



# DP18-1816: Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN)



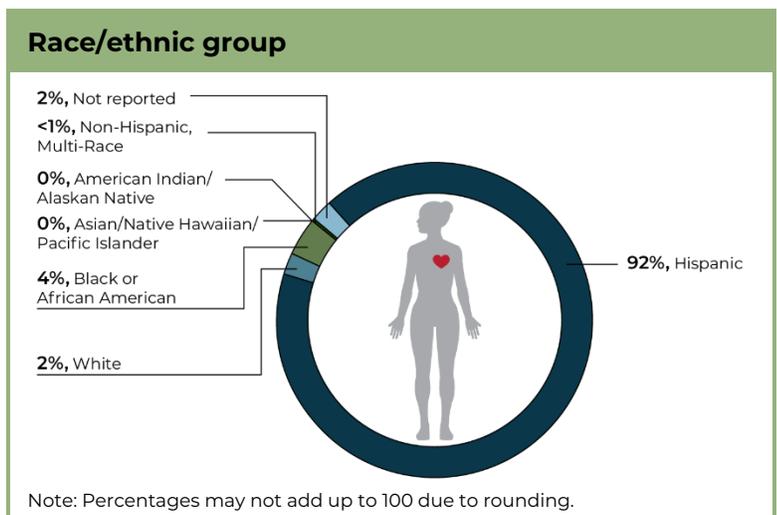
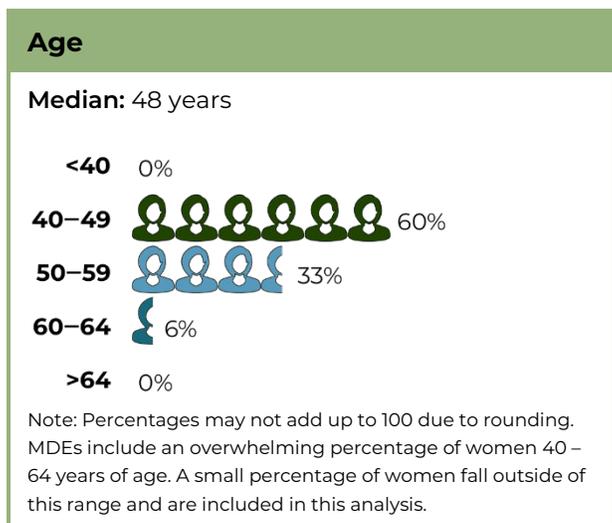
## Minnesota • Program Years 1 & 2 (September 2018 – September 2020) Recipient Profile<sup>1</sup>

The **Minnesota Department of Health** is a recipient of the CDC-funded WISEWOMAN cooperative agreement (CDC-RFA-DP18-1816). The WISEWOMAN program provides heart disease and stroke risk factor screenings and services to promote healthy behaviors to low-income, uninsured, and underinsured women aged 40 to 64 years. As a WISEWOMAN recipient, Minnesota is implementing the following strategies to improve the diagnosis, care, and management of women with hypertension: (1) strengthen clinical quality measurement, (2) support team-based care, and (3) facilitate community-clinical linkages.

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|---|---|---|
| <p><b>Core Funding:</b> \$850,000</p> <p><b>First Year Funded:</b> 2018</p> <p><b>Participation in Other CDC Heart Disease and Stroke Programs:</b></p> <ul style="list-style-type: none"> <li>■ <b>DP18-1815:</b> Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke</li> <li>■ <b>DP18-1817:</b> Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke</li> <li>■ <b>DP15-1514:</b> Paul Coverdell National Acute Stroke Program</li> </ul> | <p><b>Recipient Organization:</b><br/>Minnesota Department of Health</p> <p><b>Prevalence of Hypertension:</b> <sup>2, 3</sup><br/>23% of Minnesota WISEWOMAN participants had high blood pressure at baseline screening</p> <p><b>Key Partners:</b></p> <ul style="list-style-type: none"> <li>■ Hennepin Health</li> <li>■ Minnesota Community Care</li> <li>■ University of Minnesota Extension</li> </ul> | <p><b>WISEWOMAN Innovation Component Funding:</b> \$70,000</p> <p><b>Innovation Funding Activities:</b></p> <ul style="list-style-type: none"> <li>■ Partner with the Minnesota Community Care clinic system to provide medication therapy management to participants via telehealth</li> </ul> |
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## WISEWOMAN participants in Program Years 1 and 2

