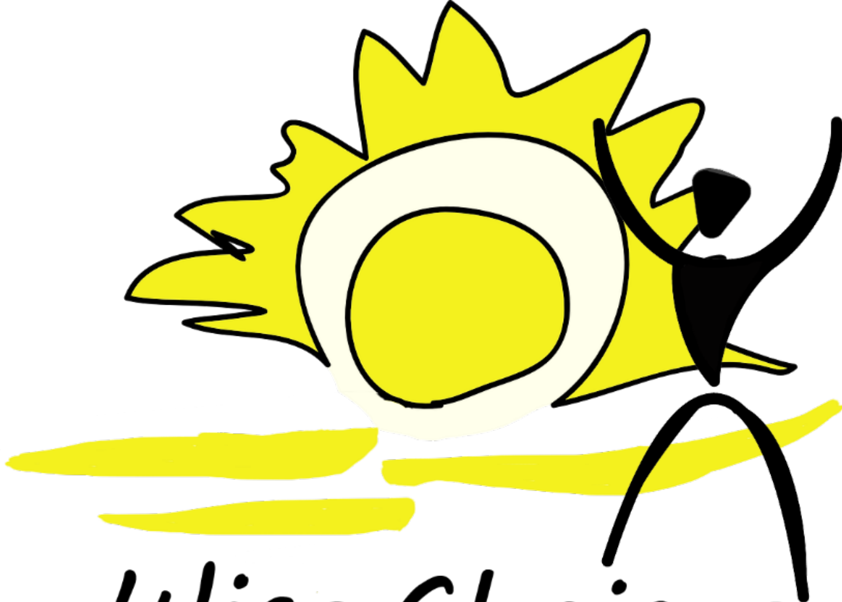
WISEWOMAN/Wise Choices Program Manual



Fiscal Year 2020
October 1, 2019 to September 30, 2020

WISEWOMAN/Wise Choices Program Policies
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12/2019

Every woman has the opportunity to improve her health and well-being and that of her community

WISEWOMAN provides opportunities and programming that empower Michigan women to make healthy lifestyle choices.

To be in WISEWOMAN, a woman must be below 250% of the Federal Poverty Level, un or under insured, and between the ages of 40-64.

The local WISEWOMAN Agency team provide these services for all WISEWOMAN participants:

- Obtain answers to the health intake questions to find out about the woman's cardiovascular disease (CVD) risk factors related to:
  - Tobacco use
  - Physical activity
  - Nutrition habits
  - Family history of early heart disease
  - Alcohol use
- Complete the clinical screening to address measurable CVD risk factors related to:
  - Weight
  - Blood pressure
  - Cholesterol
  - Glucose (sugar)
- Take the information from the health intake questions and the clinical screening and talk to the woman about her personal risk factors (This is called Risk Reduction Counseling)
- Refer the woman for medical follow-up if she needs it based on her clinical screening results, and provide medication adherence support if she is prescribed medication
- Refer the woman to healthy behavior support services including:
  - One-on-one health coaching from a WISEWOMAN Health Coach
  - Free membership to a weight loss program or a diabetes prevention program
  - Free gardening supplies and education through the WISEWOMAN Entrepreneurial Gardening program
  - Appropriate community resources that can help her make healthy lifestyle behavior changes

For the woman who is ready to make a change, the Health Coach will work with her to choose a small step that will lead to better health. The best way to be successful is to take small manageable steps.

In addition, each local WISEWOMAN Agency is required to apply the WISEWOMAN strategies:

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

Program Focus Areas

The Michigan WISEWOMAN program has three main focus areas related to participants.

- Identify and communicate risk factors for cardiovascular disease (CVD), stroke, and diabetes through clinical screening in a variety of health care settings.

- Encourage healthy lifestyle choices beginning in the clinic with a team-based approach to blood pressure and cholesterol control and extending outside the clinic by linking the woman with evidence-based programming in her community.

- Address Health Equity and Social Justice among WISEWOMAN participants and within their communities.
  - Local WISEWOMAN agencies address **Health Equity** by identifying underserved groups in their service areas and getting them into WISEWOMAN. The underserved groups may include:
    - Women with disabilities
    - Women who do not speak English
    - Lesbian, Gay, Bisexual, and Transgendered (LGBT) women,
    - Racial or ethnic minority women
    - Women whose citizenship or immigration status is not settled
  - Once in the program, many women find it difficult to think about making healthy lifestyle choices when they are having trouble paying rent, utilities, or buying food for their families. These are **Social Justice** issues. Michigan WISEWOMAN addresses these issues through special projects that connect participants with opportunities to earn extra money while learning marketable skills.

Wise Choices Program Description

The Wise Choices Program is based on the Michigan WISEWOMAN Program. Wise Choices is available to women and men 18 and older. The focus is on those whose income is less than 250% of the Federal Poverty Level. However, up to 25% of Wise Choices participants may have an income between 250% and 400% of Federal Poverty Level.

The local Wise Choices Agency team is made up of the **Clinical Staff** and a **Health Coach**.

The **Clinical Staff** responsibilities include:

1) Asking the health intake questions (health intake questions ask the participant about personal medical history and what they are doing to be healthy)
2) Doing the clinical screening for each participant
   - Measure the participant's height and weight to calculate body mass index (BMI)
   - Take blood pressure
   - Find out total cholesterol, high density lipoprotein (HDL) cholesterol, and glucose

   The clinical staff will refer the participant for medical evaluation if needed, based on the clinical screening results.

The **Health Coach** responsibilities include:

1) Taking the information from the health intake questions and the clinical screening and talking to the person about their risk factors (This is called Risk Reduction Counseling)
2) Finding out if the person is ready to make a healthy lifestyle change that can help lower their risk factors (This is called a Readiness to Change Assessment)

For the participant who is ready to make a change, the Health Coach will work with them to choose a small step that will lead to better health. The best way to be successful is to take small manageable steps.

Participants who are ready to change can also receive:

- One-on-one health coaching from a Wise Choices Health Coach
- Free membership to a weight loss program or a diabetes prevention program
- Referrals to programs in the community to help make healthy lifestyle behavior changes

Program Focus Areas

Like the Michigan WISEWOMAN program Wise Choices has three main focus areas related to participants.

- Identify and communicate risk factors for cardiovascular disease (CVD), stroke, diabetes, and other chronic diseases. The participant is better able to decide where they want to take small steps if they understand their risk factors.

- Encourage healthy lifestyle choices. Health Coaches work with each person to make lifestyle behavior changes that will help with the risk factors and symptoms they have now. Making healthy choices may also keep the participant from developing any new risk factors.

- Address Health Equity and Social Justice in the community
  - Local Wise Choices agencies address **Health Equity** by identifying underserved groups in their service areas and getting them into Wise Choices.
    The underserved groups may include:
    - People with disabilities
    - People who do not speak English
    - Lesbian, Gay, Bisexual, and Transgendered (LGBT) people,
    - Racial or ethnic minorities
    - People whose citizenship or immigration status is not settled
  - Once in the program, many participants find it difficult to think about making healthy lifestyle choices when they are having trouble paying rent, utilities, or buying food for their families. These are **Social Justice** issues. Wise Choices addresses these issues through special projects that provide participants with opportunities to earn extra money while learning marketable skills.

How Does Wise Choices Compare to WISEWOMAN?

	WISEWOMAN	**Wise Choices**
Gender	Female	All
Prerequisite	**Must** be eligible (do not have to be enrolled) for BCCCNP	**Not** enrolled in or navigated through BCCCNP
Age	40 – 64	18 and up (no upper limit)
Insurance	Uninsured or underinsured	Insurance status is not considered
Income level	Less than 250% of Federal Poverty Level (FPL)	Focus on Less than 250% FPL. Up to 25% of clients can be between 250% and 400% of FPL
Screening	Screening may take place elsewhere	Screening may take place elsewhere
Lifestyle Programs	Health Coaching	Available
	Diabetes Prevention Program	Available
	Take off Pounds Sensibly (TOPS)	Available
	Cooking Matters	Available
Special Projects	Entrepreneurial Gardening Program	Eligible
	Market Fresh Coupons	Eligible

Local WISEWOMAN Agency Requirements

Each Local WISEWOMAN Agency (LWA) funded by the Michigan Department of Health and Human Services (MDHHS) to implement the WISEWOMAN Program must adhere to the following requirements:

Program Coordination

1. Identify one person as the Local Agency Coordinator. The Coordinator's responsibilities are listed in the "Local Staff Responsibilities" document.

2. Follow all WISEWOMAN program policies and procedures.

3. Meet or show significant progress toward meeting performance measures established by the Centers for Disease Control and Prevention (CDC) and MDHHS.

4. MDHHS Program staff must train all staff members involved in the implementation of the WISEWOMAN Program **prior** to their participation in the program.

5. Provide documentation to MDHHS that WISEWOMAN Program Policies and Procedures will be followed by each staff member involved in the implementation of the program, using the Program Assurances Checklist available online.

6. Provide and regularly update contact information for all local WISEWOMAN staff in order for the MDHHS staff to maintain contact.

7. Inform the MDHHS WISEWOMAN Program Director of any program staff changes (including extended sick leave) within one week of change

8. Provide MDHHS with résumés of all staff members who will work with WISEWOMAN participants

9. Submit scheduled Financial Status Reports (FSR) in a timely manner. (monthly for Standard and Master Agreements; quarterly for Comprehensive Agreements)

10. Provide non-federal match totaling 33% of the Coordination funding received for WISEWOMAN Program caseload.
    - Documentation of the 33% match requirement of the Coordination and Screening dollars must be provided to MDHHS on an **annual** basis using the Matching Funds Reporting Form. The Matching Funds Reporting Form is submitted with the Final FSR.

    - See the WISEWOMAN website for current fiscal year WISEWOMAN Budgeting Instructions and a sample Matching Funds Report.
11. Track earned caseload throughout the fiscal year to ensure achieving an earned caseload of at least 95% of budgeted caseload without exceeding 100%.
    - The LWA will not receive Coordination funding for any participants over 100% of budgeted caseload.

- Michigan WISEWOMAN is able to amend the Comprehensive Agreement at various times throughout the year. At those times, agencies will have the opportunity to amend their budgeted caseload amount. Agencies can request a decrease or an increase in caseload. Caseload decreases will be granted. Caseload increases will be granted based on availability and past performance in meeting caseload.
- *Any LWA clearly not on pace to meet budgeted caseload for the fiscal year at midyear (April) may have caseload taken away from them and given to other Local WISEWOMAN Agencies. An agency's past performance in achieving budgeted caseload will influence WISEWOMAN decisions and actions.*

12. Collect all data elements required by MDHHS using WISEWOMAN forms.

13. Enter participant data into the WISEWOMAN module of the Michigan Breast and Cervical Cancer Information System (MBCIS). These data will be used to track progress toward meeting budgeted caseload as well as progress toward meeting other performance measures.

14. Actively participate in the Quality Improvement (QI) Process related to:
    - Data quality and completeness
    - Hypertension control
    - Health Coaching
    - Participant outcomes

15. Use Discoverer reports to assist in the QI process and to identify participants requiring follow-up.

<u>Clinical Care</u>

1. Provide all WISEWOMAN services for each participant including:
    - Collect answers to health intake questions
    - Complete the clinical screening
    - Conduct risk reduction counseling
    - Ensure medical follow-up, if needed, based on clinical screening results
    - Refer to healthy behavior support services

2. Establish a protocol to identify patients with undiagnosed hypertension using electronic health records

3. Implement Team-Based Care to reduce Cardiovascular Disease (CVD) risk with a focus on hypertension control and management

4. Clinic health care providers or those to whom program participants are referred, will use evidence-based protocols related to:
    - Management of blood cholesterol

- Prevention, detection, evaluation and treatment of high blood pressure including identifying patients with undiagnosed hypertension using electronic health records
- Medical care for patients with diabetes

5. If referring outside the local WISEWOMAN agency for medical evaluation, provide to MDHHS copies of contracts or letters of agreement with health care providers who indicate willingness to:
    - See program participants who require a medical evaluation for reimbursement at the current WISEWOMAN Program rate
    - Provide team-based care and continue to see program participants free or at reduced fees following the medical evaluation

6. Have a policy/protocol in place for participants identified to have alert blood pressure values

7. Follow case management protocols related to alert blood pressure values

8. Ensure prescription drug assistance is available for women who are unable to afford their prescription medications.

<u>Community-Clinical Linkages</u>

1. Conduct an annual community scan of each community where WISEWOMAN is offered.

2. Use the community scan to identify existing evidence-based and other community programs to support participants in lifestyle behavior change

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

4. Refer participants to appropriate evidence-based or other community programs depending on medical needs and goals. For example:
    - A person identified with pre-diabetes could be referred to the Diabetes Prevention Program (DPP)
    - A person who is interested in losing weight could be referred to a local Taking off Pounds Sensibly (TOPS) club
    - A person interested in nutrition could be referred to a Cooking Matters class
    - A person who is ready to quit smoking could be referred to the Quitline or to a local tobacco cessation program

5. Collaborate with evidence-based programs to ensure a referral system and feedback loop that informs the local agency of the status of participants who access services and identifies barriers to accessing those services.

6. Use the results of the community scan to identify gaps in evidence-based and other community programs related to nutrition, physical activity, and tobacco cessation.

7. Collaborate with community partners to develop evidence-based community programs and resources, where gaps are identified, which will benefit WISEWOMAN participants and all members of the community.

Health Equity and Social Justice

1. Identify and document underserved populations in the geographic service area of the agency. Examples include:
   - Women with disabilities
   - Women who do not speak English
   - Lesbian, Gay, Bisexual, and Transgendered (LGBT) women,
   - Racial or ethnic minority women
   - Women whose citizenship or immigration status is not settled

2. Choose at least one underserved population to prioritize for the fiscal year.

3. Conduct outreach and provide all WISEWOMAN services to selected underserved population(s).

4. Continuing education forms for all local WISEWOMAN staff must contain at least one Health Equity Social Justice educational activity not including those offered by MDHHS.

