



# DC Health Equity Summit 2021 Summary



Dear District Residents & Partners,

I am pleased to share this summary report of the DC Health Equity Summit 2021, which was planned and hosted by District of Columbia Department of Health (DC Health) Office of Health Equity, in collaboration with the Mayor's Commission on Health Equity and the Mayor's Office of Racial Equity. The Summit's theme, "Building the Roadmap to a Just Post-Pandemic Future," attracted a virtual audience of over 500 participants, who engaged with panelists and speakers that brought a breadth of multisectoral insights, challenges, and solutions to the conversation. A full spectrum of 20 participating partners included 11 government agencies, three (3) academic institutions, four (4) foundation and non-profit organizations, and representation from the DC Business community.

DC Health confirmed the first coronavirus case in Washington, DC on March 7, 2020. The City's public health workforce has been relentless in efforts to develop, implement, and provide guidance and resources to help mitigate the spread of the virus as well as the pandemic's far-reaching impacts. With the pre- and during- pandemic context as the backdrop, the inaugural Health Equity Summit aimed to disentangle and highlight the interrelated nature of social and structural determinants of health, exploring lessons from the COVID-19 emergency, underscored by the differential impacts across the Nine-Key Drivers of Opportunities for Health: education, employment, income, housing, transportation, food environment, medical care, outdoor environment, and community safety.

The challenges, experience and disparate outcomes of the pandemic in the District have, if nothing else, underscored the necessity to apply an equity-informed structural analysis to our work going forward. We know too, that in order to eliminate disparities in health outcomes, our collective actions must be intentional in three key areas: assuring access to quality healthcare, addressing social and structural determinants of health, and sustained action on structural and institutional racism. In keeping with the theme of building a just post-pandemic future, the Summit created space to focus intentionally on the key drivers of health beyond healthcare, exploring both lessons learned, as well as leveraging opportunities to disrupt persistent inequities and structural barriers.

This Summit report captures highlights from the Summit, distills key insights and takeaways, and assembles six recommended actions as the foundation for building our shared roadmap. DC Health is committed to engaging public, private, and non-profit partners to maintain momentum that leverages an equity-informed whole-of-community approach to drive collective actions for change.

Undoubtedly, the pandemic has presented us with many challenges, but it has also underscored the importance of prioritizing justice, unity, and the fierce urgency of now. Per Dr. Martin Luther King Jr.'s insights on why we can't wait, "We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly, affects all indirectly." Working together, with concern for the wellbeing of our neighbors, we demonstrated what can be accomplished when we are committed to the same goals. Our coordination and collaboration across sectors and branches of government to address the public health emergency gives me much optimism. Indeed, it demonstrates that we are a community committed to HOPE – health, opportunity, prosperity, and equity – for all.

Be Well,



LaQuandra S. Nesbitt, MD, MPH  
Director



# Acknowledgements

**Government of the District of Columbia**

Muriel Bowser, Mayor

## **Department of Health**

**Office of the Director**

LaQuandra S. Nesbitt MD, MPH, Director

**Office of Health Equity**

C. Anneta Arno, PhD, MPH, Director

## **Summit Leadership**

**The Commission on Health Equity**

Autumn Saxon-Ross, PhD, Chair

**Office of Health Equity**

C. Anneta Arno, PhD, MPH, Director & Summit Chair

**Mayor's Office of Racial Equity**

Amber Hewitt, PhD, Director & Summit Co-Chair

**Prepared by**

Makeda Vanderpuije, MPH CPH, Program Manager, OHE



## SUMMIT PARTNERS

DC Health wishes to thank all 20 participating partners that brought a breadth of multi-sectoral insights to the conversation: 11 government agencies; three (3) academic institutions; four (4) foundation and non-profit organizations; as well as representation from the DC business community:

The Commission on Health Equity;

*District Government Agency Partners:*

- Department of Human Services (DHS);
- Department of Employment Services (DOES);
- DC Public Schools (DCPS);
- Department of Parks & Recreation (DPR);
- Mayor's Office of Racial Equity within the Office of the City Administrator;
- Office of Neighborhood Safety and Engagement (ONSE);
- Department of Energy & Environment (DOEE);
- Metropolitan Police Department (MPD);
- Fire & Emergency Medical Services (FEMS);
- Department of Insurance Securities & Banking (DISB); and
- DC Water

*Academic Partners:*

- Howard University, Office of the President and Howard University College of Medicine;
- Milken Institute School of Public Health at The George Washington University; and
- Satcher Health Leadership Institute, Morehouse School of Medicine

*Foundations & Non-Profit Partners:*

- Grantmakers in Health;
- if, A Foundation for Radical Possibility;
- Health Impact Project at Pew Charitable Trusts; and
- Latin American Youth Center

*Business Community Representative:*

- DC Chamber of Commerce

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# **PART 1: ABOUT THE SUMMIT & SUMMIT SUMMARY**

## PLANNING THE SUMMIT

Convened in mid-2017, the Commission on Health Equity has long envisioned hosting a Health Equity Summit for the District, exploring progress on the application of an equity lens since release of the inaugural Health Equity Report for the District of Columbia in early 2019. Community Conversations across the District's eight (8) wards started a dialogue with residents in 2019, before in-person engagement opportunities were halted by the pandemic. Hosting the inaugural DC Health Equity Summit 2021 marks a significant milestone, enabling a timely conversation focused not only on the impact of the COVID-19 pandemic, but importantly, what we've learned, including insights and innovations that will inform our equity practice going forward. DC Health values the work of the Commission and their partnership in delivery of the Health Equity Summit 2021.

Recognizing the inextricable relationship between the persistence of health inequities and racism in the US, DC Health's Office of Health Equity engaged the Mayor's Office of Racial Equity within the Office of the City Administrator as a co-host and collaborator for the inaugural DC Health Equity Summit. The Office of Health Equity appreciates our collaborative partnership, which broadens our application of a structural and institutional racism lens, enhances perspectives on the multitude of intersectional identities represented in DC, and illustrates the complementary role of racial equity efforts in addressing health inequities.

Special thanks from the Office of Health Equity to Mayor Muriel Bowser and Dr. LaQuandra S. Nesbitt, Director DC Health, for their leadership. The Health Equity Summit co-chairs, Dr. C. Anneta Arno, Director, Office of Health Equity, and Dr. Amber A. Hewitt, Director, Mayor's Office of Racial Equity, would also like to thank the following members of the summit planning committee:

- Dr. Autumn Saxton-Ross, Chair, Commission on Health Equity
- Dr. Christopher King, Commissioner, Commission on Health Equity
- Ms. Tiffany Wilson, Thrive by Five, Executive Office of the Mayor
- Dr. Chikarlo Leak, Mayor's Office of Racial Equity
- Ms. Carmen Berry, Mayor's Office of Racial Equity
- Ms. Makeda Vanderpuije, Office of Health Equity, DC Health
- Ms. Fara Clarke, Office of Health Equity, DC Health
- Dr. Kimberley Henderson, Director, Office of Communication & Community Relations, DC Health
- Ms. Monica Casanas, Office of Communication & Community Relations, DC Health
- Mr. James Tyll, Office of Communication & Community Relations, DC Health

# ABOUT THE SUMMIT

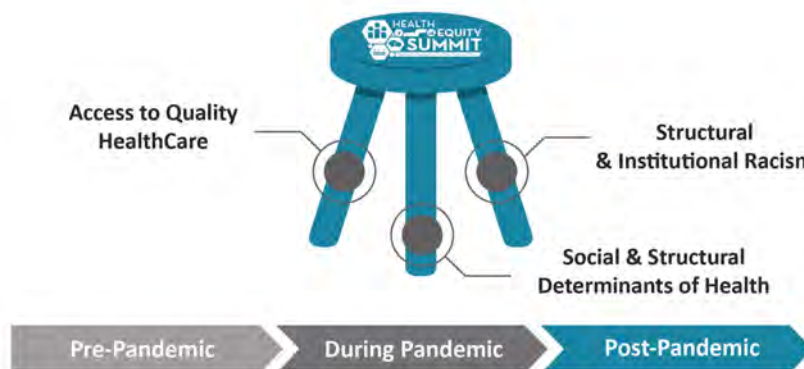
The inaugural DC Health Equity Summit was convened on December 9, 2021. The Summit was planned and hosted by DC Health's [Office of Health Equity \(OHE\)](#), in collaboration with the [Mayor's Office of Racial Equity](#) within the Office of the City Administrator, and focused on the theme "Building the Roadmap to a Just Post-Pandemic Future".

The Summit was broadcast live to a virtual audience of over 500 attendees on the Run the World online platform and Facebook Live. Summit Session videos are available on DC Health's [YouTube](#) Page.

“In order to eliminate disparities in health outcomes, our collective actions must be intentional in three key areas:

- access to quality health care;
- social and structural determinants of health; and,
- structural and institutional racism.<sup>1</sup>

-Dr. LaQuandra S. Nesbitt, Director, DC Health



**Figure 1.1. Post Pandemic 3-Legged Equity Stool**

The Summit's focus was on the 2nd and 3rd legs of the post-pandemic three-legged stool. Leaders across sectors discussed how persistent inequities impact District residents' opportunities for optimal health and how collectively, we can build a post-pandemic path that will inform and advance equitable strategies for the benefit of all.

## SUMMIT FOCUS

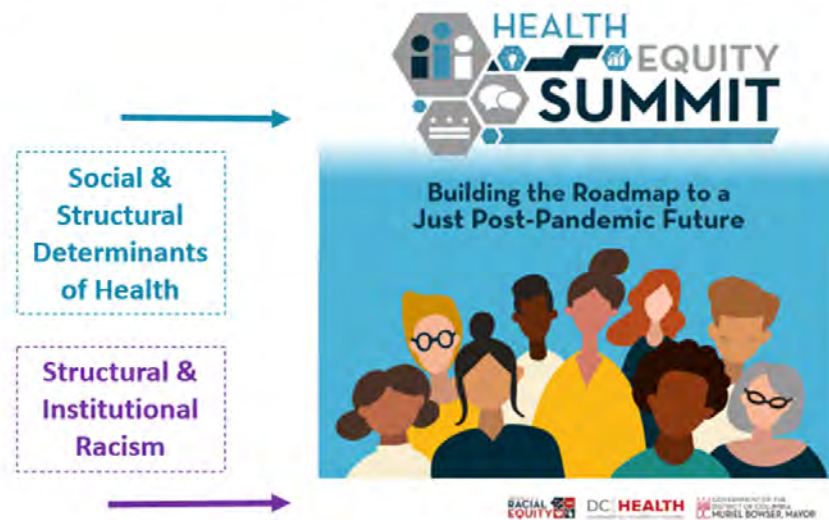


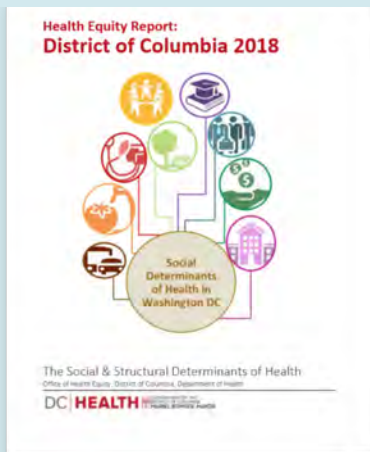
Figure 1.2. DC Health Equity Summit Focus

## SUMMIT CONTEXT - PRE- PANDEMIC

In February of 2019, DC Health released the inaugural [Health Equity Report for the District of Columbia \(DC HER 2018\)](#).<sup>2</sup> The document includes a baseline assessment of social and structural determinants of health in the District, highlighting stubbornly unequal outcomes among residents by income, place, and race across Nine Key Drivers of Opportunity for Health.

Patterns of differential health opportunities were illustrated through use of a 51-statistical neighborhood method of analysis, providing greater granularity and understanding of how these drivers impact community health at the hyper-local, sub-Ward level.

DC HER 2018 aimed to reframe the discussion of how to improve health and wellbeing for all Washingtonians beyond the limits of the traditional healthcare ecosystem, which we know accounts for only 20% of community health outcomes. The conversations that followed have catalyzed a District-wide paradigm shift towards proactive, strategic collaboration across sectors to advance health equity.





## SUMMIT CONTEXT - DURING PANDEMIC

DC Health confirmed the first coronavirus case in Washington, DC, on March 7, 2020. The city's public health workforce has been relentless in efforts to develop, implement, and provide timely guidance and resources to help mitigate the spread of the virus as well as the pandemic's far-reaching impact.



DC Health's [COVID-19 Health and Health Care Pandemic Recovery Report](#)<sup>3</sup> (May 2021) outlines the District's current and emergent health needs and presents a framework for post-pandemic health and healthcare system recovery . By design, the report's recommendations to improve the District's health system across five domains—workforce, healthcare facilities, health information technology, health planning, and community health services—are intentionally rooted in health equity.

This overview of the changes and trends observed across the health care landscape in the first 16 months of the pandemic, along with lessons learned, future directions, and recommendations, provides an important contextual and strategic foundation for building an equity-driven healthcare sector and promotes efforts not just to rebuild and restore, but to advance population health.

“The challenges, experience, and disparate outcomes of the pandemic in the District, have, if nothing else, underscored the necessity to apply an equity informed, structural analysis to our work going forward.<sup>1</sup>

”

**BEYOND HEALTHCARE - THE DC HEALTH EQUITY SUMMIT 2021**

DC Health’s ongoing public health and epidemiological leadership on the coronavirus pandemic, informed by the application of an equity lens, has underscored the necessity of engaging a multi-pronged approach to transformational change. Specifically, our collective actions must be intentional, with respect to all legs of the post-pandemic three-legged equity stool. While the COVID-19 Health and Health Care Pandemic Recovery Report focused intentionally on access to quality care, attention must be paid to the social & structural determinants of health, as well as structural & institutional racism in light of insights and opportunities generated by COVID-19. These two critical legs were the focus of the inaugural DC Health Equity Summit.

With the pre- and during- pandemic context as the backdrop, the inaugural DC Health Equity Summit 2021 was framed around the theme “Building the Roadmap to a Just Post-Pandemic Future.” The event aimed to disentangle and highlight the interrelated nature of social and structural determinants of health—exploring lessons from the coronavirus pandemic, the persistence of structural and institutional racism, and the creation of opportunities to disrupt those forces. A Health-in-All-Policies (HiAP) framework has been deployed by leaders of public and private District organizations across all nine (9) key drivers of opportunity for health, and beyond.

## SUMMIT SUMMARY AND RECOMMENDATIONS:

The following exhibits (Figures 1.3 through 1.11), provide a high-level graphic summary of the summit proceedings, concluding with a table of key recommendations. Immediately following is Figure 1.3, Differential Impacts of COVID-19, which summarizes many of the impacts of the pandemic through a Social and Structural Determinants of Health (SSDH) lens, in relation to DC Health's Nine (9) Key Drives of Health framework. Figures 1.4 through 1.10 share seven graphic illustrations, which highlight the content and key themes of the various summit sessions. Finally, Figure 1.11, DC Health Equity Summit 2021 Recommendations, provides a summary of six actions, with supporting themes, takeaways and insights.

For details on the background to the Summit, please see Part 2 of this report (page 24). For details on the Summit proceedings, including individual panels and quotes from participating speakers, please see Part 3 (page 40). Finally, details on the key insights, conclusions from the summit, as well as recommendations are provided in Part 4 (page 64). Based on the insights, themes, and takeaways from the DC Health Equity Summit 2021, DC Health will lead the development of a shared roadmap, which will engage public, private, and nonprofit partners, leveraging an equity-informed whole-of-community approach to drive collaborative actions for change. The structure and process envisioned will be informed by the six recommended actions below, as detailed in Figure 1.11 (page 23):

## HEALTH EQUITY SUMMIT 2021 RECOMMENDED ACTIONS

- Sustain Whole-of-Community Response
- Promote Culture of Wellness & DC HOPE (health, opportunity, prosperity, equity)
- Repair the Past to Transform the Future
- Prioritize Community-Engaged Practices
- Leverage Policy & Practice Change Momentum
- Anchor Collaborative Action

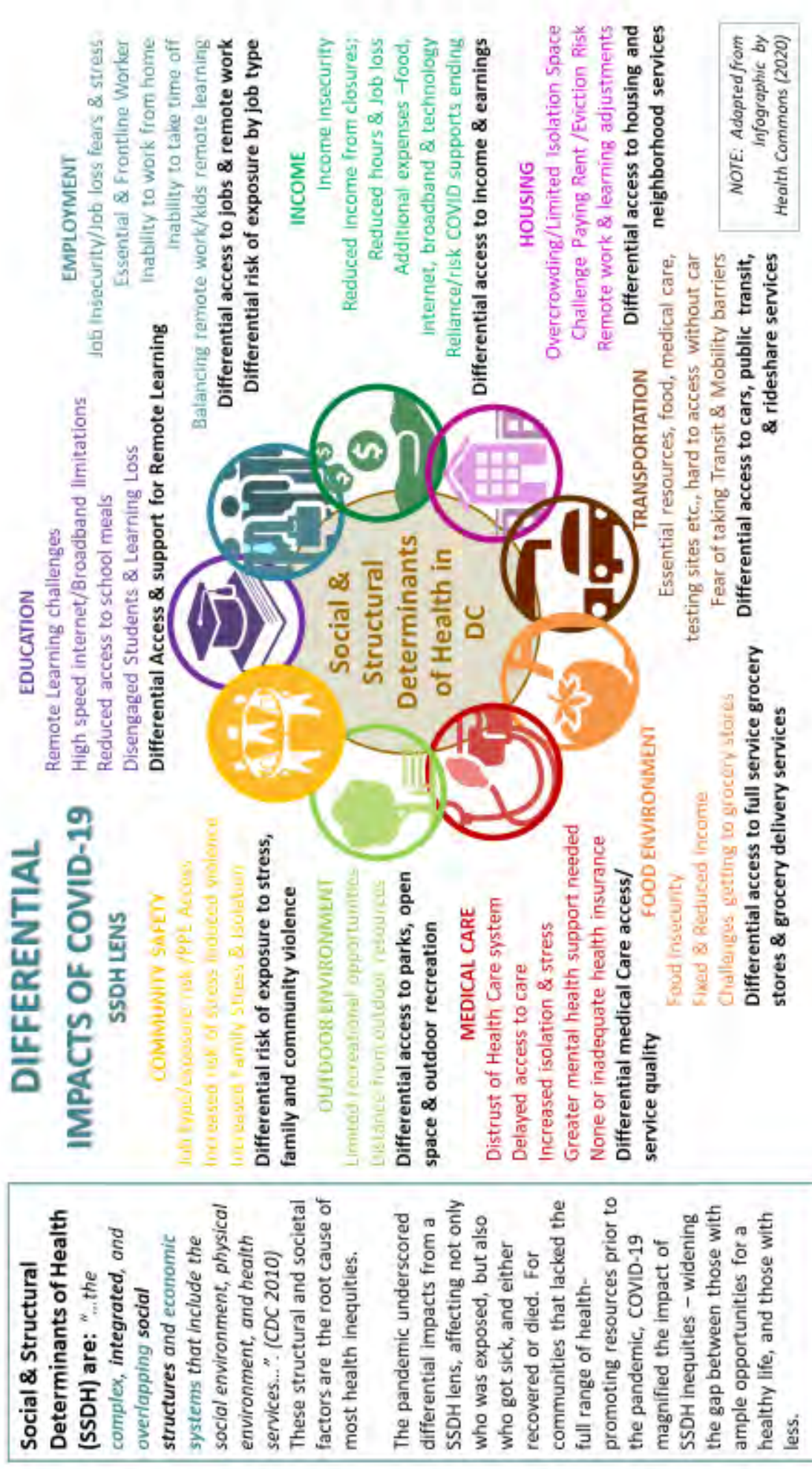


Figure 1.3. Differential Impacts of COVID-19: Nine (9) Key Drivers and Social & Structural Determinants of Health (SSDH) Lens<sup>5</sup>





**ENGAGED  
GPS**



**KEYNOTE**

**DANIEL  
DAWES,  
J.D.**

HOW CAN WE  
REPAIR THE  
PAST OF  
HEALTH INEQUITY?



RESOURCES DIFFER  
GREATLY DOWNRIVER



POLITICAL  
DETERMINATES  
OF RACISM  
GOES FROM THE  
ROOTS TO EVERY  
BRANCH

WHEN THE ROOTS ARE  
STRONG AND JUST,  
THE FRUIT IS SWEET

POLICIES WERE  
REVISED BUT  
KEPT NEUTRAL  
AS TO RACE

U.S. WAS  
RANKED  
**43<sup>RD</sup>**  
IN LIFE  
EXPECTANCY  
GLOBALLY  
(PRE-COVID)  
IN SPITE OF  
CONSUMING  
THE MOST  
HEALTH CARE  
COSTS

INTENTIONAL  
SEGREGATION  
IN D.C.



