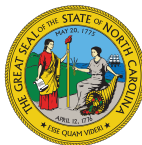


NORTH CAROLINA WISEWOMAN Program Manual



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Public Health



NC WISEWOMAN™

NC WISEWOMAN PROGRAM STAFF CONTACT INFORMATION



For questions about contracts or general NC WISEWOMAN Program information contact:

PROGRAM MANAGER

Ciara Rukse, DrPH, MPH / Office: (919) 707-5317 / Ciara.Rukse@dhhs.nc.gov

For questions about health coaching, community resources, recruitment, and ordering contact:

HEALTH EDUCATOR/INTERVENTIONIST

Brittney Sala, MPH / Office: (919) 707-5336 / Brittney.Sala@dhhs.nc.gov

HEALTH COACH

Denise Brewster, M.Ed., CHES / Cell: (919) 810-0255 / Denise.Brewster@dhhs.nc.gov

For clinical questions contact:

NURSE CONSULTANTS

Linda Buehler, BSN, RN / Cell: (919) 218-4270 / Office: (919) 707-5324 / Linda.Buehler@dhhs.nc.gov

Sherry Wright, RN / Cell: (919) 218-0183 / Office: (919) 707-5325 / Sherry.Wright@dhhs.nc.gov

For questions about surveys, focus groups, or interviews contact:

DATA MANAGER/EVALUATOR

Patricia Albert, M. Ed. / Office: (919) 707-5315 / Patricia.Albert@dhhs.nc.gov

TABLE OF CONTENTS



NC WISEWOMAN Program Staff Contact Information	2	Enrollment (Baseline) Clinical Screening	21
Introduction	5	Service Delivery Flow	21
WISEWOMAN Overview	5	Requirements	21
Background	5	Screening Cycle Timeline	22
Mission	5	Screening Calculator Section	22
NC WISEWOMAN Provider Map	5	NC WISEWOMAN Screening Data Calculator	22
WISEWOMAN Focus Areas	7	Clinical Measurements and National Guidelines	23
Hypertension Protocol	7	Blood Pressure	23
Team-Based Care	7	Guidelines for Accurate Blood Pressure Measurement	24
Community Clinical Linkages	8	Arm Size and BP Cuff Size for Adults	25
WISEWOMAN Providers	8	Cholesterol and Lipids	25
Initial Steps to Become a Provider	9	ASCVD Risk Estimator	25
Provider Site Performance Requirements	9	Fasting Glucose and Hemoglobin A1c	25
Performance Indicators and Benchmarks	9	Non-Fasting vs. Fasting Labs	26
Agreement Addendum and Contracts	10	Lab Work Documentation	26
Local Health Departments (LHDS)	10	Healthy Behavior Support Service Navigation	26
Non-LHD Agencies (Health Systems, FQHCS, etc.)	10	Healthy Behavior Support Service	
Termination of the Program	10	Navigation Protocol	27
Reimbursement	11	Diagnostic and Medical Follow-Up	28
Clinical Services Reimbursement	11	Medical Evaluation and Diagnostic Follow-Up	
Sliding Scale	11	Requirements	28
What Is Reimbursable and What is Not Reimbursable?	11	Abnormal and Alert Values	29
Healthy Behavior Support Services Navigation	11	Case Management	29
Healthy Behavior Support Services Reimbursement	12	ACA Guidelines on BP Follow-Up	30
NC WISEWOMAN Program Fee Schedule	12	Risk Reduction Counseling	31
Local Health Departments: Aid-To-County		How to Conduct Risk Reduction Counseling:	31
Database and Monthly Expenditure Report	12	Motivational Style Interviewing	32
Contractors: Contractor Expenditure Report (CER)	12	Healthy Behavior Support Services	33
Subcontractors	12	Health Coaching	35
Funding Adjustments	12	Overview of Health Coaching	35
North Carolina Breast and Cervical Cancer Control Program		Who Should Be Referred to Health Coaching?	35
Maximum Allowable Fees – WISEWOMAN Program	13	Navigator Role	35
Overview: WISEWOMAN Implementation	14	Participant Role	36
NC WISEWOMAN Program Checklist	15	Tenets of Health Coaching	36
NC WISEWOMAN Program Algorithm	17	The Tools of Health Coaching	36
Participant Eligibility, Consent and Enrollment	18	Assessing The Participant Stage of Change	36
Eligibility Requirements	18	Crafting a Smart Goal	37
Priority Population	18	Expanded Health Coaching	38
Eligible Population Requirements	18	Med-South	38
Federal Poverty Level Chart	18	Data Documentation for Health Coaching	39
Integrated Office Visit	19	Health Coaching Data Flow Process	39
Policy on Integrated Office Visits	19	North Carolina HeartWise	40
Reimbursement Guidance for		Overview of NC HeartWise	40
the Integrated Office Visit	19	Who to Refer to NC HeartWise	40
Process Flow for Co-Located Providers	19	Navigator Role	40
Process Flow for Non-Co-Located Providers	20	Participant HeartWise Role	40
Consent Form	20	NC HeartWise Session Timeline	40
Readiness to Participate in the Program	20	How to Effectively Self-Measure Blood Pressure	41
		Data Documentation For NC HeartWise	42
		NC HeartWise Delivery Sequence	42

Diabetes Prevention Program (DPP).....	43	Health Equity and WISEWOMAN.....	63
Overview of DPP.....	43	Health Equity.....	63
Who to Refer to DPP.....	43	Glossary of Key Terms, Abbreviations, and Acronyms.....	64
Online vs. In-Person DPP.....	43	Appendices.....	68
Navigator Role.....	44	Provider Education Resources.....	69
How to Make a Referral.....	44	Motivational Style Interviewing.....	70
Data Documentation.....	45	Rules for Health Coach Communications.....	72
Community Based Resources.....	45	Participant Education Resources.....	73
QuitlineNC.....	45	Dash Diet.....	74
Overview of QuitlineNC.....	45	Know Your Numbers.....	75
Adult Model Flow Chart.....	46	Million Hearts Manually Checking Bp.....	76
For Participants Not Ready to Quit.....	47	Improving Medication Adherence Among Patients.....	77
Walk With Ease.....	47	Eat Smart Move More Controlling Your Sodium.....	78
Other Community Resources.....	48	Myplate.gov.....	80
Four to Six Week Follow-Up Screening.....	48	Myplate Starter Faux Food Package.....	82
Requirements for a 4-to-6-Week Follow-Up.....	48	NC HeatWise Delivery Algorithm.....	84
Completion and Celebration.....	48	What Is Pre-Diabetes? (English Version).....	85
Annual Rescreening.....	49	What Is Pre-Diabetes? (Spanish Version).....	86
NC WISEWOMAN Program Data Management.....	50	Program Administration Forms.....	87
Use of Program Data.....	50	NC WISEWOMAN Material Order Form.....	88
Program Forms.....	50	NC WISEWOMAN Program Consent Form	
Smart Goal Section.....	51	(English Version).....	99
Complete Screening and Screening Cycle.....	52	NC WISEWOMAN Program Consent Form	
Documentation of Clinical Abnormal and Alert Values.....	52	(Spanish Version).....	101
Minimum Data Elements.....	52	My WISEWOMAN Action Plan.....	103
Data Submission and Validation Process.....	53	Staff Change Notification Form (SCNF).....	104
Local Health Departments.....	53	Data Collection Forms.....	105
Contractors.....	53	DHHS Form 4049 A and B (EHR P6, Access Page	
Data Submission Process for		One and Two).....	106
NC WISEWOMAN LHDs and Contractors.....	53	DHHS Form 4050 A and B (EHR P7, Access WW	
Data Submission Timeline.....	54	Coaching).....	108
Provider Data Validation.....	54	DHHS Form 4051 A and B (HER P6, Access	
Program Data Reports.....	54	Page One and Two).....	110
Health Services Analysis Batch Error Report.....	54	Program Data Validation Form.....	112
Monthly Mailed Reports.....	55	Data Form Requirements.....	113
Provider Tools for Data Collection and Submission.....	55	NC WISEWOMAN Data Entry Guidelines.....	114
Data Error Explanations.....	55	NC HeartWise Forms.....	140
Data Form Requirement Document.....	55	NC HeartWise Delivery Sequence.....	141
Confidentiality and Records Retention.....	55	NC HeartWise Participant Agreement Form.....	142
Confidentiality.....	55	NC HeartWise 14-Day Tracking Log.....	143
Record Retention Policy.....	56	NC HeartWise 6-Week Tracking Log.....	144
Navigator Data Management Responsibilities.....	56	Financial Documents.....	145
Data Management Technical Assistance.....	56	Sample Scope of Work.....	146
Evaluation.....	57	Local Health Department Monthly Expenditure	
Cancer Branch Performance Evaluation Team.....	57	Report (MER).....	160
Program Evaluation.....	57	Contractor Expenditure Report (CER).....	161
Performance Expectations and Quality Assurance.....	58	CER Tracking Log.....	162
Navigator Responsibilities.....	58	Performance Management and Quality	
Performance Requirements.....	58	Assurance Forms.....	163
Progress Reporting.....	59	Clinical Monitoring Forms: Triennial	
Mid-Year Review.....	59	Program Review.....	164
Clinical Monitoring.....	59	Corrective Action Plan.....	177
North Carolina Breast and Cervical Cancer Control		Quality Improvement Recommendations.....	178
Program/WISEWOMAN Monitoring Process.....	60	Internal Record Review Tool.....	179
Technical Assistance Visits.....	62		
Internal Review of Records.....	62		
Consequence of Inadequate Performance.....	62		
Quality Assurance.....	62		

INTRODUCTION



This training manual outlines the policies, guidelines, requirements, and procedures for participating in North Carolina's Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program. It is designed to provide important information on participant enrollment, program operations, and program services. North Carolina (NC) WISEWOMAN staff are available to assist you with any questions about the program via email, telephone, or in-person site visits. Please refer to the staff contact sheet for appropriate staff emails and telephone numbers.



WISEWOMAN OVERVIEW



Background

The Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Program was authorized by Congress in 1993 to provide cardiovascular screening and preventative services to women participating in the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). The two programs are components of the Breast and Cervical Cancer Mortality Prevention Act of 1990 and are considered sister programs. Currently, all WISEWOMAN grants are administered through the Centers for Disease Control and Prevention's Division for Heart Disease and Stroke Prevention. More information on the national WISEWOMAN Program can be found at: www.cdc.gov/wisewoman/index.htm.

The NC WISEWOMAN Program was funded 1995 and is one of the oldest WISEWOMAN programs in the nation. It provides cardiovascular risk screening and healthy behavior support services to women eligible for the NC Breast and Cervical Cancer Control Program (NC BCCCP).

NC WISEWOMAN Provider Map

The NC WISEWOMAN Program is currently located in 30 different service sites across the state. A copy of the current Provider Map with Nurse Consultant contact information can be found on the next page.

To learn how to become a NC WISEWOMAN Provider, please refer to the Provider section.

For additional information on both the NC WISEWOMAN Program and NC BCCCP please visit: <https://bcccp.dph.ncdhhs.gov/wisewoman.htm>.

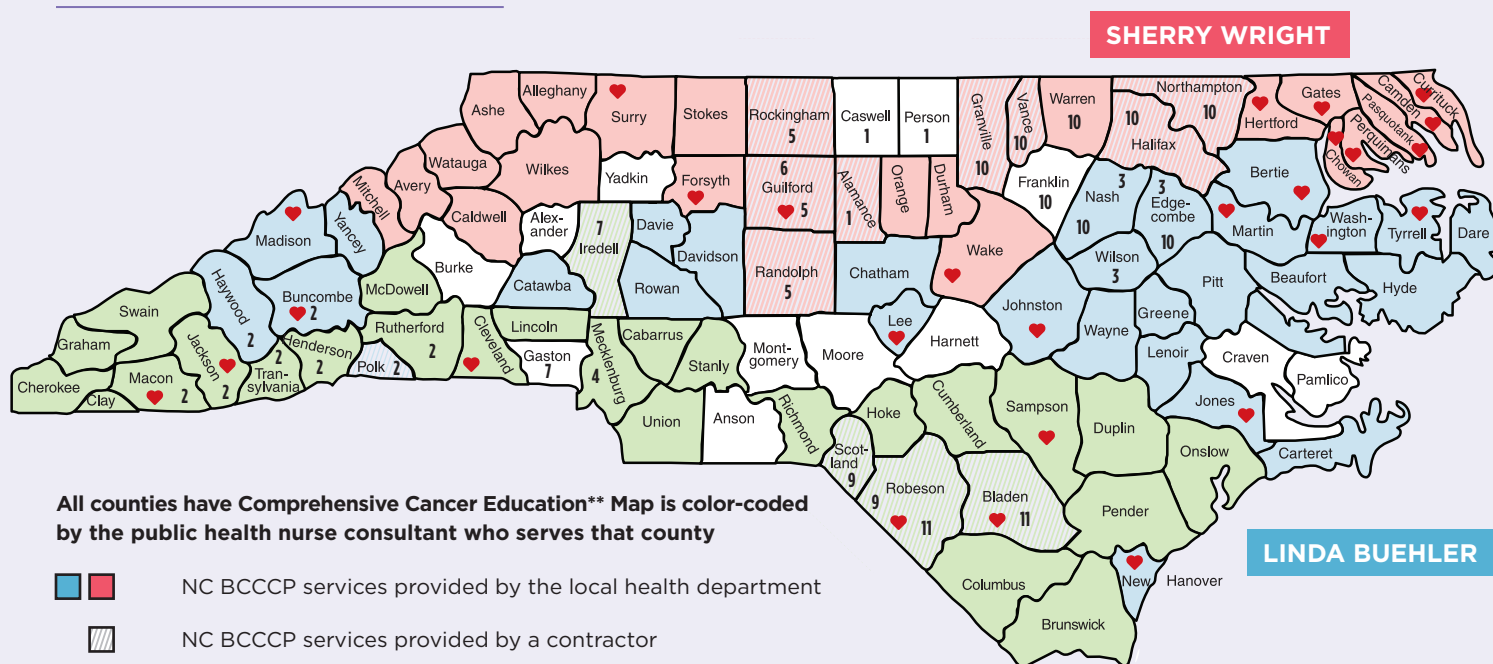
MISSION

The mission of the NC WISEWOMAN Program is to reduce the incidence and prevalence of cardiovascular disease among NC women through the provision of knowledge, skills, and opportunities for lifestyle behavior change.



NC Breast and Cervical Cancer Control Program (NC BCCCP) and NC WISEWOMAN Program

NURSE CONSULTANT REGIONS



TO MAIL OR FAX:
 1922 Mail Service Center
 Raleigh NC 27699-1922
 Fax: (919) 870-4812

Contract Providers by Region

Sherry Wright, Public Health Nurse Consultant / W: (919) 707-5325 / C: (919) 218-0183 / E: sherry.wright@dhhs.nc.gov

3. Carolina Family Health Center, Wilson (Edgecombe, Nash, and Wilson Counties)
5. Cone Health Systems (Guilford County♥; Alamance, Caswell, Person, Randolph and Rockingham Counties – do not offer WISEWOMAN services)
6. High Point Regional (Guilford County)
8. Lincoln Community Health Center (Durham County)
9. NeighborHealth Center (Wake County)
10. OIC (Nash County)
11. Rural Health Group (Edgecombe, Franklin, Granville, Halifax, Nash, Northampton, Vance, and Warren Counties)

Linda Buehler, Public Health Nurse Consultant / W: (919) 707-5324 / C: (919) 218-4270 / E: linda.buehler@dhhs.nc.gov

1. Blue Ridge Community Health Services, Hendersonville (Buncombe, Haywood, Henderson, Jackson, Macon, Polk, Rutherford, Swain, and Transylvania Counties)
2. Cabarrus-Rowan (Cabarrus and Rowan Counties)
4. Charlotte Community Health Clinic, Charlotte (Mecklenburg County)
7. Kintegra Health, Gastonia (Gaston and Iredell Counties)
12. Southeastern Regional Medical Center♥, Lumberton (Bladen and Robeson Counties)

** For BCCCP educational resources, please contact Erin Brown, NC BCCCP Program Consultant** erin.brown@dhhs.nc.gov

For WISEWOMAN educational resources, please contact Aleasia Brown, NC WISEWOMAN Interventionist aleasia.brown@dhhs.nc.gov

WISEWOMAN FOCUS AREAS



The Centers for Disease Control and Prevention (CDC) has established three areas of focus for the WISEWOMAN Program: hypertension protocols, team-based care, and community-clinical linkages. It has also identified key strategies, each one aligned with a focus area, for all WISEWOMAN Programs during this funding cycle (2018-2023). They are outlined below.



Hypertension Protocol

STRATEGY ONE: TRACK AND MONITOR CLINICAL MEASURES SHOWN TO IMPROVE HEALTH CARE QUALITY AND IDENTIFY PATIENTS WITH HYPERTENSION.

All providers should establish a protocol for hypertension management. This protocol should include how the provider site identifies individuals with hypertension; the process for referring to services if eligible; and the resources provided if a patient is not eligible for NC WISEWOMAN Program services. Providers are encouraged to use internal tracking mechanisms, such as notices in their electronic health record (EHR), to recognize eligible women with undiagnosed or uncontrolled hypertension.



Team-Based Care

STRATEGY TWO: IMPLEMENT TEAM-BASED CARE TO REDUCE CARDIOVASCULAR DISEASE (CVD) RISK WITH A FOCUS ON HYPERTENSION CONTROL AND MANAGEMENT.

The CDC defines team-based care (or multidisciplinary team approach) as establishing new staff or changing the roles of existing staff to work with a primary care provider. In alignment with The American Heart Association (AHA) and the American College of Cardiology (ACC), the CDC recommends each team includes the patient, the patient's primary care provider, and other non-physician professionals such as nurses, pharmacists, dietitians, social workers, patient navigators, and/or community health workers. Team members provide process support such as team huddles and share responsibilities of hypertension care to complement the activities of the primary care provider. These responsibilities include medication management, patient follow-up, and adherence and self-management support.¹

The NC WISEWOMAN Program has created a Team-based Care Toolkit to support the implementation of its services. The toolkit can be found at the NC WISEWOMAN Program [website](#).

Other Team-Based Care resources: <https://apps.who.int/iris/handle/10665/260424>

¹ Centers for Disease Control and Prevention. (2018). WISEWOMAN Performance Measures Guidance.



Community Clinical Linkages

STRATEGY THREE: LINK COMMUNITY AND CLINICAL RESOURCES FOR WOMEN AT RISK FOR CVD.

The CDC defines Community Clinical Linkages (CCLs) as “connections between community and clinical sectors to improve population health”². CCLs have been shown to improve clinical health outcomes in the control of coronary heart disease, cholesterol, prediabetes, diabetes, and blood pressure.

Strategies for the effective implementation of community clinical linkages include²:

L	Learn about community and clinical sectors.
I	Identify and engage key stakeholders from community and clinical sectors.
N	Negotiate and agree on goals and objectives of the linkage.
K	Know which operational structure to implement.
A	Aim to coordinate and manage the linkage.
G	Grow the linkage with sustainability in mind.
E	Evaluate the linkage.

WISEWOMAN PROVIDERS



Initial Steps to Become a Provider

Currently, all NC WISEWOMAN Programs are co-located with a BCCCP, and therefore any potential new provider must have an established BCCCP.

1. Contact the NC WISEWOMAN Program Manager or your current Nurse Consultant
2. Program staff will schedule a call to provide further information, answer any questions, and assess your site's capacity to implement the NC WISEWOMAN Program.
 - a. Capacity is determined by your site's ability to properly implement all required parts of the program.
3. A written request to provide services must be submitted to both the NC WISEWOMAN Program Manager and the Cancer Prevention and Control Branch Head.
4. Based on the type of agency (contractor or local health department) an agreement is drafted to award the agency NC WISEWOMAN Program funds.

² Centers for Disease Control and Prevention. (2016). Community Clinical Linkages for the Prevention and Control of Chronic Diseases: A Practitioners Guide.

Provider Site Performance Requirements

At minimum an NC WISEWOMAN Program site must have:

- A mechanism for identifying eligible women for referral to the NC WISEWOMAN Program
- A process for the referral of women for diagnostic follow-up for abnormal and alert level laboratory and biometric readings
- An identified staff member to be the NC WISEWOMAN Program Navigator
- Ability to manage NC WISEWOMAN Program funds in a separate cost center
- A mechanism to track and document women served within the program
- A mechanism for submitting data to the Program
- Ability to provide healthy behavior support services (HBSS) internally and/or to refer to external HBSS
- Ability to participate in NC WISEWOMAN Program trainings and professional development opportunities
- Ability to implement a team-based care approach for participants within the program

Performance Indicators and Benchmarks

NC WISEWOMAN Program providers are expected to meet the following performance indicators and use these as a basis for tracking program progress and success. These performance indicators are also outlined in the agreement addendum and contractual agreements.

MINIMUM STANDARD — PROGRAM PERFORMANCE INDICATOR	
100%	Percentage of screening target number met or exceeded
100%	Percentage of allocated NC WISEWOMAN Program funds expended for each woman screened
100%	Percentage of NC WISEWOMAN Program participants who receive risk reduction counseling
100%	Percentage of women with abnormal blood pressure values who receive follow-up as defined by NC WISEWOMAN Program policy.
100%	Percentage of NC WISEWOMAN Program participants who attend at least one session of health coaching or another lifestyle program as part of their enrollment visit.
≥80%	Percentage of NC WISEWOMAN Program participants who are actively enrolled in health coaching or another lifestyle program receive a second session.
≥60%	Percentage of NC WISEWOMAN Program participants enrolled in a lifestyle program or health coaching complete the lifestyle program or health coaching as defined by NC WISEWOMAN Program policy.
≥30%	Percentage of NC WISEWOMAN Program participants actively enrolled in the program who complete a screening cycle.
100%	Percentage of NC WISEWOMAN Program participants with an alert screening value who are seen by a healthcare provider within one week of screening or documentation that reflects why this did not occur.



Agreement Addendum and Contracts

The NC WISEWOMAN Program uses agreement addendums and contracts to provide services through local health departments and health systems. These serve as the contractual agreement between the agency and the NC Division of Public Health.

LOCAL HEALTH DEPARTMENTS (LHDS)

Local health departments are awarded funds through an agreement addendum (AA) which has six sections including the Background, Purpose, Scope of Work and Deliverables, Performance Measures and Reporting, Requirements, Performance Monitoring and Quality Assurance, and Funding Guidelines and Restrictions. A [draft SOW for the agreement addendum](#) can be found in the appendices.

NON-LHD AGENCIES (HEALTH SYSTEMS, FQHCS, ETC.)

Non-local health department agencies apply to become an NC WISEWOMAN Program provider through the Request for Applications (RFA) process. RFA's for the program are made available via the [website](#) every three years. If awarded, an agreement between the agency and the NC Division of Public Health is established through a contract. All contracts consist of the following sections: the NC WISEWOMAN Program background, the awarded targets, guidance on subcontracts, evidence-based practices, and program deliverables.

Termination of the Program

Provider sites seeking to terminate their contracts must first notify the Program Manager and the assigned Nurse Consultant to request a termination discussion. Provider sites who terminate their program:

- ✓ Notify the NC WISEWOMAN's Program Manager and Cancer Branch Head of the intent to terminate in writing including the effective date of termination on agency letterhead and signed by the Health Director.
- ✓ Complete the current program cycle through the 4-to-6-week follow-up after the third health coaching session for any participant for which funds have been drawn down (including required referrals for Diagnostic Medical Follow-Ups).
- ✓ Notify any participants with upcoming enrollment or annual rescreening appointments that the program is being terminated and provide alternative CVD/hypertension management resources.
- ✓ Continue to monitor monthly data reporting and provide follow up or corrected information until all cases are closed out.
- ✓ Return any unused NC WISEWOMAN Program funds.
- ✓ Keep any unused health education materials and tools as resources for women that may come into the health department.

Rarely, a program will be terminated due to inadequate performance and/or misuse of funds. If the program is terminated, the last five bullet points above will apply.

REIMBURSEMENT



The reimbursement guidelines provided in this manual are effective as of the current AA period (2022-2023) and are subject to change based upon federal funding levels and state funding requirements.

The NC WISEWOMAN Program awards funds to both local health departments and contractors based upon a target allocation system, which considers prior performance and capacity for screening women. Funds shall be allocated to ensure achievement of the number of health screenings and healthy behavior support services targets outlined in each provider's agreement addendum or contract. All funds allocated should be maintained in a separate cost center to assure proper auditing of expenditures.

Clinical Services Reimbursement

The NC WISEWOMAN Program does not reimburse for office visits, which are funded through NC BCCCP as part of the integrated office visit. The provider will be reimbursed at a capitated rate of **\$270** per woman for cardiovascular disease screening. Included in this capitated rate is reimbursement for:

- Laboratory tests (Lipid Panel, A1C and/or Fasting Glucose);
- Risk reduction counseling;
- Healthy behavior support services session one;
- Data entry; and
- One diagnostic medical follow-up as needed.

More information on the diagnostic medical follow-up can be found in the [Diagnostic Medical Follow-Up section](#).

SLIDING SCALE

The provider may choose to use a sliding fee scale for women whose gross income is 101% to 250% of the federal poverty level. If a woman's gross income is less than 101% of the federal poverty level, there cannot be a charge for any services covered through the NC WISEWOMAN Program. Participants must be notified of any possible charges prior to consenting to be enrolled in the NC WISEWOMAN Program. Flat fees may not be used to charge women for any services within the NC WISEWOMAN Program.

What is reimbursable and what is not reimbursable?

Reimbursable services consist of services covered in the Clinical Services Reimbursement, Healthy Behavior Support Services Service Navigation, and the Healthy Behavior Support Services section.

NC WISEWOMAN Program funds are not to be used for the reimbursement of treatment services. Only those services outlined in the NC WISEWOMAN Program Fee Schedule are reimbursable from program funds unless prior authorization is obtained from the NC WISEWOMAN Program operations staff. NC WISEWOMAN Program is the payer of last resort and funds should only be used for payment after all other third-party payment sources (including private insurance) provide evidence of partial or non-payment of program eligible services.

Reimbursement guidelines for an integrated office visit can be found under the [Integrated Office Visit Section](#).

HEALTHY BEHAVIOR SUPPORT SERVICES NAVIGATION

Providers that have opted to provide Healthy Behavior Support Service (HBSS) Navigation and have been awarded targets for HBSS Service Navigation via their agreement addendums or contract will be reimbursed at a capitated rate of \$180 per woman navigated.

HEALTHY BEHAVIOR SUPPORT SERVICES REIMBURSEMENT

The NC WISEWOMAN Program currently only reimburses for CDC approved Healthy Behavior Support Services. Providers will be reimbursed:

- \$15 each for second and third health coaching session delivered (sessions past the third health coaching will not be reimbursed)
- \$25 for referrals to the Diabetes Prevention Program (providers must document referral, see [Diabetes Prevention Program section](#) for more information)

NC WISEWOMAN Program Fee Schedule

The NC WISEWOMAN Program Fee Schedule is updated on annual basis and utilizes current procedural terminology (CPT) codes to outline services that are reimbursable under the NC WISEWOMAN Program. If the Fee Schedule below does not reflect the current program year, please access the most up to date Fee Schedule via the [program website](#).

Local Health Departments: Aid-To-County Database and Monthly Expenditure Report

Local health departments (LHDs) are required to submit for reimbursement via the State Controller's Office Aid-To-Counties (ATC) Database. Monthly submission deadlines for the ATC database can be found on the Controller's website. In addition, the LHD should submit to the Cancer Branch, monthly expenditure reports on the total number of screening targets, healthy behavior support service targets, and HBSS service navigation targets for the preceding month before requesting reimbursement via the ATC. A copy of the LHD Monthly Expenditure Report (MER) can be [found in the appendices](#) of this manual and submitted via email to the program data manager.

Contractors: Contractor Expenditure Report (CER)

Contractors must submit Contract Expenditure Reports (CER) by the 10th of each month requesting reimbursement for services rendered in the preceding month. CERs must be submitted even when no expenses are incurred in a given month. Failure to submit monthly sequential reports may delay receipt of reimbursement. A copy of the Contractor Expenditure Report can be [found in the appendices](#) of this manual and submitted via email to the Program Manager and the Administrative Assistant, Tammie.Hobby@dhhs.nc.gov.

Subcontractors

NC WISEWOMAN Programs can subcontract with other agencies to provide program services. The subcontracted agency shall not appear on the state's suspension of funding list and is held to the same program requirements and quality assurance as if they were the primary agency.

Payment to subcontractors using funds is limited to those screening and diagnostic follow-up services outlined in the [NC WISEWOMAN Program Fee Schedule](#). Payment to subcontractors outlined in the scope of work of the agreement addendum or contract, may not exceed the prevailing Medicare allowable fee for the service.

Funding Adjustments

Funding adjustments may be made in the baseline budget of the LHD or contractor. State accessible data will be reviewed to determine if budget adjustments are indicated based on compliance with performance indicators and allocated targets. Providers may submit a request via email to the NC WISEWOMAN Program Manager to request target increases and decreases based upon current screening rates and to utilize funds originally awarded for screening services for HBSS services or vice versa.

North Carolina Breast and Cervical Cancer Control Program Maximum Allowable Fees – WISEWOMAN Program

For the Period: 01/01/2022 - 12/31/2022

Revised: 01/3/2022

PROCEDURES CPT	CODE	FEE
Automated Lipid Panel*	80061	\$ 13.39
Lipid Panel (CLIA waived) ¹	80061QW	\$ 13.39
Cholesterol, Total Serum	82465	\$ 4.35
Cholesterol, Total Serum (CLIA waived)	82465QW	\$ 4.35
Lipoprotein (HDL) 83718 \$ 8.19		
Lipoprotein (HDL) (CLIA waived)	83718QW	\$ 8.19
Glucose, blood, quantitative	82947	\$ 3.93
Glucose, blood, quantitative (CLIA waived)	82947QW	\$ 3.93
Glucose, blood, reagent strip	82948	\$ 5.04
Glucose, tolerance test, three specimens	82951	\$ 12.87
Glucose, tolerance test, three specimens (CLIA waived)	82951QW	\$ 12.87
Hemoglobin A1C	83036	\$ 9.71
Hemoglobin A1C (CLIA waived)	83036QW	\$ 9.71
Basic Metabolic Profile**	80048	\$ 8.46
Basic Metabolic Profile (CLIA waived)**	80048QW	\$ 8.46
OTHER		
Routine venipuncture	36415	\$ 3.00
HEALTH COACHING (HC) - INITIAL HC SESSION IS INCORPORATED INTO SCREENING VISIT; 2 ADDITIONAL HC SESSIONS ARE ADVISED AND WILL BE REIMBURSED AS BELOW:		
Individual HC, Face-to-face, 15 minutes	98960	\$ 15.00
Individual HC, Phone, 15 minutes	98967	\$ 15.00
OFFICE VISITS		
New Patient, medically appropriate history/exam; 15-29 minutes	99202	\$ 70.70
New Patient; medically appropriate history/exam; 30-44 minutes	99203	\$ 109.00
New Patient, medically appropriate history/exam; 45-59 minutes	99204	\$ 162.93
New Patient; medically appropriate history/exam; 60-74 minutes	99205	\$ 215.62
Established Patient; evaluation and management; minimal problems	99211	\$ 22.25
Established Patient; medically appropriate history/exam; 10-19 minutes	99212	\$ 54.79
Established Patient; medically appropriate history/exam; 20-29 minutes	99213	\$ 88.29
Established Patient; medically appropriate history/exam; 30-39 minutes	99214	\$ 124.76

Note: Office Visits listed above may be used to reimburse for consultations associated with WISEWOMAN referrals, when applicable.

*Lipid Panel tests are: Total Serum Cholesterol, Lipoprotein (HDL and LDL) and Triglycerides.

**Basic Metabolic Profile - Collection Container: 1 mL Serum / One SST • Remarks: Includes NA, K, CL, CO2, GLUC, BUN, CREA, CA

¹ The Clinical Laboratory Improvement Amendments of 1988 (CLIA) law specifies that laboratory requirements be based on the complexity of the test performed and established provisions for categorizing a test as waived. Tests may be waived from regulatory oversight if they meet certain requirements established by the statute. CLIA waived tests employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; pose no reasonable risk of harm to the patient if the test is performed incorrectly; and/or are cleared by the Food and Drug Administration for home use.

Source: www.palmettogba.com/palmetto/fees_front.nsf/fee_main?OpenForm

OVERVIEW: WISEWOMAN IMPLEMENTATION



The NC WISEWOMAN Program promotes effective screening and lifestyle intervention strategies for cardiovascular health to reduce the incidence of heart disease and stroke and reduce mortality among eligible underserved women of North Carolina. The key components of the NC WISEWOMAN Program include:

- | | |
|--|-----------------------|
| ✓ Participant Consent, Eligibility, and Enrollment | ✓ Follow-Up Screening |
| ✓ Enrollment (Baseline) Clinical Screening | ✓ Annual Rescreening |
| ✓ Risk Reduction Counseling | ✓ Data Entry |
| ✓ Healthy Behavior Support Services | |

The NC WISEWOMAN Program checklist is a quick tool to ensure that all required steps parts of the program are conducted. The program algorithm provides a high-level overview of the sequencing of the required components of the program.

NC WISEWOMAN Program Checklist

ELIGIBILITY

- ☐ If enrolled in NC Breast and Cervical Cancer Control Program (NC BCCCP), eligibility is confirmed.
- ☐ If not enrolled in NC BCCCP, confirm eligibility:
 - age 40-64 years old;
 - income at or below 250% of federal poverty level;
 - uninsured or underinsured;
 - no Medicare Part B or Medicaid (unless receiving HBSS Service Navigation); and
 - risk factors for cardiovascular disease (CVD).

ENROLLMENT

- ☐ Obtain signed [consent form](#) confirming participation in the entire program.
- ☐ Complete screening form DHHS Form 4049 A and B (EHR P6, Access Page One and Two) items 1, 2, & 3).
- ☐ Complete clinical baseline screenings to include DHHS Form 4049 A and B (EHR P6, Access Page One and Two) Clinical Measurement Results:
 - blood pressure (BP) readings 2 minutes apart
 - laboratory results noting out-of-range results.
- ☐ Complete DHHS Form 4049 A and B (EHR P6, Access Page One and Two) items 4 - 10.

RISK REDUCTION COUNSELING MUST:

- ☐ Provide to every participant;
- ☐ Provide screening results verbally and in writing
- ☐ Interpret results and make recommendations based on national guidelines (KNOW YOUR NUMBERS or Passport resource see [Materials Order Form](#));
- ☐ Review health assessment results and identify areas for potential behavior change;
- ☐ Refer participants who use tobacco to QuitlineNC; document date on DHHS Form 4049 A and B (EHR P6, Access Page One and Two) and cessation resource.
- ☐ Confirm participant understands program components include health coaching calls.

- **ABNORMAL VALUE BLOOD PRESSURE** Systolic > 140 mmHg or Diastolic > 90 mmHg
Participant must be scheduled within 30 days for diagnostic visit. Document in EHR.
- **ALERT VALUE BLOOD PRESSURE** Systolic > 180 mmHg or Diastolic > 120 mmHg
Participant must be seen within 7 days for diagnostic visit. Complete "Workup Status" section of form DHHS Form 4049 A and B (EHR P6, Access Page One and Two) to document: diagnostic exam date, referral reason, and status of workup for alert level measurements. Document in EHR.

INITIAL HEALTHY BEHAVIOR SUPPORT SERVICES (HBSS) SESSION

- ☐ Identify participant readiness to change by using the Readiness Ruler
- ☐ Use motivational style interviewing techniques to allow participant to identify area from health risk assessment for possible health goal ([OARS conversation guide](#)).
- ☐ Support participant's healthy behavior change goal by using one of the following tools:
 - Health coaching
 - NC HeartWise
 - NC Diabetes Prevention Program
 - Walk with Ease
- ☐ Document HBSS area on DHHS Form 4050 A and B (EHR P7, Access WW Coaching) & provide completed My WISEWOMAN Plan (on back of the KNOW YOUR NUMBERS see [Materials Order Form](#)) to participant along with appropriate print materials and/or motivational tools.

HBSS HEALTH COACHING SESSION #2 – IN PERSON INDIVIDUALLY OR GROUP CLASS OR BY PHONE

- ☐ Approximately two to four weeks after the initial health coaching session a follow-up contact should be made with participant.
 - Use motivational style interviewing to assist participant to identify supports and/or barriers to accomplishing their health goal ([OARS conversation guide](#)).
 - Supply additional printed materials and/or motivational tools as appropriate.
 - If participant is enrolled in NC HeartWise, collect first two weeks of blood pressure measurements and document on P7 DHHS Form 4050 A and B (EHR P7, Access WW Coaching).

HBSS HEALTH COACHING SESSION #3 – IN PERSON INDIVIDUALLY OR GROUP CLASS OR BY PHONE

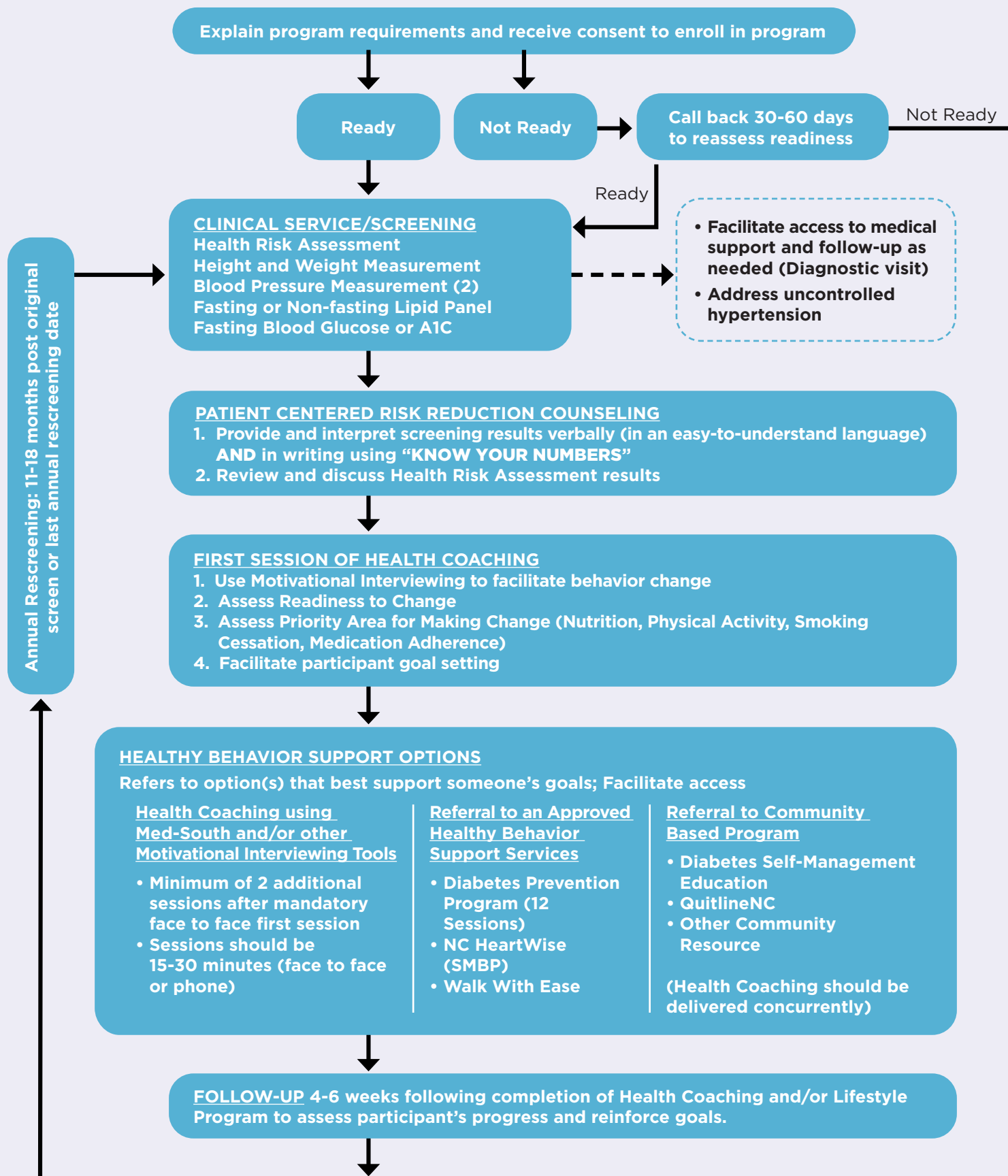
- ☐ Approximately four weeks after the initial health coaching session a follow-up contact should be made with participant.
 - Use motivational style interviewing to assist participant to identify supports and/or barriers to accomplishing their health goal ([OARS conversation guide](#)).
 - If participant is enrolled in NC HeartWise, collect 6 weeks worth of blood pressure measurements and document on DHHS Form 4050 A and B (EHR P7, Access WW Coaching).
 - Schedule follow-up in clinic screening.

FOLLOW-UP SCREENING

- ☐ Complete follow-up screening form DHHS Form 4041 A and B (EHR P6, Access Page One and Two).
- ☐ Complete clinical baseline screenings.
- ☐ Perform blood pressure readings 2 minutes apart.
- ☐ Conduct risk assessment counseling.
- ☐ Discuss health assessment results and review healthy behavior goal from initial health coaching session.
- ☐ Collect NC HeartWise self-measured blood pressures readings if appropriate.
- ☐ Schedule one-year annual rescreening visit.

- **ABNORMAL VALUE BLOOD PRESSURE** Systolic > 140 mmHg or Diastolic > 90 mmHg
Participant must be scheduled within 30 days for diagnostic visit. Document in EHR.
- **ALERT VALUE BLOOD PRESSURE** Systolic > 180 mmHg or Diastolic > 120 mmHg
Participant must be seen within 7 days for diagnostic visit. Complete “Workup Status” section of form DHHS Form 4041 A and B (EHR P6, Access Page One and Two) to document: diagnostic exam date, referral reason, and status of workup for alert level measurements. Document in EHR.

NC WISEWOMAN Program Algorithm



PARTICIPANT ELIGIBILITY, CONSENT AND ENROLLMENT



Eligibility Requirements

The NC WISEWOMAN Program does not determine eligibility for participants, but rather works in coordination with NC BCCCP to determine eligibility. Special emphasis should be given to the priority population, however, all women served must meet the eligible population requirements.

PRIORITY POPULATION

- Women ages 40 to 64
- Who are of ethnic minority
- Who are uninsured or underinsured
- Without a usual source of health care
- Whose income is less than 250% of the federal poverty level (FPL)

ELIGIBLE POPULATION REQUIREMENTS

- Women ages 40 to 64
- Women eligible for NC BCCCP, (women with gross incomes that are less than 250% of the federal poverty level according to the current FPL schedule)
- Women not enrolled in Medicare Part B or Medicaid (unless the woman is determined underinsured and eligible for [Healthy Behavior Support Services Service Navigation](#) only)

FEDERAL POVERTY LEVEL CHART

This Federal Poverty Level Chart is updated as of 01/19/22 with annual changes set by the federal government. If the below table does not reflect the current program period, please visit: <https://bcccp.dph.ncdhs.gov/Eligibility.asp#eligibility> for the updated guidelines.