Local Wise Choices
Agency Requirements

Each Local Wise Choices Agency funded by the Michigan Department of Health and Human Services (MDHHS) to implement the Wise Choices Program must adhere to the following requirements:

Program Coordination

1. Identify one person as the Local Agency Coordinator. The Coordinator's responsibilities are listed in the "Local Staff Responsibilities" document.

2. Follow all Wise Choices program policies and procedures.

3. Meet or show significant progress toward meeting performance measures.

4. MDHHS Program staff must train all staff members involved in the implementation of the Wise Choices Program **prior** to their participation in the program.

5. Provide documentation to MDHHS that Wise Choices Program Policies and Procedures will be followed by each staff member involved in the implementation of the program, using the Program Assurances Checklist available online.

6. Provide and regularly update contact information for all local Wise Choices staff in order for the MDHHS staff to maintain contact.

7. Inform the MDHHS Wise Choices Program Director of any program staff changes (including extended sick leave) within one week of change

8. Provide MDHHS with résumés of all staff members who will work with Wise Choices participants

9. Submit scheduled Financial Status Reports (FSR) in a timely manner. (monthly for Standard and Master Agreements; quarterly for Comprehensive Agreements)

10. Track earned caseload throughout the fiscal year to ensure achieving an earned caseload of at least 95% of budgeted caseload without exceeding 100%.
    - The Agency will not receive extra funding for any participants over 100% of budgeted caseload.

11. Collect all data elements required by MDHHS using Wise Choices forms.

12. Enter participant data into the Wise Choices module of the Michigan Breast and Cervical Cancer Information System (MBCIS). These data will be used to track progress toward meeting budgeted caseload as well as progress toward meeting other performance measures.

13. Actively participate in the Quality Improvement (QI) Process related to:
    - Data quality and completeness
    - Hypertension control

- Health Coaching
- Participant outcomes

14. Use Discoverer reports to assist in the QI process and to identify participants requiring follow-up.

Clinical Care

1. Provide all Wise Choices services for each participant including:
   - Collect answers to health intake questions
   - Complete the clinical screening
   - Conduct risk reduction counseling
   - Ensure medical follow-up, if needed, based on clinical screening results
   - Refer to healthy behavior support services

2. Clinic health care providers or those to whom program participants are referred, will use evidence-based protocols related to:
   - Management of blood cholesterol
   - Prevention, detection, evaluation and treatment of high blood pressure including identifying patients with undiagnosed hypertension using electronic health records
   - Medical care for patients with diabetes

3. If referring outside the local Wise Choices agency for medical evaluation, provide to MDHHS copies of contracts or letters of agreement with health care providers who indicate willingness to:
   - See program participants who require a medical evaluation for reimbursement at the current Wise Choices Program rate
   - Provide team-based care and continue to see program participants free or at reduced fees following the medical evaluation

4. Follow case management protocols related to alert blood pressure values

5. Ensure prescription drug assistance is available for people who are unable to afford their prescription medications.

Community-Clinical Linkages

1. Conduct an annual community scan of each community where Wise Choices is offered.

2. Use the community scan to identify existing evidence-based and other community programs to support participants in lifestyle behavior change

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

4. Refer participants to appropriate evidence-based or other community programs depending on medical needs and goals. For example:
    - A person identified with pre-diabetes could be referred to the Diabetes Prevention Program (DPP)
    - A person who is interested in losing weight could be referred to a local Taking off Pounds Sensibly (TOPS) club
    - A person interested in nutrition could be referred to a Cooking Matters class
    - A person who is ready to quit smoking could be referred to the Quitline or to a local tobacco cessation program

5. Collaborate with evidence-based programs to ensure a referral system and feedback loop that informs the local agency of the status of participants who access services and identifies barriers to accessing those services.

6. Use the results of the community scan to identify gaps in evidence-based and other community programs related to nutrition, physical activity, and tobacco cessation.

7. Collaborate with community partners to develop evidence-based community programs and resources, where gaps are identified, which will benefit Wise Choices participants and all members of the community.

Health Equity and Social Justice

1. Identify and document underserved populations in the geographic service area of the agency. Examples include:
    - People with disabilities
    - People who do not speak English
    - Lesbian, Gay, Bisexual, and Transgendered (LGBT)
    - Racial or ethnic minorities
    - People whose citizenship or immigration status is not settled

2. Choose at least one underserved population to prioritize for the fiscal year.

3. Conduct outreach and provide all Wise Choices services to selected underserved population(s).

4. Continuing education forms for all local Wise Choices staff must contain at least one Health Equity Social Justice educational activity not including those offered by MDHHS.

Local Coordinator

- Act as the main point of contact between the local agency and the Michigan Department of Health and Human Services (MDHHS)
- Ensure adherence to all *Local WISEWOMAN/Wise Choices Agency Requirements*
- Ensure the local agency follows all WISEWOMAN/Wise Choices Policies, Procedures, and Protocols
    - WISEWOMAN Eligibility
    - Wise Choices Eligibility
    - Clinical Screening Procedures
    - Screening and Referral Guidance
    - Non-Integrated Screening Office Visit Policy (WISEWOMAN Only)
    - Case Management Protocols
    - Multidisciplinary Team Approach (WISEWOMAN Only)
    - Two-Way Referrals (WISEWOMAN Only)
    - Community Clinical Linkages (WISEWOMAN Only)
    - Monitoring Hypertension (WISEWOMAN Only)
    - Community Navigation
    - Take off Pounds Sensibly (TOPS) Referral
    - Diabetes Prevention Program (DPP) Referral
    - Cooking Matters Referral
    - Billing and Reimbursement
    - Performance Measure Policy
    - Records Retention Policy
- Ensure scheduled (monthly for contractual; quarterly for Comprehensive Agreement) and final Financial Status Reports (FSR) are submitted in a timely manner
- Ensure timely completion and submission of the Matching Funds Report (MFR) (WISEWOMAN only)
- Participate in the monthly or quarterly Quality Improvement Process with appropriate staff
- Ensure timely entry of data into the WISEWOMAN or Wise Choices module of the Michigan Breast and Cervical Cancer Control Information System (MBCIS)
- Ensure timely and correct billing of services
- Participate in WISEWOMAN/Wise Choices conference calls, meetings, and site visits
- Work with Community Navigator to conduct community scans
- Ensure the local agency's involvement in community partnerships and collaborations made on behalf of participants

- Attend professional development trainings as required
- Conduct outreach to underserved populations in your geographic service area. Examples include people with disabilities, non-English speaking populations, Lesbian, Gay, Bisexual, and Transgendered (LGBT) populations, racial and ethnic minorities, and other populations who may otherwise be missed.
- Participate in multidisciplinary care team and update participant care plans as needed

Healthcare Provider (Physician, Physician Assistant, or Nurse Practitioner)

- Provides an update of recent history, clinical screening, and review of patient
- Reviews patients drug chart
- Provides update: current problems, responses to program activities, test results, medication, information from patient.

Clinical Screener (Physician, Nurse, or Medical Assistant)

- Conduct Health Risk Assessment
- Conduct Clinical Screening
    - Measure the participant's height and weight in order to calculate body mass index (BMI)
    - Measure the participant's blood pressure according to Clinical Screening Procedures
    - Measure the participant's total cholesterol, HDL cholesterol, and fasting glucose according to Clinical Screening Procedures
    - Measure the participant's Hemoglobin A1c using an Alere Afinion® Analyzer *(if the participant has a history of diabetes)* according to Screening and Referral Protocols
- Determine medical referrals according to *Screening and Referral Protocols*
- Participate in Blood Pressure Measurement Quality Improvement process
- Attend professional development trainings as required
- Participate in multidisciplinary care team and update participant care plans as needed

Health Coach

- Conduct community scan of community where WISEWOMAN/Wise Choices is implemented
- Engage collaboratively with clients
- Develop and regularly update a comprehensive overview of community-based resources and programs based on community scan
- Deliver risk reduction counseling to every participant to communicate the participant's risk factors in a way she can understand
- Conduct Alert Value Case Management or Hypertension Case Management when needed
- Conduct readiness to change assessment to determine if participant is ready to make healthy lifestyle changes
- Encourage participants with hypertension to set blood pressure control as a priority area
- Serve as main point of contact for WISEWOMAN care plan
- Develop a plan, based on assessment of the client which contains clearly specified goals, strategies and responsibilities for action and ensure implementation
- Participate in multidisciplinary care team and provide feedback to professionals and others, including caregivers, who are involved with the client
- Assist participants who are ready to make change to develop a goal in their chosen priority area
- Conduct Health Coaching and regularly monitor outcomes for participants who are ready to make changes
- Conduct an Outcome Evaluation on all participants who complete Health Coaching or a Lifestyle Program
- Identify or develop community linkages with organizations to meet WISEWOMAN/Wise Choices requirements for community programming
- Develop a feedback loop with organizations to receive information about attendance and outcomes of participants
- Refer participants to community based and evidence-based resources that can help the women achieve their goal
- Follow-up with all community referrals to determine extent of participation and outcomes
- Participate in the Quality Improvement process
- Attend professional development trainings as required

Multidisciplinary Team

- Conduct community scan of community where WISEWOMAN/Wise Choices is implemented

Multi-Disciplinary Team Approach

Multi-disciplinary team approach also known as team-based care is the provision of health services to individuals, families, and/or their communities by at least two health professionals who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care. The provider team can include a range of clinical personnel—such as physicians, nurse practitioners, physician assistants, nurses, care managers, dietitians, pharmacists, and social workers—as well as nonclinical staff, such as receptionists and peer counselors.

Steps to Implementing Team-Based Care (Source: AMA STEPS Forward)

1. Engage the change team
2. Determine the team composition
3. Choreograph workflows to reflect the new model of care
4. Increase communication among the team, practice, and patients
5. Use a gradual approach to implement the model
6. Optimize the care model

Below are resources that explain the concept of a multi-disciplinary approach and the various components for following this model of care within your organization.

1. STEPS Forward – Implementing Team-Based Care

• The STEPS Forward resource guide for team-based care is a practice improvement initiative from the American Medical Association.

https://www.stepsforward.org/modules/team-based-care

2. American Academy of Family Physicians (AAFP)

• The American Academy of Family Physicians provides its definition for team-based care. https://www.aafp.org/about/policies/all/teambased-care.html

3. Advancing Team-Based Care Through the Use of Collaborative Practice Agreements and Using the Pharmacists' Patient Care Process to Manage High Blood Pressure

• Descriptive summary of a learning program designed to accelerate team-based care to manage high blood pressure using the pharmacists' patient care process (PPCP) and collaborative practice agreements (CPA).

https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/cvh/cvh__ppcp/ppcp_final_project_report_-_.pdf

4. Creating Patient Centered Team Based Primary Care

• The Agency for Healthcare Research and Quality provides a comprehensive overview of transitioning to team-based delivery of care.
https://pcmh.ahrq.gov/sites/default/files/attachments/creating-patient-centered-team-based-primary-care-white-paper.pdf

5. Promoting Patient Centered Team Based Care

• The American Nurses Association provides tools for implementing team-based care.
https://www.nursingworld.org/~4af159/globalassets/docs/ana/ethics/issue-brief_patient-centered-team-based-health-care_2016.pdf

6. Team-Based Primary Care – Opportunities and Challenges

• Primary care research group, Starfield Summit, shares a guide summarizing the various components of team-based care.

https://www.graham-center.org/content/dam/rgc/documents/publicationsreports/reports/StarfieldSummit_Report_TeamBasedPrimaryCare.pdf

7. HEARTS Team-Based Care

• The HEARTS technical package created by the World Health Organization provides a strategic approach to improving cardiovascular health using team based care.

http://apps.who.int/iris/bitstream/handle/10665/260424/WHO-NMH-NVI-18.4-eng.pdf;jsessionid=DF60EDC4CC164806CB9056BA1E4133DB?sequence=1

8. Set Your Heart on Health

• The Set Your Heart on Health toolkit was designed primarily for the local health department (LHD) staff and aims to improve hypertension outcomes by strengthening collaboration between LHD's and health systems.

https://www.dhs.wisconsin.gov/publications/p02154.pdf

WISEWOMAN
Two Way Referral

Bi-Directional Referrals

Bi-Directional Referral Process - Includes both the referral information going from the WISEWOMAN provider to the evidence-based lifestyle change program or community resources and the information flowing back to the health care provider on patient participation and outcomes such as weight loss.

A bi-directional referral system considers both the information going from the health care system to the referred community program or resource (e.g., a CDC recognized lifestyle change program or a diabetes self-management education program) and the information returning from that program to the health care system. Ideally, the bi-directional referral system will be integrated with an electronic health record (EHR) system and will facilitate electronic bi-directional feedback between the community program and the health care system (e-referral system.) An e-referral system can provide baseline reports on the number of referrals, number of services received, and number of pounds lost and when integrated with the EHR, health systems can evaluate the impact of these community programs on population health. With this information community-based organizations can make the case for clinically meaningful and cost-effective programming.

Below are resources explaining the concept of a bi-directional referral system and the various components of this system.

1. CDC Guide to Referring Patients with Pre-Diabetes

- A guide for referring to and understanding the Diabetes Prevention Program. Includes examples of two-way referral forms.

https://www.cdc.gov/diabetes/prevention/pdf/STAT_toolkit.pdf

2. Agency for Healthcare, Research, and Quality (Linking Primary Care Patients to Local Resources)

- A step by step guide to linking patients to local resources for better management of obesity.

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/obesity-toolkit/obtoolkit3.html

3. Michigan Diabetes Prevention Program Example

- Examples of strategies used to develop bi-directional referral systems and eight healthcare providers.

https://midiabetesprevention.org/documents/CCL_DPAP-monitor-March-2018.pdf

4. Creating Healthcare Referral Systems that Work

• Case studies and tips from the Colorado Department of Public Health & Environment on creating healthcare referral systems.
https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/Domain4/docs/Colorado_casestudies.pdf

5. Wisconsin Department of Health Services

• A Plan-Do-Study-Act model/flow chart from Wisconsin is describing a bi-directional referral approach.

http://www.astho.org/Prevention/Chronic-Disease/Heart-Disease-and-Stroke/Million-Hearts-Tools-for-Change/Systems-Change-Diagram-Wisconsin/

Community Clinical Linkages

Clinical-community linkages help to connect health care providers, community organizations, and public health agencies so they can improve patients' access to preventive and chronic care services.