Figure 1.4. Graphic Illustration - Keynote 1a: Daniel Dawes, J.D.





# KEYNOTE

DANIEL DAWES, J.D.



DRIVING FORCES OF DIVISION:

- ★ PROPERTY TAXES
- ★ MORTGAGE RATES

HOW CAN WE DEMONSTRATE THE VALUE OF INFLUENCING CHANGE?

FIGHT RESTRICTIVE VOTING LAWS

75

YEARS PASSED BETWEEN BEN FRANKLIN'S ATTEMPT TO LEGISLATE RACIAL EQUITY AND ABE LINCOLN'S EMANCIPATION PROCLAMATION

WE CAN'T GO BACK TO NORMALCY, AS IT HAS HISTORICALLY **FAILED** US.

IN POLICY, EXCLUSION HAS BEEN EASIER TO RECOGNIZE THAN INCLUSION

Figure 1.5. Graphic Illustration - Keynote 1b: Daniel Dawes, J.D.





# FRAMING PLENARY

## CONNECTING THE DOTS DC'S EXPERIENCE



- ★ HOW HAS THE PANDEMIC AFFECTED YOUR ORGANIZATION?
- ★ ARE WE MISSION-ORIENTED, OR JUST SERVICE?
- ★ MOBILITY IN COMMUNITY IS MUCH MORE ENHANCED.

HOW DO WE INTEGRATE PUBLIC HEALTH CURRICULUM WITH FACTORS LIKE RACISM AND VIOLENCE?



HOW DO WE RETAIN PUBLIC HEALTH AND NURSING PROFESSIONALS?



WHAT KINDS OF INVESTMENTS ARE BEING MADE IN HEALTH EQUITY?

HOW DO WE DIVERSIFY THE FACES OF PHILANTHROPY TO REFLECT COMMUNITIES SERVED?

TRUST-BASED PHILANTHROPY GIVES FREER RANGE OF ITEMS TO COVER.

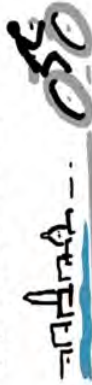


Figure 1.6. Graphic Illustration - Framing Plenary: Connecting the Dots DC's Experience





D.C. DEPT OF  
TRANSPORTATION  
USES AN EQUITY  
ASSESSMENT EVAL.



BIKESHARE STATIONS  
EAST OF THE ANACOSTIA-  
GREAT EXAMPLE OF  
GAINING CONNECTIVITY  
ACROSS D.C.

# ROAD MAP PART 1

HEALTH EQUITY REPORT 2018 PARADIGM SHIFT

TYPE OF HOUSING  
CONDITIONS, FOOD  
ACCESS ARE BIG  
FACTORS IN INEQUITY.

MOST AFFORDABLE HOUSING  
HAS HAPPENED EAST OF  
THE RIVER IN D.C., OFTEN  
IN "FOOD DESERTS", ETC.

HEALTH  
IMPACT  
PROJECT

HOW DO WE  
USE DATA TO  
INFORM DECISIONS?

ADVISORY  
COMMITTEES

SHIFT MORE  
DISCUSSIONS,  
DECISIONS TO  
COMMUNITY  
LEADERS RATHER  
THAN GOVERNMENT.

TRUST FUNDS  
**30% AMI**  
FOR AFFORDABLE  
HOUSING

COMMUNITY  
GOVERNMENT  
RELATIONSHIPS  
ARE ESSENTIAL  
FOR IMPROVEMENT.



GIFT CARDS  
FOR PARTICIPANTS  
OF COMMUNITIES  
TO SHOW THEIR  
TIME HAS



Figure 1.7. Graphic Illustration - Road Map Part 1: Health Equity Report 2018 Paradigm Shift





# ROAD MAP PART 2: PANDEMIC RESPONSE & INSIGHTS

THE VULNERABLE COMMUNITIES ARE **EXPONENTIALLY** MORE AFFECTED BY PANDEMIC.



CROSS-SECTOR COLLABORATION IS ESSENTIAL - WE CAN'T AFFORD TO WORK IN SILOS. AVOID PARALLEL SOLUTIONS.



D.C. DHS- FIRST RESPONDERS OF COVID'S EFFECTS.

I.T. INFRASTRUCTURE HAD TO CHANGE DRASTICALLY.

WHOLE-FAMILY APPROACH - CONSIDER BENEFITS OF HOUSEHOLD, NOT JUST INDIVIDUALS.



WORKER SAFETY IS A CIVIL RIGHT!

EVEN WHEN MATERIALS ARE PROVIDED FOR REMOTE LEARNING, ASSISTANCE IS STILL NEEDED FOR USE.

NO WIFI IN MANY PLACES.



Figure 1.8. Graphic Illustration - Road Map Part 2: Pandemic Response & Insights





# ROAD MAP PART 3

RACIAL-EQUITY FUTURE: A ONCE-IN-A-GENERATION OPPORTUNITY



 EQUITY AND JUSTICE ARE 2 DIFFERENT THINGS.

- ★ TECHNICAL TRAINING
- ★ COMMUNICATION
- ★ PARTNERSHIP

M.P.D. REACHES OUT TO COMMUNITIES TO ATTAIN RACIAL EQUITY.

RACE IS OFTEN AN AVOIDED TOPIC IN PARAMILITARY ENVIRONMENT.



RACIAL EQUITY IS ABOUT SHIFTING RESOURCES.

IT IS BOTH A PROCESS AND AN OUTCOME.

HOW DO WE PREPARE THE COMING GENERATIONS FOR FINANCIAL SERVICES INDUSTRY?

URGENCY AND



HYPERPRODUCTIVITY ARE PROBLEMS.

**30x30** CHALLENGE - 30% FEMALE WORKFORCE BY 2030 <sup>MPD</sup>

Figure 1.9. Graphic Illustration - Road Map Part 3: Racial-Equity Future: A Once-in-a-Generation Opportunity





# ROAD MAP PART 4

## HEALTH EQUITY FUTURE

THE OBJECTIVE  
REQUIRES MULTIPLE  
SECTORS  
WORKING  
COLLABORATIVELY.



OFFICE OF  
NEIGHBORHOOD  
SAFETY &  
ENGAGEMENT  
HAS AIDED

422 VICTIMS  
AND  
FAMILIES  
OF SHOOTING (TO  
INCIDENTS DATE).

A SMALL POPULATION  
PLAYS ROLE IN CITY'S  
VIOLENCE.



HOW DO WE RELAX  
CRITERIA FOR  
☆ HOUSING  
☆ EMPLOYMENT

COMMUNITY DOES  
NOT WANT CAKE  
BAKED FOR THEM...



...THEY WANT  
INVOLVEMENT  
IN THE PROCESS.

NATURE'S GREEN SPACE EVEN MORE IMPORTANT  
WHEN YOU'RE STUCK AT HOME!

STRATEGIZE  
COLLECTIVELY  
SO WE DON'T  
DUPLICATE  
EFFORTS.

LISTEN  
AND BE  
PRESENT

DEPT OF ENERGY  
AND ENVIRONMENT  
ASKS:

HOW DO YOU  
CREATE HEALTHY  
BUILDINGS THAT  
PROMOTE HEALTHY  
LIFESTYLES?



DC NAMED FIRST  
LEED  
PLATINUM  
CITY  
IN THE  
WORLD.

WE  
NEED  
ENVIRONMENT  
DIVERSITY  
FOR STRENGTH.



SAFE PASSAGEWAYS  
ARE NEEDED TO  
PROMOTE A WALKABLE  
AND BIKEABLE CITY  
FOR RESIDENTS.

DC WATER IS BUILDING  
220 MILES OF METRO-SIZED  
TUNNELS FOR DRAINING  
EXTREME FLOODING EVENTS.  
(MOST AFFECTED AREAS ARE OFTEN  
DISADVANTAGED RESIDENTS.)

LET'S GET COMMUNITY INPUT  
☆ BEFORE  
MAKING A PLAN!

Figure 1.10. Graphic Illustration - Road Map Part 4: Health Equity Future



## DC HEALTH EQUITY SUMMIT 2021 RECOMMENDATIONS

Actions	Themes & Takeaways	Insights
		Based on the insights, themes, and takeaways from the DC Health Equity Summit 2021: <b>“Building A Roadmap to A Just Post-Pandemic Future,”</b> DC Health will lead the development of a <b>shared roadmap</b> , which will engage public, private and non-profit partners, leveraging an equity-informed whole-of-community approach to drive collaborative actions for change. The structure and process envisioned will be informed by the following <b>six Recommended Actions</b> :
<b>1. Sustain Whole-of-Community Response</b>	<p><i>DC Pandemic Motto: All in this Together &amp; All Part of the Solution</i></p> <ul style="list-style-type: none"> <li>• Broad collaboration proved critical to addressing pandemic challenges</li> <li>• We must sustain and build on this momentum to advance equity</li> </ul>	Multi-sectoral collaboration is key. We must not return to siloes across sectors, organizations, and institutions, as was typical prior to the pandemic.
<b>2. Promote Culture of Wellness &amp; DC HOPE</b>	<p><i>DC HOPE refers to Health, Opportunity, Prosperity &amp; Equity</i></p> <ul style="list-style-type: none"> <li>• A culture of wellness is one in which good health and well-being flourish across geographic, demographic, and social sectors</li> <li>• Center District residents – maintain focus on Health, Wellbeing and Equity across the entire economy</li> <li>• Leverage the role of non-governmental institutions, in support of community health and equity both within and beyond the 9 Key-drivers</li> </ul>	<p>Prioritizing the needs of District residents is key to building a more equitable community.</p> <p>Promoting individual wellbeing and community health across all 8 wards is essential to a healthy, safe and vibrant city, where efforts are made to improve outcomes for our most vulnerable and create opportunities for all residents to thrive.</p>
<b>3. Repair Past to Transform Future</b>	<p><i>Pandemic impacts show ‘history’ is not past, but persists today. Transformational change efforts must consider historical analyses, with a racial equity lens.</i></p> <ul style="list-style-type: none"> <li>• Apply this critical filter in policy, practice, and outcome measures</li> <li>• Engage intersectional analyses; collect and disaggregate data to effectively identify and address issues</li> </ul>	<p>Persistent inequities stem from historic and contemporary roots and impacts. Equity-informed strategies and solutions require the unpacking of our contemporary context through the lens of historical analysis and racial equity.</p>
<b>4. Prioritize Community-Engaged Practice</b>	<p><i>Engage residents &amp; stakeholders; valuing lived experience as critical input &amp; lens</i></p> <ul style="list-style-type: none"> <li>• Practice Meaningful Community Engagement</li> <li>• Invest in Effective Community Listening</li> </ul>	Intentionally engaging residents and community stakeholders is critical to identifying issues and designing responsive solutions.
<b>5. Leverage Policy &amp; Practice Change Momentum</b>	<p><i>Use pandemic insights &amp; innovation to change practice, assumptions &amp; norms</i></p> <ul style="list-style-type: none"> <li>• Maintain action-oriented ‘can do’ posture, applying principles of Targeted Universalism</li> <li>• Take evidence-based and evidence-informed risks, consider and test alternate solutions; implement strategies and iterate equitable change</li> <li>• Forecast potential adverse impacts or unintended consequences, and develop mitigation strategies</li> </ul>	<p>Innovation has been one of the hallmarks of the pandemic. We learned that we CAN make changes – even within legacy systems – in response to crisis and need. Advancing equity requires proactive policy change, practice innovation, and budgetary commitment to disrupt the structural root causes of inequity.</p>
<b>6. Anchor Collaborative Action &amp; Impact</b>	<p><i>Informed by Shared Vision &amp; Accountability, Develop &amp; Measure Collective Impact</i></p> <ul style="list-style-type: none"> <li>• As form follows function, we must organize ourselves to execute on multi-sectoral collaborative actions that are aligned for change</li> <li>• Collaborative multi-sectoral actions should include targets and measure key outcomes</li> </ul>	<p>Summit showcased progress with equity - informed practice across the full spectrum. Future measures of progress and success must be informed by an equity lens and reflect desired outcomes as well as achievement of results.</p>

Figure 1.11. DC Health Equity Summit 2021 Recommendations



# **PART 2:**

# **SUMMIT BACKGROUND**

# BACKGROUND 1 - HEALTH EQUITY IN DC

## PRE-PANDEMIC CONTEXT

As in most other cities in the US, health inequities persisted in DC well before the COVID-19 pandemic, as evidenced by the inaugural DC HER published in February 2019.

### DC HER 2018 - Takeaways

- Life expectancy at birth varies by 21 years across the 51-statistical neighborhoods
- More opportunities for health (positive outcomes) are concentrated in neighborhoods with the longest life expectancy; AND the opposite is true for neighborhoods with the shortest life expectancy at birth.
- Overall it is clear that there are differential opportunities for health—by income, geography, and race in the District.



**Figure 2.1. 9 Key Drivers & Interconnected Pathways Framework**  
**Source: Health Equity Report, District of Columbia 2018 <sup>2</sup>**

The Health Equity Report for the District of Columbia (2018) is a comprehensive report focusing on social and structural determinants of health in the District. The report highlights nontraditional key drivers that affect health, which include: education, employment, income, housing, transportation, food environment, medical care, outdoor environment, and community safety. Together, through social and structural interconnected pathways, they create opportunities for health.

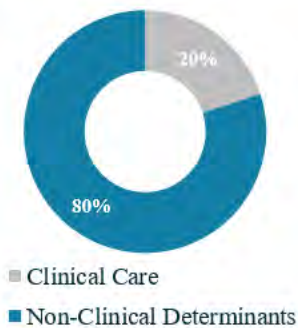
The Health Equity Report for the District of Columbia (2018) considers opportunities for health by looking at nine key drivers of health at the 51 statistical-neighborhood level. Despite wide improvements in health outcomes over the prior decade for District residents, certain health outcomes have not improved for everyone at the same rate due to health disparities and inequities. As measured by almost any indicator, these disparities are generated by structural inequities in income, race, and geography.

Key insights in the report show that, overall, clinical care drives only 20 percent of population health outcomes, while the remaining 80 percent is generated by non-clinical factors. The data throughout the report presents a picture of significant differences across neighborhoods that align with disparities in health outcomes, including life expectancy, with differences of 21 years between the two ends of the spectrum.

## DC Health Equity Report 2018: Frameworks

### Social & Structural Determinants of Health

#### Determinants of Health

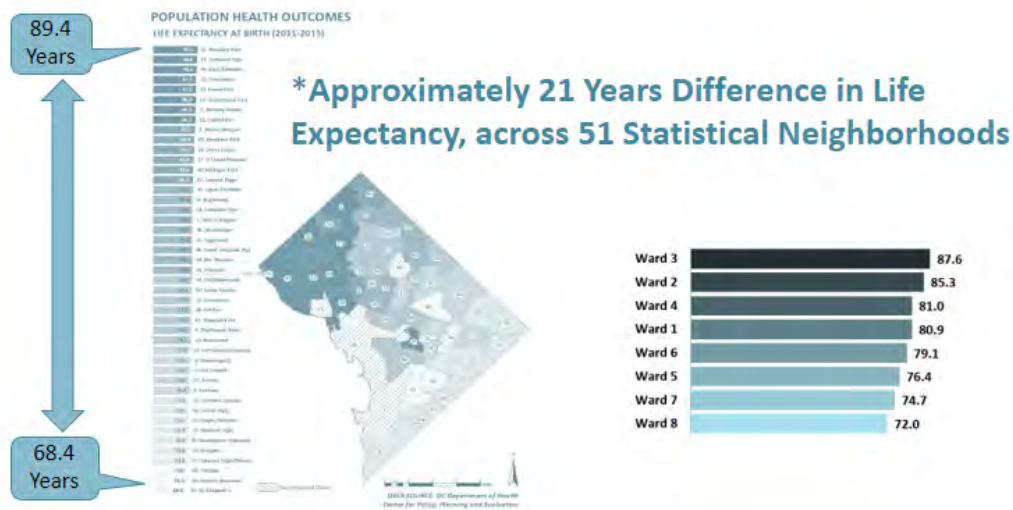


#### Health Equity 101: Key Insights

- ✓ Health is more than healthcare
- ✓ Health Inequities are neither natural nor inevitable
- ✓ Your zip-code may be more important than your genetic code for health
- ✓ The choices we make are shaped by the choices we have
- ✓ Structural Racism acts as a force in the distribution of opportunities for health
- ✓ All policy is health policy

**Figure 2.2. Social & Structural Determinants of Health<sup>3</sup>**

The 51 statistical-neighborhood-level maps and analysis presented in DC HER 2018 demonstrated the underlying drivers of differential opportunities for health, by income, place, and race. The Racial Dissimilarity Index (RDI) measures segregation between two groups, with scores from 0 through 100 indicating the percentage of non-Hispanic White population that would need to move to another census tract in order to equalize residential racial distribution in a geographic area. An RDI score of 70.9 underscored the extent of racial and economic segregation in the city. Collectively, disparities across social and structural determinants create the context for persistent, disproportionate health outcomes, which negatively affect Black and Brown populations and neighborhoods.



**Figure 2.3. DC Life Expectancy at Birth (2011-2015)<sup>4</sup>**

On the whole, the report showed that more opportunities for health (positive outcomes) are concentrated in neighborhoods with the longest life expectancy; but the opposite is true for neighborhoods with the shortest life expectancy at birth. This underscores the extent of differential opportunities for health—by income, geography, and race.

Given that an overwhelming majority of what drives a community's health occurs outside of the medical care system, it is necessary to shift our collective foci in order to address persistent health inequities. This requires a broader frame of reference—beyond traditional healthcare sector and overly-targeted health insurance and access discussions—to include the other eight Key Drivers. In this approach, the principles of a Health-in-All-Policies (HiAP) framework is applied, and efforts focus on engaging and partnering with non-health sectors, identifying solution-building opportunities, and implementing collaborative actions for change.

As the Nine (9) Key Drivers of Opportunities for Health influence community health outcomes, the impacts of the pandemic have echoed across all areas of life, with intensity of impact following patterns of community health status across the 51 statistical-neighborhoods.

The pandemic underscored differential impacts from a Social & Structural Determinants of Health (SSDH) lens, affecting not only who was exposed, but also who got sick, and either recovered or died. For communities that lacked access to a full range of health-promoting resources prior to the pandemic, COVID-19 magnified the impact of SSDH inequities—widening the gap between those with ample opportunities for a healthy life, and those with less.

On the following page, Figure 2.4 Differential Impacts of COVID-19—SSDH lens provides a conceptual framework of how differential opportunities for health—access, risks, supports, protective factors, etc., across the 9-Key Drivers operate via interconnected pathways to produce differential vulnerabilities, impacts, and outcomes, including disparities at the population health level.

During the early stages of the pandemic, steadily growing evidence demonstrated that historically marginalized communities were bearing an oversized burden of illness and death related to COVID-19, underlining the increasingly urgent need to focus on social and structural drivers of differential health outcomes. In 2020, DC Health sought to purposefully consider the cumulative impact of medical, economic, and social factors that may make a community more vulnerable to poor health outcomes. In this context, vulnerability refers to the capacity (including protective factors or lack thereof) of a community to respond to and withstand extraordinary challenges, such as disease outbreaks.

