DC Healthy People 2020 Framework

Government of the District of Columbia
Department of Health

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Acknowledgements

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The District of Columbia would like to thank the following individuals for their unwavering commitment to DC Healthy People 2020 and for supporting work that allows District residents to achieve their full potential of health:

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Children's National Medical Center
DC Asthma Coalition
DC Child and Family Services Agency
DC Department of Behavioral Health (DBH)
DC Department of Disability Services (DDS)
DC Department of Energy and the Environment (DOEE)
DC Department of Health (DOH)
Center for Policy, Planning and Evaluation (CPPE)
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Health Regulation and Licensing Administration (HRLA)
HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration (HAHSTA)
Office of the Director (OD)
DC Department of Healthcare Finance (DHCF)
DC Department of Human Services (DHS)
DC Department of Parks and Recreation (DPR)
DC Department of Transportation (DDOT)
DC Department of Youth Rehabilitation Services (DYRS)

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DC Healthy Communities Collaborative (DCHCC)
DC Hospital Association (DCHA)
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DC Office of Aging (DCOA)
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DC Office of the State Superintendent of Education (OSSE)
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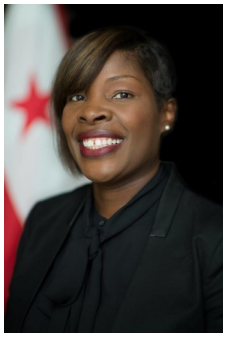
Letter from the Director



Dear District Residents and Partners,

It is a pleasure to share what has been over a year of collaborative community health improvement work in the District of Columbia. DC Healthy People 2020 is our shared community agenda that allows us to collectively monitor important population health outcomes, focus on necessary multi-sector contributions, and frame our conversations around best practices, social determinants of health, and health equity.

The framework is a first in sharing a comprehensive data warehouse of local District health and health-related objectives and aligns our work to achieve collective and measurable targets for the year 2020. I encourage you to use DC HP2020 with other stakeholders to make data-informed decisions and collaborate on evidence-based strategies. I challenge you to pursue interventions that make truly impactful population change by focusing on improving socioeconomic conditions of our residents and by implementing policies that incorporate health considerations and make healthy behaviors easier for us all.

DC Healthy People 2020 doesn't stop here. It is an ongoing process that strives to engage all sectors in population health improvement. I encourage you to join the movement to tackle the underlying social and other determinants of health, eliminate inequities, and allow all District residents to achieve our highest potential of health.

Sincerely,

LaQuandra S. Nesbitt

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

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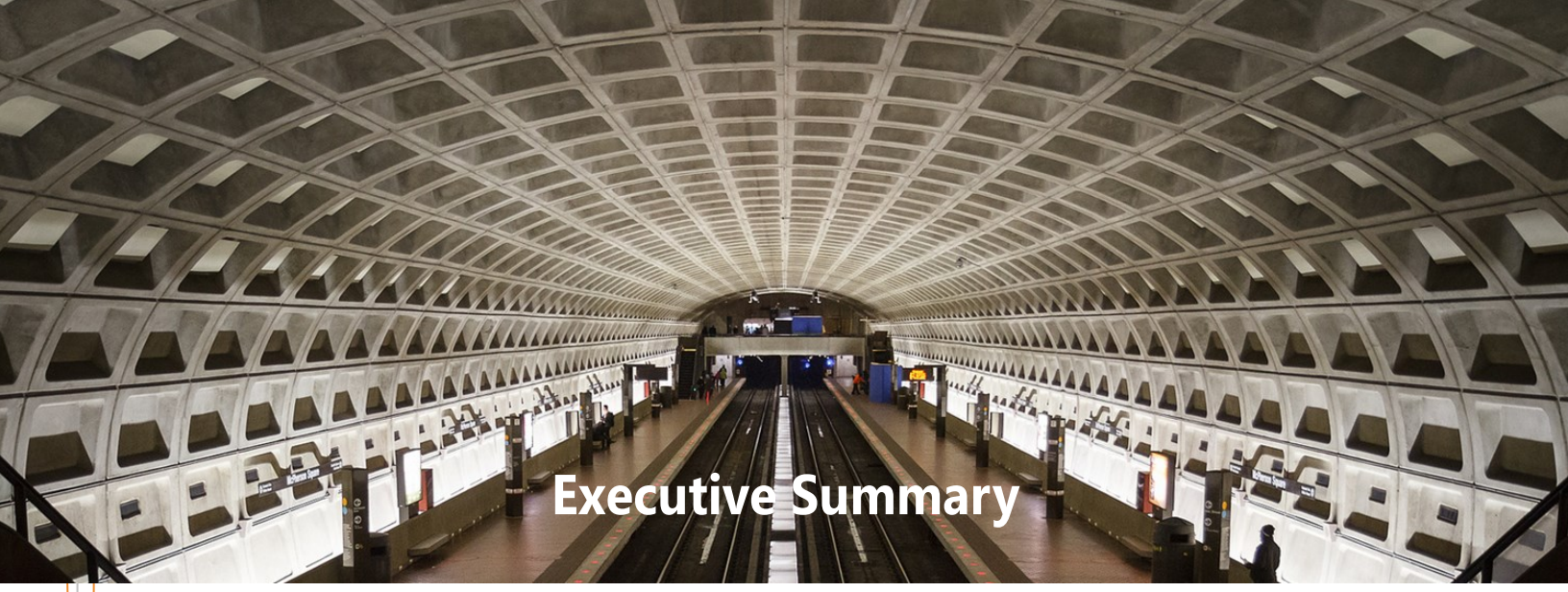


Executive Summary

The DC Healthy People 2020 (DC HP2020) framework sets goals, population-level health outcome objectives, and targets for the year 2020 and recommends evidence-based strategies to improve key health outcomes for District of Columbia residents. Over 30 agencies and organizations were represented in the collaborative process to develop DC HP2020, which was likewise informed by ongoing community input. Final decisions were collective and approved by an advisory board. The framework consists of 29 topic areas, with over 160 measurable objectives and targets. Each topic area includes recommended strategies that prioritize population health impact. Priorities were determined by a weighted process that considered stakeholder and community input, disease burden, and alignment with the national Healthy People 2020 framework.

Of the 160 objectives, 20 Leading Health Indicators (LHIs) with 13 corresponding Priority Topic Areas (PTAs) were determined through the development process and are listed below. They serve as an important summary of the progress of health status in the District of Columbia and will be used for policy and program decision-making along with the remaining objectives.

Overall, progress has been positive in achieving the DC HP2020 targets for the 20 LHIs:

- 11 indicators (55%) are improving
- 3 indicators (15%) show little or no change
- 3 indicators (15%) are getting worse
- 3 indicators (15%) have only baseline data or no data yet

PTAs are numbered 1-13 and listed in order of priority. Corresponding LHIs follow each PTA, and are used as tools and markers, but do not limit the comprehensive nature of the Priority Topic Area. Each LHI contains baseline data, most recent data and 2020 target, where applicable. More detailed information about each LHI can be found in Appendix 1. The progress symbol represents if there was a change and in which direction the change occurred.

Progress	#	Leading Health Indicator	Baseline (Year)	Recent (Year)	Target (2020)
1. Mental Health and Mental Disorders					
●	MHMD-2	Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)	6.9% (2010)	7.4% (2013)	**5.8%**

● Away from target ● Toward target ● No change ● New data/No data

Progress	#	Leading Health Indicator	Baseline (Year)	Recent (Year)	Target (2020)
2. Injury and Violence Prevention					
	AH-1.1	Reduce homicide rate among 20-24 year olds (per 100,000)	50.6 (2011)	37.6 (2014)	**32.7**
	IVP-2	Reduce fatal injuries (per 100,000)	51.4 (2012)	57.2 (2014)	**46.3**
3. Access to Health Services					
	AHS-2	Increase percentage of residents who receive preventive care	74.6% (2011)	74.0% (2014)	**80.3%**
4. Nutrition, Weight Status and Physical Activity					
	NWP-2	Decrease the number of "food deserts[1]"	9 (2015)	9 (2015)	**0**
	NWP-4.1	Reduce the proportion of children and adolescents who are considered obese	18.5% (12/13)	15.9% (14/15)	**9.9%**
5. Clinical Preventive Services					
	C-5	Increase early detection for all cancers (% in situ or local)	48.4% (2010)	51.1% (2012)	**57.0%**
	D-4	Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent	N/A	N/A	**TBD**
	HDS-4.1	Increase the proportion of adults with hypertension whose blood pressure is under control	53.8% (2013)	63.2% (2014)	**69.5%**
	IID-2.2	Increase the percentage of children aged 19 to 35 months who receive the recommended doses of vaccinations	66.2% (2010)	73.4% (2013)	**80.7%**
6. Social Determinants of Health					
	AH-2.1	Increase the 4-year high school graduation rate	59% (2010)	65.4% (2014)	**68%**
	SDH-4	Decrease proportion of persons living in poverty	18.5% (2010)	18.2% (2014)	**16.7%**
7. Substance Use					
	MHMD-4	Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders	N/A	N/A	**TBD**
8. Oral Health					
	OH-2	Increase percentage of residents who receive preventive dental care	71.1% (2012)	70.8% (2014)	**78.2%**
9. HIV					
	HIV-2	Reduce the number of new annual HIV infections in all ages	889 (2010)	553 (2013)	**275**

[1] Food deserts are understood as an urban area in which it is difficult to buy affordable or good-quality fresh food.

Progress	#	Leading Health Indicator	Baseline (Year)	Recent (Year)	Target (2020)
10. Maternal, Infant and Child Health					
	MICH-1	Decrease infant mortality rate (per 1,000 live births)	8.0 (2010)	6.8 (2013)	**6.0**
	MICH-2.1	Decrease total preterm births	11.0% (2011)	9.6% (2014)	**6.5%**
11. Tobacco Use					
	TU-4	Reduce the early initiation of the use of tobacco products among children and adolescents in grades 9-12	8.3% (2010)	9.7% (2012)	**7.5%**
12. Older Adults					
	OA-1	Improve overall health of older adults (50+)	73.6% (2011)	77.6% (2014)	**90%**
13. LGBTQ Health					
	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	10.7% (2010)	9.4% (2012)	**4.2%**

Much of the DC Healthy People 2020 framework will serve for monitoring key population health outcomes over time. Equally important is the collective evaluation and recommendation of evidence-based strategies to best impact the objectives and their use as a guide for individuals and organizations seeking to improve the health and well-being of District residents. Recommended strategies are included for each topic area, but listed below are the strategies included in the top three prioritized topic areas, along with Social Determinants of Health, which represents the most impactful way to improve population health[1]. The list of strategies is not exhaustive, rather, serves as a starting point for organizations and individuals looking to impact population health.

Mental Health and Mental Disorders

MHMD-I Improve policies and procedures to identify workplace/school bullying and establish clear guidelines for steps of resolution.

MHMD-II Screen for and improve surveillance around childhood trauma.*

MHMD-III Increase the proportion of primary care physician office visits where patients are screened for depression.

Injury and Violence Prevention

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

*Priority Data Development Agenda action (See Appendix 2)

IVP-II Use YRBS data to inform school policy and decision-making and reduce disproportionate number of school suspensions by race.

IVP-III Implement restorative justice practices for individuals upon initial contact with the criminal justice system.

Access to Health Services

AHS-I 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-II Increase and/or establish standard quality measures for hospitals, FQHCs, and community clinics.*

AHS-III Improve Health Information Exchange infrastructure.

AHS-IV Deliver health/social services as front door/back door concept, where residents are provided comprehensive services through a person-centric, coordinated system and the categorization for appropriate billing and data reporting occurs behind the scenes.

AHS-V Improve care coordination (e.g. behavioral health and dental health integrated into primary care).

Social Determinants of Health

SDH-I 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.

SDH-II Advocate for a living wage as the minimum wage.

SDH-III Restructure school resource allocation to align with an equitable model.

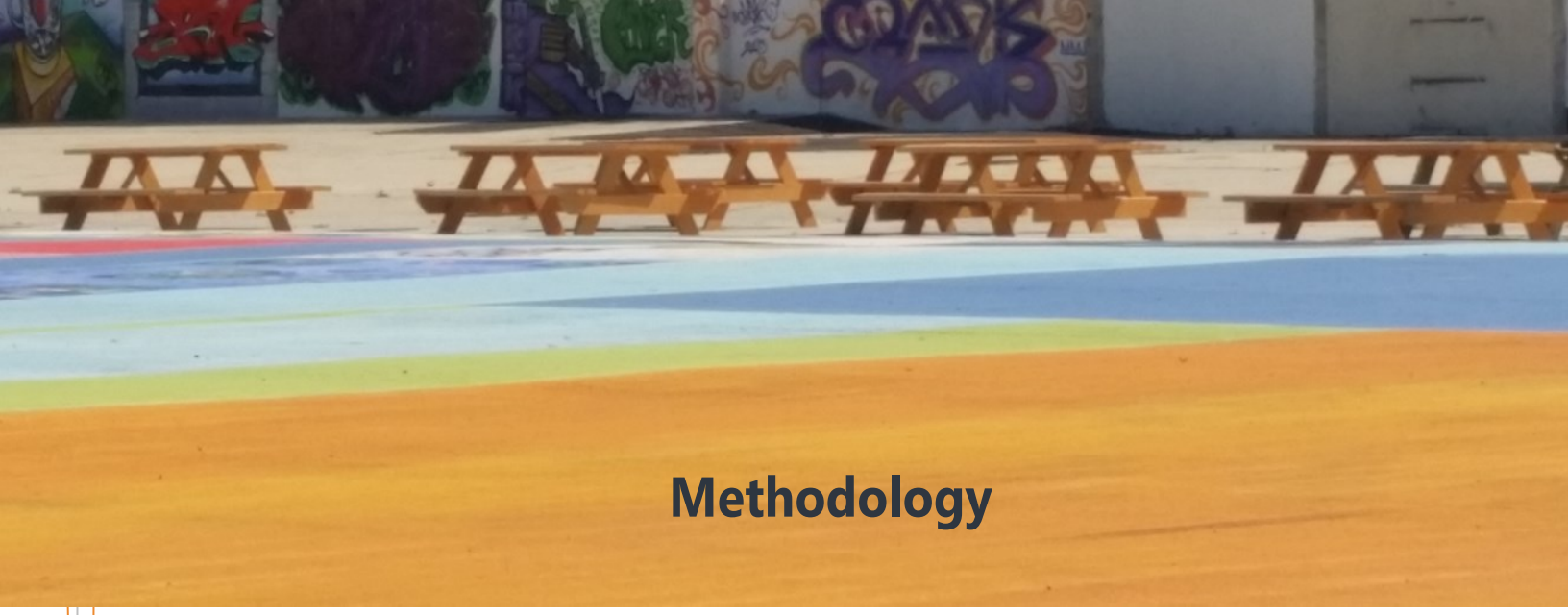
SDH-IV Support mixed-income development and the production of affordable working and living space.

SDH-V Maintain a mix of uses in neighborhoods, including affordable production space, to support the retention of well-paid manual, skilled and low-skill jobs for people with low-educational attainment and other barriers to jobs.

SDH-VI Increase surveillance and data surrounding adult literacy levels.*

More than half of key population health outcomes in the District have been improving in recent years. Special attention can be paid to outliers to better understand strategies that work well and areas that need more resources/interventions. Programs and policies can be most impactful aligning with the recommended strategies and objectives included in this framework, however strategies are not to be considered a comprehensive list of actions; rather, the most impactful recommendations to improve population health in each topic area. Most importantly, community health improvement work does not end with DC HP2020, rather it begins: more partners will make this framework even more relevant and useful for improving outcomes, and intentional gatherings to share data, discuss best practices and align services will help break down silos and improve the impact of interventions, ultimately improving health outcomes for District residents.

*Priority Data Development Agenda action (See Appendix 2)



Methodology

The DC Healthy People 2020 (DC HP2020) development process used Results-Based Accountability (RBA) to create the framework. RBA, employed by government and non-government agencies alike, guides stakeholders through a process that creates collective accountability and impact to improve population health. The DC HP2020 development process also maintained alignment with the national Healthy People 2020 and relevant city-wide plans either under development or recently released (e.g., Sustainable DC, Age-Friendly DC, and Vision Zero). The process built upon the District of Columbia Community Health Improvement Plan 2015-2018, which DC Healthy People 2020 will replace.

Figure 1: Results-Based Accountability Process*

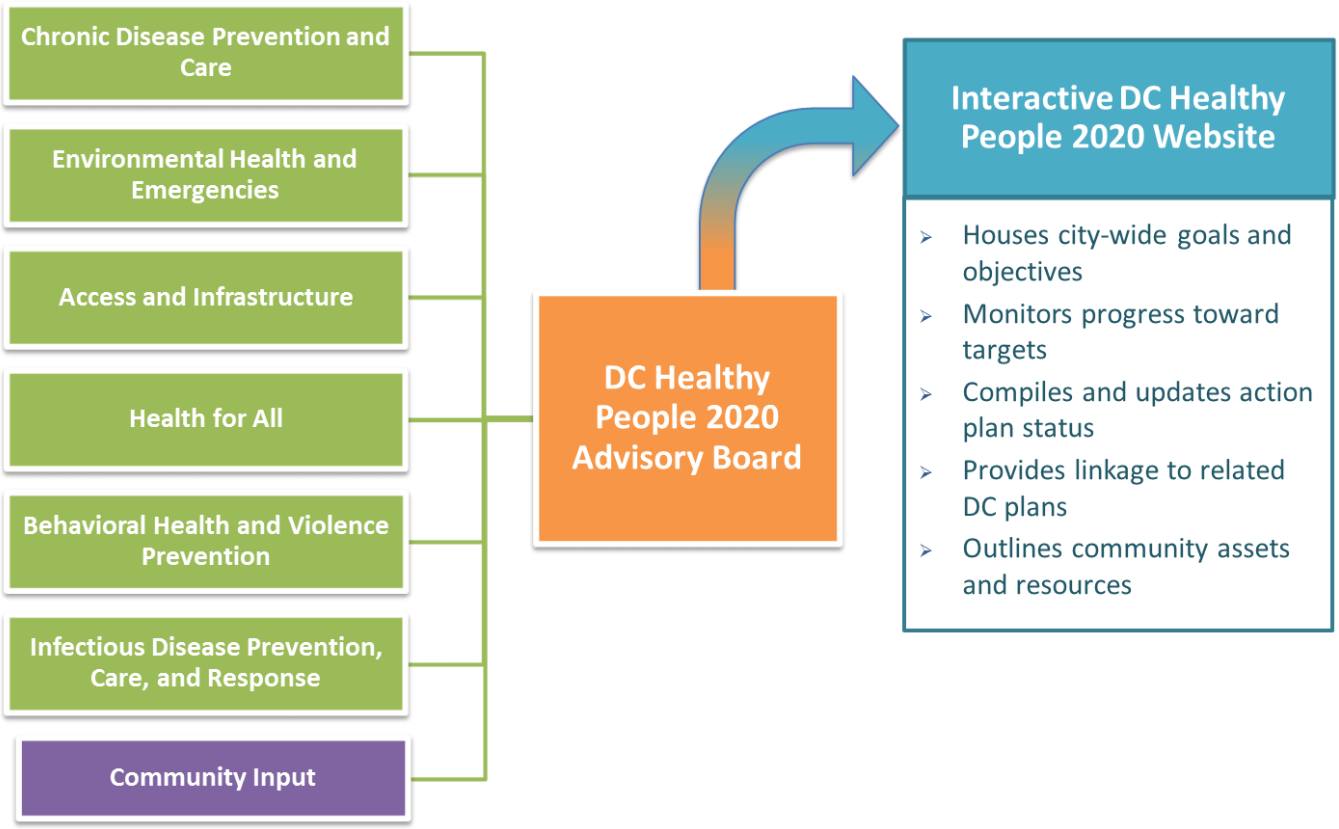
Population and focus areas were defined first, with twenty nine topic areas chosen from the 44 national topic areas, using the following criteria: 1) relevant to District residents, and 2) feasible to include. Two additional topic areas were deemed salient for District residents and were also included: Foreign-Born Populations and Hepatitis C, the latter of which was identified during the stakeholder working group meetings. Stakeholder groups were organized around topic areas, and defined descriptions, results and preliminary indicators for each one. Next, data were collected and stakeholder groups reconvened to examine trendlines and forecast targets. Evidence-based and evidence-informed strategies were compiled from the various alignment sources indicated above, as well as from public input, for evaluation and recommendation by stakeholders. Finally, the framework was compiled, reviewed, and prepared for publishing.

