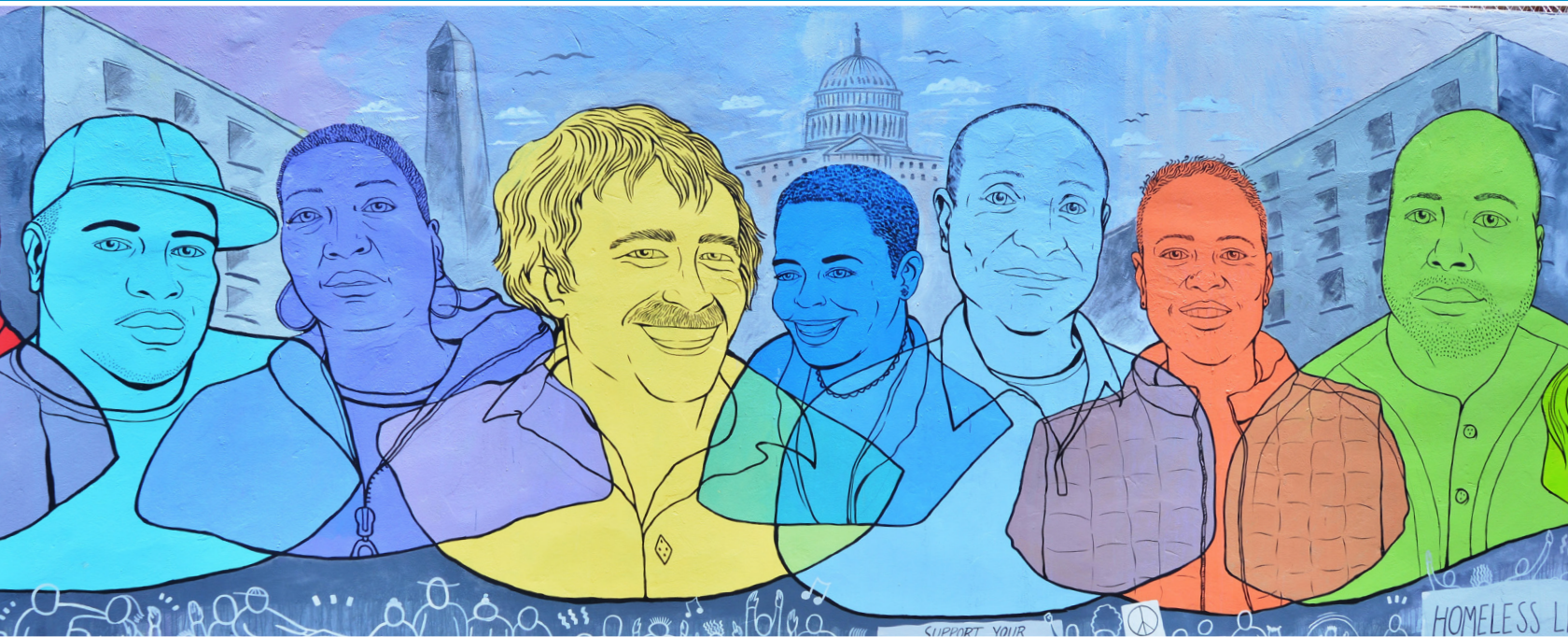# Progress through Partnerships:
Community Health Improvement Plan 2019-2022

DC Health Matters Collaborative

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

DC Health Matters
Collaborative

Community Health Improvement Plan
November 2019

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www.DCHealthMatters.org
collab@dchealthmatters.org

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Our Members

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

As the nation's children's hospital, the mission of Children's National is to excel in Care, Advocacy, Research and Education. https://childrensnational.org/
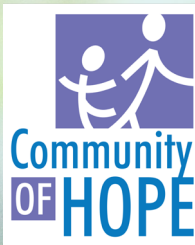
Community of Hope's mission is to create opportunities for low-income families in Washington, DC, including those experiencing homelessness, to achieve good health, a stable home, family-sustaining income, and hope. www.communityofhopedc.org

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

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

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

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

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

Ex-Officio Members

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

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

Executive Summmary

The DC Health Matters Collaborative's Community Health Improvement Plan for 2019-2022 embraces a vision of one healthy and thriving capital city that holds the same promise for all residents regardless of where they live.

The Collaborative includes non-profit hospitals (Children's National Hospital, Howard University Hospital, HSC Health Care System, and Sibley Memorial Hospital), community health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care), and ex-officio members (DC Hospital Association and DC Primary Care Association). DC Health, or the DC Department of Health, has been a guiding partner for many years. Our work focuses on improving population health through collaboration, and demonstrating success through measurable outcomes.

To date, we have completed three joint Community Health Needs Assessments (CHNA) in 2013, 2016, and 2019, with companion implementation strategies called Community Health Improvement Plans (CHIP). The Collaborative also maintains the DCHealthMatters.org web portal and the DC Health Matters Connect social resource tool. These online platforms provide health care professionals, community partners and residents with data and resources to advance health equity in the District of Columbia.

In July 2019, our Collaborative released its third CHNA. We decided to gather community input on the same four community priorities identified in our 2016 CHNA: mental health, care coordination, health literacy, and place-based care. Our 2019 CHIP will build upon successes, lessons learned and relationships built to address these four needs.

Our roadmap for action for 2019-2022 includes policy- and systems-level actions that can make a positive difference in our four priority areas. Understanding that the majority of our health is driven by social factors outside of access to health care, we embrace a policy and system change framework that addresses "upstream" factors that create conditions for optimal health in our community.

Through a multi-step process, our Collaborative elevated nine themes from the CHNA to be "priority strategies" for our 2019 CHIP. The strategies will be planned and executed through system change "sprints." The Collaborative is adopting new processes for our work that include principles from Scrum and Collective Impact frameworks to increase

Collaborative Priority Areas & Goals

Mental Health
Improve access to mental health services, including prevention and treatment of psychological, emotional and relational issues, enabling a higher quality of life for DC residents.
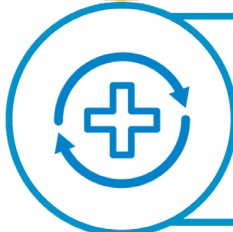
Care Coordination
Support the deliberate organization of patient care activities and information-sharing protocols among health care providers, government agencies, and community-based organizations.

Health Literacy
Improve health literacy or the ability to obtain, process, and understand health information and services, and increase capacity of the health system to respond to literacy and language needs.

