HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

MARCH 2025

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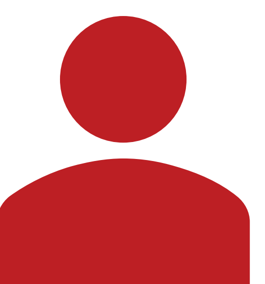
Agenda

1. **Welcome and Introductions**
2. **Understanding and Communicating Stroke Risk**
3. **Grantee Report-Out Session and Discussion**
   - MedStar Georgetown Family Practice
   - Mary’s Center
4. **Q & A and Next Steps**

Welcome!

Come on Video



Introduce Yourself in the Chat

Name, Title, Organization/Affiliation

IT'S MARCH MADNESS!

(Icebreaker)

There are six teams from the DMV area in the NCAA Men's Basketball Tournament. Who are you rooting for?

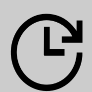
District of Columbia	Maryland	Virginia
American University	Mount St. Mary University of Maryland	Liberty University Norfolk State University Virginia Commonwealth University

Program Updates

Bonny Nunez, MPH, Public Health Analyst, DC Health

Heart Disease and Stroke Prevention Learning Collaborative: *September 2024-August 2025*

Learning Collaborative Structure

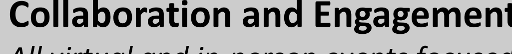


Quarterly Cycles:
Informed by Strategic Plan and participant-identified priorities based on the HIT/EHR Assessment

Capacity Building Calls:
- *Framed in data*
- *Health equity focus*
- *Focus on building and applying knowledge*

Work Plan 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

Culturally responsive, intergenerational programs and communications

- **January 15: Hypertension Management, American Heart Association, DC FEMS**

- **February 19 (10am-2pm):** In-Person Learning Collaborative Session, including broader audience at DC Health.

- **March 19:** Hypertension Management and Stroke, and Work Plan/Action Cycle Report-Out

Reporting Deadlines

(Reporting Periods)

<table>
<tr><th>Report</th><th>National
(July-June)</th><th>Innovative
(Oct – Sept)</th><th>Submission Location</th></tr>
<tr><td>Monthly Reports Template</td><td colspan="2" rowspan="2">**Due the 15th of each month**
(Reporting period is the prior calendar month, Ex: Dec period due 1/15)</td><td rowspan="2">EGMS</td></tr>
<tr><td>Monthly Fiscal Invoices</td></tr>
<tr><td>Quarterly Narrative Report(s)</td><td colspan="2" rowspan="2">**Quarterly, Due:**
• **Oct. 15th** *(July 1 – Sept 30) – Q1 for National*
• **Jan. 15th** *(Oct 1 – Dec 31) – Q1 for Innovative*
• **April 15th** *(Jan 1 – March 31)*
• **July 15th** *(April 1 – June 30)*</td><td>EGMS</td></tr>
<tr><td>Quarterly Patient Level Data Report</td><td>*Secure Server BOX*</td></tr>
<tr><td>Annual (Year End) Report</td><td rowspan="2">**Due July 15th**
(July – June)</td><td rowspan="2">**Due October 15th**
(Oct – Sept)</td><td rowspan="2">EGMS</td></tr>
<tr><td>Annual Evaluation Report</td></tr>
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Stroke Smart: Empowering Leaders to Educate and Protect

Sana Somani, MBBS, Vascular Neurologist, MedStar Washington Hospital Stroke Center

Stroke Smart: Empowering Leaders to Educate and Protect

Sana Somani, MD

Assistant Professor, Georgetown University, School of Medicine

Attending Physician, Medstar Washington Hospital Center/NIH Stroke Program

OVERVIEW

- Epidemiology
- Risk factors for stroke
- Diagnosis and outcomes
- Stroke SMART

#5 cause of death and a leading cause of disability among adults in the U.S.

About 800K Americans each year suffer a new or recurrent stroke

Kills nearly 147K people a year, about one in every 19 deaths

On average every 3 minutes and 33 seconds someone dies of stroke

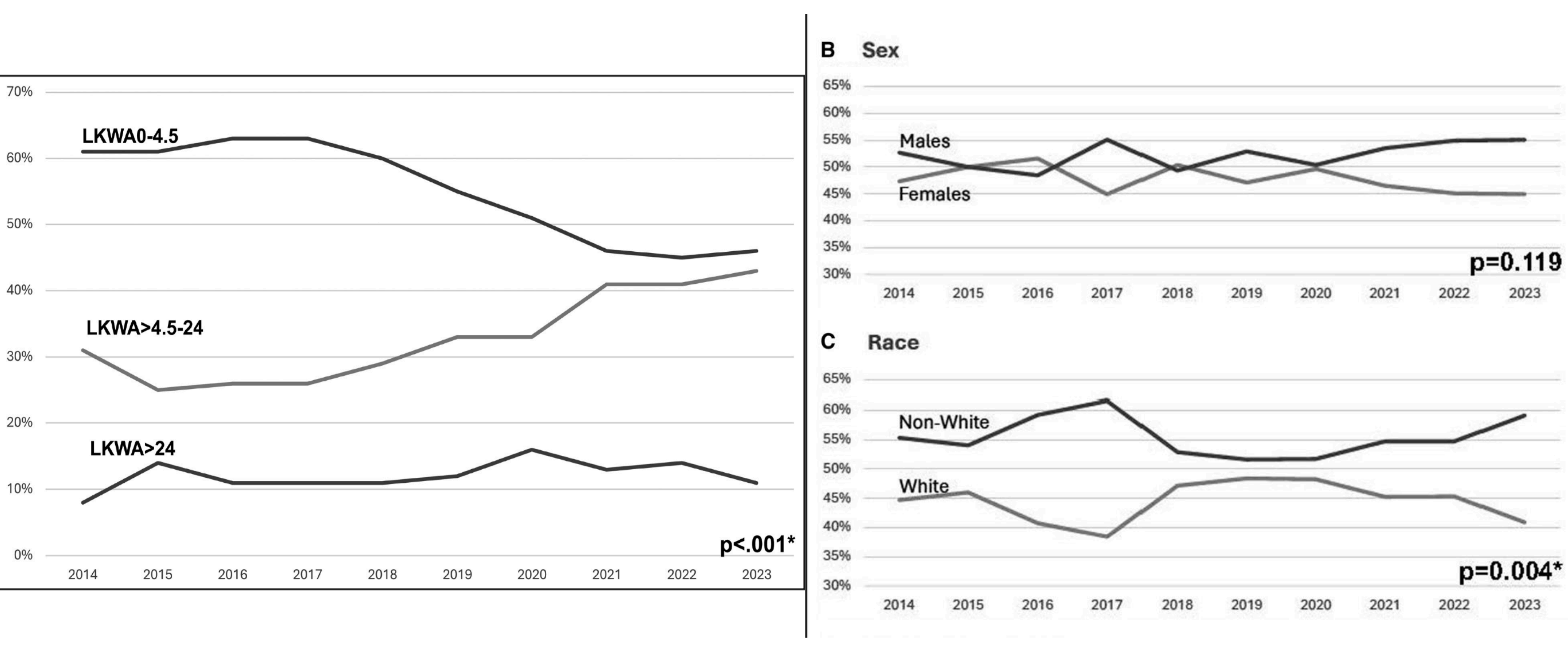
About 55,000 more women than men have a stroke each year.

