the first step in calling the Quit Line. Instead, a quit coach will contact the tobacco user to provide an intervention(s) after receiving a faxed consent form. Clients must be ready to make a quit attempt, preferably within 30 days. The program is not designed to convince a smoker to quit. Clients may also initiate calls to the Quit Line at any time.

One-call Intervention

1. Generally, there is a 20 to 40-minute assessment of tobacco use history, previous quit attempts, relapse, and life experiences that may affect the quit attempt.
2. The quit coach stresses the importance of planning for a quit attempt and offers individualized counseling to help develop a plan.

Multi-call Intervention

1. During the one-call intervention, the caller may elect to receive up to four additional calls scheduled over six months.
2. Calls usually take place around the time of the quit date and provide the caller with practical strategies for successfully quitting.
3. Quit coaches help problem-solve with callers experiencing ongoing urges to use tobacco.
4. Coaches review nicotine replacement therapy usage to ensure safe, proper, and effective use.
5. Coaches identify methods callers may use to increase their support from family and friends.

Providers can enroll in the Fax to Quit program by contacting their local UW-Center for Tobacco Research Outreach Specialists.

Section 10: Case Management

Case Management Protocols (Missed IOV, DOV)

- Case management is a short-term intensive support service used to ensure that women receive appropriate and timely medical care. Case management assists clients in understanding their treatment regimen, obtaining affordable medication, attending medical appointments, and/or reducing other barriers.
- Clients with abnormal blood pressure must be referred to a hypertension management program. The case manager will track the status of these clients.
- The medical system to which the woman is referred is responsible for providing medical follow-up and ensuring treatment.
- WISEWOMAN-funded case management services must end when:
  - The client with alert or elevated values begins receiving prescribed treatment.
  - The client is no longer eligible for WISEWOMAN services. For these clients, it is important to ensure they are directed to a health care professional who will see them regardless of their financial status or other circumstances before case management services stop.
  - The client has completed her healthy behavior support service and required follow-up screening visit.
  - The client is lost to follow-up after three recorded service contact attempts.
  - The client's blood pressure is in the controlled range.

Contacting Clients – MISSED Integrated Office Visit Appointments

The provider organization will contact clients to remind them of missed office visits. If the client makes an Integrated Office Visit (IOV) appointment but fails to show up, the provider organization will send a missed appointment notice to the client.

Contacting Clients – Missed HBSS Session(s)

The provider organization or HBSS provider organization will contact clients to remind them of missed HBSS encounters. The client is lost to follow-up after three recorded call attempts and the lost to follow-up is documented in the Med-IT® data management system Clients may decide to contact the provider and re-initiate her sessions, and can do so, if it is within four months of her rescreen date.

Contacting Clients – Missed Diagnostic Office Visit for Alert or Abnormal Values

When the results of the Integrated Office Visit indicate the need for a DOV referral and the client does not return for a DOV for further evaluation, the WISEWOMAN provider organization attempts to contact the client.

1. The WISEWOMAN provider organization sends a missed appointment notice to the client.
2. If there is no response from the client within a week of the date that the missed appointment card was mailed, the provider organization will make a follow-up telephone call. If there is still no response, the provider organization will send a program contact letter to the client.
3. The provider organization attempts to contact the client must include notification of the benefits of receiving, and the health consequences of refusing, follow-up.
4. The provider organization must assure documentation of three attempts to contact participants before designating the participant as "lost to follow-up."
5. After all attempts have been made to contact the client, she is to remain active in the Med-IT® data management system because she might return later.

The provider organization will document activities in the WISEWOMAN Med-IT® data management system client's Recall Activity screen.

Section 11: Healthy Behavior Support Services

Healthy Behavior Support Service (HBSS) Overview

WISEWOMAN'S mission is to provide clients with the knowledge, skills, and opportunities to improve their diet, physical activity, and other life habits to reduce their risk of heart disease, stroke, and diabetes. The provider organization must ensure that WISEWOMAN clients have access to healthy behavior support services after the initial or rescreening Integrated Office Visit has been completed.

Healthy Behavior Support Services Participation

Screening results, health risk assessments, readiness to change, client goals and preferences should be used to determine if a client is referred to a specific lifestyle program or health coaching.

Initial Healthy Behavior Support Service

The first Healthy Behavior Support Service encounter will happen at the IOV. This will ensure that the motivated client leaves with information on her risk factors, information on how to take small steps toward better health through goal setting, and information on how to access her HBSS option. The provider will use the Screening and Healthy Behavior Support guide [P- 00909] to facilitate the first intervention discussion.

Referral Readiness

- Once the client's level of motivation and potential social services and support needs have been determined and her chronic disease risks have been considered, the WISEWOMAN provider organization will work with her to determine which HBSS option is appropriate. The WISEWOMAN provider organization should become familiar and comfortable with discussing the available options.
- To enroll in a HBSS, the client must:
  - Indicate a readiness to change.
  - Agree that the chosen HBSS is an appropriate option.
  - Read the HBSS referral and completion promise.
- Any medical hypertension alert must be addressed before receiving any HBSS.

Documentation of Healthy Behavior Support Services

Healthy Behavior Support encounters will be documented in the WISEWOMAN Med- IT® data management system. Staff will designate "in progress" until the client finishes the required number of encounters. A follow-up screening visit should occur within four to six weeks after LSP/HC completion, or at least three months prior to the client's rescreening appointment.

Increasing Client Participation and Completion

The provider organization should use the following strategies to encourage and support completion of the intervention:

- Use motivational communication when presenting the HBSS referral and completion expectations during the initial counseling.
- Provide other supportive services to enrich the client's experience based on the provider's community resources, e.g., free limited membership to exercise facility, access to cooking demonstrations, gardening session

- Employ creative ways to engage clients, e.g., group events, video remote coaching.
- Refer clients to other community-based resources, e.g., walking trails, chronic disease management programs, community health forums to support their goals.
- Support environments that reinforce behavior change, e.g., walking groups, access to fresh fruits and vegetables.
- Provide resources such as transportation and childcare as needed.
- Provide healthy behavior enhancement tools, e.g., step counter, meal portion plate, jump rope and infusion water bottle.
- Encourage involvement of family members and friends for additional support.
- Use motivational interviewing, particularly when an individual is having difficulties maintaining behavior change.
- Establish a feedback loop mechanism with the medical provider to reinforce goals.
- Provide tips and tools for self-monitoring of progress.
- Offer additional materials/items to support maintenance of heart healthy behaviors, (e.g., cookbooks, healthy tips newsletters).

Take Off Pounds Sensibly (TOPS)

Program Focus and Overview

Take Off Pounds Sensibly (TOPS) is a national nonprofit organization that has been in the community since 1948. TOPS help its members manage weight problems through group support and education. The TOPS plan includes information about healthy eating, exercise, and behavior modification.

Intended Audience

WISEWOMAN clients who are interested in TOPS must:

1. Be overweight
2. Be able to establish a healthy and reasonable weight loss goal.
3. Read and sign the WISEWOMAN client consent form.
4. Read the Healthy Behavior Support Service participation agreement.
5. Have access to a viable phone, or internet if she selects the online option.
6. Be able to pay the required weekly chapter meeting dues.

* If the client has an alert blood pressure, she will start after she has received hypertension medical support and approval.

