Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program:

Implementation of Core Strategies in Years 1 & 2 (2018–2020)

The WISEWOMAN program is designed to prevent, detect, and control hypertension and other cardiovascular disease (CVD) risk factors by providing services to low income, uninsured, or under-insured women aged 40 to 64. These services include CVD screenings and healthy behavior support services (HBSS), such as health coaching and evidence-informed lifestyle programs for individual and group behavior change. In 2018, the Division for Heart Disease and Stroke Prevention in the Centers for Disease Control and Prevention (CDC) launched a 5-year funding cycle for the WISEWOMAN program recipients, which funds **21 states and 3 tribal organizations.** In Year 2, a total of 21,305 women participated in the WISEWOMAN program.

WISEWOMAN recipients are required to use three core strategies (see table below) to increase blood pressure control among participants and improve prevention, detection, and control of CVD.

WISEWOMAN screenings and referrals in Year 2*

16,558 women received a complete or BP+ screening

14,703 women referred to health coaching or lifestyle programs

Source: Analysis of minimum data elements for women with a complete or BP+ screening in Year 2
*See footnote below

WISEWOMAN core strategies to reduce CVD risk and associated outcomes

Strategy	Short-term outcomes (Years 1 and 2)	Intermediate outcomes (Years 3 and 4)	Long-term outcomes (Year 5 and beyond)
Strategy #1: Track and monitor clinical measures shown to improve health care quality and identify patients with hypertension	Increased reporting, monitoring, and tracking of clinical data	Increased data sharing and use	Increased blood pressure control Improved prevention, detection, and control of CVD
Strategy #2: Implement team-based care to reduce CVD risk, with a focus on hypertension control and management	Increased use of and adherence to evidence-based guidelines and policies related to team-based care	Increased engagement in self-management	
Strategy #3: Link community and clinical resources for women at risk for CVD	Increased use of data systems to identify and refer at-risk women to appropriate HBSS	Increased participation in HBSS and improved and maintained healthy behavior and lifestyle changes	

This document summarizes recipients' activities and implementation progress in Years 1 & 2 for each of the three WISEWOMAN core strategies.

Data

This document highlights data synthesized from several sources that describe implementation of WISEWOMAN's three core strategies in the first two program years (September 30, 2018, to September 29, 2020):

Program documents submitted by each recipient. These include applications, annual performance reports, and implementation briefs.

Performance measure data. Recipients submitted performance measures based on all participants enrolled in WISEWOMAN. CDC validated and aggregated the data.

Participant-level minimum data elements.* These describe participants' demographics, clinical values, responses to health assessment questions, and referrals to and engagement in HBSS.

Methods

Qualitative analysis of program documents included systematically abstracting information about each recipient's approaches to implementation and identifying themes across recipients. Quantitative analysis of performance measures and minimum data elements included validating the data and developing summary statistics of the aggregate data.

By implementing the core strategies, recipients aim to improve health outcomes.

43.5% of WISEWOMAN participants with known hypertension achieved or are currently maintaining blood pressure control through Year 2 (Source: Aggregate performance measure analysis from Year 2)

* The minimum data element analyses include participants with complete or BP+ screening records (*N* = 16,558 women). Complete screening records have valid data for key demographic and health variables. BP+ screening records have valid data for most key variables; however, unlike complete records, they do not have information about participants' diabetes lab tests (glucose or hemoglobin A1C measurements) or self-reported levels of physical activity, nutrition, or stress.

National Center for Chronic Disease Prevention and Health Promotion
Division for Heart Disease and Stroke Prevention

Strategy #1: Track and monitor clinical measures shown to improve health care quality and identify patients with hypertension

With this strategy, the WISEWOMAN program aims to improve providers' use and sharing of data to better coordinate care and promote better health outcomes.

Common approaches to implementing this strategy

Over half of recipients implemented the following:

- **Assessing WISEWOMAN providers' use of hypertension protocols** for identifying patients with undiagnosed hypertension through surveys and document review.
- **Providing training opportunities** for WISEWOMAN clinical providers and staff on collecting clinical measures, using data to monitor program operations, and implementing hypertension protocols.