Up to 80% may be prevented

EVERY 40 SECONDS, SOMEONE IN THE UNITED STATES HAS A STROKE

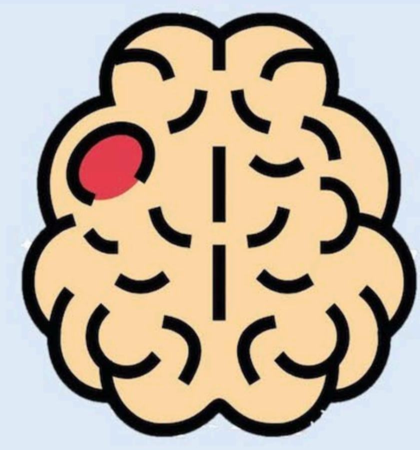
Cardiology

Amgen proudly supports the American Heart Association's EmPOWERED to Serve Initiative

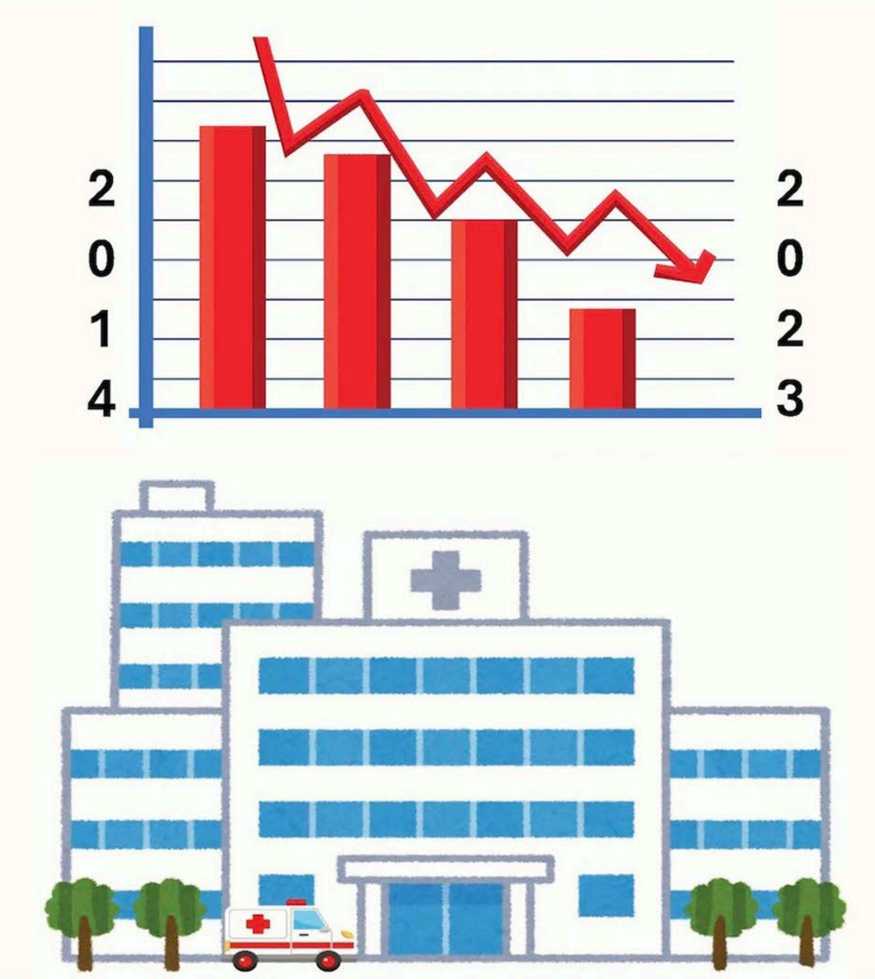


Nicholas G. Ferrone. Stroke. Ten-Year Trends in Last Known Well to Arrival Time in Acute Ischemic Stroke Patients: 2014 to 2023, Volume: 56, Issue: 3, Pages: 591-602, DOI: (10.1161/STROKEAHA.124.049169)

Trends in Last Known Well to Arrival (LKWA) Time from 2014-2023



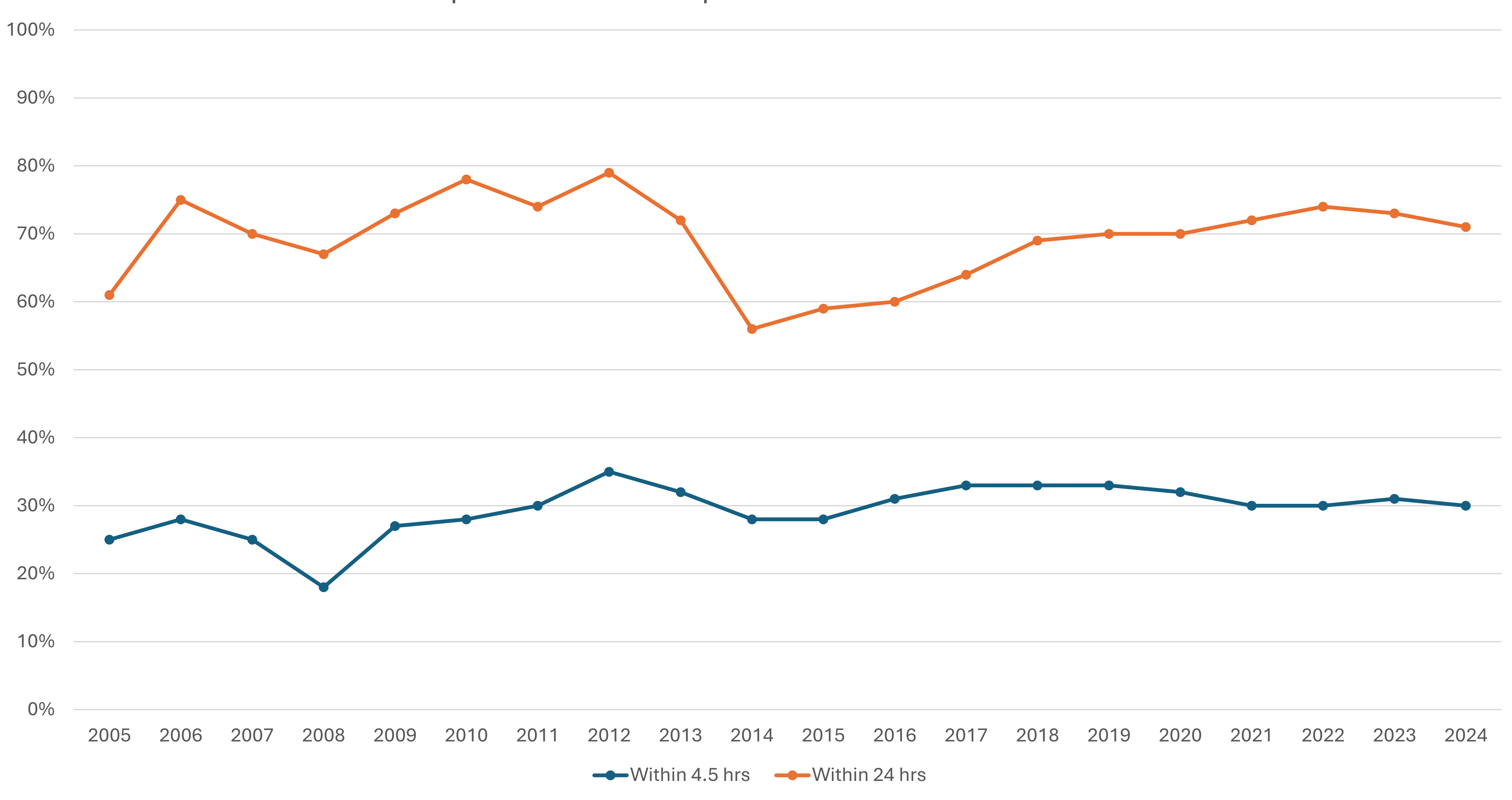
Understanding the current trends in the LKWA time may guide national efforts to increase patient eligibility for acute stroke treatments, aimed at improving outcomes in acute ischemic stroke patients.

