DC HEALTH MATTERS COLLABORATIVE

COMMUNITY HEALTH NEEDS ASSESSMENT

2022

Bread for the City — helping people

Community OF HOPE

Children's National

HUH HOWARD UNIVERSITY HOSPITAL

Mary's Center

SIBLEY MEMORIAL HOSPITAL — JOHNS HOPKINS MEDICINE

UJ UNITY HEALTH CARE — Healthier You. Healthier Communities.

COMMUNITY HEALTH NEEDS ASSESSMENT

DC Health Matters Collaborative, 2022

This assessment was co-produced by DC Health Matters Collaborative members Bread for the City, Community of Hope, Children's National Hospital, Howard University Hospital, Mary's Center, Sibley Memorial Hospital and Unity Health Care, as well as DC Behavioral Health Association, DC Hospital Association and DC Primary Care Association. This report is intended to satisfy the triennial CHNA requirements; prepared by Amber Rieke, MPH.

To learn more, please visit DCHealthMatters.org.

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MESSAGE FROM OUR CHAIR

The DC Health Matters Collaborative brings together a dedicated core of representatives from the District's nonprofit hospitals, FQHCs, and community-based organizations. This dynamic, multidisciplinary, and diverse group is committed to identify and address community and healthcare needs of District residents. Countless hours of meetings, focused on designing the Community Health Needs Assessment (CHNA) and resulting Community Health Improvement Plan (CHIP) proposals were held through 2021 and 2022. Our meetings always had a quorum and contained enlightened conversation. We thought out of the box and identified community health needs, such as care coordination and place-based care in addition to the elephant in the room (mental health). Supported by an outstanding Director of External Affairs, Amber Rieke, the Collaborative paid attention to the actions of our member organizations, the D.C. Council's health and behavioral care focus, and cemented the groundwork for a model District/statewide organization.

It is an honor to serve as Chairwoman along with Co-Chair, Pamela Carter-Nolan, PhD, Director, HU School of Public Health during Fiscal Year 2022. Sincere thank you to the Collaborative members for a job well done.

Davene M. White, MPH, RN, NNP

DC Health Matters Collaborative Chair
Director Public Health Programs,
Howard University Hospital

Contents

EXECUTIVE SUMMARY

Who We Are

The D.C. Health Matters Collaborative is a coalition of hospitals, health centers, and healthcare associations working together with community partners to assess and address health needs in the District of Columbia.

Current members include three District hospitals (Children's National Hospital, Howard University Hospital, and Sibley Memorial Hospital) and four federally qualified health centers (FQHCs) (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care). Our ex-officio members include the D.C. Behavioral Health Association, D.C. Hospital Association, and D.C. Primary Care Association.

What We Do

The Collaborative was founded in 2012 in response to new requirements in the Patient Protection and Affordable Care Act of 2010 (ACA), which mandated nonprofit hospitals to issue a Community Health Needs Assessment (CHNA) and corresponding Community Health Improvement Plan (CHIP) every three years. To reduce redundancy, combine resources, and improve partnerships, a group of hospitals and health centers came together to produce a joint District-wide CHNA and CHIP in 2013, then again in 2016 and 2019.

Since 2016, the work of the Collaborative has centered on the needs identified in assessments: mental health, care coordination, health literacy, and place-based care. DC Health Matters Collaborative recognizes that most of health is driven by social factors outside of healthcare, such as housing, education, and environment.

How We Work

All Collaborative work uses a health equity lens based on the Robert Wood Johnson Foundation's definition: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare." We recognize that health inequalities are present in our city by race, neighborhood, income, immigration status, age, gender, and other factors.

In order to work inclusively and effectively, the Collaborative adopted the "Scrum" framework for its 2019-2022 CHIP work, a flexible and collaborative project management approach for addressing complex issues. We committed to work on nine priority strategies over three years in this model.

The Community Health Data Dashboard hosted on DCHealthMatters.org is one of the Collaborative's longest running projects. This interactive data portal allows anyone from the

community to access thousands of up-to-date indicators about demographics, health outcomes, and other data about the economic and social conditions of health.

Further, we work primarily through a framework which recognizes the importance of changing policy, systems, and environment (PSE) to truly impact community health outcomes.

To this end, the DC Health Matters Collaborative jointly creates a formal advocacy agenda reflecting priority areas. Core advocacy activities include research, monitoring, supporting partners and coalitions in ongoing campaigns, educating stakeholders about relevant issues, and direct advocacy at the D.C. executive agencies and D.C. Council related to budgets, regulations, programs, or other issues.

Community Health Needs, 2019-2022

The chief influence on community health in the last three years has been the COVID-19 pandemic. Likewise, the shape and scope of this CHNA has been governed by constraints of the public health crisis and changed several times since planning began in 2020.

This final document represents an abbreviated CHNA process, and includes three main elements:

- Descriptions of the work of the D.C. Health Matters Collaborative since the 2019 CHNA was released.
- Summaries of the diverse landscape of existing local research documenting community health and other social factors, including those by D.C. Health, Georgetown University, D.C. Appleseed, MedStar and Children's National Hospital, among others.
- Interviews with leaders in health provider organizations, including FQHCs, which serve and represent low-income, minority, and medically underserved residents in our community, to identify and prioritize significant health needs in the community.

For this CHNA, community is defined by the geographic boundaries of the District of Columbia.

After two years of providing services during the public health emergency, health system stakeholders had a unique and important opportunity to take stock together. Concerns about well-being, social needs, workforce burn-out, and equity are top of mind for healthcare leaders. Stand-out themes include:

- Worsened behavioral health and mental well-being (including, but not limited to, social isolation, substance abuse, stress created during the COVID-19 pandemic, poor life satisfaction).
- Recognition of the significant impact of social needs and conditions that impact well-being (access to childcare, housing, employment, food insecurity, transportation).
- Decreased neighborhood safety and need for violence prevention.
- Barriers in accessing healthcare (such as access to and gaps in insurance coverage, fear or mistrust of providers, institutional racism and experience of discrimination, communication challenges, life circumstances).
- Acute and disparate social and healthcare needs of Black D.C. residents, which leads to worse chronic disease burden, higher mortality rates from COVID-19, less access to wealth and income opportunities, and lower life expectancy.

- Impact of patient/resident access to technology and online platforms to access healthcare, social and educational services, as well as need for providers to maximize health information exchange for care and coordination.
- The importance of emergency preparedness for government systems, health providers, and individuals.
- Urgent need for adequate labor pool health and behavioral health professions, including traditional and nontraditional positions.
- Essentiality of cultural and linguistic competence and trauma-informed care among providers, and appropriate, respectful communication with communities.

Leveraging existing assessments reduces duplication and aligning our priorities with other initiatives allows us to achieve shared outcomes for our community. Going forward, we will continue to have discussions about areas for partnership in the development and execution of our respective community health improvement work.

Selected Areas of Focus, 2022-2025

Collaborative members ultimately selected three priority areas of focus, which will be further defined and delegated through the CHIP process. The selected focus areas are broad and inclusive of many of the themes described throughout this assessment, and there is certainly no shortage of work within each issue. These are:

1. Mental Well-Being
2. Equitable Access to Care (and everything patients need - including coordination of that care, housing, and social support services.)
3. Community-Based Workforce Development (including retention and development of healthcare workforce.)

Further, the Collaborative commits to these fundamental values for future work:

- Residents deserve safe and inclusive environments, including culturally sensitive care, language access, and trauma-informed care.
- Community-led solutions will solve community challenges.
- Commitment to equity and anti-racism is necessary in all efforts to change policies and systems.
- A focus on social conditions, like housing and employment, is essential to increasing well-being.

With the three priority needs identified, the Collaborative will now develop a CHIP with concrete, actionable plans for addressing community needs through 2025, co-created with community stakeholders. The CHIP document is due to be published in November 2022.

We invite all D.C. stakeholders to join us in working toward health equity. Contact us via email at collab@DChealthmatters.org for more information.

ABOUT DC HEALTH MATTERS COLLABORATIVE

The D.C. Health Matters Collaborative is a coalition of hospitals, health centers, and healthcare associations working together with community partners to assess and address health needs in the District of Columbia. We build our work on a shared vision: One healthy and thriving capital city that holds the same promise for all residents regardless of where they live.

The Collaborative was founded in 2012 – then the "D.C. Healthy Communities Collaborative" – when new requirements in the Patient Protection and Affordable Care Act of 2010 (ACA) mandated nonprofit hospitals issue a Community Health Needs Assessment (CHNA) and corresponding Community Health Improvement Plan (CHIP) every three years.

Members

Current members include three District hospitals (Children's National Hospital, Howard University Hospital, and Sibley Memorial Hospital) and federally qualified health centers (FQHCs) (Bread for the City,

Community of Hope, Mary's Center, and Unity Health Care). Our ex-officio members include the D.C. Behavioral Health Association, D.C. Hospital Association, and D.C. Primary Care Association. Past membership has also included Providence Hospital, which has since closed, and HSC Health Care System, which has recently become part of Children's National Hospital.

Collaborative members appoint staff to participate on a steering committee, the governing body that meets monthly to discuss policy updates and report on progress on the CHIP. This CHNA was planned under the elected leadership of Julia DeAngelo, MPH, Program Manager of School Strategies of in Children's National Hospital's Child Health Advocacy Institute, and our current co-chairs, Davene M. White, MPH, RN, NNP, Assistant Professor and Director of HUH CARES Public Health Programs at Howard University Hospital, and Pamela Carter-Nolan, PhD, MPH, Director Master of Public Health program at Howard University.

Core Activities

- **Community Health Needs Assessment (CHNA)** – The review of the health and other social issues experienced by D.C. residents. The CHNA identifies priority areas that serve as the foundation for our community health improvement efforts.

- **Community Health Improvement Plan (CHIP)** – Our roadmap for action in our priority areas, developed with a focus on policy and system-level actions that can make a positive, upstream impact.

- **DCHealthMatters.org** – Our web portal offers our community data and resources to inform their understanding of D.C.'s health landscape and empower efforts to advance health equity. Our blog shares our activities and resources and features guest authors such as local health professionals and advocates.

- **D.C. Health Matters Connect** – Our online tool [DCHealthMattersConnect.org] connects providers and residents with an array of free and low-cost programs in categories like health, housing, food, and transit.

- **Advocacy Agenda** – Our formal policy advocacy plan – first launched in 2019 – for achieving citywide, legislative, and regulatory actions in support of our CHNA findings, CHIP strategies, and equity goals.

- **Community Convenings and Stakeholder Education** – Our efforts to gather diverse stakeholders to share strategies and solutions to improve health in D.C. – from grand rounds to city hall.

When the SARS-CoV-2 (COVID-19) pandemic began in the District in 2020, the Collaborative pivoted to online education and engagement. We also convened check-ins so that member organizations could share concerns, recommendations, and resources, such as videos about COVID-19 with children and vaccination information flyers.

Framework for Change

Since its inception, the Collaborative has recognized that most of health is driven by social factors outside of access to healthcare, such as housing, education, and environment. We have worked primarily through a framework which recognizes the importance of changing policy, systems, and environment (PSE) to truly impact community health outcomes. The pandemic underscored the urgency and necessity for hospitals and community health centers to address these social determinants of health.

The road to eliminating health inequities requires a diverse cross-section of stakeholders with varied expertise and lived experience to work together. We welcome all partners to collaborate with us in our current and future work.

ASSESSING NEEDS: COMMUNITY HEALTH NEEDS ASSESSMENTS, 2013 TO TODAY

CHNA Requirements

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

The CHNA regulations require the needs assessment to be conducted every three years. A subsequent CHIP is meant to guide hospitals' investments in the identified priority areas. The needs assessment and improvement plan must be adopted by hospital boards and made available to the public.

To reduce redundancy, combine resources, and improve partnerships, a group of hospitals and health centers came together in 2012 to produce a joint community health needs assessment and community health improvement plan. The Collaborative issued the first District-wide CHNA in 2013, then again in 2016 and 2019.

Definition of Community

An important piece of context for a CHNA is how "community" is defined. Collaborative organizations all serve the District of Columbia (D.C.), as well as neighboring states (Maryland, Virginia, and beyond). For this CHNA, community is defined as the residents of D.C.; not only the patients of member organizations, but all those living within the geographic boundaries of the District. At present, we do not include the nearby Virginia and Maryland counties in our analysis or improvement plan; however, we study and consult with partners in these jurisdictions as needed. Because specific utilization and patient population data for D.C. hospitals and community health centers (regardless of the patients' place of residence) is important to consider, we provide these data on DCHealthMatters.org.

Past Needs Assessments

The process for our triennial CHNA effort has evolved since the first version published in 2013. As the process has developed over CHNA cycles, the focus expanded from clinical conditions to a broader arena of factors – such as economic disadvantage, historical injustices, risk exposure, and lack of access to resources – which play a role in outcomes and represent important opportunities for improving health.

The 2013 CHNA

The Collaborative (then known as D.C.HCC) partnered with the RAND Corporation to conduct the first needs assessment, published in June 2013. The quantitative analysis of health data in the District revealed four priority areas: asthma, overweight/obesity, sexual health, and mental health and substance abuse.

The 2016 CHNA

For the 2016 CHNA, the Collaborative (then the D.C.HCC) adopted an expanded focus on qualitative data, community engagement, and non-clinical factors of health. Qualitative data sources included key informant interviews, an online survey for healthcare providers and staff, focus groups with participants from community-based organizations, and a community town hall. Data on socio-demographics, health behavior, hospital discharges, emergency department visits, and community health center visits were also included.

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

The 2019 CHNA

For the 2019 assessment, the Collaborative re-prioritized the needs identified in 2016: mental health, care coordination, health literacy, and place-based care. Acknowledging that these needs persisted in the District, members agreed to use the assessment to dig deeper rather than start anew, and leverage the capacity, expertise, and relationships that had been built to address these needs.

The Collaborative conducted a series of focus groups and interviews with D.C. community-based groups, local leaders, and other stakeholders. We also analyzed several quantitative data sources to gain a deeper understanding of demographic, socioeconomic, health behavior, and health status factors. We synthesized the many findings into four areas for action: fostering community dialogue, building relationships, developing workforce capacity, and simplifying the path to wellness.

D.C. Health Matters Collaborative members are required to report out feedback or comments on our CHNA from the community. We promoted our CHNA at local events and webinars, which were attended by stakeholders who were recruited for our mailing list and project teams and have been included since. The Collaborative has not received other CHNA feedback to note here.

2022 Needs Assessment

The shape and scope of the 2022 CHNA has changed several times since planning began in 2020. The chief influence has been the COVID-19 pandemic. The initial plan was to engage in a joint needs assessment facilitated with D.C. Health and the D.C. Hospital Association. Understandably, priorities for agencies changed with the public health emergency, besieging both public health and hospital stakeholders in March 2020. The ability to engage community members was greatly impeded due to closures and precautions around COVID-19, which extended through mid-2022. We were unable to gather community representatives in person due to the length of the pandemic; we continued to delay such community engagement with each new infection wave, ultimately running out of time to produce an event. We are eager to convene again soon.

In 2021, we partnered with the Ward 8 Community Economic Development

(W8CED) project to design a survey of Ward 8 residents using the "Well-Being in the Nation" tool. The survey used measures from the validated "Well-Being in the Nation" (WIN) survey tool which was originally developed through the National Committee on Vital and Health Statistics (NCVHS). The Ward 8 survey is intended to gain insights about how residents define their own well-being, as well as different social needs and experiences. Despite a lengthy planning process and Institutional Review Board application, we were ultimately unable to co-lead the research due to institutional barriers and COVID-19 concerns. Instead, we made a significant grant to W8CED to continue the survey, including incentives for survey participants and grassroots data collectors. We look forward to learning from the results of their modified well-being survey, expected this year.