NC BCCCP AND NC WISEWOMAN INCOME GUIDELINES EFFECTIVE JANUARY 16, 2023 (REVISED 1/19/23)

Persons in Family Unit	100 Percent Federal Poverty Guidelines* (Annual)	250 Percent Federal Poverty Guidelines* (Annual)	250 Percent Federal Poverty Guidelines* (Monthly)
1	\$14,580	\$36,450	\$3,038
2	\$19,720	\$49,300	\$4,108
3	\$24,860	\$62,150	\$5,179
4	\$30,000	\$75,000	\$6,250
5	\$35,140	\$87,850	\$7,321
6	\$40,280	\$100,700	\$8,392
7	\$45,420	\$113,550	\$9,463
8	\$50,560	\$126,400	\$10,533
For each additional family member (beyond 8) add:	\$5,140	\$12,850	\$1,071

Integrated Office Visit

NC WISEWOMAN Program office visits are expected to be integrated with the NC BCCCP office visits to the greatest extent possible. Per the National Breast and Cervical Cancer Early Detection Program (NBCCEDP) manual, the benefit of the integrated office visit is to create a stronger link to ensure that as many eligible NBCCEDP women receive appropriate cardiovascular risk assessment and risk reduction services.

POLICY ON INTEGRATED OFFICE VISITS

NC WISEWOMAN Program services to be integrated into the NC BCCCP office visit include:

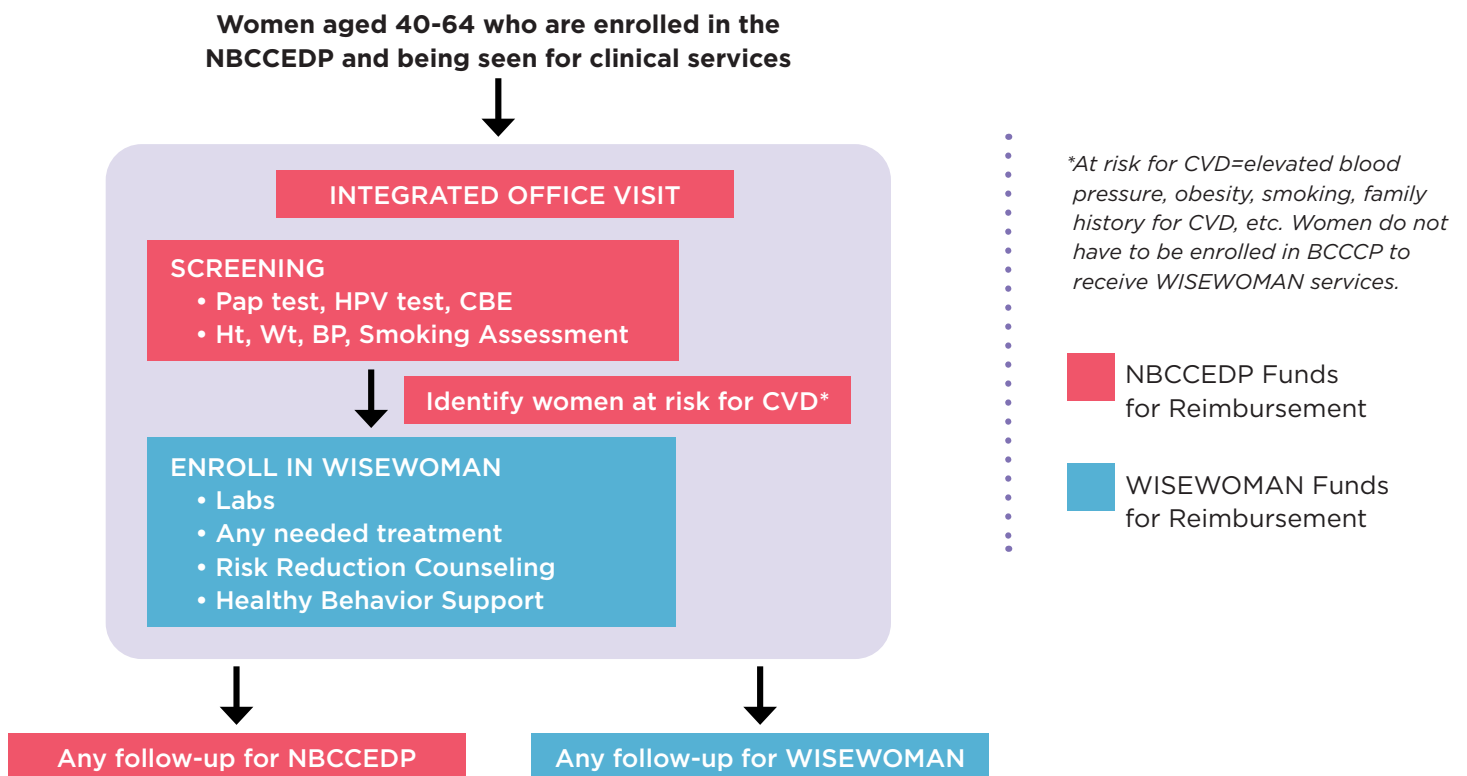
- Measurement of blood pressure (must record two systolic and diastolic)
- Height and weight measurements
- Smoking assessment and cessation referral

REIMBURSEMENT GUIDANCE FOR THE INTEGRATED OFFICE VISIT

During an integrated office visit, the following guidelines are to be followed for reimbursement of services:

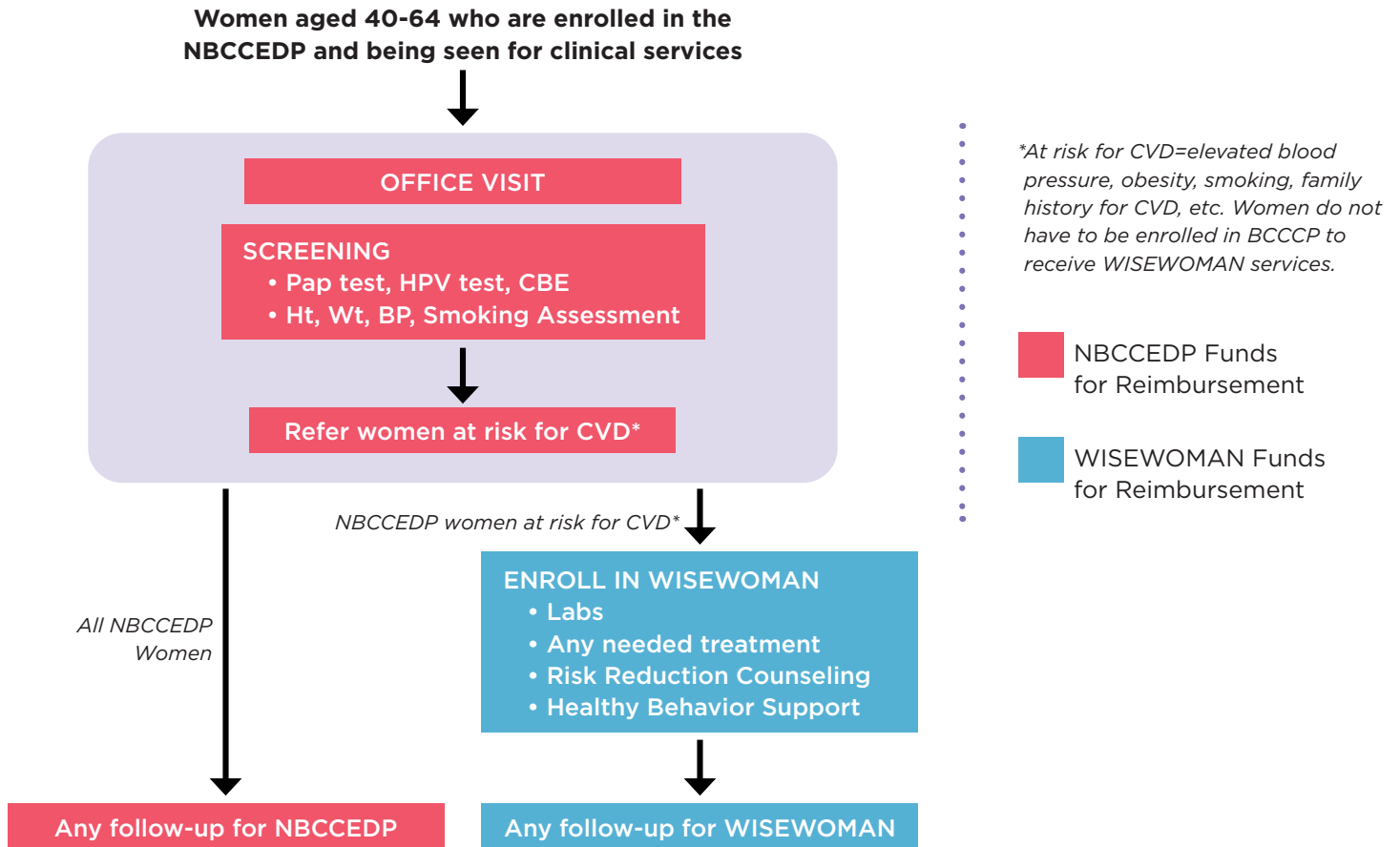
- NC BCCCP funds are used to reimburse for the integrated office visit.
- NC WISEWOMAN Program funds are used to reimburse for the costs associated with measuring cholesterol, lipids, glucose, HgA1C, or any other applicable labs.
- If the NC BCCCP and NC WISEWOMAN Program rescreening visits coincide, this is an integrated office visit, with funds for the office visit reimbursed by NC BCCCP. Any non-integrated rescreening or diagnostic office visits for WISEWOMAN services are reimbursed by the NC WISEWOMAN Program.

PROCESS FLOW FOR CO-LOCATED PROVIDERS³



³ Centers for Disease Control and Prevention. NBCCEDP Manual

PROCESS FLOW FOR NON-CO-LOCATED PROVIDERS⁴



Consent Form

READINESS TO PARTICIPATE IN THE PROGRAM

The local service provider (LSP) is responsible for reviewing each component of the NC WISEWOMAN Program to ensure women who are enrolled are ready to fully participate in the program. If a woman indicates she is not willing to participate in the HBSS and/or attend a follow-up screening, she should not be enrolled in the program. The provider should also assist the participant in addressing structural barriers to attending HBSS sessions and screenings.

A copy of the most recent consent form is provided in the appendices of this manual. Providers should maintain a signed [consent form](#) on file for each participant and a signed copy given to the participant. The consent form should be reviewed and signed by the participant at the start of each screening cycle.

READY?

Great! Proceed to obtaining a signed consent form and enrollment.

NOT READY?

No problem! Ask if you may revisit the conversation within the next 30 days OR their next NC BCCCP appointment OR their next LHD appointment?

⁴ Centers for Disease Control and Prevention. NBCCEDP Manual

ENROLLMENT (BASELINE) CLINICAL SCREENING



The enrollment or baseline clinical screening is the first screening a woman will have upon entry into the program. A woman will never have more than one enrollment or baseline clinical screening per [cooperative agreement](#); every screening thereafter will either be a follow-up or annual rescreening.

Service Delivery Flow

1. Identification of a woman through NC BCCCP, community organization, or internal program.
2. Assessment of eligibility (already completed if woman is referred from NC BCCCP).
3. Review program requirements and assess readiness to participate in the program.
4. Ready? Obtain a signed consent form.
 - a. Not Ready? Note the woman's interest and receive consent to make contact again in 30-60 days to see if she is still interested and willing to participate in the program.
5. Obtain valid lab documentation or schedule for blood draw.
6. Conduct [risk reduction counseling](#) while filling out DHHS Form 4049 A and B (EHR P6, Access Page One and Two).
7. Transition into the first HBSS session.
8. Provide educational materials and healthy behavior support tools specific to the woman's health coaching focus area.
 - a. Identify if it's appropriate for the woman to continue with health coaching or if she should be referred to another HBSS with concurrent health coaching based upon risk reduction counseling results (i.e., NC HeartWise or Diabetes Prevention Program).
9. Ensure:
 - a. Correct contact information (i.e., phone number and/or email) is present on the patient record.
 - b. Required participant data is captured on program data forms.
 - c. All enrollment/baseline screening requirements (below) have been met.
 - d. The participant has been provided with a NC WISEWOMAN Passport ([Material Order Form](#)) to document all program information.
10. Schedule second healthy behavior support services session with participant, if possible.

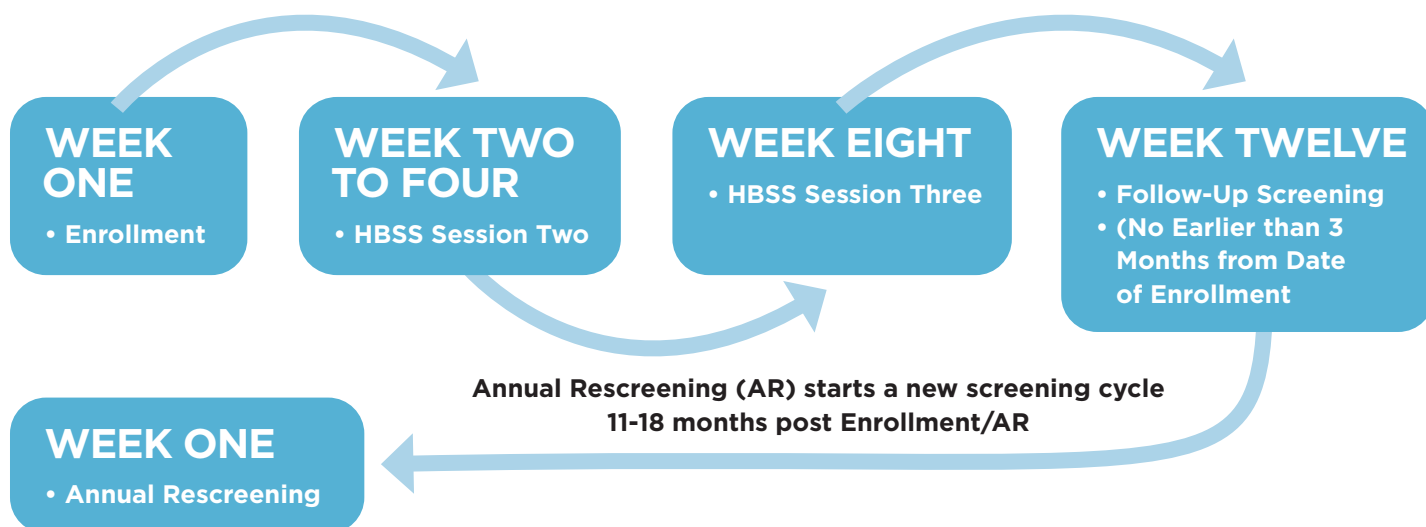
Requirements

The enrollment visit must include the following:

- ✓ Signed [consent form](#)
- ✓ Two blood pressure measurements (conducted at least 2 minutes apart)
- ✓ Height and Weight Measurement
- ✓ Labs (Lipid Panel, A1C and/or Fasting Plasma Glucose)
 - To be conducted day of visit, if possible, but no later than 30 days from day of enrollment. Please note that funds cannot be drawn down until after laboratory values are documented within the participant record. In addition, the second and third HBSS sessions should not be initiated unless lab values have been discussed with the participant.
- ✓ Documented Risk Reduction Counseling DHHS Form 4049 A and B (EHR P6, Access Page One and Two).
- ✓ Mandatory first HBSS session.
- ✓ Diagnostic Medical Follow-Up if applicable.

Screening Cycle Timeline

The diagram below shows an example of the screening cycle timeline. The initial participant visit in a five-year grant cycle regardless of participation during a previous grant cycle, is considered the enrollment visit. The second HBSS session should take place two to four weeks after the enrollment visit or the annual rescreening. It is recommended that the third HBSS session take place 4 weeks after the second session. A follow-up screening should occur three to 11 months post enrollment or annual rescreening. While the provider can initiate the follow-up screening any time within this range, it is preferable that the follow-up screening be initiated four to six weeks later. A screening date calculator is available for the calculation of individual screening dates based upon the participants date of enrollment. Please [contact the data manager](#) for a copy of the screening calculator.



Screening Calculator Section

Below is a copy of the screening calculator that can be requested from the Program Data Manager. Providers will enter in the desired number of weeks between the enrollment/annual rescreening and the second HBSS session and the second and third sessions. This will then calculate the date of the follow-up screening and when the participant is eligible for an annual rescreening.

NC WISEWOMAN SCREENING DATE CALCULATOR

How to use: Enter the participant's enrollment/annual rescreening date in the purple shaded box. Enter the desired number of weeks between screening date and 2nd HBSS session, and 2nd HBSS session and 3rd HBSS Session (Calculator default is the recommendation of 2 to 4 weeks for 2nd HBSS session and 4 weeks for 3rd HBSS session).

ENROLLMENT OR ANNUAL RESCREENING DATE	
Enrollment/Annual Rescreening Date:	11/1/2021
HEALTHY BEHAVIOR SUPPORT SERVICES	
2nd HBSS Session Date	11/29/2021
Number of Weeks After Screening Date	4
3rd HBSS Session Date	12/27/2021
Number of Weeks After 2nd HBSS Session Date	4
FOLLOW-UP	
Preferred 4 to 6 Week Follow-Up Date Range	
1/24/2022	to 2/7/2022
Latest Follow-Up Date	10/2/2022
ANNUAL RESCREENING	
Earliest Annual Rescreening Date	10/2/2022

CLINICAL MEASUREMENTS AND NATIONAL GUIDELINES



The NC WISEWOMAN Program, with guidance from the CDC, uses national guidelines informed by evidence-based science to help clinicians develop best practices in the implementation of program services. Each agency delivering services should have a presiding Medical Director, Physician, and/or Board of Directors that establishes procedures and protocols that align with the national guidelines. The NC WISEWOMAN Program and the CDC recognize that national guidelines are not fixed protocols, and that a licensed practitioner's clinical judgment is paramount so long as the agency is meeting minimum basic requirements.

Blood Pressure

The Joint National Committee and the ACC/AHA both provide national clinical guidelines for the management of blood pressure. The [2017 ACC and AHA Guidelines for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults](#) has made updates to the national clinical guidelines for blood pressure that were established in Joint National Commission (JNC) 7, which has now been updated to JNC 8. A comparison of these blood pressure readings are found below:

COMPARISON OF NATIONAL CLINICAL BLOOD PRESSURE GUIDELINES			
Category	JNC 7 Category	JNC 8 Category	2017 ACC and AHA Guidelines
Normal	≤ 120/80 mm Hg	No defined categories Pharmacological Treatment Threshold: ≥ 60 Years: ≥150/90 mm Hg ≤ 60 Years: ≥140/90 mm Hg	≤ 120/80 mm Hg
Prehypertension	120-139/ 80-89 mm Hg		120-129/ < 80 mm Hg
Stage 1 Hypertension	140-159 / 90-99 mm Hg		130-139 / 80-89 mm Hg
Stage 2 Hypertension	> 160 / 100 mm Hg		≥ 140/90 mm Hg
Hypertension Crisis	≥ 180/120 mm Hg		≥ 180/120 mm Hg
Please note that these measurements may differ for individuals with other diseases such as Diabetes and Chronic Kidney Disease.			

The NC WISEWOMAN Program will continue to use the threshold of $\geq 140/90$ for abnormal blood pressure and $\geq 180/120$ for alert level blood pressure. However, each provider site may make the determination to utilize lower thresholds for referral for medical and diagnostic follow-up. Complete guidelines for medical and diagnostic follow-up can be found [here](#).

Guidelines for Accurate Blood Pressure Measurement

The [2017 ACC and AHA Guidelines for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults](#) provides the following guidelines for the accurate measurement of blood pressure.

KEY STEPS FOR PROPER MEASUREMENT	SPECIFIC INSTRUCTIONS
STEP 1 • Properly prepare the patient	1. Have the patient relax, sitting in a chair (feet on floor, back supported) for > 5 min. 2. The patient should avoid caffeine, exercise, and smoking for at least 30 min before measurement. 3. Ensure patient has emptied his/her bladder. 4. Neither the patient nor the observer should talk during the rest period or during the measurement. 5. Remove all clothing covering the location of cuff placement. 6. Measurements made while the patient is sitting or lying on an examining table do not fulfill these criteria.
STEP 2 • Use proper technique for BP measurements	1. Use a BP measurement device that has been validated and ensure that the device is calibrated periodically. 2. Support the patient's arm (e.g., resting on a desk). 3. Position the middle of the cuff on the patient's upper arm at the level of the right atrium (the midpoint of the sternum). 4. Use the correct cuff size such that the bladder encircles 80% of the arm and note if a larger or smaller than normal cuff size is used. 5. Either the stethoscope diaphragm or bell may be used for auscultatory readings.
STEP 3 • Take the proper measurement needed for diagnosis and treatment of elevated BP/hypertension	1. Record BP in both arms. Use the arm that gives the higher reading for subsequent readings. 2. Separate repeated measurements by 1-2 min. 3. For auscultatory determinations, use a palpated estimate of radial pulse obliteration pressure to estimate systolic blood pressure (SBP). Inflate the cuff 20-30 mmHg above this level for an auscultatory determination of the BP level. 4. For auscultatory readings, deflate the cuff pressure 2 mmHg per second, and listen for Korotkoff sounds.
STEP 4 • Properly document accurate BP readings	1. Record SBP and DBP. If using the auscultatory technique, record SBP and DBP as onset of the first Korotkoff sound and disappearance of all Korotkoff sounds, respectively, using the nearest even number. 2. Note the time of most recent BP medication taken before measurements.
STEP 5 • Average the readings	Use an average of ≥ 2 readings obtained on ≥ 2 occasions to estimate the individual's level of BP.
STEP 6 • Provide BP readings to patient	Provide patients with SBP/DBP readings both verbally and in writing.

ARM SIZE AND BP CUFF SIZE FOR ADULTS

It is important that the correct BP cuff size is used for a participant when measuring blood pressure, as using the wrong BP cuff size can cause incorrect readings. The below table is adapted from the [2017 ACC and AHA Guidelines for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults](#).

ARM CIRCUMFERENCE	USUAL CUFF SIZE
22-26 cm	Small Adult
27-34 cm	Adult
35-44 cm	Large Adult
45-52 cm	Adult Thigh
Hypertension Crisis	≥ 180/120 mm Hg

CHOLESTEROL AND LIPIDS

The [2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol](#) is the national clinical guideline for the management of blood cholesterol. Lipid category values are defined as:

LIPID	NORMAL	ABNORMAL	DISEASE (ALERT) LEVEL
Cholesterol	< 200 mg/dL	200-239 mg/dL	≥ 240 mg/dL
LDL	< 100 mg/dL	100-159 mg/dL	≥ 160 mg/dL
HDL	≥ 60 mg/dL	59-41 mg/dL	≤ 40 mg/dL
Triglycerides	< 150 mg/dL	151-199 mg/dL	≥ 200 mg/dL

ASCVD RISK ESTIMATOR

The Atherosclerotic Cardiovascular Disease ([ASCVD](#)) [Risk Estimator](#) is a tool created by the American College of Cardiology to estimate the 10-year ASCVD risk for an individual. The calculator can be used as a conversation tool by the clinician on the participant's cardiovascular risk.

FASTING GLUCOSE AND HEMOGLOBIN A1C

The [2017 ACC and AHA Guidelines for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults](#) provide guidelines for the management of blood pressure in individuals who have diabetes. The [American Diabetes Association: Standards of Medical Care in Diabetes-2022](#) provides national guidelines for the management of pre-diabetes and diabetes in adults. Both national guidelines are used to inform procedures for diabetes, fasting glucose, and hemoglobin A1c measurement in the NC WISEWOMAN Program. There is a metabolic link between hypertension and diabetes, and it's important to understand the role one chronic condition can play in the development of the other.

	NORMAL	ABNORMAL	DISEASE (ALERT) LEVEL
Fasting Plasma Glucose	< 100 mg/dL	101-125 mg/dL	≥ 126 mg/dL
Hemoglobin A1c	< 5.7 %	5.7 % - 6.4%	≥ 6.5 %

Tip: A summary of all normal, abnormal, and disease (alert) level blood pressure and laboratory levels can be found [here](#).

Non-Fasting vs. Fasting Labs

According to the 2018 AHA and ACC Guidelines for the Management of Blood Cholesterol in Adults, for those 20 years of age or older and not on lipid lowering therapy, a fasting or non-fasting plasma lipid profile is sufficient in estimating the ASCVD risk and documenting baseline low density lipoprotein cholesterol (LDL-C). To reflect these guidelines, the CDC is no longer requiring that all participants be fasting at time of lab draw. However, this only applies to those participants that do not have a history of high cholesterol, are not on lipid lowering medications, and have not had a high fat meal 8 hours prior to blood work. For participants with a family history of heart attacks and atherosclerotic disease at an early age (< 50-55 years) or who have a genetic history of hyperlipemia, it is recommended that an initial fasting lipid profile be conducted. The provider should be cognizant that if repeat labs are required that the cost for the labs must come out of the capitated rate for the screening.

It is a required part of the NC WISEWOMAN Program that if a participant's initial triglyceride level is ≥ 400 mg/dl and they were non-fasting, that a repeat fasting lipid profile should be conducted.

LAB WORK DOCUMENTATION

If the participant has received labs in the past 30 days, then these lab values can be used for program reporting. The labs **must not be** self-reported from the participant. The WISEWOMAN Navigator is responsible for ensuring that labs are from a valid medical provider and clearly display a blood draw date no earlier than 30 days prior to the date of enrollment.

Healthy Behavior Support Service Navigation

If an individual has Medicaid, Medicare, or private insurance, she can still be navigated through NC WISEWOMAN Program for referral to a Healthy Behavior Support Service. The navigation protocol for this process is detailed below.



Healthy Behavior Support Service Navigation Protocol

OVERVIEW AND PURPOSE: As part of its core services, the NC WISEWOMAN Program provides Healthy Behavior Support Services (HBSS) to eligible women. The aim of service navigation is to expand the number of eligible NC women who can partake in the HBSS portion of the NC WISEWOMAN Program. Through Service Navigation, women who are deemed underinsured (with either Medicaid or private insurance) but who meet the other program eligibility criteria, can receive navigation services the NC WISEWOMAN Program for HBSS only.

- 1. Recruitment.** Identify NC WISEWOMAN Program eligible women from current or potential participant population. Women can be identified from other internal clinics, community partners, etc.
 - 1.1. Determine Eligibility.** Women deemed eligible for HBSS Navigation should meet the following eligibility criteria:
 - a. 40 to 64 years of age
 - b. Income at or below 250% of the Federal Poverty Level
 - c. Underinsured
 - 1.2. Underinsured.** Occurs when an individual cannot afford the co-pay and/or deductible for the insurance; therefore, she cannot benefit from the services covered under the insurance. A woman may also be found underinsured if insurance does not cover the same type of HBSS that are covered under the NC WISEWOMAN Program.
- 2. Assessment of Program Required Labs.** Before the enrollment visit for NC WISEWOMAN HBSS navigation the woman's record should be assessed for program required labs. Although these services cannot be covered for the woman through the NC WISEWOMAN Program, the results of these labs are still a required part of the program for risk reduction and health coaching purposes.
 - 2.1. Current Clinical Participant.** Determine if labs were performed in the last 30 days. If so, these may be used for program documentation if the required labs were performed (Fasting Glucose or Hgb A1c, Lipid Panel). Proceed with scheduling/conducting enrollment visit. If the labs are more than 30 days old, see split billing below.
 - 2.2. Non-Clinical Participant.** Determine if the participant had labs drawn by another agency/provider within the last 30 days. Obtain a copy of these labs for documentation in the participant record. If the labs are more than 30 days old, establish the participant, refer participant for office visit with clinical labs, and perform split billing for the services.
 - 2.3. Split Billing.** If a woman does not have labs that are 30 days old or less, then she needs to have an office visit with clinical lab draw. It is the responsibility of the provider to ensure that split billing is performed. The NC WISEWOMAN Program funds cannot be drawn down to cover the cost of these lab services. These services must be billed to the women's Medicaid or private insurance. This should be assessed and performed before the woman has her enrollment visit into the NC WISEWOMAN Program.
- 3. Enrollment.** After a woman's eligibility for HBSS navigation is determined and her lab status assessed, she should be scheduled for her enrollment visit for the program. HBSS navigation enrollment visit should include the following:
 - 3.1. Risk reduction counseling**
 - a. Documentation of lifestyle risks, physical activity, etc.
 - 3.2. First Health Coaching session**
- 4. Diagnostic Follow-Up.** If the participant has an alert or abnormal value, she must be referred for a diagnostic visit as per the program guidelines. However, this diagnostic visit will not be covered under the NC WISEWOMAN service navigation fee and must be billed to the participants' Medicaid or private insurance.
- 5. HBSS Services.** After her enrollment visit, the participant can continue with health coaching or be referred to one of the following approved HBSS:
 - 5.1. NC HeartWise**
 - 5.2. Diabetes Prevention Program**

- 6. Service Navigation Fee.** The provider will be reimbursed at a capitated rate of \$180 for healthy behavior support service navigation for Medicaid or private insurance participants only. This fee covers the Enrollment Visit (Risk reduction counseling, 1st health coaching session, data entry, and the 4-6-week follow-up).
- 7. Healthy Behavior Support Services.** A woman should be referred to one of the applicable healthy behavior support services. The provider should conduct the 2nd and 3rd sessions of HBSS and draw down the \$15 fee for each session. If referring to DPP a \$25 referral fee can be drawn down. After the 3rd session of HBSS, the participant can be scheduled for the 4-to-6-weeks follow-up, which is covered under the service navigation fee.
- 8. Close out of Healthy Behavior Support Service Navigation.** Successful HBSS navigation is completed when the necessary data has been captured for enrollment, she has been referred to one of the applicable HBSS and is brought back in for follow-up counseling.

DIAGNOSTIC AND MEDICAL FOLLOW-UP



A CDC requirement for all WISEWOMAN Programs is that women who have abnormal screening results have appropriate medical evaluation in accordance with standards of care and the program guidelines. All provider sites are required to have a referral process for women with abnormal and alert findings.

Medical Evaluation and Diagnostic Follow-up Requirements:

- Women with alert value blood pressure are to receive a diagnostic referral for medical evaluation and treatment immediately or within 7 days of the alert value measurement.
- Women with alert level laboratory values are to be referred for a medical evaluation and/or other appropriate follow-up within 30 days unless otherwise indicated by the judgment of the presiding medical/health director or physician.
- Women with abnormal blood pressure and/or laboratory values must receive further attention within 30 days unless otherwise indicated by the judgment of the presiding medical/health director or physician.
- Appropriate case management as outlined in the following below section.

Women may be referred for one diagnostic follow-up/medical evaluation per screening cycle (i.e., from enrollment/annual rescreening to follow-up screening). These services are included as part of the \$270 capitated rate. Additional medical evaluations are not covered.



Abnormal and Alert Values

LABORATORY VALUES						
BLOOD PRESSURE	ABNORMAL					
	Total Cholesterol	HDL	LDL	Triglycerides	Hemoglobin A1C	Fasting Glucose
≥140/90 mmHg*	200-239 mg/dL	59-41 mg/dL	100-159 mg/dL	151-199 mg/dL	5.7 % - 6.4%	101-125 mg/dL
ALERT						
≥180/120 mmHg	≥ 240 mg/dL	≤ 40 mg/dL	≥160 mg/dL	≥ 200 mg/dL	≥ 6.5 %	≥126 mg/dL

*As noted in the clinical guidelines section for Blood Pressure, some national guidelines have now lowered the abnormal threshold to ≥ 130/90. Providers may use this at their discretion as long as women with ≥140/90 are being referred for further attention.

Case Management

The CDC defines case management as a short-term intensive support service used to ensure that patients receive appropriate and timely medical care. Participants with an abnormal and/or alert value blood pressure or lab reading should receive case management services. Case management can help individuals understand their treatment regimens, find low cost or free sources of medication, attend medical appointments, and reduce other barriers.⁵

The NC WISEWOMAN Program provider is responsible for ensuring that each participant that has an abnormal or alert level blood pressure or lab value receives case management. Providers will work with their internal or external primary care to refer the participants for medical follow-up. At minimum case management documentation should include:

- Referral for a diagnostic/medical follow-up visit
- Date of diagnostic/medical follow-up visit
- Outcome and/or plan of treatment for participant

The following information should be documented in the patient's chart:

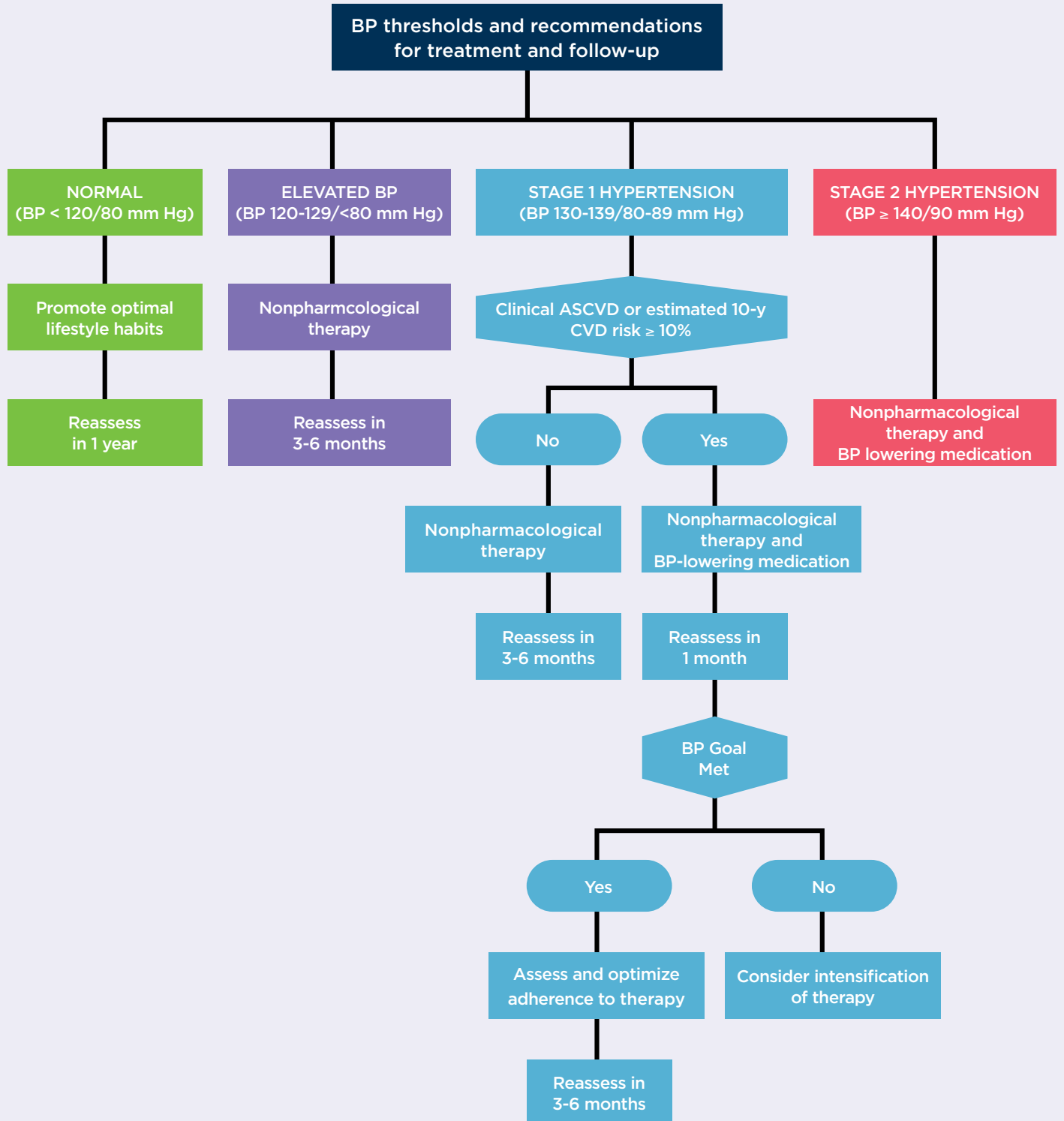
- Participant refuses a diagnostic medical follow-up,
- Participant is unable to be reached to schedule an appointment and/does not attend their diagnostic appointment,
- Provider is unable to obtain the diagnostic information from an external medical care provider.

The diagnostic referral date and status are documented on either the patient's DHHS Form 4049 A and B (EHR P6, Access Page One and Two) or DHHS Form 4041 A and B (HER P6, Access Page One and Two).

The CDC and NC WISEWOMAN Program use the 2017 ACA and AHA guidelines for the management of blood pressure as guidance for directing the need for follow-up blood pressure evaluation. These guidelines can be found in the below diagram.

⁵ Centers for Disease Control and Prevention. (2017). WISEWOMAN Technical Assistance Manual

ACA Guidelines on BP Follow-Up



RISK REDUCTION COUNSELING



Patient centered Risk Reduction Counseling (RRC) is a key part of the WISEWOMAN program to help a woman identify modifiable risk factors for cardiovascular disease. A woman should receive RRC at every screening visit even if she was found not to be at risk during a previous visit.

How To Conduct Risk Reduction Counseling:

STEP ONE

RRC is facilitated through conversation that occurs while completing DHHS Form 4049 A and B (EHR P6, Access Page One and Two) or DHHS Form 4041 A and B (HER P6, Access Page One and Two). Participant information is gathered through the following assessments of:

- Medical History
 - High Cholesterol
 - High Blood Pressure
 - Diabetes
 - Stroke or TIA
 - Heart Attack
 - Coronary Heart Disease
 - Heart Failure
 - Vascular Disease
 - Congenital Heart Disease and Defects
- Medication Status
 - Cholesterol (statin or non-statin)
 - Blood Pressure
 - Diabetes
 - Aspirin
- Home Blood Pressure Measurement
- Dietary Behaviors
 - Fruits and vegetables
 - Fish
 - Whole grains
 - Sugar sweetened beverages
 - Sodium intake
 - Alcohol consumption and frequency
- Physical Activity
- Smoking Status
- Quality of Life

The corresponding questions for the above health assessments are an important and mandatory part of the program data collection. This information documents for you and CDC the ASCVD risk profile of the participant population that is being served by the program.



STEP TWO

Use Motivational Style Interviewing to help the participant understand her risk for the development of cardiovascular disease and associated co-morbidities based upon her responses to the health assessment questions.

Motivational Style Interviewing

Motivational style interviewing combines the theories of positive psychology and motivational interviewing therapy to create a person-centered, systematic approach to helping a WISEWOMAN participant to bridge the gap between personal risk factors for heart disease and her desire and ability to reduce those risks. Both positive psychology and motivational interviewing therapy are strongly focused on participant autonomy to choose her course of action and to draw out that course using conversation which is collaborative and respectful.

Two acronyms can be used to summarize motivational style interviewing as used in the NC WISEWOMAN Program: **OARS RULE**.

These four concepts apply to conversation techniques used to elicit and identify motivations of the participant.

O	Open-ended questions
A	Affirmations
R	Reflections
S	Summaries

These four concepts apply to the health coach perspective while engaged in collaborative conversation:

R	Resist telling
U	Understand motivation
L	Listen with empathy
E	Empower

STEP THREE

As you complete the risk reduction counseling portion of the screening visit, you will start: ***Bridging the Gap from Risk Reduction Counseling to the First Health Coaching Session***

After risk reduction counseling is complete there should be a significant change in conversation style from a focused medical professional explaining factual data to peer-level collaborative conversation which is person focused. The person providing the health coaching is a knowledgeable guide, not an expert on this unique person. The job of the health coach is to draw out a participant's internal motivation, power, and dignity to craft a health goal at which she can be successful. Remember, some action is better than no action and any positive action sets up the potential for more positive action.

A risk reduction counseling transition to health coaching might follow something like this:

- Comment on positive aspects of clinical and health assessment data.
- Point out a couple of areas where clinical or health assessment data could be improved to reduce risk of heart disease.
- Use open-ended questions to give participant opportunity to express her thoughts.

Examples of open-ended questions:

- Can you tell me anything you could do to reduce any of these risks for your heart?
- What do you think about your future if you leave these risks alone and do nothing at this time?
- What might be an upside of making a small change to one of these risks now?
- Leave time and space for participant to reflect and think, then be prepared to listen closely. You may have to ask for more information to get a deeper answer.
- Acknowledge information shared with affirmation and or reflection comment. Affirmation comments express support for what was said. It is not a cheerleader, but a thoughtful, supportive comment or body language gesture. Reflection is confirming and or clarifying what you heard is what was intended. Reflection can be 'repeating back' or paraphrasing for intent.
- When you hear any words or intentions or desires about change, it is an opening to bring out the readiness ruler. **Health coaching begins with the Readiness Ruler.**

HEALTHY BEHAVIOR SUPPORT SERVICES



Once a NC WISEWOMAN Program participant has completed all screening and risk reduction counseling requirements, they should be offered HBSS, which are evidence-based lifestyle programs shown to reduce cardiovascular disease risk. They are integral to the NC WISEWOMAN Program and each participant should receive a mandatory HBSS at their enrollment and/or annual rescreening visit. CDC has approved the following HBSS:

- Health Coaching
 - Expanded Health Coaching: A participant receives health coaching in conjunction with a non-approved HBSS, such as a community resources or programs, chronic disease self-management programs, and/or other resources that may be locally available to the participant.
- NC HeartWise
- Diabetes Prevention Program
- QuitlineNC with Expanded Health Coaching
- Walk With Ease

These supportive services utilize change strategies to motivate individuals to make lifelong changes that have a positive impact on their health. The 2017 ACC and AHA guidelines for blood pressure in adults show that non-pharmacological interventions can reduce hypertension:

BEST PROVEN NONPHARMACOLOGICAL INTERVENTIONS FOR PREVENTION AND TREATMENT OF HYPERTENSION ⁶			
	Nonpharmacological Intervention	Dose	Approximate impact on Hypertension (SBP)
Weight Loss	Weight/body	Best goal is ideal body weight but aim for at least a 1-kg reduction in body weight for most adults who are overweight. Expect about 1 mm Hg for every 1-kg reduction in body weight.	-5 mm Hg
Healthy Diet	DASH dietary pattern	Consume a diet rich in fruits, vegetables, whole grains, and low-fat dairy products, with reduced content of saturated and total fat.	-11 mm Hg
Reduced intake of dietary sodium	Dietary sodium	Optimal goal is <1500 mg/d but aim for at least a 1000-mg/d reduction in most adults.	-5/6 mm Hg
Enhanced intake of dietary potassium	Dietary Potassium	Aim for 3500–5000 mg/d, preferably by consumption of a diet rich in potassium	-4/5 mm Hg
Physical activity	Aerobic	90–150 min/wk 65%–75% heart rate reserve	-5/8 mm Hg
	Dynamic Resistance	90–150 min/wk 50%–80% 1 rep maximum 6 exercises, 3 sets/exercise, 10 repetitions/set	-4 mm Hg
	Isometric Resistance	4 × 2 min (hand grip), 1 min rest between exercises, 30%–40% maximum voluntary contraction, 3 sessions/wk 8–10 wk	-5 mm Hg
Moderation in alcohol intake	Alcohol consumption	In individuals who drink alcohol, reduce alcohol to: Men: ≤2 drinks daily Women: ≤1 drink daily	-4 mm Hg

It is important that participants understand that HBSS and follow-up health coaching sessions are an integral part of the NC WISEWOMAN Program. This part of the program is included in the [consent form](#). Knowing and understanding clinical values are important but lifestyle changes are key for improving heart health.

⁵ American College of Cardiology and American Heart Association. (2017) Guidelines for prevention, detection, evaluation, and management of high blood pressure in adults.

HEALTH COACHING



Overview of Health Coaching

Health Coaching is a CDC approved HBSS option for improving cardiovascular health. The first health coaching session takes place at the initial visit. Health coaching helps the participant to identify small steps toward healthy behavior change using motivational interviewing, personalized goal setting, and active listening that addresses the participant's priority goal. This approach uses a collaborative, patient-focused approach to enable participants to take responsibility for their health and builds a climate of trust and support.

Who should be referred to health coaching?

