Community Health Needs Assessment

District of Columbia, 2019

DC Health Matters Collaborative

Children's National Health Sytem | Howard University Hospital
HSC Health Care System | Providence Health System | Sibley Memorial Hospital
Bread for the City | Community of Hope | Mary's Center | Unity Health Care

mental health | care coordination | health literacy | place–based care

Community Health Needs Assessment, June 2019
Lead authors: Chaya Merrill, DrPH and Amber Rieke, MPH

Produced by the DC Health Matters Collaborative:
Abby Goldberg Evans, MSW; Alis Marachelian, MPH, CPCC; Angelica Journagin, JD, MHA;
Courtney Coffey, MPH; Davene B. White, MPH, RN, NNP; David Poms, MPH;
Desiree de la Torre, MPH, MBA; Donna Anthony, MPH; Gemina Gena, RN, MPH;
Gina Dwyer, MPH; Joseph L. Wright, MD, MPH; Julia DeAngelo, MPH; Julie Kozminski, MPH;
Justin Palmer; Kimberle Searcy, MPH; Marti Brown Bailey, BS, CSA, CDP;
Melissa Baiyewu, MHA, CHES; Melissa Millar, Esq.; Nicole Commodore, JD;
Randi Abramson, MD; Patricia Quinn; and Yolette Gray, MPH, CHES.
Qualitative data analysis by Damian Waters, PhD.

www.DCHealthMatters.org
collab@dchealthmatters.org

Thank You

The DC Health Matters Collaborative is exceedingly thankful to the hundreds of partners who shared their time, expertise, and passion with us. We would also like to thank you for reading this report, and your interest and commitment to improving the health of all of our District of Columbia communities.

Special thanks to the members of our Community Advisory Board who contributed to the development and content: Children's Law Center, Clean Air Partners (DC–MD–VA), DC Appleseed, DC Central Kitchen, DC Fiscal Policy Institute, DC Greens, Department of Aging and Community Life, DC Police Foundation, DC Public Library, The National Alliance to Advance Adolescent Health, National Council for Behavioral Health, Seabury Resources for Aging, and the Office of the State Superintendent for Education.

The DC Health Matters Collaborative – a unique collaboration among five DC hospitals (Children's National Health System, Howard University Hospital, HSC Health Care System, Providence Health System, and Sibley Memorial Hospital) and four community health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care) – authored this community health needs assessment to serve as a community-driven foundation for our community health improvement efforts. The four priority community needs are: mental health, care coordination, health literacy, and place-based care. In interviews, focus groups, and town halls, 28 themes emerged related to these priorities. When analyzed, the themes can be organized into four action areas, or directives from the community:
1) Foster Community Dialogue, 2) Build Relationships, 3) Develop Workforce Capacity, and 4) Simplify the Path to Wellness.

This is a roadmap for the health system to bring DC closer to a state of health equity for all residents.

Background: The Impetus for Action

Hospital community benefit requirements within the Patient Protection and Affordable Care Act of 2010 (ACA) shine light on non-profit hospitals' special obligation to invest in community needs. The ACA requires all non-profit hospitals to develop a community health needs assessment with an evidence-based planning and prioritization process. Hospitals are further required to adopt strategies to address the identified needs. This strategy – often referred to as a community health improvement plan (CHIP) – guides hospitals' investment to the identified priority areas. Per the most recent regulations, the needs assessment and improvement plan must be adopted by hospital boards. Community health centers have embraced a similar philosophy and comparable requirements for decades.

In an effort to promote collaborative work that reduces redundancy and positions us to make a meaningful collective impact on health, several DC hospitals and community health centers voluntarily came together in 2012 to form a coalition – then named the DC Healthy Communities Collaborative – that would issue a joint community health needs assessment and improvement plan. To date, the Collaborative has sponsored three needs assessments – in 2013, 2016, and this current 2019 report.

The 2016 assessment represented a shift from a focus on individual clinical conditions to larger social determinants of health that affect a wide range of health and quality-of-life outcomes. In order to achieve this shift in direction, we placed a much larger emphasis on having our community's perspective shape this work. For the current 2019 assessment, we continue the same emphasis on community perspectives.

Key Objectives of This Report

The purpose of this community health needs assessment (CHNA) is to lay the foundation to engage in community health improvement efforts that lead to a more equitable state of health for DC residents. The key objectives of this report are:

- Engage community stakeholders in a bi-directional dialogue to identify systems and policy approaches to addresses community-defined needs.
- Update indicators related to the demographics, socioeconomic characteristics, health behaviors, health status, and health care utilization of DC residents on our portal – DC Health Matters – with attention to differences by ward, race, ethnicity, age, and sex.

Our Approach

The 2019 CHNA uses a concurrent nested study design. This design uses multiple approaches to collect data, but prioritizes one approach that ultimately guides the project. In our case, we prioritized qualitative methods that focused on collecting community perspectives. The other approach – collecting quantitative data – is embedded or nested into our approach and plays a supporting role.

Community Perspective (Qualitative Data)

In our qualitative work, we engaged with over 300 community stakeholders across a diverse cross-section of DC spanning health and non-health disciplines. Using semi-structured data collection tools, we conducted interviews, focus groups, and a town hall to probe community partners on how policy and systems changes can address community needs with a particular focus on elevating health equity in our city. We used the Rapid Identification of Themes from Audio (RITA) method to analyze the interview and focus group data within the Dedoose qualitative software. As a supplement to the formal qualitative data collection process, we piloted a Photovoice project with a group of adolescents to solicit their perspectives related to the influence of schools and communities on their mental health. [See Appendix 2: Focus Group & Interview Script.]

Population, Health Status, and Health Behavior Data (Quantitative Data)

In our quantitative work, we used data from the census, American Community Survey, and Claritas to provide

a basic landscape of DC population characteristics, including socioeconomic factors, such as those related to poverty, education, and housing. Additionally, we analyzed health care utilization among DC residents via hospital, emergency department and community health center data. These data serve as proxy indicators of health care access and the efficacy of preventive and primary care services. The quantitative analysis revealed troubling variances in health, well-being, and preventive behaviors that often correlate with place of residence, race, and ethnicity. These data provide important context and guide how and where we invest our resources for the greatest impact. In an effort to provide ongoing timely information to the public, the majority of the quantitative data is posted, and will be continually updated, on our portal – DCHealthMatters.org.

We also consulted reports and assessments released by colleagues in the health system – government agencies, other hospitals, and academic researchers – as we designed, collected, and analyzed our findings. [See Appendix 3: Scan of Assessments for brief summaries and opportunities for collaboration.]

Identifying and Prioritizing Community Needs

For this 2019 assessment, we continued to prioritize the four needs identified in our 2016 assessment:[1]

1. **Mental Health:** the prevention and treatment of psychological, emotional, and relational issues that lead to higher quality of life.

2. **Care Coordination:** deliberate organization of patient care activities and information-sharing protocols among all of the participants concerned with a patient's care to achieve safer and more effective care.

3. **Health Literacy:** the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

4. **Place-Based Care:** care options that are convenient and culturally sensitive.

Since the release of the 2016 CHNA, the Collaborative has organized work groups to address these four needs using policy- and systems-focused approaches. Given the time and effort that it takes to make substantive progress in these four critical areas, we – in consultation with our community partners – decided to carry forward the four needs rather than re-canvas our community to identify new needs.

Findings

Our data collection process resulted in a rich collection of 28 themes that focus on how best to address our four priority areas – mental health, care coordination, health literacy, and place-based care – from a policy and systems approach. Through analysis of these themes, the Collaborative identified four broad action areas under which the individual themes could be organized:

Action Area 1 – Foster Community Dialogue: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.

Action Area 2 – Build Relationships: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.

Action Area 3 – Develop Workforce Capacity: cultivate health and social care professionals through approaches that are responsive to the communities and persons they serve.

Action Area 4 – Simplify the Path to Wellness: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

The table on the next page provides a summary of findings for each of the four priority areas. More detail on these themes is presented in the full report.

Next Steps

The DC Health Matters Collaborative will work with community partners to address the aforementioned needs in a measurable fashion that will move DC closer to a state of health equity. Our efforts will be documented and disseminated in a three-year community health improvement plan (CHIP) that will be publicly available in November 2019.

The CHIP will be a living document of concrete, actionable plans for addressing the four community needs. It will use the action area framework to guide development of strategies for policy and systems changes. We will engage with our community advisory board (CAB) and external stakeholders (including residents and neighborhood leaders) to develop, propose and vet strategies, take action, and share accountability.

We invite all DC stakeholders to join us in working toward health equity. Community members are welcome to attend meetings of our Community Advisory Board or working groups. Contact us via email at collab@dchealthmatters.org for more information.

	mental health	care coordination	health literacy	place-based care
community dialogue	MH1. Understand community perspectives on MH. MH2. Educate stakeholders about MH. MH3. Gather data about MH in the District. MH4. Assess quality of MH services.	CC1. Improve communication among healthcare providers, social service agencies, and educational systems.	HL1. Define health literacy. HL2. Assess health literacy in the District.	PBC1. Assess community perspectives related to the distribution of community assets across the District.
build relationships	MH5. Improve relationships between and within the health system and local government agencies. MH6. Improve cultural and linguistic responsiveness of mental health services.	CC2. Incentivize collaboration among healthcare, social service, & education systems. CC3. Enhance contextually, linguistically, & culturally appropriate care.	HL3. Expand health education efforts.	
develop workforce	MH7. Increase the number of qualified health professionals. MH8. Recruit, train, and provide reimbursement for community health workers and peer support workers.	CC4. Train health services providers, including clinical/social support groups, and individuals to coordinate care.	HL4. Train health care professionals to assess health literacy and adjust communication accordingly. HL5. Utilize community health workers to promote & facilitate health literacy.	PBC2. Incentivize healthcare providers to practice in under resourced areas.
simplify path to wellness	MH9. Implement and expand case management. MH10. Promote mental health integration.	CC5. Invest in technology /other supports to facilitate coordination of services. CC6. Curate resource lists. CC7: Expand use of interdisciplinary teams in primary care. CC8. Advocate for policies that incentivize wellness.	HL6. Improve general literacy across the District.	PBC3. Continue expanding availability and access to existing services. PBC4. Promote innovative models of place-based care.

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About the DC Health Matters Collaborative

The DC Health Matters Collaborative is a coalition of hospitals and federally qualified health centers (FQHCs) that combine efforts and resources to assess and address community needs. This work is undertaken in partnership, is data-driven, and engages the community. The ultimate pursuit is an equitable and sustainable state of health for District of Columbia residents.

Our work revolves around three key products: 1) DCHealthMatters.org – a community-driven, interactive web portal that provides actionable and timely local health information and resources, 2) a community health needs assessment (CHNA) conducted every three years, and 3) a community health improvement plan (CHIP), which is a roadmap for action on identified needs. The CHIP strategies aim upstream to make changes to policy and systems. Our framework moves beyond the clinical interaction, aiming to modify the social conditions of the community and, ultimately, reduce disease and health disparities across the District of Columbia.

The Collaborative advances working groups to advance CHIP strategies in Mental Health, Care Coordination, Health Literacy, and Place-Based Care. Each group meets monthly and includes participants from members of the Collaborative and other community stakeholders and experts. We have formal and informal relationships with a variety of city organizations, including many that serve on our Community Advisory Board.

In the creation of this CHNA report, we extend our gratitude to the numerous organizations and individuals who contributed, including the government agencies and community-based organizations that participated in our focus groups, key informant interviews and town hall.

Our Members

The mission of Bread for the City is to help Washington, DC residents living with low income to develop their power to determine the future of their own communities. https://breadforthecity.org

As the nation's children's hospital, the mission of Children's National is to excel in Care, Advocacy, Research and Education. https://childrensnational.org/

Community of Hope's mission is to create opportunities for low-income families in Washington, DC, including those experiencing homelessness, to achieve good health, a stable home, family-sustaining income, and hope. www.communityofhopedc.org

Howard University Hospital (HUH) has a mission to lead in the advancement of health equality, health promotion and health outcomes on a local, national and global level. http://huhealthcare.com/

Mary's Center is a Federally Qualified Health Center whose mission is to build better futures through the delivery of health care, education, and social services. www.maryscenter.org/

The mission of The HSC Health Care System is to provide and coordinate innovative, high quality, community-based care for individuals with complex needs and their families. https://hschealth.org/

Providence is transforming to a new healthcare delivery model that re-envisions how we deliver care to meet the community's health needs and can best contribute to building healthier communities. www.providencehealthyvillage.org

Sibley Memorial Hospital's mission is to deliver excellence and compassionate care — every person, every time. www.hopkinsmedicine.org/sibley-memorial-hospital/

Unity Health Care is promoting healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. www.unityhealthcare.org

Ex-Officio Members

DC Hospital Association's mission is to be a unifying voice working to advance hospitals and health systems in the District of Columbia by promoting policies and initiatives that strengthen our system of care, preserve access and promote better health outcomes for the patients and communities they serve. www.dcha.org/

DC Primary Care Association works to create healthier communities through advocacy and the development of the infrastructure to support a high quality, equitable, integrated health care system that gives every DC resident a fair shot at a full and healthy life. www.dcpca.org/

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Chapter 1: Background

The Community Health Needs Assessment is a federal requirement for non-profit hospitals; this report is the third iteration of the DC Health Matters Collaborative's assessment. This 2019 assessment places ongoing focus on the 2016 CHNA priorities: mental health, care coordination, health literacy, and place-based care. We leverage the capacity, expertise, and relationships that have been built to address these needs more effectively.

To most Americans, Washington, DC is the seat of the country's federal government, where lawmakers debate and power brokers lobby. It is a tourist destination adorned with marble monuments, a cultural center for art and artifacts, and a hub for global connections. Beyond the "government town," the District of Columbia is a hometown. It is a community where 700,000 residents of all ages live, learn, worship, work, eat, commute, caretake, exercise, and create.

DC has robust resources and a growing, demographically diverse population. It is also currently grappling with displacement and disparities – different outcomes attributable to factors like race and income. The health disparities are especially dire; life expectancy can vary by 21 years depending on where you live in the District.[2]

This Community Health Needs Assessment, sponsored by the DC Health Matters Collaborative, is an effort to better understand current challenges and possible solutions. This report presents qualitative and quantitative information about the healthcare landscape, non-clinical conditions that influence health, and the opportunities for action in our unique and dynamic hometown.

About the Collaborative

The DC Healthy Communities Collaborative (DCHCC) was established in 2012 to combine efforts and resources to assess and address community needs.

Today, the coalition is renamed the DC Health Matters Collaborative. Membership includes five hospitals (Children's National, HSC Health Care System, Howard University Hospital, Providence Hospital, and Sibley Memorial Hospital); four Federally Qualified Health Centers (FQHCs) (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care); and two ex-officio members (DC Hospital Association and DC Primary Care Association). DC Department of Health is also a partner of the Collaborative.

"How do we get accountability and pull each other up and get the city to succeed overall?"

– Focus Group Participant

The principal products of the Collaborative are: 1) the Community Health Needs Assessment (CHNA) presented in this report, and 2) the corresponding Community Health Improvement Plan (CHIP) forthcoming in November 2019. DCHealthMatters.org, our community health data portal, supports this important work.

Collective Impact is the commitment of a group to a common agenda using a structured form of collaboration: the definition of the Collaborative.

Assessing Community Health Needs

Impetus for Action

The initial catalyst for the Collaborative's formation was a new federal requirement in the Patient Protection and Affordable Care Act of 2010 (ACA). Non-profit hospitals are required to invest in "community benefit" activities – traditionally categories in community health services and charity care – though the volume and scope of such benefits are undefined at the federal or District level. Section 9007 of the ACA added a new element to non-profit hospitals' community benefit obligations: the Community Health Needs Assessment.

The CHNA regulations require the needs assessment to be conducted every three years. A subsequent Community Health Improvement Plan (CHIP) is meant to guide hospitals' investments in the identified priority areas. The needs assessment and improvement plan must be adopted by hospital boards and made available to the public.[3] In an effort to reduce redundancy, combine resources, and improve partnerships, several hospitals and health centers came together in 2012 to form the Collaborative and issue a joint community health needs assessment and community health improvement plan.

The Collaborative issued the first District-wide CHNA in 2013 and the second in 2016. As the process has developed over two CHNA cycles, we have expanded the focus from the individual and clinical to broader social and environmental factors that affect health.

The Collaborative engages a Community Advisory Board (CAB) of community-based and government organizations to help define, guide, and evaluate our work. For the 2019 CHNA cycle, these organizations included the Children's Law Center, Clean Air Partners (DC-MD-VA), DC Appleseed, DC Central Kitchen, DC Fiscal Policy Institute, DC Greens, Department of Aging and Community Life, DC Police Foundation, DC Public Library, The National Alliance to Advance Adolescent Health, National Council for Behavioral Health, Seabury Resources for Aging, and the Office of the State Superintendent for Education.

Defining Community

An important piece of context for a community health needs assessment is "who is the community?" "Community" can be defined in several ways. Collaborative organizations all serve DC as well as neighboring Maryland and Virginia.

For this 2019 CHNA, we define our community as the residents of the District: not only the DC patients who cross into our healthcare organizations, but all those living within the geographic boundaries of the city. At present, we do not include the nearby Virginia and Maryland counties in our analysis or improvement plan; however, we consult the work of hospitals and organizations in these jurisdictions, as needed. Because specific utilization and patient population data for DC hospitals and community health centers (regardless of the patients' place of residence) is important to consider, we provide these data on DCHealthMatters.org. Data show the similarity of experiences between DC and our neighboring jurisdictions.

Assessment Evolution and Framework

The process for our triennial CHNA effort has evolved since the first version published in 2013. Collective impact remains at the heart of our efforts, while each iteration has effectively moved the focus of the work further upstream. We know that upstream factors – such as economic disadvantage, historical injustices, risk exposure, built environment, and lack of access to resources – play a fundamental causal role in poor health outcomes — and thus represent important opportunities for improving health and reducing health disparities.

The 2013 CHNA

The Collaborative (then the DCHCC) partnered with the RAND Corporation to conduct the first needs assessment, published in June 2013. The quantitative analysis of health data in the District revealed four priority areas: asthma, overweight/obesity, sexual health, and mental health and substance abuse. The 2013 assessment and improvement plan are located on DCHealthMatters.org.

Spotlight on DC Health Matters

DCHealthMatters.org provides a one-stop resource for online access to community health indicators and related resources that impact the health of DC communities. The portal contains hundreds of community health measures, evidence-based promising practices, local resources, and funding opportunities. The Community Health Needs Assessment, Community Health Improvement Plan, and an up-to-date CHIP progress tracker are also available at DCHealthMatters.org.
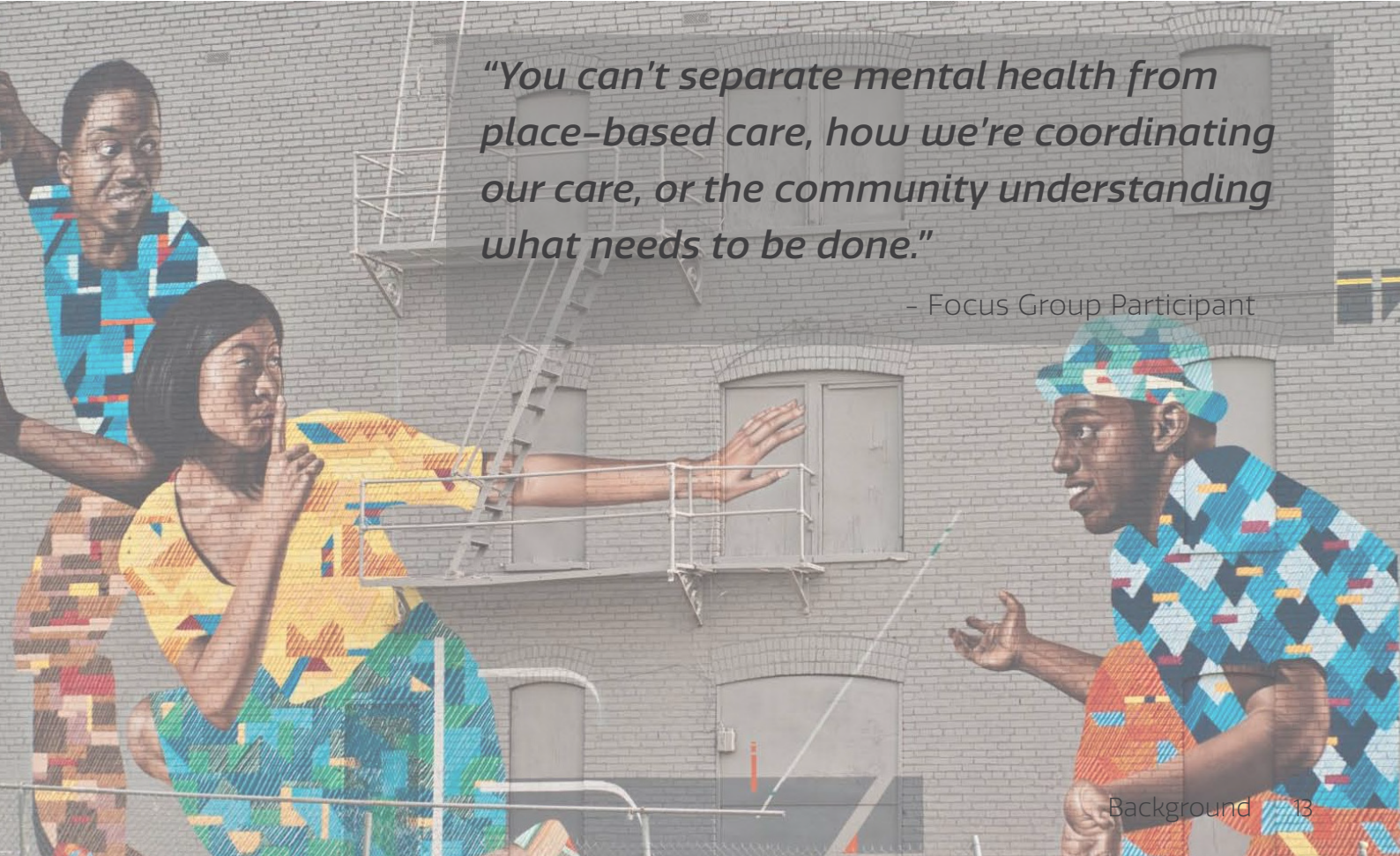
The 2016 CHNA

For the 2016 CHNA, the Collaborative (then known as DCHCC) adopted a new approach with an expanded focus on qualitative data, community engagement, and the non-clinical determinants of health such as food insecurity and community safety. Qualitative data sources included key informant interviews with 31 experts and leaders, an online survey completed by 113 healthcare providers and staff, focus groups with 40 participants from community-based organizations, and a community town hall with 80 attendees. Data on socio-demographics, health behavior, hospital discharges, emergency department visits, and community health center visits were also included.

The 2016 CHNA identified nine community-defined needs: care coordination, food insecurity, place-based care, mental health, health literacy, healthy behaviors, health data dissemination, community violence, and cultural competency. Four priorities were elevated based on importance to the community, capacity to address the issue, alignment with the mission of member organizations, and strength of existing interventions and collaboration; the four final priorities were mental health, care coordination, health literacy, and place-based care.

The 2019 CHNA

For the 2019 assessment, the Collaborative prioritized the needs identified in 2016: mental health, care coordination, health literacy, and place-based care. Acknowledging that these four needs still persist in the District, collaborative members agreed to use the assessment to dig deeper rather than start anew. This way, we can leverage the capacity, expertise, and relationships that have been built to address these needs more effectively.

As with the 2016 CHNA, the Collaborative conducted a series of focus groups and interviews with DC community-based groups, local leaders, and other stakeholders. We also analyzed several quantitative data sources to gain a deeper understanding of demographic, socioeconomic, health behavior, and health status factors. To synthesize the many findings into actionable domains, we grouped them into four action areas: foster community dialogue, build relationships, develop workforce capacity, and simplify the path to wellness.

"You can't separate mental health from place-based care, how we're coordinating our care, or the community understanding what needs to be done."

– Focus Group Participant

The 2019 CHNA report focuses largely on qualitative findings that highlight community perspectives; a wealth of up-to-date quantitative data are available on the DCHealthMatters.org data portal and integrated into this report, as relevant.

Health Equity Framework

At the start of our process, Collaborative members adopted the Robert Wood Johnson Foundation's definition of health equity as a guiding framework: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare." We recognize that health inequities are present in our city by race, neighborhood, income, immigration status, age, gender, and other factors. In our assessment process, we probed community stakeholders to share their perspectives related to health inequities and suggest how to best address inequity issues. We used the quantitative data to further assess health disparities.

Scan of Other Assessments

It is important to note that other groups in DC undertake health-related assessments for a variety of purposes and audiences. The Collaborative was formed out of a desire to collaborate and reduce duplication of effort, and we continue to learn from health systems partners and strive to align efforts. Therefore, Appendix 2 of this report is a scan of other select assessments published in DC since 2016 and highlights places of alignment. For example, we can draw from the findings of the resident-level survey that MedStar Health System conducted for its 2018 CHNA and find ways to work together going forward.

In summary, the Collaborative strove for an action-oriented, intentional process for the 2019 CHNA to build on progress and identify further opportunities to achieve equity for all residents.

Community Health Improvement Plan

The CHNA findings inform the development of the Community Health Improvement Plan (CHIP), which outlines strategies and activities by which the Collaborative can work collaboratively with community partners to address priority needs. Our CHIP strategies aim to make upstream policy- and systems-level changes. This framework moves the work beyond clinical interaction to modify social conditions in the community in order to reduce disease and improve health.

The Collaborative established working groups to advance CHIP strategies with a three-year time horizon (2016-2019). Each group meets monthly and includes members of the Collaborative, experts, and other invested community stakeholders. A progress tracker on DCHealthMatters.org is updated each month to report on the advancement toward each working group's goals and strategies.

Beyond the work of the Collaborative, the full scope of non-profit hospitals' community benefit activities is detailed in annual community benefit reports on each organization's website.

Our CHNA

The CHNA is the product of an ongoing dialogue about the community's needs related to mental health, care coordination, health literacy, and place-based care. It lays the foundation for the Collaborative's efforts to create a healthier community and more equitable system for DC residents.

This report begins with a landscape of key figures related to socio-demographic characteristics and health status of DC residents with special attention paid to differences by ward, race, and ethnicity. We also note

issues and events "beyond the numbers" contextual to our assessment. We then present our methodology and qualitative findings, including the 28 themes (or actions) that were most salient in our conversations with community stakeholders. We close with next steps and an invitation to be involved in our work.

