

HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

OCTOBER 2025

Agenda

- 1. Welcome, Program Updates**
- 2. Leveraging Social Determinants of Health Data to Support the Referral Process**
- 3. In-Service Partner Update: CRISP DC and LinkU Single Sign On and Trusted Network Development**
 - *Highlights and Updates from Mary's Center and CRISP DC*
- 4. Q & A and Next Steps**

Welcome!



Come on Video



Introduce Yourself in the Chat

Name, Title,
Organization/Affiliation



What's your favorite thing about Fall?

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



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



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



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

Welcome, Program Updates and Reminders

Bonny Nunez, MPH, Public Health Analyst, DC Health

Latrice Hughes, MPH, Public Health Analyst, DC Health

Poll: Implementing Learnings from September

- **Have you incorporated a NEW nutrition program or service provider in your workflow as a follow-up to the September in-person session? If so, how? (check all that apply)**
 - Added the nutrition provider to our list of referral sources.
 - Accessed the organization via LinkU.
 - Reached out to the nutrition provider to discuss eligibility and referral workflows and/or an agreement with them to collaborate on patients.
 - Made at least one referral to the new nutrition provider.
 - Other (Please describe in the chat box or please come off mute and share)

Poll: *What is your current status on documenting screening and referral data?*

- **How are you documenting SDOH *screening* data? (check all that apply)**
 - LinkU
 - Electronic Health Record form
 - Excel spreadsheet
 - Paper/post it notes on their desktop
 - Other (Please describe in the chat box or please come off mute and share)
- **How are you documenting SDOH *referral* data? (check all that apply)**
 - LinkU
 - Electronic Health Record form
 - Excel spreadsheet
 - Paper/post it notes on their desktop
 - Other (Please describe in the chat box or please come off mute and share)

Leveraging SDOH Data to Support the Referral Process

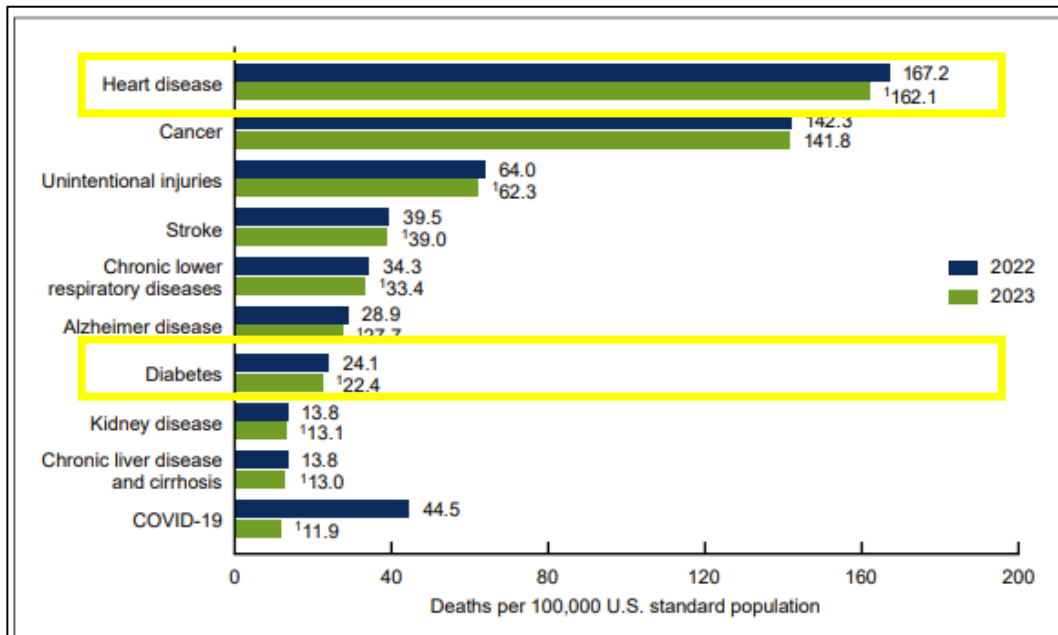
Saumya Rajamohan, Data Analyst, DC Health



Burden of Chronic Disease in the US

Chronic diseases are among the leading causes of death and disability in the United States

Age-adjusted death rate for the 10 leading causes of death in 2023: United States, 2022 and 2023



¹Statistically significant decrease from 2022 to 2023 ($p < 0.05$).
 NOTES: A total of 3,090,964 resident deaths were registered in the United States in 2023. The 10 leading causes of death accounted for 70.9% of all U.S. deaths in 2023. Causes of death are ranked according to number of deaths in 2023. Rankings for 2022 data are not shown. Data table for Figure 4 includes the number of deaths for leading causes and the percentage of total deaths.
 SOURCE: National Center for Health Statistics, National Vital Statistics System, mortality data file.

