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

WISEWOMAN™

TECHNICAL ASSISTANCE AND GUIDANCE DOCUMENT

COOPERATIVE AGREEMENT DP13-1302

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

CONTENTS

ABBREVIATIONS AND ACRONYMS

Below is a list of abbreviations and acronyms that are commonly used by the WISEWOMAN Program.

A1C Test	Glycosylated Hemoglobin Test
ABCS	Aspirin Blood Pressure Control Cholesterol Management Smoking Cessation
ACA	Affordable Care Act
ADA	American Diabetes Association
ATP III	Adult Treatment Panel III Report National Cholesterol Education Program, 2001)
BCCEDP	Breast and Cervical Cancer Early Detection Program (grantee-specific program)
BMI	Body Mass Index
CDC	Centers for Disease Control and Prevention
CHD	Coronary Heart Disease
CHW	Community Health Worker
CLIA	Clinical Laboratory Improvement Amendments
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
CVD	Cardiovascular Disease
DASH	Dietary Approaches to Stop Hypertension
DBP	Diastolic Blood Pressure
DCPC	Division of Cancer Prevention and Control
DDT	Division of Diabetes Translation
DHDSP	Division for Heart Disease and Stroke Prevention
DHHS	Department of Health and Human Services
DNPAO	Division of Nutrition, Physical Activity, and Obesity
EHR	Electronic Health Record
FFR	Federal Financial Report
FOA	Funding Opportunity Announcement
FPG Test	Fasting Plasma Glucose Test
FTE	Full Time Employee
HBP	High Blood Pressure
HDL-C	High-Density Lipoprotein Cholesterol
HIPPA	Health Insurance Portability and Accountability Act
HTN	Hypertension
IOM	Institute of Medicine
IOV	Integrated Office Visit
JNC 7	Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7, 2004)
LDL-C	Low-Density Lipoprotein Cholesterol
LSP	Lifestyle Program
MDE	Minimum Data Element
MTM	Medication Therapy Management
NBCCEDP	National Breast and Cervical Cancer Early Detection Program
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NHLBI	National Heart, Lung, and Blood Institute
NIH	National Institutes of Health
OGTT	Oral Glucose Tolerance Test
OMB	Office of Management and Budget
OSH	Office on Smoking and Health
PGO	Procurement and Grants Office
SBP	Systolic Blood Pressure
SMBP	Self-Measured Blood Pressure
TIA	Transient Ischemic Attack
TLC	Therapeutic Lifestyle Changes
USPSTF	U.S. Preventive Services Task Force
WISEWOMAN	Well-Integrated Screening and Evaluation for Women Across the Nation

INTRODUCTION

BACKGROUND

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 with access to additional preventive health services, including screenings for cardiovascular disease risk factors, referrals for medical evaluation, health coaching, and lifestyle programs.

In 2013, the CDC released Funding Opportunity Announcement (FOA) DP13-1302, which began a new 4-year cooperative agreement with 19 state and two tribal organizations. In 2014, CDC funded one additional state. In a cooperative agreement, CDC and grantees have a shared responsibility for successfully implementing the program and meeting program outcomes. This document is designed to provide WISEWOMAN grantees guidance and resources on developing, implementing, and evaluating a WISEWOMAN Program under this FOA.

CDC will have substantial involvement with grantees through a variety of methods, including developing resources, providing ongoing guidance, and disseminating relevant research findings and public health recommendations. Through grantee meetings and webinars, CDC will provide (1) an orientation to the WISEWOMAN Program, (2) professional development on cardiovascular disease prevention, health promotion, and other relevant content, and (3) forums for grantees to share their expertise and experience.

CDC will monitor and support grantees' progress toward achieving the outcomes of this cooperative agreement through (1) monthly, tailored technical assistance calls with CDC Project Officers, (2) periodic site visits by CDC Project Officers and other specialists as needed (e.g., data team members, health scientists, evaluation specialists), (3) analyses of WISEWOMAN minimum data elements, and (4) review of annual performance reports, work plans, budgets, key program activities, policies, and procedures.

The priority of the WISEWOMAN Program under this FOA is risk reduction, with a focus on hypertension control. This focus aligns with and supports Million Hearts® , a national initiative to prevent **1 million heart attacks** and strokes by 2017 (http://millionhearts.hhs.gov). Women receive risk reduction counseling and healthy behavior support options to support risk reduction.

The three major categories of healthy behavior support options include:

- Evidence-based lifestyle programs delivered through community-based organizations
- Health coaching delivered either in the health care setting or through community-based organizations
- Referrals to community-based resources that support healthy behaviors

The long-term objectives for the WISEWOMAN Program under this FOA include the following:

1. Develop systems that monitor, improve, and sustain the cardiovascular health of the population served.
2. Collect, analyze, report, and use high quality program data and information to plan, monitor progress, perform evaluation, track outcomes, and improve program effectiveness.
3. Partner with organizations to support physical activity, healthy food choices, smoking cessation, and elimination of exposure to second-hand smoke.
4. Support clinical systems of care to improve access to and delivery of cardiovascular disease preventive health services, with an emphasis on control of hypertension.
5. Leverage existing resources provided through chronic disease programs, community-based organizations, and the health care system to reduce cardiovascular risk factors in the population served; risk factors of focus include high blood pressure, diabetes, cholesterol, overweight/obese, and smoking.
6. Implement evidence-based clinical preventive services and utilize evidence-based community resources to improve cardiovascular health in the population served.
7. Build or strengthen community-clinical linkages to increase access to community-based lifestyle programs and services that promote self-management of healthy behaviors and/or chronic disease in the population served.

THE RELATIONSHIP BETWEEN WISEWOMAN AND THE NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (NBCCEDP)

The WISEWOMAN Program and NBCCEDP share some characteristics, but there are significant differences between the two programs. The major difference is the focus of the programs. WISEWOMAN's focus is to offer risk reduction counseling and healthy behavior support options to improve control of hypertension and other cardiovascular disease (CVD) risk factors. In contrast, NBCCEDP provides breast and cervical cancer screening and management.

There are several programmatic areas in which WISEWOMAN and NBCCEDP overlap. The WISEWOMAN Program shares the NBCCEDP infrastructure, which includes program oversight and delivery of services through State/Tribal health agencies with experience and expertise in:

- recruiting and working with women in the eligible population;
- delivering screening services through an established health care delivery system;
- collecting and reporting data (minimum data elements) to track, monitor, and evaluate program efforts;
- providing professional development opportunities for staff, providers, and partners;
- promoting the program and educating women about the importance of seeking care;
- assuring that quality care is provided to the women participating in the program.

The table below provides an at-a-glance comparison of WISEWOMAN and NBCCEDP.

TOPIC	WISEWOMAN	NBCCEDP
Focus of Program	Risk reduction counseling, health coaching, lifestyle programs and other healthy behavior support options to improve control of hypertension and other CVD risk factors. Provider system approaches to improve uncontrolled hypertension	Early detection of breast and cervical cancer. Population based approaches to improve systems that increase high quality breast and cervical cancer screening and management consistent with current guidelines
Services Provided	■ Heart disease and stroke risk factor screening, which includes assessment of blood pressure, cholesterol, glucose, BMI, and personal medical history ■ Health risk assessments ■ Risk reduction counseling ■ Referrals for women with abnormal screening values to health care providers for medical evaluation and management of condition(s) ■ Follow-up for uncontrolled hypertension ■ Link participants to free or low-cost medication resources ■ Referrals to health coaching, lifestyle programs, and other healthy behavior support options	■ Cancer screening, which includes clinical breast exam, Pap test, and screening mammography ■ Diagnostic tests to follow-up abnormal screening ■ Referrals for eligible women with abnormal or suspicious diagnostic test results to the state Medicaid program for treatment; for women not eligible for Medicaid, identify and refer to pro bono sources of treatment
Where Clinical Services Are Provided	■ Health care providers must be recruited from those offering NBCCEDP screening services ■ Health care facilities that employ clinical systems of care with demonstrated success in hypertension management ■ Providers must have staff skilled in providing patient-centered risk reduction counseling	■ 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
Year First State/Tribal Health Agency Was Funded	1995	1990

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TOPIC	WISEWOMAN	NBCCEDP
Targeted Age Group	40–64-year-old women enrolled in the State/Tribal BCCEDP	Cervical cancer screening: 21–64-year-old women; priority population is women rarely/never screened Mammography: 40–64-year-old women; priority population is 50–64-year-old women
Rescreening Requirement	Conduct rescreening on all WISEWOMAN participants who return for their BCCEDP annual exam within 12–18-months after their previous WISEWOMAN screening	CDC has not established a minimum standard or performance indicator related to the percent of women rescreened within a certain time period
Number of Grantees	20 State and two Tribal Organizations	50 States, DC, five Territories, and 11 Tribal Organizations
Program Administration	Through CDC's Division for Heart Disease and Stroke Prevention, Program Development and Services Branch, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP)*	Through CDC's Division of Cancer Prevention and Control, Program Services Branch, NCCDPHP

*WISEWOMAN was administered by CDC's Division of Nutrition, Physical Activity, and Obesity from its inception until September 2005.

LEGISLATIVE REQUIREMENTS

Grantees must follow the legislative requirements detailed in 42 U.S.C. Section 300k of the Public Health Service Act,[1] as amended. (NBCCEDP grantees also follow these requirements).WISEWOMAN was originally authorized as a demonstration project in 1993 through a legislative supplement to The Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354). This law, and later amendments, specify the required functions of all WISEWOMAN grantees as follows:

- Provide preventive health services that include screenings regarding blood pressure and cholesterol, and health education (i.e., provide heart disease and stroke risk factor screening and lifestyle programs) to women receiving services through NBCCEDP.
- Provide appropriate referrals for medical treatment.
- Improve the education, training, and skills of health professionals.
- Develop and disseminate public information and education programs.
- Monitor the quality and interpretation of screening procedures.
- Evaluate the above activities.

The legislation also requires that WISEWOMAN grantees comply with the following:

- Match funds from non-federal sources in an amount not less than one dollar for every three dollars of federal funds awarded.
- Be the payer of last resort. (This means that grantees cannot use WISEWOMAN funds to pay for any services that are covered by a State compensation program, an insurance policy, a federal or state health benefits program, or an entity that provides health services on a prepaid basis.) Exception: Indian Health Services is the payer of last resort if these funds are available.
- Use at least 60% of funds on direct services (e.g., screening, risk reduction counseling, lifestyle programs, and support services used to maximize participation in program services).
- Spend no more than 10% of federal funds annually for administrative expenses.
- Do not use grant funds for inpatient hospital services.
- Limit the imposition of fees for services on participants.
- Provide services through entities that provide breast and cervical cancer screening.
- Provide assurances that the grant funds will be used in the most cost-effective manner.

Most of the requirements listed above are discussed throughout this document.

1 Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and the amendment that led to the creation of WISEWOMAN can be found at http://www.cdc.gov/wisewoman/legislation_highlight.htm

WISEWOMAN FRAMEWORK

It is increasingly recognized that individual health is influenced by social factors and that healthy people tend to live in healthy communities. In addition to strong medical care systems, healthy communities have a range of environmental supports that promote and protect health across the lifespan and give people opportunities to take charge of their health.

The WISEWOMAN Program framework is based on the CDC's NCCDPHP's four domains: (1) Epidemiology and Surveillance, (2) Environmental Approaches, (3) Health Systems/Clinical Preventive Services, and (4) Community-Clinical Linkages. WISEWOMAN Program activities are focused primarily in the Health Systems and Community-Clinical Linkage domains. The Epidemiology and Surveillance domain activities (with a data focus) are intended to support all program components. The Environmental Approaches domain activities will be best accomplished through effective partnership efforts to support the primary mission of the program. Activities often cross domains and grantees should connect goals and activities in all of the domains. The socio-ecological approach represented by the four domains aligns with Healthy People 2020 and national strategies to improve the quality of health care, reduce health inequities, and contain health care costs. See Appendix B for more information on the domains.

HEALTH DISPARITIES AND HEALTH EQUITY

Racial and ethnic disparities in cardiovascular health continue to be a serious public health and social problem in the United States. Disparities are also associated with geographic location, education level, income, and other characteristics of populations that have systematically been disadvantaged.

One of the four overarching goals of Healthy People 2020 initiative is "to achieve health equity, eliminate disparities and improve the health of all groups." Health equity is attaining the highest level of health for all people.[1] Grantees should apply a health equity lens when implementing program components across the four domains. For example,

Epidemiology and Surveillance: Gathering and analyzing data to contribute to the knowledge base to support effective strategies to reduce and eliminate disparities in cardiovascular disease risks

Environmental Approaches: Supporting approaches to address the social and physical environments in which individuals live, work, and play that are often drivers of health inequities

