<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>2-3</td>
</tr>
<tr>
<td>Confidentiality Statement</td>
<td>4</td>
</tr>
<tr>
<td>Enrollment and Eligibility</td>
<td>5</td>
</tr>
<tr>
<td>Program Requirements</td>
<td>6-7</td>
</tr>
<tr>
<td>Program &amp; Documentation Guidance</td>
<td>8-9</td>
</tr>
<tr>
<td>Follow-Up for Abnormal/Alert Values</td>
<td>10</td>
</tr>
<tr>
<td>Refusal of Services/Loss to Follow-Up</td>
<td>11</td>
</tr>
<tr>
<td>Risk Reduction Counseling</td>
<td>12</td>
</tr>
<tr>
<td>Data Collection Forms</td>
<td>13</td>
</tr>
<tr>
<td>Vouching Protocol</td>
<td>14-15</td>
</tr>
<tr>
<td>Health Coaching</td>
<td>16</td>
</tr>
<tr>
<td>Weight Watchers™</td>
<td>17-18</td>
</tr>
<tr>
<td>Home Blood Pressure Monitoring</td>
<td>19-20</td>
</tr>
<tr>
<td>Medication Therapy Management</td>
<td>21-22</td>
</tr>
<tr>
<td>Re-evaluation and BP+ Screening</td>
<td>23</td>
</tr>
<tr>
<td>Health Care Provider Enrollment</td>
<td>24</td>
</tr>
<tr>
<td>Compensation &amp; Billing for Health Care Providers</td>
<td>26</td>
</tr>
<tr>
<td>Quality Assurance and Quality Improvement</td>
<td>28</td>
</tr>
<tr>
<td>Resources</td>
<td>29</td>
</tr>
<tr>
<td>Glossary</td>
<td>33</td>
</tr>
<tr>
<td>Appendix</td>
<td>35</td>
</tr>
</tbody>
</table>
Introduction

Iowa Care for Yourself (CFY) WISEWOMAN (Well-Integrated Screening and Evaluation for Women Across the Nation) is a public health program of the Iowa Department of Public Health, which provides cardiovascular disease (CVD) screening (focusing on hypertension control) integrated with the Iowa Breast and Cervical Cancer Early Detection Program (IA NBCCEDP) funded by the Centers for Disease Control and Prevention (CDC). Participants receive cardiovascular screening together with breast and cervical cancer screening.

WISEWOMAN extends the BCCEDP with additional preventive health services:

- Heart disease and stroke risk factor screening, which includes blood pressure (two measurements at each screening visit), cholesterol, glucose, weight, height, hip and waist circumference measures, personal history, family medical history, and readiness to change assessments.
- Lifestyle programs that promote heart-healthy eating and physical activity.
- Links for participants to free or low-cost community-based nutrition, physical activity, and tobacco cessation resources.
- Follow up blood pressure office visit (single follow up visit) for clients found to have alert or abnormal value blood pressure measurements at baseline screening.

Vision of Iowa CFY WISEWOMAN

A world where all women can access preventive health services and gain the wisdom to improve her health.

Mission of Iowa CFY WISEWOMAN

Provide low-income, underinsured, or uninsured 40- to 64-year-old women with the knowledge, skills, and opportunities to improve their diet, physical activity, and other life habits to prevent, delay, or control cardiovascular and other chronic diseases, such as diabetes and cancers.
Heart disease, stroke, cancer, and diabetes account for about two-thirds of all deaths in the United States. Many studies have shown that we can lower people’s risk for illness and death from these chronic diseases by reducing risk factors such as high blood pressure, high cholesterol, obesity, poor diet, sedentary lifestyle, and smoking. However, screening, behavioral interventions, and any necessary treatment services for these risk factors are often beyond the reach of underinsured and uninsured women, as according to the Department of Health and Human Services Region VII Status of Women in Iowa 13.9% of all women are below the federal poverty level and of those 13.9%, approximately 43% are ages 45 and older.

To address this unmet need for preventing and detecting heart disease, stroke, and their risk factors among uninsured women, WISEWOMAN was authorized as a program in 1993 through federal legislative supplement to the law that established The Centers for Disease Control and Prevention’s (CDC) Nation Breast and Cervical Cancer Early Detection Program (NBCCEDP).

In 1995, CDC launched the first WISEWOMAN demonstration projects in three states: Massachusetts, Arizona, and North Carolina. In 2001, Congress authorized WISEWOMAN to expand to 15 states, including Iowa. Today, Iowa continues as one of 21-funded programs in 20 states, including two tribal organizations in Alaska.
Confidentiality Statement

The Care for Yourself – WISEWOMAN Program endorses the health care standards of participant confidentiality. These standards apply to all individuals and agencies representing or working in any capacity with the Care for Yourself (CFY) Program. Any information gathered will be used only for program purposes and no participant will be identified by name without written permission.

Confidentiality is both an ethical and legal responsibility. State and federal courts uphold the common patient confidentiality standards such as the American Medical Association (AMA) ‘Code of Ethics.’ Divulging medical information (verbal, written, phone, fax, electronic, etc.) to a third party without appropriate consent from a participant is considered a breach of confidentiality whether intentional or unintentional.

All participant records and identifying information must be secured in a manner accessible only by CFY Program staff. This includes but is not limited to locking files, providing a private area for verbal communication with participants (face-to-face or by telephone) and a method for securing participant information.

The Iowa Department of Public Health, CFY Program has federal exemption related to HIPAA (Health Insurance Portability and Accountability Act), the federal law that protects personal medical information and recognizes the rights to relevant medical information of family caregivers and others directly involved in providing or paying for care. Therefore, participant program related medical information (e.g. program related data requirements) allow for accessibility of participant information related with this IDPH-CFY Program and its data requirements.
CFY WISEWOMAN Program Enrollment and Eligibility

As of July 1, 2014 the Care for Yourself - WISEWOMEN Program Screening Program serves the following:

- Women ages 40 to 64 years.
- Have incomes of up to 250% of Federal Poverty Level (FPL).
  - No proof of income is required.
- Are uninsured or underinsured.
  - Insurance does not cover these services.
  - Unable to pay a co-payment or have a high deductible.
  - No Medicaid or Medicare Part B coverage.
- Must reside in Iowa (Iowa CFY WISEWOMAN Program)*.
  - *In the case where a non-Iowa resident is enrolled in CFY WISEWOMAN Program and uses a non-Iowa health care provider, services will not be reimbursed. The surrounding states of Nebraska, South Dakota, Minnesota, Wisconsin, Illinois, and Missouri all have the National Breast and Cervical Cancer Early Detection Program integrated with WISEWOMAN available to their residents.
- Must be a Breast and Cervical Cancer Early Detection Program (BCCEDP) participant enrolled for integrated CFY program services (breast cancer screening and/or cervical cancer screening combined clinical office visit with WISEWOMAN screening services).
The purpose of (WISEWOMAN) Services is to provide screening, diagnostics, and cardiovascular-related intervention services to low-income, underinsured or uninsured women ages 40-64 years of age, earn less than the set income guidelines, or not enrolled in Medicare Part B.

WISEWOMAN Screening* Program Requirements include:

- Determine eligibility on individuals to enroll as a participant in the CFY program.
  - CFY Project Coordinator must assure all enrollment information is collected, entered and submitted into the live Web-based Data System prior to Provider Claims System (PCS)

- An office visit that includes appropriate/recommended breast and cervical cancer screening and cardiovascular screening;
  - Clinical breast exam;
  - Pelvic exam;
  - Pap test and HPV testing, as eligible and recommended by provider;
  - Two blood pressure measurements collected during the same date office visit (Refer to Screening Values section of Coordinator Binder);
    - If an abnormal value is identified, one follow-up office visit will be paid for follow-up services, within three weeks after the baseline abnormal measurement value (based on U.S. Preventive Services Task Force (USPSTF). Refer to Screening Values section of Coordinator Binder;
    - If an alert value is identified, one follow-up office visit will be paid for follow-up services within seven business days (based WISEWOMAN Program requirement). Refer to Screening Values section of Coordinator Binder;
  - Height, weight, hip circumference and waist circumference (Refer to Screening Value section of Coordinator Binder);
  - Fasting blood lipids (Refer to Screening Value section of Coordinator Binder);
  - Fasting glucose measurements or glycated HbA1c (initial A1c is only for participants previously diagnosed with diabetes). Refer to Screening Values section of Coordinator Binder.
    - If a fasting glucose alert value is identified, one follow-up office visit and a follow-up HbA1c will be paid for within seven business days (based on WISEWOMAN Program requirement)
  - Tobacco cessation referral; (see Quitline Tobacco Referral Fax form under Additional Resources in the Coordinator Binder);
  - Mammography, as eligible and recommended by provider;
  - Breast and/or cervical diagnostic services, as recommended by provider;
  - Referral for cardiovascular diagnostics, as recommended by provider;
• Referral for pre-cancer and cancer treatment, as recommended by provider; and
  • Cardiovascular Intervention delivery (health coaching, referral to evidence-based lifestyle program (EBLSP) and/or community-based resources.

* Program-eligible women may be enrolled to receive screening services dependent upon funding availability for cardiovascular services.
The Care for Yourself - WISEWOMEN Program Screening Program services include:

- A paid office visit with appropriate/recommended breast and cervical cancer screening and cardiovascular screening;
  - Two blood pressure measurements collected during the same date office visit;
    - *If an abnormal or alert value is identified, one follow-up office visit will be paid for;
  - Height, weight, hip and waist circumference;
  - Fasting blood lipids;
  - Fasting glucose measurements or glycated HbA1c (*only for clients previously diagnosed with diabetes);
    - *If an alert value is identified, one follow-up office visit will be paid for; and
- Tobacco cessation referral.

