Framework for **Improving Community Health**

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Acknowledgements

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Abbreviations Used

BRFSS – Behavioral Risk Factor Surveillance System
CDC – Centers for Disease Control and Prevention
ChildVaxView - A website summarizing childhood immunization data managed by the Centers for Disease Control and Prevention
DHCF – Department of Health Care Finance data on D.C. Medicaid recipients
FluVaxView – A website summarizing influenza immunization data managed by the Centers for Disease Control & Prevention
FQHCs – Federally-qualified health centers
NIS – National Immunization Survey
NSCH – National Survey of Children's Health
OSSE – Office of State Superintendent for Education
PRAMS – Pregnancy Risk Assessment Monitoring System: an annual survey of a sample of women having recently given birth
SNAP – Supplemental Nutrition Assistance Program
SNAP-Ed – SNAP Nutrition Education and Obesity Prevention Grant Program
SMM – Severe maternal morbidity
TBD – To be determined
UDS – Uniform Data System, a data collection system used by the Health Resources and Services Administration for federally-qualified health centers
WIC – Special Supplemental Nutrition Program for Women, Infants, and Children
YRBS – Youth Risk Behavior Surveillance System

Table of Contents

Introduction

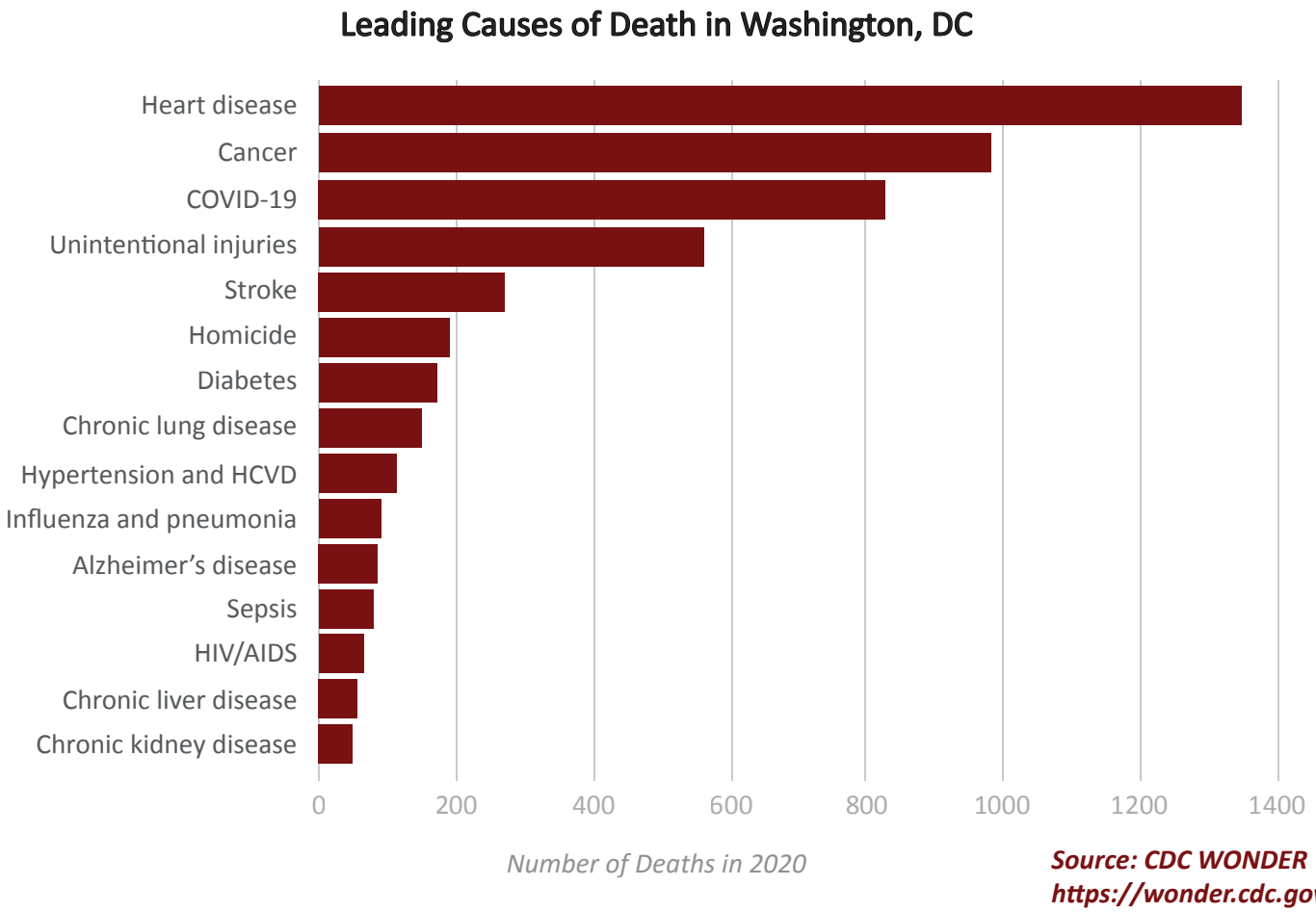
The District of Columbia Department of Health (DC Health) has adopted a vision for Washington, DC to be the healthiest city in America. To do this, DC Health promotes health, wellness and equity across the District and protects the safety of residents, visitors and those doing business in our nation's capital.

