LETTER FROM THE DIRECTOR

Dear District Residents and Partners,

In 2016, the DC Healthy People 2020 (DC HP2020) Framework was released as our shared community health improvement agenda. Through the DC HP2020 development process, a multi-sector collaborative prioritized health outcome objectives and recommended evidence-based strategies to achieve the biggest population health impact. It is our hope that stakeholders and community members will use the DC HP2020 Framework and this Annual Report and Action Plan to:

- Support shared goals to achieve collective health improvements
- Facilitate continued cross-sector collaboration to implement and support the recommended evidence-based strategies
- Align our work to achieve health equity by addressing the underlying social and structural determinants of health

We invite you to share this report and encourage you to participate in the implementation of the action plan toward our 2020 targets. Stakeholder and community input will continue to guide our work and the ongoing monitoring of DC Healthy People 2020. We are committed to engaging everyone to create environments in which every District resident has the ability to attain the highest level of health.

Thank you for your continued interest, support, and commitment to improving the health and wellness of residents of the District of Columbia.

Sincerely,

LaQuandra S. Nesbitt, MD, MPH
Director,
District of Columbia Department of Health

The DC Healthy People 2020 Framework Report, released in 2016, established three key priorities in our collective efforts to improve population health in the District: Mental Health and Mental Disorders, Injury and Violence Prevention, and Access to Health Services. The methodology for setting these priority topic areas used four criteria: stakeholder input, community input, National Healthy People 2020 relevance, and disease burden. It also emphasized the need to support health equity by addressing the social and structural determinants of health. Finally, the Data Development Agenda highlighted areas where data improvements were needed to better understand resident population health. This Annual Report and Action Plan updates key health outcome objectives and highlights work being done in the community to implement the recommended strategies and make the biggest population health impact.
Mental Health and Mental Disorders is the highest priority topic area. The DC Healthy People 2020 development process was built on the 2014 DC Community Health Needs Assessment, additional data analyses and trends, and continuous stakeholder and community engagement. The results revealed the importance of addressing the persistent and wide-ranging challenges mental health and mental disorders present in our community. Objectives and strategies were framed around the three high-level MHMD goals: prevention, appropriate diagnosis, and access to quality treatment services.

The DC Department of Behavioral Health and key partners are leading the way to implement data-driven interventions that improve mental health outcomes. Much of the work is focused on improving care coordination between primary care and behavioral health care services. One example of a current priority action is the DC Healthy Communities Collaborative’s systematic review of recent District-wide capacity assessments and evaluations of mental health services for adults and children. They plan to convene stakeholders in 2018 to finalize and release recommendations.

Goals

1. Mental health is supported through trauma prevention.
2. Those experiencing mental disorders have access to accurate and timely diagnosis and treatment.
3. All have access to appropriate and high quality mental health services.

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Mental Health and Mental Disorders

Targeted Objectives

1. Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs) (MHMD-2)

2. Increase the proportion of persons with co-occurring substance use and mental disorders who receive treatment for both disorders (MHMD-4)

Targeted Strategies

1. Screen for and improve surveillance around childhood trauma.* (MHMD-2)

2. Increase the proportion of primary care physician office visits where patients are screened for depression. (MHMD-4)

Priority Actions

<table>
<thead>
<tr>
<th>Priority Actions</th>
<th>Indicator(s)</th>
<th>Responsible Parties</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Systematic review of mental health service needs assessments and submission of policy recommendations</td>
<td>Percent of recommendations that are implemented</td>
<td>DCHCC</td>
<td>2017 - 2019</td>
</tr>
<tr>
<td>2. Continue foster and in-home care mental health screening and referrals for children</td>
<td>Percent of referrals successfully linked to care</td>
<td>DBH, CFSA</td>
<td>2017 -</td>
</tr>
<tr>
<td>3. Increase routine mental health screening in pediatric primary care</td>
<td>Percent of well-child visits that bill CPT codes 96127 or 96161</td>
<td>DC Collaborative/DC MAP</td>
<td>2017 - 2019</td>
</tr>
</tbody>
</table>

*Priority Data Development Agenda Activity
Injury and Violence Prevention (IVP)

Leading Health Indicator

- Reduce fatal injuries (per 100,000)
- Reduce homicide rate among 20-24 year olds (per 100,000)

Safe environments support that unintentional injuries and violence (physical, sexual, and emotional) are rare and responded to appropriately.