Cardiovascular (CVD) / Diabetes Screening

The policy for CVD screening of clients (40-64 yrs.) will be as follows:

- Baseline Screening: Clients 40-64 years of age will be eligible to receive an initial CVD screening in conjunction with a routine Breast and/or Cervical Screening visit.
  - The client should arrive at her appointment fasting for lab draw if not conducted prior to screening visit. (No food or drink for 9 hours)
  - Labs should be done within 30 days before or after the screening office visit.
- Second Screening: Clients will be eligible for a second required CVD screening at her next routine Breast and/or Cervical screening visit.
  - According to Program protocols, this visit should be 12-18 months after the initial screening visit.
- A CVD screening includes all of the following at each baseline or second screening visit:
  - Height/weight measurements
  - Two blood pressure readings*
  - Hip and waist circumference measurements
  - Fasting blood lipids
  - Fasting Blood glucose, and/or glycated HbA1c (A1c for clients previously diagnosed with diabetes or as a follow-up to an alert glucose value).
Also at each visit: Clients and clinicians should engage in dialog regarding tobacco use, medication access and adherence if applicable and risk reduction counseling related to healthy eating and physical activity.

A1c Testing for Clients age 40-64

- Initial Screening Visit
  - Clients previously diagnosed with diabetes should receive an HgbA1c at the initial screening visit.
- Follow-up A1c for Glucose Alert Value
  - Clients with a glucose Alert Value at the initial screening visit may have an HgbA1c paid for by the program as a follow-up test. The follow-up A1c may be conducted at the initial visit or at the follow-up visit.

*Blood Pressure Measurement Technique:

- Patients should not smoke, exercise, or have caffeine for at least 30 minutes before their blood pressure is measured.
- Patients should be seated quietly for at least 5 minutes in a chair (rather than on an exam table), with feet on the floor and arms supported at heart level.
- An appropriate sized cuff should be used (cuff bladder encircling at least 80% of the arm).
- A mercury sphygmomanometer, a recently calibrated aneroid manometer, or a validated electronic device should be used.
- At least two measurements should be taken and recorded, separated by a minimum of 2 minutes. If the first two readings differ by more than 5mmHg, additional measurements should be taken.

Medication Access/Adherence

Due to federal funding restrictions, the Program cannot assist clients financially with any medication a provider may prescribe for clients. A list of resources for free or low-cost medications can be found in the Resources section of this manual.
The Care for Yourself – WISEWOMAN Program will pay for one follow-up office visit for review of abnormal or alert results (abnormal and alert values listed below) and to determine appropriate plan for treatment.

Abnormal Screening Values: High blood pressure (hypertension) is usually defined in adults as a systolic blood pressure of 140 mmHg or higher, or a diastolic blood pressure of 90 mmHg or higher. **Program can pay for one follow-up visit if an abnormal value is identified.** Refer to Screening Values section of Coordinator Binder.

Clinicians are expected to provide appropriate medical evaluation in accordance with national guidelines immediately or within three weeks following an abnormal high blood pressure measurement for women.

Alert Screening Values: Clinicians are expected to provide appropriate medical evaluation in accordance with national guidelines immediately or within 7 business days of alert measurement. **Program can pay for one follow-up visit if one of the alert values is identified below.** Refer to Screening Values section of Coordinator Binder.

- Alert values are defined as:
  - Systolic Blood Pressure >180 mmHg Systolic or >110 Diastolic Blood Pressure on CDC WISEWOMAN Guidance for the start of this program project period.
  - Fasting or non-fasting Blood Glucose \( \leq 50 \text{ mg/dL} \) or \( \geq 250 \text{ mg/dL} \).

For clients with a Blood Glucose Alert Value, a follow-up HbA1c will be paid for at the initial screening or the follow-up visit.

If client has an Abnormal/Alert Value, please fill out the Abnormal/Alert Value section of the Master Form and email it to Lori Byrd at Lori.byrd@idph.iowa.gov
Refusal of Services

If a participant refuses any cardiovascular risk factor screening, diagnostic services and/or follow up office visits, this refusal and reason for refusal must be clearly documented in the IA CFY Program participant record.

Loss to Follow Up

If a Coordinator is unable to contact a participant in person or via phone to discuss alert and/or abnormal values, a Refusal of Recommended Services Form letter should be sent to the participant. The letter discusses the abnormal/alert values, the need for follow up and the availability of additional office visit and services. A copy of the letter sent should be kept in the participant’s file.
Risk Reduction Counseling

In conjunction with the participant’s health care provider, each Regional Program Care Coordinator (RPCC) must provide Risk Reduction Counseling to the participant. Requirements for Risk Reduction Counseling include:

- Each participant who receives cardiovascular services must receive her baseline screening and rescreening results, interpretation of the results and appropriate recommendations in accordance with the national clinical care guidelines both in writing and verbally.
- Programs should take into consideration the timing of the risk reduction counseling based on the availability of blood cholesterol and blood glucose results when making this decision.
- Programs should provide risk reduction counseling both verbally and in writing.
  - This information should be delivered to participants in easy-to-understand and culturally appropriate language. Programs can use existing materials or can develop program specific-materials to convey baseline screening and rescreening results.
The live Web-based Data System shall be utilized as described below:

- The CFY database system at: https://careforyourselfiowa.com. The CFY database system is operated by the University of Iowa – Center for Public Health Statistics (U of I - CPHS) through a contract with the Department. The U of I-CPHS provides monthly Data reports to the Department documenting the data entered by each CFY Contractor (e.g. local agency/program, health care providers, and/or laboratory). The Department uses this Data report to determine if data submitted by the Contractor is complete. If corrections to entries are required, they must be completed within the designated timeframe.

- A service is not considered complete until all data is submitted and accepted in the CFY live Web-based Data System.

  - The Department strongly recommends that all data be entered within the same month the service occurs, and/or no longer than 60 days from the date of the screening.
  - Copies of the program forms are included in the Coordinator Binder under WISEWOMAN Data Collection Forms.

### Required Forms that must be submitted in the Live Web-Based System by the Contractor

<table>
<thead>
<tr>
<th>Form Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Enrollment (Pages 1 and 2)</td>
</tr>
<tr>
<td>Screening Form</td>
</tr>
<tr>
<td>Laboratory Assessment</td>
</tr>
<tr>
<td>CVD Follow-Up (if applicable)</td>
</tr>
<tr>
<td>Health Coaching and Lifestyle Program (Pages 1 and 2)</td>
</tr>
<tr>
<td>Health Risk Assessment (Pages 1 and 2) (at enrollment and re-assessment)</td>
</tr>
<tr>
<td>CVD Evaluation Form</td>
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Payment Protocol

In FY17, payment will no longer be linked to the vouching report. Local programs can bill any amount each month, based on what was designated in the budget section of their FY17 CFY WW Application. However, previous vouching and data entry criteria are still in effect.

WISEWOMAN Screening and Lab Assessment Data Entry Criteria

The local program needs to determine if the participant will receive Breast and Cervical Cancer or WISEWOMAN services.

The Screening Form must be submitted in the database system as the starting point to determine if a participant can be placed on the WISEWOMAN data report. Participants will be on the WISEWOMAN data report if the following criteria are met:

1. The Screening Form with Comprehensive marked (Client Identification area) and Laboratory Assessment Form are submitted in the database system with a Ht, Wt, BP Measurement Date that is within 60 days from when the lab assessment is submitted in the database system. If the Lab Assessment is not submitted within 60 days, the participant will not be eligible for Comprehensive services vouching.

2. The Ht, Wt, and BP Measurement Date on the screening form EXACTLY matches at least one of the CBE, Mamm, or Pap exam dates on the Screening form.

3. A Health Risk Assessment Form must be submitted for the client.

If a Screening Form and Laboratory Assessment Form are submitted in the database system, but the above criteria are not met, the form will appear Not Complete on the Data Report. Once the issue causing the form not to be complete has been corrected (if it’s able to be corrected), the record will show up on a data report as complete if it’s within 6 months of the Ht, Wt, BP Measurement Date.

Note: For example, if the Screening form and Laboratory Assessment form were submitted in December, but the Ht, Wt, BP Measurement Date on the screening form did not match one of the CBE, Mamm, or Pap exam dates on the form, this record would not be included on the December WISEWOMAN data report, but would be listed on the Not Complete list. Once the Ht, Wt, BP Measurement Date was corrected to match one of the other exam dates, the record would then show on the data report as complete in the month that the data was corrected if meets 6-month criteria and is within the same fiscal year.
During FY 2017, the health coaching contacts/sessions on the Health Coaching Lifestyle form must be submitted within 6 months of the Ht, Wt, BP Measurement Date, and they must fall under the contract year, June 30, 2016 to June 29, 2017.

**Health Coaching and Lifestyle Program (LSP) Data Report Criteria**

The Health Coaching/LSP form with completed health coaching session information will be used to determine if a participant can be placed on the Health Coaching data report. The Health Coaching/Lifestyle Program form is submitted in the database system. Participants will be placed on the Health Coaching/Lifestyle Program Data Report list for each contact if the following criteria are met:

1. **The Annual Enrollment, first Health Risk Assessment, Screening and Laboratory Assessment** all have visit dates that are the same as, or earlier than, the first health coaching contact date which is submitted in the database system.
2. Participant has been listed on a FY17 Cardiovascular Screening Services Data Report (this means the Laboratory Assessment has been vouched as well as the Screening Form) within the last six months.
3. All Health Coaching contacts must be submitted in the database system within 6 months of the Ht, Wt, BP Measurement Date (obtained off screening form). All Health Coaching vouching for FY 2017 must fall within the same contract year.

**Risk Reduction Counseling Completion Criteria**

Risk Reduction Counseling must be done at the time that the results of the screening visit are communicated to the participant. Risk Reduction Counseling must be submitted in the database system within 60 days of the Ht, Wt., and BP Measurement Date.

**Evaluation and Follow-Up Completion Criteria**

For evaluation purposes, information from the Health Risk Assessment will be collected on participants who complete three health coaching sessions (two in some cases) to see if any progress has been made.