Place–Based Care
Partner to bring convenient and culturally sensitive care options to the community, especially areas of high need.

stakeholder engagement and allow flexibility. We will also develop a parallel policy agenda to monitor governmental actions and advocate for the policy changes that relate to our CHNA findings, CHIP strategies, and our larger goal of health equity.

Our first sprint will focus on rolling out our DC Health Matters Connect tool for the public and in our own clinics. DC Health Matters Connect is a free online resource for health care providers, social service organizations, and community members to find and connect to free or reduced-cost services across the metro area. The "closed loop" referral system is available at DCHealthmatters.org.

In the first six months of our CHIP, we will define a robust policy agenda. One of the first initiatives will be to promote the 2020 Census and address the undercounting of vulnerable populations in DC, including young children, Black and Latinx communities. Progress and outcomes on our strategies will be published on DCHealthMatters.org.

Partnership is one of our core values; we extend our gratitude to our partners and welcome the opportunity to build relationships with new stakeholders. We look forward to hearing from you. Email collab@dchealthmatters.org, and find us on Twitter @DCHMcollab or on our website at DCHealthMatters.org.

"Alone we can do so little; together we can do so much."

– Helen Keller

About the DC Health Matters Collaborative

The DC Health Matters Collaborative is a coalition of DC hospitals and federally qualified health centers (FQHCs) that envisions an equitable and sustainable state of health for all DC residents. We came together in 2012 in response to new requirements in the Patient Protection and Affordable Care Act of 2010 (ACA) mandating non-profit hospitals to issue a Community Health Needs Assessment (CHNA) and corresponding implementation strategy – referred to as our "Community Health Improvement Plan (CHIP)" – every three years.

In an effort to make a meaningful collective impact on health and reduce redundancy, our coalition – then named the DC Healthy Communities Collaborative – aligned efforts and combined resources for its first joint CHNA in 2013. To date, we have partnered to complete three joint needs assessments in 2013, 2016, and 2019, with companion CHIP.

Our current members include DC hospitals (Children's National Hospital, Howard University Hospital, HSC Health Care System, and Sibley Memorial Hospital) and community health centers (Bread for the City, Community of Hope, Mary's Center, and Unity Health Care). Our ex-officio members include the DC Hospital Association and DC Primary Care Association. Our Collaborative members appoint representatives to participate on a Steering Committee, the governing body that meets monthly to discuss policy updates and report on progress on the community health improvement plan. Our Community Advisory Board includes community-based partners as well as government agencies, including DC Health, which has been a guiding partner for many years.

The Collaborative also maintains the DCHealthMatters.org web portal and the DC Health Matters Connect social resource tool, online platforms that provide providers, partners and residents with data and resources to advance health equity.

Given that 80% of our health is driven by social factors outside of access to health care, such as housing, education and environment, our Collaborative understands the urgency and necessity for hospitals and community health centers to address these social determinants of health and other "upstream" factors.[1] The road to eliminating health inequities requires partners to work together. As such, our Collaborative is engaging a diverse cross-section of DC stakeholders with varied expertise in the health system and beyond in our current and future CHNA and CHIP. We welcome all partners to collaborate with us in this work.

Our Values

Dedication

We are committed to improving community health. In for the long haul.

Partnership

We collaborate. We are open to hearing all voices.

Optimism

We believe meaningful improvements in health outcomes are possible.

Accountability

We are reliable. We say what we will do, then do what we say.

Creativity

We use groundbreaking ideas informed by evidence-based practices to improve health outcomes.

Inclusiveness

We are intentional about health outcomes for all populations. No exceptions.

Vision:

One healthy and thriving capital city that holds the same promise for all residents regardless of where they live.

Mission:

Improve population health through collaboration and community engagement and to demonstrate our success through measureable outcomes.

Focus on Policy & Systems

The focus of our 2019 CHNA was to gain information and identify policy- and systems-level actions that could make a positive difference in our four priority areas: mental health, care coordination, health literacy, and place-based care.[2] Our work builds upon the 2016 CHIP, which was the Collaborative's first foray into addressing community needs using a policy and systems lens.

- **Policy Change** involves changes in policies at the legislative or organizational level. Policies are written rules that are enforceable and impact groups of people.
- **System Change** involves changes made to the rules within or across organizations. It is an intentional process designed to alter the components that cause the system to behave in a certain way.
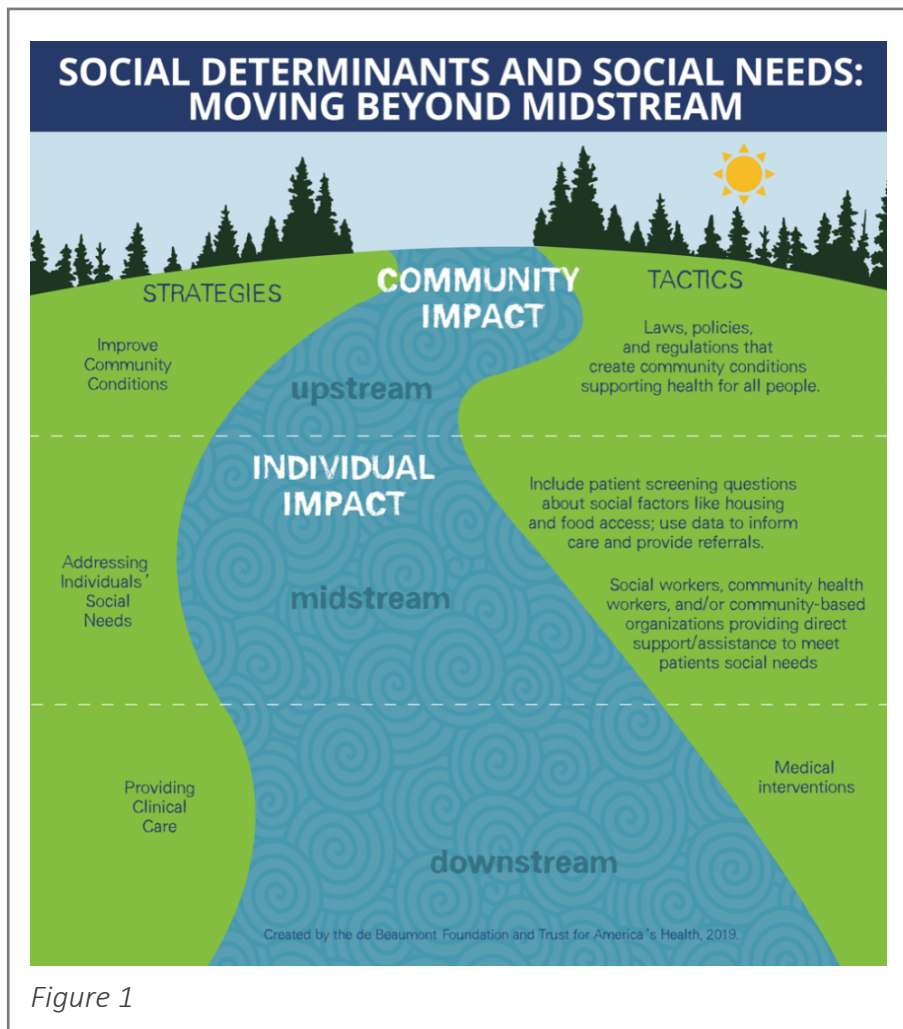
Figure 1

We recognize that interventions are needed at both the individual and community levels. Researchers often discuss health using the metaphor of a stream, with upstream factors causing downstream effects (Figure 1).[3] Using a policy and systems approach goes farther upstream than medical interventions or programs toward creating a healthier environment.

