

HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

DECEMBER 2025

Agenda

- 1. Welcome, Program Updates**
- 2. Grantee Report-Outs and Peer Sharing**
 - Whitman-Walker Health
 - Family and Medical Counseling Service, Inc.
- 3. Q & A**
- 4. Next Steps and Reminders**

Welcome!



Come on Video



Introduce Yourself in the Chat

Name, Title,
Organization/Affiliation



Ice Breaker: What is your favorite winter activity?

Welcome, Program Updates and Reminders

Bonny Nunez, MPH, Public Health Analyst, DC Health

Latrice Hughes, MPH, Public Health Analyst, DC Health

Heart Disease and Stroke Prevention Learning Collaborative: 2025-2026

Learning Collaborative Structure



Quarterly Cycles:

Informed by Strategic Plan and participant-identified priorities based on the HIT/EHR Assessment



Capacity Building Calls:

- Framed in data
- Health equity focus
- Focus on building and applying knowledge



Workplan Report-Out:

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- Identify share problem solving, best practices, innovative approaches, and partner engagement



Bi-Annual In-Person Strategic Planning:

To foster shared vision and progress toward goals



Collaboration and Engagement:

All virtual and in-person events focused on participatory engagement and collaboration, include team members where relevant



Current Cycle

Collaboration Between Partners to Strengthen Referral Making



- **October 15:** Leveraging Social Needs Data to Support Referral Processes



- **November 19:** Maximizing Your Care Team



- **December 17:** Grantee Report-Outs/Action Cycle

Whitman-Walker Health

Grantee Report-Out

Kenneth Cole, MPH, Evaluation Specialist

Using Epic to Improve Cardiovascular Health Outcomes

Whitman Walker Health (WWH)

Presentation to DC Health and the Heart Disease and Stroke Prevention Learning Collaborative



Grantee Report Out:

Goal: Establish the foundation for a high-impact, data driven care coordination model to improve cardiovascular outcomes using Epic Electronic Health Record (EHR)

Objective:	Use Epic Healthy Planet and UDS quality metrics to define a high-risk cohort of adult WWH patients (including Black men) with uncontrolled hypertension (BP \geq 140/90) and/or elevated LDL cholesterol ($>$ 100 mg/dL) and stratify by key equity variables.
Population of Focus:	Patients with uncontrolled hypertension, with a focus on Black and African American Men
Key Activities:	High-risk cardiovascular cohort defined; Healthy Planet registry built and activated in Epic; Cohort stratification summary generated by race, ethnicity, ZIP code/DC Ward, and risk level
Health Indicators:	Blood pressure measurements; LDL cholesterol measurements
Key Internal Personnel:	Lean Steering Committee; Evaluation Specialist; Data Analyst; Care Teams;
Key External Personnel:	Lean Consultant; Epic Healthy Planet Partners

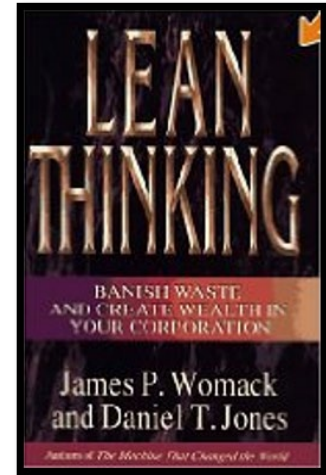
we see
healthier lives
moving forward

Background

WHITMAN-WALKER HEALTH
we see you.

What is Lean?

"A systematic approach to improving patient care with minimal waste by streamlining processes, reducing delays, and engaging staff in problem-solving. It creates a culture where everyone contributes to improving the way care is provided."



