WISEWOMAN
Program Manual

Fiscal Year 2021
October 1, 2020 to September 30, 2021

WISEWOMAN Program Policies
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Key Terms -WISEWOMAN

Baseline Cycle	A participant's first Enrollment Cycle in MBCIS*WISEWOMAN during the current grant period.
Cooking Matters (CM)	A program offered in WISEWOMAN. It takes 4 or more sessions to complete Cooking Matters.
Digital Weight Watchers	Access to a Weight Watchers app paired with health coaching. An HBSS offered by the WISEWOMAN Program.
Diabetes Prevention Program (DPP)	Diabetes Prevention Program. An HBSS offered in WISEWOMAN. DPP is considered complete after 9 classes.
Enrollment Cycle	All client program data starting at enrollment date. This includes health intake, setting a small step, participating in Health Coaching or another HBSS and completion of an Outcome Evaluation at follow up.
Entrepreneurial Gardening (EG)	A gardening assistance program available at some WISEWOMAN agencies.
Follow-up Cycle	Data collected during Follow up Screening distinguished from the Baseline/Returning Cycle. “Follow up Cycle” and “Follow up Screening” are roughly equivalent. The former term may be used in the context of data entry in MBCIS*WISEWOMAN.
Follow-up Screening	WISEWOMAN services taking place 3 to 11 months after a Baseline or Returning screening. Follow up screening consists of answering some of the Health Intake questions again, additional screening, risk reduction counseling and an outcome evaluation.
Health Coaching (HC)	This HBSS is considered complete at 5 sessions. Up to 11 additional health coaching sessions are permitted and may be reimbursed.
Health Coaching Plus	Term used by CDC when a woman completes Health Coaching but also participates in another activity offered by the WISEWOMAN program, e.g. Entrepreneurial Gardening.
Health Intake	A questionnaire covering healthy behavior and health history. The full questionnaire is completed at the start of a new cycle. Only the healthy behavior questions are completed repeated at follow up.
HBSS	*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.
LWA	Local WISEWOMAN Agency
MBCIS	The name of the database holding breast and cervical cancer screenings, colorectal cancer screenings, patient navigation data and WISEWOMAN data. MBCIS stands for “Michigan Breast and Cervical Cancer Information System.”
My Health Information pamphlet	Used for Risk Reduction Counseling (RRC). Defines and identifies the participant’s BMI, blood pressure, total cholesterol, HDL cholesterol, LDL, Triglycerides, Hemoglobin A1c, and other risk factors.
Outcome Evaluation (OE)	A summary of the WISEWOMAN participant's experiences with the program done at during the follow up screening.
Participant Agreement	A WISEWOMAN form capturing a participant's willingness to set a small step and agree to health coaching or a different HBSS.

Readiness to Change (RTC)	A participant's subjective estimate (from 1 to 10) of her desire/willingness to make healthy changes.
Returning Cycle	Any screening that starts a new Enrollment Cycle in MBCIS*WISEWOMAN years after the Baseline Cycle.
Risk Reduction Counseling (RRC)	Assessing the participant's current risk factors and advising the participant about the meaning of their risk factors and the importance of taking small steps toward better health.
Self-Efficacy	An optional WISEWOMAN participant survey related to hypertension.
Taking Off Pounds Sensibly (TOPS)	A weight loss program serving as a lifestyle program in WISEWOMAN. Twelve sessions are needed for completion (more are allowed).

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WISEWOMAN
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WISEWOMAN Program Description

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 at or below 250% of the Federal Poverty Level 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
  - Food insecurity
- Complete the clinical screening to address measurable CVD risk factors related to:
  - Weight
  - Blood pressure
  - Cholesterol, HDL, LDL, Triglycerides
  - Glucose (sugar) or A1c
- 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
- 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.
- Refer the woman to appropriate healthy behavior support services (HBSS) including:
  - One-on-one health coaching from a WISEWOMAN Health Coach
  - Membership to a weight loss program
  - Diabetes Prevention Program
  - Community resources that can help her make healthy lifestyle behavior changes

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
    - Often program 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. Michigan WISEWOMAN addresses these issues by connecting participants with local organizations that can help. In some areas, women with food insecurity issues can participate in a program that delivers local fruits and vegetables to them weekly.

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. Local agency staff involved in the implementation of the WISEWOMAN program must complete MDHHS WISEWOMAN training **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.

6. Provide and regularly update contact information for all local WISEWOMAN staff 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 caseload throughout the fiscal year to ensure achieving a 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 can 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 MBCIS*WISEWOMAN module. This 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:
    - WISEWOMAN MDE (Minimum Date Elements) submissions to CDC
        - Please respond promptly to requests for data issue correction from the WISEWOMAN Data Manager for MDE submissions (currently April and December each year)

    Data quality and completeness
    - Hypertension control
    - Health Coaching
    - Participant outcomes

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

Clinical Care

1. Provide all WISEWOMAN services for each participant:
    - 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 who will require cholesterol measurement at follow up screening

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

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

5. 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

6. 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

7. Have a policy/protocol in place for participants identified to have alert blood pressure values approved by your Medical Director.

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

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

Community-Clinical Linkages

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 healthy lifestyle behavior changes.

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 or Weight Watchers workshop
    - 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. Complete the required continuing education health equity trainings: Introduction to Health Equity and Systemic Racism. Completion certificates will be issued at the end of each training and should be emailed to MDHHS-MiWISEWOMAN@michigan.gov by June 1, 2021.

The trainings can be accessed at: https://courses.mihealth.org/PUBLIC/home.html. Local agency staff will need to create a user profile to gain access to the trainings.

5. Provide support to participants to address barriers related to food access, transportation, and physical activity.

    - Transportation vouchers can be provided in the form of gas cards, bus tokens, ride share fare, etc. to help with transportation to and from appointments.
    - Market Fresh Coupons can be provided to participants to purchase Michigan grown produce
    - WISEWOMAN funds cans be used to purchases gym memberships or to cover the cost of individual or group physical activities

*All protocols should be available on request.

MBCIS*WISEWOMAN Data and CDC Minimum Data Elements (MDEs)

Items 12 through 15 under Program Coordination in the Local WISEWOMAN Agency Requirements list deal with WISEWOMAN Program data. These items cover collecting data on forms (12), entering collected data into MBCIS*WISEWOMAN (13), participating in the Quality Improvement (QI) Process especially as it relates to data submitted to CDC twice a year (14), and using related reports (15).

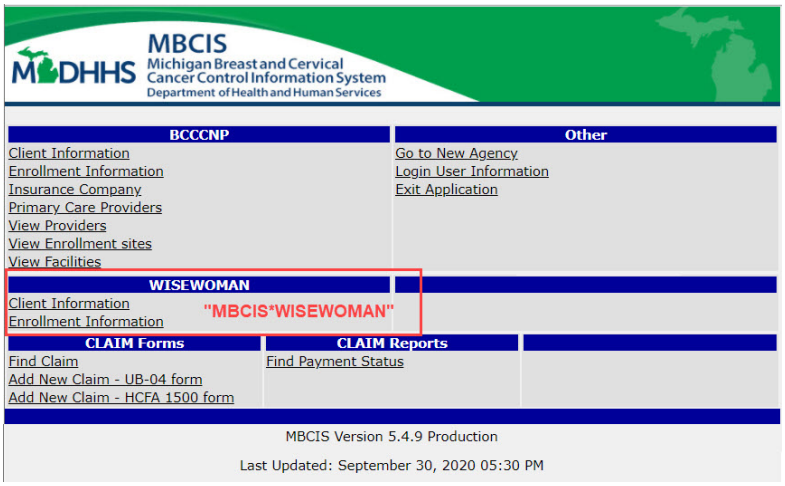
Collection and Use of Participant Data in WISEWOMAN

Much of the WISEWOMAN process involves collecting information from the women served on paper forms (or into local EHR software) and entering that information into the WISEWOMAN data module in "MBCIS." MBCIS is the database built for the Michigan Breast and Cervical Cancer Control Navigation Program (BC3NP), and it has had a module specific to the WISEWOMAN program in it since 2008. The WISEWOMAN module in MBCIS is written as "MBCIS*WISEWOMAN" when just using "MBCIS" might lead to confusion.

