WISEWOMAN™

Well-Integrated Screening and Evaluation for WOMen Across the Nation

1816 Grant Edition:
September 2018 – September 2023

Indiana Well-Integrated Screening and Evaluation for Women Across the Nation (IN-WISEWOMAN) Program Manual

Indiana Department of Health
Division of Chronic Disease, Primary Care and Rural Health
Revised August 2020

Table of Contents

INTRODUCTION

Program History

In 1993, Congress authorized the Centers for Disease Control and Prevention (CDC) to establish the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program to extend services provided to women as part of the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). WISEWOMAN provides NBCCEDP participants access to additional preventive health services, including screenings for cardiovascular disease risk factors, referrals for medical evaluation, health coaching and lifestyle programs. Because both programs are from the Breast and Cervical Cancer Mortality Prevention Act of 1990, they are considered "sister" programs.

The Indiana WISEWOMAN (IN-WISEWOMAN) Program was implemented through the Indiana Department of Health, Division of Chronic Disease, Primary Care and Rural Health. The IN-WISEWOMAN Program was introduced as an enhancement to the Indiana Breast and Cervical Cancer Program (IN-BCCP), the Indiana implementation of NBCCEDP, and is offered to women who are enrolled in IN-BCCP in targeted geographic areas. The Indiana Department of Health IN-WISEWOMAN Program first received funding from the CDC to implement the program in 2013, with current funding secured through 2023.

WISEWOMAN and NBCCEDP At-a-Glance

The NBCCEDP and WISEWOMAN Program are "sister" programs offering two distinct health services. Table 1 below gives a comparison of WISEWOMAN and NBCCEDP.

Table 1. WISEWOMAN and NBCCEDP At-a-Glance

	NBCCEDP	WISEWOMAN
Year First Funded	1990	1995
Nationwide Funded Programs	50 states, District of Columbia, 5 territories and 12 tribal organizations	21 states and 3 tribal organizations
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
Focus of Program	Early detection of breast and cervical cancer; population-based approaches and systems that increase high-quality breast and cervical cancer screening and management consistent with current guidelines	Decrease risk of cardiovascular disease (CVD), risk reduction counseling, lifestyle programs and healthy behavior support services to prevent CVD and/or improve control of hypertension and other CVD risk factors
Services Provided	• Cancer screening: ○ Breast exam and mammography	• CVD risk factor assessment/screening including

	○ Pap test • Diagnostic tests to pinpoint problems • Referrals to health care providers for medical management of conditions for women with abnormal or suspicious test results	○ Assessment of CVD history, lifestyle behavior and readiness to change status • Referrals for women with abnormal screening values to health care providers for medical evaluation • Follow-up for uncontrolled hypertension • Evidence-based lifestyle programs and/or health coaching to promote behavior changes and CVD risk reduction • Client linkage to free/low-cost medical care, medication, community-based nutrition, physical activity and tobacco cessation resources
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 the 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 reduction counseling and chronic disease management support • Regional sites offer screening services, patient navigation and healthy behavior support services

Program Need

According to the CDC National Center for Health Statistics, Indiana had the 13th highest mortality rate from heart disease in the nation in 2018.[1] Further, Indiana's overall prevalence of hypertension is approximately 35%,[2] about 6% higher than the national rate.[3] For Indiana women ages 40-64, in 2018, there were more than 1,100 deaths due to cardiovascular disease, the incidence rate of hospitalizations due to stroke was 250 per 100,000 and the incidence rate of hospitalization due to heart attack was 185

[1] https://www.cdc.gov/nchs/pressroom/sosmap/heart_disease_mortality/heart_disease.htm
[2] 2017 Indiana BRFSS
[3] https://www.cdc.gov/nchs/products/databriefs

per 100,000.[4] According to the Small Area Health Insurance Estimates from the U.S. Census Bureau approximately 16% of Indiana's women, ages 40-64, who live at or below 200% of the poverty level are uninsured.[5] The need for early detection and prevention of cardiovascular disease (CVD) for women in Indiana is high, and the WISEWOMAN Program provides the services to those with greatest need.

Program Description

The national WISEWOMAN program was created to help women understand and reduce their risk for heart disease and stroke by providing screening services for early detection and promoting lasting heart-healthy lifestyles. Through WISEWOMAN, low-income, underinsured or uninsured women ages 40-64 are provided the knowledge, skills and opportunities to improve their diet, physical activity and other lifestyle habits to prevent, delay or control cardiovascular and other chronic diseases.

Target Population

The target population for the program is low-income, uninsured or underinsured women ages 40-64 who participate in the NBCCEDP. The Indiana Department of Health targets locations where the population experiences disparities in CVD risk factors, morbidity and mortality. The Indiana Department of Health ensures that data, including burden data, are used to identify strategies and communities within these populations to support program initiatives.

Health Disparities

Disparities exist within cardiovascular health outcomes for women. These disparities are compounded by variations in disease rates and access to preventive and treatment services among low-income, uninsured and/or racial and ethnic minority populations. The Indiana Department of Health works to implement priority population approaches to prevent heart disease and stroke and reduce health disparities among women in the target population.

[4] Inpatient Hospital Discharge Data, Indiana Department of Health Data Analysis Team
[5] 2018 Small Area Health Insurance Estimates (SAHIE) Program

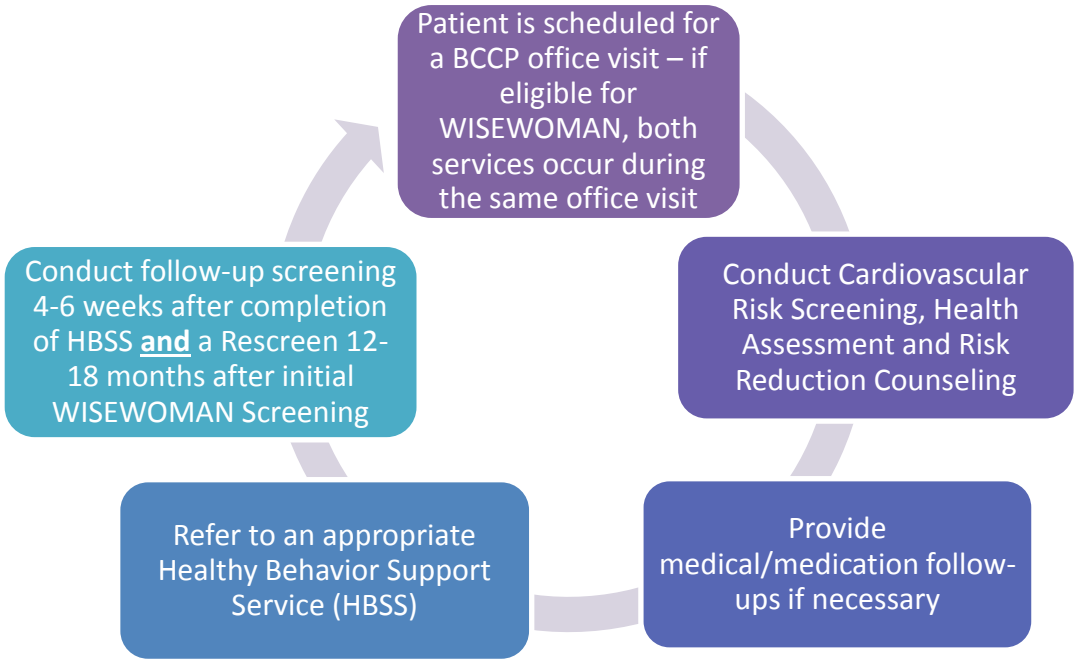
Purpose of This Manual

This manual is designed to support the IN-WISEWOMAN Program staff, partners and stakeholders by providing the policies, protocols and information needed to run a successful program, as well as to ensure the quality of data collection and management to meet CDC requirements. This program manual contains information adapted from the CDC Guidance Document, referenced throughout, and is organized by the program activities as required by the CDC for grant cycle 2018-2023.[6]

Program Overview

The IN-WISEWOMAN Program extends preventive health services to identify and reduce cardiovascular risk for women who are participants enrolled in the IN-BCCP. The service delivery flow is summarized in Figure 1.

Figure 1. WISEWOMAN Service Delivery Flow



These extended preventive health services are provided to lower the incidence of heart disease and stroke by focusing on the following three strategies:

1. **Track and monitor clinical measures** shown to improve healthcare quality and identify patients with hypertension.
2. **Implement team-based care** to reduce CVD risk with a focus on hypertension control and management.
3. **Link community resources and clinical services** that support bidirectional referrals, self-management and lifestyle change for women at risk for CVD.

[6] CDC WISEWOMAN Guidance Document

PROGRAM ROLES AND RESPONSIBILITIES

The IN-WISEWOMAN Program is implemented through collaboration with multiple partners from various levels of the socioecological model. The roles and responsibilities of each are detailed below.

Indiana Department of Health

The Indiana Department of Health is the awardee of the WISEWOMAN grant in Indiana. Because of its ties with the IN-BCCP, the IN-WISEWOMAN Program is housed in the Cancer Section within the Division of Chronic Disease, Primary Care and Rural Health. The Indiana Department of Health is responsible for managing and implementing the program and employs the IN-WISEWOMAN Program Director to oversee and manage all aspects of the program, including budget and administration, policy and protocol development, implementation, quality assurance, material development and technical assistance.

Program Management and Implementation

1. Develop guidelines and reporting requirements based on national CDC guidelines.
2. Maintain ongoing communications with the IN-WISEWOMAN provider agencies regarding program policies, procedures, screening and diagnostic data, and other issues as they arise.
3. Provide the IN-WISEWOMAN Program forms, lifestyle program and health coaching materials and program implementation manual.
4. Provide training, technical assistance and professional education resources.
5. Set, monitor and maintain quality assurance standards.
6. Maintain client confidentiality.
7. Provide promotional items, literature and other educational materials as needed.

IN-WISEWOMAN Providers

IN-WISEWOMAN providers are responsible for enrolling women and delivering services to participants in the program. They are the gatekeepers to women's lifestyle behavior changes and are accountable for referring women to appropriate IN-WISEWOMAN services to improve health and reduce risk of cardiovascular disease. Providers must adhere to the IN-WISEWOMAN Program policies and procedures, attend trainings as necessary and submit data collected for the program.

Training/Orientation

1. Participate in IN-WISEWOMAN Program orientation and training sessions.
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 and hip measurement; biometric testing procedures; and patient-centered risk reduction counseling using motivation interviewing techniques.
3. Meet licensing and certification requirements.
4. Perform medical evaluations 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.

Screening

1. Provide screening services in accordance with National Clinical Care guidelines.
2. Utilize patient-centered risk reduction counseling for all patients screened, including:
    a. Provide screening results both verbally and in writing;
    b. Explain each client's health risk based on screening results;
    c. Link patients to a health coach, healthy behavior support service and/or community resources to help them reduce their risk of heart disease, stroke and diabetes.
3. Provide a follow-up screening to patients who have completed Healthy Behavior Support Services (HBSS) 4-6 weeks after completion of HBSS.
4. Provide rescreening (or annual screening) 12-18 months after the initial screening or previous annual screening for comparison and appropriate continued care with the participant.

Follow-up Services

1. Provide 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.
2. Conduct medical follow-up for patients who have alert values (defined by CDC's guidance) immediately or within seven calendar days.
3. Conduct medication follow-up for patients who have abnormal values (defined by CDC's guidance) immediately or within six weeks.
4. Refer patients with uncontrolled hypertension to a health coach.

Community-Clinical Linkages

1. Refer patients to low-cost or free medications if they require medication therapy, and document whether patients in need of medication resources were linked to these services.
2. Refer patients with no medical home and in need of ongoing medical care to free or low-cost resources.
3. Refer patients to an IN-WISEWOMAN health coach or internal staff who meet qualifications to offer health coaching.
4. Maintain bidirectional referrals with IN-WISEWOMAN health coaches, IN-WISEWOMAN nurses and/or other community resources to remain updated on patients' progress, and use the information to further patient-centered care plans.

Data Collection and Reporting

1. Document all screening and follow-up visits.
2. Submit all documentation to the regional office.
3. Participate in quality assurance reviews and monitoring by the central office.
4. Support program evaluation as needed.

Regional Coordinating Office

The IN-BCCP contracts with regional coordinating offices in three regions throughout the state; Northern, Central and Southern. The regional coordinating offices operate at the community level and are responsible for program implementation; client recruitment; screening; rescreening; follow-up

services; facilitating community-clinical linkages; and collecting, maintaining and submitting programmatic data.

Program Implementation

1. Act as the central point of contact between the provider and the Indiana Department of Health.
2. Meet or show significant progress toward meeting performance measures established by the CDC.
3. Ensure IN-WISEWOMAN Program protocols for service delivery, case management and reporting are being followed.
4. Participate in IN-WISEWOMAN Program orientation and training sessions.
5. Ensure laboratory services used for screening meet current clinical guidelines. Ensure adherence to the manufacturer's guidelines in the use of laboratory technology.
6. Ensure providers are skilled in implementing appropriate screening services, such as accurate blood pressure measurement, accurate biometric testing procedures and waist measurement, patient-centered risk reduction counseling using motivational interviewing techniques, etc.

Client Recruitment

1. Recruit patients from the IN-BCCP.
2. Enroll patients for IN-WISEWOMAN services using the appropriate forms.
3. Encourage patient to participate in HBSS.
4. Encourage patients to return for follow-up screening and annual screening.

Screening

1. Ensure patient-centered risk reduction counseling and health coaching are delivered in accordance with program protocols.
2. Coordinate recruitment efforts to ensure that eligible women are enrolled in both programs.
3. Schedule patients for IN-WISEWOMAN services at the same appointment time as the IN-BCCP services when possible. Instruct patients to fast for at least nine hours prior to their screening lab work.
4. Ensure patients are notified whether recommended services are covered or not covered by the IN-WISEWOMAN Program prior to receiving them and that patients are not billed for any service that is covered by the IN-WISEWOMAN Program.

Follow-Up Screening

1. Schedule women for follow-up screenings four to six weeks following the completion of HBSS.
2. Ensure the provider has the participants' previous screening information (health assessment, screening results, healthy behavior support service history, etc.) available for comparison and that they appropriately confer with the participants.

Rescreening

1. Schedule women for annual screenings at 12- to 18-month intervals.

2. Ensure the provider has the participants' previous screening information (health assessment, screening results, healthy behavior support service history, etc.) available for comparison and that they appropriately confer with the participants.

Follow-up Services

1. Ensure patients receive timely and appropriate medical follow-up (unless the woman refuses), as indicated by the assessment and screenings.
    a. Ensure that participants who have alert values (as defined by CDC's guidance) have access to a medical follow-up and treatment immediately or within seven calendar days.
    b. Ensure that participants who have abnormal values (defined by CDC's guidance) are referred for medication follow-ups if deemed necessary by the provider.
    c. Ensure documentation of three attempts to contact the patient for follow-up of alert findings and/or healthy behavior support services before designating the patient as "lost to follow-up".
2. Ensure that participants with uncontrolled hypertension are referred to an IN-WISEWOMAN health coach and referred to appropriate community resources as necessary.
    a. Ensure involvement in community resources is tracked and recorded.
3. Provide case management services as needed.

Community-Clinical Linkages

1. Ensure participants needing ongoing health management are linked to reduced fee or low-cost ongoing medical treatment as indicated based on screening recommendations.
2. Assist participants in gaining access to low-cost or free medications if they require medication therapy. Ensure and document whether participants in need of medication resources were linked to these services.
3. Conduct community scans with assistance from the central office. The scans should identify existing resources in the community that support healthy lifestyle changes.
4. Provide referral to community resources to help participants achieve their lifestyle behavior change goals.
5. Maintain bidirectional referrals with providers and community resources, consistently updating information on each participant's progress as she participates in services.
6. Update bidirectional referral map semi-annually.

Data Collection and Reporting

1. Track participant services (screening, health coaching, community resources, etc.).
2. Ensure participant confidentiality and protection of medical records as required by law.
3. Ensure documentation of all screenings, assessments, healthy behavior support services and participant communications.
4. Maintain copies of all IN-WISEWOMAN forms in participants' records.
5. Provide programmatic data to data management team for data tracking and MDE submissions.
6. Participate in quality assurance reviews, program evaluation and monitoring by the central office and the program evaluator.

PARTICIPANT ELIGIBILITY AND ENROLLMENT

To qualify for IN-WISEWOMAN services, women must be enrolled in the IN-BCCP and meet the age requirements of the IN-WISEWOMAN Program. Women can enroll during IN-BCCP office visits or through special enrollments at regional coordinating offices.