All NC WISEWOMAN Program participants have their first health coaching session of the screening cycle at the enrollment or annual rescreening visit, following risk reduction counseling. Health coaching begins with the [readiness ruler](#) to determine the participants readiness to change behaviors. The participant works with their health coach to determine one or more areas of focus for brief coaching interventions. Including:

- Physical Activity
- Nutrition
- Stress Reduction
- Medication Management
- Tobacco Cessation
- Other CVD Related issues

Navigators should ask all participants about tobacco use at their enrollment visit. If the participant indicates that they are a current smoker, they should receive [expanded health coaching](#) with a [QuitlineNC](#) or other tobacco cessation resource referral.

Navigator Role

Local service providers can facilitate health coaching using a combination of team members, including health educators, the Navigator, community health workers, advance practice nurses/registered nurses, and other trained health professionals based on organizational structure. Local service providers are responsible for identifying at least one staff member who will provide health coaching. The identified staff member conducting health coaching must be knowledgeable of cardiovascular disease risks and healthy lifestyle behaviors that reduce those risks.

Health coaching or health education materials will be provided to support participants in making and maintaining healthy lifestyle choices. Relevant health education materials and motivational tools can be ordered from the NC WISEWOMAN state level Health Educator. A materials order form can be found [here](#).

Each participant will receive two (2) health coaching calls during the 12-week window between initial screening and follow-up. The first call (second health coaching session) will be made approximately two – four weeks after the clinical visit. The second call (third health coaching session) will be made approximately four weeks later or eight weeks after the clinical visit. During the second call a final follow-up appointment may be scheduled.

It is important to document 'best time(s) and day(s)' within the normal work week and work hours for coaching calls. Some program navigators create a follow-up call appointment time to assure contact and reduce the chance that calls are missed. Two attempts to reach the participant will be made during 'best time/day' window. Document attempted calls in the participants health record. Document actual sessions on DHHS Form 4050 A and B (EHR P7, Access WW Coaching). Ask the participant if it is okay to leave a message on voicemail or with another family member. Inform the participant if another NC WISEWOMAN Program team member may be doing the follow-up calls and provide that person's name and number to be recognized as a legitimate caller.

Participant Role

NC WISEWOMAN participants who are interested in health coaching must:

- Develop a Specific, Measurable, Achievable, Relevant, and Time-bound (SMART) goal to address risk factor(s), and
- Be willing to participate in all health coaching sessions, via phone or in person.

Tenets of Health Coaching

- I. Approach each participant holistically with unconditional positive regard.
- II. Recognize that each participant is unique in her world view and circumstances and is the owner of her own health choices.
- III. Interact conversationally and collaboratively with each participant to identify priority area for behavioral goal setting using motivational style interviewing and active listening skills.
- IV. Allow space for hesitancy, concerns, and motivators to be voiced and examined.
- V. Serve as a guide to assist in setting small steps for change; a partner in solving barriers and a champion for success.
- VI. Provide information, skill-building tools, and connections to resources.

The Tools of Health Coaching

Basic health coaching is a process of using [motivational interviewing](#) to allow the participant to identify, draw out solutions, and discover alternatives to be successful in achieving a personal health goal. Behavior change happens in small steps along a continuum. Success fuels confidence and confidence fuels more success over time.

ASSESSING THE PARTICIPANT STAGE OF CHANGE

The Readiness Ruler (RR) is a helpful tool to start the motivational interviewing process. The ruler gives participants an opportunity to think about change, open a discussion about barriers to change, and helps guide goal setting.

Readiness Ruler	How READY are you to make changes to improve your heart health?						
	1	2	3	4	5		
	Not Ready to Change	Considering Change	Planning to Change	Already Taking Action to Change	Maintaining Change		

Readiness Ruler CONFIDENCE	How CONFIDENT are you about making change to improve your heart health?						
	1	2	3	4	5		
	Not At All Confiden	Slightly Confiden	Somewhat Confiden	Moderately Confiden	Very Confiden		

1. Show the readiness ruler.
2. Explain the numbers
 - a. The number '1' end of the ruler means the participant has not thought about changing anything to reduce risk for heart disease, and therefore is not ready to change.
 - b. The middle '3' means the participant has thought about making positive change, and has a plan to make the changes to reduce their risk for heart disease.
 - c. The number '5' end means the participant is maintaining the new status quo and is committed to the goal.
3. Assess the participant's confidence to make heart healthy changes (on opposite side of readiness ruler).
4. Ask participant where she sees herself on the ruler.
5. Probe for insight. After the participant selects a number ask open-ended question like, "Would you share your thoughts that led you to pick that number?"
6. Recognize stage of change, readiness and self-efficacy to change based on ruler selection and comments.

Readiness Ruler Step	Coaching Guidance
1-2	• Need guidance, information, support for self-efficacy, and small steps to ensure successful change
3	• May have specific area of change in mind • Crafting change goal should include discussion about challenges and supports
4-5	• May already be engaged in change process • Acknowledge action already taken • Encourage goals that expand, support maintenance, or prevent relapse (i.e., dietary journals and participation in group activities)

Special Note: NC WISEWOMAN Program requires ALL smokers to be counseled and referred for smoking cessation support regardless of where participant is on the Readiness Ruler. Participants who refuse referral should still be provided brief counseling on health benefits of stopping or reducing smoking, encouraged to think about quitting and provided appropriate resources. Research shows even brief counseling by trusted health care providers increases the potential to quit and success of quitting⁶. If participant refuses referral, this should be documented in health record DHHS Form 4049 A and B (EHR P6, Access Page One and Two) or DHHS Form 4041 A and B (EHR P6, Access Page One and Two). Ask which other area participant is willing to address a healthy change.

CRAFTING A SMART GOAL

The health goal is crafted using the participant's expressed interest in a particular health area based on results of risk reduction counseling and position on the readiness rule. This is considered the first health coaching session. The goal should be **SMART**.

- **Specific** – Only address one area of risk i.e., weight, nutrition, physical exercise, or hypertension management;
- **Measurable** – Can be yes/no; lose five pounds, eat three fruits/vegetables a day, walk 10-15 minutes a day, take five minutes to calm/de-stress/or mediate each day.
- **Realistic** – Remember the lower the readiness ruler number guide toward a simpler and more achievable goal; higher readiness ruler number guide toward a more ambitious goal.
- **Achievable** – Does the participant have the resources to achieve the goal like a scale, access to fresh market, safe walking area outside or inside, skills of relaxation breathing?
- **Time-limited** – By program design the first follow-up call is about two-four weeks out from clinic visit and adjustments, barriers or changes can be made to the goal. The second follow-up call is about four more weeks. A few weeks at a time is not an overwhelming commitment. The maximum time of about eight to 12 weeks can produce change.



Depending on which tool you use for providing risk assessment information, Know Your Numbers or the WISEWOMAN Passport (see [material order form](#)). It is important to record the SMART goal and potential dates for future follow-up health coaching calls.

⁶ Solberg, L. (1988). Implementing a tobacco cessation program in clinical practice. Medical Times, 116(4), 119-124.

Expanded Health Coaching

Expanded health coaching is a component of Healthy Behavior Support Services (HBSS). It is an NC WISEWOMAN Program option to meet the requirement that all women must be offered HBSS, by conducting health coaching concurrently with a community resource referral. Both health coaching and expanded health coaching:

1. assess the participant's stage of change,
2. incorporate motivational interviewing,
3. assist participant in crafting a SMART health goal, and
4. support participant success with two follow-up coaching calls to address challenges, encourage problem-solving and celebrate successes.

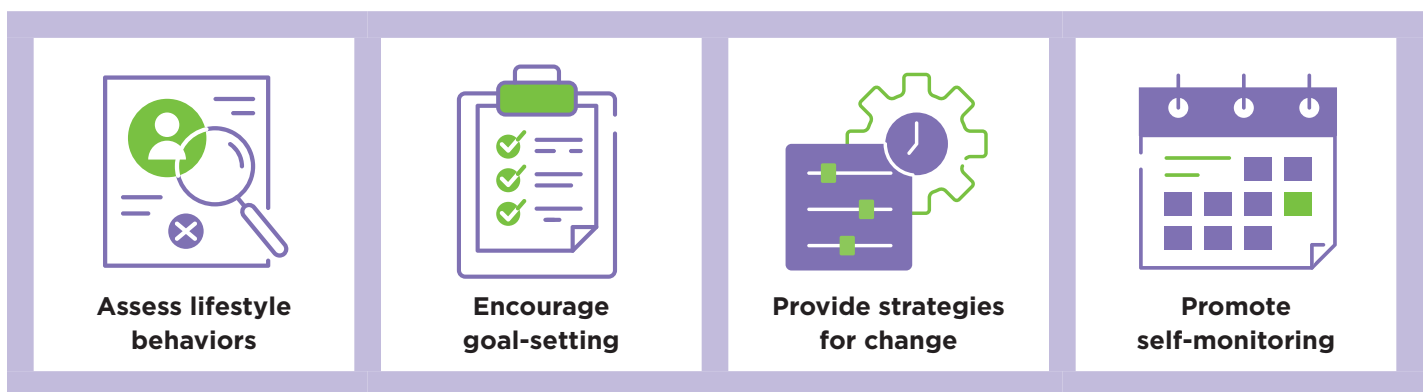
Expanded health coaching has the added component of referral to community-based programs that are established and evidence-based and meet the individualized goal of the participant. An example of enhanced health coaching may be the referral to the local senior center for regularly scheduled exercise classes for a participant who creates an individualized goal to exercise three times a week. This referral adds another layer of structure and accountability for the participant to achieve her goal. The concurrent health coaching calls provide support and opportunity to discuss challenges and successes.

Med-South

The Med-South Lifestyle Program (MSLP) is an evidence-based option created by the University of North Carolina at Chapel Hill Center for Health Promotion and Disease Prevention. This program translates a Mediterranean dietary pattern for the southeastern U.S. population and is consistent with the latest guidelines from the American Diabetes Association and US Department of Agriculture Dietary Guidelines. MSLP focuses on healthy eating habits and physical activity as the key to reducing the risk of heart disease, stroke, and other chronic illnesses.

The MSLP curriculum consists of 4 sessions that include: a brief dietary assessment, background information, and goal-setting guidance. The sessions incorporate behavioral approaches targeting motivation, self-efficacy, and self-regulation skills and include problem-solving and self-monitoring skills to address challenges to making diet and physical activity behavior changes.⁷ Navigators can use this curriculum to assist with their health coaching sessions in applicable areas of behavior change or can use the curriculum in its entirety for health coaching. Participants should be provided the applicable curriculum sections along with any other relevant healthy behavior support tools, like a cookbook, food scale, or educational resources.

MSLP can be used in health coaching to:



The NC WISEWOMAN Program makes available the Med-South Lifestyle Program Curriculum for all provider sites. Please [contact](#) the program health educator to inquire about receiving a copy of the curriculum.

⁷ Med-South Lifestyle Program: <https://hdpd.unc.edu/med-south-lifestyle-program/>

Data Documentation for Health Coaching

Health Coaching data is recorded on the DHHS Form 4050 A and B (EHR P7, Access WW Coaching). Required data includes:

- Date of the HBSS session
- Type of HBSS
- Length of the HBSS session
- Type of contact for the HBSS session
- Status of the HBSS session
- Setting of the HBSS session

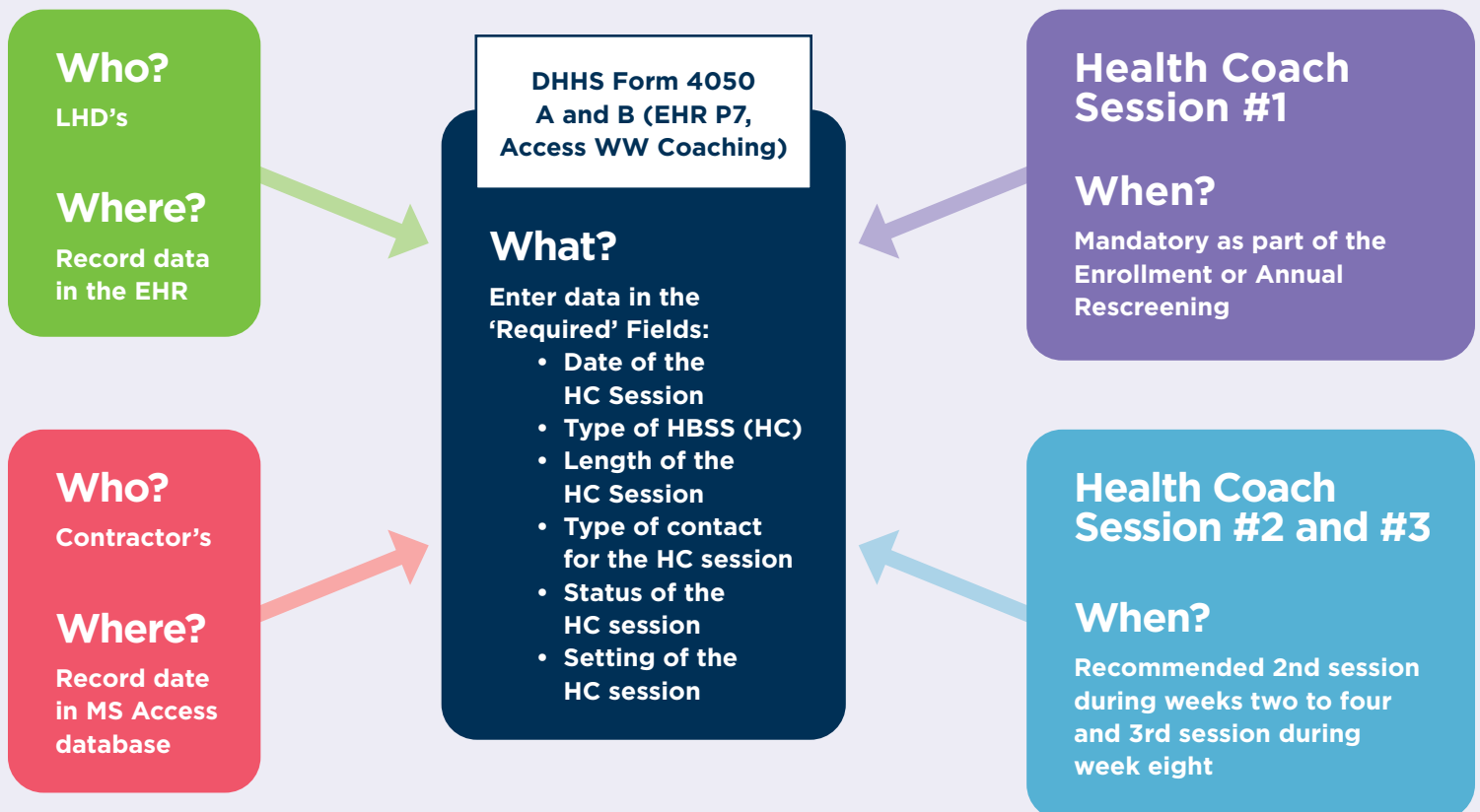
TIP: While not currently required, the program recommends documentation in the participant's chart of other information gathered during the health coaching process to assist with team-based care and other scheduled HBSS sessions.

The completion of health coaching consists of THREE documented health coaching sessions. The first session is a mandatory part of the enrollment or annual rescreening visit. Data for this session should still be recorded on the DHHS Form 4050 A and B (EHR P7, Access WW Coaching). While the spacing of the 2nd and 3rd Health Coaching sessions are left to the provider, ideally, health coaching should be completed in less than 11 months from the enrollment or annual rescreening date.

Data documentation for expanded health coaching should follow the same guideline as the data collection for health coaching.

Health Coaching Data Flow Process

Three Documented Health Coaching Sessions (Same Process for Expanded Health coaching options of DPP, Community Resource Referrals, etc.)



NORTH CAROLINA HEARTWISE



Overview of NC HeartWise

The NC WISEWOMAN HeartWise Program (NC HeartWise) aims to improve hypertension control among participants. By providing participants with self-measuring blood pressure education, targeted health coaching, and an at-home blood pressure (BP) machine, the program works to increase patients' skills in managing their hypertension. This eight-week strategy has shown to be an effective approach to control hypertension. NC HeartWise is comprised of three health coaching sessions to keep the participant engaged and on track with her goals.

Whom to Refer to NC HeartWise

NC WISEWOMAN participants at risk developing hypertension with at least one abnormal and/or alert level BP measurement, participants with [undiagnosed hypertension](#), or participants previously diagnosed with [uncontrolled hypertension](#) can be referred to NC HeartWise.

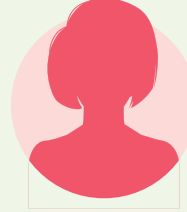
NC HeartWise Session Timeline

NC HeartWise follows the same three-session timeline as health coaching, with additional steps to capture the participant's blood pressure measurements.

NC HEARTWISE SESSION 1 (CONDUCTED AS FIRST MANDATORY SESSION OF HEALTH COACHING):

- Review the NC HeartWise Program requirements and complete the [participant agreement form](#)
- Train on Self-Measured Blood Pressure technique and why it is an important step in the program.
- Instruct on using / at-home BP machines and have them conduct a teach-back (showing the provider how to use the machine)
- Teach participants how to complete the program tracking logs
- Provide NC HeartWise educational materials, including a NC HeartWise Passport (see [material order form](#)) and [tracking logs](#)

Navigator Role



The NC WISEWOMAN Navigator is responsible for determining HBSS eligibility and providing the participant with the tools needed to be successful in their health journey. The NC HeartWise participant agreement form will be reviewed and signed by the participant. The navigator will instruct the participant on accurately measuring blood pressure (BP) and will provide a cuff for at-home use. The participant will be trained on how to fill out BP logs, use the NC HeartWise Passport, and accurately self-monitor their BP. Participants will be informed of normal, abnormal, and alert values blood pressure values. The Navigator will provide guidance throughout the duration of the NC HeartWise Program that if they have an alert level measurement, ($\geq 180/120$), they are to take their BP for a second time. If both readings are at the alert level, they need to contact a physician and/or seek immediate help.

The Navigator should have the following materials available to the participants: BP Monitors and cuff to best fit the woman, batteries (if applicable), timer, measuring tape, NC HeartWise Passports, CVD, and other relevant educational materials. All these items are available for order via the [program material order form](#).

Participant HeartWise Role

NC HeartWise Program participants are expected to follow the program by:

- Checking their BP and documenting measurements, and
- Engaging in health coaching calls.
- Accurately utilizing health education materials and motivational tools, and
- Following navigator recommendations for BP improvement.



NC HEARTWISE SESSION 2 (2-4 WEEKS AFTER SESSION ONE):

- Collect first two weeks of BP measurements.
- Determine needed adjustments to care plan (schedule an appointment with a physician, adjust BP medication, additional health coaching to re-iterate goals, etc.)
- Provide health coaching on BP control. Don't forget to congratulate the participant if they are staying on track!
- Document the first 14 days (2 weeks) of blood pressures on DHHS Form 4050 A and B (EHR P7, Access WW Coaching).

NC HEARTWISE SESSION 3 (4 WEEKS AFTER SESSION TWO):

- Provide relevant health coaching
- Document the remaining 6 weeks of blood pressures on DHHS Form 4050 A and B (EHR P7, Access WW Coaching)
- Schedule the follow-up screening within 4 to 6 weeks of this last session to collect tracking logs, their BP monitor*, and NC HeartWise Passport

*The BP monitor belongs to the participant, but they should bring it to the follow up visit to assess whether it is working properly and address any issues or concerns.

FOUR TO SIX WEEK FOLLOW-UP (4-6 WEEKS AFTER NC HEARTWISE SESSION THREE):

Participants are required to return for a follow-up visit with the provider to evaluate short-term progress and to facilitate goal adjustments as needed. In addition to the 4- to 6-week follow-up requirements, the navigator will:

- Ensure that all blood pressure measurements have been documented correctly.
- Review BP measurements with the participant and discuss trends and recommendations.
- Provide relevant health coaching and educational materials as needed.

How to Effectively Self-Measure Blood Pressure

- I. Equipment (automatic measuring home blood pressure device):
 - a. Use a cuff that measures blood pressure on the arm and is the correct size. See [cuff size chart](#).
 - b. Ensure the batteries are good and installed correctly.
 - c. Review the owner's manual to be familiar with the functions of the device.

A cuff that is too small or too big can result in an inaccurate reading. A cuff that has cracks or other damage will produce an inaccurate reading. Wrist cuffs and fingertip devices may not measure your blood pressure as accurately as an arm cuff.

- II. Preparation: Blood pressure readings vary throughout the day. If measuring and recording blood pressure for a specific purpose, chose a time of day that will work for most days during that period.
 - a. Wait 30 minutes after eating, drinking caffeine beverages or exercising.
 - b. Empty bladder and sit quietly, without distractions for about five minutes, if possible.
 - c. Sit in a comfortable chair with back supported, legs uncrossed, feet flat on the floor.
 - d. Position the cuff smoothly around the upper arm just above the fold of the elbow and level with the heart.
 - e. Support the arm on a smooth surface, palm up.
- III. Measurement:
 - a. Press the START button on the front of the machine.
 - b. Avoid talking or other distractions while the machine is working.
 - c. Remove the cuff after it has completely deflated.
 - d. Record the reading from the front of the machine in a log or blood pressure diary.

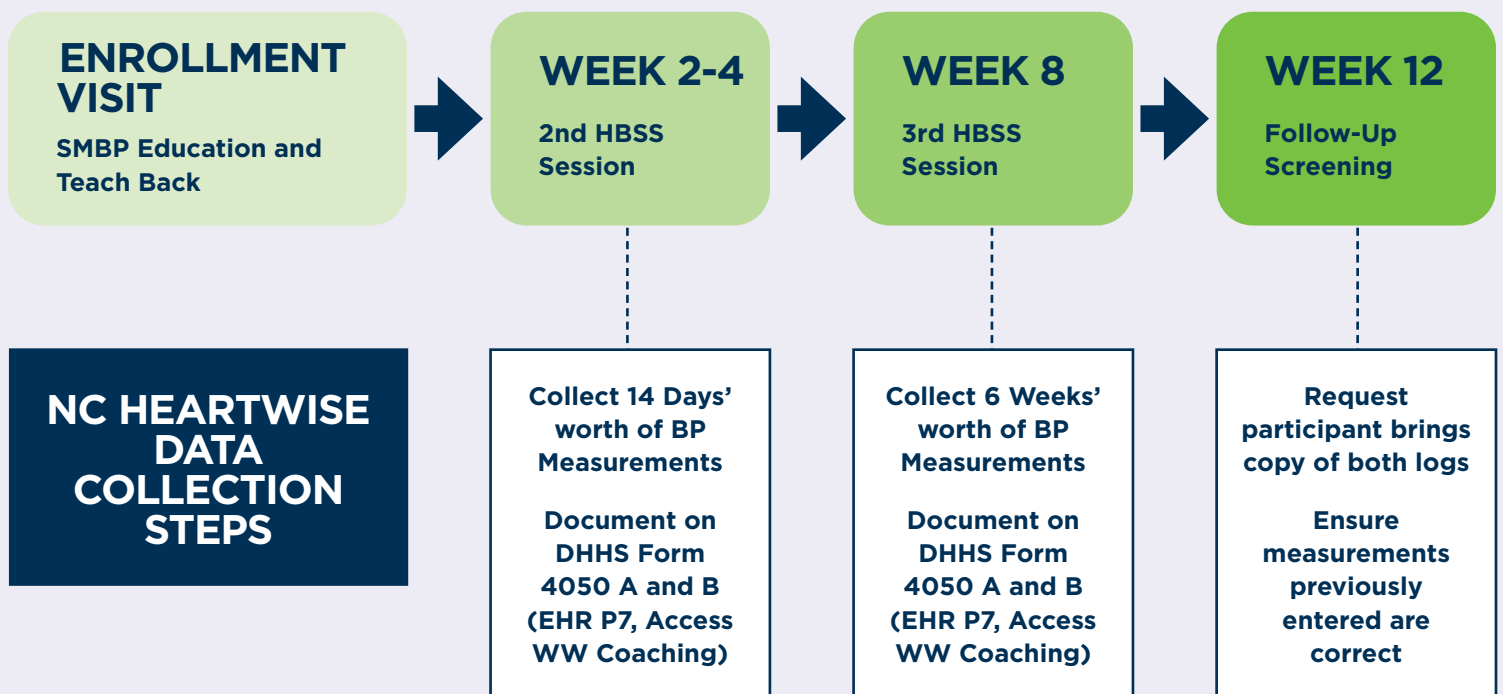
Data Documentation for NC HeartWise

Recently, the NC WISEWOMAN Program made changes to its DHHS Form 4050 A and B (EHR P7, Access WW Coaching) to include fields for the documentation of the blood pressures captured during the NC HeartWise HBSS. These measurements are not required to be faxed in or emailed, but rather will be entered with all the other HBSS data. In addition to documentation of the blood pressure measurements, the following will be documented for each NC HeartWise session facilitated:

- Date of the NC HeartWise Session
- Type of HBSS (NC HeartWise)
- Length of the NC HeartWise Session
- Type of contact for the NC HeartWise Session
- Status of the NC HeartWise Session
- Setting of the NC HeartWise Session

TIP: While not currently required, the program recommends documentation in the participant's chart of other information gathered during the NC HeartWise sessions to assist with team-based care and other scheduled HBSS sessions.

NC HeartWise Delivery Sequence



DIABETES PREVENTION PROGRAM (DPP)



Overview of DPP

The Diabetes Prevention Program (DPP) is designed to empower people at risk for developing diabetes to take charge of their health and well-being. This lifestyle program can help prevent or delay type 2 diabetes. NC WISEWOMAN Program participants can access DPP services through an online curriculum or in-person class. Individual lifestyle coaches work with participants to help them achieve individualized, clearly defined weight loss and physical activity goals. The program focuses on self-management to achieve long-term improvements in diet and physical activity.

Who to Refer to DPP

According to the CDC Standards and Operating Procedures for the Diabetes Prevention Program⁸, providers can refer NC WISEWOMAN Program participants who meet the following criteria to DPP. Those who:

- Are overweight, with a body mass index ≥ 25 kg/m² (≥ 23 kg/m² if Asian)
- Have not already been diagnosed with diabetes—if the participant had gestational diabetes, she may be eligible to participate and
- Meet at least one of the following:
 - Had a blood test result in the prediabetes range within the past year
 - Previously diagnosed with Gestational Diabetes
 - Received a high-risk (a score of 5 or higher) on the [Prediabetes Risk Test](#)

Due to the number of sessions of DPP, only participants who have indicated a readiness to change, feel that DPP is an appropriate HBSS, and have access to in-person or online sessions should be referred.

Online vs. In-Person DPP

The online program, Eat Smart Move More, Prevent Diabetes (ESMMPD) is offered in partnership with NC State University. [ESMMPD](#) is a CDC recognized 12-month program based on strategies proven to prevent or delay diabetes. Online classes are held using the GoToTraining platform and are fully accessible on a desktop, laptop, smartphone, and tablet. Classes are conducted in an interactive format by a live, trained lifestyle coach. The format of the classes allows you to interact with your instructor and classmates. You will work through challenges together as a group and celebrate each other's successes. Lunch time and evening sessions are available, and new classes begin monthly.

Navigators receive voucher codes that waive enrollment fees. Although participants are being referred to these programs, health coaching sessions (calls) should still be conducted to provide support, and keep the participant engaged and motivated to accomplish her lifestyle change goals.

The in-person program is the National Diabetes Prevention Program in partnership with the Community & Clinical Connections for Prevention and Health (CCCCPH) Branch within the NC Division of Public Health. This program encourages referrals to DPP and diabetes self-management education and support services. This program is a 12-month lifestyle change program available for adults who want to lower their diabetes risks.

⁸ Centers for Disease Control and Prevention Diabetes Recognition Program Standards and Operating Procedures.
www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf

Navigator Role

The NC WISEWOMAN Navigator's role is to facilitate program enrollment OR provide the initial referral and to conduct expanded health coaching session as the participant is enrolled in DPP. More information on how to document these expanded health coaching sessions is provided in the data documentation section for DPP.



HOW TO MAKE A REFERRAL

For online DPP, the Navigator helps the participant register for the program during their first health coaching session (have their A1c handy). The Navigator will also need to have one of the voucher codes that waives the initial enrollment fee for all NC WISEWOMAN Program participants. If you need your county specific voucher codes, please contact the Program Health Educator. To enroll, visit www.esmmpreventdiabetes.com/enroll. This program currently has English speaking trainers only.

To send a referral to the in-person DPP, the completed [referral form](#) and to dppreferral@nc.dhhs.gov via an encrypted email or fax at 866-336-2329. If the participant is Spanish speaking, use this method of referral (virtual options available as requested).

ACCESS TO THESE SERVICES INCLUDES THESE SIMPLE STEPS:

Referral to on-site program	Referral to online program
• Complete the referral form with participants (the form can be found at www.diabetesfreenc.com)	• Navigate to www.esmmpreventdiabetes.com/enroll to complete the referral
• Submit the completed referral form to: DPPReferral@dhhs.nc.gov	• Utilize one of the ESMMPD voucher codes provided by the NC WISEWOMAN Program
• The DPP Navigator will contact participants to complete enrollment	• Document and send the following information to the NC WISEWOMAN Health Educator via encrypted email - Date of Referral - Participant Name - WISEWOMAN ID - ESMMPD voucher code used
• NC WISEWOMAN Navigator and participant will complete Health Coaching sessions 2 and 3	• All NC WISEWOMAN participants should complete their 4-6 week follow up visit with their NC WISEWOMAN Navigator after the 3rd health coaching session
• All NC WISEWOMAN participants will complete their 4-6 week, face-to-face, follow up after the 3rd health coaching session	

The navigator will implement three sessions of expanded health coaching (including the first mandatory session) to “complete” the DPP HBSS.

Data Documentation

The NC WISEWOMAN Navigator is only responsible for documenting the expanded health coaching sessions that are offered in conjunction with the participants enrollment in DPP. The DHHS Form 4050 A and B (EHR P7, Access WW Coaching) will be used to document the required data, which includes:

- Date of the expanded health coaching session
- Type of expanded health coaching (DPP)
- Length of the health coaching session
- Type of contact for the health coaching session
- Status of the health coaching session
- Setting of the health coaching session

TIP: While not currently required, the program recommends documentation in the participant's chart of other information gathered during the expanded health coaching process to assist with team-based care and other scheduled HBSS sessions.

The completion of expanded health coaching consists of THREE documented expanded health coaching sessions. The first session is a mandatory part of the enrollment or annual rescreening visit. Data for this session should still be recorded on the DHHS Form 4050 A and B (EHR P7, Access WW Coaching). While the spacing of the 2nd and 3rd expanded Health Coaching session is left to the provider, ideally, expanded health coaching should be completed in less than six months from the enrollment or annual rescreening date. If the participant is enrolled in a program that lasts longer than six months, additional progress check-ins are recommended, but not required or reimbursed.

COMMUNITY BASED RESOURCES



QuitlineNC

OVERVIEW OF QUITLINENC

The CDC requires all WISEWOMAN providers to assess the tobacco use status of every participant receiving WISEWOMAN services and refer those who use tobacco to cessation services. QuitlineNC provides free cessation services to any North Carolina resident who needs help quitting commercial tobacco use, which includes all tobacco products offered for sale, not tobacco used for sacred and traditional ceremonies by many American Indian tribes and communities.

Program options include coaching, text messaging, nicotine replacement therapy (NRT), educational materials, and an online program. Pre-cessation counseling can help participants build confidence, coping skills and self-efficacy while reducing smoking to help them move toward complete cessation.

Services are available 24/7 and coaching is available in English and Spanish with translation services available for all other languages.

NC WISEWOMAN Program suggests using the Ask, Advise, Assess, Assist and Arrange Method for expanded health coaching with a tobacco cessation resource referral.

Ask all participants about tobacco use

Advise the participant to quit with a clear message about the benefits of quitting

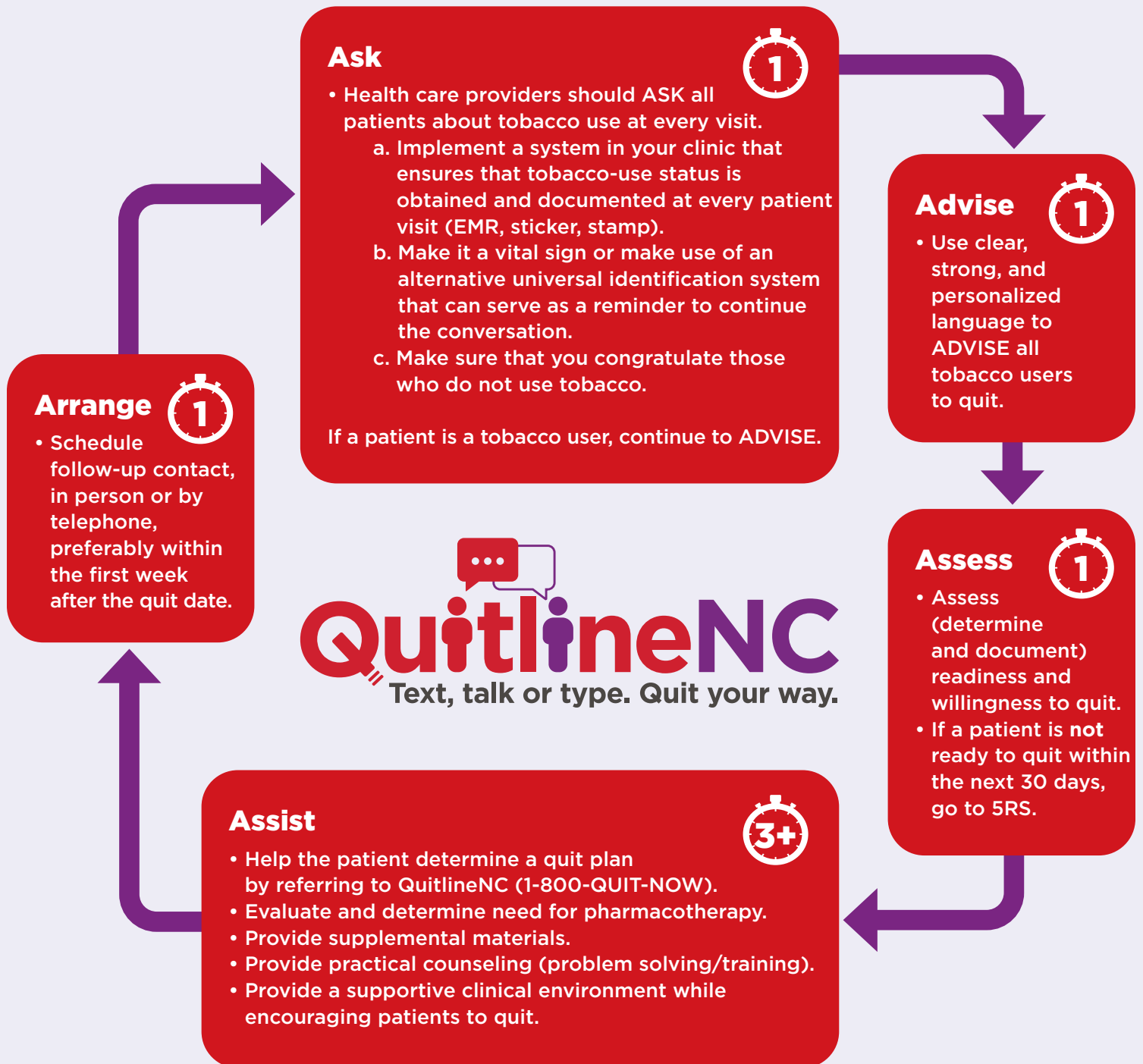
Assess the readiness to quit

Assist the participant in quitting by helping to determine a quit plan with a referral to QuitlineNC

Arrange a follow up visit via phone or in person within a week after their quit date

ADULT MODEL FLOW CHART

Interventions for patients 18 and older



The NC WISEWOMAN navigator can make a referral so that an individual from QuitlineNC will reach out to the participant directly and provide feedback to the referring provider.

Navigators can make referrals in the following ways:

- a. **Fax:** Fill out the fax referral form in English ([link](#)) and Spanish ([link](#)) to QuitlineNC at 1-800-483-3114
- b. **Secured Email:** Send a secured email (that means an encrypted, HIPAA compliant email) to supportservices@optum.com with the following information
 - i. Your **state, clinic name** and the **date** in the title; **No patient information in the title, that would be a HIPAA violation!** Ex: North Carolina: Porter Clinic - 10/19/2019
 - ii. The referral information can be included as an attachment or in the body of the email
- c. **eReferral Program:** Secure, HIPAA compliant, communication through your organization's electronic health records (EHR). Visit www.QuitlineNC.com for more information and instructions.

TIP: If an attempted referral is made and the participant is not ready, the attempted referral information should still be documented on DHHS Form 4049 A and B (EHR P6, Access Page One and Two) or DHHS Form 4041 A and B (EHR P6, Access Page One and Two).

For Participants Not Ready to Quit

The CDC requires that every woman be screened for tobacco use and referred for services, however, some participants are not ready to quit. To help participants explore their options and readiness, [motivational interviewing techniques](#) are encouraged.

If the participant is hesitant about enrolling, additional QuitlineNC materials are available through the NC WISEWOMAN Program and can be requested via the NC WISEWOMAN [Material Order Form](#) and www.quitlinenc.com. Also, participants can enroll themselves into the program by calling QuitlineNC at 1-800-QUIT-NOW (1-800-784-8669) or visiting www.quitlinenc.com.

WHO TO REFER TO QUITLINENC

All participants that use tobacco products are expected to be referred to cessation services.

DOCUMENTATION OF SMOKING CESSATION REFERRAL

Tobacco cessation referral data is documented on DHHS Form 4049 A and B (EHR P6, Access Page One and Two) or DHHS Form 4041 A and B (EHR P6, Access Page One and Two). Required data includes the date of referral, the referral resource, and the status of the referral. If a participant indicates they are a current smoker, they must have a documented cessation resource referral. If the participant declines the tobacco resource referral, the navigator should still document the attempted referral date, the attempted referral resource, and that the participant declined as the status of that referral.

Walk With Ease

The Walk With Ease program is designed for people with arthritis who want to increase their physical activity levels and are able to be on their feet for at least 10 minutes without increased pain. The program may also be appropriate for people with other chronic health conditions — such as heart disease and diabetes—who want to be more active.

Program discussion and supplemental materials cover topics such as:

- Managing arthritis pain and stiffness
- Stretching and strengthening activities to support the walking program
- Self-monitoring for physical problems while walking
- Anticipating and overcoming barriers to being physically active
- Getting and staying motivated to exercise

Online support is also available and includes video instruction, a message board, and an automated e-mail service alerting participants when milestones are reached.

To register the participant to the self-directed Walk With Ease Program, visit <https://startwalkwithease.org/Identity/Account/Register/NCCHW>, and click WISEWOMAN as the “Group.”

Other Community Resources

Local service providers are encouraged to refer women to local health improvement or community-based resources to supplement a participant’s HBSS activity. Depending on the participant, referral to community-based resources may be the most appropriate HBSS option. Referral to community-based resources can occur during risk reduction counseling or during ongoing HBSS sessions.

Community-based resources may include:

- Recreation department classes and activities
- Local parks or bike trails
- Walking groups
- Gardening programs
- Cooking demonstrations

Local service providers should refer women to local resources that fit their health goals and individual needs. Providers are encouraged to develop partnerships with external organizations to offer community-based resources at low or no cost to participants. External partnerships are encouraged to engage participants in local resources, but please note that these referrals are not required and are not reimbursed by the NC WISEWOMAN Program.

FOUR- TO SIX-WEEK FOLLOW-UP SCREENING



For a screening cycle to be considered complete, an individual must return for a follow-up screening. This provides an opportunity to re-capture key health measurements to assess the impact of adopted healthy behaviors. A participant can have this follow-up screening 3 to 11 months from the date of the first clinical visit in the screening cycle (enrollment or annual rescreening). CDC prefers that the follow-up screening is initiated 4 to 6 weeks after the 3rd HBSS session has been conducted. This follow-up screening will commonly be called the “4- to 6-week follow-up” in recognition of CDC’s preference for the timing of the visit.

Requirements for a 4-to-6-week follow-up

- Must be conducted in person;
- Occurs 4 to 6 weeks after the 3rd HBSS session; and
- Blood pressure, height, and weight must be measured.

Repeat labs are not required at the 4- to 6-week follow-up unless the provider site deems them necessary. Additional labs outside of the enrollment and annual rescreening visits are not reimbursable.

Please note that the follow-up visit should not be initiated any earlier than 3 months after the date of the first clinical visit in the screening cycle (enrollment or annual rescreening). Providers should ensure that they are spacing the 2nd and 3rd HBSS sessions so that the CDC preferred timing is achieved.

Completion and Celebration

It is important that we recognize the progress that a woman has made through her NC WISEWOMAN Program journey. Upon completion of a screening cycle, each participant should be given a completion certificate. These certificates are available to order through the program [material order form](#).

ANNUAL RESCREENING



To receive additional screening and healthy behavior support within the NC WISEWOMAN Program, a participant is eligible to have an annual rescreening starting at 11 months post the first clinical visit of the last screening cycle (enrollment and/or previous annual rescreening). Preferably, women are scheduled to return to the program no later than 18 months post the first clinical visit of the previous screening cycle. At minimum to be counted as a complete annual rescreening visit the following must occur:



Signed consent form



Two blood pressures (measured at least 2 minutes apart)



Height and weight measurements



Labs (Lipid Panel, A1C and/or Fasting Plasma Glucose)

- Conducted day of, if possible, but no later than 30 days from day of enrollment. Note: funds cannot be drawn down until after lab values are documented within the participant record. In addition, the second and third health coaching sessions are not be initiated unless lab values have been discussed with the participant.



Documented risk reduction counseling
(Complete 4049 A and B, or P6)



Mandatory first health coaching session



Diagnostic Medical Follow-Up if applicable

NC WISEWOMAN PROGRAM DATA MANAGEMENT



The NC WISEWOMAN Program is required by CDC, to collect and report data from funded activities. It is paramount to the continued implementation of the WISEWOMAN Program in North Carolina that the state program and the CDC have a clear picture of the programmatic impact for the women enrolled. This impact is measured by accurate and complete documentation of program activities and data by the local providers.

Use of Program Data

Staff use data collected through the program to:

- Ensure participant eligibility;
- Monitor grant spending and screening goals;
- Monitor data across all service delivery providers to ensure volume of data entry errors is minimal;
- Ensure clinical quality of services provided meet CDC indicators;
- Identify providers in need of funding increases or decreases; and
- Assess the impact and reach of program activities on the eligible population.

Program Forms

FORM DHHS 4049 A AND B: ENROLLMENT SCREENING AND ANNUAL RESCREENING

DHHS Form 4049 A and B is the WISEWOMAN P6 record layout and custom form in local health departments Electronic Health Record system. It is page one and two in the Access database used by contractors. The sections of the paper form are as follows:

1

NC WISEWOMAN Patient Identification, Screening, and Primary Language:

The NC WISEWOMAN Patient Information Form contains questions regarding a participant's cardiovascular health history and current behaviors that may increase her cardiovascular disease risk. This section contains the participant's demographic information. The participant may complete this form on her own or a clinic staff member may assist her in doing so.

2

Clinical Measurement Results: The Clinical Measurement Results contains information regarding a participant's biometric screening results (e.g., blood pressure, cholesterol, A1C/glucose, height, weight, HDL, LDL, and triglycerides).

3

Risk Reduction Counseling: The NC WISEWOMAN Risk Reduction section of the data collection form contains questions regarding the participant's medical history and medication status. This section contains information regarding a participant's risk for CVD. Completion of risk reduction counseling is required. A clinic staff member should complete this section of the form.

4

Medication History and Medication Status: These sections collect information on the types of medication the participant takes and adherence to taking that medication during the past week.

5

Blood Pressure and Self-Management: This section assesses whether the participant self-measures their blood pressure and reports the readings back to their provider.

