The District of Columbia’s Health in All Policies (HiAP) Task Force was created in November of 2013 to (1) research existing HiAP models and (2) provide recommendations for establishing a HiAP program within the District of Columbia. The multi-agency group, with the guidance of HiAP national experts, communicated with dynamic community leaders and health officials from throughout the country. This report provides a summary of findings from HiAP programs in similar-sized jurisdictions and from state-wide programs, and summarizes HiAP guidance from national organizations as well as international experiences with HiAP. The Task Force Report offers rationale for the establishment of a HiAP program in the District of Columbia, along with four goals and ten action items.
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Executive Summary

The Health in All Policies ("HiAP") Task Force was established by Executive Order 2013-209 on November 5, 2013. The Task Force has 2 core functions. The first is to develop a plan for the District to implement a HiAP program while the second is to submit a written report. The written report must contain an analysis of existing HiAP programs in jurisdictions of a similar size to the District of Columbia, recommend a proposed structure and goals of a HiAP program in the District, and provide a plan and timeline to implement the recommendations. The overarching mission of HiAP is to shift the culture and thought process of policy and decision makers to prioritize consideration of health and health equity during the development, implementation, and evaluation of policy and decision-making.

The submitted report shares findings from not only jurisdictions of similar size to the District, but also shares findings from jurisdictions that have made notable progress in planning for or implementing HiAP. Additionally, findings from HiAP literature that provides national guidance in developing programs and conveys international experience are summarized. It should also be noted that the Task Force consulted subject matter experts on the topic, including representatives from West Virginia University, the Centers for Disease Control and Prevention, the Planning and Community Health Research Center at the American Planning Association, the Center for Public Health Policy at the American Public Health Association, and the National Association of County and City Health Officials.

To complement the research on existing HiAP programs and the literature review, the Task Force looked at existing summary health outcome data provided by the Department of Health. All three areas of research culminate in a report that recommends both a structure for establishing a HiAP program in the District and provides specific examples of HiAP actions that the District can prioritize. The following recommended goals and actions promote a sustained and continuous pursuit of health equity for District residents.

**GOAL 1: Create a New Office to Address Health Impacts across District Agencies**

**ACTION 1.1:** Create an Office of Equity.

**ACTION 1.2:** Develop a Health Impact Assessment (HIA) tool and assist each agency when it performs a HIA on major expenditures or policy decisions.
ACTION 1.3: Develop and make HiAP training available for current and new District employees.

ACTION 1.4: Reframe current and future agency health-related programs and policies as HiAP initiatives.

GOAL 2: Define Common Goals and Measures

ACTION 2.1: Define broad equity goals for the District.

ACTION 2.2: Develop HiAP performance metrics using equity maps and other data.

GOAL 3: Integrate HiAP into Agency Operations

ACTION 3.1: Require all agencies to incorporate HiAP action items into their performance plans.

ACTION 3.2: Renew the commitment to the implementation of specific HiAP projects of value to the District.

ACTION 3.3: Design and consider specific HiAP actions in areas of the District that are disproportionately affected by equity issues.

GOAL 4: Provide Data for Decision-Making

ACTION 4.1: Develop a data repository and facilitate data sharing related to inequities in the District to help better inform policy/decision makers.
Background & Methodology

Background

The primary objective of the Sustainable DC Plan is to make the District the healthiest, greenest, and most livable city in the nation. In support of this plan, the Health in All Policies (HiAP) Task Force was created in November, 2013 to assist policymakers in considering health and health equity during the development, implementation, and evaluation of policy and decision-making. HiAP is meant to guarantee that these decisions have a beneficial or neutral impact on residents’ health. HiAP engages diverse government agencies and stakeholders to work together to improve health and advance other goals. Select cities and states across the nation, and several other countries, have recently started implementing HiAP approaches, or similar policies and strategies, in their respective jurisdictions.

The District’s HiAP Task Force mission is to develop a plan to implement a Health in All Policies program the District. The plan is intended to ensure a sustained and continuous pursuit of health equity among District residents and strengthen the vitality and livability of all District communities.

To accomplish this mission, the Task Force has conducted a review of jurisdictions of similar size to the District that have implemented HiAP-like programs. To help supplement this review, the Task Force also examined HiAP at the state level, reviewed national and international health organization white papers, and consulted with outside subject-matter experts on the issue. The Task Force then analyzed these jurisdictions (with a focus on similar-sized areas) to evaluate their relative suitability to the District’s needs and their relative strengths and weaknesses.

Finally, based on that review and analysis, the Task Force developed recommendations to implement a HiAP program in the District. these recommendations include a proposed plan and timeline to implement the recommendations, as well as an analysis of the fiscal, policy, and legislative impacts of the proposed plan.

Through this analysis, the Task Force’s ultimate goal is to make recommendations that will help establish a policy paradigm in the District that addresses the determinants of health and produces improved quality of life for all residents. Much work needs to be done to implement
the Task Force’s recommendations, but, encouragingly, many of the best features other jurisdictions have to offer are already in place in the District.

Methodology

The work performed by the Task Force was a collaborative effort. Multiple members from the lead agencies, the Department of Health (DOH) and the District Department of the Environment (DDOE), contributed to this report. The purpose of the Task Force was to improve health equity among District residents and strengthen the vitality and livability of all District communities, and the insights of these two agencies was very influential for the ultimate direction of the task force. Other offices and agencies also provided valuable input, including the Deputy Mayor for Health and Human Services, the District of Columbia Office on Aging, the District Department of Transportation, the Office of Planning and the Department of Parks and Recreation. Task Force members from these offices and departments performed a thorough review of HiAP literature, identified potential recommendations for a District HiAP program, and/or provided editing and feedback on associated work products and Task Force decision-making.

Through review of the related literature, the Task Force understood the importance of outreach for a HiAP program. Outreach efforts included meetings with the community, information collection from all District agencies and consultation with subject matter experts. On two separate occasions members of the Task Force met with members of the public to receive feedback on the potential design of a District HiAP program. To promote these public meetings, along with the Sustainable DC promotion activities, the Task Force members sent notices of the meetings to interested stakeholders, asking them to forward along the meeting announcements to their respective constituencies. To better understand existing programs and HiAP knowledge within government agencies, the Task Force met with the Chiefs of Staff of each agency to assess their knowledge of HiAP and what initiatives could be promoted to improve District residents’ health outcomes. Finally, the Task Force reached out to HiAP subject-matter experts from national organizations and universities. These experts provided helpful feedback on the Task Force’s structure, potential literature to review and recommendations to consider, as well as proposed edits to the final work product.

Before finalizing recommendations for a HiAP program in the District, the Task Force assembled relevant resources, which were used to inform its decision-making. Resources included literature on HiAP and similar initiatives considered or underway in other jurisdictions, from city-level to country-level. This ensured the Task Force had all the appropriate information
necessary to perform a proper analysis. The Task Force reached out to District employees and to outside experts to find, sort through, and analyze these materials.

**Research Methods**

*Public Health Status*

To educate Task Force members on important health issues in the District, DOH provided presentations and written reports. Specifically, DOH reviewed the 2013 Prevention Status Report (PSR), current health outcome data, and an overview of health disparities based upon analysis of 2010 data. The PSR is developed by the U.S. Centers for Disease Control and Prevention (CDC) and highlights, for all 50 states and the District of Columbia, the status of public health policies and practices designed to prevent or reduce 10 important health problems or concerns. The PSR rates specific prevention activities for each jurisdiction to determine whether or not the policy or practice in place is grounded upon evidence-based practices. In terms of health outcome data shared with the Task Force, data was provided on the top-10 leading causes of death, as well as life expectancy and infant mortality. Data was also provided by DOH on health disparities using vital statistics and the Behavioral Risk Factor Surveillance System. These statistics helped guide the Task Force’s week-to-week deliberations and shape its ultimate recommendations.

**Literature Review**

The literature reviewed came from two core sources -- national public health organizations and international organizations. Additionally, white papers were reviewed from the New Orleans Health Department and the Multnomah County Health Department. Each review was evaluated for any recommendations that could either assist the Task Force in completing its assigned responsibilities, aid the District in establishing a successful program, or provide a clearer understanding of “HiAP”. The following is a list of what was read and discussed by the Task Force members.

- Health in All Policies: Strategies to Promote Innovative Leadership, Association of State and Territorial Health Officials, 2013;
- A Health in All Policies Approach to Promote Active, Healthy Lifestyle Collaboration, National Academy of Sciences, 2013;
– Health in All Policies: An EU Literature Review, 2012
– A health in all policies approach to promote active, healthy lifestyle in Israel, 2013
– Health in All Policies: Informational White Paper, New Orleans Health Department, 2013
– The Health Equity Initiative 2008 – 2013: A Five Year Reflection: The Policy Crosswalk, Multnomah County Health Department

Jurisdictional Review

In selecting jurisdictions, the HiAP Task Force was charged with learning from jurisdictions of similar size as the District. According to the U.S. Census Bureau, the District’s population was 646,449 in 2013. The jurisdictions that were reviewed by the Task Force with similar 2013 population sizes include: Denver, Colorado with a population size of 649,495, Baltimore, Maryland with a population size of 622,104, and Multnomah County, Oregon with a population size of 766,135. Other U.S. jurisdictions were reviewed based upon their progress in planning for or implementing HiAP programs. These included Richmond, California with a population size of 107,571, King County, Washington with a population size of 2,044,449 and New Orleans, Louisiana with a population size of 378,715.
Findings & Recommendations

This section first provides an Executive Summary of Findings. Then, it discusses the Task Force’s review and analysis of HiAP-related initiatives and literature. Finally, consistent with that analysis, the Task Force proposes recommendations for a District HiAP program, including goals and action steps related to the recommendations.

Executive Summary of Findings

The Task Force identified the following significant findings from its review of the various local, state, and international jurisdictions that have considered and/or implemented Health in All Policies programs.

An initial step recommended by several jurisdictions was to narrow the focus to a priority list, then design an implementation plan for each identified priority, assigning tasks to appropriate agencies, steered by an ongoing HiAP taskforce and/or other interagency team. Funding was also identified as an important to consider for implementation.

Funding was also identified as an important to consider for implementation.

While implementing HiAP, it is recommended to track and pursue ongoing evaluation of the implementation steps and any associated outcomes, and measure outcomes against pre-existing data.

It is also important to include non-governmental stakeholders during as many phases as possible of the HiAP development and implementation process, both to capitalize on their insights and to benefit from their ongoing commitment in reaching common goals.

As for where to place a jurisdiction’s HiAP program, the consensus is that it is important to place it within the jurisdiction’s executive office. There are two principal reasons for this: (1) it establishes an undisputed authoritative basis for a multitude of agencies to implement HiAP; and (2) it removes the otherwise inescapable perception that HiAP is an attempt by the Health Department to establish some form of control over the agendas of other agencies.

As a paper on the topic from the nation of Israel stated, “HiAP can appear threatening [to other, non-health-focused agencies], like health sector imperialism.” An ongoing task force could then serve to liaise with the relevant agencies and champion their HiAP efforts.
Another effective way to ensure HiAP is implemented by all relevant agencies is to include a HiAP focus in agency performance plans\textsuperscript{1,11-13,17} and to provide them with a tool by which to measure the health impact(s) of their current and/or proposed policies\textsuperscript{11-13,20}. Several jurisdictions support the notion of requiring Health Impact Assessments as a tool to support equity-driven policy decisions\textsuperscript{1-4,11-14}.

Finally, some jurisdictions consider that a useful way for HiAP to gain acceptance as a paradigm applicable across a wide variety of agency lines is to identify ongoing programs that feature HiAP-like characteristics, and reframe these as examples of HiAP in practice. This technique promotes HiAP as a realistically attainable policy paradigm that does not necessarily require a significantly new way of doing things, but instead involves a new way of thinking about policies\textsuperscript{2-4}.

