DISTRICT OF COLUMBIA COMMUNITY HEALTH NEEDS ASSESSMENT

Prepared by

District of Columbia Department of Health

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Health Regulation and Licensing Administration

HIV/AIDS, Hepatitis, STD, and TB Administration

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EXECUTIVE SUMMARY

The District of Columbia Department of Health is pleased to present the first edition of the *District of Columbia Community Health Needs Assessment*, a comprehensive analysis of a series of indicators and outcomes that describe the overall health status of District residents. Key health indicators were compiled and reviewed from the most recent available data on the District population by age, gender, race/ethnicity, and geographic distribution in the following areas:

- Life Expectancy
- Leading Causes of Death
- Infant Mortality
- Chronic Disease
- Behavioral Patterns and Risk Factors
- Special Populations

This report provides an organized approach to meeting the needs of the underserved population. By utilizing reliable and comparable data sources to identify trends in health issues and socio-economic factors, District residents are better served. This document can also serve as a tool for developing evidence-based recommendations for public health policies, programs, and interventions to strengthen community health.

This health assessment follows the guidelines established by the Public Health Accreditation Board (PHAB) and will serve as the first step of DC DOH in the path to accreditation.

EXECUTIVE SUMMARY

The mission of the Department of Health is to promote and protect the health, safety, and quality of life of residents, visitors, and those doing business in the District of Columbia.

Our responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

With the 2013 Community Health Needs Assessment (CHNA), the Department of Health describes the current health status of District of Columbia residents and identifies areas of needed improvement. Information provided includes city demographics, the leading causes of death, contributing factors of health, priority health concerns and suggested mobilization of available assets and resources.

I. District of Columbia Demographics

During the 1950 United States Census there were a reported 802,178 residents in the District of Columbia. For every decade after 1950, the population declined. According to the 2000 Census, the District's population had reached its lowest at 572,059. This marks a 29 percent reduction in population size occurring over the 50 year time period. In 2010, the Census showed a5.2 percent increase in population size at 601,723. The most recent data records the District population size at 632,323 in 2012. For the CHNA, the DOH used2010 data. This year was selected since all of the primary population health datasets and the majority of the program datasets have been closed and validated for this time period.

So who is making up this population increase? According to the data, the age group with the largest increase from 2000 to 2010wasamong those between 20 and 34 years of age (up by 35,270 or 23 percent). In terms of ethnic makeup, the largest numerical increase by single race from 2000 to 2010 came among the District's white population, which grew from 176,101 in 2000 to 231,471 (31.4 percent), followed by the Asian population, from 15,189 to 21,056 (38.6 percent). Hispanics also showed an increase over the decade from 44,953 to 54,749 (21.8 percent).

Fluctuations in the District's population since the 1800's have been influenced by many factors including the abolition of slavery (1865), the expansion of the Federal government during and after World Wars I and II, and the Civil Rights movement (peak 1955-1968). For Black residents in the District, both the highest number and percentage of people were recorded in the 1970 Census when the Black population peaked at 537,712, accounting for 71 percent of the District's population. After the 1970 Census, the Black population in the District showed continuous decline. Four decades later, the 2010 Census counted 305,125 Black residents in the District, accounting for 50.7 percent of the total population.

The highest percentage of White residents was recorded at 80.9 percent in the 1860 Census, while the highest number of White residents was recorded at 517,865 in the 1950 Census. In the 1960s, the city changed from a majority White population to a majority Black population, with 45 percent White, 54 percent Black, 0.6 percent Asian, and 0.2 percent of residents claiming other race. Data were not available for the Hispanic population until the 1970 Census.

The Hispanic population grew from 15,671 (2.1 percent) in 1970 to an estimated 54,749 (9.1 percent) of the District's population in 2010. Also in 2010, Asians (not Hispanic or Latino) were the fastest growing racial group in the District since 2000, with an increase of 38.4 percent.

The median age in the District is 34. Unlike the U.S. population, which is aging, the District's population is trending younger. In 2010, those between the ages of 0 – 17 accounted for 17 percent of the overall population; 35 percent of residents were between the ages of 18 and 34; 37 percent of residents were between 35 and 64 year olds and 11 percent were 65 years of age or older. The median age of the U.S. population is 37 and 13 percent of American are 65 years of age and older.

Among the eight wards in the District, Ward 4 is the oldest with median age of 40 while Ward 8 is the youngest with median age of 29. The most populous ward in the District is Ward 2 with 79,915 residents and the least populated ward is Ward 8 with 70,712 residents.

II. Health Profile

Life Expectancy

Throughout the District and its neighboring communities there are varying life expectancy rates. The District's average life expectancy is 77.5 years old; Prince George's County, MD is 75 years old; Montgomery County, MD is 81.3 years old; Arlington County, VA is 80.1 years old; and Fairfax County, VA is 80.9 years old. In the District, Hispanic females live the longest reaching the average age of 88.9 years and non-Hispanic Black males have the shortest life span with a life expectancy of 68.8 years.

Infant Mortality

In the recent past, the District has experienced a high infant mortality rate (IMR). In 2007, the IMR was 13.1 deaths per 1,000 live births. However, the 2011 IMR showed a substantial decrease to 7.4 deaths per 1,000 live births which is closer in comparison to the United States IMR of 6.1 deaths per 1,000 live births than many other large urban cities. The highest incidence of infant mortality is 12.9 deaths per 1,000 live births in Ward 8 and 12.0 deaths per 1,000 live births in Ward 5. The lowest incidence is in Ward 3 no infant deaths in 2011. Teen pregnancy, low birth weight, and prematurity are contributing factors to the IMR.

Infant Mortality Rate Comparison (2010)	
District of Columbia	8.0
United States	6.1
Baltimore City, MD	11.0
Detroit City, MI	13.5
Richmond, VA	12.8

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Health Care Coverage

The District boasts high health care coverage with 93 percent of the population 18-64 years old having health insurance. Residents from Wards 3 and 6 are more likely to have health insurance than residents in other Wards throughout the District; 90.4 percent of African Americans; 97.4 percent of non-Hispanic Whites; 91 percent of Hispanics and 87.4 percent of individuals who identify as other races have health care coverage. Even though the District has a high number of insured citizens, only 36.1 percent of non-Hispanic Whites; 29.8 percent of Hispanics; and 16.9 percent of African Americans were found to have an "excellent health" status. According to the 2010 Behavioral Risk Factor Surveillance Survey (BRFSS), 25 percent of the population reported to be in "excellent health."

Top Ten Leading Causes of Death

District of Columbia (2010)	Rate per 100,000	United States (2010)	Rate per 100,000
1. Heart Disease	221.4	1. Heart Disease	179.1
2. Cancer	177.1	2. Cancer	172.8
3. Accidents	34.9	3. Chronic Lower Respiratory Diseases	42.2
4. Cerebrovascular Diseases	32.4	4. Cerebrovascular Diseases	39.1
5. Chronic Lower Respiratory Diseases	25.5	5. Accidents	38.0
6. Diabetes	24.9	6. Alzheimer's Disease	25.1
7. HIV/AIDS	20.4	7. Diabetes	20.8
8. Homicide/Assault	17.1	8. Nephritis, nephrotic syndrome and nephrosis	15.3
9. Alzheimer's Disease	18.7	9. Influenza/Pneumonia	15.1
10. Septicemia	15.3	10. Suicide	12.1

*Rank based on the number of deaths; rates are age-adjusted per 100,000 population.

Heart Disease

Almost 3 percent of the adult population in the District has been diagnosed with heart disease by a doctor. African American adults experience the highest rates of heart disease in the District with 3.7 percent having been diagnosed. Non-Hispanic white adults have the lowest rates of heart disease with 1.4 percent having ever been diagnosed. The highest prevalence of heart disease occurs in Wards 6, 7, and 8 with the lowest prevalence occurring in Wards 1 and 2. The death rate among residents with heart disease was highest in Wards 5 and 7 and the lowest in Ward 2. Death rates for heart disease among African Americans were almost triple that of whites (at 333.0 per 100,000 and 116.6 per 100,000, respectively). Most of the deaths due to heart disease were in the higher age groups with decedents aged 55 years and older accounting for 89.7 percent.

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A cause of heart disease is chronic elevated high blood pressure (hypertension). The table below provides 2011 BRFSS data on the prevalence of hypertension in the District:

"Have you ever been told by a doctor, nurse or other health professional that you have high blood pressure?"

Ward	Percent Responded "YES"
Ward 1	26.7%
Ward 2	22.3%
Ward 3	20.2%
Ward 4	33.2%
Ward 5	39.3%
Ward 6	29.6%
Ward 7	41.5%
Ward 8	40.4%

Cancer

The major cancers in the District are prostate, breast, lung and colon; with prostate, breast and colon cancer having a higher incidence rate than the United States. The death rate among residents with cancer was highest in Ward 5 and the lowest in Ward 2. The District's overall death rate among residents with cancer was 177 deaths per 100,000 people.

Disparities in cancer between White and African American residents of the District are wider than those nationwide, with African Americans much more likely to be diagnosed with and die from cancer than Whites. Nationally, the cancer death rate for African Americans was 22 percent lower than for Whites (156.7 per 100,000 and 200.3 per 100,000 respectively). In the District, African Americans had a mortality rate of 250.4 per 100,000, which was more than double the rate among Whites (111.9 per 100,000).

Across the United States, the overall cancer incidence was 11 percent higher among African Americans than among Whites. The disparity is more pronounced in the District, where the number of new cancer cases among African American residents was 59 percent higher than that among White residents.

Diabetes

Diabetes is highest among African Americans with 13.4 percent of the population having ever been told that they have the disease; 2.5 percent of Whites, 5.5 percent of Hispanics, and 7.3 percent of other race have ever been told they are diabetic. This corresponds to 8.3 percent of the overall population in the District having been diagnosed with diabetes. The highest prevalence is found in Wards 5, 7, and 8 with the lowest being in Ward 3. The death rate among residents with diabetes was highest in Ward 7 (43.6 deaths per 100,000) and the lowest in Ward 2 (6.3 deaths per 100,000).

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In regards to obesity, a contributing factor of diabetes, ***the District has 22.4 percent of the population reported as obese in 2010***. Nationally, 27.6 percent are reported as obese. The highest obesity prevalence in the District is in Ward 8 (44.4 percent) while the lowest in Ward 3 (7.5 percent). Close to 35 percent of African American residents in the District are obese; 17.1 percent of other race; 12 percent of Hispanics; and 9.6 percent of White residents are obese in the District.