Policy and systems approaches go beyond addressing individual needs with medical advice or new programs; rather, they aim to alter the systems and structures in which we work, live, and play. These systems and structures may greatly influence or impact health. Often systems changes focus on organizations changing their rules and infrastructure, or instituting processes to ensure a healthier workplace or improve patient care. Policy actions may be more external, relating to public institutions, community services, and laws and regulations, as well as budget allocations for services.

Reporting Back: 2016-2019 CHIP Strategies

Guided by our 2016 CHIP, over the past three years, our Collaborative took action in four priority areas through 10 strategies, which were selected based on organizational readiness, resource availability, in-house expertise, and alignment with institutional priorities. Collaborative organizations committed to lead or collaborating roles on strategies, and efforts were driven through three working groups focused on mental health, care coordination, and health literacy. Two of these working groups also addressed place-based care strategies.

Each working group met monthly. Leads reported outcomes through an online progress tracker on DCHealthMatters. org, gave updates at monthly Steering Committee meetings, and provided quarterly reports to our Community Advisory Board. Below is a brief summary of the 2016-2019 CHIP strategies, activities, and achievements. In our 2019 CHIP, we will continue to monitor policy and system priorities from the 2016 CHIP that are aligned with the 2019 CHNA community priorities.

Mental Health

1: Advocate for a District-wide capacity assessment and evaluation of mental health services for adults and children.

Through an environmental scan, the Collaborative identified and compiled a summary of 18 recent DC mental health needs assessments and advocated to the DC Council Committee on Health to fund a comprehensive mental health needs assessment. It also contributed to the development of a behavioral health resource: Principles and Values to Guide Child and Adolescent Public Behavioral Health Care System Transformation in the District of Columbia; a summary of the needs assessment is in the report appendix.

2: Increase capacity by addressing the recruitment, retention, accessibility, competency, and workforce roles.

The Collaborative identified provider burnout and staff turnover as key workforce barriers in providing mental health services in DC. Children's National Hospital and Mary's Center developed and delivered trainings for health and education professionals in an effort to improve self-care and mental wellness in clinical and community-based workplaces. The Collaborative also developed and disseminated an advocacy tool with practical guidance for individuals to drive policy and system-level actions in school and health care environments.

3: Advocate for policy-level solutions to improve our ability to provide mental health prevention activities and screenings and for equitable distribution of mental health services in DC.

The Collaborative created a mental health policy agenda that reflected current capacity, political will, and potential to enact policy change. The working group provided testimony to the DC Council, including in hearings on Department of Behavioral Health oversight and the Interagency Council on Behavioral Health Establishment Amendment Act of 2019. Children's National Hospital facilitated a Roundtable on School Mental Health regarding the challenges and opportunities to improve DC's school-based mental health provision.

4: Improve care coordination for mental health and substance abuse co-occurring conditions though facilitation of direct hand-offs to the next level of care and tracking of referrals.

Providence Health System piloted the Assessment and Referral Center (ARC) co-occurring direct-bed-to-bed hand-off program to improve care coordination for mental health and substance abuse. The program was discontinued when Providence closed their inpatient psychiatric unit in October 2017.

Care Coordination

1: Improve identification of resources by collaborating with community based organizations, government agencies and health care organizations.

The Collaborative identified Aunt Bertha, an online resource connection tool, and conducted 11 trainings on how to use the tool to connect patients to social resources across clinical sites and member organizations. It also generated 105 new program listings on the online platform. The Collaborative was also active in the DC Primary Care Association's (DCPCA) Positive Accountable Community Transformation (DC PACT), a coalition of community providers working to understand how to best share social determinants of health data and use technology to bridge sector divides.

The working group also trained medical staff, researchers and others about health disparities and societal barriers that affect patients from low-income neighborhoods, interventions and available resources.

Health Literacy

1: Collaborate with other health care organizations, government agencies, and community based organizations to increase public awareness and education around health literacy and health system navigation, using best practice approaches.

The Collaborative formed a partnership with and provided funding support to Wesley Theological Seminary's Heal the Sick program to launch a health literacy campaign for six faith communities across Wards 5, 7, and 8. To date, Wesley Theological Seminary assessed the faith communities' needs around health literacy, delivered a webinar on identifying individual and common assets among the faith communities, offered access to Wesley's professional training programs, researched best practices, and completed a literature review on health literacy to share with the communities. Wesley is also developing a number of one-pagers in an electronic format with links to resources and helpful information for particular audiences, such as health care practitioners and community groups, that will be finalized by the end of 2019. The health literacy campaign is expected to continue into 2020 to further build capacity in health ministries.

2: Pilot internal system changes to improve health literacy.

Mary's Center conducted a survey to assess current health literacy screening practices among DC hospitals and community health centers. Member organizations used survey recommendations to inform practices, including how to document screenings in electronic medical records. The report was disseminated among member organizations and is available on DCHealthMatters.org. The Collaborative also submitted testimony to the DC Council on the Health Literacy Council Establishment Act of 2017.

Place-Based Care

1: Advocate for financial incentives to increase the availability of convenient and culturally sensitive heath and human services in Wards 7 and 8.

The mental health working group members participated in monthly meetings of the Ward 7 and 8 Health Councils, the DC Behavioral Health Association, and other relevant stakeholder groups to identify logistic and financial barriers to providing or accessing mental health care.

2: Advocate for integration and reimbursement of community health educators/workers/promoters in health care settings and community based settings.

The Collaborative participated in meetings convened by DC Health related to best practices regarding community health workers, including financing, health literacy, training and core competencies, and standardization of practices.

Cross-Cutting Strategy

1: Provide small community grants to local organizations aiming to support Collaborative efforts that address the four priority areas in communities of high need around policy, systems, and environmental change.