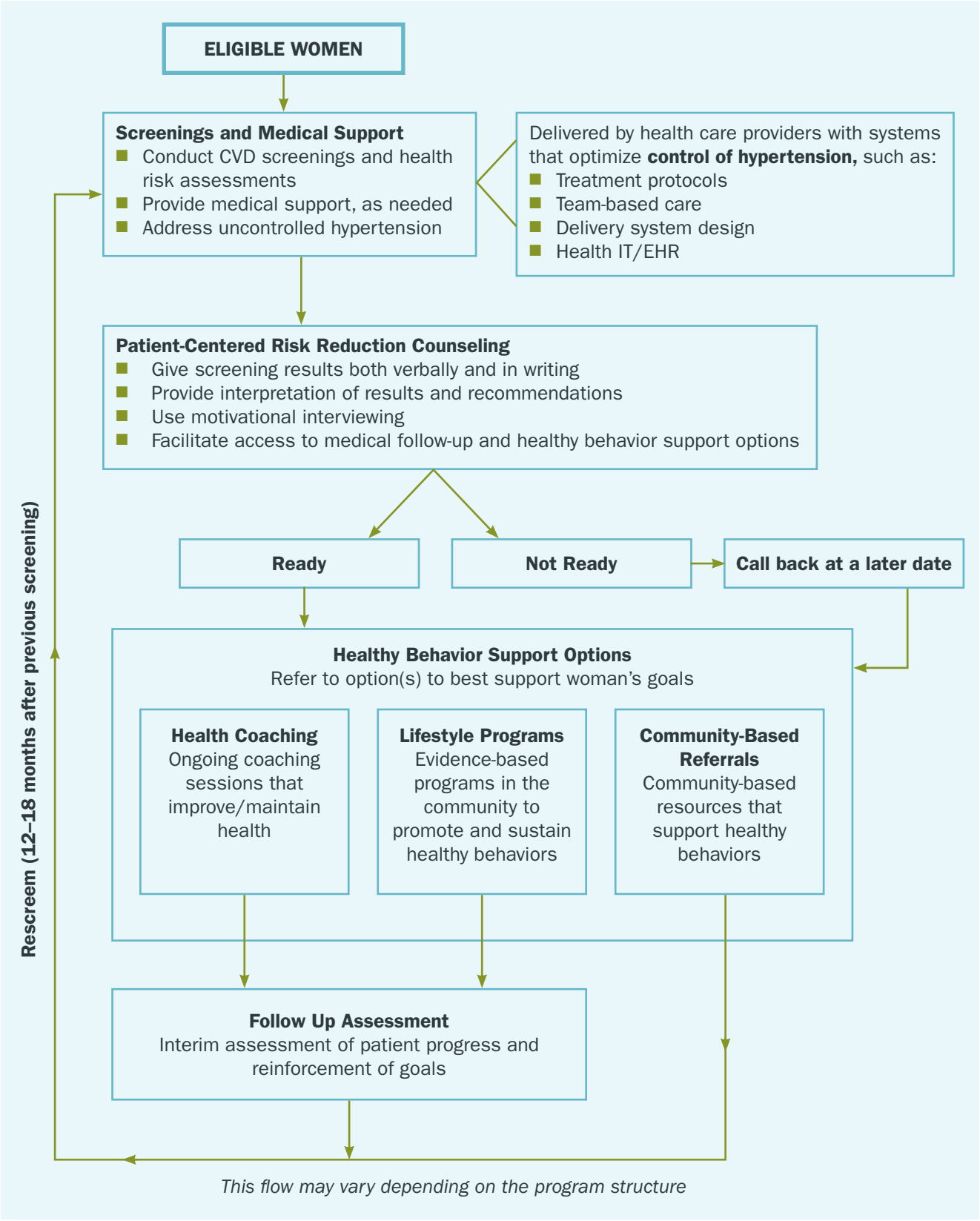
Health Systems/Clinical Preventive Services: Assuring equity in the delivery of quality health care in a culturally and linguistically appropriate manner

Community-Clinical Linkages: Assuring equity in access to culturally appropriate lifestyle programs and other community resources

1 U.S. Department of Health and Human Services. National Partnership for Action to End Health Disparities. Available from: http://minorityhealth.hhs.gov/npa/

SERVICE DELIVERY FLOW DIAGRAM FOR WISEWOMAN PROGRAM

The WISEWOMAN services depicted below are within the **Health Systems/Clinical Preventive Services** and/or **Community-Clinical Linkages Domains.** The expected outcomes are improved health behaviors and reduced CVD risk.



This flow may vary depending on the program structure

OVERVIEW OF THE DOCUMENT SECTIONS

This document is divided into three sections that correspond to the WISEWOMAN Program's components: Program Management, NCCPDHP domains (Epidemiology and Surveillance, Environmental Approaches, Health Systems/ Clinical Preventive Services, Community-Clinical Linkages), and Evaluation.

Each section includes detailed information about the WISEWOMAN Program components and includes the following categories, as applicable:

Overview:	Rationale for the activity, requirements from FOA DP13-1302 and in WISEWOMAN legislation, and other requirements determined by CDC
Guidance:	Suggestions and guidance for successful implementation of the topic
Definitions:	Definitions of key terms used in the context of the WISEWOMAN Program
References/ Resources:	References and resources related to the topic

Note: Links to non-Federal organizations in this document are provided solely as a courtesy to grantees. These links do not constitute endorsement of these organizations or their programs by CDC or the Federal government, and none should be inferred. CDC is not responsible for the content of the individual organizations' web pages found at these links.

SECTION I

PROGRAM MANAGEMENT

WISEWOMAN™

PROGRAM MANAGEMENT OVERVIEW	
Overview	Program management relies on leadership and management skills to administer the program for greatest impact within limited resources. The guidance below is specific to the WISEWOMAN Program. It does not attempt to address the many aspects of program management that apply to all public health programs. **Requirements** Grantees must comply with the following: ■ Designate a point of contact for this cooperative agreement. ■ Ensure sufficient staff with competencies needed to implement the program.* ■ Develop staffing plans if hiring is delayed. ■ Develop an annual work plan that aligns with program goals. ■ Develop, award, and monitor contracts for program services in a timely manner, including contracts with appropriate health care providers. ■ Develop an accurate budget annually and monitor expenditures (per legislation and federal guidelines). *Note: There are not FTE requirements for WISEWOMAN staffing.
Guidance	**Work Plan** Work plans should include SMART (Specific, Measurable, Achievable, Realistic, and Time-Phased) objectives and describe program strategies and activities. Grantees are encouraged to use the work plan template provided by the CDC WISEWOMAN team. **Logic Model** Grantees should develop a program specific logic model. See Appendix C for the CDC WISEWOMAN logic model.
References/Resources	CDC Division for Heart Disease and Stroke Prevention. Writing SMART objectives. 2006. Available from: http://www.cdc.gov/dhdsp/programs/nhdsp_program/evaluation_guides/smart_objectives.htm The National Association of Chronic Disease Directors. NACDD domains and competencies Available from: http://www.chronicdisease.org/?page=DomainsCompetencies

PROFESSIONAL DEVELOPMENT	
Overview	Professional development refers to the advancement of skills and expertise to succeed in a specific profession beyond training for a particular task or position. Professional development builds the capacity of the grantee to implement and evaluate the WISEWOMAN Program. Training that WISEWOMAN grantees support for their contractors and partners is also professional development. **Requirements** ■ Grantees must adhere to the following professional development requirements: ■ Attend all CDC-sponsored WISEWOMAN meetings. ■ Provide orientation to WISEWOMAN staff and providers to support program implementation. ■ Provide professional development opportunities to ensure staff have the knowledge and skills needed to implement WISEWOMAN.
Guidance	Grantees are encouraged to use a variety of formats to ensure learning occurs, such as in-person trainings, webinars, and teleconferences. Grantees can provide training themselves, arrange for external trainers, or collaborate with other agencies or grantees to conduct trainings. WISEWOMAN staff may attend national or regional meetings on heart disease, behavioral health, health promotion, public health, data, evaluation, or other content relevant to implementing the WISEWOMAN Program. **Professional Development Content** In general, professional development designed to develop skills rather than merely imparting information is most valuable. All WISEWOMAN staff should participate in skills-building training related to: ■ Implementation of CDC WISEWOMAN Program requirements, including direct services provided and the data collection system. This is commonly referred to as WISEWOMAN orientation. ■ Hypertension measurement and control, including correct blood pressure measurement technique, medication adherence, appropriate use of self-measured blood pressure monitoring, and how to work with health care providers to improve control of hypertension. ■ Patient-centered risk reduction counseling. ■ Health coaching and/or motivational interviewing and how to engage participants in WISEWOMAN programs. Grantees should ensure that WISEWOMAN staff and partners are informed regarding current guidelines on hypertension, sodium, cholesterol, diabetes, nutrition, physical activity, tobacco, and prevention of heart disease and stroke. Grantees should provide additional professional development opportunities, as needed to implement their proposed activities.

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PROFESSIONAL DEVELOPMENT	
Guidance *(continued)*	The following topics may be of particular importance for staff members who monitor direct services to participants: ■ Health care models (including patient-centered care, clinical systems design & decision supports) ■ Behavior change strategies and patient activation ■ Health literacy and plain language ■ Cultural competence/sensitivity ■ Community health strategies to sustain healthy lifestyle behaviors ■ Evidence-based interventions ■ Patient navigation in changing health system environment **CDC-Sponsored Learning Opportunities** CDC will host grantee meetings, webinars, and other distance learning opportunities throughout the cooperative agreement as needs are identified. CDC Project Officers may assist with identifying suitable professional development events. **Work Plan** Professional development plans should be described in the work plan. A two-part objective under Program Management is suggested: one for grantee personnel and one for health care providers, contractors, and other partners, as appropriate. **Budget** Professional development activities are in the 40% portion of the grantee's budget. Grantees must allocate money in their budget for any required CDC-sponsored meetings. Project Officers will provide guidance annually on any required meetings that should be included in budgets.
References/Resources	CDC Division for Heart Disease and Stroke Prevention. Educational materials for professionals. Available from: http://www.cdc.gov/dhdsp/educational_materials.htm Public Health Foundation. TRAIN. Available from: https://www.train.org/ CDC Learning Connection. Available from: http://www.cdc.gov/learning/

OVERARCHING POLICIES FOR WISEWOMAN

APPROPRIATE USE OF WISEWOMAN FUNDS

Grantees must spend WISEWOMAN funds in accordance with the requirements specified in the WISEWOMAN authorizing legislation (42 U.S. Code Section 300k of the Public Service Act, as amended) and guidance provided in this document, WISEWOMAN Technical Assistance and Guidance Document. See "Use of WISEWOMAN Funds for Clinical Services" on pages 25–26 for more information.

INTEGRATED OFFICE VISIT

The initial WISEWOMAN screening office visit must occur at the same visit with a woman's annual National Breast and Cervical Cancer Early Detection Program (NBCCEDP) office visit. This is referred to as the integrated office visit. The rescreening visit should be an integrated office visit to the extent possible. WISEWOMAN funds cannot be used to pay for the integrated office visit and must be paid for by the NBCCEDP.

NATIONAL GUIDELINES

WISEWOMAN service providers should generally follow current clinical, diet, and lifestyle guidelines (pages 29–31). Guidelines assist clinicians and patients in making decisions, but do not take the place of clinical judgment. Each WISEWOMAN health care facility should have a Medical Director or Board that establishes which specific set of guidelines that facility will follow and also provides guidance for situations not addressed by guidelines. The judgment of the Medical Director or attending clinician remains paramount.

QUALITY ASSURANCE

Grantees must monitor WISEWOMAN health care providers to ensure adherence to clinical, diet, and lifestyle guidelines (pages 29–31) and WISEWOMAN requirements. If the Medical Director protocols differ from WISEWOMAN expectations, the grantee should inform the assigned CDC Project Officer.

EXCEPTIONS

Grantees must submit a request in writing for any exceptions to requirements outlined in this document. Assigned CDC Project Officers will provide guidance to grantees on information needed to request exceptions.

GRANTS MANAGEMENT

Overview	Requirements
	Grantees must comply with the following: ■ Submit all required documentation to CDC, including an annual budget, an Annual Performance Report, and a Federal Financial Report. ■ Obtain written prior approval from CDC's Procurement and Grants Office (PGO) for certain significant changes as noted in the HHS Grants Policy Statement.[1] Failure to obtain prior approval might result in the disallowance of funds.
Guidance	**Requests to PGO[2]** To ensure that requests to PGO are complete and meet cooperative agreement requirements, grantees should do the following: ■ Review requests with assigned Project Officer before submitting to PGO. ■ Provide a courtesy copy to Project Officer of all correspondence with PGO. An electronic copy is preferred. ■ Include the following items in all correspondence to PGO: 1. A cover letter with two signatures (the signature of the Principal Investigator and the signature of the Business Office Official). 2. The Notice of Award number. 3. If the request includes a budgetary request for a contractor, include the following: ■ Name of contractor ■ Method of selection ■ Period of performance ■ Scope of work ■ Method of accountability ■ Itemized budget with justification for each line item 4. If it includes a budgetary request with match information, include the following: ■ Source of match ■ Amount of match ■ Type of match ■ Method of establishing value of noncash match ■ Method of documenting actual match received ■ How the match is tied to services or activities that directly benefit the WISEWOMAN Program. If the information listed above is not available, the grantee should indicate "to be determined" until the information becomes available. As soon as it is available, it should be submitted to PGO.

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GRANTS MANAGEMENT

Guidance

(continued)

Prior Approval Requirements

The following changes are some of the more common or relevant items that need prior approval from PGO:

1. Change in Program Manager/Director, Principal Investigator or other key staff or their absence if more than 3 months
2. Change in program scope or objectives, regardless of whether the budget is affected
3. Transferring substantive programmatic work by contracting or any other means to a third party
4. Carryover of unobligated funds from one budget period to another within an approved project period
5. Extensions of the budget/project period with or without additional funds
6. Redirection of funds that were intended for training costs
7. Publication and printing costs exceeding $25,000 for a single publication when not included in the originally approved budget
8. Redirecting more than 25% of the total amount awarded, or $250,000, whichever is less

Required Reports and Other Documents

- Annual Performance Report*: Grantees must submit the Annual Performance Report via www.grants.gov 120 days before the end of the budget period (by March 2) each year. The report should include budget information, performance measures, evaluation results, an updated work plan, successes, and challenges. Each year, CDC will provide detailed guidance to grantees about what to include.
- Annual Federal Financial Report (FFR) SF 425: Grantees must submit the FFR through eRA Commons[3] within 90 days after the end of each budget period (by September 28). The FFR should only include those funds authorized and disbursed during the timeframe covered by the report. The final FFR must indicate the exact balance of unobligated funds and may not reflect any unliquidated obligations.
- Final Performance and Financial Report: Grantees must submit a final report to include a final financial and performance report. This report is due 90 days after the end of the project period (by September 28, 2017).

*Note: Information submitted in the Annual Performance Report will be used for non-competing continuation award determinations.

