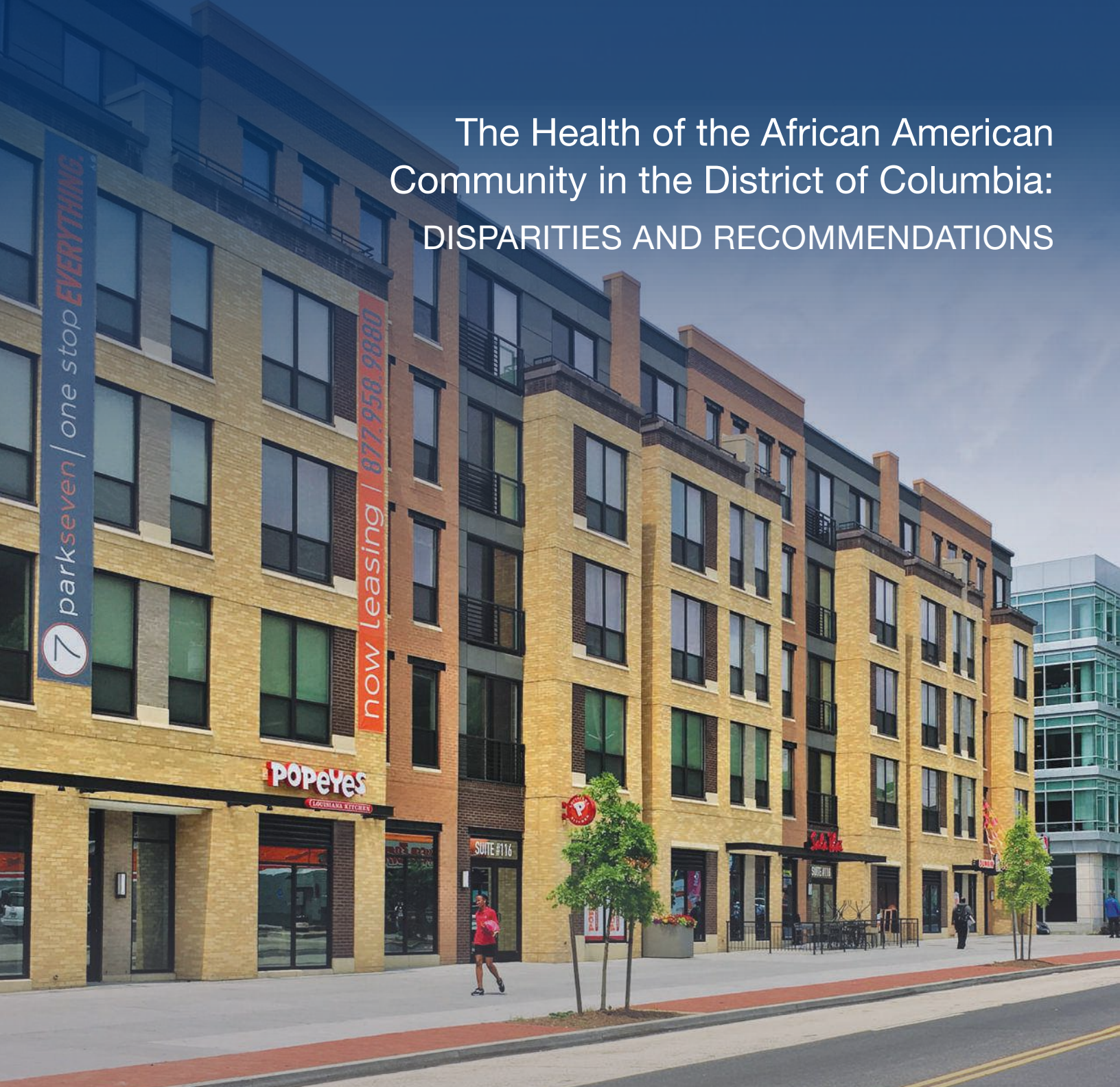


The Health of the African American Community in the District of Columbia: DISPARITIES AND RECOMMENDATIONS



GEORGETOWN UNIVERSITY
School of Nursing & Health Studies

Prepared for the
DC Commission on
African American Affairs

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My thanks to Dr. Patricia Cloonan, Dean, Georgetown University School of Nursing & Health Studies for her partnership and support of this project, which aids my work as Chair of the District of Columbia Commission on African American Affairs and adviser for DC affairs to Georgetown University President John J. DeGioia. I would also like to thank Dr. Christopher J. King, staff, and student contributors who developed a reader friendly publication that captures health disparities, their underlying causes, and potential solutions. Also, a special note of appreciation to key informants whose contributions helped shaped the recommendations.

