·2025·

Community Health Implementation Plan

HOWARD UNIVERSITY HOSPITAL

SIBLEY MEMORIAL HOSPITAL, JOHNS HOPKINS MEDICINE

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Background

The 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 (SMH) and Howard University Hospital (HUH).

The 2025 CHNA was conducted in compliance with Internal Revenue Service (IRS) 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. To ensure broad community input as required by the IRS, these organizations collaborated to collect data through focus groups, interviews and surveys, the findings of which are detailed in the CHNA 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 the written report, which has been reviewed and adopted by each hospital facility's authorizing body.
- Made the CHNA report widely available to the public through hospital websites and other distribution channels.

CHNA Summary

After a review of the available data, the following priority health needs were identified and prioritized through the 2025 CHNA process:

1. **Health Conditions** - including Behavioral Health (Mental health and Substance Use), chronic diseases, and maternal/infant health
2. **Healthcare Access** - with a focus on system navigation
3. **Social Determinants of Health** – including housing, safety, food security and economic inequality

Demographics - The Community We Serve

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.

The Social Vulnerability Index (SVI) helps show which neighborhoods might need extra help during emergencies like natural disasters or disease outbreaks. The SVI combines information about a neighborhood's income levels, housing conditions, and other important factors to create a score that shows how vulnerable that area might be to health emergencies. 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.

CHNA Implementation Strategy: Priority Needs

After review and collaboration from the Steering Committee along with community and leader feedback, the following sections outline strategies, goals, anticipated outcomes, possible partnerships and collaborations for each of the CHNA priority areas. The identified strategies will be addressed and measured by Sibley Memorial Hospital and Howard University Hospital in the subsequent 3 years.

Priority 1: Health Conditions

The Steering Committee identified Health Conditions as a priority for 2025 CHNA. Although all diagnoses and health conditions are important to the overall well-being of residents in the District of Columbia, implementation strategies were developed and tailored to focus on the four key areas: Mental Health, Chronic Disease Substance Use, and Maternal and Infant Health.

Chronic Disease

Chronic diseases represent significant health concerns for District residents and is represented in six of the ten top leading causes of death. Heart disease being the leading cause of death followed by cancer. Community members reported at our focus groups that social isolation, specifically in the senior population, has a great effect on quality of life and may create difficulty in managing chronic disease due to lack of community support systems.

To address these concerns, Sibley Memorial Hospital and Howard University Hospital will focus on improving community health and wellbeing through health navigation programs, health education programs, screenings, and community-based senior programming at our respective hospitals. Planned strategies and potential partnerships include:

HEALTH CONDITIONS: CHRONIC DISEASE

Goal: Improve community health and wellbeing through health education programs and screenings for adults.

Strategies	Anticipated Results
• SMH Virtual or in person "Ask an Expert" sessions • SMH Stroke Education/BP Screenings and education • SMH Club Memory® • Sibley Senior Association support groups • Chronic Disease Management and Cancer Management workshops • HUH Diabetic, and Sickle Cell education/management • Stop the Bleed training	• Provide access to screenings, health education, and community-health resources on chronic health issues - track number of screenings and health education sessions performed in community • Provide monthly senior health programming and health conferences -track number of health programs and participants • Increase public health literacy in community -track education sessions in community and virtual • Provide Caregiver support and Dementia support groups and education - track number of support groups and participants • Expanded access to family planning information related to sickle cell disease- track number of adults screened for SCD trait • Increase public knowledge on Stop the Bleed skill set and train more members of the community -track number of training sessions and participants

Program and Partner Examples

- Club Memory® is a stigma-free supportive social group for people with mild cognitive impairment or Alzheimer's disease and related dementias and their care partners. Club Memory® has continued to grow exponentially, in response to members' and community needs. Club Memory® serves all wards in the District of Columbia through support from the Department of Aging and Community Living (DACL) and private philanthropy.
- Sibley Senior Association (SSA) organizes in person and virtual senior programming to improve the health and wellness and combat social isolation of people 50 and older. SSA also produces multiple health education conferences that provide awareness and resources on chronic health issues.
- HUH Diabetes Treatment center focuses on treating disproportionately susceptible and severely distressed members of the patient population in the District. The clinic coordinates efforts and established a "partner of choice" relationship with community partners and District of Columbia Primary Care providers. The clinic empowers the community through education and awareness.
- HUH in partnership with DC EMS provide Stop the Bleed training educating community members and providers on bleeding control training and empower anyone to save a life by learning 3 basic actions to control severe bleeding in an injured person.

Mental Health and Substance Use

Mental health and substance use 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. Although mental health and substance use trends in the District of Columbia are similar to national patterns, major gaps in behavioral health and healthcare remain in communities with fewer resources and less access to care, especially in Wards 7 and 8 and parts of Wards 5 and 6. Focused efforts are needed in these areas to address mental health, substance use, and violence and trauma-related behavioral health concerns. Cost, difficulty obtaining an appointment, lack of behavioral health services in some parts of the District, 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.

