DP18-1816

Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN)

North Carolina • Recipient Profile[1]

Program Years 1 – 3 (September 2018 – September 2021)

The **North Carolina 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, North Carolina 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.

Year 3 Core Funding: $900,000

First Year Funded: 1995

Participation in Other CDC Heart Disease and Stroke Programs:

- **DP18-1815:** Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke

Recipient Organization: North Carolina Department of Health

Prevalence of Hypertension: [2, 3]

33% of North Carolina WISEWOMAN participants had high blood pressure at baseline screening

Key Partners:

- Community and Clinical Connection for Prevention and Health
- Office on Minority Health

Innovation Funding Amount: $40,000

Innovation Funding Activities:

- Establish protocols to facilitate bi-directional referrals between the Harbor Inc. domestic violence shelter and the Johnson County Health Department

Key Innovation Partners:

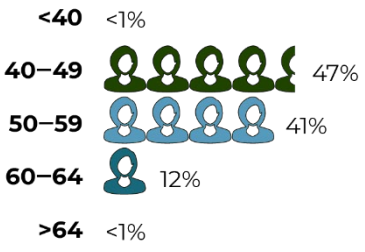
- Harbor Inc. Domestic Violence Shelter
- Johnson County Health Department

WISEWOMAN participants in Program Years 1 through 3

WISEWOMAN recipients submit data to CDC biannually describing the number of women served and the types of services received. During Program Years 1 through 3 (September 30, 2018 – September 29, 2021), the **North Carolina WISEWOMAN program served 2,616 women**; distribution of participants by age and race/ethnicity is shown below.[2]

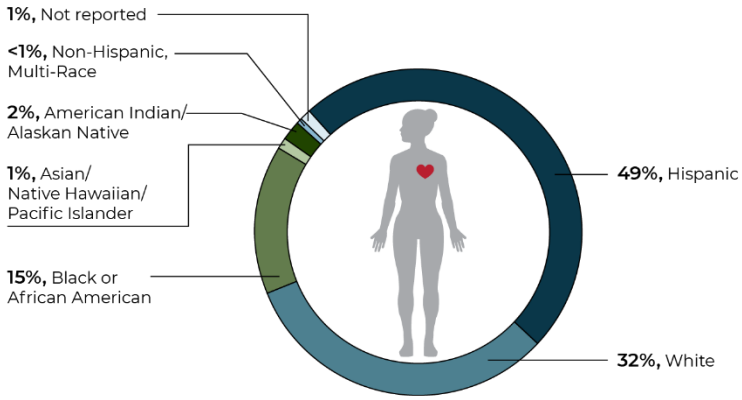
Age

Median: 50 years



Note: MDEs include an overwhelming percentage of women 40-64 years of age. A small percentage of women fall outside of this range and are included in this analysis.

Race/ethnic group



Note: Percentages may not add up to 100 due to rounding.

[1] This profile provides an overview of the activities and key achievements during Program Years 1 through 3 of the WISEWOMAN DP18-1816 program (September 2018 - September 2021), as reported within recipients' annual evaluation reports, annual progress reports for Program Years 1 through 3, annual performance measure report as of December 31, 2021, and Minimum Data Elements (MDEs). For more information, please contact DHDSPEvaluation@cdc.gov.

[2] Based on an analysis of MDE data for women who were screened in Program Years 1 through 3, including complete, BP+, and incomplete screening records (n = 2,616). Hypertension rate and distribution by age and race/ethnicity at baseline include 2,209 participants with valid data for key elements at baseline screening.

[3] 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 North Carolina program's approach to this work and provide updates on North Carolina's performance measures through the end of Program Year 3.[4]

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 North Carolina

- **Shared monthly reports with WISEWOMAN clinics** that display the number of participants served and potential data quality issues.
- **Provided technical assistance to clinical providers** on the use of data to track and monitor participants with hypertension.

Performance measures

97%	of WISEWOMAN participants were screened by providers that have a protocol for identifying patients with undiagnosed hypertension **(2,529 women)**.
10%	of WISEWOMAN providers implemented a community referral system (through bi-directional referrals) for HBSS for people with high risk for CVD **(3 providers)**.

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 North Carolina

- **Continued to provide training opportunities for clinical providers** on use of team-based care.
- **Began developing a team-based care toolkit** for providers.

Performance measures

100%	of WISEWOMAN participants were screened by providers that have policies or systems to implement a multidisciplinary team-based approach to blood pressure control **(2,619 women)**.

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. North Carolina's LSP partners include NC HeartWise..

Highlights from North Carolina

- **Conducted a series of webinars for providers** on HBSS options and referral protocols.
- **Continued disseminating the American Heart Association "Heart Healthy Toolkit"** to WISEWOMAN providers to encourage heart healthy activities in communities serving participants.

Performance measures

100%	of WISEWOMAN participants were referred to an appropriate HBSS **(2,619 women)**.
97%	of WISEWOMAN participants who were referred to an HBSS attended at least one session **(2,540 women)**.

100 out of 757 participants with known high blood pressure achieved blood pressure control in Year 3 compared to **13 out of 174** participants in Year 1.

[4] Based on an analysis of performance measure data for women who were served in Program Years 1 through 3 (n = 2,619). This data source is different than the MDE data reported on Page 1.