References/Resources

[1]HHS. Grants Policy Statement. Available from: http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf

[2]CDC Procurement and Grants Office. Templates and tools. Available from: http://ecm.cdc.gov/PGO/Grants/Pages/Template%20and%20Tools.aspx (see the Post Award Phase/Prior Approval section)

[3]eRA Commons. Available from: https://commons.era.nih.gov/commons/

BUDGET: 60/40 DISTRIBUTION OF FUNDS

Overview	**Requirements** In accordance with Public Law 101-354 and its amendments,[1] grantees must comply with the following requirements: ■ Use at least 60% of WISEWOMAN cooperative agreement funds for expenses that can be tied to an individual program participant (sometimes referred to as "direct services"). ■ Use no more than 40% of cooperative agreement funds for activities/services that do not directly benefit the woman. ■ Administrative costs, which support infrastructure activities, are considered part of the 40% budget distribution. No more than 10% of WISEWOMAN cooperative agreement funds may be used for administrative expenses (including indirect costs).[1]
Guidance	Grantees should calculate the 60/40 distribution based on the total amount of WISEWOMAN funding awarded to the grantee. The 60/40 distribution requirement does not apply to the non-federal matching funds. Each line item in the proposed budget must indicate if the item is considered to be part of direct service delivery (60%) or not (40%). Salaries should be allocated to the 60% or 40% category based on the type of activities conducted by staff (an FTE may be split between 60% and 40%). Examples of what is included in the 60/40 categories are on the next two pages of this document. Each grantee may define the basis for its administrative costs. Administrative expenses associated with all contracts are considered part of the 10% limitation placed on overall total administrative costs under the cooperative agreement award. Budgets that include administrative costs in excess of 10% will not be approved, regardless of the jurisdiction's negotiated federal indirect cost rate. The total dollar amount of federal monies awarded to the grantee is the figure that should be used as the basis for determining the 10% administrative costs.
References/Resources	[1]CDC. WISEWOMAN legislation highlights. Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and the amendment that led to the creation of WISEWOMAN available from: http://www.cdc.gov/wisewoman/legislation_highlight.htm

60/40 DISTRIBUTION OF COOPERATIVE AGREEMENT FUNDS (DOES NOT APPLY TO NON-FEDERAL MATCHING FUNDS)	
EXAMPLES OF 60% CATEGORY	
Screening and Medical Evaluation	■ Tests to access cholesterol and glucose (or A1C if applicable) as part of the baseline screening or rescreening ■ Medical evaluation for alert values or other disease-level values ■ Non-integrated screening office visits (when approved by assigned Project Officer) ■ Time spent assisting women with completing health risk assessments
Case Management	■ Coordinating timely and appropriate medical care for women with alert screening values and uncontrolled hypertension
Risk Reduction Counseling	■ Time spent verbally reviewing screening results and health risk assessment
Healthy Behavior Support Options	■ Time spent delivering health coaching ■ Enrollment fees to participate in evidence-based lifestyle programs (LSPs) ■ Time spent coordinating women's participation in LSPs and other community-based resources ■ Time spent contacting a participant to ensure that she completes the LSP ■ Time spent delivering intensive follow-up and reinforcement of lifestyle goals as part of the LSP ■ Materials/items provided to individual participants as part of the standardized LSP curriculum or to support goals (e.g., healthy food/ farmers market vouchers)
Additional Support Services	■ Transportation for participants to attend WISEWOMAN appointments and LSPs ■ Individual translation services
Other	■ Printing forms and materials to be distributed to individual participants ■ Mailing materials to individual participants

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60/40 DISTRIBUTION OF COOPERATIVE AGREEMENT FUNDS (DOES NOT APPLY TO NON-FEDERAL MATCHING FUNDS)	
	EXAMPLES OF 40% CATEGORY
Program Management	■ Management and planning ■ Administrative costs ■ Website development and maintenance ■ Development and submission of reports, such as the annual performance report ■ Billing and reimbursement ■ Professional development costs, such as conferences and trainings ■ Development of newsletters or updates for providers ■ Travel to monitor provider sites
Community Engagement	■ Resources to conduct community scans ■ Travel to meet with partners to work on environmental approaches to support heart healthy behaviors
Evaluation	■ Data management system ■ Data analysis ■ Audits to determine quality of care ■ Cost effectiveness assessments ■ Evaluation of activities ■ Documentation and dissemination of evaluation findings

BUDGET: MATCHING FUNDS

Overview	Requirements

	Grantees must comply with the following matching funds requirements:
	■ In accordance with Public Law 101-354 and its amendments,[1] grantees are required to match funds from non-federal sources in an amount not less than one dollar for every three dollars of federal funds (a ratio of 3:1). Matching funds must be tied to services or activities that directly benefit the WISEWOMAN Program.
	■ Matching funds cannot include the following:
	  ■ Services assisted or subsidized by the Federal government.
	  ■ The indirect or overhead costs of an organization.
	■ All costs designated as meeting the matching funds requirement must be documented by the grantee and will be subject to audit. The amount and the sources of the match must be included in the budget and in requests for unobligated funds.
	Note: Matching funds are not subject to the 60/40 requirement.

Guidance	Generally, if federal funds are allowed for an activity, then non-federal contributions for the same activity may be allowed as a source of matching funds. If the grantee is a Tribal Organization, Public Law 93-638 authorizes the use of funds received under the Indian Self-Determination and Education Assistance Act as matching funds.[2] Grantees must adequately describe how the matching fund is tied to services or activities that directly benefit the WISEWOMAN Program. Matching funds may be cash, in-kind, or donated services contributed by the grantee and its partners (including for-profit entities). Appropriate matching funds includes: ■ donated staff time paid for by non-federal funds; ■ donated staff time, or professional development provided by partners such as American Heart Association, American Lung Association, Department of State Parks and Recreation, and State universities; ■ donated memberships to health/wellness facilities; ■ donated materials or literature on heart health; ■ contributions to the cost of mailings; ■ donated media time for public education, awareness, and to promote WISEWOMAN; ■ requirement that local service providers contribute to the matching funds requirement; ■ uncompensated time providers/staff/volunteers spend in WISEWOMAN trainings and advisory meetings. Specific rules, required documentation, and regulations governing the matching funds requirement are included in the HHS Grants Policy Statement, Section 6.[3]

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BUDGET: MATCHING FUNDS	
References/Resources	[1]CDC. WISEWOMAN legislation highlights. Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and the amendment that led to the creation of WISEWOMAN available from: http://www.cdc.gov/wisewoman/legislation_highlight.htm [2]Indian Health Service. Indian Self-Determination and Education Assistance Act, Public Law 93-638 available from: http://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p6c3_ex_a [3]HHS. Grants Policy Statement (available from: http://www.hhs.gov/asfr/ogapa/aboutog/hhsgps107.pdf

USE OF WISEWOMAN FUNDS FOR CLINICAL SERVICES

Overview	Requirements

	Grantees must adhere to the following when using WISEWOMAN funds for clinical services:
	■ A list of suggested Current Procedural Terminology (CPT) Codes is provided in Appendix D. Any additional CPT codes must be submitted to CDC for review.
	■ Use of WISEWOMAN funds are allowed for the following services:
	  ■ Laboratory tests at the baseline/rescreening visit
	  ■ A second set of labs if the Medical Director determines they are indicated
	  ■ Risk reduction counseling
	  ■ Costs associated with providing appropriate attention to abnormal blood pressure measurements (see page 51)
	  ■ Costs associated with support services such as medication adherence, self-measured blood pressure monitoring with support, health coaching, tobacco cessation support programs, or nutrition counseling
	  ■ One office visit (per occurrence) for evaluation of alert values or other disease-level values
	  ■ Case management as needed for women who have alert screening values for blood pressure and glucose or for uncontrolled hypertension
	■ Use of WISEWOMAN funds are not allowed for the following services:
	  ■ The integrated office visit (unless approved by assigned Project Officer)
	  ■ Medication or other medical treatment or procedures for clinical conditions (in accordance with Public Law 101-354 and its amendments)
	Note: In accordance with Public Law 101-354 and its amendments,[1] WISEWOMAN funds must be the payer of last resort. Grantees cannot use WISEWOMAN funds to pay for any services that are covered by a State compensation program, an insurance policy, a federal or state health benefits program, or an entity that provides health services on a prepaid basis. Exception: Indian Health Services is the payer of last resort if these funds are available.

Guidance	Grantees should spend WISEWOMAN funds as cost-effectively as possible to provide the greatest number of women with quality cardiovascular prevention services. Follow-up visits and other contacts to reinforce medication adherence and behavior changes should generally cost substantially less than office visits with health care providers. It is recommended that contracts with health care providers be amendable to accommodate shifts in health insurance eligibility and changes in public health policies and resources.

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USE OF WISEWOMAN FUNDS FOR CLINICAL SERVICES	
References/Resources	[1]CDC. WISEWOMAN legislation highlights. Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and the amendment that led to the creation of WISEWOMAN available from: http://www.cdc.gov/wisewoman/legislation_highlight.htm

ELIGIBILITY CRITERIA FOR PARTICIPANTS	
Overview	**Requirements** Grantees must ensure that WISEWOMAN participants meet all of the following eligibility criteria. Each woman served must be: ■ Enrolled and remain eligible to participate in the State/Tribal BCCEDP (in accordance with Public Law 101-354 and its amendments[1]) ■ In the priority age range of 40–64 years old. Grantees must request CDC approval to extend services to individuals outside of the specified age range ■ Low income (250% or less of the federal poverty guidelines) ■ Underinsured or uninsured ■ Unable to pay the premium to enroll in Medicare, Part B (if eligible for Medicare)
Guidance	Grantees should develop plans to recruit NBCCEDP participants into WISEWOMAN. Recruitment plans should reflect the following WISEWOMAN objectives: ■ Provide quality screening, health coaching, and lifestyle programs to as many eligible women as possible by using the most efficient means ■ Reach groups/populations that are at disproportionate risk for cardiovascular disease
References/ Resources	[1]CDC. WISEWOMAN legislation highlights. Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) and the amendment that led to the creation of WISEWOMAN available from: http://www.cdc.gov/wisewoman/legislation_highlight.htm

CONSENT TO PARTICIPATE IN THE PROGRAM	
Overview	**Requirements** Grantees must have a process in place to obtain women's consent to participate in the WISEWOMAN Program. The consent should include the following: 1. A description of the WISEWOMAN Program purpose 2. The services provided by the program, including screening, rescreening, medical follow-up (if required), and healthy behavior support options 3. The types of tests that will be completed 4. Protection of identifiable information and use of information for monitoring and evaluation
Guidance	Additional information grantees should include on the consent form: ■ Side effects/discomfort of lab tests ■ The right to refuse services ■ Eligibility criteria ■ Billing responsibility ■ Contact information for questions

CLINICAL, DIET, AND LIFESTYLE GUIDELINES

Overview	National clinical, diet, and lifestyle guidelines translate the best available science to practice. Guidelines assist clinicians and patients in making health care decisions. Guidelines do not take the place of the health care provider's judgment. Clinical practice guidelines on hypertension, cholesterol, overweight and obesity are developed through collaborative efforts of national organizations. Additional guidelines on diseases and lifestyle are developed by national organizations such as the American Heart Association, American Diabetes Association and the American College of Cardiology. All the national guidelines are based on a rigorous review process. **Requirements** Grantees must ensure that WISEWOMAN service providers follow standard care practices, generally the current national guidelines. Each WISEWOMAN health care facility should have a Medical Director or Board that establishes which specific set of guidelines that facility will follow and also provides guidance for situations not addressed by guidelines.
Guidance	Grantees should assure the quality of all WISEWOMAN services provided. Examples of methods to assure standards of care are met for clinical and preventive services are: ■ Specify expectations regarding adherence to current guidelines in contractual agreements, training, and program manuals. ■ Provide professional development and technical assistance on guidelines and quality assurance regarding their use. ■ Conduct chart audits and/or data audits.
References/Resources	**Cardiovascular Risk and Blood Pressure** CDC. Protocol for controlling hypertension in adults. 2013. Available from: http://millionhearts.hhs.gov/resources/protocols.html Go AS, Bauman MA, Coleman King SM, Fonarow GC, Lawrence W, Williams KA, et al.. An effective approach to high blood pressure control: A Science Advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention. Hypertension. 2014;63:878–885. Available from: http://hyper.ahajournals.org/content/63/4/878 CDC. Hypertension control: Action steps for clinicians. Available from: http://millionhearts.hhs.gov/resources/action_guides.html 2013 ACC/AHA guideline on the assessment of cardiovascular risk: A report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation 2013 ACC/AHA guideline on the assessment of cardiovascular risk [presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462856.pdf

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CLINICAL, DIET, AND LIFESTYLE GUIDELINES

References/Resources

(continued)

NIH National Heart, Lung, and Blood Institute. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). Available from: http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf

Cholesterol

2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation

2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults [presentation]. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a

Diabetes

American Diabetes Association Standards of Medical Care in Diabetes—2014. Available from: http://care.diabetesjournals.org/content/37/Supplement_1/S14.full

Overweight and Obesity

2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines and The Obesity Society. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee

2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults.[presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462855.pdf

Tobacco Control

CDC. Best practices for comprehensive tobacco control programs. 2014. Available from: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/

Diet and Lifestyle Guidelines

2013 AHA/ACC guideline on lifestyle management to reduce cardiovascular risk: A report of the American College of Cardiology/ American Heart Association Task Force on Practice Guidelines. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437740.48606.d1.citation

Million Hearts.® Healthy eating & lifestyle resource center. Available from: http://recipes.millionhearts.hhs.gov/

US Department of Agriculture. Dietary Guidelines for Americans.2010. Available from: http://www.cnpp.usda.gov/DGAs2010-PolicyDocument.htm

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CLINICAL, DIET, AND LIFESTYLE GUIDELINES	
References/Resources *(continued)*	National Institutes of Health. Your guide to lowering your blood pressure. Available from: http://www.nhlbi.nih.gov/files/docs/public/heart/hbp_low.pdf HHS Office of Disease Prevention and Health Promotion. 2008 physical activity guidelines for Americans. Available from: http://www.health.gov/paguidelines/guidelines/default.aspx Quantity and quality of exercise for developing and maintaining cardiorespiratory, musculoskeletal, and neuromotor fitness in apparently healthy adults: Guidance for prescribing exercise. Med Sci Sports Exerc. 2011. Available from: http://journals.lww.com/acsm-msse/Fulltext/2011/07000/Quantity_and_Quality_of_Exercise_for_Developing.26.aspx CDC Division for Heart Disease and Stroke Prevention. GET THE FACTS: Sodium and the Dietary Guidelines. 2012. Available from: http://www.cdc.gov/salt/pdfs/sodium_dietary_guidelines.pdf National Physical Activity Plan, 2010. Available from: http://www.physicalactivityplan.org/theplan.php

MATERIALS DEVELOPMENT	
Overview	**Requirements** 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, educational and other informational materials, fact sheets, newsletter templates, and manuals. [See DHHS grants regulation at 45CFR Section 74.36][1]
Guidance	Grantees working with contractors or consultants to develop program materials should ensure that the contractor/consultant is aware of this requirement. Grantees should provide the requirement in writing to any organization involved in developing materials. 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 DP13-1302 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, grantees are encouraged to use the name WISEWOMAN (all capital letters, as it is an acronym) whenever possible on written materials.
References/ Resources	[1]The Code of Federal Regulations, Title 45. See Part 74 (Uniform Administration Requirements), Part 92 (Uniform Administration Requirements, State and Local Governments), and Part 93 (New Restrictions on Lobbying). Available from: http://www.hhs.gov/foia/45cfr5.html.

