

HEART DISEASE AND STROKE PREVENTION & INNOVATIVE HEART HEALTH LEARNING COLLABORATIVES

JULY 2025

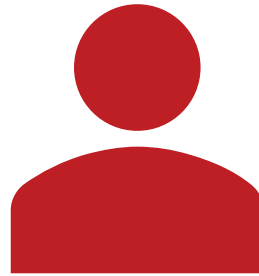
Agenda

- 1. Welcome, Program Updates**
- 2. Grantee Snapshot Report: Overview and Feedback**
- 3. Framing the Topic in Data: Defining a High-Risk Cohort through the Men's Health Initiative**
- 4. Selecting a High-Risk Cohort: Best Practices**
- 5. DCPCA: Tools for Identifying a High-Risk Cohort**
- 6. Q & A and Next Steps**

Welcome!



Come on Video



Introduce Yourself in the Chat

Name, Title,
Organization/Affiliation



What U.S. State are you most interested in visiting, and why?

Program Updates

Bonny Nunez, MPH, Public Health Analyst, DC Health

Heart Disease and Stroke Prevention Learning Collaborative: 2025-2026

Learning Collaborative Structure



Quarterly Cycles:

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



Capacity Building Calls:

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



Workplan Report-Out:

- 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

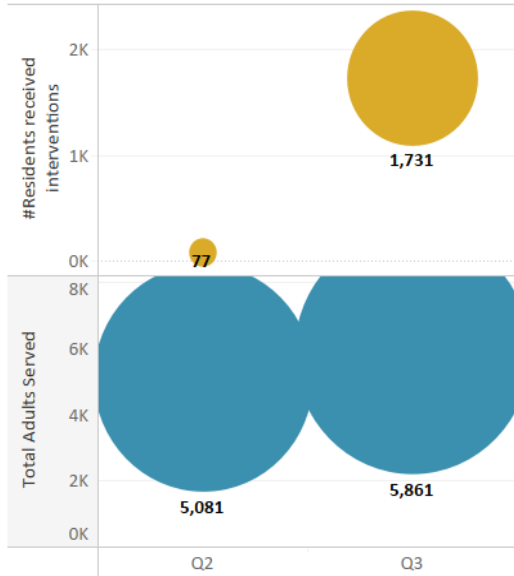
Grantee Snapshot Report: Overview and Feedback

Saumya Rajamohan, Data Analyst, DC Health

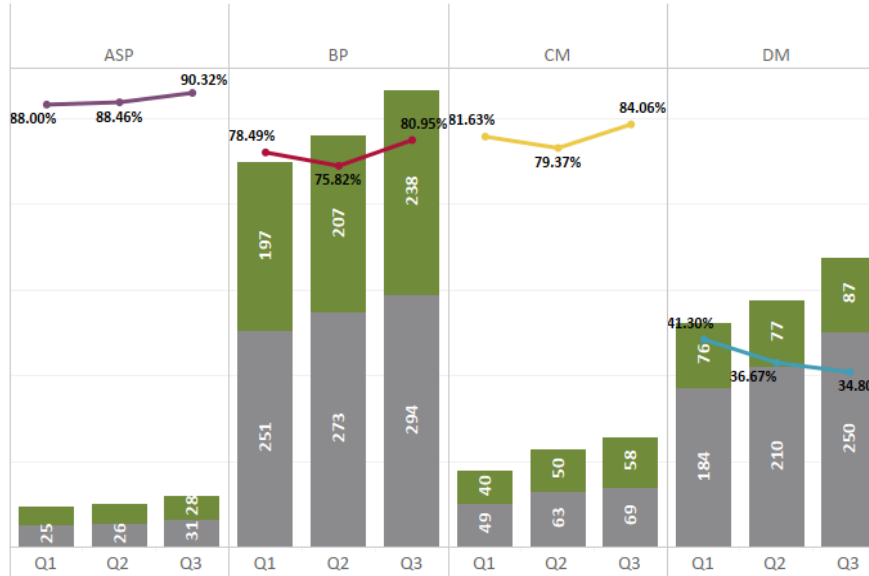
Quarterly Snapshot Report

[Grantee Name] Quarterly Snapshot Report (GY2024-2025, Q2)

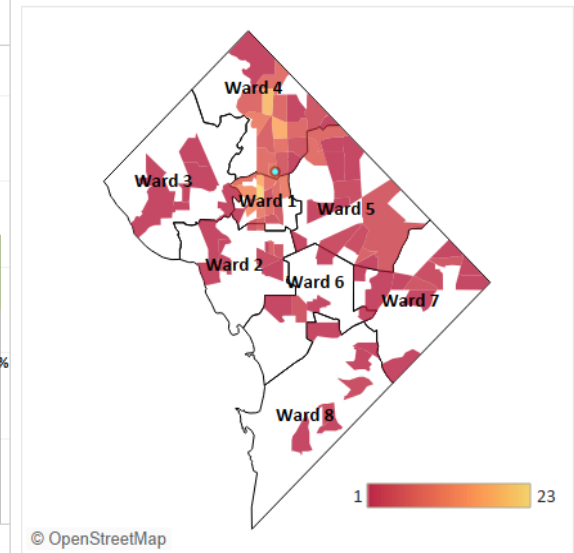
Adults served by clinics or health care systems



Control Rate at Last medical visit of GY2024-2025 Year Range



Control Rate at Last medical visit of GY2024-2025 (Q2), by Census Tract



Patients engaged in Heart Disease and Stroke interventions per workplan

A	16
Q2 B	60
C	1
D	767
E	747
Q3 F	153
G	64

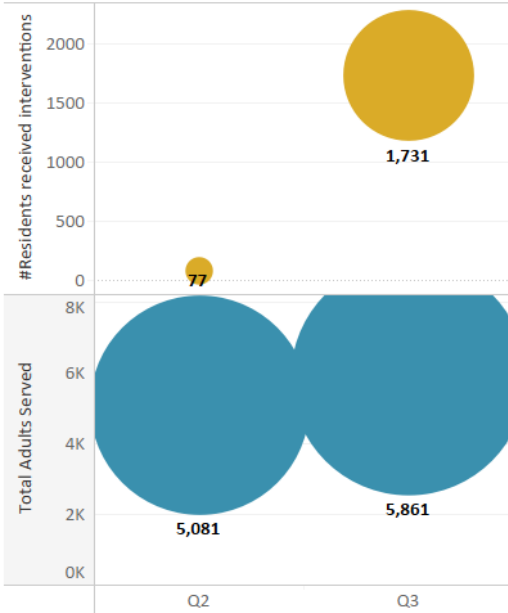
Notable updates

Q2	X cohort to pilot ABC initiative.
Q3	Support X high-risk hypertensive patients through ABC initiative

