

HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

AUGUST 2025

Agenda

- 1. Welcome, Program Updates**
- 2. Framing the Topic in Data: Hypertension Medication Adherence Trend Data**
- 3. Supporting Medication Adherence Through Data: Clinical Importance and Best Practices**
- 4. Supporting Medication Adherence Through Data: CRISP DC PopHealth Analytics Tool**
- 5. Q & A and Next Steps**

Welcome!



Come on Video



Introduce Yourself in the Chat

Name, Title,
Organization/Affiliation

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:

- Health system grantees selected to report
- 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



- **July 16:** Best Practices for Identifying a High-Risk Cohort



- **August 20:** Supporting Medication Adherence through Data



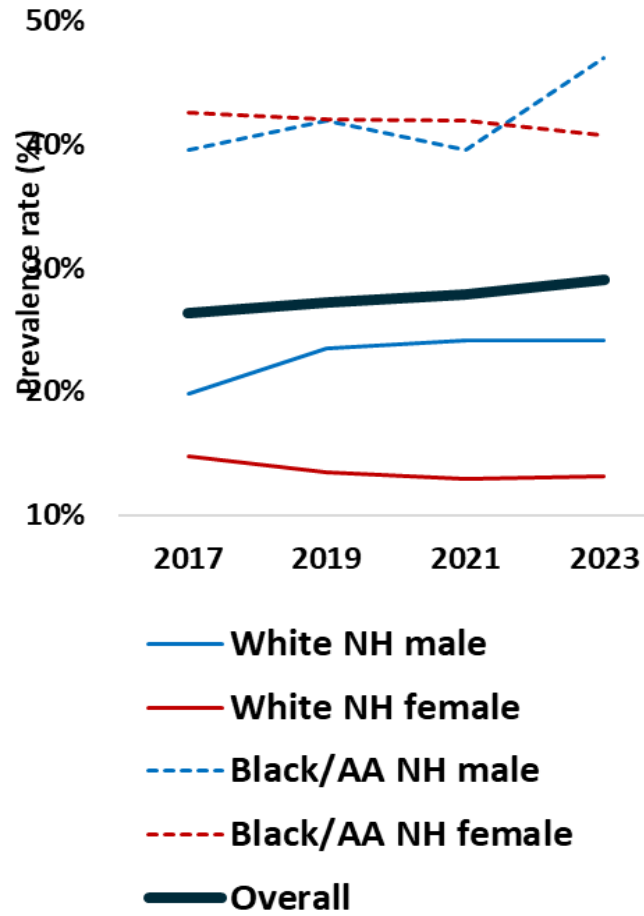
- **September 10:** In-Person Session and Workplan/Action Cycle Report Out

Framing the Topic in Data: Hypertension Medication Adherence Trend Data

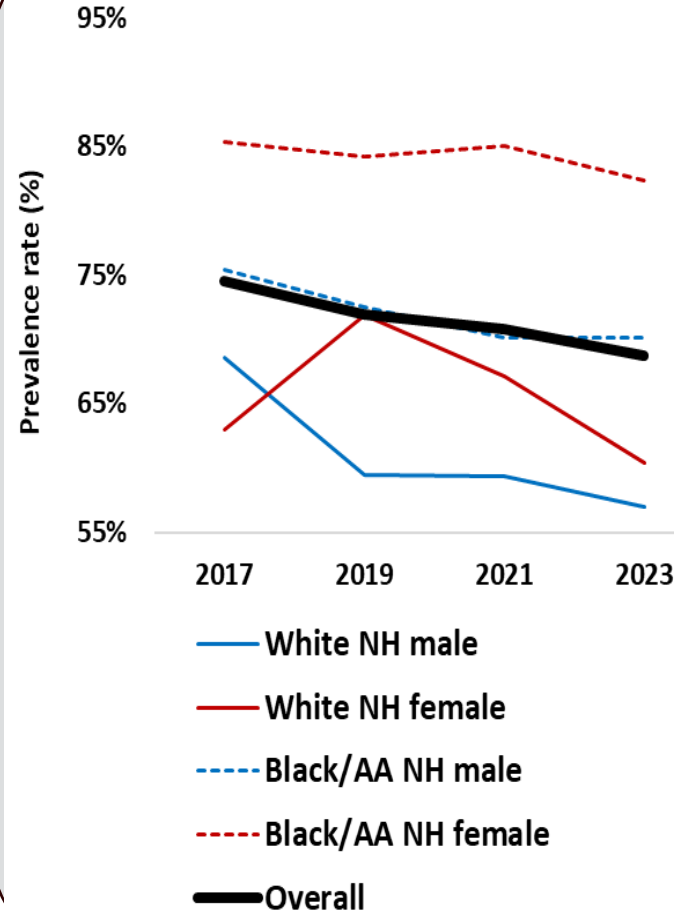
Saumya Rajamohan, Data Analyst, DC Health