About a third of recipients implemented the following:

- **Conducting site visits** to clinical provider sites to provide technical assistance to support increased use of hypertension protocols.
- **Convening monthly meetings** with clinical providers and HBSS providers to discuss performance measures, best practices for monitoring data, and barriers to using data.
- **Developing dashboards and data reports** for WISEWOMAN providers and staff.
- **Using electronic health records** to identify and track patients with undiagnosed hypertension at one or more clinical provider sites. Examples of this work include the following:
  - + Creating automated alerts for patients with high blood pressure
  - + Adding a checkbox to the electronic health record to identify and query data for patients who participate in WISEWOMAN
  - + Using dynamic worklists and registries to guide outreach

Some recipients implemented these unique approaches:

- **Creating toolkits** to help clinical providers implement protocols for identifying or managing hypertension.
- **Funding** one or more clinical provider sites to help develop hypertension protocols.
- **Partnering with other programs and organizations** to support this work.

Related performance measures

86% of WISEWOMAN participants were screened by a provider that had a protocol for identifying patients with undiagnosed hypertension.

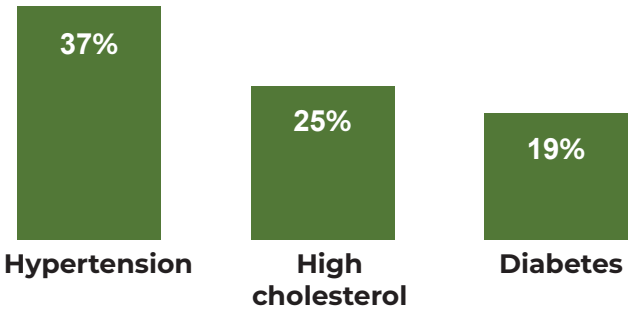
78% of WISEWOMAN providers implemented a community referral system* (through bidirectional referrals) for healthy behavior support services for women at risk for CVD.

Source: Aggregate performance measure analysis from Year 2
*See page 4 for detailed information on referral systems

Key partners for this strategy

- Chronic disease programs, such as the DP18-1815 and DP18-1817 programs
- Quality improvement organizations and experts
- Organizations with expertise in health information technology and use of electronic health records

Tracking and monitoring clinical measures helps providers identify WISEWOMAN participants with chronic diseases, such as hypertension, high cholesterol, and diabetes.



Percentage of WISEWOMAN participants with hypertension, high cholesterol, or diabetes at baseline screening

N = 16,558 participants

Source: Analysis of minimum data elements for participants with a complete or BP+ baseline screening in Year 2

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

The members of WISEWOMAN care teams vary by recipient and provider site, but teams commonly include *primary care providers, nurses, medical assistants, lab staff, social workers, pharmacists, community health workers,* and occasionally *mental health providers, diabetes educators, dieticians, recreation therapists,* and *case managers*. With this strategy, the WISEWOMAN program aims to provide patient-centered, comprehensive care and help participants self-manage their health conditions and CVD risk factors.

Common approaches to implementing this strategy

Over half of recipients implemented the following:

- **Using motivational interviewing to** encourage participants to take an active role in their health care.
- **Training clinical providers** on using a team-based care model. Examples of training topics include the following:
  - + Integrating community health workers, health navigators, and health coaches into the WISEWOMAN care team
  - + Using motivational interviewing
  - + Transitioning care in front of the patient and family to allow for increased engagement and communication
- **Conducting site visits** to learn about clinical providers' use of team-based care and provide technical assistance.
- **Referring participants** to self-monitoring blood pressure programs and providing blood pressure cuffs to support self-monitoring at home.