The goals of community clinical Linkages include:

1) Coordinating health care delivery public health and community-based activities to promote healthy behavior

2) Forming partnerships and relationships among clinical, community and public health organizations to fill gaps in needed services

3) Promote patient, family and community involvement in strategic planning and improvement activities

Types of community-clinical linkages include coordinating services at one location, coordinating services between different locations and developing ways to refer patients to resources.

Below you will find materials explaining the concept of community Clinical Linkages and the various components of this system.

The CDC developed seven strategies that have proven to be effective when implementing community-clinical linkages.

LINKAGES

1. **L**earn about the community and clinical sectors
2. **I**dentify and engage key partners from the community and clinical sectors
3. **N**egotiate and agree upon the goals and objectives of the linkage
4. **K**now which operational structure to implement
5. **A**im to coordinate and manage the linkage
6. **G**row the linkage with sustainability in mind, and
7. **E**valuate the linkage

Below are other resources that explain community clinical linkages.

Center for Disease Control and Prevention (CDC)

• This document guides public health practitioners on strategies to implement community-clinical linkages with a focus on the rationale, key considerations, and potential action steps.

https://www.cdc.gov/dhdsp/pubs/docs/ccl-practitioners-guide.pdf

• This brief provides guidance and resources for the staff of CDC-funded WISEWOMAN programs to support community-clinical linkages for delivering coordinated services to WISEWOMAN participants.

https://www.cdc.gov/wisewoman/docs/ww_brief_developing_community-clinical_linkages.pdf

Agency for Healthcare Research and Quality

• The article describes how to deliver preventive services through community-Clinical Linkages.

https://innovations.ahrq.gov/perspectives/delivering-preventive-services-through-clinical-community-linkages

• The article describes the goals, importance of, and how to put community-clinical linkages into action.

https://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/index.html

WISEWOMAN Program Strategies

Association of State and Territorial Health Offices (ASTHO)

• This issue brief discusses how public health agencies can work with clinical and community partners to improve hypertension control and highlights successful partnerships.

http://www.astho.org/Prevention/Community-Clinical-Linkages-Issue-Brief/

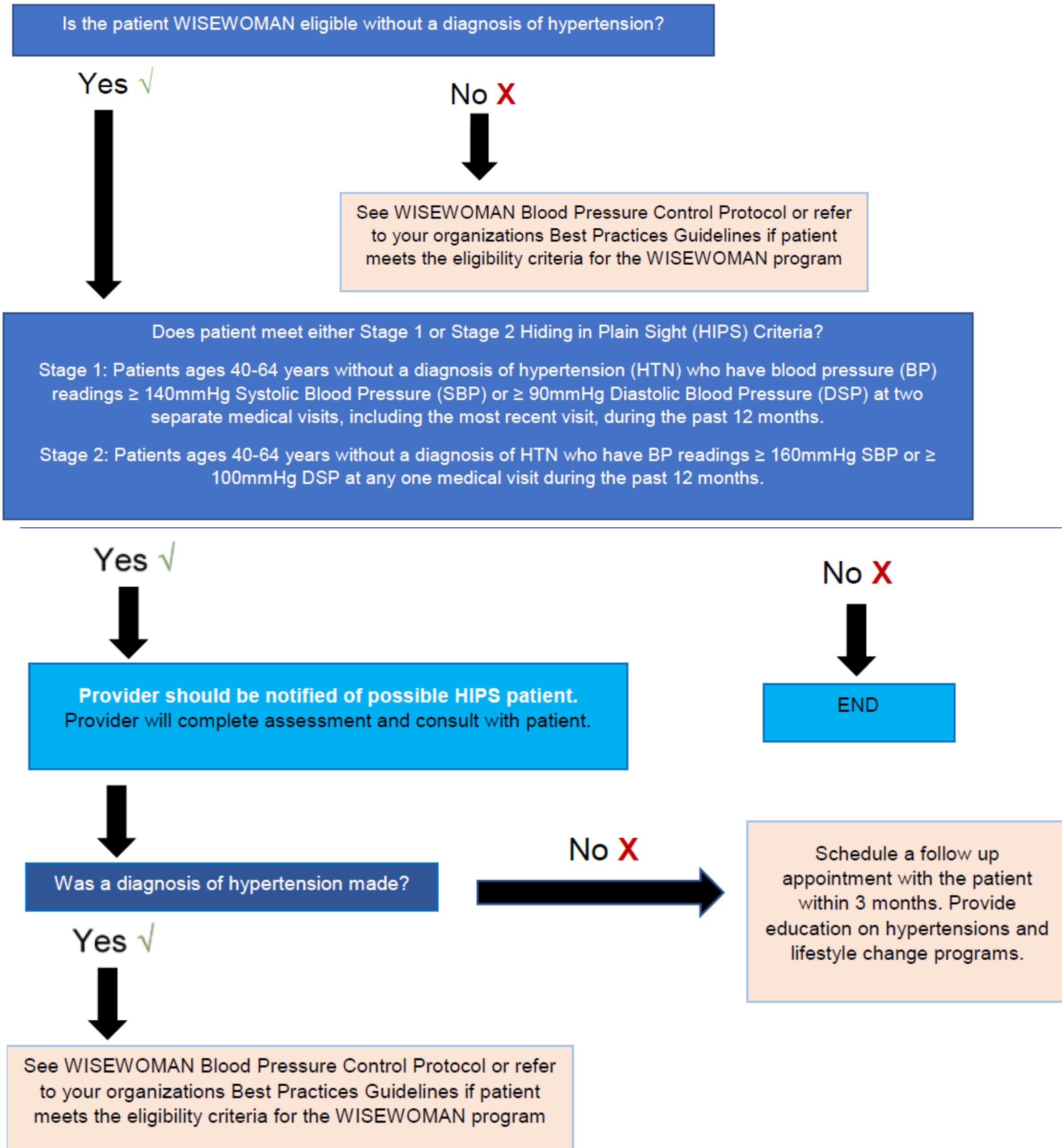
Million Hearts Community Clinical Linkages Toolkit

• A toolkit developed by the Million Hearts Initiative

http://www.heart.org/HEARTORG/Advocate/Million-Hearts-Community-Clinical-Linkages-Workgroup_UCM_500322_Article.jsp#.XBENNrmWyUn

Using Electronic Health Records to Identify and Monitor Hypertension

Electronic Health Records (EHR) include a wealth of clinical information and can be used for disease surveillance to improve health outcomes. Hypertension is a common condition and is the leading risk factor for stroke, congestive heart failure, and death. Monitoring hypertension and ensuring that a patient is taking their prescribed medications helps to prevent other severe ailments. During the first year of the grant cycle CDC wants to see increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of women with high blood pressure.



Below are resources that explain how to identify and track hypertensive patients within your organization.

1. Million Hearts – Undiagnosed Hypertension Partner Toolkit

• The Million Hearts Undiagnosed Hypertension Partner Toolkit provides sample social media messages and graphics to help raise awareness among your colleagues and patients.

https://millionhearts.hhs.gov/tools-protocols/hiding-plain-sight/toolkit.html

2. Million Hearts – Hypertension Prevalence Estimator Tool

• The Million Hearts Hypertension Prevalence Estimator Tool allows provider offices to calculate the expected percentage of patients with hypertension in your health system or practice

https://nccd.cdc.gov/MillionHearts/Estimator/

3. Million Hearts – Finding Undiagnosed Hypertensive Patients (Video)

• Learn four steps health systems and practices can take to find patients with potentially undiagnosed hypertension.

https://www.youtube.com/watch?v=rmjIgAxF5i0

4. National Association of Chronic Disease Directors (NACDD) – Fireside Chat on Identifying Undiagnosed Hypertension

• This NACDD webinar was designed to increase knowledge about identifying patients with undiagnosed hypertension.

https://www.chronicdisease.org/page/Webinar_Firesidechat

5. Association of State and Territorial Health Officials - Various resource documents related to undiagnosed hypertension

http://www.astho.org/Search.aspx?s=undiagnosed

6. Michigan Million Hearts

• The Michigan Million Hearts website promotes effective community and clinical strategies to increase the use of electronic health records to track hypertension, data, community health workers, and team-based care.

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2955_2959_82528---,00.html

WISEWOMAN Eligibility

Who is eligible to be in the WISEWOMAN program?

1. Women between the ages of 40 and 64
   and
2. With a household income at or below 250% of the federal poverty level

Women currently enrolled in the Michigan Breast and Cervical Cancer Control Navigation Program (BCCCNP) are automatically eligible for WISEWOMAN.

Women not currently enrolled in BCCCNP who meet the eligibility requirements above are also eligible for WISEWOMAN. They must complete a WISEWOMAN Enrollment form, and they must be referred to BCCCNP if their breast and cervical cancer screening services are not up to date.

For women with insurance, conduct coordination of benefits with their insurance company to ensure WISEWOMAN is the payer of last resort. **(WISEWOMAN funds may only be used to pay for services not covered by her insurance.)**

Wise Choices Eligibility

Who is eligible to be in the Wise Choices program?

Age: 18 and up (no upper limit)

Income Level: Below 400% Federal Poverty Level **(75% should be below 250% FPL).** An individual's income may be above 400% Federal Poverty Level if that person is being screened as part of an event, such as worksite wellness or senior center screening.

BCCCNP Enrollment: Not enrolled in or navigated through BCCCNP – Otherwise, they will be in the WISEWOMAN Program

Legal Gender: Any

Gender Identity: Any

Race: Any

Ethnicity: Any

Sexual Identity: Any

Disability Status: Any

Religion: Any

Mental/Behavioral Health Status: Any

Citizenship/Immigration Status: Any

Baseline Screening

The baseline screening initiates a one-year cycle.

The **Health Risk Assessment Component** evaluates the participant's medical history and current health behaviors.

- Personal Health Assessment
  - Personal history of:
    - High cholesterol
    - High blood pressure
    - Diabetes
    - Coronary Heart Disease
  - Currently taking medication to:
    - Lower cholesterol
    - Lower blood pressure
    - Lower blood sugar
  - Home blood pressure measurement

- Healthy Lifestyle Assessment
  - Nutrition
    - Fruits and vegetables
    - Fish
    - Whole grains
    - Sugar sweetened beverages
    - Sodium
  - Physical Activity
    - Weekly moderate and vigorous physical activity
  - Tobacco Use
    - Current status
    - Second hand smoke
  - Physical and emotional well-being

The **Clinical Screening Component** assesses for chronic disease risk factors and includes:

- Body Mass Index (BMI) Assessment
  - Measure the participant's height and weight, and determine BMI using a BMI wheel or chart.
- Blood Pressure Assessment
  - Measure the participant's blood pressure two times
  - Determine the category by averaging the two measurements

- Cholesterol Assessment
  - Measure the participant's Total, HDL, and LDL cholesterol and Triglycerides using the Cholestech® LDX Machine in order to obtain immediate results.

- Hemoglobin A1c
    - Measure Hemoglobin A1c using the Afinion® A1c analyzer.

See Clinical Screening Procedures for more information.

Medical Referrals

Program participants who are identified with a disease level value will be referred for blood work (if needed) and to a health care provider for evaluation. Disease level values requiring referral are:

- BP greater than **140** (systolic) and/or greater than **90** (diastolic)
- LDL Cholesterol greater than **160 and not currently being treated for high cholesterol**
- Triglycerides greater than or equal to **500**
- Hemoglobin A1c greater than or equal to **6.5% and no history of diabetes**
- Hemoglobin A1c greater than 7% **with a history of diabetes**

See Screening and Referral Guidance for more information.

Case Management

If a program participant's blood pressure and/or glucose measurements fall into the alert range, they will receive Alert Value Case Management. (Less than 3% of program participants will have values in the alert range.) Alert values are:

- Average BP is greater than **180** (systolic) and/or greater than **110** (diastolic)

See Case Management Protocols for more information.

Risk Reduction Counseling

Each participant will receive risk reduction counseling at the time of screening using the ***My Health Information*** pamphlet, geared to low or marginal literacy readers. The pamphlet defines and identifies the participant's BMI, blood pressure, total cholesterol, HDL cholesterol, LDL cholesterol, Triglycerides, and Hemoglobin A1c. The pamphlet also provides information about the participant's risks related to personal health history, physical activity, and smoking status.

Chronic Disease Control

Participants identified with hypertension, whether newly identified or existing, should receive team-based care.
Participants newly identified with diabetes are referred to a diabetes self-management education program.
Participants identified with pre-diabetes are referred to the diabetes prevention program.
Participants who choose not to participate in one of the chronic disease control options have the option of participating in a healthy behavior support service.

Readiness to Change Assessment

During the risk reduction counseling, the Health Coach will assess the participant's readiness to make healthy lifestyle behavior change. Those who are ready to change will receive health coaching to assist them in making healthy lifestyle behavior changes. Participants who are not ready to change may be rescreened in one year.

Health Coaching

Each participant who is ready to make changes is encouraged to determine one priority area. The priority areas include:

- Medication adherence
- Nutrition
- Physical activity
- Tobacco cessation

The Health Coach works with the participant to develop a goal related to their chosen priority area. The participant will receive one-on-one health coaching. They can also choose to participate in Healthy Behavior Support Service (HBSS) to assist in making healthy lifestyle behavior changes.

If they choose an HBSS, such as the Diabetes Prevention Program or Taking off Pounds Sensibly (TOPS), WISEWOMAN will cover the cost of participation in the program as long as they attend a minimum number of sessions. The participant may prefer to attend a low or no cost community-based program, such as a walking group or Supplemental Nutrition Assistance Program Education (SNAP-Ed) nutrition classes.
See Health Coaching Protocols for more information.