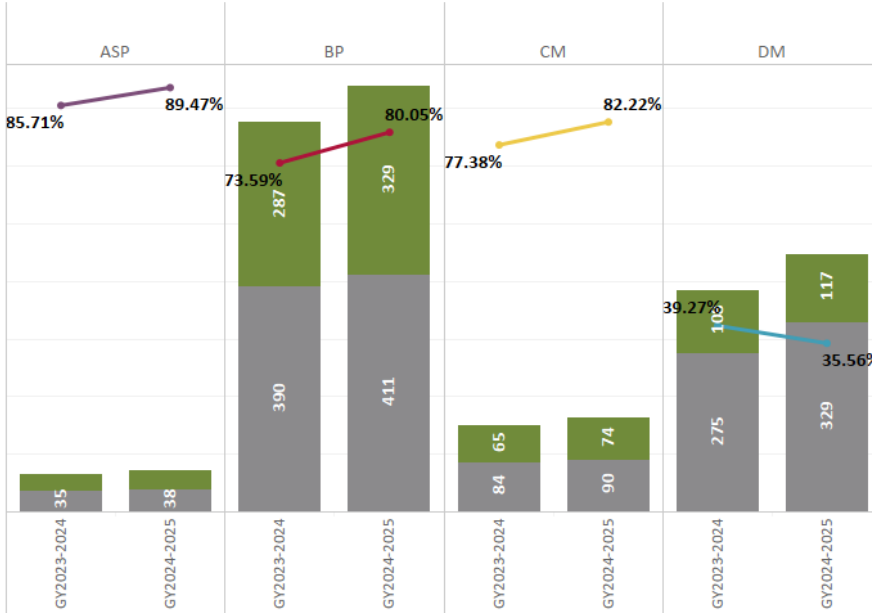
Annual Snapshot Report

[Grantee Name] Annual Snapshot Report (GY2024-2025)

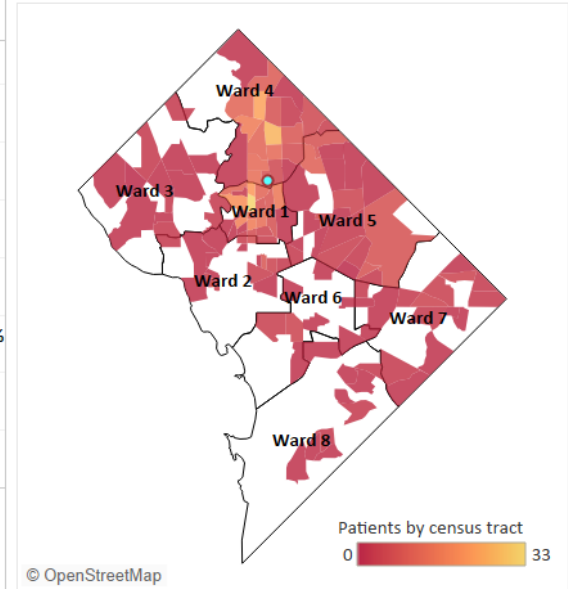
Adults served by clinics or health care systems



Control Rate at Last medical visit of All Year Range



Control Rate at Last medical visit of GY2024-2025 Year Range, by Census Tract



Patients engaged in Heart Disease and Stroke interventions per workplan

Workplan Item	Q2	Q3
A	16	767
B	60	747
C	1	153
D	16	64
E		
F		
G		

Notable updates

- Q2 X cohort to pilot ABC initiative.
- Q3 Support X high-risk hypertensive patients through ABC initiative

Framing the Topic in Data: Defining a High-Risk Cohort through the Men's Health Initiative

Bonny Nunez, MPH, Public Health Analyst, DC Health

Sharmilla Chatterjee, DC Health

Agenda

▶ Data Review

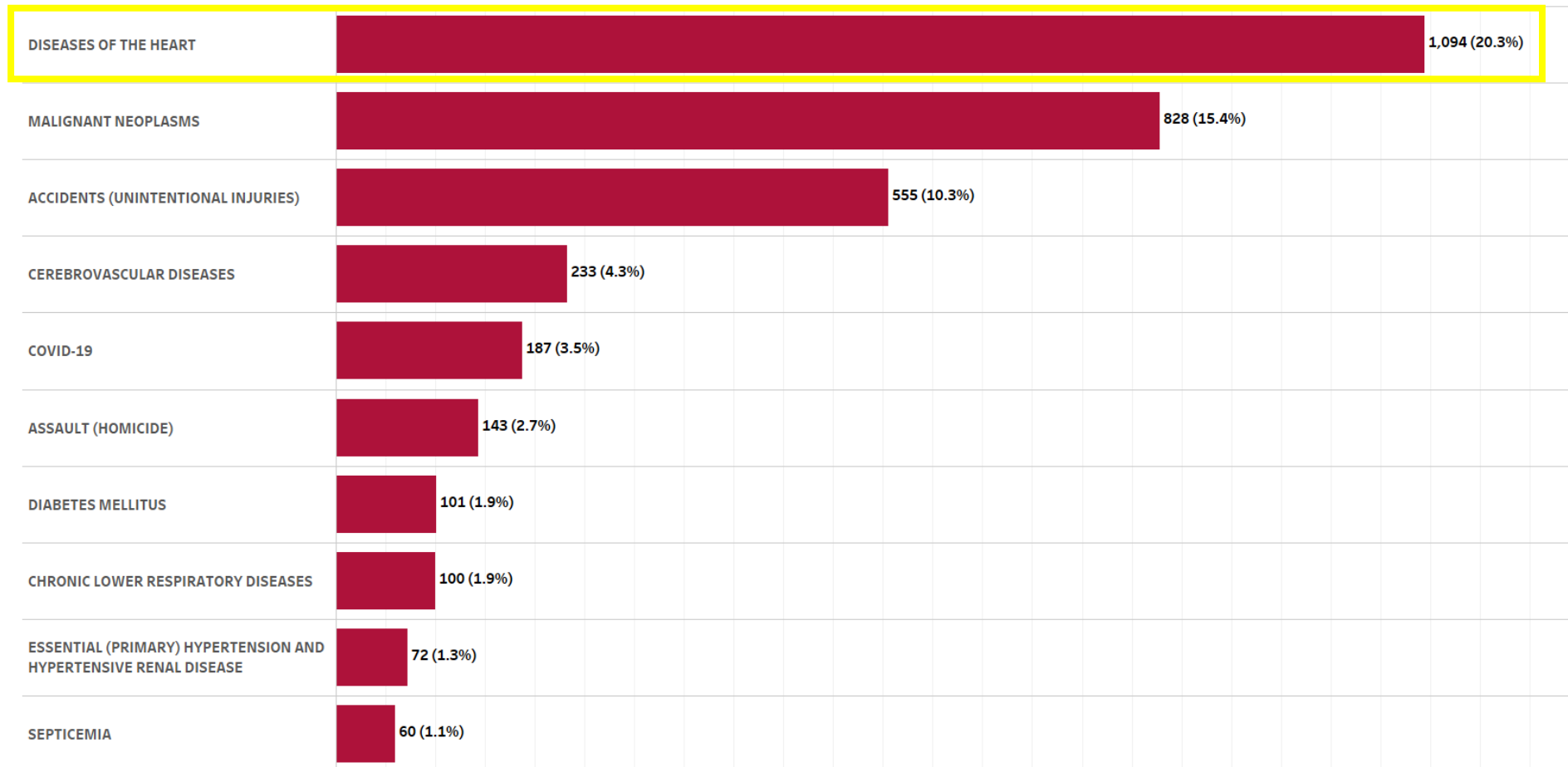
- Defining the problem and priority population

