District of Columbia Healthy Communities Collaborative

2013 Community Health Improvement Plan

FY 2014-2016

The District of Columbia Healthy Communities Collaborative

June 2013

A LETTER TO THE COMMUNITY

A little over a year ago, the District of Columbia Healthy Communities Collaborative (DCHCC) was formed with the goal to improve community health as demonstrated by measurable outcomes and best practice recognition in the District of Columbia. Since its founding, the Collaborative has worked diligently to improve the health of District residents using a collective population health approach to better understand and improve the state of health in the District of Columbia.

DCHCC members believe that the impact they will have collectively will be greater than individual efforts. To that end, Collaborative members have pledged to work together and to couple their diverse resources and expertise to achieve their shared goal of improving community health.

With the implementation of this community health improvement plan, it is our hope that the health of District of Columbia residents will be improved and residents will experience a higher level of quality of care. We will rely heavily on external stakeholders as well as community representatives to move this plan into action.

The Collaborative extends its gratitude to those community members who provided valuable input and feedback by participating in our focus groups, evaluation of the web portal and the community forum. The involvement of the community is critical to our success.

Thank you for taking time to read this plan and for your interest in improving the health of our District of Columbia community.

Regards,

Ruth F. Pollard, MS, MBA

Chair, District of Columbia Healthy Communities Collaborative

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ACKNOWLEDGEMENTS

The District of Columbia Healthy Communities Collaborative (DCHCC) was formed over a year ago to improve community health in the District of Columbia. Collaborative members commissioned a community health needs assessment, reached consensus on priorities, and developed an action plan for addressing these priorities over the next three years. This 2013 Community Health Improvement Plan (CHIP) is the culmination of the Collaborative's efforts.

District of Columbia Healthy Communities Collaborative Members

Randi Abramson, MD, Bread for the City
Marti Bailey, Sibley Memorial Hospital
Angelica Journagin, JD, MHA, Unity Health Care, Inc.
Matthew Lukasiak, Providence Hospital
Kelly Sweeney McShane, MBA, Community of Hope, DC
Chaya Merrill, DrPH, Children's National Medical Center
Ruth Fisher Pollard, MS, MBA, Children's National Medical Center
Terri A. Thompson, JD, MA, Howard University Hospital

District of Columbia Healthy Communities Collaborative Contributors

Leah Garrett, Community of Hope, DC
Rachelle Toman, MD, PhD, Community of Hope, DC
Linda Cottrell, MPH, Children's National Medical Center
Quinchela Dent-Hess, MPH, CHES, Children's National Medical Center
Phillicia Nelson, Howard University Hospital
Michael McCoy, Sibley Memorial Hospital
Melissa Q. Rossetti, Providence Hospital
Kimberle Searcy, MPH, Children's National Medical Center
Karin Werner, MPH Unity Health Care, Inc.
Tesa White, Children's National Medical Center
Karen E. Williamson, KEW Consulting, LLC

The DCHCC would like to thank the executive leaders of its member organizations:

George Jones, Executive Director, Bread for the City
Kurt Newman, MD, President and CEO, Children's National Medical Center
Kelly Sweeney McShane, MBA, Executive Director, Community of Hope, DC
Herbert C. Buchanan Jr., CEO, Howard University Hospital
Amy Freeman, CEO, Providence Hospital
Richard O. Davis, PhD, President, Sibley Memorial Hospital
Vincent A. Keane, President and CEO, Unity Health Care, Inc.

About DCHCC Organizations

Bread for the City
Started in 1974, Bread for the City is a frontline agency serving Washington's poor. Operating two centers in the District of Columbia, Bread for the City provides comprehensive services, including food, clothing, medical care, legal and social services to low-income Washington, DC residents in an atmosphere of dignity and respect.

Children's National Medical Center
Children's National Medical Center is the only exclusive provider of pediatric care in the metropolitan Washington area and is the only freestanding children's hospital between Philadelphia, Pittsburgh, Norfolk, and Atlanta. Children's National provides needed service to District children through clinical care, advocacy, research and education.

Community of Hope, DC
For over 30 years, Community of Hope has worked to improve the quality of life for homeless, low-income, and underserved families and individuals in the District of Columbia. A Federally Qualified Health Center, Community of Hope provides a full range of primary care services – including medical care, dental care, and behavioral health support – at two locations and is building a third center in Ward 8. Community of Hope's Family Health and Birth Center location is the only free-standing birth center in the District. Community of Hope also provides a range of housing options with supportive services to families who have experienced homelessness.

Howard University Hospital
Over the course of its 150-year history of providing primary, secondary and tertiary health care services, Howard University Hospital has become one of the most comprehensive health care facilities in the Washington, DC metropolitan area and is designated a DC Level 1 Trauma Center. A private, nonprofit institution, Howard University Hospital is the nation's only teaching hospital located on the campus of a historically Black university.

Providence Hospital
Providence, a member of Ascension Health, the nation's largest nonprofit Catholic health system, provides a full range of care from primary and outpatient to geriatrics. Since being chartered by President Abraham Lincoln in 1861, Providence has been meeting the needs of the Nation's Capital for orthopedics, maternity, geriatric care, behavioral health, diabetes, stroke care, and community wellness programs.

Sibley Memorial Hospital
Sibley Memorial Hospital has a distinguished history of serving the community since its founding in 1890. As a not-for-profit, full-service, 318-bed community hospital, Sibley offers medical, surgical, intensive care, obstetric, oncology, orthopedic, and skilled nursing inpatient services and a 24-hour Emergency Department. Sibley Memorial Hospital is a proud member of Johns Hopkins Medicine.