Health is more than just medical care, and prevention of disease requires more than just the actions of individuals. A **community** is healthy when the physical and social environment protects people from harm; when physical and social structures support healthy behaviors and healthy interactions among people; and when the medical care system promotes health and prevents disease. Evidence that a community is healthy can be seen in measures of: the incidence of and mortality from the most common severe diseases; the health of its mothers and children; the risk factors for the most important causes of death; and the delivery of key preventive health services.

In 2022, DC Health developed this framework to guide its actions to improve community health in the District of Columbia. The framework is designed to **prevent the leading causes of death, protect and promote the health of mothers and children, and ultimately eliminate racial and ethnic disparities in health.** The framework includes quantitative objectives, which aim to drive key measures of health to established targets over the five years. The selection of these objectives was based on: the health conditions and determinants placing a substantial burden on District residents, the availability of data to measure these determinants in the entire population of District residents or in a key subgroup; and the opportunities to make improvement in these measures through programs or policies. Each objective expresses a desired direction to improve population health and a 5-year target. This Framework then lists strategies to achieve those objectives, including actions that DC Health will undertake as well as actions that other organizations can undertake.

Leading Causes of Death

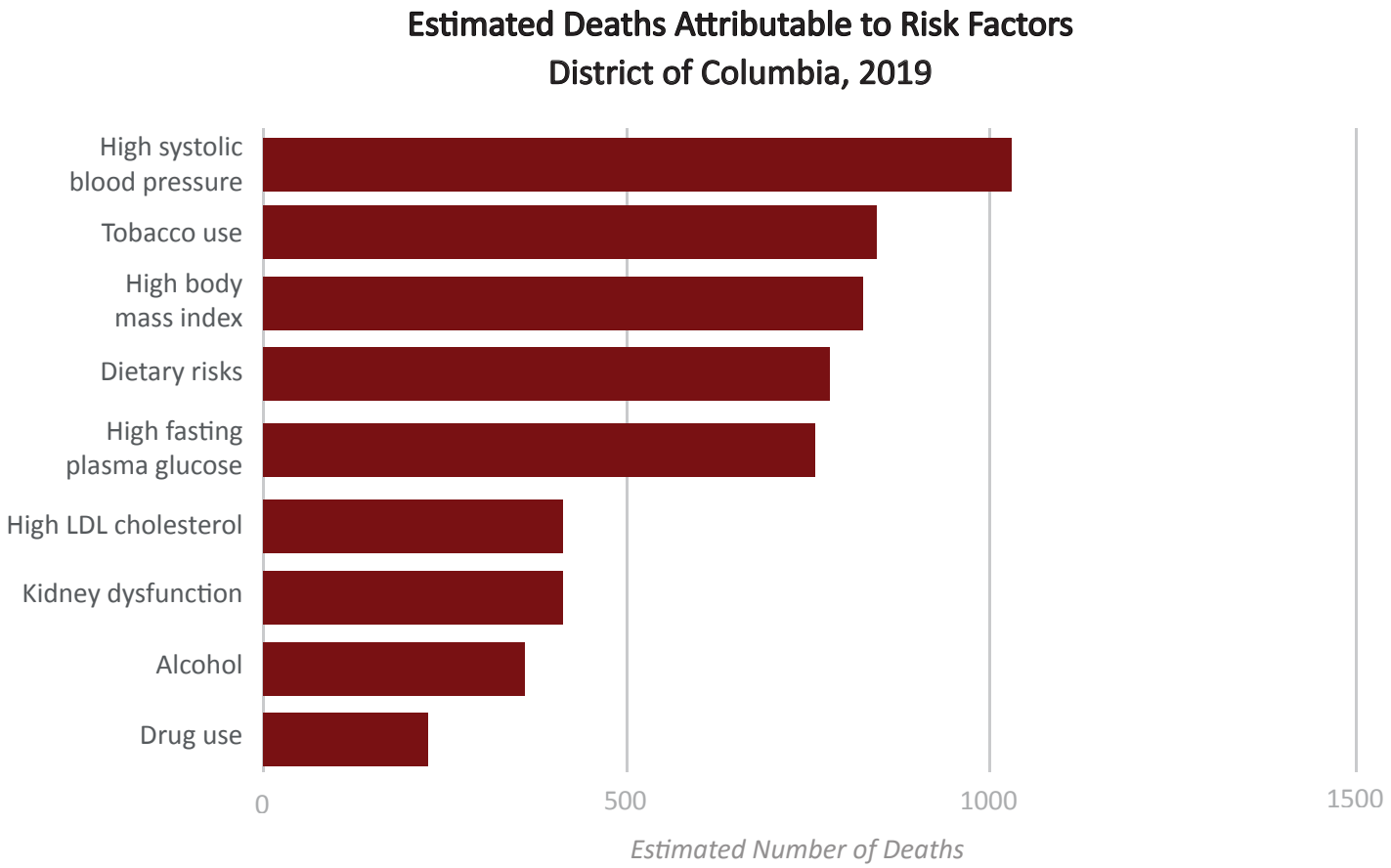
In 2020, the first year of the COVID-19 pandemic, the leading causes of death among DC residents were heart disease, cancer, COVID-19, unintentional injuries, stroke, homicide, diabetes, and chronic lung disease.



