



**DC HEALTH MATTERS  
COLLABORATIVE  
and HOWARD UNIVERSITY  
HOSPITAL**

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# EXECUTIVE SUMMARY

1.

## Who We Are

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

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

## What We Do

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

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

## How We Work

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

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

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

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

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

### Community Health Needs, 2019-2022

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

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

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

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

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

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

- The importance of emergency preparedness for government systems, health providers, and individuals.
- Urgent need for adequate labor pool health and behavioral health professions, including traditional and nontraditional positions.
- Essentiality of cultural and linguistic competence and trauma-informed care among providers, and appropriate, respectful communication with communities.

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

### [Selected Areas of Focus, 2022-2025](#)

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

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

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

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

With the three priority needs identified, the Collaborative co-developed this plan with actionable recommendations for addressing community needs through 2025 with community stakeholders.

### [CHIP Commitments to Community Partnership](#)

We invite all D.C. stakeholders to join us in working toward health equity. Contact us at 202-364-7602 to participate in our Community Health Improvement Plan.

## ABOUT DC HEALTH MATTERS COLLABORATIVE

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

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

Member organizations contributing to this plan include three District hospitals (Children’s National Hospital, Howard University Hospital, and Sibley Memorial Hospital) and four federally qualified health centers (FQHCs) (Bread for the City, Community of Hope, Mary’s Center, and Unity Health Care). Ex-officio members include the D.C. Behavioral Health Association, D.C. Hospital Association, and D.C. Primary Care Association.

This CHNA was planned under the elected leadership of Julia DeAngelo, MPH, Program Manager of School Strategies of in Children’s National Hospital’s Child Health Advocacy Institute, and our current co-chairs, Davene M. White, MPH, RN, NNP, Assistant Professor and Director of HUH CARES Public Health Programs at Howard University Hospital, and Pamela Carter-Nolan, PhD, MPH, Director Master of Public Health program at Howard University.

In addition to fulfilling the ACA requirements through joint CHNAs and Community Health Improvement Plans, the Collaborative has invested in several community assets. First, our web portal [[DCHealthMatters.org](https://DCHealthMatters.org)] offers our community data and resources to inform their understanding of D.C.’s health landscape and empower efforts to advance health equity. Our blog highlights our activities and resources and features guest authors such as local health professionals and advocates.

In the [2019 Community Health Improvement Plan](#), the Collaborative announced the launch of D.C. Health Matters Connect, our online social referral tool [[DCHealthMattersConnect.org](https://DCHealthMattersConnect.org)] which connects providers and residents with an array of free and low-cost programs in categories like health, housing, food, and transit. Other projects and policy work, detailed later in this document focused on stakeholder education related to our priority areas in Mental Health, Care Coordination, Health Literacy and Place-Based Care.

Since its inception, the Collaborative has recognized that most of health is driven by social factors outside of access to healthcare, such as housing, education, and environment. We have worked primarily through a framework which recognizes the importance of changing policy, systems, and environment (PSE) to truly impact community health outcomes. A formal policy advocacy agenda was first launched in 2019 for achieving citywide, legislative, and regulatory actions in support of our CHNA findings, CHIP strategies, and equity goals.

# COMMUNITY HEALTH NEEDS ASSESSMENTS, 2013 TO 2022

## CHNA Requirements

The initial catalyst for the Collaborative's formation was a new federal requirement in the Patient Protection and Affordable Care Act of 2010 (ACA). The Community Health Needs Assessment (CHNA) regulations require the needs assessment to be conducted every three years.

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

## Definition of Community

Collaborative organizations all serve the District of Columbia (D.C.), as well as neighboring states (Maryland, Virginia, and beyond). For this CHNA, "community" is defined as the residents of D.C.; not only the patients of member organizations, but all those living within the geographic boundaries of the District. Because specific utilization and patient population data for D.C. hospitals and community health centers (regardless of the patients' place of residence) is important to consider, we provide these data on [DCHealthMatters.org](https://www.dchealthmatters.org).