Use of MBCIS*WISEWOMAN

Because MBCIS*WISEWOMAN is part of MBCIS, one must have access to MBCIS to enter WISEWOMAN participant data. MBCIS is available as a State of Michigan MILogin application. To use MBCIS, one must submit a paper Secured Application User Agreement Access form and apply separately for use of MILogin. MILogin approval will get you to the MBCIS application, and processing of the Secured Application User Agreement Access form allows your MBCIS user role to be set up (or updated). Your MBCIS user role determines what you can see and do in MBCIS.

If you have any WISEWOMAN user role, you will be able to see the MBCIS*WISEWOMAN module in MBCIS.



CDC Minimum Data Elements (MDEs)

Custom programming allows WISEWOMAN participant data entered in MBCIS*WISEWOMAN to be exported into a data file intended for CDC.

The exported data for the MDE process is about 80% of the data entered into MBCIS*WISEWOMAN for participants. CDC gets everything except billing data, comments and notes, and some fields that could compromise PHI. The Michigan WISEWOMAN Program is required to submit MDE files to CDC twice a

year. MDE Submissions must have less than a 5% error rate, where "Errors" are defined by CDC. In recent years, submission have been at the beginning of June and December each year.

The process of a Minimum Data Elements (MDE) submission to CDC:

1. (As needed) updates to the programming used to create the data export file from MBCIS*WISEWOMAN.
2. About one month before submission due date, data from MBCIS*WISEWOMAN is exported to a file and retrieved by the Data Manager
3. The Data Manager uses CDC WISEWOMAN's validation tool to confirm file format is correct and to receive reports of "Errors" and "Quality Checks" in the data
4. CDC defined Errors in the data require action. For each Error, there are 3 possible outcomes:
    a. Data Manager corrects data when possible
    b. Data Manager contacts agency to see if data error can be resolved on LWA end
    c. Error cannot be fixed
5. Steps 2 through 4 are repeated as needed to reduce the number of Errors in the MDE file to the extent possible
6. Eventually, a data set is submitted and marked as "final" to indicate it is the official MDE file. CDC's validation tool provides our final MDE submission error rate within seconds

CDC Minimum Data Elements (MDEs) Time Periods and Submission Schedule

Time Period	Data from WISEWOMAN screenings between	MDE due date	Time Period	Data from WISEWOMAN screenings between	MDE due date
1	09/30/18 and 03/31/19*	4/1/2019	**6**	04/01/21 and 09/29/21	12/1/2021
2	04/01/19 and 09/29/19	12/2/2019	**7**	09/30/21 and 03/31/22	4/1/2022
3	09/30/19 and 03/31/20	4/1/2020	**8**	04/01/22 and 09/29/22	12/1/2022
4	04/01/20 and 09/29/20	12/1/2020	**9**	09/30/22 and 03/31/23	4/3/2023
5	09/30/20 and 03/31/21	4/1/2021	**10**	04/01/23 and 09/29/23	12/1/2023

*WISEWOMAN screening did not start until 2/1/19

Participating in the Quality Improvement (QI) Process

The QI Process as it relates to the MDE submissions is equivalent to step 4b above. If you are contacted about a data issue associated with the WISEWOMAN MDE submission, please address it as quickly as possible.

Quality improvement issues may arise from patterns of errors on CDC's validation reports. For instance, a participant has a fasting status of "non-fasting" but due to health intake data that participant must be fasting for CDC to count the data as valid. Issues like this would require an examination of procedure to assure fasting data is obtained for the MDE file.

Using Data Reports

The WISEWOMAN Program uses SPSS programming and the reporting tool Discoverer Viewer to determine and track your Performance Measures, including caseload. Any LWA staff with an active MBCIS*WISEWOMAN user ID can use a variety of WISEWOMAN reports available on Discoverer Viewer (see list below). To access Discoverer Viewer, you can view the User Access Instructions.

List of WISEWOMAN Discoverer Viewer Reports as of November 2020 (subject to change)

00 WW Claim Lines from Paid Services Table	Reports show paid services by Auth Category, FY, month or client name. Rejected services in last worksheet. Wise Choices claims are included but Program field will incorrectly say "WISEWOMAN."
01 WW Services Authorized in MBCIS_WISEWOMAN	Use this report with the paid claims report (#00) to track which authorized services have been paid. First sheet shows all services for a selected client.
02 WW Aggregate Data	Shows summary WISEWOMAN screening data with interpretations and averages. Enter date parameters to select data.
03 WW Caseload (PM3)	FY21 WISEWOMAN caseload by facility or client name. Current data in first two workbooks, older data in last two workbooks.
04 WW RTC complete (PM4)	Lists Readiness to Change (RTC) values. Second worksheet is % RTC >= 7
05 WW Participant Agreement & Contacts (PM5, PM6)	PM5 Use to determine % completing Participant Agreement. Numerator and denominator worksheets for PM6 (attend at least one HC or program contact).
07 WW Contact within 3 Weeks (PM7)	Numerator is clients receiving health coaching within 21 days. Denomintor is all clients receiving health coaching.
08 WW Participants with High BP (PM8, PM9)	Use Numerator and Denominator reports to compute PM8 and PM9. These performance measures track high BP and program contacts.
10 WW Outcome Evaluation Status (RM-A, RM-B)	Participants listed by Outcome Evaluation (OE) status. 1. Ready for OE; 2. OE Already Completed; 3. Do not need OE (Not Ready); 4. Measure A (Contacts Completed); 5 Measure B (OECompleted)
11 WW Participant Contacts	Lists and counts of LSP contacts by participant. 1. List by participant; 2. List with small step and plan; 3. Select participant by name; 4. Table showing contacts by type by FY
12 WW Lifestyle Program Summary	Review Lifestyle Program contact related information by participant. Each of the 4 worksheets is a different version of the report.
13 WW Client Contact and Mailing List	Participant listings with address info (for mail merge), phone numbers and email address. Last two worksheets show most recent contact going back to FY2017.
15 WW Case Management	Case Management case listing with case management status.
16 WW CLINICAL--High Blood Pressure	BP screening information. Separate worksheets to identify newly diagnosed BP cases and uncontrolled hypertension.
17 WW CLINICAL--Diabetes	Diabetes related screening information. Separate worksheets to identify newly diagnosed and uncontrolled glucose.
18 WW CLINICAL--High Cholesterol	Cholesterol screening information.
19a WW Women Requiring Fasting Lipids	Women listed on first worksheet require fasting lipids screening if they come in for screenin during FY21.
19b WW QI--Fasting Lipids Required	Women listed on the first worksheet should have been fasting for their lipids screening. Replacement fasting lipids are needed if they were not fasting. .
20 WW Health Intake Data by Participant	Lists Health Intake responses for all participants in your agency.
21 WW Screening Data by Participant	Screening and Follow-up Screening metrics for participants in your agency.
22 WW RRC & Referrals Resulting from Screening	A summary of the responses to the referral questions at the bottom of the WISEWOMAN Screening tab.
23 WW Outcome Tracking tab	List of Health Improvements identified on the Outcome Tracking tab.