6

Nutrition Assessment and Physical Activity Assessment: The nutrition and physical activity assessment sections use key questions from the National Health and Nutrition Examination Survey.

7

Smoking Status: This section assesses whether the participant currently uses tobacco products.

8

Quality of Life: This session assesses key quality of life indicators for the participant.

9

Tobacco Cessation Referral: If the participant indicated that they are a current smoker, then this section should be used to document either the referral or the attempted referral to a tobacco cessation resource.

10

Work Up Status: This section is used to document the status and date of the required diagnostic medical follow-up for participants with an alert level blood pressure.

TIPS:

- Enrollment date is the date the participant was first enrolled into the program with their initial screening, regardless of how many screening cycles they have received.
- Annual Rescreening occurs 11-18 months post-enrollment visit OR annual rescreening visit.
- If enrollment status changes from active, the original Screening or Annual Rescreening P6 form should be resubmitted with the enrollment status indicating **changed only**.

FORM DHHS 4050 A AND B: HEALTHY BEHAVIOR SUPPORT SERVICES

The DHHS Form 4050 A and B (EHR P7, Access WW Coaching) documents all HBSS (Health Coaching, HeartWise, and DDP) data. This form has the patient identification, referral information, Health Behavior Support Services, NC HeartWise, and Goal Setting sections. The form should be used to document any community-based resource referral and the type of referral made, any diabetes prevention program referrals, any goals that the participant is focusing on, and the topics on which the participant would like focus.

For each HBSS session, the provider should complete the following information:

- HBSS Session Date
- HBSS Session Type (ID) (Health Coaching, Enhanced Fitness, HeartWise, or MDPP)
- Length of Session
- Contact Type (e.g., Face-to-face, Phone, or Online)
- HBSS Program Completion Status (e.g., Completed, in-Progress, or Withdrawal/Discontinued)

Please note that the second HBSS should occur no later than 30 days post-enrollment visit, preferably 2 to 4 weeks post-enrollment or annual rescreening.

SMART Goal Section

This section is to aid the facilitation of health coaching. This section will not be made available in the EHR layout for this form. For more information on the facilitation of SMART Goals, see here.

FORM DHHS 4051 A AND B: FOLLOW-UP SCREENING

DHHS form 4051 A and B is the WISEWOMAN P6 record layout and custom form in local health department's Electronic Health Record system. It is page one and two in the Access database used by contractors. The form contains the same sections, except for lab values under clinical measurements, as form DHHS 4049 A and B

Complete Screening and Screening Cycle

A **COMPLETE SCREENING** is defined by having implemented all the steps outlined under the above screening type sections and collecting the required data for that screening type. Funding for the screening session should not be pulled down until the required data is collected.

A **COMPLETE SCREENING CYCLE** is defined as starting with an enrollment or annual rescreening visit, attendance of three HBSS sessions (including the first mandatory session at enrollment or rescreening), and the attendance of a follow-up screening.



Documentation of Clinical Abnormal and Alert Values

The below chart provides a concise summary for the documentation of case management information for each abnormal and alert value.

	When	What to Document	Where to Document
ABNORMAL			
Abnormal Blood Pressure Abnormal Lipids (Total Cholesterol, HDL, LDL, and Triglycerides) Abnormal A1C and/or Glucose	Within 30 days of measurement	- Date of referral for Diagnostic Medical Follow-Up (if necessary) - Information on Care Plan or Course of Treatment	Participant's EHR* Record, outside of the WISEWOMAN custom forms *Access database for contractors
ALERT			
Alert Blood Pressure	Within 7 days of measurement	- Date of referral for Diagnostic Medical Follow-up - Information on Care Plan or Course of Treatment - Status of Diagnostic Medical Follow-up	Participant's P6 (Enrollment or Annual Rescreening or Follow-Up) custom form* Page 1 and 2 of Access database for contractors
Alert Lipids (Total Cholesterol, HDL, LDL, and Triglycerides) Alert A1C and/or Glucose	Within 30 days of measurement	- Date of referral for Diagnostic Medical Follow-Up (if necessary) - Information on Care Plan or Course of Treatment	Participant's EHR* Record, outside of the WISEWOMAN custom forms *Access database for contractors

Minimum Data Elements

CDC defines 59 mandatory data variables that at minimum must be collected by funded recipients. These are defined in the program's Minimum Data Element (MDE) manual. These guidelines ensure that the same type of data is collected in a standardized manner across all funded WISEWOMAN Programs. The NC WISEWOMAN Program collects MDE data through its program data forms. The data is deidentified and submitted to the CDC semi-annually (June and December). The MDE submissions must have less than a 5% error rate, where "Errors" are defined by the CDC.

Data Submission and Validation Process

LOCAL HEALTH DEPARTMENTS

Local health departments use their EHR to enter data collected through the NC WISEWOMAN Program via the P6 and P7 custom forms created by their EHR vendor. The P6 custom form corresponds with the 4049 A and B and the 4051 A and B paper program forms. The P7 custom form corresponds with the 4050 A and B paper program form. The NC WISEWOMAN Data Manager oversees the creation of layouts for each type of custom form to convey minimum program data collection requirements to the EHR vendors.

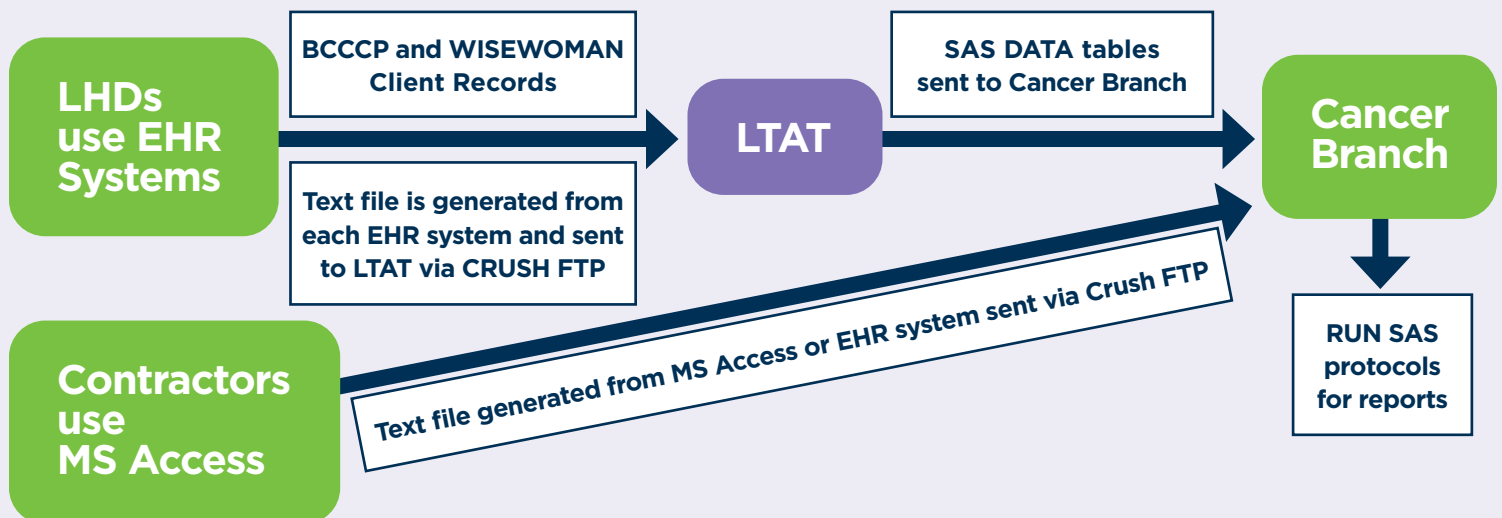
This process is completed in coordination with the Local Data Analysis and Support (LDAS) team, who oversees the Health Services Analysis (HSA) data validation system. This is the primary method of data reporting for LHD's participating in the NC WISEWOMAN Program. It is a requirement that any local health department have a mechanism for data reporting before they can become a local service provider.

Each LHD will designate a staff member to act as the individual to batch over data from the EHR. The batching process consists of a query mechanism in the EHR system to create a text file that then can be sent to the HSA system. As each EHR vendor creates mechanisms in their systems differently, the NC WISEWOMAN Program staff are unable to train local health departments on the use of the custom forms and the batching process. Rather, the local health department must submit a ticket request with their EHR vendor and contact the Local Data Analysis and Support team for additional help with these processes.

CONTRACTORS

The NC WISEWOMAN Program provides an MS Access database for the collection and submission of data from its contracted provider sites. Contractors are responsible for entering in the screening data, exporting the data text file, and then using the Crush File Transfer Protocol (FTP) for the submission of the data. The NC WISEWOMAN Data Manager validates the data from the Access database text files uploaded by the contractor. Training on the use of the Access database, gaining access to Crush, and the validation process is conducted by the NC WISEWOMAN Data Manager.

Data Submission Process for NC WISEWOMAN LHDs and Contractors



Beginning in 2018, DPH decided to collect program data from health departments via a process called LHD-HSA.

BCCCP: Breast and Cervical Cancer Control Program – cancer screening program • **EHR:** Electronic Health Record System. Created by various vendors to collect clinical data from local health departments, health care systems, hospitals. (Currently work with Cerner, Epic, Patagonia, Cure MD, GE Centricity...) • **LHD-HSA:** Local Health Department – Health System Analyses. A process of receiving data from local health departments • **LTAT:** Local Technical Assistance and Training Branch. Process raw files that come from Local Health Departments. Oversees LHD-HSA. • **WW:** WISEWOMAN program

Data Submission Timeline

The WISEWOMAN program has two federal reporting dates during the year. To meet reporting requirements please note the mandatory submission dates below. By providing this data submission schedule it clarifies the data expectations for the local program. LHD and Contractors need to have their data entered in the EHR or Access database system by the 15th of every month. However, it is preferred that the data be entered or uploaded into the system by the 10th of the month to address any issues or concerns with the data.

Enrollment, Follow -up, and/or Health coaching Date Range	Data Entry Deadline	Final Error Correction and Data Entry Deadline
September 30, 2019 to March 31, 2020	Continuously entered by the 10th of the next month	April 30, 2020
April 1, 2020 to September 29, 2020		October 31, 2020
September 30, 2020 to March 31, 2021		April 30, 2021
April 1, 2021 to September 29, 2021		October 31, 2021
September 30, 2021 to March 31, 2022		April 30, 2022
April 1, 2022 to September 29, 2022		October 31, 2022
September 30, 2022 to March 31, 2023		April 30, 2023
April 1, 2023 to September 29, 2023		October 31, 2023

Provider Data Validation

The CDC sets ranges for certain program collected variables that may occur but are believed to be improbable. The NC WISEWOMAN Program is required to verify and validate instances where these measurements are recorded within the data. Providers will review their data for any measurements that fall within these ranges, verify the accuracy, and submit a [Program Data Validation form](#) for the measurement.

Program Data Reports

The NC WISEWOMAN Program data staff uses many reports to review quality of data, to identify errors that need to be corrected, and to assess performance of the overall program. While some of these reports are ad hoc, the main reports used are detailed below.

HEALTH SERVICES ANALYSIS BATCH ERROR REPORT

The Health Services Analysis (HSA) Batch Error Report is produced when an LHD provider batches over data from their EHR. This report is not produced by program staff; it is an automatic byproduct of the HSA batching process. If a record shows up on this error report, the NC WISEWOMAN Program staff will not receive the record. This is the first round of validation checks for the program. This error report is sent via email to the staff person who batched the data and is also available in the download from state folder in Crush FTP.

Focus:

- Data missing or incorrect responses according to the established vendor layouts for the program
- Provides automatic validation reporting

Uses:

- Understand what needs to be corrected
- Understand what records have not been received by the NC WISEWOMAN Program due to initial errors
- Indication of missing Healthy Behavior Support Services records

Error_Number	Error_Data	Error_Message	Record_ID
WW608		Screen_Data is missing or invalid	P6
WW007		Visit_Type must be 1 thru 4	P6
WW020		Enroll_Status must be 1 thru 8	P6
WW040		Education must be 1 thru 4, or 77[unknown], 88[didn't answer]	P6

MONTHLY MAILED REPORTS

The Monthly Reports mailed by the NC WISEWOMAN Program consists of three separate reports: Patient List, Patient Error Report, and a Summary Factsheet. These reports are specific to the current program year. All monthly reports focus on the data for the program year as of that month.

Focus:

- Program logic errors not caught through the HSA validation (i.e., participant with no cholesterol diagnosis, but cholesterol medication is indicated)
- Program sequencing reminders (i.e., participant needs one more health coaching session)

Uses:

- Verify receipt of participant records within the program year
- Fix any programmatic errors
- Be aware of upcoming program steps (i.e. participants that need follow-up or health coaching)
- Reminder that participant needs a validation form

Provider Co.	
Note from WISEWOMAN Data Manager	
WISEWOMAN Coordinators:	
Hello, I hope you are doing well! Attached you will find your Year Three (2020-2021) WISEWOMAN Patient List and Error Report as of June 16, 2021. Please review these reports for any missing patients, ongoing errors, and data that needs to be validated.	
We have recently been informed that if EHR custom forms to collect WISEWOMAN data are edited by the provider site, this may negatively impact your ability to batch all data to the state. The WW team works with your EHR vendor to ensure that forms are up to date, please do not edit these forms.	
Very important! Please make sure that you are being consistent in your use of the Local Patient ID and Pat ID for records. If you have submitted a participant record, without one of these IDs, please do not go back and add it, as it will result in a duplicate record. Please also ensure that IDs match across each record for the participant.	
A Few Programmatic Reminder:	
Please Read	
IMPORTANT! If you are receiving this page, but no attached patient list this means that we have no available data for your provider site for Grant Year 3 (starting September 30, 2020), please contact the WISEWOMAN Data Manager to discuss this issue.	
Below you will find a summary of your data for Federal Program Year 3, use this summary to better help you understand how many screening records have been received and how they count towards your screening target. Please note that the Federal Year is split over two AA periods:	
North Carolina WISEWOMAN	
Progress Report for 2020-2021 as of November 16, 2021	
Provider Co.	
	Screening
Initial Screens	142
Follow-up Screens	99
Annual Rescreenings	208
Total Alert or Abnormal Values Needing Diagnostic Exam	88
2020-2021 Federal Program Year Target (September 30, 2020 to September 29, 2021)	500
% of Screening Target Reached	58%
	Completion of Healthy Behavior Support Services
Total Sessions of HBSS	1225
Health Coaching Sessions	1127
HeartWise Sessions	38
% of participants with complete HBSS (3 or more sessions)	77
% of participants with complete HBSS and follow-up visit	3

Provider Tools for Data Collection and Submission

Other documents the program makes available to aid providers in the collection and submission of mandatory data include:

DATA ERROR EXPLANATIONS

The NC WISEWOMAN Program provides a participant error report in its packet of monthly mailed reports. The Data Error explanation document is used to help understand how to fix the errors that may appear on the monthly error reports. A copy of this document can be requested from the Program Data Manager.

DATA FORM REQUIREMENT DOCUMENT

The Data Form Requirement document was created by the NC WISEWOMAN Program to help providers better understand data that must be collected. This document closely mirrors the same format as the EHR layouts that are provided to EHR vendors to communicate data requirements, but also contains additional logic that is helpful to the individual entering the data. A copy of this document is in the manual appendices.

Confidentiality and Records Retention

CONFIDENTIALITY

All information gathered through the process of providing NC WISEWOMAN Program services shall be deemed confidential. The local service provider and NC WISEWOMAN Program should ensure that each participant understands:

- All information collected during the provision of services is considered confidential Protected Health Information (PHI);
- All NC WISEWOMAN Service Providers are required to collect information as part of its contractual performance requirements;
- Participants consent to have this information collected and shared with NC WISEWOMAN Program personnel when consenting to be enrolled in the program;
- Participants consent that information collected by external agencies offering Healthy Behavior Support Services can be reported back to the local services provider and/or the state NC WISEWOMAN Program;
- Local service providers must adhere to all state and federal laws regarding the confidential collection and disclosure of medical or health information;

- The NC WISEWOMAN Program must adhere to all Division of Public Health HIPAA guidelines as they apply to the safeguarding of PHI by programs offering direct services;
- All participant data (electronic or paper) must be maintained securely and in a manner that ensures confidentiality;
- Paper forms containing PHI that are faxed to the NC WISEWOMAN Program are maintained in locked file cabinets and are only accessible by data and evaluation personnel; and
- Electronic forms containing PHI are maintained on a state computer drive that is only accessible by data and evaluation personnel.

RECORD RETENTION POLICY

Each local provider site is asked to follow their respective record retention policies. However, as part of monitoring visits, local providers may be asked to provide records dating back five years prior to the date of the monitoring visit.

The CDC requests that state programs maintain all records related to a grant cycle, three years post the end of that grant cycle.

NAVIGATOR DATA MANAGEMENT RESPONSIBILITIES

Each local Navigator plays an important role in the support of the NC WISEWOMAN Program by ensuring that accurate and timely data is collected and submitted. Data management responsibilities for the local Navigator include:

- Accurate participant data is entered into the state mandated data system.
- Data is entered and submitted to the NC WISEWOMAN Program by the 10th of the following month for which the data was collected (only exceptions are vendor controlled batching processes that may batch outside of this timeline).
- Data is not withheld until the completion of the screening cycle but is submitted at the completion of each screening or HBSS session.
- All test results and visit summaries, including any medical diagnostic follow-up case management details are entered as soon as they are received.
- Review Monthly Reports sent by the Data Manager/Evaluator. These Monthly Reports capture data errors and quality issues that need to be reviewed and corrected by the provider organization in a timely fashion, before the NC WISEWOMAN Minimum Data Elements (MDE) are submitted to the Centers for Disease Control and Prevention (CDC) twice each program year.
- Assure that all participant information is kept confidential.
- If paper documentation is used, the provider organization must enter the participant screening and service encounters in the program database within three working days after the participant is seen or as soon as possible after receiving information from the health care provider.
- Conduct 'real time' quality and error data entry checks.
- Attend NC WISEWOMAN Program training and/or other required training as described in the [Scope of Work](#).

DATA MANAGEMENT TECHNICAL ASSISTANCE

Local Navigators should reach out to the Program Data Manager/Evaluator for any data related technical assistance requests. If providers have questions pertaining to missing data, the inquiry must include:

- County name and/or provider site name;
- Type of screening;
- Participant ID;
- Date of service;
- Tentative date the data was submitted or batched to the state; and
- Patient name.

This information is to be submitted only via encrypted email or over the phone.

EVALUATION



The NC WISEWOMAN Program is committed to ensuring that providers have adequate support from state staff to meet programmatic goals. Critical to achieving this is ensuring that the program has a robust evaluation component in place. The NC WISEWOMAN Evaluator is equipped to provide proactive training and/or technical assistance to ensure compliance with program priorities.

Cancer Branch Performance Evaluation Team

NC WISEWOMAN Program's clinical, data, evaluation, and operations staff meet monthly to monitor provider performance regarding adherence to:

1. Program performance indicators;
2. Funding drawdown procedures;
3. Assigned screening targets; and
4. Fidelity to other agreement addendum and contract components.

During these monthly evaluation meetings, the staff collectively monitor the performance of providers and discuss training and technical assistance strategies to respond to program-wide or individual provider issues. The evaluation staff is responsible for soliciting feedback from providers on how the Program can best offer assistance in meeting program goals. Local service providers may be contacted by the NC WISEWOMAN evaluator by email, survey, or by phone to solicit your input. Note: active participation in any program evaluation effort is a provider requirement in agreement addendums and contracts, and as such requests for input by the evaluator need to be responded to in a timely manner. Input from providers is valued and is used to help inform NC WISEWOMAN Program's response to programmatic needs.



Program Evaluation

The NC WISEWOMAN Program Evaluator submits to CDC a yearly evaluation plan that coincides with the work plan activities for that program year. The evaluator then monitors and tracks the state program's performance in achieving both the work plan and evaluation plan activities. These activities are guided by the CDC defined evaluation areas that build upon each other from program year to program year and by the CDC defined [Program Focus Areas](#). In addition, the Program is expected to collect and report data that is consistent with CDC defined performance measures, which are standardized across all funded state recipients.

PERFORMANCE EXPECTATIONS AND QUALITY ASSURANCE



Navigator Responsibilities

Program navigators are the heart of this program. Other areas of this manual list requirements and responsibilities for funding, program implementation, operations, data management, etc.; below are the responsibilities and traits of a successful program navigator:

- ♥ Serve as point of contact for the NC WISEWOMAN Program;
- ♥ Implement all parts of the program with fidelity;
- ♥ Attend professional development opportunities;
- ♥ Attend NC WISEWOMAN Program offered trainings;
- ♥ Participate in monitoring and technical assistance visits as requested;
- ♥ Respond to programmatic emails, requests for meetings, and/or evaluation requests;
- ♥ Notify NC WISEWOMAN Program of any staff changes using the staff change notification form;
- ♥ Be knowledgeable about cardiovascular disease, lifestyle behavior change, and motivational interviewing; and
- ♥ Possess the desire to help the women of North Carolina live healthy lifestyles.

Performance Requirements

Minimum performance requirements are outlined in each contract and Agreement Addendum. These are designed to ensure that local service providers are meeting the standards required by DPH and CDC in their provision of program services.

100% of screening target number met or exceeded AND 100% of allocated NC WISEWOMAN Program funds expended for each woman screened

- CDC expects that programs expend 100% of the funds that are given each Program Year. This demonstrates that the funding appropriated by Congress is needed. The NC WISEWOMAN Program sets the same expectation for its individual local service providers.

100% of NC WISEWOMAN Program participants receive risk reduction counseling

- It is mandatory that each woman receives patient-centered risk reduction counseling. This performance measure captures this important expectation for local service providers.

100% of women with abnormal blood pressure values receive follow-up as defined by NC WISEWOMAN Program policy

- The NC WISEWOMAN Program wants to ensure that women who have an abnormal BP reading receive adequate diagnostic or medical follow-up with an appropriate medical professional.

100% of NC WISEWOMAN Program participants attend at least one session of health coaching or another lifestyle program as a part of the enrollment visit.

- The first HBSS session is a mandatory part of the enrollment and/or annual rescreening visit. Local service providers need to deliver this session to ensure that program participants receive at least one HBSS session, typically health coaching. This prepares participants to have the best possible chance at effecting behavior change.

≥80% of NC WISEWOMAN Program participants actively enrolled in health coaching or another lifestyle programs receive a second session.

- A second session of HBSS should be conducted within 2-4 weeks of the enrollment/annual rescreening visit. Women are not allowed to opt out of this second session, however, the program recognizes that some women will be lost to follow-up at this second session.

≥60% of NC WISEWOMAN Program participants enrolled in a lifestyle program or health coaching complete the lifestyle program or health coaching as defined by NC WISEWOMAN Program policy.

- The NC WISEWOMAN Program considers the HBSS to be complete after the third session. While some HBSS options may run for a year, as long as a participant has three concurrent sessions of health coaching she is deemed finished with her HBSS option and a four to six week follow-up can be initiated.

>30% of NC WISEWOMAN Program participants actively enrolled in the program and have completed a screening cycle.

- A screening cycle is completed when women return for their 4- to 6-week follow-up. The program expects that local service providers will use evidence-based interventions, recall reminder techniques, and assessing barriers to ensure that a woman has the best chance of attending her follow-up visit.

Progress Reporting

The NC WISEWOMAN Program provides program reports to aid the local service provider in ongoing progress monitoring. These reports are mailed to providers on a monthly and annual basis, depending upon report type. Details on each report and how they can be used is located in the data entry section under [Data Monitoring Reports](#). The provider is responsible for notifying the state program if the reports are not received.

Mid-Year Review

The NC WISEWOMAN Data Manager/Evaluator will conduct a mid-year review of provider progress each federal program year. Providers who are underperforming will be contacted for a technical assistance visit and asked to submit a quality improvement plan. The mid-year review focuses on performance in the areas of the performance requirements and AA or contract requirements.

Clinical Monitoring

The NC WISEWOMAN Program's monitoring events are conducted in coordination with NC BCCCP. These events are conducted either once a year or every three years, based upon the local service providers risk status. Multiple factors including performance measures, funding to data ratio, and program compliance. A detailed review of the process and required steps can be found in the following pages:



North Carolina Breast and Cervical Cancer Control Program/WISEWOMAN Monitoring Process

The North Carolina Breast and Cervical Cancer Control Program (BCCCP) and the Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN) Project are supervised and monitored by the Cancer Prevention and Control Branch of the Chronic Disease and Injury Prevention Section of the Division of Public Health. BCCCP is funded by the National Breast and Cervical Cancer Early Detection Program in the Centers for Disease Control and Prevention (CDC). WISEWOMAN is funded by the CDC Multi-grant.

Both programs are administered by Local Health Departments and by some additional non-health department agencies. Some agencies may only provide BCCCP services, others may provide BCCCP and WISEWOMAN, but currently no agencies provide WISEWOMAN without BCCCP.

The monitoring process for BCCCP and WISEWOMAN has been designed so that monitoring events for both programs can be accomplished simultaneously. The monitoring process is designed to verify and document the quality of services and efficiency of operations of the BCCCP/WISEWOMAN providers in North Carolina. When program services do not meet established standards, a corrective action plan will be required.

Monitoring Process:

A. ADMINISTRATION - The Monitoring Team will:

1. Monitor the CDC Performance Indicators monthly via a desk review. Compliance with Performance Indicators determines revised budget changes throughout the fiscal year and annually.
2. Monitor NC BCCCP/WISEWOMAN screening and follow-up providers who have:
 - been active providers for at least 12 full months and selected for program review
 - had documented problems or clinical concerns after orientation, training, and/or consultation
3. Perform on-site or remote monitoring of all providers approximately every 3 years. Providers may be reevaluated more frequently based upon the following indicators:
 - Persistent non-compliance with monthly monitored CDC Performance Indicators
 - Follow-up on corrective action plan implementation
 - At the request of service provider

B. MONITORING CRITERIA - Monitoring criteria have been developed by the NC BCCCP/WISEWOMAN staff and are based on both programmatic and clinical agreement addenda or contractual scope of work requirements. The clinical records selected for monitoring are a sample from a computerized listing of the NC BCCCP/WISEWOMAN data received from providers. Evaluations are completed on a minimum of 5 records and not to exceed 10 records within a three-year period.

1. **Guidelines for Monitoring for Districts**

- Schedule all counties to be monitored in a District for review on the same or consecutive days if possible.
- Each individual county within a District will be assessed for its own performance regarding documentation, follow-up, patient navigation, and other clinical concerns.
- A medical record review will be done for each county. One report to the District will address performance indicators and general management as a district, as well as findings of concern for individual counties.
- Each county will receive a copy of the cover letter and attachments.
- Corrective Action Plans will be required (if applicable) if the deficiency has potential negative impact on patient care or program performance.

2. **Guidelines for Record Selection:**

- Identify approximately 10 records per program of women screened within the previous three years. (During the monitoring event, a minimum of 5-10 records per program will be reviewed).
- Women screened may or may not have been enrolled in both programs.
- The confirmation letter, a copy of the monitoring event process, and monitoring tools will be sent to the agency ahead of time.
- The list of names and screening dates selected for the monitoring event will be sent to the BCCCP and/or WISEWOMAN navigator in advance of the event.

a. **BCCCP Records**

- Identify at least two women with abnormal breast and two with abnormal cervical findings
- Identify at least two women with normal breast and two with normal cervical findings
- The abnormal breast findings should include a woman with an abnormal CBE and a woman with a normal CBE and abnormal mammogram
- Identify at least one record of a woman enrolled in BCCM
- The remaining records can be randomly selected

b. **WISEWOMAN Record Selection:**

- Identify at least two women with normal screening findings
- Identify at least two women with abnormal screening findings
- The abnormal findings should include one or more women with alert values
- The remaining records may be selected randomly

C. MEASUREMENT OF CRITERIA - Monitoring criteria are measured against documented evidence of program administration, enrollment, screening, referral, follow-up, and education services in the patient's clinical record.

D. ANALYSIS OF THE VARIATIONS - The monitoring team will analyze the variations between the monitoring criteria and documented practice to determine the nature and scope of any identified problems. If the variations have potential negative impact on patient care or program performance, corrective action may be required.

E. PLANNED ACTION AND FOLLOW-UP - After the monitoring event is complete, a summary of findings will be discussed. Copies of the monitoring reports will be sent to the appropriate members of the program staff within 60 days. A corrective action plan template will be provided to respond to monitoring findings. A response must be submitted within 60 days of the report. The Monitoring Team will re-evaluate approximately 6-12 months after the corrective action plan is approved. Persistent non-compliance may result in forfeiture of continued funding.

F. MONITORING DOCUMENTATION - All monitoring documentation is to be maintained by the Provider agency.

Technical Assistance Visits

Local service providers can request a technical assistance visit anytime by either contacting their designated nurse consultant or contacting one of the program staff members. These visits are to address programmatic concerns or issues and can be done virtually or in person. The NC WISEWOMAN Program may also request that local service provider staff have a technical assistance visit to address issues.

Internal Review of Records

As a part of its internal quality assurance process, local service providers are required to audit a random sample of at least five NC WISEWOMAN Program patient records at least once annually to check for compliance with program requirements. An [internal record review tool](#) has been developed to assist with this process.

Consequence of Inadequate Performance

Failure to meet outlined performance requirements and benchmarks could result in the reduction of targets and funding for the local service provider. If monitoring visits uncover deficits, the NC WISEWOMAN Program staff will work with the provider to correct these deficits. However, serious ongoing deficits will result in a mandatory [Corrective Action Plan \(CAP\)](#) to be developed by the local service provider.

Persistent failure to meet program requirements will result in the termination of the agreement addendum or contract.

The most common reasons for a Corrective Action Plan include:

- Failure to draw down funding on a capitated (per woman served) basis;
- Failure to document diagnostic medical follow-up on WISEWOMAN participants with alert-value findings within one week or documenting the reason why the diagnostic referral was not done;
- Failure to conduct an internal record review of at least five patient encounters during a program year;
- Providing services to patients who are not eligible or;
- Paying more than the allowed rate for services or paying for services not allowed.

NC WISEWOMAN Program staff will initiate multiple technical assistance visits and quality improvement processes to help the provider address concerns before the issues are escalated to the provision of a CAP. A quality improvement template for programmatic issues can be found [here](#).

Quality Assurance

The goal of Quality Assurance (QA) is to assure that appropriate services are provided to each participant and that program funds are utilized as required by program protocols. QA activities ensure high-quality medical standards of care are provided to women receiving program services. Quality Assurance audits will monitor each provider organization with program implementation training and professional development activities. The processes for Performance Monitoring and Quality Assurance are established in the [Department of Health Agreement Addendum \(AA\)](#) for each LHD and in the contract for each Contractor.

HEALTH EQUITY AND WISEWOMAN



Health Equity

Health equity is achieved when everyone can attain their full health potential, and no one is disadvantaged because of socially determined circumstances. There are several factors that determine health for individuals and population groups. Underlying issues like economic stability, access to healthcare, education, social and community connections and neighborhood norms all contribute to achieving a high level of physical, mental, and social well-being. Failure to address these factors is a root cause of health inequity.

The NC WISEWOMAN Program promotes effective screening and lifestyle intervention strategies for cardiovascular health to reduce the incidence of heart disease and stroke and reduce mortality in eligible underserved women of North Carolina.

The NC WISEWOMAN Program addresses health equity by offering:

- **Healthy Behavior Support Services (HBSS)** such as Health Coaching, Diabetes Prevention, and a Self-Monitoring Blood Pressure program to support and empower participants to discover healthy lifestyle behaviors that prevent, minimize and delay the onset of cardiovascular disease. These services are available both virtually and in person, and in multiple languages to reduce access barriers
- **Partnerships** with local providers and community resources to address related health concerns, including specialists and primary care physicians, and the NC Breast and Cervical Cancer Program (NC BCCCP). Such multi-sector partnerships can work to improve the underlying community conditions that make healthy living easier, particularly in underserved communities.
- **Service Navigation** for women deemed underinsured but meet program eligibility to receive HBSS covered through the NC WISEWOMAN Program. This service creates a system where all individuals have equitable access to improved cardiovascular outcomes.
- **Team-Based Care** where the participant and all the providers involved in a participant's care work together to reduce CVD risks. Selecting appropriate team members that have expertise on the norms, culture, and needs of the populations they serve and can contribute significantly to NC WISEWOMAN efforts to reduce CVD risks.
- **Data-Driven Decision Making** to identify populations disproportionately impacted by CVD and implement strategies to increase service offerings and educational opportunities in the communities where these populations live.

Addressing the social determinants of health through a whole person care approach in our communities involves consideration of underlying factors that can hinder a person's ability to practice other healthy habits. This encompasses, tobacco cessation services, physical activity resources, and nutrition education to name a few.

GLOSSARY OF KEY TERMS, ABBREVIATIONS, AND ACRONYMS



AA	Agreement Addendum – A document used between Division of Public Health and local health departments which defines programmatic requirements and mutual roles and responsibilities
ACC	American College of Cardiology – A nonprofit medical society dedicated to enhancing the lives of cardiovascular patients.
AHA	American Heart Association – A nonprofit organization in the US that funds cardiovascular medical research, educates consumers on healthy living and fosters appropriated cardiac care to reduce disability and death from cardiovascular disease and stroke.
ASCVD	Atherosclerotic Cardiovascular Disease – A form of heart disease characterized by build up of fats, cholesterol and other substances that build up in and on the artery walls.
ATC	Aid to Counties – a state mechanism for transferring funds from the state to local entities such as health departments
Bi-Directional Referral Process	includes both the referral information going from the WISEWOMAN provider to the evidence-based lifestyle change program and the information flowing back to the health care provider on patient participation and outcomes such as weight loss.
BP	Blood pressure – a measure of the force of circulating blood on the walls of the arteries; systolic is a measure of the force during heart contraction; diastolic is a measure of the force between contractions
CAP	Corrective Action Plan – a process designed by a provider to address program deficits identified through data reports and quality assurance activities
CCL	Community Clinical Linkages – connections between community and clinical sectors to improve population health
CDC	Centers for Disease Control and Prevention
CER	Contract Expenditure Report – documentation to facilitate transfer of funds from state account to contracted agency
Cooperative Agreement	A document that reflects the relationship between the US Government and a recipient and is used when the government's purpose is to assist the intermediary in providing goods and services to the authorized recipient
CPT	Current Procedural Terminology – a uniform language for coding medical services and procedures for increased accuracy and efficiency in documentation and reporting
CRUSHFTP	Descriptive name of a secure and rapid file transfer server that can compress and expand streaming files

CVD	Cardiovascular Disease – a general term for conditions that effect the heart and blood vessels
DHHS	Department of Health and Human Services – manages the delivery of health- and human-related services for all North Carolinians, especially our most vulnerable citizens – children, elderly, disabled and low-income families.
DPH	Division of Public Health – A division within DHHS that promotes disease prevention, health services and health promotion programs that protect communities from communicable diseases, epidemics and contaminated food and water.
DPP	Diabetes Prevention Programs – general term for a series of classes designed to empower people with prediabetes or at risk of developing diabetes to take charge of their health and well-being.
EHR	Electronic Health Record – a digital version of a patient chart that makes information available instantly and securely to authorized users
ESMMDP	Eat Smart Move More Prevent Diabetes – an evidenced-based, on-line series of classes proven to prevent or delay on-set of Type 2 diabetes
FLP	Federal Poverty Level – an amount of annualized income earned by a household below which they are eligible to receive certain benefits
FTP	File Transfer Protocol – rules that govern how electronic files are transferred from one system to another over the internet
FQHC	Federally Qualified Health Center – an outpatient clinic, usually in a medically underserved area, that receives a specific reimbursement under Medicare and Medicaid
HBSS	Healthy Behavior Support Services – evidenced-based services and programs shown to increase success of healthy behavior change in individuals
HBSS SN	Healthy Behavior Support Service-Service Navigation – The provision of Healthy Behavior Support Services only and on the basis of participant provided laboratory results less than 30 days old; no clinical laboratory services provided
HC	Health Coaching – an evidence-based, CDC approved use of skillful conversation, clinical interventions and strategies to actively and safely engage participants in successful behavior change
HSA	Health Services Analysis – a data validation process to identify errors that prevent records from moving forward to the next step in the validation process
JNC 7 JNC 8	Joint National Commission – Acronym for 2017 American College of Cardiology and American Heart Association Guidelines for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults
LDAS	Local Data Analysis and Support – a team of IT professionals that oversee the Health Services Analysis data validation process
LDL-C	Low Density Lipoprotein-Cholesterol – a large protein that carries fats through the blood, sometimes referred to as “bad” cholesterol

LHD	Local Health Department – general term for health departments, health districts, public health authorities, and public health services delivered through human service agencies
LSP	Local Service Provider – general term for any agency or organization providing NC WISEWOMAN Program services in a defined service area
LTAT	Local Technical Assistance Team – human resource team which provides support for local health departments with custom forms, their specific vendor and batching processes
MDE	Minimum Data Elements – the data collection and formatting required for all programs as described in the CDC manual
MER	Monthly Expenditure Report – a count of screenings, healthy behavior support service sessions and/or service navigations for healthy behavior support services consistent with requested reimbursement funds from Aid to Counties
MSLP	MedSouth Lifestyle Program – an evidence-based series of individual counseling and supportive health coaching calls to modify diet, increase physical activity and reduce blood pressure
Navigator	Designated staff person responsible for overall program delivery
NBCCEDP	National Breast and Cervical Cancer Early Detection Program – a federally funded and administered program disseminated through state programs to reduce mortality from breast and cervical cancer
NCBCCCP	North Carolina Breast and Cervical Cancer Control Program – a federally funded state level program that provides free or low-cost screenings and follow-up to eligible women
NRT	Nicotine Replacement Therapy – the use of delivery devices such as patches or gum to gradually reduce nicotine dependency
OARS	Acronym for Open-ended questions, Affirmations, Reflections, and Summaries as conversation guidance for health coaching.
PHI	Protected Health Information / Personal Health Information – demographic, medical history, test results, conditions, insurance and other data collected and used to identify a patient and determine appropriate care
Protocol for identifying patients	Requirement that provider sites have a standardized, systematic process that is followed to identify hypertensive patients.
QA	Quality Assurance – process of monitoring fidelity to program standards and expectations to follow clinical protocols, use certified laboratories, maintain records and audit a sample of records annually
RFA	Request for Applications – Terminology used to announce the availability of funding for grant or contracted services

Risk Status	Risk status – an assessment of provider performance according to compliance with the performance requirements, funding to data ratio, handling of funds, and program requirements
RRC	Risk Reduction Counseling – a required component of the clinical visit which engages the participant in understanding which clinical and health assessment items are open to modification and the positive impact of reducing those risks
RULEs	Acronym for Resist telling; Understand motivation; Listen with empathy; Empower techniques to promote productive conversation about healthy behavior change
SAS	Statistical Analysis System – the data driven defined management system set of rules that govern how data is handled and sorted
Service Navigation	The provision of Healthy Behavior Support Services only and on the basis of participant provided laboratory results less than 30 days old; no clinical laboratory services provided
SOW	Scope of Work – a document that describes what needs to be done to successfully fulfill the work performance expectations
Team-based Care	A delivery model where patient care needs are addressed as coordinated efforts among multiple health care providers and across settings of care
Uncontrolled Hypertension	When the patient is not taking treatment to control their high blood pressure
Underinsured	The condition of having health insurance coverage with co-pays or deductibles that produce a financial hardship on the policy holder to access benefits
Undiagnosed Hypertension	Patients with multiple abnormal blood pressure values, e.g. systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg, recorded in the medical record without report of a provider diagnosis code (ICD-10: I10-I15).
Uninsured	The condition of not having any health insurance coverage

APPENDICES



Appendices.....	68
Provider Education Resources.....	69
Motivational Style Interviewing.....	70
Rules for Health Coach Communications.....	72
Participant Education Resources.....	73
Dash Diet.....	74
Know Your Numbers.....	75
Million Hearts Manually Checking Bp.....	76
Improving Medication Adherence Among Patients.....	77
Eat Smart Move More Controlling Your Sodium.....	78
Myplate.gov.....	80
Myplate Starter Faux Food Package.....	82
NC HeartWise Delivery Algorithm.....	84
What Is Pre-Diabetes? (English Version).....	85
What Is Pre-Diabetes? (Spanish Version).....	86
Program Administration Forms.....	87
NC WISEWOMAN Material Order Form.....	88
NC WISEWOMAN Program Consent Form (English Version).....	99
NC WISEWOMAN Program Consent Form (Spanish Version).....	101
My WISEWOMAN Action Plan.....	103
Staff Change Notification Form (SCNF).....	104
Data Collection Forms.....	105
DHHS Form 4049 A and B (EHR P6, Access Page One and Two).....	106
DHHS Form 4050 A and B (EHR P7, Access WW Coaching).....	108
DHHS Form 4051 A and B (HER P6, Access Page One and Two).....	110
Program Data Validation Form.....	112
Data Form Requirements.....	113
NC WISEWOMAN Data Entry Guidelines.....	114
NC HeartWise Forms.....	140
NC HeartWise Delivery Sequence.....	141
NC HeartWise Participant Agreement Form.....	142
NC HeartWise 14-Day Tracking Log.....	143
NC HeartWise 6-Week Tracking Log.....	144
Financial Documents.....	145
Sample Scope of Work.....	146
Local Health Department Monthly Expenditure Report (MER).....	160
Contractor Expenditure Report (CER).....	161
CER Tracking Log.....	162
Performance Management and Quality Assurance Forms.....	163
Clinical Monitoring Forms: Triennial Program Review.....	164
Corrective Action Plan.....	177
Quality Improvement Recommendations.....	178
Internal Record Review Tool.....	179

Provider Education Resources

Motivational Style Interviewing

Motivational style interviewing combines the theories of positive psychology and motivational interviewing therapy to create a person-centered, systematic approach to helping a WISEWOMAN participant to bridge the gap between personal risk factors for heart disease and her desire and ability to reduce those risks. Both positive psychology and motivational interviewing therapy are strongly focused on participant autonomy to choose her course of action and to draw out that course using conversation which is collaborative and respectful.

Two acronyms can be used to summarize motivational style interviewing as used in the NC WISEWOMAN Program: [OARS RULE](#). These four concepts apply to conversation techniques used to elicit and identify motivations of the participant.

O	Open-ended questions
A	Affirmations
R	Reflections
S	Summaries

These four concepts apply to the health coach perspective while engaged in collaborative conversation:

R	Resist telling
U	Understand motivation
L	Listen with empathy
E	Empower

STEP THREE

As you complete the risk reduction counseling portion of the screening visit, you will start: ***Bridging the Gap from Risk Reduction Counseling to the First Health Coaching Session***

After risk reduction counseling is complete there should be a significant change in conversation style from a focused medical professional explaining factual data to peer-level collaborative conversation which is person focused. The person providing the health coaching is a knowledgeable guide, not an expert on this unique person. The job of the health coach is to draw out a participant's internal motivation, power, and dignity to craft a health goal at which she can be successful. Remember, some action is better than no action and any positive action sets up the potential for more positive action.

A risk reduction counseling transition to health coaching might follow something like this:

- Comment on positive aspects of clinical and health assessment data.
- Point out a couple of areas where clinical or health assessment data could be improved to reduce risk of heart disease.
- Use open-ended questions to give participant opportunity to express her thoughts.

Examples of open-ended questions:

- Can you tell me anything you could do to reduce any of these risks for your heart?
- What do you think about your future if you leave these risks alone and do nothing at this time?
- What might be an upside of making a small change to one of these risks now?
- Leave time and space for participant to reflect and think, then be prepared to listen closely. You may have to ask for more information to get a deeper answer.
- Acknowledge information shared with affirmation and or reflection comment. Affirmation comments express support for what was said. It is not a cheerleader, but a thoughtful, supportive comment or body language gesture. Reflection is confirming and or clarifying what you heard is what was intended. Reflection can be 'repeating back' or paraphrasing for intent.
- When you hear any words or intentions or desires about change, it is an opening to bring out the readiness ruler. **Health coaching begins with the Readiness Ruler.**

RULEs for Health Coach Communications

What is health coaching communications and why are they important?