## Past Needs Assessments

### 2. The 2013 CHNA

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

### 3. The 2016 CHNA

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

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

#### 4. The 2019 CHNA

For the 2019 assessment, the Collaborative re-prioritized the needs identified in 2016: mental health, care coordination, health literacy, and place-based care. Acknowledging that these needs persisted in the District, members agreed to leverage the capacity, expertise, and relationships that had been built to continue addressing these needs.

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

#### 2022 Needs Assessment

Given the fatigue in the health system and the community during the COVID-19 pandemic, and the limitations to community engagement posed by COVID infection risk, such alignment was even more important in 2022.

The 2022 CHNA includes three main elements: Descriptions of the work of the D.C. Health Matters Collaborative since the 2019 CHNA was released; Summaries of the diverse landscape of existing local research on community health and other social factors; interviews with leaders in health provider organizations.

The Collaborative reviewed 16 local reports released 2019-2022 focused on health, inclusive of behavioral health, COVID-19 impacts, and relevant social issues related to health such as housing and transportation. Among others, this included:

- The [D.C. Community Health Needs Assessment](#) published in 2019 by D.C. Health.
- The [“Health Disparities in the Black Community”](#) report published June 2020 by Georgetown University’s School of Nursing and Health Studies.
- [“D.C. Frontline and Essential Workers’ Needs During COVID-19”](#) published in November 2020 by D.C. Appleseed
- [MedStar Health’s CHNA report](#) published in June 2021 by MedStar Health
- D.C. Health’s [“COVID-19 Pandemic Health and Healthcare Recovery Report”](#) released in May 2021.
- [“A Path Forward: Transforming the Public Behavioral Health System for Children, Youth, and their Families”](#) published in 2021 by Children’s Law Center, Children’s National Hospital, D.C. Behavioral Health Association, Early Childhood Innovation Network, Health Alliance Network, MedStar Georgetown University Hospital Division of Child and Adolescent Psychiatry, Parent Watch, and Total Family Care Coalition.
- [Children’s National Hospital \(CNH\) and HSC Pediatric Center \(HSC\) pediatric CHNA](#) released in June 2022.

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

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

The same five-question script developed and revised by members was used for each interview:

1. How has your organization been doing in the last 2-3 years?
2. What has changed with regards to the District of Columbia's well-being in the last 2-3 years since the 2019 CHNA, including the COVID-19 pandemic and beyond?
3. What would you say should be top priorities going forward?
4. How can the health system improve well-being in communities in D.C., especially groups that have been systemically marginalized and are experiencing worse health outcomes?
5. What policy actions would make the biggest impact to improve well-being in D.C., generally and/or in relation to what you perceive as priority areas? How would these policy changes make a difference in our community?

Lastly, a wealth of up-to-date quantitative data are continually updated on the [D.C. Health Matters Data Dashboard](#). This portal, sponsored by the D.C. Health Matters Collaborative, includes thousands of indicators across dozens of data sources, serves as a live needs assessment free for public use.

#### 5. Key Themes

There were many intersections between the top issues across local reports from recent years and those in our interviews. Stand-out themes and concerns included:

- Worsened behavioral health and mental well-being (including, but not limited to, social isolation, substance abuse, stress created during the COVID-19 pandemic, poor life satisfaction).
- Recognition of the significant impact of social needs and conditions that impact well-being (access to childcare, housing, employment, food insecurity, transportation).
- Decreased neighborhood safety and need for violence prevention.
- Barriers in accessing healthcare (such as access to and gaps in insurance coverage, fear or mistrust of providers, institutional racism and experience of discrimination, communication challenges, life circumstances).
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- The importance of emergency preparedness for government systems, health providers, and individuals.

- Urgent need for adequate labor pool health and behavioral health professions, including traditional and nontraditional positions.
- Essentiality of cultural and linguistic competence and trauma-informed care among providers, and appropriate, respectful communication with communities.