HIV/AIDS

In 2010, there were 835 newly diagnosed cases of HIV in the District and 207 deaths related to HIV infection. Data indicate that there are 14,465 persons living with HIV/AIDS in the District. Data also indicate that the number of persons living with HIV/AIDS is increasing and that the District is evidencing a decrease in both newly diagnosed cases and deaths from the disease.

Hospitalizations

The leading causes of hospitalization in the District in 2010 were:

Cause of Hospitalization	Number of admissions (2010)
1. Pregnancy-related	8,911
2. Heart disease	5,583
3. Psychoses	5,011
4. Accidents and poisoning	3,970
5. Chronic lower respiratory disease	3,500
6. Cancers and neoplasms	2,843
7. Diabetes mellitus	1,836
8. Pneumonia and influenza	1,744
9. Cerebrovascular disease	1,576
10. HIV/AIDS	551

III. Community Priorities

> *"In just one generation—20 years—the District of Columbia will be the healthiest, greenest, and most livable city in the United States. An international destination for people and investment, the District will be a model of innovative policies and practices that improve quality of life and economic opportunity. We will demonstrate how enhancing our natural and built environments, investing in a diverse clean economy, and reducing disparities among residents can create an educated, equitable and prosperous society." - Sustainable DC*

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Sustainable DC is a 20 year plan to make the District the healthiest, greenest, most livable city in the nation. Launched in July of 2011 by Mayor Gray and led by the D.C. Office of Planning and the D.C. Department of the Environment, Sustainable DC has involved 9 public working groups with over 700 people participating. Residents contributing to the Plan development included a health component with two major targets:

> Target# 1: By 2032, cut the citywide obesity rate by 50 percent;
>
> Target# 2: By 2032, ensure 75 percent of District residents live within ¼ mile of a community garden, farmers' market or healthy corner store.

To achieve these targets, the workgroups, in collaboration with DOH, have recommended that the city expand public park access and programming to promote healthy lifestyles through physical exercise (the Parks Rx Program); expand the number of corner stores carrying fresh produce (DC Healthy Corner Stores Program); introduce fresh food circulators and mobile vendors in neighborhoods with poor access to fresh foods; and expand the bonus dollars for WIC and SNAP participants to spend more money on fresh produce at farmers' markets.

Another opportunity provided for community members to contribute to city planning includes the Mayor's ***One City Action Plan*** (OCAP). The health components within the OCAP are within "***Goal# 3: Improve the Quality of Life for All***" and include:

Action# 3.2.1: Ensure Residents have Access to Quality Health Care;

Action# 3.2.2: Reduce Infant Mortality;

Action# 3.2.3: Reduce HIV/AIDS Infection and Increase the Life Span of Those Living with HIV/AIDS;

Action# 3.4.1: Improve Access to Healthy Food;

Action# 3.4.2: Expand Nutrition Education

IV. Summary

All three of the provided sections (the city demographics, the health profile, and the community priorities) are expanded upon within the CHNA and provide a better understanding of the health of the District as well as contribute to a discussion of how best to plan for improvements. Demographics provide an understanding of the city's history and allows for projections of characteristics of the District resident of the future, whereas the health profile provides a picture of what residents look like today, specifically their health status. Developing improvement plans based upon current health status and projected trends truly allows the city to move towards reaching the Sustainable DC goal of building the 'healthiest' generation. Although the numbers are critical to informed decision making, knowing what is important to residents is invaluable. The community's views on health priorities can better shape programs to ensure that residents' needs are met as well as give the Department of Health an opportunity to understand how well the public health data have or have not been shared in helping residents to best understand true priorities.

SUMMARY HIGHLIGHTS

Key Indicators

- Life expectancy for the average District resident has climbed to a historic high of 77.5 years in 2010, a 10-year gain from the life expectancy in the early 1990s.
- The number of deaths to District residents has dropped by 11.7 percent from 2006 to 2010; however, disparities persist between gender, race, and ward of residence.
- The District achieved its Healthy People 2010 objective of reducing infant mortality rate (IMR) to no more than 8 infant deaths per 1,000 live births; however the District IMR was 31 percent higher than the national rate.
- District resident seniors are projected to grow by 17.4 percent in 2030. As the population continues to live longer and the estimated life expectancy in the District continues to rise, the need for health care among the elderly will likewise increase.

Leading Causes of Death

- Heart disease and cancer are the two leading causes of death among District residents, regardless of sex and race, and they accounted for 50 percent of deaths in the District in the last 5 years.
- Among 10-24 year olds, homicide/assault is the leading cause of death (55 percent) followed by accidents (13 percent).
- Despite a 43.2 percent drop in the HIV age-adjusted mortality rate in the last 5 years, the District rate for deaths due to HIV was 8.2 times higher than the national rate in 2010.
- The leading causes of death for adults 65 and older were heart disease, cancer, cerebrovascular disease, chronic lower respiratory disease, and Alzheimer ’s disease.

Diseases and Disorders

- Significant decreases were seen in incidence and mortality rates for colorectal, breast, and prostate cancer.
- With nearly 3 percent of its population diagnosed and reported with HIV, the District has a severe and generalized epidemic and District residents between 40-49 years of age and black men have the highest rates of HIV.
- One in 100 youth in the District is HIV positive.
- Lifetime and current asthma prevalence for children in the District were higher than the national medians. Children under 5 years accounted for the largest percentage (20 percent) of emergency visits due to asthma from 2008 to 2010.
- Chronic diseases have caused most of the deaths among the elderly in the District.

SUMMARY HIGHLIGHTS

Ward Level

- Deaths due to Accidents, Diabetes, and Septicemia increased dramatically in Ward 8 from 2006 to 2010.
- Ward 8 residents have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- District residents in 10 zip codes accounted for 83 percent of total District resident hospital discharges. They belong to Wards 1, 4, 5, and 8.
- Prevalence and mortality associated with diabetes are highest in District Wards 4, 5, 7, and 8, where rates are higher than the city-wide rate.
- While 50 percent of youth live in Wards 7 and 8, less than 10 percent of the District's grocery stores are located there.

Access to Care

- Emergency visits and ambulatory services have increased steadily while patient days declined in the District.
- Pregnancy–related and Heart Disease are the two leading causes of hospitalization for DC residents.
- Although there are sufficient numbers of providers serving the general population in "Medically Underserved" designation areas in the District, there is still a shortage of providers serving the low-income and/or homeless populations in these areas.
- The District of Columbia implemented early expansion of Medicaid eligibility under the Affordable Care Act that has led to insurance coverage for 93 percent of adults and 96 percent of children living in the District – the second highest insurance rate in the nation after Massachusetts.

Health Behaviors and Risk Factors

- The District provides greater access to healthy food options compared to nationally, except in school settings.
- Currently, there are no state laws addressing childhood obesity in the District.
- District residents have a healthier body mass index (BMI) compared to the rest of country.
- The prevalence of heavy drinking for District adults is 6 percent compared to 5.1 percent nationally.
- Self-reporting of attempted suicide by District students has consistently been double the national average of 6.3 percent.
- Gay, lesbian, and bisexual District residents were more likely to report positive perceived health status, healthy weight, physical activity, lower blood pressure, and HIV testing. They were also more likely to report smoking, heavy or binge drinking, and engaging in risky behavior.
- In 2007, an estimated 100 non-fatal traffic injuries in the District involved an underage driver that had been drinking.

SUMMARY HIGHLIGHTS

Racial Disparities

- Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years).
- Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.
- Blacks have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.
- The crude death rate due to diabetes for blacks/African Americans was seven times the rate for Whites in 2010.
- Blacks/African Americans were over 3 times more likely to die from cerebrovascular diseases compared to their white counterparts.

INTRODUCTION

The District of Columbia is the urban center of the Washington Metropolitan Statistical Area (MSA), bordered by Arlington County and the city of Alexandria in Northern Virginia, Montgomery and Prince George's counties in Maryland, and the Potomac River. The District is divided into eight wards, or political subdivisions created for the purpose of voting and representation. Ward boundaries are updated approximately every ten years, based on population changes reported by the US Census Bureau. These wards provide a useful mechanism for analyzing and comparing sub-populations and for analyzing trends in the changing health status of residents. According to the 2010 Census, the population in the District was 601,723. The average number of residents per ward in 2010 was 75,215, up 5.2 percent from the 2000 average of 71,507. The largest number of residents (79,915) lived in Ward 2 and the smallest number (70,712) lived in Ward 8 in 2010. The wards are geographically, economically, and ethnically diverse and care should be taken to understand the similarities and differences when comparisons are made. The District is also divided into census tracts, drawn by the US Census Bureau, and range in population size from 1,200 to 8,000 people. In 1990, the city had 192 census tracts; the number fell to 188 in 2000 and fell again to 179 in 2010.

Mayor Gray released the Sustainable DC Plan (available at http://www.sustainabledc.org/about) in February 2013. This document, based on thousands of suggestions from the community and more than 900 recommendations from the Sustainable DC working groups, is Mayor Gray's vision and 20 -year plan for a healthier, greener, and more livable District of Columbia. The plan lays out a strategy for how the District will achieve this vision by setting goals and identifying 143 specific actions, to achieve those goals.

Mayor Gray also invited District of Columbia residents to participate in a "City-Wide Citizen Summit" on February 11, 2012. Over 1,700 residents participated in person in addition to another 500 residents who viewed the deliberations online; approximately 200 of the 500 residents actively participated in an online dialogue and voting process. The day concluded with residents providing recommendations regarding what indicators are the most important for the District of Columbia Government to measure progress toward achieving "One City." The Mayor released his One City Action Plan (available at http://mayor.dc.gov/sites/default/files/dc/sites/mayor/publication/attachments/OCAP.pdf) in July 2012.

These two plans yielded both separate and overlapping health priorities: Access to health care, asthma, HIV/AIDS, infant mortality, and obesity. Thus, these health areas were the catalyst for the creation of the District of Columbia Community Health Needs Assessment (CHNA).

INTRODUCTION

The District of Columbia Department of Health (DC DOH) understands that maintaining good health and wellness for individuals and communities depends on quality health care for the sick, as well as providing opportunities to prevent health problems and improve the basic health and well-being of District residents. A measure of the relative health of the total population of a community is its health profile or health status. Together with demographic and socio-economic data, health status indicators provide the basic information for defining the community's health needs and assessing the manner in which the health care system can meet those needs.