High blood pressure – Trends in prevalence, medication adherence & control

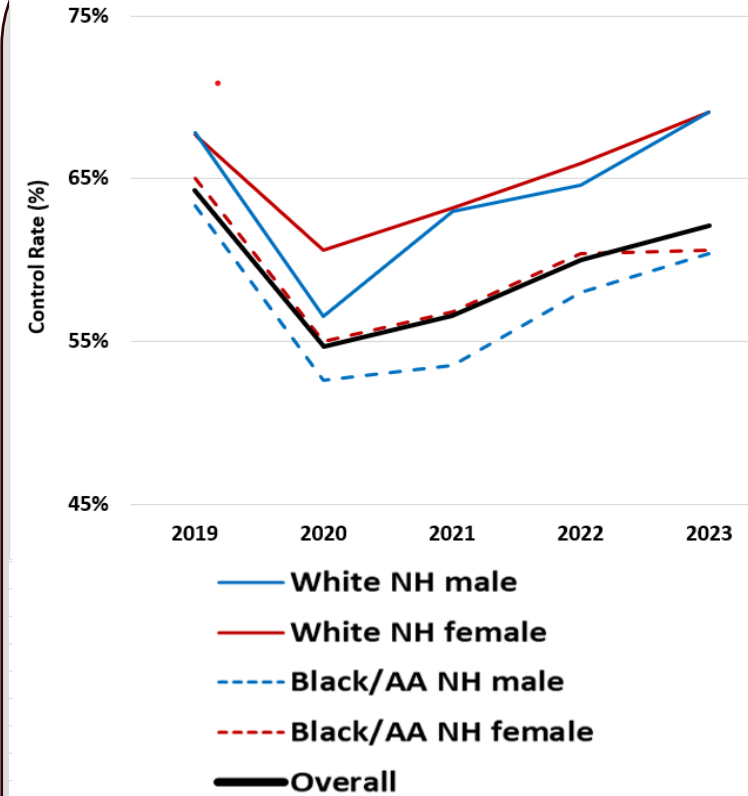
Trends in hypertension prevalence



Trends in anti-hypertensive medication adherence

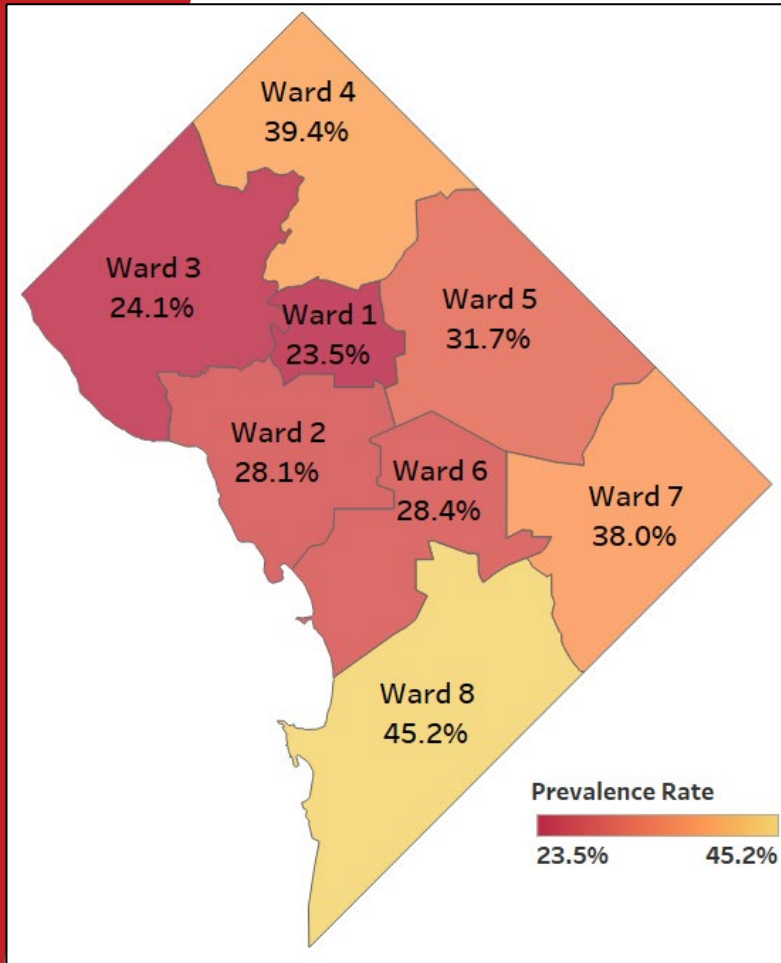


Trends in hypertension control

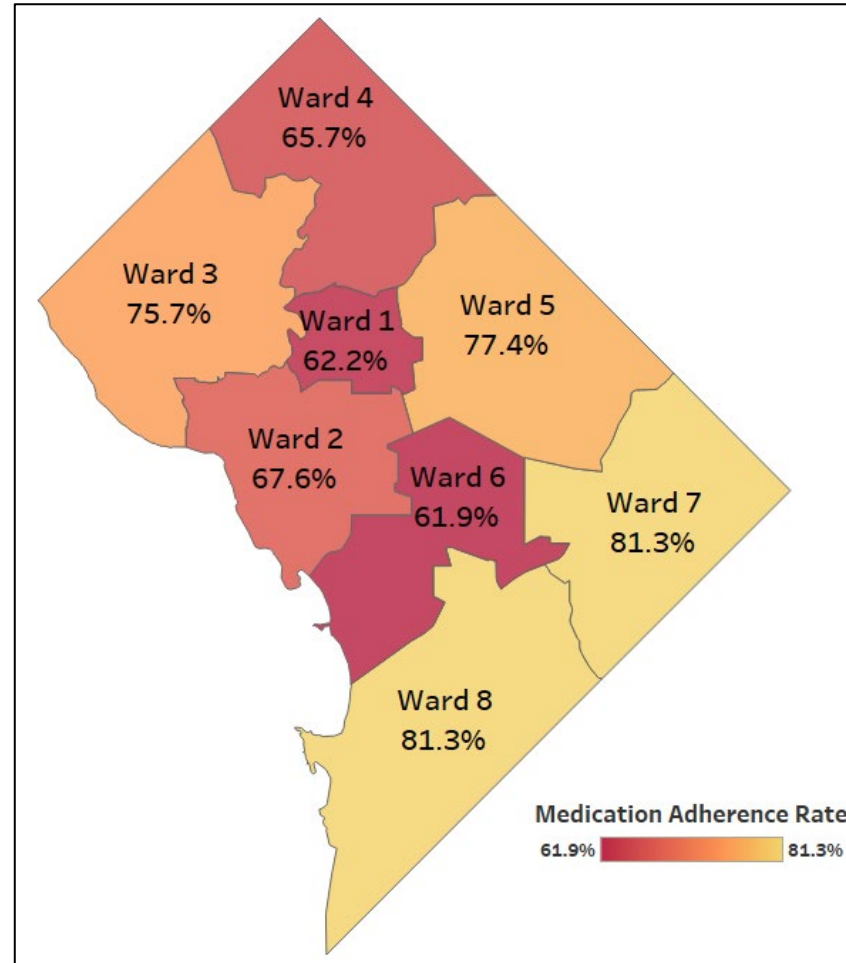


High blood pressure – prevalence, medication adherence & control - By District Wards

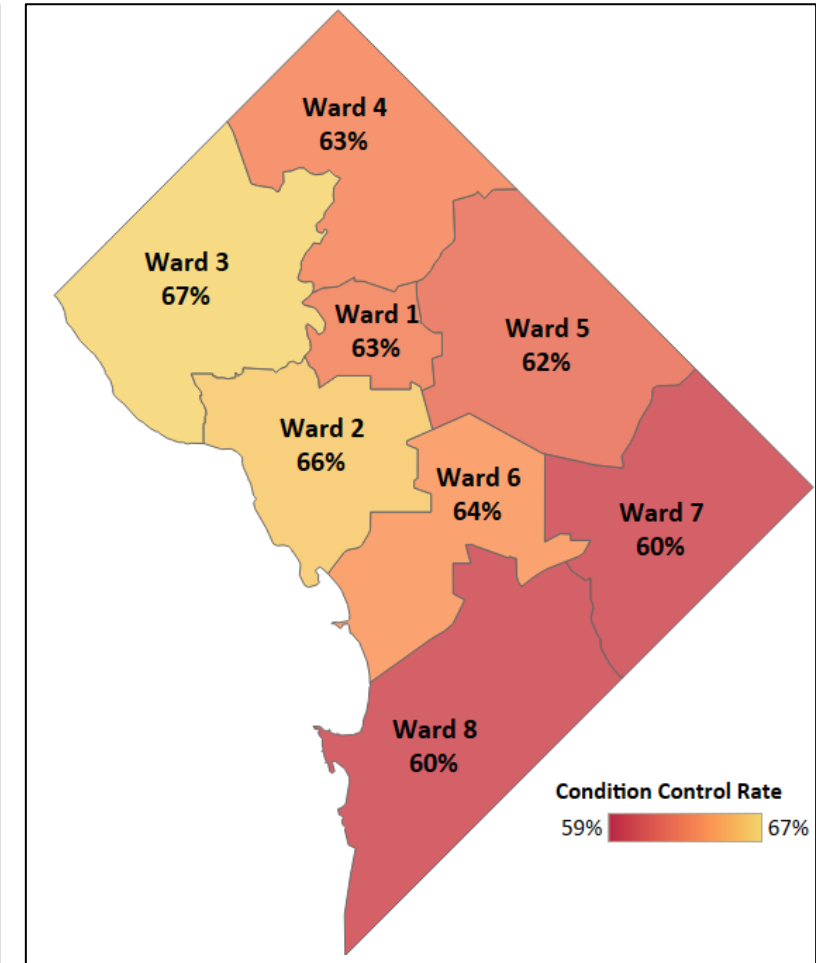
Hypertension prevalence by District Wards



Anti-hypertensive medication adherence by District Wards



Hypertension control by District Wards



Supporting Medication Adherence Through Data: Clinical Importance and Best Practices

Art Jones, MD, Principal, HMA

Prevalence of BP control <140/90

- National Health and Nutrition Examination Survey (39.4% of patients were unaware of their hypertension)

– 1999 31.8%

– 2014 53.8%

– 2018 43.7%

- HRSA for District Community Health Centers

– 2020 49.1% 2021 52.4% 2022 60.0%

– 2023 62.4% 2024 63.1%

Egan BM, Li J, Hutchison FN, Ferdinand KC. Hypertension in the United States, 1999 to 2012: progress toward Healthy People 2020 goals. *Circulation*. 2014;130:1692–1699. doi: 10.1161/CIRCULATIONAHA.114.010676

Definition of Patient Adherence

- The World Health Organization defines adherence as the extent to which a person's behavior—taking medication, following a diet, or executing lifestyle changes—corresponds with agreed-on recommendations from a health care professional.

