

HEART DISEASE AND STROKE PREVENTION LEARNING COLLABORATIVE

FEBRUARY 19, 2025



Welcome, Introductory Remarks, and Icebreaker Activity

10:00 am – 10:20 am

Agenda

Time	Topic
10:00am – 10:10am	Welcome and Introductory Remarks
10:10am – 10:20am	Introductions and Icebreaker
10:20am – 11:00am	Strategic Plan Development and Implementation
11:00am – 11:45am	Tabletop Exercise & Report Out
11:45am – 12:30pm	Lunch
12:30pm – 1:30pm	DC Health Communications and Health Promotion Updates and Discussion
1:30pm – 2:00pm	Next Steps

Meet the DC Health Team



Sarah Beckwith
Bureau Chief, Disease Prevention
and Health Promotion



Shannon Gopaul
Chronic Disease Division
Chief



Latrice Hughes
Public Health Analyst



Bonny Nunez
Public Health Analyst



Amanda Hirsch
Public Health Analyst



Tyler Shaw
Community Engagement
Specialist



Mariana Jimenez
Health Equity
Coordinator



Sharmila Chatterjee
Epidemiologist & Data
Analyst



Saumya Rajamohan
Epidemiologist & Data
Analyst

Meet the HMA Facilitation Team



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2022 LEADING CAUSES OF DEATH IN THE DISTRICT

DC, 2022						US, 2022			
Rank	Cause of death ¹	Number of Deaths	Crude Rate ²	Age-adjusted Rate ³	Percent of all deaths	Cause of death	Number of Deaths	Crude Rate ²	Age-adjusted Rate ³
1	Diseases of heart (I00-I09,I11,I13,I20-I51)	1094	162.8	160.8	20.3	Diseases of heart (I00-I09,I11,I13,I20-I51)	702,880	210.9	167.2
2	Malignant neoplasms (C00-C97)	828	123.3	121.7	15.4	Malignant neoplasms (C00-C97)	608,371	182.5	142.3
3	Accidents (unintentional injuries) (V01-X59,Y85-Y86)	555	82.6	79.4	10.3	Accidents (unintentional injuries) (V01-X59,Y85-Y86)	227,039	68.1	64.0
4	Cerebrovascular diseases (I60-I69)	233	34.7	34.0	4.3	COVID-19 (U07.1)	186,552	56.0	44.5
5	COVID-19 (U07.1)	187	27.8	27.2	3.5	Cerebrovascular diseases (I60-I69)	165,393	49.6	39.5
6	Assault (homicide) (*U01-*U02,X85-Y09,Y87.1)	143	21.3	20.1	2.7	Chronic lower respiratory diseases (J40-J47)	147,382	44.2	34.3
7	Diabetes mellitus (E10-E14)	101	15.0	14.9	1.9	Alzheimer disease (G30)	120,122	36.0	28.9
8	Chronic lower respiratory diseases (J40-J47)	100	14.9	14.4	1.9	Diabetes mellitus (E10-E14)	101,209	30.4	24.1
9	Essential hypertension and hypertensive renal disease (I10,I12,I15)	72	10.7	10.5	1.3	Nephritis, nephrotic syndrome and nephrosis (N00-N07,N17-N19,N25-N27)	57,937	17.4	13.8
10	Septicemia (A40-A41)	60	8.9	8.6	1.1	Chronic liver disease and cirrhosis (K70,K73-K74)	54,803	16.4	13.8

Data Sources: 2022 DC Mortality File, Vital Records Division, Center for Policy, Planning and Evaluation, D.C. Department of Health;

Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2022 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/ucd-icd10-expanded.html> on May 28, 2024 9:55:40 AM.

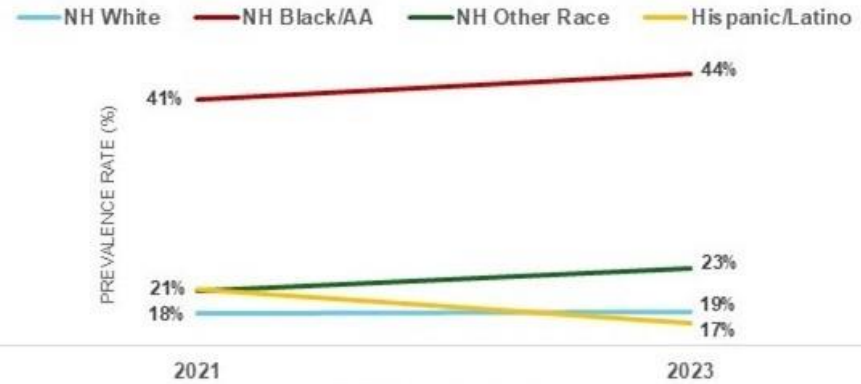
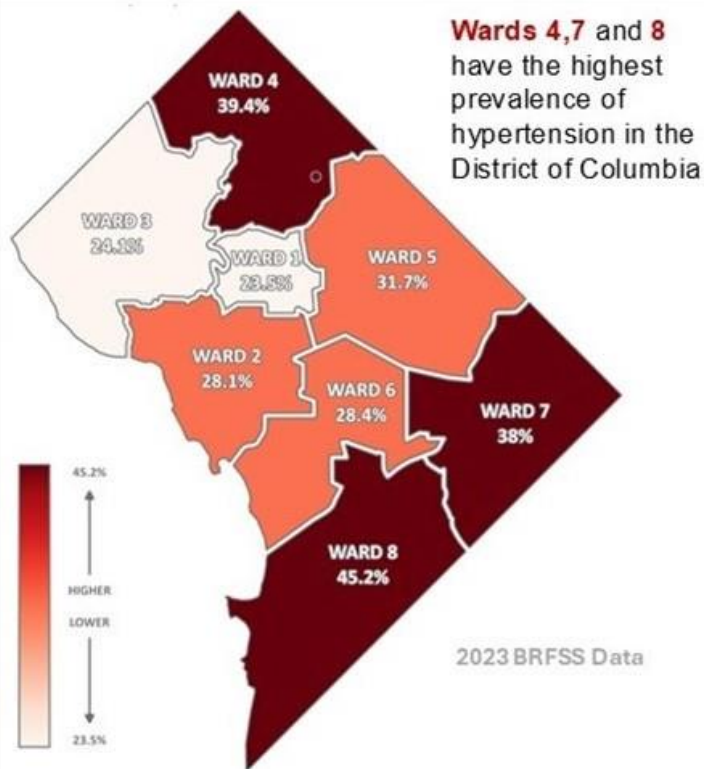
¹ ICD-10 codes for causes-113 List.

² Per 100,000 population based on populations enumerated as of July 1 of the following year.

³ Per 100,000 U.S. standard population.

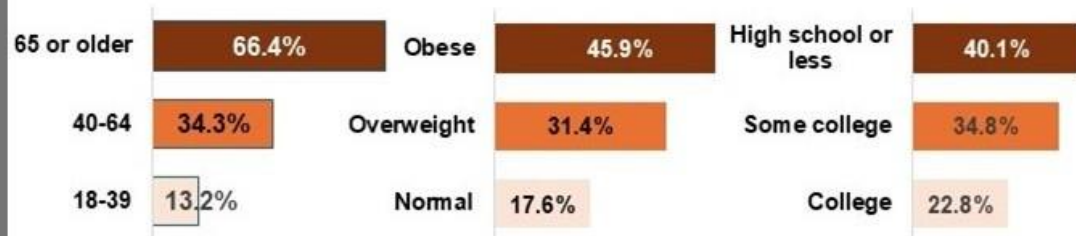
Hypertension in the District - Year 2023

29% of adult (18 years and older) DC residents have hypertension in 2023
(n= 163,561)



2X Non-Hispanic (NH) Black/African American residents were more than 2 times likely to have hypertension (44%) compared to NH White residents (19%)

- Adults aged **65 years and older** had **5 times** higher rates of hypertension compared to residents less than 40 years old.
- Adults with **obesity** were **more than 2 times** likely to have hypertension compared to adults who were normal weight (determined by BMI).
- Adults with **high school or less education** had **almost 2 times** higher rates of hypertension compared to college graduates.



Data Source: DC BRFSS 2023

LEARNING OBJECTIVES

1. Overview and status update of DC Health's *DRAFT* Strategic Plan to reduce heart disease and stroke risk in the District
 - Key themes, challenges, and preliminary recommendations
2. Obtain feedback on ways to achieve strategic goals from residents, providers, health insurance companies, community organizations, and other interested parties
3. Learn about current DC Health Communications and Health Promotion campaigns and provide feedback on their visibility and reach into the community

KEY TERMS FOR TODAY

- **Cardiovascular diseases:** diseases that affect the heart or blood vessels, including the full spectrum of conditions and contributing risk factors
 - Conditions include: coronary heart disease, heart attack, stroke, heart failure, heart rhythm problems, heart valve problems
 - Risk factors include: smoking, high blood pressure, high cholesterol, poor diet, lack of exercise, obesity, and other chronic diseases such as diabetes
- **Community-clinical linkage:** partnerships between community organizations and health care providers that help people get healthy by connecting them to resources
- **Community health worker:** a person from the community that provides health education and support to patients accessing medical care and community services

KEY TERMS FOR TODAY (cont.)