Unity Health Care, Inc.
Founded in 1985, Unity Health Care, Inc. promotes healthier communities through compassion and comprehensive health and human services, regardless of ability to pay. A Federally Qualified Health Center, Unity focuses on preventative medicine with community, homeless, and school based, and other specialty centers located in every ward of the city.

EXECUTIVE SUMMARY

Convened in January 2012, the District of Columbia Healthy Communities Collaborative (DCHCC) developed this 2013 Community Health Improvement Plan (CHIP) after engaging in a year-long strategic planning process. The Collaborative seeks to improve community health in the District of Columbia by proactively addressing community health issues through shared vision, accountability, resources, and outcomes.

The DCHCC is fortunate to have members representing District of Columbia hospitals and community health centers (several of which are Federally Qualified Health Centers) that have come together to address health issues collectively. DCHCC members include Bread for the City, Children's National Medical Center, Community of Hope, Howard University Hospital, Providence Hospital, Sibley Memorial Hospital, and Unity Health Care, Inc.

Utilizing the expertise and resources of individual member organizations and consultants, the DCHCC conducted a citywide community health needs assessment (CHNA) in 2012. The CHNA provided a comprehensive view of the health status of Washington, DC residents as well as identified the following four issues as top community health priorities:

- *Sexual health*
- *Mental health and substance abuse*
- *Obesity/overweight*
- *Asthma*

Two additional issues - access to care and stress-related conditions - were identified as priorities in the CHNA; however, the DCHCC viewed these issues as systemic issues that impact all priority conditions. Several other health conditions (e.g. cancer) were discussed in the CHNA in the context of access to care issues.

The CHIP comprises goals and objectives as well as approaches, strategic levers, community resources, and critical partners for each priority issue. CHIP strategies will be implemented over a three-year action cycle.

The CHIP process is based on the premise that community health can be raised to an optimal level through collaboration. By forming the District of Columbia Healthy Communities Collaborative, these community providers demonstrate their deep commitment to improving the health of the residents of the District of Columbia.

INTRODUCTION

A community health improvement plan is a long-term, systematic approach to address top public health problems identified in the community health assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A community health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community through a collaborative process and should address the gamut of strengths, weaknesses, challenges, and opportunities that exist in the community to improve the health status of that community.

(Adapted from: United States Department of Health and Human Services, Healthy People 2010. Washington, DC; Centers for Disease Control and Prevention, National Public Health Performance Standards Program, www.cdc.gov/nphpsp/FAQ.pdf).

The District of Columbia Healthy Communities Collaborative (DCHCC) formed over a year ago to improve community health in the District of Columbia through development and adoption of a DCHCC Community Health Improvement Plan (CHIP). The CHIP focuses on identified priority health issues and proposes goals and strategies to address these priorities over the next three years. Through focus groups, interviews and surveys, community members were involved in the CHIP development process. Prior to the development of the CHIP, a citywide community health needs assessment (CHNA) was conducted to determine the most pressing health needs based on analyses of quantitative data and community inputs. (See Appendix 1)

The CHIP guides the improvement of identified health priorities through strategies that include improvements in infrastructure, collection and dissemination of data, health promotion and disease prevention program planning, as well as advocacy for effective policy and resource allocation.

The District of Columbia

As of 2011, the District of Columbia had a population of 617,996 residents. The city's 68.3 square miles comprise eight wards. There is a great deal of diversity in the District's population and that variance is seen within each of the wards. Roughly 15 percent of the District's families have been identified as living below the poverty line, and one in four families lives within 185 percent of the federal poverty level (FPL). From 2000 to 2011, the percentage of families who live in extreme poverty (or 185 percent of FPL) decreases. From 2000 to 2011, the population of the District became slightly younger. Although a decrease of almost 8 percent was seen in the less than 18 year old group, the greatest growth was seen among those 18 to 39 years old. (Appendix 1)

Community Benefit Compliance

The Internal Revenue Service (IRS) requires 501(c)(3) not-for-profit hospitals to support their tax-exempt status via investments into the communities they serve. As organizations with

charitable missions, hospitals of the DCHCC have proactively responded to the needs of their communities through community-based programs and public-private partnerships. The transparency of these programs and partnerships may be reviewed in hospitals' community benefit reports, which are written reports to the community quantifying investments in response to needs.

On March 23, 2010, President Barack Obama signed into law The Patient Affordable Care Act (ACA). Among other provisions, the ACA established additional requirements of 501(c)(3) not-for-profit hospitals to conduct a community health needs assessment (CHNA) every three years and respond to the CHNA with an implementation strategy. To demonstrate true engagement, the ACA required local community and public health expert input. In addition to the IRS and ACA requirements, the Public Service Act requires community health center grantees under the Health Resources and Services Administration to demonstrate and document the needs of their target population to inform and improve delivery of appropriate services.

Through the District of Columbia Healthy Communities Collaborative, four hospitals and three community health centers created a shared vision, organized and shared resources, and created a shared plan to address some of the priority needs-all while meeting compliance requirements. The DCHCC Community Health Improvement Plan is the result of their efforts.

METHODOLOGY

Identification of Health Issues

The DCHCC convened in January 2012 to develop a community health improvement plan (CHIP) to address health care issues affecting communities in Washington, DC. DCHCC members, representing various backgrounds and specialties, committed to meeting monthly and later on a weekly basis to ensure the timely completion of the CHIP document.