*Adapted from Results-Based Accountability Guide at http://raguide.org.

Working Groups

Through recommendations and involvement of key representatives, stakeholders were convened from 25 agencies, organizations, universities, and other institutions for a March 2015 kickoff meeting. Six working groups were formed that covered all topic areas, and each met monthly through October 2015 to create the framework. Over the course of the development process, more agencies joined, culminating in a group of more than 100 individuals representing over 30 agencies. The final share-out meeting was held in December 2015 to review all goals, objectives, targets, and recommended strategies and to prioritize components of the plan.

DC Healthy People 2020 Development Process



Note: Green boxes indicate the six working groups

Community Involvement

Community representatives were included in the process in several ways. Many were invited to participate in the working groups, though an acknowledged barrier was the daytime meetings. Secondly, an online survey was conducted in July 2015 and an ongoing mechanism for sending input via email or telephone was set up on the DC Healthy People 2020 webpage. Finally, in-person surveys were conducted in Fall 2015 in various community locations. Received input was incorporated throughout the process, most notably in the strategy evaluation phase, where suggestions from community members were included in evaluation activities, and in the priority-setting phase, described later in more detail.

Advisory Board

The District of Columbia Statewide Health Coordinating Council (SHCC) agreed to serve as Advisory Board to the DC HP2020 development process. Presentations on the development process were shared with and incorporated feedback from the Advisory Board in April 2015, September 2015, and February 2016. The District's Health Systems Plan (HSP), including the Primary Care Needs Assessment, falls under the authority of SHCC, which will allow for appropriate alignment of the HSP with DC HP2020.

Priority Setting

The methodology for setting Priority Topic Areas (PTAs) and Leading Health Indicators (LHIs) used four criteria: Stakeholder Input, Community Input, National Healthy People 2020 (HP2020) Relevance, and Disease Burden[2]. To determine PTAs, each criterion received a value 1-3 based on the results or analysis of each component and was weighted equally. LHIs were identified using Stakeholder Input and Relevance to HP2020, ensuring that at least one LHI was included for each of the 13 PTAs.

Stakeholder Input

Throughout the DC HP2020 development process, stakeholders, as a part of the Working Groups process, interacted with and considered community health status data as well as their experiences working with specific populations within the District. The final Stakeholder Share-Out meeting, held on December 16, 2015, included a

prioritization activity in which the 30 stakeholders present indicated the Topic Areas, Objectives, Strategies, and Data Development components they felt were of highest priority.

Community Input

In addition to other opportunities for community feedback to be incorporated into DC HP2020 development, a survey was conducted at five community events in Fall 2015. Forty-eight participants took the survey to identify the key health priorities for their communities.

The community surveying process is currently under systemization in order to continuously receive community feedback, increase survey takers, and to check the pulse of the community in near real-time.

National Healthy People 2020 (HP2020) Relevance

The National HP2020 has 42 Topic Areas with over 1200 objectives. Twenty-six (26) objectives are considered Leading Health Indicators, with 12 corresponding Topic Areas. It is important that DC Healthy People 2020 align with the national priorities as closely as possible and as is relevant to the District population.

Disease Burden

The last quarter of the final score weight was a combination of reach and severity of the disease. Reach measured and assigned values depending on the percentage of District residents affected by the health issue. Severity was measured and assigned values based on how directly it caused death or severe disability. These two measures were averaged and the resulting number was used to represent the disease burden.

Final Compilation

For organizational purposes, two topic areas were added to the prioritized list to cover two objectives that had scored highly in the prioritization activity. Additionally, seven objectives were added to the LHIs to represent Topic Areas where objectives had not made the priority list (in many cases, it was due to a relatively equal distribution of votes over a large number of objectives).

DC Healthy People 2020 Goals

ACCESS TO HEALTH SERVICES

Every District resident has access to affordable, person-centric, and quality health care services in an appropriate setting.

ADOLESCENT HEALTH

1) Adolescents and young adults are socially, physically, emotionally, and mentally supported by the environments in which they regularly engage (home, school, neighborhood).
2) Adolescents and young adults are successful in school and credentialing programs and ready for a career or higher education.

ASTHMA

Those living with asthma have minor complications and lead active lives.

BLOOD DISORDERS AND BLOOD SAFETY

1) The blood supply is adequate, safe, and effective.
2) Those who experience a genetic blood or clotting disorder enjoy a good quality of life.

CANCER

1) There are few new cancer cases, particularly those diagnosed at late stage.
2) Illness, disability and death caused by cancer is greatly reduced.

DIABETES

1) Disease and economic burden of diabetes mellitus (DM) is reduced.
2) Those who have, or are at risk for, diabetes enjoy a good quality of life.

DISABILITY SERVICES

Adults and youth experiencing disabilities are successful, socially included, and respected at work, school, and university.

ENVIRONMENTAL HEALTH

1) People live free from negative health outcomes due to environmental factors.
2) District residents experience a healthy environment.

FOOD SAFETY

Food safety and hygiene are improved to reduce and limit the spread of foodborne illnesses.

FOREIGN-BORN POPULATIONS

Foreign-born District residents have equal opportunities to lead a healthy life.

HEALTHCARE-ASSOCIATED INFECTIONS

Healthcare-associated infections (HAIs) are prevented, reduced, and ultimately eliminated.

HEART DISEASE AND STROKE

1) Heart attack and stroke are rare.
2) Environments (home, school, community) support cardio- and cerebrovascular health through prevention, detection, and treatment of risk factors, especially in disproportionately affected populations.

HEPATITIS C

1) Hepatitis C Virus (HCV) cases are rare and don't unduly burden specific populations.
2) Those living with HCV enjoy a good quality of life.

HIV

1) New HIV cases in the District are rare and don't unduly burden specific populations.
2) Those living with HIV enjoy a good quality of life.
3) Stigma is reduced surrounding HIV.

IMMUNIZATION AND INFECTIOUS DISEASES

Vaccine-preventable infections are rare, and infectious diseases are properly contained.

INJURY AND VIOLENCE PREVENTION

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

LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) HEALTH

The LGBT, and the Queer/Questioning, Asexual, and Intersex (QAI) communities experience social inclusion, respect, and equal access to all community benefits and services.

MATERNAL, INFANT AND CHILD HEALTH

1) Women of child-bearing age, fathers, infants, and children have equitable access to high quality and appropriate health care.
2) Health issues for mothers, infants, and children are rare, and families thrive in their environments.

MENTAL HEALTH AND MENTAL DISORDERS

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

NUTRITION, WEIGHT STATUS AND PHYSICAL ACTIVITY

Chronic disease risk is reduced through the consumption of healthful diets and daily physical activity to achieve and maintain a healthy body weight.

OLDER ADULTS

1) Older adults live in an 'age-friendly' environment where all people can participate in society in a manner that enhances their personal growth, respect, and social inclusion.
2) Older adults have access to and information about active recreation, healthful food, and safe and walkable neighborhoods to promote healthy lifestyles.

ORAL HEALTH

1) Oral and craniofacial diseases, conditions, and injuries are prevented and controlled.
2) All residents have access to and utilize educational, preventive, and therapeutic oral healthcare services.
3) Residents accept and adopt effective preventive oral health interventions.

PREPAREDNESS AND RESPONSE

1) The DC community effectively coordinates and cooperates during emergency preparedness, response, and recovery efforts.
2) Preparedness, response, and recovery efforts are timely, effective, and continuously tested and improved.

PUBLIC HEALTH INFRASTRUCTURE

1) Data system integration and data analysis drive public health planning and research.
2) Community is thoughtfully engaged in public health planning, implementation, and evaluation processes.
3) The public health workforce is capable and qualified.

SEXUALLY TRANSMITTED INFECTIONS

1) Community capacity and access to services allows for timely and comprehensive diagnosis and treatment of STIs and complications.
2) District residents are engaging in healthy sexual behaviors.
3) Stigma is reduced surrounding STIs.

SLEEP HEALTH

1) The public is knowledgeable about how adequate sleep and treatment of sleep disorders improve health, productivity, wellness, quality of life, and safety on roads, at home, and in the workplace.
2) Sleep deprivation is rare and sleep disorders appropriately treated.
3) Environments support healthy sleep for infants, children, and families.

SOCIAL DETERMINANTS OF HEALTH

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

SUBSTANCE USE

1) Coping for mental health disorders occurs through healthy treatment and not substance use.
2) Alcohol and legally prescribed medications are used responsibly.
3) The growth, manufacture, transport, and use of illicit drugs is prevented.

TOBACCO USE

Illness, disability, and death related to tobacco use and second hand smoke exposure are minimized.

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DC Healthy People 2020 Framework

Introduction

The framework first presents one or more goals for each topic area (known as the "results" in the Results-Based Accountability process). Next, the background and importance of the topic area is briefly detailed. Objectives are listed in graphic form, with the large colored graphic representing the most recent data and the baseline and 2020 target contained in a small table just below the graphic (the legend for objectives is described below). Finally, recommended strategies are included for each topic area.

Appendix 1 details each objective, adding important information (data source, metric, multiple years of data, if applicable, notes, and the target-setting methodology). Appendix 2 is the Data Development Agenda (DDA). The DDA was created to indicate where evaluated objectives were deemed important and relevant (high proxy) but had limited data (low data). The DDA serves as a list of areas where our health outcome data infrastructure could be improved. Priority data development components are also included in the recommended strategies section for applicable topic areas.

It is important to note that Objectives serve as proxies for measuring overarching Goals. Recommended Strategies serve as a starting point for entities and individuals looking to make an impact on population health. Strategies are not a comprehensive list of all that is needed to improve health.

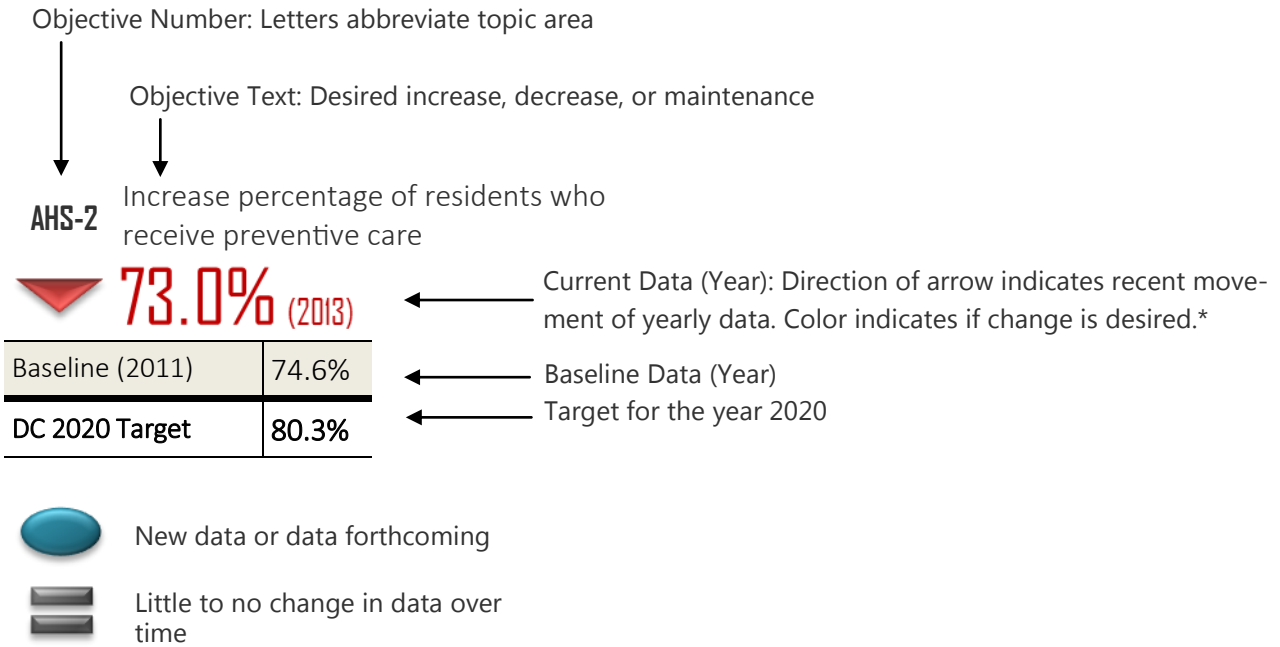
How to Use

This framework can be used in myriad ways. A collective process created this shared document that not only sets out objectives and targets for our most salient health outcomes but also provides recommendations for agencies, organizations, and individuals who are interested in joining the cause to improve the health of District residents. Together, we will hold each other accountable for the health of our population, and will commit to do our part to achieve these ambitious goals. This document is not static; rather, it is a living document that has taken a meaningful snapshot of where we are and the desired direction in which we would like to move. As a web presence is rolled out, there will be further opportunities to update the framework and share both community contributions and successes, as well as challenges encountered and obstacles surmounted.

Align your work with the goals presented within the framework; challenge yourself and your peers to make impactful changes to one or more objectives; gather ideas for implementation from the recommended strategies; or share data with your colleagues, stakeholders, and fellow community members.

The community can use the DC HP2020 framework to come together, share best practices, break down silos, and ultimately improve the health of District residents by thinking about improving population health as a holistic, multi-sector challenge. Become an active partner in the continued development and improvement of DC HP2020 by emailing DC.HP2020@dc.gov.

Legend for Objectives



*
Green = Over time, moved toward the target value
Red = Over time, moved away from the target value
Grey = Moved neither toward nor away from the target value
Blue = New data, baseline is the same as current

Access to Health Services

GOAL

Every District resident has access to affordable, person-centric, and quality health care services in an appropriate setting.

BACKGROUND

Access to health services has to do with the ability and ease individuals and groups have to gain access to appropriate affordable and quality health care services. Access to health services can be measured by factors such as ability to pay, location of facilities and services, hours of operation, physical, and cultural barriers, and the time it takes to receive services. Although District residents enjoy higher health insurance coverage levels compared to the nation, there are still barriers to receiving health services that disproportionately affect certain residents, regardless of coverage.

IMPORTANCE

Access to health services is particularly important in view of the fact that the leading causes of death in the District are largely the result of chronic diseases which can often be reduced through prevention, early diagnosis, and treatment. One of the goals of DC Healthy People 2020 is to reduce barriers to access by ensuring that lack or type of insurance coverage; one's age, sex, race, ethnicity, residence or background; the geographic location of a health care facility; and the time and manner in which services are provided are not or do not become obstacles to obtaining care. Ensuring that all residents have access to equitable care and to reduce differences in health outcomes among various racial, ethnic, gender and socio-economic groups will promote healthy and productive lives for DC residents.

OBJECTIVES AND TARGETS

AHS-1 Reduce percentage of residents without a usual place of care

14.9% (2014)

Baseline (2014)	14.9%
DC 2020 Target	13.4%

AHS-2 Increase percentage of residents who receive preventive care

74.0% (2014)

Baseline (2011)	74.6%
DC 2020 Target	80.3%

Access to Health Services

OBJECTIVES AND TARGETS (cont.)

AHS-3 Reduce non-emergent emergency room visit rate

342.8 (2014)

Baseline (2011)	325.8
DC 2020 Target	325.8

AHS-4 Reduce hospital readmission rate

9.8 (2014)

Baseline (2010)	9.8
DC 2020 Target	8.8

AHS-5 Reduce non-emergent use of emergency medical services

15.6% (2015)

Baseline (2013)	22.5%
DC 2020 Target	13.0%

AHS-6.1 Increase hospital patient satisfaction

2 stars (2014)

Baseline (2014)	2 stars
DC 2020 Target	4 stars

AHS-6.2 Reduce percentage of hospitals with long emergency department wait times

57% (2014)

Baseline (2014)	57%
DC 2020 Target	14%

RECOMMENDED STRATEGIES

AHS-I 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-II Increase and/or establish standard quality measures for hospitals, FQHCs, and community clinics.*

AHS-III Improve Health Information Exchange infrastructure.

AHS-IV Deliver health/social services as front door/back door concept, where residents are provided comprehensive services through a person-centric, coordinated system and the categorization for appropriate billing and data reporting occurs behind the scenes.

AHS-V Improve care coordination (e.g. behavioral health and dental health integrated into primary care).

*Priority data development agenda action (See Appendix 2)

Adolescent Health

GOALS

1) Adolescents and young adults are socially, physically, emotionally, and mentally supported by the environments in which they regularly engage (home, school, neighborhood).
2) Adolescents and young adults are successful in school and credentialing programs and ready for a career or higher education.

BACKGROUND

While generally enjoying good health, adolescents and young adults face a range of physiological and developmental changes, including puberty, burgeoning independence, experimentation, and risky behaviors that shape their health decisions and needs. Youth are disproportionately affected by violence and certain sexually transmitted infections (chlamydia and gonorrhea). While youth obesity is increasing nationally, District school-aged children are fitter. However, physical activity levels in District youth 18-24 have decreased over the past several years (91.4% active in 2011 vs. 75.8% in 2014[3]), which can have troubling consequences later in life.

IMPORTANCE

Adolescence is a critical developmental period with long-term implications for the health and well-being of the individual and for society as a whole. The most significant factors to adolescents' health are found in their environment, and in the choices and opportunities for health-enhancing or health-compromising behaviors that these contexts present (e.g., exposure to violence, supportive families). Additionally, African-American youth are disproportionately affected by violence and are overrepresented in the prison system, and solutions are needed to tackle the systemic inequities that exist for young people.

OBJECTIVES AND TARGETS

AH-1 Reduce death rate among 10-24 year olds (per 100,000)

45.9 (2014)

Baseline (2010)	64.8
DC 2020 Target	42.8

AH-1.1 Reduce homicide rate among 20-24 year olds (per 100,000)

37.6 (2014)

Baseline (2011)	50.6
DC 2020 Target	32.7

Adolescent Health

OBJECTIVES AND TARGETS

AH-2.1 Increase the 4-year high school graduation rate

65.4% (2013/14)

Baseline (2009/10)	59%
DC 2020 Target	68%

AH-2.2 Increase college graduation rate

43% (2007/08)

Baseline (2007/08)	43%
DC 2020 Target	47.3%

AH-3.1 Increase 8th grade math proficiency

18% (2013)

Baseline (2009)	11%
DC 2020 Target	31.1%

AH-3.2 Increase 8th grade reading proficiency

17% (2013)

Baseline (2009)	14%
DC 2020 Target	22.4%

AH-4 Decrease suspensions

12% (2013)

Baseline (2013)	12%
DC 2020 Target	10.8%

AH-5 Decrease the severity of youth offender crimes

40% (2014)

Baseline (2011)	47%
DC 2020 Target	27%

RECOMMENDED STRATEGIES

AH-I Offer comprehensive early childhood development programs for low income families.

AH-II Implement the Whole School, Whole Community, Whole Child approach to achieve comprehensive, integrated, and collaborative school health services.

AH-III Implement restorative justice practices before youth are involved with the criminal justice system.

Asthma

GOAL

Those living with asthma have minor complications and lead active lives.

BACKGROUND

Asthma is a long-term chronic disease that affects the airway passages of the lungs.[4] There is no cure for asthma, though people living with asthma may go long periods between episodes.

Indoor allergens (i.e. dust mites and mold), outdoor allergens (i.e. pollen), irritants (i.e. smoke), respiratory illnesses (i.e. cold and flu) and other conditions can trigger asthma episodes. Taking medication as prescribed, avoiding triggers and understanding preventive measures is vital to controlling the disease and improving individuals' quality of life. An estimated 9 people die each day from asthma in the U.S.. Overall, 7.3% of U.S. residents currently have asthma; 8.3% children and 7% adults.[5]

IMPORTANCE

In 2009, in the U.S., there were 479,300 hospitalizations due to asthma, 1.9 million emergency department visits and 8.9 million doctor visits. The cost burden for asthma is high and inequities persist among older and younger individuals as well as those living in substandard housing environments. Women are more likely to die from asthma than men and African Americans are 2 to 3 times more likely than any other race/ethnicity to die from asthma.[5]

Asthma

OBJECTIVES AND TARGETS

A-1 Reduce deaths due to asthma (per 100,000)

7.7 (2014)

Baseline (2010)	9.0
DC 2020 Target	3.8

A-2 Reduce emergency department (ED) visits due to asthma (per 100,000)

2919 (2015)

Baseline (2014)	2845
DC 2020 Target	2561

A-2.1 Reduce asthma-related emergency department (ED) visits in children

478 (2015)

Baseline (2015)	478
DC 2020 Target	430

A-3 Reduce hospitalization due to asthma in adults (per 100,000)

178.3 (2013)

Baseline (2010)	226.1
DC 2020 Target	91.3

A-4 Reduce asthma prevalence

11.5% (2014)

Baseline (2012)	14.7%
DC 2020 Target	10.1%

A-4.1 Reduce asthma prevalence in adults age 65 and older

7.2% (2014)

Baseline (2011)	12.6%
DC 2020 Target	8.3%

*MIP = Monitor for Informational Purposes

RECOMMENDED STRATEGIES

A-I Create a standard billing structure that will allow children to visit their doctor three times a year for asthma follow-up to prevent emergency department visits and hospitalizations.