Program Content/Materials

The WISEWOMAN program has entered into a partnership with TOPS to provide clients with a one-year membership. The membership allows the client to participate in weekly chapter meetings or online member support. There is no cost to switch between online and in-person membership or vice versa or to change chapters.

Intervention Strategies

1. In person weekly chapter meetings led by lay chapter leaders (includes weigh-in, group sharing, interactive informational presentation, inspirational activities)
2. Live Zoom meetings are scheduled on five separate days and times weekly. Topic changes each Monday. Recordings of the Online Meeting Programs can be viewed in the video library. Meetings run about 30 minutes long and starts with members sharing both scale and non-scale challenges, successes, or goals. Schedule topics are presented by the meeting facilitator or a guest speaker. The sessions end with action steps for the topic presented. Clients have the option of chatting with online members between meetings through the TOPS Facebook group.
3. Both options allow for access to free online resources and copies of TOPS Quick-start guide and magazine subscription.
4. Members can also convert membership from chapter to online or reverse.

Referral, Enrollment and Engagement Process

1. Client selects TOPS following risk counseling and readiness assessment. Clients who do not select an HBSS will be called back in approximately 30 days to determine if they are ready for a healthy behavior support intervention.
2. The screening provider documents the TOPS referral in the WISEWOMAN Med-IT® data system.
3. The provider supports the client in establishing a healthy and reasonable weight loss goal.
4. The provider helps the client to select a chapter that best fits her schedule and comfort level. Wisconsin has over 250 local chapters, including nearly 25 chapters in the Greater Milwaukee area. Please note that clients are encouraged to visit several chapters before making a final selection. TOPS allows initial visits at no charge.
5. A health coach then meets with the client to complete an initial healthy behavior support intervention. This initial intervention helps to support the client's ability to take steps toward better health through goal setting and action planning. The session will be at least 30 minutes long. Once the client has selected a chapter location, the provider organization program coordinator will send her a TOPS membership voucher to take to her next chapter meeting. The provider organization should contact the WISEWOMAN program coordinator and request the number of vouchers needed.
6. The client completes a TOPS membership application. The application and voucher are mailed to the TOPS corporate office by the chapter leader.

TOPS ® Membership Coupon This coupon entitles

_____

to a one-year membership in TOPS Club, Inc.

Use this coupon as payment for your one-year membership in TOPS Club, Inc.

If there are several TOPS chapters in your area, you may visit more than one before making a final decision on which chapter to join. Treasurer: this certificate is **NOT VALID** without official TOPS seal here.

7. The provider organization program coordinator:
   a. Retrieves the referral(s) at the end of each day and contacts client(s) to confirm specific information on the date, time and location of the TOPS Chapter that has been selected.
   b. Conducts follow-up calls at various intervals (gets status of participation, problem solves any challenges to attending, provides general motivation/encouragement).

Bi-Directional Referral Plan

The provider organization will be required to establish a bi-directional referral agreement with the TOPS chapter where they refer clients. These agreements will include:

- Client information (name, contact information).
- Date of referral.
- Referral process/flow.
- Referral provider information (name, contact information).
- Type of outcomes, e.g., weight, support services (cooking demo, movement session), completion and/or withdrawal.
- Frequency of report data.
- Provider and staff agency roles and responsibilities.

Number of Sessions Required for Completion

- Clients who attend 12 weekly chapter meetings and/or online chat discussions during the first six months will be considered complete. Document meetings in the WISEWOMAN Med-IT® data management system.
- Clients may continue to participate in TOPS until their annual membership has expired.
- If the client stops attending Chapter meetings regularly, the TOPS Chapter leader (or another member) may call or email the client.
- TOPS will send a renewal notice six to eight weeks before a member is scheduled to renew and sends an "*Oops*" your membership is past due email.
- Membership renewal will not take place until the client returns for her annual rescreen and again selects the TOPS option.

Other Support Services

1. Provider organizations will provide other supportive services to enrich the client's experience based on the provider's community resources., .
2. Clients completing TOPS may be provided a $20 gift card to support chapter meeting attendance and to help offset the required chapter meeting dues, which can range from $1–$3 per month.

Program Effectiveness, Impact

The Effectiveness and impact of TOPS will be evaluated by:

1. The number of clients who complete TOPS
2. Follow-up assessments data(changes in healthy eating, physical activity, weight loss and client self-efficacy etc.)
3. The effectiveness of bi-directional agreements

Diabetes Prevention Program (DPP)

Program Focus and Overview

The Diabetes Prevention Program (DPP) is for clients who are at high risk for developing type 2 diabetes. The program focuses on helping clients make and continue healthy lifestyle changes by eating healthier, increasing physical activity to 150 minutes per week, and losing a small amount of weight (5%–7% of body weight).

Based on research funded by the National Institutes of Health, the program has been shown to reduce the risk of developing type 2 diabetes by as much as 58%. The reduction was even greater at 71% among adults aged 60 years or older. Nearly half of the study participants were African American, Hispanic, American Indian, Asian, or Pacific Islander.

Intended Audience*

WISEWOMAN clients who are interested in DPP must:

1. Be overweight and
2. Not be pregnant and
3. Have no previous diagnosis of type 1 or type 2 diabetes and
4. Have either a blood test result in the prediabetes range within the past year:
    - Hemoglobin A1C: 5.7–6.4% or
    - Fasting plasma glucose: 100–125 mg/dL or
    - Two-hour plasma glucose (after a 75-gm glucose load): 140–199 mg/dL or
    - A previous clinical diagnosis of gestational diabetes during a previous pregnancy

OR

A positive screening for prediabetes on the Prediabetes Screening Test.

5. Read and sign the WISEWOMAN client consent form.
6. Read the Healthy Behavior Support Service participation agreement.
7. Have access to a viable phone, or computer and access to internet If she selects the online or distance learning option.

* If the client has an alert blood pressure, she will start after she has received hypertension medical support and approval.

Program Content/Materials

The following materials are used in the program:

- Participant Notebook (Core) contains worksheets and handouts for participants to use in each of the 16 core sessions of the lifestyle intervention.
- Participant Notebook (post-Core) contains worksheets and handouts for participants to use in the post-core phase of the lifestyle intervention.
- Additional materials used by participants during the lifestyle intervention include food, activity and weight tracker logbooks, and a fat and calorie counter guide.

Key Activities

1. One-hour weekly sessions facilitated by a lifestyle coach focusing on eating smaller portions, reducing fat, and discovering healthier food options to help prevent the onset of type 2 diabetes; increasing moderate physical activity and losing at least 7 percent of body weight.
2. Establishing defined weight loss and physical activity goals.
3. A private weigh-in and review of self-monitoring records.
4. Identification of barriers and action planning, in a group setting.
5. Tracking documentation of pounds lost, physical activity, and food consumption.
6. Each week has established learning objectives.
7. After completion of the core curriculum, a maintenance/post-core phase is offered to all participants. It consists of a minimum of six one-hour, group-based sessions in person, occurring once a month for the remaining year of the lifestyle program. The post-core phase is less structured than the core phase, but the framework parallels core curriculum.