WISEWOMAN
Local Staff Responsibilities

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 Agency Requirements*
- Ensure the local agency follows all WISEWOMAN Policies, Procedures, and Protocols
    - WISEWOMAN Eligibility
    - Clinical Screening Procedures
    - Screening and Referral Guidance
    - Case Management Protocols
    - Multidisciplinary Team Approach
    - Two-Way Referrals
    - Community Clinical Linkages
    - Monitoring Hypertension
    - Community Navigation
    - Weight Watchers or Digital Weight Watchers Protocols
    - 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)
- Participate in the monthly Technical Assistance meetings with appropriate staff
- Ensure timely entry of data into MBCIS*WISEWOMAN module
- Ensure timely and correct billing of services
- Participate in WISEWOMAN 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
- Participate in multidisciplinary care team and update participant care plans as needed

Clinical Screener (Physician, Nurse, or Medical Assistant)

- Conduct Health Risk Assessment
- Conduct Clinical Screening
    - Measure the participant's height and weight and calculate their body mass index (BMI)
    - Measure the participant's blood pressure according to Clinical Screening Procedures
    - Measure the participant's total cholesterol, HDL cholesterol, LDL cholesterol, triglycerides, A1c and/or fasting glucose according to Clinical Screening Procedures
    - Measure the participant's Hemoglobin A1c using an Alere Afinion® Analyzer*)* 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

- 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 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
- Participate in multidisciplinary care team and provide feedback to professionals and others, including caregivers, who are involved with the client

- Develop a care plan for the participant, based on results from the readiness to change assessment. The care plan should contain specified goals, strategies, and responsibilities for action to ensure successful implementation
- Assist participants who are ready to make change to develop a small step and plan 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
- Conduct a community scan to identify potential resources and community programs near the local WISEWOMAN agency participants can be referred to when needed
- Engage collaboratively with clients
- Develop and regularly update a comprehensive overview of community-based resources and programs based on community scan
- Identify or develop community linkages with organizations to meet WISEWOMAN 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 monthly Technical Assistance meetings with appropriate staff
- Attend professional development trainings as required

WISEWOMAN
Multidisciplinary Team Approach

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.

Each WISEWOMAN agency is expected to identify which staff at their agency that will make up the WISEWOMAN team and identify their responsibilities and involvement with the WISEWOMAN program.

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

1. Engage the change team – Bring together a multidisciplinary team which could include medical assistants, nurses, billing staff, and staff with prescriptive authority such as physicians or nurse practitioners.

2. Determine the team composition – Design the model of care that will meet the needs of participants and your team. Consider what role each current team member will play, and which current staff could learn a new skill set.

3. Choreograph workflows to reflect the new model of care – Examine all of your roles and staff responsibilities and determine your new team-based workflow to increase efficiency and improve quality.

4. Increase communication among the team, practice, and patients – Decide what type of communication tactics will be needed to keep all team members and patients updated.

5. Use a gradual approach to implement the model

6. Optimize the care model – Teams that successfully implement the team-based care model can communicate at ease, improve care coordination, and optimize on the time spent with the patient.

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.

WISEWOMAN
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

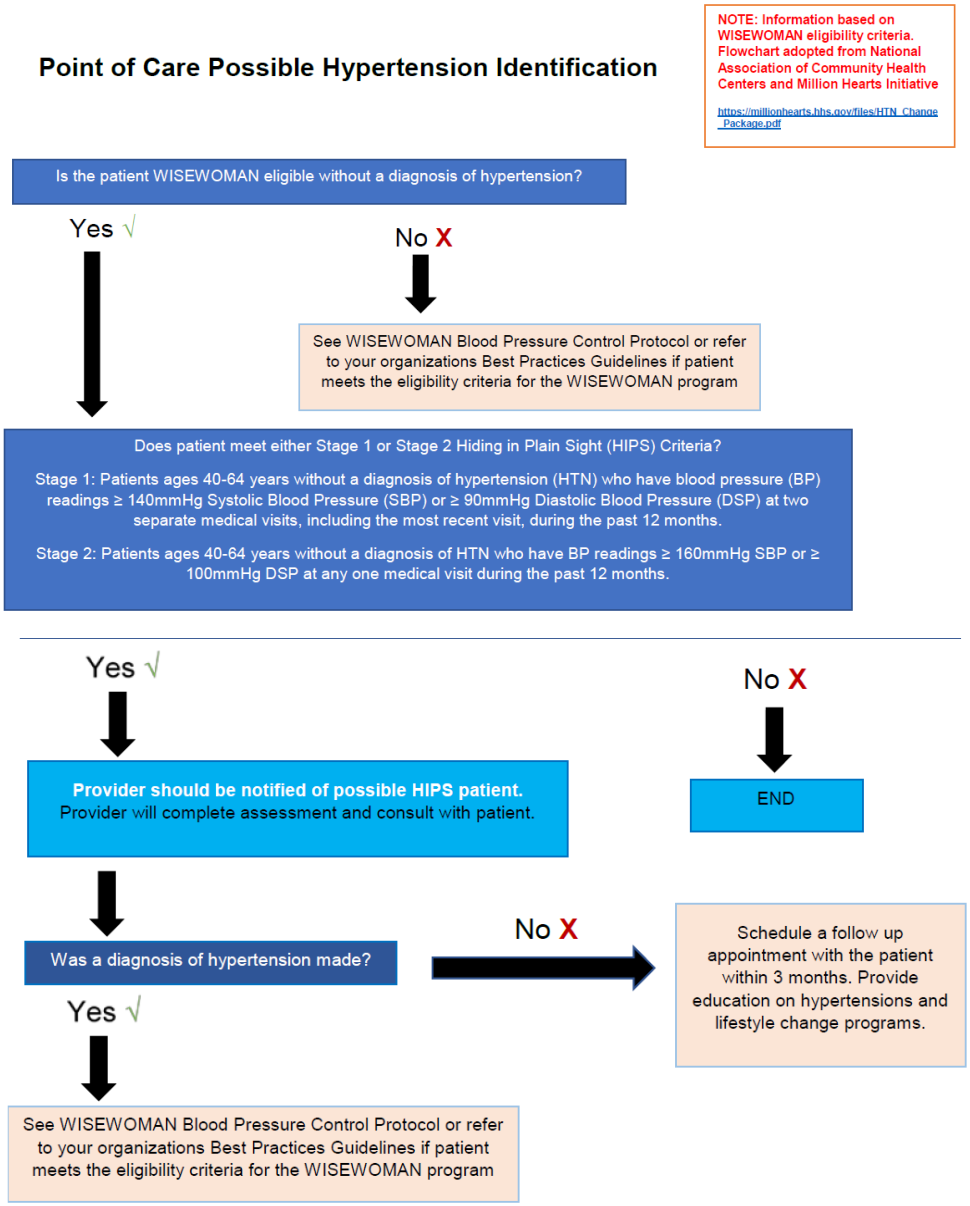
6. **G**row the linkage with sustainability in mind, and

7. **E**valuate the linkage

WISEWOMAN
Monitoring Hypertension

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.