The report serves as a component of a more comprehensive document that magnifies social and economic conditions that impact the city's African American population—particularly in the wake of massive gentrification and displacement. By focusing on these conditions and their impact on health, we hope to stimulate debate and action on pressing issues that disproportionately affect the African American community. Please join us in that very important discussion.

ACKNOWLEDGEMENTS

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Since the passage of the Affordable Care Act in 2010, the District of Columbia has made even greater strides in improving access to care and allocating resources to promote physical activity and wellness. Life expectancy has increased and some health statistics exceed *Healthy People 2020* targets. Death rates due to coronary heart disease, HIV infection, and infant mortality have declined and the majority of residents self-report their health as good or better. Per capita income, median household incomes, and the percentage of residents with a bachelor's or advanced degree are among the highest in the nation.

Despite these accomplishments, health outcomes and quality of life indicators for African American residents of the District do not reflect trends of the general population. For example, when compared to other racial groups, the life expectancy for Black residents is the lowest and Black males are most likely to be victims of homicide. Cancer rates and the prevalence of chronic disease conditions are higher than other demographic groups. There are also stark differences in the incidence of sexually transmitted infections and HIV disease. The percentage of Black families living in poverty is higher than other racial groups and the number of Black residents with a bachelor's degree or higher is the lowest of all racial and ethnic groups.

African Americans are also disproportionately impacted by high housing costs and reductions in affordable rental units. As a result, the population has consistently declined over the last few decades as racial and socioeconomic demographics have shifted. Many long-term residents who remain in the city struggle to meet basic needs, compounded by a loss of cultural identity and social cohesion in the wake of gentrification. These dynamics have a detrimental effect on total health.

While citywide efforts are underway to streamline how healthcare services are organized and delivered, the benefit of this approach on the overall health of the African American community may be marginal. An explicit focus on historically embedded social, economic, political, and environmental injustices that disproportionately impact persons of color is needed. Examples include employing a racial equity approach when conducting community health needs assessments with a goal of uncovering and eliminating systemic barriers that perpetuate segregation, neighborhood disinvestment, and inequitable distribution of resources. Public and private partnerships that examine how planning efforts, policies and business decisions disproportionately impact African American residents are needed.

Hospitals and healthcare systems, as anchor institutions, can advance the agenda by sponsoring workforce development and health professional training programs. Instituting practices aimed at local hiring and contracting with minority owned businesses—particularly those located in historically marginalized neighborhoods—can be impactful. Other strategies include integrating social factors in electronic health records; developing formal, strategic partnerships with community based organizations to meet patients' holistic needs; and exploring creative ways to engage long-term residents in establishing healthcare environments that preserve a deep, rich African American cultural identity.



EXECUTIVE SUMMARY

Health outcomes and quality of life indicators for African American residents of the District do not reflect trends of the general population.



Report findings were generated and synthesized from a variety of secondary data sources including the American Community Survey, Medical Expenditure Panel Survey, National Health Interview Survey, Behavioral Risk Factor Surveillance System, and the National Cancer Institute. Statistics were also retrieved from DChealthmatters.org—a website maintained by the *DC Healthy Communities Collaborative*.¹ The site contains a repository of over 130 community health indicators focused on prevention and wellness, morbidity and mortality, access to care, and quality of life. Data were also retrieved from the District of Columbia Department of Health’s 2014 Community Health Assessment.²

In order to uncover systemic barriers that contribute to racial differences in health status, interviews were conducted with 26 key informants. Experts included physicians, health care administrators, nurses, health educators, case managers, and community activists. Findings were analyzed and trends were identified. A broad range of recommendations is provided.

Limitation—This report includes data and trends on the general adult population. Data for other populations are not presented (e.g., children, homeless, LGBT or sexual minorities, returning citizens).

METHODOLOGY

According to the National Institutes of Health, health disparities are differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exists among specific populations in the United States.



In addition to presenting health data, this report highlights social factors that are inextricably connected to health outcomes. According to the National Institutes of Health, health disparities are differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions that exist among specific populations in the United States.³ Racial differences in health may be caused by structural or institutionalized injustices in social, economic, political, and environmental systems.^{4,5}

In order to create a city in which all residents can achieve optimal health, these factors are especially important; as empirical evidence has shown that clinical care represents a small fraction of total health status (Figure 1). Social and economic factors, such as education, employment, income and family support are strongly correlated with health status. Lifestyle behaviors, such as tobacco use, diet, exercise, alcohol and drug use and sexual activity influence health status. The physical environment also plays a key role. Examples include air and water quality, access to safe and affordable housing, and public transportation.