▶ Project Overview and Year 1 Targets

- Community Outreach
- Enhanced Clinical Care
- Payment Model

Heart Disease is the Leading Cause of Death in DC

Percent of all Deaths Among District Residents, 2022



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.

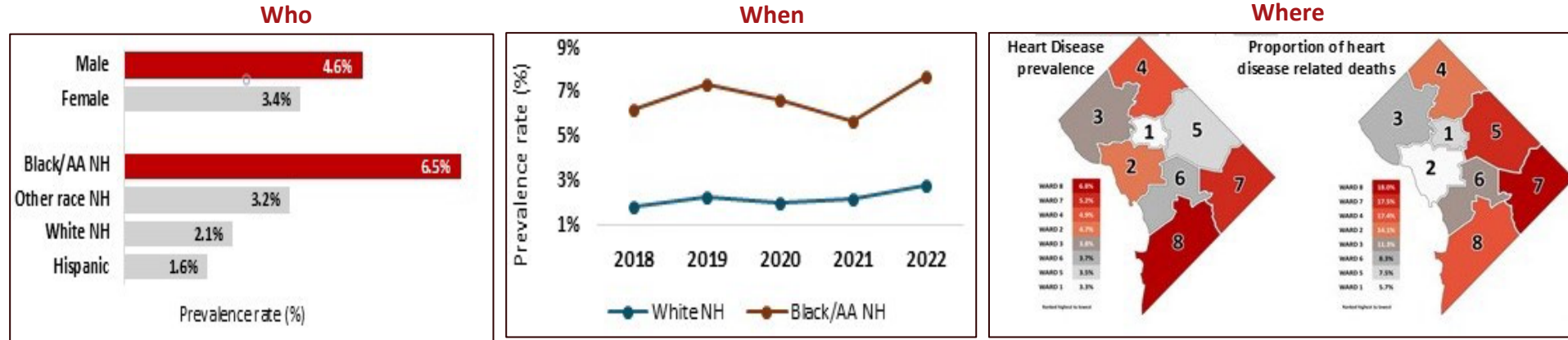
¹ ICD-10 codes for causes-113 List.

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.

Demographic and behavioral profiling to guide heart disease prevention efforts

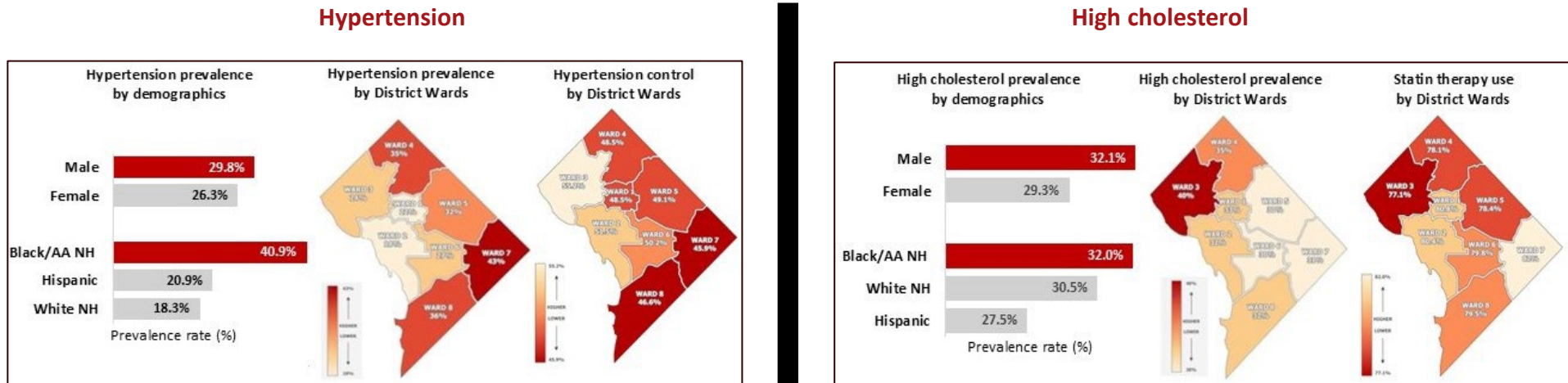
Step 1
Heart Disease in context: Who, When, and Where



Data Source: (1) DC BRFSS 2018 to 2021; (2) 2018-2022 VRD Mortality Data, Data Management and Analysis Division, CPPE, DC Health.