This report fulfills the CHNA requirements for the five non-profit hospitals that are part of the Collaborative (Children's National, Howard University Hospital, HSC Health Care System, Providence Hospital, and Sibley Memorial Hospital), and provides data to support assessment reporting requirements for the four health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care).

The DC Health Matters Collaborative thanks the hundreds of partners who shared their time, expertise, and passion with us. We look forward to continuing to work together to refresh, reframe, and refine our strategies to address community needs.

Thank you to these organizations for participating in interviews, focus groups or the town hall in support of this needs assessment.

Advocates for Justice and Education

AmeriGroup DC Medicaid

Advisory Neighborhood Commissions

AppleTree Early Learning

Bainum Family Foundation

Bernice Fonteneau Senior Wellness Center

Bread for the City

Bridgeport Healthcare

Briya Public Charter School

Catholic Charities

Center for Health and Health Care in Schools

Child and Family Services Agency

Children's National Health System

City Arts and Prep Public Charter School

Clean Air Partners (DC-MD-VA)

Commission on Fathers, Men and Boys

Community of Hope

DC Councilmembers or representatives of Anita Bonds, Brianne Nadeau, Charles Allen, David Grosso, Elissa Silverman, Jack Evans, Mary Cheh, Robert White Jr., Vincent Gray

DC American Academy of Pediatrics Chapter

DC Behavioral Health Association

DC Board of Medicine

DC Board of Nursing

DC Board of Pharmacy

DC Board of Psychology

DC Central Kitchen

DC Dental Society

DC Department of Behavioral Health

DC Department of Consumer and Regulatory Affairs

DC Department of Fire and Emergency Medical Services

DC Department of Forensic Services

DC Department of Health Care Finance

DC Department of Housing and Community Development

DC Department of Human Resources

DC Department of Human Services

DC Department of Insurance, Securities, and Banking

DC Department of Motor Vehicles

DC Department of Parks and Recreation

DC Department of Small and Local Business Development

DC Department of Transportation

DC Department of Youth Rehabilitation Services

DC Department on Disability Services

DC Department of Public Works

DC Greens

DC Health

DC Hospital Association

DC Office of Latino Affairs

DC Office of the Deputy Mayor for Education

DC Office of the Deputy Mayor for Health and Human Services

DC Office of the State Superintendent for Education

DC Office of Veterans Affairs

DC Office on Aging

DC Office on Women's Policy and Initiatives

DC Police Foundation

DC Prep Public Charter School

DC Primary Care Association

DC Public Library

DC Public Schools

DC Senior Wellness Centers

District of Learning/Fair Chance DC

Eliana's Light

ES Fitness LLC.

Food & Friends, Inc.

Fort Lincoln Family Medicine

George Washington University

Georgetown University

Georgetown University Medical Center

Hattie Holmes Senior Wellness Center

Health Services for Children with Special Needs

Howard University Hospital

HSC Health Care System

KIPP Schools DC

Kozmique Light Meditations

La Clinica Del Pueblo

Latin American Youth Center

Mary's Center

MedStar George Washington University Hospital

MedStar Health

MedStar Washington Hospital Center

Meridian Public Charter School

Metro Health

Metropolitan Police Department

Mission Partners

Model Cities Senior Wellness Center

Monument Academy

National Alliance to Advance Adolescent Health

National Council for Behavioral Health

Perry Family Health Center

Planned Parenthood of Metropolitan Washington, DC

Prince George's County Public Schools

Providence Health Care System

Radical Mindfulness

Redstone Center

Restorative DC

Seabury Resources for Aging

Sibley Memorial Hospital

So Others Might Eat

Somerset Prep DC

Spanish Catholic Center

State Board of Education

The Sibley Group

Total Family Care Coalition

United Way of the National Capital Area

Unity Health Care

University of the District of Columbia

Wendt Center For Loss and Healing

Whitman-Walker Clinic

DC Health Matters Collaborative:
Investing in Policy Work and Partnerships

In 2018, the Collaborative launched a new grant-making initiative. It awarded $150,000 ($75,000 each) to two DC-based non-profit organizations to tackle the District's priority health needs through policy and systems strategies over the next two years.

MedStar Georgetown University Hospital (MGUH) will expand the current work of the Early Childhood Innovation Network (ECIN) at MedStar Washington Hospital Center's Obstetrician–gynecologists clinic to include additional perinatal health advocacy and family navigation, case management, and support. MGUH will target its integrated mental health care model to pregnant or parenting women who receive care at the clinic, with a focus on women who are at high risk for or are evidencing symptoms of depression and anxiety.

The Institute for Public Health Innovation is serving as the backbone organization of the new D.C. Healthy Housing Collaborative, which will include numerous public and private partners. The D.C. Healthy Housing Collaborative will address the social determinants of poor housing conditions that contribute to significant inequities in asthma and other health outcomes in the District of Columbia. Project partners will work with lower-income renter households, households impacted by asthma, and housing organizations to: 1) improve understanding of and capacity for remediation of health-related housing hazards; 2) pilot a coordinated care model for home remediation and repair services; and 3) train participating families in leadership development skills (e.g. public speaking, effective testimony, community organizing, and systems thinking).

Chapter 2: Landscape

Collaborative hospitals and community health centers serve DC residents and individuals living in Maryland and Virginia, as well as national and international patients. This CHNA focuses predominantly on our DC population. The District is a unique and dynamic city, with a diverse population and many community assets. At the same time, we face striking health disparities and pressing health issues comparable to other urban areas. More detailed information, particularly related to demographic, socioeconomic and health metrics, is available at DCHealthMatters.org.

DC is a diverse urban setting that encompasses 68 square miles of land situated between the Northern Virginia counties of Arlington and Alexandria and the Maryland counties of Montgomery and Prince George's. It is the 20th most populated city in the United States, with more than 700,000 residents.[4]

DC is governed by an elected mayor and executive branch, including the Department of Health, Department of Behavioral Health, and Department of Health Care Finance which operates one of the most inclusive Medicaid programs in the country. The District's budget and laws are subject to review by the United States Congress, though it does not have voting representation in Congress.

The District is divided into eight wards of roughly equal population size, each with its own rich history, vibrant neighborhoods, and diverse population. [See Figure 1.] Each ward elects a representative to the DC Council, and five at-large Councilmembers represent all wards. The Council is effectively the legislative branch of local government and oversees the District's annual budget. Within the wards, 40 Advisory Neighborhood Commissioners (ANCs) consider a wide range of policies and programs affecting their neighborhoods, from traffic and parking to zoning and sanitation. ANCs are the body of government with the closest official ties to the people in a neighborhood. We focus most of the Collaborative's work at the ward or ANC level and present on relevant policies and programs to the DC Council.

Composition of DC Residents

In 2019, DC was home to 710,893 residents, a population comparable to the cities of Boston and Denver. DC's population has increased by 18.1% since 2010. Our city continues to be a racially and ethnically diverse city, though the proportions of racial groups are changing. [See Table 1.] Black residents comprise 45.2% of the population in 2019 compared to 50.7% in 2010; the Latinx population grew to 11.7% compared to 9.1% in 2010. DC has a sizable community of immigrants, many of whom emigrated from El Salvador and Ethiopia. Over 14% of DC's population was born in another country.[5] [See Appendix 1: Landscape Infographic for more.]

Table 1: DC Demographics, 2019

	2019	2010	Change From 2010 to 2019
TOTAL POPULATION	**710,893**	**601,723**	**18.1%**
Race			
Black	45.2%	50.7%	-10.8%
White	41.5%	38.5%	7.8%
Asian	4.2%	3.5%	20.0%
American Indian/Alaskan Native	0.4%	0.3%	33.3%
Native Hawaiian/Pacific Islander	0.1%	0.1%	[no change]
Other Race	5.2%	4.1%	26.8%
2+ Races	3.5%	2.9%	20.7%
Ethnicity			
Latino	11.7%	9.1%	28.6%
Foreign-Born Population (Immigrant)	14.7%[1]	13.5%[2]	8.9%
Sex			
Female	52.5%	52.8%	-0.6%
Male	47.5%	47.2%	0.6%
Age, years (median)	34.6	33.8	

[1]U.S. Census Bureau, 2013-2017 American Community Survey 5-Year Estimate
[2]U.S. Census Bureau, 2010 American Community Survey
2010 Source: U.S. Census Bureau, 2010 Census
2019 Source: Claritas Population Estimates, 2019. Accessed at DCHealthMatters.org (April 2019).

Compared to other states, DC is the second youngest "state" with a median age of 34.6 years – only Utah (30.7 years) has a younger median age.[6] This average reflects a number of families with children as well as the dynamic professional workforce drawn to Washington. Females comprised 52.5% of the population – a fairly stable representation since 2010.

Socioeconomic Characteristics of DC Residents

Socioeconomic status is the social standing of an individual or group. It is often measured as a combination of education, income, and occupation. Low socioeconomic status is strongly correlated with inequities in access to resources, as well as issues related to privilege, power, and control. People with lower socioeconomic status typically experience poorer health and die younger than those with more economic advantage.

Citywide averages often paint DC as a socially and economically rich city; however, a more detailed look reveals a story of profound inequities. Socioeconomic characteristics of DC residents vary immensely across the city. Health inequities follow

Figure 1: Neighborhoods in Washington, DC
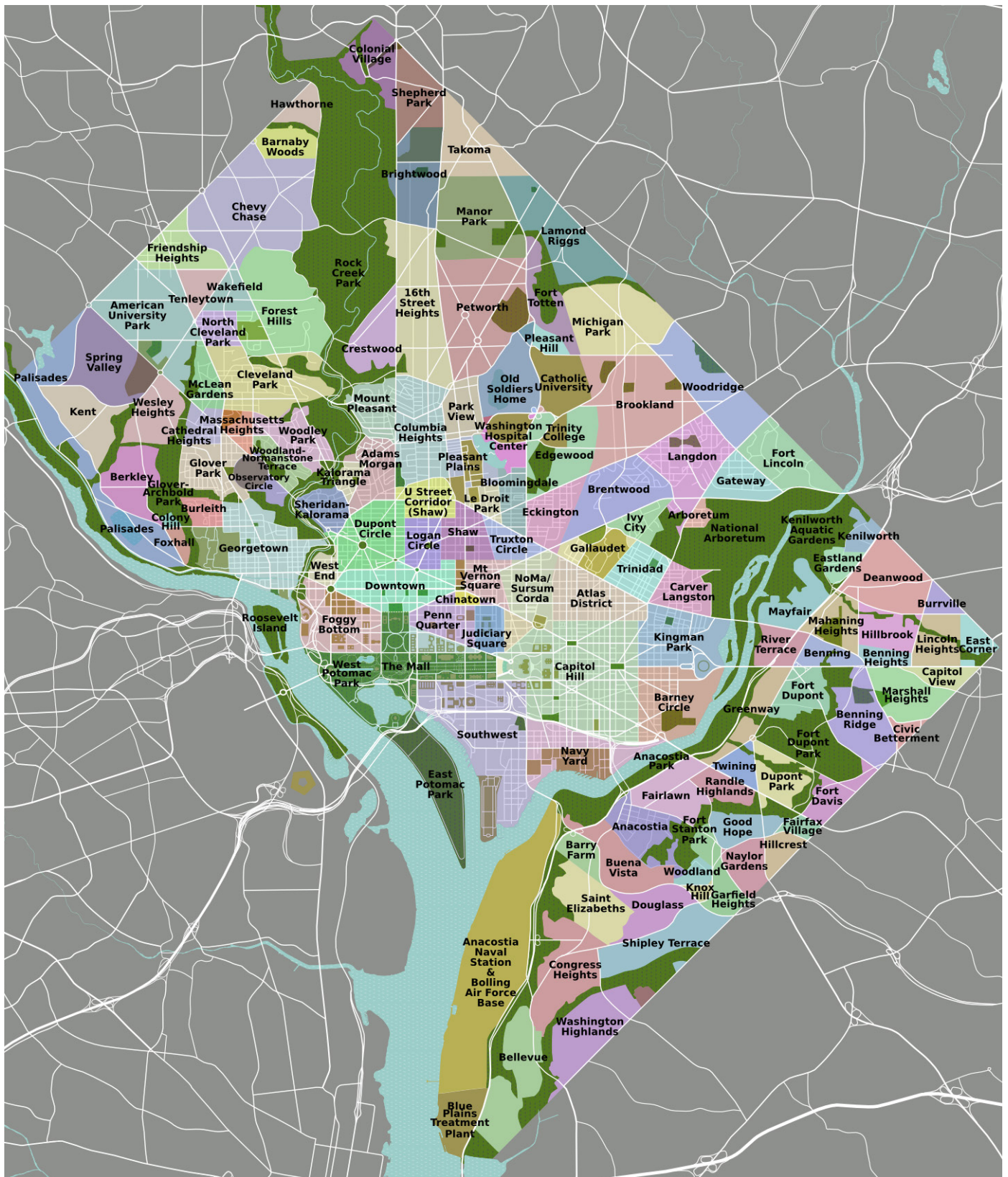
Source: by Peter Fitzgerald, 2008. Accessed at https://en.wikipedia.org/wiki/Neighborhoods_in_ Washington,_D.C.#/ (June 2019)

the same pattern. For example, there are direct correlations between the concentration of poverty in segments of the city, particularly in Wards 7 and 8, and patterns of poor health outcomes concentrated in the same areas.

The Collaborative-supported web portal – DCHealthMatters.org – provides hundreds of socioeconomic and health indicators that illustrate this pattern. In this chapter, we will highlight two illustrative examples of stark inequities – life expectancy and infant mortality – both of which are often considered prime indicators of a community's health.

Measure	Ward 3	Ward 8
Attended College[1]	94.1%	45.5%
Median Household Income[1]	$136,832	$34,824
Child Poverty[1]	2.9%	48.5%
Families Below Poverty with Children[1]	1.3%	25.4%
%Black[1]	5.4%	92.1%
%Latino[1]	9.5%	2.8%
%Unemployed[1]	2.9%	18.5%
Public Health Insurance[2]	18.7%	64.6%
Gross Rent as Percentage of Household Income (35% or more)[2]	33.8%	53.9%
Grandparents Responsible for Grandchildren[2]	16.0%	47.3%
Civilian Population with Disability[2]	5.9%	17.8%
Adult Asthma Prevalence[3]	11.6%	13.1%
Adults with Hypertension[4]	19.7%	42.2%
Adults with Depression[3]	14.7%	16.3%
Adults with Diabetes[3]	4.8%	14.5%
Adults who are Overweight or Obese[3]	44.9%	70.0%
Adults with Difficulty Remembering or Concentrating[3]	2.8%	19.3%

[1] DC Kids Count, 2016. Accessed at https://datacenter.kidscount.org/data/tables/6748-child-poverty-by-ward (June 2019).
[2] American Community Survey (ACS) Estimates, 2013-2017. Accessed at https://planning.dc.gov/page/american-community-survey-acs-estimates (April 2019).
[3] Behavioral Risk Factor Surveillance System (BRFSS), 2016. Accessed at https://dchealth.dc.gov/service/behavioral-risk-factor-surveillance-system (June 2019)
[4] 2015 data. Not available in 2016 BRFSS report.

Life Expectancy

Life expectancy is the average number of years that a newborn is expected to live. The average life expectancy in DC is 79 years.[7] This is comparable to the U.S. average, but about seven years shorter than for babies born in neighboring Virginia counties, such as Arlington or Fairfax.[8] Life expectancy *within* DC varies even more dramatically: DC has a 15+ year difference in life expectancy by ward: 87.6 years in Ward 3 compared to 72 years in Ward 8. [See Figure 2 on the next page.] The disparities are even more grave when we consider life expectancy at the DC neighborhood level: the neighborhoods with the lowest and highest life expectancies ranged from 68.4 years in the St. Elizabeth's neighborhood (Ward 8) to 89.4 years in the Woodley Park area (Ward 3), a 21-year difference. Likewise, there are significant differences in the socioeconomic status of these neighborhoods, including poverty levels. Families in St. Elizabeth's live in poverty at a rate that is more than 15 times greater than families in Woodley Park: 24.2% compared to 1.6%, respectively.[9]

Racial differences in life expectancy are also striking. When compared to other racial groups, the life expectancy for Black residents is the lowest. White males in the District are expected to live almost 15 years longer than Black males (83.2 and 68.8 years, respectively). White females in the District are expected to live approximately 9 years longer than Black females (85.2 and 76.2 years, respectively).[10]

For context, the U.S. currently has the lowest life expectancy among high-income countries. Based on Organisation for Economic Co-operation and Development (OECD) data (2016), U.S. life expectancy is 78.6 years, ranked between the Czech Republic and Turkey. The countries with the highest life expectancy include Japan (84.1 years), Switzerland (83.7 years), and Spain (83.4 years). Within the U.S., life expectancy ranges by state as well: Minnesota (81.1 years) to Mississippi (75.0 years).[11]
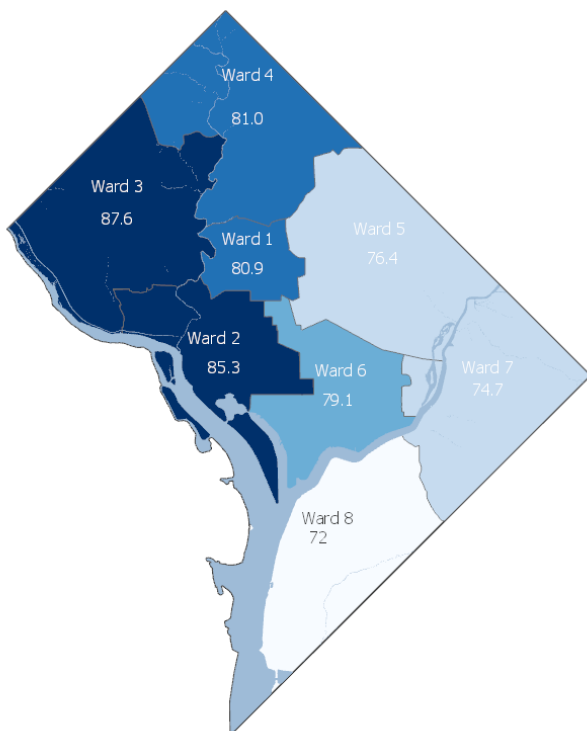
Infant Mortality

Infant mortality is defined as an infant who dies before reaching one year of age. The DC infant mortality rate (IMR) decreased from 13.1 per 1,000 live births in 2007 to 7.1 per 1,000 live births in 2016, yet continues to exceed the DC Healthy People 2020 target of 6.0 per 1,000 live births.[12]

Large disparities persist in the IMR by race and place: DC's IMR was significantly higher for infants of Black mothers compared to infants of Latina and White mothers (11.5, 5.3, and 2.6 per 1,000 live births, respectively). During the five-year period 2012-2016, Wards 5, 7, and 8 had the highest infant mortality rates of 9.2, 9.3, and 14.6 per 1,000 live births, respectively. During 2015-2016, these three wards accounted for 44% of all live births yet 66% of all infant deaths. These three wards also have the highest rates of poverty and unemployment, and the lowest level of educational attainment across the city. In contrast, the IMR in Wards 2 and 3 (two of the wealthiest wards) was about 2.2 per 1,000 live births.

Life expectancy and IMR are but two examples of the extreme inequities that exist within the boundaries of DC. To further highlight the disparities across the city, Table 2 compares selected metrics for residents in Ward 3 (the wealthiest ward) and Ward 8 (the poorest ward): it is clear that the disparities across the city are not limited to life expectancy and IMR.

As part of this 2019 CHNA effort, the Collaborative continues to update DCHealthMatters.org to provide additional demographic and socioeconomic indicators of the DC population – from a citywide, census tract, and ward perspective – with a focus on variations in age, race, ethnicity, education, and poverty.

Figure 2: Life Expectancy by Ward, 2011-2015

Source: DC Health Equity Report, February 2019

Figure 3: Infant Mortality by Ward, 2012-2016
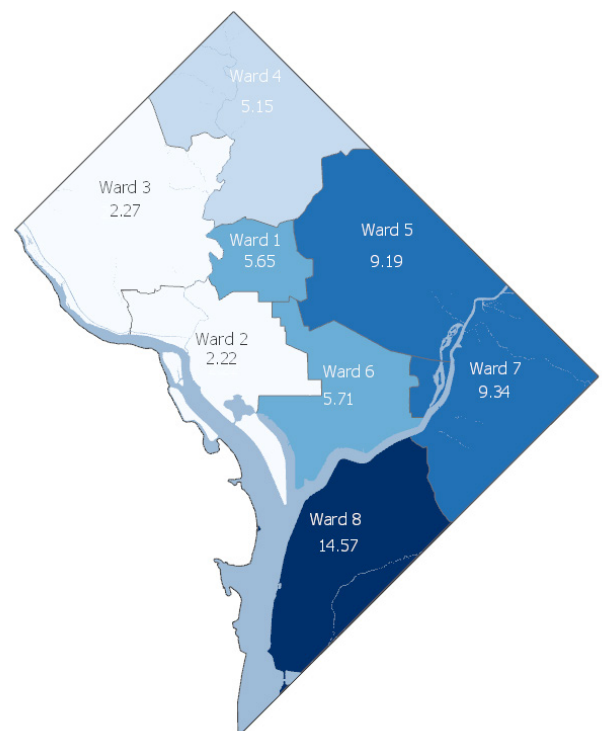
Source: DC Health Perinatal Health Report, May 2018

Community Assets

All communities have needs that require attention. However, it is important to understand each community's assets and strengths, as well. A community asset is anything that can improve the quality of life in a community. This broad definition can range from people to physical structures to community services. The DC community is rich with assets such as parks, libraries, and recreation centers. Our strongest asset is our people – diverse, inclusive, and active.

*"Being a diverse city makes us great ̣
and being a safe space for diversity."*

– Focus Group Participant

For a relatively small geographic area, DC has a high concentration of assets. However, these assets are not always dispersed in an equitable manner across the city. As part of this 2019 CHNA, we have created a map gallery on our web portal – DCHealthMatters.org – to provide a visual understanding of the distribution of physical assets in DC, including, but not limited to, recreation ce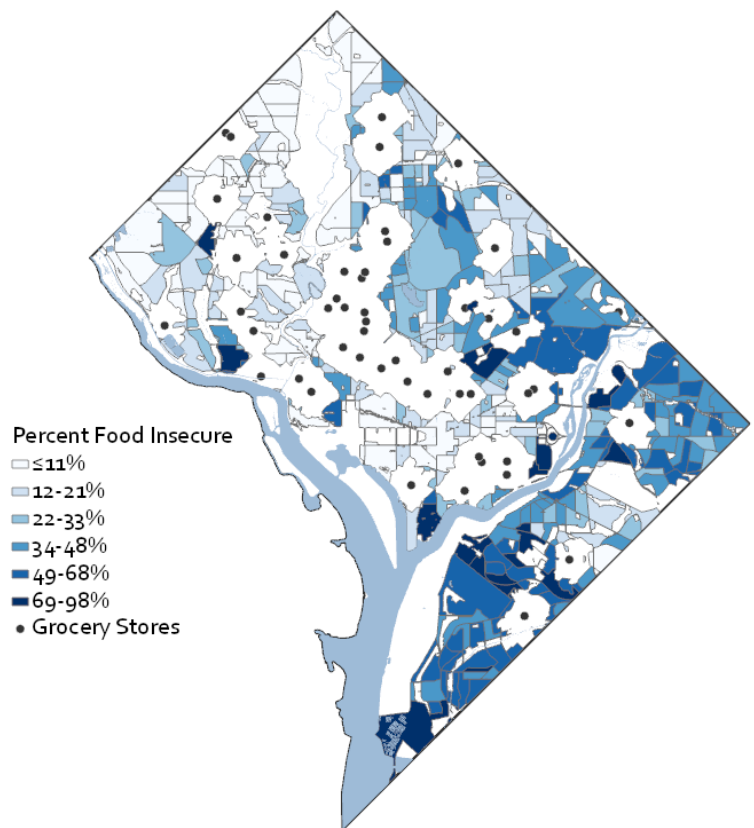nters, public schools, grocery stores, places of worship, park space, and pharmacies. Below are a few notes about these specific assets:

- **Public Schools:** DC is home to 92,245 K-12 students and 264 schools. More than half of the students (52.7%) attend DC public schools and 47.3% attend public charter schools.[13] Schools are anchor institutions in neighborhoods, offering meeting places and programs for families in addition to being centers of learning for young people. Seven DC schools have school-based health centers overseen by DC Department of Health, where students have access to comprehensive primary health services. These centers are focused on the prevention, early identification and treatment of medical and behavioral concerns that can interfere with a student's learning and improve attendance. In addition, every school has a school nurse to improve the health of students, enabling them to thrive in the classroom and beyond by creating greater alignment, integration, and collaboration between education and health.

- **Community/Recreation Centers:** Neighborhood residents often look to their community recreation centers as trusted gathering venues. To date, DC has 65 community/recreation centers. Additionally, many of these facilities offer fitness centers with a variety of wellness activities and exercise equipment. In 2016, Mayor Bowser announced that as part of the FitDC initiative, DC would waive resident fees at these fitness centers. Fitness centers exist within Wards 1, 4, 5, 6, 7, and 8.[14]

- **Grocery Stores:** There are plenty of grocery stores and independently owned supermarkets in wealthier parts of the District, like Northwest DC; however, grocery stores are rare east of the Anacostia River. [See Figure 4.] Currently, there is only one supermarket in Ward 8 and two in Ward 7, neighborhoods with a combined population of about 160,000 people. However, these supermarkets are sometimes undersupplied and often do not have WIC eligible foods available. In 2019, Ward 8 will add a full-service grocery store – Good Food Markets – as

part of a mixed-use development property in the Bellevue neighborhood. For customers who receive Supplemental Nutrition Assistance Program benefits (i.e., food stamps), Good Food Markets will provide an additional 15% discount on all fresh produce.

- **Places of Worship:** Places of worship are well distributed across the city and are especially well established in Wards 7 and 8. The Leadership Council of Healthy Communities (LCHC) identifies more than 30 places of worship in Ward 8 alone.[15] DC is also home to a variety of synagogues, mosques, and temples across the city.

- **Park Space:** DC boasts a wealth of green space, which comprises 20% of its land; 90% is owned and operated by the National Park Service (NPS). The Trust for Public Land (a national environmental group) ranks DC sixth out of 60 cities with regard to access to public parks. Rankings were calculated using three factors: park size, accessibility to residents, and how much each city spends on systems for park programs and maintenance. Park planning based upon age of residents is needed. Play space may be lacking for all ages, especially middle school students.