Health coaching communications are the key to guiding a participant to craft a health goal in which she has ownership. Successful communications heighten a participant's awareness of choices and empowers her to act on her choices. Health coaching followup is evidence-based to improve a participant's success of behavior change. To support the greatest success for both NC WISEWOMAN Program providers and participants engaged in healthy behavior support services some guidance for health coaching is provided. A health coach needs to exercise good communication skills for engaging with participant such as:

- Using participant's name regularly during conversation;
- Showing a sense of humor or humanizing a situation, to reduce stress which can cloud thinking;
- Using medical authority or specialized knowledge respectfully (not a steam roller or too much too fast); and
- Being vulnerable to level the playing field and create a safe place to talk.

These skills convey personal value and are culturally respectful across diverse peoples.

Use this RULE to check yourself in preparing for a health coaching session:

- resist telling,
- understand motivation,
- listen with empathy, and
- empower the participant.

Explanation and examples of RULE



RESIST TELLING

Avoid statements that include “you should” or “you ought to” or “if you only.” These take power away from participant and lessen their ownership in the process and outcome. Try “what would you do” or “have you considered” or “how do you see this.”



UNDERSTAND MOTIVATION

Acknowledge expressions of interest or concern which reveal motivation. For example, ask, “Can you tell me more about your family eating style, so I can understand why this might be too hard or too big to change?”



LISTEN WITH EMPATHY

Try to imagine walking in her place, her circumstances, her resources, her culture and listen for clue to barriers and supports for a behavior change.



EMPOWER

What can you say and or do that gives the participant the greatest chance to be successful? Guide her to an achievable goal. Supply her with motivational tools to remind her. Establish a relationship with her for support and accountability.

Health coaches **“RULE!”**

Participant Education Resources

Making the Move to DASH



peas



bell pepper



squash



shrimp



chickpeas

HEALTHY EATING, PROVEN RESULTS

Moving to heart healthy eating may seem difficult, but it doesn't have to be. Here are some tips to make DASH work for you.

Change gradually.

- ➔ If you now eat one or two servings of vegetables a day, add a serving at lunch and another at dinner.
- ➔ If you don't eat fruit now or have juice only at breakfast, add a serving of fruit to your meals or have it as a snack.
- ➔ Gradually increase your use of milk, yogurt, and cheese to three servings a day. For example, drink milk with lunch or dinner, instead of soda, sugar-sweetened tea, or alcohol.
- ➔ Choose fat-free or low-fat (1 percent) milk, yogurt, and reduced-fat cheese to reduce your intake of saturated fat, cholesterol, and calories and to increase your calcium.
- ➔ Read the Nutrition Facts label on frozen and prepared meals, pizza, and desserts to choose those lowest in saturated fat and *trans* fat.

Vary your proteins.

- ➔ Choose lean cuts of meat and remove skin from poultry.
- ➔ Check the labels on ground meats and poultry and select those with lower saturated fat.
- ➔ Serve fish instead of meat or poultry once or twice each week.
- ➔ Include two or more vegetarian (meatless) meals each week.

- ➔ Aim to fill ½ your plate with vegetables and fruits, ¼ with whole grains, and ¼ with fish, lean meat, poultry, or beans.
- ➔ Add extra vegetables to casseroles, pasta, and stir-fry dishes.

Select nutritious, tasty snacks.

- ➔ Fruits offer great taste and variety. Use fruits canned in their own juice or packed in water. Fresh fruits are fast and easy and dried fruits are a good choice to carry with you or to have in the car.
- ➔ Try these snack ideas: unsalted rice cakes; nuts mixed with raisins; graham crackers; fat-free and low-fat yogurt; popcorn with no salt or butter added; raw vegetables.

Make healthy substitutions.

- ➔ Choose whole grain foods for most grain servings to get more nutrients, such as minerals and fiber. For example, choose whole wheat bread or whole grain cereals.
- ➔ If you have trouble digesting milk and milk products, try taking lactase enzyme pills with the milk products. Or, buy lactose-free milk.
- ➔ If you are allergic to nuts, use beans or seeds (such as sunflower, flax, or sesame seeds).

DASH EATING PLAN

The DASH Eating Plan is a heart healthy approach that has been scientifically proven to lower blood pressure and have other health benefits. To learn more, go to www.nhlbi.nih.gov/DASH.



National Heart, Lung, and Blood Institute

Know Your Health Numbers



Blood Pressure

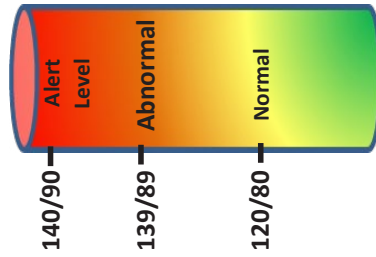
Blood pressure is the force of blood pushing against the walls of the arteries. If this pressure rises and stays high over time, it can damage the body in many ways. High blood pressure raises risk for heart disease and stroke.

Your blood pressure reading will be two numbers.

Systolic - pressure of blood in the vessel when the heart beats.

Diastolic - pressure between beats when the heart relaxes.

120/80 mmHg



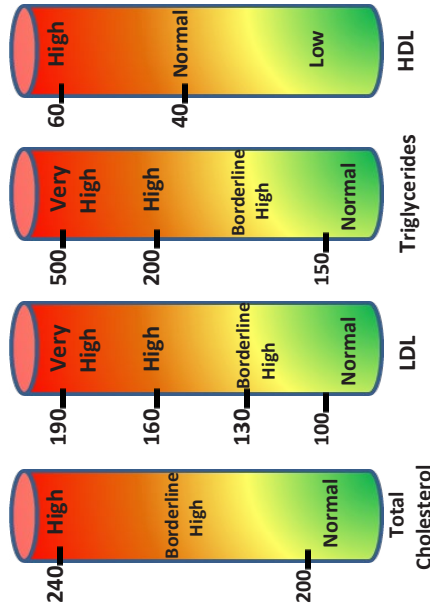
Today your blood pressure is _____.

- ☐ Normal
- ☐ Abnormal
- ☐ Alert Level

Cholesterol

Cholesterol is a soft, fat-like, waxy substance found in the bloodstream and in all your body's cells. Cholesterol is an important part of a healthy body- but too much cholesterol in the blood can increase your risk for heart disease.

Cholesterol comes from 2 sources: your body and foods that come from animals like meat, eggs, and cheese.



Today your Total Cholesterol is _____.

Your HDL is _____.

Your LDL is _____.

Your Triglycerides is _____.

Glucose

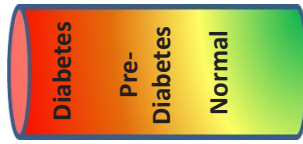
Diabetes is a disease in which blood sugar (blood glucose) levels are too high because the body does not produce or properly use *insulin*. Insulin is a tool that helps the body make energy.

There are two types of diabetes:

- Type 1 diabetes-the body does not produce insulin
- Type 2 diabetes-the body does not produce enough insulin or the cells ignore the insulin

- ☐ Fasting
- ☐ Non-fasting

Today your Glucose is _____.



Other Measures

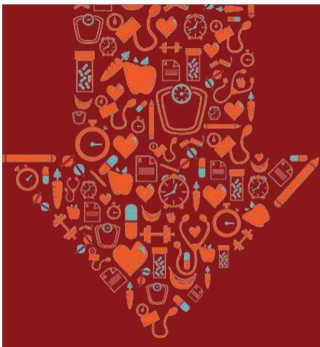
Height _____ Weight _____

Your BMI is _____.

Your hip circumference is _____.

Your waist circumference is _____.

Your next appointment is: _____



Taking Blood Pressure Manually

If you are using a manual device use these quick tips to help you take an accurate and consistent blood pressure reading.

- 1 Check the condition of the device and the cuff size to ensure the reading is accurate.** A small hole or crack in any part of the device e.g., rubber tubing, bulb, valves, and cuff can lead to inaccurate results. A cuff that is too small or too big may produce an incorrect high blood pressure reading.
- 2 It's important the patient feels comfortable and relaxed.** Reassure the patient that there are no risks or complications associated with this screening.
- 3 Have the patient relax and sit with their arm slightly bent on the same level as their heart and resting comfortably on a table or other flat surface.**
- 4 Place the inflatable blood pressure cuff securely on the upper arm (approximately one inch above the bend of the elbow).** Make sure the cuff is touching the skin. You may have to ask your patient roll up their sleeve, or remove their arm from the sleeve.
- 5 Close the pressure valve on the rubber inflating bulb and pump the bulb rapidly to inflate the cuff.** The cuff should be inflated so that the dial reads about 30 mm Hg higher than your patient's at-rest systolic pressure. (Tip: If at-rest pressure is unknown, inflate the cuff to 210 mm Hg or until the pulse at the wrist disappears).
- 6 If using a stethoscope, place the earpieces in your ears and the bell of the stethoscope over the artery, just below the cuff.** If the cuff has a built-in stethoscope bell, be sure to position the cuff so the bell is over the artery. The accuracy of a blood pressure recording depends on the correct positioning of the stethoscope over the artery and making sure the stethoscope bell does not rub on the cuff or the patient's clothing.
- 7 Now slowly release the pressure by twisting or pressing open the pressure valve, located on the bulb.** Some blood pressure devices can automatically control the rate at which the pressure falls, but generally the patient's pressure should decrease about 2 to 3 mm Hg per second. Listen through the stethoscope and note on the dial when you *first start to hear a pulsing or tapping sound*—this is the *systolic blood pressure*. If you have trouble hearing the start of the pulse, you can find the patient's systolic blood pressure by asking your patient to tell you when they can start to feel the pulse in their wrist and noting the level on the dial.
- 8 Continue letting the air out slowly.** The pulsing or tapping sounds will become dulled and finally disappear. Note on the dial *when the sounds completely stop*—this is the *diastolic blood pressure*. Finally, release the remaining air to relieve all pressure on your patient's arm.
- 9 Suggest the patient write down their numbers along with the date and time.** They can use the *Team Up. Pressure Down.* journal to keep track. Remind the patient to take their blood pressure regularly to ensure their medication are working appropriately.



As a health care professional, you can empower patients to take their medications as prescribed. Effective two-way communication is critical; in fact, it doubles the odds of your patients taking their medications properly.

Use the SIMPLE method to help improve medication adherence among your patients

Simplify the regimen

- ▶ Encourage patients to use adherence tools, like day-of-the-week pill boxes or mobile apps.
- ▶ Work to match the action of taking medication with a patient's daily routine (e.g., meal time or bed time, with other medications they already take properly).

Impart knowledge

- ▶ Write down prescription instructions clearly, and reinforce them verbally.
- ▶ Provide websites for additional reading and information—find suggestions at the **Million Hearts®** website.

Modify patients' beliefs and behavior

- ▶ Provide positive reinforcement when patients take their medication successfully, and offer incentives if possible.
- ▶ Talk to patients to understand and address their concerns or fears.

Provide communication and trust

- ▶ Allow patients to speak freely. Time is of the essence, but research shows that most patients will talk no longer than 2 minutes when given the opportunity.
- ▶ Use plain language when speaking with patients. Say, "Did you take all of your pills?" instead of using the word "adherence."
- ▶ Ask for patients' input when discussing recommendations and making decisions.
- ▶ Remind patients to contact your office with any questions.

Leave the bias

- ▶ Understand the predictors of non-adherence and address them as needed with patients.
- ▶ Ask patients specific questions about attitudes, beliefs, and cultural norms related to taking medications.

Evaluate adherence

- ▶ Ask patients simply and directly whether they are sticking to their drug regimen.
- ▶ Use a medication adherence scale—most are available online:
 - ▷ Morisky-8 (MMAS-8)
 - ▷ Morisky-4 (MMAS-4 or Medication Adherence Questionnaire)
 - ▷ Medication Possession Ratio (MPR)
 - ▷ Proportion of Days Covered (PDC)

Source: <http://www.acpm.org/?MedAdhereTTProviders>

Find and download additional materials to help your patients control hypertension at the **Million Hearts®** website.

Control your sodium

To reduce your risk of chronic disease limit your sodium intake to the following:

1500 mg/d limit

- Persons 51 and older
- African Americans
- Persons with hypertension
- Persons with diabetes
- Persons with chronic kidney disease
- Children

2300 mg/d limit for

- Any other adult

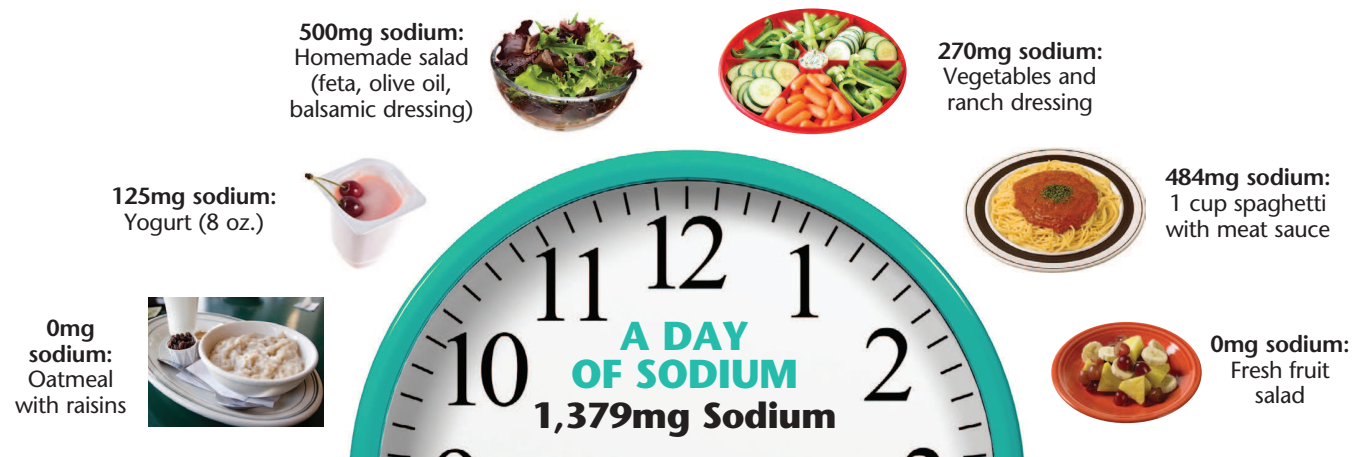


120/80 mm Hg. Keep YOUR blood pressure under control to reduce YOUR risk.

We get much of our sodium from processed foods.

INGREDIENTS: WHEAT BRAN, ROLLED OATS, SUGAR, RAISINS, CORN, DATES, BARLEY FLAKES, PECANS, PARTIALLY HYDROGENATED SOYBEAN AND/OR COTTONSEED OIL, GLYCERIN, BARLEY MALT EXTRACT, SALT, HONEY, RICE, MOLASSES, NONFAT MILK, HIGH FRUCTOSE CORN SYRUP, CORN SYRUP, **VITAMINS AND MINERALS:** SODIUM ASCORBATE AND ASCORBIC ACID, FERRIC ORTHOPHOSPHATE, NIACINAMIDE, ZINC OXIDE, VITAMIN A PALMITATE, PYRIDOXINE HYDROCHLORIDE, RIBOFLAVIN, THIAMIN HYDROCHLORIDE, FOLIC ACID, VITAMIN D, VITAMIN B12.

The ingredient list on a package can help us decide if the food is processed. The longer the ingredient list, the more processing that has occurred.



Be a label reader to make the best choice



Canned Spaghetti and Meatballs **1 cup: 925mg**



Frozen Spaghetti and Meatballs **1 cup: 568 mg**



Spaghetti and Meat Sauce made from canned meat sauce **1 cup: 484 mg**

Nutrition Facts	
Serving Size 1 cup (228g)	
Servings Per Container 2	
Amount Per Serving	
Calories 250	Calories from Fat 110
% Daily Value*	
Total Fat 12g	18%
Saturated Fat 3g	15%
Trans Fat 3g	
Cholesterol 30mg	10%
Sodium 470mg	20%
Total Carbohydrate 31g	10%
Dietary Fiber 0g	0%
Sugars 5g	
Protein 5g	

Look for **sodium** on the food label to make the best choice.



To keep your sodium intake low:

- Prepare YOUR meals.
- Enjoy MORE fruits and vegetables.
- Limit processed foods.

Beef Stir Fry

Serves 6

NUTRITION FACTS

Made with sirloin

Calories 413
Total Fat 8g
Saturated Fat 2g
Protein 19g
Carbohydrates 38g
Fiber 6g
Sugars 17g
Sodium 235mg

Ingredients

- 1 Tbsp vegetable oil
- 2 garlic cloves, chopped
- 1 small onion, chopped
- 1 pound lean beef, cut into thin strips (or other meats such as pork or chicken)
- 2 cups fresh or frozen vegetables (carrots, broccoli, cauliflower, peppers, snap peas, etc.)
- 2 cups cooked rice, hot (optional)
- 1/4 teaspoon red pepper flakes (optional)

Directions

1. Place stir-fry pan, wok or skillet over medium-high heat. Add 1 tablespoon vegetable oil.
2. When oil and pan are hot, add the garlic and onion; cook until the onions are browned.
3. Add the meat and cook until it begins to brown.
4. Add vegetables and stir until vegetables are tender.
5. Combine sauce mixture (see recipe below).
6. Pour into skillet with stir-fry. Cook until sauce bubbles.
7. Spoon stir-fry mixture over cooked rice. (optional)
8. Add red pepper flakes (optional).



Stir-Fry Sauce

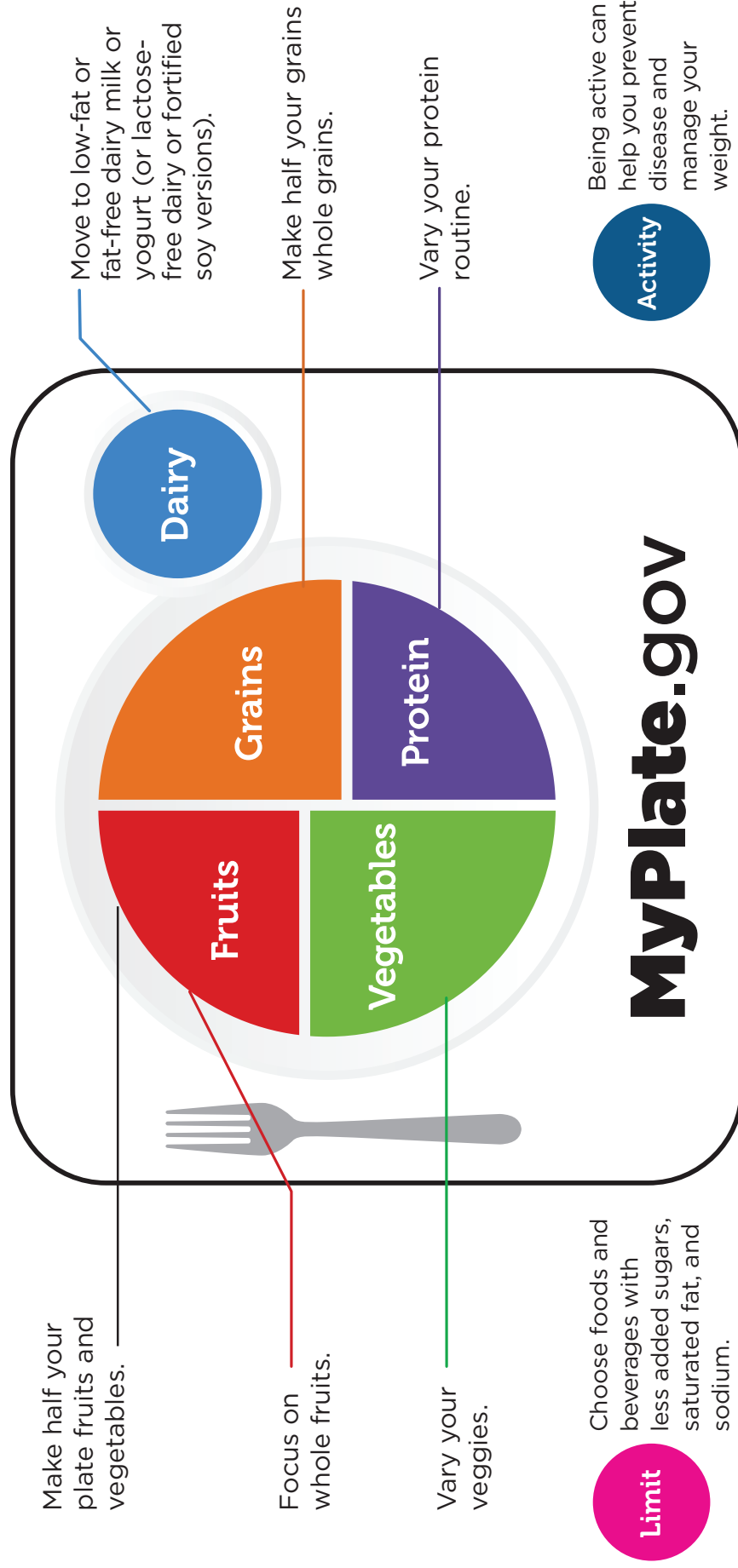
- 2 Tbsp cornstarch
- 1½ cups cool water
- 3 Tbsp low-sodium soy sauce
- 1/2 tsp black pepper

Directions

1. Combine cornstarch and cool water. Mix well with a whisk or fork.
2. Stir in remaining ingredients.
3. The cornstarch will settle to the bottom, so stir again before adding sauce to stir fry.

Start *simple* with MyPlate

Healthy eating is important at every life stage,
with benefits that add up over time, bite by bite. Small changes matter.

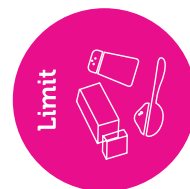


 Fruits	 Vegetables	 Grains	 Protein	 Dairy
Focus on whole fruits like fresh, frozen, canned, or dried. Buy fruits to have them available to add to your meal or eat as a snack. If you buy juice, select 100% fruit juice.	Eat a variety of vegetables and add them to mixed dishes like casseroles, sandwiches, and wraps. Fresh, frozen, and canned count, too. Look for “reduced sodium” or “no-salt-added” on the label.	Choose whole-grain versions of common foods such as bread, pasta, and tortillas. Not sure if it’s whole grain? Check the ingredients list for the words “whole” or “whole grain.”	Eat a variety of protein foods such as beans, soy, seafood, lean meats, poultry, and unsalted nuts and seeds. Select seafood twice a week. Choose lean cuts of meat and ground beef that is at least 93% lean.	Choose low-fat (1%) or fat-free (skim) dairy. Get the same amount of calcium and other nutrients as whole milk, but with less saturated fat and calories. Lactose intolerant? Try lactose-free milk or a fortified soy beverage.
Daily Food Group Targets — Based on a 2,000 Calorie Plan Visit MyPlate.gov/MyPlatePlan for a personalized plan.				
2 cups <i>1 cup counts as:</i> 1 small apple 1 large banana 1 cup grapes 1 cup sliced mango ½ cup raisins 1 cup 100% fruit juice	2½ cups <i>1 cup counts as:</i> 2 cups raw spinach 1 cup cooked collard, kale, or turnip greens 1 small avocado 1 large sweet potato 1 cup cooked beans, peas, or lentils 1 cup cut cauliflower	6 ounces <i>1 ounce counts as:</i> 1 slice of bread ½ cup cooked oatmeal 1 small tortilla ½ cup cooked brown rice ½ cup cooked couscous ½ cup cooked grits	5½ ounces <i>1 ounce counts as:</i> 1 ounce cooked lean chicken, pork, or beef 1 ounce tuna fish ¼ cup cooked beans, peas, or lentils 1 Tbsp peanut butter 2 Tbsp hummus 1 egg	3 cups <i>1 cup counts as:</i> 1 cup dairy milk or yogurt 1 cup lactose-free dairy milk or yogurt 1 cup fortified soy milk or yogurt 1½ ounces hard cheese 1 cup kefir

Choose foods and beverages with less added sugars, saturated fat, and sodium.

Limit:

- Added sugars to <50 grams a day.
- Saturated fat to <22 grams a day.
- Sodium to <2,300 milligrams a day.



Activity



Don't forget physical activity!

Being active can help you prevent disease and manage your weight.

Kids ≥ 60 min/day Adults ≥ 150 min/week

NC WISEWOMAN

MyPlate Starter Faux Food Package

A COMPREHENSIVE RESOURCE FOR TEACHING MYPLATE

Two of the leading causes of heart disease and stroke are high blood pressure and high blood cholesterol. Consuming too much sodium can increase [blood pressure](#) and the risk for [heart disease](#). Current guidelines recommend getting less than 2,300 mg a day, but Americans consume more than 3,400 mg a day on average.⁹

A healthy diet can help people with chronic diseases manage these conditions and avoid complications.



Do you remember the food pyramid? MyPlate is now the official symbol of the five food groups

- Fruits
- Vegetables
- Protein
- Grains
- Dairy

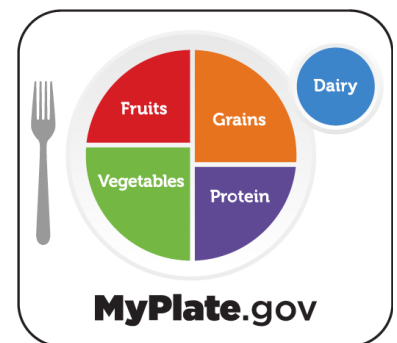
The MyPlate Food Package includes foods from each of MyPlate's food groups, this set of 20 foods model is a great tool to use in health coaching sessions. This includes 20 food cards with nutritional information for each food.

Each NC WISEWOMAN Provider will receive one food package to be used in conjunction with the MyPlate portion plate. Plates and other nutrition resources can be ordered through the NC WISEWOMAN [Material Order Form](#).

The portion plate serves as visual guide for portion control and guides conversation for participants to reach their nutrition and/or weight loss goals.

Foods in the set align with the five food groups in MyPlate:

- Fruits – apple, green grapes, cantaloupe, watermelon wedge
- Vegetables – carrots, broccoli, green beans, corn on the cob, tomato juice
- Dairy – fat-free milk, cheddar cheese cubes, strawberry Greek yogurt
- Grains – oatmeal, wheat bread, brown rice, flour tortilla
- Protein – turkey, grilled chicken breast, fish, pinto beans



Health Coaching

Once the navigator/health coach has conducted risk reduction counseling and established that the participant is interested in health coaching to address her nutrition goals, this MyPlate tool is a great resource to begin health coaching.

Provide the participant with relevant resources provided by the NC WISEWOMAN Program. This includes a food scale, fruit and veggie peeler and/or a cookbook to assist in reaching the participant's goals.

Start simple by figuring out how often the participant eats foods from each food group.

How often do you eat from the vegetable group?

Green, leafy vegetables?

Red/orange vegetables?

How often do you eat from the grain group?

These questions will help the navigator best understand the participant's current diet and what adjustments can be made.

⁹ Centers for Disease Control and Prevention. Poor Nutrition. www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

For example: The participant reveals that they eat vegetables or fruits 0-1 time per week.

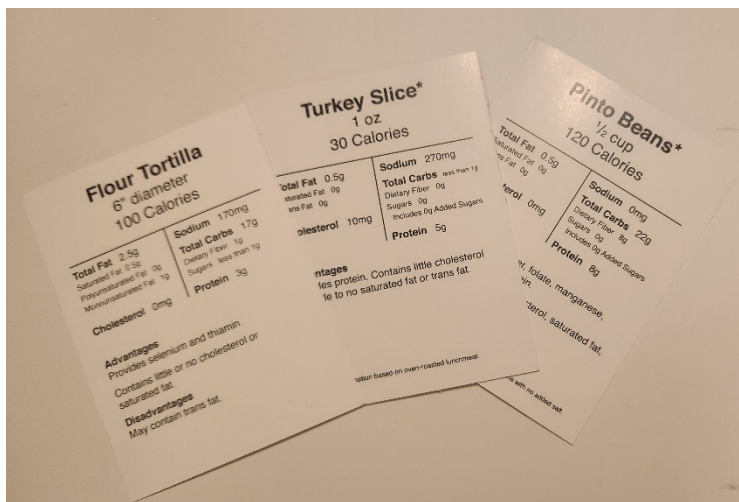
Suggest adding spinach to their morning smoothie or include leftover vegetables in an omelet to get the day started. Remind the participant that 100% vegetable or fruit juices can count as a serving.

Use the portion plate along with the faux food to demonstrate what a balanced meal would look like using foods that the participant enjoys.

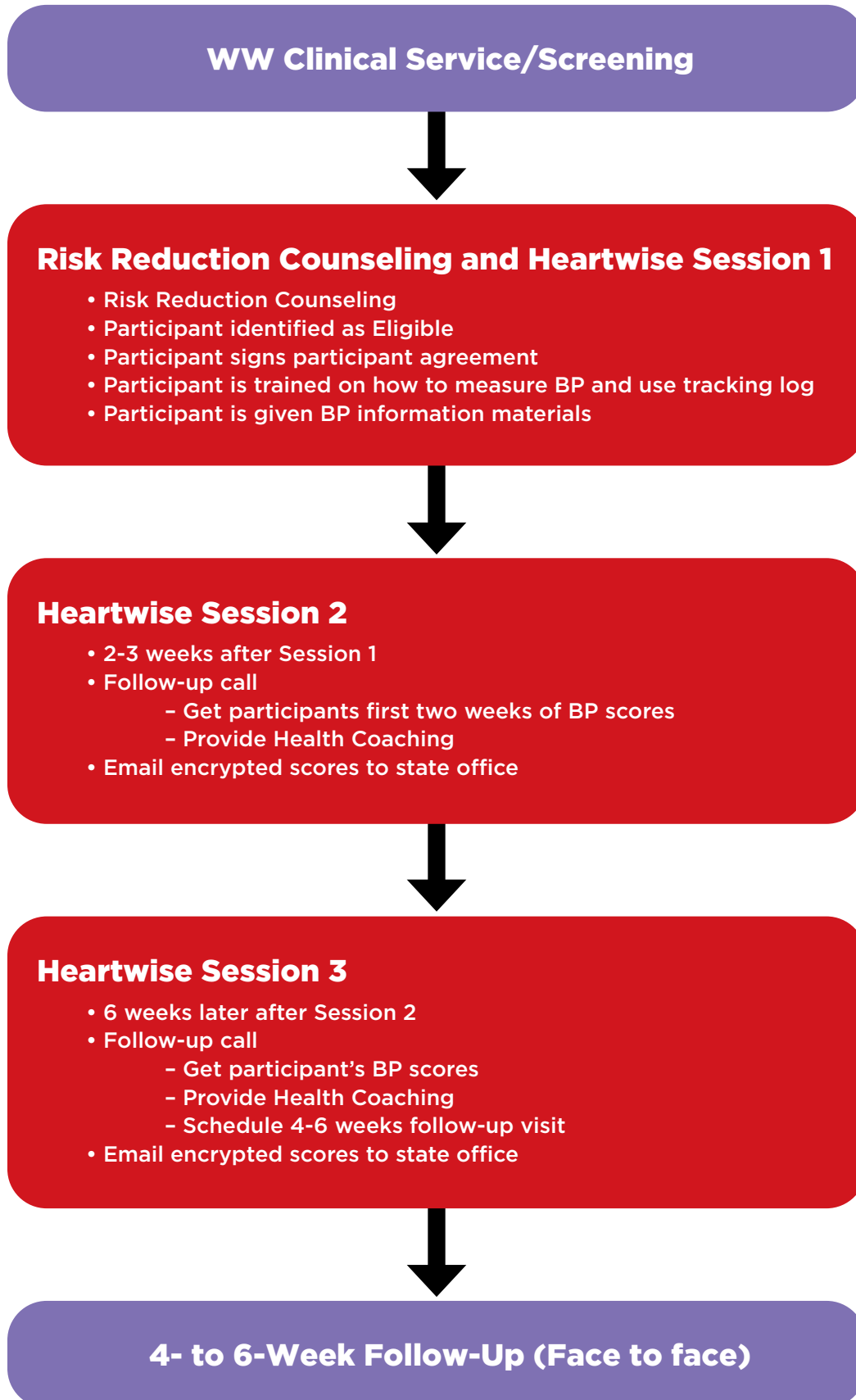
The nutrition cards provided in the set include:

- serving size
- calories
- nutrition advantages and disadvantages
- macronutrients (sodium, protein, carbohydrates, etc.)

Additional MyPlate resources and tip sheets can be found [here](#).



NC HeartWise Delivery Algorithm



What is prediabetes?

Prediabetes is a condition in which blood glucose levels are higher than normal but not high enough to be diagnosed as type 2 diabetes.

1 in **3** adults in the U.S.
has prediabetes

Why does prediabetes matter to me?

If you have prediabetes, you may have a greater risk of developing type 2 diabetes, as well as other medical conditions.

I feel fine, though.

Certain risk factors can increase your chances of having prediabetes.

How do I find out if I have prediabetes?

Prediabetes is diagnosed through a blood test. Your doctor can tell you more and order the best test for you.

Okay, now what?

The good news is that prediabetes is treatable and you *can* lower your risk of developing type 2 diabetes.

Your treatment options can include the evidence-based National Diabetes Prevention Program (National DPP) lifestyle change program, medication or medical nutrition therapy.

Get tested for prediabetes—talk with your doctor today.

¿Qué es la prediabetes?

La prediabetes es una afección en la que los niveles de glucosa en sangre son mayores de lo normal, pero no son lo suficientemente altos como para diagnosticar diabetes tipo 2.

1 de **3** adultos en los Estados Unidos tiene prediabetes

¿Por qué la prediabetes es importante para mí?

Si tiene prediabetes, puede tener un riesgo mayor de desarrollar diabetes tipo 2 y otras afecciones médicas.

Sin embargo, me siento bien.

Ciertos factores pueden aumentar sus probabilidades de tener prediabetes.

¿Cómo averiguo si tengo prediabetes?

La prediabetes se diagnostica a través de un análisis de sangre. Su médico puede brindarle más información e indicarle el mejor análisis para usted.

Está bien, ¿y ahora qué?

La buena noticia es que la prediabetes se puede tratar y usted *puede* disminuir su riesgo de desarrollar diabetes tipo 2.

Sus opciones de tratamiento pueden incluir el programa de cambio de estilo de vida basado en evidencia del National Diabetes Prevention Program (National DPP), medicamentos o terapia nutricional médica.

Hágase el análisis para detectar la prediabetes, hable con su médico hoy mismo.

Program Administration Forms

NC WISEWOMAN Material Order Form

Order the Free NC WISEWOMAN educational factsheets, promotional materials and programmatic materials for Risk Reduction Counseling and Healthy Behavior Support Services to aid in the success of participants.

Please complete the information below and email to:

Aleasia.Brown@dhhs.nc.gov

Subject Line: WISEWOMAN Materials Order Form

Orders will be processed within 30 days. Allow 5-7 business days for shipment to arrive.

If you have any questions or concerns regarding the materials or your request, please call

[Ciara Rukse, Program Manager 919-707-5317](tel:919-707-5317)

Date: _____

Contact Name: _____

Organization: _____

Shipping Address: _____

City/State/Zip: _____

Telephone: _____

E-mail: _____

Please let us know how you plan to use these items (audience, ages, activity, etc.):

WISEWOMAN Materials (Limit of 50 of each item per order), Limit of 15 for large motivational tools

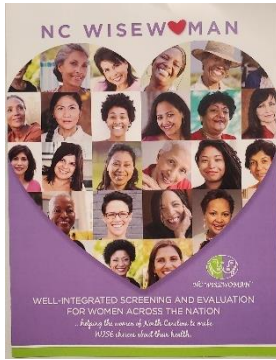
NC WISEWOMAN Materials Request Form			
Qty	NC WISEWOMAN Program Materials	Brochures Topics	
	WISEWOMAN Informational Booklet (English)	Qty	Blood Pressure and Cholesterol
	WISEWOMAN Informational Booklet (Spanish)		Ways to Improve your Cholesterol
	WISEWOMAN Know your Numbers + My Plan Worksheet (English)		Ways to Prevent and Control Blood Pressure (English)
	WISEWOMAN Know your Numbers + My Plan Worksheet (Spanish)		Ways to Prevent and Control Blood Pressure (Spanish)
	Blood pressure monitor- wrist		Healthy Snacks Pocket Card
	Arm Blood Pressure Monitor Arm (XL)		Be Smart for your Heart Pocket Card
	Arm Blood Pressure Monitor- Arm (Universal)		Women and Heart Disease
Qty	WISEWOMAN Motivational Tools		Blood Pressure Recording Cards (Spanish)
	WISEWOMAN Tote Bag		Blood Pressure Recording Cards
	WISEWOMAN Water Bottle		Healthy Heart Bookmark
	WISEWOMAN Ink Pens		Understanding Blood Pressure Bookmark
	WISEWOMAN Writing Pads	Qty	Diabetes
	Portion Control Meal Containers (SNAP A SNACK)		Ways to Lower Risk of Diabetes
	Timer (4-Pack)		Ways to Lower Risk of Diabetes (Spanish)
	AA Batteries (4-Pack)	Qty	Nutrition and Portion Sizes
	Calculator		My Plate “Do it Your Way”
	Paper Tape Measure		My Plate “Do it Your Way” (Spanish)
	Weight Scale		Physical Activity and Exercise
	Pill Cutter	Qty	Resistance band
	Pill Case		Yoga mat
	Food Scale		Ways to Lose Weight (and Keep it Off)
	Pedometers		Ways to Lose Weight (and Keep it Off) (Spanish)
	Heart Shaped Stress Ball		Ways to add Physical Activity to Your Day
	WISEWOMAN Heart-Shaped Magnets		Ways to add Physical Activity to Your Day (Spanish)
Qty	Jar opener		Get Active 10 Minutes at a Time
	Certificate of program completion with Certificate Holder		Walker’s Guide (and Record Keeper) Packet Card
	Multi-Purpose Kitchen Scoops		Jump rope
	Fruit and Vegetable Peeler		Hand sanitizer
	Health Coaching Materials		Activity tracker/Fitbit (color subject to change)
	InnerGuide’s Goal & Success Planner		Phone Holder
Qty	New Leaf “My Goals for this Month” Magnet (English)		Exercise and Depression
	New Leaf “My Goals for this Month” Magnet (Spanish)		Exercise and Stress
	Wellness Workbook (for provider)		Tobacco Education and Cessation
	Med-South Health Coaching Curriculum	Qty	Tobacco Free Families
Qty	COOKBOOKS		NC QUITLINE/Second-Hand Smoke Fact Sheets
	Dieta Mediterránea (Spanish Only)		Women and Smoking (Ten great reasons to Quit)
	Food for Thought: Healing Foods to Savor		WISEWOMAN Passports
	Heart Healthy Cookbooks for Two	Qty	HeartWise Passport (English)
	Nutrition Education		HeartWise Passport (Spanish)
	Be Wise About Snack Size Magnet		NC WISEWOMAN Passport (English)
	Be Wise About Serving Size Magnet		NC WISEWOMAN Passport (Spanish)
	ChooseMyPlate.gov Magnet		
	Healthy Eating on a Budget (Spanish)		
	Healthy Eating on a Budget (English)		
	Easy Ways to Eat Healthier		
	How to Read Food Labels		

	"Reaching for Water" Magnet		
	WISEWOMAN Lunch Bags		
	Food Graphics Plate (Clear)		
	Lunch Food Containers (Red)		
	Every Healthy Choice Leads to Another		

If items are missing from your shipment, that means the items are currently unavailable.

