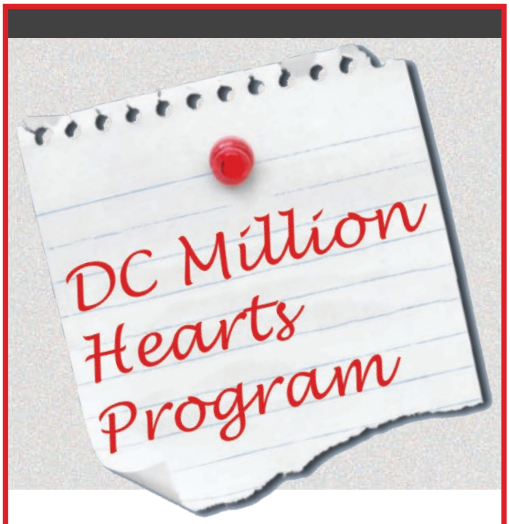
Field Notes



Problem:

When the DC Million Hearts program launched in 2013, heart disease was the leading cause of death among adults in Washington, DC. Nearly 30% of adults reported having high blood pressure—a key risk factor for heart disease.[1]

Program:

The DC Million Hearts program sought to reduce morbidity and mortality caused by heart disease among residents in Washington, DC, by convening public and private partner organizations representing multiple sectors, conducting population-level monitoring of key measures related to heart disease, and supporting QI and promising practices in chronic disease prevention and management.

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Overview

The District of Columbia Department of Health (DC DOH)—inspired by the National Million Hearts® initiative—established the DC Million Hearts program in 2013. The program was a collaborative that brought together multiple public and private organizations. The collaborative includes national and regional organizations, local health care systems, academic organizations, and community organizations that work toward the ultimate goal of reducing morbidity and mortality caused by heart disease among residents in Washington, DC.

Program Components

Core Component	Desciption
Convene Partners	The DC Million Hearts program served as a partnership between multiple public and private organizations working to achieve program goals. DC DOH used a learning collaborative approach to convene partners across multiple sectors, bringing together clinical, community, and public health partners. The learning collaborative approach consists of monthly collaborative meetings that provide partners the opportunity to share information and resources on quality improvement (QI) activities that align with DC Million Hearts goals and objectives.
Conduct Population Level Monitoring	Local health care systems reported key measures (e.g., number and percentage of patients identified as hypertensive, number and percentage of patients with blood pressure less than 140/90 mm/Hg) related to heart disease and diabetes to DC DOH. Upon receipt, DC DOH staff members compiled the data and created broad, population-level monitoring indicators used to track program progress.
Support QI	DC DOH supported QI through the following activities: - Collaborated with partners to provide 8 trainings on QI to local health care systems. - Administered 13 grants (ranging from less than $5,000 to more than $75,000) to partners to support the planning of QI interventions and promising practices designed to promote quality care among individuals with heart disease and diabetes risk factors. - Provided resources, tools, guidance, and assistance to help partners put into action QI interventions designed to provide high quality care to those with heart disease and diabetes risk factors. Resources include the American Medical Group Foundation's Measure Up, Pressure Down program and the American Heart Association's Check It, Change It tool.

Intended Participants

The DC Million Hearts program targets public and private organizations with missions, goals, and services that align with program goals. As of October 2015, 16 external partner organizations were engaged in the program: 2 academic organizations, 5 local health care systems, 6 community organizations and programs, and 3 national and regional organizations.

Field Notes

Short-Term Outcomes

- Enhanced partnerships and collaboration among DC DOH and partners.
- Increased capacity to monitor population-level measures related to heart disease.
- Increased implementation of QI interventions.

Intermediate Outcomes

- Improved management of heart disease risk factors at the District level.

Long-Term Outcomes

- Reduced morbidity and mortality due to heart disease.

Figure 1. Expected Outcomes of the DC Million Hearts Program

Goals & Expected Outcomes

The DC Million Hearts program aims to reduce morbidity and mortality caused by heart disease among residents in DC by convening partners, conducting population-level monitoring, and supporting QI. Together, DC DOH and partners work to achieve the outcomes presented in Figure 1.

Progress Toward Implementation

In 2011, the Delmarva Foundation, the Quality Improvement Organization (QIO) for providers, and health care systems in the Washington, DC, metropolitan region, developed and implemented Million Hearts-related collaborative networks. In 2013, DC DOH took the lead on the district-wide Million Hearts efforts in partnership with the Delmarva Foundation. This effort became known as the DC Million Hearts program. Although DC DOH organizes and facilitates the DC Million Hearts program—at its core—the program is a collaborative made up of multiple public and private organizations.

Community Involvement

DC DOH's connection to the community is accomplished through engaging organizations representing multiple sectors (including community-based organizations). DC Million Hearts partners shared that the program brings together public and private organizations with various connections to the community that otherwise may not connect with one another.

Program Benefits Partners

"Although we are a nonprofit, you can look at us as a private entity. We sometimes struggle to make those links (with hospitals and health care providers) and this (the DC Million Hearts program) has opened up some doors for us."

—Quote from a DC Million Hearts Partner

Reach and Impact

Key findings from an enhanced evaluability assessment[2] of the DC Million Hearts program revealed the following:

- DC DOH increased the number of partners engaged in the program from 6 organizations in 2013 to 16 in 2015.
- The number of local health care clinics represented in DC Million Hearts' population-level monitoring dataset more than doubled over the first 2 years of the program. The dataset accounted for approximately 40% of health care clinics in Washington, DC, by October 2015[3] compared with 17% in 2013.
- DC Million Hearts partners carried out numerous interventions that promoted quality care among patients at risk for heart disease. The specific QI interventions implemented varied considerably among partners. Examples included modifications to electronic health records (EHR) systems to allow providers to improve patient tracking and promotion of evidence-based chronic disease prevention and management programs.
- Aggregate data submitted by DC DOH partners for 20 health centers showed that in 2013, 53.8% of patients with hypertension had controlled blood pressure. By 2014, this had improved by nearly 10%, with 63.2% of patients with hypertension having controlled blood pressure.

1 DC DOH. District of Columbia Department of Health. Annual Health Report: Behavioral Risk Factor Surveillance System 2013. Washington, DC: DC Dept. of Health; 2013. http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2013%20Final%20BRFSS%20Annual%20Report%207%2029%2015.pdf. Accessed: April 27, 2016.
2 Losby JL, Vaughan M, Davis R, Tucker-Brown A. Arriving at results efficiently: using the enhanced evaluability assessment approach. Prev Chronic Dis. 2015;12:150413. DOI: http://dx.doi.org/10.5888/pcd12.150413. Accessed June 20, 2016.
3 DC DOH identified 51 health care clinics in the District through a needs assessment conducted in 2013.