1. **A second CVD Health Risk Assessment and BP+ Screening** needs to be completed after the client completes three health coaching contacts and/or at least 12 Weight Watchers® face-to-face sessions. In cases where the woman withdraws at the second Health coaching contact, the second Health Risk Assessment has to be completed also. The second Health Risk Assessment should have a date that is the same or up to 4 weeks after the last health coaching session and/or the 12 through 16 sessions of Weight Watchers are completed and documentation is submitted in the database system. Completion of the second Health Risk Assessment must be within six months of the screening visit.
2. The second Health Risk Assessment must be submitted in the database system within 60 days of the last health coaching session.
Referral/Enrollment in Health Coaching Sessions

Health coaching is patient-centered and may focus on health coaching include physical activity, nutrition, blood pressure monitoring, medication adherence, and/or smoking cessation. The health coaching sessions can be conducted face-to-face or telephone. Face-to-face sessions will be highly encouraged. Each WW participant will complete a lifestyle assessment at the baseline screening visit; and, the completion of the LSP/health coaching series for evaluation of improvement in minutes of physical activity, improvement in parameters identified for healthy eating, improvement in blood pressure control, and smoking behavior change, as well as for improvement in the participant’s motivation to make changes.

For a detailed plan of the approved Health Coaching guidance from the Centers for Disease Control and Prevention, refer to the Appendix A.
Iowa’s selected Lifestyle Program (LSP) is approved Weight Watchers™. Criteria for acceptable WISEWOMAN lifestyle programs (LSP) includes evidence that the proposed program will result in improvement in an individual’s health status by increasing physical activity, improved healthy eating, control of hypertension, weight loss when appropriate, and/or smoking cessation. Refer to the Weight Watchers section of the Coordinator Binder for a complete list of program criteria.

- **Participant flow** - Describe the referral process (or participant flow) from clinical setting to lifestyle program, to follow-up or interim assessment and reinforcement phase, and rescreening.
  - Iowa will offer a minimum of 20 weekly sessions for Weight Watchers™, the intensive phase of the program as supported by research outcomes.
  - To assure support, women who want to and are ready to continue to maintain their weight improvement behavior change, an additional set of 10-week coupons will be provided, at their request, to reinforce sustainability into maintenance toward becoming a Lifetime Member of Weight Watchers. The additional set of 10-week coupons will be provided for up to 350 participants if a participant demonstrates readiness to change.
  - Maintenance (and reinforcement) for WISEWOMAN purposes is the continuation of weekly weigh-in and session attendance after completing core and/or achieving goal weight.

- **Number of Sessions that will be considered complete**
  Participants must complete a minimum of 12 out of 20 Weight Watchers weekly meetings.

- **Intended Participants** - The Iowa WISEWOMAN program will refer participants to Weight Watchers™ who have a BMI > 25 AND who indicate readiness to change to improve their eating habits and/or improve their physical activity, agree Weight Watchers™ is an appropriate option, and have local access to the program sessions.
  - Based on available data (2010-2012), the Iowa WISEWOMAN program anticipates 75% of women have BMI > 25, and 85% of these women demonstrate readiness to change, interest in this program and have local options to participate. Based on target screening of 900,
women, 570 have the opportunity to be referred to the Weight Watchers™ lifestyle program (LSP) option.

- **Implementation**
  - The program is poised to offer up to 26 weekly coupons of Weight Watchers™ for the intensive phase of the program in communities served by ten WISEWOMAN Program Coordinators. The ten service areas will cover over 50 of Iowa’s 99 counties.
  - Iowa WISEWOMAN will collect Weight Watchers™ assessment measures (post 16 weeks) and information on attendance dates.
  - The coupons must be started within a 2-month period of receipt.
  - Iowa WISEWOMAN will support post intensive follow-up, either extending initial Weight Watchers™ options for participants who complete a minimum of 12 sessions in a 4 to 6-month timeframe and health coaching will be provided from the Program Coordinators (ten locations) who have been trained in motivational interviewing.
Home Blood Pressure Monitoring

The Iowa WISEWOMAN program participants who have been identified with newly diagnosed or uncontrolled hypertension will be offered the opportunity to self-monitor their blood pressure from home while attending health coaching sessions. Blood pressure monitors, blood pressure logs and additional hypertension control materials will be provided for each individual identified. Monitors will be picked up at regional offices to ensure monitor is functional and cuff is appropriate size for participant.

The RPCCs will be trained to instruct participants on how to properly take their blood pressure with the selected blood pressure monitor.

The participant will be instructed to take a blood pressure reading twice a day (morning and evening) every day during the three-month duration of the health coaching sessions. Results will be stored in the monitor’s memory. However, it should also be recorded in the participant’s BP log book.

Participants will be instructed as follows:

- Take the blood pressure readings at the same time each day.
- Do not smoke, do not drink caffeinated beverages, or do not exercise within 30 minutes prior to measuring their blood pressure.
- Do sit with their back straight and supported (kitchen or dining room chair), rather than sitting on the sofa.
- Feet should be flat on the floor.
- Arm should be supported on a flat surface with the upper arm at heart level.
- Make sure the middle of the cuff is placed directly over the brachial artery as shown by the RPCC.

Participants will receive printed and verbal instructions on proper use of the blood pressure monitor. Participants will also receive the manufacturer’s instruction booklet included with the monitor for complete instructions and safety information.

Participants will be instructed on how to record readings in the provided BP log book that they will receive. Participants will be directed to report blood pressure readings to the regional program coordinator at the health coaching sessions or at one-month
intervals, via phone or mail. The RPCCs will fax the participants’ blood pressure readings to the health care provider office.

A final copy of their BP tracking log will be sent in after the last health coaching session. The BP monitors have a backup memory that stores readings which can be accessed from the monitor, if reading is not immediately recorded in the tracking log.

Emergency/Alert Reading
A single high reading of blood pressure is not an immediate cause for alarm but should not be disregarded. When the participant’s blood pressure reaches a systolic of 180 or higher OR diastolic of 110 or higher, she should take her blood pressure several more times. If the results are consistent, the participant should contact a health care provider. If participant is unable to reach their health care provider, participants will be encouraged to seek medical attention at an urgent care facility. If any heart attack or stroke symptoms are present, participant should call 911 immediately. Information on the signs and symptoms of a heart attack and stroke will be provided to the participants.

The Iowa WISEWOMAN Program (Program) and the Department of Public Health (Department) will not reimburse the participant for any expense associated with an ambulance transport, emergency room visit, or urgent care visit. The Program and the Department are not responsible for the participant’s actions related to the blood pressure monitor including without limitation the participant’s decision to seek or not seek emergency medical care following a high blood pressure reading.

See Appendix B for the complete CDC-Approved Protocol
The Iowa WISEWOMAN program participants who have been identified by the health care providers with newly diagnosed or previously diagnosed, yet uncontrolled hypertension (with medication) are eligible for the Medication Therapy Management (MTM) health coaching program. The Regional Program Care Coordinators (RPCC) will refer eligible participants to the MTM Health Coaching Program by emailing or faxing the MTM Participant Tracking Form (See Appendix C) to the local pharmacy.

Participants will meet with the RPCC either by phone or in-person for the initial health coaching session. At the initial health coaching session, the RPCC will use motivational interviewing techniques to identify healthy lifestyles areas (i.e. exercise, nutrition or smoking cessation) in which they would like to improve in addition to the medication adherence. The RPCCs will conduct a minimum of three health coaching sessions with each participant. At each health coaching session, the RPCCs will review goals set with RPCC and those set with the pharmacist.

Sessions with the pharmacists are as follows:

**Initial MTM Visit (up to 60 minutes)**

Participants will be scheduled for the initial MTM visit at the pharmacy. Participants must bring all prescriptions, over-the-counter (OTC) medication, vitamins and supplements currently taken.

Pharmacists will:

- Complete a comprehensive medication review – physician’s list vs. participant medications
- Develop a complete medication list for records and for participant
- Complete the DRAW tool (See Appendix C)
- Discuss with participant:
  - Difficulties in taking the medication
  - Potential interactions between medication
  - Potential side effects
  - Any allergies
  - Refilling process
  - Possible low cost medication options
  - Importance of and barriers to medication adherence
  - Lifestyle choices influencing hypertension
  - Develop medication adherence and lifestyle goals with participant’s input

Participants will be provided:

- One 7-day, 28 compartment medication box
- Blood pressure readings
- *Understanding and Controlling Your High Blood Pressure* brochure
- Complete medication list with recommendations and goals set with the pharmacist

If the participant is also involved in the home blood pressure monitoring program, the pharmacist may review the proper technique for taking a blood pressure with the participant.

The pharmacist may contact the participant’s health care provider as necessary.

The pharmacist will fax or email the completed DRAW tool, medication list, and participant tracking form to the RPCC.

**Two Follow-up MTM Phone Calls** (up to 30 minutes each)

The pharmacist will follow-up via phone with participant. This phone call will allow pharmacist to:
- Reinforce medication adherence and usage information
- Review medication and lifestyle goals
- Answer participant questions

The first follow-up call will be within two (2) weeks of the initial pharmacy visit. A second follow-up call will be provided 4-6 weeks after the first phone call.

**Final MTM Visit (up to 30 minutes)**

The final MTM visit will be scheduled 12 weeks after the initial MTM visit. The pharmacist will:
- Complete the DRAW Tool (See Appendix B)
- Review and reinforce medication adherence
- Review lifestyle goals
- Complete blood pressure measurements

The pharmacist will fax and email the completed DRAW Tool and participant tracking form to the RPCC for the participant’s record.

The participant tracking tool allows documentation of participant health coaching goals to be shared between the RPCC and pharmacist. The goals will be reinforced and revisited at all participant encounters.

See Appendix C for CDC-Approved MTM Protocol
Re-Evaluation

For those participating in any lifestyle program activities such as Health Coaching, Weight Watchers, Home Blood Pressure Monitoring or Medication Therapy Management, a re-evaluation must be completed.

The re-evaluation:

1) Must be completed within 4 weeks of completion of health coaching and lifestyle programs.
2) Must be completed within the six-month timeframe for completion of the program.
3) Includes the completion of the *CVD Health Risk Assessment* form.

BP+ screening

On at least 50% of participants, at re-evaluation, the RPCC will also collect the **height**, **weight** and **blood pressure** of the participant. Blood pressures must be measured by the coordinator or health professional. It cannot be a reading taken by client with home monitor.