- **Health-related social needs:** basic things that people need to stay healthy including having enough healthy food, a safe place to live, transportation to the doctor, and enough money for medication and health related services.
 - When these needs are met, it is easier for people to take care of themselves and stay healthy.
- **Team-based care:** when different healthcare workers like doctors, nurses, pharmacists, dieticians, and community health workers work together to take care of a patient.
- **Health Literacy:** the ability to discover, comprehend, and use information and services to make informed health decisions

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

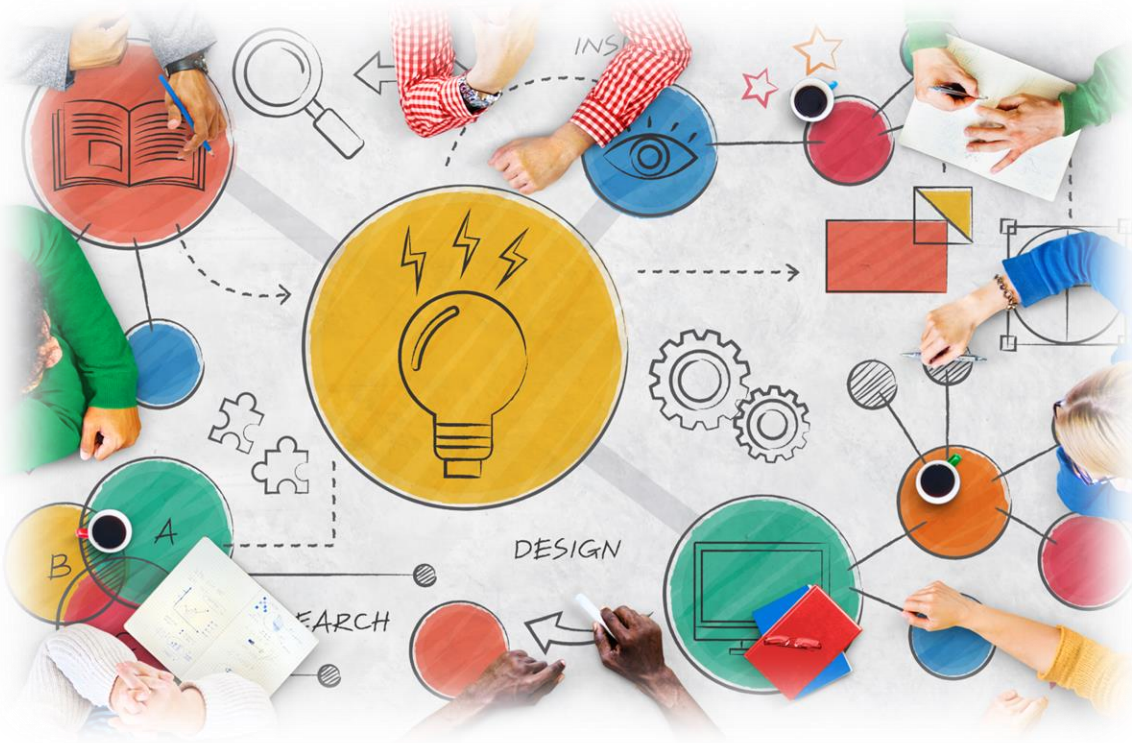
Icebreaker Activity: One Word

Write one word that describes a key challenge to reducing heart disease and stroke in the District

Instructions

1. Break into pairs and introduce yourself
2. Think of a word that describes the prompt
3. Write it on the post it note
4. Stick it on the board



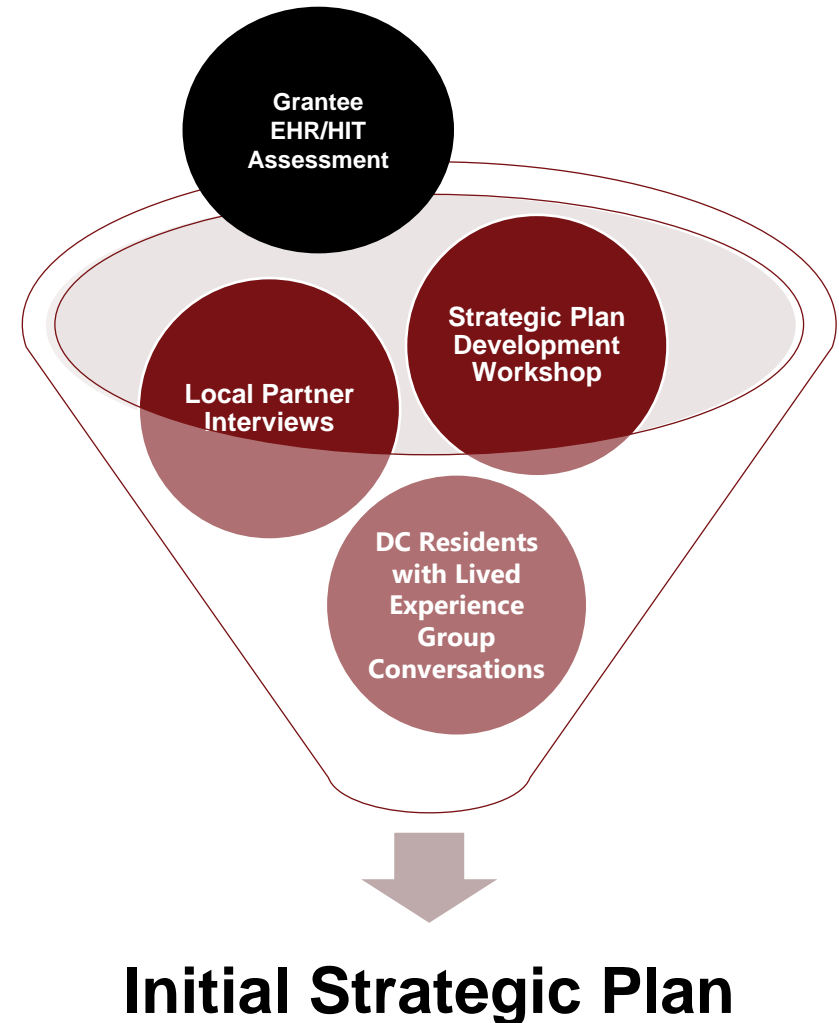


Strategic Plan Development and Implementation

10:20 am – 11:00 am

Strategic Plan Development Overview

- Collaborative effort of government, health systems, CBOs, and local partners working on heart disease and stroke prevention and management
- This plan will serve as a guide for the Heart Disease and Stroke Prevention Learning Collaborative



Understanding Key Themes & Notable Challenges

Partner Interviews	What's out there in the universe of community interventions? How do we connect?	How do we help residents access the tools needed to self-monitor?	How do we help the public recognize signs of stroke and hypertension emergencies?
Strategic Planning Workshop	How do we help the public recognize signs of stroke and hypertension emergencies and instruct on next steps?	How do CBOs effectively connect with providers who don't know what their services are?	How do we share data between providers and CBOs to track resident/patient/community improvement?
Grantee HIT/EHR Assessment	What systems do providers have in place to effectively manage hypertension and hyperlipidemia?	How well do those systems function for the care teams?	Where can technical assistance support effective strategies for hypertension and cholesterol management?
Resident Focus Conversations	How do we know when we need to see the doctor after a high blood pressure reading?	How can we expand access to existing programs so that individuals who need them can register for them?	How can we get less expensive healthy foods to manage our blood pressure?

Understanding Key Themes & Notable Challenges

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Summarizing the Key Challenges

- District residents report lack of awareness of available social need resources or face capacity issues when seeking help
- District residents report it is challenging to find which social need resources are offered, and/or find that resources have restrictions to access (including limited enrollment numbers or strict eligibility criteria)
- Clinical providers report lack of clear referral pathways and visibility into whether patients receive needed community-based services
- There is limited and unincentivized coordination between clinical care teams and social support services.

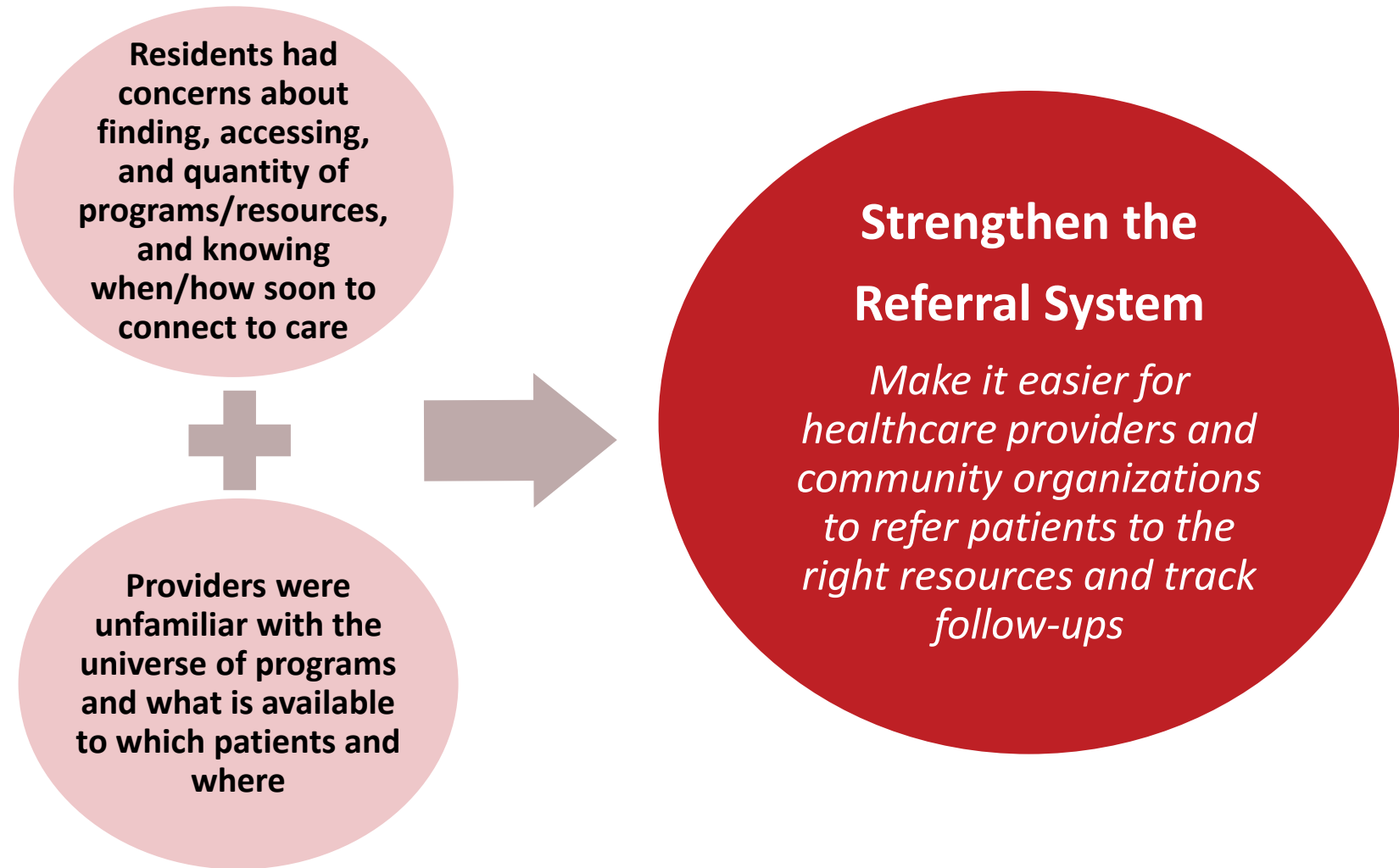
Residents said:

What are the programs?
Are there enough programs
and capacity to access them?