Referral, Enrollment and Engagement Process

1. Client selects DPP following risk counseling and readiness assessment.
   a. Clients who do not select an HBSS will be called back in approximately 30 days to determine if they are ready for a healthy behavior support intervention.
   b. The screening provider documents the DPP referral in the WISEWOMAN Med-T® data system.
2. The provider reviews program options with the client, using the Wisconsin Healthy Aging website as a resource. https://wihealthyaging.org/programs/
3. A health coach then meets with the client to complete an initial healthy behavior support intervention. This initial intervention helps to support the client's ability to take steps toward better health through goal setting and action planning. The session will be at least 30 minutes in length.
4. The provider organization program coordinator:
   a. Retrieves the referral(s) at the end of each day and contacts client(s) to confirm specific information on the date, time, and location of the DPP.
   b. Conducts follow-up calls at various intervals (gets status of participation, problem solves any challenges to attending, provides general motivation/encouragement).

Bi-Directional Referral Plan

The provider organization will be required to establish a bi-directional referral agreement with their identified DPP community providers. These agreements will include:

1. Client information (name, contact information).
2. Date of referral.
3. Referral process/flow.
4. Referral provider information (name, contact information).
5. Type of outcomes, e.g., weight, support services (cooking demo, movement sessions), completion and/or withdrawal.
6. Frequency of report data.
7. Provider and staff agency roles and responsibilities.

Number of Sessions Required for Completion

Clients who attend nine of the 16 Core sessions will be considered complete. The client should be encouraged to attend a minimum of three of the six maintenance/post-Core meetings within six months. Document sessions in the WISEWOMAN Med-IT® data management system.

Other Support Services

1. The provider organization will have allocated funding to include other supportive services to enrich the client's experience based on the provider's community resources.
2. The WISEWOMAN program will provide healthy behavior enhancement tools, e.g., step counters, meal portion plates, jump ropes, and infusion water bottles.

Program Effectiveness, Impact

The Effectiveness and impact of DPP will be evaluated by:

1. The number of clients who complete DPP
2. Follow-up assessments data (changes in healthy eating, physical activity, weight, self-efficacy)
3. The effectiveness of bi-directional agreements

Health Coaching (HC)

Health coaching is a WISEWOMAN healthy behavior support service option that will be provided by the provider organization. Health coaching will use motivational interviewing to support the client with developing and carrying out a personalized health plan that addresses her health behavior priority goal.

Major Characteristics of Health Coaching

1. Recognizing that the client is in charge of her own health.
2. Guiding the client to identify her motivators for change.
3. Providing suggestions, skill-building tools, activities, and resources.
4. Helping the client address change barriers and guiding the client to determine her solutions.
5. Serving as a collaborator and supporter of the client's change.
6. Building a climate of trust and support.

Who can perform Health Coaching?

Each provider organization will provide health coaching using a combination of the following team members: health educators, registered and/or advance practice nurses, and other trained health professionals. Community Health Workers (CHW) may serve as coaches under the supervision of a health professional previously mentioned.

Health coaches are identified by the provider organization management staff from the categories mentioned above. All coaches must be comfortable with providing one-on-one and/or group support coaching and have a caring, non-judgmental demeanor. Coaches must have knowledge of cardiovascular disease risks and healthy lifestyle behavior(s) that reduce those risks. Once identified, WISEWOMAN program staff will provide program health coaching training. Coaches must also have initial training in Motivational Interviewing (MI) and annual refreshers. Coaches should access the self-study online MI training opportunities and/or health coaching tools disseminated by WISEWOMAN program staff.

Intended Audience

WISEWOMAN clients who are interested in health coaching must:

1. Have a SMART goal to address risk factor(s).
   If the client's goal is to address abnormal blood pressure, her coaching session will start after she has received hypertension medical support.
2. Have access to a viable phone.

3. Have the ability to work one-on-one and/or in a group with a health coach.
4. Read and sign the WISEWOMAN client consent form.
5. Read the Healthy Behavior Support Service participation promise.
6. If the client has an alert blood pressure, she will start after she has receive hypertension medical support and approval.

Referral, Enrollment and Engagement Process

1. Client selects health coaching after completing risk counseling and a readiness assessment. Clients who do not select an HBSS will be called back in approximately 30 days to determine if they are ready for a healthy behavior support intervention.
2. The screening provider documents the coaching referral in the WISEWOMAN Med-IT® data system.
3. The coach then meets with the client to complete an initial healthy behavior support intervention.
4. The session will be at least 30 minutes long. Subsequent coaching sessions can range from 15-60 minutes.
5. The initial session will include:
   a. Creation of a healthy behavior change priority goal.
   b. Development of an initial action plan to support that goal.
   c. Discussion and delivery of supportive tools.
   d. Agreement on subsequent coaching sessions.

Coaching Strategies

1. Coaching sessions will use motivational interviewing to support the client with developing and carrying out a personalized action plan. The plan will address her healthy behavior goals, which may include healthy eating, physical activity, and blood pressure management.
2. Coaching can be conducted face-to face, over the phone or in a group.
3. Coaching done by a CHW can occur in the clinic, the client's home (by agreement with the client), or an agreed-upon community location.
4. Small group coaching sessions can be provided with the consent of all of the clients when they have similar goals.
5. The WISEWOMAN program will provide health coaching education aids and learning enhancement tools that will support clients in making and maintaining healthy lifestyle choices or self-monitoring skills. Additional aids and tools may be available upon identification by the WISEWOMAN staff and/or recommendation by the provider organization.
6. The provider organization may implement other strategies to reach their clients, e.g., newsletters, group reunions and walking events.

Education Aids and Learning Enhancement Tools

The WISEWOMAN state office will provide health coaching education items. Currently the state office provides jump ropes, blood pressure monitors, blood pressure tracking cards, coloring books, meal portion plates, step pedometers, lunch bags, program grocery bags, and pill boxes. Additional aids and tools may be available once identified by the state office and/or recommended by the WISEWOMAN provider organization.

Bi-Directional Referral Plan

Each provider organization is contracted to provide health coaching as part of their WISEWOMAN services. Inter-organization referral will be done through the program's data management system.

Other support services offered by the provider organization must have a bi-directional referral agreement(s). These agreements will include:

1. Client information (name, contact information).
2. Date of referral.
3. Referral process/flow.

4. Referral provider information (name, contact information).
5. Type of outcomes, e.g., weight, support service (cooking demo, movement sessions), completion and/or withdrawal.
6. Frequency of report data.
7. Provider and staff agency roles and responsibilities.

Number of Sessions required for Completion

1. The number of coaching sessions and/or mode of delivery will be based on the client's needs. The coach will allow enough time between sessions to ensure that the client has time to practice skills and/or develop the positive behavior.
2. Clients must complete a minimum of three sessions. The maximum number of health coaching sessions a client can receive will be five within seven months. Document sessions in the WISEWOMAN Med-IT® data management system. Documentation must include the client's goal and progress notes to allow for assessment of the client's progress or concerns.

Other Support Services

Each provider organization will provide other supportive services to enrich the client's experience based on the provider's community resources, e.g., access to cooking demonstrations, gardening sessions, exercise facility trial membership, transportation, and childcare.

Program Effectiveness, Impact

The Effectiveness and impact of health coaching will be evaluated by:

1. The number of clients who complete HC
2. Follow-up assessments data (changes in healthy eating, physical activity, weight, self-efficacy)
3. The effectiveness of social and supportive referrals and utilizations.

Health Coaching Blood Pressure Self-Monitoring (HCwBPSM)

Client self-monitoring of blood pressure is a valuable addition to the management of hypertension (the goal is usually less than 130/80 for most people) and is supported by the Million Hearts Initiative and the American Heart Association.