Outcome Evaluation Contact

The Health Coach will conduct an Outcome Evaluation Contact with the participant who completes Health Coaching or an HBSS in order to assess progress and to reinforce the chosen goal. The Outcome Evaluation Contact will take place between 3 and 11 months after baseline screening or rescreening.
See Health Coaching Guidance for more information.

Rescreening

WISEWOMAN/Wise Choices participants who remain eligible for the program should have the opportunity to receive rescreening services 12 to 18 months after their previous screening.

Michigan WISEWOMAN/Wise Choices
Program Flow
October 1, 2019

Screening

Client enters program → Conduct Risk Factor Screening → Screening Results

Screening Results — Abnormal → Alert Value?

Alert Value? — Yes → Alert Value Case Management → Referral for Blood Work (if needed) and Medical Evaluation

Alert Value? — No → Referral for Blood Work (if needed) and Medical Evaluation → Risk Reduction Counseling & Readiness to Change Assessment

Screening Results — Normal → Risk Reduction Counseling & Readiness to Change Assessment

Behavior Change Support

Risk Reduction Counseling & Readiness to Change Assessment → Ready to make lifestyle behavior change?

Ready to make lifestyle behavior change? — Yes → Health Coaching

Ready to make lifestyle behavior change? → Rescreening

Health Coaching — Optional → Healthy Behavior Support Service

Health Coaching — Optional → Community-Based Referral

Health Coaching / Healthy Behavior Support Service / Community-Based Referral → Outcome Evaluation Contact and Follow up Screening *(3-11 months after Screening)* *(< 4 weeks after completing Health Coaching or HBSS)*

Outcome Evaluation Contact and Follow up Screening → **Rescreening** → Screening Results

WISEWOMAN/Wise Choices Performance Measure Policy Fiscal Year 2019

(Effective Dates: October 1, 2018 to September 30, 2019)

Performance measures serve to standardize the assessment of program activities and outcomes across all local agencies. Regularly monitoring performance measures helps assess performance during program implementation and identify process improvements. The performance measures will be monitored and discussed during the technical assistance meetings.

1. **100%** of protocols or policies submitted and approved by MDHHS for: *
   - Team-based care,
   - Identifying patients with undiagnosed hypertension, and
   - Tracking two-way referrals
   - Community clinical linkages

8/2019

2. **100%** of local WISEWOMAN agency staff participate in training related to health equity and social justice within the fiscal year.
   - Numerator: # of staff who have attended at least 1 training opportunity related to health equity and social justice within the fiscal year
   - Denominator: # of staff in WISEWOMAN
3. Agency screens **at least 70%** of budgeted caseload.
4. **100%** of participants complete readiness to change scale.
5. **At least 75%** of participants who complete a participant agreement attend at least one session of health coaching or an evidence-based lifestyle program. *
6. **At least 75%** of participants of participants enrolled in health coaching receive their first health coaching contact within three weeks of the Participant Agreement.
7. **95%** of participants with high blood pressure at screening visit (140/90 or higher) are enrolled in an evidence-based lifestyle program. *
8. **90%** of participants with high blood pressure at screening visit (≥140/90) who are maintaining blood pressure control (<140/90) at follow-up screening. *

The following metrics are not performance measures yet will be monitored regularly.

A. % of participants complete a participant agreement. *
B. % of WW with RTC >/= 7
C. % of participants who participate in health coaching or an evidence-based lifestyle program complete the program (attend minimum # of sessions for LSP)
D. % of participants who complete health coaching (5 contacts) or an evidence-based lifestyle program (4 CM, 9 DPP, or 12 TOPS) receive an outcome evaluation contact
E. Average # of health coaching contacts among participants with an outcome evaluation who participated in health coaching
F. % of WISEWOMAN participants who also received Breast and Cervical services in current fiscal year

** indicates performance measures required by CDC*

12/2019

G. % of participants who present with high blood pressure, high bad cholesterol, high triglycerides, or low good cholesterol at baseline screening (triggering referral to lab work or medical evaluation) receive appropriate follow up screening (if they return for a follow up visit)

H. % of participants complete follow up screening and outcome evaluation within 4-6 weeks of completing the HBSS or the most recent Health Coaching contact if HBSS was completed early (less than 3 months).

** indicates performance measures required by CDC*

Procedure for Measurement of Blood Pressure

1. CHECK THE EQUIPMENT. Do not use if you find any problems.
   A. Make sure the gauge - mercury meniscus or aneroid needle - is at zero. (Preferably, do not use an aneroid gauge with a stop-pin.)
   B. Check the cuff for any breaks in stitching or tears in the fabric.
   C. Check the rubber tubing for cracks or leaks, especially at connections.
   D. Be sure small, regular, and large cuffs are available.
   E. Recommend 12-15 inch stethoscope tubing.

2. PLACE THE MANOMETER so it can be viewed <u>straight on</u> and within 15 inches of the viewer.

3. USE THE RIGHT ARM when possible. Upper arm should be bare and unconstricted by clothing. (You should be able to get at least one finger under a rolled-up sleeve.)

4. SELECT THE APPROPRIATE SIZE CUFF. The bladder width should equal at least 40% of the circumference of the upper arm, and the length of the bladder should be 80% of the circumference of the arm, but no more than 100%.

5. PALPATE the location of the brachial artery (on the upper arm's inner aspect.)

6. POSITION the center of the cuff's bladder over the brachial artery.

7. APPLY THE CUFF evenly and snugly one-inch (2.5cm) above the antecubital fossa (bend of arm). CHECK SNUGNESS at top and bottom of the cuff.

8. POSITION THE ARM so the cuff is at heart level. The arm should rest firmly supported on a table, slightly abducted and bent, with palm up.

9. For the first reading only, OBTAIN PALPATORY SYSTOLIC PRESSURE.
   A. Palpate the radial artery pulse.
   B. Inflate the cuff to the point where the pulse can no longer be felt.
   C. Slowly deflate the cuff, noting on the gauge the point where the pulse reappears/can again be felt. This is the estimated systolic pressure.

   Rapidly deflate the cuff. Wait at least 15-30 seconds before re-inflating the cuff to begin the first auscultatory measurement. (This allows good circulation to be reestablished.)

10. CALCULATE the maximum inflation level (MIL) by adding 30 - 40 mm Hg to the estimated systolic. (We will use this figure in Step #14.)

11. CHECK THE CLIENT'S POSITION. Legs should be uncrossed, feet resting firmly on the floor and the back supported while blood pressure is being measured. (Clients may need to be reminded to uncross their legs each time you are ready to take a blood pressure reading.)

12. INSERT the stethoscope earpieces, angled forward to fit snugly.

13. PLACE THE BELL OR THE DIAPHRAGM HEAD of the stethoscope <u>lightly</u> over brachial artery at the bend of the elbow, but with good skin contact. Avoid too much pressure, which can close off the vessel and distort the sounds, therefore altering the reading. (The bell head is preferred because it permits more accurate auscultation of the Korotkoff sounds than the diaphragm, especially in the interpretation of diastolic readings.)

14. INFLATE the cuff as rapidly as possible to maximum inflation level (MIL), calculated in Step #10 (30 – 40 mm Hg above estimated systolic pressure.)

15. DEFLATE THE CUFF SLOWLY and CONSISTENTLY at the rate of 2 mm per pulse beat. The rate of deflation should be slow enough to accurately evaluate the exact millimeter marking of the Korotkoff sounds. Once deflation has begun, never reinflate.

16. NOTE where the first sharp rhythmic sound appears in relation to the gauge's calibrations. This is the systolic pressure.

17. CONTINUE DEFLATION at the established rate. NOTE on the gauge where the last sound is heard. This is the diastolic pressure (5th Korotkoff phase) in adults.

18. CONTINUE DEFLATION for 10 mm Hg past the last sound. (This assures that the absence of sound is not a "skipped" beat but is the true end of the sound.) Then deflate the cuff rapidly and completely.

19. RECORD the readings to the nearest 1 mm Hg.

20. MAKE NOTATIONS of cuff, arm and position only if there are variations from the standard procedure of seated, regular cuff, right arm and fifth Korotkoff phase.

21. Reporting for READINGS where examiner has questions:
    A. When an auscultatory gap is heard (at least 2 initial beats, then absence of regular beats), do not record the first disappearance of sound as the diastolic reading. The sound will soon return as decompression of the vessel continues. The sound will finally disappear, indicating true diastolic.
    B. When sounds are too soft to be certain of either systolic or diastolic readings, "discard" this reading. Institute augmentation procedures on the next attempt. Always inflate the cuff to the MIL as rapidly as possible.

AUGMENTATION PROCEDURES

Have the client raise their arm prior to inflation to drain the blood from forearm. Inflate the cuff rapidly and then have the client lower his/her arm to the standard position. Apply the stethoscope immediately and begin deflation.

Or

After inflation, keep the valve closed and have the client clench fist 5-6 times. Then apply the stethoscope immediately and begin deflation.

REPEAT the measurement 30 seconds or more after the cuff is completely deflated. This allows for circulation to adequately return and permits a true reading.

NOTE: Mercury manometers are preferred because they are more accurate, easier to maintain and less likely to become decalibrated.

Source: (1) Michigan Department of Public Health and the Michigan Association for Local Public Health. *Promoting Cardiovascular Health in Michigan: Recommendations for Action*. pp 35-37, December 1991; (2) Perloff, Dorothea; Grim, Carlene; et.al..... "Human Blood Pressure Determination by Sphygmomanometry." AHA Medical/Scientific Statement: Special Report. *Circulation*. Vol. 88, No. 5, Part 1, November 1993. pp 2460-2470.

Procedure for Measuring Blood Pressure on Lower Arm

This procedure should **only be used if the upper arm is too large for a large adult cuff and an appropriate size cuff is not available**. This procedure is recommended only as a **last attempt** to get the best estimate of the blood pressure (BP) as possible.

The proportion of the bladder in the cuff to the lower arm should still meet the procedural guidelines outlined: the bladder width should be 40% and the bladder length should be 80% of the circumference of the lower arm.

Sometimes the diastolic reading may not be audible over the radial artery but the systolic at minimum could be recorded. Be sure you note that the BP was taken on the lower arm.

The procedure below is the same as the one used in the upper arm except for the changes noted in italics:

1. CHECK THE EQUIPMENT. Do not use if any problems are found.
   A. Look to see the gauge - mercury meniscus or aneroid needle is at zero. (Preferably, do not use an aneroid gauge with a stop-pin.)
   B. Check the cuff for any breaks in stitching or tears in the fabric.
   C. Check the rubber tubing for cracks or leaks, especially at connections
   D. Be sure three sizes of cuffs are accessible (small, regular, and adult large).
   E. Recommend 12-15 inch stethoscope tubing and bell/diaphragm stethoscope head.

2. PLACE THE MANOMETER so it can be viewed straight on and within 15 inches of the viewer.

3. RIGHT ARM will be used when possible. *Lower* arm should be bare and un-constricted by clothing. (You should be able to get at least one finger under a rolled up sleeve.)

4. SELECT THE APPROPRIATE SIZE CUFF. The bladder width should equal at least 40% of the circumference of the *lower* arm, and the length of the bladder should be 80% of the circumference of the arm, but no more than 100%. *Measure the circumference halfway between the wrist and elbow*.

5. PALPATE the location of the *radial* artery.

6. POSITION the center of the cuff's bladder over the *radial* artery.

7. APPLY THE CUFF evenly and snugly one-inch (2.5 cm) above the *radial artery* at the wrist. CHECK SNUGNESS at both the top and bottom of the cuff.

8. POSITION THE ARM so the cuff is at heart level. The *forearm* should *be* supported on a table, slightly abducted and bent, with palm up.

9. For the first reading only, OBTAIN ESTIMATED SYSTOLIC PRESSURE.
   A. Palpitate the radial artery pulse.
   B. Inflate the cuff to the point where the pulse can no longer be felt.
   C. Slowly deflate the cuff, noting on the gauge the point where the pulse reappears/can again be felt. This is the estimated systolic pressure.
   D. Rapidly deflate the cuff. Wait at least 15-30 seconds before re-inflating the cuff to begin the

first auscultatory measurement. (This allows good circulation to be reestablished.)

10. CALCULATE the maximum inflation level (MIL) by adding 30 mm Hg to the estimated systolic pressure. (This figure will be used in step #14)

11. CHECK THE CLIENT'S POSITION. Legs should be uncrossed, feet resting firmly on the floor and the back supported while blood pressure is being measured. (Clients may need to be reminded to uncross their legs each time you are ready to take a blood pressure measurement.)

12. INSERT the stethoscope earpieces, angled forward to fit snugly.

13. PLACE THE BELL OR THE *PEDIATRIC* DIAPHRAGM HEAD of the stethoscope <u>lightly</u> over the *radial* artery, but with good skin contact. Avoid to much pressure, which can close off the vessel and distort the sounds, therefore altering the reading. (The bell head is preferred because it permits more accurate auscultation of the Korotkoff sounds that the diaphragm, especially in the interpretation of diastolic readings.)

14. INFLATE the cuff as rapidly as possible to maximum inflation level (MIL), calculated in Step #10 (30 mm Hg above estimated systolic pressure.)

15. DEFLATE THE CUFF SLOWLY and CONSISTENTLY at the rate of 2 mm per pulse beat. The rate of deflation should be slow enough to accurately evaluate the exact millimeter marking of the Korotkoff sounds. Once deflation has begun, never re-inflate.

16. NOTE where the first sharp rhythmic sound appears in relation to the number or markings on the gauge. This is the systolic pressure.

17. CONTINUE DEFLATION at the established rate. NOTE on the gauge where the last sound is heard. This is the diastolic pressure (5th Korotkoff phase) in adults.

18. CONTINUE DEFLATION for 10 mm Hg past the last sound. (This assures that the absence of sound is not a skipped beat but is the true end of the sound.) Then deflate the cuff rapidly and completely.

19. RECORD the readings to the nearest 2mm (round to an even number). This means all readings take with non-electronic equipment will be stated and written in even number.