3 in 4 adults have at least 1 chronic condition

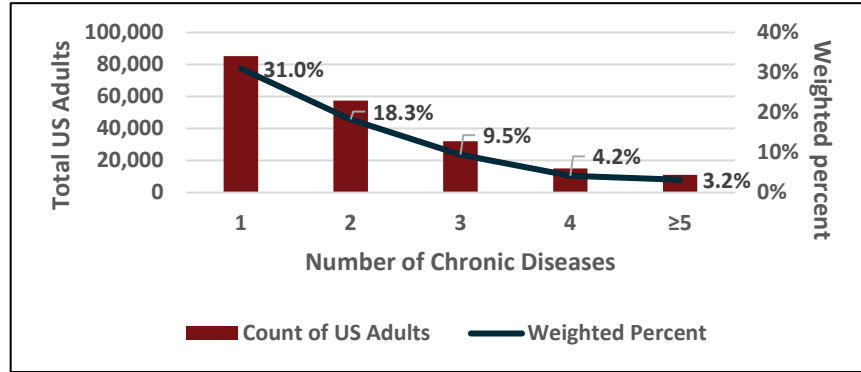
65+ yrs 90% have at least 1 chronic condition

35-64 yrs 75% have at least 1 chronic condition

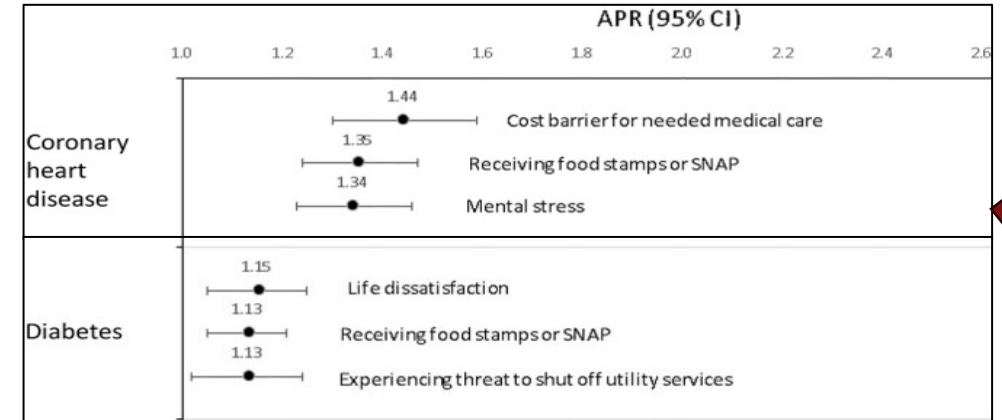
18-34 yrs 60% have at least 1 chronic condition

Overview of SDOH and HRSN Among US Adults With Chronic Diseases (BRFSS 2022 reports)

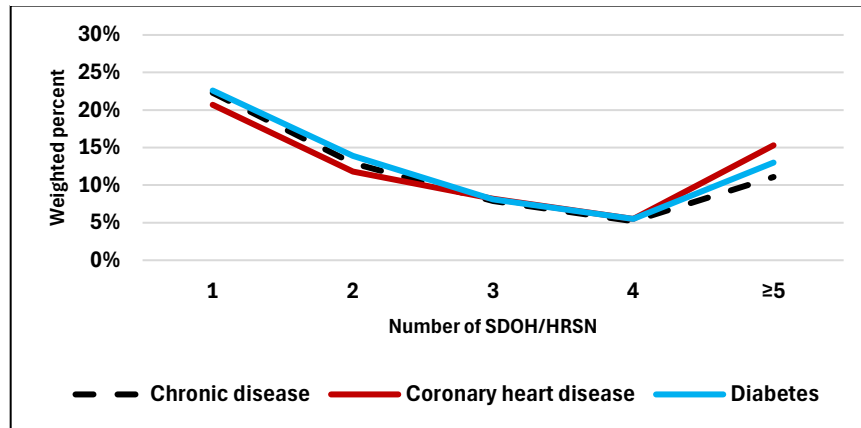
Approximately 6 in 10 US Adults lived with multiple chronic conditions