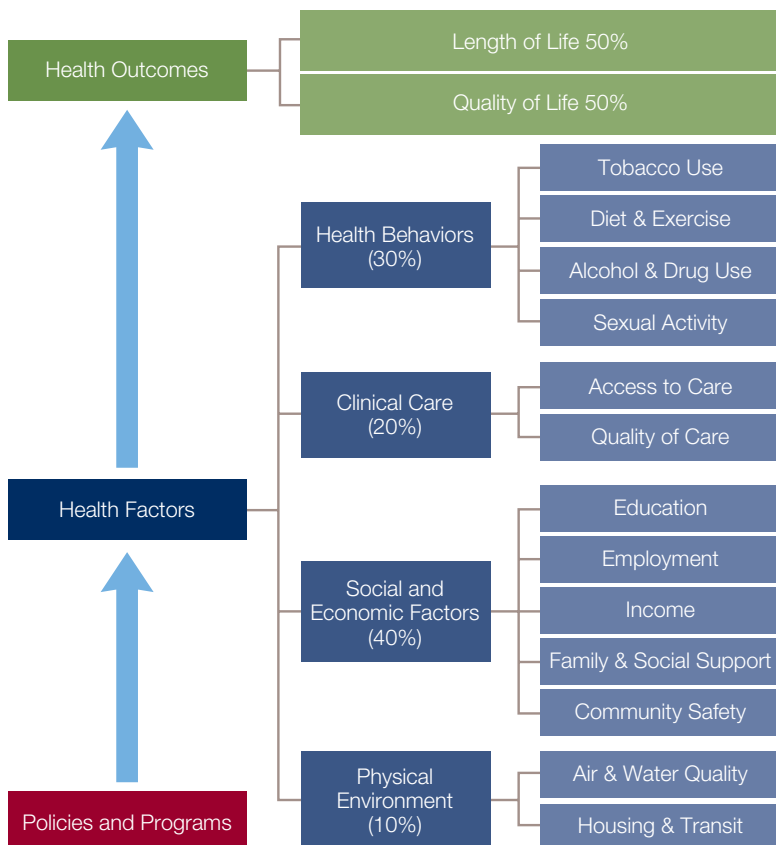
Therefore, in addition to morbidity and mortality findings, a comprehensive set of indicators that are correlated with health status and quality of life are presented. In some cases, White residents are used as a comparison group to express compelling disparities in morbidity, mortality, lifestyle behaviors, and social and economic conditions. An exhaustive list of health data is not presented; however, noteworthy disparities have been identified and extracted from secondary data.



CONTEXT

Racial differences in health may be caused by structural or institutionalized injustices in social, economic, political, and environmental systems.

Figure 1
Social Determinants of Health



County Health Rankings model © 2014 UWPHI



THE AFRICAN AMERICAN COMMUNITY

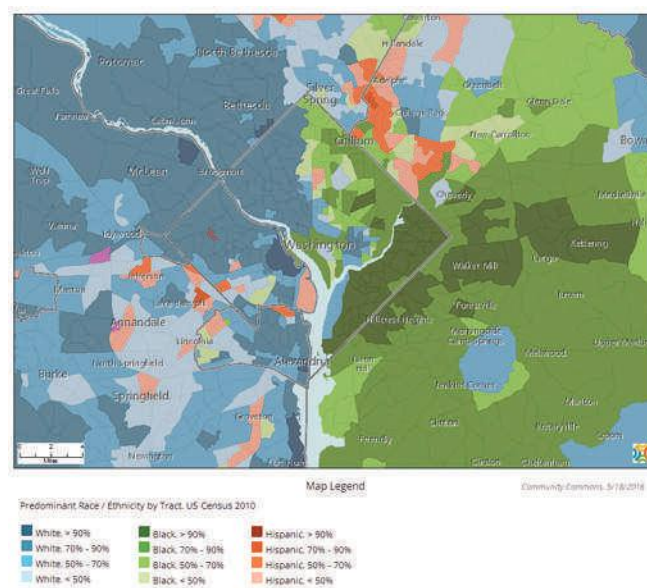
African Americans—particularly long time residents—have been disproportionately impacted by redevelopment initiatives and gentrification.