World Health Organization. Adherence to long-term therapies: evidence for action, section 1: setting the scene. Accessed January 17, 2020. https://www.who.int/chp/knowledge/publications/adherence_full_report.pdf

Hypertension Medication Adherence

- A longitudinal database study of 21 clinical trials of 4783 participants with hypertension show that the persistence declines over time and by the end of one year, almost half of the patients stop taking their medication.
- Three phases
 - Treatment initiation
 - Implementation
 - Discontinuation

Vrijens B, Vincze G, Kristanto P, Urquhart J, Burnier M. Adherence to prescribed antihypertensive drug treatments: longitudinal study of electronically compiled dosing histories. *BMJ*. 2008;336(7653):1114–1117. doi: 10.1136/bmj.39553.670231.25

Factors Associated with Nonadherence

- **Socioeconomic and demographic dimension**
 - Low health literacy
 - Lack of family or social support network
 - Unstable living conditions
 - Limited access to health care facilities
 - Lack of health care insurance
 - Inability to access or difficulty in accessing pharmacy
 - Financial insecurity

Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. *Hypertension*. 2022;79:e1–e14. DOI: 10.1161/HYP.0000000000000203

Factors Associated with Nonadherence

- **Therapy Related**
 - Complexity of medication regimen
 - Duration of therapy
 - Frequency of change of medication regimen
 - Lack of immediate benefit
 - Social stigma
 - Actual or perceived unpleasant side effects
 - Interference with lifestyle

Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. Hypertension. 2022;79:e1–e14. DOI: 10.1161/HYP.0000000000000203

Factors Associated with Nonadherence

- **Health Care System**

- Clinician communication skills
- Disparity between health beliefs of patient and clinician
- Lack of positive reinforcement from clinician
- Limited health system capacity for patient education and follow-up
- Lack of clinician knowledge about adherence and interventions to improve it
- Patient information materials written at too high a literacy level
- Changes or restrictions in formulary
- Long wait times
- Lack of continuity of care

Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. *Hypertension*. 2022;79:e1–e14. DOI: 10.1161/HYP.000000000000203

Factors Associated with Nonadherence

- **Patient-related**

- Visual , hearing or cognitive impairment
- Impaired mobility or dexterity
- Swallowing problems
- Psychological or behavioral factors including substance use disorder
- Perceived risk of disease
- Understanding the reason why medication is needed
- Expectations and attitudes toward treatment

Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. Hypertension. 2022;79:e1–e14. DOI: 10.1161/HYP.000000000000203

Factors Associated with Nonadherence

- **Patient-related**

- Beliefs about illness
- Perceived lack of benefit of treatment
- Confidence in ability to follow treatment regimen
- Motivation
- Fear of dependence or possible side effects
- Fear of stigmatization by disease
- Frustration with health care providers
- Lack of symptoms

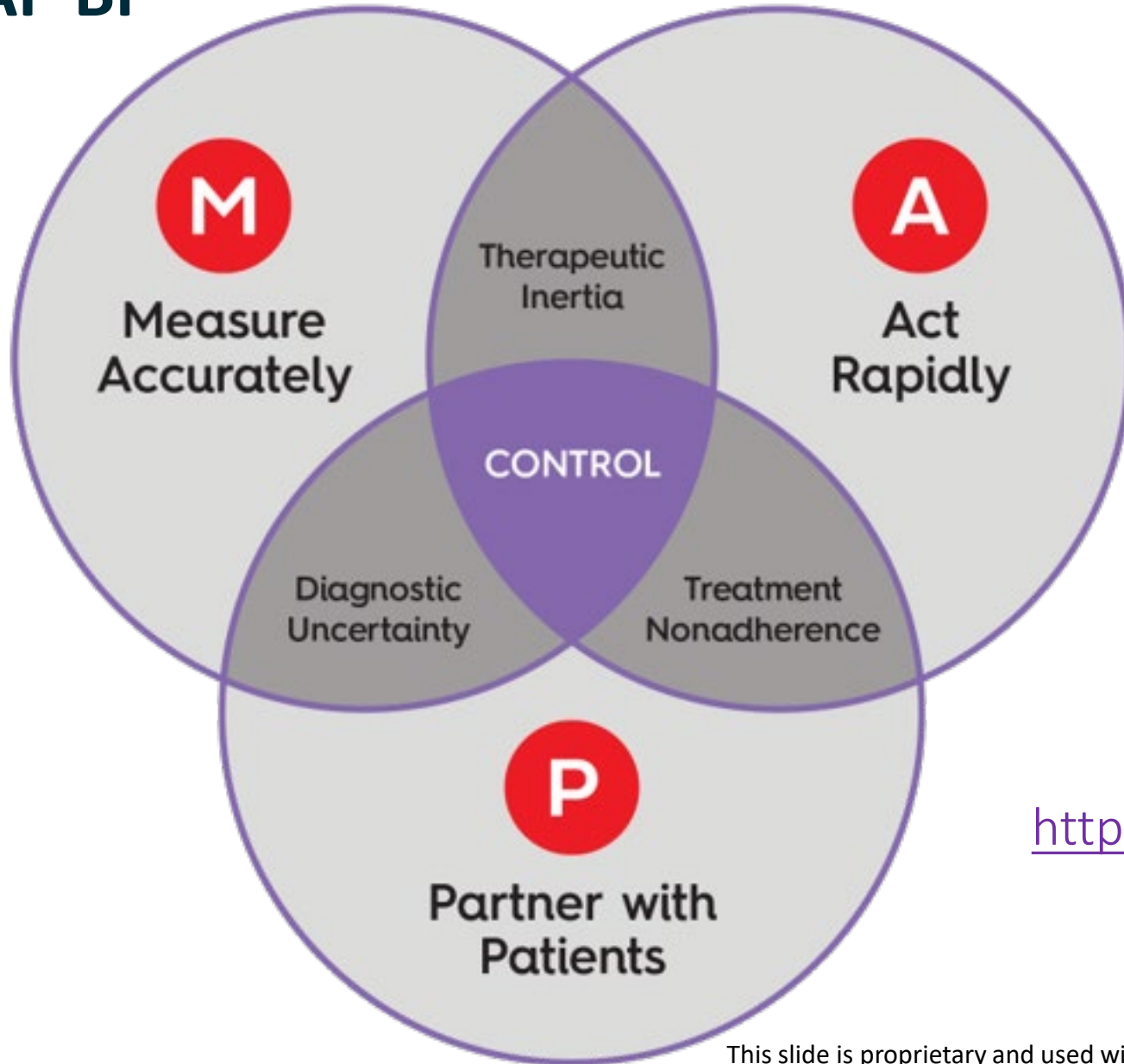
Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. *Hypertension*. 2022;79:e1–e14. DOI: 10.1161/HYP.000000000000203

