2016 DC Community Health Needs Assessment: Why, How, and So What?
Special Thank You

DC Hospital Association
DC Primary Care Association
DC Department of Health
DCHCC Community Advisory Board
The Advisory Board Company
KDS, Inc.
Requirements within the Affordable Care Act for not-for-profit, 501(c)(3) hospitals:

- Conduct a Community Health Needs Assessment (CHNA) every 3 years
- Create, adopt, and execute an implementation strategy, in form of a Community Health Improvement Plan (CHIP) designed to address the CHNA findings
- Document the impact of community benefit in a widely distributed, outcomes-based report

FQHCs have comparable requirements
Collaborating for a Better CHNA: DCHCC

4 hospitals and 4 community health centers entered into a formal partnership in January 2012 to develop a citywide needs assessment and improvement plan in 2013.

Ex-officio members include DC Hospital Association and DC Primary Care Association.

Community Advisory Board includes ~10 members representing several social determinants of health in DC.
What is the landscape of health in DC?
What facilitates and impedes health?
What health conditions are most prevalent?
What risky health behaviors are most prevalent?
What conditions are treated most commonly in healthcare settings?
What is the rate of preventable hospital/ED visits?

Subpopulation analysis by ward, age, race, income, etc. to identify health disparities
Goal of CHNA

Arrive at a set of high priority community-defined, data-driven needs that set the foundation for the Collaborative’s community health improvement efforts.

Focus on the determinants – root causes – of many health conditions.
Mental Health
prevention and treatment of psychological, emotional and relational issues that lead to higher quality of life

Place-based Care
care options that are convenient and culturally sensitive

Care Coordination
deliberate organization of patient care activities & info sharing protocols to achieve safer, more effective care

Health Literacy
ability to obtain, process, and understand basic health information to make appropriate health decisions
Qualitative: Community Engagement

- 60 Organizations: Wide variety of community organizations
- 31 Key informant interviews
- 113 Online Surveys
- 40 Focus Group Participants
- 80 Community Forums Attendees
- 6 Council Members
- 11 Government Agencies
- 15 Hospitals and Clinics
Question Asked of Community Stakeholders

- When you hear the words “healthy community,” what comes to your mind?
- What keeps people healthy in our community? What are barriers to health in our community?
- What actions, programs, and strategies do you think would make the biggest difference in the health of our community?
- What specifically can healthcare organizations – such as hospitals, community health – do to improve health in our city?
All data transcribed, coded, and analyzed using qualitative research software
Substantive Quantitative Data Gathered and Analyzed

- **Types of Data**
  - Population
  - Socio-demographic
  - Social Determinants
  - Health Behavior
  - Hospital Discharge
  - Emergency Department Visits
  - Community Health Center Visits
Welcome to DC Health Matters

A one-stop resource for community health indicators and related resources that impact the health of DC communities.

- Contains 200+ health and related indicators specific to DC
- Connects data to promising program and local resources
- Developed with intense community engagement
HEALTHY PEOPLE 2020 LEADING HEALTH INDICATOR TOPIC AREAS

1. Access to Care
2. Clinical Preventive Services
3. Environmental Quality
4. Injury and Violence
5. Maternal, Infant and Child Health
6. Mental Health
7. Nutrition, Physical Activity, and Obesity
8. Oral Health
9. Reproductive and Sexual Health
10. Social Determinants
11. Substance Abuse
12. Tobacco
13. Chronic Disease*
Smoking rates are very high in Ward 8 (40%).

The percentage of families living below the poverty level in Wards 7 and 8 is about twice the citywide average and about 15 times higher than in Ward 3.