The Collaborative utilized the expertise and resources of individual member organizations when developing the scope of work for the citywide community needs assessment and contracted with The RAND Corporation to conduct the study. RAND undertook several approaches to define the community, describe its demographics, assess its health needs, and identify access to care issues within different parts of the community. The quantitative data sources included the Behavioral Risk Factor Survey, Youth Behavioral Risk Survey, hospital discharge data, American Community Survey, and US Census data. In addition to the quantitative data, input from community representatives was obtained using stakeholder focus groups. Through analyses of the quantitative and qualitative data, six top health issues emerged:

- *Sexual health*
- *Mental health and substance abuse*
- *Obesity/overweight*
- *Asthma*
- *Access to care*
- *Stress-related conditions*

After deliberation, DCHCC members decided that access to care and stress-related conditions should not be addressed as independent priority issues as they are systemic issues that impact all of the other priority health areas. Thus, the CHIP addresses the remaining four priority issues: sexual health, mental health and substance abuse, obesity/overweight and asthma.

DCHCC members may include in their individual community health improvement plans additional health issues that support their organization's mission, including but not limited to, access to care and stress-related conditions. For example, community health centers are part of the Medical Homes DC Initiative, a project of the DC Primary Care Association with funds from the DC Department of Health (DOH) and others to expand the range of services that the centers are able to offer and end the significant shortage of primary care facilities in the District's most underserved communities. Also, a DCHCC member may include access to care issues related to specific health concerns, such as cancer prevalence, or identify approaches for addressing stress-related conditions directly impacting its primary target populations.

When identifying the priority areas to be addressed in the CHIP, DCHCC members considered the Healthy People 2020 priority areas, goals and objectives. Although the Collaborative may have used a different approach, the overall health priorities included in the DCHCC CHIP are consistent and aligned with the national Healthy People 2020 process.

Development of CHIP

DCHCC members met with internal teams within their individual organizations to assess their capacity to address the identified health areas and to prioritize the issues from their organizations' perspectives. They then came together representing their individual organizational perspectives and followed the process below to develop the CHIP:

1. Conduct Gap and Strength, Weaknesses, Opportunities, and Threats (SWOT) Analyses
2. Prioritize Issues
3. Create Action Plan
    a. Vision of Impact
    b. Strategic Levers
    c. Goals, Objectives, Approaches
    d. Role identification (Lead, Collaborate, and Support)
4. Define Monitoring

The DCHCC members collectively completed GAP and SWOT analyses for each health priority. The GAP analysis is a strategic exercise that compares the current condition to a desired outcome and identifies the "gap" as well as the actions that will close the gap. (See Appendix 2) Once the GAP analysis for each health priority was completed, DCHCC members then conducted SWOT analyses to assess the Strengths, Weaknesses, Opportunities, and Threats associated with addressing each of the priority health issues. (See Appendix 3)

The next step was to use a prioritization tool (see Appendix 4) to rank the health issues. The tool facilitates the systematic ranking of each prioritized health issue based on five factors: Magnitude of Problem; Efficacy of Interventions; Financial Implications; Organizational Capacity; and Cultural, Legal, or Political Challenges. Each factor comprises several components with assigned numerical values. When the factors are summed, the prioritization tool results in a numerical score for each issue, allowing them to be ranked. The Collaborative's ranking of the four health issues (from high to low) was sexual health, substance abuse and mental health, obesity/overweight, and asthma.

Next Collaborative members developed a Vision of Impact statement to define a broad vision for each priority area, followed by identifying strategic levers to be used to make changes within these priority areas. The Vision of Impact statement is a description of the impact that the work of the CHIP will have on the health priority at the end of the three years. It expresses "what success would look like" after the plan is executed. The strategic levers are the tools that can be employed to realize the Vision of Impact. A few examples of strategic levers are advocacy, education and resource reallocations.

The goals and objectives for each priority area were then determined focusing on desired outcomes and specific changes that would result from use of the strategic levers. Next, approaches or strategies were developed for each objective in the four priority areas.

DCHCC members identified their roles relative to each priority health issue, based on their mission, resources, programs, organizational responsibilities and other relevant factors. The role categories and definitions are below. (See Appendix 4)

- Lead: An organization in this role commits to seeing that the issue is addressed and takes responsibility for developing the resources needed to advance the issue.
- Collaborate: An organization in this role commits to significant help in advancing the issue and will participate regularly in developing strategy to advance the issue.
- Support: An organization in this role commits to helping with specific circumscribed tasks when asked.

With a draft action plan, the DCHCC held a community forum to share the plan, the process, and solicit input on the goals, objectives, approaches, and identification of critical partners. We defined critical partners as public and private organizations who we must coordinate our efforts during implementation and will share responsibility for achieving the goals and realizing the vision of impact. As a result, community members offered opportunities and commitment to collaborate and identified critical partners. Community stakeholders and the identified critical partners will be engaged during the implementation of the community health improvement plan.

Accountability and Transparency

To fulfill its commitment to enhanced accountability and transparency, the DCHCC has invested in a highly visible online portal of community health information known as "DC Health Matters" (www.DCHealthMatters.org). This community-driven information portal provides local health data as well as information on the social determinants that relate to the entire population's health.

DC Health Matters houses the CHNA and CHIP. The portal displays health metrics that correspond to each of the priority areas identified by the CHNA. DC Health Matters will also serve as the reporting, tracking and monitoring mechanism for the CHIP. For each CHIP priority objective and its approaches, the DCHCC will develop milestones and metrics for measuring progress. This monitoring information will be reported on and tracked in DC Health Matters on a quarterly basis.

DCHCC members are committed to maintaining DC Health Matters as the key platform for ensuring transparency and accountability as they work to advance community health.

ACTION PLAN

The next step in the CHIP process involves transforming the planning into action. Along with identifying the goals, objectives, and approaches to be used, the DCHCC has identified specific organizations, agencies and programs to implement the components contained in the plan.