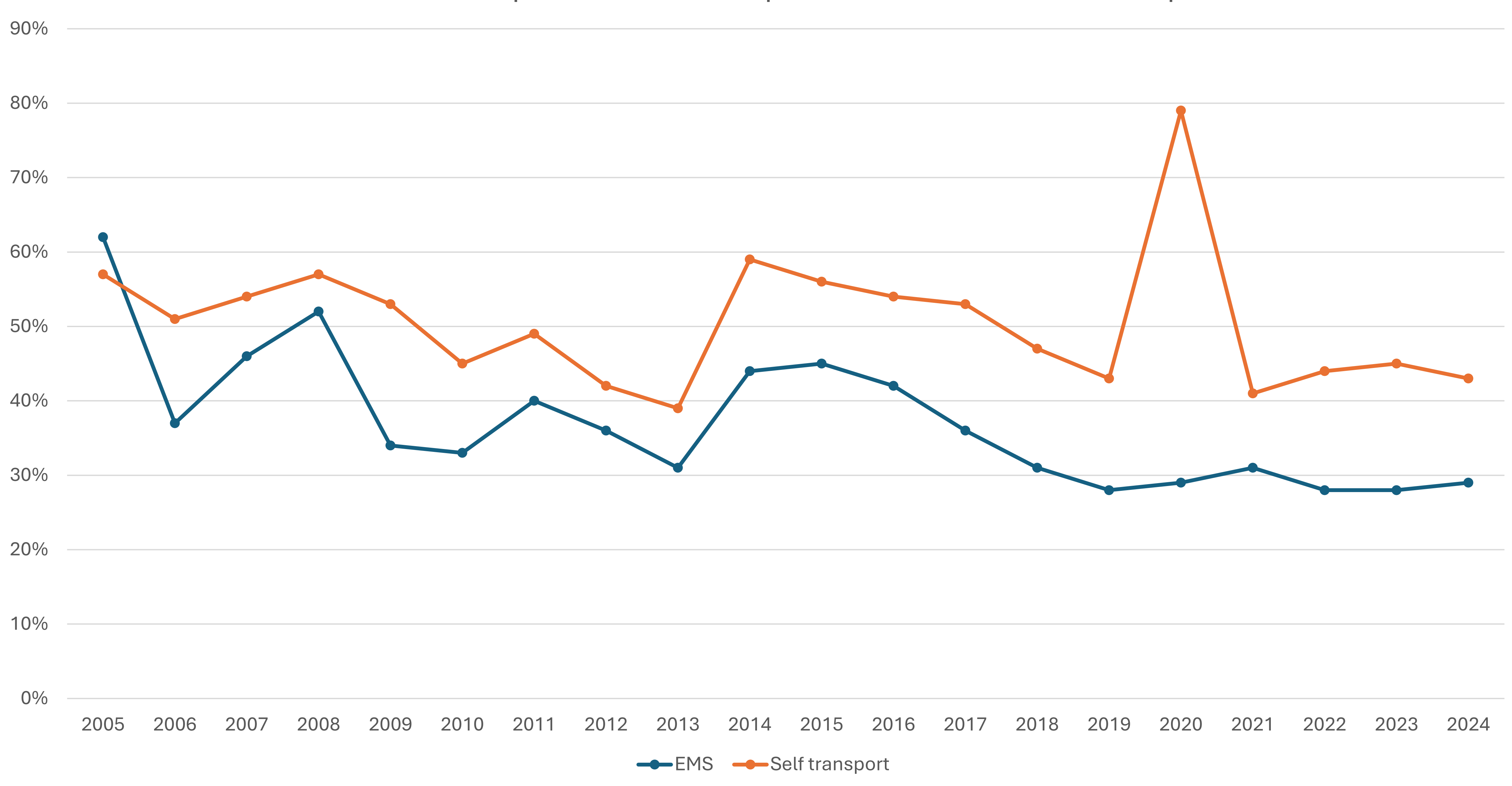


Socioeconomic disparities were observed. The late LKWA group was more likely to be older, male, Black or Asian race, Medicaid insurance, low-income, mild stroke severity, more stroke risk factors, and less likely to arrive by EMS.

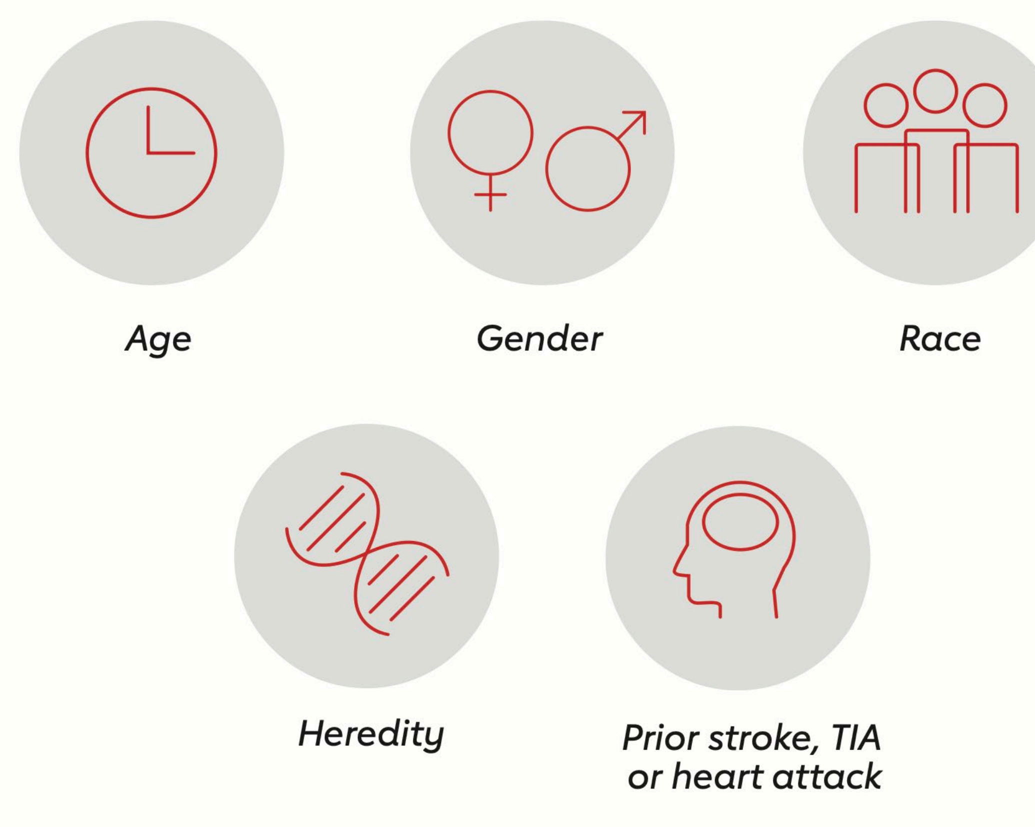
A downtrend in the early LKWA (<4.5 hours) group and an uptrend in the later LKWA (>4.5 hours) group were observed in the past decade. These trends were further exaggerated during the COVID pandemic (2020), and have not returned to pre-pandemic levels.

Nicholas G. Ferrone. Stroke. Ten-Year Trends in Last Known Well to Arrival Time in Acute Ischemic Stroke Patients: 2014 to 2023, Volume: 56, Issue: 3, Pages: 591-602, DOI: (10.1161/STROKEAHA.124.049169)


Presentation of patients to DC hospitals within stroke treatment time window
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
Within 4.5 hrs
Within 24 hrs


Presentation of patients to DC hospitals based on mode of transport
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
EMS
Self transport

Uncontrollable Factors:



Controllable Factors:

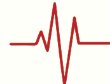
High blood pressure

Cigarette smoking

Diabetes

Carotid or other artery disease

Peripheral artery disease



Atrial fibrillation

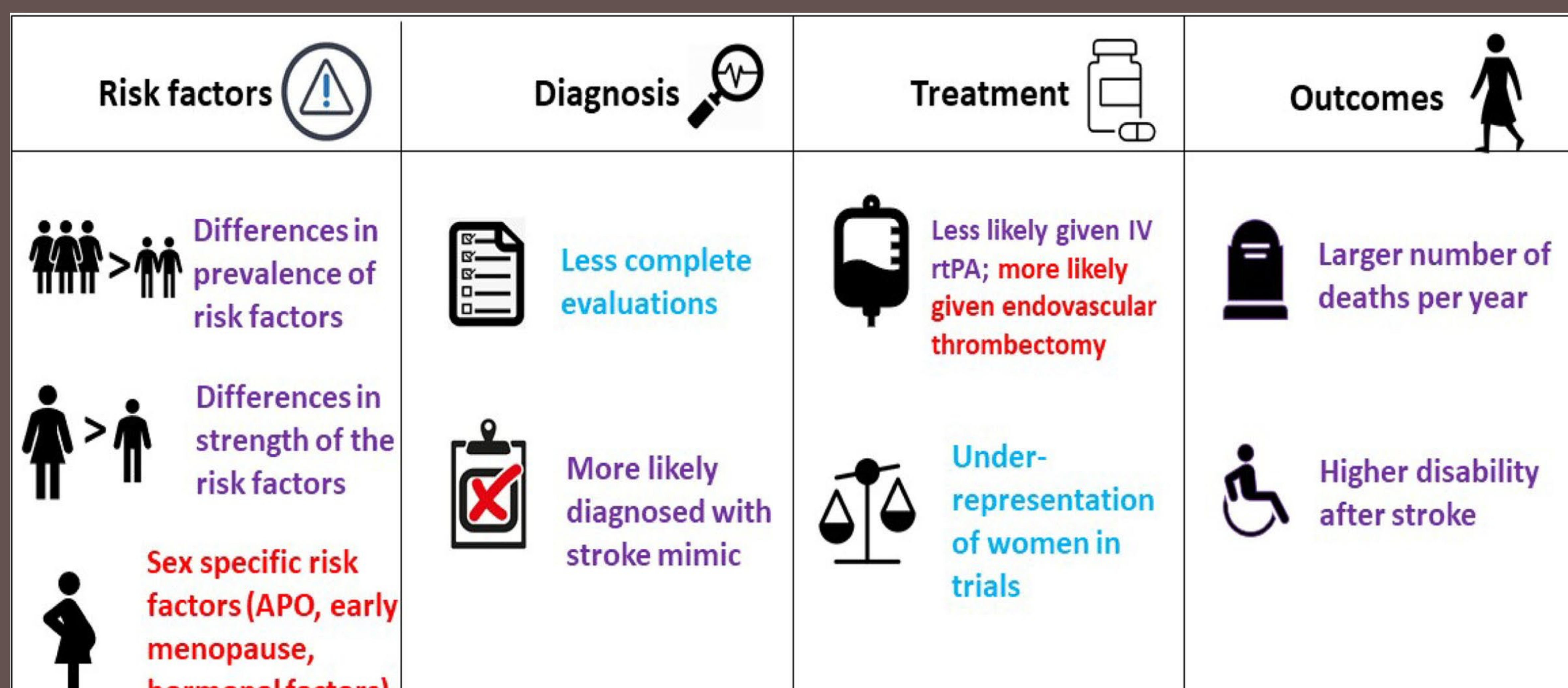
Other heart disease

Sickle cell disease (also called sickle cell anemia)

High blood cholesterol

Poor diet

Physical inactivity and obesity



Rexrode KM, Madsen TE, Yu AYX, Carcel C, Lichtman JH, Miller EC. The Impact of Sex and Gender on Stroke. Circ Res. 2022 Feb 18;130(4):512-528. doi: 10.1161/CIRCRESAHA.121.319915. Epub 2022 Feb 17. PMID: 35175851; PMCID: PMC8890686.

B E F A S T

Balance

Does the person have a sudden loss of balance?

Eyes

Has the person lost vision in one or both eyes?

Face

Does the person's face look uneven?

Arms

Is one arm weak or numb?

Speech

Is the person's speech slurred? Does the person have trouble speaking or seem confused?

Time

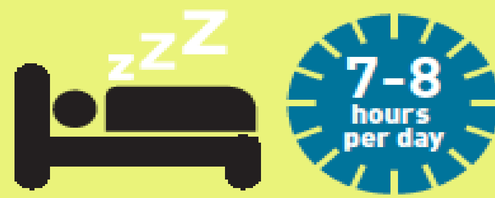
Call 9-1-1 now!

80% OF ALL STROKES CAN BE PREVENTED

Maintain a healthy body to have a sharp mind and healthy brain while reducing your risk for stroke and heart disease.

GET ENOUGH SLEEP.

For adults 7-8 hours per day, more for teenagers and children.



7-8 hours per day

BE SOCIALLY ACTIVE.

Observational studies have shown that people with poor social support or networks are at higher risk for stroke and heart disease.

EAT HEALTHY.

RECOMMENDED DAILY LIMIT **1500mg** SODIUM

SALT

EXERCISE.

GET REGULAR CHECKUPS.

Schedule regular visits with your doctor and talk to your doctor about your risks and ways to reduce them.

HIGH BLOOD PRESSURE CAN LEAD TO COGNITIVE IMPAIRMENT

DON'T SMOKE — IF YOU SMOKE, STOP.

HOW CAN I LEARN MORE?

1. Talk to your doctor, nurse or other healthcare professional
2. Call 1-888-4-STROKE (1-888-478-7653) or visit StrokeAssociation.org

Together to End Stroke™

Sources: Statistics from the American Heart Association/American Stroke Association, World Health Organization, and Centers for Disease Control and Prevention, American Heart Association

Long-term outcomes of stroke

PHYSICAL CHANGES

- Paralysis or weakness on one side of the body
- Difficulty swallowing or eating
- Physical pain
- Spasm
- Insomnia

MEMORY & COGNITIVE ABILITY

- Memory loss
- Difficulty in learning
- Difficult to grasp new information
- Mixing up information & details

COMMUNICATION

- Slurred speech
- Difficulty speaking or finding words
- Trouble understanding what others are saying
- Trouble reading & writing

EMOTIONS & PERSONALITY

- Anxiety & excessive worrying
- Depression (post-stroke depression or PSD)
- Personality changes
- Pseudobulbar (involuntary emotional expression disorder)

DC Stroke Smart

Mission

The mission of the Stroke Smart DC Action Group (SSDCAG) is to raise awareness about stroke, including the signs and symptoms, and the critical need for prompt emergency response. The group aims to empower individuals to become proactive in their communities by providing education, resources, and tools to promote stroke prevention, early recognition, and activating emergency services.

Rostro caido

Alteración del equilibrio

Perdida de fuerza en un brazo o pierna

Impedimento visual

Dificultad para hablar

Obtenga ayuda RÁPIDO, llame a emergencias!

LLAME 911 Si Observa un SIGNO LLAME 911 Si los Signos DESAPARECEN

VER VIDEO CORTO

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BE FAST

Balance Loss

Eyesight Changes

Face Drooping

Arm Weakness

Speech Difficulty

Time to call 911

CALL 911 for even ONE SIGN CALL 911 even if SIGNS STOP

VIEW SHORT VIDEO

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¿Derrame Cerebral? ¡Conozca los Signos!