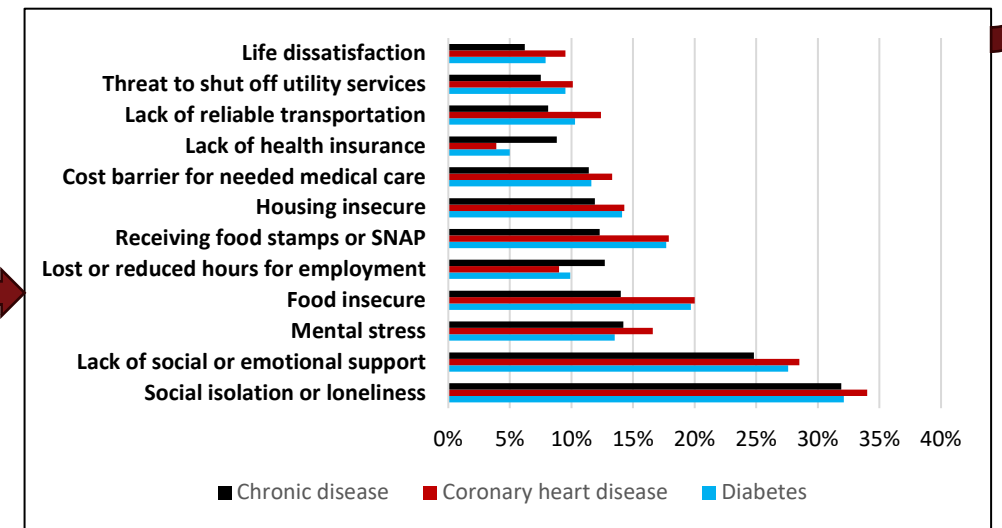
Differences in magnitude of SDOH/HRSN impact on health outcomes by chronic condition



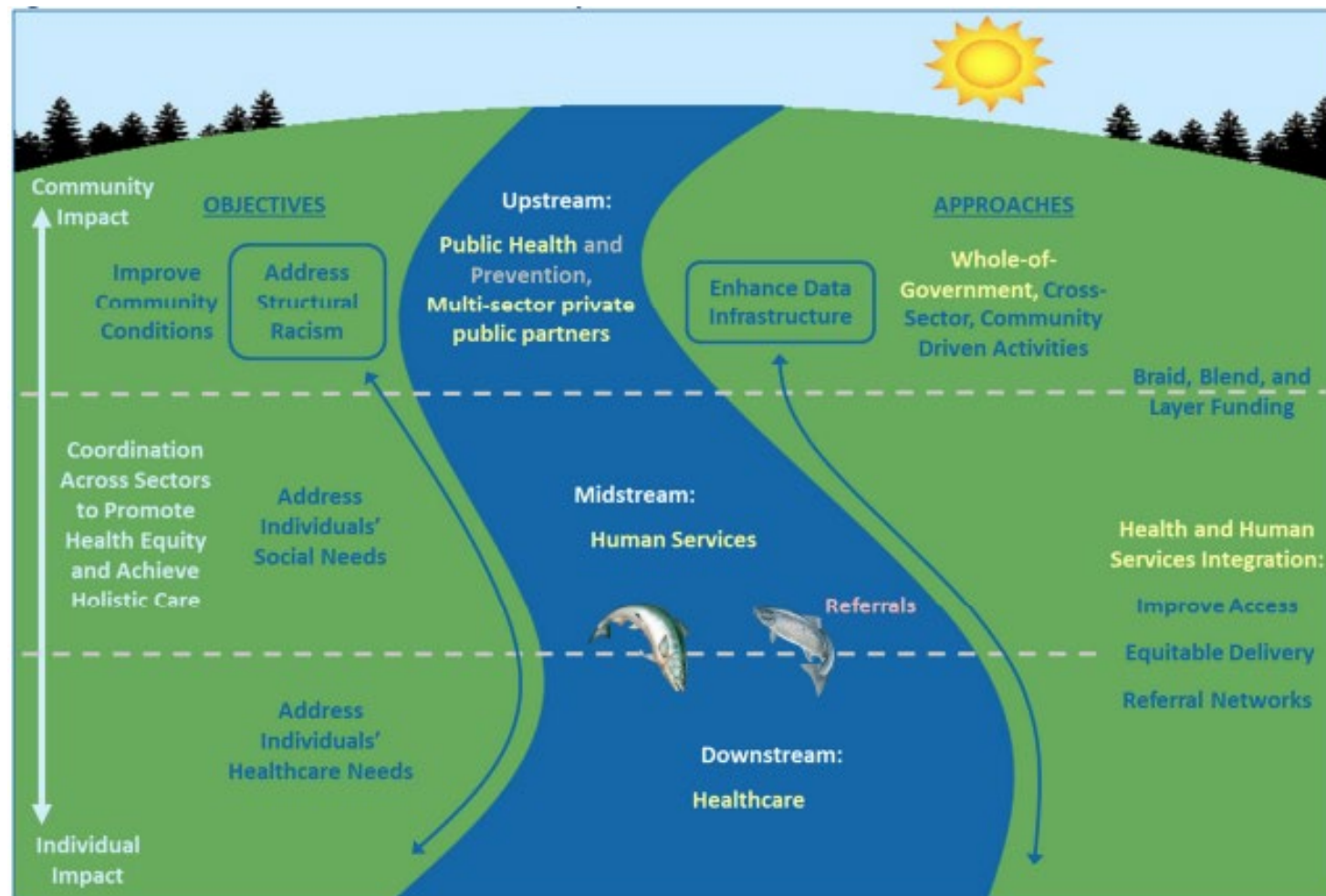
Adults facing multiple SDOH needs carry a higher burden of chronic disease



