



• 2025 •

# COMMUNITY HEALTH NEEDS ASSESSMENT

---

Howard University Hospital  
Sibley Memorial Hospital, Johns Hopkins Medicine

# Acknowledgments

This Community Health Needs Assessment (CHNA) is the product of a six-month process led by a Steering Committee with input from multiple individuals, organizations, and groups. The Steering Committee for this process was comprised of staff from Sibley Memorial Hospital and Howard University Hospital. These individuals were integral in making this comprehensive assessment possible.

CHNA Steering Committee		
Name	Title	Organization
Marti Brown Bailey	Director Emeritus, Community Health Advisor	Sibley Memorial Hospital, Johns Hopkins Medicine
Elijah McDuffie	Community Benefit Engagement Program Manager	Sibley Memorial Hospital, Johns Hopkins Medicine
Sharon L. Sellers	Assistant Director, Community Health and Sibley Senior Association	Sibley Memorial Hospital, Johns Hopkins Medicine
Julie Wagner	NCR Executive Director Community Health	Johns Hopkins Medicine
Gina S. Wilson	Director, Quality and Strategic Improvement	Howard University Hospital
Terrence Jacobs	Patient Advocate	Howard University Hospital

The Steering Committee would like to extend gratitude to all focus groups participants, community leaders, and members of the community who gave their time and input in the development of this assessment. Additionally, the Steering Committee would like to thank Dr. Joy Evans of Howard University for her assistance co-facilitating focus groups and the following organizations for participating in and supporting the CHNA process:

- Bethesda Baptist Church
- Black Women Thriving East of the River
- Brighter Day Ministries
- Capital Area Food Bank
- Children’s National Research Institute
- Community of Hope
- Council of the District of Columbia
- DC Behavioral Health Association
- DC Health
- DC Hospital Association
- DC Primary Care Association
- East Washington Heights Baptist Church
- Mary’s Center
- Shiloh Baptist Church
- So Others Might Eat (SOME)
- Unity Health Care
- Whitman-Walker Health

Ascendient Healthcare Advisors served as consultants, directing the CHNA process and developing the content of this report. The Ascendient team members involved in the development of this report included: Brian Ackerman, MHA, Partner; Chelsey Saari, DrPH, MPH, Manager; Sarah Carlson, MHA, Consultant. To learn more about Ascendient Healthcare Advisors, please visit their website at [www.ascendient.com](http://www.ascendient.com).

# Table of Contents

<b>Acknowledgments</b> .....	2
<b>Executive Summary</b> .....	7
<b>Introduction</b> .....	9
<b>Background</b> .....	9
<b>Process Overview</b> .....	10
<b>Report Structure</b> .....	11
<b>Chapter 1   Methodology</b> .....	12
<b>CHNA Process Design</b> .....	12
<b>New (Primary) Data</b> .....	12
Community Health Survey.....	12
Key Leader Survey.....	12
Community Focus Groups.....	13
Key Leader Interviews.....	13
<b>Existing (Secondary) Data</b> .....	13
<b>Data Integration</b> .....	15
<b>Comparisons</b> .....	15
<b>Prioritization Process Overview and Results</b> .....	16
<b>CHNA Data Limitations</b> .....	17
Primary (New) Data.....	17
Secondary (Existing) Data.....	18
<b>Chapter 2   Community Profile</b> .....	19
<b>Geography</b> .....	19
<b>Demography</b> .....	19
Total Population Overview.....	19
Population Density.....	20
Population Projections and Trends.....	21
Age and Sex of District Residents.....	22
Race, Ethnicity, and Languages Spoken in the District.....	24
Disability Status in the District.....	27
Veteran Status in the District.....	28

<b>Social, Economic, and Environmental Determinants of Health</b> .....	29
Social Vulnerability Index.....	30
Environmental Justice Index.....	32
County Health Rankings – Health Outcomes and Health Factors .....	33
Economic Factors Impacting the District.....	35
Educational Attainment in the District.....	39
Healthcare Access and Quality in the District .....	41
Housing Status in the District.....	42
Neighborhood Safety in the District .....	45
<b>Chapter 3   Priority Health Needs</b> .....	48
<b>Topic 1   Health Conditions</b> .....	49
Context and National Perspective .....	49
Health Conditions Overview.....	52
Mental Health .....	52
Chronic Diseases.....	56
Substance Use.....	60
Maternal and Infant Health.....	63
<b>Topic 2   Healthcare Access</b> .....	68
Context and National Perspective .....	68
Healthcare Access Overview.....	68
Insurance Coverage.....	69
Healthcare Availability .....	71
Patient Experience.....	74
<b>Topic 3   Social Determinants of Health</b> .....	79
Context and National Perspective .....	79
Social Determinants of Health Overview.....	80
Housing.....	80
Safety .....	84
Food Security.....	87
Economic Inequality.....	90
<b>Chapter 4   Community Resource Inventory</b> .....	94
<b>Community Resource Inventory</b> .....	94

<b>Community Resource Asset Mapping</b> .....	96
<b>Chapter 5   Next Steps</b> .....	107
<b>Appendix 1   Primary Data Methodology and Sources</b> .....	108
<b>Community Health Survey</b> .....	108
<b>Key Leader Survey</b> .....	123
<b>Community Focus Groups</b> .....	132
<b>Key Leader Interviews</b> .....	135
<b>Appendix 2   Detailed Primary Data Findings</b> .....	138
<b>Community Health Survey</b> .....	138
<b>Key Leader Survey</b> .....	178
<b>Community Focus Groups</b> .....	193
Ward 1 Focus Group.....	193
Ward 4 Focus Group.....	197
Ward 5 Focus Group.....	202
Ward 7 Focus Group.....	206
Ward 8 Focus Group.....	210
Virtual Focus Group with Residents of Wards 1, 4, 5, 7 and 8.....	215
<b>Key Leader Interviews</b> .....	222
Healthcare Access.....	223
Community Assets.....	224
Health and Wellness.....	225
Healthcare Experience.....	226
Social and Environmental Factors.....	227
<b>Appendix 3   Primary Data Summary</b> .....	228
<b>Appendix 4   Secondary Data Methodology</b> .....	229
<b>Methodology</b> .....	229
<b>Data Sources</b> .....	229
<b>Appendix 5   Secondary Data Comparisons</b> .....	255
<b>Description of Focus Area Comparisons</b> .....	255
<b>Detailed Focus Area Benchmarks</b> .....	256
<b>Appendix 6   Secondary Data Summary</b> .....	265
<b>Appendix 7   Summary of Prior CHNA Implementation Plans</b> .....	266

**Howard University Hospital ..... 266**  
**Sibley Memorial Hospital, Johns Hopkins Medicine ..... 267**

# Executive Summary

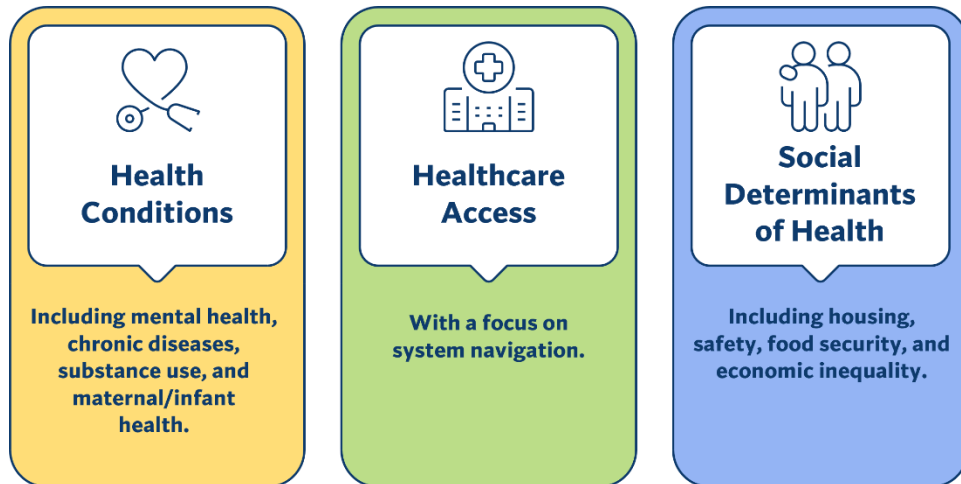
A Community Health Needs Assessment (CHNA) helps health leaders evaluate the health and wellness of the community they serve and identify gaps and challenges that should be addressed through new programs, services and policy changes. This report was created in compliance with the Internal Revenue Service requirements for not-for-profit hospitals. Employees of both Howard University Hospital and Sibley Memorial Hospital served as key members of the Steering Committee which guided the CHNA's development.

Secondary (existing) data is an important piece of the CHNA process. Numerous indicators were chosen for analysis from data sources like the Robert Wood Johnson Foundation County Health Rankings, DC Health Matters, the Annie E. Casey Foundation, the American Community Survey, and the Centers for Disease Control and Prevention. Secondary data measures were gathered and organized into six categories and 20 detailed sub-categories based on common themes. Each measure was compared to national benchmarks to identify areas of specific concern for the District of Columbia. Top community needs identified through secondary data analysis included healthcare access, health equity and social determinants of health, mental and behavioral health and housing and transit.

Primary (new) data was collected through key leader interviews, community-based focus groups and web-based surveys for community members and key leaders. These efforts gathered insights from more than 500 people who live, work or receive healthcare in the District of Columbia. Key leaders most frequently represented nonprofit organizations, but participants also included government, health, and food resource leaders among others. A total of six community-based focus groups and one ad hoc focus group were conducted with a variety of community members from different Wards, demographic groups, and lived experiences. Primary data identified access to healthcare, mental and behavioral health, chronic diseases, and social determinants of health as the top priorities impacting the health and well-being of District residents.

Considering the various data aggregated for this process, the CHNA Steering Committee and their respective organizational leaders identified priority health needs of focus for the next three-year period. Leaders evaluated primary and secondary data and participated in a prioritization process to further assess the organizations' respective abilities to impact each issue based on magnitude, severity, feasibility, urgency and cost of each priority health need.

The Steering Committee ultimately selected three top priority health needs, which are shown here in alphabetical order:



The Steering Committee has also compiled a Health Resources Inventory, which describes and/or references a variety of resources available to help District of Columbia residents better meet their health and social needs.

Following completion of this report, health leaders will use the detailed findings to develop effective or enhance existing health strategies, implementation plans and interventions, and action plans to improve the communities they serve.

Howard University Hospital and Sibley Memorial Hospital remain deeply committed to addressing the critical health concerns identified in this CHNA. We recognize these priorities as our guiding compass for improving community wellbeing. At the same time, we understand that healthcare exists in a dynamic environment subject to evolving regulations, emerging health challenges, technological advancements, and shifting social determinants. While we maintain our dedication to addressing identified needs, we embrace the flexibility necessary to adapt our approaches, reallocate resources, and develop innovative solutions in response to these forces of change. This balanced commitment—to both our established priorities and nimble responsiveness—ensures we can effectively serve our communities through changing circumstances.

# Introduction

## Background

To illustrate its commitment to the health and well-being of the community, the District of Columbia CHNA Steering Committee has completed this CHNA to understand and document the health outcomes and factors most impacting residents. This CHNA was conducted in compliance with Internal Revenue Service (IRS)<sup>1</sup> requirements for not-for-profit hospitals, which mandate completion of a CHNA every three years and adoption of an implementation strategy to address identified community health needs.

The CHNA process was led by a Steering Committee that included representatives from Howard University Hospital and Sibley Memorial Hospital. To ensure broad community input as required by the IRS, these organizations collaborated to collect data through focus groups and surveys, the findings of which are detailed in this report. The process also incorporated input from individuals representing the community's broad interests, including those with special knowledge of or expertise in public health.

The CHNA process helps local healthcare leaders continuously evaluate how to best improve and promote the health of the community. This assessment builds upon formal collaborations between the Steering Committee and other community partners to proactively identify and respond to the needs of District of Columbia residents.

For this CHNA, the Steering Committee:

- Clearly defined the District of Columbia as the community served by the participating hospitals.
- Conducted a comprehensive assessment of the health needs of that community.
- Solicited and incorporated input from people representing the broad interests of the community.
- Documented all findings in this written report, which has been reviewed and adopted by each hospital facility's authorizing body.
- Will make this CHNA report widely available to the public through hospital websites and other distribution channels.

While this assessment also aligns with the Public Health Accreditation Board (PHAB)'s Standards & Measures for Initial Accreditation of governmental public health agencies, its primary purpose is to fulfill the IRS requirements for not-for-profit hospitals under Section 501(r)(3) of the Internal Revenue Code.

---

<sup>1</sup> Internal Revenue Service. Community health needs assessment for charitable hospital organizations - Section 501(r)(3). Retrieved from: <https://www.irs.gov/charities-non-profits/community-health-needs-assessment-for-charitable-hospital-organizations-section-501r3>

## Process Overview

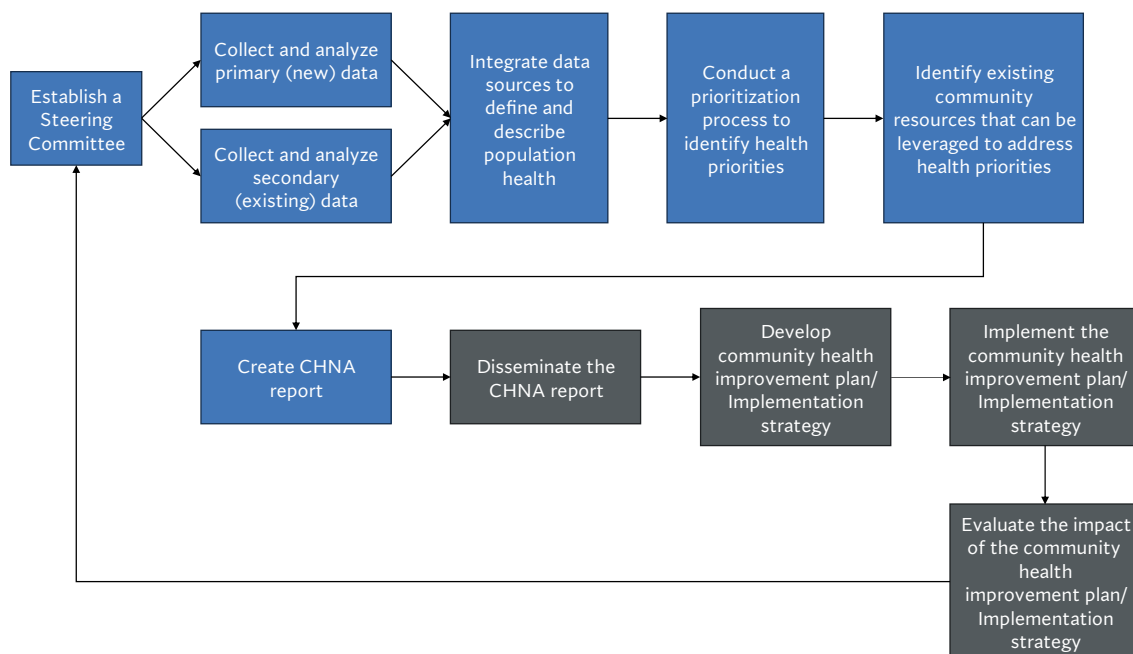
The process used to produce this CHNA followed several steps and considered numerous data sources. Both primary and secondary data were gathered, analyzed and incorporated into this report to provide a comprehensive overview of health and factors impacting health and wellbeing in the service area.

The purpose of the CHNA is to better assess, quantify, understand, and articulate the health needs of the District of Columbia. Key objectives of this process were to:

- Identify and describe the health needs of District residents.
- Identify and describe disparities in health status and health behaviors, as well as differences in the factors that contribute to poorer health outcomes.
- Understand the challenges District residents face when trying to maintain or improve their health.
- Understand service needs and gaps, particularly for underserved members of the community as it relates to their ability to maintain or improve their health.
- Uncover what District residents need to maintain or improve their health.
- Prioritize the most pressing community needs.

To achieve these objectives, the Steering Committee worked through a multi-step process documented in the blue boxes in **Figure I.1** below. The grey process steps are the next steps that will be taken by Howard University Hospital and Sibley Memorial Hospital to share CHNA findings and conduct implementation planning for each of the selected priority health need areas.

**Figure I.1: Multi-Step CHNA Process Overview**



## Report Structure

The outline below provides detailed information about each section of the report.

- 1) **Chapter 1 | Methodology** – The methodology chapter provides an overall summary of how data and information were collected and incorporated into the development of this CHNA. This also includes study limitations and the process by which priority health need areas were identified and selected.
- 2) **Chapter 2 | Community Profile** – This chapter details the demographic (such as age, gender, and race), geographic, and socioeconomic characteristics of the District.
- 3) **Chapter 3 | Priority Health Needs** – This chapter describes each identified priority health need area for the District. It summarizes new and existing data that supports and explains each health need area and why they were prioritized through the CHNA process. This chapter also describes the impact of health disparities among various sub-groups in the District specific to the priority health need areas.
- 4) **Chapter 4 | Community Resource Inventory** – This chapter documents existing health and social service resources currently available in the District that can be leveraged to address the priority health need areas.
- 5) **Chapter 5 | Next Steps** – This chapter briefly summarizes the next steps that will occur to address the priority health need areas discussed throughout the CHNA report.

In addition, the appendices define and describe various data sources used during the development of this report in detail, including:

- 1) **Appendix 1 | Primary Data Methodology and Sources** – Summaries of new data findings from key leader and community health surveys, focus groups, and key leader interviews are presented in **Appendix 1 | Primary Data Methodology and Sources**.
- 2) **Appendix 4 | Secondary Data Methodology** – Existing data measures and findings used in the prioritization process are presented in **Appendix 4 | Secondary Data Methodology**.
- 3) **Appendix 7 | Summary of Prior CHNA Implementation Plans** – Information about Steering Committee partners' actions taken to address priority health needs identified in previous CHNAs are presented in **Appendix 7 | Summary of Prior CHNA Implementation Plans**.

# Chapter 1 | Methodology

## CHNA Process Design

The process used to assess the District’s community needs, challenges, and opportunities included multiple steps. Both primary (new) and secondary (existing) data were used to ensure a more complete picture of health needs impacting residents. Various data sources gathered and reviewed for this CHNA were considered individually and integrated to identify, explain, and assist the Steering Committee in best understanding the most pressing community health needs impacting the District of Columbia.

The following sections briefly describe data gathered, analyzed, and used to inform the CHNA report and the subsequent priority health issues identified from this assessment process.

## New (Primary) Data

Engagement and feedback were gathered through multiple data collection processes over the course of several weeks from community residents and leaders throughout the District. The Steering Committee worked with Ascendent Healthcare Advisors to administer online community health and key leader surveys, to facilitate in-person and virtual community focus groups, and to complete key leader interviews. Across all four data collection strategies, 508 community and key leaders participated and offered their input and insights about health and social issues impacting their communities.

Data Collection Strategy	Total Number of Participants
Community Health Survey	424
Key Leader Survey	13
Community Focus Groups	56
Key Leader Interviews	15

### Community Health Survey

The Steering Committee worked together to develop survey questions for the community health survey. Community members aged 18-years or older were asked to participate in the online survey. Input from residents was gathered on a variety of topics, including perceptions about the most significant health and social needs in the community, personal health status, experiences seeking and receiving healthcare services, perceived barriers to accessing healthcare services, where they seek and receive health information, and health literacy. Additional details about the community health survey can be reviewed in **Community Health Survey**.

### Key Leader Survey

The Steering Committee also worked together to develop survey questions for the key leader survey. This survey was disseminated by Ascendent Healthcare Advisors to a list of more than 50 key leaders provided by the Steering Committee across the District to gather insights on several

topics. The survey asked respondents for their perceptions around greatest health and social challenges impacting the region, whether these issues have been changing over the past several years, barriers to healthcare and other services, resources currently available in the community to address known challenges, and more. Additional details about the key leader survey can be reviewed in **Key Leader Survey**.

### Community Focus Groups

Focus groups were held with residents representing five of the eight Wards within the District. They were selected based on data that indicated residents were at greatest risk for poor health outcomes. Discussion topics included health, social, and environmental needs in the community, healthcare access limitations, the needs and concerns of specific population cohorts, and perceptions of community resources. Focus group participants were asked a standard set of questions about health and social needs to identify trends across various groups and to highlight areas of concern for specific populations. Additional details about the community focus groups can be reviewed in **Community Focus Groups**

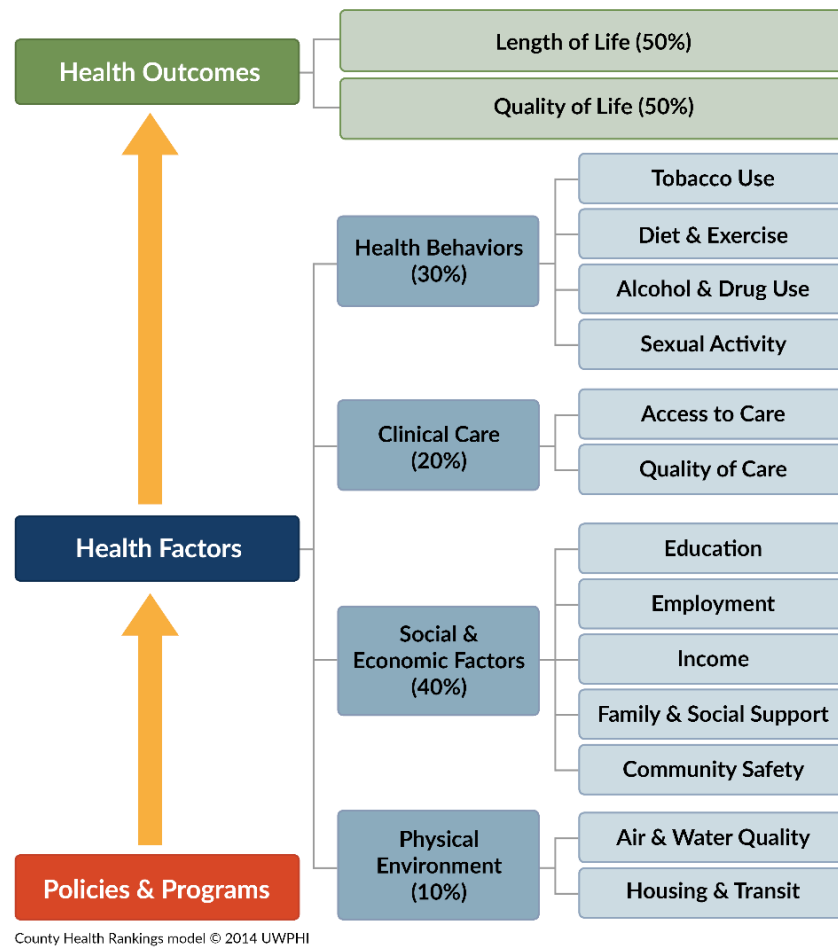
### Key Leader Interviews

The Steering Committee identified a list of key leaders representing a variety of sectors and different communities within the District who were invited to participate in interviews. Most were conducted virtually and were facilitated by Ascendent Healthcare Advisors. Interviews with Sibley Memorial and Howard University Hospitals' respective leadership were conducted by members of the Steering Committee. Interviewees were asked questions about the community they serve, specifically relating to health, social, and environmental issues and access to healthcare challenges and barriers. Additional details about the key leader interviews can be reviewed in **Key Leader Interviews**.

### Existing (Secondary) Data

Secondary data for this CHNA were gathered from multiple publicly available sources to describe geographic, demographic, social and economic factors, environmental factors, health status and disease trends, mental and behavioral health trends, and individual health behaviors. Data was gathered, organized, and presented to the Steering Committee following the County Health Rankings Model which includes a set of indicators organized by Health Factors and Health Outcomes.

**Figure 1.1: County Health Rankings Model<sup>2</sup>**



A list of select key sources of secondary data reflected in and cited throughout the District’s CHNA are reflected in the list below. Additional information about all secondary data sources, timeframes for each indicator, and indicator definitions are included in **Appendix 4 | Secondary Data Methodology**

- *American Community Survey*, as collected and published by the U.S. Census Bureau.
- *County Health Rankings*, developed in partnership by Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute.
- *DC Health Matters Community Health Dashboard*, published by the DC Health Matters Collaborative.
- *DC Data Analysis and Visualization*, published by District of Columbia Office of Planning.
- DC Health Reports.
- District of Columbia Behavioral Risk Factor Surveillance System (BRFSS).
- The Annie E. Casey Foundation.

<sup>2</sup> University of Wisconsin Population Health Institute (2024). County Health Rankings & Roadmaps. [www.countyhealthrankings.org](http://www.countyhealthrankings.org)

- *Underlying Cause of Death*, published by the Centers for Disease Control and Prevention (CDC).
- Esri Business Analyst.
- Data provided by CHNA Steering Committee members and other affiliated organizations, including CHNA reports from MedStar Health, Children’s National and the HSC Health Care System, Kaiser Permanente Mid-Atlantic States, DC Healthy People 2020, Climate Ready DC, Age-Friendly DC, Sustainable DC, District of Columbia Department of Health (DC Health), DC Health Matters 2019 and 2022 CHNAs and CHIPs, US Department Health and Human Services Surgeon General Priorities and Healthy People 2030.

## Data Integration

Primary and secondary data integration is the process of combining information collected directly from community members (primary data) with existing datasets from official sources (secondary data) to create a more comprehensive understanding of health issues.

As noted in previous sections of this report, primary data includes information gathered specifically for the assessment through methods like surveys, interviews, and focus groups. These data provide context, lived experiences, and current perceptions that may not be captured in official statistics. In contrast, secondary data comes from pre-existing sources such as census reports, national and state assessments, hospital records, and research studies. These data offer quantifiable metrics, historical trends, and comparative benchmarks.

Integration involves analyzing where these data sources align or diverge, identifying patterns that appear in both types of data, and using each to provide context for the other. This combined approach produces more robust findings that reflect both statistical realities and community perspectives, leading to more effective and targeted health interventions.

While data and key findings by data source and type are provided individually in the appendices of this CHNA report, data integration across all available sources and types was applied in **Chapter 3 | Priority Health Needs** to define, describe, and provide context and nuance surrounding the selected priority health needs.

## Comparisons

To understand the relevance of existing data collected throughout the process, each secondary data measure was compared to a benchmark, target, or similar geographic area if possible. This was done to determine how population health and factors impacting health of residents in the service area compared to similar populations or service areas. For this CHNA, each health and health factor-related indicator for the District was compared to other data as available, including the following:

- **United States:** The Steering Committee determined that comparing metrics for the District of Columbia to the United States overall was most appropriate.

Further, because of known health outcome and health factor differences within the District by Ward, there were many analyses of secondary data indicators where sub-geographies within the District were considered, and data were reported if it was available.

## Prioritization Process Overview and Results

The prioritization process for the 2025 CHNA was iterative and considered existing (secondary) data and new (primary) data gathered through a variety of methods that considered input, experiences, and perceptions of key leaders and community residents. This process began with the compilation, analysis, and discussion of secondary data across six categories and multiple focus areas based on the framework outlined in **Figure 1.1**.

Data on various indicators were presented, discussed, and prioritized according to comparisons between the District of Columbia and United States' averages. Consideration of data and health priorities identified through several other local and national initiatives, needs assessments, and analyses were also included in this first iteration of prioritization which was discussed with the Steering Committee during their second meeting in December 2024.

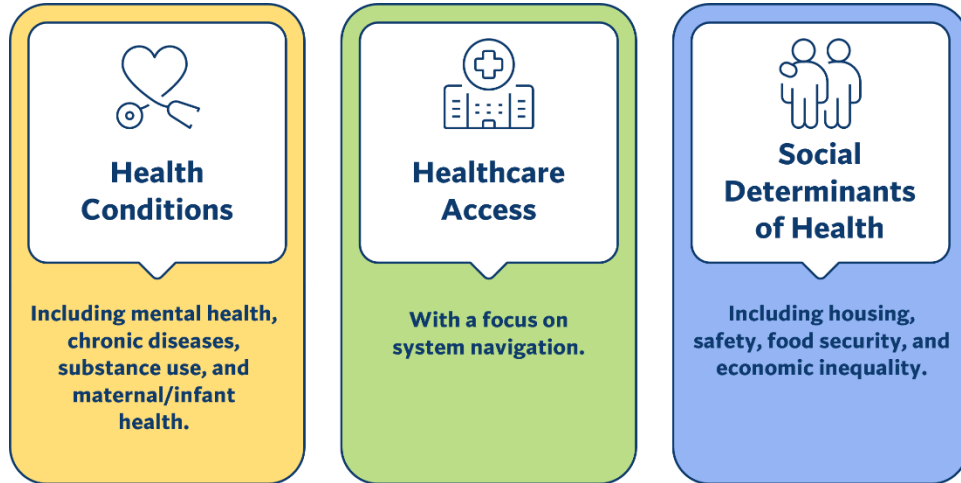
Additional primary data was gathered through community and key leader surveys, key leader interviews, and focus groups during the first two months of 2025. Primary data was added to secondary data findings and presented to the Steering Committee in March 2025.

A prioritization process was conducted using group polling to evaluate and prioritize a broader list of possible priority health outcomes, social and environmental drivers known to impact those health outcomes. Voting resulted in an abridged list of priorities that were then discussed by Steering Committee members with consideration of the following:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Availability and feasibility of solutions or strategies;
- Level of resource availability to address the health need; and,
- Community will or support to address the health need.

The top health priorities were then taken by Steering Committee members to their respective hospital leadership for further discussion and affirmation. Following this affirmation process, the final priorities were agreed upon by the Steering Committee members. The priority health needs selected through this CHNA process are not ranked in order of importance and will be addressed by the Steering Committee over the next three years of this CHNA cycle. The selected priorities for the 2025 CHNA cycle include: *Health Conditions, Healthcare Access, and Social Determinants of Health*.

**Figure 1.2: District of Columbia 2025 Priority Health Needs**



## CHNA Data Limitations

When considering the findings of this assessment, it is important to recognize the difference between using research methods to identify community needs and processes used to conduct scientific research to produce or discover new knowledge. This CHNA aligns more closely with the former, as it focused on gathering and using data from a variety of sources to identify and understand what is happening in the community. The CHNA accomplished this goal, but not without notable limitations that are described below.

Data limitations in all CHNAs can include:

- Inaccurate or incomplete secondary data;
- Limited sample size in primary data collection;
- Potential biases in self-reported information;
- Lack of data on specific demographics or health disparities; and
- Data collection methodologies.

Limitations observed in this CHNA are described more specifically in the following section of the report.

### Primary (New) Data

Elements of this assessment, like web-based surveys, focus groups, and interviews gathered insights from community members and key community health leaders on a variety of topics. Due to time and resource constraints, as well as the community-based versus research-based approaches to conducting the CHNA, primary data collected for this process was gathered through convenience-based sampling methods.

While the Steering Committee was committed to gathering input from a broad cross-section of the community, it is important to note that the data collected is not fully representative of the community's demography and geography. However, those invited and/or that chose to participate in the process offered their expertise, perceptions, and understanding of health and community

issues to the best of their ability based on their own lived experiences and/or interactions with service recipients in the region. The Steering Committee values the input and context provided via the primary data collected through the CHNA process in the District of Columbia, while also acknowledging its limitations as standalone sources of data.

## Secondary (Existing) Data

Timing of Data Collection - CHNA data may not always reflect current community conditions due to timing challenges with data sources. While developing this assessment, newer information may have been released after our analysis period ended. Most secondary data sources have a one to three-year lag between collection and publication. For instance, at the time of writing this report, the 2023 Census bureau data is the most recent available. However, it should be noted that the Steering Committee opted to use 2022 Census data in this report because the 2022 data was available at the Ward level through the District of Columbia Office of Planning.

To best address these limitations in the current planning cycle, the Steering Committee gathered supplemental insights through interviews, focus groups and online surveys of community members and leaders.

Inconsistent Data Definitions and Methodologies - CHNA metrics often suffer from inconsistent definitions and methodologies across different data sources, making meaningful comparisons challenging. National agencies may collect information using different parameters than state agencies, while states themselves frequently employ varying definitions, measurement approaches, and collection timeframes for the same health indicators. These inconsistencies can manifest in differing age group categories, racial/ethnic classifications, or geographic boundaries, creating data gaps when trying to compare communities across state lines. Additionally, changes in data collection methods over time can disrupt trend analysis, further complicating efforts to identify health disparities or measure progress effectively.

Where possible, the CHNA provides analysis by Ward but there are some indicators where this is not possible due to sourcing and the way in which data was collected. It should also be noted that the boundaries of the eight Wards in the District are updated every ten years based on the results of the latest decennial Census. The latest updates were approved in 2022 so older data may be based on slightly different Ward boundaries.

Demographic Underrepresentation - It is also worth noting that some existing data sources provide limited demographic breakdowns by factors such as gender, age, race, and ethnicity. Underrepresented populations, including undocumented immigrants, homeless individuals, or those without reliable internet access, are frequently missed in standard data collection processes. To best address these limitations, the Steering Committee identified key leaders in the District that work with and/or represent underrepresented populations to ensure their interests were raised within the primary data gathered for this assessment. Further, the Steering Committee monitored survey responses during the data collection process to identify lower response areas and inform strategic outreach to populations, had the community survey translated into four languages trying to improve accessibility, and worked to recruit focus group participants from all walks of life to share lived experiences of underrepresented groups in these forums.

## Chapter 2 | Community Profile

This section of the CHNA report describes the service area by geographic and select demographic characteristics. It is broken into two major sections – Geography and Demography - with corresponding sub-sections.

### Geography

The District of Columbia sits along the Potomac River in the mid-Atlantic region. It covers a total of 68 square miles, including 61 square miles of land and seven square miles of water. The District of Columbia is an urban area, with no population residing in a rural area.

The District of Columbia is both the capitol of the United States and a vibrant cultural hub, with its landscape dominated by iconic federal buildings, including the Capitol Building, White House, and Washington Monument. The city hosts over 175 embassies and numerous international organizations, making it a center of global diplomacy. This governmental presence drives the local economy, with federal agencies, lobbying firms, think tanks and government contractors employing a significant portion of the workforce.

The District of Columbia is divided into eight Wards, each serving as both a political and community boundary. These wards form the basic structure of the city's governance, with each electing a representative to the DC Council. The Wards showcase the District's diverse neighborhoods and communities as they vary significantly in character, demographics, and economic development.

The Ward system creates distinct identities across the city, with some wards being predominantly residential while others contain major employment centers or cultural institutions. There are notable socioeconomic differences between Wards, particularly between the Northwestern Wards, which tend to be more affluent, and the Southeastern Wards which have historically faced more economic challenges.

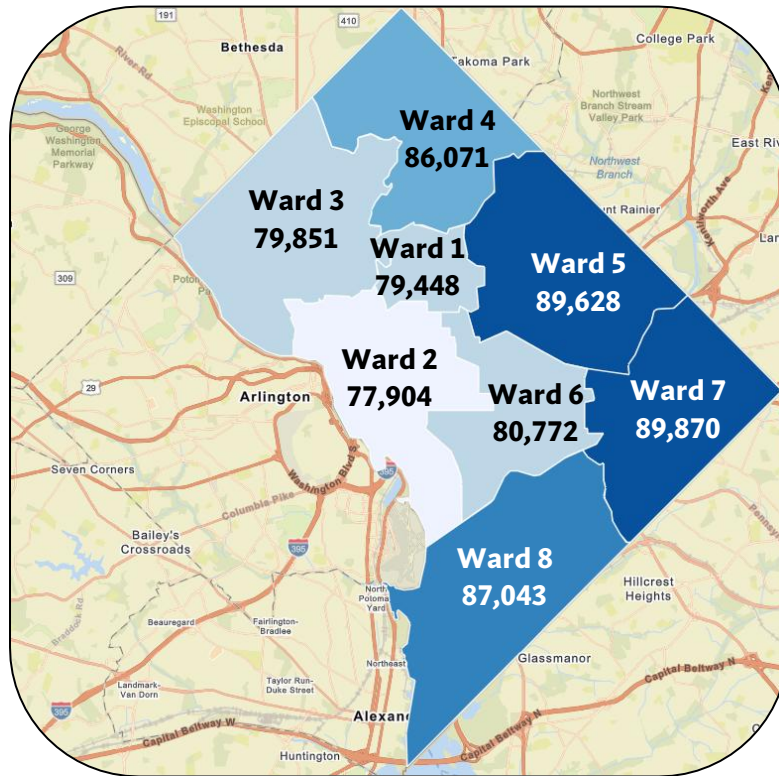
### Demography

Population figures discussed throughout this chapter were obtained from the District of Columbia Office of Planning, the U.S. Census Bureau, and Esri, a leading GIS provider that utilizes U.S. Census data projected forward using proprietary methodologies.

#### Total Population Overview

The population of the District of Columbia (670,587) represents approximately 0.2% of the total United States population. The population in the District is relatively evenly distributed across the eight Wards, with the population in each Ward ranging between 75,000 and 90,000 residents. Each Ward was represented in the primary data collection process, though participation rates were not equally distributed across the Wards.

**Figure 2.1: 2022 Population<sup>3</sup>**

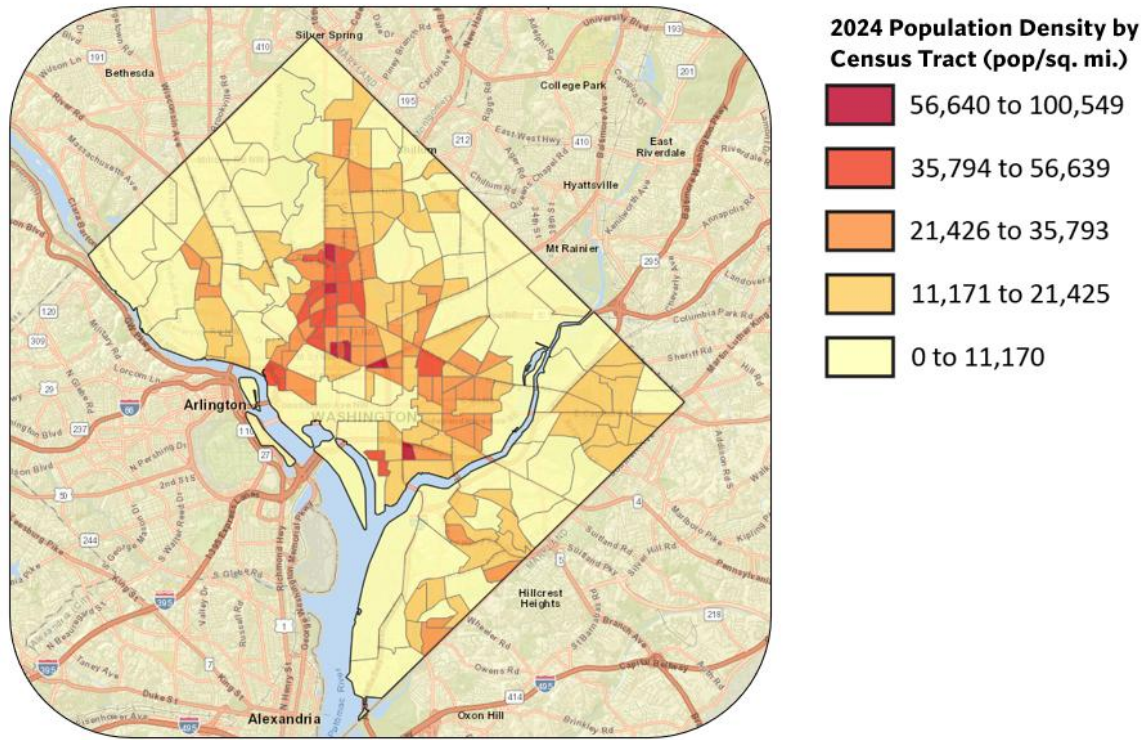


### Population Density

Population density in the District varies widely. The map below shows census tract-level data about population density. The darker colors demonstrate areas with greater population density and the lighter colors show lower population density. The densest population areas of the District are near Adams Morgan, Columbia Heights, Logan Circle and Navy Yard neighborhoods.

<sup>3</sup> District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table DP05, 5-year Estimates (2022)

**Figure 2.2: District of Columbia Population Density<sup>4</sup>**

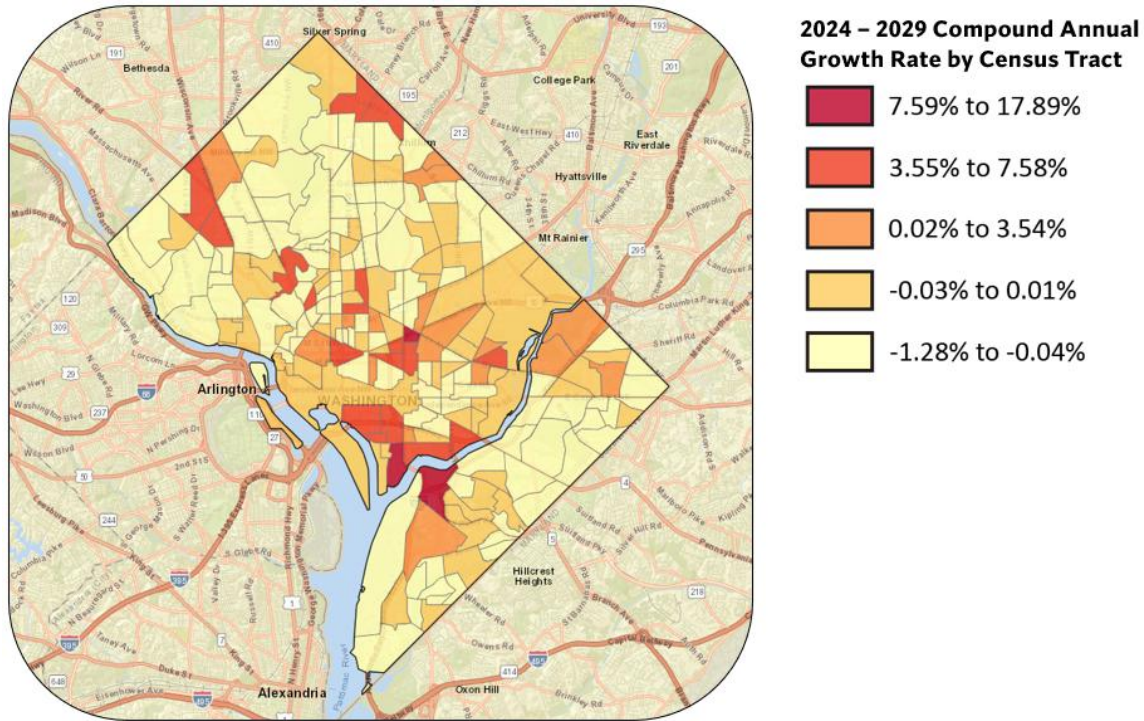


### Population Projections and Trends

The population of the District is projected to grow 0.6% annually between 2024 and 2029 with growth rates varying across the District. The map below includes census tract-level data about anticipated annual population trends, with darker colors indicating census tracts with projected population growth and lighter colors indicating census tracts with projected population losses. The greatest projected population growth is expected in The Mall, Southwest, Navy Yard, Barry Farm, Anacostia Park, Friendship Heights, Shepherd Park and Takoma neighborhood areas of the District.

<sup>4</sup> Esri, 2024

**Figure 2.3: District of Columbia Population Growth (2024-2029)<sup>4</sup>**

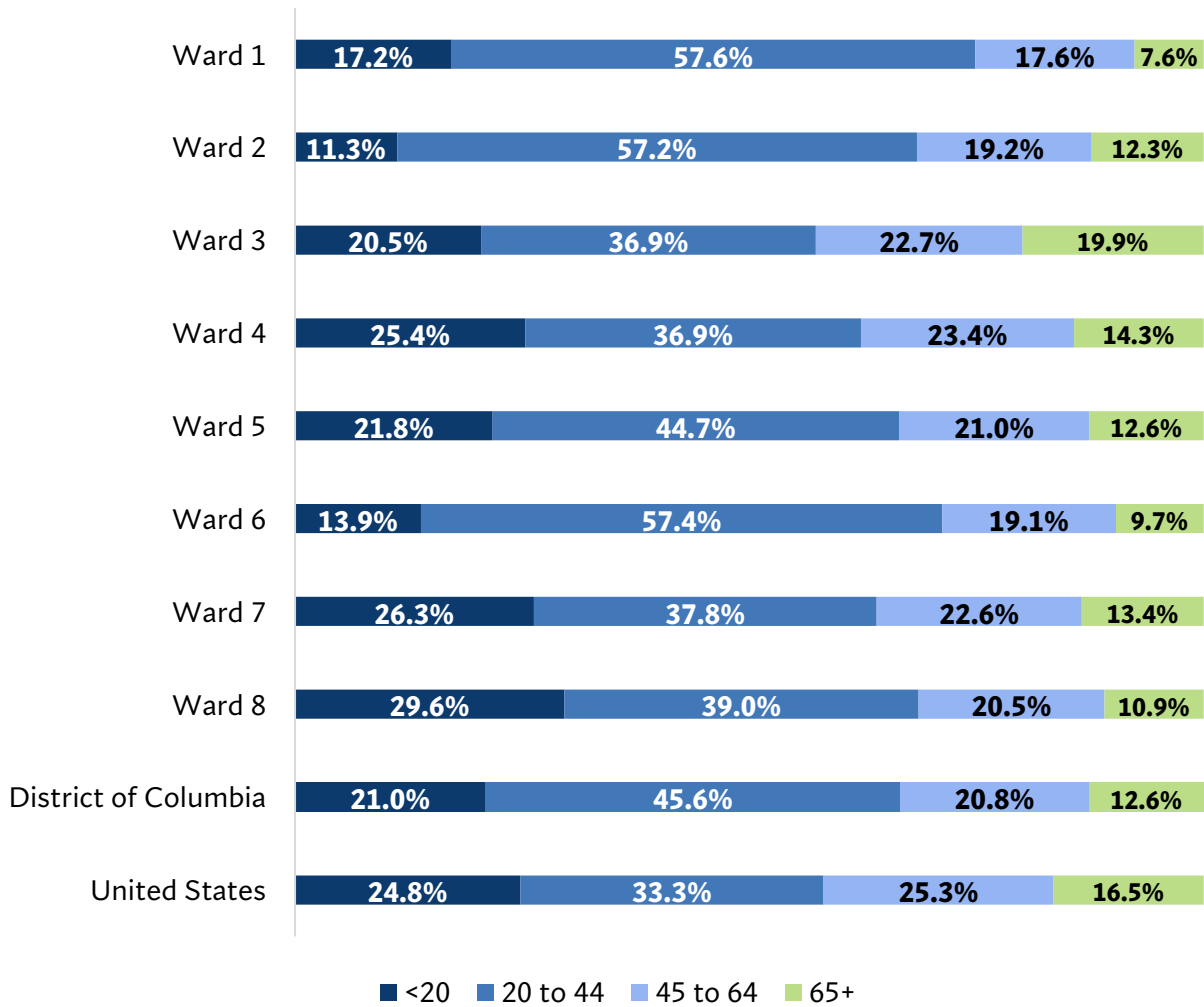


### Age and Sex of District Residents

A clear picture of our community's age and sex makeup helps leaders better understand and meet everyone's health needs. Knowing how many children, adults, and seniors live in the service area - and whether they are male or female - informs decision-making and helps ensure the right health services are being delivered in the right places. These basic details about who lives in the community also help track important health trends and compare the community's health to similar areas and similar populations.

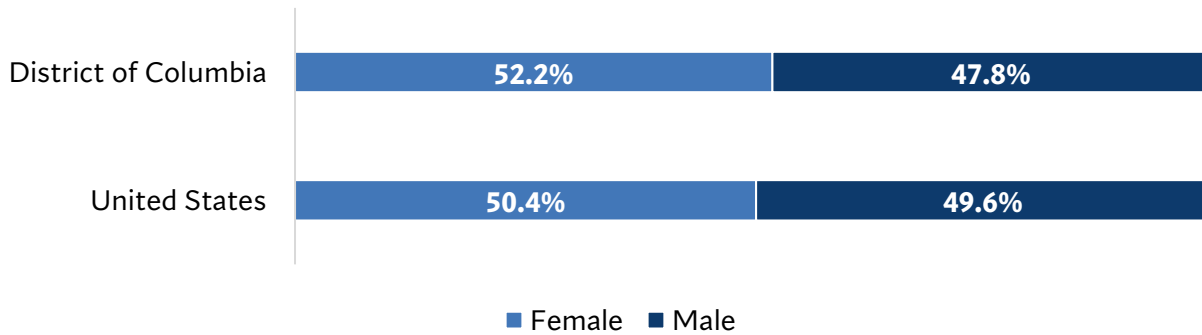
The District of Columbia has a particularly strong concentration of young and working-age adults, with smaller proportions of children and seniors compared to national demographics. Wards 4, 7, and 8 have the highest percentage of residents under age 20, while Ward 2 has a disproportionate percentage of older adults (ages 65 or older). Wards 1, 2, and 6 have the highest percentage of working-age adults (ages 20-64).

**Figure 2.4: 2022 Age Distribution, Percent of Population<sup>3</sup>**



The sex distribution of the District differs from the United States average, with a higher distribution of females than males.

**Figure 2.5: 2024 Sex Distribution<sup>5</sup>**



### Race, Ethnicity, and Languages Spoken in the District

Different cultural backgrounds can influence how people think about health, when they seek medical care, and what types of treatment they prefer. Language differences can also affect how easily community members can communicate with healthcare providers or understand health information. Some racial and ethnic groups may face higher risks for certain health conditions, like diabetes or heart disease, due to a combination of genetic, social, and environmental factors. By understanding the community’s cultural and linguistic makeup, health and other service providers can work to eliminate health disparities and ensure that quality services are accessible to everyone, regardless of their background.

#### **Race and Ethnicity of District Residents**

The District of Columbia exhibits substantial racial diversity that varies markedly across its eight Wards, contrasting with national demographics. The District of Columbia has a higher percentage of Black residents and lower percentage of White residents compared to the United States. Several Wards maintain predominantly White populations, particularly Wards 2 and 3, while nearly 85% of residents in Wards 7 and 8 are Black. The remaining racial categories (Asian, American Indian/Alaska Native, Pacific Islander, multiracial, and other racial classifications) constitute smaller proportions of District residents, mirroring national demographics.

Overall, the District of Columbia has a smaller percentage of residents that identify as Hispanic, compared the United States.<sup>6</sup> Hispanic populations vary significantly by Wards within the District with Ward 4 having nearly six times the number of Hispanic residents as Ward 8.

<sup>5</sup> U.S. Census Bureau American Community Survey Table DP05 5-Year Estimates (2022)

<sup>6</sup> Race and ethnicity (Hispanic origin) are two separate concepts, according to federal guidelines. People who are Hispanic may be of any race, and people in each race group may be either Hispanic or Not Hispanic. Source: U.S. Census Bureau Guidance on the Presentation and Comparison of Race and Hispanic Origin Data.

Table 2.1: 2022 Racial and Ethnic Distribution, Percent of Population <sup>3</sup>								
	White	Black	Asian	AIAN	Pacific Islander	Two or More Races	Other Race	Hispanic
Ward 1	51.4%	23.7%	6.1%	0.5%	0.1%	9.4%	8.8%	20.4%
Ward 2	66.8%	11.1%	9.8%	0.5%	0.1%	8.9%	2.8%	13.6%
Ward 3	74.0%	8.6%	6.4%	0.2%	0.1%	8.7%	2.1%	10.7%
Ward 4	28.5%	48.7%	1.7%	0.3%	0.0%	8.6%	12.3%	21.1%
Ward 5	26.0%	59.6%	3.1%	0.5%	0.1%	5.8%	4.9%	10.1%
Ward 6	63.0%	23.1%	4.8%	0.1%	0.0%	6.8%	2.1%	8.5%
Ward 7	7.3%	84.8%	0.6%	0.4%	0.0%	4.6%	2.3%	5.0%
Ward 8	9.6%	83.4%	1.0%	0.2%	0.0%	4.3%	1.5%	3.6%
<b>District of Columbia</b>	<b>39.6%</b>	<b>44.3%</b>	<b>4.0%</b>	<b>0.3%</b>	<b>0.1%</b>	<b>7.1%</b>	<b>4.6%</b>	<b>11.5%</b>
<b>United States</b>	<b>65.9%</b>	<b>12.5%</b>	<b>5.8%</b>	<b>0.8%</b>	<b>0.2%</b>	<b>8.8%</b>	<b>6.0%</b>	<b>18.7%</b>

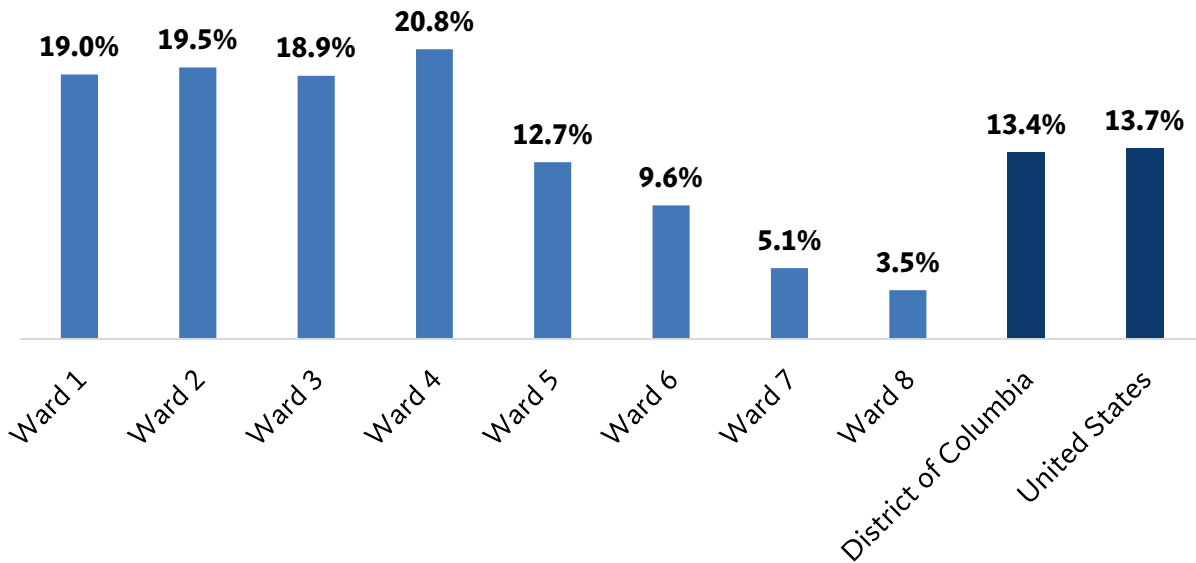
### **Foreign-Born District Residents**

The proportion of foreign-born residents helps show the diversity of experiences and potential barriers to healthcare in the community. Foreign-born residents may face unique challenges accessing health and other services due to factors like language differences, unfamiliarity with the U.S. healthcare and other systems, or concerns about immigration status. Understanding this population's size and needs when planning health services is important.

The percentage of foreign-born individuals residing in the District by Ward is provided below in **Figure 2.6**. While the percentage of foreign-born residents in the District closely mirrors that of the United States, it varies significantly depending on the Ward. Nearly 20% of residents in the central and northwestern neighborhoods in the District are foreign-born while less than 10% of residents in the southeastern Wards are foreign-born. In 2022, the three most common birthplaces for foreign-born residents of the District were El Salvador, Ethiopia, and China<sup>7</sup>.

<sup>7</sup> Data USA (2023). Retrieved from <https://datausa.io/profile/geo/district-of-columbia>

**Figure 2.6: 2022 Percentage of Foreign-Born Residents by Ward<sup>8</sup>**



**Languages Spoken at Home by District Residents**

Data about languages spoken in the community helps healthcare and other service providers understand how to effectively communicate with all residents about their health needs and available services. Understanding which languages are commonly spoken allows hospitals, clinics, and health programs to provide appropriate interpreter services and translate important health information, ensuring all community members can access and understand the care they need.

Over 80% of residents in the District of Columbia speak primarily English at home and less than 10% report speaking primarily Spanish at home, demonstrating less linguistic diversity compared to national figures. A slightly higher percentage of District residents speak Indo-European languages at home than across the United States.

Language	District of Columbia	United States
English Only	82.5%	78.3%
Spanish	9.2%	13.3%
Indo-European Languages	4.1%	3.7%
Asian and Pacific Islander Languages	2.1%	3.5%
Other Languages	2.2%	1.2%

<sup>8</sup> District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table DP02, 5-year Estimates (2022)

<sup>9</sup> U.S. Census Bureau American Community Survey Table DP02 5-Year Estimates (2022)

### **Limited English Proficiency**

People with limited English proficiency (LEP) may face challenges accessing care and other community resources that fluent English speakers do not. Language barriers may make it hard to access transportation, medical, and social services as well as limit opportunities for education and employment. Importantly, LEP community members may not understand critical public health and safety notifications. The District has a lower proportion of residents with LEP than the United States average.

**Figure 2.7: 2022 Population (Ages 5+) with Limited English Proficiency<sup>10</sup>**



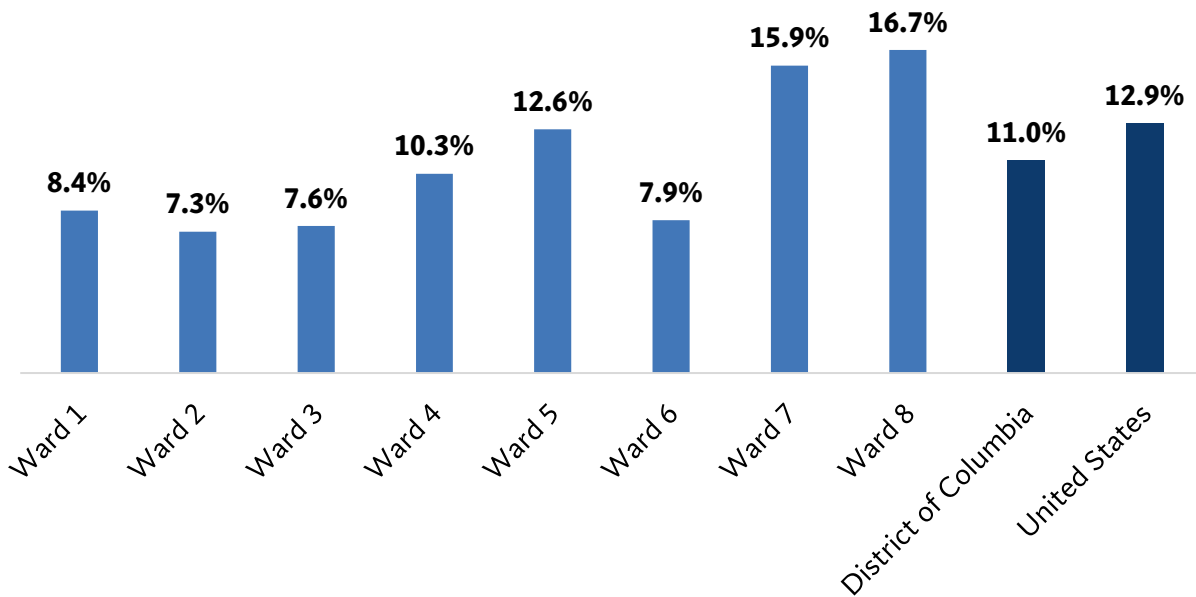
### **Disability Status in the District**

Understanding how many community members live with disabilities helps ensure healthcare services and community programs are accessible and meet everyone's needs. People with disabilities may require specialized healthcare services, accessible medical facilities, or additional support services to maintain their health and independence, making this information essential for healthcare planning. Fewer people residing in the District are living with a disability when compared to the national average, but disability rates in Wards 7 and 8 are nearly double the rates in Wards 2, 3, and 6.

---

<sup>10</sup> U.S. Census Bureau American Community Survey Table DP02 5-Year Estimates (2022). Residents over the age of 5 who speak a language other than English at home and report speaking English less than “very well.”

**Figure 2.8: 2022 Disability Rate by Ward<sup>11</sup>**



### Veteran Status in the District

Knowing how many veterans live in the community helps healthcare providers plan for their unique health needs, which may include service-related injuries or conditions requiring specialized care. Veterans may also be eligible for specific healthcare benefits and services through the VA system, so knowing the size of the veteran population helps coordinate care between local healthcare providers and veteran services. The District has a lower percentage of veterans when compared to the United States average.

**Figure 2.9: 2022 Veteran Population Percentage<sup>9</sup>**



<sup>11</sup> District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table S1810, 5-year Estimates (2022). Disability rate based on total civilian noninstitutionalized population.

## Social, Economic, and Environmental Determinants of Health

The conditions in which people live, work, and grow up - known commonly as the social determinants of health (SDOH) - play a crucial role in their overall health and well-being. These factors include access to good jobs, education, safe housing, healthy food, and transportation, as well as experiences of racism or discrimination. When communities lack these basic resources, residents are more likely to develop serious health conditions and may live shorter lives than people in communities with better resources. For example, if a neighborhood doesn't have grocery stores with fresh food or safe places to exercise, residents face a higher risk of conditions like heart disease and diabetes.

While encouraging healthy choices is important, improving community health requires addressing these underlying conditions through partnerships between healthcare providers, public health organizations, and other sectors like housing, education, and transportation. By understanding and improving these social determinants of health, communities can work to reduce health disparities and help all residents live healthier lives.



Figure outlines the Healthy People 2030 model for social determinants of health that was utilized to guide this CHNA. In the sections that follow, data highlighting social and environmental indicators impacting the health of residents in the District of Columbia are described, including:

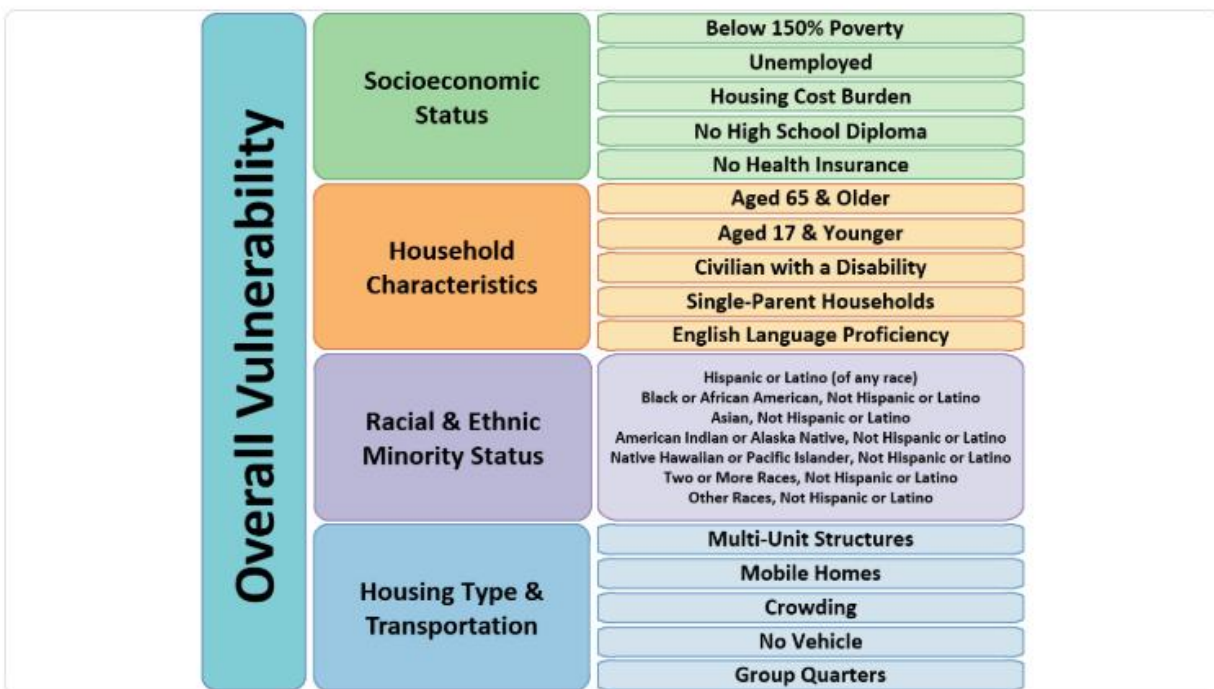
- Centers for Disease Control and Prevention's Social Vulnerability Index
- Centers for Disease Control and Prevention's Environmental Justice Index
- County Health Rankings Scores for Health Outcomes and Health Factors
- Residential Segregation Index
- Economic Factors Impacting the District
- Poverty and ALICE Households
- Educational Attainment in the District
- Healthcare Access and Quality in the District
- Housing Status in the District
- Neighborhood Safety in the District

## Social Vulnerability Index

The Social Vulnerability Index (SVI)<sup>12</sup> helps show which neighborhoods might need extra help during emergencies like natural disasters or disease outbreaks. Created by the CDC, this tool looks at different factors that can make it harder for communities to cope with these challenges, such as poverty, lack of transportation, or language barriers. The SVI combines information about a neighborhood's income levels, housing conditions, racial and ethnic makeup, and other important factors to create a score that shows how vulnerable that area might be to health emergencies. Higher SVI scores usually mean that residents in that area face more challenges staying healthy and may need more support from community services. This information helps healthcare providers and emergency planners know where to focus their efforts to help keep everyone in the community healthy and safe.

The current SVI uses 16 US Census variables from the American Community Survey which are grouped into four themes covering four major areas of social vulnerability. These variables and their corresponding categories are shown in Figure below. The data for these measures are then combined into one measure of overall social vulnerability, which is the SVI metric.

**Figure 2.10: CDC/ATSDR Social Vulnerability Index Variables<sup>12</sup>**



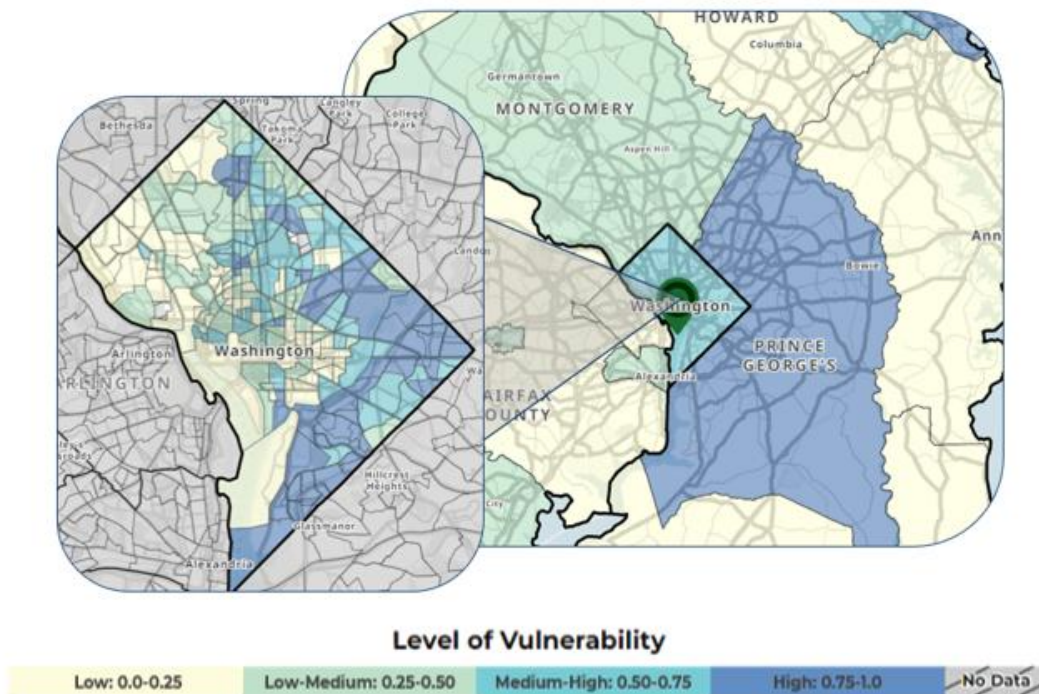
<sup>12</sup> CDC/ATSDR Place and Health – Geospatial Research, Analysis, and Services Program (GRASP) - Social Vulnerability Index (SVI) (2024). Retrieved from <https://www.atsdr.cdc.gov/place-health/php/svi/index.html>

**SVI in the District**

The closer an SVI score is to 1, the higher the social vulnerability of that community. The overall SVI score for the District is 0.6262, which indicates a medium to high level of vulnerability. **Table 2.3** illustrates SVI scores and level of vulnerability for the District and surrounding Maryland and Virginia counties. There is variation within the District, shown in **Figure 2.11**, with higher levels of vulnerability among census tracts contained within the areas corresponding with Wards 5, 7, and 8.

Table 2.3: 2022 SVI Scores and Level of Vulnerability by County <sup>13</sup>				
	District of Columbia	Maryland		Virginia
		Montgomery County	Prince George's County	Fairfax County
<b>SVI Score</b>	0.6262	0.4893	0.8161	0.2412
<b>Level of Vulnerability</b>	Medium to High	Low to Medium	High	Low

**Figure 2.11: District of Columbia Social Vulnerability Index, 2022<sup>13</sup>**



<sup>13</sup> Centers for Disease Control and Prevention (2024). Social Vulnerability Index. <https://www.atsdr.cdc.gov/place-health/php/svi/index.html>

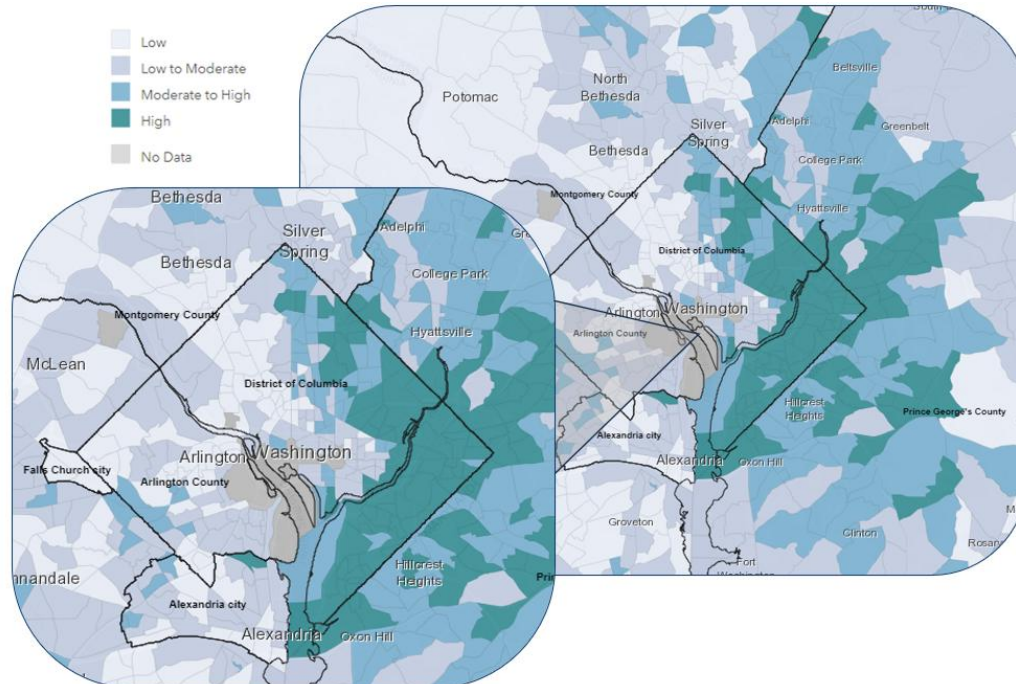
## Environmental Justice Index

The Environmental Justice Index (EJI)<sup>14</sup> helps show which neighborhoods face more environmental health risks than others due to factors like pollution, toxic sites, or other environmental hazards. Created by the CDC, this tool looks at how different environmental problems affect community health, paying special attention to areas where residents might face multiple challenges at once. The EJI combines information about environmental hazards with data about social factors like income and access to resources to create a score for each neighborhood. Higher scores usually mean that residents in that area face more environmental health risks and may need additional support to address these challenges. This information helps community leaders and healthcare providers understand where environmental problems are having the biggest impact on people's health, so they can work to make conditions safer and healthier for everyone.

### EJI in the District

EJI scores use percentile ranking to show the proportion of census tracts experiencing environmental burden relative to other census tracts in a given geography. In the District of Columbia, the EJI scores for each census tract are relative to the other census Tracts in the District. Scores range from 0 to 1, with higher scores (closer to 1) indicating communities that may experience more environmental justice concerns and greater cumulative impacts from environmental hazards and social determinants of health compared with other communities. In the District of Columbia, the level of environmental burden varies greatly across census tracts.

**Figure 2.12: District of Columbia EJI by Census Tract, 2022<sup>14</sup>**



<sup>14</sup> Centers for Disease Control and Prevention (2024). Environmental Justice Index.

[https://www.atsdr.cdc.gov/place-health/php/eji/index.html#cdc\\_generic\\_section\\_3-eji-tools-and-resources](https://www.atsdr.cdc.gov/place-health/php/eji/index.html#cdc_generic_section_3-eji-tools-and-resources)

## County Health Rankings – Health Outcomes and Health Factors

The County Health Rankings model<sup>2</sup> uses standard measures of health outcomes and health factors to rank counties on a continuum from the least healthy to healthiest in the nation. There are two rankings, one for health outcomes and one for health factors. The continuums are intended to demonstrate how an individual county fares relative to others in their respective state and the nation. Given that the District of Columbia is a unique jurisdiction, it was generally compared to the United States overall. However, in **Figure 2.13** and **Figure 2.14** the District of Columbia is compared to neighboring counties in Virginia and Maryland.

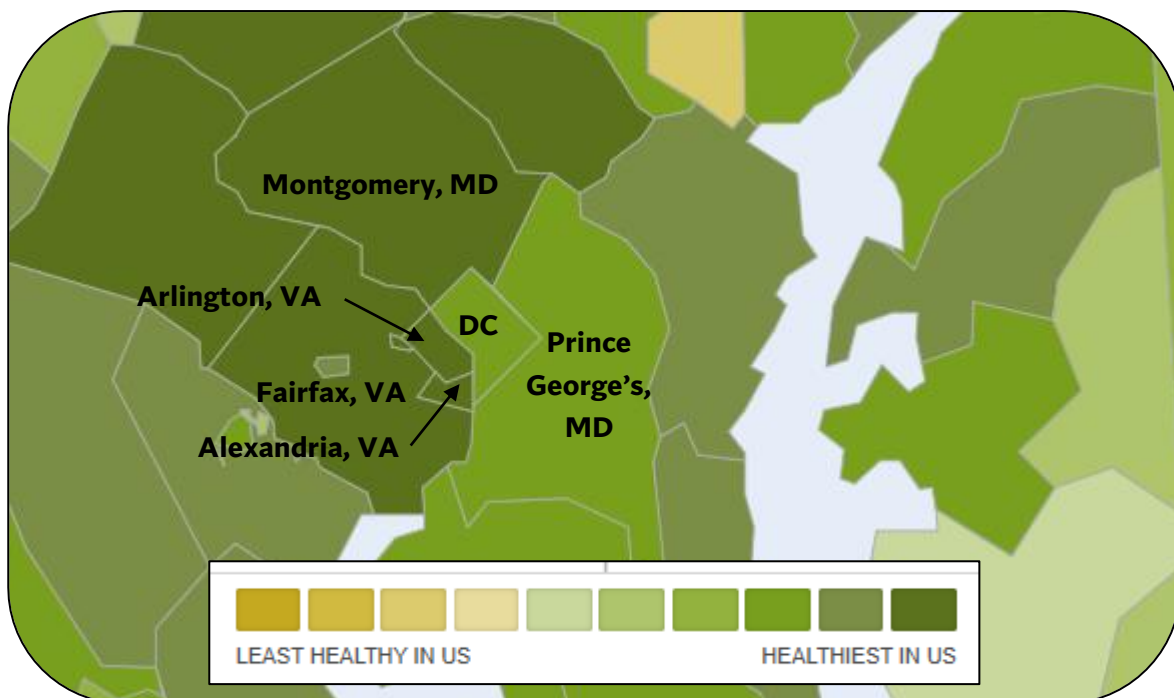
The Robert Wood Johnson Foundation and University of Wisconsin County Health Rankings allow jurisdictions to benchmark and compare their own indicators of health outcomes and community conditions, or health factors, to other jurisdictions across the United States.

### **Health Outcomes**

The County Health Rankings Health Outcome measure is a composite look at how long people in a community live and how physically and mentally healthy they are when compared to other communities across the United States.

**Figure 2.13** shows County Health Ranking maps for the District of Columbia for *Health Outcomes*. The District of Columbia ranked similar to Prince George’s County, MD but ranks lower (is considered less healthy) than Montgomery County, MD and neighboring counties and cities in Virginia.

**Figure 2.13: Health Outcomes Ranking Map<sup>2</sup>**

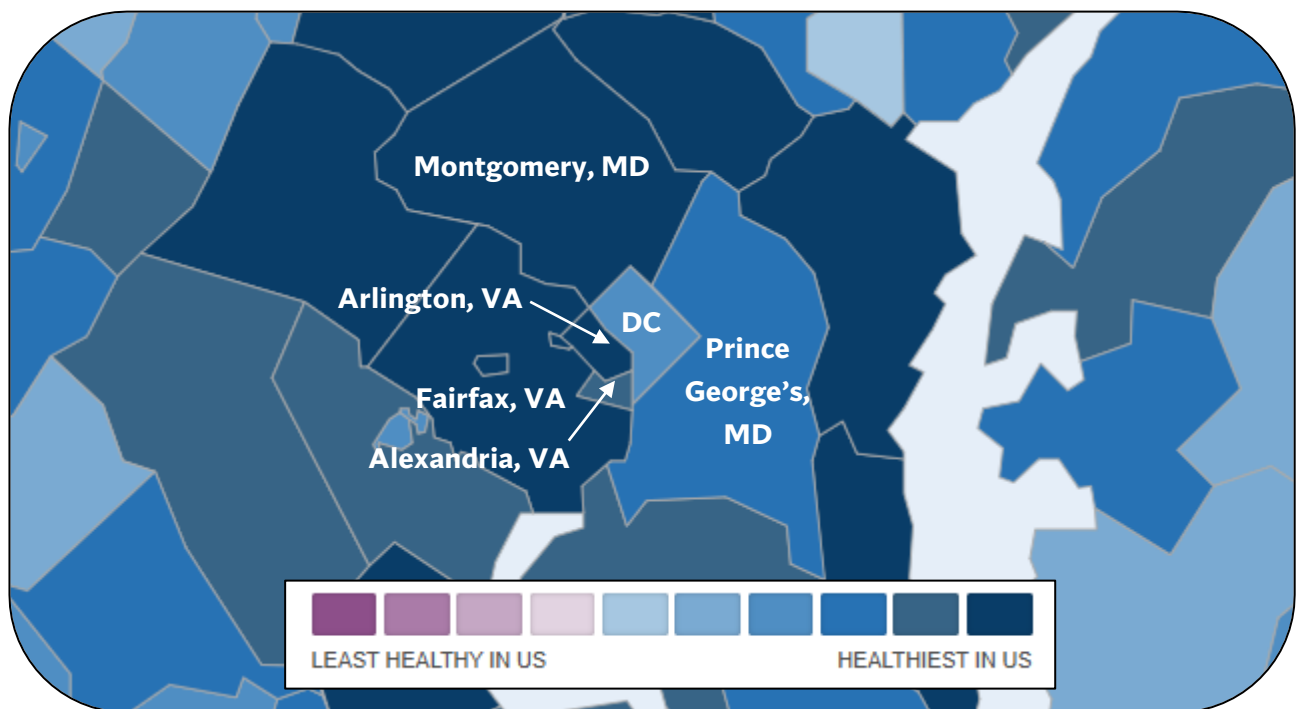


## Health Factors

The County Health Rankings Health Factors measure is a composite look at community conditions including environmental factors, health physical environment, and health infrastructure. The measure looks at the impact of social determinants of health on a community compared to across the United States.

**Figure 2.14** shows County Health Ranking maps for the District of Columbia for *Health Factors*. The District of Columbia is the least healthy when it comes to health factors and social determinants of health when compared to all neighboring counties and cities in Virginia and Maryland.

**Figure 2.14: Health Factors Ranking Map<sup>2</sup>**



## Residential Segregation Index

The residential segregation index shows how separated different racial and ethnic groups are within a community. It measures whether everyone has the opportunity to live in any neighborhood or if certain groups are concentrated in specific areas. This separation often results from historical policies and continuing practices that have limited where people can live, leading to differences in access to important resources that affect health, such as quality schools, good jobs, healthcare facilities, and healthy food options. Understanding residential segregation patterns helps explain why some groups face bigger health challenges than others and helps community leaders identify where changes are needed to ensure everyone has fair access to the resources they need to be healthy.

Residential segregation measures can range from 0 to 100, with lower values representing less segregation in a given community and higher values representing complete segregation. The index

score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas to produce a distribution that matches that of the larger area. The District of Columbia has a slightly higher segregation index than the United States.

**Figure 2.15: 2022 Residential Segregation Index (Black/White)<sup>2</sup>**



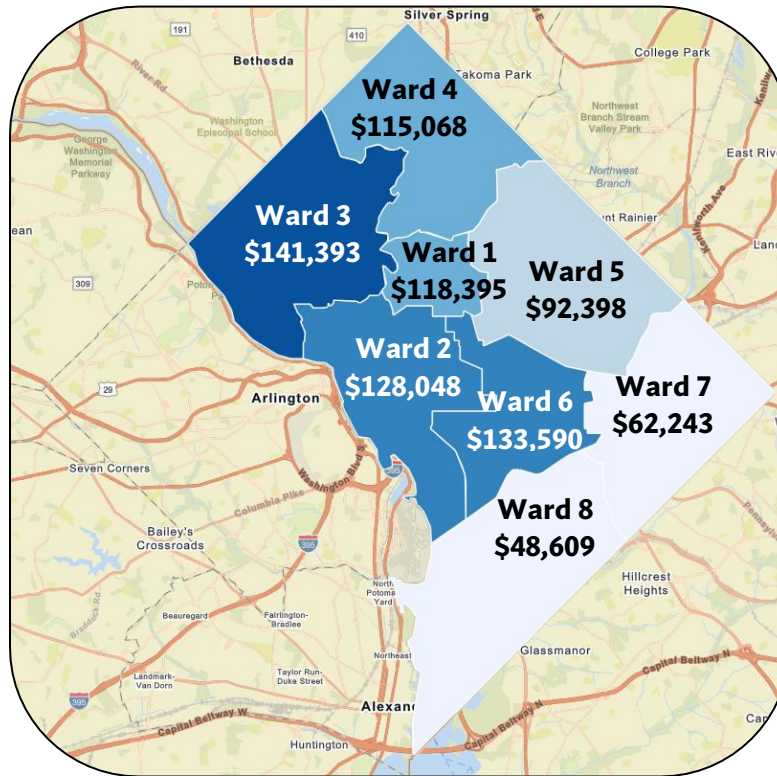
### Economic Factors Impacting the District

Understanding economic conditions in a community is crucial for addressing health needs effectively. A family's income level, employment status, and access to health insurance can significantly impact their ability to maintain good health and receive medical care when needed. Economic factors also influence where people live, which can determine their exposure to environmental health risks and their access to resources like grocery stores, pharmacies, and medical facilities. By examining these economic patterns, health planners can better identify barriers to care and services, while also developing programs that make healthcare and other services more accessible and affordable for all community members.

