CASE STUDY:
Increasing Physician Screening, Testing, and Referral of WISEWOMAN Program Participants to Evidence-Based Hypertension Management Programs
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>2</td>
</tr>
<tr>
<td>WISEWOMAN Program</td>
<td>4</td>
</tr>
<tr>
<td>Grantee Summaries</td>
<td>6</td>
</tr>
<tr>
<td><em>Mission of Hope Clinic</em></td>
<td>8</td>
</tr>
<tr>
<td><em>Truman Medical Centers</em></td>
<td>13</td>
</tr>
<tr>
<td>Lessons Learned</td>
<td>17</td>
</tr>
<tr>
<td>References</td>
<td>21</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>23</td>
</tr>
</tbody>
</table>
Introduction

Hypertension — The Challenge

Accounting for 1 in every 4 deaths, heart disease is the leading cause of death for women in the United States.\(^1\) Stroke is the fourth leading cause of death for women.\(^2\) Hypertension increases the risk for heart disease and stroke,\(^3\) and blood pressure control among those with hypertension can substantially reduce the risk of these highly prevalent diseases.\(^4\)

- Cardiovascular deaths in middle-aged women have increased because of the effects of modifiable risk factors such as obesity.\(^5\)
- Twenty-eight percent of women aged 45–54 years and 52% of women aged 55–64 years have hypertension.\(^6\) Among persons with hypertension, 40.3% of women aged 45–54 years and 34.8% of women aged 55–64 years have uncontrolled high blood pressure.\(^6\)
- Approximately 20% of adults in the United States with hypertension report that having no health insurance was the biggest barrier to health care access.\(^7\)

The Solution

Hypertension and cardiovascular disease (CVD) can be prevented by addressing lifestyle factors such as unhealthy diet, physical inactivity, tobacco use, and harmful use of alcohol. Additionally, research has shown that a team-based care model is most effective in improving outcomes for hypertension and CVD. This model should include the patient, primary care provider, and other health professionals (e.g., nurses, pharmacists, community health workers, patient navigators, dietitians, social workers, etc.).\(^8,9\) In addition to team-based care, self-measured blood pressure monitoring (SMBP) allows patients to use personal blood pressure monitoring devices to record their blood pressure at home or in other settings outside of the health care setting.\(^10,11,12\) SMBP with clinical support (e.g., one-on-one counseling, web-based or telephonic support tools, or education) from a clinical team member can improve the quality of care and subsequently improve blood pressure control and reduce the risk of disability and mortality associated with uncontrolled hypertension.\(^12,13,14\) The combination of team-based care and SMBP with clinical support has also been shown to improve patient knowledge, improve the health system process, and enhance medication adherence.\(^11\) Hypertension control interventions involving SMBP with clinical support have been used to address patient barriers such as cost and access to health care services, but concern remains regarding the ability to integrate SMBP with clinical support into standard clinical practices.\(^15\)
Starting in the fall of 2015, the American College of Preventive Medicine (ACPM) was funded by the Centers for Disease Control and Prevention’s (CDC) Division for Heart Disease and Stroke Prevention (DHDSP) for a three (3) year project to research and develop new lifestyle medicine curriculum courses and educational materials designed specifically for the needs of providers in the Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN) program.

During the first two years of the project, ACPM researched and developed four (4) lifestyle medicine courses and educational materials designed specifically for the needs of WISEWOMAN providers, as well as a three (3) part webinar series, and a resource toolkit that included practical lifestyle medicine tools and skills that providers can implement in their current practices. These newly developed resources assist providers in prescribing lifestyle modifications for women in their practice who are at high-risk for hypertension and CVD.

In the third year of the project, ACPM provided demonstration project grants to two (2) provider groups in the amount of $15,000 to implement and/or strengthen strategies to increase hypertension awareness, screening, and referral to evidence-based programs such as the YMCA’s Blood Pressure Self-Management (BPSM) program.