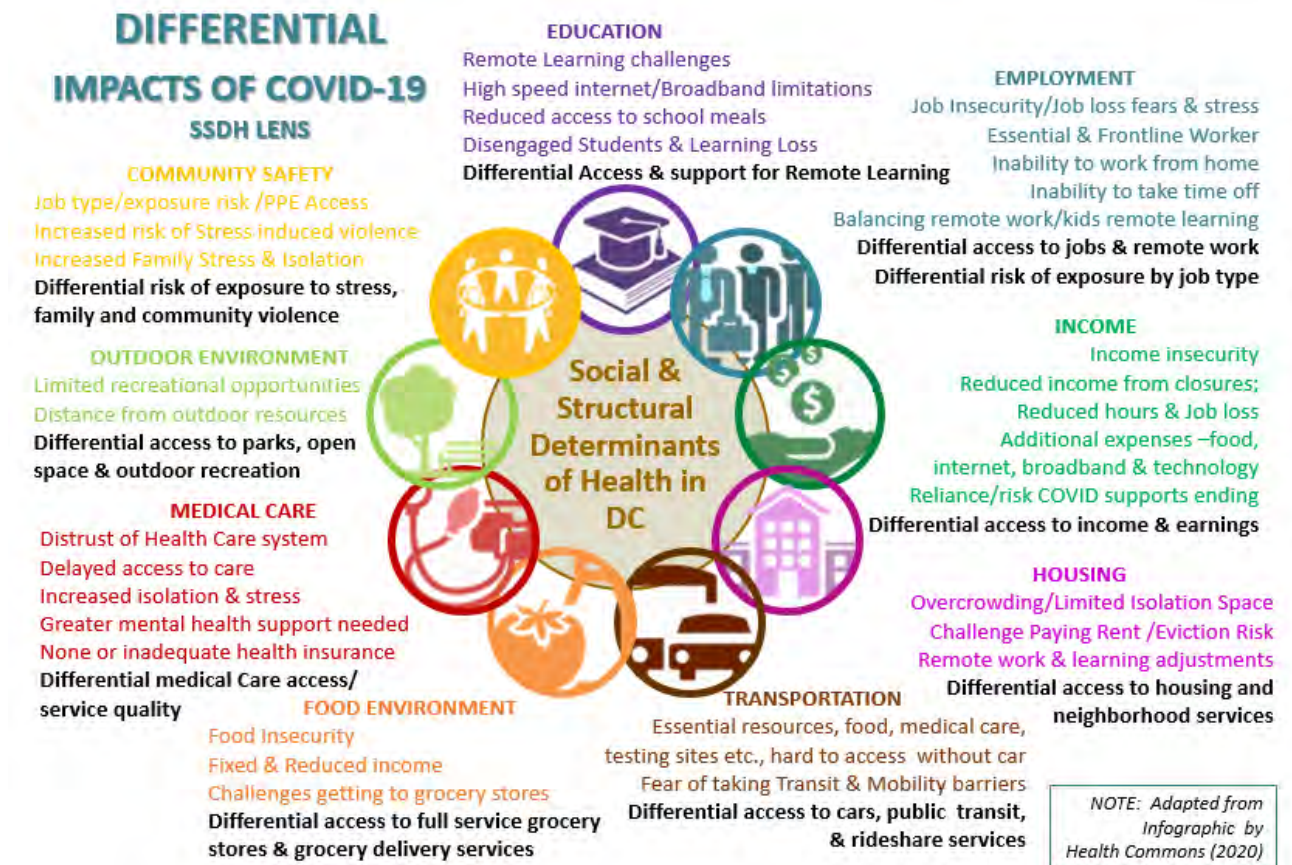


# BACKGROUND 2 - IMPACT OF COVID-19 IN DC

## DURING PANDEMIC

### COVID-19 & SOCIAL & STRUCTURAL DETERMINANTS OF HEALTH

The coronavirus pandemic created unprecedented changes in virtually all aspects of society and modern life, while calling attention to troubling inequities like those highlighted in the [Health Equity Report for the District of Columbia \(2018\)](#). Over the course of the pandemic, rates of COVID-19 infections, and their consequences, have not been evenly distributed across the District. Outcomes related to hospitalization, recovery, or deaths due to coronavirus, have varied widely by age, income, race, and place.

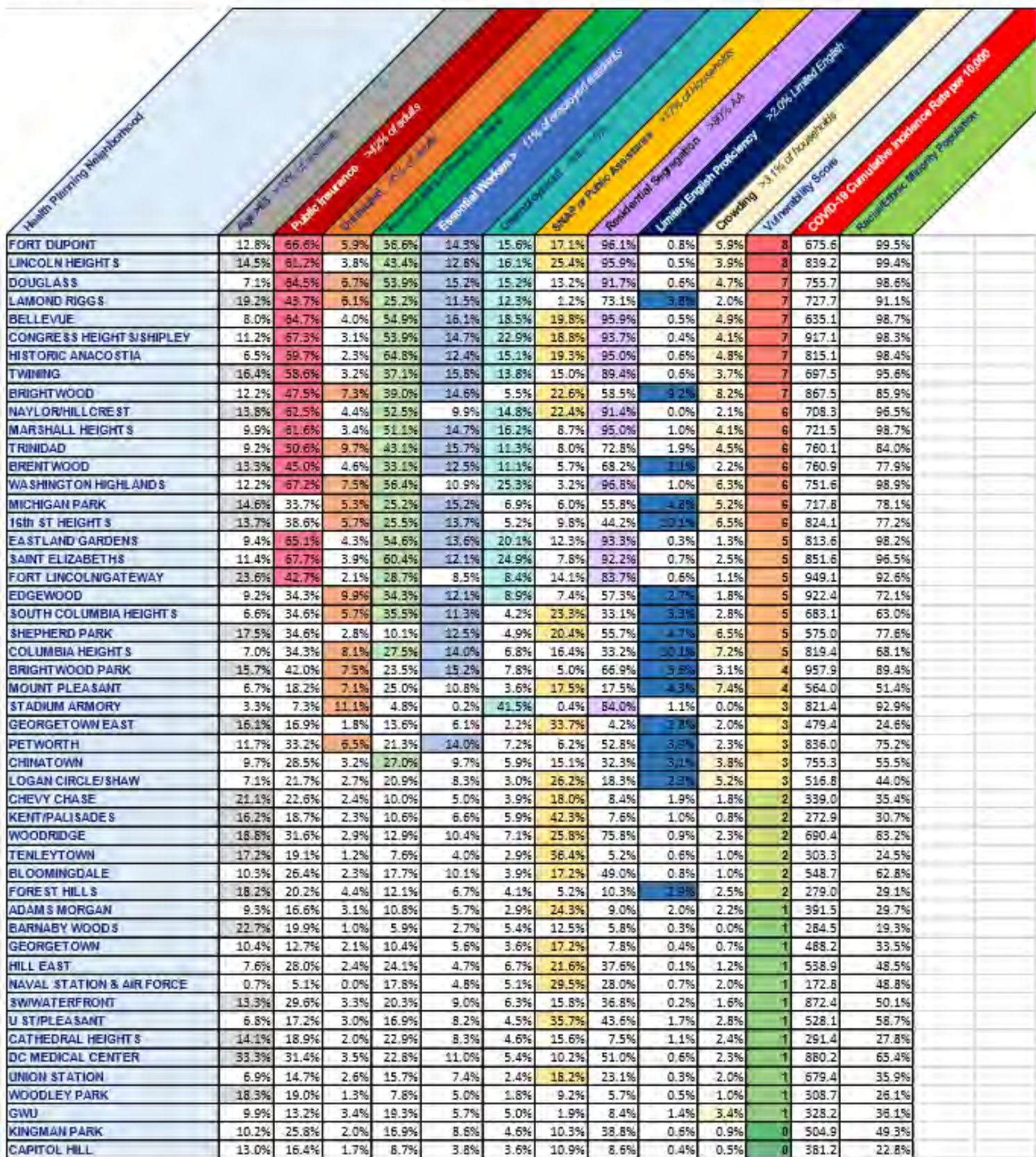


*Social & Structural Determinants of Health (SSDH) are: “the complex, integrated and overlapping structures and economic systems that include the social environment, physical environment, and health systems...<sup>6</sup>” These structural and societal factors are the root cause of most health inequities.*

Figure 2.4. Differential Impacts of COVID-19: Nine (9) Key Drivers and Social & Structural Determinants of Health (SSDH) Lens <sup>5</sup>



## DC COVID-19 Structural Vulnerability Index



Data Source: ACS 2014-2018 and DC Health 2021.

Cumulative Vulnerability Score

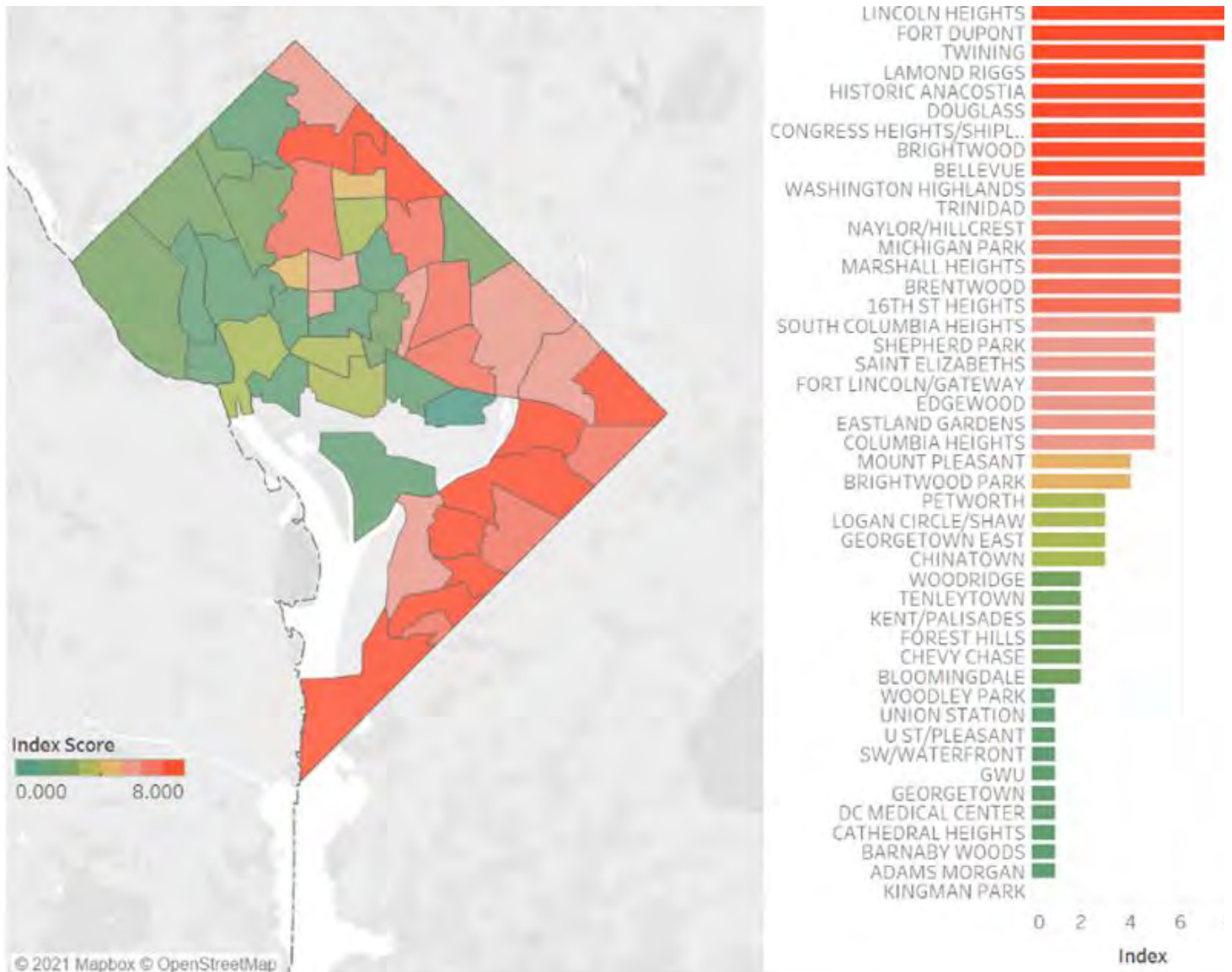
Figure 2.5. DC COVID-19 Structural Vulnerability Index (by Statistical Neighborhood)<sup>4,7</sup>



DC COVID-19 Vulnerability Index Criteria	
1. Age over 65 > 13% of Residents	6. Unemployment Rate > 8%
2. Public Insurance > 42% of Adults	7. SNAP or Public Assistance > 17% of Households
3. Uninsured > 5% of Adults	8. Residential Segregation > 80% African American
4. Income < 200% of Poverty > 25% of Households	9. Limited English Proficiency > 2.0%
5. Essential Worker > 11% of Employed Residents	10. Crowding > 3.1% of Households
<b>*NOTE: Two (2) Data Points (NOT SCORED) - Included in table for Comparative Reference</b>	
11. COVID-19 Cumulative Incidence (Rate per 10,000)	12. Race & Ethnicity (% Population)

Figure 2.6. DC COVID-19 Structural Vulnerability Index Criteria<sup>4</sup>

## DC COVID-19 Structural Neighborhood Vulnerability Index Map

Figure 2.7. DC COVID-19 Structural Neighborhood Vulnerability Index Map<sup>4</sup>

In alignment with DC Health's health equity framework and analysis, the DC COVID-19 Structural Vulnerability Index and Map (Figures 2.5, 2.6, and 2.7), used a total of ten COVID-19 vulnerability criteria, to spotlight a combination of hyper-local impacts at the statistical neighborhood level. The criteria are presented in Figure 2.6, along with two data points included in the table to provide additional context: the COVID-19 cumulative incidence rate per 10,000 as of June 30 2021; and Minority Race/Ethnicity, as a percentage of the estimated population not identifying as Non-Hispanic White. The map shows cumulative vulnerability score differences at the sub-ward level, including variations in vulnerability occurring in relatively close proximity, with one notable example seen along the 14th Street NW corridor. This data analysis and map illustrates cumulative impact, enhancing understanding, enriching contextual analysis, and informing the development of community-specific strategies. It has also served as a guide to focusing tailored, responsive solutions within the soon-to-be released Health Literacy Plan for the District.

### **Pandemic Waves and Shifting Impacts – by Race, Ethnicity and Geography**

Early on, during the pandemic's first wave (February to September 2020), Hispanic residents experienced the highest case rate followed by Black non-Hispanic residents. During the second wave (October 2020 to June 2021), residents who identified as "some other race (non-Hispanic)" had the highest case rate, and reached the highest case rate of 87.56 per 100,000 population of all races. During the second wave, all racial groups reached their highest case rate in the pandemic to date. During the third wave (June to November 2021), people who identified as "some other race" maintained a higher case rate, followed by the Black non-Hispanic population. Hispanic residents had a higher case rate in the first two waves, but as the pandemic progressed, the case rate for Hispanic residents in the District gradually decreased.

The most impacted age groups also shifted over the course of the pandemic. During the first wave, older adults (ages 45-64 or 65+) had the highest case rate, but their rate slowly decreased as the pandemic transitioned to the second wave. The second wave was markedly different, with younger residents ages 16-19 and 20-44 registering the highest case rate overall. During the third wave, adolescents ages 12-15 had the highest case rate, with 91.3 cases per 100,000 population—the highest peak observed across age groups throughout the pandemic.

Figures 2.8, 2.9, and 2.10 illustrate the differences in geographic distribution of positive COVID-19 cases as time went on and the context, as well as the virus itself, continued to evolve. During the first wave, neighborhoods in upper Northeast and near Northwest DC (especially along the 14th Street NW corridor) with larger immigrant populations were most impacted, consistent with high rates of infection amongst Hispanic residents as noted above. However, during the second wave, the impact started to shift to neighborhoods in the Northeast and Southeast quadrants. In the third wave, the most impacted neighborhoods were heavily concentrated in the Southeast quadrant of the District.

COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 1 (2/21/2020 - 9/25/2020)

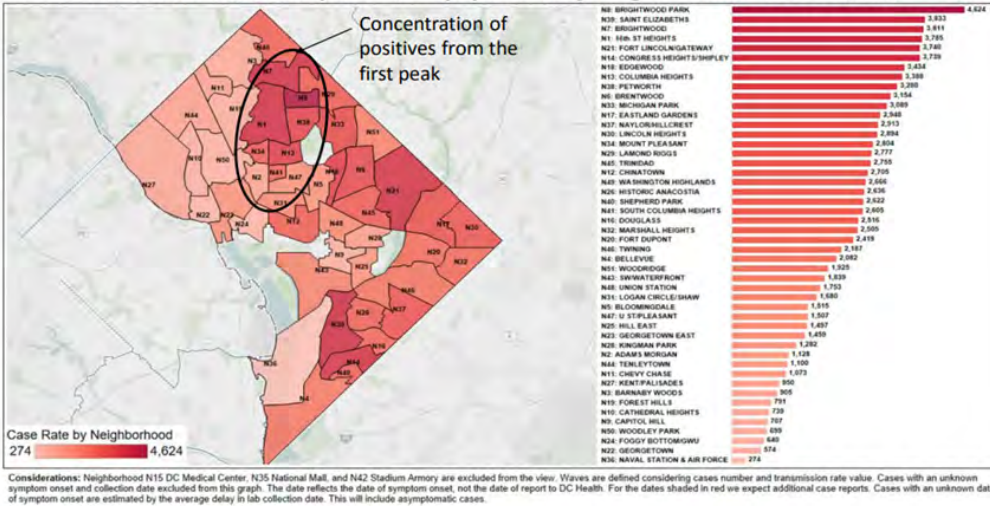
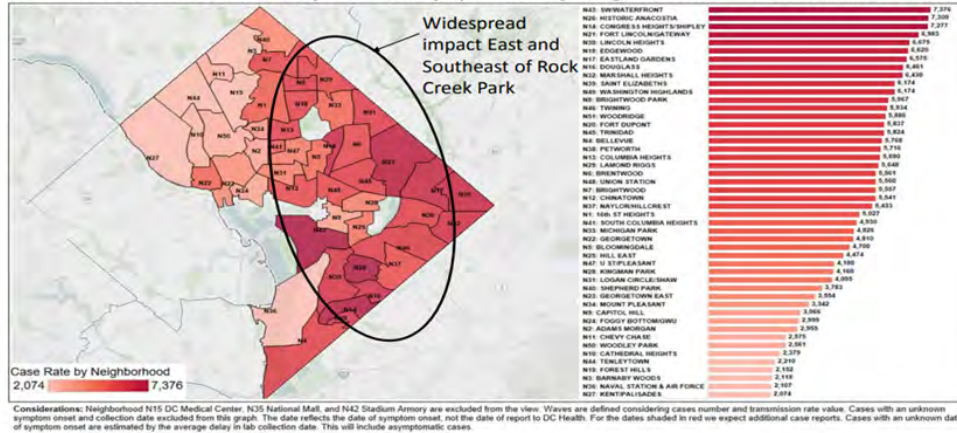


Figure 2.8. COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 1

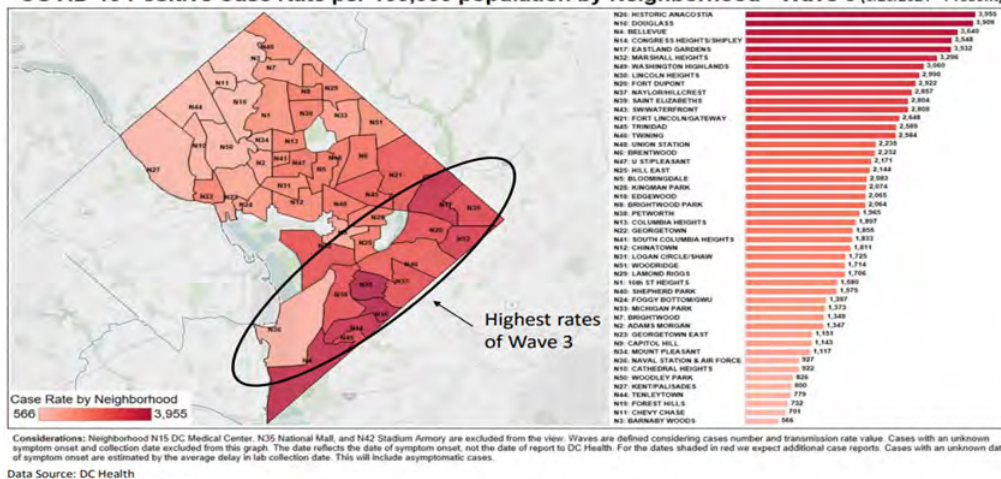
COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 2 (9/26/2020 - 6/22/2021)



Data Source: DC Health

Figure 2.9. COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 2

COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 3 (6/23/2021 - Present)



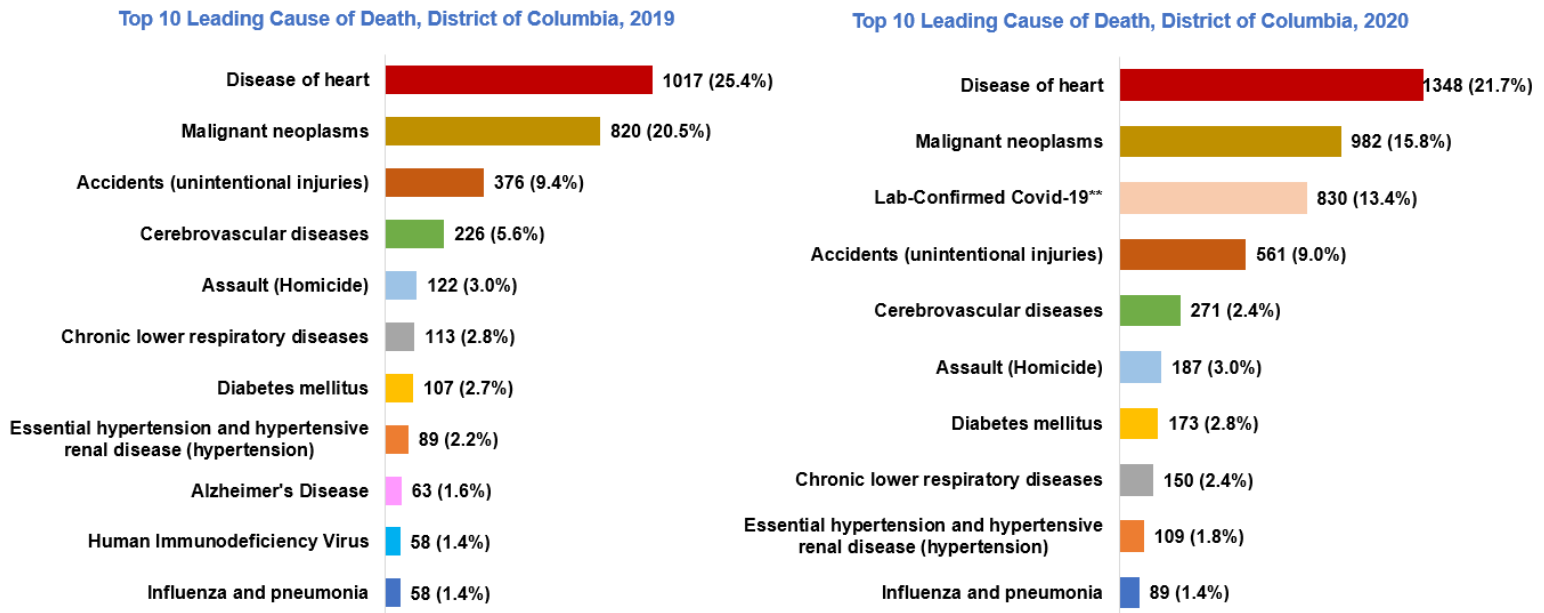
Data Source: DC Health

Figure 2.10. COVID-19 Positive Case Rate per 100,000 population by Neighborhood - Wave 3



### Leading Causes of Death – 2019 vs. 2020

The distribution of COVID-19 cases changed over time and across District neighborhoods, and the virus also had a devastating impact on the number and causes of death in DC. As shown in Figure 2.11, the February 2020 onset of the pandemic and rapid spread of the novel virus resulted in lab-confirmed COVID-19 becoming the third leading cause of death in 2020, following heart disease and cancer, and contributing to a significant increase in excess deaths.



