The District of Columbia Healthy Communities Collaborative

DISTRICT OF COLUMBIA

COMMUNITY HEALTH NEEDS ASSESSMENT

JUNE 2016

This report summarizes a community health needs assessment (CHNA) for the District of Columbia (DC) developed by the DC Healthy Communities Collaborative (DCHCC): a coalition of four hospitals (Children's National Health System, Howard University Hospital, Providence Health System, and Sibley Memorial Hospital) and four federally qualified health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care).

Letter of **Commitment** to Our **Community**

The District of Columbia Healthy Communities Collaborative (DCHCC) is pleased to share with you our *2016 Community Health Needs Assessment*. Since our beginning in 2012, the Collaborative has been committed to improving the lives and health of people living in our communities. This report is a tangible representation of our continued commitment to that goal.

Building on our 2013 community health needs assessment and the information shared on our DC Health Matters website (www.dchealthmatters.org), the 2016 assessment represents a shift from a focus on individual clinical conditions to larger social determinants of health. In order to achieve this shift in direction, this assessment placed a much larger emphasis on having our community's perspective shape this work. As a result, this report includes community thoughts from the following:

- 113 online survey respondents,
- 80 community forum attendees,
- 60 community-based organizations,
- 40 focus group participants,
- 31 key informant interviews,
- 15 hospitals and community health centers,
- 11 government agencies, and
- 8 elected officials, including DC Councilmembers and Advisory Neighborhood Commissioners.

This wealth of qualitative data allowed us to fulfill our commitment to the community by prioritizing their needs in our assessment. The implementation plan that will be developed from this assessment is our roadmap to improving the health of District of Columbia residents.

The Collaborative would like to thank everyone who was involved in development of this assessment. 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.

Thank you,

Angelica Journagin, JD, MHA
Chairperson, District of Columbia Healthy Communities Collaborative
Unity Health Care, Inc. Unity Health Care, Inc.

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> The DC Healthy Communities Collaborative authored this community health needs assessment to serve as an evidence-based, community-driven foundation for our community health improvement efforts. Working with our communities, we use this assessment to identify priority health needs in our city. Ultimately, addressing these needs will bring us closer to a state of health equity for all DC residents.

Bread for the City

Bread for the City is a frontline agency serving Washington's poor. Bread for the City provides comprehensive services, including food, clothing, medical care, legal and social services to low-income Washington, DC residents in an atmosphere of dignity and respect.

Children's National Health System

Children's National Health System is the only exclusive provider of pediatric care in the metropolitan Washington area and is the only freestanding children's hospital between Philadelphia, Pittsburgh, Norfolk, and Atlanta. Children's National provides needed service to children through clinical care, advocacy, research and education.

Community of Hope

For over 30 years, Community of Hope has worked to improve the quality of life for homeless, low-income, and underserved families and individuals in the District of Columbia. A Federally Qualified Health Center, Community of Hope provides a full range of primary care services – including medical care, dental care, and behavioral health support – at two locations and is building a third center in Ward 8.

Howard University Hospital

Over the course of its 150-year history of providing primary, secondary and tertiary health care services, Howard University Hospital has become one of the most comprehensive health care facilities in the Washington, DC metropolitan area. A private, non-profit institution, Howard University Hospital is the nation's only teaching hospital located on the campus of a historically Black university.

Mary's Center

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. We embrace culturally diverse communities whose needs too often go unmet by the public and private systems, and we provide

them with the highest quality of care, regardless of ability to pay. Mary's Center uses a holistic, multipronged approach to help participants access individualized services to set them on the path toward good health, stable families, and economic independence.

Providence Health System

Providence Health System (Providence), a member of Ascension Health, the nation's largest non-profit health system and the world's largest Catholic health system, provides a full range of care from primary and outpatient to geriatrics. Since being chartered by President Abraham Lincoln in 1861, Providence has been meeting the needs of the Nation's Capital for orthopedics, maternity, geriatric care, behavioral health, diabetes, stroke care, and community wellness programs.

Sibley Memorial Hospital

Sibley Memorial Hospital, a member of Johns Hopkins Medicine, has a distinguished history of serving the community since its founding in 1890. As a not-for-profit full-service community hospital, Sibley offers medical, surgical, intensive care, obstetric, oncology, behavioral health and a 24 hour Emergency Department. In addition, Sibley is designated a Joint Commission Certified Primary Stroke Center. Sibley's Renaissance Center for Rehabilitative Medicine is home to Sibley Senior Association, specialty centers, a skilled nursing unit and a residential Alzheimer's unit.

Unity Health Care

Unity Health Care, Inc. (Unity) was founded in 1985 as the Health Care for the Homeless Project providing primary health care services to homeless individuals and families that resided in local emergency shelters or on the streets of the District of Columbia. Unity is currently the largest primary health care agency in the area with a team of more than 980 compassionate, multicultural professionals that include medical providers, nurses, medical and dental assistants, pharmacists, counselors, and social workers.

DC Hospital Association (DCHA)

DCHA is a non-profit organization whose mission is to provide leadership in improving the health care system in the DC area, advocating for the interests of member hospitals, as they support the interests of the community.

DC Primary Care Association (DCPCA)

DCPCA is a non-profit health equity and advocacy organization dedicated to improving the health of DC's vulnerable residents by ensuring access to high quality primary health care, regardless of ability to pay. As a leader in the health care community, we work to ensure that all residents of Washington, DC have the ability and opportunity to lead healthier lives - through increased health care coverage, expanded access, improved quality, workforce development, and enhanced communication.

CHAPTER 1:
Introduction

The DC Healthy Communities Collaborative authored this community health needs assessment to serve as an evidence-based, community-driven foundation for our community health improvement efforts. Working with our communities, we use this assessment to identify priority health needs in our city. Ultimately, addressing these needs will bring us closer to a state of health equity for all DC residents.

Washington, DC is a growing city with two faces exhibiting stark differences. DC residents often refer to the difference as "the Nation's Capital" versus "the real DC." In this city of more than 660,000 residents, citywide data often give the appearance of prosperity and health, while a deeper look reveals striking disparities in health and well-being that are often directly correlated to an individual's place of residence. The city is experiencing a renewal of community activism and a reinvestment in philosophies, policies, and programs intended to bring equity to all aspects of life to all DC residents. Working towards equity requires an understanding of community needs. As such, this report, sponsored by the DC Healthy Communities Collaborative, is an example of the investment by several DC hospitals and community health centers to understand community needs from the perspective and experiences of our communities.

In this report, we analyze traditional data sources that paint a quantitative view of health in terms of rates of disease and illness in our population, as well as looking closely at contextual factors that are the determinants of health. We place strong emphasis on what community stakeholders share as their assessment of what a healthy community should look like, what factors in DC enable or prohibit healthy living, and what they define as pressing community needs. In this report and going forward, we engage them in a discussion of how we can work in partnership to address those needs.

Knowing that we must focus our efforts, we prioritize the identified needs based on our ability to make a true impact in the health and well-being of DC residents. We then marry the quantitative data with these prioritized needs to provide further focus. The product of this work is this community health needs assessment report. However, the assessment itself is simply a report. The true products of this process are the strong partnerships formed between health providers, community-based organizations, and the DC government who all share a common vision and

Health Equity

The circumstance of all DC residents having equal opportunity to attain their full health potential; a city where no resident is disadvantaged from achieving this potential because of their social position or other socially determined circumstance.

a commitment to achieving health equity for all DC residents.

In this chapter, we present information about us – often referred to as "the Collaborative" – define our impetus for action, describe how our assessment work has evolved from our prior needs assessment (completed in 2013), discuss our prioritization process, and end with the key objectives of this assessment.

The District of Columbia Healthy Communities Collaborative

DC HEALTHY COMMUNITIES COLLABORATIVE (DCHCC)

Established in January 2012, the DC Healthy Communities Collaborative (DCHCC) membership consists of DC hospitals and community health centers. The Collaborative was formed out of a desire of health care providers to combine efforts and resources to assess and address community needs in a data-driven, community-engaged manner. The three principal products of the Collaborative include: 1) the community health needs assessment (presented in this report), 2) the corresponding community health improvement plan, and 3) a web-based community health portal, DC Health Matters (described in Chapter 2).

The Collaborative membership includes four hospitals (Children's National Health 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). The DC Department of Health is a guiding partner and supporter of the Collaborative.

The Collaborative understands that elevating health equity cannot – and should not – rest with health care organizations alone. We have many formal and informal relationships with a variety of city organizations. Several of these organizations serve on our Community Advisory Board: *[list final board member organizations]*. These organizations help define, guide, implement, and evaluate our work.

IMPETUS FOR ACTION

New hospital community benefit requirements within the Patient Protection and Affordable Care Act of 2010 (ACA) led to the formation of the Collaborative. Section 9007 of the Act shines light on non-profit hospitals' special obligation to invest in community needs and creates accountability by requiring the development of a community health needs assessment with an evidence-based planning and prioritization process. The IRS Code 501(c)(3) now requires all non-profit hospitals to submit a community health needs assessment every three years starting for the fiscal year of 2012.

A community health needs assessment is a systematic examination of the health status indicators for a given population that is used to identify key problems and assets in a community. The ultimate goal of a community health assessment is to develop strategies to address the community's health needs and identified issues.

The regulations require that the needs assessment be available to the public, and hospitals are further required to adopt strategies to address the identified needs identified. 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 as a measure of true integration into each hospital's strategic and operational priorities.

While the needs assessment requirement was new for hospitals, federally-qualified health centers have been held to a comparable requirement for decades. In an effort to promote collaborative work that reduces redundancy, saves financial resources, and improves partnerships, DC hospitals and community health centers voluntarily came together to form this coalition – the DC Healthy Communities Collaborative – that would issue a joint community health needs assessment and improvement plan.

While the impetus to come together was born of compliance requirements, the Collaborative quickly moved from a focus on meeting requirements to truly investing in community health initiatives that address local health disparities – with the ultimate goal of health equity for all DC residents.

OUR DEFINITION OF COMMUNITY

For the purpose of this assessment we define our community geographically (as residents within the city boundaries of Washington, DC) and specifically (those populations served by local DC hospitals and community health centers). Geographically, Collaborative organizations share place-based communities, but also have unique regional service areas outside of DC in neighboring Maryland and Virginia

counties. This assessment focuses largely on DC residents. However, in the appendices, we do provide information specifically on all users of DC hospitals and community health centers (regardless of their place of residence).

BUILDING ON FORMER WORK: 2013 COMMUNITY HEALTH NEEDS ASSESSMENT

Per the ACA requirements, hospitals must produce a needs assessment every three years. This current report reflects the second assessment cycle for the Collaborative. The Collaborative partnered with the RAND Corporation to conduct the first needs assessment, published in June 2013. The 2013 assessment revealed four priority areas: asthma, overweight/obesity, sexual health, and mental health and substance abuse. The Collaborative created a community health improvement plan in response to those four needs and continues to make significant progress in building the infrastructure required to address these pressing health needs. Both the 2013 assessment and improvement plan are located on the DC Health Matters portal. Appendix 1 provides a summary of progress to date (Angelica insert). It is important to note that many of the efforts that originated from the 2013 needs assessment will continue to fuel future Collaborative initiatives.

KEY OBJECTIVES OF THIS REPORT

The ultimate goal of this assessment is to lay the foundation for community health improvement efforts that lead to a more equitable state of health for DC residents. This report will also fulfill the community benefit requirements for the four non-profit hospitals that are part of the Collaborative (Children's National Health System, Howard University Hospital, Providence Hospital, and Sibley Memorial Hospital); and, provide data to support assessment reporting requirements for the four member health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care).

We present the most recent data available at time of analysis – generally 2015 data – as well as trend data from 2010 to 2014. The key objectives of this report include:

1. Engage community stakeholders in a bi-irectional dialogue to identify unmet community needs related to health and well-being.

2. Describe the socio-demographics characteristics, health behaviors, health status, and health care utilization of DC residents with attention to differences by place of residence (ward), race, ethnicity, age, and sex.

3. Arrive at a set of high priority community-defined needs that set the foundation for the Collaborative's community health improvement efforts.

> The DC Healthy Communities Collaborative is exceedingly thankful to the hundreds of partners who shared their time, expertise, and passion with us. In closing, we believe that an effective approach to building a healthier DC requires an understanding of the social determinants of health in our city, a strong reliance on evidence and data, and sincere engagement from multiple stakeholders.

CHAPTER 2:
DC POPULATION LANDSCAPE & ASSETS

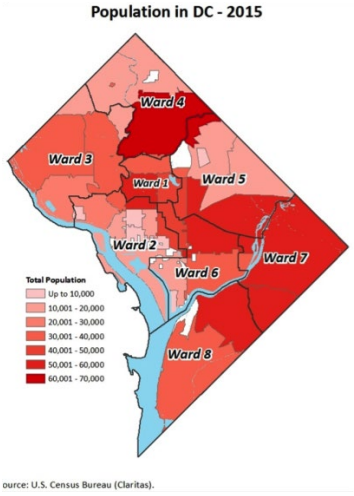
DC is a diverse and growing city with significant variances in socio-economic characteristics across geography, race, and ethnicity. In 2015, DC was home to 666,395 residents – a growth of 11% since 2010. DC continues to become a more racially and ethnically diverse city that faces many challenges similar to other urban cities.

Chapter 2 provides an overview of the demographic characteristics of the people living in DC. This information is derived from Census Bureau data, Claritas population extrapolations, and the American Community Survey. We largely focus on 2015 data and provide 2010 reference statistics to show demographic changes over time. Detailed population tables are provided in the appendices.

LAYOUT OF DC

DC is a diverse urban setting that encompasses 61 square miles of land situated between the Northern Virginia counties of Arlington and Alexandria and the Southern Maryland counties of Montgomery and Prince George's. It is the 22nd most populated city in the United States.

DC is divided into about 100 ZIP codes, four quadrants, and eight Wards that correspond to electoral districts. Citywide DC data often position DC as a wealthy city; however, a more detailed look at sub-populations reveals a story of profound inequities. Thus, when possible, the information in this assessment will be presented at a citywide level, as well as broken out by age, race, ethnicity and ward. Wards are key geo-political boundaries used in advocacy and policy initiatives – ward boundaries were redrawn in 2012 as a political redistricting initiative.



Additional cross-tabulations of data by variables are available in the appendices, as well as in the

interactive data cube and map gallery located on the DC Health Matters portal.

Inequalities in health status in the U.S. are large, persistent, and increasing. Research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination, and low socioeconomic conditions are the major risk factors for ill health and health inequalities. Conditions, such as polluted environments, inadequate housing, absence of mass transportation, lack of educational and employment opportunities and unsafe working conditions are implicated in producing inequitable health outcomes. These systematic, avoidable disadvantages are interconnected, cumulative, intergenerational, and associated with lower capacity for full participation in society.

- Center for Disease Control and Prevention

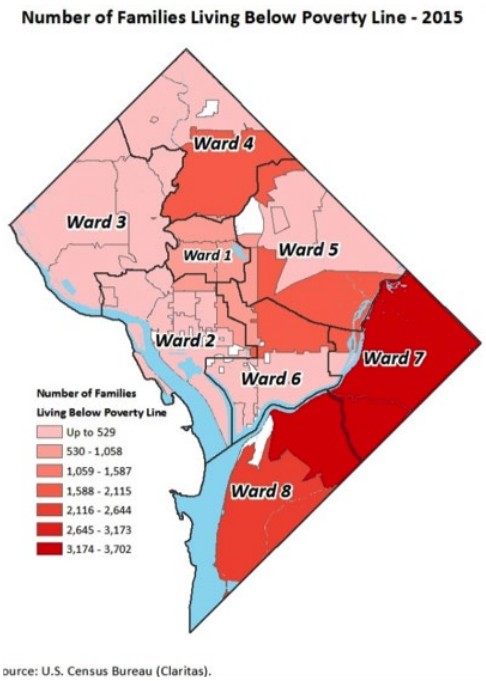
SOCIOECONOMIC CHARACTERISTICS OF DC RESIDENTS

DC is a diverse and growing city with significant variances in socioeconomic characteristics across place, race, and ethnicity. In 2015, DC was home to 666,395 residents – a growth of 11% since 2010. DC continues to become a more racially and ethnically diverse city with a growing Latino population and a declining portion of the Black population. DC is also a relatively "young"

city with a median age of about 34 years. Compared to U.S. states, DC is the tied with Texas as the second youngest state and only older than Utah who has a median age of just under 30 years.[1]

Socioeconomic characteristics of DC residents vary immensely across the city (Table 1). As indicated by the poverty map below, many indicators of socioeconomic distress are concentrated in Wards 7 and 8. The stark differences in socioeconomic factors across DC are clearly correlated to similar patterns of health disparities. A simple, yet striking example of health inequity across the city is the 16 year difference in life expectancy – a commonly accepted population health metric – by ward: 86 years in Ward 2 to 70 years in Ward 8. [2]

Appendix 2 provides an overview of the DC population – from a citywide and ward perspective – with a focus on variations in age, race, ethnicity, education, and poverty. We distill the information in Appendix 2 to provide key population highlights in Table 1 (below). Given the space constrains of this written report, we point readers to a wealth of additional local population data and maps on the DC Health Matters portal, as well as on Community Commons and County Health Rankings.



ource: U.S. Census Bureau (Claritas).

1 Based on 2010 Census data; replace with 2015 estimates, when available.

2 D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division, 2010.

Table 1: Demographic Characteristics of DC

CITYWIDE HIGHLIGHTS	WARD LEVEL HIGHLIGHTS
POPULATION	
DC had a population of 666,395 people in 2015.	Ward population averages about 82,5000 residents per ward, with Ward 2 having the largest population of 86,666 residents and Ward 8 the lowest population of 77,483 residents.
The DC population has grown 11% from 2010 to 2015 (from 601,723 to 666,395).	Each DC ward is comprised of 12-13% of the DC population. The population of each of the eight wards is similar as ward boundaries define the geo-political areas used to elect DC Council members.
AGE	
The age composition of the DC population: • 6% young children, ages 0 - 4 • 12% older children, ages 5 - 17 • 47% young adults, ages 18 – 44 • 23% middle age adults, ages 45 – 64 • 12% older adults, ages 65+ The median age in DC is 34 years.	About 35% of children reside in Wards 7 and 8; 50% of children reside in Wards 4, 7, and 8. About half (49%) of older adults people live in Wards 3, 4, and 5. Only 8% of older adults live in Ward 1.
The largest population growth is for children and older adults: 20% population increase for children and 18% increase for older adults from 2010 to 2015.	
RACE	
DC remains a diverse city with the following racial composition: 47% Black, 36% White, 11% Hispanic/Latino, and 4% Asian.	Some wards are fairly diverse, while the composition of other wards is more homogenous: • Ward 6 has a fairly equal composition of White and Black residents (43%) • Ward 3 is more than 75% White • Wards 7 and 8 are both more than 90% Black • Wards 1 and 4 both are about 20% Hispanic/Latino (comprising about 43% of the Hispanic/Latino population)
The proportion of Black residents has been decreasing. In 2010, Black residents comprised 50% of population compared to 46.6% of the population in 2015.	

CITYWIDE HIGHLIGHTS	WARD LEVEL HIGHLIGHTS
POVERTY	
Since 2010, the largest population increase has been in the Hispanic group, with a 33% growth. Hispanic residents now represent more than 10% of the DC population.	
The citywide unemployment rate remains high at 11%.	The unemployment rate in Wards 7 and 8 is more than twice the citywide average and nearly 6 times higher than in Ward 3. • Unemployment Ward 3: 4% • Unemployment Ward 7: 22% • Unemployment Ward 8: 23%
A large percentage (19%) of DC residents continue to live in poverty – virtually unchanged since 2010.	The percentage of families living below the poverty level in Wards 7 and 8 is about twice the citywide average and about 15 times higher than in Ward 3. • Live in poverty Ward 3: 2% • Live in poverty Ward 7: 25% • Live in poverty Ward 8: 29%
Poverty affects Black residents disproportionately, 27.6% compared to 8.3% in White residents.	
Nearly 30% of children live below the federal poverty level. 40.2% of Black children live below poverty level, compared to 4.9% of White children.	
Median household income is $70,354.	Median household income in Ward 3 (highest, $116,001) is more than 3 times that of Ward 8 (lowest, $36,722).
Median household income for White residents is about 2.5 higher than Black residents. Median household income for White residents is almost two times higher than Hispanic residents.	
In 2015, DC had amongst the highest unemployment rate in the country (6.8%). Black residents have highest rate of unemployment (20%), almost 5 times higher than White residents and twice as high as Hispanic residents.	

COMMUNITY ASSETS

A community asset is anything that can be used to improve the quality of life in a community. This broad definition can range from people to physical structures to community services. Every community has needs and deficits that require attention. However, it is important to understand each community's assets and strengths.

The DC community is rich with assets, such as parks, libraries, and recreation centers. However, our strongest asset is our people. DC is home to many passionate, activist-minded individuals who work tirelessly towards creating a socially just and equitable society. Community leaders, in particular, serve as invaluable assets who motivate action within and across their neighborhoods. These leaders range from faith-based pastors to community advocates to advisory neighborhood commissioners. Several of these leaders participated in this needs assessment process on behalf of their communities.

As for physical assets, 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. A series of maps in Appendix 3 provide a visual understanding of the distribution of physical assets in DC.

Importantly, we must note that what constitutes an asset varies across the city. For example, some communities view faith-based organizations as powerful assets, whereas other communities may consider outdoor recreational space to be more important assets. We believe that understanding the true assets in a community requires understanding the perspectives of people living in that area.

As part of the Collaborative's 2013 community health improvement plan, we created an online "Community Asset Map" for four priority health conditions: asthma, obesity, sexual health, and mental health & substance abuse. The asset map – located on the DC Health Matters portal – provides up-to-date information about community resources related to these four pressing health needs [link to asset map – link not live yet]. The Collaborative will continue building on this effort to ensure that our communities are aware of DC assets.

DC ASSET MAPS IN APPENDIX

Grocery stores and farmers markets
Places of worship
Parks
Metro stations
Libraries
Recreation centers
Public and charter schools
Universities and colleges
Police and fire stations
Hospitals and health centers
Pharmacies
Primary care professional service areas
Dental care professional service areas
Mental health professional service areas
Mental health resources

Given our broad definition of "assets" it is impossible to describe all – or even the majority – of DC assets in this chapter. The goal of this chapter is to provide a high level overview of assets and encourage readers to consider capitalizing on community assets when working on community health improvement efforts. A list of resources to find community assets includes:

- DC Health Matters
- DCHCC Community Asset Map
- DC Open Data
- Community Commons

The above resources are routinely updated making them excellent sources of asset information.

SPOTLIGHT ON ASSETS

While some assets are distributed inequitably across the city, all areas of DC have assets that we can draw upon, including:

Places of Worship:
Faith-based places of worship are well distributed across the city, but are especially well-established in Wards 7 and 8.

Recreation Centers:
Neighborhood residents often look to their community recreation centers as trusted gathering venues. The Town Hall Education Arts Recreation Campus (THEARC) is one thriving example; the 110,000 square-foot campus is located east of the Anacostia River in Ward 8.

Public Schools:
DC is home to 111 public schools and 52 charter schools distributed across the city.

Grocery Stores:
New grocery stores and famer's markets are underway in several areas of the city. However, food desserts continue to be a problem in the city. For example, Wards 7 and 8 are home to almost a quarter of the city's population, but only have three full-service grocery stores and three farmers' markets.