20. MAKE NOTATIONS of cuff, arm and position only if there are variations from the standard procedure of seated, regular cuff, right arm and fifth Korotkoff phase. *Be sure to note lower arm used.*

21. Reporting for READINGS where examiner has questions:
    A. When an auscultatory gap is heard (at least 2 initial beats, then absence of regular beats), do not record the first disappearance of sound as the diastolic reading. The sound will soon return as record as decompression of the vessel continues. The sound will finally disappear, indicating true diastolic.
    B. When sounds are too soft to be certain of either systolic or diastolic readings, discard this reading. Institute augmentation procedures on the next attempt. Always inflate the cuff to the MIL as rapidly as possible.

AUGMENTATION PROCEDURES

Have the client raise the arm prior to inflation to drain the blood from forearm. Inflate the cuff rapidly and then have the client lower his/her arm to the standard position. Apply the stethoscope immediately and begin deflation.

Or

After inflation, keep the valve closed and have the client open and close her/his fist 5-6 times. Then apply the stethoscope immediately and begin deflation.

22. REPEAT the measurement 30 seconds or more after the cuff is completely deflated. This allows for circulation to adequately return and permits a true reading.

Note: Use the same BP classification levels for high and normal cut off points.

Source (1) Michigan Department of Public Health and the Michigan Association for Local Public Health. *Promoting Cardiovascular Health in Michigan: Recommendation for* Action. pp 35-37, December 191; (2) Perloff Dorothea; Grim, Carlene; et.al... A Human Blood Pressure Determination by Sphygmomanometry.@ AHA Medical/Scientific Statement: Special Report. *Circulation.* Vol. 88, No.5, Part 1, November 1993. Pp 2460-2470; (3) The Sixth Report of the Joint Committee on Detection, Evaluation and Treatment of _High Blood Pressure (NIH Publication No. 98-4080, November, 1997. (4) Consultation with Grim, Clarence and Carlene. December 22, 2000.

g:bplowerarm.12-00

CHOLESTECH® BLOOD COLLECTION BY FINGER PUNCTURE FOR CHOLESTEROL AND GLUCOSE

Purpose: To safely obtain a viable whole blood capillary specimen for processing in the Cholestech LDX System® maintaining the standards required by Occupational Health and Safety Administration (OSHA), Clinical Laboratories Improvement Amendments (CLIA'88), and clinical practices.

CLIA regulations are based on the test complexity, and are classified as waived, moderate complexity, or high complexity. Facilities performing only waived tests have no routine oversight or personnel requirements and are only required to obtain a Certificate of Waiver, pay fees and follow the manufacturer's requirements. Health Departments and other facilities must follow the requirements of the policies of their laboratory director.

I. Background and Exposure Control

a) Facilities providing services that could result in contact with human blood or other potentially infectious material must have an "OSHA-Bloodborne Pathogen Exposure Control Plan" (BPECP) outlining tasks, procedures, assigned job classifications according to exposure risk (Category A or B), engineering controls, universal precautions, and personal protective equipment (PPE) required to decrease the risk of their employees' exposure to any blood borne pathogen.
b) Category A employees perform procedures or tasks conducted in routine situations as a condition of employment that could result in exposure to human blood or other infectious material. Employers must offer the Hepatitis B vaccine series, boosters, and antibody testing to Category A employees. If the employee initially declines, the employer must provide the vaccine if an employee changes their mind and is still in Category A.
c) Category A employees must be provided OSHA-approved lancets* and specific training as established in the Facility's BPECP on OSHA's standard "Occupation Exposure to Bloodborne Pathogens " before beginning to test and annually thereafter.

***OSHA Approved Lancets*
Authority: The Department of Consumer and Industry Services: Occupational Health Standards—Bloodborne Infectious Diseases by the authority conferred on the director of the department of consumer and industry services by: [sections 14 and 24 of 1974, PA 154, MCL 408.1014 and 408.1024, and Executive Reorganization Order Nos. 1996-1 and 1996-2, MCL 330.3101 and 4454.2001]
**** <u>Category A,</u> non-managerial, employees, annually, shall have direct input, documented in the "BBECP", into the <u>identification, evaluation, and selection</u> of effective engineering and work practice controls including commercially available and effective safer medical devices designed to eliminate or minimize occupational exposure, including improved technology (self-retracting lancets, needleless systems, etc.)***

II. Exposure Avoidance

a) Universal precautions (a method of infection control that treats all human blood and other potentially infectious
b) Material as capable of transmitting, HIV, HBV, and other blood borne pathogens) must be followed.
c) Place sharps container close to the collection site and place contaminated lancet into the container immediately after use. Dispose of all blood collection materials and cassettes in a biohazard waste container immediately after use following the facility's BPECP. Wear intact gloves at all times during the procedure, in addition to lab coat and other personal protective equipment as indicated.

d) Any blood spill should be cleaned immediately with a 10% bleach solution or other approved blood borne pathogen disinfectant.
e) Materials for each client's specimen should be placed on a clean, non-permeable and absorbent surface such as a small waterproof towel.

III. Machine and Work Area Preparation

Work surface should be clean and sanitary, without direct heat or bright light, and at room temperature (68-86˚F)
Set-up machine according to the "*Cholestech User Manual®. Page 9, Getting Started".* Available online at: www.cholestech.com

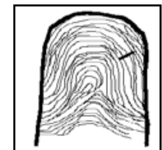
IV. Materials and Equipment:

a) 10% bleach solution or other disinfectant approved for blood-borne pathogens
b) 70% isopropyl alcohol or alcohol swab
c) Cotton balls, or gauze
d) Blood lancets and/or lancet device for skin punctures
e) Capillary tubes and Micropipettes
f) Cholestech® LDX Machine Analyzer, test cassettes, Optics check cassette
g) Water-proof towels/drapes
h) Power source
i) Quality control serum vials (high and low) and recording records
j) Personal protective equipment
k) Sharps containers and biohazardous waste containers
l) Hand gel or sink
m) Band-Aids (Optional)

V. Client Specimen Collection and Testing

Read the procedures in the Cholestech LDX User Manual® and Product Insert Instructions for testing patient samples.

a) Check signed consent for testing and HIPAA Privacy Statement if applicable. Identify the patient, and explain the procedure to them.
b) Assess the warmth/circulation of the patient's fingers and choose a site. The third or fourth (middle or ring) finger on the non-dominant hand is preferred for finger sticks. Do not use a finger with calluses and/or a wound. If improvement in circulation is needed, have the patient rub their hands together or hold below the level of their heart for a few minutes.
c) Choose a site that is on the side of the fingertip midway between the edge and midpoint of the fingertip. (see drawing)



d) Wash your hands before you put on your gloves. Hand disinfectant gels are acceptable unless the facility policies state otherwise.
e) Cleanse the client's finger with alcohol from a wipe or cotton ball for 15-30 seconds, rubbing vigorously. Wipe excess alcohol with sterile gauze let dry or it will sting and potentially make the reading inaccurate.
f) Using a sterile, OSHA-approved* blood lancet, make a deep enough puncture (1.5mm) to form a free-flowing drop of blood. A deep puncture will avoid needing to re-puncture.
g) To assure an accurate reading, squeeze the finger from the base moving to the top, DO NOT MILK the finger or allow air bubbles to collect in the capillary tube.

h) Hold the capillary tube horizontally by the end with the plunger. Insert the capillary tube tip in the drop of blood. The tube will fill by capillary action up to the black mark. Perform the filling of the tube within 10 seconds of the puncture to assure a good specimen.
i) If another drop of blood is needed and the same puncture site is viable, wipe the finger with gauze, and squeeze until a large drip of blood forms. If you can not obtain a large enough drop, choose another site, disinfect and re-puncture. It is not necessary to re-glove at this point if the gloves are intact.
j) Wipe off any excess blood and ask the patient to apply pressure to the puncture until the bleeding stops. Apply a band-aid to the site to prevent contamination.
k) Using the plunger, dispense the entire blood sample from the micropipette, into the cassette as soon as possible.
l) Once you have placed the sample into the cassette well, place the cassette in the drawer and press RUN immediately.
m) Dispose of lancet and capillary tube into the sharps container and other materials and into a biohazard waste container or as directed by the BPECP.
n) Remove gloves pulling one over the other, turning the contaminated side inside out.
o) Give the client the written result and counsel or send to the next station for counseling.
p) Put on a fresh pair of gloves for the next client.
q) At the end of the session, clean entire area and wipe down countertops with the 10% bleach solution or other designated disinfectant. Clean machine according to the manufacturer's instruction. Dispose of biohazardous materials container and sharps according to the facility's BPECP.

Analysis of Blood Sample

Follow manufacturer's instructions. *Cholestech User Manual® Testing Procedure".* Available online at: www.cholestech.com

Quality Control

Quality control practices assure that the system is working properly and giving dependable results. Good laboratory practice principles suggest that in addition to routine testing, (a-c below), external controls must be run if there is any question of the system integrity or operator technique, for example, if reagent storage or handling or when the machine operators have not performed a test in recent weeks.

a) Optics Check must be run on every day of testing before the first test is done.
b) Controls must be run each time a new lot of cassettes is opened.
c) Controls must be run anytime there is a question about the cassettes being stored properly.
d) The Cholestech LDX is a waived CLIA test so external proficiency tests are not required in the law; however, they are recommended and may be required by the laboratory director.
e) See facility policies for all lab related recording forms, corrective action plans, and other facility-specific requirements.

Refer to the Cholestech User Manual®. Quality Control, Available online at: www.cholestech.com

References:

- Cholestech ® Technical Service 1-800-733-0404
  Manufacturer's Website: www.cholestech.com
- Web-based MDCH Laboratory Procedure #RL.04.01
  http://www.michigan.gov/documents/RL_135815_7.04.01_Specimen_Collection_Blood_by_Finger_Puncture.doc

- OSHA-"Occupation Exposure to Bloodborne Pathogens" (29CFR 1910.1030)
- CMS CLIA Resource: http://www.cms.hhs.gov/clia/
- FDA CLIA Resource: http://www.fda.gov/cdrh/clia/
- HIPAA: http://www.hhs.gov/ocr/hipaa/
- MMWR-Recommendations and Reports Good Laboratory Practices for Waived Testing Sites [11/11/2005/Vol.54/No., RR-13]

WISEWOMAN/Wise Choices Program Procedure

Clinical Laboratory Improvement Amendments of 1988

General Program Description

Congress passed the Clinical Laboratory Improvement Amendments (CLIA) in 1988 establishing quality standards for all laboratory testing to ensure the accuracy, reliability and timeliness of patient test results regardless of where the test was performed. A laboratory is defined as any facility which performs laboratory testing on specimens derived from humans for the purpose of providing information for the diagnosis, prevention, treatment of disease, or impairment of, or assessment of health. CLIA is user fee funded; therefore, all costs of administering the program must be covered by the regulated facilities, including certificate and survey costs.

The final CLIA regulations were published on February 28, 1992 and are based on the complexity of the test method; thus, the more complicated the test, the more stringent the requirements. Three categories of tests have been established: waived complexity, moderate complexity and high complexity. CLIA specifies quality standards for proficiency test (PT), patient test management, quality control, personnel qualifications and quality assurance for laboratories performing moderate and/or high complexity tests. Waived laboratories must enroll in CLIA, pay the applicable fee and follow manufacturers' instructions. Because problems in cytology laboratories were the impetus for CLIA, there are also specific cytology requirements.

The Centers for Medicare & Medicaid Services (CMS) is charged with the implementation of CLIA, including laboratory registration, fee collection, surveys, surveyor guidelines and training, enforcement, approvals of PT providers, accrediting organizations and exempt states. The Centers for Disease Control and Prevention (CDC) is responsible for the CLIA studies, convening the Clinical Laboratory Improvement Amendments Committee (CLIAC) and providing scientific and technical support/consultation to DHHS/CMS. The Food and Drug Administration is responsible for test categorization.

To enroll in the CLIA program, laboratories must first register by completing an application, paying fees, being surveyed, if applicable, and becoming certified. CLIA fees are based on the certificate requested by the laboratory (that is, waived, PPM, accreditation, or compliance) and, for moderate and high complexity laboratories, the annual volume and types of testing performed. Waived and PPM laboratories may apply directly for their certificate as they aren't subject to routine inspections. Those laboratories that must be surveyed routinely; i.e., those performing moderate and/or high complexity testing, can choose whether they wish to be surveyed by CMS or by a private accrediting organization. The CMS survey process is outcome oriented and uses a quality assurance focus and an educational approach to assess compliance.

CLIA and WISEWOMAN/Wise Choices

The Cholestech LDX System is in the **waived category**. All users of waived tests are required to register with CMS and obtain a **CLIA Certificate of Waiver**. Many local health departments in Michigan are part of the Regional Lab System that the Michigan Department of Community Health oversees. If the cholesterol and glucose screening are to take place at a health department that is part of the Regional Lab System, it is important to confirm that a suitable CLIA certificate has been obtained. If the cholesterol and glucose screening are to take place through an agency other than a local health department, the application for the Certificate of waiver can be obtained through the CMS website, **http://www.cms.hhs.gov/clia/** .