Health Coaching Blood Pressure Self-Monitoring Can Be Useful:

1. To empower the client to manage her blood pressure.
2. To monitor the client who cannot get her blood pressure under control with lifestyle change and medication.
3. For clients who are starting high blood pressure (HBP) treatment to determine its effectiveness.
4. To titrate medication(s).
5. To screen for white-coat hypertension.

Contraindication for Health Coaching Blood Pressure Self-Monitoring

1. If the client has atrial fibrillation or cardiac arrhythmias. (Home devices may not be able to give accurate measurements).
2. If the client has physical and/or mental disabilities.

Intended Audience

1. WISEWOMAN clients who are in any of the following blood pressure categories:
   a. Elevated Blood Pressure measurement
   b. Stage 1 Blood Pressure measurement
   c. Stage 2 Blood Pressure measurement or higher
   d. Uncontrolled Hypertension ($\geq$140/90)

2. Have the manual dexterity to self-monitor and can do so appropriately.
3. Have access to a viable phone.
4. Have the ability to work one-on-one and/or in a group with a health coach.
5. Indicate change readiness and consent to the terms of the WISEWOMAN Client Home Blood Pressure Monitoring Agreement [F01398].
6. If the client has an alert blood pressure, she will start after she received hypertension medical support and approval.

Provider Readiness/Capacity for Health Coaching Blood Pressure Self-Monitoring Delivery

1. The provider organization responsibilities include the provision of HCwBPSM in their service contract.
2. The provider organization will provide HCwBPSM using a combination of the following team members: health coaches, registered nurses, advanced practice nurses, and other trained health professionals. Community Health Workers may serve as coaches under the supervision of one of the health professionals previously mentioned.
3. Coaches must have skills in motivational interviewing and be comfortable providing one-on-one and/or group support and have a caring non- judgmental demeanor. Coaches must have knowledge of cardiovascular disease risks, and healthy lifestyle behavior(s) that reduce those risks, and skills in taking and monitoring accurate blood pressure measures.
4. Staff who are doing HCwBPSM must attend a Target: BP SMPB implementation training including utilizing Target: BP SMBP resources and tools.

Referral, Enrollment and Engagement Process

1. Following risk counseling, information on benefits of HCwBPSM is discussed. If the client agrees she is referred.
   The screening provider documents the HCwBPSM referral in the WISEWOMAN Med- IT® data system.
2. The health coach then meets with the client to complete the initial HCwBPSM session. The session will be 30 minutes long**.** Subsequent coaching sessions can range from 20–60 minutes. The initial session will include:
   a. Discussing the Blood Pressure Home Self-Monitoring agreement, having the client sign the agreement, and providing a copy of the agreement to the client.
   b. Developing an initial action plan, to include the home self-monitoring start date. (The plan can also include healthy eating, physical activity, smoking cessation, and medication adherence).
   c. Reviewing the importance of blood pressure measurement.

Service Delivery Procedure

Procedure	Team Members	Activities/Comments
1. Determine start date and frequency.	• Clinical provider	Based on clinical provider recommendations, measurements should be taken until the next visit (2–4 weeks).
2. Validate the monitor for accuracy by checking the monitor's readings against the office equipment.	• Health coach, nurse	After initial validation, have client bring BP monitor in and check for accuracy during the face-face HCwBPSM coaching sessions.
3. Instruct on proper technique for taking blood pressure at home. Provide blood pressure monitor and other skill enhancement tools as	• Health coach, nurse	Use Blood Pressure-Small Changes, Big Results section in the WISEWOMAN Program Screening and Healthy Behavior Support Healthy Lifestyle Guide (P00909). Show Target: BP SMBP training video.

Procedure	Team Members	Activities/Comments
needed.		
4. Discuss blood pressure measurements reporting and documentation.	• Health coach	Have client take measurements weekly and thereafter, based on the client measurements. If abnormal, the client may have to report more frequently. Document HCwBPSM, in the LSP/HC section, including pertinent notes, e.g., BP goal, BP measurements, successes and challenges.
5. Conduct HCwBPSM sessions	• Health coach, • Clinical provider, • Pharmacist	Frequency normally is 2–4-week intervals. May need to titrate medication until mean out-of-office blood pressure is according to current HTN recommendations and the client's goal. Assess highs or lows, compare morning and evening readings to those obtained 3–4 hours after medication is taken. Screen for white-coat hypertension. Refer to clinical provider for HTN management visit(s) based on client needs.
6. Follow-up on blood pressure readings that are too high or too low.	• Nurse, Clinical provider, Health coach	Ensure client knows to call 911 immediately if she has signs or symptoms of a heart attack or stroke. Ensure client knows who to call between office visits for clinical and/or health coaching sessions and knows how/when to report BP data to provider.

Number of Sessions Required for Completion

1. Clients must complete a minimum of 3 sessions. If after the 3 sessions the client continues to have problems with home measurement techniques, understanding, or control, the client may have an additional 2 sessions.
2. The number of HCwBPSM coaching sessions and/or mode of delivery will be based on the client's needs. The coach will allow enough time between sessions to ensure that the client has time to practice skills and/or develop the positive behaviors.
3. Coaching should be conducted both face-to-face and over the phone. Face-o-Face encounters should be held until the client is skilled in the process and reporting log.
4. Small group HCwBPSM coaching sessions can be provided with the consent of all group members.

Education Aids and Learning Enhancement Tools

The WISEWOMAN state office will provide HCwBPSM education items. Currently the state office provides jump ropes, blood pressure monitors, blood pressure pocket tracking cards, coloring books, meal portion plates, step pedometers, lunch bags, program grocery bags, and pill boxes. Additional aids and tools may be available once identified by the state office and/or recommended by the WISEWOMAN provider organization.

Bi-Directional Referral Plan

The provider organization is required to conduct HCwBPSM as part of their WISEWOMAN contract agreement. Other support services offered by the provider organization must have a bi-directional referral agreement. The agreement will include:

1. Client information (name, contact information).

2. Date of referral.
3. Referral process/flow.
4. Referral provider information (name, contact information).
5. Type of outcomes (e.g., cooking demonstrations and movement sessions), completion, withdrawal, and frequency of report data.
6. Provider and staff agency roles and responsibilities.

Other Support Services

Provider organization will have allocated funding to include other supportive services to enrich the client's experience based on the provider's community resources, e.g., access to cooking demonstrations, gardening sessions, exercise facility trial memberships, transportation, and childcare as needed.

.Program Effectiveness, Impact

The Effectiveness and impact of HCwBPSM will be evaluated by:

1. The number of clients who complete coaching sessions
2. Follow-up assessments data (changes blood pressure, increased at home monitoring, physical activity, healthy eating, smoking cessation, self-efficacy etc.
3. The effectiveness of bi-directional agreements, and/or social and supportive referrals and utilizations.

Health Coaching with Walk with Ease (HCwWWE)

Program Focus and Overview

The Arthritis Foundation's Walk with Ease Program is for people with arthritis, joint pain and stiffness, or other chronic conditions such as cardiovascular disease. The program focuses on physical activity and how to start walking safely and stick with it. The Walk With Ease program is offered as a self-guided course that participants can complete at their own pace or in a community setting. Wisconsin is proposing to offer the self-guided model as part of physical activity through health coaching.

