

WISEWOMAN Evaluation

Field Placement with Center for Urban Population Health

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Outline

- Overview
- WISEWOMAN
- Evaluation
- Methods
- Results
- Challenges
- Competencies

Overview

- Assist Center for Urban Population Health with Year 2 Evaluation
- Focus: Process and efficiency
- CUPH:
 - Partnership: UW-Madison, UW-Milwaukee, Aurora Health Care
 - Mission: Advance population health research and education to improve health or urban communities (CUPH, n.d.)
 - Methods:
 - Identify social determinants
 - Design and implement interventions
 - Measure intervention effectiveness



WISEWOMAN

- **Well-Integrated Screening and Evaluation in WOMen Across the Nation**
- Funded by CDC Center for Health Promotion and Disease Prevention
- Focus:
 - Reduce risk of heart disease and stroke by...
 - Promoting healthy behavior in...
 - Women who are:
 - Ages 40-64
 - Low-income
 - Uninsured or underinsured
- Sister program: Well Woman



WISEWOMAN in Wisconsin

- Centers for Disease Control (CDC)
 - Grantor
- Wisconsin Department of Health Services (DHS)
 - Grantee
- Wisconsin Women's Health Foundation (WWHF)
 - Program Administrator
- Aurora Walker's Point Community Clinic and St. Croix Co. Health Dept.
 - Provider Organizations
- Center for Urban Population (CUPH)
 - Evaluator