A-II Increase referrals to evidence-based interventions that target a wide variety of asthma triggers through home visits. (e.g. Healthy Homes Program where specialists visit homes to assess environmental hazards that can trigger asthma or other health issues in children and work with property owners to fix a wide range of specific hazards.)

A-III Increase the number of children and adults with a long-term asthma management plan (i.e. asthma action plan).

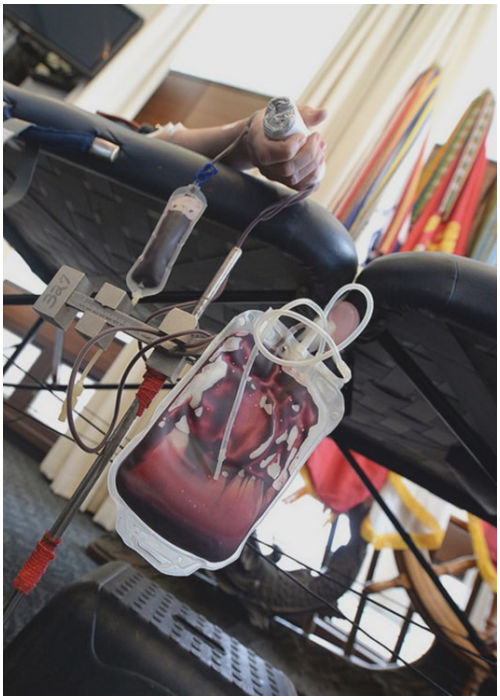
Blood Disorders and Blood Safety

GOALS

1) The blood supply is adequate, safe, and effective.
2) Those who experience a genetic blood or clotting disorder enjoy a good quality of life.

BACKGROUND

Blood disorders include hemoglobinopathies (affecting the protein in red blood cells that carry oxygen) and abnormal bleeding and clotting (e.g. hemophilia). Hemoglobinopathies, such as sickle cell anemia, are inherited, lifelong blood disorders that result in abnormal hemoglobin. Deep vein thrombosis, where blot clots develop in the veins of the leg affects about 1.2 million Americans annually.[6]



Blood transfusions are lifesaving for people with severe bleeding disorders or decreased blood production and for people undergoing surgery or recovering from severe accidents.[6] Although an estimated 38 percent of the U.S. population is eligible to donate blood at any given time, less than 10% of that eligible population actually do each year.[7] Despite efforts by blood banks, there is still a blood shortage, especially in rare blood types.[6]

IMPORTANCE

While hemoglobinopathies affect a small slice of the population, this area is important due to disproportionate morbidity and treatment costs. Early diagnosis and treatment can prevent complications of bleeding and clotting disorders.[6] Unfortunately, there is no true picture of the prevalence or screening rates in the District, other than anecdotal data from providers, which is an area of concern and one where action is needed. The literature exists and research continues on this topic, but it remains an emerging area of public health importance.

Blood Disorders and Blood Safety

Blood safety is of paramount importance as a safe and adequate blood supply is vital for health services such as surgeries, cancer treatment, emergency management of trauma, and care of persons with hemoglobinopathies who are on chronic transfusion therapy. Outreach and education to inform the public about the importance of donating blood can help alleviate blood shortages.

OBJECTIVES AND TARGETS

BDBS-1 Reduce the number of persons who develop venous thromboembolism (VTE) (per 100,000)

61.0 (2013)

Baseline (2010)	61.0
DC 2020 Target	54.9

RECOMMENDED STRATEGIES

BDBS-I Build data infrastructure around population-level health indicators for sickle cell anemia incidence and prevalence.

BDBS-II Improve data surrounding District blood donation rates and blood shortages.

Cancer

GOAL

1) There are few new cancer cases, particularly those diagnosed at late stage.
2) Illness, disability and death caused by cancer is greatly reduced.

BACKGROUND

Cancer is a group of more than 100 different diseases that begin when abnormal cells in the body grow out of control. Normally, cells grow and divide to create new cells as they are needed to keep the body healthy. Sometimes this process of growing new cells does not work properly and cancer forms. Although national death rates for many individual cancer types have declined over the past decade, rates for a few cancers have stabilized or even increased.[8]

Likewise, the District of Columbia has experienced overall declines in both incidence and mortality; however, cancer still remains the second leading cause of death. In particular, lung and breast cancers affect District residents at a higher rate than in the rest of the U.S. Additionally, all cancers affect Black residents disproportionately, and, of those who have cancer, more Black residents die as a result.[9]

IMPORTANCE

Some cancers are preventive and risk can be reduced by avoiding tobacco, eating a balanced diet; maintaining a healthy weight; exercising regularly; getting timely cancer screenings, health assessments and treatment; and, avoiding environmental risks such as the sun or chemicals.

A range of hard-to-reach demographic groups have unmet needs relating to information, support and cancer services. There is evidence of inequities at each stage of the patient pathway, from information provision through palliative care.

OBJECTIVES AND TARGETS

C-1 Decrease the death rate of breast cancer (per 100,000)

31.1 (2012)

Baseline (2010)	29.8
DC 2020 Target	16.6

C-2.1 Decrease the death rate of colorectal cancer (per 100,000)

12.3 (2012)

Baseline (2010)	19.0
DC 2020 Target	17.4

C-2.2 Reduce the racial gap in colorectal cancer death rates (Black/White)

16.0 (2012)

Baseline (2011)	17.7
DC 2020 Target	7.4

Cancer

OBJECTIVES AND TARGETS

C-3.1 Reduce the colorectal cancer incidence rate (per 100,000)

39.9 (2012)

Baseline (2010)	45.9
DC 2020 Target	32.0

C-3.2 Reduce the racial gap in colorectal cancer incidence rates (Black/White)

23.3 (2012)

Baseline (2011)	29
DC 2020 Target	16.4

C-4 Decrease cervical cancer incidence[α] (per 100,000)

8.1 (2012)

Baseline (2010)	9.5
DC 2020 Target	8.6

C-5 Increase early detection for all cancers

51.1% (2012)

Baseline (2010)	48.4%
DC 2020 Target	57.0%

C-6 Reduce late-stage female breast cancer

27.2% (2012)

Baseline (2010)	28.4%
DC 2020 Target	25.6%

C-7 Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines

67.9% (2014)

Baseline (2014)	67.9%
DC 2020 Target	74.7%

[α]Cervical cancer incidence rates should be interpreted with caution due to low numbers that can produce unstable rates

RECOMMENDED STRATEGIES

C-I Increase the early detection/screening and appropriate management of cancer including risk reduction.

C-II Continue successful evidence-based programs: Project WISH, Citywide Patient Navigation Network, DC Screen for Life, mammography surveillance system project.

C-III Expand existing databases and tracking systems to include health equity factors and cancer survivors who are living 5 years or longer after diagnosis.

C-IV Increase the participation of the District's minority populations in clinical trials.

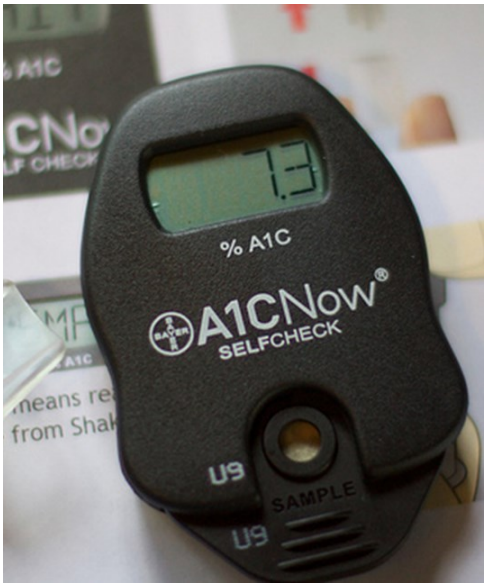
Diabetes

GOALS

1) Disease and economic burden of diabetes mellitus (DM) is reduced.
2) Those who have, or are at risk for, diabetes enjoy a good quality of life.

BACKGROUND

Diabetes is a disease that is caused by the presence of high blood glucose (a type of sugar) levels in the body over an extended period of time. Diabetes is the result of the pancreas not producing enough insulin or the body not being able to properly utilize the insulin to process glucose. There are three types of diabetes. Type 1 diabetes is caused by the failure of the pancreas to produce enough insulin and is not related to lifestyle factors. Type 2 is the result of cells' ability to properly respond to the insulin. The third kind, gestational diabetes, occurs when pregnant women, without a history of diabetes, develop high blood glucose levels during pregnancy.[10]



IMPORTANCE

Diabetes disproportionately affects different racial and ethnic groups, notably African-American/Black, Native American, and Hispanic/Latino populations. Many health problems and complications can occur if the condition is not properly controlled and treated. These include complications of the heart, eyes, kidneys, feet, nerves, and other organs and body systems. The good news is that diabetes (type 2) can be prevented and controlled. Good eating habits, physical activity, weight control, and regular medical and dental check-ups can prevent or delay the onset of type 2 diabetes. It is also important to be aware of a few of the risk factors for diabetes such as a family history, lack of exercise, and high body mass index (BMI).[10]

Diabetes

OBJECTIVES AND TARGETS

D-1 Reduce the diabetes death rate (per 100,000)

19.4 (2014)

Baseline (2010)	24.7
DC 2020 Target	22.6*

D-2 Reduce new cases of diagnosed diabetes in the population

22.4% (2014)

Baseline (2011)	21.0%
DC 2020 Target	18.6%

D-3.1 Increase the proportion of persons with diabetes who have at least an annual eye exam

72.9% (2014)

Baseline (2011)	81.9%
DC 2020 Target	87.0%

D-3.2 Increase the proportion of persons with diabetes who have at least an annual foot exam

70.6% (2014)

Baseline (2011)	76.9%
DC 2020 Target	84.6%

D-4 Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent

Data Forthcoming

*Target has been met

RECOMMENDED STRATEGIES

D-I Create a centralized, coordinated data system in the electronic health records that can easily alert doctors of diabetes risk factors and refer patients to programs that will help them reduce these risk factors.

D-II Increase use of community health workers to engage residents with pre-diabetes and diabetes in behavior change strategies.

D-III Improve access to affordable, nutritious food through full-service grocery stores, mobile markets, and programs that provide financial assistance and incentives for buying fresh fruits and vegetables.

D-IV Build data infrastructure to include population-level information on those with diabetes who have annual dental visits.

Disability Services

GOAL

Adults and youth experiencing disabilities are successful, socially included, and respected at work, school, and university.

BACKGROUND

Just under 18% of District adults reported living with a disability in 2013, slightly lower than the national proportion of nearly 20%.[11] However, disparities persist: In Ward 8, the figure nearly doubles to 31.8%. District children ages 5-17 are more likely to live with a disability (7.3%) compared to the nation (5.3%).[12] Disabilities may be physical, developmental, or sensory, and may be experienced as short– or long-term. The largest age group living with disabilities is seniors.[12]

IMPORTANCE

Persons living with disabilities can face not only challenges to physical accessibility but also social discrimination and fewer employment opportunities. As a result, they are disproportionately affected by a host of health issues including tobacco use, mental health disorders, obesity, and lack of access to healthcare. In order to achieve health equity, accessibility and other considerations need to be incorporated into all facets of community health, development, and healthcare to allow people living with disabilities to reach their full health potential.[11]

Disability Services

OBJECTIVES AND TARGETS

DS-1 Reduce the percentage of children in foster care placed in group homes or congregate care

3.7% (2014)

Baseline (2010)	7.3%
DC 2020 Target	3.3%

DS-2 Increase employment among people with disabilities

20% (2013)

Baseline (2013)	20.0%
DC 2020 Target	22.0%

DS-3 Increase the proportion of adults with disabilities who report sufficient social and emotional support

67.9% (2010)

Baseline (2010)	67.9%
DC 2020 Target	74.7%

RECOMMENDED STRATEGIES

DS-I Increase reasonable accommodation policies in workplaces.

DS-II Increase access to technology (computers, tablets, smartphones, and WiFi) at home and in public places for low-income residents who are disabled and/or isolated.

DS-III Promote guidelines for health care providers to discuss transition planning with youth with special health care needs.

OA-IV When renovating playgrounds and parks, design new infrastructure for active recreation, including workout equipment, for all ages and abilities.

Environmental Health

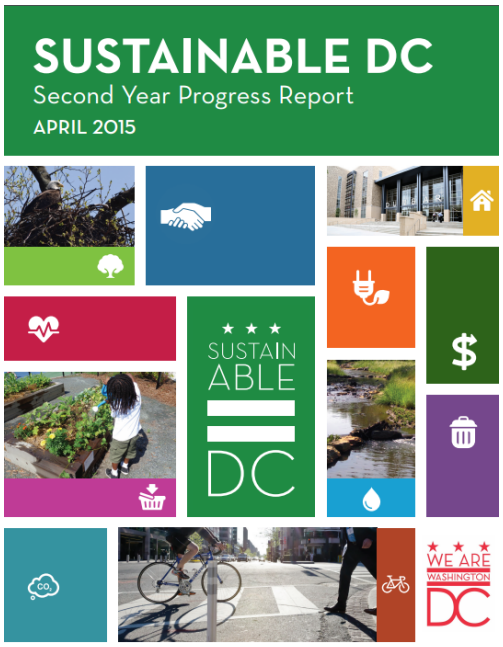
GOALS

1) People live free from negative health outcomes due to environmental factors.
2) District residents experience a healthy environment.

BACKGROUND

Environmental health consists of preventing or controlling disease, injury, and disability related to the interactions between people and their environment. Environmental factors can include air quality, healthy homes, water quality, appropriate waste disposal, built environment, climate change, and sustainability.[13]

The District of Columbia is a national leader in sustainability, having achieved a 4-star community rating through Sustainability Tools for Assessing and Rating (STAR) Communities in 2014. Sustainable DC is a plan that outlines long-term sustainability goals through the year 2032 and strategies for achieving them.[14]



IMPORTANCE

An urban environment with older housing stock presents substantial challenges in ensuring environmental health. Exposure to toxins in the environment can leave lasting effects on overall health, and is especially impactful for children. Healthy environments have traditionally been built inequitably, and those who are working toward the development, implementation, and enforcement of environmental laws, regulations, and policies may combat past wrongs through environmental justice. This ensures that everyone enjoys the same degree of protection from environmental and health hazards and equal access to the decision-making process to have a healthy environment in which to live, learn, and work.[15]

Environmental Health

OBJECTIVES AND TARGETS

EH-1 Reduce "unhealthy" air quality index days

8 days (2015)

Baseline (2012)	24 days
DC 2020 Target	0 days

EH-2 Reduce incidence of high blood lead levels in children

172 cases (2012)

Baseline (2010)	334 cases
DC 2020 Target	155 cases

EH-3 Increase % of waterways that are considered "swimmable" and "fishable"

0% (2013)

Baseline (2012)	0%
DC 2020 Target	10%

EH-4 Increase District Walkscore*

74 (2014)

Baseline (2012)	73
DC 2020 Target	77

EH-5.1 Decrease injury rate associated with high heat index days

0.57 (2013)

Baseline (2010)	0.59
DC 2020 Target	0.20

EH-5.2 Decrease injury rate associated with extreme cold weather days

2.3 (2013)

Baseline (2010)	3.3
DC 2020 Target	0.7

*Walkscore determines the walkability of a city based on several factors (scale is 0-100).

RECOMMENDED STRATEGIES

EH-I Eliminate environmental health threats such as mold, lead, and carbon monoxide in at least half of the District's affordable housing.

EH-II Identify existing laws, regulations, and policies that conflict with sustainability goals and areas where new authority is required.

EH-III Green industrial areas and create green buffers between industrial use and residential neighborhoods.

EH-IV Improve enforcement of air quality regulations, especially on industrial uses.

EH-V Conduct health impact assessments for new developments and renovations.

Food Safety

GOAL

Food safety and hygiene are improved to reduce and limit the spread of foodborne illnesses.

BACKGROUND

The food safety system takes into account producing, transporting, storing, preparing, and eating of food. Contamination may occur at any stage and result in one or more people becoming infected with a food-borne illness. At least two people becoming infected from the same food is considered an outbreak.[16]

Nationally, those experiencing most food-borne illnesses are children younger than 4 and people older than 50 years of age.[16] This is not the case within the District of Columbia. Data show that those most affected by foodborne illnesses are between the ages of 25 and 64.[17]

IMPORTANCE

Food-borne diseases result in increased hospitalizations, days lost from work, and can have serious complications in the very old, very young, and people with compromised immune systems. If not responded to quickly, food-borne illness outbreaks can affect large groups of people, especially in urban areas like the District where populations are more dense. For this reason, food safety inspectors and investigators are included in emergency preparedness and response activities.

Food Safety

OBJECTIVES AND TARGETS

FS-1 Prevent an increase in rate of confirmed cases of food-borne illnesses (per 100,000)


48.6 (2012)

Baseline (2010)	44.3
DC 2020 Target	44.3

FS-1.1 Reduce confirmed infection rate of Salmonella transmitted commonly through food (per 100,000)


14.1 (2012)

Baseline (2010)	15.6
DC 2020 Target	11.4

FS-1.2 Reduce confirmed infection rate of Shigella transmitted commonly through food (per 100,000)


4.9 (2012)

Baseline (2010)	5.8
DC 2020 Target	2.1

FS-1.3 Prevent an increase in confirmed infection rate of Giardia transmitted commonly through food (per 100,000)


15.5 (2012)

Baseline (2010)	9.9
DC 2020 Target	9.9

FS-1.4 Reduce confirmed infection rate of Campylobacter transmitted commonly through food


12.2 (2012)

Baseline (2010)	10.4
DC 2020 Target	8.5

RECOMMENDED STRATEGIES

FS-I Continue expansion of streamlined food establishment inspections that focus on key food-related observations.

FS-II Implement quality improvement initiatives to improve food establishment inspection efficiencies, target at-risk establishments and create expedited inspections for high performing establishments.

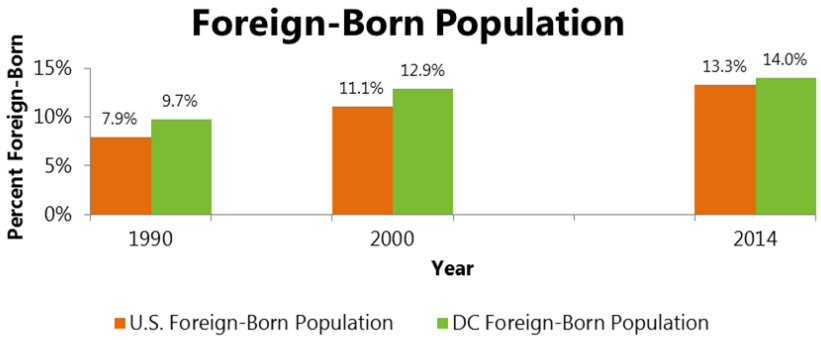
Foreign-Born Populations

GOAL

Foreign-born District residents have equal opportunities to lead a healthy life.

BACKGROUND

Foreign-born populations are particularly at risk for not having adequate access to health care. Language barriers, cultural differences, and less access to basic support services are contributing factors that decrease access to health care for those who are foreign-born. Furthermore, the District of Columbia's high cost of living presents additional challenges to affording and accessing care. Because foreign-born populations are less likely to have adequate care, they are often underrepresented in both local and national health data, including the District. For these reasons, little is known about the current health status of foreign-born individuals in the District.