Eligibility Criteria

Participants must:

- Be enrolled and remain eligible to participate in the IN-BCCP
- Be in the priority age range of 40-64 years old
- Earn 200% or less of the federal poverty level
- Be underinsured or uninsured
- Be enrolled in Medicare, Part A only (if eligible for Medicare)

*If the participant meets eligibility criteria at the time of the initial screening but experiences a change in eligibility status in one or more areas during the annual cycle of services, she may continue to receive IN-WISEWOMAN Program services through rescreening.

Participant Enrollment

Providers should recruit current IN-BCCP participants who meet IN-WISEWOMAN age requirements to enroll in the IN-WISEWOMAN Program. The IN-WISEWOMAN Program services may begin either during an integrated screening visit with an IN-BCCP provider or at a nonintegrated office visit following the IN-BCCP screening.

Integrated versus Nonintegrated Visits

The intent and benefit of coupling NBCCEDP and WISEWOMAN is to create a stronger link to ensure that women aged 40-64 who are enrolled in the NBCCEDP also receive appropriate cardiovascular disease risk assessment and risk reduction in states that have both NBCCEDP and WISEWOMAN programs. Therefore, the CDC strongly recommends that office visits for IN-WISEWOMAN screenings are integrated into the IN-BCCP screening office visit when possible. Table 2 outlines details about integrated and nonintegrated visits.

Table 2. Integrated versus Nonintegrated Visits

	Integrated Visit	Nonintegrated Visit
When and Where	The IN-WISEWOMAN Program screening services occur at the same time and location as IN-BCCP services.	The IN-WISEWOMAN Program screening services occur at a different time and possibly different location than IN-BCCP services. *Providers must make every effort to enroll women in the WISEWOMAN Program within 60 days of the IN-BCCP office visit.
Screening Services	Integrated Screening Services: -Pap test and/or HPV test and/or CBE -Height and weight measurement to calculate body mass index -Blood pressure measurement -Smoking assessment and referral for cessation if needed Enroll in IN-WISEWOMAN and provide the following services: Labs including: -Cholesterol (Total, LDL, HDL) -Lipids -Glucose -A1C -Risk reduction counseling -Referral for medical/medication follow-up -Referral to health coach/lifestyle program	Screening services may be provided by a provider or IN-WISEWOMAN nurse and include: - Blood pressure measurement -Height and weight measurement to calculate body mass index -Smoking assessment and referral for cessation if needed -Cholesterol (Total, LDL, HDL) -Lipids -Glucose -A1C -Risk reduction counseling -Referral for medical/medication follow-up -Referral to health coach/lifestyle program
Reimbursement	The office visit is reimbursed with IN-BCCP funds.	The office visit is reimbursed with IN-WISEWOMAN Program funds.
	IN-WISEWOMAN funds are used to reimburse costs associated with: -IN-WISEWOMAN labs -Risk reduction counseling	IN-WISEWOMAN funds are used to reimburse all IN-WISEWOMAN services including: -Clinical measures, -IN-WISEWOMAN labs -Risk reduction counseling

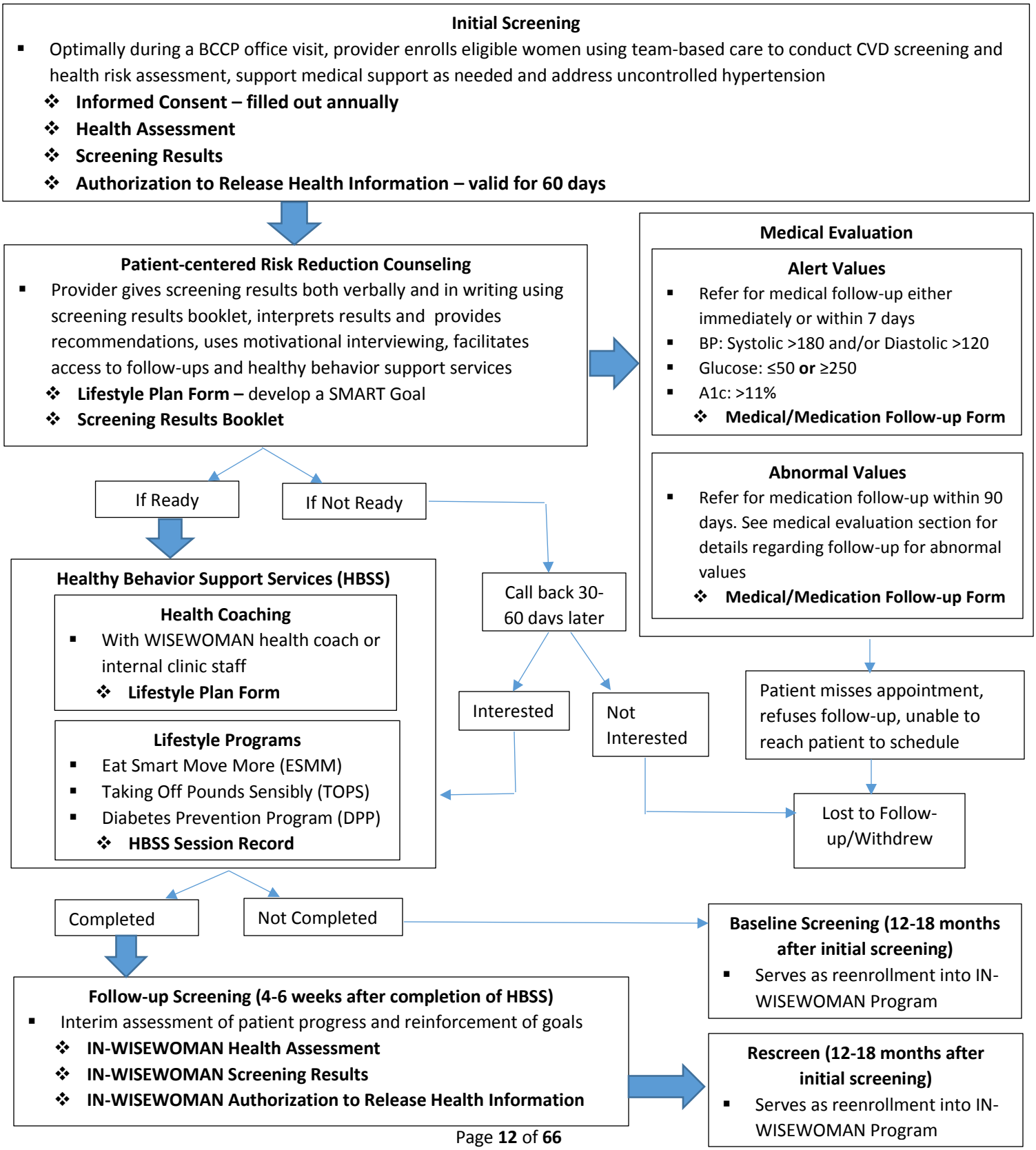
Required Enrollment Forms

To enroll a participant in the IN-WISEWOMAN Program and get paid for services, the following forms must be completed and on file:

- IN-WISEWOMAN Informed Consent – filled out annually
- IN-WISEWOMAN Health Assessment
- IN-WISEWOMAN Screening Results
- IN-WISEWOMAN Authorization to Release Health Information – valid for 60 days; should be signed during any office visit/screening with participants

The IN-WISEWOMAN Program flow is illustrated in Figure 2, with the required forms bolded.

Figure 2. IN-WISEWOMAN Program Flow



CARDIOVASUCLAR DISEASE SCREENING

Providers conducting IN-WISEWOMAN screening services must comply with the following requirements:

- Maintain a valid and current IN-WISEWOMAN Provider Agreement with the Indiana Department of Health (refer to your Provider Agreement for more details)
- Conduct screenings for women enrolled in the IN-WISEWOMAN Program
- Collect **all** data with IN-WISEWOMAN forms
- Conduct screenings in accordance with the National Care Clinic guidelines

The IN-WISEWOMAN Program screening consists of:

- Health risk assessment
- Clinical measurements
- Risk reduction counseling
- Appropriate referrals to healthy behavior support services
- Referral for further medical evaluation (based on designated clinical measurements)

Health Risk Assessment

The information collected during the health risk assessment provides individuals with an assessment of their cardiovascular disease health risks and helps providers work collaboratively with participants to make decisions to improve health.

The health risk assessment includes:

- Participant demographics
- Health history
- Lifestyle assessment
- Tobacco use assessment

The participant should fill out a Health Assessment Form in the language the participant understands best. Participants with lower literacy levels should be assisted in completing the assessment form. The Health Assessment Form should be filled out by the participant before risk reduction counseling.

Tobacco Use Assessment and Referral Policy

The CDC requires all WISEWOMAN organizations to assess all enrolled participants for tobacco use status and refer those who use tobacco to cessation services. The Indiana Department of Health is committed to ensuring all IN-WISEWOMAN participants who are interested in quitting tobacco have equal opportunities to access a variety of effective cessation treatments. If a participant answers that she currently uses tobacco products on her Health Assessment, providers should advise the participant that quitting tobacco use is a crucial step she can take to protect her health. The Indiana Department of Health recommends referring participants to the Indiana QuitLine[7] or offering other evidence-based behavioral and pharmacotherapy treatment options that the participant prefers.

WISEWOMAN funds can be used for various tobacco cessation programs (beyond the QuitLine), especially if the QuitLine does not address language or other cultural barriers. However, WISEWOMAN

[7] https://www.in.gov/quitline/

funds cannot be used for nicotine replacement therapies. Many quit lines and other tobacco cessation resources offer these therapies at little or no cost.

Clinical Measurements

The clinical screening component assesses for chronic disease risk factors. The CDC requires that clinical services be delivered in a health care setting that will:

- Be user-friendly for patients (culturally and linguistically appropriate and easy to navigate)
- Be efficient for patients and staff in terms of cost and time
- Use treatment protocols to improve control of hypertension
- Have quality assurance processes in place
- Use multidisciplinary health care teams
- Have effective training procedures
- Have mechanisms to track information through electronic health records
- Have mechanisms to communicate information to the patient and the patient's primary health care team[8]

To participate in the IN-WISEWOMAN Program, the following clinical measures must be collected for each participant:

- Height, weight and body mass index (BMI)
- Waist circumference
- Blood pressure (average of two readings)
- Cholesterol (total, LDL, HDL)
- Triglycerides
- A1C or glucose levels

Height, Weight and BMI

Height and weight are required for all IN-WISEWOMAN Program participants as part of all screenings (initial, follow-up, baseline and rescreen). Waist circumference is an optional measurement that the IN-WISEWOMAN Program strongly recommends for BMIs >35. The waist circumference can be used alone as an indicator of health risk because abdominal obesity is the primary issue.

According to the American College of Sports Medicine, BMI is used to assess weight relative to height and is calculated by dividing body weight in kilograms by height in meters squared (standard BMI charts or tables can be used). For most people, obesity-related health problems increase beyond a BMI of 25. A BMI of >30 is associated with increased risk of hypertension, total cholesterol/high-density lipoprotein (HDL) cholesterol ratio, coronary disease and mortality. BMI can be used to help participants compare their own weight status to that of the general population.[9] (See Table 3.)

[8] CDC Guidance Document
[9] ACSM's Guidelines for Exercise Testing and Prescription

Table 3. BMI Classifications

Classification	BMI	Follow-up Guidelines
Underweight	<18.5	Refer to health coach.
Normal	18.5-24.9	Refer to health coach.
Overweight	25.0-29.9	Refer to health coach.
Obese	30.0 and above	Refer to health coach.

Waist Circumference

Body fat distribution is an important predictor of the health risks of obesity. Abdominal fat provides an increased risk of hypertension, metabolic syndrome, type 2 diabetes, dyslipidemia, coronary artery disease and premature death compared with individuals who demonstrate fat distributed in the hip and thigh. The waist circumference can be used alone as an indicator of health risk because abdominal obesity is the primary issue. Risk classification for waist circumference in adults can be found in Table 4.[10]

Table 4. Waist Circumference Classifications

Risk Category	Waist Circumference	Follow-up Guidelines
Very low	<70 cm (27.5 in)	Refer to health coach.
Low	70-89 cm (28.5-35 in)	Refer to health coach.
High	90-109 cm (35.5 – 43.0 in)	Refer to health coach.
Very high	≥110 cm (43.5 in)	Refer to health coach.

Note: The procedure for taking waist circumference can be found in Appendix A.

Blood Pressure

According to the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC), the relationship between blood pressure (BP) and risk for cardiovascular events is continuous, consistent and independent of other risk factors. The higher the BP, the greater the chance of heart attack, heart failure, stroke and kidney diseases.[11] Table 5 generalizes the WISEWOMAN Program BP classifications based on the American Heart Association's BP thresholds and recommendations for treatment and follow-up[12] as well as the CDC's guidance for alert values. Uncontrolled hypertension is defined as cases where treatment for hypertension has not achieved these target blood pressures. Positive lifestyle changes should be encouraged for all participants with uncontrolled hypertension.

[10] ACSM's Guidelines for Exercise Testing and Prescription
[11] https://jamanetwork.com/journals/jama/fullarticle/1791497
[12] https://www.heart.org/-/media/files/health-topics/high-blood-pressure/tylenol-hbp/aha18hyperpocketguideprint3final-approved.pdf?la=en

Table 5. Classification and Follow-up Recommendations for Blood Pressure

BLOOD PRESSURE VALUES AND FOLLOW-UP PROTOCOL					
Blood Pressure Classification	**Systolic BP mmHg**		**Diastolic BP mmHg**	**Lifestyle Modification**	**Follow-up Protocol**
Normal	<120	and	<80	Encourage	Refer to health coach.
Prehypertension	120-129	and	<80	Yes	Refer for medication follow-up immediately or within 90 days. Refer to health Coach.
Stage 1 Hypertension	130-139	or	80-89	Yes	Refer for medication follow-up immediately or within 90 days. Refer to health coach.
Stage 2 Hypertension	140-180	or	90-120	Yes	Refer for medication follow-up immediately or within 90 days. Refer to health coach.
Alert Values	>180	and/or	>120	Yes	**Refer for medical follow-up immediately or within 1 week.** Refer to health coach.

Note: Proper blood pressure measurement techniques and common positioning problems can be found in Appendix A.

Lipid and Blood Sugar Laboratory Tests

Maintaining healthy cholesterol and blood sugar levels lowers the chance of developing cardiovascular disease. Cholesterol and glucose or A1C measurements must be collected as part of the initial/annual screening. The IN-WISEWOMAN classifications and follow-up protocols for required IN-WISEWOMAN lab results are shown in Tables 6 through 9 below.

LABORATORY TEST REQUIREMENTS:

- Laboratory tests should be done within 30 days before or after the screening visit.
- **Record all values regardless of fasting status.**
- Fasting laboratory tests are preferred over nonfasting, in accordance with national clinical guidelines.
    - **Women should fast a minimum of 9 hours prior to fasting tests.**
- For participants with pre-existing diabetes, or for those who are nonfasting, the A1C should be performed for glucose testing.
- Organizations may use A1C tests (point-of-care or laboratory).
    - The A1C (Glycosylated Hemoglobin) test should be performed in a laboratory using a method that is up-to-date in certification and standardization.
- Providers may test and record both glucose and A1C for participants.
- Participant should receive a fasting lipid profile if she has:
    - A family history of heart attacks
    - Early onset atherosclerotic disease
    - A genetic history of hyperlipidemia
    - A nonfasting triglyceride level of ≥400 mg/dL

- Providers should make every effort to refer participants to the provider currently treating existing conditions. If the participant does not have a medical home, providers should proceed with internal protocols for management and treatment.
- The IN-WISEWOMAN Program will reimburse providers for medical follow-ups and medication follow-ups for the designated values in Table 10. Refer to the Reimbursement Section for more information about reimbursement.

EXCEPTIONS TO LABORATORY TEST REQUIREMENTS:

- In cases where labs were done prior to 30 days, the medical director at the organization should determine the length of time labs are considered valid.

Table 6. Classification and Follow-up Protocols for Adult Lipid Values: Nonfasting

Classification	Total Cholesterol (mg/dL)	HDL Cholesterol (mg/dL)	LDL Cholesterol (mg/dL)	Triglycerides (mg/dL)	Follow-up Protocol
Low		<40			Refer to health coach.
Normal	<200	>40 >60 (optimal)	<100		Refer to health coach.
Borderline High	200-239		100-159		Refer for fasting lipid profile **within 90 days if not currently being treated for high cholesterol**. Refer to health coach.
High	≥240		160-189		Refer for fasting lipid profile and/or medication follow-up **within 90 days if not currently being treated for high cholesterol.** Refer to health coach.
Very High	≥400		≥190	≥400	Refer for fasting lipid panel and/or medication follow-up **within 90 days.** Refer to health coach.