During the four (4) month demonstration project period, the selected provider groups successfully developed tools and resources including, but not limited to, case studies, physician education materials, provider workflows and methods to increase the promotion and dissemination of CDC, DHDSP, and other existing online resources.
The WISEWOMAN program serves low-income, uninsured, or underinsured women aged 40 to 64 years, with CVD and stroke risk factors by providing screenings, testing, and services that promote healthy behaviors to reduce the risk for CVD and stroke. The CDC provides funding to local WISEWOMAN programs to enable qualifying women to receive free screenings and counseling to discuss their risk for heart disease and stroke. Women are then supported as they participate in healthy behavior support services that include evidence-based lifestyle programs, individual health coaching, and community resources. The services provided by each WISEWOMAN program vary, but all are designed to promote lifelong heart-healthy lifestyle changes. Diagram 1 illustrates the services provided by the WISEWOMAN program.

*Diagram 1. WISEWOMAN Program Services*

The WISEWOMAN program aims to improve the delivery of heart disease and stroke prevention services by focusing on reducing CVD risk factors—specifically improving blood pressure control—among high-risk women. WISEWOMAN helps integrate innovative and evidence-based approaches to heart disease and stroke prevention within health care systems and throughout
communities. The WISEWOMAN program helps women understand and reduce their risk for heart disease and stroke and promotes lasting heart-healthy lifestyles.

At the time of this case study, the WISEWOMAN program consisted of 21 programs in 19 states and 2 tribal organizations. As of June 2017, the WISEWOMAN program has served over 79,000 women —91% of whom had at least one risk factor for heart disease and stroke—and provided nearly 126,000 healthy behavior support services to reduce these women’s risk for heart disease and stroke.\(^{16}\) Diagram 2 depicts the states and tribal organizations that received fiscal year 2017 funding from the WISEWOMAN program.

**Diagram 2. WISEWOMAN Program Fiscal Year 2017 Map**

Source: [https://www.cdc.gov/wisewoman/locations/index.htm](https://www.cdc.gov/wisewoman/locations/index.htm)
Grantee Summaries

ACPM selected two grantees in early 2018 for the demonstration project:
- Mission of Hope Clinic – Raytown, MO
- Truman Medical Centers, University Health Community Care at Linwood – Kansas City, MO

STRATEGIC PARTNER

The YMCA’s BPSM program is one part of the YMCA of the USA’s (Y-USA) suite of evidence-based chronic disease prevention programs. As of February 2018, the program was offered at 176 sites in 28 states. The program focuses on regulated home self-monitoring of one’s blood pressure using proper measuring techniques, individualized support, and nutrition education for better blood pressure management. With support from a trained Healthy Heart Ambassador, participants learn to measure and record their blood pressure, attend personalized consultations, and attend Nutrition Education Seminars. Healthy Heart Ambassadors also communicate with the patient’s primary care provider regarding the blood pressure logs and visits. Table 1 provides an overview of the YMCA’S BPSM program.

Table 1. Overview of the YMCA’s BPSM program

<table>
<thead>
<tr>
<th>YMCA’s BPSM Program</th>
<th>Program Components</th>
<th>Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A 4-month program focused on key behaviors and education to support lifestyle modification</td>
<td>Blood pressure self-monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Nutrition education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Personalized support from a health coach (Healthy Heart Ambassador)</td>
</tr>
<tr>
<td></td>
<td>Two personalized office hour consultations per month (10–15 minutes each) with a Healthy Heart Ambassador</td>
<td>How to use blood pressure cuff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encourage self-monitoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review blood pressure log</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discuss barriers to lifestyle change</td>
</tr>
<tr>
<td></td>
<td>Weekly check-ins from a Healthy Heart Ambassador</td>
<td>Encourage sharing of data with primary care provider</td>
</tr>
<tr>
<td></td>
<td>Monthly nutrition education seminar</td>
<td>Check-ins via email, phone, or text massage</td>
</tr>
<tr>
<td></td>
<td>3-month family membership provided if the patient meets 1-month milestones</td>
<td>Overview of the DASH diet</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reducing sodium intake</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tips for shopping, preparing, and cooking food for better blood pressure management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Heart healthy eating for life</td>
</tr>
<tr>
<td></td>
<td>i.e., attends two office visits and one nutritional seminar</td>
<td></td>
</tr>
</tbody>
</table>
PURPOSE OF THIS CASE STUDY