\*\* The number of deaths due to COVID-19 reported here was based on D.C. Vital Records data and may not match the number of COVID-19 deaths reported in 2020 through the COVID surveillance system due to differences in reporting processes.

**Figure 2.11. Top 10 Leading Causes of Death Among District Residents (Deaths Occurring in the District), 2019 and 2020<sup>4</sup>**

National and local data and research suggests, however, that this leading cause of death comparison may not account for the full impact of COVID-related deaths due to other causes, including where residents may have forgone critical care out of an abundance of caution, an inability to pay due to change in employment status, or other factors not reflected in official pandemic data. For example, the May 2021 COVID-19 Pandemic Health and Health Recovery Report cites a significant increase in 2020 deaths due to diabetes, accidents, homicide, chronic lower respiratory disease, and heart diseases; these increases may have been caused by “poor continuity of preventative and chronic disease care management, higher risk behaviors due to pandemic-related stress and trauma, or lower quality of high acuity healthcare delivery services due to healthcare resources being focused on the COVID-19 pandemic.”

## STATUS OF COVID-19 - DECEMBER 9 2021

Since March 30, 2020, the COVID-19 Health and Medical Branch has continued to support COVID-19 diagnostic sampling in the District. On the date of the Summit, December 9, 2021, the District reported an overall total of 68,460 positive cases, displayed by race/ethnicity in Figure 2.12. Black/African Americans have the highest incidence of positive cases, comprising 52% of cases overall.

Total Positive COVID-19 Cases: By Race & Ethnicity (12.9.21)		
RACE & ETHNICITY	Total Positive Cases	Percent
<b>ALL Positive Cases</b>	<b>68,460</b>	<b>100</b>
Asian	1,418	2
Black/African American	<b>35,363</b>	<b>52</b>
Hispanic/Latinx	10,337	16
Non-Hispanic White	16,656	25
Other/Multi Racial	114,494	21

Figure 2.12. Total Positive COVID-19 Cases: by Race & Ethnicity<sup>4</sup>

Tragically, 1,197 District residents had lost their lives to COVID-19. Total lives lost by race/ethnicity are shown in Figure 2.13, and Black/African Americans comprised 76% of all deaths. In her opening remarks, Director Nesbitt acknowledged the deceased, as well as all residents impacted by the coronavirus, with a moment of silence.

Total Lives Lost Due to COVID-19: By Race & Ethnicity (12.9.21)		
RACE & ETHNICITY	Total Lives Lost	Percent
<b>ALL Lives Lost</b>	<b>1,197</b>	<b>100</b>
Asian	14	1
Black/African American	<b>922</b>	<b>76</b>
Hispanic/Latinx	126	11
Non-Hispanic White	112	10
Other/Multi Racial	23	2

Figure 2.13. Lives Lost due to COVID-19: by Race & Ethnicity<sup>4</sup>

Lives lost due to COVID-19 were not evenly distributed across the District's eight wards. As seen in Figure 2.14, a greater number of deaths were to residents living in Wards 4, 5, 7, and 8 when compared to the remaining wards.

Figure 2.15 displays the geographical distribution of positive COVID-19 cases across 51 Statistical-Neighborhoods. On the map, higher incidence of positive cases can be seen in the Northeast and Southeast quadrants of the District.

Total Lives Lost Due to COVID-19: by WARD (12.9.21)		
WARD	Total Lives Lost	Percent
<b>ALL Lives Lost</b>	<b>1,197</b>	<b>100</b>
Ward 1	112	10
Ward 2	52	5
Ward 3	58	5
Ward 4	<b>175</b>	<b>15</b>
Ward 5	<b>219</b>	<b>18</b>
Ward 6	129	11
Ward 7	<b>188</b>	<b>16</b>
Ward 8	<b>237</b>	<b>19</b>

Figure 2.14. Total Lives Lost Due to COVID-19 by Ward<sup>4</sup>

# CUMULATIVE IMPACT OF COVID-19 IN DC - ON SUMMIT DAY

## Cumulative COVID-19 Incidence by Statistical Neighborhood

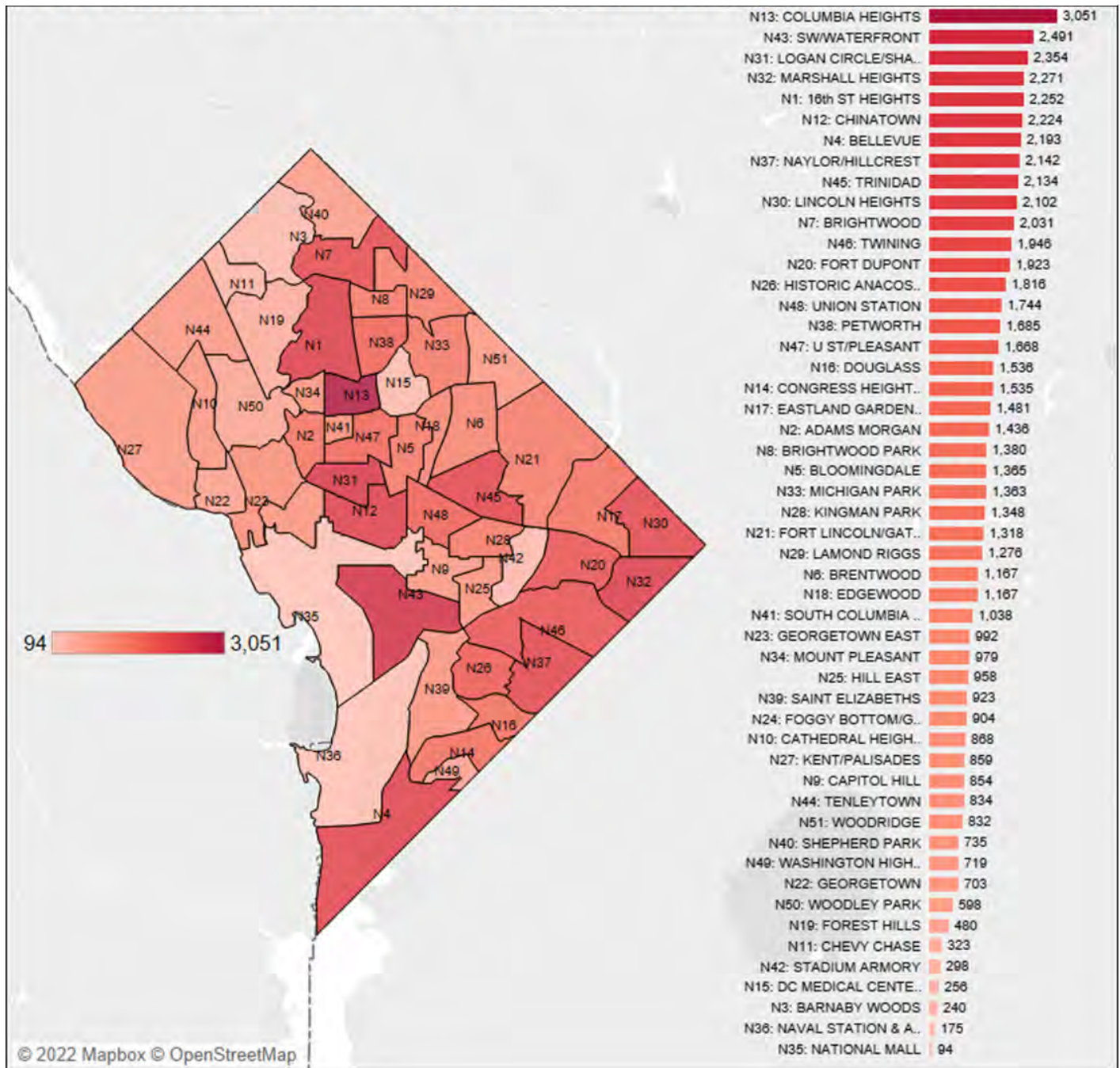


Figure 2.15. Cumulative Incidence by Statistical Neighborhood<sup>4</sup>



## BACKGROUND 3 - ACCESS TO QUALITY HEALTHCARE

### POST-PANDEMIC RECOVERY



Figure 2.16. Equity Programs and Policy Framework<sup>3</sup>

DC Health published the [COVID 19 Pandemic Health & Healthcare Recovery Report](#) in May 2021. This section provides a high level summary of the report, with emphasis on recommendations addressing implicit bias in the healthcare system.

The COVID-19 Pandemic Health and Healthcare Recovery Report addresses population health concerns as a result of the pandemic, including delayed preventative and chronic disease care; long-term effects of COVID-19 infection; economic impact and job loss; mental health stress, social isolation, trauma, and grief; and loss of academic, social, and emotional growth in children. Five functional areas critical to addressing the health needs of District residents are explored through a foundational equity lens: health planning, healthcare and public health workforce, health information technology, healthcare facilities, and community health services.

Many policies, procedures and operations of the healthcare system were altered to address the rapid surge and magnitude of the COVID-19 pandemic. The public health crisis necessitated a massive shift to virtual environments for health systems planning and to facilitate healthcare access through telehealth, assisted telehealth, or home-based models. The report recommended that the post-pandemic healthcare ecosystem should embrace these changes to deliver care to District residents when, where, and how they want to receive it. This paradigm shift began as an essential adjustment to the pandemic, but has the potential to be a critical equity driver in healthcare delivery.

Included among the report's 39 recommendations, is the prioritization of implicit bias training and policies, both in the short and long term. This includes mandatory training of new employees entering the health workforce, competencies for academic medical and public health curriculums, and diversification to increase the percentage of physicians who identify as people of color.

Other recommendations include addressing health literacy more substantively and prioritizing strategic partnerships that integrate disparate health data systems to more effectively monitor various public health indicators in the District. Additionally, the COVID-19 Pandemic Health and Healthcare Recovery Report can serve as a model for other state and local health departments to help map out their post-pandemic futures, not only to recover, but to thrive.

Finally, in framing the importance of a pandemic recovery lens that extends far beyond healthcare, the following is noted:

“The challenges, experience, and disparate outcomes for the pandemic in the District, has, if nothing else, underscored the necessity to apply an equity-informed structural analysis to our work going forward. In order to eliminate disparities in health outcomes, our collective actions must be intentional in three key areas: access to quality care; social and structural determinants of health; and structural and institutional racism”. The connection of these dots inspired Figure 1.1: Post Pandemic 3-legged Equity Stool

# **PART 3: SUMMIT PROCEEDINGS**



# TRIP MAP: SUMMIT PROCEEDINGS

HEALTH EQUITY SUMMIT 2021 AGENDA	
SESSION TIMES & TITLES	THEMES & SPEAKERS
10:00 – 10:20 am <b>Summit Welcome &amp; Framing</b>	Dr. LaQuandra S. Nesbitt, Director, DC Health Dr. C. Annetta Arno, Director, Office of Health Equity, DC Health
10:20 – 11:10 am <b>Keynote Address</b> “National & Historic Context”	<b>Theme: Engage GPS: What's the Landscape?</b> Daniel E. Dawes, JD, Executive Director, Satcher Health Leadership Institute, Morehouse School of Medicine
11:10 – 11:20 am BREAK	
11:20 – 12:00 pm <b>Framing Plenary</b> “Connecting The Dots: DC's Experience”	<b>Theme: Packing Our Bags: How Must We Prepare?</b> Moderator: Dr. LaQuandra S. Nesbitt, Director, DC Health Speakers: <ul style="list-style-type: none"> <li>Dr. Lynn Goldman, Dean, Milken Institute School of Public Health, George Washington Univ.</li> <li>Dr. Cara James, President &amp; CEO, Grantmakers in Health</li> <li>Dr. Hugh Mighty, VP, Clinical Affairs &amp; Dean, Howard University College of Medicine</li> <li>Ms. Angela Franco, President &amp; CEO, DC Chamber of Commerce</li> </ul>
12:00 – 12:30 pm LUNCH BREAK	
12:30 – 1:20 pm <b>Roadmap Part1</b> “Health Equity Paradigm Shift”	<b>Theme: Get On Board: Adjusting Our Seatbelts?</b> Moderator: Dr. Autumn Saxton-Ross, Chair, Commission on Health Equity Speakers: <ul style="list-style-type: none"> <li>Andrew Trueblood, Director, DC Office of Planning (OP)</li> <li>Nana Bailey, JD, Director of Equity &amp; Inclusion, DC Department of Transportation (DDOT)</li> <li>Drew Hubbard, Director, DC Department of Housing &amp; Community Development (DHCD)</li> <li>Dr. Ruth Lindberg, Director, Health Impact Project, Pew Charitable Trusts</li> </ul>
1:20 – 1:30 pm AFTERNOON BREAK 1	
1:30 – 2:20 pm <b>Roadmap Part 2</b> “Pandemic Response & Insights”	<b>Theme: Rest Stop: Opportunities to Rest or Stop?</b> Moderator: Dr. Christopher King, Commissioner, Commission on Health Equity Speakers: <ul style="list-style-type: none"> <li>Laura Zeilinger, Director, DC Department of Human Services (DHS)</li> <li>Dr. Unique Morris-Hughes, Director, DC Department of Employment Services (DOES)</li> <li>Dr. Bren Elliott, Chief, School Improvements &amp; Supports, DC Public Schools (DCPS)</li> <li>Lupi Quinteros-Grady, President &amp; CEO, DC Latin American Youth Center</li> </ul>
2:20 – 2:30 pm AFTERNOON BREAK 2	
2:30 – 3:30 pm <b>Roadmap Part 3A - Concurrent Session 1</b> “Racial Equity Futures - The Fierce Urgency of Now”	<b>Theme: Are We There Yet: Racial Equity Future?</b> Moderator: Dr. Amber Hewitt, Director, Mayor's Office of Racial Equity Speakers: <ul style="list-style-type: none"> <li>Karima Woods, Commissioner, DC Department of Insurance, Securities &amp; Banking (DISB)</li> <li>Captain Paul Hrebenak, Director, DC Metropolitan Police Department (MPD)</li> <li>Amy Mauro, Chief of Staff, DC Fire &amp; Emergency Medical Services Department (FEMS)</li> <li>Temi F. Bennett, Esq., Director of Policy at If, A Foundation for Radical Possibility</li> </ul>
2:30 – 3:30 pm <b>Roadmap Part 3B - Concurrent Session 2</b> “Health Equity Futures – A Once-In-A-Generation Opportunity”	<b>Theme: Are We There Yet: Health Equity Future?</b> Moderator: Dr. C. Annetta Arno, Director, Office of Health Equity, DC Health Speakers: <ul style="list-style-type: none"> <li>Delano Hunter, Director, Department of Parks &amp; Recreation (DPR)</li> <li>Delbert McFadden, Director, Office of Neighborhood Safety &amp; Engagement (ONSE)</li> <li>Tommy Wells – Director, DC Department of Energy &amp; Environment (DOEE)</li> <li>Keisha L. Powell, Chief Operating Officer &amp; Executive VP, DC Water</li> </ul>
3:53 – 4:00 pm <b>Closing Remarks</b>	Dr. C. Annetta Arno, Director, Office of Health Equity, DC Health Dr. Amber Hewitt, Director, Mayor's Office of Racial Equity

Figure 3.1. DC Health Equity Summit 2021 Agenda

The following summary of Summit proceedings from the inaugural DC Health Equity Summit 2021 includes conversation excerpts that have been edited for length and clarity. The views expressed are the sole opinions of the credited speaker, and are not intended to reflect any official position of DC Health or the District of Columbia government.

## SUMMIT WELCOME & FRAMING

As a kickoff to the Summit's scheduled sessions, DC Health Director LaQuandra S. Nesbitt, MD, MPH and Office of Health Equity Director C. Anneta Arno, PhD, MPH welcomed the virtual audience, thanked the event partners, and provided an overarching frame for the information and dialogue to be covered during the event.



**LaQuandra S. Nesbitt, MD MPH**  
DC Department of Health Director

### **LaQuandra S. Nesbitt, MD MPH:**

*"Opportunities for health are driven by a broad spectrum of societal, structural, and institutional laws, policies, and practices—from housing, to employment, to education. Today's event is one of our key initiatives to engage different partners and address the racial, geographic, institutional, and financial barriers that have led to disparate health outcomes across communities. I believe strongly in bringing our communities together with our health leaders, policy makers, and experts in order to foster an open and honest dialogue, and build trust in one another as we work together to identify and move forward, eliminating health inequities."*

### **C. Anneta Arno, PhD, MPH:**

*"As Dr. Martin Luther King, Jr. said, 'we may have all come on different ships, but we're in the same boat now.' It is now necessary to train our collective focus on addressing the social and structural determinants of health, as well as structural and institutional racism. We are modelling the kind of work - collaboration and connection—that's needed to get the work done."*



**C. Anneta Arno, Ph.D., MPH**  
Director, Office of Health  
Equity, DC Health



## Engage GPS: What's the Landscape?

National & Historic Context



**Daniel E. Dawes, JD**  
Satcher Health Leadership  
Institute, Morehouse School of  
Medicine

### KEYNOTE ADDRESS

While the DC HER 2018 illustrated the root causes and disparate outcomes related to the social and structural determinants of health on a uniquely hyper-local level, the trends and inequities observed also occur along similar lines of income, place, and race across many US metropolitan areas. The history of Washington DC, and many American cities reflect national trends, where socio-demographic contextual factors interconnect to produce persistently differential opportunities for communities and individuals to reach their full health potential. It is worth restating that only 20% of community health outcomes are generated by the health and medical care system, with 80% determined by factors like housing, education, employment, and proximity to safe and health-promoting built and natural environments. The stark differences in observed outcomes are not natural or inevitable. They are the result of a much broader spectrum of societal, structural, and institutional norms, laws, policies, and practices. None are permanent, nor set in stone. Changes to institutional structures can and will change these outcomes if undertaken with an equity lens.

Improving the health of all District residents in a way that provides everyone an opportunity for a healthy life will require purposeful, transformational change across all aspects of society. Beyond increasing awareness, change across systems and communities through applied policies will help us realize a more equitable, inclusive, and healthy future.