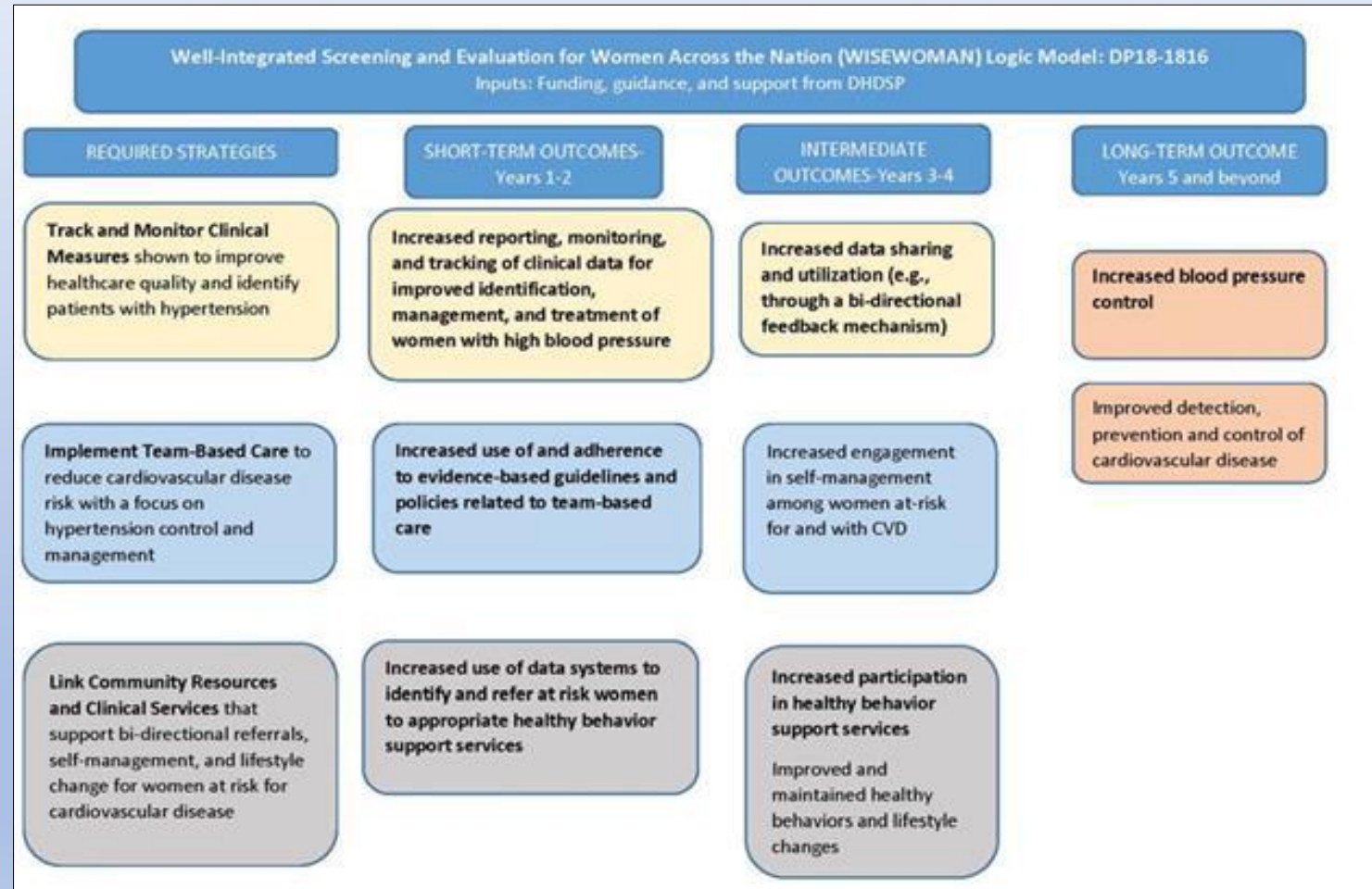


WISEWOMAN Strategies

1. Track and monitor **clinical measures** shown to improve healthcare quality and identify patients with hypertension.
2. Implement **team-based care** to reduce CVD risk with a focus on hypertension control and management.
3. **Link community resources and clinical services** that support bi-directional referrals, self-management and lifestyle change for women at risk for cardiovascular disease.



WISEWOMAN Logic Model*



*Source: WISEWOMAN Implementation Manual (Wisconsin DHS, 2020)

Purpose of Evaluation

- Year 2-Efficiency Improvement Plan and Process Model
- Focus: Walker's Point
- CDC deliverables:
 - Process models
 - Visual representation of how processes link to outputs and short-term outcomes (CDC, 2020)
 - Analysis of inefficiencies
 - Program improvements
- My role:
 - Create process models
 - Help with analysis and recommendations



Process Evaluation Concepts

- Purpose:
 - “How well the program is operating” (Rossi et al., 2004, pp 56-57).
- Based on process theory:
 - “Activities, resources, and interventions needed to achieve health change” (Issel & Wells, 2018, p 19).
- Two kinds:
 - Service utilization
 - Program organization



Methods: Process Models

- Learn about the program
- Gather information
 - Program documents
 - Provider survey
 - Interviews/focus groups
- Write out processes
- Convert to models using MS Word Drawing Tools