### **Median Household Income**

Median household income shows the typical earnings of households in a community. This information helps show whether families in the area typically have enough money to cover basic needs like housing, food, and healthcare, while also making it easier to compare economic conditions across different communities.

**Figure 2.16: 2022 Median Household Income by Ward<sup>15</sup>**



The median household income in the District of Columbia (\$101,722) is 35% higher than the national average (\$75,149)<sup>16</sup>. While this substantial income difference suggests a relatively affluent population base with greater purchasing power and economic resources compared to most American communities, there are significant income disparities between Wards with residents in Ward 3 earning nearly three times as much as in Ward 8.

### **Income Inequality**

The income inequality ratio helps show how fairly money is distributed across a community by comparing the income of the richest households to that of the poorest households. Communities with high income inequality often see bigger differences in health outcomes, as some residents have plenty of resources to stay healthy while others struggle to afford basic needs that affect their health, like nutritious food, safe housing, and medical care. Tracking income inequality is important because it can reveal whether economic opportunities are available to everyone in the community or whether certain groups face bigger barriers to achieving financial stability that could affect their health.

The gender pay gap is an important metric because economic inequality directly affects health outcomes through reduced access to healthcare, nutrition, and quality housing. This economic

<sup>15</sup> District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table S1901, 5-year Estimates (2022)

<sup>16</sup> U.S. Census Bureau American Community Survey Table S1901 5-Year Estimates (2022)

disparity often signals broader systemic inequities that particularly impact women's health and frequently intersects with other social factors like race and caregiving responsibilities, allowing healthcare planners to develop more targeted interventions.

<b>Table 2.4: Income Inequality Measures<sup>2</sup></b>		
	<b>District of Columbia</b>	<b>United States</b>
Income Inequality Ratio	6.6	4.9
Gender Pay Gap	0.87	0.81

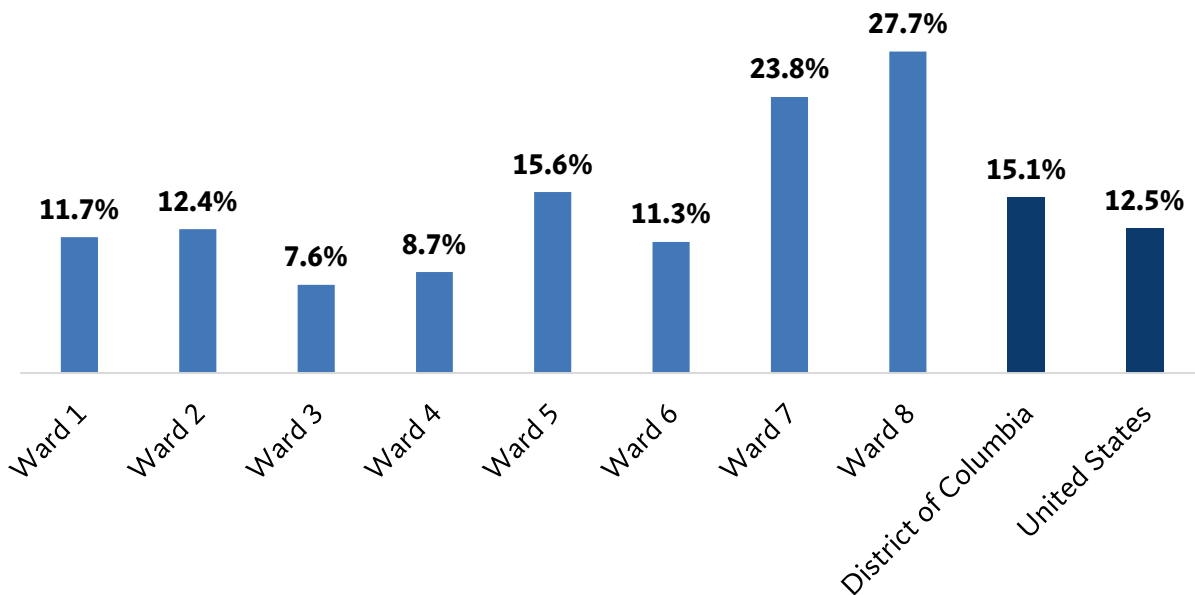
Income inequality measures the ratio of household income at the 80<sup>th</sup> percentile and the 20<sup>th</sup> percentile, whereby a higher income inequality ratio indicates a greater division between the top and bottom ends of the income spectrum in a community. Communities with greater income inequality may have worse outcomes on a variety of metrics, including mortality, poor health, sense of community, and social support. As seen in the table above, the District of Columbia has a significantly higher income inequality ratio than the United States overall, reiterating a significant wealth gap in the District.

The gender pay gap metric is a ratio of women’s median earnings to the median earnings of men for all full-time, year-round workers. The gender pay gap in the District of Columbia (women earn \$0.87 for every \$1.00 men earn) indicates that there is better gender pay equality in the District compared the United States overall but there is still work to be done to achieve equity.

**Poverty and ALICE Households**

Many households earn more than the federal poverty level but still struggle to afford basic necessities - these families are often described as ALICE households (Asset Limited, Income Constrained, Employed). The federal government sets poverty guidelines each year, and households earning less than 200% of these guidelines are often eligible for assistance programs since the official poverty level doesn't fully capture the income needed to meet basic needs in most communities. ALICE households include working families who earn more than 200% of the federal poverty level but still have difficulty covering essential expenses like housing, food, transportation, healthcare, and childcare in their local area. Together, the percentage of households below 200% of the federal poverty level combined with ALICE households shows how many families in the community may be struggling financially, even if they aren't considered officially "poor" by federal standards.

**Figure 2.17: 2022 Percentage of Households Living in Poverty by Ward<sup>17</sup>**



The percentage of households below the Federal Poverty Level (FPL) in the District of Columbia is higher than the United States overall and varies across Wards. Close to one in four households are living in poverty in Wards 7 and 8 while less than one in ten households are living in poverty in Wards 3 and 4.

In the District of Columbia Metro Area, 27% of households are considered ALICE households, compared to 29% nationally.<sup>18</sup> This, coupled with the percentage of the population living in poverty, means that many households in the District are struggling financially to cover the costs of basic expenses like housing, food, transportation, healthcare, and childcare. Data specific to the District of Columbia (i.e., not the metro area) and at the Ward level is currently unavailable for ALICE households and therefore cannot be reflected in this report.

### **Residents Receiving SNAP/Food Stamps**

SNAP (Supplemental Nutrition Assistance Program) participation rates serve as a key economic indicator, helping healthcare organizations understand financial stability within their communities. These data help identify areas where residents may face economic challenges that could impact their ability to maintain good health, allowing for more targeted support and resource allocation.

<sup>17</sup>District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table S1701, 5-year Estimates (2022)

<sup>18</sup> United for ALICE (2024). Retrieved from <https://www.unitedforalice.org/all-reports>. The District of Columbia Metro Area is based on the Washington-Arlington-Alexandria, DC-VA-MD-WV Metro Statistical Area

**Figure 2.18: 2024 Percentage of Residents Receiving Food Stamps / SNAP<sup>19</sup>**



The percentage of residents receiving food stamps/SNAP (Supplemental Nutrition Assistance Program) benefits in The District of Columbia is higher than the percentage across the United States indicating a higher proportion of residents require assistance to afford food compared to the national average.

**Unemployment**

The unemployment rate shows the percentage of people who are actively looking for work but cannot find jobs in the community. This number is important because job loss often means losing health insurance and income, which can make it harder for people to stay healthy and get medical care when needed. Examining unemployment patterns can also reveal whether certain neighborhoods or groups in the community face greater challenges finding stable work, which helps identify areas where additional support services may be needed.

**Table 2.5: 2023 Unemployment Rate Estimates by Race/Ethnicity<sup>20</sup>**

	District of Columbia	United States
White	2.7%	3.4%
Black	9.9%	7.2%
Asian	2.6%	3.5%
Hispanic	4.9%	5.2%
<b>Total Unemployment Rate</b>	<b>5.3%</b>	<b>4.3%</b>

Overall, the District of Columbia’s employment rate is higher than the national average though disparities exist across races and ethnicities. Unemployment for White, Asian, and Hispanic residents is lower than the respective national averages, however the unemployment rate for Black residents in the District is nearly three percentage points higher than the unemployment rate for Black residents nationwide.

**Educational Attainment in the District**

Educational attainment shows the highest level of education that adult residents have completed, such as high school, college, or graduate degrees. Education levels are often connected with health

<sup>19</sup> Center on Budget and Policy Priorities (2024). *A Closer Look at Who Benefits from SNAP: State-by-State Fact Sheets*. Retrieved from [https://www.cbpp.org/research/food-assistance/a-closer-look-at-who-benefits-from-snap-state-by-state-fact-sheets#District\\_of\\_Columbia](https://www.cbpp.org/research/food-assistance/a-closer-look-at-who-benefits-from-snap-state-by-state-fact-sheets#District_of_Columbia).

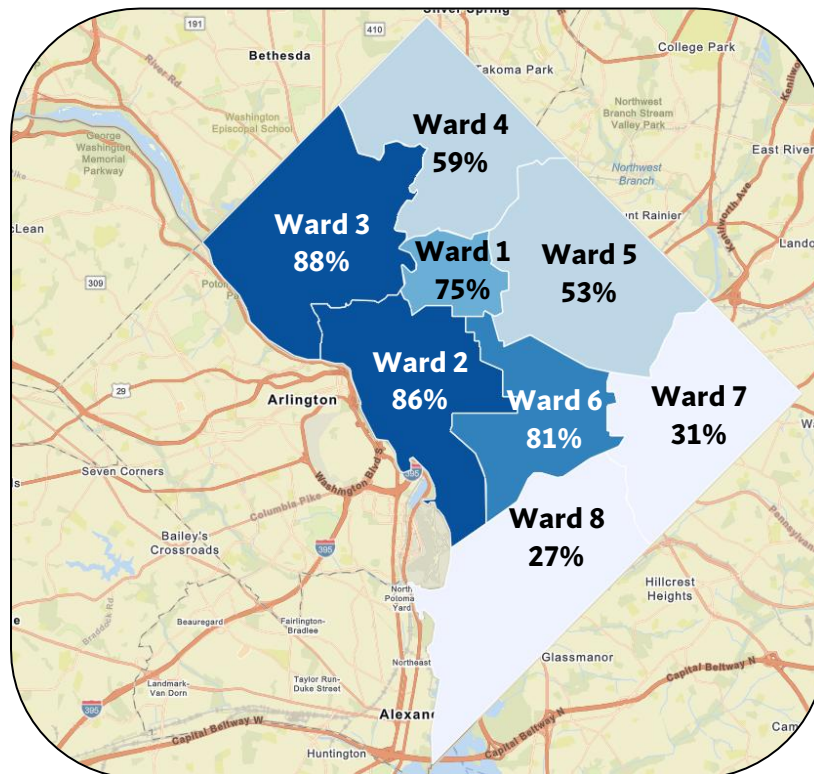
<sup>20</sup> U.S. Census Bureau American Community Survey Table S2301 1-Year Estimates (2023)

outcomes since higher levels of education typically lead to better-paying jobs with health insurance benefits and can help people better understand health information and navigate the healthcare system. Looking at education patterns across different areas of the community can help identify neighborhoods where residents might face more challenges accessing and understanding health information or services.

Table 2.6: 2022 Educational Attainment <sup>9</sup>		
	District of Columbia	United States
Less than 9 <sup>th</sup> Grade	3.0%	4.7%
Some High School, No Diploma	4.3%	6.1%
High School Graduate (or Equivalent)	15.0%	26.4%
Some College, No Degree	12.0%	19.7%
Associate’s Degree	3.1%	8.7%
Bachelor’s Degree	25.8%	20.9%
Graduate or Professional Degree	36.9%	13.4%

The District of Columbia has a more educated population than the United States with a larger percent of the population pursuing education beyond high school. Rates of high school completion are higher for District residents compared to nationwide estimates.

**Figure 2.19: 2022 Percentage of Population with a Bachelor’s Degree or Higher by Ward<sup>8</sup>**



The District of Columbia has notably high advanced educational attainment levels, with nearly two-thirds of residents having Bachelor’s degree or higher compared to only about one-third nationally. However, this varies significantly across Wards with nearly 90% of residents in Wards in the Northwest having an advanced degree compared to roughly 30% in the Southeast Wards.

**Healthcare Access and Quality in the District**

Healthcare Access and Quality is crucial in a community health needs assessment because it directly impacts health outcomes through access to preventive care, early diagnoses, and chronic disease management. It helps reveal disparities between different population groups, showing where certain communities might face barriers like transportation challenges or lack of insurance coverage. The data highlights gaps in specific services, such as mental health care or pediatric specialists, allowing healthcare organizations to better direct their resources. Poor access often leads to delayed care and increased emergency department use, resulting in worse outcomes and higher costs. Understanding these patterns helps communities plan targeted improvements to their healthcare system.

**Health Insurance Status**

Health insurance status is a critical indicator in a community health needs assessment because it directly affects whether people can afford to seek medical care when they need it. Uninsured individuals often delay or avoid preventive care and regular check-ups, which can lead to more severe health problems being discovered at later stages. Insurance coverage patterns also reveal potential economic disparities within a community and can help healthcare organizations identify where to focus their outreach efforts and financial assistance programs.

**Table 2.7: 2023 Percent Insured by Age<sup>21</sup>**

	District of Columbia	United States
18 Years and Younger	97.3%	94.6%
19 to 64 Years Old	95.8%	88.0%
65 Years and Older	99.4%	99.2%

The percentage of residents with health insurance in the District of Columbia is higher than the insurance rate across the United States. This difference is particularly noticeable in residents aged 19 to 64, as the insurance rate in the District is nearly 8% higher than the rate nationwide. This report will further explore why District residents struggle to access healthcare despite high rates of insurance in **Topic 2 | Healthcare Access**.

**Patient-Provider Ratios**

Provider-to-patient ratios are crucial metrics because they directly indicate how accessible essential healthcare services are for community members - when there are too few providers for the population, people face longer wait-times and may delay or forego needed care. Access to primary care providers enables preventive services and early intervention, while dental and mental health providers address critical needs that, if left untreated, can significantly impact overall health

---

<sup>21</sup> U.S. Census Bureau American Community Survey Table S2701 5-Year Estimates (2023)

outcomes and quality of life. These ratios also help identify potential healthcare deserts where additional resources and recruitment efforts may be needed to ensure equitable access to comprehensive care services across the community.

<b>Table 2.8: Patient-Provider Ratios<sup>2</sup></b>		
	<b>District of Columbia</b>	<b>United States</b>
Total Population per Primary Care Physician	780	1,330
Total Population per Dentist	770	1,360
Total Population per Mental Health Provider	150	320
Total Population per Advanced Practice Provider	440	760

Patient-provider ratios in the District of Columbia are higher than the national benchmarks across all listed specialties, meaning residents living in the District may have better access to primary care, dental, and mental health providers when compared to others across the United States. However, it should be noted that there are a variety of other factors impacting access to healthcare in the District beyond the patient to provider ratios. These factors are explored and further analyzed and discussed in **Topic 2 | Healthcare Access**.

### Housing Status in the District

Housing status describes whether community members own or rent their homes, how much they typically spend on housing costs, and whether they have stable housing at all. When families spend a large portion of their income on housing (more than 30% is considered "cost-burdened"), they may have less money available for healthcare, healthy food, and other necessities that affect their well-being. Housing metrics also track overcrowding, the quality and age of available housing, and homelessness in the community - all factors that can directly impact residents' health through exposure to environmental hazards like mold, lead paint, or unsafe living conditions.

**Figure 2.20: Percent of Households with Severe Housing Problems<sup>22</sup>**



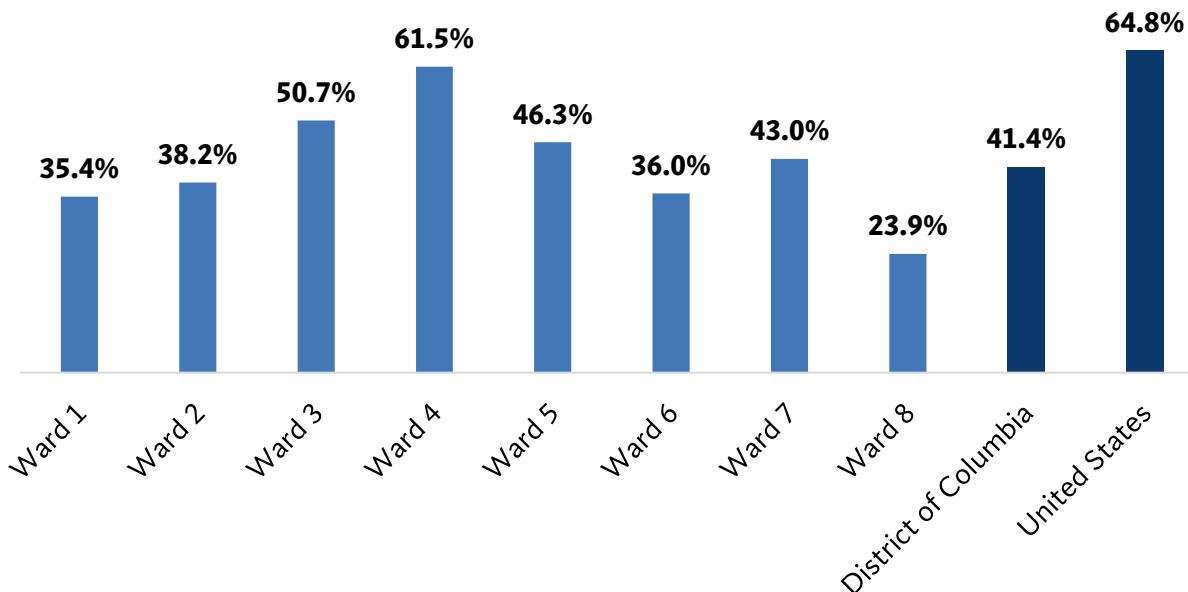
In the District of Columbia close to one in five residents experience overcrowding, high costs, lack of kitchen facilities or lack of plumbing facilities as it relates to their housing, a rate that is higher than the national average.

<sup>22</sup> Percentage of households with at least 1 of four housing problems: overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities.

### **Homeownership**

Homeownership rates can indicate economic stability in a community and show whether residents are likely to have roots in the area long-term, which affects how healthcare and other services should be planned and delivered. Owning a home often represents a family's biggest financial asset, which can impact their ability to afford healthcare and maintain stable living conditions that support good health.

**Figure 2.21: 2022 Percentage of Households that are Homeowners by Ward<sup>23</sup>**



Rates of homeownership vary across the District with Ward 4 having the highest rate of homeownership and Ward 8 having the lowest rate. None of the District's eight Wards meet the average rate of homeownership in the United States which is nearly 65%.

### **Cost of Housing**

The amount of money residents spend on housing directly affects how much they can spend on other necessities that impact health, including medical care, healthy food, and recreational activities. When families are forced to spend a large portion of their income on housing costs, they may delay getting medical care, skip medications, or make other choices that can harm their health in both the short and long term.

---

<sup>23</sup> District of Columbia Office of Planning; U.S. Census Bureau, American Community Survey 5-year Estimates (2022) and American Community Survey Table S0501, 5-year Estimates (2022)

**Figure 2.22: Percent of Households with Severe Housing Cost Burden<sup>24</sup>**



In the District of Columbia roughly one in six residents spend 50% or more of their household income on housing, indicating a housing affordability concern in the District.

**Fair Market Rent**

Fair housing markets are fundamentally linked to community health outcomes because housing stability and affordability directly impact people’s ability to meet other basic needs, including healthcare, nutrition, and preventive care. When families are overburdened by housing costs, they often must make difficult tradeoffs between paying rent and other essential expenses like medication, healthy food, or preventive medical visits. Additionally, wage levels that don’t keep pace with housing costs can force people into substandard housing conditions that may expose them to health hazards like mold, pest infestations, or poor ventilation, while also creating chronic stress from financial instability that can lead to both physical and mental health challenges. Relative to Maryland and Virginia state values and the United States, the District of Columbia has higher fair market rent.

**Table 2.9: 2024 Fair Market Rent<sup>25</sup>**

Home Size	District of Columbia	Virginia	Maryland	United States
<b>One Bedroom</b>	\$1,803	\$1,363	\$1,608	\$1,390
<b>Two Bedroom</b>	\$2,045	\$1,573	\$1,909	\$1,670
<b>Three Bedroom</b>	\$2,544	\$2,044	\$2,437	\$2,161
<b>Four Bedroom</b>	\$3,015	\$2,453	\$2,811	\$2,493

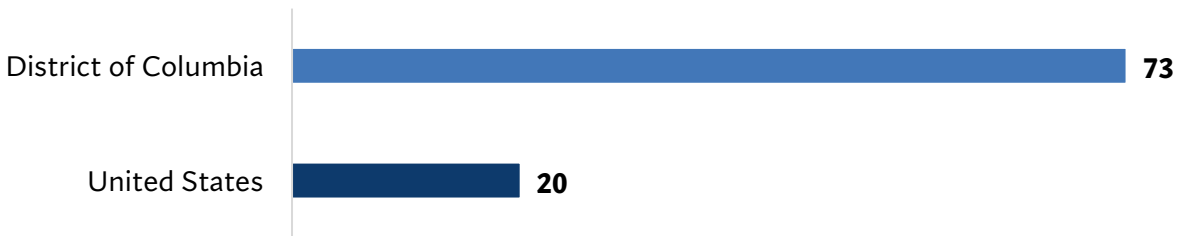
**Homelessness**

People experiencing homelessness face significant challenges maintaining their health and accessing regular medical care, making it crucial to understand how many community members lack stable housing. Homeless individuals often have more complex health needs and may rely heavily on emergency services, so tracking this information helps healthcare providers and community organizations develop appropriate services and outreach programs to better serve this vulnerable population.

<sup>24</sup> Percentage of households that spend 50% or more of their household income on housing

<sup>25</sup> National Low Income Housing Coalition, Out of Reach (2024)

**Figure 2.23: Homelessness per 10,000 People<sup>26</sup>**



The rate of homelessness in the District of Columbia is over three times as high as the rate across the United States.

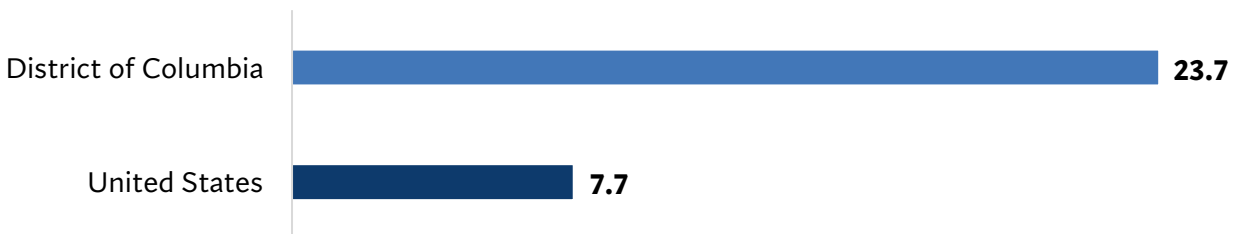
### Neighborhood Safety in the District

Crime and safety significantly impact overall health through both direct and indirect pathways. Violence directly causes physical injuries, disabilities, and deaths, while chronic exposure to unsafe environments can lead to persistent stress, anxiety, and other mental health issues. The Healthy People 2030 initiative recognizes these connections through objectives specifically targeting violence prevention and community safety as key social determinants of health.

### Homicides

Homicides devastate community health beyond the immediate loss of life, creating psychological trauma that ripples through neighborhoods and contributes to chronic stress, decreased physical activity, and social isolation among residents. These violent deaths also erode social cohesion and trust in institutions, leading to neighborhood disinvestment and deteriorating physical environments that further compromise residents' mental and physical wellbeing.

**Figure 2.24: 2022 Age-Adjusted Homicide Rate per 100,000 People<sup>27</sup>**

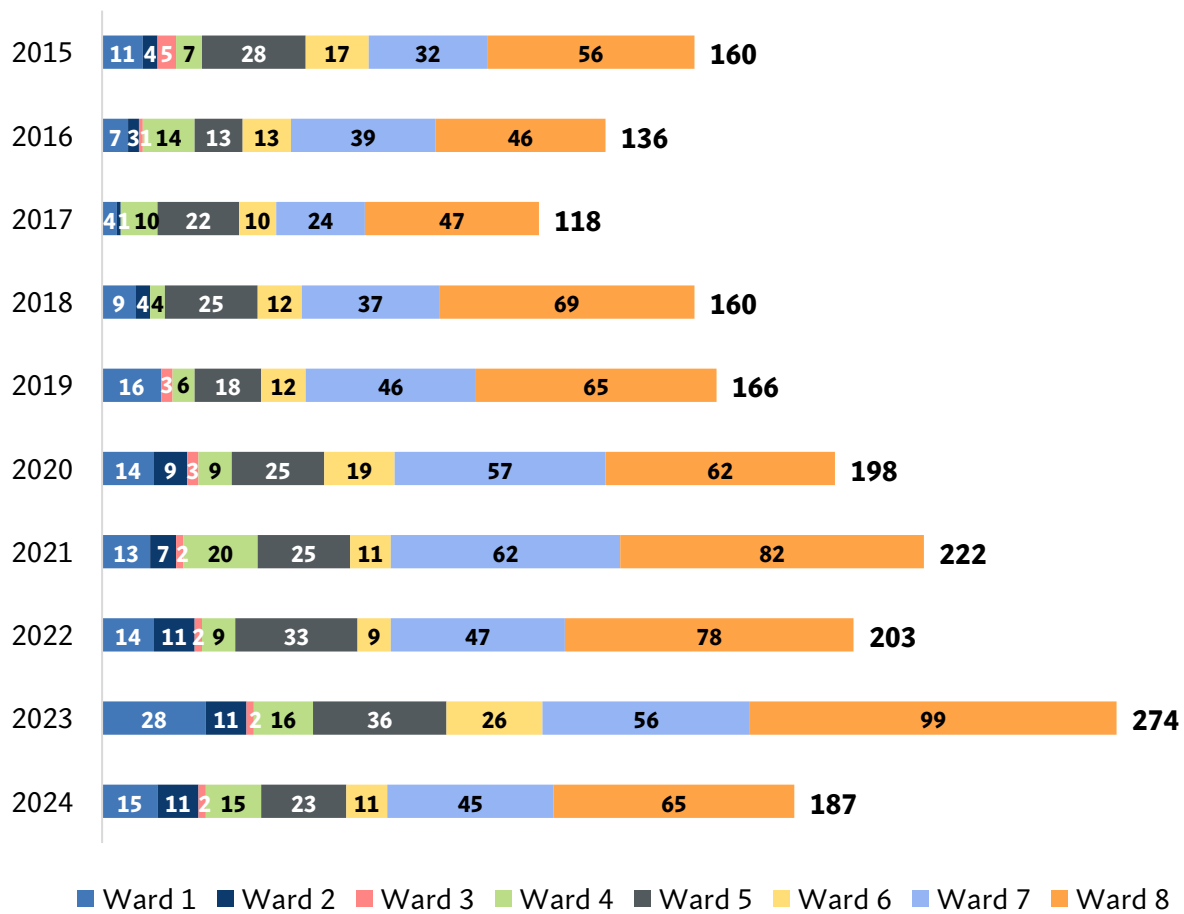


The homicide death rate in the District of Columbia is over three times as high as the homicide death rate across the United States. Over the past 10 years, there has been an average of 182 homicides within the District annually, peaking at 274 in 2023. The most homicides have consistently occurred in Ward 8 over the past 10 years.

<sup>26</sup> United States Department of Housing and Urban Development, 2023 Annual Homeless Assessment Report to Congress (AHAR)

<sup>27</sup> CDC Wonder; Underlying Cause of Death, 2018–2022, Single Race Results, Age-Adjusted.

**Figure 2.25: 10-Year Homicide Trend by Ward<sup>28</sup>**

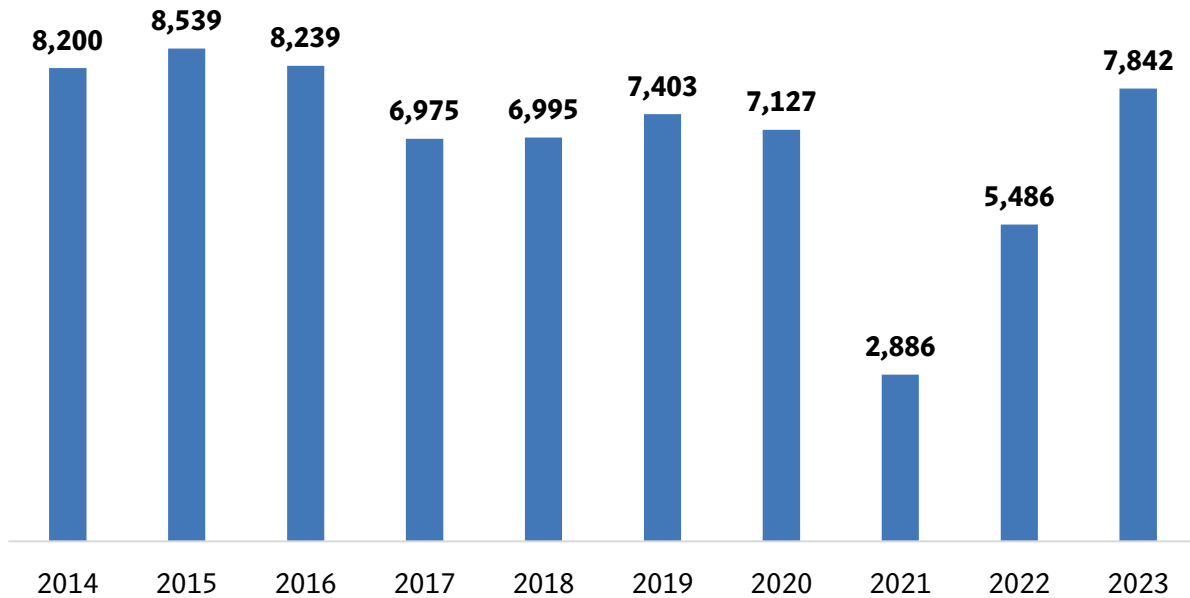


**Violent Crime**

Like homicides, the persistent presence of violent crime erodes neighborhood health by creating an atmosphere of fear that restricts residents' mobility, reduces social interaction, and triggers chronic stress responses with long-term physiological consequences. Communities experiencing high rates of violent crime often suffer from factors that ultimately contribute to health disparities and reduced quality of life.

<sup>28</sup> Open Data DC – Crime Incidents (2015-2024). Retrieved from <https://opendata.dc.gov/>

**Figure 2.26: 10-Year Violent Crime Trend in the District of Columbia<sup>29</sup>**



Other than a decline during the COVID-19 pandemic, violent crime (which includes homicide, rape, robbery, and aggravated assault) volumes have remained close to or above 7,000 over the past ten years. In 2023, violent crimes in the District reached the highest volumes since 2016.

---

<sup>29</sup> Federal Bureau of Investigation Crime Data Explorer Data Discovery Tool. Retrieved from <https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/query>

## Chapter 3 | Priority Health Needs

This chapter describes the District of Columbia's three priority health needs and discusses supporting data for each. The information in this section includes national and state perspectives while also integrating key findings from secondary data and primary data (including findings from the key leader survey, community health survey, key leader interviews, and focus groups) gathered for this assessment.

Priority health needs were determined through review of available data, discussion among Steering Committee members, and a prioritization voting process. Data was reviewed at various points in the CHNA development process, including during a prioritization meeting held once all data had been analyzed, compiled, and themed. During the prioritization meeting, Steering Committee members participated in a voting process to narrow a list of 12 health concerns and socio-environmental drivers that had emerged as possible priority health needs.

A shorter list of priority health needs resulted from that voting process and were proposed focus areas for local health leaders to address over the next three years. Additional discussion was held amongst Steering Committee members and Howard University Hospital and Sibley Memorial Hospital leadership to ensure these priorities were universally agreed upon. As noted in **Prioritization Process Overview and Results**, the Steering Committee considered the following factors when determining the priority needs reported in this assessment:

- Size and scope of the health need;
- Severity and intensity of the health need;
- Availability and feasibility of solutions or strategies;
- Level of resource availability to address the health need;
- Community will or support to address the health need.

Ultimately, the Steering Committee decided on three priority needs areas. The priority needs are listed in alphabetical order and all will be addressed by the leaders of Sibley Memorial Hospital and Howard University Hospital in health improvement plans guided by this CHNA. While the information presented in this chapter focuses specifically on the District's three identified priority need areas, a broad array of primary and secondary data across various topics was analyzed for the purposes of this report. Complete data findings and source information are captured in **Appendix 1 | Primary Data Methodology and Sources** of this report.

# Topic 1 | Health Conditions

## Context and National Perspective

### **Chronic Conditions**

As society has changed and people live longer, chronic health conditions have become more common than communicable diseases like typhoid and cholera. As defined by the World Health Organization (WHO), chronic diseases are those with a long duration, that are influenced by a combination of genetic, environmental, psychological, or behavioral factors.<sup>30</sup> Chronic health conditions are extremely common in the United States, with 6 in 10 Americans living with at least one chronic disease, such as diabetes, obesity, cancer, hypertension, or heart disease.<sup>31</sup>

Chronic diseases are the leading cause of death and disability in the United States.<sup>31</sup> According to the WHO, chronic health conditions kill 43 million people globally each year<sup>32</sup> The number of individuals living with a chronic health condition is expected to increase as the U.S. population continues to age. The population over the age of 50 is expected to increase by 61% to 221.1 million people by 2050.<sup>33</sup> Among those 221 million, nearly two-thirds (142.7 million people) are expected to have at least one chronic health condition, with approximately 15 million people living with multiple chronic health conditions.<sup>33</sup>

Cancer is a group of diseases characterized by the uncontrolled growth and spread of abnormal cells that can result in death if not treated. While the risk of dying from cancer has declined significantly over the past 30 years, it remains the second most common cause of death in the U.S. Incidence of new cancer cases has continued to rise, with 2 million new cases expected to be identified in 2025.<sup>34</sup> This trend is largely affected by the aging and growth of the population and by a rise in diagnoses of 6 of the 10 most common cancers—breast, prostate, melanoma, uterine corpus, pancreas, and colorectal cancer.<sup>35</sup> Some research has attributed this rise to the impact of the obesity epidemic.<sup>36</sup> Cigarette smoking is another significant risk factor for cancer, and is

---

<sup>30</sup> World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.

<sup>31</sup> CDC (2024). *National Center for Chronic Disease Prevention and Health Promotion*. Retrieved from <https://www.cdc.gov/chronic-disease/about/index.html>.

<sup>32</sup> World Health Organization (WHO) (2023). *Noncommunicable diseases*. Retrieved from <https://www.who.int/news-room/fact-sheets/detail/noncommunicable-diseases>.

<sup>33</sup> Ansah, J.P. & Chiu, T.C., (2022). Projecting the chronic disease burden among the adult population in the United States using a multi-state population model. *Frontiers in Public Health*. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9881650/>.

<sup>34</sup> American Cancer Society (2025). *ACS Fast & Figures 2025*. Retrieved from <https://www.cancer.org/research/cancer-facts-statistics/all-cancer-facts-figures/2025-cancer-facts-figures.html>.

<sup>35</sup> Siegel RL, Kratzer TB, Giaquinto AN, Sung H, Jemal A. Cancer statistics, 2025. *CA Cancer J Clin*. 2025; 75(1): 10-45. doi:[10.3322/caac.21871](https://doi.org/10.3322/caac.21871)

<sup>36</sup> Siegel RL, Kratzer TB, Giaquinto AN, Sung H, Jemal A. Cancer statistics, 2025. *CA Cancer J Clin*. 2025; 75(1): 10-45. doi:[10.3322/caac.21871](https://doi.org/10.3322/caac.21871)

responsible for about 20% of all cancers and 30% of cancer deaths in the U.S. each year.<sup>37</sup> Notably, recent trend analysis has shown that there is a widening gap in cancer incidence for those younger than age 50 with women being almost as twice as likely to develop cancer than men.<sup>38</sup>

The CDC recommends four ways to prevent chronic conditions and maintain good physical health. Recommended healthy behaviors include stopping or refraining from smoking, eating low-fat whole food diets, exercising moderately for at least 150 minutes a week, and limiting or refraining from consuming alcohol.<sup>39</sup> Annual physical exams with a primary care provider are also necessary to help prevent or treat chronic health conditions. Yearly screenings can allow providers to identify any warning signs for developing conditions and enable patients to correct or develop healthy behaviors to avoid developing a physical health condition. A CDC study noted that one-third of visits to health centers in 2020 were for preventive care.<sup>40</sup> For those living with chronic conditions, the CDC recommends some general steps people can take to manage their diseases. These include taking medications as prescribed by a provider, self-monitoring symptoms as needed (such as conducting home blood sugar checks), and regularly seeing a provider for check-ups.<sup>41</sup>

## **Behavioral Health**

The definition of behavioral health often describes conditions related to both mental health and substance use.<sup>42</sup> Mental health is defined as an emotional, psychological, and social state of well-being that impacts every stage of life and affects how one handles relationships, daily stressors, and health behaviors.<sup>43</sup> Substance use disorders (SUDs) are complex conditions in which there is uncontrolled use of a substance (such as alcohol or drugs), despite harmful consequences.<sup>44</sup>

Mental illnesses are common in the United States. An estimated 58.7 million adults – nearly one in four – live with a mental health condition. Nearly one in twenty adults live with a serious mental illness such as schizophrenia, bipolar disorder, or major depression disorder that can significantly interfere with one’s ability to carry out life activities. Mental health issues also impact children at high rates with nearly 8 million children (nearly one in seven) ages 3 to 17 having a current diagnosed mental or behavioral health condition.<sup>43</sup>

---

<sup>37</sup> American Cancer Society (2024). *Health risks of smoking tobacco*. Retrieved from <https://www.cancer.org/cancer/risk-prevention/tobacco/health-risks-of-tobacco/health-risks-of-smoking-tobacco.html>

<sup>38</sup> American Cancer Society (2025). *Cancer incidence rates for women under 50 rises above men’s*. Retrieved from <https://www.cancer.org/research/acs-research-news/cancer-incidence-rate-for-women-under-50-rises-above-mens.html>.

<sup>39</sup> CDC (2024). *Preventing chronic diseases: What you can do now*. Retrieved from <https://www.cdc.gov/chronic-disease/prevention/index.html>

<sup>40</sup> CDC (2022). *Characteristics of visits to health centers: United States, 2020*. Retrieved from <https://www.cdc.gov/nchs/products/databriefs/db438.htm>.

<sup>41</sup> CDC (2024). *Living with a chronic condition*. Retrieved from <https://www.cdc.gov/chronic-disease/living-with/index.html>

<sup>42</sup> American Medical Association (2022). *What is behavioral health?* Retrieved from <https://www.ama-assn.org/delivering-care/public-health/what-behavioral-health>.

<sup>43</sup> CDC. (2024). *Mental health*. Retrieved from <https://www.cdc.gov/mental-health/about/index.html>

<sup>44</sup> American Psychiatric Association (2024). *Addiction and substance use disorders*. Retrieved from <https://www.psychiatry.org/patients-families/addiction-substance-use-disorders>.

Substance use disorders (SUDs) often occur in conjunction with other mental illnesses. In 2023, 16 million (46.9%) young adults aged 18-25 reported having either a SUD or Acute Mental Illness (AMI) in the past year. In that same year, 17.1% (48.5 million) of all U.S. adults were reported as having an SUD.<sup>45</sup> These trends have been increasing in recent years, rising from 3.7% of adults with co-occurring AMI and SUD in 2018 to 13.5% by 2021, with the highest incidence among multiracial adults.

Both mental illnesses and SUDs can occur due to multiple factors, including genetics, drug and/or alcohol usage, isolation, adverse childhood experiences, and chronic health conditions. Additionally, these conditions can act like other chronic health conditions, in that they can worsen or improve depending on the environment. Access to behavioral health services has evolved in the past five years, especially during the COVID-19 pandemic. However, accessing care remains challenging. According to the National Institute of Mental Health, less than half (47.2%) of adults with a common mental illness received any mental health services in 2021, while those with an SMI were more likely (65.4%) to have received services.<sup>46</sup>

The pandemic significantly impacted public mental health and well-being in many ways. Community members continue to grapple with pandemic-related effects of isolation and loneliness, financial instability, long-term health impacts, and grief, all of which are drivers for developing both mental health conditions and substance use disorders. In addition, both drug overdose and suicide deaths have sharply increased over the past several years - often disproportionately impacting younger people and communities of color.<sup>47</sup>

There are multiple common forms of SUDs, such as alcohol use, cocaine use, cannabis use, opioid use, and methamphetamine use disorders. Treatment for behavioral health conditions generally cannot follow a cookie-cutter approach, as each person receiving treatment will have different needs. Treatment is typically provided through various therapies, inpatient admissions, and forms of medication-assisted treatment. Opioid overdoses are one of the most common types of deaths related to SUDs and can be preventable and treatable if caught in time. In 2022, nearly 108,000 people died from a drug overdose death and approximately 82,000 of those deaths involved opioids. The number of individuals that died from overdose deaths in 2022 was ten times the number in 1999.<sup>48</sup> Multiple efforts have been coordinated to increase the availability of overdose-reversing medications such as Naloxone in public facilities and over-the-counter, as was approved in 2023 by the FDA.

---

<sup>45</sup> SAMHSA (2024). *Highlights from the 2023 National Survey on Drug Use and Health*. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH%202023%20Annual%20Release/2023-nsduh-main-highlights.pdf>.

<sup>46</sup> National Alliance on Mental Illness (NAMI) (2023). *Mental health by the numbers*. Retrieved from <https://www.nami.org/about-mental-illness/mental-health-by-the-numbers/>

<sup>47</sup> Panchal, N., Saunders H., Rudowitz, R. and Cox, C. (2023). *The Implications of COVID-19 for Mental Health and Substance Use*. Kaiser Family Foundation. Retrieved from <https://www.kff.org/mental-health/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use>

<sup>48</sup> CDC (2024). *Understanding the opioid overdose epidemic*. Retrieved from <https://www.cdc.gov/overdose-prevention/about/understanding-the-opioid-overdose-epidemic.html>

## Health Conditions Overview

The Steering Committee identified *Health Conditions* as priority for 2025 CHNA. Although all diagnoses and health conditions are important to the overall well-being of residents in the District of Columbia, this report will focus on four key areas: Mental Health, Chronic Disease Substance Use, and Maternal and Infant Health. Primary and secondary data were used to identify key trends and to highlight disparities that exist between different populations based on geographic location, race, ethnicity, age, and other demographic factors. Understanding these disparities is crucial for developing targeted interventions and allocating resources effectively to improve health outcomes for all District residents.

## Mental Health

### **Mental Health Across the District of Columbia**

Mental health emerged as a consistent health concern in the District of Columbia. According to secondary data, the mental health of District residents closely mirrors national mental health trends. The percentage of residents reporting frequent mental distress is close to the national rate and, on average, residents report the same number of poor mental health days per month as the national average. Additionally, nearly one in five District residents report being diagnosed with a depressive disorder.

**Table 3.1: Secondary Mental Health Measures<sup>2,49</sup>**

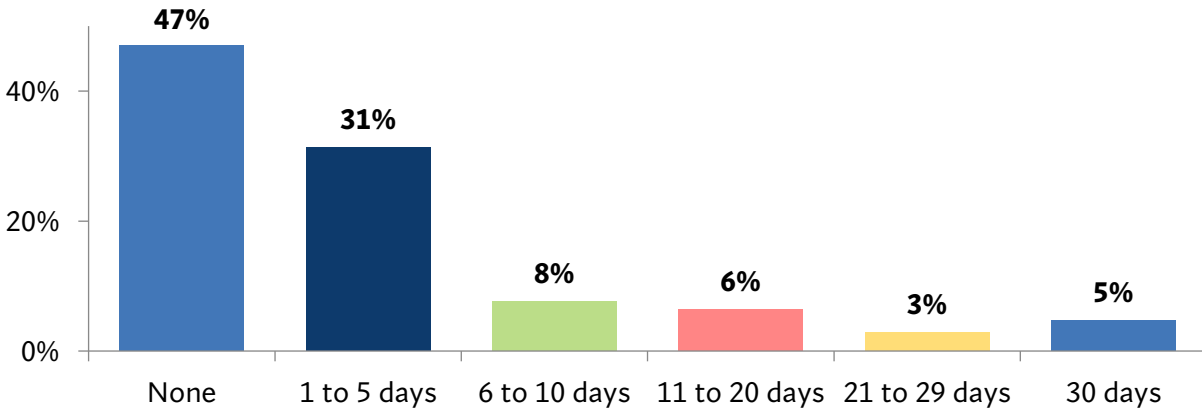
Indicator	District of Columbia	United States
Experiencing Frequent Mental Distress	14%	15%
Average Poor Mental Health Days per Month	4.8	4.8
Depressive Disorder Diagnosis	19.8%	-
Total Population per Mental Health Provider	150	320

Despite these relatively positive overall statistics, primary data collection revealed that mental health was consistently identified as a top health concern by community members and key leaders. Mental health was tied for the top health problem identified in the key leader survey and was the top health problem identified by the 18-44 age group in the community health survey. Mental health was also mentioned as a concern in 14 of the 15 of the key leader interviews.

Although nearly half of the community health survey respondents indicated that they had no poor mental health days in the last month, on average survey respondents reported experiencing 4.7 poor mental health days per month, which is consistent with the 4.8 days reported in the secondary data. It should also be noted that 5% of survey respondents indicated they considered all of their days in the past month poor mental health days.

<sup>49</sup> District of Columbia BRFSS (2020) “Diagnosed with a Depressive Disorder”

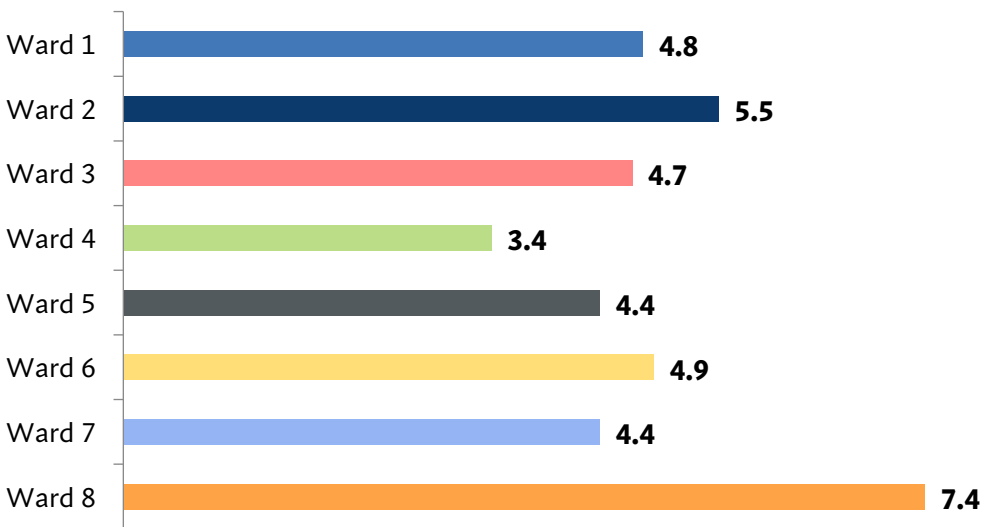
**Figure 3.1: How many days was your MENTAL health not good in the last 30 days? (n=357)**



**Disparities in Mental Health Across the District of Columbia**

Despite overall mental health measures suggesting similar burden in the District when compared to the United States averages, significant disparities exist across the District. Ward 8 residents reported significantly more poor mental health days compared to residents in other Wards. Focus group findings indicated that residents in Wards 7 and 8 expressed greater concerns about mental health, particularly among youth and older adult populations.

**Figure 3.2: How many days was your MENTAL health not good in the last 30 days (by Ward)? (n=357)**

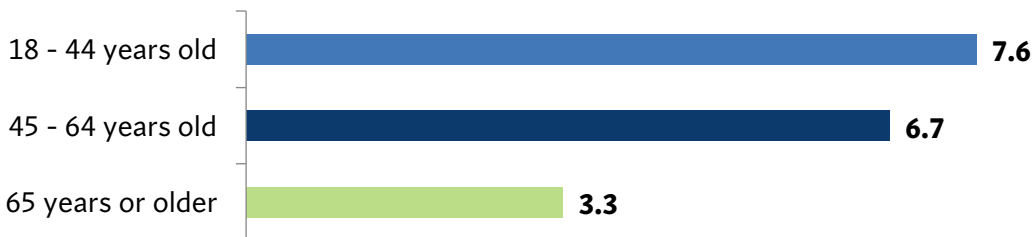


*“But we’re still not doing enough to meet the needs of mental health. We see so many of our youngsters and seniors born in crisis”*  
– Ward 7 Resident

*“I just see high rates of anxiety and...mental health challenges in my community and particularly amongst kids. It really feels like that’s been on the rise post-COVID”*  
– Virtual Focus Group Participant

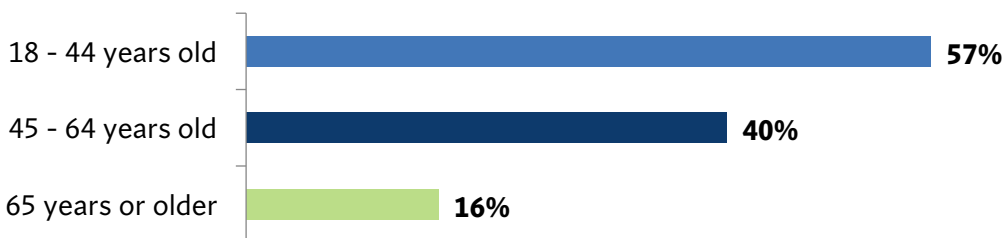
Age and racial and ethnic related disparities are also evident in the data. Younger survey respondents reported considerably more poor mental health days compared to respondents 65 years or older.

**Figure 3.3: How many days was your MENTAL health not good in the last 30 days (by Age Group)? (n=357)**



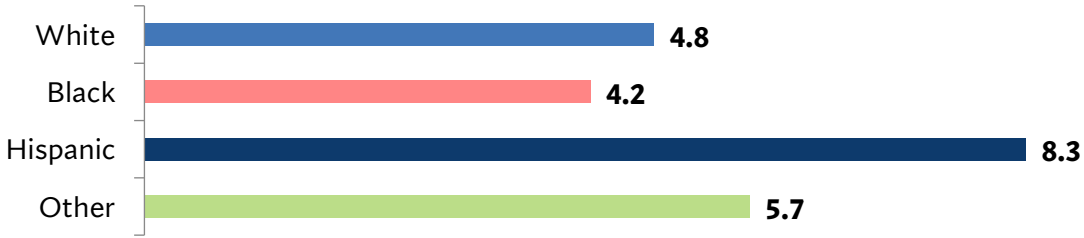
Younger survey respondents were also significantly more likely to view mental health as a community health problem than older adults.

**Figure 3.4: Percentage of respondents reporting mental health as one of the 3 biggest health concerns (by Age Group)**



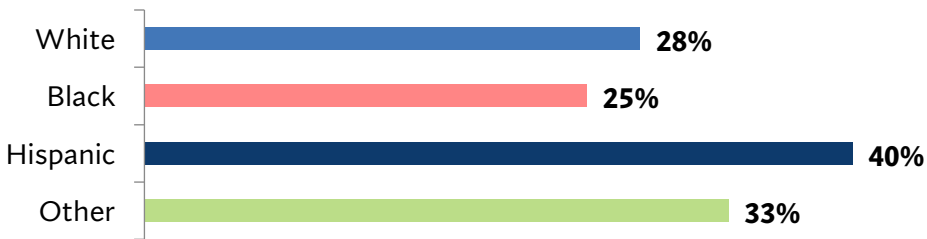
The data reveals notable racial and ethnic disparities in mental health outcomes. Hispanic respondents reported substantially higher numbers of poor mental health days compared to White and Black residents.

**Figure 3.5: How many days was your MENTAL health not good in the last 30 days (by Race/Ethnicity)? (n=357)**



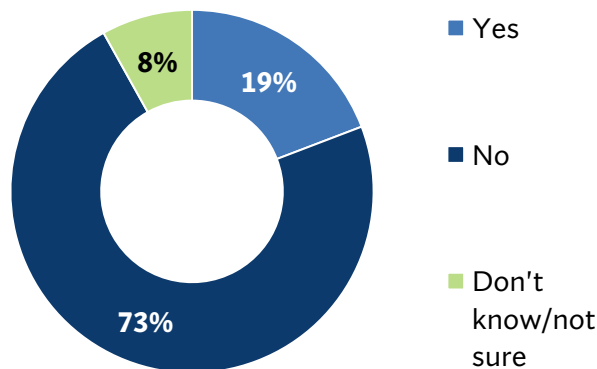
Similar trends were seen across races and ethnicities with the percentage of community health survey respondents reporting mental health as a top health concern for the community.

**Figure 3.6: Percentage of respondents reporting mental health as one of the 3 biggest health concerns (by Race/Ethnicity)**



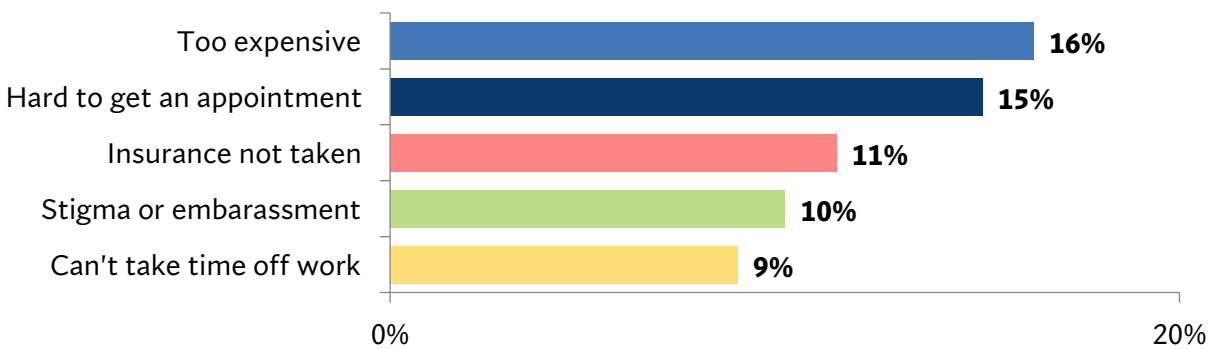
Despite the District having a better mental health provider ratio compared to the national ratio, access issues persist, indicating problems with how care is distributed and delivered. Nearly one in five community health survey respondents reported needing help with their mental health in the past year but not accessing care.

**Figure 3.7: In the past year, was there a time you needed mental health help but did not get it? (n=421)**



Cost, difficulty obtaining an appointment, and insurance acceptance were listed as the primary barriers for community health survey respondents who did not obtain mental healthcare in the past year despite needing it.

**Figure 3.8: Why Couldn't you get help with your mental health? (top 5 responses displayed excluding "Other") (n=80)**



Key leader survey respondents reported mixed perceptions about whether there were enough mental health providers in the District, with 54% somewhat agreeing and 46% somewhat disagreeing (**Figure A2.67**). Key leader interviews emphasized the inadequacy of mental health services, particularly for those with chronic and severe mental illnesses.

*"The mental health system in the District is also not great, especially for people with chronic, chronic and severe mental illnesses, and there's a lot of weaknesses in it right now, and providers have been going out of business." – Key Leader*

The data collectively indicates that while the District performs well on some mental health metrics compared to national averages, there are significant disparities in mental health outcomes and access to care across different Wards and demographic groups. These disparities suggest a need for targeted interventions to address mental health concerns, particularly in underserved communities and among youth and Hispanic populations.

## Chronic Diseases

### **Chronic Diseases Across the District of Columbia**

Chronic diseases represent significant health concerns for District residents and is represented in six of the ten top leading causes of death. Heart disease is the leading cause of death in the District with the death rate per 100,000 population being higher than the national average. The death rate for cancer, the second leading cause of death in the District, is slightly lower than the national death rate.

**Table 3.2: 2022 Leading Causes of Death (Age-Adjusted per 100,000 Population)<sup>27</sup>**

Indicator	District of Columbia	United States
Heart Disease	182.6	167.2
Cancer	141.8	142.3
Accidents (Unintentional)	90.9	64.0
Stroke	42.1	39.5
COVID-19	33.1	44.5
Homicide	23.7	7.7
Diabetes	18.2	24.1
Chronic Lower Respiratory Disease	17.3	34.3
Hypertension	11.9	10.3
Septicemia	11.3	10.1

As seen in **Table 3.3**, chronic conditions were amongst the top health concerns when both key leaders and community members were asked about health problems in the District of Columbia. Additionally, chronic disease management was mentioned in 14 of the 15 key leader interviews as a significant healthcare challenge in the District and nearly half of community health survey respondents reported being diagnosed with high blood pressure (**Figure A2.41**).

**Table 3.3: What are the 3 Biggest Health Concerns in your Community?**

Community Health Survey	Key Leader Survey
<b>1. Older adult health</b>	1. Mental Health (tie)
<b>2. Heart problems</b>	<b>1. Diabetes or high blood sugar (tie)</b>
<b>3. Diabetes or high blood sugar</b>	<b>2. Heart disease or high blood pressure</b>
4. Mental Health	<b>3. Cancer</b>
<b>5. Cancer</b>	4. Alcohol and drug problems
-	5. Smoking and tobacco use

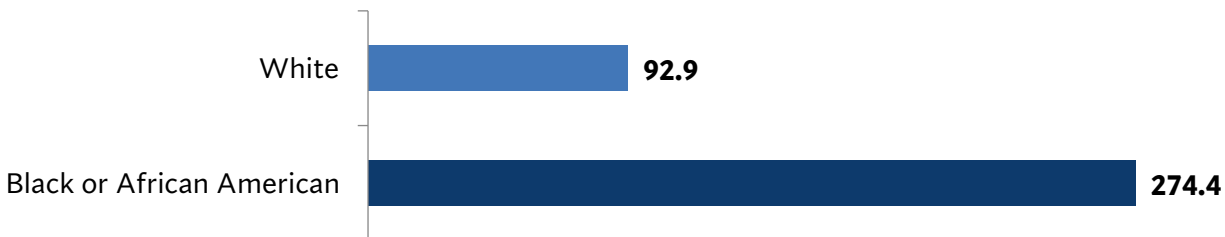
*“Everybody you know over the age of 45 is on some kind of medication.” – Ward 8 Resident*

### **Disparities in Chronic Diseases Across the District of Columbia**

Racial disparities in chronic disease prevalence are substantial across the District. In the key leader survey, 92% of respondents responded “No” to the question “*In your opinion, are health and social/environmental needs similar across DC?*” As noted, heart disease is the leading cause of death in the District of Columbia with a rate that is higher than the national average. The differences between the heart disease death rate for Black residents and White residents is particularly

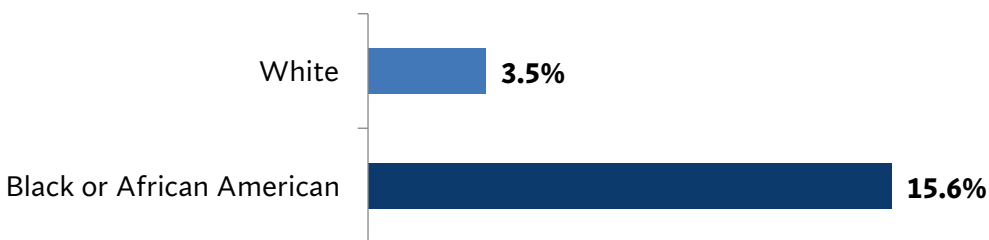
startling though, with the death rate for Black residents being nearly three times as high as the rate for White residents.

**Figure 3.9: 2022 Heart Disease Deaths by Race/Ethnicity<sup>50</sup>**



Similarly, Black residents have a diabetes prevalence that is nearly four times higher than White residents. These disparities were also highlighted in the community health survey, where Black respondents cited diabetes as a health problem at a rate more than twice as high as White respondents (**Figure A2.14**).

**Figure 3.10: 2022 Adults Who Report Ever Being Told by a Doctor that they Have Diabetes by Race/Ethnicity<sup>51</sup>**



Key leader interviews also consistently shared that health outcomes for these diseases were often worse for Hispanic and Black residents.

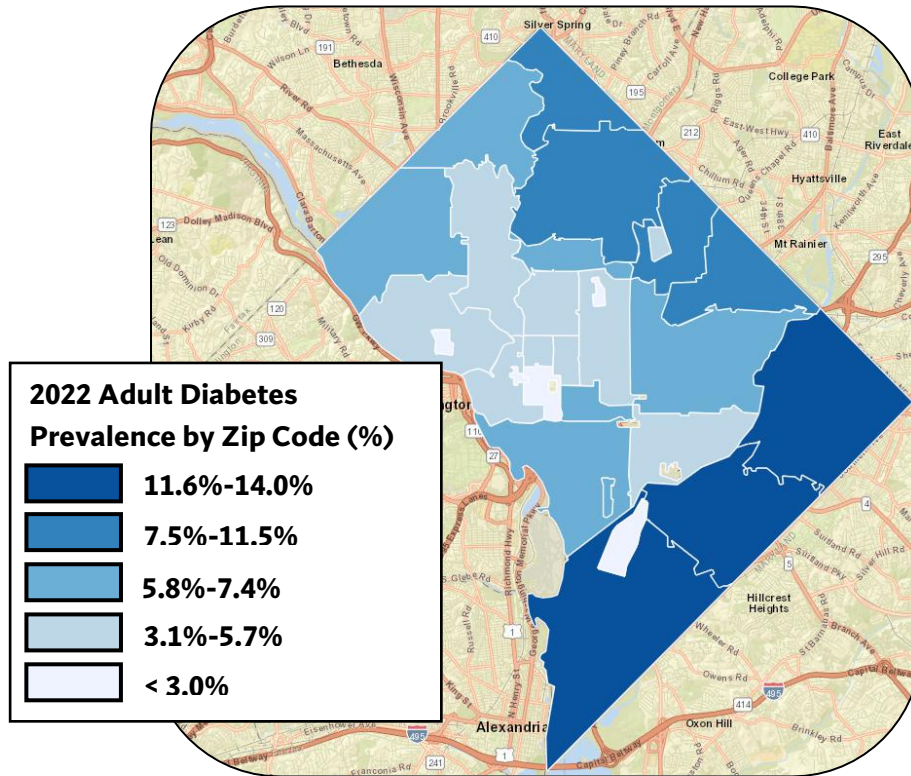
*“The black population, particularly people who reside in Ward 7 and 8 do experience disproportionate levels of chronic disease. I think that’s also true for the Hispanic community, particularly in Ward 4 Columbia Heights area.” – Key Leader*

Geographic disparities in chronic disease prevalence are substantial across the District. Diabetes prevalence in the Southeast (Wards 7 and 8) is significantly higher than in the Northwest. Concern over chronic diseases was highlighted during the focus groups in Wards 1 and 4 and the virtual focus group.

<sup>50</sup> CDC Wonder; Underlying Cause of Death via Kaiser Family Foundation. Retrieved from <https://www.kff.org/other/state-indicator/number-of-heart-disease-deaths-per-100000-population-by-raceethnicity-2/>

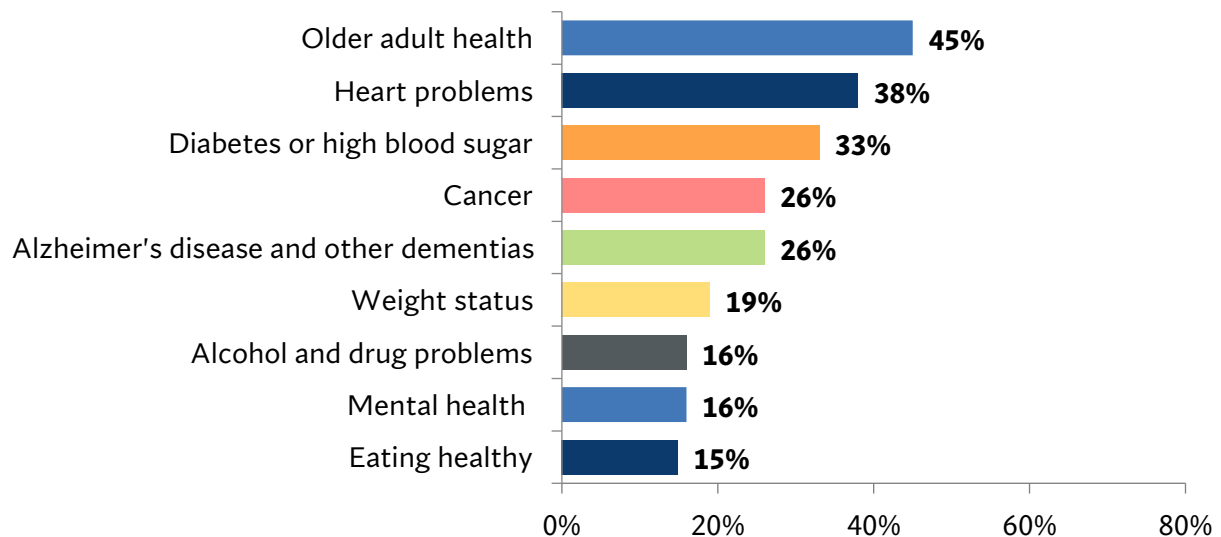
<sup>51</sup> DC Health Matters

**Figure 3.11: 2022 Adults Diabetes Prevalence (%) by Zip Code<sup>51</sup>**



Given that nearly two-thirds of community health survey respondents were age 65 or older, older adult health was naturally identified as a top health concern in the community health survey. The other top health problems identified by those age 65 or older were all related to chronic disease (heart problems, diabetes, cancer, and dementia).

**Figure 3.12: What are the 3 biggest health problems in your community? Responses from participants ages 65+ (n=269)**



Focus group discussions reinforced these concerns, with Ward 7 participants putting a particular emphasis on dementia and aging concerns and Ward 1 residents discussing the importance of senior community groups to maintain socialization.

*“Isolation, especially for seniors, affects that quality of life and that’s one way to get people kind of involved in the community” – Ward 1 Resident*

The data clearly indicates that chronic diseases, particularly heart disease and diabetes, represent significant health challenges in the District, with pronounced disparities across geographic areas and racial groups. While the District performs better overall than national averages on some indicators, the substantial disparities in outcomes suggest a need for targeted interventions that address both clinical care needs and the underlying SDOH that contribute to these disparities.

## Substance Use

### **Substance Use Across the District of Columbia**

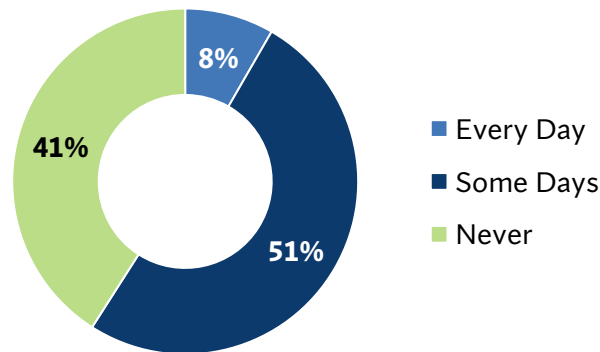
Substance use presented as a significant health concern in the District of Columbia. Secondary data demonstrated that the District has a higher percentage of residents reporting excessive drinking compared to the national average. Alcohol impaired driving deaths represent a quarter of all driving deaths which is slightly lower than the percentage seen across the United States. Although the opioid dispensing rate within the District is lower than the national average, the drug overdose death rate in the District is more than twice the national rate.

<b>Indicator</b>	<b>District of Columbia</b>	<b>United States</b>
Percent of Population Reporting Excessive Drinking	24%	18%
Alcohol Impaired Driving Deaths (% of all Driving Deaths)	25%	26%
Drug Overdose Death Rate per 100,000 Population	57	27
Opioid Dispensing Rate per 100 Persons	30.3	37.5

Primary data collection reinforced substance use as a community concern. Alcohol and drug problems were identified as significant health concerns by 23% of both community health survey (**Figure A2.12**) and key leader survey (**Figure A2.60**) respondents, however only 8% of community health survey respondents reported drinking every day.

<sup>52</sup> CDC (2023). Opioid dispensing rate maps. Retrieved from <https://www.cdc.gov/overdose-prevention/data-research/facts-stats/opioid-dispensing-rate-maps.html>

**Figure 3.13: How often do you drink alcohol (beer, wine, or liquor)? (n=420)**



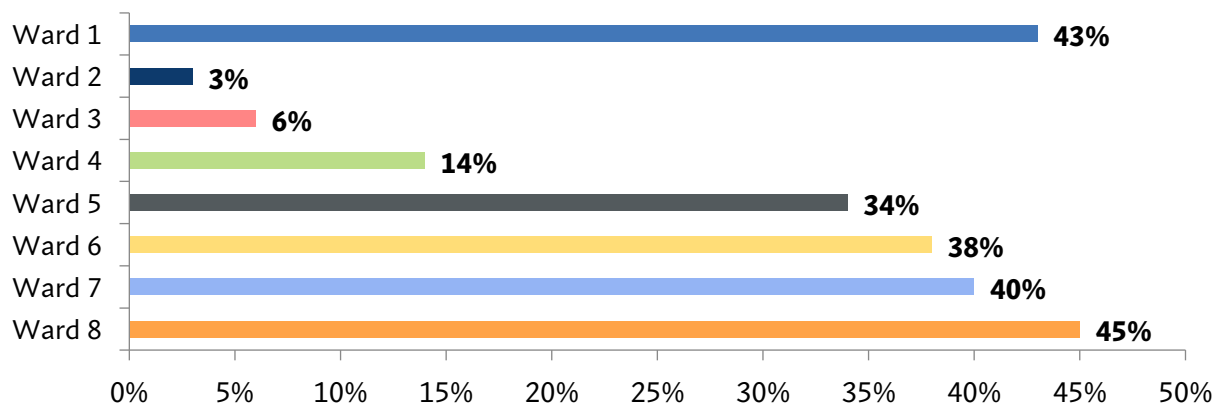
**Disparities in Substance Use Across the District of Columbia**

Geographic variations in substance use concerns were evident in the primary data. Focus group findings revealed varying levels of concern about substance use across Wards. Residents in Wards 1 and 7 expressed concerns about substance use affecting their communities. This aligns with other health disparities observed in these Wards and suggests that substance use intersects with other social and economic challenges in these areas.

*“We also have the general problem...you know the alcohol...that’s symptomatic of what the problem (is) I think. So, it looked like we have a high incident of alcohol just because you tend to see a lot of our neighbors ...they look like life has beat them down...trying to self-medicate.”*  
 – Ward 7 Resident

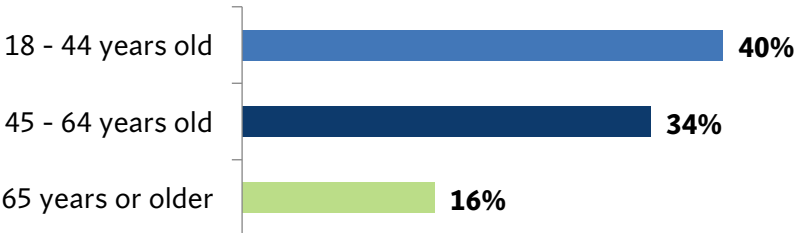
Community health survey data showed significant disparities in the percentage of respondents that reported alcohol and drug problems as a top health concern with over 40% of respondents expressing concern in Wards 1, 7 and 8 and less than 10% in Wards 2 and 3.

**Figure 3.14: Percentage of respondents reporting alcohol and drug problems as one of the 3 biggest health concerns (by Ward)**



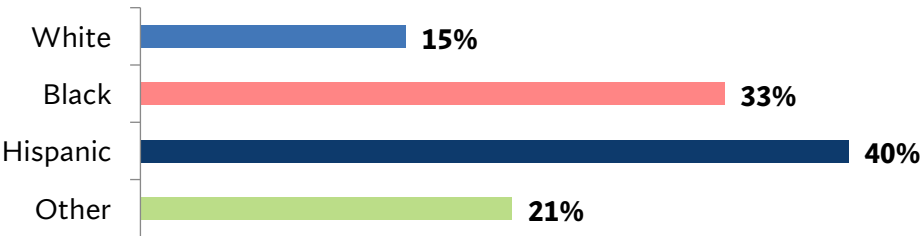
Age-related patterns emerged in the perception of substance use problems. The community health survey revealed that younger adults were more likely to identify alcohol and drug problems as a major health concern compared to older adults.

**Figure 3.15: Percentage of respondents reporting alcohol and drug problems as one of the 3 biggest health concerns (by Age Group)**



Racial and ethnic disparities were also apparent in perceptions of substance use problems. Hispanic and Black survey respondents were significantly more likely to identify alcohol and drug problems as a health concern compared to White respondents. This concern was echoed by Hispanic residents in the Ward 4 focus group, who specifically mentioned substance use disorder and addiction as health issues.

**Figure 3.16: Percentage of respondents reporting alcohol and drug problems as one of the 3 biggest health concerns (by Race/Ethnicity)**



Key leader interviews highlighted significant concerns regarding substance use treatment capacity in the District with substance use and related treatment needs being mentioned in 10 of the 15 key leader interviews. These observations highlighted the interconnection between substance use, mental health, and the criminal justice system noting the issues that arise when a reactive, instead of proactive, approach is taken for substance use disorder treatment. Notably though, 61% of key leader survey respondents agreed that there are enough substance use treatment providers in the District (**Figure A2.67**).

*“I’m particularly concerned about a decrease in the number of substance use residential beds...that’s a pretty big concern in [our] jurisdiction... [we also have] one of the highest opioid overdose rates...” – Key Leader*

*“Speaking of substance use... our jail service... is probably the biggest substance use treatment center in DC.” – Key Leader*

The data on substance use in the District presents a complex picture. While self-reported excessive drinking and drug use may be relatively low among survey respondents, the high overdose death rate and consistent mentions of substance use concerns in focus groups and interviews suggest that substance use disorders remain a significant public health challenge. The apparent gap in treatment resources, particularly residential treatment beds, points to a need for expanded services and better integration with mental health care to address co-occurring conditions. The geographic and demographic variations in substance use concerns also indicate that targeted, community-specific approaches may be necessary to effectively address substance use disorders in the District.

## Maternal and Infant Health

### **Maternal and Infant Health Across the District of Columbia**

Maternal and infant health indicators reveal significant concerns in the District of Columbia. The District has a higher percentage of low birthweight births compared to the national average. Conversely, the percentage of premature births in the District is lower than the national rate. Within the District, over 30% of mothers do not receive prenatal care in the first trimester. Of particular concern are the District's maternal and infant mortality rates. The maternal mortality rate, pregnancy-related mortality rate, and infant mortality rate are all higher than the national rates. These indicators collectively point to areas where maternal and infant health outcomes in the District fall short of national benchmarks.

Indicator	District of Columbia	United States
Low Birthweight (% of Births <5lbs, 8oz)	10.8%	8.6%
Premature Births (% of Births <37 weeks)	10.7%	12.0%
Prenatal Care in First Trimester	68.3%	-
Pregnancy-Related Mortality Rate	44.0	28.4
Maternal Mortality Rate	23.1	20.7
Infant Mortality Rate (number of infant deaths (within 1 year) per 1,000 live births)	6.6	5.6

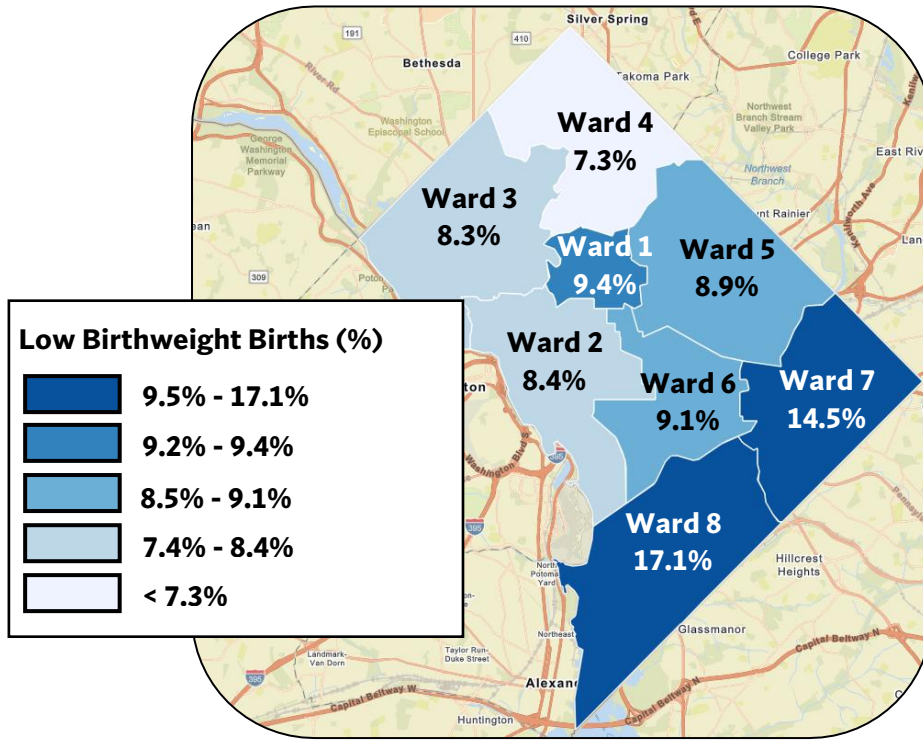
### **Disparities in Maternal and Infant Health Across the District of Columbia**

Geographic disparities in maternal and infant health outcomes are pronounced and persistent within the District. Wards 7 and 8 consistently show poorer outcomes across multiple indicators. In 2023, the percentage of low birthweight births in Wards 7 and 8 were close to or double the percentage in Ward 4. Similarly, in 2023 preterm birth rates in Ward 7 and Ward 8 were higher than the District average. Rates for both low birthweight births and preterm births have remained consistently higher in these Wards over time, indicating persistent geographic health disparities as seen in **Table A5.21** and **Table A5.22**.

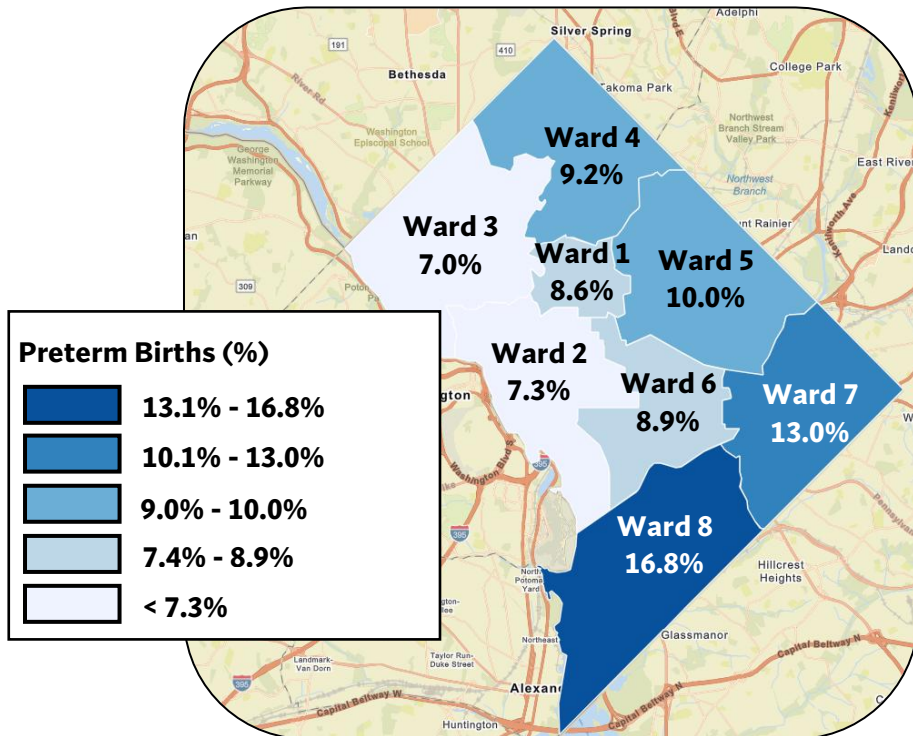
<sup>53</sup> Annie E Casey Foundation (DC = 2023, USA = 2022).