We also solicited input in 2021 from the District of Columbia Department of Health (DC Health), though staff and leadership were unavailable for interviews. The D.C. Department of Behavior Health (DBH) participated in and provided input during our Behavioral Health Workforce listening session, as described in the Mental Health Sprint #2 section, below. In addition, we took into account information published by DC Health, including its Pandemic Health Recovery Report, in identifying and prioritizing health needs of the DC community (see "Pandemic Health Recovery Report," page 29). We will continue to pursue opportunities for partnership in the work ahead.

We solicited input on our DC Health Matters Collaborative 2019 Community Health Needs Assessment report by providing an email address on our website, but did not receive any specific comments from members of the public in response via that email address.

This final document represents an abbreviated CHNA process, and includes three main elements:

- Descriptions of the work of the D.C. Health Matters Collaborative since the 2019 CHNA was released;
- Summaries of the diverse landscape of existing local research on community health and other social factors [page 23];
- Interviews with leaders in health provider organizations [page 33], including FQHCs which serve low-income and/or medically under-served residents.

A wealth of up-to-date quantitative data are continually updated on the D.C. Health Matters Data Dashboard. This portal, sponsored by the D.C. Health Matters Collaborative, includes thousands of indicators across dozens of data sources.

Adapting to our current challenges, the Collaborative will focus on CHIP development process for more inclusive conversation and outreach, and connection with colleagues and neighbors to plan future work together.

ADDRESSING NEEDS: COMMUNITY HEALTH IMPROVEMENT WORK, 2019 TO 2022

The work of the D.C. Health Matters Collaborative is outlined in "Progress through Partnership: Community Health Improvement Plan, 2019-2022." The CHIP uses a health equity lens based on the Robert Wood Johnson Foundation's definition: "Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and healthcare." We recognize that health inequalities are present in our city by race, neighborhood, income, immigration status, age, gender, and other factors.

Project "Sprints"

The Collaborative adopted the "Scrum" framework for its 2019-2022 CHIP work, a flexible and collaborative project management approach for addressing complex issues. In brief, this approach focuses on sprint teams executing one strategy at a time in focused, time-limited "sprints," replacing the former working groups that meet monthly to concurrently address all strategies. This intent for this change was to increase participation of stakeholders on time-bound projects.

At the outset of each sprint, the team generated, delegated, and executed a list of activities to address the selected community health improvement strategy. The sprint planning stage process included:

- Assignment of team roles and inviting colleagues and community advisors,
- Writing "SMARTIE" goal (Specific, Measurable, Ambitious, Realistic, Time-bound, Inclusive and Equitable),
- Completion of logic model as the foundation of the project plan,
- Defining "success" for sprint review at end of project period,
- Map stakeholder groups and leverage existing networks,
- Plan community dialogue (format, timing, audience, and objective will vary by sprint).

These focused sprints were taken on one at a time to ensure focused and rapid progress towards a pre-defined system change goal. Each sprint had a designated lead organization to manage the sprint process, while all other members collaborated and supported the effort's success. At the end, the work and the process were each evaluated by the team.

2019 CHIP: Priorities for Action

1 **Mental Health Theme 1:** Educate stakeholders of all kinds about Mental Health, such as DC residents, community groups, policymakers, health providers, health system leadership and students. Topics could include identifying mental health conditions, finding services, the challenges of system navigation, treating mental health as part of whole-person health, and fighting stigma.

Lead:
Children's National Hospital
Collaborate:
Community of Hope,
Howard University Hospital,
HSC Health Care System,
Unity Health Care

2 **Mental Health Theme 2:** Improve relationships between and within the (mental) health system and local government agencies to address challenges with referrals, communication, and receiving grants and information. Potential focus on facilitating coordination and referrals for mental health and substance abuse co-occurring conditions.

Lead:
Howard University Hospital
Collaborate:
Children's National Hospital,
Community of Hope,
HSC Health Care System,
Mary's Center,
Unity Health Care

3 **Mental Health Theme 3:** Identify and advance strategies for increasing the number of licensed mental health professionals. Includes addressing recruitment, retention, accessibility and competency of current mental health workforce and the "pipeline" of new practitioners. Could include special focus on culturally and linguistically diverse clinicians and/or those trained in trauma-informed care.

Policy Agenda

Collaborate:
Bread for the City,
Community of Hope,
Howard University Hospital,
Unity Health Care

4 **Mental Health Theme 4:** Promote Mental Health integration in primary care settings and schools in order to lower barriers to care, facilitate early identification and treatment of mental health issues, and reduce stigma. Continue work to expand access to and enhance capacity within the District's school-based mental health program.

Lead:
Mary's Center
Collaborate:
Children's National Hospital,
Community of Hope,
Howard University Hospital,
Unity Health Care

5 **Care Coordination Theme 1:** Improve communication, awareness and referral capabilities between health care providers, social service agencies, and educational systems. Through expansion of the DC Health Matters Connect tool resource referral tool (powered by Aunt Bertha), promote the value of identifying and addressing non-clinical factors impacting patients' health (e.g., hunger, housing, legal, etc).

Lead:
HSC Health Care System
Collaborate:
Children's National Hospital,
Howard University Hospital,
Sibley Memorial Hospital

6 **Care Coordination Theme 2:** Promote, facilitate, and advocate for policy and system changes that incentivize collaboration among health care and social service and education systems. Could include focus on collaboration in funding opportunities, improvements to data-sharing, or engaging partners from other sectors across the city and within organizations.

Policy Agenda:
Children's National Hospital
Collaborate:
Community of Hope,
Howard University Hospital,
HSC Health Care System

7 **Health Literacy Theme 1:** Collaborate with other health care organizations, government agencies and community-based organizations (ex: health ministers) to expand health education efforts, including education on navigating the health system. Leverage existing resources, research best practice approaches and community preferences, and focus on linguistic and cultural appropriateness.

Lead:
Mary's Center
Sibley Memorial Hospital
Collaborate:
Bread for the City,
Children's National Hospital,
Howard University Hospital

8 **Health Literacy Theme 2:** Improve the capacity of health professionals to assess health literacy and adjust communication. Work may focus on screening tools, communication skills, training, cultural effects, and/or financing of services.

Lead:
Howard University Hospital
Collaborate:
Children's National Hospital,
HSC Health Care System,
Sibley Memorial Hospital

9 **Place-Based Care Theme 1:** Support development and expansion of place-based care in convenient, appropriate and accesible locations, including expanding the use of technology and co-located services to facilitate medical encounters. May involve research and advocacy on financial incentives for providers to practice in under-resourced areas and/or expanding the accessibility of existing services.

Policy Agenda:
Howard University Hospital
Collaborate:
Community of Hope,
HSC Health Care System

Sprint Project Spotlight

Mental Health Sprint #2: May - September 2021

Lead: Mary's Center

Collaborators: Children's National, Howard University, Unity Health Care, Community of Hope

The focus of this sprint was to improve both understanding among policymakers and the community of the pervasiveness of behavioral health needs in D.C., as well as the importance of integrating behavioral health services into non-traditional spaces (e.g., schools, primary care clinics, homeless services), the need for workforce expansion, and the value of interagency collaboration. Through a series of listening sessions and roundtable discussions, we brought key players together on these topics to ultimately advocate for ways to increase access to care and improve pathways to the behavioral health workforce.

Outcomes:

- More than 50 adults and youth registered to attend the Behavioral Health Workforce listening session for adults and youth; the youth session also included a panel of diverse providers to share the training and workforce experiences of a behavioral health provider.
- Across the three listening sessions, attendees represented DBH, D.C. hospitals/health systems, federally qualified health centers, core service agencies, policy and advocacy organizations and D.C. public schools.
- Expanded D.C. Health Matters Collaborative reach by including new multidisciplinary stakeholders in the working groups and reaching new and diverse community partners in the listening sessions.
- Developed and shared a white paper and blog post that summarized the behavioral workforce challenges and offered solutions.
- Ongoing engagement with D.C. Councilmembers and staff to further discuss behavioral health workforce issues, including sharing findings in testimony at two public hearings and engaging one-on-one with members' offices to discuss recommendations.

### Care Coordination Sprint #1: November 2019 - March 2020

Lead: HSC Health Care System

Collaborators: Children's National Hospital, Howard University Hospital, Sibley Memorial Hospital

The Collaborative decided to address needs for improving communication, awareness, and referral capabilities among healthcare providers, social service agencies and educational systems, by launching D.C. Health Matters Connect (Connect).

Connect is a free online directory to search and connect with social service programs in the D.C. metropolitan area, which the Collaborative piloted in our 2016 CHIP. The four-month launch process focused on implementing the tool at our clinical sites while also educating stakeholders on the use of the tool to increase care coordination across disciplines.
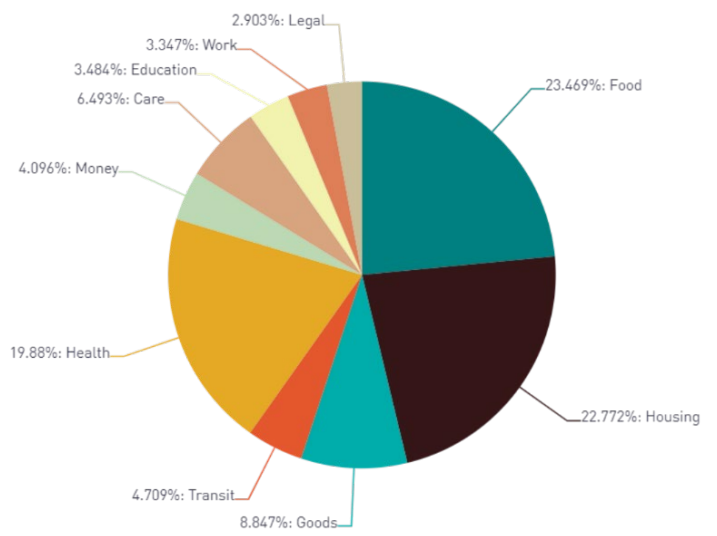
Top 5 Search Terms | All Dates

Legend: emergency food, food pantry, help find housing, food delivery, help pay for utilities
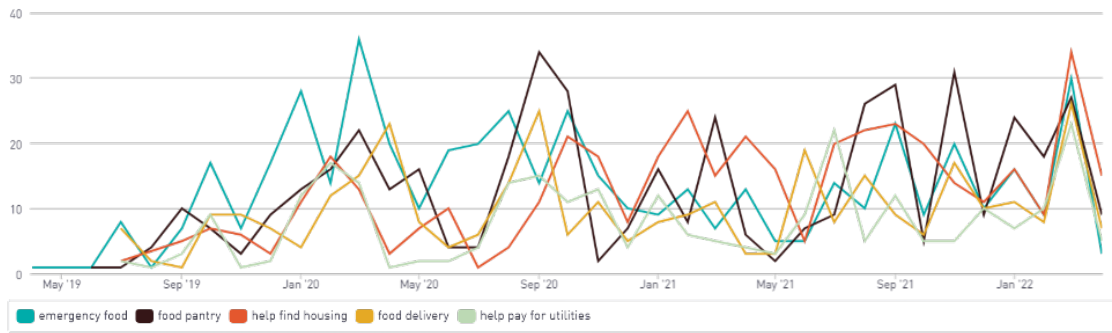
Outcomes:

- Purchased a shared Findhelp (formerly "Aunt Bertha") license to develop D.C. Health Matters Connect.
- Trained 32 organizations across seven wards (and organizations serving the whole District).
- Gave three public trainings attended by over 50 individuals.
- Recorded online training.
- Provided education to organizations across seven different sectors (health, behavioral health, faith, education, insurance, community volunteers, and government).
- Created and disseminated over 1,500 informational postcards about Connect.

- Created education materials about D.C. Health Matters Connect, with embedded feedback mechanism.
- Invited 12 individual organizations to share information about D.C. Health Matters Connect in newsletters.
- Engaged in landscape conversations with D.C. Primary Care Association, a leading local voice on resource connection platforms, and other D.C. Findhelp customers regarding opportunities for collaboration.
- Ongoing usage numbers through April 2022 included 18,642 searches on Connect. See more usage data below:

ⓘ Most Common Search Terms | All Dates

TERM	DOMAIN	SEARCHES
emergency food	food	491
food pantry	food	462
help find housing	housing	432
food delivery	food	338
help pay for utilities	housing	270
help pay for housing	housing	237
bus passes	transit	157
job placement	work	155
temporary shelter	housing	143
help pay for food	food	139
housing vouchers	housing	137
government food benefits	food	129
help pay for internet or phone	housing	120
diapers & formula	goods	118
clothing	goods	117

Searches by Category | All Dates

2.903%: Legal
3.347%: Work
3.484%: Education
6.493%: Care
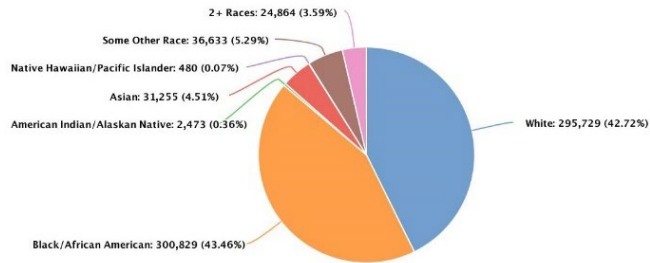4.096%: Money
19.88%: Health
4.709%: Transit
8.847%: Goods
22.772%: Housing
23.469%: Food

D.C. Health Matters Data Dashboard

The [Community Health Data Dashboard [DCHealthMatters.org]](#) is one of the Collaborative's longest running projects. This interactive data portal allows anyone from the community to access thousands of up-to-date indicators about demographics, health outcomes, and other data about the economic and social conditions of health.

A broad range of D.C. demographic indicators and information is provided by Claritas, updated frequently. For example, as of March 2022, the D.C. Population was 692,263 people, a 15% increase since 2010. The median age of D.C. residents was 34.8 years.

A sample of data visualizations from the Dashboard is previewed here.