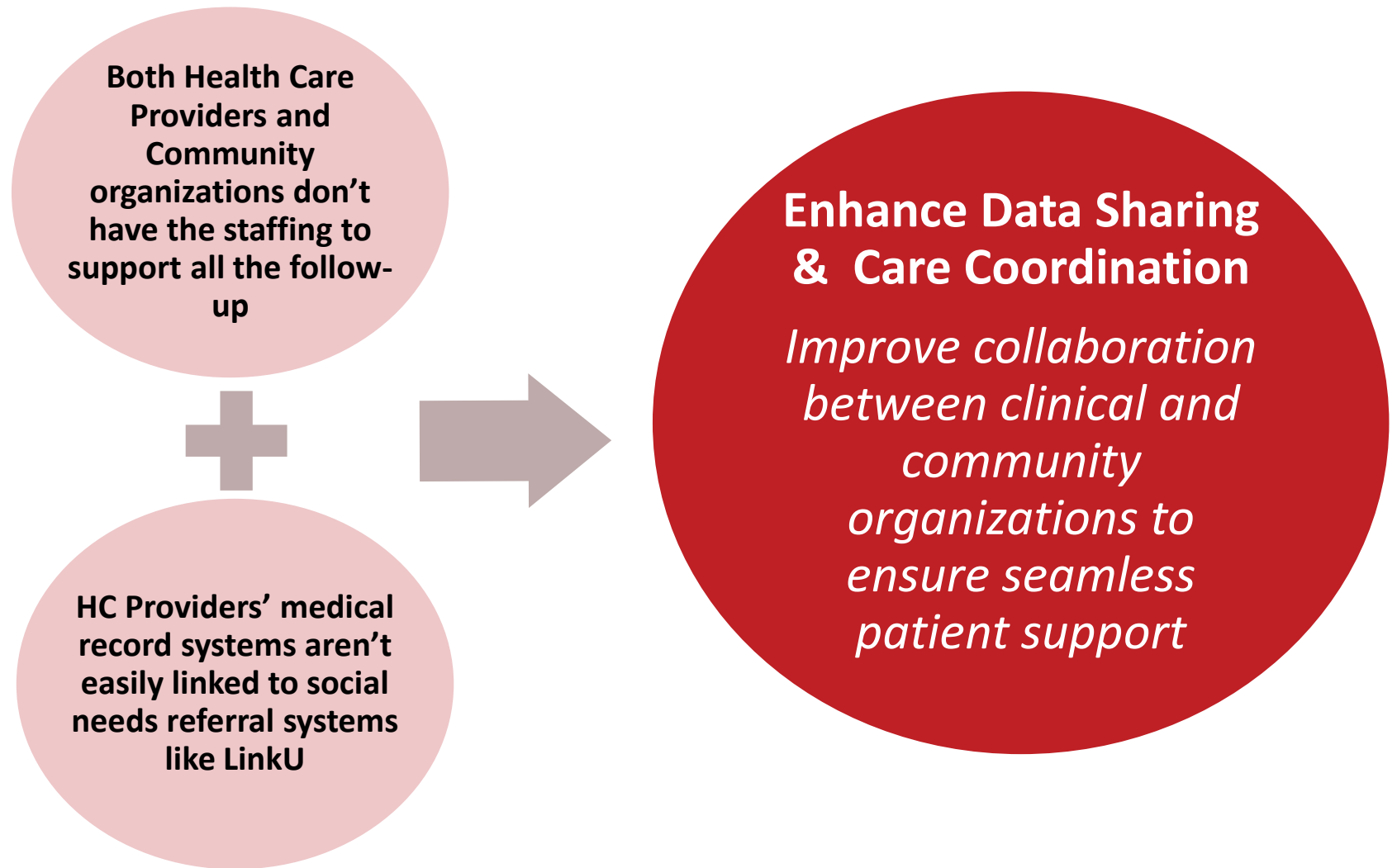
Health Care providers said:

How do we connect patients
to community services?
How do sustain these
workflows without clear ways
to pay for them?

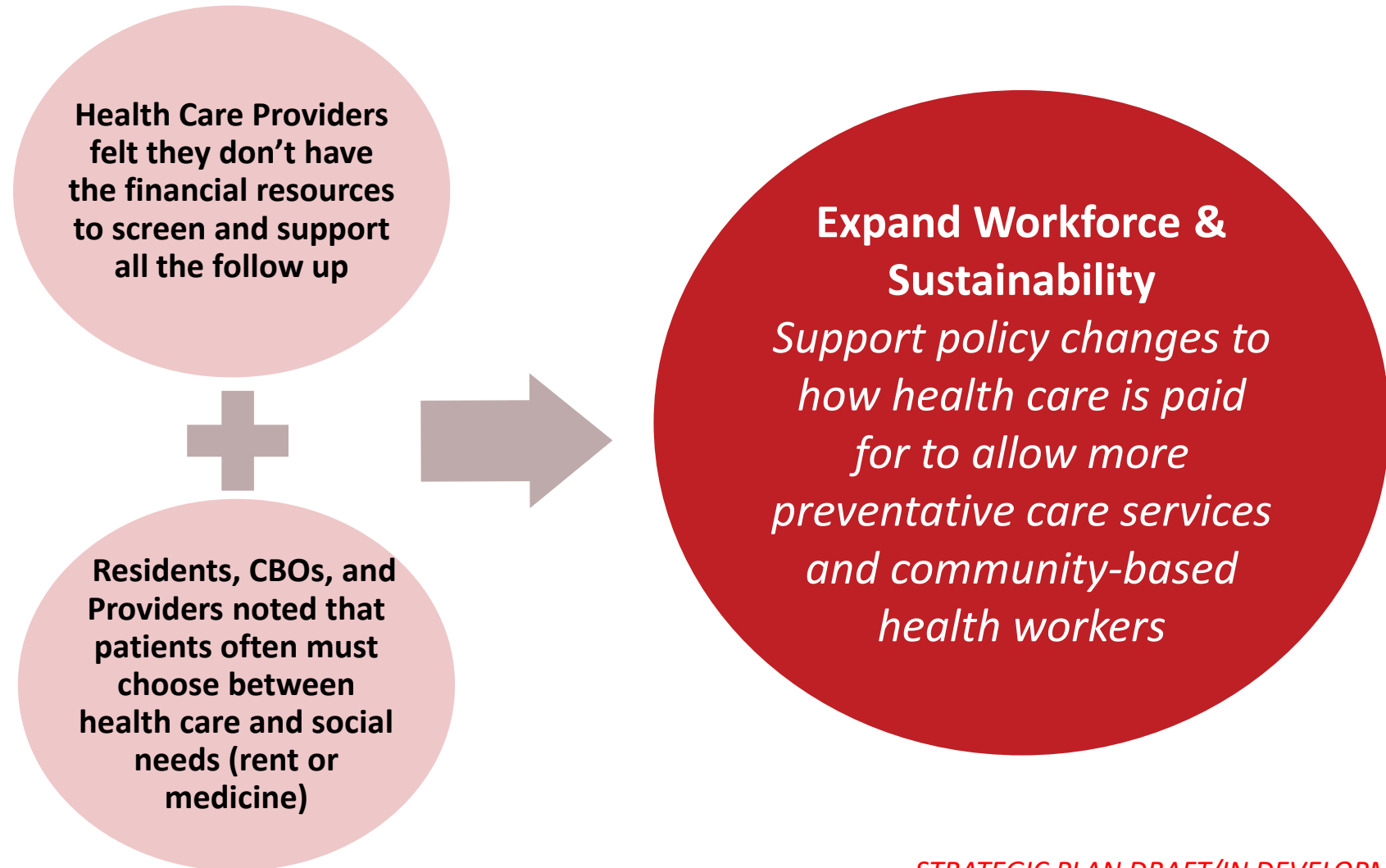
Draft Strategic Recommendations: Short Term



Draft Strategic Recommendations: Medium Term



Draft Strategic Recommendations: Long Term



Strengthen the Referral System

Make it easier for healthcare providers and community organizations to refer patients to the right resources and track follow-ups

Recommended Action Steps

- Train healthcare providers and community organizations on **how to use LinkU for referrals and closed-loop tracking**, using standardized measures to evaluate referral system effectiveness and improve hypertension management.
- Host **monthly virtual Learning Collaboratives and semi-annual in-person convenings** to foster strong partnerships between health systems and community-based organizations (CBOs) and improve hypertension management.
- Simplify messaging and **promote existing self-monitoring blood pressure (SMBP)** and other evidence-based programs in clinical and community settings, **ensuring residents know how to access them.**
- Co-develop with residents, a **Heart Health Resident Action Guide** with clear steps on where to go for blood pressure checks, how to recognize symptoms of high blood pressure, understand blood pressure readings, take needed medications, and access blood pressure management support.
- Coordinate and publish a **master calendar of health and wellness events** and opportunities across DC Health and other District agencies.

Enhance Data Sharing & Care Coordination

Improve collaboration between clinical and community organizations to ensure seamless patient support

Recommended Action Steps:

- Work with managed care organizations (MCOs), health systems, and District agencies to investigate barriers and identify solutions to **increasing the use of remote patient monitoring for high blood pressure**.
- Increase the number of health systems and CBOs that **integrate social needs data collection, screening, and referrals into their workflows** (incentivize with payment reform).
- Establish **standardized data-sharing agreements** to monitor hypertension management measures and track patient progress between provider referrals and connections to community resources.
- Expand training for providers on **risk stratification and the use of Health Information Technology (HIT)**, incorporating clinical guidance on standing orders and the use of decision-support tools for more efficient medication management and patient care planning.
- Promote **medication adherence by expanding pharmacy-led interventions**, medication synchronization programs, and pharmacist-led medication therapy management.