Focus group members reported there are not enough resources to meet the needs of substance use or mental health for youth and seniors, consequently bringing up higher rates of anxiety and other mental health challenges specifically after COVID. Community members believe access to mental health providers is dwindling in that providers are leaving wards 7 and 8 or going out of business.

To address these concerns, the following approaches should be expanded or considered:

- Implementing trauma-informed care principles such as safety, trust, collaboration, and empowerment to create supportive and recovery-focused environments.
- Harm Reduction: Utilizing harm reduction strategies to minimize the negative effects of substance use, which can also address trauma-related concerns.
- Community Coalitions: Engaging community members in coalitions or partnerships to prevent substance use and address related violence and trauma.
- Strengths-Based Approaches: Recognizing and leveraging the inherent skills and abilities of individuals to promote self-actualization and wellness, which can also help in managing substance use and trauma.

Sibley Memorial Hospital and Howard University Hospital will focus on improving behavioral health through prevention, assessment and access to appropriate behavioral health and substance use services though community-based programs, sharing resources and providing care through specialized programs at our respective hospitals. Planned strategies and potential partnerships include:

HEALTH CONDITIONS: MENTAL HEALTH & SUBSTANCE USE

Goal: Improve mental health through prevention, assessment and access to appropriate quality behavioral health and substance use services.

Strategies	Anticipated Results
• SMH behavioral health community education, support groups and nonprofit sponsorships • SMH/HUH 988 suicide and crisis lifeline service education • SMH Mental Health First Aid, Dementia specific training to community leaders • SMH Behavioral Health ED construction and services • HUH Telemedicine resources that include mental health and substance use disorder treatment • HUH Mental health outreach and to provide Narcan training • HUH Peer Recovery Coaches • HUH Harm Reduction efforts, including community education, outreach, and overdose education and naloxone distribution (OEND) in neighborhoods experiencing the highest rates of overdose deaths. • HUH use of trauma-informed care principles in the provision of behavioral health treatment services. • Consider deployment of a Naloxone and Harm Reduction vending machine onsite (outside or inside) Howard University Hospital.	• Construction of SMH behavioral health ED to accommodate 16 beds by 2028. • Expand access and participation in education sessions through outreach efforts -track number of outreach events and participants • Expand 988 awareness by providing information at outreach events- track number of events • Provide linkages to care and services addressing substance use disorders-track number of referrals • Maintain active participation in Brain Health workgroup-track number of meetings attended • Expand First Aid mental health, training to more community-based organizations (CBO) and staff -track number of staff , community members and CBOs trained • Expand Narcan sessions to mobile clinics - track number of Narcan kits and supplies provided

Program Examples

- HUH Peer recovery specialists provide non-clinical support designed to enhance treatment and recovery for individuals with substance use disorders. Peer recovery specialists are individuals with lived experience from mental and/or substance use disorders who are in recovery who not only provide peer support but have received specialized training and certification and thus are also able to refer and assist with treatment resources.
- SMH Emergency Department will be constructing a new 16-bed Behavioral Health ED wing that will address the rising behavioral health needs in our community.
- HUH Better Together Community Advisory Board is a joint effort between Howard University Hospital and the Howard University Faculty Practice Plan's Behavioral Health Clinic. Chaired by the Executive Director of the DC Dream Center, and with representation on the Board of persons with lived experience, the pastor of the Pennsylvania Avenue Baptist Church, the founder and facilitator of Ward 8 Community Economic Development (W8CED) planning process, and a representative of Building Bridges and THEARC.

Maternal and Infant Health

The District of Columbia's maternal and infant health outcomes are below the national benchmarks. The District presents a higher percentage of low birthweight births compared to the national averages and more concerning is that the maternal and infant mortality rates in DC are higher than the national average. Within the District, over 30% of mothers do not receive prenatal care in the first trimester. These statistics are more geographically predominant east of the Anacostia river. To address these concerns, Sibley Memorial Hospital and Howard University Hospital will focus on improving access to maternal health services and educational resources with a focus on perinatal, fetal medicine with the intention to reduce morbidity and mortality. We plan to accomplish this through our specialized maternal health programs, district-based maternal health collaborative participation, health education programs, and providing community support. Planned strategies and potential partnerships include:

HEALTH CONDITIONS: MATERNAL AND INFANT HEALTH

Goal: Improve access to maternal health services and education resources with a focus on perinatal, fetal medicine and ultimately to contribute to the reduction of morbidity and mortality.