**Findings**

The findings gained through literature review, research on existing HiAP programs, and discussions with both public health officials and HiAP subject-matter experts are presented within this section. The section is presented in the following order:

- Findings from National and State Literature
- Findings from Similar-Sized Jurisdictions
- Findings from Other Jurisdictions

This section only includes review of United States jurisdictions. Review of international Health in All Policies literature is included in Appendix I.
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<th>Findings From National &amp; State Literature</th>
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<td><strong>Source:</strong></td>
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<td><strong>Overview:</strong></td>
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<tr>
<td><strong>Lessons Learned:</strong></td>
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associated with the aforementioned levers include:

- Improve data sharing between schools and social service agencies to improve access to nutrition assistance programs;
- Include healthy homes assessments in weatherization programs;
- Incorporate messages around the importance of physical activity and healthy nutrition at the Department of Motor Vehicles, Department of Parks and Recreation, Department of Human Services and other Departments that frequently have captive audiences;
- Provide lactation accommodations to support breastfeeding;
- Incorporate health and health equity criteria into requests for proposals (RFPs) from agencies outside the health cluster;
- Incorporate strategies that promote community health into comprehensive land use and transportation plans;
- Streamline permitting process for vendors that encourage health behaviors – e.g., Farmer’s markets in underserved areas;
- Establish procurement policies that require District vending machines to provide a minimum number of healthy options;
- Improve enforcement of smoking bans; conduct economic development research on the return on investment of particular health outcomes of specific policies;
- Amend local laws allowing for mobile produce vending in residential areas of need;
- Increase vehicle licensing fees to raise revenue for healthy transit projects; and educate non-health staff on how their work relates to health outcomes.

### Findings From National & State Literature

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<tr>
<th>Source:</th>
<th>Association of State and Territorial Health Officials (ASTHO)(^7),(^18)</th>
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<tr>
<td>Overview:</td>
<td>In January 2013, the Association of State and Territorial Health Officials (ASTHO) published HiAP guidance for states entitled <em>Health in All Policies: Strategies to Promote Innovative Leadership</em>. ASTHO’s guidance is based on support of the National Prevention Strategy, which includes four key strategic directions: healthy and safe community environments, empowered people, clinical and community preventive services, and elimination of health disparities. The guidance focuses on identification of key characteristics that foster</td>
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successful cross-sector collaboration: (1) creating shared goals, (2) engaging partners early/developing partner relationships, (3) defining a common language, (4) activating the community, and (5) leveraging funding and investment.

The ASTHO guide provides valuable talking points for use when introducing the concept of HiAP to non-health agencies/sectors and provides implementation case studies tied to each of the key characteristics noted above.

**Applicable to D.C.:** ASTHO recommends that each state identify an issue of critical importance to all leaders and apply a HiAP approach as a solution. Obesity in California is used as an example of success, and is further explored later in this document. While it may seem intuitive, the document also recommends becoming an asset to other agencies, making an effort to understand partner agency processes, and modeling/tailoring HiAP so agencies can easily adopt it. The key case study highlighted here is Massachusetts’ adoption of health impact assessments in their environmental impact review process. The guidance document also recommends looking at funding in new and innovative ways, particularly highlighting the development of complementary relationships with relevant university programs and using other state health officials as resources/experts to contribute to this thought process. The Oregon Health Authority’s experience with implementation of health impact assessments is the associated case study for this recommendation.

**Lessons Learned:** Generalized recommendations from ASTHO:

1. Inventory places where health related considerations can be integrated into existing policy frameworks;
2. Identify opportunities to incorporate cross-sector work in funding opportunities;
3. Create opportunities to educate non-health professionals in HiAP principles;
4. Utilize health impact assessments as tools to integrate health into current policy processes;
5. Provide health consultation to other sectors as part of an interagency agreement;
6. Pursue opportunities to participate in state taskforces with multiple agencies;
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<tr>
<td>7.</td>
<td>Create opportunities to utilize common data or indicators across sectors;</td>
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<td>8.</td>
<td>Build sufficient time and funding into cross agency collaborations;</td>
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<td>9.</td>
<td>Identify and showcase champions in cross agency work to provide model for collaboration and motivate others to be proactive;</td>
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<td>10.</td>
<td>Produce tools and resources that can be used across sectors to promote collaboration; and</td>
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<td>11.</td>
<td>Ensure program staff has sufficient training and capacity necessary to implement goals and objectives.</td>
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**Findings From National & State Literature**

**Source:** *California*\(^{17, 18}\)

**Overview:** Summarized below are findings from an Institute of Medicine white paper entitled *Health in All Policies: Improving Health Through Intersectoral Collaboration*. The paper discusses the creation of the California Health in All Policies Task Force. It was established through a governor’s executive order in 2010 and was housed under the state’s Strategic Growth Council, a cabinet level committee. The lead agency is the Department of Public Health (CDPH), who partnered with the University of California, San Francisco, in the beginning and now partners with the Public Health Institute, with funding for staff from the California Endowment. The order gave the Task Force the following responsibilities:

- Identify priority programs, policies, and strategies to improve the health of Californians and simultaneously advance the other goals of the SGC;
- Submit a report to the SGC recommending programs, policies, and strategies to improve the health of Californians while advancing the SGC’s goals;
- Describe the benefits for health, climate change, equity, and economic well-being that may result if the recommendations are implemented;
- Review existing state efforts, consider best/promising practices used by other jurisdictions and agencies;
- Identify barriers to and opportunities for
interagency/intersectoral collaboration, and propose action plans;
- Convene regular public workshops to present its work plan; and
- Solicit input from stakeholders in developing its report.

To accomplish these goals, in 2010, the Task Force brought together 19 state agencies, departments, and officers to participate and meet regularly over the next year with stakeholders to develop 1,200 ideas of work. These ideas were then narrowed down to 34 recommendations presented to the SGC and stakeholders, who further narrowed it to 11 priority recommendations for implementation. The Task Force then created implementation plans for each, and all plans were approved by May 2012. Currently, the Task Force is in the process of carrying out the eleven implementation plans through an interagency team approach, with HiAP staff facilitating the work. Most of the implementation plans do not have additional funding, and are supported by the agencies involved. There are three plans which have had additional funding: ‘farm-to-fork’ policies, healthy and sustainable food procurement, and community safety through violence prevention. The Task Force has also moved into the California Department of Health’s newly created Office of Health Equity.

| Applicable to D.C.: | The California model was created from a Governor’s executive order, which is similar to the leadership support the District has through the Mayor’s office and Sustainable DC. The Task Force is led by their Department of Public Health, which DC’s Department of Health also leads along with the District Department of the Environment. It is important to note that the Task Force was funded with staff coordinating the efforts among the agencies. The beginnings of the California HiAP Task Force focused on figuring out key recommendations to implement among the relevant agencies and then implementing them. Moving forward, this approach could work well for the District. |
| Lessons Learned: | In general, the most important take away from the California Task Force was that it completed work over a long period of time. They formed in 2010 and only began to implement recommendations in 2012 and, thus, had an extended amount of time for research and for |
developing recommendations. The paper also shared a robust section of “Issues in Implementation” that the District can consider when moving into the implementation phase:

1. Evidence, Evaluation, Data, and Tools
   a. Need to incorporate more rigorous evaluation on the impact of HiAP and have ongoing developmental evaluation of implementation. Outcomes evaluation is very difficult to measure with a policy decision; therefore, associating strong data sources from the planning phase is crucial to measuring impact.
   b. The health impact assessment is a tool that is helpful to use when measuring impact of policies/programs, but it requires time and funding.

2. Collaboration
   a. Lack of time and resources pose a challenge for government agencies to carry out HiAP work, both with intersectoral work and even with silo’d programs within an agency. Must de-silo programs through a variety of actions including: dedication from top leadership, integration of collaboration goals in all agency programs, commitment to implementable policy goals, and stakeholder involvement.

3. Institutionalization
   a. Several questions will be raised regarding this topic to be aware of, including:
      i. Where should Health in All Policies be placed within the structure of government?
         I. Placement in a health agency could hurt collaboration. Efforts should be made to place in the executive office of government. Health agencies will then play a leadership role.
      ii. How should Health in All Policies be funded?
         I. It can be unfair to burden an agency with the funding, but it can also be complicated to distribute funding and

* The term “silo” refers to an agency program/initiative that is solely conducted by the agency, without interaction with other agencies. “De-silo” refers to integrating other agencies in certain programs to improve the outcomes of said programs.
cause inflexibility.

iii. *When is it appropriate to incorporate a health lens analysis?*
   1. There must be resources to figure out what policies impact health and the addition of an effective screening process.

iv. *How will governments build workforce capacity for Health in All Policies?*
   1. There must be an addition of staff with the appropriate technical skills, both in health and other governmental agencies.

4. **Stakeholder Engagement**
   a. Most stakeholder groups do not include vulnerable and disadvantage communities who would most benefit from health in all policies. The location, timing, and/or language at public sessions could negatively affect participation, along with distrust in government. Efforts should be based on community needs and including the community as partners.

5. **Leadership and Political Will**
   a. The HiAP framework must focus on health outcomes in policy decisions. This framework does not support the traditional frame of individual responsibility. Information cannot *just* be shared with leaders and policy makers. Leadership must communicate the relationship between health, equity, sustainability and the economy.
## Findings from Similar-Sized Jurisdictions

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<th><strong>Source:</strong></th>
<th>Multnomah County, Oregon&lt;sup&gt;8,15&lt;/sup&gt;</th>
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<tr>
<td><strong>Overview:</strong></td>
<td>In 2007, Multnomah County, Oregon, funded its Health Equity Initiative, “a countywide effort focusing on health inequities . . . to eliminate racial and ethnic health disparities.” The initiative defined health disparities as the “differences between population groups in the presence of disease, health outcomes, or access to care.” Using previous data, the Multnomah County Health Department identified several disparities that required intervention. Then, the initiative identified broad reasons that determined why the disparities occurred, including income and social status, education, working conditions, and physical environments. To improve the disparities, the initiative focused on three main policy areas: upstream, midstream, and downstream. Upstream policies address the root causes of the social determinants of health, like racism, classism, and powerlessness. Midstream policies target the social determinants of health by also addressing racism, classism, and powerlessness; for instance, by fostering “affordable low-income housing and home ownership.” Downstream policies improve “access and quality in services delivery system[s],” like when allocating funds in a budget to target racial and ethnic disparities for healthcare. Then, the initiative solicited comments on how to address each stream from members of the public, national health experts, the county’s health department, and associated literature. Through this solicitation and after receiving additional public feedback, the initiative received and ranked 83 meritorious recommendations; these were organized into 18 categories, like healthcare, education, and community built environment.</td>
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<td><strong>Applicable to D.C.:</strong></td>
<td>Procedurally speaking, while the Multnomah County Department of Health performed a great deal of work with the initiative, none of it could have been done without the support of elected representatives. In Multnomah County, the county Chair, promoted and helped fund the health equity initiative. Additionally, because HiAP is a comprehensive, cross-sector health analysis, having input from multiple county agencies, outside experts, and members of the public is key. Specifically, consulting with outside national experts, who had</td>
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knowledge of how similar initiatives were conducted in other jurisdictions, seemed to be useful.

The initiative also came out with strong policy recommendations. These recommendations related to topics ranging from community safety to education, and areas in-between. Strong recommendations included:

- Expanding residential and outpatient drug and alcohol treatment centers;
- Making public space more attractive and usable which would have the effect of bringing community together and discouraging crime;
- Taxing gun sales to leverage funds for violence prevention activities;
- Conducting health impact assessments on ballot measures;
- Increasing availability of affordable housing;
- Expanding quantity and quality of parks and green space to enhance access for those affected by inequities;
- Increasing taxes on unhealthy products (e.g. tobacco, sodas, junk food);
- Creating a "Health Equity" section for new employee orientation; and
- Providing training to raise awareness of social determinants of health to the community and policymakers.

Lessons Learned:

A key suggestion for implementing HiAP in the District is to provide sufficient funding for HiAP-related work and policies moving forward.