Program Focus and Overview

WISEWOMAN clients who are interested in becoming more physically active. Client must meet the following criteria:

1. Are interested in becoming more physically active and can establish a healthy and reasonable walking goal.
2. Have viable access to a phone
3. Comfortable working in an individual-self-directed program as well as one-one and/or in a group with a health coach
4. Read and sign WISEWOMAN client consent form
5. Read and sign Health Coaching with Walk With Ease referral and completion agreement

**If the client has an alert blood pressure, she will start after she has received hypertension medical support and approval.*

Program Materials

The following materials are used in the program:

- Arthritis Foundation Walk with Ease Guidebook
- WISEWOMAN Screening and Healthy Lifestyle Support Guide

Key Activities - Self-Directed with Health Coaching

1. Clients will receive a Walk with Ease Guidebook https://www.afstore.org/search.asp?searchString=walk+with+ease&_gl and on-line walking videos instructions on stretching exercise and tools

https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease/wwe-exercises. The guidebook provides health education, stretching and strengthening exercises, motivational strategies, walking schedules.

2. Health coach conducts check-ins are done to determine progress.
    a. Coaching sessions will use motivational interviewing to support the client with developing and carrying out a personalized action plan that addresses her physical activity SMART goal.
    b. Coaching done by a CHW can occur in the clinic, the client's home (with approval of the client) or an agreed-upon community location.
    c. Small group coaching sessions can be provided with client consent and if the clients have similar priority goals.
    d. The health coach will help the client develop/refine a walking plan that meet her needs, choose when and where to walk, learn to exercise safely, stay motivated, address barriers, offer encouragement and clarify any questions. Each step of the Walk with Ease program has accompanying support information (printed, online).
3. Clients can choose to walk three times a week for 6 weeks or two times a week for 9 weeks.
4. Each session consists of 5 steps for a total of 22-54 minutes:
    a. Step 1 Warm up (3-5 minutes)
    b. Step 2 Gently stretch (4-5 minutes)
    c. Step 3 Walk (5-30 minutes)
    d. Step 4 Cool Down (3-5 minutes))
    e. Step 5 Gently Stretch (7-9 minutes)

Number of Sessions Required for Completion

Clients must complete a minimum of 3 health coaching sessions and 9 self-guided walking sessions to be considered complete. Document coaching and self-guided walking activities in the WISEWOMAN Med-IT® data management system.

Referral, Enrollment and Engagement Process

1. Client selects HCwWWE following risk counseling and readiness assessment.
   The screening provider documents the HCwWWE referral and identified social services and supportive needs referral in the WISEWOMAN Med- IT® data system.
    a. Clients who do not select an HBSS will be called back in approximately 30 days to determine if they are ready for a healthy behavior support intervention.
2. The coach then meets with the client to complete an initial healthy behavior support intervention.
3. The session will be at least 30 minutes long. Subsequent coaching sessions can range from 15-60 minutes.
4. The initial session will include:
    a. Creation of a reasonable physical activity goal.
    b. Development of an initial action plan to support that goal.
    c. Discussion and delivery of supportive tools.
    d. Agreement on subsequent coaching sessions.
5. The provider organization program coordinator:
    a. Conducts follow-up calls at various intervals (get status of participation, assess social and supportive needs, problem solve any challenges to attending, provide general motivation/encouragement).

Bi-Directional Referral Plan

The provider organization is contracted to provide Health Coaching with Walk with Ease, as part of their WISEWOMAN services. Inter organization HBSS and social and supportive services will be done through the program's Med-IT® data management system.
Other bi-directional services with community partners must have bi-directional referral agreement(s).

The agreement will include:

1. Client information (name, contact information).
2. Date of referral.
3. Referral process/flow.
4. Referral provider information (name, contact information).
5. Type of outcomes (e.g., number of minutes walking, other PA sessions), completion, withdrawal, and frequency of report data.
6. Provider and staff agency roles and responsibilities.

Other Support Services

Provider organization will have allocated funding to include other supportive services to enrich the client's experience based on the provider's community resources, e.g., access to cooking demonstrations, gardening sessions, exercise facility trial memberships, transportation, and childcare as needed.

Number of Sessions Required for Completion

The number of Walk with Ease coaching sessions and/or mode of delivery will be based on the client's needs. The coach will allow enough time between sessions to ensure that the client has time to practice skills and/or develop the positive behavior and complete self-guide walking sessions.

- The minimum for 6 weeks completion = 3 health coaching sessions + 18 self-guided walking sessions.
- The maximum 9 weeks completion 5 health coaching sessions + 18 self- guided walking sessions.

Program Effectiveness, Impact

The Effectiveness and impact will be evaluated by:

1. The number of clients who completed
2. Follow-up assessments data (changes in healthy eating, physical activity, weight, self-efficacy etc.)
3. Effectiveness of bi-directional agreements and/or social and supportive referrals and utilizations.

30 Day Call Backs

Purpose

The Healthy Behavior Support and Readiness Assessment contact is for clients who did not choose an HBSS option at the time of their IOV and gave permission for the provider to call back in 30 days to assess their readiness to enroll in an HBSS option. This encounter should be used as an opportunity to not only determine the client's readiness to select an HBSS option, but as a chance to conduct "health coaching" conversations, which will help foster program completion. This encounter is considered as a health coaching encounter if all the following criteria are met:

1. All items on the Health Behavior Encounter form/module are addressed and completed.
2. The discussion is done in the Spirit of MI and documentation supports the conversation addressing progress, barriers, and community resources.
3. The conversation should be 10–15 minutes.
   If the client expresses that she does not want to choose an option or discuss her IOV SMART goal, the encounter cannot be billed as an HBSS session. (See the Healthy Behavior Encounter form.)

At the end of the call, you are encouraged to ask permission to contact her again to see how she is doing. If there is a second 30-day encounter and it meets the above criteria, the client will have completed the recommended three HC support contacts. Document the session in the WISEWOMAN Med- IT® data management system.

Remember, clients who complete three coaching encounters through the 30-day call back service are eligible to receive the follow-up screening service.

If the client selects an HBSS option and is referred to the service, the 30-day call back(s) should be discontinued

Setting the Tone for the 30-day Call

"I understand that you are not ready to select a HBSS option today, however you have selected a priority area and established a SMART goal you would like to work on. We have lots of tools that can help you meet your goals."

"Thanks for giving me permission to call you back in 30 days to see how you are doing. Maybe then you might be ready to select one of the HBSS options. During the call I would also like to see how you are doing on the SMART goal you wrote today, and if you need any additional information and/or tools. We call this conversation health coaching …would that be okay?"

Section 12: Follow-up Screening – LSP/HC Complete

Purpose of Assessment

The follow-up screening allows the provider organization to offer additional support to the client while giving the agency an opportunity to collect mid-term outcome data. The provider must have the client's previous screening data (health history assessment, healthy lifestyle assessment, social services and support needs assessment, screening results, healthy behavior support, etc.) available to compare and to appropriately confer with the client.

Timing for Assessment

This encounter is to be provided only after the client has completed her healthy behavior intervention. The visit should occur within four–six weeks after LSP/HC completion, or at least three months prior to the client's re-screening appointment.

1. Health Coaching

   *Clients who complete 3 coaching encounters through the 30-day call back service are eligible to receive the follow-up screening services.