Figure 4: Food Insecurity and Grocery Stores, 2011-2015

Percent Food Insecure
- ≤11%
- 12-21%
- 22-33%
- 34-48%
- 49-68%
- 69-98%
- Grocery Stores

Source: District of Columbia GIS Office. Accessed at https://opendata.dc.gov/datasets/low-food-access-areas (May 2019)

- **Pharmacies:** Pharmacies are important community assets, especially among populations with high rates of chronic illness. Pharmacies have long been in short supply in Wards 7 and 8 despite those areas being home to a high percentage of residents with chronic illness that require medications. As of 2018, there are 22 pharmacies in Wards 7 and 8. There were 17 in Ward 1, which is about half as populous as Ward 7 or 8.[16]

- **Hospitals and Community Health Centers:** The District is home to eight acute care hospitals and several federally qualified health centers (FQHCs) that provide comprehensive primary and specialty care. Among the eight hospitals, the following are part of the DC Health Matters Collaborative: Children's National, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital. The Collaborative's newest member is the HSC Health Care System, which is comprised of a health plan, pediatric specialty hospital, home health agency, and rehabilitative therapy centers. As for primary care, the District's FQHCs have 52 locations in DC that provide care largely to low-income residents covered by Medicaid and living in households earning less than 200% of the federal poverty level. The following FQHCs are members of the Collaborative: Bread for the City, Community of Hope, Mary's Center, and Unity Health Care. There are hundreds of other non-profit and private practices that provide primary care services to residents.

The Landscape Beyond the Numbers

In closing Chapter 2, we highlight six pressing issues that DC residents have faced – some unique to DC and others shared across the nation – since our 2016 CHNA. These issues are commonly referred to at the Collaborative's community gatherings – be they public forums, focus groups, or workgroup meetings – as critical areas of concern among our community partners and DC residents:

- Closure of Hospitals
- Shortage of Birthing Facilities
- Threats to Immigrant Health
- Gentrification
- Suicide Among Teens
- Opioid Abuse

We provide here a short synthesis of each issue along with selected references for those who would like to learn more.

Closure of DC Hospitals

Providence Health System in Ward 5 – DC's longest continuously operating hospital – closed inpatient psychiatric and acute care services in 2018-2019. Until the end of April 2019, Providence continued running a scaled-back emergency department, after ending most acute-care services in December 2018. The closure was contested by many DC residents, as well as Catholic and union leaders, who accused Ascension, Providence's parent organization, of abandoning its religious mission to serve poor patients. Providence is now working to develop a "Healthy Village" that focuses on primary and preventive care. The first large investment in the village will be bringing an urgent care center to the campus.

Providence serves some of DC's poorest neighborhoods; 86% of its patients are on Medicare or Medicaid.[17]

Some stakeholders argue that the District has one of the highest hospital bed-to-population ratios in the nation, making it possible, in theory, for the other DC hospitals to absorb Providence's patient population. However, other hospitals are maldistributed across the city, making it difficult for residents in Wards 5, 7, and 8 to access care. [See Figure 5.] DC Council hearings on this issue can be found on the DC Council website.[18]

Shortage of Birthing Facilities

In late 2017, DC saw the closure of two hospital maternity wards that served predominantly Black and low-income women: Providence Health System in Ward 5 and United Medical Center (UMC) in Ward 8. Providence Hospital in Northeast closed its maternal and infant care department in October of 2017 (a year before closing acute care services); United Medical Center in Southeast DC, the city's only public hospital, permanently closed its maternity unit

Figure 5: Hospitals in DC by Ward in 2017
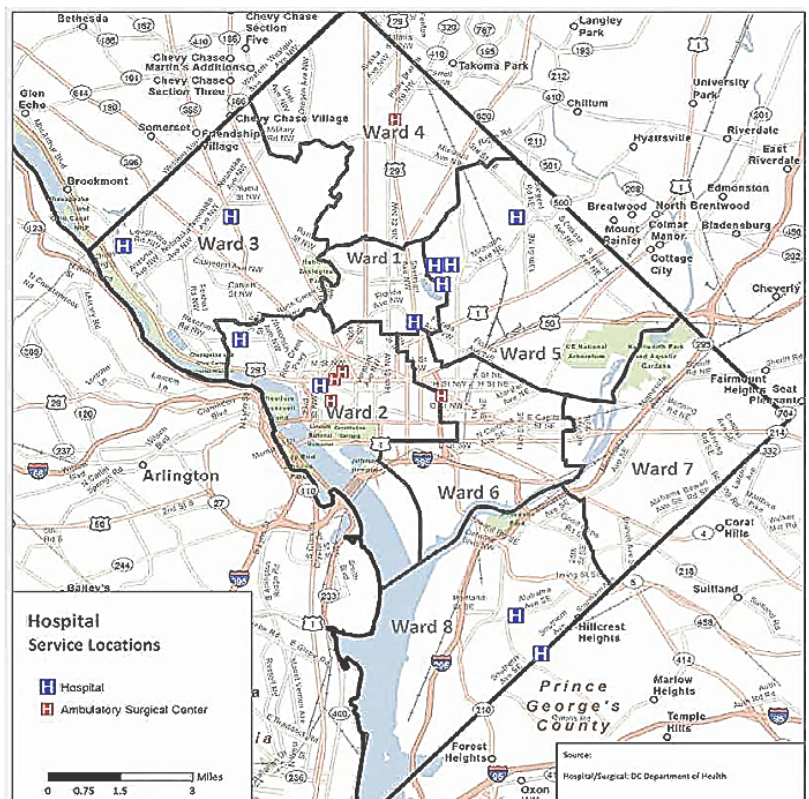
Source: DC Health Systems Plan, 2017, accessed at https://dchealth.dc.gov/node/1274961 (June 2019)

and prenatal services two months later. Additionally, DC Department of Health Care Finance did not renew MedStar's managed care arm – Family Choice – for one of three five-year managed-care contracts; this further limited access to birthing services at Washington Hospital Center (a MedStar facility) for Medicaid-insured women. DC women, particularly those who live in the east end of the city, are finding it difficult to access maternal care, including prenatal, delivery, and postnatal services. The impact of these closures on maternal and child health outcomes for the residents of the District, particularly those living closest to UMC, remains uncertain and a concern.

As of October 2018, DC's rate of maternal mortality was 36.1 per 100,000 live births, while the nationwide rate is 20.7, according to an analysis of data from the Centers for Disease Control and Prevention.[19] Internationally, the U.S. is the only developed country to show a steady increase in maternal mortality from 1990-2015, according to a 2017 report funded by the Bill & Melinda Gates Foundation.[20]

Black women are three to four times more likely than white women to die from childbirth in the U.S. The District is a case in point. DC's chief medical examiner testified at a December hearing on maternal mortality that 75% of the maternal deaths DC recorded between 2014 and 2016 were Black women.[21] A documentary from *The Atlantic* – "Maternity Desert" – follows a 24-year-old Black woman living in Southeast DC as she navigates a high-risk pregnancy that, combined with her Medicaid coverage, requires her to visit a hospital every two weeks to be seen by an Ob–Gyn.[22] Her experience is shared by many pregnant women in DC.

These issues of access and equity are present alongside high infant mortality and teen pregnancy rates, creating what some perceive as a maternal care crisis in DC. To address this, DC Council established a Maternal Mortality Review Committee[23] within the Office of the Chief Medical Examiner to determine the causes associated with maternal mortalities of District residents. The law went into effect in June 2019 and MMRC members were beginning to be sworn into office.

Threats to Immigrant Health

Comparable to many towns across the U.S., issues of immigration – and, particularly immigrant health – are top of mind for DC residents. In 2015, 95,117 immigrants comprised 14.1% of DC's population: 48,047 women, 42,852 men, and 4,218 children. The top countries of origin for immigrants were El Salvador (15.3% of immigrants), China (4.9%), Ethiopia (4.7%), Mexico (4%), and India (3.9%). An enduring concern among immigrant families, as well as the healthcare community, is immigrant access to health and prevention services, such as annual check-ups, immunizations, and chronic care.

DC Healthcare Alliance is a unique benefit funded by local dollars offered to residents not eligible for Medicaid, primarily recent or undocumented immigrants. It is a popular program, but participation in the Alliance program has remained relatively flat in recent years while the immigrant population has grown. [See Figure 6.]

Administrative and logistic barriers may make it difficult for the immigrant community to use health and well-being services. An example of an administrative burden is the need for face-to-face interviews every six months at a DC social service center to maintain coverage in the Immigrant Health program. In contrast, DC residents with Medicaid coverage only need to renew every 12 months and can do so online if they choose. This type of barrier is particularly

Figure 6: DC Alliance Enrollment, July 2010-November 2017
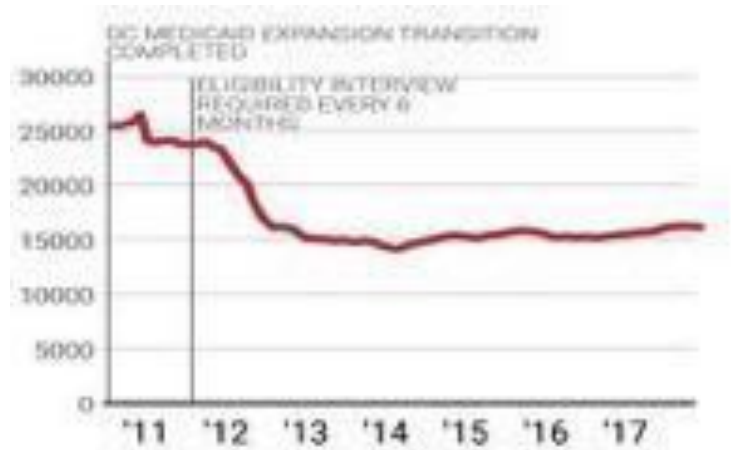
Source: DC Department of Health Care Finance. Accessed at https://dhcf.dc.gov/page/monthly-medicaid-and-alliance-enrollment-reports (April 2019)

"Things like gentrification, housing, community violence, and safety aren't always thought about from this public health perspective, so connecting those dots is going to improve so many outcomes that we're all collaboratively working towards."

– Town Hall Participant

painful for immigrant residents, who are grappling with hostile federal policies that make accessing public benefits a fearful, intimidating process.

Also, "public charge" fears may be hindering participation in the program. Public charge is the degree to which an individual is likely to become "primarily dependent on the government for subsistence, as demonstrated by either the receipt of public cash assistance for income maintenance, or institutionalization for long-term care at government expense."[24] The meaning of "primarily dependent on" has been changed by the current federal administration to the extent that immigration officials could turn away immigrants seeking to come to or remain in the US if they have received, or are judged likely to receive in the future, benefits tied to need. Individuals who are likely to become a public charge are inadmissible to the US and ineligible to become lawful permanent residents, though this has historically not been an issue since most need-based programs are not available to non-citizens.

Two pieces of legislation passed by the DC Council have sought to ease barriers. One allows undocumented beneficiaries to re-apply for the program over the phone, and the other allows beneficiaries to re-apply just once a year and at community health centers, where people often feel more comfortable. The DC Fiscal Policy Institute estimates that these changes could increase the number of people covered by 1,600-6,000 enrollees. While both bills were passed unanimously into law in 2017, they were not fully accounted for in the budgets for Fiscal Year 2018 or 2019.[25]

Gentrification

Gentrification is a process of renovating urban neighborhoods. It is a common and controversial topic in politics and urban planning, as gentrification can improve the material quality of a neighborhood while pricing out and displacing current, established residents and businesses. In addition, displacement has many health implications that contribute to disparities among special populations, including the poor, women, children, the elderly, and members of racial/ethnic minority groups. These special populations are at increased risk for the negative

consequences of gentrification, including increased stress and poor mental health. In DC, several neighborhoods are undergoing gentrification, including Columbia Heights, Navy Yard, and Petworth. [See Figure 7.]

DC residents worry that rising housing costs will drive low-income residents out of their neighborhoods, with upscale developments such as the $2.5 billion construction of The Wharf. The National Community Reinvestment Coalition's study found that the District had the highest percentage of gentrifying neighborhoods out of all the cities analyzed (2000-2013).[26] Frustrations have risen to the level of lawsuits. A lawsuit against the government filed in 2018 alleged that around 39,000 Black residents had been forced out of the city from 2000-2010, while the area gained 50,000 White residents.[27] In another example, low-income Black residents won a case against the DC Housing Authority, temporarily stopping the $400 million planned razing and redevelopment of Barry Farm, one of the city's largest public housing complexes.

Suicide Among Youth

Teen suicide is a growing health concern nationally, as well as within DC. It is the second-leading cause of death for young people ages 15-24, surpassed only by accidents, according to the US Centers for Disease Control and Prevention.[28] Mental illness is the leading risk factor for suicide.

Figure 7: Gentrification and Displacement in DC Neighborhoods, 2000-2013
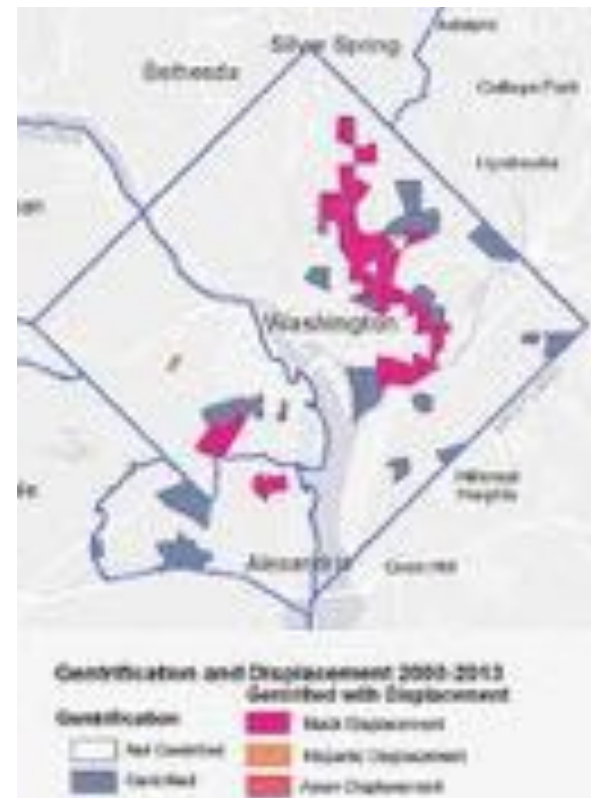
Source: NCRC, "Shifting neighborhoods: Gentrification and cultural displacement in American cities," 2019. [Note: map from 2000-2013 notes no Asian or Hispanic Displacement in DC at that time.]

In February 2018, the Office of the State Superintendent of Education (OSSE) released the 2017 DC Youth Risk Behavior Survey (YRBS) report, which provides a broad analysis of youth health risk behavior, including a deep dive into the mental health of DC's youth. The survey revealed that about 17% of high schoolers in the District reported having attempted suicide in 2017 – compared to about 7.4% nationally.[29] A closer look at the District's racial/ethnic minority and sexual minority youths reveals even more startling statistics. [See Figure 8.] Black and Latinx high schoolers in the District reported a rate of attempted suicide three times that of White students. And nearly a third of lesbian, gay, or bisexual high schoolers reported attempting suicide in the past year, compared with 1 in 8 heterosexual high schoolers. The mental health of DC's youth remains a pressing issue among our community. More information is available via the YRBS report.[30]

Figure 8: Suicide Attempts among DC High Schoolers

Source: District of Columbia Youth Risk Behavior Survey, 2017. Accessed at https://osse.dc.gov/service/dc-youth-risk-behavior-survey-yrbs (April 2019)

Opioid Abuse

Opioids are a class of drugs that includes the illegal drug heroin,

synthetic opioids such as fentanyl, and pain relievers available legally by prescription, such as oxycodone, hydrocodone, codeine, morphine, and many others. With prolonged use, pain-relieving effects may lessen and pain can become worse. In addition, the body can develop dependence. Opioid abuse and addiction have become a national crisis – and this drug epidemic hits close to home.

The District has one of the highest rates of opioid abuse in the United States. The number of people who have died from opioid-related overdoses in the District has more than tripled over three years. [See Figure 9.] About 279 people in the District died in 2017 from opioid overdoses, up from 83 people in 2014, according to District figures. The majority of deaths was among Black residents, and most were adults aged 40-69. Fatal overdoses were more common among men, and were most prevalent in Wards 7 and 8.[31]

Now, DC has released a plan aimed at dialing back those numbers. The plan, known as LIVE. LONG. DC., has seven broad goals focusing on prevention, treatment, and recovery.[32] Under the initiative, DC will

Figure 9: Opioid Deaths in DC and US Populations, 1999-2016
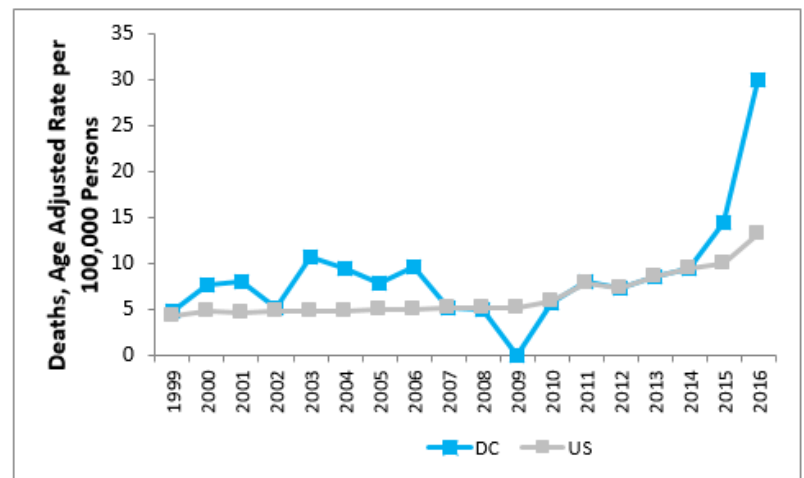
Source: Centers for Disease Control and Prevention WONDER Online Database, Multiple Cause of Death Files, 1999-2016. Accessed at https://wonder.cdc.gov/ (April 2019)

establish a review board to examine opioid-related deaths and launch programs to educate residents on the risks of drug use. A federal grant will largely fund the roughly $24 million initiative.

DC released its plan days after a *Washington Post* investigation found the city lagged in responding to the opioid crisis. According to the Post, District officials distributed the overdose reversal drug Naloxone at a lower rate compared to cities with similar opioid problems.

Conclusion

The District is a unique and dynamic city, with a diverse population and many community assets. At the same time, we face many of the same health issues as other urban areas. Further, we see startling segregation and health disparities. This chapter provided an abbreviated backdrop to DC's geography, demographic, and socioeconomic characteristics, community assets, and pressing issues. The four CHNA priority areas – mental health, care coordination, health literacy, and place-based care – remain critical areas of focus in our ever-changing DC landscape. More detailed information, particularly related to socioeconomic and health metrics, is available at DCHealthMatters.org.

Chapter 3: Methods

The 2019 CHNA used a structured, mixed-methods approach – a combination of qualitative and quantitative data – to delve deeper into stakeholder perspectives on four priority needs that the DC community identified in the 2016 CHNA: mental health, care coordination, health literacy, and place-based care. As the Collaborative's assessments have evolved from the initial 2013 version to the current 2019 CHNA, our emphasis on non–clinical determinants of health, community engagement, health equity, and shared ownership continues to grow.

The DC Health Matters Collaborative has conducted three community health needs assessments (CHNAs) that were released in 2013, 2016, and 2019. The methods we used across these three assessments share many attributes, but there are also some key differences. All of the Collaborative's CHNAs relied on a mixed methods approach that integrated both quantitative and qualitative data:

- **2013:** The assessment methods focused heavily on quantitative data and identified four clinical priorities: obesity, sexually transmitted infections, asthma, and mental health.

- **2016:** The assessment methods prioritized the role of qualitative data (community perspectives) in defining new priority needs and shifted our focus from clinical areas to broader non-clinical determinants of health. The assessment identified four priority needs: mental health, care coordination, health literacy, and place-based care.

- **2019:** The assessment methods continued to prioritize the input of community stakeholders while using the quantitative data to provide contextual information. The 2019 CHNA focused on gathering community perspectives on how the healthcare system and partners can use policy and systems changes to address the four priority areas identified in the 2016 assessment: mental health, care coordination, health literacy, and place-based care.

As the Collaborative's assessments have evolved from the initial 2013 version to the current 2019 CHNA, our emphasis on non-clinical determinants of health, community engagement, health equity, and shared ownership continues to grow.

Overview of the 2019 CHNA Process

For the 2019 CHNA, the Collaborative worked over a 16-month period – November 2017 through February 2019 – to design the assessment, collect and analyze data, meet with community stakeholders, and draft the final report.

Each Collaborative member organization contributed to the assessment. Individuals with advanced public health research expertise and data analytics skills led the design and data efforts, trained facilitators led qualitative data collection, policy experts connected emerging findings to policy initiatives, and editors reviewed the final product for cohesion and clarity. In addition to internal reviewers, representatives from the Collaborative's Community Advisory Board also reviewed the findings to ensure that they resonated with their experiences.

Assessment Focus: Policy and Systems Changes

The focus of this 2019 CHNA is to gain information that strengthens and/or identifies policy and systems actions that can make a positive difference in our four priority areas: mental health, care coordination, health literacy, and place-based care. Our work builds upon the 2017-2019 CHIP, which was the Collaborative's first foray into addressing community needs using a policy and systems lens.

Policy change involves changes in policies at the legislative or organizational level. Policies are written rules that are enforceable and impact groups of people.

Systems change involves changes made to the rules within or across organizations. It is an intentional process designed to alter the components that cause the system to behave in a certain way.

Policy and systems approaches go beyond addressing community needs with "new programs"; rather, they alter the systems that create the structures in which we work, live, and play. Policy and systems changes work hand-in-hand. Often systems changes focus on organizations changing their rules and infrastructure or instituting processes at the higher system level that ensure a healthier workplace; these systems changes can result in broader policy changes.

Study Design: Concurrent Nested Design

The 2019 CHNA uses a concurrent nested study design. This design uses multiple approaches to collect data, but prioritizes one approach that ultimately guides the project. In our case, we prioritized qualitative methods that focused on collecting community perspectives. The other approach – collecting quantitative data – is embedded or nested into the project and plays a supporting role. Traditionally, assessments often prioritize quantitative methods and use qualitative data (such as community input) to further explain, corroborate, or discount the quantitative findings. We have flipped that model to ensure that the qualitative data (community's perspectives) drive our work, with the quantitative data playing a secondary explanatory role.

Qualitative Data

We collected the qualitative data through semi-structured interviews with invited community stakeholders, as well as a series of focus groups. Our assessment team included trained qualitative researchers who provided guidance about the research methods, assisted with the data collection, and conducted structured analysis of the large volume of recorded data using Dedoose coding software.

The interviews (n = 32) and focus groups (n = 7) followed a semi-structured format and utilized similar sets of questions related to how policy and systems changes can address our four priority areas with a particular focus on elevating health equity in our city (Appendix 1). Under the guidance of our qualitative research experts, Collaborative leadership and community partners facilitated the interviews and focus groups. All interviews and focus groups were digitally recorded.

Table 3. Qualitative Data Sources

Data Source	#
Organizations Represented	118
Key Informant Interviews	32
Focus Groups Participants	67
Council Members/ANCs	7
Town Hall Attendees	53

Qualitative Data Source: Community Stakeholders

We engaged community stakeholders from a variety of sectors including, but not limited to, health, education, transportation, social service, and advocacy, as well as government officials and agencies. Table 3 (previous page) includes a summary of the participants.

Our efforts were focused at the organization level rather than the DC resident level. We drew DC resident perspectives from other local needs assessments, as described in Appendix 3, and will be engaging directly with DC residents as we develop the Community Health Improvement Plan (CHIP). The Collaborative looks forward to learning from DC Department of Health's citywide resident-level survey that assesses community perspectives on health and well-being. The survey data collection period is May 2019 – July 2019, with publication of results in November 2019.

Qualitative Data Analysis Methods

We used the Rapid Identification of Themes from Audio (RITA) method to analyze the interview and focus group data within the Dedoose qualitative software.[33] This unique data analysis method allows researchers to work directly from audio recordings of the interviews and focus groups rather than the traditional qualitative method of coding from transcribed documents. Working directly with the audio files allows for a more efficient, less costly data analysis approach that can capture nuanced vocal expressions that are not as easily apparent within written transcripts.

The RITA method identifies themes by tabulating the frequency of themes in standard time intervals across the data. The analysis occurred through a six-step process:

Step 1. Identify research foci

The assessment focused on identifying specific policy and systems actions that health systems and community organizations can undertake to improve mental health, care coordination, health literacy, and place-based care in the city.

Step 2. Develop a codebook

The codebook lists and defines codes. These codes were informed by the findings of the 2016 CHNA, existing research, field notes taken by the focus group leaders and interviewers, and the review of a subset of the focus group and interview data.

Step 3. Designate time intervals

We divided the audio data into standard two-minute intervals to balance the desires between retaining the specificity of the data and capturing participants' complete ideas. The research team also generated a coding grid listing each code as a row and columns for each two-minute interval.

Step 4. Refine the codebook

Refining the codebook involved checking a randomly selected subsample of the interviews and focus groups to ensure that the codebook reflected all codes represented in the data accurately.

Step 5. Code data

Coding involved identifying the presence of ideas/constructs within each time interval. Two qualitative researchers independently coded each interview, and differences were resolved through consensus.[34] Codes were grouped into larger themes. Themes present in at least 15% of CHNA interviews and focus groups are included in this report.

Step 6. Summarize codes into themes

We identified a total of 28 themes across the four priority areas. The themes were then organized into four action areas: Foster Community Dialogue, Build Relationships, Develop Workforce Capacity, and Simplify Paths to Wellness.
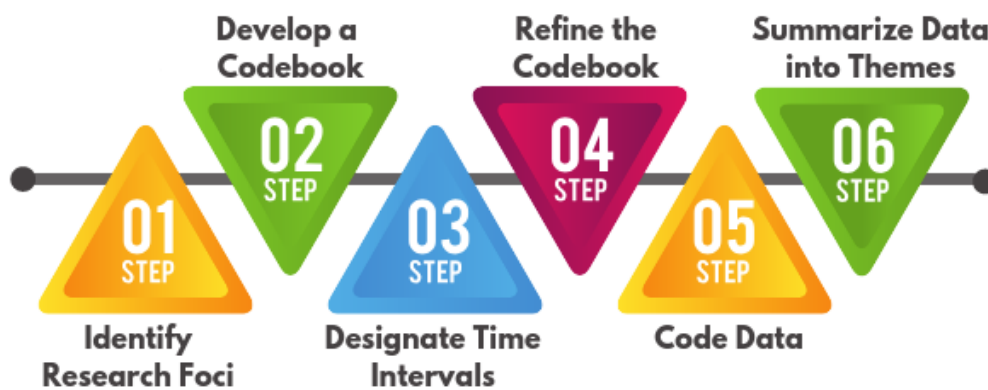
Town Hall Conversations

As described above, we focused most of our data collection at the organization level, while drawing on resident-level surveys and conversations convened by other groups. [See Appendix 2: Scan of Assessments for details on MedStar Health's CHNA and DC Health's Health Systems Plan.]