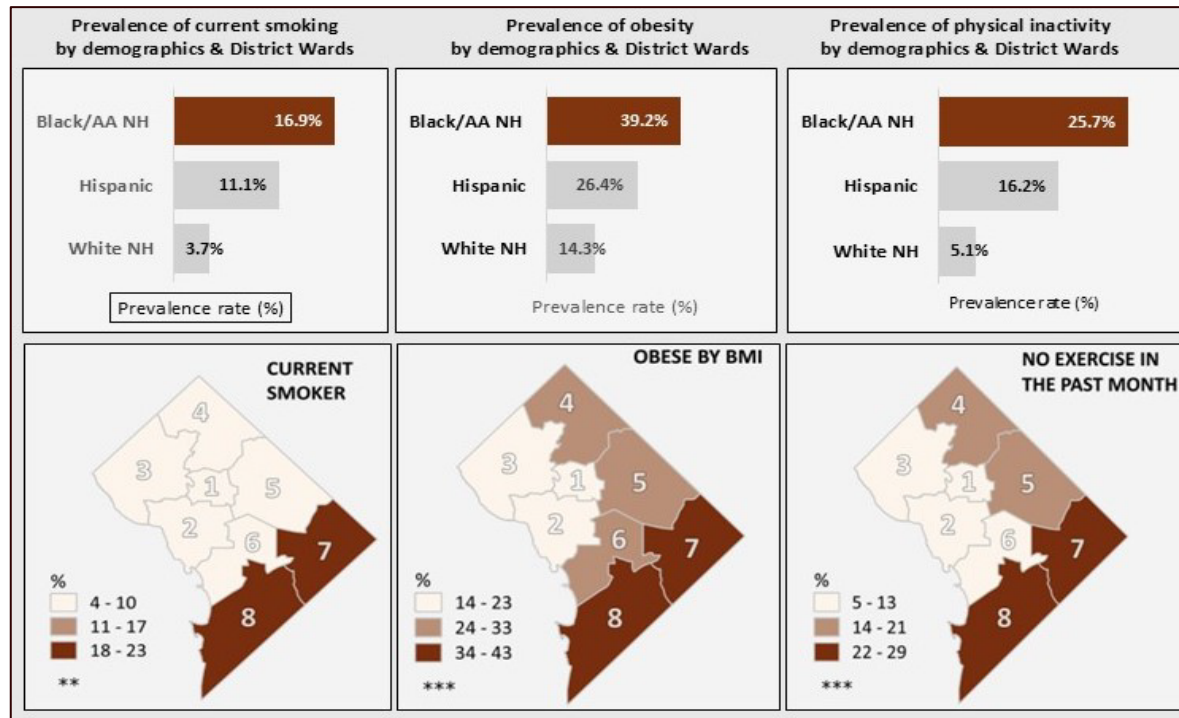
Selection 1: Black/AA residents in Wards 7 & 8 in the District

Step 2a
Heart Disease: Profiling clinical risk factors



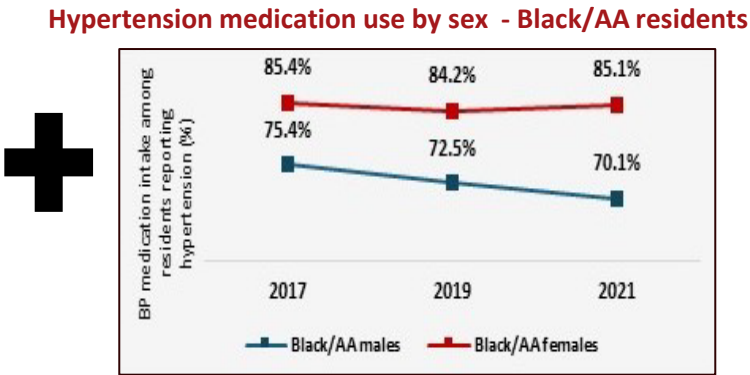
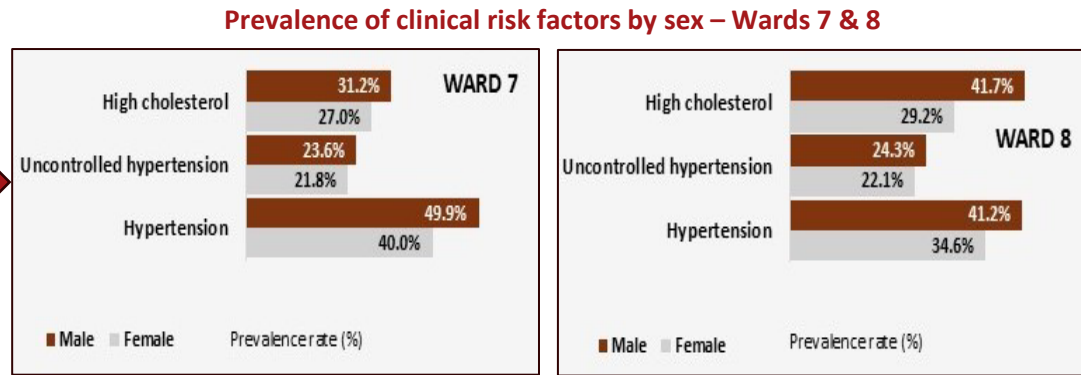
Data Source: (1) DC BRFSS 2021; (2) DC Heart Disease & Stroke report, 2022

Step 2b
Heart Disease:
Profiling
behavioral risk
factors



Selection 2: Male Black/AA residents in Wards 7 & 8 in the District

Step 3
Sex based
differences in
clinical risk
factors for heart
disease



Selection 3: Male Black/AA residents in Wards 7 & 8 in the District

Data source: DC BRFSS 2017 to 2022

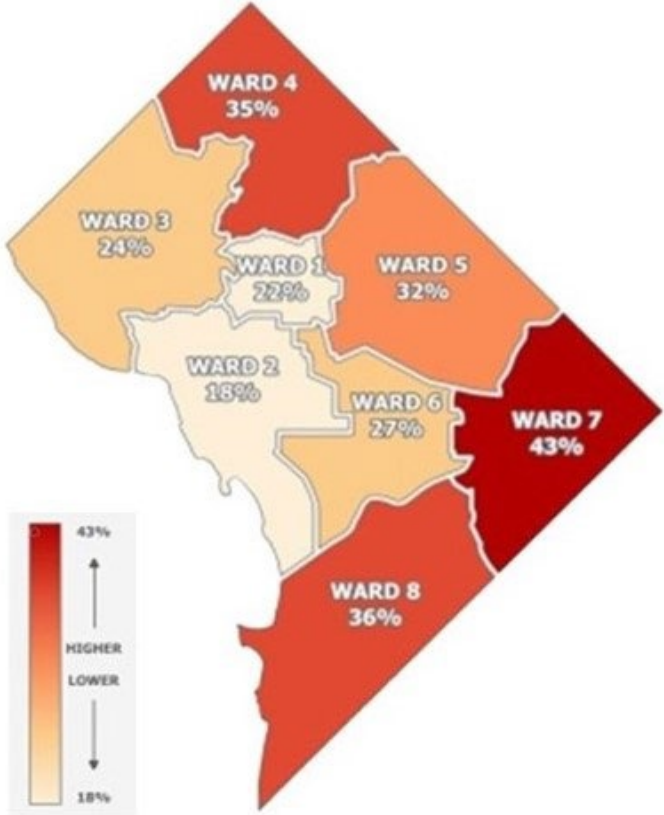
Impact of Heart Disease on Black Men in Wards 7 and 8 in the District