The Collaborative awarded $150,000 to two non-profit organizations over a two-year period:

1. MedStar Georgetown University Hospital expanded the current work of the Early Childhood Innovation Network (ECIN) to include additional perinatal health advocacy and family navigation, case management, and support, with a focus on women at high risk for or evidencing symptoms of depression and anxiety.

2. The Institute for Public Health Innovation facilitated the Housing Remediation Pilot Project with DC Healthy Housing Collaborative, offering remediation services to address poor housing conditions contributing to asthma and other health outcomes.

2019 Community Health Needs Assessment

The CHNA is a federal requirement for non-profit hospitals. The 2019 CHNA placed an ongoing focus on the 2016 CHNA priorities: mental health, care coordination, health literacy, and place-based care. We leverage the capacity, expertise, and relationships that have been built to address these needs more effectively.

The key objectives of the 2019 CHNA were:

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

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

1. **Mental Health:** prevention and treatment of psychological, emotional, and relational issues, enabling a higher quality of life for DC residents.
2. **Care Coordination:** the deliberate organization of patient care activities and information-sharing protocols among health care providers, government agencies, and community-based organizations.
3. **Health Literacy:** the ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions.
4. **Place-Based Care:** convenient and culturally sensitive care options for the community, especially areas of high need.

Given the time and effort that it takes to make substantive progress in these four critical areas, we – in consultation with over 300 community partners – decided to carry forward the four needs rather than re-canvas our community to identify new needs.Our data collection process resulted in a rich collection of 28 themes that focus on how best to address our four priority areas. Through analysis of these themes, the Collaborative identified four broad action areas under which the individual themes were organized:

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

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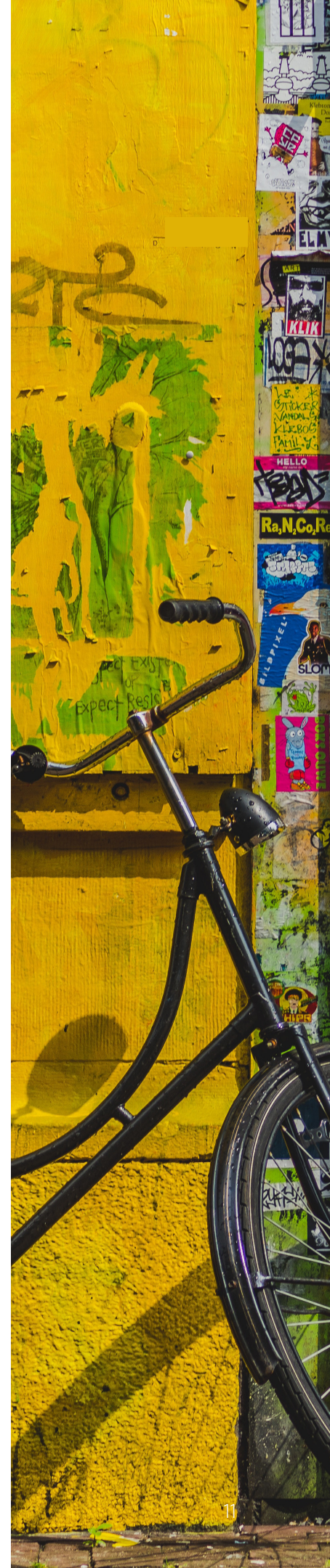
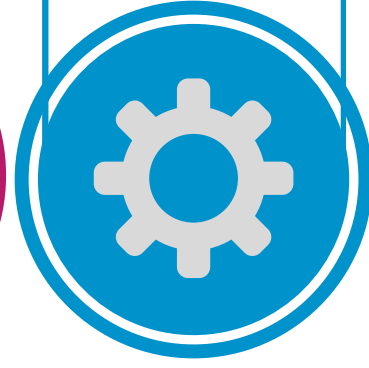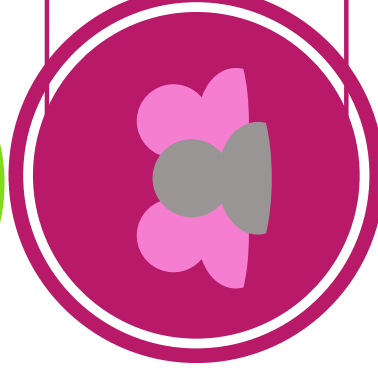|	mental health	care coordination	health literacy	place-based care
community dialogue	MH1. Understand community perspectives on MH. MH2. Educate stakeholders about MH. MH3. Gather data about MH in the District. MH4. Assess quality of MH services.	CC1. Improve communication among healthcare providers,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

Selecting Priorities & Frameworks for Action

While all the findings in the CHNA were salient and important, Collaborative members carefully reviewed and selected findings to focus on over the next three years.

Member organizations completed a matrix to identify the strategies that most aligned with their organization goals and resources. Criteria for scoring included:

- Willingness to publicly support advocacy and policy action on the issue,
- Alignment with the organization's mission or vision,
- Willingness to contribute resources to activities, and
- Willingness to dedicate significant staff time to activities, including taking a leadership role.

Through a structured prioritization process with all member organizations and Community Advisory Board members, the Collaborative ultimately selected nine strategies for the 2019 CHIP that offer the opportunity to influence policies, systems, or social conditions that can make a difference in the lives of DC residents. [See table on pages 14-15.]

The Collaborative identified which strategies were already being addressed by other groups or programs. Some recommended strategies were consolidated to eliminate redundancy and increase impact. A subset of the strategies were assigned to the policy agenda, meaning the group will monitor and advocate for legislative action. For the findings not addressed through the 2019 CHIP, individual Collaborative organizations may address them separately in other efforts. In addition, the Collaborative plans to align with other ongoing work such as DC Health's community health needs assessment, the Mayor's Commission on Healthcare Systems Transformation's forthcoming recommendations, and the community health improvement efforts of the DC Hospital Association and DC Primary Care Association.

For each strategy, organizations selected roles with the following expectations:

- **Lead –** Member organization leads or delegates sprint tasks such as mapping stakeholders, developing logic models, and planning and executing associated activities. The lead organization is responsible for facilitating sprint meetings and reporting on progress.
- **Collaborate –** Member organization participates on sprint team and supports sprint lead to achieve objectives with resources, engagement, and execution of activities and documentation of outcomes.
- **Support –** Through Steering Committee participation, member and ex-officio organizations support sprint and policy implementation efforts by providing continuous feedback and subject matter expertise. Though not on sprint team, organizations may identify colleagues to contribute to activities.