#### [Selected Areas of Focus for 2023-2025](#)

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

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

# COMMUNITY HEALTH IMPROVEMENT WORK, 2019-2022

The recent work of the D.C. Health Matters Collaborative followed the blueprint outlined in [“Progress through Partnership: Community Health Improvement Plan, 2019-2022.”](#) Nine targeted strategies became project “sprints” executed over three years. Each sprint was co-led by different constellations of members. [See chart on next page.]

In addition to this project work, the D.C. Health Matters Collaborative jointly created a formal advocacy agenda for citywide, legislative, and regulatory actions related to CHNA findings, CHIP strategies, and equity goals.

## 6. Mental Health

- a. Advocate for ongoing support and quality assurance of the school behavioral health expansion program.
- b. Research strategies, educate stakeholders, and advocate for regulatory and/or legislative remedies to increase the number of licensed mental health professionals practicing in D.C., especially those serving neighborhoods with highest need.
- c. Research the crisis response system in D.C., educate stakeholders, and advocate for improvements.

## 7. Access & Place-Based Care

- a. Advocate for reforms to D.C. Alliance health insurance program recertification to insure more D.C. residents, including extending the recertification period from six months to one year to align with Medicaid requirements.
- b. Research and advocate for expanded strategies to employ Community Health Workers (CHWs) and similar peer models in health settings, including financing/financial support for positions, preventing turnover, standardization, and training.

## 8. Care Coordination

- a. Advocate for policy and system changes, across the city and within organizations, that incentivize collaboration and improve data sharing among healthcare and social service and education systems (including the [Community Resource Information Exchange \[CoRIE\]](#).)

## 9. Social Conditions of Health

- a. Monitor, research, educate about, and support partners related to current and emerging community social and economic needs.

The 2019-2022 chapter of the D.C. Health Matters story has been one of expanded reach, project sprints, successful advocacy, and a deepened commitment to equity. The next chapter will be informed by the new needs assessment and community consultation.

## 2019 CHIP: Priorities for Action

1	<b>Mental Health Theme 1:</b> Educate stakeholders of all kinds about Mental Health, such as DC residents, community groups, policymakers, health providers, health system leadership and students. Topics could include identifying mental health conditions, finding services, the challenges of system navigation, treating mental health as part of whole-person health, and fighting stigma.	<b>Lead:</b> Children's National Hospital <b>Collaborate:</b> Community of Hope, Howard University Hospital, HSC Health Care System, Unity Health Care
2	<b>Mental Health Theme 2:</b> Improve relationships between and within the (mental) health system and local government agencies to address challenges with referrals, communication, and receiving grants and information. Potential focus on facilitating coordination and referrals for mental health and substance abuse co-occurring conditions.	<b>Lead:</b> Howard University Hospital <b>Collaborate:</b> Children's National Hospital, Community of Hope, HSC Health Care System, Mary's Center, Unity Health Care
3	<b>Mental Health Theme 3:</b> Identify and advance strategies for increasing the number of licensed mental health professionals. Includes addressing recruitment, retention, accessibility and competency of current mental health workforce and the "pipeline" of new practitioners. Could include special focus on culturally and linguistically diverse clinicians and/or those trained in trauma-informed care.	<b>Policy Agenda</b>  <b>Collaborate:</b> Bread for the City, Community of Hope, Howard University Hospital, Unity Health Care
4	<b>Mental Health Theme 4:</b> Promote Mental Health integration in primary care settings and schools in order to lower barriers to care, facilitate early identification and treatment of mental health issues, and reduce stigma. Continue work to expand access to and enhance capacity within the District's school-based mental health program.	<b>Lead:</b> Mary's Center  <b>Collaborate:</b> Children's National Hospital, Community of Hope, Howard University Hospital, Unity Health Care
5	<b>Care Coordination Theme 1:</b> Improve communication, awareness and referral capabilities between health care providers, social service agencies, and educational systems. Through expansion of the DC Health Matters Connect tool resource referral tool (powered by Aunt Bertha), promote the value of identifying and addressing non-clinical factors impacting patients' health (e.g., hunger, housing, legal, etc).	<b>Lead:</b> HSC Health Care System  <b>Collaborate:</b> Children's National Hospital, Howard University Hospital, Sibley Memorial Hospital
6	<b>Care Coordination Theme 2:</b> Promote, facilitate, and advocate for policy and system changes that incentivize collaboration among health care and social service and education systems. Could include focus on collaboration in funding opportunities, improvements to data-sharing, or engaging partners from other sectors across the city and within organizations.	<b>Policy Agenda:</b> Children's National Hospital  <b>Collaborate:</b> Community of Hope, Howard University Hospital, HSC Health Care System
7	<b>Health Literacy Theme 1:</b> Collaborate with other health care organizations, government agencies and community-based organizations (ex: health ministers) to expand health education efforts, including education on navigating the health system. Leverage existing resources, research best practice approaches and community preferences, and focus on linguistic and cultural appropriateness.	<b>Lead:</b> Mary's Center Sibley Memorial Hospital  <b>Collaborate:</b> Bread for the City, Children's National Hospital, Howard University Hospital
8	<b>Health Literacy Theme 2:</b> Improve the capacity of health professionals to assess health literacy and adjust communication. Work may focus on screening tools, communication skills, training, cultural effects, and/or financing of services.	<b>Lead:</b> Howard University Hospital  <b>Collaborate:</b> Children's National Hospital, HSC Health Care System, Sibley Memorial Hospital
9	<b>Place-Based Care Theme 1:</b> Support development and expansion of place-based care in convenient, appropriate and accessible locations, including expanding the use of technology and co-located services to facilitate medical encounters. May involve research and advocacy on financial incentives for providers to practice in under-resourced areas and/or expanding the accessibility of existing services.	<b>Policy Agenda:</b> Howard University Hospital  <b>Collaborate:</b> Community of Hope, HSC Health Care System