**Key Question: How has COVID-19 Underscored the Connection between Structural Racism & Health in Every Aspect of Society?**



## THE POLITICAL DETERMINANTS OF HEALTH INEQUITIES: Repairing the Past and Building a More Equitable and Just Post-Pandemic Future for DC

Esteemed professor Daniel Dawes joined the inaugural DC Health Equity Summit to share his insights on health disparities and the root causes of inequity nationally. His work with the Morehouse School of Medicine's Satcher Health Leadership Institute aims to create systemic change and advance the equity movement through innovative research and programming. Dawes outlined the historical and contemporary context around the inequitable outcomes we see in the District and cities nation-wide. Though our country consumes more than half of the world's healthcare resources, those resources fail to meet the health needs of our population. The US ranks 43rd in life expectancy globally, despite the significant proportion of Gross Domestic Product (GDP) dedicated to health-related spending. Improvement in population health from one generation to the next remains elusive, and the key to these mystifying results lies in the wide gap in outcomes between different racial and ethnic groups.

In the Summit's Keynote Address, Dawes posits that a new addition to the health determinants framework—the political determinants of health—have created the social and structural drivers that impact population health outcomes. Using countless examples from US history, including stories which don't often make it into the history books, he discussed how "Big P" Policy—such as the trans-Atlantic slave trade which led to epigenetic 'weathering' and intergenerational trauma—and "little p" policy—such as higher payments and more severe penalties acting as a 'poverty tax' for individuals with less access to capital and economic opportunity—operate as the main root causes of health inequities in the US, and why seemingly race-neutral laws and policies have failed to address equity.

Instead, throughout history these policies have often served to prioritize majority groups over others, by way of:

- systemically structuring relationships, as in the case of 'redlining' policies, anti-miscegenation laws, and anti-immigration practices;
- the intentional distribution of key resources like child and home health care support, and the structure of the social safety net; and
- influencing the administration of power through voter ID and suppression laws.

Daniel Dawes calls on advocates and those working to advance health equity to be deliberate in efforts to examine if health outcomes are systemic, avoidable, and/or unjust, and shared his hope that when we come together as a society to address the root causes and political drivers of such outcomes, we can heal the past and improve outcomes for all.

### Highlights from Keynote Speaker Professor Daniel E. Dawes, JD:

“The political determinants of health involve the systemic process of structuring relationships, distributing resources, and administering power... to shape opportunities that either advance health equity or exacerbate health inequities.”

“[In both historical and contemporary instances,] 'racially neutral' laws and policies, once implemented, have had a disproportionately negative impact on Black and Brown communities—by design.”



Figure 3.2. Policy & policy<sup>8</sup>

“Only policy can fix what policy has created—we must leverage the political determinants of health to advance health equity and ensure that every single person in our community stands a fair chance to reach their optimal health and full potential. And, we must demonstrate the value of investing in change.”



## Packing Our Bags: How Must We Prepare?

Connecting the Dots - DC's Experience



**Moderated by:**  
Dr. LaQuandra S. Nesbitt,  
Director, DC Health

### FRAMING PLENARY

The swift and unpredictable onset of the coronavirus pandemic brought with it an urgent need for leaders, community members, and stakeholders at all levels to collaborate on solutions to protect and preserve the health, safety, and vibrancy of the District and its residents. The emergent challenges and disparate outcomes brought to light by COVID-19 have truly amplified the connection between social determinants, structural racism, and population health in every aspect of society. In this new landscape, leaders across sectors have to ask themselves:

- *What is my role in addressing key drivers of health outside of my traditional scope of practice and expertise?*
- *As the workforce changes from one day to the next, how can we equip employees with what they need to be resilient?*
- *How must we approach education and training of the future workforce to address equity challenges and be responsive to a wide range of potential crises?*
- *With an understanding of the interconnected pathways that bridge population health to social, structural, and political determinants, how can leaders leverage current and future investments to advance health and racial equity for all?*

In the past, we have been too narrowly focused on documenting and quantifying disparities, rather than on identifying the root causes, developing solutions, and taking action to address them.

Contemporary challenges call for innovation, and collective action offers a path to solution-building that reflects a wider scope of expertise, experience, and perspective on how to address persistent population health challenges faced by our communities. As one example of a collaborative pandemic recovery effort, ReOpen DC convened over 250 community and government leaders to work together for a total of 25,000+ hours on a series of recommendations to the Mayor in order to inform and advise the best approaches to a phased reopening plan for Washington, DC.

Under the leadership of Mayor Muriel Bowser, initiatives like these—which bring together experts, policymakers, and the public across a multitude of focus areas—illustrate the enthusiasm and potential for continued cross-sector dialogue and solution-building towards the realization of the vision for the District as the healthiest city in the nation.

The inaugural DC Health Equity Summit is a key initiative to engage partners beyond traditional public health and health care sectors to address racial, geographical, institutional, and financial barriers contributing to uneven and inequitable community health outcomes.

Conversations between novel coalitions of leaders in higher education, philanthropy, and the business sector highlighted the innovative approaches that are being used in the District to advance health and equity for all Washingtonians. In the first panel of the day, 'DC's Experience—Connecting the Dots', DC Health Director Dr. LaQuandra S. Nesbitt spoke with panelists who discussed a shift from the documentation and quantification of disparities, to leveraging institutional resources and efforts to address the root causes driving inequitable outcomes.

One example of ongoing efforts to advance this work include Howard University Hospital's critical role in helping the District eliminate longstanding health disparities through its Centers for Excellence. The District and DC Health proudly supports this program, which will provide care and services tailored to the specific needs of our community. In order to “do the greatest good for the greatest number of people”, the medical and public health workforce of the future must be trained to respond to both known and unanticipated crises, and trained in an equity-informed approach to clinical care and population health.

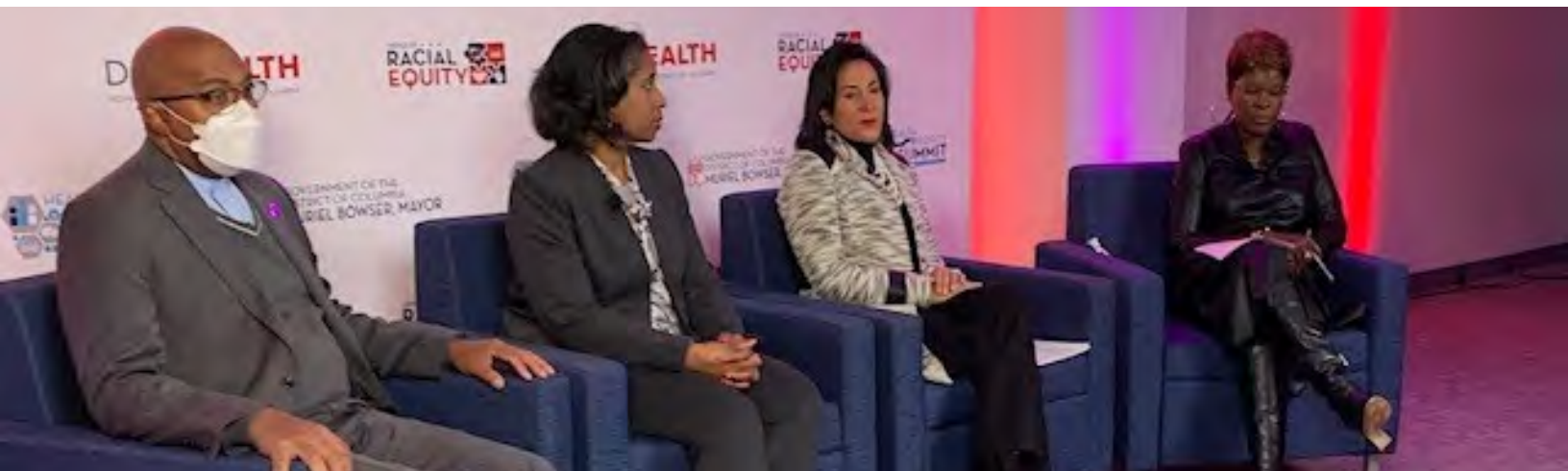
Dean Lynn Goldman of the Milken Institute School of Public Health at The George Washington University discussed the importance of a needed evolution of that institution's research and pedagogy in order to support students and faculty with interest in nontraditional areas, such as addressing violence and racism as public health issues.

Dr. Hugh Mighty, Dean of Howard University College of Medicine and Senior Vice President of Health Affairs, reflected on the unique opportunity for Howard University—a Historically Black College & University (HBCU) with deep DC roots stretching back to its founding in 1867—to leverage the whole institution in addressing long-standing disparities in the District in a more integrated way.



The pandemic generated new discussion in the business community around business recovery and economic development, health care, education, and workforce development which were showcased at the DC Chamber of Commerce's State of the District Conference. President & CEO Angela Franco touched on her experiences leading in this challenging time; sharing how the Chamber and its members play a role in integrating equity as a tenet of business practices, as well as promoting health equity in particular, to boost the impacts of positive economic development more broadly.

Also considered was the capacity to leverage investments such as the American Rescue Plan and other coronavirus pandemic relief efforts to sustain and advance equity and anti-racism focused initiatives, especially through the strategic orientation of foundations and other philanthropic organizations. Dr. Cara James, President & CEO of Grantmakers in Health, explored these ideas in light of this unprecedented opportunity to inform, direct, and activate new social change. Diversifying leadership and establishing meaningful bi-directional engagement with community members and stakeholders was a common theme applicable across all sectors represented.



**Key Question: What have we learned from the response to the pandemic, and how do these lessons inform & drive practice change going forward?**

**Dr. Lynn Goldman**

*"There's a lot that we learned about health disparities that's important—not just numbers, but the systemic nature of disparities and how institutions like our own are involved in helping to create those and have a role in helping to take those apart. And that's a place that I feel that we have a responsibility to do a lot of work in the future."*

**Dr. Cara James**

*"As leaders, we are questioning and thinking about our role in advocacy and policy, because as we know, that also is so important to the outcomes that we are all trying to achieve and affects our ability to do the work."*

**Angela Franco**

*"It is important, as leaders, to stress the importance of keeping our employees healthy, of keeping ourselves healthy and understanding that health is part of what we do... We still need to translate health equity more for the business community, including helping them understand that they don't have to be experts in health. What's needed are basic tools to help [make an impact]."*

**Dr. Hugh Mighty**

*"Education for the public is critical, and not necessarily going and getting a degree, but training our students to relay information to others—building trust and communication to bring the community in as laypeople experts, to more effectively address violence in schools, for example. You can get community folks to engage pregnant women early on. By leveraging the university as a whole, we are going to be able to address health disparities in a new way."*

**Panelists:**



**Dr. Lynn Goldman**  
Dean of Milken Institute  
School of Public Health,  
George Washington  
University



**Dr. Cara James**  
President & CEO,  
Grantmakers in Health



**Angela Franco**  
President & CEO, DC  
Chamber



**Dr. Hugh Mighty**  
Senior Vice President of  
Health Affairs; Dean,  
Howard University College  
of Medicine



## Get on Board: Adjust Our Seatbelts?

Health Equity - Paradigm Shift



**Moderated by:**

Autumn Saxton-Ross, PhD, Chair,  
Commission on Health Equity; VP  
of Education & Chief Equity  
Officer at National Recreation  
and Park Association

[DC HER 2018](#) has served not only as a uniquely framed source of hyper-local social and structural determinants of health data, but also as a starting point for conversations around the unique role of government—especially sectors not traditionally thought to impact health—in driving and shaping community health outcomes. District Government agencies and officials have built on the knowledge gleaned from DC HER 2018 to inform and advance equity-focused policy. DC HER 2018 has been cited and/or served as a model for discussion in the [Housing Equity Report](#) (2019), the [Comprehensive Plan for the District of Columbia, Update](#) (2021) and Equity Crosswalk; as well as the work and activities of the Food Policy Council within the Office of Planning<sup>9,10</sup>.

### SELECTED DISTRICT INVESTMENTS IN HOUSING COST ASSISTANCE



<i>STAY DC (Stronger Together Assisting You):</i>	<b>\$350 million</b>
<i>Tenant-Based Rental Assistance Program:</i>	<b>\$1.5 million</b>
<i>COVID-19 Housing Assistance Program:</i>	<b>\$20 million</b>
<i>Housing Stabilization Grants:</i>	<b>\$11.5 million</b>
<i>DC Mortgage Assistance Program (DCMAP):</i>	<b>\$1 million</b>
<i>Emergency Rental Assistance Program:</i>	<b>\$14 million</b>
<i>Emergency Solutions Grants:</i>	<b>\$27.7 million</b>
<i>Low Income House Energy Assistance Program:</i>	<b>\$16 million</b>

The foundation for equity-informed practice within this framework, along with lessons learned from the pandemic, offers an opportunity to re-envision what a “new normal” could look like. How can resources be leveraged to further shift policy and practice to advance health equity? Critical investments include those intended to support safe and stable housing for residents, particularly in the face of financial crises brought on by the pandemic.

Figure 3.3. Selected District Investments in Housing Cost Assistance<sup>11</sup>

These supports, in tandem with others in education, employment and other sectors, afforded needed assistance to DC residents when so much was uncertain.

This 'Health Equity Report 2018 Paradigm Shift' panel, moderated by Commission on Health Equity Chair, Autumn Saxton-Ross, PhD, brought together representatives from the housing, transportation, city planning, and philanthropy sectors to talk about the impact of the equity shift on their work. Beyond simply naming equity, District agencies and partners have integrated equity-informed strategies, policies, and practices into enduring city-wide planning, such as the Equity Crosswalk published as a supplement to the Comprehensive Plan for the District of Columbia, Update (2021). This document affirms that “equity is realized through targeted actions and investments to improve outcomes for those who face the worst health, social, and economic challenges” and brings attention to Comprehensive Plan policies and actions that explicitly address racial equity. The Housing Equity Report released in 2019—one of the first of its kind—laid out the current affordable housing landscape, and proposed specific targets to achieve Mayor Bowser’s bold goal of building 36,000 new homes, including 12,000 which are affordable to low-income residents, by 2025. DC Office of Planning (OP) Director Andrew Trueblood relayed the critical nature of this agency’s work to address resident housing and food access needs, and how important it has been to have the insights and data shared within DC HER 2018 as a resource.

Nana Bailey-Thomas, Director of Equity and Inclusion at the DC Department of Transportation, touted the agency’s forward-thinking strategy in implementing an equity statement, and the work that has followed to apply equity-focused strategies and drive an internal cultural shift towards equitable practice. The DDOT equity assessment tool evaluates proposed projects for community impact and measures resident and stakeholder engagement in the planning process. Many of these efforts began before the onset of the coronavirus pandemic, which has prompted even closer examination of the agency’s decision-making and old assumptions about how well the District performs overall, but especially in neighborhoods in dire need of additional social and community infrastructure assets and resources.

DC’s Office of Housing and Community Development (DHCD), represented by interim Director Drew Hubbard, worked closely with OP on the Housing Equity Report, and described how the work of DHCD goes beyond the creation of affordable housing and encompasses creative strategies to ensure DC residents are able to obtain and retain stable housing. The pandemic necessitated shifts to redirect rental assistance funds, secure new federal funding to meet need, and rethink virtual service delivery offerings to engage with a broader cross-section of community members when in-person opportunities were not possible.



What remains important regardless of pandemic status is the need for housing standards that support health, emergency resources to keep public housing safe and accessible, and expanding access to affordable housing in areas where it is lacking, so that residents may more equitably benefit from health and wellness-promoting benefits and amenities commonly found within resource-rich communities.

Complementing the collective enthusiasm for meaningful community engagement, Ruth Lindberg of the Health Impact Project shared efforts to promote stakeholder engagement and an assets-based approach in the work she leads. Highlights of these efforts include a commitment to empower community stakeholders to drive the direction and foci of grant-making, as well as supporting policy makers through a legislative “Health Note” tool being piloted to consider, broadly and specifically, the potentially unanticipated health impacts of proposed laws and regulations. Notably, Health Impact Project’s work to foster cross-sector collaboration has enabled the District of Columbia to model new ways of disrupting siloes and advancing equity through the [DC Calling All Sectors Initiative](#), led by DC Health’s Office of Health Equity. This multi-agency, public-private initiative seeks to examine how our systems can continue to work with community-based organizations to enhance support and improve health outcomes for residents at the intersection of pregnancy and housing insecurity and homelessness.

Panelists discussed insights that arose both before and during the pandemic, including new perspective on the need for collaboration and sharing institutional learning and best practices, the value of engaging, recruiting, and hiring District residents with lived experiences, and both the vulnerability and remarkable resiliency of historically marginalized communities. Increased willingness to take action toward a more equitable future was cited as a sign of hope for progress and alignment with stated goals.

## Key Question: How have non-health sectors engaged their role as drivers of health equity in the District?

### **Drew Hubbard**

*“We became the first jurisdiction to advance and adopt an equity housing plan—taking a deliberate look to attract affordable housing proposals in all 8 wards, and specifically west of the park in areas where you don’t have affordable housing traditionally. There is \$400 million this year in the Housing Production Trust Fund to help meet that need and produce affordable housing across the city.”*

### **Ruth Lindberg**

*“We support convenings and cross-sector collaborations to really help organizations and governments identify different policies and practices and research that can promote health equity and integrate them into their work. A couple of strategies include thinking about how to use data to inform our investments and targeting our funding in community use; elevating the importance of stakeholder engagement, particularly with residents with lived experience that may be directly affected; and thinking about an asset-based framework for the way we shape our initiatives.”*

### **Andrew Trueblood**

*“The DC Office of Planning built health equity into the District of Columbia’s Comprehensive Plan update. Because of the work of DC Health on the Health Equity Report, the District’s codified plan talks about everything from housing, to infrastructure, to neighborhoods. Around issues of economic opportunity and health outcomes, our Food Policy Council is supporting a double-sided goal of supporting local business and entrepreneurs and food access to ultimately improve health outcomes. That is the type of cross-cutting work across agencies, and across funding sources, that has been impactful.”*

### **Nana Bailey-Thomas**

*“DDOT has an equity assessment tool, and every project that applies for federal or local funding goes through this assessment. Many of the questions are focused on underserved communities in the District. Another part of the equity assessment tool is to get program managers, as well as chiefs, to understand, ‘Where is your project touching the community?’ Effective and meaningful community engagement is crucial.”*

### **Panelists:**



**Drew Hubbard**  
Interim Director DC  
Office of Housing and  
Community Development  
(DHCD)



**Ruth Lindberg**  
Director, Health Impact  
Project



**Andrew Trueblood**  
Director, DC Office of  
Planning (OP)



**Nana Bailey-Thomas**  
Director of Equity and  
Inclusion, DC Department  
of Transportation (DDOT)



## Rest Stop: Opportunities to Rest or Stop?

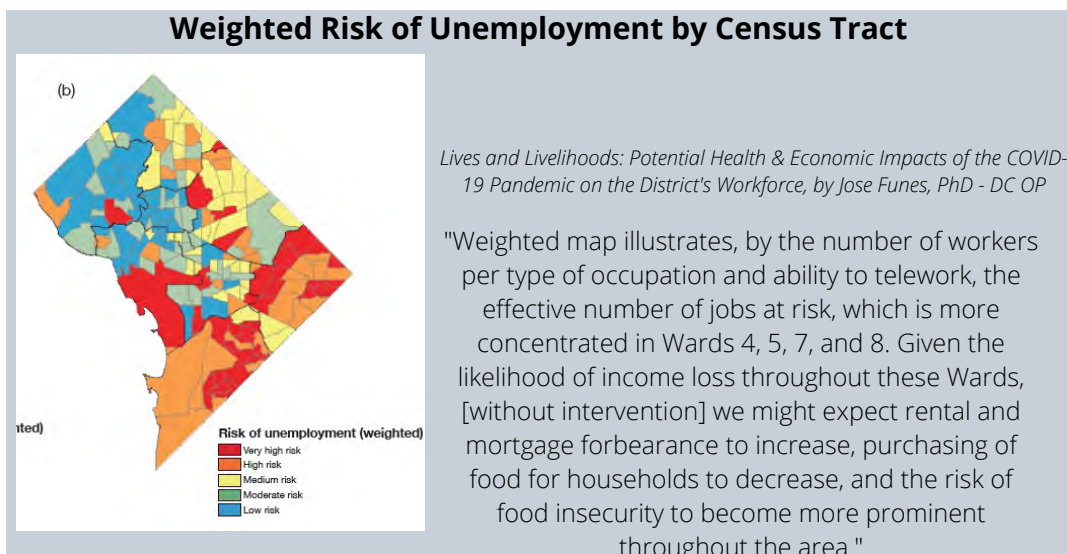
Pandemic Response and Insights



**Moderated by:**

Dr. Christopher King  
Commissioner, Commission on Health  
Equity; Associate Professor and Chair of the  
Department of Health Systems  
Administration, Georgetown University

Very early on in the coronavirus pandemic, it became clear that breaking policy silos would be necessary to tackle this new and ever-evolving public health emergency, including the social and economic crises it has generated. District agencies—and especially those in sectors not traditionally thought to impact health—faced a litany of new questions about how they will provide services, information, and other resources to the residents they serve. The new contexts faced by agencies include adjusting to change often while in a remote posture for the first time, with no end in sight. Instead of facing these new questions in silos, leaders and officials across District government and community-based organizations came together like never before to share information, disseminate lessons learned, and promote best practices. Technology resources were leveraged and new collaborations were built in order to maintain pre-pandemic levels of service, as well as to respond to emergent needs and solve shared problems in real-time.