Strategies	Anticipated Results
• SMH involvement in Ward 8 Health Council Health and Wellness series partnership • SMH involvement in National Doula Collaborative support • SMH Maternal Health Access Program • Transforming Maternal Health (TMaH) Provider Incentive Program participation • HUH Woman and Infant Services discharge education resources, vaccinations • HUH Community Baby Showers	• Enhance learning through maternal health education programs-track maternal health education sessions in community and virtual • National Doula collaborative meetings participation rates-track number of meetings attended • Maternal Health Access Program to provide high quality care and navigation expansion - track number of persons served • Community led efforts that focus on maternal health needs support • Continue to offer ongoing support, supplies, and resources to our families. Enhance education on breastfeeding, lactation and infant support -track number of persons served and resources provided

Program Examples

- SMH Maternal Health Access Program expands early identification of high-risk women, established a clinical care coordination program and developed innovative methods to monitor pregnancy with the goal of improving both maternal and neonatal outcomes in the District of Columbia.
- The Women & Infant Services at Howard University Hospital (HUH) provide care to expectant and new mothers, infants, and families in the D.C. area. HUH itself is a major teaching hospital affiliated with Howard University College of Medicine. Within this hospital, the women and infant services include maternity/labor & delivery care, newborn and infant support, lactation and breastfeeding services, and perinatal-behavioral health care support (among other things).
- Howard University Faculty Practice Plan in partnership with community organizations host community vaccination clinic where families receive school physicals and children's vaccines to ensure a healthy start to the school year.

Priority 2: Healthcare Access

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. Healthcare access goes beyond just having insurance, it means that District residents must also obtain timely, appropriate care when needed as well as providing opportunities to educate and aid in the navigation of an already complex healthcare system. Like the priorities listed before, there are significant geographical healthcare access barriers. Healthcare resources are unevenly distributed across the District.

To address these concerns, Sibley Memorial Hospital and Howard University Hospital will focus on improving and expanding community access to person-centered, comprehensive, quality health care providers and programs as well as medical and non-medical services.

We plan to accomplish this through community organizations and partnerships with District government programs to support healthcare education, navigation efforts and access to screenings and health education in community. Planned strategies and potential partnerships include:

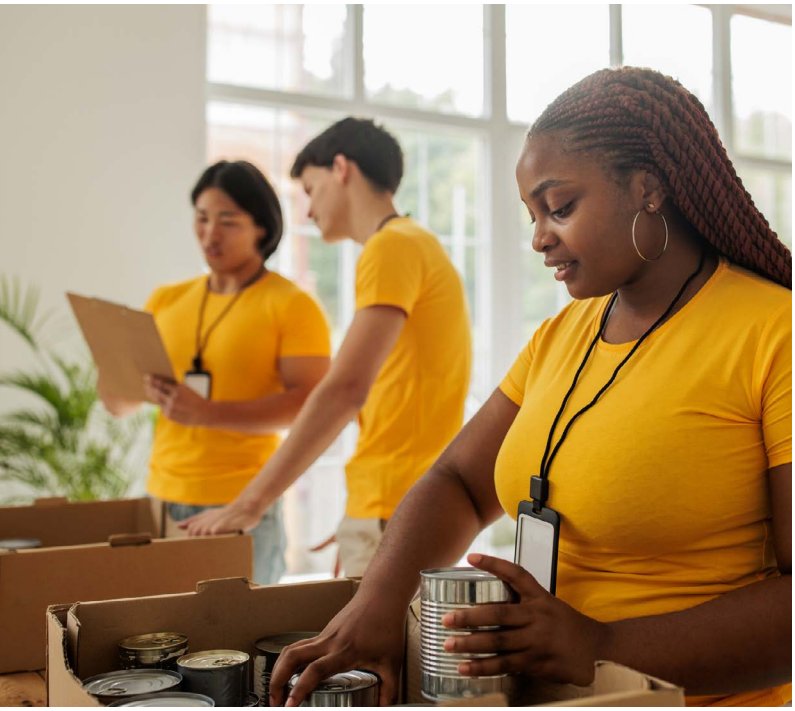
HEALTHCARE ACCESS: HEALTHCARE NAVIGATION/ ACCESS TO HEALTHCARE PROFESSIONALS

Goal: Improve and expand community access to person-centered comprehensive, quality health care providers and programs, as well as medical and non-medical services.