Expand Workforce and Sustainability

Support policy changes to how health care is paid for to allow more preventative care services and community-based health workers

Recommended Action Steps:

- Develop a **Clinical QI Playbook** on hypertension and stroke prevention and management to be used in healthcare workforce development training.
- Work with District agencies to identify policy changes that allow **reimbursement for non-clinical health workers, such as Community Health Workers (CHWs)** and care coordinators.
- Collaborate with academic institutions to create **training and recruitment programs for community-based healthcare roles.**
- Support the **adoption of value-based care models that incentivize prevention** and social needs screening and link to reimbursement strategies for CHWs and CBO-led programs.
- Work with the DC Health Primary Care Office and DC Department of Health Care Finance (DHCF) and other agencies to **pilot sustainable funding mechanisms for team-based care.**

Measuring Strategic Plan Success

To ensure accountability and progress, we will track the following metrics:

- % increase in successful closed-loop referrals (i.e., patients connected to and receiving services)
- # of providers trained on social needs screening and referral tools
- % of residents in target wards enrolled in self-monitoring programs
- % of residents in target wards achieving hypertension control
- Increase in Medicaid or MCO reimbursement for CHWs and social needs screenings



Tabletop Exercise & Report Out

11:00 am – 11:45 am

Tabletop Report Out – Guiding Questions

We will now organize ourselves into groups according to stakeholder type:

Residents of DC, Community-Based Organizations and Other Partners, Clinics and Healthcare Providers

General Discussion Questions:

- *Do the recommendations developed resonate with you?*
- *Do the action items developed and proposed sound good to you?*
- *What is missing and should be included? What do you see as next steps?*
- *How do you think we can best achieve these recommendations and action items?*
- *How would you like to stay informed and involved in the process?*



Lunch

11:45 am – 12:30 pm



DC Health Communications and Health Promotion Updates and Discussion

12:30 pm – 1:30 pm

AGENDA

- ▶ OVERVIEW
 - HEALTH LITERACY
- ▶ GO GO DC CAMPAIGN
- ▶ LIVING WELL WEBSITE
- ▶ DC QUIT NOW
- ▶ DISCUSSION

OVERVIEW

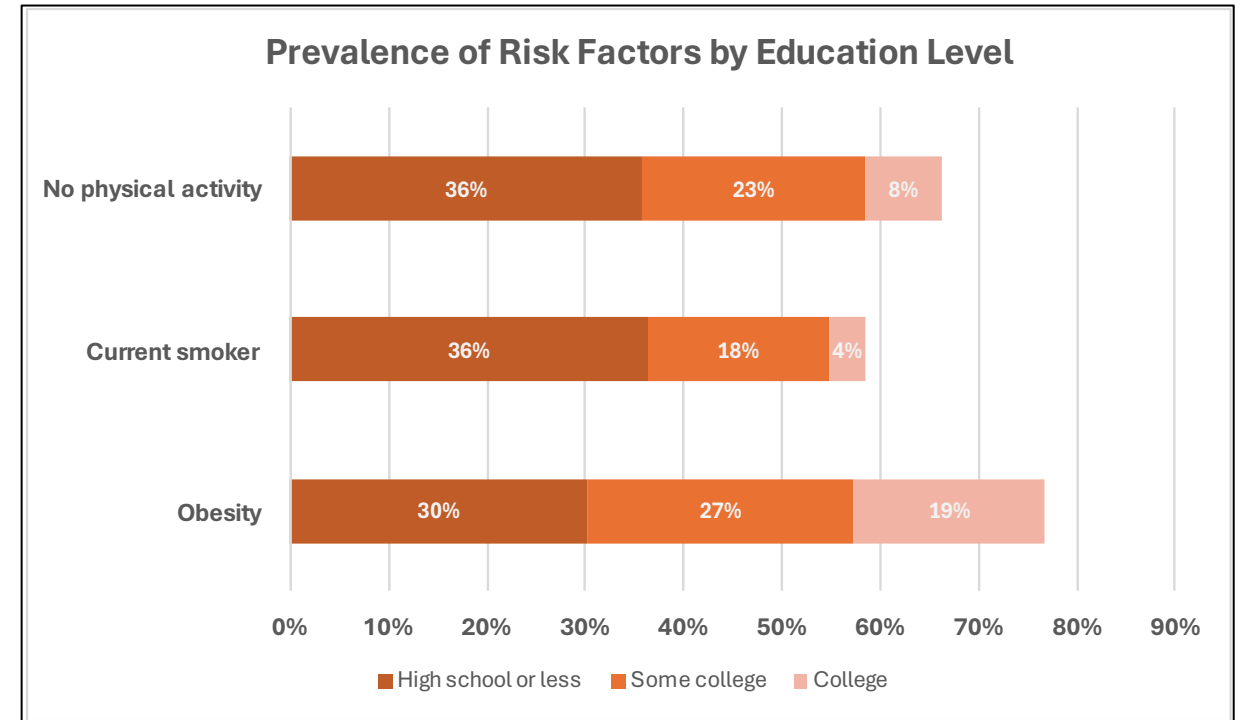
Health Literacy

Education and Health: Exploring the Connection

DC residents with high school education or less were 2x more likely to have hypertension compared to residents with a college education.

Other risk factors for hypertension:

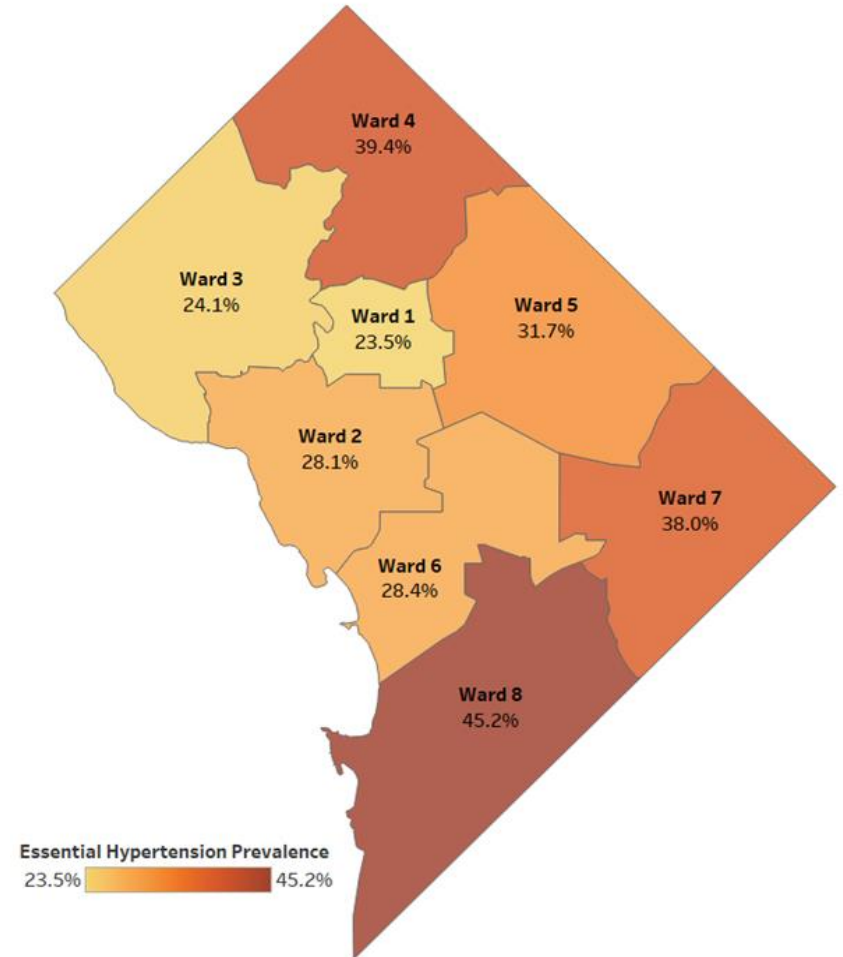
- Those who did not participate in any physical activity or exercise during the past 30 days other than their regular job were 2x more likely to have hypertension.
- Persons with a smoking history (former or current smokers) were 3x more likely to have hypertension.
- Persons with obesity were 3x more likely to have hypertension than those with normal weight.



Data Source: DC Health Behavioral Risk Factor Surveillance System, 2023

Assessing Patient Experience with Healthcare

- ▶ The 2023 DC Health BRFSS Health Literacy survey assessed if residents believed they sometimes or never had an informative appointment with their doctor or other health care professionals
- ▶ A close look at DC residents residing in priority wards (Wards 4,5,7 and 8) revealed, on average:
 - **1 in 7** residents felt their doctors or health professionals sometimes or never explained things in a way that was easy to understand
 - **3 in 20** felt their doctors or health professionals sometimes or never listened carefully to them during the consult
 - **1 in 10** felt their doctors or health professionals sometimes or never showed respect for what they had to say



What is Healthy Literacy ?

DC Health is dedicated to leading and engaging District partners in achieving health equity through collaborative practice change, including reducing health disparities by advancing health literacy.

Through this work, we can help to increase DC residents' ability to:

- discover
- comprehend
- use information and services to make informed health decisions.



Personal health literacy is an individual's ability to find, understand, and use health information and services to make health-related decisions about one's own health



Organizational health literacy is how well organizations help people find, understand, and use information and services to make health-related decision and actions for themselves and others



Professional health literacy is how well health professionals and other workers can communicate and help people understand health related information and access the services they need

Why is health literacy important?



Greater Health and wellness for all

- Improving health literacy can reduce medical errors, increase use of preventive care, assist in patients' chronic condition management, and improve morbidity and mortality rates



Improved health equity

- Limited health literacy can worsen health disparities related to race, age, income, and education, among other factors. Addressing health literacy can improve outcomes for marginalized populations



Reduced costs and better care

- Limited health literacy can result in increased emergency department and overall hospital use, costing the U.S economy up to \$349 billion annually. Enhancing health literacy can improve people's care and reduce costs.

Strategic Planning Recap: Health Literacy

Key Challenges:

- District residents report lack of awareness of available social needs resources or face program capacity issues when seeking help
- Clinical providers report lack of clear referral pathways and visibility into whether patients receive needed community-based services.

Through systems-level strategies, we will work to advance individual and organizational healthy literacy:

- Promote an environment where every resident knows where to turn for heart health support and resources
- Support every provider so that they have the tools to connect residents to heart health resources

GO GO DC CAMPAIGN

Go Go DC



Go Go DC: Bus Ads



★ GO ★ GO ★
ON A WALK
LIVINGWELL.DC.GOV

LET'S GET HEALTHY DC

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR



★ GO ★ GO ★
EAT HEALTHY
LIVINGWELL.DC.GOV

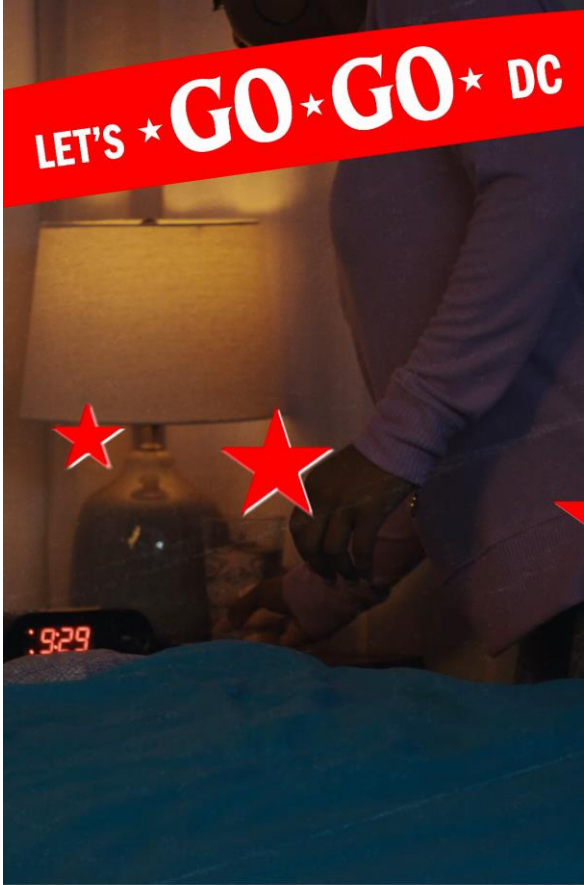
LET'S GET HEALTHY DC

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR

Go Go DC: Live Boards & Radio



★ GO ★ GO ★
LIVINGWELL.DC.GOV



★ GO ★ GO ★
LIVINGWELL.DC.GOV



Go Go DC: Social Media

FOR FEBRUARY'S HEART HEALTH MONTH

★ GO ★ GO ★

GET HEART

HEALTHY

LIVINGWELL.DC.GOV

LET'S GET HEALTHY DC

DC HEALTH GOVERNMENT OF THE DISTRICT OF COLUMBIA
GOVERNMENT OF THE DISTRICT OF COLUMBIA **DC MURIEL BOWSER, MAYOR**

Let's hear from you! (Poll Everywhere)