Injury and Violence Prevention is a key public health issue that is especially relevant in the District of Columbia, where overall, homicides are the 8th leading cause of death and accidents are the 3rd leading cause of death (2015). The public health approach to violence prevention applies a focus on the social determinants of health to ensure that the root causes of violence, including education, economic stability, housing, criminal justice, social services, and environmental justice, are addressed holistically.

The Safer, Stronger DC initiative, coordinated and supported by the newly opened Office of Neighborhood Safety and Engagement, brings government stakeholders (including the Department of Health, Public Schools, Police, Behavioral Health, and others), private businesses, non-profit organizations, faith-based organizations, and community representatives together to work in alignment to improve key violence-related health objectives. In July 2017, the Safer, Stronger DC initiative provided a total of $1.5 million in community grants to 33 DC community organizations to implement youth enrichment, violence prevention/mediation, mentoring, and family support programs. The next round of grants, an additional $1.4 million, will be awarded for Fiscal Year 2018.
## Injury and Violence Prevention

### Targeted Objectives

<table>
<thead>
<tr>
<th>Priority</th>
<th>Targeted Objective</th>
<th>Responsible Parties</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Decrease homicide rate (IVP-1.1)</td>
<td>MPD</td>
<td>2017 -</td>
</tr>
<tr>
<td>2</td>
<td>Reduce firearm-related death (IVP-1.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Prevent an increase in fall-related deaths (IVP-2.2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Decrease pedestrian deaths (IVP-3.3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Decrease deaths associated with motor vehicles (IVP-4.2)</td>
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</tr>
</tbody>
</table>

### Targeted Strategies

- Prioritize transportation infrastructure improvements related to bicycle and pedestrian safety using injury and crash data. (IVP-1)

### Priority Actions

<table>
<thead>
<tr>
<th>Priority</th>
<th>Action</th>
<th>Indicator(s)</th>
<th>Responsible Parties</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Continue the Anonymous Tip Line and Firearm Tip Reward Program</td>
<td>Number of illegal guns recovered</td>
<td>MPD</td>
<td>2017 -</td>
</tr>
<tr>
<td>2</td>
<td>Continue the DC Falls Free Coalition and Safe at Home program</td>
<td>Rate of hospital admissions due to falls</td>
<td>DCOA, DCHD</td>
<td>2017 -</td>
</tr>
<tr>
<td>3</td>
<td>Continue to implement Vision Zero</td>
<td>Percent of action plan strategies completed or in progress on schedule</td>
<td>EOM, DDOT</td>
<td>2017 - 2019</td>
</tr>
</tbody>
</table>
Access to Health Services is vital for support of long-lasting interventions such as vaccines and treatment regimens for chronic disease. These services must be appropriate in quantity and quality and the health care system must be structured to minimize barriers to those seeking care. As outlined in the DC Health Systems Plan, released in 2017, social determinants of health represent the most critical barrier to full engagement in primary care services. Care coordination and service integration were identified as targeted areas for improvement.

The DC Department of Health Care Finance (DHCF), together with other healthcare and government partners, launched the My Health GPS program, which links DC Medicaid beneficiaries who have multiple chronic conditions to a patient-centered medical home. The program provides wraparound services and incentivizes innovative patient engagement tactics to improve health outcomes. In the first three months of the program launch, My Health GPS enrolled (including informed consent, biopsychosocial assessment, and care plan development) 2,600 residents.
Priority Actions Indicator(s) Responsible Parties Time Frame

1. Finalize a Primary Care Needs Assessment Needs Assessment published DOH 2017 – 2018
2. Implement My Health GPS All cause hospital readmission within 30 days* DHCF, FQHCs, PCPs, MCOs, DOH, DBH, FEMS, DHS 2017 –
3. Implement a nurse triage line Nurse triage line incorporated into the 911 system FEMS, DHCF, OUC, EOM Mar 2018 – Sep 2018