According to the United States Census Bureau, the population of the District of Columbia is 676,929. African Americans represent 46 percent—a slight decrease from almost 51% percent in 2010. The White population has grown by more than 5% since 2010.^{1,6} The city is densely populated and noticeably segregated by ward. Black residents represent 5–10% of the population in western parts of the city and more than 90% in neighborhoods east of the river (Figure 2).⁷

Health outcomes and quality of life indicators for those east of the river do not reflect progress that has been made in other parts of the city. According to the 2016 Healthy Community Institute’s SocioNeeds Index—a value based on social and economic factors and preventable hospitalizations, communities east of the river—particularly zip codes 20032, 20020, and 20019 are among the worst in the nation.⁸ When compared to the western parts of the city, residents are more likely to have lower incomes, lower educational levels, higher morbidity and premature mortality rates, as well as increased exposure to crime. Moreover, low cost, unhealthy food products are more accessible and pervasive than affordable, healthy food products.

Throughout the city, African Americans—particularly long time residents—have been disproportionately impacted by redevelopment initiatives and gentrification. Over the past three decades, the Black population has dropped nearly 20%, as individuals and families have migrated to contiguous counties or other more affordable localities.⁷ Many existing residents face a housing cost burden in the wake of rising rental and real estate costs across the city. Since housing is inextricably linked to health and quality of life, these dynamics have grave implications for thousands of residents. Destabilized housing and housing cost burden can lead to homelessness, food insecurity, job loss, and social disconnection.⁹ Chronic or survival stress associated with meeting day-to-day needs increase risks for chronic disease conditions and mental dysfunction.⁹

Figure 2
Predominant Race/Ethnicity by Tract, U.S. Census 2010



Due to the cost of medical care, insurance is important for annual physicals, preventive screenings, diagnostic services, disease management, and prescriptions. Since the implementation of the Affordable Care Act, the District has experienced an upward trajectory in adult insurance rates. Compared to other states, it has one of the highest insured rates in the nation. Almost 93% of Black adults are insured and more than 98% of Black children are insured. Nearly 85% of Black residents receive routine medical checkups—the highest percentage of all racial and ethnic groups.²

Although the city boasts high rates of health insurance and medical checkups, there are noteworthy disparities in hospitalization rates. Within a twelve-month period, 75,533 residents were hospitalized; Blacks represented 73%, Whites 15%. Residents from Wards 1, 4, 5 and 8 accounted for 83% of total discharges.² Pregnancy, mental health issues, substance abuse, chronic disease conditions and treatment of complex comorbidities were key drivers of hospitalizations. Almost 80% of residents were discharged for home care.²

Oral health is a key contributor to health status and linked to health issues, such as heart disease, cancer, stroke, diabetes and preterm low-birth weight babies. Seventy-two percent (72%) of adult residents in the city had a teeth cleaning within the past year. Compared to other racial and ethnic groups, Black residents (61%) were the lowest demographic to have a cleaning.¹



ACCESS TO CARE

Life expectancy is defined as the number of years a newborn is expected to live. While life expectancy has improved for all populations in the city, Black residents do not fare as well as other racial groups. For example, White males in the District are expected to live almost 15 years longer than Black males (83.2, 68.8, respectively). White females in the District are expected to live approximately 9 years longer than Black females (85.2, 76.2, respectively).²

MORTALITY

Infant Mortality



Death within the first twelve months of life is one of the most widely used proxies for assessing the overall health status of a population.

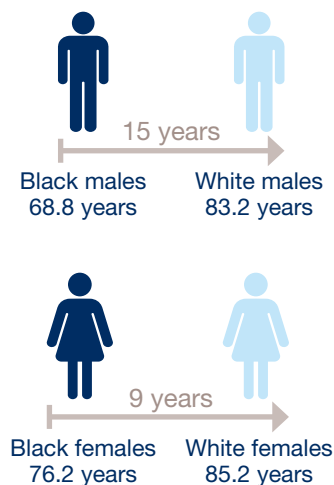
The District has been successful in consistently reducing infant mortality rates over time. For example, in 2007, the citywide rate was 13.1 deaths/1,000 live births. In 2013, the citywide rate was 6.8/1,000 live births. However, during the same reporting period (2013), infant mortality rates in the African American community were 9.9/1,000—a noteworthy contrast to a rate of 1.7/1,000 among Whites.¹ Birth defects, preterm birth, Sudden Infant Death Syndrome (SIDS), pregnancy complications, and accidents are the top five leading causes of infant mortality in the United States.¹⁰

Homicide



African Americans are more than 10 times more likely than Whites to be victims of homicide. Male victims represent 89% of homicide cases and persons between the ages of 15 and 34 account for the majority of cases.²

Differences in Life Expectancy in the District of Columbia





MORBIDITY



Coronary Heart Disease/High Blood Pressure

In most cases, heart disease is preventable, yet it continues to be the leading cause of death in the United States.¹¹ Among District residents, the age-adjusted death rate due to coronary heart disease has improved over time.

