DP18-1816

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

Minnesota • Recipient Profile[1]

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

The **Minnesota 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, Minnesota 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: $850,000

First Year Funded: 2018

Participation in Other CDC Heart Disease and Stroke Programs:

- **DP18-1815:** Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke
- **DP18-1817:** Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke
- **DP15-1514:** Paul Coverdell National Acute Stroke Program

Recipient Organization: Minnesota Department of Health

Prevalence of Hypertension: [2, 3]

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

Key Partners:

- University of Minnesota Extension Center
- Stairstep Foundation
- American Indian Cancer Foundation

Innovation Funding Amount: $70,000

Innovation Funding Activities:

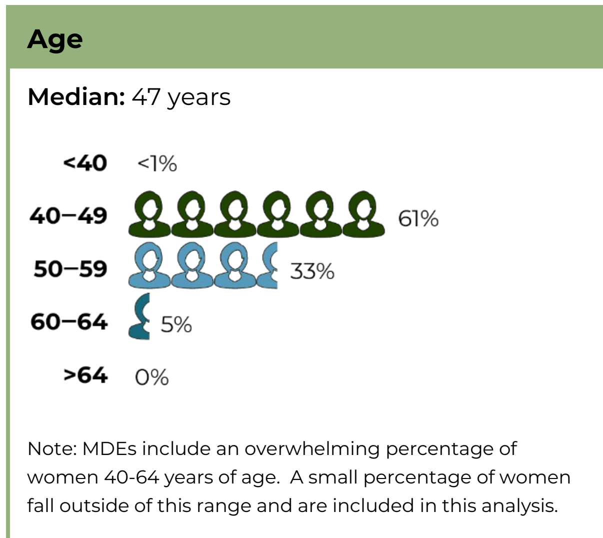
- Partner with the Minnesota Community Care clinic system to provide medication therapy management to participants via telehealth

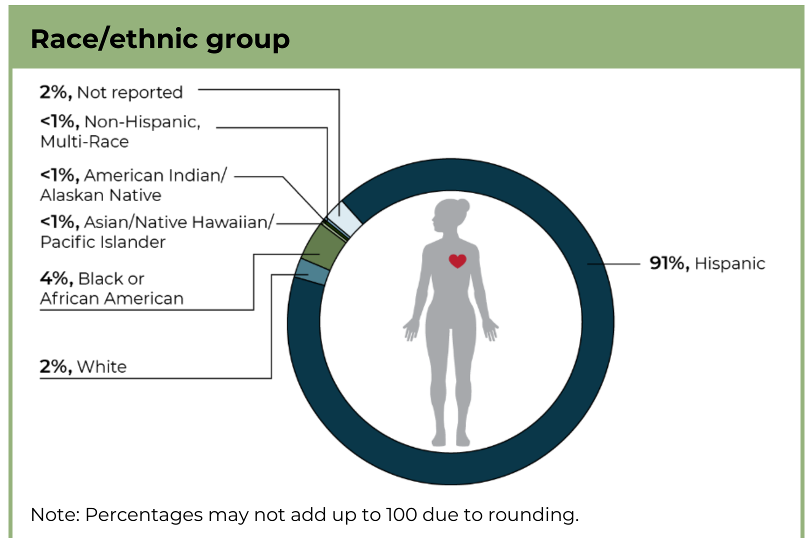
Key Innovation Partners:

- Minnesota Communtiy Care

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 **Minnesota WISEWOMAN program served 1,302 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 = 1,302). Hypertension rate and distribution by age and race/ethnicity at baseline include 1,069 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 Minnesota program's approach to this work and provide updates on Minnesota'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 Minnesota

- **Developed reports** to track participants with hypertension.
- **Helped WISEWOMAN clinics use electronic health record data** to identify patients who are eligible for WISEWOMAN.

Performance measures

94%	of WISEWOMAN participants were screened by providers that have a protocol for identifying patients with undiagnosed hypertension **(1,356 women)**.
100%	of WISEWOMAN providers implemented a community referral system (through bi-directional referrals) for HBSS for people with high risk for CVD **(6 providers)**.

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

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

Highlights from Minnesota

- **Conducted an annual training** on team-based care.
- **Provided technical assistance to clinics** to improve care coordination across team members.

Performance measures

100%	of WISEWOMAN participants were screened by providers that have policies or systems to implement a multidisciplinary team-based approach to blood pressure control **(1,442 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. Minnesota's LSP partners include the National Diabetes Prevention Program, East Lake Wellness Program, and Eat Smart Be Active Learning Circles..

Highlights from Minnesota

- **Referred participants to Walk with Ease,** a self-guided walking curriculum with health coach support.
- **Updated the community resource guides for each WISEWOMAN clinic** that list the HBSS options available in the area and provide guidance on referral criteria.

Performance measures

72%	of WISEWOMAN participants were referred to an appropriate HBSS **(1,038 women)**.
54%	of WISEWOMAN participants who were referred to an HBSS attended at least one session **(556 women)**.

0 out of 233 participants with known high blood pressure achieved blood pressure control in Year 3 compared to **0 out of 15** participants in Year 1.

[4] Based on an analysis of performance measure data for women who were served in Program Years 1 through 3 (n = 1,442). This data source is different than the MDE data reported on Page 1.