SDOH/HRSN Prevalence estimates were higher among adults with chronic diseases vs those without



Social Determinants of Health Ecosystem



Data Source: Whitman, A., Lew, N. D., Chappel, A., Aysola, V., Zuckerman, R., & Sommers, B. D. (2022, April 1). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Assistant Secretary for Planning and Evaluation. Retrieved October 9, 2025, from <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84a0ae8ff0fae7474af82/SDOH-Evidence-Review.pdf>

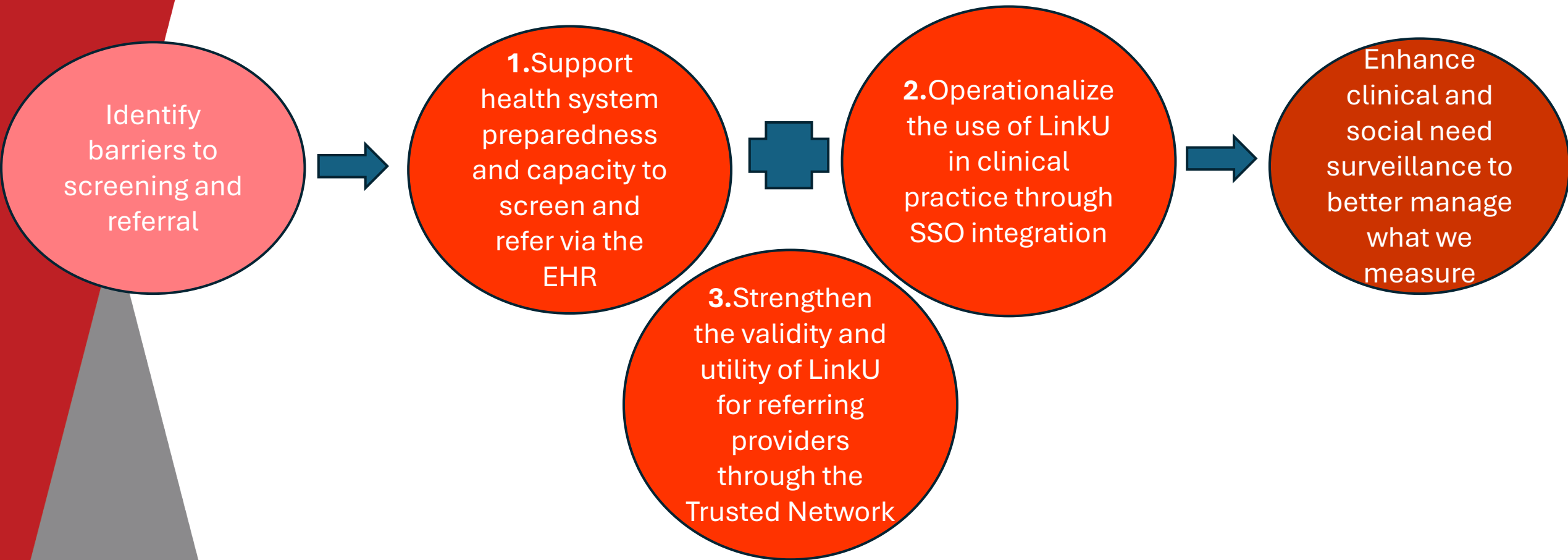
In-Service Partner Update: CRISP DC and LinkU Single Sign On and Trusted Network Development