For example, in 2005–2007, the rate was 193/100,000 and during 2012–2014, the rate was 133/100,000. Despite improvements in the general population, Blacks are two times more likely to die from coronary heart disease when compared with White counterparts. They are also two times more likely to have high blood pressure than Whites and other racial groups.¹ Risk factors for coronary heart disease include tobacco use, high blood pressure, unhealthy diet, physical inactivity, tobacco, and harmful use of alcohol.¹²



Stroke

Stroke is the fifth cause of death and the leading cause of disability in the United States.¹³ Among District residents, the age-adjusted death rate due to stroke has decreased over time. For example, in 2005–2007, the rate was 40/100,000 and in 2012–2014, the rate was 32/100,000. Despite improvements in the general population, Blacks are two times more likely to die from a stroke when compared with White counterparts.¹ Risk factors include high blood pressure, cigarette smoking, high blood cholesterol, poor diet, physical inactivity, and obesity.



Diabetes

Diabetes is the seventh leading cause of death in the United States and the root cause of several disabling conditions.¹⁴ Examples include end-stage renal disease, non-traumatic lower extremity amputation, and blindness.

Within the past six years, the percentage of adults with diabetes in the District ranged from 7.5% to 10.9%. In 2014, 8.4% of adults had diabetes. Almost 15% of Black and 3% of White residents are living with the disease.¹ Risk factors include high blood pressure, cigarette smoking, high blood glucose, poor diet, physical inactivity, and obesity.

Since 2005–2007, the age-adjusted death rate due to diabetes for the general population declined from 31/100,000 to 20/100,000 in 2012–2014; however, death rates among Blacks with diabetes are six times higher than Whites.¹



Mental Health

Poor mental health is an underlying cause of many chronic disease conditions and linked to lower productivity and hindered social advancement. It also impacts how one handles stress and interacts with others. When compared to other races, African Americans in the District are more than two times more likely to report 15–30 days of poor mental health. Percentages are higher among persons with less than a high school education and those with household incomes less than \$15,000.²



Perceived Health Status

Perceived health status is how people feel about their health. It is correlated with productivity and how inclined one is to be socially and economically involved in his or her community. Among the general population, 87% of District residents report their health as “good or better.” Only 78% of African Americans perceive their health as “good or better,” which represents the lowest percentage when compared with Whites, other races, and Hispanics.¹

Cancer

Cancer is the second leading cause of death in the United States, accounting for nearly one out of every four deaths.¹⁵



Among women, **breast cancer** is the leading cause of cancer death and the incidence rate in the District has ranged from 128/100,000 to 143/100,000 during the past nine years. While the incidence rate is slightly higher for White women (149/100,000) than Black women (136/100,000), Black women are 1.5 times more likely to die from breast cancer. Breast cancer is associated with increased age, heredity, obesity, and alcohol use.¹



Prostate cancer is the leading cause of cancer death among men in the United States. Among the general male population in the District, prostate cancer incidence rates ranged from 184/100,000 to 198/100,000 between 2003 and 2012. Black males in the District are almost two times more likely to develop prostate cancer and three times more likely to die from the disease than their White counterparts.¹ The two greatest risk factors for prostate cancer are age and race. Men over age 65 and those of African descent represent demographics with the highest incidence rates in the United States.¹



Colorectal cancer is the second leading cause of cancer in the United States. Among the general population in the District, the colon cancer incidence rate has decreased from nearly 52/100,000 during 2003–2007 to 44/100,000 in 2008–2012. However, Black residents are two times more likely to develop and die from colon cancer compared to Whites. Risk factors include a family history of colorectal cancer, inflammatory bowel disease and heavy alcohol use. According to the Centers for Disease Control, almost 60% of colon cancer related deaths can be averted through age appropriate screening procedures among persons age 50 and older. Black District residents (65%) are less likely to have age appropriate screenings than Whites (78%) and Hispanics (68%).¹



Lung/bronchus cancer is the second most common cause of cancer in both men and women. Among the general population in the District, incidence rates have remained relatively stable at close to 60/100,000. However, Black residents are almost two times more likely to develop the disease than Whites, Asian/Pacific Islanders, and Hispanics. They are also two times more likely to die from the disease.¹ The most significant risk factor for lung/bronchus cancer is smoking.



