WISEWOMAN, Healthy Woman

Assessing and Addressing the Health and Social Needs of Women Ages 40 - 64

April 2021

WISEWOMAN™

Well-Integrated Screening and Evaluation for WOMen Across the Nation

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Introduction

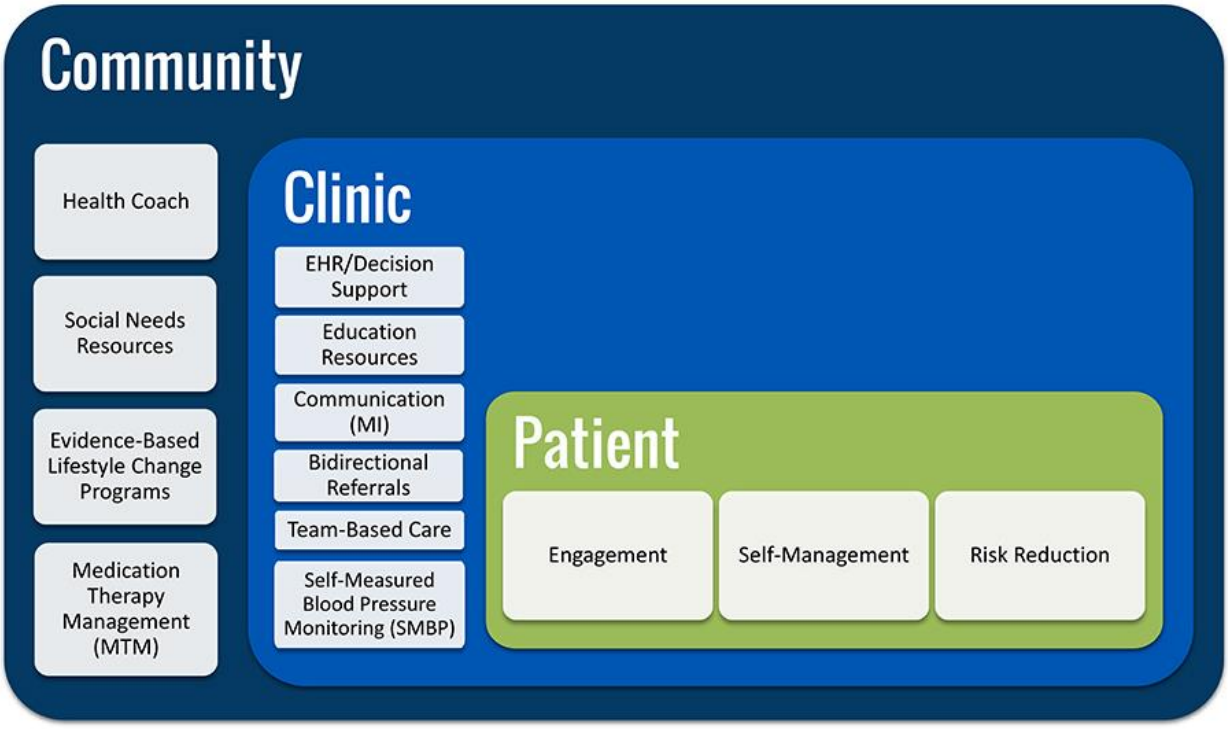
The WISEWOMAN (**W**ell-**I**ntegrated **S**creening and **E**valuation for **WOM**en **A**cross the **N**ation) program was created to help women understand and reduce their risk for heart disease and stroke by providing services to promote lasting heart-healthy lifestyles. Working with low-income, uninsured and underinsured women aged 40 to 64 years, the program provides heart disease and stroke risk factor screenings and services that promote healthy behaviors. The WISEWOMAN program currently is administered through CDC's Division for Heart Disease and Stroke Prevention (DHDSP) and is operated on a state-by-state basis. Services provided by each WISEWOMAN program vary, but all are designed to promote lifelong heart-healthy lifestyle changes.

Initiated in fall 2020 in Delaware, strategies to achieve WISEWOMAN goals include tracking and monitoring clinical measures to improve healthcare quality and identify patients with hypertension; promote team-based care to reduce cardiovascular risk; and develop clinic/community links to support evidence-based lifestyle change for at-risk women. The long-term outcomes are increased blood pressure control and improved detection, prevention, and control of cardiovascular disease.

Purpose of Module

Previous modules in this series have sought to assist primary care providers (PCPs) and care teams with enhanced patient communication through motivational interviewing and to implement patient-centered team-based care, including developing patient engagement. This module is designed to help providers identify, assess, and address the relevant health and social needs of patients in the WISEWOMAN population. A future installment will focus on referrals to evidence-based lifestyle change programs to close the care loop through communication, medical care, self-management, and community connections.