Alert Value Case Management

- If a program participant's blood pressure measurement falls into the alert range, they will receive Alert Value Case Management (Less than 3% of program participants will have values in the alert range.)
  Alert values are:
  - Average Blood Pressure **greater than 180** (systolic) **and/or greater than 110** (diastolic)
- For each person who qualifies for Alert Value Case Management:
  - Set up an appointment for medical evaluation within 7 days from the date of the screening
  - Complete a Case Management Form
  - Fax the completed form to MDHHS within five business days after the Resolution Date (MDHHS staff will enter the appropriate data and authorizations into the MBCIS WISEWOMAN/Wise Choices module)
- For a Participant Status of *Complete*:
  - Assist the program participant with addressing barriers to ensure they attend a medical evaluation
  - If the participant attends the medical evaluation after 7 days, the case manager must document the reason for not meeting the deadline
  - Obtain information about the treatment prescribed and document it on the Case Management form
  - Record the date of the medical evaluation as the Resolution Date on the Case Management form
- For a Participant Status of *Refused referral*:
  - Record the date the participant refused as the Resolution Date on the Case Management form
  - Document the client's reason for refusal on the Case Management form
- For a Participant Status of *Lost to Follow-up*:
  - Document three unsuccessful attempts to contact the participant by phone
  - Document the date a letter was sent to the participant
  - If the participant does not respond to the letter within 14 days, they will be considered Lost to Follow-up
  - Record the date the participant was considered Lost to Follow-up as the Resolution Date on the Case Management form
- For a Participant Status of *Noncompliant*:
  - Document three contacts with or attempts to contact the participant
  - Document the reasons the participant gives for not attending the Medical Evaluation
  - If the participant does not attend the medical evaluation within 14 days after the third contact, they will be considered Noncompliant

  - Record the date the participant was considered Noncompliant as the Resolution Date on the Case Management form

- Alert Value Case Management concludes when the program participant attends the medical evaluation, refuses the referral, is determined to be lost to follow-up, or is determined to be noncompliant
- Once Alert Value Case Management concludes, the program participant will receive health coaching services (The Health Coach should encourage the participant to follow-through with medical care and indicated treatment)
- The organization may bill once during each cycle for reimbursement of Alert Value Case Management services provided to an eligible program participant with a participant status of *Complete*

WISEWOMAN/Wise Choices Screening and Referral Guidance

Health Intake and Clinical Screening

Baseline/Rescreening

At intake WISEWOMAN/Wise Choices staff will:

- Collect answers to Health Intake questions to assess personal medical history and current health behaviors of participant
- Measure height, weight, blood pressure, lipids, and A1c
    - Please note, if participant has had the measurements assessed by their primary care physician within 30 days prior to intake appointment, you do **not** have to do a reassessment. You must, however, get a copy of clinical results and input information into MBCIS within 30 days.
- Conduct risk reduction counseling
- Refer for medical evaluation as needed based on the clinical screening results

Follow Up

At follow up (<u>between 3-11 months after Baseline/Rescreening</u>):

- Collect answers to follow-up questions
- Measure weight and blood pressure
- Measure lipids and/or A1C if elevated at Baseline/Rescreening
- Conduct Outcome Evaluation

Body Mass Index

- **Obese:** BMI ≥30 Consider as risk factor for CVD.
    - No referral for Medical Evaluation
- **Overweight:** BMI 25.0-29.9
    - No referral for Medical Evaluation
- **Normal:** BMI 18.5-24.9
    - No referral for Medical Evaluation
- **Underweight**: BMI <18.5
    - No referral for Medical Evaluation

Blood Pressure Screening

Agency staff conducting the Blood Pressure Screening must follow the Procedures for Measurement of Blood Pressure and Procedure for Measuring Blood Pressure on Lower Arm included in the WISEWOMAN/Wise Choices Program Clinical Screening Procedures.

- **Alert:** >180 (systolic) **and/or** >110 (diastolic) (Alert Value Case Management)
    - Refer for Medical Evaluation – Participant should be seen **immediately or within 1 week** depending on clinical situation and complications
    - Provide team-based care
- **Stage 2 Hypertension:** 160-180 (systolic) **and/or** 100-110 (diastolic)
    - Refer for Medical Evaluation
    - Provide team-based care
- **Stage 1 Hypertension:** 140-159 (systolic) **and/or** 90-99 (diastolic)

  - Refer for Medical Evaluation
  - Provide team-based care
- **Prehypertension:** 120-139 (systolic) **and/or** 80-89 (diastolic)
  - No referral for Medical Evaluation
- **Normal:** <120 (systolic) **and** <80 (diastolic)
  - No referral for Medical Evaluation

Lipid Panel Screening

1. Screening for Total, HDL, and LDL cholesterol, and Triglycerides must be done using a Cholestech LDX, for immediate receipt of results.

2. Agency staff conducting the Cholesterol Screening must follow the Cholestech® Blood Collection by Finger Puncture for Cholesterol and Glucose included in the WISEWOMAN/Wise Choices Program Clinical Screening Procedures.

3. Agency staff responsible for maintaining the Cholestech® LDX Analyzer must follow the Quality Control procedures outlined in the WISEWOMAN/Wise Choices Program Clinical Screening Procedures

4. Handling error messages or "out of range" values when using the Cholestech machine.
   a. If you receive an error message saying, "Reaction Did Not Occur," repeat the test with a new cassette and a new finger stick sample. If the message reappears, refer the participant for a fasting lipid panel at a participating laboratory.
   b. For any of the following out of range values, refer for a fasting lipid panel at a participating laboratory if the LDX displays:
      i. Total Cholesterol: *<100 mg/dl* or *>500 mg/dl*
      ii. HDL: *<15 mg/dl, >100 mg/dl,* or *N/A*
      iii. LDL: *N/A*
      iv. Triglycerides: *<45 mg/dl* or *>650 mg/dl*
   c. When entering the Screening Results in the WISEWOMAN/Wise Choices module of MBCIS, leave the results that you did not obtain blank. Put a note in the Screening Notes saying "Unable to Obtain Cholesterol/HDL/Glucose Results. Referred for fasting lipid panel." Send an email to MiWISEWOMAN@michigan.gov with ONLY the MBCIS number of the participant (no personal identifiers) and a note. MDHHS will authorize the screening bundle.

Total Cholesterol

- **High:** ≥ 240 mg/dL
  - Referral based on LDL
- **Borderline High:** 200-239 mg/dL
  - Referral based on LDL
- **Normal:** <200 mg/dL
  - Referral based on LDL

HDL Cholesterol

- **Undesirable:** <40 mg/dL
    - If LDL is ≥ 160, refer for Medical Evaluation **if not currently being treated for high cholesterol**
- **Desirable:** 40-59 mg/dL
    - No referral for Medical Evaluation
- **Very Desirable:** ≥60 mg/dL
    - No referral for Medical Evaluation

LDL

- **High:** ≥160 mg/dL
    - Refer for Medical Evaluation **if not currently being treated for high cholesterol**
- **Borderline High:** 130 – 159 mg/dL
    - No referral for medical evaluation
- **Normal:** ≤ 129 mg/dL Fasting
    - No referral for medical evaluation

Triglycerides

- **Severe:** Fasting ≥ 500 mg/dl
    - Refer for medical evaluation
- **High:** ≥400 mg/dl and < 500 mg/dl
    - If not fasting, refer for fasting lipid panel at a participating laboratory
    - Refer for medical evaluation if LDL in fasting lipid panel ≥160
- **Acceptable:** ≥175 mg/dl and ≤399 mg/dl
    - No referral for medical evaluation
- **Desirable**: < 175 mg/dl
    - No referral for medical evaluation

A1c

All participants should receive an A1c analysis using the Alere Afinion® Analyzer.

Participants with a history of Diabetes

- **Elevated**: > 7%
    - Refer to provider treating diabetes to discuss glucose control
    - If not currently seeing a provider, refer for Medical Evaluation
- **Desirable:** ≤ 7%
    - No referral for Medical Evaluation

Participants with no history of Diabetes

- **Elevated**: ≥ 6.5%
    - Refer to laboratory for Fasting Plasma Glucose or A1c
    - If laboratory values are elevated, refer for medical evaluation.
- **Increased Risk**: 5.7-6.4%

    - Refer to Diabetes Prevention Program
- **Desirable**: < 5.7%
    - No referral for Medical Evaluation

Participant Readiness to Change

- **Participant is not ready to make changes**
    - No referrals to community resources required
- **Participant is ready to make changes**
    - Conduct Expanded Health Coaching
        - Includes one-on-one goal setting and follow-up contacts
        - May refer to an evidence-based lifestyle program to support goal
            - Taking Off Pounds Sensibly (TOPS)
            - Diabetes Prevention Program (DPP)
            - Cooking Matters
            - WISEWOMAN Entrepreneurial Gardening Program
            - MDHHS Tobacco Quitline
        - May refer to community-based program to support goal
            - Supplemental Nutrition Assistance Program Education (SNAP-Ed)
            - Walking group
            - Michigan State University Extension (MSUE) Nutrition Programming
            - YMCA
            - Other community-based programs identified in the Community Scan

Health Coaching

Health Coaching is a Centers for Disease Control and Prevention (CDC) WISEWOMAN approved evidence-based strategy for improving health. Health Coaches work with WISEWOMAN and Wise Choices participants to identify and set small steps toward healthy behavior change using motivational interviewing, goal setting, and active listening. Health Coaches focus on building one-on-one relationships with participants and becoming mentors.

Health Coaches take a holistic view. They understand and respect participant's work and home routines, personal relationships, and emotional lives, knowing they combine to shape overall health. Health Coaches know "one size fits all" doesn't work. Instead, they encourage small steps, that emphasize the participant's unique needs.

They are supportive allies who help track a participant's progress, identify and help participants access all potential resources and supports, and break down external and internal barriers standing between the participant and better health.

WISEWOMAN/Wise Choices Health Coaching includes:

Risk Reduction Counseling

Each participant receives risk reduction counseling at the time of screening using the WISEWOMAN or Wise Choices ***My Health Information*** pamphlet geared to low or marginal literacy readers. The pamphlet defines and identifies the participant's Body Mass Index (BMI), blood pressure, total cholesterol, High-Density Lipoprotein (HDL) cholesterol, Low-Density Lipoprotein (LDL), Hemoglobin A1c, and other risk factors.

The risk reduction counseling component includes:

- Assessing the participant's current risk factors by reviewing the My Health Information pamphlet with the participant.
- Advising the participant about the meaning of their risk factors and the importance of taking small steps toward better health.

Readiness to Change

The Health Coach will determine every participant's readiness and confidence to make lifestyle changes based on the ***Readiness Ruler*** and application of Stages of Change theory.

A participant should report at least a 7 on the Readiness Ruler in order to set a goal or small step. For participants reporting less than a 7, the Health Coach should focus on identifying what it would take for them to be a 7 on the readiness ruler and addressing those factors.

Not Ready to Make Change

For participants who are not ready to make changes, the Health Coach will:

- Talk with the client using good Motivational Interviewing techniques
- Provide the participant with health education information related to their risk factors and information about community resources

Ready to Make Change

For participants who are ready to make changes the Health Coach will:

- Guide the participant in setting a small step (see below) using the ***Participant Agreement*** form.

Setting a Small Step

For participants who are ready to make a change the Health Coach will:

- Talk with the participant using good Motivational Interviewing techniques
- Encourage the participant to identify one priority area. The priority areas include:
    - Medication Adherence
    - Nutrition
    - Physical activity
    - Smoking cessation
- Work with the participant to set a small step related to their chosen priority area using the information from the WISEWOMAN or Wise Choices ***Health Intake*** forms.
- Encourage the participant to focus on setting a small step they are interested in achieving
- The small step should be
    - Specific (focus on one priority area)
    - Measurable (i.e. eat one more vegetable a day, walk 10 minutes a day)
    - Attainable (make it a small step, not a huge leap)
    - Relevant (it should be something the participant wants to do)
    - Time-Bound (i.e. do it every day for two weeks)
- Help the participant set a plan that covers who, where, when, what, and how

Healthy Behavior Support Services

Healthy behavior support services (HBSS) are evidence-based interventions, practices, or programs that have peer-reviewed, documented evidence of effectiveness helping people make and maintain healthy changes. (Record all HBSS contacts, classes, and meetings in the MBCIS WISEWOMAN/Wise Choices module)

Health Coaching

For participants who are ready to make changes the Health Coach will:

- Make regular contact with the participant to encourage success with the small step
- The first contact should take place within one week and no more than two weeks after the participant sets a small step.
- Document each contact using the ***WISEWOMAN or Wise Choices Contact Form***

- Provide assistance, as appropriate, to help the participant overcome barriers to successfully reaching the small step
- Help the participant set a new small step as the participant reaches and feels comfortable with the previous small step
- Provide additional educational materials and referrals to appropriate community resources related to the small step
- Make promotional contacts, such as calling a participant to talk about Market Fresh coupons

Diabetes Prevention Program (DPP)

The DPP is a program for participants identified with pre-diabetes to help prevent or delay the onset of type 2 diabetes. It includes 16 weekly classes and monthly follow-up for eight months

See Diabetes Prevention Program Referral Protocol for more information.

Take Off Pounds Sensibly (TOPS)

TOPS is a weight loss support and wellness education program based in the community.

See Take Off Pounds Sensibly (TOPS) Referral Protocol for more information

Cooking Matters

Cooking Matters was created to empower low-income individuals and families with the skills they need to stretch their food dollars and maximize the benefits received through public nutrition programs like SNAP and WIC.

- Equips participants with the knowledge and tools necessary to move toward a healthier lifestyle
- Teaches participants how to shop economically
- Focuses on a variety of topic areas such as
  - Selecting and preparing fresh produce
  - Making a shopping list
  - Reviewing nutrition labels
  - Using the same ingredients to make different recipes

Local Community Resources

Each community has unique free resources that can help the participant achieve their small step. WISEWOMAN/Wise Choices participants should be referred to appropriate free/low cost community programs to support identified small steps. In the absence of local community programming, agencies are encouraged to work with community partners to develop programming to meet the WISEWOMAN/Wise Choices participant's health needs and those of other community members.

