West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH | Office of Maternal, Child and Family Health

West Virginia WISEWOMAN

West Virginia WISEWOMAN Program Policies and Guidelines

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WISEWOMAN Program Overview

"*The most important way to prevent cardiovascular disease is by adopting heart healthy habits and to do so over one's lifetime. More than 80% of all cardiovascular events are preventable through lifestyle changes, yet we often fall short in terms of implementing these strategies and controlling other risk factors*." Roger S. Blumenthal, MD FACC.

The Well-Integrated Screening and Evaluation for WOMen Across the Nation (WISEWOMAN) program helps West Virginia women aged 35-64 to understand and reduce their risk for heart disease and stroke and promote lasting heart-healthy lifestyles. The program employs evidence-based strategies proven to reduce heart disease and stroke prevalence through early detection and treatment of hypertension and high cholesterol. Further, it helps participants achieve the best health possible by addressing social and economic factors that lead to disparities in health care. The program combines integrated visit and support services to help women make lifestyle changes to reduce cardiovascular disease.

The program also increases healthy behaviors to reduce cardiovascular disease (CVD) risks through improved diet, increased physical activity, tobacco cessation, and medication adherence support. Participant's risk factor profiles determine risk reduction counseling and healthy behavior support services (HBSS). These HBSS recommendations include health coaching and evidence-based lifestyle programs. Some of the current approved programs are Take off Pounds Sensibility (TOPS), Weight Watchers, Dining with Diabetes, and Walk with Ease.

WISEWOMAN participants are assessed using clinical and health behavior indicators associated with these cardiovascular disease risk factors. Participants are evaluated at the initial screening, follow-up, and the rescreening.

How to Become a WISEWOMAN Provider

To provide WISEWOMAN screening services, a provider must:

- Be a West Virginia Breast & Cervical Cancer Screening Program (BCCSP) provider
- Serve patients utilizing a team-based care approach and completing the online clinic team-based care assessment
- Participate in all WISEWOMAN trainings
- Participate in annual site visits
- Utilize an Electronic Health Record (EHR) for patient care
    - CareHalo can be used in lieu of an EHR if your clinic does not have an EHR. CareHalo has the ability to integrate with your clinic EHR if desired to reduce burden in providing programmatic data.
- Use WISEWOMAN data platform (CareHalo) for programmatic data collection

Use the EHR record or the CareHalo platform to query, monitor, and track clinical, HBSS utilization, and social services and support needs data for improved identification, management, referrals, treatment, and outcomes of those at risk for CVD, particularly hypertension.

Track and monitor clinical measures shown to improve health and wellness, health care quality, and identify patients at risk of and with CVD, particularly hypertension in collaboration with the program and epidemiologist.

Provide CVD risk assessment to under and uninsured participants in the priority age range of 35-64 years during the initial, follow-up, and reassessment office visits, as appropriate.

Use standardized procedures to identify social services and social support needs of participants and assess the referral and utilization of those services, such as food assistance, transportation, housing, childcare, etc. Refer participants to appropriate social support services, refer to HBSS, and track and monitor use through the CareHalo platform and/or through working with your WISEWOMAN Care Coordinator.

Work with WISEWOMAN Program staff, including the Program Coordinator, Epidemiologist, and the WISEWOMAN Care Coordinator, to implement program activities and monitor success of the program.

Ideally the WISEWOMAN visits are integrated with a BCCSP screening

- The WISEWOMAN program prefers that visit coincides with annual WVBCCSP screening visits, defined as an "integrated visit".

- Integrated office visits should be billed to WVBCCSP with additional services (i.e. labs, HBSS, health coaching) billed to the WISEWOMAN program.

- If the WISEWOMAN office visit is a standalone visit that does not coincide with the annual WVBCCSP screening visit, the office visit will be billed to the WISEWOMAN Program.

- If the WISEWOMAN office visit is not a WVBCCSP integrated visit that does not coincide with the screening visit, ensure participant is enrolled in WVBCCSP and breast and cervical cancer screenings are up to date. The office visit will be billed to the WISEWOMAN Program.