CUPH
Center for Urban
Population Health

*Data-driven. Evidence-based.
Community-engaged.*

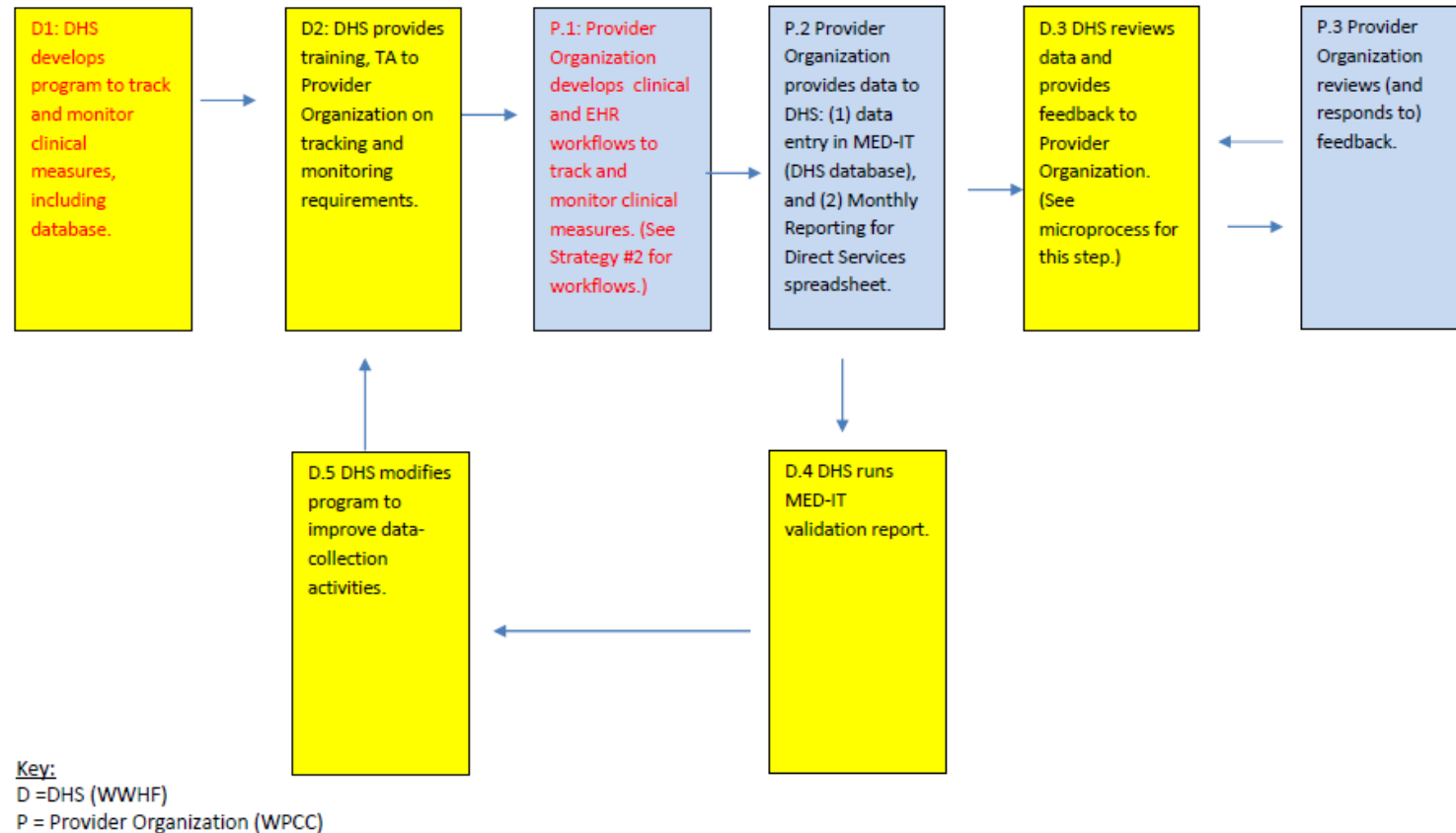
Methods: Analysis & Recommendations

- Compare to expected workflows
- Analyze data
 - Provider survey
 - WWHF Monthly Feedback Report for Walker's Point
- Discuss workflows with CUPH & WWHF
- Apply knowledge from school and work
 - Team-based care
 - Electronic health records
 - Program theory