**Figure 3.4. Weighed Risk of Unemployment by DC Census Tract** <sup>12</sup>



Central to the story of the pandemic has been the unprecedented number of people who have been impacted in some shape or form, and especially those who are most vulnerable. Frontline responders and other essential workers—typically, those who were not able to perform work duties remotely—faced a double burden of high risk of exposure to the virus, as well as high risk of job and income insecurity.

Families with children faced new considerations about the need and accessibility of high-speed internet; how to support their children's virtual learning; their own ability to work or access childcare; as well as increased stress, social isolation, trauma, and grief across the family unit. Many of the differential risks of the COVID-19 pandemic across DC Health's Nine (9) Key Driver Framework, from a social and structural determinants of health lens, are summarized in Figure 2.4.

In this 'Pandemic Response and Insights' Summit session, representatives across the sectors of employment, human services, education, and youth service discussed the community-responsive strategies employed during the pandemic. The session, moderated by Christopher King, PhD, FACHE, of the Commission on Health Equity, included heartening retellings of panelists' experience with, and approach to, a people-centered pandemic response.

Sharing from the perspective of a community-based organization (CBO), Latin American Youth Center (LAYC) President, Lupi Quinteros-Grady, discussed how critical it was to be able to pivot and employ new strategies swiftly when faced with new challenges. She noted that within the first two weeks of the pandemic, LAYC had reinvented their approach to outreach and addressed misunderstandings that arose about the needs of the young people they serve. LAYC's role as a bridge connecting the Latinx community to a spectrum of resources has proven a lifeline for those needing support and a buffer against social isolation. CBOs like LAYC respond to the needs of residents across many contexts and circumstances; when working together to share what they've learned, these organizations break down siloes and help communities to survive and thrive.

Department of Employment Services (DOES) Director, Dr. Unique Morris-Hughes, noted DOES' historical and contemporary role as an economic first responder and reflected on the front-line work of this agency to help individuals impacted by the financial crisis brought about by COVID-19. More than ever before, DOES staff saw and understood how critical benefits like unemployment insurance help residents survive challenging times.

District of Columbia Public Schools (DCPS) representative Dr. Bren Elliot, chimed in, noting that historically marginalized students and families are even more vulnerable during times of crisis, and the impact is exponential. Many essential workers and their families were more vulnerable to exposure to the virus, as well as to financial devastation. In order to meet emergent needs in the community, the role of DCPS schools were expanded as facilities opened to function as meal sites and vaccine clinics for children, or temporarily repurposed as childcare sites for essential workers. Recognizing that the need for mental health support extended to the entire family unit, behavioral health resources were made available to students and parents alike. In these ways, schools became a link in the chain of needed services and supports, connecting to provide relief to families across the District amidst the ever-shifting landscape of the pandemic.

Though the most visible Department of Human Services (DHS) programs address the specific needs of DC's unhoused residents, Director Laura Zeilinger made sure to emphasize the agency's overarching mission of social justice, achieved through connecting residents with economic opportunity. During the pandemic, the agency's work was further complicated by disparities in access to technology. With many District buildings closed and the public under stay-at-home order, the processing and approval process for crucial public benefits was transitioned to a virtual platform to allow for remote access; however, those without reliable access risked missing out on needed benefits. Another learning curve was related to the confluence of factors experienced by unhoused residents and those in congregate settings that put them at increased risk of COVID. To ensure the health and safety of residents and staff, DHS swiftly established new policies and mobilized new offerings to ensure social distancing for those in need of shelter, including hotel stays and temporary single-occupancy housing. At the time of the Summit, there were approximately 500 people in non-congregate shelter placements, and additional support for unhoused individuals remained available to promote opportunities for self-sufficiency and access to safe and stable housing. Collaboration—whether between landlords partnering with the District to provide leases to families in need of a home, across government agencies, or with organizations providing services to community members—remains a key ingredient to success in advancing the work of these panelists' agencies and organizations.

**Key Question: How will we engage an equity-informed disruption of the status quo through policy and practice change?**

**Laura Zeilinger**

*There were a lot of things that we knew, that were driven home in a very profound way. We're only successful as a community—the government does not work alone, we act in partnership with organizations, with our residents, and across sectors to address disparities in technology, education, housing, and food security."*

**Dr. Unique Morris-Hughes**

*"We had to scale up very nimbly, and be able to adjust to over 60 statute and policy changes. One thing that has been reinforced is continuing to hire and recruit from the community. Because what I've learned is that in a time of crisis, we were able to communicate and interact with people who had the same lived experience [and could empathize -...] that makes a difference."*

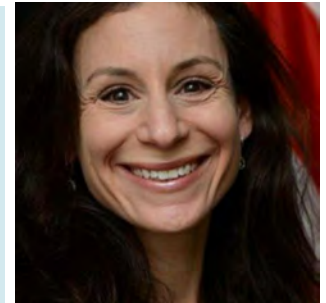
**Dr. Bren Elliott**

*"Our historically marginalized students and families are even more vulnerable during times of crisis...having a safe place for students to learn was essential for these families [who are often employed as essential workers]...there were many ways that the school district had to lean in, [from] opening our schools as meal sites, vaccine clinics; supporting immunization compliance, providing space for childcare for essential workers...we needed to support, and a big part of that, was mental health support, not only for our students, but for parents as well...it's about supporting the whole child and the whole family in things that they needed to be successful, not only in school, but to be able to thrive in their homes and communities."*

**Lupi Quinteros-Grady**

*"We see the mental health [need within] the community we serve but also the staff that are in direct service and the toll that it has taken [on direct service providers and frontline workers]. I've come to be creative about what we need to do to continue to be flexible, but at the same time be able to pay attention to our staff so that they can be whole and continue to do the work that they do to serve our communities."*

**Panelists:**



**Laura Zeilinger**  
Director, DC Department  
of Human Services (DHS)



**Dr. Unique Morris-Hughes**  
Director, DC Department of  
Employment Services (DOES)



**Dr. Bren Elliott**  
Chief of School  
Improvements and  
Supports, DC Public Schools  
(DCPS)



**Lupi Quinteros-Grady**  
President & Chief Executive  
Officer of Latin American  
Youth Center





## Are We There Yet: Racial Equity Future?

The Fierce Urgency of Now



**Moderated by:**

Amber Hewitt, PhD, Director,  
Mayor's Office of Racial Equity



### STRUCTURAL RACISM

*...the totality of ways in which societies foster racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, health care, and criminal justice. These (inequitable systems) patterns and practices in turn reinforce discriminatory beliefs, values, and distribution of resources.*<sup>13</sup>



Promoting health equity requires us to confront and address the root causes of inequities across all the key drivers of opportunities for health, knowing that building a healthy community has benefits that extend well beyond health alone. Creating equitable opportunities for health in the District of Columbia requires multiple sectors working collaboratively, each doing their part in promoting improved outcomes.

Generations after eliminating explicit legal discrimination in the US, disparities by race and ethnicity persist, perpetuating generational patterns of disadvantage and inequity. The pandemic highlighted the disproportionate impact of COVID-19 illness and death on Black/African-American and Hispanic/Latinx District residents—just one example of the ways that historically marginalized communities continue to fare worse than their White, Non-Hispanic counterparts. In calling out these inequities, it is important to recall that disparities in health outcomes are neither natural nor inevitable, but a product of interconnected social, structural, and political factors discussed in some detail throughout the DC Health Equity Summit panels and presentations. Similarly, efforts to advance health equity are strongly linked to the advancement of racial equity, and should be intentionally considered when exploring solutions to address and transform the root causes of disparate outcomes across all key health drivers of opportunities for health.

DC Health is fortunate to have partnered with the Mayor's Office of Racial Equity (ORE) within the Office of the City Administrator to host this Summit. The newly-minted Office is responsible for collaborating with District agencies, residents, and external stakeholders to make meaningful progress toward a more racially equitable city. ORE develops capacity in District government and the community: hosting trainings for government staff; piloting a suite of racial equity tools and processes with 12 District agencies; convening the Interagency Committee on Racial Equity, which will provide ongoing racial equity initiative implementation support and accountability; and advancing the development of outcome-oriented, high-quality racial equity indicators and data standards.

Dr. Amber Hewitt, Director of ORE and the District's Chief Equity Officer, moderated this panel on 'DC's Racial Equity Future: The Fierce Urgency of Now', featuring leaders in public safety, finance, and philanthropy. Dr. Hewitt led a discussion around how these leaders are moving the needle on health equity and racial equity, calling attention to efforts designed to break historical barriers to employment opportunities and advancement, and recognizing intersectionalities among the diverse population of those who live, learn, work, play, and age in the District of Columbia.

This session laid out a vision of an equitable future through innovation and systems transformation. Indeed, Temi F. Bennet, Esq. of the newly rebranded if, A Foundation for Radical Possibility, detailed the 2021 shift to racial justice as an organizing principle, including participatory grantmaking, expanded language access, promoting a culture of rest and work/life balance, and cross-sector collaboration with government. With a history going back 86 years, the foundation's strategic plan based on racial justice, grounded in the belief that eliminating health inequities could not be achieved without it—both evolving and returning to their roots.

Three of the 12 District agencies participating in ORE's Racial Equity Pilot Cohort spoke to their experiences and the context of this work, which include an organizational assessment of racial equity and the development of an agency racial equity action plan. Captain Paul Hrebenak of the Metropolitan Police Department (MPD) shared efforts to shift workforce pipeline and recruitment strategies to diversify the Police Department and reflect the diversity of the community served. Engaging young residents through cadet training and increasing racial diversity in law enforcement through the 30 by 30 initiative are just two strategies cited to advance this work. DC Fire and Emergency Medical Services (FEMS) is one of the most diverse fire departments among big cities; Chief of Staff Amy Mauro shared their work to address a history of systemic discrimination and increase representation of staff who identify as Latino/a and Asian. And Commissioner Karima Woods of the DC Department of Insurance, Securities & Banking (DISB) described their actions to address Diversity, Equity, and Inclusion within the agency following the summer of civil unrest sparked by the murder of George Floyd. All partners involved in this DC Racial Equity Cohort pilot will benefit from technical assistance and coordination to develop better community engagement models and advance opportunities for the next generation as the District continues to learn and recover from this pandemic.

**Key Question: How will we move beyond models limited to compensating for the impact of structural racism?**

**Karima Woods**

*"We know that there is a direct correlation between one's physical health and their financial health. We're using a number of tools to help remove barriers that limit access to quality healthcare and we are also a part of a number of national conversations happening right now on the racial inequities in the financial services industry. In summer 2021 we expanded our financial services academy, which is a public-private partnership between our department and local education institutions and private companies focused on introducing and exposing high school and college students—particularly those from underrepresented communities—to the financial service sector with the goal of building a pathway to a career"*

**Captain Paul Hrebenak**

*"Chief Contee has started an independent cultural assessment for MPD to take stock of the opportunities within our department for groups of people who don't traditionally have opportunities for advancement into management, and what can we do better in the future. Our cadet program is a way to bring youth from the community into the police department so that our department can look like the community it polices, and we need to continue to move the needle on that. [Importantly,] sometimes we stop talking and start listening more."*

**Amy Mauro**

*"The fire department is one of the largest providers of healthcare in the District—improving the compassion and competence of our EMS care is a top priority. We also consider ourselves a partner in the access of equitable healthcare. We started the nurse care triage line in 2018 with the goal of diverting non-emergency patients away from 911 and emergency departments and into a primary care setting so that those patients can get the right healthcare 'home' and hopefully improve their health and their health outcomes overall."*

**Temi F. Bennet, Esq**

*"We have shifted from a racial equity lens to a racial justice lens—justice requires acknowledgement of past harms in order to heal. We have shifted our entire grant-making portfolio to participatory grantmaking where the community actually decides where the money goes. At the end of the day, racial equity is about shifting resources into communities that have been divested from for centuries."*

**Panelists:**



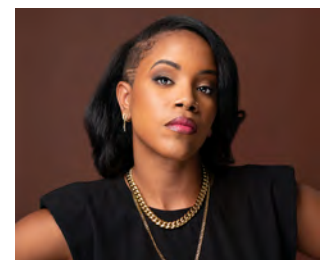
**Karima Woods**  
Commissioner, DC  
Department of Insurance,  
Securities & Banking  
(DISB)



**Captain Paul Hrebenak**  
Director,  
DC Metropolitan Police  
Department (MPD)



**Amy Mauro**  
Chief of Staff, DC Fire and  
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Possibility



## Are We There Yet: Health Equity Future?

A Once-In-A Generation Opportunity



**Moderated by:**  
Dr. C. Anneta Arno, Director,  
Office of Health Equity

### SOCIAL DETERMINANTS OF HEALTH

“

*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*<sup>14</sup>

”

As illustrated in DC HER 2018, and again in the response to the COVID-19 pandemic, equitable community health improvements will not be achieved by the health care system or public health working on their own. As 80% of community health outcomes are created outside of the traditional health care system, it is critical to employ a HiAP approach in an effort to improve population health and advance health equity.

Since its inception in 2015, DC Health’s Office of Health Equity has worked to address the root causes of health disparities beyond healthcare and health behaviors, while informing, educating, and empowering community stakeholders at all levels.



Convening this Summit is only the latest chapter in OHE's commitment to multi-sector partnerships to advance its mission to eliminate health inequities. The 'Health Equity Future: A Once-in-a-Generation-Opportunity' panel served as an example of this mission in practice across the District. In this session, moderated by Office of Health Equity Director C. Anneta Arno, PhD, MPH, panelists from the outdoor environment, community safety, and water utility sectors discussed challenges addressed, and successes reached, through a whole-of-community approach to problem solving, the role of institutions as role-models and conveners of multi-sector change efforts, and the work that must continue to bring the vision for an equitable post-pandemic future into reality.

In unpacking and discussing the concept that health equity is everybody's work, panelists shared key ideas for collective transformational change in the District. The need to have diversity for strength and resilience was noted, including within the workforce across all organizational functions and levels. Additionally, the importance of holistic wellness, including stress management and access to outdoor environments that promote health, have been elevated during COVID-19. There remains much to be learned about tailoring services and supports for communities that continue to experience barriers to opportunities for health, such as those with highly concentrated poverty, violence, and crime. Solutions will only be found by focusing on where the challenges are, such as accessing and retaining employment for traditionally excluded populations such as returning citizens. Listening to community needs, then planning, coordinating, and implementing solutions together, is key to successful outcomes as a result of responsive efforts.

The dialogue also turned to the importance of practicing meaningful community engagement that centers residents in the planning, development, and implementation of solutions in neighborhoods. This needs to be embedded in everyday work and should be framed around genuine listening, and not simply performative "check the box" outreach. Meaningful engagement means that we must create an environment that is conducive and consistent with relationship building. This must come with awareness too, that what works in one place may not work in another, even if it's just two blocks away. Questions related to engaging young people were also raised. Direct engagement, with emphasis on meeting young Washingtonians where they are, is critical insight for understanding how the younger generation want to be engaged.

Finally, in considering the role of all the sectors in moving the equity needle, the collaborative DC Flood Taskforce addresses District flood events and water damage as a useful model for driving change. We know that flood events and water damage will be more frequent and severe in the future due to climate change, and that most of the areas in the District that are known to be at risk of flooding are inhabited by residents that are vulnerable and economic disadvantaged. This collaborative process has representation from across District agencies, all working together on this issue while applying an equity lens.

Similarly, DC Water will be creating an integrated model of the District's water mains/pipe system and natural water systems to help drive decisions on investments on infrastructure and policy change. It is anticipated that the infrastructure bill will provide historic levels of funding for the water sector. In doing so, however, it will be important to maximize climate resilience, specifically in historically marginalized communities and those communities more susceptible to climate change impacts.

While many important examples of policy and practice change during the pandemic were shared, the DC Water story crystalized a key idea. For their efforts to prepare the District for climate events, their equity-focused practice change is consciously centering those certain to be mostly affected. While the engineering processes are sufficient for equity-focused practice, the shift in intent to engaging vulnerable residents as the primary recipient of the intervention demonstrated a transformative shift in planning, and is worthy of highlighting as a model. Perhaps the current-state and the desired future-state are not as different as we assume. Perhaps, a recentering of who these interventions are intended to serve is sufficient to transform practice.

**Key Question: How will we engage an equity-informed disruption of the status quo through policy and practice changes?**

**Delbert McFadden**

*“We need to look at government and see where there are challenges with getting this small population [of returning citizens] the services and supports they need, from housing to job training and employment... How do we work with businesses and government to relax some of the criteria for employment and for housing? To jointly develop strategy, feedback, and partnership with and for the community—planning together and making sure that we strategize collectively so that we’re not duplicating efforts is so important. With stimulus funding we are able to utilize community wellness ventures to provide culturally specific and culturally competent services and meet individuals where they are.”*

**Tommy Wells**

*“For our city to be resilient, and to be able to respond to a health crisis or any type of crisis, you have to have diversity for strength and resiliency... We know the importance of inclusion. It’s one thing to say, ‘We’re going to be equitable and ... ensure that everybody has the same thing.’ But if [the community is] not part of deciding what that thing is, then is it really equity?... We no longer contract out stakeholder engagement in communities, because why would [we] buy that capacity instead of creating [it]?”*

**Kishia L. Powell**

*“We know [climate change] directly impacts our neighborhoods and communities... The DC Flood Task Force—13 agencies working together from across the District...—has laid out several action areas from governance to more specific things like mapping, modeling, and implementation... [and the infrastructure bill] provides historic levels of funding for the water sector... We know that one of the things that this administration wants to maximize under the use of these funds is climate resilience in specifically disadvantaged communities and those communities that are most physically and economically vulnerable to climate change.”*

**Panelists:**



**Delbert McFadden**  
Director, Office of  
Neighborhood Safety &  
Engagement (ONSE)



**Tommy Wells**  
Director, DC Department of  
Energy & Environment (DOEE)



**Kishia L. Powell**  
Chief Operating Officer and  
Executive Vice President, DC  
Water

# PART 4: KEY INSIGHTS AND TAKEAWAYS



# KEY INSIGHTS AND TAKEAWAYS

## 6 KEY QUESTIONS & SUMMIT LEARNINGS

The Health Equity Report: District of Columbia 2018 prompted new discussions about policy, practice, decisions, and investments (or lack thereof) across all sectors (public, private, and non-profit)—especially those well outside public health and healthcare, such as in education, employment, housing, and transportation. All of these systems together affect the health, well-being, and quality of life of District residents.

In convening the inaugural DC Health Equity Summit 2021, DC Health's Office of Health Equity, in collaboration with the Mayor's Office of Racial Equity, envisioned a conversation that would unpack and connect the dots related to the social and structural determinants of health in the District. Informed by the impacts, insights, and contemporary experiences made explicit by the COVID-19 pandemic, the Summit would explore the drivers of persistent health inequities, with an emphasis on the identification of opportunities for disruption of status quo, including structural and institutional racism in the pandemic-recovery context. The Summit agenda and sessions were designed to address six key questions:

### Key Question 1 (KQ1):

- **How has COVID-19 underscored the connection between structural racism and health in every aspect of society?**

### Key Question 2 (KQ2):

- **What have we learned from the response to the pandemic, and how do these lessons inform and drive practice change going forward?**

### Key Question 3 (KQ3):

- **How have non-health sectors engaged their role as drivers of health equity in the District?**

### Key Question 4 (KQ4):

- **How will we engage an equity-informed disruption of the status quo through policy and practice change?**

### Key Question 5 (KQ5):

- **How will we move beyond models limited to compensating for the impact of structural racism?**

### Key Question 6 (KQ6):

- **How can the lessons of the pandemic drive a strategic reimagining of the response to achieving health equity?**

In this concluding section, we summarize what was learned across Summit conversations, by drawing from their content in answering the key questions above. Additional research has also been added to flesh out the answers where appropriate.

### KQ1: How has COVID-19 Underscored the connection between structural racism and health in every aspect of society?

The pandemic vividly underscored the connection between the social and structural determinants, including structural racism, and health, with ramifications across every aspect of society. [Figure 2.4, Differential Impacts of COVID-19](#), illustrates the underlying differential risks across the 9-Key Drivers, as well as their interrelationship. Data on pandemic health outcomes in the District, summarized as of December 9, 2021 (the date of the Summit), show a total positive COVID-19 case count of 68,460. Of these, 52% of cases were Black/African American residents; 25% non-Hispanic White residents; 21% Other/Multi-Racial residents; and 16% Hispanic/Latinx residents. Of these positive cases, a total of 1,197 District residents had lost their lives. Deaths from COVID-19 disproportionately impacted Black/African Americans, who sustained 76% of all deaths. Their share compares with 11% and 10% of deaths among Hispanic/Latinx, and non-Hispanic White residents.