In February 2019, after coding results, we convened a town hall event at a DC community venue – The Hill Center at The Old Naval Hospital – with three objectives:

1. Share key themes from the CHNA data collection to date;
2. Probe for more details related to the themes;
3. Collaborate with stakeholders and community partners to prepare for future action.

More than 50 community stakeholders across a wide area of disciplines and sectors attended the town hall. Photos and insights – including feedback and details related to the themes presented – are woven throughout this report and will inform our upcoming CHIP efforts. Attendee participation, energy, and feedback corroborated our sense of a renewed energy to work in partnership to improve health and well-being among DC residents. We will host more community gatherings as a centerpiece of our CHIP efforts; feedback from residents and organizations on our proposed strategies will be fundamental to achieving our goals.

Photovoice: A Pilot Project to Capture Community Voices

Photovoice is a qualitative method used in community-based participatory research that gives voice to underrepresented populations through the use of photography. Photovoice programs are a structured creative process through which people express their voices, opinions, and raise awareness about a topic in the community.

In an effort to bring diverse voices into our assessment, and to partner with more community-based organizations, the DC Health Matters Collaborative sponsored a Photovoice project in collaboration with the Latin American Youth Center (LAYC) in the spring of 2019. Seven high school students, representing a diverse group of DC high schools, were selected and compensated to participate in a 12-week Photovoice aterschool program. LAYC staff led the students through a series of educational activities related to mental health topic as well as Photovoice concepts. After discussing these topics together, participants went out into the community with cameras to capture their perspectives related to risk and protective factors related to mental health in their community and schools. The photographs were taken at community settings in Wards 1 and 2 as well as a public high school (Columbia Heights Education Campus). Select photographs were interpreted through discussions in a group setting and narratives were developed that explain how the photos respond to the research question. These selections were printed on canvas and participants presented two exhibits – one at Latin American Youth Center and another for Community Health Improvement Week at Children's National. A sample of the Photovoice images and accompany text follows this chapter.

Quantitative Data

The quantitative data reflect various attributes of our DC population, including demographic, socioeconomic, health status, and healthcare utilization metrics. Our assessment team included trained public health and data analytics experts who led the data collection, analysis, and reporting of the metrics.

All of these metrics are available on our DCHealthMatters.org portal. As described in Chapter 1, this interactive web portal is a one-stop resource for community health indicators and related resources that are tailored to the DC community. DC Health Matters' customizable Community Health Dashboard tool allows for comparison of DC metrics against national averages, past trends, and Healthy People 2020 goals. The portal also includes a Disparities Dashboard to view data by race, age, and gender. More comprehensive – and continually updated – data are available at DCHealthMatters.org.

Several chapters in this CHNA report include relevant quantitative data to add context and clarity. The Collaborative also used the quantitative data to guide internal discussions related to the qualitative themes that were derived from conversations with our community stakeholders.

Quantitative Data Sources

We collected the quantitative data through several secondary data sources, such as census population data, local surveys, surveillance data, and administrative healthcare records (primary care, hospital admissions, and emergency room visits). Below is a description of select data sources.

Census Bureau and American Community Survey

We used the Census Bureau's population estimates and the American Community Survey data to arrive at a description of the DC population. These population estimates are commonly used in federal funding allocations, as survey controls, as denominators for rates, and as indicators of recent demographic changes. We supplement these two data sources with Claritas estimates that provide enhanced 2010 Census data and extrapolations.[35]

Table 4. Quantitative Data Sources

Data Source
Census Population Estimates
Claritas Population Estimates
Decennial Census
American Community Survey
Youth Risk Behavior Surveillance System
National Survey of Children's Health
National Survey of Children with Special Health Care Needs
DC Perinatal Health and Infant Mortality Report
Annual Epidemiology Surveillance Report
Metropolitan Police Department Annual Report
DC Hospital Association IBM Care Comparison

Note: these are a subset of the data available on DCHealthMatters.org

Survey and Surveillance Data

We relied on several surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS) and Youth Risk Behavior Survey (YRBS), as well as disease surveillance data, to gain a sense of general health status and behavior among DC residents. BRFSS and YRBS are both instruments from the Centers for Disease Control and Prevention (CDC) that are administered by DC Health and OSSE respectively.

Healthcare Utilization Data

We obtained hospital administrative files from the DC Hospital Association to analyze inpatient hospital discharges and emergency department visits for all DC community, acute care hospitals. We accessed primary care data from the Health Resources Services Administration (HRSA) Uniform Data System (UDS). These data sources enabled us to display the rates at which healthcare services are used, the most common reasons for accessing care, and potentially preventable visits. In addition, these utilization statistics can be indicators of the availability and efficacy of preventive and primary healthcare.

Quantitative Data Analysis Methods

Our data analysis methods varied based on the data source. Certain data files, such as the YRBS and BRFSS surveys, were already tabulated, customized for the DC population, and available online; other data sources, such as the healthcare utilization data, required more robust data management and analysis. Statistical analyses were performed using SAS software (SAS software version 9.4; SAS Institute). When possible, we created maps to visually represent demographic, socioeconomic, and health indicators from a geographic perspective. All maps were produced using ArcGIS Pro software (version 2.1, Esri). Data metrics and maps are posted to the DCHealthMatters.org portal.

Action Areas

Our data collection process resulted in a rich collection of 28 themes that focus on how best to address our four priority areas – mental health, care coordination, health literacy, and place-based care – from a policy and systems approach. Guided by the RWJF Action Framework concept, the Collaborative developed and mapped the individual themes into four broad action areas:

- **Action Area 1 – Foster Community Dialogue**: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.
- **Action Area 2 – Build Relationships**: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.
- **Action Area 3 – Develop Workforce Capacity**: cultivate health and social care professionals through approaches that are responsive to the communities and persons they serve.
- **Action Area 4 – Simplify the Path to Wellness**: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

These action areas translate a broad range of themes into four domains of action. These areas will guide how the Collaborative and community partners will respond to the CHNA findings, as will be documented in the upcoming CHIP (release date: November 2019).

Conclusion

The Collaborative used a structured, mixed-methods approach to delve deeper into stakeholder perspectives on four priority needs that the DC community identified in the 2016 CHNA: mental health, care coordination, health literacy, and place-based care. Our methods placed an emphasis on non-clinical determinants of health, community engagement, and health equity. We supplemented the qualitative findings with quantitative data that resides largely on our DCHealthMatters.org portal. Our data collection led to the identification of a substantive list of community-defined themes (actions) that are described in the following chapters. Using the action area framework, the Collaborative will work with community partners to move from identifying actions to addressing them.

Spotlight on Photovoice

Estefany Carranza-Orellana (12th Grade)

Surroundings

The best way to keep from falling deep is to be around people that are open-minded and that listen. TRUE friends are the best people to be around as they are honest and will accept the flaws that are slowly being discovered day by day. These people will be with you through each new discovery, each new episode, and each turning point. Through it all they are with you every step of the way. Being around positive surroundings will help you from submerging into the darkness of your mind and emotions as it will keep you uplifted and in reality.

Reaching Out

Help is not always therapy! It is finding the thing that works for you. Whether it be a book, music, running, swimming, boxing, eating, the best thing is to find your thing. Reaching out for support takes great vulnerability, for many people are afraid to show weakness. As it takes great courage it should also be greatly received. Through this time it is best to know your limits. Finding those coping mechanisms and friends help alleviate your conscience and self-esteem.

Voice

Although many people do not enjoy talking about their personal problems, just talking in general is a great stress reliever. It takes away the boulder that constantly sits on your shoulders. Talking does not mean spilling out every secret that makes you; it just means sitting and having a chat. It can be about anything. Open up to the heavier things when the time arrives. People are able to get through their days by just having a conversation with one another.

Alleviation

As you come to terms with yourself and those around you it makes it easier to go through life. No one is really alone as there are many that go through the same issues. Fly high and soar into the world just like a white dove. Show others that even through the darkness, light has a way of shining through.
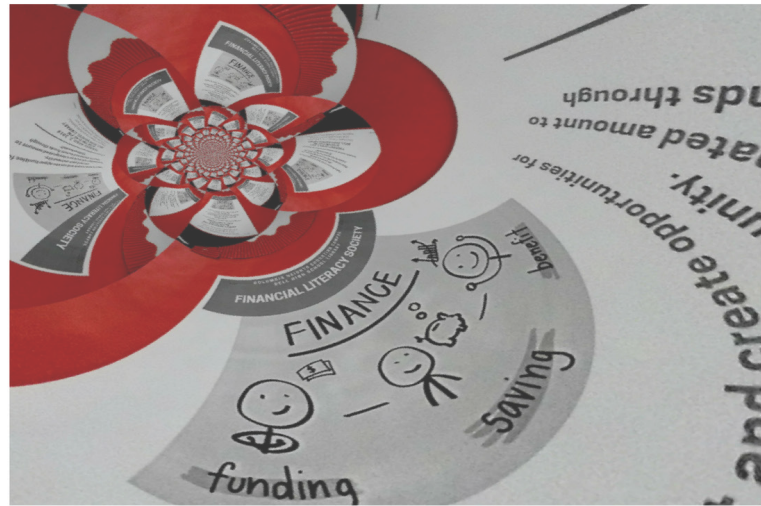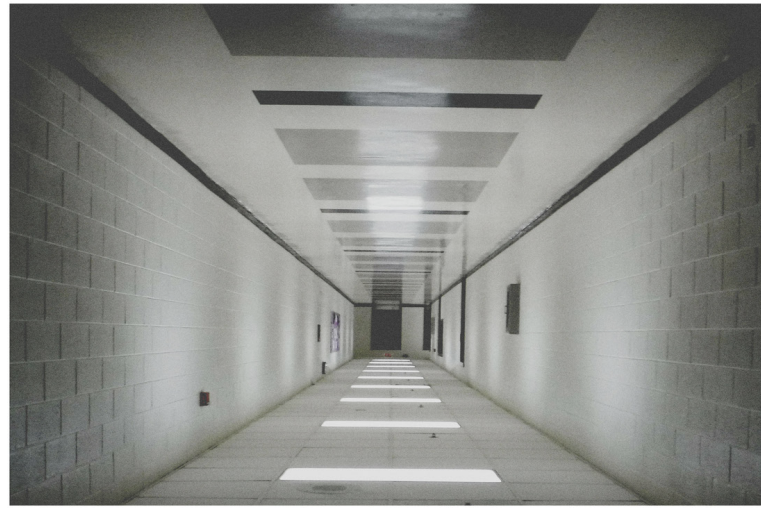
Skylar Hopper-Roberts (12th Grade)

Liquor Tree

This picture shows how your vision is impaired when you are intoxicated. It made me feel terrible because every day I see intoxicated people throw their liquor bottles down or leave their empty six pack cases in my environment and I begin to not only see the harm being done to my community mentally, I see the destruction of my environment that individuals work so hard to keep clean. I do not want the younger generation to think that it is ok to destroy their minds, because addiction is a disease.

Panic Attack

The walls are moving closer, the light is dimming, is the door to success far or close, you can't tell. Are you going to make it to the door or are you going to have a mental breakdown because of the pressure. This flipped hallway is the reality of a senior trying to make it to college. This is my reality every day at my school, I constantly suffer panic attacks or cry by myself because I am scared of failing. This is not healthy and I feel as if schools, especially rigorous academic schools, should focus on the mental state of their students, not just what their GPA looks like.

Gold Is Not Always Right

According to www.secureteen.com 30% of boys are pressured by their peers to take part in sexual activity. Every so often, it is the male peers who direct this pressure towards other teenagers forcing them to have sex even when they are not ready. 23% of girls feel the same kind of pressure. However, even if these individuals give in they are judged by people because of who their sexual partners are, how many times they had sex, if they were "good enough", and if they fail any of these expectations they are teased which leads to suicide, depression, social anxiety, and paranoia.

Financial Plan

In this picture I wanted to capture the good and bad of a financial aid class. It educates you, but it scares you as well, because of all the money you have to think about paying for an education you deserve. You are either stuck paying back loans, or not going to college.
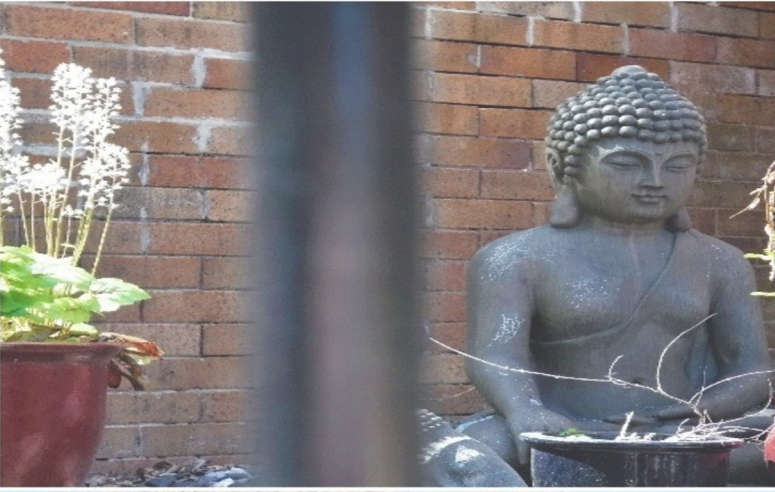
Wendy Blanco (12th Grade)

Dona Nobis Pacem

I titled this picture collage Dona Nobis Pacem, which means grant us peace because we humans deserve peace because conflicts shatter and development occurs.

Our lives are a mixture of different roles, but it is very important to have balance in our lives. Sometimes, there are obstacles and barriers; however, it's not impossible. The pole in the middle of the Buddha picture signifies that. As you see in the left corner of the picture, the flowers have not bloomed yet. This demonstrates that the water and nourishment are needed daily to get to that state. Our minds work similarly as we get older. Here, Buddha was captured because Buddhism is a main form of mental training involving meditation. To be exact, studies have shown Buddhism reduces stress, anxiety and even depression.

Murals offer access to art and creative expressions and here is where we see the difference between murals and graffiti. Murals promote a sense of identity and highlight diversity in one's neighborhood. In the bright mural picture, I saw and felt the color yellow representing happiness, honor, optimism and enlightenment. The brown woman in the middle made me feel inspired to reach for my goals even if they might seem impossible. I can imagine what it might represent to others walking by.

Going to a park in Adams Morgan and watching kids play is ordinary. Yet, have you seen kids play in a playground and know exactly what they want to do and set a plan for the day? The layout of the playground reinforces the idea that toddlers and kids have the ability and access to get on the swings, slides, monkey bars, etc. This enables a good mental health for kids at a young age. This is because at a young age, one can be aware of their actions and enjoy time. Here, the kids demonstrated great time management, communication skills and teamwork.

Hope Moshi (12th Grade)

Climate change is mental health today

According to the National Institute of Mental Health, as of 2017 an estimated 17.3 million adults in the United States had at least one major depressive episode. As for adolescents between 12 and 17 there are an estimated 2.3 million in the United States who experience at least one major depressive episode with severe impairment. The idea behind this collage is to illustrate how the way we treat the environment is a physical image of how we feel on the inside and how it ultimately negatively affects people in return. This trash that we released ourselves is polluting the air and sea, and in return comes back to us as we inhale these bad gases and we see these animals and creatures like turtles going extinct and becoming endangered when they are meant to be holding our planet in balance. Mental health is a struggle for people and while it cannot be seen physically, people express it through the way they treat the environment and the way they treat their surroundings.

These images depict the true form of society's mental health state today, as we see a cut down tree illustrating the bareness mental health can leave on a person, how bare and lonely it is, with no branches to cover it. We see trash near the harbor portraying how no matter how much we try and hide the struggles we have, they can still be seen even if it is just a little spot that no one pays attention to. Lastly the image of the tree with "you're ugly" tagged on the front with an arrow pointing to it is a cry for help. This tag is speaking on behalf of people going through insecurities that have manifested over the years and no one ever admits to their insecurities. However, this tree does it for you as it says what the person feels, and this sign can trigger someone experiencing these insecurities. As of today, we mistreat and misuse our environment which reflects mental health as the data shows 17 million people are struggling with mental health diseases.

Jaden Randolph (11th Grade)

Protect our youth

With this collage the picture that says 'protect children not guns' is a risk factor and protective factor. The reason for this is because in my school specifically we have to go through metal detectors and put our backpacks through an x-ray machine. The officers in school are too worried about cell phones while students are entering the school with pocket knives and lighters.

This is bad, because they are there to protect us, and they are more worried about the cell phones rather than our safety. It's a risk factor because it puts a strain on our mental health because we are worried that someone will get killed since the officers are worried about cell phones rather than weapons.

The sign acts as a protective factor because it is promoting child safety. People playing basketball and taking pictures are examples of things that we can be doing to relieve ourselves from the stress around our safety, that we are faced with every day.

The bus stop also acts as a protective factor of mental health because it is giving us more examples of things that we can do as youth to help us better our mental health.

Overall, our safety affects our mental health and these are some ways that we can relieve our stress.
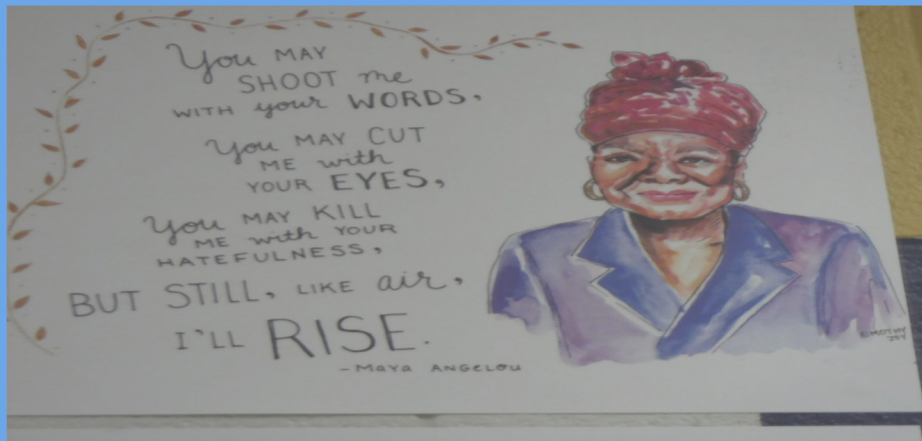
Jordan Hopper-Roberts (10th Grade)

Youth Empowerment

I titled this collage "Youth Empowerment," as this collage shows women encouraging other women to be strong, powerful women who encourage young people to be their best selves and be great. This collage relates to mental health because it empowers young women to have strong emotional wellness in a patriarchal society. I believe it's important for youth to see murals and posters of respected people that will encourage them to be themselves and spread positivity. These posters and murals show youth that if they work hard and believe in themselves they can do anything they put their mind to.

The first picture in the collage affects the mental health of people of color by giving the viewer a feeling of pride, by showing the three people happy. The mural is bright and colorful and gives me a feeling of happiness or pride.

The second picture is of Ruth Bader Ginsburg, an American lawyer and jurist. I chose this picture because it gave me pride to see a woman working in the courtroom. This picture made me feel powerful and encouraged me to challenge myself. This poster connects to mental health because it has a positive effect on women and encourages girls to get outside their comfort zone.

The third picture is of Maya Angelou, an African American author and poet. I chose this picture because it affects my mental health in a positive way. The lines from her poem "Still I Rise" describe how she feels on a daily basis and makes me personally feel inspired. This picture connects to mental health because it encourages people in general to feel good about themselves no matter what others may say.

The last picture is of my sister, taking a picture of a mural of Thomas Edison. I included this picture because I've seen most youth do not take notice in it, whereas Skylar admires it. This image connects to mental health because it shows a member of the community admiring a mural instead of painting over it or defacing it as I've seen done before.

Skylar Hopper-Roberts (12th Grade)

I, Too Am America
Feeling like you belong is important because without identity you are lost. This mural represents diversity, and with diversity comes a sense of identity. This makes me feel happy and accepted, especially during a time where people of color and different ethnic backgrounds are discriminated against by the current president.

Black Girl Magic
Women of color are constantly being mentally abused every day, and told they are not beautiful enough because they don't fit society's idea of beauty. Also, both women are Afro-Latina, a group often misrepresented in the Latino community because they are not considered Latino enough or too African. This picture shows that people of color are beautiful too and that you shouldn't have to starve yourself or bleach your skin to be beautiful. It helps avoid identity issues. This relates to mental health because according to www.factfile.org, "males are 5 to 9 times less likely to have dissociative identity disorder than females." This makes me feel upset, because not accepting who you are can make you feel alone and lost in the world.

They Won't Do It Again
At my school we don't have these posters, and I feel as if this is a problem. This poster gives teenagers knowledge that they can apply to their own life. Teens who suffer dating abuse are subject to long-term consequences like alcoholism, eating disorders, promiscuity, thoughts of suicide, and violent behavior. According to www.dosomething.org 1 in 3 young people will be in an abusive or unhealthy relationship.

La Universidad-Almost There!
Going to college is a very exciting experience, especially for families of color. As a senior I am excited to go to college and can't wait to further my education, however the closer I get the more I feel anxiety about my future and what the world expects of me. I feel as if schools should not only provide counseling, but provide stress relieving activities such as yoga or meditation.

Chapter 4: Mental Health

Mental health is a state of well-being in which an individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to community.[36] The importance of mental health is stressed in WHO's definition of health: "Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."

The 2016 Community Health Needs Assessment (CHNA) identified mental health as a priority need for which the healthcare sector could play a leading role in impacting positive change. Stakeholders noted the following challenges related to mental health in the District in 2016: mental health stigma, disconnection of mental health from primary care encounters, difficulty maintaining engagement with patients through follow-up visits, and substance use. The 2016 CHNA also found that an inequitable distribution of mental health resources across the District — from screenings to therapists and psychiatrists — complicated access to care for residents of under-resourced areas of the District, specifically Wards 5, 7, and 8. The former assessment also identified a shortage of pediatric psychiatrists in the District. The complete 2016 CHNA, as well as supporting quantitative data relating to mental health, can be found on DCHealthMatters.org.

As part of the 2019 CHNA process, the Collaborative conducted a series of citywide interviews and focus groups to probe deeper into how the healthcare system and citywide partners could address mental health issues in the District. This chapter summarizes the top ten mental health themes that resulted from this qualitative data collection process. A detailed description of our methodology is included in Chapter 3.

Ten Mental Health Themes Organized into Four Action Areas

The DC Health Matters Collaborative engaged with more than 300 DC stakeholders to identify policy- and systems-level actions that hospitals, community health centers, and the broader healthcare system should consider to improve mental health care in the District. The most frequent themes are organized into four action areas. These action areas provide the Collaborative with a framework for measurable and sustainable actions across the priorities:

Action Area 1 – Foster Community Dialogue: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.

Action Area 2 – Build Relationships: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.

Action Area 3 – Develop Workforce Capacity: cultivate health and social care providers through approaches that are responsive to the communities and persons they serve.

Action Area 4 – Simplify the Path to Wellness: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

As part of the qualitative analysis, we grouped individual codes from the interviews and focus groups into larger themes for each of the priority areas. The resulting themes and code frequencies related to mental health, organized within these action areas, are below.

These themes will guide the Collaborative's development of the Community Health Improvement Plan (CHIP) and the tangible goals that the Collaborative establishes for improving mental health care in the District.

community dialogue

MH1. Understand community members' perspectives on mental health.	25%
MH2. Educate stakeholders about mental health.	50%
MH3. Gather data about mental health in the District.	22%
MH4. Assess quality of mental health services.	14%

build relationships

MH5. Improve relationships between and within the health system and local government agencies.	47%
MH6. Improve cultural and linguistic responsiveness of mental health services.	28%

develop workforce

MH7. Increase the number of qualified health professionals.	67%
MH8. Recruit, train, and provide reimbursement for community health workers and peer support workers.	19%

simplify path to wellness

MH9. Implement and expand case management.	25%
MH10. Promote mental health integration.	31%

mental health findings

Mental Health Themes Related to Fostering Community Dialogue

The "Foster Community Dialogue" action refers to facilitating communication and collaboration among DC stakeholders, including residents, providers, community organizations, and policymakers. Genuine dialogue is bi-directional, iterative communication whereby all stakeholders have opportunities to express their views and experiences about mental health, including perceived needs, preferences, and resources.

Mental Health Theme 1: Understand community members' perspectives.

Understanding community members' beliefs and perspectives about mental health and related needs and services is essential for designing care systems and interventions that are accessible and responsive. Moreover, involving community members in defining priorities helps to avoid paternalistic approaches, acknowledges community members' agency, and positions the healthcare system as a collaborative partner. Collaborative should gather information about community members' perspectives about mental health, including:

- Concerns and questions about mental health
- Awareness of mental health services available in the District
- Areas of interest for education about mental health
- Barriers and preferences in accessing mental health services

Participants identified grassroots education efforts (e.g., door knocking), social media, and town halls as strategies for gathering these perspectives.

> *"As much as I think we're removing stigma barriers for depression or anxiety or other things that primary care clinics tend to be comfortable with... the conversation just has to continue to evolve on addictions, or we're not going to see as much progress there."*
>
> – Focus Group Participant

Mental Health Theme 2: Educate stakeholders about mental health.

Participants noted that stigma about mental health has decreased since the 2016 CHNA, but gaps in knowledge about mental health and treatment options have persisted. Many providers, policymakers, and community members lack general knowledge about mental health issues and services available in the District.

- **Community Members:** Participants identified gaps in knowledge about mental health as a factor contributing to inequity across the District. In addition to soliciting information from community members about what they would like to learn about mental health, participants noted that knowledge gaps — particularly about mood, personality, and substance use disorders — may also contribute to mental health stigma, which discourages residents from accessing care. Healthcare organizations should also work to inform community members about the availability of services and how to engage those services.

- **Political Entities:** Healthcare organizations in the District should also educate local officials about the urgency of mental health needs in the District, including DC Councilmembers and their staff and Advisory Neighborhood Commissioners, as well as Constituent Services staff for the DC Mayor and Council members. These education efforts should target:
- Acuity of mental health needs in the District
- Volume of services rendered
- Unmet need for services
- Resources required (e.g., funding, personnel, infrastructure) to provide services and meet unmet needs
- Community perspectives on mental health

Mental Health Theme 3: Gather data about mental health in the District.