Be Stroke Smart

STROKE SIGN TEST: SMILE

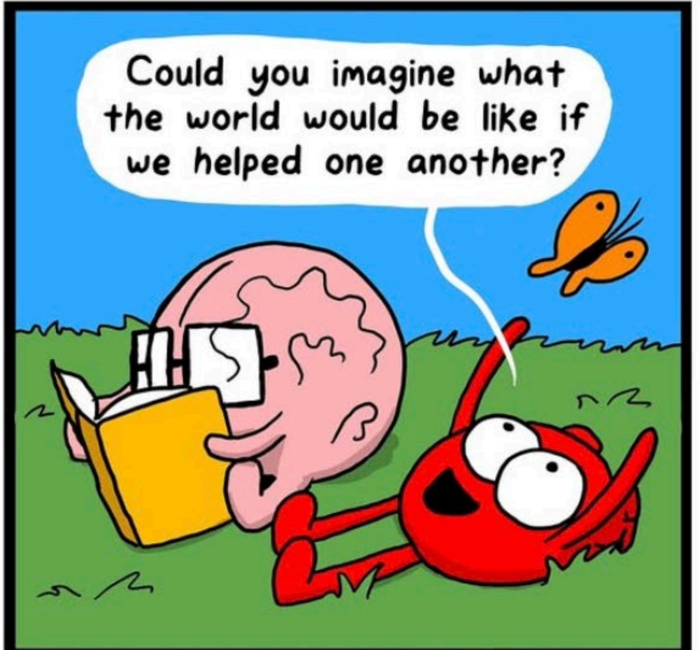
STROKE SIGN TEST: RAISE ARMS

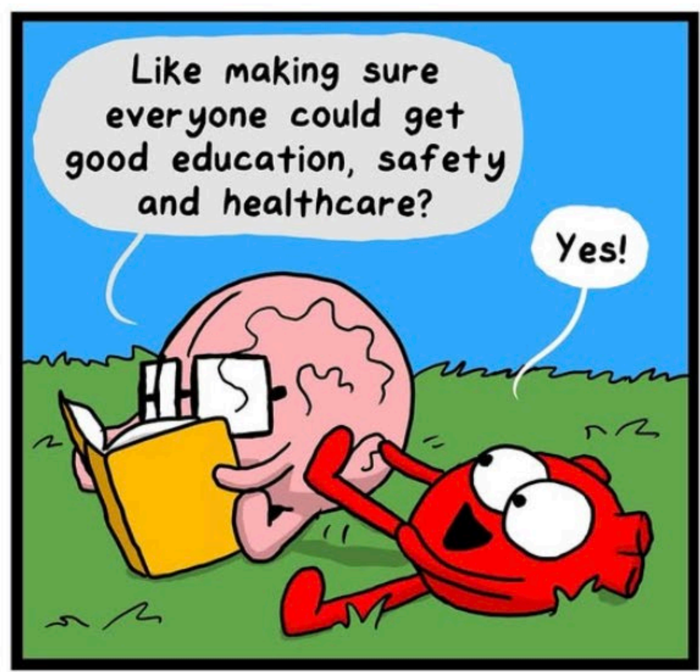
OTHER STROKE SIGNS

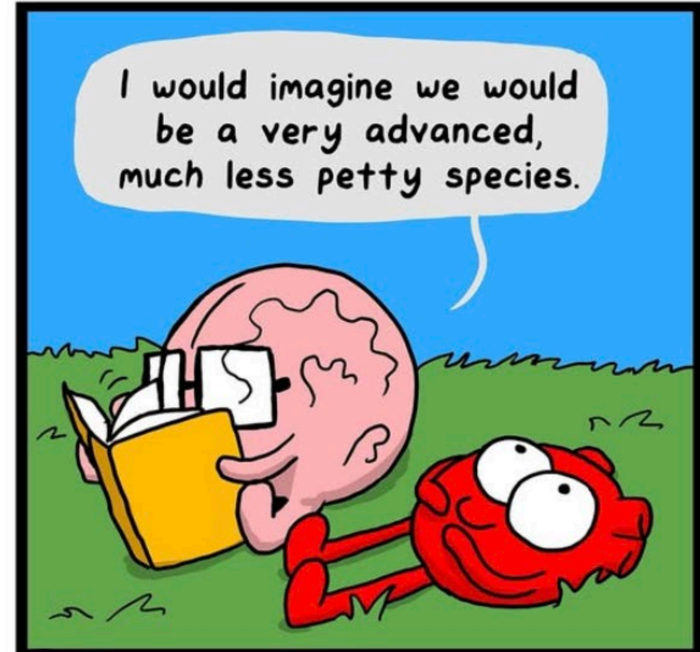
SUDDEN TROUBLE: CALL 911

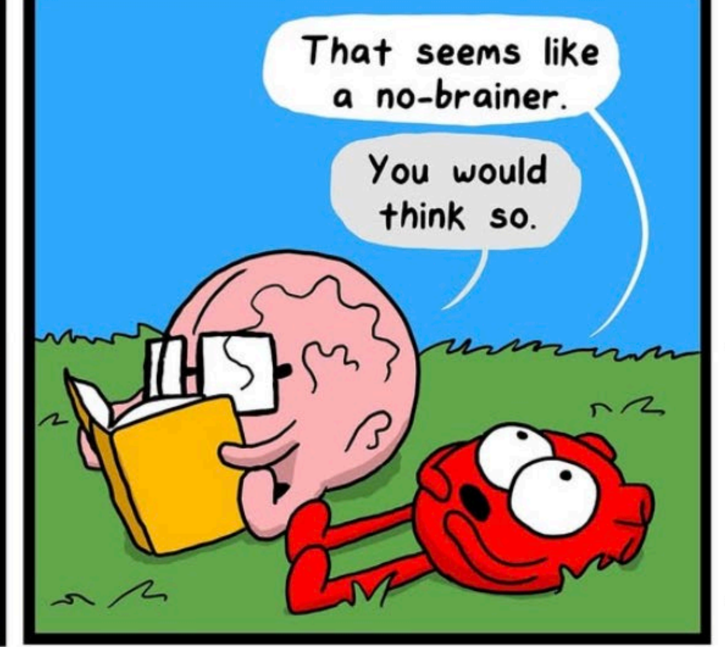
- Speaking or Understanding
- Walking or Balance • Seeing
- Weak or Numb on one side of body

QUESTIONS?









#WorldHealthDay @WorldHeartFederation @theAwkwardYeti

Grantee Report-Out Session and Discussion

Jeff Weinfeld, MD, Family Physician, MedStar Spring Valley

Wendy Quinteros, RMA, Program Coordinator, Mary's Center

It's how we treat people.

SDOH Screening/
Community Health Advocate Referral Project
DC/MedStar Million Hearts Project

Jeff Weinfeld, MD, MBI

Tobie Smith, MD

Learning Objectives

By the end of the talk, you will be able to:

- Describe the MedStar SDOH screening and CHA referral project
- Describe the current status of screening and referral
- Provide input of the challenges of limited resources

MedStar Status as of 7/1/23

- No formal inpatient or outpatient SDOH screening
- A form to document screening and referrals was in the EHR
- A version of FindHelp was accessible within the EHR

Knowledge and Compassion
Focused on You

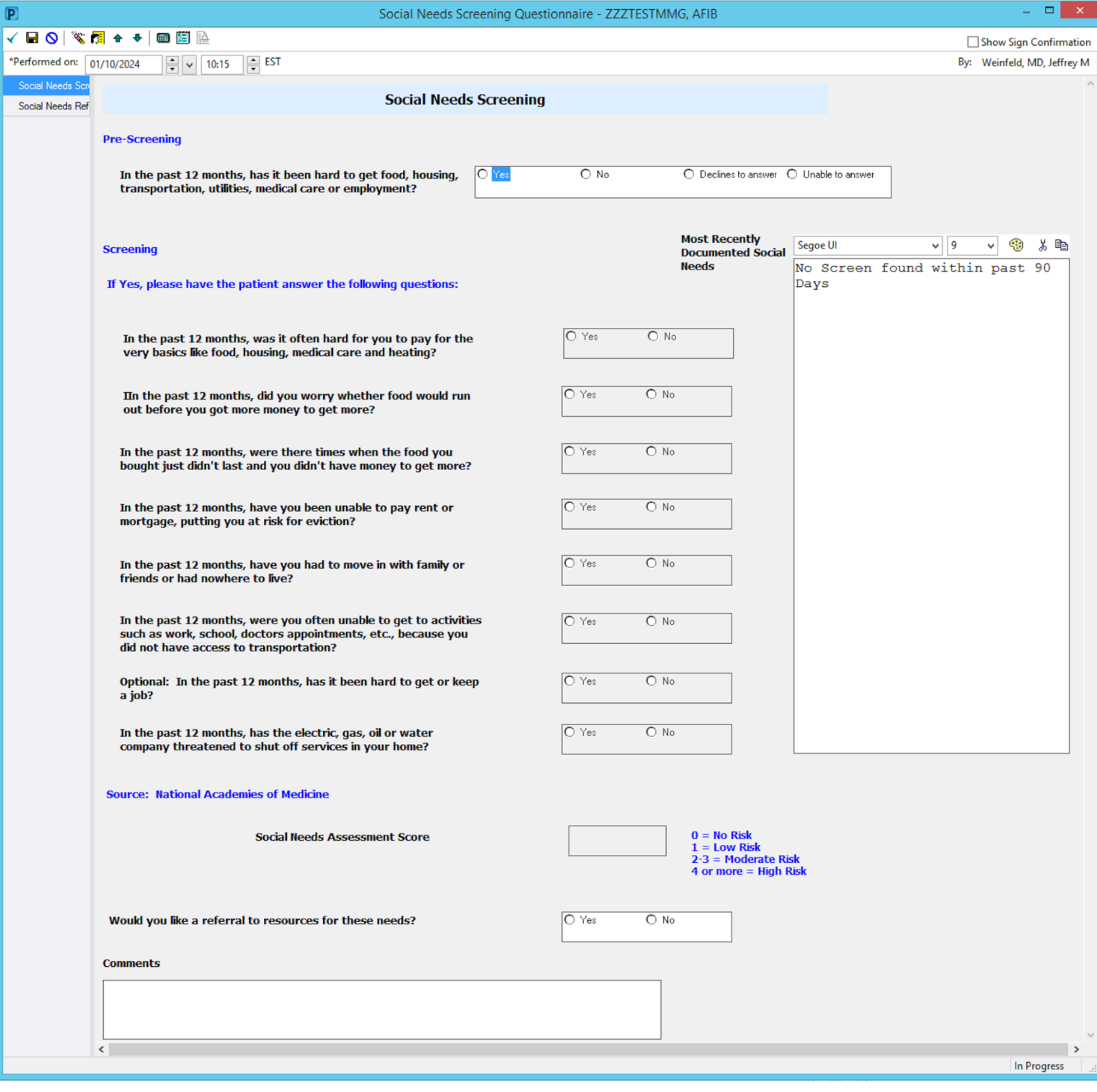
Community Health Advocate (CHA) Referral Project