Join by Text

Send **hmapoll360** and your message to **22333**

OR

Join by Web

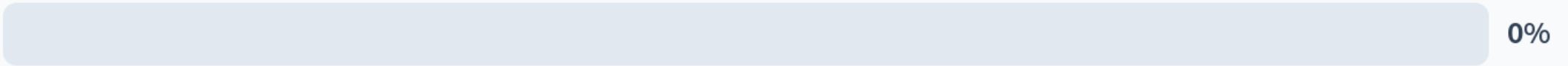
Join by QR code

Scan with your camera app

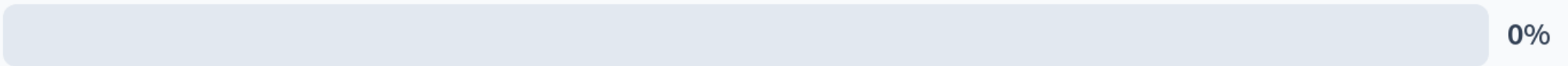


Have you seen our commercial advertisement?

Yes

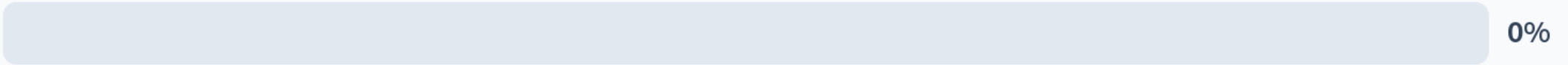


No

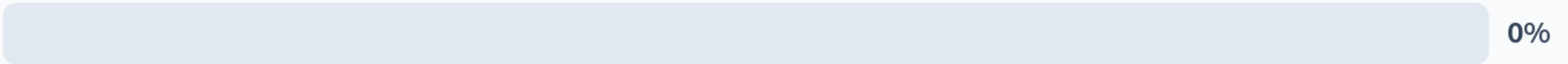


Was the message of the advertisement clear to you?

Yes



No

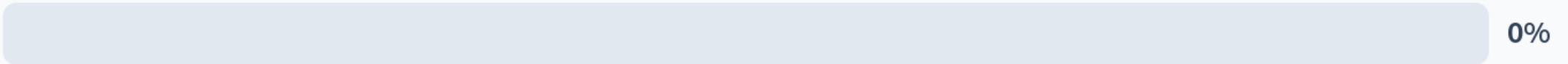


Were the visual ads memorable?

Yes

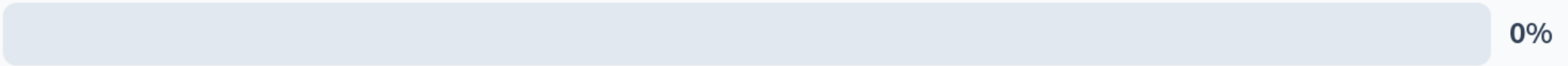


No

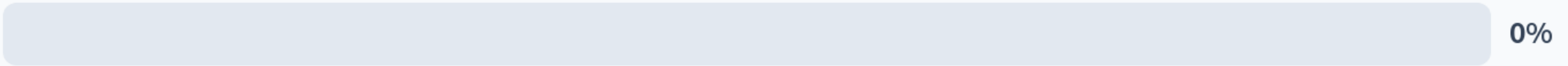


After seeing/hearing the advertisements, are you more likely to visit livingwell.dc.gov?

Yes

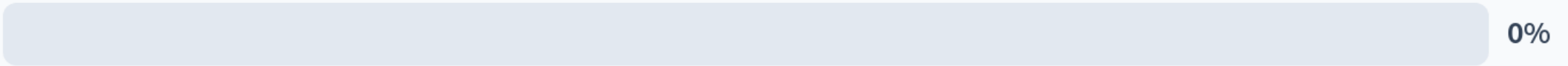


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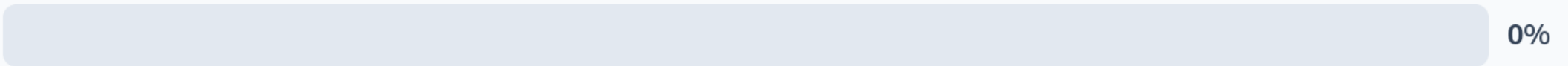


Do you think these advertisements were aimed at the right target audience?

Yes

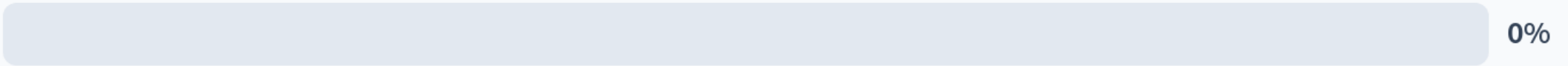


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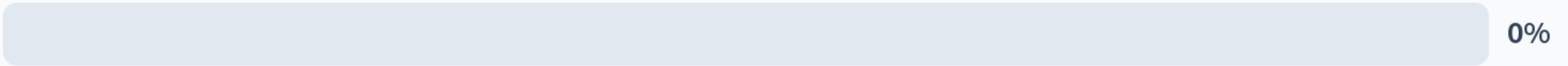


Do these initiatives promote health literacy?

Yes



No



Let's hear from you? Group Discussion

- What do you remember most about the advertisements you saw or heard?
- What advertisement or part of the ads stood out to you the most? Why?
- What do you think the ads were trying to communicate?
- Where else should these ads be located to reach more people?
- What else could be done to promote heart health awareness and calls to action for residents and partners?

LIVING WELL WEBSITE

OVERVIEW

Purpose: to advance individual and organizational health literacy

LIVING
WELL DC

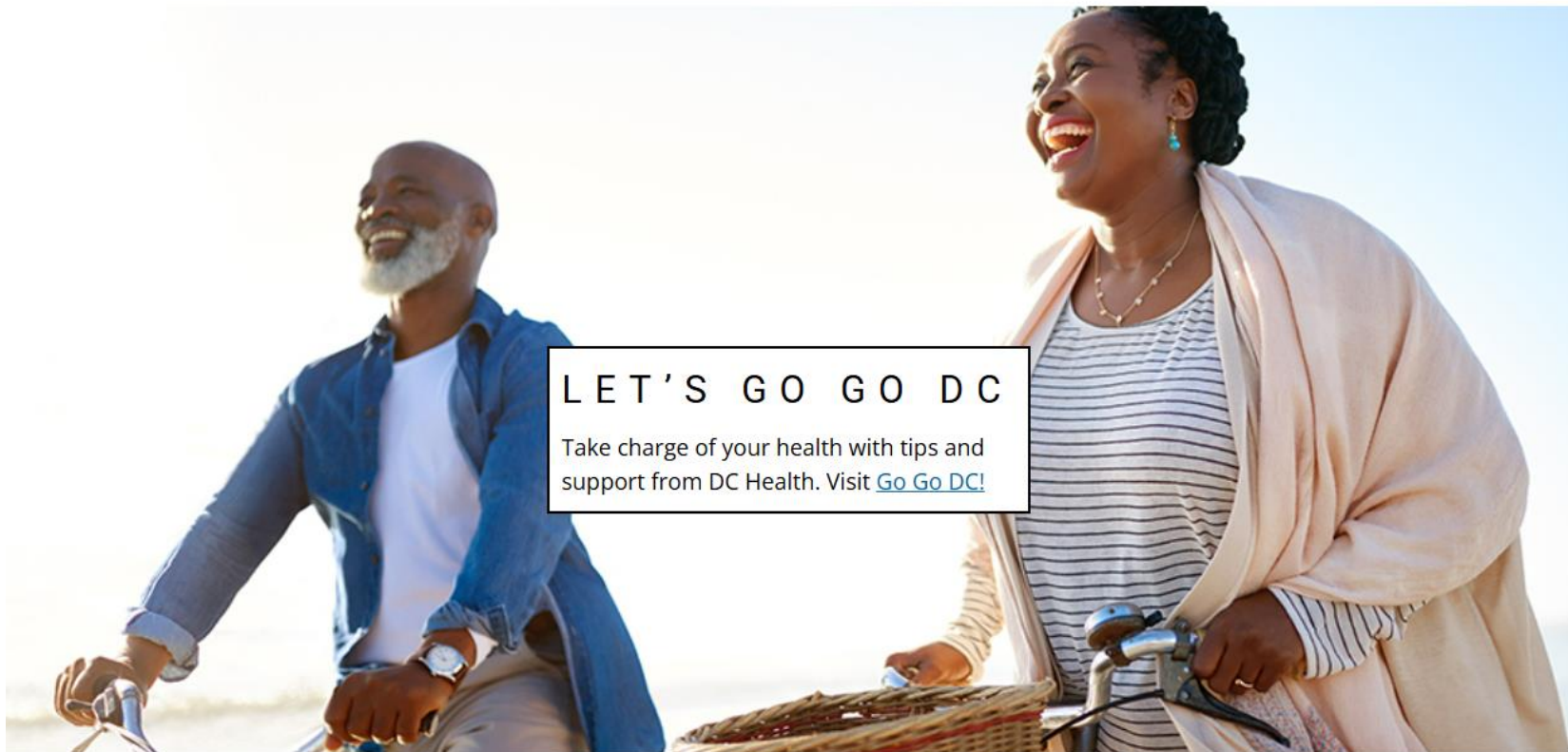
ADVANCING HEALTH LITERACY PROJECT

RESIDENTS

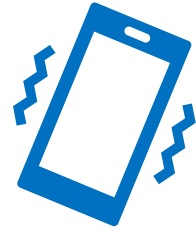
COMMUNITY ORGS

HEALTHCARE ORGS

HEALTH JOURNAL



Let's hear from you! (Poll Everywhere)