WISEWOMAN Dimensions of Health



Medical Preventive Services for the WISEWOMAN Population

The U.S. Preventive Services Task Force (USPSTF) preventive services that received A or B ratings, appropriate for women aged 40 to 64 years.

Topic	Description	USPSTF Grade
Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening adults aged 40-70 years who are overweight or obese	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.	B
Breast Cancer: Screening women aged 50 to 74 years	The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.	B
Cervical Cancer: Screening women age 21 to 65 years	For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (contesting).	A

Topic	Description	USPSTF Grade
Healthy Diet and Physical Activity for Cardiovascular Disease Prevention in Adults with Cardiovascular Risk Factors: Behavioral Counseling Interventions: adults with cardiovascular disease risk factors	The USPSTF recommends offering or referring adults with cardiovascular disease risk factors to behavioral counseling interventions to promote a healthy diet and physical activity	B
High Blood Pressure in Adults: Screening: adults aged 18 years or older	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.	A
Statin Use for the Primary Prevention of Cardiovascular Disease in Adults: Preventive Medication: adults aged 40 to 75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that all adults without a history of cardiovascular disease (CVD) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are aged 40 to 75 years; 2) they have 1 or more CVD risk factors (ie, dyslipidemia, diabetes, hypertension, or smoking), and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults aged 40 to 75 years.	B
Interventions for Tobacco Smoking Cessation in Adults, nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and US Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.	A
Weight Loss to Prevent Obesity-Related Morbidity and Mortality in Adults: Behavioral Interventions: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index (BMI) of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multi- component behavioral interventions.	B

Adapted from USPSTF 2021 A and B Recommendations,
https://www.uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations

WISEWOMAN Interventions - Clinical

WISEWOMAN offers support for implementation of team-based care to reduce CVD risk with a focus on hypertension control and management, such as:

- WISEWOMAN cardiovascular disease workflow
- Clinical decision support (CDS) in the electronic health record (EHR)
- Protocol for identifying patients with undiagnosed hypertension
  - Aligns with evidence-based Million Hearts Undiagnosed Hypertension Tool Kit
- Self-measured blood pressure (SMBP) program, including provision of home monitors for eligible patients, patient training, and patient-facing hypertension videos in English and Spanish
  - Aligns with evidence-based Million Hearts Self-Measured Blood Pressure Monitoring
- Medication Therapy Management with a pharmacist
  - CDC supports enhanced medication therapy management as a best practice, noting strong evidence exists that the use of MTM by pharmacists is effective in improving patient medication adherence. Studies examining MTM have generally found it to be effective and to have strong internal and external validity. MTM trials have been replicated in many different contexts with positive results.
- Fitbit devices for up to 20 eligible patients, with training by qualified bilingual health coach
  - A 2020 Canadian systematic review and meta-analysis examined 41 articles and 37 studies of interventions using Fitbit devices and found:
    - Significant increase in daily step counts and moderate-to-vigorous physical activity
    - Significant decrease in weight
    - Nonsignificant increase in objectively measured and self-reported sedentary behavior
    - The authors concluded that the use of Fitbit devices in interventions has the potential to promote healthy lifestyles in terms of physical activity and weight. Fitbit devices may be useful to health professionals for patient monitoring and support.
- A 2016 meta-analysis examined effects of health coaching on physical activities, dietary behaviors, health responsibility, stress management, and smoking behaviors among populations with cardiovascular risk factors.
  - Reviewed 15 randomized trials in which motivational interviewing and education sessions were common coaching interventions with telephone calls or face-to-face contacts as the main contact methods.

- Health coaching for health behaviors showed small but significant effect sizes on physical activities, dietary behaviors, health responsibility, and stress management except for smoking behaviors.

Relationship of Health and Social Needs

PCPs train intensely for years to become skilled in assessing and treating complex patient health needs. Typically medical training does not address social determinants of health (SDOH). Even the best healthcare delivered in isolation from social needs is insufficient to fully promote health in the WISEWOMAN population. Socioeconomic status factors including income, educational attainment, and subjective perceptions of social class and status influence quality of life and are reliable predictors of physical and psychological health outcomes across the lifespan. PCPs understand that social needs are critical to patient health but may not feel prepared or equipped to assess and meet these issues.

The National Association of Community Health Centers (NACHC) PRAPARE pilot analyzed the relationship between social determinants of health and outcomes and found:

- There is a positive correlation between the number of social determinant risks a patient faces and having hypertension.
- Stress levels affect the likelihood of having hypertension control.
- More complex patients face upward of ten social determinant risks.