Targeted Objectives

1. Reduce percentage of residents without a place of care (AHS-1)
2. Increase percentage of residents who receive preventive care (AHS-2)
3. Reduce non-emergent emergency room (ER) visit rate (AHS-3)
4. Reduce non-emergent use of emergency medical services (EMS) (AHS-5)
5. Reduce percentage of hospitals with long emergency department wait times (AHS-5)

Targeted Strategies

- Implement and test an integrated clinical network to improve care by transferring chronically ill patients who rely on emergency room visits for health care to patient-centered medical homes. (AHS-1)
- Improve care coordination (e.g., behavioral health and dental health integrated into primary care). (AHS-4)

*Full Indicator List (pp. 16-19)
Social Determinants of Health

Goal

Achieve health equity by addressing social determinants of health and structural/system-level inequities.

Social and structural determinants of health play a larger role in our health outcomes than any other individual factor. Focusing our efforts in this area has been proven to create the largest impact on population health improvement. The DC Department of Health’s Office of Health Equity is releasing an inaugural Health Equity Report to re-frame how we have traditionally thought about public health and health equity and to provide a baseline assessment and opportunities for health improvement in the District of Columbia. DC Healthy People 2020 supports and guides partners in equity work across sectors so that all residents can achieve their highest level of health.

In 2016, the DC Department of Healthcare Finance and partners developed the State Health Innovation Plan to link health service payments to outcomes and support a person-centered approach to care delivery. The report details the District’s plan to improve consumer health outcomes and increase health equity by addressing social determinants of health, and focusing on prevention and care management. By 2021, the city will reinvest savings from the system redesign to increase impact.

Leading Health Indicator

1. Increase the 4-year high school graduation rate
2. Decrease proportion of persons living in poverty

<table>
<thead>
<tr>
<th>2010 - 2011</th>
<th>2016 - 2017</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>59%</td>
<td>72.4%</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2010</th>
<th>2015</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>18.5%</td>
<td>18%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>
### Social Determinants of Health

#### Targeted Objectives

1. Decrease proportion of households that spend more than 30% of income on housing (SDH4)
2. Decrease unemployment rate (SDH4)

#### Targeted Strategies

- Increase multi-sector public, private and non-profit partnerships to further population health improvement through a coordinated focus on social determinants of health and health equity. (SDH4)
- Increase minimum wage to living wage. (MICH4)
- Support mixed-income development and the production of affordable working and living space. (SDH IV)

#### Priority Actions

<table>
<thead>
<tr>
<th>Priority Actions</th>
<th>Indicator(s)</th>
<th>Responsible Parties</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Implement Neighborhood Prosperity Fund</td>
<td>Percent Unemployed</td>
<td>DMPED</td>
<td>2017 –</td>
</tr>
<tr>
<td>2. Establish Housing Preservation Fund</td>
<td>Percent of affordable housing units preserved</td>
<td>DHCD, EOM</td>
<td>2017 –</td>
</tr>
<tr>
<td>3. Increase the minimum wage to $15/hour</td>
<td>Legislation passed</td>
<td>EOM</td>
<td>2017</td>
</tr>
<tr>
<td>4. Finalize a State Health Innovation Plan</td>
<td>Report published</td>
<td>DHCF</td>
<td>2017</td>
</tr>
</tbody>
</table>
Data Development Agenda Actions

Goal

1. To improve quality and reliability of a broad set of key population-level health data.

The Data Development Agenda is an appendix to the DC Healthy People 2020 Framework that outlines priority areas for data infrastructure improvements. Already, strides have been made to improve available health outcome data on District residents. For example, DOH has begun implementing the Pregnancy Risk Assessment and Monitoring System (PRAMS), a survey of mothers who have recently given birth. PRAMS data will allow for deeper analysis of maternal, infant and child health trends in the District of Columbia, a topic area that continues to experience disparate outcomes. The objectives listed in the data development agenda on the following page have been identified during the DC Healthy People 2020 development process as indicators that would be useful to monitor over time, but that lack a quality and timely data source. It is important to highlight and support actions that improve data infrastructure for future monitoring of key health outcome data.
Data Development Agenda