Results: Macro Process Model

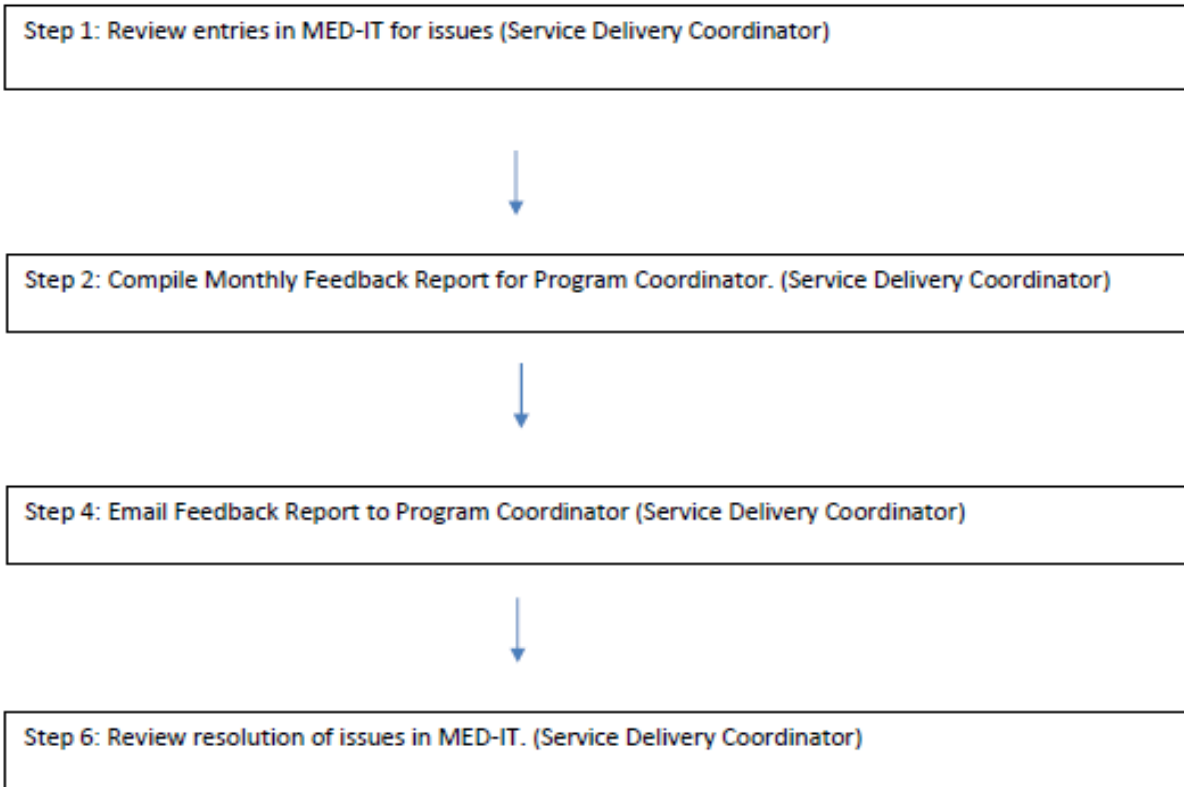
STRATEGY #1 MACROPROCESS MODEL: TRACK & MONITOR CLINICAL MEASURES



Red font used to depict most-recent changes to CUPH and WWHF

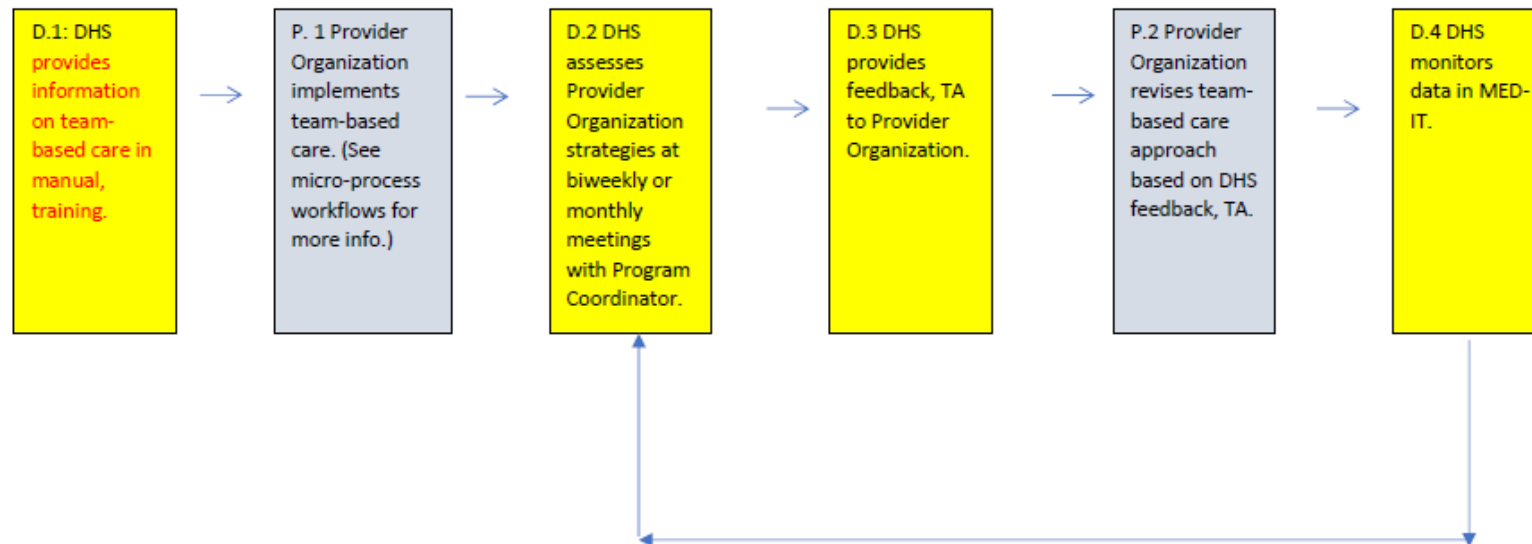
Results: Micro Process Model

Step D.3 Microprocess Model: DHS Provides Feedback Report to Provider Organization



Results: Macro Process Model

STRATEGY #2 MACRO-PROCESS MODEL: TEAM-BASED CARE*



Key:

D =DHS (WWHF)

P = Provider Organization (WPCC)

Red font used to depict most-recent changes to CUPH and WWHF

Results: Micro Process Model

Step P1 Microprocess Model: Integrated Office Visit¹

PRE-VISIT

Step 1: Monitor wait list, check for eligibility, and schedule patient (Program Coordinator)

Step 2: Make reminder call day before (appt. and fasting labs), ask risk assessment questions (WP Staff person²)

Step 3: Pre-chart, verify what labs are needed (MA)

VISIT

Step 4 (outside exam room): Obtain height, weight, BMI, and pulse (Intake Person)