Population by Race
City: District of Columbia

- 2+ Races: 24,864 (3.59%)
- Some Other Race: 36,633 (5.29%)
- Native Hawaiian/Pacific Islander: 480 (0.07%)
- Asian: 31,255 (4.51%)
- American Indian/Alaskan Native: 2,473 (0.36%)
- White: 295,729 (42.72%)
- Black/African American: 300,829 (43.46%)

Claritas, 2022. www.dchealthmatters.org

Population by Ethnicity
City: District of Columbia

- Hispanic/Latino: 83,640 (12.08%)
- Non-Hispanic/Latino: 608,623 (87.92%)
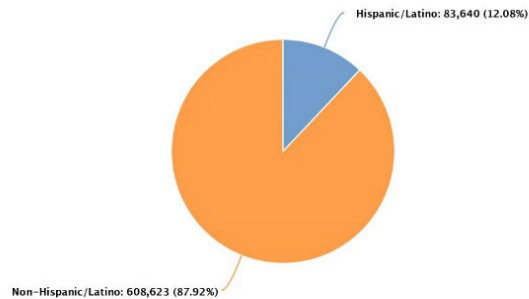
Claritas, 2022. www.dchealthmatters.org

Workers by Means of Transportation to Work
City: District of Columbia

- Other: 8,647 (2.34%)
- Worked at Home: 25,865 (6.99%)
- Walked: 49,575 (13.40%)
- Public Transport: 127,352 (34.42%)
- Bicycle: 15,726 (4.25%)
- Carpooled: 19,847 (5.36%)
- Drove Alone: 122,999 (33.24%)
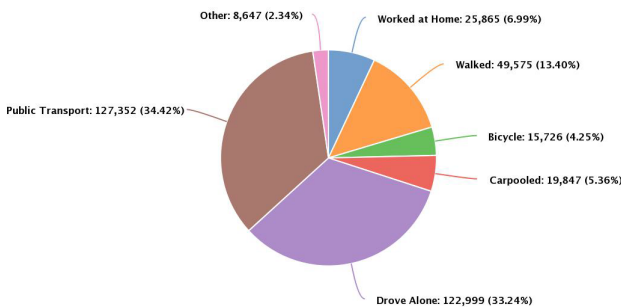
Claritas, 2022. www.dchealthmatters.org

Median Household Income by Race
City: District of Columbia

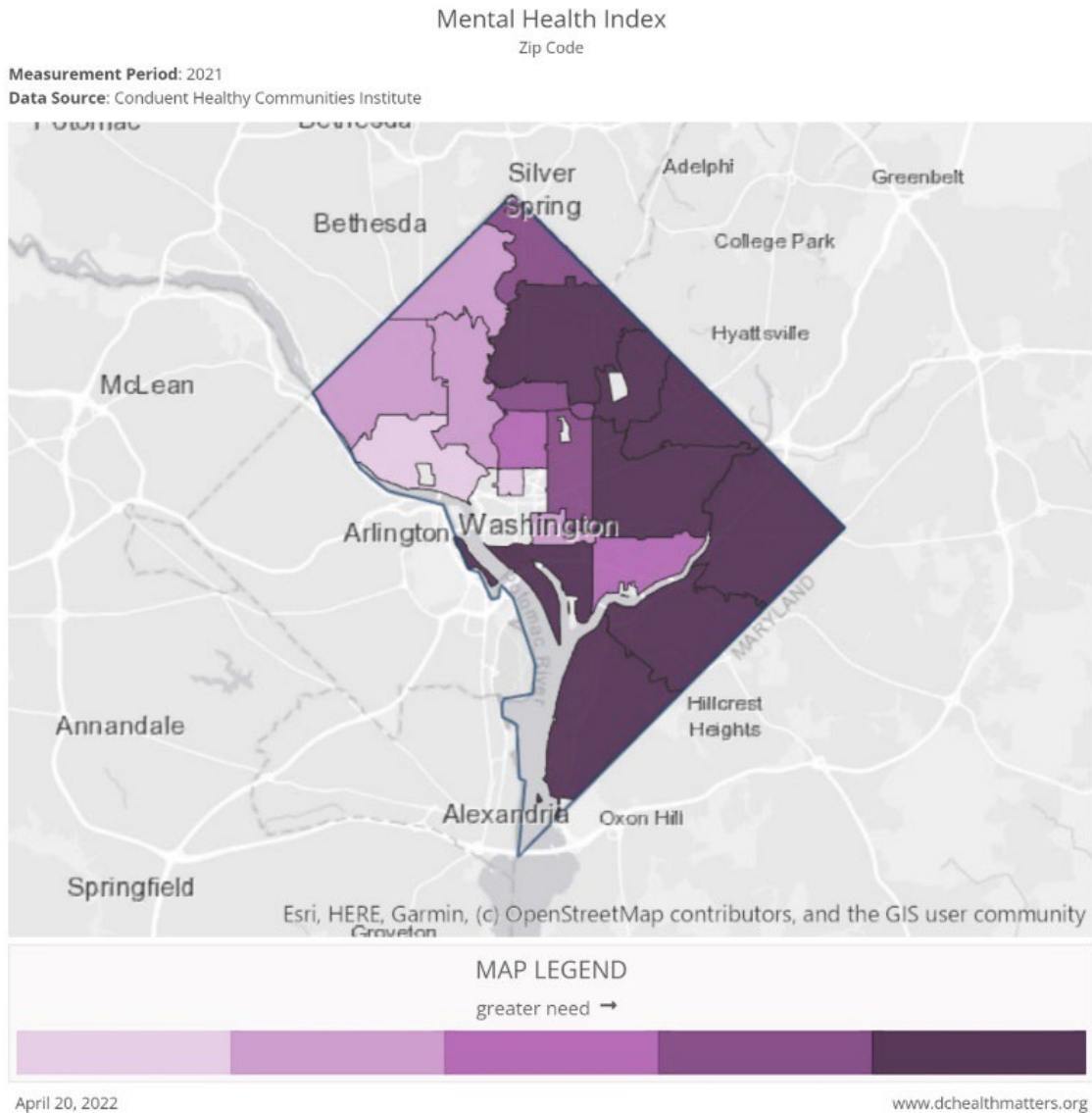| Race	Dollars
All	102 806
White	160 914
Black/African American	53 629
American Indian/Alaskan Native	50 850
Asian	123 057
Native Hawaiian/Pacific Islander	147 368
Some Other Race	69 198
2+ Races	110 540
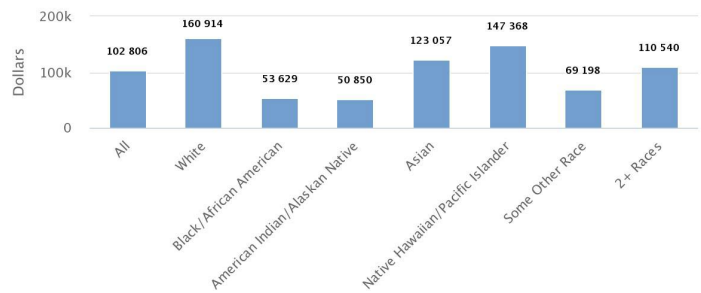
Claritas, 2022. www.dchealthmatters.org

The website includes features like the "SocioNeeds Index Suite" created by Conduent Healthy Communities Institute, which provides analytics around social determinants of health to advance equitable outcomes for a range of topics.

For example, the 2021 Mental Health Index, created by Conduent Healthy Communities Institute, is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Interact with the index suite on D.C.HealthMatters.org.

Mental Health Index
Zip Code

Measurement Period: 2021
Data Source: Conduent Healthy Communities Institute

Potomac Bethesda Silver Spring Adelphi Greenbelt College Park McLean Hyattsville Arlington Washington MARYLAND Annandale Hillcrest Heights Alexandria Oxon Hill Springfield Groveton

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MAP LEGEND
greater need →

April 20, 2022

www.dchealthmatters.org

Healthy People 2030

Healthy People 2030 is a comprehensive set of key disease prevention and health promotion objectives, developed and disseminated by the U.S. Department of Health and Human Services' (HHS) Office of Disease Prevention and Health Promotion.

The health objectives and targets allow communities to assess their health status and build an agenda for community health improvement. The local effort toward targets is coordinated by the D.C. Department of Health.

In the spirit of alignment, the Collaborative closely considers the objectives in its work and tracks indicators within the Data Dashboard. A snapshot is previewed in this chapter.

Healthy People 2030 Progress Tracker

Health / Cancer

	VALUE	COMPARED TO:	
Age-Adjusted Death Rate due to Breast Cancer	**25.4** Deaths per 100,000 females (2015-2019)	❌ HP 2020 Target (20.7)	❌ HP 2030 Target (15.3)
Age-Adjusted Death Rate due to Colorectal Cancer	**14.4** Deaths per 100,000 population (2015-2019)	✅ HP 2020 Target (14.5)	❌ HP 2030 Target (8.9)
Age-Adjusted Death Rate due to Lung Cancer	**28.3** Deaths per 100,000 population (2015-2019)	✅ HP 2020 Target (45.5)	❌ HP 2030 Target (25.1)
Age-Adjusted Death Rate due to Prostate Cancer	**26.5** Deaths per 100,000 males (2015-2019)	❌ HP 2020 Target (21.8)	❌ HP 2030 Target (16.9)
Colon Cancer Screening	**78.6%** (2020)	✅ HP 2020 Target (70.5%)	✅ HP 2030 Target (74.4%)
Mammogram in Past 2 Years: 50-74	**81.0%** (2020)	❌ HP 2020 Target (81.1%)	✅ HP 2030 Target (77.1%)

Health / Family Planning

	VALUE	COMPARED TO:
Teen Pregnancy Rate	**31.7** Pregnancies per 1,000 females aged 15-19 (2015)	❌ HP 2030 Target (31.4)

Health / Heart Disease & Stroke

	VALUE	COMPARED TO:	
Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	**37.5** Deaths per 100,000 population (2018-2020)	❌ HP 2020 Target (34.8)	❌ HP 2030 Target (33.4)
Age-Adjusted Death Rate due to Coronary Heart Disease	**102.7** Deaths per 100,000 population (2018-2020)	✅ HP 2020 Target (103.4)	❌ HP 2030 Target (71.1)
High Blood Pressure Prevalence	**27.2%** (2019)	❌ HP 2020 Target (26.9%)	✅ HP 2030 Target (27.7%)

Health / Immunizations & Infectious Diseases

	VALUE	COMPARED TO:	
Tuberculosis Incidence Rate	2.7 Cases per 100,000 population (2020)	❌ HP 2020 Target (1.0)	❌ HP 2030 Target (1.4)

Health / Maternal, Fetal & Infant Health

	VALUE	COMPARED TO:	
Mothers who Smoked During Pregnancy	2.5% (2015-2016)	❌ HP 2020 Target (1.4%)	✅ HP 2030 Target (4.3%)
Preterm Births	0.1% (2019)	✅ HP 2020 Target (9.4%)	✅ HP 2030 Target (9.4%)

Health / Mental Health & Mental Disorders

	VALUE	COMPARED TO:	
Age-Adjusted Death Rate due to Suicide	6.4 Deaths per 100,000 population (2018-2020)	✅ HP 2020 Target (10.2)	✅ HP 2030 Target (12.8)

Health / Physical Activity

	VALUE	COMPARED TO:	
Adults who are Sedentary	18.2% (2018)	✅ HP 2020 Target (32.6%)	✅ HP 2030 Target (21.2%)

Health / Prevention & Safety

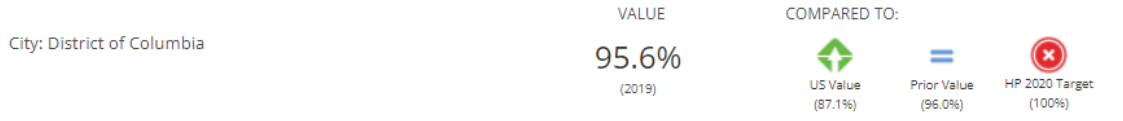|	VALUE	COMPARED TO:	
Age-Adjusted Death Rate due to Unintentional Injuries	64.6 Deaths per 100,000 population (2018-2020)	❌ HP 2020 Target (36.4)	❌ HP 2030 Target (43.2)

Health / Tobacco Use

	VALUE	COMPARED TO:	
Adults who Smoke	11.3% (2020)	✅ HP 2020 Target (12.0%)	❌ HP 2030 Target (5.0%)

Health / Wellness & Lifestyle
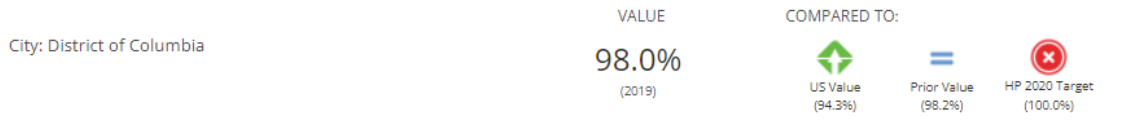
	VALUE	COMPARED TO:
Insufficient Sleep	36.5% (2018)	❌ HP 2030 Target (31.4%)

Health / Health Care Access & Quality

Adults with Health Insurance

	VALUE	COMPARED TO:		
City: District of Columbia	95.6% (2019)	US Value (87.1%)	Prior Value (96.0%)	HP 2020 Target (100%)

Children with Health Insurance

	VALUE	COMPARED TO:		
City: District of Columbia	98.0% (2019)	US Value (94.3%)	Prior Value (98.2%)	HP 2020 Target (100.0%)

Could Not See a Doctor Because of Cost

	VALUE	COMPARED TO:	
City: District of Columbia	10.4% (2017)	Prior Value (9.3%)	Trend

Persons with Private Health Insurance Only

	VALUE	COMPARED TO:		
City: District of Columbia	62.3% (2019)	US Value (55.4%)	Prior Value (61.0%)	Trend

Persons with Public Health Insurance Only

	VALUE	COMPARED TO:		
City: District of Columbia	23.9% (2019)	US Value (23.4%)	Prior Value (26.4%)	Trend

Community / Public Safety

	VALUE	COMPARED TO:	
Age-Adjusted Death Rate due to Motor Vehicle Traffic Collisions	5.9 Deaths per 100,000 population (2018-2020)	HP 2020 Target (12.4)	HP 2030 Target (10.1)
Alcohol-Impaired Driving Deaths	28.2% Percent of driving deaths with alcohol involvement (2015-2019)	HP 2030 Target (28.3%)	
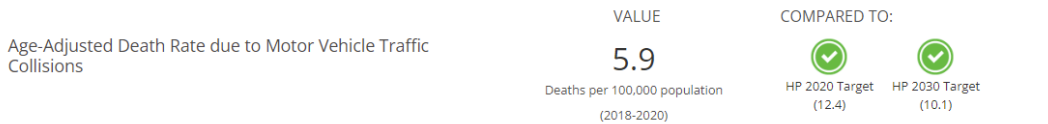
Community / Transportation

	VALUE	COMPARED TO:	
Workers Commuting by Public Transportation	31.5% (2016-2020)	HP 2020 Target (5.5%)	HP 2030 Target (5.3%)

Economy / Poverty

	VALUE	COMPARED TO:
People Living Below Poverty Level	15.5% (2016-2020)	HP 2030 Target (8%)

Advocacy Agenda

The D.C. Health Matters Collaborative's mission is to address the needs we identify together as partners in the health system. This includes jointly create a formal advocacy agenda reflecting priority areas. Within the policy agenda, the Collaborative will advocate for citywide, legislative, and regulatory actions related to CHNA findings, CHIP strategies, and equity goals. The policy agenda is overseen and executed by the Collaborative's Director of External Affairs and member organizations.

Advocacy activities include research, monitoring, supporting partners and coalitions in ongoing campaigns, educating stakeholders about relevant issues, and direct advocacy at the D.C. executive agencies and D.C. Council related to budgets, regulations, programs, or other issues. We aim to always work with the lens of health equity and racial equity, guided by our members and tools, such as the Ten Essential Questions for Policy Development, Review and Evaluation.

Agenda items we have advanced in the last three years include:

Mental Health

1. Advocate for ongoing support and quality assurance of the school behavioral health expansion program.
   - The Collaborative hosted a webinar in 2020 about meeting the emotional wellness and treatment needs of D.C. students and families through school-based services.
2. Research strategies, educate stakeholders, and advocate for regulatory and/or legislative remedies to increase the number of licensed mental health professionals practicing in D.C., especially those serving neighborhoods with highest need.
   - Our 2020 StoryMap "Don't Cut D.C.'s Lifeline to Mental Health" describes the imperative for robust community-based services.
   - "Improvements to Behavioral Health Integration and Service Provision in D.C.: Listening to our Behavioral Health Workforce and Youth" white paper completed summer 2021.
3. Research the crisis response system in D.C., educate stakeholders, and advocate for improvements.
   - Testimony before the D.C. Council Committee on the Judiciary and Public Safety about non-law enforcement alternative responses to mental health crises, December 2020. Watch the full roundtable here.
   - Released "Re-Routing Behavioral Health Crisis Calls from Law Enforcement to the Health System" white paper on D.C.'s crisis response system, current challenges, and opportunities to increase health and reduce harm in 2021.