Amanda Hirsch, MPH, Public Health Analyst, DC Health

*Rosa Goyes, Director of Community Health Programs,
Mary's Center*

Abby Lutz, MS, Program Manager, CRISP DC

Leveraging Shared Technology to Support Care Coordination: Implementing the LinkU Single Sign-On and DC Health Trusted Network



LinkU Single Sign-On and DC Health Trusted Network: Progress To-Date

1. Health Systems Change

- 7/7 (100%) of health system partners have implemented new policies, procedures or workflows to leverage their EHR/HIT to identify and manage patient needs
- 7/7 (100%) of health system partners have implemented new policies, procedures or workflows to surveil screenings and referrals conducted
- % increase in screening and referral

2. LinkU SSO

- 35 agencies onboarded to SSO pilot
- 5 funded health systems onboarded to SSO pilot

3. Trusted Network

- 50+ clinical and non-clinical partners identified for inclusion in Trusted Network
- Phase 1 of Trusted Network implementation underway
- Phases 2 and 3 to be completed by end-of-year

Grantee Highlight

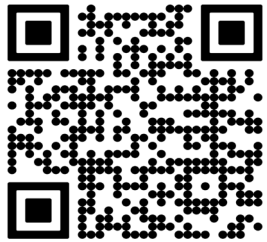


1. Why did Mary's Center prioritize screening and referral for social needs?
2. How has Mary's Center strengthened the screening and referral processes?
3. What is Mary's Center's experience adopting the SSO tool so far?
4. What are the next steps for addressing challenges and working toward improvements?



Leverage LinkU via CRISP DC to Support Whole Person Care

Abby Lutz, Project Manager, CRISP DC



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 Poll Question

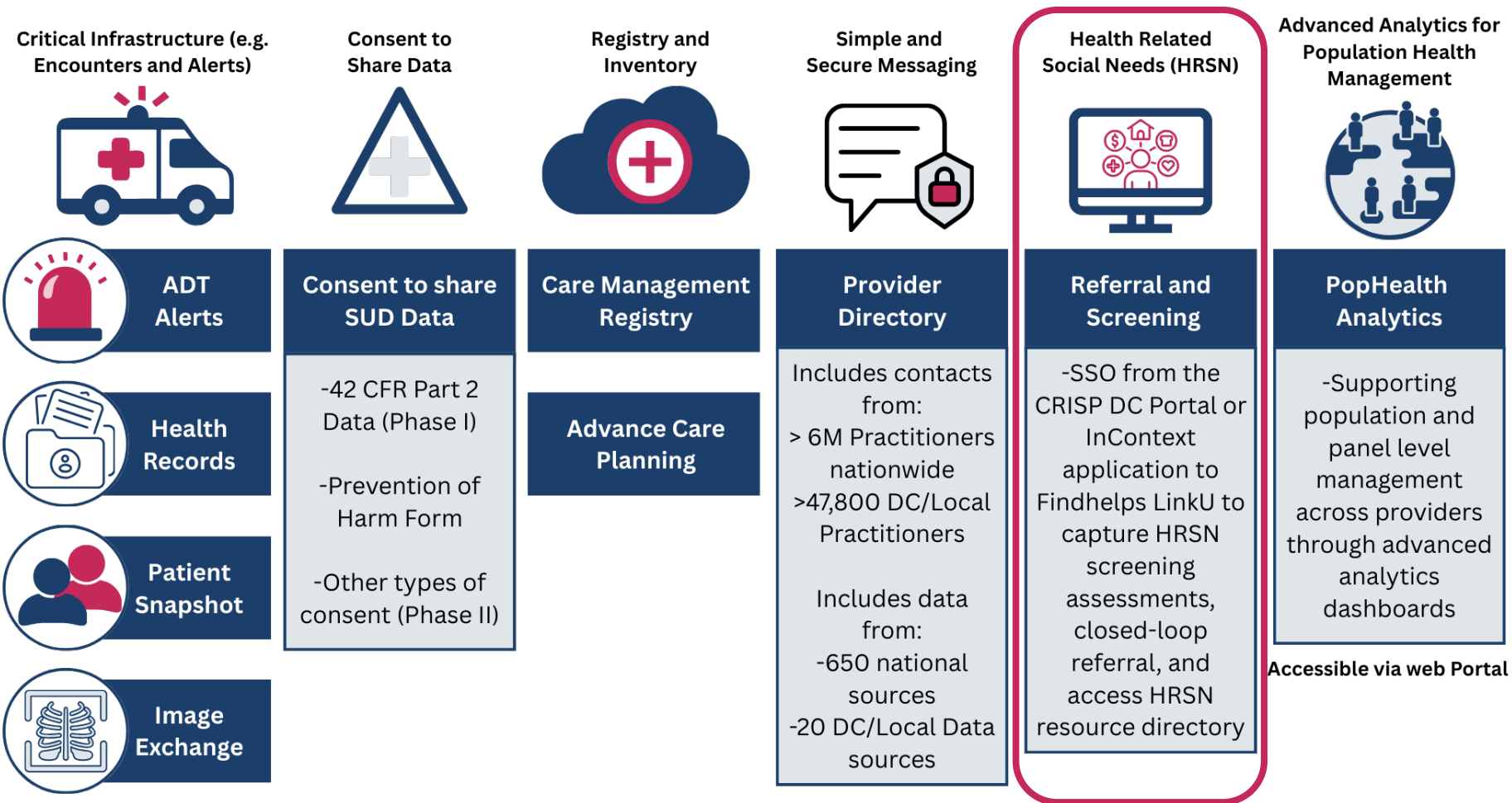
Have you used the LinkU platform through CRISP DC?