Source: CDC WONDER https://wonder.cdc.gov/

These health problems are only rarely cured by medical care. For that reason, the most effective strategy to prevent deaths is to prevent these diseases from occurring, either through primary prevention – vaccination or addressing risk factors (such as smoking) - or through secondary prevention - identifying biologic markers of risk (such as high blood pressure) and treating them to prevent progression to disease.

There is no established method to count the number of deaths attributable to important risk factors like smoking or high blood pressure. However, the Global Burden of Disease project has developed estimates of these attributable deaths. By their estimates, the underlying causes to which the greatest number of deaths can be attributed in DC residents are: high blood pressure, tobacco use, high body mass index, unhealthy diet, high blood sugar, and high blood cholesterol, shown on the next page.



Source: IHME Global Burden of Disease project, http://ghdx.healthdata.org/gbd-results-tool

The Health of Mothers, Infants and Children

The health status of mothers, infants and children is an important measure of the health status of DC residents in the future. Indicators of their health status include adverse outcomes during pregnancy and the perinatal period, the risk factors for those adverse outcomes, and factors that influence health for children during their formative years (e.g. whether children have healthy diets and are receiving recommended preventive care). Adverse outcomes of pregnancy include pre-eclampsia, preterm birth, low birth weight, and infant mortality, and the risks for those include the health conditions of women when they become pregnant, teen pregnancy, unintended pregnancy, and use of tobacco or other drugs during pregnancy.

DC Health has adopted a strategy to improve perinatal health outcomes that is based on these seven core priorities:

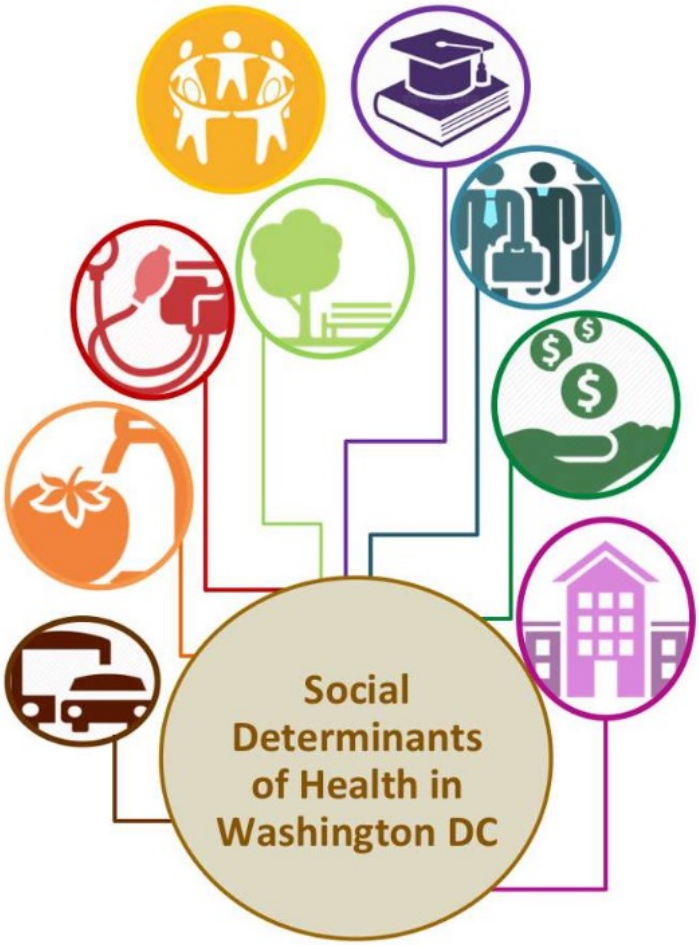
- Every teenage girl and woman is in control of her reproductive health
- Every pregnant woman receives patient-centered, high-quality prenatal care beginning in the 1st trimester
- Every healthcare provider has the tools and resources they need to provide quality care and manage complex social needs of women and infants
- Every healthcare facility and organization providing maternal and infant care has the tools and resources to practice evidence-based health care and to document QI/QA activities
- Every newborn receives high-quality neonatal care in the hospital and outpatient setting
- Every parent and caregiver has the life skills and resources needed to nurture and provide for their family
- Every infant, mom, and dad has a safe and healthy environment to thrive and receive the support they need to promote early childhood development and learning