# NEXT STEPS IN COMMUNITY HEALTH IMPROVEMENT,

As previously summarized, priorities identified from the 2022 Community Health Needs Assessment for future work were:

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

## Community Health Planning Conference

With the three priority needs identified, the Collaborative's steering committee convened a two-day "Community Health Planning Conference" virtually in July 2022. The purpose of the convening was to gain input from stakeholders to produce recommendations for the collaborative's future work. Over 90 registrants participated, from government and non-governmental partners, local neighborhood leaders and residents, on-the-ground professionals in health and other sectors, and people with lived experience of illness and community organizing. The two days included structured dialogue, as well as presentations from member organizations and partners about relevant initiatives within the health sector.

Participants were briefed on the needs assessment findings and priority areas, which informed the conversation prompts. The conference dialogue concluded with hundreds of recommendations from participants, abbreviated and summarized below.

1. What can/should be done to improve equitable access to care?
  - Re-engage people into healthcare - health fairs, on-site exams and screening. Schedule appointments and enroll in insurance on site.
  - Back-to-school events to catch up on vaccines and engage parents as well.
  - Use a "menu" of creative options for patient engagement, and bring in trusted partners for events, education and questions.
  - Utilize trauma-informed approach, cultural sensitivity and responsiveness, linguistic communication.
  - Discuss and address discrimination and exclusion with all staff across programing, such as racism, sexism, ableism, ageism, homophobia, etc.
  - Change organizational architecture that cannot effectively address problems; overcome institutional inertia when progress and change are called for to achieve better outcomes.
  - Fair pay in the workforce.
  - More safeguards are needed to ensure patients do not lose coverage or care relationships during life changes or challenges. For example, it should be less difficult to continue care with chosen providers when one leaves a job or is incarcerated.
  - Take an asset-based approach to planning, programs, spending, and interventions.
  - Close coverage gaps for services in DC Alliance program.

- Invest (equitably and adequately) in community health promoters to build trust and connect people to care (including vulnerable populations, like undocumented immigrants).
- Volumes for emergency calls is increasing (rebounding) - how to address this?