This case study documents the experiences of Mission of Hope Clinic and Truman Medical Centers, University Health Community Care at Linwood in referring patients to the BPSM program at the YMCA of Greater Kansas City. This case study discusses the approaches, barriers, and the scalability plans of each organization. This information will be helpful to other healthcare organizations, practices, and/or providers interested in developing and implementing models for screening and referring high-risk and WISEWOMAN patients to evidence-based blood pressure self-management programs. Although the grantees served similar target populations, there was variability between the grantees regarding organizational size, organizational structure, staffing models, and resources. This variability of grantees makes the case study examples more relevant as models for use by the diverse clinical entities that strive to meet the needs of women who are at high-risk for hypertension and CVD.
Mission of Hope Clinic

BACKGROUND

Mission of Hope Clinic is a stand-alone safety net clinic located in Raytown, Missouri. The clinic serves uninsured and underserved populations in the entire Kansas City metropolitan area (including Jackson, Platte, Clay, Johnson, and Wyandotte counties) by offering acute and chronic care services, laboratory services, and dental services. The Kansas City metropolitan area comprises the urban core of Kansas City, as well as surrounding suburban and rural communities. The clinic currently serves a higher ratio of Hispanic patients (38% of total patient population at the clinic). As of 2013, the poverty rate in Jackson County increased by 50% since 2000 (an increase of 38,629 unique individuals). Diagram 3 describes the demographics of Jackson County, Missouri.

Diagram 3. Demographics of Jackson County, Missouri

The clinic receives referrals from all the major Kansas City metropolitan area hospitals, including Truman Medical Centers, Research Medical Center, and St. Luke’s Hospital of Kansas City. The clinic serves as a healthcare home for patients needing complex acute and chronic care, until they are able to procure insurance. The clinic’s staffing model includes one paid nurse practitioner, four volunteer nurse practitioners, two volunteer physicians, and three volunteer dentists.
PRE-DEMONSTRATION PROJECT APPROACH

Prior to its involvement in the demonstration project, the clinic had no involvement in any formal SMBP clinical support. However, patients received lifestyle modification recommendations, medication management, and handouts on nutrition and exercise.

DEMONSTRATION PROJECT

Patients were referred to the YMCA’s BPSM program through one of the following pathways as shown in Diagram 4:

- **Point of care** – Patients were initially required to return for a second visit after the first elevated blood pressure prior to the referral, but this was later revised so that patients could be referred at the initial visit with the provider.
- **Retrospective electronic medical record (EMR) query** – Staff retrieved information from previously entered electronic medical records. Retrospective EMR queries can be done based on vital signs and/or ICD-10 (International Classification of Diseases, Tenth Edition) descriptors.
- **Outreach** – Staff contacted the list of women eligible for WISEWOMAN program services (list provided by the Missouri Department of Health and Senior Services as part of its WISEWOMAN program process). Eligible patients were contacted by the program coordinator or a YMCA of Greater Kansas City Healthy Heart Ambassador to assess their interest in the referral (Mission of Hope established a business associate agreement with the YMCA of Greater Kansas City for a YMCA outreach staff member to provide support to the demonstration project).
A referral order was placed via the EMR (and/or a care coordination note was completed, as appropriate). The clinic’s WISEWOMAN coordinator completed the YMCA’s BPSM program intake form and sent the form to the Healthy Living Community Coordinator at the YMCA of Greater Kansas City via secure fax and/or email. Once referred to the program, patients received an agreement form, program outline, blood pressure cuff, and home recording forms.