<sup>54</sup> District of Columbia Office of the Medical Examiner. *Maternal Mortality Review Committee 2019-2020 Annual Report*. Retrieved from <https://ocme.dc.gov/page/2019-2020-maternal-mortality-review-committee>

**Figure 3.17: 2023 Percentage of Low Birthweight Births<sup>53</sup>**

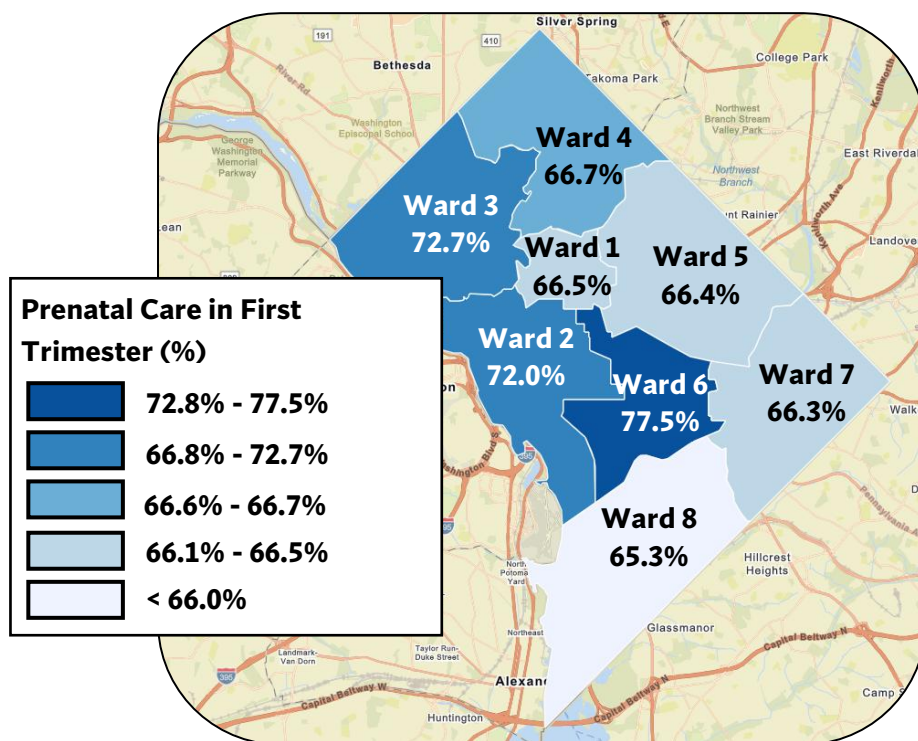


**Figure 3.18: 2023 Percentage of Preterm Births<sup>53</sup>**



Prenatal care access also shows significant geographic variation. Prenatal care in the first trimester was lowest in Wards 7 and 8 while Wards 2, 3, and 6 had rates above 70%. As seen in **Table A5.23** trends over the past seven years show improvement in first-trimester prenatal care rates in Wards 7 and 8, unlike the decline seen in Wards 1, 2, and 3. Despite this improvement, the rates in Wards 7 and 8 remain below the District average, suggesting persistent barriers to early prenatal care in these areas.

**Table 3.19: 2023 Percentage of Births with Prenatal Care Beginning in First Trimester<sup>53</sup>**

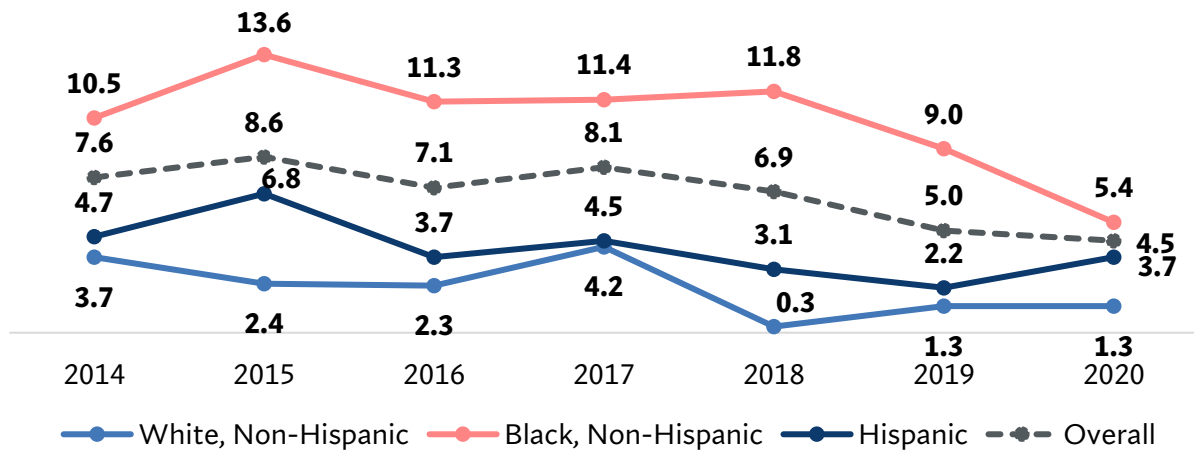


*"...east of the Anacostia River...there are health resources that just aren't as accessible. You know, there isn't as much prenatal care accessible east of the river."*  
 – Key Leader

Pregnancy-related mortality also shows notable geographic concentration. DC's Maternal Mortality Review Committee found that 70% of pregnancy-associated deaths occurring between 2014 and 2018 were among women residing in Wards 7 and 8.<sup>54</sup>

The most striking disparity in maternal and infant health outcomes is along racial lines. While the infant mortality rate has decreased from 2014 to 2020 (the most recent year with race/ethnicity breakdowns) babies born to Black mothers are still more than four times as likely to die before their first birthday than babies born to White mothers in the District. Infants born to Hispanic mothers are close to three times more likely to die than those born to White mothers. Historical data show this disparity has persisted over time. Like other measures discussed, the infant mortality rates are highest in Wards 7 and 8.

**Figure 3.20: 2014-2020 Infant Mortality Rates by Maternal Race and Ethnicity in the District of Columbia<sup>55</sup>**



While maternal and infant health was not among the top health concerns in the overall community health survey or key leader survey, focus group discussions in specific Wards highlighted its importance. Wards 4 and 5 specifically discussed maternal health outcomes, with those in Ward 4 noting disparities for childbearing people of color.

*“I will be completely transparent that I specifically chose to give birth to my children at a hospital that is not in DC because of the fact that, as a Black woman, I had heard terrible statistics” – Ward 4 Resident*

The data collectively indicates substantial room for improvement in maternal and infant health outcomes in the District of Columbia. While some indicators show positive trends, such as improving rates of first-trimester prenatal care in historically underserved Wards, significant disparities persist across geographic and racial lines. These disparities suggest a need for targeted interventions to address barriers to care, improve healthcare quality, and address underlying SDOH that contribute to poor maternal and infant health outcomes, particularly in Wards 7 and 8 and among Black mothers and their infants.

<sup>55</sup> DC Health. 2022 *Perinatal Health and Infant Mortality Report*. <https://dchealth.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/2022-07-CPPE-PHIMreport-9-web.pdf>

**Key Takeaways:**

1. Mental health is a major concern in the District of Columbia, with younger residents, Hispanic populations, and residents of Ward 8 reporting significantly more poor mental health days than other groups.
2. Chronic diseases, particularly heart disease and diabetes, show stark racial disparities, with Black residents experiencing a heart disease death rate nearly three times higher than White residents and diabetes prevalence nearly four times higher.
3. Substance use issues are distributed unevenly across the District, with certain communities expressing significantly higher levels of concern about alcohol and drug problems and noting that access to treatment resources remains inadequate to meet community needs.
4. Maternal and infant health outcomes reveal persistent geographic and racial inequities, with most pregnancy-associated deaths occurring among women in Wards 7 and 8 and with infants born to Black mothers being more than four more times likely to die before their first birthday than their White counterparts.

## Topic 2 | Healthcare Access

### Context and National Perspective

Access to care means patients can get high quality, affordable healthcare in a timely fashion to achieve the best possible health outcomes. It considers several components, such as insurance coverage, physical access to locations where care is provided, the ability to receive timely care, and whether there are enough providers in the workforce to meet patient demand.

From a national perspective, approximately one in ten people in the United States do not have health insurance, which means they are less likely to have access to a primary care provider or to afford the services or medications they need.<sup>56</sup> Access to healthcare services is a challenge even for those who are insured.<sup>57</sup> Access issues are anticipated to increase in coming years. Growing shortages of both nurses and doctors are being driven by several factors, including population growth, the aging United States population requiring higher levels of care, provider burnout (physical, mental and emotional exhaustion) made worse by the COVID-19 pandemic, and a lack of clinical training programs and faculty – particularly for nurses. The aging of the current physician workforce is also driving anticipated personnel shortages. According to the Association of American Medical Colleges (AAMC), there is estimated to be a shortage of physicians in the U.S., which impacts both primary and specialty care.<sup>58</sup>

The ability to access healthcare is not evenly distributed across groups in the population. Groups who may have trouble accessing care include the chronically ill and disabled (particularly those with mental health or substance use disorders), low-income or homeless individuals, people located in certain geographical areas (rural areas), members of the LGBTQIA+ community, and certain age groups - particularly the very young or the very old.<sup>59</sup> In addition, individuals with limited English proficiency face barriers to accessing care, experience lower quality care, and have worse outcomes for health concerns.<sup>60</sup>

### Healthcare Access Overview

*Healthcare Access* was identified as a priority for the 2025 Community Health Needs Assessment because it is a fundamental component of community health and well-being. In the District of Columbia, healthcare access encompasses more than simply having insurance coverage or the

---

<sup>56</sup> U.S. Department of Health and Human Services Office of Disease Prevention and Health Promotion (2023). *Healthy People 2030: Health Care Access and Quality*. Retrieved from <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality>.

<sup>57</sup> Phillips, K.A., Marshall, D.A., Adler, L., Figueroa, J., Haeder, S.F., Hamad, R., Hernandez, I., Moucheraud, C., Nikpay, S. (2023). Ten health policy challenges for the next ten years. *Health Affairs Scholar*. Retrieved from: <https://academic.oup.com/healthaffairsscholar/article/1/1/qxad010/7203673>

<sup>58</sup> Association of American Medical Colleges (AAMC) (2024). *The complexities of physician supply and demand: Projections from 2021 to 2036*. Retrieved from <https://www.aamc.org/media/75236/download?attachment>.

<sup>59</sup> Joszt, L. (2018). 5 Vulnerable Populations in Healthcare. *American Journal of Managed Care*. Retrieved from <https://www.ajmc.com/view/5-vulnerable-populations-in-healthcare>.

<sup>60</sup> Espinoza, J. and Derrington, S. (2021). How Should Clinicians Respond to Language Barriers That Exacerbate Health Inequity? *AMA Journal of Ethics*. Retrieved from <https://journalofethics.ama-assn.org/article/how-should-clinicians-respond-language-barriers-exacerbate-health-inequity/2021-02>.

presence of healthcare facilities within the region. True access requires that residents can obtain timely, appropriate, and culturally competent care when needed. While the District has certain advantages in terms of healthcare infrastructure and insurance coverage, significant barriers to meaningful access persist. These barriers manifest differently across geographic areas and demographic groups, creating disparities in healthcare utilization and health outcomes. Understanding these access challenges requires examining the gap between insurance coverage and actual access to services, the practical barriers to obtaining appointments, and the patient experience navigating a complex healthcare system.

## Insurance Coverage

### **Insurance Coverage Across the District of Columbia**

The District of Columbia has one of the highest rates of health insurance coverage in the nation. As noted in **Health Insurance Status**, census data shows only about 4% of adults under the age of 65 are uninsured compared to 12% nationally. This advantage extends across age groups with the uninsured rates for children also being lower than the national average. This high level of health insurance coverage was frequently cited as one of the District's healthcare strengths in key leader interviews.

### **Disparities in Insurance Coverage Across the District of Columbia**

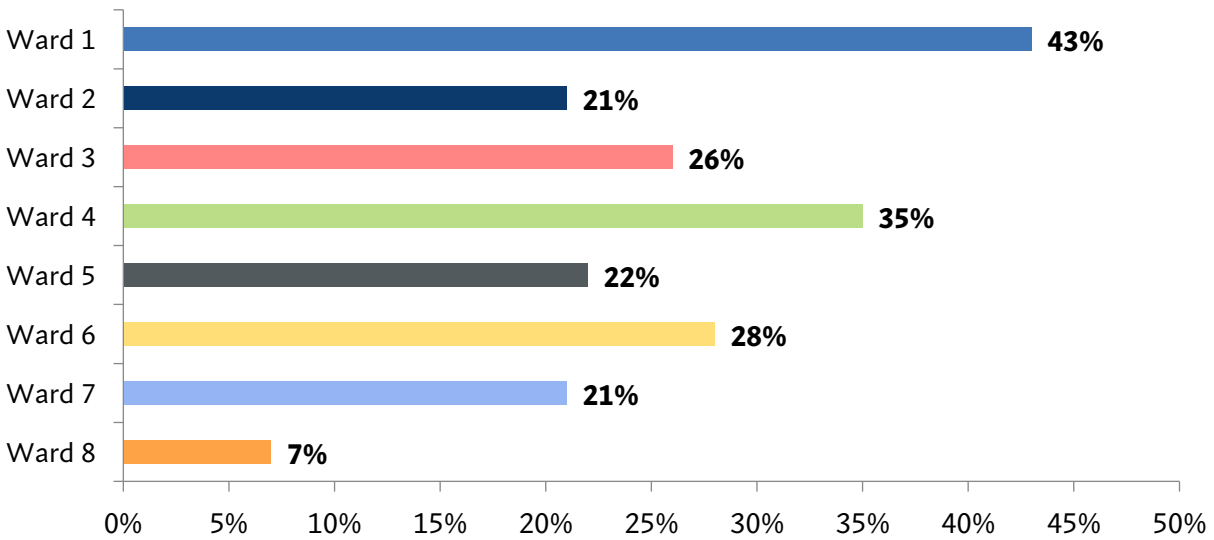
Despite this high insurance coverage, primary data collection revealed a consistent theme: having insurance does not guarantee access to needed healthcare services. This discrepancy was discussed in 11 of the 15 key leader interviews, indicating widespread recognition of this systemic issue among those working in healthcare and nonprofit organizations.

*“There's this disconnect with people believing that because people are insured in DC that they have access to services, and we know in the field that they don't necessarily.”*

– Key Leader

Similarly, 25% of community health survey respondents and 31% of key leader survey respondents noted health insurance issues as one of the most important social and environmental problems that impact health in the District. Notably, residents of Wards 1 and 4 reported insurance issues at a higher rate than other Wards.

**Figure 3.21: Percentage of respondents reporting insurance issues as one of the 3 biggest social or environmental concerns that impact health (by Ward)**



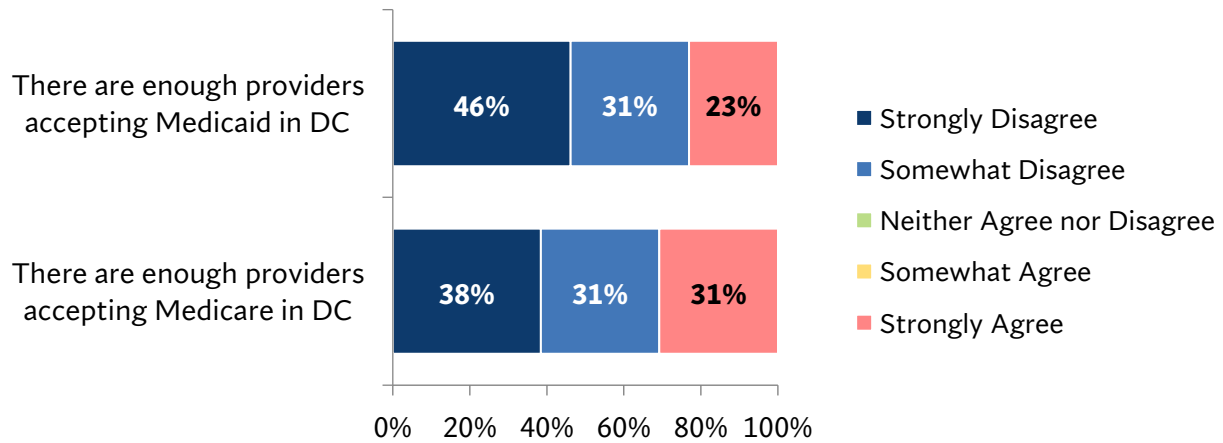
Several factors contribute to this gap between coverage and access. Community survey respondents identified insurance-related barriers even when they had coverage, with 21% of survey respondents reporting that providers not accepting their insurance made it difficult to get medical care (**Figure A2.22**). Additionally, 16% cited that co-pays and/or deductibles were too expensive, creating financial barriers despite having insurance. These findings indicate the type of insurance coverage, associated out-of-pocket costs, and provider networks significantly impact actual access to care.

The issue of insurance acceptance varies across the District. In the key leader survey, over two-thirds of respondents expressed that there are not enough providers accepting Medicaid and Medicare in the District, limiting options for those with public insurance. The virtual focus group echoed this sentiment about accessing services with Medicaid. A 2025 Kaiser Family Foundation analysis that showed, among all states in the US, the District of Columbia has the highest rate of providers opting out of Medicare.<sup>61</sup>

---

<sup>61</sup> Kaiser Family Foundation (2025). *How many physicians have opted out of the Medicare program?* Retrieved from <https://www.kff.org/medicare/issue-brief/how-many-physicians-have-opted-out-of-the-medicare-program/>

**Figure 3.22: Key leader rating of Medicare and Medicaid provider availability in the District (n=13)**



When community health survey respondents were asked what made it hard to get medical care in the last year, more than 20% shared that they faced issues with insurance coverage. This was similar across Wards and demographic groups. Focus groups also revealed the complexity of understanding and using insurance presents additional barriers, highlighting that having insurance is only beneficial when residents understand how to effectively use their coverage to access services.

*"The hospital can provide the interpretation services, but if the patient doesn't know where to go, what to do, or how insurance works..." – Ward 1 Resident*

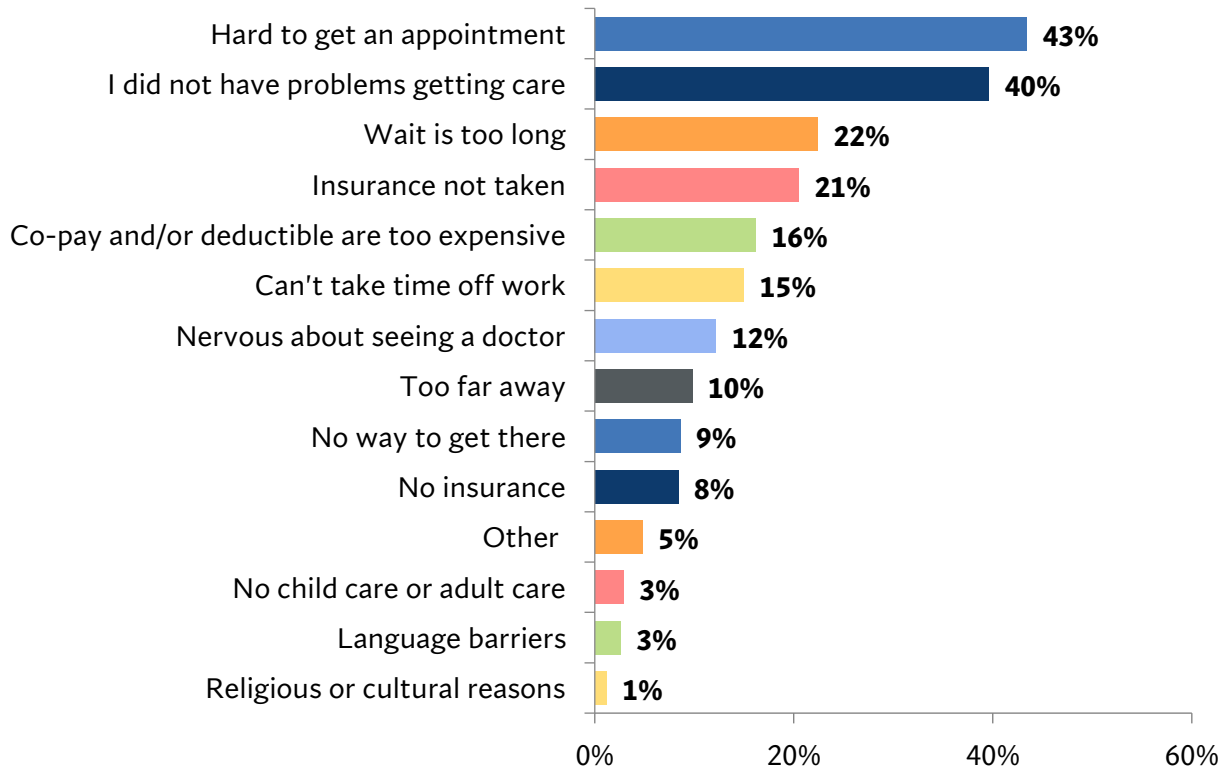
The findings collectively indicate that while the District's high insurance coverage rate is a strength, significant work remains to ensure that insurance translates to meaningful access to care. Insurance acceptance by providers, affordability of out-of-pocket costs, and understanding how to navigate insurance benefits all represent areas where improvements could help close the gap between coverage and access.

## Healthcare Availability

### **Healthcare Availability Across the District of Columbia**

Securing timely medical appointments emerged as a major healthcare access challenge in the District of Columbia. According to the community survey, difficulty obtaining appointments was the top barrier to accessing medical care, cited by over 40% of respondents followed by long wait times with over 20% of respondents. These appointment access barriers were reported across all Wards but manifested differently in various parts of the District.

**Figure 3.23: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (n=419)**



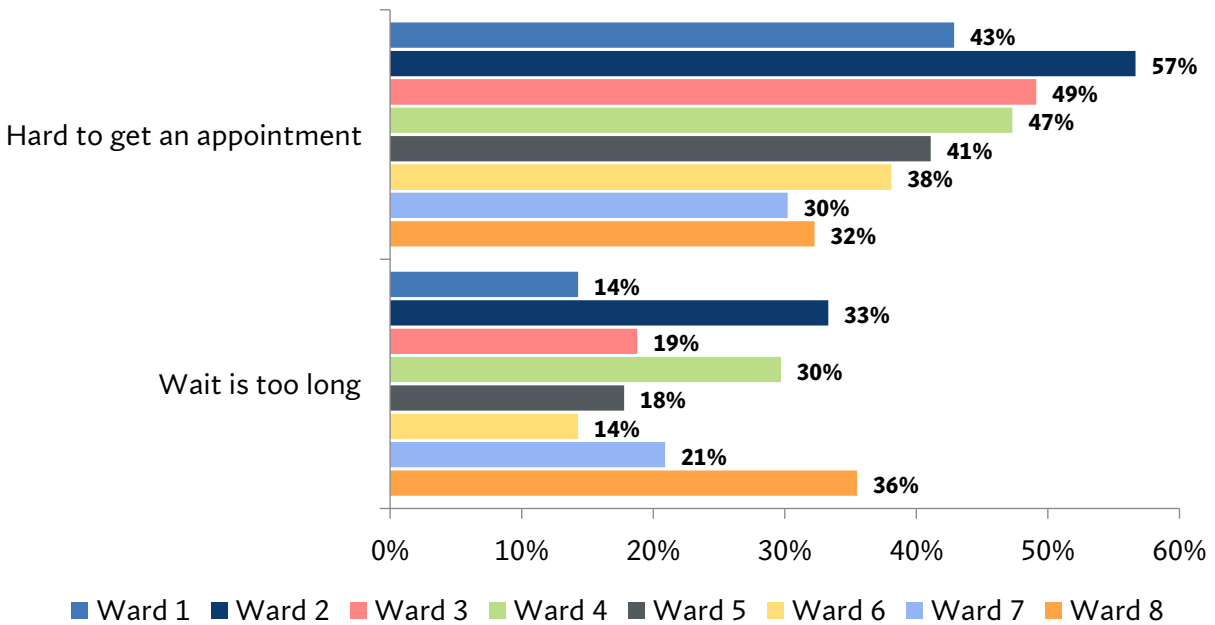
**Disparities in Healthcare Availability Across the District of Columbia**

Geographic disparities in healthcare services and appointment access are pronounced in the District. Secondary data shows that while the District has favorable provider-to-population ratios overall (**Patient-Provider Ratios**), these providers are not evenly distributed. Data gathered from key leaders also suggested that, while the ratios ‘look good’ on paper, not all licensed providers included in the dataset are actively practicing medicine (i.e., they may be researchers, working in policy roles, etc.). Furthermore, many residents of Maryland and Virginia migrate into the District for medical care, further skewing the provider ratios since the providers are serving a population beyond that of District of Columbia residents. Key leader interviews consistently referenced this issue, with 14 of the 15 key leader interviewees mentioning geographic disparities in service availability as a major access issue. The location of healthcare facilities throughout the District can be seen in **Figure 4.1**.

*"The access to services like hospitals and clinics are all concentrated in certain areas where the demand is not where the services are provided." - Key Leader*

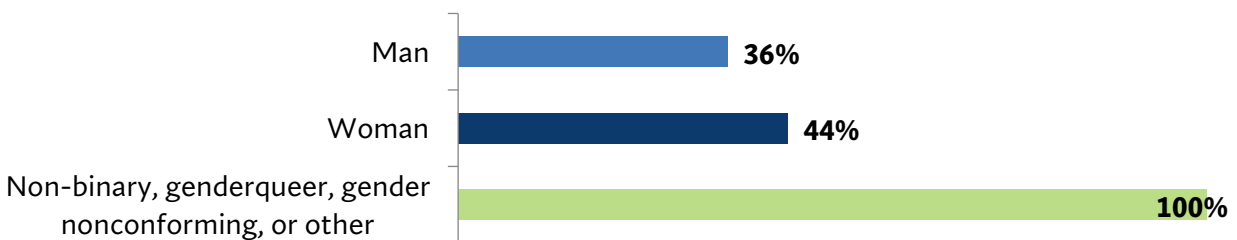
In the community health survey, respondents from seven of the eight Wards reported that difficulty obtaining appointments was the biggest barrier to accessing medical care. Respondents from Ward 8 reported that long wait times were the biggest barrier.

**Figure 3.24: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (by Ward)**



Although participation was limited, all respondents who identified as non-binary, genderqueer, or gender non-conforming identified difficulty getting an appointment as a barrier to accessing medical care. This was also the top reason identified by both men and women when addressing barriers to healthcare.

**Figure 3.25: Community Health Survey respondents indicating it that “Hard to get an appointment” made it hard to get medical care in the last year (by Gender)**



These sentiments were echoed in the focus groups in Wards 4, 7, and 8 which noted that there were limited urgent cares and hospital access points in their community, and they had to travel across town or state lines to access care.

*“[there are] no urgent cares are in the area. [I] have to get in the car and drive to Maryland...”*  
 – Ward 4 Resident

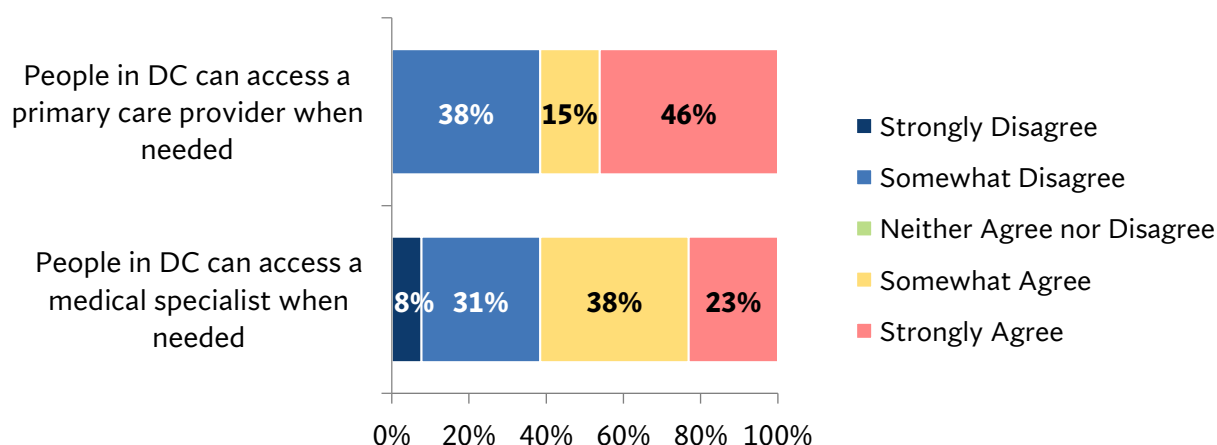
Primary data also shed light on how primary and specialty care access presents particular challenges across the District. Although key leader survey respondents generally agreed that there

were enough providers in the District, key leader interviews shed nuance on the issue sharing that ancillary services and wait times can make accessing specialty care difficult and untimely.

*“Despite an expansion around primary care and services in the District over the last 20 years, there continues to be challenges with access to primary care...”* – Key Leader

*“When you get into specialty care, it really is a really long time before you can get a visit, and you need to often have a diagnostic before the visit...”* – Key Leader

**Figure 3.26: Key leader rating of primary and specialty care provider availability in the District (n=13)**



The data collectively indicates that despite the District's favorable overall provider-to-population ratios, significant appointment access challenges persist, particularly for residents in underserved geographic areas, those seeking specialty care, and certain demographic groups. The planned opening of new healthcare facilities in underserved areas was noted as a potential positive development, but comprehensive strategies are needed to address the geographic maldistribution of healthcare resources and long wait times for appointments.

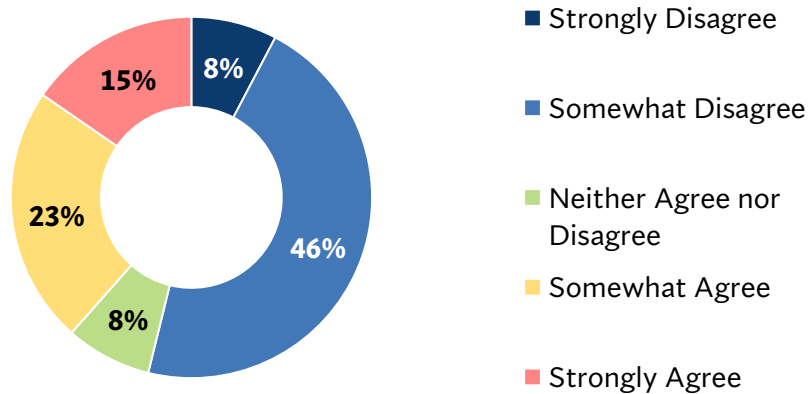
## Patient Experience

The patient experience of navigating the healthcare system in the District of Columbia presents significant challenges that impact access to care and health outcomes. Primary data collection revealed two predominant themes affecting patient experience: system navigation challenges and cultural competency gaps. These factors were consistently highlighted across focus groups, key leader interviews, and community surveys as critical barriers to effective healthcare access.

### **System Navigation**

System navigation emerged as a universal challenge across the District. In the community health survey 17% of respondents said they need help coordinating care across multiple doctors, the second highest need reported for being able to manage health problems (**Figure A2.42**). Furthermore, over half of key leaders surveyed thought that community members did not understand health-related information when it was presented to them.

**Figure 3.27: People in the community I serve have an understanding of health-related information when it is presented to them? (n=13)**



Key leader interviews revealed the complexity of the healthcare system, including the lack of communication between entities, and how this creates barriers even for insured patients who are attempting to access care. The difficulty of navigating and coordinating healthcare in the system for both patients and providers was mentioned in almost every key leader interview. Focus group findings also reinforced these themes, though system navigation challenges manifested differently across the Wards.

<p><i>"If the system was working well, you would not need an advocate... if someone could call and get an appointment, or someone could call and say, 'Hey, I need a prescription refilled', or there was another way to contact." – Key Leader</i></p>	<p><i>"These are because you can't just say, here's your referral. Go to [a hospital system]. Right? It's really coordinating with them and saying, Okay, how are you gonna get there? Do you know which bus to take? Do you have tokens?" – Key Leader</i></p>
<p><i>"[it is] hard to find information even if you're looking for it. Hard to access the things that are available." – Ward 5 Resident</i></p>	

The growing number of digital access barriers was also discussed in the focus groups in Wards 4 and 5. The increasing reliance on digital platforms for scheduling appointments, accessing test results, and communicating with providers creates additional hurdles for residents with limited digital literacy or access to technology.

**Cultural Competency**

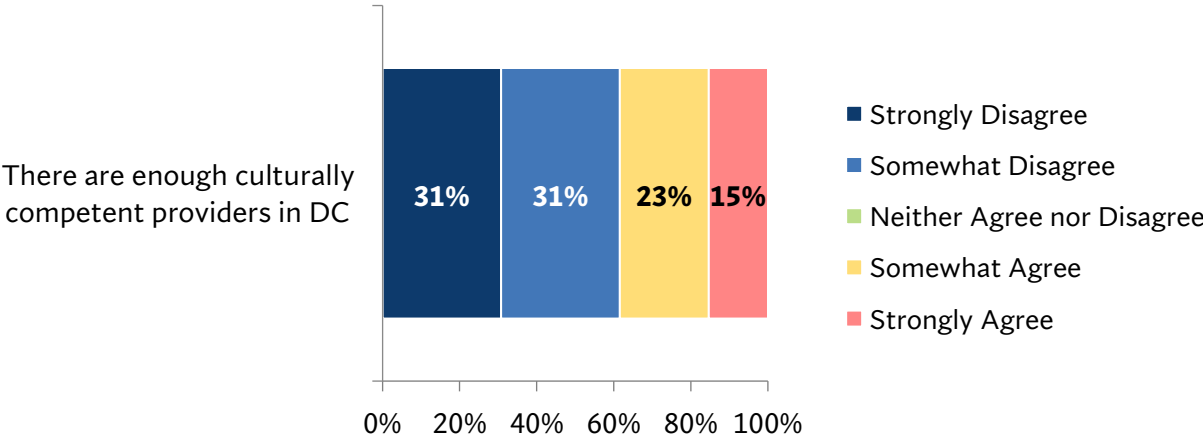
Cultural competency emerged as another critical aspect of patient experience affecting healthcare access. The Healthcare Workforce Diversity Tracker published by the Fitzhugh Mullan Institute for Health Workforce Equity at The George Washington University measures the diversity of a profession compared to the diversity of the working age population (ages 20 to 65) in a state. A diversity index below 1.0 indicates that the given race is under-represented in the profession

compared to the benchmark population. As seen in **Table 3.6**, Black and Hispanic physicians are under-represented in the District of Columbia which could create significant gaps in culturally responsive healthcare delivery. When patients cannot access providers who share their cultural background, language, or lived experiences, communication barriers may arise, trust in the healthcare system can diminish, and nuanced understanding of cultural health beliefs may be lost in the clinical encounter.

Table 3.6: 2023 Diversity Index for Healthcare Labor Force in the District of Columbia <sup>62</sup>				
	White	Asian	Black	Hispanic
Physician	1.28	2.30	0.68	0.52

Key leaders expressed concern over cultural competency in the key leader survey, with over 60% of respondents disagreeing that there are enough culturally competent providers in the District.

**Figure 3.28: Key leader rating of culturally competent provider availability in the District (n=13)**



Furthermore, the importance of cultural competency in clinical care was brought up in 11 of the 15 key leader interviews. Key leaders shared how cultural competency can encompass demographic characteristics beyond race and ethnicity and ultimately impact health outcomes.

<sup>62</sup> Fitzhugh Mullan Institute for Health Workforce Equity at the George Washington University. Health Workforce Diversity Tracker. Retrieved from <https://www.gwhwi.org/diversitytracker.html>

*"...populations who are underrepresented are more likely to have better outcomes when they have providers who look like them... more adherent to their regimens of care, there's more trust and relationship."*

- Key Leader

*"...we also have people who just don't seem to be as equipped as they need to be to address cultural differences, sexual orientation, gender identity issues other factors, that if someone is not like them, they just don't seem to be able to work with those people with the level of humility and trust building that they need to."*

- Key Leader

Focus group participants across different Wards shared their own experience with cultural competency in the healthcare system, though these manifested differently by community. Ward 1 discussions centered on Hispanic needs, specifically translation/interpretation services and overcoming fear and mistrust. Ward 4 emphasized diverse population needs more broadly. Ward 5 participants specifically mentioned discrimination and racism in the healthcare setting and poor experiences with providers of varying quality and cultural competency. Ward 8 residents noted that there is historical mistrust of healthcare system due to quality assurance concerns. Overall, focus group participants shared a desire for respectful, comprehensive care that acknowledges patients' cultural backgrounds, preferences, and lived experiences.

*"I demand you respect me; you advocate for me, or you are not my doctor."*

- Ward 1 Resident

*"People tend to determine if you are African American or not by the sound of your voice or the vernacular that you use...I've had a number of bad experiences when it comes to the healthcare system. I have been treated as if I'm not a person, I'm just a number..."*

-Ward 5 Resident

*"Give us more than 20 minutes and a prescription. Take a wholistic approach."*

- Ward 7 Resident

The data indicates that improving patient experience in the District requires addressing both system navigation challenges and cultural competency gaps. Strategies might include enhancing navigation support services, increasing the diversity of the healthcare workforce, providing comprehensive cultural competency training for providers, and developing more patient-centered approaches to care delivery that recognize the diverse needs of District residents.

**Key Takeaways:**

1. Despite DC having among the highest insurance coverage rates nationally, residents still face substantial barriers to receiving care, with appointment availability being the most common challenge.
2. Healthcare resources are unevenly distributed geographically, forcing residents in underserved areas (particularly Wards 7 and 8) to travel long distances for care, while facilities remain concentrated in more affluent areas.
3. Cultural competency gaps persist throughout the healthcare system, with Black and Hispanic physicians significantly underrepresented relative to the population, contributing to communication barriers and diminished trust among diverse communities.
4. System navigation remains challenging for many residents, who struggle to coordinate care across providers, understand healthcare information, and effectively use digital platforms, creating additional hurdles even for those with insurance.

## Topic 3 | Social Determinants of Health

### Context and National Perspective

The World Health Organization defines Social Determinants of Health (SDOH) as the non-medical factors that influence health outcomes. These are the conditions in which people are born, grow, work, live and age, and the wider set of external forces and systems shaping the conditions of daily life. Examples of SDOH that can influence health status and health equity in positive or negative ways include income, education, unemployment or job security, food insecurity, housing, early childhood development, social inclusion or non-discrimination, structural conflict and access to affordable, high-quality healthcare.<sup>63</sup>

As seen in **Figure 3.29**, the American Hospital Association categorizes SDOH factors into the following domains: food, housing, transportation, health behaviors, violence, education, social support and employment.

**Figure 3.29: Social Determinants of Health<sup>64</sup>**



SDOH are not experienced equally by all people and are often linked to one another. The impacts of SDOH on populations are profound, can persist across generations, and often drive health inequities based on race, ethnicity or socioeconomic status. When health systems use their resources to address SDOH among patient populations, it can strengthen the quality of the care they provide while reducing health inequities.<sup>65</sup> Evidence-based SDOH programs that can be adopted by hospitals or health systems that may reduce healthcare costs and improve outcomes include supportive housing for individuals with chronic health conditions, food and nutrition access, patient transportation services, cash payment or income support for individuals with disabilities,

<sup>63</sup> World Health Organization (2024). *Social determinants of health*. Retrieved from [https://www.who.int/health-topics/social-determinants-of-health#tab=tab\\_1](https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1).

<sup>64</sup> American Hospital Association (2025). *Social determinants of health series*. Retrieved from <https://www.aha.org/social-determinants-health/populationcommunity-health/community-partnerships>

<sup>65</sup> American Medical Association (2022). *What are social determinants of health?* Retrieved from <https://www.ama-assn.org/delivering-care/health-equity/what-are-social-determinants-health>.

and multidisciplinary patient care coordination teams.<sup>66</sup> Research published in JAMA suggests that collecting patient data on social adversity and health-related social needs (HRSN) can be used to develop better trust and support for their patients and help identify broader community social needs.<sup>67</sup>

## Social Determinants of Health Overview

The Steering Committee identified *Social Determinants of Health* as a priority for the 2025 CHNA. While the District benefits from many advantages as an urban center, including robust public transportation, abundant community resources, and progressive policies, these benefits are not equitably distributed. There are numerous social and environmental factors that influence health outcomes in the District of Columbia, but this report will focus on four key determinants: Housing, Safety, Food Security, and Economic Inequality. Primary and secondary data were used to identify key trends and to highlight disparities that exist between different populations based on geographic location, race, ethnicity, age, and other demographic factors. These four determinants were selected because they repeatedly emerged in both quantitative and qualitative data as critical factors shaping health outcomes across the District. Understanding how these social factors vary across communities is essential for developing targeted interventions that address root causes of health disparities and create environments where all District residents can thrive.

## Housing

### **Housing Across the District of Columbia**

Housing emerged as a critical SDOH in the District of Columbia, affecting residents' health through multiple pathways including affordability, quality, stability, and homelessness. As seen in more detail in **Housing status**, secondary data reveals significant housing challenges in the District compared to national averages. The District has a higher percentage of residents experiencing severe housing problems and severe housing cost burden. Additionally, homeownership in the District is substantially lower than the national average, indicating greater housing instability.

Perhaps most concerning is the District's homelessness rate, which is more than three times the national rate. This elevated rate reflects the acute housing affordability crisis in the District, where fair market rent substantially exceeds the national average and bordering states.

---

<sup>66</sup> Whitman, A., De Lew, N., Chappel, A., Aysola, V., Zuckerman, R. & Sommers, B. (2022). *Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts*.

Retrieved from

<https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>.

<sup>67</sup> Chen, A., Gwynn, K. & Schmidt, S. (2023). Addressing health-related social needs in the clinical, community, and policy domains. *JAMA Network*. Retrieved from

<https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2804105>.

**Table 3.7: Secondary Housing Measures<sup>2,23,26</sup>**

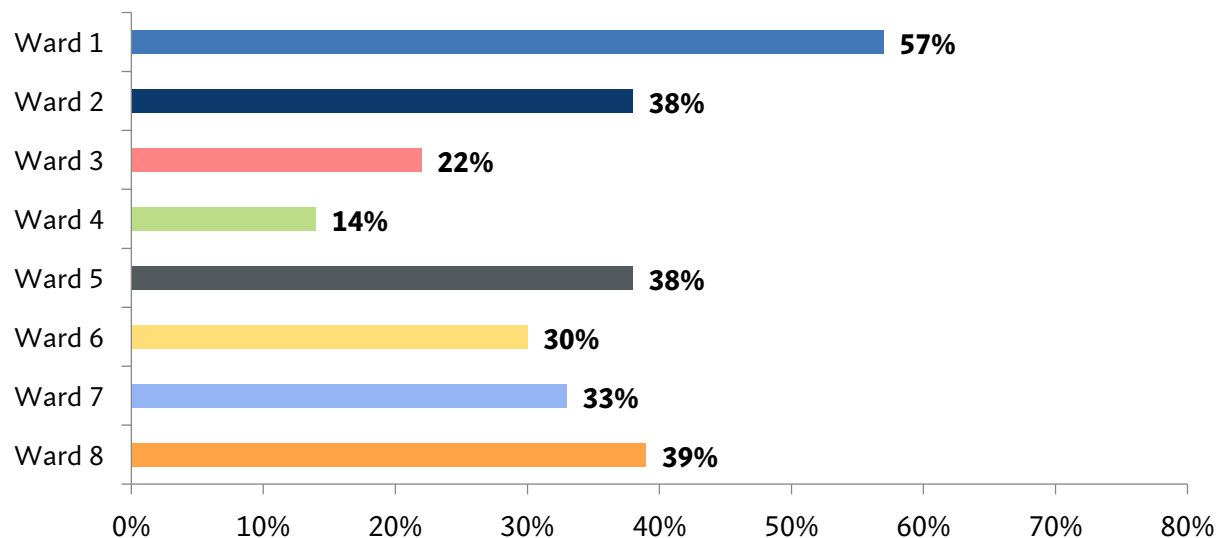
Indicator	District of Columbia	United States
Households with Severe Housing Problems	19%	17%
Households with Severe Housing Cost Burden	17%	14%
Homeownership Percentage	41%	65%
Homelessness per 10,000 People	73	20

### **Disparities in Housing Across the District of Columbia**

*“I am not seeing as much affordable housing going in. It’s all extremely expensive, like, if I was to try and purchase there now, we would not be able to.” – Ward 4 Resident*

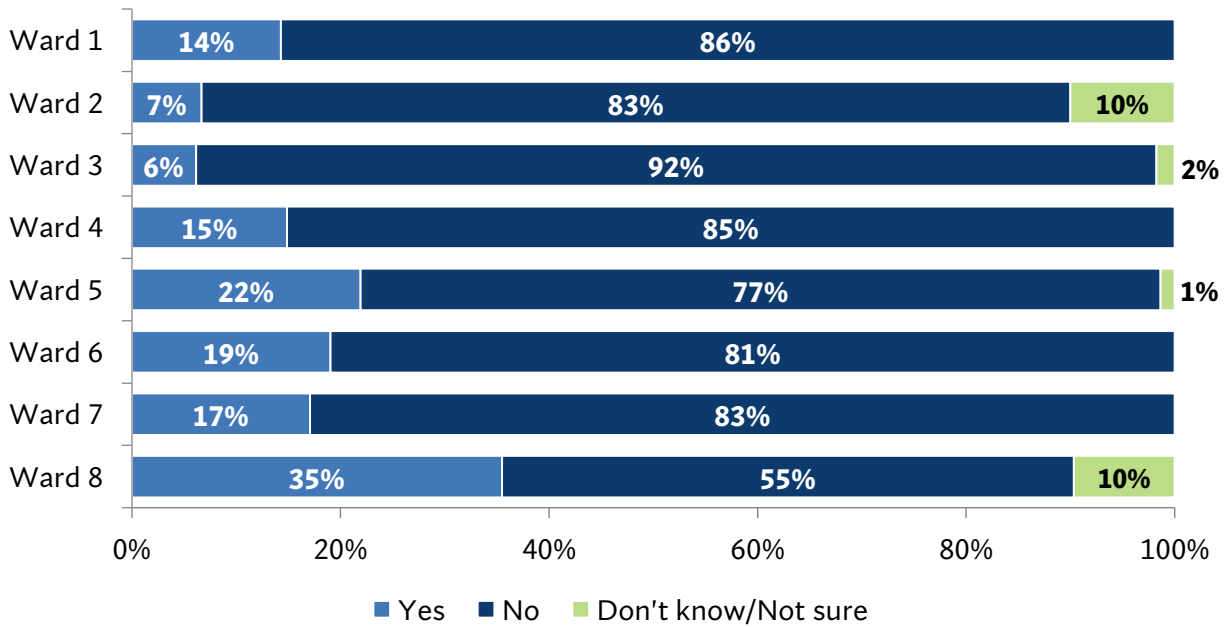
Housing affordability concerns were echoed in primary data collection. Housing problems or homelessness was identified as the second biggest social and environmental problem affecting health in the community in both the community health survey (29% of respondents, **Figure A2.17**) and key leader survey (69%, **Figure A2.62**). As seen in **Figure 3.30**, in the community health survey, the percent of residents from six of the eight Wards reported housing and homelessness as a concern at rates above the survey average (29%). Over half of respondents from Ward 1 reported housing and homelessness was impacting the health of the community.

**Figure 3.30: Percentage of respondents reporting housing and homelessness as one of the 3 biggest social or environmental concerns that impact health (by Ward)**

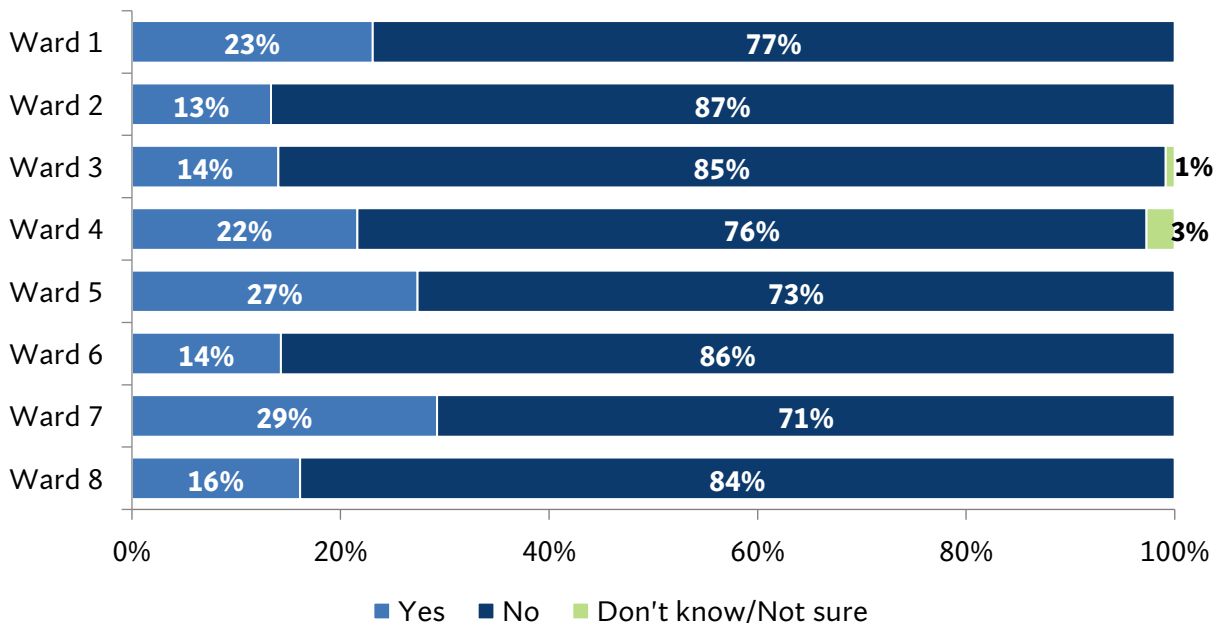


The community health survey revealed geographic variations in housing insecurity, as well. Residents of Ward 8 reported being worried about having enough money to pay their rent/mortgage in the past 12 months at higher rates than other Wards (**Figure 3.31**). Similarly, respondents from Wards 5 and 7 reported higher rates of utility insecurity — lacking electricity, water, or heating — compared to the District average (**Figure 3.32**).

**Figure 3.31: In the past 12 months, were there times when you were worried about having enough money to pay your rent or mortgage? (by Ward) (n=419)**



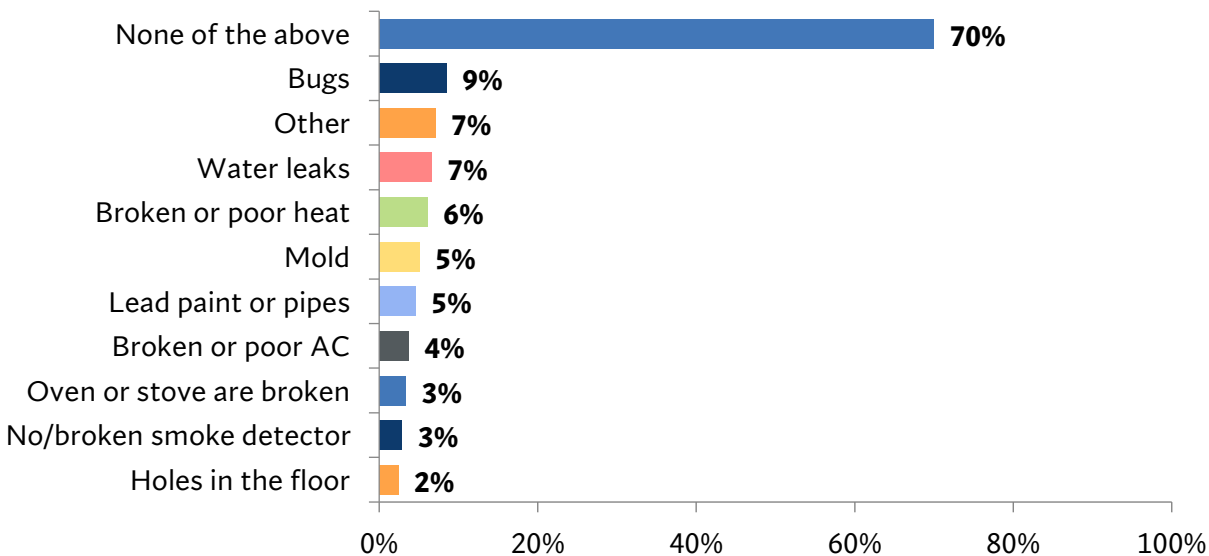
**Figure 3.32: In the past 12 months, were there times when you did not have electricity, water, or heating in your home? (by Ward) (n=418)**



Housing quality also emerged as a health concern in the District. While 70% of community survey respondents reported no housing quality issues, common problems among those that did report issues included bugs, water leaks, broken or poor heat, mold, and rodents (written in). These issues

were not evenly distributed across Wards, with 16% of Ward 8 respondents reporting mold issues and 14% of Ward 1 respondents reporting bug problems (**Figure A2.48**).

**Figure 3.33: Do you have any of the following problems in your home? (n=410)**



Although a significant amount of pride was conveyed during focus groups when discussing neighborhoods, housing availability and quality and homelessness were regularly brought up as concerns. Residents conveyed that community members were living in poor conditions in public housing and housing owned by “slum lords.”

<p><i>“...[our] neighborhood was built by black people for Black people.”</i></p> <p>– Ward 7 Resident</p>	<p><i>“...[speaking about housing quality] despair brings about chaos... it’s a cycle, its generational.”</i></p> <p>– Ward 8 Resident</p>
--	--

Key leader interviews consistently identified housing as a critical SDOH affecting health outcomes in the District. Housing issues were mentioned in 11 of the 15 key leader interviews.

<p><i>“We also know that people don’t get better unless their social needs are addressed in the district. Of course, particularly housing is a critical concern...”</i></p> <p>– Key Leader</p>	<p><i>“Housing is significant... around 10,000 of our patients experience homelessness at some point throughout the year.”</i></p> <p>– Key Leader</p>	<p><i>“She was probably in her mid-seventies... home was sold from out from under her... she died like within a couple months of becoming homeless...”</i></p> <p>– Key Leader</p>
---	--	--

The data indicates that addressing housing needs—improving affordability, quality, and stability—would likely yield significant health benefits for District residents. The geographic disparities in

housing challenges suggest that targeted interventions may be needed in specific Wards, particularly Wards 5, 7, and 8, where housing instability and quality issues appear most acute.

## Safety

### **Safety Across the District of Columbia**

Neighborhood safety emerged as a significant SDOH for District residents, with both objective crime data and subjective perceptions of safety affecting health behaviors and outcomes. Secondary data revealed concerning safety indicators for the District compared to national averages. The District's violent crime and homicide rates are more than three times the national rate. Similarly, firearm fatalities are substantially higher than the national average. Additional safety data points and trends for the District of Columbia can be found in **Crime and safety**.

Indicator	District of Columbia	United States
Injury Deaths (per 100,000 Population)	90.9	64.0
Firearm Fatalities (per 100,000 Population)	21.4	14.2
Motor Vehicle Crash Deaths (per 100,000 Population)	8.4	13.3
Homicides (per 100,000 Population)	23.7	7.7
Suicides (per 100,000 Population)	6.1	14.2
Violent Crimes (per 100,000 Population)	1,169	373
Juvenile Arrest Rate (per 1,000 Juveniles)	15	-
Teens Forced to Have Sex (% of all Teens)	6.2%	8.5%

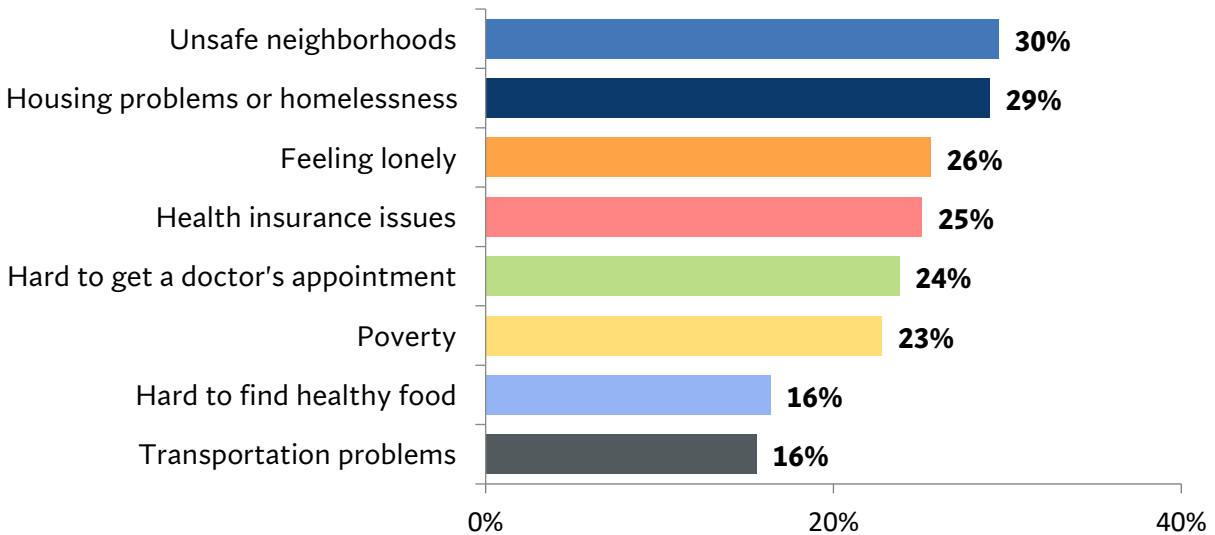
### **Disparities in Safety Across the District of Columbia**

The impact of safety concerns on residents' perceptions and behaviors was evident in primary data collection. In the community health survey, unsafe neighborhoods were identified as the top social and environmental problem affecting health for 30% of all respondents. This concern was expressed across all Wards but was most pronounced in Wards 7 and 8.

---

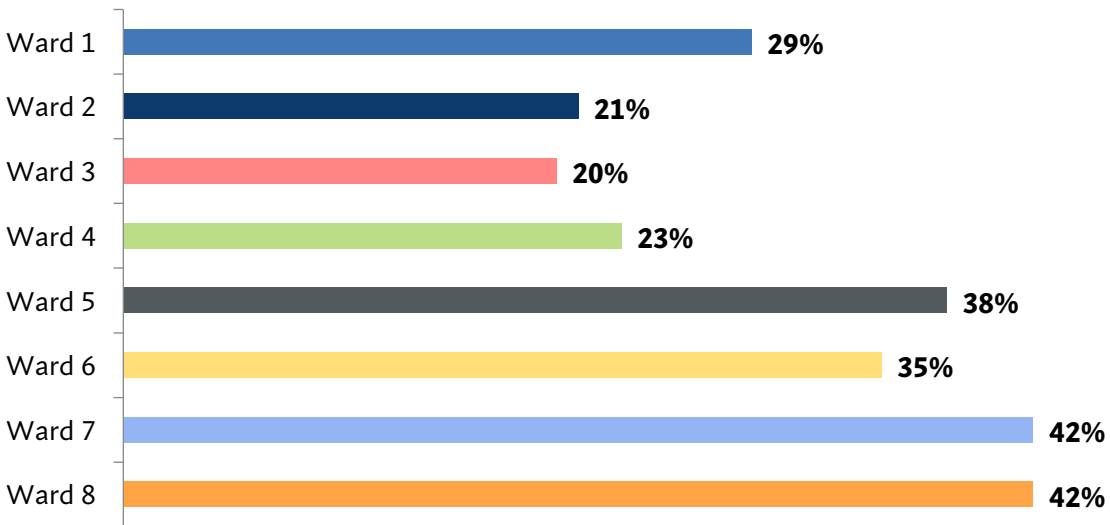
<sup>68</sup> Rate calculated utilizing 2023 violent crime data from Federal Bureau of Investigation Crime Data Explorer (retrieved from <https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/home>) and U.S. Census Bureau, American Community Survey Table DP05, 5-year Estimates (2022)

**Figure 3.34: What are the 3 biggest social and environmental problems that affect the health of your community? (n=403)**



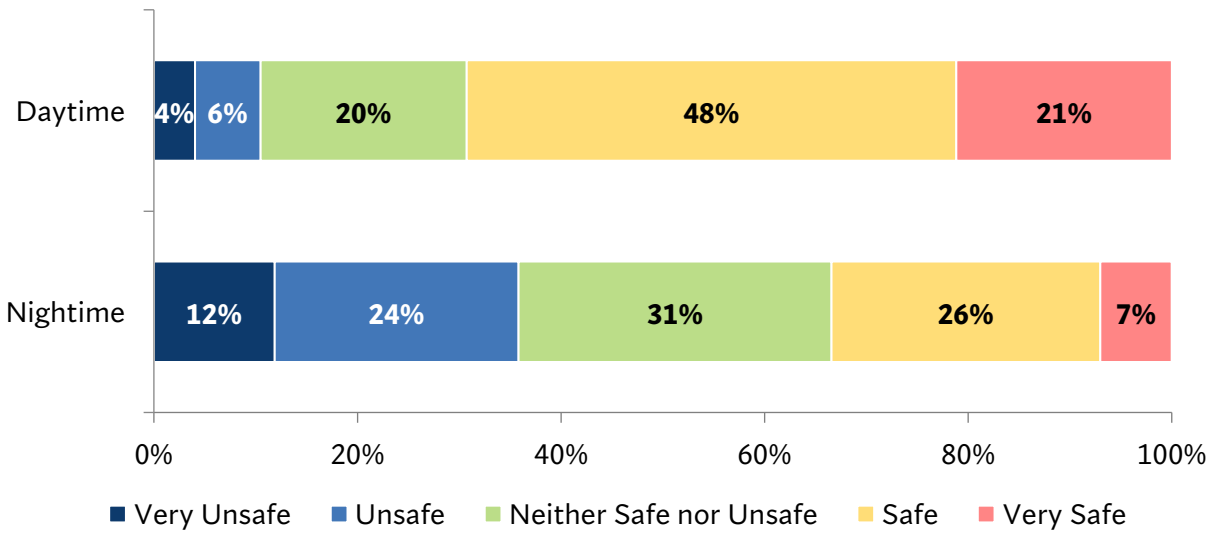
Note: only showing responses with more than 15%

**Figure 3.35: Percentage of respondents reporting unsafe neighborhoods as one of the 3 biggest social or environmental concerns that impact health (by Ward)**



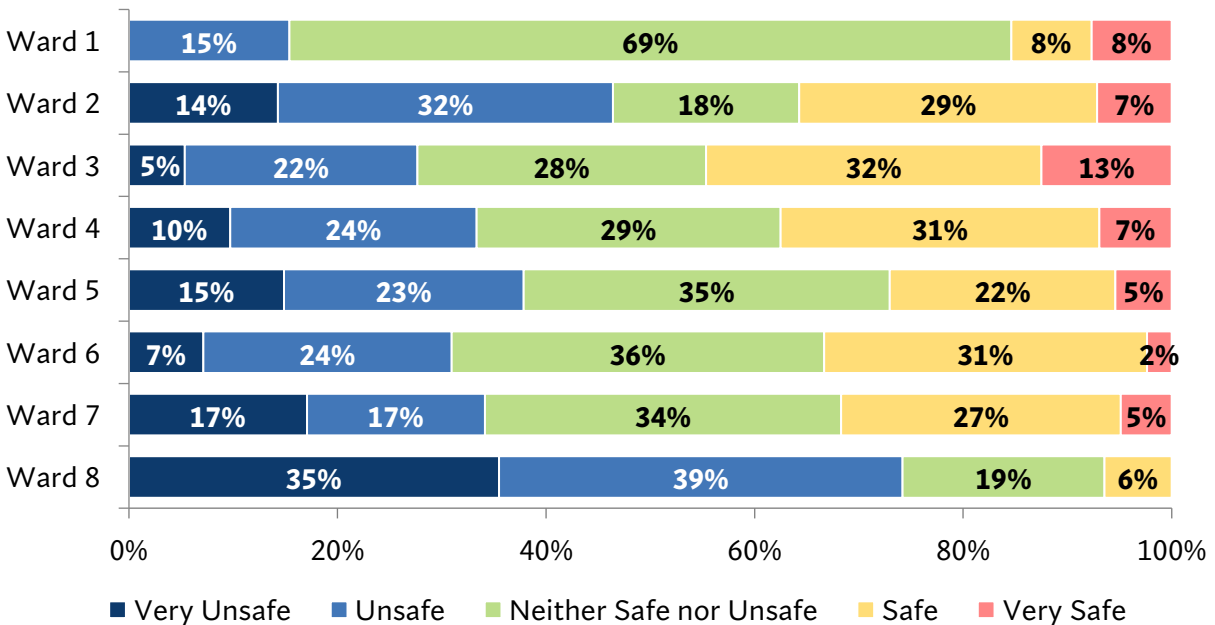
Perceptions of safety varied dramatically by time of day. Across the District, the percentage of people that reported feeling unsafe ("very unsafe" or "unsafe") when outside alone at nighttime was over three times higher than those reporting feeling unsafe in the daytime.

**Figure 3.36: How safe do you feel in your neighborhood when you are outside alone? (n=413)**



When looking closer at the responses related to safety at nighttime, geographic disparities in safety perceptions were substantial. Nearly 75% of respondents from Ward 8 and nearly 50% from Ward 2 reported feeling unsafe when outside alone at nighttime. These perceptions align with objective crime data showing higher violent crime rates in certain areas of the District.

**Figure 3.37: How safe do you feel in your neighborhood when you are outside alone AT NIGHTTIME? (n=413)**



As noted in **Crime and safety**, there are high rates of violent crime and homicides in the District of Columbia. This trend intensifies existing safety concerns and potentially exacerbates health impacts. The relationship between safety and mental health was particularly evident in primary

data collection, with multiple focus groups noting how violence and fear affect psychological well-being. Ward 7 residents discussed how there are beautiful community parks, but people are too afraid to use them because of safety concerns, illustrating how safety concerns can restrict health-promoting behaviors like physical activity.

*“[District residents] have quite a lot of green space, but the safety of that space I think is a deterrent.” – Key Leader*

As it relates to safety, trust in law enforcement varies among District residents, with most community health survey respondents indicating they trust the police “somewhat,” “a lot,” or “to a great extent”. This reflects a foundation of community-police relationships that could be further strengthened to enhance neighborhood safety and security. Among focus group participants, neighborhood safety was frequently mentioned alongside policing and community-police relations. Key leader interviews also highlighted safety as a SDOH affecting health. In discussing social and environmental factors, key leaders noted how community violence affects both physical safety and mental health, particularly for children and youth, creating trauma that has lasting health impacts.

*“Violence disproportionately effects younger Black individuals. Younger children are getting into violent crimes.” – Ward 4 Resident*

The data demonstrates that safety concerns—both objective crime rates and subjective perceptions of safety—significantly impact health behaviors and outcomes in the District. The geographic disparities in safety suggest that targeted interventions may be needed in specific Wards, with particular attention to how safety concerns interact with other SDOH like housing quality, access to recreation spaces, and mental health resources.

## Food Security

### **Food Security Across the District of Columbia**

Aggregate secondary data revealed somewhat mixed indicators related to food access in the District. The District has a higher Food Environment Index (scored from 0 [worst] to 10 [best]) compared to the national average indicating better overall food environments. Similarly, only 2% of District residents have limited access to healthy foods, compared to 6% nationally. However, 37% of District residents experience food insecurity – limited or uncertain access to adequate, nutritious food – and, as noted in **Residents Receiving SNAP/Food Stamps**, a higher percentage of residents in the District of Columbia have SNAP benefits compared to the United States overall.

**Table 3.9: Secondary Food Measures<sup>2,69</sup>**

Indicator	District of Columbia	United States
Food Insecurity	37%	-
Percent of Population with Limited Access to Health Food	2%	6%
Food Environment Index	8.5	7.7

**Disparities in Food Security Across the District of Columbia**

While these aggregate statistics suggest relatively favorable food environments in the District of Columbia additional research and primary data demonstrated that food security was a significant issue faced by many in the District. Research provided by the Capital Area Food Bank revealed that food insecurity across the Metro area is growing across all income brackets below \$225,000 and among individuals with a college education.<sup>69</sup> A map of grocery stores in the District (**Figure 4.4**) indicates that there are currently only four grocery stores east of the Anacostia River.. Furthermore, primary data collection revealed significant geographic disparities in food access. Focus group participants provided additional context to grocery stores east of the Anacostia River, stating that even though they are closer, residents prefer to go across town for higher quality groceries and better shopping experiences. Focus group participants in Ward 8 shared the pride and joy they felt by being able to grow their own food in their yards or community gardens.

*“I go to Capitol Hill to buy my groceries. I’d love to go to my own neighborhood grocery store, but circumstances have prevented it” – Ward 7 Resident*

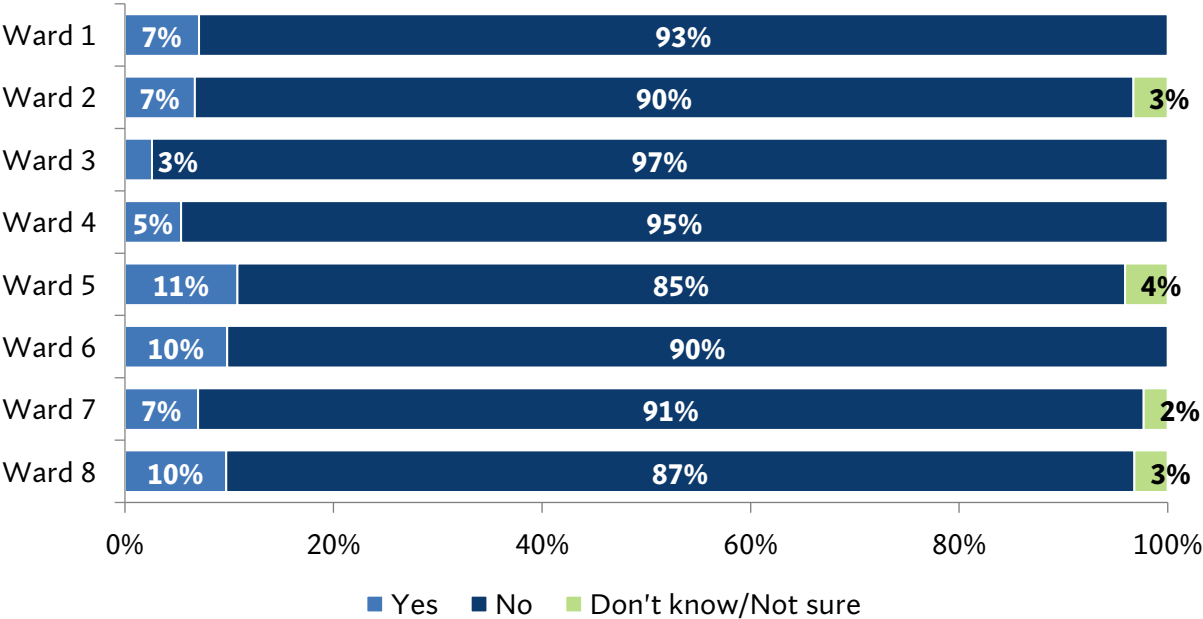
The geographic disparity in food access was emphasized by key leaders who highlighted both the existence of food access disparities and the perception that policy responses have been insufficient.

<p><i>“There are a lot of resources around food access, but they are not addressing the underlying problem that we don’t have grocery stores in Ward 8.” – Key Leader</i></p>	<p><i>“Having food deserts - yes, our people live in food deserts... Do we see real jurisdictional efforts being made to address food deserts? It’s not fast enough.” – Ward 7 Resident</i></p>
---	---

In the community health survey, 7% of total respondents reported that someone in their household skipped meals or ate less food in the past year because there wasn't enough money for food. The rates of survey respondents reporting this were slightly higher in Wards 5, 6, and 8.

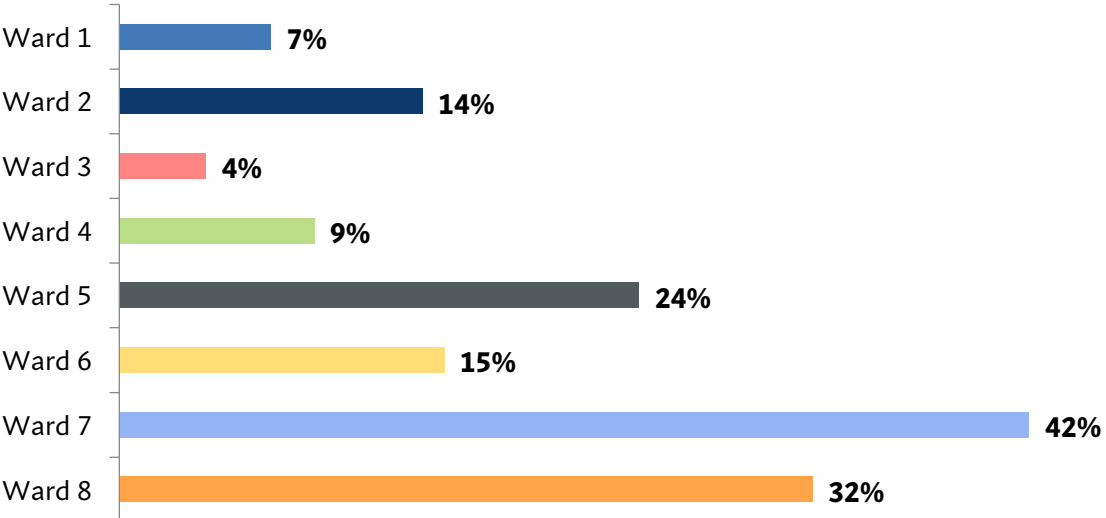
<sup>69</sup> Capital Area Food Bank. 2024 Hunger Report. Retrieved from <https://hunger-report.capitalareafoodbank.org/report-2024/>

**Figure 3.38: In the past 12 months, did you or someone in your household skip meals or eat less food because there wasn't enough money for food? (by Ward) (n=422)**



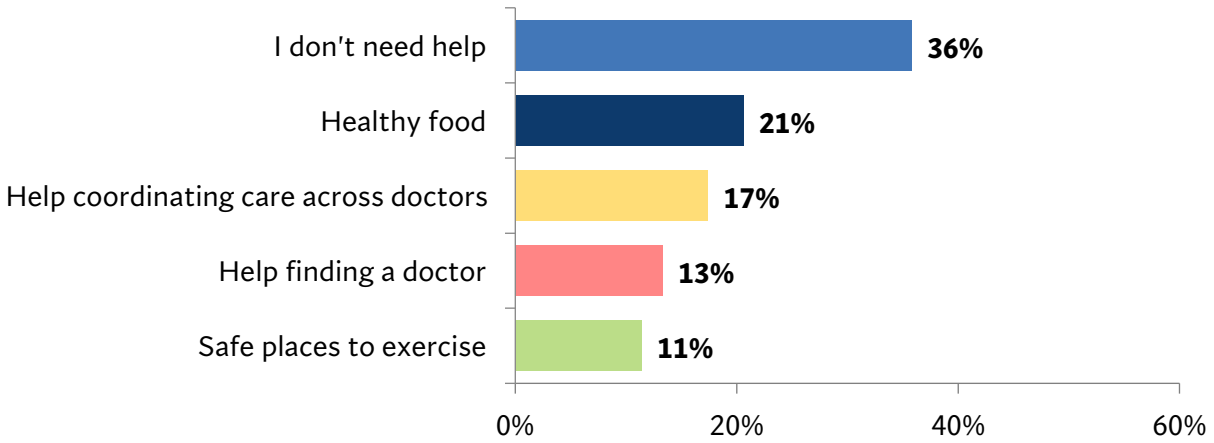
The impact of food insecurity on health was noted in multiple data sources. In the community health survey, 16% of respondents identified "hard to find healthy food" as a significant social/environmental problem affecting health. This concern was most pronounced in Wards 1 and 8.

**Figure 3.39: Percentage of respondents reporting difficulty finding healthy food as one of the 3 biggest social or environmental concerns that impact health (by Ward)**



Additionally, when asked what they needed to take care of their health problems, "healthy food" was the most frequently cited need among those requiring assistance.

**Figure 3.40: What do you need to take care of your health problem(s) mentioned? (Top 5 Answers)**



The data indicates that while the District has certain strengths in its overall food environment, significant disparities exist in food access and food security across geographic areas and demographic groups. Addressing these disparities would likely improve health outcomes, particularly for residents in Wards 7 and 8 where food access challenges are most acute.

## Economic Inequality

### **Economic Inequality Across the District of Columbia**

Economic inequality represents a profound SDOH in the District of Columbia, affecting health outcomes through multiple pathways including access to resources, exposure to stressors, and opportunities for healthy living. As noted and defined in **Poverty and ALICE Households**, although some measures such as the percentage of ALICE (Asset Limited, Income Constrained, Employed) households and the gender pay gap are better than the national average, other secondary data measures reveal stark economic differences. Racial economic disparities in the District are particularly severe with the unemployment rate for Black residents being more than three times higher than for White residents. Additional details relating to the measures shared in **Table 3.10** and household income disparities can be found in **Economic Factors Impacting the District**

**Table 3.10: Secondary Income and Employment Measures<sup>2,18,20,19</sup>**

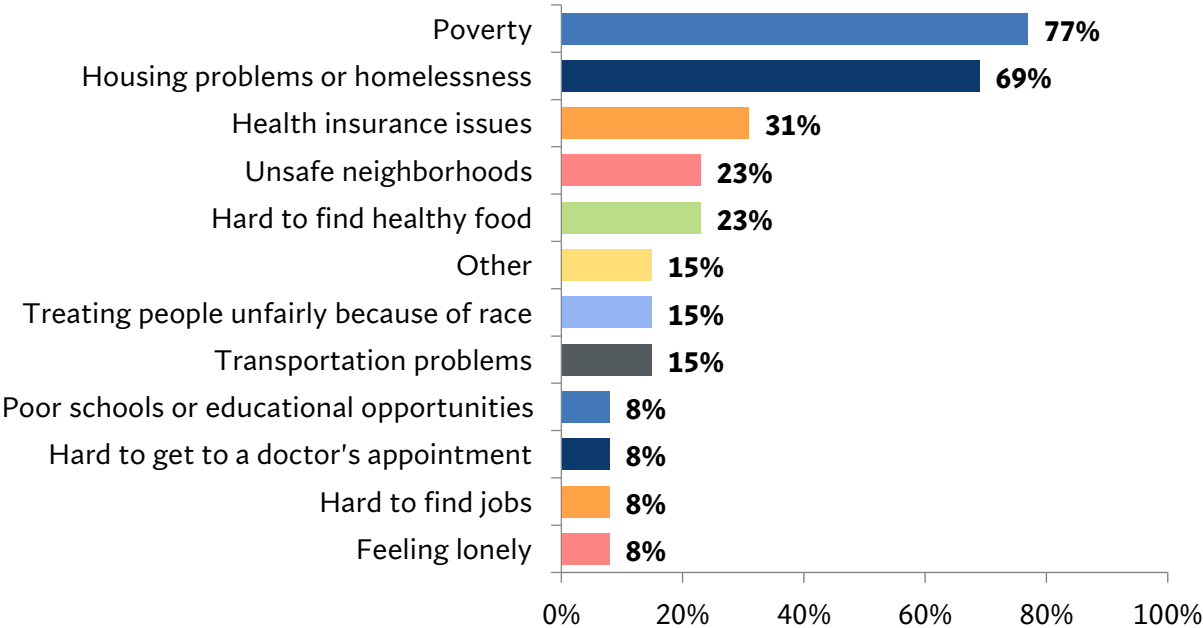
Indicator	District of Columbia	United States
Percent of Children in Poverty	20%	16%
Percent of ALICE Households	27%	29%
Income Inequality	6.6	4.9%
Gender Pay Gap	.87	.81
Living Wage	\$62.51	-
Percent of Food Stamp/SNAP Recipients	20%	12%

Unemployment	5.3%	4.3%
--------------	------	------

**Disparities in Economic Inequality Across the District of Columbia**

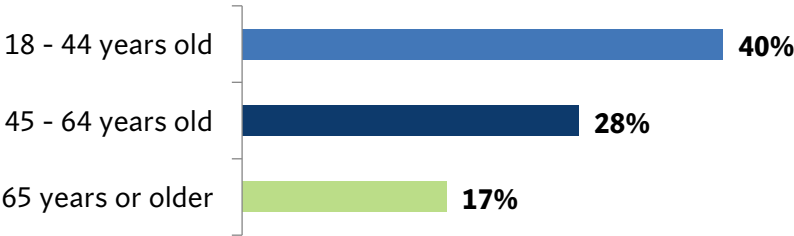
Primary data collection reinforced the significance of economic factors as determinants of health. In the key leader survey, poverty was identified as the top social and environmental problem affecting the health of the community.

**Figure 3.41: What are the 3 biggest social and environmental problems that affect health in your community? (n=13)**



In the community health survey, 23% of respondents identified poverty and 12% of respondents identified employment as major social and environmental problems affecting health. Concern over poverty was pronounced among younger respondents (18-44 years old), with 40% identifying poverty as a top health-related social problem compared to just 17% of respondents aged 65 and older.

**Figure 3.42: Percentage of respondents reporting poverty as one of the 3 biggest social or environmental concerns that impact health (by Age Group)**



Key leader interviews consistently highlighted economic stability as a critical SDOH in the District. Economic issues were mentioned in 80% of the key leader interviews, with two interviewees

describing what is often known as the "benefits cliff" phenomenon, where slight increases in income can result in loss of benefits, creating ongoing economic instability.

*"Folks who are making above 30% [of the poverty level] right? It's that those folks who aren't the poorest of the poor. If you will...it's easier to get housing, if you have no income than it is to get housing, if you have minimum wage."*

- Key Leader

*"Asset Limited Income Constrained and yet still Employed... you got a job but if you make just a hair bit more now, you're cut off from your benefits."*

- Key Leader

Focus group discussions across multiple Wards highlighted the impact of economic factors on health often noting that when financial decisions need to be made, food, shelter, and utilities are often prioritized above health. This commentary illustrates how economic pressures can force health concerns to a lower priority, delaying preventive care and exacerbating health conditions. Residents participating in the Ward 8 focus group also emphasized how limited employment opportunities in the neighborhood can and has perpetuated generational poverty.

*"...they're not really thinking about health... they're thinking about 'I have to pay the electric bill, or I have to pay rent'"*

- Virtual Focus Group Participant

*"The challenge is, how do we achieve a healthy lifestyle... regardless of the amount of money you make?"*

- Ward 8 Resident

Educational attainment—a key factor in economic opportunity—shows similar geographic and racial disparities in the District. While the District overall has a higher percentage of residents with bachelor's degrees or higher (62.7%) than the national average (34.3%), this educational advantage is not equally distributed. The percentage of adults with bachelor's degrees or higher ranges from less than one-third in Wards 7 and 8 to nearly 90% in Wards 2 and 3 (**Figure 2.19**).

The data indicates that addressing economic inequality—through employment opportunities, educational access, income supports, and asset-building programs—would likely yield significant health benefits for District residents. The geographic and racial disparities in economic indicators suggest that targeted interventions may be needed in specific Wards and for specific populations to effectively address the health impacts of economic inequality.

**Key Takeaways:**

1. Residents across the District of Columbia experience housing instability and affordability challenges while also contending with quality issues like mold, water leaks, and poor heating that can directly impact health conditions.
2. Safety concerns profoundly impact health behaviors with residents reporting feeling unsafe at night and limiting their use of community resources like parks and limiting physical activity that could improve health outcomes.
3. Despite overall favorable food environment statistics, there are only four grocery stores east of the Anacostia River forcing many residents to drive across town or state lines for better food options.
4. Economic inequality creates severe health disparities along racial lines, with the unemployment rate for Black residents being more than three times higher than for White residents, and educational attainment varying significantly across Wards.