Interventions for Improving Medication Adherence

- Patient education and counseling
- Simplifying treatment regimens
- Pharmacist consultation
- Motivational interviewing
- Reminders, monitoring, and feedback
- Self-monitoring of blood pressure
- Patient incentives

Choudhry, NK et al. Medication Adherence and Blood Pressure Control: A Scientific Statement from the American Heart Association. *Hypertension*. 2022;79:e1–e14. DOI: 10.1161/HYP.0000000000000203

AMA MAP BP™



<https://map.ama-assn.org>



Partner with Patients

Strategy: Engaging patients in self-management of their BP

Following up
frequently

Using collaborative
communication

Assessing & Addressing
medication
adherence

Counseling
and supporting
positive lifestyle change

Using
self-measured BP

Source: AMA MAP BP™

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Follow-up Every 2-4 weeks Until BP is Controlled

- Schedule follow-up before patient leaves
- Generate lists of patients who are due follow-up
- Identify other members of the care team can support follow-up
- Develop outreach processes
- SMBP

Source: AMA MAP BP™

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Train team members on collaborative communication strategies

Collaborative communication strategies

Partner with patients



How clinicians communicate with patients can influence treatment adherence. Below are some strategies you can implement immediately to help you communicate more effectively.

Strategy	Example
Begin with open-ended questions about adherence, including recent medication use	AVOID: "Are you taking your medicines?" TRY: "How are your medications working for you?"
Address "red flags" (e.g., missed appointments, prescription refills, requested labs, and lack of therapeutic response to medication change)	AVOID: "Why did you miss your appointment?" TRY: "I noticed you missed your clinic visit two months ago. Is there something we can do to help you get your follow-up care?"
Explore reasons for possible non-adherence	AVOID: "Let me prescribe a different pill that might work better." TRY: "What do you think would make it easier?"
Elicit patient views on options and priorities to customize a care plan for each patient	AVOID: "Have you considered using a pillbox?" TRY: "What do you think would work for you?" or "What has worked for you in the past?"
Remain non-judgmental at all times	AVOID: Educational statements like "It's really important to take your pill if you want to control your blood pressure." TRY: Supportive statements like "Let's think about this problem together; maybe we can come up with something that will work for you."
Use teach-back to ensure understanding of the care plan	AVOID: Close-ended questions like "Does this make sense to you?" TRY: "What is your understanding of what we've discussed today?"
Use positive reinforcement to encourage healthy ideas or behaviors	AVOID: "You haven't been eating healthy or losing weight, only walking. You are not helping lower your blood pressure like we discussed." TRY: "It's good that you've been walking. Let's talk about other things you can do to control your blood pressure."

Use collaborative communication

How would you respond:

You're still taking all
the same
medications, right?

VS

How is your lisinopril
working for you?
How are you taking
it?

Source: AMA MAP BP™

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High blood pressure? Medicine can help you take control.

When your blood pressure is too high, it can hurt your body — including your heart, brain, kidneys, eyes, and nerves. But you have the power to protect your health.

Taking medicine is taking action.

Here's why. Blood pressure medicine is . . .



Effective.

It's one of the best ways to lower blood pressure.



Safe.

Blood pressure medicines are well-tested and widely used. And most people don't feel side effects at lower doses.



Simple.

A single pill that contains 1 to 3 medicines is usually all you'll need.



A healthy choice.

And one that works together with other healthy choices, like eating well and staying active.



Low cost.

It's often covered by insurance or through discount programs. Most people can find an option that works with their budget.

Talk to your doctor or care team today about what a healthy blood pressure is for you, and using medicine as part of your plan.

AMA MAP™
Hypertension

This resource is part of AMA MAP™ Hypertension Quality Improvement Program. Using a single or subset tool or resource does not constitute implementing the program. This content is provided only for informational purposes and should not be used in place of an actual doctor's visit.

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SMBP Education

Measure Accurately: Self-Measured BP Best Practices

Learning Objectives

1. Describe the importance of SMBP
2. Explain the seven steps for identifying and training patients to accurately perform and document SMBP measurement

Module  Take Quiz  Resources



https://edhub.ama-assn.org/ama-cvd-prevention-education/interactive/18933518?resultClick=1&bypassSolrId=M_18933518

SMBP Jumpstart: A Self-Measured Blood Pressure Curriculum

Learning Objectives

1. Articulate the value of an SMBP program to health center leadership, care team members, patients, and community members
2. Develop an adaptable and iterative SMBP program strategy
3. Identify and prioritize what components are most crucial for successfully implementing an SMBP program
4. Incorporate clinical knowledge of SMBP best practices and patient data into treatment plans
5. Configure and manage an inventory of SMBP devices

Module  Take Quiz  Resources



https://edhub.ama-assn.org/ama-cvd-prevention-education/interactive/18835921?resultClick=1&bypassSolrId=M_18835921