WISEWOMAN recipients submit data to CDC biannually describing the number of women served and the types of services received. During Program Years 1 and 2 (September 30, 2018 – September 29, 2020), the **Minnesota WISEWOMAN program served 605 women**; distribution of participants by age and race/ethnicity is shown below.<sup>2</sup>



<sup>1</sup> This profile provides an overview of the activities and key achievements during Program Years 1 and 2 of the WISEWOMAN DP18-1816 program (September 2018 – September 2020), as reported within recipients' annual evaluation reports, annual progress reports for Program Years 1 and 2, annual performance measure report as of December 31, 2020, and Minimum Data Elements (MDEs). For more information, please contact [DHDSPEvaluation@cdc.gov](mailto:DHDSPEvaluation@cdc.gov).

<sup>2</sup> Based on an analysis of MDE data for women who were screened in Program Years 1 and 2, including complete, BP+, and incomplete screening records (n = 605).

<sup>3</sup> High blood pressure is defined as systolic blood pressure > 139 mmHg or diastolic blood pressure > 89mmHg.



## WISEWOMAN strategies to promote cardiovascular health

The WISEWOMAN program uses **evidence-based approaches to heart disease and stroke prevention** within health care systems and throughout communities. Women who are screened and found to have high blood pressure, diabetes, or high blood cholesterol receive clinical care and are referred to healthy behavior support services (HBSS), including lifestyle programs, health coaching, and risk reduction strategies with community support. Below, we describe the Minnesota program’s approach to this work and provide updates on Minnesota’s performance measures at the end of Program Year 2.<sup>4</sup>



### Strategy 1. Track and monitor clinical measures shown to improve healthcare quality and identify patients with hypertension

The WISEWOMAN program aims to **improve sharing and use of clinical data** among providers to facilitate care coordination and promote better health outcomes.

| Highlights from Minnesota  | Performance measures   |
|--|--|
| <ul style="list-style-type: none"> <li>Developed a report to track participants who are at an increased risk for hypertension.</li> <li>Helped WISEWOMAN clinics develop workflow models for identifying and managing patients with hypertension.</li> </ul> | <p><b>95%</b> of WISEWOMAN participants were screened by providers that have a protocol for identifying patients with undiagnosed hypertension (<b>606 women</b>).</p> <hr/> <p><b>100%</b> of WISEWOMAN providers implemented a community referral system (through bi-directional referrals) for HBSS for people with high risk for CVD (<b>4 providers</b>).</p> |



### Strategy 2. Implement team-based care to reduce CVD risk with a focus on hypertension control and management

**Use of team-based care** helps ensure provider adherence to evidence-based guidelines and policies for participants with high blood pressure and high cholesterol and increases participation of non-physician team members. This approach also helps participants manage their own health and CVD risk factors.

| Highlights from Minnesota   | Performance measures   |
|---|--|
| <ul style="list-style-type: none"> <li>Conducted an annual training on team-based care.</li> <li>Encouraged clinical providers to conduct regular care team meetings to ensure participants receive appropriate referrals and follow-up.</li> </ul> | <p><b>100%</b> of WISEWOMAN participants were screened by providers that have policies or systems to implement a multidisciplinary team-based approach to blood pressure control (<b>636 women</b>).</p> |



### Strategy 3. Link community resources and clinical services that support bi-directional referrals, self-management, and lifestyle change for women at risk for CVD

**Linkages to HBSS**, including health coaching and lifestyle programs (LSPs), help engage participants in the WISEWOMAN program. Minnesota’s LSP partners include the National Diabetes Prevention Program, East Lake Wellness Program, and Eat Smart Be Active Learning Circles.

| Highlights from Minnesota   | Performance measures  |
|---|---|
| <ul style="list-style-type: none"> <li>Referred participants to pharmacists for support with Medication Therapy Management.</li> <li>Developed tailored guides for each WISEWOMAN clinic that list the HBSS options available in the area and provide guidance on referral criteria.</li> </ul> | <p><b>58%</b> of WISEWOMAN participants were referred to an appropriate HBSS (<b>368 women</b>).</p> <hr/> <p><b>47%</b> of WISEWOMAN participants who were referred to an HBSS attended at least one session (<b>172 women</b>).</p> |

**The activities described above contribute to improved health outcomes related to blood pressure control. As a long-term measure, this will be reported in subsequent years.**

<sup>4</sup> Based on an analysis of performance measure data for women who were served in Program Years 1 and 2 (n = 636). This data source is different than the MDE data reported on Page 1.