## 2. What can/should be done to improve workforce development in the community?

- Consult with community members and experts about needed positions and training.
- Support for specific position training and credentialing, as needed.
- Build career pathways from start to promotion.
- Build partnership with existing programs (*i.e.* Healthcare Workforce Partnership)
- Use institutions (like public libraries) for delivering community-based programming.
- Expand digital literacy programs to get people “job-ready.”
- Better connections and awareness for middle and high school students about future job opportunities, in healthcare and other sectors.
- Consider certain forms of unpaid work like caretaking and childcare as worthy of workforce investment (*i.e.* through basic income.)
- Shift certain jobs to require fewer hours per worker, allowing more workers for the same amount of work.
- Support people starting small businesses and gig workers, who may have less of a safety net through employers.

## 3. What can/should be done to retain and develop the healthcare workforce?

- Expand the number of positions for community health workers and peer specialists. [A shared responsibility with government agencies.]
- More funding opportunities for workforce investment.
- Investigate and address the dire need for highly qualified mental health specialists, social workers, etc.
- Programs that support entrepreneurship in healthcare.
- Address long timeframe for credentialing and licensing in D.C. that has impacted our ability to hire new providers and other staff (*i.e.* social workers, professional counselors).
- Create environments prepared to encounter our mental health crisis, which often requires de-escalation from staff (ex: Mental Health First Aid to all of our front line staff.)
- Educate the general public around the career ladder in health professions, outreach to community to recruit and build awareness.
- After-school programming and field trips for children about health professions; more internship opportunities for teenagers.
- Re: retention - early career professionals may start working with under-served populations and eventually transition to private or telehealth practice due to burnout
- Use payment models geared toward value and not volume, that allow freedom/creativity for how payments can be used for services. Recovery-oriented, value-driven care can retain people who can see outcomes and reward for their work.

- Ensure a culture of safety; everyone deserves to feel physically and emotionally safe in the facility and environment they work.
  - Don't penalize health professionals for seeking behavioral health treatment. Allow healthcare workforce to care for itself without kicking out the workforce.
  - Consider para-professionals to extend capacity of teams. (Ex: Coaches and Peer Counselors are a lower level of care that can meet many needs when clinicians are not available or accessible.)
  - More health system involvement in budget advocacy, expanding focus beyond just payment policy issues.
  - More creative funding, pilots, etc. Professionals can pursue creative, innovative ideas to keep them engaged.
  - Competitive pay, more reasonable caseloads for mental health providers, increased funding for degrees mental health careers.
  - Free trainings and certifications for healthcare workers to expand their roles
  - Provider childcare for children of nurses and other health professionals.
  - Bridges to healthcare careers for mid-career people in other sectors (education, academic, research) who want to move into clinical work.
  - Free and accessible workshops that address self-care for caregivers and caregiving professions.
  - Increase pay.
  - Explore how healthcare/social services can be more preventive, rather than crisis management many of the times.
  - Create community and cohesiveness with colleagues (ex: nursing residency cohorts.)
  - Training for healthcare workers to work in violence prevention programs or detox unit or in substance abuse.
  - Reach out to young Black and Brown boys as a special outreach population for information about career tracks, like nursing and health professionals
4. What can/should be done regarding social conditions and other non-clinical factors to achieve equitable access to care?
- Workforce development, income opportunities, wealth building.
  - Incorporate social risk payment models into Medicaid and other healthcare payment systems (to reflect more time spent with patients to meet broader needs).
  - Incorporate social risk into capital investment in D.C. (housing, food access, etc.)
  - Address social isolation.
  - End stigma associated with accessing mental health services.
  - Policing and community violence - in targeting "at risk" people and groups.
  - More community voice in the up-front planning of government initiatives.
  - Bridge gap in trust and communication between government entities and the community served.