# Chapter 4 | Community Resource Inventory

This chapter outlines resources, facilities, programs, and services throughout the District of Columbia region that can be leveraged or better coordinated to address the priority health needs identified through the CHNA process.

## Community Resource Inventory

The list of resources below is representative of the services available in the District of Columbia, but this list is not exhaustive. While the resources, facilities, and programs listed in this section have been categorized into common groups, these organizations and programs may offer services beyond that categorization or topic area. It is important to note that while the District overall may be adequately served by what exists currently for a given topic or need area, not all geographies and demographic groups are equally served. The need for more or different resources to better meet community needs may be dependent on population factors.

There are many local organizations currently working to address aspects of each of the priority health needs identified through the 2025 CHNA process. A few examples of these organizations are highlighted below.

Category	Organization / Resource
<b>Medical Resources</b>	<ul style="list-style-type: none"> <li>• <a href="#">Hospitals</a></li> <li>• <a href="#">DC Primary Care Association Health Centers</a></li> </ul>
<b>Substance Use Resources</b>	<ul style="list-style-type: none"> <li>• <a href="#">My Recovery DC</a></li> </ul>
<b>Food Pantries and Other Food Assistance Resources</b>	<p>The Capital Area Food Bank maintains an up-to-date list of partner locations where individuals can see where food is available and if the location is currently open. Additionally, those in need can contact the Hunger Lifeline for more personalized information by calling (202) 644-9807 or by emailing <a href="mailto:hungerlifeline@capitalareafoodbank.org">hungerlifeline@capitalareafoodbank.org</a>.</p> <ul style="list-style-type: none"> <li>• <a href="#">Food Assistance Map</a></li> </ul>
<b>Shelter and Housing Resources</b>	<p>To supplement the locations listed below, the district of Columbia maintains the following useful housing maps:</p> <ul style="list-style-type: none"> <li>• <a href="#">Low Barrier Shelters</a></li> <li>• <a href="#">Transitional Housing</a></li> </ul>
<b>Educational Institutions</b>	<ul style="list-style-type: none"> <li>• <a href="#">District of Columbia Public School Directory</a></li> <li>• <a href="#">District of Columbia Public Charter Schools</a></li> </ul>
<b>Emergency Services and Public Resources</b>	<ul style="list-style-type: none"> <li>• <a href="#">Libraries</a></li> <li>• <a href="#">Fire Stations</a></li> <li>• <a href="#">Police Districts</a></li> </ul>
<b>Parks and Recreation Facilities</b>	<p>The District of Columbia Department of Parks and Recreation maintains up to date maps on their websites of public recreational opportunities in the District:</p>

Category	Organization / Resource
	<ul style="list-style-type: none"><li data-bbox="683 247 1036 275">• <a href="#">Athletic Fields &amp; Courts</a></li><li data-bbox="683 285 997 312">• <a href="#">Community Gardens</a></li><li data-bbox="683 323 932 350">• <a href="#">Fitness Centers</a></li><li data-bbox="683 361 889 388">• <a href="#">Playgrounds</a></li><li data-bbox="683 399 977 426">• <a href="#">Recreation Centers</a></li><li data-bbox="683 436 954 464">• <a href="#">Specialty Centers</a></li><li data-bbox="683 474 878 501">• <a href="#">Local Parks</a></li><li data-bbox="683 512 1042 539">• <a href="#">Spray Parks/Splash Pads</a></li><li data-bbox="683 550 889 577">• <a href="#">Indoor Pools</a></li><li data-bbox="683 588 915 615">• <a href="#">Outdoor Pools</a></li></ul>

## Community Resource Asset Mapping

Asset mapping is a strategic process of identifying and documenting a community's existing resources, strengths, and capabilities to better understand and leverage local assets.<sup>70</sup> By mapping these assets, the service area can better visualize the distribution of resources, identify potential service gaps, strengthen partnerships between organizations, and ultimately improve access to essential services for all community members.<sup>71</sup>

Understanding local assets is particularly valuable for addressing SDOH and ensuring equitable access to resources across the District of Columbia's diverse communities. For the District of Columbia, the asset mapping process included cataloging various resources including:

- Medical resources, including healthcare facilities and providers
- Substance use resources
- Food pantries and other food assistance resources
- Educational institutions
- Parks and recreation facilities
- Emergency services, and other public resources that contribute to residents' wellbeing.
- Shelter and housing resources

It should be noted that the maps on the following pages are **not** an exhaustive representation of all community assets and resources available to improve community health and wellbeing in the District of Columbia. Rather, these maps are intended to provide some perspective about what and where resources currently exist in the community so as new resources are developed, they can be strategically deployed to fill gaps in geographic access for those most in need of services. Community resource directories like [FindHelp](#) may be able to provide the most up-to-date information about community resources.

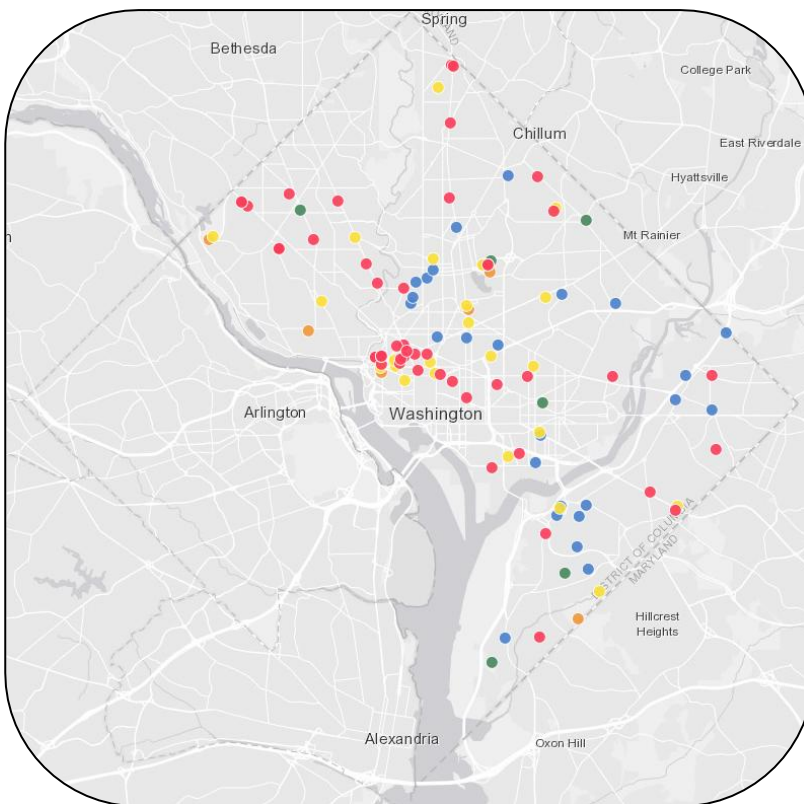
---

<sup>70</sup> UCLA Center for Health Policy Research. (n.d.). Asset mapping: Section 1. Health DATA Program – Data, Advocacy and Technical Assistance.

<sup>71</sup> National Center for Farmworker Health. (2021). Community asset mapping guide.

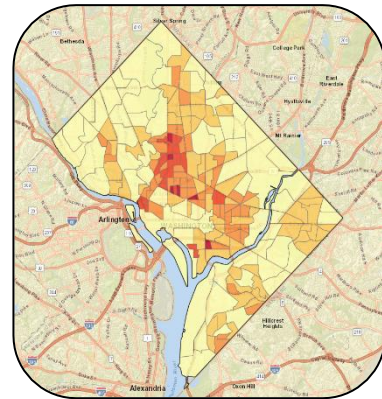
Medical resources, such as [hospitals](#), [health centers](#), and primary care providers are distributed throughout the District of Columbia but not equitably. Private primary care options are concentrated in more densely populated Northeast and downtown neighborhoods. There is only one hospital east of the Anacostia River where there is the highest level of social vulnerability in the District. Please note that the links provided above are not inclusive of all providers that are mapped in **Figure 4.1**.

**Figure 4.1: Medical Resources in the District of Columbia<sup>72</sup>**

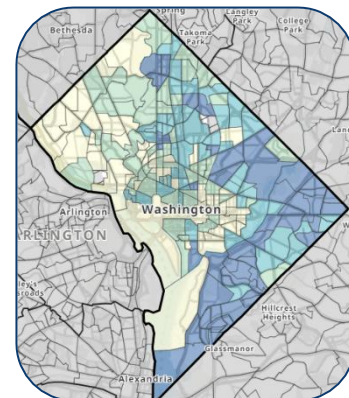


- Private Primary Care
- Hospital Affiliated Primary Care
- Community Non-Profit Primary Care
- Acute Care Hospital
- Specialty Hospital

**Population Density**



**Social Vulnerability Index**

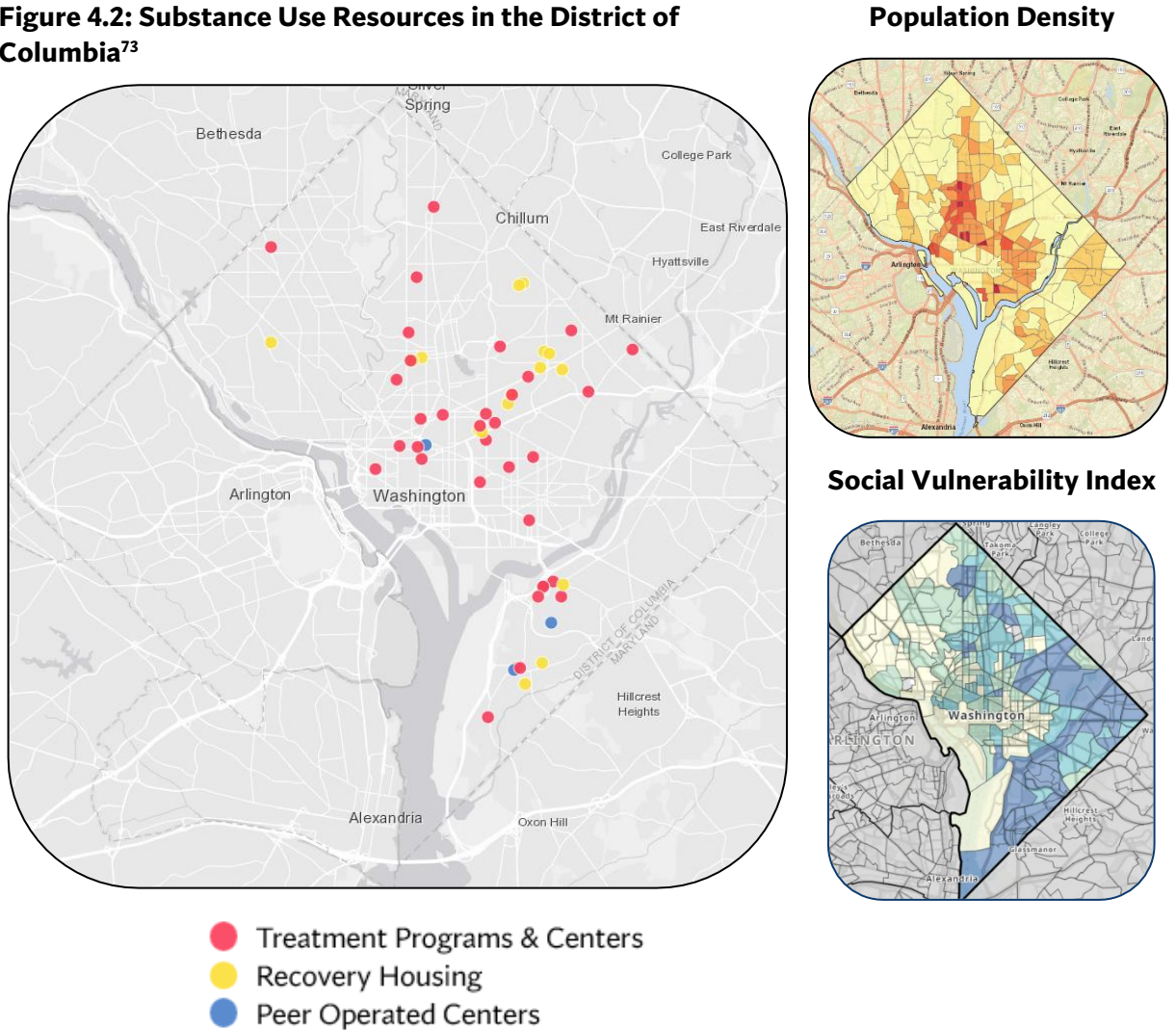


*“What happens beyond the hospital, all the preventative things that need to take place...[there is] not access to some facilities needed” – Ward 8 Resident*

<sup>72</sup> Locations retrieved from DC Health (<https://dchealth.dc.gov/node/173192>), DC Primary Care Association (<https://www.dcpca.org/health-centers>), websites for MedStar, Johns Hopkins, George Washington University, Howard University, Providence Health, and Children’s Nation, and additional internet searches for primary care physicians.

There are [substance use treatment and recovery programs](#) and recovery housing located throughout the District, though resources are concentrated in downtown neighborhoods (high population density) and in Ward 8 (high social vulnerability). Please note that the links provided above are not inclusive of all providers that are mapped in **Figure 4.2**.

**Figure 4.2: Substance Use Resources in the District of Columbia<sup>73</sup>**

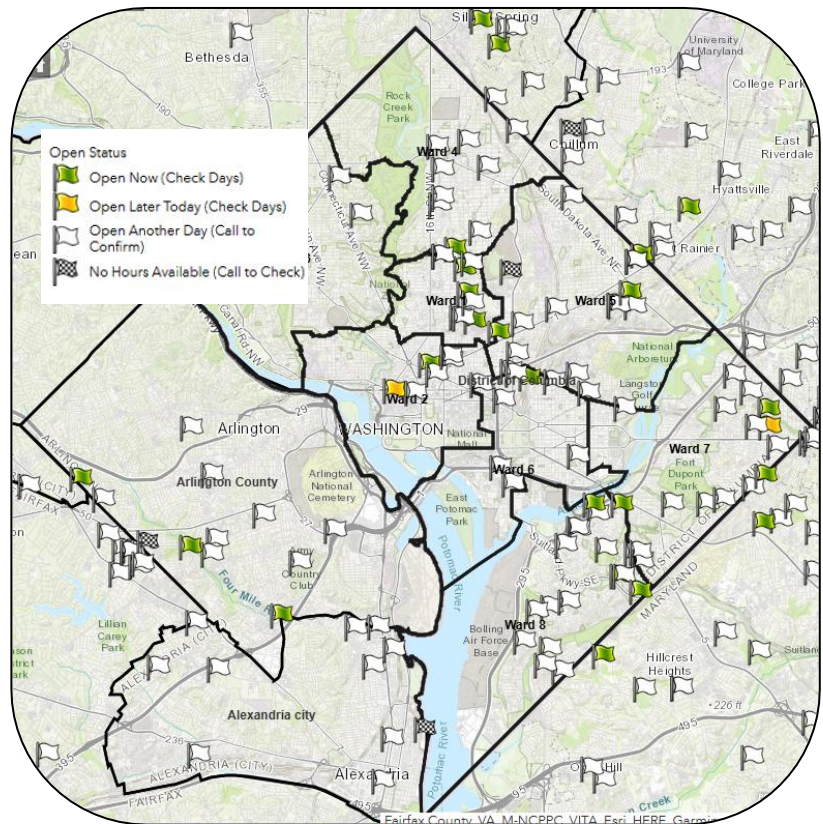


*“I just wanted to mention a lot of times we overlook addiction as a disease, so there a lot of alcohol abuse and substance abuse in general.” – Virtual Focus Group Participant*

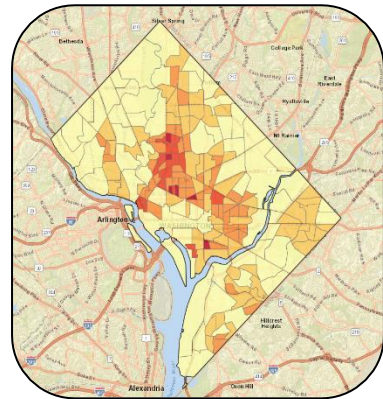
<sup>73</sup> Locations retrieved from My Recovery DC (<https://myrecoverydc.org/services-by-ward/>)

The Capital Area Food Bank works with over 400 nonprofit organizations across the District of Columbia, Maryland and Virginia to distribute food to those in need as well as directly distributing food in the community. Within the District, food distribution sites are more concentrated in Wards 1, 4, 7, and 8 and there are limited options in Ward 3. Community members can learn more about food distribution opportunities through the [Interactive Partner Map](#) (**Figure 4.3**) or by contacting the Hunger Lifeline at (202) 644-9807 or by emailing [hungerlifeline@capitalareafoodbank.org](mailto:hungerlifeline@capitalareafoodbank.org).

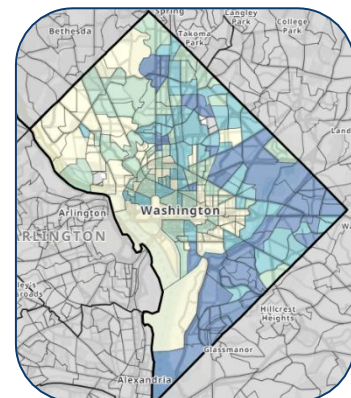
**Figure 4.3: Food Access Resources in the District of Columbia via the Capital Area Food Bank<sup>74</sup>**



**Population Density**



**Social Vulnerability Index**

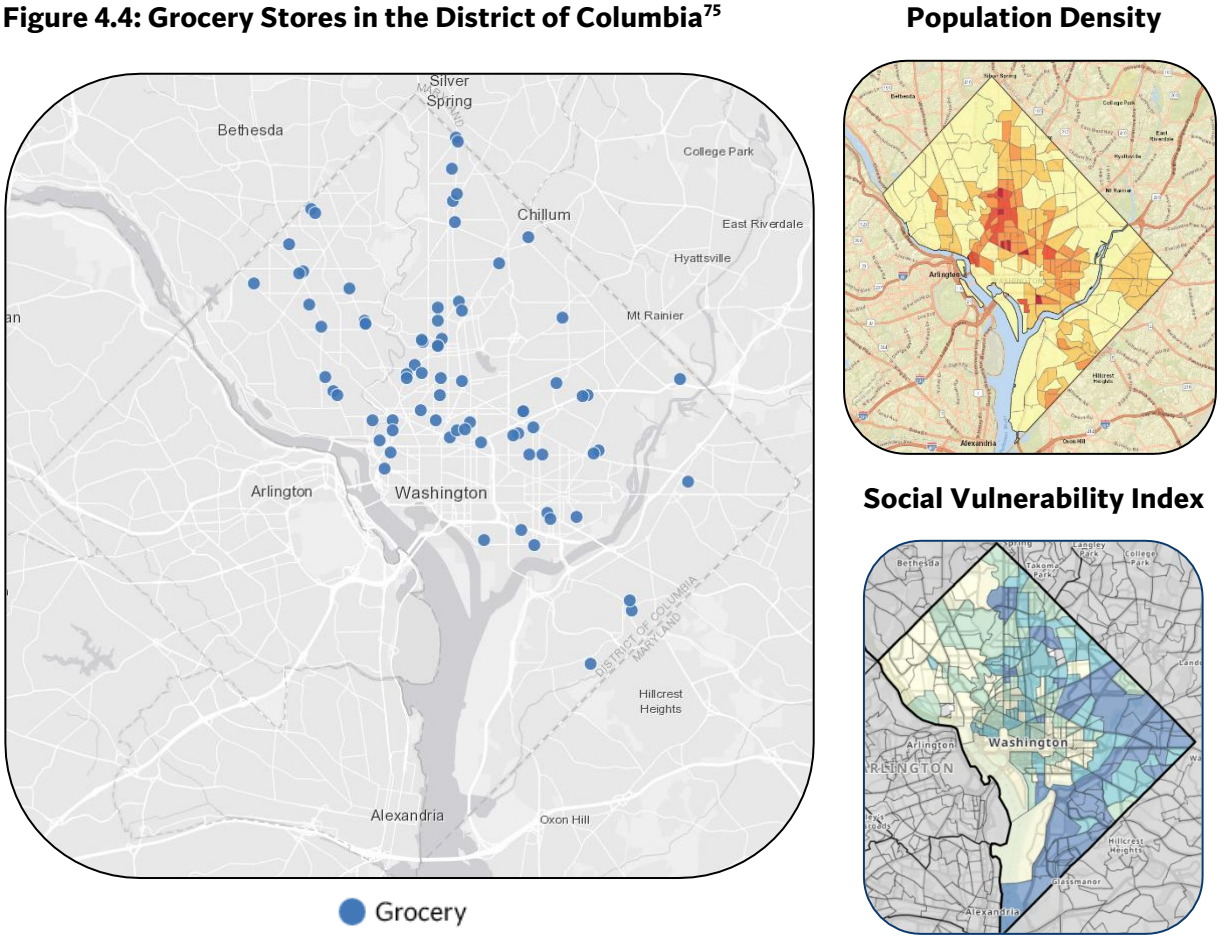


*“I am grateful they’re getting food and I also wish there was a more dignified way for them to get access. They’re waiting in line – like you can see the line – and you know...why can’t it be more dignified so that it gets delivered to something, right?” – Ward 4 Resident*

<sup>74</sup> Please note that the map pictured is an example of the resource that can be found on the Capital Area Food Bank website (<https://www.capitalareafoodbank.org/find-food-assistance/>). The “open status” of distribution sites changes depending on the time the map is accessed. The map above is from February 2025.

As of January 2025, there were 76 grocery stores in the District of Columbia, as seen in **Figure 4.4**. There is a higher density of grocery stores in the Northwest region of the District and in areas where the population is the densest. There are only four grocery stores east of the Anacostia River where the population is considered the most socially vulnerable.

**Figure 4.4: Grocery Stores in the District of Columbia<sup>75</sup>**

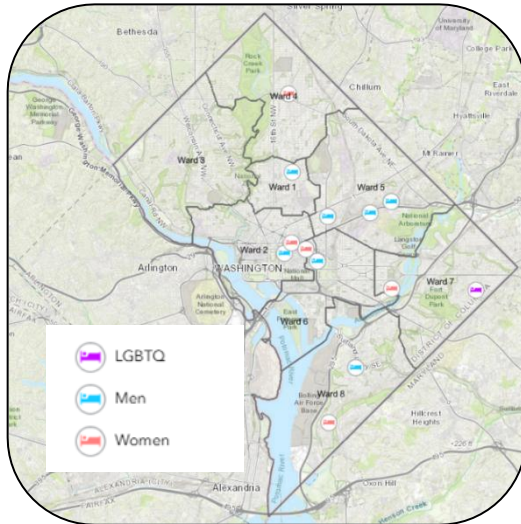


*“Why could they not put in a decent market or decent food? You know we have lots of fast food and that’s good, but where’s our fresh fruits and vegetables?”*  
 – Ward 7 Resident (referring to a new shopping center)

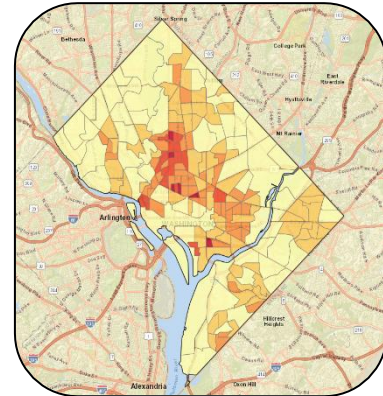
<sup>75</sup> Locations retrieved from Open Data DC (<https://opendata.dc.gov/datasets/DCGIS::grocery-store-locations/explore>). Please note that the raw data needs to be downloaded and filtered to latest update to exclude closed stores.

The image below is an example of the [Low Barrier Shelter \(Figure 4.5\)](#) and [Transitional Housing \(Figure 4.6\)](#) maps available on the DC Department of Human Services website. Low barrier shelters provide immediate and easy access to shelter by eliminating barriers to entry such as sobriety requirements. Transitional housing is designed to support individuals and families experiencing homelessness to transition into permanent, affordable housing, typically within a set timeframe. Housing resources in the District of Columbia are concentrated in central areas with the highest population density and in areas with the highest social vulnerability.

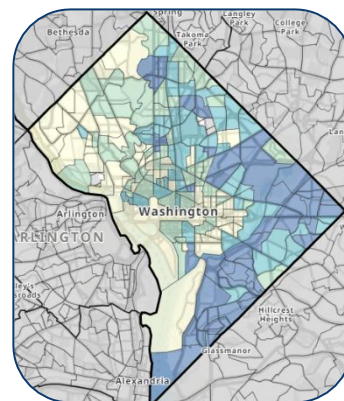
**Figure 4.5: Low Barrier Shelters for Single Adults in the District of Columbia<sup>76</sup>**



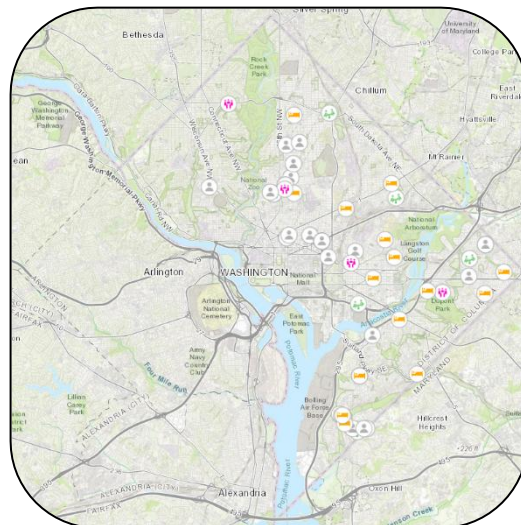
**Population Density**



**Social Vulnerability Index**



**Figure 4.6: Transitional Housing Available in the District of Columbia<sup>77</sup>**

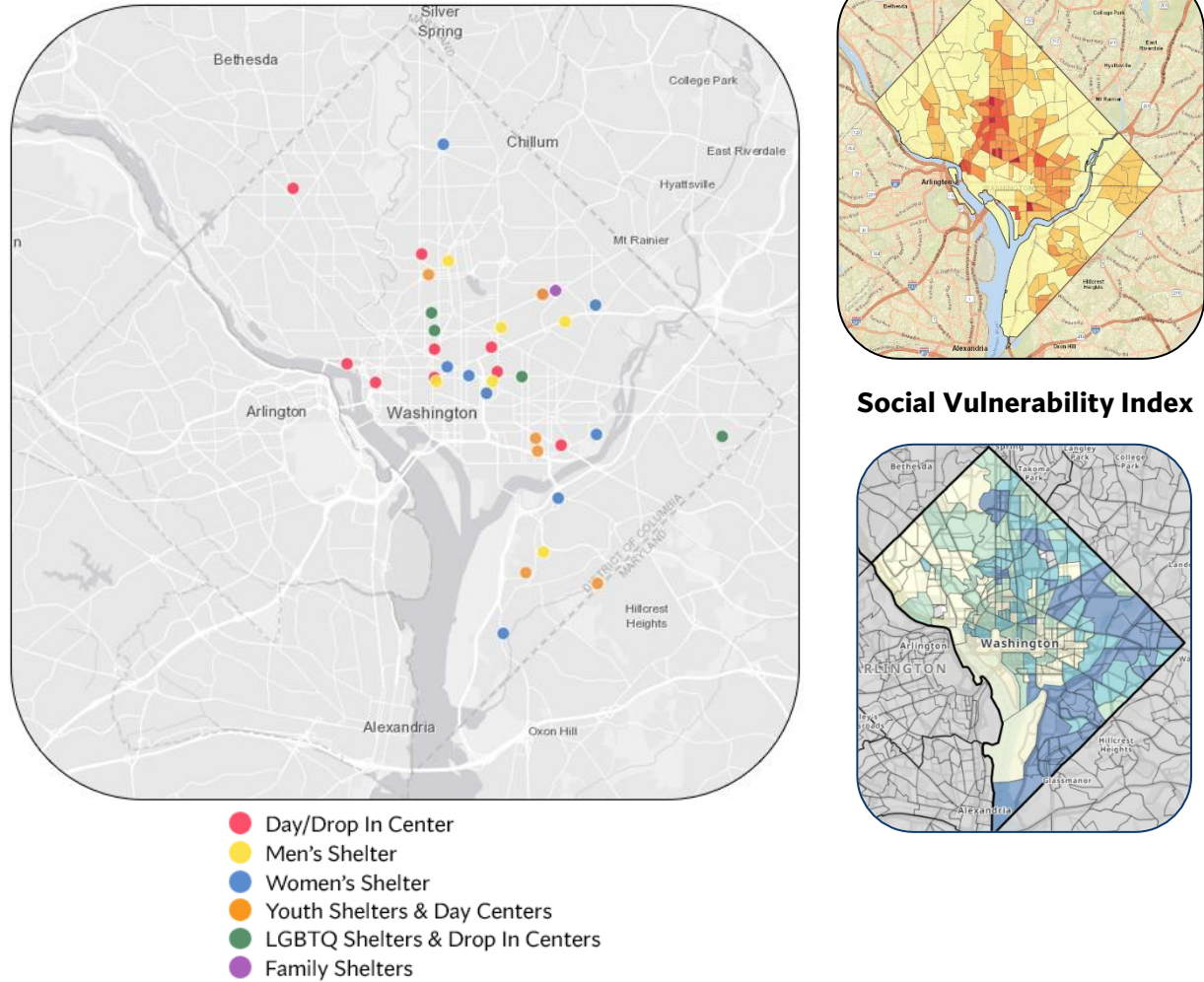


<sup>76</sup> Locations retrieved from the DC Department of Human Services (<https://dhs.dc.gov/page/how-access-shelter>)

<sup>77</sup> Locations retrieved from the DC Department of Human Services (<https://dhs.dc.gov/page/transitional-housing-individuals>)

As of February 2025, there are numerous shelters and day centers within the District tailored to various demographic groups and with different barriers/requirements for usage. Shelters and Day Centers are primarily concentrated in areas with high population density or high social vulnerability, as seen in **Figure 4.7**.

**Figure 4.7: Shelters and Day Centers in the District of Columbia**<sup>78</sup>

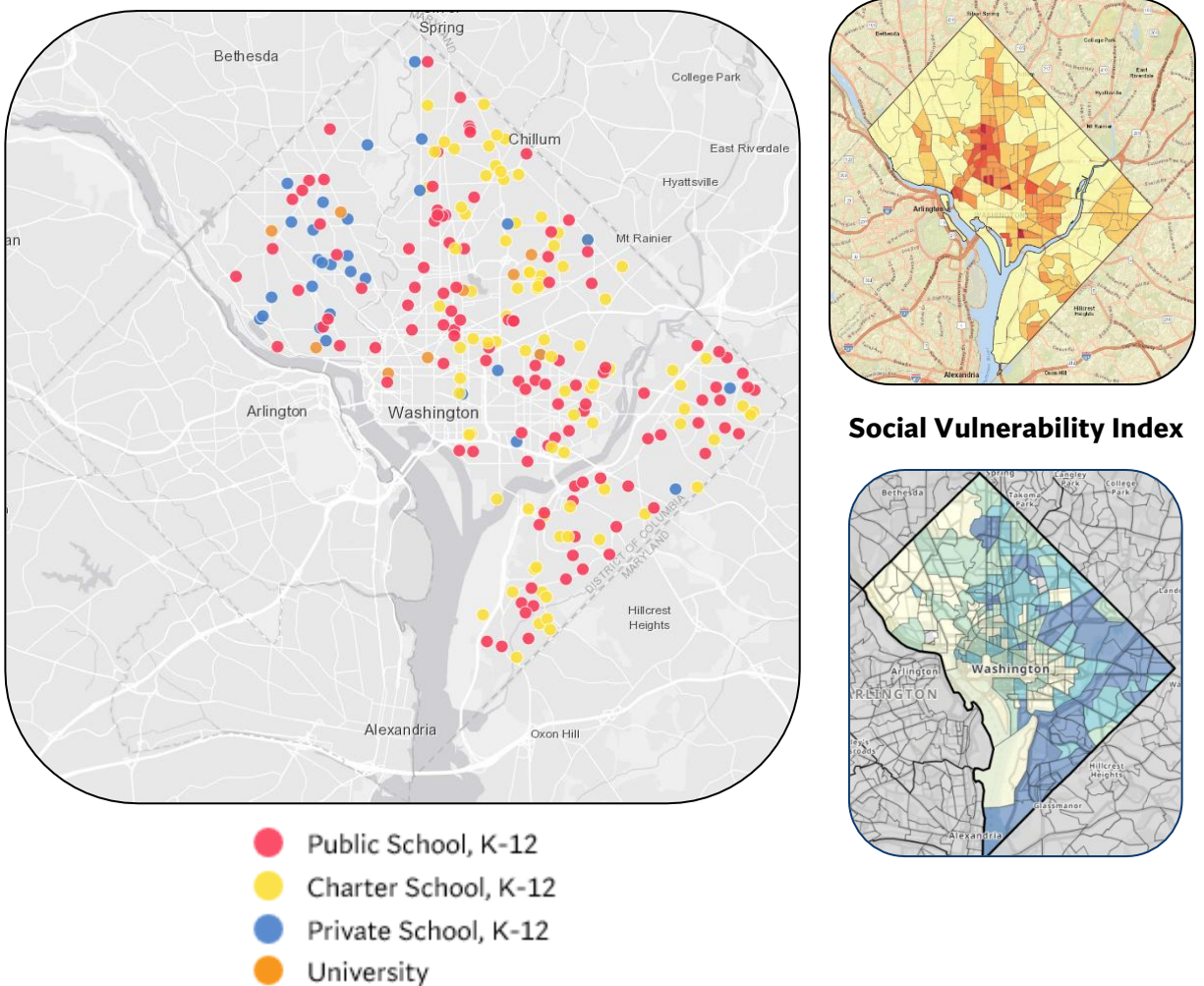


*“There are concerns and I’ve heard people say that sometimes homeless shelters are not really in condition to receive people [and] to really help people inside. They are really dangerous and people [would] rather stay on the streets than go in.” – Ward 1 Resident*

<sup>78</sup> Locations retrieved from the DC Department of Human Services (<https://dhs.dc.gov/>), the DC Mayor website (<https://mayor.dc.gov/>), and The Washington Legal Clinic for the Homeless (<https://www.legalclinic.org/>)

A mix of over 230 educational institutions are found throughout the District of Columbia, ranging from K-12 schools ([public](#), [public charter](#), and private) to well-known universities. As seen in **Figure 4.8**, public schools are evenly distributed throughout the District, modeling population density. Notably, there are few charter schools in the Northwest, but a high concentration of private schools.

**Figure 4.8: Education in the District of Columbia<sup>79</sup>**

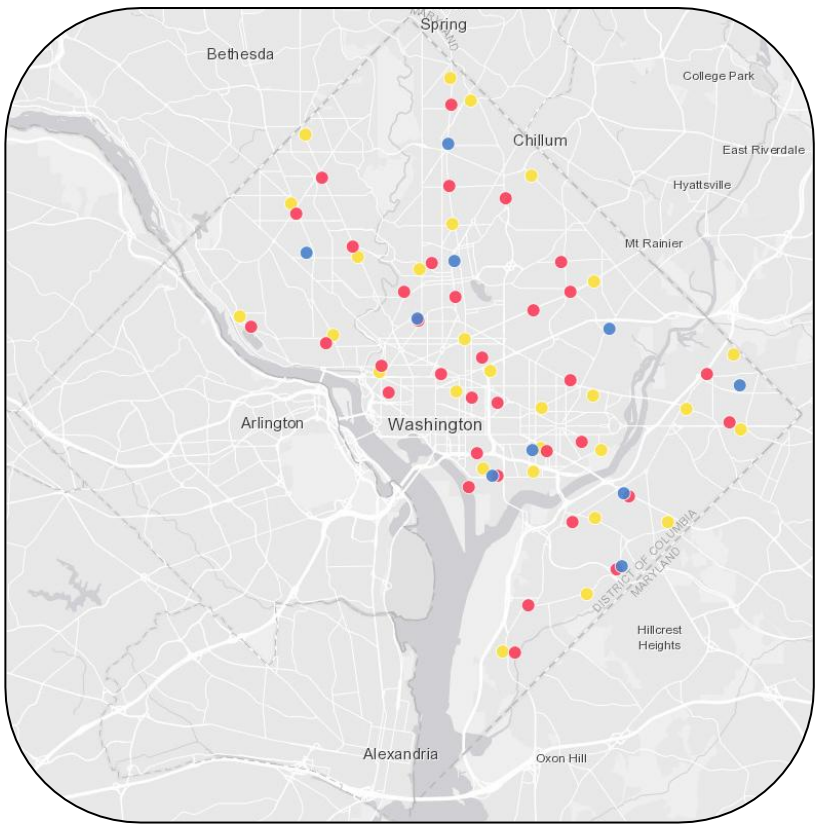


*“I also think just the push for preventative care and regular healthcare...is important. You know, schools do a really good job when it’s time for... vaccinations and things.”*  
 – Ward 5 Resident

<sup>79</sup> Locations retrieved from the District of Columbia Public Schools (<https://dcps.dc.gov/publication/printable-school-directory>), the DC Public Charter School Board (<https://dcpcs.org/>), and additional internet searches for private schools and universities.

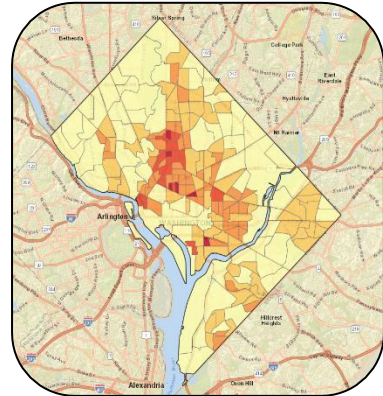
Emergency services and public resources are conveniently distributed throughout the city for the safety of District residents, as shown in **Figure 4.9**. There are 26 [public libraries](#) in the District. There are seven [Metropolitan Police Districts](#) in the District of Columbia, each of which has at least one police station. There are 33 [Engine Companies](#) (fire stations) across the District of Columbia.

**Figure 4.9: Emergency Services and Public Resources in the District of Columbia<sup>80</sup>**

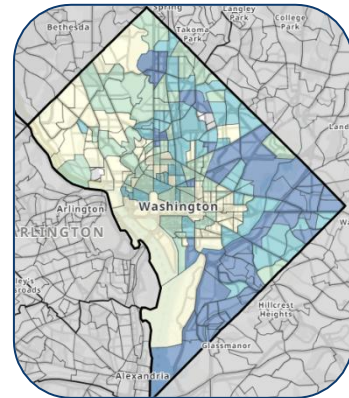


- Fire Station
- Public Library
- Police Station

**Population Density**



**Social Vulnerability Index**

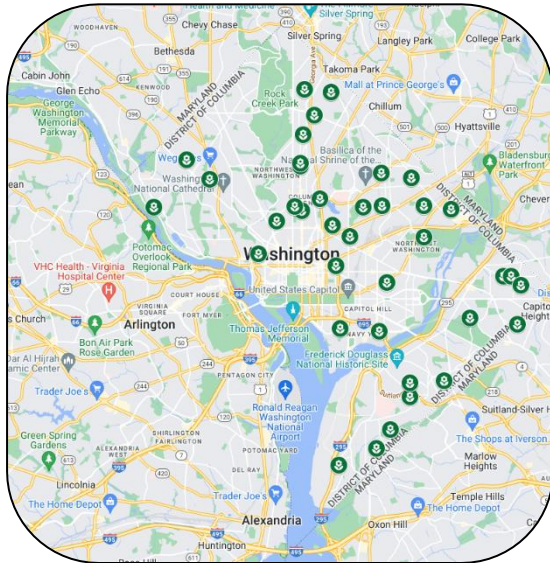



*“Being able to communicate with the police department.”*  
 – Ward 4 Resident (when asked what they liked about living in the District)

<sup>80</sup> Locations retrieved from the DC Public Library (<https://www.dclibrary.org/plan-visit>), the Metropolitan Police Department (<https://mpdc.dc.gov/page/maps-mpdc-police-districts-and-psas>) and Open Data DC (<https://opendata.dc.gov/datasets/DCGIS::fire-stations/explore?location=38.894917%2C-77.015000%2C10.71>)

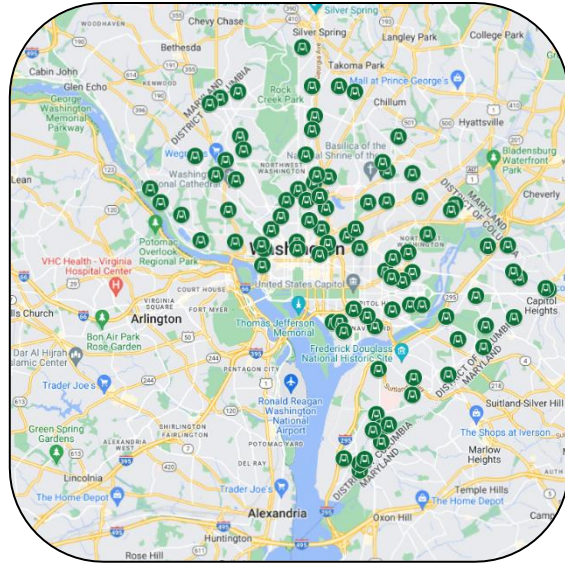
The images below are examples of the [Community Gardens](#), [Playgrounds](#), [Recreation Centers](#), and [Local Parks](#) maps available through the District of Columbia Department of Parks and Recreation<sup>81</sup>. These public resources support physical activity and access to fresh fruits and vegetables produced in local communities throughout the District.

**Figure 4.10: Community Gardens in the District of Columbia**



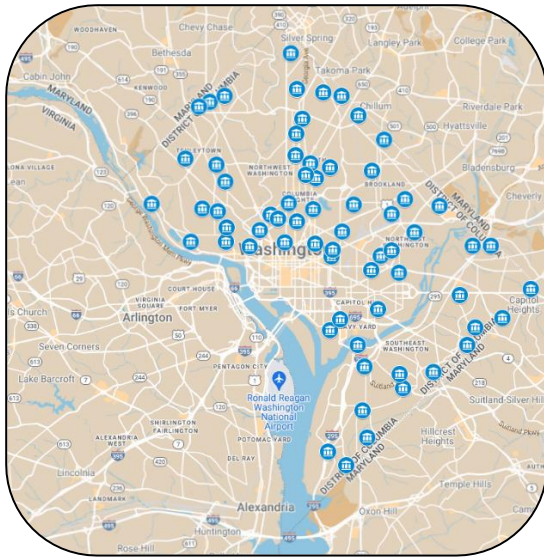
 Community Garden


**Figure 4.11: Playgrounds in the District of Columbia**



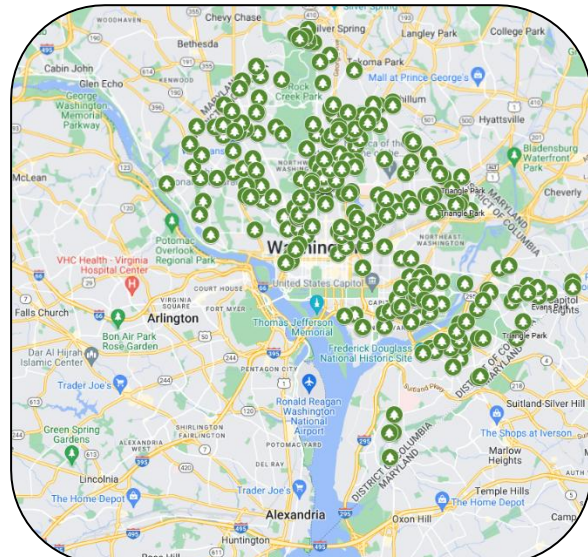
 Playgrounds


**Figure 4.12: Recreation Centers in the District of Columbia**



 Recreation Centers

**Figure 4.13: Local Parks in the District of Columbia**

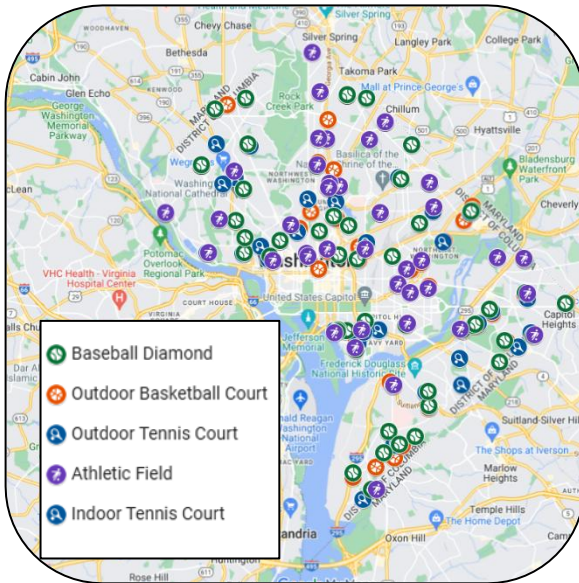


 Local Parks

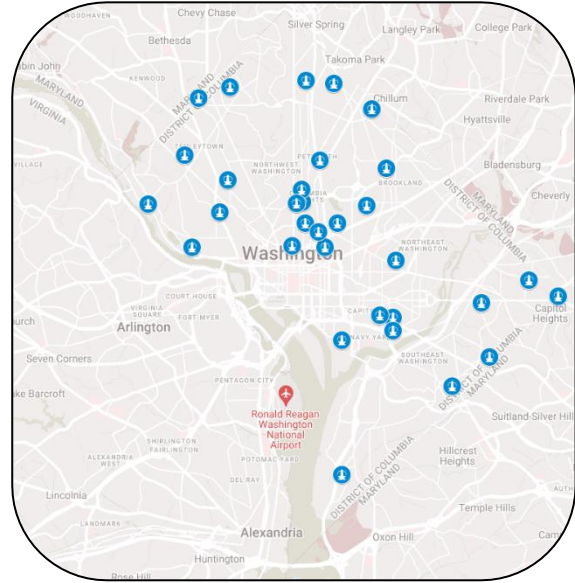
<sup>81</sup> Locations retrieved from DC Department of Parks and Recreation (<https://dpr.dc.gov/locations>)


The images below are examples of the [Athletic Fields & Courts](#), [Spray Parks](#), [Indoor Pools](#), and [Outdoor Pools](#) maps available through the District of Columbia Department of Parks and Recreation<sup>81</sup> There are a variety of facilities available to support physical activity across the District.

**Figure 4.14: Athletic Fields & Courts in the District of Columbia**



**Figure 4.15: Spray Parks / Splash Pads in the District of Columbia**



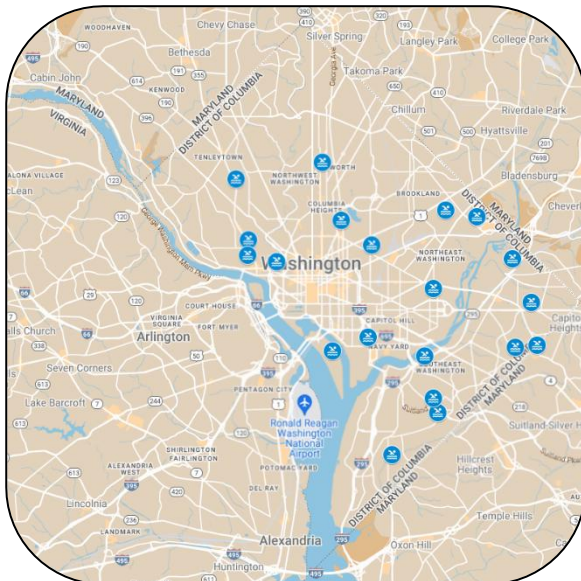
 Spray Parks / Splash Pads


**Figure 4.16: Indoor Pools in the District of Columbia**



 Indoor Pool

**Figure 4.17: Outdoor Pools in the District of Columbia**



 Outdoor Pool

## Chapter 5 | Next Steps

The CHNA findings will be used by community health leaders to develop effective strategies aimed at addressing the priority health needs identified in this report. The immediate next step in the CHNA process is to develop community-based health improvement strategies and action plans to address the priorities identified in this assessment.

Steering Committee organizations will leverage information from this CHNA to develop implementation and action plans for their local community, while also working with other organizations and agencies in the service area to ensure the priority health need areas are addressed in the most efficient, effective, and collaborative way. The Steering Committee believes that the most effective strategies will be those that have the collaborative support of community organizations and residents. The strategies developed will include measurable objectives through which progress can be measured.

# Appendix 1 | Primary Data Methodology and Sources

This CHNA’s development incorporated primary data collection via multiple methods: focus group discussions, key leader interviews, web-based key leader and community health surveys. An overview of the processes, tools, analytic methods used to determine key findings, and brief key findings from each data source are provided in this Appendix. More detailed findings from each primary data source are provided in **Appendix 6 | Secondary Data Summary**.

## Community Health Survey

### **Overview**

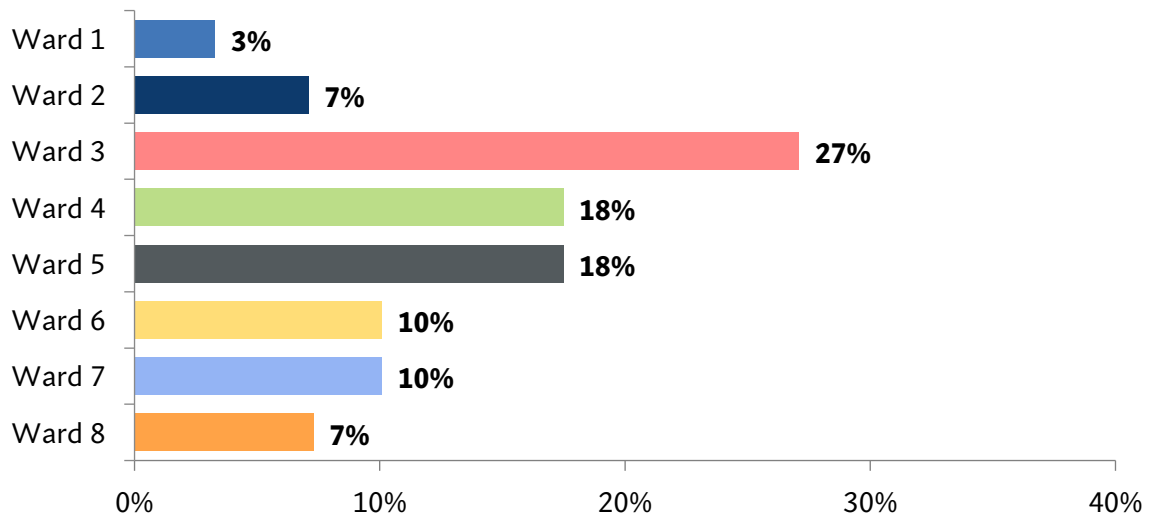
A total of 452 Community Health Surveys were completed when the survey was open between January 31, 2025, and February 24, 2025. The data analysis only includes the 424 survey respondents that reported living in an identified Ward in the District. For the sake of accessibility, the survey was available in English, Spanish, Haitian Creole, Chinese (Simplified), and Amharic. Approximately 0.7% of the surveys were completed in Spanish and no surveys were completed in Haitian Creole, Chinese, or Amharic.

In general, survey questions focused on:

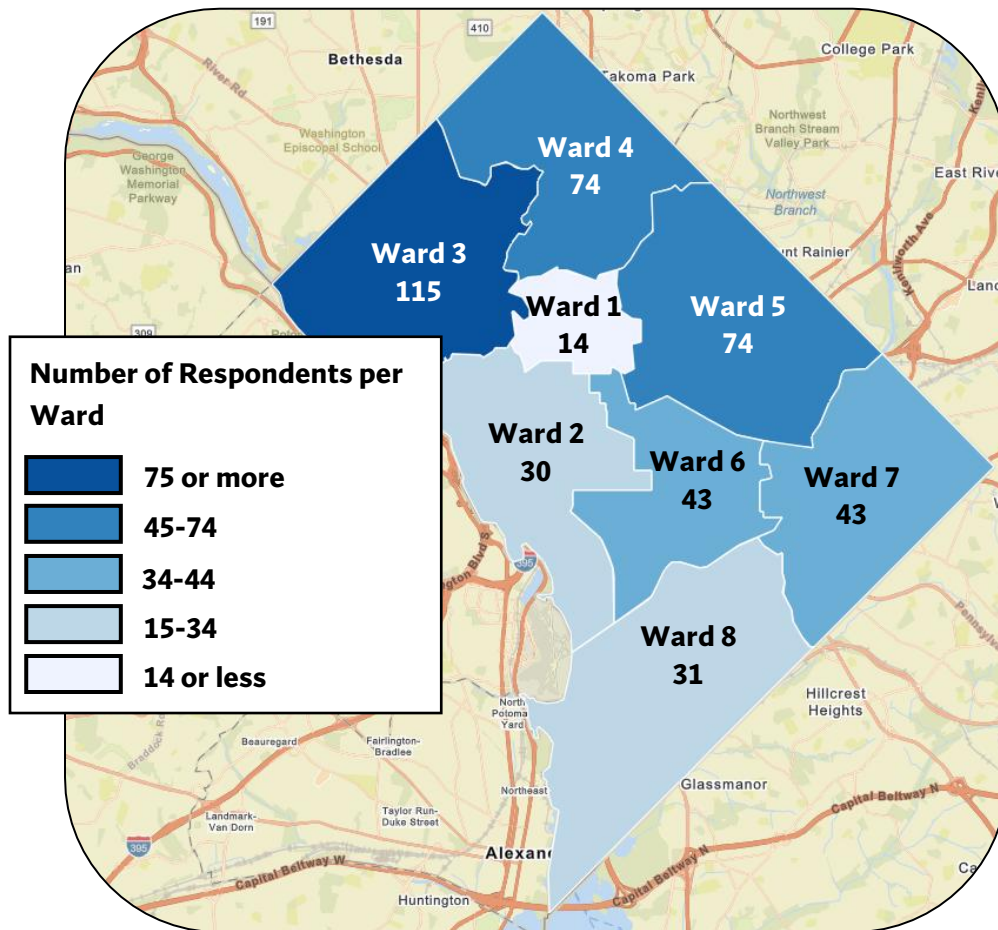
- Community health problems and concerns
- Community social / environmental problems and concerns
- Access and barriers to healthcare
- Physical health, mental health, and alcohol use
- Housing, financial security, and neighborhood safety

Consistent with one of the survey process goals, community member respondents represented all eight Wards in the District, though Ward 3 was over-represented compared to other Wards and Ward 1 was underrepresented. **Figure A1.1** and **Figure A1.2** provide additional information on the Ward of residence for survey respondents. Additional demographic data about community health survey respondents is portrayed below.

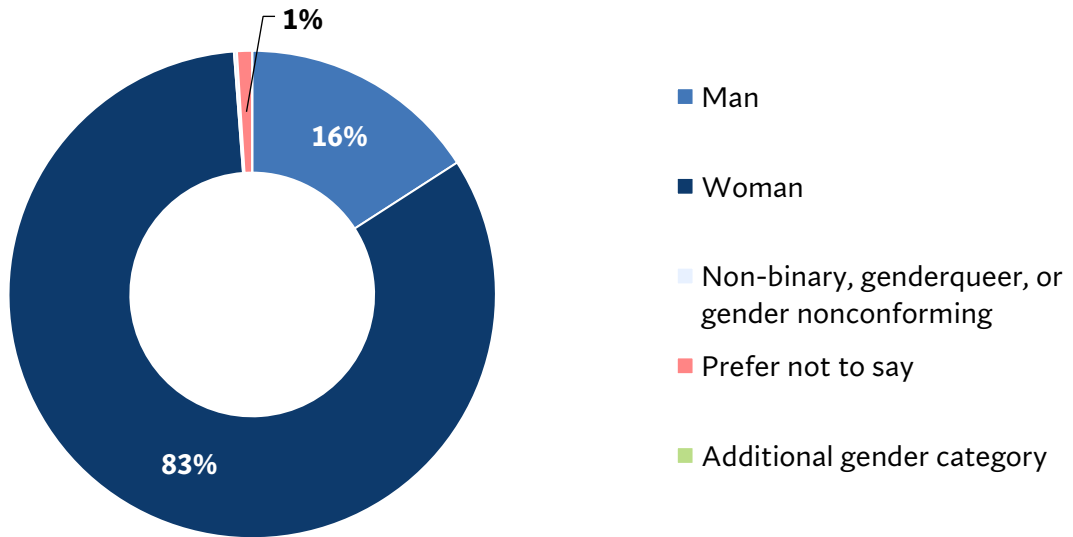
**Figure A1.1: Respondent Ward of Residence (n=424)**



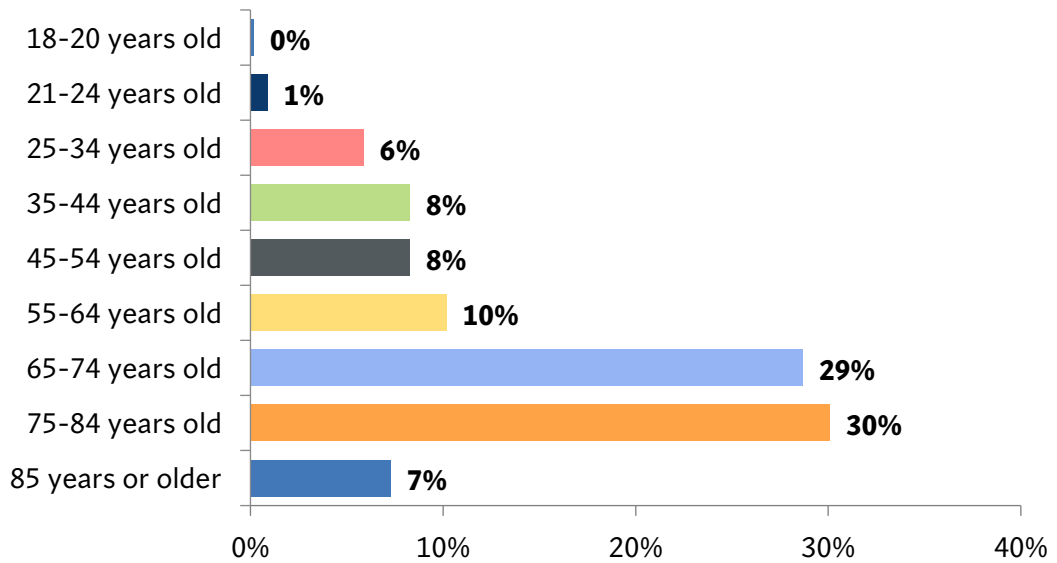
**Figure A1.2: Respondent Ward of Residence Mapped (n=424)**



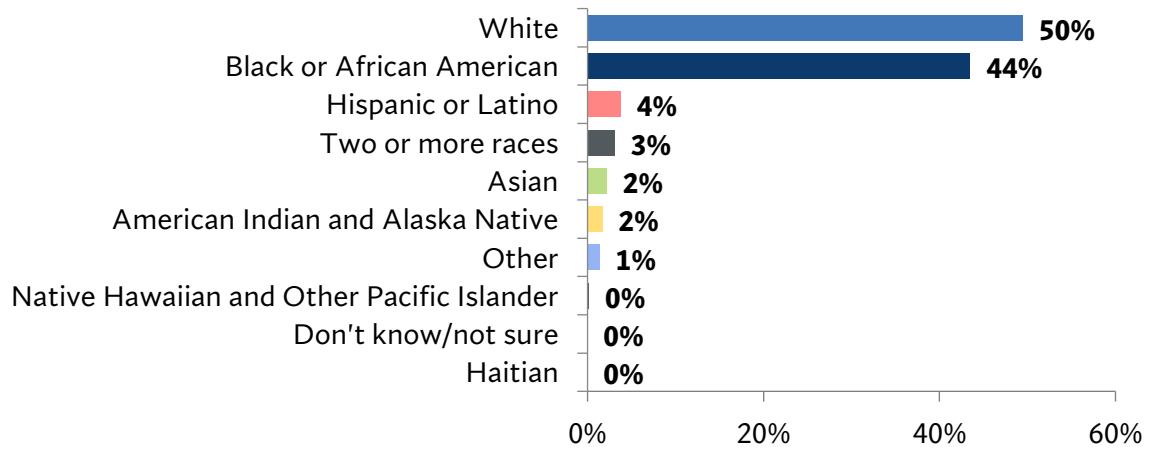
**Figure A1.3: Gender Identity (n=421)**



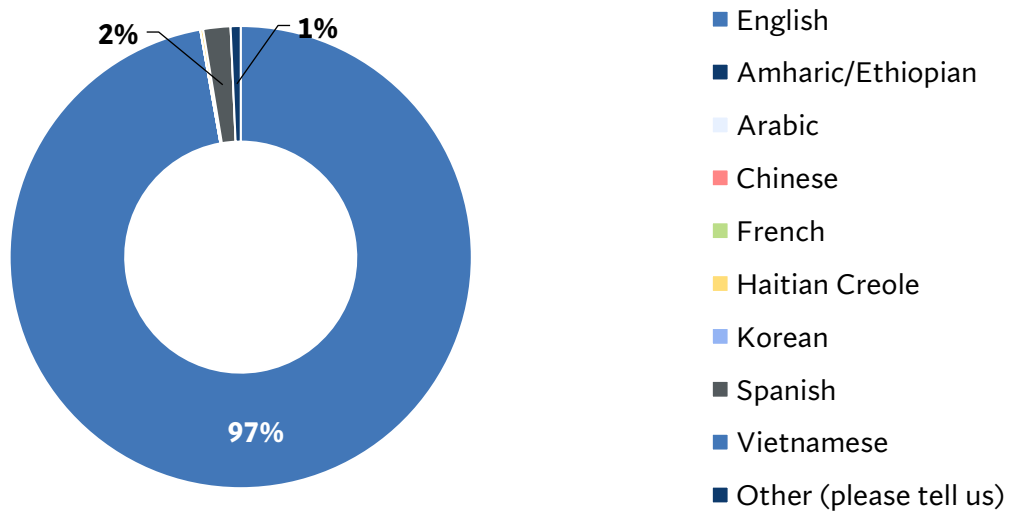
**Figure A1.4: Age Group (n=422)**



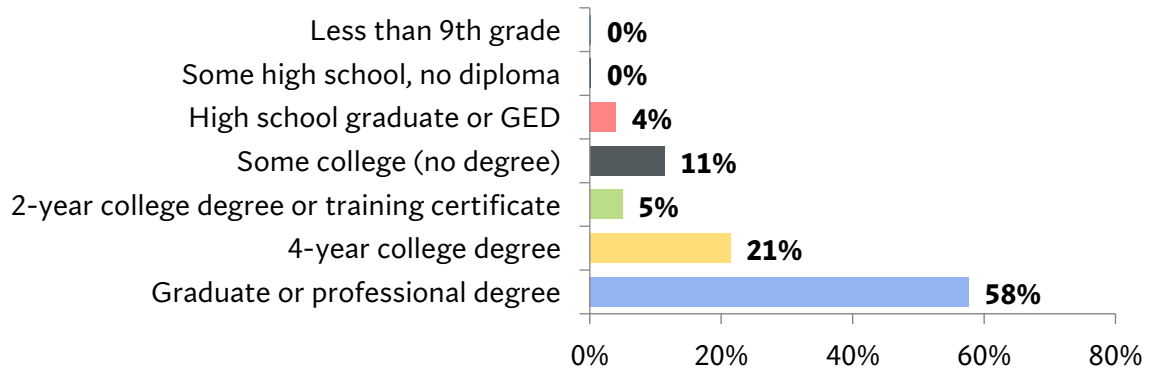
**Figure A1.5: Race and Ethnicity (n=418)**



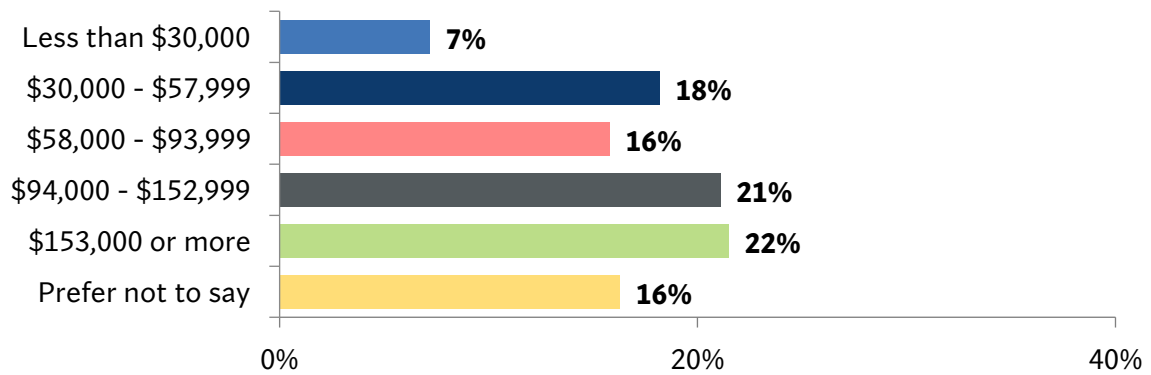
**Figure A1.6: Language Spoken at Home (n=419)**



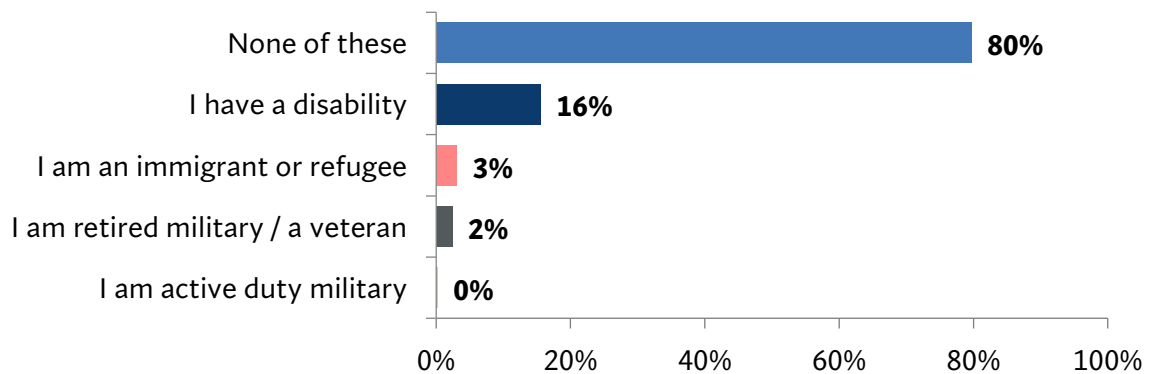
**Figure A1.7: Education Level (n=422)**



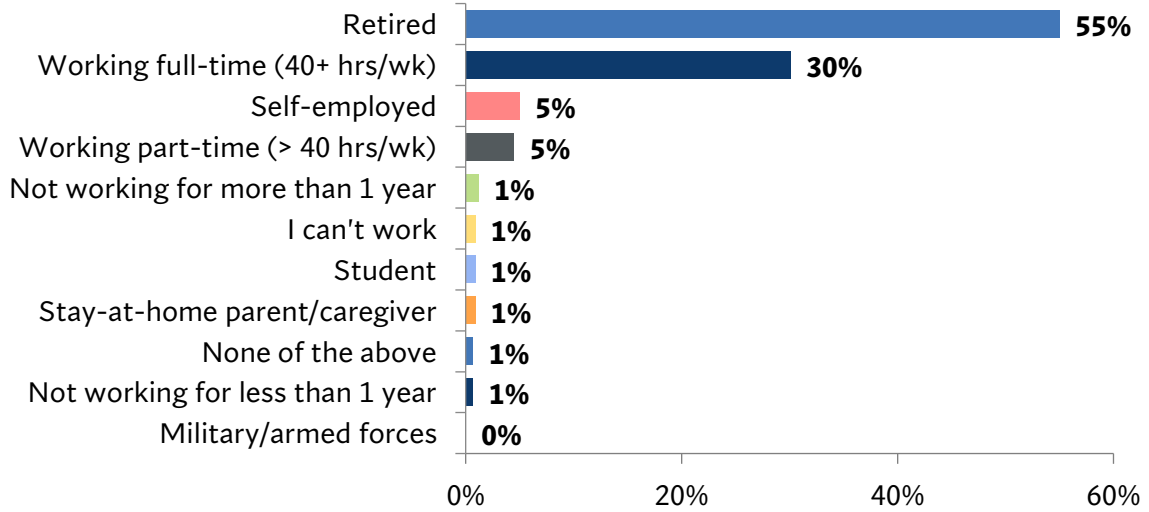
**Figure A1.8: Household Income before Taxes (n=418)**



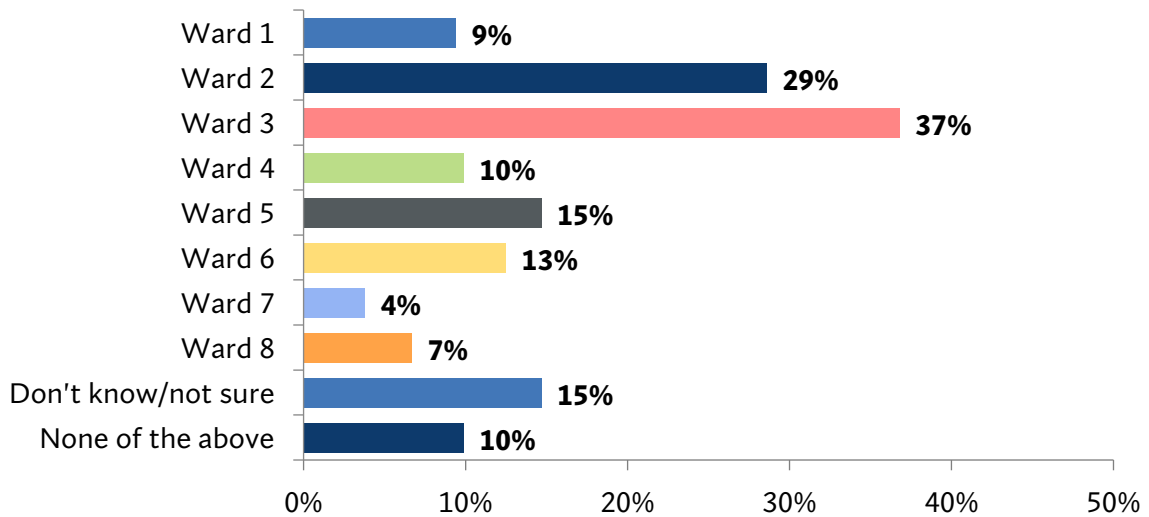
**Figure A1.9: Other Identifying Statuses (n=418)**



**Figure A1.10: Employment Status (n=422)**



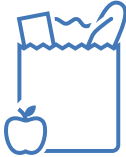


**Figure A1.11: Wards Respondents Report Working in or Receiving Healthcare in (n=416)**



## Summary of Key Findings

The key findings from the Community Survey are detailed below:

		
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Difficulty obtaining an appointment</li> <li>• Long wait times</li> <li>• Insurance coverage issues</li> <li>• High out of pocket costs</li> </ul>	<p><b>Health and Wellness</b></p> <ul style="list-style-type: none"> <li>• Older adult health</li> <li>• Chronic diseases (heart disease, diabetes, cancer)</li> <li>• Mental health</li> <li>• Substance use</li> </ul>	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Neighborhood safety</li> <li>• Housing problems and homelessness</li> <li>• Loneliness</li> <li>• Poverty</li> </ul>

### Key Takeaways:

1. Residents identified unsafe neighborhoods as a major social determinant impacting health, reporting higher safety concerns at nighttime particularly in Wards 7 and 8.
2. Housing problems and homelessness ranked as a top concern with many reporting financial concerns about being able to afford utilities and their rent or mortgage.
3. Residents report difficulty obtaining appointments, followed by long wait times and insurance issues as the leading obstacles to accessing medical care.
4. District residents identify older adult health, heart problems, and diabetes as the biggest health challenges facing the community.

## Community Health Survey Instrument



SIBLEY MEMORIAL  
HOSPITAL  
JOHNS HOPKINS MEDICINE

\* Required information

Dear Neighbor,

We invite you to participate in the District of Columbia Community Health Survey, led by Sibley Memorial Hospital and Howard University Hospital.

Your answers are private - we won't know who filled out the survey. Your answers will help hospitals make the District healthier. The survey takes about 10 minutes to complete.

Before You Start:

- You must be 18 or older to take this survey
- Please answer all questions

If you have questions about this survey, please email [chelseysaari@ascendient.com](mailto:chelseysaari@ascendient.com). Ascendient Healthcare Advisors is helping us with this survey.

Thank you for your time and participation!

\* 1. Are you 18 or older? (Select one option)

- Yes
- No

[If "No"] Survey ends

\* 2. The District is divided into 8 Wards. Which Ward do you live in? (Select one option)

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Don't know/not sure
- None of the above

3. Which Ward(s) do you work in or get healthcare in? (Check all that apply)

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Don't know/not sure
- None of the above

4. How old are you? (Select one option)

- 18-20 years old
- 21-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75-84 years old
- 85 years or older

5. Which of the following best describes your gender? (Select one option)

- Man
- Woman
- Non-binary, genderqueer, or gender nonconforming
- Prefer not to say
- Additional gender category (please tell us): \_\_\_\_\_

6. How would you best describe your race or ethnic background? (Check all that apply)

- American Indian and Alaska Native
- Asian
- Black or African American
- Haitian
- Hispanic or Latino
- Native Hawaiian and Other Pacific Islander
- White
- Two or more races
- Don't know/not sure
- Other (please tell us): \_\_\_\_\_

7. Which language is most often spoken in your home? (Select one option)

- English
- Amharic/Ethiopian
- Arabic
- Chinese
- French
- Haitian Creole
- Korean
- Spanish
- Vietnamese
- Other (please tell us) \_\_\_\_\_

8. What is the highest level of school you finished?

(Select one option)

- Less than 9th grade
- Some high school, no diploma
- High school graduate or GED
- Some college (no degree)
- 2-year college degree or training certificate
- 4-year college degree
- Graduate or professional degree

9. What best describes your job situation?

(Select one option)

- Working full-time (40+ hours each week)
- Working part-time (less than 40 hours each week)
- Military/armed forces
- Retired
- Self-employed
- Stay-at-home parent/caregiver
- Student
- Not working for less than 1 year
- Not working for more than 1 year
- I can't work
- None of the above

10. How much money does your household make each year before taxes?

Include all money from: jobs, Social Security, family help, welfare, retirement, investments, and other sources.

(Select one option)

- Less than \$30,000
- \$30,000 - \$57,999
- \$58,000 - \$93,999
- \$94,000 - \$152,999
- \$153,000 or more
- Prefer not to say

11. Do any of these describe you? (Check all that apply)

- I am an immigrant or refugee
- I am active duty military
- I am retired military / a veteran
- I have a disability
- None of these

12. What are the 3 biggest health problems in your community? [Please select up to 3 options.]

- Alcohol and drug problems
- Alzheimer's disease and other dementias
- Breathing problems (like asthma and COPD)
- Cancer
- Child and adolescent health
- Dental health
- Diabetes or high blood sugar
- Eating healthy
- Heart problems (like high blood pressure)
- Long lasting health problems (like autoimmune disorders and chronic pain)
- Mom and baby health
- Mental health (like feeling sad or worried)
- Older adult health
- Sexually transmitted infections
- Smoking or tobacco use
- Stroke
- Weight status (like being overweight or obese)
- Other (please tell us) \_\_\_\_\_

13. What are the 3 biggest social and environmental problems that affect health in your community? [Please select up to 3 options.]

- Child abuse and neglect
- Feeling lonely
- Hard to find healthy food
- Hard to find jobs
- Hard to get a doctor's appointment
- Health insurance issues
- Housing problems or homelessness
- No places to exercise
- Not enough child care
- Not enough public spaces (e.g., sidewalks, parks)
- Pollution and environmental changes
- Poor schools and educational opportunities
- Poverty (not enough money)
- Transportation problems
- Treating people unfairly because of age
- Treating people unfairly because of disability
- Treating people unfairly because of gender
- Treating people unfairly because of race
- Unsafe neighborhoods
- Violence at home
- Other (please tell us) \_\_\_\_\_

14. There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (Check all that apply)

- Can't take time off work
- Co-pay and/or deductible are too expensive
- Hard to get an appointment
- Insurance not taken
- Language barriers
- Nervous about seeing a doctor
- No child care or adult care
- No insurance
- No way to get there
- Religious or cultural reasons
- Too far away
- Wait is too long
- I did not have problems getting care
- Other (please tell us) \_\_\_\_\_

15. Where do you usually go when you're sick or need health advice? (Check all that apply)

- Doctor's office
- Emergency room
- Family or friends
- Health department
- Internet
- Spiritual community
- Urgent care
- Veteran's (VA) hospital or clinic
- Don't go one place most often
- Some other place (please tell us) \_\_\_\_\_

16. How many days was your MENTAL health not good in the last 30 days?  
(Enter a value between 0 and 30)

---

17. In the past year, was there a time you needed mental health help but did not get it? (Select one option)

- Yes
- No
- Don't know/not sure

[If “Yes”] Next question appears

18. Why couldn't you get help with your mental health?

(Select one option)

- Can't take time off work
- Hard to get an appointment
- Insurance not taken
- Language barriers
- No child care or adult care
- No insurance
- No one looks like me
- No way to get there
- Religious or cultural reasons
- Stigma or embarrassment
- Too expensive
- Too far away
- Wait is too long
- None of these
- Other (please tell us) \_\_\_\_\_

19. Considering your overall PHYSICAL health, how healthy is your body right now? (Select one option)

- Very Healthy
- Healthy
- Okay
- Not Very Healthy
- Not Healthy At All
- Don't know/not sure

20. Has a doctor, nurse, or other healthcare provider ever told you that you have any of these health problems? (Check all that apply)

Your answers are private - we won't know who filled out the survey.

- Arthritis (joint pain)
- Asthma
- Cancer
- Chronic Obstructive Pulmonary Disease (COPD)
- Dementia/short-term memory loss
- Depression or anxiety
- Diabetes (not during pregnancy)
- Eye problems
- Heart disease, stroke, or other cardiovascular disease
- High blood pressure (hypertension)
- High cholesterol
- Immunocompromised condition not otherwise listed
- Kidney disease
- Liver disease
- Long COVID
- Lung disease
- Mental illness not otherwise listed (including bipolar disorder, schizophrenia, borderline personality disorder, dissociative identity disorder)
- Osteoporosis (weak bones)
- Physical disabilities
- Sexually transmitted infections (including chlamydia, syphilis, gonorrhea and HIV)
- Other (please tell us) \_\_\_\_\_
- None of these

[If answer is NOT "None of these"] Next question appears

21. What do you need to take care of your health problem(s) mentioned above? (Check all that apply)

- I don't need help managing my health problem
- Better insurance
- Healthy food
- Help coordinating care across multiple doctors
- Help finding a doctor
- Help getting to appointments
- Help making appointments
- Help paying co-pays and deductibles
- Help paying for medicine or medical equipment
- Help understanding doctor's instructions
- Help understanding how to take medicine
- Home health care
- Safe places to exercise
- I don't know
- Other (please tell us) \_\_\_\_\_
- None of these

22. How often do you drink alcohol (beer, wine, or liquor)?

(Select one option)

- Every Day
- Some Days
- Never

23. In the past 12 months, did you or someone in your household skip meals or eat less food because there wasn't enough money for food? (Select one option)

- Yes
- No
- Don't know/not sure

24. Do you have any of the following problems in your home? (Check all that apply)

- Bugs
- Broken or poor AC
- Broken or poor heat
- Holes in the floor
- Lead paint or pipes
- Mold
- No smoke detector / broken smoke detector
- Oven or stove are broken
- Water leaks
- Other (please tell us) \_\_\_\_\_
- None of the above

25. In the past 12 months, were there times when you:

	Yes	No	Don't know/Not sure
(a) Were worried about having enough money to pay your rent or mortgage?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) Did not have electricity, water, or heating in your home?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

26. Do you trust the police in the District? (Select one option)

- Not at all
- A little
- Somewhat
- A lot
- To a great extent

27. How safe do you feel in your neighborhood when you are outside alone?

	Very Unsafe	Unsafe	Neither Safe nor Unsafe	Safe	Very Safe
(a) Daytime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) Nighttime	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

# Key Leader Survey

## Overview

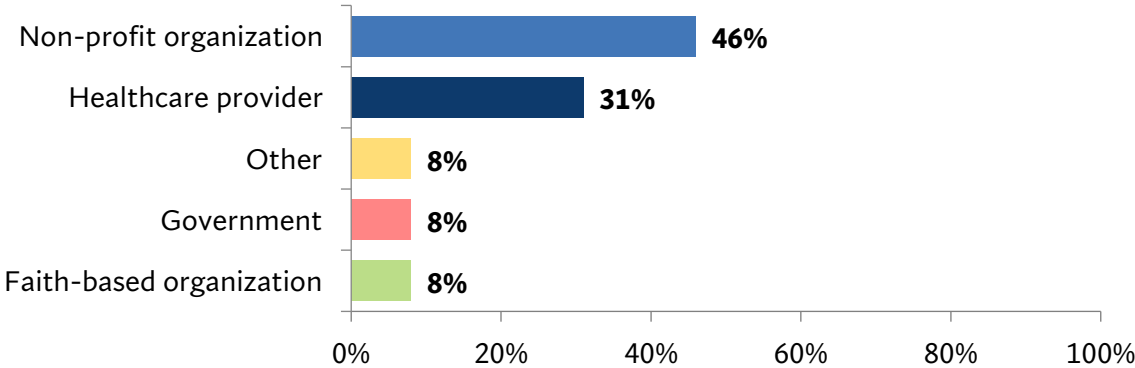
A total of 13 key leaders completed the web-based Key Leader Survey, which was available for responses between January 9 and February 24, 2025. Key leaders represented a variety of organizations throughout The District of Columbia. The figures below show the distribution of Key Leader survey respondents by type of organization and by Wards in which the leaders' organizations are in and/or serve.