- Assist participant in identifying and connecting with community resources and programs to support them in being successful at achieving the small step
- Provide participant with health education information to support efforts at behavior change

Outcome Evaluation Contact

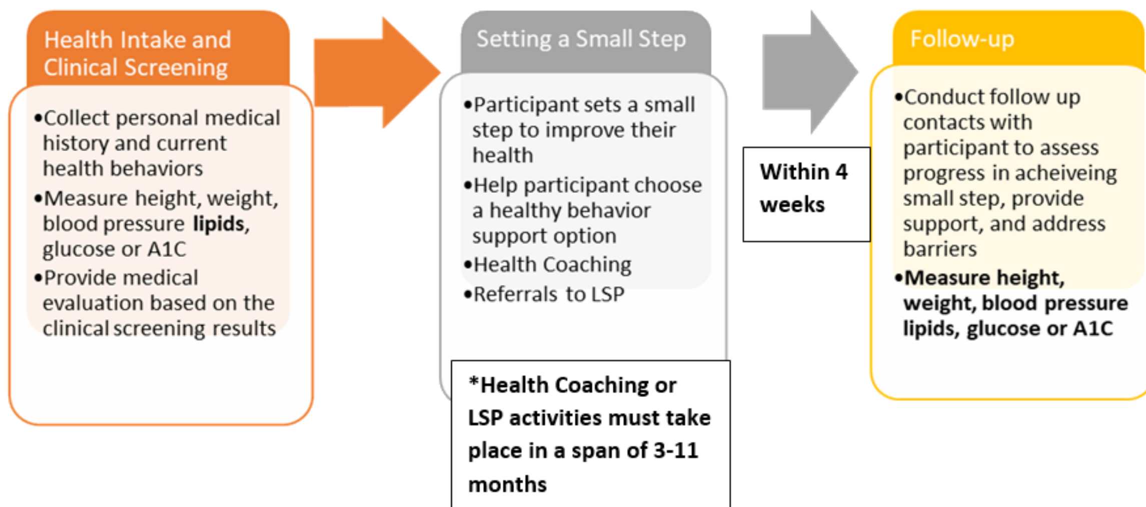
The outcome evaluation contact is required for participants who are ready to make change, have established a small step, and have completed Health Coaching or another Healthy Behavior Support Service. The purpose of the contact is to assess progress and reinforce changes made. Outcome Evaluation must take place **no earlier than 3 months and no later than 11 months after screening. It should also take place within 4 weeks of completing Health Coaching or HBSS.**

What is Considered Complete? (Document all contacts, classes, and meetings in the MBCIS WISEWOMAN/Wise Choices module)

- Health Coaching – at least five (5) Health Coaching contacts after the Participant Agreement is completed
- Diabetes Prevention Program – At least nine (9) classes
- TOPS – At least twelve (12) meetings
- Cooking Matters – At least four (4) classes
- Michigan Tobacco Quitline – When contacted by Quitline to say participant completed

Completing the Outcome Evaluation Contact

- The outcome evaluation contact will be face-to-face with the participant to assess biometric measurements and lifestyle changes including height, weight, blood pressure lipids, glucose or A1C
- The Outcome Evaluation Contact form should not be sent to the participant to complete.
- For participants referred to a Healthy Behavior Support Service outside the clinic, the Health Coach will track when the participant completes the program. Immediately follow up with the program to determine attendance, graduation, and outcomes documented by the program.
- Please see figure below to understand flow with outcome evaluation.



Rewards

- Rewards such as Market Fresh coupons are only provided to participants who are ready to make change and have set a small step.
- Rewards provided by the Michigan Department of Health and Human Services (MDHHS) may be used to motivate program participants to make healthy lifestyle changes and assist with successful goal attainment. Agencies can determine how to use the rewards to best meet the needs of program participants.

Other Health Coaching Requirements

Tracking and Quality Improvement

- Local WISEWOMAN/Wise Choices program staff will develop and maintain a tracking system to ensure each program participant receives an appropriate number of health coaching contacts according to motivation
- MDHHS will provide agencies access to Discoverer reports for use in tracking participant progress. These reports should be used in conjunction with the agency's tracking system
- Health Coaches will participate in the WISEWOMAN/Wise Choices Quality Improvement Process by:
  - Reviewing quality improvement reports at least monthly
  - Participating in quarterly quality improvement conference calls with MDHHS staff

Training and Professional Development

All local WISEWOMAN/Wise Choices program Health Coaches will:

1) Be trained by WISEWOMAN/Wise Choices staff from MDHHS.

2) Be trained in Motivational Interviewing. MDHHS will make Motivational Interviewing Training available at least once per year.

3) Maintain regular and timely communication with the MDHHS Intervention Specialist. This will allow the Intervention Specialist to provide Health Coaches with new information related to health coaching, community resource development and to assess the changing needs of the Health Coach.

4) Take part in training and professional development provided by MDHHS. These include:
   a. Annual Meeting
   b. Conference calls, such as quarterly Quality Improvement calls
   c. Special trainings provided by MDHHS
   d. Motivational Interviewing videos on WISEWOMAN website

5) Take part in other training and professional development opportunities throughout the year. Health Coaches will keep track of the training and professional development they take part in and report them to MDHHS at the end of each fiscal year using the ***Continuing Education Tracking*** form.

Community Scan

The Health Coach will conduct a community scan of each community where WISEWOMAN or Wise Choices is offered. Community scans identify resources such as clinics, support groups, and programs able to help participants make healthy behavior changes to prevent or delay the onset of chronic conditions or to manage existing chronic conditions.

WISEWOMAN/Wise Choices Home Blood Pressure Monitoring Program Guidance

Overview

Self-measured blood pressure monitoring (SMBP) program, also known as home blood pressure monitoring, plus clinical support helps people with hypertension lower their blood pressure. SMBP is the regular measurement of blood pressure by the patient outside the clinical setting, either at home or somewhere else. SMBP requires the use of a home blood pressure measurement device by the participant to measure blood pressure at different points in time. *WISEWOMAN/Wise Choices agencies are responsible for purchasing blood pressure monitors for their participants.*

SMBP plus clinical support can improve access to care and quality of care for individuals with hypertension while making blood pressure control more convenient and accessible across the population. Clinical support includes regular one-on-one counseling, web-based or telephonic support tools, and educational classes.

Who qualifies for SMBP?

Current WISEWOMAN or Wise Choices participants with a measured blood pressure >140 mm HG systolic and /or 90 mm HG diastolic on the first and subsequent readings during an office visit. Agencies may consider additional criteria such as:

- ✓ The participant has elevated readings persisting for two or more subsequent office visits.
- ✓ The participant has the capacity to take an accurate measurement and willingness to take blood pressure readings consistently.
- ✓ The participant must be capable of documenting the readings if the loaner device does not have memory storage capability.
- ✓ The participant meets the above criteria and has expressed a desire to take blood pressure readings at home, but is unable to purchase a home blood pressure device.

What type of blood pressure monitor should my agency purchase?

Most WISEWOMAN programs in the country use Omron-brand upper arm monitors due to their accuracy and variable cuff sizes. Specific models that are being used include Omron 5 Series, 7 series, and 10 series (Model numbers: BP742N, BP760N, & BP785N).

Your agency may choose to purchase any type of monitor that fits the needs of your participants. Before you purchase any monitors – check the dabl© website: http://www.dableducational.org. It provides details on clinically validated monitors which are recommended for use. Make sure to purchase monitors that are recommended for self-measurement of blood pressure.

Last updated: 11/4/2019

Agencies should expect to spend about $40-80 on each blood pressure monitor. If the monitor requires batteries, please purchase and provide the participants with the appropriate size and number of batteries as well. All WISEWOMAN agencies should develop policies and protocols to track the blood pressure monitors that are purchased and given out to participants. MDHHS can request such logs for review at any time, for example during site visits. Contact MDHHS WISEWOMAN for more information.

Word from the Field

WISEWOMAN programs recommend purchasing larger cuffs to make available to participants.

Which type of monitor is better- upper arm or wrist?

Blood pressure measurements taken at the wrist are usually higher and less accurate than those taken at your upper arm. That's because the wrist arteries are narrower than and not as deep under your skin as those of the upper arm.

However, some people cannot have their blood pressure measured at the upper arm because they have a very large arm or find blood pressure measurements painful. In these cases, measuring blood pressure at the wrist is acceptable. It is the decision of each WISEWOMAN/Wise Choices agency to choose if they will purchase wrist monitors in addition to upper arm monitors. Before you purchase any monitors – check the dabl© website: http://www.dableducational.org.

Word from the Field

One WISEWOMAN program said keeping a sample monitor, along with several cuff sizes, allows participants to try it out and decide if they would like to enroll in SMBP.

Where can I find guidance for clinicians or clinics implementing the SMBP program?

- The American Medical Association and Johns Hopkins Medicine, is designed for use by physician offices and health centers to engage patients in SMBP. They include a sample blood pressure monitor loaner log, informational handouts for patients, and provider training materials.
    - Self-Measured Blood Pressure Monitoring Program: Engaging Patients in Self-Measurement

- Million Hearts published a guide to help clinicians implement SMBP in their practices by providing evidence-based action steps and resources.
    - Self-Measured Blood Pressure Monitoring: Action Steps for Clinicians

What are steps for enrolling WISEWOMAN/Wise Choices participants in SMBP?

- ✓ Provide details on the SMBP program
- ✓ Ask participant to sign SMBP agreement (refer to page 5)
- ✓ Enroll participant in Health Coaching and schedule follow-up contacts
    - Ideally, the health coaching sessions should occur on a weekly basis
- ✓ Calibrate machine
- ✓ Educate participant on how to take an accurate measurement of blood pressure using the monitor
    - **Infographic**: The American Heart Association offers tips for getting the most accurate blood pressure readings.
    - **Video**: The American Medical Association helps train care teams and patients on how to properly measure blood pressure. The video is also available in Spanish.
    - **Checklist**: *Target BP* has a comprehensive checklist for training participants to use their blood pressure monitor:
- ✓ Make sure the participant knows how to use the machine's history function or use a paper log to record each measurement.
    - Mobile apps can be useful in tracking and setting reminders to measure blood pressure. However, it should be noted that mobile apps should not be used to measure blood pressure. It is not as accurate as and is not a substitute for a cuff or other blood pressure monitor.
- Provide (or develop a plan for) education on lifestyle changes that can help lower blood pressure.
    - Handout: What Can I Do To Improve My Blood Pressure? English/ Spanish/ Traditional Chinese
    - The American Heart Association has free tools for managing blood pressure, including interactive tools, blood pressure tracking logs, educational resources (fact sheets and brochures), and an online support network.
- ✓ During each health coaching contact, record most recent blood pressure readings from in MBCIS.
    - See the "Contacts" tab or "Other contacts" tab
- ✓ Share results with the participant's provider

How can my agency integrate SMBP within our team-based care model?

Must Be Done by a Licensed Clinician	Can Be Done by a Non-licensed Person (e.g., medical assistant, local public health department, community health organization, community health workers)	Must Be Done by Patient
1. Diagnose hypertension 2. Prescribe medication(s) 3. Provide SMBP measurement protocol 4. Interpret patient-generated SMBP readings 5. Provide medication titration advice 6. Provide lifestyle modification recommendations	1. Provide guidance on home blood pressure (BP) monitor selection 2. If needed, provide home BP monitor (free or loaned) 3. Provide training on using a home BP monitor 4. Validate home BP monitor against a more robust machine 5. Provide training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log) 6. Reinforce clinician-directed SMBP measurement protocol 7. Provide outreach support to patients using SMBP 8. Share medication adherence strategies 9. Provide lifestyle modification education	1. Take SMBP measurements 2. Take medications as prescribed 3. Make recommended lifestyle modifications 4. Convey SMBP measurements to care team 5. Convey side effects to care team

Optional Tasks – Can be Done by a Non-licensed Person
1. Reinforce training on using a home BP monitor
2. Reinforce training on capturing and relaying home BP values to care team (e.g., via device memory, patient portal, app, log)

Where can I find additional resources?

- Million Hearts has gathered a collection of tools and protocols for clinicians as well as participants that might be helpful. It includes a collection of success stories of SMBP as well.
    - https://millionhearts.hhs.gov/tools-protocols/smbp.html
- National Association of Community Health Centers has a helpful guide for implementing SMBP that includes sample protocols, patient education handouts, tips for success and much more.
    - https://www.nachc.org/wp-content/uploads/2018/09/NACHC-Health-Care-Delivery-SMBP-Implementation-Guide-08222018.pdf

[INSERT AGENCY CONTACT INFORMATION]

WISEWOMAN HOME BLOOD PRESSURE MONITORING AGREEMENT

The Michigan WISEWOMAN Program is providing you with a blood pressure monitor at no charge. The monitor will help you track your blood pressure over the course of time in order to get your blood pressure under control. By accepting the Blood Pressure Home Monitor, you must understand and agree to the following.

A. I will be expected to:

1. Receive instruction on how to use the monitor and the proper techniques for taking my blood pressure at home
2. Take my blood pressure at home as directed by my health care provider
3. Record all of my blood pressure readings
4. Share all of my blood pressure readings with my health care provider.
5. Join in all follow-up office visits and/or blood pressure management health coaching sessions
6. Follow healthy eating and physical activity recommendations
7. Stop or reduce my use of tobacco products if I currently smoke
8. Keep the blood pressure monitor in a safe and secure place at home
9. Bring the monitor to my office visits to allow the provider to check it for accuracy

B. I understand:

1. That taking my blood pressure at home may help me get and keep my blood pressure under control
2. That all of my blood pressure readings will be shared with the WISEWOMAN provider and kept confidential
3. That my blood pressure readings will only be used for program administration and evaluation
4. That there is no cost to me for the Blood Pressure monitor
5. What I should do if my blood pressure reading(s) is too high or too low

Blood pressure device serial number: ____

I have read, understand, and agree to all of the items listed above.

SIGNATURE – Participant	Date Signed	Print Participant Name & MBCIS #
SIGNATURE – WISEWOMAN Provider	Date Signed	Print Name of Provider

WISEWOMAN/Wise Choices
Take Off Pounds Sensibly (TOPS) Referral

Establish a Relationship with the local TOPS Chapter(s)

When completing the Community Scan, identify the Take Off Pounds Sensibly (TOPS) Club chapter(s) in your community. Information about TOPS locations is available at: http://www.tops.org/

The Health Coach will contact all TOPS Club Chapters in their area to establish a relationship and a two-way referral process in order to track the participant's:

- Attendance
- Weight changes

Health Coaches are encouraged to attend each local meeting as a guest in order to get a better understanding of the meeting's culture and how best to refer participants.