- More focus on the built environment: ventilation to prevent or reduce airborne illnesses, lead-free DC, adequate maintenance for public housing, walkability/bikeability, safe parks, etc.
  - Interventions must start with communication.
  - Address housing insecurity and homelessness.
  - Better coordination with housing information systems and other health and human service providers.
  - Remedy transportation issues, especially when the location of health providers (especially specialists) may be difficult to navigate, including on public transportation.
  - Adequate, safe, affordable childcare is foundation of an economy and education system that works for everyone, regardless of socioeconomic status.
  - There is a teacher shortage due to teacher pay, burn-out, and other factors that must be attended to.
  - Neighborhoods are being increasingly segregated by income and race, so services are concentrated. (There used to be more independent medical practices East of the River, now less so.)
  - “Affordable” housing is smaller, less green space, not accessible for families.
  - Recognize and address that some people have a distrust in the medical system due from past bad experiences or experiences of their families.
  - Kids need access to play space everywhere in the city!
  - Regarding homelessness and health- the health system is not set up to accommodate those who have more challenges with fitting in to the standard health system structure- i.e.- navigating the system to make appointments, being discharged from clinics if miss appointments, short visits that don't allow time to address social needs and individual challenges, assumptions about access to resources to adhere to typical treatment plans, etc. Those with the most challenges are falling through the cracks which are intentionally built into the system to not have to accommodate the patients that challenge the status quo of how we deliver care.
  - Multi-generational households need space, which may only be found in certain parts of the city. Especially important for Black and Brown families, and/or those caring for aging family members.
  - Improve noise hygiene across the city. (Ex: ban consumer fireworks.)
  - Be mindful of shift in access to reproductive and abortion services and the consequent impact on demand in DC.
  - People need respite care! For all ages. How can creative funding support families as well as providers? (Ex: part of Medicare hospice benefit, Dept. of Aging public services)
  - Engage service users to re-design and engage in improvement, also can be healing. Create spaces for lived experience to guide solutions.
  - Better ensure cultural sensitivity and awareness, as well as myths, especially related to services and programming.
5. What can/should be done to improve mental well-being across the lifespan?
- Recognize the pervasiveness of trauma and violence. Acknowledge community grief and loss in recent years.

- Understand and improve the school response to students experiencing violence (in school and in community).
- Undertake work specific to grief. (*i.e.* Are there any conversations regarding grief education to those who have experienced death?)
- Remedy the long waitlists for providers and ensure the full array of services across the District.
- Life circumstances can impede ability to learn in school, such as kids who are handling adult responsibilities and situations, especially related to income and housing insecurity, contributing to childcare.
- Universal education and therapeutic initiatives, broad social-emotional skills, mediating conflict, violence prevention, for kids and adults.
- Invest in the “right menu of high-quality tools.”
- Reduce school-to-prison pipeline with reform to discipline procedures and build skills.
- Restorative justice programming.
- Attention to social/structural conditions of health.
- Respite support essential for people w/ Substance use disorder (SUD) and their families and other support groups (ex: AA, Al-Anon)
- Address “gateway” activities and events to substance abuse, especially for children.

6. What can we learn from community-based health improvement initiatives, past and present?

- Throwing money at the problem doesn’t work. There is a long history of initiatives that don’t work but continue to get funded. Instead, take a performance-based approach for investment.
- Some residents believe funding goes to groups or people who “parachute” into communities, who aren’t from the neighborhoods they serve.
- Understand how and why people use services and systems, and how to effectively implement “right care, right time” solutions across sectors.
- There are numerous groups working on improving the health care and behavioral health system in the landscape, but they are not always well-known or coordinated. How can we better leverage the work being done and resources that exist? How can we get more community to share their input with the various task groups and collaboratives?
- Stay in conversation with people on the ground, not just professional silos.
- Innovations will come from outside the health domain, where most impact on health is occurring.
- Prioritize trust building, and be trustworthy.
- Tap into a wealth of perspectives for better ideas.

## HOWARD UNIVERSITY HOSPITAL – PLAN FOR COMMUNITY IMPROVEMENT 2022-2025

Howard University Hospital (HUH), is fully committed to work collaboratively with the D.C. Health Matters Collaborative, D.C. Health and other government partners, D.C. Hospital Association and other community-based organizations, residents, and communities of faith to accomplish the following goals during 2022 – 2025, utilizing many of the tools and opportunities suggested during the Community Health Planning Conference. Each year, HUH will conduct a review of progress made towards each goal, measuring the impact of each strategy.