Table 7. Classification and Follow-up Protocols for Adult Lipid Values: Fasting

Classification	Total Cholesterol (mg/dL)	HDL Cholesterol (mg/dL)	LDL Cholesterol (mg/dL)	Triglycerides (mg/dL)	Follow-up Protocol
Low		<40			Refer to health coach.
Normal	<200	>40 >60 (optimal)	<100	<150	Refer to health coach.
Borderline High	200-239		100-159	150 - 199	Refer to health coach.
High	≥240		160-189	≤200-499	Refer for medication follow-up **within 90 days if not currently being treated for high cholesterol.** Refer to health coach.
Very High	≥400		≥190	≥500	Refer for medication follow-up **within 90 days.** Refer to health coach.

Table 8. Classification and Follow-up Protocols for Adult A1C and Glucose Values

Classification	Glucose mg/dL (Fasting)	A1C % (Nonfasting)	Follow-up Protocol
Desirable	70-99	< 5.7	No referral for medical evaluation. Refer to health coach.
Pre-diabetes	100-125	5.7-6.4	Referral for medical evaluation **will NOT be paid for by WISEWOMAN Program.** Refer to health coach.
Diabetes	126-250	≥ 6.5	Refer to provider treating diabetes. **If not currently seeing a provider, refer for medication follow-up within 90 days.** Refer to health coach.
Alert	≤50 **or** ≥250	≥ 11	Refer to provider treating diabetes. **If not currently seeing a provider, refer for medical follow-up <u>immediately or within 1 week.</u>** Refer to health coach.

Table 9. Additional Guidance Regarding Personal History and Glucose/A1C

Values	Personal History?	Follow-up Protocol
Fasting Plasma Glucose >100 **Or** **Casual Plasma Glucose >100** **Or** **Casual or Fasting Plasma Glucose ≤50**	No	Refer for follow-up fasting plasma glucose. (Follow-up fasting plasma glucose cannot occur on the same day as the screening glucose.)
	Yes	Refer for hemoglobin A1C. (Participant should not receive a follow-up fasting plasma glucose.)

Risk Reduction Counseling

Participant-centered risk reduction counseling (RRC) is a major component of the IN-WISEWOMAN Program. RRC can help IN-WISEWOMAN participants become effective and informed managers of their health and health care. Studies indicate that patients who are engaged and actively participate in their own care have better health outcomes. Providers should use motivational interviewing (MI) with all IN-WISEWOMAN participants (see Appendix B). **Providers and IN-WISEWOMAN staff should deliver program services and ensure use of program materials and handouts in the language the participant understands best.**

PROVIDERS MUST COMPLY WITH THE FOLLOWING REQUIREMENTS:

- Participants must receive screening results, interpretation of the results and recommendations in accordance with national guidelines. This information must be provided both verbally and in writing.
    - **Providers should use the IN-WISEWOMAN Screening Results Booklet to provide results to participants.**
- Provide risk reduction counseling to all IN-WISEWOMAN Program participants face-to-face at the time of their screening visits.
    - If laboratory results are not available at the time of the screening visit, provide counseling based on available information. Complete risk reduction counseling when laboratory results are available.
        - This can be provided in person or by phone.
        - If provided by phone, ensure the participant receives a copy of her screening results.
    - If the clinic does not have staff available to provide RRC in the language the participant understands best, the participant should be referred to IN-WISEWOMAN staff for RRC completion.
- During RRC, staff must:
    - Discuss the patient's screening and health risk assessment results.
    - Ensure the patient understands her CVD risk as compared to other women her age.
    - Consider a patient's language, health literacy and cultural background in the interaction.
    - Use motivational interviewing skills.
        - The Indiana Department of Health encourages utilizing Brief Action Planning (BAP), a type of MI, with participants to empower them to set their own health goals and be in control of their health plan.
        - The Indiana Department of Health offers BAP training to interested providers upon request. BAP is just one way to use MI (see Appendix B for motivational interviewing tools and BAP resources).
    - Collaboratively identify strategies to support goals (e.g., health coaching, lifestyle programs and other healthy behavior support services).
        - **Providers should use the Lifestyle Plan Form to create a Specific, Measureable, Attainable, Realistic, Timely (SMART) goal with participants. (This SMART goal created during risk reduction counseling does not count as a health coaching session.)**
            - **Providers will only be reimbursed for RRC with the submission of a completed Lifestyle Plan Form to the regional office.**

Referring Participants to Medical Evaluation

During RRC, if screening results indicate a participant has elevated or alert values, the provider should refer the participant for medical evaluation and:

- Arrange follow-up for women with uncontrolled hypertension.
- Reduce barriers to understanding the treatment regimen and receiving medication, particularly for hypertension.
- Provide chronic disease self-management support.

For more information regarding follow-up, see the Medical Evaluation for Alert and Abnormal Values section.

Referring Participants to Healthy Behavior Support Services

IN-WISEWOMAN offers Healthy Behavior Support Services (HBSS) to every participant, upon completion of an IN-WISEWOMAN screening, to decrease risk of cardiovascular disease and improve overall health. **This includes women with normal screening values because other factors, such as stress, may increase risk for cardiovascular disease.** During RRC, providers should refer the participant to appropriate HBSS. Providers will:

- Inform the participant that an IN-WISEWOMAN staff member will check in with her in 30-60 days to follow up on participation and progress in the HBSS.
- If the participant is not interested or ready for an HBSS option at the time of RRC, an IN-WISEWOMAN health coach will follow up in 30-60 days to provide another opportunity to enroll in HBSS.
- Submit paperwork to the IN-WISEWOMAN coordinating office.
    - Participant will be assigned to an IN-WISEWOMAN health coach upon receiving paperwork.

For more information about HBSS, see the HBSS section.

Referring Participants to Other Community Resources

Regional staff update Community Scans yearly. Providers should be familiar with accessible resources available to participants that focus on preventing cardiovascular disease. Regional staff and providers should work together to ensure women are aware of and/or referred to community programs and resources that can be utilized between IN-WISEWOMAN services. For more information about Community Scans, see the Community-Clinical Linkages section of this manual.

MEDICAL EVALUATION FOR ALERT AND ABNORMAL VALUES

WISEWOMAN requires that women with abnormal screening results have appropriate medical evaluation in accordance with standards of care and WISEWOMAN Program guidelines. The medical provider will determine the need for follow-up visits based on criteria as indicated in the next sections. The purpose of the follow-up is to avoid women falling through the cracks and at the same time avoid incurring unnecessary visits and costs. Providers should:

- Ensure all women have access to free or low-cost medical care and medication, as needed.
- Have an effective referral process for abnormal findings.
- Ensure that all paperwork is submitted to the regional office so that every woman is assigned to a health coach who will guide her through the IN-WISEWOMAN Program.

Mandatory Visits for Alert Values

WISEWOMAN alert values indicate the need for immediate attention. (See Table 10.) They are based on current clinical practice and risk to the individual's health.

- **Providers must arrange to ensure these patients receive medical evaluation and treatment either immediately or within seven calendar days of the alert measurement** in accordance with national standards of care and the judgement of the medical director.
    - **This is known as a medical follow-up.**
    - **Complete the Medical/Medication Follow-up Form for medical follow-up.**
- If the patient cannot arrange to be seen by a medical provider within the allotted seven calendar days, case management services must be implemented with attempts to get the patient to return for follow-up.
    - **Use the Medical/Medication Follow-up Form to document the date(s) staff attempted to contact patient.**
        - **After three attempts, the patient is considered lost to follow-up.**
        - **Submit the form with the contact attempt dates to the regional office to document the patient's status.**
- If the patient refuses medical evaluation for alert values, the medical provider will inform the client of the benefits of receiving further care and the health consequences of refusing a medical follow-up.
    - The provider or IN-WISEWOMAN staff must receive either verbal or written refusal of services from the patient.
    - **Use the Screening Results Form, Waiver to decline recommended WISEWOMAN Services on the bottom of page two for refused services.**
        - **Submit the form with the patient's refusal to the regional office to document the patient's status.**

Uncontrolled Hypertension Management

Providers should have established standard protocols for follow-up of uncontrolled hypertension. The protocol may vary depending on the capacity of the health care facility, but at a minimum should

include medication counseling. If a provider does not have protocols in place, IN-WISEWOMAN staff will work with the provider to establish them. Protocols may include:

- Team-based care and community-clinical linkages with pharmacists, nutritionists, nurse educators, community health workers or others
- Use of electronic reporting and tracking of blood pressure trends

The aim is to establish or strengthen practical methods to track and improve control of hypertension, a major focus of the WISEWOMAN Program. Patients with uncontrolled hypertension must be referred to a hypertension management program, such as:

- HBSS
- Community resource that focuses on reducing blood pressure, eating healthy or increasing physical activity
- Self-measured blood pressure monitoring

Medication Follow-up for Elevated Blood Pressure

The IN-WISEWOMAN Program provides one medication follow-up office visit following an abnormal BP value found at the initial/annual screening. A woman is referred for a medication follow-up for the BP values detailed in Table 10. Medication follow-up guidance:

- The medication follow-up should be completed within 90 days of the abnormal value.
    - If the woman is not able to schedule within the 90 days, she can receive medication follow-up during her follow-up screening instead of during a separate office visit.
        - A follow-up screening may only be completed if the participant has completed HBSS. Find more information about the follow-up screening on page 34.
- **Providers must complete the Medical/Medication Follow-up Form for these office visits.**
    - **Submit the completed form to the regional office.**
- A medication follow-up may be used to confirm a new diagnosis of hypertension and/or may consist of rechecking blood pressure, medication management, discussing current medications, deciding to change medications or prescribing new medication, etc.
- **If the patient refuses services, the provider should document a written or verbal refusal using the Waiver for Refusal of Services on page two of the Screening Results Form.**
    - **Submit the form with the patient's refusal to the regional office to document the patient's status.**
- **If the patient is currently being treated for hypertension or uncontrolled BP by another provider, she should be referred back to that provider for ongoing treatment. If a woman is referred to her own provider/medical home for follow-ups, the IN-WISEWOMAN provider will note the name and location of this provider on the Screening Results Form under referrals.**
    - **Submit the form with the patient's provider information to the regional office to document the patient's status.**
    - The medical system to which the woman is referred is then responsible for providing medical follow-up and ensuring treatment.

- In the event the woman is unable or unwilling to return to her existing provider, the IN-WISEWOMAN provider should follow internal protocols to accept the woman as a new patient.

Other Abnormal Screening/Laboratory Values

Follow-ups for abnormal findings other than elevated blood pressure are covered only under limited circumstances. IN-WISEWOMAN 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. The office visit may only be reimbursed when one of the following situations occur:

- Further evaluation is needed to confirm whether the client has a new diagnosis of dyslipidemia or diabetes.
- Further evaluation is needed to determine if medication or other more immediate treatment is needed that could not be appropriately assessed/done during the initial office visit.
- A patient is prescribed medication during the initial or annual screening and further evaluation is needed to determine if the medication is working or needs to be altered.

Medication Follow-up for Abnormal Values other than Blood Pressure

The office visit for abnormal findings is **not intended to monitor the status of treatment**. The IN-WISEWOMAN Program will reimburse for **one office visit** for abnormal findings when based on program-specified criteria. (See Table 10.) Medication follow-up guidance:

- **Providers should complete the Medical/Medication Follow-up Form for these office visits.**
  - **Submit the completed form to the regional office.**
- A medication follow-up may consist of fasting labs/lipid panel, rechecking blood pressure, medication management, discussing current medications, deciding to change medications or prescribing new medication, etc.
- The medication follow-up should be completed within 90 days of the abnormal value.
  - If the woman is not able to schedule within the 90 days she can receive medication follow-up during her follow-up screening instead of during a separate office visit.
    - A follow-up screening may only be completed if the participant has completed HBSS. Find more information about the follow-up screening on page 34.
- **If the patient refuses services, the provider should document a written or verbal refusal using the Waiver for Refusal of Services on page two of the Screening Results Form.**
  - **Submit the form with the patient's refusal to the regional office to document the patient's status.**
- **If the patient is currently being treated for dyslipidemia or diabetes by another provider, she should be referred back to that provider for ongoing treatment. If a woman is referred to her own provider/medical home for follow-ups, the IN-WISEWOMAN provider will note the name and location of this provider on the Screening Results Form under referrals.**

- **Submit the form with the patient's provider information to the regional office to document the patient's status.**
- The medical system to which the woman is referred is then responsible for providing medical follow-up and ensuring treatment.
  - In the event the woman is unable or unwilling to return to her existing provider, the IN-WISEWOMAN provider should follow internal protocols to accept the woman as a new patient.

Table 10. Values for Medical and Medication Follow-ups

Measurement	Alert Level (Medical Follow-up)		Uncontrolled / Abnormal Level (Medication Follow-up)	
	Values	Follow-up Requirement	Values	Follow-up Requirement
Blood Pressure	Systolic >180 mmHg OR diastolic >120 mmHg	Immediately or within 7 days of initial screening	Systolic >120 mmHg OR diastolic >80 mmHg*	Immediately or within 90 days of initial screening. *If provider does not recommend medication, refer to health coach for lifestyle behavior change.
A1C/Blood Glucose	Blood glucose <50 mg/dL or >250 mg/dL A1C ≥11%	Immediately or within 7 days of baseline screening	Blood glucose >126 mg/dL A1C >6.5%	Immediately or within 90 days of initial screening if not currently being treated.
Cholesterol	N/A	N/A	Nonfasting total 200-239	Refer for fasting lipid profile within 90 days if not currently being treated for high cholesterol.
			Total ≥240 LDL 160-189	If not fasting, refer for fasting lipid profile within 90 days. If fasting, refer for medication follow-up within 90 days if not currently being treated for high cholesterol.
Triglycerides	N/A	N/A	Fasting ≥200 OR Nonfasting ≥400	Refer for fasting lipid panel and/or medication follow-up within 90 days.

Reimbursement for Follow-ups

- IN-WISEWOMAN will pay for **one** medical/medication follow-up per patient per annual cycle if she has an alert or abnormal value(s) as indicated in Table 10 above and meets the guidelines in the sections above.

    - This includes an office visit and additional approved labs (please see the approved CPT code list).
    - If the woman is already being treated for an issue, she should continue care with her primary care provider. IN-WISEWOMAN **will not** pay for follow-up visits for patients already being treated for abnormal values.
- If the provider completes medical evaluation or medication management and/or prescribes or changes medication during the initial/annual cardiovascular disease screening visit, the provider should use the office visit code that reflects time spent with the patient.
    - During an integrated office visit, the IN-BCCP is billed for the office visit.
        - IN-WISEWOMAN pays for WISEWOMAN labs and RRC.
    - If services occur at a different time/different office visit than the IN-BCCP visit, this is considered a nonintegrated visit and IN-WISEWOMAN will pay for the office visit and all IN-WISEWOMAN services. (Refer to the approved CPT code list.)
- When possible, the provider should coordinate medical/medication follow-ups with the follow-up screening.
- **The Medical/Medication Follow-up Form must be completed and submitted to be reimbursed for services. Refer to the approved CPT codes list for approved services.**
- The provider may want to continue following up with a woman after a medical/medication follow-up due to medication changes, new prescriptions, etc.
    - **The cost for these follow-ups is not the responsibility of the IN-WISEWOMAN Program.**
    - IN-WISEWOMAN does not pay for any medical services after the medical/medication follow-up until the follow-up screening. (See the Follow-up Screening section for details.)
- The IN-WISEWOMAN Program is **not** a treatment program.

Lost to Follow-up

The IN-WISEWOMAN Program understands there are numerous reasons a medical follow-up may not be completed within seven days or a medication follow-up within 90 days. If the follow-up does not occur within the required timelines, indicate one of the following reasons on the bottom of the Medical/Medication Follow-up Form:

- Patient refused medical follow-up (please include the date of refusal).
- Patient did not show up for appointment (please include the date of the scheduled appointment that the patient missed).
- If neither of the above, please specify why next to the line that says “other”.

Staff should also document date(s) they attempt to contact participants to schedule them for their medical/medication follow-up on the Medical/Medication Follow-up Form.