The CHNA is a comprehensive analysis and review of the health status and quality of life of District residents. This document was developed by utilizing information collected by the DOH through various survey instruments, disease registries, and other essential public health databases maintained and administered by DOH and, for the first time, consolidated in one report. The CHNA provides in-depth analyses of the District's population trends, key health indicators and issues, such as: Mortality and Life Expectancy, Promoting Healthy Behaviors, Promoting Healthy and Safe Communities, Improving Access to Quality Healthcare Services, Preventing and Reducing Diseases and Disorders, Special Populations, and Community Partnerships. This information will be used to reduce health disparities, improve health outcomes, identify gaps, allocate resources and develop and implement policies to further strengthen the health care system to ensure that there is equitable access to quality healthcare services for all residents in the District. It also serves as a resource document which catalogs the District's assets, healthcare facilities, other public health infrastructure, and numerous community partnerships mobilized to address these health issues in alignment with focus areas identified in the Mayor's ***One City Action Plan*** and ***Sustainable DC Plan***.

KEY INDICATORS AT-A-GLANCE

Table 1. Key Indicators At-a-Glance, District of Columbia and United States, 2010

The following "At-A-Glance" section of the report allows quick comparison of key health indicators between the District of Columbia and the United States. A "thumbs up" graphic is used for a favorable outcome for the District (e.g., the percentage of obese residents is lower in the District compared to national). All data in this table, unless indicated otherwise, are from the 2010 reporting period.

Mortality and Life Expectancy	District of Columbia		United States
Life Expectancy (At Birth, Age in Years)	77.7		78.7
Leading Causes of Death (Age-adjusted Death Rate, Per 100,000 Population)			
Heart Disease	239.7		178.5
Cancer	193.0		172.5
Accidents	36.9	👍	37.1
Cerebrovascular Disease	35.5	👍	39.0
Chronic Lower Respiratory Disease	27.0	👍	42.1
Diabetes	26.7		20.8
HIV Disease	21.4		2.6
Alzheimer's Disease	20.3	👍	25.0
Homicide/Assault	16.9		5.3
Septicemia	16.7		10.6
Maternal and Child Health Outcomes			
Infant Mortality (Per 1,000 Births)	8.0		6.1
Low Birth Weight (Percent of Births)	10.2		8.2
Preterm Birth (Percent of Births)	10.3	👍	12.0
Teen Birth Rate (Per 1,000 Women Aged 15-19 Years)	45.4		34.2
Fertility Rate (Births Per 1,000 Women Aged 15-44 Years)	56.4	👍	64.1
Access to Care			
Health Care Coverage, Any Type (Percent Adults Aged 18-64)	92.2	👍	85.0
Enrollment in Medicaid Managed Care (Percent, 2009 Data)	66.0		71.2
Enrollment in Health Maintenance Organizations or HMOs (Percent, 2008 Data)	64.1	👍	24.8
Physician-to-Resident Ratio (Per 100,000 Population, 2009 Data)	817	👍	273
Nurse-to-Resident Ratio (Per 100,000 Population, 2009 Data)	1,483	👍	842

Note: Key indicators have been included on the basis of their relevance to public health; the availability and quality of the data; and the reliability and comparability of estimates. These indicators are derived from multiple sources and are expressed in their original format (e.g., survey questionnaire) or simplified for tabulation purposes. The statistical significance of rate or percentage differences between the District of Columbia and United States was not assessed for this presentation. All such comparisons are informal.

KEY INDICATORS AT-A-GLANCE

Table 1, Cont'd. Key Indicators At-a-Glance, District of Columbia and United States, 2010

The following "At-A-Glance" section of the report allows quick comparison of key health indicators between the District of Columbia and the United States. A "thumbs up" graphic is used for a favorable outcome for the District (e.g., the percentage of obese residents is lower in the District compared to national). All data in this table, unless indicated otherwise, are from the 2010 reporting period.

Health Behaviors

	District of Columbia		United States
Tobacco Use			
Current Smokers (Percent Adults 18 and Older)	15.6		17.3
Cigarette Use in Last 30 Days (Percent High School Students, 2011 Data)	12.5		18.1
First Time Cigarette Use Before Age 13 (Percent High School Students, 2011 Data)	8.3		10.3
Alcohol Consumption			
Heavy Drinkers (Percent Adults 18 and Older Having More than 2 Drinks Per Day)	6.1		4.9
Binge Drinkers (Percent Adults 18 and Older Having 5 or More Drinks on 1 Occasion)	15.4		15.1
Alcohol Use in Last 30 Days (Percent High School Students, 2011 Data)	32.8		38.7
First Time Alcohol Use Before Age 13 (Percent High School Students, 2011 Data)	21.3		20.5
Physical Activity			
30+ Minutes of Moderate Physical Activity 5 or More Days Per Week (Percent Adults 18 and Older, 2009 Data)	45.5		49.4
20+ Minutes of Vigorous Physical Activity 3 or More Days Per Week (Percent Adults 18 and Older, 2009 Data)	65.9		70.8
Fruit and Vegetable Consumption			
Five or More Times Per Day (Percent Adults 18 and Older, 2009 Data)	31.5		23.5
Less than 5 Times Per Day (Percent Adults 18 and Older, 2009 Data)	68.5		76.5
Screening and Immunization			
Blood Cholesterol Test During Lifetime (Percent Adults 18 and Older, 2009 Data)	88.1		80.6
Mammogram within Past 2 Years (Percent Women Aged 40 and Older)	80.0		75.2
Prostate-Specific Antigen (PSA) Test within Past 2 Years (Percent Men Aged 40 and Older)	60.9		53.2
Flu Shot within Past Year (Percent Adults 65 and Older)	60.9		68.8
Oral Health			
Dental Visit within Past Year (Percent Adults 18 and Older)	75.3		69.6
Injury			
Seatbelt Use (Percent Adults 18 and Older)	90.3		85.3
High Risk Behavior			
Marijuana Use During Lifetime (Percent High School Students, 2011 Data)	43.0		39.9
Marijuana Use in Last 30 Days (Percent High School Students, 2011 Data)	26.1		23.1
First Time Marijuana Use Before Age 13 (Percent High School Students, 2011 Data)	11.0		8.1
Drinking and Driving (Percent High School Students, 2011 Data)	5.4		8.2
Carried a Handgun (Percent High School Students, 2011 Data)	7.5		5.1

Note: Key indicators have been included on the basis of their relevance to public health; the availability and quality of the data; and the reliability and comparability of estimates. These indicators are derived from multiple sources and are expressed in their original format (e.g., survey questionnaire) or simplified for tabulation purposes. The statistical significance of rate or percentage differences between the District of Columbia and United States was not assessed for this presentation. All such comparisons are informal.

KEY INDICATORS AT-A-GLANCE

Table 1, Cont'd. Key Indicators At-a-Glance, District of Columbia and United States, 2010

The following "At-A-Glance" section of the report allows quick comparison of key health indicators between the District of Columbia and the United States. A "thumbs up" graphic is used for a favorable outcome for the District (e.g., the percentage of obese residents is lower in the District compared to national). All data in this table, unless indicated otherwise, are from the 2010 reporting period.

Chronic Health Indicators	District of Columbia		United States
Overweight and Obesity (BMI)			
Neither Overweight nor Obese (Percent Adults 18 and Older)	43.7		35.3
Overweight (BMI 25.0-29.9) (Percent Adults 18 and Older)	33.8		36.2
Obese (BMI 30.0-99.8) (Percent Adults 18 and Older)	22.4		27.6
Cardiovascular Diseases			
Had a Heart Attack or Myocardial Infarction (Percent Adults 18 and Older)	2.8		4.1
Had Angina or Coronary Heart Disease (Percent Adults 18 and Older)	2.6		4.1
Had a Stroke (Percent Adults 18 and Older)	3.4		2.6
Diabetes			
Diagnosed with Diabetes (Percent Adults 18 and Older)	8.3		8.7
Asthma			
Current Asthma (Percent Adults 18 and Older)	10.4		9.1
Lifetime Asthma (Percent Adults 18 and Older)	16.0		13.8
Current Asthma (Percent Children 17 and Under)	18.0		8.4
Lifetime Asthma (Percent Chldren 17 and Under)	22.4		12.4

Note: Key indicators have been included on the basis of their relevance to public health; the availability and quality of the data; and the reliability and comparability of estimates. These indicators are derived from multiple sources and are expressed in their original format (e.g., survey questionnaire) or simplified for tabulation purposes. The statistical significance of rate or percentage differences between the District of Columbia and United States was not assessed for this presentation. All such comparisons are informal.

METHODOLOGY

The District of Columbia Community Health Needs Assessment (CHNA) is a comprehensive analysis and review of multiple indicators of health and health outcomes affecting the quality of life of District residents. In order to measure progress toward the District's health goals, this report provides baseline data using 2010 statistics or the most recent available data for each indicator. The District of Columbia Department of Health (DC DOH) developed this document by utilizing the wealth of information collected through various survey instruments, disease registries, and other essential databases maintained within and administered by DC DOH. All data in this report, unless indicated otherwise, were compiled by the Center for Policy, Planning, and Evaluation (CPPE) of DC DOH. Data are specific to District residents unless indicated otherwise. All charts, graphs, and maps are referred to as "Figures." Following each figure, information is given on the source of the data. Integrated in this report are comparisons of District rates with national estimates and benchmarks, and in some cases, data from selected states or cities of comparable size and population. Also taken into account are the geo-political subdivisions or wards in the District, which allow health data to be stratified and displayed (ward maps) in a manner unique to the District and most relevant to the residents of each ward. When possible, this report presents 5-year data trends to identify emerging health issues and which subpopulations in the District are at-risk. Where applicable, objectives of the Healthy People 2010 Initiatives are included and updates are given on whether or not the objectives were met.

In July 2012, Mayor Vincent C. Gray unveiled the One City Action Plan, a comprehensive strategy that describes in specific steps how the Mayor's One City vision will be achieved. Organized by goals, strategies and actions, the plan provides District residents and business leaders alike with a concrete roadmap to understand and measure progress and hold city officials accountable in the areas that matter most to stakeholders. One of the overarching goals of the One City Action Plan is to "Improve the Quality of Life for All". Based on citizen input, several focus areas were established, and these include: 1) Reducing infant mortality, 2) Lowering the obesity rate, 3) Expanding access to quality health care, and 4) Reducing HIV infection and increasing the life span of those living with HIV/AIDS.