Access & Place-Based Care

4. Advocate for reforms to D.C. Alliance health insurance program recertification to insure more D.C. residents, including extending the recertification period from six months to one year to align with Medicaid requirements.
   - After years of advocacy, the administration then permanently implemented the changes as part of the District's Fiscal Year 2023 budget.

5. Research and advocate for expanded strategies to employ Community Health Workers (CHWs) and similar peer models in health settings, including financing/financial support for positions, preventing turnover, standardization, and training.
   - A team conducted surveys and landscape research into the practice, financing, training, and expertise of CHWs in D.C. Findings were shared with government and health system partners to advance certification and financing projects.

Care Coordination

6. Advocate for policy and system changes, across the city and within organizations, that incentivize collaboration and improve data sharing among healthcare and social service and education systems (including the Community Resource Information Exchange [CoRIE].)
   - The Collaborative renewed its investment in the D.C. Health Matters Connect tool to enable providers and residents to easily find and connect to services.
   - Participated in the CoRIE project, pursuing integration of community resource platforms and social determinants screenings into health information exchange.

Social Conditions of Health

7. Monitor, research, educate about, and support partners related to current and emerging community social and economic needs.
   - Read our 2020 testimony in support of the REACH Act, which would create an Office of Racial Equity to oversee Racial Equity Impact Assessments (REIAs) for all proposed legislation, as well as the development of Racial Equity Action Plans and annual metrics for all government agencies.

Organizational Development

The D.C. Health Matters Collaborative was honored to join the 2020 Integrator Learning Lab, led by Nemours Children's Health System's National Office of Policy & Prevention with funding support from the Kresge Foundation. The six-month lab brought together nine community groups from across the country for technical assistance on catalyzing and sustaining multi-sector population health networks.

Through this lab, the Collaborative received coaching and resources around our identified growth areas, to evaluate our governance structure and deepen our community engagement efforts. Over the two years since receiving the training, we:

- Increased participation in monthly Collaborative meetings and regular sharing of information on COVID-19 resources.
- Launched community health improvement project system change "sprints" using principles and resources gained from technical assistance.
- Elevated the story of our Collaborative in a case example on the Moving Health Care Upstream website.
- Conducted a member survey and strategic planning retreat to help prioritize our key activities and core functions, and communicate our value to stakeholders.

- Participated in training on an equity impact assessment to help guide our approach to community engagement and inclusion in our efforts to make system and policy change.
- Made financial contributions totaling $10,000 to local, Black-led community-based organizations to support their racial justice work.
- Increased organizational capacity and reach by hosting three semester-long internships with undergraduate students from the Georgetown University's Healthcare Management and Policy Program.
- Increased organizational online presence through Twitter and D.C.HealthMattersBlog.org;
- Launched a newsletter with a distribution list of 1,300+ subscribers.

The 2019-2022 chapter of the D.C. Health Matters story has been one of expanded reach, project sprints, successful advocacy, and a deepened commitment to equity. The next chapter reviews the broader D.C. story through a landscape review of reports on health and social conditions, followed by an analysis of interviews with member health leaders. See Next Steps on page 55 for the plans for the next chapter of community health improvement.

HIGHLIGHT: HOSPITALIZATION DATA

Data sourced and analyzed by D.C. Hospital Association and Children's National Hospital.

The top ten most common principal diagnoses for in-patient hospitalizations (recorded before the public health emergency during the COVID-19 pandemic) were led by birth, sepsis, and hypertension complications. Among visitors to emergency departments, most frequent principal diagnoses were upper respiratory infections, superficial injuries, abdominal pain, sprains, and chest pain.

INPATIENT HOSPITAL ADMISSIONS, 2019		
Clinical Classification System Category	Frequency	Percent
Liveborn	13261	10.6
Sepsis	5774	4.62
Hypertension complications	5427	4.34
Mood disorders	3575	2.86
Other complications of delivery	3296	2.64
Device complications	2933	2.34
Respiratory failure	2437	1.95
Acute cerebrovascular disease	2386	1.91
Complications from procedures	2364	1.89
Schizophrenia and other psychotic disorders	2253	1.8

Source: D.C. Hospital Association, 2019

EMERGENCY DEPARTMENT VISITS, 2019		
Clinical Classification System Category	Frequency	Percent
Other upper respiratory infection	21280	6.07
Superficial injury	13904	3.97
Abdominal pain	11766	3.36
Sprain	11394	3.25
Chest pain	11353	3.24
Back problem	10260	2.93
Other connective tissue disease	9717	2.77
Other injuries	9628	2.75
Other joint disorders	8150	2.33
Viral infections	7997	2.28

Source: D.C. Hospital Association, 2019

In-patient hospitalization admissions related to mental health conditions accounted for about 7% of all principal diagnoses in 2020; the most frequent diagnosis was mood disorders. Mental health conditions accounted for about 6% of all principal diagnoses in emergency department visits, with alcohol-related and substance-related disorders being the most frequently logged.

INPATIENT HOSPITAL ADMISSIONS, 2020		
Mental Health Condition	Frequency	Percent
Mood disorders	2877	38
Schizophrenia & psych disorders	2015	27
Alcohol-related disorders	967	13
Substance-related disorders	458	6
Suicide/self-inflicted injury	350	5

Source: D.C. Hospital Association, 2020

EMERGENCY DEPARTMENT VISITS, 2020		
Mental Health Condition	Frequency	Percent
Alcohol-related disorders	3985	29
Substance-related disorders	3910	28
Anxiety disorders	1503	11
Mood disorders	1311	10
Schizophrenia & psych disorders	1002	7

Source: D.C. Hospital Association, 2020

LANDSCAPE OF LOCAL LITERATURE

Efficiency and alignment are important for the D.C. Health Matters Collaborative, and we have featured reports by partners in past needs assessments. Given the fatigue in the health system and the community during a pandemic, and the limitations to community engagement posed by COVID infection risk, such alignment was even more important in 2022.
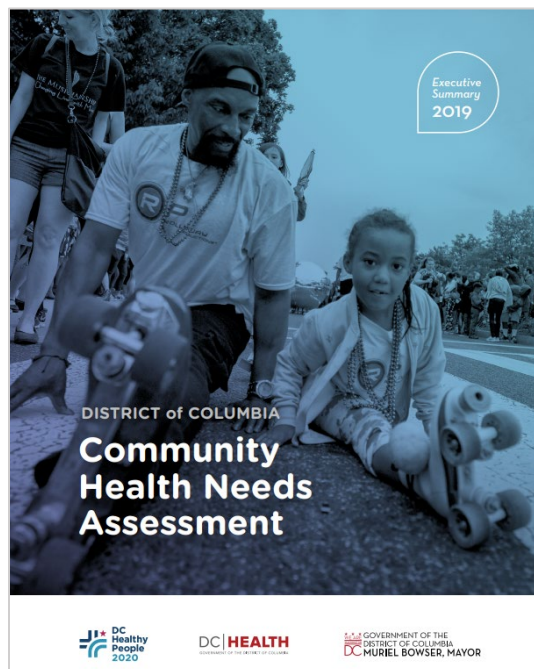
The Collaborative reviewed 16 local reports released 2019-2022 focused on health, inclusive of behavioral health, COVID-19 impacts, and relevant social issues related to health such as housing and transportation. Standardized criteria to review each is reported in this chapter: key findings, populations of focus, noted health and disparities, reference to the social conditions of health, relation in time and content to COVID-19, and any recommendations or responsibilities assigned to the health system and therefore relevant to the Collaborative. A selection is summarized in this chapter, in chronological order of release.

D.C. Health 2019 CHNA

The [D.C. Community Health Needs Assessment](#) was published in 2019 by D.C. Health. With all residents as their target population, it analyzes the health conditions of D.C. through quantitative metrics and indicators and provides lists of current resources that could meet health needs in the community. Among these metrics are the 20 Leading Health Indicators prioritized by D.C.'s Healthy People 2020 efforts, ten of the indicators are improving. Five are getting worse, including injury and violence prevention, and mental health, especially within the youth and LGBTQ+ community. The CHNA was released as an interactive microsite that provides information about these indicators in detail.

The report's targeted population are all D.C. residents, and the data used for the report are tailored towards this group. Primary sources came from D.C. Health's data records and registries, and secondary data was obtained from multiple District and national-level agencies. D.C. Health created its own survey to get direct input from D.C. residents and had a total of 843 responses. Data reflects the health status of D.C. shortly before the pandemic.

The report provides health outcome metrics, such as infant mortality, life expectancy, income, and chronic disease. Outcomes are stratified by race to highlight disparities. For example, the CHNA survey showed that 45% of respondents felt isolated from others in their community; higher numbers were seen by those identifying as Hispanic/Latinx and Asian. The Social Vulnerability Index shows that Wards 7 and 8 have the highest needs in D.C. At the end of each section is a list of assets, resources, and promising practices that can potentially address these disparities.

Multiple barriers in accessing healthcare were described such as financial, spatial, temporal, and language barriers. The CHNA survey noted that the leading barriers to healthcare services are long wait times, costs, and finding a provider that accepts insurance. The CHNA does recommend some resources and initiatives to improve access to the healthcare system but does not further detail responsibilities beyond clinical healthcare.

Health Disparities in the Black Community: An Imperative for Racial Equity in the District of Columbia (Georgetown University)

The "Health Disparities in the Black Community" report was published in June 2020 by Georgetown University's School of Nursing and Health Studies. It is a successor to the 2016 report, "The Health of the African American Community in the District of Columbia: Disparities and Recommendations." The new report highlights the significant differences in health and socioeconomic conditions between Black D.C. residents and other races. Recommendations are proposed that reflect best practices from the Institute for Healthcare Improvement and other organizations.

The report utilizes a variety of secondary sources including the American Community Survey, Behavioral Risk Factor Surveillance Survey, CD.C. 500 Cities Project, and the National Cancer Institute. Eight key informant interviews with healthcare professionals were done as a primary source. Also used hospital CHNAs, as well as D.C. Health Matters data. Report uses data from before the COVID-19 pandemic yet highlights that the disproportionate impact

of the pandemic on racial minorities is due to their conditions beforehand.
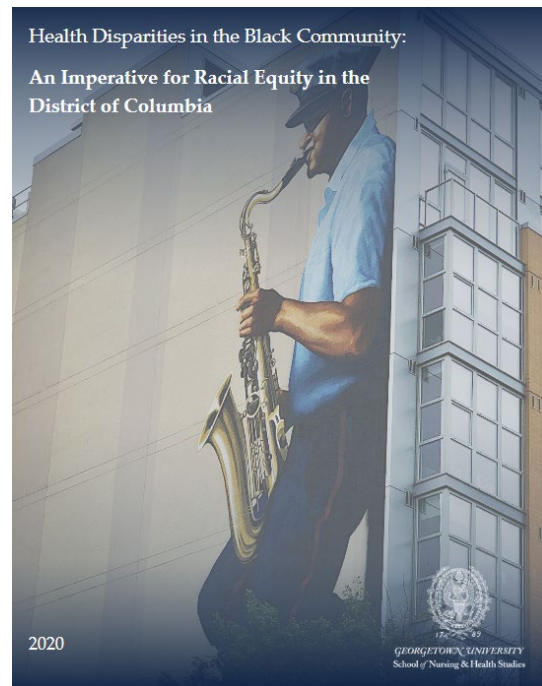
The report draws out many distinct health and socio-economic disparities between Black and White D.C. residents, as well as other races. For instance:

- 92% of Wards 7 and 8 residents are Black, and the 2019 Community Needs Index shows that these Wards have the highest needs in D.C.
- Wards 7 and 8 also have the lowest life expectancy (74.7 and 72 years respectively).
- Compared to White residents, Black residents are 2.5 times more likely to die from heart disease, 2 times more likely to die from stroke, 7 times from diabetes, 6 times from diabetes-related causes, and 2 times higher to die from cancer.
- The percentage of Black families in poverty is 22%, the highest compared to all ethnicities and racial groups.
- Annual median household income is $43,546 for Black residents, while it is $135,263 for White residents. The overall median household income in D.C. is $82,604.
- Only 26% of Black residents have a bachelor's degree. Over 90% of White residents have a bachelor's degree or higher.
- About 50% of Black residents own their homes, compared to over 70% of White residents.

The report advocates for hospitals to create formal partnerships with community-based providers to meet the social and healthcare needs of Black residents. In addition to using culturally tailored clinical services and appropriate, respectful communication vehicles with patients, the authors advocate for hospitals to reframe their business models and consider inclusive housing, local sourcing, and place-based investing.

D.C. Frontline and Essential Workers' Needs During COVID-19 (D.C. Appleseed)

"D.C. Frontline and Essential Workers' Needs During COVID-19" was published in November 2020 by D.C. Appleseed, a research and advocacy organization "dedicated to making D.C. a better place for residents and workers." The report identifies a list of needs for essential workers and the extent their needs have been met, along with recommendations and next steps to help mitigate the problems essential workers are facing, while maximizing efficiency of current resources.

The report highlights the fragmentation of resource allocation and unmet needs of essential workers. Although it originally defined essential workers as people working in hospitals and healthcare, the definition was expanded to childcare, grocery, transportation, sanitation, and postal delivery workers. The rationale was that these workers helped hospital and healthcare workers get their job done.
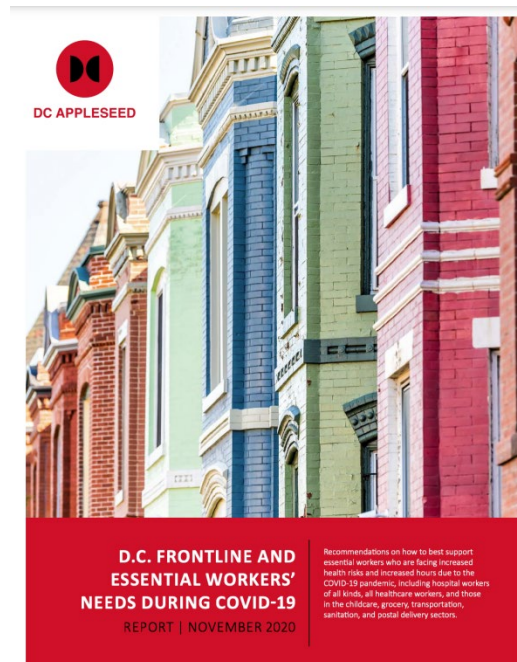
Interviews were conducted with D.C. government officials, nonprofit leaders, hospitals, and health centers. D.C. Appleseed also was affiliated with a survey to D.C. home healthcare workers. The report was released prior to the vaccine roll-out.

The results revealed obvious disparities, for example:

- Black workers were overrepresented as essential workers, as they made up 62% of all frontline industry workers in D.C.
- 25% of all frontline workers earned incomes that place them below 200% of the poverty line.
- 60% of frontline workers did not have a 4-year degree.
- 43% of frontline workers had a child or senior to take care of at home. One of the main issues essential workers faced at that time were access to safe childcare and eldercare.

In addition, many of the resources and support were only for healthcare workers at that point in the pandemic. Those that worked in childcare, grocery, transport, sanitation, and postal delivery were not given as much support. These frontline workers also have more risk of getting infected due to less priority of getting personal protective equipment and supplies.

Mental health was a big concern for workers as they faced increasing stress at work and home. Existing resources at the time, such as free subscriptions to apps, did not fully meet or protect worker's mental health.