### RECOMMENDATIONS AND COMMITMENTS

MENTAL WELL BEING			
Goal	Strategies	Metrics/What we are Measuring	Potential Partner Organization
Implementation of Addiction Consult Services (ACS) and inpatient withdrawal management.	<ul style="list-style-type: none"> <li>Implement a multi-disciplinary addiction consult team (ACT) supporting withdrawal management, behavioral health evaluations, treatment initiation, and referral to continue treatment within HUH.</li> <li>Recruit and hire 1 an Addiction Psychiatrist or Addiction Medicine physician.</li> <li>Train and assign Addiction Medicine Fellows, Psychiatry residents, and medical students to provide ACS.</li> </ul>	<ul style="list-style-type: none"> <li>Number of addiction trainees completing addiction medicine rotations/training at HUH.</li> <li>Number of addiction consults provided within HUH.</li> </ul>	

<p>Provide addiction consults to patients with substance use or co-occurring disorders.</p> <p>Addiction consults include evaluation and diagnosis, treatment plan, motivational enhancement therapy, recovery coaching, patient navigation, and linkage to community-based supports.</p>	<ul style="list-style-type: none"> <li>• Implement ACT consults, SBIRT training, and SBIRT within HUH</li> <li>• Provide education and training to medical and nursing personnel in the ED and all inpatient medical, surgical, trauma, OB/GYN and psychiatry services about SBIRT and ACT referrals.</li> <li>• Provide addiction medical consults including patients treated in the ED and all inpatient medical, surgical, and OB/GYN and psychiatry services.</li> </ul>	<ul style="list-style-type: none"> <li>• Provide an estimated 40 addiction consults per month to patients hospitalized or evaluated in the ED.</li> </ul>	<ul style="list-style-type: none"> <li>• HUH ACS and referrals from HUH to community-based care.</li> <li>• DBH Addiction Referral Center.</li> <li>• Residential and ambulatory substance use disorder treatment services</li> <li>• Core Service Agencies, and FQHC's.</li> </ul>
<p>Implement Mothers First, an HUH Collaborative Maternal Behavioral Home-based Care Service.</p>	<ul style="list-style-type: none"> <li>• Screen all patients seeking care at clinic practices in the Department of OB/GYN (including Women's clinic, Benning Rd., practice, Perinatal Diagnosis Center, MFM practice at Benning Rd.) for behavioral health problems.</li> <li>• Enroll all eligible high-risk pregnant women with significant behavioral health problems into the collaborative care model incorporating doula home visiting service with behavioral health support in addition to standard prenatal and postpartum care. Estimated 120 women between January 1, 2023, and September 30, 2023, will meet criteria for high risk pregnancy and significant behavioral health problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Successful development and implementation of the program.</li> <li>• Number of women that meet criteria for high risk pregnancy and significant behavioral health problems.</li> </ul>	<ul style="list-style-type: none"> <li>• Community organizations</li> <li>• FQHC's (including Unity Healthcare, Mary's Center, Community of Hope)</li> <li>• Doula home visiting program (Mamatoto village).</li> </ul>

EQUITABLE ACCESS TO CARE CORDINATION			
Goal	Strategies	Metrics/What we are measuring	Potential Partner Organizations
Expand Open Access ambulatory substance use disorder (SUD) and co-occurring SUD and psychiatric disorder clinics.	<ul style="list-style-type: none"> <li>• Provide same day/next-day initiation or continuation of SUD treatment, including Medication for Opioid Use Disorder (MOUD) with buprenorphine at HU Ambulatory Behavioral Health Clinic.</li> <li>• Hire and onboard a Clinical Psychologist.</li> <li>• Train and assign Addiction Medicine fellows, psychiatry residents, medical students to provide SUD treatment at ambulatory clinic.</li> <li>• Publicize availability of Open Access clinic and conduct outreach and engagement in the community.</li> <li>• Peer recovery specialists and care coordinators maintain contact and provide support to patients enrolling in treatment to maintain treatment engagement and participation.</li> </ul>	<ul style="list-style-type: none"> <li>• Number of Open Access clinic sessions operated per week.</li> <li>• Number of patients evaluated in Open Access clinics.</li> </ul>	<ul style="list-style-type: none"> <li>• Referring clinics and hospitals.</li> <li>• District of Columbia network of Peer Recovery Specialists.</li> </ul>