- Live in poverty Ward 3: 2%
- Live in poverty Ward 7: 25%
- Live in poverty Ward 8: 29%

<table>
<thead>
<tr>
<th>Leading Health Indicator or Proxy Indicator</th>
<th>Citywide (DC)</th>
<th>Ward 1</th>
<th>Ward 2</th>
<th>Ward 3</th>
<th>Ward 4</th>
<th>Ward 5</th>
<th>Ward 6</th>
<th>Ward 7</th>
<th>Ward 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults who were diagnosed with depression, 2013 (%)</td>
<td>20.9</td>
<td>22.4</td>
<td>18.7</td>
<td>23.7</td>
<td>15.4</td>
<td>16.4</td>
<td>23.2</td>
<td>18.4</td>
<td>28.0</td>
</tr>
</tbody>
</table>
## Crime Data

<table>
<thead>
<tr>
<th>Crime Type</th>
<th>1/1/2014 to 12/31/2014</th>
<th>1/1/2015 to 12/31/2015</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homicide</td>
<td>105</td>
<td>160</td>
<td>↑</td>
</tr>
<tr>
<td>Sex Abuse</td>
<td>311</td>
<td>276</td>
<td>↓</td>
</tr>
<tr>
<td>Robbery Excluding Gun</td>
<td>2157</td>
<td>2103</td>
<td>↓</td>
</tr>
<tr>
<td>Robbery With Gun</td>
<td>1112</td>
<td>1249</td>
<td>↑</td>
</tr>
<tr>
<td>Assault Dangerous Weapon (ADW) Excluding Gun</td>
<td>1794</td>
<td>1640</td>
<td>↓</td>
</tr>
<tr>
<td>Assault Dangerous Weapon (ADW) Gun</td>
<td>673</td>
<td>751</td>
<td>↑</td>
</tr>
<tr>
<td><strong>Total Violent Crime</strong></td>
<td><strong>6152</strong></td>
<td><strong>6179</strong></td>
<td>↔</td>
</tr>
<tr>
<td>Burglary</td>
<td>3179</td>
<td>2534</td>
<td>↓</td>
</tr>
<tr>
<td>Theft</td>
<td>14613</td>
<td>14000</td>
<td>↓</td>
</tr>
<tr>
<td>Theft F/Auto</td>
<td>11333</td>
<td>10971</td>
<td>↓</td>
</tr>
<tr>
<td>Stolen Auto</td>
<td>3121</td>
<td>2794</td>
<td>↓</td>
</tr>
<tr>
<td>Arson</td>
<td>26</td>
<td>18</td>
<td>↓</td>
</tr>
<tr>
<td><strong>Total Property Crime</strong></td>
<td><strong>32272</strong></td>
<td><strong>30317</strong></td>
<td>↓</td>
</tr>
<tr>
<td><strong>Total Crime</strong></td>
<td><strong>38424</strong></td>
<td><strong>36496</strong></td>
<td>↓</td>
</tr>
</tbody>
</table>

Source: Metropolitan Police Department
Graduation rates range from **100% to 32%** by high school.
Hospitalization Rates

Liveborns, Mood Disorders, Congestive Heart Failure, Schizophrenia, Septicemia
# Top 5 Reasons for ED Visits

<table>
<thead>
<tr>
<th>RANK</th>
<th>CHILDREN'S NATIONAL</th>
<th>GEORGE WASHINGTON</th>
<th>GEORGETOWN UNIVERSITY</th>
<th>HOWARD UNIVERSITY</th>
<th>PROVIDENCE</th>
<th>SIBLEY MEMORIAL</th>
<th>WASHINGTON HOSPITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Other upper respiratory infections</td>
<td>Abdominal pain</td>
<td>Alcohol-related disorders</td>
<td>Superficial injury; contusion</td>
<td>Sprains and strains</td>
<td>Alcohol-related disorders</td>
<td>Abdominal pain</td>
</tr>
<tr>
<td>2</td>
<td>Asthma</td>
<td>Nonspecific chest pain</td>
<td>Other injuries and conditions due to external cause</td>
<td>Sprains and strains</td>
<td>Superficial injury; contusion</td>
<td>Superficial injury; contusion</td>
<td>Nonspecific chest pain</td>
</tr>
<tr>
<td>3</td>
<td>Superficial injury; contusion</td>
<td>Sprains and strains</td>
<td>Abdominal pain</td>
<td>Other connective tissue disease</td>
<td>Other upper respiratory infections</td>
<td>Sprains and strains</td>
<td>Other injuries and conditions due to external cause</td>
</tr>
<tr>
<td>4</td>
<td>Fever of unknown origin</td>
<td>Superficial injury; contusion</td>
<td>Superficial injury; contusion</td>
<td>Alcohol-related disorders</td>
<td>Abdominal pain</td>
<td>Abdominal pain</td>
<td>Spondylosis; intervertebral disc disorders</td>
</tr>
<tr>
<td>5</td>
<td>Otitis media and related conditions</td>
<td>Spondylosis; intervertebral disc disorders; other</td>
<td>Sprains and strains</td>
<td>Other upper respiratory infections</td>
<td>Spondylosis; intervertebral disc disorders</td>
<td>Spondylosis; intervertebral disc disorders</td>
<td>Superficial injury; contusion</td>
</tr>
</tbody>
</table>
## Top 5 Reasons for ED Visits, By Age