NC WISEWOMAN PROGRAM MATERIALS

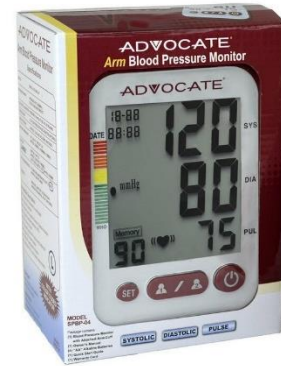
WW Informational Booklet
English & Spanish



Blood Pressure Monitor -Wrist

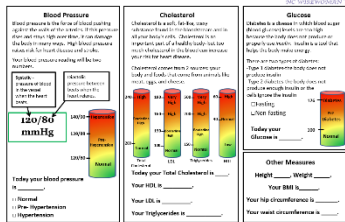


Blood Pressure Monitor –Arm
(size XL)



WW Know your Numbers Worksheet
English & Spanish

Know Your Health Numbers



Blood Pressure Monitor –Arm
(Universal Size)



WISEWOMAN MOTIVATIONAL TOOLS

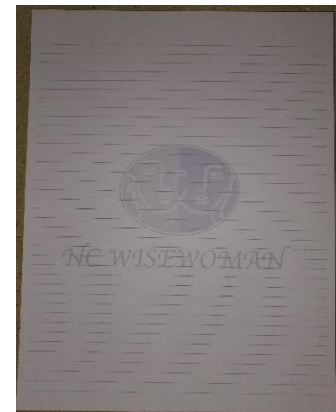
WW Tote Bag



Water Bottle



WISEWOMAN Note Pad



WW Ink Pen



Portion Control Snack Container



Fruit and Veggie Peeler



Batteries



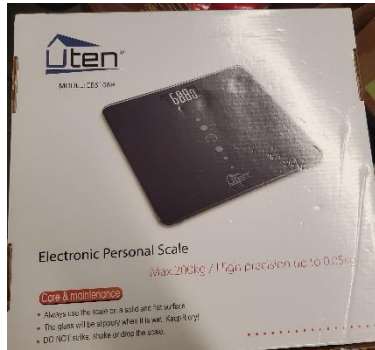
Calculator



Digital Timers
(4-pack)



Weight Scale



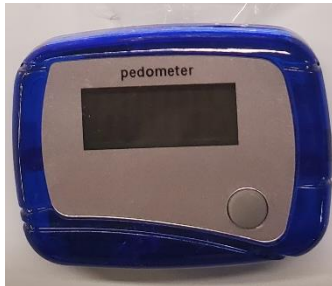
Food Scale



Pill Case



Pedometer



Pill Cutter



Stress Ball



WW Magnet



Jar Opener



Program Certificate and Holder



HEALTH COACHING MATERIALS

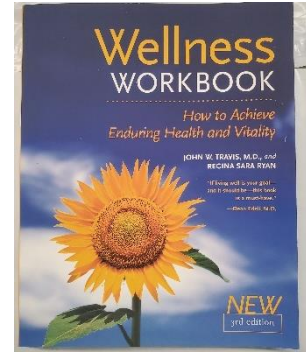
InnerGuide's Goal and Success Planner



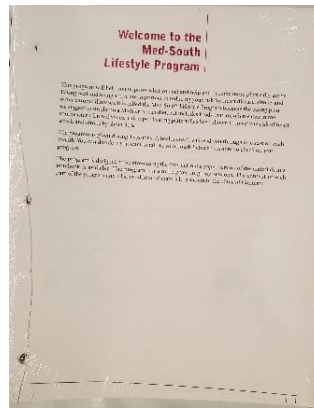
New Leaf "My Goals for this Month" Magnet (English and Spanish)



Wellness Workbook (For Providers)

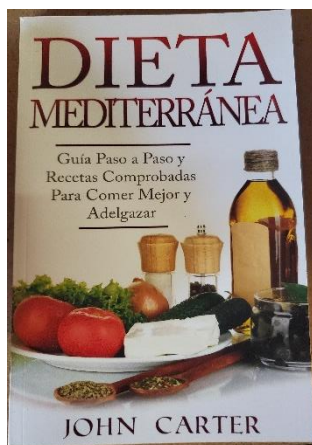


Med-South Health Coaching Curriculum

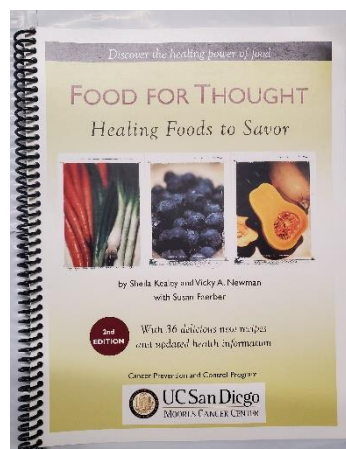


COOKBOOKS

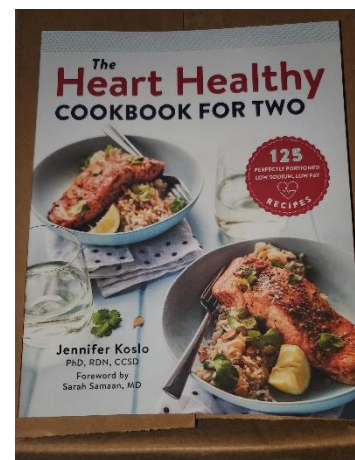
Dieta Mediterránea (Spanish Only)



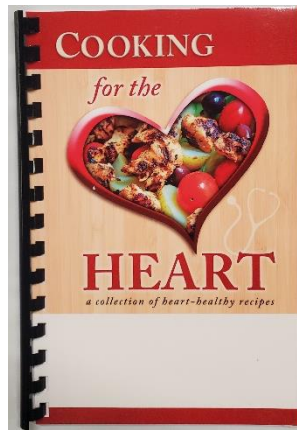
Food for Thought: Healing Foods to Savor



Heart Healthy Cookbooks for 2



Cooking for the Heart (English and Spanish)



NUTRITION EDUCATION

Be Wise about Snack Size Magnet



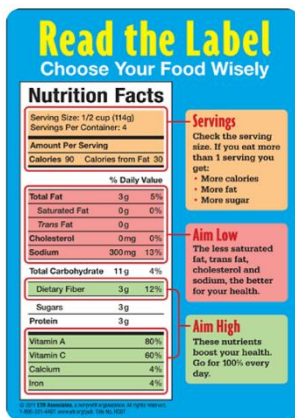
Be Wise about Serving Size Magnet



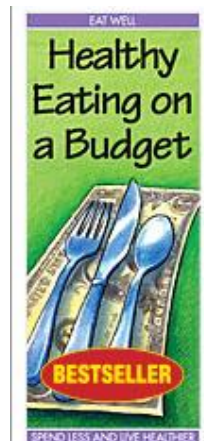
ChooseMyPlate.gov Magnet



Read the Label (How to Read Food Labels)



Healthy Eating on a Budget English and Spanish



Easy Ways to Eat Healthier



Reach for Water
Magnet



WW Lunch Bag



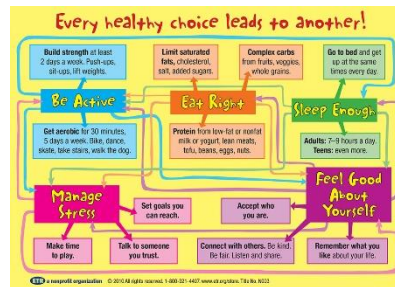
Clear Food Graphics Plate



Lunch Food Containers



Every Healthy Choice Leads to Another



Food Graphics Plate (Spanish)



BROCHURE TOPICS

Blood Pressure and Cholesterol

Ways to Improve your Cholesterol
English & Spanish



Ways to Prevent and Control
Blood Pressure
English & Spanish



Women and Heart Disease



Be Smart for your Heart Pocket Card



Blood Pressure Recording Cards (Spanish)



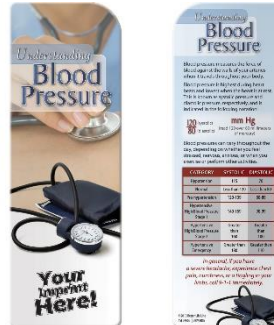
Healthy Heart Bookmark



Healthy Snacks Pocket Card



Understanding Blood Pressure Bookmark

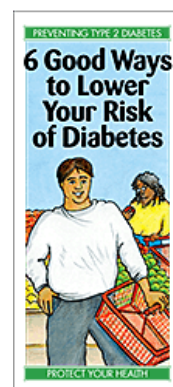
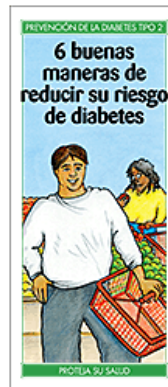


Nutrition and Diabetes

My Plate "Do it Your Way"



Good Ways to Lower Your Risk of Diabetes



PHYSICAL ACTIVITY AND EXERCISE

Resistance Band

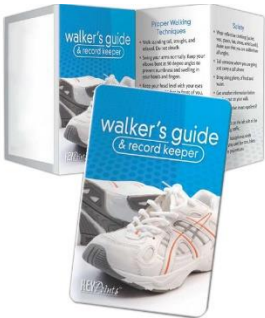
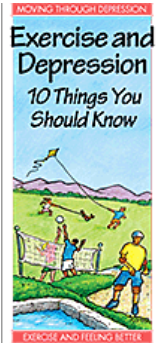


Yoga Mat



Jump Rope



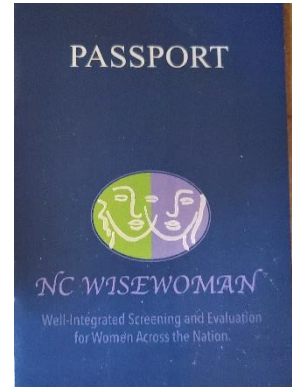
Ways to Lose Weight (& Keep it off) English & Spanish 	Ways to add Physical Activity to Your Day English and Spanish 	Get Active 10 Minutes at a Time 
Walker's Guide (and Record Keeper) Pocket Card 	Exercise and Depression 	Exercise and Stress 
Activity Tracker/FitBit (Color may vary) 	Phone Holder Waist Pack 	Hand Sanitizer 
TOBACCO EDUCATION AND CESSATION		
Tobacco Free Families 	NC QUITLINE/Second-Hand Smoke Fact Sheets 	Women and Smoking (Ten great reasons to Quit) 

WISEWOMAN PASSPORTS

WW HeartWise Passports
English & Spanish



WISEWOMAN Passports
English & Spanish





NC WISEWOMAN Program Consent Form

I agree to take part in the NC WISEWOMAN Program. The program is designed to help me reduce my risk for heart disease, stroke, and other chronic diseases such as diabetes. The NC WISEWOMAN Program provides free screening tests. It also provides a NC WISEWOMAN Program navigator or health coach who will contact me to talk about easy ways to eat smart, be fit, and live well.

I agree to have my height, weight, blood pressure, cholesterol, and glucose measured or tested. I understand that a blood sample or finger stick is needed to check cholesterol and glucose. I understand that my screening provider will ask some questions about personal and family medical history and some questions about health behavior. I do not have to answer any questions I am not comfortable answering.

The screening tests and possible side effects have been explained to me. These risks include some discomfort and very minor risk associated with a routine blood draw from a vein in my arm. Based upon my results, my screening provider will refer me to an appropriate lifestyle behavior or health coaching support service.

If my blood pressure, blood cholesterol, or glucose is too high, my screening provider will refer me to a clinician for medical follow-up. There is no cost for the first medical evaluation if it is required. However, if the clinician recommends further testing, services or medication, it will be my responsibility to cover these costs.

I understand that I am committing to **three** (3) health coaching sessions and a face-to-face follow-up visit with my NC WISEWOMAN Program navigator after the completion of my 3rd health coaching session.

I understand that I will be asked to take part in the NC WISEWOMAN Program again when I return in 11-18 months for my breast and cervical annual exam. The same screening tests and paperwork will be completed at that appointment. It is very important that I return for this appointment because I will learn if there are any changes in my risk for heart disease or stroke and it will help my screening provider learn if this program was useful.

I understand that physical activity is a part of the NC WISEWOMAN Program.

Please answer Yes or No to the following questions:

1. Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	☐ Yes ☐ No
2. Do you feel pain in your chest when you do physical activity?	☐ Yes ☐ No
3. In the past month, have you had chest pain lasting more than one minute when you were not doing physical activity?	☐ Yes ☐ No
4. Do you lose your balance because of dizziness, or do you ever lose consciousness?	☐ Yes ☐ No
5. Is your doctor currently prescribing drugs for your blood pressure or heart condition (for example, water pills)?	☐ Yes ☐ No

6. Do you have a bone or joint problem that could be made worse by a change in your physical activity?	☐ Yes ☐ No
7. Do you know of any other reason why you should not do physical activity?	☐ Yes ☐ No

If the answer to any one of the questions 1 through 7 above is Yes, I will get permission from my doctor or clinician to take part in the physical activity portion of the program.

I understand that I do not have to participate in this program. I have the right to drop out of the program at any time. However, my readiness to participate will be assessed prior to enrollment.

I agree and understand that I will be contacted by NC WISEWOMAN Program staff to discuss my progress during health coaching sessions.

Information collected about me is protected under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule. I also agree that if I take part in group activities, I will not reveal health or personal information that I might learn about other participants. If am referred to a lifestyle service, I am consenting to share my information with the NC WISEWOMAN Program from that service.

If I have any questions about the program, I may call the NC WISEWOMAN Program Coordinator at my local health agency. I may also call the North Carolina Department of Health and Human Services, Division of Public Health at 919-707-5300 and ask to speak to a NC WISEWOMAN Program Nurse Consultant. My local NC WISEWOMAN Program Coordinator is:

Name of local coordinator

Telephone number

I have read and understand the information presented here. I freely give my consent to take part in the NC WISEWOMAN Program.

Sign Your Name (or Legal Representative)

Date

Local Service Provider Representative

Date



Formulario de consentimiento del programa NC WISEWOMAN

Acepto participar en el programa NC WISEWOMAN. El programa pretende ayudarme a reducir mi riesgo de sufrir una enfermedad cardíaca, un accidente cerebrovascular y otras enfermedades crónicas como la diabetes. El programa NC WISEWOMAN proporciona pruebas de detección gratuitas. También proporciona un asesor o entrenador de salud del programa NC WISEWOMAN que se pondrá en contacto conmigo para hablar sobre formas fáciles para alimentarse de manera inteligente, estar en forma y vivir bien.

Acepto que midan o evalúen mi altura, mi peso, la presión arterial, el colesterol y la glucosa. Entiendo que se necesita una muestra de sangre o un pinchazo en el dedo para controlar el colesterol y la glucosa. Entiendo que mi proveedor de exámenes de detección hará algunas preguntas sobre los antecedentes médicos personales y familiares y algunas preguntas sobre el comportamiento de salud. No tengo que responder a ninguna pregunta que no me sienta cómoda respondiendo.

Me han explicado las pruebas de detección y los posibles efectos secundarios. Estos riesgos incluyen algunas molestias y un riesgo muy menor asociado con una extracción de sangre de rutina de una vena en el brazo. Según mis resultados, mi proveedor de exámenes de detección me remitirá a servicio de apoyo para un comportamiento apropiado del estilo de vida o un entrenamiento de salud.

Si mi presión arterial, mi colesterol en sangre o mi glucosa son demasiado elevados, mi proveedor de exámenes de detección me derivará a un clínico para el seguimiento médico. No hay ningún costo para la primera evaluación médica si es necesaria. Sin embargo, si el médico recomienda más pruebas, servicios o medicamentos, será mi responsabilidad cubrir estos costos.

Entiendo que me comprometo a **tres** (3) sesiones de entrenamiento de salud y una visita de seguimiento presencial con mi asesor del programa NC WISEWOMAN después de completar mi 3 era sesión de entrenamiento de salud.

Entiendo que se me pedirá que participe en el programa NC WISEWOMAN nuevamente cuando regrese en 11 a 18 meses para mi examen anual de mamas y cuello uterino. En esa cita se completarán las mismas pruebas de detección y papeleo. Es muy importante que regrese para esta cita porque sabré si hay algún cambio en mi riesgo de sufrir una enfermedad cardíaca o accidente cerebrovascular, y ayudará a mi proveedor de exámenes de detección a saber si este programa fue útil.

Entiendo que la actividad física es parte del programa NC WISEWOMAN.

Le pedimos que responda Sí o No a las siguientes preguntas:

1. ¿Alguna vez su médico le ha dicho que tiene una afección cardíaca y que solo debe hacer la actividad física recomendada por un médico?	☐ Sí ☐ No
2. ¿Siente dolor en el pecho cuando realiza una actividad física?	☐ Sí ☐ No
3. En el último mes, ¿ha tenido dolor en el pecho de más de un minuto de duración cuando no estaba realizando una actividad física?	☐ Sí ☐ No
4. ¿Pierde el equilibrio debido a mareos o alguna vez ha perdido el conocimiento?	☐ Sí ☐ No

5. ¿Su médico le está recetando medicamentos para la presión arterial o afección cardíaca (por ejemplo, diuréticos)?	☐ Sí ☐ No
6. ¿Tiene un problema óseo o articular que podría empeorar por un cambio en su actividad física?	☐ Sí ☐ No
7. ¿Conoce alguna otra razón por la que no deba hacer actividad física?	☐ Sí ☐ No

Si la respuesta a cualquiera de las preguntas 1 a 7 anteriores es Sí, obtendré permiso de mi médico para participar en la parte de actividad física del programa.

Entiendo que no tengo que participar en este programa. Tengo derecho a abandonar el programa en cualquier momento. Sin embargo, mi disposición para participar será evaluada antes de la inscripción.

Estoy de acuerdo y entiendo que el personal del programa NC WISEWOMAN se pondrá en contacto conmigo para conversar sobre mi progreso durante las sesiones de entrenamiento de salud.

La información recopilada sobre mí está protegida por la Norma de Privacidad de la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA). También acepto que, si participo en actividades grupales, no revelaré información personal o de salud que pueda conocer sobre otros participantes. Si me remiten a un servicio de estilo de vida, doy mi consentimiento para compartir mi información con el programa NC WISEWOMAN de ese servicio.

Si tengo alguna pregunta sobre el programa, puedo llamar al coordinador del programa NC WISEWOMAN de mi agencia de salud local. También puedo llamar al Departamento de Salud y Servicios Humanos de Carolina del Norte, División de Salud Pública al 919-707-5300 y pedir hablar con un consultor de enfermería del programa NC WISEWOMAN. Mi coordinador local del programa NC WISEWOMAN es:

Nombre del coordinador local

Número de teléfono

He leído y entiendo la información aquí presentada. Doy mi libre consentimiento para participar en el programa NC WISEWOMAN.

Firme con su nombre (o representante legal)

Fecha

Representante local del proveedor de servicios

Fecha

My WISEWOMAN Plan

Healthy Behavior Change Priority		Remember: <u>Make Your Goals SMART!</u>	
☐ Physical Activity ☐ Healthy Eating ☐ Tobacco Cessation Referral ☐ Hypertension- Medication / SMBP ☐ Diabetes Prevention Referral		Specific: Be as clear as possible regarding what you will do. Measurable: Spell out exactly what you will do, how long, and how often. Achievable: Pick a goal that you know you can reach. Realistic: Don't make your goal too hard. Time-Bound: Pick a time frame. Setting a time limit will help you take action.	
My SMART Goal	My Action Plan (list three actions to reach the goal)	Timeframe	
I will try to _____ How much _____ How often _____ How long _____	1.	Start Date: / / Goal Date: / /	
Important Dates, Appointments, and Reminders			
Date	Action Item		
	Follow-up coaching call		
	Follow-up coaching call		
	Follow-up screening visit		

Staff Change Notification Form

NC Breast and Cervical Cancer Control Program
 NC WISEWOMAN Project
 Health Directors, Nursing Directors,
 Nursing Supervisors, BCCCP Navigators,
 WISEWOMAN Coordinators, Health Educators, Finance Staff



Please complete and submit within 30 days of a status change with any Health Director, Nursing Director, Program Director, Nursing Supervisor, BCCCP Navigator, WW Coordinator, Health Educator, or Finance staff position (new hire, position vacancy, position elimination, and/or other changes).

Please provide a generic e-mail address for your agency if you haven't done so already.

Submit by mail or fax: **NC DHHS/Division of Public Health
 Cancer Prevention and Control Branch
 BCCCP/WISEWOMAN
 1922 Mail Service Center
 Raleigh, NC 27699-1922**

FAX: (919) 870-4812

Provider's Dedicated BCCCP Email Address or Essential Point of Contact:

Need membership on e-mail distribution list for:

☐	Health Director	☐	BCCCP Navigator	☐	Interim	Effective Date _____
☐	Nursing Director	☐	WW Coordinator	☐	Finance	
☐	Nursing Supervisor	☐	Health Educator			

First Name _____ Last Name _____

Degrees/Credentials _____

Position/Job Title _____

Agency _____

Address _____

Phone _____ Fax _____ E-mail _____

Name of staff person who previously held this position _____

Other Change

☐	Position Vacancy	☐	Position Elimination	Effective Date _____
☐	Position Change	☐	Other _____	

Comments:

Data Collection Forms

WISEWOMAN Screening (DHHS 4049A)				Agency:	
1. Patient Identification		Patient Name: Last _____ First _____ M.I. _____			
HIS ID (CNDS): _____		Date of Birth: ____/____/____		Inactive Date: ____/____/____	
Enrollment Status: ☐ Active ☐ Has Insurance ☐ Moved ☐ Age Ineligible ☐ Income Ineligible ☐ Lost To Follow-up ☐ Deceased ☐ Request to Drop BCCCP Referral Status: ☐ Actively enrolled in BCCCP ☐ Not Enrolled in BCCCP WISEWOMAN Referral Only					
2. Patient Enrollment/Annual Screening			3. Primary Language Spoken at Home		
Screening Date ____/____/____		Visit Type: ☐ New Enrollee ☐ Rescreening (11 – 18 months)		☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ French ☐ Italian ☐ Japanese ☐ Korean ☐ Polish ☐ Russian ☐ Tagalog ☐ Vietnamese ☐ Creole ☐ Portuguese ☐ Hmong ☐ Other Language ☐ Don't want to answer	
Race 1: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown Race 2: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown ☐ NA					
Zip Code _____			Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown		
Years of education: ☐ <9 th grade ☐ Some high school ☐ High school grad. or equiv. ☐ Some college or higher ☐ Don't know ☐ Don't want to answer					
WW Patient Navigation Paid By: ☐ BCCCP ☐ WISEWOMAN ☐ Indian Health Services/Tribal Funds ☐ Other Funds ☐ N/A (did not receive navigated services)					
Clinical Measurement Results (For 1st BP, 2nd BP, Weight, Total Cholesterol, HDL, LDL, Glucose, 777=Unable to Obtain, 888=Client Refused For Height, Waist: 77=Unable to Obtain, 88=Client Refused For A1C & Triglycerides: 777=Unable to Obtain, 888=Client Refused)					
Clinical Measurement Date ____/____/____		Blood Pressure 1 st Reading ____/____		Blood Pressure 2 nd Reading ____/____	
Height (inches) _____		Weight (pounds) _____		Waist Circumference (inches) _____	
Blood Draw Date ____/____/____		Fasting Status ☐ Fasting (at least 9 hrs.) ☐ Non-fasting			
Total Cholesterol _____	HDL _____	LDL (fasting) _____	Triglycerides (fasting) _____	A1C (for diabetics and non-fasting) _____	Glucose (fasting) _____
Risk Reduction Counseling					
Risk Reduction Counseling Date ____/____/____					
4. Medical History (DKNS=don't know/not sure, DWTA=don't want to answer)			5. Medication Status (NA/55=Not Applicable, 0=None, DKNS/77=don't know/not sure, DWTA/88=don't want to answer)		
a. Do you have high cholesterol ? ☐ Yes ☐ No ☐ DKNS ☐ DWTA b. Do you have hypertension (high blood pressure) ? ☐ Yes ☐ No ☐ DKNS ☐ DWTA c. Do you have Diabetes (either Type 1 or Type 2)? ☐ Yes ☐ No ☐ DKNS ☐ DWTA d. Have you been diagnosed as having: I. Stroke/transient ischemic attack (TIA) ☐ Yes ☐ No ☐ DKNS ☐ DWTA II. Heart Attack ☐ Yes ☐ No ☐ DKNS ☐ DWTA III. Coronary Heart Disease ☐ Yes ☐ No ☐ DKNS ☐ DWTA IV. Heart Failure ☐ Yes ☐ No ☐ DKNS ☐ DWTA V. Vascular Disease (peripheral arterial disease) ☐ Yes ☐ No ☐ DKNS ☐ DWTA VI. Congenital Heart Disease and Defects ☐ Yes ☐ No ☐ DKNS ☐ DWTA			a. Do you take a statin medication to lower your cholesterol? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA b. Do you take other (non-statin) medication to lower your cholesterol? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA c. Do you take medication to lower your blood pressure? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA d. Do you take medication to lower your blood sugar (for diabetes)? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA e. Are you taking aspirin daily to help prevent a heart attack or stroke? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA f. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? _____ (number of days) g. During the past 7 days, on how many days did you take prescribed medication (including diuretics) to lower your blood pressure? _____ (number of days) h. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)? _____ (number of days)		

WISEWOMAN Screening Record 2 DHHS (4049B)		Agency:
1. Patient Identification		
HIS ID (CNDS):		
Patient Name: <i>Last</i> <i>First</i> <i>M.I.</i>		
6. Blood Pressure, Self-Measurement (at Home or using other calibrated sources)		7. Nutrition Assessment (00=None, 88=Don't want to answer, DWTA=don't want to answer)
a. Do you measure your blood pressure? ☐ Yes ☐ No-Was never told to measure blood pressure ☐ No-Doesn't know how to measure blood pressure ☐ No-Doesn't have equipment ☐ DKNS ☐ DWTA ☐ Not Applicable b. How often do you measure your blood pressure? ☐ Multiple times per day ☐ Daily ☐ A Few times per week ☐ Weekly ☐ Monthly ☐ DKNS ☐ DWTA ☐ Not Applicable c. Do you regularly share blood pressure readings with a health care provider for feedback? ☐ Yes ☐ No ☐ DKNS ☐ DWTA ☐ Not Applicable		a. How many cups of fruits and vegetables do you eat in an average day _____ (in cups) b. How many vegetables do you eat in an average day? _____ (in cups) c. Do you eat fish at least two times a week? ☐ Yes ☐ No ☐ DWTA d. Thinking about all the servings of grain products you eat in a typical day; how many are whole grains? ☐ Less than half ☐ About half ☐ More than half ☐ DWTA e. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? ☐ Yes ☐ No ☐ DWTA f. Are you currently watching or reducing your sodium or salt intake? ☐ Yes ☐ No ☐ DWTA g. In the past 7 days, how often do you have a drink containing alcohol? _____ (Number of Days) ☐ DWTA h. How many alcoholic drinks, on average, do you consume during a day you drink? _____ (Number of Drinks) ☐ DWTA
8. Physical Activity Assessment (000=None, 888=Don't want to answer)		
a. How much moderate physical activity do you get in a week? _____ (in minutes) b. How much vigorous physical activity do you get in a week? _____ (in minutes)		
9. Smoking status (66=less than one, 88=don't want to answer, 00=none)		
a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form) ☐ Current ☐ Quit (1-12 months ago) ☐ Quit(>12 months ago) ☐ Never Smoked ☐ DWTA		
10. Quality of Life Assessment (77=Don't know/Not Sure, 88=Don't want to answer)		
a. Over the past 2 weeks, how often have you been bothered by any of the following problems? I. Little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More than half ☐ Nearly Every Day ☐ DWTA II. Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several Days ☐ More than half ☐ Nearly Every Day ☐ DWTA		
Tobacco Cessation Resource Referral		Referral Date ____ / ____ / ____
Type of Cessation Resource	Status of Cessation Resource	
☐ Quit Line ☐ Community-based tobacco program ☐ Other tobacco cessation resources	☐ Yes - Completed Tobacco Cessation Program ☐ No - Partially completed Tobacco Cessation Program ☐ No - Discontinued from tobacco cessation activity when reached ☐ No - Could not reach to conduct tobacco cessation activity ☐ Client Refused Referral	
Workup Status		
Diagnostic Exam Date ____ / ____ / ____	Referral Reason ☐ Blood Pressure	
What is the status of the work-up? ☐ 1. Medically necessary ☐ 2. Not medically needed ☐ 3. Medically necessary follow-up appointment declined ☐ 8. Client refused workup		
Comments		
Comments:		

NC WISEWOMAN Healthy Behavior Support Services (DHHS 4050A)				Agency:	
1. Patient Identification		CNDS ID:		Local Patient ID:	
Patient Name: Last		First		M.I.	
2. Referral Information					
Community-Based Resource Referral Made? ☐ Yes ☐ No			Community-Based Resource Type (check all that apply): ☐ Physical Activity ☐ Nutrition ☐ Behavioral Health ☐ Housing and Social Support Services		
Diabetes Prevention Program Referral Made? ☐ Yes ☐ No					
What area would the participant like to focus on changing (check all that apply)? ☐ Nutrition ☐ Physical Activity ☐ Stress Management ☐ Smoking ☐ Blood Pressure ☐ Diabetes ☐ Other					
What barriers (if any) were experienced in the completion of the HBSS (check all that apply)? ☐ Transportation ☐ Financial Issues ☐ Family and Social Support ☐ Housing Issues ☐ Employment Issues ☐ Lack of Motivation/Commitment ☐ Education/Health Literacy ☐ Unrealistic Goal Setting ☐ Lack of Time ☐ Other					
3. Healthy Behavior Support Services					
HBSS Session Date	HBSS ID Diabetes Prevention Program (DPP) Enhanced Health Coaching (EHC)	Length of Session in minutes	Contact Type	HBSS Completion Status	HBSS Setting
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination
____/____/____	☐ Health Coaching ☐ NC HeartWise ☐ EHC: DPP Online ☐ EHC: DPP In-Person ☐ EHC: Community Resource Referral		☐ Face-to-Face ☐ Phone ☐ Online	☐ Completed ☐ In Progress ☐ Withdrawal/Discontinued	☐ Individual ☐ Group ☐ Combination

NC WISEWOMAN Healthy Behavior Support Services (DHHS 4050B)				Agency:	
1. Patient Identification		CNDS ID:		Local Patient ID:	
Patient Name: <i>Last</i> <i>First</i> <i>M.I.</i>					
4. NC HeartWise Data					
Program Date	Systolic	Diastolic	Program Date	Systolic	Diastolic
Day One			Day Eight		
Day Two			Day Nine		
Day Three			Day Ten		
Day Four			Day Eleven		
Day Five			Day Twelve		
Day Six			Day Thirteen		
Day Seven			Day Fourteen		
Week One			Week Four		
Week Two			Week Five		
Week Three			Week Six		
Goal Setting: S.M.A.R.T					
Participant SMART Goal: _____ _____ Resources Needed: _____ _____					

NC WISEWOMAN Follow-up Screening (DHHS 4051A)		Agency:	
1. Patient Identification		Patient Name: <i>Last</i> _____ <i>First</i> _____ <i>M.I.</i> _____	
HIS ID (CNDS): _____		Date of Birth: ____/____/____	Inactive Date: ____/____/____
Enrollment Status: ☐ Active ☐ Has Insurance ☐ Moved ☐ Age Ineligible ☐ Income Ineligible ☐ Lost To Follow-up ☐ Deceased ☐ Request to Drop BCCCP Referral Status: ☐ Actively enrolled in BCCCP ☐ Not Enrolled in BCCCP WISEWOMAN Referral Only			
2. Patient Enrollment/Annual Screening		3. Primary Language Spoken at Home	
Screening Date ____/____/____	Visit Type: ☐ Follow-up—LSP/HC Complete	☐ English ☐ Spanish ☐ Arabic ☐ Chinese ☐ French ☐ Italian ☐ Japanese ☐ Korean ☐ Polish ☐ Russian ☐ Tagalog ☐ Vietnamese ☐ Creole ☐ Portuguese ☐ Hmong ☐ Other Language ☐ Don't want to answer	
Race 1: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown Race 2: ☐ White ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown ☐ NA			
Zip Code _____		Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown	
Years of education: ☐ <9 th grade ☐ Some high school ☐ High school grad. or equiv. ☐ Some college or higher ☐ Don't know ☐ Don't want to answer			
WW Patient Navigation Paid By: ☐ BCCCP ☐ WISEWOMAN ☐ Indian Health Services/Tribal Funds ☐ Other Funds ☐ N/A (did not receive navigated services)			
Clinical Measurement Results (For 1st BP, 2nd BP, Weight, Total Cholesterol, HDL, LDL, Glucose, 777=Unable to Obtain, 888=Client Refused For Height, Waist: 77=Unable to Obtain, 88=Client Refused For A1C & Triglycerides: 7777=Unable to Obtain, 8888=Client Refused)			
Clinical Measurement Date ____/____/____		Blood Pressure 1st Reading ____/____	Blood Pressure 2nd Reading ____/____
Height (inches) _____		Weight (pounds) _____	Waist Circumference (inches) _____
Risk Reduction Counseling			
Risk Reduction Counseling Date ____/____/____			
4. Medical History (DKNS=don't know/not sure, DWTA=don't want to answer)		5. Medication Status (NA/55=Not Applicable, 0=None, DKNS/77=don't know/not sure, DWTA/88=don't want to answer)	
a. Do you have high cholesterol ? ☐ Yes ☐ No ☐ DKNS ☐ DWTA b. Do you have hypertension (high blood pressure)? ☐ Yes ☐ No ☐ DKNS ☐ DWTA c. Do you have Diabetes (either Type 1 or Type 2)? ☐ Yes ☐ No ☐ DKNS ☐ DWTA d. Have you been diagnosed as having: I. Stroke/transient ischemic attack (TIA) ☐ Yes ☐ No ☐ DKNS ☐ DWTA II. Heart Attack ☐ Yes ☐ No ☐ DKNS ☐ DWTA III. Coronary Heart Disease ☐ Yes ☐ No ☐ DKNS ☐ DWTA IV. Heart Failure ☐ Yes ☐ No ☐ DKNS ☐ DWTA V. Vascular Disease (peripheral arterial disease) ☐ Yes ☐ No ☐ DKNS ☐ DWTA VI. Congenital Heart Disease and Defects ☐ Yes ☐ No ☐ DKNS ☐ DWTA		a. Do you take a statin medication to lower your cholesterol? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA b. Do you take other (non-statin) medication to lower your cholesterol? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA c. Do you take medication to lower your blood pressure? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA d. Do you take medication to lower your blood sugar (for diabetes)? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA e. Are you taking aspirin daily to help prevent a heart attack or stroke? ☐ Yes ☐ No ☐ NA ☐ DKNS ☐ DWTA f. During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol? _____ (number of days) g. During the past 7 days, on how many days did you take prescribed medication (including diuretics) to lower your blood pressure? _____ (number of days) h. During the past 7 days, on how many days did you take prescribed medication to lower blood sugar (for diabetes)? _____ (number of days)	

NC WISEWOMAN Follow-up Screening DHHS (4051B)		Agency:	
1. Patient Identification		HIS ID (CNDS):	
Patient Name: Last _____ First _____ M.I. _____			
6. Blood Pressure, Self-Measurement (at Home or using other calibrated sources)		7. Nutrition Assessment (00=None, 88=Don't want to answer, DWTA=don't want to answer)	
a. Do you measure your blood pressure? ☐ Yes ☐ No-Was never told to measure blood pressure ☐ No-Doesn't know how to measure blood pressure ☐ No-Doesn't have equipment ☐ DKNS ☐ DWTA ☐ Not Applicable b. How often do you measure your blood pressure? ☐ Multiple times per day ☐ Daily ☐ A Few times per week ☐ Weekly ☐ Monthly ☐ DKNS ☐ DWTA ☐ Not Applicable c. Do you regularly share blood pressure readings with a health care provider for feedback? ☐ Yes ☐ No ☐ DKNS ☐ DWTA ☐ Not Applicable		a. How many cups of fruits and vegetables do you eat in an average day _____ (in cups) b. How many vegetables do you eat in an average day? _____ (in cups) c. Do you eat fish at least two times a week? ☐ Yes ☐ No ☐ DWTA d. Thinking about all the servings of grain products you eat in a typical day; how many are whole grains? ☐ Less than half ☐ About half ☐ More than half ☐ DWTA e. Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly? ☐ Yes ☐ No ☐ DWTA f. Are you currently watching or reducing your sodium or salt intake? ☐ Yes ☐ No ☐ DWTA g. In the past 7 days, how often do you have a drink containing alcohol? _____ (Number of Days) ☐ DWTA h. How many alcoholic drinks, on average, do you consume during a day you drink? _____ (Number of Drinks) ☐ DWTA	
8. Physical Activity Assessment (000=None, 888=Don't want to answer)			
a. How much moderate physical activity do you get in a week? _____ (in minutes) b. How much vigorous physical activity do you get in a week? _____ (in minutes)			
9. Smoking status (66=less than one, 88=don't want to answer, 00=none)			
a. Do you smoke? Includes cigarettes, pipes, or cigars (smoked tobacco in any form) ☐ Current ☐ Quit (1-12 months ago) ☐ Quit(>12 months ago) ☐ Never Smoked ☐ DWTA			
10. Quality of Life Assessment (77=Don't know/Not Sure, 88=Don't want to answer)			
a. Over the past 2 weeks, how often have you been bothered by any of the following problems? I. Little interest or pleasure in doing things? ☐ Not at all ☐ Several Days ☐ More than half ☐ Nearly Every Day ☐ DWTA II. Feeling down, depressed, or hopeless? ☐ Not at all ☐ Several Days ☐ More than half ☐ Nearly Every Day ☐ DWTA			
Tobacco Cessation Resource Referral			Referral Date ____ / ____ / ____
Type of Cessation Resource		Status of Cessation Resource	
☐ Quit Line ☐ Community-based tobacco program ☐ Other tobacco cessation resources		☐ Yes - Completed Tobacco Cessation Program ☐ No - Partially completed Tobacco Cessation Program ☐ No - Discontinued from tobacco cessation activity when reached ☐ No - Could not reach to conduct tobacco cessation activity ☐ Client Refused Referral	
Workup Status			
Diagnostic Exam Date ____ / ____ / ____		Referral Reason ☐ Blood Pressure	
What is the status of the work-up? ☐ 1. Medically necessary ☐ 2. Not medically needed ☐ 3. Medically necessary follow-up appointment declined ☐ 8. Client refused workup			
Comments			
Comments:			

WISEWOMAN Screening Validation Form		Agency:
Patient Identification	Patient Name: <i>Last</i> <i>First</i> <i>M.I.</i>	
Local Patient or CND SID:	Date of Birth: ____/____/____	Inactive Date: ____/____/____
Patient Enrollment and Blood Draw		
Screening Date: ____/____/____	Blood Draw Date: ____/____/____	
Data being validated (Range of measures that must be validated):		Validated Measure: (If you are correcting a measurement, please do so in your system and re-batch the corrected record)
☐ Systolic 1 or 2 (<74 mmHg OR >230 mmHg)		
☐ Diastolic 1 or 2 (<12 mmHg OR >122 mmHg)		
☐ Total Serum Cholesterol (<60 mg/dL OR >400 mg/dL)		
☐ HDL (<7 mg/dL OR >155 mg/dL)		
☐ LDL (<20 mg/dL OR >344 mg/dL)		
☐ Triglycerides (<12 mg/dL OR >1000 mg/dL, fasting) *If Trigly over 400, lab should be repeated as fasting if not on lipid lowering meds or have a history of high cholesterol		
☐ Hemoglobin A1C (<4.0 OR > 13.0)		
☐ Glucose (<50 mg/dL OR >275 mg/dL)		
☐ Height (<58 inches (4ft. 10 inches) OR >74" (6ft. 2 inches))		
☐ Weight (<90lbs. OR >350 lbs.)		
☐ Physical Activity (<10 minutes OR >1700 minutes) * includes both moderate and vigorous activity		
Signature of Staff Person Validating Measure	Date of Validation	
	____/____/____	
Additional Comments:		
<i>Please fax this form to 919-870-4812, attn. NC WISEWOMAN Data Manager.</i>		



Data Form Requirements

NC WISEWOMAN Data Entry Guidelines
Updated September 2022

Updated Date: 09/23/2022
Effective 01/01/2023

Table of Contents

Forms Submission..... 7

Administrative Data 7

Record ID..... 7

Action 7

County/Facility Code 7

Screening Date 7

Administrative Action 7

Local Participant Identifier..... 7

CNDS ID 7

Record ID..... 7

Action 7

County/Facility RSC..... 7

Local Patient Identifier..... 7

Entry/Last Change Date 7

Program Type..... 7

Enrollment (Baseline) Screening..... 8

Entry/Last Change Date 8

Visit Type..... 8

Primary Language at Home..... 8

Enrollment Status..... 8

BCCCP Referral Status 8

Inactive Date 8

Education Level 8

Clinical Measurement Date..... 9

BP Systolic 9

BP Diastolic..... 9

BP Systolic 2 9

BP Diastolic 2..... 9

Height - Inches 9

Weight - Pounds..... 9

Waist Circumference - Inches 9

Blood Draw Date 9

Did you Fast Before Blood Draw 9

Serum Cholesterol Level 10

HDL Level..... 10

LDL Level	10
Triglycerides Level.....	10
HgA1C.....	10
Blood Glucose Level	10
Do you have high cholesterol?.....	10
Do you have high blood pressure?	10
Do you have diabetes?	10
Have you had a stroke or transient ischemic attack (TA)?	10
Have you had a heart attack?	10
Do you have coronary heart disease?.....	10
Have you had heart failure?.....	11
Do you have vascular disease (peripheral arterial disease)?.....	11
Do you have congenital heart disease and defects?	11
Do you take a statin to lower your cholesterol?.....	11
Do you take other (non-statin) medication to lower your cholesterol?.....	11
During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol?	11
Do you take medication to lower your Blood Pressure?	11
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Pressure?.....	11
Are you taking medication to lower your blood sugar?	11
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Sugar?.....	12
Do you measure your blood pressure at home?	12
How often do you measure your blood pressure at home?.....	12
Do you regularly share blood pressure readings with a healthcare provider for feedback?	12
How much fruit do you eat in an average day?	12
How many vegetables do you eat in an average day?.....	12
Do you eat two servings or more of fish weekly?.....	12
How many servings of whole grains do you eat daily?	12
Do you drink less than 36 ounces (450 cal) of beverages with added sugars weekly	13
Are you currently watching or reducing your sodium or salt intake?	13
How many minutes of moderate physical activity (exercise) do you get in a week?	13
Vigorous physical activity minutes per week?	13
Smoking status	13
Over the past 2 weeks, how often have you been feeling down, depressed or hopeless?	13
Over the past 2 weeks, how often have you had little interest or pleasure in doing thing?	13
Counseling Date	13
Tobacco Cessation Referral Date	13

Tobacco Cessation Resource.....	13
Status of Cessation Referral	13
Diagnostic Exam Date	14
Medical Evaluation Referral Reason	14
Status of the Work-up.....	14
Comments	14
Enrollment Date	14
Participant Navigation Paid for by	14
Are you taking Aspirin daily to help prevent a heart attack or stroke?.....	14
In the past 7 days, how often do you have a drink containing alcohol?	14
How many alcoholic drinks, on average do you consume during a day you drink?	14
After being prescribed medication, on what date did you have your blood pressure re-measured by a healthcare provider, or with another community resource?	14
Required Data Collection for a 4-6 week Follow-up	15
Entry/Last Change	15
Visit Type	15
Enrollment Status.....	15
Inactive Date	15
Clinical Measurement Date.....	15
BP Systolic1	15
BP Diastolic1.....	15
BP Systolic 2	16
BP Diastolic 2.....	16
Height - Inches	16
Weight - Pounds.....	16
Do you have high cholesterol?.....	16
Do you have high blood pressure?	16
Do you have diabetes?	16
Have you had a stroke or transient ischemic attack (TA)?	16
Have you had a heart attack?	16
Do you have coronary heart disease?.....	17
Have you had heart failure?.....	17
Do you have vascular disease (peripheral arterial disease)?.....	17
Do you have congenital heart disease and defects?	17
Do you take a statin to lower your cholesterol?.....	17
Do you take other (non-statin) medication to lower your cholesterol?.....	17

During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol?	17
Do you take medication to lower your Blood Pressure?	17
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Pressure?	18
Are you taking medication to lower your blood sugar?	18
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Sugar?	18
Do you measure your blood pressure at home?	18
How often do you measure your blood pressure at home?	18
Do you regularly share blood pressure readings with a healthcare provider for feedback?	18
How much fruit do you eat in an average day?	18
How many vegetables do you eat in an average day?	19
Do you eat two servings or more of fish weekly?	19
How many servings of whole grains do you eat daily?	19
Do you drink less than 36 ounces (450 cal) of beverages with added sugars weekly?	19
Are you currently watching or reducing your sodium or salt intake?	19
How many minutes of moderate physical activity (exercise) do you get in a week?	19
Vigorous physical activity minutes per week	19
Smoking status	19
Over the past 2 weeks, how often have you been feeling down, depressed or hopeless?	19
Over the past 2 weeks, how often have you had little interest or pleasure in doing thing?	19
Risk Counseling Date	20
Diagnostic Exam Date	20
Medical Evaluation Referral Reason	20
Status of the Work-up	20
Comments	20
Enrollment Date	20
Participant Navigation Paid for by	20
Are you taking Aspirin daily to help prevent a heart attack or stroke?	20
In the past 7 days, how often do you have a drink containing alcohol?	20
How many alcoholic drinks, on average do you consume during a day you drink?	20
After being prescribed medication, on what date did you have your blood pressure re-measured by a healthcare provider, or with another community resource?	21
Required Data Collection for Lifestyle Program/Health Coaching	21
County/Facility Code	21
Local Patient Identifier	21
CNDS ID	21
Entry/Last	21

Change Date.....	21
Session Date.....	21
LSP/HC ID	21
Primary HBSS Focus	21
Length of Session - minutes	21
Contact Type	22
Program Completion Status.....	22
HBSS Setting.....	22
Screening Date	22
Was a Community Resource Referral made?	212
Type of Community Resource Referral?	212
What (if any) barriers were experienced in the completion of the HBSS?	212
Was a diabetes prevention program referral made?	212
Day 1 HeartWise Systolic	212
Day 1 HeartWise Diastolic.....	212
Day 2 HeartWise Systolic	22
Day 2 HeartWise Diastolic.....	223
Day 3 HeartWise Systolic	213
Day 3 HeartWise Diastolic.....	213
Day 4 HeartWise Systolic	223
Day 4 HeartWise Diastolic.....	223
Day 5 HeartWise Systolic	223
Day 5 HeartWise Diastolic.....	223

Forms Submission			
Types: P6 (4049 A & B) and P7 (4050A) Baseline (Enrollment) : P6 and P7 (First Health Coaching or HeartWise) HBSS: Submit separate P7 form for each session completed 4 to 6 week follow-up: Submit new P6 form with Type 3 OR 4			
Administrative Data			
*required for all records, no matter screening cycle.			
Field Name	R=Required S=Situational NR=Not Required	Values	Logic/Comments
Record ID	R	WISEWOMAN = P6	May be automatically created by system
Action	R	A = Add D = Delete	NOTE: If the record is submitted as an Add and the record already exists at the State it will be processed as a Replace.
County/Facility Code	R	001-100 (LHD Counties) 500-599 (Contractors)	County FIPS code. May be automatically created by system
Screening Date	R	YYYY-MM-DD Format.	Note: this is the same as the service date.
Administrative Action		Valid Values Y=Yes N=No	
Local Participant Identifier	R	Local participant identifier used by county vendor system	
CNDS ID	R	Medicaid ID (retrieve from Avatar or Local DSS. CNDS is not used for billing or citizenship status)	Unique identifier for patient across all counties; allows us to track patients over multiple years and if patient moves from county to county
Service Record			
*All encounters (P6 and P7) should have a separate service record in order to be received			
Record ID	R	Valid Value=SR	
Action	R	Valid Values: A-Add D-Delete	Note: If the record is submitted as an ADD and the record already exists at the State it will be processed as a Replace.
County/Facility RSC	R	Valid Values: 001-100 (County where service was provided if LHD); 500-599 (Facility Root System Code)	
Local Patient Identifier	R	Local Patient Identifier used by county vendor system.	
Entry/Last Change Date	R	Date the service was entered or last changed.	
Program Type	R	Valid Values: WW	