Join by Text

Send **hmapoll360** and your message to **22333**

OR

Join by Web

Join by QR code

Scan with your camera app

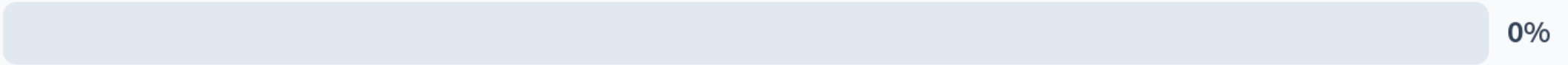


Let's hear from you! (Poll Everywhere)

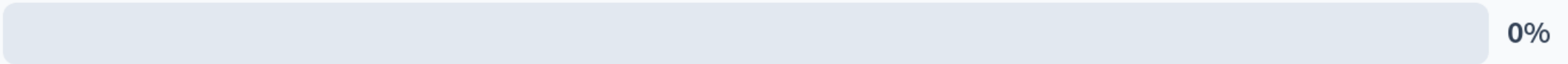
- Have you used the website to find local health services? (Y/N)
- Do you feel the website represents your health concerns and the needs of those in your community? (Y/N)
- Is the information on the website helpful and up-to-date? (Y/N)
- Are the resources, trainings, and webinars listed on the website helpful and comprehensive? (Y/N)
- Would your organization be interested in contributing content (i.e., success stories, highlights, organizational updates) and publishing on the website? (Y/N)

Have you used the website to find local health services?

Yes

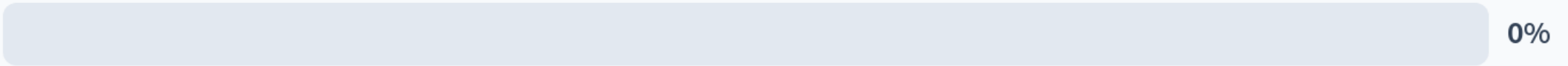


No

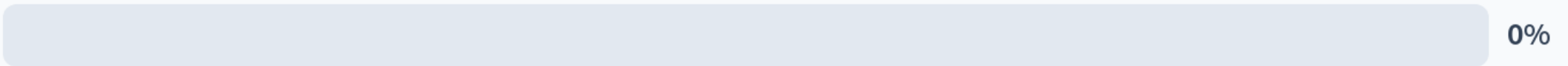


Is the information on the website helpful and up-to-date?

Yes

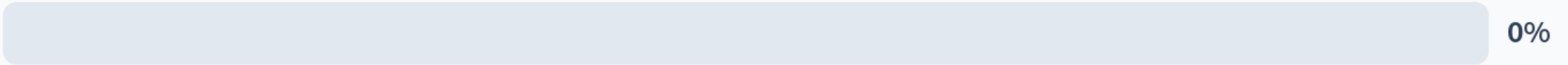


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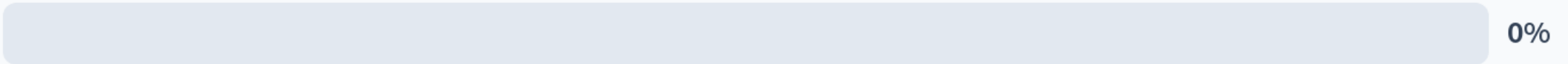


Are the resources, trainings, and webinars listed on the website helpful and comprehensive?

Yes

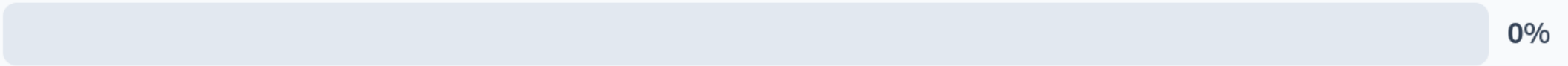


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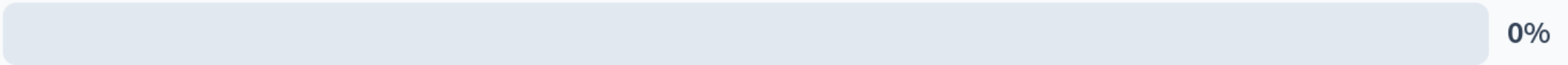


Would your organization be interested in contributing content (i.e., success stories, highlights, organizational updates) and publishing on the website?

Yes



No



Let's hear from you! Group Discussion

- What health topics or resources do you wish were easier to find?
- How can we support local health services and programs?
- What features would you like to be included on the website?
- What additional educational materials or tools would help you connect to the services on the website?
- How did you hear about the website?

Let's hear from you! Group Discussion

- When combining information from the Health Knowledge and Go Go DC tabs, which new title below are you more likely to use?
 - Healthy Living
 - Health Resources
 - Healthy Habits
 - Other (please describe)

RESIDENTS

Health Knowledge

Go Go DC

District Services

Diseases and Conditions

Health Journal

Event Calendar

Tobacco Mass Media Campaign

Antonio Brown Jr., MPH

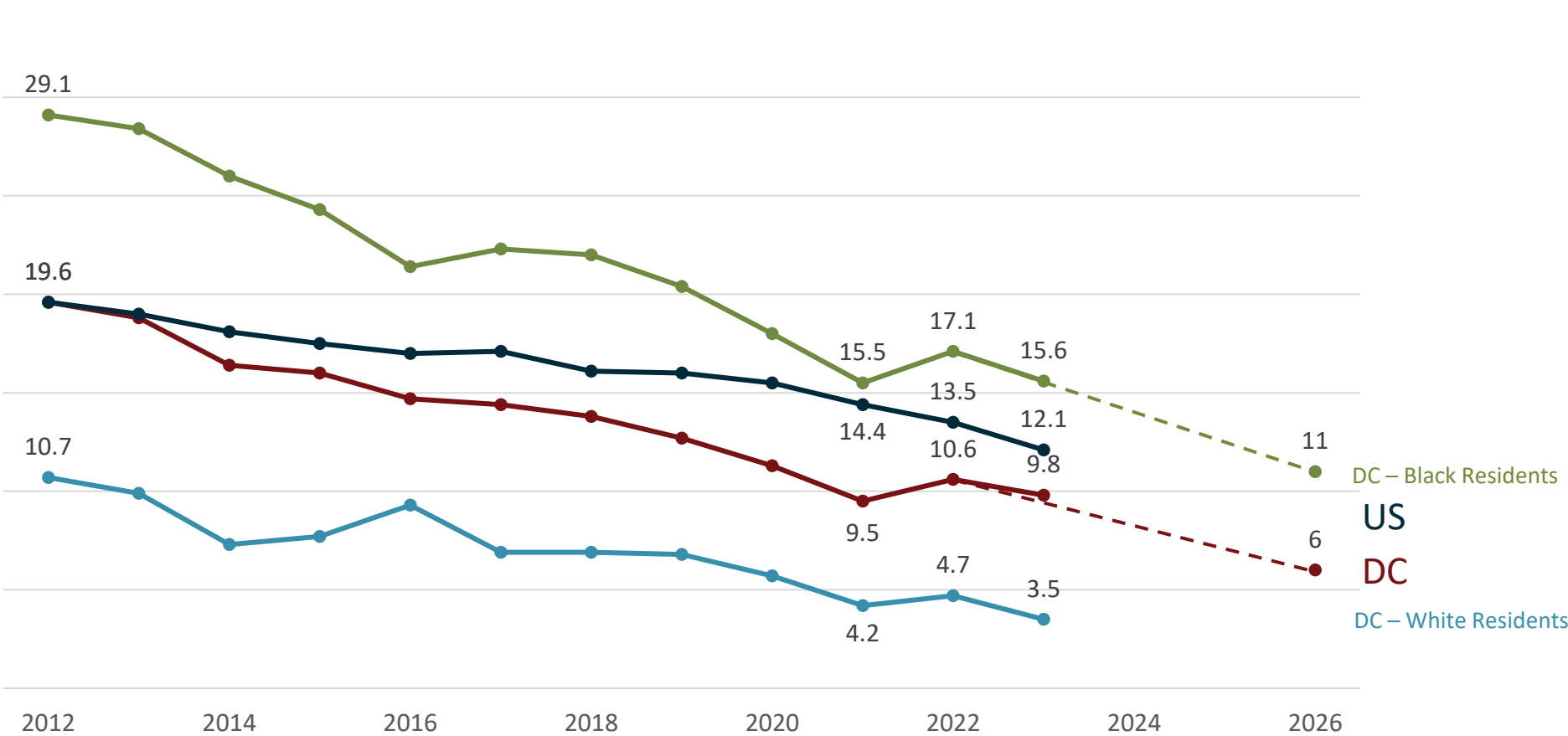
OVERVIEW

- ▶ Smoking Trend Data
- ▶ DCQuitNow Background Info
- ▶ Hope From a Former DC Smoker Campaign
- ▶ How To Integrate Into The Work You Do