Park Space:
DC boasts a wealth of green space, which comprises 20% of its land, of which 90% is owned and operated by the National Park Service (NPS). With regard to access to public parks, the Trust for Public Land (a national environmental group) ranks DC sixth out of 60 cities. Rankings were calculated using three factors: park size, accessibility to residents and how much each city spends on park systems for programs and maintenance.

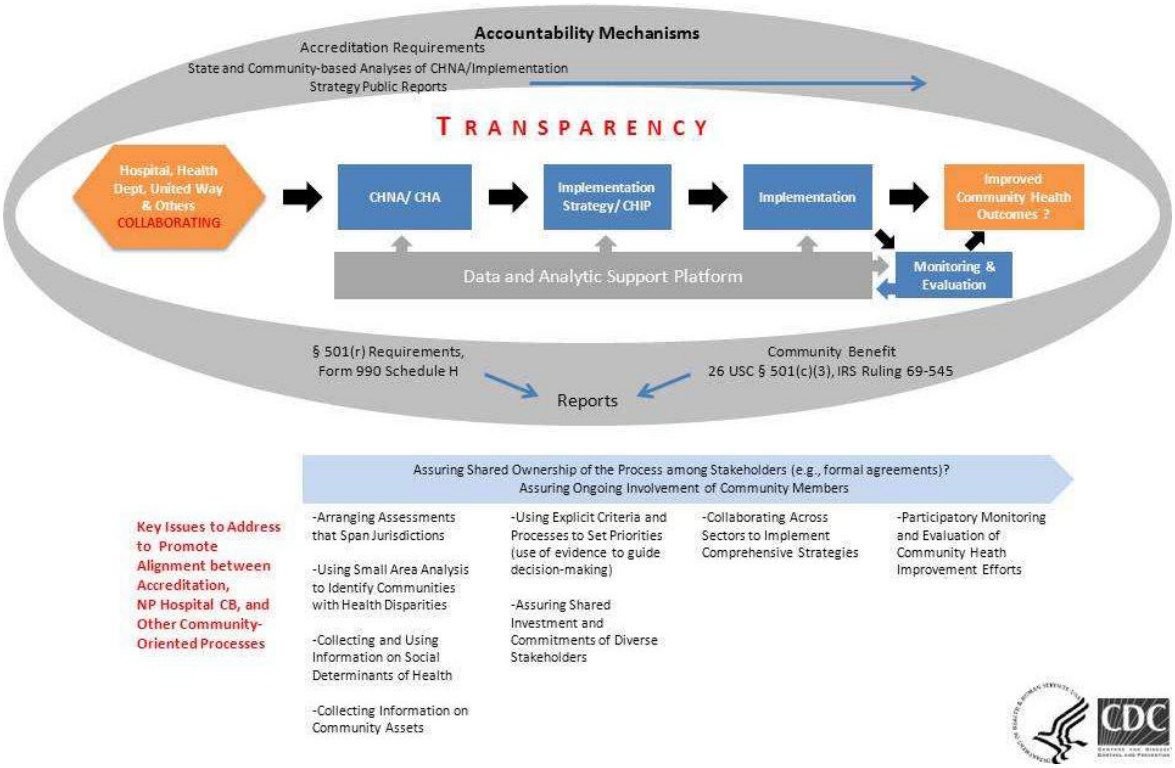
Pharmacies:
Pharmacies are important community assets especially in populations with high rates of chronic illness. In DC, pharmacies are concentrated in Wards 2; there are only 6 pharmacies in Wards 7 and 8 despite being home to a high percentage of residents with chronic illness that require medications.

Please see the appendices for maps that show the allocation of the above resources across the city.

CHAPTER 3:
Assessment Methods

In Chapter 3 we describe our data sources and methods for identifying and prioritizing unmet community needs. We used a mixed-methods approach – a combination of qualitative and quantitative data – to provide a balanced and comprehensive view of health and well-being for DC residents. Our approach and framework is in alignment with the Centers for Disease Prevention and Control (CDC)-issued Community Health Improvement Model that positions needs assessments as the first key step in the community health improvement process (Figure 1). A notable emphasis in this framework – and subsequently in our approach – is the critical importance of shared ownership and community engagement.

Figure 1: Community Health Improvement Model



OVERVIEW OF THE PROCESS

As noted earlier, this report is the second assessment sponsored by the Collaborative. The first assessment – released in 2013 – was contracted out to the RAND Corporation. For this current assessment, the Collaborative made the deliberate decision to bring the assessment work "in-house" as it would give us more ownership of the process and product, but most importantly put us in more direct contact with our community stakeholders.

Over an 18-month period (September 2015 through March 2016), the Collaborative worked to design the assessment, collect and analyze data, meet with community stakeholders, and draft the final report. Our progress on the needs assessment was a standing agenda item on our monthly Steering Committee meetings. Each Collaborative member contributed to the assessment in their own way, each playing to their own strengths. Individuals with advanced public health research expertise and data analytics skills led the design and data efforts, community engagement experts ensured that the voice of our communities was well-represented, trained facilitators led our qualitative data collection, policy experts connected emerging findings to policy initiatives, and editors reviewed the final product for cohesion and clarity. In additional to internal Collaborative reviewers, additional reviewers included researchers from the RAND Corporation and representatives from the Collaborative 's community advisory board.

The following sections describe, in more detail, our methods related to securing and analyzing qualitative and quantitative data for this assessment.

QUALITATIVE DATA

QUALITATIVE DATA SOURCES / COMMUNITY STAKEHOLDERS	NUMBER
Community Organizations Represented	60
Key Informant Interviewees	31
Online Surveys	113
Focus Group Participants	40
Community Forums Attendees	80
Council Members / ANCs	8
Government Agencies	11
Hospitals and Clinics	15

Our qualitative data consisted of semi-structured dialogues with community stakeholders to obtain their perspectives on health in DC. Data were collected through a series of interviews, focus groups, online surveys, and town hall meetings. Our assessment team included trained qualitative researchers who provided guidance about the qualitative research methods, led the data collection, and conducted structured analysis of the large volume of community data.

Community Stakeholder Participants

Community stakeholder perspectives were a critical component of this assessment. In order to obtain a balanced perspective on community health, we gave careful consideration to recruiting community participants from health, education, transportation, social service, advocacy, and government groups and agencies that represented DC communities. Individual DC residents also participated in this process, namely through our town hall meetings and online surveys.

QUALITATIVE DATA COLLECTION METHODS

The interviews, focus groups, town hall meetings, and online surveys followed a semi-structured format and utilized similar sets of questions; the interview and discussion protocols (Appendices 4-7). Whereas the interviews, focus groups, and town-hall meetings allowed for iterative exchanges among participants and facilitators, the nature of the online surveys did not provide such opportunities.

Under the guidance of our qualitative research experts, Collaborative leadership led the vast majority of qualitative data collection initiatives. This process strengthened the Collaborative's relationship with community stakeholders through the meaningful interactions and conversations. We will rely on these strong relationships as we work in partnership to respond to the identified community needs.

Interviews, focus groups, and town hall conversations were digitally recorded and transcribed by a professional transcription company. The data were entered into Dedoose (SocioCultural Research Consultants, 2014), a software program used for managing qualitative data and facilitating analysis. Dedoose helps researchers include multiple perspectives when analyzing assessment data. It is particularly helpful when asking complex, open-ended questions without absolute answers.

Employing the constant-comparison approach, analysis was aimed at identifying the main themes among participants' experiences and perspectives of factors that support or compromise the health of DC community members. Analysis began with "open coding"—line-by-line coding that identified granular aspects of participants' perspectives and experiences. This first stage of analysis employed both a priori and emergent codes. A priori codes (e.g., "collocate services") were those informed by prior research and professional experience of the investigative team. Emergent codes (i.e., "community health workers") were unanticipated codes drawn from participants' discussions during focus groups and interviews. Analysis then turned to identifying themes by looking for repetition of similar experiences across and within cases as well as identifying similarities and differences among codes.

Code frequencies were also tabulated to help identify themes and verify that the analysis highlighted the salient themes that represented the broad perspectives included in the data. Tabulating codes contributed to the iterative process of constant-comparison by highlighting codes and themes that were described most frequently by participants. The final stage of analysis involved identifying dimensions of each of these high-frequency codes to understand the diversity of experiences represented therein as well as comparing codes with each other to understand the interrelationships between the codes.

Three methods were employed to identify the most pressing community needs: repetition supported by identifying frequencies of codes and themes present in the data, identifying similarities and differences present in data, followed by sorting themes into conceptually-similar priority areas. Due to the complexity of some of the issues that emerged as salient to community members (i.e., economic stability), the remedies extend beyond the scope of hospitals' and health care organizations' capacities to meaningfully and specifically address. Thus, this report highlights those priority areas that were more linear and lent themselves to targeted interventions with measurable impacts.

QUANTITATIVE DATA

DATA SOURCE	YEAR
Census Population Data	2010, 2015
American Community Survey	2010, 2015
Behavioral Risk Factors Surveillance System	2012, 2013
Youth Risk Behavior Surveillance Survey	2013
CDC Wonder	2011
National Survey of Children's Health	2011-12
National Survey of Children with Special Health Care Needs	2009-10
Senior Needs Assessment	2012
Infant Mortality Report	2013
Annual Epidemiology Surveillance Report	2013
Metropolitan Police Dept. Annual Report	2014-15
DC Hospital Association Administrative Data	2010-14
HRSA FQHC Data	2012-14

Quantitative data consisted of Census population data, health status and behavior survey data, surveillance reports, and health care provider administrative data. A large amount of the quantitative data was obtained from our DC Health Matters web portal that serves as a clearinghouse of community health metrics and related data.

Census Population Data

We use the Census Bureau's Population Estimates and 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 strong data sources with Claritas estimates that provide enhanced 2010 Census data and extrapolations.

Survey and Surveillance Data: Leading Health Indicators

We relied on several surveys, such as the Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), as well as disease surveillance data, to gain a sense of general health status and behavior among DC residents (Table 2). Data tables from these health status surveys are included as Appendix 8. In order to organize the large volume of quantitative data, we borrowed the nationally-accepted Healthy People 2020 leading health indicators framework developed within the Department of Health and Human Services.

The Healthy People initiative provides science-based, national objectives for improving the health of all Americans over the next 10 years. The DC Department of Health is leading DC's local Healthy People 2020 effort. The goals of this initiative are to:

- Encourage collaborations across communities and sectors.
- Empower individuals toward making informed health decisions.
- Measure the impact of prevention activities.

Figure 2: Healthy People 2020 Priority Areas

1. Access to Care
2. Clinical Preventive Services
3. Environmental Quality
4. Injury and Violence
5. Maternal, Infant and Child Health
6. Mental Health
7. Nutrition, Physical Activity, and Obesity
8. Oral Health
9. Reproductive and Sexual Health
10. Social Determinants
11. Substance Abuse
12. Tobacco
13. Chronic Disease*

*Per IOM Recommendations

Healthy People 2020 includes a small national set of 12 high-priority topic areas that represent significant threats to the public's health (Figure 2).[3] Within these topic areas, Healthy People 2020 identified 26 Leading Health Indicators (LHIs) that were selected to address determinants of health that promote quality of life, healthy behaviors, and healthy development across all life stages. The LHIs provide a way to assess the health of the nation for key areas, facilitate collaboration across diverse sectors, and motivate action at the national, state, and local levels.

3 In addition to the 12 Healthy People topic areas, we added the topic of "Chronic Disease" per Institute of Medicine recommendations (CITE!!!!).

In this assessment, we present the national Healthy People 2020 LHIs (or close proxy indicators) for the DC population. As DC's local Healthy People 2020 indicators are finalized (expected in mid-2016), we will use the local indicators to inform the Collaborative community health improvement plan. The majority of these national and local indicators – and many additional metrics – are easily accessed on the DC Health Matters portal.

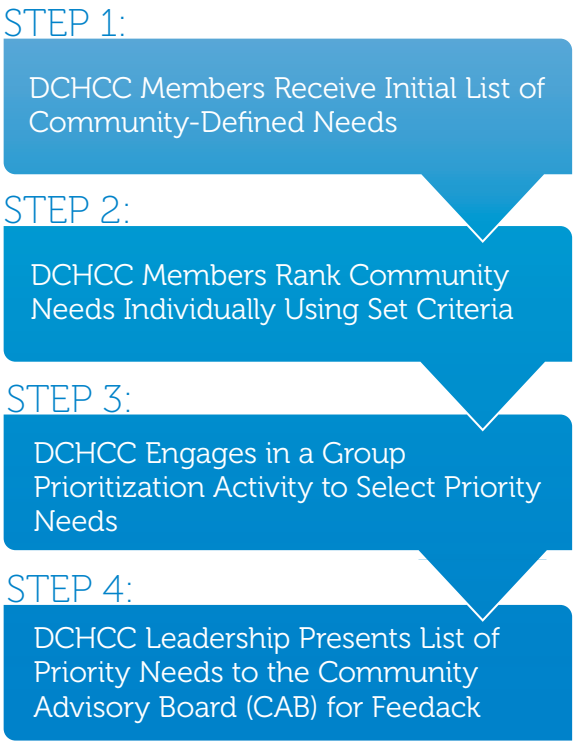
Hospital and Community Health Center Data (Quantitative Provider Data)

In addition to the Census population and survey data, we analyzed hospital administrative data files (inpatient discharges and emergency department visits) provided by the DC Hospital Association and the Health Resources Services Administration (HRSA) Uniform Data System (UDS) Community Health Center data. These data sources enabled us to display the rates at which health care services are used, the most common reasons for accessing care, and potentially preventable visits. In addition, utilization statistics that can be indicators of the availability and efficacy of preventive and primary health care.

Prioritization Process

Analysis of the qualitative community data revealed a list of pressing health needs. Acknowledging the importance of each need, the next step for the Collaborative was to use a structured process – we chose a modified Hanlon method – to prioritize needs that would be the focus of our community health improvement initiatives.

The Hanlon method is a widely used and referenced quantitative tool that ranks health-related needs based on select weighted criteria. The goal of this method was to identify and compare the list of community-defined needs in a relative framework,



as equally as possible, and in a somewhat objective manner.

The Hanlon method has three major objectives:

1. to allow decision-makers to identify explicit factors to be considered in setting priorities
2. to organize the factors into groups that are weighted relative to each other
3. to allow the factors to be modified as needed and scored individually

Using the "Community Needs Ranking Tool," (Figure 3) all DCHCC members ranked the community-identified needs to arrive at a shorter list of priority needs.

Figure 3: Community Needs Ranking Tool

LIST OF COMMUNITY IDENTIFIED NEEDS*	IMPORTANCE TO COMMUNITY (A)*	CAPACITY TO ADDRESS (B)	ALIGNMENT WITH MISSION/VISION (C)	EXISTING COLLABORATIONS/ INTERVENTIONS (D)	FINAL SCORE (MAX=100)
Score each criterion: 0 (very low agreement) to 10 (very high agreement)					
[Need 1]	[score 0-10]	[score 0-10]	[score 0-10]	[score 0-10]	[4a+2.5b+2.5c+1d]
[Need 2]	[score 0-10]	[score 0-10]	[score 0-10]	[score 0-10]	[4a+2.5b+2.5c+1d]
[Need 3]	[score 0-10]	[score 0-10]	[score 0-10]	[score 0-10]	[4a+2.5b+2.5c+1d]
[Need 4]	[score 0-10]	[score 0-10]	[score 0-10]	[score 0-10]	[4a+2.5b+2.5c+1d]
[Need 5]	[score 0-10]	[score 0-10]	[score 0-10]	[score 0-10]	[4a+2.5b+2.5c+1d]

*These two columns are populated in accordance with the qualitative analysis findings.

CHAPTER 4:
Community Perspective

We place strong emphasis on what our community stakeholders' perspectives on health in DC and the unmet needs in our community. Nine community-defined needs emerged from the qualitative data collection: care coordination, food insecurity, bringing care to the community, mental health, health literacy, healthy behaviors, health data dissemination, community violence, and cultural competency.

Chapter 4 presents findings related to the community's perspective on health in DC. To ensure a strong community voice in this assessment, we engaged many residents and representatives across the city in rich dialogue framed around the assets and barriers to health in DC. We sought to understand how community stakeholders define a "healthy community", document health inequities that exist among DC's residents, and understand the social determinants that perpetuate their presence. Ultimately, our goal was to arrive at a list of community-defined needs that may be difficult to isolate with quantitative data alone.

Importantly, we asked community stakeholders for recommendations on how we can work collectively across organizations and with other groups in DC to address community needs. These recommendations will inform the Collaborative's community health improvement plan.

9 COMMUNITY DEFINED NEEDS

1. Care Coordination
2. Food Insecurity
3. Bring Care to the Community
4. Mental Health
5. Health Literacy
6. Healthy Behaviors
7. Health Data Dissemination
8. Community Violence
9. Cultural Competency

PARTICIPANTS

We conducted 39 individual interviews with leaders from 21 health care institutions, 12 administrators of local government agencies, and six members of the DC Council. Additionally, we hosted five focus groups with staff from 60 different community-based organizations and social service agencies. DC residents, community representatives, and health care providers completed 113 online surveys. We also conducted two public town hall meetings. Each town hall drew about 80 participants. In our qualitative work, our goal was to reach a broad representation of DC community stakeholders across health and non-health disciplines.

We conducted the focus groups and town hall meetings in local establishments such as community health centers, the Town Hall Education Arts Recreation Campus (THEARC), and Busboys and Poets restaurant. Overall, we engaged with more than 300 community stakeholders across a diverse cross section of DC (Table 2). A list of participants is available in Appendix 9.

Table 2: Demographic Characteristics of Community Stakeholders Who Participated in the Community Health Needs Assessment

DEMOGRAPHIC	% OF TOTAL PARTICIPANTS (N=X)
Gender	
Male	19.0%
Female	79.6%
Race	
Black	36.5%
White	47.6%
Other	14.2%
Ethnicity	
Hispanic	8.6%
Non-hispanic	86.4%
Profession	
Healthcare (Clinical)	45.0%
Non-Clinical	55.0%

***Based on available responses*

HIGHLIGHTED FINDINGS

Using Dedoose qualitative software to organize and analyze the qualitative data, a large number of thematic codes emerged. Open coding identified 2,120 text excerpts across 157 interviews, focus groups, and online survey responses. Codes were applied 5,248 times across the data. Code frequencies were also tabulated to help identify themes and verify that the analysis highlighted the true perspectives of the participants. Each code appeared an average of 8.0 times across the data.

Our qualitative analysis of stakeholder feedback revealed nine pressing community needs: care coordination, food insecurity, bring care to the community, mental health, health literacy, healthy behaviors, health data dissemination, community violence, and cultural competency. Of note, 57.4% of participants endorsed economic stability and 29.7% of participants indicated housing security—and their absence—as core issues shaping the health behaviors and outcomes among DC's residents, thus placing them among the most commonly-identified factors contributing to health disparities in our community. Despite the salience of economic stability and housing insecurity as core social determinants of health, this assessment focuses on needs that fall more directly within the purview of health care organizations and align with our capacities for immediate action. The following nine needs are presented in depth, in order of importance to the community based on the qualitative analysis.

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.

Our community stakeholders (20.8%) clearly identified the need for enhancing "care coordination" as a means to improve the health of DC's communities. Complexity of the health care system, lack of communication between providers, lagging shared electronic medical records systems, and non- co-located health care services were identified as contributing to community members' difficulties accessing health care services. Colocation of services generally leads to greater access to care and more patient/family satisfaction due to services being provided in a setting familiar to patients. In addition, colocation contributes to more appropriate use of health services and improved clinical outcomes.

Focus group attendees notes that these difficulties were heightened among community members who were socioeconomically vulnerable, had limited health literacy, and had inconsistent patterns of service utilization. Care coordination may also be especially important for helping community members manage chronic health issues that require regular, and sometimes intensive, engagement with the health care system.

Stakeholders noted that knowledge about services available across the city is a prerequisite for providing "warm handoffs" in which referral sources personally introduce and facilitate connections between patients and their next providers, including fellow medical staff, specialists or support services. The "warm handoff" approach to care provides clarity in what can be a confusing, convoluted health care environment for patients, thus reducing the risk of patient attrition along the course of care.

> **To me, it should not be that hard to help people get good quality care that is connected to other care that they already getting. I do not understand why my doctor does not know that I have been to the ED. And, why doesn't the ED know that I have diabetes.**
>
> *—Focus Group Participant*

A discrete definition of care coordination did not emerge from the data; participants used the term to describe a host of services and actions to include data sharing, unified case management, and coordinated care planning. In order to coordinate care, participants suggested that health care professionals become more familiar with the services offered by other organizations and provide clearer direction and connection with their next point of contact on their treatment trajectory.

FOOD INSECURITY

Food insecurity exists when people lack sustainable physical or economic access to enough safe, nutritious, and socially acceptable food for a healthy and productive life. Food insecurity may be chronic, seasonal or temporary.

Limited access to financial resources and geographic separation from grocery stores contributed to about 50% of participants identifying food access as a factor that detracted from the health of DC residents. Participants noted that access to affordable healthy food is a challenge for many DC residents, leading to hunger and a host of poor health outcomes. Fully addressing food insecurity will require taking a close look at nutrition, economic conditions, and overall well-being of DC residents.

> **I would say to me nutrition is a barrier, because you have a lack of access to healthy food. A lot of people can't afford fresh food and it's cheaper to buy food in a box that is filled with chemicals and artificial things that really aren't meant inside humans, as opposed to fresh produce. So, people may know about it, but they don't have access to it. So, I don't know how you fix that problem, but I see it as a barrier.**
>
> *—Focus Group Participant*

Respondents noted that neighborhoods are changing and food options are expanding in some areas where food deserts existed. Food deserts are areas that lack access to affordable and healthy foods (fruits, vegetables, whole grains, low-fat milk, etc.) that comprise the full range of a healthy diet. In particular, Wards 7 and 8 have experienced an uptick in organic markets as well as grocery stores that provide healthier food options. However, financial barriers constrain some residents' abilities to obtain healthier food even if they are "available." In light of these challenges, participants were able to provide examples of several promising programs that could be adapted or expanded in DC:

- ***Farmers' markets at hospitals***— farmers markets should be offered on the grounds of health care organizations to allow patients to purchase fresh produce at a reasonable price. This will reinforce the directives patients receive from providers to eat healthier, and underscore the commitment of institutions to making healthy options an easy option.

- ***Veggiebucks" food vouchers***—programs that offer families vouchers from their doctors to purchase produce at farmers markets should be expanded.

- ***Joyful Food Markets***—this program, which provides elementary school students with produce to share with their family on a monthly basis through their school, is a promising model.

In addition to the financial and geographic barriers contributing to food insecurity, participants targeted nutrition knowledge and dietary behaviors as pressing community needs.

BRING CARE TO THE COMMUNITY

Bringing Care to the Community – also known as place-based care – means providing care options that are convenient and culturally sensitive.

A brief online survey response—"meet individuals in their own communities, rather than waiting for them to seek care"—inspired a code that ultimately grew into a theme echoed by 19.8% of participants. Participants' descriptions of "meeting people where they are" fell into two domains: 1) organizational flexibility and 2) place-based care. Ultimately, organizational flexibility to adapt to what people need was subsumed in other needs such as "cultural competency." 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.