In line with these priority areas identified in the One City Action Plan, appropriate key indicators were also identified and included in the CHNA to provide an understanding of the District's status in each area and to enable monitoring of improvement over time.

METHODOLOGY

Data Sources

The *Behavioral Risk Factor Surveillance System* (BRFSS) is a state-based system of telephone surveys of adults 18 years of age and older. The BRFSS does not include adults residing in group quarters or institutions (such as nursing homes, hospitals, or prisons) or adults without landline or cellular phone service. BRFSS estimates in the District are based on data weighted to reflect the characteristics of the resident adult population. National estimates were obtained from the national BRFSS website (http://www.cdc.gov/BRFSS). These estimates are the medians of the individual estimates from the 50 states and the District of Columbia. Because these estimates were not constructed by pooling all national BRFSS data, it is not possible to assess statistically significant differences between the District and the US. All such comparisons are informal.

The *DC Cancer Registry* (DCCR) collects, maintains, and reports cancer incidence on all cancers diagnosed and/or treated in the District. DCCR tracks all types of malignant cancers, and certain benign tumors, and publishes annual reports on the incidence and mortality of cancer in the District. Data is collected from acute care hospitals, labs, and other reporting agencies mandated under existing law.

The *District of Columbia Census 2010 Atlas* is the book published by the DC State Data Center that contains all gathered census information within the District of Columbia.

The *District of Columbia Vital Records Division* (DC VRD) is a division of CPPE within DC DOH. DC VRD is required by law to register birth and death events that occur in District of Columbia hospitals, birthing centers, nursing homes, and funeral homes. DC VRD reports birth and death record information to the National Center for Health Statistics and to the Social Security Administration.

The *Epidemiological Report (2012): Alcohol, Tobacco and Other Drug Consumption, Consequences, and Risk Factors in the District of Columbia* gathers data from 2005 through 2012 on addiction-related topics including crime statistics.

Healthy People 2010 is a nationwide framework of measurable objectives with 10-year targets designed to increase the quality and years of healthy life and to eliminate health disparities. The Healthy People 2010 Final Report provides a quantitative end-of-decade assessment of progress in achieving these objectives in the District.

The *HIV/AIDS, Hepatitis, STD and TB Annual Report* provides information on new diagnoses and prevalent, or living cases of HIV, viral hepatitis, sexually transmitted diseases, and tuberculosis in the District. Surveillance data on these nationally and locally reportable diseases are routinely collected by HAHSTA within DC DOH.

The *District of Columbia Hospital Discharge Data* is an annual file of all inpatient discharges for patients admitted and discharged within the same calendar year in the 8 acute care hospitals located in the District. It includes hospital identifiers, patient diagnosis and treatment information, admission date, discharge date, demographic information, and expected source of payment (e.g. Medicare, Medicaid, private insurance, etc.)

The *Sustainable DC Food Workgroup* is one of nine workgroups that makes up the Sustainable DC Plan, released in February 2013. This document is Mayor Gray's vision and 20-year plan for a healthier, greener, and more livable District of Columbia. The Food Workgroup assesses nutritious food access and security as well as obesity rates.

METHODOLOGY

The *Title V Maternal and Child Health (MCH) Needs Assessment* is a comprehensive, District-wide needs assessment that examines the current health situation of the District's mothers, women, children and youth, including children and youth with special health care needs. It assesses trends in population characteristics, health status indicators, risk factors, health system attributes, and availability and accessibility of quality services for MCH populations

The *Youth Risk Behavior Survey* (YRBS) is a school-based survey administered to students in grades nine through twelve. It monitors priority health-risk behaviors (unintentional injuries and violence, sexually transmitted diseases (STDs), alcohol and drug use, tobacco use, dietary behavior, and physical activity) and prevalence of obesity and asthma in youth and young adults.

Limitations

While this state-wide assessment presents many important issues and topics, it does not present every possible health-related issue. The issues and indicators selected are intended to show the scope and complexity of population health. Further, some indicators should be interpreted with caution since they were derived from self-reported data which present potential sources of bias. This assessment also does not include the many programs and services that are currently implemented to address these health-related issues either by the DOH or by other stakeholders.

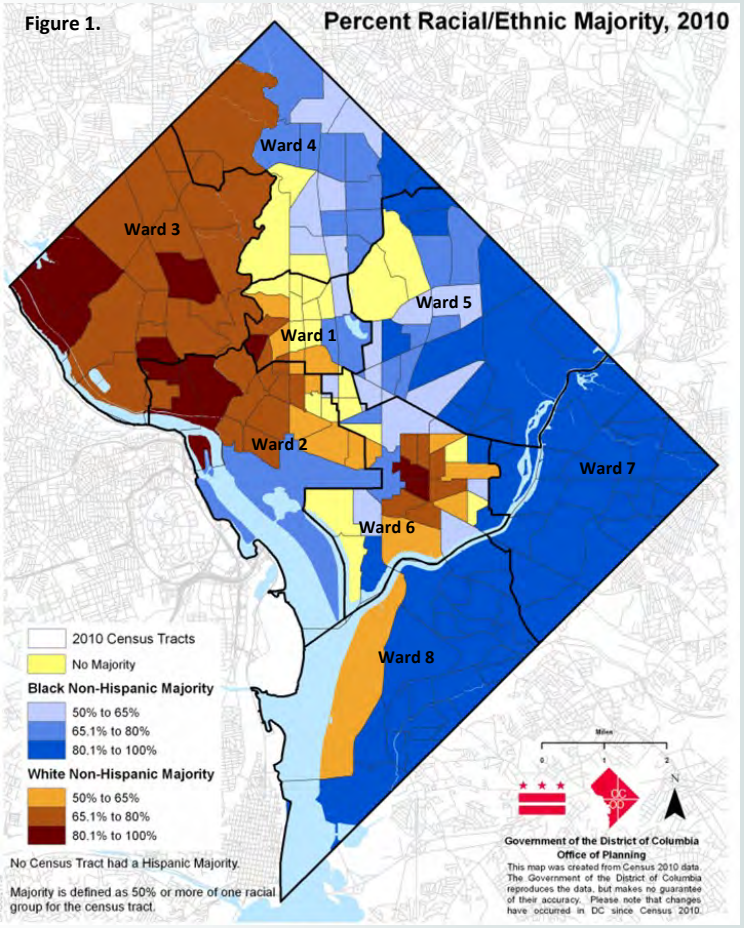
Demographic Characteristics of the District of Columbia

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

In highly diverse populations like the District of Columbia, constantly changing demographic characteristics have important implications for the health of residents. Health disparities—inequalities in determinants of health or health outcomes between groups of people—are essential considerations when promoting healthy behaviors and safe communities, implementing efforts to prevent disease and disability, and distributing healthcare services.

In 2010, the US Census Bureau counted 601,723 residents in the District, continuing a trend of population growth since the 2000 Census when the population count was at 572,059. According to the 2010 Census, the population distribution in the District was 50.7 percent Black or African American, 38.5 percent white, 3.5 percent Asian, 0.3 percent American Indian and Alaska Native, 0.1 percent Native Hawaiian and Pacific Islander, 4.1 percent some other race, and 2.9 percent individuals from two or more races. Hispanics or Latinos made up 9.1 percent of the District's population in 2010.

Figure 1. Percent Racial/Ethnic Majority, 2010



Blacks or African Americans. Blacks or African Americans are the largest racial group in the District and represent a majority in four of the District's eight wards (Ward 4, Ward 5, Ward 7, and Ward 8). In 2010, they comprised 305,125 residents or 50.7 percent of the total population, down from 60 percent reported in 2000. For Black residents in the District, both the highest number and percentage of people were recorded in the 1970 Census when the Black population peaked at 537,712, accounting for 71.1 percent of the District's population. After the 1970 Census, the Black population in the District showed continuous decline.

Whites or Caucasians. Whites or Caucasians are the second largest racial group in the District and represent a majority in four of the District's eight wards (Ward 1, Ward 2, Ward 3, and Ward 6). In 2010, they accounted for 231,471 residents or 38.5 percent of the District's total population, an increase from 30.8 percent reported in 2000. Whites were the majority population in 1950, peaking at 517,865 people or 64.5 percent of the total population, but declined since then. However in 2010, US Census data indicated a 31.6 percent increase for Whites (not Hispanic or Latino), placing White residents as the second fastest growing racial group.

Asians and Pacific Islanders. According to the 2010 Census, Asians (not Hispanic or Latino) were the fastest growing racial group in the District since 2000, with an increase of 38.4 percent. The In 2000, there were 15,189 Asians and 348 Native Hawaiians and Other Pacific Islanders residing in the District. In 2010, Asians accounted for 21,056 people or 3.5 percent of the District's population, and Native Hawaiian and Other Pacific Islanders comprised 302 people or 0.1 percent of the District's total population. Office of Asian and Pacific Islander Affairs (OAPIA) was re-established in January 1992 to assist this group of residents, which is comprised of 12 major ethnic groups who speak over 40 different languages.

Hispanics or Latinos. Hispanics or Latinos may be of any race. In 2010, Hispanics or Latinos were the third fastest growing group in the District's population. Between 1990 and 2000, the Hispanic or Latino population grew by 37.4 percent. From 2000 and 2010, the Hispanic population increased again by 21.8 percent, from 44,953 (7.9 percent) in 2000, to 54,749 (9.1 percent) in 2010. The majority of Hispanics or Latinos in the District reside in Ward 1 (15,827 or 20.8 percent), followed closely by Ward 2 (14,179 or 18.7 percent). The District Government established the Office of Latino Affairs in 1976 in response to a growing Latino population.

Source:

District of Columbia Government. *INDICES 2011: A Statistical Index of District of Columbia Government Services*. DC Office of Planning, December 2011.

District of Columbia Government. *District of Columbia Census 2010 Atlas*. DC Office of Planning, July 2012.