2. Health Coaching with Blood Pressure Self-Monitoring (3-5) sessions.

2. Health Coaching with Walk with Ease (3-5 coaching) sessions and complete a least 9 self-guided walking sessions
3. Lifestyle Programs
   a. TOPS – 12 meetings within a 6-month period.
   b. Diabetes Prevention Program - 9 of the 16 classes.
4. he Clinical Follow-up Assessment can occur:
   a. When/if the client is returning to the clinic for another reason.
   b. As a group wellness program, such as client recognition events, general risk reduction/health information presentations, etc. This format can increase the reach of the program and allow clients the opportunity to gain support from other women in the program

During the follow-up screening, the following services must be provided:
Cardiovascular history risk, social services and support and lifestyle assessments.

1. Clinical screening measures (weight, pressure readings).
   If the client had an abnormal cholesterol and/or glucose at the initial screening, the provider should administer a fasting cholesterol and glucose screening based on provider clinical judgement.
2. Clinical provider (NP, PA, MD) must review total follow-up assessment, and provide risk counseling and any necessary medical referrals.

Client Follow-up Assessment Screening - Referrals

Assessment	Follow-up
1. Elevated values (cholesterol, glucose).	✓ Provide additional risk counseling. ✓ Linked to a provider for ongoing care.
2. Elevated BP with HTN management sessions remaining.	✓ Provide client with remaining HTN sessions.
3. Elevated BP with no remaining HTN management visits.	✓ Link to provider for ongoing care.

Document visits in the WISEWOMAN Med-IT® data management system.

Section 13: Rescreen Services

Rescreening Visit

1. All WISEWOMAN clients will be considered a "baseline screen" in Year 1 of the 2023 funding period .
2. Rescreen designation will begin if the clients return for services in subsequent years. It is recommended that rescreening office visits occur 12 months following the last screening office visit. However, rescreening may occur 12–18 months following the baseline screening, in order to be scheduled with the Well Woman Program office visit. The rescreening visit should be an Integrated Office Visit to the extent possible.
3. The provider organization will provide clients with a follow-up phone call or text or mailing prior to her annual rescreen visit.
4. The provider must have the client's previous screening data (health history, healthy lifestyle and social services and support assessments, screening results, healthy behavior support, etc.) available to compare and to appropriately confer with the client.

Rescreening Integrated Office Visit Procedures

1. Rescreening provides the WISEWOMAN provider organization:
   a. A chance to reassess the client's heart disease, stroke, and diabetes risk factors, as well as to support progress toward the client's lifestyle behavior changes over time and determine any new/continuing clinical or social services and support needs
   b. The opportunity to provide feedback to the client regarding her progress toward reaching behavior goals, and reducing her heart disease, stroke, and diabetes risk factors.
2. The WISEWOMAN provider organization will contact clients up to one month prior to when their annual rescreen visit is scheduled to take place. Additional contacts from the provider organization to the client are executed as described previously in Contacting Clients Missed Integrated Office Appointments.
3. The annual rescreen visit should include all the services provided during the initial IOV, including healthy lifestyle, social services and support and CVD history assessment, risk counseling, appropriate medical referrals as needed, healthy behavior support services, and bi-directional social services and support referrals as needed.
4. Document the visit in the WISEWOMAN Med-IT® data management system.

Section 14: Data Management

Confidentiality of Client Information

1. All information gathered through the process of providing services to WISEWOMAN clients shall be deemed confidential.
2. WISEWOMAN clients will be made aware of the collection of information concerning them at the time of enrollment. Such information may be shared with program evaluation staff and appropriate staff at the Department of Health Services and others as required for coordination of care, claims payment, and as required by the federal funding source.
3. The WISEWOMAN provider organization is subject to all federal and state laws regarding confidentiality and disclosure of medical or other health information. Client information shall not be discussed in public except in professional settings required for the delivery of services or performance of other functions officially assigned to the program.
4. All clients' data and medical records or computerized files shall be maintained securely. Data files must be stored in a confidential manner.
5. In all cases, it is the provider organization and screening provider that "hold" the confidential information, not an individual employed by the agencies. Each agency must have its own procedure governing access to case files to individuals within the agency. If a program is monitored by a public agency (federal, state, or county) and is reviewing a program, he/she must request to review a client's files. However, the laws governing confidentiality of those files also extends to the public agent and files cannot be released to a third party.

Client Medical Record Maintenance

1. The WISEWOMAN medical provider will incorporate documentation of WISEWOMAN services for each client. The WISEWOMAN record must include documentation of WISEWOMAN and Well Woman service delivery information.
2. The client medical record files/data must be maintained in accordance with accepted medical record maintenance standards.
   a. Provider organizations using EMR systems must verify the data for accuracy and completeness prior to being entered in the WISEWOMAN data system. The provider does not have to print paper copies of the records as long as these records can be accessed to verify participant data.
   b. Provider organizations not using systems must keep copies of all of the client's paper forms.
3. The WISEWOMAN provider organization will enter data regarding the client's healthy lifestyle, health history, social services and support assessments, screening, follow-up findings (when applicable), and healthy behavior support encounter(s) into the WISEWOMAN Med-IT® data system within three working days after the client is seen or as soon as possible after receiving information from the health care provider.

Data Collection and Management

Wisconsin will be using OxBow Data Management System, LLC (Med-IT®) as our data system provider. Med-IT® is a web-based data system to collect and manage WISEWOMAN client services. The database is updated and maintained by OxBow-Med-IT® to meet the Centers for Disease Control and Prevention WISEWOMAN reporting, documentation, and evaluation requirements.

Provider Organization Responsibilities

Provider organizations will only have access to their client screening and healthy behavior support services data.

1. Enter accurate and complete data (demographic, CVD and lifestyle and social services and support assessments, clinical measurements, blood work values, risk counseling, LSP) and

HC referral information during the screening visits (baseline, follow-up, and rescreen). Providers will also enter the diagnostic and/or hypertension management screening visit when applicable.
2. Assure that all client information is kept confidential.
3. The program provides program forms. Information gathered on the forms represents all data that must be entered in Med-IT®. If paper documentation is used, or if the provider uses an EMR system, the provider organization must enter the client screening and service encounters into the program data system within **three working days** after the client is seen or as soon as possible after receiving information from the health care provider.
   a. The only program form that is sent to the state office is the Monthly Reporting for Direct Services form. This form should be sent via confidential mail or secured email by the 10th day of the month to reflect the activities from the previous month to the state office.
   b. Current forms can be found on the Department of Health Services website.
4. Conduct "real time" quality and error data entry checks.
5. Review validation reports sent by the data manager. These validation reports capture any data errors and quality issues that should be reviewed and corrected by the provider organization in a timely fashion, before the WISEWOMAN Minimum Data Elements (MDE) are submitted to the Centers for Disease Control and Prevention (CDC) twice each fiscal year.
6. Conduct program management activities using client data reports: WW Abnormal Assessment, LSP/HC Status, Hypertension and Diagnostic Referrals, Social Services and Support , Clients By Provider and queries.

State Office Responsibilities

1. Provide initial and refresher trainings and technical assistance on WI Med-IT® data entry and extraction.
2. Facilitate OxBow Med-IT® training as needed.
3. Monitor data and provide feedback on:
   a. Reporting accuracy.
   b. Quality of services based on National Clinical Care Guidelines and CDC program guidelines.
   c. Program evaluation/outcomes.
4. Maintain the program data system in order to support:
   a. MDE submissions.
   b. Program evaluation and performance measures.
   c. Provider feedback reports.
   d. Data quality and data system efficiency.
   e. User compliance and login authority.
5. Provide monthly validation reports.
6. Assure HIPPA compliance of the database.
   Maintain/update Med-IT® User Log, e.g., authorize users, deactivate users, or change user roles and responsibilities as needed.
7. Maintain WI Data Entry and Extraction Instruction Guide.
8. Implement OxBow Data Management Systems Med-IT® Release Notes as needed.