Many participants used the concept of deploying community health workers as a concrete example of bringing care to the community. As reflected in the rich discussions, many stakeholders felt that community health workers provide customized care, deliver health information, and even conduct basic health screenings. The general consensus among participants was that community health workers should be members of the communities they serve, allowing community members to feel better understood and respected, enabling meaningful communication and the conveyance of health information. Lastly, taking advantage of the number of faith-based organizations in certain areas of DC to offer community health worker-led health screenings, for example, uses a familiar place and a trusted person in the community to encourage healthy behavior.

Community health workers usually work toward a few targeted outcomes (e.g., nutrition, hypertension, and diabetes). Community health workers may also help coordinate care, help identify health resources for community members, assist with scheduling appointments, provide information and reminders about the location and time of appointments. Home-visiting was also identified as part of the community health worker role. Further along the continuum of care, participants discussed the possibility of developing a contingent of community health workers who were qualified to provide nursing care. Other participants also shared that using physicians in a similar manner—as "traveling doctors" would reduce barriers to care by bringing medical care directly to participants.

> **We really need true community health professionals that are going to make sure that people, when they come home from the hospital, that they actually have food to eat and that they actually have their prescriptions, some of the old-fashioned things.**
>
> *—Focus Group Participant*

Many participants mentioned taking advantage of mobile unit services that bring medical care to their community along with attending hallmark community sponsored health fairs in the community that provide an array of primary care health services. Assistance with insurance enrollment, referrals to other social support services and a solid connection to ongoing care was mentioned as another benefit to participating in these offerings. Furthermore, participants mentioned partnering with school-based health centers and local federally qualified health centers, for example, to offer additional health and wellness activities to particular areas of the city.

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 group of reading, listening, analytical and decision-making skills, and the ability to apply these skills to health situations.

Health literacy emerged as an important component of community health—nearly half (46.5%) of participants discussed health knowledge and literacy during the interviews and through online surveys. Participants indicated that low health literacy can affect overall health outcomes, result in lack of access to and awareness of supportive services offered by health care systems, and may cause confusion about health insurance processes. Participants also noted poor attitudes about preventive care that resulted in more missed appointments. While general literacy issues are a concern, the focus here is on the population's need for focused health literacy education.

Community members also noted that DC has experienced an expansion in cultural diversity over several decades. As a result, health care organizations must pay attention to cultural and linguistically appropriate services.

When developing and delivering health literacy programs, participants noted the importance of first understanding the communities' characteristics and audiences, including their strengths, cultural backgrounds, and challenges they might face. Health literacy programs should have clearly-defined learning and behavioral objectives that reflect this knowledge. Additional resources should be provided to train health care professionals and increase their awareness of this issue and cultural competency in general.

> **An inability to communicate with a healthcare provider not only creates a barrier to accessing health care but also undermines trust in the quality of medical care received.**
>
> *—Focus Group Participant*

Participants identified several possible targets for health literacy programs that would benefit DC residents:

- Healthy food choices and nutrition, particularly for residents with limited resources
- Resources (e.g., health care, safety net, recreation opportunities) that are available in residents' communities and how to access these resources
- Pregnancy prevention, where appropriate, especially long-acting reversible contraceptive methods
- Perinatal education regarding prenatal care and infant safety
- Managing chronic illnesses, developing expectations following new diagnoses, and information about promoting lifestyle changes.

MENTAL HEALTH SERVICES

Mental health services are provided by government, professional, or community organizations that aid in the prevention and treatment of psychological, emotional, and relational issues as well as access to therapy and psychiatry services.

Approximately 42.6% of participants discussed mental health as an indicator of healthy communities and an important target of intervention for health care organizations. Concerns about mental health and recommendations for services were broad, including psychological, emotional, and relational issues as well as access to therapy and psychiatry services.

Participants expressed concern about reducing the stigma associated with seeking mental health services. Unfortunately, the stigma associated with seeking mental health services affects all groups spanning from the pediatric population to the senior community. Community members repeatedly noted that as a result of such stigma and inadequate screening by primary care practitioners, identification is often missed. In addition, for those who do receive an intervention, the lack of patient compliance with the course of treatment and delays in follow-up services frequently result in reoccurring episodes. Fortunately, in DC, there is now a mandate for specific health care organizations to provide mental health screenings in the primary care setting, laying the foundation to substantially address the mental health needs of DC residents. Participants also expressed concern about substance abuse among DC residents. Lastly, participants voiced concerns regarding the lack of specific mental health services – such as psychiatric services for children – in certain areas of DC.

Participants felt that mental health should be considered a public health issue and the DC community needs to use policy to redress broad determinants of mental health while targeted community organizations address individual concerns. Specific ideas for improving mental health services in DC included: 1) Provide services to address trauma and loss among residents, 2) Universal screening and treatment, especially for disenfranchised and vulnerable populations such as DC jail inmates, and 3) Create more mental health and substance abuse treatment facilities, services, and transitional programs.

> **I think we've got to work to really remove the stigma around accessing mental health care... I think there are a lot of young people out there who need our help. So, I think to the extent we can try to continue to remove the stigma associated with accessing mental health care, I think the better off the community will be.**
>
> *—Town Hall Member*

HEALTHY BEHAVIORS

Healthy behaviors refer to the actions of individuals, groups, and organizations that promote primary, secondary and tertiary prevention of disease and facilitate longer, healthier physical and mental health. Central to this concept is creating communities and environments that make healthy choices the easy choices.

A majority of participants (77.2%) identified healthy behaviors, particularly being physically active, maintaining a balanced diet, avoiding smoking, and attending regular well-person medical visits as being important for keeping residents of DC healthy. Many communities in DC do not make it easy to lead an healthy life. Adopting healthy behaviors is challenging when access to healthy foods is limited, community violence prompts fear of outdoor exercise, and access to preventive health care services is not convenient.

Participants spoke about nutrition education programs extensively and their potential to enhance residents' knowledge and contribute to behavioral changes. There is a need for nutrition programs that both bridge the gaps in access and provide instruction about healthy eating and shopping for healthy foods while on a budget. In this vein, community members recommended cooking demonstrations that teach DC residents how to adapt traditional recipes to make them healthier and prepare new, appetizing dishes using fresh produce and healthy ingredients.

An important theme in this discussion was the need to tailor healthy behavior initiatives in a culturally appropriate manner by tapping the expertise of community members. People living in the community should be engaged in these programs from the outset. Town hall attendees discussed how programs fail when the same approach is used for different groups. As one participant noted: What works for Black *DC residents living in Ward 8 has little chance of working for Latino residents living in Ward 5! That's just common sense.*

Participants also noted the importance of incentivizing participation in these programs. Incentives, while an added initial cost to the program, may create buy-in among residents who might not otherwise participate or engage in the health behavior. It is also essential that programs are designed to be sustainable in the long-term; participants may need time to notice the intrinsic benefits of adopting health behaviors. Thus, the programs offer a "bridge" until behavior changes can be learned, adopted, and incorporated into residents' daily routines.

> **"Medicare has a part of their package that speaks to wellness visits and it is the hardest thing to get seniors to go to a wellness visit. I suspect that it's not just seniors, because if I'm well and I'm feeling healthy and I'm not upset, why am I going to a doctor?"**
>
> *—Town Hall Member*

Participants offered several ideas about ways hospitals and health care organizations may encourage the adoption of healthy behaviors through physical fitness classes (i.e., free Zumba classes), smoking cessation support, encouraging breastfeeding, or disease management education programs for recently-diagnosed patients, among others. Ultimately, these health behaviors are linked to better health outcomes for patients.

HEALTH INFORMATION DISSEMINATION

Disseminating health information is the process through which individuals and groups become aware of, receive, accept, and utilize disseminated health information.

An emergent theme from the analysis was the notion that health care organizations should do more to inform community members about the services they provide, as well as advance "awareness campaigns" to provide information about health and promote healthy behaviors.

Participants and interviewees endorsed multimodal approaches that are targeted to specific audiences and suggested a range of possible outlets for reaching community members with health messages and information. The word cloud below provides a visual summary of the suggested outlets for disseminating information about health services to DC community members. Words that appear larger in the word cloud reflect those that occurred more frequently in participants' narratives.

As the word cloud suggests, there was strong consensus around churches and word-of-mouth as channels for sharing health information. Internet, radio, television, social media, newspapers, and community organizations were also endorsed. Schools may represent a special case as participants presented the idea of connecting with schools to disseminate health information targeted at both children and their families.

Within the overarching theme of multimodal contact, there was consensus that text messaging and social media would be effective for conveying health messages aimed at youth or young adults. In addition, participants strongly supported the use of local and trusted websites, such as the Collaborative's DC Health Matters portal, and targeted email messages as potentially useful means of distributing information to residents. These electronic avenues for dissemination, however, might be less fruitful for reaching older adults.

Participants noted the importance of targeting health messages for their intended audiences. To do this effectively, stakeholders discussed the need to know the audiences and get the messaging out in various innovative ways. Additionally, participants also suggested disseminating information through organizations that present "pinch points" in the process of accessing services—organizations where there are relatively few access points and provide services for large numbers of target audience members. Examples of such "pinch points" include: the Department of Motor Vehicles; Women, Infants, and Children offices; and the Department of Human Services.

> **I think just in general that you have to get a little creative in how you message and who you message to and kind of break outside of the traditional, assume you understand the roles that people play in their lives and get the messaging out in various innovative ways.**
>
> *—Town Hall Member*

COMMUNITY VIOLENCE

Community violence can be defined as exposure to intentional acts of interpersonal violence committed in public areas. Experience of violence can lead to injury, psychological and emotional stress, risky or unhealthy behaviors, disease, disability, social problems, or early death.

Safety was a commonly-named characteristic of healthy communities (20.8%). The fear driven by the lack of safety in some areas of DC detracted from community members' utilization of recreation spaces, walking as transportation, and participation in physical activity.

Community members noted that DC is plagued with high numbers of violence throughout the city; however, some sections show much higher occurrences of violence. Furthermore, the strong correlation between health and violence should be noted. Individuals that experience a violent act are more likely to experience psychological and emotional stress, which in turn can lead to the adoption of risky and unhealthy behaviors, followed by disease, disability, social problems and/or early death. Social and economic conditions can contribute to the level of violence, especially in certain areas of the city where declining businesses and general poverty results in an increase in violence and crime. In DC, the three types of violent crimes that are on the rise are: homicide, robbery with gun, and assault with dangerous weapon. In contrast, the number of property crimes (such as, theft and arson) was lower in 2015. As of November 2015, the DC homicide count stood at 135 which is a more than a 50% increase compared to the 90 homicides in 2014. Homicides increased in 2015 in every ward, except in Ward 4 where there was no change in the number of homicides compared to 2014. In 2014, Ward 5 experienced 0 homicides. The number of homicides in 2015 is greatest in Ward 8 (49 homicides) and lowest in Ward 2 (4 homicides).

The lack of safety present in some communities presents a barrier for practicing healthy behaviors that mitigate risk for chronic health conditions. Specifically, the DC neighborhoods of Lamond Riggs, Queens Chapel, Fort Totten, and Pleasant Hill have experienced an uptick in violence while the neighborhoods of Eastland Gardens and Kenilworth have noticed an improvement in overall safety. Access to parks, community centers, and other recreation spaces ranked as the second most frequently endorsed characteristic of healthy communities (50.5%) and the top factor that keeps people healthy in DC. Whereas the availability of recreation spaces, particularly parks, was identified as a strength of the city, fear of community violence detracted from utilization of these facilities and resources.

> **Persons aren't going to feel comfortable or safe going outside to exercise or just be out in their neighborhood for fear of what may happen or victimization or because of safety concerns. So, you may have a park in the neighborhood, but who is going to the park if there is crime in the park, and all you hear is bad things going on in the park. Who is going to the park even if it's there? So, safety and safety concerns in the neighborhood is a real barrier, as well.**
>
> *—Focus Group Member*

Community members suggested bringing together multi-disciplinary teams to collaboratively address the issues of violence with law enforcement at the center of this effort. DC is similar to several other urban cities of this size with its occurrences of violence. Several other cities on a national level have pulled together such task forces to address the needs of its community. DC should follow a similar approach that is reflective of our community.

SELECTING PRIORITY NEEDS

While the Collaborative recognized the importance of all nine community-defined needs, we selected priority needs using a structured prioritization process that scored each of the needs according to 1) importance to our community, 2) capacity to address, 3) alignment with organizational and citywide mission and 4) strength of existing intervention/collaborations.

Starting with the nine needs that were defined by our community stakeholders, we used a modified Hanlon ranking method to score the needs by the following criteria and weights:

1) Importance to Community (40%),

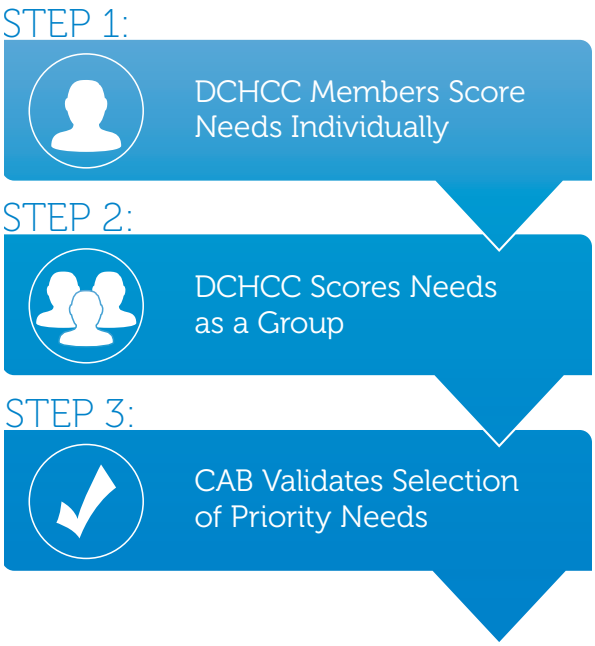
2) Capacity to Address (25%) ,

3) Alignment with Mission/Vision (25%)

4) Existing Collaborations or Interventions (10%).

Definitions of these criteria are included in Chapter 2 (Methods).

The scoring was a three-step process: Individual DCHCC organization Scoring, Group DCHCC Scoring, and Community Advisory Board (CAB) Validation.



INDIVIDUAL SCORING

In the fall of 2015, Collaborative member hospitals and community health centers individually scored the list of needs using a modified Hanlon prioritization method. To assist with this process, each organization received a summary of each need and relevant quantitative data. These scores reflect each institution's perspective based on the three criteria.

For each need, Collaborative members scored each criterion on a scale of 0 (very low) – 10 (very high): *the higher the score, the more agreement that the need is in alignment with the criterion.* We calculated average scores for each need to inform a group prioritization activity.

The individual scoring revealed high concordance of scores among the Collaborative organizations. The three conditions with the highest scores were: mental health, bring care to the community, and care coordination. The average scores per need

(Table 3) were used to inform the group discussion.

Table 3: Individual Priority Scoring Averages

COMMUNITY-DEFINED NEED	INITIAL SCORE
Mental Health	**89.3**
Bring Care to the Community	**89.2**
Care Coordination	**88.6**
Health Literacy	80.6
Cultural Competence	78.4
Healthy Behaviors	76.9
Health Data Dissemination	76.6
Food Insecurity	70.5
Community Violence	56.8

Group DCHCC Scoring

Collaborative members engaged in an in-person group prioritization activity with the goal of paring down the list of needs to a select number of priority needs that will be the Collaborative's areas of focus in the next three-year CHIP cycle. Given the high scores that all Collaborative members gave to three community needs (mental health, bring care to the community, and care coordination), the Collaborative quickly came to consensus that these three needs would rise to "priority needs."

Table 4: DHCC Group Priority Scores

COMMUNITY-DEFINED NEED	FINAL SCORE
Mental Health	**89.1**
Bring Care to the Community	**89.1**
Care Coordination	**88.2**
Health Literacy	78.9
Cultural Competence	77.3
Healthy Behaviors	77.2
Health Data Dissemination	77.0
Food Insecurity	73.8
Community Violence	56.2

The DCHCC spent substantive time discussing the remaining six community needs. The rich discussion revealed a strong desire to consider adding health literacy, cultural competence and health data dissemination as priority areas. Ultimately, health literacy was added so that the Collaborative could focus on empowering DC residents to understand, navigate, and assess the DC health care environment.

Following the group DCHCC prioritization meeting, DCHCC members were given time to submit any changes to their individual organization scores for each of the needs. This was intended to give organizations some time to digest the conversation at the prioritization meeting and consult with their colleagues and leadership. Only one Collaborative organization submitted revised scores. Final scores were recalculated based on submitted changes (Table 4). Table 5 contains a detailed summary of DCHCC members' mean scores on the four criteria used in the ranking tool (importance to the community, capacity to address, alignment with mission/vision, and existing collaborations/ interventions).

Community Validation

Table 5: Priority Ranking Summary, with Criteria Detail

DCHCC COMMUNITY NEEDS PRIORITIZATION TABLE
ALL SCORES

COMMUNITY-IDENTIFIED NEED	FOUR CRITERIA Score each criterion: 0 (very low agreement) to 10 (very high agreement)				FINAL SCORE [Max = 100]
	Importance to Community	Capacity to Address	Alignment with Mission/ Vision	Existing Collaborations/ Interventions	
Mental Health	**9**	**8.6**	**9.4**	**8.1**	**89.1**
Bring Care to the Community	**10**	**7.4**	**9.1**	**7.7**	**89.1**
Care Coordination	**10**	**7.6**	**8.8**	**7.3**	**88.2**
Health Literacy	9	6.7	8.0	6.2	78.9
Cultural Competence	7	8.0	9.0	6.8	77.3
Healthy Behaviors	8	7.0	8.3	6.9	77.2
Health Data Dissemination	8	7.3	8.0	6.7	77.0
Food Insecurity	10	4.8	6.6	5.4	73.8
Community Violence	7	3.6	6.2	3.8	56.2

The DCHCC met with the Community Advisory Board in November 2015 for their validation of the selected priority needs. CAB members were very supportive of the selected needs and committed to being engaged partners in devising and implementing a plan to address the identified needs.

QUOTATIONS

[Consider adding a quotes page that features quotes from the DCHCC orgs and/or CBOs?]

CHAPTER 5:
Health Status and Behavior

We organized the bulk of our quantitative data in the Healthy People 2020 framework, with a specific focus on the evidence-based Leading Health Indicators. The data reveal troubling variances in health, well-being and preventive behaviors that often correlate with place of residence, race, and ethnicity. These disparities are highlighted throughout the chapter.

In Chapter 5, we organize the DC health status and health behavior data to align with the Healthy People 2020 priority topic areas. The DC Department of Health is leading the local Healthy People movement and the Collaborative is an active member of this initiative. A much more detailed analysis of DC's status on the Healthy People 2020 indicators is available on the DC Department of Health website.

In this chapter, we provide abbreviated findings for each of the Healthy People 2020 topic areas. Given the space constraints of this written report, we are not able to provide breakouts of all subpopulations. Additional cross-tabulations of data are available in the appendices as well as in the interactive data cube and map gallery located on the DC Health Matters portal. Other valuable sources of health status and behavior data include:

- Community Commons
- Kaiser Family Foundation
- Neighborhood Info DC
- County Health Rankings

HEALTHY PEOPLE 2020

HEALTHY PEOPLE 2020 LEADING HEALTH INDICATOR TOPIC AREAS

1. Access to Care
2. Clinical Preventive Services
3. Environmental Quality
4. Injury and Violence
5. Maternal, Infant and Child Health
6. Mental Health
7. Nutrition, Physical Activity, and Obesity
8. Oral Health
9. Reproductive and Sexual Health
10. Social Determinants
11. Substance Abuse
12. Tobacco
13. Chronic Disease*

**Per IOM Recommendations*

Healthy People 2020 provides a comprehensive set of 10-year national goals and objectives for improving the health of all Americans. It contains 42 topic areas with more than 1,200 metrics. We focus our assessment on a smaller set of 12 Healthy People 2020 priority topic areas that are selected to communicate high-priority health issues. Healthy People 2020 includes 1-3 Leading Health Indicators (LHIs) for each topic area, for a total of 26 LHIs. In this report, we present the Healthy People-recommended LHIs or provide close proxy data. We pay particular attention to differences by ward, race, ethnicity, age and gender. Note: Unless otherwise noted, results have been tested for statistical significance to ensure that results are not due to random chance.

HIGHLIGHTED FINDINGS

Access to Care

A person's ability to access health services has a profound effect on every aspect of his or her health, yet at the start of the decade (prior to the Affordable Care Act), almost 1 in 4 Americans did not have a primary care provider (PCP) or health center where they can receive regular medical services.

HP 2020 RECOMMEND METRICS: ACCESS TO HEALTH SERVICES

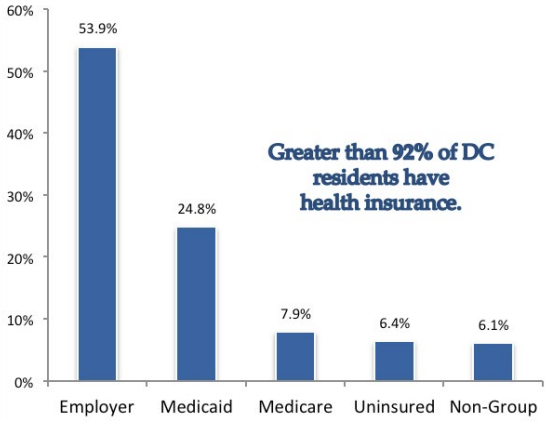
Adults who had no health care coverage (Target: 0%)

Adults who do not have one person they think of as their personal health care provider

Adults who delayed getting medical care because could not get an appointment soon enough

Access to health services – as measured by health insurance coverage – is high in DC with more than 92% of adults having health insurance, higher than the national average of 83.2%.

More than half of DC residents are covered by employer-based insurance and a quarter by Medicaid. Relative to adults, a much higher percentage of children (~50%) are insured by Medicaid or the Children's Health Insurance Program (CHIP).[4] Based on 2013 data, the Centers for Medicare and Medicaid Services estimates that 97.6% of eligible children in DC, based on household income, are enrolled in Medicaid or CHIP; the rate nationally is 88.3%.[5] Note: DC policies and programs are generally very generous compared to other states; and, DC implemented Medicaid expansion sooner than required. These both contribute to our high insured rates.



While DC residents are highly insured, a large percentage (23.8%) report not having someone they think of as their health care provider. In fact, about 10% of adults delayed getting medical care because they could not get an appointment soon enough. Health insurance does not always equate to timely and appropriate care.

4 Kaiser Family Foundation. Health Insurance Coverage of Children, 0 – 18 years. http://kff.org/other/state-indicator/children-0-18/?state=dc

5 Centers for Medicare and Medicaid Services. Medicaid.gov Keeping America Healthy: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/District-of-Columbia.html.

Table 5: Healthcare Access in DC, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward							
		1	2	3	4	5	6	7	8
Adults who had no health care coverage, 2013 (%)	8.7	8.1	4.7	4.8	8.9	8.6	4.4	15.3	7.6
Adults who do not have one person they think of as their personal health care provider, 2013 (%)	23.8	17.7	19.8	11.7	18.6	23.9	16.1	22.4	20.7
Adults who delayed getting medical care because could not get an appointment soon enough, 2013 (%)	9.7	14.2	10.9	6.8	6.0	10.4	12.3	6.1	10.5
Children who do not have personal doctor or nurse, 2013 (%)	10.2	data not available							

Summary

Ward

- The highest rate of uninsurance is in Ward 7 with 15.3% of residents lacking insurance, whereas the lowest rate of uninsurance is in Wards 2, 3, and 6 with less than 5%.
- Adults living in Wards 3 and 6 are more likely to have one person who they think of as their personal health care provider than adults living in other parts of the city. In the remaining wards about 20% or more adults report not having a personal health care provider.
- 14.2% of adults living in Ward 1 reported delaying care because they could not get an appointment – twice the rate reported by residents living in Ward 7.