American Heart Association and Health Equity

Each decade, the American Heart Association (AHA) develops an Impact Goal to guide its overall strategic direction and investments in its research, quality improvement, advocacy, and public health programs. Guided by the AHA's Mission Statement, to be a relentless force for a world of longer, healthier lives, the 2030 Impact Goal is anchored in an understanding that to achieve cardiovascular health for all, the AHA must include a broader vision of health and well-being and emphasize health equity. In the next decade, by 2030, the AHA will strive to equitably increase healthy life expectancy beyond current projections, with global and local collaborators, from 66 years of age to at least 68 years of age across the United States and from 64 years of age to at least 67 years of age worldwide. The AHA commits to developing additional targets for equity and well-being to accompany this overarching Impact Goal. To attain the 2030 Impact Goal, we recommend a thoughtful evaluation of interventions available to the public, patients, providers, healthcare delivery systems, communities, policy makers, and legislators.

Assessing Social Needs

PCPs and care teams must have an understanding of their patients' complexity—both clinically and non-clinically-- in order to make informed care decisions that are patient-centered and interventions that are appropriately tailored. But what data should be collected? How should it be used? And how can this process be integrated into a busy clinical practice?

The American Academy of Family Physicians EveryONE project recommends a team-based approach for addressing social determinants of health in primary care and suggests a SDOH implementation plan that includes:

- Planning tasks, such as evaluating patient flow and staff workflow, defining your system, and making team assignments
- Establishing a culture of health equity, with training for patients to better understand why the data are requested and training for staff about the impact of SDOH, health literacy, and cultural proficiency
- Implementation tasks, such as:
  - Selecting an assessment tool
  - Integrating tool into EHR or developing an alternate documentation process
  - Providing staff training on new protocols
  - Creating a list of community-based resources or use the 211-dialing code
- Ongoing tasks, including screening patients, matching needs to available resources, making referrals and following up, and monitoring measures of success

PRAPARE Tool

Consider adopting a standardized social needs screening tool into the practice. The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences, or PRAPARE tool, is a 21-question patient SDOH assessment. It was created by the National Association of Community Health Centers (NACHC), The Association of Asian Pacific Community Health Organizations (AAPCHO) and the Oregon Primary Care Association (OPCA). PRAPARE is a national effort to help health centers and other providers collect and apply the data they need to better understand their patients' SDOH. It is both a standardized patient social assessment tool consisting of a set of national core measures as well as a process for addressing the social determinants of health at both the patient and population health levels. By using PRAPARE, providers can better target clinical and non-clinical care, often in partnership with other community based organizations, to drive care transformation and delivery system integration as well as improved health and cost reductions.

The PRAPARE tool is evidence-based and tested/vetted by staff and patients in the field. It is patient-centered, actionable, and can be adapted to fit within any workflow. The PRAPARE

Implementation and Action Toolkit provides abundant free resources to help practices understand, plan, train, implement, analyze, and respond to SDOH data.

ICD-10 Z Codes: Linking SDOH to Diagnoses/Problem Lists

According to the American Hospital Association, a tool available to capture data on the social needs of patients is the ICD-10 codes Z55-65, which identify non-medical factors that may influence a patient's health status. These Z codes identify issues related to a patient's socioeconomic situation, including education and literacy, employment, housing, lack of adequate food or water or occupational exposure to risk factors like dust, radiation, or toxic agents. Using Z codes allows for better tracking needs and identification of solutions to improve community health.

AHA notes that any clinician involved in a patient's care can document a patient's social needs, according to a 2018 coding rules clarification. "Clinician" is defined here as anyone who meets the requirements to document in the official medical record, including but not limited to social workers, community health workers, case managers, nurses, or other providers.

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z55 – Problems related to (r/t) education and literacy	Illiteracy, schooling unavailable, underachievement in a school, educational maladjustment and discord with teachers and classmates.
Z56 – Problems r/t employment and unemployment	Unemployment, change of job, threat of job loss, stressful work schedule, discord with boss and workmates, uncongenial work environment, sexual harassment on the job, and military deployment status.
Z57 – Occupational exposure to risk factors	Occupational exposure to noise, radiation, dust, environmental tobacco smoke, toxic agents in agriculture, toxic agents in other industries, extreme temperature, and vibration.
Z59 – Problems r/t housing and economic circumstances	Homelessness, inadequate housing, discord with neighbors, lodgers and landlord, problems related to living in residential institutions, lack of adequate food and safe drinking water, extreme poverty, low income, insufficient social insurance and welfare support.
Z60 – Problems r/t social environment	Adjustment to life-cycle transitions, living alone, acculturation difficulty, social exclusion and rejection, target of adverse discrimination and persecution.