Strategies	Anticipated Results
• SDOH screenings and linkages to service programs • SMH Memory Screenings in community • Medicaid renewal and eligibility • Provide patient transportation assistance • HUH Navigation Clinics • HUH Ryan White Program • SMH Cancer Navigation program	• Expand awareness of FindHelp resources through promotion and outreach to patients and community members by dispersing information at community outreach events • Expand access to memory screening resources for community and community partners - track number of persons screened • Expand awareness of medical and non-medical services to people living with HIV through the Ryan White Program - track number of encounters and referrals made • Navigate FQHC partner patients with suspicious cancer findings into care - track number of referrals and follow up

Program Examples

- SMH reaches large community groups with Self-Administered Gerocognitive Exams (SAGE) designed to detect early signs of cognitive, memory or thinking impairments. These screenings are not a diagnosis but serve as a preliminary step to identify potential cognitive impairment.
- United Health Care navigation clinics at Howard University Hospital provide patient and community support on healthcare navigation and healthcare access. Navigators provide real-time updates to Medicare and Medicaid recipients, provide resources and locations to address insurance concerns, and ensure that community members have adequate information to make appropriate health choices.
- SMH Cancer Navigation program in partnership with Unity Health Care meets with patients and caregivers to identify barriers or needs in their cancer journey. The team makes referrals, schedules appointments, provides transportation, and offers support groups for those battling cancer



Priority 3: Social Determinants of Health

The Steering Committee identified Social Determinants of Health as a priority for the 2025 CHNA. The District of Columbia has strengths in the social landscape that include robust public transportation benefits and an abundance of community resources. However, these resources are not equitably distributed across community members. There are other social and environmental factors that can influence health outcomes. This report will focus on Housing and Food Insecurity as community members reported those determinants to be the most critical.

Food Insecurity

According to the Capital Area Food Bank-Food Hunger report, 36% of households experienced food insecurity within the past year which notable increased from 32% of households in 2023.

This increase is attributed to rising financial pressure on low-income households fueled by inflation on food and other necessities. Consequently, more households are facing limited access to nutritious food options but also consuming less. (CAFB Food Hunger Report, 2025)

To address these concerns, Sibley Memorial Hospital and Howard University Hospital will focus on providing resources to address food insecurity in the District. We plan to accomplish this through participation in community coalitions that address food insecurity, collaboration with respective hospital care coordination departments to provide resources to patients in need, and community partnerships focused on food access. Planned strategies and potential partnerships include:

SOCIAL DETERMINANTS OF HEALTH: FOOD INSECURITY

Goal: Provide resources to address food insecurity.

Strategies	Anticipated Results
• SMH Case Management Food Insecurity efforts • Community Organizations Food Insecurity Initiatives support • SMH involvement in DC Food Action Collaborative participation • NourishHUFood Pantry	• Enhance awareness to food insecurity resources and explore food partnerships- track find help referrals • Attend and actively participate in the DC Food Action Collaborative – track number of meetings attended

Program Examples

- SMH Case Management Find Help tool utilization allows clinical team to make referrals to food programs that patients are eligible for and can access easily.
- NourishHU Food Pantry partners with community and corporate organizations to supply nutritious food options to expand food access to students in need.

Housing

Housing emerged as a critical SDOH in the District of Columbia, affecting residents' health through multiple pathways including affordability, quality, stability, and homelessness. Comparing District data to national averages, the District has a higher percentage of residents experiencing severe housing problems, home ownership is substantially lower than the national average, and homelessness is more than three times the national rate. Residents reported in our focus groups that they see less affordable housing options in the market and homeownership is becoming unattainable.

To address these concerns, Sibley Memorial Hospital and Howard University Hospital will focus on providing awareness and resources to address the housing and homelessness crisis. We plan to accomplish this through participation in community coalitions that address housing instability, partnerships with local respite care facilities focused on populations that are homeless, and supporting local homeless organizations. Planned strategies and potential partnerships include:

SOCIAL DETERMINANTS OF HEALTH: HOUSING AND HOMELESSNESS

Goal: Provide awareness and resources to address housing and homelessness

Strategies	Anticipated Results
• Housing and homelessness community workgroups/ committee participation • Respite care partnerships • Housing/Homelessness Organizations support	• Enhance housing insecurity resources awareness- track findhelp referrals • Participate in DC housing collaborative meetings- track number of meetings attended

Program Examples

- Attend the DC Healthy Housing Collaborative (DCHHC) which is a coalition of many organizations working together to improve the health of District of Columbia residents
- HUH partnership with Urban Health Initiative providing clothing, resources, and supplies to help homeless on the hospital lawn.

Next Steps

As anchor institutions in the District, Sibley Memorial Hospital and Howard University Hospital are committed to making positive health impact and improving health access to serve the needs of community members. Steering Committee hospital leaders will leverage information from the CHNA to guide and inform implementation and the action plans noted above. This work will be achieved by working internally, and with other nonprofit organization and District agencies to ensure the priority health need areas are addressed in the most efficient, effective, and collaborative way. The Community Health Improvement Plan strategies will be reviewed annually during the three-year CHNA cycle. As part of this process, hospital leaders will gather feedback and review metrics to guide the work and to report on community impact and health outcomes.

JOHNS HOPKINS

MEDICINE

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