BP+ screening data will be recorded on the *CVD Evaluation* form.
Contractors shall conduct Healthcare Provider Recruitment as follows:

- Identify and recruit healthcare providers and laboratories to enroll as official providers of healthcare screening and diagnostic services for the CFY program.
  - Complete a new or renewal WISEWOMAN Healthcare Provider Agreement for each WISEWOMAN healthcare provider as needed.
  - A separate Healthcare Provider Agreement needs to be completed for Breast and Cervical Cancer and WISEWOMAN Screening Services.
  - Assure all new healthcare provider applications/agreements are submitted to the Department.
  - Update healthcare provider information after consulting with the Program Consultant (Breast and Cervical Cancer and/or WISEWOMAN).
- The Contracted CFY Project Coordinator is responsible for orienting the enrolled healthcare facilities/providers on all CFY requirements and program updates.
- The Contracted CFY Project Coordinator will work collaboratively with the Department to assure all enrolled healthcare providers within the designated service area collect and report the required data.

Healthcare providers in the state have an opportunity to participate in the Care for Yourself-WISEWOMEN Program. Providers who participate in the program adhere to the following items listed below.

- **Sign a five-page contract** - The five-page contract allows health care providers to participate in the Program by agreeing to follow procedures described in each direct service section of the program’s Provider Contract Manual. Refer to the Health Care Provider Enrollment section of the Coordinator Binder for a complete list of agreement forms.
  - Care for Yourself – WISEWOMAN Cooperative Agreement;
  - Care for Yourself – WISEWOMAN Application for Health Care Facility and Health Care Provider Enrollment;
- **Copy of the facility W-9 form.**
- **Copy of CLIA (Clinical Laboratory Improvement Amendments, standards for laboratories) Certificate**, if applicable.
- **Accept the fee schedule** - Refer to the Health Care Provider Enrollment section of the Coordinator Binder for a complete list of agreement forms.
- **Supply needed data about program enrolled participants screened** - The program attempts to interfere as little as possible with your facility’s standard procedures while collecting important public health information about enrolled participants.
clients. This manual describes all documentation needed to participate in the program.

- **Submit for reimbursement of procedures according to program guidelines** - Procedures are reimbursed for enrolled clients according to the guidelines set by the program’s funder, the Centers for Disease Control and Prevention. These guidelines are designed to meet the greatest public health need.
  - **Assure staff participation in professional continuing education** and training necessary to provide competent breast and cervical cancer screening, cardiovascular screening, diabetes screening, and follow up services.
  - **Assure that healthcare providers serving the clients of the program have a valid, current license, certification or registration** to practice their profession or occupation as required by state statutes.
  - **Maintain appropriate state and federal occupational and facility licenses and certifications** required to perform the services provided.
  - **Utilize only the contracted providers for referral.**
  - **Discuss with client the services that are not covered by the Program and how those services will be paid for.**

Email the five-page contract with the attached Cooperative Agreement and Application for Health Care Facility and Provider Enrollment to Sonya Loynachan at Sonya.loynachan@idph.iowa.gov.

Questions on provider agreement/application, please call Sonya Loynachan, Program Manager at 515-725-0693.
Compensation and Billing

Before being reimbursed by the Care for Yourself- WISEWOMEN Program, a healthcare provider agrees to provide reports of findings and recommendations which are necessary to compile data and reports to the funder, the Centers for Disease Control and Prevention.

The Care for Yourself - WISEWOMEN Program contracts with Provider Claim Systems (PCS), a division of North Iowa Community Action Organization (see contact information in the inset box below) to process claims and reimburse health care providers for covered services.

Reimbursable Services

Program reimbursement services and payment schedule can be found in Health Care Provider Enrollment section located in the Coordinator Binder. Federal law requires that reimbursement with federal funds may not exceed Iowa Medicare Part B rates. Medicare and IA CFY Program reimbursement rates are updated annually. A woman enrolled in the IA CFY Program should not be billed for:

- Any Care for Yourself- WISEWOMEN Program covered service, and
- Collection and transportation of specimens. These costs are to be included in the office visit reimbursement. They should not be billed separately.

Claims Processing: Contact Provider Claim System (PCS)

1) Submit claims for reimbursement of services according to local Care for Yourself Program coordinator request; or

2) Provider facilities can submit claims to Provider Claim Systems (PCS) at the address below:

WISEWOMAN Program/Provider Claim Systems
PO Box 1608
Mason City, IA 50402-1608

Questions related about claims can be directed to 1-800-547-6789.

Allow 3 weeks for reimbursement from the time PCS receives the claim for reimbursement. PCS will send a remittance notice with the reimbursement check to identify claims being paid to the provider.
CLAIM FORMS

Originals of the HCFA 1500 and the UB 04 are the only accepted forms to submit claims for payment. The following information must be included for a claim to be processed:

- Participant name and address
- Participant ID number
- Participant Birth Date
- Date of service
- CPT code for each approved service(s) provided
- Charge for service
- Facility name, address, Tax ID number and NPI number
- Billing name, address and NPI number
- If insurance is involved, complete the following:
  - For the HCFA 1500, Boxes 28 (Total Charge), 29 (Amount Paid), & 30 (Balance Due)
  - For the UB 04, Boxes 54 (Prior Payments) and 55 (Est. Amount Due)
  - Submit the Explanation of Benefits (EOB) from an insurance company

Third-Party Billing

The Care for Yourself – WISEWOMAN program is the payer of last resort. Participating healthcare providers agree to file insurance, Medicare and other third-party claims first. You agree to accept the rates listed on the Fee Schedule as payment in full.

If the third-party payment is greater than or equal to the maximum allowable cost described in the Fee Schedule, that amount must be considered payment in full. **DO NOT BILL** the program or the client for services.

If the third-party payment is less than maximum allowable costs describe in the Fee Schedule, the claim should be sent to the Program, along with a copy of the explanation of benefits from the third-party payer. **Do not bill the client for these services.**
Quality Assurance and Improvement are integral components of the IA CFY Program and contribute to program success. The purpose of quality assurance and improvement is to:

- Ensure the quality of services delivered through the program
- Monitor performance and identify opportunities for improvement
- Plan effective strategies for improving services
- Program requirements and monitoring activities include:
  - Professional Licensure and Accreditation – health facilities and professionals must be currently licensed or accredited to practice
  - Reporting standards for radiological, laboratory and pathology – reports must be reported according to national standards
  - Standards for adequacy of follow-up – data reports track appropriate and timely diagnostic, short-term and rescreening services
  - Case Management services – local program staff evaluate needs, implement plans and refer participants who need diagnostic services and/or are diagnosed with cancer or heart disease risks
  - Accurate data and documentation – Minimum Data Elements (MDE) are reported to CDC semiannually
  - Evaluations – reports (e.g. but not limited to: mid-year program progress report and end-of-year final program report) are completed routinely and as needed to assess how well IA CFY Program is meeting CDC-set goals and objectives.
  - Adherence to CDC policies and guidelines.

Regional Program Care Coordinators (RPCC) are required to attend the Health Care Provider Site Visits for all regional providers.
Professional and Public Education and Informational Resources

**American Heart Association**
Statements, Guidelines & Clinical Updates
http://www.heart.org/HEARTORG/HealthcareResearch/Healthcare-Research_UCM_001093_SubHomePage.jsp

**Blood Pressure**
The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7)
http://www.nhlbi.nih.gov/guidelines/hypertension/

United States Preventive Services Task Force (USPSTF) – Screening for High Blood Pressure Task Force Recommendation's
http://www.uspreventiveservicestaskforce.org/uspstf07/hbp/hbpsum.htm

**Diabetes**
American Diabetes Association Clinical Practice Recommendations:
http://professional.diabetes.org/ResourcesForProfessionals.aspx?cid=84160

CDC Diabetes: www.cdc.gov/diabetes

**Diet – Healthy Eating**
Dietary Guidelines for Americans
http://www.healthierus.gov/dietaryguidelines/

Therapeutic Lifestyle Changes (TLC) diet principles (ATP III)

DASH eating plan (JNC 7)

**Cholesterol**
National Cholesterol Education Program, Adult Treatment Panel III Report (ATP III)
http://www.nhlbi.nih.gov/guidelines/cholesterol/

Implications of Recent Clinical Trials for the National Cholesterol Education Program Adult Treatment Panel III Guidelines
Heart and Stroke
Million Hearts Initiative: http://millionhearts.hhs.gov/index.html

CDC Heart Disease and Stroke Prevention: http://www.cdc.gov/dhdsp/

Krames Patient Education
(800) 333-3032
1100 Grundy Lane
San Bruno, CA 94066-3030
http://www.krames.com
One-stop-shop for client education materials in a variety of print and electronic formats available for purchase.

Medline Plus
www.medlineplus.gov
A service of U.S. National Library of Medicine and the National Institutes of Health. Site contains information on more than 650 health topics, drug information, a medical encyclopedia, and dictionary, as well as directories, current news and interactive tutorials. (Select articles available in 40 different languages, downloadable in PDF format.)

Medication Access – Due to federal funding rules WISEWOMAN program funds cannot be used for treatment, including medication. Therefore, State/Tribal programs must develop a system to ensure access to free or low-cost medications for women who require this augmentation to lifestyle behavior changes.

Minimum data elements related to medication access for women with alert screening values must be collected and submitted to CDC.

A list of potential resources follows.*

SafeNetRx
safenetrx.org
The Iowa Drug Donation Repository
Iowa is one of the few states in the country that has a drug donation repository to provide short-term pharmaceutical assistance to low income and under-or uninsured patients. The Iowa Drug Donation Repository, managed by the SafeNetRXis not intended to supplant state or federal programs but to serve patients who need short-term assistance, such as an insured patient who cannot afford a drug co-pay or a senior who has reached the Medicare Assistance coverage gap.

The Repository accepts medical supplies and non-controlled medications that have an expiration date greater than six months from the date of the donation, are contained in original sealed or unit-dose tamper-evident packaging, and do not require refrigeration. Iowans at or below 200% of the federal poverty level who are uninsured or underinsured are eligible to receive medication and supplies from the Iowa Drug Donation Repository if their health care providers request assistance on behalf of their eligible patients. The requested medications are then distributed through participating medical facilities and pharmacies. Over
220 medical facilities across Iowa, including community health centers, rural health clinics, free clinics, physicians’ clinics, hospitals and pharmacies partner with the Repository help meet the pharmaceutical needs of their eligible patients.