In general, survey questions focused on the following topics:

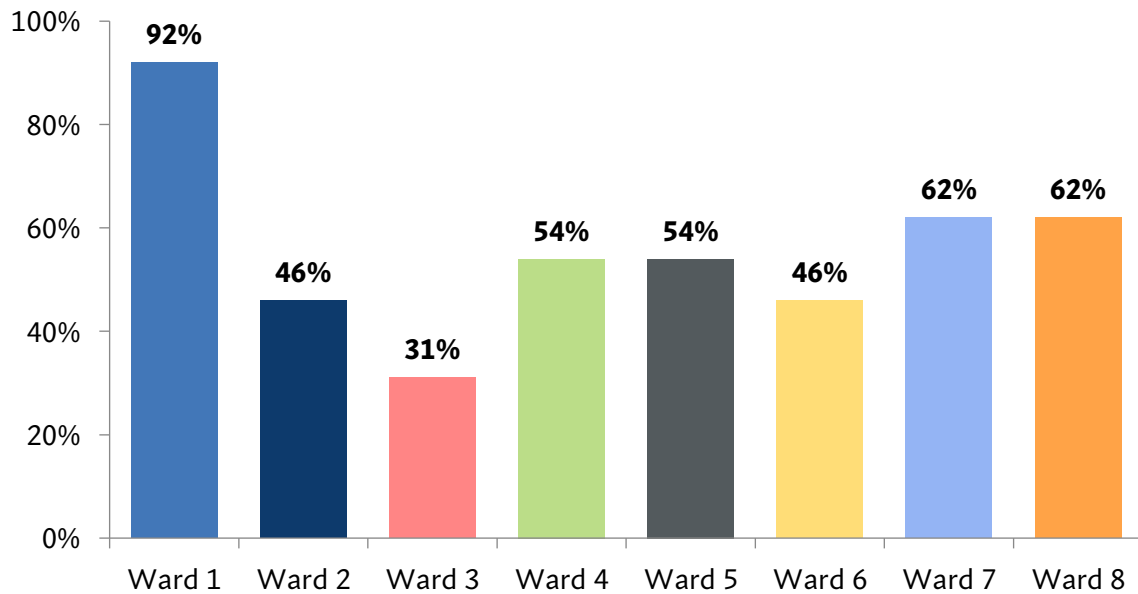
- Top community health needs
- Top social drivers that impact health
- Availability of community resources
- Access to care (barriers to care and locations of care)
- Health literacy

**Figure A1.12** shows the distribution of key leader survey respondents by type of organization, while **Figure A1.13** shows distribution of key leader survey respondents based on the Ward in which their organization is located.

**Figure A1.12: Organization Description (n=13)**



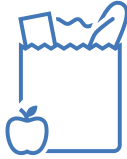



**Figure A1.13: Organization Location or Service Area by Ward (n=13)**



**Summary of Key Findings**

Key findings from the key leader survey are detailed below:

			
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Difficulty obtaining an appointment</li> <li>• Other commitments or priorities like work and childcare / adult care</li> <li>• Mistrust</li> <li>• Language barriers</li> <li>• Out of pocket costs (co-pay, deductible, medications)</li> </ul>	<p><b>Health and Wellness</b></p> <ul style="list-style-type: none"> <li>• Mental health</li> <li>• Chronic diseases (heart disease, diabetes, cancer)</li> <li>• Substance use</li> </ul>	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Poverty</li> <li>• Housing and homelessness</li> <li>• Healthcare access issues</li> <li>• Access to healthy food</li> <li>• Discrimination</li> <li>• Transportation barriers</li> </ul>	<p><b>Population with Greatest Unmet Need</b></p> <ul style="list-style-type: none"> <li>• Black/African American community</li> <li>• Persons in poverty</li> <li>• Unhoused population</li> <li>• Seniors/elderly</li> <li>• Hispanic/Latino population</li> <li>• Refugees and immigrants</li> </ul>

### Key Takeaways:

1. Key leaders recognized and identified disparities and inequities based on geography (Ward) and subpopulations, noting that data has remained largely unchanged or has worsened.
2. Key leaders believe residents do not access healthcare when they need it because of various social barriers and availability of needed services in the District.
3. The biggest perceived health issues in the District by key leaders are mental health, diabetes, heart disease, and cancer.
4. Key leaders report that the biggest social and environmental issues impacting the District are poverty, housing/homelessness, health insurance issues, and neighborhood safety.

### Key Leader Survey Instrument



\* Required Information

Dear Community Leader,

Thank you in advance for your participation in this survey, which is one component of the District of Columbia (DC) Community Health Needs Assessment (CHNA). Input from community leaders is a critical component of this assessment process.

Questions in this survey were developed to assess the perceived health and social needs of residents throughout DC. Findings will be used to help identify specific groups within DC that are most in need of additional resources. The survey should take about 10 minutes to complete, and your answers are anonymous and confidential.

Ascendient Healthcare Advisors is the consultant partner for this CHNA process. For questions about this survey, please contact Ascendient Healthcare Advisors: [chelseysaari@ascendient.com](mailto:chelseysaari@ascendient.com)

Thank you for your time and participation!

\* 1. Please select the category that best describes your organization (Select one option)

- Community Development Corporation
- Faith-based organization
- Government
- Healthcare provider
- Higher education institution
- Media
- Non-profit organization
- Public – private partnership
- Other (please tell us) \_\_\_\_\_

2. Which Ward do you live in? (Select one option)

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Don't know / not sure
- None of the above

3. Please select the Ward(s) your work is located in and/or what Ward(s) you primarily serve.

- Ward 1
- Ward 2
- Ward 3
- Ward 4
- Ward 5
- Ward 6
- Ward 7
- Ward 8
- Don't know / not sure
- None of the above

4. What is the name of the organization you work for?

\_\_\_\_\_

5. How do you believe the health of the community you serve has changed over the past three years? (Select one option)

- Greatly improved
- Improved
- No change
- Worsened
- Greatly worsened

[If “Greatly improved” or “Improved”] Next question appears

6. In what way(s) has the health of the community you serve improved?

[If “Greatly worsened” or “Worsened”] Next question appears

7. In what way(s) has the health of the community you serve worsened?

[If “No change”] Next question appears

8. Why do you think there has been no change in the health of the community?

9. What are the 3 main reasons people in your community don't get healthcare when they need it? [Please select up to 3 options.]

- Can't take time off work
- Co-pay and/or deductible are too expensive
- Doctors are hard to understand
- Family is unsupportive
- Hard to get an appointment
- Insurance not taken
- Language barrier
- Medications are too expensive
- Mistrust of doctors
- Nervous about seeing a doctor
- No child care or adult care
- No insurance
- No way to get there
- Religious or cultural reasons
- Stigma or embarrassment
- Too far away
- Wait is too long
- Other (please tell us) \_\_\_\_\_
- None/there are no barriers to care

10. What are the 3 biggest health problems in your community? [Please select up to 3 options.]

- Alcohol and drug problems
- Alzheimer's disease and other dementias
- Breathing problems (e.g., lung disease, asthma, COPD)
- Cancer
- Child and adolescent health
- Dental health
- Diabetes or high blood sugar
- Eating healthy
- Heart disease or high blood pressure
- Long-lasting health problems (e.g., autoimmune disorders, chronic pain)
- Mom and baby health
- Mental health (e.g., depression, anxiety)
- Older adult health
- Sexually transmitted infections
- Smoking or tobacco use
- Stroke
- Weight status (being overweight or obese)
- Other (please tell us) \_\_\_\_\_

11. Do you know of any resources available in the community to address some of the health issues you identified in the previous question? (Select one option)

- Yes
- No
- Not sure

[If "Yes"] Next question appears

12. If yes, please name at least one resource that is/could be leveraged.

13. What are the 3 biggest social and environmental problems that affect health in your community? [Please select up to 3 options.]

[Please consider providing a response. This information will be helpful for survey administrators.]

- Child abuse or neglect
- Feeling lonely
- Hard to find healthy food
- Hard to find jobs
- Hard to get to a doctor's appointment
- Health insurance issues
- Housing problems or homelessness
- No places to exercise
- Not enough child care
- Not enough public spaces (e.g., sidewalks, parks)
- Pollution and environmental changes
- Poor schools or educational opportunities
- Poverty (not enough money)
- Transportation problems
- Treating people unfairly because of disability
- Treating people unfairly because of age
- Treating people unfairly because of race
- Treating people unfairly because of gender
- Unsafe neighborhoods
- Violence at home
- Other (please tell us) \_\_\_\_\_

14. Do you know of any resources in the community to address some of the social/environmental issues you identified in the previous question? (Select one option)

- Yes
- No
- Not sure

[If “Yes”] Next question appears

15. If yes, please name at least one resource that is/could be leveraged

16. In your opinion, are health and social/environmental needs similar across DC? (Select one option)

- Yes
- No
- Not Sure

[If “No”] Next question appears

17. Which Ward or neighborhood do you feel experiences the greatest level of need?

18. Which subpopulation(s) on this list does your organization serve? (Select all that apply.)

- Black/African American community
- Children/Youth
- Hispanic/Latino community
- Justice-involved individuals
- LGBTQIA+ community
- Military and veterans
- Persons experiencing homelessness
- Persons in poverty
- Persons with disabilities
- Refugees/immigrants
- Seniors/Elderly
- Uninsured population
- Women in pregnancy
- Young adults
- Youth in foster care
- Other (please tell us) \_\_\_\_\_
- None of the above

19. Among those served by your organization, which subpopulation(s) appear to have the greatest unmet needs when it comes to health and social services? [Please select up to 3 options.]

- Black/African American community
- Children/Youth
- Hispanic/Latino community
- Justice-involved individuals
- LGBTQIA+ community
- Military and veterans
- Persons experiencing homelessness
- Persons in poverty
- Persons with disabilities
- Refugees/immigrants
- Seniors/Elderly
- Uninsured population
- Women in pregnancy
- Young adults
- Youth in foster care
- Other (please tell us) \_\_\_\_\_
- None of the above

20. Please rate each of the following statements for the community you serve:

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
(a) People in DC can access a doctor, including nurse practitioners and physician assistants (Family/General Practitioner, Ob/Gyn, Pediatrician), when needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(b) People in DC can access a medical specialist (Cardiologist, Dermatologist, etc.) when needed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(c) There are enough providers accepting Medicaid in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(d) There are enough providers accepting Medicare in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(e) There are enough providers accepting patients without insurance in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(f) There are enough dentists in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(g) There are enough culturally competent healthcare providers in DC*	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(h) There are enough mental health providers in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(i) There are enough substance use treatment providers in DC	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

\* Cultural competence is the ability of an individual to understand and respect values, attitudes and beliefs that differ across cultures and consider and respond appropriately to these differences in planning, implementing and evaluating health education and program and interventions

21. Is there a subset of members in your community who do not trust the services that you provide? (Select one option)

Yes

No

Not Sure

[If “Yes”] Next question appears

22. If yes, please provide additional detail

---

23. From the list provided, where do you feel members of the community you serve most frequently seek medical care? (Select all that apply.)

- Alternative medicine provider (acupuncture, chiropractic, naturopath, etc.)
- Community clinic/FQHC
- Emergency department
- Health department
- Hospital/medical campus
- Primary care provider (physician, nurse, etc.)
- Spiritual community
- Telehealth or virtual visit
- Walk-in or urgent care
- Veterans Affairs (VA) hospital or clinic
- Do not seek care
- Other (please tell us) \_\_\_\_\_

24. People in the community I serve have an understanding of health-related information when it is presented to them  
(Select one option)

- Strongly Disagree
- Somewhat Disagree
- Neither Agree nor Disagree
- Somewhat Agree
- Strongly Agree

[If “Strongly Disagree” or “Somewhat Disagree”] Next question appears

25. If you disagree, what do you see as the biggest challenges or issues with health literacy among the population you serve?

26. What suggestions do you have for health leaders in your community to improve the health and well-being of people living in DC?

27. Are there any other questions you wish we had asked?

# Community Focus Groups





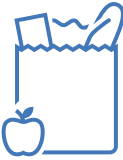
## Overview

Five focus groups were conducted between January 28, 2025 and February 4, 2025. As noted below, five of the focus groups took place in person and one focus group was held virtually. The focus groups included representation from 56 community members of Wards 1, 4, 5, 7 and 8. All participants were given a \$25 gift card once the focus group concluded. Participants that attended an in-person focus group also received a boxed meal.

- Ward 1 Focus Group at Shiloh Baptist Church
- Ward 4 Focus Group at Mary’s Center – Petworth
- Ward 5 Focus Group at Bethesda Baptist Church
- Ward 7 Focus Group at East Washington Heights Baptist Church
- Ward 8 Focus Group at Brighter Day Ministries
- Virtual Focus Group for Wards 1,4,5,7 and 8

## Summary of Key Findings

The key findings from the Community Focus Groups are detailed below:



				
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Geographic disparities in healthcare locations</li> <li>• System navigation challenges</li> <li>• Technology and digital barriers</li> <li>• Language and cultural barriers</li> <li>• Insurance related issues</li> </ul>	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Strong community relationships</li> <li>• Community-based organizations</li> <li>• Educational institutions as community anchors</li> <li>• Neighborhood diversity</li> <li>• Many green spaces and parks</li> </ul>	<p><b>Health and Wellness</b></p> <ul style="list-style-type: none"> <li>• Mental health</li> <li>• Chronic diseases</li> <li>• Substance use disorders</li> <li>• Maternal health issues</li> <li>• Age-related health concerns</li> </ul>	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Provider-patient relationship improvement opportunities</li> <li>• Discrimination concerns</li> <li>• Need for self-advocacy</li> <li>• Care coordination difficulty</li> <li>• Quality concerns</li> </ul>	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Housing challenges</li> <li>• Food access problems</li> <li>• Safety concerns</li> <li>• Transportation barriers</li> <li>• Economic challenges</li> </ul>

### Key Takeaways:

1. There are pronounced access differences for healthcare and social services across the District, with Wards 7 and 8 most severely impacted.
2. Each Ward discussed the strong social networks within their respective communities and the support they provide to residents.
3. There are universal challenges with navigating complex health and social resource systems, regardless of Ward.
4. Cultural competency needs were expressed in all Wards but manifested differently by Ward. Needs ranged across racial/ethnic, age, trust-related issues.

### Focus Group Discussion Guide Script and Questions

The discussion guide used to guide semi-structured conversations with each focus group is provided below.

 H O W A R D U N I V E R S I T Y H O S P I T A L	 SIBLEY MEMORIAL HOSPITAL JOHNS HOPKINS MEDICINE
District of Columbia 2025 CHNA Focus Group Discussion Guide	
Facilitator Name	
Date	
Time	
Location	
Population(s) Represented	
Number of Participants	
Section	Core Questions and Probes
Welcome	<ul style="list-style-type: none"><li>• Welcome participants to the focus group on behalf of Sibley Memorial and Howard University Hospitals.</li><li>• Introduce co-facilitators.</li></ul>
Participant Introductions	<ul style="list-style-type: none"><li>• Welcome</li><li>• Please tell us your first name, how long you've lived in the District, and something you like about your community.</li></ul>
Health and Wellness	<ul style="list-style-type: none"><li>• What are some of the issues that keep District residents from living healthy lives?</li><li>• What are some of the most serious health problems facing people who live in the District?</li><li>• What do you think could be done to better address these issues and health problems within your community?</li></ul>
Health and Wellness –	<ul style="list-style-type: none"><li>• Thinking about the issues and health problems we've discussed so far, how do you think different groups of people are affected by those issues/problems?</li></ul>

Section	Core Questions and Probes
Disparities/ Inequities	<ul style="list-style-type: none"> <li>• Do you have a sense of who is most affected by these issues/health problems within this Ward?</li> <li>• Are there certain places (geographic areas) within your community where these issues/health problems seem to present more of an issue when compared with others?</li> </ul>
Social & Env Determinants of Health	<ul style="list-style-type: none"> <li>• We know that factors within communities, things like [<i>access to health insurance, violence and safety, housing access and quality, homelessness, poverty, employment, access to healthy food, discrimination, educational opportunities and others</i>] can impact health and quality of life. <ul style="list-style-type: none"> <li>◦ What types of factors do you think are most impacting quality of life for people living in the District?</li> </ul> </li> <li>• What do you think could be done to address some of these issues within your community?</li> </ul>
Access to Care	<ul style="list-style-type: none"> <li>• Access to healthcare is a concern for some residents in the District. What are some of the reasons people do not seek or receive healthcare when they need it?</li> <li>• What do you think health leaders within the District could be doing to improve access to healthcare for people living in your Ward?</li> <li>• When you think about your community and the healthcare services available in this Ward, do you think there are enough medical, dental, and behavioral health services nearby? <ul style="list-style-type: none"> <li>◦ In your opinion, are there enough health services/facilities available to meet community need near where you live, work or spend most of your time?</li> <li>◦ Can you find medical, dental, and/or behavioral healthcare services within a reasonable timeframe when you need it?</li> </ul> </li> <li>• We'd like to hear about your experiences with providers in the District. <ul style="list-style-type: none"> <li>◦ When you think about times you've interacted with providers like doctors, dentists, nurses, therapists, emergency personnel or others, would you say it was generally more positive or negative?</li> <li>◦ Can you give us some examples as to why your experience was positive or negative?</li> </ul> </li> </ul>
Suggestions/ Closing	<ul style="list-style-type: none"> <li>• There are a lot of resources available in the District. What do you see as some of the greatest strengths or assets that you or others in your community can access to help you live a healthier life?</li> </ul>

Section	Core Questions and Probes
	<ul style="list-style-type: none"> <li>• If you could speak directly to a local health leader, what would you tell them should or could be done in the District to make it a better place to live? <ul style="list-style-type: none"> <li>◦ What would improve your quality of life?</li> <li>◦ What would you want local health leaders to know?</li> </ul> </li> <li>• Given what we've discussed today, what do you think residents in your community – you, your neighbors, local leaders – could do to help improve the health of your community?</li> </ul>
Conclusion	<ul style="list-style-type: none"> <li>• Thank participants for their time and participation.</li> <li>• Ask if there are other thoughts or questions that were raised for participants during the discussion. [<i>i.e., was there anything we did not ask about or discuss that you think is important to share with health leaders in the District?</i>]</li> <li>• Direct participants to the registration area to receive their gift card.</li> </ul>





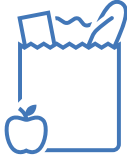
# Key Leader Interviews

## Overview

A total of 15 key leader interviews were conducted key leader interviews were conducted between January 15, 2025 and February 27, 2025. Ascendant Healthcare Advisors conducted 13 of the 15 interviews virtually and two interviews were conducted by Howard University Hospital and Sibley Memorial Hospital with their respective leadership. Participating key leaders primarily represented healthcare and nonprofit organizations in the District of Columbia.

## Summary of Key Findings

Some of the key findings from the key leader interviews conducted for the CHNA process included the following:



				
<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Geographic disparities in service availability</li> <li>• Insurance coverage doesn't guarantee access</li> <li>• System navigation</li> </ul>	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Active community organizations</li> <li>• Innovative program development</li> <li>• Strong safety net infrastructure</li> <li>• Faith-based organization engagement</li> </ul>	<p><b>Health and Wellness</b></p> <ul style="list-style-type: none"> <li>• Mental health issues (and service gaps)</li> <li>• Chronic disease management and challenges</li> <li>• Co-occurring conditions</li> <li>• Substance use (and treatment needs)</li> </ul>	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Challenges with care coordination</li> <li>• Complex system navigation challenges</li> <li>• Provider-patient relationships</li> <li>• Cultural competency in provision of care</li> </ul>	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Housing issues (access and quality)</li> <li>• Economic stability</li> <li>• Growing food insecurity and access to food</li> <li>• Social and community context</li> </ul>

### Key Takeaways:

1. Leaders discussed high health insurance coverage rates in the District yet many additional barriers inhibit access to needed services.
2. Community-based organizations and faith-based groups are trying to fill gaps in needed services, particularly for addressing SDOH.
3. Chronic conditions and mental health top the list of concerns among District leaders. These are often co-occurring and poorly managed.
4. Many key leaders expressed how the people they serve cannot prioritize their health because they are struggling with basic needs like housing and food access.

### Key Leader Interview Questions

A copy of the data collection instrument used to guide semi-structured key leader interviews for the CHNA process is provided below.

 HOWARD UNIVERSITY HOSPITAL	 SIBLEY MEMORIAL HOSPITAL JOHNS HOPKINS MEDICINE
District of Columbia 2025 CHNA	
Key Leader Interview Guide	
Facilitator Name	
Date	
Time	
Participant Name	
Participant Organization	
<b>FACILITATOR INTRODUCTION:</b>	
<p>"Thank you for participating in our interview today! My name is [NAME] and I represent Ascendent Healthcare Advisors, a consulting firm working with [client/org name(s)]. We are conducting a community health needs assessment to find out more about the health and social issues facing residents in the [service area], the ways those needs are currently being addressed, and where there might be opportunities to address them more effectively. We are speaking to a variety of different community leaders and organizations through this process, and the results of these interviews will help health leaders throughout DC develop programs and services to address some of these challenges. We expect this interview to take 45 to 60 minutes, and we are so appreciative of your time today. We may record today's discussion to assist with notetaking, but we will not be using any identifying information, like participant names, in our results. Can I answer any questions for you before we begin the interview?"</p>	

#### INTRODUCTION

1. Can you please tell me a little bit about your role and the organization you work for? Is your work focused on specific populations or geographic areas of DC?

#### HEALTH AND WELLNESS

2. What are some of the most significant problems or concerns in the community you serve?
  - a. Which populations are most impacted by these concerns?
  - b. How have these concerns changed over the past three years (have they gotten better, worse or stayed the same?)
3. I'd like you to think more specifically about health conditions impacting the community you serve. What are the most serious health problems facing people who live in DC?
  - a. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?
  - b. Are there particular areas in the community that are more affected by these problems than others?
  - c. What resources are currently available to address these issues?
4. Thinking about the health problems you just described, what programs, interventions or strategies could be implemented to address these issues in the future?

#### SOCIAL & ENVIRONMENTAL DETERMINANTS OF HEALTH

5. What are some of the environmental and/or social conditions that affect quality of life for members of the community you serve?
  - a. Examples of social and environmental issues that negatively impact health: availability or access to health insurance, domestic violence, housing problems, homelessness, lack of job opportunities, lack of affordable childcare, limited access to healthy food, neighborhood safety/ street violence, poverty, racial/ethnic discrimination, limited/poor educational opportunities.
  - b. Are there particular groups of people (i.e. race, ethnicity, age, LGBTQ+, etc.) who are more affected by these problems than others?

- c. Are there particular areas in the community that are more affected by these problems than others?
  - d. What resources are currently available to address these issues?
6. Thinking about the social and environmental issues you described, what programs, interventions or strategies could be implemented to address these issues in the future?

#### ACCESS TO CARE

7. What are some of the barriers that prevent people in DC from getting healthcare when they need it?
  - a. What suggestions do you have for addressing these barriers?
8. What are your perceptions of the health-related services that are available in DC, including medical care, dental care and behavioral healthcare?
  - a. Are there enough locations providing these types of care for people who need it?
  - b. Do you think community members can find medical, dental or behavioral healthcare within a reasonable timeframe when they need it?

#### SUGGESTIONS FOR COMMUNITY IMPROVEMENTS

9. What are some of the strengths or community assets in DC that can help residents live healthier lives?
10. What do you think local health leaders should do to improve health and quality of life in DC? What do you want local health leaders to know?

#### CONCLUSION

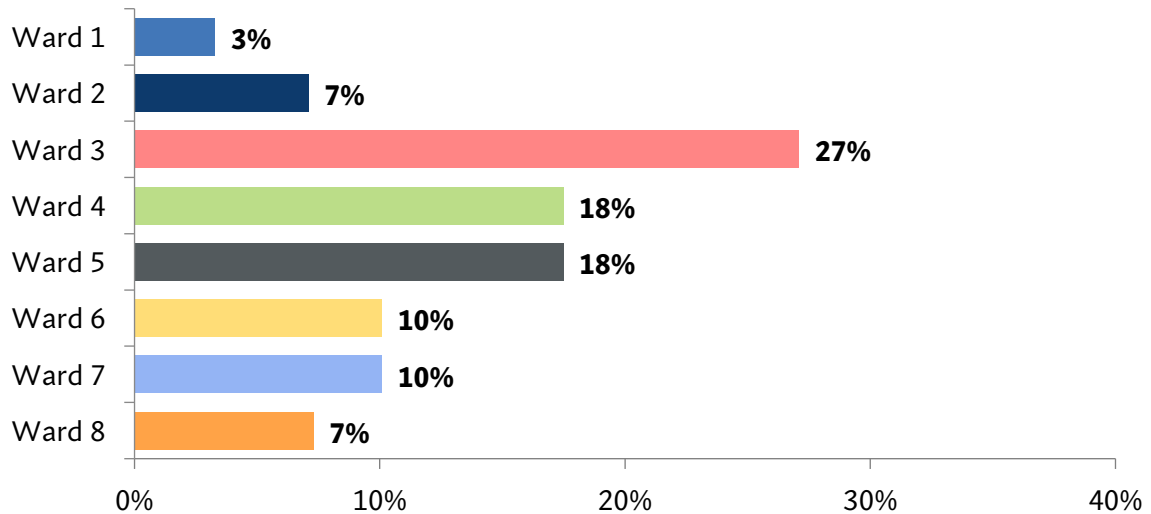
11. Are there any other thoughts you'd like to share before we conclude?

# Appendix 2 | Detailed Primary Data Findings

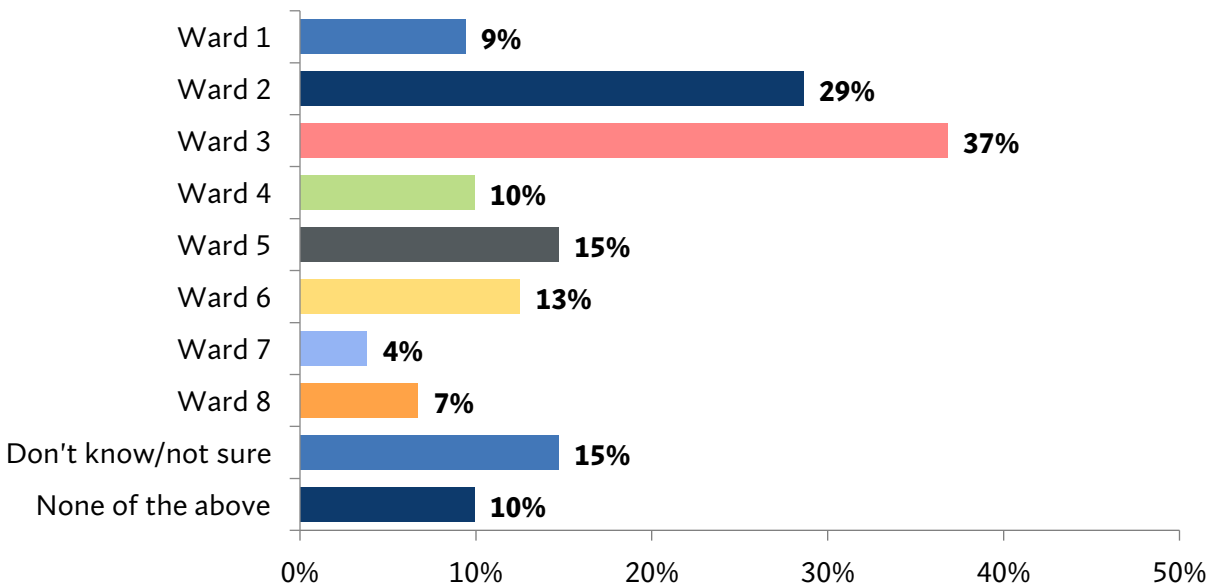
## Community Health Survey

Figures detailing the findings from the Community Health Survey are displayed below:

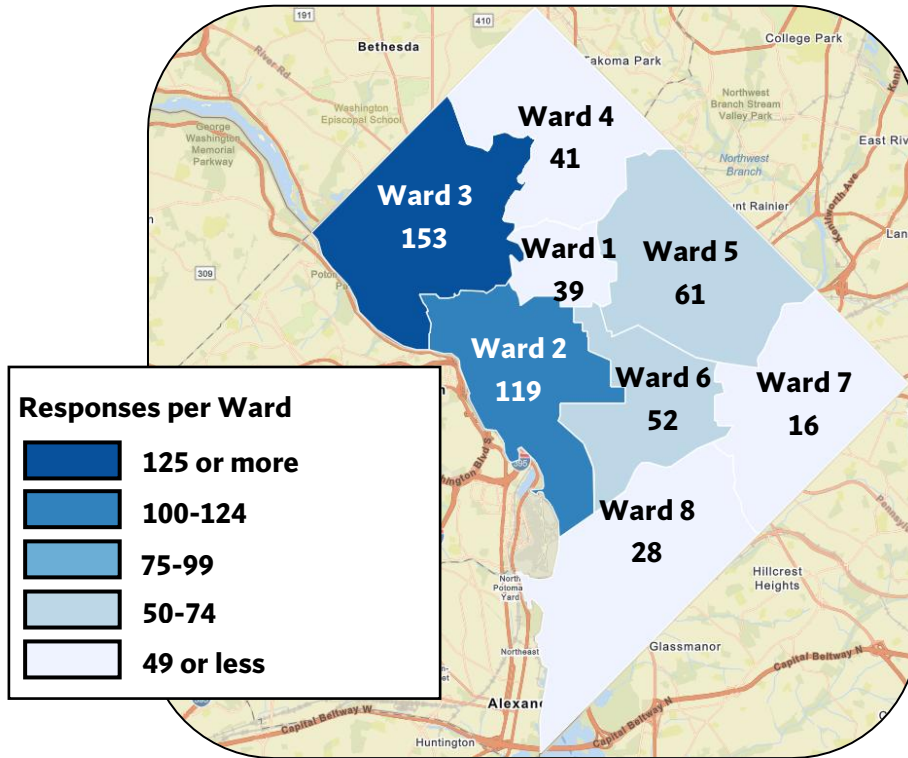
**Figure A2.1: The District is divided into 8 Wards. Which Ward do you live in? (n=424)**



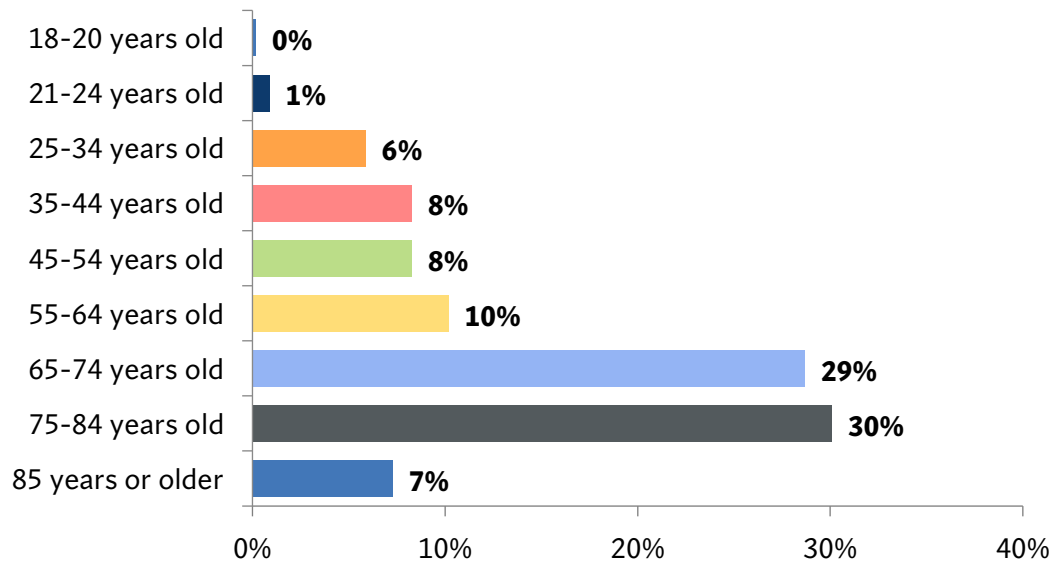
**Figure A2.2: Which Ward(s) do you work in or get healthcare in? (n=416)**



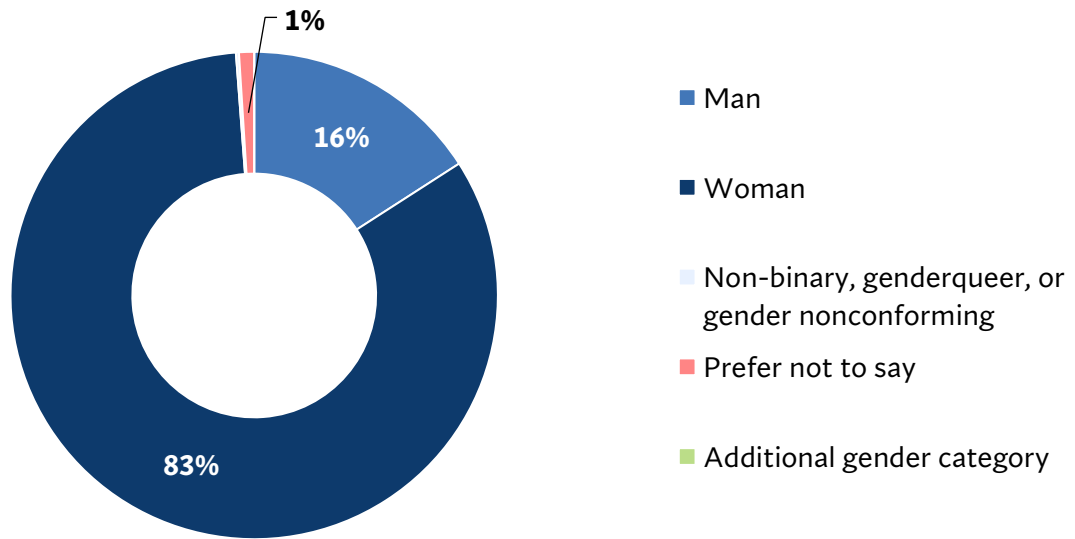
**Figure A2.3: Wards Respondents Report Working in or Receiving Healthcare in Mapped (n=416)**



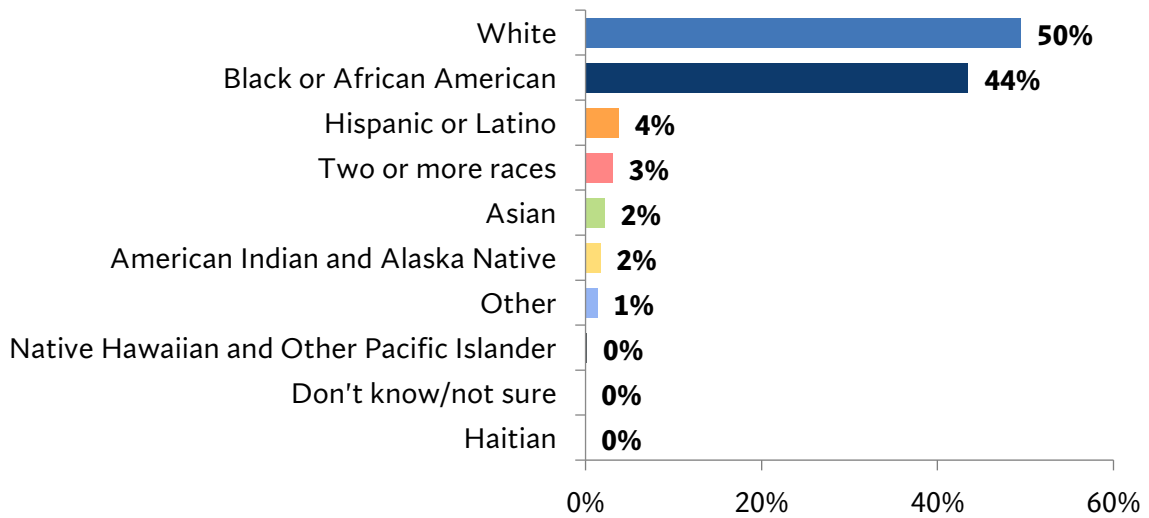
**Figure A2.4: How old are you? (n=422)**



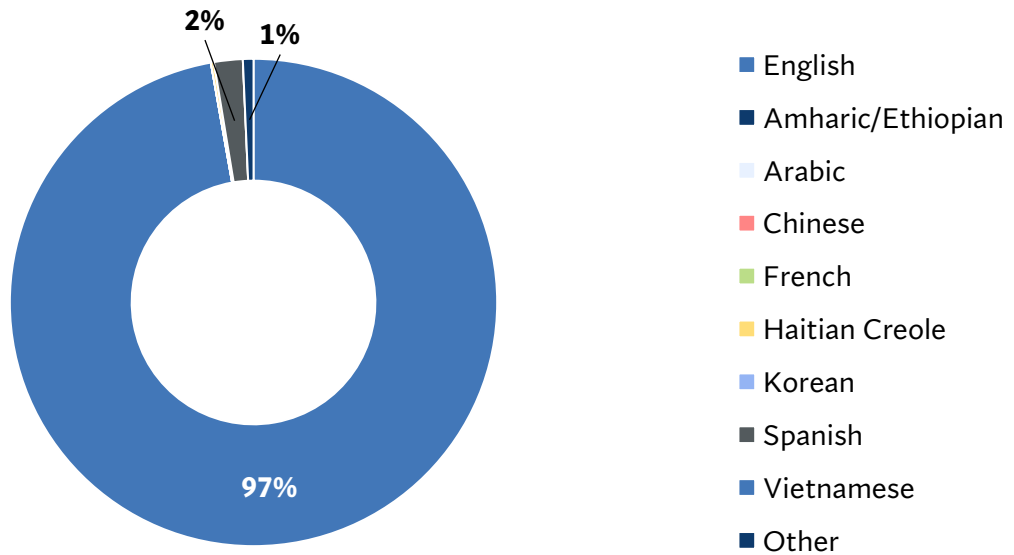
**Figure A2.5: Which of the following best describes your gender? (n=421)**



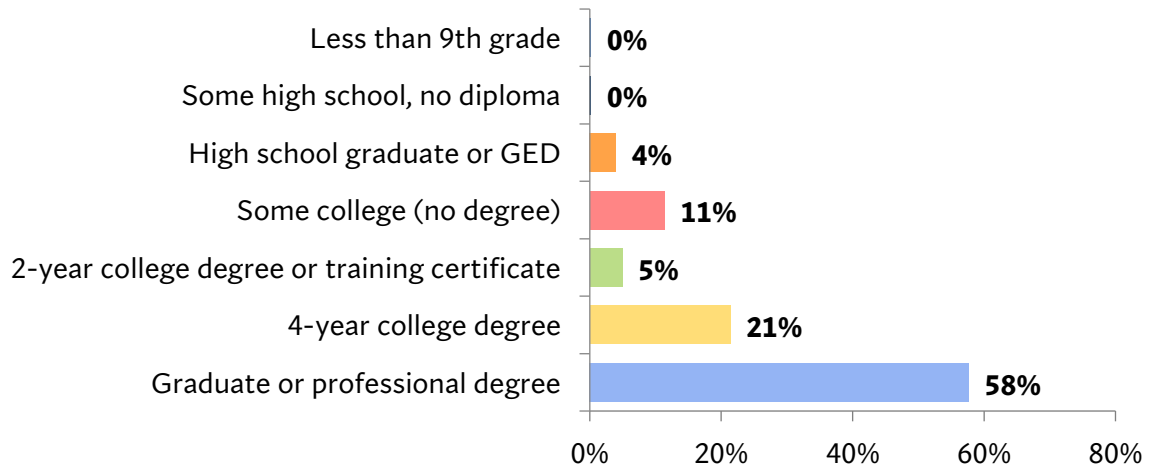
**Figure A2.6: How would you best describe your race or ethnic background? (n=418)**



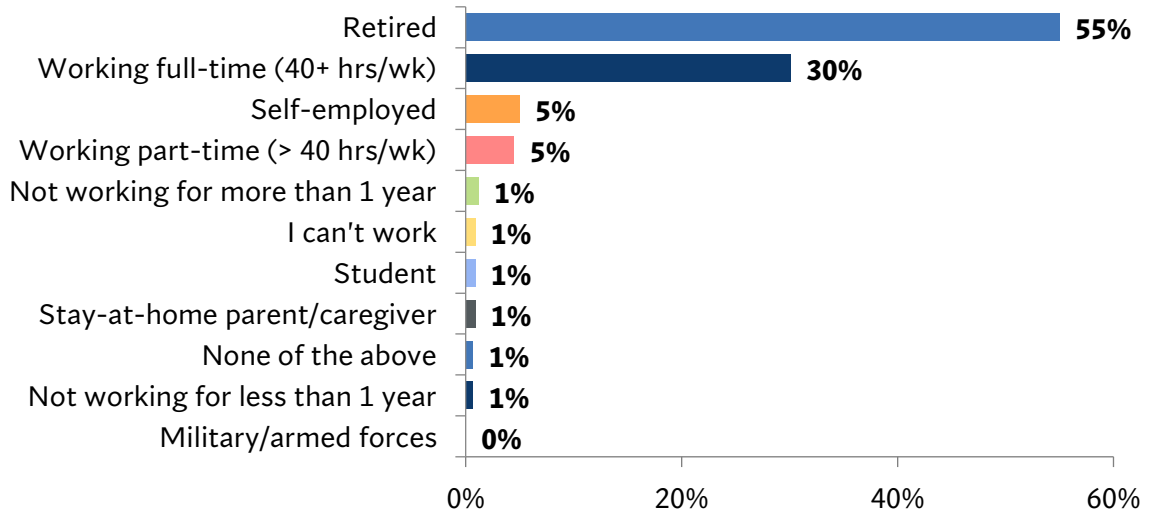
**Figure A2.7: Which language is spoken most often in your home? (n=419)**



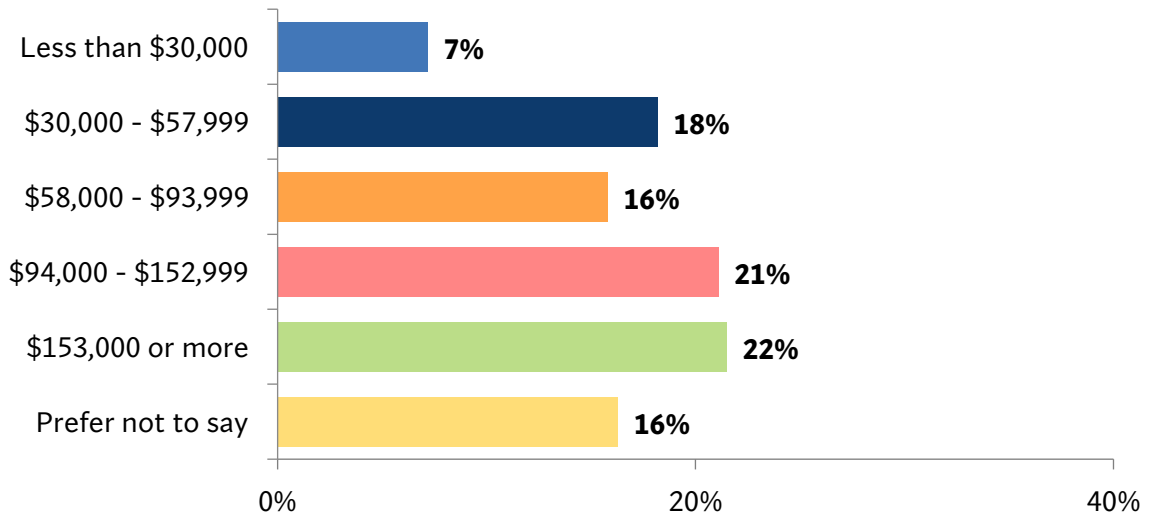
**Figure A2.8: What is the highest level of school you finished? (n=422)**



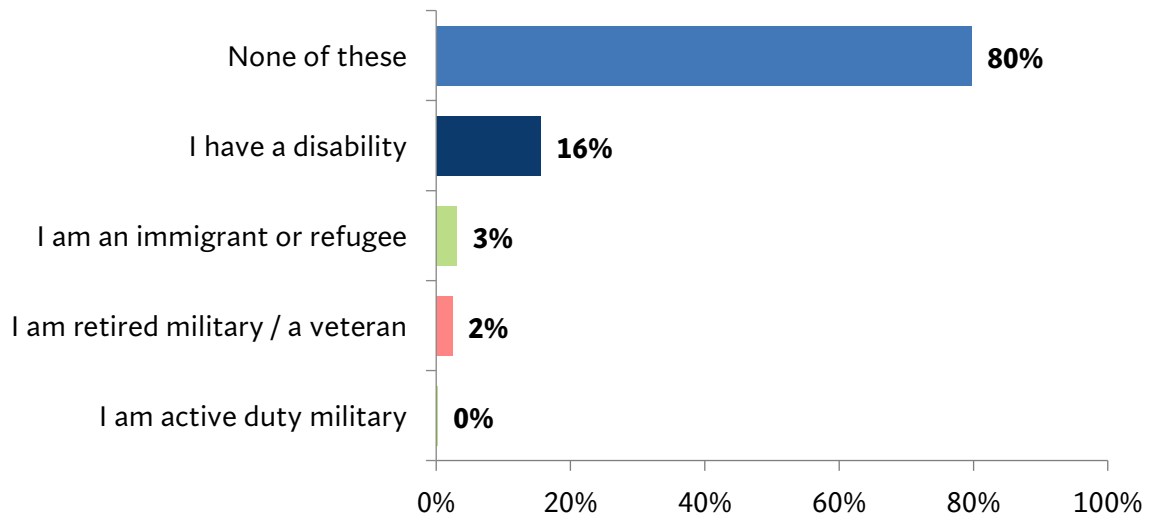
**Figure A2.9: What best describes your job situation? (n=422)**



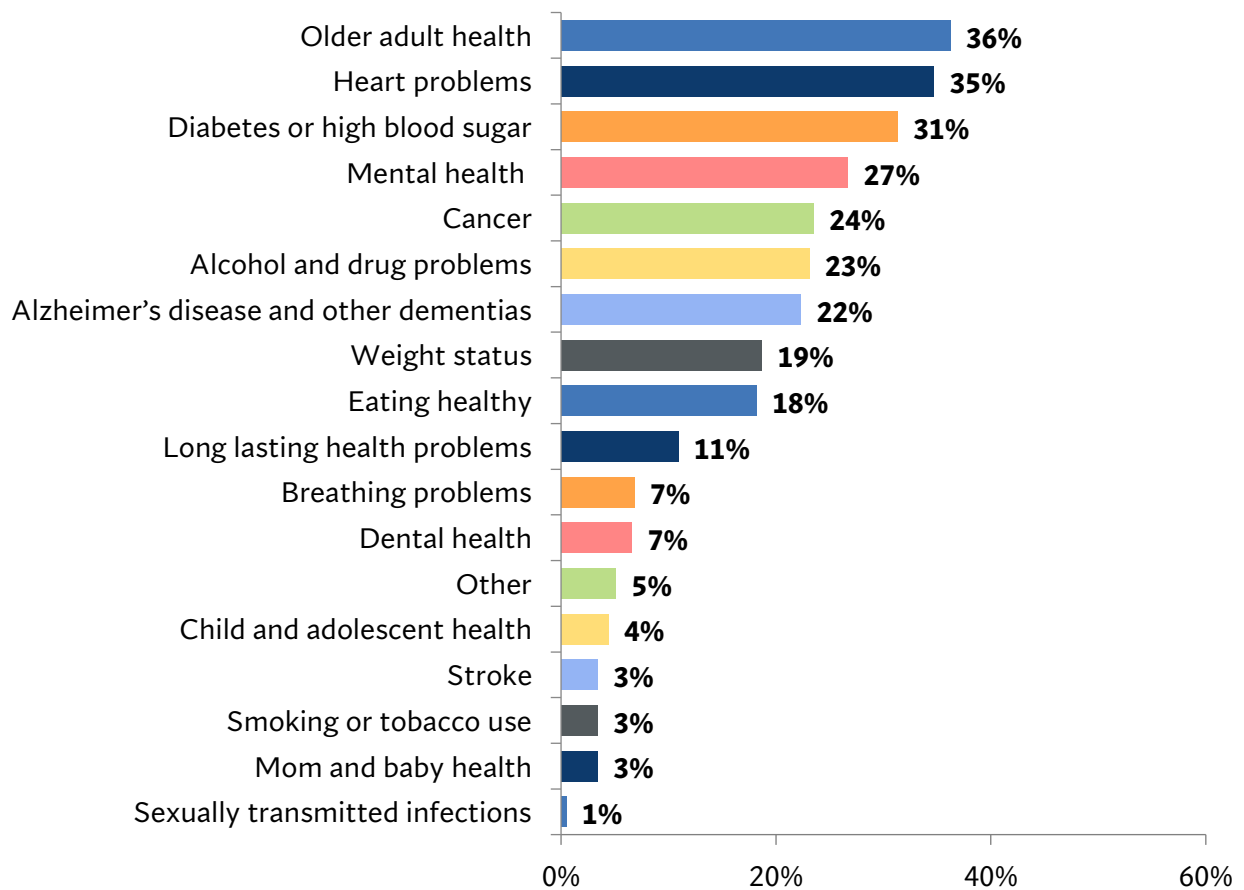
**Figure A2.10: How much money does your household make each year before taxes? Include all money from: jobs, Social Security, family help, welfare, retirement, investments, and other sources (n=418)**



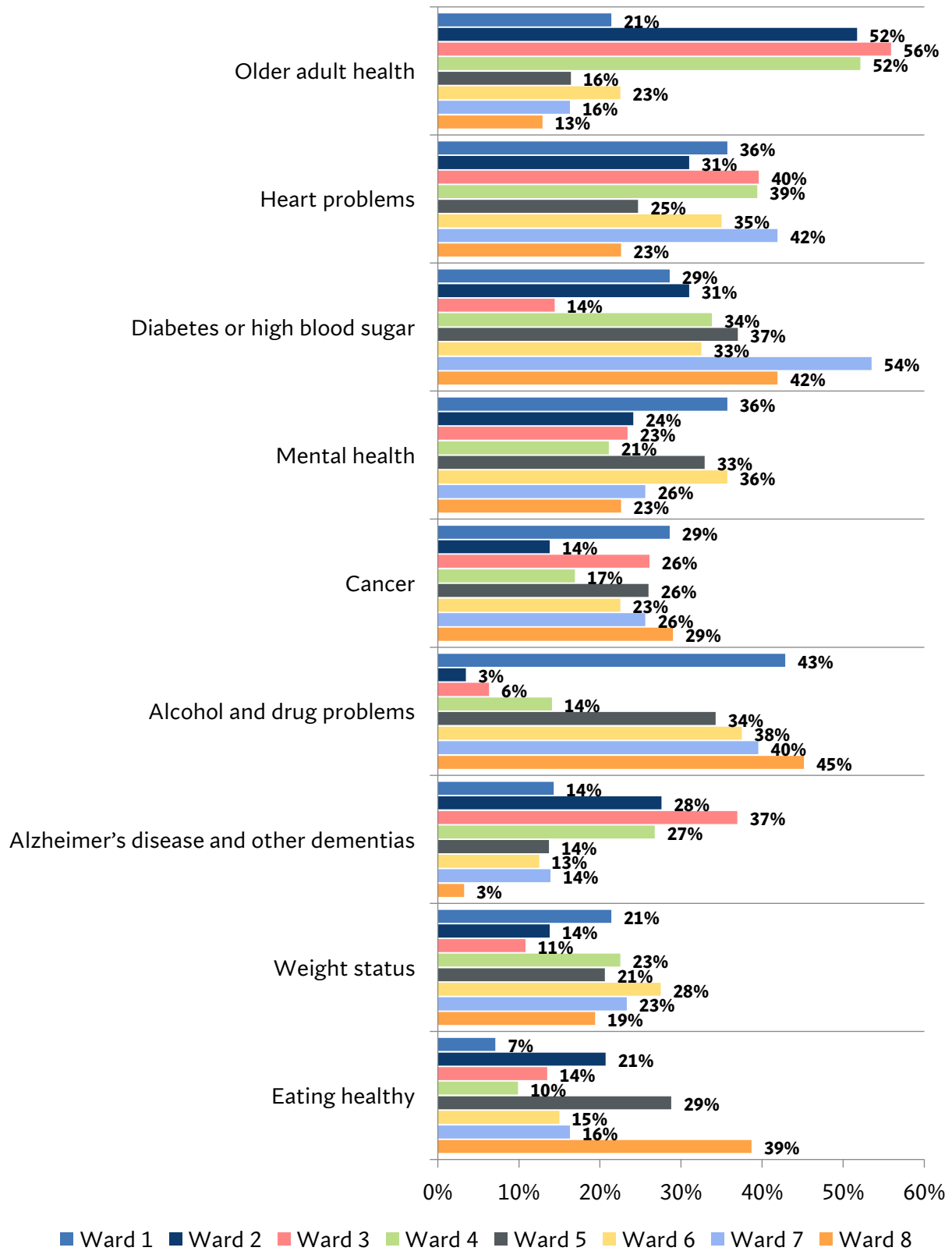
**Figure A2.11: Do any of these describe you? (n=418)**



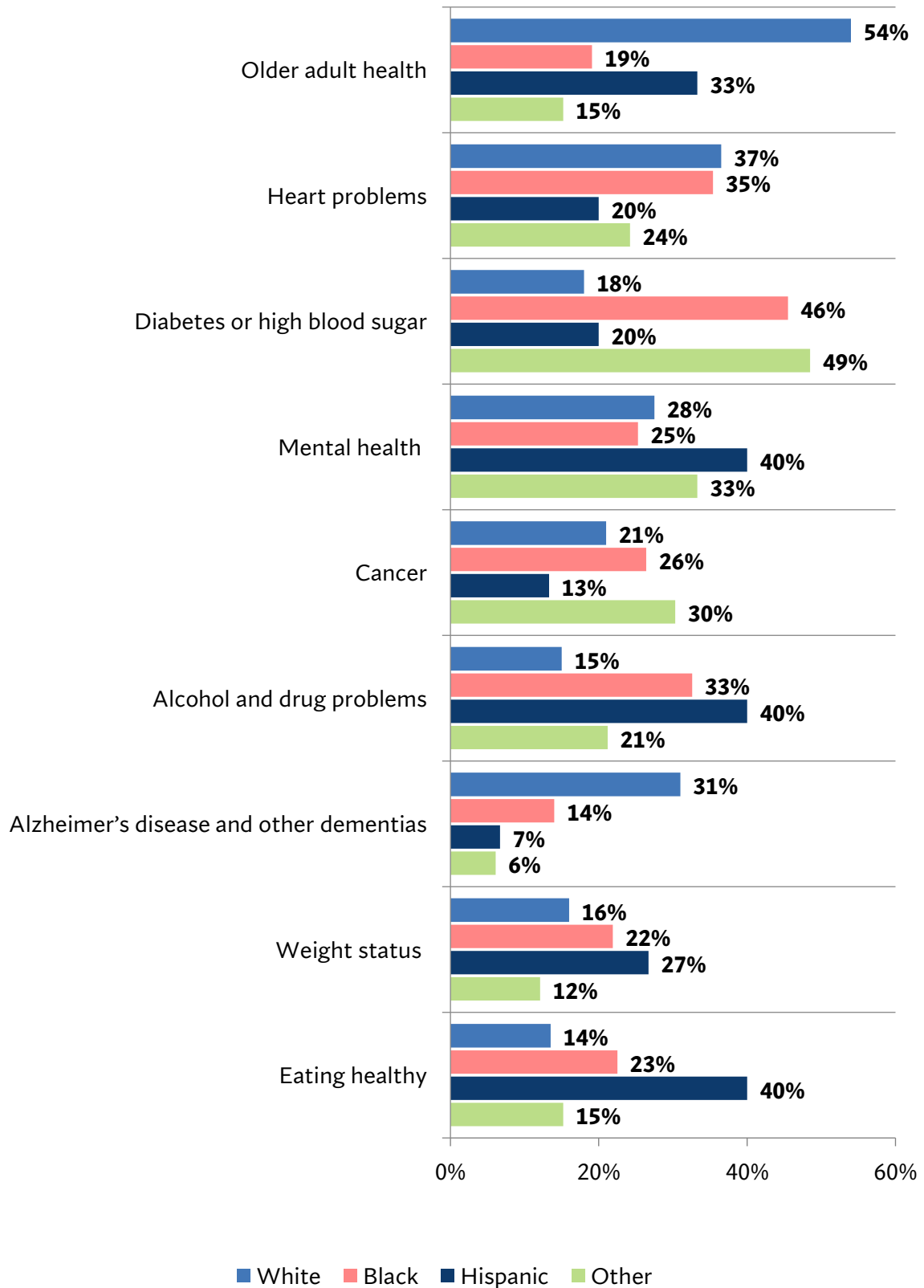
**Figure A2.12: What are the 3 biggest health problems in your community? (n=412)**



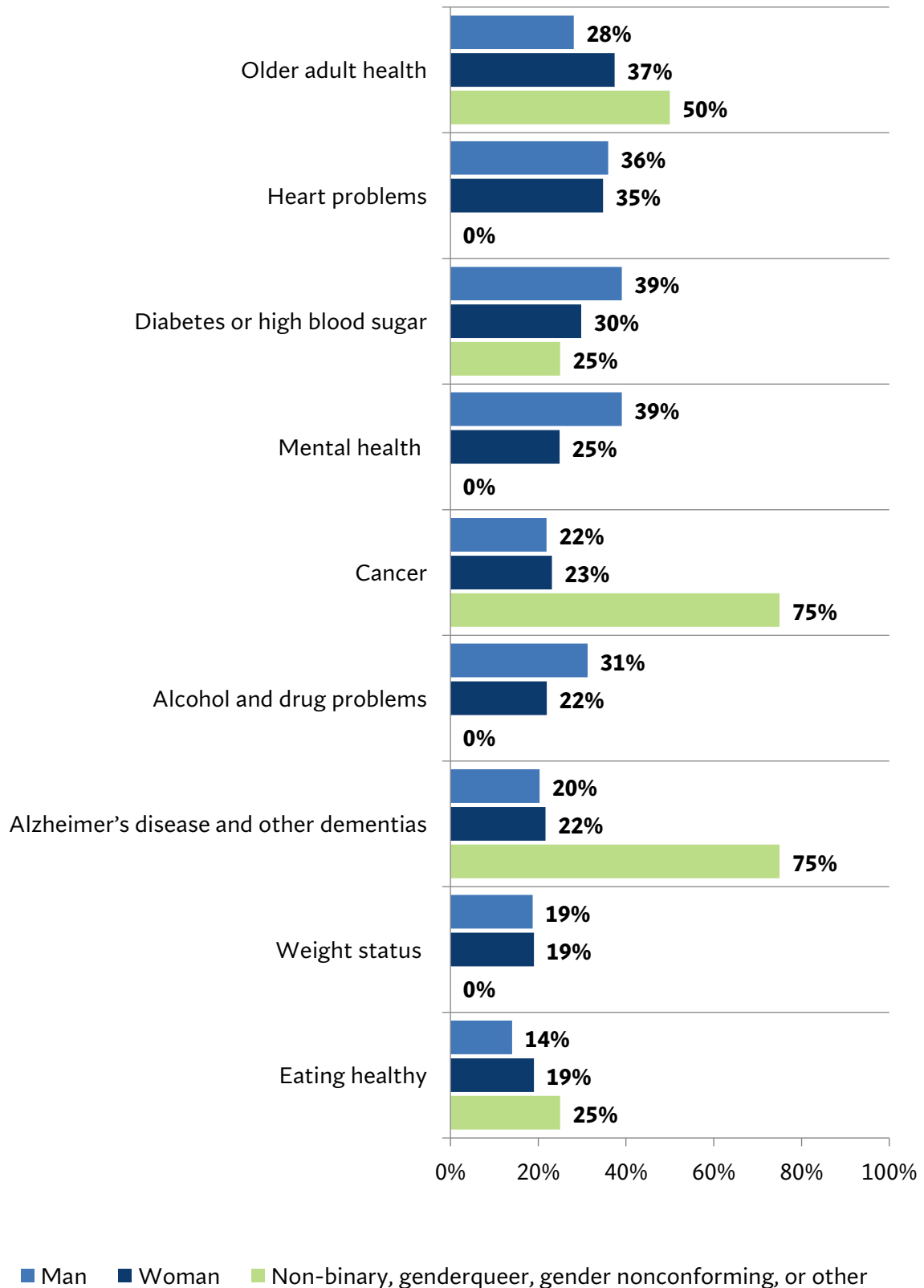
**Figure A2.13: What are the 3 biggest health problems in your community? (by Ward)**



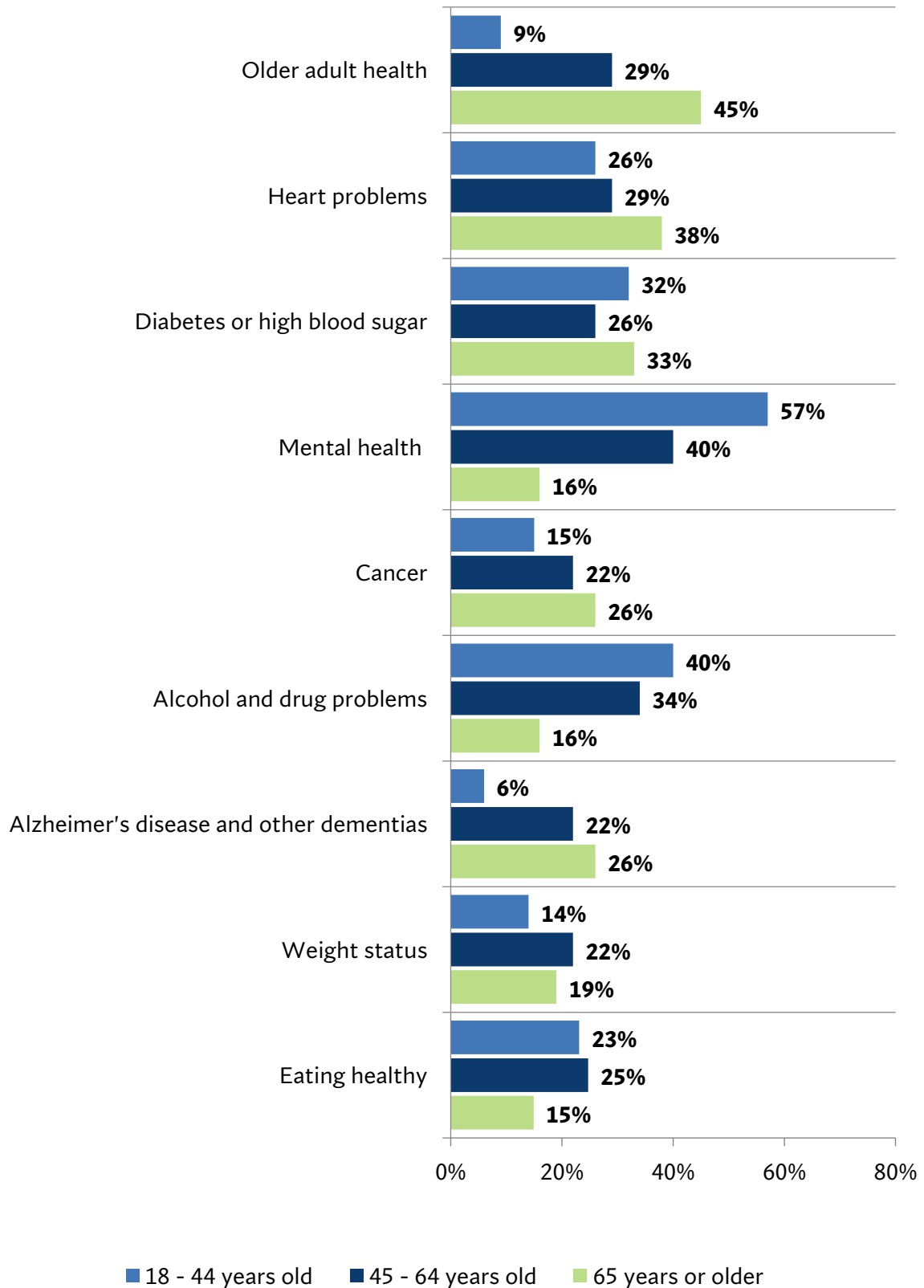
**Figure A2.14: What are the 3 biggest health problems in your community? (by race/ethnicity)**



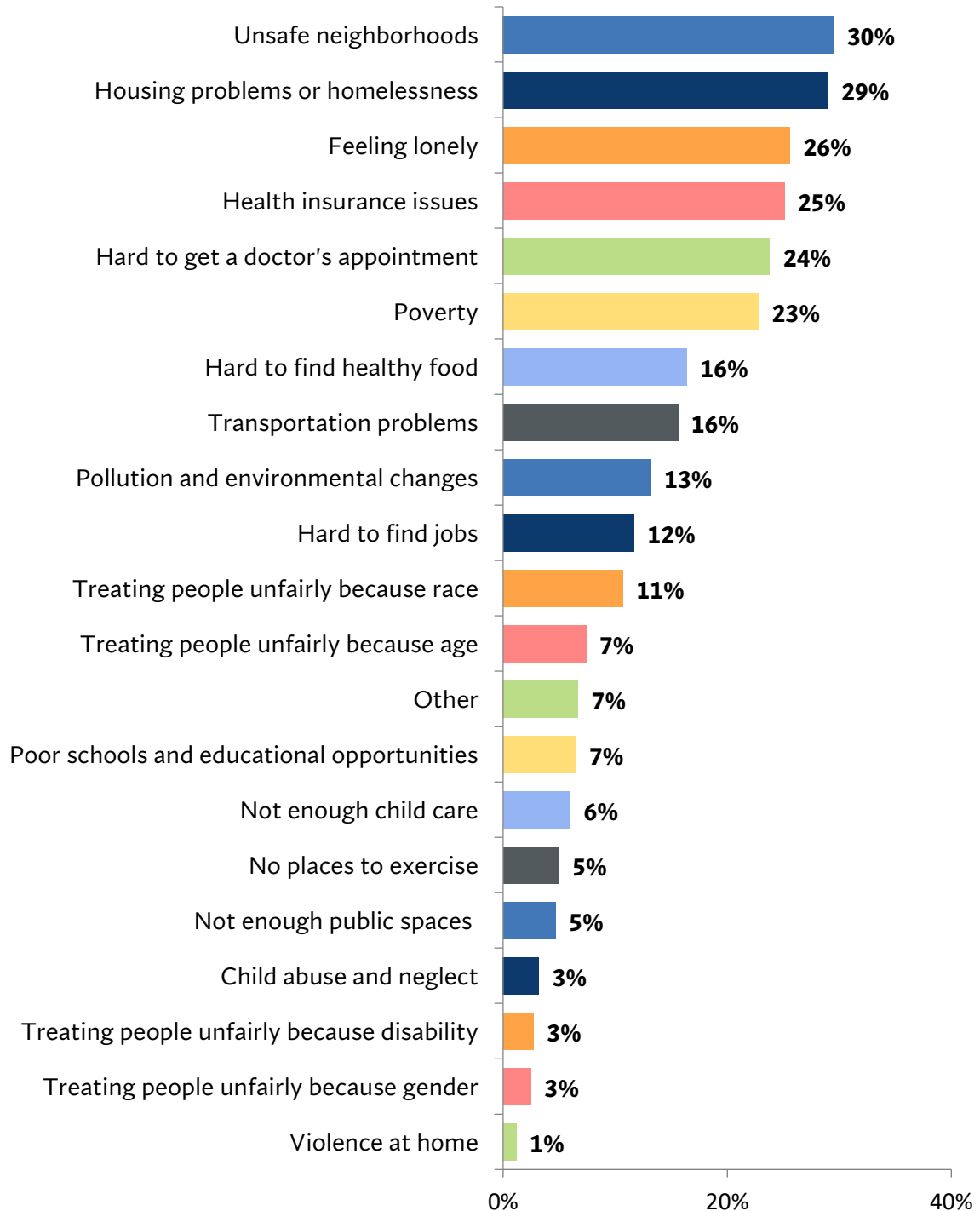
**Figure A2.15: What are the 3 biggest health problems in your community? (by gender)**



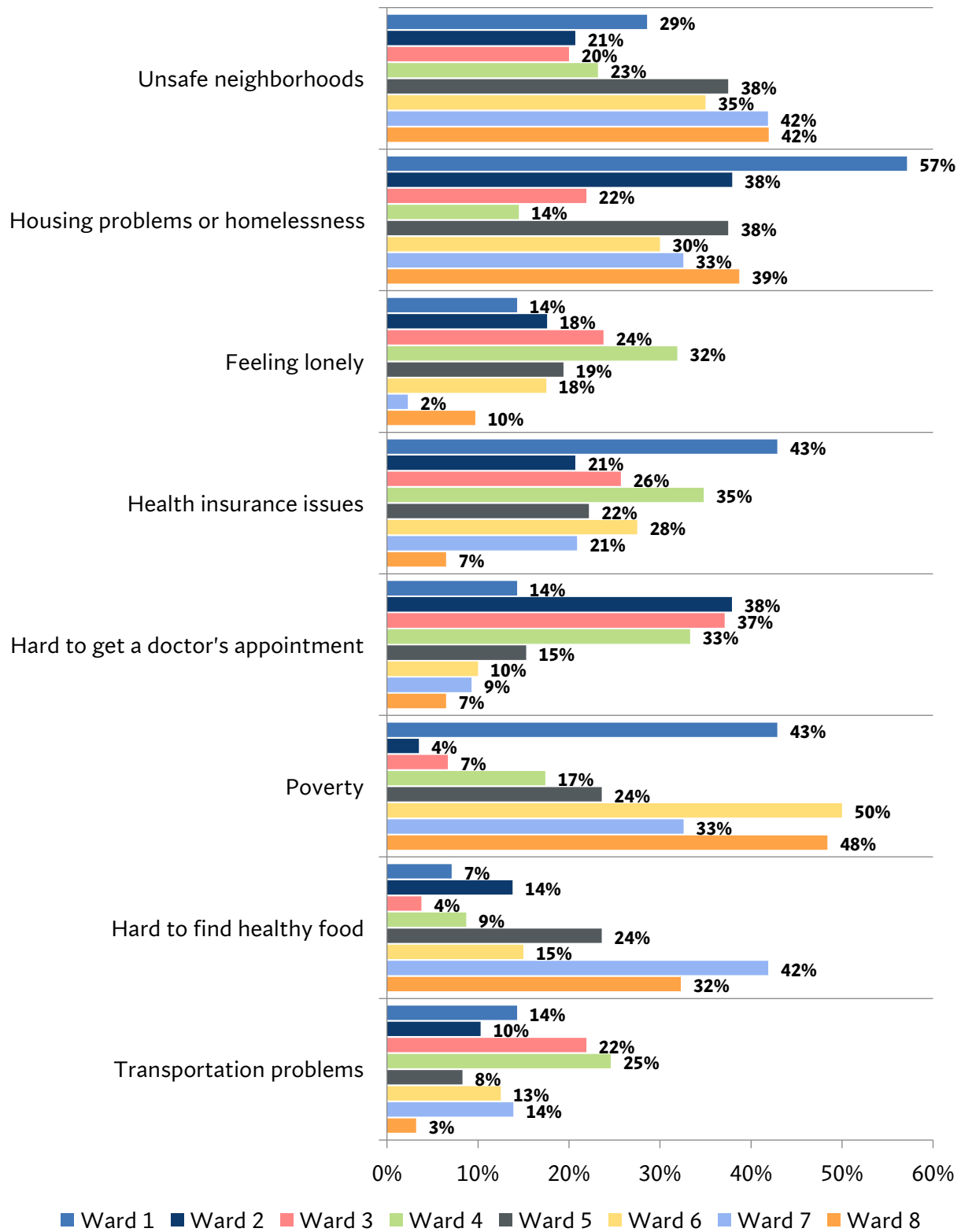
**Figure A2.16: What are the 3 biggest health problems in your community? (by age group)**



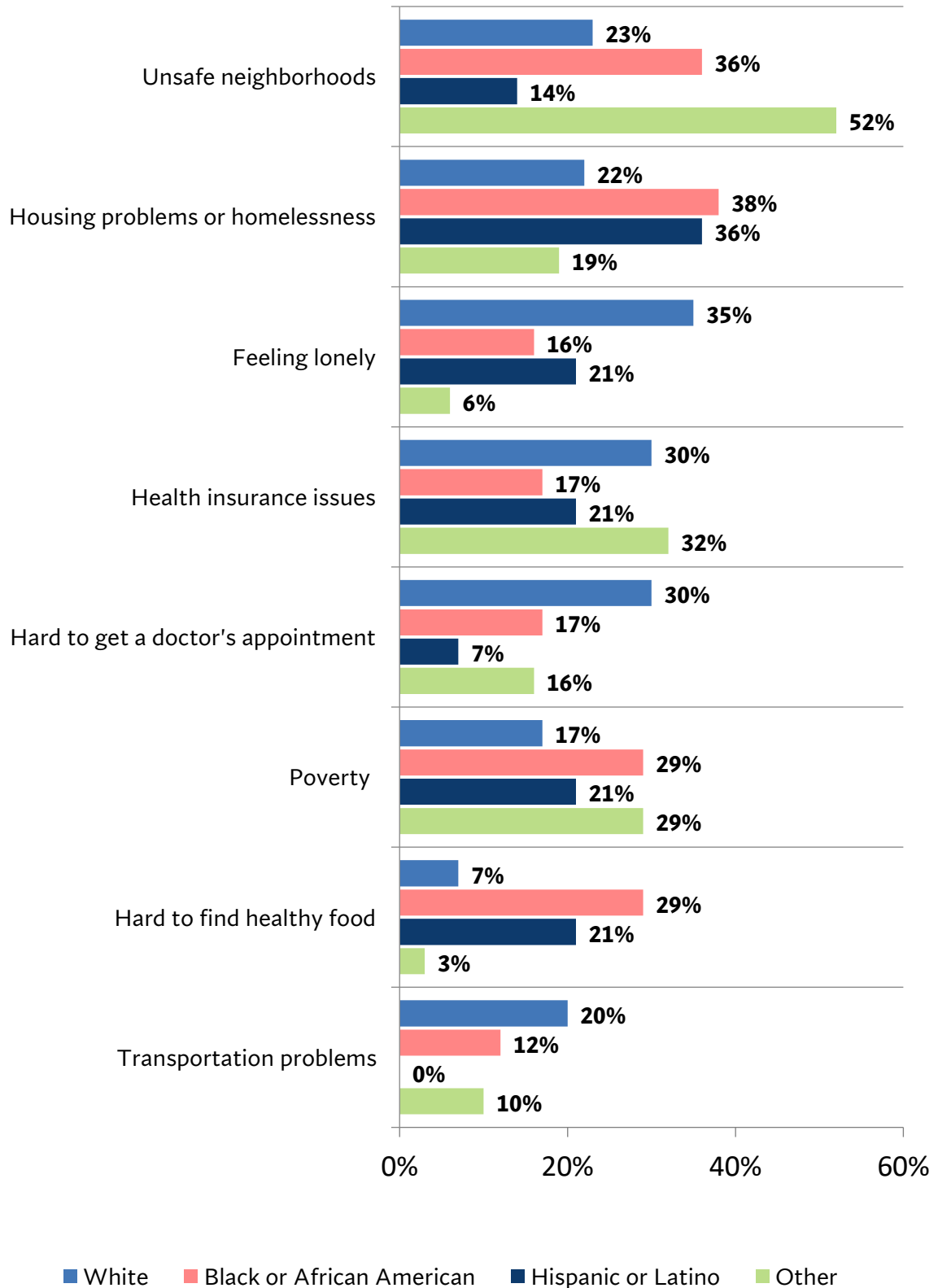
**Figure A2.17: What are the 3 biggest social and environmental problems that affect the health in your community? (n=403)**



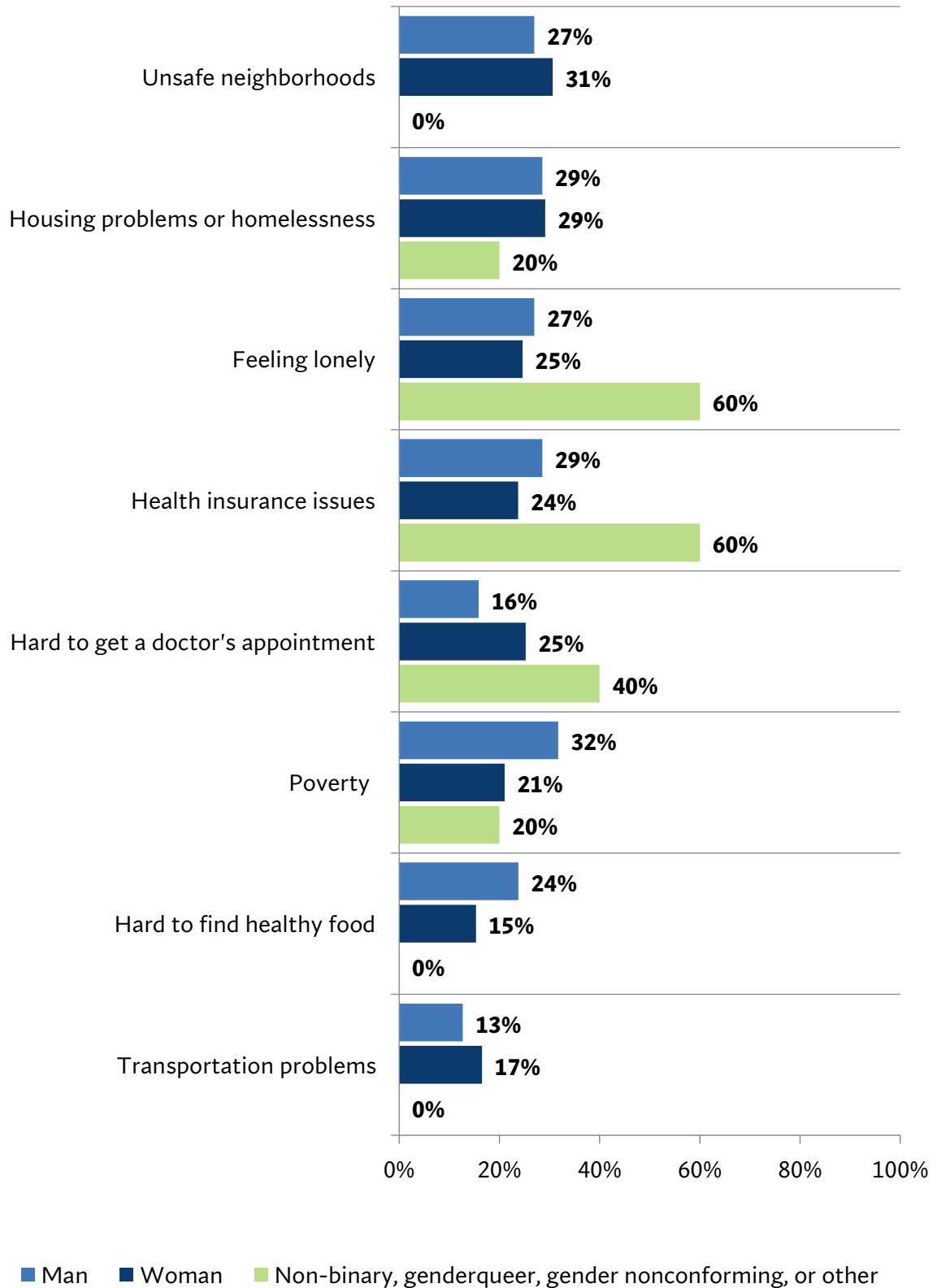
**Figure A2.18: What are the 3 biggest social and environmental problems that affect the health in your community? (by Ward)**



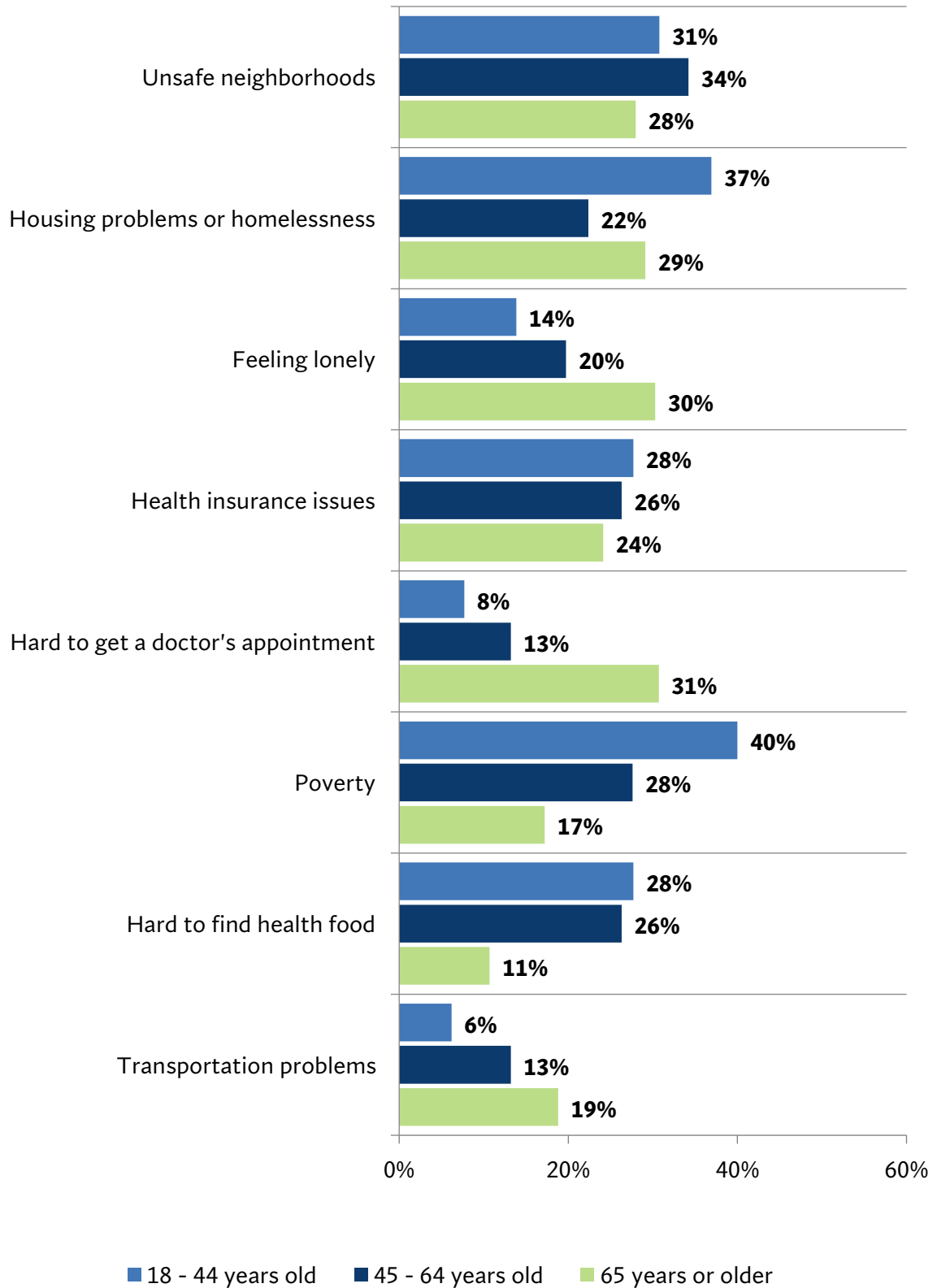
**Figure A2.19: What are the 3 biggest social and environmental problems that affect the health in your community? (by race/ethnicity)**