ICD-10-CM Code Category	Problems/Risk Factors Included in Category
Z62 – Problems r/t upbringing	Inadequate parental supervision and control, parental overprotection, upbringing away from parents, child in welfare custody, institutional upbringing, hostility toward and scapegoating of child, inappropriate excessive parental pressure, personal history of abuse in childhood, personal history of neglect in childhood, Z62.819 Personal history of unspecified abuse in childhood, Parent-child conflict, and sibling rivalry.
Z63 – Problems r/t primary support group, including family circumstances	Absence of family member, disappearance and death of family member, disruption of family by separation and divorce, dependent relative needing care at home, stressful life events affecting family and household, stress on family due to return of family member from military deployment, alcoholism and drug addiction in family.
Z64 – Problems r/t to certain psychosocial circumstances	Unwanted pregnancy, multiparity, and discord with counselors
Z65 – Problems r/t other psychosocial circumstances	Conviction in civil and criminal proceedings without imprisonment, imprisonment and other incarceration, release from prison, other legal circumstances, victim of crime and terrorism, and exposure to disaster, war and other hostilities.

Meeting Social Needs – Delaware Resources

As a provider, you understand that assessments require resources to address identified needs. Practices can develop a basic list of community resources to provide to patients. Here are some Delaware-specific resources:

- DE 211 Helpline – A central resource available by phone or online that works collaboratively statewide to help Delawareans in need, by connecting them to appropriate resources that lead to acceptable resolution of identified concerns and advocate to reduce or eliminate gaps in services.
- Supplemental Nutrition Assistance Education Program (DE SNAP-Ed) - The primary purpose of SNAP is to prevent the debilitating effects of hunger by providing nutrition assistance to millions of eligible individuals and families. The Supplemental Nutrition Program – Education (SNAP-Ed) is a research-based federal nutrition education and

obesity prevention program. In Delaware, the University of Delaware is the lead organization for SNAP-Ed. Working with partners across the state, the goal is to provide individuals and families with access to opportunities for healthy foods, and education about healthy behaviors.

- Food$mart - Expanded Food and Nutrition Education Program (EFNEP) offers free nutrition education classes for people with limited resources and children 0-18 living at home. Those eligible for SNAP, WIC, Head Start or free/reduced school lunches are eligible.
- Delaware State Service Centers – The 15 State Service Centers located throughout Delaware offer family support services, including emergency assistance, community resource assistance, and information/referrals.
- HelpIsHereDE – This site offers comprehensive information and resources on mental health and substance use, including prevention, treatment/recovery, and overdose prevention.
- Delaware Food Pantries – FoodPantries.org maintains information about local food pantries, soup kitchens, food banks, and other food help.
- Delaware Division of Services for Aging and Adults with Physical Disabilities – This state agency offers a comprehensive listing of services for older Delawareans and adults with physical disabilities.
- Delaware Division of Public Health, Bureau of Health Equity - Office of Women's Health and Office of Minority Health

Referrals to Community-Based Resources

To facilitate referrals to community organizations, Unite Delaware is a coordinated care network of health and social care providers. Partners in the network are connected through a shared technology platform, UniteUs, which enables them to send and receive electronic referrals, address people's social needs, and improve health across communities.

Unite Delaware enables providers to:

- Easily refer and connect your clients to local services they need in the community.
- Improve your clients' health and well-being through strengthened collaboration with partners offering a wide array of services.
- Track the outcomes of all referrals and services delivered for your clients.
- Measure the impact of your organization and the services you deliver.
- Improve organizational capacity through accurate referrals and access to a wealth of data on local service delivery

Additional Resources for Your Practice

FindHelp.org (formerly Aunt Bertha)

FindHelp.org is a free online social services search engine. It lists available services including food, housing, transportation, health care, finances, education, employment, legal aid, and goods/supplies. The services are based on ZIP code and allow for electronic referrals.

Community Tool Box

The Community Tool Box is a free online resource with tools for learning and assessing community needs and resources, addressing social determinants of health, engaging stakeholders, action planning, building leadership, improving cultural competency, planning and evaluation, and sustaining efforts over time.

WISEWOMAN-related Community Based Lifestyle Change Programs

A number of community-based lifestyle change programs are available to assist patients in developing and maintaining healthy habits. Some are covered by payers or offered at no cost. Programs include:

- YMCA Diabetes Prevention Program
- YMCA Weight Loss
- Healthy Heart Ambassadors
- Delaware Division of Public Health: Chronic Disease Self-Management Programs
- Healthy Delaware Quit Tobacco

Watch for more information about evidence-based lifestyle change programs in your community, including how to refer your patients, in an upcoming WISEWOMAN module.