If you would like to donate medications or sign up your medical facility to dispense donated medications and supplies, please contact IPDC at (515) 327-5405 or you may visit the web site at www.iowapdc.org.

State Pharmaceutical Assistance Programs
https://www.medicare.gov/pharmaceutical-assistance-program/state-programs.aspx
It identifies states that have programs to provide pharmaceutical coverage or assistance, primarily to low-income older people or people with disabilities who do not qualify for Medicaid.

340B Drug Discount Program
This website is a Health Resources and Services Administration program that gives certain Federally-funded grantees access to low-cost pharmaceutical drugs.

Goodrx.com
http://www.goodrx.com
The website compares the prices of pharmaceutical drugs available at local pharmacies.

The Partnership for Prescription Assistance
https://www.pparx.org/
The Partnership for Prescription Assistance helps qualifying patients without prescription drug coverage receive the medicines they need for free or nearly free. The partnership strives to increase awareness of patient assistance programs and boost enrollment of those who are eligible. They offer a single point of access to more than 475 public and private programs, including nearly 200 offered by biopharmaceutical companies.

Rx Assist
www.rxassist.org
A Web site developed by Volunteers in Health Care, a program of the Robert Wood Johnson Foundation, to provide health care practitioners with information on how to access programs that offer a limited supply of free or low-cost medications.

Rx Hope
https://www.rxhope.org/
A free program that helps physician’s offices apply for, obtain, and track requests for no-cost medications offered by Federal, State, and charitable organizations.

*NOTE: Links to non-Federal organizations in this document are provided solely as a courtesy to health care providers and agencies. These links do not constitute endorsements of these organizations or their programs by CDC or the Federal government, CDC nor the state program is responsible for the content of the individual organizations’ Web pages found at these links.
National Women’s Health Information Center
www.4woman.gov
Gateway for women’s health resources and materials for consumers and professionals. Maintained by the U.S. Dept. of Health & Human Services.

National Women’s Health Network
(202)682-2640
www.nwhn.org
Provides newsletters and position papers on women’s health topics.

Office of Minority Health
The Office is dedicated to improving the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities.

Obesity
Obesity Education Initiative’s Guidelines for Weight Management
http://www.nhlbi.nih.gov/about/oei/

The Practical Guide: Identification, Evaluation, and Treatment of Overweight and Obesity in Adults
http://www.nhlbi.nih.gov/guidelines/obesity/ob_home.htm

Physical Activity
CDC/American College of Sports Medicine (ACSM) recommendations
http://www.cdc.gov/nccdphp/dnпа/physical/recommendations/older_adults.htm

Surgeon General’s recommendations for physical activity
http://www.cdc.gov/nccdphp/sgr/contents.htm

The Task Force on Community Preventive Services systematic reviews of community interventions to increase physical activity
http://www.thecommunityguide.org/pa/default.htm

Tobacco Cessation
Quitline Iowa
https://www.quitnow.net/iowa/

Additional Resources can be found at:
http://www.cdc.gov/wisewoman/
A1C Test – Glycated hemoglobin, as known as hemoglobin A1c or A1C, or sometimes also HbA1c. It is a hemoglobin test to measure the average plasma glucose concentration over previous months (approximately over six to 12 weeks of time; over a period of 120 days) to assess how diabetes is being controlled and is used in conjunction with home blood sugar monitoring to make adjustments in medicines for patients with diabetes.


BCCEDP - Breast and Cervical Cancer Early Detection Program a State/Tribal-level program is federal funded through the CDC resulting from the Breast and Cervical Cancer Mortality Prevention Act of 1990 (Public Law 101-354) legislated in 1995. The WISEWOMAN program was a legislative supplement to the Breast and Cervical Cancer Mortality Prevention Act, in 1993 through legislative. WISEWOMAN originally began as a demonstration project and then as a program in 1995

BODY MASS INDEX (BMI) – A measurement of body mass that is correlated with skinfold thickness and body density

CARDIOVASCULAR – Pertaining to the heart and blood vessels

CDC – Acronym for Centers for Disease Control and Prevention

CFY – Care for Yourself

CLIA – Clinical Laboratory Improvement Amendments standards for laboratories

CHOLESTEROL – A waxy, fat-like substance present in every cell in the body and in many foods

CVD – Acronym for Cardiovascular Disease.

DASH – Dietary Approaches to Stop Hypertension

DBP – Diastolic blood pressure

DHHS – Department of Health and Human Services

DIABETES – Diabetes mellitus is a chronic syndrome of impaired carbohydrate, protein, and fat metabolism due to insufficient secretion of insulin or to target tissue insulin resistance

DIAGNOSTIC SERVICES – Services rendered to a client who needs follow up after a screening visit that resulted in an abnormal finding

FASTING – Abstaining from all food and drink, 9 hours

FOLLOW UP VISIT – A scheduled repeat visit with a client to reevaluate a condition that was noted at the screening visit, as abnormal or alert value

HC – Health Care Provider

HBP – High blood pressure

HDL-C – High-density lipoprotein cholesterol
HIPAA (Health Insurance Portability and Accountability Act) – The federal law that protects personal medical information and recognizes the rights to relevant medical information of family caregivers and others directly involved in providing or paying for care

HTN – Hypertension

HYPERTENSION – Persistently high arterial blood pressure


LDL-C – Low-density lipoprotein cholesterol

LIPID PANEL – A group of blood tests that determines risk of coronary heart disease; includes total cholesterol, HDL, LDL, and triglycerides

MDE – Minimum data element

MTM – Medicated Therapy Management

NHLBI – National Heart, Lung, and Blood Institute

NIH – National Institutes of Health

OBESE – A body mass index (BMI) of 30 or above

RISK FACTORS – An aspect of personal behavior or lifestyle, environment exposure, or inherited characteristic which, on the basis of epidemiologic evidence, is known to be associated with a health related condition considered important to prevent

SCREENING GUIDELINES – Screening requirements for WISEWOMEN for reimbursement by program funder

SBP – Systolic blood pressure

TLC – Therapeutic lifestyle changes

Triglycerides – According to Mayo Clinic, triglycerides are a type of fat (lipid) found in your blood. When you eat, your body converts any calories it doesn't need to use right away into triglycerides. The triglycerides are stored in your fat cells. Later, hormones release triglycerides for energy between meals. If you regularly eat more calories than you burn, particularly "easy" calories like carbohydrates and fats, you may have high triglycerides (hypertriglyceridemia)

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

Appendix A; Health Coaching Protocol
Appendix B: Home Blood Pressure Monitoring Program Protocol
Appendix C: Medication Therapy Management

1. Program Protocol
2. DRAW Tool
3. Participant Tracking Form
Appendix A
Iowa WISEWOMAN Health Coaching Protocol  
APPROVAL – Year 2 Screening  
FINAL APPROVED 5.14.14

- **How will women be referred to Health Coaching**  
Women are identified for the program by first being eligible candidates for the Iowa Breast and Cervical Cancer Early Detection (IBCCEDP), as WISEWOMAN (WW) is required by CDC to be integrated with the BCCEDP screening health care provider office visit. Women with cardiovascular disease (CVD) risk factors will be further identified through: a) the program assessment form questions, and b) by CDC required CVD screening measures for WISEWOMAN.

Participants will be provided a health assessment and CVD screening (to include measures of: blood pressure, height and weight to determine Body Mass Index (BMI) and hip and waist circumference, fasting cholesterol lipid panel, fasting glucose and/or HbA1C) at an office visit integrated with BCCEDP. Following the collection of the screening-related data, participants will receive risk reduction counseling (RRC). Based on the participant’s readiness to change and identified risk factors, the (RPCC) also known as the local program coordinator will work with the participant to determine if the participant is ready, not ready, or would like to be contacted at a later date to further discuss healthy behavior support options (e.g. health coaching, Weight Watchers® and/or community based referrals). If the participant determines themselves as “ready” for health coaching services an assessment status of Life’s Simple 7™ will be used to create an individualized health score on individual goals and action plans from the regional program care coordinator RPCC. The RPCC staff members are trained community partners including public health nurses, nutritionists, dieticians, or trained interventionists. Refer to the Iowa WISEWOMAN Service Flow Diagram that was revised April 2014 for how the health coaching protocol will work with the Iowa CFY program.

- **Mode of Delivery/Contact Type**
  1. **Setting: Face-to-face;** Strongly encouraged, however due to the rural communities and barriers with transportation this preferred method may not always be an option  
  Definition: Session was completed face-to-face. This includes education, counseling, and goal review and/or setting new goals, referral/monitor of LSP and/or community based resources.
  2. **Setting: Phone**  
  Definition: Session was completed via phone. This includes education, counseling, and goal review and/or setting new goals, referral/monitor of LSP and/or community based resources.

- **Key components/characteristics of the coaching**
Risk reduction counseling (RRC) is separate from health coaching and is provided at the time of the women’s initial screening visit. The participant must understand her CVD risks compared to other women her age. If laboratory results are unavailable during the participants screening visit, RRC will be provided based on what information is available at that time. Complete RRC will be provided when laboratory results are available. In addition, a copy of the participant’s results will be mailed to their home and further discussed once complete information is available. During the RRC, following the health risk assessment (HRA) helps assist in educating women on methods for behavior change without waiting for reported results of high cholesterol or A1C.

IDPH will provide medical follow-up to participants who have been newly diagnosed with hypertension (HTN) or identified with HTN while on medication. A paid second follow-up office visit will be provided for further evaluation of abnormal results. Approximately 32 percent of participants screened through IA WW have HTN.

There will be three components of health coaching. The three components include physical activity, nutrition and smoking cessation. The Iowa WISEWOMAN program schedules health coaching sessions periodically throughout the year to provide support and resources to participants while they are adopting new health behaviors. During each follow-up session the health coach/RPCCs completes the following:
  1. Assess the perceived success of the participant in reaching the goal that they set;
  2. Reassess health behaviors related to the goal;
  3. Determine if other lifestyle changes were made (compare enrollment form to lifestyle assessment form once enrolled participant has received some health coaching sessions); and
  4. Provide support and community-based resource referrals to help the participant reach new or existing goal and to help assist with any barriers that may have been identified.