As with the DC HER 2018 picture of opportunities for health linked to income, geography, and race, the distribution of vulnerability, risk of infection, and lost lives correlate with social and structural drivers, as demonstrated by [Figures 2.5, 2.6, and 2.7, The DC-COVID-19 Structural Vulnerability Index](#).

The pandemic vividly underscored the connection between structural racism and health across every aspect of society. Health outcomes in the District, presented in the section on “Impact of COVID” (Background 2) which includes the DC-COVID 19 Structural Vulnerability Index, illustrate these connections. In framing the conversation, Daniel Dawes effectively demonstrated the importance of connecting historical and contemporary contexts, making the case that policy is not race-neutral. On the contrary, his presentation, “The Political Determinants of Health Inequities: Repairing the Past and Building a More Equitable and Just Post Pandemic Future for DC”, vividly explained how we got here in the first place. It is the cumulative impact of the much broader national landscape of “big-P and little-p” policy, going back 400 years. Quoting William Faulkner, Dawes noted that “The past is never dead. It’s not even past.” From this vantage point, it is evident that the disparate impacts of the pandemic in the District are symptomatic of deep historic and structural roots—including structural and institutional racism.

## **KQ2: What have we learned from the response to the pandemic, and how do these lessons inform and drive practice change and the way forward?**

The COVID-19 pandemic impacted us all, underscoring the breadth and scope of our interdependency. Organizations and institutions, both large and small, had to adjust their operations to meet the needs of customers and staff. The pandemic also changed how organizations perceived and responded to their individual and collective roles in our community.

The DC HER 2018 emphasized that healthcare access is only one determinant of health and that eight other sectors, or drivers, impact our community's health. The District is rich in nationally and internationally acclaimed academic institutions, and is proud of the leadership they provide in both medicine and public health. They play an important role in building the knowledge base and positioning themselves to deliver on scientific and thought leadership, including an expanded healthcare workforce (e.g. Centers of Excellence at Howard University). Many gaps and opportunities for improvement remain, however, in integrating the broader social and structural determinants of health landscape essential to appropriately addressing key drivers of health such as education, economic development, and housing. Our local universities and institutions have an important role to play in being more directly responsive to the unique needs and challenges of the District. As a historically Black college and university (HBCU), and one of the District's oldest and most revered institutions, Howard University has a unique opportunity to lead in this space. As Dr. Hugh Mighty noted, "by leveraging the university as a whole, we are going to be able to address health disparities in a new way."

Moving beyond programs limited to and developed around outdated service-learning paradigms, institutions of higher education have a vested interest in building strong, more engaged relationships with the communities surrounding their campuses. A great example of a purposeful and engaged university/community partnership, is the University of Louisville (UofL) Signature Partnership Initiative, which is dedicated to enhancing the quality of life and economic opportunity for residents of West Louisville<sup>15</sup>. Their goal is to work with various community partners to improve the education, health, wellness, and social status of individuals and families who live in their urban core. Working closely with community, residents, Jefferson County Public Schools, Louisville Metro Government, Metro United Way, the Urban League, faith based organizations, and many others, the University has coordinated and enhanced existing programs and launched new programs designed to eliminate or reduce disparities that West Louisville residents experience in education, health, economic, and social conditions. The University draws upon the expertise and energy of faculty, staff, and students from every school and college at UofL to deal with quality of life issues affecting the Louisville community. A host of other examples and models can also be found across the country, such as those showcased by the Democracy Collaborative<sup>16</sup>.

DC Health released the COVID-19 Health and Healthcare Pandemic Recovery Report in May 2021. It identifies workforce as one of the core elements of focus in the post-pandemic recovery environment. Public health education and training has historically embraced the tenet of “doing the greatest good for the greatest number of people”. In line with this philosophy, and underscored by the pandemic experience, it is critical to infuse an equity-focused approach to public health education and training for the current and future public health workforce. The dialogue identified some critical and innovative ways that the curriculum, capstone experiences, and scholarly activity at our local academic institutions, such as Milken Institute School of Public Health, must evolve to effectively support student and faculty with interest in nontraditional areas such as addressing violence and/or racism as a public health issue.

As part of the national response to the global pandemic, the American Rescue Plan and other COVID relief funding efforts have provided unprecedented investments in health, including public health infrastructure. The inclusion of measures such as an eviction moratorium in pandemic response legislation is a promising signal of efforts to change the conversations and drive attention to social and structural determinants more broadly. In a similar vein, foundations and philanthropic organizations have been rethinking their traditional investment portfolios and practices in health, and are looking to shift the types of investments they make, with an emphasis on advancing equity and supporting anti-racism practice. Initiatives within our community and region include, for example, the update to the Greater Washington Community Foundation’s 2021 vision to develop a bold 10-year strategic vision that will leverage resources and expertise to lead our community in addressing the most catalytic opportunity of our lifetimes: closing the region's racial wealth gap.

Other examples include the Partnership to End Homelessness, through which local government agencies, nonprofit service providers, philanthropists, business leaders, and DC residents are joining forces to end homelessness by strengthening systems and bringing deeply affordable and supportive housing to every ward of the city. Led by the District’s Interagency Council on Homelessness, in collaboration with the Greater Washington Community Foundation, the partnership brings together the public and private sectors to advance effective and innovative solutions that will accelerate the development of affordable housing and ensure homelessness in DC is rare, brief, and nonrecurring<sup>17</sup>.

Announced in early 2022, the Health Equity Fund (HEF) is the largest in The Community Foundation’s nearly 50-year history. The fund is an unprecedented \$95 million reinvestment in DC neighborhoods and nonprofits<sup>18</sup>.



“As we all know, the COVID-19 pandemic further widened and amplified pre-existing health inequities. The Health Equity Fund offers a once-in-a-lifetime opportunity to catalyze systemic, lasting change to improve health outcomes and social determinants of health<sup>19</sup>.”

Similarly, the DC Chamber’s hosting of the “State of the District Conference” (October 1st 2021), focused on moving past the pandemic to rebuild our economy. Their session emphasized the key elements of business recovery and economic development, health care, education, and workforce development. Consideration of the role the Chamber, its members, and the business community more generally play in integrating equity as a core competency, and in promoting health equity in particular, was part of the Summit's framing plenary session.

### KQ3: How have non-health sectors engaged their role as drivers of health equity in the District?

An overarching Summit theme was exploring how non-health sectors operationalize their role as drivers of health equity. With an emphasis on the eight non-healthcare key drivers of opportunity for health, the discussion focused on examples of how they are explicitly applying concepts of equitable distribution into policy and practice in initiatives and project implementation. Panelists explored both the pre-pandemic “early adopters” paradigm shift, and the “rapid response adopters” during the pandemic. Emphasis focused on how principles of equity were explicitly communicated to staff and prioritized within agencies and organizations, in reframing traditional professional practice and challenging underlying assumptions.

There is clear evidence that, even prior to the pandemic, several of our District Government partners had begun to embrace an equity-informed, Health in All Policies (HiAP) paradigm shift, generated and/or expedited by publication of the Health Equity Report for the District of Columbia (2018). The explicit adoption of an equity lens in the approved update to the Comprehensive Plan Amendment (2021) for the District of Columbia, is strong evidence of early adoption. The update includes a supplemental Equity Crosswalk that highlights Comprehensive Plan policies and actions that explicitly center racial equity. Publication of the Housing Equity Report (2019) provides an analysis of current affordable housing distribution and proposes specific targets to achieve Mayor Bowser’s bold goal of building 36,000 new homes, including 12,000 homes affordable to low-income residents, by 2025. Highlighting the District as one of first jurisdictions to advance and adopt an equity housing plan and strategy, this effort also reflects the importance of collaborative practice and the impact of a District-wide commitment to equity. Jointly published by the Department of Housing and Community Development (DHCD) and the Office of Planning (OP), the policy priorities in the Housing Equity Report underscore an equity-informed shift in planning for affordable housing in DC with an emphasis on promoting investment in affordable housing across all 8 wards, supported by annual increases in the Housing Production Trust Fund, up to \$400M in 2021.

The District Department of Transportation (DDOT) also shared their example of applying an equity assessment tool to all federal and locally-funded projects. Their assessment tool prioritizes the needs of underserved communities, reflecting their commitment to effective and meaningful community engagement.

Other equity tools being applied include “Health Notes,” a promising new tool piloted in DC by the Health Impact Project in collaboration with the Council of the District of Columbia’s Office of the Budget Director. The tool was used to evaluate the potential health benefits of SmartTrip cards to adult residents (18 years and older), who were ineligible for other transit subsidy programs. The goal of Health Notes is to help policy makers identify the potential and often overlooked connections between various sectors and health.

#### KQ4: How will we engage an equity-informed disruption of the status quo through policy and practice change?

If nothing else, the COVID-19 emergency has forcefully connected the dots between the social and structural determinants of health, accentuating the intersectionality across social, economic and political systems within which we all live learn, work, play, and age—including their persistent inequities. In particular, it underscored the fragmentation and dysfunction of the status quo that had to be addressed as a pandemic response imperative.

Across the spectrum, interdisciplinary analysts, practitioners, and policymakers have aptly framed the worldwide COVID-19 pandemic as the embodiment of a “wicked problem,” a crisis context in which multiple urgent, interdependent societal goals simultaneously arise, generating competing priorities for resources and attention. Population health measures implemented to address both short and longer term health risks and impacts of COVID-19 sickness and deaths revealed the social repercussions of containment policies, including the differential impacts of social inequities, mental health issues due to social isolation, as well as intergenerational conflicts, to name but a few. Pandemic-related data also clearly illustrated how race and place drove unequal vulnerability to the economic crisis COVID-19 created<sup>20</sup>.

Arguably, however, the seemingly unique circumstances of the last two years have only exacerbated existing “wicked problems”. As noted during the Summit, progress towards community health improvement has for too long been limited to well-meaning agencies and organizations working mostly in silos, frequently applying outdated paradigms within legacy systems that collectively failed to examine and address their role in perpetuating the root causes of health inequities. In documenting the story of COVID-19’s impact on the Human and Social Services Sector across the northeastern United States, including interrelated issues amplified across the public, private, and non-profit sectors, the Federal Emergency Management Agency (FEMA) Region 3 noted<sup>21</sup>:

*“Human and social service programs are set up to deal with wicked problems in the public sphere, and the pandemic has presented vexing issues that require the sector to confront issues such as the fact that the pandemic has not impacted all Americans in the same way. Social class, race, ethnicity, being deemed an essential worker, and gender has arisen as primary determinants of both infection rates and economic impacts... essential workers, many of whom earn low wages and do not receive benefits from their employers, have suffered disproportionately. Concurrently, furloughs in sectors with high levels of female employment and the increased burden of child-care duties on working mothers have created a large gender disparity in terms of employment outcomes ...”*

It is worth remembering too, that the human services sector itself, is an important part of the District's economy. Prior to the pandemic, the sector employed about 11.3 % of the labor force. Some 24% of the DC budget was devoted to human and social services, and 27% to public education. A total of 10,448 registered nonprofits employed 26% of the private workforce, and generated an estimated \$37 billion in annual revenue<sup>21</sup>.

Faced with potentially devastating impacts on District residents, especially given those in social and geographic concentration within communities with less optimal opportunities for health, human service agencies and sectors faced a tsunami of need as a direct consequence of the pandemic. Organizations serving vulnerable populations had to respond rapidly to ensure the continuity of services to meet people's needs—needs exacerbated by the pandemic. In particular, organizations were forced to rethink their traditional reliance on in-person service delivery and supports models.

In 2019, prior to the pandemic, the median household income in DC was \$92,266, an increase of 8.29% over the previous year, and significantly above the national median of \$62,712. Overall income inequality at 0.44 (measured using the Gini Index), was lower than the national average. However, the median family income among DC households with children in 2019 (\$106,700) reflects considerable inter-group differences; from \$247,900 for White families, to \$92,800 for Hispanic Families, and \$47,400 for Black families<sup>22</sup>. Layered in addition to these data is the depth and skewed impact of poverty in the District, which in 2019 was significantly higher (16.2%) than the national average of 12.3%; with Black/African Americans representing nearly 65% of those living in poverty (79,190 people); followed by White (15% or 16,824 people), and Hispanic residents (8% or 8,776 people)<sup>23</sup>. These official poverty rates are based on the national poverty threshold in 2019 for single individuals at \$13,011; while that for a family of four, including two related children under 18, was \$25,926<sup>24</sup>.

In 2020, after the onset of the pandemic, the federal government's response included two economic stimulus payments to households, expanded unemployment benefits, and expanded assistance programs such as Supplemental Nutrition Assistance Program (SNAP). All were critical to aiding both individuals and families during challenging times. Overall, however, the data show that even these critical supports had differential impacts by income, place, and race across the country and within the District, underscoring structural biases in the application and impact of policies and programs.



The Supplemental Poverty Measure (SPM), a post-tax and transfer poverty measure, captures expansion of unemployment insurance (like the official poverty measure), but also includes stimulus payments and expansions to SNAP that are not included in the official poverty measure. In 2020, the national SPM rate was 9.1%, not only the lowest rate since estimates were initially published for 2009, it was also 2.6 percentage points lower than the 2019 SPM rate of 11.8. Much was made in the press of the fact that this was the first time in the history of the SPM that poverty was lower using the SPM than the official poverty rate, generally demonstrating the tangible efficacy of pandemic support expansion. In contrast, however, the District of Columbia, along with 11 states (including neighboring Maryland and Virginia), saw SPM rates that were higher than official poverty rates in 2020. This confirms that the experience and challenges of poverty in our region during the crisis was actually more pronounced than indicated by the official poverty rates despite additional pandemic supports. Higher SPM rates by state may occur for many reasons. Geographic adjustments for housing costs, as well as different mixes of housing tenure, may result in higher SPM thresholds. Higher nondiscretionary expenses, such as taxes or medical expenses, may also drive higher SPM rates<sup>25</sup>.

Differential impacts of policies and programs that are seemingly sociodemographic- and race-neutral on their face, are underscored in a recently published study on the impact of government transfers on the Black-White child poverty gap. Using both the official poverty and supplemental poverty measures prior to the pandemic (2017-2019), it concluded that government transfers and tax credits are effective in equalizing incomes of Black and White children in poverty, but are entirely ineffective in closing the Black-White poverty gap. In particular, it was noted that Black children are nearly three times more likely to live in poverty than White children, both before AND after accounting for government transfers (including specific basic needs like food or shelter) and cash and tax credits (that can be used more flexibly). They show, too, that government transfers and tax credits impact Black and White children in poverty differently: in-kind transfers disproportionately benefit Black children, while cash transfers and tax credits disproportionately reduce poverty and raise incomes for White children. Indeed, “after accounting for all transfers and tax credits, the Black-White child poverty gap is slightly larger than where it started... [Up from 2.71 to 2.86, showing that] ... altogether, transfers and tax credits do not narrow the Black-White child poverty gap. If anything, they slightly exacerbate it.”<sup>26</sup> The persistence of this gap is an indication of the impact of deeply-embedded structural racism on socioeconomic outcomes across the population, and it begs further scrutiny of the role that social policy may play in addressing, or sustaining, inequity.

### KQ5: How will we move beyond models limited to compensating for the impact of structural racism?

The Health Equity Report for the District of Columbia (2018)'s precept “Structural racism acts as a force in the distribution of opportunities for health” was both well-known and documented prior the pandemic. The racialized impacts and disparate outcomes of COVID-19, underscored by the disproportionate burden borne by Black and Brown communities, has demonstrated its prescience, in the face of underlying socioeconomic inequities, including their persistence across all the key drivers of opportunities for health.

COVID-19 has explicitly connected the dots between traditional notions of health limited to medical care alone, to a much broader understanding about what drives health. It has underscored the intersectionality across the social, economic, and political systems within which we live, learn, work, play and age, including the underlying drivers of structural and institutional racism. COVID-19 has not simply been a health crisis, but has sent far-reaching shock waves across the entire society. It has resulted in massive job loss and unemployment, economic crisis and restructuring, and reconfiguration of both work and school, directly impacting families, communities, and social life.

It is likely no coincidence either, that the pandemic has coincided with an upsurge in White supremacy, evidenced in acts of racial violence. This backdrop, together with the palpable impacts and inequities of COVID-19, culminated also in increased anti-racist activism, including protests against police brutality, spurred on by the deaths of George Floyd in Minneapolis and Breonna Taylor in Louisville. National protests that often culminated on DC streets, reached a crescendo in the District in summer of 2020. On June 1st, 2020, peaceful demonstrators—many of whom were DC residents—were met with violence and tear gas by federal forces between Lafayette Park and St. John’s Church. Four days later, Mayor Bowser memorialized our resolve and collective response with DC values, painting a two-block area of 16th Street, NW with large yellow letters declaring: “BLACK LIVES MATTER”. When introducing the memorial, she noted:

*“There are people who are craving to be heard and to be seen and to have their humanity recognized. We had that opportunity to send that message loud and clear on a very important street in our city<sup>27</sup>.”*

Acknowledging racism is a critical first step. We know, however, that because systemic and structural racism permeates all sectors and areas, addressing them will require mutually reinforcing actions in multiple sectors and places. In order to “move beyond models limited to compensating for the impact of structural racism,” together, we must proactively identify and address forms of racism that are pervasively and deeply imbedded in systems, laws, written and unwritten policies, and entrenched practices and beliefs, that are produced, condoned, and that perpetuate unfair treatment and oppression of people of color with adverse health consequences<sup>28</sup>.

## KQ6: How can the lessons of the pandemic drive a strategic reimagining of the response to achieving health equity?

As we've known well before the pandemic, and called for in the Health Equity Report for the District of Columbia (2018), promoting health equity requires us to directly face and address underlying socioeconomic inequities across all the key drivers of opportunities for health, with knowledge that building a healthy community has benefits that extend well beyond traditional notions of health alone. Creating equitable opportunities for health in the District of Columbia requires multiple sectors working collaboratively, each doing their part in promoting improved outcomes.

While none of us could have predicted the COVID-19 pandemic, its differential impacts and inequitable outcomes were predictable, made all the more explicit in a crisis of this magnitude. The last two years have shown us how preexisting gaps rapidly widen with a crisis. The impact of COVID-19 fell disproportionately on those already negatively impacted by structural inequities. Across all measures, social, economic, geographic, and medical, inequitable impacts have ravaged Black and Brown populations and communities the most. In DC, a disproportionate burden of both COVID-19 infection and mortality has been borne by Black/African American residents. Our efforts to dismantle structural inequities, therefore, must be understood in a broader context of improving daily life for residents of color, but also mitigating the risks of disproportionate harm from future pandemics, natural disasters, and the impact of climate change.

The overarching question and essence of conversations at the Summit, was essentially focused on how we operationalize the concept of “unravelling” persistent inequities. What does that look like? What are the models? Does a playbook for unravelling inequities even exist? How do we bridge the gap between changing the conversation on health equity, to changing the practice to address health inequities? What must collaborative practice change look like? How can the lessons of the pandemic drive a strategic reimagining of the response to achieving health equity? How will we build the roadmap to a just post pandemic future?

The DC Water story served as a light bulb moment in this respect. In their efforts to prepare the District for climate change events, their equity-informed initiative pivoted to consciously centering both the places and the people certain to be most affected. When considering geographic impacts, and with engineering processes as a starting point, their ‘targeted universalism’ principles acknowledge current gaps in opportunity. These persistent gaps are driven by socio-demographic differences in how residents in areas of the District most vulnerable to the effects of climate change are situated, in relation to climate impacts and our universal goals. As such, DC Water’s shift of focus to engaging historically marginalized residents as the primary recipient of their proposed equity-informed actions and intervention, demonstrates a transformative shift in planning and implementation worth highlighting as a model. It also suggests that our strategic reimagining of equity-informed responses must include a similar shift in focus. It underscores the potential of re-centering who solutions are intended to serve as critical, by prioritizing those most susceptible to adverse outcomes and intentionally applying targeted universalism principles with mutually reinforcing impact.

As was pointed out through the 6-hour-long summit sessions and proceedings, the early-adopter paradigm shift to equity-focused policy and practice had already begun pre-pandemic, and served as a foundation for an equity-focused pandemic response. The practical experience and lessons learned from the pandemic reinforce those pre-pandemic choices, and have prompted a broad expansion of this conversation across all sectors, including recognition of the need for transformational practice change. In sum, the stage of changing the conversation to educate non-health stakeholders of their role in driving health outcomes is complete. What was a niche and academic idea in 2015 is now the public policy consensus. Persuasion has given way to action. Equity-focused practice is no longer the elective choice of a handful of visionary leaders, but a basic expectation and a core tenet of good governance.



