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District of Columbia Community Health Needs Assessment

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The DCHCC represents a unique collaboration among four D.C.-area hospitals (Children’s National Medical Center, Howard University Hospital, Providence Hospital, and Sibley Memorial Hospital) and two FQHCs (Community of Hope and Unity). In spring 2013, an additional community health center—Bread for the City—joined the DCHCC membership. In response to its community commitment, current economic challenges, and new federal guidelines, DCHCC set forth to conduct a CHNA that summarizes and evaluates community health needs with attention to health status, health service needs, and the input of community stakeholders. CHNAs are increasingly used to lay a factual foundation for community health decisionmaking. The CHNA described in this report 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. It includes analysis of existing demographic, health status, and hospital service use data from the DC Health Matters (DCHM) portal,¹ supplemented by hospital and emergency department (ED) discharge data. We complement our analysis of 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 this written CHNA are as follows:

1. Describe the sociodemographics and health status of the population served by DCHCC with attention to differences by age, gender, race/ethnicity, and ward.
2. Examine inpatient and ED hospitalization rates to better understand patterns of health care use among residents of the local area with attention to differences by zip code, health care facility, and age, where relevant.
3. Describe the perspectives of community stakeholders with attention to barriers and facilitators to health service use and recommendations for health program and policy improvement.

**Sociodemographic Trends**

In 2011, the D.C. population totaled 617,996. Approximately 50 percent of the District’s residents are black, 35 percent are white, 10 percent are Hispanic, and 4 percent are Asian. Overall, the proportion of District residents that is black decreased from 2000 to 2011 (from 59.5

¹ See http://www.dchealthmatters.org.
percent to 49.5 percent), while the proportion that is Hispanic grew slightly (from 7.9 percent to 9.5 percent), the proportion that is Asian grew from 2.6 percent to 3.6 percent, and the proportion that is white grew from 27.7 percent to 35.3 percent. Fifteen percent of District residents report speaking a language other than English at home.

Roughly 15 percent of the District’s families live below the federal poverty level (FPL). The percentage of families who live in extreme poverty (or 185 percent of FPL) decreased from 2000 to 2011. Further, the percentage of residents who are college graduates sharply increased in the last decade (from 39 percent to 53 percent). The District population has become slightly younger, with the greatest growth (18.3 percent) among 18–39 year olds, but with a decrease of almost 8 percent in the population under 18 years old.

**Health Needs and Risk Behaviors**

We principally used the Behavior Risk Factor Surveillance System (BRFSS) survey and Youth Risk Behavior Survey (YRBS) to explore health needs and risk behaviors in the District. Where relevant, we also used data from the D.C. Department of Health, the National Center for Health Statistics, the Substance Abuse and Mental Health Services Administration (SAMHSA), and other local studies. Our findings focus on the areas of (1) general health quality and the use of preventive services, (2) nutrition and obesity, (3) chronic disease, (4) reproductive and sexual health, (5) mental health and substance use, (5) oral health, and (6) injuries.

**General Health and the Use of Preventive Services**

*Insurance Status.* As reported in previous health needs assessments, the District boasts a significantly smaller percentage of residents who are uninsured (7.7 percent) compared with the general U.S. population (18 percent). The number of children without insurance is also low relative to the U.S. population (7.5 percent of children nationally are uninsured as of 2011). According to the 2007 National Survey of Children’s Health (the most recent survey wave available), approximately 3.5 percent of District children were uninsured. In 2009, the D.C. Department of Healthcare Finance estimated that approximately 60 percent of children ages 0–21 were publicly insured.

*Self-Reported Health.* Only 3 percent of District residents (compared to 18 percent of U.S. residents) report only fair or poor health. In addition, fewer District residents on average note days of impairment in the past month due to poor physical health compared to the U.S. average (3.4 days versus 3.9 days). These impairment days are greatest among those 40 years of age or older.

*Use of Preventive Health Services.* The use of preventive health services is better in the District than nationwide (75 percent in the District had a routine checkup, compared to 67 percent in the United States). While these trends are generally positive, the percentage of older residents who have ever received a pneumococcal vaccine is less than the U.S. rate overall (63 percent in the District compared to 69 percent nationally), suggesting a possible point of health intervention. There are regional (by ward) differences in these outcomes.