Participants who participate in health coaching will be tracked through data collection forms and an electronic data-base system at The University of Iowa, Center for Public Health Statistics through data collection and organizing for monitoring and analysis.
on a monthly basis. Participant outreach recruitment, enrollment with consent-giving, pre-screening assessment, assistance with screening appointment scheduling, and data gathering and reporting is handled by the RPCCs. Health coaching sessions will be provided depending on the participants’ needs and readiness to change. In addition, the participant will have the opportunity to be referred to a lifestyle program (LSP) that shows effectiveness in improving diet and physical activity and incorporate national diet and lifestyle recommendations, if interested. Participants who are involved with the LSP will receive intensive follow-up and reinforcement of goals. Follow-up will be conducted within four weeks after LSP completion to assess the woman’s progress and reinforce goals.

- **Method of Documentation of coaching delivered**

The *Care for Yourself* program partners with Iowa’s NBCCEDP to maintain an integrated database that allows the program to electronically collect required data. Participant outreach, enrollment with consent-giving, pre-screening assessment, assistance with screening appointment scheduling, and data collection and reporting is handled by the regional program care coordinator (RPCC). All interactions with the participants are entered into the Iowa *Care for Yourself* database system. IDPH will continue to contract with The University of Iowa, College of Public Health, Center for Public Health Statistics (UICPHS) to manage data collection. UICPHS will manage program data, prepare Minimum Data Elements (MDEs) for submission, and work with state staff on program evaluation. The UICPHS will be responsible for revising the current web-based data system to meet the requirements of the CDC and assure all data is available for program evaluation. While this data handling and preparation is not a formal evidence-based program, the data continues to be successfully and strategically managed process directed by the supervision of public health prepared biostatisticians at the university level with rigor and reliability for over 10 years in working with the WW program, and including management of the Iowa BCC program data.

- **Anticipated number of sessions/dosage/mode and in what timeframe**

Sessions will be provided depending on the participants’ needs and readiness to change. A minimum of three sessions within 6 months is considered complete. The recommended dose is determined by the participant’s values within each category. One or more elevated value(s) within a category (Blood Pressure, Cholesterol, Glucose, BMI, and Uncontrolled Hypertension/Alerts) are counted as one risk factor.

**Session Delivery Timeframe**

Patients receive the recommended dosage based on the interval. Each “X” represents one health coaching session. The numbers along the top represent the number of months after the initial screening and outlines when each health coaching session should be conducted (Example: a participant with 3 RF should receive a health coaching session in months 1, 2, 6, and follow-up during rescreening appointment).

*The delivery timeframe serves as a guide to the RPCC’s. However, it is up to the RPCC and the participant to determine the appropriate number of health coaching sessions provided.*
### Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Values*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>Greater than 140 SBP or Greater than 90 DBP</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Total Cholesterol (TC) Greater than 240, LDL Greater than 160, LDL, HDL Lower than 40, Triglycerides Greater than 200</td>
</tr>
<tr>
<td>Glucose</td>
<td>Non-fasting Greater than 200 or Fasting Greater than 100</td>
</tr>
<tr>
<td>BMI</td>
<td>BMI greater than 28</td>
</tr>
<tr>
<td>Alert Value(s)</td>
<td>SBP &gt;160 or DBP &gt;100, Total Cholesterol &gt;400, or Glucose &gt;250 or &lt;50</td>
</tr>
<tr>
<td>Smoking Status</td>
<td>Participant reports that they smoke</td>
</tr>
</tbody>
</table>

*Values based on CDC WISEWOMAN program screening level criteria established by national screening guidelines.

- **Proposed Plan for follow-up when health coaching is complete**

  Once participants complete the LSP and/or health coaching sessions, they will be contacted via telephone or have a face-to-face to schedule an appointment within a four-week period. At the follow-up session they will be asked to complete a follow-up lifestyle assessment form to facilitate analysis of changes made in health behavior (nutrition, physical activity, smoking) and health status for the program over time. The completion of the lifestyle assessment form will assist in assessments of participant behavior change outcomes. The data collection results from the lifestyle assessment will allow the WW program to provide further data analysis and program evaluation on changes made among the participants based on the participation in the LSP and/or health coaching sessions. Every year women who were previously enrolled in the program will receive a reminder letter to recall them to the program to schedule their next appointment for routine screenings.
Iowa WISEWOMAN
High Blood Pressure (HBP) Health Coaching Protocol

1. **Rationale:** Evidence of past effectiveness with specific population and/or brief explanation of why this approach can be expected to be appealing and effective with the target population.

Hypertension (HTN) is the single largest risk factor for cardiovascular disease. Based on previous Iowa WISEWOMAN data (FY 2010-2012), it is estimated out of the 900 women to be screened, approximately 324 (36%) will have HTN. Of those 324, approximately 40 (12%) will be newly diagnosed and 123 (38%) will have uncontrolled HTN. Research suggests home self-monitoring of blood pressure may lead to better control of blood pressure in patient.

*Grantee proposes to refer participants newly diagnosed or previously diagnosed, yet uncontrolled hypertension with or without medication.*

**Study 1:** Clinician Summary AHRQ Pub. No. 12-EHC002-3, February 2012. *Effectiveness of Self-Measured Blood Pressure Monitoring in Adults With Hypertension.*


**Conclusions:**

In the management of hypertension, SMBP alone versus usual care yielded a modest reduction in clinic systolic BP (SBP) and diastolic BP (DBP) at 6 months (SBP/DBP -3.1/-2.0 mmHg) and 12 months (SBP/DBP -1.2/-0.8 mmHg). Meta-analyses showed that the net reduction in SBP and DBP was statistically significant at 6 months but not at 12 months. Combining additional support with SMBP monitoring led to greater BP reduction when compared to usual care at up to 12 months of follow-up based on consistent findings in six high-quality studies. However, the evidence was too limited to determine the superiority of any one form of clinical support, as modalities varied widely across studies. The evidence is weak or insufficient to determine if SMBP with or without additional support has an impact on other outcomes (including mortality, quality of life, number of medications used, medication adherence, and health care encounters). Additional research is needed to determine the effect of SMBP on BP control beyond 12 months and to determine long-term clinical consequences of SMBP.


N=527

**Abstract**

**BACKGROUND:**

Control of blood pressure is a key component of cardiovascular disease prevention, but is difficult to achieve and until recently has been the sole preserve of health professionals. This study assessed whether self-management by people with poorly controlled hypertension resulted in improved blood pressure control compared with usual care.

**METHODS:**

This randomized controlled trial was undertaken in 24 general practices in the UK. Patients aged 35-85 years were eligible for enrolment if they had blood pressure more than 140/90 mm Hg despite antihypertensive treatment and were willing to self-manage their hypertension. Participants were randomly assigned in a 1:1 ratio to self-management, consisting of self-monitoring of blood pressure and self-titration of antihypertensive drugs, combined with tele-monitoring of home blood pressure measurements or to usual care. Randomization was done by use of a central web-based system and was stratified by general practice with minimization for sex, baseline systolic blood pressure, and presence or absence of diabetes or chronic kidney disease. Neither
participants nor investigators were masked to group assignment. The primary endpoint was change in mean systolic blood pressure between baseline and each follow-up point (6 months and 12 months). All randomized patients who attended follow-up visits at 6 months and 12 months and had complete data for the primary outcome were included in the analysis, without imputation for missing data. This study is registered as an International Standard Randomized Controlled Trial, number ISRCTN17585681.

FINDINGS:
527 participants were randomly assigned to self-management (n=263) or control (n=264), of whom 480 (91%; self-management, n=234; control, n=246) were included in the primary analysis. Mean systolic blood pressure decreased by 12.9 mm Hg (95% CI 10.4-15.5) from baseline to 6 months in the self-management group and by 9.2 mm Hg (6.7-11.8) in the control group (difference between groups 3.7 mm Hg, 0.8-6.6; p=0.013). From baseline to 12 months, systolic blood pressure decreased by 17.6 mm Hg (14.9-20.3) in the self-management group and by 12.2 mm Hg (9.5-14.9) in the control group (difference between groups 5.4 mm Hg, 2.4-8.5; p=0.0004). Frequency of most side-effects did not differ between groups, apart from leg swelling (self-management, 74 patients [32%]; control, 55 patients [22%]; p=0.022).

INTERPRETATION:
Self-management of hypertension in combination with telemonitoring of blood pressure measurements represents an important new addition to control of hypertension in primary care.

N=593
Abstract
BACKGROUND: To determine which of the 3 interventions was most effective in improving blood pressure (BP) control, a 4-arm randomized trial with 18-month follow-up at the primary care clinics at a Veterans Affairs Medical Center was performed.

METHODS: Eligible patients were randomized to either usual care or 1 of 3 telephone-based intervention groups: (1) nurse-administered behavioral management, (2) nurse and physician-administered medication management, or (3) a combination of both. Of the 1,551 eligible patients, 593 individuals were randomized; 48% were African American. The intervention telephone calls were triggered based on home BP values transmitted via tele-monitoring devices. Behavioral management involved promotion of healthy behaviors. Medication management involved adjustment of medications by a study physician and nurse based on hypertension treatment guidelines.

RESULTS: The primary outcome was a change in BP control measured at 6-month intervals over 18 months. Both the behavioral management and medication management alone showed significant improvements at 12 months-12.8% (95% confidence interval [CI], 1.6%-24.1%) and 12.5% (95% CI, 1.3%-23.6%), respectively but not at 18 months. In subgroup analyses, among those with poor baseline BP control, systolic BP decreased in the combined intervention group by 14.8 mm Hg (95% CI, -21.8 to -7.8 mm Hg) at 12 months and 8.0 mm Hg (95% CI, -15.5 to -0.5 mm Hg) at 18 months, relative to usual care.