# CONCLUSIONS & RECOMMENDATIONS

The challenges that our most vulnerable families face are complex and multi-faceted, such that no single system has either the resources, expertise, capacity, or responsibility for coming up with solutions on their own. This means that all sectors, public, private, and nonprofit, must work together, focused on developing a shared approach to responsive and timely policy, practice, and system changes to address the needs of District families. Even prior to the pandemic, systems and programs typically lacked a common language or shared approach essential to meeting the needs of the most vulnerable and marginalized. The result was underperforming fragmented systems out of tune with the reality and lived experience of the people they are charged to serve<sup>29</sup>.

Since the Summit, and by the spring of 2022, the pandemic's long tail and persistent consequences across the social and structural determinants of health are still very much in evidence. Not only have there been disproportionate impacts on the health of people of color and other high-need groups, but similar impacts are evident on economic and social factors. Many people continue to face hardship, as documented by the most recent Census Bureau Household Pulse Survey, summarized below<sup>30</sup>:

- More than one in eight American adults (13.6%) reported that they or someone in their household had experienced a loss of employment income in the past four weeks;
- More than six in ten (61.3%) adults reported at least a little difficulty paying for usual household expenses in the past 7 days, and 31.8% used credit cards or loans to meet household spending needs;
- Some 7% of adults had no confidence in their ability to make next month's housing payment (across renters and owners), and 10.3% reported food insufficiency in their household;
- Nearly one in three (31.4%) adults reported symptoms of depression or anxiety.

The pandemic experience of pivoting to respond to the needs of the District's most historically marginalized families where they are has provided invaluable insights into what is achievable if we set aside traditional assumptions of what's permissible. It demonstrates that systems should be both proactive in identifying needs and barriers, and informed by the lived experience of our most marginalized residents. Being responsive by centering our most historically marginalized residents is essential to a more just post-pandemic future.

We must anchor collaborative actions for impact, informed by a shared vision, and develop and measure collective impact. As form follows function, we must also organize ourselves to execute on multi-sectoral collaborative efforts that are aligned for sustained progress towards equity-informed transformational change. Our multi-sectoral collaborative solutions should include targets and measures. The process does not have to be a single coordinated campaign, but rather a set of actions, investments, and program and policy initiatives that are better aligned and informed by a shared understanding of the challenges and a shared vision of an improved system<sup>29</sup>.

The active engagement of multi-sectoral government, non-profit, philanthropic, academic, and business sector representatives in the daylong inaugural DC Health Equity Summit illustrated the influence of the Health Equity Report for the District of Columbia (2018) as an inflection point, marking the shift to proactively advancing health equity. The COVID-19 pandemic further emphasized the need for urgent action to advance equity for all Washingtonians. Necessity drove a swift evolution of Health in All Policies practice change, initiated before the pandemic by early adopters forming a "coalition of the willing", to effectively engaging the "coalition of the necessary" in the District's pandemic response. The pandemic has illuminated importance and efficacy of a whole-of-community response that engages virtually all aspects of society.

As we build our roadmap to a just post-pandemic future, we must: leverage these practical experiences and insights in actionable ways; engage public, private, and non-profit partners; and sustain equity-informed, whole-of-community collaborative strategies and actions as a force multiplier to advance equity and drive transformational change. The structure and process envisioned will be informed by the following six recommended actions, also detailed in Figure 4.1:

- **Sustain Whole-of-Community Response**
- **Promote Culture of Wellness & DC HOPE (health, opportunity, prosperity, equity)**
- **Repair the Past to Transform the Future**
- **Prioritize Community-Engaged Practices**
- **Leverage Policy & Practice Change Momentum**
- **Anchor Collaborative Action**



DC HEALTH EQUITY SUMMIT 2021 RECOMMENDATIONS		
Actions	Themes & Takeaways	Insights
Based on the insights, themes, and takeaways from the DC Health Equity Summit 2021: <b>“Building A Roadmap to A Just Post-Pandemic Future,”</b> DC Health will lead the development of a <b>shared roadmap</b> , which will engage public, private and non-profit partners, leveraging an equity-informed whole-of-community approach to drive collaborative actions for change. The structure and process envisioned will be informed by the following <b>six Recommended Actions</b> :		
<b>1. Sustain Whole-of-Community Response</b>	<p><i>DC Pandemic Motto: All in this Together &amp; All Part of the Solution</i></p> <ul style="list-style-type: none"> <li>Broad collaboration proved critical to addressing pandemic challenges</li> <li>We must sustain and build on this momentum to advance equity</li> </ul>	Multi-sectoral collaboration is key. We must not return to siloes across sectors, organizations, and institutions, as was typical prior to the pandemic.
<b>2. Promote Culture of Wellness &amp; DC HOPE</b>	<p><i>DC HOPE refers to Health, Opportunity, Prosperity &amp; Equity</i></p> <ul style="list-style-type: none"> <li>A culture of wellness is one in which good health and well-being flourish across geographic, demographic, and social sectors</li> <li>Center District residents – maintain focus on Health, Wellbeing and Equity across the entire economy</li> <li>Leverage the role of non-governmental institutions, in support of community health and equity both within and beyond the 9 Key-drivers</li> </ul>	<p>Prioritizing the needs of District residents is key to building a more equitable community.</p> <p>Promoting individual wellbeing and community health across all 8 wards is essential to a healthy, safe and vibrant city, where efforts are made to improve outcomes for our most vulnerable and create opportunities for all residents to thrive.</p>
<b>3. Repair Past to Transform Future</b>	<p><i>Pandemic impacts show ‘history’ is not past, but persists today. Transformational change efforts must consider historical analyses, with a racial equity lens.</i></p> <ul style="list-style-type: none"> <li>Apply this critical filter in policy, practice, and outcome measures</li> <li>Engage intersectional analyses; collect and disaggregate data to effectively identify and address issues</li> </ul>	<p>Persistent inequities stem from historic and contemporary roots and impacts. Equity-informed strategies and solutions require the unpacking of our contemporary context through the lens of historical analysis and racial equity.</p>
<b>4. Prioritize Community-Engaged Practice</b>	<p><i>Engage residents &amp; stakeholders; valuing lived experience as critical input &amp; lens</i></p> <ul style="list-style-type: none"> <li>Practice Meaningful Community Engagement</li> <li>Invest in Effective Community Listening</li> </ul>	Intentionally engaging residents and community stakeholders is critical to identifying issues and designing responsive solutions.
<b>5. Leverage Policy &amp; Practice Change Momentum</b>	<p><i>Use pandemic insights &amp; innovation to change practice, assumptions &amp; norms</i></p> <ul style="list-style-type: none"> <li>Maintain action-oriented ‘can do’ posture, applying principles of Targeted Universalism</li> <li>Take evidence-based and evidence-informed risks, consider and test alternate solutions; implement strategies and iterate equitable change</li> <li>Forecast potential adverse impacts or unintended consequences, and develop mitigation strategies</li> </ul>	<p>Innovation has been one of the hallmarks of the pandemic. We learned that we CAN make changes – even within legacy systems – in response to crisis and need. Advancing equity requires proactive policy change, practice innovation, and budgetary commitment to disrupt the structural root causes of inequity.</p>
<b>6. Anchor Collaborative Action &amp; Impact</b>	<p><i>Informed by Shared Vision &amp; Accountability, Develop &amp; Measure Collective Impact</i></p> <ul style="list-style-type: none"> <li>As form follows function, we must organize ourselves to execute on multi-sectoral collaborative actions that are aligned for change</li> <li>Collaborative multi-sectoral actions should include targets and measure key outcomes</li> </ul>	<p>Summit showcased progress with equity - informed practice across the full spectrum.</p> <p>Future measures of progress and success must be informed by an equity lens and reflect desired outcomes as well as achievement of results.</p>

Figure 4.1. DC Health Equity Summit 2021 Recommendations

## IN CLOSING...

Key insights from the Summit are already in use, informing practice, policy, and the way we move forward in the work to advance equity for all who live, learn, work, play, and age in Washington, DC.

DC Health anticipates staying engaged with residents and stakeholders as we continue the conversation and collectively set an agenda to address the root causes of health inequities in the District of Columbia.

“*Because health equity is  
EVERYBODY's work!*”

- C. Anneta Arno, PhD, MPH, Director,  
Office of Health Equity, DC Health



# GLOSSARY

Term	Definition
<b>Anti-Miscegenation Laws</b>	Edicts that made it unlawful for African Americans and white people to marry or engage each other in intimate relationships. The measures first appeared in the United States in colonial times and had two functions: to maintain the racial caste system necessary for the expansion of slavery, and to perpetuate the idea of white supremacy.
<b>Anti-Racism</b>	The active process of identifying and challenging racism, by changing systems, organizational structures, policies and practices, and attitudes, to redistribute power in an equitable manner.
<b>Behavioral Health</b>	Behavioral health includes the emotions and behaviors that affect your overall well-being. Behavioral health is sometimes called mental health and often includes substance use. Just like for physical health, behavioral health providers are trained professionals who can address and treat behavioral health challenges such as mental illness and addiction.
<b>Burden of Illness/Disease</b>	The number or actual count of persons affected by a chronic disease, condition, or risk factor is often used as the most fundamental measure of burden in a population. This measure is useful when assessing the need for health care or public health services as a direct measure of the burden on these systems.
<b>Climate Resilience</b>	Climate resilience is the ability to anticipate, prepare for, and respond to hazardous events, trends, or disturbances related to climate. Improving climate resilience involves assessing how climate change will create new, or alter current, climate-related risks, and taking steps to better manage these risks.
<b>Collective Impact</b>	Joint efforts of a network of community members, organizations, and institutions who advance equity by learning together, aligning, and integrating their actions to achieve population- and systems- level change.
<b>Community Engagement</b>	The process of working collaboratively with and through groups of people connected by geographic proximity, special interests, or similar situation to address issues affecting the wellbeing of those people. Community engagement can take many forms, and partners can include organized groups, agencies, institutions, and individuals. Community engagement can also be seen as a continuum of community involvement: outreach, consultation, involvement, collaboration, and shared leadership.
<b>Community Health</b>	The collective well-being of community members. In addition to living in the same neighborhood or region, these populations often share health characteristics, ethnicities, and socioeconomic conditions. Public health professionals engaged in community health identify how variables related to socioeconomic status — such as income levels, nutrition, crime, and transportation resources — impact people. They also determine how the community's medical and educational resources contribute to residents' lifestyles and what improvements are called for.
<b>Disparities</b>	A measurable difference in outcomes for populations or communities.

# GLOSSARY CONT.

<b>Diversity</b>	A multiplicity of shared and different individual and group experiences, values, beliefs, and characteristics among people.
<b>Economically Disadvantaged</b>	Economically disadvantaged individuals have been subjected to racial or ethnic prejudice or cultural bias within American society because of their identities, and whose ability to compete in the free enterprise system has been impaired due to diminished capital and credit opportunities as compared to others in the same or similar line of business who are not disadvantaged.
<b>Equity</b>	Equity is defined as “the state, quality or ideal of being just, impartial and fair.” The concept of equity is synonymous with fairness and justice. It is helpful to think of equity as not simply a desired state of affairs or a lofty value. To achieve and sustain equity, it needs to be thought of as a structural and systemic concept.
<b>Discrimination</b>	Actions — including policies and practices — or thoughts, based on conscious or unconscious bias, that favor one group over others.
<b>Health</b>	The WHO constitution states: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
<b>Health Disparity</b>	A particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.
<b>Health Equity</b>	The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.
<b>Health In All Policies (HiAP)</b>	A collaborative approach that integrates and articulates health considerations into policymaking across sectors to improve the health of all communities and people. HiAP recognizes that health is created by a multitude of factors beyond healthcare and, in many cases, beyond the scope of traditional public health activities. The HiAP approach may be effective in identifying gaps in evidence and achieving health equity.
<b>Health Literacy</b>	Two interrelated concepts, dependent on context, as appropriate: <ul style="list-style-type: none"> <li>- Personal Health Literacy: An individual’s ability to find, understand, and use information and services to inform health-related decision and actions for themselves and others</li> <li>- Organizational Health Literacy: How well individuals are equitably empowered by organizations to find, understand, and use information and services to inform</li> </ul>
<b>Health Outcomes</b>	Changes in health that result from measures or specific health care investments or interventions.
<b>Housing Insecurity</b>	An umbrella term that includes several housing problems that people may experience, including affordability, safety, quality, and loss of housing.

# GLOSSARY CONT.

<b>Implicit Bias</b>	A form of bias based on race, gender, sexual orientation and other group identifications that occurs automatically and unintentionally, that nevertheless affects judgments, decisions, and behaviors. Implicit bias occurs across various settings and circumstances. For example, research has shown implicit bias can pose a barrier to recruiting and retaining a diverse scientific workforce and can also affect how healthcare providers interact with patients.
<b>Incidence Rate</b>	The number of new cases of a disease divided by the number of persons at risk for the disease.
<b>Inequity</b>	Differences in well-being that disadvantage one individual or group in favor of another. These differences are systematic, patterned and unfair and can be changed. Inequities are not random; they are caused by past and current decisions, systems of power and privilege, policies, and the implementation of those policies.
<b>Institutional Racism</b>	Racial inequity within institutions and systems of power, such as places of employment, government agencies, and social services. It can take the form of unfair policies and practices, discriminatory treatment, and inequitable opportunities and outcomes. A school system that concentrates people of color in the most overcrowded and under-resourced schools with the least qualified teachers compared to the educational opportunities of white students is an example of institutional racism.
<b>Intersectionality</b>	An approach or lens that recognizes that health is shaped by a multi-dimensional overlapping of factors such as race, class, income, education, age, ability, sexual orientation, immigration status, ethnicity, indigeneity, and geography.
<b>Nine (9) Key Drivers of Opportunities for Health</b>	The conditions in the environments in which people are born, live, learn, work, play, and age affect a wide range of health, functioning, and quality of life outcomes and risks. These social determinants of health are presented in DC's Health Equity Report as nine key drivers: Education; Employment; Income; Housing; Transportation; Food Environment; Medical Care; Outdoor Environment; and Community Safety.
<b>Life Expectancy</b>	Life expectancy tells us the average number of years of life a person who has attained a given age can expect to live.
<b>Marginalized Communities</b>	Those groups excluded from mainstream social, economic, educational, and/or cultural life. Examples of marginalized populations include, but are not limited to, groups excluded due to race, gender identity, sexual orientation, age, physical ability, language, and/or immigration status.
<b>Paradigm Shift</b>	A fundamental change in the underlying assumptions of a situation.
<b>People Of Color</b>	Often the preferred collective term for referring to non-white racial groups. Racial justice advocates have been using the term "people of color" (not to be confused with the pejorative "colored people") since the late 1970s as an inclusive and unifying frame across different racial groups that are not white, to address racial inequities. While "people of color" can be a politically useful term and describes people with their own attributes (as opposed to what they are not, e.g., "non-white"), it is also important whenever possible to

# GLOSSARY CONT.

	identify people through their own racial/ethnic group, as each has its own distinct experience and meaning, and the more specific identifier may be more appropriate.
<b>Police Brutality</b>	Various human rights violations by the police that might include beatings, racial abuse, unlawful killings, torture, or indiscriminate use of riot control agents at protests.
<b>Political Determinants of Health</b>	The systematic process of structuring relationships, distributing resources, and administering power, operating simultaneously in ways that mutually reinforce or influence one another to shape opportunities that either advance health equity or exacerbate health inequities
<b>Population Health</b>	Considering the health status and health outcomes within a group of people rather than the health of one person at a time.
<b>Practice Change</b>	A collaborative and generally cross-disciplinary process that uses the best available evidence to improve health care and health.
<b>Protective Factors</b>	Individual or environmental characteristics, conditions, or behaviors that reduce the effects of stressful life events. These factors also increase an individual's ability to avoid risks or hazards and promote social and emotional competence to thrive in all aspects of life, now and in the future.
<b>Public Health</b>	The science of protecting and improving the health of people and their communities. This work is achieved by promoting healthy lifestyles, researching disease and injury prevention, and detecting, preventing, and responding to infectious diseases.
<b>Race</b>	Race is a socially constructed system of categorizing humans largely based on observable physical features (phenotypes), such as skin color, and on ancestry. There is no scientific basis for or discernible distinction between racial categories. The ideology of race has become embedded in our identities, institutions and culture and is used as a basis for discrimination and domination.
<b>Racial Equity</b>	Both a process and an outcome: as a process, we apply a racial equity lens when those most impacted by structural racial inequity are meaningfully involved in the creation and implementation of the institutional policies and practices that impact their lives; As an outcome, we achieve racial equity when one's race will no longer predict opportunities, outcomes, or the distribution of resources for residents of the District, particularly Black residents.
<b>Racial Justice</b>	The systematic fair treatment of people of all races that results in equitable opportunities and outcomes for everyone. All people are able to achieve their full potential in life, regardless of race, ethnicity or the community in which they live. A "racial justice" framework can move us from a reactive posture to a more powerful, proactive and even preventive approach.
<b>Racial Wealth Gap</b>	The racial wealth gap refers to the difference in assets owned by different racial or ethnic groups and results from a range of economic factors that affect the overall economic well-being of these different group. The term reflects disparities in access to opportunities, means of support, and resources.



# GLOSSARY CONT.

<b>Racism</b>	The concept of racism is widely thought of as simply personal prejudice, but in fact, it is a complex system of racial hierarchies and inequities. At the micro level of racism, or individual level, are internalized and interpersonal racism. At the macro level of racism, we look beyond the individuals to the broader dynamics, including institutional and structural racism.
<b>Social &amp; Structural Determinants of Health</b>	<p>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.</p> <p>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.</p>
<b>Social Justice</b>	A process, not an outcome, which (1) seeks fair (re)distribution of resources, opportunities, and responsibilities; (2) challenges the roots of oppression and injustice; (3) empowers all people to exercise self-determination and realize their full potential; (4) and builds social solidarity and community capacity for collaborative action.
<b>Socioeconomic</b>	The social standing or class of an individual or group.
<b>Structural Determinants of Health</b>	The 'root causes' of health inequities, that shape the quality of the Social Determinants of Health experienced by people in their neighborhoods and communities. Structural determinants include the governing process, economic and social policies that affect pay, working conditions, housing, and education. The structural determinants affect whether the resources necessary for health are distributed equally in society, or whether they are unjustly distributed according to race, gender, social class, geography, sexual identity, or other socially defined group of people.
<b>Structural Racism</b>	The racial bias across institutions and society. It describes the cumulative and compounding effects of an array of factors that systematically privilege white people and disadvantage people of color.
<b>Systemic Change</b>	Addressing the causes, rather than the symptoms, of a societal issue by taking a holistic (or 'systemic') view. Systemic change is generally understood to require adjustments or transformations in the policies, practices, power dynamics, social norms or mindsets that underlie the societal issue at stake. It often involves the collaboration of a diverse set of players and can take place on a local, national or global level.
<b>Transformational Change</b>	Transformational change is a process designed to create significant change in the culture and work processes of an organization and produce significant improvement in performance.
<b>Underserved Communities</b>	Populations sharing a particular characteristic, as well as geographic communities, that have been systematically denied a full opportunity to participate in aspects of economic, social, and civic life.

# GLOSSARY CONT.

<b>Structural Vulnerability</b>	The capacity (including protective factors or lack thereof) of a community to respond to and withstand extraordinary challenges, such as disease outbreaks
<b>Vulnerable Population</b>	Populations more susceptible to the adverse effects of environmental harms. These include groups that public health experts widely regard as physiologically vulnerable--children, the elderly, pregnant individuals, and individuals with asthma or compromised immune systems. They also include members of working-class, racially marginalized, immigrant, linguistically isolated, and Native American communities, whose abilities to withstand and recover from environmental harms are compromised by racist biases and violence, exclusion from medical and other social services, fear of interacting with law enforcement, and other social factors.
<b>White Supremacy</b>	A historically based, institutionally- perpetuated system of exploitation and oppression of continents, nations and peoples of color by white peoples and nations of the European continent; for the purpose of maintaining and defending a system of wealth, power and privilege. The idea (ideology) that white people and the ideas, thoughts, beliefs, and actions of white people are superior to People of Color and their ideas, thoughts, beliefs, and actions. While most people associate white supremacy with extremist groups like the Ku Klux Klan and the neo-Nazis, white supremacy is ever present in our institutional and cultural assumptions that assign value, morality, goodness, and humanity to the white group while casting people and communities of color as worthless ("worth less"), immoral, bad, and inhuman and "undeserving."

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