<table>
<thead>
<tr>
<th>RANK</th>
<th>AGE 00-17</th>
<th>AGE 18-44</th>
<th>AGE 45-64</th>
<th>AGE 65+</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Other upper respiratory infections</td>
<td>Abdominal pain</td>
<td>Alcohol-related disorders</td>
<td>Nonspecific chest pain</td>
</tr>
<tr>
<td>2</td>
<td>Superficial injury; contusion</td>
<td>Sprains and strains</td>
<td>Spondylosis; intervertebral disc disorders</td>
<td>Spondylosis; intervertebral disc disorders</td>
</tr>
<tr>
<td>3</td>
<td>Asthma</td>
<td>Superficial injury; contusion</td>
<td>Nonspecific chest pain</td>
<td>Superficial injury; contusion</td>
</tr>
<tr>
<td>4</td>
<td>Fever of unknown origin</td>
<td>Other upper respiratory infections</td>
<td>Abdominal pain</td>
<td>Other injuries and conditions due to external cause</td>
</tr>
<tr>
<td>5</td>
<td>Other injuries and conditions due to external cause</td>
<td>Nonspecific chest pain</td>
<td>Sprains and strains</td>
<td>Abdominal pain</td>
</tr>
</tbody>
</table>
Top 5 Reasons for ED Visits, By Ward

<table>
<thead>
<tr>
<th>RANK</th>
<th>WARD 1</th>
<th>WARD 2</th>
<th>WARD 3</th>
<th>WARD 4</th>
<th>WARD 5</th>
<th>WARD 6</th>
<th>WARD 7</th>
<th>WARD 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Other upper respiratory infections</td>
<td>Alcohol-related disorders</td>
<td>Superficial injury; contusion</td>
<td>Other upper respiratory infections</td>
<td>Other upper respiratory infections</td>
<td>Other upper respiratory infections</td>
<td>Other upper respiratory infections</td>
<td>Other upper respiratory infections</td>
</tr>
<tr>
<td>2</td>
<td>Abdominal pain</td>
<td>Superficial injury; contusion</td>
<td>Alcohol-related disorders</td>
<td>Superficial injury; contusion</td>
<td>Superficial injury; contusion</td>
<td>Superficial injury; contusion</td>
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<td>Superficial injury; contusion</td>
</tr>
<tr>
<td>3</td>
<td>Superficial injury; contusion</td>
<td>Abdominal pain</td>
<td>Other injuries and conditions due to external cause</td>
<td>Abdominal pain</td>
<td>Sprains and strains</td>
<td>Abdominal pain</td>
<td>Sprains and strains</td>
<td>Asthma</td>
</tr>
<tr>
<td>4</td>
<td>Alcohol-related disorders</td>
<td>Other upper respiratory infections</td>
<td>Open wounds of extremities</td>
<td>Sprains and strains</td>
<td>Abdominal pain</td>
<td>Sprains and strains</td>
<td>Abdominal pain</td>
<td>Sprains and strains</td>
</tr>
<tr>
<td>5</td>
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<td>Sprains and strains</td>
<td>Abdominal pain</td>
<td>Other injuries and conditions due to external cause</td>
<td>Nonspecific chest pain</td>
<td>Other injuries and conditions due to external cause</td>
<td>Asthma</td>
<td>Abdominal pain</td>
</tr>
</tbody>
</table>
The quantitative data allow us to produce powerful visuals that tell the asthma story in DC. Such as...