WISEWOMAN Program Eligibility and Services

Participant Eligibility

- West Virginia resident
- Eligible for WVBCCSP
- Income at or below 250% of the current Federal Poverty Level
- Uninsured or *Underinsured
- Receiving Medicaid and have a healthcare barrier:
    - Can be navigated through BCCSP to WISEWOMAN services via Patient Navigation Only
- Must be between the ages of 35-64
- Must have at least one cardiovascular disease risk such as:
    - High Blood Pressure
    - High Blood Cholesterol Levels
    - Diabetes
    - Obesity
    - Tobacco Use

*Underinsured example: The participant has creditable insurance, however, HBSS are not covered, and the participant meets other WISEWOMAN eligibility criteria.

Eligible Participants Will Receive

- Screening for risk of heart disease and stroke
- Bloodwork for cholesterol and blood glucose
- Educational Materials
- Health Coaching
- Referral to Healthy Behavior Support Services (HBSS)
- At-home blood pressure monitor with enrollment into the WISEWOMAN Self-Monitoring Blood Pressure (SMBP) program intervention
- Referral to social services based on community health needs

Screening Requirements

The participant will have 3-4 screenings annually:

- Initial Screening or Enrollment
- Follow-Up
- Annual Rescreening
- One additional acute visit to address abnormal results may be billed

Initial Screening/Enrollment
Integrated Medical Provider Visit:

- Complete health history
- Vitals (2 Blood Pressure readings, Height, Weight, Waist Circumference)
- Labs (Lipid Panel, Blood Glucose, A1C) Ideally labs would be drawn at the initial visit, however, labs drawn within 90 days are acceptable. If not on lipid lowering therapy, measurement of either a fasting or a non-fasting plasma lipid profile is effective in estimating cardiovascular risk and documenting baseline. It is not recommended to measure a non-fasting LDL if the participant has consumed a high fat meal 8 hours prior to blood work.
- Complete all program forms
    - Client Enrollment
    - Client Screening
    - Health History
    - Risk Assessment & Care Plan
    - Community Health Needs (CHN)
    - Health Coaching
    - Consent Release Form
- Medication (if needed)
- Referral to Self-Monitoring Blood Pressure (SMBP) if indicated or another approved healthy behavior support services (HBSS)
    - Supply the participant with a blood pressure monitor (if enrolled in SMBP)
    - Assist participant in downloading the myCareHalo app
    - Walk participant through process to pair (Bluetooth) phone with blood pressure monitor
    - Educate the participant how to take their blood pressure and see readings on the app on their phone
- Schedule a follow-up visit in 3-6 months from initial screening or enrollment

Health Coaching Visit: Health coaching is a required component of the WISEWOMAN Program. The health coach portion can be scheduled as a call if a health coach is not located in the clinic, or you can utilize the WISEWOMAN Care Coordinator to do the health coaching portion via phone call if needed.

- Goal setting/homework
- Referrals to healthy behavior support services (HBSS)

- Motivational interviewing
- Problem solving
- Referral to social support service based on community health needs
- Complete health coach form

Follow-Up visit should be scheduled after expected completion of HBSS, ideally in 3-6 months after the initial visit. This visit can be performed via telephone by assigned clinic staff or the WISEWOMAN Care Coordinator. Medical visit is optional.

- Initiate any HBSS referrals as appropriate
- Provide social service referrals as appropriate
- Update forms
    - Update Risk Assessment & Care Plan
    - Update Health History
    - Update Community Health Needs
    - Health Coaching
- Schedule rescreening visit in 11-13 months from initial screening or enrollment

Health Coaching Visit: Health coaching is a required component of the WISEWOMAN Program. The health coach portion can be scheduled as a call if a health coach is not located in the clinic, or you can utilize the WISEWOMAN Care Coordinator to do the health coaching portion via phone call if needed.

- Goal setting/homework
- Referrals to healthy behavior support services (HBSS)
- Motivational interviewing
- Problem solving
- Referral to social support service based on social determinants of health
- Complete health coach form

Annual Rescreening with medical provider to be scheduled within 11-13 months after initial screening or enrollment

Medical Provider Visit:

- Complete health history
- Vitals (2 Blood Pressure readings, Height, Weight, Waist Circumference)
- Labs (Lipid Panel, Blood Glucose, A1C) Ideally labs would be drawn at the initial visit, however, labs within 90 days are acceptable. If not on lipid lowering therapy, measurement of either a fasting or a non-fasting plasma lipid profile is effective in estimating cardiovascular risk and documenting baseline. It is not recommended to measure a non-fasting LDL if the participant has consumed a high fat meal 8 hours prior to blood work.
- Complete all program forms
    - Client Enrollment
    - Client Screening
    - Health History
    - Risk Assessment & Care Plan
    - Community Health Needs (CHN)
    - Health Coaching
    - Consent Release Form
- Medication (if needed)
- Referral to Self-Monitoring Blood Pressure (SMBP) if indicated or another approved healthy behavior support services (HBSS)
- Schedule follow-up visit in 3-6 months from initial screening or enrollment

Health Coaching Visit: Health coaching is a required component of the WISEWOMAN Program. The health coach portion can be scheduled as a call if a health coach is not located in the clinic, or you can utilize the WISEWOMAN Care Coordinator to do the health coaching portion via phone call if needed.

- Goal setting/homework
- Referrals to healthy behavior support services (HBSS)
- Motivational interviewing
- Problem solving
- Referral to social support service based on community health needs
- Complete health coach form

Schedule COMBINED enrollment or initial screening visit to include medical visit and health coaching as needed. The health coaching portion can be conducted via telehealth by a WISEWOMAN Care Coordinator if needed. The WISEWOMAN Program can be tailored to meet your clinic's individual needs.
***See appendix 1 for Flow Charts**

WISEWOMAN Care Coordinator and Health Coaching

Once the patient's care plan has been developed

- An alert is sent to the WISEWMAN Care Coordinator (WWCC) on the CareHalo platform
- The WWCC will then review the patient's chart and care plan
- Within one week the WWCC will call the patient to:
    - Assess barriers
    - Provide resources
    - Provide education

If at any point the participant experiences barriers or lacks progress with her care plan, the WWCC:

- Provides education, resources, and referrals as needed
- Refers to Health Coach when participant:
    - Lacks motivation to follow through with care plan
    - Experiences circumstances that interfere with care plan adherence
    - Requires problem solving to meet care plan goals

WWCC will review the CareHalo platform every two weeks to ensure attendance to the healthy behavior support services and review progress on the care plan.

- The WWCC can also assist the participant in setting up the blood pressure monitor for the SMBP HBSS via telephone call:
    - Assist participant in downloading the myCareHalo app
    - Walk participant through the process to pair (Bluetooth) phone with blood pressure monitor
    - Educate the participant on how to take their blood pressure and see readings on the app on their phone

WWCC second telephone contact with patient midway through the patient's individual care plan

Example: WWCC will call the participant in four weeks if the patient is enrolled in an eight-week class or WWCC will call in six weeks if the patient is enrolled in a 12-week class.

WWCC will:

- Assess barriers
- Provide resources
- Provide education
- Refer to social support service based on community health needs

If your clinic does not have a Patient Navigator to act as the WISEWOMAN Care Coordinator, you can use the Program's WWCC. The WWCC can also conduct health coaching.

Schedule COMBINED enrollment/initial screening visit to include medical visit and health coaching as needed. The health coaching portion can be conducted via telehealth by a WISEWOMAN Care Coordinator if needed. The WISEWOMAN Program can be tailored to meet your clinic's individual needs.

Minimum Data Element (MDE) Requirements

The minimum data elements are required by the Centers for Disease Control and Prevention (CDC), the federal funder for the WISEWOMAN Program. The data elements are collected via completed program forms. The data can be captured through paper forms or your electronic medical records and then transferred to the CareHalo platform or directly through the CareHalo platform via data entry.

The program MDEs guide all WISEWOMAN programmatic activities and can be grouped into 3 main categories:

- Track and monitor clinical measures shown to improve health and wellness, health care quality, and identify patients at risk of and with cardiovascular disease (CVD), particularly hypertension through the EHR and CareHalo platform.

- Implement team-based care to prevent and reduce CVD risk with a focus on hypertension prevention, detection, control, and management through the mitigation of social support barriers to improve outcomes.

- Link community resources and clinical services that support comprehensive bidirectional referral and follow-up systems aimed at mitigating social support barriers and supporting participation in, and completion of, lifestyle change programs.

This can be achieved by the patient navigator or the WISEWOMAN care coordinators.

Healthy Behavior Support Services (HBSS)

HBSS are evidence-based programs that assist in healthy behavior change to lower the participants CVD risk factor and to meet the individual's care plan goals. These programs are evidence-based and CDC approved. The medical provider or health coach can refer participants to HBSS.