*Barriers to Care.* Residents of some wards reported greater difficulty seeing a provider in the prior year due to cost. More 18–39 (11.2 percent) and 40–64 (11.6 percent) year olds missed care due to cost compared to those aged 65 years and older (5.7 percent).
Nutrition and Obesity

*Obesity and Overweight.* Black residents have a significantly higher rate of overweight and obesity as compared to white residents (66 percent black versus 40 percent white). Overweight and obesity is higher among those 40 years and older (62 percent) compared to those 18–39 years old (43 percent). Obesity is more prevalent in Wards 7 and 8 (21 percent and 32 percent, respectively), while general overweight is more prevalent in Wards 4 and 5 as compared to other wards (36 percent and 37 percent, respectively).

*Exercise.* Overall, District residents are more likely to report exercise in the prior month compared to the national average (80 percent in the District compared to 74 percent in the United States). However, self-reported rates of getting enough exercise are lowest among older adults in the District (70 percent of those 65 years and older compared to 86 percent of those 18–39 years old). District children between the ages of 6 and 17 were less likely to engage in physical activity (defined as 20 minutes or more of activity causing them to sweat) within the prior week compared to children in this age range nationally. Seventeen percent of District children between the ages of 6 and 17 reported no physical activity within the prior week as compared to 10.3 percent of children nationwide. Differences in these health behaviors across wards were also observed.

Chronic Disease and Disability

*General Trends in Chronic Disease.* Reported percentages of District residents with coronary heart disease, arthritis, and chronic obstructive pulmonary disorder (COPD) are lower than nationwide rates, but rates of asthma are higher (16 percent in the District compared to 14 percent in the United States). However, racial disparities were observed, with blacks having higher rates of heart disease, arthritis, COPD, and asthma. Ward differences were observed in the rates of most chronic diseases, particularly cardiovascular disease, asthma, diabetes, and emotional health limitations.

*Cancer.* In terms of the most recent 2009 data, the age-adjusted incidence of prostate and pancreatic cancers was higher in the District than the U.S. average. Lung and skin cancer incidence was lower in the District than in the nation. The incidence of pediatric cancer (all cancers among those younger than 20) is comparable to incidence nationwide. Blacks have considerably higher rates of cancer than whites in the District, as well as compared to overall rates nationwide.

Reproductive and Sexual Health

*Reproductive Health.* There were 9,156 births in the District in 2010, including 1,458 to mothers of Hispanic ethnicity (all races) and 4,940 to black mothers. Overall, the percentage of preterm births (prior to 37 weeks gestation) in the District declined from 16.0 percent of all births in 2006 to 13.6 percent of all births in 2010 (Martin et al., 2012). Infant mortality in 2010 was at its lowest rate in a decade, having declined from 10.6 per 1,000 live births in 2001 to 8.0 per 1,000 live births in 2010.

*Sexual Health.* The number of newly diagnosed human immunodeficiency virus (HIV) (including AIDS) cases has also declined in the past five years, as have deaths from HIV (including AIDS); the majority of new cases were among blacks. District residents report higher rates of HIV testing as compared to the rest of the country, and those rates are highest among those 18–39 years old. D.C. continues to report high rates of gonorrhea and chlamydia as compared to the rest of the country, with rates particularly high in Wards 7 and 8. Youth
ages 15–19 have also accounted for an increase in the proportion of chlamydia and gonorrhea cases in the city over the past five years.

**Mental Health and Substance Use**

*Mental Health.* According to data from the 2010 and 2011 National Surveys of Drug Use and Health, 22.6 percent of District adults over the age of 18 reported any mental illness as compared to 19.8 percent of adults nationwide. Diagnosis of depressive disorder among adults also appears to be comparable to U.S. reports, although fewer people in the District report having the necessary social or emotional support (asked in the survey as “do you feel you have enough social or emotional support?” [45 percent in the District compared to 51 percent nationally]). Diagnosis of depressive disorder was more common among those 40–64 years old than among other age groups. More white adult residents than black residents report being diagnosed with depressive disorder (18 percent versus 15.4 percent). District youth have lower rates of feelings of sadness as compared to the rest of the country, with 23 percent of District high school students reporting feeling sad or hopeless for at least two weeks in the past 30 days compared to 28 percent of youth nationally.

*Mental Health Service Use.* According to a 2010 report about behavioral health care in the District, there is significant unmet need particularly for persons with mental illness and Medicaid managed care, DC Alliance, or those who lack insurance. Approximately 60 percent of adults and 72 percent of adolescents enrolled in Medicaid managed care plans were estimated to have an unmet need for depression care (Gresenz, 2010).