Priorities for Action

The DC Health Matters Collaborative elevated nine themes to be "priority strategies" for the 2019-2022 Community Health Improvement Plan through a multi-step prioritization process of its 2019 Community Health Needs Assessment findings. Some additional strategies were assigned to a policy agenda, meaning the group will monitor and advocate for legislative action on the theme. For each strategy, member organizations volunteered for "lead" or "collaborate" roles, or committed to support the work through participation on the Steering Committee.

1

Mental Health Theme 1: Educate stakeholders about Mental Health. Audiences may include: 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

Care Coordination Theme 1: Improve communication, awareness and referral capabilities among health care providers, social service agencies, and educational systems. Promote the value of identifying and addressing non-clinical factors impacting patients' health (e.g., hunger, housing, transportation, legal, etc.).

Lead:
HSC Health Care System

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

5

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.

Lead:
Children's National Hospital

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

6

Health Literacy Theme 1: Collaborate with other organizations and community-based organizations 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. Continue to work with faith-based health ministers to build capacity.

Lead:
Mary's Center
Sibley Memorial Hospital

Collaborate:
Bread for the City, Children's National Hospital, Howard University Hospital

7

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

8

Place–Based Care Theme 1: Support development and expansion of place-based care in convenient, appropriate and accessible 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.

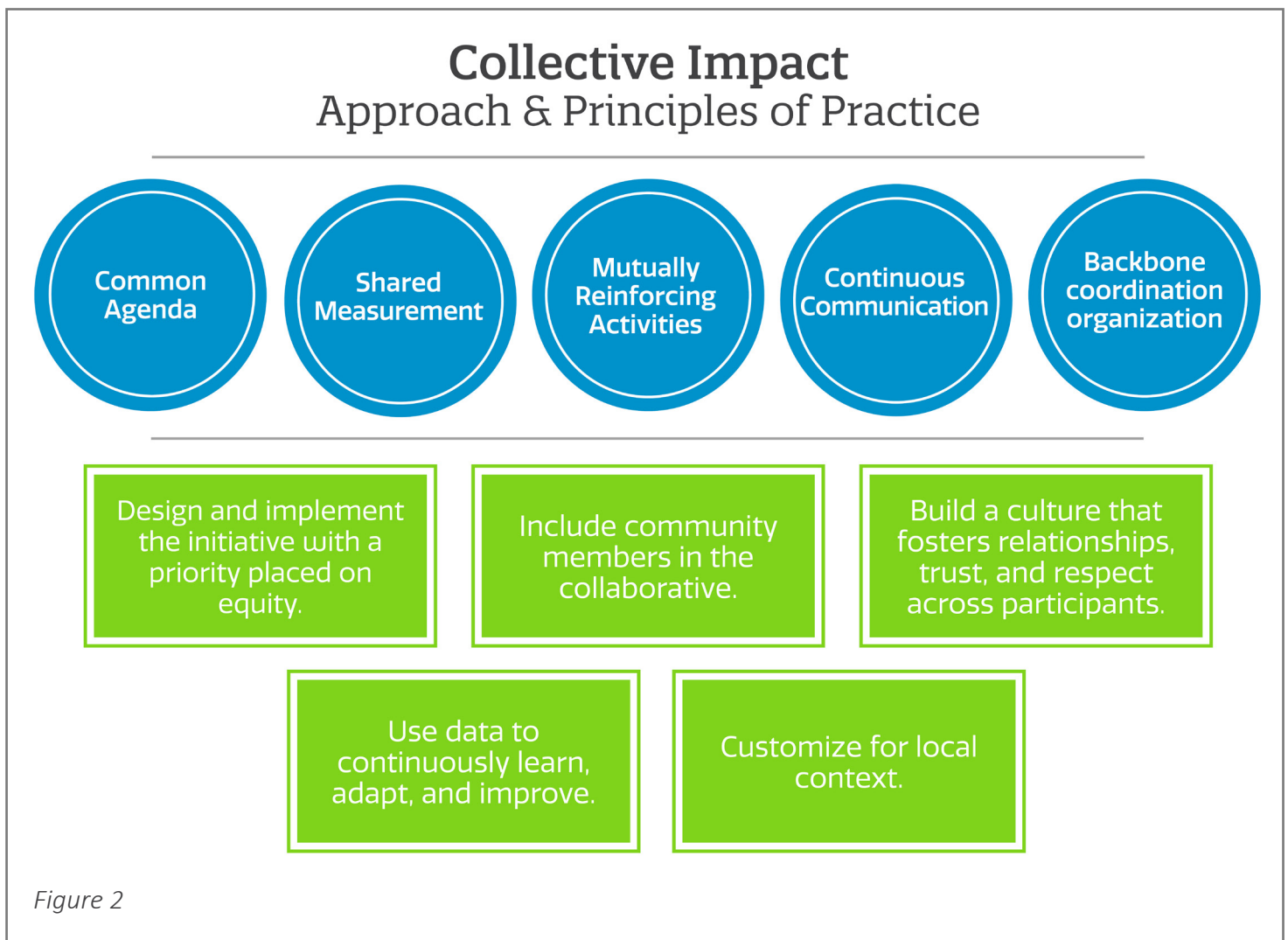**Lead:**
Howard University Hospital

Collaborate:
Community of Hope, HSC Health Care System

9

Roadmap for Action: Systems Change "Sprints" & Policy Agenda

The Collaborative is adopting new processes for its work in the future. First, the "Scrum" framework, a flexible and collaborative approach for addressing complex issues, will be used to implement the nine strategies. In brief, this approach focuses on sprint teams executing one strategy at a time in focused, time-limited "sprints," replacing the 2016 CHIP working groups that meet monthly to concurrently address all strategies. Additionally, the Collaborative will adopt lessons learned from Collective Impact, a framework used for cross-sector collaborations on population-level change efforts (Figure 2).[4]

For our first system change sprint, the Collaborative will focus on a care coordination strategy and implement the DC Health Matters Connect tool for the public and across member organizations (see pages 19-21). The second sprint will focus on a health literacy strategy and expand our current partnership with congregation-based health ministers in Wards 5, 7, and 8.

Collective Impact
Approach & Principles of Practice

- Common Agenda
- Shared Measurement
- Mutually Reinforcing Activities
- Continuous Communication
- Backbone coordination organization

- Design and implement the initiative with a priority placed on equity.
- Include community members in the collaborative.
- Build a culture that fosters relationships, trust, and respect across participants.
- Use data to continuously learn, adapt, and improve.
- Customize for local context.