- **After three attempts, the patient is considered lost to follow-up.**
- **Submit the form with the contact attempt dates to the regional office to document the patient’s status.**

HEALTHY BEHAVIOR SUPPORT SERVICES

Patients, not health care providers, are the primary managers of their health. Those who are uninsured or underinsured often have fewer resources and more barriers to participating in regular physical activity and accessing healthy foods. The IN-WISEWOMAN Program works with providers to connect clinical services with community resources via referrals to healthy behavior support services (HBSS) and other community programs.

Once an IN-WISEWOMAN participant has completed all screening and risk reduction counseling (RRC) requirements, she should be provided with information about HBSS. HBSS Programs include: Health Coaching, Eat Smart Move More (ESMM), Diabetes Prevention Program (DPP) and Taking Off Pounds Sensibly (TOPS). Participants should work with their health care provider and/or health coach to choose the HBSS that best fits them based on service availability, geography/location of services and type of program.

If a patient is referred to an HBSS from a provider's office:

- An IN-WISEWOMAN health coach will check in with the patient to ensure her participation/completion of HBSS.
- If the patient refuses HBSS from the clinic, the clinic staff will inform the woman that an IN-WISEWOMAN health coach will contact to her in 30-60 days to see if she would like to enroll at that time.

If the patient is not referred from the provider's office, an IN-WISEWOMAN health coach will contact the patient to enroll her in HBSS. If a patient is:

- **Ready for HBSS**, the health coach will enroll her.
- **Not ready for HBSS**, the health coach will obtain permission to contact her in 30-60 days. If not ready on the second call, the health coach will ask permission to contact her one more time 30-60 days later.

Health Coaching

Health coaching uses a collaborative patient-focused approach to prepare patients to take responsibility for their health and well-being. Health coaching encompasses five principal roles:

1. Building skills to manage one's health
2. Bridging the gap between clinician and patient
3. Helping patients navigate the health care system
4. Offering emotional support
5. Providing continuity and communication between the patient and health care team

Preliminary studies indicate that health coaching can improve management of diabetes, hyperlipidemia, weight loss, physical activity and other chronic diseases. For many participants, health coaching is the most appropriate and/or preferable HBSS. Upon completion of RRC, the provider or health coach may refer a participant to health coaching based on the participant's preference and needs. Health coaching

can be completed by IN-WISEWOMAN health coaches or by internal clinical staff.[13] IN-WISEWOMAN health coaches must meet the training and professional development standards included in Table 11.

Table 11. Training Requirements and Professional Development

IN-WISEWOMAN Health Coaches at Regional Sites	Health Coaches Within Clinic
Must be Brief Action Planning (BAP) certified within 6 months of hire[14] ▪ BAP trainers at the Indiana Department of Health offer trainings as needed, including practice calls and annual follow-up calls to ensure efficacy. ▪ The Centre for Collaboration, Motivation and Innovation (CCMI) facilitates a certification phone call.	Must have training in motivational interviewing ▪ Indiana Department of Health staff provides BAP training as needed.
Must complete the Indiana Department of Health Health Coach Training within 6 months of hire.	Must have health education certification and/or background in behavioral health, diabetes prevention, physical activity and/or nutrition (i.e. CHES, NCBDE, AADE, ACE, ACSM, NASM, etc.). [15] *If RN, must have certification in addition to RN. *The Indiana Department of Health Health Coach Training is available as needed.
Strongly encouraged to obtain and maintain a national certification in health coaching, community health worker or similar concentration (i.e. CHES, NBHWC, CHW, ACE Health Coach).	Must sign IN-WISEWOMAN Letter of Intent, and the IN-WISEWOMAN program director must approve of internal health coach(es) based on qualifications, certifications and background.
Strongly encouraged to obtain and maintain a health certification focused in physical activity and nutritional guidelines (i.e. ACE, ACSM, NASM).	Must immediately notify the IN-WISEWOMAN program director of any staff changes related to health coaching in the clinic.
Must provide approved and appropriate health coaching materials to each participant.	Must provide approved and appropriate health coaching materials to each participant (health coaching materials will be provided to clinic by the IN-WISEWOMAN Program). *Additional materials may be used upon approval from the IN-WISEWOMAN program director.
Must send all health coaching documentation to the data manager within 60 days of sessions.	Must send all health coaching documentation to the regional coordinator within 60 days of sessions.

[13] Internal clinical staff must meet qualifications set by IN-WISEWOMAN program director in order to provide health coaching sessions to participants.
[14] Find more information about BAP and CCMI here: https://centrecmi.ca/brief-action-planning/
[15] Must be approved by IN-WISEWOMAN program director.

Health Coaching Guidelines

- Each health coaching session **must be at least 30 minutes** and can be up to 60 minutes.
- Health coaching sessions may be completed by phone or in person.
    - It is strongly encouraged that at least one session is an in-person, walking session.
- Each participant must receive IN-WISEWOMAN health coaching materials. (See materials below.)
- In-person heath coaching sessions may be completed one-on-one or in small groups of up to four participants.
- Health coaches must complete an IN-WISEWOMAN Lifestyle Form for each health coaching session.
- Clinics that provide onsite health coaching will need to send an IN-WISEWOMAN Lifestyle Form for each health coaching session to the regional office.
    - Clinics will be reimbursed for health coaching sessions upon receiving all health coaching forms/documentation. Refer to the Reimbursement Section for more details.
        - **Clinics must use approved CPT codes.**

Health Coaching Materials

- Screening results booklet:
    - A screening results booklet must be given to each participant in person, by mail or via email in the language the participant best understands.
- Lifestyle Plan:
    - A copy of the Lifestyle Plan must be given to the participant in person, by mail or via email in the language the participant best understands.
- American Heart Association (AHA) Six-Week Beginner Walking Plan as appropriate.
- AHA Life's Simple 7 Handouts as appropriate.
- Health coaches may use additional materials with approval from the IN-WISEWOMAN program director and at clinic/organization expense.

Completion of Health Coaching

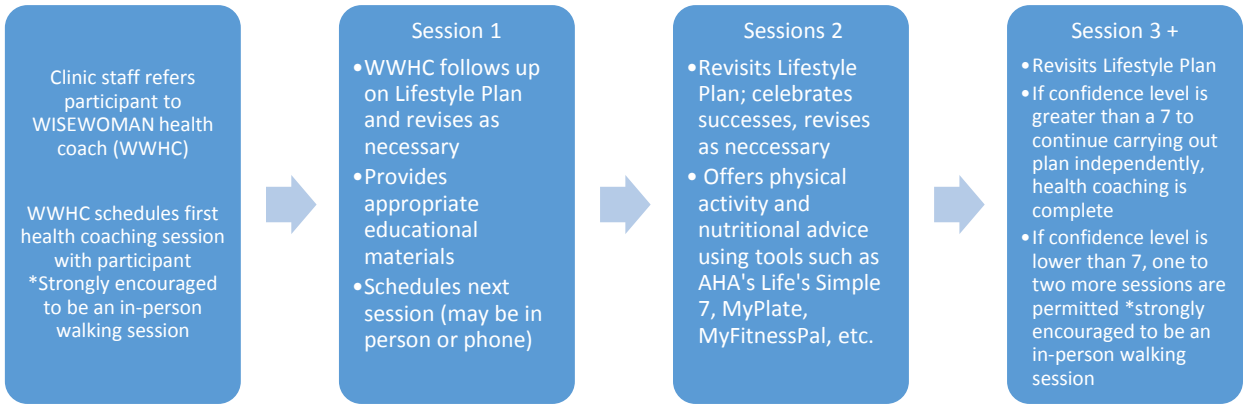
- Participant completes at least three, 30-minute sessions.
- Participants are eligible for up to six sessions based on need:
    - If, during the third health coaching session, the participant's confidence level is greater than a seven to continue carrying out her health plan independently, health coaching is complete.
    - If her confidence level is lower than a seven, it is recommended that she continue sessions.
- **The first three health coaching sessions must be completed within six months of RRC.**

Health Coaching in Various Settings

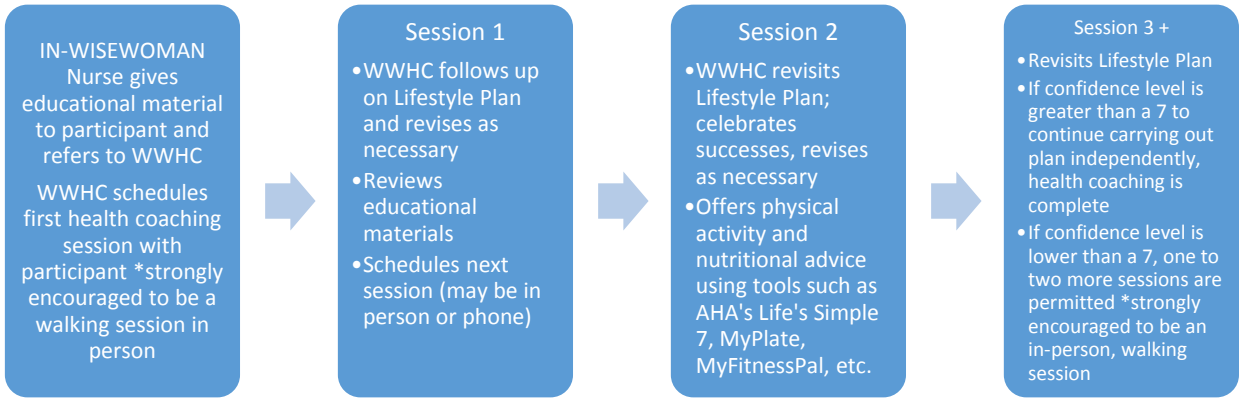
The IN-WISEWOMAN program allows for health coaching to be provided by IN-WISEWOMAN health coaches or by internal clinical staff as described in the section above. It can be completed in multiple settings. Figure 3 shows the flow for health coaching in integrated, nonintegrated and clinical settings.

Figure 3. Health Coaching Flow by Setting

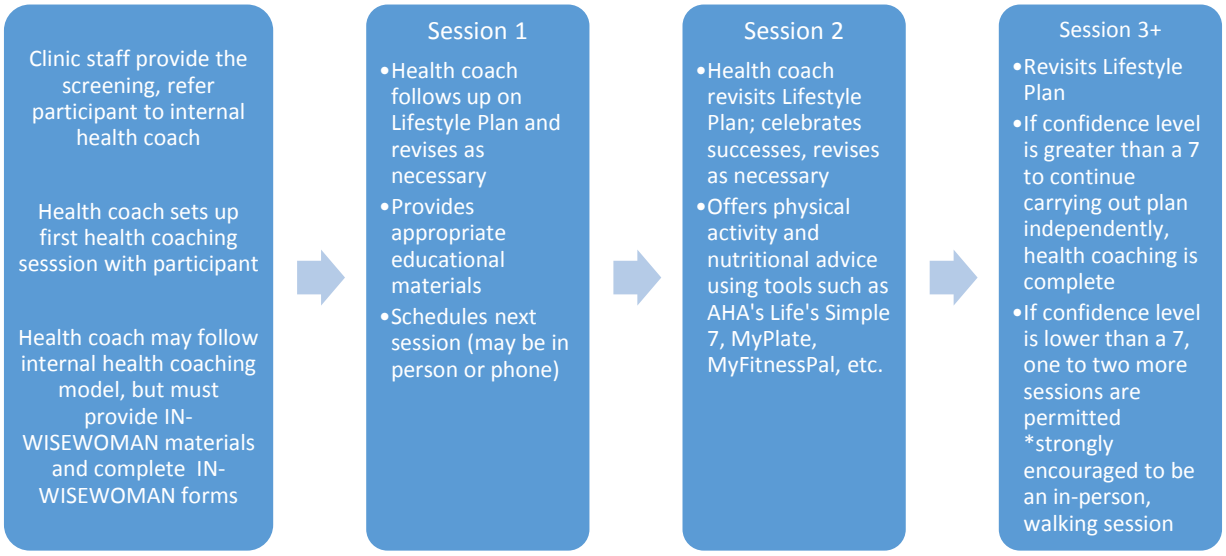
Integrated



Nonintegrated



Within Clinic



Diabetes Prevention Program

The Diabetes Prevention Program (DPP) is a curriculum-based HBSS that focuses on the prevention of type 2 diabetes among persons at risk. Organizations choosing to implement the DPP must follow the required referral/eligibility, course content and staff training for the National Diabetes Prevention Program.[16]

IN-WISEWOMAN participants should be considered for referral to the DPP if they:

- Indicate a readiness to make healthy changes in their life during RRC
- Agree that the DPP is an appropriate behavior support service for their needs
- Have access to a local DPP
- Meet the additional DPP eligibility requirements as outline by the CDC
    - Be at least 18 years old and
    - Be overweight (body mass index ≥25; ≥23 if Asian), and
    - Not be pregnant, and
    - Have no previous diagnosis of type 1 or type 2 diabetes, and
        - Have a blood test result in the prediabetes range within the past year:
            - Hemoglobin A1C of 5.7% - 6.4%, or
            - Fasting plasma glucose of 100-125 mg/dL, or
            - Two-hour plasma glucose (after a 75 gm glucose load) of 140-199 mg/dL, or
    - Have been previously diagnosed with gestational diabetes, or
    - Take the Prediabetes Risk Test and receive a screening result of high risk for type 2 diabetes[17]

This standardized lifestyle program uses lifestyle coaches who facilitate sessions and work with program participants to help them in achieving individualized, clearly defined weight loss (5%) and physical activity goals (150 minutes per week). The program focuses on lifestyle changes to achieve long-term improvements in diet and physical activity.

Each DPP session includes:

- A private weigh-in and review of self-monitoring records
- Discussions on various topics
- Identification of barriers
- Action planning in a group setting

Dosage and Session Timing

The DPP curriculum usually takes approximately one year to complete and consists of two phases, core and maintenance. The DPP course phases are shown in Table 12.

[16] https://www.cdc.gov/diabetes/prevention/index.html
[17] https://www.cdc.gov/diabetes/risktest/index.html

Table 12. DPP Course Phases

Curriculum Phase	Total # of Sessions in Curriculum	Length of sessions	Location or Format	Timing of Session
Core phase	16	60 minutes	In person	Weekly
Maintenance phase	6	60 minutes	In person	Monthly

Completion of DPP

The participant must attend nine of the 16 core DPP sessions within 22 weeks and three of the post-core, maintenance phase sessions within six months of core completion.

DPP Locations

Check the Indiana Department of Health Diabetes Program web page for current DPP locations.

Eat Smart Move More

Eat Smart Move More (ESMM) is run by Purdue Extension and is adapted from North Carolina's Faithful Families Eating Smart and Moving More program.[18] It is a free program available in most parts of the state.

ESMM includes seven weekly or biweekly interactive group sessions. The lessons are 45-60 minutes in length and cover a variety of topics, including four core classes:

- Eating Smart at Home: Simple solutions for planning, shopping, fixing and eating more meals at home. Families who eat together at home eat more fruits and vegetables and less fat. Eating at home as a family is a great way to begin to eat smart.
- Eating Smart on the Run: Eating out has become a way of life for many families. Eating in restaurants often means eating more fat, sugar and calories and fewer fruits and vegetables. Eating away from home can also mean large portion sizes and too many soft drinks. Eating smart on the run provides women skills to choose wisely when eating foods away from home.
- Moving More, Everyday, Everywhere: Building physical activity into the day doesn't require special equipment or a special place. Women learn ways to take advantage of everyday opportunities like taking the stairs and parking farther away. Moving more can also be a fun family event like a trip to a park or a walk after dinner. Every step counts toward the recommended 30 minutes for adults and 60 minutes for children per day.
- Moving More, Watching Less: Television, computers and video games are a major part of everyday life. Moving More, Watching Less gives women simple strategies to help turn off the TV and be active and look for other activities.

Completion of ESMM:

[18] https://snapedtoolkit.org/interventions/programs/faithful-families-eating-smart-and-moving-more-faithful-families/

Participants must attend at least five of the seven classes, with four of them being the four core classes, to complete this HBSS.

ESMM Locations

For current ESMM locations, visit the Purdue Extension web page or ask the regional coordinating office.

Health coaches will check in with participants within two weeks of signing up for ESMM to ensure their participation. They will also follow up with the participant throughout participation in ESMM, including when the classes are scheduled to conclude to document overall participation and completion.

Taking Off Pounds Sensibly

Taking Off Pounds Sensibly (TOPS)[19] supports weight loss by providing participants with the tools, information, support and accountability needed to be successful. By participating in TOPS, women receive:

- A subscription to members-only resources, which include healthy eating tips, recipes and fitness guides
- A step-by-step guide and magazine subscription to TOPS News magazine
- Weekly meetings (in-person or online)

Completion of TOPS:

- Participant must attend 12 chapter meetings within a six-month period.