Source: U.S. Census Bureau American Community Survey (ACS)

IMPORTANCE

More individuals who are foreign-born are relocating to the District than ever before. Compared to their U.S. born counterparts, they are more likely to experience obstacles in accessing care and therefore are underserved by the health care system.[18] It is important to increase the understanding and knowledge about the health status of foreign-born District residents. These efforts can help identify interventions that will increase access for this population. Foreign-born District residents should have equal opportunities to reach their full health potential, a fundamental goal of DC Healthy People 2020.

In some cases, foreign-born residents have shown better health outcomes than their U.S.-born counterparts, with benefits decreasing the more time they spend in the U.S. However, it is important to examine baseline levels and their relation to health improvement (e.g. foreign-born Latinos may have poorer oral health that improves over time). Understanding more about the protective factors foreign-born residents bring with them and what exposures contribute to the changes in health status can serve to improve health outcomes for the whole population.

Foreign-Born Populations

OBJECTIVES AND TARGETS

FBP-1 Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) foreign-born populations

2 systems (2015)

Baseline (2014)	2 systems
DC 2020 Target	4 systems

RECOMMENDED STRATEGIES

FBP-I Improve data about foreign-born population health by including appropriate demographic questions in health-related surveys and forms.

FBP-II Increase cultural/linguistic competency of healthcare providers.*

FBP-III Increase access to dental care for foreign-born populations.*

FBP-IV Increase access to education for foreign-born populations.*

Healthcare-Associated Infections

GOAL

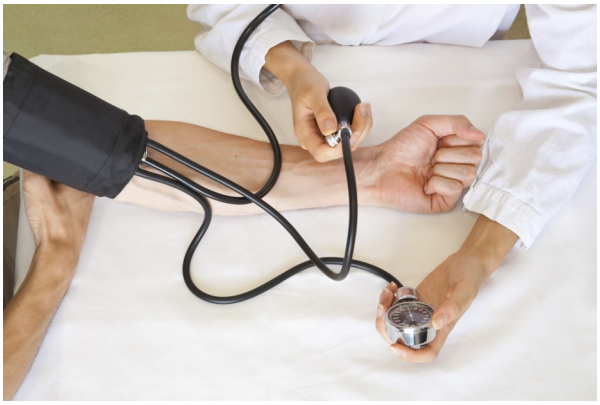
Healthcare-associated infections (HAIs) are prevented, reduced, and ultimately eliminated.

BACKGROUND

Healthcare-Associated Infections (HAIs) are infections that develop in a patient during or shortly after receiving treatment for a separate medical or surgical condition in a healthcare setting.

Healthcare-Associated Infections can be categorized into six types:

- Surgical site infections (SSIs)
- Central line-associated bloodstream infections (CLABSIs)
- Ventilator-associated pneumonia (VAPs)
- Catheter-associated urinary tract infections (CAUTIs)
- Clostridium difficile (C.diff)
- Methicillin-Resistant Staphylococcus Aureus (MRSA)



Currently, only CLABSIs and MRSA are reportable diseases mandated by the District of Columbia Department of Health through the National Healthcare Safety Network (NHSN) system, while the remaining may be reported on a voluntary basis.[19]

IMPORTANCE

HAIs are a major public health problem and may result in significant patient morbidity and mortality, prolonged hospital stays, increased antimicrobial resistance, and increased costs from additional diagnostic and therapeutic interventions. These probable consequences add to costs already incurred by the patient's underlying disease and undue emotional and psychological stress to patients and their families.

Healthcare-Associated Infections

OBJECTIVES AND TARGETS

HAI-1 Maintain better-than-expected rate of central line-associated bloodstream infections (CLABSIs)

0.78 SIR (2012)

Baseline (2011)	0.67 SIR*
DC 2020 Target	<1 SIR*

HAI-2 Maintain better-than-expected rate of catheter-associated urinary tract infections (CAUTIs)

0.98 SIR (2014)

Baseline (2011)	0.81 SIR*
DC 2020 Target	<1 SIR*

HAI-3 Decrease antibiotic-resistant infection rate (Methicillin-Resistant Staphylococcus Aureus (MRSA)) (per 100,000)

16.6 (2013)

Baseline (2011)	15.3
DC 2020 Target	13.6

*SIR = Standard Infection Ratio

RECOMMENDED STRATEGIES

HAI-I Change policy to promote antibiotic stewardship and enforce guidelines for management of multi-drug-resistant organisms in health care settings.

HAI-II Advocate for inclusion of remaining healthcare-associated infections under mandatory reporting requirements.

Heart Disease and Stroke

GOALS

1) Heart attack and stroke are rare.
2) Environments (home, school, community) support cardio- and cerebrovascular health through prevention, detection, and treatment of risk factors, especially in disproportionately affected populations.

BACKGROUND

Heart disease and stroke in the District are the 1st and 3rd leading causes of death, respectively. Rates per 100,000 of heart disease deaths are higher in the District (212.5) than nationally (170.5), though the stroke death rate is lower (33.7 and 36.9, respectively).[9] Several factors increase the risk of heart disease and stroke including poor nutrition, lack of physical activity, tobacco use, and mental disorders. This topic particularly impacts African-Americans, those older than 45 years of age, and those living in Wards 5, 7, and 8. Stroke prevalence in the District (3.2%) is higher than the national figure (2.8%) and disproportionately affects African American residents and those living in Wards 7 and 8.[9]

IMPORTANCE

In the District, 32.3% of all deaths are the result of heart disease or stroke. Disparities are stark, especially among African-American/Black residents who experience 3 times the rate of heart disease deaths compared to Whites.[9] In addition, heart disease and stroke lead to increased costs associated with hospitalizations and disability and decreased quality of life.

OBJECTIVES AND TARGETS

HDS-1 Reduce coronary heart disease deaths (per 100,000)

▼ 131.2 (2014)

Baseline (2010)	153.4
DC 2020 Target	99.4

Heart Disease and Stroke

OBJECTIVES AND TARGETS

HDS-1.1 Reduce heart disease death rate in non-Hispanic Black adults (per 100,000)

163.4 (2014)

Baseline (2010)	192.7
DC 2020 Target	128.3

HDS-1.2 Reduce heart disease death rate in Hispanic adults (per 100,000)

53.7 (2014)

Baseline (2010)	91.7
DC 2020 Target	49.6

HDS-2 Reduce stroke deaths (rate per 100,000)

33.0 (2014)

Baseline (2010)	32.0
DC 2020 Target	27.0

HDS-3 Decrease ER visits related to heart disease (per 100,000)

5.4 (2014)

Baseline (2010)	4.5
DC 2020 Target	3.9

HDS-4 Reduce the proportion of adults with hypertension

28.4% (2013)

Baseline (2011)	30.0
DC 2020 Target	26.9

HDS-4.1 Increase the proportion of adults with hypertension whose blood pressure is under control

63.2% (2014)

Baseline (2013)	53.8%
DC 2020 Target	69.5%

RECOMMENDED STRATEGIES

HDS-I Increase hypertension care through improved communications and data sharing among providers, nurses, pharmacists, other care givers, and patients.

HDS-II Increase surveillance of early diagnosis of heart disease and stroke.

Hepatitis C

GOALS

1) Hepatitis C Virus (HCV) cases are rare and don't unduly burden specific populations.
2) Those living with HCV enjoy a good quality of life.

BACKGROUND

Hepatitis is a medical condition characterized by the inflammation of the liver. Viral hepatitis has long been a concern of organizations working in the HIV/AIDS field because of the high rates of co-infection. It is estimated that 25 percent of people living with HIV are co-infected with Hepatitis C virus, though certain groups, like people who inject drugs, have even higher rates of co-infection. The two (i.e., HIV and viral hepatitis) are often called "twin epidemics' since they share modes of transmission and disproportionately affect many of the same populations.[20]

IMPORTANCE

Persons infected with viral hepatitis are at a high risk for developing chronic hepatitis and related conditions such as chronic liver disease, cirrhosis and primary hepatocellular carcinoma (liver cancer), and they risk transmitting hepatitis infection to others.[21] New medication has been developed to cure Hepatitis C. However, access to this lifesaving treatment is hampered due to high costs.

Hepatitis C

OBJECTIVES AND TARGETS

H-1 Reduce mortality related to Hepatitis C infection (per 100,000)

4.4 (2014)

Baseline (2010)	3.8
DC 2020 Target	3.4

H-2 Increase access to and affordability of Hepatitis C treatment

37.5% (2016)

Baseline (2016)	37.5%
DC 2020 Target	62.5%

RECOMMENDED STRATEGIES

H-I Increase access to and affordability of Hepatitis C treatment to all in need via Medicaid and/or private insurance.

H-II Increase opt-out screening for Hepatitis C as a routine part of primary care consistent with recommended clinical guidelines.

HIV

GOAL

1) New HIV cases in the District are rare and don't unduly burden specific populations.
2) Those living with HIV enjoy a good quality of life.
3) Stigma is reduced surrounding HIV.

BACKGROUND

It is estimated that nearly 1.1 million people living in the United States have been infected with Human Immunodeficiency Virus (HIV). Approximately 16,423 District of Columbia residents are living with HIV, though new infections have been steadily declining over the past 5 years.[22]

African Americans living in the District are disproportionally impacted by HIV with 75% of District residents living with HIV identifying as African American/Black. Over 90% of all females in the District living with HIV are African American, experiencing a rate over 24 times the rate of White women in the District.[22]

IMPORTANCE

Advances in HIV prevention and treatment have helped reduce the burden of the infection and have allowed persons living with HIV (PLWH), with proper treatment, to control the infection similar to a chronic disease. However, the District is still experiencing a continued generalized epidemic (2.5% of the population are PLWH). Those living with HIV face barriers to access to care due to stigma and other social determinants (e.g. low levels of education, income, discrimination, etc.). PLWH can live many years without symptoms, passing HIV on to sexual and injection drug use partners, and it is estimated that 1 in 5 people are unaware of their status.[22]

OBJECTIVES AND TARGETS

HIV-1 Reduce deaths from HIV infection*

12.2 (#10) (2013)

Baseline (2010)	20.4 (#7)
DC 2020 Target	Off Top 10

HIV-2 Reduce the number of new annual HIV infections in all ages

553 (2013)

Baseline (2010)	889
DC 2020 Target	275

HIV-3 Increase the percentage of HIV positive individuals in care that are virally suppressed

75% (2014)

Baseline (2013)	72%
DC 2020 Target	90%

HIV-4 Increase the percentage of HIV-positive persons who know their status

89% (2013)

Baseline (2013)	89%
DC 2020 Target	90%

HIV-5 Increase the percentage of individuals diagnosed with HIV that are in care

64% (2014)

Baseline (2013)	63%
DC 2020 Target	90%

*(#) indicates position on Top Ten Leading Causes of Death

RECOMMENDED STRATEGIES

HIV-I Improve enforcement of HIV surveillance data sharing and reporting.

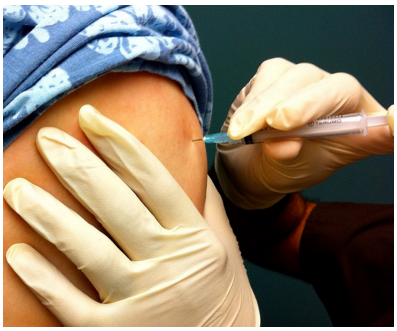
HIV-II Care coordination to incorporate routine opt-out HIV testing into primary care visits.

Immunization and Infectious Diseases

GOAL

Vaccine-preventable infections are rare and infectious diseases are properly contained.

BACKGROUND



Immunization has played a vital role in increasing life expectancy in the 20th century, largely due to improving child survival through reduction in infectious disease mortality and disability due to immunization. Current vaccination efforts in the U.S. target 17 vaccine-preventable diseases across the lifespan.[23]

IMPORTANCE

Even with such advances in vaccines, the effectiveness depends on vaccinating a large majority of the population being protected (herd immunity). Without widespread immunization, the entire community is at risk for outbreaks that have not been seen in generations. In addition, given the global nature of disease transmission and the District's location in a thriving metropolitan area with intense commuting and tourism, the threat for catastrophic infectious disease epidemics remains high.

Infectious diseases that are not yet eradicated remain a major cause of illness, disability, and death. The minor risks of vaccines are dwarfed by the substantial effects of infections such as measles, which cause death or permanent disability in up to 10% of those who contract it.[24]

OBJECTIVES AND TARGETS

IID-1.1 Reduce cases of Measles

▼ 1 case (2012)

Baseline (2009)	2 cases
DC 2020 Target	0 cases

IID-1.2 Prevent increase in cases of Mumps

= 2 cases (2012)

Baseline (2009)	2 cases
DC 2020 Target	2 cases

IID-1.3 Maintain elimination of Rubella

= 0 cases (2012)

Baseline (2009)	0 cases
DC 2020 Target	0 cases

IID-1.4 Reduce cases of Varicella

▼ 18 cases (2012)

Baseline (2010)	20 cases
DC 2020 Target	8 cases

Immunization and Infectious Diseases

OBJECTIVES AND TARGETS

IID-1.5 Prevent an increase in cases of Pertussis

26 cases (2012)

Baseline (2010)	14 cases
DC 2020 Target	14 cases

IID-1.6 Prevent increase in cases of meningococcus

2 cases (2012)

Baseline (2010)	1 case
DC 2020 Target	1 case

IID-1.7 Reduce new infection rate of Hepatitis B (per 100,000)

61.5 (2013)

Baseline (2011)	74.6
DC 2020 Target	27.1

IID-1.8 Reduce infection rate of Tuberculosis (per 100,000)

5.7 (2013)

Baseline (2012)	5.8
DC 2020 Target	3.3

IID-2.1 Increase vaccination rates in school-aged children

83.2% (2014)

Baseline (2014)	83.2%
DC 2020 Target	91.5%

IID-2.2 Increase the percentage of children aged 19 to 35 months who receive the recommended doses of vaccinations

73.4% (2012)

Baseline (2010)	66.2%
DC 2020 Target	80.7%

IID-2.3 Increase annual influenza vaccination rate

41.3% (2014)

Baseline (2011)	37.7%
DC 2020 Target	41.3%

RECOMMENDED STRATEGIES

IID-I Reduce client out-of-pocket costs for vaccinations, including flu vaccine (via Medicaid and/or private insurance companies).

Injury and Violence Prevention

GOAL

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

BACKGROUND

Injuries are classified as either intentional (e.g., assault, homicide, suicide) or unintentional (e.g., poisoning, falls, transportation, etc.). Rates of suicide and unintentional injury deaths are lower for DC residents (6.1 and 32.5 per 100,000, respectively) compared to the U.S. (12.6 and 40.0, respectively). However, unintentional fall deaths have been on the rise for District seniors over the past two years. The District's homicide rate (17.3 per 100,000) is 3 times the national rate (5.3).[25]

IMPORTANCE

Injury and violence have often been categorized as public safety and law enforcement concerns, but with unintentional injury as the 3rd leading cause of death for District residents and homicide the 8th, they both clearly impact public health.[25] In addition, many residents are affected by these issues, not only directly, but indirectly through, for example, environments that experience frequent incidents of violence. Childhood trauma due to exposure to violence can lead to health consequences later in life.[26] Unsafe environments also dissuade residents from engaging socially with community, attending school regularly, or using the outdoors for exercise.

OBJECTIVES AND TARGETS

IVP-1 Decrease crime rate (property and violent crime rate per 100,000)

5427 (2015)

Baseline (2012)	5561
DC 2020 Target	5005

IVP-1.1 Decrease homicide rate (per 100,000)

14.0 (2014)

Baseline (2012)	11.6
DC 2020 Target	10.4

IVP-1.2 Reduce firearm-related deaths (rate per 100,000)

11.8 (2014)

Baseline (2012)	9.3
DC 2020 Target	8.4

IVP-2 Reduce fatal injuries (rate per 100,000)

57.2 (2014)

Baseline (2012)	51.4
DC 2020 Target	46.3

Injury and Violence Prevention

OBJECTIVES AND TARGETS

IVP-2.1 Prevent an increase in poisoning deaths (rate per 100,000)

▲ 16.1 (2014)

Baseline (2010)	15.0
DC 2020 Target	15.0

IVP-2.2 Reduce fall-related deaths (rate per 100,000)

▲ 9.9 (2014)

Baseline (2012)	8.6
DC 2020 Target	7.7

IVP-3 Reduce fire-related injury and death (rate per 100,000)

▲ 47.9 (2015)

Baseline (2013)	44.3
DC 2020 Target	39.9

IVP-4.1 Decrease pedestrian deaths

▼ 9 deaths (2013)

Baseline (2010)	13 deaths
DC 2020 Target	3 deaths

IVP-4.2 Decrease deaths associated with motor vehicles

▼ 26 deaths (2013)

Baseline (2011)	32 deaths
DC 2020 Target	10 deaths

IVP-5.1 Decrease bullying among Middle Schoolers

▲ 29.9% (2012)

Baseline (2010)	27.9%
DC 2020 Target	25.1%

IVP-5.2 Decrease bullying among High Schoolers

▲ 10.9% (2012)

Baseline (2010)	9.7%
DC 2020 Target	8.7%

IVP-6 Reduce child abuse and neglect rate (number of reports)

▼ 811 (2013)

Baseline (2011)	1050
DC 2020 Target	528

RECOMMENDED STRATEGIES

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

IVP-II Use YRBS data to inform school policy and decision-making and reduce disproportionate number of school suspensions by race.

IVP-III Implement restorative justice practices for individuals upon initial contact with the criminal justice system.

Lesbian, Gay, Bisexual, Transgender and Queer/ Questioning (LGBTQ) Health

GOALS

The LGBTQ, asexual and intersex communities experiences social inclusion, respect, and equal access to all community benefits and services.

BACKGROUND

Due to prejudice, discrimination, stigma, and social exclusion, individuals who are LGBTQ, asexual, and/or intersex often do not experience equitable access to health care and community benefits and services when compared to their cisgender, gender conforming and heterosexual counterparts. As a result, they often are not fully engaged in these services. Furthermore, the historical lack of data on gender and sexual minorities has hindered the understanding and knowledge about the health status of these populations.[27] Although comprehensive data are lacking on these populations, current research shows that gender and sexual minorities often experience worse health outcomes than their cisgender and heterosexual peers.[28]

IMPORTANCE

Although there have been significant policy and legal milestones for gender and sexual minorities, these populations still experience inequities to health and community benefits and services. It is important that we increase the understanding and knowledge of the health status of LGBTQ, as well as asexual, and/or intersex individuals in the District. Data suggest that while LGB individuals have similar chronic disease health outcomes, they fare worse than others in mental health and infectious disease health outcomes.[29] Health status of transgender populations is limited and more population-level health data are needed to better understand populations who face social and other barriers to achieving their full health potential. A deeper comprehension for all is essential to achieving social inclusion, respect, and equal access to all health and community benefits and services for these populations.

Lesbian, Gay, Bisexual, Transgender, and Queer/ Questioning Health

OBJECTIVES AND TARGETS

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

2 systems (2015)

Baseline (2014)	2 systems
DC 2020 Target	4 systems

LGBTH-2 Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) lesbian, gay and bisexual populations

4 systems (2015)

Baseline (2013)	5 systems
DC 2020 Target	12 systems

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

9.4% (2012)

Baseline (2010)	10.7%
DC 2020 Target	4.2%

RECOMMENDED STRATEGIES

LGBTH-I Increase data surrounding LGBTQAI communities by including appropriate demographic questions in health-related surveys and forms.

Maternal, Infant and Child Health

GOAL

1) Women of child-bearing age, fathers, infants, and children have equitable access to high quality and appropriate health care.
2) Health issues for mothers, infants, and children are rare and they thrive in their environments.