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 current year's federal poverty level (FPL) and
3. Are uninsured or underinsured

Women currently enrolled in the Michigan Breast and Cervical Cancer Control Navigation Program (BC3NP) are **automatically eligible** for WISEWOMAN.

**NOTE: Women who have Medicare Part A & B coverage are NOT eligible for the WISEWOMAN Program.*

The WISEWOMAN program is 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 claim via paper claim submission to the Michigan Department of Health and Human Services for claims processing. WISEWOMAN will pay up to the rates on the WISEWOMAN rate schedule, less any primary insurance payment, and contracted providers will accept that payment as payment in full.

NOTE - Primary insurance only needs to be billed for LABS and MEDICAL REFERRALS (not the screening bundle (99450), health improvement bundle (S9445), additional health coaching contacts (S0341), or positive improvements (S0316)).

For questions regarding billing and reimbursement for the WISEWOMAN program, please contact Tory Doney at DoneyT@michigan.gov.

WISEWOMAN
Program Flow

Baseline Screening

The baseline screening initiates a one-year cycle. A baseline screening is the client's first screening and only happens once. Each annual screening will be the client's *returning* 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
    - Secondhand smoke
  - Physical and emotional well-being
  - Food access

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 to obtain immediate results.
- Hemoglobin A1c or Fasting Glucose

- 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 **180** (systolic) and/or greater than **110** (diastolic)
- LDL Cholesterol greater than **160 mg/dL and not currently being treated for high cholesterol**
- Triglycerides greater than or equal to **500 mg/dL**
- Hemoglobin A1c greater than **7%**
- Fasting Glucose greater than **250 mg/dL**

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)
- Fasting Glucose ≥ **250 mg/dL**

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.

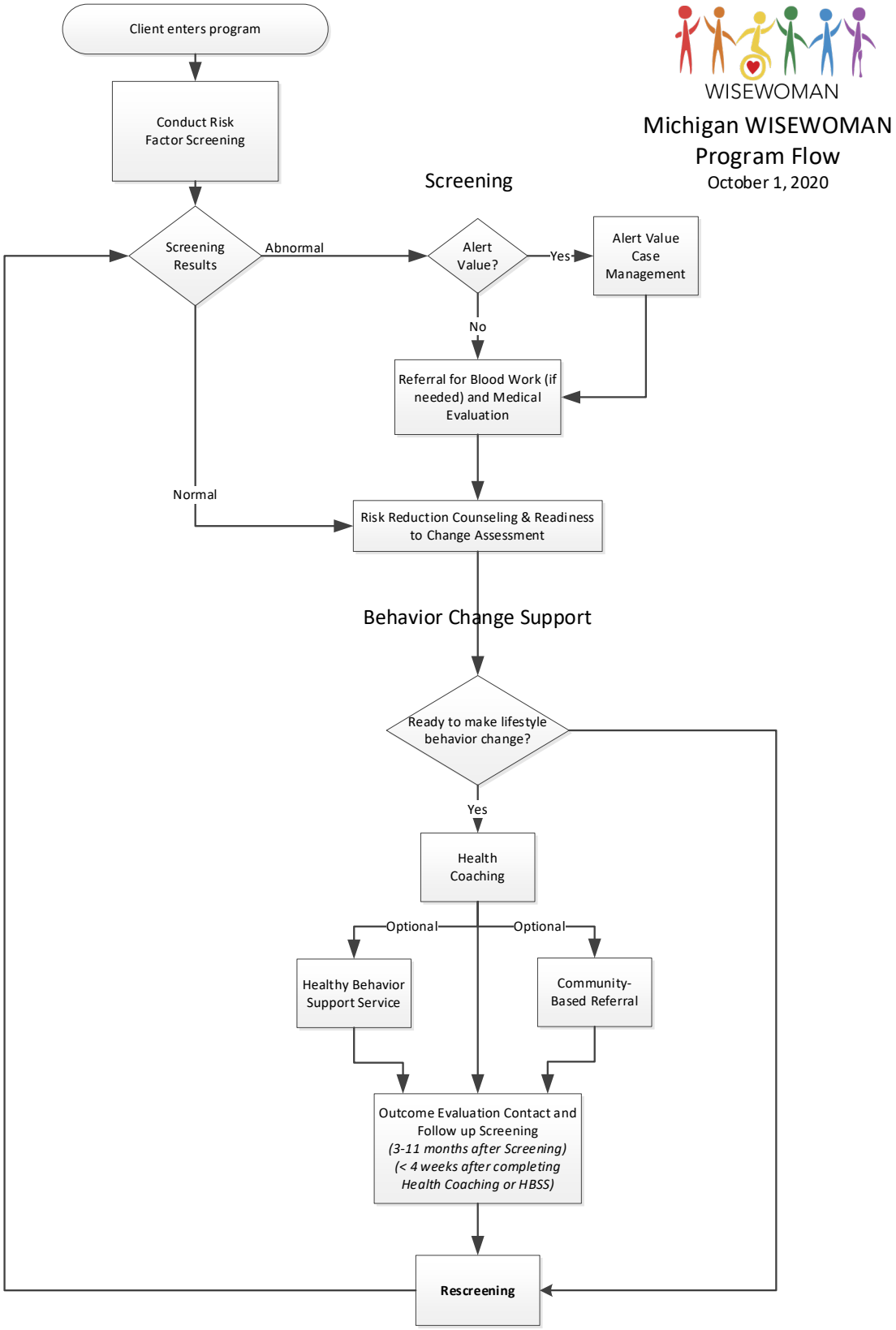
If they choose an HBSS, such as the Diabetes Prevention Program, Taking off Pounds Sensibly (TOPS), or Weight Watchers (WW) WISEWOMAN will cover the cost of participation in the program as long as they attend a minimum number of sessions. The participant may prefer to attend a low or no cost community-based 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 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.

Re-screening
WISEWOMAN participants who remain eligible for the program should have the opportunity to receive rescreening services 12* to 18 months after their previous screening.

*Annual cycle expected, but rescreening may take place at 11 months after the enrollment date of the previous WISEWOMAN cycle.

Figure 1 - Michigan WISEWOMAN Program Flow



WISEWOMAN
Performance Measure Policy
Fiscal Year 2021
(Effective Dates: October 1, 2020 to September 30, 2021)

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.

** indicates performance measures required by CDC*

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

2. **100%** of local WISEWOMAN agency staff participate in the 2 required health equity trainings by June 1, 2021.
    - Trainings "Introduction to Health Equity" (ID: H0300-2016) and "Systemic Racism" (ID: H0301) can be accessed at https://courses.mihealth.org/PUBLIC/home.html

3. Agency screens **at least 95%** of budgeted caseload.

4. **100%** of participants complete readiness to change scale.

5. **80%** of participants complete a participant agreement. *

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 yet performance measures, however, will be monitored regularly:

A. % of participants who participate in health coaching or an evidence-based lifestyle program complete the program (attend minimum # of sessions for LSP)

B. % of participants who complete health coaching (5 contacts) or an evidence-based lifestyle program (4 CM, 9 DPP, 12 TOPS, or 12 WW) receive an outcome evaluation contact

WISEWOMAN Clinical Screening Procedures

Procedure for Measurement of Blood Pressure

1. Check the equipment. Do not use the equipment 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 straight on and within 15 inches of the viewer.

3. Use the right arm when possible. Upper arm should be bare and unrestricted 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 lightly 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 lightly over the *radial* artery, 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 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 (5^{th} 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.