Enrollment (Baseline) Screening *All variables marked with a required, must be recorded at the enrollment visit			
Field Name	R=Required S=Situational NR=Not Required	Values	Logic/Comments
Entry/Last Change Date	R	Date record was added or modified YYYY-MM-DD Format.	May be automatically created by the system. *Can be any date format as long as day, month, and year is present.
Visit Type	R	Valid Values: 1=New Enrollee 2=Re-Screening Visit 3=Follow-up LSP/HC Complete 4=Follow-up LSP/HC not complete	Note, if appointment date is 11 to 18 months after New Enrollee visit, Type must be 2=Re-Screening Visit, regardless if patient was or was not seen for a Follow-up.
Primary Language at Home	R	Preferred language in system. Other values include: 777=Other Language 888=Don't want to answer	
Enrollment Status	R	Valid Values: 1=Active 2=Has Insurance 3=Moved 4=Age Ineligible 5=Income Ineligible 6=Lost to Follow-up 7=Deceased 8=Request to Drop	
BCCCP Referral Date	R	Valid Values: 1=Actively Enrolled in BCCCP 2=Not enrolled in BCCCP WW Referral Only	Note: CDC requires now for <u>all</u> visit types
Inactive Date	S	YYYY-MM-DD Format.	Only required if participant is inactive. *Can be any date format as long as day, month, and year is present.
Education Level	R	Preferred education level in system. Other values include: Valid Values: 1=9 th grade 2 = Some high school 3= High school grad or equiv. 4= Some college or higher 7=Don't Know/Not Sure	

		8=Don't want to answer	
Clinical Measurement Date	R	YYYY-MM-DD Format.	Required if clinical measurements are performed. *Can be any date format if day, month, and year is present. Note: This date must be <u>on or before</u> the date of Risk Reduction Counseling and Health Coaching Session One
BP Systolic1	R	Valid Values: 010-300 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all new enrollment screenings
BP Diastolic1	R	Valid Values: 010-200 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all new enrollment screenings
BP Systolic 2	R	Valid Values: 010-300 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all new enrollment screenings
BP Diastolic 2	R	Valid Values: 010-200 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all new enrollment screenings
Height - Inches	R	Valid Values: 52 – 76 (inches) 777 = Unable to obtain 888 = Client refused Blank - Not specified.	Required for all new enrollment screenings
Weight - Pounds	R	Valid Values: 074 - 460 777 = Unable to obtain 888 = Client refused Blank - Not specified.	Required for all new enrollment screenings
Waist Circumference - Inches	S	Valid Values: 16 - 71 77 = Unable to obtain 88 = Client Refused	Only Required if waist circumference measured on Service Date.
Blood Draw Date	S	YYYY-MM-DD Format. Note: Required if Visit Type is "1" or "2"	Required for all new enrollment screenings *Can be any date format if day, month, and year is present.
Did you Fast Before Blood Draw	S	Valid Values: Y=Yes N=No	Only Required if labs were performed for participant

		Note: Required if Visit Type is “1” or “2”	
Serum Cholesterol Level	R	Valid Values: 001-999	Required for all new enrollment screenings
HDL Level	R	Valid Values: 001-999	Required for all new enrollment screenings
LDL Level	R	Valid Values: 001-999	Required for all new enrollment screenings
Triglycerides Level	R	Valid Values: 001-999	Required for all new enrollment screenings
HgA1C	R	Valid Values: 02.0-20.0 777=unable to obtain 888=client refused Blank=Not specified Note: Required if HgA1c is measured on Service Date.	Required for all new enrollment screenings Note: Only HgA1C or glucose is required, not both.
Blood Glucose Level	R	Valid Values: 001-999 Note: Required if measured on Service Date.	Required for all new enrollment screenings Note: Only HgA1C or glucose is required, not both.
Do you have high cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all new enrollment screenings
Do you have high blood pressure?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all new enrollment screenings
Do you have diabetes?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all new enrollment screenings
Have you had a stroke or transient ischemic attack (TA)?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of these conditions?”
Have you had a heart attack?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of these conditions?”
Do you have coronary heart disease?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know	Required for all new enrollment screenings

		8 = Don't want to answer	Note: This was previously “Do you have any of these conditions?”
Have you had heart failure?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of these conditions?”
Do you have vascular disease (peripheral arterial disease)?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of these conditions?”
Do you have congenital heart disease and defects?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of these conditions?”
Do you take a statin to lower your cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you take medication to lower your cholesterol?”
Do you take other (non-statin) medication to lower your cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you take medication to lower your cholesterol?”
During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings Note: this should be recorded as “Not Applicable” if “Do you have high cholesterol?” is recorded as no.
Do you take medication to lower your Blood Pressure?	R	Valid Values: 1 = Yes 2 = No 55 = Not applicable 77 = Don't know 88 = Don't want to answer	Required for all new enrollment screenings Note: this should be recorded as “Not Applicable” if “Do you have high blood pressure” is recorded as no.
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Pressure?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings Note: this should be recorded as “Not Applicable” if “Do you have high blood pressure” is recorded as no.
Are you taking medication to lower your blood sugar?	R	Valid Values: 1 = Yes 2 = No 55 = Not applicable 77 = Don't know 88 = Don't want to answer	Required for all new enrollment screenings Note: this should be recorded as “Not Applicable” if “Do you

			have diabetes is recorded as no".
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Sugar?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings Note: this should be recorded as "Not Applicable" if "Do you have diabetes" is recorded as no.
Do you measure your blood pressure at home?	R	Valid Values: 1 = Yes 2 = No - Was never told to measure BP 3 = No, doesn't know how to measure BP 4 = No, doesn't have equipment 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings
How often do you measure your blood pressure at home?	R	Valid Values: 1 = Multiple times per day 2 = Daily 3 = A few times per week 4 = Weekly 5 = Monthly 6 = Other 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings Note: This should be recorded as "Not Applicable" if participant does not measure their blood pressure at home.
Do you regularly share blood pressure readings with a healthcare provider for feedback?	R	Valid Values: 1 = Yes 2 = No 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer"	Required for all new enrollment screenings Note: This should be recorded as "Not Applicable" if participant does not measure their blood pressure at home.
How much fruit do you eat in an average day?	R	Valid Values in cups: 0 thru 15 cups 88 = Don't want to answer	Required for all new enrollment screenings
How many vegetables do you eat in an average day?	R	Valid Values in cups: 0 thru 15 cups 88 = Don't want to answer	Required for all new enrollment screenings
Do you eat two servings or more of fish weekly?	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer"	Required for all new enrollment screenings
How many servings of whole grains do you eat daily?	R	Valid Values: 1 = Less than half of servings 2 = About half of servings 3 = More than half of servings 88 = Don't want to answer	Required for all new enrollment screenings

Do you drink less than 36 ounces (450 calories) of beverages with added sugars weekly	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer	Required for all new enrollment screenings
Are you currently watching or reducing your sodium or salt intake?	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer	Required for all new enrollment screenings
How many minutes of moderate physical activity (exercise) do you get in a week?	R	Valid values in minutes: 010 thru 1700 888 = Don't want to answer	Required for all new enrollment screenings
Vigorous physical activity minutes per week?	R	Valid Values in minutes: 000 thru 1700 888 = Don't want to answer	Required for all new enrollment screenings
Smoking status	R	Valid Values: 1 = Current Smoker 2 = Quit 1-12 months ago 3 = Quit more than 12 months ago 4 = Never Smoked 88 = Don't want to answer	Required for all new enrollment screenings
Over the past 2 weeks, how often have you been feeling down, depressed or hopeless?	R	Valid Values: 0 = Not at all 1 = Several days 2 = More than half 3 = Nearly every day 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings
Over the past 2 weeks, how often have you had little interest or pleasure in doing thing?	R	NEW Valid Values: 0 = Not at all 1 = Several days 2 = More than half 3 = Nearly every day 77 = Don't know/Not sure 88 = Don't want to answer	Required for all new enrollment screenings
Risk Reduction Counseling Date	R	YYYY-MM-DD format. Risk Reduction Counseling Date	Required for all new enrollment screenings
Tobacco Cessation Referral Date	S	"YYYY-MM-DD format.	Required for any participant recorded as "current smoker"
Tobacco Cessation Resource	S	"Valid Values: 1 = Quit Line 2 = Community-based tobacco program 3 = Other tobacco cessation resources	Required if cessation referral date is recorded
Status of Cessation Referral	S	"Valid Values: 1 = Yes - Completed tobacco cessation activity 2 = No - Partially completed tobacco cessation activity	Required if cessation resource is recorded

		3 = No - Discontinued from tobacco cessation activity when reached 4 = No, Could not reach to conduct tobacco cessation activity Note: Required if Smoking Cessation is Yes."	
Diagnostic Exam Date	S	YYYY-MM-DD format. Appointment date for BP Alert.	Required if systolic blood pressure is greater than >180 mmHg OR if diastolic blood pressure is > 120 mmHg
Medical Evaluation Referral Reason	S	Default to Blood Pressure. Diagnostic referral for High Glucose no longer required.	
Status of the Work-up	S	Valid Values: 1 = Medically necessary 2 = Not medically needed 3 = Medically necessary follow-up appointment declined 8 = Client refused workup	Required if diagnostic exam date is entered.
Comments	S		
Enrollment Date		YYYY-MM-DD format.	*Please note that this is the original enrollment date, and should not change for any subsequent visit types related to the cycle.
Participant Navigation Paid for by	R	Valid Values: 1 = BCCCP Funds 2 = WISEWOMAN Funds 3 = Indian Health Service/Tribal Funds 4 = Other Funds 5 = Not applicable (did not receive navigated service)	Required for all new enrollment screenings
Are you taking Aspirin daily to help prevent a heart attack or stroke?	R	Valid Values: 1=Yes 2=No 77=Don't know/not sure 88=Don't want to answer	Required for all new enrollment screenings
In the past 7 days, how often do you have a drink containing alcohol?		Valid Values: Number of Drinks=00-07 88= Don't Want to Answer	Required for all new enrollment screenings
How many alcoholic drinks, on average do you consume during a day you drink?	R	Valid Values: Number of Drinks=00-50 88= Don't Want to Answer	Required for all new enrollment screenings
After being prescribed medication, on what date did you have your blood pressure re-measured by a healthcare provider, or with another community resource?	S	YYYY-MM-DD format.	Not required but can record additional blood pressure measurements if measured.

Required Data Collection for a 4-6 week Follow-up			
Enrollment (Baseline) Screening *All variables marked with a required, must be recorded at the Follow-up visit.			
Field Name	R=Required S=Situational NR=Not Required	Values	Logic/Comments
Entry/Last Change Date	R	Date record was added or modified YYYY-MM-DD Format.	May be automatically created by the system. *Can be any date format as long as day, month, and year is present.
Visit Type	R	Valid Values: 1=New Enrollee 2=Re-Screening Visit 3=Follow-up LSP/HC Complete 4=Follow-up LSP/HC not complete	*Should be type 3 OR 4 for 4 to 6 week follow-up
Enrollment Status	R	Valid Values: 1=Active 2=Has Insurance 3=Moved 4=Age Ineligible 5=Income Ineligible 6=Lost to Follow-up 7=Deceased 8=Request to Drop	
Inactive Date	S	YYYY-MM-DD Format.	Only required if participant is inactive. *Can be any date format as long as day, month, and year is present.
Clinical Measurement Date	R	YYYY-MM-DD Format.	Required if clinical measurements are performed. *Can be any date format if day, month, and year is present.
BP Systolic	R	Valid Values: 010-300 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all 4 to 6 week follow-up screenings
BP Diastolic	R	Valid Values: 010-200	Required for all 4 to 6 week follow-up screenings

		777=Unable to Obtain 888=Client Refused Blank=Not Specified	
BP Systolic 2	R	Valid Values: 010-300 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all 4 to 6 week follow-up screenings
BP Diastolic 2	R	Valid Values: 010-200 777=Unable to Obtain 888=Client Refused Blank=Not Specified	Required for all 4 to 6 week follow-up screenings
Height - Inches	R	Valid Values: 52 – 76 (inches) 777 = Unable to obtain 888 = Client refused Blank - Not specified.	Required for all 4 to 6 week follow-up screenings
Weight - Pounds	R	Valid Values: 074 - 460 777 = Unable to obtain 888 = Client refused Blank - Not specified.	Required for all 4 to 6 week follow-up screenings
Do you have high cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: This was previously “Do you have any of the following conditions?”
Do you have high blood pressure?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: This was previously “Do you have any of the following conditions?”
Do you have diabetes?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know/Not sure 8 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: This was previously “Do you have any of the following conditions?”
Have you had a stroke or transient ischemic attack (TA)?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of the following conditions?”
Have you had a heart attack?	R	Valid Values: 1 = Yes 2 = No	Required for all new enrollment screenings

		7 = Don't know 8 = Don't want to answer	Note: This was previously “Do you have any of the following conditions?”
Do you have coronary heart disease?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of the following conditions?”
Have you had heart failure?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of the following conditions?”
Do you have vascular disease (peripheral arterial disease)?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of the following conditions?”
Do you have congenital heart disease and defects?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you have any of the following conditions?”
Do you take a statin to lower your cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you take medication to lower your cholesterol?”
Do you take other (non-statin) medication to lower your cholesterol?	R	Valid Values: 1 = Yes 2 = No 7 = Don't know 8 = Don't want to answer	Required for all new enrollment screenings Note: This was previously “Do you take medication to lower your cholesterol?”
During the past 7 days, on how many days did you take prescribed medications to lower your cholesterol?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: this should be recorded as “Not Applicable” if “Do you have high cholesterol?” is recorded as no.
Do you take medication to lower your Blood Pressure?	R	Valid Values: 1 = Yes 2 = No 55 = Not applicable 77 = Don't know 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: this should be recorded as “Not Applicable” if “Do you have high blood pressure” is recorded as no.

During the past 7 days, on how many days did you take prescribed medications to lower your Blood Pressure?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: this should be recorded as "Not Applicable" if "Do you have high blood pressure" is recorded as no.
Are you taking medication to lower your blood sugar?	R	Valid Values: 1 = Yes 2 = No 55 = Not applicable 77 = Don't know 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: this should be recorded as "Not Applicable" if "Do you have diabetes is recorded as no".
During the past 7 days, on how many days did you take prescribed medications to lower your Blood Sugar?	R	Valid Values: 0 thru 7. 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: this should be recorded as "Not Applicable" if "Do you have diabetes" is recorded as no.
Do you measure your blood pressure at home?	R	Valid Values: 1 = Yes 2 = No - Was never told to measure BP 3 = No, doesn't know how to measure BP 4 = No, doesn't have equipment 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
How often do you measure your blood pressure at home?	R	Valid Values: 1 = Multiple times per day 2 = Daily 3 = A few times per week 4 = Weekly 5 = Monthly 6 = Other 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings Note: This should be recorded as "Not Applicable" if participant does not measure their blood pressure at home.
Do you regularly share blood pressure readings with a healthcare provider for feedback?	R	Valid Values: 1 = Yes 2 = No 55 = Not Applicable 77 = Don't know/Not sure 88 = Don't want to answer"	Required for all 4 to 6 week follow-up screenings Note: This should be recorded as "Not Applicable" if participant does not measure their blood pressure at home.
How much fruit do you eat in an average day?	R	Valid Values in cups: 0 thru 15 cups 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings

How many vegetables do you eat in an average day?	R	Valid Values in cups: 0 thru 15 cups 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Do you eat two servings or more of fish weekly?	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer"	Required for all 4 to 6 week follow-up screenings
How many servings of whole grains do you eat daily?	R	Valid Values: 1 = Less than half of servings 2 = About half of servings 3 = More than half of servings 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Do you drink less than 36 ounces (450 cal) of beverages with added sugars weekly?	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Are you currently watching or reducing your sodium or salt intake?	R	Valid Values: 1 = Yes 2 = No 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
How many minutes of moderate physical activity (exercise) do you get in a week?	R	Valid values in minutes: 010 thru 1700 888 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Vigorous physical activity minutes per week	R	Valid Values in minutes: 000 thru 1700 888 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Smoking status	R	Valid Values: 1 = Current Smoker 2 = Quit 1-12 months ago 3 = Quit more than 12 months ago 4 = Never Smoked 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Over the past 2 weeks, how often have you been feeling down, depressed or hopeless?	R	Valid Values: 0 = Not at all 1 = Several days 2 = More than half 3 = Nearly every day 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings
Over the past 2 weeks, how often have you had little interest or pleasure in doing thing?	R	NEW Valid Values: 0 = Not at all 1 = Several days 2 = More than half 3 = Nearly every day 77 = Don't know/Not sure 88 = Don't want to answer	Required for all 4 to 6 week follow-up screenings

Risk Reduction Counseling Date		YYYY-MM-DD format.	Required for all 4 to 6 week follow-up screenings
Diagnostic Exam Date	S	YYYY-MM-DD format. Appointment date for BP Alert.	Required if systolic blood pressure is greater than >180 mmHg OR if diastolic blood pressure is > 120 mmHg. *Referral for alert blood pressure readings are still required during 4 to 6 week follow-up
Medical Evaluation Referral Reason	S	Default to Blood Pressure. Diagnostic referral for High Glucose no longer required.	
Status of the Work-up	S	Valid Values: 1 = Medically necessary 2 = Not medically needed 3 = Medically necessary follow-up appointment declined 8 = Client refused workup	Required if diagnostic exam date is entered.
Comments	S		
Enrollment Date		YYYY-MM-DD format.	*Please note that this is the original enrollment date, and should not change for any subsequent visit types related to the cycle
Participant Navigation Paid for by	R	Valid Values: 1 = BCCCP Funds 2 = WISEWOMAN Funds 3 = Indian Health Service/Tribal Funds 4 = Other Funds 5 = Not applicable (did not receive navigated service)	Required for all 4 to 6 week follow-up screenings
Are you taking Aspirin daily to help prevent a heart attack or stroke?	R	Valid Values: 1=Yes 2=No 77=Don't know/not sure 88=Don't want to answer	Required for all 4 to 6 week follow-up screenings
In the past 7 days, how often do you have a drink containing alcohol?		Valid Values: Number of Drinks=00-50 88= Don't Want to Answer	Required for all 4 to 6 week follow-up screenings
How many alcoholic drinks, on average do you consume during a day you drink?	R	Valid Values: Number of Drinks=00-50 88= Don't Want to Answer	Required for all 4 to 6 week follow-up screenings

After being prescribed medication, on what date did you have your blood pressure re-measured by a healthcare provider, or with another community resource?	S	YYYY-MM-DD format.	Not required but can record additional blood pressure measurements if measured.
Required Data Collection for Lifestyle Program/Health Coaching			
Field Name	R=Required S=Situational NR=Not Required	Values	Logic/Comments
Record ID	R	WISEWOMAN=P7	
Action		Valid Values: A=Add D=Delete	Note: If the record is submitted as an Add and the record already exists as the State it will be processed as a Replace.
County/Facility Code	R	Valid Values: 001-100, 500-599	
Local Patient Identifier	R	Local Patient Identifier used by county vendor system.	
CNDS ID	R	Medicaid ID (retrieve from Avatar or Local DSS. CNDS is not used for billing or citizenship status)	Unique identifier for patient across all counties; allows us to track patients over multiple years and if patient moves from county to county
Entry/Last Change Date	R	YYYY-MM-DD format. Date data was entered or last changed.	
Session Date	R	YYYY-MM-DD format.	Required , as the first Health Coaching is mandatory at enrollment screening
LSP/HC ID	R	Valid Values: 1 = Health Coaching 7=NC HeartWise 8 = EHC: DPP Online 9= EHC: DPP In-Person 10= EHC Community Resource Referral	
Primary HBSS	S	Valid Values: 1 = Nutrition 2 = Physical Activity 3 = Stress Management 4 = Smoking 5= Blood Pressure 9 = Other	Required , as the first Health Coaching is mandatory at enrollment screening
Length of Session - minutes	R	Valid Values: Free form text	Required , as the first Health Coaching is mandatory at enrollment screening

Contact Type	R	Valid Values: 1 = Face to Face 2 = Phone 3 = Online	Required , as the first Health Coaching is mandatory at enrollment screening
Program Completion Status	R	Valid Values: 1 = Completed 2 = In Progress 3 = Withdrawal/Discontinued	Required , as the first Health Coaching is mandatory at enrollment screening
HBSS Setting	R	Valid Values: 1 = Individual 2 = Group 3 = Combination	Required , as the first Health Coaching is mandatory at enrollment screening
Screening Date	R	YYYY-MM-DD format.	Must match Screening Date of corresponding P6 (WW) record
Was a Community Resource Referral made?	R	Valid Value: 1 = Yes 2 = No	
Type of Community Resource Referral	S	Valid Values 1 =Physical Activity 2 = Nutrition 3 = Behavioral Health 4 = Housing and Social Support Services	
What (if any) barriers were experienced in the completion of the HBSS?	S	1 = Transportation 2 = Financial Issues 3 = Family/Social Support 4 = Housing Issues 5 = Employment Issues 6 = Lack of Motivation/Commitment 7 = Education/Health Literacy 8 = Unrealistic Goal Setting 9 = Lack of time 10 = Other	
Was a diabetes prevention program referral made?	S	Valid Values: 1 = Yes 2 = No	
Day 1 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 1 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 2 HeartWise Systolic	s	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	

Day 2 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 3 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 3 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 4 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 4 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 5 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 5 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 6 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 6 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 7 HeartWise Systolic	s	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 7 HeartWise Diastolic	S	Valid Values: 010-300	

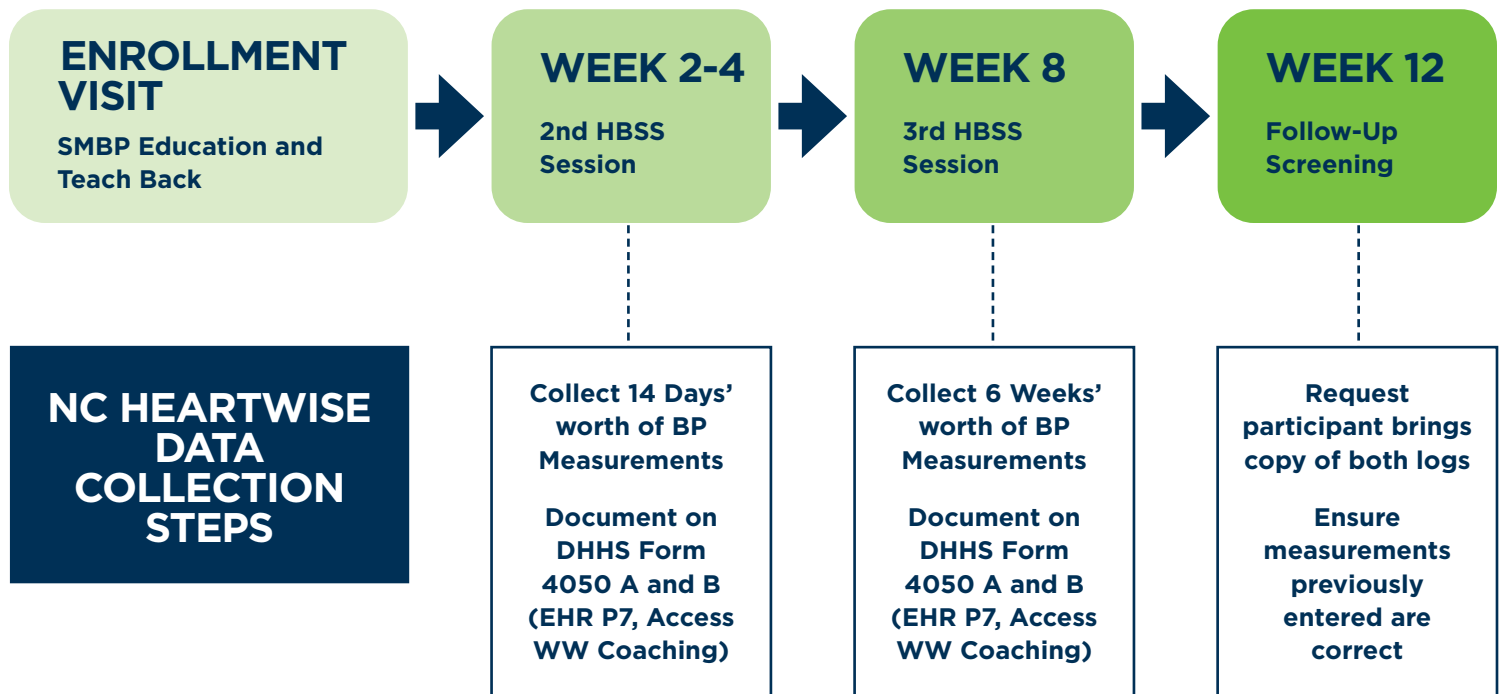
		777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 8 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 8 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 9 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 9 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 10 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day10 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 11 HeartWise Systolic	s	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 11 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 12 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 12 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused	

		Blank = Not specified	
Day 13 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 13 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day 14 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Day14 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 1 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 1 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 2 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 2 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 3 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 3 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	

Week 4 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 4 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 5 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 5 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 6 HeartWise Systolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	
Week 6 HeartWise Diastolic	S	Valid Values: 010-300 777 = Unable to obtain 888 = Client refused Blank = Not specified	

NC HeartWise Forms

NC HeartWise Delivery Sequence



NC WISEWOMAN *HeartWise Hypertension Control Program*

NC HeartWise Participant Agreement Form

After a discussion with my provider, I have been offered the option of participating in the North Carolina WISEWOMAN Self-Measured Blood Pressure Monitoring Initiative.

As a participant in *HeartWise Hypertension Control Health Coaching*, I understand that:

- The NC WISEWOMAN program will supply me with a digital blood pressure monitor, blood pressure tracking log and medication holder to use at home to check and record my blood pressure.
- I will be trained to use the monitor and log my readings. I agree to follow the instructions provided to me by clinic staff.
- I agree to take my blood pressure twice each day, write it in my blood pressure tracking log and provide this information to my NC WISEWOMAN program provider at upon request.
- I understand that taking my blood pressure medication as directed is very important for me to gain and maintain control of my blood pressure.
- If I am referred to other health care professionals, such as a pharmacist or a nutritionist, I agree to attend my appointments.
- I agree to update my NC WISEWOMAN provider, should my contact information change.
- I agree to contact my provider at _____, if I have any questions related to my blood pressure.
- I understand that a single high reading of blood pressure is not an immediate cause for alarm but should not be disregarded. If I have a high blood pressure reading, I should retake my blood pressure several times to confirm it is in fact elevated and call the clinic.
- If my blood pressure reading is consistently 180/120 or above, I should immediately contact my doctor or call 9-1-1 and seek medical attention if I am having signs and symptoms of a heart attack or stroke.
- I agree and understand that I may be contacted by WISEWOMAN staff to discuss my progress during follow-up sessions and may be asked to participate in a follow-up survey.

I release my NC WISEWOMAN provider and clinic from any claim arising or resulting from or relating in any way to my use of the blood pressure monitor provided to me, the result of my blood pressure monitoring or my participation in this *HeartWise Hypertension Control Health Coaching*.

I have been offered the option to participate in the Self-Measured Blood Pressure Monitoring Initiative, and I choose to **DECLINE** participation.

I have been offered the option to participate in the Self-Measured Blood Pressure Monitoring Initiative, and I choose to participate.

Participant Name (Printed)			Participant Signature		Date
Mailing Address	City	State	Zip Code	Phone Number	
NC WISEWOMAN Site			Staff Name (Printed)		
Monitor Serial ID			Initial Enrollment Date		
CNDS ID					

Please enter NC HeartWise data on Form DHHS 4050 A and B (P7 in EHR and page one and two in Access database)

9/2022

NC HeartWise Daily Blood Pressure Tracking Log

Participant

CNDS ID#: _____

Site Name: _____

Instructions: Please record your blood pressure readings at least once a day, every day for two weeks in your tracking log. At the end of these two weeks, your NC WISEWOMAN Provider/Health Coach will contact you to complete your first health coaching session.

Follow-Up Date: ____/____/____

DATE		TIME	BLOOD PRESSURE		NOTES	
			AM / PM	SYSTOLIC		DIASTOLIC
				(Upper Number)		(Lower Number)
DAY 1		AM / PM				
DAY 2		AM / PM				
DAY 3		AM / PM				
DAY 4		AM / PM				
DAY 5		AM / PM				
DAY 6		AM / PM				
DAY 7		AM / PM				
DAY 8		AM / PM				
DAY 9		AM / PM				
DAY 10		AM / PM				
DAY 11		AM / PM				
DAY 12		AM / PM				
DAY 13		AM / PM				
DAY 14		AM / PM				

Good Job! Keep up the good work for the next six weeks!

NC HeartWise Weekly Blood Pressure Tracking Log

CNDS ID#: _____

Site Name: _____

Instructions: We encourage you to take their blood pressure every day, at least twice a day. For the next six weeks, record your blood pressure readings once a week. At the end of the 6th week your NC WISEWOMAN Provider/Health Coach will complete your 2nd follow-up session.

2nd Follow-Up Date: ____/____/____

DATE		TIME	BLOOD PRESSURE		NOTES
			SYSTOLIC	DIASTOLIC	
			(Upper Number)	(Lower Number)	
Week 1		AM / PM			
Week 2		AM / PM			
Week 3		AM / PM			
Week 4		AM / PM			
Week 5		AM / PM			
Week 6		AM / PM			

You Did It!

Financial Documents

N. C. Department of Health and Human Services
Division of Public Health

SCOPE OF WORK

BACKGROUND

Cardiovascular disease (CVD), diseases of the heart and blood vessels, is a preventable disease that kills one person every 36 seconds in the United States. Approximately 659,000 individuals die in the United States annually from heart disease, which is 1 in every 4 deaths. Currently, cardiovascular disease and stroke are the second and fifth leading causes of death in North Carolina respectively (CDC National Center for Health Statistics, 2017).

From 2017 to 2019, heart disease killed 155.5 people per 100,000 North Carolinians while strokes accounted for 81.3 deaths per 100,000 North Carolinians. Heart disease deaths overwhelmingly impact all racial ethnicities, but mortality rates tend to vary depending on race and ethnicity among females. In the United States, heart disease is the leading cause of death among African American and White females. Heart disease is the second leading cause of death among Hispanic, American Indian, and Asian females (CDC, 2019).

Healthy Behavior Support Services are lifestyle interventions aimed at the reduction of CVD risk. The NC WISEWOMAN focuses on interventions that reduce hypertension, a leading cause of CVD. The best non-pharmacological interventions to reduce hypertension include weight loss, reduction in sodium intake, healthy diet, physical activity, and moderation in alcohol intake. A diet rich in fruits, vegetables, whole grains, and fish has shown to decrease blood pressure by 11 mm Hg (ACC & AHA, 2017).

Annually, the NC WISEWOMAN Program provides approximately 2,000 screenings for uninsured women ages 40 to 64 years old with a focus on women who are minorities. These women also receive referral for healthy behavior support services, which enables them to participate in evidence-based interventions to affect lifestyle change. If these services were not offered through contracts, then these screenings and intervention services would not be available for the low-income and minority women who are at the most risk for the development of CVD.

Comparison Data: North Carolina WISEWOMAN

Heart disease mortality rate was 128.1 per 100,000 women (US – 2017- 2019)

Mortality rate from strokes was 36.2 per 100,000 women (US – 2017-2019)

Heart disease mortality rate was 121.4 per 100,000 women (NC – 2017-2019)

Mortality rate from strokes was 40.2 per 100,000 women (NC – 2017-2019)

Centers for Disease Control and Prevention National Center for Health Statistics (2017). Multiple Cause of Death 1999-2016 on CDC WONDER Online Database.

Centers for Disease Control and Prevention. (2019). Health Equity. Leading Causes of Death in Females, United States.

American Heart Association. (2017). Cardiovascular disease: A costly burden for America Projections through 2035.

American College of Cardiology and American Heart Association. (2017). Guidelines for the prevention, detection, evaluation, and management of high blood pressure in adults.

PURPOSE

The purpose of this contract is to provide NC WISEWOMAN Project cardiovascular disease screening and lifestyle behavior support options to NC BCCCP eligible women ages 40-64.

COUNTIES

This contract serves the following North Carolina County (ies): All 100 counties.

PERFORMANCE REQUIREMENTS

- A. The contractor shall:
 - 1. Provide 65 cardiovascular disease screenings (baseline or rescreening) including follow-up and the initial health coaching for women eligible for NC BCCCP at a capitated rate of \$270 per screening.
 - 2. Provide 10 Healthy Behavior Support Services Service Navigation screenings (baseline or rescreening without a clinical office visit) including follow-up and the initial health coaching for women deemed to be underinsured with Medicaid or private insurance needing referral for HBSS only, at a capitated rate of \$180 per HBSS SN screening.
 - 3. Refer participants to additional health coaching and participants shall receive up to two more sessions, by phone or in person. The Contractor shall be reimbursed for up to 130 sessions at a rate of \$15 per session. Additional sessions beyond these will not be reimbursed.
- B. The contractor shall provide the following services:
 - 1. NC WISEWOMAN Project screening as an integrated part of the NC BCCCP office visit, when feasible, or to be completed by another provider when not receiving HBSS service navigation.
 - 2. Initial screening (baseline) and annual screening (rescreening) requirements must include:
 - a. Demographic profile
 - b. Personal medical history
 - c. Behavior risk factor profile
 - d. Two blood pressure measurements at least two minutes apart
 - e. Fasting or non-fasting serum cholesterol/HDL
 - f. Fasting glucose and/or hemoglobin A 1c
 - g. Height and weight
 - h. Patient-centered risk reduction counseling
 - i. Initiation of one health coaching session
 - j. Provision or referral to two additional health coachings or healthy behavior support options
 - 3. Follow-up screening requirements must include:
 - a. Demographic profile
 - b. Personal medical history
 - c. Behavioral risk factor profile
 - d. Two blood pressure measurements at least two minutes apart
 - e. Height and weight

- f. Patient-centered risk reduction counseling
- 4. Enrollment visit for Healthy Behavior Support Service Navigation requirements include:
 - a. Assessment and Documentation of existing lab values
 - b. Personal medical history
 - c. Behavior risk factor profile
 - d. Two blood pressure measurements
 - e. Height & weight
 - f. Risk reduction counseling
 - g. Healthy behavior support services
- 5. Screening services and Healthy Behavior Support Services (HBSS) (lifestyle program and/or health coaching) may be subcontracted to physicians or other providers.
- 6. Lifestyle programs are evidence-based interventions that educate women through participation, about healthy behaviors. They receive support on how to integrate these behaviors into their daily lives.
- 7. Health coaching is the use of evidence-based skillful conversation, clinical interventions, and strategies to engage patients actively and safely in health behavior change.
- 8. All NC WISEWOMAN participants shall receive patient-centered risk reduction counseling and appropriate HBSS according to their clinical and behavioral risk factors.
- 9. All NC WISEWOMAN participants shall receive one mandatory session of Health Coaching (included as part of the capitated rate) during the clinical screening visit. All participants shall be referred for two additional health coaching session, by phone or in person.
- 10. Participants shall be brought back in for a follow-up screening 4 to 6 weeks after completion of HBSS to assess progress and reinforce goals (included as part of the capitated rate). If participant does not complete HBSS, participant shall be brought back in for follow-up visit no earlier than 3 months and no later than 11 months post baseline screening date.
- 11. All participants who self-report as a smoker shall be provided information about smoking cessation services and a documented attempt at a smoking cessation services referral. All participants who smoke and desire to quit within the next 30 days must be referred to QuitlineNC.
- 12. Referral, tracking and follow-up services shall be provided for all participants with abnormal and alert screening results. The current recommendations by the following national programs shall be followed as guidelines for screening, referral, and follow- up:
 - a. 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/

APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A report of the American College of Cardiology/American Heart Association Task Force on clinical practice guidelines

- b. 2017 ACC/AHA & JNC 8 Hypertension Guidelines
 - c. The American Diabetes Association's Clinical Practice Recommendations
13. All medical referrals, recalls for rechecks, follow-ups, and annual rescreenings shall be initiated and tracked by the Contractor.
14. NC WISEWOMAN Project participants shall be rescreened 11 to 18 months following the initial NC WISEWOMAN Project screening(baseline).
15. All participants with abnormal and alert screening results shall receive appropriate medical follow-up in accordance with national and program guidelines.
- a. Participants with abnormal or alert level screening results shall be allowed one diagnostic visit to a clinic with prescribing authority per screening cycle for follow-up.
 - b. All participants with a blood pressure alert value shall receive Patient Navigation to assist with accessing indicated medical care and a referral for medical evaluation and treatment immediately or within seven days of the alert measurement. Alert values are:
 - I. Systolic blood pressure ≥ 180 mm/hg.
 - II. Diastolic blood pressure ≥ 120 mm/hg.
 - c. For all participants requiring a medical referral, the following information must be documented in the patient record and in a data system compatible with the North Carolina state data system within one week of the date of screening.
 - I. Date and source of medical referral
 - II. Follow-up documentation (date the patient was seen by a physician and the results of the visit, e.g., status of medications or changes in medications)
 - III. For all participants not receiving medical follow-up within seven days sufficient documentation regarding why medical follow-up did not occur including, dates and number of attempts made to contact the participant if they could not be reached, must be provided and placed in the patient record and in a data system compatible with the North Carolina state data system.
 - IV. Link participants and document requiring follow-up of alert values and medication therapy to available resources.
 - d. All standing orders or protocols developed for nurses in support of this program must be written in the North Carolina Public Health Nursing Professional Development Unit's (PHNPDU) format. All contractors shall

have a policy in place that support nurses working under standing orders:
<https://ncpublichealthnursing.org/standing-orders/>.

- C. Require its NC WISEWOMAN coordinator to attend the following public and professional educational sessions:
1. The NC BCCCP/NC WISEWOMAN Project Biennial Update conference and all scheduled statewide conference calls.
 2. One of the NC WISEWOMAN Project Orientation training sessions which are offered throughout the year. The Project Orientation training session incorporates Project Orientation, Data Entry, and Patient-Centered Risk Reduction Counseling and Healthy Behavior Support Services (HBSS). New coordinators are required to attend the first NC WISEWOMAN Project Orientation session following their date of hire.
 3. Blood Pressure Measurement continuing education via self-paced modules or as offered by the state (Blood Pressure Measurement Training Mini-Course) shall be completed by the NC WISEWOMAN Coordinator and by all staff who measure blood pressure for NC WISEWOMAN.

PERFORMANCE STANDARDS

- A. The Contractor shall meet the following program standards:
1. Provide services either at its own site, at satellite sites or through subcontract agreements with other providers. All subcontracts must follow the same guidance for deliverables, quality of service and follow-up as the Contractor follows.
 2. Use evidence-based resources and program guidance to meet contract requirements. The contractor shall be held to a standard percentage of performance indicators met and number contracted to serve or be subject to loss of NC WISEWOMAN Project funds. The performance indicators to be met are included in this contract to ensure that the minimum goals to be attained for the year are clearly understood.
 3. Define the priority population as women ages 40 to 64, who are of ethnic minority, who are uninsured or underinsured, without a usual source of health care, and whose income is less than 250% of the federal poverty level. Special emphasis should be given to the priority population, however all women served must meet the eligible population requirements.
 4. Limit the enrollment into the NC WISEWOMAN Project to women between the ages of 40 to 64 who are eligible for NC BCCCP.
 - a. All women provided services through this program must be eligible for NC BCCCP with gross incomes that are less than 250% of the federal poverty level according to schedules in effect at the beginning of the Agreement Addendum term.
 - b. Those women who are age 65 who had been previously enrolled in the NC WISEWOMAN Project and who otherwise remain eligible for NC BCCCP

may return for their rescreening eleven months to eighteen months after their initial NC WISEWOMAN Project visit.

- c. Women enrolled in Medicare Part B or Medicaid are not eligible for NC WISEWOMAN Project enrollment or program funded services, unless determined eligible for NC WISEWOMAN HBSS Service Navigation.

B. Continued funding for NC WISEWOMAN Project is based on the Contractor's performance in all areas listed in the table below. Individual program performance indicators are assigned a weighted value.

Minimum Standard	Program Performance Indicator
100%	Percentage of screening target number met or exceeded
100%	Percentage of allocated NC WISEWOMAN Project funds expended for each woman screened
100%	Percentage of NC WISEWOMAN Project participants who receive risk reduction counseling
100%	Percentage of women with abnormal blood pressure values who receive follow-up as defined by NC WISEWOMAN Project policy.
100%	Percentage of NC WISEWOMAN Project participants attend at least one session of health coaching or another lifestyle program as part of their enrollment visit.
≥80%	Percentage of NC WISEWOMAN Project participants who are actively enrolled in health coaching or another lifestyle program receive a second session.
≥60%	Percentage of NC WISEWOMAN Project participants enrolled in a lifestyle program or health coaching complete the lifestyle program or health coaching as defined by NC WISEWOMAN Project policy.
≥30%	Percentage of NC WISEWOMAN Project participants actively enrolled in the program complete a screening cycle.
100%	Percentage of NC WISEWOMAN Project participants with an alert screening value who are seen by a healthcare provider within one week of screening or documentation reflects why this did not occur.

C. Reporting Requirements: All data including initial screening, referrals, follow-up results and intervention data shall be recorded by the contractor in a data system compatible with the North Carolina state data system:

- 1. The Contractor shall enter NC WISEWOMAN patient data into a data system compatible with the North Carolina state data system, transfer the data to the state through the designated secure upload protocol, and separately report the total

women screened no later than the tenth of each month for the previous month's screenings. The state data system uses Common Name Data Service (CNDS) as the unique patient identifier, so to be compatible with the state data system, submission of the CNDS ID is necessary.

2. The Contractor shall not withhold inputting data on any patient when waiting for the completion of follow-up. Even if the data is pending laboratory workup, the screening data shall be entered by the tenth of the month as noted in Subparagraph (1) above.
 3. All test results, including follow-up shall be updated as soon as received and according to NC WISEWOMAN timelines pending findings should be resolved as soon as possible and data in Contractor data system should be updated as necessary.
- D. Comply with the following privacy and security requirements and perform the following tasks in protection of the Division's Confidential Information.
1. The Contractor shall comply with all applicable laws, ordinances, codes, rules, regulations, licensing requirements, electronic storage standards concerning privacy, data protection, confidentiality, and security including those of federal, state, and local agencies having jurisdiction where business services are provided for accessing, receiving, or processing all confidential information.
 2. The Contractor shall implement internal data security measures, firewalls, and other security methods utilizing appropriate hardware and software necessary to monitor, maintain, and ensure data integrity in accordance with all applicable federal regulations, state regulations, DHHS privacy and security policies, and local laws. The Contractor will maintain all security safeguards throughout the term of this agreement. In addition, the Contractor agrees to maintain compliance with the following:

NC DHHS Privacy Manual and Security Manual, both located online at:

<https://policies.ncdhhs.gov/departamental/policies-manuals/section-viii-privacy-and-security/manuals>

NC Statewide Information Security Manual, located online at:

<https://it.nc.gov/statewide-information-security-policies>
 3. If the DHHS Division or Office determines that some or all the activities within the scope of this contract are subject to the Health Insurance Portability and Accountability Act of 1996, P.L. 104-91, as amended (HIPAA), or its implementing regulations, the Contractor agrees to comply with all HIPAA requirements and will execute such agreements and practices as the Division or Office may require ensuring compliance.
 4. The Contractor shall protect the confidentiality of all information, data, instruments, documents, studies, or reports given to the Contractor under this agreement in accordance with the standards of the DHHS privacy and security policies, applicable local laws, state regulations, and federal regulations

including: the Privacy Rule at 45 C.F.R. Parts 160 and 164, subparts A and E, Security Standards at 45 C.F.R. Parts 160, 162 and 164, subparts A and C ("the Security Rule"), and the applicable provisions of the Health Information Technology for Economic and Clinical Health Act (HITECH). The Contractor shall not disclose or make information available to any individual or organization without the prior written consent of the DHHS Division or Office except permitted by this contract for performing its obligations. The Contractor acknowledges that in receiving, storing, and processing confidential information, it will implement necessary privacy and security measures to safeguard all information.