Health Coaching is a required component of the WISEWOMAN Program. When combined with other HBSS referrals, such as Dining with Diabetes, the health coach can help guide the participants through completion of these classes and help to emphasize how these lifestyle changes can reduce CVD risk.

HBSS include:

- Health Coaching
- Self-Monitoring Blood Pressure
- Weight Watchers
- Take off Pounds Sensibly
- Dining with Diabetes
- Walk with Ease

All HBSS must be approved by the CDC. The WISEWOMAN Program seeks the CDC's approval for HBSS that may be offered at your clinic or community programs.

The WISEWOMAN Program requires updates on attendance and completion of these HBSS and the data is captured in the participant's care plan and the CareHalo platform.

Tracking participant's attendance and completion will fulfill the CDC's requirement for bidirectional referral. More importantly, bi-directional referrals will help you as the provider ensure the participants have a foundation to improve their lifestyle and reduce CVD risk.

Please consult the WISEWOMAN Program Coordinator with questions about HBSS eligibility.

Health Coaching

The role of a Health Coach (HC) is to partner in a patient's behavior change process. This process involves supporting the patient as they set a CVD care plan and encourage the development of sustainable healthy behaviors and attitudes. Health Coaching is a mandatory component of each HBSS.

- The HC will follow the participants through completion of each HBSS for which they are referred. During the initial visit, the HC will help participants set health goals, make referral to healthy behavior support services (HBSS), and engage in motivational interviewing/problem solving.
- During the follow-up visit, the HC will review homework, assess progress toward health goals, engage in motivational interviewing/problem solving and plan for completion of the health care plan.
- During the patient's annual rescreening/follow up screening integrated visit, the HC will reinforce healthy behavior, engage in goals for a maintenance plan and develop goals for the new care plan as needed, and refer to healthy behavior support service for new health goals.

Health Coaching HBSS completion: At minimum, participants will receive three health coaching visits (initial, follow-up, and annual re-screening). Participants may have a total of six additional health coaching visits throughout the year as needed.

Self-Monitoring Blood Pressure (SMBP)

Bluetooth and cellular blood pressure monitors will be provided to patients who qualify. When the participant takes her blood pressure, the results are uploaded in real-time into the CareHalo platform and to the participants' myCareHalo App.

Eligibility for the SMBP includes one or more of the following:

- Diagnosis of hypertension
- Blood pressure reading above 130/80 (the American College of Cardiology/American Heart Association - ACCA/AHA 2017) guidelines without specific diagnosis of hypertension
- The provider requests remote home blood pressure monitoring per clinical judgment

Alert values are determined at the initial appointment and are based upon the individual's goals as determined by the medical provider. The blood pressure level is set by the medical provider in the CareHalo platform. If the blood pressure reading is elevated for the participant, an alert will be sent to the CareHalo platform to notify clinic staff.

If a blood pressure reading is not taken in a 24-hour timeframe, a reminder will be sent to the participant via one way SMS message and a chat message through the myCareHalo app. If blood pressure is not taken in a 48-hour timeframe, an alert will be sent to the provider and WISEWOMAN Care Coordinator. The health professional or WISEWOMAN Care Coordinator will reach out to the patient.

Health coaches complement this HBSS by reviewing self-measured blood pressure logs with participants and offering guidance on how lifestyle choices-such as diet, physical activity, stress management, and medication adherence-impact blood pressure control. Health coaching with SMBP centers around reducing sodium intake, limiting alcohol, staying active, and monitoring blood pressure consistently at the same time each day. Health coaching also helps participants problem-solve common barriers such as device use, forgetfulness, or discouragement from fluctuating readings. Health coaches work closely with the clinic, CareHalo coordinator/health coach, and program coordinator to ensure seamless support that is focused on long-term blood pressure management and cardiovascular risk reduction. Health coaching also provides encouragement for other WISEWOMAN provided HBSS that could positively impact WISEWOMAN participant's cardiovascular health.

SMBP HBBS completion: Three health coaching sessions and participants must take their blood pressure a minimum of 15 times per month for three months.