Some hospitals had provided free transportation as well as housing for workers that needed to quarantine after COVID-19 exposure in the early months of the pandemic response. In addition, some hospital provided on-site food pantries and emergency support funds for their employees. Other resources, such as childcare, were not commonly provided by healthcare employers. These resources were distributed mainly by other organizations and federal agencies, although there were issues regarding how these resources were distributed and whether they fully met worker's needs.

The report authors recommend a centralized website collating all benefits, resources, and programs from public and private sources, as well as direct cash benefits to workers to allow them to use for their desired personal needs.

The Role of Built and Social Environmental Factors in COVID-19 Transmission (Science Direct)

"The Role of Built and Social Environmental Factors in COVID-19 Transmission" report was conducted by Science Direct to investigate whether social and environmental factors influence COVID-19 transmission. Washington D.C. was the city of focus, and multiple indicators were analyzed through the different Wards.

The report focuses on housing quality, living conditions, travel patterns, race/ethnicity, household income, and COVID-19 outcomes in Washington D.C. and relates it to transmission of COVID-19. Data was collected from the American Community Survey, D.C. government's coronavirus online dashboard, and D.C. Health Matters.

Based on the data collected, housing quality, living condition, race, and occupation were strongly correlated with COVID-19 death count. Hot spots for COVID-19 were

identified in Zip codes 20018, 20020, and 20024. Two of these zip codes have high percentage of Black population, and all have high percentages of essential workers. The highest incidence rates for COVID-19 were found in Wards 1, 4, 7, and 8. However, highest mortality rates from COVID-19 have been found only in Wards 7 and 8.

Housing quality and living condition were strong predictors for death count of COVID-19. In addition, travel patterns, demographic status, and occupation were also strong predictors. Those who are Black, over 65 years old, and/or were essential workers had higher chances of infection.

The report emphasizes how social determinants can impact health outcomes; Wards 7 and 8 have the highest level of unemployment, longest commute times and highest percentages of essential workers. Likewise, Wards 7 and 8 are impacted the most by the COVID-19 pandemic.

The report concludes with a COVID-19 determinants of health model that emphasizes addressing needs of marginalized communities to help improve health outcomes and mitigate spread. The data in this report should bolster D.C. policymakers and stakeholders to make decisions that can support those who need assistance the most.
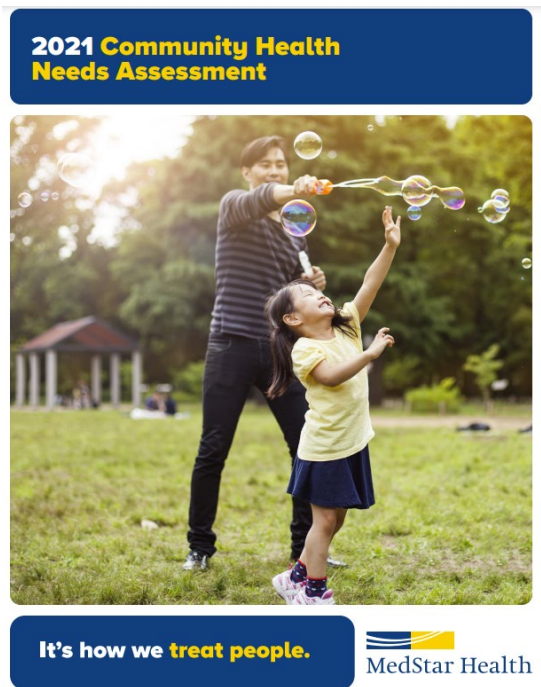
MedStar 2021 Community Health Needs Assessment

MedStar Health's CHNA report was published in June 2021 by MedStar as part of its nonprofit status requirement.

MedStar Health's primary sources for the assessment were a 23-question survey conducted during 2020, with over 4,700

responses, and community input sessions of 4,000 participants. They also used secondary data from a multitude of national and regional agencies, such as Centers for Disease Control and Prevention, D.C. Health, and Centers for Medicare and Medicaid Service. The CHNA includes detailed demographics for targeted Zip codes. The report does not focus on COVID-19, but does include some questions regarding COVID-19, such as whether respondents had been infected, or sought some kind of financial or food assistance during the crisis.

Each of the 10 hospitals in the large system name a "Community Benefit Service Area" as its population of focus. MedStar Health identified its population through hospital utilization data, disease incidence and prevalence, hospital proximity, and other factors. Each hospital is provided a list of zip codes that serve as their population of focus.

The report provides a list of social barriers and potential solutions to help address them. Barriers include high costs of housing,

health literacy, and racial inequities. Some solutions proposed are providing incentives to lower housing costs, advocating for more health education in schools, and investing more in marginalized communities. Hospitals in D.C. have noted an expressed need for mental health and substance use resources.

[The MedStar CHNA](#) identified three overarching categories:

Health and Wellness:
- Chronic disease prevention and management
- Behavioral health: substance use disorders and mental health
- Maternal and child health
- Aging and older adult health

Access to Care and Services:
- Access to affordable healthcare and insurance
- Fear/mistrust of providers
- Transportation

Social Determinants of Health:
- Housing and homelessness
- Employment
- Food insecurity
- Neighborhood safety and community violence
- Racial discrimination

MedStar highlights that racial justice and health equity are the guiding principles of their approach. It also notes a system-wide strategy to promote equity, inclusion, and diversity in recruiting and workplace culture.

2019-2020 State of D.C. Schools (D.C. Policy Center)

The "[2019-2020 State of D.C. Schools](#)" report was published in March 2021 by D.C. Policy Center, which is an annual report on the performance of public schools in D.C. It highlights the challenges students and families had with virtual learning during the 2019-2020 and 2020-2021 school years.

The report focuses on students, families, and teachers in the D.C. public school system. There was a total of 94,412 students at the beginning of the 2019-2020 school year; students of color represented 88% of enrollment in D.C. schools. For the report, D.C. Policy Center used secondary data and statistics from the Office of the State Superintendent of Education (OSSE), and held focus groups of high school students, parents, teachers, and adult learners.

Key challenges mentioned in the report were mental health concerns (for both parents and students), communication challenges, and students' access to technology during virtual learning. Students that were English learners or had disabilities faced hardships receiving accommodations. It was also difficult for families to help children with schoolwork while working.
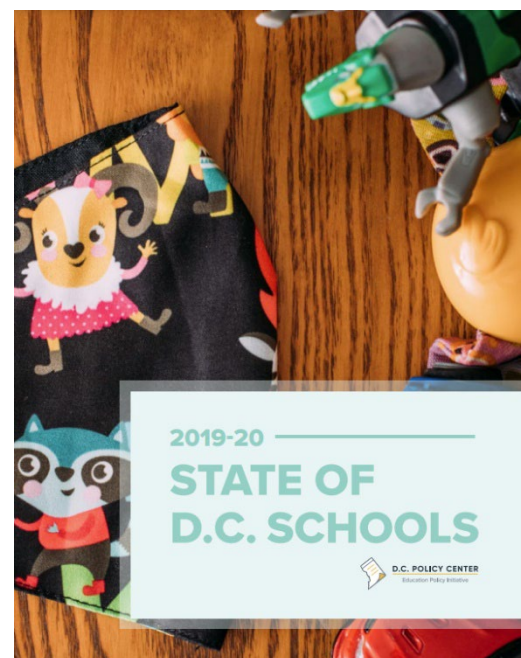
- Based on a parent survey, 41% thought that their children were somewhat anxious, and 13% thought their children were very anxious.
- 24% of D.C. children lacked broadband internet access (37% in Wards 7 and 8).
- 45% reported that their family's financial situation has become somewhat or significantly more stressful due to the pandemic.
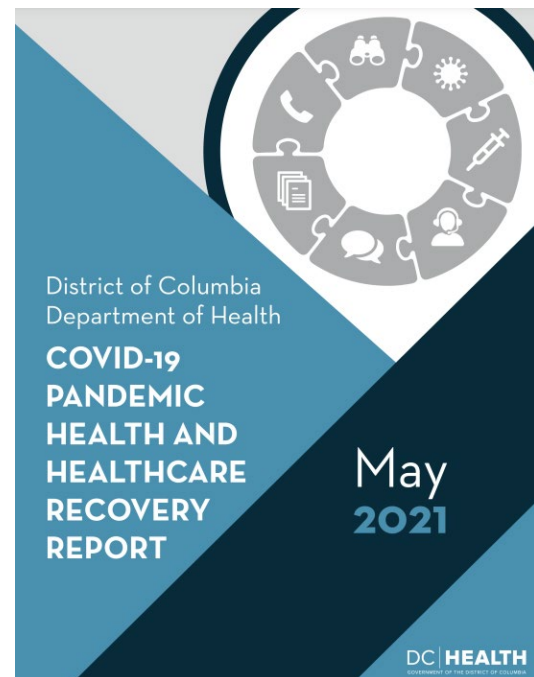
Important lessons learned in the 2019-2020 school year were to be innovative, invest in communication, and to assist meeting student and families' needs beyond school. Many schools and teachers took initiative to help provide mental health support, technology, and food address families' basic needs. The concerns for mental health should be addressed in D.C. public schools.

Pandemic Health Recovery Report (D.C. Health)

D.C. Health's "COVID-19 Pandemic Health and Healthcare Recovery Report" was released in May 2021. The report focuses on the detrimental health, economic, and education impacts caused by the pandemic, as well as D.C. Health's response. It utilizes secondary data and surveys from federal agencies such as the Agency for Healthcare Research and Quality (AHRQ), Kaiser Family Foundation, and the U.S. Census Bureau. It first recounts the pandemic response in the first year, followed by the health and social determinant effects of it on residents.

While the report's scope includes all residents, the disproportionate impact on Black and Latinx residents is highlighted. The report draws out indicators such as employment changes and disparities; in Ward 8 the unemployment rate went from 11.7% in March 2020 to 16.1% at time of release about a year later.

Survey results showed that 85% of residents say their well-being has declined during the past year, and 62% are struggling to meet their workload and balance work with other responsibilities. Perceived social isolation was a problem during the pandemic, especially for young adults, and isolation was associated with poor life satisfaction. Higher level of substance use was also associated

District of Columbia
Department of Health

COVID-19
PANDEMIC
HEALTH AND
HEALTHCARE
RECOVERY
REPORT

May
2021

DC | HEALTH

with higher perceived social isolation. Seven out of 10 Black people believed that the healthcare system treats people unfairly based on race "very" or "somewhat often."

Next steps are laid out for better health system integration and utilizing health information technology to better prepare for future pandemics. Some of these steps include better care coordination, maximizing health information exchange, establishing supply and equipment networks, and strengthening emergency preparedness.

The report also advocates for expanded scope in school-based health providers and home/patient-centered models to provide more access to health services in the community. Pipelines to healthcare through positions like Community Health Workers

A Path Forward Report

"A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families" was published in 2022 by a coalition of authors as "a blueprint for creating a successful public behavioral health system." (Children's Law Center, Children's National Hospital, D.C. Behavioral Health Association, Early Childhood Innovation Network, Health Alliance Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.) Work on the report began in 2017 and continued through the COVID-19 pandemic. The authors note that "the pandemic has only exacerbated many of those experiences and created new traumas.


and care coordinators can help promote community engagement and outcomes. In addition, health systems should utilize health information technology to provide more efficient care to patients and to share data for population health analysis.

Due to COVID-19, children have faced unprecedented levels of disruption, isolation, and toxic stress."

The report identifies a vision for the public behavioral health system for children; describe the current system in six domains (leadership and governance, service delivery, workforce, financing, information and communication, and technology); analyze gaps between current reality and the model system and best practice; and develop recommendations to bridge identified gaps informed by best practices, and input from expert stakeholders, District youth and caregivers.

The report focuses on the public behavioral health system and individuals under age twenty-one. A fundamental value of the vision for the system is "family-centered care," so parents and family members of people with mental health conditions have also been sought, analyzed, and referenced in recommendations.

While data on behavioral health needs and outcomes in D.C. is not centrally available, national reports and surveys were used as data sources. The report also dedicates a chapter to special populations, such as children experiencing homelessness, justice-involved youth, and children in foster care, among others. A Path Forward often notes the imperative to address the social determinants of health and mitigate poverty to ensure optimal health outcomes for D.C. youth.
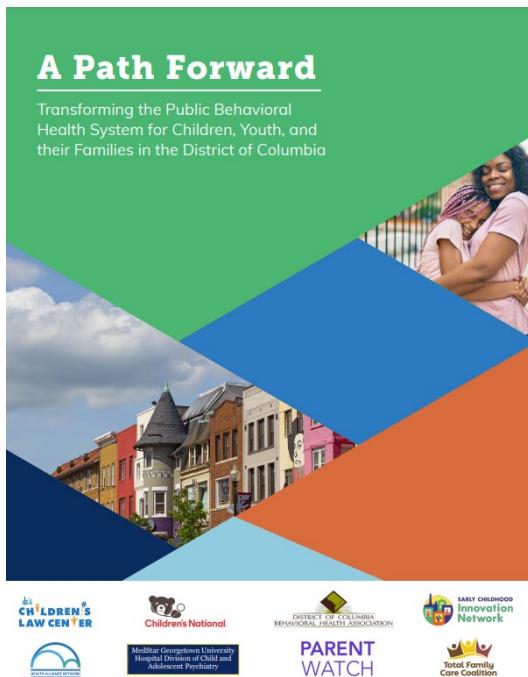
The report makes 94 recommendations to improve the public behavioral health system through government agency action, investment, or legislative means. Most recommendations name more than one actor, and some include co-leadership from Managed Care Organization contractors. Several name as non-governmental stakeholders such as the hospitals, primary care providers, Core Service Agencies, or community organizations. For example, non-governmental health system actors should participate to:

- Improve services for youth at risk for or diagnosed with substance use disorders (SUD).
- Implement strategies and incentives to create an adequate labor pool of diverse behavioral health professionals for children.
- Incorporate best practices to improve the cultural competence among providers.

- Enable integration of peer specialists, community health workers, and other nontraditional behavioral health professionals across settings.
- Incorporate best practices to improve the trauma-informed care and trauma-responsive interventions among providers.
- Develop and periodically update a comprehensive behavioral health awareness strategy for children and families in D.C., with leadership from D.C. youth and families.
- Ensure timely access to discharge summaries with CRISP.
- Increase access to affordable, high-quality behavioral health services and social supports for justice-involved youth and their families.
- Develop a system of care for transition-age youth to ensure care continuity.
- Expand the bilingual/multilingual behavioral health workforce.

Children's National Hospital, Regional Community Health Needs Assessment, 2022

Children's National Hospital (CNH) and HSC Pediatric Center (HSC) issued a pediatric CHNA in June 2022. While Collaborative members, this CHNA is different than prior

assessments as it focuses on children and families and is a regional assessment of the hospitals' primary service area, which includes D.C., and Prince Georges County and Montgomery County, Maryland.

The focus of the CNH 2022 CHNA is understanding variances in neighborhood-level conditions – such as the quality of early childhood education and access to healthy foods – that impact the opportunity for children to develop in a healthy way. The authors measured opportunity levels using the "The Child Opportunity Index 2.0" (COI) which is a composite index based on 29 neighborhood-level indicators covering three domains (education, health and environment, and social and economic), and four outcome variables (physical health, mental health, household income, neighborhood-level poverty).

CHNA process also conducted engagement activities over 2021 - during COVID-19 pandemic - with community and hospital stakeholders to understand and address perspectives (focus groups, interviews,

online input forms, and a PhotoVoice project.)