SECTION II

CDC'S NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION DOMAINS

WISEWOMAN™

DOMAIN 1:
EPIDEMIOLOGY AND SURVEILLANCE

The anticipated outcome of the Epidemiology and Surveillance Domain is collection and use of quality assured data to monitor progress, track outcomes, conduct evaluation, and improve program effectiveness. WISEWOMAN data contributes to the body of evidence regarding the effectiveness of prevention services and their public health impact.

DATA SYSTEM AND COLLECTION ACTIVITIES	
Overview	WISEWOMAN data collection is used to track changes in women's cardiovascular risk factors, monitor the delivery and effectiveness of services, and evaluate program outcomes. **Requirements** Grantees must comply with the following data collection requirements: ■ 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 assure the quality and timeliness of the data submitted to 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.
Guidance	Grantees should identify lead staff for data management. Grantees should consider using the CDC developed WISEWOMAN data system. Grantees may consider hiring a contractor to perform some data system design and reporting functions. Grantees should discuss data contracting options with their assigned Project Officer early in the decision making process. Grantees should use data systems that are robust enough to be modified as necessary. Systems should allow the creation of meaningful reports for programs, providers, CDC, and other stakeholders. Grantees should continually assess their data system to ensure it is effectively and efficiently meeting program needs. ■ Effective data management includes 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.
References/ Resources	CDC Division for Heart Disease and Stroke Prevention. Interactive atlas of heart disease and stroke. Available from: http://apps.nccd.cdc.gov/DHDSPAtlas CDC Division for Heart Disease and Stroke Prevention. GIS resources. Available from: http://www.cdc.gov/dhdsp/maps/gisx/resources/index.html CDC Division for Heart Disease and Stroke Prevention. Maps and Statistics. Available from: http://www.cdc.gov/heartdisease/maps_statistics.htm

MINIMUM DATA ELEMENTS

Overview	WISEWOMAN minimum data elements (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. CDC submits WISEWOMAN MDEs to the Office of Management and Budget (OMB) for approval. **Requirements** Grantees must adhere to all MDE requirements as follows: ■ Collect and submit MDEs to CDC semi-annually using CDC's standardized submission process. ■ Meet the data requirements outlined in the most current WISEWOMAN MDE Manual. ■ Ensure all data submitted to CDC are de-identified consistent with the Health Insurance Portability and Accountability Act (HIPAA).[1] ■ MDE wording and response options should be in accordance with those approved by OMB.
Guidance	**Submission of Minimum Data Elements** The semiannual submissions are due April 1st and October 1st of each program year. ■ The April submission includes MDEs for services provided from July 1–December 31 of the previous year. ■ The October submission includes MDEs for services provided from January 1–June 30 of the current year. The time lag between data collection and submission allows for complete collection and quality assurance of data. **Additional Data** Grantees are encouraged to collect additional data to monitor, manage, and evaluate program efforts and share with CDC. Grantees are encouraged to collaborate with other programs on additional data collection. **Data Security[1]** Prior to electronic data transfer to the CDC data contractor, grantees must remove all personal identifiers and assign a unique ID code for each woman in the database. Grantees should establish a reliable system for regularly backing up and safely storing data. Typically, IT units or departments have procedures for such back-up and storage systems. The issues of how long to keep and securely store paper copies of records are also critical. Grantees should adhere to their agencies' record retention requirements. Additional guidance on data security is available in the WISEWOMAN MDE Manual.

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MINIMUM DATA ELEMENTS	
Guidance *(continued)*	**Data Collection Forms** Grantees should have medical and subject matter experts review all forms. Grantees should pilot-test data collection forms with providers, data entry staff, and patients, when possible, prior to finalizing forms. The CDC technical assistance contractor is available to review data collection forms for consistency with MDEs. **Technical Assistance** Additional data management technical assistance is provided to grantees through a contractor. The contractor's role includes: ■ providing clarification on MDE collection and reporting requirements; ■ managing the semi-annual MDE submissions; ■ maintaining, improving, and distributing resources for collecting, reporting, and validating MDEs; ■ managing the WISEWOMAN data website; ■ providing technical support for CDC developed WISEWOMAN data system. Grantees can email technical assistance requests to the TA HelpDesk at WISEWOMANTA@mathematica-mpr.com
References/Resources	[1]The Health Insurance Portability and Accountability Act (HIPPA) protects all individually identifiable health information in any form (electronic or non-electronic) that is held or transmitted by a covered entity. Information on HIPPA is available from: http://www.hhs.gov/ocr/privacy/hipaa/understanding/index.html

DOMAIN 2:
ENVIRONMENTAL APPROACHES

Improvements in social and physical environments make healthy behaviors more feasible. The anticipated outcomes in the Environmental Approaches Domain are environmental changes in communities that result in more places for physical activity, increased access to healthy food, smoking cessation services, and more smoke-free public places. Environmental approaches have broad reach, sustained health impact, and are best buys for public health.

COMMUNITY SCANS	
Overview	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. **Requirements** Grantees must complete community scans or assess and update existing scans every 2 years. Grantees are expected to scan the available resources in communities where WISEWOMAN participants live, work, play, and receive screening services.
Guidance	**Types of Resources for Inclusion in Scans** ■ Local evidence-based lifestyle programs. Scans should also identify lifestyle programs that need to be expanded to reach communities convenient to 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 level. Grantees may be able to use existing data from other agencies or collaborate with other agencies to complete scans. Many state and local agencies and organizations conduct assessments to inform public health or health care decisions. Grantees are encouraged to review and update existing information before conducting additional scans. Community scans can be a part of larger community strategic planning efforts. 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. **Data Sources** Grantees may work with the following groups to identify existing data sources for community scans: ■ Local United Way, 911, or service referral call centers ■ Local planning unit or coalitions, community action agencies ■ Local health, mental health, or social service departments ■ Hospitals ■ Chamber of Commerce ■ Extension Service, Area Agency for Aging, and Area Health Education Centers ■ Academic institutions

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COMMUNITY SCANS	
References/Resources	**Resources for Developing and Conducting Community Scans** Compassion Capital Fund National Resource Center. Conducting a community assessment. Available from: http://strengtheningnonprofits.org/resources/guidebooks/Community_Assessment.pdf University of Kansas. Assessing community needs and resources. Available from: http://ctb.ku.edu/en/dothework/tools_tk_content_page_78.aspx Administration for Children and Families. CCF/SCF tools conducting a community assessment. 2012. Available from: http://www.acf.hhs.gov/programs/ocs/resource/conducting-a-community-assessment-1 Community Action Partnership. Community needs assessment online tool. Available from: http://www.communityactioncna.org/default.aspx Community Commons. Available from: http://www.communitycommons.org/ National Association for County and City Health Officials (NACCHO). Resource center for community health assessments and community health improvement plans. Available from: http://www.naccho.org/topics/infrastructure/CHAIP/chachip-online-resource-center.cfm **Resources Appropriate for Underserved Sub-Populations** CDC Division of Community Health. A practitioner's guide for advancing health equity: community strategies for preventing chronic disease. 2013. Available from: http://www.cdc.gov/nccdphp/dch/pdf/HealthEquityGuide.pdf

STRATEGIC PARTNERSHIPS TO SUPPORT ENVIRONMENTAL APPROACHES	
Overview	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. **Requirements** Grantees must work with partners to increase options to reinforce healthful behaviors in the following areas: Physical activity, healthy food choices, smoking cessation, and smoke-free environments in communities where WISEWOMAN participants live, work, play, and receive screening services. These partnerships can include state, community-based, governmental, and non-governmental entities.
Guidance	Grantees 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. Grantees 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. **Increasing Physical Activity** Grantees should work with partners to 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, promote bicycling as a mode of transportation). **Increasing Healthy Food Access** Grantees should work with partners to 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. **Increasing Tobacco Cessation/Smoke-Free Environments** Grantees should work with partners on evidence-based strategies such as comprehensive smoke-free air policies in workplaces, health care settings, multi-unit housing, and outdoor areas. Grantees should 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.

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STRATEGIC PARTNERSHIPS TO SUPPORT ENVIRONMENTAL APPROACHES

Guidance *(continued)*	**Building on Existing Chronic Disease Efforts** Grantees 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 **Other Partnerships** Grantees may want to work with local pharmacies and WISEWOMAN providers to participate in Team Up Pressure Down1 or with a community organization to increase WISEWOMAN participants' access to other programs and services. Grantees should also consider partnerships to address underlying factors that impact health and health equity. Grantees may consider job sharing or joint funding of complementary partnership activities with other chronic disease programs.
References/ Resources	Million Hearts.® Resources: Team Up. Pressure Down. Available from: http://millionhearts.hhs.gov/resources/teamuppressuredown.html Public health interventions to reduce sodium intake. J Public Health Manag Pract. 2012. Available from: http://journals.lww.com/jphmp/toc/2014/01001 See page 72 for resources on evaluating partnerships.

DOMAIN 3:
HEALTH SYSTEMS/CLINICAL PREVENTIVE SERVICES

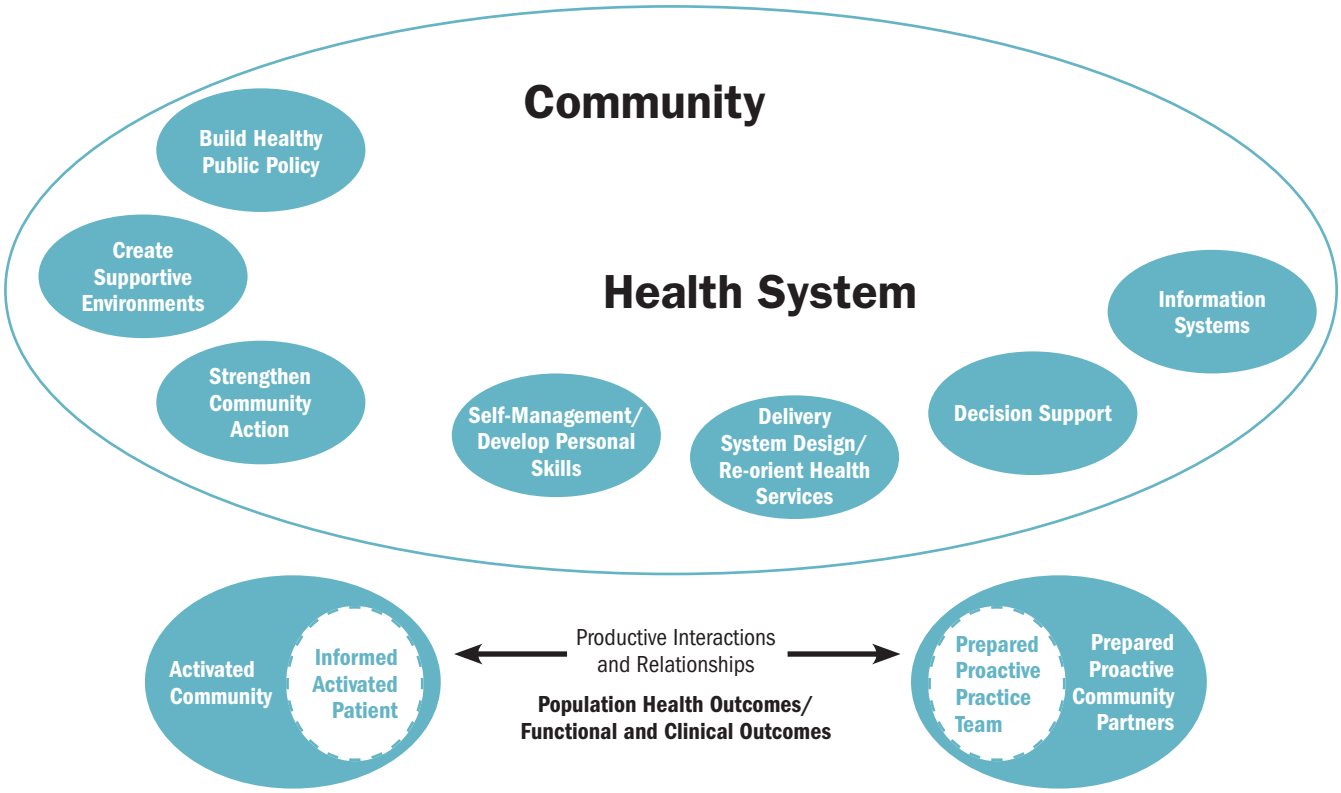
The WISEWOMAN Program primarily functions within the Health Systems/Clinical Preventive Services and Community-Clinical Linkages Domains and activities often cross domains. The anticipated outcomes in the Health Systems/Clinical Preventive Services Domain are clinical systems that deliver services more efficiently and effectively, including ways to systematically improve hypertension control.

The WISEWOMAN Service Delivery Flow Diagram (p. 11) begins with eligible women being screened. Grantees ensure delivery of WISEWOMAN screening and other preventive services through arrangements (typically contracts or memoranda of understanding) with appropriate health care facilities.

Screenings and health risk assessments inform the risk reduction counseling session, where the WISEWOMAN participant and counselor collaboratively decide on the appropriate next steps.

Further medical support is provided, as needed. In addition, women will be referred to healthy behavior support options based on readiness.

The Expanded Chronic Care Model below has been widely adopted to show the key components of effective health care and prevention rather than disease management approaches. This framework shows how the health care delivery system fits in a socio-ecological model. The WISEWOMAN Program aligns conceptually with the Expanded Chronic Care Model, and with many of the activities outlined in CDC's Funding Opportunity Announcement (FOA) DP13-1305, State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health.



Barr VJ, Robinson S, Marin-Link B, Underhill L, Dottas A, Ravensdale D, et al. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. Hosp Q. 2003;7(1);73-82.

SYSTEMS TO IMPROVE CONTROL OF HYPERTENSION

Overview

Improving control of hypertension is a major focus of the WISEWOMAN Program. WISEWOMAN providers are expected to conduct additional preventive services for WISEWOMAN participants who have uncontrolled hypertension.

The key elements that a hypertensive woman needs to effectively manage her hypertension are:

1. Being an informed, activated patient working in a productive relationship with a prepared and proactive health care team (as shown in the Expanded Chronic Care Model on page 43).
2. Access and adherence to medications or other treatments prescribed.
3. Lifestyle modification: Avoiding tobacco, limiting sodium, eating a healthy diet, maintaining a healthy weight, getting regular physical activity, managing stress, and moderating alcohol consumption.