- Grant awarded to WWH from DC Health for process improvement
- Utilize inter-departmental teams to identify waste in WWH workflows and **empower staff to make change**
- Entering Year 2

Goals:

- Improving clinic efficiency and effectiveness
- Increase revenue
- Address and improve health outcomes like hypertension and other cardiovascular issues

New Electronic Medical Records (EHR)

- WWH switched from eClinical Works to Epic in November 2025
- Epic brings high-quality care coordination and reporting tools that can be used to improve quality improvement projects at WWH
- WWH will utilize these tools in its Lean process improvement work to optimize clinical workflows and better engage patients – especially Black and African American Men – in care

Future Objective Plans

- **Leverage Epic Tools to create a care coordination workflow for the defined population**
 - Create and test Epic tools like SmartSets and Our Practice Advisories to help close care gaps for the targeted high-risk group.
 - Care gaps and Problem list customization

CARE GAPS

- HIV Viral Load
- Zoster Vaccines (2 of 2)
- Meningococcal Vaccine (2 - ...)
- Anal Pap
- Diabetes: Hemoglobin A1C
- Hepatitis B Screening
- Hepatitis B Vaccines (1 of 3 ...)
- MMR Vaccines (1 of 2 - Risk...)
- Colorectal Cancer Screenin...
- Show fewer

Problem List

Cardiac and Vasculature
Hyperlipidemia
Primary hypertension

GEN Diabetes Type 1 and 2

- Diagnosis
 - Diabetes Mellitus Type 1 [Click for more](#)
 - Diabetes Mellitus Type 2 [Click for more](#)
- Orders
 - Labs - Today [Click for more](#)
 - Labs - Future [Click for more](#)
- Medications
 - Insulins [Click for more](#)
 - ACE Inhibitor
 - captopril (Capoten) 12.5 MG tablet
 - Take by mouth.
 - Normal
 - This medication will not be e-prescribed. Invalid items: Provider**

OurPractice Advisories [Expand All](#)

Important (4)

This patient has a diagnosis of myocardial infarction or coronary artery disease and has not been prescribed antiplatelet therapy. Complete the recommended SmartSet or indicate the reason for not prescribing.

ID: 1012

[Open SmartSet](#) [Do Not Open](#) [Antiplatelet Therapy Preview](#)

Future Objective Plans

- **Create and baseline actionable metrics to monitor the effectiveness of the created care coordination workflow**
 - Metrics will directly monitor health outcomes, care team adherence, and equity gaps
 - Examples:
 - % of Patients with BP Control
 - Visit Completion Rates
 - % offered Statin Therapy
 - Metrics will contain documented definitions, numerators, and denominators

Questions and Comments?

- *Have others experienced similar challenges and opportunities with electronic health record transitions or updates? If so, what did you learn?*
- *Do other organizations leverage Lean in your setting? If so, how? Related to which activities?*
- *What other suggestions do you have for the Whitman-Walker Health team to help with next steps?*

Family and Medical Counseling Service, Inc.

Grantee Report-Out

Ajani Armand, BS, MPH Candidate, QI Specialist

Angela Chatman, MSN, RN, Nurse Care Coordinator



Family and Medical Counseling Service Inc.



1st PDSA : Improve patient engagement in Care Coordination Series

Plan

- **What are we testing** : If continuing to **offer a patient incentive of \$100** and **shortening time frame from 6 or 8 months to 6 or 8 weeks would improve patients' engagement** in '6 session Hypertension Education Series'/ '8 session Dual Diagnosis Series' with Care Coordination team. **Baseline Data: GY25 Qtr. 3 baseline data indicates that 9 patients were referred to program.** Outreach attempt was made to all 9 to follow-up and engage in services. 8 were reached and 3 were linked to services. **During Qtr. 3 only 4 patients successfully completed program** and received \$50 gift card **Goal:** To improve patient engaging into Care Coordination Education Series from 3 (baseline qtr. 3 data) to **15 patients in qtr. 4 and improve program completion** from 4 (baseline qtr. 3 data) to 10 patients.
- **On whom are we testing the change:** FMCS DC MHI Care Coordinator and FMCS medical eligible hypertension patients with a BP greater than or equal to 140/90 and diabetes patients with an A1c greater than or equal to 9.
- **Where** : FMCS DC Facility
- **Data to collect:**
 - How many patients eligible for program
 - How many patients targeted for outreach and engagement into program using messenger campaign
 - How many patients referred by medical providers
 - How many patients responding to campaign
 - How many patients engaged and linked to program.
 - How many patients received telephone reminders for all appointments scheduled
 - How many patients kept all scheduled appointments
 - How many patients completed program
 - Care team feedback
 - Patient feedback