Priority Area: Sexual Health

Vision of Impact: By 2016, DCHCC will ensure the integration of preventative services related to sexual health into primary care, ambulatory and other community based services.

Strategic Levers: Advocacy, education, policy, and data

Goal 1: Advocate for integration of routine screenings for sexually transmitted infections in primary care settings.

Objective 1A: By year end 2014, DCHCC will establish a credible data repository to guide and inform evidence based clinical, policy and community advocacy relating to STIs.

Lead: Children's National Medical Center
Collaborate: Howard University Hospital
Support: DCHCC

Approach 1A-1: Partner with appropriate public health and private agencies to retrieve and share data through DCHM.

Approach 1A-2: Disseminate STI related data from DCHM through local and regional forums.

Objective 1B: By year end 2015, DCHCC will develop continuing education (CE) for STI conditions.

Lead: Howard University Hospital
Collaborate: Providence Hospital
Support: DCHCC, Unity Health Care, Inc.

Approach 1B-1: Partner with experts to create objectives and content for continuing education units for STI conditions.

Approach 1B-2: Identify existing professional development opportunities to offer STI continuing education.

Objective 1C: By year end 2014, DCHCC and partners will advocate and educate the Council of the District of Columbia for funding sources for STI screenings.

Lead: Howard University Hospital
Collaborate: Unity Health Care, Inc.
Support: DCHCC

Approach 1C-1: Select a community champion to be the voice of the DCHCC.

Approach 1C-2: Utilize data to create advocacy and implementation strategies.

Approach 1C-3: Mobilize community champions and DCHCC to present to the Council of the District of Columbia.

Objective 1D: By year end 2016, DCHCC members will adopt insurance billing for HIV testing where appropriate.

Lead: Providence Hospital, Howard University Hospital
Collaborate: Children's National Medical Center, Sibley Memorial Hospital
Support: DCHCC

Approach 1D-1: Educate DCHCC members and their affiliates on available billing codes related to HIV.

Approach 1D-2: Establish a finance subcommittee of DCHCC to promote and adopt best practices for HIV insurance billing.

Approach 1D-3: Monitor reimbursement for unbundled HIV testing.

Objective 1E: By year end 2016, DCHCC will create a framework for applying best practices of HIV models to other STI conditions.

Lead: Howard University Hospital
Collaborate: Unity Health Care, Inc.
Support: DCHCC

Approach 1E-1: Convene a subcommittee of experts to identify, evaluate and recommend HIV screening best practice models that can be translated to other STI conditions.

Goal 2: Strengthen partnerships related to maternal and infant health.

Objective 2A: By year end 2016, DCHCC will develop, distribute, and maintain a community assets map in support of maternal and infant health.

Lead: Children's National Medical Center
Collaborate: Providence Hospital

Support: DCHCC

Approach 2A-1: Convene public and private sector leaders in maternal and infant health to identify community assets.

Approach 2A-2: Use DCHM to disseminate the community assets map.

Objective 2B: By year end 2016, DCHCC will support implementation of the CMMI (Centers for Medicare and Medicaid Innovation) Strong Start Partnership.

Lead: Providence Hospital
Collaborate: Unity Health Care, Inc., Howard University Hospital, Sibley Memorial Hospital, Community of Hope
Support: DCHCC

Approach 2B-1: Enhance Prenatal Care through Centering/Group Visits

Approach 2B-2: Enhance Prenatal Care at Birth Center

Approach 2B-3: Enhance Prenatal Care at Maternity Care Homes

Priority Area: Mental Health and Substance Abuse

Vision of Impact: By 2016, DCHCC will ensure the integration of services related to mental health and substance abuse into primary care, ambulatory and other community based services.

Strategic Levers: Advocacy, education, and data

Goal 1: Advocate for integration of routine screenings for mental health and substance abuse in primary care, ambulatory, and community based services.

Objective 1A: By year end 2014, DCHCC will establish public and private partnerships to facilitate the sharing of integration strategies addressing mental health and substance abuse.

Lead: Children's National Medical Center
Collaborate: Sibley Memorial Hospital, Unity Health Care, Inc., Providence Hospital, Community of Hope
Support: DCHCC

Approach 1A-1: Partner with appropriate public and private health agencies to retrieve and share data through DCHM.

Approach 1A-2: Disseminate mental health and substance abuse related data from DCHM through local and regional forums.

Approach 1A-3: Identify best practices related to integration of routine screenings and associated barriers.

Approach 1A-4: Communicate integration models to DCHCC members and partners.

Objective 1B: By year end 2015, DCHCC and partners will advocate and educate the Council of the District of Columbia for funding sources for mental health and substance abuse screenings.

Lead: Howard University Hospital
Collaborate: Providence Hospital
Support: DCHCC

Approach 1B-1: Select a community champion to be the voice of DCHCC.

Approach 1B-2: Utilize data to create advocacy and implementation strategies.

Approach 1B-3: Mobilize community champions and DCHCC to present to the Council of the District of Columbia.

Goal 2: Advocate for access points where mental health and substance abuse services can be provided/are available.

Objective 2A: By year end 2015, DCHCC will advocate for scope of practice expansion for other professionals to provide mental health and substance abuse services.

Lead: Howard University Hospital
Collaborate: Unity Health Care, Inc.
Support: DCHCC

Approach 2A-1: Identify qualified professionals that can provide mental health and substance abuse services and advocate for expansion or clarification of scope of practice.

Approach 2A-2: Work with respective associations to expand or clarify scope of practice.

Objective 2B: By year end 2015, DCHCC will develop and advocate for the adoption of mental health and substance abuse questions in the electronic medical record.