Race and Ethnicity

- Black DC residents are four times more likely to be uninsured than White DC residents (12.8% versus 3.2%).
- Residents of Hispanic or Latino descent have the highest rates of uninsurance (17.7%).

Age and Gender

- Comparable to national trends, young and older DC residents are more highly insured; young adults and middle-aged DC residents (particularly men) have higher rates of uninsurance than other age groups.
- Men were more than twice as likely to be uninsured than women (12.1% versus 5.8%).

Sources: DC Department of Health BRFSS and National Survey of Children's Health;

Clinical Preventive Services

Clinical preventive services, such as routine disease screening and scheduled immunizations are key to reducing death and disability and improving health. These services both prevent and detect illnesses and diseases—from flu to cancer—in their earlier, more treatable stages, significantly reducing the risk of illness, disability, early death, and medical care costs.

HP 2020 RECOMMEND METRICS: CLINICAL PREVENTIVE SERVICES

Adults who receive a colorectal cancer screening based on the most recent guidelines

Adults with hypertension whose blood pressure is under control

Persons with diagnosed diabetes whose A1c value is >9 percent

Children aged 19 to 35 months who receive the recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines

Among adults we looked at routine preventive services, such as mammograms and pap smears for women and prostrate-specific antigen (PSA) test for men. A high percentage of women complied with mammogram and pap smear guidelines, but the same is not true for men's compliance with health recommendations. A summary of preventative services utilization is presented in Table 6.

Table 6: Clinical Preventative Service Utilization in DC

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Race & Ethnicity		
		White	Black	Hispanic
Adults who did not have a flu shot within past 12 months	61.5	52.1	68.4	66.4
Men aged 40+ who have had a PSA test within the past 2 years, 2012 (%)	44.5	49.2	43.2	NA
Women aged 50+ who have had a mammogram within the past 2 years, 2012 (%)	83.7	80.4	84.6	NA
Women aged 18+ who have had a pap test within the past 3 years, 2012 (%)	81.2	83.6	83.8	NA

Summary

Race and Ethnicity

- A much higher percentage of Black and Hispanic residents, 66 %– 68%, do not have a flu shot in the past 12 months compared to White residents.
- White and Black women have similar pap smear rates with about 84% having a pap smear in the last 3 years.
- More than 40% of White and Black DC males aged 40+ had a PSA test within the past 2 years.

Age and Gender

- Greater than 80% of women complied with mammogram and pap smear guidelines by having these preventive procedures within the recommended time period. Compliance was not as high among men: about 40% of men aged 40+ have had a PSA test within the past 2 years.

Sources: DC Department of Health BRFSS.

Environmental Quality

The environment directly affects health status and plays a major role in quality of life, years of healthy life lived, and health disparities. Air quality is a key measure of environmental quality.

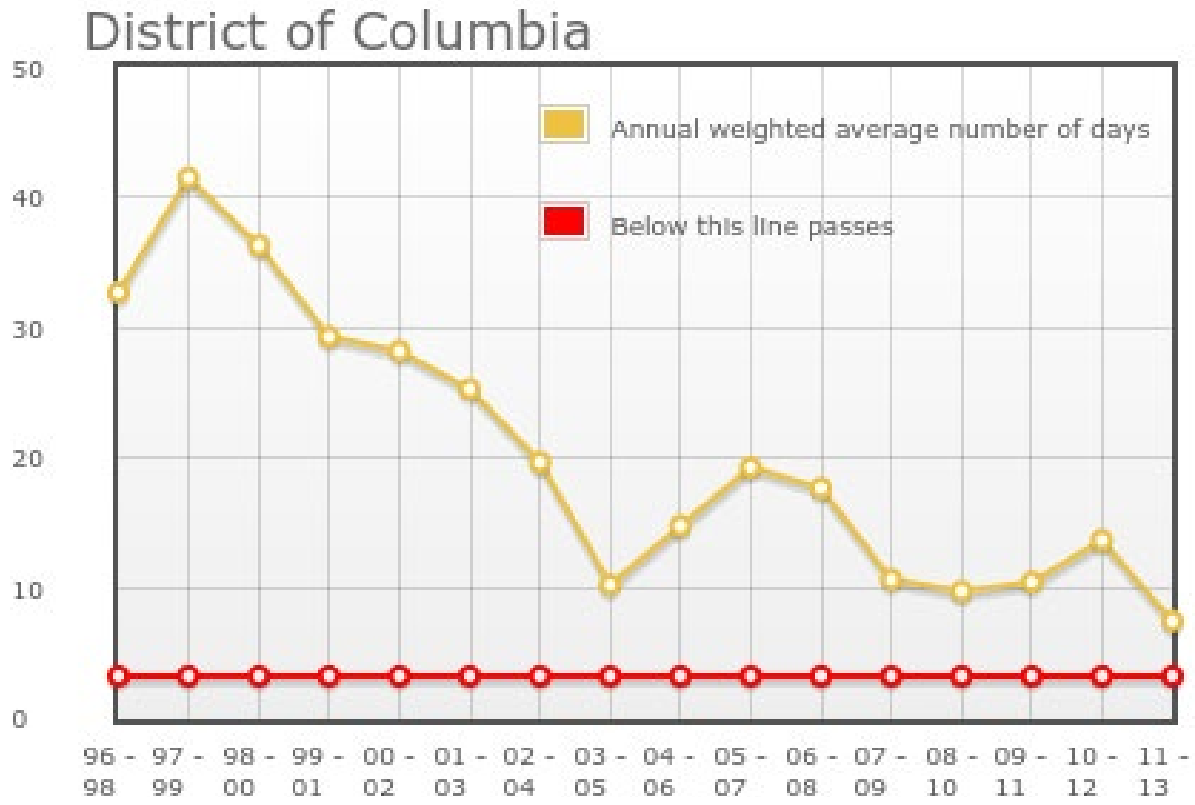
As reported in the 2015 State of the Air report, DC received an 'F' for ozone levels in 2015 despite incremental improvement in ozone levels over time (Figure 3). DC fared better in other categories, though. The city got a 'C' in 24-hour particle pollution, which measures all the pollutants in the air throughout the year, and just a 'pass' grade in the average annual particle pollution.

HP 2020 RECOMMEND METRICS: ENVIRONMENTAL DETERMINANTS

Air Quality Index (AQI) exceeding 100

Children exposed to secondhand smoke

Figure 3: Ozone Levels in DC 1996-2013



Injury and Violence

Motor vehicle crashes, homicide, domestic and school violence, child abuse and neglect, suicide, and unintentional drug overdoses are all important public health concerns in the United States. In addition to their immediate health impact, the effects of injuries and violence extend well beyond the injured person or victim of violence, affecting family members, friends, coworkers, employers and communities.

HP 2020 RECOMMEND METRICS: INJURY AND VIOLENCE

Fatal injuries

Homicides

While DC's homicide rate has increased between 2014 and 2015, per the DC Metropolitan Police Department, the rate appears to have begun its increase in 2013 and not 2014. In 2015, the DC homicide count stood at 156 which is about 50% greater than the 105 homicides in 2014. The three types of violent crime that are on the rise citywide are: homicide, robbery with gun, and assault with dangerous weapon. In contrast, the number of property crimes (such as, theft and arson) is lower in 2015. Crime data, with a focus on violent crime, is provided below by neighborhood, ward, and citywide. Also, information on traffic fatalities is noted below. In general, there has been a decrease in traffic accidents that result in death over the past 20 years. In 2015, there were 26 traffic fatalities in DC – no increase from 2014. More detailed crime information can be obtained from the DC Metropolitan Police Department.

Figure 4: Injury and Violence Distribution, by Ward

		Ward							
Leading Health Indicator or Proxy Indicator	Citywide (DC)	1	2	3	4	5	6	7	8
Homicides, 2015	156	11	4	5	7	27	17	32	53
Motor Vehicle Fatal Crashes, 2015	26								

Summary

- Homicides increased in 2015 in every ward, except in Ward 4 where there was one less homicide in 2015 (7 homicides in 2015 compared to 8 in 2014).
- The number of homicides in 2015 was lowest in Wards 2, 3, and 4 with 4, 5, and 7 homicides, respectively.
- The number of homicides in 2015 was greatest in Ward 8 (53 homicides). Ward 7 has the second greatest number of homicides (32 homicides).
- In Ward 8, the number of homicides was 13 times greater than in Ward 2 (in 2015).

Crime Type	Number of Crimes Reported Between		Change
	1/1/2014 to 12/31/2014	01/01/2015 to 12/31/2015	
Homicide	105	156	↑
Sex Abuse	311	275	↓
Robbery Excluding Gun	2157	2101	↓
Robbery With Gun	1112	1250	↑
Assault Dangerous Weapon (ADW) Excluding Gun	1794	1637	↓
Assault Dangerous Weapon (ADW) Gun	673	748	↑
Total Violent Crime	**6152**	**6167**	↔
Burglary	3179	2533	↓
Theft	14613	14010	↓
Theft F/Auto	11333	10965	↓
Stolen Auto	3121	2797	↓
Arson	26	18	↓
Total Property Crime	**32272**	**30323**	↓
Total Crime	**38424**	**36490**	↓

Definition of symbols in "Change" column:

↓: Decrease in the number of crimes reported compared to the prior time period.

Annual Violent Crim, By Neighborhood Between 2014 to 2015

Rank	Neighborhood	%	# increased	Avg Annual Violent Crime #
MOST REGRESSED				
1	Lamond Riggs, Queens Chapel, Fort Totten, Pleasant Hill	49	24	56
2	Kalorama Heights, Adams Morgan, Lanier Heights	49	23	84
3	Brookland, Brentwood, Langdon	38	35	119
4	Takoma, Brightwood, Manor Park	33	28	103
5	NoMa, Union Station, Stanton Park, Kingman Park	33	53	187

Rank	Neighborhood	%	# decreased	Avg Annual Violent Crime #
MOST IMPROVED				
1	Eastland Gardens, Kenilworth	-68	-28	22
2	Fairfax Village, Naylor Gardens, Hillcrest, Summit Park	-41	-16	36
3	River Terrace, Benning, Greenway, Fort Dupont	-24	-45	160
4	Sheridan, Barry Farm, Buena Vista	-21	-22	115
5	Howard University, Le Droit Park, Cardozo/Shaw	-18	-20	139

Source: Metropolitan Police Department (NEED TO UPDATE TABLE for 2015 FULL YEAR DATA, NOT AVAILABLE YET

20-Year Traffic Fatality Trend

Year	'95	'96	'97	'98	'99	'00	'01	'02	'03	'04	'05	'06*	'07	'08	'09	'10	'11	'12	'13	'14**	2015
Fatalities	62	65	63	59	47	52	72	50	69	45	49	43	54	39	33	25	32	19	29	26	26

Source: Metropolitan Police Department)

Maternal, Infant, and Child Health

The well-being of mothers, infants, and children determines the health of the next generation and can help predict future public health challenges for families, communities, and the medical care system. Moreover, healthy birth outcomes and early identification and treatment of health conditions among infants can prevent death or disability and enable children to reach their full potential.

In 2013, there were 9,264 live births and 63 infant deaths to DC residents, resulting in an infant mortality rate of 6.8 deaths for every 1,000 live births, which is slightly higher than the national average of 6.0. In DC, the number of infant deaths decreased from 74 in 2012 to 63 in 2013, a decrease of 14.9%. The overall DC infant mortality rate decreased by 13.9% from a rate of 7.9 per 1,000 live births in 2012 to 6.8 per 1,000 live births in 2013. Premature births in the District increased from 9.9% in 2012 to 10.6 percent in 2013.

HP 2020 RECOMMEND METRICS: MATERNAL AND INFANT HEALTH

All Infant deaths

Total preterm live births

Table 7: Maternal, Infant, and Child Health, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward							
		1	2	3	4	5	6	7	8
Infant Mortality Rate per 1,000 births, 2013	6.8	5.7	0	1.2	5.1	11.9	4	9.7	10.9
Preterm Births (%), 2013	10.6	8.7	6.7	7.8	9.4	10	10.5	16.2	11.9

Summary

Ward

- From 2012 to 2013, infant mortality rates decreased in Wards 1, 2, 6, and 8 but increased in Wards 4, 5, and 7.
- There was no change in infant mortality rates in Ward 3.

Race and Ethnicity

- The infant death rate to Black mothers decreased from 12.3 per 1,000 live births in 2012 to 9.9 per 1,000 live births in 2013, a decrease of 19.5%.
- The infant death rate to White mothers was 3.4 per 1,000 live births in 2012 and 1.7 for 2013, a decrease of 50%.
- The infant death rate to Hispanic mothers increased by 25.5% from 5.1 per 1,000 live births in 2012 to 6.4 per 1,000 live births in 2013.
- Preterm births have increased across all racial groups in 2013, with the highest climb of 11.6 percent among Asian/Pacific Islander mothers. In contrast, an 8% drop in preterm births was seen among Hispanic/Latina mothers who delivered from 2012 to 2013.

Age and Gender

- The proportion of births to teen mothers (15-19 years of age) decreased by 18.4% from 2012 to 2013. There were 637 births to teen mothers in 2013.

Source: DC Department of Health.

Mental Health

The burden of mental illness in the United States is among the highest of all diseases, and mental disorders are among the most common causes of disability.

Mental health challenges continue to be a pressing issue in DC with about 20% of adults diagnosed with depression and about 15% of children considering suicide. Of particular concern in DC is the well-documented mismatch between mental health needs and available treatment.

HP 2020 RECOMMEND METRICS: MENTAL HEALTH

Suicides

Adolescents who experience major depressive episodes

Table 8: Mental Health, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Adults who were diagnosed with depression, 2013 (%)	20.9	22.4	18.7	23.7	15.4	16.4	23.2	18.4	28.0
Youth considered attempting suicide, 2013 (%)	14.8	data not available							
Seniors feeling lonely, sad or isolated, 2012 (%)	17.2	16.4	23.1	10.3	16.3	16.8	19.3	19.4	19.2

Summary

Ward

- Clinically-diagnosed depression is most prevalent in Ward 8 (28%) and least prevalent in Wards 4 and 5 (about 15%).

Race and Ethnicity

- There is not much variation in diagnosed depression between White, Black, and Latino DC residents: prevalence is about 20% in each group.

Age and Gender

- The rate of attempted suicide in youth is nearly twice as high among girls compared to boys (18.9% versus 9.9%).
- Seniors living in Ward 2 appear to be the most lonely, sad and isolated (23.1%) especially in comparison to seniors living in Ward 3 (10.3%).
- Comparable to national data, women in DC are diagnosed with depression more frequently than men.

Sources: DC Department of Health BRFSS, YRBS, and Senior Needs Assessment

Nutrition, Physical Activity, and Obesity

Good nutrition, physical activity, and a healthy body weight are essential parts of a person's overall health and well-being. Together, these can help decrease a person's risk of developing serious health conditions, such as high blood pressure, high cholesterol, diabetes, heart disease, stroke, and cancer.

More than 50% of DC residents are overweight (30.9%) or obese (22.8%). Physical activity among DC adults varies greatly across the city; overall, about 20% of DC residents did not participate in any physical activity in a 30-day period.

HP 2020 RECOMMEND METRICS: NUTRITION, PHYSICAL ACTIVITY, AND OBESITY

Adults who meet current federal physical activity guidelines for aerobic physical activity and muscle-strengthening activity

Adults who are obese

Obesity among children and adolescents

Total vegetable intake for persons aged 2 years and older

Table 10: Nutrition, Physical Activity, and Obesity, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward							
		1	2	3	4	5	6	7	8
Adults who were overweight, 2013 (%)	30.9	27.8	33.3	28.8	32.3	36.6	30.5	36.3	27.0
Adults who were obese, 2013 (%)	22.8	24.9	15.3	12.0	27.2	32.1	22.1	35.0	42.8
Adults who did not participate in any physical activities within past 30 days, 2013 (%)	19.5	16.4	12.1	10.5	19.2	21.0	16.1	27.7	34.5
Children weight status, age 10-17 years (Overweight or Obese), 2011-12 (%)	35.0	data not available							
Youth not physically active at least 60 minutes per day 5+ Days/Wk, 2013 (%)	71.9	data not available							
Seniors who engage in moderate physical activity (for at least 30 mins a day, at least 1 day per week), 2012 (%)	79	55	81.6	100	79.6	81.4	76.4	72	94.3

Summary

Ward

- About 70% of DC adult residents in Wards 5, 7, and 8 are either overweight or obese.
- Obesity is most prevalent in Ward 8 with 42.8% of residents being obese.
- Physical inactivity is greatest in Ward 8 with more than a third of residents (34.5%) not participating in physical activity; physical activity is most common in Ward 3 with only about 10% of residents physically inactive.

Race

- The percent of Black DC residents who are obese is 3.7 times greater compared to White DC residents (36.4% versus 9.8%); among Hispanic and Latino residents overweight is highly prevalent with 39.1% being overweight, but a smaller percent being obese (15.3%).
- The percentage of Black DC residents who did not exercise is about 3 times greater compared to White residents (29.5% versus 9.3%); about 17% of Hispanic residents did not exercise within a 30-day period.

Age/Gender

- More than a third (35%) of children ages 10-17 years are overweight or obese in DC.
- More than 70% of youth are not physically active at least 60 minutes per day, five days a week.
- About 60% of DC adult males and 50% of adult females are either overweight or obese.

Sources: DC Department of Health BRFSS, YRBSS, National Survey of Children's Health, and Senior Needs Assessment.

Oral Health

Oral diseases ranging from dental caries (cavities) to oral cancers cause pain and disability for millions of Americans. The impact of these diseases does not stop at the mouth and teeth. A growing body of evidence has linked oral health, particularly periodontal (gum) disease, to several chronic diseases, including diabetes, heart disease, and stroke.

The Pew Charitable Trust released a 50-state report card in 2011, The State of Children's Dental Health, that focused on children's dental health. It found that a child's state of residence can make a big difference in the health of their teeth.

HP 2020 RECOMMEND METRICS: ORAL HEALTH

Children, adolescents, and adults who visited the dentist in the past year

The report gave grades of an A or B to 27 states, while 23 states and DC received a C or lower grade for meeting just three or four of Pew's eight evidence-based, cost-effective policies that all states can adopt to improve children's dental health. DC is making progress in important dental initiatives, such as incentivizing the use of fluoride varnish and dental sealants in high-risk children.

Slightly higher than US averages, more than 70% of DC adults visited a dentist or dental clinic in the past 12 months and even more children (83%) had a dental visit in the past 12 months.

Table 9: Oral Health in DC

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Race & Ethnicity		
		White	Black	Hispanic
Adults visited a dentist or dental clinic within past year for any reason, 2012 (%)	71.1	79	65	69
Children with 1 or more Preventive Dental Care Visit (1-17yrs), 2011-12 (%)	82.3	79	87	68

Summary

Race and Ethnicity

- The percent of adults accessing a dentist in the past 12 months did not vary much by race and ethnicity. White DC residents had highest rate of dental visits while Black DC residents had lowest rate of dental visits. Percent did not vary by race and ethnicity despite white DC residents having highest rate of dental visits and black DC residents had lowest rate? Perhaps modify the wording

Age and Gender

- More DC children see the dentist than adults. About 83% of children had a dental visit in the past 12 months compared to 70% of adults.

Sources: DC Department of Health BRFSS and National Survey of Children's Health.

Reproductive and Sexual Health

An estimated 19 million new cases of sexually transmitted infections (STIs) are diagnosed each year in the United States—almost half of them among young people age 15 to 24. Untreated infections can lead to serious long-term health consequences, especially for adolescent girls and young women, including reproductive health problems and infertility, fetal and perinatal health problems, cancer, and further sexual transmission of HIV.

HP 2020 RECOMMEND METRICS: REPRODUCTIVE AND SEXUAL HEALTH

Sexually active females aged 15 to 44 years who received reproductive health services in the past 12 months

Knowledge of serostatus among HIV-positive persons

The rate of STIs in DC is high. Healthy People 2020 focuses on HIV figures as a leading health indicator. In 2013, DC had 86 new HIV cases per 100,000 population and 2,540 living HIV cases per 100,000. About 29% of adults have not been tested for HIV.

Table 10: Reproductive and Sexual Health, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward							
		1	2	3	4	5	6	7	8
Adults who have not been tested for HIV, 2013 (%)	29.3	19.7	33.2	44.5	32.1	25.9	33.2	23.0	16.6
Had sexual intercourse before age 13 Yrs, 2013 (%)	14.9	data not available							
Rate of newly diagnosed HIV per 100,000, 2013	85.5	data not available							
Rate of Chlamydia, 2013 (per 100,000 pop)	1,028	413.2	258.0	75.7	338.8	666.7	332.9	1,445.8	1,173.4
Rate of Gonorrhea, 5 Yrs Average 2009-2013 (per 100,000 pop)	406.7	250.3	179.6	23.3	162.1	388.6	241.3	627.9	754.6
Rate of Syphilis, primary & secondary, 5 Yrs Average Aggregate 2009-2013 (per 100,000 pop)	25.2	31.6	38.0	3.6	15.3	27.2	22.8	30.7	25.5

Summary

Ward

- Ward 3 has the most adults who have not been tested for HIV (44.5%) and Ward 8 has the least (16.6%).
- There are dramatic differences in the rates of sexually transmitted diseases across wards. Based on 2009-2013 average data, rates of chlamydia and gonorrhea are highest in Wards 7 and 8 and lowest in Ward 3. For example, the rate of chlamydia is more than 19 times higher in Ward 7 (1446 per 100,000) compared to Ward 3 (76 per 100,000).

Race and Ethnicity

- Rates of HIV, chlamydia, gonorrhea, and syphilis are greater among Black DC residents compared to White or Hispanic residents.

Age / Gender

- More than twice the percent of children under the age of 13 had sexual intercourse in DC compared to the national average (14.9% compared to 5.6%).

Sources: DC Department of Health BRFSS, YRBSS, and Annual Epidemiology and Surveillance Report.

Social Determinants

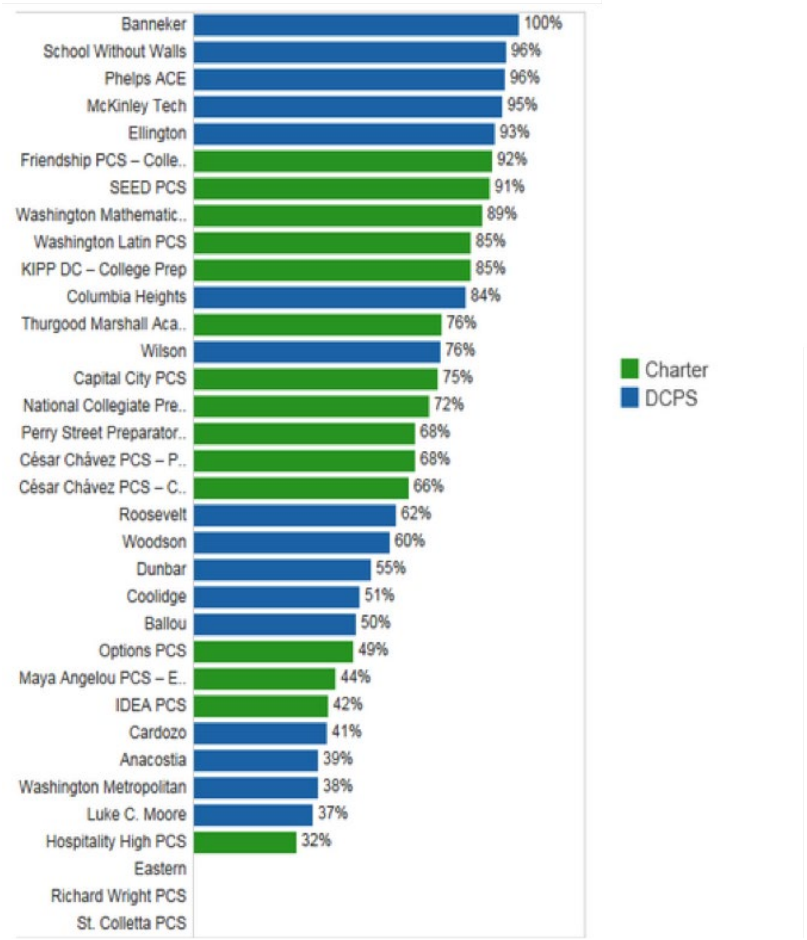
A range of personal, social, economic, and environmental factors contribute to individual and population health. A key social determinant of health is education and particularly high school graduation rates.