Blood Collection
by finger puncture
for Cholestech® and Afinion™

Purpose: To safely obtain a viable whole blood capillary specimen for processing in the Cholestech LDX System® and the Afinion™ AS100 Analyzer 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 oversite 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]
**** Category A, non-managerial, employees, annually, shall have direct input, documented in the "BBECP", into the identification, evaluation, and selection 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. Always wear intact gloves 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 Cholestech LDX according to the *"Cholestech User Manual®. Page 9 Getting Started".* Available online at: www.cholestech.com
Set up Afinion AS100 Analyzer according to the *"Alere Afinion AS100 Analyzer Manual. Page 9 Getting Started".*
Available online at:
http://www.nwprimarycare.com/Staff%20Training%20Info/Afinion%20AS100%20Analyzer%20User%20Manual%20US.pdf

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 drop of blood forms. If you cannot 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: https://www.fda.gov/medical-devices/ivd-regulatory-assistance/clinical-laboratory-improvement-amendments-clia
- HIPAA: https://www.hhs.gov/hipaa/index.html
- MMWR-Recommendations and Reports Good Laboratory Practices for Waived Testing Sites [11/11/2005/Vol.54/No., RR-13]

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 are not 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

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/ .**

WISEWOMAN
Case Management

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 (fax # 517-763-0290) 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 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***:
  - 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 ***Non-compliant***:
  - 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
Screening and Referral Guidance

Health Intake and Clinical Screening

Baseline/Returning Screening

At intake WISEWOMAN staff will:

- 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*WISEWOMAN (Referral tab).
- Collect answers to Health Intake questions to assess personal medical history and current health behaviors of participant
- Conduct risk reduction counseling
- Refer for medical evaluation – as needed – based on the clinical screening results

Follow-Up

At follow up (between 3-11 months after Baseline/Returning Screening):

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

Body Mass Index

- **Obese:** BMI ≥30 Consider at 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 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 / Blood Pressure Control Support
- **Stage 2 Hypertension:** 160-180 (systolic) **and/or** 100-110 (diastolic)
  - Refer for Medical Evaluation
  - Provide Team-Based Care / Blood Pressure Control Support
- **Stage 1 Hypertension:** 140-159 (systolic) **and/or** 90-99 (diastolic)
  - Refer for Medical Evaluation

- Provide Team-Based Care / Blood Pressure Control Support
- **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 *Blood Collection by Finger Puncture for Cholestech® and Afinion™* included in the WISEWOMAN Program Clinical Screening Procedures.

3. Most participants do not have to be fasting for the lipid panel. There is one exception.
   a. A participant who answers "Yes" to question 2, 3, or 4 on the Health Intake must receive a fasting lipid panel.
      i. If the participant is not fasting at screening must be referred for a fasting lipid panel
      ii. The participant will not count toward caseload until the fasting lipid is entered into MBCIS*WISEWOMAN

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

5. Handling error messages or "out of range" values when using the Cholestech machine.
   b. 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.
   c. 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
   d. When entering the Screening Results in the MBCIS*WISEWOMAN module, 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
  - Refer for Fasting Lipid Profile and Medical Evaluation **if not currently being treated for high cholesterol Borderline**
- **Borderline High:** 200-239 mg/dL
  - Refer for Fasting Lipid Profile **if not currently being treated for high cholesterol** (If LDL from fasting lipid profile is ≥ 160, refer for Medical Evaluation)
- **Normal:** <200 mg/dL

- No referral for Fasting Lipid Profile or Medical Evaluation

HDL Cholesterol

- **Undesirable:** <40 mg/dL
  - Refer for fasting Lipid Profile **if not currently being treated for high cholesterol** (If LDL from fasting lipid profile is ≥ 160, refer for Medical Evaluation)
- **Desirable:** 40-59 mg/dL
  - No referral for Medical Evaluation
- **Very Desirable:** ≥60 mg/dL
  - No referral for Medical Evaluation

LDL

- **High** ≥ 160
  - Refer for Medical Evaluation
- **Borderline High:** 130-159
  - No referral for Medical Evaluation
- **Normal:** <100 – 129
  - No referral for Medical Evaluation

Triglycerides

- **Very High**: ≥500
  - Refer for medical evaluation
- **High**: 200-499
  - Refer for medical evaluation (If value is ≥ 400 and patient is not fasting, refer for a fasting lipid panel)
- **Borderline**: 150 –199
  - No referral for medical evaluation
- **Normal**: <150
  - No referral for medical evaluation

Fasting Glucose

- ***Alert**: ≥ 250 mg/dL Fasting
  - Referral for Medical Evaluation & Alert Value Case Management
- **Pre-diabetes**: 100-125 mg/dL Fasting
- **Diabetes**: 126-249 mg/dL Fasting
- **Desirable**: 70-99 mg/dL Fasting
  - No referral for Medical Evaluation

A1c Screening

1. Screening for A1c should be done using an Alere Afinion AS100 Analyzer for immediate receipt of results.
2. Agency staff conducting the A1c Screening must follow the *Blood Collection by Finger Puncture for Cholestech® and Afinion™* included in the WISEWOMAN Program Clinical Screening Procedures.

A1c

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

WISEWOMAN Program
Health Coaching Guidance

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 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" does not 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 Health Coaching includes:

Risk Reduction Counseling
Each participant receives risk reduction counseling at the time of screening using the WISEWOMAN ***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), Triglycerides, 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 Make Healthy Lifestyle Behavior Change
formerly known as Readiness to Change (RTC)

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 [CM(1]health coaching to assist them in making healthy lifestyle behavior changes. Participants who are not ready to change should be encouraged to make a healthy behavior change and offered health coaching. However, If the participant still does not want to set a goal (i.e., do a small step and plan) record "NO GOAL" or similar in the Participant Agreement tab in MBCIS*WISEWOMAN. The participant may be rescreened in one year.

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 ***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 module)

Health Coaching

For participants who have set a small step and plan 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 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

Weight Watchers

Weight Watchers is a newly approved healthy behavior support system for FY21. The local WISEWOMAN agency (LWA) will work with a local Weight Watchers branch to purchase a Weight Watchers package for their clients.

- In-person or the Digital app sessions are available

Local Community Resources

Each community has unique free resources that can help the participant achieve their small step. WISEWOMAN 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 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

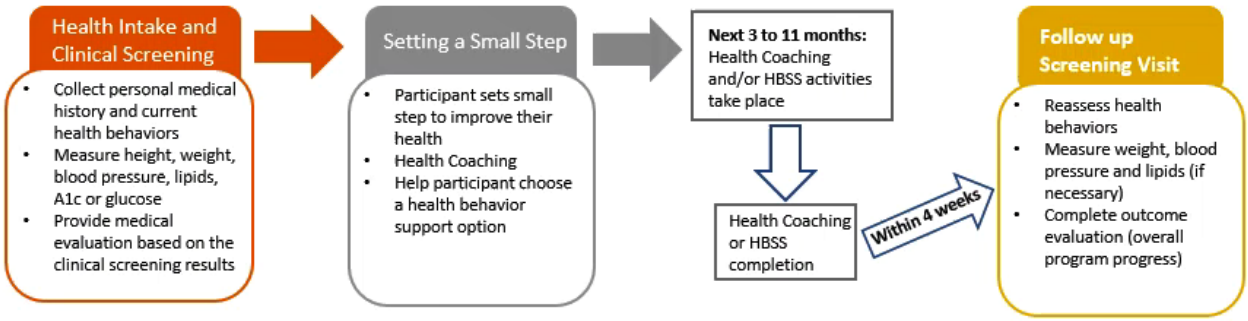
The outcome evaluation contact is required for participants who are ready to make change, have established a small step, and have completed Health Coaching or another Healthy Behavior Support Service. The purpose of the contact is to assess progress and reinforce changes made. Outcome Evaluation must 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 module)