Lee, Barrett A., John Iceland, and Gregory Sharp. "Brown University: Racial and Ethnic Diversity Goes Local." Sep 2012. Council on Foreign Relations. Mar 2013. http://www.s4.brown.edu/us2010/Data/Report/report08292012.pdf

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

Table 2. Population by Race and Hispanic Origin, District of Columbia, Census 2000 and 2010

Race and Hispanic or Latino Origin	2000		2010		Change, 2000 to 2010	
	Number	Percent of Total Population	Number	Percent of Total Population	Number	Percent
ALL AGES						
RACE						
Total Population	**572,059**	**100.0%**	**601,723**	**100.0%**	**29,664**	**5.2%**
One Race	558,613	97.6%	584,407	97.1%	25,794	4.6%
White	176,101	30.8%	231,471	38.5%	55,370	31.4%
Black or African American	343,312	60.0%	305,125	50.7%	-38,187	-11.1%
American Indian and Alaska Native	1,713	0.3%	2,079	0.3%	366	21.4%
Asian	15,189	2.7%	21,056	3.5%	5,867	38.6%
Native Hawaiian and Other Pacific Islander	348	0.1%	302	0.1%	-46	-13.2%
Some Other Race	21,950	3.8%	24,374	4.1%	2,424	11.0%
Two or More Races	13,446	2.4%	17,316	2.9%	3,870	28.8%
HISPANIC OR LATINO RACE						
Total Population	**572,059**	**100.0%**	**601,723**	**100.0%**	**29,664**	**5.2%**
Hispanic or Latino (of any race)	44,953	7.9%	54,749	9.1%	9,796	21.8%
Not Hispanic or Latino	527,106	92.1%	546,974	90.9%	19,868	3.8%
One Race	517,522	90.5%	534,324	88.8%	16,802	3.2%
White	159,178	27.8%	209,464	34.8%	50,286	31.6%
Black or African American	340,088	59.4%	301,053	50.0%	-39,035	-11.5%
American Indian and Alaska Native	1,274	0.2%	1,322	0.2%	48	3.8%
Asian	15,039	2.6%	20,818	3.5%	5,779	38.4%
Native Hawaiian and Other Pacific Islander	273	0.0%	216	0.0%	-57	-20.9%
Some Other Race	1,670	0.3%	1,451	0.2%	-219	-13.1%
Two or More Races	9,584	1.7%	12,650	2.1%	3,066	32.0%

Source: US Census Bureau, Census 2000 and 2010 data.

Table 3. Population by Ward, District of Columbia, Census 2000 and 2010

Geography Area	Population Number		Population Change, 2000 to 2010	
	2000	2010	Number	Percent
District of Columbia	**572,059**	**601,723**	**29,664**	**5.2%**
WARD				
Ward 1	73,364	76,197	2,833	3.9%
Ward 2	68,869	79,915	11,046	16.0%
Ward 3	73,718	77,152	3,434	4.7%
Ward 4	75,179	75,773	594	0.8%
Ward 5	71,440	74,308	2,868	4.0%
Ward 6	68,035	76,598	8,563	12.6%
Ward 7	70,527	71,068	541	0.8%
Ward 8	70,927	70,712	-215	-0.3%

Note: Census 2000 counts are as published in Census 2000 reports and thus do not include any changes published subsequently due to boundary changes or to the Count Question Resolution program. Census 2010 data are as published before redistricting of wards.

Source: US Census Bureau, Census 2000 Redistricting Data (Public Law 94-171) Summary File, Table PL1, and Census 2010 Redistricting Data (Public Law 94-171) Summary File, Table P1.

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

Women. In 2010, more than half (317,501 or 52.8 percent) of District residents were women. Between 2000 and 2010, the female population grew at a slightly slower rate (4.9 percent) than the male population (5.5 percent). This resulted in a sex ratio of 89.5 males per 100 females in the District. Figure 2 shows more females to males in the pink and darker pink shaded areas, while males dominate the central parts of the city, and in Ward 8 where Bolling Air Force Base is located.

Children. In 2010, there were 100,815 children younger than 18 years of age in the District. This represented a significant decrease in the number and percent of children younger than 18 years, from 114,992 or 20 percent in 2000 to 100,815 or 16.8 percent in 2010. The largest decrease by five-year age grouping was the 5-9 year old group, which decreased by 9,238 or 26 percent between 2000 and 2010.

Older Adults. In 2010, about 16.4 percent (98,512) of the District's population were people 60 years old and older, a slight increase from 16.1 percent (91,878) in 2000. District resident seniors are projected to grow by 17.4 percent in 2030. Much of this growth is attributed to the baby boomer generation, individuals born between 1946 and 1964. In 2010, more than 35,107 clients were served by DC Office on Aging (OoA) and its grantee agencies. The most requested services by seniors were counseling, congregate and home delivered meals, transportation, wellness service, and case management.

Figure 2. Sex Ratio, 2010

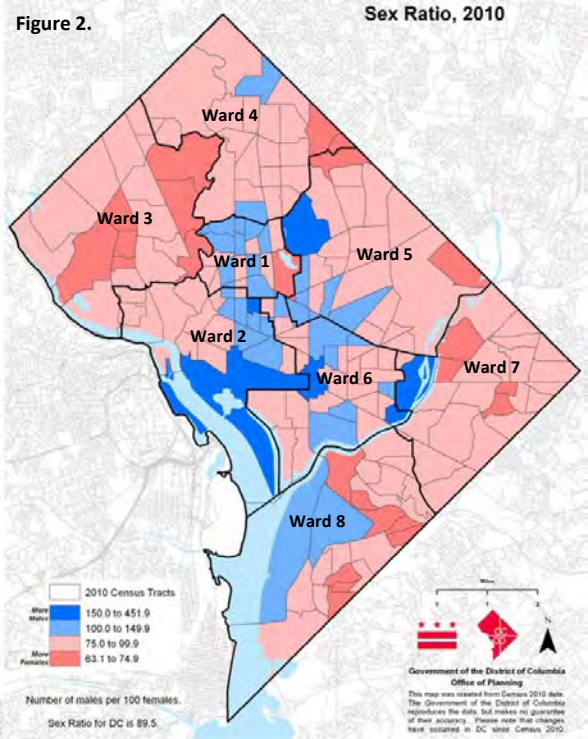


Figure 3. Percent Population Under 18 Years, 2010

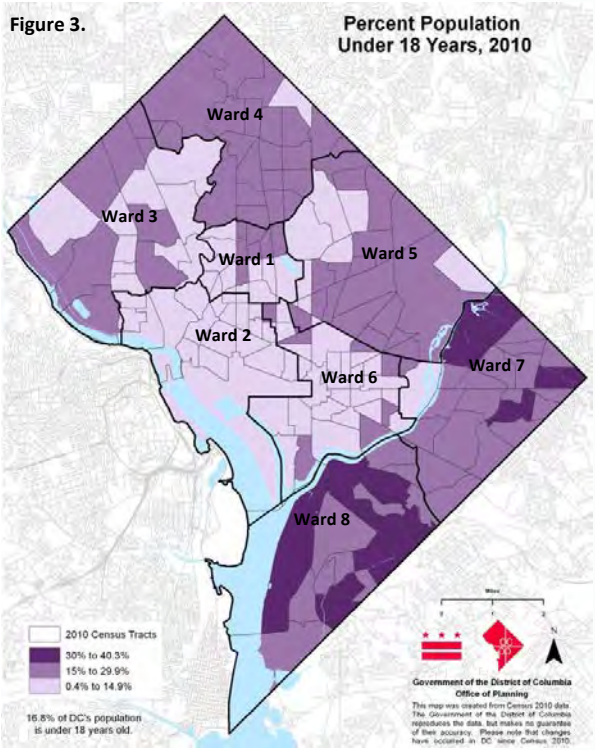
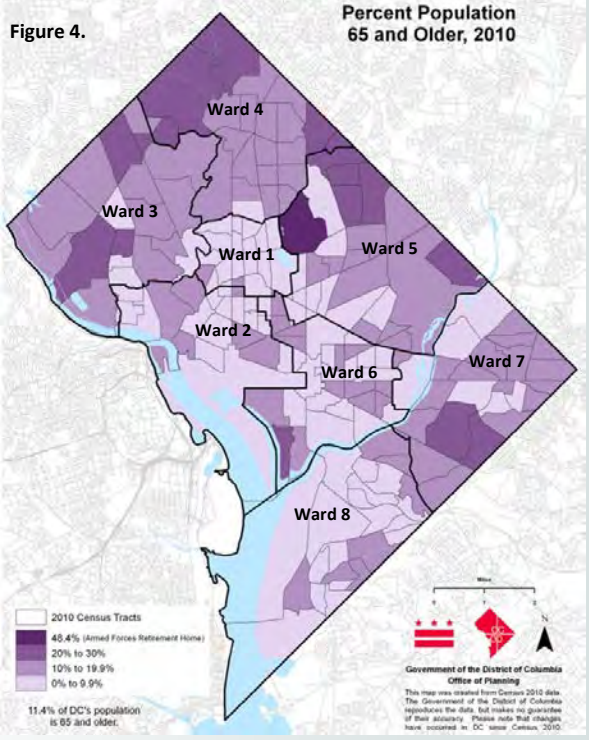


Figure 4. Percent Population 65 and Older, 2010



Source:

District of Columbia Government. *District of Columbia Census 2010 Atlas*. DC Office of Planning, July 2012.

District of Columbia Government. *INDICES 2011: A Statistical Index of District of Columbia Government Services*. DC Office of Planning, December 2011.

District of Columbia Government. *Senior Needs Assessment*. DC Office on Aging 2012.

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

Socio-economic Factors. Social and economic factors such as income, poverty status, marital status, living arrangements, and education are known to affect health conditions in several ways. Low socio-economic status (SES) is a shorthand label that encompasses individuals and family groups who have low paying jobs or are unemployed, families and individuals living in substandard housing, and families more likely to have only a single parent in residence. Health disparities almost always exist between poor people and those with higher incomes. For example, the risk of death from heart disease is more than 25 percent higher for low-income people than for the overall population. Planning to improve health must take into consideration SES factors that may act as barriers to the implementation of health policy and interventions.

Income. Median family and per capita incomes in the District have always been relatively higher when compared to the US. According to the US 2010 American Community Survey 1-year estimates, the District of Columbia's median household income was listed at $60,903 compared to the US median of $50,046. Households living in census tracts in Ward 3 and pockets of census tracts in Wards 2, 4 and 6 showed higher income levels than the rest of the city, regardless of race or ethnicity.