Rate of Asthma ED Visits per 1,000 Children, 0-17 years, in DC

Heavily Concentrated in Wards 7 & 8

Concentration of Poverty in DC: Mimics the Asthma ED Visits Map
## Repeat Hospital and ED Visits

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>% OF PATIENTS WITH MORE THAN 1 HOSPITAL STAYS</th>
<th>% OF PATIENTS WITH MORE THAN 1 ED VISITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s National Health System</td>
<td>18%</td>
<td>40%</td>
</tr>
<tr>
<td>George Washington University Hospital</td>
<td>14%</td>
<td>25%</td>
</tr>
<tr>
<td>Georgetown University Hospital</td>
<td>17%</td>
<td>18%</td>
</tr>
<tr>
<td>Howard University Hospital</td>
<td>16%</td>
<td>26%</td>
</tr>
<tr>
<td>National Rehab Hospital</td>
<td>9%</td>
<td>N/A</td>
</tr>
<tr>
<td>Providence Health System</td>
<td>15%</td>
<td>25%</td>
</tr>
<tr>
<td>Sibley Memorial Hospital</td>
<td>10%</td>
<td>20%</td>
</tr>
<tr>
<td>United Medical Center</td>
<td>19%</td>
<td>N/A</td>
</tr>
<tr>
<td>Washington Hospital Center</td>
<td>19%</td>
<td>26%</td>
</tr>
</tbody>
</table>
Selecting Priority Needs

- Modified Hanlon Prioritization Method
  - Importance to Community (40%)
  - Capacity to Address (25%)
  - Alignment with Mission/Vision (25%)
  - Existing Collaborations/Interventions (10%)

STEP 1:
DCHCC Members Receive Initial List of Community-Defined Needs

STEP 2:
DCHCC Members Rank Community Needs Individually Using Set Criteria

STEP 3:
DCHCC Engages in a Group Prioritization Activity to Select Priority Needs

STEP 4:
DCHCC Leadership Presents List of Priority Needs to the Community Advisory Board (CAB) for Feedback
# DCHCC Community Needs Prioritization Table

## All Scores

<table>
<thead>
<tr>
<th>Community-Identified Need</th>
<th>Importance to Community (a)</th>
<th>Capacity to Address (b)</th>
<th>Alignment with Mission/Vision (c)</th>
<th>Existing Collaborations/Interventions (d)</th>
<th>Final Score [Max = 100]</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Mental Health</td>
<td>9</td>
<td>8.6</td>
<td>9.4</td>
<td>8.1</td>
<td>89.1</td>
</tr>
<tr>
<td>1. Care Coordination</td>
<td>10</td>
<td>7.6</td>
<td>8.8</td>
<td>7.3</td>
<td>88.2</td>
</tr>
<tr>
<td>3. Meet People Where They Are</td>
<td>10</td>
<td>6.6</td>
<td>8.3</td>
<td>7.0</td>
<td>84.2</td>
</tr>
<tr>
<td>4. Health Literacy</td>
<td>9</td>
<td>6.7</td>
<td>8.0</td>
<td>6.2</td>
<td>78.9</td>
</tr>
<tr>
<td>9. Cultural Competence</td>
<td>7</td>
<td>8.0</td>
<td>9.0</td>
<td>6.8</td>
<td>77.3</td>
</tr>
<tr>
<td>6. Healthy Behaviors</td>
<td>8</td>
<td>7.0</td>
<td>8.3</td>
<td>6.9</td>
<td>77.2</td>
</tr>
<tr>
<td>7. Health Data Dissemination</td>
<td>8</td>
<td>7.3</td>
<td>8.0</td>
<td>6.7</td>
<td>77.0</td>
</tr>
<tr>
<td>2. Food Insecurity</td>
<td>10</td>
<td>4.8</td>
<td>6.6</td>
<td>5.4</td>
<td>73.8</td>
</tr>
<tr>
<td>8. Community Violence</td>
<td>7</td>
<td>3.6</td>
<td>6.2</td>
<td>3.8</td>
<td>56.2</td>
</tr>
</tbody>
</table>
Mental Health
prevention and treatment of psychological, emotional and relational issues that lead to higher quality of life