Racial and Ethnic Health Disparities

Black/African American and Latinx residents often have worse health outcomes than White residents. For example, Black/African-Americans are substantially more likely than Whites in DC to die of heart disease, unintentional injuries, diabetes, and homicide. Black/African-American infants are four times as likely as White infants to die in the first year of life.

As outlined in the DC Health 2018 Health Equity Report, these health inequities are neither natural nor inevitable, but instead are shaped by the social determinants of health, which are themselves influenced by structural racism. The Health Equity Report identified nine "key drivers" of health inequities: education, employment, income, housing, transportation, the food environment, medical care, the outdoor environment, and community safety. While some of these "key drivers" (such as medical care and food environments) can be influenced by DC Health, others (such as education and transportation) are outside of DC Health's purview. These key drivers are within the responsibility of other government agencies - supporting the Health Equity Report's position that "all policy is health policy".

This Framework for Improving Community Health addresses health equity in two ways. First race- and ethnicity-specific targets for key objectives are included where large disparities exist. Second, the Framework outlines actions that DC Health will undertake and actions other organizations can undertake to reduce those disparities.



Objectives and Strategies

Improving the health of a community requires actions by many individuals and organizations. Listed below are objectives for what DC Health wants to achieve by 2026 grouped in seven areas:

- Access to health services
- Clinical preventive services for adults
- Maternal and reproductive health services
- Care of young children
- Preventive services for children and adolescents
- Tobacco and marijuana use
- Nutrition, physical activity, and weight status

Objectives measure the entire District population whenever possible; some objectives measure an important subgroup (e.g. DHCF data on Medicaid recipients) for whom the most detailed data is available.

A strategy is summarized after each group of objectives. That strategy includes the actions that DC Health will undertake, followed by actions that others can undertake take to help meet the objectives. The actions included are not intended to represent a comprehensive description of every step that must be taken to the District to meet the objectives, but instead reflect those actions that DC Health recognizes as particularly influential and valuable.

Objectives – Access to Health Services

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Increase the percent of District residents age 40 to 64 who reported a primary care visit within the previous 12 months	Overall	52%	2021	66%	DHCF
	Black or African-American Men	44%	2021	55%	
Increase percent of adults who visited the dentist or dental clinic within the past 12 months	Overall	74%	2018	78%	BRFSS
	Black or African-American	65%	2018	71%	
Reduce the use of emergency department by District residents for preventable dental emergencies (/100,000 residents)	Overall	834	2019 - 2020	666	Hospital discharge data

Strategy – Access to Health Services

DC Health will:

- Analyze existing data on accessibility and use of primary medical care and oral health care and disseminate reports summarizing the needs identified
- Provide financial incentives, including loan repayment, to recruit or retain health care providers in underserved areas
- Test models of care that facilitate access while still providing high quality care
- Procure or generate data from consumers on accessibility and quality of primary care and share findings and recommendations with health care providers

Health care providers and health systems:

- Reduce barriers to primary care by offering more walk-in/urgent care options, evening and weekend hours, and telehealth visits
- Reduce language barriers to patient access by hiring multilingual patient-facing staff

Health plans can:

- Collect and disseminate data on access to care and align financial incentives for providers that regularly meet access goals
- Develop payment models that offer incentives for providers to engage all patients assigned to them

Objectives – Clinical Preventive Services for Adults

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Increase the percent of residents with hypertension whose have achieved blood pressure control	Overall	79%	2019	83%	Million Hearts database
	Patients in FQHCs	64%	2019	69%	UDS Data
Reduce the proportion of adults with diabetes who have an A1c value above 9 percent	Overall	34%	2019	29%	Million Hearts database
	Patients in FQHCs	33%	2019	28%	UDS Data
Increase the percent of residents with high blood cholesterol who are on (prescribed) statin therapy	Overall	72%	2021	80%	Million Hearts database
	Patients in FQHCs	73%	2021	80%	UDS Data
Increase percent of adults receiving colorectal screening as recommended	Overall	79%	2020	86%	BRFSS
	Black or African-American Men	71%	2020	79%	
	Patients in FQHCs	41%	2020	55%	UDS Data
Reduce incidence of late-stage colorectal cancer (/100,000)	Overall	19.1	2018	17.3	DC Cancer Registry
Reduce incidence of late-stage breast cancer (/100,000)	Overall	43	2018	39.6	DC Cancer Registry
	Black or African-American	47	2018	40.6	
Increase the percent of residents 18 or older who have received an immunization against influenza	Overall	56%	2020-21	65%	BRFSS (FluVaxView)
	Black or African-American	46%	2020-21	58%	
Increase the percent of residents age 65 or older who are up to date with vaccinations against COVID-19*	Overall	64%	Jan 2022	90%	Immunization Registry