	Ward 7	Ward 8
Median age of those with heart disease	66 years	55 years
Overall rates		
Heart Disease in Ward	4%	9%
% of early deaths from heart disease in Ward	61%	70%
High blood pressure in Ward	50%	41%
Persistent uncontrolled high blood pressure in Ward	24%	24%
High cholesterol in Ward	31%	42%

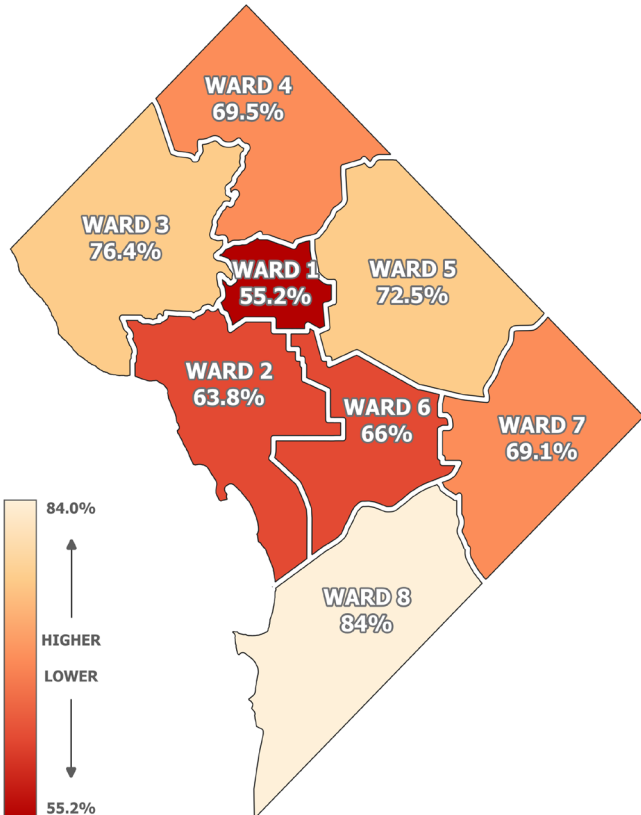
Data Source: (1) DC BRFSS 2018 to 2022 Analyzed by Chronic Disease Division, CHA, DC Health; (2) 2018-2022 VRD Mortality Data, Data Management and Analysis Division; CPPE, DC Health; (3) U.S. Census Bureau (2022). American Community Survey 1-year estimates.

Risk factor Prevalence Profile – By District Wards

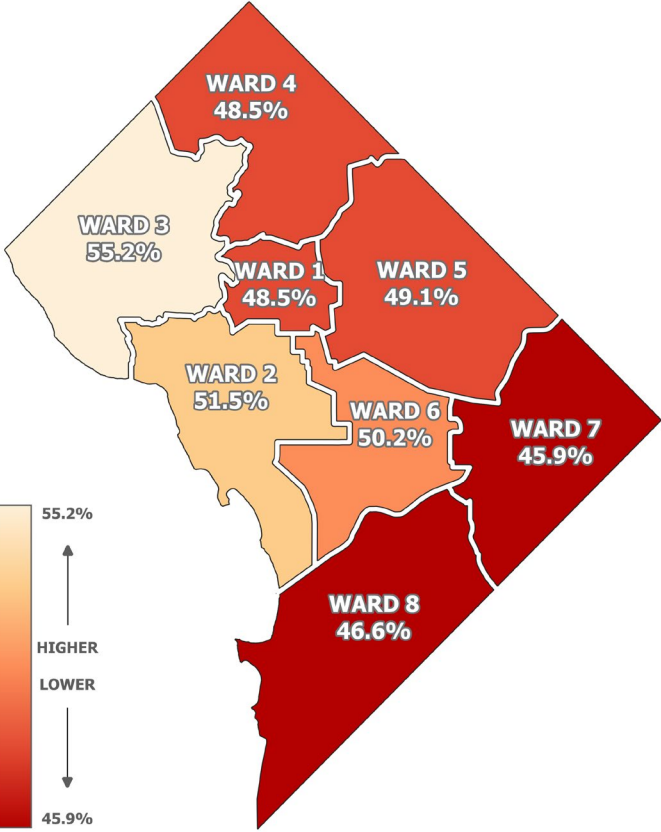
Hypertension prevalence



Hypertension medication use

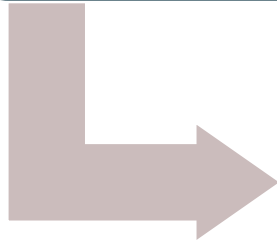


Hypertension control



Conclusions from the Data

Early deaths from heart disease and lower life expectancy among Black men in Wards 7 and 8



High rates of heart disease and hypertension among Black men in Wards 7 and 8



Persistent uncontrolled hypertension among Black men in Wards 7 and 8



Gap between self-reported medication adherence and hypertension control

Selecting a High-Risk Cohort: Best Practices

Jodi Pekkala, HMA

The What and Why: High-Risk Cohort for Interventions



Workplan Design Requirement

- Heart Disease and Stroke Prevention & Innovative Heart Health Learning Collaboratives **work plans must:**
 - Identify and define a high-risk cohort for intervention that includes Black men
 - Criteria to consider when defining cohorts include: Abnormal blood pressure; Hypertension, hyperlipidemia, and/or diabetes undermanagement; Medication non-adherence; Low engagement in care



Goals/Benefits

- The purpose of identifying a high-risk cohort:
 - Conserves practice resources: focused intervention on smaller target
 - Right-sizes activities to available funding
 - Targets areas with the most potential impact
 - Allows for tailored intervention to meet the specific challenges faced