BACKGROUND

Improving the well-being of women, infants and children is an important public health priority in the District of Columbia and the nation. A major indicator of a region's health is its infant mortality rate (IMR). The District has made great strides in the past decade, reducing the infant mortality rate to 6.8 infant deaths per 1,000 live births in 2013. However, the national IMR at this time was lower (6.0). Low birth weight, pre-pregnancy weight status, and inadequate prenatal care each contribute to the high IMR in the District.[30]

IMPORTANCE

The cognitive and physical development of a child is influenced by health status and the health behaviors of the mother before, during and after pregnancy. Studies have linked unhealthy pregnancies to more respiratory and psychological disorders in children.[31]

Pregnancy is an opportunity to affect multiple health behavior changes while a mother is receiving prenatal care. In many cases the health risks that women, infants and children experience (e.g., unhealthy weight, poor nutrition, substance use, etc.) are preventable or manageable.[31]

OBECTIVES AND TARGETS

MICH-1 Decrease infant mortality rate (per 1,000 live births)

▼ 6.8 (2013)

Baseline (2010)	8.0
DC 2020 Target	6.0

MICH-2.1 Decrease total preterm births

▼ 9.6% (2014)

Baseline (2011)	11%
DC 2020 Target	6.5%

MICH-2.2 Increase births with timely entry into prenatal care

▲ 68.3% (2014)

Baseline (2011)	66.8%
DC 2020 Target	78.4%

Maternal, Infant and Child Health

OBJECTIVES AND TARGETS

MICH-2.3 Increase abstinence from cigarette smoking among pregnant women

52.3% (2011)

Baseline (2010)	57.5%
DC 2020 Target	63.3%

MICH-3.1 Increase exclusive breastfeeding for the first 6 months of life

17.3% (2014)

Baseline (2010)	11.7%
DC 2020 Target	21.2%

MICH-3.2 Increase breastfeeding support in maternity hospitals (mPINC* score)

80 (2013)

Baseline (2011)	79
DC 2020 Target	100

MICH-4 Decrease the rate of child deaths (per 100,000)

23.1 (2014)

Baseline (2010)	19.3
DC 2020 Target	17.4

MICH-5.1 Increase well-child visits

63% (2014)

Baseline (2012)	69%
DC 2020 Target	76%

MICH-5.2 Increase well-woman visits

76.9% (2014)

Baseline (2011)	79.3%
DC 2020 Target	87.2%

*mPINC Score derives from a hospital survey that measures infant breastfeeding care processes, policies, and staff expectations in maternity care settings.

RECOMMENDED STRATEGIES

MICH-I Increase minimum wage to a living wage.

MICH-II Increase centering pregnancy programs (services for pregnant women in intimate group settings).

MICH-III Screen women related to intimate partner and/or sexual violence and refer to services if warranted.

MICH-IV Increase the number of family-friendly work environments and the adoption of breastfeeding policies that provide adequate time and places for working mothers to breastfeed or pump.

MICH-V Increase the proportion of children with special health care needs who have access to a medical home.

Mental Health and Mental Disorders

GOALS

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

BACKGROUND

Mental health is a state of successful performance of mental function, resulting in productive activities, fulfilling relationships, and the ability to adapt and cope with life situations.[32] Mental health disorders are a variety of conditions that affect mood, thinking and behavior. One in five American adults aged 18 and older, or about 45 million people, suffered from mental illness in in 2011.[33] Similarly, studies estimate that, in a given year, more than half of people living with mental illness do not receive care. Over the past two years, District adults reporting depression grew from 16.0% in 2011 to 20.9% in 2013, eclipsing the 2013 national percentage of 18.7%.[34]

IMPORTANCE

Mental health issues are a major cause of disability.[32] Mental illness is often co-occurring with substance use, and both are critical risk factors for suicide.[33] Mental and physical health are intertwined: Those living with mental illness face more barriers to healthy living, while physical illnesses such as chronic disease can negatively affect a person's mental health and likelihood for treatment adherence and/or recovery. In addition, stigma surrounding mental illnesses and treatment is a barrier to diagnosing and receiving appropriate care.

Mental Health and Mental Disorders

OBJECTIVES AND TARGETS

MHMD-1 Decrease suicide rate (per 100,000)

 7.7 (2014)

Baseline (2010)	6.9
DC 2020 Target	5.0

MHMD-1.1 Decrease suicide attempts in High Schoolers

 13.4% (2012)

Baseline (2010)	11.5%
DC 2020 Target	10.4%

MHMD-1.2 Decrease suicide attempts in Middle Schoolers

 10.2% (2012)

Baseline (2010)	8.7%
DC 2020 Target	7.8%

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

 7.4% (2012)

Baseline (2010)	6.5%
DC 2020 Target	5.8%

MHMD-3 Decrease hospital readmissions for mental health issues

 9.9% (2014)

Baseline (2010)	8.6%
DC 2020 Target	8.1%

MHMD-4 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders

 Data forthcoming (2015)

RECOMMENDED STRATEGIES

MHMD-I Improve policies and procedures to identify workplace/school bullying and establish clear guidelines for steps of resolution.

MHMD-II Screen for and improve surveillance around childhood trauma.*

MHMD-III Increase the proportion of primary care physician office visits where patients are screened for depression.

*Priority data development agenda action (See Appendix 2)

Nutrition, Weight Status and Physical Activity

GOAL

Chronic disease risk is reduced through the consumption of healthful diets and daily physical activity to achieve and maintain a healthy body weight.

BACKGROUND

Proper nutrition and physical activity are key to maintaining a healthy weight. The District is one of the fit-test cities in the U.S. and has the second lowest obesity rate in the nation (22.8% in 2013).[11] Still, disparities are large with 36.4% of African American adults experiencing obesity and Wards 5, 7 and 8 well above the national figure. The same trend exists for those who participate in physical activities.[11] Factors that can affect proper nutrition can include access to affordable, fresh fruits and vegetables, income, time to prepare meals, culturally relevant nutrition education, and mental health.

IMPORTANCE

Poor nutrition and lack of physical exercise can lead to the worsening of chronic diseases such as diabetes, cancer and cardiovascular disease and can also affect the development of babies if pregnant women are not receiving proper nutrients. Food access and community safety are key determinants of health that, when appropriately tackled, can improve nutrition and physical activity.

OBJECTIVES AND TARGETS

NWP-1.1 Increase fruit consumption

64.7% (2013)

Baseline (2013)	64.7%
DC 2020 Target	71.2%

NWP-1.2 Increase vegetable consumption

78.0% (2013)

Baseline (2013)	78.0%
DC 2020 Target	83.8%

NWP-2 Decrease the number of "food deserts"

9 deserts (2015)

Baseline (2015)	9 deserts
DC 2020 Target	0 deserts

NWP-3.1 Increase the rate (per 100,000) of licensed nutritionists/dietitians practicing in DC

4.7 (2012)

Baseline (2010)	2.1
DC 2020 Target	15.0

Nutrition, Weight Status and Physical Activity

OBJECTIVES AND TARGETS

NWP-3.2 Include nutritionists/dietitians under Medicaid

No (2015)

Baseline (2010)	No
DC 2020 Target	Yes

NWP-4.1 Reduce the proportion of children and adolescents who are considered obese

15.9% (SY2014/15)

Baseline (SY2012/13)	18.5%
DC 2020 Target	9.9%

NWP-4.2 Reduce the proportion of adults who are considered obese

21.7% (2014)

Baseline (2012)	23.7%
DC 2020 Target	19.2%

NWP-5 Reduce the proportion of High Schoolers who are considered overweight

17% (2012)

Baseline (2010)	18%
DC 2020 Target	13%

NWP-6.1 Increase physical activity levels in High Schoolers

28.1% (2012)

Baseline (2010)	28.4%
DC 2020 Target	31.6%

NWP-6.2 Increase physical activity levels in youth ages 18-24

75.8% (2014)

Baseline (2011)	91.4%
DC 2020 Target	87.0%

NWP-6.3 Increase physical activity levels in adults

79.2% (2014)

Baseline (2011)	76.4%
DC 2020 Target	88.6%

RECOMMENDED STRATEGIES

NWP-I Adopt use of health impact assessments for new and existing construction or improvement projects to ensure safe communities that promote healthy living and physical activity.

NWP-II Incorporate best practices to improve healthy food offerings in schools.

NWP-III Plan for walkable, bikeable, mix-use neighborhoods that encourage and promote physical activity.

NWP-IV Encourage development of full-service grocery stores in food deserts and augment offering of healthy, affordable foods at corner stores.

Older Adults

GOAL

1) Older adults live in an 'age-friendly' environment where all people can participate in society in a manner that enhances their personal growth, respect, and social inclusion

2) Older adults have access to and information about active recreation, healthful food, and safe and walkable neighborhoods to promote healthy lifestyles.

BACKGROUND

Older adults are among the fastest growing population in the U.S., and the District of Columbia is similarly preparing for expected growth among the 50+ year old population.[12]

The District of Columbia is striving to become an age-friendly city, which is an international process coordinated by the World Health Organization. A city is evaluated comprehensively for age-friendliness by assessing built environment, social and civic participation, technology, community support, and preparedness/resilience, to name a few.[35]

IMPORTANCE

As people age, they often have to manage chronic and other diseases that affect quality of life. The built environment and social determinants of health are important to consider. The District's AARP Livability Index score, which measures how livable a neighborhood is, is 58 [scale is zero (very poor) through 100 (excellent)].[35] In addition, older adults are disproportionately affected by injuries, with falls causing severe disability for many, and health services for this and related issues should be tailored for these populations.

Older Adults

OBJECTIVES AND TARGETS

OA-1 Improve overall health of older adults (50+)

76.9% (2013)

Baseline (2011)	73.6%
DC 2020 Target	90.0%

OA-2 Increase seniors who participate in regular physical activity (50+)

76.2% (2013)

Baseline (2010)	72.4%
DC 2020 Target	89.6%

OA-3 Ensure all residents have access to parks and open spaces within 1/2 mile

97% (2015)

Baseline (2012)	96%
DC 2020 Target	100%

OA-4 Reduce the rate (per 100,000) of emergency department visits due to falls among older adults (65+)

2798 (2015)

Baseline (2014)	2053
DC 2020 Target	MIP*

OA-5 Prevent an increase in elder abuse (cases)

831 (2014)

Baseline (2012)	892
DC 2020 Target	892

*MIP = Monitor for Informational Purposes

RECOMMENDED STRATEGIES

OA-I Include screening in preventive care and prenatal visits related to abuse of elderly and vulnerable adults.

OA-II Increase access to technology (computers, tablets, smartphones, and wifi) at home and in public places for low-income residents age 50+.

OA-III Increase older adults (50+) who volunteer or participate in civic activities.

OA-IV When renovating playgrounds and parks, design new infrastructure for active recreation, including workout equipment, for all ages and abilities.

Oral Health

GOALS

1) Oral and craniofacial diseases, conditions, and injuries are prevented and controlled.
2) All residents have access to and utilize educational, preventive, and therapeutic oral healthcare services.
3) Residents accept and adopt effective preventive oral health interventions.

BACKGROUND

Only about 60% of adults have had a dental visit within the past year and over 90% have had dental caries (tooth decay) at some point in their lives. Additionally, over one-quarter of US adults (27.4%) have untreated dental caries. While the share of children and adolescents who receive preventive dental care has increased over time to 83%, dental caries is still the most prevalent chronic disease observed among this population. The CDC estimates that 18% of children and adolescents 5-19 years have untreated dental caries.[36]

At present, the District of Columbia is working to build its oral health surveillance capabilities, including data related to childhood caries, sealants, and access to oral healthcare. However, preliminary data suggest that 28% of District adults failed to access dental care within the past year; patterns of lower access are observed among Hispanic residents and all residents who do not identify as White.[37]

IMPORTANCE

Preventive dental care is vital over the life course to maintain oral health and improve quality of life. There are not only barriers to access to preventive dental care for certain groups, but African American residents, Hispanic residents, and those living in poverty are all disproportionately affected by untreated dental caries.

Oral Health

Oral diseases, from cavities to cancer, cause pain and disability for many Americans.[38] Several systemic diseases, such as diabetes and cardiovascular conditions, have oral manifestations; regular and comprehensive dental exams aid in the early diagnosis of these conditions.[39] In addition, those living with untreated oral conditions may experience difficulty speaking, eating, or smiling, which can affect social inclusion and mental health.

OBJECTIVES AND TARGETS

OH-1 Decrease number of emergency department visits related to oral health chief complaints (rate per 100,000 pop.)

382.6 (2015)

Baseline (2014)	318.6
DC 2020 Target	286.7

OH-2 Increase percentage of adult residents who receive preventive oral health care

70.8% (2014)

Baseline (2012)	71.1%
DC 2020 Target	78.2%

RECOMMENDED STRATEGIES

OH-I Enforce school-based oral health assessment reporting to include annual dental visits, untreated tooth decay, dental caries, and dental sealants.

OH-II Increase referrals from physicians who identify patients with oral health conditions to dentists.

OH-III Enhance population health monitoring related to emerging indicators, such as emergency department dental visits and perinatal oral health visits.

Preparedness and Response

GOALS

1) The DC community effectively coordinates and cooperates during emergency preparedness, response, and recovery efforts.
2) Preparedness, response, and recovery efforts are timely, effective, and continuously tested and improved.

BACKGROUND

Preparedness and response involves effective collaboration among Government agencies, nongovernmental organizations, the private sector, communities, and individuals. Planning, training, and ongoing quality improvement are crucial to executing essential services, response, and recovery during and after an emergency.[40]

IMPORTANCE

The District of Columbia, like all major cities, faces many threats with the potential for large-scale health consequences, including disease outbreaks, natural disasters, and terrorist attacks. The public health, health care, and emergency response systems must be prepared to mitigate the morbidity and mortality associated with these threats. Securing the District's health and effectively and expediently responding to emergencies are formidable challenges, and a shared responsibility for all parts of the city.

Preparedness and Response

OBJECTIVES AND TARGETS

PR-1.1 Reduce the time necessary to issue official information to the public about a public health emergency

Data Forthcoming

PR-1.2 Reduce the time necessary to activate designated personnel in response to a public health emergency.

Data Forthcoming

PR-1.3 Reduce the time for State public health agencies to establish after action reports and improvement plans following responses to public health emergencies and exercises.

Data Forthcoming

RECOMMENDED STRATEGIES

PR-I Improve data infrastructure surrounding timeliness of emergency response communications and events.

Public Health Infrastructure

GOALS

1) Data system integration and data analysis drive public health planning and research
2) Community is thoughtfully engaged in public health planning, implementation, and evaluation processes.
3) The public health workforce is capable and qualified.

BACKGROUND

Public health infrastructure addresses the capacity of the District of Columbia's public health system to provide the ten (10) essential public health services. These areas are specific to public health and not health care, which is addressed in Access to Health Services topic area. However, there is some overlap with regard to health information which may be collected for health care utilization but with the purpose of public health planning and response.

The District is unique in that the Department of Health (DOH) is considered both a state health department and a local health department. In 2015, DOH achieved public health accreditation, a testament to its ability to effectively provide the essential public health services.

IMPORTANCE

Public health departments serve as role models, regulators, and conveners, also providing guidance for agencies and organizations serving residents to improve population health outcomes. Not only do public health agencies need to interact with all sectors to implement effectively the 10 essential services, its workforce must be properly qualified and prepared to achieve these goals. Further, decision-makers rely on robust data and analysis to inform policies and programs, and it is crucial for the public health agencies to support comprehensive data sharing and analysis capabilities.

Public Health Infrastructure

Components that enable public health departments to provide the essential services include:

- A capable and qualified workforce
- Up-to-date data and information systems
- Assessment of and response to public health needs[1]

Additionally, cross-sector partnerships are key in improving population health and addressing social determinants, from healthcare and public health to transportation, public safety, and housing.

OBJECTIVES AND TARGETS

PHI-1 Maintain public health accreditation for the District of Columbia Department of Health

Yes (2016)

Baseline (2015)	Yes
DC 2020 Target	Yes

PHI-2 Evaluate employees using public health core competencies in individual performance plans

No (2015)

Baseline (2010)	No
DC 2020 Target	Yes

RECOMMENDED STRATEGIES

PHI-I Create a program linking local universities that have public health programs (GWU and Hopkins) and public health agencies to keep professionals in the area and utilize student expertise through practicums and tailored classes.

PHI-II Increase multi-sector public, private and non-profit partnerships to further population health improvement through a coordinated focus on social determinants of health to advance health equity.

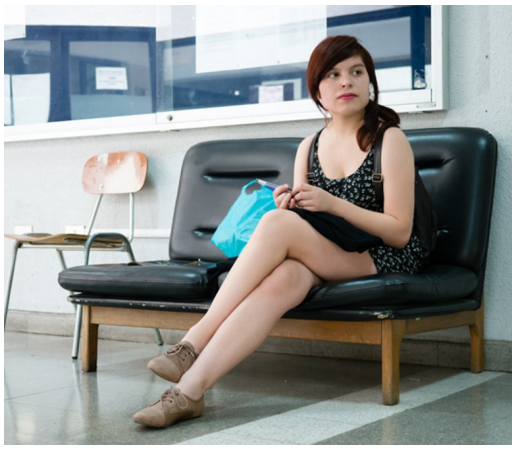
Sexually Transmitted Infections

GOALS

1) Community capacity and access to services allows for timely and comprehensive diagnosis and treatment of STIs and complications.
2) District residents are engaging in healthy sexual behaviors.
3) Stigma is reduced surrounding STIs.

BACKGROUND

Sexually transmitted infections (STIs) refer to more than 25 infectious organisms that are transmitted primarily through sexual activity.[41] Some of these infections, however, can also be transmitted non-sexually, such as from mother to infant during pregnancy or childbirth. Despite their burdens, costs, and complications, and the fact that they are largely preventable, STIs remain a significant public health problem in the United States as well as in the District of Columbia, where the rate of, for example, chlamydia is nearly double the national rate .[42]



Unlike chlamydia and gonorrhea, which predominantly affect youth and young adults (under 25 years of age) in 2013, almost two-thirds (62.2%) of primary and secondary syphilis cases were found in adults 30 years of age or older.[43]

IMPORTANCE

STDs cause many harmful, often irreversible, and costly clinical complications, such as:

- Reproductive health problems
- Fetal and perinatal health problems
- Cancer
- Facilitation of the sexual transmission of HIV infection[42]

While resources exist for disproportionately affected populations, more data related to screenings and reinfections in young people could help inform interventions to improve outcomes.

Sexually Transmitted Infections

Because many cases of STIs go undiagnosed—and some common viral infections, such as human papillomavirus (HPV) and genital herpes, are not reported to states at all—the reported cases of chlamydia, gonorrhea, and syphilis represent only a fraction of the true burden of STIs in the United States.

OBJECTIVES AND TARGETS

STI-1 Reduce new chlamydia infections among 13-24 year olds*

▲ 4418 (2013)

Baseline (2010)	4077
DC 2020 Target	3669

STI-2.1 Reduce gonorrhea reinfection rates in 13-24 year olds

Data Forthcoming

STI-2.2 Reduce gonorrhea cases in 13-24 year olds*

▲ 1446 (2013)

Baseline (2010)	1366
DC 2020 Target	1331

STI-3.1 Reduce transmission rate of syphilis (primary and secondary) (per 100,000)

▼ 23.8 (2013)

Baseline (2009)	25.3
DC 2020 Target	22.4

STI-3.2 Decrease transmission of syphilis among men who have sex with men (cases)

▼ 89 (2013)

Baseline (2009)	112
DC 2020 Target	82

STI-4 Increase regular screenings for genital Chlamydia in 13-24 year olds

Data Forthcoming

*Notes: Due to increased screening, reported numbers of infections may rise before they fall.

RECOMMENDED STRATEGIES

STI-I Increased screening for STIs, included as a part of preventive care checkups.

Sleep Health

GOALS

1) The public is knowledgeable about how adequate sleep and treatment of sleep disorders improve health, productivity, wellness, quality of life, and safety on roads, at home, and in the workplace.
2) Sleep deprivation is rare and sleep disorders appropriately treated.
3) Environments support healthy sleep for infants, children, and families.

BACKGROUND

It is estimated that 50 to 70 million Americans chronically suffer from a disorder of sleep and wakefulness, hindering daily functioning and adversely affecting health and longevity.[44]

Data are scarce, but sleep deprivation can have many causes including stress, excessive noise or light, the need to work multiple jobs to afford basic needs, or physical factors such as diet or exercise.

IMPORTANCE

The cumulative long-term effects of sleep deprivation and sleep disorders have been associated with a wide range of deleterious health consequences including an increased risk of hypertension, diabetes, obesity, depression, heart attack, and stroke. Increased public education and greater awareness of the burden of sleep loss and sleep disorders as well as scientific advances have poised the field of somnology and sleep medicine for great strides. However, advances will require an organized strategy to increase and coordinate efforts in training and educating the public, researchers, and clinicians, as well as improved infrastructure and funding for this endeavor.[44]

Sleep Health

OBJECTIVES AND TARGETS

SH-1 Decrease sleep-related infant deaths (per 1000 live births)

64.8 (2013)

Baseline (2010)	65.5
DC 2020 Target	59.0

SH-2 Increase the proportion of adults who get sufficient sleep

59.5% (2013)

Baseline (2013)	56.5%
DC 2020 Target	70.8%

SH-3 Increase the proportion of students in grades 9 through 12 who get sufficient sleep

Data Forthcoming

RECOMMENDED STRATEGIES

SH-I Advocacy for adoption of clinical guidelines for the evaluation, management, and long-term care of obstructive sleep apnea in adults (Adult Obstructive Sleep Apnea Task Force of the American Academy of Sleep Medicine).