CONCLUSIONS: Overall intervention effects were moderate, but among individuals with poor BP control at baseline, the effects were larger. This study indicates the importance of identifying individuals most likely to benefit from potentially resource intensive programs

2. Flow diagram or algorithm of how women will be referred to Health Coaching (at what point in WISEWOMAN flow diagram, what criteria will be used to identify women)
Iowa WISEWOMAN HBP Health Coaching
The Iowa WISEWOMAN program participants who have been identified by the health care providers with newly diagnosed or previously diagnosed, yet uncontrolled hypertension (with or without medication) will be eligible for the self-monitoring blood pressure (SMBP) health coaching program. The Regional Program Care Coordinators (RPCC) will refer eligible participants to the HBP Health Coaching Program.
3. **Who** will provide the coaching (credentials & training)?

Regional Program Care Coordinators (RPCC) will provide the health coaching sessions in-person and via phone.

Each RPCC has completed health coaching certification training provided through the Iowa Chronic Care Consortium (ICCC). The health coaching program is an online, 26-week program, which concludes with a practical exam for certification.

In addition, continued education courses will be provided through face-to-face meetings and/or by webinar to help RPCC’s develop and improve skills in population health team-based management, health care management, patient self-management support, and building community-clinical linkages.

Regional Program Care Coordinators (RPCCs) will be provided training on proper blood pressure measurements using the Million Hearts and American Heart Association materials. The RPCCs will be trained to instruct participants on how to properly take their blood pressure using the appropriate blood pressure monitor.

4. In what **setting**? (be as specific as possible—e.g., what clinics or community centers, describe type of room and privacy afforded)

HBP Health Coaching will be provided at each of the ten Iowa WISEWOMAN regions. The initial HBP health coaching will be provided at the RPCCs office in a private room. Additional health coaching session will be conducted either in the RPCC office or over the telephone.

5. **Key components/characteristics of the coaching**—Explain how this program plan differs from other program services.

The Health Coaching program is an individualized program adaptable to the needs and readiness level of each participant. Coaching will take into consideration to the participant’s health priorities and willingness/ability to make a change. The health coach will utilize motivational interviewing techniques to assist the participant in setting SMART goals. She will help the participant overcome barriers and will serve as a source of support and encouragement to the participant when working to reach goals.

Each participant will receive:
- Blood pressure monitor; either the Omron BP785 or the LifeSource UA-789 (extra-large cuff)
- BP Tracking Log
- BP Monitoring instruction sheet
- BP Monitor setup instructions
- Self-addressed stamped envelopes (to send tracking log to RPCC)
- American Heart Association *Understanding and Controlling High Blood Pressure* booklet

The participant will be instructed to take a blood pressure reading twice a day (morning and evening) every day during the three-month duration of the health coaching sessions. Results will be stored in the monitor’s memory. However, it should also be recorded in the participant’s BP log book.

Participants will be instructed as follows:
- Take the blood pressure readings at the same time each day.
- Do not smoke, do not drink caffeinated beverages, or do not exercise within 30 minutes prior to measuring their blood pressure.
- Do sit with their back straight and supported (kitchen or dining room chair), rather than sitting on the sofa.
- Feet should be flat on the floor.
• Arm should be supported on a flat surface with the upper arm at heart level.
• Make sure the middle of the cuff is placed directly over the brachial artery as shown by the RPCC.

Participants will receive printed and verbal instructions on proper use of the blood pressure monitor. They will be instructed on how to record readings in the provided BP log book. Participants will be directed to report blood pressure readings to the regional program coordinator at the health coaching sessions or at one-month intervals, via phone or mail. The RPCC will fax the participants’ blood pressure readings to the health care provider office.

Participants also receive instructions on abnormal and alert blood pressure values and appropriate medical attention for alert values.

In subsequent health coaching sessions, the RPCC will discuss goals set at the initial health coaching session, new goals will be set as needed and questions will be answered regarding their blood pressure and/or medication taken. BP Tracking Logs will be reviewed.

6. **Method of Documentation of coaching delivered**— (health record, community agency notes, reports, or other)
   The total number and length of each session will be tracked by the RPCC. The data will be incorporated in the WISEWOMAN participant record at the RPCC’s office and in the WISEWOMAN database system for submission with the MDEs.

7. **Anticipated number of sessions/dosage/mode and in what timeframe**— (sessions, in minutes, face-to-face or other) and how that will be determined
   Three health coaching sessions will occur over a three-month timeframe, with each session approximately one month apart. The overall timeframe from screening to reassessment is six months. The reassessment will occur within 4 weeks of the 3rd health coaching session.

8. **Cost projections and reimbursement methodology**— x number of woman projected, proposed CPT codes (if relevant) and reimbursement plan
   Health coaching is a required part of the RPCC’s contract. It is not fee for service, therefore there are not specific CPT codes or reimbursement plans for their activities. Costs include purchase of blood pressure monitors, printing of tracking logs and American Heart Association informational brochures.
   - Blood Pressure Monitors $70-80 per participant
   - Tracking logs $2.00 per participant
   - Informational Brochures $5.00 per participant

9. **Proposed methods to evaluate impact of health coaching**— including what measures the grantee proposes to use that will add to the evidence base
   During the Risk Reduction Counseling, participants are assessed to determine their level of readiness for change and their health priorities and goals. This assessment will be used to guide the health coaching process and establish a baseline for evaluating the effectiveness of health coaching. During the health coaching sessions, the RPCC will assist the participants in setting small measurable goals that will be recorded. Progress toward these goals will be assessed and the end results will be recorded. Improvements in MDE behavioral assessment measures will be captured at the reassessment through the CVD Health Risk Assessment form.

10. **Proposed Plan for follow-up when health coaching is complete** (interim assessment of patient progress and reinforcement of goals)— how/when will program expect women to return or complete follow-up assessment
    Within 4 weeks after the participant completes her health coaching, she will receive a post intervention assessment via phone or in person with the RPCC.
Iowa WISEWOMAN  
Medication Therapy Management (MTM)  
Health Coaching Protocol

1. **Rationale:** Evidence of past effectiveness with specific population and/or brief explanation of why this approach can be expected to be appealing and effective with the target population.

Based on previous Iowa WISEWOMAN data (FY 2010-2012), it is estimated that out of the 900 women to be screened, approximately 324 (36%) will have Hypertension (HTN). Of those 324, approximately 40 (12%) will be newly diagnosed and 123 (38%) will have uncontrolled HTN.

A major cause of uncontrolled hypertension is poor adherence to prescribed medication. Approximately 40% of patients with newly diagnosed hypertension will discontinue their medications within the first year of treatment.

*Grantee proposes to refer participants newly diagnosed or previously diagnosed, yet uncontrolled hypertension with medication.*


**Objective:** Assess clinical and economic outcomes of a community-based, long-term medication therapy management (MTM) program for hypertension (HTN)/dyslipidemia.

**Design:** Quasi-experimental, longitudinal, pre-post study.

**Setting:** 12 community and hospital pharmacy clinics in Asheville, N.C., over a 6-year period from 2000 through 2005.

**Participants:** Patients covered by two self-insured health plans; educators at Mission Hospitals; 18 certificate-trained pharmacists.

Interventions: Cardiovascular or cerebrovascular (collectively abbreviated as CV) risk reduction education; regular, long-term follow-up by pharmacists (reimbursed by health plans) using scheduled consultations, monitoring, and recommendations to physicians.

**Results:** Sufficient data were available for 620 patients in the financial cohort and 565 patients in clinical cohort. Several indicators of cardiovascular health improved over the course of the study: mean systolic blood pressure, from 137.3 to 126.3 mm Hg; mean diastolic blood pressure, from 82.6 to 77.8 mm Hg; percentage of patients at blood pressure goal, from 40.2% to 67.4%; mean low-density lipoprotein (LDL) cholesterol, from 127.2 to 108.3 mg/dL; percentage of patients at LDL cholesterol goal, from 49.9% to 74.6%; mean total cholesterol, from 211.4 to 184.3 mg/dL; and mean serum triglycerides, from 192.8 to 154.4 mg/dL. Mean high-density lipoprotein (HDL) cholesterol decreased from 48 to 46.6 mg/dL. The CV event rate during the historical period, 77 per 1,000 person-years, declined by almost one-half (38 per 1,000 person-years) during the study period. Mean cost per CV event in the study period was $9,931, compared with $14,343 during the historical period. During the study period, CV medication use increased nearly threefold, but CV-related medical costs decreased by 46.5%. CV-related medical costs decreased from 30.6% of total health care costs to 19%. A 53% decrease in risk of a CV event and greater than 50% decrease in risk of a CV-related emergency department (ED)/hospital visit were also observed.

**Conclusion:** Patients with HTN and/or dyslipidemia receiving education and long-term MTM services achieved significant clinical improvements that were sustained for as long as 6 years, a significant increase in the use of CV medications, and a decrease in CV events and related medical costs.

Background: Suboptimal utilisation of pharmacotherapy, non-adherence to prescribed treatment, and a lack of monitoring all contribute to poor blood (BP) pressure control in patients with hypertension.

Objective: The objective of this study was to evaluate the implementation of a pharmacist-led hypertension management service in terms of processes, outcomes, and methodological challenges.

Method: A prospective, controlled study was undertaken within the Australian primary care setting. Community pharmacists were recruited to one of three study groups: Group A (Control - usual care), Group B (Intervention), or Group C (Short Intervention). Pharmacists in Groups B and C delivered a service comprising screening and monitoring of BP, as well as addressing poor BP control through therapeutic adjustment and adherence strategies. Pharmacists in Group C delivered the shortened version of the service.

Results: Significant changes to key outcome measures were observed in Group C: reduction in systolic and diastolic BPs at the 3-month visit (P<0.01 and P<0.01, respectively), improvement in medication adherence scores (P=0.01), and a slight improvement in quality of life (EQ-5D-3L Index) scores (P=0.91). There were no significant changes in Group B (the full intervention), and no differences in comparison to Group A (usual care). Pharmacists fed-back that patient recruitment was a key barrier to service implementation, highlighting the methodological implications of screening.

Conclusion: A collaborative, pharmacist-led hypertension management service can help monitor BP, improve medication adherence, and optimise therapy in a step-wise approach. However, blood pressure screening can effect behaviour change in patients, presenting methodological challenges in the evaluation of services in this context.
2. **Flow diagram or algorithm** of how women will be referred to Health Coaching (at what point in WISEWOMAN flow diagram, what criteria will be used to identify women)

**Iowa WISEWOMAN HBP Health Coaching**

The Iowa WISEWOMAN program participants who have been identified by the health care providers with newly diagnosed or previously diagnosed, yet uncontrolled hypertension (with medication) are eligible for the Medication Therapy Management (MTM) health coaching program. The Regional Program Care Coordinators (RPCC) will refer eligible participants to the MTM Health Coaching Program.