Figure 5. Median Household Income, ACS 2006-2010

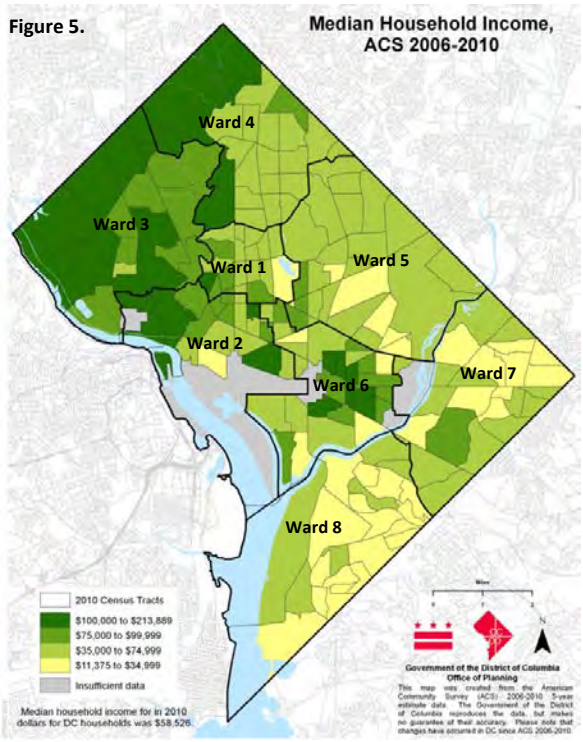
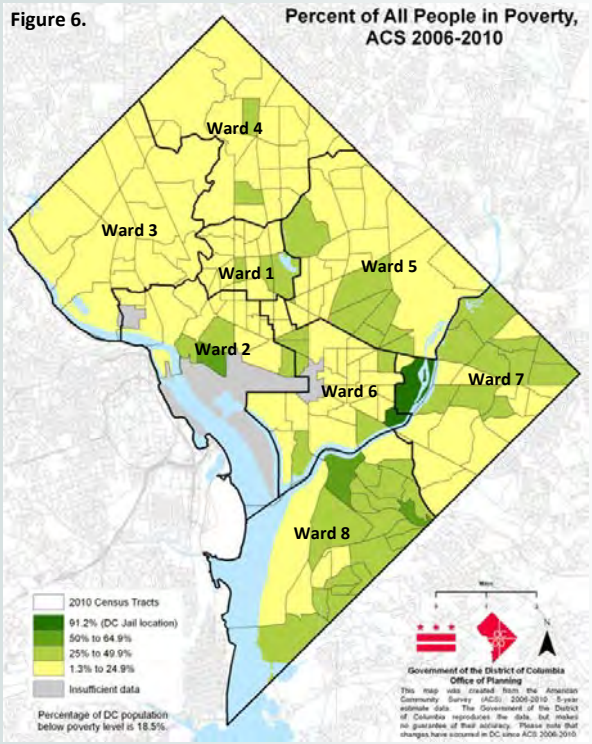


Figure 6. Percent of All People in Poverty, ACS 2006-2010



Poverty. The poverty rate in the District of Columbia is listed at 22.5 percent for 2010, up from 20 percent in 2000. In general, poverty rates are higher in the eastern half of the city, but pockets of high poverty exist elsewhere, mainly as a result of a high group quarters population. As illustrated on Figure 6, poverty rates by census tract ranged from 1.3 percent to as high as 91.2 percent. It must be noted that the census tract with a poverty rate of 91.2 percent represents the Central Detention Facility (CDF/DC Jail) with all group quarters population. Similarly, the next highest poverty rate was recorded at 64.7 percent with this census tract housing mainly students in university dormitories.

Marital Status. There were 1,900 marriages in the District of Columbia in 2009. In 2009 the marriage rate per 1,000 population was 4.7 compared to the rate of 4.9 in 2000[1]. Using the percent of births to married women as a proxy, 44.7 percent of the women who gave birth in 2010 were married. The US 2010 American Community Survey 1-year estimates indicate that among male population 15 years and older (243,152), 58.9 percent or 143,315 residents were never married, compared to 68,482 or 28.2 percent who were married.

Source:

District of Columbia Government. *INDICES 2011: A Statistical Index of District of Columbia Government Services*. DC Office of Planning, December 2011.

District of Columbia Government. *District of Columbia Census 2010 Atlas*. DC Office of Planning, July 2012.

[1]US National Center for Health Statistics, National Vital Statistics Report (NVSR), *Births, Marriages, Divorces, and Deaths: Preliminary Data for 2009*, Vol. 58, No. 25, August 2010, and prior reports.

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

Education. Educational attainment for the period 2006-2010 shows 86.5 percent of the population 25 years and over had at least graduated from high school (Figure 7) and 49.2 percent had a bachelor's degree or higher (Figure 8). In 2010, 54,702 (13.8 percent) of District residents had some college experience but no degrees; 13,337 residents or 3.2 percent had associate degrees; 96,573 (23.2 percent) had obtained a bachelor's degree; and 112,251 (26.9 percent) had a graduate or professional degree. Over the past 10 years in the District, there were no significant changes in educational achievement for residents who attained their high school diplomas, some college but no degrees, and associate degrees, but a notable increase was observed for residents who attained a bachelor's degree or graduate or professional degree.

Unemployment. Unemployment statistics are strong indicators of residents' ability to obtain adequate health care. Most people obtain health insurance coverage through their jobs and lose coverage when they become unemployed. According to the American Community Survey (ACS), the unemployment rate for the District in 2010 was 8.2 percent. From 2005-2009, Ward 7 had the highest unemployment rate (19 percent), followed by Ward 8 (17 percent), and Ward 5 (13 percent) (Figure 9). Unemployment also has implication for stress, poor nutrition, poor living conditions, and other factors that may affect the health and well-being.

Figure 9. Percent Unemployment by Ward, ACS 2005-2009

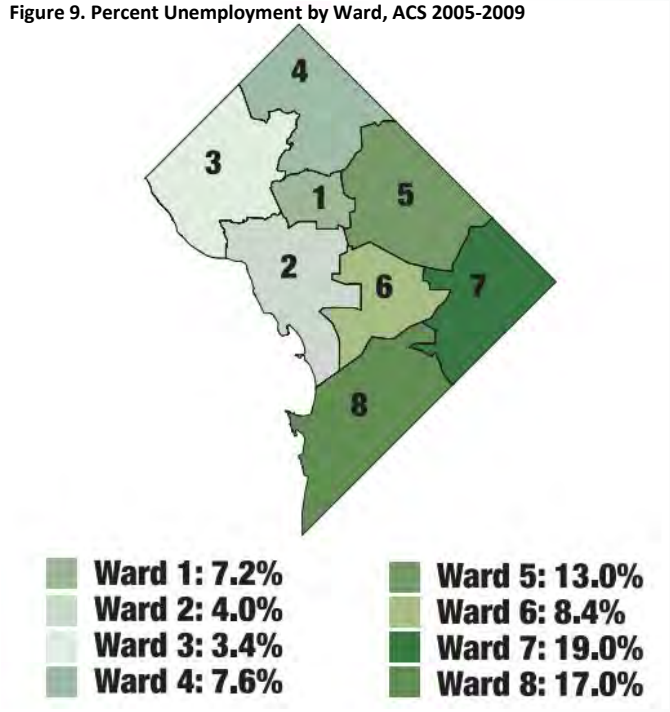


Figure 7. Percent Completed High School, ACS 2006-2010

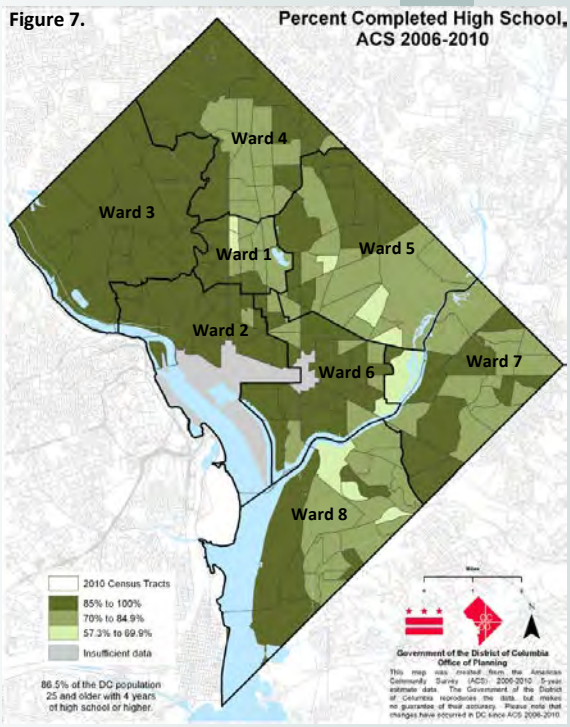
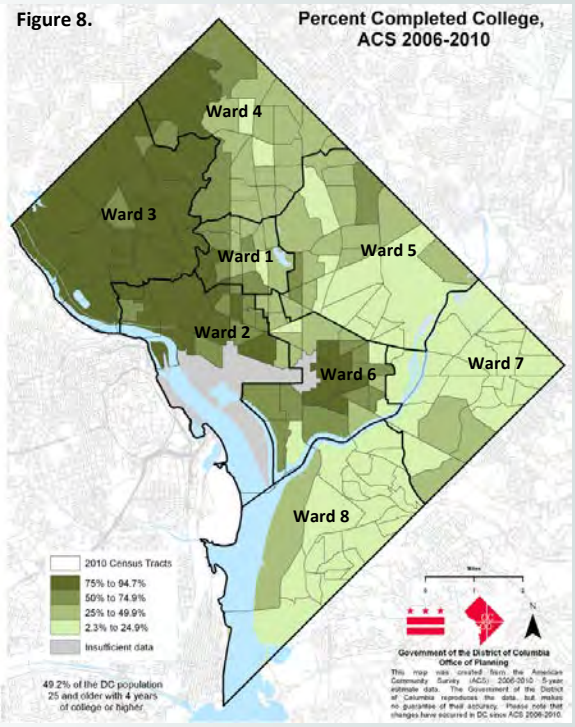


Figure 8. Percent Completed College, ACS 2006-2010

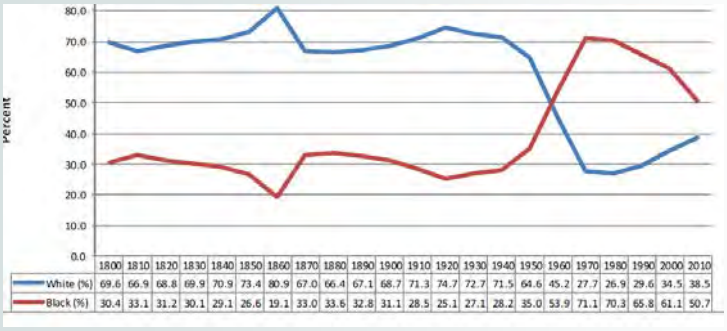


Source:
District of Columbia Government. *District of Columbia Census 2010 Atlas*. DC Office of Planning, July 2012.
Sustainable DC Plan, available at http://sustainable.dc.gov/sites/default/files/dc/sites/sustainable/page_content/attachments/SDC%20Final%20Plan_0.pdf

POPULATION TRENDS

Racial and ethnic composition in DC is constantly changing.