SH-II Improve collaboration to create a streamlined strategy for increasing awareness and coordinating resources to improve sleep health.

MICH-I Increase the minimum wage to a living wage.

Social Determinants of Health

GOALS

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

BACKGROUND

The World Health Organization (WHO) defines social determinants of health as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems."[45] Examples of social determinants of health include, but are not limited to: socioeconomic conditions, social norms and attitudes, access to educational, economic, and job opportunities, access to health care services, quality of education and job training, racial segregation, exposure to crime, violence, and social disorder, language/literacy, and culture.[46] The social determinants of health drive an estimated 50% of a population's health outcomes.[47]

IMPORTANCE

The social determinants of health are the most significant drivers of differences in health outcomes (i.e., health disparities) and health inequities in the District of Columbia. Neighborhoods and communities with poor social determinants indicators typically have the worst health outcomes. Achieving health equity within the District will require a concentrated effort that engages a diverse group of public, private, and nonprofit entities – including both traditional health as well as non-health agencies – working together in multi-sector collaborative partnerships towards a shared Health in All Policies (HiAP) informed agenda. A HiAP approach recognizes that many factors beyond traditional healthcare impact health, and goes further than traditional public health activities.[48] By understanding and engaging the underlying social determinants of health, we can better address individual and population health and institute policies and programs across a variety of sectors that can drive health equity within the District.

OBJECTIVES AND TARGETS

SDH-1 Decrease proportion of persons living in poverty

18.2% (2014)

Baseline (2010)	18.5%
DC 2020 Target	16.7%

SDH-1.1 Decrease proportion of older adults aged 65+ years living in poverty

13.8% (2014)

Baseline (2010)	14.1%
DC 2020 Target	12.7%

Social Determinants of Health

OBJECTIVES AND TARGETS

SDH-1.2 Decrease proportion of children aged 0-17 years living in poverty

27.5% (2014)

Baseline (2010)	29.6%
DC 2020 Target	26.6%

SDH-2 Decrease proportion of households that spend more than 30% of income on housing

50.7% (2014)

Baseline (2010)	48.6%
DC 2020 Target	43.7%

SDH-3.1 Decrease racial segregation

29.2% (2014)

Baseline (2010)	35.4%
DC 2020 Target	24.5%

SDH-3.2 Decrease racial isolation

8.4% (2014)

Baseline (2010)	11.2%
DC 2020 Target	3.7%

SDH-4 Decrease unemployment rate

7.8% (2014)

Baseline (2012)	9.0%
DC 2020 Target	7.0%

SDH-5 Decrease economic food insecurity

12.9% (2013)

Baseline (2013)	12.9%
DC 2020 Target	11.6%

RECOMMENDED STRATEGIES

SDH-I 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.

MICH-I Increase minimum wage to a living wage.

SDH-II Restructure school resource allocation to align with an equitable model.

SDH-III Support mixed-income development and the production of affordable working and living space.

SDH-IV Maintain a mix of uses in neighborhoods, including affordable production space, to support the retention of well-paid manual, skilled and low-skill jobs for people with low-educational attainment and other barriers to jobs.

SDH-V Increase surveillance and data surrounding adult literacy levels.*

*Priority data development agenda action (See Appendix 2)

Substance Use

GOALS

1) Coping for mental health disorders occurs through healthy treatment and not substance use.
2) Alcohol and legally prescribed medications are used responsibly.
3) The growth, manufacture, transport, and use of illicit drugs is prevented.

BACKGROUND

In 2012, an estimated 23.1 million Americans aged 12 years and older required treatment for substance use.[49] Rates of adolescents using illicit drugs has increased from 2010-2012, though alcohol use is on the decline.[49] Overall, the District has a higher percentage of residents reporting use of illicit drugs (12.3%) vs. 8.8% nationally.[49,50]

In 2015, the District of Columbia decriminalized possession of small amounts of marijuana for residents 21 and over. Additionally, the District allows residents the use of medical marijuana prescribed by a physician. The new status of marijuana will bring additional legislation, regulation, treatment, and prevention strategies for a new legal substance, and may change usage patterns moving forward.

IMPORTANCE

The results of substance use manifest on the individual, family, and community levels. It can cause premature death, unemployment, childhood trauma, and, in some cases, death. It is often used as a coping mechanism for mental disorders, and stigma for both conditions as well as other barriers leave many without access to appropriate treatment.

OBJECTIVES AND TARGETS

SU-1 Decrease drug-induced deaths (rate per 100,000)

▲ 15.7 (2014)

Baseline (2010)	14.9
DC 2020 Target	11.3

SU-2 Decrease impaired driving

= 88 arrests (2014)

Baseline (2010)	88 arrests
DC 2020 Target	MIP*

SU-3 Decrease hospitalization rate due to substance use (rate per 100,000)

▲ 6.6 (2014)

Baseline (2012)	4.5
DC 2020 Target	4.5

*Monitor for Informational Purposes

Substance Use

OBJECTIVES AND TARGETS

SU-4.1 Increase proportion of high school seniors who have never used alcohol

29.0% (2012)

Baseline (2010)	30.7%
DC 2020 Target	33.0%

SU-4.2 Increase proportion of high school seniors who have never used marijuana

60.9% (2012)

Baseline (2007)	45.6%
DC 2020 Target	67.0%

SU-4.3 Increase proportion of high school seniors who have never used illicit drugs

30.4% (2012)

Baseline (2012)	30.4%
DC 2020 Target	33.4%

SU-5.1 Reduce alcohol use in adolescents grades 9-12

31.4% (2012)

Baseline (2010)	32.8%
DC 2020 Target	25.8%

SU-5.2 Prevent an increase in illicit drug use in adolescents grades 9-12

25.3% (2012)

Baseline (2010)	19.7%
DC 2020 Target	19.7%

SU-6 Reduce binge drinking in adults 18 and older

24.9% (2014)

Baseline (2011)	25.0%
DC 2020 Target	20.8%

SU-7.1 Decrease middle schoolers who have used synthetic cannabinoids (K2/Spice)

10.2% (2012)

Baseline (2012)	10.2%
DC 2020 Target	9.0%

SU-7.2 Decrease high schoolers who have used synthetic cannabinoids (K2/Spice)

20.0% (2012)

Baseline (2012)	20.0%
DC 2020 Target	18.0%

RECOMMENDED STRATEGIES

SU-I Limit alcohol outlet density and restrict hours/days when sale is permitted.

SU-II Improve population-level data infrastructure around non-medical use of prescription drugs.

Tobacco Use

GOALS

Illness, disability and death related to tobacco use and second hand smoke exposure are minimized.

BACKGROUND

Smoking causes cancer, heart disease, stroke, diabetes, and lung diseases such as COPD, emphysema and bronchitis. For every individual who dies from a smoking-related disease, an estimated 30 more individuals suffer with at least one serious illness related to smoking.[51]

The District has about the same percentage of current adult smokers as the nation (18.8% and 19%, respectively), though a higher percentage of middle school students smoke in the District. Males, adults aged 55-64 years, African Americans, adults with less than a high school education, people with household incomes less than $15,000 and residents of Ward 8 are more likely to be current smokers.[11,,50]

The most common source of secondhand smoke is cigarettes, followed by cigars, pipes and other tobacco products. Cigarettes contain more than 7,000 chemicals, hundreds that are toxic and approximately 70 that cause cancer. Exposure to secondhand smoke can occur within the home, car, workplace or public places such as recreational settings. E-cigarettes are an emerging modality perceived as less harmful than traditional cigarettes; however, there are similar risks associated with their use.[52]

IMPORTANCE

On average, smokers die 19 years earlier than nonsmokers. If the rates among youth smokers continue in the U.S., 5.6 million Americans younger than aged 18 years are estimated to die prematurely due to a smoking related illness.[51]

It is especially important to prevent initiation of tobacco product use among children and adolescents between the ages of 12 and 18 years as it will decrease the likelihood that they will become adult smokers. Often, behaviors such as drinking, smoking and risky sexual behaviors that begin before the individual becomes an adult will more likely result in behavior patterns that progress throughout adulthood.

OBJECTIVES AND TARGETS

TU-1 Reduce the proportion of adults who smoke cigarettes

16.4% (2014)

Baseline (2011)	20.8%
DC 2020 Target*	16.9%

*Target achieved

TU-1.1 Reduce the proportion of Black/African-American adults who smoke

26.0% (2014)

Baseline (2011)	30.8%
DC 2020 Target	19.8%

Tobacco Use

OBJECTIVES AND TARGETS

TU-1.2 Reduce the proportion of Hispanic adults who smoke

14.2% (2013)

Baseline (2012)	21.7%
DC 2020 Target	10.7%

TU-2 Reduce use of cigarettes by adolescents

13.8% (2012)

Baseline (2010)	12.5%
DC 2020 Target	11.3%

TU-3 Increase households protected by smoke-free rules

80.7% (2011)

Baseline (2011)	80.7%
DC 2020 Target	88.8%

TU-4 Reduce the early initiation of the use of tobacco products among children and adolescents in grades 9-12

9.7% (2012)

Baseline (2010)	8.3%
DC 2020 Target	7.5%

TU-5.1 Reduce use of e-cigarette products by High Schoolers

Data Forthcoming

TU-5.2 Reduce use of e-cigarette products by Middle Schoolers

Data Forthcoming

RECOMMENDED STRATEGIES

TU-I Actively promote adoption of smoke-free policies in all public and private multi-unit housing within the District.

TU-II Expand city-wide smoke-free areas to include private K-12 schools and universities.

TU-III Strengthen the enforcement of existing laws prohibiting smoking at bus stops.

TU-IV Improve surveillance of children exposed to secondhand smoke.

TU-V Increase the number and types of healthcare providers that refer patients for tobacco cessation interventions.

Conclusions

More than half of key population health outcomes in the District have been improving over time. Special attention can be paid to outliers to better understand strategies that work well and areas that need more resources/interventions. Programs and policies can be most impactful aligning with the recommended strategies and objectives included in this framework. Most importantly, community health improvement work does not end with the DC HP2020, rather it begins: more partners will make this framework even more relevant and useful for improving outcomes, and intentional gatherings to share data, discuss best practices and align services will help break down silos and improve the impact of interventions, ultimately improving health outcomes for District residents.

As more partners and stakeholders join the effort to improve population health, the evolution of the framework will continue to adapt to the expressed needs of the community. It will take on new/expanded forms and carry out the core functions as follows:

- The traditional public health paradigm of focusing on clinical care, disease burden, and health behaviors will expand to include social and physical determinants of health, allowing the community to frame and tackle recalcitrant public health issues using a health equity lens and collective impact.
- Gather more stakeholders and partners into the development process, facilitating the alignment of evidence-based strategies and interventions for a more impactful and holistic community health improvement plan.
- In Summer 2016, DC HP2020 framework data will be available via a robust, interactive website that will visualize data by topic area and allow users to further explore objectives and progress by geographic region, race/ethnicity, age, and sex.
- Population health outcomes will continue to be monitored over time and shared with stakeholders and the wider community.
- Partners will be encouraged to continue evaluating strategies and interventions to grow the evidence base and share best practices with others.

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Appendix I: Data Metrics and Notes

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)*	Notes
1. Access to Health Services (AHS)												
	AHS-1	Reduce percentage of residents without a place of care	When you are sick, where do you usually go for care or advice?	BRFSS					**14.9%**		**13.4%**	Those who answer "no place of care" (8.2%) or ER (6.7%)
	AHS-2	Increase percentage of residents who receive preventive care	% of those who have had a checkup within the last 12 months	BRFSS		**74.6%**	74.1%	73%	74%		**80.3%**	
	AHS-3	Reduce non-emergent emergency room (ER) visit rate	(ER visits x 1000)/(# of beneficiaries)	DHCF	286.3	**325.8**	329.3	337.1	342.8		**325.8**	Not age adjusted
	AHS-4	Reduce hospital readmission rates	(# of repeat hospital admissions within 30 days)/(# of beneficiaries)	DHCF	**9.8**	10.4	9.8	10.2	9.8		**8.8**	Not age adjusted
	AHS-5	Reduce non-emergent use of emergency medical services(EMS)	(Priority 3 calls (after medical evaluation))/(total EMS calls)	FEMS				**22.5**	21.2	15.6	**13.0**	Calendar years
	AHS-6.1	Increase patient satisfaction	Average hospital star rating out of 5	HCAHPS					**2**		**4**	Acceptable indicator for hospitals. No standard quality measure for FQHCs or community clinics.
	AHS-6.2	Reduce the proportion of all hospitals emergency department visits in which the wait time to see an emergency department clinician exceeds the recommended time frame	(# of hospitals with median wait times above 60 mins)/(total # of hospitals)	CMS					**57%**		**14%**	DC average: 55 min
2. Adolescent Health (AH)												
	AH-1	Reduce death rate among 10-24 year olds	(# of deaths among persons aged 10-24 years x 100,000)/(total population aged 10-24 years)	Vital records	**64.8**	72.6	71.3	47.5	45.9		**42.8**	
	AH-1.1	Reduce homicide death rate among 20-24 year olds	(# of deaths due to homicide among persons aged 20-24 years x 100,000)/(total population aged 20-24 years)	Vital records	36.3	**50.6**	46.9	35.6	37.6		**32.7**	
	AH-2.1	Increase the 4 year high school graduation rate	% of students who received a high school diploma within 4 years of entering 9th grade	Raise DC (OSSE)	**59%**	57%	62%	61%	65.4%		**68%**	2010 = SY2009/2010. Metric aligns with Raise DC, doesn't include IEP graduation rate

Away from target Toward target No change New data/No data

*Unless otherwise noted, targets were determined using either of the following methods: trendline projection, 10% increase from baseline, or alignment with the national Healthy People 2020 target.

Blue data points represents the baseline of each indicator.

Progress toward or away does not necessarily represent a statistically significant difference; rather, it is used for general illustration at this time.

Unless otherwise indicated, rates are age-adjusted.

2014 Vital Records data are preliminary and may change slightly after finalized.

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
2. Adolescent Health (AH) (cont.)												
	AH-2.2	Increase college graduation rate	(# of certified HS grads who enroll in college within 12 months and graduate from college (BA or AA) within 6 years of HS grad)/(# of certified HS grads who enroll in college within 12 months)	OSSE	**43% (2007/ 2008)**						**47.3%**	Data for SY2007-2008 via Raise DC Progress Report 2015, 10% from SY2007/2008
	AH-3.1	Increase 8th grade math proficiency	% of 8th grade students scoring "proficient" or "advanced" on DCCAS reading assessment/PARCC	OSSE	**11% (2009)**	17%		18%			**31.1%**	
	AH-3.2	Increase 8th grade reading proficiency	% of 8th grade students scoring "proficient" or "advanced" on DCCAS reading assessment/PARCC	OSSE	**14% (2009)**	16%		17%			**22.4%**	
	AH-4	Decrease suspensions (<10 days per year)	% of students suspended for <10 days under federal guidelines (drugs, alcohol, violence, weapons).	Learndc.org				**12%**			**10.8%**	Suspensions a better indicator as expulsions are so low.
	AH-5	Decrease the severity of youth offender crimes (%)	% of newly committed youth to DYRS with a felony offense type	DYRS		**47%**	44%	43%	40%		**27%**	FY2011-2014
3. Asthma (A)												
	A-1	Reduce deaths due to asthma	(# of deaths due to asthma x 1,000,000)/ (total population)	Vital records	**9**	6.4	13.6	9.6	7.7		**3.8**	
	A-2	Reduce emergency departments (ED) visits (rate) due to asthma	Asthma-related chief complaints	ESSENCE					**2845**	2919	**2561**	
	A-2.1	Reduce asthma-related emergency department (ED) visits in children	Asthma-related chief complaints in those under 18	ESSENCE						**478**	**430**	
	A-3	Reduce hospitalization due to asthma in adults	(ICD-9-CM code 493 in 18 and older)/(# of persons 18 and older)	Hospital Discharge	**226.1**	215.5	205.6	178.3			**91.3**	
	A-4	Reduce asthma prevalence	% diagnosed asthma in adults (18+)	BRFSS		10.1%	**14.7%**		11.5%		**10.1%**	
	A-4.1	Reduce asthma prevalence in adults age 65 or older	% diagnosed asthma in 65+	BRFSS		**12.6%**	11.2%	9.2%	7.2%		**8.3%**	
4. Blood Disorders and Blood Safety (BDBS)												
	BDBS-1	Reduce the number of persons who developed venous thromboembolism (VTE)	ICD-9 Codes: 453.2,453.40-42,453.50-52,453.6, 453.71-72, 453.74-77, 453.79, 453.81-87, 453.89)/total population	Hospital Discharge	**61.0**	70.1	62.0	61.0			**54.9**	
5. Cancer (C)												
	C-1	Decrease the death rate of breast cancer	(# of female deaths due to breast cancer x 100,000)/(# of female population)	DC Cancer Registry	**29.8**	26.3	31.1				**16.6**	
	C-2.1	Decrease the death rate of colorectal cancer	(# of deaths due to colorectal cancer x 100,000)/(total population)	DC Cancer Registry	**19**	19.3	12.3				**17.4**	
	C-2.2	Reduce the racial gap in colorectal cancer death rates (Black/White)	Black rate minus White rate	DC Cancer Registry		**17.7**	16				**7.4**	Disparity gap, not ratio. Target: return to 2009 value

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
5. Cancer (C) (cont.)												
	C-3.1	Reduce the colorectal cancer incidence rate	(# of cases x 100,000)/(total population)	DC Cancer Registry	**45.9**	43.7	39.9				**32.0**	
	C-3.2	Reduce the racial gap in colorectal cancer incidence rates (Black/white)	Black rate minus White rate	DC Cancer Registry		**29**	23.3				**16.4**	Disparity gap, not ratio.
	C-4	Decrease cervical cancer incidence	(# of cases due to cervical cancer x 100,000)/ (total population)	DC Cancer Registry	**9.5**	13.7	8.1				**8.6**	Cervical cancer incidence should be interpreted with caution due to low numbers.
	C-5	Increase early detection for all cancers	(# of cases in situ and local)/(# of diagnosed cases)	DC Cancer Registry	**48.4%**	51.8%	51.1%				**57**	Includes: Prostate, female breast, lung & bronchus, and colon & rectal.
	C-6	Reduce late-stage female breast cancer	(# of regional and distant diagnosis)/ (# of diagnosed cases)	DC Cancer Registry	**28.4**	29.8	27.2				**25.6**	
	C-7	Increase the proportion of adults who receive a colorectal cancer screening based on the most recent guidelines	Those 50+ years who have had a combination of blood stool test, sigmoidoscopy, and/or colonoscopy.	BRFSS					**67.9**		**74.7**	Metric is a CDC approved methodology that aligns with HP2020.
6. Diabetes (D)												
	D-1	Reduce the diabetes death rate	(# of deaths due to diabetes x 100,000 (ICD-10 codes E10-E14))/ (total population)	Vital records	**24.7**	25.6	24.2	17.5	19.4		**22.6**	
	D-2	Reduce the new cases of diagnosed diabetes in the population with low income	(# of diagnosed diabetes within the past year)/(Medicaid population)	DHCF		**21.0**	20.7	22.2	22.4		**18.6**	
	D-3.1	Increase the proportion of persons with diagnosed diabetes who have at least an annual eye exam	(% of those 18+ years with diagnosed diabetes who have at least an annual eye exam)	BRFSS		**81.9%**	79.1%	74.4%	72.9%		**87%**	
	D-3.2	Increase the proportions of persons with diagnosed diabetes who have at least an annual foot exam	(% of those 18+ years with diagnosed diabetes who have at least an annual foot exam)	BRFSS		76.9%	71.9%	79.5%	70.6%		**84.6%**	
	D-4	Reduce the proportion of persons with diabetes with an A1c value greater than 9 percent	(# of adults 18-75 with A1c value greater than 9%)/(# of adults (18-75 years) diagnosed with diabetes)	DOH-Million Hearts								Data coming in 2016
7. Disability Services (DS)												
	DS-1	Reduce the percentage of children in foster care placed in group homes/ congregate care	(# of children in foster care placed in group homes/congregate care)/(# of children in foster care)	CFSA	**7.3%**	6.2%	5.0%	4.3%	3.7%		**3.3%**	
	DS-2	Increase employment among people with disabilities	% of persons with a job in the community	NCI				**20%**			**22%**	
	DS-3	Increase the proportion of adults with disabilities who report sufficient social and emotional support		BRFSS	**67.9**						**74.7**	