Cervical cancer is one of the most common forms of cancer deaths for American women. Among the female population in the District, cervical cancer rates have declined over time. However, Black women are two times more likely to develop the disease than White women.¹ The human papilloma virus (HPV), which is transmitted through sexual contact, is the most significant risk factor for cervical cancer. The survival rate for cervical cancer is high when detected early through a Pap Test. Almost 80% of both Black and White residents receive a Pap Test based on recommended guidelines.¹



Influenza/Pneumonia Vaccinations

Influenza is a contagious disease that can lead to pneumonia. Persons age 65 and older with flu or pneumonia are more likely to die than those who are younger. Vaccines are highly effective in preventing both conditions; however, 47% of Black residents over age 65 receive a flu vaccine and 58% receive a pneumonia vaccine. Low vaccination rates may explain why influenza and pneumonia death rates are almost two times higher in Blacks than Whites.¹



Unintentional Injuries

Unintentional injuries such as poisonings, falls and motor vehicle crashes are a leading cause of death for Americans. The age-adjusted death rate due to unintentional injuries in the District exceeds national targets; however, rates among African Americans do not meet those targets and are almost two times greater than Whites and Hispanics.¹

Despite improvements in the general population, Blacks are two times more likely to die from coronary heart disease [and] two times more likely to have high blood pressure than Whites and other racial groups.



HEALTH BEHAVIORS



Exercise/Weight

Obesity and sedentary lifestyle are root causes of many preventable health conditions. Among District residents, 76% of adults report engaging in physical activity within the past 30 days; however, Blacks report it less than all other racial groups (67%). While obesity percentages among White (10%) and Hispanic (20%) adult residents exceed national targets, the percentage among Blacks is highest (34%).¹



Tobacco Use

Tobacco use is an underlying cause of some of the most common preventable illnesses in the United States. Among the adult population, 16% of District residents smoke and rates among Blacks are three times higher than Whites.¹



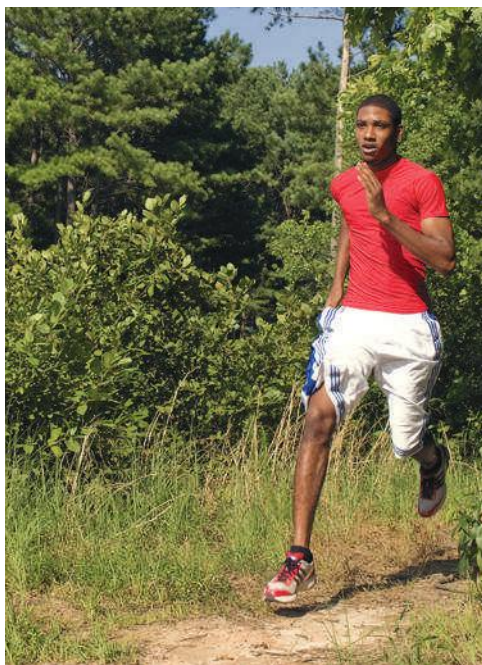
Sexually Transmitted Infections (STI)

Chlamydia and gonorrhea are commonly reported STIs in the United States. Chlamydia rates among Black residents in the District (1,088/100,000) are ten times higher than Whites (105/100,000) and five times higher than other racial groups. Gonorrhea rates are almost seven times higher in Blacks (445/100,000) when compared with Whites (67/100,000). While syphilis rates in the city have declined over the years, the number of new cases among Blacks (31/100,000) is two times higher than other races. Risk factors for STIs include unprotected sex, multiple sex partners, and alcohol/drug use.^{1,2}

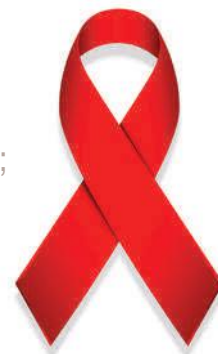


Human Immunodeficiency Virus (HIV)

As a result of citywide initiatives aimed at reducing HIV infection, the number of new cases has dropped 57% since 2007. However, Blacks make up the majority of new and existing cases. Currently, 16,740 persons have HIV; Blacks represent 74%. In 2014, there were 396 newly diagnosed HIV cases; Blacks represented 71%. Unprotected sex and intravenous drug use are leading causes of transmission.²



In 2014, there were 396 newly diagnosed HIV cases; Blacks represented 71%.