The YMCA of Greater Kansas City sent the Mission of Hope Clinic health care team progress notes reflecting participant attendance; blood pressure, weight, and physical activity data; a summary of any health issues or medication compliance concerns that have arisen; a summary of key social issues or other factors impacting the patient’s health and wellness; and the date of the next scheduled visit. The YMCA uses a protocol to determine if the health care team should be contacted regarding urgent issues. The YMCA’s Healthy Heart Ambassador also encourages program participants to bring their blood pressure cuff and blood pressure log to their next scheduled clinic visit.
MEASURES OF SUCCESS

Thirty-five (35) patients receiving services at Mission of Hope Clinic through the WISEWOMAN program met the eligibility criteria. Two (2) patients agreed to be referred to the YMCA’s BPSM program, both of which fully participated in the program. Table 2 illustrates the YMCA’s BPSM program eligibility criteria, and Table 3 shows the clinic’s demonstration project results (at the time this case study was completed patients were still enrolled in the YMCA’s BPSM program so no patients had completed the program).

Table 2. Eligibility criteria for the YMCA’s BPSM program

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age ≥ 18 years of age</td>
<td>Recent cardiac event</td>
</tr>
<tr>
<td>English or Spanish-speaking</td>
<td>Atrial fibrillation or other arrhythmia</td>
</tr>
<tr>
<td>In office blood pressure &gt; 140/90, diagnosis of hypertension and/or on antihypertensive medication</td>
<td>At risk for lymphedema</td>
</tr>
<tr>
<td>Two or more elevated blood pressure readings within the last 12 months</td>
<td></td>
</tr>
</tbody>
</table>

Table 3. Mission of Hope Clinic results

<table>
<thead>
<tr>
<th>Demonstration Project Outcome Measure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of WISEWOMAN patients who qualify for the blood pressure self-management program</td>
<td>35</td>
</tr>
<tr>
<td>Number of WISEWOMAN patients who are referred to blood pressure self-management program</td>
<td>2</td>
</tr>
<tr>
<td>Number of WISEWOMAN patients who enroll in the blood pressure self-management program</td>
<td>2</td>
</tr>
</tbody>
</table>
SCALABILITY / NEXT STEPS

Mission of Hope Clinic anticipates using the workflow established during the demonstration project to continue to generate referrals to the YMCA of Greater Kansas City’s BPSM program. The clinic also hopes to continue its work with the Missouri Department of Health and Senior Services for annual visits and screening for hypertension in the future, as appropriate. The clinic plans to identify a staff member and lead provider to champion and support the referral process, and the clinic will also pursue alternative funding to support the involvement of a YMCA Healthy Heart Ambassador in its work. The clinic is also planning a social media campaign to raise awareness of hypertension in its service area and emphasize the clinic’s role in improving hypertension and cardiovascular disease in the area through referrals to the YMCA’s BPSM program.
Truman Medical Centers

BACKGROUND

Truman Medical Centers is an integrated health care system in Jackson County and Kansas City, Missouri. The service area is comprised of 58 zip codes, home to the urban core of Kansas City as well as suburban and rural communities surrounding the Kansas City metropolitan and reflects the same patient demographics as Mission of Hope Clinic in Diagram 3 – Demographics of Jackson County, Missouri.

In February 2018, Truman Medical Centers opened a newly constructed primary care clinic, the University Health Community Care at Linwood. The clinic is connected to the James B. Nutter, Senior Community Center/Linwood YMCA and provides the community access to primary care prevention and treatment services coordinated with the YMCA’s health and wellness team. The Truman Medical Centers and YMCA partnership care team aims to provide a coordinated model of health promotion and disease prevention that gives the community easy access to high quality health care and a healthy lifestyle for all ages. In addition to having an onsite care team, the Coordinated Clinical-Community Care model provides access to health screenings, health-related educational programs, behavioral health counseling, and other special programs for members of the community, patients, Truman Medical Centers and YMCA employees.