- Health Coaching – at least five (5) Health Coaching contacts after the Participant Agreement is completed – maximum of 16
- Diabetes Prevention Program – At least nine (9) classes
- TOPS – At least twelve (12) meetings
- Cooking Matters – At least four (4) classes
- Weight Watchers – At least twelve (12) in-person sessions
- Health Coaching + Digital Weight Watchers – At least 5 HC with twelve (12) digital logins
- 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.
    - These rewards need to be tracked and reported back to MDHHS with a template to be provided by MDHHS

Other Health Coaching Requirements

Tracking and Quality Improvement

- Local WISEWOMAN 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 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 program Health Coaches will:

1) Be trained by WISEWOMAN 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 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
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 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 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 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: http://www.dableducational.org or https://www.validatebp.org/. They provide details on clinically validated monitors which are recommended for use. Make sure to purchase monitors that are recommended for self-measurement of blood pressure.

Agencies should expect to spend about $40-80 on each blood pressure monitor. If the monitor requires batteries, 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

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

*In addition to the form below, BP monitor serial number may be tracked on the Participant Agreement tab in MBCIS*WISEWOMAN. See the "Participant given the following" section of the tab.

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 is because the wrist arteries are narrower than and not as deep under your skin as those of the upper arm.

Word from the Field

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

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 agency to choose if they will purchase wrist monitors in addition to upper arm monitors. Before you purchase any monitors – check: http://www.dableducational.org or https://www.validatebp.org/.

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 participants in SMBP?

- ✓ Provide the participant with details on the SMBP program
- ✓ Ask participant to sign SMBP Monitoring Agreement (refer to page 56)
- ✓ Enroll participant in Health Coaching and schedule follow-up contacts

- Ideally, the health coaching sessions should occur on a weekly basis
- Let participant know that they will be asked for their most recent blood pressure readings at each health coaching contact

✓ 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*WISEWOMAN.

- Use the Contacts tab

✓ Share results with the participant's provider

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)

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

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 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 my blood pressure readings
4. Share all my blood pressure readings with my health coach and 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 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 the items listed above.

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

WISEWOMAN
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 to track the participant's:

- Attendance
- Weight changes

Health Coaches are encouraged to attend each local meeting as a guest 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 a TOPS Club if they meet all the following criteria:

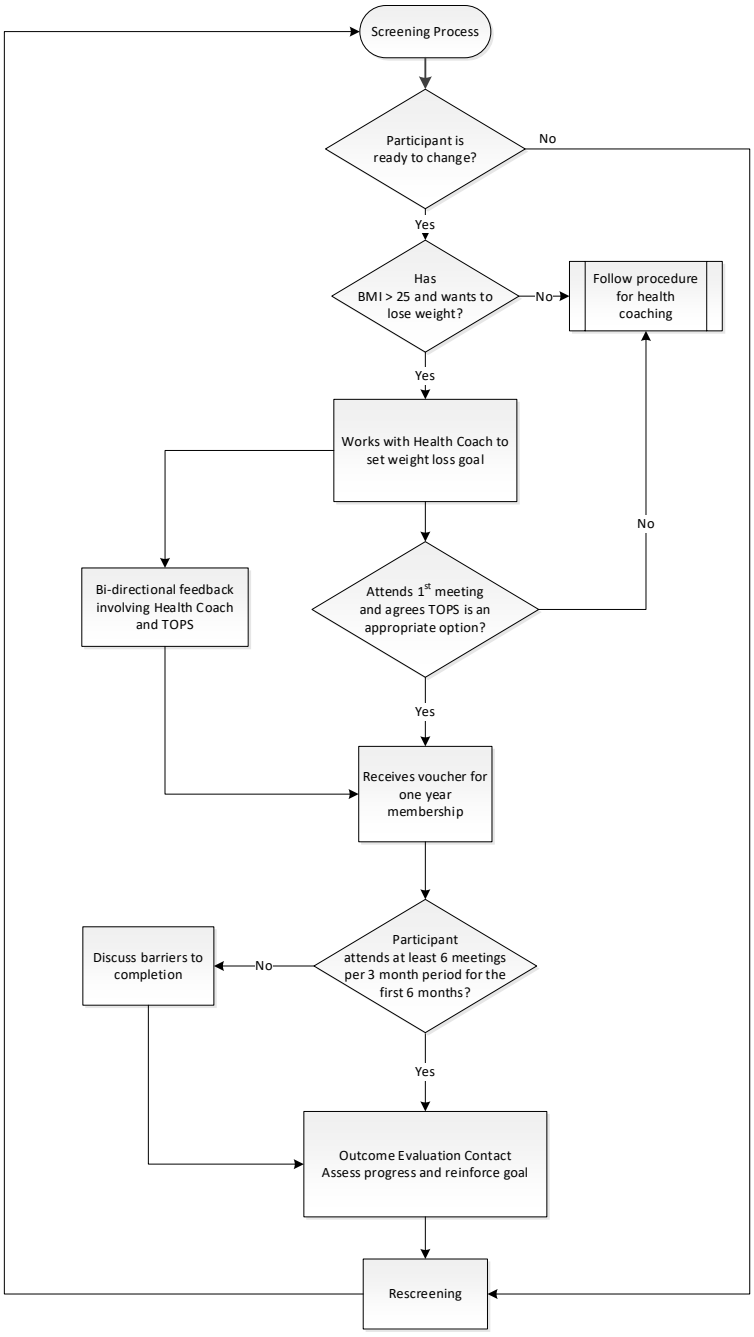
- Has a BMI ≥25
- Indicates a readiness to change
- Has access to TOPS Club Chapter meeting(s)
- Has attended one meeting and agrees TOPS Club is an appropriate option
- Commits to attending at least 6-chapter meetings each 3-month period for the first 6 months (12 meetings)

The Health Coach will:

- Work with the participant to complete the Participant Agreement and set a weight loss small step and plan
- 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 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 (Small step and plan)
- Complete and sign the WISEWOMAN 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 6 chapter meetings during each 3-month period for 6 months
- Pay monthly chapter dues



WISEWOMAN

WISEWOMAN
Take Off Pounds Sensibly (TOPS) Flow
October 1, 2020

WISEWOMAN
Diabetes Prevention Program (DPP) Referral

Establish Relationship with Diabetes Prevention Program (DPP)

When completing the Community Scan, determine if there is a Diabetes Prevention Program 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 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 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 (DPP) 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*WISEWOMAN