Participants expressed the need for more comprehensive, in-depth data about mental health morbidity, disparities, and service utilization in the District. These data could be used to design interventions, develop provider training curricula, and inform strategic planning — including where to locate services. Participants noted the need for the following types of information:

- **Diagnoses and procedures:** Identifying common diagnoses/procedures may help inform training needs
- **Numbers served:** Assess the number of patients served, including patient demographics that may allude to health equity concerns
- **Unmet need:** Determine numbers of persons on waitlists, length of time from intake to first session

Participants suggested that the advent of the Chesapeake Regional Information System for Our Patients (CRISP), a health information exchange tool, may offer opportunities to help gather data about mental health service utilization across the District.

Mental Health Theme 4: Assess quality of mental health services.

Participants proposed involving stakeholders in developing an agreed-upon set of quality measures to enable the District to evaluate existing mental health services. Evaluating existing service models (e.g., co-locating mental health services in primary care settings) and programs may help identify approaches that are effective in promoting mental health, preventing and treating illness, and reducing disparities among residents of the District. For example, participants noted that there is not a clear and consistent measurement tool used across the District to identify when behavioral services have been terminated because therapeutic goals have been attained or when services have ended due to other factors (e.g., transfer or referral to another provider, client declining further treatment, and lack of attendance).

Participants felt that reporting standards should encourage consistent reporting while minimizing the burden of reporting these data. Standardizing process and outcome measures may help determine the effectiveness of services. The health system, in conjunction with community members, should identify and implement universal quality measures for mental health, including:

- Possible process indicators: referral data, follow-up completion rates, and patient engagement in treatment following discharge from hospitalization
- Possible outcome indicators: symptom acuity

Participants recommended that quality measures be sufficiently nuanced to capture process and outcome data about patient care while not disincentivizing the provision of services for persons with complex mental health issues. This is especially important because persons with complex mental health issues may simultaneously be most in need of services while having difficulty maintaining consistent connection with mental health and other resources.

Table 5. Citywide Emergency Department and Inpatient Admissions Related to Mental Health, District of Columbia, 2017

CITYWIDE EMERGENCY DEPARTMENT VISITS, 2017			
Mental Health Condition	# ED visits	% ED visits	Cumulative %
ALC-related disorders	5,244	39.1%	39.1%
Substance-related disorders	3,578	26.6%	65.6%
Anxiety disorders	1,140	8.5%	74.1%
Mood disorders	1,012	7.5%	81.7%
Schizophrenia & psych disorders	890	6.6%	88.3%
Suicide/self-inflicted injury	591	4.4%	92.7%
CITYWIDE INPATIENT HOSPITAL ADMISSIONS, 2017			
Mental Health Condition	# admissions	% admissions	Cumulative %
Mood disorders	2,576	51.8%	51.8%
Schizophrenia & psych disorders	1,905	38.3%	90.1%
Anxiety disorders	114	2.3%	92.4%
Delirium	107	2.2%	94.6%
Adjustment disorders	75	1.5%	96.1%
Attention deficit	75	1.5%	97.6%

> *"I'm always baffled by why we can't trust each other and work together. And if we do that effectively, then maybe that feeling of trust would come down to our patients, our families and communities."*
>
> – Focus Group Participant

Mental Health Themes Related to Building Relationships

Building relationships requires trust and genuine collaboration. Community members' distrust of the healthcare system and mental health services contributes to reluctance to seek treatment for psychological, emotional, behavioral, and substance abuse disorders, particularly among racial and ethnic minorities and among immigrants. Similarly, distrust between healthcare organizations may keep providers from sharing promising practices or information about patients/clients. Relationship-building will require providers to address issues that create distrust or discourage collaboration among providers, such as the competitive local and federal grant landscapes, shared patient populations, and lack of funding sources that incentivize collaboration.

Mental Health Theme 5: Improve relationships between and within the health system and local government agencies.

Some participants reported difficulty working with DC Department of Health and the DC Department of Behavioral Health (DBH), including challenges referring patients for services, managing grants, and receiving funding, as well as receiving information from either agency. Participants also noted that they were often unclear about DC Department of Health's and DBH's priorities and roles in coordinating mental healthcare services across the District. Participants identified the creation of an Interagency Council on Mental & Behavioral Health as a possible way to promote collaboration between the health system and DC governmental agencies. This Council would:

- Report directly to the DC Mayor, City Administrator, and Deputy Director
- Identify mental health service models and approaches that are effective for providing services in DC
- Recommend strategies and policies that the District could use to meet the mental health needs of District residents and reduce mental health disparities in the District[37]

Mental Health Theme 6: Improve cultural and linguistic access to mental health services.

Cultural and linguistic issues often result in minority and immigrant residents facing unique contexts that complicate accessing healthcare in the District. Some participants noted that while much focus is given to disparities by neighborhood, there are also elevated risks for mental illness by race or immigration status.

Spotlight on Mental Health Workgroup:
Building a Resilient Mental Health Workforce

The Collaborative's workgroups implement the strategies for policy and system change laid out in the 2016 CHIP. The Collaborative's Mental Health Workgroup identified provider burnout and staff turnover as key barriers to providing behavioral health services through a workforce survey and other information collected. As a response, the workgroup developed and delivered trainings and gathered policies, practices and resources to support self-care for mental health and primary care providers. Additionally, the workgroup held a Building a Resilient Health Care Workforce in Washington DC community convening in October 2018 with more than 30 healthcare providers and professionals from local hospitals, community health centers, government, and education sectors to identify strategies for individuals and organizations to promote mental wellness and self-care in their workplaces. As a result of the convening, participants learned about local workplace wellness programs, initiatives and practices, and discussed strategies to promote and sustain efforts.

Please visit our 2017-2019 Community Health Progress Tracker at DCHealthMatters.org to learn more about the accomplishments of the Mental Health Workgroup.

Table 6. Mental Health Among DC High Schoolers, 2017

Measure	Number (%)
Felt sad or hopeless (almost every day for 2 weeks or more in a row so that they stopped doing some usual activities) in past 12 months	8,175 (27.2%)
Seriously considered attempting suicide	8,153 (15.7%)
Made a plan about how they would attempt suicide	8,176 (15.8%)
Attempted suicide	6,861 (16.0%)
Suicide attempt resulted in injury, poisoning, or overdose that had to be treated by a doctor or nurse	6,690 (6.6%)
Were electronically bullied	8,227 (8.9%)
Were bullied on school property	8,281 (11.5%)
Did not got to school because they felt unsafe at school or on their way to or from school	8,346 (10.0%)

Source: District of Columbia Youth Risk Behavior Survey 2017. Accessed at https://nccd.cdc.gov/Youthonline/ App/Results.aspx (April 2019).

For example, the OSSE Youth Risk Behavior Survey found that Latina high school students in the District were 3.6 times more likely to report suicide attempts as their white female classmates.[38] Racial, ethnic, immigrant, and sexual minorities also face the specter of biases that may contribute to pathological normative behavior. This may be particularly relevant for children's behaviors in schools. A pediatrician discussed disparities in how children's behaviors might be perceived and referred for behavioral services across the District:

> *From a behavioral health perspective, there are behaviors that are developmentally appropriate and tolerated in some parts of the city that are not tolerated in other parts of the city. Behaviors that are tolerated in Ward 3 get a child in detention or expulsion from daycare or school in Wards 7 or 8. That inequity creates a labeling of children. From a behavioral health perspective, there is a need to make sure that there are clinicians who are willing to call out the question as opposed to immediately prescribing medication. This is a critical component of care for kids in the city.*

Recruiting, retaining, and training mental health providers who understand the challenges facing minority residents and can provide care in ways that are culturally and linguistically responsive is key for enhancing the capacity of the mental health workforce across the District.

- **Recruit and retain linguistically diverse clinicians:** Participants noted that there was a shortage of Spanish and Amharic-speaking clinicians across the District. Increasing the number of clinicians who are able to provide services in Spanish and Amharic will reduce barriers for residents seeking care.
- **Trauma-informed care:** Residents in Wards 5, 6, 7, and 8 face elevated risks for exposure to community violence. The healthcare system and mental health providers are uniquely positioned to help train other social service providers and inform the design of systems — school, social service, and healthcare — that acknowledge the sequelae of trauma and provide environments where survivors may access support. Healthcare organizations should also continue to train their providers about trauma-informed care and strategies for treating trauma.

Mental Health Themes Related to Developing Workforce Capacity

Developing Workforce Capacity spans a broad set of objectives aimed at cultivating a health and social services workforce that is responsive to the communities and persons they serve, and building capacity in

the institutions in which they work. Specific to mental health, participants noted that the healthcare system may further build its workforce by increasing the number of licensed and lay mental health professionals as well as enhancing their cultural and linguistic competence.

Mental Health Theme 7: Increase the number of qualified mental health professionals.

Participants discussed the critical need to expand the capacity of DC's mental health system to better respond to needs. Specifically, participants perceived a shortage of psychiatrists (particularly pediatric psychiatrists), child psychologists, drug and alcohol abuse counselors, and fully licensed therapists.

Some participants disagreed, noting that there may not be a shortage of providers but there is an issue with how the providers are distributed across the District, with Wards 5, 6, 7, and 8 facing the brunt of the distribution disparity. Participants identified strategies for increasing the number of licensed mental health professionals, including:

- Increasing clinical training opportunities (e.g., psychology internships/externships) in high-need areas across the District
- Incentivizing fully licensed providers to provide services in high-need areas
- Offering competitive salaries that help offset the high cost of living in the DC metropolitan area
- Continuing to revise reimbursement rate policies to encourage clinicians to provide services in the District
- Providing ongoing training and continuing education courses for practicing clinicians

Participants also recommended training non-mental health professionals to a) recognize mental health needs, and b) refer clients to mental health services, including primary care physicians, emergency room physicians and staff, community health workers, and peer support workers.

Mental Health Theme 8: Recruit, train, and provide reimbursement for Community Health Workers and Peer Support Workers (CHW/PSW).

In addition to gathering information directly from community members about their perspectives on mental health, participants identified increasing utilization of Community Health Workers and Peer Support Workers as a way to build trusting relationships with community members. Community Health Workers/Peer Support Workers may build rapport with community members through shared experiences, understanding of cultural circumstances affecting communities, and the additional time they can devote during appointments. Respondents suggested CHW/PSWs receive training regarding:

- Identification of mental health and substance use needs (e.g., administering screens)
- Referral protocols
- Cultural competence
- Documentation of appointments
- Maintaining appropriate boundaries
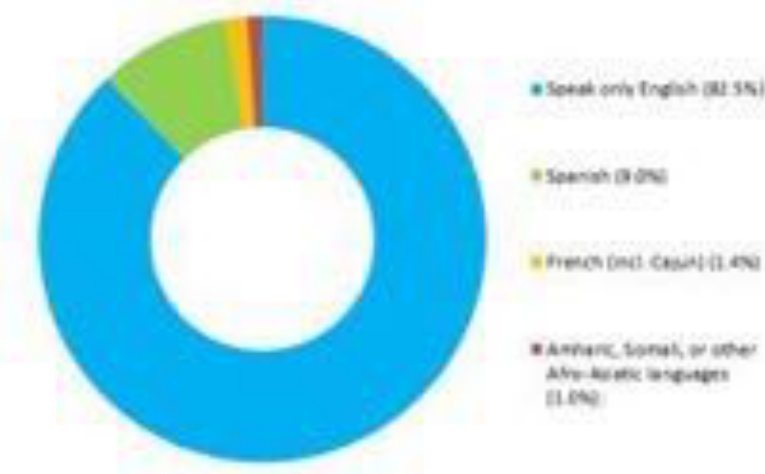
> *"I want to hire more District residents, but there is not a lot of workforce development happening on the mental health side that can really help us develop more people that already live in this community to come into mental health. Finding that workforce is super challenging."*
>
> – Focus Group Participant

- Ethical considerations when working with community members who have mental health needs
- Referral coordination and connection with external mental health services

Currently, funding for CHWs and PSWs is often tied to temporary funding sources like grants rather than reimbursement for services through insurance coverage. Unfortunately, this funding strategy may limit Community Health Workers' and Peer Support Workers' abilities to maintain relationships with community members. Healthcare organizations should advocate for reimbursement structures for these roles that incentivize staffing these positions.

Mental Health Themes Related to Simplifying the Path to Wellness

Simplifying the path to wellness refers to making it easier for DC residents to engage with the health system, by removing complexity, redundancy, and inefficiency within health and social service organizations. This includes easing access to mental health services as well as addressing non-clinical factors that impact well-being and one's ability to engage with the healthcare system. The result is a system wherein the "right" thing is also the "easy" thing to do. In this vein, participants spoke about the need to increase the availability of case management services and continue integrating mental health services within other settings, specifically schools and primary care clinics.

Mental Health Theme 9: Implement and expand case management.

Case management services help patients identify and connect with resources or navigate challenging realities. Participants identified the primary non-clinical determinants of health for residents of the District as income instability, housing instability, racial discrimination, immigration/documentation status, and community violence. Each of these contexts can precipitate and exacerbate mental health issues as well as access to mental healthcare. Case management services may help residents navigate the challenging realities imposed by these contexts. In addition to addressing these larger issues, participants discussed case management focus on:

- Transition care after discharge from hospitalization or emergency room visits
- Assistance with referrals
- Ongoing engagement with mental health services

Mental Health Theme 10: Promote mental health integration.

Since the Collaborative released the 2016 CHNA, the District has seen the expansion of mental health services into primary care and school settings. This has resulted from the combined efforts of the health system and policymakers to develop partnerships with primary care providers and schools, adapt approaches to providing mental health services, and modify and develop reimbursement policies for these services. A senior staff member for a DC Council member discussed how school-based mental health represents an improvement in mental healthcare in the District over the past few years:

> *I think the District has made some improvements with respect to school-based mental health. We've done that through a couple budget cycles and trying to fund mental health services within some of the schools for students on a wide variety of mental health priorities, not just trauma and violence....There has to be continued investments in mental health. The school-based health centers are a promising step forward. Kids are in school every day. We are putting care in schools.*

Integrating mental health services into primary care and school settings facilitates early identification of mental health issues, lowers barriers to seeking care, reduces stigma, and helps normalize mental health as part of overall health. In discussing further development of mental health integration into primary care and schools, participants identified different but overlapping needs for the primary care versus school settings.

- Community stakeholders suggested that mental health services provided in **primary care settings** should include:
    - Mental health and substance abuse screenings
    - Ongoing outpatient therapy services
    - Psychiatric consultation and medication management
    - Mental health personnel – such as therapists, psychiatrists, and community health workers – integrated into primary care settings
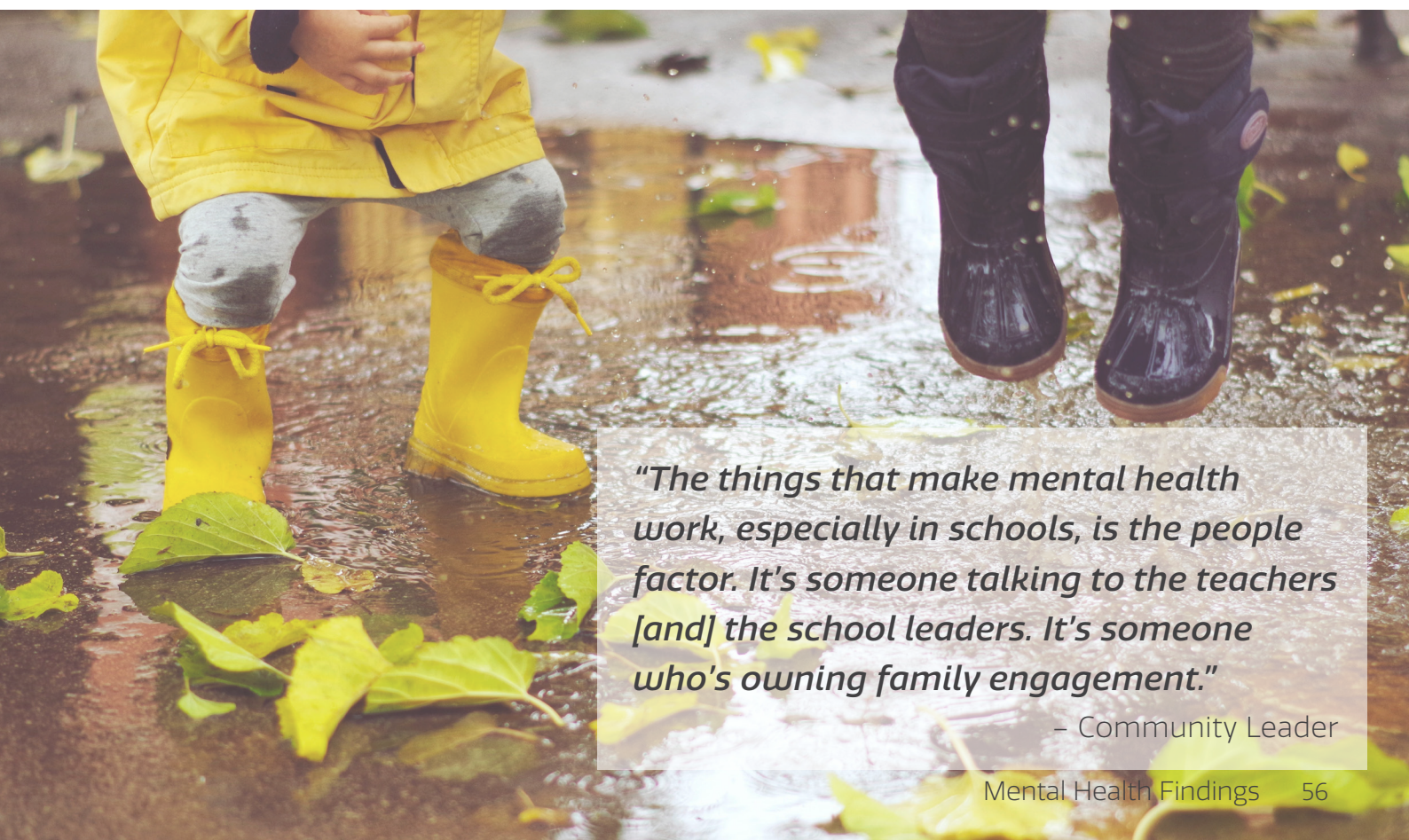
"The things that make mental health work, especially in schools, is the people factor. It's someone talking to the teachers [and] the school leaders. It's someone who's owning family engagement."

– Community Leader

- Mental health integration in **schools** should include:
  - Mental and behavioral health screening
  - Early intervention services
  - Outpatient psychotherapy services, including individual and family therapy
  - Extended hours to facilitate parents' participation in children's treatment and family therapy
  - Mental health personnel – such as licensed counselors, therapists, and clinical social workers – integrated into primary care settings

Conclusion

Mental health remains a priority concern for our community stakeholders. Issues of inequitable distribution of mental health resources across the District, rising rates of depression and suicidal ideation, and persistent stigma weigh heavily on our community. This chapter described many opportunities to improve access to and delivery of high-quality mental healthcare, as well as to improve relationships with communities and within the health system.

As with the other priority areas, the mental health themes will inform the development of the 2019 Community Health Improvement Plan (CHIP). Through the CHIP, the Collaborative will further operationalize these findings into strategies for systems changes and advocacy priorities to improve mental health in the District in the years ahead.

Figure 11: Health Professional Shortage Areas (HPSAs) for Mental Health in DC, 2017
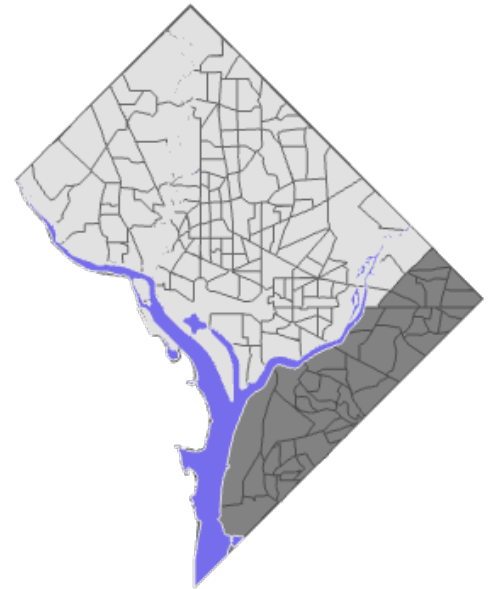
Source: Health Resources & Services Administration, Health Professional Shortage Areas (HPSAs), accessed at https://data.hrsa.gov/data/download (June 2019.)

Chapter 5: Care Coordination

Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. This means that the patient's needs and preferences are known ahead of time and communicated at the right time to the right people, and that this information is used to provide safe, appropriate, and effective care to the patient.

The 2016 Community Health Needs Assessment (CHNA) identified care coordination as a priority need for which the healthcare sector could play a leading role in impacting positive change. In 2016, stakeholders identified the following challenges requiring better care coordination: the impact of non-clinical determinants of health, complexity of the healthcare system, lack of communication across providers, incompatible electronic medical records systems, and disconnected health resources. The complete 2016 CHNA, as well as supporting quantitative data, can be found on DCHealthMatters.org.

As part of the 2019 CHNA process, the Collaborative conducted a series of citywide interviews and focus groups to probe deeper into how the healthcare system and partners across the city could address care coordination issues in the District. This chapter summarizes the top nine care coordination themes that resulted from this qualitative data collection process. A detailed description of our methodology is included in Chapter 3.

Eight Care Coordination Themes Organized into Four Action Areas

The DC Health Matters Collaborative engaged with more than 300 DC stakeholders to identify policy- and systems-level actions that hospitals, community health centers, and the broader healthcare system should consider to improve care coordination in the District. The most frequent themes are organized into four action areas. These action areas provide the Collaborative with a framework for driving measurable and sustainable actions:

Action Area 1 – Foster Community Dialogue: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.

Area 2 – Build Relationships: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.

Action Area 3 – Develop Workforce Capacity: cultivate health and social care providers through approaches that are responsive to the communities and persons they serve.

Action Area 4 – Simplify the Path to Wellness: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

As part of the qualitative analysis, we grouped individual codes from the interviews and focus groups into larger themes for each of the priority areas. The resulting themes and code frequencies related to care coordination, organized within these action areas, are on the next page.

These themes will guide the Collaborative's development of the Community Health Improvement Plan by informing our actions for improving care coordination in the District.

Care Coordination Themes Related to Fostering Community Dialogue

Fostering community dialogue refers to encouraging communication and collaboration among DC stakeholders, including residents, providers, community organizations, and policymakers. Genuine dialogue is bi-directional and iterative communication whereby all stakeholders have opportunities to express their views and experiences about care coordination, including perceived needs, preferences, and resources.

care coordination findings

community dialogue
frequency

CC1. Improve communication among healthcare
providers, social service agencies, and educational systems.
56%

build relationships

CC2. Incentivize collaboration among healthcare, social
service, and education systems.
89%

CC3. Enhance contextually, linguistically, and culturally
appropriate care.
44%

develop workforce

CC4. Train health services providers, including clinical/social support
groups, and individuals to coordinate care.
39%

simplify path to wellness

CC5. Invest in technology and other supports to facilitate coordination
of services.
39%

CC6. Curate resource lists.
86%

CC7: Expand use of interdisciplinary teams in primary care.
28%

CC8. Advocate for citywide policies that incentivize wellness.
83%

Care Coordination Theme 1: Improve communication among healthcare providers, social service agencies, and educational systems.

Participants identified three targets for improving communication among healthcare providers, social service agencies, and educational systems:

- **Discharge Planning & Communication:** Develop a better system to convey medical records, discharge orders, and follow-up recommendations following hospitalizations or emergency room encounters to patients' primary care team.
- **Referral Feedback:** Equip clinicians, particularly specialists and those in private practice, to inform referring providers when patients present for care, as well as share medical records.
- **Feedback Following Prescription Fulfillment:** Implement a system that informs physicians when patients' prescriptions have been filled to help physicians track adherence and coordinate care for patients in an effort to improve patient outcomes.

Care Coordination Themes Related to Building Relationships

Care coordination requires building collaborative relationships among an array of stakeholders. Distrust, competition among providers, and regulatory restrictions (e.g., Health Insurance Portability and Accountability Act [HIPAA], Family Educational Rights and Privacy Act [FERPA]) have inhibited collaboration across healthcare organizations, social service agencies, and education systems. Participants noted some successes since 2016 in overcoming regulatory barriers and collaborating across systems (e.g., the expansion of school-based health centers). Several challenges remain, including a lack of funding that incentivizes collaborative partnerships, and concern about poor cultural competence among healthcare providers.

Care Coordination Theme 2: Incentivize collaboration among healthcare, social service, and education systems.

Healthcare organizations should advocate for policy and system changes, across the city and within organizations, that incentivize collaboration among healthcare and social service and education systems, specifically changes that:

- **Prioritize collaboration in grant opportunities:** Competition for funding, including for grants, may de-incentivize collaboration between organizations. Policies and grant opportunities could instead require and/or reward collaboration among healthcare organizations, social services agencies, education systems, and other community stakeholders.

- **Encourage data sharing among healthcare organizations:** Healthcare organizations may be reluctant to share information with other organizations for various reasons, ranging from patient privacy concerns to potential loss of competitive advantage. However, it may be advantageous for healthcare organizations to share:
  - Patient-level data: medical records, referral information, and case management notes
  - Health systems-level data: standardized health quality data, health outcome data, service utilization.

  Data sharing may facilitate better coordination of patient care and serve as a catalyst for quality improvement efforts.

- **Engage social service agencies:** Healthcare organizations should communicate with social services agencies (e.g., housing organizations, DC Public Schools (DCPS), food pantries) to help patients address non-clinical determinants of health. There are programs in the District that have already endeavored to do so. For example, DCPS developed an interagency memorandum of agreement with the DC Department of Health Care Finance and DC Department of Health to (a) determine where to place school-based health centers and (b) connect students with healthcare providers. A CHNA participant involved in this effort shared:

  > *We've navigated FERPA and HIPAA to allow us to share our student data with DC Medicaid. They tell us which of our students have Medicaid, have gone to the doctor in the past two years for a well-child visit, and have gone to the dentist in the past two years. We then use that data to prioritize the needs of our schools by rank-ordering the schools and working with the Department of Health to identify providers who can come and provide services… We've developed a plan with two oral health providers to provide oral health services to our students. We can [now] bring more services directly into our schools that our students need.*

  OSSE is working to expand similar efforts into charter schools. Another example of an important social service connection is between healthcare organizations and food services, such as the Capital Area Food Bank (CAFB), given the connection between food insecurity and health.