PRE-Demonstration Project Approach

University Health Community Care at Linwood opened in February 2018, which aligned with the start of the demonstration project.

Demonstration Project

Patients were referred to the YMCA’s BPSM program as follows:

A Truman Medical Centers, University Health Community Care at Linwood care team member identified potential YMCA BPSM program participants as part of the pre-visit planning process (See Table on page 10 for the YMCA’s BPSM program eligibility criteria). A staff member discussed the program with patients during a pre-visit phone call. If the patient was interested in the program, the patients’ chart was flagged so that the YMCA’s BPSM program would be discussed at the upcoming clinic appointment.
A referral order was placed in eCare, the health system’s clinical transaction database platform (and/or a care coordination note was completed, as appropriate).

A Truman Medical Centers, University Health Community Care at Linwood care team member completed the YMCA’s BPSM program intake form and securely faxed it to the Healthy Living Community Coordinator at the YMCA of Greater Kansas City.

The Healthy Living Community Coordinator contacted the patient to discuss the program and encourage enrollment.

Once referred to the program, patients received an agreement form, program outline, blood pressure measurement device, and blood pressure log. Diagram 5 reflects the Truman Medical Centers, University Health Community Care at Linwood demonstration project workflow.

Diagram 5. Truman Medical Centers, University Health Community Care at Linwood demonstration project workflow
MEASURES OF SUCCESS

Thirty-two (32) patients seen at Truman Medical Centers, University Health Community Care at Linwood met the eligibility criteria. Seventeen (17) patients agreed to be referred to the YMCA’s BPSM program, and two (2) patients enrolled in the program. The Truman Medical Centers, University Health Community Care at Linwood care team also collaborated with its Kansas City-based EMR vendor, Cerner Corporation, to implement a mechanism to incorporate systematic clinical decision support to identify eligible patients and flag a recommendation for “SMBP with clinical support program” referral at the point of care. This health maintenance reminder served to prompt the care team to initiate the referral. The electronic workflow was implemented in June of 2018, toward the end of the reporting period. Within the first week of implementation, fourteen (14) referrals were sent to the YMCA (at the time this case study was completed patients were still enrolled in the YMCA’s BPSM program, so no patients had completed the program).

Table 4. Truman Medical Centers, University Health Community Care at Linwood results

<table>
<thead>
<tr>
<th>Demonstration Project Outcome Measure</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of WISEWOMAN patients who qualify for the blood pressure self-management program</td>
<td>32</td>
</tr>
<tr>
<td>Number of WISEWOMAN patients who are referred to blood pressure self-management program</td>
<td>17</td>
</tr>
<tr>
<td>Number of WISEWOMAN patients who enroll in the blood pressure self-management program</td>
<td>2</td>
</tr>
</tbody>
</table>
SCALABILITY / NEXT STEPS

Truman Medical Centers, University Health Community Care at Linwood anticipates ongoing referrals to the YMCA’s BPSM program and scaling the work to include participants across the health system is currently part of its ongoing partnership discussions. Truman Medical Centers expects that successful scaling will require the following:

A Wellness Navigator – This team member will serve on the extended care team and help coordinate referrals between Truman Medical Centers and the YMCA’s BPSM program.