Lead: Unity Health Care, Inc.
Collaborate: Howard University Hospital, Community of Hope
Support: DCHCC

Approach 2B-1: Convene a group to review questions related to mental health and substance abuse questions in the electronic medical record.

Approach 2B-2: Identify best practices.

Approach 2B-3: Make recommendations.

Objective 2C: By year end 2016, DCHCC will advocate for enhanced reimbursement for the diagnosis and treatment of mental health and substance abuse services.

Lead: Howard University Hospital, Unity Health Care, Inc.
Collaborate: Providence Hospital, Community of Hope
Support: DCHCC

Approach 2C-1: Educate DCHCC members and their affiliates on billing codes relating to mental health and substance abuse services.

Approach 2C-2: Establish a finance subcommittee of DCHCC to promote and adopt best practices for mental health and substance abuse services insurance billing.

Objective 2D: By year end 2016, DCHCC will create a framework for best practices using navigator models for mental health and substance abuse conditions.

Lead: Sibley Memorial Hospital
Collaborate: Children's National Medical Center, Providence Hospital
Support: DCHCC

Approach 2D-1: Convene a subcommittee of experts to identify, evaluate and recommend best practice navigator models that can be translated to mental health and substance abuse conditions.

Objective 2E: By year end 2015, DCHCC will develop, distribute, and maintain a community assets map in support of mental health and substance abuse services.

Lead: Children's National Medical Center
Collaborate: Sibley Memorial Hospital, Howard University Hospital, Providence Hospital, Bread for the City
Support: DCHCC

Approach 2E-1: Convene public and private sector leaders in mental health and substance abuse services to identify community assets.

Approach 2E-2: Use DCHM to disseminate the community assets map.

Goal 3: Promote mental health and substance abuse competency for providers.

Objective 3A: By year end 2015, DCHCC will promote existing CE and develop continuing education on mental health and substance abuse for other providers.

Lead: Sibley Memorial Hospital
Collaborate: Children's National Medical Center
Support: DCHCC

Approach 3A-1: Identify and promote existing opportunities for CE. Determine gaps in opportunities.

Approach 3A-2: Based on a gap analysis, partner with experts to create objectives and content for CE units on mental health and substance abuse.

Approach 3A-3: Identify existing professional development opportunities to offer mental health and substance abuse CE.

Priority Area: Obesity/Overweight

Vision of Impact: By 2016, DCHCC will advocate for public health infrastructure to support healthy lifestyles and the treatment of obesity and related conditions.

Strategic Levers: Advocacy and data

Goal 1: Collaborate with the District of Columbia Government to align and integrate public and private resources for prevention and treatment of obesity and other related conditions.

Objective 1A: By year end 2016, DCHCC will facilitate the sharing of integration strategies addressing the prevention and treatment of obesity and related conditions.

Lead: Howard University Hospital, Providence Hospital
Collaborate: Sibley Memorial Hospital, Unity Health Care, Inc., Children's National Medical Center, Community of Hope
Support: DCHCC

Approach 1A-1: Partner with appropriate public health and private agencies to retrieve and share data through DCHM.

Approach 1A-2: Disseminate data related to obesity and related conditions from DCHM through local and regional forums.

Approach 1A-3: Identify best practices related to integration of prevention and treatment of obesity and related conditions and associated barriers.

Approach 1A-4: Communicate best practices for integration models to DCHCC members and partners.

Objective 1B-1: By year end 2015, DCHCC will develop, distribute, and maintain a community assets map in support of the prevention and treatment of obesity and related conditions.

Lead: Children's National Medical Center, Howard University Hospital
Collaborate: Providence Hospital, Sibley Memorial Hospital, Unity Health Care, Inc.
Support: DCHCC

Approach 1B-1: Convene public and private sector leaders in obesity and related conditions to identify community assets.

Approach 1B-2: Use DCHM to disseminate the community assets map.

Goal 2: Create a network for sharing of best practices of prevention and treatment of obesity and other related conditions within DCHCC.

Objective 2A: By year end 2016, DCHCC will identify and disseminate best practices for prevention and treatment of obesity and other related conditions.

Lead: Providence Hospital, Sibley Memorial Hospital
Collaborate: Children's National Medical Center, Unity Health Care, Inc., Howard University Hospital, Community of Hope
Support: DCHCC

Approach 2A-1: Convene a subcommittee of experts to identify, evaluate and recommend obesity and other related conditions best practice models.

Approach 2A-2: Utilize DCHM to disseminate obesity and other related conditions best practice models.

Priority Area: Asthma

Vision of Impact: By 2016, DCHCC will advocate for and promote the treatment and coordination of asthma within a primary care setting.

Strategic Levers: Advocacy, policy, and data

Goal 1: Strengthen partnerships related to asthma care coordination between or among providers.

Objective 1A: By year end 2016, DCHCC leaders will develop, distribute, and maintain community assets map for asthma care.

Lead: Children's National Medical Center
Collaborate: Bread for the City
Support: DCHCC

Approach 1A-1: Convene public and private sector leaders in asthma care to identify community assets.

Approach 1A-2: Use DCHM to disseminate the community assets map.

Objective 1B: By year end 2016, DCHCC will identify and utilize best practices approach for case coordination from emergency to primary care.

Lead: Howard University Hospital
Collaborate: Unity Health Care, Inc., Sibley Memorial Hospital, Community of Hope
Support: DCHCC

Approach 1B-1: Convene a subcommittee of experts to identify, evaluate and recommend best practice models for asthma case coordination (emergency to primary care and pediatric to adult).

Approach 1B-2: Use DCHM to disseminate best practice models.