*Smoking and Substance Abuse.* Smoking is less common in the District compared to the United States overall. However, binge drinking and heavy drinking is more common, with a rate of 25 percent in the District for binge drinking compared to 18 percent in the United States and a rate of 10 percent for heavy drinking in the District compared to 6 percent in the United States). By age group, more 18–39-year-olds report binge and heavy drinking (39 percent binge; 13 percent heavy) and more 40–64-year-olds report being current smokers than other age groups (23 percent versus 11 percent of those 65 years and older and 21 percent for 18–39-year-olds). As with mental health diagnoses, there are also racial differences in substance use. More white residents than black residents report frequent engagement in binge (32 percent white versus 18 percent black) and heavy drinking (12 percent white versus 7 percent black). The District has higher rates of illicit drug use for all people ages 12 and above as compared to the United States nationwide, with 13.5 percent of District residents reporting any illicit drug use in the past 30 days as compared to 8.8 percent of residents nationwide.

**Oral Health**

More residents in the District have had a tooth removed due to decay (48 percent in the District compared to 45 percent in the United States); however, more residents also report having their teeth cleaned as compared to the overall U.S. rate (73 percent in the District versus 69 percent in the United States). In the District, rates of any dental visit, as well as preventive care dental visits, specifically among children covered by Medicaid, are low but comparable to the national average. The rate of having any teeth removed increases with age, with nearly 70 percent of those 65 years or older reporting that experience.
Injuries

**General Injury Prevention.** District residents engage in injury prevention behaviors similar to the rest of the country; however, black residents report a lower rate of seatbelt use (85 percent) as compared to white residents (89 percent). White residents are more likely to report falls than black residents (17 percent white versus 14 percent black), but there is no difference in falls by age.

**Youth Violence.** There was no difference between the United States overall and the District in terms of carrying weapons on school property, and fewer District youth reported being bullied at school (10 percent) compared to the U.S. report of 20 percent. On the other hand, more high school youth in the District reported physical abuse in intimate relationships (e.g., boyfriend/girlfriend) (15 percent versus 9 percent).

**Violent Crime.** The District has a higher violent crime rate as compared to the rest of the country, with 1,202.1 violent crimes per 100,000 population as compared to a national rate of 386.3 per 100,000 in 2011. The murder rate was also higher, with 17.5 murders per 100,000 in 2011 as compared to a rate of 4.7 per 100,000 nationwide. However, the District has observed a downward trend in the number of homicides, reaching a 20-year low of 78 total homicides in 2012 compared to 243 homicides in 2003 and 454 in 1993.

Health Service Use

**Access to and Use of Preventive Services**

The uninsurance rate is quite low in the District (7.7 percent) compared to the national uninsurance rate (16 percent). Sixty percent of those without insurance cited no regular source of care compared to only 15 percent of those with insurance. Fewer residents with insurance missed care due to cost. Cancer screenings (e.g., mammograms, pap smears, colonoscopies, prostate-specific antigen [PSA] tests) are more common among those with insurance than those without insurance.

**Inpatient and Emergency Department Discharges**

**General Rates.** From 2006 to 2011, overall inpatient discharge rates for D.C. residents remained fairly steady. However, when examined by age, rates among those 65 years and older fell from 299 to 269 per 1,000. For ED discharges, rates were also steady across age groups generally. However, discharge rates were steady among those 0–17 years old through 2009 and then increased substantially in 2010 and 2011.

**Discharge Reasons.** We examined the top reasons across all hospitals for inpatient and ED discharges. The top reasons for inpatient discharges are diseases of the heart, complications related to injury and poisoning, and pregnancy. For ED discharges, respiratory infections and contusions were frequently cited (the second and third most reported, respectively), though conditions without a clear diagnosis were the most common.

**Ambulatory Care Sensitive Inpatient and ED Discharges**

We use 2000–2011 DC Hospital Association (DCHA) data to describe trends in hospitalizations that are sensitive to the availability and effectiveness of outpatient services, such as primary and specialty care. These are referred to as ambulatory care sensitive (ACS) hospitalizations and are used as a proxy for the availability and use of primary and preventive health
services. Often, rates of ACS hospitalizations are used to determine where need is high in a community, yet health service availability is low or health service use is inappropriate.

ACS Rates. Like overall inpatient and ED discharges, ACS inpatient discharges have sharply declined among those 65 years and older but have held steady across all other age groups. ACS ED discharges are greatest among those 0–17 years old, with a sharp increase in 2010 and 2011. This increase appears to have been driven predominantly by ED discharges in Ward 8, followed by Ward 7.

Asthma. For inpatient and ED discharges, asthma rates among those 0–17 years old experienced some decline in 2004 but have sharply increased since that point.