DC is home to 111 traditional public schools and 52 charter schools. DC's overall public school 2015 graduation rate increased to 65.4% - a six point increase from 2014 to 2015. While still lagging well behind the 81% national graduation average, DC is making significant progress. We provide the four-year adjusted cohort graduation rates, by school and subpopulations, from the DC Office of the State Superintendent of Education.

HP 2020 RECOMMEND METRICS: SOCIAL DETERMINANTS

Students who graduate with a regular diploma 4 years after starting 9th grade

Figure 5: Four-Year High School Graduation Rates in D.C.'s Public Schools, 2014



Source: DC Office of Revenue, 2015

Figure 6: Summary of DC Graduation Rates

DC 2015 4-year Adjusted Cohort Graduation Rates, by Subgroup

	2015 ACGR by Subgroup										
		Gender		Race					Economic Disadvantage	ELL	SPED
Sector	Overall	Female	Male	African-American	Latino	White	Asian	Multi-Ethnic			
STATE	65.4% (3210)	72.0% (1746)	58.9% (1464)	63.9% (2548)	65.6% (379)	84.5% (191)	79.4% (54)	74.4% (32)	65.8% (2661)	59.6% (235)	42.9% (462)
DCPS	64.4% (2223)	69.9% (1159)	59.2% (1064)	61.7% (1656)	66.0% (299)	85.6% (184)	81.7% (49)	78.9% (30)	63.9% (1735)	60.3% (190)	40.7% (299)
PCS	71.7% (961)	79.5% (570)	62.7% (391)	72.4% (867)	66.9% (79)	DS (<25)	DS (<25)	DS (<25)	72.6% (900)	59.7% (40)	54.1% (153)
State Programs	22.0% (26)	34.0% (17)	13.2% (9)	22.9% (25)	DS (<25)	DS (<25)	DS (<25)	DS (<25)	28.3% (26)	DS (<25)	DS (<25)

Notes: The number of graduates in SY2014-15 is included in the parenthesis (). Some subgroups of graduates are not reported (DS: data suppression) because the denominator is below the minimum n-size of 25 students.
As of 10/19/15, LEAs are still reconciling Economic Disadvantage, ELL and Special Education status of the students on their cohorts; these breakdowns will be released at a later time.

Race and Ethnicity

- Black and Latino students have a much lower graduation rate than White students (about 65% versus 85%).
- Compared to their graduation rate in DC Public Schools, Black students graduated at a much higher rate in Public Charter Schools (72.4% versus 61.7%).
- Graduation rates for Latino students was Latino students were about the same – about 66% – regardless of the type of school.

Age / Gender

- Female students have a higher graduation rate than male students (72.0% versus 58.9%).
- Compared to their graduation rate from DC Public Schools, female students graduated at a much higher rate from Public Charter Schools (79.5% versus 69.9%).

Substance Abuse

The use of mind- and behavior-altering substances continues to take a major toll on the health of individuals, families, and communities nationwide.

Substance abuse is a serious problem in DC with very evident disparities by ward, race, and gender.

HP 2020 RECOMMEND METRICS: SUBSTANCE ABUSE

Adolescents using alcohol or any illicit drugs during the past 30 days

Adults engaging in binge drinking during the past 30 days

Table 11: Substance Abuse, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward							
		1	2	3	4	5	6	7	8
Adults who are binge drinkers, 2013 (%)	22.4	25.5	25.1	18.5	14.7	15.8	18.9	14.2	16.2
Adults who are heavy drinkers, 2013 (%)	6.4	7.0	5.5	11.2	NA	NA	NA	NA	NA
Youth binge drinking in past 30 Days, 2013 (%)	12.3	data not available							
Youth currently using marijuana, 2013 (%)	32.2	data not available							

Summary

Ward

- Adult binge drinking varies by ward with highest prevalence in Wards 1 and 2 (about 25%) compared to about 14% in Wards 4 and 7.

Race

- Binge drinking is twice as prevalent among White versus Black DC adults (32.2% versus 14.5%).
- Heavy drinking is also much more prevalent in White DC residents: 11.7% self-reported being heavy drinkers compared to 2.6% of Black residents.

Age / Gender

- While about 6-7% of males and females report being heavy drinkers; binge drinking is more prevalent in males (28.2% versus 17.1%).

Sources: DC Department of Health BRFSS and YRBS.

Tobacco

Tobacco use is the single most preventable cause of disease, disability, and death in the U.S., yet more deaths are caused each year by tobacco use than by all deaths from HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides and murders combined.

Smoking remains common in DC with about 20% of adults being current smokers.

HP 2020 RECOMMEND METRICS: TOBACCO

Adults who are current cigarette smokers

Adolescents who smoked cigarettes in the past 30 days

Table 12: Tobacco Usage, by Ward

Leading Health Indicator or Proxy Indicator	Citywide (DC)	Ward 1	2	3	4	5	6	7	8
Adults who were current smokers, 2013 (%)	18.8	15.5	8.6	9.3	14.4	20.4	17.3	24.1	41.0
Smoked Before Age 13 Yrs, 2013 (%)	9.7	data not available							

Summary

Ward

- Smoking is, by far, most prevalent in Ward 8 with more than 40% of adults self-reporting as current smokers. Wards 2 and 3 have the lowest percentage of smokers (less than 10% each).

Race and Ethnicity

- The prevalence of smoking is about three times higher among Black DC residents compared to White residents (28.4% versus 9.9%). About 14.2% of Hispanic DC adults are current smokers.

Age and Gender

- A larger percentage of DC men smoke compared to women: 23.4% versus 14.7%.
- About 10% of DC youth began smoking before the age of 13 years.

Sources: DC Department of Health BRFSS and YRBSS.

Chronic Disease

Chronic diseases are responsible for seven of 10 deaths each year, and treating people with chronic diseases accounts for 86% of our nation's health care costs (CDC, 2015). Many chronic diseases are preventable. While Healthy People 2020 did not designate chronic disease as a leading health topic, we include some statistics on chronic disease in DC.

Table 13: Chronic Disease, by Ward

Selected Chronic Disease Indicators	Citywide (DC)	Ward 1	2	3	4	5	6	7	8
Adults who were diagnosed with arthritis, 2013 (%)	19.5	17.0	20.2	19.8	23.2	27.6	23.0	27.8	28.6
Adults who currently have asthma, 2013 (%)	11.9	9.9	12.5	7.2	9.5	10.7	12.3	14.2	20.6
Adults who were diagnosed with diabetes, 2013 (%)	7.8	6.6	4.8	3.1	8.4	10.9	6.5	14.5	16.0
Adults who were diagnosed with kidney disease, 2013 (%)	2.4	NA	NA	NA	NA	3.2	2.0	3.8	4.2
Adults who were diagnosed with depression, 2013 (%)	20.	22.4	18.7	23.7	15.4	16.4	23.2	18.4	28.0
Adults who were diagnosed with COPD, 2013 (%)	5.8	3.5	2.4	5.4	4.2	5.9	3.7	8.5	16.4
Adults who had a stroke, 2013 (%)	3.2	NA	NA	NA	4.5	3.7	NA	5.7	5.5
Adults who were diagnosed with heart disease, 2013 (%)	2.6	NA	NA	3.3	3.1	3.1	NA	3.2	4.5
Adults who had a heart attack, 2013 (%)	4.1	NA	NA	2.3	3.7	5.7	2.9	7.3	12.3
Youth ever told by doctor that they have Asthma, 2013 (%)	31.0	data not available							
Seniors with Diabetes, 2012 (%)	NA	13	20	13.8	11.7	14.7	12.9	14.9	16.5
Seniors with Arthritis, 2012 (%)	NA	26.1	24.4	27.7	25.6	23.1	26.1	25.3	22.9

Summary

Ward

- Nearly every chronic condition we studied was most common in Ward 8: arthritis, asthma, high cholesterol, hypertension, diabetes, depression, COPD, heart disease, and heart attack
- Asthma is much more common in Wards 7 and 8 than other areas of the city.
- Arthritis did not vary much by ward – about 25% of seniors in all wards were diagnosed with arthritis.
- The prevalence of heart attacks was much higher in Ward 8 than other wards: 4-5 times higher as compared to the percent in Wards 3 and 6 (greater than 12% versus under 3%).
- The rate of most chronic conditions is relatively low in Ward 1, with the exception of depression: greater than 20% of adults have been diagnosed with depression in this ward.

Race and Ethnicity

- Black and Latino DC residents tend to have the highest rates of chronic conditions: arthritis, asthma, diabetes, kidney disease, COPD, stroke, heart disease, heart attack,
- Overall invasive cancer rates are 37% higher for Black residents compared to White residents.

Age and Gender

- As expected, chronic conditions are generally highest among the older DC residents and lowest among youth.
- Asthma is very common in DC with nearly a third (31%) of youth being told by a doctor or nurse that they have asthma.

Sources: DC Department of Health BRFSS, YRBSS, and Senior Needs Assessment.

CHAPTER 6:

HOSPITAL AND COMMUNITY HEALTH CENTER UTILIZATION

Hospital, emergency department and community health center (primary care) data offer important insights into health care utilization among DC residents. These sources also serve as proxy indicators of health care access and the efficacy of preventive and primary care services.

Chapter 6 presents hospital and community health center data that provides an overview of health care utilization for the DC population at DC facilities. We use data from two sources to describe access to care among adults and children: citywide hospital administrative data (including inpatient and emergency department visits) and primary care utilization statistics from federally qualified health centers (FQHCs).

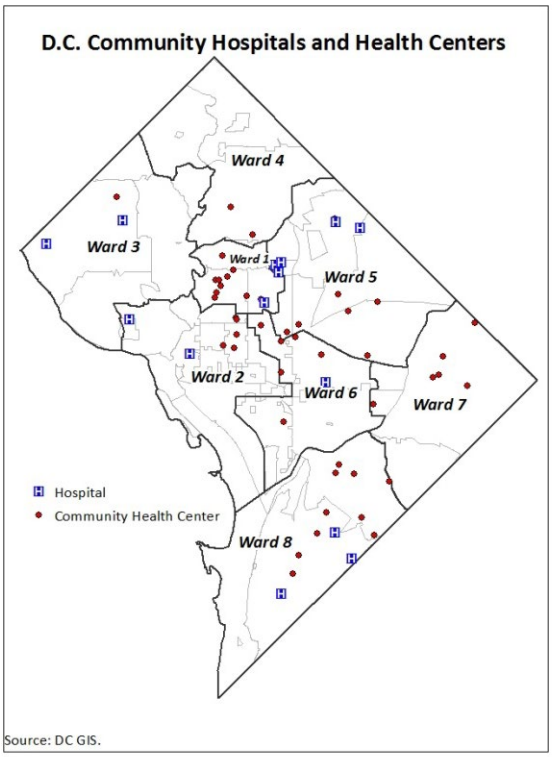
As discussed in Chapter 5, access to health insurance is high in DC among the adult and pediatric population. In this chapter, we look at exactly what hospital, emergency department and health center services are utilized. In addition, these data allow us to identify trends in hospitalization that are sensitive to the availability and efficacy of primary care. Finally, we provide summary data from FQHCs. The appendices contain detailed hospital and FQHC profiles that present utilization statistics for each facility by several dimensions, including age, race, ethnicity and ward.

HEALTH CARE FACILITIES IN CHNA

The health care utilization is depicted in this report for nine DC community hospitals and four FQHCs. While this needs assessment is largely focused on DC residents, it is noteworthy that about a third of all hospital-based care at DC hospitals is delivered to Maryland residents and ten percent to Virginia residents. The hospital data below are limited to DC residents; however, the appendices provide data for total hospital utilization regardless of patient state of residence, as well as separate tables that are limited to health care utilization by DC residents. For the FQHC information, we include patient utilization data for all patients regardless of patient state of residence because that is what FQHC's report to the Health Resources Services Administration in the Uniform Data System.

COMMUNITY HOSPITALS are defined as non-federal, short-term general, and other special hospitals. Other special hospitals include obstetrics and gynecology; eye, ear, nose, and throat; rehabilitation; orthopedic; and other individually described specialty services.

FEDERALLY-QUALIFIED HEALTH CENTERS are health centers that receive grants under Section 330 of the Public Health Service Act. They must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.



HOSPITAL-BASED CARE

Inpatient Hospital Discharges

We analyzed 2010–2014 hospital discharge data to understand the landscape of hospital care in DC. Classification of condition is based on primary diagnosis code using Agency for Healthcare Research and Quality (AHRQ) Classifications Software (CCS) for ICD-9-CM.[6]

DC residents had about 74,000 hospital discharges in 2014. The overall number of hospitalizations remained fairly stable with only a 3% decrease from 2010 to 2014, while the rate of hospital stays decreased given the growth in the DC population. Tables 15 and 16 provide the number and rates of inpatient discharges over time. For the rates, the numerator is the number of discharges among DC residents and the denominator is the DC population. Notable highlights regarding trends in hospital utilization over time, as well as a more detailed look at 2014 hospital data, are provided later in this chapter and additional information can be found in Appendix 10.

6 http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp

Table 14: Inpatient Discharges Among DC Residents

UTILIZATION BY DEMOGRAPHICS, 2010-2014

	2010	2011	2012	2013	2014
Total Discharges	76,132	76,951	77,143	75,074	73,763
GENDER (% OF TOTAL)					
Female	58%	58%	58%	57%	58%
Male	42%	42%	42%	43%	42%
AGE GROUP (% OF TOTAL)					
00-17	17%	17%	17%	16%	16%
18-64	58%	59%	58%	59%	59%
65+	25%	24%	25%	25%	25%
RACE (% OF TOTAL)					
Asian	1%	1%	1%	1%	1%
Black	73%	72%	71%	72%	71%
White	15%	15%	16%	16%	15%
Other/Unknown	10%	11%	12%	12%	13%
ETHNICITY (% OF TOTAL)					
Hispanic	6%	4%	5%	10%	
Non-Hispanic	92%	91%	91%	84%	N/A
Unknown	2%	4%	4%	6%	
Insurance (% of Total)					
Commercial	30%	31%	30%	31%	32%
Medicaid	36%	35%	36%	35%	35%
Medicare	30%	30%	31%	31%	31%
Other/Unknown	4%	4%	4%	3%	2%
DC WARD (% OF TOTAL)					
Ward 1	11%	11%	11%	10%	10%
Ward 2	8%	8%	8%	8%	7%
Ward 3	6%	6%	6%	6%	6%
Ward 4	13%	13%	13%	13%	13%
Ward 5	15%	15%	15%	15%	15%
Ward 6	13%	13%	13%	13%	12%
Ward 7	17%	17%	17%	17%	18%
Ward 8	17%	17%	17%	18%	18%
HOSPITAL (% OF TOTAL)					
Children's National Health System	5%	5%	5%	5%	5%
George Washington University Hospital	14%	16%	16%	18%	18%
MedStar Georgetown Univ Hospital	6%	6%	7%	7%	8%
Howard University Hospital	14%	14%	12%	11%	11%
MedStar National Rehab Hospital	1%	1%	1%	1%	1%
Providence Hospital	14%	13%	13%	12%	12%
Sibley Memorial Hospital	9%	8%	8%	8%	8%
United Medical Center	6%	6%	7%	7%	8%
MedStar Washington Hospital Center	30%	29%	31%	31%	29%

Source: DC Hospital Association.

Table 15: Inpatient Hospital Discharges Among DC Residents per 1,000 Population, 2010-2014

	2010	2011	2012	2013	2014
Inpatient Discharges per 1,000 DC population	**127**	**124**	**121**	**116**	**112**
RACE & ETHNICITY					
Inpatient Discharges per 1,000 White DC residents	49	48	49	44	43
Inpatient Discharges per 1,000 Black DC residents	183	180	175	170	163
Inpatient Discharges per 1,000 Hispanic/Latino DC residents	80	56	66	111	NA
AGE GROUP					
Inpatient Discharges per 1,000 DC children (less than 18 years)	125	125	120	109	104
Inpatient Discharges per 1,000 DC adults (18-64 years)	102	101	99	95	93
Inpatient Discharges per 1,000 DC older residents (65+ years)	281	269	269	255	242
GENDER					
Inpatient Discharges per 1,000 Female Residents	139	136	133	126	123
Inpatient Discharges per 1,000 Male Residents	113	111	108	104	100
WARD					
Inpatient Discharges per 1,000 Ward 1 Residents	112	111	112	98	93
Inpatient Discharges per 1,000 Ward 2 Residents	72	78	78	69	64
Inpatient Discharges per 1,000 Ward 3 Residents	62	60	60	57	54
Inpatient Discharges per 1,000 Ward 4 Residents	131	131	135	123	116
Inpatient Discharges per 1,000 Ward 5 Residents	157	154	153	144	139
Inpatient Discharges per 1,000 Ward 6 Residents	132	127	126	116	109
Inpatient Discharges per 1,000 Ward 7 Residents	177	192	189	176	171
Inpatient Discharges per 1,000 Ward 8 Residents	180	174	177	180	178

Source: DC Hospital Association

Table 16: Top 5 Reasons for Discharge, 2014
(represent 23% of total discharges)

RANK	CONDITION
1	Liveborn
2	Mood disorders
3	Congestive heart failure; nonhypertensive
4	Schizophrenia and other psychotic disorders
5	Septicemia (except in labor)

Source: DC Hospital Association.

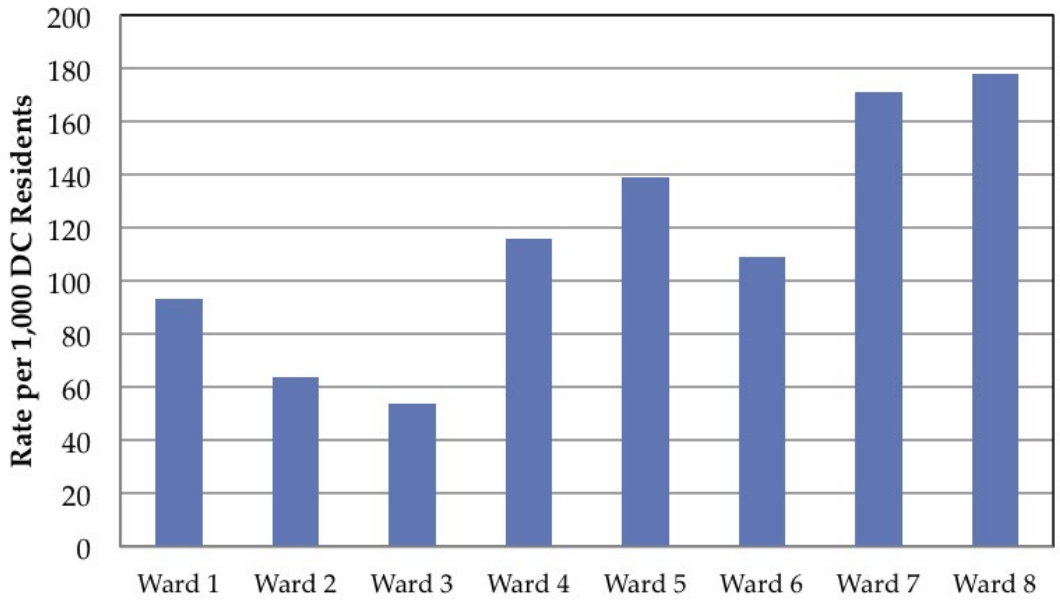
General Inpatient Hospital Utilization Trends

From 2010 to 2014, the following overall trends are present:

- The rate of hospital utilization among DC residents has decreased by 12%, from 127 to 112 hospital discharges per 1,000 DC residents.
- The average length of stay remained about the same from 2010-2-14: 5.4 days in 2010 to 5.5 days in 2014.
- Females continue to account for a higher percent of discharges than males: 58% versus 42%.
- The rate of hospital stays for Black and White residents each decreased by more than 10%. Black patients continue to account for about three-quarters of all discharges.
- Public insurance (Medicaid – including Children's Health Insurance Plan and Alliance - and Medicare) continue to account for two-thirds of all discharges.
- The most common reasons for hospital stays have remained relatively stable: Live born account for 10% of all discharges followed by mood disorders, congestive heart failure, schizophrenia, and septicemia.

Highlighted Findings: Inpatient Hospital Utilization by Ward, Race & Ethnicity, Age, and Gender

Figure 10: Inpatient Discharge Rate



Source: DC Hospital Association.

Ward

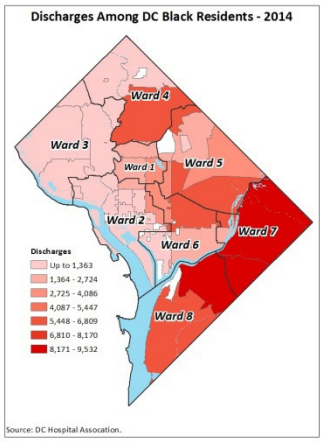
- Hospital utilization varied greatly by ward, with residents in Ward 3 accounting for the least hospital discharges (about 6% of all discharges) and residents in Wards 7 and 8 accounting for the most discharges (each about 18% of all discharges).

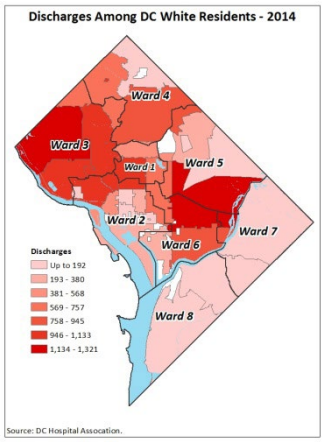
- The hospitalization rate in Ward 8 was more than 3 times higher than in Ward 3 (178 hospital discharges per 1,000 Ward 8 residents compared to 54 discharges per 1,000 Ward 3 residents). The proportion of hospital stays across racial groups has remained steady with Black residents accounting for about 70% of all hospital stays, while White residents account for 15% of all hospital stays.

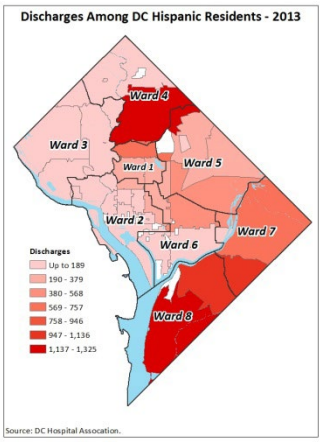
- The hospitalization rate for Black residents is almost four times higher than White residents while the hospitalization rate for Hispanic residents is about twice as high as for White residents.