Figure 2

At the beginning of each sprint, the team engages in a sprint planning process and creates a list of activities and events related to the targeted strategy to address one of our community needs. The sprint team delegates and executes the components of the project for a short, pre-defined time toward a tangible end goal. Meetings are held frequently to keep work moving. At the end, the work is evaluated by the team, then the process itself is reviewed to inform and improve the process for the next sprint.

This framework has the following benefits:

1. Clear Roles

The CHIP implementation will be overseen by the Collaborative Chair. Member organizations will take turns leading sprints. All Collaborative members will contribute input and resources toward the sprint goal.

2. Time-Bound

Most sprints will run four to eight months. The 2016 CHIP working groups addressed strategies concurrently, but the 2019 CHIP systems change sprints will run one at a time, with some overlap during evaluation of one and planning of the next. If we have every Collaborative organization involved for the project planning, execution and evaluation of strategies, we can achieve systems changes faster and more effectively.

3. Frequent Meetings

For the sprint to be effective there must be strong engagement, ongoing communication, and a high level of accountability. Therefore, sprint teams will meet frequently and report to the Collaborative Steering Committee monthly.

4. Inclusive

The Collaborative believes that we can include more diverse voices through this approach because it may be easier for colleagues and community members to commit to projects for shorter periods of time.

5. Responsive

This framework allows teams to be more flexible and responsive; we will plan each project as a first step of a sprint, rather than create a years-long logic model.

6. Hyper-Focused

Through this framework, we can bring busy people together for a discreet amount of time to be highly productive. By bringing in more partners – including the most relevant experts and impacted groups for the project at hand – the Collaborative can create better, more inclusive solutions to community health challenges.

7. Measurable, Visible Outcomes

Each of the nine strategies represents a complex community-identified issue that the health system can address, and needs dedicated energy and creativity to log tangible results. An essential step of sprint planning is creating a definition of success that will be measured at the end of a sprint. We will identify the most relevant tools for evaluation and be able to log and share our progress accordingly.

The sprint planning stage will become a template that is used throughout all systems change sprints. Standard components will include:

- Selection of strategy for sprint by Steering Committee,
- Assignment of team roles,
- Define sprint goal by sprint team and community advisors,
- Write SMARTIE goal (Specific, Measurable, Ambitious, Realistic, Time-bound, Inclusive and Equitable),[5]
- Complete logic model, including input/outcomes (the foundation of the project plan),
- Define "success" for sprint review at end of time period,
- Map stakeholder groups and leverage existing networks, and
- Plan community dialogue (format, timing, audience and objective will vary by sprint)

As detailed on Page 7, the Collaborative focuses on policy and systems actions to improve health in DC. The projects undertaken in sprints will focus primarily on systems actions – internal system improvements, brokering relationships and dialogue, capacity building, etc. For the duration of the next three years, the Collaborative will also develop a policy agenda aligned with our systems change efforts.

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 will be overseen by the Collaborative's Director of External Affairs, and will include all member organizations.

Features of the policy agenda will include but are not limited to:

- Identify and monitor legislative and executive-level governmental policies, proposed or enacted,
- Outline and research necessary policy action proposals,
- Create advocacy campaigns and testimony, including education of policymakers on priority areas and social determinants of health,
- Respond to new events, environmental changes, and community discussions related to health and social determinants of health, and
- Map stakeholder groups and existing networks.

One example of this citywide advocacy work is outreach for the upcoming U.S. Census 2020, which is one of the most "upstream" issues our Collaborative can support. The count of residents will have a significant impact on political representation, allocation of federal funds for important health and social programs, and the accuracy of DC data. We are joining efforts with partners from several health systems, local government agencies, and other community organizations to advocate for an accurate count, particularly for our hardest-to-reach and populations who face vulnerabilities (see page 22).

Launching the First Systems Change Sprint: DC Health Matters Connect

Educate stakeholders on the use and benefit of DC Health Matters Connect, an online directory to search and connect with social service programs.

Background

The first sprint for the 2019 CHIP is to launch DC Health Matters Connect, an online directory to search and connect with an array of social service programs. Part of the work will be implementing the tool in our clinical sites, while also educating stakeholders on the use and benefit of the tool in order to increase coordination of care across disciplines.

This sprint builds on the 2016 CHIP wherein the Collaborative sought systems changes to support the deliberate organization of patient care activities and information-sharing protocols to achieve safer and more effective care. District stakeholders expressed the desire to have easily manageable resource lists and bi-directional communication when making referrals.

After researching multiple solutions, the Care Coordination working group partnered with the Capital Area Food Bank to pilot the use of the Food Bank Network in three clinical sites, an online community resources inventory that helps communities locate and refer social programs across the region. Pilot participants provided positive feedback on the simplicity, benefit, and effectiveness of the site, with over 90% recommending it be shared with additional providers. Based on these results, the Collaborative launched the DC Health Matters Connect site powered by Aunt Bertha (an online community resource tool) in the spring of 2019. Our first sprint for the 2019 CHIP focuses on implementing this immediate solution for patients, while also gathering evidence for a larger conversation about the importance of coordinating care programs.

DC Health Matters Collaborative has partners across the District that also focus on the social determinants of health and are committed to finding solutions to support residents. The project takes into consideration the efforts of our partners as well as the vast body of work that DCPCA – an ex-officio Collaborative Member – has completed through the DC Community Resource Information Exchange Planning Initiative funded by the Department of Health Care Finance (DHCF). The initiative provided guidance to DHCF about how to build a technical architecture to support access, exchange, and use of social determinants of health information in DC. The Collaborative will continue to work with DCPCA and other partners to explore the use and coordination of social determinant platforms in our community.

DC Health Matters Connect Sprint Goal

DC Health Matters Connect is a space for health care providers, social service organizations, and community members to search and connect to direct services across the metro area that are free or reduced cost. The "closed loop" referral system is freely available online at DCHealthmatters.org. Our goal is that service providers and residents will be educated about the availability of the tool and its use, so they can more easily reach resources in their community. When users create a free account, the tool can be used to facilitate conversations across providers of all types (health, education, community-based, social services) to coordinate care for clients and patients.

SMARTIE Goal for Sprint #1

Specific: Disseminate information through in-person trainings, online resources, and community conversations to equip referring partners with the knowledge they need to refer participants to social resources in DC.

Measurable: Equip at least 14 partners across three different fields with resources to utilize Connect; increase searches on the platform by 20%.

Ambitious: Plan is challenging enough that achievement would mean significant progress.

Realistic: Goals are possible to execute and track.

Time-Bound: Completed in six months.