Weight Watchers

Weight Watchers (WW) is an evidence-based program to reduce CVD risk. Adults who have cardiovascular disease, diabetes and obesity may benefit from the Weight Watchers program. Weight Watchers is a weight loss and lifestyle program which encourages healthy eating habits and lifestyle choices. The program is flexible and personalized, allowing participants to choose foods they eat while tracking their intake using a points system.

The Program will supply qualifying participants with unlimited access to a 3-month membership to the online WW app. Membership does not include in- person meetings, but there is an option within the app to join an online group. The membership does NOT include the Weight Watchers clinic, which offers dietitian appointments and GLP1 weight loss medication.

Participants can track their food, exercise and weight easily in the user-friendly app. Food can be searched and tracked by name, scanning bar codes on packaging, or taking a picture of their plates. Restaurants (by name) are also in the app, which makes eating out easy to track.

WISEWOMAN participants enrolled in the WW program and health coaching receive personalized support through phone calls and CareHalo messaging by reinforcing the program's focus on building healthy habits around food, movement and mindset. Health coaches will provide social service referrals as needed. The health coach also provides accountability, celebrates both progress and setbacks, helps participants navigate any challenges regarding using the WW program, and most importantly, stay motivated to improve cardiovascular health.

WW HBSS completion: Three health coaching sessions and participant must use the app to track their food and/or weight and exercise for three months.

Whereas the program can't track the participant's progress through the WW app, a series of questions will be sent to the participants throughout the HBSS via the myCareHalo app such as, "Have you logged your food and weight this week"?.

Visit the Weight Watchers website for more information:
https://www.weightwatchers.com/us/

Take off Pounds Sensibly (TOPS)

TOPS is an evidence-based program that is effective in helping participants lose weight and reduce their CVD risk. TOPS is associated with moderate weight loss among participants who remain in the program for at least one year.

The Program will supply qualifying participants a one-year membership to TOPS. Participants will have the option to attend in person (dependent on meeting locations) or virtually.

Participants will be given a step-by-step guide on how to get started, along with information about the Exchange System, which simplifies how they eat. Participants will receive a bimonthly member magazine and gain instant access to the exclusive members-only section of the website, which offers recipes, daily inspiration calendars, a health library, fitness guides, and more.

There is no app for TOPS. Participants log progress through pen and paper.

Health coaching provides personalized support to WISEWOMAN participants engaged in TOPS by reinforcing weight management strategies and helping participants apply what they learn in meetings to their daily lives. Health coaches complement the TOPS program by offering one-on-one support via telephone or CareHalo messaging between TOPS group sessions. This may look like encouraging WISEWOMAN participants in setting realistic weight loss goals (using SMART goals technique). The health coach works alongside WISEWOMAN participants participating in TOPS to reinforce TOPS messages like portion control, mindful eating, and the importance of small steps with consistency. By providing additional accountability check-ins at the midway point and as needed, health coaching strengthens the WISEWOMAN participant's commitment to long-term weight loss and therefore improved cardiovascular health.

TOPS HBSS completion: Three health coaching sessions and participants must attend one class a week for 3 months.

A series of questions will be sent to the participants throughout the HBSS via the myCareHalo app such as, "Did you attend a TOPS meeting this week?".

The WISEWOMAN providers or the Care Coordinator should make every effort to obtain class attendance records from the TOPS facilitator.

Visit the TOPS website for more information: https://www.tops.org/home

Dining with Diabetes

Dining with Diabetes is an evidence-based program. Adults with Type 2 diabetes or pre-diabetes will learn how to effectively plan healthy meals and prepare well-balanced, nutritious dishes. When combined with Health Coaching, Dining with Diabetes can reduce CVD risk by helping participants achieve healthy blood pressure levels through nutritious lifestyle changes.

This class is offered by the WVU Extension Office. The group class may be offered in person or virtually.

WISEWOMAN participants who are enrolled in the Dining with Diabetes program receive health coaching to provide support in applying the program's nutrition and self-management lessons to their day-to-day lives. Health coaches complement the WVU Extension-led program by helping to troubleshoot challenges like meal prep fatigue, grocery budgets, and family needs or demands (i.e. social support referrals). Health coaches will provide goal-setting support and accountability between the weekly class meetings. Health coaches will answer questions that might come up regarding lifestyle changes to improve blood sugar control and reduce cardiovascular risk.

Dining with Diabetes HBSS completion: Three health coaching sessions and documented attendance and completion of a Dining with Diabetes class.