Families Living Below Poverty Level

Poverty is associated with a number of factors that impact health status such as food insecurity, unsafe or unhealthy housing, and exposure to crime and violence. Among the general population, 14% of District families live below the poverty line. Compared to all racial groups, the percentage of Black families in poverty (22%) is higher than all other racial and ethnic groups. Moreover, one out of four Black adult residents live below the poverty line.¹



Household Income

Median household income reflects relative affluence and prosperity of a neighborhood or community. Higher median household incomes are more likely to have educated residents, lower unemployment rates, and structural conditions that promote physical activity and access to amenities that foster wellbeing. Compared to all racial and ethnic groups, the median household income for Blacks is lowest (\$40,000)—three times less than Whites (\$115,000).¹



Unemployment

Unemployment is associated with a number of factors that impact health. Examples include poor nutrition, unhealthy living conditions, and chronic stress. Unemployment percentages are greatest in wards with high densities of Black residents: Ward 8 (17%), Ward 7 (19%). Unemployment percentages are lowest in Ward 3 (3.4%).²



Educational Attainment

Persons with a bachelor’s degree or higher are more likely to have health insurance coverage, higher paying jobs, and greater freedom to make choices for social advancement and healthy living. Among all residents age 25 and older, more than 50% have a bachelor’s degree or higher. However, less than 25% of Black residents age 25 and older have a bachelor’s degree or higher.¹



Food Insecurity

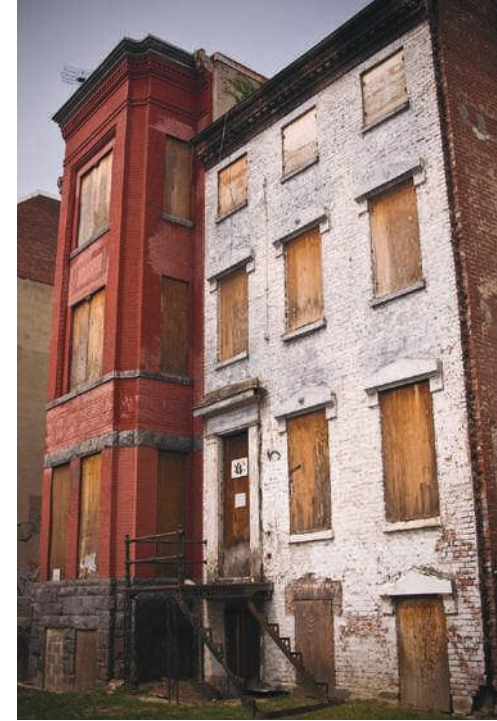
Almost 15% of DC residents experience food insecurity—defined as limited or uncertain availability of nutritionally adequate food.¹⁶ Poor access to healthy food results in irregular dietary habits, increasing risk for obesity and various forms of chronic disease conditions. Due to lower income levels and cost of housing burden, Black residents are disproportionately impacted. Wards 7 and 8 have been identified as food deserts.¹⁷



Home Ownership and Housing Cost Burden

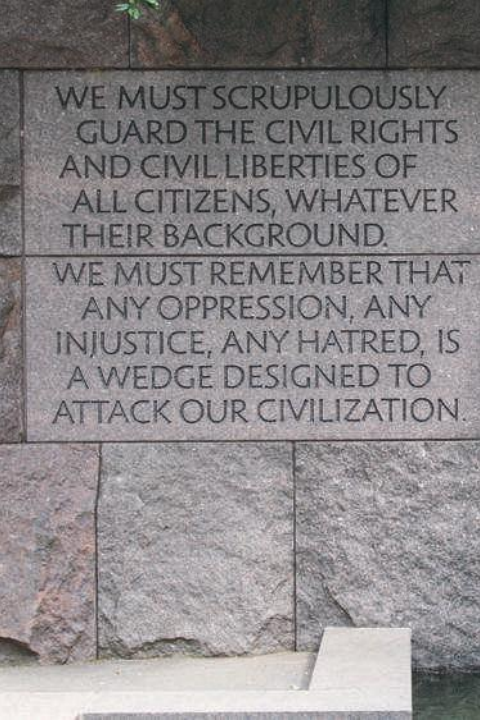
Home ownership is linked to financial security, wealth building and greater engagement in civic affairs. However, only 37% of housing units in the city are occupied by their owners.¹ Percentages are lower in Wards 7 and 8 and other zip codes with higher densities of African American and Hispanic residents.