Figure 10. Percentage of District Population by Selected Race Categories, 1800-2010



Population growth rate was faster in the working-age group than in other ages.

- While the population of seven of the eight Wards in the District grew between Census 2000 and 2010, Ward 2 and Ward 6 experienced the most growth (16 percent and 12.6 percent, respectively). Ward 8 lost 215 people during the decade.
- Unlike the US population which is aging, given an increase in median age of 1.9 years between 2000 and 2010, the District's population is trending younger.
- While the District lost population among its youngest (5-14 years) and oldest population groups (65 years and over), the tremendous increase in number and percent in the 20-34 years age group more than accounted for these losses and contributed to a lower median age.
- This large, younger cohort seems to have been attracted to the area because of job opportunities and lifestyle.
- In 2010, the median age of the District's population decreased to 33.8 years, from 34.6 years in 2000.
- The youngest population by median age was in Ward 8 (29.6 years) and Ward 2 (29.9 years).
- Ward 4 had the oldest median age at 40 years, followed by Ward 5 at 38.2 years.

Source:

District of Columbia Government. *INDICES 2011: A Statistical Index of District of Columbia Government Services*. DC Office of Planning, December 2011.

US Census. The Washington Post. May 4, 2011.

The fluctuations in the District's population since the 1800's have been influenced by many factors including the abolition of slavery (1865), the expansion of the Federal government during and after World Wars I and II, and the Civil Rights movement (peak 1955-1968). For Black residents in the District, both the highest number and percentage of people were recorded in the 1970 Census when the Black population peaked at 537,712, accounting for 71.1 percent of the District's population.

- The District remains a majority Black or African American population enclave from 2000 to 2010. However, the number and proportion of Blacks or African Americans are declining, while the number and proportion of Whites and other races, except for Native Hawaiian and other Pacific Islanders, are increasing.
- The Hispanic population is also increasing. The number of Hispanics and Whites living in the District grew by 21.8 and 31.4 percent, respectively, while the number of Black residents in the District of Columbia dropped by 11.1 percent.

Figure 11. Population Growth of Ages 20-34 by Ward, 2000-2010

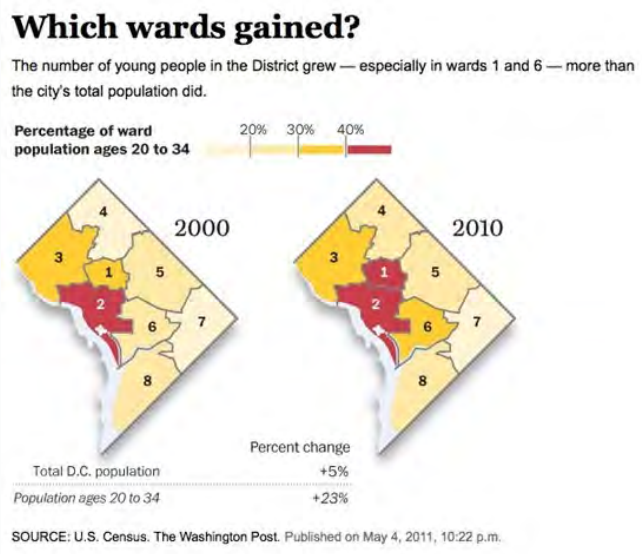
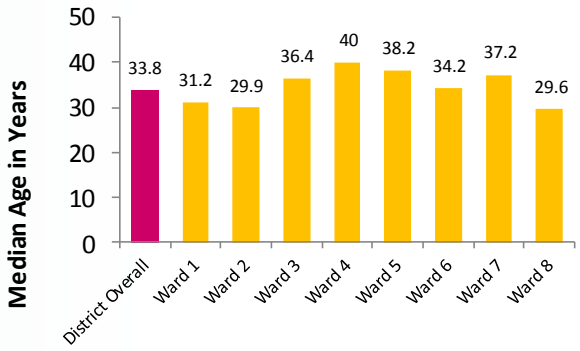


Figure 12. Median Age by District of Columbia Wards, 2010



Source: DC Office of Planning/State Data Center

DISCUSSION OF DATA AND TRENDS WITH FOCUS ON *ONE CITY* PRIORITY AREAS

MORTALITY AND LIFE EXPECTANCY

The District recently reduced its Infant Mortality Rate (IMR) to eight infant deaths per 1,000 live births—the lowest it has been in decades. The IMR is the best known indicator of a community's health status and this historic low and positive trend in the District's IMR indicates that we are on track to achieve the ambitious goal set 10 years prior. As outlined in the One City Action Plan's strategies to improving the quality of life for all, the Department of Health (DOH) will continue to utilize the Infant Mortality Action Plan in the following three ways: (1) increasing the capacity of home visitation for pregnant women; (2) enhancing collaboration within DOH and between other agencies, and (3) increasing coordination between the government and community organizations. In conjunction with these efforts, DOH will for the first time conduct multidisciplinary studies based on the unique collaboration between market research and public health data. Geographically summarized demographic data on lifestyle preferences, spending habits and on health care utilization will enable DOH to make data-driven decisions targeting areas with high infant mortality rates in the District.

Mortality data in this report can be used to monitor and evaluate the health status of the District of Columbia in terms of current mortality levels and long-term mortality trends, as well as to identify segments of the population at greatest risk of death from specific diseases and injuries. Differences in death rates among demographic groups, including racial and ethnic groups, may reflect group differences in factors such as socioeconomic status, access to medical care, and the prevalence of risks specific to a particular group. Measures of mortality in this report include infant mortality, life expectancy, the number of deaths, crude, and age-adjusted death rates. The populations used to calculate death rates for 2010 shown in this report were produced under a collaborative arrangement with the DC Office of Planning, State Data Center and the US Census Bureau and are based on counts for the 2010 Census.

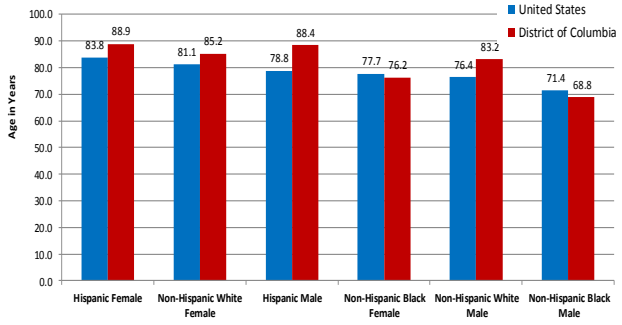
LIFE EXPECTANCY

Life expectancy has improved for all DC residents, regardless of sex and race.

Life expectancy, the average age to which a newborn is expected to live, is considered a fundamental measure of a community's health. As with decreasing mortality rates, increasing life expectancy over time can signal improved health in a population.

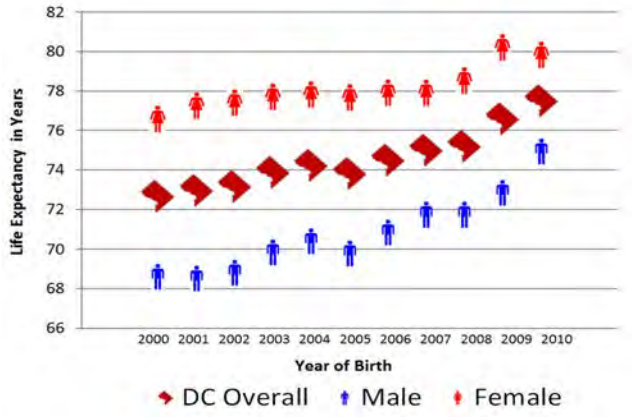
- In the District of Columbia, average life expectancy has climbed to a historic high of 77.5 years in 2010, a 10-year gain from the life expectancy in the early 1990's.
- District residents are expected to live 1 year shorter than the average United States resident. In 2010, life expectancy in the United States was 78.7 years, compared to 77.5 years in the District.

Figure 13. Life Expectancy at Birth, by Hispanic Origin, Race, and Sex: District of Columbia and United States, Preliminary 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 14. Life Expectancy at Birth, DC Overall and by Gender, 2000-2010