Using the COI to score opportunity levels within census tracts in the service area, CNH and HSC selected neighborhoods with the lowest opportunity levels (bottom 10th percentile) and a minimum population of 1,000 children residing within the tract. These criteria yielded fifteen tracts in D.C. and six tracts in Prince Georges County, MD.

Of the indicators in the COI ranked highest priorities by community and hospital stakeholders, the CHNA prioritizes four key focal areas for the next three years:

- Access to healthy food,
- Health insurance coverage,
- Employment rate, and
- Early childhood education.

As a member of DC Health Matters Collaborative, CNH will continue to participate in Collaborative CHIP activities while focusing on this regional, pediatric lens.

HEALTH SYSTEM INSIGHTS: INTERVIEWS WITH LOCAL LEADERS

Interviews with our member organization's leadership have been a key element of our needs assessment process through the last decade. After two years of providing services during the public health emergency, health system stakeholders had a unique and important opportunity to take stock.

In 18 interviews, Steering Committee members spoke with their leadership about where we are as a health system and as a city, where we want to be, and how to best get there.

Member Organizations

- Randi Abramson, MD, Chief Medical Officer, Bread for the City
- George Jones, Chief Executive Officer, Bread for the City
- Jeannine Sanford, Esq, Chief Operating Officer, Bread for the City
- Alsan J. Bellard, Jr, MD, MBA, Chief Medical Officer, Health Services, Community of Hope
- Kelly Sweeney McShane, MBA, President and Chief Executive Officer, Community of Hope
- David Sternberg, MHA, Vice President for Community Impact and Evaluation, Community of Hope
- Victoria Roberts, Vice President for Health Services, Community of Hope
- Donna Anthony, MPH, Vice President and Chief of Staff, Children's National Hospital
- Lee S. Beers, MD, Medical Director, Community Health and Advocacy, Children's National Hospital
- Hope Rhodes, MD, MPH, Medical Director, Children's Health Center THEARC, Children's National Hospital
- Anita L.A. Jenkins MBA, RCP, FABC, Chief Executive Officer, Howard University Hospital
- Maria Gomez, RN, MPH, Founder and Former President and CEO of Mary's Center, Mary's Center
- Hasan A. Zia, MD, MBA, FACS, President and Chief Operating Officer, Sibley Memorial Hospital
- Jessica Henderson Boyd, MD, MPH, MA, President and CEO, Unity Health Care

Ex-Officio Organizations

- Mark LeVota, MBA, Executive Director, D.C. Behavioral Health Association
- Jacqueline Bowens, MS, President and Chief Executive Officer, D.C. Hospital Association
- Tamara Smith, MS, President and Chief Executive Officer, D.C. Primary Care Association
- Patricia Quinn, Vice President of Policy and Partnerships, D.C. Primary Care Association

The same five-question script developed and revised by members was used for each interview. Top themes and narratives are described in this chapter, and are taken together with other reports to determine the Collaborative's priorities.

1. How has your organization been doing in the last 2-3 years?

2. What has changed with regards to the District of Columbia's well-being in the last 2-3 years since the 2019 CHNA, including the COVID-19 pandemic and beyond?

3. What would you say should be top priorities going forward?

4. How can the health system improve well-being in communities in D.C., especially groups that have been systemically marginalized and are experiencing worse health outcomes?

5. What policy actions would make the biggest impact to improve well-being in D.C., generally and/or in relation to what you perceive as priority areas? How would these policy changes make a difference in our community?

1. How has your organization been doing in the last 2-3 years?

Impacts of COVID-19

It is impossible to discuss recent community health and organizational experience separate of the COVID-19 pandemic. The onset of COVID-19 in early 2020 was a "very scary and different time," which changed fundamental behavior and social systems, caused unprecedented stress, and strained business models. "The stress of the pandemic built and built and built, and pushed on an already fragile infrastructure for many," said one interviewee.

Healthcare providers engaged in heroic efforts to respond to community needs. This began with scrambling for appropriate protective equipment and supplies, and contending with new care protocols as more patients with COVID sought acute care. Initially, hospitals and health centers may have postponed or canceled elective procedures and well visits, taken care virtually, or paused services indefinitely.

"I like to keep us optimistic and not reminisce so much about the horrible things and what didn't get done, but what we learned from it, and how we can move forward and learn to be more efficient, effective, and supportive of the people that work for us."

– Maria Gomez

As the pandemic progressed, organizations pivoted to serve as hubs for walk-up COVID-

19 testing, then special vaccination initiatives, partnering with D.C. Health in these new services. "We've committed a lot of resources to COVID." This investment must continue as the pandemic extends into its third calendar year. Organizations have had to respond to the new threats and expectations while continuously supporting clients, patients, and employees. Interviewees reflected that "the pandemic has set us back, but also taught us to do things differently."

Workforce Retention and Attraction

The pandemic had a significant, undeniable impact on the healthcare workforce, which interviewees described as burned out, taxed, exhausted, tired, and disengaged. After multiple waves of case surges, and a multitude of changes and increased demands, one interviewer noted: "We can't understate how close to the brink of collapse we've come on several occasions or, because the effects are cumulative, just how close we might get if we don't do some course correction to shore up some parts of the healthcare sector that are still extremely vulnerable."

> *"At this moment, the health team is exhausted and trying to figure out what comes next."*
> – Victoria Roberts

Health professionals have been working harder than they have ever worked. Staff were asked to take more on within the clinic, to meet surge demand and cover colleagues who are sick, quarantining after exposure, lost childcare, or leave the work altogether. "I think [leaders and community] assume everybody always will hang in there, because they always have hung in there," noted one leader, "but I think that's a dangerous assumption, based on what I hear and see."

This is already evident in the "exodus of talent from acute care hospitals that suffered a great burden" during the pandemic. Some providers lost workers after the imposition of COVID vaccination mandates. The workforce is clearly at a crisis point.

Leaders are seeing high levels of staff turnover and difficulty recruiting new employees, noting highest demand for nurses, therapists, and other essential positions that cannot work remotely, such as medical and dental assistants. They are re-thinking staffing models and "using talent creatively," such as working at the top of their scope of practice. Some have experimented with new pathways to bring early-career professionals into the organization as they get licensed (ex: dental assistants, social workers), and working with more students and medical residents.

The community depends on the sector's resilience and staff retention, which requires focus to improve individual well-being, as well as creative systemic planning. Providers recognize the urgent need for staff to feel valued and to be adequately compensated. "If we need to pay more, where's that funding? Or if we need to reduce workloads, how can we make that sustainable?"

Re-Creating the Care Environment

> *"Everyone from the acute care hospitals to our public health leaders and the FQHCs, rallied together [during the pandemic] and did a really great job in creating processes and programs on the fly."*
>
> – Hasan Zia

The re-creation of the healthcare environment over the last several years has been exhausting, but interviewees also noted successes. Organizations have had to change the way they operate, showing tremendous flexibility and resilience.

The health landscape has added new assets, and the local Medicaid program has continued a transition to managed care models of reimbursement. More resources have and will locate in Ward 8, with lawmakers and leaders hoping to create a coordinated health system east of the Anacostia River. All while delivering completely new types of services like COVID-19 testing, vaccinations, treatment options, additional clinical follow-up, and care coordination for those who tested positive.

Telehealth and Remote Service Delivery

The impact of the transition to "telehealth" and remote service delivery was years in the making, but implemented in week at the outset of the pandemic. Providers and payors rolled-out the modality going much faster than anyone anticipated, to large groups of patients. "We've learned that innovation and progress are possible." Many organizations reported that telehealth still constituted up to a third of services delivered in 2022.

Telehealth was certainly essential to serve individuals and keep the organization open during COVID. Organizations found varying degrees of utilization, either due to preferences, barriers or technological literacy – for both staff and patients. Some viewed telehealth as more accessible for some, and enabled providers to "put eyes on patients" vulnerable to abuse (especially children and older adults.) Others noted that it may not suit all patients or services if they do not have appropriate privacy, or sufficient technology access.

> *"How can we leverage technology for our patients in a way that helps our community without alienating them?"*
>
> – Jessica Boyd

Financial Investment from Government and Philanthropy

The impact of COVID-19 was not as financially disastrous as it could have been, due to the District's financial reserves and "big actions" to address provider needs and stabilize infrastructure. Funding and regulatory changes from the government allowed for the telehealth transformation. Interviewees expressed gratitude for support from the local and federal government during the pandemic that

allowed organizations to maintain their stability. They also recognized how the local "safety net" for residents is stronger in D.C. than other places in the country.

Leaders recalled the sense of "we were all in it together," and responsive collaboration between agencies and providers. Interviewees also noted the ways that local philanthropic organizations offered more operating support and other flexibility with using funding.

The needs of the pandemic will change, but leaders hope to see continued investment in innovation and the safety net. For example, investment in early childhood health ("birth-to-five") initiatives and parental mental health, support for families with young children, has been notable in recent years.

"That is definitely going to have a long-term impact on lots of outcomes, both health-related and socio-economic outcomes."

> *"I don't want us to lose track of what people were willing to do at a moment of crisis to say, 'this is how we're going to take care of each other.' Then rolled up their sleeves and did it. There is a different sense of what's possible from seeing how much we can pivot and approach things differently. There's a tale of possibility for every woe."*
> — Mark LeVota

Improved Communication and Recognition of Interdependence

> *"A new pandemic will come, and it could be worse. COVID gives us a sense of what to do to prepare for next time. It was a warning, and we need to learn from it."*
> — Alsan Bellard

The heat of the pandemic forged provider collaboration, sharing of information and resources, and ability to communicate across entities – "which we should preserve." Interviewees spoke proudly about how organizations and sectors came together, "seeing the different strengths and roles of each player in the health system and our dependency on one another.

2. What has changed with regards to the District of Columbia's well-being in the last 2-3 years since the 2019 CHNA, including the COVID-19 pandemic and beyond?

Physical Health Poorer

COVID-19 is the direct cause of a high level of mortality and morbidity among District residents, including the impacts of "long COVID." Additionally, interruptions in care during the pandemic resulted in lower volumes of preventive care, screenings, decreased prenatal care, and less robust management of chronic conditions, like Diabetes and hypertension. One interviewee observed and "Pre-COVID gaps in inequality, health outcomes, life expectancy, etc., may just continue to get bigger. That unfortunately tracks around income and geographic lines in D.C."

Worse Mental Health and Substance Use

> *"We know that far too many people who needed mental health or substance use treatment were not getting it, and felt like they had a hard time accessing it, and sometimes reported that even when they got it, that it wasn't an appropriate level of quality, and that it didn't respect their culture and community in ways that they needed to feel comfortable to expect treatment to be successful. Then we had a pandemic, and none of that made life any easier."*
>
> – Mark LeVota

Since 2016, our CHNAs have noted a lack of wide-spread access to appropriate, high quality, respectful mental health and substance use services despite high need in D.C. Over the last decade, D.C. has observed an alarming increase in opioid overdoses, due to historical drug use as well as more lethal drugs (ie. fentanyl).

COVID exacerbated the mental health crisis, locally and nationally, with a miasma of social isolation, anxiety, depression, despair, and disconnection from care. The shortage in mental health providers meant that higher needs could not be met; for example, there has been lower enrollment in substance use treatment despite higher need. "We will need to find the clinicians to support all that mental health work."

In our interviews, "distress and disenfranchisement" was also tied to the experience of, and cultural conversation about, racial injustice. Some recalled the turbulence of national politics that permeated the local landscape, from federal government shut-downs to protests after the murder of George Floyd and the summer of "racial reckoning" in 2020. Occurring during a surge in community violence, the community was experiencing "a very real social phenomenon of death and dying."

Justice and Equity Work

Current events and the pandemic both precipitated conversations about anti-racism, historical abuses of people of color by institutions and the medical field. As COVID disproportionately killed and hospitalized Black, Latinx, and Native Americans across the country, "we were understanding so much of health outcomes is not related just to the direct care that is delivered." Importantly, while organizations have become more fluent in the language and story of systemic racism, and people see how critical that is to outcomes, the commitment to center "anti-racism" needs sustained attention.

There were several case studies in the intersection of marginalization with the pandemic. One interviewee remembered that when the District's FHQC's received its first batch of COVID-19 vaccination doses, "we saw white community members had more access to the vaccines than our usual Black and brown clients" due to online registration requiring internet access.

> *"COVID really pulled back the covers on what a lot of folk already knew existed: Why are there parts of the city and people that look a certain way, who are chronically, disproportionately impacted by sub-optimal health outcomes and others are not. COVID-19 just really made the stark contrast clear, and you couldn't ignore it."*
>
> – Hope Rhodes

"Vaccine hesitancy" played out with lower uptake among Black residents, attributable to a legacy of racism in scientific and medical fields. Distrust in the healthcare system and government recommendations were "very entrenched" among some neighborhoods and patient populations. Leaders we interviewed acknowledged and mourned the cultural distrust and disconnect, taking it on as work to be done.

Importance of Social Conditions of Health in the Spotlight

A frequent theme in conversations was how the COVID-19 pandemic "brought to light" the importance and impact of social conditions, especially housing, food access, and the social environment.

Physical well-being requires access to good food, yet food insecurity has increased, especially among lower income communities. It requires access to good recreation, but some neighborhoods are not safe for kids to play outside. Violent crime and trauma were also often noted. Many, especially those working with children and parents, lamented the educational and social impacts of school closures and remote schooling. "Access to quality education is the civil rights issue of this generation."

Meanwhile, housing prices climb and housing instability continues. People may be displaced due to costs, and what one interviewer described as "divestment from longstanding residents." An interviewer celebrated the District's housing investments during COVID, especially with handling a federal administration with unsupportive policies. For example, programs to house individuals in hotels and offering housing vouchers for units. On the

other hand, interviewees described the housing support system in D.C. as a "broken," "over-bureaucratic" mess. The people who are most at risk due to barriers, one stated, are the very young and very disenfranchised.

Interviewees felt that social support services need to be better integrated into healthcare and should become part of the payment process.

"COVID has brought to light many of the social drivers of health and the impact on communities of color. I think it has also brought greater awareness to the need for housing, food deserts, to address substance use and behavioral health that hit communities of color particularly. From a quality-of-life perspective, we are not doing well. Certainly, we have coverage and healthcare services. But do people feel like their communities are thriving? Absolutely not. Do we need more investment in the community? Absolutely."

– Tamara Smith

Economic and Social Distress

Health providers have watched families stuck in patterns of instability during the pandemic due to losing loved ones and job changes. The general stress and disconnection - from each other and social services - impacts wellness.

Society changed during COVID, but one interviewee believed it ultimately made privileged people more comfortable. It was a "missed opportunity for innovation if we had rebuilt society to work for our most vulnerable and our frontline workers." Wages and social supports for workers have not met increased needs. COVID's impact on general workforce was significant, especially stress of not being able to participate in the economy or earn sufficient income. Several interviewees believed the District is "more segregated than ever before."

Lost Focus on Prevention Care and Delayed Care

Many health providers saw less of their patients altogether during the pandemic and fear the impacts for the next five-20 years in health outcomes. During the pandemic, for example, children could not access education where they may have received special supports and interventions, such as speech therapy or behavioral health counseling. "I shudder to think what that will look like for certain populations down the line."

Across populations, providers feel they are still playing catch up on routine screenings and exams. Providers feel they have built bridges to new services related to COVID-19, while other essential services "have fallen through cracks," like immunizations, cancer screening, medication-assisted treatment (MAT) for substance abuse, or pre-exposure prophylaxis (PReP) for HIV prevention. Care coordination – the organization of connections and referrals across a patient's care – is struggling, stalled in progress with the massive system disruption.