Objective 1C: By year end 2016, DCHCC will create a framework for replicating best practices focused on prevention and treatment of asthma (e.g. IMPACT DC).

Lead: Children's National Medical Center
Collaborate: Howard University Hospital, Community of Hope
Support: DCHCC

Approach 1C-1: Convene a subcommittee of experts to identify, evaluate and recommend best practice models for asthma care that can be translated across populations.

Approach 1C-2: Endorse the recommendation for replicating best practices.

Approach 1C-3: Use DCHM to disseminate best practice models.

Goal 2: Advocate for policy changes related to reimbursement for asthma care.

Objective 2A: By year end 2016, DCHCC will advocate for reimbursement for the comprehensive solutions (non-clinical and clinical) and for prevention and treatment of asthma care.

Lead: Howard University Hospital
Collaborate: Unity Health Care, Inc., Community of Hope
Support: DCHCC

Approach 2A-1: Develop a concept inclusive of a Medicaid waiver for reimbursement.

Approach 2A-2: Educate specific District of Columbia governmental bodies on the needs of the population.

Objective 2B: By year end 2016, DCHCC will advocate for additional funding for tobacco cessation programs.

Lead: Sibley Memorial Hospital
Collaborate: Unity Health Care, Inc., Howard University Hospital, Providence Hospital
Support: DCHCC

Approach 2B-1: Convene entities in the District of Columbia to identify funding sources.

Approach 2B-2: Develop and apply for existing private and federal funding opportunities (CDC).

(Howard University Addendum)

Priority Area: Cancer

Vision of Impact: By 2016, HUH will advocate for public health infrastructure to support screening, prevention and treatment services for cancer and related conditions.

Strategic Levers: Advocacy, education, policy, and data

Goal 1: Advocate for integration of routine screenings for cancer in primary care settings.

Objective 1A: By year end 2014, HUH and partners will advocate and educate the Council of the District of Columbia for funding sources for cancer screening and preventive services.

Approach 1A-1: Utilize data to create advocacy and implementation strategies.

Approach 1A-2: Mobilize community champions and HUH to present to the Council of the District of Columbia.

Objective 1B: By year end 2016, HUH will create a framework for applying best practices of screening models to cancers.

Approach 1B-1: Convene a group of experts to identify, evaluate and recommend best practice models for disease screening that can be translated to cancer screening.

Objective 1C: By year end 2016, HUH will create a best practice framework for using navigator models in cancer care.

Approach 1C-1: Convene a group of experts to identify, evaluate and recommend best practice navigator models that can be translated to cancer care.

Goal 2: Promote cancer screening and preventive service competency for providers.

Objective 2A: By year end 2015, HUH will promote existing CE and develop continuing education on cancer screening and preventive service for health care providers.

Approach 2A-1: Identify and promote existing opportunities for CE. Determine gaps in opportunities.

Approach 2A-2: Based on a gap analysis, partner with experts to create objectives and content for CE units on cancer screening and preventive service.

Approach 2A-3: Identify existing professional development opportunities to offer cancer screening and preventive service CE.

Goal 3: Collaborate with the District of Columbia Government to align and integrate public and private resources for prevention and treatment of cancer and other related conditions.

Objective 3A: By year end 2016, HUH will facilitate the sharing of information addressing the prevention and treatment of cancer and related conditions.

Approach 3A-1: Partner with appropriate public health and private agencies to retrieve and share data through accessible web portals.

Approach 3A-2: Disseminate data related to cancer and related conditions through local and regional forums.

Objective 3B: By year end 2015, HUH will develop, distribute, and maintain a community assets map in support of the prevention and treatment of cancer.

Approach 3B-1: Convene public and private sector leaders in cancer and related conditions to identify and map community assets.

Approach 3B-2: Use accessible web portals to disseminate the community assets map.

Objective 3C: By year end 2016, HUH will advocate for additional funding for tobacco cessation programs.

Approach 3C-1: Convene entities in the District of Columbia to identify funding sources.

Approach 3C-2: Develop and apply for existing private and federal funding opportunities (e.g., CDC).

CONCLUSION

The Community Health Needs Assessment identified six priorities for the District of Columbia. Through a deliberative process, the District of Columbia Healthy Communities Collaborative decided to address the four issues the group believed it could most effectively influence.

After just a year of meeting, the DCHCC is proud to have produced this first CHIP. The Collaborative members acknowledge that this initial plan primarily focuses on building and strengthening infrastructure, laying the foundation for future efforts that directly address services issues.

Through the CHIP, DCHCC will address the increasing rates of sexually transmitted infections by advocating for more widespread screenings and strengthening partnerships that support reproductive health. Concerns about access to mental health and substance abuse services will be targeted by advocating for integrated, more widespread screening services and improved awareness of these issues by all providers. Growing rates of obesity among segments of District residents and obesity's deleterious impact on other health conditions will be addressed by working to make better utilization of public and private resources and ensuring wider sharing of best practices for the prevention and treatment of obesity and related conditions. Increasing diagnoses of asthma and preventable hospitalizations related to asthma will be addressed by working to strengthen asthma care coordination and advocating for better asthma care reimbursement policies.

The DCHCC is committed to improving health outcomes for the District of Columbia by implementing its action plan. Over the next few years, continuing to partner with stakeholders and community members who can help to achieve the goals will be critical to the success of the CHIP. Working together and as individual institutions, the Collaborative is committed to making the District of Columbia a healthier community for all.