Care Coordination Theme 3: Enhance contextually, linguistically, and culturally appropriate care.

Participants discussed the importance of assessing the specific needs of Spanish-speaking and other cultural and linguistic minority community members; participants suggested using this information to develop care coordination services that are responsive to unique needs of these community members. Providing culturally and linguistically competent care coordination services will help improve the experiences of Spanish-speaking patients in the healthcare system and improve health outcomes. Recommendations include:

__Data Highlight:__
Among 61,004 people age five and older who speak Spanish at home, 26,452 don't speak English very well.[39]

> *"The health system is set up in such a way that you are truly managing your care on your own."*
>
> – Focus Group Participant

- **Design care coordination services that consider the needs of Spanish-speaking patients:** Spanish-speaking patients may face unique, non-clinical contexts that impact health (e.g., immigration issues, language barriers).

- **Ensure that care coordination, marketing, and outreach efforts are tailored to Spanish-speaking populations:** Care coordination programs should retain Spanish-speaking staff and provide written materials in Spanish. In addition to producing materials in Spanish, the messages contained therein should reflect the preferences and needs of Spanish-speaking communities.

Care Coordination Themes Related to Developing Workforce Capacity

Developing workforce capacity spans a broad set of objectives aimed at cultivating a health and social service workforce that is responsive to the communities and persons they serve, and building capacity in the institutions in which they work. Healthcare, social service, and educational systems often function in silos both across and within systems; further workforce training offers opportunities to equip providers to work across existing barriers to coordinate care.[40]

Care Coordination Theme 4: Train health services providers, including clinical/social support groups, and individuals to coordinate care.

Participants discussed the need to train providers to coordinate care. This training should address:

- The value and role of care coordination in promoting positive health outcomes
- Identifying non-clinical factors impacting patients' health (e.g., housing quality and instability, income instability, immigration issues) and making referrals to appropriate services

"Informational awareness is a big problem. I think people want help but they don't know where to find it."

– Focus Group Participant

- Utilizing technological resources (e.g., the Health Information Exchange, Aunt Bertha) to facilitate care coordination
- Strategies for managing and following up on referrals

Including care coordination concepts early in professional training initiatives (e.g., medical school internships, fellowships, graduate training, and community health workers' programs) will help equip the workforce to coordinate care within and across health and social service systems.

We note that coordinating care is an essential feature of Medicaid managed care organizations (MCOs) currently operating in the District. Therefore, the MCOs should be consulted about the impact of this model in DC, including best practices, lessons learned, and opportunities for future improvement.

Care Coordination Themes Related to Simplifying the Path to Wellness

Simplifying the path to wellness refers to making it easier for DC residents to engage with the health system by removing complexity, redundancy, and inefficiency within health and social service organizations. Coordinating care aids patients by clarifying next steps, wayfinding, and addressing other barriers. The result of this support is a system wherein the "right" thing is also the "easy" thing to do. Participants spoke about the need to increase the availability of case management services, invest in technology that facilitates care coordination, expand integrated care models, advocate for value-based contracts, and address non-clinical determinants of health.

Care Coordination Theme 5: Invest in technology and other supports that better facilitate coordination of services.

Recent years have seen the advent of new technologies for sharing patient information and connecting patients with resources. Specific technology approaches to evaluate, expand, fund, and/or initiate information-sharing include:

- **Aunt Bertha:** an online portal that helps connect patients with community resources
- **Health Information Exchange:** secure and protected exchange of health information
- **Hack-a-thons:** events where programmers create technological solutions to healthcare problems
- **Unite Us:** an online care coordination tool currently used by the U.S. Veterans Administration to facilitate referrals, track patients' progress, and follow up with referrals

Spotlight on DC Health Matters Connect
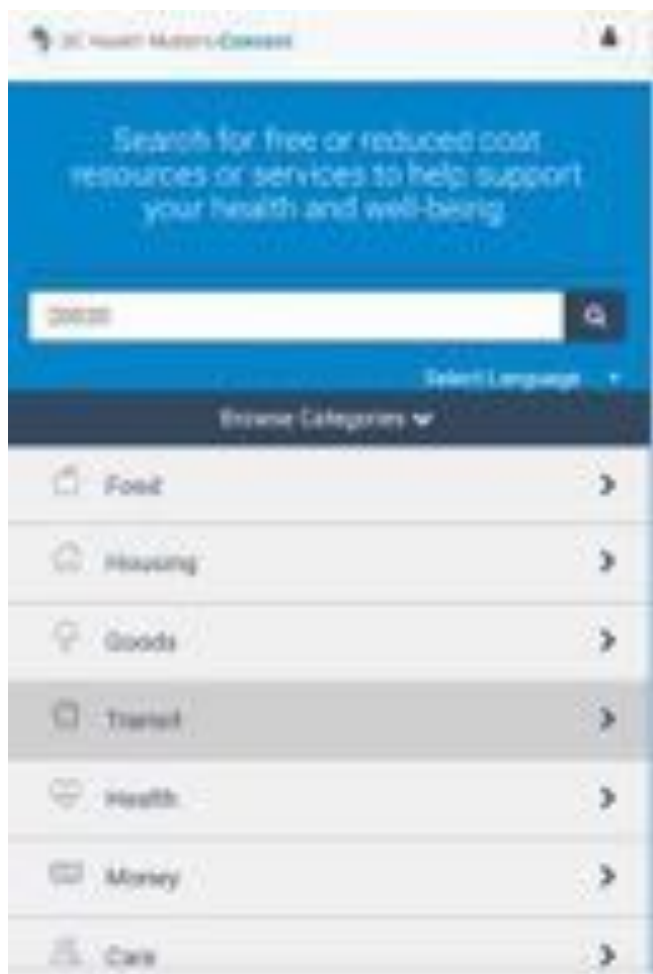
Launching in 2019, [DC Health Matters Connect](#) will connect individuals and providers with thousands of social services, listed by zip code. The platform facilitates referrals and follow-up between providers.

Each of these tools has been deployed to limited extents to assist DC residents; however, providers may not use these resources due to lack of knowledge, time, or perceived value. Participants recommended continued development, evaluation, and scaling of these tools to assess their effectiveness.

Care Coordination Theme 6: Curate and disseminate resource lists.

Participants discussed the need for up-to-date resource lists that are made widely available to members of the community, healthcare organizations, community agencies, social workers, community health workers, and other personnel who work with community members. Perennial changes in funding and programming for support services make it difficult to maintain an accurate account of service providers. Organizations may create their own lists rather than sharing resources: a product of what participants described as "working in silos."

Aunt Bertha — an online database that helps community members find resources for food, clothing, shelter, employment, and social services in communities across the country — was identified as a valuable tool in connecting families to needed services. The Collaborative has been actively working to expand the use and functionality of the tool in the District as part of the 2016-2019 CHIP, and will launch the tool as [DC Health Matters Connect](#) in 2019. CHNA Participants said that the healthcare system in the District should continue to support and expand the use of Aunt Bertha in the following areas:

- **Support and expand the platform:** Aunt Bertha is a bi-directional tool that allows community-based organizations to post information about their services, while also providing community members and organizations free and unlimited access to that information. Aunt Bertha has additional subscriptions that allow organizations to access additional features, including team data sharing and reporting capabilities. The Collaborative has worked in partnership with the Capital Area Food Bank to promote the use of Aunt Bertha but did not own a direct license itself until 2019. Stakeholders suggested encouraging new organizations to employ the tool.
- **Educate providers and social service agencies about Aunt Bertha:** Providers and social service agencies may not use Aunt Bertha due to lack of knowledge, time, or perceived value; the Collaborative should inform users about this resource.

Care Coordination Theme 7: Expand the use of interdisciplinary teams in primary care.

Drawing from the example of the MyHealthGPS[41] program, participants noted that interdisciplinary and coordinated care was a promising approach for improving healthcare services in the District. MyHealthGPS, launched in 2017, draws on this model by embedding interdisciplinary teams in primary care settings to integrate and coordinate care for eligible patients on Medicaid with chronic health issues.[42] Participants recommended that this model be expanded to serve:

"Care coordination is probably where I'm most optimistic."

– Healthcare Leader

- Patients with fewer or no chronic illnesses
- Complex contextual barriers (i.e., income instability, housing instability, limited English proficiency)

Care Coordination Theme 8: Advocate for citywide policies that incentivize positive health outcomes and wellness.

Participants recommended that healthcare organizations support the exploration of efforts to develop value-based contracts (VBCs), which tie payment to outcomes rather than service volume:

- Assess physicians' and healthcare organizations' motivations for resisting and/or pursuing VBC: According to participants, managed care organizations in the District have explored VBCs in recent years, and have encountered resistance from providers with concerns about reimbursement. Understanding healthcare providers' perspective and concerns about VBCs will help in developing the compromises necessary to establish these contracts across the District.
- Develop reimbursement schedules for VBCs: Physicians have expressed concerns that linking medical reimbursement to health outcomes does not account for the time they spend on patient care, nor their limited control over their patients' non-clinical determinants of health. Reimbursement rates should be formulated based on research on best practices to balance these concerns.

Conclusion

Developing systems, infrastructure, and tools for coordinating care remains a priority for our DC community. Several issues present challenges, including adverse non-clinical determinants of health, disjointed communication among healthcare providers and with other systems, lack of collaboration among providers, and a lack of culturally and linguistically appropriate services. This chapter described opportunities to improve care coordination services across the District.

As with the other priority areas, the care coordination themes will inform the development of the 2019 Community Health Improvement Plan (CHIP). Through the CHIP, the Collaborative will further operationalize these findings into strategies for systems changes and advocacy priorities to improve care coordination in the District in the years ahead.

Spotlight on Care Coordination Workgroup:
Launching a Resource Connection Tool

The Collaborative's workgroups implement the strategies for policy and system change laid out in the 2016 CHIP. Over the last several years, the Collaborative's Care Coordination Workgroup supported the organization of patient care activities and information sharing among healthcare providers, government agencies, and community organizations across Washington. A key accomplishment was the identification of a resource connection tool. Aunt Bertha was piloted by three Collaborative members (Children's National, Mary's Center and Providence) with the help of the Capitol Area Food Bank. The pilot included eleven trainings advocating for the use of the tool across the organizations. Additionally, those participating in the pilot enhanced two areas of Aunt Bertha by adding 105 new program listings to the platform (within the areas of pediatric mental health and senior services). Based on the feedback of the participants, the pilot was successful; this led the Care Coordination group to continue exploring the use of a resource inventory across the DC community. The Care Coordination Workgroup decided to purchase a license for Aunt Bertha and implement the tool across Collaborative organizations.

Please visit our 2017-2019 Community Health Progress Tracker at DCHealthMatters.org to learn more about the accomplishments of the Care Coordination Workgroup.

Chapter 6: Health Literacy

Health literacy is the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions. Health literacy requires a complex combination of reading, listening, analytical and decision-making skills, and the ability to apply these skills to health situations.

The 2016 Community Health Needs Assessment (CHNA) identified health literacy as a priority need for which the healthcare sector could play a leading role in impacting positive change. In 2016, stakeholders noted the following challenges related to health literacy in the District: low general literacy, limited knowledge about health, lack of awareness about available services, and trouble understanding how to navigate our complex health system, as well as communication barriers between providers and residents. The complete 2016 CHNA, as well as supporting quantitative data, can be found on DCHealthMatters.org.

For the 2019 CHNA, the Collaborative conducted a series of interviews and focus groups to assess how the health system and its partners across the District could improve health literacy in the District. This chapter summarizes six major themes that emerged from the qualitative data collection process. A detailed description of the methodology is included in Chapter 3.

Six Health Literacy Themes Organized into Four Action Areas

The DC Health Matters Collaborative engaged more than 300 stakeholders across the District to identify policy and systems-level actions that the health system should consider to improve health literacy among residents. The six most salient themes are organized into four action areas. These action areas provide the Collaborative with a framework for driving measurable and sustainable action:

Action Area 1 – Foster Community Dialogue: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.

Action Area 2 – Build Relationships: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.

Action Area 3 – Develop Workforce Capacity: cultivate health and social care providers through approaches that are responsive to the communities and persons they serve.

Action Area 4 – Simplify the Path to Wellness: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

As part of the qualitative analysis, we grouped individual codes from the interviews and focus groups into larger themes for each of the priority areas. The resulting themes and code frequencies related to health literacy, organized within these action areas, are on the next page.

These themes will guide the Collaborative's development of the Community Health Improvement Plan (CHIP) by informing our actions for improving health literacy in the District.

Health Literacy Themes Related to Fostering Community Dialogue

Fostering community dialogue refers to encouraging communication and collaboration among DC stakeholders, including residents, providers, community organizations, and policymakers. Genuine dialogue is bi-directional, iterative communication whereby all stakeholders have opportunities to express their views and experiences about health literacy, including perceived needs, preferences, and resources.

health literacy findings

community dialogue

	frequency
HL1. Define health literacy.	**19%**
HL2. Assess health literacy in the District.	**22%**

build relationships

HL3. Expand health education efforts.	**69%**

develop workforce

HL4. Train healthcare professionals to assess health literacy and adjust communication accordingly.	**31%**
HL5. Utilize community health workers to promote and facilitate health literacy.	**17%**

simplify path to wellness

HL6. Improve general literacy across the District.	**17%**

Health Literacy Theme 1: Define health literacy

Participants observed that there is not a standard definition of health literacy employed by healthcare organizations and policymakers across the District. Defining what health literacy uniquely means in the District will allow stakeholders to begin to assess health literacy supports and needs in communities across DC. Current definitions of health literacy may place blame on patients/residents, stigmatize health literacy barriers, and employ paternalistic approaches to conceptualizing health literacy. A pediatrician noted:

> *I think we still take a very paternalistic view of how we create health literacy, and we have not effectively figured out what the patients really want to be more informed about. So we produce, as a healthcare system, a lot of information to improve the knowledge that people have around their disease or their health maintenance but we don't ask them what they really need. That has to start to shift.*

A broad range of informants should help define health literacy and the metrics for assessing it, including DC residents, health literacy content experts, clinicians, and insurance providers.

Health Literacy Theme 2: Assess health literacy across the District

Healthcare organizations should collaborate to assess the current state of health literacy in the District. The last comprehensive assessment of DC's health literacy data, from the 2003 National Assessment of Adult Literacy (NAAL),[43] is outdated and may not reflect current dynamics (e.g., internet or phone access). A new assessment should:

- **Measure residents' health literacy:** Participants identified the following as targets of measuring residents' health literacy:
  - Knowledge about navigating the healthcare system, including patient rights and health insurance
  - Health knowledge, regarding physical health, medical terminology, mental health, and substance use disorders
  - Ability to understand written and oral health communication, including during medical appointments, that would allow patients to make informed decisions

- **Gather information about how DC residents access health information:** Understanding patients' current and preferred mediums for accessing health information is vital to developing health communication strategies. A senior advisor discussed the need to understand how community members access health information:

  In terms of disseminating information, you have to meet people where they are. Information has to be disseminated at DC Rec Centers, at churches, at schools, and through social media such as Twitter and Facebook. People who don't have regular access to email still somehow find their way onto Twitter and Facebook. There's a reason almost everyone has a Facebook account. Those are means to get people involved.

- **Assess the health literacy needs of immigrant residents:** Immigrant residents face unique challenges when accessing the health system, including language and cultural barriers that add to any baseline health literacy challenges. Further, immigrant residents may also face contextual challenges (e.g., concerns about immigration status or hospitals' use and reporting of information) that contribute to mistrust or misunderstandings.

Health Literacy Themes Related to Building Relationships

An increase in residents' health literacy may also support the development of trusting relationships with the healthcare system. Engaging community members about their preferences for receiving and accessing health information and continuing health education efforts, as well as expanding cultural and linguistic competence, offers ways to build sustainable relationships.

Health Literacy Theme 3: Expand health education efforts

Participants noted that certain policies have increased health literacy efforts across the District. The leader of one healthcare organization in the District discussed how regulations requiring the Certificates of Need attainment process to include health education contributed to their organization expanding outreach efforts in Wards 7 and 8:

When we talk about health equity, I'll give you a prime example: kidney transplantation. We went for a Certificate of Need and part of our focus was outreach, and there's no outreach being done in Wards 7 and 8. However, they have the largest number of residents on dialysis. When you look at that and begin to look at why, you begin to see that they did not have the health knowledge to understand that they were a candidate for a transplant. They thought that dialysis was something that they would do for the rest of their life. There wasn't anyone — really anyone — doing the screening and doing the outreach in a way that helped them through and educated them to a different life, a different opportunity, a different option of dealing with their health issues.

Participants recommended that future health education efforts:

- **Identify community members' preferences for health literacy and education:** Seeking an understanding of community members' preferences for health education directly will help healthcare organizations develop initiatives that better meet true needs.

Spotlight on Health Literacy Workgroup:
Assessing Clinical Screening for Health Literacy

The Collaborative's workgroups implement the strategies for policy and system change laid out in the 2016 CHIP. To this end, our Health Literacy Workgroup connected with multiple stakeholders to assess the current health literacy screening practices in Washington, DC among Federally Qualified Health Centers (FQHC) and hospitals. Survey responses were collected from 48 respondents total; 25 respondents were staff representing hospitals and 23 were staff representing FQHCs. Conclusions included that overall, health literacy practices are being implemented in both hospitals and FQHCs, but there needs to be improvement. Major barriers to implementing health literacy practices include the belief that there is inadequate time to implement a program and the concern that there is a lack of monetary resources to implement a program. The recommendations included the importance of addressing the gaps and barriers to implementing health literacy practices to achieve better patient understanding, as well as for both health centers and hospitals to invest resources that prioritize patient education in order to create more effective means of communication between patient and provider. The full report is available on our website.[44]

Please visit our 2017-2019 Community Health Progress Tracker at DCHealthMatters.org to learn more about the accomplishments of the Health Literacy Workgroup.

- **Identify initiatives that effectively improve health literacy:** Identifying, incentivizing, and expanding initiatives that have made positive impact and support health literacy will help healthcare organizations and policymakers better understand the nature and scope of health literacy challenges across the District.

- **Expand current education efforts in more languages:** Health literacy represents a disproportionate challenge for non-native English speakers and immigrant communities. Future health education efforts should be provided in more languages, particularly Spanish. They should also be designed and conducted in ways that are culturally appropriate and relevant to residents.

Health Literacy Themes Related to Developing Workforce Capacity

Workforce development spans a broad set of objectives aimed at cultivating a health and social service workforce that is responsive to the communities and people they serve, and building capacity in the institutions in which they work. Participants noted that the healthcare workforce could be trained to screen patients for health literacy levels and adjust communications to meet patients' specific needs. Additionally, participants suggested that expanding the use of community health workers across the District may help promote health literacy across the District and help residents engage with the healthcare system.

Health Literacy Theme 4: Train healthcare professionals to assess health literacy and adjust communication.

Clinicians may lack training about how to serve and empower patients across levels of health literacy. Equipping providers with the knowledge and tools to address diverse health literacy levels will help meet patients' needs and promote positive health outcomes. Health professionals should receive training to enhance their abilities to:

"The definition of health literacy places the responsibility on the individuals to better understand the healthcare system, as opposed to placing the responsibility on the system to better understand the barriers and the community. There's a need to rethink that."

– Focus Group Participant
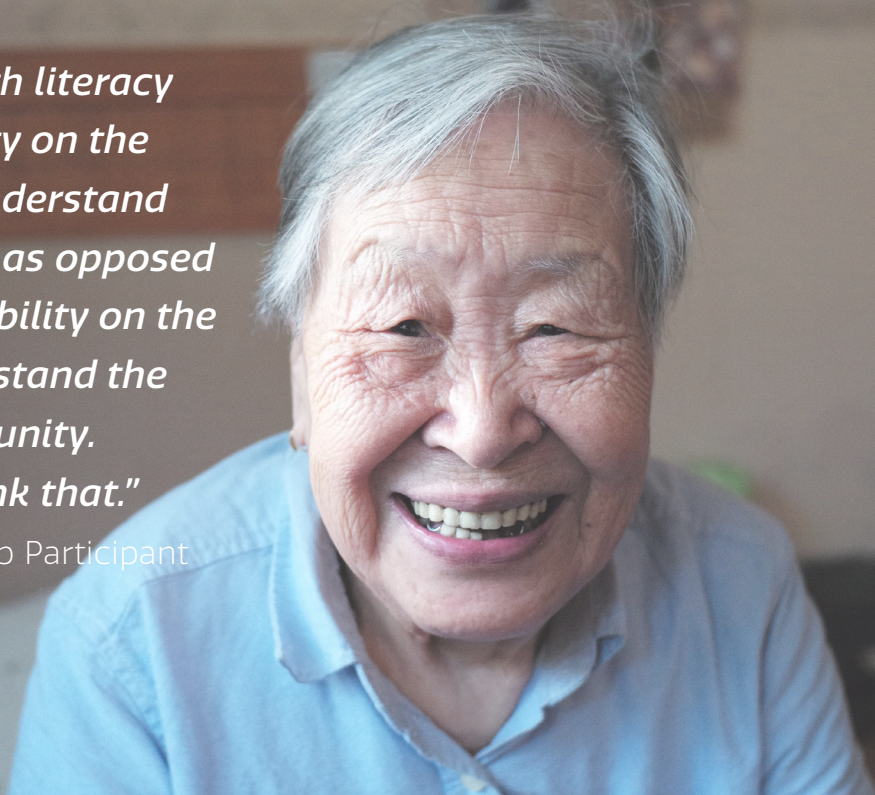
- **Use screening tools to measure patients' health literacy:** Healthcare organizations should identify health literacy screening tools to help providers identify when patients may have difficulty understanding health information. Providers should receive training to a) administer these tools, b) interpret the findings, and c) identify individual patients' health literacy strengths and barriers that may support their abilities to navigate the healthcare system, understand diagnoses, understand directions for taking prescriptions, follow medical advice, make health decisions, and advocate for their needs.

- **Communicate across health literacy gradients:** Providers should receive training to enhance how they effectively communicate with patients, including:
  - Reducing the use of jargon
  - Limiting medical counseling to two to three points
  - Distributing and explaining medical information in plain language
  - Using diagrams or drawings
  - Enhancing the readability of medical literature
  - Using teach-back and show-back techniques to demonstrate understanding

Health Literacy Theme 5: Utilize Community Health Workers to promote and facilitate health literacy.

Utilizing community health workers (CHWs) represents an opportunity to increase equity, by serving communities through trusted peers when trust or access may be barriers to "traditional" health settings. With appropriate training and oversight, employing CHWs can help community members overcome health literacy barriers related to:

- **Navigating the healthcare system:** Assisting community members with "wayfinding" within the healthcare system, accessing care, and interacting with various components of care delivery (e.g., insurance, primary care, medical specialties, discharge planning).

- **Coordinating referrals and follow-up care:** CHWs can help schedule referral appointments and follow up on referral completion and/or prescription fulfilment.

- **Connecting with community resources:** Helping patients address non-clinical determinants of health by helping them contact and engage social service agencies and other community organizations.

- **Providing health information:** CHWs may help direct patients to reliable, accurate, culturally, and linguistically appropriate health education resources as well as providing direct health education themselves.
- **Supporting immigrants and patients with limited English proficiency:** Hiring CHWs with diverse language and cultural backgrounds can provide a direct contact for immigrant and language minority patients, thereby reducing the barriers that they face when accessing the healthcare system.

Several organizations across the District currently employ CHWs, but their roles and titles vary and their continued presence is often contingent on tenuous funding mechanisms, such as grants or philanthropic funds. Work is needed regarding:

- **Standardization of the CHW Role:** A common definition of the role of CHWs across the District is necessary, including standardizing the role, responsibilities, scope of practice, and ethics. Further defining the CHW role will allow for the development of training, professional development, and continuing education for CHWs. Standardizing the CHW role will also help providers and community members develop expectations for working with CHWs across the District.
- **Financing of the CHW Services:** Many of the services that CHWs provide occur external to the medical encounter but are necessary for patients to access care, enact the behaviors, or procure the resources (e.g., prescriptions) that support health. However, there is little or no guaranteed funding for these services, and CHWs are often funded through grants or philanthropic funds. This results in the inconsistent presence, interruptions and delays in accessing services, and underutilization of CHWs across healthcare entities in the District. Securing a system of consistent and equitable financing for CHW services will promote the wider adoption of CHWs across healthcare entities, solid role within the team of care, and a realistic livable wage for the workers in the District.

Health Literacy Themes Related to Simplifying the Path to Wellness

Simplifying the path to wellness refers to making it easier for DC residents to engage with the health system by removing complexity, redundancy, and inefficiency within health and social service organizations. The result is a system wherein the "right" thing is also the "easy" thing to do. Promoting general literacy and health literacy among District residents will help them access health services and promote better health outcomes for all residents across the city.

Health Literacy Theme 6: Improve general literacy across the District.

General literacy is often a predecessor to health literacy. When a patient's basic reading level is low, interpreting health information and/or following medical instructions will be difficult. In order to enhance general literacy in the community, healthcare organizations should work with other sectors, such as the education system, to advocate for policies that support and expand existing literacy programs across the District, including policies that:

Literacy estimates in DC are outdated by more than 15 years:
In 2003, 19% of DC residents 16 years and older lacked basic prose literacy skills.[45]

- Strengthen literacy education in public schools: Primary and secondary schools lay the foundation for general literacy. Enhancing literacy education through DC schools will equip students to understand health materials, navigate healthcare systems, and make health decisions as adults. The DC Council passed the Healthy Schools Act in 2010 requiring public and charter schools to provide health education to students. Further, the DC State Board of Education revised the

Health Learning Standards in 2016, which resulted in greater emphasis on health skills and how to apply health skills and knowledge to medical decision-making. Collaborative members can draw on these policy mandates and continue to advocate for the incorporation of health literacy into general K-12 education curricula.

- Include health in adult literacy curricula: Adult literacy programs often focus on job readiness but may not include instruction related to health literacy. Healthcare organizations can collaborate with existing adult literacy programs to include health literacy components.

Conclusion

Health literacy continues to be a top priority in the DC community. This chapter described several opportunities for the healthcare system to address this, including better defining and assessing health literacy, increasing general literacy levels among residents of all ages, and considering mechanisms to enhance residents' abilities to understand and navigate the healthcare system, possibly through the integration of community health workers. These actions could potentially improve health outcomes – and equity – across the District.

Combined with the findings identified in other chapters of this CHNA, the health literacy themes will inform the development of the 2019 Community Health Improvement Plan (CHIP). Through the CHIP, the Collaborative will further operationalize these findings into strategies for systems changes and advocacy priorities to improve health literacy in the District in the years ahead.