Diabetes. Diabetes is also a key condition for ACS calculations, particularly inpatient discharges. Overall, inpatient discharges related to diabetes have declined among the older age groups (40 years and older) and have held steady among younger age groups. By ward, there is a lot of “noise” in the inpatient discharges, particularly in Wards 7 and 8, among 0–17-year-olds, with sharp increases and decreases since 2006.

Sepsis and Cellulitis. Sepsis-related discharges are still high among those 65 years and older and are most common among those in Ward 5. The rate of cellulitis is also fairly high and generally steady among all age groups, with some increase since 2008 among those 0–17 years old.

Other Trends. One of the most notable trends over the last few years is a sharp decline in heart disease–related discharges, particularly those related to coronary atherosclerosis. A key trend in ED discharges in the past few years is in the area of “stress-related discharges,” namely headaches, migraines, and back pain. Discharges related to these problems have all increased. For example, the rate of ED discharges due to back pain has sharply increased, especially among those 40–64 years old and is greatest in this age group among those in Wards 5, 6, and 7.

Visits to Federally Qualified Health Centers
Unity Health Care, Community of Hope, La Clinica del Pueblo, and Mary’s Center are the four District grantees designated as FQHCs and captured in the national Uniform Data System (UDS) as of the time of this study. In 2011, there were a total of 122,891 patients served by these clinics, with 45 percent being male patients and 55 percent being female patients.

Stakeholder Perspectives
For this assessment, we also convened four focus groups with community stakeholders (e.g., leaders from community-based organizations, health and social service agencies, and faith-based groups) to discuss community health issues and recommendations for improvement. Our findings from these focus groups largely confirmed findings from our survey and hospital discharge data analysis. We identified nine common themes that emerged in our focus group discussions: (1) behavioral health, (2) obesity and nutrition, (3) preventive health services, (4) specialty services, (5) eldercare and end-of-life services, (6) disability services, (7) information technology, (8) case management, and (9) social determinants/social services.

Behavioral Health. Behavioral health services are limited for persons with Medicaid and persons for whom English is not their primary language. In particular, there are limited transitional services available to persons with behavioral health needs, especially among non-English
speaking populations. More services are needed to help support community-based independent living for persons with behavioral health needs.

**Obesity and Nutrition.** There are few programs targeting obesity and promoting healthy eating. In particular, more programs should be developed that focus on the entire family.

**Preventive Health Services.** Focus group participants felt that hospitals in the District tended to focus on acute treatment services rather than preventive health care services. Hospitals should work with social service agencies to promote more programs that support healthy behaviors.

**Specialty Services.** There is a particular need for specialty services, such as pain management services and oncology services. The shortage of specialty services is greatest in Wards 7 and 8. Participants recommended provider practice incentives (such as loan repayment) and partnerships between hospitals and community-based health organizations to provide needed specialty services in areas where there are shortages.

**Eldercare and End-of-Life Services.** District residents who are primary caregivers for elderly family members have little support to help them provide effective home-based care. Case management efforts should focus on supporting eldercare. In addition, residents are often not aware of hospice and end-of-life services available in the community.

**Disability Services.** There are limited services available to support persons with disabilities in the city. Furthermore, health care providers are often ill equipped to treat this population due to a lack of medical education in this area. An expansion in the number of health and social service programs for persons with disabilities is needed.

**Information Technology.** There is little linkage of information systems across health care settings, often leading to duplicative services. More investment in a regional health information system is needed to help address this problem.

**Case Management.** There is little linkage of case management across hospitals to provide continuity of care for residents who may use services at multiple sites. There is also little linkage of hospitals to medical homes at discharge. There is a need for more-intensive patient navigation services to help residents make the greatest use of health services in the city.

**Social Determinants/Social Services.** A number of social determinants influence health care status in the city, including poverty, cultural differences, language, housing, and literacy. For hospitals and health care organizations to be most effective, providers must develop a greater awareness of these social determinants and their impact on the health of District residents. Programs that target these social determinants are needed, including greater cultural competency training and health interventions more appropriately tailored to the languages and literacy levels of District residents.

**Conclusion**

The CHNA revealed six priority areas: asthma, obesity, mental health, sexual health, stress related disorders (e.g., headache, back pain), and general access to health services. We determined priority areas by using a combination of quantitative (administrative, survey) and qualitative (focus group) data analysis, as well as considering broader national health priority areas, paying particular attention to issues that have persisted over the last decade or experienced a recent increase or spike in the District. Despite high insurance rates, health care services are not evenly distributed by ward, creating significant challenges to access. In particular, specialty
services such as oncology and pain management services are lacking in Wards 7 and 8. There is a need for the expansion of these services, as well as greater care coordination between health and social services to help residents navigate the system and obtain needed services.