About a third of recipients implemented the following:

- **Integrating pharmacists into WISEWOMAN care teams** to promote participants' medication adherence.
- **Integrating community health workers into WISEWOMAN care teams** to recruit participants and help them self-manage their CVD risk factors.
- **Disseminating guidance and resources to WISEWOMAN care teams** about team-based care, such as videos that describe best practices, monthly digital newsletters, and webinars.

Some recipients implemented these unique approaches:

- **Encouraging use of shared decision making curricula and tools** such as Brief Action Planning and Know Your Numbers.
- **Partnering with clinics that have experience using team-based care** such as Federally Qualified Health Centers with Patient-Centered Medical Home certifications.

Related performance measures

93% of WISEWOMAN participants were screened by a provider with policies or systems in place to implement a multidisciplinary team-based approach to blood pressure control.

Source: Aggregate performance measure analysis from Year 2

Key partners for this strategy

- Pharmacies
- Professional organizations that provide trainings on care coordination
- Statewide organizations and coalitions that support the expanded role of health coaches and community health workers

Recipients use team-based care to help participants self-manage their CVD risk factors and other health conditions.

Monitor blood pressure at home

Percentage of all participants with uncontrolled hypertension who monitor their blood pressure at home

N = 3,114 participants with uncontrolled hypertension at baseline screening

Source: Analysis of minimum data elements for participants with a complete or BP+ baseline screening in Year 2

Strategy #3: Link community resources and clinical services that support bidirectional referrals and lifestyle change for women at risk for CVD

Linkages between community and clinical resources are intended to engage participants in HBSS, including health coaching (HC), lifestyle programs (LSP), and other community-based resources. With this strategy, the WISEWOMAN program aims to improve coordination between clinical providers and HBSS providers and promote healthy behavior and lifestyle change among participants.

Common approaches to implementing this strategy

Over half of recipients implemented the following:

- **Referring participants to LSP and HC programs** focused on weight loss, healthy diet, and exercise.
- **Referring participants to community-based organizations** such as YMCAs, food pantries, community gardens, farmers markets, and faith-based organizations.
- **Training providers** on identifying women to refer to HBSS, addressing barriers to HBSS attendance, and improving coordination between clinical providers and HBSS providers.
- **Leveraging new or existing partnerships** with community-based organizations.

About a third of recipients implemented the following:

- **Referring women to tobacco cessation resources.** According to an analysis of the minimum data elements, about one third of women who identified as smokers were referred to and completed a tobacco cessation resource.
- **Encouraging health coaches to use evidence-based resources** such as toolkits from the American Heart Association's EmPowered to Serve and Check.Change.Control programs.
- **Translating** health education materials into multiple languages.
- **Offering a variety of HBSS by phone and video,** including Weight Watchers, the National Diabetes Prevention Program, self-monitoring blood pressure with clinical support programs, telehealth services, and telehealth services led by pharmacists.

Some recipients implemented these unique approaches:

- **Establishing electronic bidirectional notification systems** that automatically alert clinical providers of participants' HBSS attendance.
- **Using social media or text messages** to encourage engagement in HBSS.

Related performance measures

85% of WISEWOMAN participants were referred to an appropriate HBSS.

80% of WISEWOMAN participants who were referred to HBSS attended at least one session.

Source: Aggregate performance measure analysis from Year 2

Key partners for this strategy

Organizations that provide evidence-based HBSS, including YMCAs, Weight Watchers, and Taking Off Pounds Sensibly, Inc.

Parks, farmers markets, and other local resources that support physical activity and healthy eating

State agencies that provide opportunities for bidirectional referrals, such as tobacco cessation and expanded food and nutrition programs

Recipients refer participants with a *hypertension diagnosis* to LSP and HC programs that promote heart-healthy lifestyle changes.

Were referred to one or more LSP/ HC programs

Attended one or more LSP/HC sessions

Percentage of all participants with hypertension who were referred to, attended, and completed an LSP or HC program

N = 3,114 participants with uncontrolled hypertension at baseline screening

Source: Analysis of minimum data elements for participants with a complete or BP+ baseline screening in Year 2