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Provider Treatment Inertia

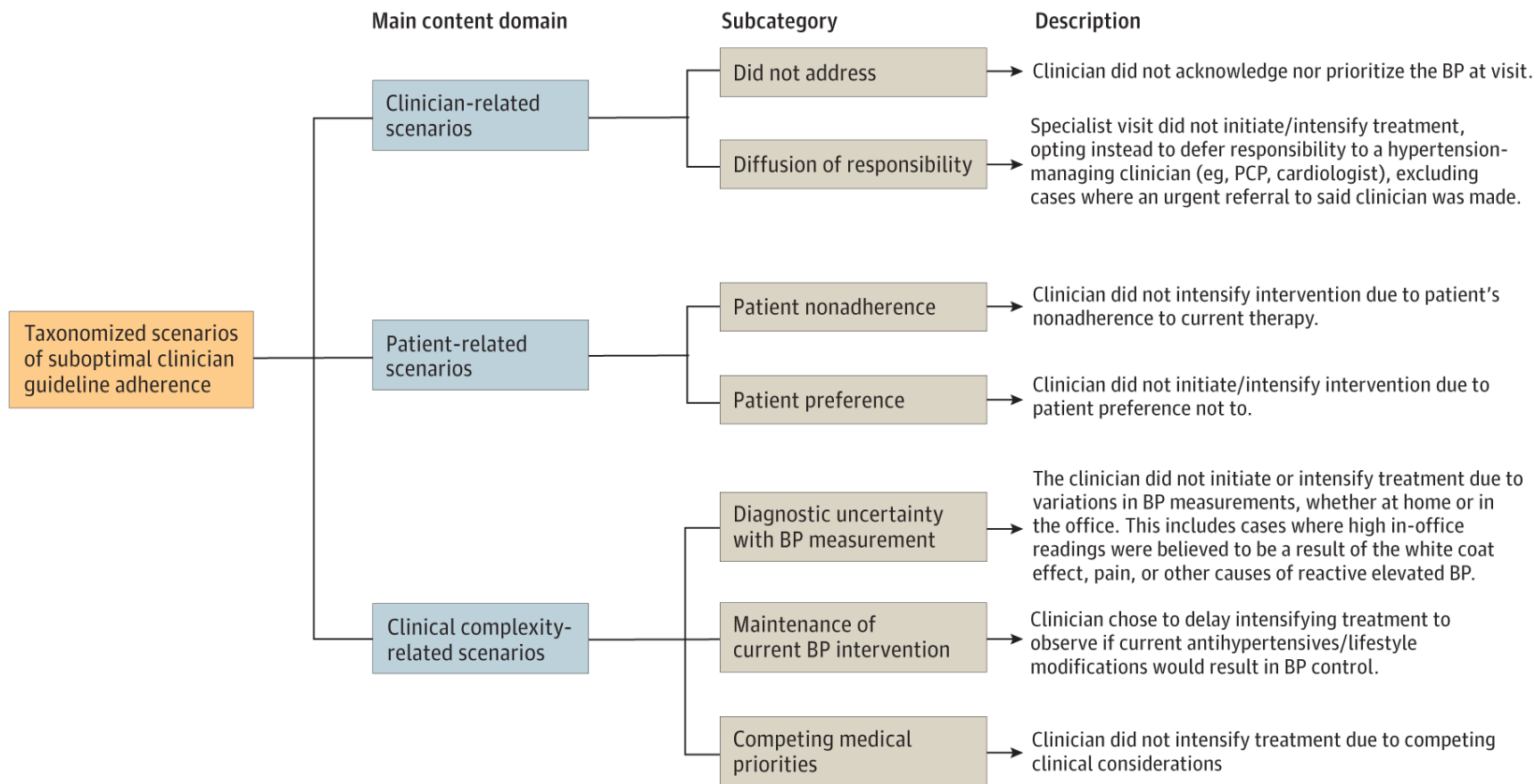
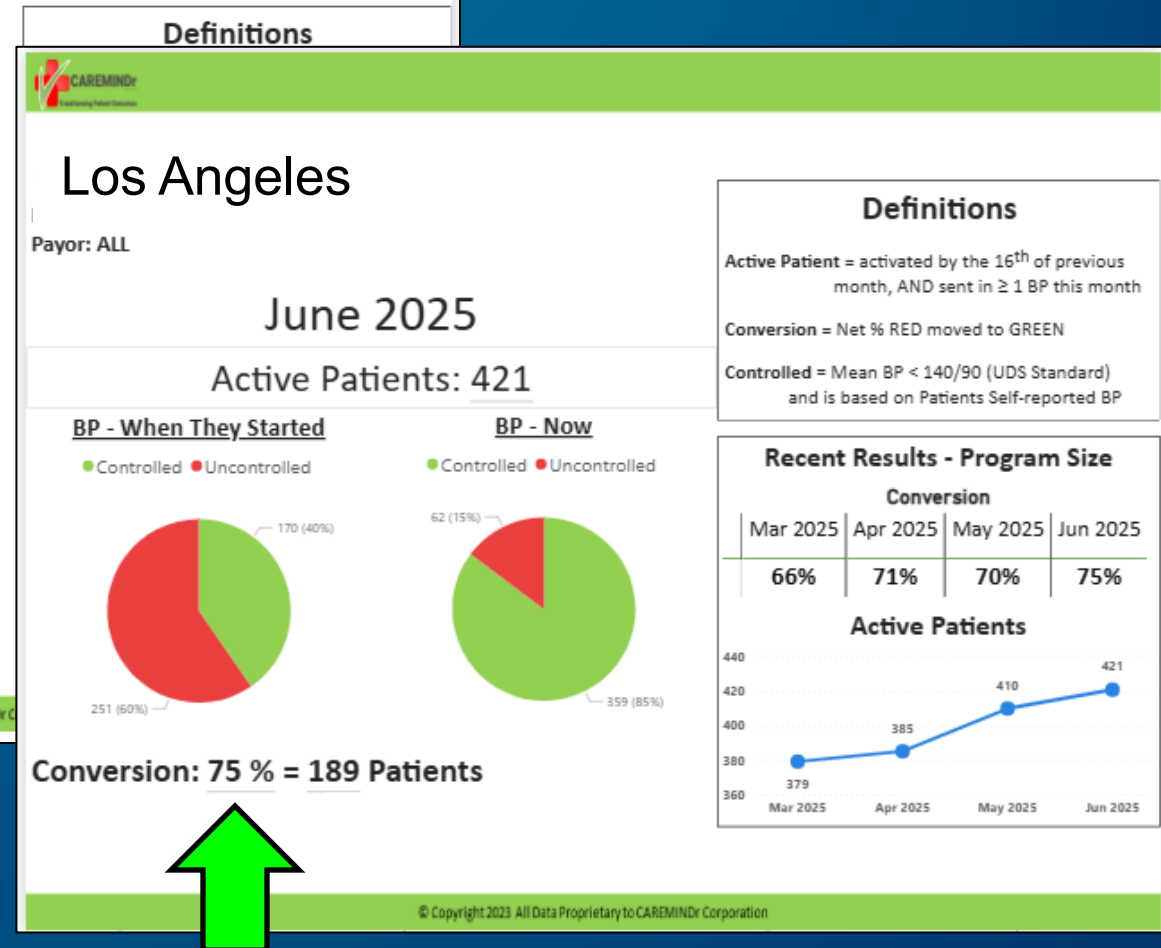
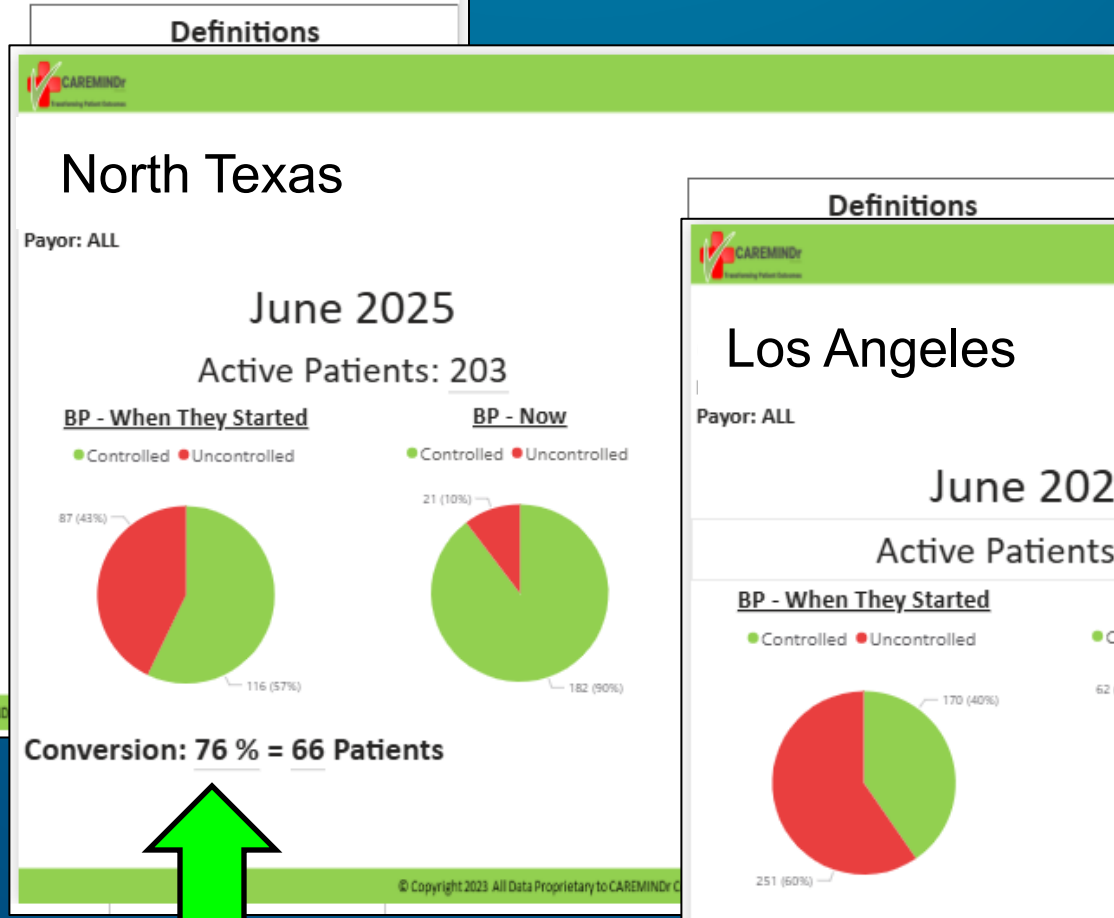
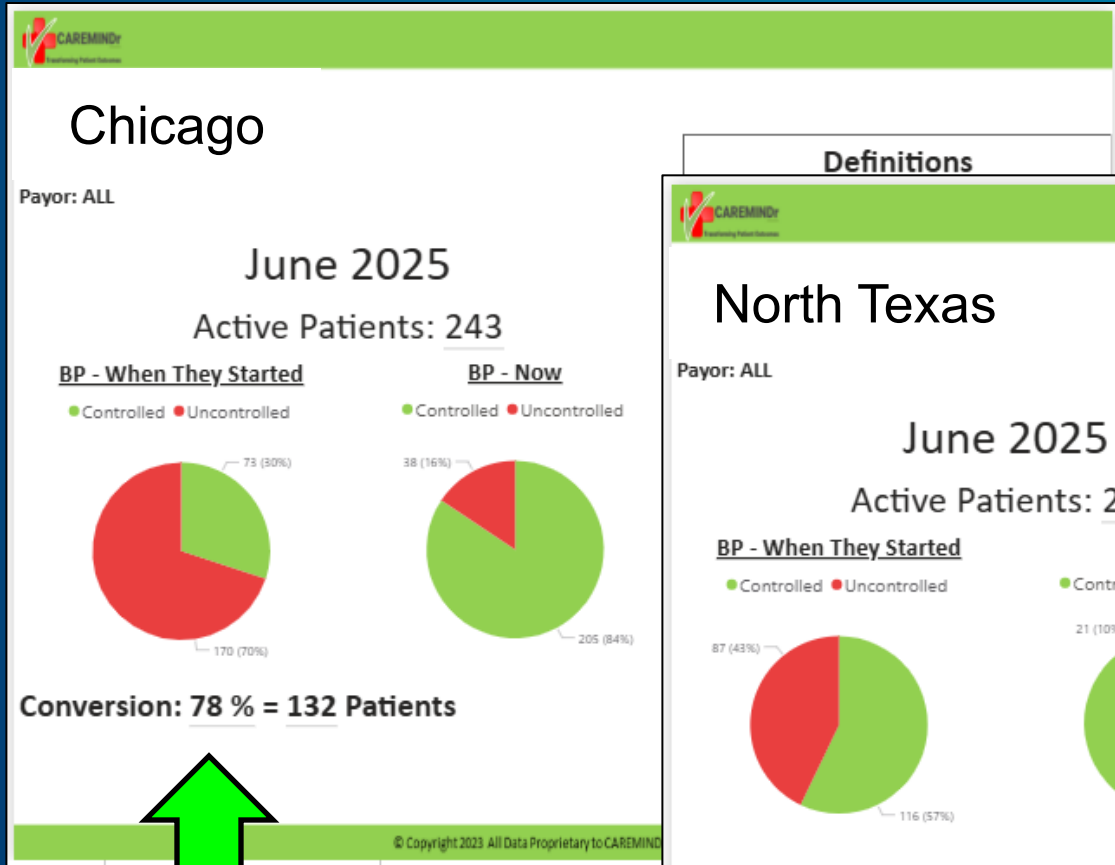