Do

- Continued to offer a patient incentive of \$100 during PDSA.
- **Identified 206 eligible patients** to send messenger campaign informing them of program and incentive to outreach and engage in program. **(eligible visit between May 1, 2024 and 4/30/2025)**



1st PDSA : Improve patient engagement in Care Coordination Series

- **Developed Messenger Campaign and sent to patients on May 5, 2025** Text 1: FMCS Alert: You are eligible for FMCS Hypertension Education Program! Earn a \$100 gift card. Contact Angela Foster at (202) 889-7900 *203 ASAP. Limited spots! Voicemail/Voice Message: FMCS Alert: Great news! You are eligible to enroll in our FMCS Hypertension Education Program. For participation you will receive a \$100 gift card upon completion. Contact Tracie Robinson at (202) 889-7900 as soon as possible for more information. We are looking forward to hear from you soon!

Study

- **What Happened** : 200 unique patients were reached via text and voice modalities. Campaign emphasized \$100 incentive and need to respond ASAP. Campaign was sent out on May 5, 2025 at 12:30pm. At about 2:30pm received an email from Angel indicating she was getting an influx of call (~40 patients) . **17 patients were enrolled into the program with 16 coming from the campaign** and 1 patient from doctor referral, Dr. King. Out of the 17 that were enrolled, 9 patients were able fully complete the program .
- **Observations/ feedback** : Shortening the time frame was successful and seemed feasible for both staff and patients. It moved clients through more swiftly, and they appeared to enjoy the camaraderie of the group format. However, concerns during feedback included information retention and the reduced opportunity for individual sessions to discuss personal challenges. Patients have preferred group sessions, as an individual session option was offered to complete the program, but none chose that option

Act

What changes should we make before the next cycle: The changes implemented have proven successful to increase enrollment, but still some barriers with completion rate. A possible adjustment in incentive rollout could help with completion rates.

2nd PDSA : Improve patient participation in MHI activities.



Plan

- **What are we testing** : If using campaigns promoting incentives can improve group participation.
- **Goal:** To improve patient engaging into group fitness/patient education sessions.
- **On whom are we testing the change:** FMCS medical eligible hypertension patients with a BP greater than or equal to 140/90
- **Where :** FMCS DC Facility
- **Data to collect:**
 - How many patients eligible for program
 - How many patients targeted for outreach and engagement into program using messenger campaign
 - How many patients responding to campaign
 - How many patients engaged and linked to program
 - How many patients kept scheduled appointments
 - Care team feedback
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Do

- Continue to offer a patient incentive for 1st 10 patients participating in groups. during PDSA measurement period
- Identify eligible patients to send messenger campaign informing them of program and incentive to outreach and engage in program.
- Develop Messenger Campaign and send to patients :
 - FMCS Stroke Awareness Month: Join us May16th. First 10 clients to register & attend get a \$25 gift card! Call Nurse Angela at 202-889-7901x206 for more info.
 - FMCS Let's Get Fit! Wed, May 21 @ 12:30. JOIN for Tips, Giveaways & WALK! First 10 to Register & Stay get \$25 gift card! Call Angel @ 202-889-7900 extension. 203
 - FMCS Workshop: First 10 to register & stay get a \$20 Giant gift card! Join us May 28 @ 1PM for Blood Pressure Matters! Call Nurse Angela @ 202-889-7901 x206.
- Ensure to schedule patient for sessions fist call first serve
- Provide first 10 patients incentives

2nd PDSA : Improve patient participation in MHI activities.



Study

- **What Happened :** ~ 750 patients reached through campaigns. Patient enrollment and participation did increase.
 - 39 patients registered for event on May 16th, and 37 patients attended and participated in event
 - 23 patients registered for walk on May 21st, and 12 patients attended and participated in event
 - 9 patients registered for event on May 28th, and 7 patients attended and participated in event
- **Observations/ feedback :** Incentive messaging did increase participation in events. It is important for all staff involved to be aware of when messaging is sent out and to agree on the workflow for identifying the “first 10.” Clear communication should be provided to patients regarding their eligibility to receive a gift card. It is not best to send campaigns out on a Friday, but also not too far in advance of the event.