Similar to the proposal in Multnomah County, the District should consider using funds to provide training to raise awareness about health inequities in the District and why they occur. This is suggested particularly because some District agency officials perceive that their work does not relate to health. For instance, in discussions with agencies' chief of staffs, some participants did not believe that their agency's work could not improve health outcome. As in Multnomah County, funding could go towards training new employees or current policymakers to raise awareness on health equity. Similar to thriving HiAPs in other jurisdictions, one key to success in Multnomah County was support by the County Council Chair. This helped create many strong policies related to improving health equity.
## Findings from Similar-Sized Jurisdictions

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<th>Source:</th>
<th>Denver, Colorado¹</th>
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<td><strong>Overview:</strong></td>
<td>Also reviewed was Denver, Colorado’s Community Health Improvement Plan, entitled Be Healthy Denver. The plan was released in February 2014, and focuses on five-year goals and objectives aligned under two main priority health areas: access to care, including behavioral health, and healthy eating and active living, including the built environment. Under healthy eating and active living, there is an objective for the city and county governments to incorporate health considerations and analysis in city policy, processes, and planning.</td>
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<td><strong>Applicable to D.C.:</strong></td>
<td>Some objectives included the following actions:</td>
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<td>• Implement healthy vending policies and practices in city buildings and worksites;</td>
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<td>• Promote the inclusion of health considerations in Denver’s 2014 Comprehensive Plan;</td>
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<td>• Promote a city health impact prioritization policy for use in evaluating capital improvement projects;</td>
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<td>• Establish a set of potential criteria, processes, and tools for use in budget processes for determining the health impacts of capital improvement projects;</td>
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<td>• Engage other city departments in developing a plan for expanding the use of health impact assessments to inform neighborhood plans, as adopted by the Denver City Council in its 2014 Priorities; and</td>
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<td>• Complete a Health Impact Assessment (HIA) in partnership with other city departments.</td>
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While the overall plan does not weave health in all policies considerations throughout, the objective and action items above clearly address the concept. The plan goes on to mention that these health actions will help focus attention of health equity issues in the city, and that the Denver Environmental Health and Denver Public Health departments will assist other agencies with personnel, health data, and other resources.

| Lessons Learned: | There are many other aspects of this plan which could be applicable to a HiAP strategy in the District. Specific indicators are spelled out under |
both of the overarching health priority areas, focused on where data already exist. The determinations for priority areas were initially based on a recent community health needs assessment, and equity runs throughout the plan. Additionally, the same two departments are the lead on this plan as are the lead on the District’s HiAP Task Force. Their responsibility to assist other agencies through the process of incorporating health considerations is something that a District plan could model as well. Finally, Appendix III includes a description of all of the initiatives already underway in the District that address healthy eating and physical activity as well as a list of best practices for both. Weaknesses of Denver’s plan include a limited focus on HiAP and no clear structure laid out for how the action items will be pursued.

### Findings from Similar-Sized Jurisdictions

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<th><strong>Source:</strong></th>
<th><em>Baltimore, Maryland</em>[^2][^3][^14]</th>
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| **Overview:** | Baltimore approached HiAP by first creating a policy agenda, *Healthy Baltimore 2015*, and then convening a Cross Agency Health Taskforce (CAHT) to connect government agencies to the agenda. The city’s approach highlights the need to consider the role that each city agency can play in making built and social environments more supportive of physical activity. Baltimore encourages city agencies to promote health through policies, program design, standard operating procedures and internal practices.  

> “Every aspect of government, society and the economy has the potential to affect health and health equity.”

> -- Oxiris Barbot,  

> Baltimore City Health Commissioner

*Healthy Baltimore 2015* was created by the health department in May 2011. It is a comprehensive health policy agenda for the city that identifies ten priority areas where the city believes it can have the largest impact on reducing morbidity and mortality, as well as improving the quality of life for city residents. The plan includes data that reflect the groups with the largest inequities by race, gender, education, or income to further highlight opportunities for addressing health inequities. Shortly after the release of *Healthy Baltimore 2015*, Baltimore’s mayor established the 10 priority areas:. |

[^2]: Baltimore, Maryland
[^3]: Healthy Baltimore 2015
[^14]: Oxiris Barbot, Baltimore City Health Commissioner
1. Promote access to quality health care for all
2. Be tobacco free
3. Redesign communities to prevent obesity
4. Program heart health
5. Stop the spread of HIV and other sexually transmitted infections
6. Recognize and treat mental health needs
7. Reduce drug use and alcohol abuse
8. Encourage early detection and cancer
9. Promote healthy children and adolescents
10. Create health promoting neighborhoods

The Baltimore taskforce (CAHT) was comprised of 21 city agencies. Taskforce members reviewed the 10 priority areas of *Healthy Baltimore 2015* and selected areas where they could strengthen existing efforts and where new efforts could be initiated. As part of their continued participation, taskforce members promote health and *Healthy Baltimore 2015* in their agencies and champion internal agency efforts to promote physical activity. The Health Department is responsible for coordinating the taskforce and providing administrative support, as well as offering health expertise via training and technical assistance.

HiAP projects created by CAHT:
- Baltimore Development Corporation: MainStreets program for attracting vendors to high-need communities;
- City Schools: Safe Routes for Walking to School;
- Department of General Services: Expanded bike parking;
- Housing: Youth leadership clubs in public housing to promote social cohesion, leadership and physical activity;
- Library: Get Fit @ Your Library program;
- Zoning: Decrease density of vacant building by 20% and liquor stores by 15%; and
- Transportation: Prioritization of pedestrian and bicycle safety.

**Applicable to D.C.:**

There are 4 core features of Baltimore’s HiAP program that should be underscored:

*Feature #1:* Baltimore utilizes an interagency taskforce. The Taskforce is comprised of both public health agencies and other government agencies that one might not automatically think of when thinking of
health policy. Below is a list of the agencies participating in the Baltimore Taskforce.

- Baltimore City Public Schools
- Baltimore Development Corporation
- City Solicitor’s Office
- Department of General Services
- Department of Health
- Department of Human Resources
- Department of Planning
- Department of Public Works
- Department of Recreation and Parks
- Department of Transportation
- Family League
- Fire Department
- Free Library
- Housing Authority
- Mayor’s Office of Criminal Justice and Police Department
- Mayor’s Office of Employment Development
- Mayor’s Office of Human Services
- Mayor’s Office of Information Technology
- Mayor’s Office of Neighborhoods
- Office of the Labor Commissioner
- Parking Authority

- Feature #2: Baltimore appears to utilize a concept similar to the national “Healthy People” plan, i.e. “Healthy Baltimore.” Healthy People is a comprehensive plan to improve the nation’s health; the Plan has set long-term health objectives every decade since 1979. Currently, the 2020 objectives are established and each State works to mimic the plan at the state level, developing objectives and targets. Below is a list of “Healthy” objectives selected by Baltimore.
  - Access to Care
  - Heart Disease and Stroke
  - HIV/AIDS
  - Maternal and Infant Health
  - Mental Health
  - Nutrition, Weight Status (Obesity) and Physical Fitness
  - Pediatric Health
  - Sexually Transmitted Diseases
  - Social Determinants of Health
Feature #3: In addition to the ten priority areas, Baltimore convened all agencies around one core health issue, promoting increased physical activity. The ten priority areas allows for each agency to find their own niche. Having one core health issue brings everyone together to make a large-scale impact and focuses resources on one message to residents. The message to increase physical activity is now sent to residents from multiple sources and more often than if just one agency were leading the charge.

Feature #4: Nationally, notation has been made that Baltimore has really worked to comprehensively revise its zoning codes to improve the built environment and its impact on residents’ health. This led to a health impact assessment on the first draft of the revised zoning code. The health impact assessment recommended limiting the concentration of alcohol outlets and instituting land use and design elements to reduce crime (e.g., lighting standards), which is also important for promoting walkability.

Lessons Learned: Baltimore created the following list of lessons learned:
- Require full leadership support and engagement;
- Build overlap between each government agency’s mission and priorities with health or quality of life;
- Spend time and energy on the “early adopters;”
- In time, create common language and understanding of health in all policies;
- Utilize non-traditional partners to general creative thinking;
- Help agencies see their role in HiAP by holding one-on-one meetings, aside from the group Taskforce meetings; and
- Ensure that Taskforce members are fully empowered and supported in their role.
# Findings from Other Jurisdictions

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<tr>
<th>Source:</th>
<th><em>King County, Washington</em>¹¹,¹²,¹³</th>
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| **Overview:** | King County is in northwest Washington state, where the city of Seattle is located. It began focusing on equity and social justice in early 2008. As of the time of the drafting of this Health in All Policies report, King County’s most recent report on this initiative was published in August 2013. Although not specifically titled “Health in All Policies,” the equity and social justice initiative is extremely similar to a HiAP initiative because it focuses on upstream sources of health inequities. To solve these inequities, the initiative posed the question: “[W]hat is the comprehensive approach we need to get at the root causes [of the problem?]”

Demographically, King County is comparable to the District of Columbia. While overall, 35% of its population consists of “people of color,” in ten different zip codes, 70% of the people are people of color.* Furthermore, because other neighborhoods have a super majority of Caucasian residents, the jurisdiction has concluded that “place and race matter are predictors of income and many important outcomes such as life expectancy and education.” King County committed to health equity because “remaining a leader in our global economy … depends on everybody being able to reach her and his full potential.” |
| **Applicable to D.C.:** | King County prioritized its efforts on “people of color, low-income communities, and people with limited English proficiency.” In three different cities within the county, the initiative focused on a determinant of equity. For instance, to address language barriers in the City of Kent, the school district provided “extensive staff development in language and cultural awareness . . . .” Additionally, to tackle disproportionality in student discipline, the school district revised discipline guidelines “to reduce the amount of class time students miss[ed] because of disciplinary issues.”

In another city, the City of Northgate, the initiative focused on safe and efficient transportation because of the areas busy transit center. Accordingly, as government entities reviewed planning efforts for a |

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* Additionally, three zip codes are ranked in the top-30 nationally for being the most racially and ethnically diverse.
light rail, the entities reviewed the efforts though “the lenses of public health, livability and equity.” This would ensure “the best possible neighborhood development outcomes . . . .”

Other key practices from the county or agency perspective include:

- Requiring all agencies to include equity and social justice impacts in their budgets and business plans;
- Incorporating specific consideration of equity and social justice in the County Council’s budget deliberation process;
- Creating equity maps, to help county staff for equity analyses;
- Examining bus fare options for people with lower income;
- Creating a program to redirect those involved with low-level drug activities to community-based services, instead of incarceration, as a disproportionate number of African Americans have overrepresented these kinds of police bookings;
- Offering basic Equity and Social Justice training to all employees;
- Focusing on emergency event dissemination and preparation to populations that are traditionally disadvantaged;
- Creating an equity and social justice inter-branch team that advised the county on how to build equity and social justice into all aspects of the county’s management and plans, as well as “supporting a robust set of [equity and social justice] trainings;” and
- Creating an Equity Impact Review Tool for the county to use because they are required to “consider equity and social justice impacts in all decision-making so that decisions increase fairness and opportunity for all people” or to mitigate a decision’s negative impact.

Lessons Learned:
Out of the American jurisdictions reviewed, the King County Equity and Social Justice initiative is arguably one of the most effective. The District should consider creating a HiAP team that can advise District agencies how to consider health in their decision-making, like in King County.* The team could also offer HiAP training to all District employees.

* To assist with this, the inter-branch team could develop maps similar to King County that show health inequities among District residents.
Related to Council decision-making, the District may want to enact legislation requiring HiAP to be considered in the budget-making process. The HiAP Task Force has already drafted a plan require each agency to include action steps and key performance indicators that are implemented to achieve a general HiAP objective.

One significant policy that the District should consider is to require all agencies to take health equity considerations into account in their decision-making. An agency could “consider” health equity by performing a health impact assessment, done by using a tool similar to the King County Equity Impact Review Tool.