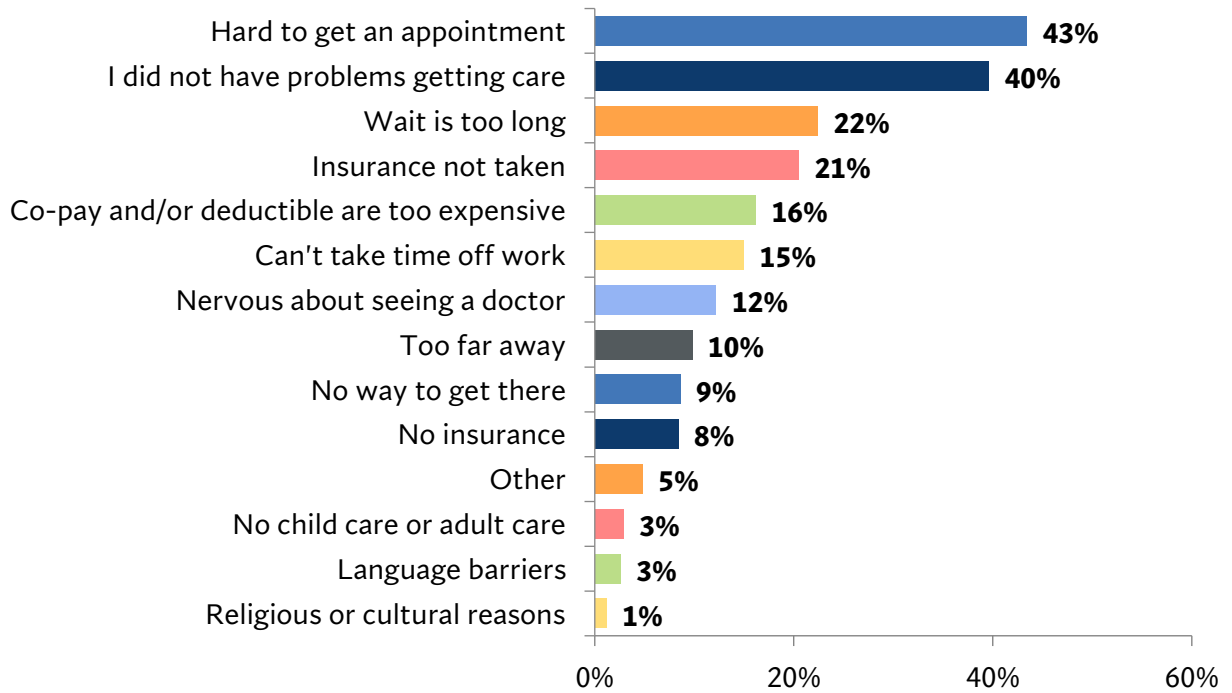
**Figure A2.20: What are the 3 biggest social and environmental problems that affect the health in your community? (by gender)**



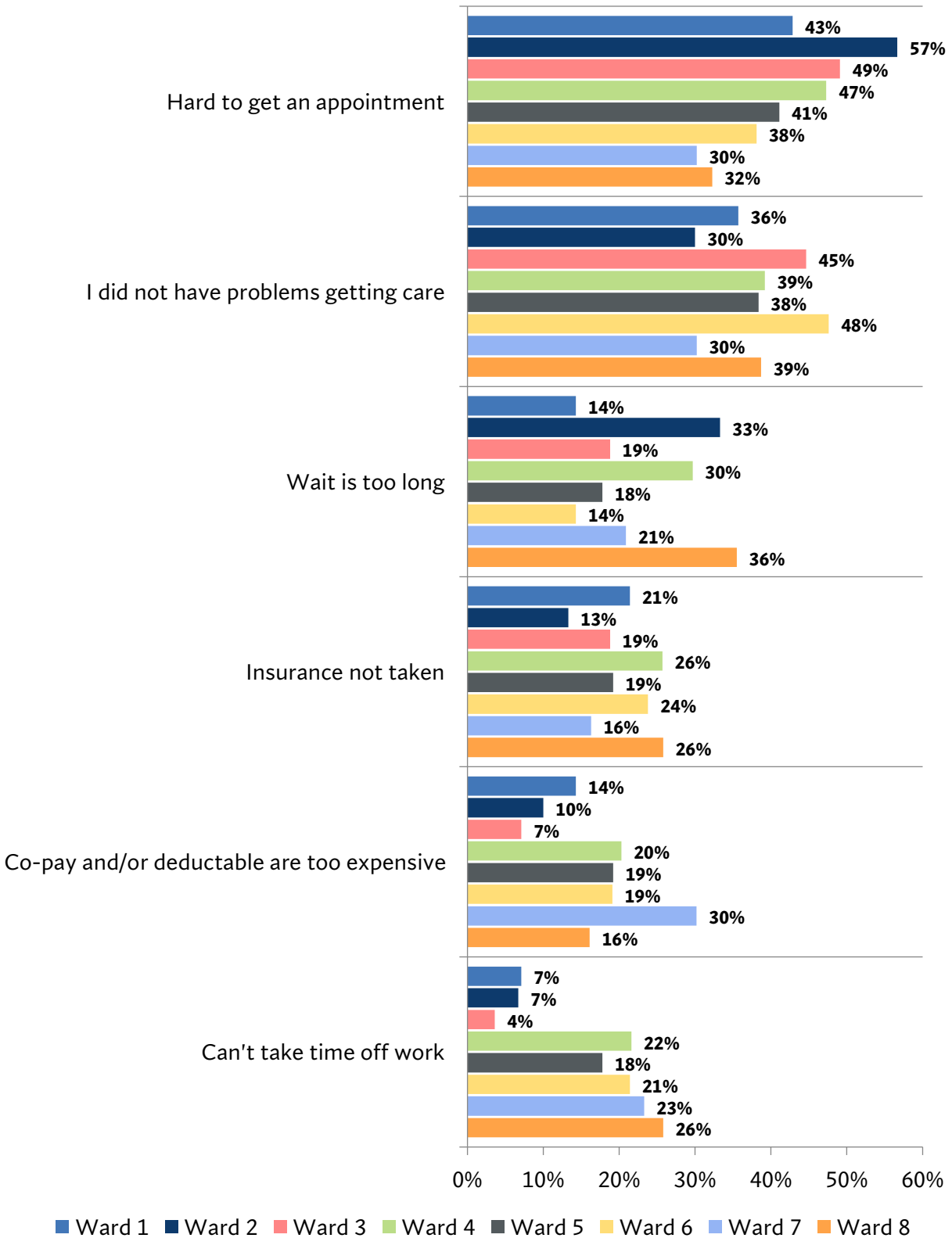
**Figure A2.21: What are the 3 biggest social and environmental problems that affect the health in your community? (by age group)**



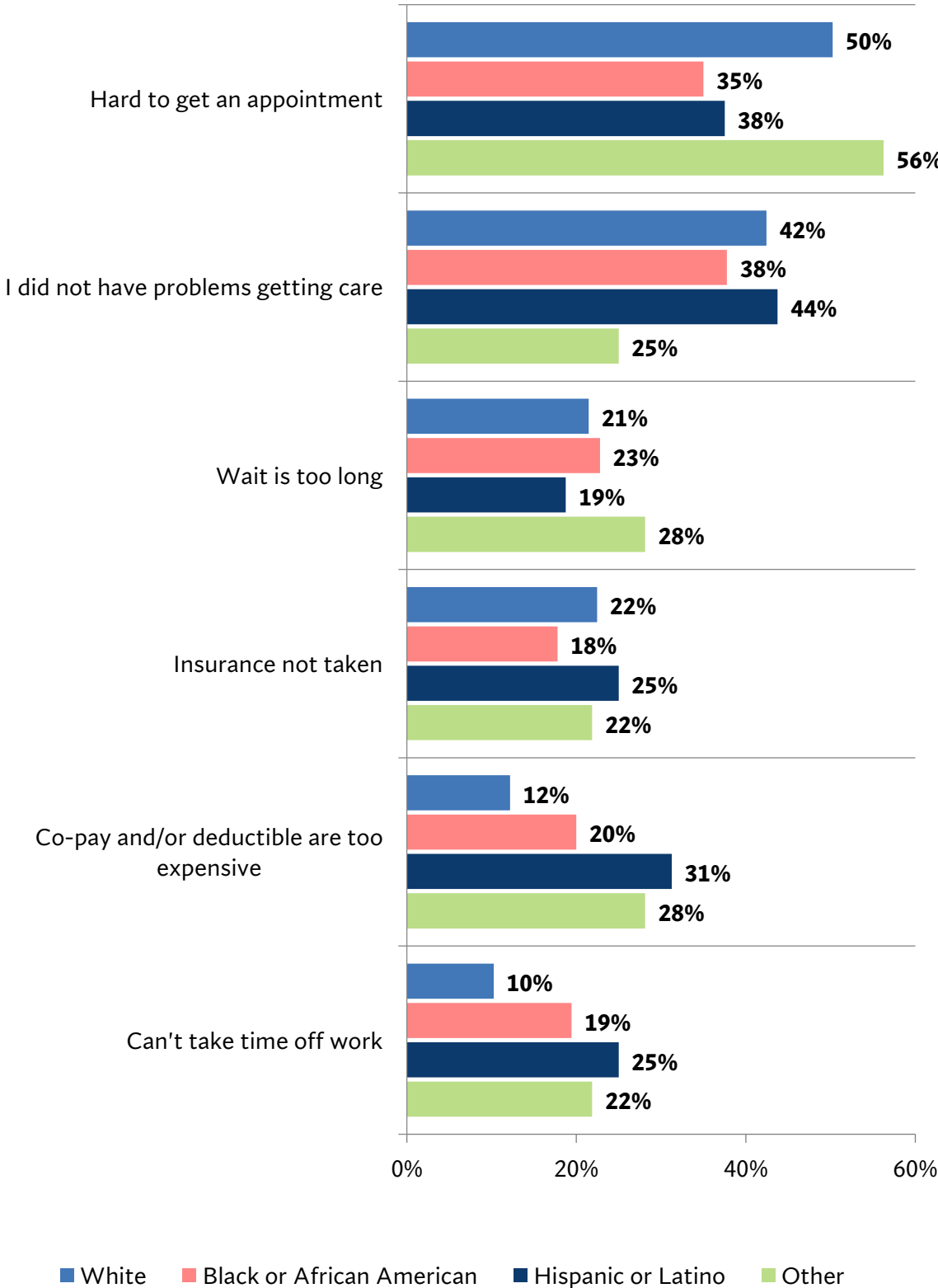
**Figure A2.22: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (n=419)**



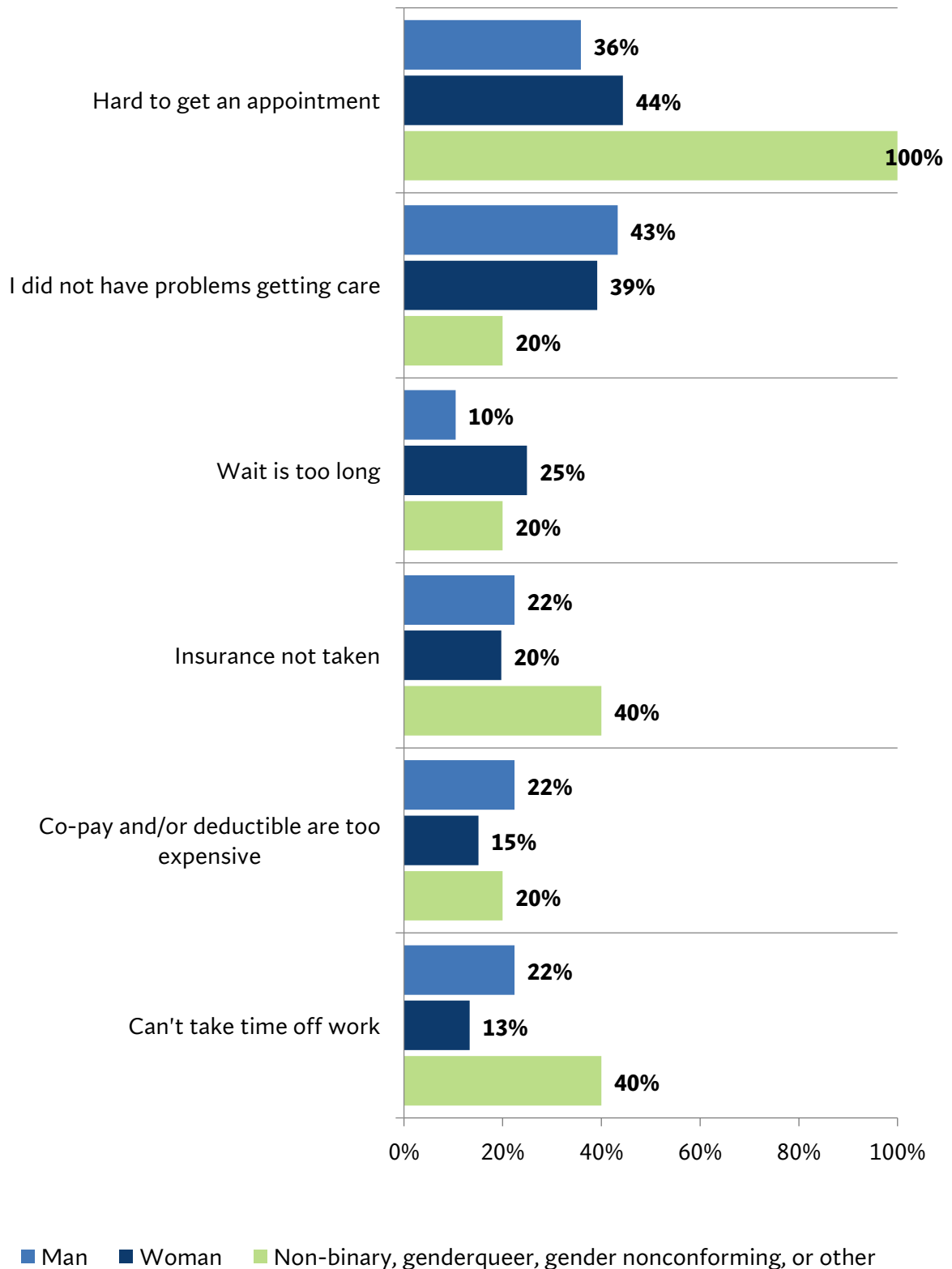
**Figure A2.23: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (by Ward)**



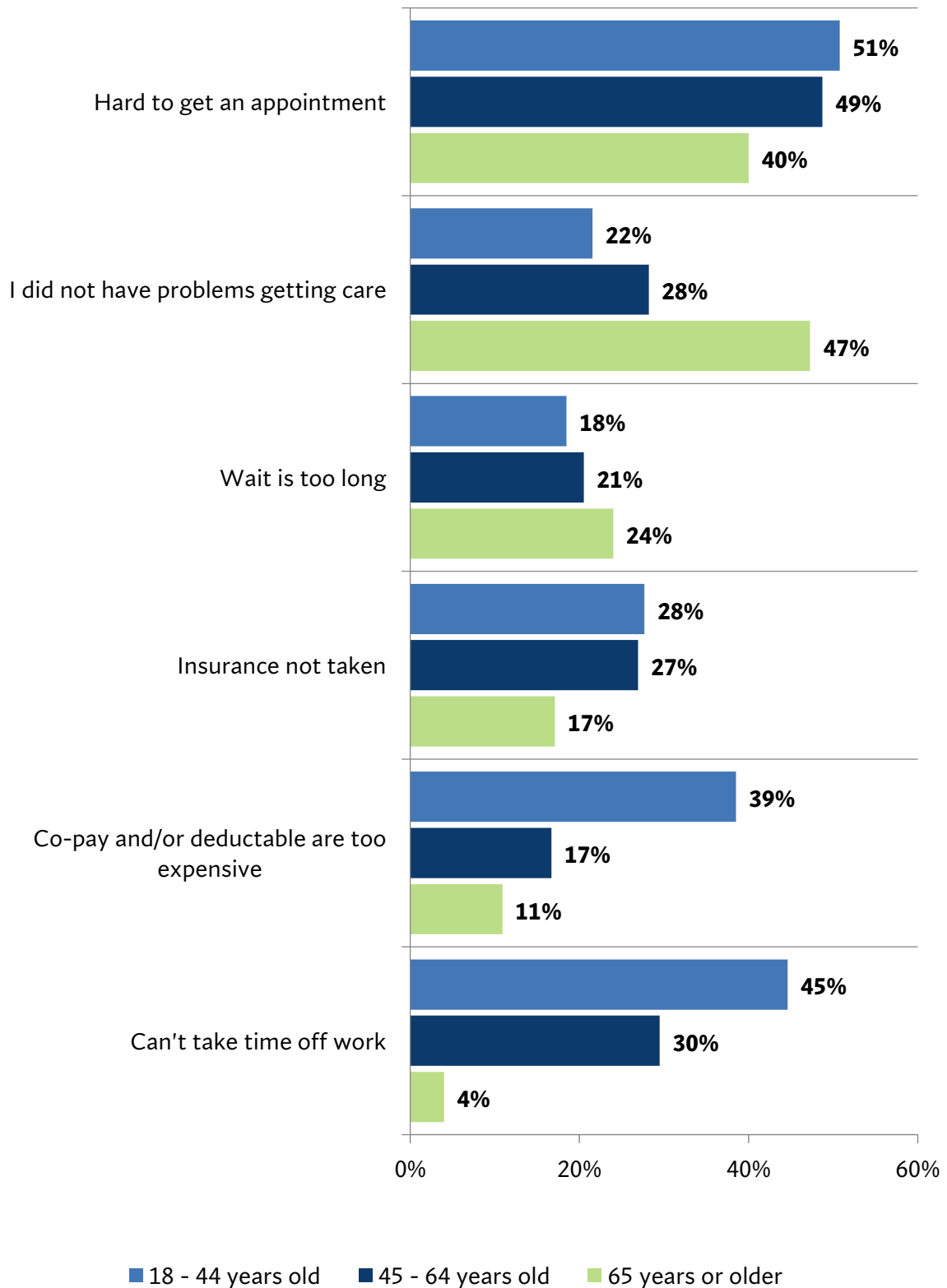
**Figure A2.24: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (by race/ethnicity)**



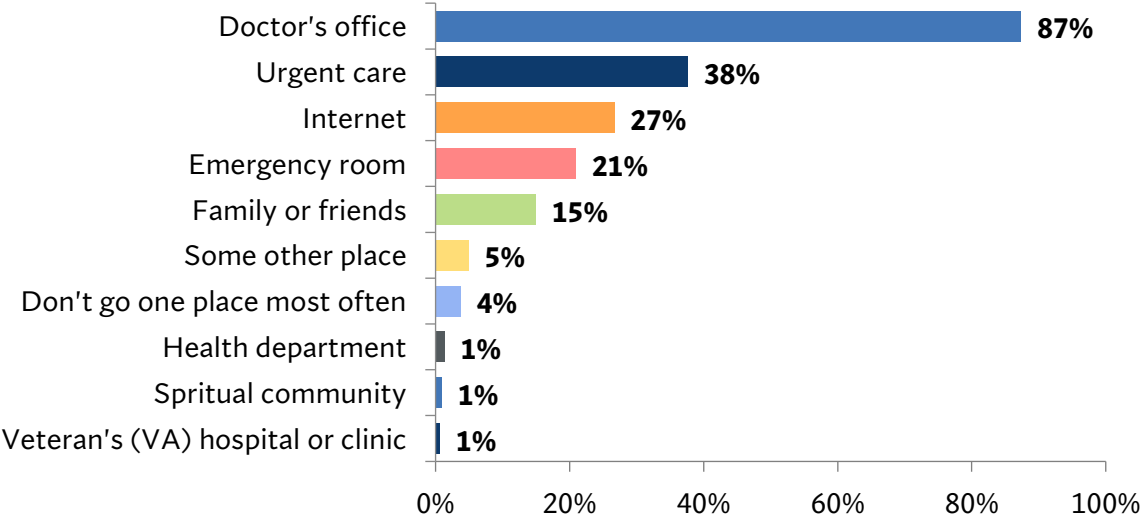
**Figure A2.25: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (by gender)**



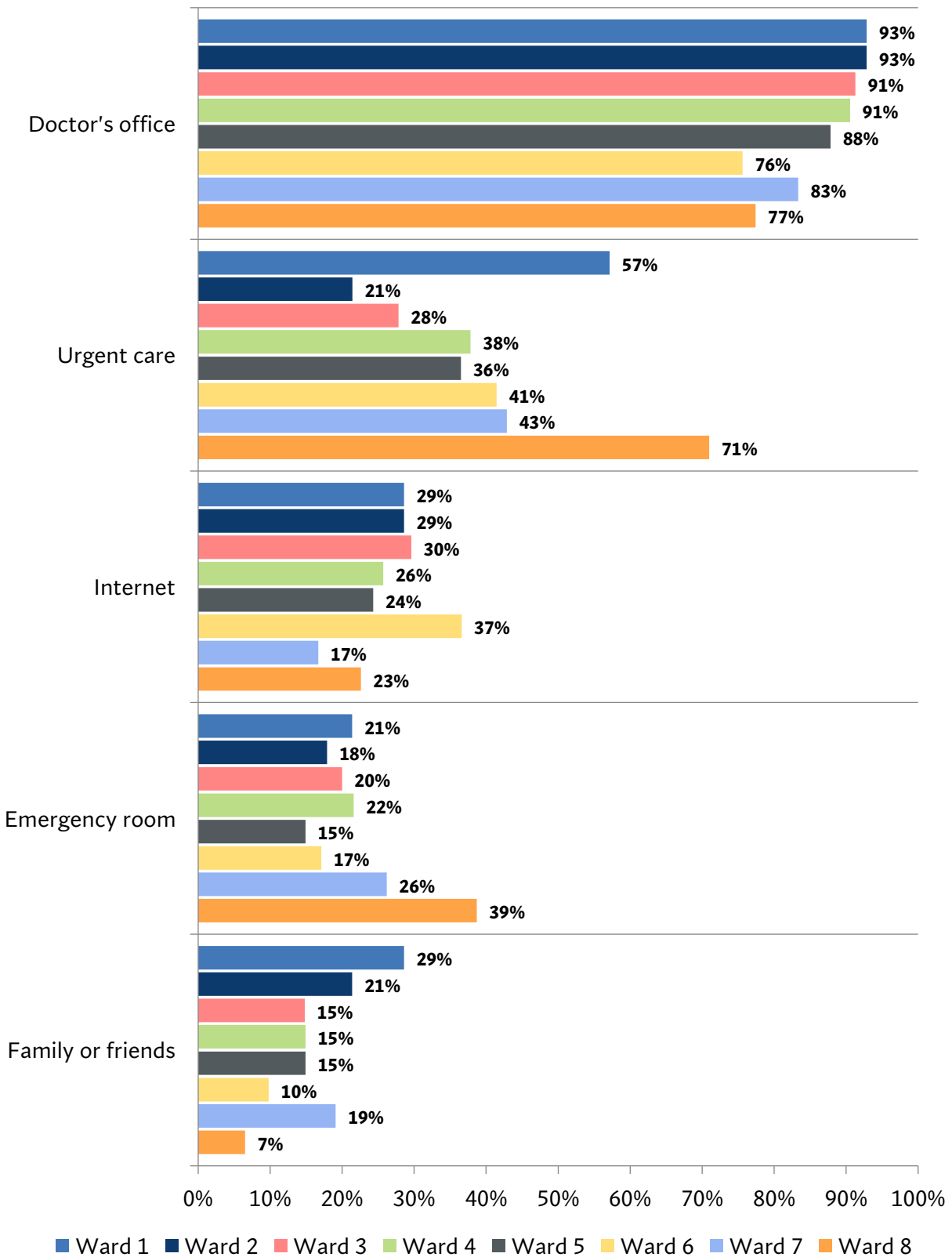
**Figure A2.26: There are many reasons people delay getting medical care. What made it hard to get medical care in the last year? (by age group)**



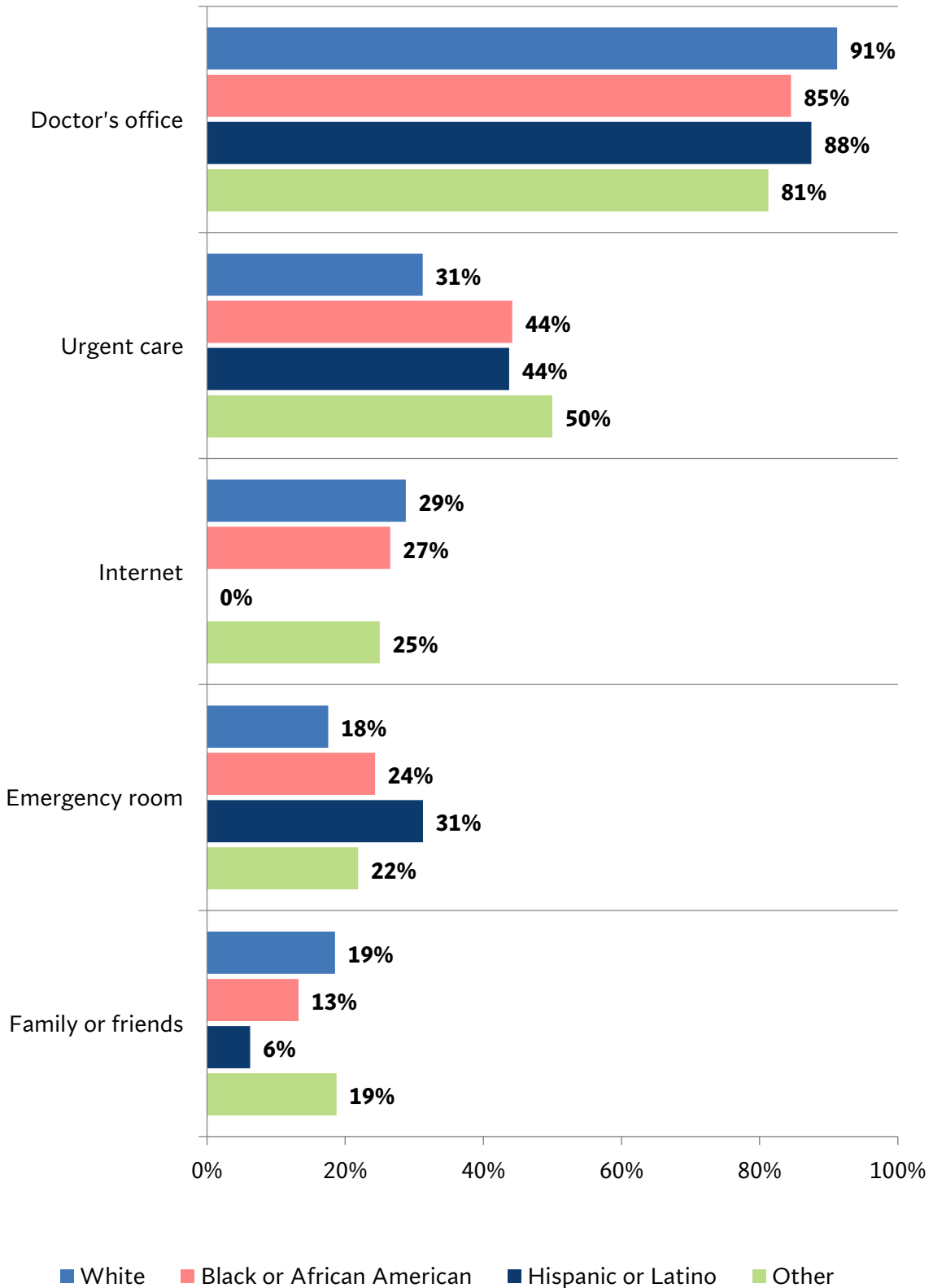
**Figure A2.27: Where do you usually go when you're sick or need health advice? (n=419)**



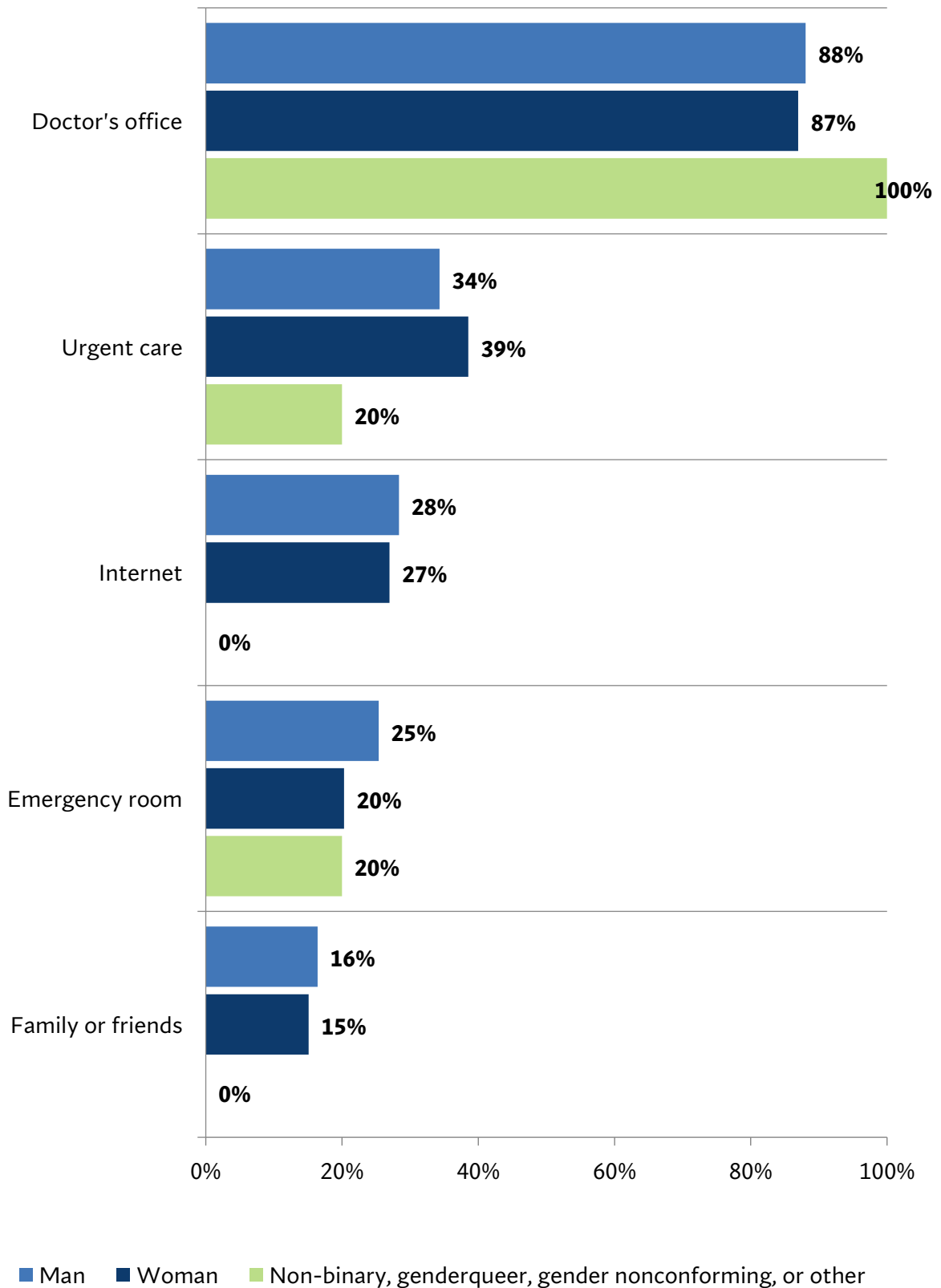
**Figure A2.28: Where do you usually go when you're sick or need health advice? (by Ward)**



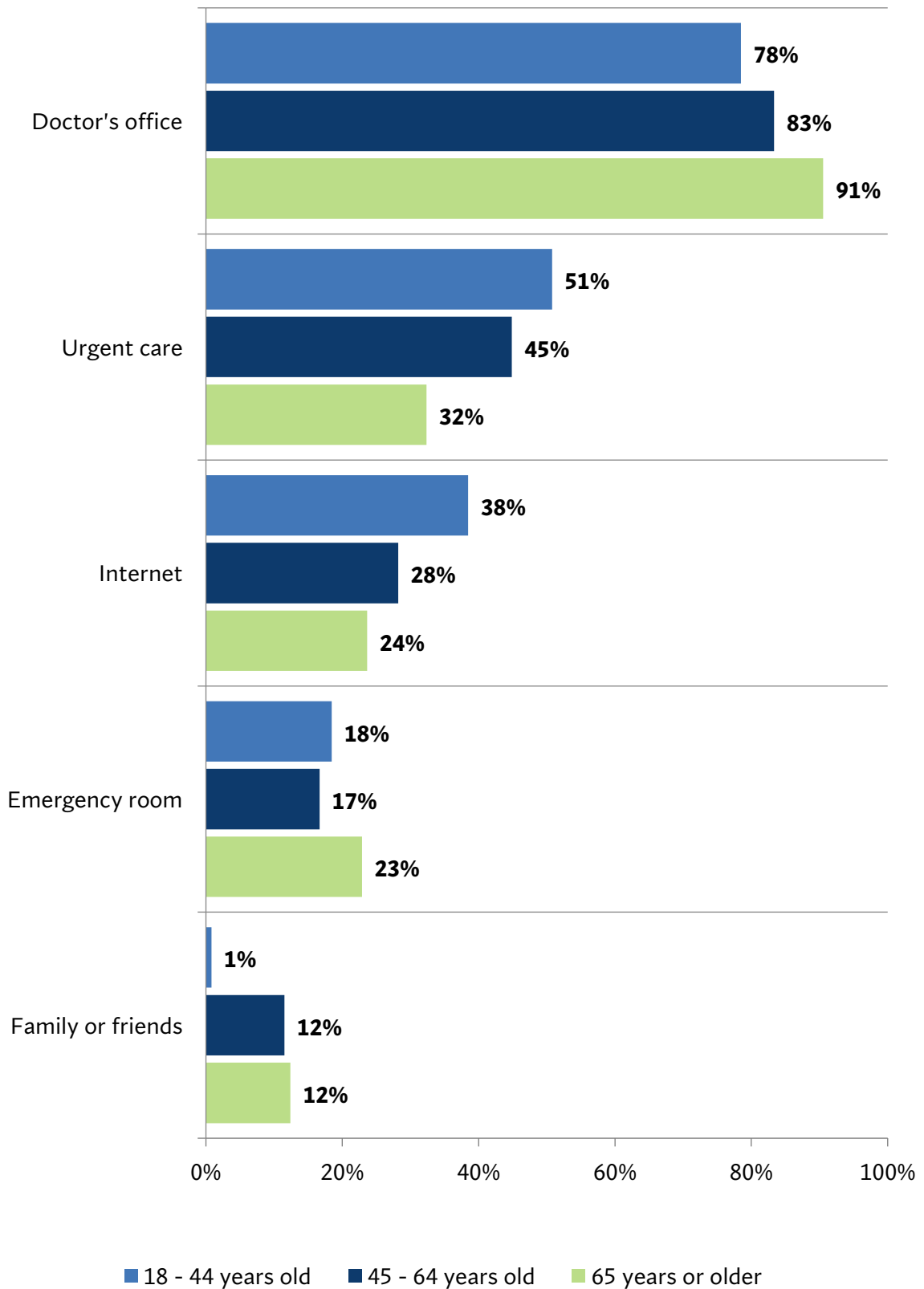
**Figure A2.29: Where do you usually go when you're sick or need health advice?**  
(by race/ethnicity)



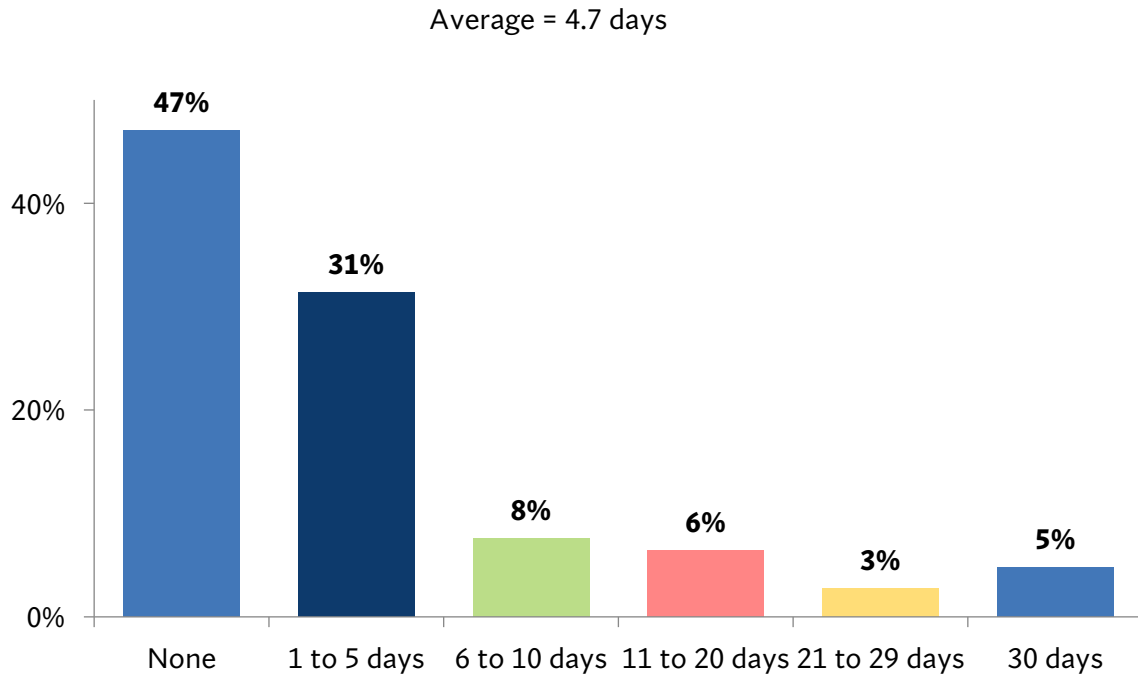
**Figure A2.30: Where do you usually go when you're sick or need health advice? (by gender)**



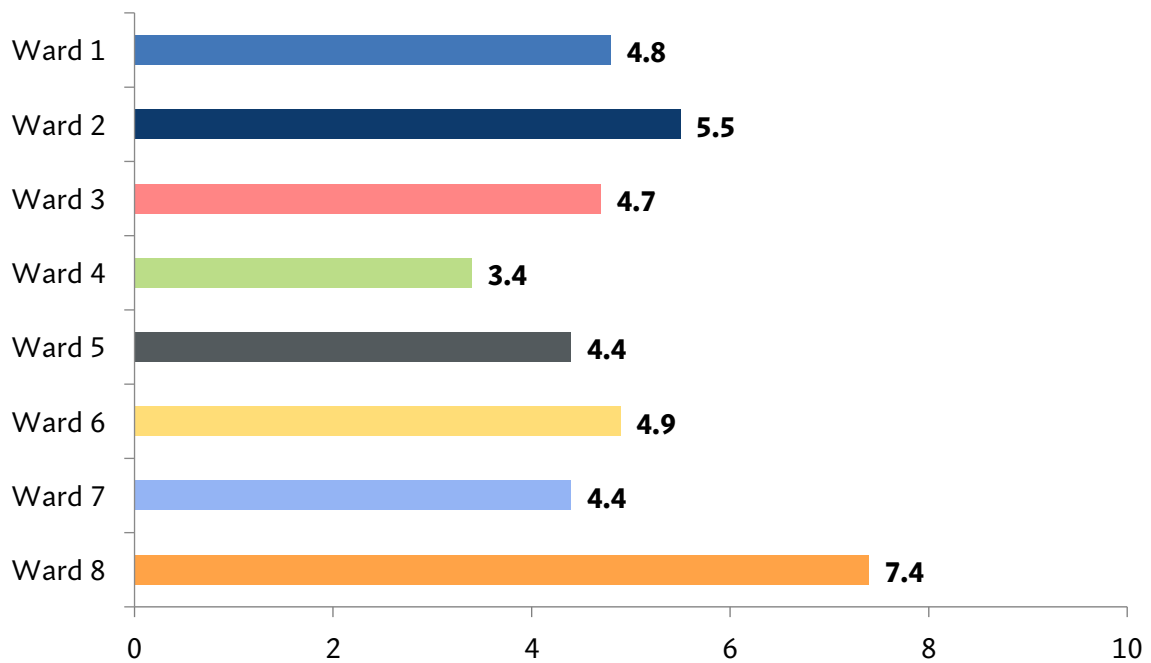
**Figure A2.31: Where do you usually go when you're sick or need health advice? (by age group)**



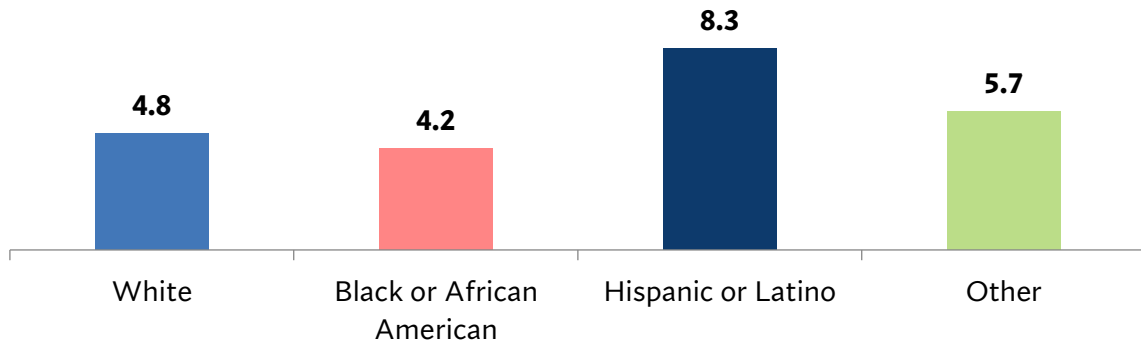
**Figure A2.32: How many days was your MENTAL health not good in the last 30 days? (n=357)**



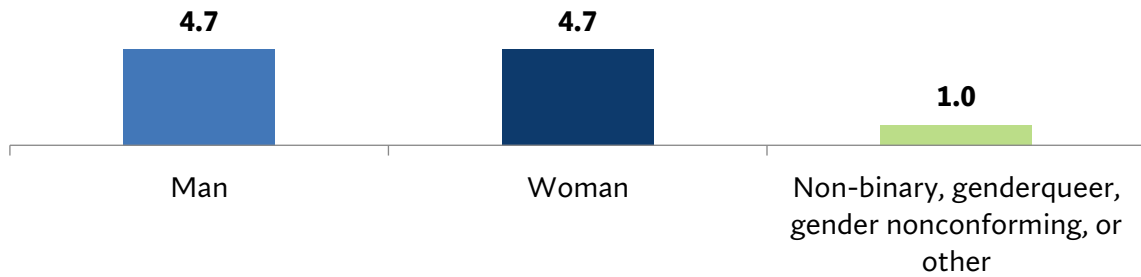
**Figure A2.33: How many days was your MENTAL health not good in the last 30 days? (by Ward)**



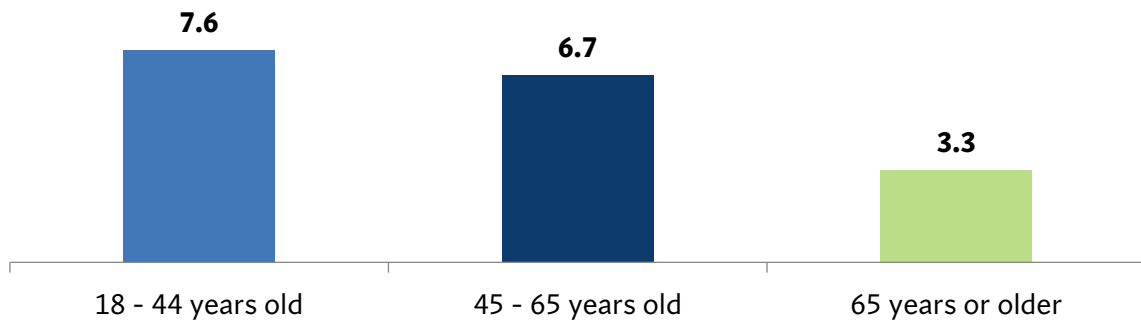
**Figure A2.34: How many days was your MENTAL health not good in the last 30 days? (by race/ethnicity)**



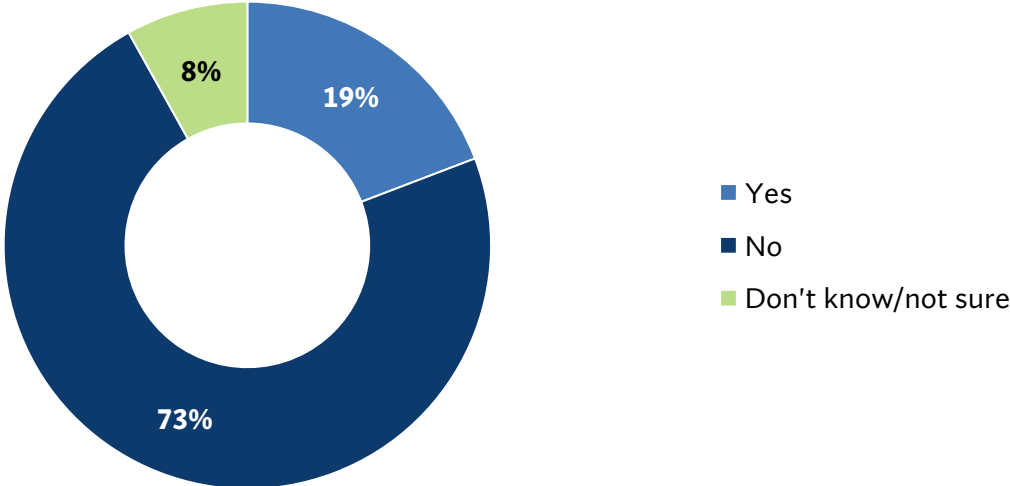
**Figure A2.35: How many days was your MENTAL health not good in the last 30 days? (by gender)**



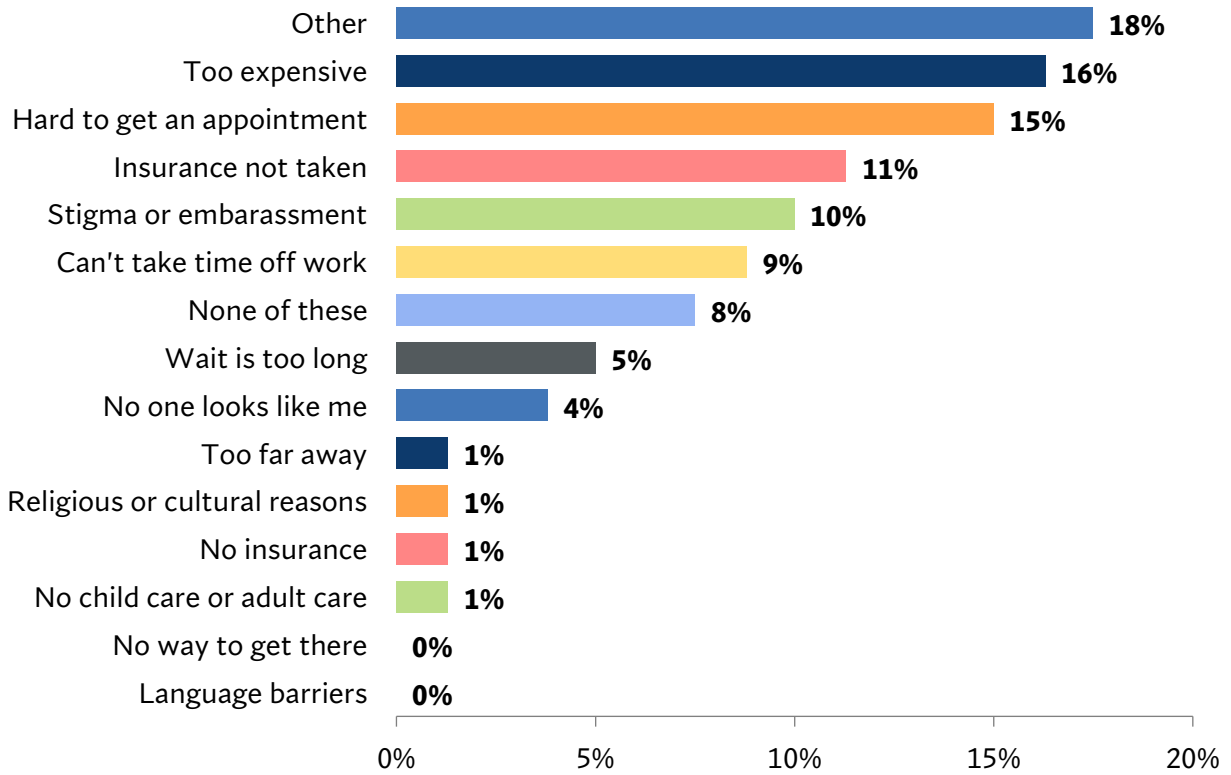
**Figure A2.36: How many days was your MENTAL health not good in the last 30 days? (by age group)**



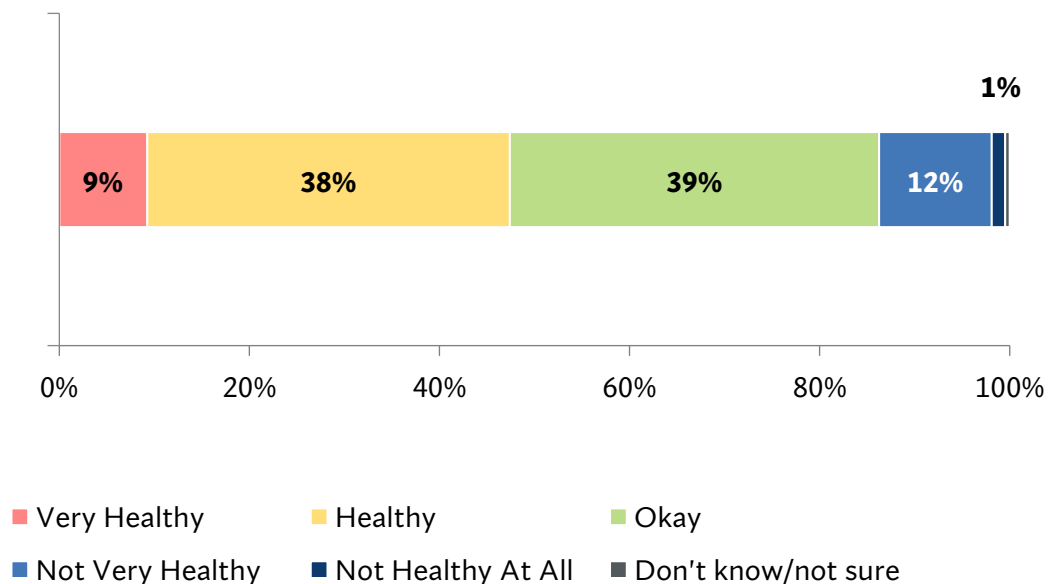
**Figure A2.37: In the past year, was there a time you needed mental health help but did not get it? (n=421)**



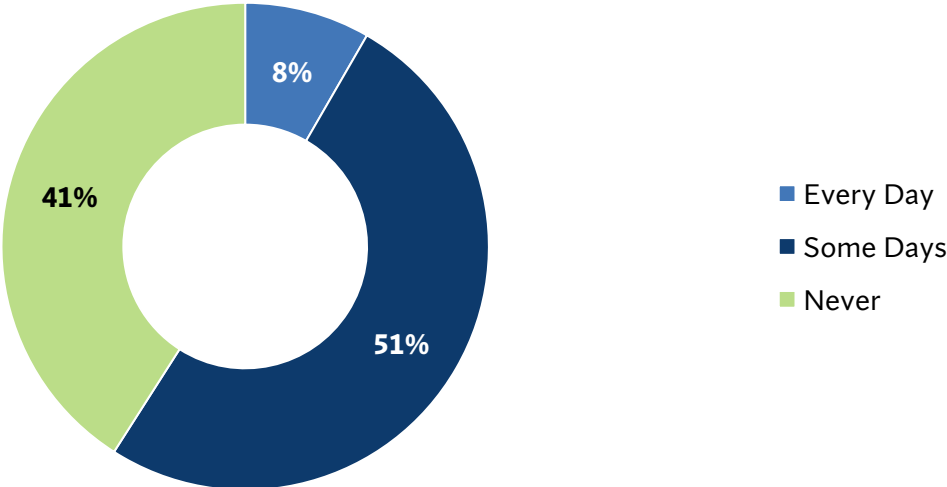
**Figure A2.38: Why couldn't you get help with your mental health? (n=80)**



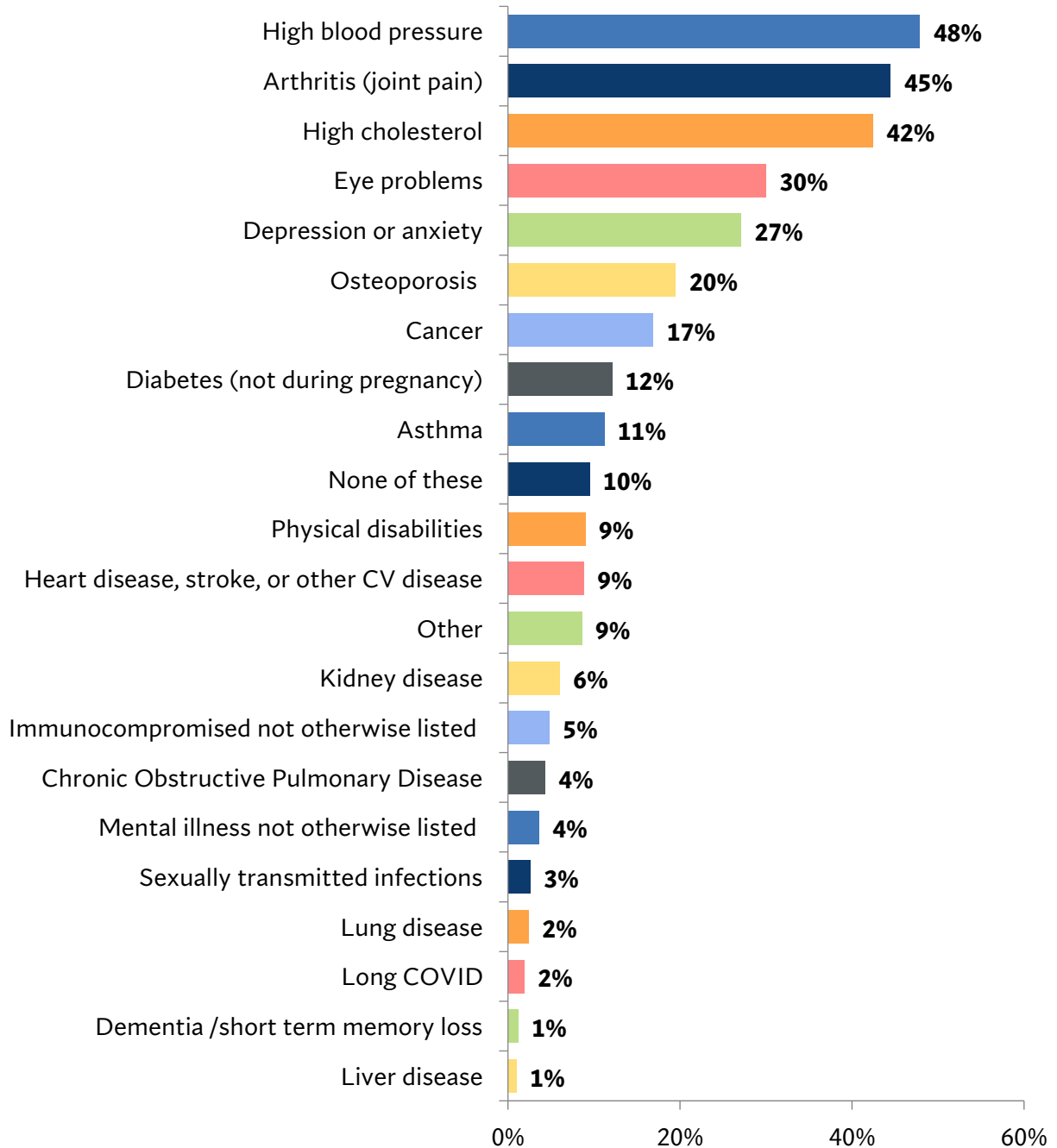
**Figure A2.39: Considering your overall PHYSICAL health, how healthy is your body right now? (n=422)**



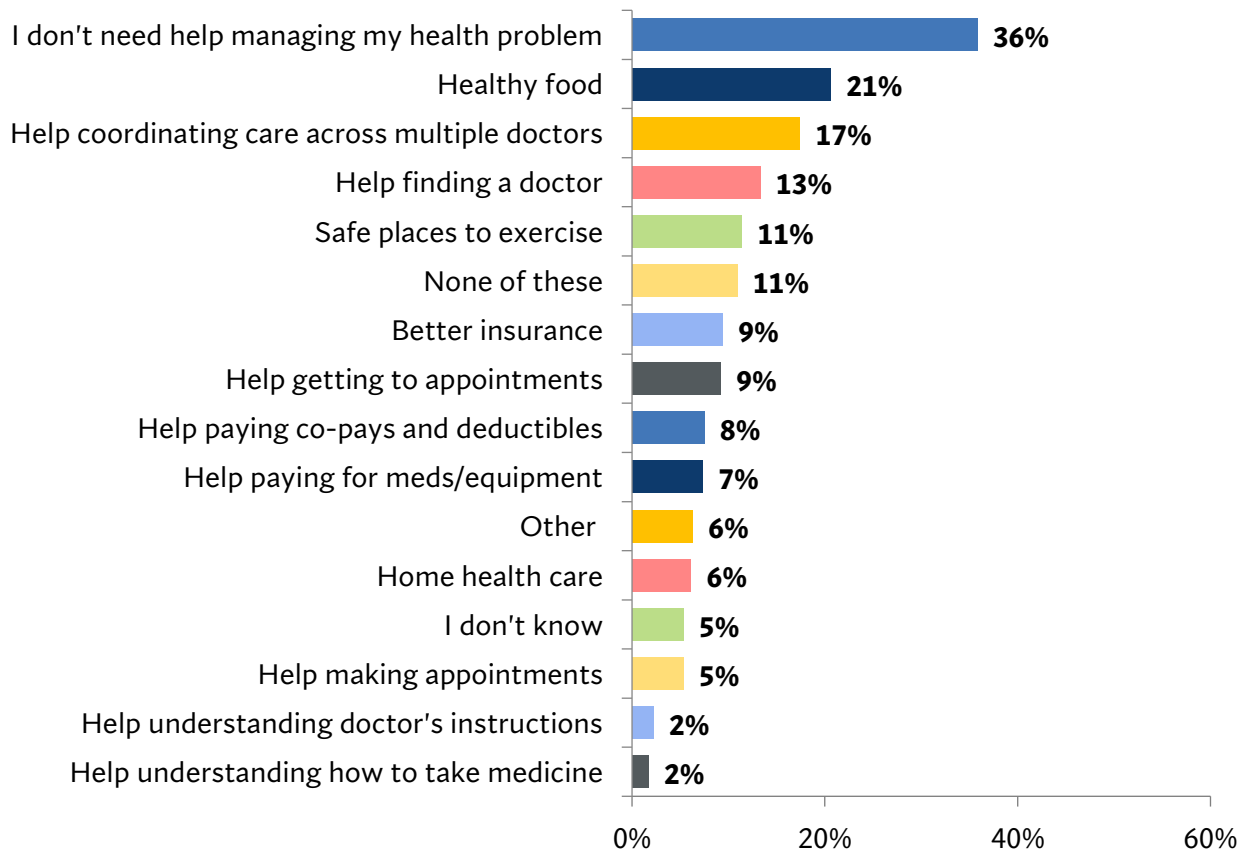
**Figure A2.40: How often do you drink alcohol (beer, wine, or liquor)? (n=420)**



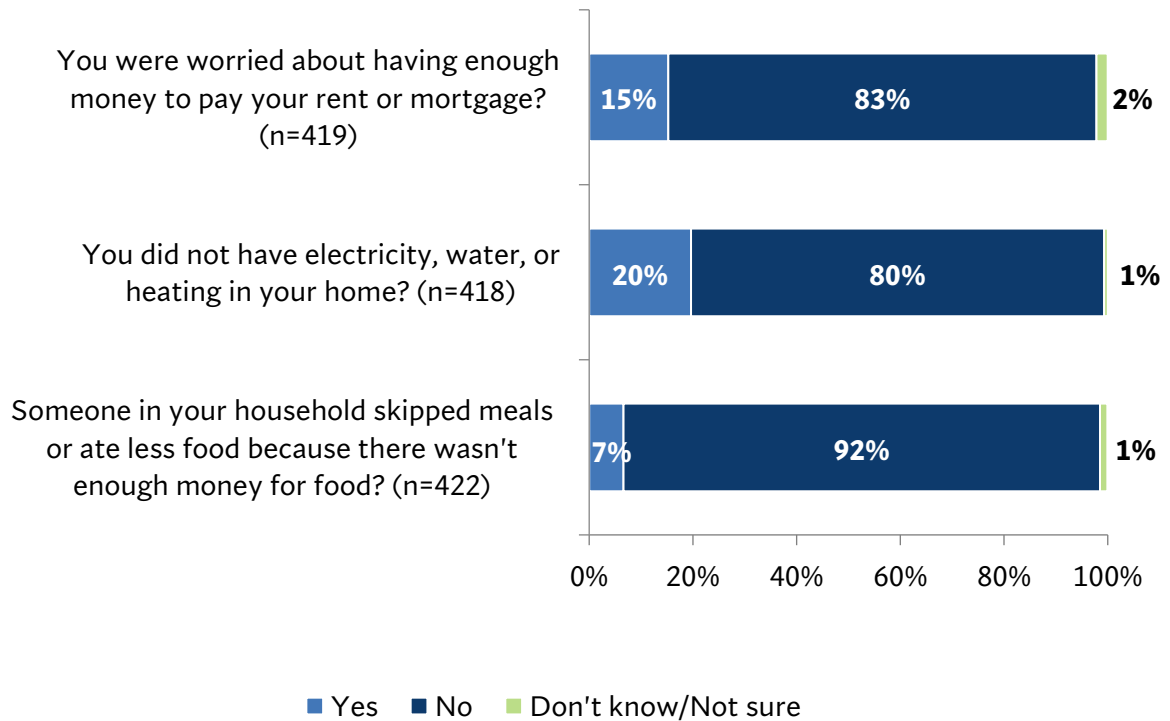
**Figure A2.41: Has a doctor, nurse, or other healthcare provider ever told you that you have any of these health problems? *Your answers are private - we won't know who filled out the survey.* (n=420)**



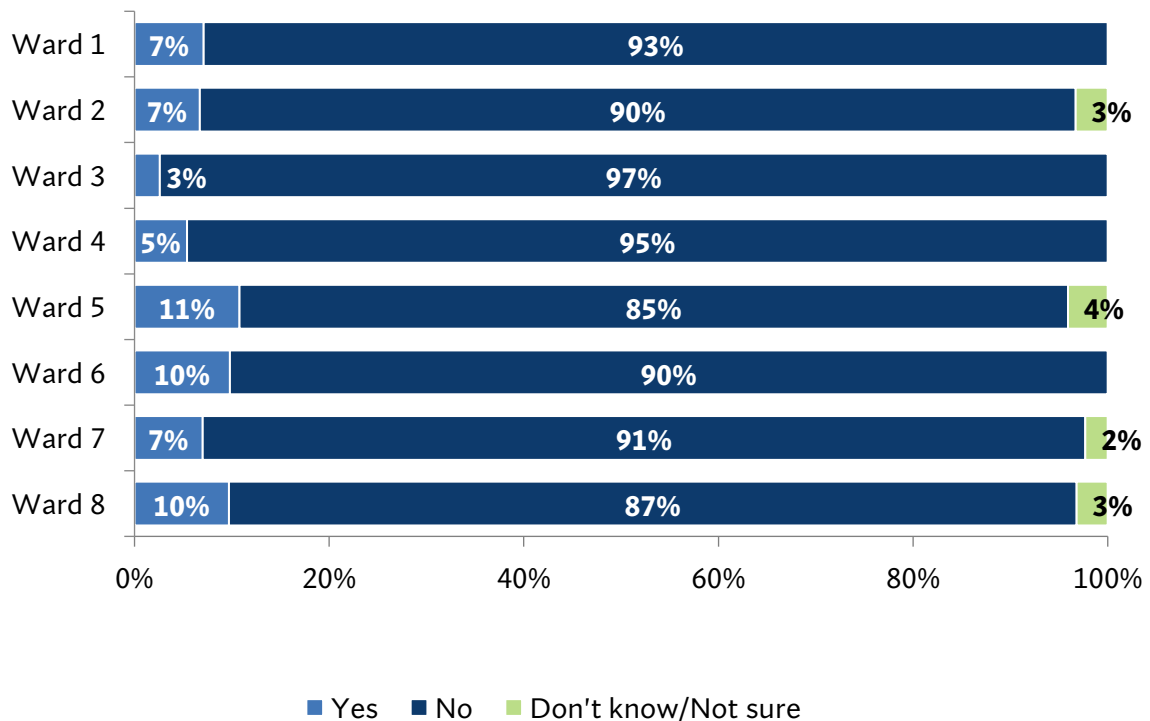
**Figure A2.42: What do you need to take care of your health problem(s) mentioned above?  
(n=413)**



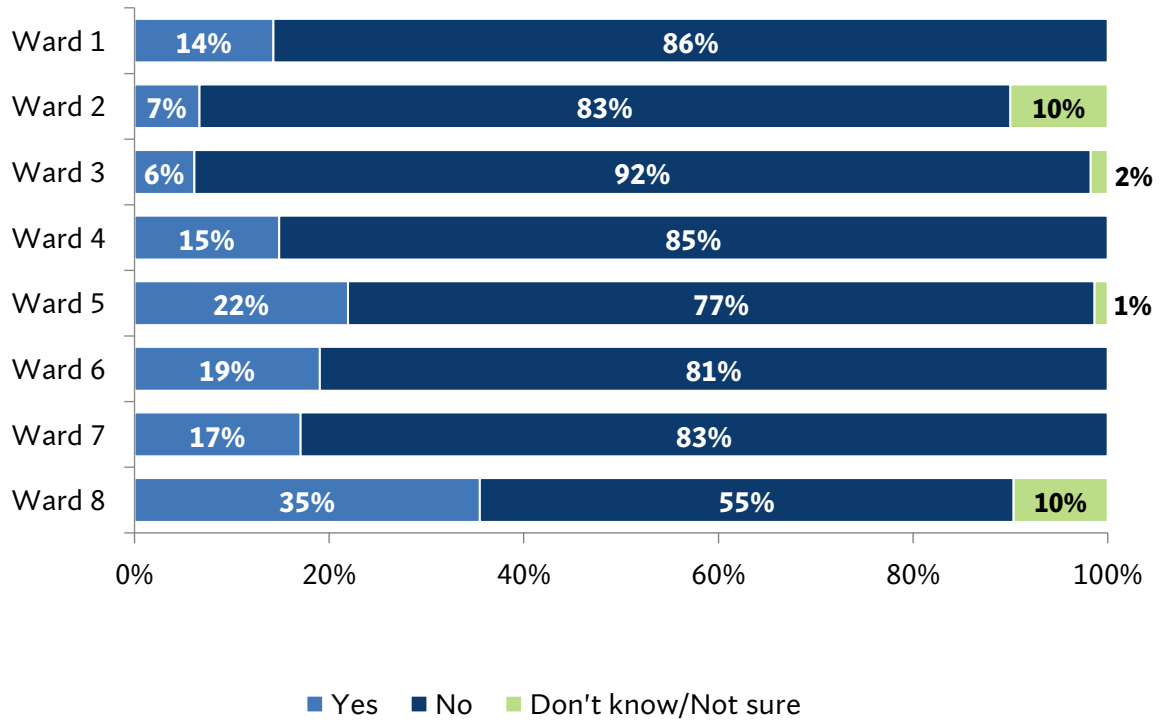
**Figure A2.43: In the past 12 months, were there times when:**



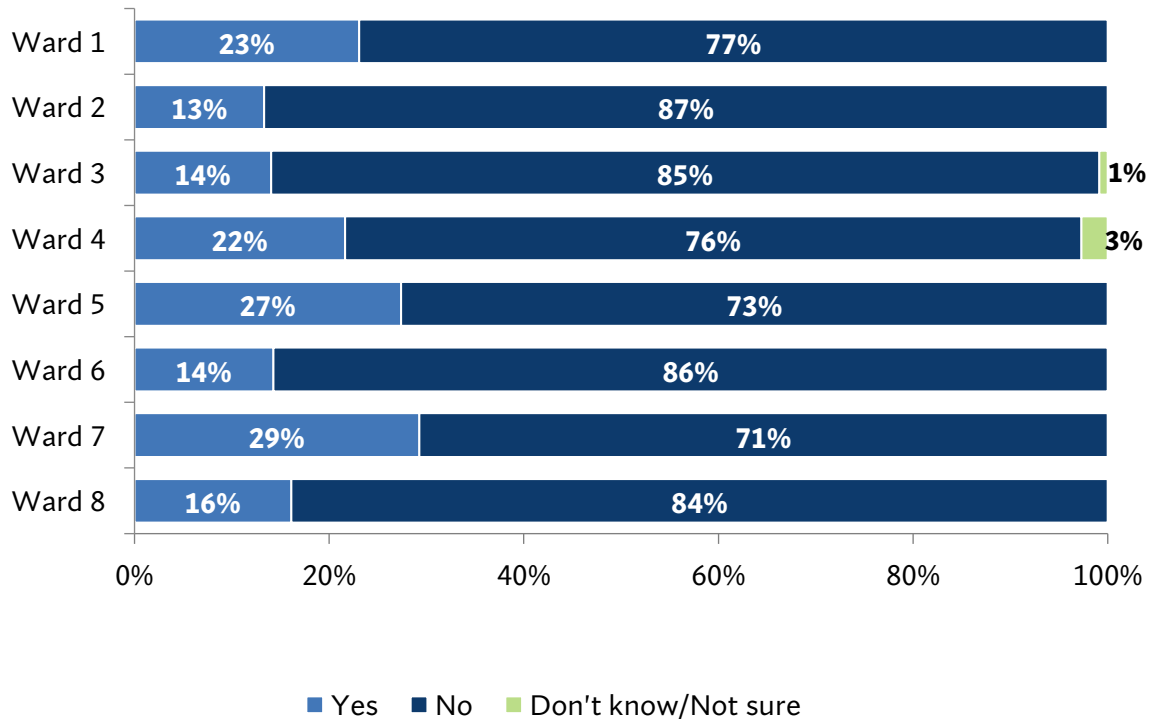
**Figure A2.44: In the past 12 months, did you or someone in your household skip meals or eat less food because there wasn't enough money for food? (n=422) (by Ward)**



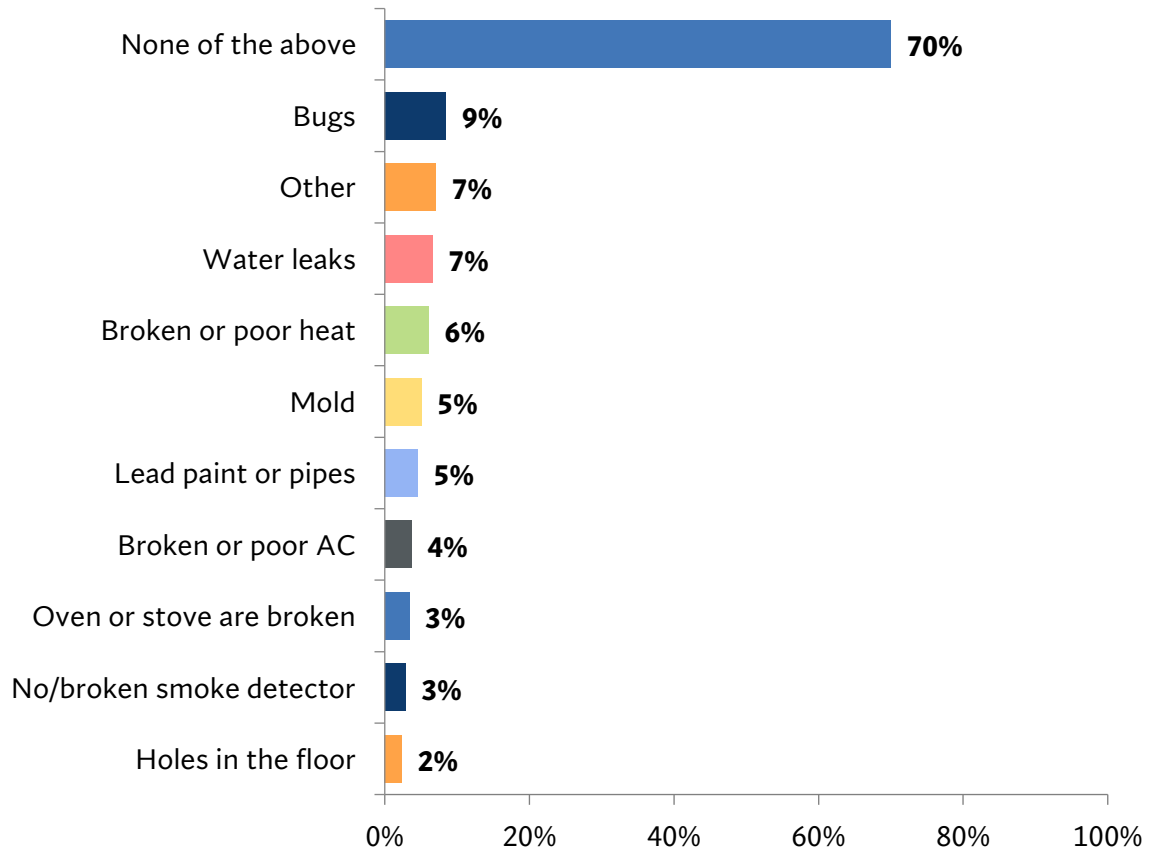
**Figure A2.45: In the past 12 months, were there times when you were worried about having enough money to pay your rent or mortgage? (n=419) (by Ward)**



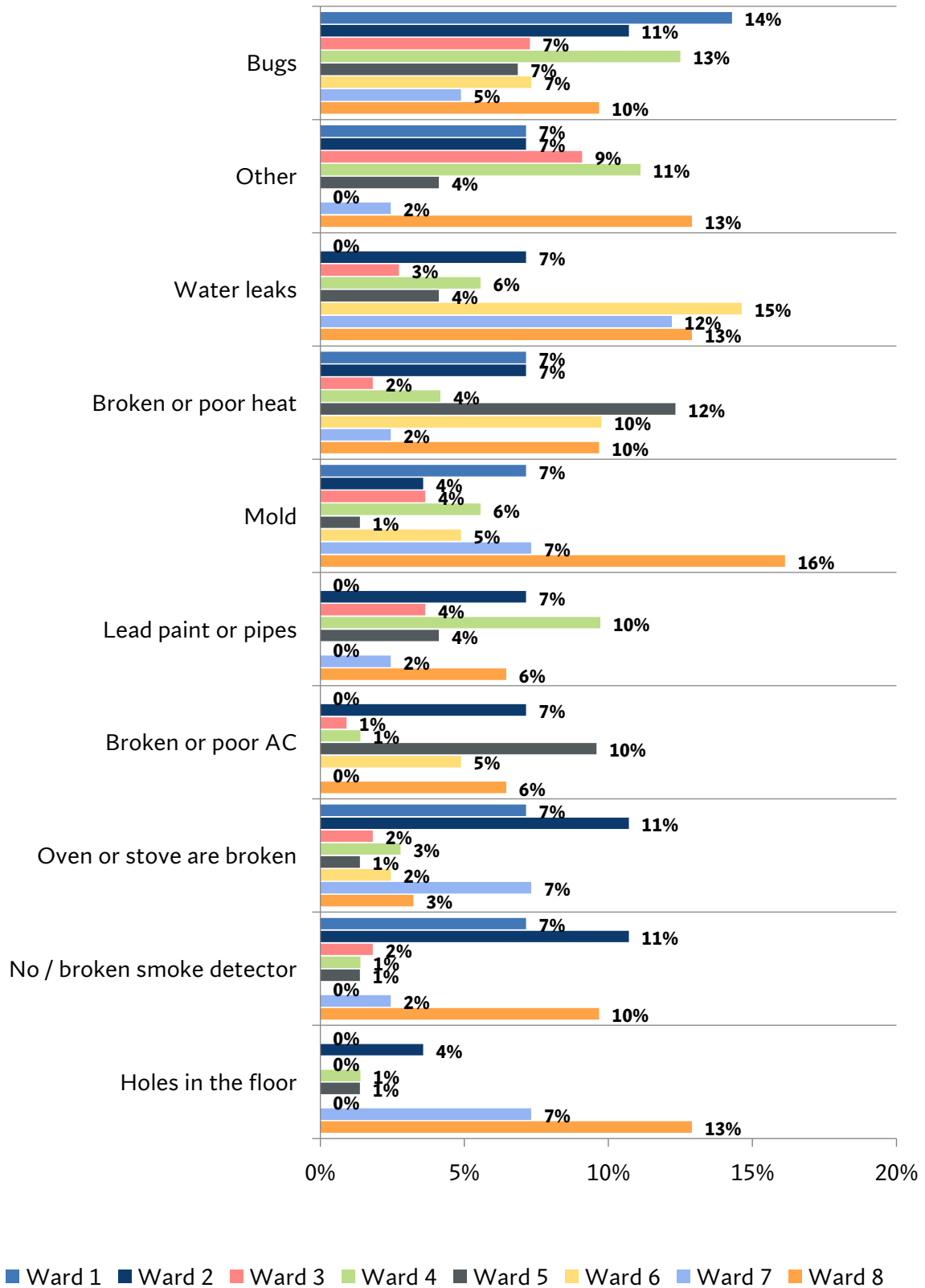
**Figure A2.46: In the past 12 months, were there times when you did not have electricity, water, or heating in your home? (n=418) (by Ward)**



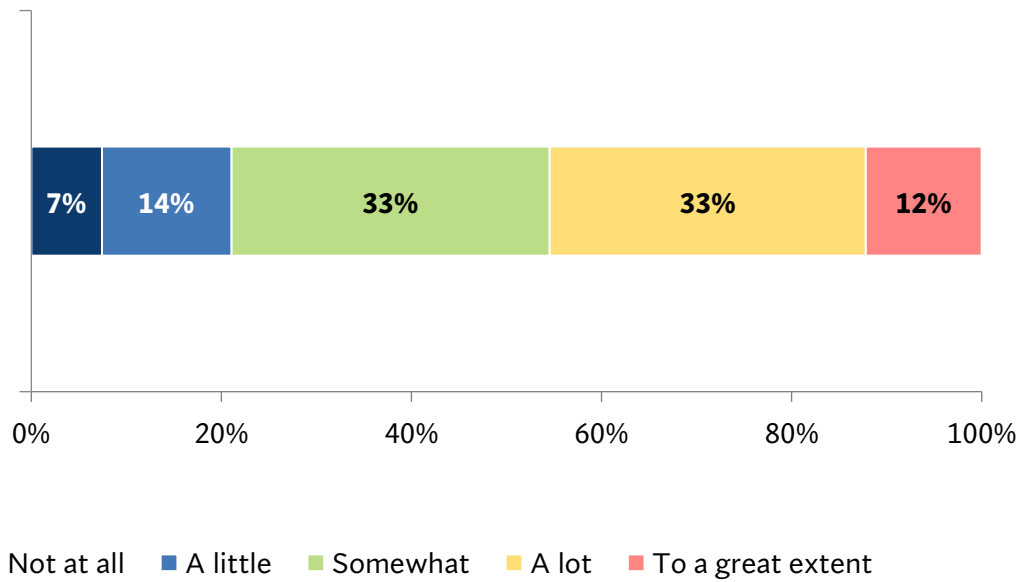
**Figure A2.47: Do you have any of the following problems in your home? (n=410)**



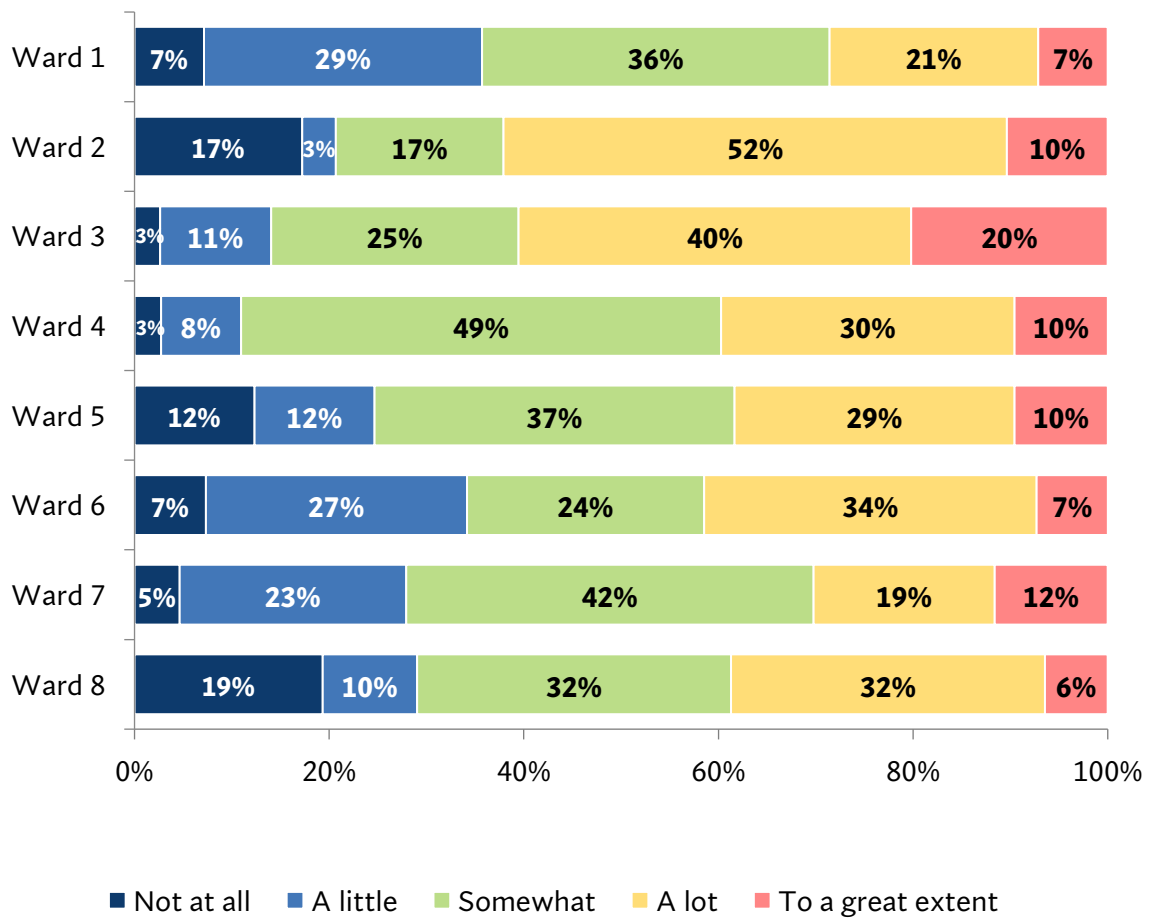
**Figure A2.48: Do you have any of the following problems in your home? (by Ward)**