- The proportion of hospital stays for Hispanic residents has increased over time (from 6% to 10%) which mimics the population growth of Hispanic individuals living in DC. Note: Ethnicity is unavailable in 2014 data due to a change in the data submission form; thus we provide 2013 ethnicity information.

Race & Ethnicity





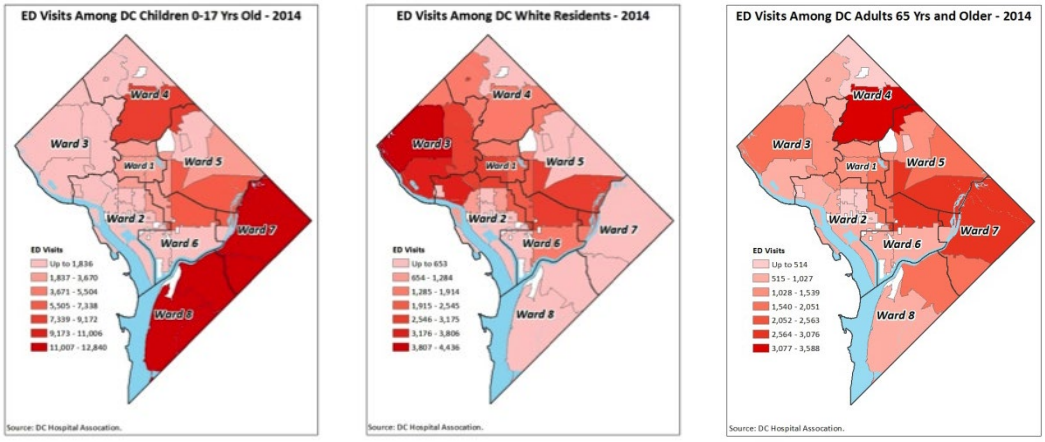


- The proportion of hospital stays across racial groups has remained steady with Black residents accounting for about 70% of all hospital stays, while White residents account for 15% of all hospital stays.

- The hospitalization rate for Black residents is almost four times higher than White residents while the hospitalization rate for Hispanic residents is about twice as high as for White residents.

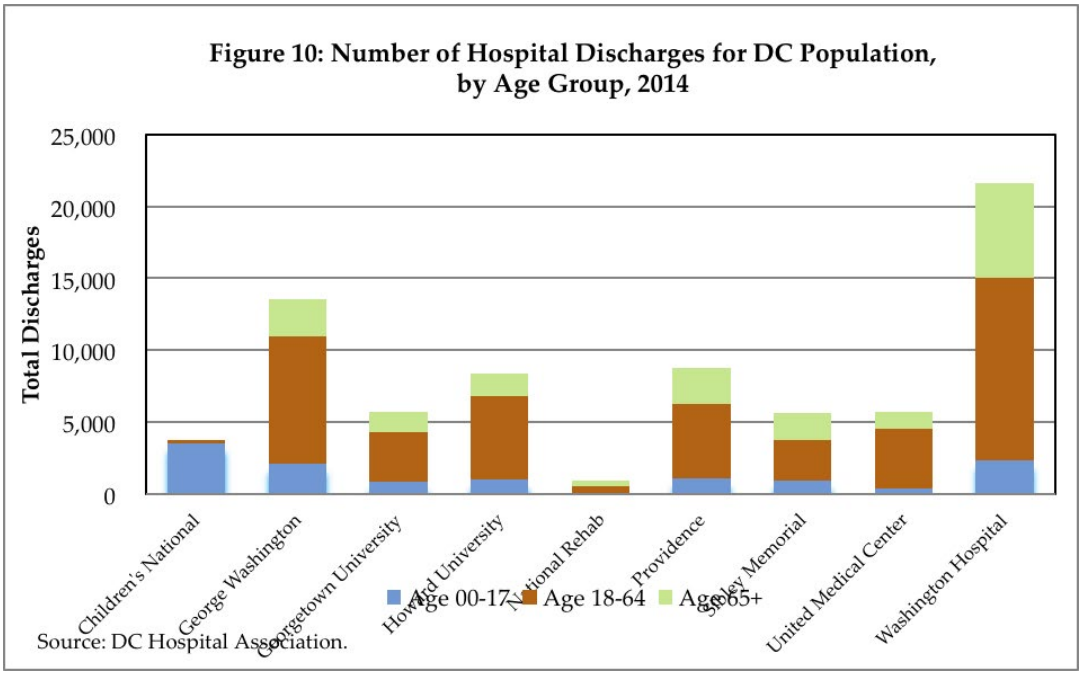
- The proportion of hospital stays for Hispanic residents has increased over time (from 6% to 10%) which mimics the population growth of Hispanic individuals living in DC. Note: Ethnicity is unavailable in 2014 data due to a change in the data submission form; thus we provide 2013 ethnicity information.

Age & Gender



- Rates of hospital utilization varied by age group: older DC residents (65+ years) have the highest discharge rate (242 discharges per 1,000), more than double children (104 discharges per 1,000) which was the second highest group.
- The rate of hospital discharges continues to be higher for women than men (123 discharges per 1,000 versus 100 discharges per 1,000).

Highlighted Findings: Inpatient Hospital Utilization, by Hospital



- The volume of inpatient discharges differs by hospital, with Washington Hospital Center accounting for approximately 30% of all discharges.

- Children's National experiences the greatest number of discharges in the 0–17 age group while Washington Hospital Center reports the most number of discharges in the adult population between 18 and 64 years old as well as older adults (65+ years).

Highlighted Findings: Inpatient Hospital Utilization, by Condition

The five most common reasons for hospital discharges varied by hospital. More detailed information by specific hospital can be found in Appendix 10. Live borns are the most common reason for hospital discharges across the majority of DC hospitals.

Table 17: Top 5 Reasons for Discharge by Hospital, 2014

RANK	CHILDREN'S NATIONAL	GEORGE WASHINGTON	GEORGETOWN UNIVERSITY	HOWARD UNIVERSITY	NATIONAL REHAB	PROVIDENCE	SIBLEY MEMORIAL	UNITED MEDICAL CENTER	WASHINGTON HOSPITAL
1	Mood disorders	Liveborn	Liveborn	Liveborn	Rehabilitation care; fitting of prostheses	Liveborn	Liveborn	Schizophrenia and other psychotic disorders	Liveborn
2	Asthma	OB-related trauma to perineum and vulva	Complication of device; implant or graft	Septicemia (except in labor)	Acute cerebrovascular disease	Schizophrenia and other psychotic disorders	Osteoarthritis	Mood disorders	Congestive heart failure; non-hypertensive
3	Epilepsy; convulsions	Mood disorders	Spondylosis; intervertebral disc disorders	Mood disorders	E Codes: Unspecified	Mood disorders	Other complications of birth	Liveborn	Acute myocardial infarction
4	Pneumonia (except that caused by TB or STI)	Other complications of birth	Osteoarthritis	Diabetes mellitus with complications	Intracranial injury	Septicemia (except in labor)	OB-related trauma to perineum and vulva	Congestive heart failure; non-hypertensive	Complication of device; implant or graft
5	Sickle cell anemia	Prolonged pregnancy	Complications of surgical procedures or medical	Sickle cell anemia		Congestive heart failure; non-hypertensive	Previous C-section	Asthma	Coronary atherosclerosis and other heart disease

Source: DC Hospital Association

The top reasons for hospital discharges also varied across age groups. More detailed information by specific age group can be found in Appendix 10. Asthma is a most common reason for hospital stays among children. Congestive heart failure is the most common reason for hospital stays among older adults (65+ years). Excluding live borns, asthma is the top reason for hospital stays in children 0-17 years accounting for 10% of all discharges.

Table 18: Top 5 Reasons for Discharge by Age Group, 2014

RANK	AGE 0-17	AGE 18-44	AGE 45-64	AGE 65+
1	Liveborn	Other complications of birth	Schizophrenia and other psychotic disorders	Congestive heart failure; nonhypertensive
2	Asthma	Mood disorders	Mood disorders	Septicemia (except in labor)
3	Mood disorders	OB-related trauma to perineum and vulva	Congestive heart failure; nonhypertensive	Acute cerebrovascular disease
4	Acute bronchitis	Prolonged pregnancy	Diabetes mellitus with complications	Acute and unspecified renal failure
5	Pneumonia (except that caused by TB or STI)	Other complications of pregnancy	Pneumonia (except that caused by TB or STI)	Pneumonia (except that caused by TB or STI)

Source: DC Hospital Association.

The most common reasons for hospital discharges varied by ward; however, live borns were the most common reason across all wards. More detailed information by ward can be found in Appendix 10.

Table 19: Top 5 Reasons for Discharge by Ward, 2014

RANK	WARD 1	WARD 2	WARD 3	WARD 4	WARD 5	WARD 6	WARD 7	WARD 8
1	Liveborn	Liveborn	Liveborn	Liveborn	Liveborn	Liveborn	Liveborn	Liveborn
2	Mood disorders	Mood disorders	Osteoarthritis	Congestive heart failure; non-hypertensive	Mood disorders	Mood disorders	Congestive heart failure; non-hypertensive	Mood disorders
3	Schizophrenia and other psychotic disorders	Other complications of birth	Mood disorders	Mood disorders	Congestive heart failure; non-hypertensive	Schizophrenia and other psychotic disorders	Mood disorders	Schizophrenia and other psychotic disorders
4	Other complications of birth	Schizophrenia and other psychotic disorders	Other complications of birth	Other complications of birth	Schizophrenia and other psychotic disorders	Congestive heart failure; non-hypertensive	Schizophrenia and other psychotic disorders	Congestive heart failure; non-hypertensive
5	OB-related trauma to perineum and vulva	OB-related trauma to perineum and vulva	Pneumonia (except that caused by TB or STI)	Schizophrenia and other psychotic disorders	Septicemia (except in labor)	Other complications of birth	Septicemia (except in labor)	Diabetes mellitus with complications

Source: DC Hospital Association.

The most common reasons for hospital discharges also varied by race and ethnicity. More detailed information by specific race and ethnicity can be found in Appendix 10. Ethnicity data in 2014 is unavailable and therefore we used 2013 data to compute top reasons for hospital stays in the Hispanic population.

Table 20: Top 5 Reasons for Discharge by Race and Ethnicity, 2014

RANK	BLACK	WHITE	HISPANIC (2013 DATA)
1	Liveborn	Liveborn	Liveborn
2	Mood disorders	OB-related trauma to perineum and vulva	Schizophrenia and other psychotic disorders
3	Congestive heart failure; nonhypertensive	Other complications of birth; puerperium affecting	Mood disorders
4	Schizophrenia and other psychotic disorders	Mood disorders	Congestive heart failure; nonhypertensive
5	Septicemia (except in labor)	Prolonged pregnancy	Septicemia (except in labor)

Source: DC Hospital Association.

Outpatient Emergency Department Visits

We analyzed 2010-2014 hospital outpatient or "treat-and-release" emergency department (ED) data to understand the landscape of ED use in DC. A large proportion of emergency department (ED) visits in the U.S. are for non-urgent conditions. Use of the ED for non-urgent conditions may lead to unnecessary testing and treatment, unnecessary cost, and weaker patient-primary care provider relationships.

DC residents had about 257,000 ED visits in 2014, an increase of 13% in ED utilization since 2010. Below we provide the number and rates of ED visits over time. For the rate, the numerator is the number of outpatient ED visits among DC residents and the denominator is the DC population. ED counts exclude visits from United Medical Center which was unavailable at the time this report was generated. Classification of condition is based on primary diagnosis code using CCS for ICD-9-CM.[7]

More detailed information can be found in Appendix 10.

7 http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp

Table 21: ED Visits Among DC Residents

UTILIZATION BY DEMOGRAPHICS, 2010-2014

	2010	2011	2012	2013	2014
Total ED Visits	228,023	252,204	255,406	248,051	257,113
GENDER (% OF TOTAL)					
Female	55%	55%	54%	54%	53%
Male	45%	45%	46%	46%	47%
AGE GROUP (% OF TOTAL)					
00-17	23%	27%	27%	27%	27%
18-64	67%	64%	64%	63%	63%
65+	10%	9%	9%	10%	10%
RACE (% OF TOTAL)					
Asian	1%	1%	1%	1%	1%
Black	75%	75%	76%	75%	75%
White	12%	12%	12%	12%	12%
Other/Unknown	12%	12%	12%	12%	12%
ETHNICITY (% OF TOTAL)					
Hispanic	7%	6%	7%	8%	
Non-Hispanic	91%	90%	91%	90%	N/A
Unknown	2%	4%	2%	2%	
INSURANCE (% OF TOTAL)					
Commercial	34%	32%	31%	30%	29%
Medicaid	45%	47%	49%	49%	50%
Medicare	12%	12%	12%	13%	14%
Other/Unknown	9%	9%	8%	8%	7%
DC WARD (% OF TOTAL)					
Ward 1	12%	12%	11%	11%	11%
Ward 2	8%	7%	7%	7%	7%
Ward 3	5%	5%	5%	5%	5%
Ward 4	14%	13%	13%	13%	13%
Ward 5	17%	16%	16%	16%	15%
Ward 6	14%	13%	13%	12%	12%
Ward 7	17%	17%	18%	18%	19%
Ward 8	14%	16%	17%	17%	17%
HOSPITAL (% OF TOTAL)					
Children's National	20%	24%	25%	25%	25%
George Washington Univ Hospital	16%	15%	15%	16%	17%
Georgetown Univ Hospital	7%	6%	6%	6%	6%
Howard University Hospital	16%	15%	14%	14%	14%
Providence Hospital	13%	12%	12%	12%	11%
Sibley Memorial Hospital	6%	6%	6%	7%	7%
Washington Hospital Center	22%	21%	21%	20%	20%

Source: DC Hospital Association.

Table 22: ED Visits Among DC Residents per 1,000 Population, 2010-2014

	2010	2011	2012	2013	2014
ED Visits per 1,000 DC population	**379**	**407**	**402**	**382**	**390**
RACE & ETHNICITY					
ED Visits per 1,000 White DC residents	118	121	120	112	114
ED Visits per 1,000 Black DC residents	564	613	617	593	602
ED Visits per 1,000 Hispanic/Latino DC residents	291	247	268	302	N/A
AGE GROUP					
ED Visits per 1,000 DC children (less than 18 years)	515	648	645	602	597
ED Visits per 1,000 DC adults (18-64 years)	355	361	357	338	344
ED Visits per 1,000 DC older residents (65+ years)	328	335	328	325	360
GENDER					
ED Visits per 1,000 Female Residents	395	421	416	390	395
ED Visits per 1,000 Male Residents	362	390	387	373	385
WARD					
ED Visits per 1,000 Ward 1 Residents	366	396	379	338	336
ED Visits per 1,000 Ward 2 Residents	220	250	251	225	225
ED Visits per 1,000 Ward 3 Residents	157	165	168	163	166
ED Visits per 1,000 Ward 4 Residents	409	435	440	407	404
ED Visits per 1,000 Ward 5 Residents	511	536	536	504	507
ED Visits per 1,000 Ward 6 Residents	402	406	406	374	375
ED Visits per 1,000 Ward 7 Residents	551	648	665	607	632
ED Visits per 1,000 Ward 8 Residents	447	535	568	565	579

Source: DC Hospital Association.

Table 23: Top 5 Reasons for Discharge, 2014 (represent 23% of total visits)

RANK	CONDITION
1	Other upper respiratory infections
2	Superficial injury; contusion
3	Abdominal pain
4	Sprains and strains
5	Other injuries and conditions due to external cause

Source: DC Hospital Association.

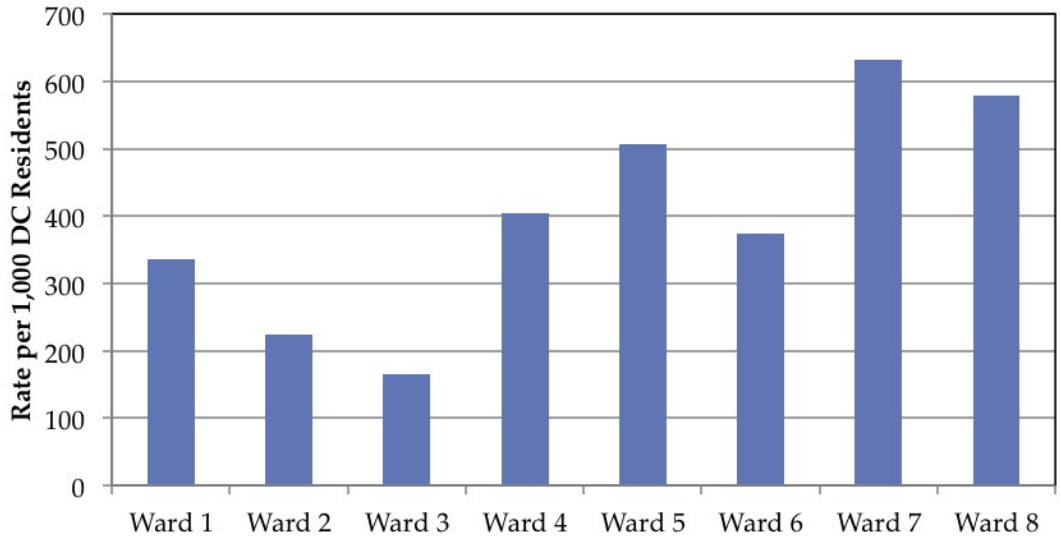
General Emergency Department Utilization Trends

From 2010 to 2014, the following overall trends are present:

- ED utilization among DC residents increased by 13% between 2010 and 2014.
- Women continue to account for slightly more than half (53%) of all ED visits.
- The rate of ED visits for Black DC residents increased by about 7% whereas the rate decreased slightly among White residents. Black patients continue to account for three-quarters of all ED visits.
- The rate of ED visits increased for children (16%) and older adults (10%); whereas the rate decreased among adults ages 18-64 years (-3%).
- Medicaid was the primary insurer for half of all ED visits in 2014 compared to 45% in 2010.
- The top five reasons for ED visits (other upper respiratory infections, superficial injury/contusion, abdominal pain, sprains and strains, and other injuries and conditions) continue to account for about 20% of all ED visits.

Highlighted Findings: Emergency Department Utilization, by Ward, Race & Ethnicity, Age, and Gender

Figure 7: ED Visit Rate, 2014



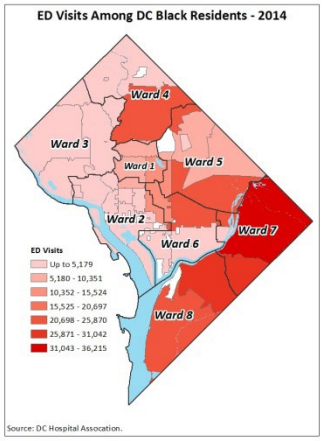
Source: DC Hospital Association.

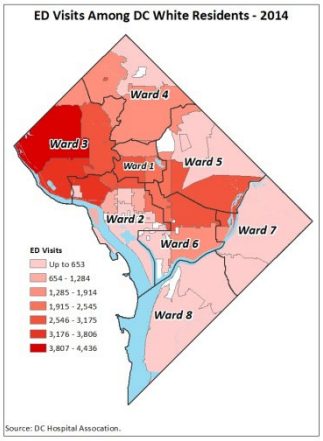
Ward

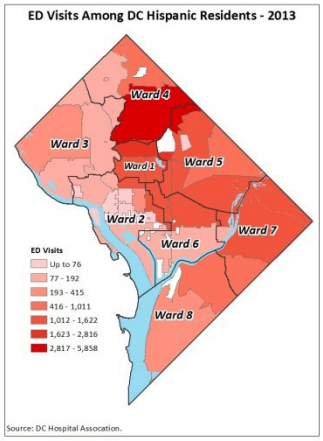
- ED utilization varied greatly by ward, with residents in Ward 3 accounting for the least ED visits (about 5% of all visits) and residents in Wards 7 and 8 combined accounting for the most visits (about 36% of all visits).

- The ED utilization rate in Ward 7 was more than three times higher than in Ward 3 (632 ED visits per 1,000 Ward 7 residents compared to 166 ED visits per 1,000 Ward 3 residents).

Race & Ethnicity





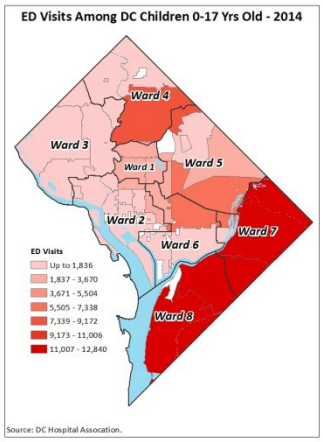


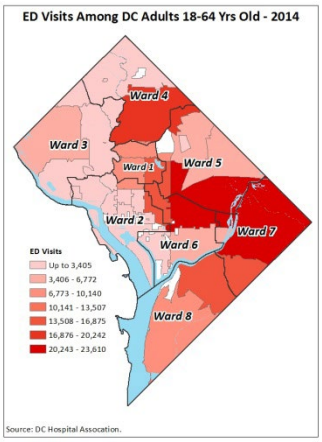
The proportion of ED visits across racial groups has remained steady with Black residents accounting for about 75% of all ED visits, while White residents account for 12% of all ED visits. Hispanic residents account for about 8% of all ED visits.

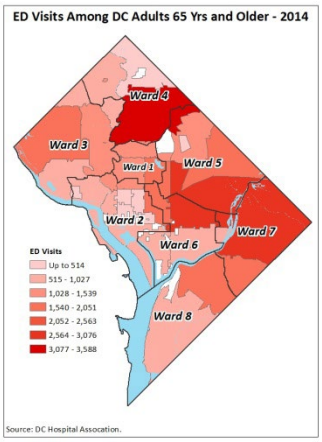
- ED visit rate for Black residents is more than five times higher than White residents while the rate for Hispanic residents is about 2.5 times higher than White residents.

- ED utilization has remained steady for Hispanic residents accounting for about 8% of all ED visits in 2013.

Age/Gender

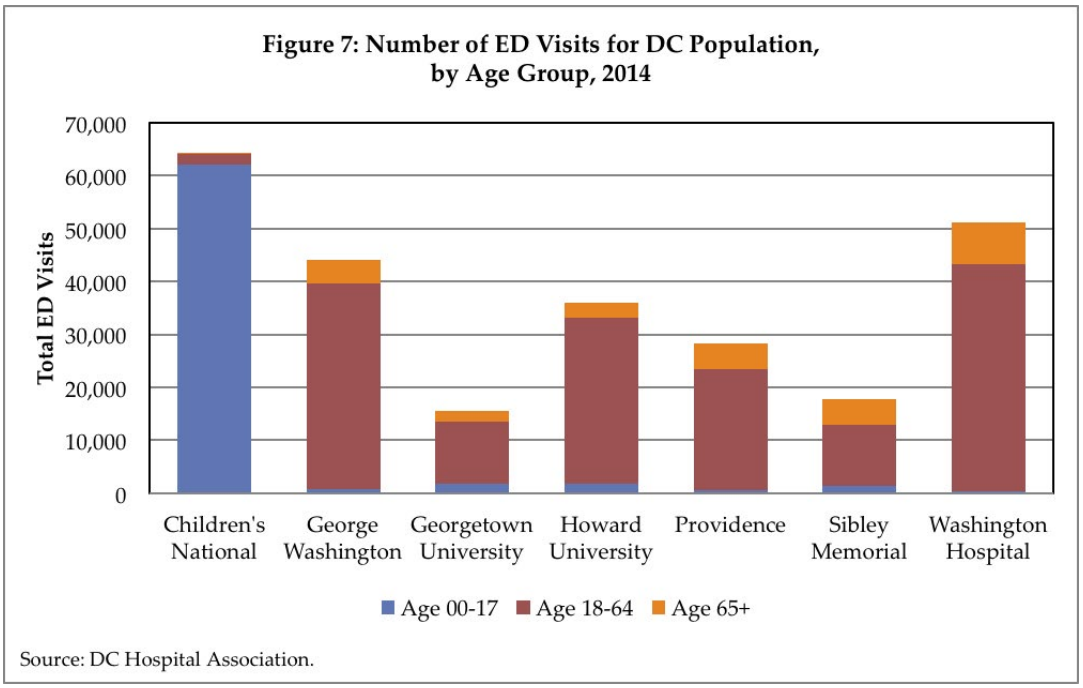






- Rates of ED visit varied by age group: children have the highest ED visit rate (597 visits per 1,000) followed by older DC residents, 65+ years (360 visits per 1,000).
- Women have slightly higher ED visit rate compared to men, 395 visits per 1,000 vs. 385 visits per 1,000.