5. The Contractor will implement strong encryption algorithm that meets industry encryption standard criteria as defined by NIST and HIPAA Security Standards to encrypt all confidential information including protected health information (PHI) and personally identifiable information (PII) while in transit to ensure data confidentiality and security.
6. The Contractor shall implement internal data security measures, environmental safeguards, firewalls, access controls, and other security methods utilizing appropriate hardware and software necessary to monitor, maintain, and ensure data integrity in accordance with all applicable federal regulations, state regulations, local laws, and DHHS privacy and security policies. In the event the Contractor obtains written consent by a DHHS Division or Office to enter into a third-party agreement to whom the Contractor provides confidential information, the Contractor shall ensure that such agreement contains provisions reflecting obligations of data confidentiality and data security stringent as those set forth in the contract.
7. In addition to any DHHS Privacy and Security Office (PSO) notification requirements in a Business Associate Agreement (BAA) with a DHHS Division or Office, the Contractor shall report all suspected and confirmed privacy/security incidents or privacy/security breaches involving unauthorized access, use, disclosure, modification, or data destruction to the DHHS Privacy and Security Office at <https://security.ncdhhs.gov> within twenty-four hours after the incident is first discovered. If the privacy or security incident involves Social Security Administration (SSA) data or Centers for Medicare and Medicaid Services (CMS) data, the contractor shall report the incident within one hour after the breach is first discovered. At a minimum, such privacy and security incident report will contain to the extent known: the nature of the incident, specific information about the data compromised, the date the privacy or security incident occurred, the date the Contractor was notified, and the identity of affected or potentially affected individual(s). During the performance of this contract, the contractor is to notify the DHHS Privacy and Security Office of any contact by the federal Office for Civil Rights (OCR) received by the contractor. In addition, the Contractor will reasonably cooperate with DHHS Divisions and Offices to mitigate the damage or harm of such security incidents.
8. If any applicable federal regulations, state regulations, local law, or rules requires the DHHS division/office or the contractor to give affected persons written notice

of a privacy or security breach arising out of the contractor's performance under this contract, the contractor shall bear the cost of the notice.

9. Auditors shall have access to persons and records for all contracts or grants entered by State agencies or political subdivisions in accordance with General Statute 147-64.7. Additionally, as the State funding authority, the Department of Health and Human Services shall have access to persons and records for all contracts or grants entered by State agencies or political subdivision.
10. Records shall not be destroyed, purged, or disposed of without the express written consent of the DHHS Division or Office. State basic records retention policy requires all grant records to be retained for a minimum of five years or until all audit exceptions have been resolved, whichever is longer. If the contract is subject to federal policy and regulations, record retention may be longer than five years. Records must be retained for a period of three years following submission of the final Federal Financial Status Report, if applicable, or three years following the submission of a revised final Federal Financial Status Report. Also, if any litigation, claim, negotiation, audit, disallowance action, or other action involving this Contract has been started before expiration of the five-year retention period described above, the records must be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular five-year period described above, whichever is later. The record retention period for Temporary Assistance for Needy Families (TANF) and MEDICAID and Medical Assistance grants and programs is a minimum of ten years. The record retention period for the Health Insurance Portability and Accountability Act (HIPAA) is six years. For the Internal Revenue Service (IRS) and the Social Security Administration (SSA), the record retention period is seven years.

PERFORMANCE MONITORING AND QUALITY ASSURANCE

A. Contractor responsibilities for quality assurance

1. The Contractor shall follow NC WISEWOMAN Project clinical protocols for follow up of abnormal findings:
 - i. Protocol for follow-up of high blood pressure: The Eighth Report of the Joint National Committee on the Detection, Evaluation and Treatment of High Blood Pressure (JNC VII), published by the National Institutes of Health, National Heart, Lung, and Blood Institute (NHLBI).
 - ii. Protocol for follow-up of abnormal lipid values: 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol: A report of the American College of Cardiology/American Heart Association Task Force on clinical practice guidelines.
2. The Contractor shall:
 - i. Use laboratories certified under the most recent Clinical Laboratory Improvement Amendments (CLIA) for laboratory services including serum total cholesterol, HDL, blood glucose, and/or glycosylated hemoglobin A1c testing.

- ii. Maintain clinical records for each woman receiving NC WISEWOMAN Project services as a part of the patient's individual medical record.
 - iii. Audit a random sample of at least five NC WISEWOMAN patient records at least once annually to check for compliance with program requirements.
 - iv. The Contractor shall respond to NC WISEWOMAN Project evaluation requests in a timely manner. This includes completing evaluation surveys, focus groups, and interviews as outlined in the CDC and NC WISEWOMAN Evaluation plans.
- B. The Cancer Prevention and Control Branch's NC WISEWOMAN Project responsibilities for monitoring
 - 1. NC WISEWOMAN Project staff will conduct a risk assessment of the Contractor. Risk categories will be determined prior to the release of this contract and reassessed at least annually. The Contractor will be categorized as low risk or high risk and will be notified by NC WISEWOMAN Project staff about its categorization prior to the start of this contract. The Contractor's risk category can change at any time and will be reassessed if irregularities are noted. The frequency and intensity of monitoring techniques applied will be directly proportional to the level of risk assigned. A contractor categorized as low risk will receive a detailed monitoring event at least every three years. A contractor categorized as high risk will be notified by letter of the high-risk assessment and a specific date for corrective action and details about the monitoring plan will be defined on the letter. A contractor categorized as high risk will receive a monitoring event at least annually.
 - i. The purpose of the monitoring event is to verify and document timeliness and adequacy of follow up, quality of services, efficiency of operations, and compliance with program requirements.
 - ii. The monitoring event will be conducted on-site at the Contractor if possible. Alternatively, a remote monitoring event may be conducted if travel to the Contractor is not possible.
 - iii. NC WISEWOMAN staff will provide advance notice to the Contractor of the date, time, and location of the monitoring event.
 - 2. NC WISEWOMAN Project staff will review the Contractor's Program Performance Indicators in the access data system (or a data system compatible with the North Carolina state data system) monthly.
 - i. The Contractor's Program Performance Indicators are reviewed monthly and technical assistance is provided as needed.
 - ii. If the Contractor is not meeting monthly performance indicators at the time of the midyear performance evaluation, NC WISEWOMAN Project staff will notify the Contractor that it has been placed on "high risk status" and will require a Corrective Action Plan (CAP). The CAP will be submitted and implemented in the following month.

3. If the Contractor is placed on high-risk status, NC WISEWOMAN Project staff will notify Contractor by letter of high-risk status and a specific date for corrective action and details about the monitoring plan will be identified in the letter. The NC WISEWOMAN staff will provide the Contractor with more frequent technical assistance if there are indications of problems meeting performance requirements or if requested by the Contractor.
4. NC WISEWOMAN Project staff will ensure that Contractor screening goals are based on prior screening performance, compliance with CDC performance indicators, and continued NC WISEWOMAN Project funding.

C. Consequences of Inadequate Performance

1. Failure to meet targets or expend funds as expected may result in reduced targets and funding.
2. If monitoring uncovers deficits, NC WISEWOMAN Project staff will work with the Contractor to correct these deficits.
 - i. Serious ongoing deficits will require development and implementation of a Corrective Action Plan
 - ii. Persistent failure to meet program requirements will result in termination of the contract.
3. If the Contractor terminates or is terminated from the NC WISEWOMAN Project, the Contractor is required to:
 - i. Notify the NC WISEWOMAN Project Program Director of the intent to terminate in a letter written on the Contractor's letterhead and signed by the contract administrator, which includes the effective date of the termination.
 - ii. Identify resources in the community and refer women who have abnormal findings found prior to termination of the WISEWOMAN Project.
 - iii. Notify all current WISEWOMAN participants of closure of the program and offer them assistance to find alternative providers of screening services.
 - iv. Identify alternative resources in the community for patients wishing to continue cardiovascular screening.
 - v. Continue to monitor monthly data reports and provide follow up or corrected information until all cases are closed out.
 - vi. Maintain all WISEWOMAN records and program manuals according to the local record retention schedule.
 - vii. Return any unused NC WISEWOMAN funds.
 - viii. Close out any active WISEWOMAN participants for which funds have been drawn down.

REIMBURSEMENT

A. Financial

1. The Contractor shall be reimbursed at a capitated rate of \$270 per woman (including first health coaching) for providing cardiovascular disease screening services through the NC WISEWOMAN Project for up to the number of women specified in the PERFORMANCE REQUIREMENTS section.
2. If electing to provide optional service for women with Medicaid and private insurance, the Contractor will be reimbursed at a capitated rate of \$180 for healthy behavior support service navigation for Medicaid or Private Insurance participants only. This fee covers the enrollment visit (Risk Reduction Counseling, 1st Health Coaching, data entry, and the 4- to 6-week follow-up). The Contractor is responsible for ensuring that service navigated women do not have clinical services paid through the NC WISEWOMAN Project, but rather their Medicaid or private insurance is billed for the clinical services (i.e., office visit and labs if needed).
3. The contractor shall be reimbursed at a rate of \$15 per session for second and third health coaching sessions for up to the number of women specified in PERFORMANCE REQUIREMENTS section. Additional sessions beyond these will not be reimbursed.
4. The total funds awarded from the NC WISEWOMAN Project shall be maintained by the Contractor in a separate budget cost center to assure proper auditing of expenditures. Funding allocations are based on performance measures as stated in PERFORMANCE STANDARDS section.
5. Monies shall be allocated to ensure achievement of the numbers of health screenings and Health Coaching specified in PERFORMANCE REQUIREMENTS section and payment for NC WISEWOMAN Project-approved services rendered by outside medical providers through subcontracts. These may include medical evaluation for abnormal results. (Refer to the most recent Fee Schedule for WISEWOMAN, available at <https://bcccp.dph.ncdhhs.gov/providers.htm>)
6. The Contractor may submit in writing via email to the Program Manager to request:
 - i. To use awarded HBSS Service Navigation funds to conduct additional regular screening services (i.e., utilize funds for two HBSS Service Navigation targets at a capitated rate of \$180 each to cover one additional regular screening target at a capitated rate of \$270 each)
 - ii. To use awarded regular screening funds to conduct additional HBSS service navigation screenings (i.e., utilize funds for one regular screening target at a capitated rate of \$270 to cover one additional HBSS Service Navigation target at a capitated rate of \$180 each)
 - iii. To use awarded HBSS funds to conduct additional regular or HBSS Service Navigation screenings (i.e., utilize a combination of unused \$15

health coaching session targets) to cover additional regular screening targets at \$270 each or HBSS Service Navigation screening targets at \$180 each)

7. NC WISEWOMAN Project funds shall not be used to reimburse for treatment services. Payment to a subcontractor using NC WISEWOMAN funds is limited to those screening and diagnostic follow-up services listed in the current NC WISEWOMAN Project Services Fee Schedule. Only services listed on the NC WISEWOMAN Project Fee Schedule are reimbursable with Program funds unless prior authorization is obtained from NC WISEWOMAN Project staff
8. The Contractor must submit Contract Expenditure Reports (CER) by the 10th of each month requesting reimbursement for services rendered in the preceding month. CERs must be submitted even when no expenses are incurred in a given month. Failure to submit monthly sequential reports may delay receipt of reimbursement.

B. Payment for Services

1. The payment to subcontractors for any service described in PERFORMANCE REQUIREMENTS section shall not exceed the prevailing Medicare-allowable fee for the service. Fee schedules will be provided to the participating subcontractor by NC WISEWOMAN Project.
2. NC WISEWOMAN Project funds shall only be used for payment after all other third-party payment sources (including private insurance) provide evidence of partial or non-payment of program eligible services. NC WISEWOMAN Project the payer of last resort.
3. Women whose gross incomes are less than or equal to 100% of the federal poverty level cannot be charged for any services covered through NC WISEWOMAN Project. Participants should be notified of any possible charges prior to committing to the procedure.
4. Sliding fee scales may be used for women whose gross incomes are between 101% and 250% of the federal poverty level. A flat fee cannot be charged for NC WISEWOMAN Project services to any woman enrolled in NC WISEWOMAN Project.

C. Contract Budget Adjustments

1. The number of women screened in compliance with performance indicators determined by the number of women that have cardiovascular screening paid partially or in full using NC WISEWOMAN funds.
2. To retain the baseline budget for NC WISEWOMAN for the following fiscal year, the Contractor must screen a minimum of 100% of their allocated number of women awarded each year.
3. The contractor may submit in writing via email to program staff a request to use awarded HBSS funds to meet additional screening or HBSS service navigation

needs; and/or to request to use screening or HBSS service navigation funds awarded to meet additional screening needs.

4. NC WISEWOMAN staff will evaluate Contractor performance midyear. Those Contractors that are not meeting performance indicators midyear will be notified that they have been placed on "high risk status" and will require a Corrective Action Plan (CAP). The CAP shall be submitted and implemented in the following month. A follow up performance review will determine if any budget adjustments are necessary, if these findings suggest that further review of the Contractor's performance is needed:
 - i. A pattern of expenditures that may lead to a surplus of funds in the contract year may result in a one-time budget decrease.
 - ii. Contractors exceeding their targeted numbers and complying with performance indicators may receive additional funds only if available.
 - iii. Contractors not meeting patient targets will be assessed for funding and patient target realignments.
5. Funding adjustments may be made in the baseline budget of Contractors. State accessible data will be reviewed midyear to determine if budget adjustments are indicated based on compliance with performance indicators and patient targets.

Local Health Department Monthly Expenditure Report

LHD Legal Name

Purpose
Screening, follow-up services, and lifestyle behavior support options for cardiovascular disease on behalf of WISEWOMAN eligible women.

Total Expenditure

I hereby certify that the funds requested on the above expenditure report were to the best of my knowledge for women served according to the provisions in the current fiscal year Agreement Addendum. It is also my understanding that this form be completed and faxed before funding is requested in Aid to County, and that required data to support this service and expense will be entered into the state required compatible data system.

Date _____

Date _____

To: Patricia Albert Email: Patricia.Albert@dhhs.nc.gov Fax: 919-870-4812

N.C. Department of Health and Human Services
Division of Public Health
Chronic Disease & Injury/Cancer Prevention: WISEWOMAN
Section/Branch

Contract Expenditure Report

mo/yr of expenditure

Contract ID #:

16001

Contractor

NCAS #:

\$0.00

Project Director

Total Expenditure

To provide NC WISEWOMAN Project cardiovascular disease screening & lifestyle options to BCCCP eligible women.

Purpose

Contractor match is REQUIRED by this contract:

	X
--	----------

(Place an "X" in the appropriate box.)

YES

NO

Item Description	Number of Screenings	Contractor Amount	DHHS Amount
Client Services		Do not use this column.	
Cardiovascular Services			\$0.00
Health Coaching			\$0.00
Diabetes Program Referrals			\$0.00
HBSS Service Navigation			\$0.00
Subtotal			\$0.00
THIS SECTION FOR DPH USE ONLY:			
Company 2B01			
Account	Center		
536C02	1313-3720-AL	WW Federal	\$0.00

As chief executive officer or designee of the contracting organization, I hereby certify that the units billed to DHHS on this public payment voucher have been delivered in accordance with the conditions of the contract, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract

As chief executive officer or designee of the recipient organization, I hereby certify that the cost or units billed for reimbursement on the above Request for Reimbursement were incurred and delivered according to the provisions of the assistance agreement. I further certify that any required matching expenditures have been incurred, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract

Authorized Contractor Printed Name & Title

Signature

Date

Mail to: Appropriate Division Contract Administrator

DHHS-DPH Contract Administrator Signature & Date

DHHS-DPH Branch Head Signature & Date

DHHS-DPH Contract Administrator Printed Name

DHHS-DPH Branch Head Printed Name

CER Tracking Log

[illegible]

Performance Management and Quality Assurance Forms

North Carolina Breast and Cervical Cancer Control Program and WISEWOMAN Project Triennial Program Review

Agency/Contractor: _____ Date of Event: _____

Time Frame Covered by Review: _____ to _____

Cancer Branch Review Team:

☐ Cindy Herndon, Nurse Consultant

☐ Angie Moody, Nurse Consultant

☐ Sherry Wright, Nurse Consultant

Agency personnel present at the entrance conference:

☐ Health Director: _____

☐ Director of Nursing/RN Supervisor: _____

☐ BCCCP Navigator: _____

☐ WISEWOMAN Navigator: _____

☐ _____

Sources utilized for collection of information:

☐ Patient Chart or EMR ☐ HIS/Vendor System ☐ Staff Member ☐ Log Books/Tickler File ☐ Training Manual

Triennial Assessment Worksheet

Breast Cancer Performance Indicator	CDC Standard	FY ____ as of ____
1. Screening mammograms provided to women > 50 years of age	≥ 75%	
☐ Abnormal screening results with complete follow-up	≥ 90%	
☐ Abnormal screening results; Time from screening to diagnosis > 60 days	≤ 25%	
2. Treatment started for breast cancer	≥ 90%	
3. Breast cancer; time from diagnosis to treatment >60 days	≤ 20%	
Cervical Cancer Performance Indicator	CDC Standard	FY ____ as of ____
4. Initial Program Pap test, never screened	≥ 20%	
5. Abnormal screening with complete follow-up	≥ 90%	
6. Abnormal screening results: time from screening to diagnosis >90 days	≤ 25%	
7. Treatment started for diagnosis of HSIL, CIN 2,3, CIS, Invasive Cancer	≥ 90%	
8. HSIL, CIN 2,3; time from diagnosis to treatment >90 days	≤ 20%	
9. Invasive carcinoma; time to diagnosis to treatment >60 days	≤ 20%	

WISEWOMAN Performance Indicators	CDC STANDARD	FY ____ as of ____
1. Percentage of screening target number met or exceeded	100%	
2. Percentage of women receiving valid risk reduction counseling	≥90%	
3. Percentage of follow up for abnormal blood pressure	100%	
4. Percentage of follow up for alert blood pressure	100%	
5. Percentage of women attending at least one session of HBSS or HC.	≥80%	
6. Percentage of women with complete programs	≥60%	

Fiscal Management	Results	Comments
1. Verification that all fee schedules and income eligibility guidelines in use are current	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
2. Evidence that current contracts or letters of agreement are in place with all providers	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
3. Current CLIA certification is on file for laboratory provider(s)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
4. Current MQSA certification is on file for mammography provider(s)	BCCCP ☐ Yes ☐ No	

5. Evidence that a budget monitoring process/system is in place with separate accounts for BCCCP and WISEWOMAN	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
6. Verification that appropriate payment(s) are made for BCCCP/ WW procedures (Review payment invoices and vouchers from encounters reviewed)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
7. Verification that patients are not charged inappropriately for BCCCP/ WW covered services (Verify patient ledger of encounters reviewed)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
8. Verification that sliding scale fee is applied appropriately for income. Consult with the administrative consultants if indicated.	BCCCP ☐ Yes ☐ No ☐ NA WISEWOMAN ☐ Yes ☐ No ☐ NA	
9. Evidence that BCCCP/WW funds are requested on the basis of the number of women served (and Health Coaching or Lifestyle Program sessions for WISEWOMAN)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
<u>Clinical Management</u>	<u>Results</u>	<u>Comments</u>
1. A review of not less than 5 or more than 10 medical records and documents to include normal and abnormal findings.		
a. Consent Form is current, signed and dated annually	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
b. HIPAA consent is signed and current relative to agency policy	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
c. Documentation of all referrals to a medical provider for evaluation of abnormal results is present	BCCCP ☐ Yes ☐ No ☐ NA WISEWOMAN ☐ Yes ☐ No ☐ NA	
d. Patient education is documented (i.e., Colorectal cancer screening, physical activity, nutrition, smoking behavior, insurance information, etc.)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	

e. Patients are informed of results of examinations and all test results	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
f. Documentation is present of all attempts to notify patient of abnormal results [The third attempt must be documented by certified letter return receipt.]	BCCCP ☐ Yes ☐ No ☐ NA WISEWOMAN ☐ Yes ☐ No ☐ NA	
g. Documentation of outcome of all follow up services provided to patient is present	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
h. Case closure due to non-compliant patient is documented Patient status is updated/ documented	BCCCP ☐ Yes ☐ No ☐ NA WISEWOMAN ☐ Yes ☐ No ☐ NA	
i. Pap test reports are filed in medical record	☐ Yes ☐ No ☐ NA	
j. Mammogram results are filed in medical record	☐ Yes ☐ No ☐ NA	
k. Patient Navigation for abnormal/alert findings is appropriately documented: BCCCP - Needs Assessment ☐ Yes ☐ No ☐ NA Patient Navigation Plan ☐ Yes ☐ No ☐ NA WISEWOMAN - Needs Assessment ☐ Yes ☐ No ☐ NA Patient Navigation Plan ☐ Yes ☐ No ☐ NA		
l. BCCM application is completed for all eligible women	☐ Yes ☐ No ☐ NA	
2. Evidence of a tracking system in place for follow up of abnormal results and annual rescreening (i.e., computer program, notebook, tickler cards, logs)	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
3. Evidence that appropriate materials for patient education are available and provided	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	
4. Evidence of accurate medical record documentation	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA	

5. Medical record organization is logical and consistent	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
<u>General Management</u>	<u>Results</u>	<u>Comments</u>										
1. Evidence that BCCCP and WW patient services are discussed as part of a policy and procedure/ clinical service review	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
2. Evidence of a regular schedule (at least annually) of clinical record reviews conducted by staff and corrective plans made and implemented for identified deficiencies	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
3. Are there additional quality improvement exercises conducted regularly? (Describe in "Comments")	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
4. Are standing orders/protocols in NC Board of Nursing format?	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
5. Evidence that ERRN competencies are maintained according to UNC guidelines	☐ Yes ☐ No											
6. Evidence of timely submission of patient services/data following the date of service	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
7. Evidence that clinical forms are current and reflect required program data fields	BCCCP ☐ Yes ☐ No WISEWOMAN ☐ Yes ☐ No ☐ NA											
8. Current copies of the following information are available and accessible? <table border="0"> <tr> <td><u>Breast & Cervical Cancer Control Program</u></td> <td><u>Responses</u></td> </tr> <tr> <td>■ BCCCP Training Manual</td> <td>☐ Yes ☐ No</td> </tr> <tr> <td>■ BCCCP Patient Navigation Kit (Included in PY 21-22 Training Manual)</td> <td>☐ Yes ☐ No</td> </tr> <tr> <td>■ Breast and Cervical Screening Manuals: A Guide for Health Departments and Providers</td> <td>☐ Yes ☐ No</td> </tr> <tr> <td>■ Recruitment and Education Resource Notebook</td> <td>☐ Yes ☐ No</td> </tr> </table>			<u>Breast & Cervical Cancer Control Program</u>	<u>Responses</u>	■ BCCCP Training Manual	☐ Yes ☐ No	■ BCCCP Patient Navigation Kit (Included in PY 21-22 Training Manual)	☐ Yes ☐ No	■ Breast and Cervical Screening Manuals: A Guide for Health Departments and Providers	☐ Yes ☐ No	■ Recruitment and Education Resource Notebook	☐ Yes ☐ No
<u>Breast & Cervical Cancer Control Program</u>	<u>Responses</u>											
■ BCCCP Training Manual	☐ Yes ☐ No											
■ BCCCP Patient Navigation Kit (Included in PY 21-22 Training Manual)	☐ Yes ☐ No											
■ Breast and Cervical Screening Manuals: A Guide for Health Departments and Providers	☐ Yes ☐ No											
■ Recruitment and Education Resource Notebook	☐ Yes ☐ No											

9. Current copies of the following information available and accessible?

WISEWOMAN Project

- | | | | |
|---|------------------------------|-----------------------------|-----------------------------|
| ■ WISEWOMAN Training Manual | ☐ Yes | ☐ No | ☐ NA |
| ■ Med South Lifestyle Program Manual | ☐ Yes | ☐ No | ☐ NA |
| ■ 2017 ACC/AHA and JNC8 Hypertension Guidelines | ☐ Yes | ☐ No | ☐ NA |
| ■ 2018 AHA/ ACC/ AACVPR/ AAPA/ ABC/ ACPM/ ADA/ AGS/ APhA/ ASPC/ NLA/ PCNA <i>Guideline on the Management of Blood Cholesterol</i> | ☐ Yes | ☐ No | ☐ NA |
| ■ American Diabetes Association Clinical Practice Recommendations | ☐ Yes | ☐ No | ☐ NA |

Additional Comments or Findings: _____

Name and Title of Agency Persons at Exit Conference

- ☐ Cindy Herndon, Nurse Consultant
- ☐ Angie Moody, Nurse Consultant
- ☐ Sherry Wright, Nurse Consultant
- ☐ _____
- ☐ Health Director: _____
- ☐ Director of Nursing/RN Supervisor: _____
- ☐ BCCCP Navigator: _____
- ☐ WISEWOMAN Navigator: _____
- ☐ _____
- ☐ _____

Agency Comments at Exit Conference

North Carolina Breast and Cervical Cancer Control Program and WISEWOMAN Project
Pre-Assessment Survey **MUST** be completed & returned prior to Triennial Program Review

Agency/Contractor

BCCCP Navigator: _____ **WISEWOMAN Navigator:** _____

Assessment Completed By: _____
(Name) (Position/Job Title) (Date)

Performance Management		
Breast Cancer Performance Indicator	CDC Standard	FY _____ as of _____
1. Screening mammograms provided to women > 50 years of age	≥ 75%	
2. Abnormal screening results with complete follow-up	≥ 90%	
3. Abnormal screening results; Time from screening to diagnosis > 60 days	≤ 25%	
4. Treatment started for breast cancer	≥ 90%	
5. Breast cancer; time from diagnosis to treatment >60 days	≤ 20%	
Cervical Cancer Performance Indicator	CDC Standard	FY _____ as of _____
6. Initial Program Pap test, rarely or never screened	≥ 20%	
7. Abnormal screening with complete follow-up	≥ 90%	
8. Abnormal screening results: time from screening to diagnosis >60 days	≤ 25%	
9. Treatment started for diagnosis of HSIL, CIN 2,3, CIS, Invasive Cancer	≥ 90%	
10. HSIL, CIN 2,3; time from diagnosis to treatment >90 days	≤ 20%	
11. Invasive carcinoma; time to diagnosis to treatment >60 days	≤ 20%	
Screening Rate	Most recent 12-month period _____ to _____	Previous 12-month period _____ to _____
12. What is your screening rate for mammograms? (Number of women who receive age-appropriate mammograms divided by the number of women who are due for a mammogram during a one-year period)	_____ %	_____ %
13. What is your screening rate for cervical cancer screening (Pap and/or HPV testing)? (Number of women who receive age-appropriate cervical cancer screening divided by the number of women who are due for screening during a one-year period)	_____ %	_____ %
WISEWOMAN PERFORMANCE INDICATORS	CDC STANDARD	FY _____ as of _____
1. Percentage of screening target number met or exceeded	≥95%	
2. Percentage of women receiving valid risk reduction counseling	100%	
3. Percentage of follow up for abnormal blood pressure	100%	
4. Percentage of follow up for alert blood pressure or glucose.	100%	
5. Percentage of women attending first session of LSP or HC	100%	
6. Percentage of women attending second LSP or HC session	≥80%	
7. Percentage of women who complete program	≥60%	

Patient Eligibility & Enrollment	Response		
1. All women enrolled in our BCCCP/WW Project meet the program financial eligibility requirements – under 250% of FPG for current fiscal year.	☐ Yes ☐ No		
2. Income for program eligibility is assessed by:	☐ Self-declaration ☐ Written documentation ☐ Other: _____		
3. BCCM income eligibility is verified and documented in the patient medical record	☐ Yes ☐ No ☐ NA		
4. Patient insurance information is documented in the medical record Some other records? _____ Where? _____	☐ Yes ☐ No ☐ Yes ☐ No ☐ NA		
5. The BCCCP/WW income guidelines are updated each year.	☐ Yes ☐ No		
6. Patients are enrolled in BCCCP/WW program through the following mechanisms:	☐ Self Referral ☐ Internal agency referrals ☐ Other (please specify): _____		
Fiscal Management	Response		
7. List the name and title of person(s) responsible for the management of federal and state BCCCP and/or WW budget and expenditures. Name: _____ Title: _____ Name: _____ Title: _____			
8. The BCCCP/WW navigator(s) participate(s) in management of program budgets.	☐ Yes ☐ No		
9. a. Total funds allocated for FY	9a. ☐ Federal \$ _____	☐ State \$ _____	☐ WW \$ _____
b. Reimbursement requested to date	9b. ☐ Federal \$ _____	☐ State \$ _____	☐ WW \$ _____
c. Other local funds allocated for FY (e.g., Komen, ACS, agency funds, etc.)	9c. ☐ BCCCP \$ _____		☐ WW \$ _____
10. Does the agency apply a Sliding Fee Scale for BCCCP/WW services?	☐ Yes ☐ No		
11. Are women charged for BCCCP/WW covered services?	☐ Yes ☐ No		
12. Please forward a copy of the following items to the attention of Tavonya Thompson, Operations Manager, via fax at (919) 870-4812 or electronically at Tavonya.Thompson@dhhs.nc.gov : a. Accounting policy & procedure ☐ Sent via ☐ fax ☐ email Date: _____ b. Most recent approved agency budget ☐ Sent via ☐ fax ☐ email Date: _____ c. Most recent agency audit (as well as findings and response, if applicable) ☐ Sent via ☐ fax ☐ email Date: _____			
Contracts			
12. Name and title of the person(s) who has responsibility for ensuring that contracts for all services are current. Name: _____ Title: _____ Name: _____ Title: _____			
13. Current contracts or letters of agreement are on file for the following services: ☐ Breast U/S ☐ Colposcopy ☐ Fine Needle Aspiration			

BCCCP/WISEWOMAN Pre-Assessment Survey

☐ Pathology ☐ Radiology ☐ Surgical Consult ☐ WISEWOMAN Medical Evaluation ☐ Mammograms – the contracted facility is accredited under the Mammography Quality Standards Act (MQSA) regulations ☐ Pap tests – the facility is certified under the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) ☐ WISEWOMAN Lab Services – the facility is certified under the most recent Clinical Laboratory Improvement Amendments (CLIA) or other approved certification.		
14. Laboratory services for pap testing are provided by:	Name of Lab/Facility:	
15. Analysis of blood for Total Cholesterol, HDL, and Glucose/A1C is conducted	☐ Onsite ☐ Offsite (If off site please provide name of reference lab _____)	
16. a. The CLIA Certificate for the onsite lab is current b. The CLIA Certificate for the offsite lab is current	a. ☐ Yes ☐ No ☐ NA b. ☐ Yes ☐ No ☐ NA	
17. Contracts for ALL services provided above are reviewed and renewed annually ☐ Yes ☐ No		
18. List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Additional worksheets for this question are attached for your use. Name and Title: _____ Agency or Organization: _____ Address: _____ _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education
<u>Continuous Quality Improvement</u>		
19. The agency adheres to tobacco-free campus standards as described in NC G.S. 130A-498	☐ Yes ☐ No	
20. The agency conducts continuous quality improvement activities at least annually (describe: _____)	☐ Yes ☐ No	
21. Policies and procedures are reviewed and updated at least annually	☐ Yes ☐ No	
22. For WISEWOMAN providers: Policy in place for management of patients with abnormal blood pressure results (including alert blood pressure and undiagnosed hypertension)	☐ Yes ☐ No	
23. For WISEWOMAN providers: Does your agency provide team-based care?	☐ Yes ☐ No	
24. Standing orders/protocols are in NC Board of Nursing format and are reviewed and updated at least annually	☐ Yes ☐ No	
25. An electronic health record policy has been submitted to the NC State Archives (required for LHDs/ highly recommended for contract providers)	☐ Yes ☐ No	
<u>Clinical Procedures & Program Resources</u>		
26. Current copies of the following are available and accessible to all relevant staff:		
<u>Breast & Cervical Cancer Control Program</u> ■ BCCCP Training Manual ■ BCCCP Patient Navigation Kit (included in PY 21-22 Training Manual)	<u>Responses</u> ☐ Yes ☐ No ☐ Yes ☐ No	

BCCCP/WISEWOMAN Pre-Assessment Survey

- Breast and Cervical Screening Manuals: A Guide for Health Departments and Providers
- Recruitment and Education Resource Notebook

☐ Yes ☐ No

☐ Yes ☐ No

WISEWOMAN Project

- WISEWOMAN Training Manual
- Med South Lifestyle Program Manual
- 2017 ACC/AHA and JNC-7 hypertension guidelines
- 2018 AHA/ACC/AACVPR/AAPA/ABC/ACPM/ADA/AGS/APhA/ASPC/NLA/PCNA Guideline on the Management of Blood Cholesterol
- American Diabetes Association Clinical Practice Recommendations

Responses

☐ Yes ☐ No ☐ NA

☐ Yes ☐ No ☐ NA

☐ Yes ☐ No ☐ NA

☐ Yes ☐ No ☐ NA

☐ Yes ☐ No ☐ NA

27. The BCCCP/WISEWOMAN Training Manual is updated annually.

☐ Yes ☐ No

28. In which clinics are BCCCP/WISEWOMAN participants screened?

☐ BCCCP Clinic (schedule) _____

☐ General adult health clinic (schedule) _____

☐ Both of above (schedule) _____

☐ Primary Care Clinic (schedule) _____

☐ Other (schedule) _____

29. Referrals to providers outside of your agency are documented on what form?

☐ DHHS 2734 (Referral/Follow-up Form)

☐ Other agency form _____

30. Name and title of person(s) responsible for coordinating follow-up and providing patient navigation of patients with abnormal clinical results:

Name: _____ Title: _____

Name: _____ Title: _____

31. Evidence-based interventions (EBIs) are used to increase community demand, community access, and/or provider delivery

- a. Client reminders (cards, letters, phone calls, etc.)
- b. Minimize administrative barriers (simplify enrollment protocol, enhance clinic flow, etc.)
- c. Provide alternative screening sites (breast care center, mobile exam unit, etc.)
- d. Provide alternative screening hours (evening, weekend, etc.)
- e. Provide transportation
- f. Provide translation
- g. Provide childcare
- h. Provider reminders (chart flags, EHR/EMR flags, spreadsheet, reports, etc.)
- i. Other _____

a. ☐ Yes ☐ No

b. ☐ Yes ☐ No

c. ☐ Yes ☐ No

d. ☐ Yes ☐ No

e. ☐ Yes ☐ No

f. ☐ Yes ☐ No

g. ☐ Yes ☐ No

h. ☐ Yes ☐ No

i. ☐ Yes ☐ No

BCCCP/WISEWOMAN Pre-Assessment Survey

32. Are activities conducted to connect community residents to breast and cervical cancer screening services and/or increase screening in the population? a. Community Health Worker outreach b. Patient navigation program c. Presentations to service organizations (women's clubs, etc.) d. Faith-based outreach e. Work-site outreach/presentations f. Other _____	a. ☐ Yes ☐ No b. ☐ Yes ☐ No c. ☐ Yes ☐ No d. ☐ Yes ☐ No e. ☐ Yes ☐ No f. ☐ Yes ☐ No				
33. Community outreach activities are conducted at least once per year Please describe _____ _____ _____	☐ Yes ☐ No				
34. A directory of community resources is available as a patient handout	☐ Yes ☐ No				
35. Survivor resources are offered to patients who are diagnosed with breast or cervical cancer or precancer	☐ Yes ☐ No				
36. Each patient signs a consent form annually to participate in: a. BCCCP b. WISEWOMAN	a. ☐ Yes ☐ No b. ☐ Yes ☐ No ☐ NA				
37. Notification of Receipt of Privacy Practices is signed, dated and in the chart a. BCCCP b. WISEWOMAN	a. ☐ Yes ☐ No b. ☐ Yes ☐ No ☐ NA				
38. Identify all health care professionals responsible for providing services to BCCCP women and/or clinical assessments and/or team-based care to WISEWOMAN participants in your agency. Additional worksheets for this question are attached for your use. Name: _____ Position: (RN, MD, NP, PA) _____ Agency or Organization: _____	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr style="background-color: #cccccc;"> <th colspan="2" style="text-align: left; padding: 5px;">Additional training completed:</th> </tr> <tr> <td style="width: 50%; padding: 5px; vertical-align: top;"> <u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____ </td> <td style="width: 50%; padding: 5px; vertical-align: top;"> <u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____ </td> </tr> </table>	Additional training completed:		<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____
Additional training completed:					
<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____				
Our program requests consultation from Cancer Branch staff in the following areas: <table style="width: 100%;"> <tr> <td style="width: 33%; vertical-align: top; padding: 5px;"> <u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____ </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____ </td> <td style="width: 33%; vertical-align: top; padding: 5px;"> <u>ADDITIONAL NEEDS</u> Check all that apply: ☐ Fiscal Management/contracts ☐ Data training ☐ Program Orientation ☐ Recruitment and Community Resources ☐ Other _____ </td> </tr> </table>		<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____	<u>ADDITIONAL NEEDS</u> Check all that apply: ☐ Fiscal Management/contracts ☐ Data training ☐ Program Orientation ☐ Recruitment and Community Resources ☐ Other _____	
<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____	<u>ADDITIONAL NEEDS</u> Check all that apply: ☐ Fiscal Management/contracts ☐ Data training ☐ Program Orientation ☐ Recruitment and Community Resources ☐ Other _____			
<u>Comments:</u> _____ _____					

Additional Sheet for Question 18 (Please make additional copies of this page, as needed)

List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Name and Title: _____ Agency or Organization: _____ Address: _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education
List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Name and Title: _____ Agency or Organization: _____ Address: _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education
List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Name and Title: _____ Agency or Organization: _____ Address: _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education
List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Name and Title: _____ Agency or Organization: _____ Address: _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education
List all health care professionals and/or agencies to whom you refer women receiving BCCCP/WW services. Name and Title: _____ Agency or Organization: _____ Address: _____	<u>BCCCP</u> ☐ Mammography ☐ Follow-up abnormal breast ☐ Follow-up abnormal cervix ☐ Surgical consult ☐ Other _____	<u>WISEWOMAN</u> ☐ WISEWOMAN Medical Evaluation ☐ Nutrition Services ☐ Physical Activity ☐ Smoking Cessation ☐ Diabetes Education

Extra Sheet for Question 38 (Please print additional copies of this page, as needed)

BCCCP/WW Professionals	Additional training completed:	
Identify all health care professionals responsible for providing services to BCCCP women and/or clinical assessments and/or team-based care to WISEWOMAN participants in your agency. Name: _____ Position: (RN, MD, NP, PA) _____ Agency or Organization: _____	<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____
Identify all health care professionals responsible for providing services to BCCCP women and/or clinical assessments and/or team-based care to WISEWOMAN participants in your agency. Name: _____ Position: (RN, MD, NP, PA) _____ Agency or Organization: _____	<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____
Identify all health care professionals responsible for providing services to BCCCP women and/or clinical assessments and/or team-based care to WISEWOMAN participants in your agency. Name: _____ Position: (RN, MD, NP, PA) _____ Agency or Organization: _____	<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____
Identify all health care professionals responsible for providing services to BCCCP women and/or clinical assessments and/or team-based care to WISEWOMAN participants in your agency. Name: _____ Position: (RN, MD, NP, PA) _____ Agency or Organization: _____	<u>BCCCP</u> Check all that apply: ☐ Physical Assessment of Adults ☐ BCCCP Orientation ☐ BCCCP Patient Navigation ☐ Breast & Cervical Cancer Medicaid (BCCM) ☐ Clinical Breast Exam ☐ Other _____	<u>WISEWOMAN</u> Check all that apply: ☐ WISEWOMAN Orientation ☐ Med South Orientation ☐ Blood Pressure Measurement Review ☐ Other _____

**NORTH CAROLINA
BREAST AND CERVICAL CANCER CONTROL PROGRAM/WISEWOMAN
Monitoring Committee Findings
& Corrective Action Template**

Agency: _____

Date of Monitoring Event: _____

FY _____

After the monitoring event is complete, a summary of findings will be discussed by the monitoring team with provider staff at the end of the event. Copies of the monitoring reports will be sent to the appropriate members of the program staff within 60 days.

A Corrective Action Plan (CAP) needs to be submitted **and implemented within 60 days** addressing each out-of-compliance issue identified using the following template:

The Monitoring Team will re-evaluate 6-12 months after the corrective action plan is approved.

Continuation of the provider's service contract will be evaluated based upon the ability to meet performance indicators for delivery of contract services and monitoring criteria.

Compliance Issues	Agency Corrective Action Plan (CAP) Response	Person Responsible	Implementation Date

Quality Improvement Recommendations

Agency: _____

Date of Monitoring Event: _____

FY _____

The following Quality Improvement Recommendations do not require a Corrective Action Plan. These are recommendations which the NCBCCCP and WISEWOMAN Project strongly recommend.

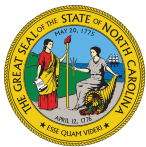
Guidance from the Monitoring Review Team	Agency Plan of Action

WISEWOMAN Provider Agency _____

Date _____

Reviewer(s) _____

Legend: ✓ =Yes P = Partial O=No N/A =Not Applicable	WISEWOMAN CLINICAL RECORD REVIEW							
Records (# - last 4 digits)								
Dates of Service								
BCCCP/WW Integration								
Consent/Release of Information								
BCCCP Eligibility								
Level of Education								
Team-based Care								
Policy for Management of Abnormal/Alert BP								
History - Clinical Screening								
Health Assessment Complete								
Height and Weight Measurement								
Blood Pressure 1 st and 2 nd Measurement								
Cholesterol/ HDL/ LDL								
Fasting Glucose or HgA1C								
Risk Reduction Counseling								
Counseling Date								
Smoker referred to QuitlineNC or other resource								
Educational Interventions								
Patient referred to HC/ HBSS								
Additional HC/ HBSS sessions, if referred								
4-6 week post HC/ HBSS in-person follow-up								
Abnormal/Alert BP follow up								
In-house clinical evaluation/physician referral								
Patient Notification								
Referral Results								
Refusal Documented								
Abnormal Cholesterol follow up								
Patient Notification								
In-house clinical evaluation/physician referral								
Referral Results								
Refusal Documented								
Abnormal Blood Glucose follow up								
Patient Notification								
In-house clinical evaluation/physician referral								
Referral Results								
Refusal Documented								
Patient Navigation								
Needs assessment/Care plan/Documentation								
Clinical Rescreening								
11-18 month re-screening								



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**
Division of Public Health



NC WISEWOMAN

Well-Integrated Screening and Evaluation for Women Across
the Nation • www.ncdhhs.gov/divisions/public-health • NCDHHS
is an equal opportunity employer and provider. • 3/23