The District may also want to consider HiAP pilot projects, which focus on segments of the city or wards that suffer from particular health inequities.

The equity and social justice initiative in King County seems to be successful because it has buy-in from County executives and the jurisdiction considers equity and social justice in the budget and other policy decisions. The executives and the County’s departments are likely promoting this initiative because the inter-branch team advises the County on how to incorporate the initiative into planning and decision-making. In essence, the inter-branch team gives county officials a better perspective on the acute equity issues facing the county.

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<th>Findings from Other Jurisdictions</th>
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<tr>
<td><strong>Source:</strong></td>
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<td><strong>Overview:</strong></td>
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residents experiencing the factors that contribute to health inequity.”

To improve health equity, Richmond focused on six main cumulative stressors: governance and leadership, economic development and education, full service and safe communities, residential and built environments, environmental health and justice, and quality and accessible health homes and social services.

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<th>Applicable to D.C.:</th>
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| From an organizational perspective, Richmond does an extremely good job of focusing on different actions and how they will improve cumulative stressors. For instance, within “Governance and Leadership Implementing Actions,” the initiative lists an action to accomplish, how to accomplish or measure the action, how the action focuses on health equity, the department responsible for implementing the action, and measuring the action’s desired outcome. Unlike other jurisdictions, Richmond’s layout provides specific criteria for how to make sure that actions aimed at improving health equity are achieved. Additionally, Richmond has really looked at all policies for Health in All Policies. To improve health and health equity of its residents, the city has plans to improve, inter alia, community parks, zoning, housing code enforcement, and even the arts. Finally, Richmond is using significant amounts of data to inform their decision-making. Within each “cumulative stressor,” the jurisdiction looked at data from surveys, reports, and other statistics to assess current conditions and future health objectives. Richmond developed several strong actions to improve health equity in their city. For example, since there is a strong correlation between educational attainment and a person’s health, the jurisdiction collected more data on absenteeism in public schools with the ultimate desired goal of decreasing the number of students who are chronically absent. To decrease the stress related to unsafe communities, Richmond set a measure to replace all city lights with LEDs, which are brighter than normal street lights so residents would feel safer in their neighborhood at night. To incentivize healthier eating, the city expedited permit reviews for all retail business providing a minimum of 10 percent shelf space for fresh produce. In another effort to promote healthy activity, the jurisdiction is seeking to improve park quality in underserved areas. To accomplish this, Richmond aims to increase the number of “community parks and
aquatic facilities in underserved communities [that are] renovated to state-of-the-art standards[.]

Other strong plans, policies, or programs include:

- Encouraging socioeconomic class integration and reducing neighborhood segregation, as well as increasing the number of new affordable housing units in middle/upper-income neighborhoods;
- Targeting reductions in air pollutants for given pollutants and emission sources;
- Providing training for city staff on HiAP and develop city capacity to conduct Health Equity Impact Assessments;
- “Requir[ing] an HVAC system with filtration for sensitive use sites that are within 500 feet of a high traffic road[;]”
- Working with the Health Department to get people health insurance via the health care exchange; and
- Including access to a healthcare facility as part of the city’s transportation plan.

**Lessons Learned:**

Once a District Health in All Policies initiative is sustained, the District may want to take a closer look at Richmond’s HiAP strategy because it includes many helpful and specific programs, policies, and initiatives. To incorporate health in their decision-making, Richmond targets multiple non-health-centric areas for health-related improvements. When the District implements a HiAP program, it should consider following a model similar to Richmond’s, which details needed actions, identifies implementing agencies, and describes how to accomplish the actions.

A broader recommendation for the District is to implement agency training on HiAP and to develop agency capacity to conduct health impact assessments. Finally, while the District’s Department of Health has a great amount of relevant health data, it might also be helpful to follow Richmond’s lead on collecting additional data from surveys and reports to more comprehensively assess health equity conditions in the District.
## Findings from Other Jurisdictions

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<th><strong>Source:</strong></th>
<th><em>New Orleans, Louisiana</em>⁴</th>
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| **Overview:** | In August, 2013, the New Orleans Health Department (NOHD) published a comprehensive White Paper on Health in All Policies (HiAP) and how it could apply to New Orleans. One of the principal goals behind the NOHD initiative was to “identify ways the department can utilize HiAP to strengthen, implement and establish NOHD priorities and maximize impact by leveraging existing resources.”

Community stakeholders weighed in on overall NOHD policy planning efforts with a vision statement that called for “a safe, equitable New Orleans, whose culture, institutions, and environment support health for all.” Driven by the desire to reduce significant health disparities, the NOHD community health improvement planning process focused heavily on the importance of addressing the social determinants of health and putting in place an all-sectors approach to health.

The New Orleans Health Department believes that a HiAP approach would be a helpful way to progress towards health equity. Among other things, NOHD recognizes that “a range of facilitators and barriers to community health [exist] in the economic, environmental, political, social, and technological realms.”

The NOHD emphasis on addressing the social determinants of health and “promoting a culture of HiAP” can be seen in several current New Orleans strategies, including those concerning

- **Violence Prevention**, in that the City’s murder reduction strategy, dubbed “NOLA for Life,” cuts across agency boundaries and includes a focus on promoting jobs and rebuilding neighborhoods;
- **Complete Streets**, a program steered by an Advisory Committee that is co-chaired by the Department of Public Works and the Office of Planning, and includes a number of other agencies and organizations, such as the Parks and Parkways Department, the Regional Transportation Authority, the Health Department, and three advocacy groups (AARP, a cyclist organization, and a public transportation advocacy group); and |
- Healthy Lifestyles, in that this program/strategy includes a focus on ensuring the built environment contains healthy and safe housing for all.

While New Orleans has not yet established a HiAP taskforce, it has started to include a Health Impact Assessment (HIA) into some of its important city projects. The most notable example is the ongoing effort to create a fresh food market on an old school site, thereby benefiting New Orleans residents who need access to healthy foods, while at the same time redeveloping a blighted site in need of attention. This process benefited from a Health Impact Assessment, and the NOHD feels strongly that the Health Impact Assessment methodology has potential for describing how health plays a role even in “non-health” scenarios.

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<td>Although there is no formal, Administration-sanctioned HiAP strategy in place in New Orleans, the NOHD has made significant strides towards encouraging a HiAP approach whenever feasible. Notable positive features of what has occurred to date are as follows:</td>
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<tr>
<td>- NOHD focused on redefining existing and/or planned programs into HiAP “wins,” thereby encouraging policymakers and agency decision-makers to view HiAP as a realistically achievable strategy that can help achieve multiple cross-cutting goals. Low-hanging fruit can be re-characterized as programs or projects that are HiAP in nature. District examples include: DMHHS’ Age-Friendly City Initiative, DDOE’s DC Partnership for Healthy Homes, DOH’s Live Well DC, OP’s Healthy by Design, and DDOT’s moveDC (see Appendix III).</td>
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<td>- NOHD has started to encourage the use of a Health Impact Assessment to ensure health impacts are considered in decision-making involving what may otherwise appear as a non-health-related initiative or project. This is an approach that may also be productive in the District, perhaps as a stepping stone towards a more robust and comprehensive HiAP approach.</td>
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<td>- NOLA for Life, a violence prevention program initiated by the New Orleans Mayor, created a heat map of crime and compared it to the Department of Public Works (DPW) list of street light outages. DPW agreed to prioritize the outages to</td>
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improve overall street safety. Repairing outages is within normal operations for DPW, and the prioritizing of high-profile crime hotspots as a collaborative measure to increase safety is an excellent example of how what appears at first to be a non-health-related program can be reframed as a HiAP success story.

**Lessons Learned:**

One year after producing a first-rate white paper on how New Orleans could develop and implement a comprehensive Health in All Policies program, NOHD’s Manager of Strategic Performance and Partnerships stated in a telephone conversation on June 16, 2014, that the local “political environment” was such that this concept/proposal could not advance any further for the time being. Accordingly, it would seem that one significant lesson learned is that leadership buy-in is essential for progress to be made in establishing HiAP in the District. A plan should be considered to educate the incoming Administration on HiAP and present it as a realistically feasible paradigm shift that will greatly benefit District residents.

A HiAP focus should begin on small, visible wins, e.g., incorporate HiAP into existing programs/strategies and redefine them as current HiAP strategies. In other words, pick low-hanging fruit such as existing DC programs that can easily be reframed as HiAP success stories.

A District HiAP program should highlight shared objectives and performance measures that maximize collective impact.

The task force recommends including technology tools to process data from a variety of sources (like a GIS map) that would allow multiple agencies to simultaneously track their own progress, the progress of other agencies, identify problems as they arise, and monitor outcomes on a city-wide level, as opposed to only agency-wide. This is because, in New Orleans, street light crime outage collaboration did not include a reporting mechanism for accountability or measure of impact.

The District needs to articulate a clear vision or intent for implementation, intersectoral collaboration, and a certain degree of authority over intended targets or outcomes. Prioritizing certain health-related inequities is the appropriate first step, followed by identifying ongoing or planned programs that can impact those inequities.
To more solidly embed HiAP within District agencies, NOHD recommends considering new hires with a diversity of skillsets that are at the core of the HiAP philosophy of addressing the social determinants of health, including policymaking, urban design, community organizing, education, and economic development. Finally, it seems important to prevent momentum from being lost. Accordingly, it may be desirable to legislatively require a HiAP taskforce or commission to ensure progress continues on this front.
Recommendations

This section contains the task force’s recommendations to implement a HiAP program in the District of Columbia. The section is broken down into a main goal and the actions to achieve the goal. Actions are further broken down into a summary discussion and examination of expected benefits, a completion date, fiscal impacts, political/citizen impacts, legislative/regulatory impacts, the recommendation itself, and incentives (if applicable).

After a review of jurisdictions that are a similar size to the District of Columbia, an analysis of HiAP literature, a review of public health data and discussions with HiAP subject-matter experts, the Health in All Policies Task Force offers the following recommendations on a proposed structure and goals for a HiAP program in the District:

**GOAL 1: Create a New Office to Address Health Impacts across District Agencies**

**ACTION 3.1: Create an Office of Equity.**

a. **Summary:** The mission of the Office of Equity (Office) should be to institutionalize within District Government the fostering of improved equity conditions for District residents. The Office should have broad oversight, housed within the Executive Office of the Mayor, Office of the City Administrator, or n a Deputy Mayor’s office, with each District agency being required to create a liaison office or assign a key position to facilitate District-wide equity activities. A core function of the Office should be to manage the District’s HiAP program. Based on the Task Force’s research, HiAP policies are most successful when there is: (1) an overarching strategy; (2) an executive office to hold agencies accountable implementation; (3) a neutral convener to bring multiple agencies to the table to find common ground; and (4) inter-sectorial collaboration.

Generally, the Office should be expected to implement the Task Force recommendations and follow the spirit of this report. To assist the Office, staff should be required to complete HiAP training or have pre-existing HiAP experience. Once staff is trained in HiAP, the Office should advise the Mayor, Council, and District agencies on HiAP considerations. Additionally, the Office should assist and oversee the analysis and completion of agency Health Impact Assessments. Consideration should be given as to whether the Office should have the ability to raise funds, similar to the Mayor’s Council on Physical Fitness, Health, and Nutrition. Finally, the Office should partner with universities and other influential stakeholders to strengthen and build support for its initiatives.
The Office of Equity should coordinate its work with all District agencies and offices. In particular, the Office should have strong relationships with the public health and environmental agencies, the executive offices on special populations, and -- if enacted -- the current legislatively proposed Commission on Health Disparities. There are at least seven District government agencies that play a key role in public health: DOH, DDOE, DBH, DDS, DCOA, DHS and DHCF. DOH plans to create its own Office of Health Equity to serve as liaison to the executive level Office. It is important that all agencies establish such equity-focused liaisons.