Appendix 1

SUMMARY

The District of Columbia (DC) Healthy Communities Collaborative (DCHCC) represents a unique collaboration among five DC area hospitals (Children's National Medical Center, Howard University, Providence Hospital, Sibley Memorial Hospital, and United Medical Center) and two federally qualified health centers (FQHCs) (Community of Hope and Unity). In response to its community commitment, current economic challenges, and new federal guidelines, DCHCC set forth to conduct a community health needs assessment (CHNA) that summarizes and evaluates community health needs with attention to health status, health service needs, and the input of community stakeholders. Community health needs assessments are increasingly used to lay a factual foundation for community health decision-making. The CHNA is intended to guide DCHCC's decisions about where and how to allocate resources and implement appropriate health interventions for the population served by the hospitals and FQHCs within DCHCC. The CHNA described in this report includes analysis of existing demographic, health status, and hospital service use data from the DC Health Matters (DCHM) portal, supplemented by hospital and emergency department discharge data. We also complement these quantitative data with an analysis of current stakeholder perspectives regarding health need as well as health policy and investment priorities. The key objectives of the CHNA are:

1. To describe the socio-demographics, health status, and health environment of the population served by DCHCC with attention to differences by age, gender and race/ethnicity;

2. To examine inpatient and emergency department hospitalization rates in order to better understand patterns of health care use among residents of the local area, with attention to differences by zip code; and

3. To describe the perspectives of community stakeholders with attention to barriers and facilitators to health service use and recommendations for health program and policy improvement.

http://www.dchealthmatters.org/

Appendix 2

Community Health Improvement Plan Process
GAP Analysis Template

Instructions: Please include information about your program in the table listed below. Information should be provided in order to best identify any potential gaps and ways to address these areas.

GAP	Target Condition/Program	Current State	Goal State/Desired Outcomes	Timeline	Action Items and Responsible Person
1					
2					
3					
4					
5					

Appendix 3

Community Health Improvement Plan
SWOT Template

1. **Strengths**: A strength is a factor that provides benefits to the overall success of the program/intervention and/or address a critical need for the success of the intervention/program.
2. **Weaknesses**: A weakness is a limitation that prevents the program/intervention from being fully successful.
3. **Opportunities**: This relates to any positive or favorable current or future advantage or trend.
4. **Threats**: This relates to any unfavorable situation, trend, or changes.

Priority Health Issue: Sexual Health

Strengths	**Weaknesses**
• HIV and all STI's have tests for screening and partners have ability to test • There are established HIV testing programs • Per Unity, there is a Family Planning grant that has subcontracted to 5 CHCs • Established ED programs @ CNMC to test for HIV • Great data; proven clinical interventions	• Primary care doctors don't feel comfortable having sex education talk • Not much available at all hospitals in terms of Sexual Health Education and Prevention • CNMC HIV testing program is not a reimbursed service at this moment
Opportunities	**Threats**
• Possible collaboration with the DC Government campaign in support of sexual health • There is more funding available for HIV • Strong national focus/partnerships	• Poor intergovernmental coordination as it relates to funding • Community based stigma • Cultural stigma regarding sexual issues • Lack of safe sex messaging throughout media ex. Television shows

Community Health Improvement Plan
SWOT Template

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Priority Health Issue: Mental Health & Substance Abuse

Strengths	**Weaknesses**
• There is a successful Behavioral Health Unit at Sibley as well as within other DCHCC partners. • There is a renewed focus on Mental Health throughout the city • Access to patients is not an issue • Data is available • AA Meetings are housed at Providence 7 nights a week	• Lack of Coordination • There is limited access to services • Supervision and Compliance is an issue • Poor reimbursement for Mental Health Services • The distinction between mental health and behavioral health is non-distinct • Space, Time and Money is a challenge • Need for more providers specifically for outpatient care • Better management of the continuum of care once out of hospital setting and enters into community
Opportunities	**Threats**
• Mental Health is an issue that affects a widespread amount of people • DCHCC should take advantage of awareness occurring on the national level • Regarding Substance Abuse, there is a well-established Tobacco cessation case management program in the city	• The stigma and denial on an individual level • Stress related to substance abuse • The APRA application is cumbersome • Reticence about housing mental health programs in some facilities; those more difficult managed programs • Marijuana use is a challenging topic and is

• There is a lack of teen alcohol and drug abuse programs; therefore offering these programs would prove beneficial • The merging of the Department of Mental Health and APHA may assist with better managing mental illness/mental health cases • Defining the differences between mental and behavioral health • Co-locating services within primary care • Providing an educational series on reducing the stigma surrounding Mental Health throughout all DCHCC organizations and educating on understanding signs of mental illness • Work with agencies such as Department Of Justice for criminals who are suffering from mental health issues • Implement the model that Providence uses with AA classes being offered • Consider implementing a program in public schools for early intervention • National Council of Alcoholism-ability to work with them as part of a Board and their ability to provide expertise in field in community. They would provide resources and partnership.	a Political Hot Potato

Community Health Improvement Plan
SWOT Template

1. **Strengths**: A strength is a factor that provides benefits to the overall success of the program/intervention and/or address a critical need for the success of the intervention/program.
2. **Weaknesses**: A weakness is a limitation that prevents the program/intervention from being fully successful.
3. **Opportunities**: This relates to any positive or favorable current or future advantage or trend.
4. **Threats**: This relates to any unfavorable situation, trend, or changes.