SMOKING TREND DATA

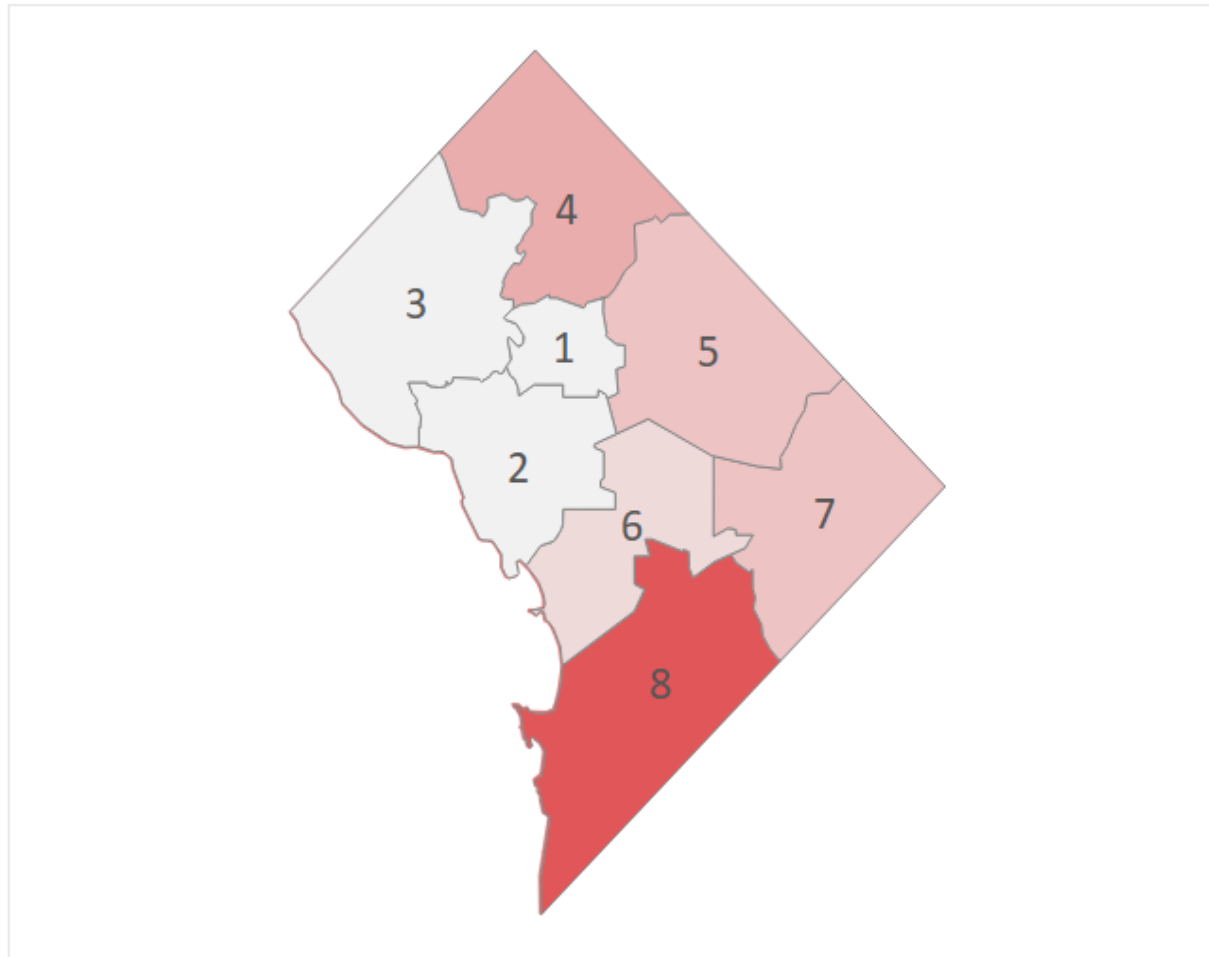
Data & Demographics

SMOKING PREVALENCE TRENDS IN DC - ADULTS



SMOKER DEMOGRAPHICS

Smoked 100 Cigarettes in Lifetime by Ward



Map Filter
Click or ctrl+click (multi)
the map shapes

Ward 1	20.9%
Ward 2	21.1%
Ward 3	22.7%
Ward 4	29.9%
Ward 5	27.9%
Ward 6	24.8%
Ward 7	27.9%
Ward 8	44.7%

DCQuitNow Cessation Services

DCQUITNOW SERVICES



Personalized Coach Support

Find a coach who will help you create a Quit Plan and offer guidance at every step. Connect via Text A CoachSM, chat, or call 1-866-784-8454 toll free.



Lessons on Living Tobacco Free

Understand how to stay motivated, beat urges, and use medications to enjoy life free from tobacco.



Nicotine Replacement Therapy (NRT)

Get gum or patches—based on eligibility—at no additional cost to help curb cravings and double your chance of quitting for good.



One Stop for Online Resources

Get daily advice on how to manage triggers, track progress you've made, and connect with others who are trying to quit—all in one place.

DCQUITNOW SERVICES



Long-Term Success

Rest assured your Quit Plan is designed to help you make changes that last, with ongoing coach support throughout the program and beyond.



Access Anywhere, Anytime

Use the mobile app to set your quit date, read tips to beat cravings, and message your coach for 24/7 support from wherever you are.



Text Message Support

Customized, interactive text messaging to help guide you along your quit journey.

*People who use tobacco that utilize DCQuitNow services are **60% more likely to quit successfully** compared to those who attempt to quit without help.*

CESSATION PROGRAMS: DCQuitNow

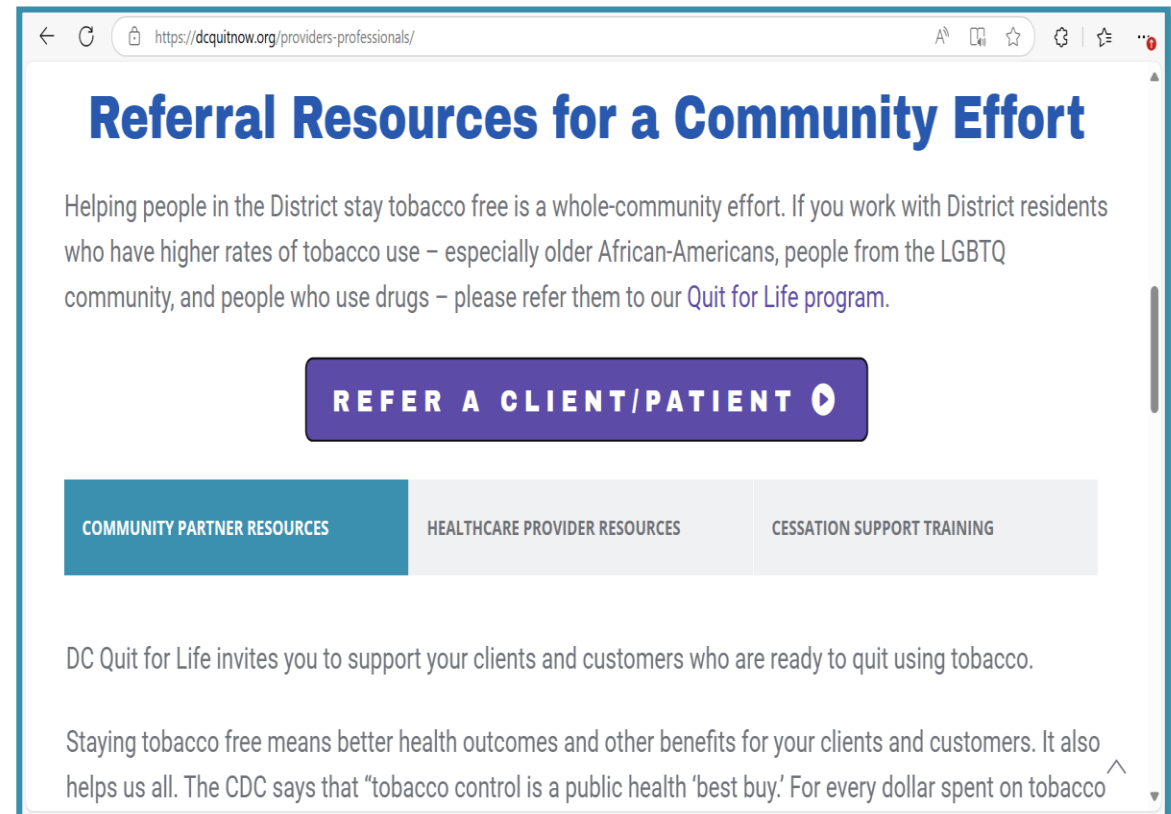
Services Offered

- **Individualized Coaching:** coaching 1:1 or with a group over the phone, online, or by text for tailored support; available 24/7
 - **Behavioral Health Track:** Extended support for those living with depression, anxiety, and other behavioral health conditions
 - **Pregnancy & Postpartum Track:** Specialized support to help people planning to get pregnant or expecting or those who recently gave birth
- **Nicotine replacement therapy (NRT):** Up to 12 weeks NRT medication available at no cost
- **Online Support:** Access online tips, tricks, and tools to handle triggers
- **Personalized Quit Plans:** Determine your path to cessation

DC QUIT NOW

Cessation Services

1-800-QUIT-NOW
dcquitnow.org



← ↻ <https://dcquitnow.org/providers-professionals/> A 📄 ☆ ⚙️ ⌵ ⌵ ⌵

Referral Resources for a Community Effort

Helping people in the District stay tobacco free is a whole-community effort. If you work with District residents who have higher rates of tobacco use – especially older African-Americans, people from the LGBTQ community, and people who use drugs – please refer them to our [Quit for Life program](#).

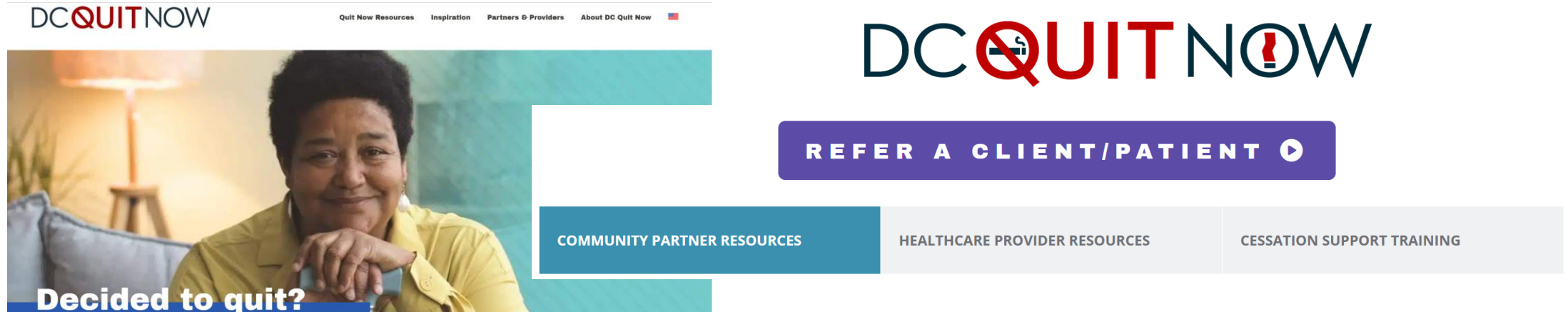
REFER A CLIENT/PATIENT ▶

COMMUNITY PARTNER RESOURCES HEALTHCARE PROVIDER RESOURCES CESSATION SUPPORT TRAINING

DC Quit for Life invites you to support your clients and customers who are ready to quit using tobacco.

Staying tobacco free means better health outcomes and other benefits for your clients and customers. It also helps us all. The CDC says that “tobacco control is a public health ‘best buy.’ For every dollar spent on tobacco” ^

DCQUITNOW & HOPE CAMPAIGN WEBSITE



The screenshot shows the top section of the DCQUITNOW website. On the left is the DCQUITNOW logo. To its right is a navigation menu with links for "Quit Now Resources", "Inspiration", "Partners & Providers", and "About DC Quit Now". Below the navigation is a large hero image of a woman in a yellow shirt with her hands clasped. Overlaid on the right side of the hero image are three buttons: a teal "COMMUNITY PARTNER RESOURCES" button, a purple "REFER A CLIENT/PATIENT" button with a play icon, and a grey "CESSATION SUPPORT TRAINING" button. At the bottom left of the hero image, the text "Decided to quit?" is displayed in white on a blue background.