Step 5a (in exam room): Finish risk assessments, obtain waist measurement (Intake Person)³

Step 5B: Obtain BPs and point-of-care labs, place orders for additional labs as needed. (MA)³

Step 6 (outside exam room): Finish writing measurements in Screening & Healthy Lifestyle guide, huddle with Clinician (Intake Person).

Step 7 (in exam room): Review guide with patient, provide risk-reduction counseling, discuss goals (Clinician)

Step 8 (outside exam room): Huddle with Coordinator (Clinician)

Step 9a (in exam room): Conduct exit interview/health coaching, help pt. develop SMART goal & choose HBSS (Program Coordinator)

Step 9b: Complete charting, document HTN or DOV referral in Epic check-out note (Clinician)

Step 10: Check out patient, schedule for DOV and/or HTN Management as needed (Front Desk)

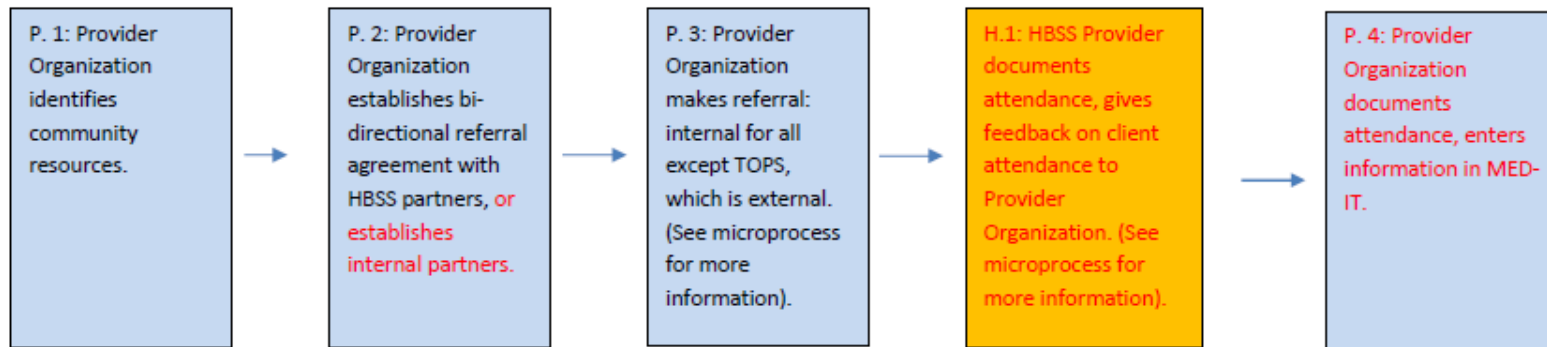
¹ Basic IOV Visit. IOV Visit for SMBP+HC is slightly different. NOTE: Visit doesn't happen if patient is not fasting.