A. Yes

B. No, I have access, but I have not yet logged in

C. No, I have not yet received access to LinkU through CRISP DC

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



Accessible via web Portal



Streamline Social Needs Referrals with LinkU Integration



With funding from DHCF, CRISP DC has partnered with the DC Department of Health and findhelp to integrate **LinkU**, DC Health's screening, referral and resource directory platform. LinkU integration with CRISP DC will provision providers with Single Sign On (SSO) access to seamlessly launch from the CRISP DC Portal into LinkU without having to re-enter login information to:

- Conduct a **social needs screening assessment**
- Send **closed-loop referrals** to community-based organizations
- Search for **community resource information** available in the District



Launch LinkU Directly from the CRISP DC WebPortal and InContext Application

Let's take a look at our Clickable PPT available on the CRISP DC Website



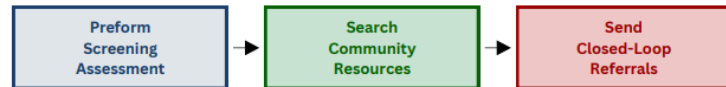
Equip Your Team with go to LinkU Resources for Seamless Care Coordination

CRISP DC

Health Related Social Needs Solution

How does it work?

CRISP DC together with the DC Department of Health is launching LinkU, DC Health's screening and referral platform powered by findhelp. CRISP DC users can seamlessly access the LinkU platform and connect patients to community resources through a Single Sign-On (SSO) solution available via the CRISP DC HIE Portal and InContext application.



The LinkU platform allows providers to:

- Perform a social needs screening assessment
- Search for community resource information available in the District
- Send closed-loop referrals to community-based organizations

Social Needs Screening Assessment

- Providers can use LinkU's standardized **Community Needs Assessment** to screen clients across key domains: Living Situation, Financial, Food, Medical, Mental Health, Transportation, Legal, Safety, and Substance Use.
- Screening data captured in LinkU will be accessible in CRISP DC, ensuring care teams have up-to-date social needs history.

Community Resource Inventory

- Providers can search within LinkU using a zip code or a specific program to **find available resources** for patients.
- Available programs: **Food, Housing, Goods, Transit, Health, Money, Care, Education, Work and Legal.**

www.crispdc.org

dcoutreach@crisphealth.org

CRISP DC

Introduction

What makes LinkU different?