WISEWOMAN grantees can improve control of hypertension in their population by augmenting any or all of these elements.

Requirements

Grantees must work with their WISEWOMAN health care providers to improve the control of hypertension.

Grantees must work with health care providers that have systems of care with demonstrated success in hypertension management.

Guidance

WISEWOMAN services should be delivered in health care settings 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 multi-disciplinary 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.

Strategies to Improve Hypertension Control

- evidence-based treatment protocols
- self-measured blood pressure monitoring with support
- team-based health care
- medication adherence and access support

See table on pages 46–47 for more details on these and other strategies to improve hypertension control.

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SYSTEMS TO IMPROVE CONTROL OF HYPERTENSION	
Definitions	**Normal Blood Pressure** Systolic <120 mmHg and Diastolic <80 mmHg **Pre-Hypertension** Systolic 120–139 mmHg or Diastolic 80–89 mmHg **Stage 1 Hypertension** Systolic 140–159 mmHg or Diastolic 90–99 mmHg **Stage 2 Hypertension** Systolic >160 mmHg or Diastolic >100 mmHg **Control of Hypertension** Managing hypertension to maintain blood pressure readings of <140 mmHg systolic and < 90 mmHg diastolic. **Uncontrolled Hypertension** Cases where treatment for hypertension has not achieved these target blood pressures.
References/Resources	Improving Chronic Illness Care. The chronic care model. Available from: http://www.improvingchroniccare.org/index.php?p=The_Chronic_CareModel&s=2 CMS. Quality improvement organizations. Available from: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html **Toolkits** Million Hearts.® Resources: Toolkits. Available from: http://millionhearts.hhs.gov/resources/toolkits.html Institute for Healthcare Improvement. Partnering in self-management support: A toolkit for clinicians. Available from: http://www.ihi.org/knowledge/Pages/Tools/SelfManagementToolkitforClinicians.aspx **Million Hearts® Action Guide Series** Hypertension control: action steps for clinicians. Available from: http://millionhearts.hhs.gov/resources/toolkits.html Self-measured blood pressure monitoring: action steps for public health practitioners. Available from: http://millionhearts.hhs.gov/resources/toolkits.html CDC National Center for Chronic Disease Prevention and Health Promotion. A program guide for public health: partnering with pharmacists in the prevention and control of chronic diseases. Available from: http://www.cdc.gov/dhdsp/programs/nhdsp_program/docs/pharmacist_guide.pdf

BROAD STRATEGIES TO IMPROVE PRIMARY CARE[1]		
STRATEGY/APPROACH	**DESCRIPTION**	**EXAMPLES**
Delivery System Design (sometimes called Clinical Practice Design or Redesign)	Processes to: ■ be efficient for patients and staff ■ consistently deliver quality care ■ reliably document care	■ Prescribing anti-hypertensive medication consistent with national guidelines ■ Streamlining patient registration processes to minimize waiting time
Self-Management Support	Activities to increase patients' skills in managing their own health	■ Teaching patients how to measure and track their blood pressure
Decision Support	Automated messages for clinicians	■ Using computer-generated prompts to remind a clinician that a patient's blood pressure is abnormal and to consider adjusting medication
Health Information Technology (Health IT) Note: Health IT can be used to implement Decision Support or Delivery System Design.	Storage, retrieval, sharing, and use of health care information, and data for communication and decision making[2]	■ Using health IT reports to determine which patients with hypertension are not well-controlled ■ Using heath IT reports to determine which patients have not returned for follow-up
APPROACHES SHOWN TO BE EFFECTIVE IN CONTROLLING HYPERTENSION		
Evidence-Based Treatment Protocols[3]	Simple, evidence-based treatment protocols can have a powerful impact in improving control by clarifying titration intervals and treatment options, and by expanding the types of staff that can assist in timely follow-up with patients. When embedded in electronic health records, protocols can serve as clinical decision support at the point of care so no opportunities are missed to achieve control.	Veterans Affairs (VA)/Department of Defense (DOD) Kaiser Permanente (KP)

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BROAD STRATEGIES TO IMPROVE PRIMARY CARE[1]		
Self-Measured Blood Pressure Monitoring with Support[4]	Blood pressure readings (taken by patient outside of a clinical setting) reported to the health care team who advise or take action as indicated.	Patient measures blood pressure at home and emails readings to health care team who then provide advice or make needed adjustments in medications.
Team-Based Care[5]	The use of a multi-disciplinary team to improve the quality of hypertension management for patients	Physician diagnoses hypertension and prescribes anti-hypertensive medication and refers to nutritionist to counsel on DASH diet.
Medication Adherence and Access Support	Medication adherence and access support can include the following: ■ Explaining what the medication is intended to do and the correct way to take medication ■ Assessing tolerance and appropriateness of medication for a particular patient ■ Assuring access to affordable medication	When a patient is prescribed a new anti-hypertensive medication, (1) pharmacist provides Medication Therapy Management services[6] and (2) a case manager helps find an affordable source of medication.
References/Resources	[1]Adapted from the Expanded Chronic Care Model. Barr VJ, Robinson S, Marin-Link B, Underhill L, Dottas A, Ravensdale D, et al. The expanded chronic care model: an integration of concepts and strategies from population health promotion and the chronic care model. Hosp Q. 2003;7(1);73-82. [2]Healthit.gov Tools & Resources/Glossary http://www.healthit.gov/policy-researchers-implementers/glossary [3]Evidence-based Treatment Protocols for Improving Blood Pressure Control Resources from Million Hearts® http://millionhearts.hhs.gov/resources/protocols.html [4]The Agency for Healthcare Research and Quality Self-Measured Blood Pressure findings: "Self-Measured Blood Pressure Monitoring: Comparative Effectiveness." Agency for Healthcare Research and Quality. January 2012. www.effectivehealthcare.ahrq.gov/reports/final.cfm [5]Community Guide. Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control. http://www.thecommunityguide.org/cvd/teambasedcare.html [6]Medication Therapy Management (MTM) as defined by the American Pharmacists Association are a broad range of services that pharmacists provide that optimize therapeutic outcomes for individual patients. Pharmacists provide MTM to help patients get the best benefit from medication by actively managing drug therapy and resolving medication-related problems.	

BASELINE SCREENINGS AND RESCREENINGS

Overview	**Requirements** Grantees must comply with the following screening requirements: ■ Conduct baseline screenings as part of an integrated office visit (see page 17 for the Integrated Office Visit policy). See Appendix E for valid screening requirements. ■ Rescreen participants 12–18 months* after their previous screening. The rescreening visit should be an integrated office visit to the extent possible. ■ Collect the participant's demographics and complete the health risk assessment prior to or at the baseline visit. ■ Conduct screenings in accordance with clinical guidelines (see pages 29–31). *Note: Although a rescreening visit should occur 12–18 months following the previous visit, an 11 month cutoff has been established to allow flexibility for women who return just before the one-year mark.
Guidance	**Time Frame for Completing Screening Services** Health professionals need complete screenings and health risk assessments to evaluate a patient's cardiovascular risk, provide patient-centered risk reduction counseling, and determine appropriate next steps. Therefore, all labs should be completed at the screening visit or within as short a time frame as possible after the initial visit. It is ideal to have all this information at the integrated office visit, but CDC recognizes that this may not always be possible. Labs should be done within 30 days before or after the screening office visit. In cases where labs were done prior to 30 days, Medical Directors should determine the length of time labs are considered valid. **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. ■ 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. ■ An appropriate sized cuff should be used (cuff bladder encircling at least 80% of the arm). ■ A mercury sphygmomanometer, a recently calibrated aneroid manometer, or a validated electronic device should be used. ■ 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.

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BASELINE SCREENINGS AND RESCREENINGS	
Guidance *(continued)*	**Laboratory Tests** ■ Fasting laboratory tests are preferred in accordance with national clinical guidelines. ■ Women should fast a minimum of 9 hours prior to fasting tests. ■ Grantees may use A1C tests (point-of-care or laboratory).
References/ Resources	[1]NIH National Heart, Lung, and Blood Institute. The seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). Available from: http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf NIH National Heart, Lung, and Blood Institute. Reference card from the seventh report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). Available from: http://www.nhlbi.nih.gov/guidelines/hypertension/phycard.pdf 2013 ACC/AHA guideline on the assessment of cardiovascular risk: a report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation 2013 ACC/AHA guideline on the assessment of cardiovascular risk [presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462856.pdf American Diabetes Association. Standards of Medical Care in Diabetes—2014. Available from: http://care.diabetesjournals.org/content/37/Supplement_1/S14.full 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437739.71477.ee.citation 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults [presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462857.pdf

FOLLOW-UP ASSESSMENTS	
Overview	Follow-up assessments provide an opportunity to assess short-term health outcomes in women who participate in health coaching or lifestyle programs. They can also provide valuable information about how a program is working and indicate the need for revisions. **Requirements** ■ Grantees must conduct follow-up assessments for all women who complete health coaching and lifestyle programs.* ■ Grantees have the option of conducting follow-up assessments for all women who participate in health coaching and lifestyle programs. ■ Follow-up assessments should occur within 4 weeks of completing health coaching/lifestyle program sessions. Grantees should refer to their approved health coaching/lifestyle program templates for the number of sessions required for completion. Data from follow-up assessments completed after 4 weeks should still be reported to CDC. ■ Follow-up assessments must include specific variables as indicated in the MDE manual. *If a woman receives rescreening within 3 months of completing health coaching or a lifestyle program, then the follow-up assessment requirement is met.
Guidance	Results from follow-up assessments should be discussed with the woman to reinforce and/or establish new goals. Follow-up assessments do not require an office visit; however, grantees may choose to bring women back in for an office visit to assess improvements beyond those that are required.

REFERRAL FOR MEDICAL EVALUATION OF UNCONTROLLED HYPERTENSION AND OTHER ABNORMAL FINDINGS (INCLUDING ALERTS)

Overview	Grantees will assure that women with abnormal screening results have appropriate medical evaluation in accordance with standards of care and WISEWOMAN Program guidelines.
	Requirements
	Grantees must ensure the following:
	■ All women with WISEWOMAN alert values must receive:
	  ■ medical evaluation and treatment immediately or within 7 days of the alert measurement, in accordance with national standards of care and the judgment of the Medical Director;
	  ■ case management to assist women with accessing indicated medical care.
	■ All women with abnormal blood pressure measurements must receive further attention as appropriate, based on the individual situation.
	■ All women with disease-level blood pressure or laboratory values, must be referred for medical evaluation if not currently being treated.
	■ All women with uncontrolled hypertension must receive case management and other appropriate follow-up.
	■ All women must have access to free or low-cost medical care and medication, as needed.
	■ Health care providers must have an effective referral process for abnormal findings.
	*Abnormal blood pressure measurements, disease-level values and alert values are noted in Appendix F.

Guidance	**Timeframe for Alert Value Referrals** The Medical Director of the provider clinic should determine whether a particular alert value needs immediate attention or follow-up within 7 days. **Follow-up of Abnormal Blood Pressure Measurements** WISEWOMAN service providers should assess each woman whose blood pressure is above normal. The Medical Director of the provider clinic should determine appropriate actions based on the individual situation. Appropriate actions might be a nurse visit for blood pressure recheck within a specific time period, communication with the primary care health care provider after scheduled visit, or referral for medical evaluation. 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.

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REFERRAL FOR MEDICAL EVALUATION OF UNCONTROLLED HYPERTENSION AND OTHER ABNORMAL FINDINGS (INCLUDING ALERTS)

Guidance *(continued)*	**Follow-up of Uncontrolled Hypertension** Grantees should work with their health care providers to establish standard protocols for follow-up of uncontrolled hypertension. The protocol will vary depending on the capacity of the health care facility, but at a minimum should include medication counseling. The protocol may include team-based care with pharmacists, nutritionists, nurse educators, community health workers or others. It may include use of electronic reporting and tracking of blood pressure trends, and self-measured blood pressure monitoring among other strategies. The aim is to help health care providers establish or strengthen practical methods to track and improve control of hypertension.
Definitions	**WISEWOMAN Alert Values:** WISEWOMAN alert values are laboratory results that indicate the need for immediate attention. They are based on current clinical practice and risk to the individual's health. The alert values are: ■ Systolic blood pressure >180 mmHg or Diastolic blood pressure >110 mmHg ■ Fasting blood glucose <50 mg/dL or >250 mg/dL **Case management** Case management is a short-term intensive support service used to ensure that patients receive appropriate and timely medical care. Case management also assists patients in understanding the treatment regimen, obtaining affordable medication, attending medical appointments, and/or reducing other barriers.
References/ Resources	CDC. Hypertension control: Action steps for clinicians. 2013. Available from: http://millionhearts.hhs.gov/resources/action_guides.html Go AS, Bauman MA, Coleman King SM, Fonarow GC, Lawrence W, Williams KA, et al. An effective approach to high blood pressure control: A Science Advisory from the American Heart Association, the American College of Cardiology, and the Centers for Disease Control and Prevention. Hypertension. 2014;63:878–885. Available from: http://hyper.ahajournals.org/content/63/4/878 Frieden T, Coleman-King S, Wright J. Protocol-based treatment of hypertension: A critical step on the pathway to progress. JAMA. 2013. Available from: http://www.astho.org/Million-Hearts/Resources/Protocol-Based-Treatment-of-Hypertension/ 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437738.63853.7a.full.pdf

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REFERRAL FOR MEDICAL EVALUATION OF UNCONTROLLED HYPERTENSION AND OTHER ABNORMAL FINDINGS (INCLUDING ALERTS)	
References/ Resources *(continued)*	2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults [presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462857.pdf Huecker MR, Danzl DF. Metabolic & Endocrine Emergencies. In: Stone CK, Humphries RL, editors. Current diagnosis and treatment. Emergency medicine. New York: McGraw-Hill; 2011. Million Hearts.® Tools and resources. Available from: http://millionhearts.hhs.gov/resources/tools.html