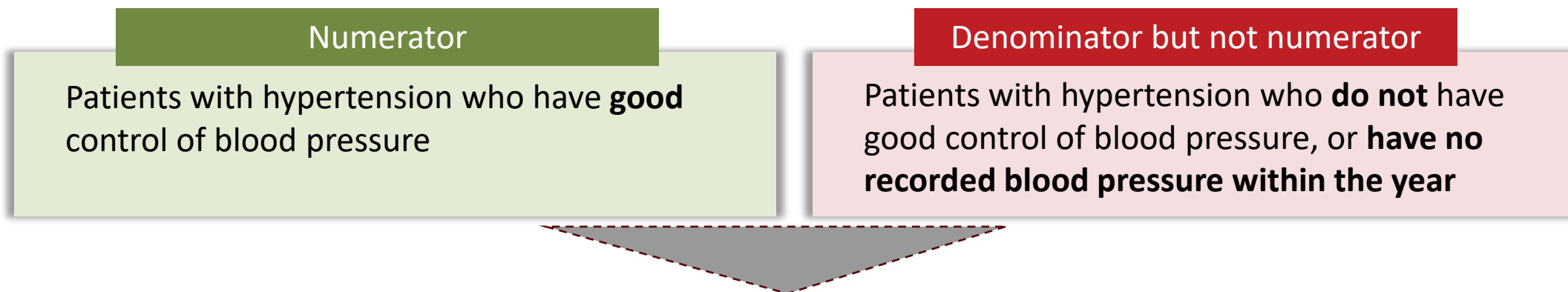
The How: High-Risk Cohort for Interventions

DC Health Chronic Disease Surveillance Dashboard Measures

Measure	Description
Controlling High Blood Pressure	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year
Diabetes: HbA1c Poor Control (>9%)	The percentage of patients 18–75 years of age with diabetes whose most recent hemoglobin A1c [HbA1c] was >9.0% during the measurement year
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	The percentage of patients with a previous/current diagnosis of ASCVD, ≥ 20 years who have ever had an LDL-C level ≥ 190 mg/dL or previous/current diagnosis of familial hypercholesterolemia, or 40-75 years with a diagnosis of diabetes, who are using or who receive an order/ prescription for statin therapy
Coronary Artery Disease (CAD): Antiplatelet Therapy	The percentage of patients ≥ 18 years of age with CAD who are taking or were prescribed aspirin or clopidogrel

- What do we know about the populations in these measures:
 - In the numerator?
 - In the denominator, but not the numerator?

The How: A Hypertension Example



- How do these populations differ: what does your data show you?
 - Demographic factors: race/ethnicity, age, geography, gender, insurance status
 - Health and social factors: Comorbid conditions, HRSN factors, recent (annual) depression screen
 - Care factors: length of time since last appointment, frequency of missed appointments (2 or more in past year), medication adherence rates (e.g., fill rates <80% do not fill new prescriptions within 7 days)

The How: A Hypertension Example (continued)

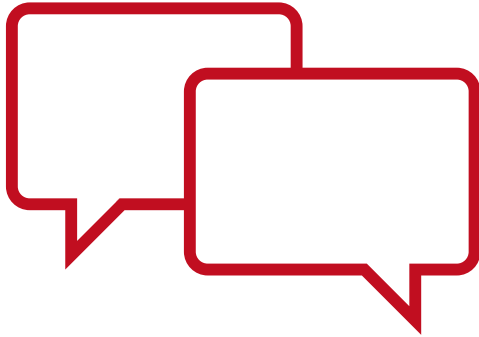


- Assess difference rate: statistically significant, or 5-10% or more difference
- What interventions are needed/might be effective, given the characteristic of the high-need cohort?
- Right-size the intervention to refine the cohort: ensure feasibility

Lower-risk cohort, with less (or no) intervention
Example: text appointment reminders

High-risk cohort, with strong intervention
Example: care management outreach to address HRSN and assistance with scheduling

Discussion



- Have you gone through this process with your data?
 - What factors did you consider?
 - What does your data show you?
- If not, what would you need to do this?
- Where do you need assistance?

Utilizing the eCW Optimization Toolkit

Empowering Clinical Teams to Identifying & Manage High-Risk Cohorts

*Marlene Fuentes, Director of eCW Support Services,
DCPCA*

Objective

Demonstrate how the eClinicalWorks (eCW) Optimization Toolkit can support clinical teams in identifying and managing high-risk patient cohorts – particularly those with chronic conditions like hypertension, diabetes, and hyperlipidemia.

Today's Focus

- ❑ Why optimization matters
- ❑ Identifying the right patients
- ❑ Toolkit features & workflows
- ❑ Data capture & reporting
- ❑ Putting data into action



Why the Toolkit Matters

Toolkit Features Support Clinical Teams:

- Identifying high-risk patient population
- Capturing data to feed actionable reports
- Designing dashboards for role-specific follow-up
- Triggering clinical interventions
- Assigning follow-up tasks to care team



The toolkit helps automate, standardize, and act on data.

Identifying High-Risk Cohorts

eCW Clinical Rule Engine (CRE) can be configured to identify a high-risk cohort and trigger interventions at the time of treatment.



CRE in Vitals to automate interventions for **Abnormal Blood Pressures** include but not limited to:

- Triggering a CPT code
- Linking to further screenings for lifestyle habits that can impact BP
- Triggering follow-up