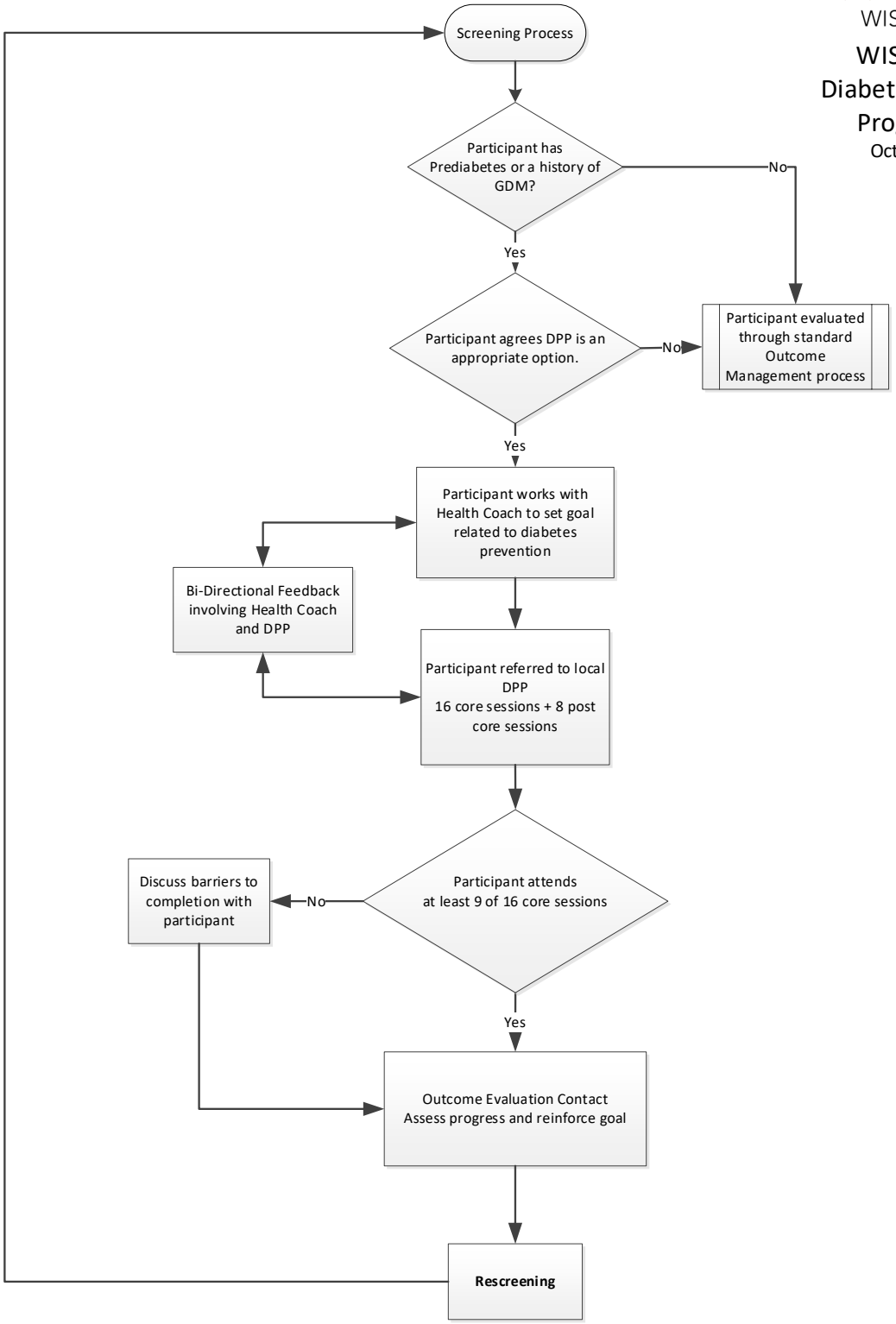
The participant will:

- Develop a Participant Agreement (Small Step and plan)
- Attend Diabetes Prevention Program sessions
- Complete the Diabetes Prevention Program
    - Complete means the participant attended at least 9 of 16 core sessions

WISEWOMAN

WISEWOMAN Diabetes Prevention Program Flow

October 1, 2020



WISEWOMAN
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 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 6 two-hour class sessions over 6 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 6 two-hour class sessions over 6 weeks

WISEWOMAN Weight Watchers (WW) Referral

Establish a relationship with a local Weight Watchers (WW) branch:

It is the responsibility of the local WISEWOMAN agency to develop a partnership with their local WW site to make referrals. Visit https://www.weightwatchers.com/us/find-a-workshop/ to find a WW workshop near your agency.

WW Referral Criteria:
A participant may be referred to WW if they meet the following criteria:

- BMI ≥ 25
- Has access to a WW workshop or Digital Platform
- Has attended 1 health coaching session and can commit to attending 6 WW workshops in a three-month period for the first 6 months (12 workshops total) **or**
- Can commit to attending 5 health coaching sessions and make a minimum of 12 digital logins on the WW digital platform

Health Coaches will need to establish a relationship with their local WW branch and establish a method for completing two-way referrals to track participants:

- Attendance
- Weight changes

Health Coaches will have two options to refer participants to WW:

(1) Health Coaching + WW Digital Plus Option: This option allows for participants to receive one - on-one health coaching sessions and 6-month access to the digital WW program (online app).

- Participants who take this route will be required to complete 5 health coaching sessions while using the digital Weight Watchers platform for a minimum of 3 months with a minimum of 12 digital logins.

(2) WW workshop will allow participants to meet weekly with an in-person coach and local members while also having access to the digital workshop tools.

- Participants will be required to attend 1 health coaching session at their local WISEWOMAN agency before receiving a referral for a 3-month access to their local WW workshop.
- Participants must attend a minimum of 6 sessions in a 3-month period to gain a 2nd 3-month membership voucher to their local WW workshop. To be considered complete, participants must attend 12 WW sessions over a 6-month period.

The Health Coach will:

- Work with the participant to complete the Participant Agreement and set a weight loss small step
- Provide the participant with a list of local WW chapters or Digital WW platform options
- 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 after they have attended WW Workshop meetings for six months **or** completed 5 health coaching contacts and 12 digital WW logins.

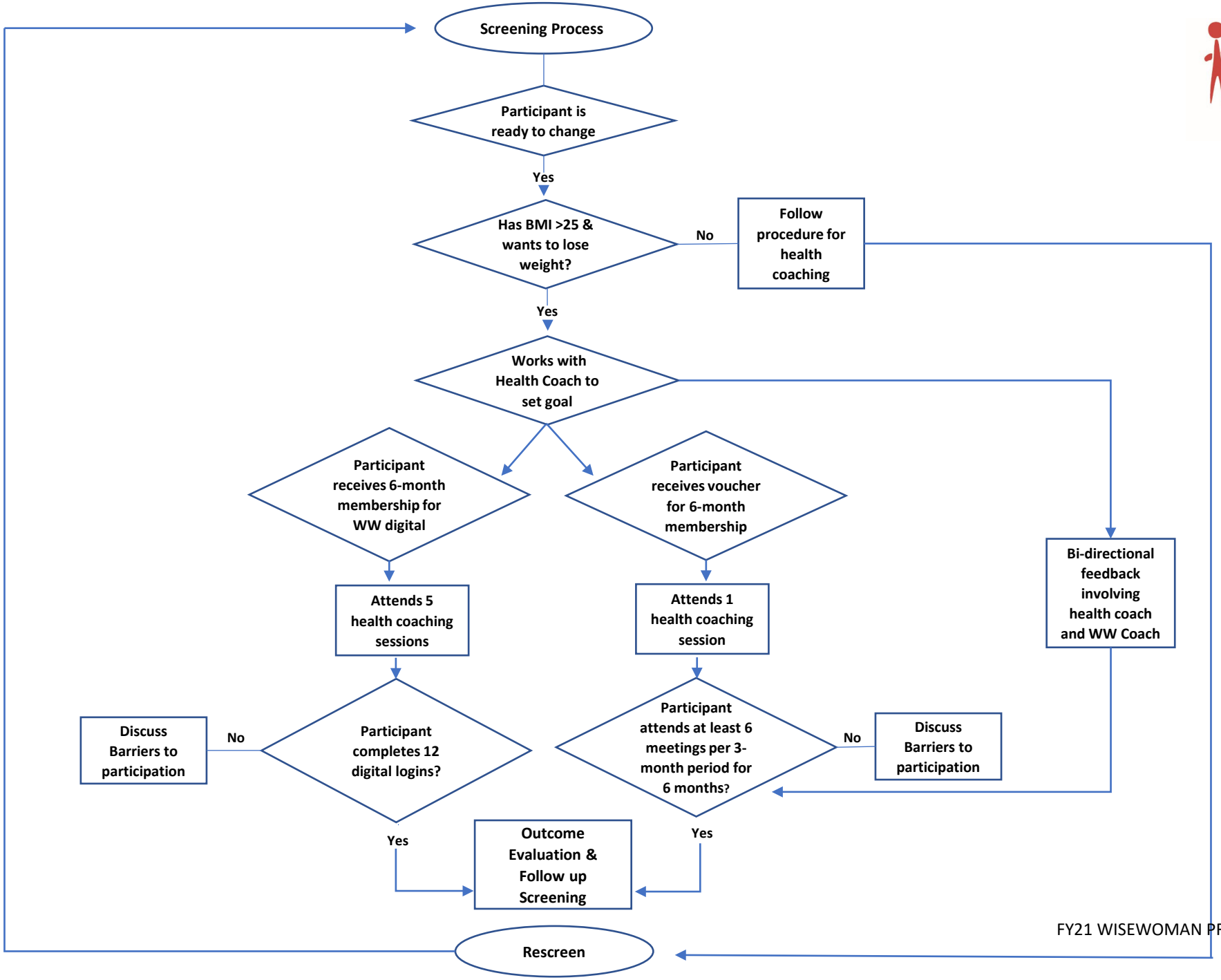
The participant will:

- Develop a Participant Agreement
- Provide the Health Coach with the date and location of the WW Workshop attended
- Attend at least 1 health coaching contact prior to attending six-chapter meetings during each three-month period for six months **or** complete 5 health coaching contacts and 12 digital WW logins

WISEWOMAN

Weight Watchers Flow

October 1, 2020



Reimbursement

Only Current Procedural Terminology (CPT) Codes and HCPCS Codes included in the Current Fiscal Year WISEWOMAN 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 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 or Z00.01 Rate: $75.00

- Enrollment Form
- Informed Consent Form
- Health Intake Form (3 pages)
- Screening Form – Height, Weight, Waist Circumference, Blood Pressure, Cholesterol, HDL, LDL, Triglycerides, 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 and plan – 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) **Improve 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 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 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 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 screening. Lab results must be entered into the MBCIS*WISEWOMAN 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 office visit. (Can only be billed by labs) Lab results must be entered into the MBCIS*WISEWOMAN 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

The WISEWOMAN program is 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 claim via paper claim submission to the Michigan Department of Health and Human Services for claims processing. WISEWOMAN will pay up to the rates on the WISEWOMAN rate schedule, less any primary insurance payment, and contracted providers will accept that payment as payment in full.

NOTE - Primary insurance only needs to be billed for LABS and MEDICAL REFERRALS (not the screening bundle (99450), health improvement bundle (S9445), additional health coaching contacts (S0341), or positive improvements (S0316)).

WISEWOMAN
Billing and Reimbursement Guidance

Claims may be submitted electronically using the State of Michigan Data Exchange Gateway (DEG) or File Transfer System (FTS). 835 electronic remittance advice (835RA) 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. Paper Submission Guidelines

WISEWOMAN also accepts electronic claim submission. Please visit our website for all details regarding electronic claim submission. Reimbursement & Billing Website

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

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. Memos will be sent to LWA coordinators closer to the deadlines with more specifics regarding the deadlines.

Administration	• Coordinator • Recruitment • Administrative Overhead • Attending Meetings/Calls/T.A.	N/A – paid via Coordination funds	$150 – paid through contract (EGrAMS/FSR)
Enrollment / Screening "bundle"	• Consent Form • Enrollment Form • Health Intake Form *(3 pages)* • Screening – Height; Weight; Waist Circumference (*optional*); Blood Pressure; Cholesterol; HDL; LDL; Triglycerides; Glucose or A1c • Risk Reduction Counseling • Readiness Assessment • Set small step – Participant Agreement	99450 – CPT Z00.00 *or* Z00.01 – ICD-10 - Biometric Screening Bundle; including consent, enrollment, health intake, risk reduction counseling & readiness assessment, if applicable	**$75** – DOS = date of Enrollment
Health Improvement "bundle"	• Health Coaching Contacts (5) **--OR--** • Track attendance and completion of referral to DPP (12), TOPS (9), Cooking Matters (4), Weight Watchers (12), Entrepreneurial Gardening, or community resource • Follow-up health intake, Follow-up screening and Outcome Evaluation	S9445 – CPT Z71.9 – ICD-10 - Health Improvement Bundle; including patient education – client exhibits positive changes on outcome evaluation contact	**$425** – *including* screening -or- **$300** – follow-up health intake and outcome evaluation *only* DOS = date of the Outcome Evaluation
Additional Health Coaching	• Per contact after 5 (in Health Improvement Bundle) • Up to 11 *additional* HC sessions will be paid by MDHHS – total of 16	S0341 – CPT Z71.9 – ICD-10	**$25** – DOS = date of the contact
Improved / Positive Outcomes	• Blood pressure – Under control and/or lower • Weight loss of at least 1% of your baseline weight • Tobacco use – Quit or substantial reduction • Glucose or A1c – Lowered • Nutritional improvements including, but not limited to decreased sugar and/or salt intake, increased fruit and/or vegetable intake • Increased Exercise times	S0316 – CPT Z71.9 – ICD-10 - Improved Outcomes; Disease management program, follow-up/reassessment (Outcome evaluation contact completed) – including controlled BP, weight loss; tobacco cessation; lowered glucose or A1c; etc.	**$100** DOS = date of approval by MDHHS **MDHHS approved **
Alert Value Case Management	• Monitoring / Case Management of alert value Blood Pressure	99429 – CPT	**$75** – DOS = resolution date
DPP – Diabetes Prevention Program	• Client attends a Diabetes Prevention Program Session	0403T	**$25** – DOS = date of session

WISEWOMAN
Records Retention Policy

This policy pertains **only** to WISEWOMAN 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 and authorized for reimbursement
- Agencies that document WISEWOMAN participant care in Electronic Medical Records **do not** need to print paper copies of records if 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 agency for the time 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

Michigan WISEWOMAN Program
Michigan Department of Health and Human Services
Lansing, Michigan 48933

RELEASE

I give the Michigan WISEWOMAN Program permission to use the information I have initialed below on the WISEWOMAN website, on social media, and in print for educational materials, brochures, presentations, articles, and other publications for educational and public health purposes, without compensation or time limitation.

Initial all that apply.

_____ My Name

_____ Photos of me

_____ Videos of me

_____ My Quotes

Name (please print) _____

Organization (if applicable) _____

Signature _____

Date _____

APPENDIX

A

Resources –

Multidisciplinary Team Approach

WISEWOMAN
Multidisciplinary Team Approach
Resources

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

APPENDIX

B

Resources –

Two-Way Referral

WISEWOMAN
Two Way Referral
Resources

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/

APPENDIX

C

Resources –

Community Clinical Linkages

WISEWOMAN
Community Clinical Linkages
Resources

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

APPENDIX

D

Resources –

Monitoring Hypertension

WISEWOMAN
Monitoring Hypertension
Resources

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