Act

What changes should we make before the next cycle: Possibly, a generalized script to hand out for when patients call to limit any possible confusion

Questions



- **What other types of messaging have resonated with your patients beyond monetary incentives?**
- **Have you found alternative incentives that improved engagement or completion?**
- **What strategies have been most effective in improving completion rates for your care coordination series?**





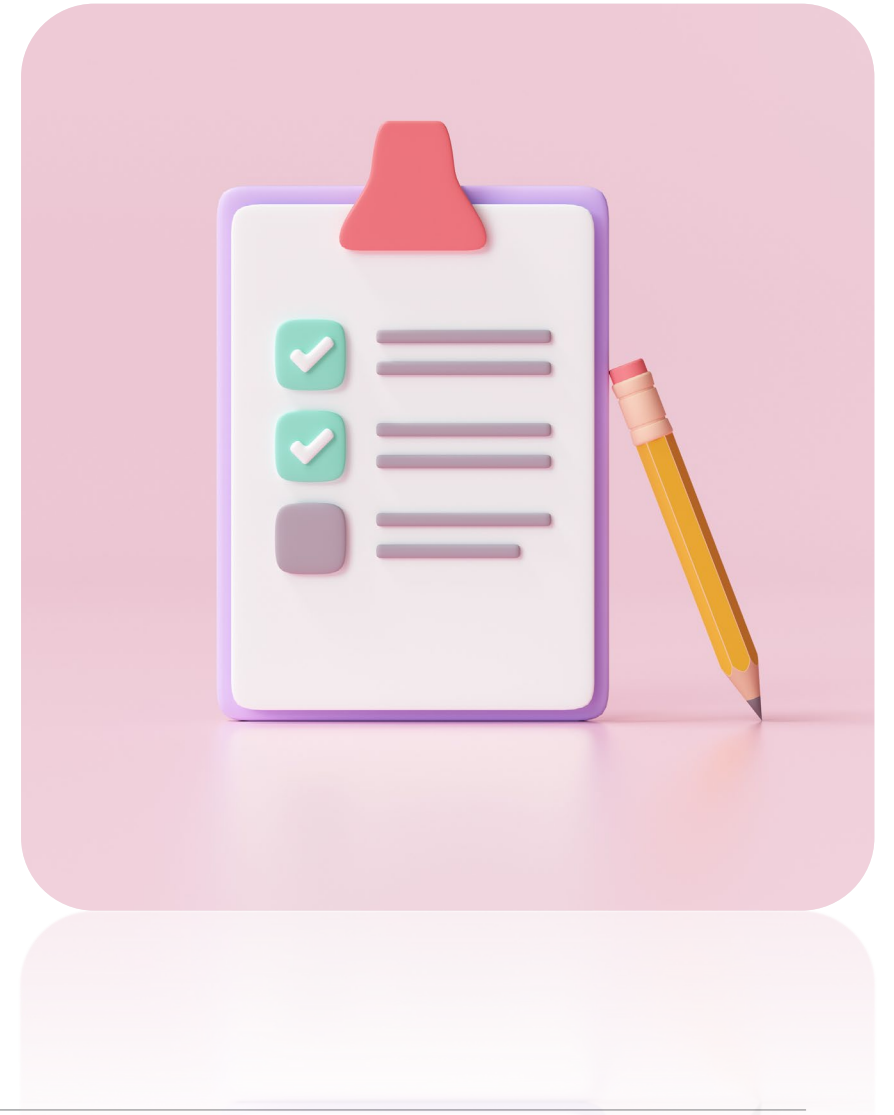
Next Steps and Reminders

Latrice Hughes, MPH, Public Health Analyst, DC Health

Bonny Nunez, MPH, Public Health Analyst, DC Health

Quick Evaluation Poll

- 1. To what extent did the session meet objectives?**
(1 - not at all to 5 - met all objectives)
- 2. How would you rate the session overall?**
(1 - poor to 5 - excellent)



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Reminders!

- Due January 7, 2026
 - Patient-Level Data submission
 - *note updated date!*
- Due January 15, 2026
 - Quarterly Reporting submission



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Next Cycle



- **January 21:** Statin Therapy 101



- **February 11:** In-Person Session – *Save the date email and more details coming soon!*



- **March 18:** Grantee Report-Outs/Action Cycle

HAPPY HOLIDAYS



DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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