² Depends on staffing availability.

³ This is happening at more or less same time, although intake person pauses while BP being taken.

Results: Macro Process Model

STRATEGY #3 MACROPROCESS MODEL: COMMUNITY LINKAGES*



Key:

P = Provider Organization (WPCC)

H = Healthy Behavior Support Service (HBSS) Provider

Results: Micro Process Model

Step P3 Microprocess Model: Provider Organization Makes Referral to HBSS Program

IOV Visit

Step 1: Conduct risk reduction counseling, determine readiness to make BH change, recommend SMBP if appropriate. (Clinician)

After IOV except as noted:

Step 2: Help patient choose HBSS, confirms SMBP if recommended, documents in Exit Note (Program Coordinator)¹

Step 3: Document HBSS selection in Monthly Report Spreadsheet, add patient name, DOB & IOV date in the Health Coaching Spreadsheet as appropriate (Program Coordinator).

TOPS Referral
(external)

Step 4a: Call TOPS with referral information (Program Coordinator)²

iVenga y Relajase! Referral
(internal)

Ste 4b: Send Epic message to Venga Coordinator³ (Program Coordinator)

Health Coaching Referral
(internal)

Step 4c: Send Epic message to Health Coach (Program Coordinator).

Health Coaching + SMBP
(internal)

Step4d: Contact RN for first session *at the IOV*. If not available, put in Epic check-out note for scheduling (Clinician). Send Epic message to Health Coach for remaining sessions (Program Coordinator).

¹ If no HBSS is chosen, Provider Organization calls back in 30 days to see if patient is ready.

² This was done by fax pre-pandemic on weekly basis.

³ Venga Coordinator is also the Health Coach

Results: Data Analysis

- Provider survey, limited data
- Feedback report for Walker's Point

| Task | Instances | Percent |
|-----------------------------------------------------------|------------------|----------------|
| Re-enter cycle note as Hypertension Referral Visit | 10 | 40% |
| Schedule client for Hypertension Management Visit | 9 | 36% |
| Obtain missing blood pressure or A1C measurement | 4 | 16% |
| Other | 2 | 8% |
| Total | 25 | 100% |

Results: Efficiencies

- Team-based care
 - Different roles
 - Communication via messaging, huddles
 - Some cross-training
- Internal HBSS providers
 - Communication advantages



Results: Inefficiencies

- Database not optimized, causing:
 - Re-entry of data.
 - Challenges with monitoring quality
- Limits on database expertise
- Clinical support staff absent from team meetings?

- Unclear how patients are identified



Results: Recommendations

- Continue to optimize database:
 - Modify fields to capture all data
 - Improve QA mechanisms
 - Better use of report functionality
- Provide additional training on database
 - To: WWHF, CUPH and Walker's Point
 - About: Data entry, report writing
- Ensure clinical support staff are included in team-based care
 - Appoint Medical Assistant Champion



Field Placement Challenges:

- Pandemic
 - Virtual meetings
 - Limited data sources
- Absence of Walker's Point Program Coordinator
- Limited access to quantitative data
- Different expectations
 - CUPH: Focused on CDC deliverables
 - WWHF: Focused on details of workflows



Field Placement Competencies:

- Apply public health theories, concepts and models.
- Select data collection methods
- Analyze data using biostatistics, informatics, etc.
- Interpret results of data analysis
- Demonstrate how evaluation design and data analysis are used to conduct outcome and impact analysis.



Gratitude List

This field placement was brought to you by....

- Virtual platforms (Zoom, MS Teams & Box)
- Weekly meetings with preceptor, Michelle, and Carrie, two fellow data nerds
- Feedback and support from preceptor & Dr. Zusevics
- Patient instruction from WWHF re: the complexities of WISEWOMAN
- Walker's Point staff persevering in the presence of the pandemic and the absence of their Program Coordinator

References

Center for Urban Population Health. (n.d.). *Approach*. Retrieved December 6, 2020 from

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