MEDICATION ACCESS	
Overview	Most people with hypertension require medication to control and maintain their blood pressure at recommended levels. In populations that are uninsured or underinsured, paying for medication can be problematic. Cost can be a major factor in non-adherence to treatment plans and high rates of uncontrolled hypertension. **Requirements** Grantees must ensure access to affordable medication for women who require it, particularly for hypertension.
Guidance	Examples of methods to ensure access to free or low cost medication include: ■ Require health care providers to assist women with accessing affordable medication ■ Provide orientation and training on useful sources/avenues for affordable medication ■ Maintain a database of useful resources and websites for affordable medication that providers can use ■ Offer a forum for providers or social service agencies to share resources and tips on accessing affordable medication ■ Reimburse providers for services related to helping patients access medication, such as submitting applications to pharmaceutical companies ■ Follow-up with providers to obtain a description of the process that will be used to ensure medication access ■ Conduct periodic audits to determine if participants who need medication resources were linked to these services ■ Conduct periodic client surveys that include questions about medication access
References/ Resources	The following are potential resources for free or low-cost medications: **340B Drug Pricing Program & Pharmacy Affairs** Health Resources and Services Administration (HRSA) requires drug manufacturers to provide outpatient drugs to eligible health care organizations/covered entities at significantly reduced prices. http://www.hrsa.gov/opa/index.html **Partnership for Prescription Assistance** The Partnership brings together America's pharmaceutical companies, doctors, other health care providers, patient advocacy organizations, and community groups to help patients obtain free or low-cost medicines. http://www.pparx.org/en/prescription_assistance_programs **Federal Trade Commission (FTC)** FTC provides useful consumer information regarding prescription savings programs and generic drugs. http://www.consumer.ftc.gov/articles/0063-generic-drugs-and-low-cost-prescriptions

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MEDICATION ACCESS	
References/ Resources *(continued)*	**Medicare Information** Information about the specific drug plans available in a particular area and about Medicare drug plans in general are available at 1-800-MEDICARE (1-800-633-4227). www.medicare.gov **NeedyMeds** NeedyMeds keeps up-to-date information from pharmaceutical companies on patient assistance programs. http://www.needymeds.org/ **RxAssist** Funded by The Robert Wood Johnson Foundation, RxAssist is a web-based medication resource center for providers, advocates, consumers, and caregivers. http://rxassist.org/providers **Rx Hope** RxHope contracts directly with pharmaceutical companies to provide an electronic application process for their patient assistance programs. RxHope provides this service to physicians and patients free of charge. https://www.rxhope.com/ **State Pharmaceutical Assistance Programs** This website identifies states that have programs to provide pharmaceutical coverage or assistance, primarily to low-income older people or people with disabilities who do not qualify for Medicaid. http://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx

HEALTH RISK ASSESSMENTS	
Overview	A health risk assessment is a health questionnaire that provides individuals with an evaluation of their health risks and quality of life. The information from the assessments helps providers work collaboratively with patients to make decisions and improve their health. **Requirements** Grantees must comply with the following requirements: ■ Conduct cardiovascular health risk assessments for each WISEWOMAN participant during screening visits. Health risk assessment results and screening values provide the basis for risk reduction counseling tailored to each individual. Required questions for health risk assessments are outlined in the MDE manual. ■ Ensure completion of assessments for all participants prior to risk reduction counseling. ■ If assessments are completed prior to the screening office visit, the information must be available to the clinician/counselor and incorporated into risk reduction counseling.
Guidance	Patients may complete forms for health risk assessment in the health care setting at the time of screening, or they may complete it before their initial visit. Patients needing assistance because of linguistic, cultural, health literacy, or other issues should be offered support to complete the information accurately. Providers should review health risk assessment questions with participants to ensure they are accurate and complete. Health risk assessments are used to: ■ provide data to calculate individual cardiovascular risk; ■ monitor the risk reduction counseling interaction and goal setting process; ■ establish baseline health behaviors to measure any changes at interim visits and rescreening; ■ identify health needs among the population. **Additional Health Risk Assessment Questions** Beyond those reported to CDC, grantees may choose to incorporate other assessment questions that align with provider clinical practice protocols, evaluation needs, or other program purposes. If additional questions are used, grantees should use validated questions. Grantees are encouraged to share additional information collected with their assigned Project Officer. These data may add to the knowledge base and support additional understanding of facilitators and barriers to improving health outcomes.
References/ Resources	CDC. A framework for patient-centered health risk assessments: providing health promotion and disease prevention services to Medicare beneficiaries. Available from: http://www.cdc.gov/policy/ohsc/HRA/FrameworkForHRA.pdf

RISK REDUCTION COUNSELING

Overview

Patient-centered risk reduction counseling is a major component of the WISEWOMAN Program. Risk reduction counseling, skillfully provided, can help 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. The Expanded Chronic Care Model relies on an informed and activated patient interacting with a prepared, proactive practice team.

Requirements

Grantees must comply with the following requirements:

- Provide risk reduction counseling to all WISEWOMAN participants face-to-face at the time of their screening visits*.
- 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.
- During the face-to-face counseling, counselors must:
  - Discuss participant's screening and health risk assessment results (see page 56)
  - Assure participant understands her CVD risk as compared to other women her age
  - Consider a patient's language, healthy literacy, and cultural background in the interaction
  - Use motivational interviewing skills
  - Collaboratively identify goals and strategies to support goals (e.g., health coaching, lifestyle programs and other healthy behavior support options)
  - Facilitate access to healthy behavior support options
  - Obtain permission to check back in 30–60 days to follow-up if the participant is not interested or ready for a healthy behavior support option
  - Arrange follow-up for women with uncontrolled hypertension (see page 52)
  - Reduce barriers to understanding the treatment regimen and receiving medication, particularly for hypertension
  - Provide chronic disease self-management support

Note: Chronic disease self-management support refers to generic self-management support methods as depicted in the Expanded Chronic Care Model (page 43) and should not be construed as recommending any specific programs.

*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 by phone or in-person and a written copy sent to the patient.

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RISK REDUCTION COUNSELING	
Guidance	**Developing a Patient-Centered Risk Reduction Plan** A patient-centered risk reduction plan should be developed collaboratively by the patient and counselor. Counselors should offer options, not directives. Steps should be acceptable to the patient, explicit, and achievable. The plan should recognize the counselor's limited role and focus on increasing the patient's skills and providing resources needed to achieve behavior change. **Risk Reduction Counseling Skills** There are a number of approaches and curriculums designed to provide the necessary skills for effective patient-centered counseling. Common elements include: ■ talking with, rather than to, the patient; ■ responding with sensitivity and considering health literacy or cultural issues that may emerge; ■ maintaining a non-judgmental attitude, using active listening, asking open ended questions; ■ supporting positive risk reduction changes already made by the patient; ■ helping the patient identify barriers to risk reduction (e.g., knowledge gaps, skills needed, socio-economic and other life circumstances that are barriers to being healthy). **Materials** Grantees may want to use existing materials[1] or develop their own materials to explain screening results. Grantees may also want to use materials to discuss healthy food choices such as those lower in overall calories, free of trans fats, and low in sodium.[1] **Use of Community Scan Data** Grantees should use the results of community scans and other data sources to provide risk reduction counselors information on available and approved local lifestyle programs and other resources to support healthy behaviors.
References/ Resources	**[1]Materials to explain screening results for use during counseling** NIH National Heart, Lung, and Blood Institute. What is high blood pressure? Available from: http://www.nhlbi.nih.gov/health/dci/Diseases/Hbp/HBP_WhatIs.html NIH National Cholesterol Education Program. High blood cholesterol: what you need to know. Available from: http://www.nhlbi.nih.gov/health/public/heart/chol/wyntk.pdf American Heart Association. What your cholesterol levels mean. Available from: http://www.heart.org/HEARTORG/Conditions/What-Your-Cholesterol-Levels-Mean_UCM_305562_Article.jsp NIH National Diabetes Education Program. Know your blood sugar numbers. Available from: http://ndep.nih.gov/publications/PublicationDetail.aspx?PubId=17

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RISK REDUCTION COUNSELING	
References/ Resources *(continued)*	**Risk Calculation** 2013 ACC/AHA guideline on the assessment of cardiovascular risk: A report from the American College of Cardiology/American Heart Association Task Force on Practice Guideline. Circulation. 2013. Available from: http://circ.ahajournals.org/content/early/2013/11/11/01.cir.0000437741.48606.98.citation 2013 ACC/AHA guideline on the assessment of cardiovascular risk [presentation]. Available from: http://my.americanheart.org/idc/groups/ahamah-public/@wcm/@sop/@smd/documents/downloadable/ucm_462856.pdf American Heart Association. Life's simple 7 action plan. Available from: http://mylifecheck.heart.org/ American Heart Association. Heart attack risk calculator. Available from: http://50.56.33.51/hart01/main_en_US.html Wilson PWF, Agostino RB, Levy D, Belanger AM, Silbershartz H, Kannel WB. Prediction of coronary heart disease using risk factor categories. Circulation. 1998;97;1837-1847. Available from: http://circ.ahajournals.org/content/97/18/1837.full.pdf+html **Sodium Materials for Use during Counseling** CDC Division for Heart Disease and Stroke Prevention. GET THE FACTS: Sodium and the Dietary Guidelines. 2012. Available from: http://www.cdc.gov/salt/pdfs/sodium_dietary_guidelines.pdf CDC Division for Heart Disease and Stroke Prevention. How to control your hypertension. Learning to control your sodium intake. A fotonovela. Available from: www.cdc.gov/bloodpressure/docs/English_Novella.pdf CDC Division for Heart Disease and Stroke Prevention. Promotora guide. How to control your hypertension. Learning to control your sodium intake. Available from: http://www.cdc.gov/bloodpressure/docs/Promotora_Guide.pdf **Lifestyle Resource** Million Hearts.® Healthy eating & lifestyle resource center. Available from: http://recipes.millionhearts.hhs.gov/

DOMAIN 4: COMMUNITY-CLINICAL LINKAGES

The WISEWOMAN Program functions primarily within the Health Systems/Clinical Preventive Services and Community-Clinical Linkages Domains and activities often cross domains.

Anticipated outcomes for the Community-Clinical Linkages Domain are increased use of community resources to improve cardiovascular health, including evidence-based lifestyle programs and resources that promote self-management of healthy behaviors and/or chronic disease.

The WISEWOMAN Service Delivery Flow Diagram (p. 11) depicts the Community-Clinical Linkages Domain activities and highlights the three primary healthy behavior support options offered by WISEWOMAN: (1) evidence-based lifestyle programs, (2) health coaching, and (3) community-based resources. Each of these options is elaborated upon in the following pages.

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. It is anticipated that WISEWOMAN programs can add to the evidence base about how to increase participation in programs to reduce cardiovascular risks.

LIFESTYLE PROGRAMS

Overview

Lifestyle programs (LSPs) are one of the WISEWOMAN healthy behavior support options to which programs can refer women. Through participation in LSPs, women learn about healthy behaviors and receive support on how to integrate these behaviors into their daily lives.

Requirements

- Grantees must offer at least one approved lifestyle program.
- Grantees must comply with the following requirements for evidence-based lifestyle programs:
  - Select evidence-based lifestyle programs that (1) show effectiveness in improving diet and physical activity,[1] (2) incorporate national diet and lifestyle recommendations, and (3) are culturally appropriate and delivered using easy-to-understand language.
  - Identify, enhance, or build systems that facilitate and track provider referrals to lifestyle programs.
  - Refer women to evidence-based lifestyle programs, as appropriate.
  - Ensure intensive follow-up to support participants in the maintenance of their behavior change after completion of the core elements of the lifestyle program curriculum.

Note: USPSTF recommends intensive behavioral counseling via high intensity interventions focused on exercise and diet; high intensity is defined as 30 minutes or more of an activity.

- Grantees must conduct follow-up assessments for all women who complete lifestyle programs. Refer to page 50 for more information.

Guidance

Lifestyle Program Selection and Approval

- Lifestyle programs generally follow a standardized curriculum, include multiple sessions, and incorporate face-to-face interaction.
- Lifestyle programs must be approved by CDC before grantees can use WISEWOMAN funds for LSP services. Grantees should contact their assigned Project Officer regarding the process for approval.
- Grantees should partner or contract with community-based organizations to provide evidence-based lifestyle programs, rather than serving as the provider of the LSP. Some appropriate programs are offered by TOPS Club, Inc. (Take Off Pounds Sensibly), Weight Watchers, and providers of the National Diabetes Prevention Program.[2]
- Grantees should involve the participants and organizations that serve them in determining which lifestyle programs to provide.
- Generally, tobacco cessation programs do not address nutrition and physical activity and would not be considered a lifestyle program; these would be considered an additional community resource. However, tobacco cessation programs that include content on physical activity and nutrition and meet other established LSP criteria may be submitted for approval as an LSP.
- Medication therapy management[3] by pharmacists that include content on physical activity and nutrition and meet other established lifestyle program criteria may be appropriate as an LSP.
- Programs with evidence in controlling hypertension, other CVD risk factors and supporting weight loss may be an appropriate LSP.

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LIFESTYLE PROGRAMS

Guidance

(continued)

Lifestyle Program Participation

- Screening results, health risk assessments, and client goals and preferences should be used to determine if a participant is referred to a specific lifestyle program or if other healthy behavior support options such as health coaching and/or other community-based resources are more appropriate. In some cases, it may be appropriate to refer women to an LSP and other healthy behavior support options.
- Grantees are expected to implement strategies aimed at increasing motivation or removing barriers to participation for women who are at high risk for cardiovascular disease but are not ready to participate in lifestyle programs or other services.
- To increase lifestyle program participation and completion of recommended sessions, grantees are encouraged to:
  - follow-up with women periodically to encourage participation and discuss any barriers;
  - use resources to reduce barriers to participation such as transportation;
  - offer multiple LSP options in order to meet varying and diverse participant needs, such as programs that offer services in the evening and on weekends;
  - work with community health workers (CHWs) to encourage women to participate; CHWs are shown to be effective in facilitating access to community resources.
- Strategies that may be effective in providing support for maintenance of behavior change:
  - using motivational interviewing particularly when an individual is having difficulties maintaining behavior change;
  - establishing a feedback loop mechanism with the provider to reinforce goals;
  - providing tips and tools for self-monitoring of progress;
  - offering materials/items to support maintenance of heart healthy behaviors (e.g., cookbooks, pedometers, healthy tips newsletters);
  - continually referring women to other community-based resources to support their goals;
  - involving family members and friends for additional support;
  - encouraging social support or environments that reinforce behavior change, including using social media.