Era of Innovation and Community-Led Efforts

Themes of exhaustion and struggle were forefront in our interviews. However, interviewees also celebrated the sense of innovation found in new services and supports which proliferated to meet community needs. Alongside the government and philanthropic investments, mutual aid organizations and grass-roots solutions were explicitly community-led, intent to change the status quo of service delivery when the landscape was especially chaotic. There are lessons to be learned from these models in an evolving dialogue about trust and power; we discuss the need for community leadership in system change later in this chapter.

Theme: Significant issues or trends of last 2-3 years in healthcare organizations and D.C. community broadly	**Frequency**
Workforce issues (retention, attraction, burn-out)	16
Re-creating the care environment & landscape	15
Telehealth & technology changes	14
Mental health and substance use (Poorer, high need)	11
COVID-19 pandemic presented major challenges	11
Good financial investment from government in crisis	8
Economic & social distress in community	6
Impact of COVID on Social Determinants of Health & disparities clear	6
Recognition of interdependence & improved partnerships amid crisis	5
Racial justice issues and equity work present	4
Lost focus on prevention and primary care; delayed services	4
Increased violence in communities	4
Housing (unaffordable, leads to displacement)	4
Communication between stakeholders has improved	3
Community leadership, innovation rising	3
Food access & food insecurity	3
Education stresses (childcare, virtual learning) for kids and families	3
Distrust of health system apparent	3
Difficult to operate organizations, financially	3
Disparities in access to care persist and have come to light	3
Care Coordination still struggling	2
Physical Health poorer	2
Organization is successful and seeing impacts of work	1
Remote work changed workplace	1
Insufficient access to recreation	1
Emergency preparedness needed	1
Segregation increased	1
Government structures and payment landscape has changed	1

3. Since 2016, the D.C. Health Matters Collaborative has focused on four priority areas: mental health, health literacy, care coordination, access to place-based care. Would you say these – or something else – should be top priorities going forward?

The Collaborative has continued with the same four priorities over several iterations of needs assessments for one main reason: they continued to be significant, long-term challenges to D.C.'s overall health.

Interviewees for this assessment made the case to keep most of these areas of focus, noting ways the landscape has changed within topics, while adding several to the board.

Racial Equity

Any priorities and projects should start from a racial equity viewpoint, as we see the healthcare system is severely affected by systemic racism. The system's success with any of the issues described here is contingent on the ability of systems, organizations, and individuals to address stigma, racism, discrimination, cultural relevance, power imbalance, and inequality.

Care Coordination

> *"We need to focus more on the intersectionality between different healthcare providers, schools, and community supports."*
>
> – Donna Anthony

It is well understood that meaningfully coordinating patient care is essential to healthcare delivery success, and that the system will end up paying more in the end without this coordination. Yet, D.C.'s system is "just as far from figuring it out as we were three years ago." Providers listed roadblocks and speedbumps related to transitions between levels of care, in coordination of services, and in sharing records and intake forms across providers. Individuals still can't maneuver the health system easily.

"We can still be duplicative, conflicting, and fragmented." In a moment when staffs are already over-extended, it is especially important to use workforce and resources efficiently. The system needs to innovate in data sharing, collaboration between providers, intersections of workflows, and streamlining of systems, however, "finances are always the sticking point."

When it comes to some services, such as behavioral health treatment, there aren't enough services available, full stop. One hospital shared that the length of stay has increased because they are unable to discharge patients to appropriate, timely post-acute services.

Mental Health

Mental health needs have only escalated since 2016's assessment. Interviewees felt strongly that mental health should continue to be a Collaborative focus. Some noted that awareness about mental wellness has increased in recent years, with less stigma, more open conversation, and increased understanding of trauma. However, access to services has *not* improved, especially related to substance use disorder (SUD) treatment. Further, while disorders may be distributed throughout the population, the ability to cope and live with mental health challenges is very context-specific, underscoring again the importance of work toward equity and meeting social needs.

Health Literacy

In past years, Collaborative work around health literacy related to understanding between patients and providers. Interviewees noted that, in the COVID pandemic, the topic took on a much more expansive character. Health literacy is more important than ever, but is now about filtering external sources, battling "my own research," and "misinformation."

Some interviewees felt the Collaborative could continue to take on health literacy projects, especially issues that interrupt access to care, such as translation services, and programs to improve general literacy. Notably, the misinformation about COVID points back to the need to improve trust in the health system. On the other hand, some interviewers felt that recent years have revealed a "huge" and "intangible" problem, beyond our scope. "If health literacy is actually science literacy, how can we really get on top of that?"

Place-Based Care

> *"People are more likely to access care in an environment where they feel safe, secure, welcome, that there are people there who look like them, people who can hear them."*
>
> – Jacqueline Bowens

"Place-based care" is an umbrella term the Collaborative has defined as "services that meet people where they are." The selection of this priority area in 2019 responded to closure of hospital services east of the Anacostia River. Interviewees felt that, generally, there has been improvement in access to places for care. Two specific service types – reproductive health and mental health – were called out as still lacking. Place-based care includes the need to integrate services into community settings like schools, home visiting, mobile units, and telehealth.

Services must also be culturally and linguistically appropriate, trusted, consistent, high quality, respectful, and available without long waits. Ideas such as open or flexible scheduling for appointments may be inconvenient for staff, but more accommodating of the community. Leaders also noted that it is a financial lift to operate services like mobile units and home visitation. Providers need to "drum up dollars" for these kinds of services when the reimbursement from payors is insufficient.

Workforce Development

> *"It is desperately important to create new pathways for workforce development. It was already on everyone's radar five years ago, these workforce shortages. It's just much worse now. We must be creative about pipelines and creating more clinical opportunities, such as in nursing and mental health, and other supportive roles as well which have the potential to be good, stable jobs. Will healthcare be a major employer in D.C. in five years? Yes, but how will we educate and train this workforce, especially from Ward 8? We need to stop poaching from each other, because that is just increasing costs. We must take this seriously."*
>
> – Victoria Roberts

As discussed in length throughout our interviews, the District urgently needs an overhaul of the workforce development pipeline and creation of opportunities for employment. While our members have called out the need for workforce development among health professionals especially, District residents and families need broad access to diverse and sustainable opportunities for earning income and creating wealth, which can stabilize all other socio-economic aspects of life.

Social Conditions of Health

Several interviewers encouraged the Collaborative to prioritize work improving other drivers of well-being, like housing and food insecurity. "Everyone is kind of moving in the right direction and trying to focus on that work," but meaningful solutions to "whole-person needs for social care" will require considerable leadership, partnership, data-sharing, and leverage to fully realize.

Many noted, however, that leadership and agencies should derive their goals *from* residents and the most impacted populations, creating opportunities for them to share their opinion and lived experiences to direct system changes.

Other suggested priority topics which were named less frequently included outreach and education related to primary care, addressing community violence, improving data sharing between stakeholders, better community engagement on the part of hospitals, improving trust between health providers and residents, and the custodial care needs of the aging population.

4. How can the health system improve well-being in communities in D.C., especially groups that have been systemically marginalized and are experiencing worse health outcomes?

After discussion of the challenges and barriers to be overcome, interviewees generated an extensive list of possible actions for the health system.

Community Outreach and Trust-Building

- Going into the community, neighborhoods and to events where people are gathering to deliver healthcare (ex: COVID testing and vaccines), the "old fashioned way."
- Commitment to education and awareness campaigns.
- Engage in conversations with community and responding to questions (ex: town halls with unhoused people about vaccine.)

Care Coordination

- Increase communication among provider networks, collectively screening and identifying gaps in care.
- Coordination and delegation of duties among providers without competing. Recognize strengths and assets of each

partner, as well as hold each other accountable for quality.
- Take a holistic and multi-generational approach to improving well-being. Not thinking about caring for adults and kids in separate silos, but rather recognizing "one big ecosystem."
- More accessible, connected health and human services entry points.
- Create a "no wrong door" system, wherein patients have more choice about where to get care.

Data Sharing

- Share data among the health system without compromising privacy. (Ex: use of Chesapeake Regional Information System for our Patients [CRISP] should be more widespread.)
- Incentives throughout hospitals, agencies, and community-based organizations to use shared systems, to achieve better outcomes.

Improve Equitable Access to Care

- Going into neighborhoods with care, especially specialty services.
- "Safe passage" programs to health centers in areas with safety risks due to violence or traffic.
- Convenient operating hours, appointment openings that are easy to access, and staff that can support all these operations, such as walk-in clinics and open scheduling.

> *"One thing that I think about in regards to poverty is the poverty of time. Not just food and housing. How are we giving people valuable time back? So, less time commuting, leveraging telehealth so a mom doesn't have to take her kid on two buses to get to a 30-minute appointment. That means more time for them to earn money or to be together as a family. More time for them to do homework, and all of the things that make an impact. It's time for us to be really creative."*
>
> *– Donna Anthony*

- Ensuring presence of healthcare providers who understand and "look like our patients."
- Shift expectations on patients to navigate, manage, and "do things" like labs and pharmacy trips, which all act as barriers. "We should do these things for people, if necessary, pick up things they can't handle."

- Increase access to referrals to specialty providers (i.e. oncology, pulmonary).
- Improve medical record accessibility, which provides additional portability for care. "HIPPA is the Health Information *Portability* and Accountability Act, after all."
- Local hospitals and academic centers could translate research into actionable improvements to benefit the community, "to take that research and do better by our patients."

Improve Patient Experience

- Quality improvement based on patient feedback. "Listen to people that actually receive the care, on a consistent basis. Aggregate what they tell you in systematic ways and adjust your behavior accordingly."
- Instead of solely focusing on costs, hospitalization, or death metrics, which ignore those who never engage or have bad experiences in the health system, also look at beneficiary experience surveys as measures of success.
- Collaborate across the system to design new interventions, encourage ongoing engagement.
- Install third-party accountability structures and patient advocates. (For example, more patient representation on boards.) "You can't be accountable if the folks you are trying to work for aren't in the process."
- Transparency about organizational policies, improvements, outcomes, metrics, and priorities to the community.
- Honesty. For example, admit when organizations are short-staffed. "Don't overpromise, don't ruin trust."
- Invest in ways that are comfortable to provide feedback.

> *"How we treat people will show itself in our health outcomes. If they felt that nobody cared about them in that visit, they won't follow up with treatment and prescriptions."*
>
> — Anita Jenkins

Culturally Sensitive Care

- Mandatory cultural sensitivity training for all health professions.
- Ensure language services are available so all patients feel welcome.
- Safe and inclusive environments, reflective of the community served, and making people feel welcome, heard, understood.
- Fully implement trauma-Informed care, which is part of culturally competent care.

Invest in Workforce Retention and Development

- "Focus on making our healthcare workers well." Make investments to ensure the health and wellbeing of our frontline workers, including pay, flexibility, good treatment.
- Focus on workforce morale efforts to retain and engage staff.
- Create more partnerships between education institutions that are training the next generation of healthcare workers. "So many people come to the district to get degrees and then leave. How are we keeping that talent?"
- Expand workforce beyond "traditional profiles." For example, nurses in Labor and Delivery hospital units who use wheelchairs and are doing very well.

- Initiate strategic planning, such as an innovation lab and human-centered design research.
- Focus on equity in workforce development, bringing the resident community into the workforce with a livable wage with pathway of advancement.
- Revise hiring process to account for lived experience.
- Empower resident community with skills and capacities for health and healing, such as training like Mental Health First Aid.

Community-Led Solutions to Community Challenges

- Create opportunities for community members to share their experiences and ideas.
- Align with initiatives at the community level, especially to address socio-economic conditions. For example, the Ward 8 Community Economic Development project.
- Deploy resources and energy to go to where people are (health center, church, schools, etc.).
- While developing and implementing tools in the clinic like social needs screeners, and seek to understand if patients and families *want* to be screened for those things.
- Consult with providers and community groups but recognize these cannot be a proxy for "the community."
- Take time to ask people what their greatest challenges are, instead of assuming.
- Troubleshoot with patients about how to get to all appointments. "Engaging people is like preventive medicine."

Respite Opportunities

- Support community members who have taken on so many different roles for their families over the last two years with respite opportunities.

Re-Defining "Wellness" to Include Social Conditions

- Recognize the health system's interest in improving housing, education, safety, inequality, and economics.
- Create income and education opportunities, increasing communities' capacity to meet their own needs.
- Improve transportation infrastructure and supports.
- Ensure access to safe, affordable housing. "Everything housing related!"
- Face climate change and how that's impacting our work, healthcare, and community life.

Continue Anti-Racism Work

- Recommit to the Diversity, Equity and Inclusion (DEI) initiatives in the workplace. "We shouldn't have to have a 'George Floyd moment' to keep it at the forefront."
- Bring more people of color into leadership to reflect communities served.
- Address institutional racism and implicit bias, from personal learning to organizational procedures for recruitment, retention, vendors and contracting.
- "Get comfortable and unafraid" speaking up about disparities, unfair treatment, micro-aggressions, etc.

Address Vaccine Hesitancy

- Push beyond vaccine hesitancy to improve the COVID-19 vaccination rate.

Emergency Preparedness

- Convene a city-wide summit to de-brief about our COVID experience and to prepare for next disaster (whether viral, weather, or other).

Engage in Advocacy and System Change

- Embed advocacy work into organizational culture to impact larger policies.
- Root out issues where we see them impact health or other factors and spend resources and energy to address systemically.
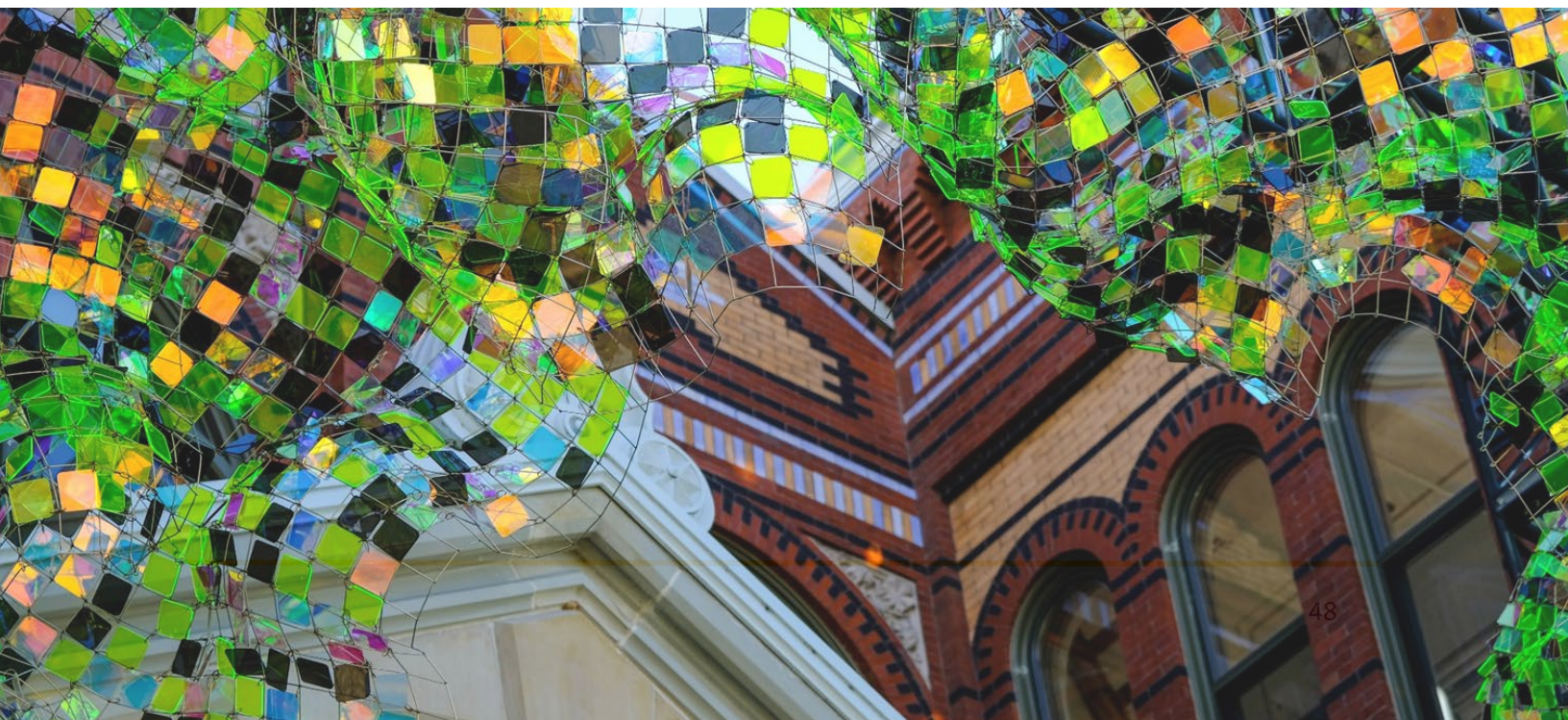
5. What policy actions would make the biggest impact to improve well-being in D.C., generally and/or in relation to what you perceive as priority areas? How would these policy changes make a difference in our community?

