DP18-1816

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

Connecticut • Recipient Profile[1]

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

The **Connecticut Department of Health** is a recipient of the CDC-funded WISEWOMAN cooperative agreement (CDC-RFA-DP18-1816). The WISEWOMAN program provides heart disease and stroke risk factor screenings and services to promote healthy behaviors to low-income, uninsured, and underinsured women aged 40 to 64 years. As a WISEWOMAN recipient, Connecticut is implementing the following strategies to improve the diagnosis, care, and management of women with hypertension: (1) strengthen clinical quality measurement, (2) support team-based care, and (3) facilitate community-clinical linkages.

Year 3 Core Funding: $600,000

First Year Funded: 2000

Participation in Other CDC Heart Disease and Stroke Programs:

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

Recipient Organization: Connecticut Department of Health

Prevalence of Hypertension: [2, 3]

28% of Connecticut WISEWOMAN participants had high blood pressure at baseline screening

Key Partners:

- Breast and Cervical Cancer Early Detection Program
- Consultation Center at Yale University
- FDI Medical

Innovation Funding Amount: $95,000

Innovation Funding Activities:

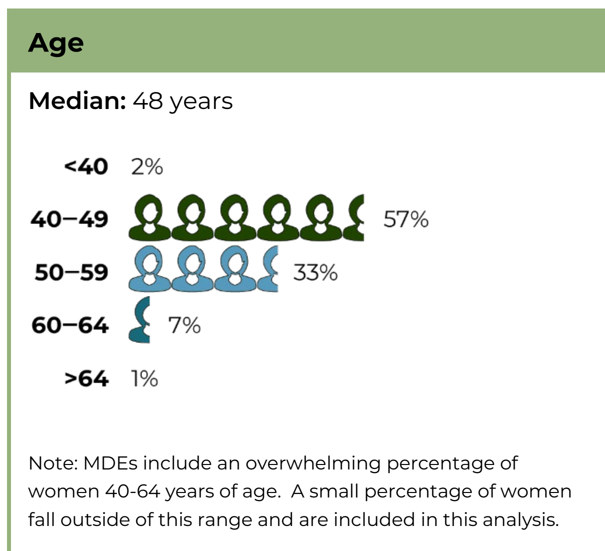
- Train and implement bi-directional referrals with academic detailers and community pharmacists

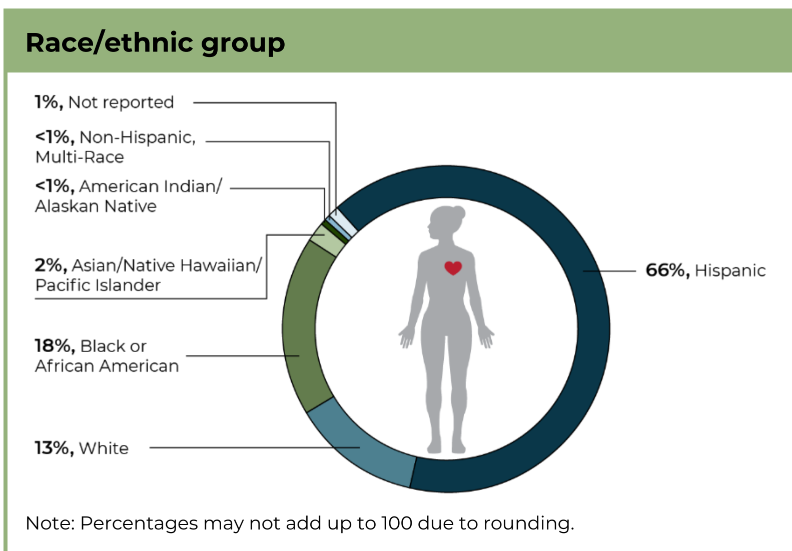
Key Innovation Partners:

- University of Connecticut School of Pharmacy
- Community pharmacists

WISEWOMAN participants in Program Years 1 through 3

WISEWOMAN recipients submit data to CDC biannually describing the number of women served and the types of services received. During Program Years 1 through 3 (September 30, 2018 – September 29, 2021), the **Connecticut WISEWOMAN program served 2,080 women**; distribution of participants by age and race/ethnicity is shown below.[2]





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

[2] Based on an analysis of MDE data for women who were screened in Program Years 1 through 3, including complete, BP+, and incomplete screening records (n = 2,080). Hypertension rate and distribution by age and race/ethnicity at baseline include 2,015 participants with valid data for key elements at baseline screening.

[3] High blood pressure is defined as systolic blood pressure > 139 mmHg or diastolic blood pressure > 89mmHg.

WISEWOMAN strategies to promote cardiovascular health

The WISEWOMAN program uses **evidence-based approaches to heart disease and stroke prevention** within health care systems and throughout communities. Women who are screened and found to have high blood pressure, diabetes, or high blood cholesterol receive clinical care and are referred to healthy behavior support services (HBSS), including lifestyle programs, health coaching, and risk reduction strategies with community support. Below, we describe the Connecticut program's approach to this work and provide updates on Connecticut's performance measures through the end of Program Year 3.[4]

Strategy 1. Track and monitor clinical measures shown to improve healthcare quality and identify patients with hypertension

The WISEWOMAN program aims to **improve sharing and use of clinical data** among providers to facilitate care coordination and promote better health outcomes.

Highlights from Connecticut

- **Generated quarterly reports** identifying participants who are eligible for referrals, follow-up, and rescreenings.
- **Conducted virtual site visits** with WISEWOMAN screening sites to provide support on data use and monitoring.

Performance measures

98%	of WISEWOMAN participants were screened by providers that have a protocol for identifying patients with undiagnosed hypertension **(2,790 women)**.
NR[5]	of WISEWOMAN providers implemented a community referral system (through bi-directional referrals) for HBSS for people with high risk for CVD

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

Use of team-based care helps ensure provider adherence to evidence-based guidelines and policies for participants with high blood pressure and high cholesterol and increases participation of non-physician team members. This approach also helps participants manage their own health and CVD risk factors.

Highlights from Connecticut

- **Provided technical assistance to WISEWOMAN clinics** to explore options for including pharamcists, behaviorists, and dieticians on care teams.
- **Collaborated with community pharmacists** to provide medication therapy management to participants facing barriers to medication adherence.

Performance measures

91%	of WISEWOMAN participants were screened by providers that have policies or systems to implement a multidisciplinary team-based approach to blood pressure control **(2,593 women)**.

Strategy 3. Link community resources and clinical services that support bi-directional referrals, self-management, and lifestyle change for women at risk for CVD

Linkages to HBSS, including health coaching and lifestyle programs (LSPs), help engage participants in the WISEWOMAN program. Connecticut's LSP partners include the National Diabetes Prevention Program and Weight Watchers.

Highlights from Connecticut

- **Implemented a new health coaching curriculum (Health Coaching with Healthy Food)** designed for participants who show signs of food insecurity.
- **Convened a virtual meeting for WISEWOMAN clinics** on healthy behavior support service referral options.

Performance measures

99%	of WISEWOMAN participants were referred to an appropriate HBSS **(2,840 women)**.
NV[6]	of WISEWOMAN participants who were referred to an HBSS attended at least one session

131 out of 338 participants with known high blood pressure achieved blood pressure control in Year 3 compared to an **unknown number** of participants in Year 1.[7]

[4] Based on an analysis of performance measure data for women who were served in Program Years 1 through 3 (n = 2,861). This data source is different than the MDE data reported on Page 1.
[5] NR = Not reported; reporting of this measure is not required.
[6] NV = Not valid; value is not included in the aggregate analysis.
[7] The number of participants that achieved blood pressure control is unknown because the recipient did not submit valid data for this measure in Year 1.