Regarding special populations, the Office should work closely with the following special population offices:

- Office on African Affairs;
- Office on Asian and Pacific Islander Affairs;
- Office of Disability Rights;
- Office of Gay, Lesbian, Bisexual and Transgender Affairs; and
- Office on Latino Affairs.

These offices will be able to provide insight related to existing health equity disparities, as well as identify policies to improve equity. If the District of Columbia Council legislates the creation of a Commission on Health Disparities, given the similarity and overlap of their respective missions, the Task Force would strongly recommend that the Commission and the Office of Equity coordinate their work to the extent possible, and that the Office focus on implementing HiAP and increasing overall equity for residents throughout the District.

b. **Expected Benefits:** The creation of an Office of Equity with strong agency and community partnerships would allow the District to position itself as a champion for innovative and streamlined approaches to improving health outcomes. An office that works to ensure environmental justice, equity within transportation and public works policies, within city planning, and that considers equity in all other areas, will have the greatest possible impact on public health. Fair access to health services and public programs is clearly meaningful; yet equity built in among all District policies will ultimately have greater impact on quality of life and health outcomes. An Equity Office located within a senior executive office will have the authority needed facilitate inter-agency cooperation and compliance.

c. **Completion Date:** Fiscal Year 2016.
d. **Fiscal Impact:** Estimated fiscal impact takes into consideration the staffing costs for an Office of Equity with 4 FTEs and sufficient resources for training needs. Additionally, 1 FTE is requested for DOH, since the majority of the work done by the Office will require that DOH provide on-going support for identification of relevant health data, clarification of existing health policies, and support in analyzing health impacts. This position would rest within the Office of the Director within DOH and work closely with the DC Healthy People Plan Coordinator and the Office of Equity to set long-term (2020) targets and monitor annual health statistics as well as quarterly performance goals. In addition, for each fiscal year beyond Fiscal Year 2016, $50,000 is added to base salaries to account for an increase in personnel costs due to automatic step increases, an increase in fringe benefits, and indirect costs. Finally, initial implementation costs are required in FY16 to pay IT-related costs for adding a HiAP module to the performance management database (a Quickbase application).

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Implementation Costs</th>
<th>Operational Costs</th>
<th>Total Costs</th>
<th>FTE Increase</th>
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<tbody>
<tr>
<td>2015</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>2016</td>
<td>$11,000</td>
<td>$600,000</td>
<td>$600,000</td>
<td>5.0</td>
</tr>
<tr>
<td>2017</td>
<td>N/A</td>
<td>$650,000</td>
<td>$650,000</td>
<td>N/A</td>
</tr>
<tr>
<td>2018</td>
<td>N/A</td>
<td>$700,000</td>
<td>$700,000</td>
<td>N/A</td>
</tr>
<tr>
<td>Total</td>
<td>$11,000</td>
<td>$1,950,000</td>
<td>$1,961,000</td>
<td>5.0</td>
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e. **Political/Citizen Impacts:** The creation of an Office of Equity will enable citizen participation on this issue to flourish. Public input on equity issues will be able to be funneled to one centralized entity within the District government, at the highest level possible.

f. **Legislative/Regulatory Impacts:** Legislation proposing to create the Office of Equity would need to be drafted.

g. **Recommendations:** Although improvement to the public’s health is the ultimate goal of HiAP work, the Task Force recognizes that identifying and working on the social determinants of health is paramount in promoting a high quality of life for all residents, and therefore strongly recommends that the Office of Equity focus on all areas affecting equity, such as education, the economy, and the
environment. The Office of Equity should act as coordinator and the main
government entity tasked with ensuring HiAP is implemented in the District.

**ACTION 3.2: Develop a Health Impact Assessment (HIA) tool and assist each agency when it performs a HIA on proposed major expenditures or policy decisions.**

**a. Summary:** The District should develop a Health Impact Assessment tool that agencies use to conduct assessments. Each District agency should perform a HIA on major expenditures or policy decisions. The proposed Office of Equity should set threshold limits for when an assessment is necessary. At least initially, the Office should provide technical oversight on the drafting and completion of assessments, including ensuring a comprehensive analysis is presented of all relevant issues.

The HIA tool should offer a comprehensive method of gathering information to advise planning and decision-making about policies and programs that impact resident’s quality of life and health. The tool should provide definitions for important terms and should cover three main elements: (1) Does the decision being examined impact the health of residents, and if so, what are the positive and negative health impacts of the decision? (2) Who is affected by the decision? (3) Are there feasible agency actions that could mitigate the negative impacts, and/or enhance the positive impacts?

**b. Expected Benefits:** Development of a Health Impact Assessment tool for use by all agencies will enable a comprehensive analysis to be completed by each agency as it considers proposed policy decisions and major expenditures. Creation of such a tool will ensure that all agencies are using the same methodology to arrive to their respective conclusions. Use of such a tool should result in more health-conscious decisions being made by agencies, as well as improved health outcomes for District residents. Ultimately, the analysis provided through the HIA tool should result in agency proposal modifications that produce no health-detrimental outcomes, and more health-positive outcomes.

**c. Completion Date:** Development of the Health Impact Assessment tool should be completed within four (4) months from the formation of the Office of Equity.

**d. Fiscal Impact:** N/A

**e. Political/Citizen Impacts:** Creation and mandatory use of a Health Impact Assessment tool will have a significant impact on the District. Politically, use of the tool will require agencies and policy-makers to confront the health impacts of their
desired policies. If adverse health impacts are identified, it will require agencies to address them. If positive health impacts are identified, it may spark additional ideas to enhance them. For citizens, the use of such a tool will improve transparency regarding anticipated health impacts of policy decisions and may produce additional opportunities for helpful citizen input and policy support.

f. **Legislative/Regulatory Impacts:** Although the Task Force does not anticipate that development of a Health Impact Assessment tool and its use will require legislation, if the tool is required to be used within certain parameters of applicability, it is possible that legislation may be needed to make the use of the HIA tool mandatory under certain specifically specified circumstances. Similarly, there may be a need to incorporate provisions regarding the use of the HIA tool within certain regulations. For example, if an HIA analysis result in a finding of negative health impacts, an agency should be required to revisit and make adjustments to the proposed policy and/or expenditure in question.

g. **Recommendations:** Upon its creation, the Office of Equity should prioritize the creation of a Health Impact Assessment tool. The Office should study the tool currently in use in King County, Washington, as it is considered a model HIA tool and has been in use for some time. The Office should assist with Health Impact Assessments, which offer a systematic method of gathering information to advise decision makers, with the goal of improving policies and programs and thereby improving residents’ quality of life and their health.

**ACTION 3.3: Develop and make HiAP training available for current and new District employees.**

a. **Summary:** District employees could improve their awareness of health outcomes and quality of life factors related to government decisions. Accordingly, the Office of Equity should develop and make available training opportunities to all current and new District employees.

b. **Expected Benefits:** A key to implementing HiAP is to ensure that policy makers understand how their choices can impact the health of District residents. HiAP training for District employees will improve decision makers’ choices related to health outcomes in the District and enhance the culture and thought process for health-based decision-making.
c. **Completion Date:** The development of HiAP training courses should be timed so that they are made available to District employees within six months from the formation of the Office of Equity.

d. **Fiscal Impact:** The development of HiAP training materials should be a major work product of the Office of Equity, which should absorb related costs in the Office’s budget.

e. **Political/Citizen Impacts:** There are no anticipated political/citizen impacts.

f. **Legislative/Regulatory Impacts:** There are no anticipated legislative/regulatory impacts.

g. **Recommendation:** Training should include the development of white papers, fact sheets and a website, in-person tutorials and other technical assistance. All of these resources should explain HiAP and how officials can better incorporate HiAP in decision-making. Those receiving such training should include, but not be limited to, agencies’ chief of staff, performance plan managers, and possibly an agency HiAP liaison, similar to current agency FOIA officers.

**ACTION 3.4: Reframe current and future agency health-related programs and policies as HiAP initiatives.**

a. **Summary:** Many agencies have current initiatives or programs that operate within a HiAP framework. For instance, the Department of Health’s *Live Well DC!* is a HiAP initiative. In addition, *Sustainable DC* has many initiatives that mirror HiAP-consistent projects in similar-sized jurisdictions. Current initiatives that can be characterized as consistent with HiAP can be found in Appendix III. Once established, the Office of Equity should communicate to District agencies how their current programs and projects already relate to HiAP, and how best to incorporate HiAP concepts in future planned activities. This action should clearly define how past and future agency work relates to Health in All Policies in the District.

b. **Expected Benefits:** When agencies understand that some of their work already fits the HiAP paradigm, it will make future agency buy-in that much easier.

c. **Completion Date:** The reframing of current District health-related policies and programs should be reframed as HiAP initiatives no later than three months from the creation of the Office of Equity. The reframing of future planned, health-related
District agency policies and programs should be reframed as HiAP initiatives on an ongoing basis once the Office of Equity is created.

d. **Fiscal Impact:** N/A

e. **Political/Citizen Impacts:** The reframing of current and future health-related District programs and policies as HiAP initiatives should result in a greater public appreciation of the broad scope of health impacts that non-health-focused programs and policies can have. This should immediately result in a greater understanding of the HiAP paradigm’s potential for improved health equity in the District.

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** Once established, the Office of Equity should immediately identify current and planned District agency programs and policies that can easily be reframed as HiAP initiatives, produce a list of them, with a short explanation for why each one fits the HiAP paradigm, and disseminate the list broadly, both to agencies and on the Office of Equity website.

**GOAL 2: Define Common Goals and Measures**

**ACTION 2.1: Define broad equity goals for the District.**

a. **Summary:** This action focuses on the overall effort to achieve equity in the District. Cognizant of existing and emerging trends, once established the Office of Equity should take a leadership role in developing broad equity goals and measures that will guide HiAP initiatives and priorities across the District. These broad goals and measures should focus on improving the quality of life for District residents and address the social determinants of health. Additionally, District agencies should receive direction or recommendations on HiAP policies that they may want or need to pursue.

b. **Expected Benefits:** By focusing on defining the most important equity goals and measures needed for the District to reduce disparities, the Office of Equity should design a roadmap for the District to follow into the future. This roadmap should not only serve as a set of guideposts for the present, but should also provide long-term
stability for the vision of greater equity in the District by providing performance milestones to measure progress.

c. **Completion Date:** The Office of Equity should complete this action within the first three months of its formation.

d. **Fiscal Impact:** N/A

e. **Political/Citizen Impacts:** The citizen impact of this action will be to draw attention to the most important equity disparities affecting the District population. The political impact will be to re-prioritize issues that require attention due to the significant nature of existing disparities.

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** After performing an analysis of social, economic, health, and other disparities in the District, the Office of Equity should draw a roadmap highlighting the social determinants most in need of improvement to further greater equity in the District. Such goal posts should provide a framework for agencies to develop HiAP action items in their individual performance plans.

**ACTION 2.2: Develop HiAP performance metrics aligned to the previously defined broad equity goals by using equity maps and other data.**

a. **Summary:** The Office of Equity’s crafting of District-wide goals will guide District agencies on equity issues. First, the Office of Equity should determine the metrics for achieving the identified equity goals. These metrics can then be used by agencies to assess whether and how well various programs and projects are meeting HiAP goals. Metrics will help agencies understand District government and District resident expectations with respect to achieving HiAP objectives.

b. **Expected Benefits:** Defining metrics will help agencies more concretely understand how to measure performance vis a vis an established HiAP goal.
c. **Completion Date:** Once established, the Office of Equity should complete this action within 9 months of its formation.

d. **Fiscal Impact:** Though difficult to predict, it is likely that the development of performance metrics aligned to broad equity goals will result in a fiscal impact, consisting of budgetary pressures for individual agencies to refocus existing priorities and programs on new equity-oriented goals and performance metrics.

e. **Political/Citizen Impacts:** Realignment of programmatic priorities to meet newly crafted performance metrics can create pressures that translate into political impacts -- both of a very positive and of a potentially negative variety. The citizen impact should be universally positive when viewed through an equity-focused lens.