Lifestyle Program Training

Programs should ensure that personnel delivering lifestyle programs are appropriately trained. LSPs can be delivered by a range of professionals (e.g., public health nurses, community pharmacists, nutritionists/dietitians, behavioral counselors, health educators, social workers, clinic health psychologists, exercise specialists, community health workers, or other trained interventionists).

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LIFESTYLE PROGRAMS	
Definitions	**Evidence-based lifestyle program** A lifestyle program that has evaluation evidence of improvement in an individual's health status by increasing physical activity, improving healthy eating, supporting weight loss as appropriate, hypertension control, and/or smoking cessation. **Medication therapy management (MTM)** A broad range of services that pharmacists provide that optimize therapeutic outcomes for individual patients. Pharmacists provide MTM to help patients get the best benefit from medication by actively managing drug therapy and resolving medication-related problems.
References/ Resources	[1]Interventions to promote physical activity and dietary lifestyle changes for cardiovascular risk factor reductions in adults: a scientific statement from the American Heart Association. 2010. Circulation. Available from: http://circ.ahajournals.org/cgi/content/full/122/4/406 [2]CDC Diabetes Prevention Recognition Program. Available from: http://www.cdc.gov/diabetes/prevention/pdf/DPRP_Standards_09-02-2011.pdf [3]American Pharmacists Association. What is medication therapy management? Available from: http://www.pharmacist.com/mtm

HEALTH COACHING	
Overview	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]: 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 WISEWOMAN grantees can offer health coaching as one healthy behavior support option to reduce a woman's cardiovascular risk. Preliminary studies indicate that health coaching can improve management of diabetes, hyperlipidemia, cancer pain, asthma, weight loss and physical activity. **Requirement** ■ Grantees must offer women healthy behavior support options. Health coaching is one of the options that grantees can provide.
Guidance	For some participants, health coaching may be the most appropriate or preferable healthy behavior support option. **If grantees choose to offer health coaching, the following apply:** ■ Grantees must submit a health coaching protocol for CDC approval. Grantees should contact their assigned Project Officer regarding the approval process. ■ The coaching program must have evidence of success in improving physical activity, nutrition, tobacco cessation, weight loss, medication management or hypertension control. ■ Health coaching should be on-going. Generally, women should receive at least three sessions within 6 months and additional sessions as needed. ■ Grantees should identify, enhance, or build systems that facilitate and track provider referrals to coaching programs. ■ Grantees must conduct follow-up assessments for all women who complete health coaching. Refer to page 50 for more information. **Health Coaching Training** Grantees should ensure that personnel delivering health coaching are appropriately trained and there is a plan to monitor coaching skills. Health coaching can be delivered by a range of professionals (e.g., public health nurses, community pharmacists, nutritionists/dietitians, behavioral counselors, health educators, social workers, clinic health psychologists, exercise specialists, community health workers, or other trained staff).

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HEALTH COACHING	
Guidance *(continued)*	**Expanded Health Coaching** Grantees may propose to offer expanded health coaching. Expanded health coaching is a program option where women receive health coaching in conjunction with an established, evidence-based, community program (e.g., walking program, chronic disease self-management program) that does not meet the criteria for a lifestyle program but is focused on a specific goal identified by the individual woman.
References/Resources	[1]Bennett HD, Coleman EA, Parry C, Bodenheimer T, Chen EH. Health coaching for patients. Family Practice Management. 2010. Available from: http://www.aafp.org/fpm/2010/0900/p24.html National Consortium for Credentialing of Health & Wellness Coaches. Available from: http://ncchwc.org/ CDC Division for Heart Disease and Stroke Prevention. The community health worker's sourcebook: a training manual for preventing heart disease and stroke. Available from: http://www.cdc.gov/dhdsp/programs/spha/chw_sourcebook/index.htm

COMMUNITY-BASED RESOURCES	
Overview	Referral to community-based resources is a WISEWOMAN healthy behavior support option to reduce a woman's cardiovascular disease risk. Community-based resources supplement other healthy behavior support options (i.e., lifestyle programs and health coaching) and other preventive services that may be available in the clinic, such as medication counseling. For an individual woman, referral to community-based resources may be the most appropriate healthy behavior support option. In most cases, WISEWOMAN funds should be used for CDC-approved health coaching or lifestyle programs and not other community-based resources. Grantees should develop partnerships to offer community-based resources at low or no cost to women. **Requirements** Grantees must comply with the following: ■ Identify, enhance, or build systems that facilitate and track provider referrals to community-based resources. ■ Ensure that all current smokers are advised to quit and referred appropriately to the free state-based quit line or other tobacco cessation programs. Grantees must confirm that counseling was attempted or completed.
Guidance	WISEWOMAN participants should be referred to community-based resources to support identified goals. These resources may include self-management programs that support chronic disease management, physical activity, nutrition, and tobacco cessation. Typically initial referral occurs during risk-reduction counseling. These referrals may also occur during lifestyle programs or health coaching sessions. Grantees should use results from community scans and partnerships to gather information on resources that may be available and appropriate for WISEWOMAN participants. **Physical Activity/Nutrition Resources** Examples of resources to support physical activity and healthy food choices include: ■ Recreation departments ■ Local parks ■ Walking/biking trails ■ Mall walking programs ■ Gardening programs ■ Food coupon programs ■ Farmers' markets ■ Nutrition classes offered by Cooperative Extension Service

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COMMUNITY-BASED RESOURCES	
Guidance *(continued)*	**Tobacco Cessation Resources** ■ WISEWOMAN funds can be used for other tobacco cessation programs, especially if the quit line does not address language and other cultural barriers. ■ WISEWOMAN funds cannot be used for nicotine replacement therapies. Many quit lines and other tobacco cessation resources offer these therapies at no or reduced cost. **Other Resources** Grantees should refer women to additional resources that offer support for specific challenges that the woman is facing. These resources may include: ■ Mental health services ■ Translation services ■ Job training ■ Violence prevention services ■ Transportation services ■ Discount/free cost medication programs ■ Faith-based programs

SECTION III

EVALUATION

EVALUATION ACTIVITIES

Overview	Evaluation of WISEWOMAN activities will (1) demonstrate program effectiveness in improving hypertension control and other cardiovascular risk among the target population, (2) provide useful information to drive continuous program improvement, (3) contribute to the evidence base for specific program activities, and (4) contribute to the evidence base for disparate populations. **Requirements** Grantees must comply with the following evaluation requirements: ■ Conduct both process and outcome evaluation of their program activities. ■ 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 CDC. ■ Report cumulative evaluation findings for the 4-year project period in the Final Performance Report. ■ Address the three priorities areas determined by CDC: (1) uncontrolled hypertension; (2) health coaching and/or lifestyle programs; and (3) one additional area. See Appendix G for more information.
Guidance	**Strategies for Developing Evaluation Plan** CDC will work with grantees to develop a detailed evaluation and performance measurement plan as part of their first year activities. The evaluation should be developed based on the priorities and emerging needs identified in collaboration with stakeholders. Grantees should consider the following strategies when developing their evaluation plan: ■ Use CDC Evaluation Framework[1] or similar model. ■ Create and use a program specific logic model. ■ Develop SMART (Specific, Measurable, Attainable, Relevant, and Time-phased) objectives to define the program's expected outputs and outcomes. ■ Conduct process evaluations to help ensure quality of services and fidelity to program components. ■ Conduct outcome evaluations to measure changes in knowledge, behavior, risk, and health status. ■ Ensure use of evaluation results by (1) engaging key stakeholders throughout the evaluation process, (2) reporting findings, and (3) using evaluation results for program improvement. **Use of Evaluation Findings in Program Planning & Improvement** Information gathered for monitoring and evaluation should be used for on-going 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.

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EVALUATION ACTIVITIES	
Guidance *(continued)*	**Evaluation Dissemination** Grantees should share their evaluation results with other grantees, decision-makers, and other stakeholders for maximum impact. Potential mechanisms for dissemination include best practice toolkits, fact sheets, issues briefs, webinars, and presentations. Grantees should consider publishing evaluation results. **Data Sources** Data sources for evaluation may include quantitative and qualitative data collected by the grantee (e.g., MDEs, program administrative data, case studies, interviews or surveys with stakeholders, including participants, program staff, and partners). Data sources overall are expected to go beyond information available in the MDEs alone. **Technical Assistance** The CDC WISEWOMAN Program will provide evaluation guidance and support to grantees. Grantees can receive one-on-one technical assistance from a CDC evaluator by contacting their assigned Project Officer. **Monitoring versus Evaluation** Routine monitoring is one aspect of program management and may inform evaluation. Monitoring activities are not sufficient for evaluation. **National Evaluation** CDC will conduct a national evaluation of the WISEWOMAN Program to assess program processes and outcomes. The national evaluation may use data from grantees.
Definitions	**Process evaluation** Assessments of the program implementation. **Outcomes evaluation** Assessments of the achievement of program outcomes. The outcomes evaluation is informed and complemented by the process evaluation.
References/Resources	[1]CDC. A framework for program evaluation. Available from: http://www.cdc.gov/eval/framework/index.htm CDC. Introduction to program evaluation for public health programs: A self-study guide. 2011. Available from: http://www.cdc.gov/eval/guide/CDCEvalManual.pdf CDC. Evaluation reporting: a guide to help ensure use of evaluation findings. Available from: http://www.cdc.gov/dhdsp/docs/Evaluation_Reporting_Guide.pdf CDC. Developing an evaluation plan. 2006. Available from: http://www.cdc.gov/dhdsp/programs/nhdsp_program/evaluation_guides/evaluation_plan.htm CDC Division for Heart Disease and Stroke Prevention. Program evaluation tip sheet: evaluating training events. Available from: http://www.cdc.gov/DHDSP/programs/nhdsp_program/docs/Tip_Sheet_Evaluating_Training.pdf

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EVALUATION ACTIVITIES	
References/Resources *(continued)*	Rogers T, Chappelle EF, Wall HK, Barron-Simpson R. Using DHDSP outcome indicators for policy and systems change for program planning and evaluation. 2011. Available from: http://www.cdc.gov/dhdsp/programs/nhdsp_program/evaluation_guides/docs/Using_Indicators_Evaluation_Guide.pdf **Resources on evaluating partnerships** Butterfoss FD. Evaluating partnerships to prevent and manage chronic disease. Prev Chronic Dis. 2009. Available from: http://www.cdc.gov/pcd/issues/2009/apr/08_0200.htm CDC. Evaluation guide: fundamentals of evaluating partnerships. 2008. Available from: http://www.cdc.gov/dhdsp/programs/nhdsp_program/evaluation_guides/docs/partnership_guide.pdf

PERFORMANCE MEASURES SUMMARY	
Overview	There are differences between collecting performance measures and conducting an evaluation. Performance measures support the ongoing monitoring and reporting of program accomplishments, particularly progress towards pre-established goals. Performance measures may address the type or level of program activities conducted (process), the direct products and services delivered by a program (outputs), and/or the results of those products and services (outcomes).[1] Collecting performance measures helps determine progress toward particular goals, while program evaluation gathers information to make a judgment on how well a program is doing in a particular context. Collection of performance measures alone is not sufficient to meet WISEWOMAN evaluation expectations. **Requirements** Grantees are expected to meet or exceed the WISEWOMAN Program performance measures. A list of current performance measures is provided on page 74.
Guidance	WISEWOMAN Program performance measures will be used to assess grantee performance and progress toward meeting WISEWOMAN goals. CDC may update performance measures throughout the cooperative agreement.
References/Resources	[1]US Government and Accountability Office. Performance measurement and evaluation: definitions and relationships. 2011. Available from: http://www.gao.gov/products/GAO-11-646SP US Environmental Protection Agency. Guidelines for measuring the performance of EPA partnership programs. Available from: http://www.epa.gov/evaluate/pdf/tools/guidelines-measuring-epa-partnership-program.pdf

PERFORMANCE MEASURES

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.)

APPENDICES

WISEWOMAN™

APPENDIX A:
ALPHABETICAL INDEX OF TOPICS

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APPENDIX B:
FOUR DOMAINS OF CHRONIC DISEASE

DOMAIN 1: EPIDEMIOLOGY AND SURVEILLANCE

Epidemiology and surveillance allow us to collect, analyze, and share data to help identify and solve problems and evaluate public health efforts. The data can be used to guide and monitor programs and interventions, research, and policies to improve public health.

DOMAIN 2: ENVIRONMENTAL APPROACHES

Environmental approaches promote health and support and reinforce healthy behaviors in schools and child care settings, work sites, and communities.