Highlighted Findings: Emergency Department Utilization by Hospital



- Children's National Health System had the most number of ED visits, accounting for about 25% of all ED visits. Washington Hospital Center had the second highest number of ED visits, accounting for about 20% of all ED visits.

- As expected, Children's National experienced the largest number of ED visits in the 0-17 age group while Washington Hospital Center reported the most number of ED visits in the older adult (65+ years) population.

Highlighted Findings: Emergency Department Utilization by Condition

Top five reasons for ED visits varied by hospital. More detailed information by specific ho spital can be found in Appendix 10.

Table 24: Top 5 Reasons for ED Visit by Hospital, 2014

RANK	CHILDREN'S NATIONAL	GEORGE WASHINGTON	GEORGETOWN UNIVERSITY	HOWARD UNIVERSITY	PROVIDENCE	SIBLEY MEMORIAL	WASHINGTON HOSPITAL
1	Other upper respiratory infections	Abdominal pain	Alcohol-related disorders	Superficial injury; contusion	Sprains and strains	Alcohol-related disorders	Abdominal pain
2	Asthma	Nonspecific chest pain	Other injuries and conditions due to external cause	Sprains and strains	Superficial injury; contusion	Superficial injury; contusion	Nonspecific chest pain
3	Superficial injury; contusion	Sprains and strains	Abdominal pain	Other connective tissue disease	Other upper respiratory infections	Sprains and strains	Other injuries and conditions due to external cause
4	Fever of unknown origin	Superficial injury; contusion	Superficial injury; contusion	Alcohol-related disorders	Abdominal pain	Abdominal pain	Spondylosis; intervertebral disc disorders
5	Otitis media and related conditions	Spondylosis; intervertebral disc disorders; other	Sprains and strains	Other upper respiratory infections	Spondylosis; intervertebral disc disorders	Spondylosis; intervertebral disc disorders	Superficial injury; contusion

Source: DC Hospital Association.

- Other upper respiratory infections are the top reason for ED visits at Children's National followed by asthma.

- Alcohol-related disorders are the top reason for ED visits at Georgetown University Hospital and Sibley Memorial Hospital.

- Abdominal pain is the most common reason for ED visits at George Washington University Hospital and Washington Hospital Center.

Top five reasons for ED visits varied by age group. More detailed information by specific age group can be found in Appendix 10.

Table 25: Top 5 Reasons for ED Visit by Age Group, 2014

RANK	AGE 00-17	AGE 18-44	AGE 45-64	AGE 65+
1	Other upper respiratory infections	Abdominal pain	Alcohol-related disorders	Nonspecific chest pain
2	Superficial injury; contusion	Sprains and strains	Spondylosis; intervertebral disc disorders	Spondylosis; intervertebral disc disorders
3	Asthma	Superficial injury; contusion	Nonspecific chest pain	Superficial injury; contusion
4	Fever of unknown origin	Other upper respiratory infections	Abdominal pain	Other injuries and conditions due to external cause
5	Other injuries and conditions due to external cause	Nonspecific chest pain	Sprains and strains	Abdominal pain

Source: DC Hospital Association.

- Other upper respiratory infections are the top reason for ED visits in children.
- Alcohol-related disorders are the top reason for ED visits in adults ages 45 to 64.
- Nonspecific chest pain is the most the most common reason for older patients (65+ years) to visit the ED.
- Asthma is one of the top five reasons for ED visit reported only in children.

Top five reasons for ED visits varied by ward. More detailed information by specific ward can be found in Appendix 10.

Table 26: Top 5 Reasons for ED Visit by Ward, 2014

RANK	WARD 1	WARD 2	WARD 3	WARD 4	WARD 5	WARD 6	WARD 7	WARD 8
1	Other upper respiratory infections	Alcohol-related disorders	Superficial injury; contusion	Other upper respiratory infections	Other upper respiratory infections	Other upper respiratory infections	Other upper respiratory infections	Other upper respiratory infections
2	Abdominal pain	Superficial injury; contusion	Alcohol-related disorders	Superficial injury; contusion	Superficial injury; contusion	Superficial injury; contusion	Superficial injury; contusion	Superficial injury; contusion
3	Superficial injury; contusion	Abdominal pain	Other injuries and conditions due to external cause	Abdominal pain	Sprains and strains	Abdominal pain	Sprains and strains	Asthma
4	Alcohol-related disorders	Other upper respiratory infections	Open wounds of extremities	Sprains and strains	Abdominal pain	Sprains and strains	Abdominal pain	Sprains and strains
5	Other injuries and conditions due to external cause	Sprains and strains	Abdominal pain	Other injuries and conditions due to external cause	Nonspecific chest pain	Other injuries and conditions due to external cause	Asthma	Abdominal pain

Source: DC Hospital Association.

- Other upper respiratory infections are the top reason for ED visits in all Wards except for Wards 2 and 3.
- Alcohol-related disorders are the top reason for ED visits in Ward 2 while superficial injury/ contusion is the top reason for ED visits in Ward 3.
- Asthma is one of the top five reasons for ED visit reported only in Wards 7 and 8.

Top five reasons for ED visits varied by race and ethnicity. More detailed information by specific race and ethnicity can be found in Appendix 10. Ethnicity data in 2014 is unavailable and therefore we used 2013 data to compute top reasons for ED visit in the Hispanic population.

Table 27: Top 5 Reasons for ED Visit by Race and Ethnicity, 2014

RANK	BLACK	WHITE	HISPANIC (2013 DATA)
1	Other upper respiratory infections	Superficial injury; contusion	Other upper respiratory infections
2	Superficial injury; contusion	Other injuries and conditions due to external cause	Abdominal pain
3	Sprains and strains	Open wounds of extremities	Sprains and strains
4	Abdominal pain	Abdominal pain	Alcohol-related disorders
5	Asthma	Alcohol-related disorders	Superficial injury; contusion

Source: DC Hospital Association.

- Other upper respiratory infections are the top reason for ED visits among Black and Hispanic patients.
- Asthma is in the top five reasons for an ED visit for Black residents, but not for White or Hispanic residents.
- Alcohol-related disorders are in the top 5 reasons for an ED visit for White and Hispanic residents, but not for Black residents.

Potentially Preventable ED Visits

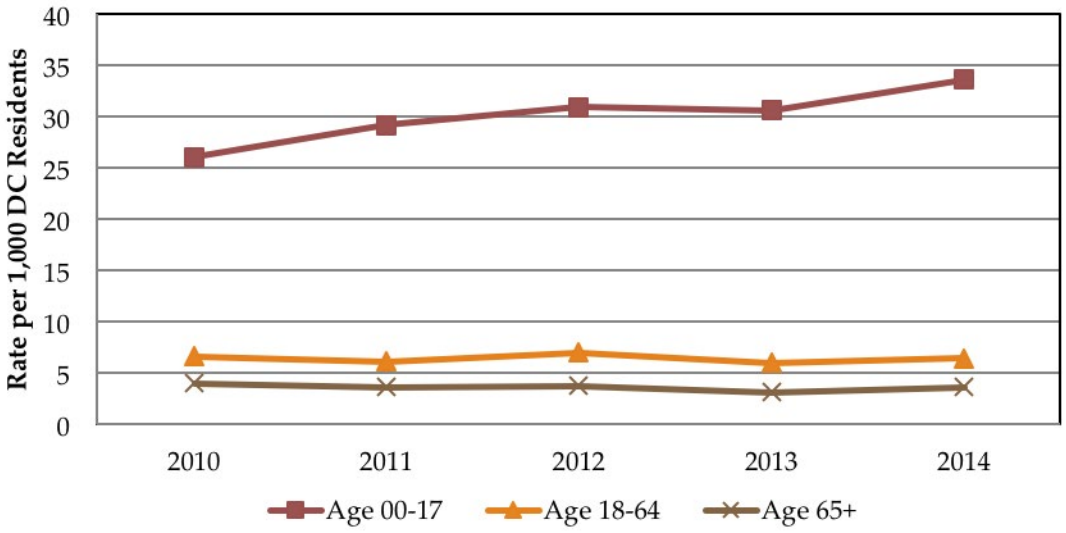
We use 2010 to 2014 emergency department data to identify potentially preventable ED visits, also known as ambulatory care sensitive (ACS) visits, which could be prevented if proper preventive and primary care services were available and accessed. Often these visits are used as a proxy for understanding the efficacy of primary and preventive health services. These data reveal communities in which the need for primary care health services may be high but availability low, or communities in which ED utilization is inappropriate for other reasons.

We estimate that 30% of all ED visits are considered ACS visits in DC. Using the AHRQ CCS codes, we classified the following as ACS conditions: other upper respiratory infections, abdominal pain, asthma, headache (including migraine), skin and subcutaneous tissue infections, urinary tract infections, allergic reactions, other gastrointestinal disorders, fever of unknown origin, otitis media and related conditions,

nausea and vomiting, acute bronchitis, other skin disorders, other upper respiratory disease, malaise and fatigue, diabetes mellitus without complication, and diabetes mellitus with complications.

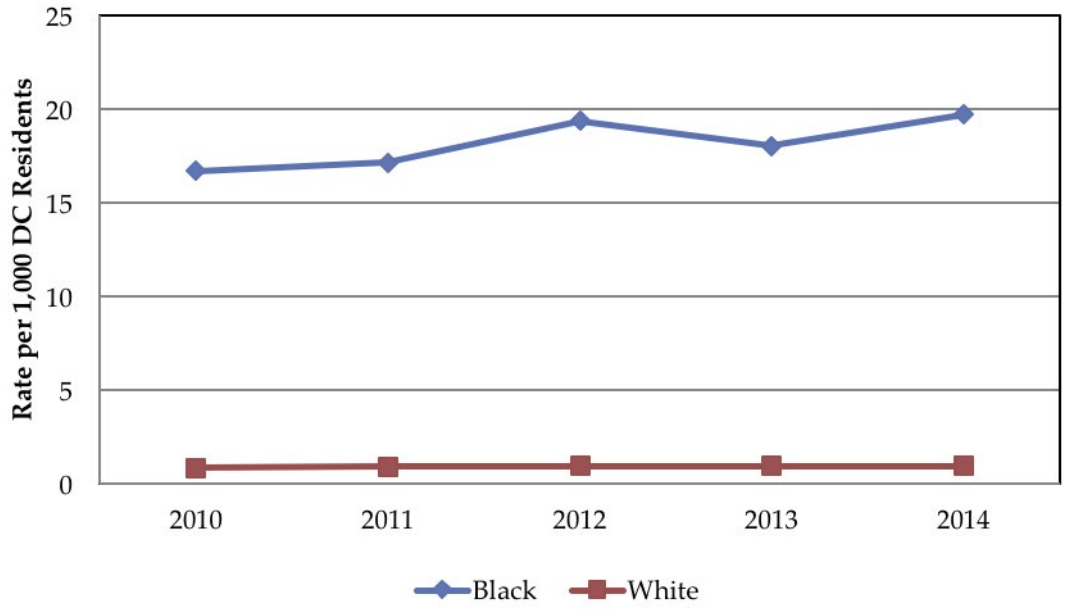
In this report we take a closer look at two well-established ACS conditions that are very prevalent in the DC population: asthma and diabetes.

Figure 9: ED Visit Rate for Asthma by Age, 2010-2014



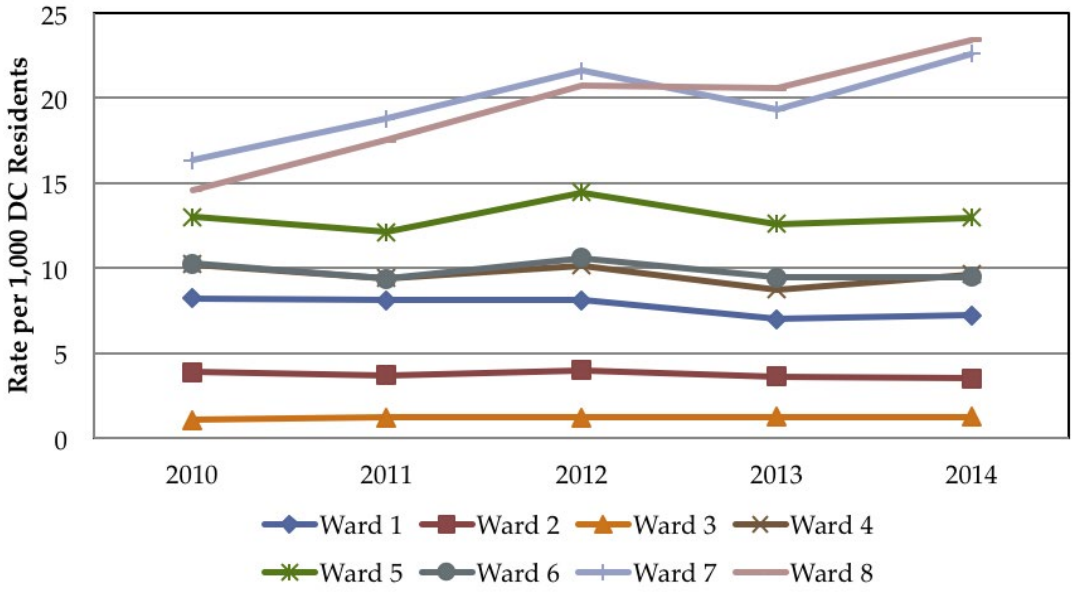
Source: DC Hospital Association.

Figure 10: ED Visit Rate for Asthma by Race, 2010-2014



Source: DC Hospital Association.

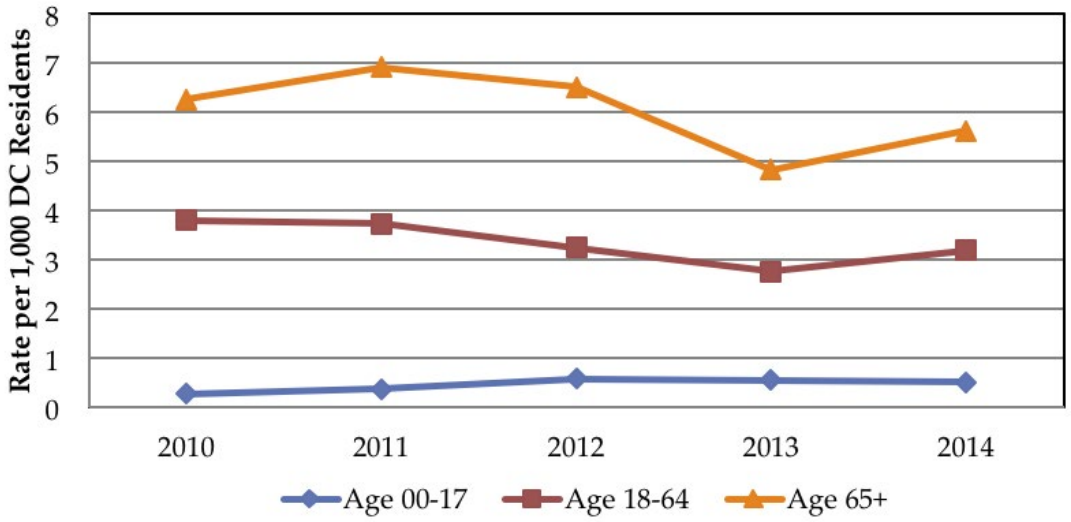
Figure 11: ED Visit Rate for Asthma by Ward, 2010-2014



Source: DC Hospital Association.

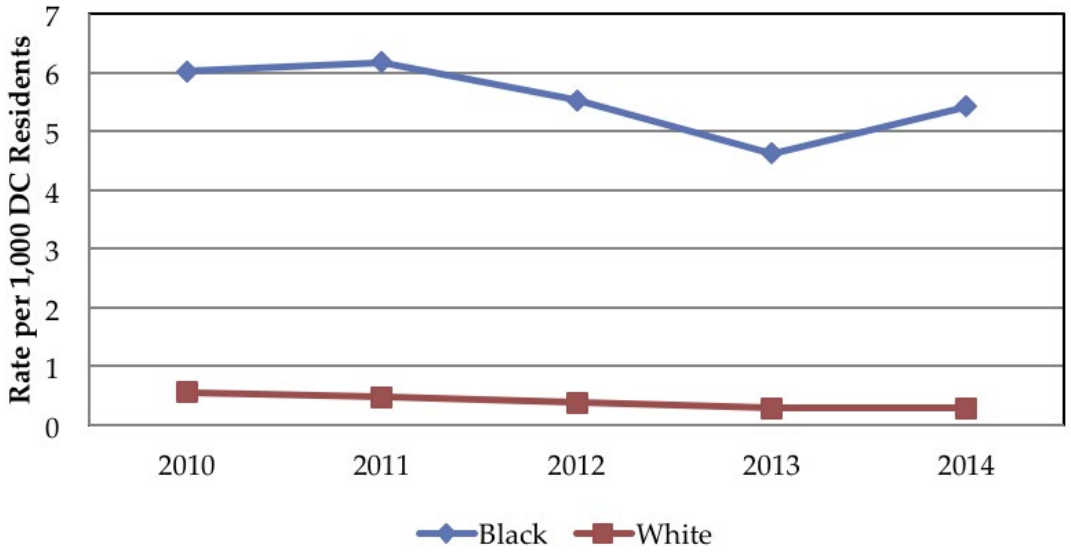
- The highest asthma ED visit rate is reported in children, with an increase of about 30% between 2010 and 2014.
- The asthma rate of ED visit for Black residents is 20 times higher than for White residents (20 visits per 1,000 compared to 1 visit per 1,000 residents).
- The asthma rate of ED visits in Wards 7 and 8 is 23 times higher than in Ward 3.

Figure 12: ED Visit Rate for Diabetes by Age, 2010-2014

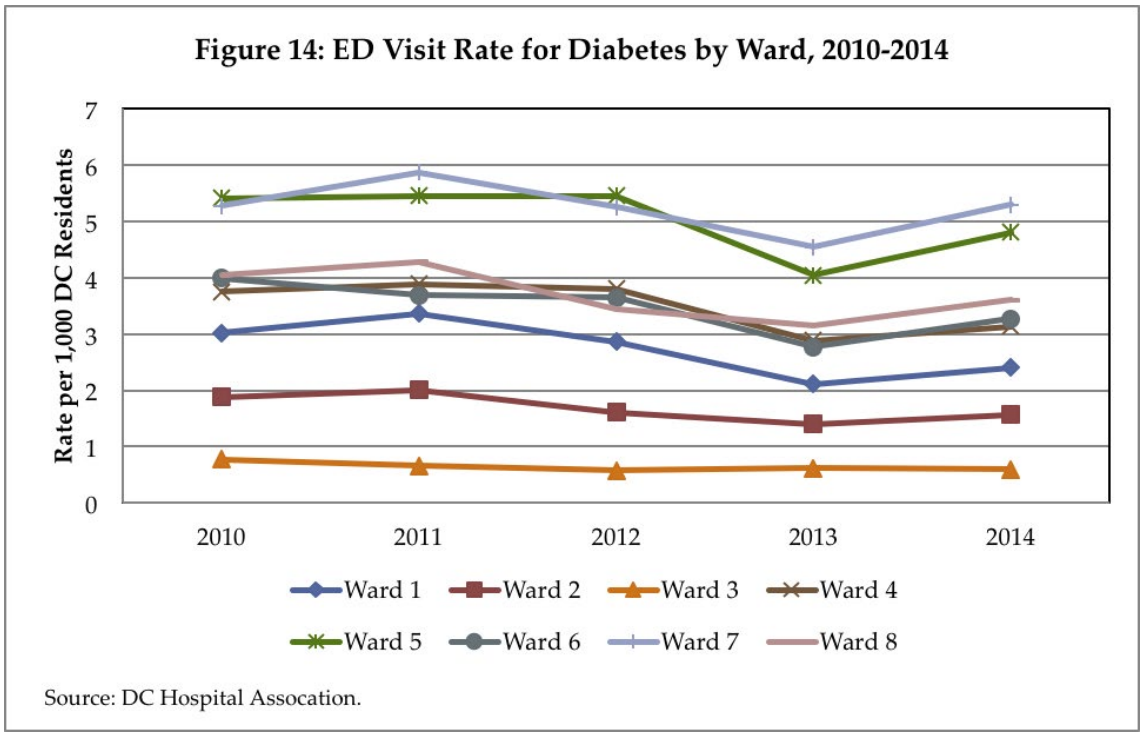


Source: DC Hospital Association.

Figure 13: ED Visit Rate for Diabetes by Race, 2010-2014



Source: DC Hospital Association.



- Older DC residents, 65+ years, have the highest diabetes ED visit rate with approximately 5 visits per 1,000 residents.
- The rate of ED visits for diabetes among Black residents is 5 times higher than White residents (about 5 visits per 1,000 compared to 1 visit per 1,000 residents).
- The rate of ED visits for diabetes in Wards 5 and 7 is 5 times higher than in Ward 3.

Repeat Users of Hospital-Based Care

Hospitalizations are costly. Patients may make multiple visits to the hospital for many reasons including the patient's complex health ailments, planned admissions, poor quality care, and missed opportunities for better coordinated care and communication.

Repeat ED visits by the same individual can be used as proxy to measure adequacy, efficiency, and convenience of the primary care network and/or identify groups of residents who need help navigating our complex health system. Repeat ED use is of particular concern as ED utilization has increased substantially across the country after passage and implementation of the ACA. Some policymakers thought that once people had health insurance, they'd stop using emergency rooms for basic health care; the opposite has occurred. Newly insured people, especially by Medicaid, are accessing emergency rooms for care. Note: Due to our data limitations, repeat ED users can only be calculated within a single hospital.

Table 28: Repeat Users Among DC Residents, 2014

HOSPITAL	% OF PATIENTS WITH MORE THAN 1 HOSPITAL STAYS	% OF PATIENTS WITH MORE THAN 1 ED VISITS
Children's National Health System	18%	40%
George Washington University Hospital	14%	25%
Georgetown University Hospital	17%	18%
Howard University Hospital	16%	26%
National Rehab Hospital	9%	N/A
Providence Hospital	15%	25%
Sibley Memorial Hospital	10%	20%
United Medical Center	19%	N/A
Washington Hospital Center	19%	26%

Source: DC Hospital Association

- United Medical Center and Washington Hospital Center have the highest percentage of patients with multiple hospital stays (19% each).
- Sibley has the lowest percentage of patients who have multiple hospital stays (10%).
- Children's National has the highest percentage (40%) of patients with more than one ED visit.
- Georgetown University Hospital had the lowest percentage (18%) of their patients with more than 1 ED visits.