Completion of HBSS

As defined in the section above, each HBSS has a defined number of sessions the participant must attend in order to complete the HBSS. Four to six weeks following HBSS completion, the participant should be seen for a follow-up screening:

- Health coaches will be in contact with women throughout their participation in HBSS, regardless of the program they choose and will notify participants when they have completed HBSS.
- Providers and health coaches should work together to ensure participants are scheduled for follow-up screening 4-6 weeks after completion of HBSS.
- Follow-up screenings will preferably be completed at the same location as the initial screening.
    - Under special circumstances, the follow-up screening may be performed at a different, approved IN-WISEWOMAN Provider location.
- Follow-up screenings are nonintegrated visits. If the participant's rescreen/annual screening (12-18 months after initial/baseline screening) falls within a month of when the follow-up screening should be scheduled, she should be scheduled **only** for her rescreen/annual screening and bypass the follow-up screening.

HBSS Forms

- Health Coaching

[19] https://www.tops.org/tops/TOPS/Default.aspx

    - **A Lifestyle Plan Form should be filled out for every health coaching session and submitted to the regional office.**
- All other HBSS
    - **HBSS program leaders and health coaches should work together to maintain and complete the HBSS Session Record Form for each participant in HBSS programs other than health coaching.**
    - Regional staff should submit the HBSS Session Record to the data manager after the first HBSS session is recorded and after the last HBSS session occurs. This will allow documentation in the data system of all women who have begun HBSS and completed their first session, as well as identify whether the participant has completed HBSS or dropped out of the program and, if completed, the date of completion.

Lost to Follow-up

A woman is considered lost to follow-up in the following scenarios:

1. When offered HBSS options, the participant refuses services **and does not** give permission for staff to follow up 30-60 days later.
2. Staff has attempted to contact the participant three times, 30-60 days after the initial/annual screening and the participant:
    - Did not answer all three times.
    - Was not interested in the program on three consecutive calls.
    - OR
    - The health coach sent a letter to the participant after no response on the phone and received no response after waiting two weeks.
    - A mixture of the above.

As long as the health coach has refusal of services or three calls or letters documented with no responses or no interest in enrollment, the woman is considered lost to follow-up or withdrawn from the program. When a participant is considered lost to follow-up, health coaches should:

- **Document that the participant is lost to follow-up or withdrawn from the program in the regional office internal data base.**
- **Include updated numbers in the monthly report for the IN-WISEWOMAN program director.**

Ideally, if a participant is lost to follow-up in one annual cycle and would like to re-enroll the following year:

- The woman can be re-enrolled into the program a second time.
- If she is lost to follow-up a second time, it is strongly encouraged that she be referred to an alternative community program focused on heart healthy lifestyles but not be reenrolled in the IN-WISEWOMAN Program.

FOLLOW-UP SCREENING

Each annual cycle of WISEWOMAN services includes an opportunity to complete a follow-up screening with women who have completed HBSS. Follow-up screenings help assess short-term participant health outcomes and can provide valuable information about program impact. A follow-up screening should occur 4-6 weeks after completion of HBSS.

Follow-up Screening Requirements

Follow-up screenings are conducted in person and must meet all the requirements of an initial IN-WISEWOMAN screening, including:

- Completion of a health assessment
- Height and weight measurements to calculate body mass index (BMI)
- Waist circumference
- Blood pressure measurement(s)
- Cholesterol (total, HDL and LDL)
- Glucose or A1C
- Risk reduction counseling
- Referral for medical evaluation if needed
- Referral to community resources

Forms needed:

- Authorization to Release Health Information
- Health Assessment (**check the "follow-up health assessment" box**)
- Screening Results (**check the "follow-up screening" box**)
- For Risk Reduction Counseling
    - Lifestyle Plan
    - Screening Results Booklet

Providers must have a tracking system and established procedures for contacting participants when they are due for a follow-up screening. Health coaches will also work with participants and providers to ensure completion of follow-up screenings.

Follow-up Screening Timing

The follow-up screening occurs 4-6 weeks after the participant's final HBSS session. It must occur at least three months after the participant's initial/annual screening and should occur no later than 11 months after the initial screening. If it is after the 3- to 11-month window, the participant should receive her annual screening and begin the annual cycle of IN-WISEWOMAN again.

- Example 1: If a participant has an annual screening on February 1 and completes HBSS six weeks later, the organization must wait until at least May 1 (three months after the initial screening) to complete a follow-up screening.

- Example 2: If a participant begins an HBSS program on June 1 and completes HBSS on May 1 of the following year (11 months after the initial screening), she should forego the follow-up screening and be scheduled for her annual screening instead.

Risk Reduction Counseling at Follow-up Screenings

The RRC conversation during follow-up screenings should differ from the initial screening discussion. During follow-up screenings, RRC should:

- Ensure completion of:
  - Health Assessment Form (in the language the patient understands best)
  - Lifestyle Plan: The Lifestyle Plan is necessary for RRC to help the participant revise her current SMART Goal or set a new one based on her follow-up screening results.
  - Screening Results Booklet: The Screening Results Booklet is filled out, explained and given to the participant to take home (in the language the patient understands best).
- Ensure the patient understands her risk and how it may have changed since her initial or previous annual screening.
- Assess tobacco use:
  - If the participant is a tobacco user and was not willing to be referred to tobacco cessation resources at the baseline visit, reassess to determine if she is interested in being referred now.
- Discuss the participant's health assessment responses, blood pressure results and any other clinical measurements available at the time of visit, and relate these outcomes to the participant's relative risk of developing cardiovascular disease.
- Ensure the patient is referred for appropriate medical follow-up and evaluation services if the participant has any newly uncontrolled/abnormal or alert level clinical measurements.
- Review the participant's progress and achievements made during HBSS, and discuss her plans for maintaining health behavior activities in the future.
  - Highlight any improvements from the initial screening in health risk behaviors reported on the Health Assessment Form.
- Remind the participant of her annual rescreening due date.

Referrals to HBSS should **not** be a part of the follow-up screening RRC conversation. Prior to conducting a follow-up screening, organization staff should confirm that the patient has reached the maximum number of HBSS sessions or is not interested in continuing with additional sessions for that year. If a participant expresses interest in restarting HBSS sessions after the completion of the follow-up screening, she should be encouraged to return for a rescreening visit where she may initiate additional HBSS as part of her next annual cycle of services.

TEAM-BASED CARE

The second strategy of the national WISEWOMAN Program is *to implement team-based care to reduce cardiovascular disease risk with a focus on hypertension control and management*; the goal is to increase use of and adherence to evidence-based guidelines and policies related to team-based care (below). The coinciding performance measure is the number and percentage of WISEWOMAN participants with WISEWOMAN providers that have policies or systems to implement a multidisciplinary team approach to blood pressure control.

Based on the definition from the National Academy of Medicine,[20] the IN-WISEWOMAN Program staff proposes the following definition for team-based care as it applies to the IN-WISEWOMAN Program:

The provision of coordinated health services by an optimized care team, including the patient and at least two health providers, to achieve patient-centered, organized, high-quality care.

Implementing Team-based Care

Team-based care to improve blood pressure control is a health systems-level, organizational intervention that relies on multidisciplinary teams to improve the quality of hypertension care for patients.

Team-based care is established by adding new staff or changing the roles of existing staff who work with a patient's primary care provider. Teams include the patient; the patient'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 the primary care provider's activities. These responsibilities include medication management, patient follow-up, and adherence and self-management support.

Team-based care guidelines and policies typically aim to do the following:

- Facilitate communication and coordination of care among team members
- Enhance team members' use of evidence-based guidelines
- Establish regular, structured follow-up mechanisms to monitor patients' progress and schedule additional visits as needed
- Actively engage patients in their own care by providing them with education about hypertension medication, adherence support (for medication and other treatments) and tools and resources for self-management (including health behavior change)[21]

Values and Principles of Team-based Care

Referencing the values of team-based care as stated by the National Academy of Medicine,[22] the IN-WISEWOMAN Program staff encourages honesty, discipline, creativity, humility and curiosity among

[20] https://nam.edu/perspectives-2012-core-principles-values-of-effective-team-based-health-care/
[21] Cardiovascular Disease: Team-Based Care to Improve Blood Pressure Control
[22] https://nam.edu/perspectives-2012-core-principles-values-of-effective-team-based-health-care/

optimized care teams. Further, the IN-WISEWOMAN Program staff strongly encourages each optimized care team to include the following principles when delivering care to patients:

- Shared goals among the patient and the optimized care team
- Clear roles and expectations for each member of the optimized care team
- Mutual trust among all team members
- Effective communication with consistent channels for open communication, accessible to all team members across all settings
- Measureable processes and outcomes the team agrees on for reliable and timely feedback.

Brief Action Planning

The IN-WISEWOMAN Program acknowledges that, in a team-based care setting, patients are the primary managers and experts of their own health. IN-WISEWOMAN Program staff strongly encourage using motivational interviewing (MI) with participants in the clinical setting. This allows health providers to identify not only participants' concerns and constraints, but also their strengths, which can then lead to an increase in participants' confidence that they can achieve their goals and improve their health.

Brief Action Planning (BAP)[23] is a self-management support technique that involves using a structured step-by-step process to help individuals set goals and make concrete action plans. BAP training is grounded in the principles and practice of MI and behavior change theory and research, emphasizing compassion, acceptance, partnership and evocation to support patients to make the changes that are most important to them. Because BAP embraces the spirit of MI but offers an abbreviated, structured method, providers are able to utilize MI within their time constraints and still put participants in the driver's seat of their health plan.

The Indiana Department of Health staff provides BAP training to the IN-WISEWOMAN Program team, including providers who choose to participate. More information about MI and BAP is included in Appendix B. Health coaches are required to be trained in BAP within six months of their hire or have training in MI to be qualified to provide health coaching as an HBSS.

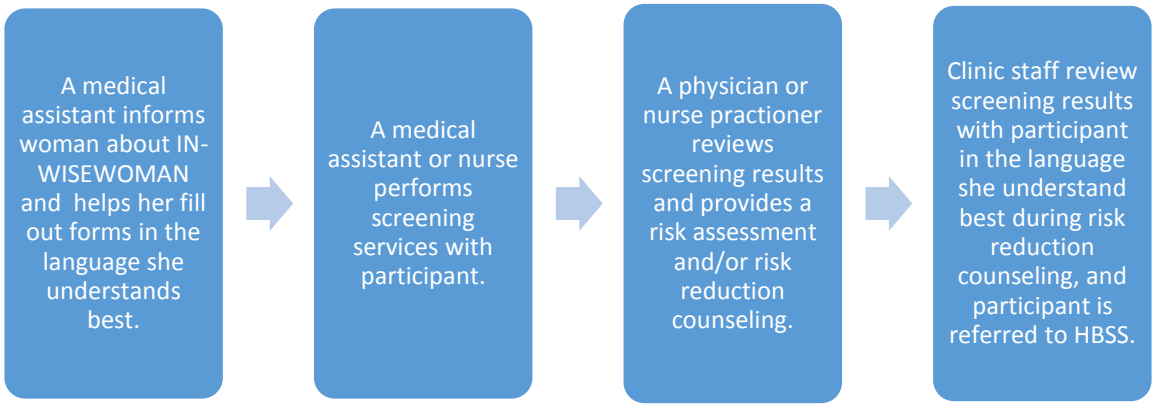
[23] https://centrecmi.ca/brief-action-planning/

Examples of Team-based Care

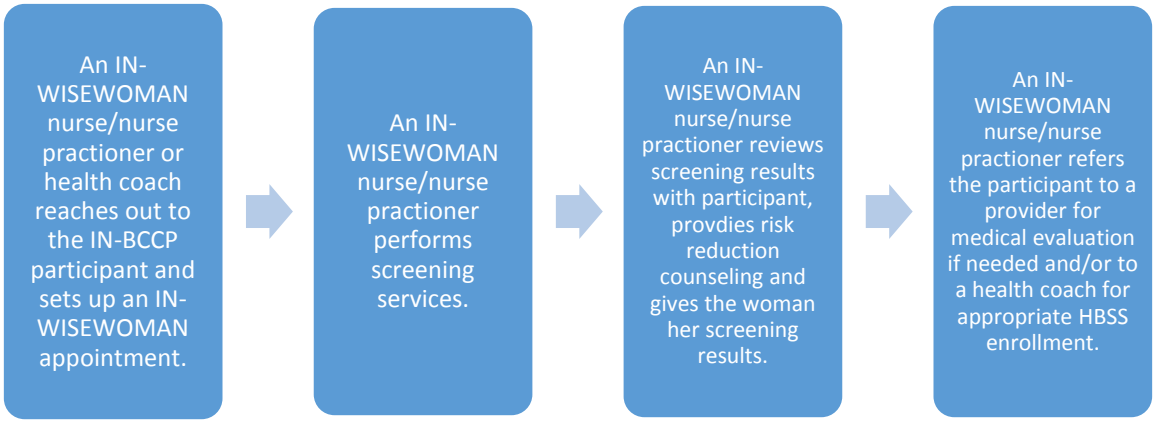
Team-based care is unique to each provider location. Further, team-based care at integrated visits differs from nonintegrated visits. (See Figure 4.)

Figure 4. Team-based Care Flow in Different Settings

Example of Integrated Visit:



Example of Nonintegrated Visit:



In both instances, the participant receives health services from numerous health providers to enhance her experience, set shared goals, optimize her care and improve health outcomes.

COMMUNITY-CLINICAL LINKAGES

The third strategy of the National WISEWOMAN Program is *to Link Community Resources and Clinical Services that support bidirectional referrals, self-management and lifestyle change for women at risk for CVD.* The IN-WISEWOMAN Program refers participants to HBSS and other community programs via bidirectional referrals to create a more robust base of support for participants and a stronger link between clinic and community.

Because participants may complete HBSS and their follow-up screening within six months of their initial/annual screening, there may be six or more months without HBSS sessions or less communication between IN-WISEWOMAN staff and participants until their annual screening. Therefore, providers and regional staff are expected to work together to provide health navigation and barrier reduction assistance to participants as they progress through an annual WISEWOMAN cycle of service to ensure participants are involved in community programs and have support in some capacity between the IN-WISEWOMAN Program activities.

Providers, health coaches and community program leaders should work together to strengthen community-clinical linkages by:

- Using the IN-WISEWOMAN HBSS Session Record Sheet and Lifestyle Plan forms to keep all entities informed about participants' progress and participation in HBSS and other community resources.
- Updating Bidirectional Referral Maps semiannually
- Updating community scans annually

Community Scans

WISEWOMAN community scans refer to a systematic review of local resources that support improvements in the cardiovascular risk of participants and the identification of gaps in such resources. Regional staff and providers in each county/region in which IN-WISEWOMAN is offered should work together to identify resources that are applicable and accessible to the women and their specific needs. The scan should include the available resources in communities where IN-WISEWOMAN participants live, work, play and receive screening services. **Community scans must be updated and submitted to the CDC every two years.**

Types of Resources to Include in Community Scans

The types of information that should be included in community scans include:

- Local evidence-based lifestyle programs
- Lifestyle programs that could be expanded to reach communities convenient to IN-WISEWOMAN participants
- Resources that support physical activity, healthy food choices, disease self-management and smoking cessation
- Resources that address participant barriers to accessing care and changing behavior (e.g., transportation, mental health, housing resources)
- Resources appropriate for underserved sub-populations

- Health care providers with systems that offer optimal settings to support improvements in cardiovascular risk among the participant population
- Strategic partnership opportunities at the state and local levels

Staff may use existing data from other agencies and/or collaborate with other agencies to complete scans. The State Chronic Disease Plan and State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health are potential sources or collaborators for community scans. Staff may work with the following groups to identify existing data sources for community scans:

- Service referral call centers, 211
- Local planning unit or coalitions, community action agencies
- Local health, mental health or social service departments
- Hospitals
- Chambers of commerce
- Extension services, Aaea Agencies for Aging and area health education centers
- Academic institutions

For more resources regarding developing and conducting community scans, refer to page 40 of the CDC WISEWOMAN Guidance Document.

Strategic Partnerships to Support Environmental Approaches

Partnerships allow for more efficient use of resources and play a key role in advancing the broader goals of the WISEWOMAN Program. The purpose of developing strategic partnerships to support environmental approaches is to increase opportunities for physical activity, healthy food choices, smoking cessation and smoke-free public places. These partnerships can include state, community-based, governmental and non-governmental entities.