Identifying High-Risk Cohorts

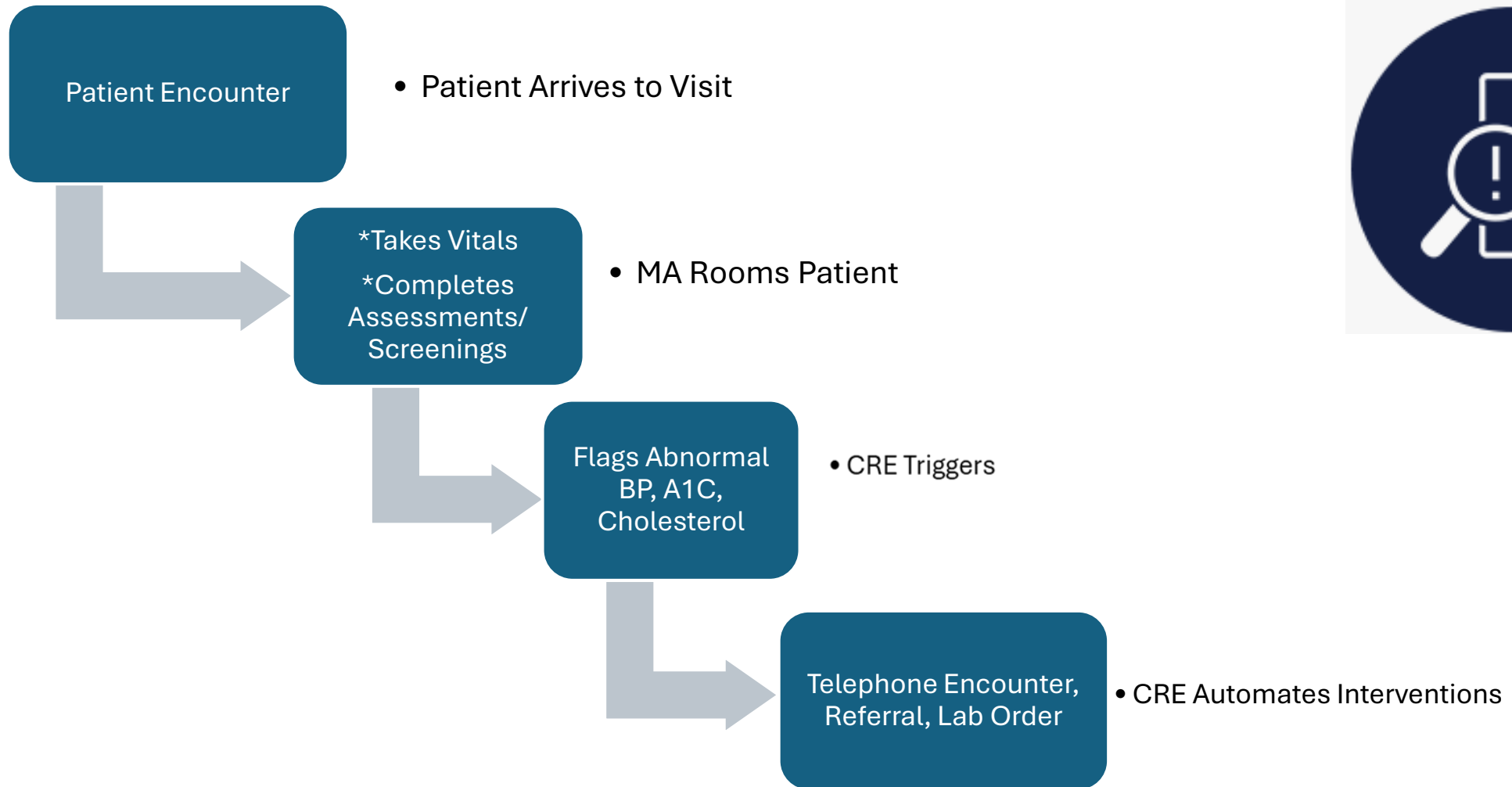
Leveraging the CRE in multiple areas within the progress note to identify and address different triggering points such as high A1C results, hyperlipidemia, gaps in care, non-adherence to treatment, and more. Once identified, the CRE automates interventions to better manage the patients with chronic conditions:

- Generate TEs for Care Team to Follow-up
- Create an Appointment
- Add to Problem List
- Order Lab/DI/Procedure
- Generate Referrals for Health Maintenance
 - ✓ Annual Vision Exam
 - ✓ Colorectal Screening
 - ✓ Mammogram Screening



Undermanaged chronic conditions = missed interventions

Identifying High-Risk Cohorts



Templates Capture Data

Build customized templates aligned with workflows to capture data that supports specific roles (e.g., RN, Care Manager, MA, Patient Navigator).

Health Centers Utilize different Reporting Tools:

- eCW Registry
- eBO
- eLoom
- Relevent
- Azara

Getting the right data for the right care team is critical when generating reports, designing dashboards, and creating flowsheets.

- Optimize Pre-visit Planning Reports/Dashboards for Care Team
 - View Targeted Patient Population with an Upcoming Appointment
 - Identify Care Gaps & Key Areas for that Specific Role to follow-up
 - Ability to Monitor and Track more Efficient
 - Keep Patients with Low Engagement in Care Connected to Care

If the data is not captured correctly, reports/dashboards are useless.



Templates Capture Data

Example of how DCPCA assist with creating templates to produce reports that provide role-specific dashboards to view what's pending, last intervention, and other key indicators – all in one window.

Meet with Care Team

- ✓ Understand their current workflow
- ✓ Learn what they are trying to accomplish & if there are any reporting requirements
- ✓ Identify key data that will need an intervention and/or follow-up
 - ✓ Flagging Responses that need to stand out in the Progress Note
 - ✓ Linking Responses to CRE
- ✓ Ensure data is not duplicated
- ✓ Help optimize/minimize "clicks"

Templates Capture Data

Interventions Provided:

- Assisted with transportation
 - o Ordered MCO transportation
 - o Provided Uber/Lyft transportation
 - o Educated on how to order MCO transportation
 - o Assisted with finding public transportation routes
 - o Explored other transportation support options
 - o Other
- Assisted with language access
 - o Ordered interpreter via MCO
 - o Assisted with connecting to interpreter services at facility
 - o Other
- Assisted with Care Coordination
 - o Requested records
 - o Inquired about support provided by facility/outside provider
 - o Connected to support provided at facility/outside provider
 - o Referral sent to outside facility
 - o Other
- Screened for SDoH barriers and connected to resources
 - o LinkU screener completed
 - o Prepare screener completed
 - o Connected to resources (specify)

Navigation status:

- Screening
 - o Awaiting patient readiness/availability
- o Needs appointment
- o Appt scheduled
 - Date and time
 - Location
 - Transportation details
 - Interpreter details
 - Other details
- o Completed screening – awaiting results
- o Completed screening – results received and reviewed
- o Other

- Diagnostics

- o Awaiting patient readiness/availability
- o Needs appointment
- o Appt scheduled
 - Date and time
 - Location
 - Transportation details
 - Interpreter details
 - Other details
- o Completed diagnostic - awaiting results
- o Completed diagnostic– results received and reviewed
- o Other

Next Steps:

- Continue navigation support for:
 - o Screening in process
 - o Repeat Screening needed or in process
 - o Diagnostics needed or in process
 - o Connection to Treatment needed or in process
- End navigation support due to:
 - o Patient declines navigation
 - o Patient chose not to proceed with follow-up care
 - o Unable to reach after multiple attempts
 - o Screening complete, no f/u needed
 - Next screening due: (month, year)
 - Type of screening due: (dropdown of options)
 - o Diagnostic complete, no f/u needed
 - Next screening due: (month, year)
 - Type of screening due: (dropdown of options)
 - o Connection to treatment complete, no f/u needed
 - Connected to outside treatment navigation support
 - Declined outside treatment navigation support

Data in Action – Pre-Visit Tool

Breast Cancer Prevention Navigator Huddle report: >

Showing results from the last time this report was run at 7/15/2025 7:43 AM. If the queried data has changed since then, results may be out of date.