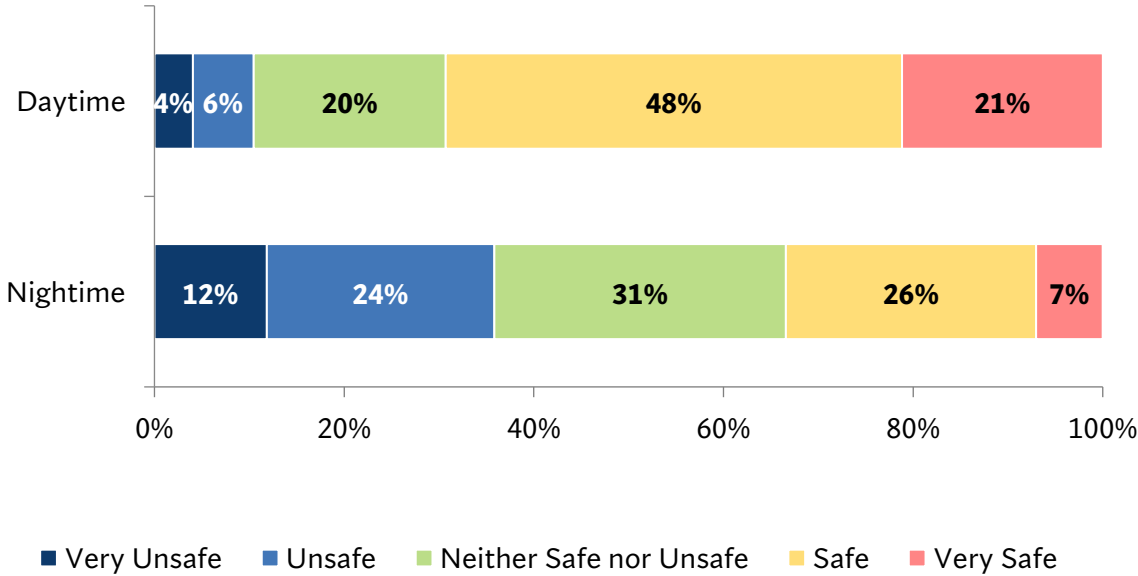
**Figure A2.49: Do you trust the police in the District? (n=418)**



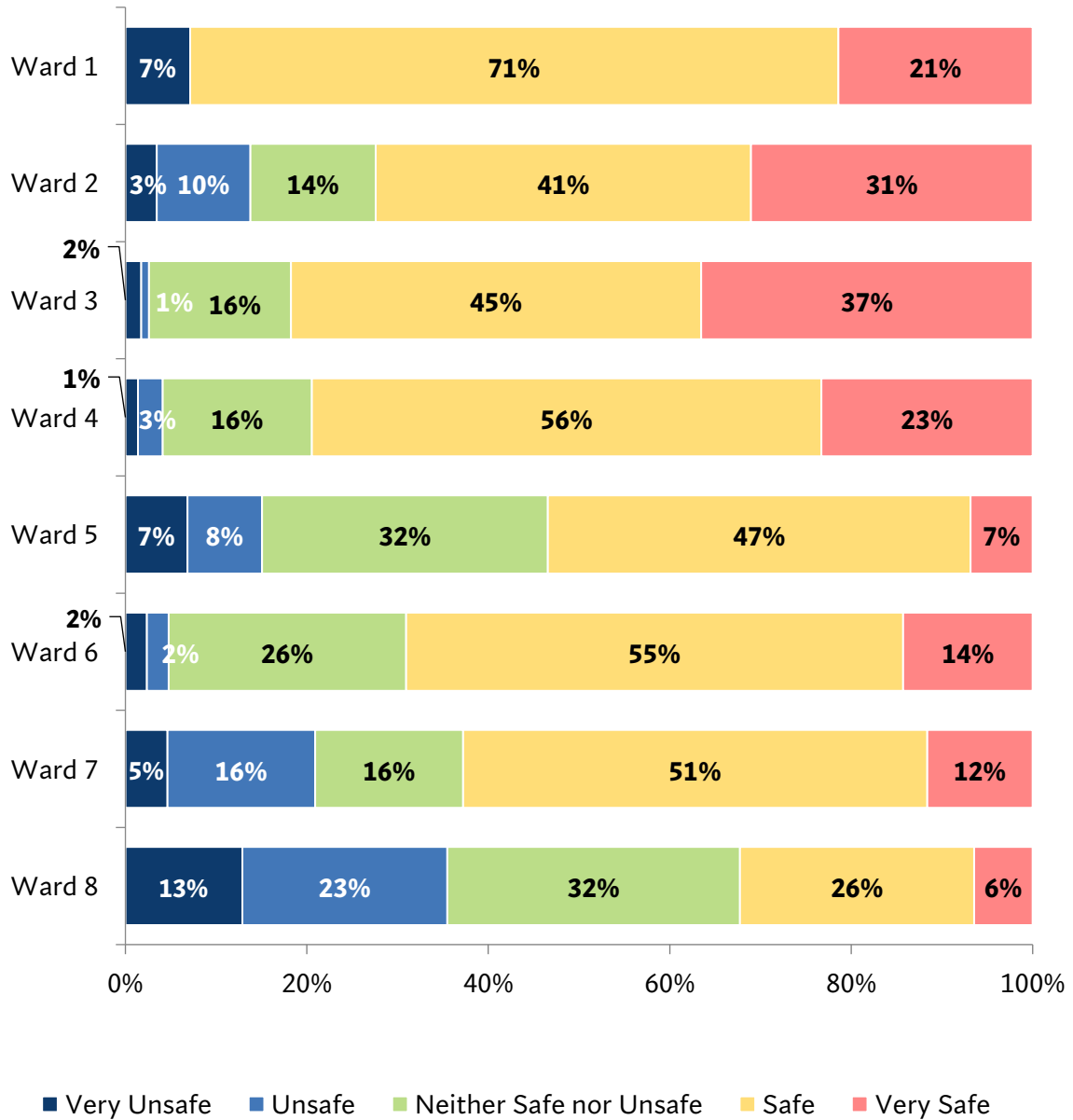
**Figure A2.50: Do you trust the police in the District? (by Ward)**



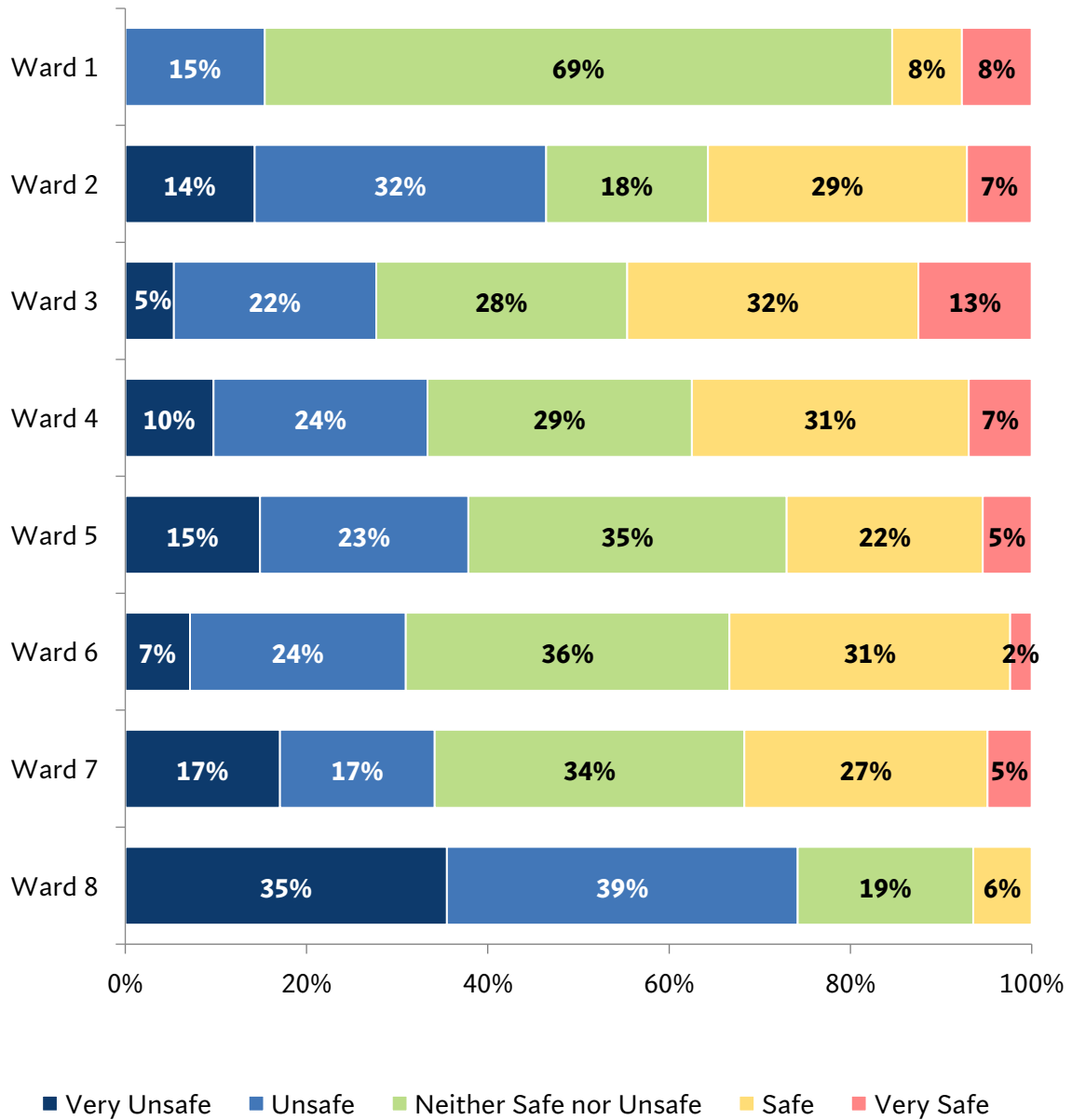
**Figure A2.51: How safe do you feel in your neighborhood when you are outside alone? (n=413)**



**Figure A2.52: How safe do you feel in your neighborhood when you are outside alone at DAYTIME? (by Ward)**



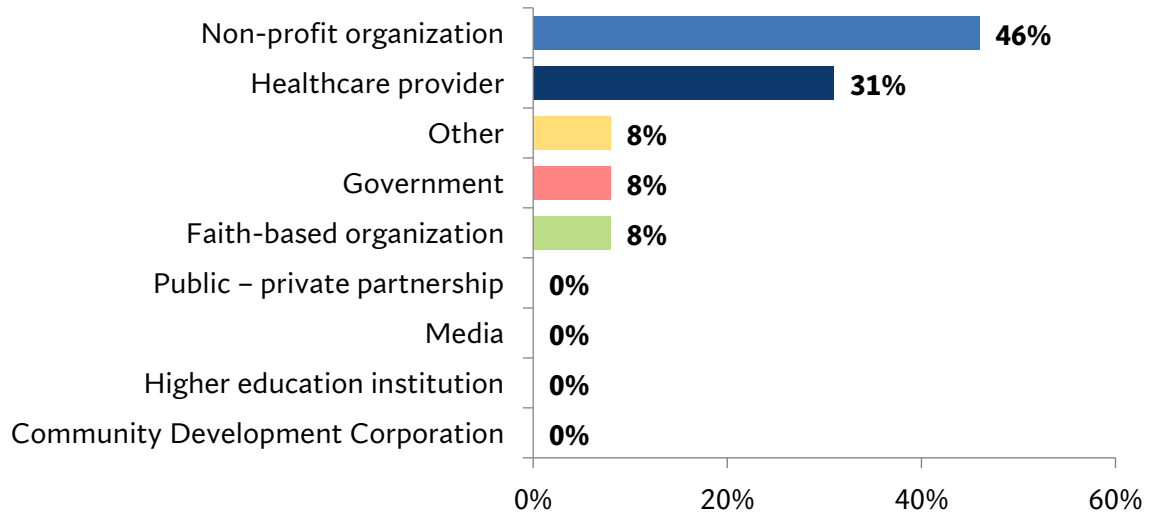
**Figure A2.53: How safe do you feel in your neighborhood when you are outside alone at NIGHTTIME? (by Ward)**



## Key Leader Survey

Figures detailing findings from the Key Leader Survey are displayed below:

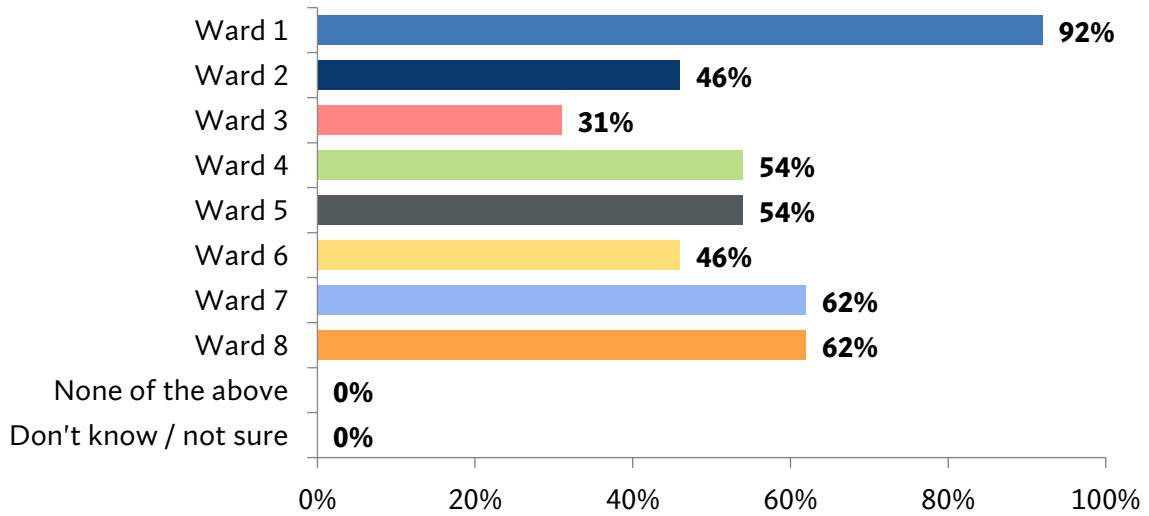
**Figure A2.54: Please select the category that best describes your organization (n=13)**



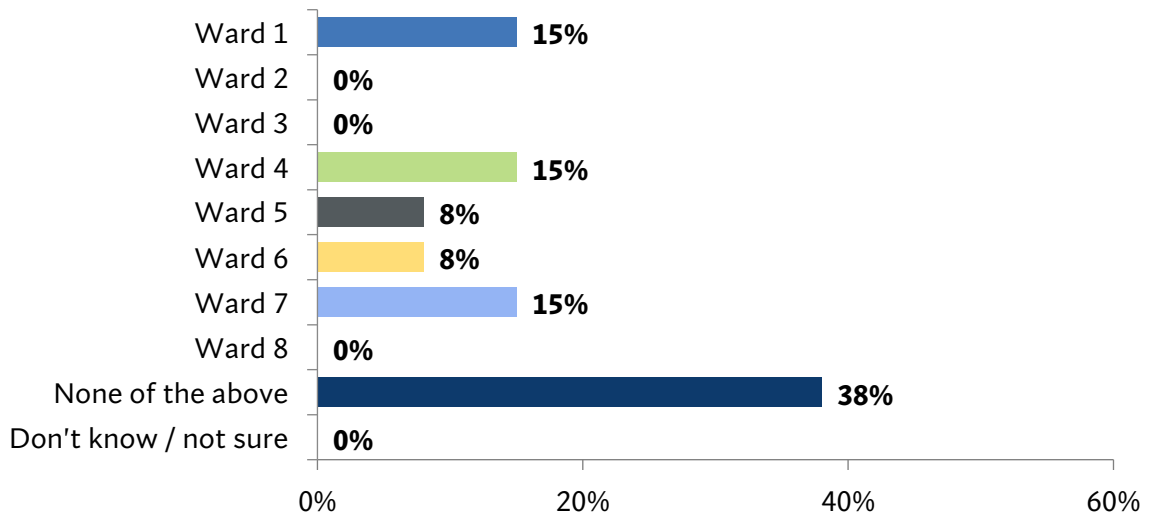
**Figure A2.55: What is the name of the organization you work for? (n=13)**

- Age-Friendly DC
- Bread for the City
- Christ House (2)
- Food & Friends
- Health Alliance Network
- Jane Bancroft Robinson Foundation
- La Clinica del Pueblo (2)
- The Pennsylvania Avenue Baptist Church
- Seabury Resources for Aging
- Sibley Memorial Hospital
- United Planning Organization

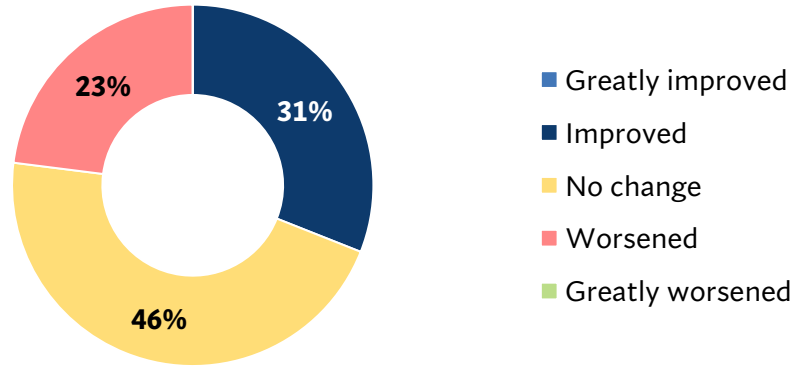
**Figure A2.56: Please select the Ward(s) your work is located in and/or what Ward(s) you primarily serve? (n=13)**



**Figure A2.57: Which Ward do you live in? (n=13)**



**Figure A2.58: How do you believe the health of the community you serve has changed over the past three years? (n=13)**



**In what way(s) has the health of the community you serve improved?**

- “Growth of number of physicians/specialties to serve community. Outreach to underserved individuals, such as Sibley’s Maternal Health Access Program, Geriatric nurse navigators in Sibley’s Emergency Department.”
- “Building New Urgent Care Facility East of the River, new Hospital being build, increased programming from churches on health access”
- “COVID helped residents take a closer look at personal health and community health strengths and weaknesses”

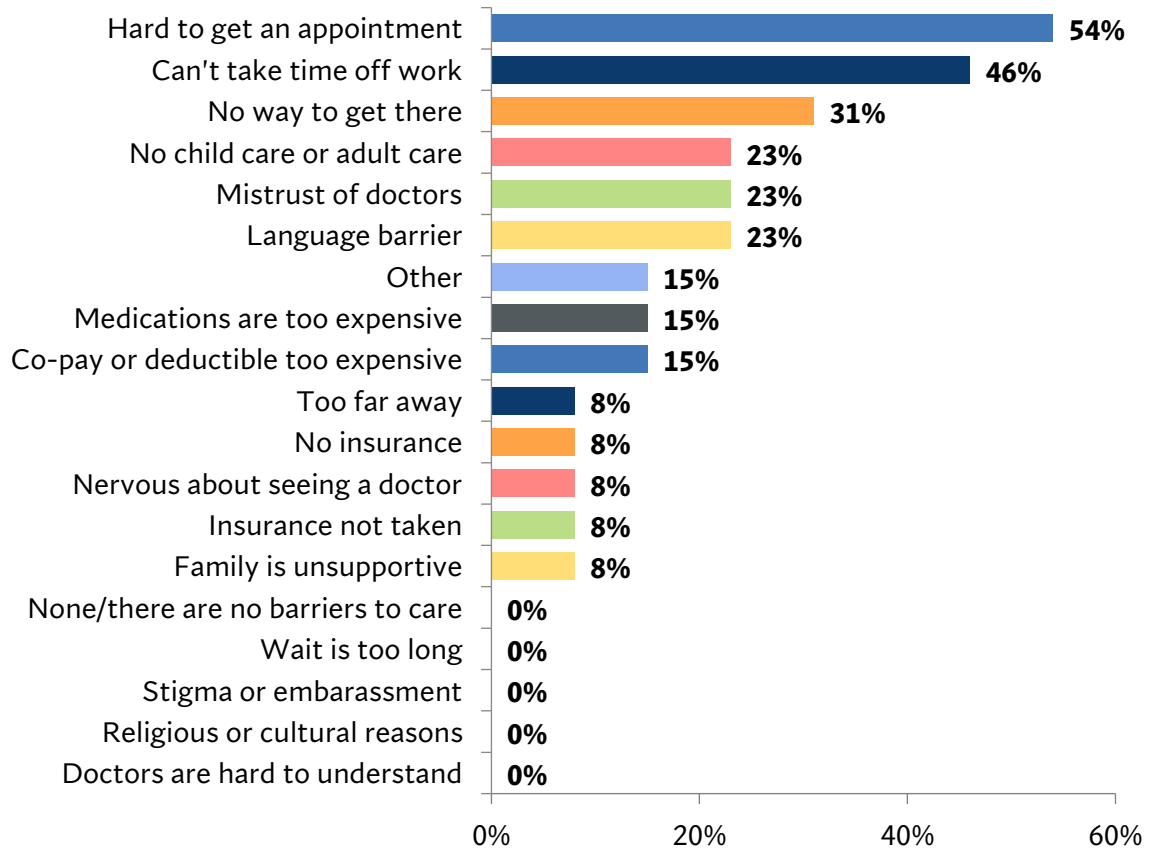
**In what way(s) has the health of the community you serve worsened?**

- “We had many clients who re-engaged with health care post-COVID and got diagnosed with new illnesses at later stages due to lack of screening during COVID. We also had existing clients with chronic conditions who were not managing them as well during COVID.”
- “There has been a notable rise in chronic diseases such as diabetes, hypertension, and heart disease. This increase is likely due to a combination of factors, including limited access to preventive care, unhealthy diets, and the stress associated with socioeconomic challenges.”
- “Decrease in affordable housing options and rental subsidy, increase in food insecurity, and decrease in free or affordable transportation.”

**Why do you think there has been no change in the health of the community?**

- “Many vulnerable homeless individuals with medical needs still presenting for our services”
- “We continue to observe high rates of Diabetes, High Blood Pressure, and mental health issues in throughout the city.”
- “Disparity data has remained unchanged or worsened”
- “The issues driving healthcare disparities are systemic. The poor health outcomes really are largely caused by the social determinants not being met for residents. And we need a systematic transformation of policies both public and within private institutions to ensure that community members have better access and redress to the social determinants they need.”

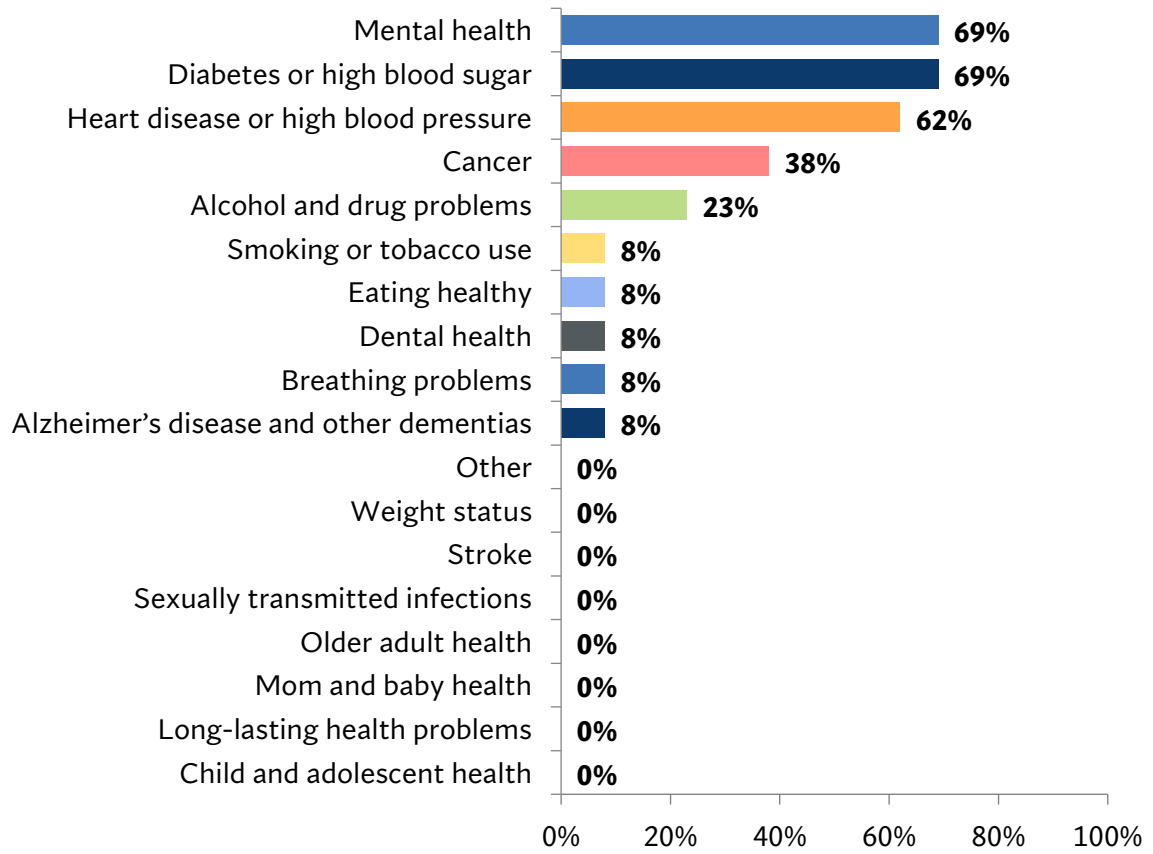
**Figure A2.59: What are the 3 main reasons people in your community don't get healthcare when they need it? (n=13)**



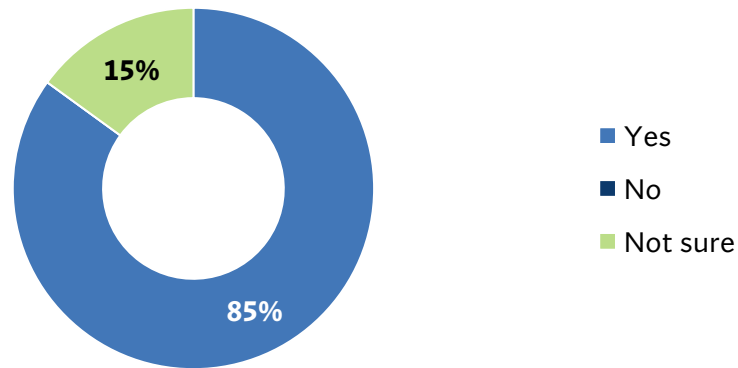
**“Other” answers include:**

- “Individuals who are homeless, difficulty navigating all systems”
- “They feel they have to prioritize other socio-economic needs, i.e. work, housing, etc.”

**Figure A2.60: What are the 3 biggest health problems in your community? (n=13)**



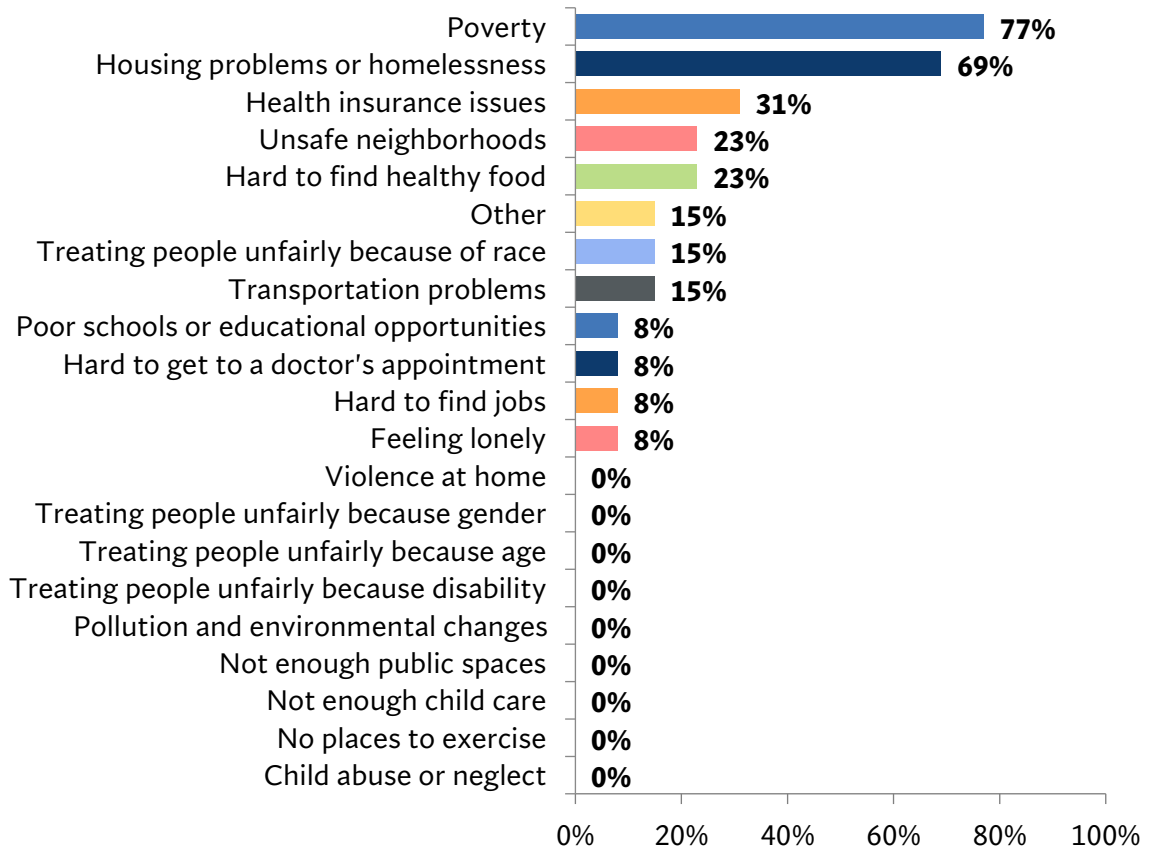
**Figure A2.61: Do you know any resources available in the community to address some of the health issues you identified in the previous question? (n=13)**



**If yes, please name at least one resource that could be leveraged.**

- “Respite care for homeless individuals”
- “Food & Friends-we’re in the business of addressing health problems through medically-tailored nutrition.”
- “Nonprofits such as Iona Senior Services do a good job with individuals with dementia (including a recent Federal grant), but more coordination is needed with other programs.”
- “Federally Qualified Health Centers”
- “Federally Qualified Health Centers, Community Health Workers, Social Service Agencies, one hospital”
- “My own agency, Bread for the City, provides services seeking to help address some of these ailments and access to services”
- “Our own clinic offers wrap around services addressing these issues. Access to specialty care when we need it is important, and we have several partnerships in place.”
- “MBI Mental Health Services, prevention network, Ralph Lauren Cancer Center (Georgetown), [Ward] Infinity Johns Hopkins”
- “Our Christ House medical staff works to improve our patients’ health, and our case managers work to get eligible benefits and housing.”
- “Area clinics, free senior wellness centers that offer lunch and wellness and educational activities, and free nutritious lunch at community dining sites.”

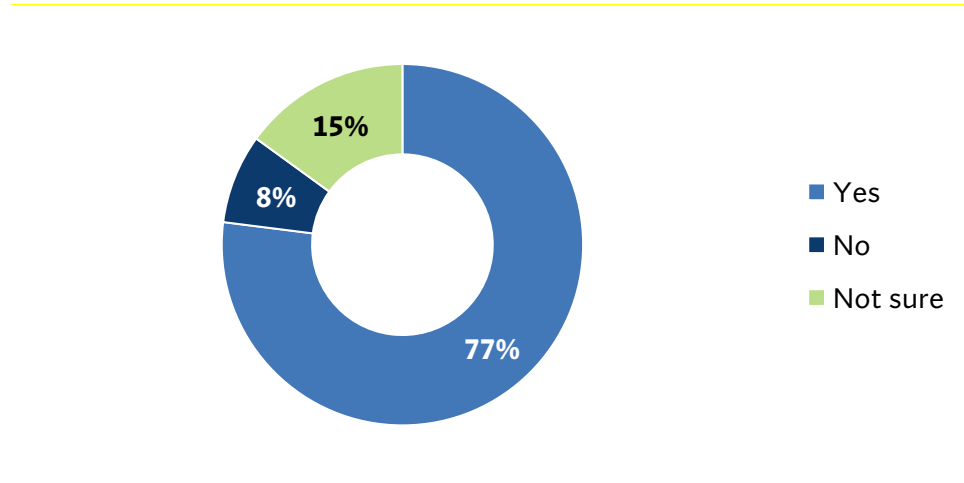
**Figure A2.62: What are the 3 biggest social and environmental problems that affect health in your community? (n=13)**



**“Other” answers include:**

- “Substance abuse”
- “Income and wealth inequality”

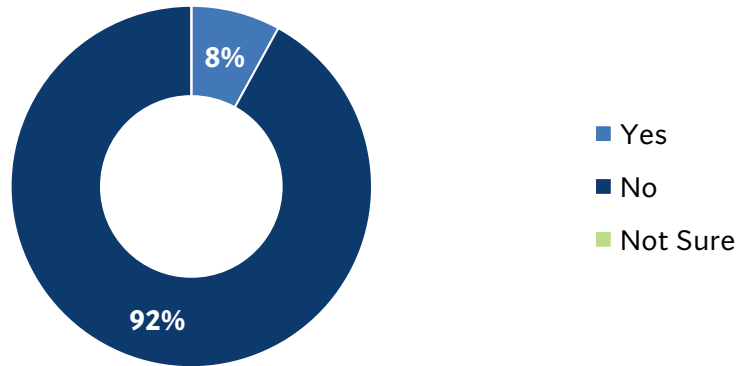
**Figure A2.63: Do you know any resources available in the community to address some of the social/environmental issues you identified in the previous question? (n=13)**



**If yes, please name at least one resource that could be leveraged.**

- “UnitedHealthcare homeless outreach”
- “United Planning Organization”
- “DC’s Emergency Rental Assistance Program, LIHEAP emergency utility assistance”
- “Many social service agencies”
- “I think that this City is wealthy enough to reform the tax system and share the wealth to address some of the disparities.”
- “ElectED DC, Education Forward DC, Marshall Heights CDO”
- “Christ House and Unity Health Care are two organizations that address these issues.”
- “Utilize the free nutritious meals at senior wellness centers and community dining sites and contact DACL and the DACL Lead Agencies for transportation opportunities.”

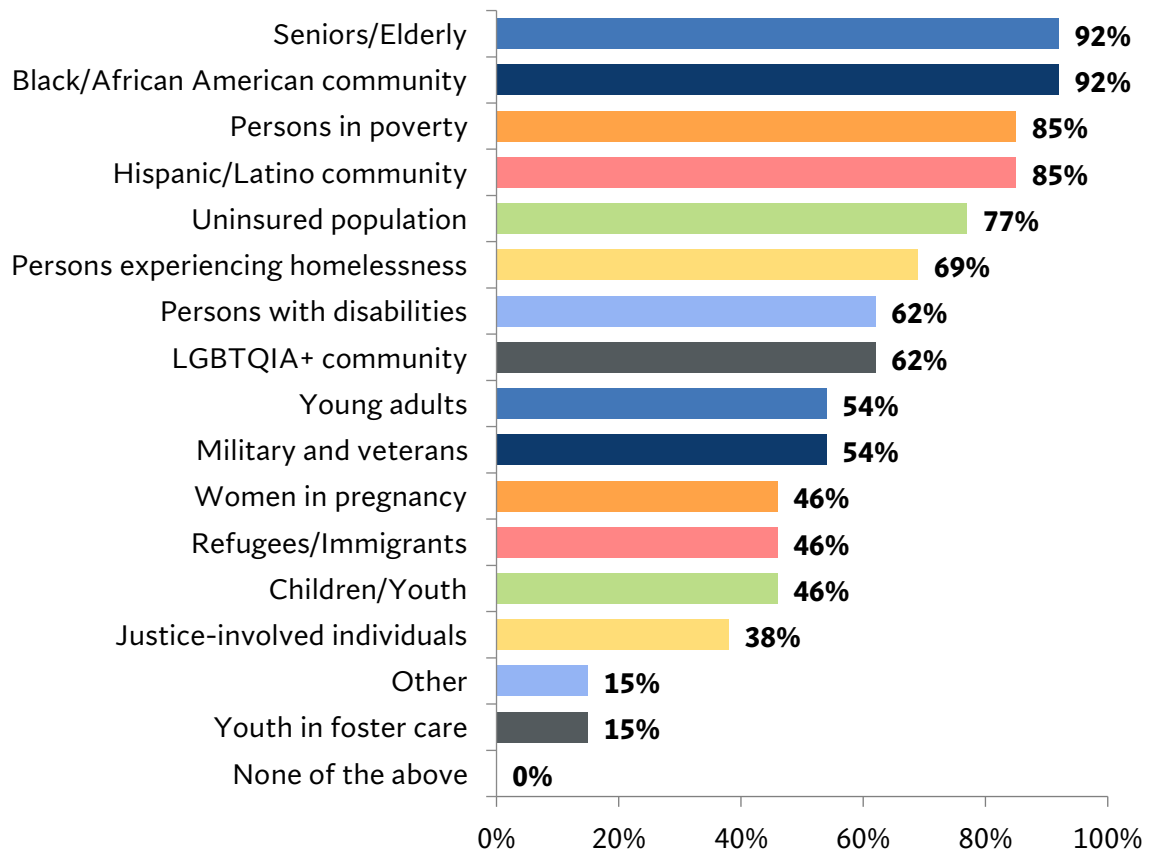
**Figure A2.64: In your opinion, are health and social/environmental needs similar across DC? (n=13)**



**Which ward or neighborhood do you feel experience the greatest level of need? (n=13)**

- East of the river
- Wards 8 and 7
- Wards 8, followed by 7, 5
- Wards 7 & 8 lack geographic access to health services
- Ward 8
- Ward 7 & 8
- Wards 7 & 8
- Wards 5, 7 & 8
- 7 and 8
- Wards 5, 6, 7, & 8
- The needs are insufficiently met in Wards 8, 7 and parts of 2 than in the other Wards in DC.

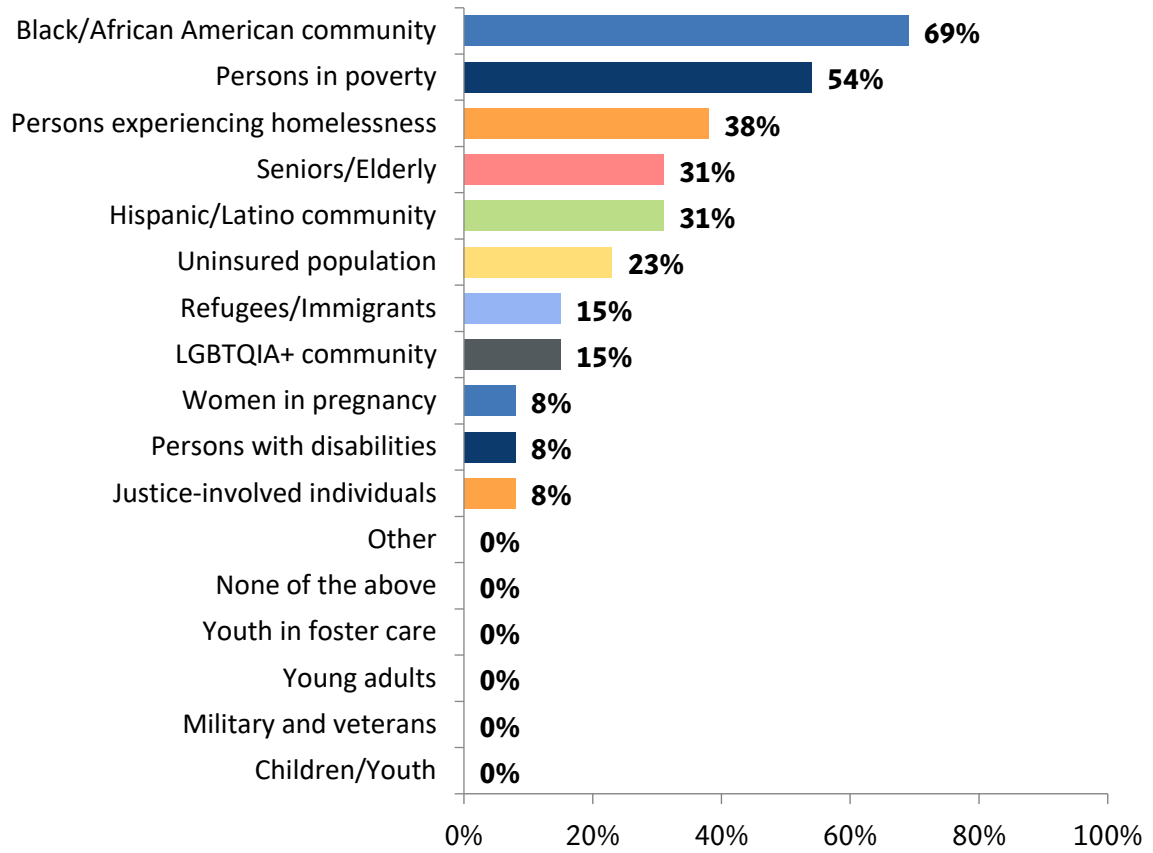
**Figure A2.65: Which subpopulation(s) on this list does your organization serve? (n=13)**



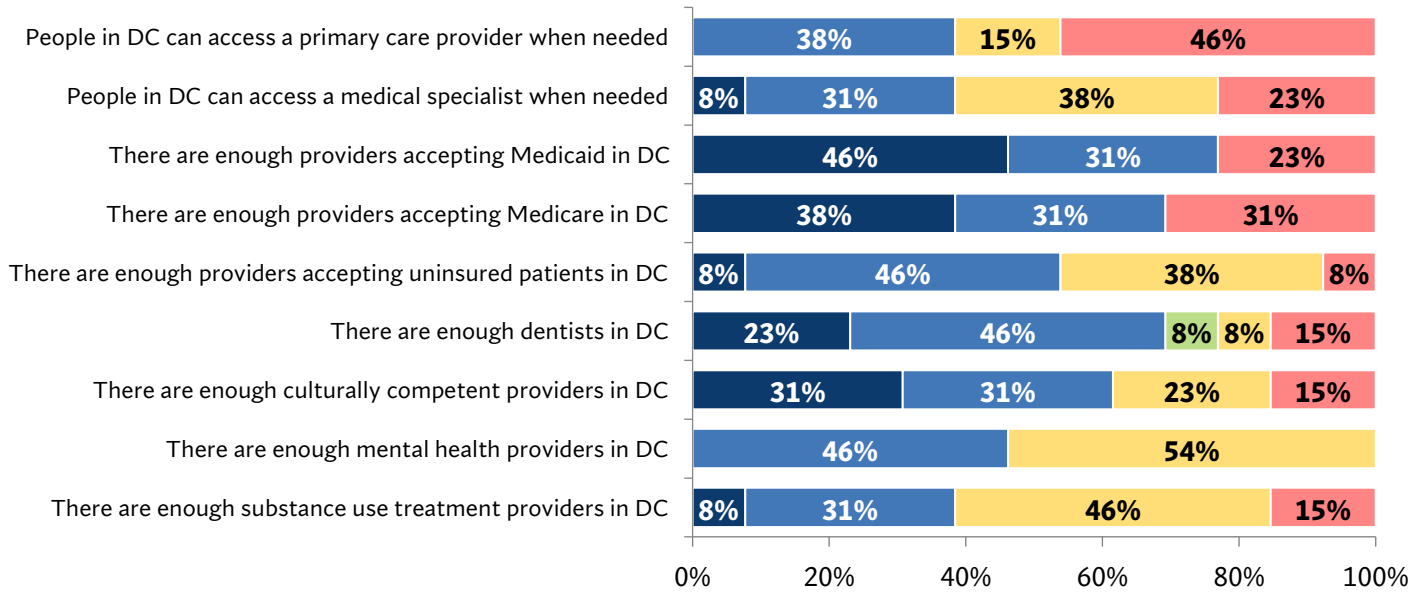
**“Other” answers include:**

- “All populations, but pregnant women & seniors make up large part of patient population”
- “Anyone else in need”

**Figure A2.66: Among those served by your organization, which subpopulation(s) appear to have the greatest unmet needs when it comes to health and social services? (n=13)**

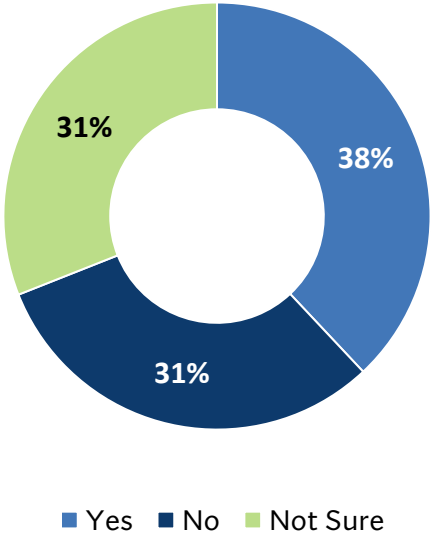


**Figure A2.67: Please rate each of the following statements for the community you serve: (n=13)**



■ Strongly Disagree 
 ■ Somewhat Disagree 
 ■ Neither Agree nor Disagree 
 ■ Somewhat Agree 
 ■ Strongly Agree

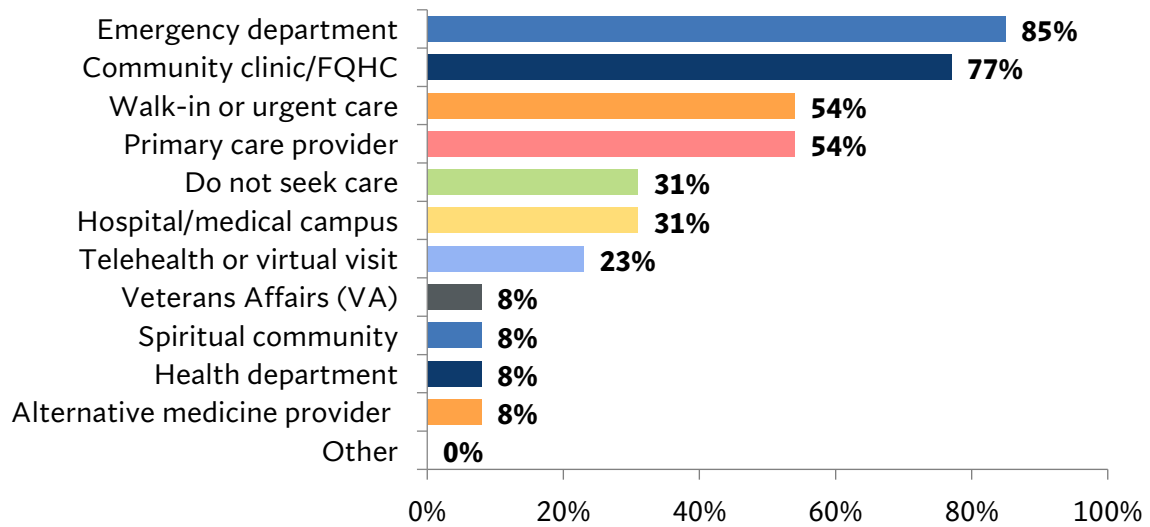
**Figure A2.68: Is there a subset of members in your community that do not trust the services you provide? (n=13)**



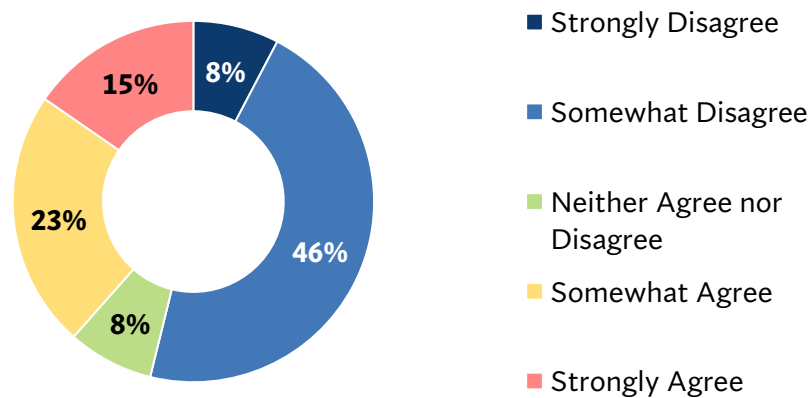
**If yes, please provide additional detail.**

- “Hispanic, undocumented residents”
- “Providers who do not look like their patients are less trusted, whether by race, language, gender, etc.”
- “Due to historical bias and racism many people from diverse backgrounds distrust the medical profession generally”
- “Many people of color just don't trust the system (systems) including non-profits like Bread for the City.”

**Figure A2.69: From the list provided, where do you feel members of the community you serve most frequently seek medical care? (n=13)**



**Figure A2.70: People in the community I serve have an understanding of health-related information when it is presented to them? (n=13)**



**If you disagree, what do you see as the biggest challenges or issues with health literacy among the population you serve?**

- “Understanding their conditions and medications”
- “Misinformation from the internet.”
- “Regardless of formal education, navigation thru the health system is difficult: understanding insurance (commercial, Medicaid/Medicare), what provider most helpful in specific situations, use of ED v. Urgent Care, etc.”
- “Language Barrier + Literacy Levels”
- “Misinformation”

- “Literacy, trust, consistent message and outreach, investment, cultural competency, who is the messenger, etc”
- “Lack of knowledge/education; substance abuse; confused state of mind”

**What suggestions do you have for the health leaders in your community to improve the health and well-being of people in DC?**

- “Easier access when an individual is sick to get in to be seen”
- “Provide more place-based mental health services in housing developments”
- “Better coordination with community-based organizations that address social determinants of health.”
- “Coordination among hospitals and other providers with community services, and navigators for all patients, regardless of illness or services needed. Services should include not only high quality health care (including telemedicine and home care), but also transportation, appropriate food, housing, and other social services. Assessments of patients/clients at admission/intake should be comprehensive, not just limited to the organization's primary focus.”
- “Provide universal access to health care and language access for immigrants and refugees.”
- “Diversify the medical professionals, quality customer service training, culturally competent care training, longer visits, referral resources, follow-up protocols post patient visit, primary care and specialty care coordination, mental health care services and professionals”
- “Continue to work to support community members/patients access the social determinants that account for 80% of health and wellness outcomes.”
- “Communication & training for older adults”
- “Advocate for policy, teach-in sessions, academia institutions partnering with FBOs (Faith Based Organizations) and CBOs (Community Based Organizations)”
- “Investment in infrastructure, outreach and messaging, accessibility, advocacy, environmental change”
- “Greater acceptance of non-insured/Medicaid patients”
- “Conduct as much outreach as possible to educate residents about local resources.”

**Are there questions you wish we had asked?**

- “No” (5)
- “No. Thank you.”
- “What healthcare services you have received within the last 12 months”
- “Do providers know of mental health and substance use services to refer patients?”
- “How health providers work collaboratively with community orgs to effectively serve those in need?”
- “Comprehensive coordination care”
- “Who is working on a payment model so that FBOs (Faith Based Organizations) and CBOs (Community Based Organizations) can get direct payments to build capacity?”

# Community Focus Groups






Key findings and quotes from each of the focus groups are summarized below.

## Ward 1 Focus Group

The Ward 1 Focus Group took place on January 28, 2025, at Shiloh Baptist Church. The focus group was attended by seven community members.

### Notable Quotes and High-Level Findings from Ward 1

<p><i>“The hospital can provide the interpretation services, but if the patient doesn’t know where to go, what to do or how insurance work”</i></p> <p>- Ward 1 Resident</p>	<p><i>“I demand you respect me; you advocate for me, or you are not my doctor.”</i></p> <p>- Ward 1 Resident</p>
--	--

	<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Language and cultural barriers are a concern.</li> <li>• Better system navigation and coordination is needed.</li> </ul>
	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Strong engagement and organized activities.</li> <li>• Active senior programs, including Club Memory®.</li> <li>• Multiple healthcare resources/facilities.</li> </ul>
	<p><b>Healthcare and Wellness</b></p> <ul style="list-style-type: none"> <li>• Diabetes, mental health and substance use.</li> <li>• Need more emphasis on prevention</li> </ul>
	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Hospitals could improve coordination, collaboration and information sharing.</li> <li>• Patients believe trust and respect in the provider relationship is crucial.</li> <li>• Emphasized the need for patient self-advocacy.</li> </ul>
	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Housing is an issue, specifically due to gentrification and mixed-income housing challenges.</li> <li>• Neighborhood safety and workforce development need improvement.</li> </ul>

## More Detailed Findings from Ward 1

### Access to Care

#### Cultural Access and System Navigation

- Language and system navigation are significant barriers for Latino and Amharic-speaking communities
- Even when interpretation services are available, patients struggle to understand insurance, how to access care, and where to go
- Cultural taboos affect health screening participation, particularly for Hispanic/Latino males regarding STD and cancer screenings
- Word of mouth is noted as an important communication channel in these communities

#### Service Coordination

- Mobile health units visit neighborhoods, but Latino communities often don't understand where these services come from
- Outreach to explain "the basics" of healthcare access is recommended
- Some improvements are occurring, such as the addition of three African language interpreters at Bread for the City

#### Availability of Services

- Positive experiences reported with LGBTQ and mental health services at Whitman Walker Health
- Sibley Hospital described as welcoming

### Community Assets

#### Social Capital

- Strong community engagement evidenced by organized neighborhood clean-ups
- Community members take care of stray cats, indicating grassroots cooperation
- Increased sense of connection reported since the pandemic
- Historical context of community activism in response to loitering and drug activity

#### Community Programs

- DC described as "a great place for seniors to live"
- Club Memory® program highlighted as a valuable resource
- Seniors "walk and talk" program mentioned as upcoming
- Howard's stretch outreach center praised for making "a huge difference"

#### Healthcare Resources

- Multiple community-based health centers available: Bread for the City, Mary's Center, Howard
- Need identified for better collaboration among hospitals, particularly to benefit low-income residents

- Some discussion of hospital capacity issues, noting Providence Hospital closure and overcrowding at Howard

## Health and Wellness

### Physical Health Conditions

- Diabetes identified as a significant health issue in the Hispanic/Latino community
- Cancer reported as less prevalent in the Hispanic/Latino community, though one resident shared a personal experience with prostate cancer
- Need identified for more communication among men about cancer screening

### Mental Health

- Depression mentioned as a major health issue in the District

### Substance Use

- Alcoholism and drugs cited as major health problems in the District

## Healthcare Experience

### Provider Relationships

- Strong emphasis on establishing relationships with doctors
- Concern that provider computer use during visits hinders relationship building

### Care Quality

- Perception of an "iron gate" around Sibley Hospital
- Residents know how to "get through the gate" at Georgetown and Howard
- Desire expressed for "the best healthcare in the nation"
- Questions raised about Sibley's reputation after Johns Hopkins affiliation
- One participant shared negative experience at Sibley during the pandemic, citing facility issues (dirty floors)

### Patient Empowerment

- Strong focus on self-advocacy with examples like "I demand that you respect me" and "You advocate for me or you are not my doctor"
- One resident shared a story of successful self-advocacy regarding medication at their preferred pharmacy, noting "Money talks"

### Care Coordination

- Need identified for continued development of collaboration among providers
- Specific mention of collaboration regarding Protected Health Information (PHI) and care information sharing
- Historical reference that care coordination is "not as tight as it used to be"

- Past collaboration that has since stopped would have been helpful for a community member who experienced leg amputation

### **Provider Communication**

- One resident reported positive experience with concierge primary care practice
- Focus on hospital rankings for specific services important to some residents

### **Cultural Responsiveness**

- Strong emphasis on respect and trust as priorities in healthcare interactions

## **Social and Environmental Determinants of Health**

### **Housing**

- Shaw neighborhood has many abandoned and vacant properties
- Need identified to transform and develop affordable housing to keep residents in DC
- Housing issues noted to shift throughout the city due to gentrification
- Mixed-income building in Dupont Circle created safety concerns for low-income residents due to violence, drugs, and weapons
- Large homeless population noted at 7th & T Street in Shaw

### **Economic Stability**

- Section 8 program described as "well-intended" but not meeting all needs
- Gap identified in workforce support related to housing programs

### **Community Safety**

- Clear division noted west of 16th Street with "little diversity"
- Ongoing challenge regarding placement of low-income individuals of color
- Recognition that all families want similar things: good schools, safe neighborhoods

### **Social and Community Context**





- Unhoused population often needs medical services
- Homeless shelters described as not providing adequate conditions or safety
- Some residents prefer staying on streets rather than in shelters

## Ward 4 Focus Group

The Ward 4 Focus Group took place on January 28, 2025, at Mary’s Center in Petworth. The focus group was attended by nine community members.

### Notable Quotes and High-Level Findings from Ward 4

<p><i>“I feel like there’s not an equal distribution of investment in our community to keep our community safe and keep it clean”</i></p> <p>- Ward 4 Resident</p>	<p><i>“Violence disproportionately effects younger black individuals. Younger children are getting into violent crimes.”</i></p> <p>- Ward 4 Resident</p>
<p><i>“It’s expensive being poor.”</i></p> <p>- Ward 4 Resident</p>	

	<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Lack of access to pharmacy services, urgent care.</li> <li>• Technology barriers for older residents.</li> <li>• Perceptions about resource privileges affecting care access and limited awareness of resources available.</li> <li>• Language and cultural barriers.</li> </ul>
	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Strong neighborhood diversity, cross-generational community makeup.</li> <li>• Active citizen associations.</li> <li>• Strong support network of nonprofit organizations.</li> </ul>
	<p><b>Healthcare and Wellness</b></p> <ul style="list-style-type: none"> <li>• Maternal health issues, especially for black women.</li> <li>• Mental health challenges, particularly among the unhoused.</li> <li>• Diabetes, asthma, and allergies.</li> <li>• Substance use disorder and addiction.</li> </ul>
	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Mixed experiences with hospitals.</li> <li>• Diversity of providers, specifically mental health providers, is needed.</li> </ul>



### **Social and Environmental Factors**

- Food access challenges, despite new Whole Foods.
- Housing affordability and homelessness.
- Transportation reliability.
- Violence and crime, disproportionately distributed in the Ward.
- Environmental issues like pollution, smoke, and traffic.

## **More Detailed Findings from Ward 4**

### **Access to Care**

#### **Availability of Services**

- Significant pharmacy access issues since 2020, with Target and CVS closing pharmacies
- No 24/7 pharmacies available in DC, requiring residents to drive to Maryland or Virginia for overnight needs
- CVS closed minute clinics, limiting access to primary and urgent care
- No urgent care facilities in the area, requiring travel to Maryland or other parts of DC
- Geographic distribution issues with services concentrated in certain areas

#### **Digital Access**

- Generational issues affect access to healthcare, particularly for older residents who struggle with technology requirements for pre-registration and other digital processes

#### **Geographic Access**

- Health resource locations can be difficult to find or access
- Transportation to social services or government offices is challenging due to expensive parking garages
- Cross-jurisdictional care seeking is common, with residents traveling to Maryland or Virginia

#### **Cultural Access**

- Documentation status is a barrier, with concerns that undocumented individuals avoid seeking care due to fears of ICE raids on medical facilities
- One Latina resident noted difficulty finding a Latina mental health provider with cultural competence
- Language and cultural taboos (like health STD and cancer screening) exist for Hispanic population

#### **Financial Access**

- Acknowledgment that accessing desired healthcare requires privilege in terms of insurance, transportation, and other resources
- Lack of insurance identified as a primary barrier to seeking healthcare.

## Community Assets

### Social Capital

- Strong neighborhood communication with police department
- Mutual aid and community camaraderie through Facebook groups and neighbors looking out for one another
- Neighborhood diversity valued, with interracial families, seniors who raised children, younger new families, and working adults
- Friendly environment noted as a community strength
- Support networks identified as important community assets

### Community Organizations

- Very active citizens associations in Shepherd Park and Colonial Park neighborhoods
- Community organizations provide essential support for vulnerable populations

### Community Programs

- Department of Parks and Recreation (DPR) offers courses, but they are often canceled or changed
- DPR noted as the most financially accessible option but described as unreliable
- High competition for class enrollment mentioned as a barrier
- Educational programs, webinars, and activities for seniors highlighted as beneficial

## Health and Wellness

### Violence and Safety Impact

- Violence disproportionately affects younger Black individuals
- Observations of younger children (middle to high school age) involved in violent crimes, including gun possession
- Increase in violent crimes including gun violence, robberies, and stabbings noted

### Population Health Disparities

- Maternal health disparities highlighted, with one participant stating she deliberately delivered her children outside DC due to concerns about maternal mortality statistics for Black women

### Health Conditions

- Diabetes identified as a prevalent health concern in the Hispanic/Latino community
- Mental health issues, particularly among the homeless
- Easy access to drugs and substance abuse cited as significant concerns

## Healthcare Experience

### System Navigation Experience

- Healthcare coordination described as difficult, with administrative hassles
- System navigation challenges reported, particularly with insurance issues
- Washington Hospital Center described as not having a strong reputation
- Providence Hospital closure noted as creating access issues for that area

### Care Quality

- Mixed experiences with different hospitals:
  - "Extraordinary care at Sibley" reported by one participant with another praising specialty care
  - Georgetown and Howard described as "go-to" providers with "excellent" doctors
  - Concerns that Howard University has not opened facilities in Walter Reed's former space
  - Observation that Medicaid and Medicare patients have difficulty accessing care, with easier experiences reported at Howard compared to Sibley (which was described as "very expensive")
- One Medical praised for referral connections with MedStar and virtual care offerings
- Overall satisfaction with quality of care when it is accessible

## Social and Environmental Determinants of Health

### Food Security and Access

- Access to grocery stores requires a car in many cases
- Whole Foods now available but many neighborhood residents are priced out
- Sanitation issues reported at local Safeway
- Food insecurity evidenced by people lining up for food in the middle of the day, which creates employment barriers
- Food access issues disproportionately affect Latino families, particularly matriarchal Latino families
- Latino communities more severely affected by COVID (as essential workers), with families needing additional support after losing family members during the pandemic

### Community Safety

- Increase in violent crimes noted, including around the Walter Reed area
- Shepherd Park, previously isolated, experiencing more violence as the barrier of the shut-down Walter Reed space changes

### Transportation Systems

- Metro described as unreliable, not always arriving on time
- Residents report driving neighbors to medical appointments due to transportation barriers

## **Housing**

- African Americans losing homes due to rising prices
- Latino and immigrant communities also affected by housing affordability issues
- Limited affordable housing with increasing housing costs and taxes
- Concerns about condominium development ("the condos are taking over")
- Recommendation for policy changes to require developers to reinvest in the community
- Expressed concern about the growing number of homeless individuals

## **Environmental Conditions**

- Ward 4 described as "particularly dirty"
- Environmental factors such as smoke, traffic, and pollution that affect respiratory health
- Fewer old growth trees resulting in higher summer electric bills
- Limited access to Rock Creek Park and restricted walkability/paths
- Perception that Ward 4 receives less attention than Northwest DC west of Rock Creek Park
- Inequitable distribution of investment to maintain community safety and cleanliness
- Ward 4 described as being in the middle economically - not qualifying as a high-poverty ward but lacking the wealth to reinvest in the community

## **Economic Stability**

- Concerns about development patterns, referencing Southwest Waterfront development as unsustainable
- Inability to sustain increasing prices
- Observation that mobility and wellness correlate with ability to access services
- Quote: "It's expensive being poor"

## Ward 5 Focus Group

The Ward 5 Focus Group took place on January 30, 2025, at Bethesda Baptist Church. The focus group was attended by 12 community members.

### Notable Quotes and High-Level Findings from Ward 5

*“People tend to determine if you are African American or not by the sound of your voice or the vernacular that you use...I’ve had a number of bad experiences when it comes to the healthcare system. I have been treated as if I’m not a person, I’m just a number...”*

– Ward 5 Resident



#### Access to Care

- Impact of Providence Hospital closure has negatively affected community.
- System navigation challenges, especially for seniors.
- Digital barriers to accessing care.



#### Community Assets

- Strong generational connections and long-term residents.
- Diverse neighborhoods with active civic associations.



#### Healthcare and Wellness

- Maternal health issues.
- Mental health challenges related to poverty.



#### Healthcare Experience

- Discrimination and racism in the healthcare setting.
- Varying experiences with the quality and cultural competency of providers.
- Transactional instead of holistic healthcare experiences.



#### Social and Environmental Factors

- Environmental justice and health impacts of industry, like air pollution.
- Transportation cost barriers.

## More Detailed Findings from Ward 5

### Access to Care

#### Geographic Access

- Concerns about healthcare and emergency services access being obstructed by development in the ward
- Development adding more population to an area with already limited access
- Hospitals not located in highly populated geographic areas of the district
- Providence Hospital closure described as "devastating to the community"

#### System Navigation

- Traffic and infrastructure challenges affecting access, including changing addresses and difficulties finding homes
- "Hard to find information even if you're looking for it"
- "Hard to access the things that are available"
- Knowledge gap: residents "don't know how to access what is available to them"

#### Digital Access

- Ageism and digital barriers mentioned as access challenges, particularly for older residents
- Strong sentiment that "computers do not replace people"

#### Financial Access

- Affordability of treatments identified as a barrier
- Income noted as a factor in system navigation
- Emergency department used for conditions that could be prevented with better access
- Public transportation described as "cost prohibitive" and "not convenient" for appointments

#### Availability of Services

- Employment constraints: residents "can't take PTO so they use emergency rooms as access points"
- Appointment availability limitations
- Challenges working through all care needs within one system
- Long waitlists for specialists
- Observation that private practices "no longer seem to exist," increasing reliance on emergency systems not available in the area

### Community Assets

#### Social Capital

- Strong emphasis on "caring and looking out for one another, camaraderie"
- Diverse people and types of neighborhoods/offering

- Long-term residents described as "a foundation of the Ward"
- Evolution with younger generations noted
- Generational connections: "People know and love each other, it's generational -- families stay"
- Active civic associations that "work well with city leaders and community"

### **Healthcare Resources**

- Call to "reopen Providence Hospital -- 'it's criminal that it's closed'"
- Recommendation for workforce recruitment, particularly local recruitment from universities

## **Health and Wellness**

### **Mental Health**

- "Mental health crises" linked to poverty: "below poverty line, not making minimum wage"

### **Population Health Disparities**

- Maternal healthcare described as "not good" with varying experiences
- Ward 5 described as "worse off than some wards, but not compared to Ward 7/8"
- Environmental concerns about Ward 5 and cancer rates

### **Health Prevention/Wellness**

- Emphasis on preventive care and its importance
- Recognition that "schools do a good job of ensuring access to things like vaccines"

## **Healthcare Experience**

### **Care Quality**

- Staffing/workforce issues resulting in long wait times
- Providence Hospital closure described as "devastating" with problematic patient flow and gaps in access
- Observation that "people with access to concierge medicine get better care"
- Care equity concerns: "Don't give us less than what we'd get if we lived in Ward 3"
- Recommendation for "more support/integration between traditional and naturalist medicine"

### **System Navigation Experience**

- "'Suffering in silence' -- basic customer service, coordination, lack of knowledge of how to navigate the system"
- Frustration that "computers do not replace people"

### **Discrimination and Bias**

- Racism described as impacting access to care
- Experiences of being judged "based on voice, color of skin, treated as a number"
- "Lack of care, lack of attention -- not believed by providers, needs an advocate"
- Perception that providers assume patients are "drug seeking" and are there "to brutalize, not support, to dismiss"

### **Provider Relationships**

- Powerful statement: "CARE -- care has been removed. Care about the people has been removed. We are individuals/people, not data"

## **Social and Environmental Determinants of Health**

### **Environmental Conditions**

- "Environmental challenges -- trash station, bus station, industrial/pollution, traffic"
- Ward 5 noted as the "only ward zoned for industry"
- "Development and new businesses are changing the neighborhoods, not conducive to the health of the neighborhood"
- Environmental concerns linked to cancer rates
- Issues with trash, rodents ("they are walking the streets with you"), and pet waste
- Observation about "income impacts on the wards -- the investment in greenspaces is not here"

### **Social and Community Context**

- "Changes in quality of life affecting ability to age in place"

### **Transportation Systems**

- Public transportation described as "cost prohibitive, not convenient at times to get to appointments"

### **Economic Stability**

- Mental health crises linked to being "below poverty line, not making minimum wage"
- "Income impacts on the wards" affecting investment in greenspaces

## Ward 7 Focus Group

The Ward 7 Focus Group took place on January 29, 2025, at East Washington Heights Baptist Church. The focus group was attended by seven community members.’

### Notable Quotes and High-Level Findings from Ward 7

<p><i>“Give us more than 20 minutes and a prescription. Take a wholistic approach.”</i></p> <p>– Ward 7 Resident</p>	<p><i>“[our] neighborhood was built by black people for black people.”</i></p> <p>– Ward 7 Resident</p>	<p><i>“You hear a lot of negative things about southeast, but I quickly shut them down. I love southeast.”</i></p> <p>– Ward 7 Resident</p>
--	---	---

	<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• No hospitals and limited urgent care in the community.</li> <li>• Travel across town required to access care.</li> </ul>
	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Pride in neighborhood and historical black community.</li> <li>• Schools are community anchors.</li> </ul>
	<p><b>Healthcare and Wellness</b></p> <ul style="list-style-type: none"> <li>• Increasing mental health needs for youth and seniors.</li> <li>• Dementia and aging concerns.</li> <li>• Substance use affecting community.</li> </ul>
	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Emphasized the need for self-advocacy.</li> <li>• Communication issues with providers.</li> <li>• Poor experiences with home health services.</li> </ul>
	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Low quality grocery stores limit food access.</li> <li>• Beautiful green spaces, but physical activity and exercise limitations due to safety concerns.</li> <li>• High concentration of subsidized housing.</li> </ul>

## More Detailed Findings from Ward 7

### Access to Care

#### Geographic Access

- Significant hospital access gap: "No hospitals in the northeast"
- Residents must travel "across town for healthcare" with facilities described as "crowded"
- Some residents report "driving far across town to go to Sibley" Hospital
- Limited urgent care availability: "I don't even know if we have any real urgent care(s)"

#### Availability of Services

- Howard noted as having "a few primary care practices"
- United mentioned as having "opened up a practice"
- Limited healthcare options requiring travel to other areas of the city

#### System Navigation

- Challenges understanding "coverage and entitlements"
- Personal example shared of an "81 [year old] living with metastatic cancer" who "lives alone in 4 story house and cannot get help"

### Community Assets

#### Social Capital

- Strong community pride: "I love ward 7. I love houses. I love the community. I love the people."
- Defense against negative perceptions: "You hear a lot of negative things about southeast, but I quickly shut them down. I love southeast."
- Historical context: "Neighborhood was built by black people for black people"
- Value comparison: "If you picked up Ward 7 and put it in Ward 1 it would be worth millions of dollars"
- Quiet, residential character with "friendly neighbors"
- Strong community bonds: "We always look out for each other"

#### Physical Environment Assets

- "Beautiful green space"
- Urban-suburban mix: "Like being in the 'suburbs' of DC"

#### Community Organizations

- Educational assets: "20ish schools in Ward 7 and many productive initiatives"

#### Community Programs

- Limited recreation center activities
- Programs "geared more to children than older adults"

## Health and Wellness

### **Mental Health**

- "Not doing enough to meet the needs of mental health issues that are impacting youngsters and seniors"

### **Physical Health Conditions**

- Aging concerns, specifically dementia
- Diabetes linked to food environment: "sugary and processed foods are impacting health of residents"

### **Substance Use**

- "Alcoholism and substance use" prevalent
- Neighbors described as "struggling and look like 'life has beat them down'"
- Belief that "neighbors are self-medicating through drugs and alcohol"
- Observation of these issues "in their own families"

### **Population Health Disparities**

- Health problems concentrated in "public housing communities"
- Historical improvement noted: "used to be worse in these areas but has improved"
- Reference to Benning Terrace neighborhood (formerly called "simple city") affected by these health problems
- "Chronic conditions affect older residents"
- Importance of "educating children on making healthy choices"

### **Health Prevention/Wellness**

- "Limited promotion of healthy activity in the Ward"

## Healthcare Experience

### **Care Quality**

- Residents report "being afraid to go home post-discharge because of lack of healthcare nearby"
- Positive response to "Blue Rock Care which is new to the area" that "keeps people engaged and taking care of themselves" through "weekly zoom calls"
- "Poor experiences with home health aid services"
- Concern that "nursing staff many places are not up to par"

### **Patient Empowerment**

- Emphasis that one "must be a self-advocate for medical care and needs"

### **Provider Communication**

- "Poor experience at Washington Hospital Center" involving "lack of communication and attention to patient's needs"
- "They do not listen to you. They do not pay attention to you"
- Perception that "physicians just want to write scripts and not listen to you"
- Request: "Give us more than 20 minutes and a prescription. Take a holistic approach"

### **Provider Relationships**

- Desire for "medical providers to listen, understand the community and care about the community"

## **Social and Environmental Determinants of Health**

### **Housing**

- "Ward 7 has the highest number of subsidized housing communities"

### **Food Security and Access**

- Strongly negative assessment: "Food selection around here is atrocious" regarding grocery stores and restaurants
- Quality concerns: "Safeway grocery store has gone downhill"
- Residents report "going to Capitol Hill to buy groceries"
- Poor conditions: "Moldy meat and sticky floors" with one resident reporting "wanting to cry in the grocery store"
- "Neighborhood Lidl is not up to par with other Lidl grocery stores. No fresh fruits and vegetables"
- Closure of healthy options: "Yes Organic market closed in the area"
- Dissatisfaction that "no healthy options in new Penn Branch shopping centers"
- Economic barriers: "Healthy food selection is not available because many of the clientele in the neighborhood cannot afford it"
- Systemic barriers creating a "Catch 22 situation" where "the issue perpetuates, and residents eat unhealthy food"
- Observation of "many families with only processed food in grocery cart"

### **Community Safety**

- "Residents feel unsafe going on walks"
- Specific fears about "stray dogs or having her dogs taken"

### **Social and Community Context**






- "Low sense of community activism in Ward"
- "Complaint amongst ourselves, but do little to make it better"
- "There are not enough squeaky wheels in Ward 7"

## Ward 8 Focus Group

The Ward 8 Focus Group took place on January 29, 2025 at Brighter Day Ministries. The focus group was attended by 10 community members.

### Notable Quotes and High-Level Findings from Ward 8

<p><i>“I love it here. [a lot of people think] woe is Ward 8, but there are great authentic people.”</i></p> <p>– Ward 8 Resident</p>	<p><i>“...[speaking about housing quality] despair brings about chaos... it’s a cycle, its generational.”</i></p> <p>– Ward 8 Resident</p>	<p><i>““Everybody you know over the age of 45 is on some kind of medication.”</i></p> <p>– Ward 8 Resident</p>
---	--	--

	<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Preventative services and healthcare services are not accessible but look forward to new hospital opening.</li> <li>• Don’t know service available because poor outreach.</li> </ul>
	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• Strong community relationships with active leaders.</li> <li>• Community gardens and houses with yards.</li> </ul>
	<p><b>Healthcare and Wellness</b></p> <ul style="list-style-type: none"> <li>• Mental health issues are disproportionately affecting youth and elders.</li> <li>• Mental health is impacted by presence of violence.</li> </ul>
	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Value provider authenticity.</li> <li>• Historical mistrust of healthcare system due to quality assurance concerns.</li> <li>• Desire more care integration.</li> </ul>
	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Poor living conditions in affordable housing.</li> <li>• Limited employment opportunities lead to generational poverty.</li> <li>• Limited recreational facilities and poor walkability.</li> </ul>

## More Detailed Findings from Ward 8

### Access to Care

#### Availability of Services

- Significant provider gap: "Participants do not feel like there are doctors or mental health providers in Ward 8"
- Recent opening of Whitman-Walker offering mental health, dental, and primary care services
- Preventative services described as "not accessible," specifically primary care and healthy foods
- Recent opening of an urgent care facility, primarily used by seniors

#### System Navigation

- "Residents do not understand what insurance covers"
- "People do not know what is available to them"
- Limited knowledge of available services - "poor marketing and outreach, especially compared to other Wards"
- Reluctance to call 911 expressed
- Focus group revealed that "participants do not know of resources available" despite the existence of resources

### Community Assets

#### Social Capital

- Strong sense of community: "Great community in Ward 8... built on great relationships"
- Comparison to other areas: "Didn't feel same sense of community in other neighborhoods in DC"
- Historical completeness: "At one point, Ward 8 had everything you needed"
- Pride in community: "I love it here"
- Recognition of negative perceptions: "A lot of time is woe ward 8" contrasted with reality of "great authentic people"
- Discomfort in other areas: "Feel disjointed in northwest"
- Long-term residence: Multiple participants have lived in the area for decades (since 1956, 1974, 25+ years, 32 years, 50+ years, since birth)

#### Physical Environment Assets

- Gardening opportunities: "Can grow a garden in the front yard"
- Community sharing: "People share their gardens, seeds, etc."

#### Community Leadership

- Community gardens advocacy: "One participant is a huge advocate for community gardens"
- Initiative to "develop community gardens in neighborhood to provide healthy options"

- Emphasis on grassroots approaches: "Consistency brings the heart my brother!"
- Call for community investment: "Invest in us" through community ambassador model
- Need for "real advisory councils to see what is and is not working"
- Challenges with engagement: "difficult to get people to do this in Ward 8 because fear of getting shot"

### **Community Programs**

- Inequitable service distribution: "DPR does not offer services equally across the Wards, especially children's services"

## **Health and Wellness**

### **Physical Health Conditions**

- Diabetes and cancer identified as prevalent conditions
- "Limited obesity (lots of walking), but high rates of hypertension"
- Medication prevalence: "Everybody you know over the age of 45 is on some kind of medication"

### **Mental Health**

- Identified as a "big issue for young people and elders"
- Stressors identified as things "you cannot control -- culture, skin color"
- Need expressed for "someone to talk to"
- Connection made between mental health and violence

### **Violence and Safety Impact**

- Specific demographic impact: "Violence: young men and teenage girls impacted -- 'we are losing them'"
- Belief that "mental health and violence are related"

### **Population Health Disparities**

- Generational impact: "Grandmas are most affected because that is where the kids end up in the end"
- Economic dimension: "Difficult for grandmothers because likely on a fixed income"
- Ward demographics: "Huge population of seniors in Ward 8 taking care of their families"
- Child vulnerability: "Kids are heavily impacted by these health issues 'because they have no say so'"
- Concerns about "youth utilizing unsupervised technology"
- Reduced outdoor play: "Kids do not play outside as much anymore. Parks are locked up"

## **Healthcare Experience**

### **System Navigation Experience**

- System fragmentation: "Resources exist but lack of coordination and dissemination of information"
- Information barriers evident from focus group: participants "do not know of resources available"

### **Care Coordination**

- System integration needed: "Lacking comprehensive healthcare system that integrates all of these things"
- Holistic approach advocated: "Healthy lifestyle means thinking beyond the hospital"

### **Cultural Responsiveness**

- Historical mistrust: "Black folks do not trust healthcare industry because of the history"

### **Care Quality**

- Need for "quality assurance on healthcare providers coming in"
- Concern that some resources "are not providing follow up care, have enough capacity, etc."
- Criticism of healthcare focus: "focuses on the sick part (where the money is) and not the wellness part"

### **Provider Relationships**

- Emphasis on authentic care: "People know if you care about them"
- Desire for providers who "care and do not just come because of the job"

## **Social and Environmental Determinants of Health**

### **Food Security and Access**

- Severe limitations: "No access to healthy foods in Ward 8. Food deserts."
- Predominance of "convenience / corner stores"
- Economic constraints: "Many families are of SNAP benefits and run out before the month"

### **Housing**

- Poor conditions in affordable housing: "holes in the wall, mold"
- Management issues: "Slumlords are not managing properties well"
- Rights emphasis: "Even if people are getting federal assistance, they still have a right to safe housing"
- Cycle of disadvantage: "Despair brings about chaos" and "it's a cycle, it's generational"
- Severe conditions in some areas: "3rd street is like a 3rd world -- some places don't have heat"

### **Economic Stability**

- Gentrification: "6 figure households moving into Anacostia"

- Impact of economic status: "Lower income households are most impacted by these health issues"
- Poverty affects preventive care: "When you are living at or below poverty level you are not going to the doctor regularly or eating healthy"
- Employment concerns: "Limited employment opportunities for young people in the community"
- Business perception: "Companies do not see what Ward 8 has to offer"
- Development patterns: "Some industry is coming in because many residents cannot afford services"

### **Social and Community Context**

- Family structure challenges: "Young single mothers and fathers"
- Root of issues: "Many issues start in the home"
- Home environment concerns: "Home should be a peaceful place but is often stressful"

### **Discrimination and Bias**






- Community stigma: "People look down on southeast side"
- Perception issues: "Stigma associated with the neighborhood"

## Virtual Focus Group with Residents of Wards 1, 4, 5, 7 and 8

The Virtual Focus Group took place on February 4, 2025 over Zoom. The focus group was attended by 11 community members from various Wards: Ward 1 (3), Ward 4 (2), Ward 7 (2), and Ward 8 (4).