Chapter 7: Place-Based Care

Place-based care refers to the delivery of educational, preventive, and clinical resources and services to convenient locations outside of traditional medical practices, such as community centers, schools, and other neighborhood venues.

The 2016 Community Health Needs Assessment (CHNA) identified place-based care as a priority need for DC residents. Specifically, the 2016 CHNA found that an inequitable distribution of healthcare resources across the District complicated the process of accessing care for residents of Wards 5, 7, and 8. Stakeholders identified potential solutions, such as utilizing community health workers, home visiting from nurses and doctors, and providing mobile medical units to help bring care to residents. The 2016 CHNA report also envisioned making schools and other community resources hubs where medical services may be co-located to reduce residents' barriers to accessing services and improve health outcomes. The complete 2016 CHNA, as well as supporting quantitative data, can be found on DCHealthMatters.org.

For the 2019 CHNA, the Collaborative conducted a series of citywide interviews and focus groups to probe deeper into how the healthcare system and citywide partners could address place-based care issues in the District. This chapter summarizes the top ten place-based care themes that resulted from this qualitative data collection process. A detailed description of the methodology is included in Chapter 3.

Four Place-Based Care Themes Organized into Four Action Areas

The DC Health Matters Collaborative engaged with more than 300 stakeholders to identify policy and systems-level actions that hospitals, community health centers, and the broader healthcare system should consider to improve place-based care in the District. The most frequent themes are organized into four action areas. These action areas provide the Collaborative with a framework for driving measurable and sustainable actions:

Action Area 1 – Foster Community Dialogue: facilitate communication and collaboration among residents, health professionals, community organizations, policymakers, and other stakeholders.

Action Area 2 – Build Relationships: strengthen trust and genuine relationships as a foundation for collaboration to improve health and well-being.

Action Area 3 – Develop Workforce Capacity: cultivate health and social care providers through approaches that are responsive to the communities and persons they serve.

Action Area 4 – Simplify the Path to Wellness: make it easier to engage with the health system by removing complexity, redundancy, and/or inefficiency within health and social service organizations.

As part of the qualitative analysis, we grouped individual codes from the interviews and focus groups into larger themes for each of the priority areas. The resulting themes and code frequencies related to place-based care, organized within these action areas, are on the next page.

These themes will guide the actions that the Collaborative proposes to address issues related to improving place-based care in the Collaborative's Community Health Improvement Plan. [Note: No place-based care themes grouped exclusively into the "Build Relationships" action area, though it is a secondary aspect of most themes.]

community dialogue

PBC1. Assess community perspectives related to the distribution of community assets across the District.

33%

build relationships

[no place-based care themes grouped into this action area]

--

develop workforce

PBC2. Incentivize healthcare providers to practice in under-resourced areas.

72%

simplify path to wellness

PBC3. Continue expanding availability and access to existing services.
PBC4. Promote innovative models of place-based care.

81%
56%

place-based care findings

Place–Based Care Themes Related to Fostering Community Dialogue

Fostering community dialogue refers to encouraging communication and collaboration among DC stakeholders, including residents, providers, community organizations, and policymakers. Genuine dialogue is bi-directional, iterative communication whereby all stakeholders have opportunities to express their views and experiences about place-based care, including how to define and evaluate place-based care across the District.

Place–Based Care Theme 1: Assess community perspectives related to the distribution of community assets across the District.

Since the 2016 report, the Collaborative and other groups have worked on initiatives to enhance place-based care, including extending the hours of primary care clinics and expanding school-based health centers across the District. At the same time, hospitals have closed or reduced service areas in neighborhoods we had identified as under-resourced. The Health System Plan produced by DC Department of Health (summarized in Appendix 3) outlines service utilization, coverage, and travel patterns. Using this document as a foundation, stakeholders should also evaluate the effectiveness of current place-based care efforts and identify areas for improvement. This kind of assessment will allow the healthcare system and policymakers to develop evidence-based initiatives.

Two major themes emerged in our conversations regarding such evaluation:

- **Define benchmarks for evaluating place-based care:** The healthcare system and policymakers should define markers of successful place-based care, specific to the context of the District. These measures should include:

- Community-driven markers of success: Community members' definitions and expectations of place-based care should help define successful place-based care in the District.
- Caseload size: Expected caseload size for clinical providers and support providers (i.e., social workers, case managers, community health workers) should also be identified for the purpose of measuring healthcare quality.
- Geographic distribution of healthcare resources: Equitable geographic distribution of healthcare resources may, in part, help to define success.

- **Assess a wide range of perspectives and topics:** The assessment should gather information from a range of stakeholders through several lenses, including DC residents, non-clinical organizational staff, and special populations (e.g., immigrants, non-native English speakers, and youth). Specific topics of interest include:
  - Physician and provider burden
  - Residents not already connected to a managed care organization (MCO): existing data may oversample persons who are connected to MCOs or other healthcare organizations. Ensure that data collected includes persons who are not connected to existing health resources.

Place-Based Care Themes Related to Developing Workforce Capacity

Workforce development spans a broad set of objectives aimed at cultivating a health and social service workforce that is responsive to the communities and persons they serve, and building capacity in the institutions in which they work. Encouraging the establishment and viability of high-quality healthcare resources that are located in all of the communities where residents live and work represents a way to promote place-based care and health equity across the District.

Place-Based Care Theme 2: Incentivize healthcare providers to practice in under-resourced areas.

Healthcare resources are unevenly distributed across the District; participants felt there were fewer places to seek high-quality care in Wards 5, 7, and 8. The conversations for this CHNA occurred after Providence Health System closed its obstetrics unit in 2017 and as it moved to close its acute care services. A healthcare executive discussed the impact of these closures on healthcare access for residents in the most under-served areas of DC:

Another warning sign is the closure of Providence and the closure of two obstetric units — Providence and UMC. The good news is that they're thinking about a [new] hospital — but that's not until 2023. None of this was planned very well.

Figure 12: Fertility Hot Spots and Cold Spots, with Operational Birthing Hospital Locations
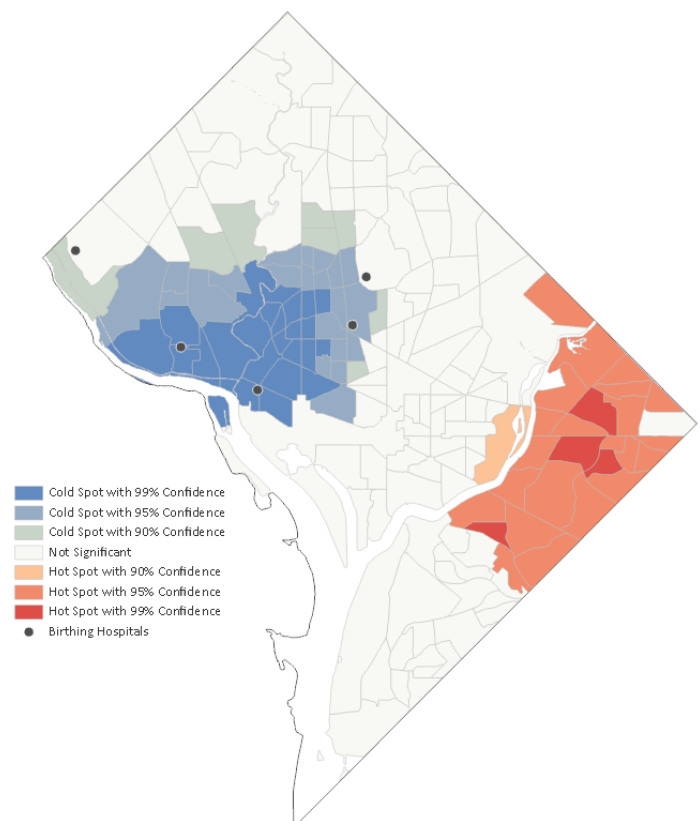
Hot and cold spots based on fertility rate of women age 15-50 by Census Tract. Source: 2013-2017 American Community Survey 5-year estimates

These developments have exacerbated the difficulties that residents of Wards 5, 7, and 8 have experienced when accessing healthcare. Participants recommended advocating for policies that correct this pattern, including:

- **Incentivize the establishment and maintenance of healthcare services:** Incentivize the establishment and maintenance of practices and clinics providing these services in under-resourced areas, particularly Ob-Gyn providers, acute care organizations, and mental health services — inpatient, outpatient, and psychiatric. Incentives may include tax abatements, student and business loan forgiveness, or access to capital.

- **Supplemental funding to sustain services:** It may be difficult for healthcare providers to balance high proportions of patients using public insurance in some neighborhoods with insufficient reimbursement rates, which threatens the long-term sustainability of healthcare resources. Providing ongoing, supplemental funding for healthcare organizations serving certain areas of the District will boost the economic viability of maintaining clinical services.

Private and small practices offer opportunities for providers to build trusting, longitudinal relationships with patients and communities, and enhance geographic health equity by increasing access to primary care throughout the District. However, few private practices exist in Wards 5, 7, and 8. The healthcare system should support, incentivize, and advocate for the growth of private practices in under-resourced communities across the District, including:

- **Assess barriers and facilitators to establishing private practices in the District:** Policymakers need information about what motivates medical and mental health providers to establish private practices in under-resourced areas so they may develop initiatives and incentives to encourage the establishment of private practices in the District.

- **Loan forgiveness for providers in private practice:** The healthcare system should research and advocate for incentives like loan forgiveness for providers operating private practices in under-resourced areas, including physicians, advanced practice nurses, clinical psychologists, and licensed clinical social workers. This may encourage providers to establish private practices in communities.

Spotlight on Place-Based Care Work:
Connecting with Communities of Faith

The Collaborative's Mental Health and Health Literacy Workgroups each intergrated one place-based care strategy from the CHIP into their agendas. In an effort to meet people where they are, the Health Literacy Workgroup took a deeper dive in supporting health literacy improvement efforts in faith communties and congregations. With Collaborative support, Wesley Theological Seminary selected Health Ministries within Wards 5, 7, and 8 to assess the needs of their congregation's population, develop culturally competent content; help to mobilize, coordinate, and disseminate educational resources; and build a sense of trust among collaborators and congregation. One objective emerged early: working with health ministers to support their community members to navigate the system of care. Through the summer of 2019 Wesley will conduct "train the trainer" education for Health Ministers on requested topics and work with the collaborative to build relationships between congregations and health institutions. In the meantime, Wesley produced a summary report about target populations and best practices, and is currently conducting a survey among providers about their experience with culturally relevant topics such as African American folk practices and spiritual assessments in the clinic to identify areas for future work.

Please visit our 2017-2019 Community Health Progress Tracker at DCHealthMatters.org to learn more about the accomplishments of the Health Literacy and Mental Health Workgroups.

Place-Based Care Themes Related to Simplifying the Path to Wellness

Simplifying the path to wellness refers to making it easier for DC residents to engage with the health system by removing complexity, redundancy, and inefficiency within health and social service organizations. The result is a system wherein the "right" thing is also the "easy" thing to do. This includes easing access to healthcare services through place-based care. Participants spoke about the need to expand primary care hours, develop and disseminate resource lists, and develop novel approaches to place-based care.

Place-Based Care Theme 3: Continue to expand the availability and accessibility of existing healthcare services.

Participants discussed ways to increase accessibility to healthcare services:

- **Maintain and expand extended hours at primary care clinics:** Several healthcare organizations in the District have extended the hours of operation of primary care clinics. This may enable patients with inflexible schedules due to work, school, caregiving commitments, transportation limitations, or other circumstances to access care. It may also divert patients with non-urgent health issues from emergency departments. Clinics with traditional hours of operation (9am to 5pm) should consider this change.
- **Extend hours of school-based clinics:** School-based clinics are embedded in locations that are familiar to youth and families. Extending the hours of operations beyond the school day will allow parents greater opportunities to participate in their children's medical visits and promote better pediatric outcomes.

Place-Based Care Theme 4: Develop and deploy innovative models of place-based care.

Focus group and interview participants believed that developing innovative place-based models of care will help to expand the capacity and reach of healthcare organizations across the District. Healthcare organizations
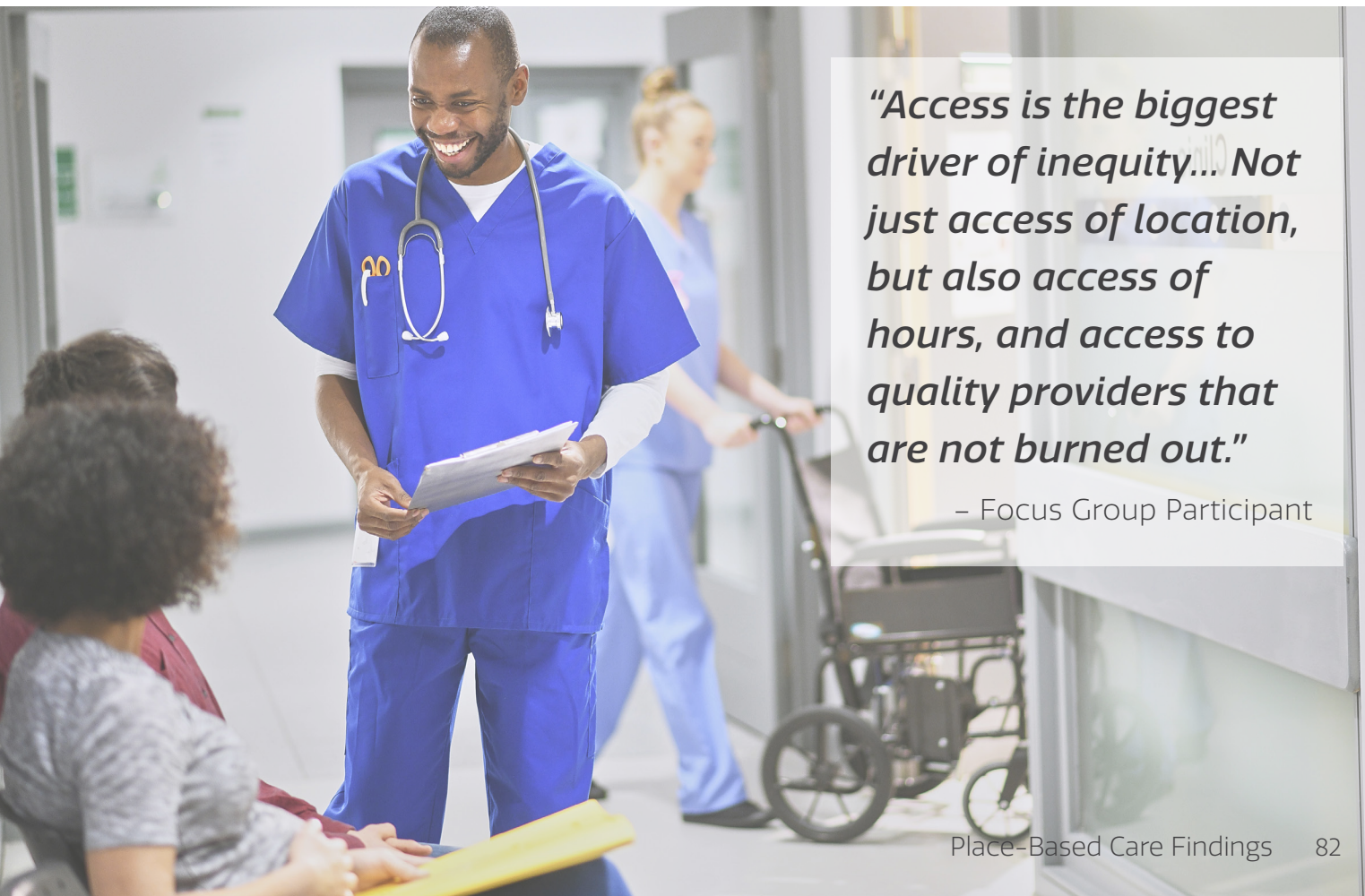
> *"Access is the biggest driver of inequity... Not just access of location, but also access of hours, and access to quality providers that are not burned out."*
>
> – Focus Group Participant

can support the development of innovative approaches through:

- **Expanding the use of technology to facilitate medical encounters:** Recent years have seen the growth of technology platforms to facilitate medical appointments. Continue to adopt and expand telehealth and telemedicine options for meeting with patients.

- **Co-locating medical services with social service and community organizations:** Conducting medical encounters in non-traditional locations may help reduce barriers to accessing care for residents (i.e., schools, libraries, home visitation, community centers, social service agencies, etc.). Changes to the federal Free Care Rule in 2016 expanded the ability of states to collect Medicaid reimbursement for medical services, thereby opening the door for the growth of school-based medical services. A program coordinator in the District discussed how healthcare organizations and DC Public Schools are collaborating to determine the most advantageous approach to securing reimbursement for school-based health services:

> *We've been working with [DC] Healthcare Finance to figure out if we wanted to amend the State Plan and include all of the other medical services that are being provided by schools that are not just for students receiving special education services…. We have not made a final determination because of the way that we seek reimbursement from the Feds. It may not actually be in our financial best interest to do this but we're still trying to run some numbers. It might make sense for some charter schools to do it, but not DCPS…. That's one thing that's exciting that the City is trying to decide but it could definitely increase access to federal reimbursement.*

Conclusion

As initially identified through the 2016 CHNA, place-based care remains a priority for our community stakeholders. The unbalanced distribution of healthcare resources and community trust across the District is a barrier to health equity. This chapter highlighted opportunities to improve access to conveniently located, high-quality healthcare services by expanding existing healthcare services and developing new models of place-based care.

As with the other priority areas, the place-based care themes will inform the development of the 2019 Community Health Improvement Plan (CHIP). Through the CHIP, the Collaborative will further distill these findings into strategies for systems changes and advocacy priorities to improve place-based care in the District in the years ahead.

More from our conversations

"People need to be culturally competent. We need to be neighborhood competent, too."
– Focus Group Participant

"Health equity is really about meeting a patient where they are." *– Focus Group Participant*

"If we're going to locate in a community, we should get community buy-in. It would be a good practice if folks just take a little moment and include the neighborhood in the process. What do they want?" *– Focus Group Participant*

"I've been practicing in DC for about ten years, and I think we're at a real height of scarcity and high barriers to medically impactful services. What I see is my families just having to fight for everything… housing and education and Medicaid." *– Focus Group Participant*

"Better resources and uniform training of coordinators would be helpful. There isn't a linear guide to services in DC. Each organization has created a working document that works for them that is siloed." *– Focus Group Participant*

"Things are not well translated – when we get anything for free or anything sent to us, many times the Spanish is really bad. You want to cry." *– Focus Group Participant*

"What is it that we believe? If a hospital says 'the thing that is most important to us is health equity' then everything runs from that. If you have something like that as your focus, then everything falls into place." *– Focus Group Participant*

"Our patients need to know that we hear everything else they are dealing with."
– Focus Group Participant

"We can't be afraid to say we may need to target our resources differently to truly achieve 'one DC.'" *– Town Hall Participant*

"Racism is a determinant of health. It's not all implicit bias. Some of the racism is willful and deliberate in the clinical setting." *– Town Hall Participant*

"Patients need the empowerment to say 'I am here to get your help, but this is my life, my body and my decision to make.' We need to teach shared decision-making."
– Town Hall Participant

"I think the policy/systems perspective is the best approach to achieve equity. The downside is that it's a long process. It takes so many years, but it is really what's needed."
– Government Official

Chapter 8: Next Steps

This Community Health Needs Assessment (CHNA) is an important, but not final, step in our community health improvement efforts. The findings from this report will inform our Community Health Improvement Plan (CHIP) which will detail our response to the assessment findings. We invite all DC stakeholders to join us in working toward health equity for District residents.

This 2019 Community Health Needs Assessment (CHNA) focuses on the four priority areas that our community stakeholders prioritized in the 2016 assessment: mental health, care coordination, health literacy and place-based care. We engaged with a diverse group of community stakeholders to determine policy and systems-level actions the healthcare sector could take in order to make progress in the four priority areas. Our assessment process led to a substantive list of 28 recommended actions that we detailed in Chapters 4-7.

As our next step, the Collaborative – in partnership with our community stakeholders – will develop a Community Health Improvement Plan (CHIP) that outlines how we move from assessing to actually addressing the District's health needs.

Community Health Improvement Plan

To be released in November 2019, the CHIP will be a living document of concrete, actionable plans for addressing the four community needs. It will use the action area framework from this report to guide development of strategies for policy and systems changes. We will engage with external stakeholders, our community advisory board (CAB) members, and other community representatives to create and move this plan into action, as shared accountability of this plan is critical for success. We will also host community-level conversations, and reach out to more residents and neighborhood leaders.

We will continue to apply an equity lens in developing our improvement plan by pursuing these following short- and long-term actions (adapted from Healthy People 2020):

- Pay attention to the root causes of health inequities and health disparities, specifically social determinants of health and the role of health policy in increasing health equity
- Focus particular attention on groups that have experienced major obstacles to health associated with socioeconomic disadvantages, including historical and contemporary injustices
- Promote equal opportunities for all people to be healthy and to seek the highest level of health-care possible
- Distribute resources in a manner that progressively reduces health disparities and improves health for all
- Put forth continuous efforts to maintain a desired state of equity after avoidable health inequities and health disparities are eliminated

"It's not just who is at the table, but how they are brought to the table and how they are engaged at the table. If you invite me to the table, invite me as an equal player, let me help set the agenda.'"

– Focus Group Participant

As our member organizations – and the health system in general – look to make a real difference in our community, we must work cohesively, reach across all sectors, and share accountability. The Collaborative has taken steps in the right direction by bringing several local hospitals, community health centers, government agencies, and community organizations to the table. We must sustain these collaborations to see true impact.

Collaboration with Community Partners

The Collaborative was formed out of a desire to collaborate on citywide community health improvement initiatives. We strive to learn from and align efforts with our peers while reducing duplication and sharing resources. Appendix 3 of this report is a Scan of Other Assessments, which summarizes five assessments published in DC since 2016 and places for potential alignment with the Collaborative's work. The two most analogous efforts are MedStar Health's 2018 Community Health Needs Assessment, and DC Department of Health's 2017 Health Systems Plan.

There is significant intersection between the priorities named in the Collaborative's and Medstar's CHNAs. Specifically, we share an emphasis on mental and behavioral health, linkage to resources and services, and attention to non-clinical factors that impact health such as transportation. We are also in dialogue with many of the same key partners and community-based organizations. Going forward, we will continue to have discussions about areas for partnership in the development and execution of our respective Community Health Improvement Plans.

Our assessment also identified many of the same needs as DC Health's Health Systems Plan. There are also many recommendations that we share, support, and plan to work toward together, including efforts to:

- Promote the bi-directional integration of medical and behavioral health services in outpatient settings through co-located and enhanced referral models.
- Reduce stigma around behavioral health issues.
- Promote health literacy to improve health outcomes.
- Support workforce training and capacity building efforts, including evidence-informed place-based strategies.
- Promote health equity by implementing policies and practices across all sectors that aim to address social determinants of health, improve health outcomes, and reduce disparities.

The Collaborative has engaged with staff from MedStar Health and DC Department of Health in this and prior CHNA efforts, and will continue to work with them as part of CHIP planning and implementation, workgroup projects, and the community advisory board.

Accountability and Transparency

To enhance accountability and transparency, the Collaborative will continue to evolve our online portal of community health information known as DCHealthMatters.org. As noted earlier, this portal is a clearinghouse of community health indicators and related resources that are tailored to the DC community. DCHealthMatters.org will house both this needs assessment and the accompanying CHIP. It will serve as the reporting, tracking, and monitoring mechanism for the CHIP and include a community feedback tool. We will use several data sources to track progress on our CHIP goals, including citywide survey data, hospital administrative data, demographic population files, and qualitative community perspectives (focus groups/interviews).

The Collaborative is committed to maintaining DCHealthMatters.org to ensure transparency and accountability as we work to advance community health. In addition to posting the assessment to DCHealthMatters.org, each Collaborative organization will post this assessment and the corresponding CHIP to their individual organizational websites.

Join Us on This Journey

We invite all DC stakeholders to join us in working toward health equity. Community members are welcome to attend meetings of our Community Advisory Board or working groups. Contact us via email at collab@dchealthmatters.org for more information.

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Appendix 1: Landscape Infographic

The DC Health Matters Collaborative (DCHMC) is a coalition of hospitals and health centers that work with community partners to improve health and well-being in DC communities. This infographic is part of the DCHMC Community Health Needs Assessment. It highlights several DC socio-demographic and health characteristics.

CY2019
washington, dc

3 4 1 5 2 6 7 8

race

Two+ 3.5%
Other 5.6%
Asian 4.2%
White 41.5%
Black 45.2%

ethnicity

11.7% latino

age

34.6 years

< 18 yrs (19%)
18-44 yrs (47%)
45 -64 yrs (22%)
65+ yrs (12%)

sex

47.5%
52.5%

more data available at DCHealthMatters.org

life expectancy
80.7 years

varies by **17 years** across the District wards

Leading Causes of Death
rates per 100,000 residents, 2015

Heart Disease	Cancer	Accident	Stroke	Diabetes
186.2	166.3	39.4	37.9	25.6

200
150
100
50
0

13.7% families living in poverty (2013-17)

$83K median household income (2019)

10% did not graduate high school (2019)

7.1 deaths per 1,000 infant births (2016)

i

Infant mortality and life expectancy - two key measures of population health vary dramatically across the District.

dc wards

1

IMR

5.7
deaths per 1,000 births

Neighborhoods

Columbia Heights, Mount Pleasant, Adams Morgan, U Street, Pleasant Plains, Park View, Shaw, LeDroit Park, Meridian Hill, Lanier Heights, Kalorama & more

Life Expectancy

80.7 years

2

IMR

2.2
deaths per 1,000 births

Neighborhoods

Chinatown, Dupont Circle, Federal Triangle, Foggy Bottom, Georgetown, Logan Circle, Mount Vernon Square, Penn Quarter, Shaw, Sheridan Kalorama, SW Federal Center, U Street Corridor, West End & more

85.2 years

3

IMR

2.3
deaths per 1,000 births

Neighborhoods

American University Park, Cathedral Heights, Chevy Chase, Cleveland Park, Forest Hills, Foxhall, Glover Park, Palisades, Potomac Heights, Tenleytown, Wesley Heights, Woodley Park & more

86.1 years

4

IMR

5.2
deaths per 1,000 births

Neighborhoods

Brightwood, Brightwood Park, Chevy Chase, Colonial Village, Crestwood, Fort Totten, Hawthorne, Manor Park, Petworth, Riggs Park, Shepherd Park, Sixteenth Street Heights, Takoma & more

79.1 years

5

IMR

9.2
deaths per 1,000 births

Neighborhoods

Bloomingdale, Brentwood, Brookland, Carver Langston, Edgewood, Ft Lincoln/Totten, Gateway, Ivy City, Michigan Park, Pleasant Hill, Queens Chapel, Stronghold, Trinidad, Woodridge & more

Life Expectancy

75.8 years

6

IMR

5.7
deaths per 1,000 births

Neighborhoods

Barney Circle, Capitol Hill, Judiciary Square, Kingman Park, Mount Vernon Triangle, Navy Yard, Near Northeast, NoMa, Shaw, Southwest Waterfront, Sursum Corda, Swampoodle & more

78.4 years

7

IMR

9.3
deaths per 1,000 births

Neighborhoods

Benning, Deanwood, Dupont Park, Eastland Gardens, Fort Davis, Fort Dupont, Fort Stanton, Good Hope, Greenway, Hillbrook, Hillcrest, Kenilworth, Lincoln Heights, Marshall Heights, Mayfair, Penn Branch & more

71.7 years

8

IMR

14.6
deaths per 1,000 births

Neighborhoods

Anacostia, Barry Farm, Bellevue, , Buena Vista, Congress Heights, Douglass, Fairlawn, Garfield Heights, Knox Hill, , Shipley Terrace, Washington Highlands, Woodland

69.0 years

Appendix 2:
Focus Group & Interview Script

1. What is your reaction to the Collaborative's strategies and approach to [insert priority area]?

2. With regards to [insert priority area], what has changed in the last 2-3 years since the 2016 CHNA?

3. We know from our work that health inequities are present in our city (ex: by race, neighborhood, income, immigration status, etc.). What are the biggest issues you see in DC related to inequity generally and specifically related to [insert priority area]? What can the Collaborative do to take steps towards equity, in general and in [priority areas]?