EQUITABLE ACCESS TO CARE CORDINATION			
Goal	Strategies	Metrics/What we are measuring	Potential Partner Organizations
Increase access to culturally appropriate community-based SUD treatment services in communities at high risk for substance use disorders.	<ul style="list-style-type: none"> <li>Implement low threshold community-based SUD treatment services in Wards 7, 8 and possibly 5 and 6.</li> </ul>	<ul style="list-style-type: none"> <li>Number of MOUs executed.</li> <li>Number of community-based sites implemented.</li> <li>Number of tele-psychiatry visits per month per site.</li> <li>Number of patients receiving onsite peer recovery services per month per site.</li> </ul>	<ul style="list-style-type: none"> <li>The DC Dream Center and the Pennsylvania Avenue Baptist Church.</li> <li>Holy Trinity United Baptist Church.</li> </ul>

COMMUNITY-BASED WORKFORCE DEVELOPMENT			
Goal	Strategies	Metrics/What we are measuring	Potential Partner Organizations
Help to strengthen D.C. community workforce.	<ul style="list-style-type: none"> <li>Advocate for workforce development initiatives, specially targeting at-risk youth.</li> <li>Increase community outreach.</li> </ul>	<ul style="list-style-type: none"> <li># of community centers, recreational halls visited.</li> </ul>	<ul style="list-style-type: none"> <li>Community Leaders.</li> </ul>
	<ul style="list-style-type: none"> <li>Implement Apprenticeship and Training programs.</li> </ul>	<ul style="list-style-type: none"> <li># of people enrolled in program.</li> </ul>	<ul style="list-style-type: none"> <li>Workforce Investment Council.</li> <li>DC Apprenticeship Council.</li> </ul>
	<ul style="list-style-type: none"> <li>Engage in residency programs and externship programs, specifically nursing.</li> <li>Target local colleges and universities with nursing programs.</li> </ul>	<ul style="list-style-type: none"> <li># of local applicants for programs.</li> </ul>	<ul style="list-style-type: none"> <li>Local High Schools and Colleges.</li> </ul>
	<ul style="list-style-type: none"> <li>Enhance sense of community through DC Volunteerism.</li> <li>Increase the number of DC residents that volunteer in Healthcare facilities.</li> </ul>	<ul style="list-style-type: none"> <li># of registered volunteers, target High School and seniors.</li> </ul>	<ul style="list-style-type: none"> <li>Government Officials.</li> <li>Community Leaders and places of worship.</li> </ul>

### Ongoing Investment in Infrastructure

The D. C. Health Matters Collaborative will continue to host our [Data Dashboard](#) of community health indicators and resources tailored to D.C. [DCHealthMatters.org](https://DCHealthMatters.org) serves as the reporting, tracking, and monitoring mechanism for all DC Health Matters Collaborative work.

## ACRONYM LIST

<b>ACA</b>	Patient Protection and Affordable Care Act of 2010
<b>CHIP</b>	Community Health Improvement Plan
<b>CHNA</b>	Community Health Needs Assessment
<b>CHW</b>	Community Health Workers
<b>CoRIE</b>	Community Resource Information Exchange
<b>COVID-19</b>	SARS-CoV-2
<b>CRISP</b>	Chesapeake Regional Information System for our Patients
<b>DC</b>	District of Columbia (also “the District”)
<b>DCHCC</b>	DC Healthy Communities Collaborative (former name for DC Health Matters Collaborative)
<b>FQHC</b>	Federally Qualified Health Centers
<b>MAT</b>	Medication-Assisted Treatment for substance abuse
<b>OSSE</b>	Office of the State Superintendent of Education
<b>PSE</b>	Policy, System, And Environment framework
<b>PrEP</b>	Pre-Exposure Prophylaxis for HIV
<b>SUD</b>	Substance Use Disorder