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
8. Environmental Health (EH)												
	EH-1	Reduce "unhealthy" air quality index days	# of unhealthy air quality days (ozone levels at orange, red, or purple)	EPA AQI			24	1	6	8	**0**	Using the following meters: Takoma, McMillian, River Terrace, Aurora Hills, Alexandria
	EH-2	Reduce incidence of blood lead levels in children	# of cases (blood lead level > 5 ug/dL, <71 months of age)	DOEE	334		172				**155**	
	EH-3	Increase % of waterways that are considered "swimmable" and "fishable"	% of District river and stream miles that are impaired				0%	0%			**10%**	
	EH-4	Increase District Walkscore	Walkscore*	Walkscore.com			73		74		**77**	https://www.walkscore.com/methodology.shtml
	EH-5.1	Decrease injury rate associated with high heat index days	Heat stroke and hyperthermia chief complaints	ESSENCE						88		Monitor for informational purposes
	EH-5.1	Decrease injury rate associated with high heat index days	Heat stroke hospitalizations (992.0)	Hospital Discharge	0.59	0.69	0.93	0.57			**0.20**	
	EH-5.2	Decrease injury rate associated with extreme cold weather days	(Hypothermia chief complaints)/(DC population)	ESSENCE					42	45		Monitor for informational purposes
	EH-5.2	Decrease injury rate associated with extreme cold weather days	Hypothermia hospitalizations (991.6 and 778.3)/(total DC resident hospitalizations)	Hospital Discharge	3.27	0.73	1.14	2.28			**0.7**	
9. Food Safety (FS)												
	FS-1	Prevent an increase in confirmed cases of foodborne illnesses	(# of cases)*100,000/(total DC population)	DOH-DE-DSI	44.3	48.2	48.6				44.3	Not age-adjusted
	FS-1.1	Reduce confirmed infection of Salmonella transmitted commonly through food	(# of cases)*100,000/(total DC population)	DOH-DE-DSI	15.6	18.0	14.1				11.4	Not age-adjusted
	FS-1.2	Reduce confirmed infection of Shigella transmitted commonly through food	(# of cases)*100,000/(total DC population)	DOH-DE-DSI	5.8	6.3	4.9				2.1	Not age-adjusted
	FS-1.3	Prevent an increase in confirmed infection of Giardia transmitted commonly through food	(# of cases)*100,000/(total DC population)	DOH-DE-DSI	9.9	10.7	15.5				9.9	Not age-adjusted
	FS-1.4	Reduce confirmed infection of Campylobacter transmitted commonly through food	(# of cases)*100,000/(total DC population)	DOH-DE-DSI	10.4	11.3	12.2				8.5	Not age-adjusted
10. Foreign-Born Populations (FB)												
	FBP-1	Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) foreign-born populations							2		**4**	Currently, 2 collect (HRLA records, Census). Target to align with transgender national target.

*Walkscore determines the walkability of a city based on several factors. Scores range from 0-100. 70-89 is Very Walkable, where most errands can be accomplished on foot.

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
11. Healthcare-Associated Infections (HAI)												
	HAI-1	Maintain better-than-expected rate of central line-associated bloodstream infections (CLABSIs)	SIR*	NHSN	0.61	**0.67**	0.78				**<1**	Expected SIR is 1. Lower than 1 is better than expected for facility
	HAI-2	Maintain better-than-expected rate of catheter-associated urinary tract infections (CAUTIs)	SIR*	NHSN	1.032	**0.81**	1.339	1.32	0.976		**<1**	Expected SIR is 1. Lower than one is better than expected for facility.
	HAI-3	Decrease antibiotic resistant infections, specifically Methicillin-Resistant Staphylococcus Aureus (MRSA)	(# of reported MRSA (ICD-9 codes: 038.12, 041.12, 482.42)*100,000)/(DC population)	Hospital discharge	12.3	**15.3**	15.8	16.6			**13.6**	
12. Heart Disease and Stroke (HDS)												
	HDS-1	Reduce coronary heart disease deaths	(# of coronary heart disease-related deaths x 100,000 (ICD-10 codes 120-125))/(total population)	Vital records	153.4	134.0	141.0	133.8	131.2		**99.4**	
	HDS-1.1	Reduce heart disease death rate in non-Hispanic Black adults	(# of coronary heart disease-related deaths in non-Hispanic black adults x 100,000 (ICD-10 codes 120-125)/(total population)	Vital records	**192.7**	160.2	177.7	165.7	163.4		**128.3**	Target setting method: marriage of ambition and realism
	HDS-1.2	Reduce heart disease death rate in Hispanic adults	(# of coronary heart disease-related deaths in Hispanics x 100,000 (ICD-10 codes 120-125)/(total population)	Vital records	**91.7**	88.9	103	60.6	53.7		**49.6**	Target setting method: marriage of ambition and realism
	HDS-2	Reduce stroke deaths	(# of stroke-related deaths x 100,000 (ICD-10 codes 160-169))/(total population)	Vital records	**32.0**	34.5	34.9	30.2	33		**27.0**	Target setting method: used national data trendline to improve our data at the same rate
	HDS-3	Decrease ER visits related to heart disease	(# of ER visits related to heart disease x 1000)/(total Medicaid population)	DHCF	**4.5**	4.3	4.6	5.0	5.4		**3.9**	
	HDS-4	Reduce the proportion of adults with hypertension	(# diagnosed with hypertension)/(# adults (18+) DC population)	BRFSS		**30%**		28.4%			**26.9**	
	HDS-4.1	Increase the proportion of adults with hypertension whose blood pressure is under control	(those who have blood pressure reading below or equal to 140/90 (NQF-18))/(# of adults (18-85) diagnosed with hypertension))	DOH—Million Hearts				**53.8%**	63.2%		**69.5%**	
13. Hepatitis C (H)												
	H-1	Reduce mortality related to Hepatitis C infection	(# Hepatitis C-related deaths * 100,000/total population)	Vital Records	**3.8**	5.6	3.8	5.4	4.4		**3.4**	
	H-2	Increase access to and affordability of Hepatitis C treatment	(# of private carriers who classify Hep C treatment as Tier 2 + # who do not require pre-auth.)/(2 x #carriers)	DISB						**37.5%** (2016)	**62.5%**	Target represents that all carriers meet at least one of the desired criteria.

*Standard Infection Ratio (SIR) is a summary statistic used to measure relative difference in HAI occurrence during a reporting period compared to a common referent period (e.g., standard population). In HAI data analysis, the SIR compares the actual number of HAIs with the predicted number based on the baseline U.S. experience (e.g., standard population), adjusting for several risk factors that have been found to be most associated with differences in infection rates. (CDC)
A SIR of 1 means that the facilities are performing as expected based on their size and other factors. A SIR of less than 1 means they are performing better than expected.

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
14. HIV/AIDS (HIV)												
	HIV-1	Reduce deaths from HIV infection	(# of deaths (ICD-10 codes B20-B24))/(DC population)	Vital records	**20.4**	14.7	15.4	12.2			**13.2**	To measure prevention effectiveness
	HIV-2	Reduce the number of new HIV infections in all ages	(# of new infections)/(# of HIV individuals)	DOH-HAHSTA	**889**	738	678	553			**275**	Target: 50% reduction as part of 90/90/90/50 plan (from 2013 data point)
	HIV-3	Increase viral suppression among persons living with HIV	(# of HIV+ individuals with undetectable viral load)/(HIV+ individuals in care)	DOH-HAHSTA				**72%**	75%		**90%**	Target: 90% with viral load suppression as part of 90/90/90/50 plan
	HIV-4	Increase the number of HIV-positive persons who know their status	Estimate/Estimate	CDC				**89%**			**90%**	Currently developing methodology for doing internal estimates
	HIV-5	Increase those living with HIV who are in care	(# of HIV individuals who had at least one viral load and/or CD4 laboratory result reported during the specified year)/ (individuals living with HIV)	DOH-HAHSTA				**63%**	64%		**90%**	In care definition being refined, numbers may slightly change
15. Immunization and Infectious Diseases (IID)												
	IID-1.1	Reduce cases of Measles	# of reported cases	DOH-DE-DSI	**2 (2009)**	0	1				**0**	
	IID-1.2	Prevent increase in cases of Mumps	# of reported cases	DOH-DE-DSI	**2 (2009)**	2	2				**2**	
	IID-1.3	Maintain elimination of Rubella	# of reported cases	DOH-DE-DSI	**0 (2009)**	0	0				**0**	
	IID-1.4	Reduce cases of Varicella	# of reported cases	DOH-DE-DSI	**20**	20	18				**8**	
	IID-1.5	Prevent an increase in cases of Pertussis	# of reported cases	DOH-DE-DSI	**14**	10	26				**14**	
	IID-1.6	Prevent increase in cases of meningococcus	# of reported cases	DOH-DE-DSI	**1**	1	2				**1**	
	IID-1.7	Reduce new cases of Hep B	(# of reported cases)*100,000/(total population)	DOH-HAHSTA	89.1	**74.6**	55.1	61.5			**27.1**	Consider using 19 and older to align with national HP2020
	IID-1.8	Reduce cases of Tuberculosis	# of reported cases	DOH-HAHSTA			**5.8**	5.7			**3.3**	
	IID-2.1	Increase vaccination rates in school children		Immunization Registry					**83.2%**		**91.5%**	
	IID-2.2	Increase the percentage of children aged 19 to 35 months who receive the recommended doses of vaccinations	(DTaP, polio, MMR, Hib, Hepatitis B, varicella, and pneumococcal conjugate vaccine (PCV))/(DC population (aged 19-35 months)	National Immunization Survey	**66.2%**	73.1%	73.4%				**80.7%**	
	IID-2.3	Increase annual influenza vaccination rate		BRFSS		**37.7%**	36.9%	38.5%	41.3%		**41.3%**	

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
16. Injury and Violence Prevention (IVP)												
	IVP-1	Decrease crime rate	(Reported violent and property crime incidents x 100,000)/(total population)	MPD Crime Map			**5561.4**	5528.7	5823.3	5427.0	**5005.3**	
	IVP-1.1	Decrease homicide rate	Aligns with National HP2020 Metric	Vital records	17.1	15.5	**11.6**	12.0	14.0		**10.4**	https://www.healthypeople.gov/node/4764/data_details
	IVP-1.2	Reduce firearm-related death	# of firearm deaths	Vital records	14.0	11.8	**9.3**	8.8	11.8		**8.4**	
	IVP-2	Reduce fatal injuries	Aligns with National HP2020 Metric	Vital records	61.3	53.6	**51.4**	53.6	57.2		**46.3**	https://www.healthypeople.gov/node/4725/data_details
	IVP-2.1	Prevent an increase in poisoning deaths	(# of poisoning deaths x 100,000)/(total population)	Vital records	**15.0**	14.4	14.1	15.8	16.1		**15.0**	Preventing an increase
	IVP-2.2	Prevent an increase in fall-related deaths	Aligns with National HP2020 Metric	Vital records	10.3	8.0	**8.6**	10.0	9.9		**7.7**	https://www.healthypeople.gov/node/4752/data_details
	IVP-3	Reduce fire-related injury and death	(# occurrences of EMS response to smoke inhalation/burns x 100,000)/(total population)	FEMS				**44.3**	49.0	47.9	**39.9**	Excludes chemical burns
	IVP-4.1	Decrease pedestrian deaths	# of pedestrian deaths	DDOT	**13**	8	7	9			**3**	0 by 2024, Aligns with Vision Zero
	IVP-4.2	Decrease deaths associated with motor vehicles	Total traffic fatalities	MPD	25	**32**	19	29	26		**10**	0 by 2024, Aligns with Vision Zero
	IVP-5.1	Decrease bullying among Middle Schoolers	(% of students in grades 6-8 who have been bullied in the past 12 months)	YRBS	**27.9%**		29.9%				**25.1%**	
	IVP-5.2	Decrease bullying among High School-ers	(% of students in grades 9-12 who have been bullied in the past 12 months)	YRBS	**9.7%**		10.9%				**8.7%**	
	IVP-6	Reduce child abuse and neglect	# of substantiated and indicated reports of child abuse or neglect	CFSA	1430	**1050**	895	811			**528**	
17. Lesbian, Gay, Bisexual, and Transgender Health (LGBTH)												
	LGBTH-1	Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on (or for) transgender populations	# of population based data systems used to monitor HP2020 objectives that include at least one question that in-clude transgender populations						**2**		**4**	Currently, 2 collect (HAHSTA, Cen-sus).
	LGBTH-2	Increase the number of population-based data systems used to monitor Healthy People 2020 objectives which collect data on or for lesbian, gay, and bisexual populations	# of data systems that include at least one question that include lesbian, gay, and bisexual populations, or a specific reference to those populations					5	**4**		**12**	2013: 5 collected (YRBS, HAHSTA, Census, BRFSS, MPD)); 2014: BRFSS no longer collected
	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	% of students who have been harassed on school property one or more times during past 12 months	YRBS	**10.7%**		9.4%				**4.2%**	

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
18. Maternal, Infant, and Child Health (MICH)												
	MICH-1	Decrease infant mortality rate	(# of infant deaths 0-364 days x 1000)/(# of live births)	Vital records	**8**	7.4	7.9	6.8			**6.0**	
	MICH-2.1	Decrease total preterm births (%)	(# of infants borth before 37 completed weeks of gestation)/(# of live births)	Vital records	10.3%	**11%**	9.9%	10.6%	9.6%		**6.5%**	
	MICH-2.2	Increase births with (timely entry into) prenatal care	(DC Births with prenatal care in the 1st trimester)/(all DC births for which prenatal care status is known)	Vital records	70%	**66.8%**	65.2%	65.6%	68.3%		**78.4%**	Indicator moving in the wrong direction. Racial disparity getting worse.
	MICH-2.3	Increase abstinence from cigarette smoking among pregnant women	% of who quit smoking by first prenatal visit and stayed off cigarettes	WIC	**57.5%**	52.3%					**63.3%**	
	MICH-3.1	Increase exclusively breastfeeding for first 6 months of life	(% who exclusively breastfeed at 6 months)/(# of women surveyed)	CDC	**11.7%**	17.1%	14.8%	14.6%	17.3%		**21.1%**	CDC Breastfeeding Report card
	MICH-3.2	Increase breastfeeding support in maternity hospitals	mPINC Score*	CDC		**79**		80			**100**	
	MICH-4	Decrease the rate of child deaths	(# of deaths among children x 100,000 (aged 1-9 years))/(# of children 1-9)		**19.3**	12.9	20.6	21.0	23.1		**17.4**	
	MICH-5.1	Increase well-child visits	(# under age 21 with appropriate well-child visit(s) within the past year)/(beneficiaries under 21 years, eligible for at least 90 continuous days)	DHCF	81%	81%	**69%**	63%	63%		**76%**	Fiscal years. Rates dropped from FY2011-2012 due to change in the periodicity schedule for well-child visits.
	MICH-5.2	Increase well-woman visits	% women 18+ years who had visited the doctor for a routine checkup within the past year	BRFSS		**79.3%**			76.9%		**87.2%**	
19. Mental Health and Mental Disorders (MHMD)												
	MHMD-1	Decrease suicide rate	Aligns with National HP2020 Metric	Vital records	**6.9**	5.4	5.5	5.6	7.7		**5.0**	https://www.healthypeople.gov/node/4804/data_details
	MHMD-1.1	Decrease suicide attempts in High Schoolers	Attempt within past 12 months	YRBS	**11.5**		13.4				**10.4**	
	MHMD-1.2	Decrease suicide attempts in Middle Schoolers	Lifetime attempts	YRBS	**8.7**		10.2				**7.8**	
	MHMD-2	Reduce the proportion of adolescents aged 12 to 17 years who experience major depressive episodes (MDEs)	% of adolescents aged 12-17 years with MDEs	NSDUH	6.9	**6.5**	7.2	7.4			**5.8**	18+ data not available
	MHMD-3	Decrease hospital readmissions for mental health issues	% readmissions within 30 days of discharge	DBH	**8.6%**	8.8	10.7%	8.0%	9.9%		**8.1%**	
	MHMD-4	Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders*	(# of persons (aged > 18 years) with co-occurring substance abuse and mental disorders who receive treatment for both disorders)/(total population aged 18 years)	GAIN-SS								Data new, will be ready in 2016

*mPINC Score derives from a hospital survey that measures infant breastfeeding care processes, policies, and staff expectations in maternity care settings.

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
20. Nutrition, Weight Status, and Physical Activity (NWP)												
	NWP-1.1	Increase fruit consumption	% who consumed fruit one or more times a day	BRFSS				**64.7%**			**71.2%**	Monitored every other year
	NWP-1.2	Increase vegetable consumption	% who consumed vegetables one or more times a day	BRFSS				**78.0%**			**83.8%**	Monitored every other year
	NWP-2	Decrease the number of "food deserts"	# of USDA defined "food deserts" low-income and low-access at 1 mile	USDA					**9**		**0**	Current data (retrieved 7/30/15, updated 3/11/15) low income and low access at 0.5 mile: 59 deserts)
	NWP-3.1	Increase the rate of nutritionists/ dietitians practicing in the District	(# of actively practicing nutritionists and dietitians x 100,000)/(DC population)	DOH-HRLA	**2.1**	3.7	4.7				**15.0**	
	NWP-3.2	Include nutritionists/dietitians under Medicaid	Does Medicaid cover nutritionist/ dietitian visits?	DHCF	**No**	No	No	No			**Yes**	
	NWP-4.1	Reduce the proportion of children and adolescents who are considered obese	(# of school children and adolescents ages 3-20 who are considered obese)/ (total enrolled)	School Health Data			**18.5%**	18.6%	15.9%		**9.9%**	2012 is SY2012-2013, 2013 is SY2013 -2014, etc.
	NWP-4.2	Reduce the proportion of adults who are considered obese	(% of adults 18+ years considered obese)	BRFSS		**23.7%**	21.9%	22.8%	21.7%		**19.2%**	
	NWP-5	Decrease overweight rate in High Schoolers	% of high schoolers considered overweight	YRBS	**18%**		17%				**13%**	
	NWP-6.1	Increase physical activity levels in students in grades 9-12	(% of students who were physically active for at least 60 mins per day on five or more of the past seven days)	YRBS	**28.4%**		28.1%				**31.6%**	
	NWP-6.2	Increase physical activity levels in youth 18-24	(% of youth 18-24 who participate in any physical activities or exercise during past month)	BRFSS		**91.4**	86.7	79.1	75.8		**87.0%**	
	NWP-6.3	Increase physical activity levels in adults	(% of adults 18+ years who participated in any physical activities or exercise during past month)	BRFSS		**76.4%**	82.6%	79.2%			**88.6%**	2013 data= 100-those who did not participate in physical activity in last 30 days
21. Older Adults (OA)												
	OA-1	Improve overall health of older adults (50+)	(% of 50+ adults who rated their health status as good or better health)	BRFSS		**73.6%**	80%	76.9%			**90%**	
	OA-2	Increase seniors who participate in regular physical activity (50+)	(% of seniors 50+ who participated in physical activities in the past 30 days)	BRFSS		**72.4%**	74.5%	76.2%			**89.6%**	
	OA-3	Ensure all residents have access to parks and open spaces with 1/2 mile	Parkscore Index*	The Trust for Public Land					**72.0**	81.0	**100**	Parkscore scale is from 0-100.
	OA-4	Reduce the rate of emergency department visits due to falls among older adults (65+)	# of fall-related chief complaints in 65+	ESSENCE					**2053**	2798		Monitor for informational purposes
	OA-5	Prevent an increase in elder abuse	# of allegations for neglect, self-neglect, exploitation, abuse, or emergency	DHS			**892**	838	831		**892**	Reports are expected to increase before decreasing due to outreach.

*Parkscore Index measures park access (% residents living within 1/2 mile of park), park size (median park size and % of city area dedicated to parks), services (number of playgrounds per 10,000 residents), and investment (per capita park spending).