Description

Patients who have a medical visit appt on the parameter date who are due for breast cancer screening (per UDS care gap in Relevant) or who have the breast cancer navigator name in circle of care regardless of mammogram status.

Parameters [Reset to defaults](#)

Appt start date

07/16/2025

Appt end date

07/16/2025

Appt location

2 of 37

▶ Refresh

Average run time: 23 sec. Last run time: 3 sec.

Export results

Results

Due by Appt Provider

Due by Appt site

Add view ▼

Show chart

Patient_id	Dob	Patient_name	Age	Language	Appt Date time	App Provider
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	English	2025-07-16 08:40 AM	[REDACTED]
[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	Spanish	2025-07-16 09:20 AM	[REDACTED]

Data in Action – Engagement

This example shows a report used to send-out text campaigns to outreach patients who self-identified African American woman ages 21-65 years and nonadherent to cervical screening guidelines:

PatFirstName	dob	Age	Email	Phone	CellPhone	EthnicityCode	Ethnicity	VoiceEnabled	webenabled	textenabled	PatientGender	PatientLanguage	race
F		47				2186-5	Not Hispanic or Latino	1	1	1	female	English	Black or African American
S		58				2186-5	Not Hispanic or Latino	1	0	1	female	English	Black or African American
C		53				2186-5	Not Hispanic or Latino	1	1	1	female	English	Black or African American
S		32				2186-5	Not Hispanic or Latino	1	1	1	female	English	Black or African American

The report looked for woman with:

- No Pap test in the last 3 years OR
- No HPV test in the last 5 years

Data in Action – Engagement

Campaigns

Back

20250623 ISA PAP Outreach - Published

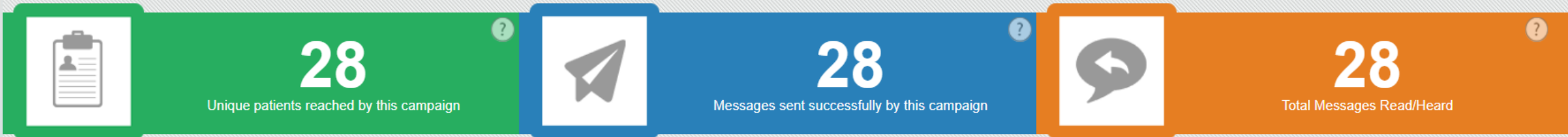
Dashboard reports use data from **Mar 02, 2025**.



Campaign activated on **Jun 23, 2025**

Campaign running for last **22 days**

Provider



Unique Patient reach

Heard	Read	Voicemail	Unconfirmed
0 (0%)	28 (100%)	0 (0%)	0 (0%)



Questions???

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

Bonny Nunez, MPH, 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

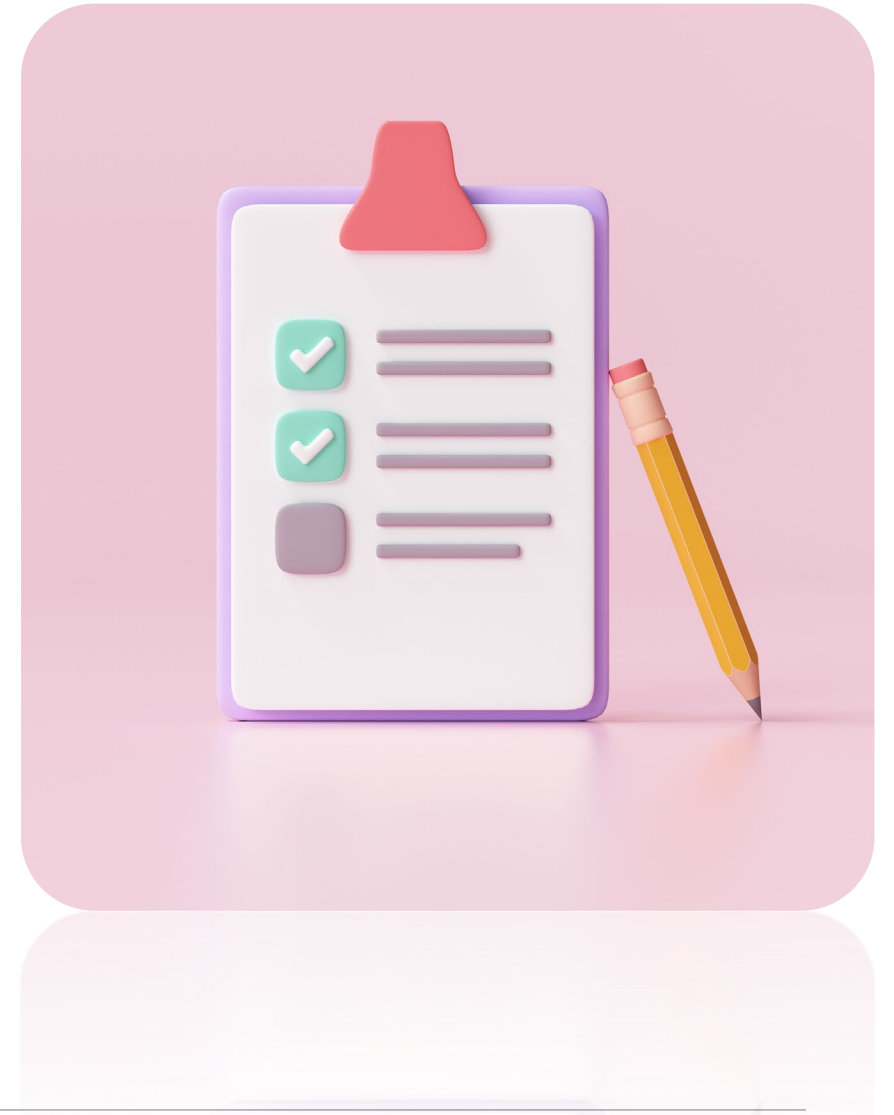
Information Session: July 30, 2025, 12pm – 1pm ET



- **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

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- **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

DC | HEALTH

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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