TOPS Club Referral Criteria

A program participant may be referred to TOPS Club if they meet all the following criteria:

- Has a BMI ≥25
- Indicates a readiness to change
- Has access to TOPS Club Chapter meeting(s)
- Has attended one meeting and agrees TOPS Club is an appropriate option
- Commits to attending at least six chapter meetings each three month period for the first six months (12 meetings)

The Health Coach will:

- Work with the participant to complete the Participant Agreement and set a weight loss small step
- Work with the participant to complete the WISEWOMAN TOPS Membership Agreement
- Provide the participant with a list of local TOPS Club chapters
- Maintain regular contact with the participant to encourage regular attendance
  - If the they have trouble attending meetings, discuss barriers to participation
- Conduct an Outcome Evaluation Contact with the participant after they have attended TOPS Club meetings for six months

The participant will:

- Develop a Participant Agreement
- Complete and sign the WISEWOMAN/Wise Choices TOPS Membership Agreement
- Attend one free TOPS Club meeting
- Provide the Health Coach with the date and location of the TOPS meeting attended
- Redeem the membership voucher when they receive it in the mail
- Attend at least six chapter meetings during each three month period for six months
- Pay monthly chapter dues

WISEWOMAN/Wise Choices
TOPS Referral
Page 2

WISEWOMAN/Wise Choices
Take Off Pounds
Sensibly (TOPS) Flow
March 1, 2019

Screening Process

Participant is ready to change?
- No → Rescreening
- Yes ↓

Has BMI > 25 and wants to lose weight?
- No → Follow procedure for health coaching
- Yes ↓

Works with Health Coach to set weight loss goal
→ Bi-directional feedback involving Health Coach and TOPS → Receives voucher for one year membership
↓

Attends 1st meeting and agrees TOPS is an appropriate option?
- No → Follow procedure for health coaching
- Yes ↓

Receives voucher for one year membership
↓

Participant attends at least 6 meetings per 3 month period for the first 6 months?
- No → Discuss barriers to completion → Outcome Evaluation Contact
- Yes ↓

Outcome Evaluation Contact
Assess progress and reinforce goal
↓

Rescreening → Screening Process

WISEWOMAN/Wise Choices Diabetes Prevention Program Referral

Establish Relationship with Diabetes Prevention Program

When completing the Community Scan, determine if there is a Diabetes Prevention Program (DPP) in your community. Information about DPP locations is available at: http://www.midiabetesprevention.org.

If there is no local DPP, participants in that community will not have DPP as an option. There is no expectation for a WISEWOMAN/Wise Choices Agency to begin a Diabetes Prevention Program.

If there is a local DPP, the Health Coach will contact the Program to establish a relationship. The DPP and Health Coach will need to develop:

- A referral process that allows WISEWOMAN/Wise Choices participants to be referred to the DPP and a feedback mechanism to get information about the participant's attendance back to the referring agency.

Diabetes Prevention Program Referral Criteria

A program participant may be referred to a Diabetes Prevention Program if they meet all the following criteria:

- Has a BMI ≥24 kg/m2 (≥22 kg/m2, if Asian)
- Is identified with prediabetes **or** has a history of gestational diabetes mellitus (GDM)
- Indicates a readiness to change
- Agrees DPP is an appropriate option
- Has local access to a DPP

The Health Coach will:

- Work with the participant to complete the Participant Agreement and set a goal related to diabetes prevention
  - (Goal could be to complete the DPP)
- Refer the participant to the local DPP using the established referral process
- Maintain regular contact with the participant to encourage them to attend all sessions
  - If they have trouble attending sessions, discuss barriers to participation
- Conduct an Outcome Evaluation Contact with the participant after the 16 core sessions are over to assess progress and reinforce behavior change(s)
- Enter data from each class into MBCIS

The participant will:

- Develop a Participant Agreement
- Attend Diabetes Prevention Program sessions
- Complete the Diabetes Prevention Program
  - Complete means the participant attended at least 9 of 16 core sessions

WISEWOMAN/Wise Choices Diabetes Prevention Program Flow

March 1, 2019

WISEWOMAN/Wise Choices
Cooking Matters Program Referral

Establish Relationship with Cooking Matters Program

When completing the community scan, determine if there is a Cooking Matters host site in your community. Information about Cooking Matters is available at: http://www.cookingmattersmi.org/.

The Health Coach will contact community-based agencies in the area who host the Cooking Matters program to develop a relationship and a two – way referral process in order to track the participant's:

- Attendance

Cooking Matters Referral Criteria

A program participant may be referred to a Cooking Matters program if they meet the following criteria:

- Indicates a readiness to change
- Has access to a Cooking Matters program
- Agrees to attend at least 4 of the six 2 hours of class sessions over six weeks

The Health Coach will:

- Work with the participant to complete a participant agreement and set a small step
- Work with participant to complete the WISEWOMAN Cooking Matters Agreement
- Provide the participant with the list of Cooking Matters programs in the area
- Maintain regular contact with the participant to encourage regular attendance (If they have trouble attending meetings, discuss barriers to participation)
- Conduct an Outcome Evaluation Contact with the participant at the completion of the 6-week cohort.

The participant will:

- Complete a participant agreement
- Attend at least 4 of the six 2 hours of class over six weeks

REIMBURSEMENT

Only Current Procedural Terminology (CPT) Codes and HCPCS Codes included in the Current Fiscal Year WISEWOMAN/Wise Choices Unit Cost Reimbursement Rate Schedule are eligible for reimbursement. The most current Rate Schedule information is available at: http://www.miwisewoman.org/bill-reimburse.html

WISEWOMAN/Wise Choices Providers can bill for the following services for each program participant during each one-year cycle:

1) **ENROLLMENT BUNDLE**
CPT Code: 99450, ICD-10 Code: Z00.00, Rate: $75.00

Enrollment Form
Informed Consent Form
Health Intake Form (3 pages)
Screening Form – Height, Weight, Waist Circumference, Blood Pressure, Cholesterol, Glucose or A1c
Readiness Assessment
Completion of Risk Reduction Counseling
Referral for Medical Evaluation *
Referral for Lab Work **
Referral for Case Management ***
Set small step – Participant Agreement

2) **HEALTH IMPROVEMENT BUNDLE**
CPT Code: S9445, ICD-10 Code: Z71.9, Rate: $425.00

Health Coaching Contacts (5)
Track attendance and completion of referrals
- Diabetes Prevention Program (DPP) – 12 classes
- Taking off Pounds Sensibly (TOPS) – 9 classes
- Cooking Matters (CM) – 4 classes
- Entrepreneurial Gardening
- Other Community Resources

Follow-up Questions/Intake and Outcome Evaluation/Follow-up Screening

3) **IMPROVED OUTCOMES**
CPT Code: S0316, ICD-10: Z71.9, Rate: $100.00,
MDHHS Approved**

MDHHS will review the Follow-up Intake and Outcome Evaluation to see if there are any measurable improved outcomes. Some of the items that will be reviewed are:

Blood Pressure – decreased or under control
Weight – loss
Tobacco Use – substantial reduction or quit

Glucose/A1c – lowered

4) **ADDITIONAL HEALTH COACHING CONTACTS**
CPT Code: S0341, ICD-10 Code: Z71.9, Rate: $25.00 each

In addition to the BUNDLES, beginning March 2019 the following services are also available:

- * One Medical Evaluation Office Visit (see rate sheet for list of allowable codes) if screening results for blood pressure, cholesterol, and/or glucose warrant a referral. The Medical Evaluation must be entered into the MBCIS WISEWOMAN or Wise Choices module.
- ** One fasting lipoprotein panel (lipid panel) (CPT Code: 80061/80061QW) if cholesterol screening results warrant a referral. Lab results must be entered into the MBCIS WISEWOMAN/Wise Choices module.
- ** One follow-up fasting plasma glucose (FPG) (CPT Code: 82947/82947QW) if glucose screening results warrant a referral or if participant is not fasting at the initial WISEWOMAN/Wise Choices screening. Lab results must be entered into the MBCIS WISEWOMAN/Wise Choices module. (If participant requires both a fasting lipoprotein panel and a fasting plasma glucose, both tests should be conducted at the same time.)
- ** One glycated hemoglobin (HbA1c) (CPT Code: 83036/83036QW) test for a participant who is not fasting at the WISEWOMAN/Wise Choices office visit. (Can only be billed by labs) Lab results must be entered into the MBCIS WISEWOMAN/Wise Choices module.
- ** One venipuncture charge (CPT Code: 36415) for the blood draw associated with the fasting lipoprotein panel (lipid panel) and/or the fasting plasma glucose (FPG) or Glycated Hemoglobin (HbA1c) when the test is NOT performed on the Cholestech Machine.
- *** Alert Value Case Management (CPT Code: 99429) for a program participant with an Alert value for Blood Pressure or Glucose (one time per participant per annual cycle).
  - When billing for Alert Value Case Management, the date of service should be the same as the resolution date.
  - MDHHS will enter the data and authorization related to Case Management.

BILLING

WISEWOMAN and Wise Choices are to be considered the PAYER OF LAST RESORT. All other insurances must be billed first and the primary insurance's Explanation of Benefits (EOB) showing a payment and/or rejection must accompany the WISEWOMAN/Wise Choices claim via

paper claim submission to the Michigan Department of Health and Human Services for claims processing (see below for more details about claim submission). WISEWOMAN/Wise Choices will pay up to the rates on the WISEWOMAN/Wise Choices rate schedule, less any primary insurance payment, and contracted providers will accept that payment as payment in full.

Claims may be submitted electronically using the State of Michigan Data Exchange Gateway (DEG) or File Transfer System (FTS). 835 electronic remittance advice files are available for those providers submitting electronic claims. Please contact Tory Doney for more information. Paper claims are also accepted and can be mailed to the address below. There are guidelines that must be followed for submitting paper claims or paper claims will be returned, unprocessed.

Tory Doney
Billing & Reimbursement Coordinator
(517) 335-8854 – phone
(517) 763-0290 – fax
DoneyT@michigan.gov

Reimbursement & Billing Website

Paper Submission Guidelines
MDHHS Claims
109 Michigan Ave
WSB 5th Floor
Lansing, MI 48933

Year-end Claims Processing: Claims with dates of service October 1, 20xx to September 30, 20yy must be on file by October 15, 20yy.

WISEWOMAN / Wise Choices Reimbursement

Code	Rate	Description of Bundle/Services	Billing Date of Service	Conditions	ICD-10
99429	$75	Alert Value Case Management	Resolution Date	Case management form received at MDHHS	I10; R03.0
99450	$75	Screening • Consent Form • Enrollment Form • Health Intake Form • Screening – Height; Weight; Blood Pressure; Cholesterol; Glucose or A1c • Risk Reduction Counseling • Readiness Assessment • Set small step – Participant Agreement	Date of Enrollment / Initial Screening	- **SCREENING BUNDLE**; including program enrollment, consent, health intake questions, risk reduction counseling, readiness assessment & initial biometric screening and client sets small step with a completed Participant Agreement form.	Z00.00
S9445	$425	Health Improvement • Health Coaching Contacts (5) **-- OR --** Tracking attendance & completion of referral to DPP (9), TOPS (12), Cooking Matters (4), Entrepreneurial Gardening, or other community resources • Follow-up questions, follow-up screening, and outcome evaluation	Date of Outcome Evaluation	- **HEALTH IMPROVEMENT BUNDLE**; including patient education – Health Coaching Contacts (5), OR tracking attendance & completion of referral to DPP (9), TOPS (12), Cooking Matters (4), Entrepreneurial Gardening, or other community resources. Follow-up questions, follow-up screening, and outcome evaluation completed.	Z71.9
S0316	$100	Improved Outcomes • Blood pressure – Under control • Weight loss • Tobacco use – Quit or substantial reduction • Glucose or A1c – Lowered • Physical Activity- Increased • Nutrition - Improved	Date of Outcome Evaluation * Can only be billed if outcomes are positive * ** **MDHHS Approved** **	- **IMPROVED OUTCOMES BUNDLE**; client exhibits positive changes on outcome evaluation contact – including controlled BP, weight loss; tobacco cessation; lowered glucose or A1c	Z71.9
S0341	$25	Additional Health Coaching • Per contact after 5	Date of contact	5 Health Coaching Contacts in the Health Improvement bundle must be completed prior to these additional contacts.	Z71.9
0403T	$25	Client attends a Diabetes Prevention Program Session	Date of session	DPP contact data in MBCIS Minimum data required LSP/HC Program is “Diabetes Prevention Program (DPP)” Contact Type is “Face-to-Face” Length of Session is at least “60 minutes” Completed Program is not “N/A”	Z71.9

WISEWOMAN/Wise Choices Records Retention Policy

This policy pertains **ONLY** to WISEWOMAN/Wise Choices local coordinating agencies, **NOT** subcontracted providers. Agencies that have clinical data retention policies should continue to follow those policies unless the time frames stated in those policies are **LESS** than this policy.

For agencies using Electronic Medical Records

- Data must be verified for accuracy and completeness prior to being entered in MBCIS/WISEWOMAN/Wise Choices and authorized for reimbursement
- Agencies that document WISEWOMAN/Wise Choices participant care in Electronic Medical Records **DO NOT** need to print paper copies of records as long as these records can be accessed to verify participant data

Time Frame for Retention of Paper Data Forms

The following paper data forms must be retained at the WISEWOMAN/Wise Choices agency for the time period specified below.

- Informed Consent: All signed consent forms for the client, for each year enrolled in the program
- Health Intake Questions and Readiness Ruler: Keep **current** year's copy
- Screening Form, Case Management Form, and Referral for Medical Evaluation:
  - Participants with alert values: Keep for **3** years from date of screening
  - Participants with uncontrolled hypertension: Keep for **2** years from date of screening
  - Participants with no alert values or uncontrolled hypertension: Keep **current** year's copy
- Participant Agreement: Keep for **2** years
- TOPS Membership Agreement: Keep for **3** years
- Contact Form: Keep for **2** years
- Follow-up Questions: Keep **current** year's copy
- Outcome Evaluation Contact: Keep for **2** years

12/2019