In interviews, health leaders lauded D.C. as "resource rich" community, and recognized opportunities for systemic policy changes, including government regulation, funding, payment models, and more, to improve community health.

Outreach About Available Services and Benefits

- Ensure people know what benefits and services they are eligible for and how they use the system, even before they need them.

Data-Sharing Infrastructure

- More intentionally collect and employ data to plan District services. Invest where data demonstrates an improvement in outcomes.
- Enact "Health in All Policies" framework, including emergency assistance, human services, law enforcement, environment, etc. "Every department should have a plan related to health impact."
- Enhance policy infrastructure around data collection and data sharing, while protecting the rights of individuals.
- Study promising data screening work from other jurisdictions around functional assessments. "Money should follow a patient throughout systems."
- Collaborative, cross-sector, centralized data collection, assessment, tracking, and planning.
- Shunt resources into the spaces and places where disparities persist.

Integrating Healthcare into Schools

- Continue to build healthcare delivery infrastructure within schools, to keep children healthy and keep them learning.

Workforce Development

- Create an environment to attract healthcare talent by addressing cost of living, using incentives like loan repayment programs, etc. "Don't create competitive disadvantages for ourselves against regional employers."
- Look critically at systems and assumptions about professional licensing. "Boards may need to rethink their duty to 'safety' and current processes – there is a safety issue when there aren't enough providers to serve."
- Update regulations and licensing requirements, recognizing new landscape with telehealth, patients could be served across borders, and interstate reciprocity.
- Focus on building the behavioral health workforce (social workers, psychologists and other positions), especially "culturally congruent" providers and current residents. "Make it lucrative," paying equal to its value in society.
- Consult economic and labor experts on ways to improve workforce retention and wellness.
- Increase health professional pay, with more transparency in salary structures across the system.

- Broaden practical workforce development within K-12 settings, beyond the emphasis on college.

Address Poverty and Inequality

- Have open conversations and enact thoughtful policy regarding the wealth gap by race and neighborhood. (Examples include tax increases and "baby bonds.") "The racial divide is just so obvious, and we can't really move forward without addressing it."
- Provide direct cash payments and tax credits, such as universal basic income programs and child tax credit which showed results in reducing poverty.

Social Supports

- Incentivize increased coordination around meeting social needs.
- Automate enrollment in programs, as easy as we make it to register to vote at the Department of Motor Vehicles.
- Use infrastructure support and technical assistance to connect nonprofit providers to each other.
- Improve understanding and sensitivity among government employees about the barriers of social conditions, to improve client experience and reduce stigma.
- Guarantee everyone has access to the internet, regardless of income, and support people can call on (like interpreters) to access technology.

Housing

- Remove barriers to housing. As an example, reverse the policy that disallows low-income public housing from including undocumented immigrants.
- Affordable housing for healthcare workforce.

- Mitigate the displacement of low-income residents.
- Address violence in communities to prevent disinvestment and economic distress in neighborhoods.

Revise Investments and Reimbursement Models

- Decrease barriers to and burdens of funding for individuals and organizations from foundations and government.
- Deploy "Head Start" model to all kinds of supports; rather than narrowly targeting individual services, give services to a whole group. A whole cohort or population benefits from investment when a certain number of members are eligible for designation.
- Include "well-being" as a metric in the health system and in reimbursement.
- Promote quality of services over quantity, for example, by moving towards "value-based care."
- Compensate enough for seeing patients that that organizations serving higher-risk patients – those who are medically complex or require referrals to other services – is sustainable financially. For example, typical physician appointments are about 20 minutes, where 40 minutes per visit may be more appropriate.
- Revise payment models to cover care coordination.
- Consider allowing providers to collect a "facility fee" for services delivered by mobile units, which would be available in the clinic.
- Improve communication and collaboration between government and community-based organizations.
- More opportunities for health providers to work together.

- Implement an Interagency Council on Behavioral Health including consumers, families, and providers to collectively assess and address needs and barriers.

- Share power with community members, for example, to determine how resources are spent.

Theme: Health system actions and/or policies to improve well-being in the District of Columbia	Frequency
Healthcare workforce (retention, development)	16
Improve equitable access to care	8
Revise investments/pay models/reimbursement rates	8
Meet housing needs	7
"Quality" improvement based on patient feedback	6
Community-led solutions to community challenges	6
Continue DEI/anti-racism work	6
Care coordination improvement	5
Improve social conditions of health	5
Data Sharing & Collection	5
Safe and inclusive environments (Culturally sensitive care, language access, trauma informed care)	4
Increase income and education opportunities	4
Address poverty and inequality	2
Emergency preparedness needed	1
Respite opportunities for families/parents	1
Reduce burden on patients/families "give people time back"	1
Better transportation	1
Address Climate Change	1
Medical record accessibility	1
Address vaccine hesitancy	1
Ensure universal internet access	1
Prevent violence	1
Low birth weight	1

PRIORITY AREAS FOR ACTION

Summary of Key Themes

There are many intersections between the top issues across local reports from recent years – including community health needs assessments by D.C. Health and MedStar Health – and those in our interviews. Stand-out themes and concerns include:

- Worsened behavioral health and mental well-being (including, but not limited to, social isolation, substance abuse, stress created during the COVID-19 pandemic, poor life satisfaction).
- Recognition of the significant impact of social needs and conditions that impact well-being (access to childcare, housing, employment, food insecurity, transportation).
- Decreased neighborhood safety and need for violence prevention.
- Barriers in accessing healthcare (such as access to and gaps in insurance coverage, fear or mistrust of providers, institutional racism and experience of discrimination, communication challenges, life circumstances).
- Acute and disparate social and healthcare needs of Black D.C. residents, which leads to worse chronic disease burden, higher mortality rates from COVID-19, less access to wealth and income opportunities, and lower life expectancy.
- Impact of patient/resident access to technology and online platforms to access healthcare, social and educational services, as well as need for providers to maximize health information exchange for care and coordination.
- The importance of emergency preparedness for government systems, health providers, and individuals.
- Urgent need for adequate labor pool health and behavioral health professions, including traditional and nontraditional positions.
- Essentiality of cultural and linguistic competence and trauma-informed care among providers, and appropriate, respectful communication with communities.

Leveraging existing assessments reduces duplication and aligning our priorities with other initiatives allows us to achieve shared outcomes for our community. Going forward, we will continue to have discussions about areas for partnership in the development and execution of our respective community health improvement work.

Prioritization Process

Between February-April 2022, the D.C. Health Matters Collaborative engaged in a process to select key areas of focus for future work (to be further defined in the CHIP later this year). The prioritization process included analysis of themes from reports and interviews, a retreat to review

and discuss themes, a facilitated prioritization exercise, and a formal vote.

Collaborative members agreed to continue its practice of limiting priority areas to four or less, to allow for better focus and impact. Criteria considered for selection included:

- Alignment with other organizational assessments and initiatives, and strength of existing partnerships
- Frequency of theme

- The capacity of the Collaborative and individual members to enact positive change on topic, including expertise, authority, and interest
- Feasibility of change in three years
- Past history with content matter
- Fit within a health equity lens
- Appropriateness for an "upstream" PSE framework

Selected Areas of Focus for 2022-2025

With the above criteria, steering committee members ultimately prioritized three areas of focus, which will be further defined and delegated through the CHIP process.

1. Mental Well-Being
2. Equitable Access to Care (and everything patients need - including coordination of that care, housing, and social support services.)
3. Community-Based Workforce Development (including retention and development of healthcare workforce.)

The selected focus areas are broad and inclusive of many of the themes described throughout this assessment, and there is certainly no shortage of work within each issue. Further, the collaborative commits to these fundamental values for future work:

- Residents deserve safe and inclusive environments, including culturally sensitive care, language access, and trauma-informed care.
- Community-led solutions will solve community challenges.
- Commitment to equity and anti-racism is necessary in all efforts to change policies and systems.
- A focus on social conditions, like housing and employment, is essential to increasing well-being.

CHNA regulations also require hospitals to explanation why other areas *not* chosen as priorities. Due to the above criteria, certain significant health needs listed in the Summary Key Themes will not be addressed as explicit priorities (e.g., neighborhood safety and violence prevention, emergency preparedness, cultural and linguistic competence). However, we believe that the interconnectedness of social conditions and health outcomes means that some improvement to priority areas may positively move these other "downstream" issues. Several of the key theme needs (e.g., social determinants of health access, disparity in meeting needs of Black residents, access to technology) may fall within the "equitable access to care" category. These topics will be further refined in the CHIP process as recommended actions are developed. (See next chapter, page 55.)

NEXT STEPS IN COMMUNITY HEALTH IMPROVEMENT

With the three priority needs identified, the Collaborative will now consult community stakeholders to develop a Community Health Improvement Plan that outlines concrete plans for addressing community needs. The CHIP document is due to be published in November 2022.

The Collaborative's steering committee is in the planning stages of activities for the summer of 2022, including a conference-style convening and interviews outside of member organizations. As the community engagement for this needs assessment was truncated – primarily due to COVID-19 – the Collaborative members are committed to gaining input from government and non-governmental partners, local neighborhood leaders and residents, on-the-ground professionals in health and other sectors, people with lived experience of illness and marginalization.

The result of the CHIP planning season will be actionable recommendations for changes to policy, systems, and programs, co-created by the D.C. community and health system. In November's CHIP document, member organizations will name their commitments to selected strategies to pursue in the next CHNA/CHIP cycle, 2022-2025.

The Collaborative will continue to host our Data Dashboard of community health indicators and resources tailored to D.C. DCHealthMatters.org serves as the reporting, tracking, and monitoring mechanism for all DC Health Matters Collaborative work, including CHIP activities and community feedback. In addition, each Collaborative organization will post this assessment and the corresponding CHIP to their individual websites.

We invite all D.C. stakeholders to join us in working toward health equity. Contact us via email at collab@DChealthmatters.org for more information.
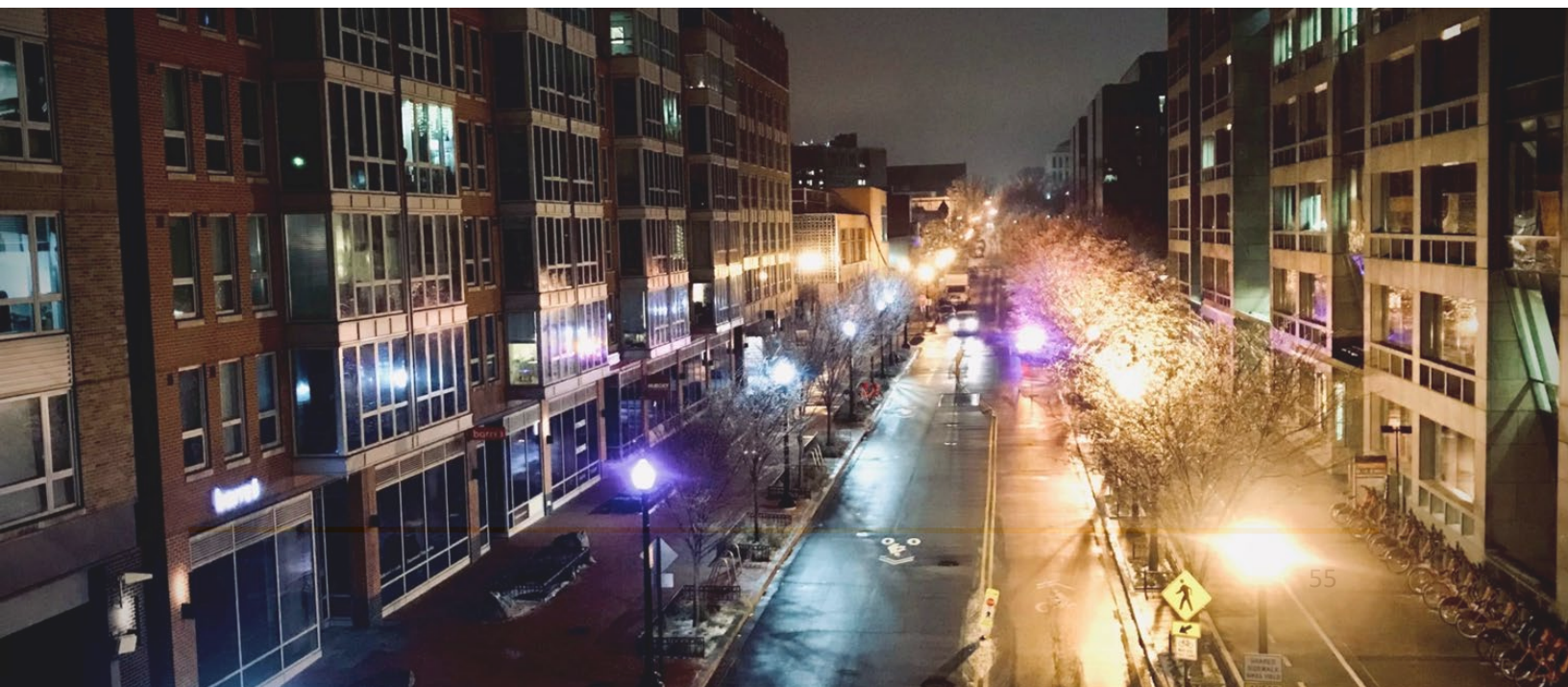
ACRONYM LIST

ACA   Patient Protection and Affordable Care Act of 2010

CHIP   Community Health Improvement Plan

CHNA   Community Health Needs Assessment

CHW   Community Health Workers

CoRIE   Community Resource Information Exchange

COVID-19   SARS-CoV-2

CRISP   Chesapeake Regional Information System for our Patients

DC   District of Columbia (also "the District")

DCHCC   DC Healthy Communities Collaborative (former name for DC Health Matters Collaborative)

FQHC   Federally Qualified Health Centers

MAT   Medication-Assisted Treatment for substance abuse

OSSE   Office of the State Superintendent of Education

PSE   Policy, System, And Environment framework

PReP   Pre-Exposure Prophylaxis for HIV

SUD   Substance Use Disorder

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