Priority Health Issue: Obesity/Overweight

Strengths	**Weaknesses**
• Strong bariatric programs (all hospitals) • The collaborative can provide a powerful voice in obesity advocacy • Have data on obesity/overweight rates within the District • There are many preventive programs related to obesity • Unity has model program that can be replicated • Strong adult disease- related programs that impact obesity i.e. diabetes, hypertension	• Program data show limited long term results; helps while patient is a part of program; once a patient is gone the problem reoccurs • No distinct nutrition programs • It is difficult for programs to show sustained results, which hurts getting funding • Reimbursement Issues • Integration of behavioral specialists
Opportunities	**Threats**
• National successful programs, such as Weight Watchers, to partner with. • BikeShare Model • Legislation change; Healthy Schools Act • Collaboration with other players and partners (e.g., local chefs for healthy cooking education, Bike Share, DCPS, DDOT) • High visibility of Michelle Obama's Let's Move program • Partnering with Sodexho, Marriott nutritionists	• Environmental (fast food, no safe play spaces) • Generational obesity • Hiring nutritionists; there is a lack of nutritionists

Community Health Improvement Plan
SWOT Template

1. **Strengths**: A strength is a factor that provides benefits to the overall success of the program/intervention and/or address a critical need for the success of the intervention/program.
2. **Weaknesses**: A weakness is a limitation that prevents the program/intervention from being fully successful.
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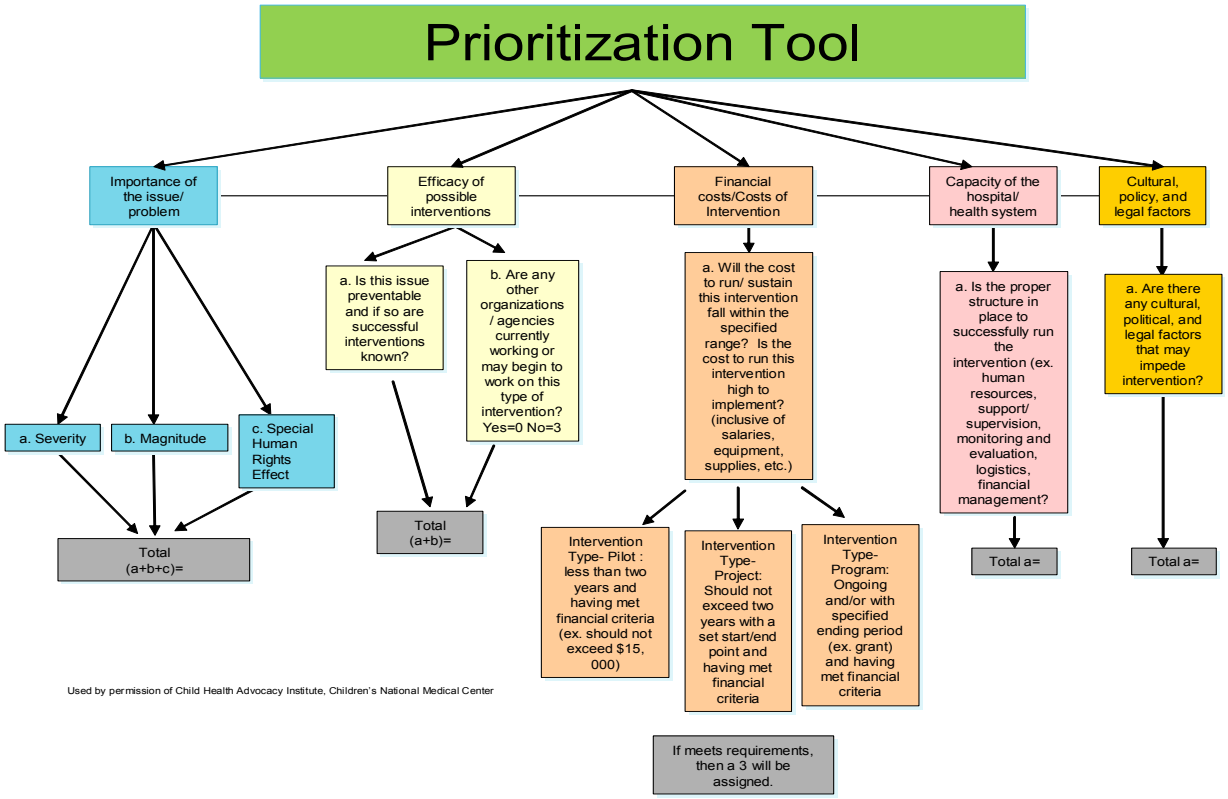
4. **Threats**: This relates to any unfavorable situation, trend, or changes.

Priority Health Issue: Asthma

Strengths	**Weaknesses**
• Great leader in childhood asthma @ CNMC • Ability to translate IMPACT DC model to adult population • All partners well connected to DCHA or DCPCA, both of which could play strong advocacy role • Existing relationship with patients; everyone has asthma patients • For CNMC & Unity, asthma is a priority; may be a priority of other partners • The collaborative could be a powerful advocate and voice for change • Data available to bring about change	• Inadequate space for treatment • Inadequate funding; non-reimbursable funding for treatment, coordination of care and transition • Hospital based EMR doesn't connect to primary care EMR (technology and data sharing issues) • An established asthma program is not present within all organizations that have a high asthma population • There is not a recognized leader in adult asthma
Opportunities	**Threats**
• Partnering for external funding for pilots in adult populations by replicating IMPACT model • Existing external organizations that we can work with • There is a need to have a standard reimbursed service; permanent reimbursed services • ACA funding for asthma • DC data sharing platform being developed • Breathe DC/ALA shifting to asthma • Have a model to implement smoking	• Air and housing quality. Overall environmental aspects

cessation program for inpatients	

Appendix 4



Rating Scale

Rate each criterion on scale:
High = 3 Medium = 2 Low = 1

Appendix 5


Transportation
Social Services
Education
Health
LEAD
SUPPORT
Advocates
Fire and EMS
COLLABORATE
Community Based Organizations
Police
Business