IN-WISEWOMAN staff should work with partners to increase options to reinforce healthful behaviors in the following areas:

- **Physical activity:** Increase the number of affordable, safe, attractive and convenient places for physical activity. Examples include partnerships that promote building and encouraging use of walking trails, parks and playgrounds; joint use agreements; and active transportation (e.g., complete street designs, safe routes to school programs and promoting bicycling as a mode of transportation).
- **Healthy food choices:** Improve the accessibility, availability and affordability of healthful foods in communities, such as those lower in overall calories, free of trans fats and low in sodium. Examples include working with partners that promote farmers' markets, gardening programs, food coupon programs, improved procurement guidelines, provision of full-service grocery stores, mobile vending carts and restaurant initiatives.
- **Smoking cessation and smoke-free environments:** Work with partners on evidence-based strategies such as comprehensive smoke-free air policies in workplaces, health care settings, multiunit housing and outdoor areas. Collaborate with the state/tribal tobacco control programs and other organizations (e.g., American Lung Association, American Heart Association, American Cancer Society) to identify or develop free or low-cost tobacco cessation strategies or resources.
- **Medication Access:** Work with local pharmacies and IN-WISEWOMAN providers to participate in Team Up Pressure Down! Potential resources for free or low-cost medications include:

pharmaceutical assistance programs (PAPs), 340B Drug Pricing Program and Pharmacy Affairs, Partnership for Prescription Assistance, Federal Trade Commission, 1-800-MEDICARE, NeedyMeds, RxAssist, Rx Hope and other state pharmaceutical assistance programs.

- **Health Equity:** Consider partnerships to address underlying factors that impact health and health equity such as the Indiana Minority Health Coalition, local Hispanic Latino Minority Health Coalitions, local refugee support organizations, Indiana Community Health Workers Association, Indiana Community Action Association, Indiana Office of Community and Rural Affairs and others.
- **Other Partnerships:** Work with community organizations to increase IN-WISEWOMAN participants' access to other programs and services. Consider job sharing or joint funding of complementary partnership activities with other chronic disease programs.

IN-WISEWOMAN staff may work with other CDC-funded chronic disease programs to leverage existing coalition activities on behalf of WISEWOMAN participants. Partners might include the following:

- State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health
- State and local Public Health Actions to Prevent Obesity, Diabetes, and Heart Disease and Stroke
- Programs to Reduce Obesity in High Obesity Areas
- Racial and Ethnic Approaches to Community Health (REACH)
- A Comprehensive Approach to Good Health and Wellness in Indian Country
- Partnerships to Improve Community Health (PICH)
- National Implementation and Dissemination for Chronic Disease Prevention
- Tobacco Free Living Coalitions
- Million Hearts®
- Obesity Prevention Coalitions
- Safe Streets Coalitions
- Health Equity Coalitions
- Physical Activity and Move More Coalitions
- Coalitions focused on healthy diet, such as those working on sodium reduction or healthy food procurement policies

Use of Community Scan Data

IN-WISEWOMAN staff should use community scan results and other data sources to identify the priority needs of the WISEWOMAN population (and their communities) and form partnerships that are working to address these needs. Many efforts to build healthy environments are accomplished at the local level and can be done by working with local health agencies, health care providers or other entities. Staff should have clear roles and responsibilities when working toward identified partnership objectives. Attending meetings is insufficient to meet the expectations for contributing to environmental changes.

Regional staff should provide individuals facilitating risk reduction counseling with the results from the community scans to inform them of available and approved local lifestyle programs and other resources to support healthy behaviors. Further, the information should be used to establish bidirectional referrals between the clinic and community resources to strengthen community-clinical linkages.

Bidirectional Referrals

A bidirectional referral considers both the information going from the health care provider to the health coach or community lifestyle change program (referral), as well as information going back to that referring health care provider (feedback). Providers, regional staff and additional community partners should make every effort to refer participants to appropriate resources as well as provide feedback regarding participants' behavior updates and/or progress. [24]

Importance of Bidirectional Referrals

Bidirectional referrals support IN-WISEWOMAN participants by:

- Emphasizing prevention and the role of healthcare outside the clinical setting.
- Ensuring that information is moving both from the provider to the health coach or community program and from the health coach or community program back to the provider.
- Increasing the number of touchpoints with patients, which may increase the likelihood for them to enroll in programs or improve their health outcomes.
- Allowing providers to reinforce positive behaviors demonstrated when feedback is provided on a patient's program progress.
- Keeping the community program and health coach in front of mind for providers, which may result in a greater number of referrals being made.
- Improving care continuity for the patient by establishing the health coach or community program as practice extenders and members of the care team.
- Establishing a bidirectional referral pathway can be beneficial to providers, health coaches and community programs alike and ultimately can enhance the patient experience and improve health outcomes.[25]

Community-Clinical Linkages and Bidirectional Referral Mapping

Once the community scan is completed, regional staff should identify five to 20 community resources with which to establish bidirectional referrals. These resources will be mapped in a bidirectional referral resource map. (See Figure 5.) These resources should be those with which providers and/or regional staff have relationships, or plan to build relationships, and will most often refer participants to. These resources will provide meaningful information back to the provider regarding next steps for patient care.

Referrals to community-based resources can occur during risk reduction counseling or HBSS sessions. Participants should be referred to community-based resources based on identified goals, needs, interests and access.

There are numerous categories of resources that can be used, but the three main categories of resources, as they are listed in the community scan and in the example map below, are: Clinical, Local Public Health and Community.

- Clinical Resources may include:
    - Health systems /clinics /providers
    - Specialists

[24] https://www.chronicdisease.org/mpage/domain4_referral
[25] Ibid.

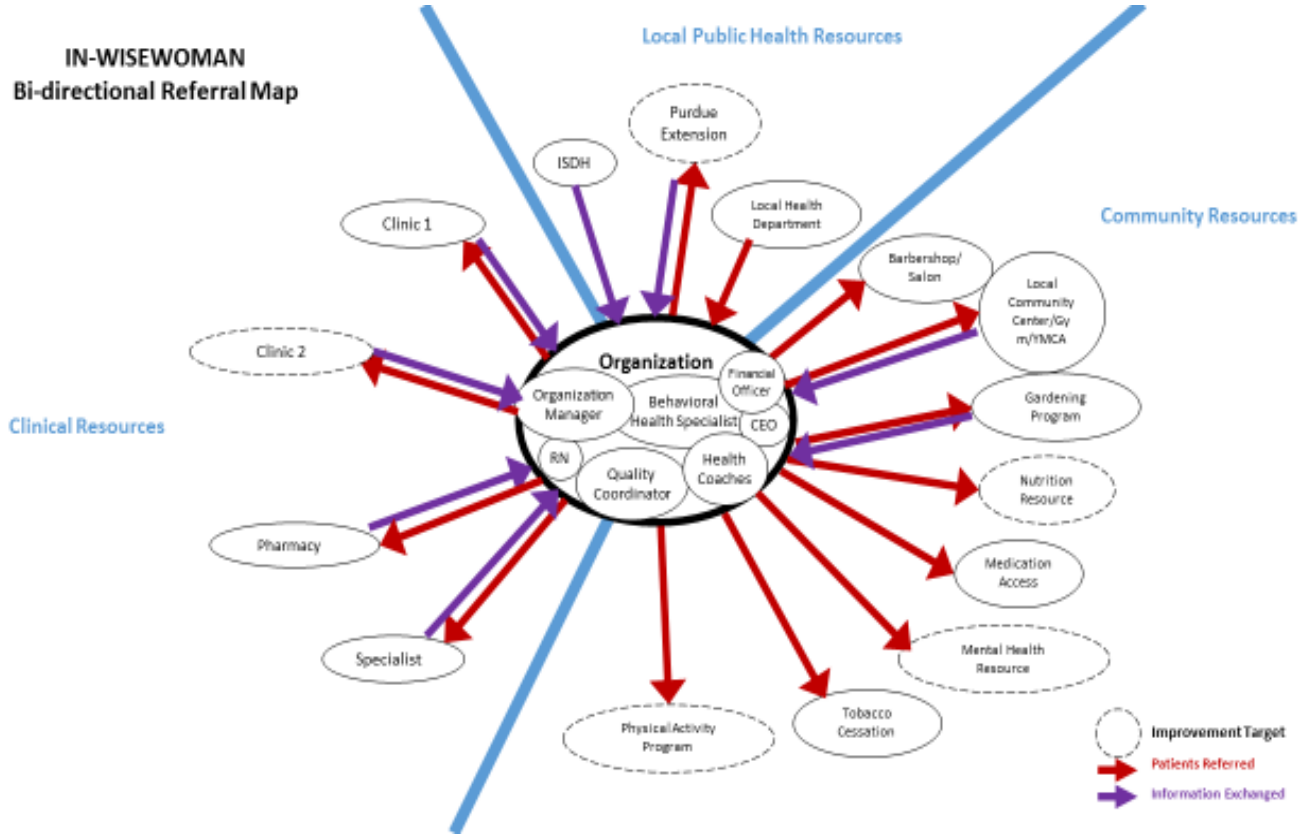
    - Hospitals
    - Imaging centers
    - Pharmacies
    - Long-term health care facilities
- Local Public Health Resources may include:
    - Local health departments
    - Community-based health care professionals (public health nurses, community health workers, home-visiting programs, EMS)
    - Insurance companies – MCOs/ACOs
    - Purdue Extension
    - QuitLine
    - Data repositories/health information exchanges
- Community-based resources may include:
    - Libraries
    - Barbershops/salons
    - Exercise facilities/recreation departments
    - Community centers
    - Food pantries/Meals on Wheels
    - Locals parks, walking or biking trails
    - Walking groups (e.g. mall walking programs)
    - Gardening programs
    - Food coupon programs
    - Farmers' markets
    - Nutrition classes offered by Cooperative Extension Services
    - Chronic disease self-management programs
    - Tobacco cessation programs
    - Mental health services
    - Violence prevention services
    - Discount/free medication programs
    - Transportation resources
    - Faith-based organizations

Steps to Creating /Updating the Community-Clinical Linkage and Bidirectional Referral Map:

1. The center bubble of the map should include the organization, clinic or health care provider that is establishing bidirectional referrals in the community via the IN-WISEWOMAN Program. (Add staff of the organization, clinic or health care provider to the center bubble.)
2. Draw three lines to separate the sheet into three separate sections. (Typically the three sections are clinical, local public health and community resources.)
3. Draw bubbles for the five to 20 resources with whom you currently refer women to most or who you plan to build a bidirectional referral with.
    - Bubbles around resources that you would like to improve bidirectional referrals with should have a dotted line.

4. Place red arrows from the center bubble to the resources that the organization refers to.
5. For each resource that provides information back to the organization, place a purple arrow back to the center bubble.
6. The goal is to have red and purple arrows going to and from each resource.
7. Maps must be updated twice a year but can be revised as new resources are identified and/or new relationships are established.

Figure 5: Bidirectional Referral Map Example



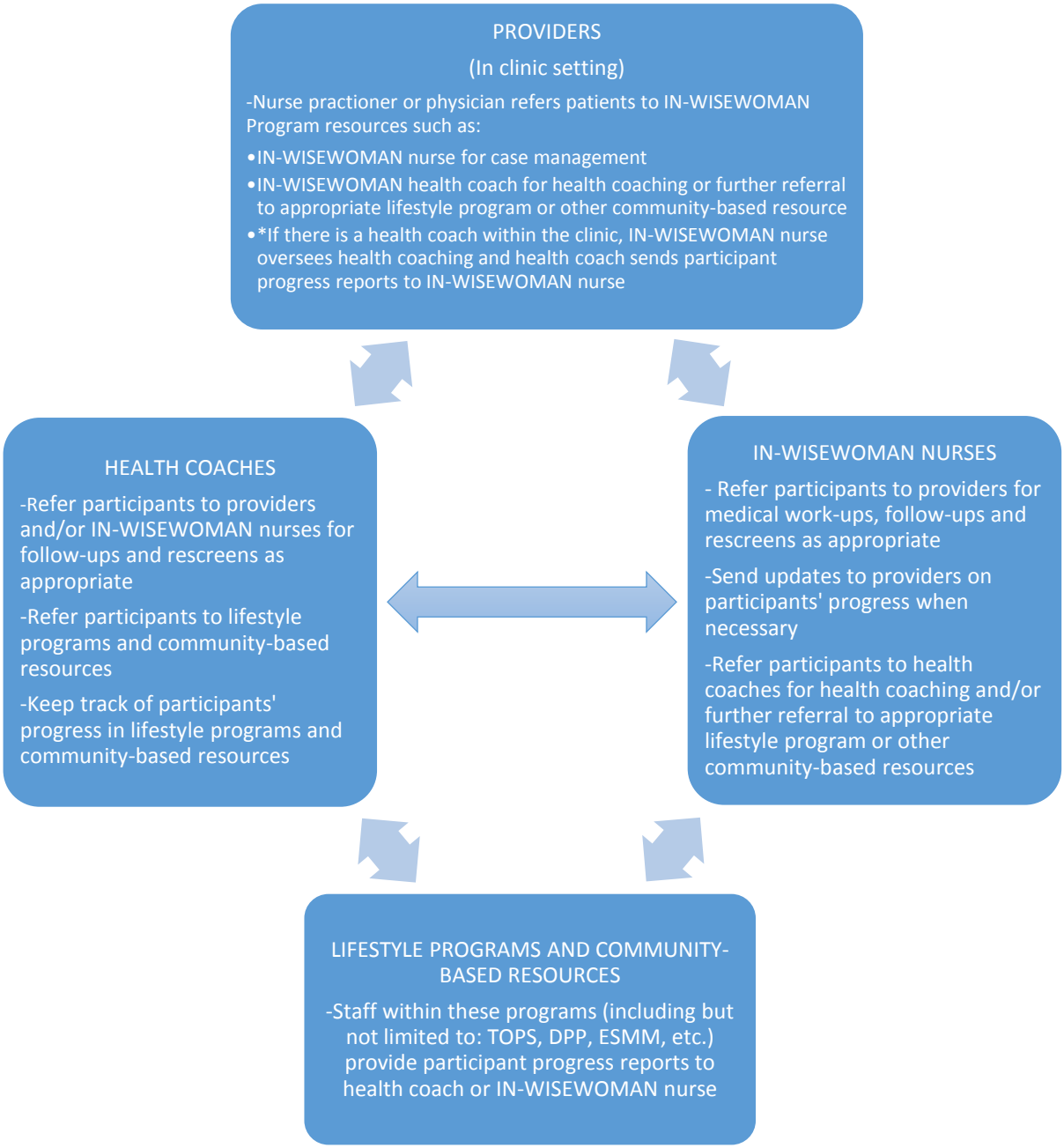
Forms for Bidirectional Referrals

Optimally, bidirectional referrals will be initiated by utilizing electronic medical records, and the information collected and exchanged via bidirectional referrals will also be updated in electronic medical records. When this is not possible, the IN-WISEWOMAN Program uses the Lifestyle Plan Form and HBSS Session Record to keep providers updated on the progress and behavior change, or lack thereof, of participants. These forms may be kept at clinics and/or with health coaches and should be updated with each class attended by the participant, each resource utilized or with each health coach check-in. This information should be accessible to providers and health coaches but must remain HIPAA compliant.

Communication and Coordination of Bidirectional Referrals

Effective bidirectional referrals and strong communication pathways are essential for positive health outcomes among IN-WISEWOMAN Program participants. Bidirectional referrals occur as shown in Figure 6.

Figure 6: Bidirectional Referral Flow



ANNUAL RESCREENING

WISEWOMAN participants are eligible to begin a new annual cycle of services after each anniversary of their initial screening. Annual rescreenings must follow all of the initial screening requirements described in the Cardiovascular Disease Screening section of this manual. This screening acts as a re-enrollment to the program and must begin with re-enrollment to the IN-BCCP before IN-WISEWOMAN services can continue. The same guidelines apply for medical follow-ups, HBSS completion and follow-up screenings in each annual cycle.

HBSS and Annual Rescreening

Participants who complete an annual rescreening are also able to receive additional HBSS sessions. The selected HBSS type may be the same or different as was received in previous years. If a participant is receiving HBSS sessions over an extended period of time and reaches 18 months since the initial or most recent annual screening, the participant must receive a new rescreening before any additional HBSS sessions can be completed. This is true even if the participant has not reached the maximum number of annual sessions for her selected HBSS.