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** The Office of Equity should capitalize on available District data and mapping tools to determine what performance metrics to focus on, to achieve its broad equity goals. Initiatives derived from this process, such as performance metrics related to combating obesity or incentivizing immunizations, should be planned in collaboration with the District agency or agencies with primary roles in delivering the relevant public program.

**GOAL 3: Integrate HiAP into Agency Operations**

**ACTION 3.1:** Require District agencies to incorporate HiAP action items in their performance plans.

a. **Summary:** All District agencies should be required to implement HiAP in their performance plans. Performance plan managers, as well as the Executive Office of the Mayor staff responsible for evaluating performance plans should also receive HiAP training. The Task Force has drafted a sample initiative and key performance indicators to include HiAP in agency performance plans (see Appendix IV). To support this action, a Mayor’s order could be issued to institutionalize this requirement, although it may not be necessary.

b. **Expected Benefits:** By implementing HiAP in agencies’ performance plans, HiAP will be institutionalized in the agencies’ day to day work.
c. **Completion Date:** This action should be timed so that execution by agencies can begin no later than October 1, 2016.

d. **Fiscal Impact:** This recommendation does not have a fiscal impact.

e. **Political/Citizen Impacts:** N/A

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** Each agency should be directed to place a HiAP-focused objective in its performance plan to ensure agency decisions consider health impacts on District residents and contribute to a healthier District environment. Each agency should be required to craft at least one initiative and Key Performance Indicator, consistent with this overall objective.

**ACTION 3.2: Renew agency commitments to the implementation of specific HiAP projects of value in the District.**

a. **Summary:** District agencies are already implementing HiAP projects and programs that are helping to increase health equity in the District, whether directly or by focusing on the social determinants of health. Agencies should renew their commitment to such programs and should consider ways to accelerate progress in their implementation. Specific programs and initiatives subject to this action include:

- A Capital Commitment
- Age-Friendly City Initiative
- Healthy By Design
- Live Well DC
- moveDC
- New Community Living Strategic Plan
- One City One Hire
- Play DC
- Raise DC
- Sustainable DC
- Working Towards a Healthy DC: The District of Columbia’s Overweight and Obesity Action Plan
These programs and others are included with greater detail in Appendix III. Additional ideas for projects that may be useful for the District to consider can be found within the white papers listed under the References section of this Report.

b. **Expected Benefits:** By re-committing to existing HiAP programs, agencies can capitalize on current activities to make progress in achieving greater health equity in the District, whether directly or by focusing on social determinants of health.

c. **Completion Date:** This action should be taken by agencies as early as possible in 2015.

d. **Fiscal Impact:** N/A

e. **Political/Citizen Impacts:** Renewing or strengthening a commitment to an equity-focused program or initiative will have a positive political and citizen impact.

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** Each agency should take ownership of programs or initiatives, including those listed above, that produce progress in addressing the social determinants of health and in reducing disparities in health equity. This means renewing commitments to such programs and initiatives, as well as thinking strategically about ways to leverage resources to increase their effectiveness.

**ACTION 3.3:** Design and consider specific HiAP actions in areas of the District that are disproportionately affected by equity issues.

a. **Summary:** To ensure all District residents reach their full potential, the District should focus on improving health equity in the District. For example, specific areas in the District have disproportionately higher rates of disease than the overall average rates of disease in the District. Using appropriate information, such as a health equity map, the District should design initiatives and pilot projects focused on improving specific health outcomes in certain high-risk geographical areas within the District. The District should communicate these initiatives to agency leaders, with the intent that agencies consider these initiatives when making decisions. Examples of such initiatives or projects are provided in Appendix III.

b. **Expected Benefits:** Focusing on initiatives that address specific disproportionate health impacts in well-defined sections of the District is the most direct way to target health disparities and should result in positive health equity outcomes.
c. **Completion Date:** This action should be undertaken no later than October 1, 2016.

d. **Fiscal Impact:** Selected projects with significant expected positive impacts could require additional funding.

e. **Political/Citizen Impacts:** Focusing on specific neighborhoods identified as being impacted by specific health problems should have a direct positive outcome on residents’ health. However, as agencies learn and are trained to include health considerations into specific initiatives and actions under their performance plans, it will be essential to ensure that the plans are reality-based and are designed so that progress can be measured and tracked. Otherwise, agencies would run the risk of being held accountable for failing to achieve stated goals and objectives, and that may result in negative political consequences for agencies and the Administration.

f. **Legislative/Regulatory Impacts:** N/A

g. **Recommendation:** The District should use available data, in particular data from the Department of Health, to identify areas in the District that suffer from disproportionately high levels of disease or other health-related problems. The District should then determine, researching other jurisdictions as appropriate, what kinds of projects could be conducted that would have a positive health impact on the relevant affected parts of the District, and should communicate these proposed projects to the appropriate agencies for their consideration. Projects that should be considered include those that would have a positive impact on residents’ overall quality of life, including positive environmental, educational and economic impacts.

**GOAL 4: Provide Data for Decision Making**

**ACTION 4.1:** Develop a data repository and facilitate data sharing related to inequities in the District to help better inform policy/decision makers.

a. **Summary:** Once established, the Office of Equity should serve as a hub to disseminate data related to inequities in the District. For example, the Office should include relevant data on their website, with links to other agencies’ sites. The Office should also facilitate the development of a broad scope of new data sources on equity, with potential applicability across agencies. The Office should use such data while analyzing health impact assessments, during training to agency employees, and while improving equity, as well as health care utilization data in the District.
The Office of Equity should stress the importance and help facilitate the development of and access to health data to better inform policy and decision makers.

b. **Expected benefits**: Enhancing data-sharing will improve health awareness when agencies make health-related and other policy decisions. This will ultimately improve the health of District residents.

c. **Completion date**: Ongoing.

d. **Fiscal impact**: There are no costs associated with this specific activity, but an FTE should be assigned to facilitate this effort. If established, an FTE from the Office of Equity would be ideal.

e. **Political/Citizen Impacts**: The use of data will allow District agencies to make informed decisions directly related to addressing inequities in the District. Accordingly, the political/citizen impact should be mainly positive.

f. **Legislative/Regulatory impacts**: N/A

g. **Recommendation**: District agencies should be required to publicize and analyze data pertaining to health inequities and the factors contributing to them.
# Timeline

## Long Term Project/Plan Schedule

<table>
<thead>
<tr>
<th>Fiscal Year (Month)</th>
<th>Event/Action</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2015</strong> (Jan. - May)</td>
<td>Develop legislation for Council to consider</td>
<td>The Administration drafts legislation to create the Office of Equity.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct.)</td>
<td>Office of Health Equity opens</td>
<td>Office of Equity operational, to assist with implementation of Health in All Policies in the District, including all goals and actions cited in the task force report.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct. – Dec.)</td>
<td>Promotion of data sharing</td>
<td>One immediate duty of office is to promote data sharing among District agencies.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct. - Dec.)</td>
<td>HiAP messaging</td>
<td>Immediately communicate with District agencies, explaining Health in All Policies and how their work might already relate to it.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct. ‘15 – Jan. ’16)</td>
<td>Develop HIA tool</td>
<td>Create DC HIA tool, using King County (WA) HIA tool as model.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct. ‘15 – Mar. ’16)</td>
<td>Research/Plan training materials for District employees</td>
<td>Begin developing training materials to educate District employees on HiAP and how it should be implemented in the District.</td>
</tr>
<tr>
<td><strong>2015</strong> (Oct. ‘15 – June ’16)</td>
<td>Develop equity data/maps</td>
<td>The District gathers data and maps to begin determining how to better further the goal of health equity in the District.</td>
</tr>
<tr>
<td><strong>2016</strong> (Oct.)</td>
<td>Finalize initial District-wide HiAP objectives and metrics</td>
<td>Develop initial District-wide HiAP objectives and metrics to measure and track progress towards these objectives.</td>
</tr>
<tr>
<td><strong>2016</strong> (Oct.)</td>
<td>Assist agencies in focusing on establishing equity</td>
<td>Provide agencies with equity data and maps to suggest ways of designing policies and programs to improve equity among District residents.</td>
</tr>
<tr>
<td><strong>2016</strong> (Oct.)</td>
<td>HiAP Performance Plan implementation</td>
<td>Ensure agency performance plans include HiAP components.</td>
</tr>
</tbody>
</table>
References

   http://www.denvergov.org/Portals/746/documents/CHIP%20Full%20Report%20FINAL.pdf


3. **Cross Agency Task Force: Overview, BALTIMORE CITY HEALTH DEPARTMENT,**

4. **HEALTH IN ALL POLICIES: INFORMATIONAL WHITE PAPER, NEW ORLEANS HEALTH DEPARTMENT (2013).**

5. **HEALTH IN ALL POLICIES: HELSINKI STATEMENT: FRAMEWORK FOR COUNTRY ACTION, WORLD HEALTH ORGANIZATION (2014),**
   http://apps.who.int/iris/bitstream/10665/112636/1/9789241506908_eng.pdf?ua=1

6. **HEALTH IN ALL POLICIES (HiAP): FRAMEWORK FOR COUNTRY ACTION, WORLD HEALTH ORGANIZATION (2014),**
   http://www.who.int/cardiovascular_diseases/140120HPRHiAPFramework.pdf?ua=1

7. **HEALTH IN ALL POLICIES: STRATEGIES TO PROMOTE INNOVATIVE LEADERSHIP, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (2013),**
   http://issuu.com/astho/docs/astho_hiap_toolkit

   MULTNOMAH COUNTY HEALTH DEPARTMENT (2009), https://multco.us/file/8456/download

9. **ROB HOWARD & STEPHEN GUNTHER, HEALTH IN ALL POLICIES: AN EU LITERATURE REVIEW 2006-2011 AND INTERVIEW WITH KEY STAKEHOLDERS. (2012),**


11. **KING COUNTY: EQUITY AND SOCIAL JUSTICE ANNUAL REPORT, KING COUNTY EXECUTIVE OFFICE (2013),**


13. King County Equity Impact Review Tool, King County (2010), http://www.kingcounty.gov/exec/equity/~/media/exec/equity/documents/KingCountyEIRTool2010.ashx


18. LINDA RUDOLPH ET AL., HEALTH IN ALL POLICIES: IMPROVING HEALTH THROUGH INTERSECTORAL COLLABORATION, NATIONAL ACADEMY OF SCIENCES (2013), http://iom.edu/~/media/Files/Perspectives-Files/2013/Discussion-Papers/BPH-HiAP.pdf


Appendices

Appendix I: International HiAP Literature Review

<table>
<thead>
<tr>
<th>Region/Country (ies):</th>
<th>South Australia, Australia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title of Case Study :</td>
<td><em>The South Australian Approach to Health in All Policies: Background and Practical Guide: Version 2</em></td>
</tr>
<tr>
<td>Author(s):</td>
<td>Department of Health, Government of South Australia</td>
</tr>
<tr>
<td>Date of Publication:</td>
<td>November 2011</td>
</tr>
<tr>
<td>Reviewed by:</td>
<td>Nick Kushner, Capital City Fellow, DMHHS</td>
</tr>
</tbody>
</table>

**OVERVIEW OF HIAP ACTIVITIES:**

South Australia is a state in Australia that has implemented HiAP through a HiAP Unit within its Department of Health. The HiAP Unit is tasked with guiding partner agencies through a Health Lens Analysis (HLA) process and with finding connections between the strategic plan and health and wellness.