Goals:

- Broaden SDOH Screening
- Provide a CHA to assist patients with social needs

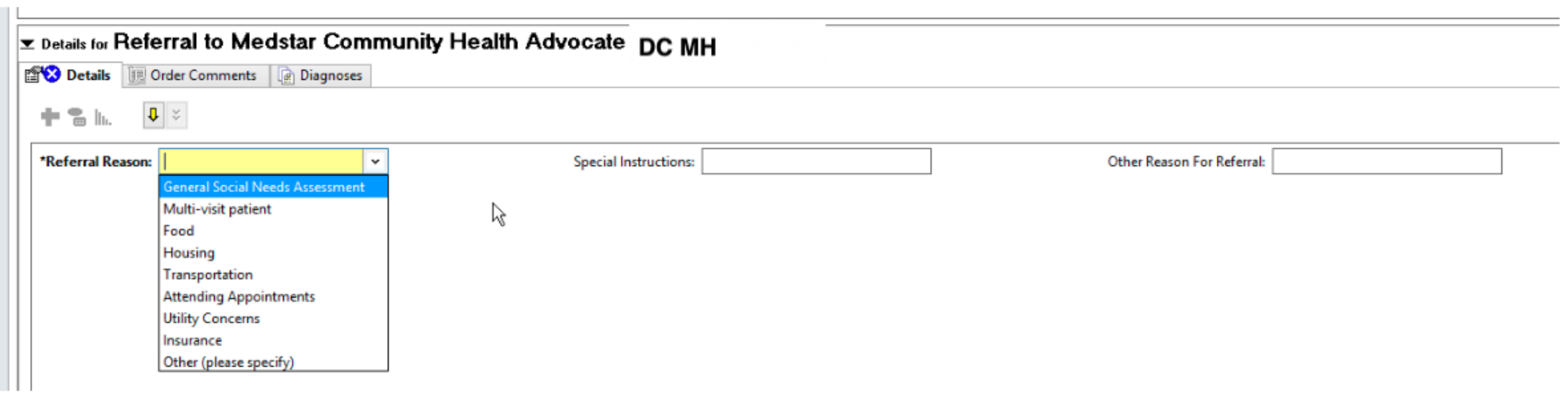
- Initial workflow idea: Doctors or MAs would screen and refer

EHR Social Needs Screening form – Tab 1, Screening



EHR Referral Added

- Identify a social need that your patient wants help with
- Let them know they will get a call back from a MedStar CHA
- How to make a referral to CHA
  - Place order for **MedStar Community Health Advocate DC MH**



Logistics

- Order in system 2/20/24
- Order is turned on at each practice
- Go-live communication with practices
- Provided posters for placement in the office
- Meetings with practices for promotion

Wonderful Doctors!!

Does your patient have unmet social needs?

Food
Employment
Utilities
Social Determinants
Transportation
Other
Housing
Financial
Safety

If they are a DC resident, have a need, and want assistance, they are eligible for assistance from a community health worker.

Place a Referral to: MedStar Community Health Advocate DC MH

Your patient will get a call back from a Community Health Advocate and attempt to connect them to a community resource

Supported by the MedStar/Georgetown Million Hearts Project with a grant from the DC Department of Health.
Email Jeffrey.M.Weinfeld@MedStar.net for more information

Online/iPad Screening

- Opportunity: Online Intake/check-in before visits
  - Vendor - Tonic
  - https://tonicforhealth.com/
- Our adaption:
  - Use Tonic for SDOH screening at first pilot site
  - Occurring before every preventive visit

Year 1

- FL
  - Chose due to relationship, ease of initiation
  - Start: EHR screening before preventive visits; EHR referral of positive screens
- NY
  - Chose due to location near Ward 7/8
  - Start: Ad/hoc screening and EHR referral

- End: Tonic Screening before preventive visits w/query and/or manual for referral

Work Plan 7/1/24

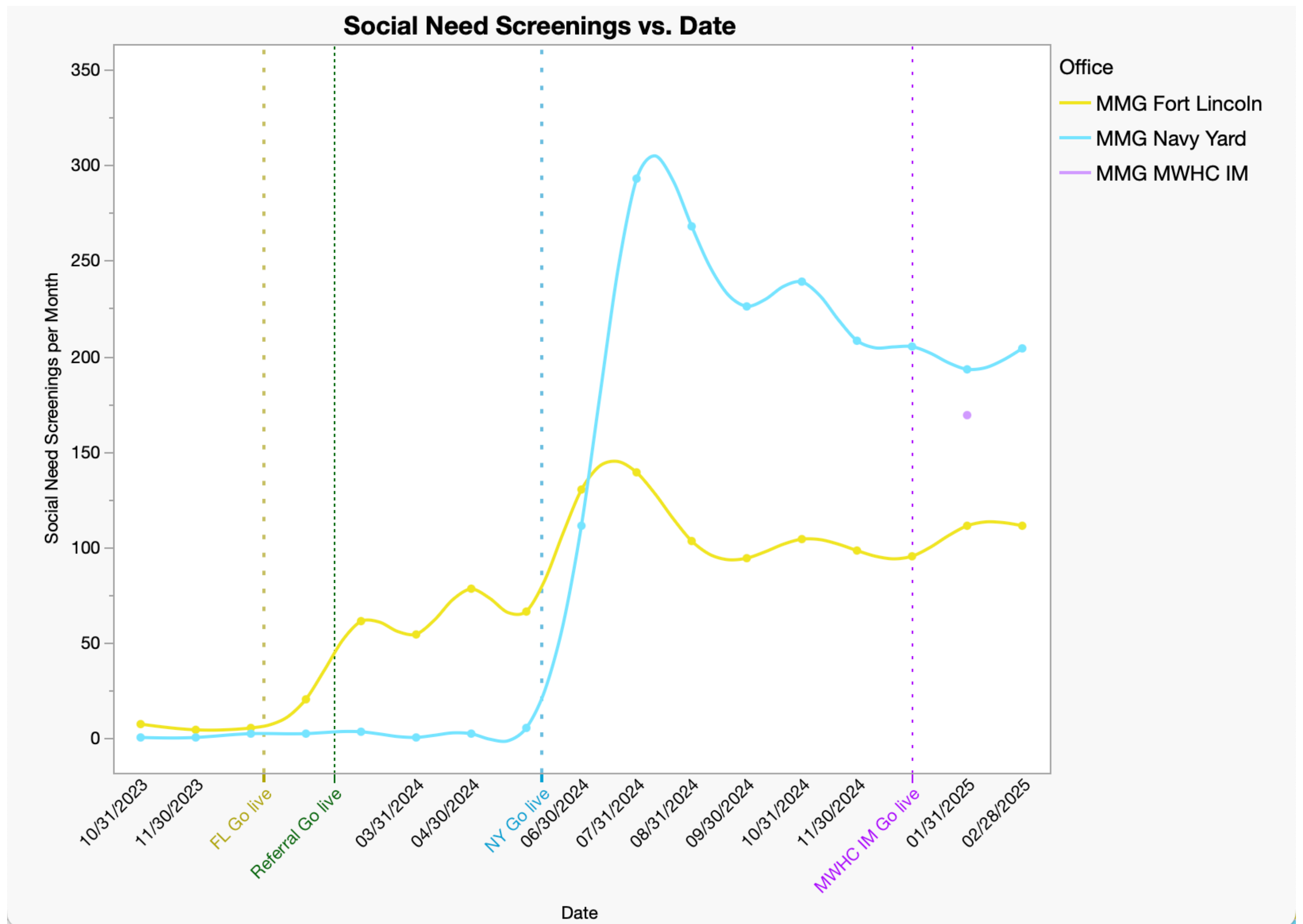
GOAL 1: By June 29, 2025 expand social determinant screening to patients at all DC MedStar primary care offices and one nearby office.					
Measurable Objectives/Activities:					
Objective #1: By June 29, 2025 increase the percent of MedStar DC patients in DC offices who screened for SDOH during wellness visits to 10% (baseline unknown).					
Key Indicator(s): Number of screenings conducted per month, percent of patients screened per clinic					
Key External Partner(s): Community Health Division, AVP Health Equity, AVP Community Medicine					
Key Activities to Meet this Objective:	Start Date:	Completion Date:	Actual Start Date:	Actual Completion Date:	Key Personnel (Title)
A. Develop go-live plan for SDOH screening for remaining 6 offices not in the pilot (2 pilot offices to continue screening)	6/30/24	8/30/24			PI, Expert, Advisory group
B. Propose and gain approval for plan	9/1/24	9/30/24			PI
C. Deploy go-live plan	10/1/24	12/31/24			Expert
D. Explore and identify measures of SDOH screening available in the system	6/30/24	12/31/24			PI, Data analyst, Advisory group
E. Using QI process improve screening rates	1/1/24	6/29/25			PI, Expert