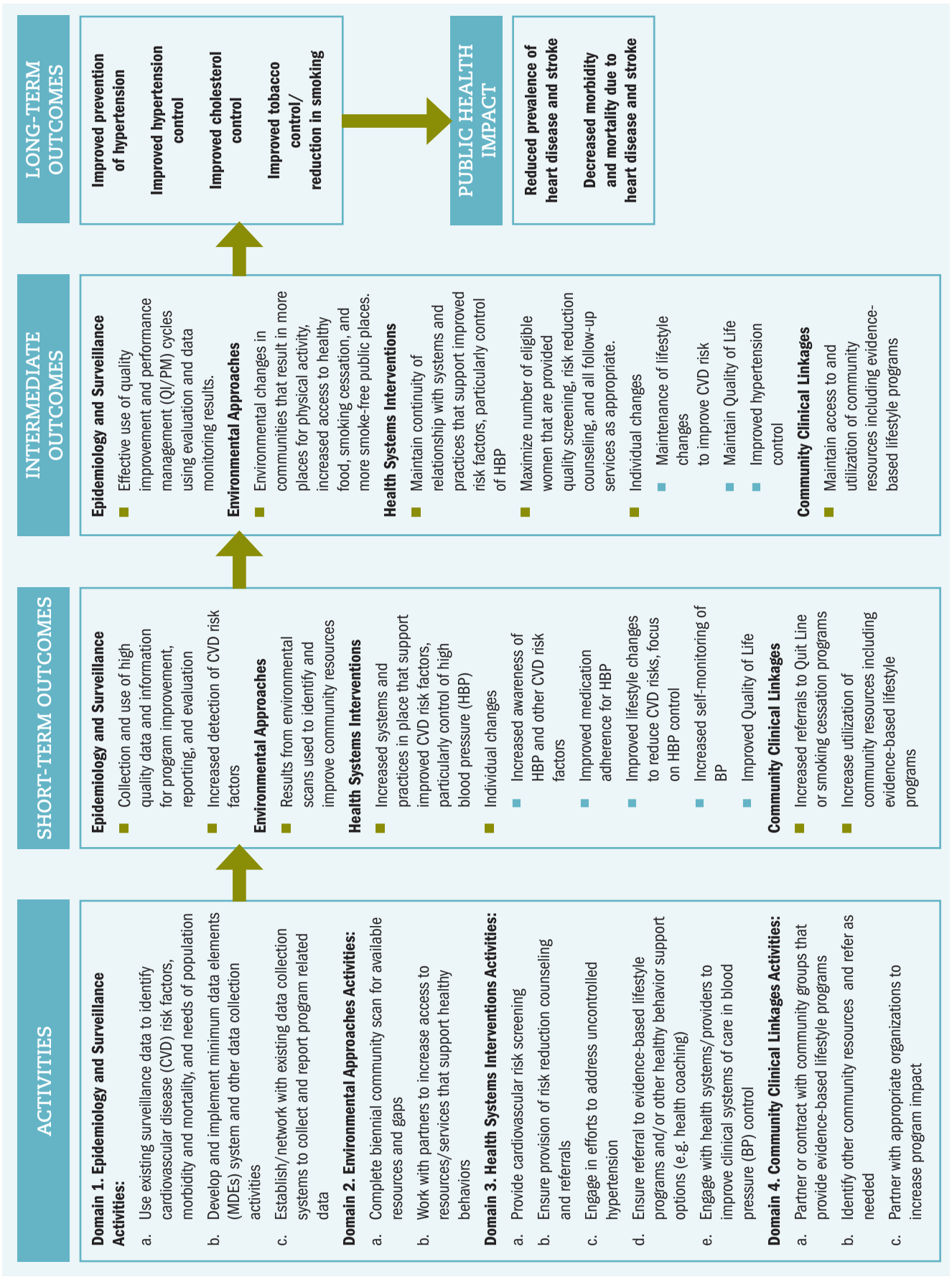
DOMAIN 3: HEALTH SYSTEM/CLINICAL PREVENTION SERVICES

Health system strategies improve the delivery and use of clinical and other preventive services that are designed to prevent disease or detect it early, reduce risk factors, and manage complications.

DOMAIN 4: COMMUNITY-CLINICAL LINKAGES

Community-clinical linkage strategies link community and clinical services to ensure that people with or at high risk of chronic diseases have access to the resources they need to prevent or manage these diseases.

APPENDIX C:
CDC WISEWOMAN LOGIC MODEL



APPENDIX D:
CDC ALLOWABLE CURRENT PROCEDURAL TERMINOLOGY (CPT) CODES

Below are the allowable WISEWOMAN services and procedures and corresponding 2013 Current Procedural Terminology (CPT) Codes. The following services described in the 2013 CPT are appropriate for use of WISEWOMAN funds. Any additional CPT codes must be submitted to CDC for approval.

NOTE

- WISEWOMAN must be the payer of last resort. (Exception: Indian Health Services is the payer of last resort if these funds are available).
- WISEWOMAN funds cannot be used to pay for the integrated office visit and must be paid for by the NBCCEDP.

CPT CODES — GROUPED INTO CATEGORIES OF SERVICES (ASCENDING ORDER)	
CPT Code	**Laboratory Tests**
36415	Routine venipuncture
80061 **80061QW**	Lipid panel
82465 **82465QW**	Cholesterol, total
83718 **83718 QW**	HDL cholesterol
CPT Code	**Tests to Assess Glucose & Diabetes**
82947 **82947QW**	Glucose; quantitative
82948	Glucose; blood, reagent strip
82951 **82951QW**	Glucose tolerance test
83036 **83036QW**	Hemoglobin, glycated (A1c)
80048	Basic metabolic profile
CPT Code	**Nutrition Services** Generally, services delivered by Registered Dietitians (RD) to patients/clients receiving medical nutrition therapy services for a particular disease or condition.
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

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CPT CODES — GROUPED INTO CATEGORIES OF SERVICES (ASCENDING ORDER)	
97803	Reassessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Group (two or more individuals), each 30 minutes
CPT Code	**Education and Training for Patient Self-Management** Prescribed by a physician or other qualified health professional
98960	**Individual —** Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
98961 **98962**	**Group —** Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; **2–4 patients; 5–8 patients**
CPT Code	**Telephone Services & Other Non-Face-to-Face Services**
98966 **98967** **98968**	Telephone assessment and management service provided by a qualified nonphysician health professional to an established patient: 5–10 minutes of medical discussion; 11–20 minutes; 21–30 minutes of discussion
98969	Online assessment and management service provided by a qualified nonphysician health professional to an established patient, not originating from a related service assessment and management service provided within previous 7 days, using the internet or similar electronic communications network
CPT Code	**Office Visits**
99201	New Patient — history, exam, straightforward decision-making; 10 minutes
99202	New Patient — *expanded* history, exam, straightforward decision-making; 20 minutes
99203	New Patient — *detailed* history, exam, straightforward decision-making; 30 minutes
99204	New Patient — *comprehensive* history, exam, moderate complexity decision-making; 45 minutes
99205	New Patient — *comprehensive* history, exam, high complexity decision-making; 60 minutes
99211	Established Patient — evaluation and management, may not require presence of physician; 5 minutes
99212	Established Patient — history, exam, straightforward decision-making; 10 minutes
99213	Established Patient — *expanded* history, exam, straightforward decision-making; 15 minutes

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CPT CODES — GROUPED INTO CATEGORIES OF SERVICES (ASCENDING ORDER)	
CPT Code	**Medical Team Conference and Consultation**
99366	Medical team conference, Direct (Face-to-Face) Contact with Patient and/or Family Medical team conference with interdisciplinary team of health professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional. Team conference services of less than 30 minutes duration are not reported separately.
CPT Code	**Preventive Medicine Services –Office Visits**
99386	New patient: Initial comprehensive preventive medicine evaluation and management – history, examination, counseling/guidance, risk factor reduction, ordering of appropriate laboratory/diagnostic procedures — 40–64 years of age
99396	Established patient: Periodic comprehensive preventive medicine evaluation and management – history, examination, counseling/guidance, risk factor reduction, ordering of appropriate immunizations, lab procedures, etc. — 40–64 years of age
99401 **99402** **99403** **99404**	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual: 15 minutes; 30 minutes; 45 minutes; 60 minutes
99406 **99407**	Preventive Medicine Tobacco Use Cessation: Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes; greater than 10 minutes
99411 **99412**	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; 30 minutes; approximately 60 minutes
CPT Code	**Other Preventive Services, Telephone & Internet Services**
99420	Administration and interpretation of health risk assessment instrument
99429	Unlisted preventive medicine service
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 5–10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 11–20 minutes of medical discussion

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CPT CODES — GROUPED INTO CATEGORIES OF SERVICES (ASCENDING ORDER)	
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related evaluation and management service provided within the previous 7 days nor leading to an evaluation and management service or procedure within the next 24 hours or soonest available appointment; 21–30 minutes of medical discussion
99444	Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related evaluation and management service provided within the previous 7 days, using the Internet or similar electronic communications network

REFERENCE

American Medical Association. Current Procedural Terminology 2013 (CPT®), Professional Edition, 2012.

APPENDIX E:
VALID SCREENING DEFINITION

Screenings, including baseline screenings and rescreenings should, at a minimum, include:

- ❑ Blood pressure date
- ❑ Month and year of birth
- ❑ Race and ethnicity
- ❑ Previous cardiovascular disease risk (high cholesterol, hypertension, diabetes, coronary heart disease/chest pain, heart attack, heart failure, stroke/TIA, vascular disease, or congenital heart defects)
- ❑ Use of medications to lower cholesterol, blood pressure, or blood sugar
- ❑ Diet (consumption of fruits, vegetables, fish, whole grains, and beverages with added sugar)
- ❑ Physical activity (moderate and vigorous physical activity)
- ❑ Smoking status
- ❑ height and weight
- ❑ first systolic blood pressure
- ❑ first diastolic blood pressure
- ❑ total cholesterol
- ❑ fasting glucose or A1C

*Refer to MDE manual for more information

APPENDIX F:
INTERPRETATION AND CLASSIFICATION OF BLOOD PRESSURE, GLUCOSE, CHOLESTEROL, AND BODY MASS INDEX VALUES

BLOOD PRESSURE CLASSIFICATION			
Normal (mmHg)	**Pre-Hypertension (mmHg)**	**†Hypertension (mmHg)**	
		Stage 1	**Stage 2**
<120 Systolic **and** <80 Diastolic	120–139 Systolic **or** 80–89 Diastolic	140–159 Systolic **or** 90–99 Diastolic	> 160 Systolic **or** > 100 Diastolic

Note: Guidelines recommend that the diagnosis of hypertension be based on two or more blood pressure readings on at least separate occasions.

†Disease-level values

REFERENCES

NIH National Heart, Lung, and Blood Institute. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7). Available from: http://www.nhlbi.nih.gov/files/docs/guidelines/jnc7full.pdf

AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2011 Update: A Guideline From the American Heart Association and American College of Cardiology Foundation. Available from: http://circ.ahajournals.org/content/early/2011/11/01/CIR.0b013e318235eb4d.citation

LIPID AND AIC VALUES: NONFASTING VALUES			
Measurement	**Normal**	**Abnormal**	
Total Cholesterol* (mg/dL)	<200 **(desirable)**	**Borderline High** 200–239	†**High** >240
HDL Cholesterol* (mg/dL)	>40 >60 **(optimal)**	**Low** <40	
1A1C	<5.7%	**Prediabetes** 5.7%–6.4%	†**Diabetes** > 6.5%

*Note: HDL and Total Cholesterol classification is the same regardless of fasting status.

†Disease-level values

CHOLESTEROL RECOMMENDATIONS

ATP III recommends a complete lipoprotein profile (total cholesterol, LDL cholesterol, HDL cholesterol, and triglycerides) as the preferred initial test. If the testing opportunity is nonfasting, only the values for total cholesterol and HDL cholesterol are usable.

When nonfasting total cholesterol is >200 mg/dL or HDL is <40 mg/dL, a follow-up lipoprotein profile is needed for appropriate management based on LDL.

[1]A1C TEST

The A1C (Glycosolated Hemoglobin) test should be performed in a laboratory using a method that is National Glycohemoglobin Standardization Program (NGSP) certified and standardized to the Diabetes Control and Complications Trial (DCCT) assay.

LIPID VALUES: FASTING VALUES (FASTING FOR > 9 HOURS)				
Measurement	**Normal**	**Abnormal**		
LDL Cholesterol* (mg/dL)	<100 **(optimal)** 100–129 **(near optimal/ above optimal)**	**Borderline High** 130–159	†**High** 160–189	†**Very High** >190
Triglycerides (mg/dL)	< 150	**Borderline High** 150–199	†**High** 200–499	†**Very High** >500
Total Cholesterol (mg/dL)**	<200 **(desirable)**	**Borderline High** 200–239	†**High** >240	
HDL Cholesterol (mg/dL)**	>40 >60 **(optimal)**	**Low** <40		

*Note: The optimal LDL values are lower for individuals at high risk (or with known Coronary Artery Disease)

**Note: HDL and Total Cholesterol classification is the same regardless of fasting status.

†Disease-level values

REFERENCE

NIH National Heart, Lung, and Blood Institute. Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). Available from: http://www.nhlbi.nih.gov/guidelines/cholesterol/atp3_rpt.htm

GLUCOSE VALUES: FASTING VALUES (FASTING FOR > 8 HOURS)			
Measurement	**Normal**	**Abnormal**	
Fasting Plasma Glucose (mg/dL)	FPG <100	**Prediabetes** FPG 100–125	†**Diabetes** FPG >126
Oral Glucose Tolerance Test (OGTT) (mg/dL)	OGTT <140	**Prediabetes** OGTT 140–199	†**Diabetes** OGTT >200

†Disease-level values

REFERENCE

American Diabetes Association. Standards of Medical Care in Diabetes—2014. Available from: http://care.diabetesjournals.org/content/37/Supplement_1/S14.full

BODY MASS INDEX (BMI) CLASSIFICATION						
	Underweight	**Normal Weight**	**Overweight**	**Obesity (Class 1)**	**Obesity (Class 2)**	**Extreme Obesity (Class 3)**
Height and Weight — BMI (kg/m²)	<18.5	18.5-24.9	25-29.9	30-34.9	35-39.9	>40

REFERENCE

NIH National Heart, Lung, and Blood Institute. Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults: The evidence report. Available from: http://www.ncbi.nlm.nih.gov/books/NBK2003/

WISEWOMAN ALERT VALUES WISEWOMAN Alert values are laboratory results that indicate the need for immediate attention.	
Measurement	**WISEWOMAN Alert Values**
Blood Pressure	Systolic >180 mmHg **OR** Diastolic >110 mmHg
Blood Glucose	<50 mg/dL or >250 mg/dL

REFERENCE

Huecker MR, Danzl DF. Metabolic & Endocrine Emergencies. In: Stone CK, Humphries RL, editors. Current diagnosis and treatment. Emergency medicine. New York: McGraw-Hill; 2011.

APPENDIX G:
GRANTEE EVALUATION EXPECTATIONS:
WHAT SHOULD WISEWOMAN GRANTEES EVALUATE?

The purpose of this document is to provide additional guidance to grantees on expectations for program evaluation.

The Evaluation of the WISEWOMAN program will occur at two levels: the grantee level and the national level.

GRANTEE LEVEL PROGRAM EVALUATION

Grantees are required to conduct process and outcome evaluation of their program efforts; however, they are not expected to evaluate all program efforts.

Grantees are encouraged to describe the WISEWOMAN components or pathways (e.g. lifestyle program, clinical support systems, health coaching, and community referrals) that were effective. More specifically, the program evaluation should include the following:

1. Evaluation of efforts to address uncontrolled hypertension.
2. Description and evaluation of the health coaching and /or lifestyle program.

In addition, evaluate one or more of the areas below:

3. Demonstrate significant value of the WISEWOMAN program.
4. Health outcomes and behavior change related to smoking cessation, increase in physical activity, healthy eating, and hypertension control.
5. Clinical support systems delivered by health care providers within the WISEWOMAN program that optimize control of hypertension such as:
    a. Use treatment protocols
    b. Team-based care
    c. Delivery system design
    d. Health information technology/Electronic Health Records (EHR)
    e. Self-management support
6. Partnerships with community based organizations that contribute significant resources to the program.