**as of August 2022, "up to date" includes an initial vaccination series and a booster dose.*

Strategy – Clinical Preventive Services for Adults

DC Health will:

- Assist health care systems and clinics with increasing the proportion of patients meeting guidelines for receipt of preventive services for heart disease, stroke, cancer and diabetes
- Provide free breast and cervical cancer screening and diagnostic services to uninsured women through Project WISH
- Provide technical assistance and funding to clinics to increase cancer screening and access to diagnostic and treatment services
- Use mass media to promote screenings and other clinical services to prevent heart disease, stroke, cancer and diabetes
- Distribute COVID-19 vaccine to health care providers
- Maintain a central registry of vaccinations (including vaccinations against COVID-19) and make data on vaccinations available to providers and the public

Health care providers and pharmacists can:

- Become enrolled as a COVID-19 vaccine provider
- Offer COVID-19 vaccine and influenza vaccine to all eligible patients and strongly encourage vaccination

Health systems and health care group practices can:

- Measure quality indicators for smoking cessation counseling, hypertension control, diabetes management, statin prescription, breast cancer screening, colorectal cancer screening, influenza and COVID-19 vaccination, and establish continuous quality improvement processes to improve system performance
- Measure completion and timeliness of follow-up care for patients with positive breast and colorectal cancer screening tests and establish continuous quality improvement processes to improve system performance
- Establish collaborative care arrangements with pharmacists to assist in management of patients with hypertension or diabetes

Health plans can:

- Provide financial incentives, such as value-based payments, for high performance by providers on delivery of preventive health services, particularly: smoking cessation counseling, hypertension control, diabetes management, statin prescription, breast cancer screening, colorectal cancer screening, influenza and COVID-19 vaccination

Community-based, community-serving, and faith-based organizations can:

- Promote and refer community members to preventive services, especially: smoking cessation counseling, breast and colon cancer screening, diabetes management, high blood pressure treatment, and vaccination against COVID-19 and influenza

Employers can:

- Promote and refer employees to preventive services, especially: smoking cessation counseling, breast and colon cancer screening, diabetes management, high blood pressure treatment, and vaccination against COVID-19 and influenza

Objectives – Maternal and Reproductive Health Services

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Increase the percent of women age 18-44 who have had a preventive health visit in the past 12 months	Overall	54%	2021	70%	DCHF
Increase the percent of pregnant women who initiate prenatal care in the 1st trimester	Overall	68%	2019-20	75%	DC Vital Statistics
	Black or African-American	55%	2019-20	62%	
Reduce severe maternal morbidity (/10,000 deliveries)	Overall	259	2019	233	DC Vital Statistics, SMM Reporting
	Black or African-American	323	2019	290	
Reduce preterm births	Overall	9.8%	2020	9.4%	DC Vital Statistics
	Black or African-American	13.6%	2017-18	11.4%	
Reduce births to teens age 15-19 (/1,000)	Overall	15.6	2020	10.4	DC Vital Statistics
	Black or African-American	23.3	2020	15.5	
	Hispanic/Latinx	31.7	2020	21.1	
Reduce the percent of births that are unintended	Overall	36%	2020	28%	PRAMS
	Black or African-American	53%	2020	40%	
Reduce smoking in pregnancy (last 3 months)	Overall	3.5%	2019	1.5%	PRAMS
	Black or African-American	7.4%	2019	3.0%	
Reduce marijuana use during pregnancy	Overall	5.4%	2019	2.5%	PRAMS
	Black or African-American	10.5%	2019	5.0%	

Strategy – Maternal and Reproductive Health Services

DC Health will:

- Promote the early initiation of prenatal care through communications campaigns in partnership with community organizations
- Work with health care providers, health systems, and health plans to improve access to the most effective forms of contraception
- Support a collaborative among perinatal health providers to reduce the incidence of the most severe complications of pregnancy
- Support the expanded use of evidence-based models for prenatal care services such as Centering Pregnancy
- Develop standard clinical quality measures for birthing hospitals and requirements to be met for patient discharge
- Promote respectful care practices and standards through training and technical assistance to health care organizations
- Work with DHCF and other partners to increase the access to and use of doula and midwifery services

Health care providers and health systems can:

- Write prescriptions for oral contraceptives for 12 months for interested women
- Become trained in insertion of intrauterine devices
- Offer the most effective contraceptives, including long-acting reversible contraceptives, at initial patient encounters and after delivery
- Communicate to women of childbearing age the importance of initiation of prenatal care as soon as they are aware that they are pregnant
- Ask all pregnant women about smoking and marijuana use, and provide cessation counseling/services to those who are using substances
- Put in place policies to help sustain a culture where bias is not acceptable and all people receive respectful care
- Encourage pregnant women to breastfeed their infants and refer them to lactation support services

Health plans can:

- Reimburse for contraceptives in ways that increase convenience to patients, including fully reimbursing for long-acting reversible contraceptives and 12-month prescriptions for oral contraceptives
- Communicate to women of childbearing age the importance of initiation of prenatal care as soon as they are aware that they are pregnant.
- Inform members about the doula services benefit

Community-based and community-serving organizations can:

- Disseminate information about clinics and organizations that provide contraception and other reproductive health services
- Encourage women of childbearing age to initiate prenatal care as soon as they are aware they are pregnant and inform them about support services through Help Me Grow (1-800-MOM-BABY)
- Encourage pregnant women to breastfeed their infants and refer them to lactation support services
- Assess tobacco use among constituents and refer persons who smoke to tobacco DCQuitNow (800-Quit NOW or www.dcquitnow.org)
- Assess marijuana use among constituents and refer persons who in search of support to DBH (202.442.4202) or the ACCESS Helpline (888-793-4357)

Employers can:

- Ensure employees are provided information about the DC Paid Family Leave Program and other maternity/paternity benefits

High schools and schools of higher education:

- Provide on-site reproductive health services at school-based health centers, including offering the most effective forms of contraception

Objectives – Care for Young Children

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Increase the percent of mothers breastfeeding infants at 8 weeks of age*	Overall	78%	2020	82%	PRAMS
	Black or African-American	63%	2020	75%	
Increase the percent of children under age 3 who are screened for development using standardized tools	Overall	32%	2019 - 20	45%	NSCH
Increase the number of at-risk families with children under the age of 5 enrolled in home visiting or home visiting support services	Overall	TBD	2021	TBD	TBD

Strategy – Care for Young Children

DC Health will:

- Maintain a central support and referral service for pregnant women and caregivers of young children to connect them to a broad range of supportive services (Help Me Grow- 1-800-MOM-BABY)
- Expand the number of low-income parents of young children receiving assistance with developmental or behavior problems through the Healthy Steps program
- Promote screening and early detection of developmental delays among children using standardized tools such as the Ages and Stages questionnaire, and link families to appropriate community services and resources
- Support place-based initiatives that offer two-generational approaches to promote developmental screening and healthy parenting

Health care providers and health systems can:

- Screen young children for developmental delay using standardized tools (such as the Ages and Stages Questionnaire or the Survey of the Well-Being of Young Children) and refer children with potential delays for further evaluation.
- Refer District families with young children to the Help Me Grow program (1-800-MOM-BABY) for resources and services.
- Screen families with young children for tobacco use and provide tobacco cessation support through referral to DCQuitNow

Health plans can:

- Designate a perinatal care manager to assist with families' transition to appropriate resources post birth.

Community-based and community-serving organizations can:

- Refer pregnant women or parents of young children in need of support to Help Me Grow (1-800-MOM-BABY).
- Offer trainings on developmental screening and preventive care

Schools, school systems, and institutions of higher education can:

- Connect teen parents and families to the Help Me Grow program (1-800-MOM-BABY)
- Offer free or affordable child care for teen parents to finish high school.

For breastfeeding-specific strategy, see p. 21.

Objectives – Preventive Services for Children and Adolescents

Objective	Baseline	Base Year	2026 Target	Data Source
Reduce the number of emergency department visits for asthma in children and adolescents (/10,000)	218	2019	118	Hospital discharge data
Increase the percent of children with up-to-date vaccinations at 2 years of age	71%	2018 Birth Cohort	80%	NIS (ChildVaxView)
Increase the percent of children enrolled in Kindergarten who have received two doses of MMR vaccine	88%	2021	95%	Immunization Registry
Increase the percent of children age 6 months - 17 years who receive 2+ doses of influenza vaccine	69%	2020-21	78%	NIS (FluVaxView)
Increase the percent of adolescents age 10-18 who have had a primary care visit in the previous 12 months	52%	2021	63%	DHCF
Reduce the percent of high school students who reported seriously considering attempting suicide	19%	2019	15%	YRBS

Strategy – Preventive Services for Children and Adolescents

DC Health will:

- Maintain a registry of immunizations, build interfaces between the registry and providers electronic health records, and help providers use data to achieve a high level of immunization coverage among their patients
- Enroll providers in the federal Vaccines for Children program and help them order and maintain vaccines for eligible children
- Support schools' enforcement of the vaccination mandate by providing access to data on students' vaccination status
- Support a central registry of children with asthma and actions by health care providers to provide consistent preventive treatment and refer those with uncontrolled asthma for home environmental services
- Support schools by providing acute nursing care, care coordination, preventive services, and referrals to behavioral health services
- Support health and education partners establish best practices in school health through policy guidance and protocols
- Support the operation of school-based health centers in high schools and work with school systems to facilitate enrollment of students in these health centers
- Pilot and gradually expand the use of telehealth services in schools
- Work with DBH and other partners to support access to behavioral health services for children in schools

Health care providers and health systems can:

- Establish processes to monitor the immunization status of all children, immunize children on schedule, and conduct outreach to children who are not up-to-date on immunizations
- Promote COVID-19 vaccination and annual influenza vaccination in children
- Conduct annual well child visits, including preventive screenings, and establish processes to ensure children receive this care
- Refer children with uncontrolled asthma to home-based environmental services to reduce asthma triggers
- Screen families for tobacco use and provide tobacco cessation support through referral to DCQuitNow
- Improve access to behavioral health services for children and adolescents

Health plans can:

- Offer financial incentives to providers who meet child preventive health targets
- Reimburse for home-based environmental services for children with moderate to severe asthma

Community-based and community-serving organizations can:

- Amplify DC Health guidance by resharing social media posts and partnering on communications campaigns
- Help children and adolescents with behavioral health problems receive care and supportive services

Schools, school systems, and institutions of higher education can:

- Implement and sustain processes to identify students with mental health or substance use problems and systems to provide or refer them to appropriate treatment
- Foster ongoing relationships with youth serving agencies and community organizations to promote adolescent health and wellness within schools.
- Encourage families to enroll children in school-based health centers and educate students about the services offered by them.

Objectives – Tobacco and Marijuana Use

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Reduce smoking prevalence among adults	Overall	11%	2020	6%	BRFSS
	Black or African-American	18%	2020	11%	
Reduce prevalence of smoking or use of high school students	Overall	10%	2019	6%	YRBS
Reduce prevalence of marijuana use among high school students	Overall	29%	2019	23%	YRBS

Strategy – Tobacco and Marijuana Use

DC Health will:

- Deliver messages in mass media and social media warning youth about the risks of using tobacco and encouraging users to quit
- Promote policies that expand smoke-free and tobacco-free spaces
- Provide DCQuitNow - 1-800-QUIT-NOW or dcquitnow.org - cessation services to DC residents
- Work with other District agencies to enforce restrictions on the sale of tobacco products, including sales to persons under age 21 and sales of flavored products
- Help tobacco users quit by providing cessation support over the telephone and via web-based dashboards and responsive text messaging
- Help health care providers assist their patients with quitting tobacco use by providing tools and connections to cessation services
- Work with other District agencies to develop and disseminate messages in the mass media about the harms of marijuana use
- Provide tools to help health care providers to counsel and assist their patients with quitting marijuana use

Health care providers and health systems can:

- Ask all patients (including youth) about tobacco use and provide treatment through in-clinic counseling, referral to counseling, prescription of cessation medications, and referral to DCQuitNow
- Ask all patients (including youth) about marijuana use, advise on its effects, and refer to behavioral health resources available through the patients' insurance, Department of Behavioral Health (202-442-4202), ACCESS Healthline (1-800-793-4357)

Health plans can:

- Reimburse DCQuitNow for cessation services provided to beneficiaries
- Reimburse health care providers for tobacco and marijuana cessation services
- Reimburse for all FDA-approved tobacco cessation medications
- Engage with the DC Tobacco Free Coalition to support policy, systems, and environmental changes to reduce tobacco use

Community-based, community-serving, and faith-based organizations:

- Assess tobacco use among constituents and refer persons who smoke to tobacco DCQuitNow
- Adopt 100% smoke-free facilities
- Engage with the DC Tobacco Free Coalition to support policy, systems, and environmental changes to reduce tobacco use
- Educate community members about the risks of marijuana use and the resources available to support those who wish to quit

Employers can:

- Encourage smokers to quit and refer them to DQuitNow cessation services
- Adopt 100% smoke-free facilities

Schools, school systems, and institutions of higher education can:

- Adopt 100% tobacco-free campuses
- Encourage smokers to quit and refer them to DCQuitNow
- Sponsor youth tobacco control ambassadors as part of the DC Health Youth Engagement Tobacco Control Initiative
- Implement age-appropriate, evidence-based substance use prevention curricula

