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

Utah • Program Years 1 & 2 (September 2018 – September 2020)
Recipient Profile[1]

The **Utah 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, Utah 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.

Core Funding: $1,100,000

First Year Funded: 2008

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
- **DP18-1817:** Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke

Recipient Organization: Utah Department of Health

Prevalence of Hypertension: [2, 3]

21% of Utah WISEWOMAN participants had high blood pressure at baseline screening

Key Partners:

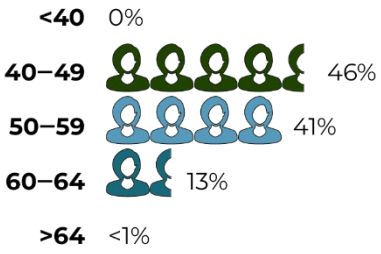
- Million Hearts Coalition
- Federally Qualified Health Centers
- Local Health Departments

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 **Utah WISEWOMAN program served 2,308 women**; distribution of participants by age and race/ethnicity is shown below.[2]

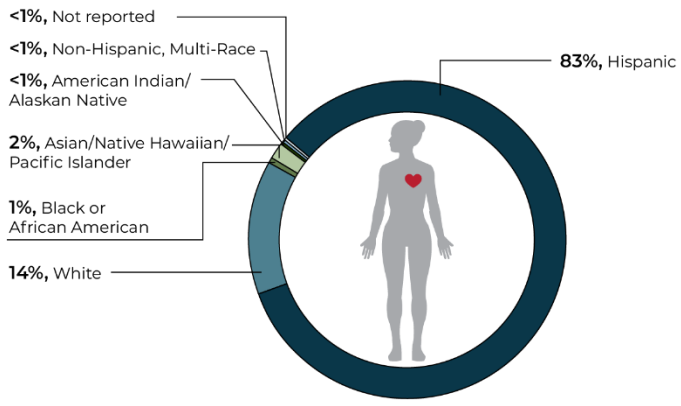
Age

Median: 50 years



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

[2] 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 = 2,308).

[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 Utah program's approach to this work and provide updates on Utah's performance measures at the end of Program Year 2.[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 Utah

- **Launched a new data system** with expanded capabilities for tracking and monitoring clinical measures.
- **Used surveillance data from Utah's Indicator Based Information System** to identify gaps in services, CVD risk factors, and social determinants of health to inform program planning.

Performance measures

100% of WISEWOMAN participants were screened by providers that have a protocol for identifying patients with undiagnosed hypertension **(2,637 women)**.

100% of WISEWOMAN providers implemented a community referral system (through bi-directional referrals) for HBSS for people with high risk for CVD **(11 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 Utah

- **Collaborated with pharmacists** to develop workflows and plans for the Medication Therapy Management program.
- **Partnered with Million Hearts Coalition** to help clinics implement Automated Office Blood Pressure measurement.

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 **(2,637 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. Utah's LSP partners include Medication Therapy Management, Expanded Food and Nutrition Education Program, and Weight Watchers.

Highlights from Utah

- **Maintained a list of available community-based resources** on the program website.
- **Trained HBSS providers** on use of trauma-informed care.

Performance measures

92% of WISEWOMAN participants were referred to an appropriate HBSS **(2,432 women)**.

99% of WISEWOMAN participants who were referred to an HBSS attended at least one session **(2,420 women)**.

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.

[4] Based on an analysis of performance measure data for women who were served in Program Years 1 and 2 (n = 2,637). This data source is different than the MDE data reported on Page 1.