Place-based Care
care options that are convenient and culturally sensitive

Care Coordination
deliberate organization of patient care activities & info sharing protocols to achieve safer, more effective care

Health Literacy
ability to obtain, process, and understand basic health information to make appropriate health decisions
More than 20% of DC adults are diagnosed with depression, with the highest prevalence being in Ward 8.

15% of DC youth have attempted suicide, with the rate twice as high in girls.

Seniors living in Ward 2 appear to be the most lonely, sad and isolated (23%).

Mental health disorders are in the top five reasons for hospital admissions at UMC, Providence, Children’s, Howard, and GWU Hospitals.
Community Health Workers
Place-Based Care Convenience

- All wards – except Ward 3 – include areas that are primary care shortage areas
- Wards 7 and 8, and parts of Wards 2 and 6, are dental health shortage areas
- Wards 7 and 8 are mental health shortage areas
Complexity of Care System
Poor Information Sharing
Lack of Communication

- DC residents are a highly insured population, but nearly a quarter (23.8%) report not having a personal health care provider
- Men living in Wards 5, 7, 8 report highest rates of no personal care provider
- Data show infant mortality rates decreasing across the city; highest rates continue to be in Black mothers and in Ward 8

<table>
<thead>
<tr>
<th>Qualitative Findings</th>
<th>Quantitative Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main Qualitative Themes From DC Stakeholders Related to Care Coordination</td>
<td>Selected DC Health Status and Utilization Indicators Related to Care Coordination</td>
</tr>
<tr>
<td>DC community stakeholders identified the need for enhancing “care coordination” as a means to improve the health of DC’s communities.</td>
<td>Qualitative metrics directly related to care coordination are limited in DC. Below are indicators that are associated with or can lead to poor care coordination:</td>
</tr>
<tr>
<td>Complexity of the health care system, lack of communication between providers, lagging shared electronic medical record systems, and non-co-located health care services were identified as contributing to community members’ difficulties accessing health care services.</td>
<td>While DC residents are highly insured, a large percentage, 23.8%, report not having someone they think of as their personal health care provider. About 30% of adults delayed getting medical care because they could not get an appointment soon enough.</td>
</tr>
<tr>
<td>These difficulties were heightened among community members who were socioeconomically vulnerable, had limited health literacy, and had inconsistent patterns of service utilization.</td>
<td>Men are less likely to have a primary care provider and residents in Wards 5, 7 and 8 have the lowest rates of having someone they consider their provider.</td>
</tr>
<tr>
<td></td>
<td>The infant mortality rate (IMR) is decreasing in DC. The highest rates continue to be among Black mothers and those residing in Ward 8. IMR can be reduced with highly coordinated prenatal care.</td>
</tr>
<tr>
<td></td>
<td>More than 20% of residents in Wards 1, 2, 3 and 4 speak a second language at home.</td>
</tr>
<tr>
<td></td>
<td>United Medical Center and Washington Hospital Center have the highest percentage of their patients who have multiple hospitalizations at 10%.</td>
</tr>
<tr>
<td></td>
<td>DC maps show areas that are designated as health professional shortage areas.</td>
</tr>
<tr>
<td></td>
<td>Primary care: All wards, except Ward 3, include areas that are designated as primary care shortage areas.</td>
</tr>
<tr>
<td></td>
<td>Dental care: Wards 7 and 8, and parts of Wards 3 and 6, are classified as dental health professional shortage areas.</td>
</tr>
<tr>
<td></td>
<td>Mental health: Wards 7 and 8 are designated as mental health professional shortage areas.</td>
</tr>
<tr>
<td></td>
<td>Six DC hospitals participate in a Health Information Exchange (HIE) with the Chesapeake Regional Information System for our Patients (CRISP) that is intended to help with care coordination efforts.</td>
</tr>
</tbody>
</table>
| | Health literacy and education services provided by professionals help residents understand basic health information that is necessary to make appropriate health decisions. These services are strictly tied to grant availability, they are scarce, and are not currently billable services.
Confusion about Health Care
Poor Overall Literacy