Screening Definitions

The following box appears on the Screening Results Form and Health Assessment Form to ensure the correct data is collected and entered for each specific step in the WISEWOMAN process.

For office use only

☐ Initial Screening (1st screening in program)
☐ Follow-Up Screening (4-6 weeks after completion of HBSS)
☐ Re-Screening (12-18 months after initial screening if utilized WISEWOMAN services)
☐ Baseline Screening (12-18 months after initial screening if WISEWOMAN services were not utilized)

Initial Screening: Each participant will have only one initial screening. This is the first screening she completes when entering the program. In the scenario that a woman does not participate for numerous years after the initial screening and reenters the program, she will need another screening before participating in HBSS, and that will be a new baseline screening.

Follow-up Screening: Every effort should be made to help participants complete an HBSS program. When she does complete HBSS, she should come back to the clinic four to six weeks later for a follow-up screening. This screening includes a new health assessment (follow-up health assessment) and lab values. See the Follow-up Screening section for more details.

Annual Screening: All participants should be screened 12-18 months after her initial screening and every 12-18 months after that. An annual screening may be considered either a rescreen or baseline screening.

Rescreening: This annual screening will be called a rescreening if and only if the participant has attended HBSS sessions, attended follow-up appointments as needed and been in regular contact with a health coach since her initial screening or her last annual screening. This screening includes the same services as described in the Cardiovascular Disease Screening section.

Baseline Screening: If a woman does not participate in HBSS and does not have contact with IN-WISEWOMAN staff during the 12-18 months after her initial or last annual screening, her annual screening will be considered a new baseline screening. This screening includes the same services as described in the Cardiovascular Disease Screening section.

FORMS

There are IN-WISEWOMAN forms to go along with each step of the program. It is pertinent these are completed and submitted in a timely manner. (See Table 13.)

Table 13. IN-WISEWOMAN Forms

Form Name	Form #	Spanish Form #	Distributed by	Completed by	Purpose
Informed Consent	55479 (R3 / 2-20)	55534 (R3 / 6-20)	Indiana Department of Health and/or regional staff	Participant	1. Informs participant of program activities and services covered by the program
Health Assessment	55472 (R4 / 2-20)	52842 (R4 / 6-20)	Indiana Department of Health and/or regional staff	Participant	1. Collects participant demographics, health history and lifestyle behaviors 2. Allows provider to assess CVD risk
Screening Results	55477 (R8 / 2-20)	56980 (6-20)	Indiana Department of Health and/or regional staff	Screener or provider	1. Collects participant clinical measures and lab results 2. Offers referral guidance to providers 3. Collects risk reduction counseling and referral information
Lifestyle Plan	55474 (R5 / 2-20)	56979 (6-20)	Indiana Department of Health and/or regional staff	Staff at provider's office/health coach/ WISEWOMAN nurse	1. Used in risk reduction to assist participant in creating a SMART Goal/Lifestyle Plan 2. Filled out during every health coaching session
Medical / Medication Follow-up	55476 (R4 / 2-20)	55690 (R2 / 6-20)	Indiana Department of Health and/or Regional Staff	Provider	1. Collects labs and other results from follow-up visit with participant 2. Collects referrals and recommendations from provider for participant
Authorization to Release Health Information	55783 (R / 2-20)	55798 (R / 6-20)	Indiana Department of Health and/or regional staff	Participant and provider	1. Allows participant's medical information to be used for evaluation and CDC collection purposes 2. Valid for 60 days – must be filled out for any new visit/information after 60 days of last signature

PROGRAM FUNDING AND REIMBURSEMENT

In order to be reimbursed for WISEWOMAN services, a valid, current BCCP enrollment must first be submitted to the regional office, and the provider must follow the guidelines below:

Provider Agreement

- Sign and maintain current WISEWOMAN Provider Agreement with the Indiana Department of Health
- Notify the Indiana Department of Health of any staff changes, changes to address or billing information

WISEWOMAN Forms

- Ensure the participant is currently enrolled in the BCCP Program and meets WISEWOMAN age reuquirements
- Fill out required WISEWOMAN forms **completely**
- Ensure forms in the appropraite language are used

Send Forms to Regional Office

- Ensure enrollment forms for both programs are on file at the regional coordinating office
- Ensure forms are sent to the appropriate regional coordinating office within 30 days of service

Regional Office Scans Forms to Data Manager

- Regional coordinators review documents to ensure forms are filled out completely
- Regional staff scans documents to data manager within 30 days of receiving

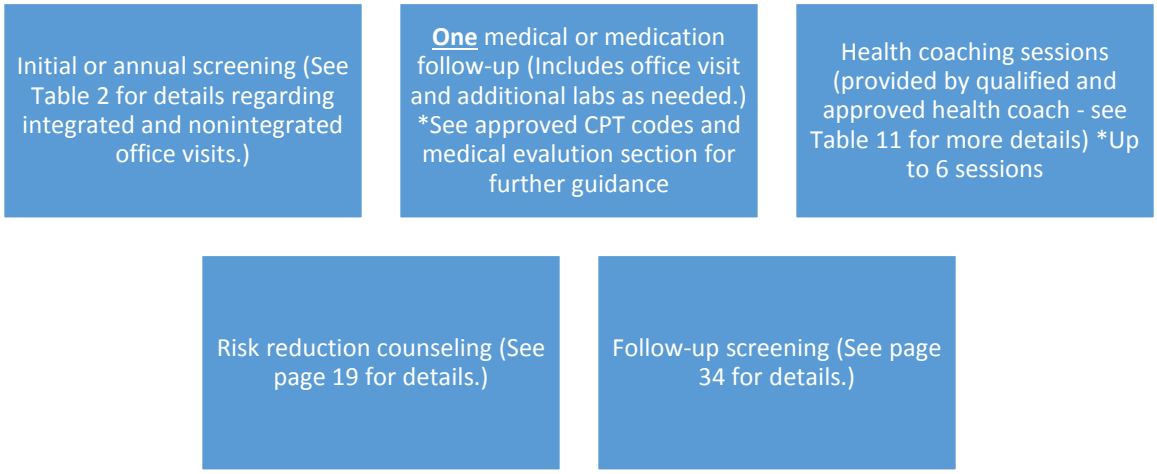
Data Manager Enters Data and Submits MDEs

- Data manager enters data in data system as they receive documents
- Data manager submits Minimum Data Elements (MDEs) twice a year per CDC requirements

Providers are Reimbursed

- IN-WISEWOMAN program director reviews billed services
- IN-WISEWOMAN program director approves services rendered
- Indiana Department of Health releases funds to reimburse providers
- Third-party payer reimburses providers

IN-WISEWOMAN Program providers can bill for the following services for each program participant during each one-year cycle:



Provider Responsibility

1. Fill out coinciding forms for completed services.
2. Send completed forms and claims to regional office.
3. Bill for appropriate CPT codes.

PROGRAM MONITORING AND EVALUATION

The first strategy of the WISEWOMAN Program is to *track and monitor clinical measures shown to improve healthcare quality and identify patients with hypertension.* The Indiana Department of Health contracts with a data manager and a program evaluator to collect and submit data to the CDC, evaluate progress and better understand how to continue improving the IN-WISEWOMAN Program, serving more women efficiently and effectively.

Data Collection and Reporting

National WISEWOMAN Program data collection is used to track changes in women's cardiovascular risk factors, monitor the delivery and effectiveness of services and evaluate program outcomes.

The IN-WISEWOMAN Program follows the data collection requirements established by the CDC:

- Establish and use a data system that collects all required minimum data elements (MDEs) and other program-related data.
    - The system must have mechanisms to ensure the quality and timeliness of the data submitted to the CDC.
- Use existing surveillance data to identify cardiovascular risk factors and needs of their population to inform program planning.
- Use data for performance measurement, monitoring and evaluation.

To accomplish data collection, the IN-WISEWOMAN Program will use the data collection forms listed in the Forms section of this manual. Medical and subject matter experts have reviewed the IN-WISEWOMAN Program forms.

Data Manager

The Indiana Department of Health contracts with a data manager to perform data system design and reporting functions for the IN-BCCP and the IN-WISEWOMAN Programs. The data manager is responsible for efficiently meeting program needs including the following: creating and maintaining a data system that is robust and flexible enough to be modified as necessary

- Ensure data system allows for the creation of meaningful reports for programs, providers, the CDC and other stakeholders.
- Ensure the ability to use data to:
    - Monitor outcomes of clinical services, lifestyle programs and other services
    - Evaluate and measure program performance
    - Conduct data quality assurance
    - Prepare reports
    - Communicate program efforts and results to the CDC, the public, legislators and other stakeholders

MDEs

The CDC-defined WISEWOMAN MDEs are a set of standardized data variables needed to ensure that consistent and complete information is collected for each WISEWOMAN participant. MDEs serve the

purposes of describing, monitoring and assessing individual and program progress. The CDC submits WISEWOMAN MDEs from all grantees to the Office of Management and Budget (OMB) for approval.

MDE requirements:

- Collect and submit MDEs to the CDC semi-annually using the CDC's standardized submission process.
- Meet the data requirements outlined in the most current WISEWOMAN MDE manual.
- Ensure all data submitted to the CDC are de-identified, consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- MDE wording and response options should be in accordance with those approved by OMB.

The CDC encourages collecting additional data to monitor, manage and evaluate program efforts and share with the CDC. Further, it is encouraged to collaborate with other programs on additional data collection.

Program Evaluation

Evaluation of WISEWOMAN activities will: demonstrate program effectiveness in improving hypertension control and other cardiovascular risk among the target population, provide useful information to drive continuous program improvement, contribute to the evidence base for specific program activities and contribute to the evidence base for disparate populations.

Program evaluators will:

- Conduct both process and outcome evaluation of their program activities:
  - Process evaluation will assess program implementation.
  - Outcomes evaluation will assess the achievement of program outcomes. The outcomes evaluation is informed and complemented by the process evaluation.
- Develop an overarching 4-year evaluation plan and specific annual plans for each program year and submit them for CDC approval.
- Use evaluation findings to make revisions and improvements to the program.
- Report evaluation findings annually to the CDC.
- Report cumulative evaluation findings for the 4-year project period in the Final Performance Report.
- Address the three priority areas determined by CDC: uncontrolled hypertension, health coaching and/or lifestyle programs and one additional area.

Program Evaluator

The Indiana Department of Health contracts with a program evaluator to capture progress toward identified outcomes. The IN-WISEWOMAN program evaluator works with the Evaluation Advisory Group (EAG) to develop evaluation tools and processes for the IN-WISEWOMAN Program that will allow the Indiana Department of Health and other interested parties to benefit from the collective experience of participants, health coaches and providers involved in the program. The program evaluator's evaluation design for the IN-WISEWOMAN Program involves collecting both qualitative (or "descriptive") data and quantitative (or "hard") data. Regional staff will collect client data and submit that data to the data

manager. The data manager will capture participant data in a database developed specifically for the IN-WISEWOMAN Program. The primary objective of the evaluation is to create an accurate picture of program implementation and client participation in grant-funded services.

Evaluation Advisory Group

The EAG was established to ensure quality and accuracy of evaluations. The EAG is composed of key program stakeholders. (See Table 14.) The EAG provides input on the design and implementation of the Evaluation Plan and meets quarterly to review and advise on the evaluation plan, evaluation activities and products produced by the program evaluator. The EAG members are prompted by the program evaluator and IN-WISEWOMAN program director to engage in peer discussion around challenges that may not be evident in key data indicators. This ensures that the EAG will engage in continuous quality and program improvement. Additionally, the program evaluator will provide the Indiana Department of Health with summary products each year that include recommendations for program improvement that are informed by members of the EAG.

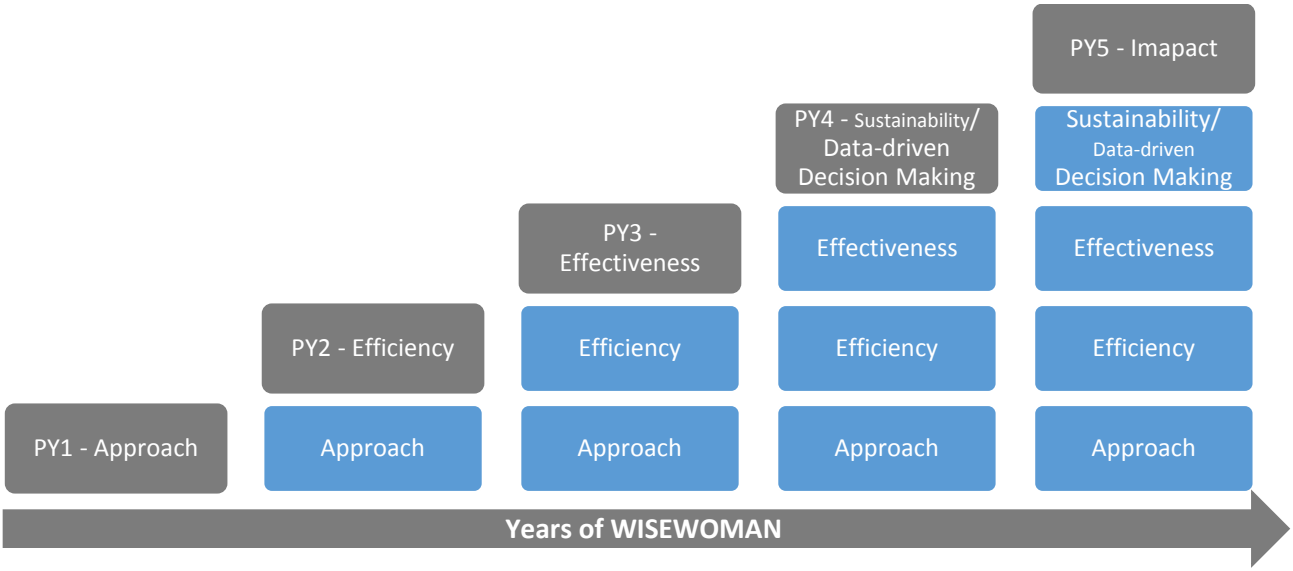
Table 14. EAG Members

Role	Agency	Role/Use of Evaluation Findings
Program Evaluator		Facilitate EAG and develop evaluation products
IN-WISESOMAN Program Director	Indiana Department of Health	Program design and implementation
IN-BCCP Program Director	Indiana Department of Health	Interface with IN-BCCP program
Comprehensive Cancer Section Director	Indiana Department of Health	Program design
Cardiovascular Disease and Diabetes Section Staff	Indiana Department of Health	Interface with cardiovascular and diabetes program
Central Regional Coordinator	YWCA	Patient outreach and education, provider recruitment, population outreach and education
Central Region Nurse	YWCA	Patient outreach and education, provider recruitment, population outreach and education
Central Region Health Coach	YWCA	Patient outreach and education, provider recruitment, population outreach and education
Northern Regional Coordinator	United Health Services	Patient outreach and education, provider recruitment, population outreach and education
Northern Region Nurse	United Health Services	Patient outreach and education, provider recruitment, population outreach and education
Northern Region Health Coach	United Health Services	Patient services, provider satisfaction, provider technical assistance, outreach and education
IN-WISEWOMAN Provider	Varies	Patient services, provider satisfaction, provider technical assistance, outreach and education
MDE Data Management		Understanding of available data and data limitations

Evaluation Approach

WISEWOMAN evaluation utilizes a five-year stepwise evaluation approach, starting in Program Year One with process evaluation of the approach and, building to Program Year Five, the outcome evaluation of impact of the program. (See Figure 7.) Each year will have evaluation components of the previous years that act as building blocks to evaluate the overall program.