Figure Legend:

Taxonomy of Scenarios of Suboptimal Clinician Guideline Adherence in the Management of Severe Hypertension BP indicates blood pressure; PCP, primary care physician.



Supporting Medication Adherence Through Data: CRISP DC PopHealth Analytics Tools

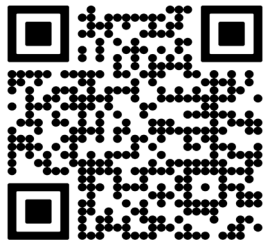
Corrine Jimenez, CRISP DC

Vinay Balani, hMetrix



PopHealth Analytics: Medication Adherence Reports

August 20, 2025



Follow CRISP DC
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The DC HIE is a Health Data Utility with Six Core Capabilities for Providers

Critical Infrastructure
(e.g. Encounters and Alerts)



ADT Alerts



Health Records



Patient Snapshot



Image Exchange

Accessible via InContext

Consent to Share Data



Consent to Share SUD Data

-42 CFR Part 2 Data (Phase I)

-Prevention of Harm Form

-Other types of consent (Phase II)

Accessible via InContext

Registry and Inventory



Care Management Registry

Advance Care Planning

Accessible via InContext

Simple and Secure Messaging



Provider Directory

Includes contacts from:

> 6M Practitioners nationwide
>47,800 DC/Local Practitioners

Includes data from:
-650 national sources
-20 DC/Local Data sources

Accessible via InContext

Health Related Social Needs (HRSN)



Referral and Screening

-SSO to findhelp's LinkU to capture HRSN screening assessments, closed-loop referrals, and access HRSN resource directory

Advanced Analytics for Population Health Management



PopHealth Analytics

-Supporting population and panel level management across providers through advanced analytics dashboards

PopHealth Analytics Overview

PopHealth Analytics offers secure access to comprehensive healthcare data and powerful analytics tools, empowering healthcare organizations to enhance patient care across the District of Columbia.

By leveraging **Medicaid claims data**, PopHealth supports effective **population-level** and **panel-level** management, driving better decision-making and improving health outcomes throughout the community.

The Reports

- The PopHealth suite of reports is designed with a diverse group of DC HIE users in mind to support their analyses and interventions.
- The analytics can assist users in planning and developing care coordination efforts for targeted chronic conditions, beneficiaries of interest, and more!

Report Utility

- Analyze aggregate demographic data.
- Stratify, compare, and drill down data points for populations by chronic disease, SDOH, high risk, timeframes, and other classifications.
- Monitor progress on nationally recognized quality measures.
- Visualize data to help strengthen communication across clinical and non-clinical settings.

PopHealth Access is Managed via *Role Manager*

Role Manager is the dedicated tool that controls all users' access to the PopHealth Analytics tool

- Allows for creation of PopHealth POCs
 - *POCs are able to grant access to the PopHealth reports to new End Users within their own organization*
- Based on an **Organization's Type**, as defined in our CRM, access is automatically granted to the associated reports that the specific Organization Type is provisioned to view

These Organization Types are automatically provisioned to access the reports we'll review today, once they request and are credentialed for PopHealth access:

- Hospitals
- FQHCs
- Payors
- DHCF



Today's Demo: Medication Adherence Reports

Medication Adherence Reports

available in PopHealth:

- Hypertension Medication Adherence Report
- Statin Medication Adherence Report

Importance of these reports:

- Non-adherence can worsen chronic conditions and increase hospitalizations.
- Early identification enables timely outreach, education, and care coordination.