Additional funding – Identification of funds for blood pressure devices and to support team member salaries. Truman Medical Centers is exploring the potential to leverage reimbursement from remote patient monitoring (RPM; CPT Code 99091) or chronic care management to sustain and scale the program.
Lessons Learned

The demonstration project was a strong complement to the services offered by Mission of Hope Clinic and Truman Medical Centers, University Health Community Care at Linwood. Given the 4-month project period and the absence of workflows existing at each site to support the referrals to the YMCA’s BPSM program, grantees astutely recognized the need to invest the required time in designing and solidifying their referral workflows. While this delayed project implementation, it best positioned the sites to mature so that they could support sustainable and scalable processes to make SMBP with clinical support referrals a standard clinical workflow. As the staff worked to identify an appropriate workflow, the process also revealed areas in which the clinic staffing and efficiency could be improved. Preferably, establishing workflows and ensuring organizational capacity should be prioritized prior to launch. After project launch, flexibility should be encouraged, as workflows may still require revision to optimize outcomes and remove barriers to patient enrollment and engagement. The demonstration project also highlighted the importance of a strong lead clinician to provide project oversight, serve as a champion among other staff clinicians, and leverage the entire care team to support the project.

Challenges encountered by the grantees are listed in Table 5. Grantees desired a longer project period, given the challenges associated with outreach to and communication with patients, patients’ lack of transportation, and the required number of office visits initially required for intake into the YMCA’s BPSM program. As the demonstration project progressed, grantees increasingly worked with the YMCA of Greater Kansas City staff to identify workarounds, and this collaborative approach was integral to the demonstration project’s success. While the organizations worked well together, it is essential that time is allowed in the planning phase to cultivate and/or strengthen this type of clinical–community partnership to make certain that there is clear communication, dedicated staff at both organizations, and warm handoffs whenever possible. Going forward, the relationship with the YMCA of Greater Kansas City could also be used to support ongoing care team education as well as review of processes and outcome metrics.

One of the greatest successes of the demonstration project is Truman Medical Centers’ work with Cerner Corporation to incorporate systematic clinical decision support to identify eligible patients for referral to the YMCA’s BPSM program at the point of care. This accomplishment substantially increases the likelihood that the referral program will be sustained, that associated data and outcomes will be followed after the end of the demonstration project, and that reimbursement for enrollments in SMBP with clinical support will be explored. Retrospective review and referral also increases the total number of people who may be referred to an
evidence-based program, in turn providing the potential to effectively enhance patients’ quality of life and decrease the morbidity and mortality from uncontrolled hypertension and CVD.

*Table 5. Challenges encountered during the demonstration project*

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Type of Organization</th>
<th>Challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mission of Hope Clinic</td>
<td>Safety Net Clinic</td>
<td>• Transportation&lt;br&gt;• Patients’ caregiver duties&lt;br&gt;• Difficulty contacting patients&lt;br&gt;• Lack of provider oversight and leadership&lt;br&gt;• Staff turnover&lt;br&gt;• Number of visits required for initial referral workflow&lt;br&gt;• Lack of trust between patients and new contacts (due to concerns regarding their immigrant status)</td>
</tr>
<tr>
<td>Truman Medical Centers</td>
<td>Integrated Health Care System</td>
<td>• Clinical workflow integration&lt;br&gt;• Patients’ competing priorities&lt;br&gt;• Participant conversion&lt;br&gt;• Lack of elevated blood pressure alert in the EMR</td>
</tr>
</tbody>
</table>

**Future Considerations**

This case study presents the implementation of processes and workflows to increase the referral and enrollment of current WISEWOMAN participants to the YMCA’s BPSM program at two sites. Although the grantees served similar target populations, there was variability between the grantees regarding organizational capacity, geographic region, and resources. Mission of Hope Clinic is a small, safety net clinic in a suburban city and Truman Medical Centers, University Health Community Care at Linwood is part of a large, integrated health care system. Based on this variability, the grantees’ approaches to the demonstration project were tailored to their organizations.

The information in this case study can serve as models for clinics and healthcare systems serving similar populations at high-risk for hypertension and CVD that would like to increase the referral of patients to the YMCA’s BPSM or other SMBP with clinical support programs. Each organization will need to identify the high-risk populations, identify potential challenges to referral and
enrollment to such programs, and adapt the models accordingly. For example, Mission of Hope Clinic revised its referral workflows to allow patients to be referred to the YMCA’s BPSM program if they had one elevated blood pressure reading and were prescribed blood pressure medication instead of waiting for a follow-up appointment and two high blood pressure readings.