Objectives – Nutrition, Physical Activity, and Weight Status

Objective	Population	Baseline	Base Year	2026 Target	Data Source
Increase the percentage of mothers breastfeeding infants at 8 weeks of age	Overall	78%	2020	82%	PRAMS
	Black or African-American	63%	2020	75%	
Increase participation in WIC among eligible pregnant women, infants, new mothers, and children	Overall	45%	2018	65%	FNS WIC Eligibility and Program Reach Report
Reduce the prevalence of obesity in 2- to 4-year olds participating in WIC	Overall	13%	2018	10%	FNS WIC Participant Characteristics Report
Reduce the percent of high school students consuming soda or pop drinks one or more times per day	Overall	15%	2019	10%	YRBS
Reduce the prevalence of obesity in adolescents in high school	Overall	17%	2019	14.5%	YRBS
Increase the percent of adult residents who report eating vegetables at least one time per day	Overall	84%	2019	87%	BRFSS
	Black or African-American	77%	2019	83%	
	Hispanic/Latinx	76%	2019	82%	
Stop the increase in obesity in adults	Overall	25%	2020	25%	BRFSS
	Black or African-American	40%	2020	40%	

Strategy – Nutrition, Physical Activity, and Weight Status

DC Health will:

- Establish cross-agency data-sharing agreements to increase enrollment in WIC and senior nutrition programs
- Encourage hospitals to have breastfeeding-promoting policies (Baby-Friendly or equivalent) and provide lactation support to new mothers
- Promote breastfeeding and provide healthy food to low-income pregnant women, mothers, infants, and children through the WIC program
- Increase access to healthy food by supporting the availability of fruits and vegetables at corner stores and schools
- Provide financial incentives to low-income seniors to purchase fresh produce at Farmers markets and corner stores
- Develop and implement a plan to address obesity in the District by countering the marketing of unhealthy foods
- Work with other DC government agencies to improve the healthfulness of food purchased and distributed by government.

Health systems and health care providers can:

- Connect all new breastfeeding mothers with lactation support providers in the community and lactation support apps
- Designate a community lactation care coordination role to assist breastfeeding women in navigating and accessing lactation support services in the community
- Complete CDC's mPINC survey on breastfeeding support services
- Eliminate all formula marketing practices, such as accepting free or discounted formula supplies and promotional materials from manufacturers, and store formula products away from patients' view
- Refer all potentially eligible pregnant women and mothers of infants and young children to the WIC program
- Counsel all patients and their families to reduce consumption of sugar-sweetened beverages
- Measure patients' heights and weights and provide nutrition counseling or referrals to dietitians to patients who are overweight or obese
- Assess patients' physical activity, record the assessment in EHRs, and promote physical activity
- Refer patients with or at risk for diabetes to evidence-based lifestyle changes programs such as DC SNAP-Ed, the Diabetes Prevention Program, and Diabetes Self- Management Education and Support

Health plans can:

- Promote lactation support as a reimbursable service
- Provide wellness incentives such as reimbursement for community-supported agriculture participation or gym memberships
- Include medically-tailored, home-delivered meals and groceries as a covered benefit for patients with diet-related chronic conditions

Community-based and community-serving organizations can:

- Provide training to all direct service staff to improve their lactation support skills
- Refer potentially eligible pregnant women and mothers of infants and young children to the WIC program
- Refer individuals to evidence-based nutrition education and lifestyle change programs such as DC SNAP-Ed, the Diabetes Prevention Program, and Diabetes Self- Management Education and Support

Employers can:

- Offer only healthy food in food service operations (such as cafeterias and vending machines). See https://www.cdc.gov/nutrition/food-service-guidelines/index.html
- Develop an organizational policy related to offering healthy foods and beverages at meetings and conferences
- Ensure water is available and free to employees throughout the day

Employers can (cont'd):

- Provide lactation rooms and other supports for breastfeeding employees, as summarized in the District of Columbia Workplace Breastfeeding Support Toolkit, available at https://dchealth.dc.gov/service/breastfeeding-workplace

Schools, school systems, and institutions of higher education can:

- Offer only healthy food in food service operations (such as cafeterias and vending machines). Schools see https://osse.dc.gov/service/healthy-schools-act and colleges/universities see https://www.cdc.gov/nutrition/food-service-guidelines/index.html.
- Use point-of-decision prompts to highlight healthy food and beverage choices in cafeterias
- Integrate healthy food and beverage requirements into large-scale food service contracts
- Make water available throughout the school day

Early care and education:

- Establish a memorandum of agreement with WIC to facilitate referrals of potentially eligible children
- Follow guidance in the OSSE Healthy Tots "A step by step guide for implementing wellness guidelines in Child Development Facilities."
- Implement "10 Steps to Breastfeeding Friendly Child Care Centers". See https://sph.unc.edu/cgbi/ten-stepsto-breastfeeding-friendly-child-care/
- Make water accessible or available indoors, outside, at meals, and upon request
- Avoid screen time for children under 2 years of age
- **P**rovide education to parents on limiting screen time

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