These Reports empower providers to:

- Identify beneficiaries at risk of non-adherence to their prescription regimens for managing chronic conditions
- View lists of individuals by risk level to identify those at highest risk of requiring targeted intervention

Context

- Medication non-adherence when managing chronic diseases can lead to increased health care utilization and complications
- Early intervention in the non-compliance can offset that increased utilization and improve outcomes
- hMetrix developed a prediction model to identify patients at high risk of not being adherent to their prescribed treatment regimen
- This model will provide needed details to better inform care management interventions
- This model is custom built for the DC Medicaid population using administrative claims data

Medication Adherence Prediction Model

- Model was developed to improve the identification of patients who are likely to be non-adherent to their prescription regimen for the management of a chronic condition over the next 1 year
 - Model contains chronic condition-specific modules
- Model target: Identify individuals with less than 80% Proportion of Days Covered (PDC) for specific prescriptions
 - Literature typically places the threshold for adequate adherence at 80% for most medications
- Model was developed using 3 years of data:
 - Training period: 2-year look back (Years 1 & 2)
 - Testing for model performance: 1 year (Year 3)

Model Parameters

Inclusion Criteria

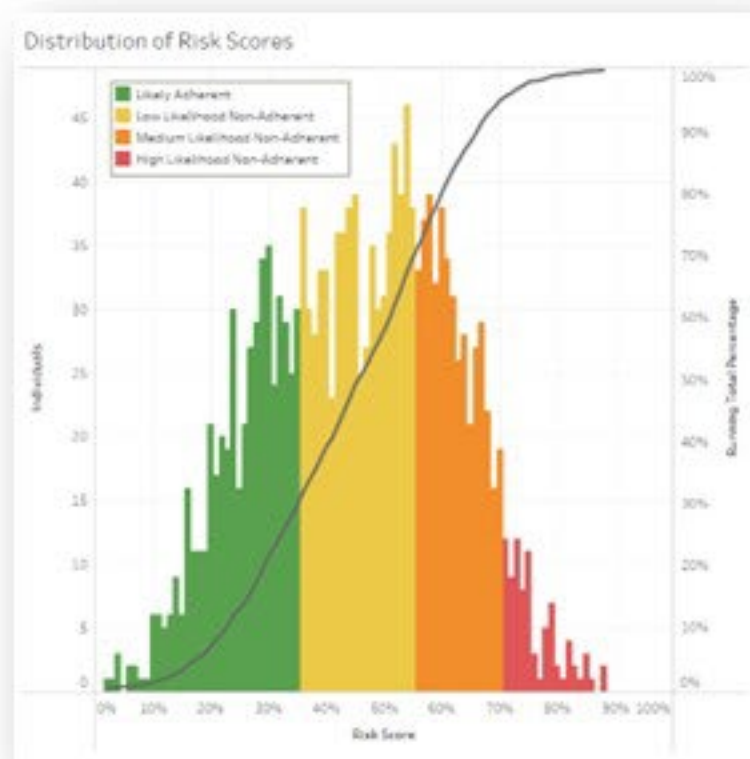
- 18+ years old
- Enrolled in Medicaid for entire PDC period of interest
- At least 2 specific prescription fills with 90 days supply in the prior 2 years
 - Ensures medication is prescribed for chronic disease treatment, rather than acute treatment

Claims Variables of Interest

- PDC across multiple drug categories
- Prescription drug costs
- Health care utilization costs
- Inpatient LOS
- SDOH flags (based on Z-code diagnoses)

Model Results

- *Model has strong performance in predicting non-adherence*
 - Predicted a beneficiary to be non-adherent when beneficiary was non-adherent based on claims (True Positive) more than 50% of the time
 - Predicted beneficiary to be adherent when beneficiary was adherent based on claims (True Negative) almost 75% of the time
 - Prior adherence is the largest predictor of future adherence



Integration with PopHealth

- Stand-alone report
- Population Navigator columns
 - Provide relevant patient-specific PDC across several drug categories over the prior 1 year
- Resources will enable care teams to target patients at high risk of being non-adherent and can then work with the patient to improve adherence

Based on Claims Data Through 7/31/2023

Statin Adherence Prediction Tools

ENS Panel: *Panel Name* (Panel ID: 1234)

Non-Adherence Risk Category

- █ Likely Adherent (0% to 30%)
- █ Low Likelihood Non-Adherent (30% to 55%)
- █ Medium Likelihood Non-Adherent (55% to 71%)
- █ High Likelihood Non-Adherent (71% to 100%)

Medicaid ID	First Name	Last Name	Gender	Date of Birth	Age	Care Program/MCO	Zip Code	Has Diabetes	Has Heart Failure	Statin PDC (Prior 1 year)	Likelihood of Statin Non-Adherence
1030568676	JODI	SMITH	Male	3/1/1955	68	UNITEDHEALTHCARE OF THE MID ATL	20018	No	No	1.4%	78.6%
1030154514	WHITNEY	IMIG	Female	6/1/1962	61	AMERIGROUP DISTRICT OF COLUMBIA	20032	Yes	No	0.0%	78.5%
1030094994	ROBIN	SIMON	Female	9/1/1966	56	AMERHEALTH DISTRICT OF COLUMBIA	20032	Yes	No	0.0%	77.3%
1030104116	GEOFFREY	PITTMER	Male	2/1/1954	69	UNITEDHEALTHCARE OF THE MID ATL	20002	No	No	11.0%	76.5%
1030633171	ALEXANDRA	HAHN	Male	3/1/1965	58	AMERHEALTH DISTRICT OF COLUMBIA	20017	No	No	45.5%	76.0%
1030346966	ALLISON	SUN	Male	10/1/1951	71	FEE-FOR-SERVICE	20032	No	No	12.5%	75.7%
1030837310	THOMAS	FINCHAM	Female	8/1/1954	68	FEE-FOR-SERVICE	20008	No	No	68.3%	75.4%
1030023389	CHELSEA	DOSS	Female	2/1/1985	38	AMERHEALTH DISTRICT OF COLUMBIA	20020	No	No	0.0%	74.8%
1030063608	DANESH	RILLING	Male	6/1/1954	69	FEE-FOR-SERVICE	20002	No	No	70.0%	74.7%
1030808531	PATTY	RUIZPUIG	Female	8/1/1953	69	AMERIGROUP DISTRICT OF COLUMBIA	20016	No	No	67.7%	74.2%
1030340013	RUBEN	HICKS	Male	7/1/1952	71	FEE-FOR-SERVICE	20008	No	No	8.4%	74.2%
1030016909	KRISTINA	FORTICH	Male	9/1/1978	44	AMERHEALTH DISTRICT OF COLUMBIA	20032	No	No	26.1%	74.2%
1030961014	ALAN	HITT-HAWES	Male	12/1/1955	67	AMERHEALTH DISTRICT OF COLUMBIA	53230	No	No	12.5%	73.9%
1030130620	AMANDA	DURRANCE	Male	8/1/1954	68	UNITEDHEALTHCARE OF THE MID ATL	20009	No	No	25.5%	73.0%
1030549093	GLEN	SIMPSON	Male	9/1/1958	64	AMERIGROUP DISTRICT OF COLUMBIA	20743	No	No	0.0%	73.7%
1030472102	KENNETH	DANQUAH	Female	8/1/1966	56	AMERHEALTH DISTRICT OF COLUMBIA	20002	No	No	0.0%	73.4%
1030024833	DALJIAN	WESTMAN	Female	12/1/1985	37	AMERIGROUP DISTRICT OF COLUMBIA	20020	No	No	72.8%	73.4%
1030435531	ROBERT	NOSEK	Female	11/1/1975	47	AMERHEALTH DISTRICT OF COLUMBIA	20019	No	No	28.8%	73.3%
1030336510	ROCHELLE	ERTL	Male	11/1/1955	67	FEE-FOR-SERVICE	20009	No	No	33.6%	73.3%
1030274494	DENYEL	ATHANS	Female	7/1/1965	58	FFS	20019	Yes	No	58.6%	73.0%
1030163253	SHANWON	HOUSEHOLTER	Male	3/1/1956	67	FEE-FOR-SERVICE	20032	No	No	33.6%	72.9%
1030150971	KELLI	COSTELLOCOFF	Female	12/1/1962	60	AMERHEALTH DISTRICT OF COLUMBIA	20019	No	No	0.0%	72.9%
1030300742	SHAUNA	BEITYAKOV	Male	11/1/1965	57	AMERIGROUP DISTRICT OF COLUMBIA	20019	No	No	72.0%	72.8%
1030133627	SANDRA	FOREMAN	Female	11/1/1941	81	FEE-FOR-SERVICE	20020	Yes	Yes	21.4%	72.6%
1030077092	PATRICIA	SANDAS	Female	9/1/1983	39	AMERHEALTH DISTRICT OF COLUMBIA	20020	No	No	41.8%	72.5%
1030069999	THERESA	CALLUS	Female	1/1/1976	47	AMERHEALTH DISTRICT OF COLUMBIA	20020	No	No	2.9%	72.4%
1030401679	ELIZABETH	NGO	Male	4/1/1967	56	UNITEDHEALTHCARE OF THE MID ATL	20020	Yes	No	0.0%	72.0%
1030362116	CHARLENE	PARMAR	Female	11/1/1965	57	AMERHEALTH DISTRICT OF COLUMBIA	20019	No	No	40.3%	71.9%