<table>
<thead>
<tr>
<th>General Insight</th>
<th>LESSONS LEARNED</th>
<th>What Didn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health Lens Analysis is akin to Health Impact Analysis</td>
<td>• When HiAP was being introduced, a conference was convened and top-level staff from all agencies attended.</td>
<td></td>
</tr>
<tr>
<td>• The HiAP Unit did HLAs of specific targets/goals in the strategic plan. This meant tackling something as big as a whole plan or initiative. (Note: All agencies are required to report on progress towards the strategic plan).</td>
<td>• Evaluation was built in to all HLAs and the Health Unit partnered with universities to conduct this.</td>
<td></td>
</tr>
<tr>
<td>• Justified the use of HiAP by showing the rise in healthcare expenditures.</td>
<td>• Qualitative surveys were given to the partners of every HLA to evaluate the process, impact, and outcome.</td>
<td></td>
</tr>
<tr>
<td>• Ten HiAP principles were defined early on - one was the understanding that every government policy</td>
<td></td>
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</table>
could have positive or negative health impacts.

<table>
<thead>
<tr>
<th>RECOMMENDATIONS FOR WASHINGTON, D.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>• Work to convene a conference to introduce HiAP to top level staff from all agencies.</td>
</tr>
<tr>
<td>• Undertake significant projects such as the evaluation of entire plans for HiAP principles.</td>
</tr>
<tr>
<td>• Create a dedicated department/office that can assist partner agencies with HiAP analysis and research.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region/Country (ies):</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Title of Case Study:</strong></td>
<td>Health in All Policies (HiAP) Framework for Country Action</td>
</tr>
<tr>
<td><strong>Author(s):</strong></td>
<td>World Health Organization</td>
</tr>
<tr>
<td><strong>Date of Publication:</strong></td>
<td>2014</td>
</tr>
<tr>
<td><strong>Reviewed by:</strong></td>
<td>Alice Kelly, Policy Branch Manager, DDOT</td>
</tr>
</tbody>
</table>

**OVERVIEW OF HIAP ACTIVITIES:**

Statement from 8th Global Conference on Health Promotion: 1) Prioritize health and equity as core government responsibility. 2) Affirm effective policy convergence for health and well-being. 3) Recognize need for political will, courage, and strategic foresight.

Framework: 1) Establish the need and priorities for HiAP. 2) Frame planned action. 3) Identify supportive structure and processes. 4) Facilitate assessment and engagement. 5) Ensure monitoring, evaluation, and reporting. 6) Build capacity.

<table>
<thead>
<tr>
<th><strong>GENERAL INSIGHT</strong></th>
<th><strong>LENSSES LEARNED</strong></th>
<th><strong>WHAT WORKED WELL</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific considerations of framework (what data/capacities do organizations have to leverage towards HiAP?)</td>
<td>Brief overview of Ecuador’s National Good Living Plan (coordinating health, education, labor, and migration); Sweden’s Vision Zero (health, transport, justice, and environment);</td>
<td>N/A</td>
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and Thailand IP Law (health, commerce, and justice).

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<tr>
<th>RECOMMENDATIONS FOR WASHINGTON, D.C.</th>
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<tbody>
<tr>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>Inventory existing capacities, data sources, plans, and authority. Identify/survey political and demographic environment.</td>
</tr>
<tr>
<td><strong>Intermediate Goals</strong></td>
</tr>
<tr>
<td>Re-evaluate agency business plans. Interagency coordination on health issues.</td>
</tr>
<tr>
<td><strong>Long-term Objectives</strong></td>
</tr>
<tr>
<td>Building interdisciplinary health conscious workforce. Build community capacity. Enhance research capacities.</td>
</tr>
</tbody>
</table>

Region/Country (ies): Israel

Title of Case Study: A Health in All Policies Approach To Promote Active, Healthy Lifestyle in Israel

Author(s): Yannai Kranzler et al.

Date of Publication: February 2013

Reviewed by: Brian Footer, Policy Advisor, DCOA

OVERVIEW OF HIAP ACTIVITIES:

The National Program to Promote Active, healthy Lifestyles (“National Program”) is an inter-ministerial, intersectorial effort to address obesity and its contribution to the country’s burden of chronic disease.

The defining characteristic that makes the National Program a case study for HiAP is the intersectorial collaboration. The process used to develop the National Program allowed for diverse input that increased buy-in and understanding across sectors. Development stages included:

1. Development of clear goals and policy guidelines around obesity, nutrition and physical activity (involved doctors, nurses, health promoters, academics, and government experts)
2. Development of an operations plan set actions, divisions of labor, and budgets (involved Ministries on Health, Education, and Culture and Sport)
3. Obtained agreements to collaborate from additional ministries (included but not limited to Ministries on Finance, Agriculture, and Communications)
4. Government adoption that solidified commitments and plans

The inter-ministerial steering committee and working groups are governance structures which formalize points of interaction between health and other sectors. The structure and collaboration resulted in a major paradigm shift that brought health to the center of Israel’s political agenda.
### LESSONS LEARNED

<table>
<thead>
<tr>
<th>General Insight</th>
<th>What Worked Well</th>
<th>What Didn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>By narrowing the health focus to obesity, untraditional partners were able to better comprehend how they could participate and how to measure outcomes. For example, more than one in five Israeli children aged 12-18 are overweight or obese. In order to assist in curbing obesity, the Ministry of Communications and stakeholders in television and cable were able to work on ethical codes to ban marketing of unhealthy foods during children’s programs.</td>
<td>Sharing the burden of evidence support, setting goals and targets, coordination, policy guidance, implementation and management.</td>
<td>The National Program specifically focuses on curbing obesity, which limits the evaluation of determinants of health. HiAP sets sights on broader health policy issues like poverty and social equity.</td>
</tr>
</tbody>
</table>

### RECOMMENDATIONS FOR WASHINGTON, D.C.

<table>
<thead>
<tr>
<th>Short-term</th>
<th>Intermediate Goals</th>
<th>Long-term Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clearly identify and define “health” in order to increase understanding and buy-in.</td>
<td>Promote regular collaboration and sharing of information throughout implementation. When different initiatives were stalled or came against certain barriers, partner ministries were able to help move things along. For example, to support the initiative repealing the requirement to obtain doctors permission to join a gym, the Health Ministry assisted by obtaining letters from the national councils of family doctors, pediatricians, and sports doctors, declaring the safety of the suggested change.</td>
<td>Establish an academic driven, independent “Evaluation Committee.” Israel’s five universities, as well as the Ministries of Health, Education, and Culture and Sport, informs the list of indicators and evaluation strategies, and helps draw conclusions. Grants are available for universities and other research and evaluation institutions interested in researching and evaluating aspects of the program.</td>
</tr>
</tbody>
</table>
OVERVIEW OF HIAP ACTIVITIES:

In the European context, seven key themes emerged for the implementation of HiAP: leadership, governance and strategy, partnership and stakeholder engagement, capacity and technical skills, health equity, tactics and culture/values.

The following conclusions were drawn: “1) Explicit political commitment to HiAP at the highest possible level is a pre-requisite for success. Health systems need to show leadership in advocating for health and the HiAP approach. 2) EU member states, countries and regions should be encouraged to develop overarching strategies and action plans that endorse a HiAP approach. 3) Working in partnership, particularly with communities, is a neglected area in the implementation of HiAP. 4) Although technical skills (such as data analysis and interpretation) were recognized as important capacity and capability issues, stronger emphasis needs to be placed on the development of softer skills (such as negotiation and relationship building) to influence OGDs and other sectors and to resolve conflicts and raise awareness of health equity. 5) There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus. This needs to be addressed as a priority by EU Member States, Countries and Regions. 6) A focus on win-win policies is recommended, but Health must take a truly collaborative approach; ‘Health for All Policies’ as well as ‘Health in All Policies’.”

LESSONS LEARNED

<table>
<thead>
<tr>
<th>General Insight</th>
<th>LESSIONS LEARNED What Worked Well</th>
<th>What Didn’t work</th>
</tr>
</thead>
<tbody>
<tr>
<td>As the District of Columbia continues to plan for the incorporation of HiAP principles into policy decision-making, there are key mechanisms and processes that would need to be considered (as found in the European context). These include (see page 13): 1. A common</td>
<td>1. Community participation 2. Timing – early entry into the policy making process 3. Incorporation of already existing health initiatives into HiAP 4. Government buy-in</td>
<td>1. Governance issues may present barriers to HiAP approach 2. A lack of understanding of politics by the health sector 3. Not enough capacity (both within health and other sectors) to plan and implement</td>
</tr>
</tbody>
</table>
understanding among government agencies (also outside government stakeholders) of shared values to reduce health inequity and to understand the importance of social determinants of health;

2. Raising awareness and strengthening support including using annual reports and mass media;

3. Improved information and research to both improve impact assessment and to evaluate the effect of HiAP approach;

4. Examination of structures and mechanisms for cross-sectoral working at European, national regional and local levels;

5. Look for win-win situations to develop new partnerships;

6. Provide training to develop skills – to build capacity in working across sectors;

7. Increase resources – especially designation of staff time to HiAP activities; and

4. When there was a lack of common health targets across sectors

5. When the health sector did not have robust or extensive data to inform policy decisions

6. Government departments working in silos
8. The changes over time in the health status of disadvantaged groups should be used as an indicator of the quality of development in countries.

<table>
<thead>
<tr>
<th>RECOMMENDATIONS FOR WASHINGTON, D.C.</th>
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<tbody>
<tr>
<td><strong>Short-term</strong></td>
</tr>
<tr>
<td>Note: “Short-term” has been understood to mean almost immediate attainable goals:</td>
</tr>
<tr>
<td>- Government commitment for HiAP;</td>
</tr>
<tr>
<td>- Formation of key partnerships within government and between public and private sectors;</td>
</tr>
<tr>
<td>- Identification of key priorities, discussion for the collection of relevant data, and initial consideration of win-win goals (in other words start the process to building robust knowledge and evidence base);</td>
</tr>
<tr>
<td>- Development of ideas for innovation and experimentation; and</td>
</tr>
<tr>
<td>- Overarching strategy that endorses a HiAP approach.</td>
</tr>
</tbody>
</table>
## Appendix II: Specific HiAP Projects for Consideration

<table>
<thead>
<tr>
<th>Project Description</th>
<th>Agencies Involved in Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decreasing the number of students who are chronically absent by collecting data on absent students</td>
<td>DCPS, PCSB, OSSE, DOH</td>
</tr>
<tr>
<td>Replace all city lights with LEDs (or focus on underserved areas); residents will feel safer in their neighborhood at night</td>
<td>DDOT, DPR, DGS</td>
</tr>
<tr>
<td>Expedite permit reviews for all retail business providing a minimum of 10% shelf space for fresh produce (or other favorable healthy activity)</td>
<td>DCRA, DOH, DDOE, DC Council (amending laws to expedite)</td>
</tr>
<tr>
<td>Improve park quality in underserved areas</td>
<td>DPR, DGS</td>
</tr>
<tr>
<td>Increase the number of new affordable housing units in middle/upper-income neighborhoods</td>
<td>DCHA, DHCD, DMPED</td>
</tr>
<tr>
<td>Require an HVAC system with filtration for sensitive use sites that are within 500 feet of a high traffic road</td>
<td>DCRA, DPR, DGS</td>
</tr>
<tr>
<td>Improve access to health care (including making access part of the transportation plan)</td>
<td>DDOT, DOH, DHCF, DHS</td>
</tr>
<tr>
<td>Create health equity maps, to help staff for equity analyses</td>
<td>DOH, DDOT, DDOE</td>
</tr>
<tr>
<td>Examine bus fare options for people with lower income</td>
<td>DHCF, DDOT</td>
</tr>
<tr>
<td>Create a program to redirect those involved with low-level drug activities to community-based services</td>
<td>MPD</td>
</tr>
<tr>
<td>Focusing on emergency event dissemination and preparation to populations that are traditionally disadvantaged</td>
<td>HSEMA, OUC</td>
</tr>
<tr>
<td>Make public space more attractive and usable</td>
<td>DDOT, DPR, OP, DPW, OZ</td>
</tr>
<tr>
<td>Discourage the purchase and use of unhealthy products</td>
<td>DOH, DBH</td>
</tr>
<tr>
<td>Improve data sharing between schools and</td>
<td>DCPS, DHS, DYRS, CFSA, DMHHS, DBH, DOH,</td>
</tr>
<tr>
<td>Social Service Aims</td>
<td>Responsible Agencies</td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Improve access to nutrition assistance programs</td>
<td>OCTO</td>
</tr>
<tr>
<td>Incorporate messages around the importance of physical activity and healthy nutrition at departments that frequently have captive audiences</td>
<td>DMV, DPR, DHS, DCRA, DOH, DCPL, DDOT</td>
</tr>
<tr>
<td>Provide lactation accommodations to support breastfeeding</td>
<td>DCHR and all agencies</td>
</tr>
<tr>
<td>Incorporate health and health equity criteria into requests for proposals from agencies outside health cluster (possibly by performing health impact assessment)</td>
<td>OCP and all agencies</td>
</tr>
<tr>
<td>Establish procurement policies that require District vending machines to provide a minimum number of healthy options</td>
<td>DDS, DOH, DGS, DCHA</td>
</tr>
<tr>
<td>Improve enforcement of smoking bans</td>
<td>MPD, DOH, DBH, DCRA, DCHA</td>
</tr>
<tr>
<td>Conduct economic development research on the return on investment of particular health outcomes of specific policies</td>
<td>Office of Health Equity</td>
</tr>
<tr>
<td>Implementation of workplace wellness programs</td>
<td>All agencies</td>
</tr>
</tbody>
</table>