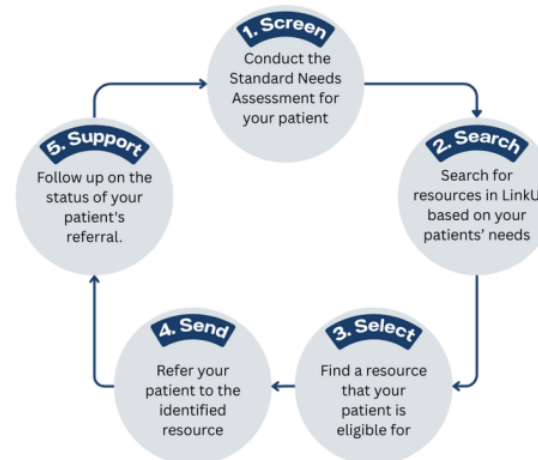
LinkU, DC Health's instance of **Findhelp**, is an all-in-one screening, referral, and resource directory platform that can easily be launched from CRISP DC.

Organizations that have been onboarded to the platform have access to these key benefits:

- **Seamless Access:** No extra login needed- launch directly from CRISP DC.
- **Personalized Support:** Screening assessments suggest tailored search areas based on your patient's needs
- **Direct Patient Connection:** Send resources straight to patients so they can quickly access care.
- **Referral Tracking:** Monitor the status of referrals you've sent and receive timely updates.
- **Team Collaboration:** Work together with colleagues to support patients in your care.
- **Enhanced Care Coordination:** Data collected in LinkU flows back to the HIE for a complete patient record.

Workflow

Please see below the desired flow for using the LinkU platform.



3

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LinkU In Action

“As a Population Health Manager at an FQHC, I use LinkU via CRISP DC when I identify a patient in need and the patient expresses interest in receiving support. Within LinkU, I can search for housing resources for my patients and send referrals to programs they are eligible for. Using LinkU ensures that I will be kept up to date on the status of my patients’ referrals, so I know when my patients were able to receive support for their needs.”



- **LinkU Onboarding Progress**

- Successfully onboarded and provisioned access to LinkU through the DC HIE for **35 organizations**
 - **9** FQHCs
 - **5** Hospitals (including Cedar Hill Regional Medical Center)
 - **18** Behavioral Health, SUD, Housing, LTC, and Primary Care Clinics

- **What's Next?**

- Ensuring that all onboarded organizations have received initial training on the LinkU platform.
- 1:1 TA in partnership with eHealth DC to assist with integrating the LinkU platform into existing workflows.



From Screening to Connection, Here's What's Built In!

- 1. Seamless Access:** No extra login needed- launch directly from CRISP DC
- 2. Personalized Support:** Screening Assessments suggest tailored search areas based on your patients' needs
- 3. Direct Patient Connection:** Send resources directly to the patient so they can quickly access care
- 4. Referral Tracking:** Monitor the status of referrals you've sent and receive timely updates
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Coming Soon: Data Exchange with the DC HIE



HIE InContext GILBERT GRAPE Male | Jan 1, 1984

CARE TEAM CARE ALERTS REFERRAL HISTORY

Referral History

Date of Referral	Source	Program Name
2023-03-23	SSReferral	Fitness & Exercise
2023-03-23	SSReferral	Fitness & Exercise
2023-03-30	SSReferral	Fitness & Exercise
2023-04-17	SSReferral	Home Delivered Meals (Meals on Wheels)
2023-04-17	SSReferral	Fitness & Exercise
2023-04-17	SSReferral	Caregiver Resources
2024-04-05	CRISPPreferralUI	TEST for Referrals

Navigation menu: PATIENT INFORMATION, CLINICAL DATA, MEDICATION MANAGEMENT, CARE COORDINATION, SOCIAL NEEDS DATA, DATA FROM CLAIMS, APPS

HIE InContext GILBERT GRAPE Male | Jan 1, 1984

ASSESSMENTS CONDITIONS

Assessments

Date ↓	Source
2023-03-06	Priority Partners Referrals
2022-10-07	Meritus Medical Center
2022-09-30	Meritus Medical Center
2022-09-17	Meritus Medical Center
2022-06-20	MCH Ventures, Inc.
2022-06-20	Community Care of West Virginia
2022-06-13	Luminis Health - Anne Arundel Medical Center
2022-04-04	Meritus Medical Center
2022-01-03	Meritus Medical Center

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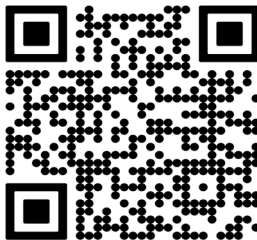
- Data captured through the LinkU platform, such as screening and referral data will flow back to the DC HIE and be viewable in the care coordination and social needs subtabs.



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

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

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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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DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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