4. We may have an opportunity to work with the DC Department of Health or other agencies to collect new data or make existing data more accessible. What information do you think is missing (or too hard to access) about [insert priority area] in DC?

5. What policy actions do you think would make the biggest difference in [insert priority area] in DC? How would these policy changes make a difference in our community? *[An example of policy actions related to asthma would be new regulations about indoor air quality in schools.]*

6. What systems changes within healthcare organizations do you think would make the biggest difference in [insert priority area] in DC? How would these changes in the healthcare system impact [priority area] in DC? *[An example of systems change related to asthma would be new screening tools integrated into ED visits for asthma attacks.]*

7. What are the best ways to engage DC organizations, groups and leaders in this important work?

8. Are there any additional comments you would like to make based on the discussion we've had here today?

Appendix 3: Scan of Assessments

The DC Health Matters Collaborative was formed out of a desire to collaborate on citywide community health improvement initiatives. We strive to learn from and align efforts with our peers while reducing duplication and sharing resources. Producing a CHNA – this report – is a requirement for all non-profit hospitals and federally qualified health centers: a requirement that we have embraced as a sincere opportunity to collaborate with community organizations in improving the health and well-being of DC residents.

We know that we are not alone in our desire to define and respond to community needs. Several other groups in DC undertake health-related assessments and surveys for a variety of purposes and audiences. Presented below are summaries of a selection of six assessments published in DC since 2016, their findings, and places for potential alignment:

- **MedStar Health: Community Health Needs Assessment, 2018**
- **DC Department of Health: Health Equity Report, 2019**
- **DC Department of Health: DC Health Systems Plan, 2017**
- **The District of Columbia State Medicaid Health IT Plan (2018-2023): Improving Care Through Innovation**
- **District of Columbia Office of the State Superintendent of Education: DC Youth Risk Behavior Survey, 2017**
- **Washington Area Women's Foundation: District of Columbia Family Planning Community Needs Assessment, 2018**

Appendix 3: Scan of Assessments

We found many shared themes among these assessments. In brief, the most common areas of overlap were:

- A need for stronger, seamless linkages to and among the many available services in the District
- A perceived shortage or maldistribution of high-quality services, from primary care to mental health services
- Transportation as a key barrier to or facilitator of health access
- Low health literacy, specifically a lack of information – or misunderstanding or negative perceptions about – services available in the District and prescribed treatment options, often paired with a mistrust or sense of alienation from the health system
- A need for services, education, and support related to mental health-related issues (e.g., substance use and depression) for residents of all ages
- Disparate and inequitable health outcomes and care access by race/ethnicity, neighborhood, gender, sexual orientation, and language spoken
- Opportunities for collaboration and innovation among providers, agencies, organizations and sectors

These common themes strengthen the Collaborative's resolve to address priority health needs. The Collaborative welcomes opportunities to collaborate with our peers in making a difference in the health and well-being of DC residents.

MedStar Health: Community Health Needs Assessment, 2018

Scope and Purpose

MedStar Health is a non-profit health system that operates hospitals, ambulatory care, and urgent care centers and the MedStar Health Research Institute in the region. Three of MedStar's ten hospitals operate in DC: MedStar Washington Hospital Center (MWHC), MedStar National Rehabilitation Hospital, and MedStar Georgetown University Hospital (MGUH). To meet the ACA's CHNA requirements, MedStar used a systematic approach to identify the needs and assets, with a special focus on underserved communities within its geographic footprint. The report was released in 2018, as MedStar's three-year CHNA cycle began the calendar year before the Collaborative's.

Each hospital's Advisory Task Force used quantitative population-level data, as well as findings from a survey and community input sessions, to name health priority areas that span health outcomes as well as social, environmental, and economic barriers. There were 3,345 survey respondents, and 150 people participated in community input sessions. Task Forces also identified potential implementation strategies and key partners to address priority areas. One CHNA report was published by the system, with data and recommendations broken out by hospital. For the three hospitals located in the District of Columbia, the combined "community benefit service area" covers zip codes 20011, 20019, and 20020, with emphasis on wards 5, 7, and 8.

Appendix 3: Scan of Assessments

Brief Summary of Findings

Within the MedStar CHNA report, there is a chapter for each hospital with population-level health outcomes data related to high-priority diseases, strategies, and anticipated outcomes of actions in the area, and metrics for evaluation (program-specific and public health metrics). Priorities were identified in three overarching categories:

- Health and wellness
- Access to care and services
- Social determinants of health

The community health priorities for DC hospitals varied only marginally; all included:

- Chronic Disease Prevention and Management
- Linkage to Resources and Services
- Transportation (to or from health-related services)
- Food Access
- Employment
- Housing

MedStar's Georgetown University Hospital and Washington Hospital Center also included behavioral health and access to mental health services as priorities, and Georgetown additionally listed access to substance use services and linkage to resources and services within schools. MedStar identified broad system-wide priorities that encompassed all of the above, plus access to affordable child care.

For each priority, hospital Task Forces determined the level of engagement for which the organization was best positioned – leader, partner, or supporter – "based on factors such as system strengths and assets, community expertise and assets, and current programming." The CHNA also includes the community assets named by survey respondents, including local health departments, community healthcare providers and organizations, social service agencies, pharmacies, faith-based institutions, schools, homeless shelters, employment agencies, food banks, and other community-based organizations. Key partners operating in the service area and issue areas are detailed in the CHNA chapters, including DC and Maryland government agencies, local organizations, and community resources like Aunt Bertha.

Opportunities for Connection

Since the Collaborative's formation, MedStar representatives have been engaged in discussions about our respective CHNA processes. Ultimately, MedStar did not join the Collaborative as they focused on a systemwide CHNA process that included their facilities outside of DC. For the Collaborative's current 2019 CHNA, MedStar staff participated in our focus group sessions. The Collaborative also studied MedStar's community survey as providing important insight into the perspectives of community members.

Readers will notice significant intersection between the priorities named in the Collaborative's and Medstar's CHNAs. Specifically, we share an emphasis on mental and behavioral health, linkage to resources and services, and attention to non-clinical factors that impact health such as transportation. We are also in dialogue with many of the same key partners and community-based organizations.

Appendix 3: Scan of Assessments

Going forward, we will continue to have discussions about areas for partnership in the development and execution of our respective Community Health Improvement Plans.

DC Health: Health Equity Report, 2019

Scope and Purpose

The DC Department of Health (herein referred to as DC Health) released "Health Equity in the District of Columbia" in February 2019. The purpose of the report is to document "a baseline assessment of health equity and opportunities for health in Washington, DC." The report presents select health outcomes of DC residents (e.g., leading causes of death, life expectancy) as well as structural, non-clinical "key drivers" of health. The Health Equity Report paints a visual picture of disparate health outcomes and inequities present in the city, especially by race, by mapping data across eight wards and 51 neighborhoods. The key takeaway is that "your zip code may be more important than your genetic code for health."

The stated goals of the report are to:

- Develop a baseline assessment of social determinants of health in the District of Columbia.
- Inform the narrative regarding improving opportunities for health and achieving health equity.
- Engage a broad spectrum of the community in essential multi-sectorial solution development.

Brief Summary of Findings

The bottom line of the Health Equity report is: "While the overall health of District residents has improved during the past decade, health disparities and inequities – as measured by almost any indicator – are evident by race, income, and geography across the District of Columbia." This is seen in both population health data and other non-clinical indicators. As a starting point, nearly 1 in 5 Black residents (19.5%) report fair/poor health, compared to 9.1% of all other races.

Through mapping data related to nine key drivers, we see a more robust, nuanced and comprehensive snapshot of the well-being of District residents and the state of equity in the community. The "Nine Key Drivers" are Education, Employment, Income, Housing, Transportation, Food Environment, Medical Care, Outdoor Environment and Community Safety. Research shows that indicators related to these nine drivers, such as lack of jobs, racial and economic segregation, and concentrated poverty, negatively impact neighborhood quality, community safety, and quality of life. Below are selected data highlights from the report for the nine drivers of health:

1. **Education**
   "The 2016 adjusted cohort graduation rate data reveal racial and ethnic differences. White students had a 91.4% graduation rate, compared with African-American students (67.7%), and Latino students (69.2%)."

2. **Employment**

Appendix 3: Scan of Assessments

"Six neighborhoods in Wards 7 and 8 had unemployment rates in excess of 20%, and one neighborhood (Bellevue) had an unemployment rate of 30%. At the other end of the spectrum, unemployment in Wards 2 and 3 averaged just 3.7% for the same period – 40% lower than the national average."

3. Income

"In 2015, the median household income for Black households in the District was $40,677, barely over a third of that of White households at $115,890. Within the District, 21% of adults earning $15,000 or less reported only fair/poor health, compared with only 3.0% of those earning $75,000 or more."

4. Housing

"The occurrence of cost-burdened households (gross rent as a percentage to household income equal to 35% or greater) differs in concentration across the District, ranging from 19.9% of households in Capitol Hill to a high of 59.6% in Historic Anacostia."

5. Transportation

"Despite the growth of new rideshare options, access gaps in public transportation remain in the District, especially further away from the center. Capital Bikeshare and bike lanes are also much more concentrated towards the city center, with a paucity of biking options beyond."

6. Food Environment

"The large majority of residents live within one mile of a grocery store. [However,] food insecurity remains a major barrier to healthy eating in the District, with 11.4% of residents classified as food insecure from 2011–2016 and 4.0% classified as very low food security."

7. Medical Care

Though a high percentage of DC residents have insurance coverage (94.2%), there are disparities by racial/ethnic resident groups. "Nearly 1 in 7 Hispanic residents (13.5%) have no health insurance compared with 1 in 15 (11.8%) Black residents, and 1 in 30 (3.5%) White residents."

8. Outdoor Environment

"Analysis showed that vulnerability to climate change was not evenly distributed. Wards 7 and 8 had the highest concentrations of vulnerability, as well as a large elderly population."

9. Community Safety

"Between 2009 and 2013, the District ranked first in the nation in firearms deaths. Mortality due to homicide was 16.0 per 100,000 in the District, three times the national rate of 5.2. Of all homicide deaths in the District, over 70% were people ages 16 to 39 years, and 81% were Black males."

Opportunities for Connection

The Health Equity report will serve as an important reference for the Collaborative. The Collaborative shares DC Health's philosophy that "opportunities for health are created primarily outside of the healthcare and traditional public health systems." As health systems, our members are committed to "collaborative action for change" across sectors to achieve health equity. We are especially interested in learning more from community partners about what the report notes as: "the historical forces

Appendix 3: Scan of Assessments

that have left a legacy of racism and segregation, as well as structural and institutional factors that perpetuate persistent inequities."

The Collaborative and DC Health have a shared mission of assessing and addressing community needs. Several of the high-priority needs identified in the Collaborative's assessment process are noted in the Health Equity report. For example, health literacy is elevated as a systemic issue: "More than 1 in 3 adults have limited health literacy. Few adults (12 %) are considered "proficient." Only 9% scored in the highest numeracy levels. Nearly 9 in 10 adults may lack the skills to manage their health and prevent disease; with consequences for how individuals and communities understand their health risks, the benefits available to them, the ways in which they access medical care, including the health behaviors they exhibit." The Report also noted that discrimination and generational poverty can impact mental health. As part of our CHIP work, we will work with several community partners, including DC Health, to develop goals and measures for social and racial equity as suggested in the Health Equity Report.

DC Department of Health: DC Health Systems Plan, 2017

Scope and Purpose

By law, DC's State Health Planning and Development Agency (SHPDA) within the Department of Health (DC Health) is tasked with developing a comprehensive Health Systems Plan (HSP) to "serve as a guide for public and private investments in public health and healthcare delivery systems" and "help promote the health and well-being of residents across the District." SHPDA published the current HSP in 2017. The qualitative data collection process for the HSP is similar to the Collaborative process, including key informant interviews and community-based focus groups engaging service providers, health department officials, community stakeholders, and community residents. Quantitative data to describe D.C.'s population were compiled from existing sources including Healthy People 2020, the Behavioral Risk Factor Surveillance System (BRFSS) survey, the DC Health Matters Collaborative's CHNA, and the U.S. Census Bureau. The Plan assesses data and trends related to hospital services, primary care, specialty care, behavioral health, and post-acute care services. It concludes with recommendations in the priority areas of Health Services Strengthening, Health Systems and Structures, and Community Health.

Brief Summary of Findings

The HSP contains a broad range of DC demographics and health status data, as well as key social determinants of health and barriers to care in the District (poverty, income, and employment; education; housing and homelessness; safety and violence; transportation; food access; health literacy). It names key health issues and disparities in DC according to data and community input: health insurance coverage and access to care; health risk factors (e.g., obesity, tobacco use, and alcohol abuse); chronic and complex conditions; behavioral health (including anxiety, depression, special challenges for children and people experiencing homelessness, and suicide); mental illness and substance use; oral health; maternal and child health.

Key findings of the Health Systems Plan – many of which echo our own findings – paint a picture of the healthcare landscape in DC:

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- The top major diagnostic category in DC in 2014 was pregnancy and childbirth; mental diseases and disorders was #5.

- While there are not major service gaps or surpluses in DC by the numbers, resources may be maldistributed or inaccessible to low-income patients or non-native English speakers.

- Hospital data reveal that many residents travel long distances to facilities across town, though they may have other resources closer to their homes, indicating that supply may be less of an issue per se than the reputation of institutions.

- A high proportion of DC residents are not fully engaged in appropriate primary care; 40-66% of Medicaid enrollees living in some wards are not engaged in care.

- Emergency services may be overused and accessed inappropriately for non-emergency care and/or for conditions that may be prevented with appropriate primary care services.

- Lack of coordination and health literacy need to be addressed in order to increase primary care usage and health status.

DC Department of Health notes that the health field is shifting to focus more on preventive services, as well as the social determinants of health. It further encourages more collaboration across sectors and institutions in order to "improve care coordination, reduce fragmentation of services, support patient/provider communication, enhance primary care medical and specialty care follow-up, and promote smoother care transitions." It notes the opportunity for the DC Health Matters Collaborative to expand its membership to include all of DC's hospitals and the leading community-based community health and social service agencies.

The Plan next presents a landscape of DC's Public and Private Behavioral Health System, utilization statistics, and challenges. While DC Department of Health states that there is not a general shortage of behavioral health providers in the District, interviewees reported a shortage of certain types of professionals, particularly psychiatrists (especially child psychiatrists). Financial barriers exist, such as insufficient insurance benefits and a shortage of providers willing to accept insurance. Further, stigma, lack of health literacy, the challenge of navigating insurance coverage, and racial/ethnic, linguistic and cultural barriers present challenges to meeting the need for these services. As with other sectors, there is a need for more coordinated care, better mental health integration into primary care and other settings, and enhanced capacity in the workforce. Workforce capacity recommendations include supporting patient navigator or community health worker programs and regular training for providers.

The District of Columbia's post-acute care system (including long-term care, nursing homes, rehabilitation facilities, hospice, and home health) is also covered in the HSP. Again, the service capacity in this sector was found to be sufficient for demand, with opportunities to improve coordination and service integration, family and caregiver engagement, multi-sector collaboration, and health literacy, among others.

Opportunities for Connection

Our assessment identified many of the same needs as the HSP. We appreciate that the Collaborative's 2016 CHNA was a quoted source for the HSP, and recommendations were made for our group.

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The three community forums of residents that were conducted as part of the HSP assessment are especially valuable, as was the effort to hold forums in neighborhoods "experiencing the greatest health disparities." As with the MedStar CHNA, we can learn from what forum participants expressed for the HSP.

There are also many recommendations that we share, support, and could work toward together. These areas of alignment with the HSP are numerous:

- Promote the bi-directional integration of medical and behavioral health services in out-patient settings through co-located and enhanced referral models.
- Reduce stigma around behavioral health issues.
- Promote well-coordinated, patient-centered care transitions that enhance patients' recovery, increase independence, and reduce inappropriate hospital readmissions.
- Promote multi-sector collaboration within and across service systems and sectors.
- Promote health literacy "universal precautions" to improve health outcomes.
- Support initiatives that improve supportive systems (e.g., transportation, scheduling, insurance enrollment) and empower system navigation and self-management.
- Support workforce training and capacity building efforts, including evidence-informed place-based strategies.
- Explore sustainable financing structures to address social determinants of health, barriers to access and engagement, care coordination, and service integration, and funding streams such as community benefit funding, alignment of government programs and investments, payment reform/value-based payment, and private foundation or corporate support.
- Promote health equity by implementing policies and practices across all sectors that aim to address social determinants of health, improve health outcomes, and reduce disparities.

The Collaborative has engaged DC Department of Health in this and prior CHNA efforts, as well as CHIP planning and implementation, workgroup projects, and the community advisory board. We will consult the Department of Health's HSP in the development of the CHIP, and the Department of Health will continue to be a critical partner.

The District of Columbia State Medicaid Health IT Plan (2018-2023): Improving Care Through Innovation

Scope and Purpose

The District of Columbia Department of Health Care Finance (DHCF) is DC's Medicaid agency as well as the State Health Information Technology Coordinator, responsible for policy related to electronic health records (EHRs), health information technology (health IT), and health information exchange (HIE). It is required by the federal Centers for Medicare & Medicaid Services (CMS) to produce the State Medicaid Health Information Technology Plan every two years, in order to assess current health IT and HIE implementation, evaluate evolving needs, and define goals and metrics to evaluate success. The most recent plan was released in October 2018. The plan highlights the District's goal to "design

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and implement an electronic network that provides actionable health-related information whenever and wherever it is needed, to support person-centered care and improve health outcomes" by 2021.

The plan presents a portrait of health and services in DC, details the current technology and HIE landscape, and includes feedback collected through 29 interviews and five focus groups with health system stakeholders, including patients, payers, and providers. The feedback informed a roadmap for meeting the District's HIE and health IT goals – for individual health, population health, and public health – over the next five years.

Brief Summary of Findings

Common themes were identified through stakeholder interviews and focus groups, and surveying other local assessments about opportunities for improvement in health IT and HIE. The findings included:

- A lack of well-coordinated, person-centered care
- The impact of social determinants on residents' care
- Disparities in health outcomes
- Gaps in public health information

DHCF's State Medicaid Health IT Plan's top priority projects related to improving health IT and HIE use for 1) transitions of care across settings, and 2) public health connectivity, including registries and case reporting. Areas "for longer-term consideration" included the collection, exchange, and use of data about social determinants of health, and using analytics to manage population health.

The plan further outlines a "maturity model" for the system and an evaluation framework for DHCF's goals and activities, as well as the intention to develop a structured, ongoing community engagement process.

Opportunities for Connection

The Health IT Plan shares common findings with our needs assessment, including the opportunity to improve information sharing across providers, improve care coordination, and track referrals. Members of the Collaborative participated in the interviews and focus groups for the plan, and we hope to directly engage with the DC HIE Policy Board – "an entity designed to reflect the diversity and composition of the District's health system." There is potential for collaboration, especially in better tracking of transitions of care (including the use of Aunt Bertha.) It could also be possible for the Collaborative to serve as a hub for connections to clinicians for technical assistance, community engagement, and education described in the plan.

District of Columbia Office of the State Superintendent of Education: DC Youth Risk Behavior Survey, 2017

Scope and Purpose

The Youth Risk Behavior Survey (YRBS) is a survey of health risk behaviors conducted in middle and high schools every two years in Washington, DC and around the United States. The CDC developed

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the Youth Risk Behavior Surveillance System (YRBSS) in 1990 to monitor priority health risk behaviors that contribute markedly to the leading causes of death, disability, and social problems among youth and adults in the United States. The Office of the State Superintendent of Education (OSSE) – the state education agency for the District – oversees the survey administration and analysis in DC. These behaviors are often established during childhood and early adolescence. The biennial YRBS included data from more than 30,000 District students in grades six through 12. YRBS data are compared to results from 2015.

Brief Summary of Findings

The YRBS covers six topic areas including: Behaviors that contribute to unintentional injuries and violence; tobacco use; alcohol and other drug use; sexual risk behaviors; unhealthy dietary behaviors; physical inactivity. The report contains a tremendous amount of data, including several metrics relevant to issues of equity; for example:

- Lesbian, gay, or bisexual high school students were two to three times more likely to feel sad or hopeless and to think seriously about, plan, and attempt to kill themselves.
- Female high school students are 45% less likely to be physically active (at least four days per week) than male peers, while Black and Hispanic students were less active than their white peers.

The survey also revealed increases from 2015 in the following behaviors:

- High school marijuana use
- Middle schoolers who had their first drink of alcohol under age 11
- Middle school and high school students who had ever had sex
- High school students who had been threatened or injured with a weapon on school property in the last year

Further, the increase in risky behaviors is compounded by a decrease in the use of prevention methods that could mitigate harm; condom use among sexually active high schoolers is down from 66.6% in 2015 to 61.2% in 2017.

OSSE uses the YRBS data to target trainings for District teachers and principals at public and public charter schools and licensed personnel at child development facilities on how to identify and refer students with behavioral health needs. Data are also used for public awareness campaigns and training parents, family members, teachers, school personnel, and peers for curriculum or resources: for example, how to assist youth facing mental health challenges or crises. OSSE is revamping current programs and strategically partnering with various agencies and organizations to address the issues reflected in the report.

Opportunities for Connection

It is important to understand real-world behaviors – and, if possible, the social and environmental factors behind them – in order to anticipate areas for intervention. Healthcare organizations and providers can partner with the education sector in this multi-faceted work: for example, working with OSSE to expand the availability of resources to schools and families. The findings reflect a disconnect

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between evidence-based curriculum available to educators and real-world behaviors of students; this may point to issues of health literacy discussed throughout this CHNA. OSSE's recommendation to diversify professional development offerings intersects with what we've detailed in this CHNA about workforce capacity. OSSE's drive to include youth at the table to address some of the risky behaviors identified in the YRBS fits within our Community Dialogue domain.

Washington Area Women's Foundation: District of Columbia Family Planning Community Needs Assessment, 2018

Scope and Purpose

Researchers from the George Washington University Milken Institute School of Public Health (GW), with support from the Washington Area Women's Foundation and The Alexander and Margaret Stewart Trust, conducted a community needs assessment for the DC Family Planning Project. The purpose was to analyze the landscape of family planning services and contraceptive utilization in the District for women ages 15-29. The report is based on primary and secondary qualitative and quantitative data through May 2018. The data was gathered through surveys, focus groups, and interviews with family planning providers and administrators, as well as more than 1,600 women ages 15-29 living in or receiving healthcare services in DC across all eight wards.

Brief Summary of Findings

The statistical backdrop of the assessment is a relatively high teen birth rate in DC: 25.6 births per 1,000 teens (ages 15-19) in 2015, compared to 22.3 births per 1,000 teens nationally. The rate was highest among teens in Wards 4, 5, 7, and 8.

The researchers found a disconnect between the availability and utilization of contraceptive services (including same-day appointments and low- or no-cost services). This gap may be due to:

- Limited availability of adolescent-friendly services
- Concerns about confidentiality
- Low levels of knowledge or negative perceptions about the side effects and comfort of contraceptive methods

As a result, a significant number of sexually active young women are not accessing reproductive healthcare. Levels of knowledge about highly effective Long Acting Reversible Contraceptive (LARC) methods – such as intrauterine devices (IUDs) and implants – were lowest among teens, Black adolescents/women, and adolescents/women living in Wards 4, 5, 7, and 8.

The report notes that a woman's ability to obtain and adhere to contraceptives impacts education and workforce participation, family stability, and mental well-being for her and her children. Social determinants of health can be major barriers to this access, from housing insecurity and limited access to transportation to low health literacy and concerns about safety.

Recommendations based on these findings include a range of education and outreach efforts for different audiences, increased reimbursement for provision of sexual health services, and a focus on

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making services and providers more adolescent-friendly.

Opportunities for Connection

Many of the overarching themes of the report match our CHNA findings, especially the underlying mistrust or concerns about cultural appropriateness of available health services. The stories told in the report echoed those we heard in focus groups, especially related to health literacy: a disconnect between availability and one's knowledge of services, misinformation about prevention and treatment options, the need for culturally appropriate care (particularly for adolescents and young women of color), and some workforce capacity and communication issues. Going forward, the Collaborative should work with the DCFPP Community Advisory Board as they identify opportunities to broker trusting relationships with providers and improve access to health information among young women across DC.

Conclusion

This chapter presented summaries of five assessments published in DC since 2016 while noting many places of alignment with the Collaborative's CHNA findings. As the Collaborative works toward responding to its CHNA findings in its upcoming Community Health Improvement Plan (CHIP), we place high value in working in partnership with our peers, highlighting existing resources, and learning from analogous assessments. Through our respective research, key themes have emerged that present opportunities to work together, from supporting better linkages to and between services to increasing health literacy across the lifespan of all residents. Collaboration is the core of the Collaborative's model and work, and will be critical to making a significant and sustainable impact on the health of our community.

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