Accessing Med- IT®

1. Provider organizations do not need to install additional software beyond a web browser. Med-IT® supports the most recent versions of Internet Explorer. Provider organizations may also use Firefox or Chrome.
2. Email the data manager, Courteney Dickinson <Courtney.dickinson@dhs.wisconsin.gov>, with the following information to request training and to obtain a temporary user ID:
   a. Provider Organization name.
   b. Street address and zip code.

c. Staff name(s) (first and last), title/role, phone number and email address.

Med-IT® Training and Password Changes

1. All staff requesting new access to Med-IT® are required to attend a training.
2. The training will be tailored to the staff's role and responsibilities.
3. Once a training date has been scheduled, the program data manager will send a temporary login password and a copy of the OxBow Data Management Med-IT® Initial Login Guide. Staff are required to change their temporary password within 24 hours. The password change and login must be done before the training.
4. Login access should not be shared with unauthorized team members.

Staff are required to change their password periodically. The system will let the user know they have to reset their password when trying to log into Med-IT®.

Terminating Access

When a provider organization and/or individual staff is no longer authorized to access the WISEWOMAN database, the provider program coordinator must email the program data manager within 10 business days of the termination. The email should contain the name of the staff, the provider organization's name, and reason for the termination.

Data Reporting

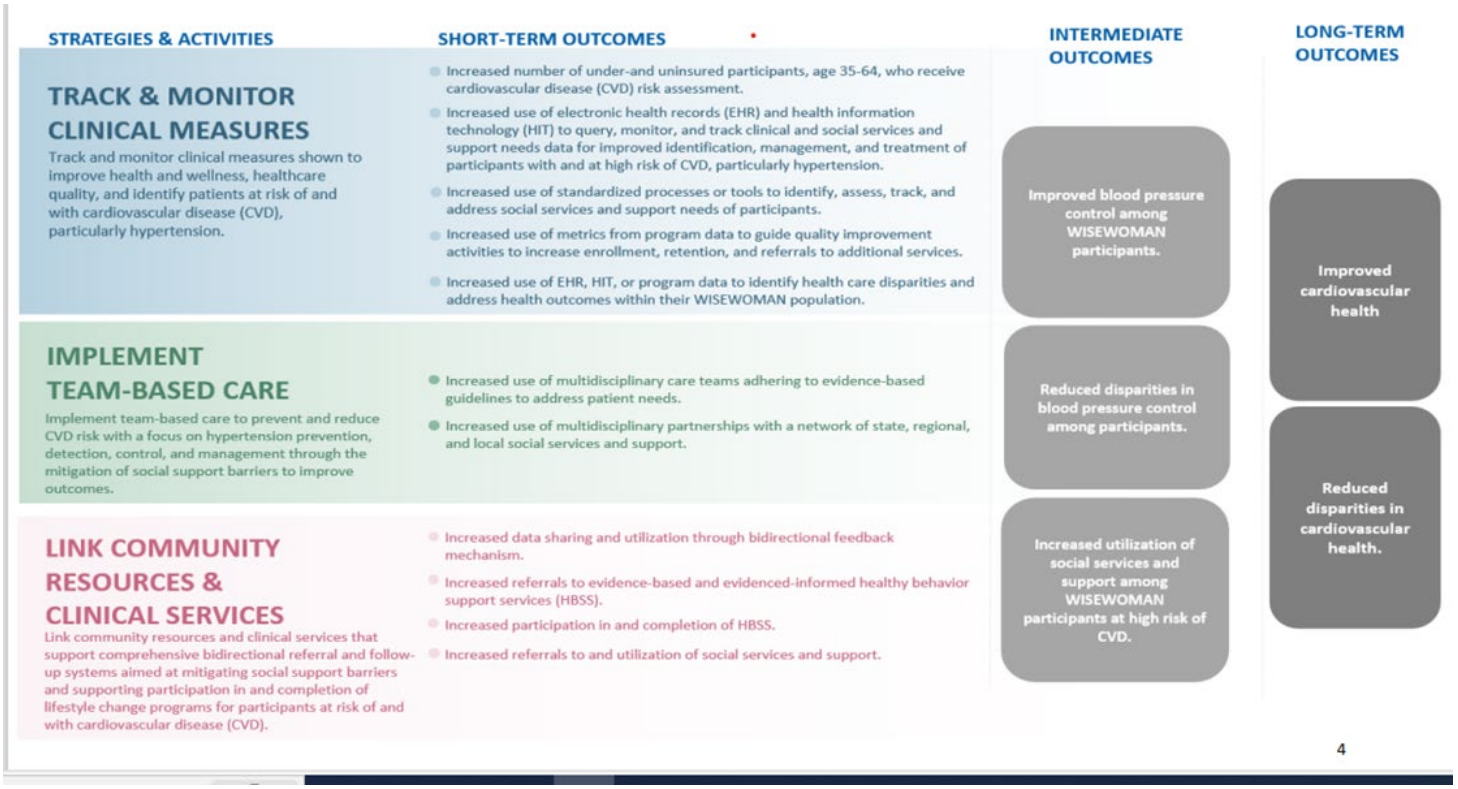
The WISEWOMAN Program was authorized by Congress and is funded by tax dollars. It is paramount that we have a clear picture of the program's impact on the women we serve. This can only be done by accurate and complete documentation. Ensuring that all the required data are entered in the Med-IT® data system is the foundation for capturing reliable WISEWOMAN service activity. These data will be used for program evaluation and to assess the impact of WISEWOMAN in reaching underserved women with cardiovascular disease screening, patient-centered risk counseling, healthy behavior support intervention, and low or/no cost health care referrals.

Quality Assurance

The goal of quality assurance (QA) is to assure that appropriate services are provided to each client and that program funds are utilized as required by program protocols. QA activities ensure high-quality medical standards of care are provided to women receiving WISEWOMAN program services. Quality assurance audits will monitor each WISEWOMAN provider organization's compliance with program implementation training and professional development activities. Program training and professional development activities will be recorded on the WISEWOMAN Provider Assurances and Training Checklist form. These forms will be kept with the provider organizations. Annually, a copy of each form will be sent to the state office.

Section 15: WISEWOMAN Evaluation

Strategies and Activities Logic Model



Program Evaluation

WISEWOMAN evaluation will provide information to stakeholders to ensure accountability, improve the program at the state and CDC levels, and expand practice-based evidence through sharing successful strategies. CDC will also provide evaluation technical assistance to WISEWOMAN program staff to support Wisconsin's evaluation and performance measurement efforts.