### Notable Quotes and High-Level Findings from Virtual Focus Group

<p><i>“... there’s nothing more palpable in a community where you find that community to be disenfranchised the most... people are bonded and united in ways over generations.”</i></p> <p>- Ward 8 Resident</p>	<p><i>“...they’re not really thinking about health... they’re thinking about ‘I have to pay the electric bill, or I have to pay rent.’”</i></p> <p>- Ward 8 Resident [talking about Wards 7 and 8]</p>
--	--

	<p><b>Access to Care</b></p> <ul style="list-style-type: none"> <li>• Lack of geographic access to providers, pharmacies, etc. in Wards 7 and 8.</li> <li>• Challenges with Medicaid and impact on patient access.</li> </ul>
	<p><b>Community Assets</b></p> <ul style="list-style-type: none"> <li>• New and long-standing community organizations helping residents meet needs.</li> </ul>
	<p><b>Healthcare and Wellness</b></p> <ul style="list-style-type: none"> <li>• Chronic disease concerns, specifically heart disease, hypertension, and diabetes.</li> <li>• Mental health, particularly among kids.</li> <li>• Substance use disorder.</li> </ul>
	<p><b>Healthcare Experience</b></p> <ul style="list-style-type: none"> <li>• Mixed experiences expressed across Wards.</li> </ul>
	<p><b>Social and Environmental Factors</b></p> <ul style="list-style-type: none"> <li>• Lack of grocery store access but there was also focus on growing own food and creating/accessing innovative resources.</li> <li>• Housing availability and quality are both issues.</li> <li>• Poverty and income challenges.</li> </ul>

## More Detailed Findings from Virtual Focus Group

### Access to Care

#### Availability of Services

- Pharmacy access has declined: "Limited access to pharmacies. Target and CVS closed pharmacies. There is not a single 24/7 pharmacy in DC"
- Residents must cross jurisdictional boundaries for certain services: "Residents have to drive to Maryland and Virginia if need something overnight"
- Service gaps noted: "CVS also closed minute clinics which makes it harder to access primary care and urgent care"
- Lack of urgent care facilities: "No urgent cares are in the area. Have to get in the car and drive to Maryland or to another area of DC"
- One participant stated: "I don't see providers in my community because there aren't any so I'm going to other wards to get care"

#### Digital Access

- Technology creates barriers for older populations: "Generational issues with access because you have to know how to use technology to access healthcare (pre-registering, etc.)"
- Some positive experiences with digital health: "Enjoy virtual care offerings" from One Medical

#### Cultural Access

- Documentation status creates barriers: "Very worried that individuals will not seek care due to ICE being authorized to raid medical facilities"
- Cultural competency needs: "Hard to find a Latina mental health provider that has cultural competence"
- Diversity in mental health providers lacking: "Lack of mental health services in DC. Hard to find mental health providers of color, particularly women"

#### Financial Access

- Insurance affects access: "Accessing healthcare with Medicaid and Medicare can be difficult"
- Resource disparities: "Can take privilege to seek desired healthcare -- insurance, transportation, etc."
- Cost barriers: "It would be very expensive to have stayed at Sibley"

#### System Navigation

- Complexity challenges: "Administrative hassles. Navigating the healthcare system is difficult. Participants report having issues with insurance"
- Medicaid issues highlighted by one participant: "Medicaid has become now completely defunct or inefficient for people who used to provide these services in the community"

## Community Assets

### Social Capital

- Community connections valued: "Enjoy being able to communicate with police department in the community"
- Mutual aid networks active: "Mutual aid and community camaraderie (like Facebook groups). 'Neighbors looking out for one another'"
- Diversity appreciated: "Neighborhood was initially appealing because many interracial families. Friendly environment. Neighborhood is diverse"
- Demographic mix: "Seniors who raise children. Younger new families. Working adults"
- Strong community ties: "People know and love each other, it's generational -- families stay"
- Relationship with leaders: "work well with city leaders and community"
- Pride in place: "I love Ward 7. I love houses. I love the community. I love the people"
- Historical identity: "Neighborhood was built by black people for black people"

### Community Organizations

- Active civic engagement: "Very active citizens association in Shepherd Park neighborhood. Colonial Park is also active"
- Educational resources: "20ish schools in Ward 7 and many productive initiatives"

### Community Programs

- Reliability issues with some programs: "DPR (Department of Parks and Recreation) offers courses but are often cancelled or changed"
- Affordability challenges: "Most financially accessible option (DPR) is not reliable. Very competitive to get into classes"
- Inequitable distribution: "DPR does not offer services equally across the Wards, especially children's services"

### Physical Environment Assets

- Green spaces appreciated: "Beautiful green space. Like being in the 'suburbs' of DC"
- Urban agriculture opportunities: "Can grow a garden in the front yard. People share their gardens, seeds, etc."

## Health and Wellness

### Physical Health Conditions

- Diabetes prevalent: "Diabetes. Resident reports sugary and processed foods are impacting health of residents"
- Hypertension common: "Limited obesity (lots of walking), but high rates of hypertension"
- Medication use high among older adults: "Everybody you know over the age of 45 is on some kind of medication"

### **Mental Health**

- Service gaps for youth and seniors: "Not doing enough to meet the needs of mental health issues that are impacting youngsters and seniors"
- Post-pandemic increases noted: "very high rates of anxiety and mental health challenges in my community, and particularly amongst kids"
- Need for services that understand community context

### **Substance Use**

- Alcoholism and substance use identified as issues
- Observation that "neighbors are struggling and look like 'life has beat them down'"
- Belief that "neighbors are self-medicating through drugs and alcohol"

### **Violence and Safety Impact**

- Demographic impact: "Violence disproportionately effects younger black individuals. Younger children are getting into violent crimes"
- Firsthand observations: "see middle to high schoolers pull out guns"
- Specific impact on certain groups: "Violence: young men and teenage girls impacted -- 'we are losing them'"
- Connection to mental health: "Believe mental health and violence are related"

### **Population Health Disparities**

- Maternal health concerns: "One participant stated that she purposely delivered her children outside of DC because wary of maternal mortality statistics for black women"
- Stark disparities in maternal outcomes: "When you really get down to the details of the data, the city is basically saying it is 100% okay for black women to die postpartum"
- Racial health disparities: "Black people are dying at much higher rates than their white counterparts any illness you look at"
- Social determinants acknowledged: "It doesn't matter if you're poor or if you're middle class, or if you're upper class, black people are still dying at much higher rates"

## **Healthcare Experience**

### **Provider Relationships**

- Trust and respect emphasized: "Very important to establish relationship with doctor. Hard to do this when the doctor is on the computer during visit"
- Self-advocacy necessary: "I demand that you respect me"; "You advocate for me or you are not my doctor"
- Communication barriers: "They do not listen to you. They do not pay attention to you"
- Need for engagement: "Medical staff must listen to you and pay attention to you"

### **Care Quality**

- Variable by facility: "Georgetown and Howard are her 'go to' providers. The doctors are excellent"
- Quality concerns: "Washington Hospital Center does not have a strong reputation"
- Positive experiences: "Extraordinary care at Sibley"
- Provider time constraints: "Give us more than 20 minutes and a prescription. Take a holistic approach"
- Hospital closures impacting care: "Closure of Providence was devastating to the community -- flow of patients is problematic"
- Equity concerns: "Don't give us less than what we'd get if we lived in Ward 3"

### **System Navigation Experience**

- Coordination challenges: "Healthcare coordination. Administrative hassles. Navigating the healthcare system is difficult"
- Knowledge barriers: "'Suffering in silence' -- basic customer service, coordination, lack of knowledge of how to navigate the system"
- Technology vs. human touch: "'Computers do not replace people'"
- Resource fragmentation: "Resources exist but lack of coordination and dissemination of information"

### **Cultural Responsiveness**

- Historical mistrust: "Black folks do not trust healthcare industry because of the history"
- Racism impacting care: "Racism -- impact of accessing care; judging people based on voice, color of skin, treated as a number"
- Provider assumptions: "Providers think people are drug seeking, 'there to brutalize, not support, to dismiss'"

### **Care Coordination**

- Integration needed: "Lack of communication and attention to patient's needs"
- System fragmentation: "Lacking comprehensive healthcare system that integrates all of these things"
- Holistic approach advocated: "Healthy lifestyle means thinking beyond the hospital"
- Service connections appreciated: "Utilize One Medical and appreciate the referral connections between One Medical and MedStar"

## **Social and Environmental Determinants of Health**

### **Food Security and Access**

- Access requires transportation: "Access to grocery stores. May need a car to access"
- Affordability barriers: "There is now Whole Foods but many people in neighborhood are priced out"
- Quality concerns: "There is a Safeway, but it is unsanitary"
- Severe limitations in some areas: "'Food selection around here is atrocious' in terms of grocery stores and restaurants"

- Quality issues: "Safeway grocery store has gone downhill. Residents report going to Capitol Hill to buy groceries. Moldy meat and sticky floors"
- Fresh food lacking: "Neighborhood Lidl is not up to par with other Lidl grocery stores. No fresh fruits and vegetables"
- Food assistance limits: "Many families are of SNAP benefits and run out before the month"

### **Housing**

- Affordability crisis: "African Americans are losing homes due to rising prices. Also affects Latino and immigrant communities"
- Development concerns: "Limited affordable housing. Increased housing cost and taxes. Developers keep building condos -- 'the condos are taking over'"
- Policy recommendations: "Should require putting something back into it -- policy changes needed"
- High concentration in some wards: "Ward 7 has the highest number of subsidized housing communities"
- Quality issues: "A lot of time the affordable housing doesn't look good -- holes in the wall, mold"
- Management problems: "Slumlords are not managing properties well. Cyclical problem"

### **Community Safety**

- Increasing violence: "Increase in violent crimes including gun violence, robberies, stabbings"
- Geographic changes: "Shepherd Park was isolated for a while but the barrier of having a shut down space (Walter Reed) is bringing more violence into community"
- Activity limitations: "Residents feel unsafe going on walks"
- Personnel issues: "Police services: Some officers may be scared. One officer/commander was doing a good job but was then transferred to another ward"

### **Environmental Conditions**

- Ward-specific issues: "Ward 4 seems particularly dirty"
- Tree canopy disparities: "Less old growth trees, so electric bills in the summer are high"
- Recreational access: "Less access to Rock Creek Park and limited walkability/paths"
- Investment inequity: "Not given as much attention as Northwest DC that is west of Rock Creek Park. 'Not an equal distribution of investment to keep our community safe and clean'"
- Industrial impacts: "Environmental challenges -- trash station, bus station, industrial/pollution, traffic; only ward zoned for industry"
- Animal control issues: "Trash, rodents, etc. are problematic -- 'they are walking the streets with you' (i.e., rats)"

### **Economic Stability**

- Development concerns: "If development on southwest waterfront is what DC will look like, many of us will not be there"
- Cost of living pressures: "Cannot sustain the increase in prices"

- Mobility advantages: "If you are able and well you are able to move around and get the services"
- Poverty costs: "It's expensive being poor"
- Work-food assistance conflict: "This would also be hard to maintain a job if they have to get in line in the middle of the way. Wishes there was a more dignified way to access these services"
- Pandemic effects: "Latino communities more largely effected by COVID (essential workers). See families needing additional support now due to having lost family members during the pandemic"

### **Transportation Systems**

- Reliability issues: "Metro does not always show up on time"
- Community solutions: "Resident reports having to take neighbors to medical appointments"
- Cost barriers: "Public transportation is cost prohibitive, not convenient at times to get to appointments"

## Key Leader Interviews

Fifteen key leader interviews were conducted as part of the 2025 CHNA process between January 15 and February 27, 2025. Most (13) were completed virtually by Ascendent Healthcare Advisors. Interviews with Sibley Memorial Hospital and Howard University Hospital leadership were conducted by members of the Steering Committee. Notes from these interviews were provided to Ascendent for inclusion in the final analysis. Each interview took between 45 and 60 minutes, and those conducted virtually were recorded via Zoom.

Transcripts and interview notes were coded using a codebook established for the CHNA process. Coded interview data were then analyzed for themes. Key findings and quotes from the key leader interviews are summarized below based on the key topics of healthcare access, community assets, health and wellness concerns, healthcare experience, and social and environmental factors.

# Healthcare Access



Key Themes	Interviews with Mentions	Supporting Quotes
<b>Geographic disparities in service availability</b>	<b>14/15</b>	<ul style="list-style-type: none"> <li>• "East of the Anacostia River. There are health resources that just aren't as accessible. You know there isn't as much prenatal care accessible east of the river. People have to go into other parts of DC."</li> <li>• "There's not a lot of Hospital Service east of the River... right now United Medical Center is operating on a pretty limited basis."</li> <li>• "The access to services like hospitals and clinics are all concentrated in certain areas where the demand is not where the services are provided."</li> </ul>
<b>Availability of services</b>	<b>15/15</b>	<ul style="list-style-type: none"> <li>• "Like the rest of the country. Our healthcare system is suffering from a workforce crisis. It got worse through the COVID Public Health Emergency. But it was already there before."</li> <li>• "When you get into the specialty care, it is a really long time before you can get a visit, and you need to often have a diagnostic before the visit."</li> <li>• "There are not enough locations to provide behavioral health and dental needs to the most vulnerable community."</li> </ul>
<b>System navigation</b>	<b>13/15</b>	<ul style="list-style-type: none"> <li>• "... because you can't just say, here's your referral. Go to [hospital]...It's really coordinating with them and saying, 'Okay, how are you gonna get there? Do you know which bus to take? Do you have tokens?'"</li> <li>• "They're not well organized. I think there are a lot of people that try to do that kind of coordinating work, but it's very fragmented..."</li> </ul>
<b>Insurance coverage doesn't guarantee access</b>	<b>11/15</b>	<ul style="list-style-type: none"> <li>• "DC's current system of Medicaid has been a mess. The MCOs ... contract awards, and then the suing, and then who's getting the contract? And then they're constantly re-enrolling people in different ones."</li> <li>• "Even though the District of Columbia is a highly, highly insured jurisdiction, people do not understand how to use their insurance and what it means."</li> <li>• "There's this disconnect with people believing that because people are insured in DC that they have access to services, and we know in the field that they don't necessarily."</li> </ul>

## Community Assets



Key Themes	Interviews with Mentions	Supporting Quote(s)
<b>Strong safety net infrastructure</b>	<b>10/15</b>	<ul style="list-style-type: none"> <li>• "DC does invest in its safety net in a way that other cities, don't the DC. Council, the DC. Government is really I mean, they're willing to recognize it."</li> <li>• "[I] love that we are one of the few places in the country that has a program for insurance for undocumented individuals... my mind can't even understand what undocumented families do in other parts of the country."</li> <li>• "Our size is to our benefit because it doesn't take 6 months to a year to like move change... the public health community is actually quite close knit."</li> </ul>
<b>Innovative program development</b>	<b>11/15</b>	<ul style="list-style-type: none"> <li>• "What we found is that community health workers, navigators, peers are a major component to helping with people who have lived experiences."</li> <li>• "We have a program that is patient legal services... one of our oldest programs is, we have attorneys on staff who help with health harming legal issues."</li> <li>• "DC has made some inroads with some unique programs like Produce RX prescriptions."</li> </ul>
<b>Active community organizations</b>	<b>12/15</b>	<ul style="list-style-type: none"> <li>• "We have great partner organizations. There are several other FQHCs within a mile of us, you know. Bread for the City is a great partner, Mary's Center community health."</li> <li>• "I think that there are some really valuable community-based organizations so like Martha's table... has a lot of great resources that are really well connected."</li> </ul>
<b>Faith-based organization engagement</b>	<b>4/15</b>	<ul style="list-style-type: none"> <li>• "We definitely see it emphasized more in those areas where there has historically been disinvestment because people are saying, 'Well, we're not getting an investment in the resources we're gonna invest in it ourselves.'"</li> <li>• "The faith-based organizations are really strong in DC... they have become centers for people to congregate but also to learn about services to educate."</li> </ul>

Health and Wellness



Key Themes	Interviews with Mentions	Supporting Quote(s)
<b>Mental health issues (and service gaps)</b>	<b>14/15</b>	<ul style="list-style-type: none"> <li>• <i>"Well, behavioral health is a big, and we've seen a major spike in that again. After the pandemic."</i></li> <li>• <i>"The mental health system in the District is also not is really not great, especially for people with chronic...and severe mental illnesses, and there's a lot of weaknesses in it right now, and providers have been going out of business."</i></li> <li>• <i>"There's truly just are not enough pediatric psychiatrists that are in the city or willing to work in the city... and yet the explosion of mental health needs is not going to decline."</i></li> </ul>
<b>Chronic disease management challenges</b>	<b>14/15</b>	<ul style="list-style-type: none"> <li>• <i>"The black population, particularly people who reside in Ward 7 and 8 do experience disproportionate levels of chronic disease. I think that's also true for the Hispanic community, particularly in Ward 4 Columbia Heights area."</i></li> <li>• <i>"I think the cancers. The numbers are small, but that again, that's like the delay in diagnosis, and nobody wants to go get those screenings."</i></li> </ul>
<b>Co-occurring conditions</b>	<b>9/15</b>	<ul style="list-style-type: none"> <li>• <i>"...the people we're seeing are more sick and have much more comorbidities every year. The rate of clients diagnosed with some sort of comorbidity, is increasing, and the severity of what we're seeing is increasing."</i></li> <li>• <i>"We have pretty significant co-occurring mental health disorders associated with medical disorders... our mental health needs are pretty great in our population."</i></li> <li>• <i>"Something like 80% of the people who are admitted to United Medical Center also have diabetes... you came for something else but this is also a co-occurring condition."</i></li> </ul>
<b>Substance use (and treatment needs)</b>	<b>10/15</b>	<ul style="list-style-type: none"> <li>• <i>"For the services that that I'm familiar with, I'm particularly concerned about a decrease in the number of substance use residential beds...that's a pretty big concern in a jurisdiction that's also one [with] the highest opioid overdose rates."</i></li> <li>• <i>"There's a sort of cycle of substance use and sometimes then incarceration and then homelessness."</i></li> </ul>

## Healthcare Experience



Key Themes	Interviews with Mentions	Supporting Quote(s)
<b>Complex system navigation challenges</b>	<b>13/15</b>	<ul style="list-style-type: none"> <li>"...how do people know about what services there [are]? How do we make sure they connect? Who has the capacity? Who doesn't have the capacity, how easily accessible enough that they are."</li> <li>"...[hospital has] amazing providers. Yet their systems are the opposite of amazing...right now, like my mom needs a procedure on her eyes and has not been able to get anyone on the phone."</li> <li>"Communities particularly in Wards 7 and 8 where emergency departments are used as primary care... it's hard to really blame people for that."</li> </ul>
<b>Challenges with care coordination</b>	<b>12/15</b>	<ul style="list-style-type: none"> <li>"Instead of building on initiatives and expanding initiatives. You just have do-overs. So, you see a lot of duplication. You see a lot of silos."</li> <li>"It's hard to exchange information when there's multiple different service providers on multiple different platforms."</li> <li>"If they could actually prioritize effectiveness and work together and do collaborative projects where the small amounts that they are going to be able to contribute would catalyze something bigger. But we need structural change and that requires real coordination and purpose."</li> </ul>
<b>Provider-patient relationships</b>	<b>12/15</b>	<ul style="list-style-type: none"> <li>"The most important thing is to listen to the community and not themselves and their bottom line. Right? So and what is it that they can actually do and measure and engage the community and hear their voices?"</li> <li>"Are you greeted? Are you greeted in a friendly manner? Are you treated as less than, or in a way that gives you the impression that you, being there is not valued except because you're going to generate a bill."</li> </ul>
<b>Cultural competency in provision of care</b>	<b>11/15</b>	<ul style="list-style-type: none"> <li>"People in our community sometimes go to the doctor and never see doctors that look like them."</li> <li>"Populations who are underrepresented are more likely to have better outcome when they have providers who look like them. (They are) more adherent to their regimens of care; there's more trust and relationship."</li> </ul>

## Social and Environmental Factors



Key Themes	Interviews with Mentions	Supporting Quote(s)
<b>Economic stability</b>	<b>12/15</b>	<ul style="list-style-type: none"> <li>• <i>"There definitely is kind of a gap between... the income that makes people eligible for some of those programs..."</i></li> <li>• <i>"Asset limited income constrained and yet still employed... you got a job but if you make just a hair bit more now you're cut off from your benefits."</i></li> </ul>
<b>Housing issues (access and quality)</b>	<b>11/15</b>	<ul style="list-style-type: none"> <li>• <i>"...we see the amount of affordable housing rapidly decreasing. And really, we're seeing a war on homelessness in a way that's not helping. It's criminalizing."</i></li> <li>• <i>"The emergency rental assistance program, which is to help with housing...it opened for all of 2025 and closed in 4 hours because it got that many applications."</i></li> <li>• <i>"She was probably in her mid-seventies... home was sold from out from under her... she died like within couple months of becoming homeless."</i></li> <li>• <i>"We have very high rates of pediatric asthma... and that most of them are living in public housing."</i></li> </ul>
<b>Growing food insecurity and access to food</b>	<b>11/15</b>	<ul style="list-style-type: none"> <li>• <i>"... there's very few grocery stores east of the river...A small grocery store opened near us in Ward 8, and it only lasted about a year, and then it closed."</i></li> <li>• <i>"We heard from a lot of people that like, yeah, we have to decide if we're going to pay this bill or buy food or pay rent or buy food."</i></li> <li>• <i>"Most people can't walk to a grocery store, many people don't own a car, the corner stores do not necessarily carry healthy food."</i></li> </ul>
<b>Social and cultural context</b>	<b>10/15</b>	<ul style="list-style-type: none"> <li>• <i>"Our community is segregated...while we're very culturally diverse, there are patches of this community where people never see people other than those that look like themselves, which for such a small plot of land, that is surprising."</i></li> <li>• <i>"People's fear to be in public these days... people who are undocumented or family members of people who are undocumented."</i></li> <li>• <i>"Is there racial and ethnic discrimination? Absolutely. Is that getting better or worse? That's getting worse."</i></li> </ul>

## Appendix 3 | Primary Data Summary

Potential Priority Areas	Secondary Data Findings	Focus Groups	Key Leader Interviews	Key Leader Web Survey	Community Health Survey
Healthcare Access	✓	✓	✓	✓	✓
Mental & Behavioral Health	✓	✓	✓	✓	✓
Chronic Disease & Cancer	✓	✓	✓	✓	✓
Health Equity & Social Determinants of Health	✓	✓	✓	✓	✓
Housing & Transit	✓	✓	✓	✓	✓
Employment & Poverty	✓	✓	✓	✓	✓
Food Security	✓	✓	✓	✓	
Safety & Violence	✓	✓			✓
Substance Use	✓	✓	✓	✓	✓
Built Environment	✓	✓			
Maternal & Infant Health	✓	✓			
Sexual Health	✓	✓			
Aging & Older Adult Health		✓			✓
Healthcare Workforce					
Communicable Disease					
Social Connection					

# Appendix 4 | Secondary Data Methodology

Many individual secondary data measures were analyzed as part of the CHNA process. These data provide detailed insight into the health status and health-related behavior of residents in the county. These secondary data are based on statistics of actual occurrences, such as the incidence of certain diseases, as well as statistics related to social determinants of health.

## Methodology

All individual secondary data measures were grouped into six categories and 20 corresponding focus areas based on “common themes.” To draw conclusions about the secondary data for the District of Columbia, its performance on each data measure was compared to established targets/benchmarks. If the District of Columbia’s performance was more than five percent worse than the comparative benchmark, it was concluded that improvements could be needed to better the health of the community. Conversely, if an area performed more than five percent better than the benchmark, it was concluded that while a need is still present, the significance of that need relative to others is likely less acute. The most recently available data for the District of Columbia was compared to national averages.

The following methodology was used to assign a priority level to each individual secondary data measure:

- If the data were more than 5 percent worse = High need
- If the data were within or equal to 5 percent (better or worse) = Medium need
- If the data were more than 5 percent better = Low need

Additionally, data were also viewed with consideration of performance over time and whether the measure has improved or worsened compared to the prior CHNA timeframe, if possible.

## Data Sources

The following tables are organized by each of the twenty focus areas and contain information related to the secondary data measures analyzed including a description of each measure, the data source, and most recent data time periods.

**Table A4.1: Access to Care**

Measure	Description	Data Source	Most Recent Data Year(s)
Uninsured Children (<19)	Uninsured Children is the percentage of the population under age 19 that has no health insurance coverage in a given county.  Numerator = Number of people under age 19 who currently have no health insurance coverage. A person is uninsured if they are not currently covered by insurance through a current/former employer or union,	American Community Survey, Table S2701 5-Year Estimates.	2019-2023

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>purchased from an insurance company, Medicare, Medicaid, Medical Assistance, any kind of government-assistance plan for those with low incomes or disability, TRICARE or other military health care, Indian Health Services, Veterans Affairs, or any other health insurance or health coverage plan.</p> <p>Denominator = County population under age 19</p>		
Uninsured Adults (19–64)	<p>Uninsured Adults is the percentage of the population ages 19 to 64 that have no health insurance coverage in a given county.</p> <p>Numerator = Number of people ages 19 to 64 who currently have no health insurance coverage. A person is uninsured if they are not currently covered by insurance through a current/former employer or union, purchased from an insurance company, Medicare, Medicaid, Medical Assistance, any kind of government-assistance plan for those with low incomes or disability, TRICARE or other military health care, Indian Health Services, Veterans Affairs, or any other health insurance or health coverage plan.</p> <p>Denominator = County population ages 19-64</p>	ACS, Table S2701 5-Year Estimates.	2019-2023
Uninsured Adults (<65)	<p>Uninsured Adults is the percentage of the population ages 65 and older that have no health insurance coverage in a given county.</p> <p>Numerator = Number of people ages 65 and older who currently have no health insurance coverage. A person is uninsured if they are not currently covered by insurance through a current/former employer or union, purchased from an insurance company, Medicare, Medicaid, Medical Assistance, any kind of government-assistance plan for those with low incomes or disability, TRICARE or other military health care, Indian Health Services, Veterans Affairs, or</p>	ACS, Table S2701 5-Year Estimates.	2019-2023

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>any other health insurance or health coverage plan.</p> <p>Denominator = County population ages 65 and older</p>		
Primary Care Physician Ratio	<p>Primary Care Physicians is the ratio of the population to primary care physicians. The ratio represents the number of individuals served by one physician in a county, if the physicians were equally distributed across the population.</p> <p>Left: Represents county population Right: Represents the primary care physicians corresponding to county population. Primary care physicians include practicing non-federal physicians (M.D.s and D.O.s) under age 75 specializing in general practice medicine, family medicine, internal medicine, and pediatrics</p>	<p>Area Health Resource File/American Medical Association</p> <p>Robert Wood Johnson Foundation (RWJF) &amp; University of Wisconsin Population Health Institute (UWPHI), County Health Rankings. Accessed November 2024.</p>	2021
Dentist Ratio	<p>The ratio of the population to dentists. The ratio represents the population served by one dentist if the entire population of a county were distributed equally across all practicing dentists.</p> <p>Left: Represents county population Right: Represents the dentists corresponding to county population. Registered dentists with a National Provider Identifier are counted.</p>	<p>Area Health Resource File/National Provider Identifier</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2022
Mental Health Provider Ratio	<p>The ratio of the population to mental health providers. The ratio represents the number of individuals served by one mental health provider in a county, if providers were equally distributed across the population.</p> <p>Left: Represents county population Right: The right side of the ratio represents the mental health providers corresponding to county population. Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, mental health providers that treat alcohol and other drug abuse, and advanced</p>	<p>CMS, National Provider Identification</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed September 2024.</p>	2023

Measure	Description	Data Source	Most Recent Data Year(s)
	practice nurses specializing in mental health care		
Advanced Practice Primary Care Provider Ratio	<p>Other Primary Care Providers is the ratio of the county population to the number of primary care providers other than physicians. The ratio can be interpreted as the number of individuals served by an alternative provider in a county, if the population were equally distributed across providers.</p> <p>Left: Represents county population Right: The right side of the ratio is the number of other primary care providers in a county. Other primary care providers include nurse practitioners, physician assistants, and clinical nurse specialists.</p>	<p>CMS, National Provider Identification</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed September 2024.</p>	2023

**Table A4.2: Built Environment**

Measure	Description	Data Source	Most Recent Data Year(s)
% Broadband Access	<p>Broadband Access is the percentage of households with a broadband internet connection through subscription.</p> <p>Numerator = Number of households in a county with a broadband internet subscription of any type (e.g., cable, DSL, fiber-optic, cell phone, or satellite) at their place of residence. The numerator includes affirmative responses to the ACS question: “At this house, apartment, or mobile home- do you or any member of this household have access to the Internet?”</p> <p>Denominator = Total number of households in county</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2018-2022
Households with Computer	Percentage of households in which there are one or more types of computing devices (computer, tablet, smart phone, etc.).	<p>ACS, 5-year estimates</p> <p>DC Health Matters. Accessed November 2024.</p>	2018-2022

**Table A4.3: Diet and Exercise**

Measure	Description	Data Source	Most Recent Data Year(s)
Food Environment Index	<p>The Food Environment Index ranges from a scale of 0 (worst) to 10 (best) and equally weights two indicators of the food environment:</p> <p>1) Limited Access to Healthy Foods estimates the percentage of the population that is low income and does not live close to a grocery store. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size. Living close to a grocery store is defined differently in rural and non-rural areas; in rural areas, it means living less than 10 miles from a grocery store whereas in non-rural areas, it means less than 1 mile.</p> <p>2) Food Insecurity estimates the percentage of the population without access to a reliable source of food during the past year. A two-stage fixed effects model was created using information from the Community Population Survey, Bureau of Labor Statistics, and American Community Survey to estimate Food Insecurity.</p>	<p>USDA Food Environment Atlas; Feeding America Map the Meal Gap</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2019 / 2021
Physical Inactivity	<p>Percentage of adults aged 18 and over reporting no leisure-time physical activity (age-adjusted).</p> <p>Numerator = Number of respondents who answered "no" to the question, "During the past month, other than your regular job, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise?"</p> <p>Denominator = Number of respondents age 18 and older</p>	<p>Behavioral Risk Factor Surveillance System (BRFSS)</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021
Population with Access to Exercise Opportunities	<p>Access to Exercise Opportunities measures the percentage of individuals in a county who live reasonably close to a location for physical activity. Locations for physical activity are defined as parks or recreational facilities. Individuals are</p>	<p>Opportunities ArcGIS Business Analyst and ArcGIS Online; YMCA; US Census TIGER/Line Shapefiles</p>	2020, 2022, 2023

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>considered to have adequate access to exercise opportunities if they:</p> <ul style="list-style-type: none"> <li>• reside in a census block that is within a half mile of a park, or</li> <li>• reside in a census block that is within one mile of a recreational facility in an urban area, or</li> <li>• reside in a census block that is within three miles of a recreational facility in a rural area.</li> </ul> <p>Numerator = The numerator is the total 2020 population living in census blocks with adequate access to at least one location for physical activity. Adequate access is defined as census blocks where the border is a half-mile or less from a park, 1 mile or less from a recreational facility in an urban area, or 3 miles or less from a recreational facility in a rural area. Parks include local, state, and national parks. Recreational facilities include YMCAs as well as businesses including a wide variety of facilities such as gyms, golf courses, tennis courts and pools, identified by the following Standard Industry Classification (SIC) codes: 799101, 799102, 799103, 799106, 799107, 799108, 799109, 799110, 799111, 799112, 799201, 799701, 799702, 799703, 799704, 799707, 799711, 799717, 799723, 799901, 799908, 799958, 799969, 799971, 799984, or 799998.</p> <p>Denominator = 2020 resident county population</p>	<p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	
<p>Adult Obesity Prevalence</p>	<p>Adult Obesity is based on responses to Behavioral Risk Factor Surveillance System (BRFSS) surveys and is the percentage of the adult population (ages 18 and older) that reports a body mass index (BMI) greater than or equal to 30 kg/m<sup>2</sup>. Participants are asked to self-report their height and weight; BMIs are calculated from these reported values.</p>	<p>BRFSS  RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	<p>2021</p>

Measure	Description	Data Source	Most Recent Data Year(s)
	Numerator= Number of adult respondents age 18 and older with a BMI greater than or equal to 30kg/m2. Denominator = Number of adult respondents age 18 and older		

**Table A4.4: Education**

Measure	Description	Data Source	Most Recent Data Year(s)
School Segregation	School Segregation measures how evenly representation of racial and ethnic groups in the student population is spread across schools using Theil's Index, a segregation index. The index ranges from 0 to 1 with lower values representing a school composition that approximates race and ethnicity distributions in the student populations within the county, and higher values representing more segregation.	National Center for Education Statistics  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2022-2023
School Funding Adequacy	School Funding Adequacy is the average gap in dollars between actual and required spending per pupil among school districts. Required spending is an estimate of dollars needed to achieve United States average test scores in each school district. This measure looks at funding through an equity lens, not every district's needs for funding are the same, and this measure of school funding takes that into account.	School Finance Indicators Database  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2021
Disconnected Youth	Numerator = Number of people, ages 16-19, who are neither working nor in school.  Denominator = Total county population, ages 16-19.	ACS, 5-year estimates  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2018-2022
4 Year High School Graduation Rate	High School Graduation is the percentage of the ninth-grade cohort that graduates from high school in four years.  Numerator = Number of cohort members who earned a regular high school diploma by the end of the school year.  Denominator = Number of first-time 9th graders four years prior to graduation, plus students who transferred in, minus students who	EDFacts  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2020-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	transferred out, emigrated, or died during school years.		
Reading Scores	Reading Scores is the average grade level performance in the county for 3rd graders on English Language Arts standardized tests. For example, a score of 3.5 indicates that the 3rd graders are performing half a grade level better than expected for 3rd graders.	Stanford Education Data Archive  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2018
Math Scores	Math Scores is the average grade level performance in the county for 3rd graders on math standardized tests. For example, a score of 3.5 indicates that the 3rd graders are performing half a grade level better than expected for 3rd graders.	Stanford Education Data Archive  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2018

**Table A4.5: Employment**

Measure	Description	Data Source	Most Recent Data Year(s)
Unemployment Rate	Numerator = Total number of people in the civilian labor force, ages 16 and older, who are unemployed but seeking work. Denominator = Total number of people in civilian labor force, ages 16 and older.	ACS, Table 2301 1-Year Estimates.	2023

**Table A4.6: Environmental Quality**

Measure	Description	Data Source	Most Recent Data Year(s)
Air Pollution	Air Pollution - Particulate Matter is a measure of the fine particulate matter in the air. It is reported as the average daily density of fine particulate matter in micrograms per cubic meter. Fine particulate matter is defined as particles of air pollutants with an aerodynamic diameter less than 2.5 micrometers (PM2.5).	Environmental Public Health Tracking Network  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2019
Presence of Water Violation	Indicator of the presence of health-related drinking water violations. 'Yes' indicates the presence of a violation, 'No' indicates no violation.	EPA Safe Drinking Water Information System. Accessed November 2024.	2024

**Table A4.7: Family, Community, and Social Support**

Measure	Description	Data Source	Most Recent Data Year(s)
Percentage of Children that Live in Single-Parent Household	<p>Children in Single-Parent Households is the percentage of children (under 18 years of age) living in family households that are headed by a single parent.</p> <p>Numerator = Number of children in family households where the household is headed by a single parent (male or female head of household with no spouse present).</p> <p>Denominator = Number of children living in family households in a county. Foster children and children living in non-family households or group quarters are not included in either the numerator or denominator.</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2018-2022
Childcare Cost Burden	<p>Child Care Cost Burden is the cost of child care for a household with two children as a percent of median household income.</p> <p>Numerator = Child care cost data provided by the Living Wage Institute</p> <p>Denominator = Median household income data calculated from the Small Area Income and Poverty Estimates.</p>	<p>The Living Wage Institute</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2022 & 2023
Childcare Centers	<p>Child Care Centers measures the number of child care centers per 1,000 population under age 5.</p> <p>Numerator = Total number of child care centers in a county. The data include center-based child daycare locations (including those located at school and religious institutes) and does not include group, home, or family-based child care.</p> <p>Denominator = Total resident population under 5 years old in a county.</p>	<p>Homeland Infrastructure Foundation-Level Data (HIFLD)</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2010-2022
Social Associations (membership associations per 10,000 population)	<p>Social Associations measures the number of membership associations per 10,000 population. Rates measure the number of events in a given time period divided by the average number of people at risk during that period. Rates help us compare health data across counties with different population sizes.</p>	<p>County Business Patterns</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>Numerator = The numerator is the total number of membership associations in a county. The membership organizations (NAICS code) in this measure include civic organizations (813410), bowling centers (713950), golf clubs (713910), fitness centers (713940), sports organizations (711211), religious organizations (813110), political organizations (813940), labor organizations (813930), business organizations (813910), and professional organizations (813920).</p> <p>Denominator = Total resident population of county.</p>		
Residential Segregation - Black/White	<p>Racial/ethnic residential segregation refers to the degree to which two or more groups live separately from one another in a geographic area. The index of dissimilarity is a demographic measure of the evenness with which two groups (Black and white residents, in this case) are distributed across the component geographic areas (census tracts, in this case) that make up a larger area (counties, in this case).</p> <p>The residential segregation index ranges from 0 (complete integration) to 100 (complete segregation). The index score can be interpreted as the percentage of either Black or white residents that would have to move to different geographic areas in order to produce a distribution that matches that of the larger area.</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings.</p> <p>Accessed November 2024.</p>	2018-2022
Socially and Emotionally Supported	<p>“How often do you get the social and emotional support you need?” with response being “Always/Usually”</p>	<p>District of Columbia Behavioral Risk Factor Surveillance System (DC BRFSS) 2020 Annual Health Report</p>	2019-2020
Diversity Index	<p>The Diversity Index from Esri represents the likelihood that two persons, chosen at random from the same area, belong to different races or ethnic groups. Ethnic diversity, as well as racial diversity, is included in Esri’s definition of the Diversity Index. Esri’s diversity calculations accommodate up to seven race groups: six single-race groups (White, Black, American Indian,</p>	<p>Esri Business Analyst.</p> <p>Accessed November 2024.</p>	2024

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>Asian, Pacific Islander, Some Other Race) and one multiple-race group (two or more races). Each race group is divided into two ethnic origins, Hispanic and non-Hispanic. If an area is ethnically diverse, diversity is compounded. The Diversity Index is available down to the block group level geography.</p> <p>Esri's definition of diversity is two-dimensional and combines racial diversity with ethnic diversity. This measure shows the likelihood that two persons, chosen at random from the same area, belong to different races or ethnic groups. If an area's entire population belongs to one race group and one ethnic group, an area has zero diversity. The Diversity Index is a continuum that ranges from 0 (no diversity) to 100 (complete diversity), where an area's index tends toward 100 when the population is more evenly divided across race and ethnic groups. If an area's entire population is divided evenly into two race groups and one ethnic group, the diversity index equals 50. As more race groups are evenly represented in the population, the diversity index increases. Race and Hispanic origin data are reported by the Census Bureau and other agencies as grouped summary data; therefore, in practice, the Diversity Index will not reach the maximum value of 100.</p>		

**Table A4.8: Food Security**

Measure	Description	Data Source	Most Recent Data Year(s)
Food Insecurity	<p>Food Insecurity estimates the percentage of the population who did not have access to a reliable source of food during the past year.</p> <p>Numerator = Population with a lack of access, at times, to enough food for an active, healthy life or with uncertain availability of nutritionally adequate foods. This survey was conducted by NORC at the University of Chicago</p>	Capital Area Food Bank, Hunger Report 2024.	2024

Measure	Description	Data Source	Most Recent Data Year(s)
	with funding from the Capital Area Food Bank (CAFB).  Denominator = 2022 ACS population estimates.		
Children Eligible for Free or Reduced Lunch	DC information gathered from DC Public Schools  National rate is percentage of children enrolled in public schools that are eligible for free or reduced price lunch.	DC: DC Public Schools  USA: RWJF & UWPHI, County Health Rankings. Accessed November 2024.	DC (2024)  2021-2022 (USA)
Limited Access to Healthy Food	Limited Access to Healthy Foods measures the percentage of the population that is low income and does not live close to a grocery store.  Numerator = Number of people who are low income and do not live close to a grocery store. Living close to a grocery store is defined differently in rural and nonrural areas; in rural areas, it means living less than 10 miles from a grocery store; in nonrural areas, less than one mile. Low income is defined as having an annual family income of less than or equal to 200 percent of the federal poverty threshold for the family size.  Denominator = 2010 U.S. Census Population.	USDA Food Environment Atlas  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2019

**Table A4.9: Housing and Homelessness**

Measure	Description	Data Source	Most Recent Data Year(s)
Severe Housing Problems	Numerator = Number of households with 1 of 4 housing problems: lack of kitchen facilities, lack of plumbing facilities, overcrowding, or high housing costs. Incomplete kitchen facilities is defined as a unit which lacks a sink with running water, a stove or range, or a refrigerator. Incomplete plumbing facilities is defined as lacking hot and cold piped water, a flush toilet, or a bathtub/shower. Overcrowding is defined as more than one person per room. Severe cost burden is defined as monthly housing costs (including	Comprehensive Housing Affordability Strategy (CHAS) data  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2016-2020

Measure	Description	Data Source	Most Recent Data Year(s)
	utilities) that exceed 50% of monthly income. Denominator = Total number of households in county		
Severe Housing Cost Burden	Severe Housing Cost Burden is the percentage of households that spend 50% or more of their household income on housing.  Numerator = Total number of households in a county that spend 50% or more of their household income on housing. Denominator = Total occupied housing units for which housing cost burden is computed in a county.	ACS, 5-year estimates  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2018-2022
Homeownership	Homeownership is the percentage of occupied housing units that are owned.  Numerator = Total number of owner-occupied housing units in a county. Denominator = Total occupied housing units in a county.	ACS, Table S0501 5-Year Estimates.	2018-2022
Homelessness per 10,000 People	"Experiencing Homelessness" describes a person who lacks a fixed, regular, and adequate nighttime residence.	The U.S. Department of Housing and Urban Development The 2023 Annual Homelessness Assessment Report (AHAR) to Congress	2023

**Table A4.10: Income**

Measure	Description	Data Source	Most Recent Data Year(s)
Children in Poverty	Numerator = Number of people under age 18 living in a household whose income is below the poverty level. Poverty status is defined by family; either everyone in the family is in poverty or no one in the family is in poverty. The characteristics of the family used to determine the poverty threshold are number of people, number of related children under 18, and whether or not the primary householder is over age 65. Family income is then compared to the poverty threshold; if that family's income is below that threshold, the family is in poverty.	ACS, 5-year estimates  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	Denominator = Total number of people under age 18 in a county.		
ALICE Households % Asset Limited, Income Constrained, Employed Households	Percentage of households who are earning more than the Federal Poverty Level, but not enough to afford the basics where they live.	United for ALICE. Data accessed March 2025.	2024
Income Inequality Ratio	<p>Income Inequality is the ratio of household income at the 80th percentile to that at the 20th percentile</p> <p>Numerator = 80th percentile of median household income in a county. Income, defined as “total income,” is the sum of the amounts reported separately for wage or salary income; net self-employment income; interest, dividends, or net rental or royalty income or income from estates and trusts; Social Security or Railroad Retirement income; Supplemental Security Income (SSI); public assistance or welfare payments; retirement, survivor, or disability pensions; and all other income. Receipts from the following sources are not included as income: capital gains, money received from the sale of property (unless the recipient was engaged in the business of selling such property); the value of income “in kind” from food stamps, public housing subsidies, medical care, employer contributions for individuals, etc.; withdrawal of bank deposits; money borrowed; tax refunds; exchange of money between relatives living in the same household; gifts and lump-sum inheritances, insurance payments, and other types of lump-sum receipts. Denominator = 20th percentile of median household income by county.</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2018-2022
Gender Pay Gap	<p>Ratio of women's median earnings to men's median earnings for all full-time, year-round workers, presented as "cents on the dollar."</p> <p>Numerator = Women's median annual earnings for full-time, year-round</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
	workers ages 16 and older with earnings in a county.  Denominator = Men's median annual earnings for full-time, year-round workers ages 16 and older with earnings in a county.		
Hourly Living Wage	The Living Wage methodology includes household composition, varies geographically, and is based on market-driven costs for each element of the basic needs budget; savings and leisure expenditures are not included in the Living Wage. Basic household expenses include the cost of food (USDA low-cost food plan), childcare, health care (insurance premiums and out of pocket costs), housing, transportation, other necessities (clothing, personal care items), civic engagement, broadband service, and cell phone service. This contrasts with the official federal poverty thresholds which are based on a multiple of the most basic food budget (USDA lowest cost, thrifty food plan) for a household and do not vary geographically (they are the same for all states and D.C.). The Living Wage reflects an hourly wage.	The Living Wage Institute  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2023
Food Stamp / SNAP Recipients	Percent of residents receiving food stamps / SNAP	Center for Budget and Policy Priorities. Accessed January 2025.	2024

**Table A4.11: Length of Life**

Measure	Description	Data Source	Most Recent Data Year(s)
Years of Potential Life Lost  (number of deaths among residents under age 75 per 100,000 population, age-adjusted)	All the years of potential life lost in a county during a 3-year period are summed and divided by the total population of the county during that same time period. This value is then multiplied by 100,000 to calculate the years of potential life lost under age 75 per 100,000 people.  Numerator = Cumulative number of years of potential life lost from deaths among county residents under age 75, over a three-year period	NCHS  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2019-2021

Measure	Description	Data Source	Most Recent Data Year(s)
	Denominator = Aggregate population under age 75 for the three-year period		
Premature Death  (years of potential life lost before age 75 per 100,000 population age-adjusted)	<p>Premature Age-Adjusted Mortality measures the number of deaths among residents under the age of 75 per 100,000 population. Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period.</p> <p>Numerator = Number of total deaths under the age of 75 Denominator = Total population under the age of 75</p>	<p>National Center for Health Statistics (NCHS)</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2019-2021
Life Expectancy	Life Expectancy measures the average number of years from birth people are expected to live, according to the current mortality experience (age-specific death rates) of the population. Life Expectancy calculations are based on the number of deaths in a given time period and the average number of people at risk of dying during that period.	<p>NCHS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2019-2021
Child Mortality	<p>Child Mortality measures the number of deaths occurring before age 20 per 100,000 population. Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period.</p> <p>Numerator = Number of deaths occurring before the age of 20 Denominator = Total population under the age of 20</p>	<p>NCHS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2018-2021
Infant Mortality	Number of infant deaths (less than one year old) per 1,000 live births.	Annie E. Casey Foundation. Accessed November 2024.	2022 (USA) 2023 (DC)
Heart Disease Death Rate	Age-adjusted deaths per 100,000 population Diseases of the heart (I00-I09, I11, I13, I20-I51)	CDC Wonder; Underlying Cause of Death (CDC Wonder; UCD), 2018-2022, Single Race Results. Accessed November 2024.	2022
Cancer Death Rate	Age-adjusted deaths per 100,000 population Malignant neoplasms (C00-C97)	CDC Wonder; UCD. Accessed November 2024.	2022
Stroke Death Rate	Age-adjusted deaths per 100,000 population Cerebrovascular diseases (I60-I69)	CDC Wonder; UCD. Accessed November 2024.	2022

Measure	Description	Data Source	Most Recent Data Year(s)
COVID-19 Death Rate	Age-adjusted deaths per 100,000 population COVID-19 (U07.1)	CDC Wonder; UCD. Accessed November 2024.	2022
Diabetes Death Rate	Age-adjusted deaths per 100,000 population Diabetes mellitus (E10-E14)	CDC Wonder; UCD. Accessed November 2024.	2022
Chronic Lower Respiratory Disease Death Rate	Age-adjusted deaths per 100,000 population Chronic lower respiratory diseases (J40-J47)	CDC Wonder; UCD. Accessed November 2024.	2022
Hypertension Death Rate	Age-adjusted deaths per 100,000 population Essential hypertension and hypertensive renal disease (I10, I2, I15)	CDC Wonder; UCD. Accessed November 2024.	2022
Septicemia Death Rate	Age-adjusted deaths per 100,000 population Septicemia (A40-A41)	CDC Wonder; UCD. Accessed November 2024.	2022

**Table A4.12: Maternal and Infant Health**

Measure	Description	Data Source	Most Recent Data Year(s)
Low Birthweight (< 2500 grams)	Live births weighing less than 2,500 grams (5.5 pounds). The data reflects the mother's place of residence, not the place where the birth occurred. Births of unknown weight are not included in these calculations.	Annie E. Casey Foundation. Accessed November 2024.	2022 (USA) 2023 (DC)
Premature Births	Babies born with a gestational age of less than 37 completed weeks. Birth certificates that did not report gestational age are not included in this tabulation. Per 1,000 live births.	Annie E. Casey Foundation. Accessed November 2024.	2022 (USA) 2023 (DC)
Prenatal Care in First Trimester	Percent of births with prenatal care beginning in the first trimester.	Annie E. Casey Foundation. Accessed November 2024.	2023
Pregnancy-Related Mortality Rate	The DC pregnancy-related mortality rate for 2014-2018 is the number of DC-resident pregnancy-related deaths divided by the total number of DC-resident live births during these years, multiplied by 100,000.	DC Office of the Chief Medical Examiner; Maternal Mortality Review Committee 2019-2020 Annual Report.	2014-2018
Maternal Mortality Rate	The DC maternal mortality rate (MMR) for 2014-2018 is the number of DC-resident maternal deaths divided by the total number of DC resident live births during these years, multiplied by 100,000.	DC Office of the Chief Medical Examiner; Maternal Mortality Review Committee 2019-2020 Annual Report.	2014-2018

**Table A4.13: Mental Health**

Measure	Description	Data Source	Most Recent Data Year(s)
Frequent Mental Distress	<p>Percentage of adults reporting 14 or more days of poor mental health per month (age-adjusted).</p> <p>Numerator = Number of adults who reported 14 or more days in response to the question, “Now, thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”</p> <p>Denominator = Total number of adult respondents in a county.</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021
Poor Mental Health Days per Month	<p>Poor Mental Health Days is the average number of mentally unhealthy days reported in the past 30 days.</p> <p>Numerator = Number of days respondents reported to the question “Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?”</p> <p>Denominator = Total number of adult respondents in a county.</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021
% Depressive Disorder Diagnosis	<p>Answer yes to “Has a doctor, nurse or other health professional ever told you that you had a depressive disorder (including depression, major depression, dysthymia, or minor depression)?”</p>	<p>DC BRFSS 2020 Annual Health Report</p>	2020
% Used Prescription Antianxiety Medications	<p>Percent of adults who were prescribed and used antianxiety medications in the last 12 months.</p>	<p>ESRI Business Analyst. Data accessed November 2024.</p>	2024
% Used Prescription Antidepressant Medications	<p>Percent of adults who were prescribed and used antidepressant medications in the last 12 months.</p>	<p>ESRI Business Analyst. Data accessed November 2024.</p>	2024
% Visited Mental Health Provider	<p>Percent of adults who saw a psychologist or psychiatrist in the past 12 months.</p>	<p>ESRI Business Analyst. Data accessed November 2024.</p>	2024

**Table A4.14: Physical Health**

Measure	Description	Data Source	Most Recent Data Year(s)
Frequent Physical Distress	<p>Percentage of adults reporting 14 or more days of poor physical health per month (age-adjusted).</p> <p>Numerator = Number of adults who reported 14 or more days in response to the question, "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"</p> <p>Denominator = Total number of adult respondents in a county</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021
Poor Physical Health Days per Month	<p>Poor Physical Health Days measures the average number of physically unhealthy days reported in the past 30 days.</p> <p>Numerator = Average number of days reported by respondents to the question "Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good?"</p> <p>Denominator = Total number of adult respondents in a county.</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021
Poor to Fair Health	<p>Poor or Fair Health is the percentage of adults in a county who consider themselves to be in poor or fair health.</p> <p>Numerator = Number of respondents who answered "Would you say that in general your health is Excellent/Very good/Good/Fair/Poor?" with fair or poor.</p> <p>Denominator = Total number of adult respondents in a county.</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021
Adult Diabetes Prevalence	<p>Numerator = Number of adults 18 years and older who responded "yes" to the question, "Has a doctor ever told you that you have diabetes?" Both Type 1 and Type 2 diabetes diagnoses are included. Women who indicated that they only had diabetes during pregnancy were not considered to have diabetes.</p> <p>Denominator = Total number of respondents (age 18 and older) in a county.</p>	<p>BRFSS</p> <p>DC Health Matters. Accessed November 2024</p>	2022

Measure	Description	Data Source	Most Recent Data Year(s)
HIV Prevalence	<p>HIV Prevalence is the rate of diagnosed cases of HIV for people aged 13 years and older in a county per 100,000 population. Rates measure the number of events in a given time period divided by the average number of people at risk during that period.</p> <p>Numerator = Number of diagnosed cases of HIV for people aged 13 years and older. HIV is a reportable disease meaning that when a provider treats a patient for HIV they are required to report that case to their health department.</p> <p>Denominator = Total population aged 13 years and older.</p>	<p>National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2021

**Table A4.15: Quality of Care**

Measure	Description	Data Source	Most Recent Data Year(s)
Medicare Mammography Screening	<p>Mammography Screening is the percentage of female fee-for-service (FFS) Medicare enrollees, ages 65-74, who received an annual mammogram.</p> <p>Numerator = Number of women ages 65-74 enrolled in Medicare Part B for at least one month of the selected year who have had a mammogram in the last year (Current Procedural Terminology/Healthcare Common Procedure Coding System codes: 77052, 77057, 77063, G0202).</p> <p>Denominator = Number of female Medicare beneficiaries ages 65-74 enrolled in Medicare Part B for at least one month of the selected year. Individuals enrolled in Medicare Advantage at any point during the year are excluded.</p>	<p>Mapping Medicare Disparities Tool (MMDT)</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021
Medicare Flu Vaccinations	<p>Flu Vaccinations is the percentage of fee-for-service Medicare enrollees who had a reimbursed flu vaccination during the year.</p> <p>Numerator = This numerator is the number of Medicare beneficiaries enrolled in fee-for-service Medicare Part B for at least one month of the selected year and who have received a</p>	<p>MMDT</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>covered influenza vaccine in the last year (Current Procedural Terminology/Healthcare Common Procedure Coding System codes: 90630, 90653-90657, 90660-90662, 90672-90674, 90685-90688, Q2035-Q2039, G0008).</p> <p>Denominator = The denominator is the number of Medicare beneficiaries enrolled in fee-for-service Medicare Part B for at least one month of the selected year. Individuals enrolled in Medicare Advantage at any point during the year are excluded.</p>		
Preventable Medicare Hospital Stays	<p>Preventable Hospital Stays measures the number of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period.</p> <p>Numerator = Number of discharges for Medicare beneficiaries ages 18 years or older continuously enrolled in Medicare fee-for-service Part A and hospitalized for any of the following reasons: diabetes with short or long-term complications, uncontrolled diabetes without complications, diabetes with lower-extremity amputation, chronic obstructive pulmonary disease, asthma, hypertension, heart failure, dehydration, bacterial pneumonia, or urinary tract infection.</p> <p>Denominator = Number of Medicare beneficiaries ages 18 years or older continuously enrolled in Medicare fee-for-service Part A. Individuals enrolled in Medicare Advantage at any point during the year are excluded. In addition, beneficiaries who died during the year, but otherwise were continuously enrolled up until the date of death, as well as beneficiaries who became eligible for enrollment following the first of the year, but were continuously enrolled from that date to the end of the year, are included in the denominator.</p>	<p>MMDT</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021

**Table A4.16: Safety**

Measure	Description	Data Source	Most Recent Data Year(s)
Injury Death Rate	Age-adjusted deaths per 100,000 population Accidents (unintentional injuries) (V01-X59, Y85-Y86)	CDC Wonder; UCD. Accessed November 2024.	2022
Firearm Fatality Death Rate	Age-adjusted deaths per 100,000 population Injury and Intent Mechanism - All Causes of Death - Firearm	CDC Wonder; UCD. Accessed November 2024.	2022
Motor Vehicle Crash Death Rate	Age-adjusted deaths per 100,000 population Motor vehicle accidents (V02-V04,V09.0,V09.2,V12-V14,V19.0-V19.2,V19.4-V19.6,V20-V79,V80.3-V80.5,V81.0-V81.1,V82.0-V82.1,V83-V86,V87.0-V87.8,V88.0-V88.8,V89.0,V89.2)	CDC Wonder; UCD. Accessed November 2024.	2022
Homicide Death Rate	Age-adjusted deaths per 100,000 population Assault (homicide) (*U01-*U02, X85-Y09, Y87.1)	CDC Wonder; UCD. Accessed November 2024.	2022
Suicide Death Rate	Age-adjusted deaths per 100,000 population Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)	CDC Wonder; UCD. Accessed November 2024.	2022
Violent Crime Rate	Violent crime rate is calculated with FBI violent crime data from Crime Data Explorer and Census.gov population data	Crime: Federal Bureau of Investigation Pop.: ACS, Table S2504 5-Year Estimates	2023 (Crime) 2022 (Pop.)
Teens Forced to Have Sex	Based on percent of self reported response to "Were ever physically forced to have sexual intercourse (when they did not want to)?"	CDC High School Youth Risk Behavior Survey Data.	2021
Juvenile Arrests	Numerator = Number of delinquency cases formally processed in juvenile court (petitioned) and the number of delinquency cases informally handled (non-petitioned) for individuals ages 0 to the upper age of jurisdiction for a juvenile court. Non-petitioned cases often result in dismissal or informal sanctions such as fines, community service, informal probation, or referral to a social services agency. Petitioned cases could also be dismissed, but the accused juvenile offender still has their case processed by a juvenile court judge before determining their decision. The upper age in which a juvenile court has jurisdiction is 17. It is important to note that the	Easy Access to State and County Juvenile Court Case Counts  RWJF & UWPHI, County Health Rankings. Accessed November 2024.	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>numerator is cases and not offenders as a juvenile could have multiple delinquency violations.</p> <p>Denominator = Population ages 10 to the upper age of jurisdiction. The upper age is 17. The population value is rounded to the nearest 100. The age range of 10 to upper age is used because 99.4% of all juvenile arrests occur among those who are 10 and older.</p>		

**Table A4.17 Sexual Health**

Measure	Description	Data Source	Most Recent Data Year(s)
Chlamydia Rate	<p>Numerator = Number of reported chlamydia cases in a county</p> <p>Denominator = Total county population</p> <p>Rate is per 100,000 population</p>	<p>National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021
Teen Birth Rate	<p>Teen Births is the number of births to females ages 15-19 per 1,000 females in a county.</p> <p>Numerator = Total number of births to mothers ages 15-19 in the 7-year time period</p> <p>Denominator = Aggregate female population, ages 15-19, over the 7-year time period</p>	<p>National Center for Health Statistics (NCHS)</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2016-2022

**Table A4.18: Substance Use Disorders**

Measure	Description	Data Source	Most Recent Data Year(s)
Excessive Drinking	<p>Excessive Drinking is the percentage of adults that report binge or heavy drinking in the past 30 days.</p> <p>Numerator = Number of adult respondents reporting either binge drinking or heavy drinking. Binge drinking is defined as a woman consuming more than four alcoholic drinks during a single occasion or a man consuming more than five alcoholic drinks during a single occasion. Heavy drinking is defined as a woman drinking more than one drink</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021

Measure	Description	Data Source	Most Recent Data Year(s)
	<p>on average per day or a man drinking more than two drinks on average per day.</p> <p>Denominator = Total number of adult respondents in a county.</p>		
Alcohol-Impaired Driving Deaths	<p>Alcohol-Impaired Driving Deaths is the percentage of motor vehicle crash deaths with alcohol involvement.</p> <p>Numerator = Total number of alcohol-impaired motor vehicle crash deaths in the 5-year period. The National Highway Traffic Safety Administration classifies a fatal crash as alcohol-related or alcohol-involved if either a driver or a non-motorist (usually a pedestrian or bicyclist) had a measured or estimated blood alcohol concentration of 0.01 grams per deciliter or above.</p> <p>Denominator = Total number of motor vehicle crash deaths in the 5-year period.</p>	<p>Fatality Analysis Reporting System</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2017-2021
Drug Overdose Death Rate	<p>Rates measure the number of events (e.g., deaths, births) in a given time period divided by the average number of people at risk during that period. Rates help us compare health data across counties with different population sizes. Drug Overdose Deaths is the number of deaths due to drug poisoning per 100,000 population.</p> <p>Numerator = Deaths from accidental, intentional, and undetermined drug poisoning by and exposure to: 1) nonopioid analgesics, antipyretics and antirheumatics, 2) antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified, 3) narcotics and psychodysleptics (hallucinogens), not elsewhere classified, 4) other drugs acting on the autonomic nervous system, and 5) other and unspecified drugs, medicaments and biological substances, over a 3-year period. ICD-10 codes used include X40-X44, X60-X64, X85, and Y10-Y14.</p> <p>Denominator = Aggregate annual population over the 3-year period</p>	<p>NCHS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2019-2021

Measure	Description	Data Source	Most Recent Data Year(s)
Opioid Prescription Dispensing Rate	Opioid prescriptions dispensed (per 100 persons).	Center for Disease Control and Prevention. Data accessed November 2024.	2023

**Table A4.19: Tobacco Use**

Measure	Description	Data Source	Most Recent Data Year(s)
Adult Smoking	<p>Adult Smoking is the percentage of the adult population in a county who both report that they currently smoke every day or some days and have smoked at least 100 cigarettes in their lifetime.</p> <p>Numerator = The numerator is the number of adult respondents who reported “Yes” to the following question: Have you smoked at least 100 cigarettes in your entire life? and “Every day or some days” to the question: Do you now smoke cigarettes every day, some days, or not at all?</p> <p>Denominator = Total number of adult respondents in county</p>	<p>BRFSS</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2021
High School Cigarette Use	Percent of high school students reporting using cigarettes on least 1 day during the 30 days before the survey. Based on DC school district.	CDC High School Youth Risk Behavior Survey Data. Accessed November 2024.	2023
Adult E-Cigarette Use	Adults who are current e-cigarette users. Variable calculated from one or more BRFSS questions (Crude Prevalence).	BRFSS. Accessed November 2024.	2023

**Table A4.20: Transportation Options and Transit**

Measure	Description	Data Source	Most Recent Data Year(s)
Driving Alone to Work	<p>Numerator = Number of workers who commute alone to work via car, truck, or van.</p> <p>Denominator = Total workforce.</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2018-2022
Long Commute/Driving Alone	<p>Numerator = Number of workers who drive alone (via car, truck, or van) for more than 30 minutes during their commute.</p> <p>Denominator = Number of workers who drive alone (via car, truck, or van) during their commute.</p>	<p>ACS, 5-year estimates</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024</p>	2018-2022

Measure	Description	Data Source	Most Recent Data Year(s)
Traffic Volume	<p>Traffic Volume at the county level is calculated with EJScreen data by aggregating all the census block data within a county, and weighing by the number of people in the corresponding blocks. The measure is reported as the average count of vehicles per meter per day within 500 meters of a census block centroid (the center point of a census block), divided by distance in meters, presented as the population-weighted average of blocks in each county. The closest traffic is given more weight through inverse distance weighting. A highway with 16,000 Annual Average Daily Traffic (AADT) at 400 meters distance would result in a score of <math>16,000/400=40</math>.</p> <p>Numerator = Average count of vehicles per meter per day within 500 meters of a census block centroid (the center point of a census block). Denominator = Includes all interstate, principal arterial, other National Highway System, and HPMS sample section roads.</p>	<p>EJSCREEN: Environmental Justice Screening and Mapping Tool</p> <p>RWJF &amp; UWPHI, County Health Rankings. Accessed November 2024.</p>	2023
Workers Commuting by Public Transportation	This indicator shows the percentage of workers aged 16 years and over who commute to work by public transportation.	ACS, 5-year estimates  DC Health Matters. Accessed November 2024	2018-2022
Percent of Households with No Vehicle Available	The percentage of households that report having no vehicle available.	ACS, Table S2504 5-Year Estimates	2018-2022

# Appendix 5 | Secondary Data Comparisons

## Description of Focus Area Comparisons

When viewing the secondary data summary tables, please note that the following color shadings have been included to identify how the District of Columbia compares to the national benchmark.

### Secondary Data Summary Table Color Comparisons

Color Shading	Priority Level	The District of Columbia Description
Green	Low	Represents measures in which the District of Columbia scores are <b>more than five percent better</b> than the most applicable target/benchmark and for which a low priority level was assigned.
Yellow	Medium	Represents measures in which the District of Columbia scores are comparable to the most applicable target/benchmark scoring <b>within or equal to five percent</b> , and for which a medium priority level was assigned.
Red	High	Represents measures in which the District of Columbia scores are <b>more than five percent worse</b> than the most applicable target/benchmark and for which a high priority level was assigned.

Note: Please see the methodology section of this report for more information on assigning need levels to the secondary data.

Please note that to categorize each metric in this manner and identify the priority level, the District of Columbia value was compared to the benchmark by calculating the percentage difference between the values, relative to the benchmark value:

$$(District\ of\ Columbia\ Value - Benchmark\ Value) / (Benchmark) \times 100 = \% \text{ Difference Used to Identify Priority Level}$$

For example, for the Food Environment Index metric, the following calculation was completed:

$$(0.2 - 0.6) / (0.6) \times 100 = 66.7\% = \text{Displayed as } \mathbf{Low\ Priority\ Level}, \text{ Shaded in Green}$$

This metric indicates that the percentage of the population with limited access to healthy foods in the District of Columbia is 66.7 percent better (or, in this case, lower) than the percentage of the population with limited access to healthy foods in the United States.

Measures indicating a need level of “**N/A**”, are included in the assessment and following tables simply as an informational data point about the service area. The “**N/A**” designation is included to indicate there was either:

- No available benchmark comparison for a given measure, or
- It was not appropriate to assess the metric as “better” or “worse” than the US average.

## Detailed Focus Area Benchmarks

**Table A5.1: Access to Care**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
% Uninsured Children (<19)	5.4%	2.7%	2019-2023	Low
% Uninsured Adults (19-64)	12.0%	4.2%	2019-2023	Low
% Uninsured Adults (65+)	0.8%	0.6%	2019-2023	Low
Primary Care Physicians Ratio	1,330:1	780:1	2021	Low
Dentist Ratio	1,360:1	770:1	2022	Low
Mental Health Provider Ratio	320:1	150:1	2023	Low
Advanced Practice Primary Care Provider Ratio	760:1	440:1	2023	Low

**Table A5.2: Built Environment**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
% Broadband Access	88%	89%	2018-2022	Medium
% Household with Computer	94%	95.4%	2024	Medium

**Table A5.3: Diet and Exercise**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
Food Environment Index	7.7	8.5	2019 / 2021	Low
% Physically Inactive	23%	16%	2021	Low
% with Access to Exercise Opportunities	84%	100%	2020 / 2022 / 2023	Low
% Adult Obesity	34%	25%	2021	Low

**Table A5.4: Education**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
School Segregation	0.24	0.34	2022-2023	High
School Funding Adequacy	\$634	\$(4,931)	2021	High
Disconnected Youth	7%	7%	2018-2022	Medium
% 4 Year High School Graduation Rate	86%	75%	2020-2021	High
Reading Scores	3.1	2.9	2018	High
Math Scores	3.0	2.8	2018	High

**Table A5.5: Employment**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Unemployed	4.3%	5.3%	2023	High

**Table A5.6: Environmental Quality**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
Air Pollution	7.4	8.9	2019	High
Drinking Water Violations	N/A	Yes	2024	High

**Table A5.7: Family, Community and Social Support**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Children in Single-Parent Households	25%	45%	2018-2022	High
Childcare Cost Burden	27%	41%	2022 / 2023	High
Childcare Centers	7	8	2010-2022	Low
Social Association Rate	9.1	29.6	2021	Low
Segregation Index – Black/White	63.0	66.0	2018-2022	Medium

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Socially and Emotionally Supported	N/A	70.6%	2019-2020	<b>N/A</b>
Diversity Index	72.5	73.5	2024	Medium

**Table A5.8: Food Security**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
Food Insecurity	-	37%	2024	<b>N/A</b>
Children Eligible for Free or Reduced Priced Lunch	51%	High Availability	2024 (DC) 2021-2022 (USA)	Low
% Population w/ Limited Access to Healthy Foods	6%	2%	2019	Low

**Table A5.9: Housing and Homelessness**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Severe Housing Problems	17%	19%	2016-2020	High
% Severe Housing Cost Burden	14%	17%	2018-2022	High
% Homeowners	64.8%	41.4%	2018-2022	High
Homelessness	20	73	2023	High

**Table A5.10: Income**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Children in Poverty	16%	20%	2018-2022	High
% ALICE Households	29%	27%	2024	Low
Income Inequality	4.9	6.6	2018-2022	High

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
Gender Pay Gap	0.81	0.87	2018-2022	Low
Living Wage	N/A	\$62.51	2023	N/A
% Food Stamp / SNAP Recipients	12%	20%	2024	High

**Table A5.11: Length of Life**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
Years of Potential Life Lost	8,000	9,000	2019-2021	High
Premature Deaths	390	470	2019-2021	High
Life Expectancy	77.6	77.1	2019-2021	Medium
Child Mortality Rate	50.0	70.0	2018-2021	High
Infant Mortality Rate	5.6	6.6	2022 (USA) 2023 (DC)	High
Heart Disease Death Rate	167.2	182.6	2022	High
Cancer Death Rate	142.3	141.8	2022	Medium
Stroke Death Rate	39.5	42.1	2022	High
COVID-19 Death Rate	44.5	33.1	2022	Low
Diabetes Death Rate	24.1	18.2	2022	Low
Chronic Lower Respiratory Disease Death Rate	34.3	17.3	2022	Low
Hypertension Death Rate	10.3	11.9	2022	High
Septicemia Death Rate	10.1	11.3	2022	High

**Table A5.12: Maternal and Infant Health**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Low Birthweight	8.6%	10.8%	2022 (USA) 2023 (DC)	High
% Premature Births	12.0%	10.7%	2022 (USA) 2023 (DC)	Low
% Prenatal Care, First Trimester	N/A	68.3%	2023	N/A
Pregnancy Related Mortality Rate	28.4	44.0	2014-2018	High
Maternal Mortality Rate	20.7	23.1	2014-2018	High

**Table A5.13: Mental Health**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Frequent Mental Distress	15%	14%	2021	Low
Poor Mental Health Days per Month	4.8	4.8	2021	Medium
% Depressive Disorder Diagnosis	N/A	19.8%	2020	N/A
% Used Prescription Antianxiety Medications	8.4%	7.2%	2024	N/A
% Used Prescription Antidepressant Medications	7.7%	6.4%	2024	N/A
% Visited Mental Health Provider	5.0%	6.6%	2024	N/A

**Table A5.14: Physical Health**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Frequent Physical Distress	10%	8%	2021	Low
Poor Physical Health Days per Month	3.3	2.7	2021	Low
% Fair or Poor Health	14.0%	13%	2021	Low
% Adults with Diabetes	11.5%	8.0%	2022	Low
HIV Prevalence	382	2,382	2021	High

**Table A5.15: Quality of Care**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
% Medicare Mammography Screening	43%	35%	2021	High
% Medicare Flu Vaccine	46%	41%	2021	High
Preventable Medicare Hospital Stays	2,681	3,723	2021	High

**Table A5.16: Safety**

<b>Measure</b>	<b>National Benchmark</b>	<b>District of Columbia Data</b>	<b>Most Recent Data Year</b>	<b>District of Columbia Need</b>
Injury Deaths	64.0	90.9	2022	High
Firearm Fatalities	14.2	21.4	2022	High
Motor Vehicle Crash Deaths	13.3	8.4	2022	Low
Homicides	7.7	23.7	2022	High
Suicides	14.2	6.1	2022	Low
Violent Crimes	373	1,169	2022	High
Teens Forced to Have Sex	8.5%	6.2%	2021	Low
Juvenile Arrest Rate	N/A	15	2021	N/A

**Table A5.17: Sexual Health**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
Chlamydia Rate	495.5	1,037.5	2021	High
Teen Birth Rate	17.0	18.0	2016-2022	High

**Table A5.18: Substance Use Disorders**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
% Excessive Drinking	18%	24%	2021	High
% Driving Deaths with Alcohol	26%	25%	2017-2021	Medium
Drug Overdose Mortality Rate	27	57	2019-2021	High
Opioid Prescriptions Dispensed	37.5	30.3	2023	Low

**Table A5.19: Tobacco Use**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
% Adult Smokers	15%	11%	2021	Low
% High School Cigarette Use	3.5%	3.1%	2023	Low
% Adult E-Cigarette Use	7.7%	5.6%	2023	Low

**Table A5.20: Transportation Options and Transit**

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
% Drive Alone to Work	72%	30%	2018-2022	Low
% Long Commute – Drives Alone	36%	50%	2018-2022	High
Traffic Volume	108	573	2023	High
Workers Commuting by	3.8%	24.7%	2018-2022	Low

Measure	National Benchmark	District of Columbia Data	Most Recent Data Year	District of Columbia Need
Public Transportation				
% Households w/ No Vehicle	8.3%	35.7%	2018-2022	High

**Table A5.21: 2017-2023 Percentage of Low Birthweight Births<sup>53</sup>**

Ward	2017	2018	2019	2020	2021	2022	2023	Trend
Ward 1	9.2%	7.6%	8.1%	6.6%	7.5%	8.1%	9.4%	-
Ward 2	5.4%	6.2%	6.5%	6.3%	7.4%	5.7%	8.4%	↑
Ward 3	5.8%	5.0%	7.1%	6.1%	7.0%	6.5%	8.3%	↑
Ward 4	8.7%	8.0%	8.2%	7.6%	7.3%	6.8%	7.3%	↓
Ward 5	10.8%	9.4%	10.0%	9.4%	9.2%	9.5%	8.9%	↓
Ward 6	7.5%	7.4%	7.9%	8.5%	6.8%	8.8%	9.1%	↑
Ward 7	15.8%	15.2%	12.9%	14.2%	14.2%	14.8%	14.5%	↓
Ward 8	14.9%	16.1%	14.5%	13.6%	14.0%	13.9%	17.1%	↑
<b>DC Overall</b>	<b>10.5%</b>	<b>10.0%</b>	<b>9.9%</b>	<b>9.6%</b>	<b>9.6%</b>	<b>9.9%</b>	<b>10.8%</b>	-

**Table A5.22: 2017-2023 Percentage of Preterm Births<sup>53</sup>**

Ward	2017	2018	2019	2020	2021	2022	2023	Trend
Ward 1	9.4%	7.2%	8.8%	6.8%	9.1%	10.4%	8.6%	↓
Ward 2	6.8%	7.0%	7.5%	6.5%	8.4%	7.0%	7.3%	↗
Ward 3	7.0%	7.2%	10.1%	8.9%	9.3%	6.8%	7.0%	-
Ward 4	10.4%	9.6%	8.6%	7.7%	8.0%	7.8%	9.2%	↓
Ward 5	9.9%	10.0%	10.4%	9.4%	9.2%	10.1%	10.0%	-
Ward 6	7.5%	8.0%	7.9%	9.6%	7.1%	8.2%	8.9%	↑
Ward 7	16.3%	13.7%	12.4%	14.3%	13.2%	13.5%	13.0%	↓
Ward 8	13.5%	14.1%	15.1%	12.4%	14.2%	13.4%	16.8%	↑
<b>DC Overall</b>	<b>10.6%</b>	<b>10.1%</b>	<b>10.4%</b>	<b>9.8%</b>	<b>10.1%</b>	<b>10.2%</b>	<b>10.7%</b>	-

**Table A5.23: 2017-2023 Percentage of Births with Prenatal Care Beginning in First Trimester<sup>53</sup>**

<b>Ward</b>	<b>2017</b>	<b>2018</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>	<b>2022</b>	<b>2023</b>	<b>Trend</b>
Ward 1	70.1%	69.1%	73.9%	73.2%	72.5%	61.7%	66.5%	↓
Ward 2	77.6%	80.3%	79.0%	81.9%	58.7%	68.0%	72.0%	↓
Ward 3	85.2%	83.1%	84.9%	81%	82.2%	75.8%	72.7%	↓
Ward 4	69.2%	65.3%	69.4%	69.6%	70.3%	60.4%	66.7%	↘
Ward 5	67.5%	66.8%	66.0%	67.3%	74.1%	63.5%	66.4%	↘
Ward 6	77.5%	75.7%	78.6%	77.3%	78.3%	75.0%	77.5%	-
Ward 7	58.9%	56.8%	55.9%	60.0%	67.0%	55.5%	66.3%	↑
Ward 8	55.9%	51.2%	53.4%	55.1%	62.9%	55.1%	65.3%	↑
<b>DC Overall</b>	<b>68.3%</b>	<b>66.3%</b>	<b>68.1%</b>	<b>68.8%</b>	<b>70.3%</b>	<b>62.7%</b>	<b>68.3%</b>	-

# Appendix 6 | Secondary Data Summary

The table and graphic below include summaries of potential priority need areas, as identified by the secondary data analysis process, as well as priority areas of need identified by other state, local, and national sources. These preliminary findings were shared with the Steering Committee during the review and discussion of secondary data.

Potential Priority Area	Secondary Data Findings	MedStar	Children's National / HSC	Kaiser	DC Healthy People 2020	Climate Ready DC	Age-Friendly DC	Sustainable DC 2.0	DC Health Systems Plan	2019 DCHM CHNA/CHIP	2022 DCHM CHNA/CHIP	US Office of the Surgeon General	Healthy People 2030
Healthcare Access	✓	✓	✓	✓	✓		✓		✓	✓	✓		
Health Equity & Social Determinants of Health	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓		✓
Housing & Transit	✓	✓		✓		✓	✓	✓	✓		✓		
Safety & Violence	✓	✓		✓	✓		✓					✓	
Employment & Poverty	✓		✓	✓			✓						
Food Security		✓						✓	✓				
Mental & Behavioral Health	✓	✓		✓	✓				✓	✓	✓	✓	
Social Connection							✓	✓		✓	✓	✓	
Built Environment	✓	✓				✓	✓	✓					
Healthcare Workforce									✓	✓	✓	✓	
Chronic Disease & Cancer	✓	✓	✓										
Substance & Tobacco Use	✓	✓		✓									
Aging & Older Adults		✓					✓		✓				
Sexual Health	✓			✓									
Maternal & Infant Health	✓												
Communicable Disease												✓	

## Appendix 7 | Summary of Prior CHNA Implementation Plans

The immediately prior CHNA process for both Howard University Hospital and Sibley Memorial Hospital was conducted as part of the DC Health Matters Collaborative (The Collaborative). The Collaborative united hospitals and community health centers to collectively assess and address community health needs through data-driven, community-engaged partnerships aimed at achieving equitable and sustainable health outcomes for DC residents. Formed in 2012 in response to the Affordable Care Act's requirement for non-profit hospitals to conduct triennial community health needs assessments (a requirement FQHCs had faced for decades), the Collaborative evolved beyond regulatory compliance to strategically invest in community health initiatives targeting local needs and disparities. Its membership comprised four non-profit hospitals and four community health centers, along with three ex-officio members.

In 2024, Howard University Hospital and Sibley Memorial Hospital conducted their 2025 Community Health Needs Assessment together but outside of the broader Collaborative. Former Collaborative members, while not part of the Steering Committee for this CHNA process, were involved in the Howard/Sibley CHNA process through key leader interviews.

For more information about the previous CHNA process, please visit:  
<https://www.dchealthmatters.org/files/index/display?alias=aboutus>

### Howard University Hospital

The Community Health Improvement Plan (CHIP) Howard University Hospital (HUH) for 2022 - 2025 committed to work with community and government partners toward goals of **mental well-being, equitable access, and community-based workforce development**.

As we continue with the improvement plan through to the end of 2025, we want what has been done thus far. HUH has collaborated with stakeholders and continued with strategic efforts towards goals to improve the health of the community, in every area of the CHIP work.

In improving both **equitable access to care and mental well-being**, HUH increased the number of community health fairs providing free health education and screening along with vaccinations for children returning to school. In support of women's health, HUH provided community baby showers that included opportunities to provide information on perinatal health and opportunities to provide diapers and supplies to care for newborns.

HUH recognized the district's public health needs of economic development and **workforce training** as priority work areas. To address this, HUH partnered with Howard University's Faculty Practice Plan (FPP) to provide workforce training to students. This was through a structured professional development and educational program, allowing students healthcare experience. This apprenticeship provided relevant skills and experiences for those interested in the entering the

healthcare field. This development was instrumental in students receiving, critical first-hand experience and training.

The work of the 2022 – 2025 Community Health Improvement Plan continues to positively impact the health of residents in all areas of the District of Columbia through the end of calendar year 2025.

## **Sibley Memorial Hospital, Johns Hopkins Medicine**

The Community Health Improvement Plan (CHIP) Sibley Memorial Hospital for 2022 - 2025, Johns Hopkins Medicine (SMH/JHM), committed to work with community and government partners toward goals of **mental well-being, equitable access, and community-based workforce development**.

While the work is still underway through the end of 2025, much has been done to work toward the goals. For example, in every area of the CHIP work, SMH/JHM provided experts to deliver community education, and collaborated with other hospitals and community leaders to develop strategies and measure work toward goals in the improvement of community health.

In just one case of simultaneously improving both **mental health and access to care** in support of older adults, SMH/JHM significantly increased the number of support groups for persons experiencing grief or caring for individuals with cognitive changes, e.g., Alzheimer's. These groups now serve all wards of the District.

In addition, we provided training for local communities of faith in **Mental Health First Aid**. Mental Health First Aid is an evidence-based, early-intervention course that teaches participants about mental health and substance use challenges. It teaches skills needed to recognize and respond to signs and symptoms of mental health and substance use challenges, as well as how to provide someone with initial support until they are connected with appropriate professional help.

Further, SMH-JHM recognized the district's public health needs of economic development and **workforce training** as priority work areas. To address this, SMH/JHM partnered with District of Columbia's Office of State Superintendent for Education to provide workforce training to students. Students, many in a first-time job experience, are provided with relevant healthcare skills and experiences under the guidance of our expert professionals. This development was instrumental in students receiving scholarships, critical first-hand experience, and advancing into other jobs.

The work of the 2022 – 2025 Community Health Improvement Plan continues to positively impact the health of residents in all areas of the District of Columbia through the end of calendar year 2025.