Manage the Stress of Quitting



Medications to Help Curb the Urge

HOPE FROM A FORMER DC SMOKER

DCQuitNow Health Communications Campaign

GOALS AND OBJECTIVES

Program Goal

- Reduce rates of combustible tobacco use by DC adult residents

Campaign Goal

- Increase use of DC Health's tobacco cessation resources and quit services

Communication Objectives

- Increase awareness of DC Health's tobacco cessation resources
- Increase calls to DC Quitline
- Increase visits to DCQuitNow.org
- Increase enrollment in tobacco cessation programs
- Increase use of cessation medication

FORMATIVE RESEARCH

- Environmental Scan
- 10 Focus Groups
- 1500 Respondent Survey
- Ad Testing

KEY INSIGHTS

Most smokers want to quit

- 4 in 5 current users have tried to quit, and 4 and 5 current users would like to quit.
- Most current smokers are ready to quit.

Barriers to quitting are significant

- Stress is the biggest barrier to quitting. DC smokers have challenging circumstances (e.g., low SES, divorce)

CDC Tips campaign's negative frame is recognized as effective, and it appealed to DC residents

- Tips has a lot of research behind it.
- Focus group participants found the Tips ad compelling. Survey participants found health consequence messaging compelling.

KEY INSIGHTS

Tips lacks local resources

- To augment CDC Tips, DC Health should provide local resources in an attractive and accessible way.

DC campaign should inspire and encourage DC residents to succeed in staying off tobacco

- To leverage Tips' negative messaging, DC campaign can inspire people to successfully stay tobacco free with stories of real people successfully quitting and reframing "failed quit attempts" as "practice attempts."

REAL STORIES FROM REAL SMOKERS

HOPE
FROM A DC
EX-SMOKER

**"I'm proud of myself.
My daughter is even more proud of me."**
— Keisha G., Kingman Park

DC's personalized and **free** program can help you quit for good.

- Coaches
- Medications
- Daily support

See Keisha's story, and find out what's right for you. 

DCQUITNOW.org
1-800-QUIT-NOW

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MAYOR MURIEL BOWSER



REAL STORIES FROM REAL SMOKERS



HOPE
FROM A DC
EX-SMOKER

**"Quitting is not easy.
But it is possible."**
— Jeff S., Kingman Park

DC's personalized, free program gives you a 60% better chance at quitting for good.

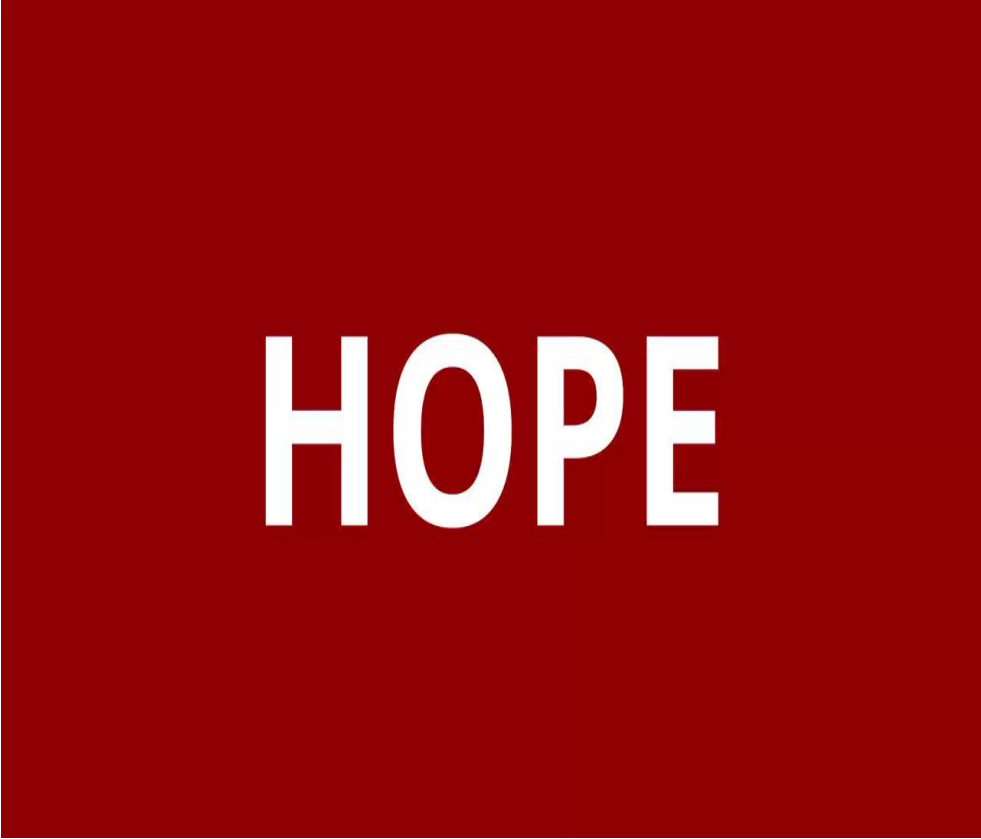
- Coaches
- Medications
- Daily support

See Jeff's story, and find out what's right for you.

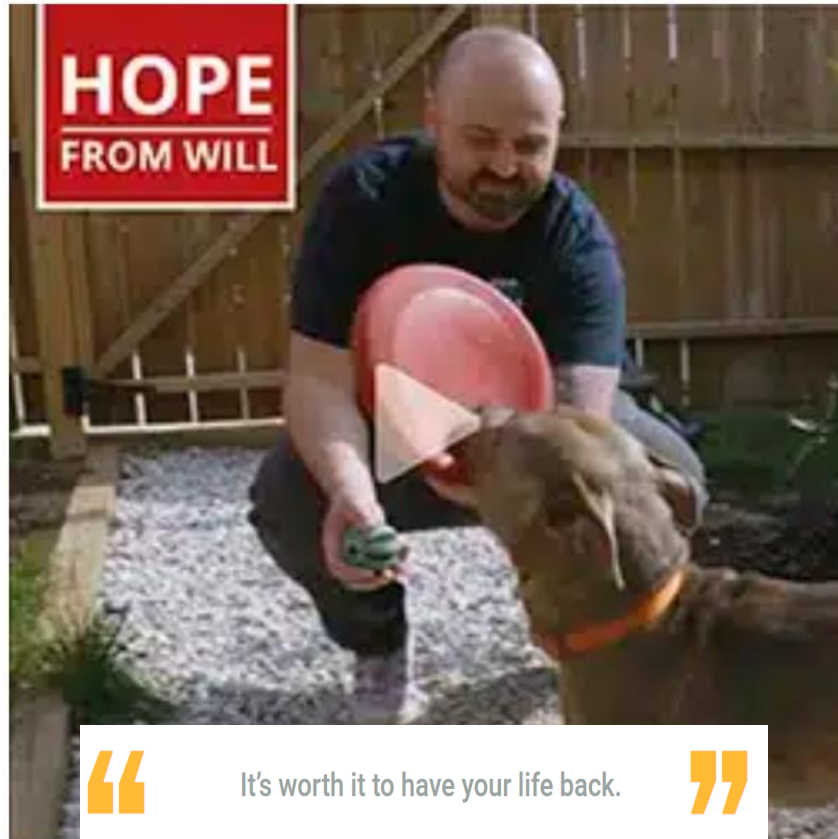


DCQUITNOW.org
1-800-QUIT-NOW

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA
MUSSEL BOWSER, MAYOR



DCQUITNOW CAMPAIGN: WEBSITE



HOW CAN YOU HELP?

- 1. Partner Meetings:** Invite us to partner meetings to present on the campaign
- 2. Campaign Toolkit:** Share the campaign toolkit (coming soon!) with partners
- 3. Socials:** Follow us on [Instagram](#), [X](#), and [Facebook](#) and share any relevant content



INSTAGRAM AND FACEBOOK POST

Quitting smoking is hard, but it can be easier with support! @DCQuitNow is a new program that offers FREE resources to help you quit smoking!

- 📞 A toll-free helpline for support and guidance
 - 💬 Daily support and encouragement texts
 - 📱 A free app with tips, inspiration, and challenges
 - 🌟 Personalized coaching for your quitting journey
 - 🚫 FREE nicotine replacement therapy options
- Follow @DCQuitNow and visit DCQuitNow.org to access these resources. #QuitSmoking #SmokeFree #StopSmoking #BreakingHabits

X Post

Attention DC residents! Ready to kick your smoking habit? DC Quit Now offers free resources, personalized support, and tools to help you stay tobacco-free. Visit DCQuitNow.org or call 1-800-QUIT-NOW to start your quit journey.

OTHER WAYS TO HELP

- Quit kits upon request for patients who are trying to quit/referred to DCQN or other services/treatment
- Highlight the provider trainings & other resources on the website
- We can provide palm cards to promote DCQN
- Ask what other resources would be helpful?

CAMPAIGN ROLL OUT

- Social media pre-campaign ads launched
 - Facebook, Instagram, X
- New website: dcquitnow.org
- Next steps
 - Campaign toolkit
 - Press release
 - Bus wraps & bus shelter ads
 - Radio
 - Community newspapers
 - Digital advertising / social boosting

The slide features a white background with two vertical dark teal lines on either side of the central text. The bottom of the slide is decorated with overlapping geometric shapes: a large red triangle on the left, a grey triangle on the right, and a dark red triangle at the bottom center.

QUESTIONS/COMMENTS



Next Steps

1:30 pm – 2:00 pm

Next Steps for Strategic Plan

This Plan serves as a roadmap to improving heart health in the District. Over the coming months, DC Health will:

- Release a quarterly progress dashboard to report on key metrics.
- Conduct ongoing resident and provider listening sessions to refine and improve strategies.
- Develop an annual action plan for the learning collaborative, identifying key partner leads.

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

Quick Evaluation Poll

Thank you for joining us!

Please scan the QR code to complete a brief evaluation for today's session.



https://healthmanagement.qualtrics.com/jfe/form/SV_9N7kr82dbKFHaU6

Thank you for your participation today!


THANK YOU!


DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA


2201 Shannon Place SE, Washington, DC 20020

 dchealth.dc.gov

 [@_DCHealth](https://twitter.com/_DCHealth)

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 [dchealth](https://www.tiktok.com/@dchealth)

 [DCHealth](https://www.youtube.com/DCHealth)