Inclusive: Engage with sites across Wards in DC including but not limited to 7 & 8; embed non-clinical stakeholders in sprint team as well as those receiving training.

Equitable: Provide definition of equity and social determinants of health in all training and roll-out activities; review potential access issues in platform.
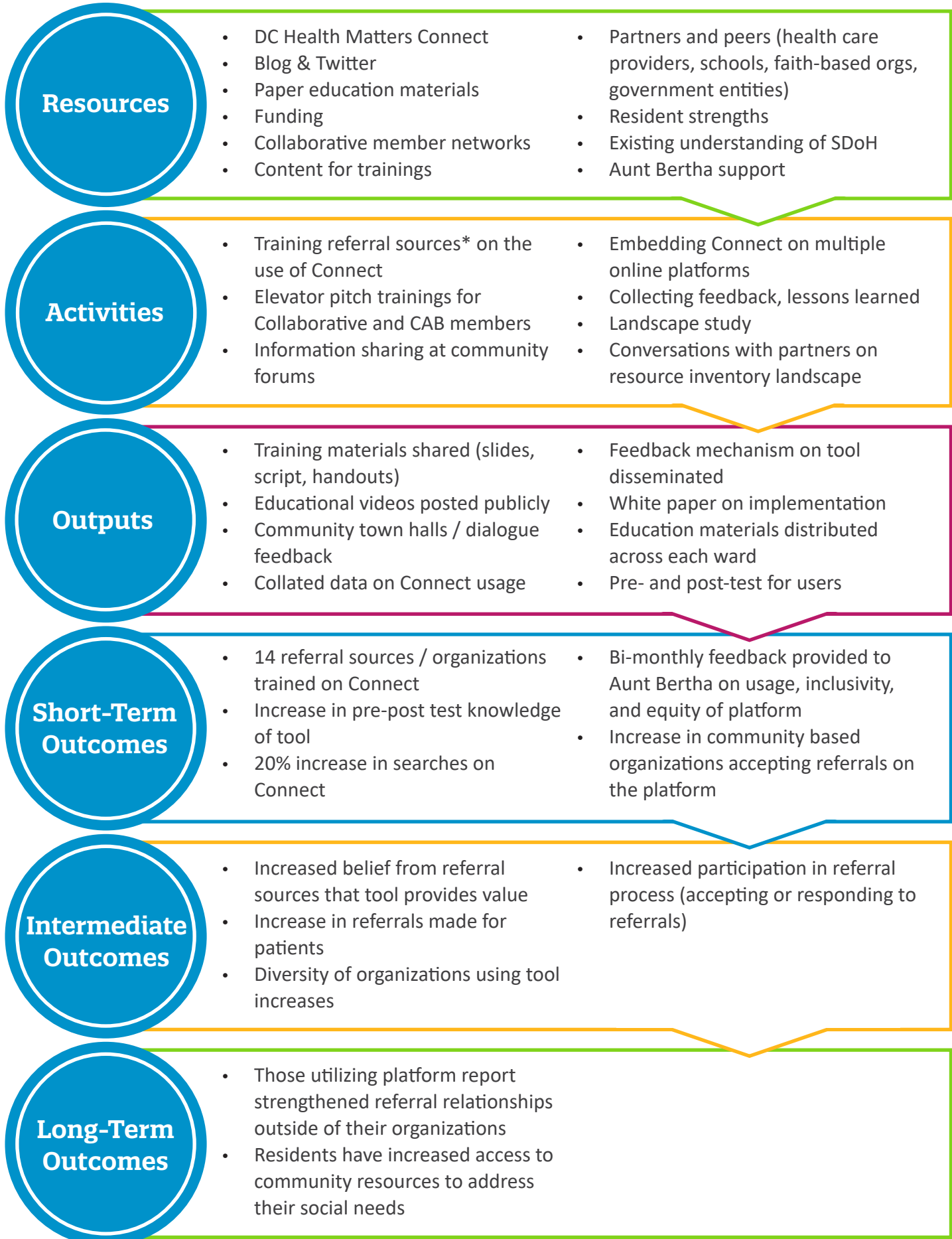

Sprint Focus

The DC Health Matters Connect six-month sprint will focus on engagement and education of community-based organizations with a focus on "referral sources" (defined here as those who work with individuals to help them navigate through their social needs, regardless of what setting they are in).

As we encourage health care providers, Collaborative members, and others referral sources to utilize DC Health Matters Connect, more DC residents will benefit from the resource inventory and referral connection capabilities.

See the logic model on the next page for the resources, activities and outcomes planned during the sprint period. Updates on this sprint and other actions taken on the strategies are posted in our Progress Tracker on DCHealthMatters.org.

Logic Model for Sprint #1: Connect Launch

Resources

- DC Health Matters Connect
- Blog & Twitter
- Paper education materials
- Funding
- Collaborative member networks
- Content for trainings
- Partners and peers (health care providers, schools, faith-based orgs, government entities)
- Resident strengths
- Existing understanding of SDoH
- Aunt Bertha support

Activities

- Training referral sources* on the use of Connect
- Elevator pitch trainings for Collaborative and CAB members
- Information sharing at community forums
- Embedding Connect on multiple online platforms
- Collecting feedback, lessons learned
- Landscape study
- Conversations with partners on resource inventory landscape

Outputs

- Training materials shared (slides, script, handouts)
- Educational videos posted publicly
- Community town halls / dialogue feedback
- Collated data on Connect usage
- Feedback mechanism on tool disseminated
- White paper on implementation
- Education materials distributed across each ward
- Pre- and post-test for users

Short-Term Outcomes

- 14 referral sources / organizations trained on Connect
- Increase in pre-post test knowledge of tool
- 20% increase in searches on Connect
- Bi-monthly feedback provided to Aunt Bertha on usage, inclusivity, and equity of platform
- Increase in community based organizations accepting referrals on the platform

Intermediate Outcomes

- Increased belief from referral sources that tool provides value
- Increase in referrals made for patients
- Diversity of organizations using tool increases
- Increased participation in referral process (accepting or responding to referrals)

Long-Term Outcomes

- Those utilizing platform report strengthened referral relationships outside of their organizations
- Residents have increased access to community resources to address their social needs

*Referral source defined as those who work with patients and community members to help them navigate through the process of addressing their social needs. Examples include: social work teams, school counselors, physician practices, family support workers, case managers, constituent services and may be independent or embedded within an organization.