Median gross monthly rent during 2010–2014 was \$1,302, compared to a national average of \$920.¹⁸ In areas of the city with more dense populations of African Americans, the percentage of households spending 30 percent or more of their income on housing is higher than households in other parts of the District.^{8,18}



SOCIAL AND ECONOMIC FACTORS

Poverty is associated with a number of factors that impact overall health status such as food insecurity, unsafe or unhealthy housing, and exposure to crime and violence.



Improving the health of the African American District residents requires an explicit and cross-sectoral agenda to eliminate social, economic and environmental conditions that stymie upward mobility and compromise well being across the life span. As the city continues to experience rapid growth and economic progress, proactive efforts are needed to address policies, practices, and norms that perpetuate segregation and inequitable distribution of resources—disproportionately burdening African American residents.

There are also unique opportunities for the healthcare sector. In light of health reform goals, hospitals—as anchor institutions—can advance the health of the populations they serve by applying a racial equity lens in how care is delivered, ensuring leadership at all levels is a reflection of the community served. They can also conduct community health assessments that support a broad agenda around the identification of structural and institutionalized practices that negatively impact African American residents. Establishing business guidelines that support localized wealth building through procurement, supply chain management and local investments can also be impactful.

CONCLUSION

Proactive efforts are needed to address policies, practices, and norms that perpetuate segregation and inequitable distribution of resources—disproportionately burdening African American residents.

African American Residents in the District of Columbia are

6 times more likely to die from diabetes related complications

2 times more likely to die from coronary heart disease

2 times more likely to die from a stroke

3 times more likely to be obese

3 times more likely to die from prostate cancer

3 times more likely to smoke

1.5 times more likely to die from breast cancer

3.5 times more likely to live below the poverty level

Comparison Group: Self-reported non-Hispanic White residents
Sources: National Cancer Institute | Centers for Disease Control and Prevention | DC Health Risk Factor Surveillance System | American Community Survey

Social, Economic and Environmental

- **Employ** a racial equity approach when conducting community health needs assessments with a goal of uncovering or rectifying systemic barriers that perpetuate segregation, neighborhood disinvestment, and inequitable distribution of resources
- **Develop** formal mechanisms to proactively examine how planning efforts, policies and business decisions may disproportionately impact people of color
- **Convene** anchor institutions, local entrepreneurs and businesses to explore opportunities for localized wealth building initiatives
- **Provide** incentives that attract new businesses to historically marginalized neighborhoods
- **Enforce** local hiring mandates for city funded projects
- **Develop, support or reinforce** policies to ensure the availability of affordable housing across all eight wards of the city
- **Offer** incentives and support place based initiatives to increase the availability of affordable healthy food products and high quality recreational facilities
- **Develop** integrated social media platforms to connect residents with real-time social support services (e.g., food, housing, employment)
- **Support** collaborative efforts between employers and training institutions to offer pipeline workforce development and job skills training programs

Clinical Care and Health Systems

- **Analyze** service utilization and morbidity data by race/ethnicity, zip code or neighborhood / **Develop** strategic partnerships with community-based organizations to hone in on specific geographic populations
- **Educate and increase** institutional awareness of institutionalized bias and structural causes of poor health
- **Establish** coalitions or partner with entities that advocate for policies or practices that promote racial equity
- **Ensure** board and senior leadership reflect the diversity of the community
- **Create** culturally tailored clinical services and communication vehicles
- **Expand** the capacity and functionality of the Electronic Health Record (EHR) to include social factors
- **Institute** practices and protocols aimed at local hiring and contracting with minority owned businesses—particularly those located in historically marginalized neighborhoods
- **Sponsor** workforce development and competency-based health professional training programs
- **Examine** cost of living and offer livable wages for front-line and entry level positions
- **Explore** creative ways to engage long-term residents in creating healthcare environments that visually preserve a deep, rich African American cultural identity
- **Integrate** mental health in primary care and ensure the availability of behavioral health services



SUMMARY OF RECOMMENDATIONS

Employ a racial equity approach when conducting community health needs assessments with a goal of uncovering or rectifying systemic barriers that perpetuate segregation, neighborhood disinvestment, and inequitable distribution of resources



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