Community Health Center Visits

We report 2014 FQHC data to understand the landscape of primary care utilization in DC. Data captured in the national Uniform Data System (UDS) from the following FQHCs are included in this analysis – Community of Hope, Family and Medical Counseling Services, La Clinica Del Pueblo, Mary's Center for Maternal & Child Care, Unity Health Care, and Whitman-Walker Clinic. Utilization data are inclusive of all patients regardless of patient state of residence because that is what is reported by health centers in UDS. More detailed information can be found in Appendix 11.

General Primary Care Utilization

Table 29: DC Health Center Profile

TOTAL PATIENTS SERVED BY DEMOGRAPHICS, 2012-2014

	PATIENTS SERVED			% OF TOTAL		
	2012	2013	2014	2012	2013	2014
Total	**141,877**	**150,671**	**164,383**	100%	100%	100%
AGE GROUP						
00-17	32,502	36,013	39,195	23%	24%	24%
18-64	103,271	107,740	117,046	73%	72%	71%
65+	6,105	6,918	8,142	4%	5%	5%
RACE & ETHNICITY						
Non-Hispanic White	5,186	6,143	8,941	4%	4%	5%
Racial and/or Ethnic Minority	137,540	145,593	156,926	97%	97%	95%
Hispanic/Latino Ethnicity	42,139	45,750	49,714	30%	30%	30%
Black/African American [1]	105,745	110,280	118,577	75%	73%	72%
Asian [1]	1,737	1,848	2,073	1%	1%	1%
INCOME STATUS						
Patients at or below 200% of poverty	135,135	142,597	154,246	95%	95%	94%
Patients at or below 100% of poverty	101,785	111,479	119,041	72%	74%	72%
INSURANCE						
Uninsured	19,185	26,909	30,204	14%	18%	18%
Medicaid/CHIP [2]	81,828	85,737	94,159	58%	57%	57%
Medicare	7,316	7,642	9,139	5%	5%	6%
Other Third Party	33,574	30,383	30,881	24%	20%	19%
SERVICES						
Medical	126,398	136,608	149,657	89%	91%	91%
Dental	24,805	27,529	31,277	17%	18%	19%
Mental Health	14,715	12,087	15,366	10%	8%	9%
Substance Abuse	1,144	1,104	1,012	1%	1%	1%
MEDICAL CONDITIONS						
Asthma	11,945	12,679	13,264	8%	8%	8%
HIV	10,493	9,040	12,673	7%	6%	8%
PRENATAL						
Prenatal Patients	5,973	6,092	5,989	4%	4%	4%
Prenatal patients who delivered	3,292	3,246	3,501	2%	2%	2%

Notes:

1. Includes Hispanic/Latino and Non-Hispanic/Latino.

2. Includes Medicaid, Medicaid CHIP, and Other Public Insurance CHIP.

Source: HRSA Health Center Program Grantee Profiles (Uniform Data System).

- FQHCs served about 164,000 patients in 2014, an increase of 16% from 2012.
- 44% of these patients are male and 56% female.
- About a quarter of patients served are children.
- About 95% of patients served are non-White. Almost three-quarters of patients served are Black/African American and 30% of patients served are Hispanic/Latino ethnicity. About 18% of patients served are uninsured.
- More than half of patients served have Medicaid/CHIP insurance.
- About 72% of patients served lived at or below 100% of federal poverty level.

Table 30: DC Health Center Profile

UTILIZATION BY SERVICE AND QUALITY OF CARE MEASURES, 2014

	COMMUNITY OF HOPE	FAMILY & MEDICAL COUNSELING SERVICE	LA CLINICA DEL PUEBLO	MARY'S CENTER	UNITY HEALTH CARE	WHITMAN-WALKER CLINIC
TOTAL						
Patients Served	9,054	2,178	3,402	34,116	108,595	7,038
Cost per Patient	$953	$3,191	$2,067	$759	$946	$3,841
MEDICAL CONDITIONS (% OF PATIENTS WITH MEDICAL CONDITIONS)						
Hypertension [1]	32%	32%	22%	11%	21%	19%
Diabetes [2]	12%	12%	14%	6%	13%	8%
Asthma	11%	11%	5%	6%	9%	7%
HIV	56%	56%	8%	0%	3%	46%
QUALITY OF CARE MEASURES - PREVENTIVE HEALTH SCREENING & SERVICES						
Cervical Cancer Screening	72%	94%	89%	69%	62%	59%
Adolescent Weight Screening and Follow Up	82%	0%	27%	81%	84%	0%
Adult Weight Screening and Follow Up	58%	18%	80%	73%	60%	51%
Adults Screened for Tobacco Use and Receiving Cessation Intervention	91%	63%	7%	75%	87%	62%
Colorectal Cancer Screening	34%	72%	63%	26%	19%	31%
Childhood Immunization	83%	0%	100%	91%	69%	0%
Depression Screening	20%	28%	56%	56%	0%	30%
QUALITY OF CARE MEASURES - CHRONIC DISEASE MANAGEMENT						
Asthma Treatment (Appropriate Treatment Plan)	76%	93%	91%	89%	92%	33%
Cholesterol Treatment (Lipid Therapy for Coronary Artery Disease Patients)	73%	58%	92%	95%	78%	73%
Heart Attack/Stroke Treatment (Aspirin Therapy for Ischemic Vascular Disease Patients)	90%	34%	85%	94%	81%	82%
Blood Pressure Control (Hypertensive Patients with Blood Pressure < 140/90)	63%	70%	67%	66%	64%	69%
Diabetes Control (diabetic patients with HbA1c <= 9%)	81%	83%	73%	70%	56%	71%
HIV Linkage to Care	89%	28%	100%	92%	83%	98%

Notes:

1. Hypertensive adults as a percent of estimated adult medical patients of ages 18-85.

2. Diabetic adults as a percent of estimated adult medical patients of ages 18-75.

Source: HRSA Health Center Program Grantee Profiles (Uniform Data System).

- HIV patients account for 8% of total patients served by FQHCs. Community of Hope and Whitman-Walker saw the largest proportions of HIV patients. Community of Hope served about 40% and Whitman-Walker served about 25% of HIV patients.

- About 8% of all patients served had asthma. Unity Health Care served the largest proportions of patients with asthma, accounting for 70% of all asthma patients served by FQHCs.

- Among the reporting FQHCs, Unity Health Care and Mary's Center served the largest percentage of patients, 66% and 21% respectively.

- Mary's Center reported the lowest average cost per patient ($759), while Whitman-Walker Clinic reported the highest cost per patient ($3,841).

- Both Community of Hope and Family & Medical Counseling Service reported that about third of their patients had hypertension.

CHAPTER 7:
BRINGING IT ALL TOGETHER

The DC Healthy Communities Collaborative elevated the community's voice in this community health needs assessment. Community stakeholders were key in identifying the most pressing health-related needs. We then looked broadly at quantitative citywide data to further our understanding of the needs.

HIGHLIGHTS OF QUALITATIVE COMMUNITY DATA

This community health needs assessment was designed to identify unmet community needs as defined by community stakeholders. These needs focus on the social determinants of health and well-being, rather than on individual clinical conditions. Our analysis of community perspectives revealed nine needs: care coordination, food insecurity, bringing health care to the community, supporting health literacy, mental health services, community violence and safety, cultural competence, encouraging healthy behaviors, and disseminating health information. While the DC Healthy Communities Collaborative recognizes the importance of all nine issues, we selected four priority needs using a structured prioritization process (described in Chapters 3 and 4):

- Mental Health
- Bring Care to the Community (Place-based care)
- Health Literacy
- Care Coordination

These selected community needs cut across nearly all clinical conditions and often contribute to health outcomes. The Collaborative commits to working jointly with our community partners to address the aforementioned needs in a community-engaged, measurable fashion that will move DC closer to the state of health equity that all DC residents deserve.

USING THE QUANTITATIVE DATA TO ADD FOCUS TO COMMUNITY NEEDS

As we move from the assessment phase to developing and implementing the community health improvement plan, the quantitative data enable us to make informed decisions about appropriate areas of focus. Ultimately, the quantitative data guide the Collaborative in deciding where, within each of the prioritized community needs, to invest our resources for the greatest impact by providing the data to answer such questions:

- What is the demographic composition of the city?
- Where do different populations, such as young children or older adults, live in DC?
- What areas of the city and subpopulations are disproportionately impacted by poverty and other determinants of health?
- Where and among whom are unhealthy behaviors – smoking, substance abuse, and inactivity – more prevalent?
- What are the rates of chronic conditions across the city and in different racial and ethnic groups?
- What top health conditions are the DC hospitals and community health centers treating?
- What community assets are available in different parts of the city?

Answers to these types of questions will help the Collaborative refine our approach to addressing the four community needs. Knowing where health inequities exist, understanding where chronic conditions are most prevalent, having information on healthcare utilization patterns, and pinpointing areas that lack important assets are the types of important insights that the quantitative data provide.

The Collaborative's next step is to lead the development and implementation of a response –the Community Health Improvement Plan (CHIP)– that addresses the four priority needs. Each Collaborative organization looks forward to sharing resources to issue a joint response to each community need. The Collaborative will not work in isolation. We will engage a broad array of DC stakeholders, including members of our CAB as well as those individuals and organizations who have participated in this assessment process. The improvement plan will be available to the public in November 2016.

An example of how the quantitative data can add dimension and focus to qualitative findings may be illustrative. For instance, in the case of addressing health literacy, the Collaborative will share resources across institutions (such as training materials or literacy experts) and issue a broad joint response (such as training on navigating the health insurance market, learning to read the appropriate dosage of a drug prescribed by a clinician, or understanding a food label). However, individual Collaborative organizations may choose a different population of focus based on what the quantitative data elucidate. Perhaps Hospital A, for example, may decide to focus health literacy efforts on parents of children with asthma given the recent increase in asthma-related ED visits among DC children. However, Hospital B may elect to work with DC residents living with sickle cell disease given that Hospital B is the primary provider of sickle cell care to adults in DC. Similarly, Clinic A might want to focus on male residents in Ward 7 as they have the highest uninsurance rates. The key is to agree to a general plan of action that promotes sharing of resources and expertise across multiple organizations while simultaneously allowing organizations to focus on their populations of interest. The quantitative data help define each organization's focus within each of the broadly defined community needs.

The four tables below highlight the community feedback around each of the needs and provide examples of how the quantitative data support a deeper understanding of the needs. In essence, the tables are meant to be illustrative of how the quantitative data can add dimension and focus to each of the community needs. A more thorough integration of the different data types will occur as the Collaborative moves from the assessment phase into developing the community health improvement plan.

MENTAL HEALTH

Mental health services are provided by government, professional, or community organizations that aid in the prevention and treatment of psychological, emotional, and relational issues as well as access to therapy and psychiatry services.

QUALITATIVE FINDINGS	QUANTITATIVE FINDINGS	
Main Qualitative Themes From DC Stakeholders Related to Mental Health	Selected DC Health Status and Utilization Indicators Related to Mental Health	Distribution of Selected DC Assets Related to Mental Health
Community stakeholders had serious concerns about the state of mental health in DC.	*Several mental health indicators revealed that the prevalence of mental health diagnoses is high with large disparities across place and race.*	*Mental health resources are distributed unevenly across the city, but there are many assets – such as recreation centers and community clinics – that can help address mental health gaps*
• A pervasive sentiment was that mental health is an underlying determinant of health that needs to be addressed broadly at the policy level while community organizations work to address individual resident needs. • Stakeholders specifically noted the need for universal mental health screening, initiatives to de-stigmatize mental illness, and programs for people dealing with substance abuse. • Stakeholders expressed concern about the prevalence of stigma associated with seeking mental health services. • Recommendations for services were broad, including psychological, emotional, and relational issues as well as access to therapy and psychiatry services.	• More than 20% of DC adults are diagnosed with depression; the highest prevalence is in Ward 8 (28%) and lowest prevalence in Wards 4 and 5 (about 15%). • About 15% of DC youth have attempted suicide; the rate is nearly twice as high among girls compared to boys (18.9% versus 9.9%). • More than 17% of DC seniors expressed feeling lonely, sad, or isolated. Seniors living in Ward 2 appear to be the loneliest, most sad, and isolated (23.1%) especially in comparison to seniors living in Ward 3 (10.3%). • Mental health diagnoses, such as mood disorders, schizophrenia and other psychotic disorders are in the top five reasons for hospital admissions at: United Medical Center, Providence Hospital, Children's National Health System, Howard University Hospital, and George Washington University Hospital. • Alcohol-related disorders are the most common reason for an ED visit at Georgetown University Hospital and Sibley Memorial Hospital and the top reasons for ED visits in Wards 2 and 3.	• Wards 7 and 8 are designated as mental health professional shortage areas. • Mental health resources for children are concentrated around Ward 2 while most children live in Wards 4, 7, 8. • Aging services are concentrated in Ward 2 whereas older adults are concentrated in Wards 3, 4, and 5. • Availability of multilingual, culturally mindful mental health professionals is limited.

BRING CARE TO THE COMMUNITY

Bring Care to the Community – also known as place-based care – is providing care optionsthat are convenient and culturally sensitive.

QUALITATIVE FINDINGS	QUANITATIVE FINDINGS	
Main Qualitative Themes From DC Stakeholders Related to Place-Based Care	Selected DC Health Status and Utilization Indicators Related to Place-Based Care	Distribution of Selected DC Assets Related to Place-Based Care
The need to "bring health care to the community" focuses on providing care resources, including educational, preventive, and clinical resources, in convenient locations, such as community centers, schools, churches, and other neighborhood venues. Making care options easy to access and culturally sensitive is the main focus of "bringing care to the community."	*Making care convenient is a goal of place-based care. Rates of preventive services, such as immunizations, are likely to be higher if these services were located in community settings that individuals visit for other purposes.*	*DC is rich with health care assets, but the distribution of these assets is not always equitable.*
• Many participants used the concept of deploying community health workers as a concrete example of bringing care to the community. • Community health workers present opportunities to provide customized care, deliver health information, and perhaps conduct basic health screenings • Community health workers conducting health screenings, for example, could serve to be effective by using a familiar place in the community and a trusted person in the community to encourage healthy behavior.	• A much higher percentage of Black and Hispanic residents, 66 %– 68%, do not have a flu shot in the past 12 months compared to White residents (52.1%). • Place-based programs and messaging around exercise and smoking could help address high rates of inactivity in Wards 7 and 8 and the extremely high rate of smoking (41%) in Ward 8. • Children's National has the highest percentage (40%) of their patients with more than one emergency department visits. Many of these cases are non-urgent visits. This may suggest inadequacies in the local primary care options.	• DC maps show areas that are designated as health professional shortage areas: *Primary care*: All wards, except Ward 3, include areas that are defined as primary care shortage areas. *Dental care:* Wards 7 and 8, and parts of Wards 2 and 6, are classified as dental health professional shortage areas. *Mental health:* Wards 7 and 8 are designated as mental health professional shortage areas. • Schools are assets that can be used to deliver preventive care in places where children already congregate. There are six school-based health centers in DC senior high schools: Anacostia, Ballou, Cardozo, Coolidge, Dunbar and Woodson. • Pharmacies are concentrated in Ward 2; there are only 6 pharmacies in Wards 7 and 8 despite the high percentage of residents with chronic illness that require medications.

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.

QUALITATIVE FINDINGS	QUANITATIVE FINDINGS	
Main Qualitative Themes From DC Stakeholders Related to Care Coordination	Selected DC Health Status and Utilization Indicators Related to Care Coordination	Distribution of Selected DC Assets Related to Care Coordination
DC community stakeholders identified the need for enhancing "care coordination" as a means to improve the health of DC's communities. • Complexity of the health care system, lack of communication between providers, lagging shared electronic medical records systems, and non- co-located health care services were identified as contributing to community members' difficulties accessing health care services. • These difficulties were heightened among community members who were socioeconomically vulnerable, had limited health literacy, and had inconsistent patterns of service utilization.	*Quantitative metrics directly related to care coordination are limited in DC. Below are indicators that are associated with or can lead to poor care coordination:* • While DC residents are highly insured, a large percentage, 23.8%, report not having someone they think of as their personal health care provider. About 10% of adults delayed getting medical care because they could not get an appointment soon enough. • Men are less likely to have a personal care provider and residents in Wards 5, 7, and 8 have the lowest rates of having someone they consider their provider. • The infant mortality rate (IMR) is decreasing in DC. The highest rates continue to be among Black mothers and those residing in Ward 8. IMR can be reduced with highly coordinated prenatal care. • More than 20% of residents in Wards 1, 2, 3 and 4 speak a second language at home. • United Medical Center and Washington Hospital Center have the highest percentage of their patients who have multiple	*Care coordination requires an array of assets.* • DC maps show areas that are designated as health professional shortage areas: Primary care: All wards, except Ward 3, include areas that are defined as primary care shortage areas. Dental care: Wards 7 and 8, and parts of Wards 2 and 6, are classified as dental health professional shortage areas. Mental health: Wards 7 and 8 are designated as mental health professional shortage areas. • Six DC hospitals participate in a Health Information Exchange (HIE) with the Chesapeake Regional Information System for our Patients (CRISP) that is intended to help with care coordination efforts. • Health literacy and education services provided by professionals help residents understand basic health information that is necessary to make appropriate health decisions. These services are strictly tied to grant availability, they are scarce, and are not currently billable services.

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 group of reading, listening, analytical, and decision-making skills, and the ability to apply these skills to health situations.

QUALITATIVE FINDINGS	QUANITATIVE FINDINGS	
Main Qualitative Themes From DC Stakeholders Related to Health Literacy	Selected DC Health Status and Utilization Indicators Related to Health Literacy	Distribution of Selected DC Assets Related to Health Literacy
Health literacy emerged as an important component of community health:	*Health literacy often focuses on teaching individuals how to navigate the health care system. Having health insurance is the first step in gaining access to preventive and clinical services. In DC most of the population is insured.*	*DC is rich with resources that can aid health literacy:*
• DC stakeholders indicated that low health literacy is a significant concern in DC. It can affect overall health outcomes, result in lack of access to and awareness of supportive services offered by health care systems, and may cause confusion about health insurance processes. • Health literacy is particularly a problem for the growing immigrant population in DC and also for individuals with low levels of education or those who are affected by a digital divide. • Participants also noted an additional unexpected outcome of more missed appointments due to poor attitudes about preventive care.	• Greater than 90% of DC adults have health insurance and the vast majority of children are insured with 70% insured by public insurance. • While DC residents are highly insured, a large percentage, 23.8%, report not having someone they think of as their health care provider. This may be a by-product of low health literacy, as access to care does not equate to proper utilization of care. • ED over-utilization may be a result of health literacy issues, as patients may not understand how to properly utilize the health care system. For example, the asthma ED visit rate in Wards 7 and 8 is 23 times higher than in Ward 3; and, is 20 times higher with Black residents compared to White residents. • More than 20% of residents in Wards 1, 2, 3 and 4 speak a second language at home. The health care system is difficult to navigate for native English speakers; thus, even more difficult when English is not the primary language.	• DC Health Link is a program through the DC Health Benefit Exchange Authority that educates consumers on how to access and utilize health insurance. • Agencies, such as the DC Department of Health and the US Department of Health & Human Services when given availability of dollars, will fund Health Education services to improve health literacy initiatives across the city. Availability of these dollars is scarce and driven by advocacy efforts. • Local libraries and universities offer continuing education adult classes that include literacy programs, some, but not many, having a health component.

CHAPTER 8:
Next Steps

This community health needs assessment 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.

In Chapter 8, we conclude this report with a few notes about our next steps. As stated in Chapter 2, CDC research documents that poverty, income and wealth inequality, poor quality of life, racism, sex discrimination and low socioeconomic conditions are the major risk factors for ill health and health inequities. The CDC further states that societal conditions such as inadequate housing, polluted environments and lack of educational and employment opportunities are drivers of inequitable health outcomes. And, if only 10 to 20 percent of health status relates to direct health services, we must ask a provocative question: if all of these systematic and cumulative interconnectors are rooted in socioeconomics, yet impact health outcomes, can the existing health care system help health in our communities?

Traditionally, hospitals have been a place for "sick people"—a place where people go to see a doctor and get treatment. That tradition is changing. Hospitals are recognizing that health is fundamentally an evolution of where you are born, live, learn, work, and age. This continuum is an amalgamation of complex factors we know as social determinants of health. As hospitals insert themselves in the new paradigm of creating health, partnerships with Federally Qualified Health Centers and other community-based health providers are essential.

The DC Healthy Communities Collaborative believes that health care providers can help heal our communities. And, we will do this this by engaging the community, understanding general health status and behaviors, studying utilization of health care services, and developing and implementing a plan that will bring our charitable missions into action for maximum impact on health.

COMMUNITY HEALTH IMPROVEMENT PLAN

The Collaborative – in partnership with our community stakeholders – will develop a data-driven community health improvement plan that will be publicly available in November 2016. This plan will be a living document that will provide concrete actionable steps for addressing the four community needs identified in this report: mental health, bring care to the community, care coordination, and health literacy.

Collaborative members have pledged to work together with the shared goal of moving towards health equity for all DC residents. We will rely heavily on external stakeholders, our CAB members and other community representatives to create and move this plan into action.

In developing our improvement plan, we will work towards health equity in DC by pursuing the following short- and long-term actions (adapted from Healthy People 2020):

- Attention to the root causes of health inequities and health disparities, specifically social determinants of health.
- Particular attention to groups that have experienced major obstacles to health associated with socio-economic disadvantages, historical and contemporary injustices.
- Promotion of equal opportunities for all people to be healthy and to seek the highest level of health possible.
- Distribution of resources needed to be healthy in a manner that progressively reduces health disparities and improves health for all.
- Continuous efforts to maintain a desired state of equity after avoidable health inequities and health disparities are eliminated.
- While there are a growing number of excellent programs in communities across the country, the program portfolio of many non-profit hospitals includes a large number of small programs spread over a wide geographic area; most are insufficient in the scale, targeting or design elements necessary to produce measurable outcomes.

As we look to make a real difference in these important community needs, we must work more cohesively on priorities, governance and shared accountability across all sectors. 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.

ACCOUNTABILITY AND TRANSPARENCY

To fulfill its commitment to enhance accountability and transparency, the Collaborative will continue sponsorship of the online portal of community health information known as DC Health Matters. As noted earlier, this community-driven information portal provides local health data as well as information on social determinants of health.

DC Health Matters will house both this needs assessment (written version as well as an interactive electronic version) and the accompanying community health improvement plan. It will serve as the reporting, tracking and monitoring mechanism for the community health improvement plan and include a community feedback tool. Several data sources will be used to track progress on each of the goals we will develop, including citywide survey data, hospital administrative data, demographic population files, and qualitative community perspectives (focus groups/interviews).

Collaborative members are committed to maintaining DC Health Matters as the key platform for ensuring transparency and accountability as we work to advance community health. In addition to posting the assessment to DC Health Matters, each Collaborative organization will post this assessment and corresponding CHIP to individual organizational websites.

JOIN US IN THIS JOURNEY

We invite all DC stakeholders to join us in working towards health equity. Contact us via www.dchealthmatters.org for more information.

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

– Martin Luther King, Jr.