**Follow-up Health Care Provider Visit** ➔ **Abnormal or Alert Value** ➔ **WISEWOMAN Screening Visit** ➔ **Risk Reduction Counseling** ➔ **Healthy Options** ➔ **Other Health Coaching/LSP Option** ➔ **MTM Health Coaching Option**

**Pharmacist**

*Initial MTM In-person Visit*
- Rx list vs. client brown bag
- DRAW Tool – adherence
- BP measurement
- Medication and lifestyle goals

1-2 weeks ➔ **First Follow-up Phone Call**
- Review of visit
- Questions & answers

4-6 weeks ➔ **Second Follow-up Phone Call**
- Review of adherence
- Questions & answers

4-6 weeks ➔ **Final MTM In-person Visit**
- DRAW Tool – adherence
- BP measurement
- Revisit medication and lifestyle goals

**RPCC**

*Health Coaching #1*
- MTM Program Overview
- Healthy Lifestyle Goals

1 month ➔ **Health Coaching #2**
- Healthy Lifestyle Goals Reviews and Revisions

1 month ➔ **Health Coaching #3**
- Healthy Lifestyle Goals Reviews and Revisions

Within 4 weeks ➔ **Reassessment/Follow-up BP+ Screening**

Contact Health Care Provider as necessary
3. **Who will provide the coaching (credentials & training)?**
Regional Program Care Coordinators (RPCC) will provide the health coaching sessions in-person and via phone.

Each RPCC has completed health coaching certification training provided through the Iowa Chronic Care Consortium (ICCC). The health coaching program is an online, 26-week program, which concludes with a practical exam for certification.

In addition, continued education courses will be provided through face-to-face meetings and/or by webinar to help RPCC’s develop and improve skills in population health team-based management, health care management, patient self-management support, and building community-clinical linkages.

Pharmacists have completed professional development on Medication Therapy Management (MTM) and patient coaching as part of licensure requirements. All pharmacies currently provide MTM services to their general patient population. Pharmacists have received training on the WISEWOMAN program and MTM program protocol from the Intervention and Community Resources Coordinator.

4. **In what setting? (be as specific as possible—e.g., what clinics or community centers, describe type of room and privacy afforded)**
MTM Health Coaching is available within all ten Iowa WISEWOMAN regions. Health coaching sessions with the RPCC will be conducted either in the RPCC office or over the telephone. The MTM services would be provided in a private room at each pharmacy.

5. **Key components/characteristics of the coaching**—Explain how this program plan differs from other program services.
The Health Coaching program is an individualized program adaptable to the needs and readiness level of each participant. Coaching will take into consideration to the participant’s health priorities and willingness/ability to make a change. The health coach will utilize motivational interviewing techniques to assist the participant in setting SMART goals. She will help the participant overcome barriers and will serve as a source of support and encouragement to the participant when working to reach goals.

Participants will meet with the RPCC either by phone or in-person for the initial health coaching session. At the initial health coaching session, the RPCC will use motivational interviewing techniques to identify healthy lifestyles areas (i.e. exercise, nutrition or smoking cessation) in which they would like to improve in addition to the medication adherence. The RPCCs will conduct a minimum of three health coaching sessions with each participant. At each health coaching session, the RPCCs will review goals set with RPCC and those set with the pharmacist.

Sessions with the pharmacists are as follows:

**Initial MTM Visit (up to 60 minutes)**
Participants will be scheduled for the initial MTM visit at the pharmacy. Participants must bring all prescriptions, over-the-counter (OTC) medication, vitamins and supplements currently taken.

Pharmacists will:
- Complete a comprehensive medication review – physician’s list vs. participant medications
- Develop a complete medication list for records and for participant
- Complete the DRAW tool (See Appendix B)
- Discuss with participant:
  - Difficulties in taking the medication
  - Potential interactions between medication
  - Potential side effects
  - Any allergies
  - Refilling process
  - Possible low cost medication options
- Importance of and barriers to medication adherence
- Lifestyle choices influencing hypertension
- Develop medication adherence and lifestyle goals with participant’s input

Participants will be provided:
- One 7-day, 28 compartment medication box
- Blood pressure readings
- *Understanding and Controlling Your High Blood Pressure* brochure
- Complete medication list with recommendations and goals set with the pharmacist

If the participant is also involved in the home blood pressure monitoring program, the pharmacist may review the proper technique for taking a blood pressure with the participant.

The pharmacist may contact the participant’s health care provider as necessary.

The pharmacist will fax or email the completed DRAW tool, medication list, and participant tracking form to the RPCC.

**Two Follow-up MTM Phone Calls** (up to 30 minutes each)
The pharmacist will follow-up via phone with participant. This phone call will allow pharmacist to:
- Reinforce medication adherence and usage information
- Review medication and lifestyle goals
- Answer participant questions

The first follow-up call will be within two (2) weeks of the initial pharmacy visit. A second follow-up call will be provided 4-6 weeks after the first phone call.

**Final MTM Visit (up to 30 minutes)**
The final MTM visit will be scheduled 12 weeks after the initial MTM visit. The pharmacist will:
- Complete the DRAW Tool (See Appendix B)
- Review and reinforce medication adherence
- Review lifestyle goals
- Complete blood pressure measurements

The pharmacist will fax and email the completed DRAW Tool and participant tracking form to the RPCC for the participant’s record.

The participant tracking tool allows documentation of participant health coaching goals to be shared between the RPCC and pharmacist. The goals will be reinforced and revisited at all participant encounters.

6. **Method of Documentation of coaching delivered**— (health record, community agency notes, reports, or other)
The total number and length of each RPCC health coaching session will be tracked by the RPCC. The data will be incorporated in the WISEWOMAN participant record at the RPCC’s office and in the WISEWOMAN database system for submission with the MDEs.

The Participant Tracking Form is the referral and tracking form used for all WISEWOMAN MTM participants. This form will collect participant information, dates and times of appointments, health coaching goals, blood pressure (BP) measurements, MTM goals, notes regarding participant visits and calls, and pharmacist-to-health care provider discussion notes.

This form will act as an on-going record for each participant to be shared with the RPCC and the pharmacist. A copy of the forms will be kept in participant file with the RPCC and the pharmacist. Once the form is completed, the RPCC will provide a copy to the Intervention and Community Resources Coordinator for use in program tracking, data collection and analysis.
7. **Anticipated number of sessions/dosage/mode and in what timeframe**—(sessions, in minutes, face-to-face or other) and how that will be determined

Three RPCC-led health coaching sessions will occur over a three-month timeframe, with each session approximately one month apart. The overall timeframe from screening to reassessment is six months. The reassessment will occur within 4 weeks of the 3rd health coaching session.

The four sessions with the pharmacist include the Initial in-person visit, two follow-up phone calls and a final in-person visit. The phone calls will be scheduled within 2 weeks of the initial visit and 4-6 weeks after the first phone call. The final in-person visit will be scheduled three months after the initial in-person visit.

8. **Cost projections and reimbursement methodology**—x number of woman projected, proposed CPT codes(if relevant) and reimbursement plan

Health coaching is a required part of the RPCC’s contract. It is not fee for service, therefore there are not specific CPT codes or reimbursement plans for their activities. Reimbursement for the pharmacist is indicated in the table below.

<table>
<thead>
<tr>
<th>Participant Encounter</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial MTM Pharmacist Visit (maximum one hour)</td>
<td>CPT Codes 99605 ($45) and up to three 99607 ($10)</td>
</tr>
<tr>
<td>Follow-up MTM Phone Calls (max. 30 minutes each)</td>
<td>CPT codes 99606 ($20) and up to one 99607 ($10)</td>
</tr>
<tr>
<td>Final MTM Visit (max. 30 minutes)</td>
<td>CPT codes 99606 ($20) and up to one additional 99607 ($10)</td>
</tr>
</tbody>
</table>

Additional costs include:
- Pill boxes $10 each
- Hypertension brochure $2 each
- Transportation Voucher $25 each

9. **Proposed methods to evaluate impact of health coaching**—including what measures the grantee proposes to use that will add to the evidence base

During the Risk Reduction Counseling, participants are assessed to determine their level of readiness for change and their health priorities and goals. This assessment will be used to guide the health coaching process and establish a baseline for evaluating the effectiveness of health coaching. During the health coaching sessions, the RPCC will assist the participants in setting small measureable goals that will be recorded. Progress toward these goals will be assessed and the end results will be recorded. Improvements in MDE behavioral assessment measures will be captured at the reassessment through the CVD Health Risk Assessment form.

The Year 4 Evaluation Plan includes questions addressing Health Coaching and MTM program outcomes:

1) To what extent have women with uncontrolled HTN (BP values >139 systolic and/or >89 diastolic) reached controlled HTN (BP values equal to <139 systolic and/or equal to or <89 diastolic) following completion of health coaching /LSP?

2) To what extent did completion of three health coaching sessions contribute to improving participants' management of CVD risk measures, over a six month program period (including risk for diabetes, hyperlipidemia, overweight/obesity; smoking cessation)?

3) To what extent have participants, who were referred to MTM, reached a controlled BP level by the end of intervention timeframe?

4) To what extent has MTM been implemented to improve participant HTN?
Iowa WISEWOMAN staff will compare blood pressure readings and DRAW Tool results from the initial MTM visit to the final MTM visit to assess effectiveness of the intervention, as well as assess participant medication adherence. The staff will also review the number of participants eligible for MTM services versus how many were actually referred for services.

10. **Proposed Plan for follow-up when health coaching is complete** (interim assessment of patient progress and reinforcement of goals)—how/when will program expect women to return or complete follow-up assessment

   Within 4 weeks after the participant completes her health coaching, she will receive a post intervention assessment in person with the RPCC. The participant’s height, weight, blood pressure and health risk assessment will be measured.