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
22. Oral Health (OH)												
	OH-1	Decrease number of emergency department visits related to oral health chief complaints	# of persons visiting ED with OH-related chief complaints*100,000/total population	ESSENCE					**318.6**	382.6	**286.7**	Not age-adjusted
	OH-2	Increase percentage of residents who receive preventive care	% adults 18+ years who have had a dental check up within the past year	BRFSS			71.1%		**70.8%**		**78.2%**	
23. Preparedness and Response (PR)												
	PR-1.1	Reduce the time necessary to issue official information to the public about a public health emergency.										Under development
	PR-1.2	Reduce the time necessary to activate designated personnel in response to a public health emergency.										Under development
	PR-1.3	Reduce the time for State public health agencies to establish after action reports and improvement plans following responses to public health emergencies and exercises.										Under development
24. Public Health Infrastructure (PHI)												
	PHI-1	Maintain public health accreditation for the District of Columbia Department of Health (DOH)	Is the DC DOH accredited by the Public Health Accreditation Board (PHAB)?	PHAB						Yes	**Yes**	
	PHI-2	Evaluate employees using public health core competencies in individual performance plans	Are DOH employees currently evaluated using public health core competencies?	PeopleSoft	**No**	No	No	No	No		**Yes**	
25. Sexually Transmitted Infections (STI)												
	STI-1	Reduce new Chlamydia infections among 13-24 year olds	# of reported new cases 13-24 year olds	DOH-HAHSTA	**4077**	5090	5092	4418			**3669**	
	STI-2.1	Reduce gonorrhea reinfection rates in 13-24 year olds	TBD	DOH-HAHSTA								Data forthcoming in 2016
	STI-2.2	Reduce gonorrhea cases in 13-24 year olds	# of reported cases 13-24 year olds	DOH-HAHSTA	**1366**	1753	1505	1446			**1331**	
	STI-3.1	Reduce transmission rate of syphilis (primary and secondary)	((# of reported primary cases + # of reported secondary cases) x 100,000)/(total DC population)	DOH-HAHSTA	**25.3 (2009)**	28.6	25.4	23.8			**22.4**	
	STI-3.2	Decrease in transmission of syphilis among men who have sex with men (MSM)	# of new cases of syphilis in MSM	DOH-HAHSTA	**112 (2009)**	103	109	89			**81.9**	
	STI-4	Increase regular screenings for genital Chlamydia in 13-24 year olds	(total # of denominator screened at least once in the measurement year)/(# of beneficiaries 13-24)	DHCF								Data forthcoming in 2016

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
26. Sleep Health (SH)												
	SH-1	Decrease sleep-related infant deaths	(# of infant sleeping deaths x 100,000)/ (# of live births)	OCME	**65.5**	53.8	85.4	64.8			**59**	Co-sleeping deaths report 2009-2013 by OCME
	SH-2	Increase the proportion of adults who get sufficient sleep	(# who get enough rest or sleep during the past 30 days)/(DC population 18+)	BRFSS				**56.5%**	59.5%		**70.8%**	
	SH-3	Increase the proportion of students in grades 0 through 12 who get suffi-cient sleep*	(# of 9-12 grades who sleep for more than 8 hours or more hours per night)/ (total population in grade 9-12)	YRBS								Data forthcoming (June 2016)
27. Social Determinants of Health (SDH)												
	SDH-1	Decrease proportion of persons living in poverty	% of people whose income in the past 12 months is below the poverty line	Census, ACS	**18.5%**	18.2%	18.5%	18.6%	18.2%		**16.7%**	Selected Economic Characteristics 2010-2014 ACS 5 Year Estimates
	SDH-1.1	Decrease proportion of older adults aged 65+ living in poverty	% of people 65+ whose income in the past 12 months is below the poverty line	Census, ACS	**14.1%**	14%	13.6%	14%	13.8%		**12.7%**	Selected Economic Characteristics 2010-2014 ACS 5 Year Estimates
	SDH-1.2	Decrease proportion of children aged 0-17 years living in poverty	Percentage of people under 18 years whose income in the past 12 months is below poverty line	Census, ACS	**29.6%**	28%	28.9%	28.75	27.5%		**26.6%**	Selected Economic Characteristics 2010-2014 ACS 5 Year Estimates
	SDH-2	Decrease proportion of households that spend more than 30% of income on rent	Gross rent as percent of household in-come (GRAPI) (30% or more)	ACS, 2014, 1 year estimates	**48.6%**	49.4%	48.1%	49.3%	50.7%		**43.7%**	
	SDH-3.1	Decrease racial segregation	(# of census tracts where Black popula-tion is 85% or more)/(total census tracts)	Census, ACS	**35.4%**	33.7%	33.1%	32.0%	29.2%		**24.5%**	2010 data point is based off 2006-2010 ACS population estimates, 2011 off 2007-2011, etc.
	SDH-3.2	Decrease racial isolation	(# of census tracts where Black popula-tion is less than 5%)/(total census tracts)	Census, ACS	**11.2%**	11.2%	10.1%	9.0%	8.4%		**3.7%**	2010 data point is based off 2006-2010 ACS population estimates, 2011 off, 2007-2011, etc.
	SDH-4	Decrease unemployment rate	Unemployment rate	Department of Labor	9.4%	10.2%	**9.0%**	8.5%	7.8%		**7.0%**	
	SDH-5	Decrease economic food insecurity	Those who worry or stress about finding nutritious meals usually or sometimes within past year	BRFSS				**12.9%**			**11.6%**	
28. Substance Use (SU)												
	SU-1	Decrease drug-induced deaths	(# of poisoning deaths related to drug-use)/(total population)	Vital records/ OCME	**14.9**	14.6	13.7	16.4	15.7		**11.3**	
	SU-2	Decrease impaired driving	# of arrests for impaired driving (drug/ alcohol)	MPD Crash Data	**88**	93	76	101	88			Monitor for informational purposes. Would like to improve metric in the future
	SU-3	Decrease hospitalization due to sub-stance use	(# of hospitalizations * 1000)/(# of bene-ficiaries)	DHCF	5.2	5.3	**4.5**	6.1	6.6		**4.5**	
	SU-4.1	Increase proportion of high school seniors who have never used alcohol	% of 12th grade students who report never using alcohol	YRBS	**30.7**		29				**33%**	

Progress	#	Objective	Metric	Data Source	2010	2011	2012	2013	2014	2015	Target (2020)	Notes
28. Substance Use (SU) (cont.)												
	SU-4.2	Increase proportion of high school seniors who have never used marijuana	% of 12th grade respondents who have never used marijuana	YRBS	**45.5% (2007)**		60.9%				**67%**	
	SU-4.3	Increase proportion of high school seniors who have never used illicit drugs	% of 12th grade respondents who have never used any illegal drugs	YRBS			**30.4%**				**33.4%**	
	SU-5.1	Reduce alcohol use in adolescents grades 9-12	% of adolescents in grades 9-12 reporting use of alcohol during the past 30 days	YRBS	**32.8%**		31.4%				**25.8%**	
	SU-5.2	Prevent an increase in illicit drug use in adolescents grades 9-12	% of adolescents in grades 9-12 reporting use of alcohol or any illicit drugs during the past 30 days	YRBS	**19.7%**		25.3%				**19.7%**	
	SU-6	Reduce binge drinking in adults 18 and older	% of persons engaging in binge drinking during the past 30 days—adults aged 18 years and older	BRFSS		**25%**	23.1%		24.9%		**20.8%**	
	SU-7.1	Decrease middle schoolers who have used synthetic cannabinoids (K2/Spice)	% of students who used K2 one or more times during their lifetime	YRBS			**10.2%**				**9%**	
	SU-7.2	Decrease high schoolers who have used synthetic cannabinoids (K2/Spice)	% of students who used K2 one or more times during their lifetime	YRBS			**20%**				**18%**	
29. Tobacco Use (TU)												
	TU-1	Reduce the proportion of adults who smoke cigarettes	% of smokers 18+	BRFSS		**20.8%**	19.6%	18.8%	16.4%		**16.9%**	
	TU-1.1	Reduce the proportion of Black/African American adults who smoke	% of current smokers who smoked at least 100 cigarettes in their life and now smoke every day or some days	BRFSS		**30.8%**	29.1%	28.4%	26%		**19.8%**	
	TU-1.2	Reduce the proportion of Hispanic adults who smoke	% of current smokers who smoked at least 100 cigarettes in their life and now smoke every day or some days	BRFSS		15.2%	**21.7%**	14.2%			**10.7%**	
	TU-2	Reduce use of cigarettes by adolescents (past month)	% of middle and high school who smoked one or more cigarettes per day in the past 30 days	YRBS	**12.5%**		13.8%				**11.3%**	
	TU-3	Increase households protected by smoke-free rules	% of households protected by smoke-free rules	STATE		**80.7%**					**88.8%**	
	TU-4	Reduce the early initiation of the use of tobacco products among children and adolescents in grades 9-12	% who smoked a whole cigarette before age 13	YRBS	**8.3%**		9.7%				**7.5%**	
	TU-5.1	Reduce use of e-cigarette products by High Schoolers		YRBS								Data forthcoming
	TU-5.2	Reduce use of e-cigarette products by Middle Schoolers		YRBS								Data forthcoming

Appendix 2: Data Development Agenda

Introduction

The purpose of a data development agenda is to improve quality and reliability of population-level health data. It provides the population-level health outcome objectives which have been deemed important through the DC Healthy People 2020 (DC HP2020) development process but have little reliable data. Agenda items are displayed as desired DC HP2020 objectives; however, there may be many ways to obtain and build the data infrastructure for each potential objective. Agenda items flagged as "Infrastructure" are health data infrastructure improvements that could give analysts and others access to many different types of health outcome data. By not sticking to traditional boundaries of current data availability, data infrastructure and surveillance systems can be molded to monitor population health based on desired health outcomes rather than limiting health outcome monitoring to current data infrastructure and surveillance. Through these suggested data improvements, new and different strategies can be developed to tackle problems where we had previous data gaps.

Agenda items flagged with an asterisk have been deemed "priority" data development objectives or infrastructure improvement. The data development agenda serves as a living document; as new information is uncovered or as data infrastructure improvements are made, we can shift objectives from the data development agenda to the DC Healthy People 2020 framework for continued monitoring.

Methodology

The DC Healthy People 2020 framework was developed using Results-Based Accountability. Stakeholders were gathered and organized into six working groups that met monthly over ten months (March 2015 – December 2015). For each of the twenty-nine topic areas, stakeholders identified overarching goals, measurable objectives, targets for the year 2020 and appropriate strategies to impact objectives. While determining which measurable objectives were the best proxies for the population-level goals of DC Healthy People 2020, data availability was not considered at first. Teams selected candidate objectives, and evaluated each one based on how well it measured the overarching health outcome goal (proxy power) and how good the existing data were in terms of quality and availability (data power). If a key objective was determined to have high proxy power but low data power, it became a part of the data development agenda.

For the prioritization activity, stakeholders were asked to vote among data development agenda items and objectives. If an agenda item received three or more votes, it was marked as "priority."

In the following agenda, the 40 items are categorized under their respective topic areas, arranged alphabetically. The following objectives were organized based on the prioritization activity. Following some items, a brief description is included to improve understanding.

Access to Health Services

1. **Increase standard quality measures for hospitals, FQHCs, and community clinics.*** ***(Infrastructure)***
   Ensure quality primary care and other comprehensive services to underserved areas or populations measure, monitor, and improve based on health outcomes.

Access to Health Services (cont.)

2. Increase availability of patient-level data on preventive services, patient-satisfaction and appropriate care.* *(Infrastructure)*

Standard quality measure data should be readily accessible to patients and others (online and upon request) and include patient satisfaction and appropriate care such as regulatory inspection, public satisfaction surveys, third party assessment, benchmarking outcomes indicators, etc.

3. Increase linguistically and culturally competent care.*

Quality and appropriate care measures should incorporate language and culture.

Blood Disorders and Blood Safety

4. Monitor sickle cell anemia incidence and prevalence (Infrastructure)

Understanding these key health outcome measures will guide research, better track this blood disorder, and improve appropriate health care services.

Cancer

5. Expand existing databases and tracking systems to include health equity factors (e.g. income, geographic factors, etc.)* *(Infrastructure)*

6. Increase the participation of the District's minority populations in clinical trials.

Having more of the minority populations in clinical trials allow researchers gain a better understanding of the health issues affecting all populations.

7. Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis.

Understand how well we are treating cancer via survivorship

Diabetes

8. Increase the proportion of persons with diagnosed diabetes who have at least an annual dental exam.

To complement comprehensive care that those with diabetes should receive (eye, foot, and dental exams)

Disability Services

9. Increase the proportion of youth with special care needs whose health care provider has discussed transition planning.

It is important for students and youth with special care needs to have a transition plan because it prepares them for career and post high school life.

Foreign-Born Populations

Increase linguistically and culturally competent care.* (included under Access to Health Services)

10. Increase surveillance of foreign-born individuals' health status.

11. Increase access to dental care for foreign-born individuals.

Improving data infrastructure surrounding preventive dental care access so populations who likely have different needs and experiences accessing preventive oral health services, such as foreign-born populations, can be identified.

12. Increase access to education for foreign-born populations.

Tracking education levels in home countries and translations to the U.S. educational and professional environment will allow for better needs assessments and educational advancements when tackling social determinants of health.

Heart Disease & Stroke

13. Increase early diagnosis of heart disease.

To improve monitoring and appropriate interventions before heart attack occurs.

14. Increase in early diagnosis of stroke.

To improve monitoring and appropriate interventions before a serious stroke occurs.

15. Decrease costs for heart disease and stroke care.

To measure cost benefits of interventions at a local level.

16. Reduce the proportion of adults with high total blood cholesterol levels.

To measure alongside blood pressure levels.

Injury and Violence Prevention

17. Decrease intimate partner violence.*

18. Decrease sexual violence.*

19. Increase the number of states and the District of Columbia that link data on violent deaths from death certificates, law enforcement, etc.* (Infrastructure)

20. Reduce firearm-related injury.*

Firearm-related death data are more available than injury-related data.

Maternal, Infant, and Child Health

21. Increase the proportion of children with special health care needs who have access to a medical home.*
A medical home is the center of a child's medical needs. Currently, it is the model of a partnership between the patient, family, healthcare provider, and specialists from the community. Data is needed to better track this population.

Mental Health and Mental Disorders

22. Decrease childhood trauma.*
For example, one-time events or sustained events that could lead to childhood trauma include physical or emotional abuse, community or family violence, homelessness, and/or housing instability.

23. Increase the proportion of primary care physician office visits where patients are screened for depression.
Depression screening can increase early diagnosis and appropriate treatment and mental health outcomes.

Nutrition, Weight Status, and Physical Activity

24. Increase the total contribution of vegetables to the diets of the population aged 2 to 17 years.*
To complement data related to adult vegetable consumption.

Older Adults

25. Increase residents who age in place.*
Aging in place is a term for individuals who live independently at home even as they grow older.

26. Increase access to primary, urgent, and long-term care for older adults.
Some data exist for primary and urgent care access, but more comprehensive data that also include long-term care access is needed.

27. Reduce the proportion of preventable deaths in persons with diagnosed Alzheimer's disease and other dementia.
Alzheimer's death data exist, but could be improved by understanding preventable deaths.

28. Increase older adults (50+) who volunteer or participate in civic activities.

29. Increase access to technology for older adults.

30. Reduce the rate of Emergency Department (ED) visits due to falls among older adults.
Improve access to ED data to complement syndromic surveillance.

Oral Health

31. Reduce the proportion of children and adolescents with untreated dental decay.
Little local data exist.

32. Reduce the proportion of children and adolescents who have dental caries in their primary or permanent teeth.

33. Increase the proportion of children, adolescents, and adults who used the oral health care system in the past year.
Data for adults is monitored every two years by BRFSS, but data could be improved and extended to access for children and adolescents, especially vulnerable sub-populations such as children with special health care needs.

34. Increase the proportion of children and adolescents who have received dental sealants on their molar teeth.

Public Health Infrastructure

35. Increase data sharing and open data policies.* (Infrastructure)

36. Increase the percentage of public health employees meeting or exceeding performance plan competencies.

Social Determinants of Health

37. Increase literacy levels.*
No population-wide (or near population-wide) literacy levels data were identified.

Substance Abuse

38. Reduce the past year non-medical use of drugs.

39. Decrease hospital readmissions due to heroin/opioid overdose.

Tobacco Use

40. Reduce the proportion of children aged 3 to 11 years exposed to secondhand smoke.*
Age group aligns with the national Healthy People 2020 framework.

Appendix 3: Full Stakeholder List

DC Healthy People 2020 development was a collaborative process and the framework is considered a shared community agenda. The District of Columbia would like to acknowledge and thank the following individuals for their participation in and commitment to this important process.

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Appendix 4: List of Acronyms

AARP	American Association of Retired Persons
ACS	American Community Survey
AQI	Air Quality Index
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CAUTI	Catheter-associated urinary tract infections
CDC	Centers for Disease Control and Prevention
CFSA	DC Child and Family Services Agency
CHA	Community Health Administration (DOH)
CLABSI	Central line-associated bloodstream infections
CMS	National Centers for Medicare and Medicaid
CPPE	Center for Policy, Planning and Evaluation (DOH)
DBH	DC Department of Behavioral Health
DC HP2020	District of Columbia Healthy People 2020
DCHA	District of Columbia Hospital Association
DDA	Data Development Agenda
DDOT	District of Columbia Department of Transportation
DE-DSI	Division of Epidemiology-Disease Surveillance and Investigation
DHCF	DC Department of Healthcare Finance
DHS	DC Department of Human Services
DISB	DC Department of Insurance, Securities, and Banking
DOEE	DC Department of Energy and the Environment
DOH	DC Department of Health
DYRS	DC Department of Youth Rehabilitative Services
EPA	Environmental Protection Agency
ESSENCE	Electronic Surveillance System for the Early Notification of Community-Based Epidemics
FEMS	Fire and Emergency Medical Services
FQHC	Federally Qualified Health Centers
GAIN-SS	Global Appraisal of Individual Needs Short Screener
HAHSTA	HIV/AIDS, Hepatitis, STD, and Tuberculosis Administration
HCAHPS	Hospital Consumer Assessment of Healthcare Providers & Systems
HCV	Hepatitis C Virus
HEPRA	Health Emergency Preparedness and Response Administration (DOH)
HP2020	National Healthy People 2020
HRLA	Health Regulation and Licensing Administration (DOH)
K2/Spice	Terms used for commercially sold synthetic cannabinoids
IMR	Infant Mortality Rate
LGB	Lesbian, Gay and Bisexual
LGBT	Lesbian, Gay, Bisexual, and Transgender
LGBTQ	Lesbian, Gay, Bisexual, Transgender, and Queer/Questioning
LBGTQAI	Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, Asexual and Intersex
LHI	Leading Health Indicator
MPD	DC Metropolitan Police Department
MRSA	Methicillin-Resistant Staphylococcus Aureus
NCI	National Core Indicators
NHSN	National Healthcare Safety Network
NSDUH	National Survey on Drug Use and Health

OCME	DC Office of the Chief Medical Examiner
OSSE	DC Office of the State Superintendent for Education
PHAB	Public Health Accreditation Board
PLWH	Person Living with HIV
PTA	Priority Topic Area
STAR	Sustainability Tools for Assessing and Rating
STATE	State Tobacco Activities Tracking and Evaluation
USDA	United States Department of Agriculture
WIC	Women, Infants and Children
WISH	Women Into Staying Healthy
YRBS	Youth Risk Behavioral Survey

Topic Area Abbreviations:

AHS	Access to Health Services
AH	Adolescent Health
A	Asthma
BDBS	Blood Diseases and Blood Safety
C	Cancer
D	Diabetes
DS	Disability Services
EH	Environmental Health
FS	Food Safety
FBP	Foreign-Born Populations
HAI	Healthcare-Associated Infections
HDS	Heart Disease and Stroke
H	Hepatitis C
HIV	Human Immunodeficiency Virus
IID	Immunization and Infectious Diseases
IVP	Injury and Violence Prevention
LGBTH	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
PR	Preparedness and Response
PHI	Public Health Infrastructure
STI	Sexually Transmitted Infections
SH	Sleep Health
SDH	Social Determinants of Health
SU	Substance Use
TU	Tobacco Use

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