Targeted Objectives

Foreign-Born Populations
1. Increase linguistically and culturally competent care.* (also in Access to Health Services)* (1)
2. Increase surveillance of foreign-born individuals’ health status. (10)

Oral Health
8. Reduce the proportion of children and adolescents with untreated dental decay. (39)
9. Reduce the proportion of children and adolescents who have dental caries in their primary or permanent teeth. (32)
10. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year. (33)
11. Increase the proportion of children and adolescents who have received dental sealants on their molar teeth. (34)

Injury and Violence Prevention (IVP)
3. Decrease intimate partner violence.* (17)
4. Decrease sexual violence.* (58)
5. Increase the number of states and the District of Columbia that link data on violent deaths from death certificates, law enforcement, etc.* (9)
6. Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) transgender populations. (LGBTH-1)
7. Increase the number of population-based data systems (LGBTH-2)

LGBT Health
6. Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) transgender populations. (LGBTH-1)
7. Increase the number of population-based data systems (LGBTH-2)

Tobacco Use
12. Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke. (40)

Priority Actions | Targeted Objectives | Responsible Parties | Time Frame
---|---|---|---
1. Implement PRAMS | Foreign-born populations, IVP, Oral Health, Tobacco Use | DOH | 2017 –
2. Increase BRFSS data infrastructure | LGBTH | DOH | 2017 –
3. Build a Trauma Registry | IVP | DOH | 2017 –
4. Build a Violent Death Reporting System | IVP | DOH, OCME, MPD | 2017 –
5. Implement an Oral Health Surveillance System | Oral Health | DOH, DHCR, DCPCA, DCPS, OSSE | 2017 –

*Priority Data Development Agenda Activity
LOOKING FORWARD

This Annual Report and Action Plan serves to monitor Leading Health Indicator data points (Appendix A) and highlight priority actions underway in the implementation of the DC Healthy People 2020 Framework. Looking forward, our shared community agenda will be re-evaluated and updated periodically to ensure our priorities are in line with health outcome trend data and District resident and stakeholder values and experiences. Ongoing stakeholder and resident involvement in DC HP2020 implementation will allow for sharing of best practices and data monitoring activities in order to better align District initiatives and achieve sustained improvements in population health.

The results for our most recent year data are mixed. In some areas, for example diabetes management and childhood vaccination rates, we are moving positively in the direction of our 2020 targets. We’ve even reached some of our 2020 goals early, including reducing early initiation of tobacco use among adolescents and increasing the 4-year high school graduation rate, the latter of which has a revised 2020 target to improve alignment with city-wide goals. However, there is still considerable work left to do in order to turn the curve on indicators that are moving away from their targets and shrink the disparate outcomes disproportionately affecting residents who experience racial and economic disparities, and who live in certain neighborhoods of the District.
### Leading Health Indicator Chart