Policy Agenda Example: Census 2020

During the last CHIP, the DC community experienced several pressing issues – from unforeseen closures of DC hospitals and an increase in opioid use, to national threats on immigrant health. [A more detailed summary is available in the 2019 CHNA at DCHealthMatters.org.] The Collaborative is positioning itself to respond to timely and/or unexpected issues that impact DC communities during our three-year 2019 CHIP cycle. We highlight one critical advocacy initiative that the Collaborative will adopt for a six-month period in our CHIP: addressing the undercount of populations who experience vulnerabilities in the 2020 U.S. Census.

The U.S. government conducts a census every 10 years as mandated by the founders in the Constitution. The last census was conducted in 2010; the next census will take place in 2020. The importance of counting every single person cannot be overstated. The census determines political representation, allocation of federal funds for social service programs, and much more. However, we know that there is a serious threat of a differential undercount in the 2020 Census, meaning that the expected undercount is different for different populations, leading to a serious equity issue.

It is often the populations who experience vulnerabilities who are not counted, such as young children, Black and Latinx communities, immigrants, and elderly individuals. For every person who is not counted, local governments will lose federal funding for vital programs, including Medicaid, food stamps, Head Start, and many more. The populations who disproportionately benefit from these programs are the ones at highest risk of not being counted.

As of 2018, over 100,000 DC residents were under the age of 18, including 45,000 children under the age of five. School-aged children, especially children under five, are one of the most undercounted populations across the country. Children living in lower-income, informal, shared-custody or immigrant households are especially at risk of not being counted. The federal government distributes over $6 billion annually to DC to support vital programs based on census data.

The Collaborative sees the threat of the census undercount as a critical equity issue. We will work to ensure that all of DC's residents are counted, with a particular focus on young minority children as they are at the highest risk of undercount. Using a strong community engagement strategy, the Collaborative will work with community organizations to focus on the exact DC neighborhoods where the undercount is expected to be the greatest (see map in Figure 3).[6] Our Census advocacy work will showcase the power of the Collaborative in leveraging resources of the individual member organizations to have a collective impact on the 2020 Census and most importantly, a positive future impact for our DC communities.

Figure 3
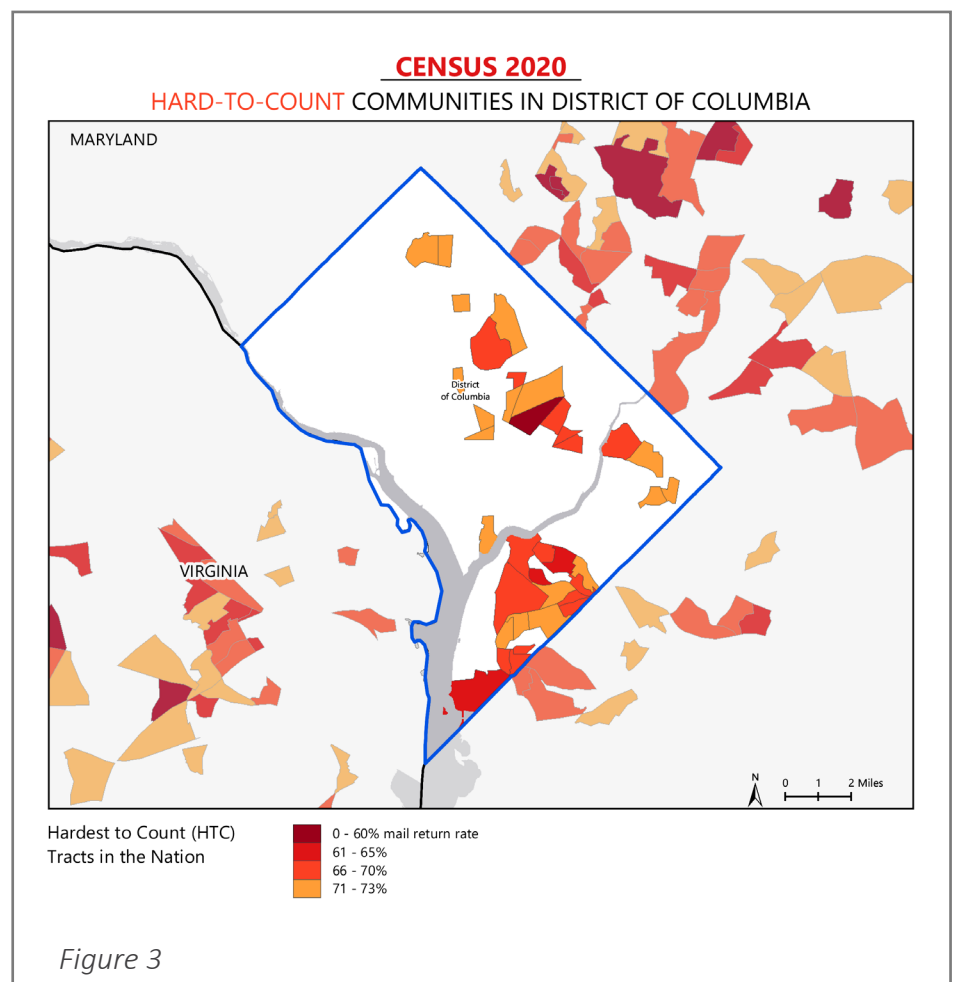
Conclusion

Collaboration is at the core of the DC Health Matters Collaborative's model and work, and is critical to making a significant and sustainable impact on the health of our community. We invite all DC stakeholders to join us in working toward health equity.

Community members are welcome to attend meetings of our Community Advisory Board, attend events and/or join a sprint team. Contact us via email at collab@dchealthmatters.org for more information. Follow us on our social media platforms – Twitter or LinkedIn.

Current and past CHNAs and CHIPs are available on DCHealthMatters.org. The portal also serves as the reporting, tracking and monitoring mechanism for the CHIP. DC Health Matters Collaborative members are committed to maintaining the portal as the key platform for ensuring transparency and accountability as they work to advance population health, in addition to being a central location for population health data for the community to use.

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

Thank you to our partners serving on our Community Advisory Board and working groups.

Advocates for Justice and Education

Capital Area Food Bank

Children's Law Center

DC Behavioral Health Association

DC Central Kitchen

DC Greens

DC Health

DC Public Library

DC PACT

The George Washington University

Howard University

Institute for Public Health Innovation

La Clinica del Pueblo

Latin American Youth Center

MedStar Georgetown University Hospital

The National Alliance to Advance Adolescent Health

National Council for Behavioral Health

Office of the State Superintendent of Education

Parents Amplifying Voices for Education

Providence Health Village

Seabury Resources for Aging

University of the District of Columbia

University of Maryland

Ward 8 Health Council, Mental Health Subcommittee

Wendt Center for Loss and Healing

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