Even though the patients in this case study were current WISEWOMAN program participants, it should be noted that these referral and enrollment models can also apply to other patient populations. It should also be noted that healthcare settings that are not primarily safety net clinics can also adapt these processes for their populations as well. While the sites involved in the demonstration project also provide wrap-around services, formal wrap-around services were not specifically included in the demonstration project. Given the challenges encountered by high-risk populations, the addition of a formal wrap-around approach could be included in the referral process. Additionally, interventions that are family-focused can be very effective in improving the self-care of patients. 17 The inclusion of family members of the qualifying patient—including male spouses or partners who live in the household—uses the natural support systems of patients and could increase a female participant’s enrollment and retention in SMBP with clinical support programs.

Customization of EMR systems may also increase the referral of patients to SMBP with clinical support programs. As seen in the case of the Truman Medical Centers, University Health Community Care at Linwood care team, this mechanism will potentially help providers to identify more patients at the point of care who are at risk for hypertension and CVD and to recommend appropriate interventions and community programs to decrease the risk.

Based on the challenges both demonstration project grantees noted as wells as areas for process improvement identified in the lessons learned section of this case study, there is a need for additional recommendations to assist with the planning and implementation of screen, test, refer processes for health care settings. Diagram 6 highlights additional recommendations for implementing processes to refer and enroll patients in SMBP with clinical support programs. Health care systems will need to tailor the models in this case study and recommendations to align with their organizational structures, resources, service areas, and patient populations.
Diagram 6. Recommendations for implementing processes to screen/test/refer patients to SMBP with clinical support programs

1. Understand your organizational structure, resources, and supports that will be needed to create and implement referral models.

2. Identify a provider champion to help support the planning and adoption of hypertension control interventions such as SMBP with clinical support.

3. Use a risk stratification algorithm to identify high-risk populations.

4. Partner with EMR vendors to customize systems to help providers identify high-risk patients at the point of care.

5. Identify potential barriers and solutions to implementing screen/test/referral processes for your organization, and potential barriers that may limit patient enrollment in SMBP with clinical support programs.

6. Include community based organizations when planning screen/test/referral processes to increase provider cultural competence and clinical-community linkages.

7. Include family/household members when referring patients to SMBP with clinical support programs as they are natural support systems for patients.
References


Acknowledgements

**Funding Acknowledgement:** The ACPM–WISEWOMAN Grant Project is supported by a five-year cooperative agreement between ACPM and the CDC Office of State, Tribal, and Territorial Support (OSTLTS), and support from the CDC Division for Heart Disease and Stroke Prevention (DHDSP).

**ABOUT DHDSP**

The CDC’s Division for Heart Disease and Stroke Prevention (DHDSP) works to improve cardiovascular health through public health strategies and policies that promote

- Healthy lifestyles and behaviors
- Healthy environments and communities
- Access to early and affordable detection and treatment

The CDC supports all 50 states and the District of Columbia to conduct heart disease and stroke prevention efforts. Funded Programs include:

- WISEWOMAN
- State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Associated Risk Factors and Promote School Health
- Paul Coverdell National Acute Stroke Program
- Sodium Reduction in Communities Program (SRCP)

**ABOUT ACPM**

The American College of Preventive Medicine (ACPM) is a professional medical society of more than 2,700 preventive medicine and public health physicians who manage, research, and influence population health. Preventive medicine physicians are employed in a wide range of sectors and settings, and ACPM Fellows are sought after leaders in local, national, and international health sectors. To these specialists, ACPM provides a dynamic forum for the exchange of knowledge and offers high-quality educational programs well as professional development resources and networking opportunities.

For more information, visit the ACPM–WISEWOMAN Grant Project website. For instructions on how to access the WISEWOMAN provider online courses please contact Shannon Haworth.