• ED over-utilization may be a result of health literacy issues. Asthma ED rates in Wards 7 & 8 are more than 20 times higher than in Ward 3.

• More than 20% of residents in Wards 1, 2, 3, and 4 speak a second language at home

• Insurance does not equate to access – highly insured population, but use of primary care services low in some populations
Moving Forward

How do we address the identified needs?

COMMUNITY HEALTH IMPROVEMENT PLAN
Example: Reducing Unnecessary ED Visits
The CHNA in Action: Identifying Health Disparities in Our Community
We know that health starts in the communities in which our children and families live.

The Child Health Advocacy Institute leads initiatives that improve the health of our community, with a focus on programs, policies, and systems that impact the determinants of health and populations that experience health inequities.

This embodies the commitment of Children’s National “to building a brighter, healthier future for all children, not just the ones who come through our doors.”
Background

- Environmental Context 2010 – 2014 data
  - ED utilization rate in Ward 7 is more than 3xs higher than in Ward 3 (632 vs 166 ED visits per 1000)
  - ED visit rate for Black residents is more than 5xs higher than White residents
  - Children have the highest ED visits rate (597 visits per 1000); Children’s National has the busiest ED in the city

- Children’s National Goals
  - Decrease ED utilization and increase primary care utilization
  - Move from volume-based care to value-based care

Source: CHNA, pp 66 – 68
Digging Deeper

- Children’s National at UMC Emergency Department Utilization
- (May 2015 through April 2016)

- 37,214 visits and 21,564 unique patients
- 34% were Goldberg patients
- 428 patients had 6 or more visits
- Almost 80% had a low acuity level
- More than 60% had DC Medicaid
- Almost 60% of patients visited the ED between 7am and 6pm
- Busiest days of the week in the ED were Monday and Tuesday
Reason for visiting the ED

• Perceived higher quality of care in the ED
• Convenience of the ED hours, location, short wait time, free Wi-Fi, snacks
• Easier to get a school/work note
• Overestimation of child’s conditions as urgent
• Not knowing who the child’s pediatrician is
• Transportation
Why Is this a Health Disparities Issue?

• ED overuse for low acuity conditions is a health disparities issue
• Individual Health Effects
  ▪ Lack of connection to primary care
  ▪ Lack of trust of primary care
  ▪ Lack of access to preventive care services
• Population Health Effects
  ▪ Disconnected culture of care
  ▪ Lack of access to primary care
  ▪ Overburdening of ER with low acuity visits
  ▪ Disparities in care and outcomes
• System Level Health Effects
  ▪ Health care system costs
  ▪ Low acuity care rendered in a high acuity setting diverts dollars from other important services, such as education
How Do We Begin to Address This Health Disparity?

- **Goal**
- This collaborative effort aims to improve the health and wellbeing of children in Wards 7 and 8 by decreasing patient emergency department utilization for low acuity levels and increasing primary care utilization.
Next Steps

- Focus groups with caregivers and clinicians
- Physician champions within the primary care setting overseeing patients with high ED visits
- Expand beyond Goldberg patients to include non-Goldberg patients to impact population health
- Identify policy, systems, and environmental changes that support CHNA priorities
THANK YOU

QUESTIONS & DISCUSSION