A series of questions will be sent to the participants throughout the HBSS via the myCareHalo app such as, "Did you attend your class this week?".

The WISEWOMAN providers or the Care Coordinator should make every effort to obtain class attendance records from the Dining with Diabetes facilitator.

Visit the WVU Extension website for more information:
https://extension.wvu.edu/food-health/diabetes/dining-with-diabetes
https://www.youtube.com/watch?v=GzES4AKs3Pg

Walk with Ease

The Arthritis Foundation developed the Walk with Ease program to help participants reduce the pain of arthritis and improve overall health. Program participants experience improvements in levels of pain, fatigue, and stiffness as well as better perceived control over arthritis, balance, strength and walking pace. Regular walking can significantly lower the CVD risk and stroke.

The program can be done alone or in a group setting (provided there is a group close by). Participants will be supplied with the Walk with Ease Guidebook which has helpful information such as:

- Developing a walking plan that will meet your needs
- Staying motivated
- Managing your pain
- Learning to exercise safely

Health coaching provides one-on-one support to WISEWOMAN participants enrolled in Walk with Ease by helping them build confidence in physical activity and set attainable walking goals to complement the Walk with Ease program. In addition, the health coach will check in between classes and assist participants in overcoming any barriers (i.e. social service referrals) to regular exercise along with helping them track progress. For example, health coaching will offer encouragement and accountability through telephonic calls or CareHalo messaging via the CareHalo app. The health coach will reinforce key messages of the Walk with Ease program-such as starting slow, using proper footwear, and recognizing signs of overexertion-while also helping WISEWOMAN participants incorporate walking into their daily routines. Specific examples a health coach might provide to complement the Walk with Ease program include picking a parking spot farther from the entrance of the place they are going to or creating new routines to increase physical activity with family members like after-work walks.

Walk with Ease HBSS completion: Three health coaching sessions and walk 3 times a week for 6 weeks.

A series of questions will be sent to the participants throughout the HBSS via the myCareHalo app such as, “How many Walk with Ease sessions have you attended this week?”

Visit the Walk with Ease website for more information:
https://www.arthritis.org/health-wellness/healthy-living/physical-activity/walking/walk-with-ease

Team-Based Care

A team-based care approach to patient care enables clinics to meet patient needs and preferences by actively engaging patients as full participants in their care, while encouraging and supporting all health care professionals to function to the full extent of their education, certification, and licensure.

The team should be led by a physician or advanced practice professional, and can include other members of the healthcare staff such as:

- Front Desk staff
- Nurses
- Medical Assistants
- Pharmacists
- Health Coaches
- Behavioral Health Providers
- Social Workers
- Navigators
- Community Health Workers
- Volunteers
- Family Members

Team-Based Care Assessment

An online team-based care assessment will be completed by your clinic to identify existing resources for participants, possible barriers to program implementation, and individual clinic needs.

Appendix

West Virginia WISEWOMAN Program Flow Chart

West Virginia WISEWOMAN Care Coordinator Flow Chart

Glossary

Bi-Directional Referral
A bi-directional referral system considers both the information going from the health care system to the referred community program or resource (e.g., a CDC recognized lifestyle change program) and the information returning from that program to the healthcare system.

Community Health Needs
Conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Evidence-Based Interventions
Program practices that have evidence to show that they are effective at producing results and improving outcomes when implemented.

Health Coaching
A health coach is someone who uses evidence-based conversation and strategies to engage participants in behavior change that improves their health.

Healthy Behavior Support Services (HBSS)
HBSS are evidence-based programs that assist in healthy behavior change to lower the participant's CVD risk factor and to meet the individual's care plan goals. These programs are evidence-based and CDC approved. The medical provider, WISEWOMAN care coordinator, or health coach can refer participants to HBSS.

Patient Navigation
A patient navigator can assist participants if they experience barriers or lack of progress with their care plan, such as providing resources and education or refer to the health coach.

Self-Monitoring Blood Pressure
Self-Monitoring Blood Pressure is an evidence-based intervention to help monitor hypertension. The participants monitor their blood pressure at home and readings are provided to their healthcare provider.

WISEWOMAN Care Coordinator

A WISEWOMAN Care Coordinator is someone who helps participants communicate with their healthcare provider so they get information they need to make decisions on their health care.