**List of Agency Acronyms**

- **CFSA**: Child and Family Services Agency
- **DBH**: Department of Behavioral Health
- **DCHA**: District of Columbia Housing Authority
- **DCPL**: District of Columbia Public Library
- **DCPS**: District of Columbia Public Schools
- **DCRA**: Department of Consumer and Regulatory Affairs
- **DDOE**: District Department of the Environment
- **DDOT**: District Department of Transportation
- **DDS**: Department of Disability Service
- **DGS**: Department of General Services
- **DHCD**: Department of Housing and Community Development
- **DHCF**: Department of Health Care Finance
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>DCHR</td>
<td>DC Department of Human Resources</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services</td>
</tr>
<tr>
<td>DMHHS</td>
<td>Office of the Deputy Mayor for Health and Human Services</td>
</tr>
<tr>
<td>DMPED</td>
<td>Office of the Deputy Mayor for Planning and Economic Development</td>
</tr>
<tr>
<td>DMV</td>
<td>Department of Motor Vehicles</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DPR</td>
<td>Department of Parks and Recreation</td>
</tr>
<tr>
<td>DPW</td>
<td>Department of Public Works</td>
</tr>
<tr>
<td>DYRS</td>
<td>Department of Youth Rehabilitation Services</td>
</tr>
<tr>
<td>HSEMA</td>
<td>Homeland Security and Emergency Management Agency</td>
</tr>
<tr>
<td>MPD</td>
<td>Metropolitan Police Department</td>
</tr>
<tr>
<td>OCP</td>
<td>Office of Contracting and Procurement</td>
</tr>
<tr>
<td>OCTO</td>
<td>Office of the Chief Technology Officer</td>
</tr>
<tr>
<td>OP</td>
<td>Office of Planning</td>
</tr>
<tr>
<td>OSSE</td>
<td>Office of the State Superintendent of Education</td>
</tr>
<tr>
<td>OUC</td>
<td>Office of Unified Communications</td>
</tr>
<tr>
<td>OZ</td>
<td>Office of Zoning</td>
</tr>
<tr>
<td>PCSB</td>
<td>Public Charter School Board</td>
</tr>
</tbody>
</table>
Appendix III: Existing District HiAP Programs & Initiatives

Directly Related

- **Working Towards a Healthy DC: The District of Columbia’s Overweight and Obesity Action Plan (DOH):** Plan to combat the obesity epidemic in the city.
- **Live Well DC (DOH):** Activities and resources to help the District community make healthy lifestyle decisions.
- **Healthy By Design (OP):** A citywide initiative aimed at developing a healthier, more livable, more walkable city.
- **Sustainable DC (D DOE & OP):** A plan to make the District the healthiest, greenest, and most livable city in the United States.
- **Age-Friendly City Initiative (DMHHS):** Collaborating to make the District an inclusive urban environment that encourages active and healthy aging.

Indirectly Related

- **New Community Living Strategic Plan (Office on Aging):** A comprehensive framework for the DC Office on Aging to address various issues impacting the city’s seniors, persons living with disabilities and caregivers.
- **Climate Action Plan (D DOE):** The District’s plan to reduce the carbon footprint of the District government and the community as a whole.
- **A Capital Commitment (DCPS):** District of Columbia Public Schools’ 2017 Strategic Plan: DCPS’s five year strategic plan to build a high-quality, vibrant school district.
- **Raise DC (DCPS):** Raise DC is a public-private partnership that seeks to align citywide efforts around shared outcomes so that District youth can achieve success from cradle to career.
- **District-wide Bullying Prevention Policy (DCHR):** A guide for creating and implementing bullying prevention policies.
- **Play DC (including Parks and Natural Spaces Public Access Plan) (DPR):** The vision framework for the Parks and Recreation Master Plan.
- **moveDC (DDOT):** A plan to develop a bold and implementation-focused vision for the District’s transportation future.
- **One City One Hire (DC Employment Services):** An employer-driven hiring initiative with the goal of putting District residents back to work.
- **One City Action Plan (all):** Citywide agenda to grow and diversify the District economy, educate and prepare the District workforce, and improve the quality of life for all.
Appendix IV: HiAP Performance Plan Instructions

Health in All Policies Performance Plan Instructions for Agencies:
Beginning with the FY 2016 agency Performance Plan development, it is now required that all District agencies, include an Objective within its 2016 Plan that addresses Health in All Policies. Please use the objective language below in your Performance Plan. Additionally, each agency must identify an Initiative and Key Performance Indicator (KPI) related to the Objective. An example of a relevant Initiative and KPI is provided below the Objective language.

**OBJECTIVE [X]:** Ensure agency decision-making activities, specifically the development and revision of policy, considers impact on the health of District residents and contributes to a healthier D.C.

**Example INITIATIVE [X.1]:** [XYZ Agency] shall consult with recognized public health experts to help identify existing or newly-forming [XYZ Agency] initiatives, programs, or policies that have potential health implications for District residents. Of those initiatives, programs, or policies, [XYZ Agency] shall find those that relate to the top-ten causes of death and the top-ten greatest health inequalities for District residents. In consultation with the experts, [XYZ] shall identify goals and respective action steps for each goal to improve the initiatives or programs so as to decrease the rate of the top-ten causes of death and reduce the disparity of the top-ten greatest health inequalities for District residents. Ultimately, this will lead to improving the health and health equity of District residents. Completion Date: September, 2016.

**Example Key Performance Indicators – [XYZ Agency]**

<table>
<thead>
<tr>
<th>Measure</th>
<th>FY 2016 Projection</th>
<th>FY 2017 Project</th>
<th>FY 2018 Projection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of agency initiatives/programs that can be improved and are related to District residents’ top-ten health disparities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of new or revised action steps that aim to improve the above initiatives/programs, so as to decrease the top-ten health disparities for District residents</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix V

CDC: Prevention Status Report, DC 2013
The Prevention Status Reports (PSRs) highlight—for all 50 states and the District of Columbia—the status of public health policies and practices designed to prevent or reduce 10 important health problems or concerns. Below is a summary of the District of Columbia’s PSR ratings for 2013.

<table>
<thead>
<tr>
<th>PSR Policies and Practices by Topic</th>
<th>2013 PSR Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excessive Alcohol Use</strong></td>
<td></td>
</tr>
<tr>
<td>District beer tax</td>
<td>Red</td>
</tr>
<tr>
<td>District distilled spirits tax</td>
<td>Red</td>
</tr>
<tr>
<td>District wine tax</td>
<td>Red</td>
</tr>
<tr>
<td>Commercial host (dram shop) liability law</td>
<td>Green</td>
</tr>
<tr>
<td>Local authority to regulate alcohol outlet density</td>
<td>Not applicable</td>
</tr>
<tr>
<td><strong>Food Safety</strong></td>
<td></td>
</tr>
<tr>
<td>Speed of pulsed-field gel electrophoresis (PFGE) testing of reported <em>E. coli</em> O157 cases</td>
<td>Data not available</td>
</tr>
<tr>
<td>Completeness of PFGE testing of reported <em>Salmonella</em> cases</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Healthcare-Associated Infections (HAIs)</strong></td>
<td></td>
</tr>
<tr>
<td>District health department participation in districtwide HAI prevention efforts</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Heart Disease and Stroke</strong></td>
<td></td>
</tr>
<tr>
<td>Implementation of electronic health records</td>
<td>Red</td>
</tr>
<tr>
<td>Pharmacist collaborative drug therapy management policy</td>
<td>Green</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td></td>
</tr>
<tr>
<td>District Medicaid reimbursement for routine HIV screening</td>
<td>Green</td>
</tr>
<tr>
<td>District HIV testing laws</td>
<td>Green</td>
</tr>
<tr>
<td>Reporting of CD4 and viral load data to district HIV surveillance program</td>
<td>Green</td>
</tr>
<tr>
<td><strong>Motor Vehicle Injuries</strong></td>
<td></td>
</tr>
<tr>
<td>Seat belt law</td>
<td>Green</td>
</tr>
<tr>
<td>Child passenger restraint law</td>
<td>Yellow</td>
</tr>
<tr>
<td>Graduated driver licensing system</td>
<td>Red</td>
</tr>
<tr>
<td>Ignition interlock law</td>
<td>Red</td>
</tr>
<tr>
<td><strong>Nutrition, Physical Activity, and Obesity</strong></td>
<td></td>
</tr>
<tr>
<td>Secondary schools not selling less nutritious foods and beverages</td>
<td>Green</td>
</tr>
<tr>
<td>District nutrition standards policy for foods and beverages sold or provided by district government agencies</td>
<td>Red</td>
</tr>
<tr>
<td>Inclusion of nutrition and physical activity standards in district regulations of licensed childcare facilities</td>
<td>Red</td>
</tr>
<tr>
<td>District physical education time requirement for high school students</td>
<td>Red</td>
</tr>
<tr>
<td>Average birth facility score for breastfeeding support</td>
<td>Yellow</td>
</tr>
<tr>
<td><strong>Prescription Drug Overdose</strong></td>
<td></td>
</tr>
<tr>
<td>District pain clinic law</td>
<td>Red</td>
</tr>
<tr>
<td>Prescription drug monitoring programs following selected best practices</td>
<td>Red</td>
</tr>
<tr>
<td><strong>Teen Pregnancy</strong></td>
<td></td>
</tr>
<tr>
<td>Expansion of district Medicaid family planning eligibility</td>
<td>Yellow</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td></td>
</tr>
<tr>
<td>District cigarette excise tax</td>
<td>Green</td>
</tr>
<tr>
<td>Comprehensive district smoke-free policy</td>
<td>Green</td>
</tr>
<tr>
<td>Funding for tobacco control</td>
<td>Red</td>
</tr>
</tbody>
</table>
**PSR Rating System***

<table>
<thead>
<tr>
<th>Green</th>
<th>The policy or practice is established in accordance with supporting evidence and/or expert recommendations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>The policy or practice is established in partial accordance with supporting evidence and/or expert recommendations.</td>
</tr>
<tr>
<td>Red</td>
<td>The policy or practice is either absent or not established in accordance with supporting evidence and/or expert recommendations.</td>
</tr>
</tbody>
</table>


**More Information**

For more information about public health activities in the District of Columbia, visit the District of Columbia Department of Health website ([http://www.dchealth.dc.gov/](http://www.dchealth.dc.gov/)). For additional resources and to view reports for other states, visit the CDC website ([http://www.cdc.gov/stltpublichealth/psr/](http://www.cdc.gov/stltpublichealth/psr/)).

**Suggested Citation**