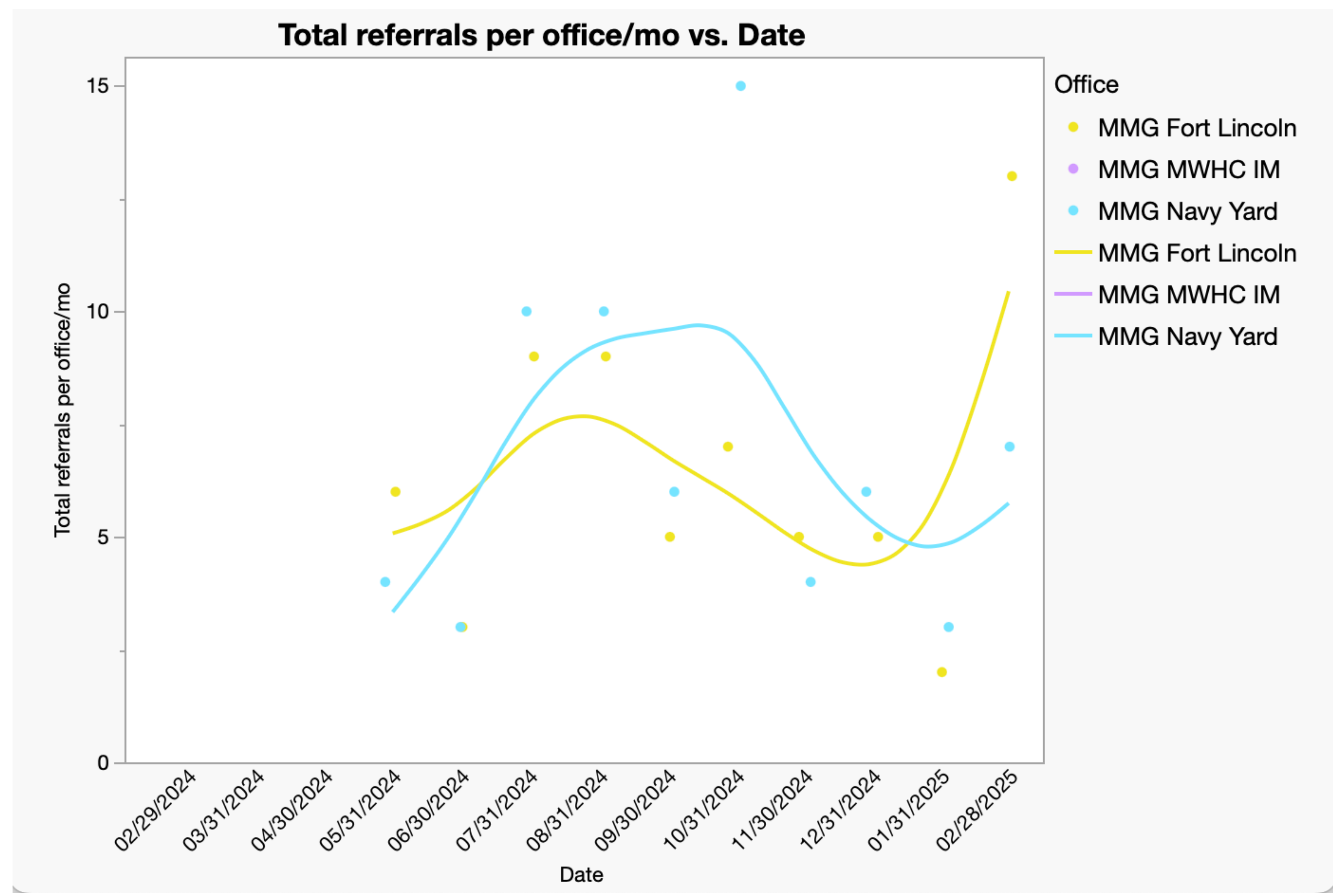
Challenge

- Leadership concern that we would be screening patients who would not receive reach-out from CHA
  - Change in plan to limit screening to a volume that our CHA could handle
  - Assessed capacity and volume of potential sites
  - ➢ Selected one additional site for screening

MWHC IM

- High %DC and Medicaid patients
- Multiple meetings
- Piloting MA SDOH screening yearly in EHR at end of 2024
- Docs/MAs managing positive screens
- Included SDOH screenings in MH Project as of 1/1/25
- They will use CHA referral as of 3/1/25


Social Need Screenings vs. Date
Social Need Screenings per Month
350
300
250
200
150
100
50
0
Office
MMG Fort Lincoln
MMG Navy Yard
MMG MWHC IM
10/31/2023
11/30/2023
FL Go live
Referral Go live
03/31/2024
04/30/2024
NY Go live
06/30/2024
07/31/2024
08/31/2024
09/30/2024
10/31/2024
11/30/2024
MWHC IM Go live
01/31/2025
02/28/2025
Date


Total referrals per office/mo vs. Date
Total referrals per office/mo
15
10
5
0
02/29/2024
03/31/2024
04/30/2024
05/31/2024
06/30/2024
07/31/2024
08/31/2024
09/30/2024
10/31/2024
11/30/2024
12/31/2024
01/31/2025
02/28/2025
Date
Office
MMG Fort Lincoln
MMG MWHC IM
MMG Navy Yard
MMG Fort Lincoln
MMG MWHC IM
MMG Navy Yard

Choose your sites carefully!

Office	Social Need Screenings Per Month	Positive Screen rate (%)	DC Residents	DC Medicaid
MMG Fort Lincoln	94	10.5	Medium	High
MMG Navy Yard	111	2	High	Low
MMG MWHC IM	169	17	High	High

Discussion

- How do you balance
  - Workload among the team to manage SDOH screening and referral?
  - Demand of positive screens and supply of people (CHAs) to manage them?

Thank you!