**Data Notes and Sources are included in Appendix B**

<table>
<thead>
<tr>
<th>Number</th>
<th>Leading Health Indicator</th>
<th>Baseline (Year)</th>
<th>Recent (Year)</th>
<th>Target (2020)</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Mental Health and Mental Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MHMD-2</td>
<td>Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)</td>
<td>6.9% (2010)</td>
<td>10.0% (2015)</td>
<td>5.8%</td>
<td>Getting Worse</td>
</tr>
<tr>
<td>2. Injury and Violence Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AH-1.1</td>
<td>Reduce homicide rate among 20-24 year olds (per 100,000)</td>
<td>46.9 (2012)</td>
<td>49.3 (2016)</td>
<td>32.7</td>
<td>Improving</td>
</tr>
<tr>
<td>IVP-2</td>
<td>Reduce fatal injuries (per 100,000)</td>
<td>49.4 (2012)</td>
<td>83.9 (2016)</td>
<td>46.3</td>
<td>Getting Worse</td>
</tr>
<tr>
<td>3. Access to Health Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AHS-2</td>
<td>Increase percentage of residents who receive preventive care</td>
<td>74.6% (2011)</td>
<td>76.2% (2015)</td>
<td>80.3%</td>
<td>Improving</td>
</tr>
<tr>
<td>4. Nutrition, Weight Status and Physical Activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NWP-2</td>
<td>Decrease the number of food deserts</td>
<td>9 (2014)</td>
<td>6 (2015)</td>
<td></td>
<td>Getting Worse</td>
</tr>
<tr>
<td>NWP-4.1</td>
<td>Reduce the proportion of children and adolescents who are considered obese</td>
<td>20.6% (11/12)</td>
<td>19.5% (16/17)</td>
<td>14.5%</td>
<td>Improving</td>
</tr>
<tr>
<td>5. Clinical Preventive Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C-5</td>
<td>Increase early detection for cancer (% in situ or local)</td>
<td>48.4% (2010)</td>
<td>55.2% (2014)</td>
<td>57.0%</td>
<td>Improving</td>
</tr>
<tr>
<td>D-4</td>
<td>Reduce the proportion of persons with poor control of diabetes</td>
<td>57.1% (2013)</td>
<td>33.8% (2015)</td>
<td>27.2%</td>
<td>Improving</td>
</tr>
<tr>
<td>HDS-4.1</td>
<td>Increase the proportion of adults with hypertension whose blood pressure is under control</td>
<td>55.7% (2013)</td>
<td>61.9% (2015)</td>
<td>77.4%</td>
<td>Improving</td>
</tr>
<tr>
<td>IID-2.2</td>
<td>Increase the percentage of children aged 19 to 35 months who receive the recommended doses of vaccinations</td>
<td>66.2% (2010)</td>
<td>76.3% (2015)</td>
<td>80.7%</td>
<td>Improving</td>
</tr>
<tr>
<td>6. Social Determinants of Health</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>AH-2.1</td>
<td>Increase the 4-year high school graduation rate</td>
<td>59% (10/11)</td>
<td>72.4% (16/17)</td>
<td>80%</td>
<td>Improving</td>
</tr>
<tr>
<td>SDH-4</td>
<td>Decrease proportion of persons living in poverty</td>
<td>18.5% (2010)</td>
<td>18.0% (2015)</td>
<td>16.7%</td>
<td>Improving</td>
</tr>
<tr>
<td>7. Substance Use</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>MHMD-4</td>
<td>Increase the proportion of persons with co-occurring substance use and mental disorders who receive treatment for both disorders</td>
<td>N/A</td>
<td>N/A</td>
<td>TBD</td>
<td>Improving</td>
</tr>
<tr>
<td>8. Oral Health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OH-2</td>
<td>Increase percentage of residents who receive preventive dental care</td>
<td>71.1% (2012)</td>
<td>72.5% (2015)</td>
<td>78.2%</td>
<td>Improving</td>
</tr>
<tr>
<td>Number</td>
<td>Leading Health Indicator</td>
<td>Health Indicator Data Source</td>
<td>Notes &amp; Descriptions</td>
<td></td>
<td></td>
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<tr>
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</tr>
<tr>
<td><strong>9. HIV</strong></td>
<td>HIV-2 Reduce the number of new annual HIV infections in all ages</td>
<td>NSDUH</td>
<td>Minor changes in earlier data points due to use of intercensal populations, updated baselines.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Vital Records</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>10. Maternal, Infant and Child Health/Perinatal Health</strong></td>
<td>MICH-1 Decrease infant mortality rate (per 1,000 live births)</td>
<td>NWP-2 USDA</td>
<td>Change in data source for NWP-4.1; updated baseline, updated target to match HP2020.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MICH-2.1 Decrease total preterm births</td>
<td>NWP-4.1 Universal Health Certificate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>11. Tobacco Use</strong></td>
<td>TU-4 Reduce the early initiation of the use of tobacco products among children and adolescents in grades 9-12</td>
<td>DC Cancer Registry</td>
<td>C-5 Includes female breast, prostate, colorectal, and lung bronchus cancers.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>UDS</td>
<td>Change in data source for D-4 and HDS-4.1; updated baselines and targets.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>12. Older Adults</strong></td>
<td>OA-1 Improve overall health of older adults (50+)</td>
<td>OSSE</td>
<td>Doesn’t include IEP graduation rate. Updated target to reflect “A Capital Commitment Strategic Plan.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>13. LGBTQ Health</strong></td>
<td>LGBTH-3 Decrease the percentage of youth in grades 9-12 who were threatened or hurt because someone thought they were gay, lesbian, or bisexual</td>
<td>GAIN-SS</td>
<td>Currently awaiting the GAIN-SS system launch to collect this information.</td>
<td></td>
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</tr>
</tbody>
</table>