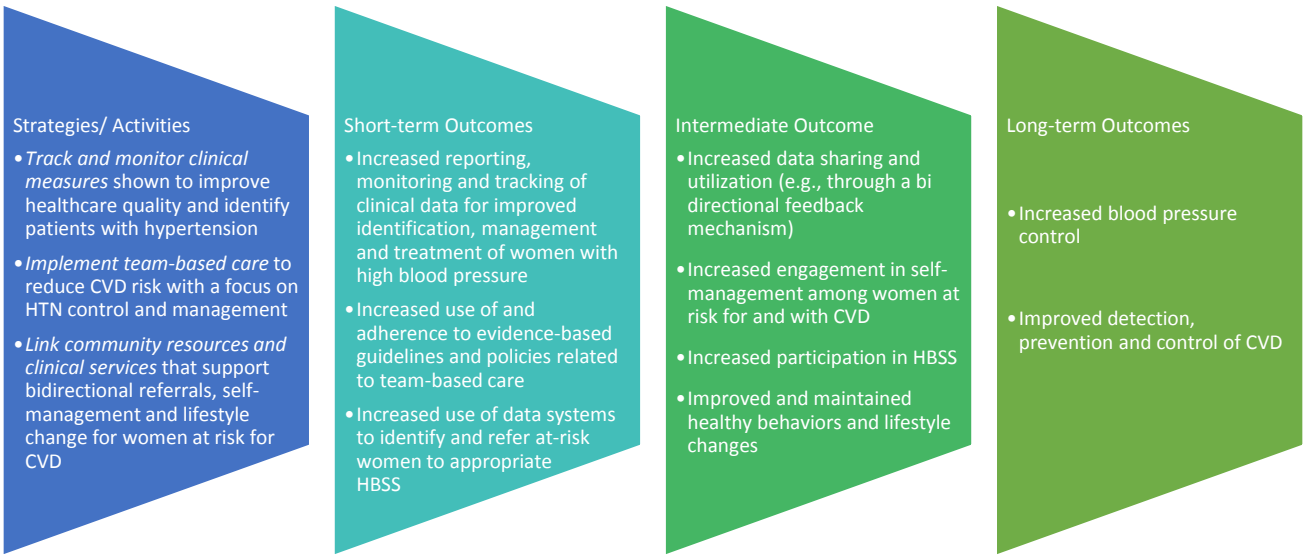
Figure 7. Stepwise Evaluation Approach



Logic Model

The logic model provides a graphic representation of the WISEWOMAN program strategies and activities as well as the short-, intermediate and long-term outcomes. (See Figure 8.) The logic model serves as a reference tool for developing the annual evaluation questions.

Figure 8. Logic Model



Evaluation Plan

In the first months of the funding cycle, a five-year evaluation plan was developed; this document serves as an overarching guide to the program evaluation. The CDC guidance provides the broad description of the evaluation core areas. (See Table 15.) Each year the program evaluator, with the EAG, uses that guidance to develop the evaluation approach for the coming program year.

Table 15: CDC Program Year Evaluation Guidance

Evaluation Core Area	Description
PY1 – Approach	Describes the intervention or activities implemented that will continue throughout the course of the grant, the expected outcomes and how the associated activities will lead to outcomes among the priority population
PY2 – Efficiency	Describes how implementation of the grant affected efficiencies within the recipient health department, related to infrastructure, management, partners and financial resources
PY3 – Effectiveness	Describes the extent to which they have been effective in implementing the selected strategies. This includes the reach of the strategies, steps taken to expand reach, early outcomes and a description of the facilitators and barriers
PY4 – Sustainability	Reflects on the data generated from grant activities and describes how they will use or have used this data to inform the implementation of the strategies throughout the grant period and after the grant ends
PY5 – Impact	Describes the health impact or measurable change in health, behavior and environment of the identified priority population

Evaluation Reporting and Use of Evaluation Findings

The program evaluator will work with the Indiana Department of Health to develop customized evaluation products tailored to stakeholder groups. Formative feedback will be provided on an ongoing basis via email, phone and in-person meetings between the evaluation contractor, program staff and EAG.

Annual evaluation summary reports will be developed by the evaluation contractor that include recommendations for program improvement that are informed by members of the EAG. These reports will be shared with the Indiana Department of Health and EAG. The Indiana Department of Health will share evaluation products with stakeholders.

Information gathered for monitoring and evaluation will be used for ongoing program planning and improvement. Examples include providing monthly performance feedback to clinical providers and conveying patient feedback to staff. Evaluation findings may indicate the need for revisions in program components to meet the needs of participants.

Performance Measures

In addition to the annual evaluation work, the program evaluator will assist the IN-WISEWOMAN program director with the collection and reporting of program performance measures. Performance measure targets have been developed for PY1 through PY5. (See Table 16.)

Table 16: Program Performance Measures and Targets

Performance Measure	Year 1 Actual			Year 2 Target			Year 3 Target			Year 5 Target		
	num	*den*	*%*	*num*	*den*	*%*	*num*	*den*	*%*	*num*	*den*	*%*
ST1: #/% of WISEWOMAN participants within WISEWOMAN providers with a protocol for identifying patients with undiagnosed hypertension	162	254	64%	450	652	69%	701	1,002	70%	1,341	1,862	72%
ST2: #/% of WISEWOMAN participants within WISEWOMAN providers that have policies or systems to implement a multi-disciplinary team approach to blood pressure control	135	254	53%	352	652	54%	551	1,002	55%	1,061	1,862	57%
ST3: #/% of at-risk women in WISEWOMAN referred to an appropriate healthy behavior support service	227	254	89%	587	652	90%	902	1,002	90%	1,676	1,862	90%
I4: #/% of WISEWOMAN providers with an implemented community referral system (tracking bidirectional referrals) for healthy behavior support services for people with high risk for CVD (optional measure)	2	9	22%	3	10	30%	4	11	36%	5	12	42%
I5: #/% of women in WISEWOMAN referred to a healthy behavior support service who attend at least one session	217	227	96%	558	587	95%	857	902	95%	1,592	1,676	95%
LT6: #/% of women in WISEWOMAN with known high blood pressure who have achieved or are currently maintaining blood pressure control	17	61	28%	108	215	50%	169	331	51%	338	614	55%

GRANT ADMINISTRATION

As a WISEWOMAN grantee, the Indiana Department of Health is responsible for grant administration. The IN-WISEWOMAN program director oversees program contractors, subrecipients and other partners, providing program training and quality assurance to ensure successful program implementation and positive outcomes.

Annual Work Plan and Budget Negotiations

The IN-WISEWOMAN Program uses work plans to define program activities and deliverables for subrecipients participating in the IN-WISEWOMAN Program. These work plans outline a subrecipient's WISEWOMAN activities and program requirements for the year and must be updated at least annually.

Prior to the start of each new grant year, the IN-WISEWOMAN program director will contact subrecipients to initiate an annual work plan and budget negotiation process. Subrecipients will be required to review work plans and update as needed, as well as submit their annual budget. If a subrecipient is interested in adding activities or strategies to those they are currently implementing, it will be discussed as part of the work plan negotiations.

Progress Reports

Subrecipients will be required to submit **monthly** progress reports to the IN-WISEWOMAN program director to provide status of program services and contract deliverables. These can be informal and may be done either by email or phone.

The goal of the progress reports is to increase participating subrecipients' abilities to make changes throughout the fiscal year that enable them to maximize volume and quality of screenings completed as well as streamline reporting expectations across IN-WISEWOMAN contracts where possible.

Program Training and Assistance

The Indiana Department of Health and the IN-WISEWOMAN Program staff offer program training and assistance to ensure the program is implemented successfully and runs smoothly. The program director develops and establishes protocols, quality assurance measures and program materials for continued program progress and improvement.

Program Materials

Program materials include this program manual, the coinciding abbreviated version, screening forms, screening results booklet, approved CPT code list, health coaching tools and materials as well as BAP materials. The IN-WISWOMAN Program has a program web page within the Indiana Department of Health website. Many of the forms, tools and documents referenced in this manual are available on the IN-WISEWOMAN web page.

Program Communication and Training Events

The IN-WISEWOMAN Program offers multiple training activities and communication opportunities throughout the year to share updates and provide technical assistance to contracting organizations including:

- Quarterly site visits with regional coordinating offices
- Quarterly WISEWOMAN and EAG meetings
- Monthly calls with regional coordinating staff
- BAP training
- Provider training – at least annually
- Health coach trainings/modules
- Topic-specific memos and emails
- Individual calls

Questions and Technical Assistance

The IN-WISEWOMAN Program staff will provide on-demand training and technical assistance to providers whenever needed. This assistance will be made available through one-on-one communications as well as during scheduled program meetings and events.

Organizations are welcome and encouraged to contact the IN-WISEWOMAN program director for questions and technical assistance. Contact information is located at the end of this document.

Please contact your regional coordinating office for questions regarding the following:

- Participant eligibility questions or enrollment issues
- Health risk assessment questions or screening requirements
- How to send data/forms to regional coordinators
- General questions related to the IN-WISEWOMAN Program or participant-related questions

Quality Assurance

The IN-WISEWOMAN Program provides feedback to organizations as part of the quality assurance and quality improvement process. This process includes performance measures, site visits, form checks and performance improvement plans.

Performance Measures

Funding received from the CDC national WISEWOMAN Program is contingent upon IN-WISEWOMAN meeting or exceeding several quality assurance parameters and performance measures. The national WISEWOMAN organizational-level performance measures are created to align with the state's performance measures and program requirements from the CDC.

WISEWOMAN grantees are expected to meet or exceed the following performance measures:

1. Program submits minimum data elements files on schedule and with no more than a 5% error rate. (Calculated from final MDE submission for each period and provided in a final validation report.)

2. Program has actively engaged with a minimum of two public or private partner organizations to promote and support environmental changes for increased physical activity, access to healthy food choices, smoking cessation and elimination of exposure to secondhand smoke. (Data source is information provided in the annual performance reports (APRs).)

3. Program has met or exceeded 95% of its CDC-approved screening goals. Screening goals include baseline and rescreenings (calculated using MDEs).

4. Program delivers risk reduction counseling to 100% of women screened. Risk reduction counseling includes appropriate referral to health coaching, community resources or lifestyle programs (calculated using MDEs and APRs).

5. Program follows-up with 100% of women with abnormal blood pressure values. Follow-up parameters should be determined by WISEWOMAN guidelines and facility medical protocol (calculated using MDEs and APRs).

6. Program ensures that 80% of women referred to a lifestyle program or health coaching participate in the program. Participation is defined as attendance at a minimum of one lifestyle program or coaching session (calculated using MDEs).

7. Program ensures that 60% of women who participate in a lifestyle program or health coaching complete the program. Completion is defined as the number of sessions that the evidence base for the program has determined to be required for behavior change (calculated using MDEs and APRs).

The target values for organization-level performance measures may change from year to year of the grant depending on CDC performance targets for the state. The IN-WISEWOMAN program director will send out an updated list of the organization-level performance measures at the beginning of each grant year to ensure participating organizations are up-to-date on performance expectations.

Organizations are expected to monitor their monthly service delivery to ensure they are meeting established targets for yearly performance measures. An organization's ability or inability to meet performance measures may impact future IN-WISEWOMAN Program funding amounts.

Site Visits

The IN-WISEWOMAN program director will conduct site visits with organizations over the course of the multiyear grant. Site visits include a review of an organization's performance and processes and serve as an opportunity to highlight program successes, challenges encountered, lessons learned, useful tools and technical assistance needs. Organizations will be notified of a site visit request six weeks prior to the scheduled visit. Detailed information on visit requirements will be provided with this request.

Form Checks

Form checks include a review of a select number of a participant forms to compare clinic records to those in the data system and will be conducted throughout the multiyear grant cycle. These serve as an opportunity to determine quality and fidelity of the IN-WISEWOMAN Program services provided and assist organizations in identifying areas for potential quality improvement. Form checks are conducted by the IN-WISEWOMAN program director and will be done internally by reviewing the data management system. The IN-WISEWOMAN program director will pull forms from the data management system at random at least every month.

Performance Improvement Plans

If a funded organization becomes out of compliance with the contract, the program director may require a performance improvement plan.

Materials Development

Organizations are able to use existing materials or assist the IN-WISEWOMAN program director in creating new materials to provide WISEWOMAN services and support discussion around participant-centered goals and healthy behaviors. WISEWOMAN funding may be used to develop original materials following certain restrictions.

The CDC retains an unrestricted right to use, reproduce, adapt and disseminate products developed using WISEWOMAN federal funds. These products may include program participant materials, graphic designs, education and other informational material, fact sheets, newsletter templates and manuals. If an organization is working with subcontractors or consultants to develop program materials, they should ensure the subcontractor/consultant is aware that any materials that they produce with WISEWOMAN funds will be the property of the CDC.

The funding source should be noted on any material or publication developed using WISEWOMAN funds. An appropriate citation would be:

> *The creation of this [insert material name or description] was made possible by cooperative agreement DP18-1816 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.*

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

CONTACT INFORMATION

Northern Region: Green
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Currently no coverage in Southern Region

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APPENDIX A

Blood Pressure and Waist Circumference Measurement Technique

Blood Pressure Measurement Technique:

Accurate blood pressure measurements are critical for detecting and managing high blood pressure. Blood pressure measurements should be done using the following proper technique:

1. Patients should not smoke, exercise or have caffeine for at least 30 minutes before their blood pressure is measured.
2. Patients should be seated quietly for at least 5 minutes in a chair (rather than on an exam table), with feet on the floor and arms supported at heart level.
3. An appropriate sized cuff should be used (cuff bladder encircling at least 80% of the arm). Many adults require a large adult cuff.
4. A mercury sphygmomanometer, a recently calibrated aneroid manometer or a validated electronic device should be used.
5. Wrap cuff firmly around the upper arm at heart level; align the cuff with the brachial artery.
6. At least two measurements should be taken and recorded, separated by a minimum of 2 minutes. If the first two readings differ by more than 5mmHg, additional measurements should be taken.
7. Provide participant's specific BP numbers and BP goals both verbally and in writing.

Common positioning problems can lead to inaccurate BP measurement and can have a serious impact on the numbers you use to diagnose and determine treatment. These evidence-based tips can help ensure correct positioning in the clinical setting:

Table 1. Common Positioning Errors and Effect on BP

When patient has ...	BP can change by this much …
Cuff over clothing	10–40 mm Hg
Full bladder	10–15 mm Hg
Conversation or is talking	10–15 mm Hg
Unsupported arm	10 mm Hg
Unsupported back	5–10 mm Hg
Unsupported feet	5–10 mm Hg
Crossed legs	2–8 mm Hg

Waist Circumference Measurement Technique:

- With the patient standing, arms at the sides, feet together and abdomen relaxed, a horizontal measure is taken at the narrowest part of the torso (above the umbilicus and below the xiphoid process).
- Duplicate measurements are recommended. The average of the two measures should be used, provided each measure is within 5mm.

Appendix B

Patient-centered Risk Reduction Counseling and Health Coaching

The CDC WISEWOMAN Program has adopted the use of patient-centered risk reduction counseling and health coaching using motivation interviewing (MI) techniques. MI is a client-centered behavior change counseling approach. The primary goal of MI is to guide the client in understanding the reasons for her mixed feelings about a desired behavior change and to identify internal motivation that will help her move past her hesitance or unwillingness to make a behavior change. The four major principles of MI are:

1. Expressing empathy
2. Supporting hope and possibility
3. Rolling with resistance
4. Developing discrepancy

With MI, the provider seeks to understand the patient's perspective, recognizing that patients who need to make changes are at different levels of readiness to make changes. It affirms that the client has the freedom to choose whether to make behavior changes and that the way changes are made are self-directed by the client. MI is nonjudgmental and involves collaboration and not confrontation; evocation and 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

All staff providing health coaching to IN-WISEWOMAN participants must be trained in MI or have a Brief Action Planning (BAP) certification. Providers and other staff completing risk reduction counseling with patients are encouraged to also be trained in MI or have a BAP certification and to use the following approaches and skills for effective participant-centered counseling:

- Using MI techniques
- Talking with, rather than to, the participant
- Responding with sensitivity and considered health literacy or cultural issues that may emerge
- Maintaining a nonjudgmental attitude, using active listening and asking open-ended questions
- Supporting positive risk reduction changes already made by the participant
- Assisting the participant in identifying barriers to risk reduction (e.g., knowledge gaps, skills needed, socioeconomic and other life circumstances that are barriers to being healthy)

A number of Indiana Department of Health staff, including the IN-WISEWOMAN program director, are certified to offer BAP trainings, and trainings are available upon request. More information about BAP can be found in the Team-based Care section of this manual.

Motivational Interviewing Resources

Training videos you can access on YouTube:

- Ineffective Physician: https://www.youtube.com/watch?v=80XyNE89eCs
- Effective Physician: https://www.youtube.com/watch?v=URiKA7CKtfc
- Mr. Smith's Smoking Evolution: https://www.youtube.com/watch?v=0z65EppMfHk
- Benjamin Zander "How to Give an A"(talks about how to help people realize their full potential; useful for the Spirit of MI - 14 minutes): https://www.youtube.com/watch?v=qTKEBygQic0&feature=youtu.be

- Coaching with Compassion (describes brain research that supports using a compassionate approach to teaching - 2 ½ minutes): https://www.youtube.com/watch?v=ZFjgAxmRaYo