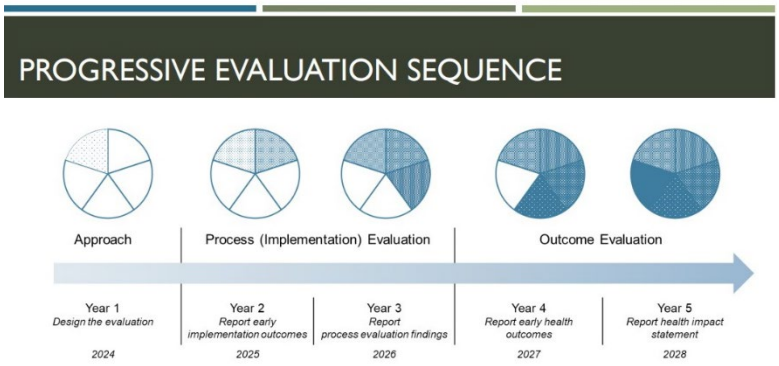
Overview of the WISEWOMAN Evaluation Approach

Ongoing monitoring, evaluation, and learning will be critical elements of the WISEWOMAN Program. There will be three primary components for the WISEWOMAN evaluation approach:

1. CDC-led comprehensive evaluation.
2. Wisconsin program-led evaluations.
3. CDC program Performance Measures.

The WISEWOMAN program will use a Progressive Evaluation Sequence

approach to evaluate program activities illustrated below. This will allow us to describe the health impact of the program by the end of the funding period.



Minimum Data Elements (MDEs)

WISEWOMAN Minimum Data Elements (MDEs) are a set of standardized data variables developed by CDC. These data variables ensure consistent and complete information. The DP-23-0003 cooperative agreement will collect 71 MDEs which are separated into eight categories: Administrative, Demographic, Health History and Medication Use, Behavioral, Clinical Values, Risk Reduction Counseling, Healthy Behavior Support Services, and Social Determinants of Health. MDEs serve the purposes of describing, monitoring, and assessing individual and program progress. The MDE data are obtained from the client health history, healthy lifestyle and social service and support needs assessments, screening, diagnostic, case management, and healthy behavior support contact data submitted by the WISEWOMAN provider organization. The state WISEWOMAN program collects and submits MDE data to CDC in June and December.

Performance Measures

Performance measures support the ongoing monitoring and reporting of program accomplishments at the state and CDC levels. Wisconsin is required to establish baseline values and annual target values and to report to CDC on each of the required measures.

Measure 1: # and % of WISEWOMAN providers with a protocol for using EHR and HIT data to query, monitor, and track clinical data to identify, manage, refer, and treat patients at risk of CVD, particularly hypertension.

Measure 2: # and % of WISEWOMAN providers using standardized processes or tools to identify, assess, track, and address social services and support needs of WISEWOMAN participants.

Measure 3: # and % of WISEWOMAN providers using standardized processes or tools to identify and address health care disparities.

Measure 4: # and % of WISEWOMAN providers who use multidisciplinary care teams that adhere to evidence-based guidelines.

Measure 5: # and type of social services and support within the recipient's network.

Measure 6: # and % of WISEWOMAN providers with an implemented community referral system (tracking bidirectional referrals) for medical follow-up, healthy behavior support services, and social services and support.

Measure 7: # and % of WISEWOMAN participants with known hypertension who have achieved or are currently maintaining blood pressure control.

Measure 8: # and % of WISEWOMAN participants, reported by race and ethnicity, with known hypertension who have achieved or are currently maintaining blood pressure control.

Short-Term Outcomes	
Intermediate Outcomes	
Long-Term Outcomes	

Section 16: Program Materials

All the documents listed can be accessed at this webpage.

Wisconsin encounter forms were developed to capture the WISEWOMAN Minimum Data Elements for DP18-1816. Only forms noted should be submitted to the state office monthly.

WISEWOMAN Forms and Publications–Integrated Office Visit

Number and Title	Description
Client Consent [F-01218 &	Used to provide client information on the services provided including screening, follow-up screening, rescreening, medical follow-up (if required), social services and support needs (if required), possible risks, and the potential benefits of their involvement in the program, protection of identifiable information, and use of information for monitoring and evaluation.
Health History Assessment [F-01219 &	Used to provide data (CVD history, medication prescribed and adherence, blood pressure self-monitoring practices) to support risk counseling and health coaching process and establish baseline indicators to assess health change at follow-up screening and rescreening visits.
Healthy Lifestyle Assessment [F-01220 &	Used to provide data (diet composition, alcohol consumption, physical activity level, use of tobacco products, depression) to support risk counseling and health coaching process, establish baseline indicators to assess health change at follow-up screening and rescreening visits.
Social Services and Support Assessment	Used to provide data(socioeconomic factors e.g., transportation, housing food insecurity, childcare, home safety etc.) that my impede lifestyle and clinic risk changes.
Screening Activity Report [F-01221]	Used to capture medical and lifestyle risk factors, clinical screening measurements, lab results, risk counseling, and clinical, social services and support needs and community follow-up referrals.
Healthy Behavior Encounter [F-01225]	Used to capture first and subsequent health coaching encounter activities (number of sessions, completion status, tools provided and community linkages, e.g., tobacco cessation, healthy eating, physical activity,
IOV Assessment Packet [F-01219-pckt &	Integrated Office visit forms (includes: Health History Assessment, Healthy Lifestyle Assessment, Social Services and Support Needs Assessment, Screening Activity, Healthy Behavior Encounter).
Program Screening and Healthy Behavior Support Guide [P-00909 &	Take-home education and support guide. Used to support risk counseling and health coaching. Guide provides screening results, information on healthy behavior support services, health coaching action planning, information on healthy eating, physical activity, and abnormal blood pressure. The guide also provides a sampling of free and/or no cost community resources.

WISEWOMAN Forms and Publications-Healthy Behavior Support Services

Number and Title	Description
Program Screening and Healthy Behavior Support Guide [P-00909 &	See description used in the IOV list.
Healthy Behavior Encounter [F-01225]	See description used in the IOV list.
Client Home Blood Pressure Monitoring Agreement [need form numbers for English and Spanish	Used to provide information on the purpose and the expectation(s) for BPSM. The client must agree and sign the agreement to receive blood pressure monitoring equipment.
Motivational Interviewing (MI) Encounter Flow Chart [P-00916]	Used as a quick reference guide when using MI.
WISEWOMAN Stages of Change Tip Sheet [P-00905]	Used as a quick reference guide for determining client readiness to change stage.

WISEWOMAN Forms and Publications–Diagnostic and HTN Management

Number and Title	Description
Diagnostic and Hypertension Management Referral [F-01222]	Used to capture the management and/or diagnostic services performed during the diagnostic and hypertension management follow-up visit (referral reasons, clinical findings including new diagnosis ICD codes, services assistance, work-up status, blood pressure readings).
Case Management [F-01223]	Used to document when the client refuses services or if the client was unable to be reached after three documented attempts.

WISEWOMAN Forms and Publications–Program Administration and Quality Assurance

Number and Title	Description
***Provider Assurances and Training Checklist** [F-01229]	Used to document WISEWOMAN staff implementation training and/or professional development requirements.
***Monthly Reporting for Direct Services** [F-01421]	Used to document monthly client WISEWOMAN services activity. The form is submitted to the state office by the 15th of the month to reflect the previous month's activity.
WISEWOMAN Program Provider Organization Implementation Manual [P-00917]	Used to provide provider organization staff implementation guidance on their roles and responsibilities, program overview, goals, framework for delivering services, and guidelines for WISEWOMAN direct services and program evaluation.

Well Woman Program Income Eligibility Guidelines [P-43029]	Provides income guidelines to be eligible for Well Woman. The guidelines are determined by the U.S. Department of Human Services and published by the Federal Register Journal each year.
WISEWOMAN Allowable CPT Codes [P-00906]	Provides a listing of the WISEWOMAN services codes that can be used.

Section17: Staff Directory

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