**Data Sources & Notes**

**Priority Topic Area**

- Mental Health and Mental Disorders
- Injury and Violence Prevention
- Access to Health Services
- Nutrition, Weight Status and Physical Activity
- Clinical Preventive Services
- Social Determinants of Health
- Substance Use
- Oral Health
- HIV
- Maternal, Infant and Child Health/Perinatal Health
- Tobacco Use
- Older Adults
- LGBTQ Health

**Health Indicator Data Source**

- MHMD-2 NSDUH
- AH-1 Vital Records
- IVP-2 Vital Records
- AHS-2 BRFSS
- NWP-2 USDA
- NWP-4.1 Universal Health Certificate
- C-5 DC Cancer Registry
- D-4 UDS
- IID-2.2 National Immunization Survey
- AH-2.1 OSSE
- SDH-4 Department of Labor
- MHMD-4 GAIN-SS
- OH-2 BRFSS
- HIV-2 DOH-HAHSTA
- MICH-1 Vital Records
- MICH-2.1 Vital Records
- TU-4 YRBS
- OA-1 BRFSS
- LGBTH-3 YRBS
Appendix C

Glossary

BRFSS  Behavioral Risk Factor Surveillance System
CFSA  DC Child and Family Services Agency
CPT  Current Procedural Terminology
DBH  DC Department of Behavioral Health
DC Collaborative  DC Collaborative for Mental Health in Pediatric Primary Care
DC HP2020  District of Columbia Healthy People 2020
DC MAP  DC Mental Health Access in Pediatrics
HCC  District of Columbia Healthy Communities Collaborative
DCOAR  DC Office of Aging
DDOT  DC Department of Transportation
DHCD  DC Department of Housing and Community Development
DHCF  DC Department of Healthcare Finance
DHS  DC Department of Human Services
DMPED  DC Office of the Deputy Mayor for Planning and Economic Development
DOH  DC Department of Health
EOM  DC Executive Office of the Mayor
FEMS  DC Fire and Emergency Medical Services
FQHC  Federally Qualified Health Center
GAIN-SS  Global Appraisal of Individual Needs-Short Screener
HAHSTA  HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration
HP2020  National Healthy People 2020
MCO  Managed Care Organization
MDE  Major Depressive Episode
MDP  DC Metropolitan Police Department
NSDUH  National Survey on Drug Use and Health
OCME  DC Office of the Chief Medical Examiner
OHE  Office of Health Equity
OSSE  DC Office of the State Superintendent for Education
OUC  DC Office of Unified Communications
PCP  Primary Care Provider
PRAMS  Pregnancy Risk Assessment and Monitoring System
UDS  Uniform Data System
YRBS  Youth Risk Behavior Survey

Topic Area Abbreviations

AHS  Access to Health Services
AH  Adolescent Health
C  Cancer
D  Diabetes
HDS  Heart Disease and Stroke
HIV  Human Immunodeficiency Virus
IID  Immunization and Infectious Diseases
IVP  Injury and Violence Prevention
LGBTQ  Lesbian, Gay, Bisexual and Transgender Health
MICH  Maternal, Infant and Child Health
MHMD  Mental Health and Mental Disorders
NWP  Nutrition, Weight Status and Physical Activity
OA  Older Adults
OH  Oral Health
SDH  Social Determinants of Health
TU  Tobacco Use

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