Contact information

- Jeffrey.M.Weinfeld@medstar.net

Socios de Salud / Health Partners Program

Chronic Disease Care Coordination at Mary's Center: Broader Context

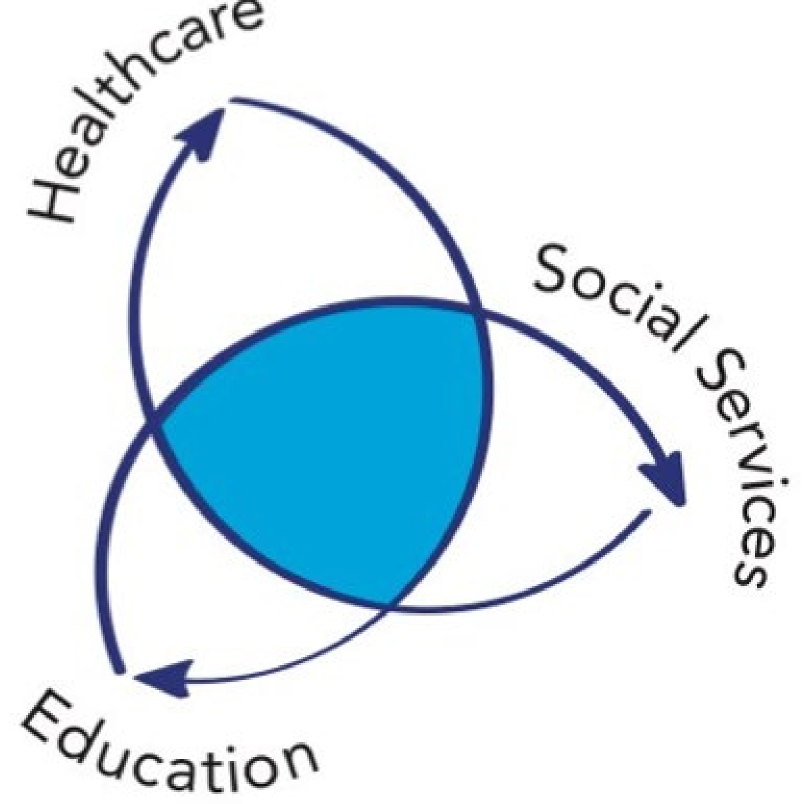
Health Partners/Socios de Salud: Short-term self-management care coordination program for participants with uncontrolled DM or HTN. Participants are paired with a care coordinator to support with their self-management goals. Care coordinators provide routine follow-up, ongoing care coordination, and serve as a point of contact between medical visits. All MC participants, regardless of insurance status, can be referred to this program.

My Health GPS Program: Long-term care coordination program available to DC Medicaid enrollees with 3 or more chronic/complex conditions. Participants are paired with a care coordinator who supports with goal-setting, ongoing care coordination, and routine follow-up between medical visits. These visits are reimbursed by DC Health Care Finance, so we want to ensure eligible participants who need this extra support are enrolled.

Facilitated Telemedicine: MAs travel to participants' homes to facilitate a telemedicine visit with their clinician; they do an environmental assessment, get vitals, administer POC tests, draw labs, and support with care coordination. Participants must be insured to be eligible for this service.

Socios de Salud / Health Partners

Care coordination support towards self-management



Population of Focus: Enrollment Criteria

- Diagnosis:
  - Uncontrolled diabetes (HbA1c >9),
  - **Uncontrolled hypertension (BP>140/90)**

- Self-management support need
  - Education
  - Medication titration
  - Goal-setting
  - Healthcare system navigation

- Readiness to engage in self-management

- **(For IHH: DC residency)**

Health Partners / Socios Enrollment

- Care coordinator assigned by Program Coordinator
- 3 initial outreach attempts – greater success if referral clinician already discussed program with participants
- Program explanation
- Care Coordination visit for enrollment with care plan initiated, SDOH screening completed

Health Partners / Socios Engagement

- Customized care plans
- Self-monitoring logs
- Mutually developed diet/lifestyle/SDOH goals
- Regular communication between care coordinators and Pts – default q2w

Buy-in Is Key!

Participants can be withdrawn from the program if:

- Lack of Pt engagement
- Pt unable to be reached
- Frequent no-shows to appointments
- Expressed lack of interest in participation
- The care coordinator notifies the PCP and other relevant members of the care team if the participant is withdrawn

Graduation

Treatment goals met
- HbA1C, blood pressure targets

Participant-established goals met
- Self-management
- Medication management
- Scheduling
- Healthcare system navigation
- Communication with clinic

A Look at Our Workplan

- Goal:
  - **GOAL 1: Work with at least 65 participants in a revised Mary's Center Health Partners/Socios de Salud Program, a comprehensive care coordination program aimed at improving health outcomes for individuals with hypertension, which will include personalized care plans, and education on monitoring and lifestyle changes.**
- Objective:
  - **Objective #3: Train staff on the revised program and associated processes**

What health indicators/measures are you tracking? How?

- For overall program:
  - A1c at time of enrollment in program vs. A1c at graduation
  - Blood pressure at time of enrollment vs. blood pressure at graduation
  - Rates of SMBP, rates of care plan completion, rates of SDOH screening completion, rates of referrals to social services
    - Outcomes team produces recurring reports with health metrics over time
    - Manual tracking for some elements

- For this objective (training on program):
  - Train clinical teams on care plan and program workflows
  - Develop materials for key stakeholder regarding the program and key processes
  - Train clinical team on referral processes
    - Manual documentation of training events and participants
    - Outcomes team produces recurring reports on referral/enrollment volume relative to trainings

Key activities: Formalizing staff training and capacity-building

- Care coordinator trainings (onboarding and continuing education)
  - NEW this grant cycle: trained 10 CNCs as Care Coordinators
    - Initial training on program for new care coordinators
    - Insulin titration standing orders (training for RN care coordinators)
    - SDOH screener training
    - Upcoming refresher on enrollment process

- Clinician trainings (participant profile, referral process)
  - NEW this grant cycle: 1:1 onboarding for new clinicians
    - Presentation at organization's Clinical Leadership meeting:
    - Presentation at organization's Care Coordination and Collaboration meeting
    - Presentation for clinicians at site-specific huddle
    - 1:1 program orientations with new clinicians x2, mapping of clinicians who require training

Who are the key personnel (internal): Describe each person's role

- Wendy Quinteros, Population Health Program Coordinator:
  - Program management, training, quality improvement
- Karina Calix, Population Health MA / Glenda Corado, Population Health MA:
  - Support with program administration, manage participant panels
- Clinical Nurse Coordinators (10):
  - Manage participant panels
- Elysia Jordan, VP of Nursing Services / Sarah Gold, Nurse Manager of Care Coordination:
  - Clinical support and program oversight

Who are the key partners (external): Are there any community organizations or other stakeholders involved?

- In addition to referring program participants to internal programs / resources (i.e. BHAP – insurance support, FSWs – housing, food insecurity resources), we rely on various external community organizations such as Food and Friends
- We look forward to enhancing our utilization of LinkU to ensure we are fully leveraging and tracking referrals to external resources

Describe a success:

- 5 new HTN referrals to the program in March 2025 in the 2 weeks following 2 clinician training events (compared to 1 new HTN referral in February 2025, 0 in January 2025)

Describe a challenge:

- Enrollment status data through EMR vs. internal tracking sheet

What is the status?

- We are working closely with our Outcomes team to ensure alignment between our internal tracking sheet and the data pulled from our EMR

What is your next step?

- Comparing our manual tracking sheet with Outcomes data to ensure alignment, with the aim of shifting to automated recurring reports that accurately capture Pts by enrollment status (i.e. referred/pending enrollment, enrolled, withdrawn, graduated) and key health metrics (i.e. A1c at time of enrollment relative to A1c at time of data pull)

Questions & Comments

Thank You

Next Steps and Q&A

Bonny Nunez, MPH, Public Health Analyst, DC Health

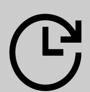
Quick Evaluation Poll

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)

Heart Disease and Stroke Prevention Learning Collaborative: *September 2024-August 2025*

Learning Collaborative Structure

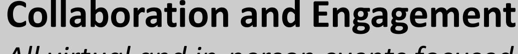


Quarterly Cycles:
Informed by Strategic Plan and participant-identified priorities based on the HIT/EHR Assessment

Capacity Building Calls:
- *Framed in data*
- *Health equity focus*
- *Focus on building and applying knowledge*

Work Plan 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

Next Cycle

Collaboration Between Partners to Strengthen Referral Making

- **April 23:** Screening and Referral - Leveraging Shared Technology Solutions

- **May 21:** Team-Based Care to Support Referral Making

- **June 18:** Workplan/Action Cycle Report out

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