Data are masked and do not include PHI

- Please feel free to ask about any of the reports we reviewed today, or other general PopHealth questions.
- Questions may also be put into the chat or sent to the PopHealth team after the meeting here: corrine.jimenez@crisphealth.org

If you'd like to take the next steps to getting access to the PopHealth tool, please contact your organization's PopHealth POC.

- If you would like to confirm who your PopHealth POC is, please contact the CRISP DC team using the above email.
- If your organization *does not yet have access to PopHealth*, please contact your **HIE Administrator** for next steps.

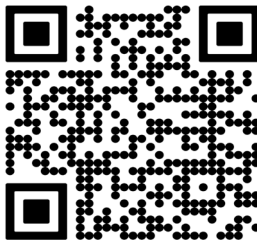


Connecting Care
CRISP  **DC**

For CRISP DC related inquiries please contact outreach at dcoutreach@crisphealth.org.

For support contact support@crisphealth.org or call 833.580.4646.

800 Maine Ave SW
Washington, DC 20024
833.580.4646 | www.crispdc.org
dcoutreach@crisphealth.org



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Next Steps and Q&A: Upcoming Key Deadlines and Other Opportunities

Latrice Hughes, MPH, CPH, Public Health Analyst, DC Health

Key Deadlines for National CVD Program Grantees

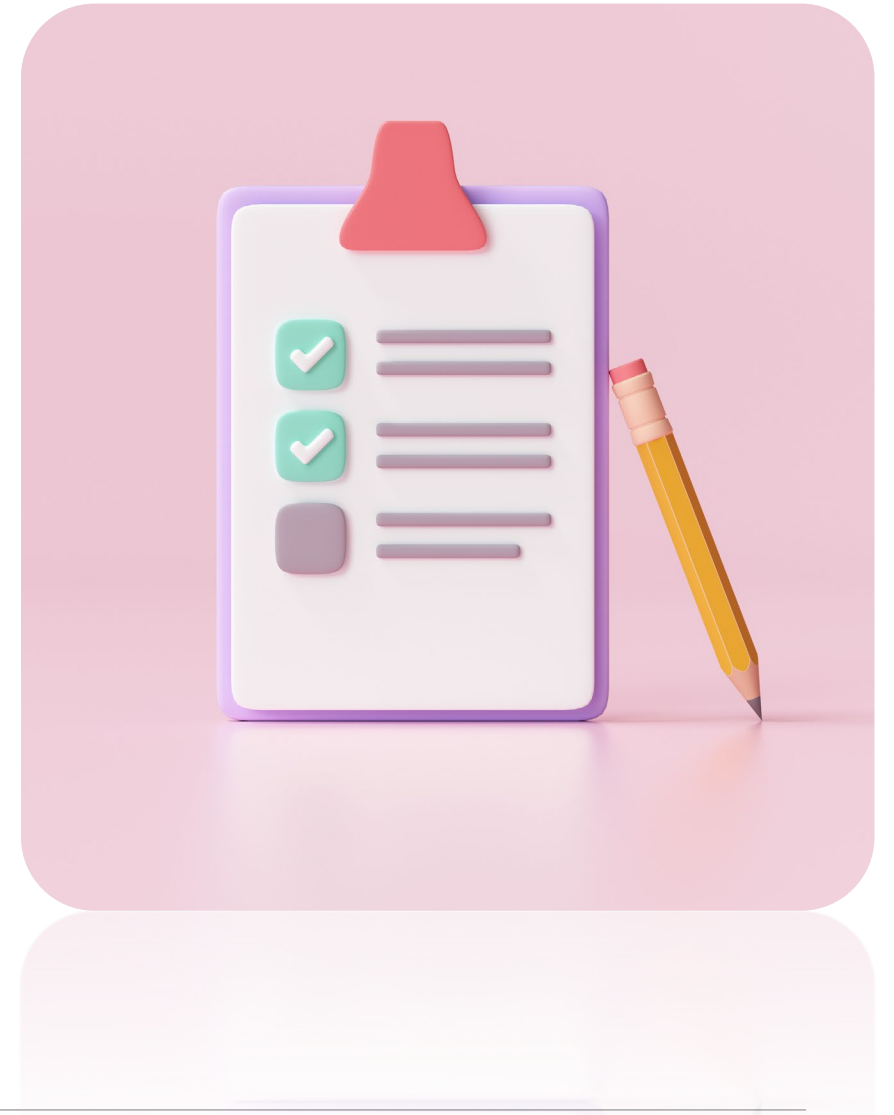
- ✓ **By 5/23:** Submit initial grantee workplan, project budget, and budget justification.
- ✓ **By 6/13:** DC Health will review and provide input on workplans.
- ✓ **By 6/20:** Submit a final grantee workplan with incorporated edits.
- ✓ **By 7/1:** New project period and workplan implementation begins. DC Health completes final action plan for implementation, including grantee workplan interventions and metrics.
- **By 9/29:** Submit evaluation plan

Key Deadlines for Innovative Program Grantees

- **By Friday, August 22nd:** Submit initial grantee workplan, project budget, and budget justification.
- **By Friday, August 29th:** DC Health will review and provide input on workplans.
- **By Friday, September 5th:** Submit a final grantee workplan with incorporated edits.
- **By Wednesday, October 1st:** New project period and workplan implementation begins. DC Health completes final action plan for implementation, including grantee workplan interventions and metrics.

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)



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:

- Health system grantees selected to report
- 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



- **July 16:** Best Practices for Identifying a High-Risk Cohort



- **August 20:** Supporting Medication Adherence through Data



- **September 10:** In-Person Session and Workplan/Action Cycle Report Out

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