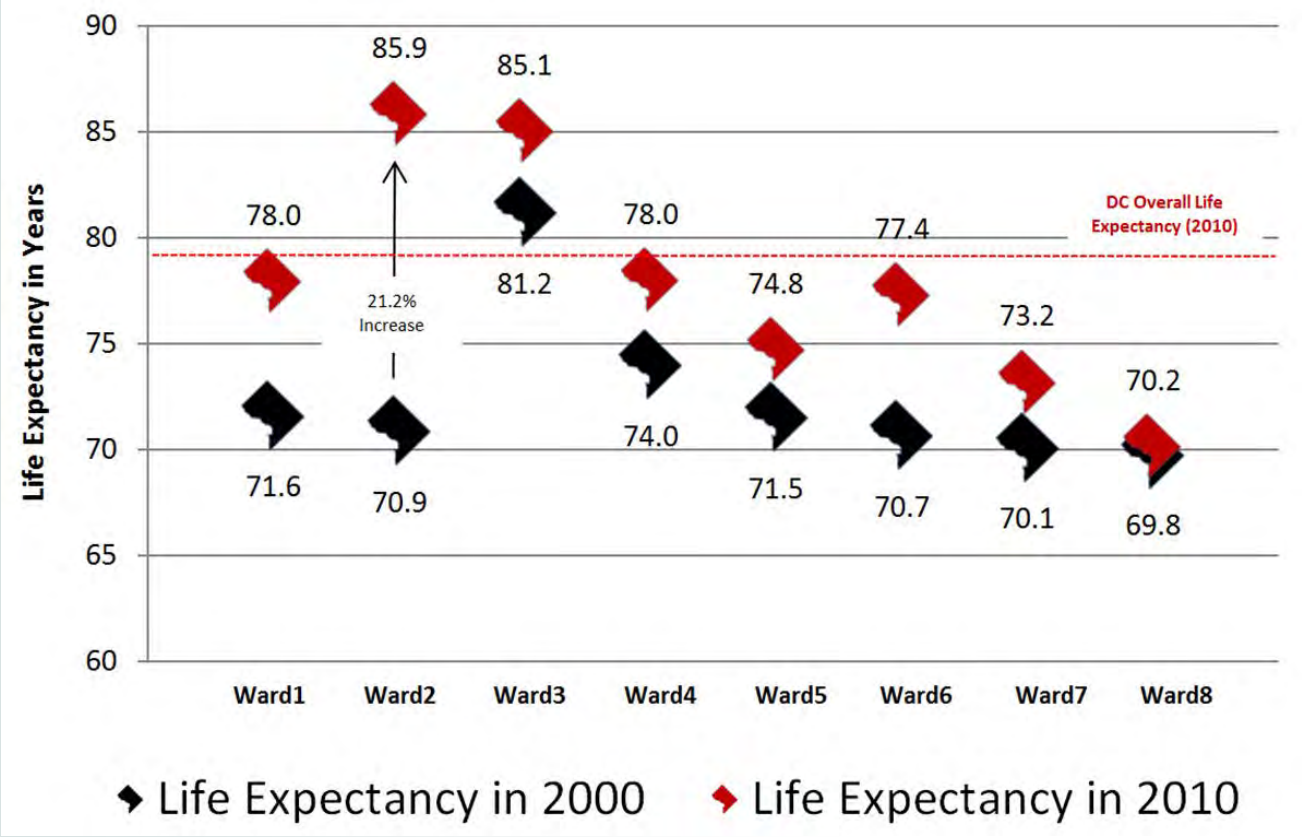


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

- Hispanic females were expected to live the longest in the District (88.9 years), trailed closely by Hispanic males (88.4) years. Hispanic females in the United States were expected to live to 83.8 years, on the average.
- Non-Hispanic white female DC residents had the third highest life expectancy (85.2 years), followed by non-Hispanic white males (83.2 years).
- Non-Hispanic black males and females had the lowest life expectancy in the District, at 68.8 and 76.2 years, respectively.
- The largest differential is between Hispanics and non-Hispanic blacks, the former having an advantage of 19.6 years in men and 12.7 years in women.
- Women live longer than men in the District; however the life expectancy disparity between men and women has narrowed to 5 years in 2010. Life expectancy for male and female DC residents in 2010 were 74.9 and 79.8 years, respectively. In 1990, men and women born in the District were expected to live 61.8 and 73.9 years, respectively, a 12-year gap.
- Although life expectancy is lower for black than for white DC residents, the gains in life expectancy during the past decade have been greater for blacks. From 1989 to 2009, life expectancy rose 10.4 years for black men and 7.9 years for white men. It went up 6.1 years for black women and 4.2 years for white women.
- Of all the subgroups, black males born in the District have the lowest life expectancy in 2010. They are expected to live an average of 68.7 years. In 1990, the average black male born in the District were not expected to reach the age of 60.
- Overall gains in life expectancy could be explained by a combination of factors, such as reductions in infant mortality, effectiveness of medical interventions, improvements in public health-related policy, and availability of health insurance in the District.
- For many reasons, the District is increasingly becoming a transient city, therefore migration, shift in the resident population, and urbanization also play key roles in life expectancy.

LIFE EXPECTANCY BY WARD

Figure 15. Life Expectancy at Birth by Ward, 2000-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Life expectancy has improved for all DC residents, regardless of ward of residence.

- Residents in all wards of the District are expected to live longer than residents born in 2000.
- In 2010, Wards 2 and 3 have the longest life expectancy (85.9 and 85.1 years, respectively). Wards 7 and 8 have the shortest life expectancy in 2010 (73.2 and 70.2 years, respectively).
- Ward 2 residents saw the highest climb in life expectancy (21.2 percent) from 2000 to 2010. Residents in Ward 2 born in 2010 are expected to live 15 years longer than those born in 2000.
- This may be explained by significant gains in the number of residents (16 percent growth from 2000-2010), lower mortality rate, an influx of younger people (median age of 29.9 years), and a growing Hispanic population (18.7 percent).
- Between 2000 and 2010, Ward 6 gained 6.7 years in life expectancy, the second highest increase (9.5 percent) among all wards.
- Gains in life expectancy for Wards 1, 3, 4, 5, 7, and 8 were 6.4, 3.9, 4.0, 3.2, 3.1, and 0.4 years, respectively.
- In 2010, residents in Wards 5, 6, 7, and 8 have a shorter life expectancy than the average DC resident (77.5 years).
- Although each ward improved in expected longevity within the past decade, Ward 8 residents are expected to live an average of half a year longer from 2000 to 2010 (69.8 years to 70.2 years, respectively).
- This may be explained by a loss in the number of residents (-0.3 percent from 2000 to 2010) and high mortality rate due to specific causes of death.

Note:

Life expectancy computation relies heavily on a mathematical relationship between the number of deaths and residents in a given population, therefore estimates by ward must be treated with caution. For example, wards with large Hispanic populations are likely to inflate their life expectancy as a result of Hispanic origin misclassification in the death certificate.

INFANT MORTALITY

The District achieved its Healthy People 2010 objective of reducing infant mortality to no more than 8 infant deaths per 1,000 live births.

District of Columbia	Rate per 1,000 Live Births
Five-year Comparison	
2006	11.3
2007	13.1
2008	10.9
2009	9.9
2010	8.0
City Comparison	
Baltimore City, Maryland	11.0
Detroit City, Michigan	13.5
District of Columbia	8.0
Richmond, Virginia	12.8
Ward Comparison	
Ward 1	4.1
Ward 2	2.9
Ward 3	5.0
Ward 4	11.3
Ward 5	10.3
Ward 6	9.8
Ward 7	6.6
Ward 8	10.4
Total	8.0
Mother's Race/Ethnicity	
Race	
Black	10.7
White	4.9
Asian/Other	1.0
Ethnicity	
Non-Hispanic Black	10.5
Non-Hispanic White	5.3
Hispanic	3.7

Mother's Age	Percentage of Total Infant Deaths
< 20	5.5
20-24	16.4
25-29	17.8
30-34	28.8
35-39	26.0
40+	5.5

Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

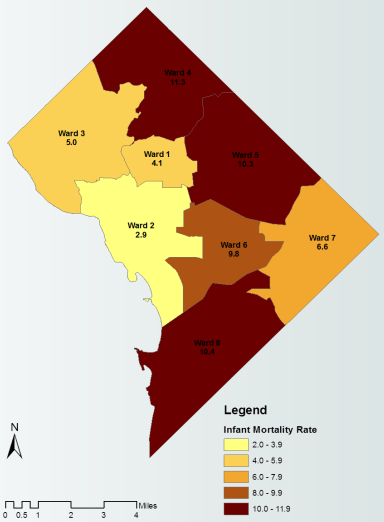
The infant mortality rate (IMR) is the most commonly used index for measuring the risk of dying during the first year of life. The rates presented in this report are calculated by dividing the number of infant deaths that occurred during 2010 by the number of live births for the same period and are presented as rates per 1,000 live births.

- For every 1,000 live births to District of Columbia residents in 2010, approximately eight infants died before reaching their first birthday. In 2010, there were 73 infant deaths in the District, resulting in an IMR of 8.0 per 1,000 live births, a 29.2 percent decline since 2006 and a historic low for the District.
- The District's IMR is comparable to cities of similar size and population mix. Compared to Baltimore (MD), Detroit (MI), and Richmond (VA), the District's rate has followed a downward trend and consistently ranked lowest in 2006, 2009, and 2010.
- In 2010, the IMR in Wards 1, 2, 3, and 7 were lower than the DC rate (8.0 per 1,000); the IMR in Wards 1, 2, and 3 were lower than the national rate (6.1 per 1,000).
- From 2009 to 2010, IMR decreased in Wards 1, 2, 5, 7 and 8 but increased in Wards 3, 4 and 6.
- Ward 8 had the largest meaningful decrease from 28 infant deaths in 2009 to 17 in 2010.
- Ward 4 had the highest IMR in 2010, followed by Ward 8 and Ward 5, respectively.
- Of the 3 wards with high IMR, Ward 4 had the oldest mothers, with a mean age of 33.4 years (Range: 29 to 41 years). Two-thirds of infant deaths in Ward 4 occurred to mothers aged 30-39 years.
- Age of mother plays a critical role in pregnancy and infant health. In 2010, a total of 40 infants (55 percent of all 73 infant deaths) died to mothers 30-39 years of age in the District. Thirty-two of these 40 infants (80 percent) were low birth weight.

Note:

Due to the small number of infant deaths by ward, caution should be exercised when interpreting the percentage increase in the infant mortality rate, which is highly variable and does not meet standards of reliability or precision.

Figure 16. Map of Infant Mortality Rate by Ward, 2010



INFANT MORTALITY TRENDS

In 2010, the District of Columbia's infant mortality rate (IMR) was 31 percent higher than the national rate.

- The infant death rate to non-Hispanic white mothers was 2.9 per 1,000 live births in 2006 and 5.3 for 2010, an increase of 82.7 percent (13 infant deaths in 2010 to District residents). This was slightly higher than the national rate (5.1 per 1,000 non-Hispanic white live births).
- The infant death rate to non-Hispanic black mothers decreased from 17.4 per 1,000 live births in 2006 to 10.5 per 1,000 live births in 2010, a decrease of 39.7 percent. For the first time, the DC rate for infant mortality in black mothers was lower than the US rate (12.0 per 1,000 non-Hispanic black live births).
- Overall reduction in IMR in the District may be explained by declines in infant deaths to black mothers.
- The leading cause of infant mortality was Congenital malformations, which accounted for 15.8 percent, followed by maternal complications of pregnancy (15.6 percent), and short gestation/ low birth weight (14.6 percent).

Figure 17. Infant Mortality Rate by Race/Ethnicity, 2006-2010

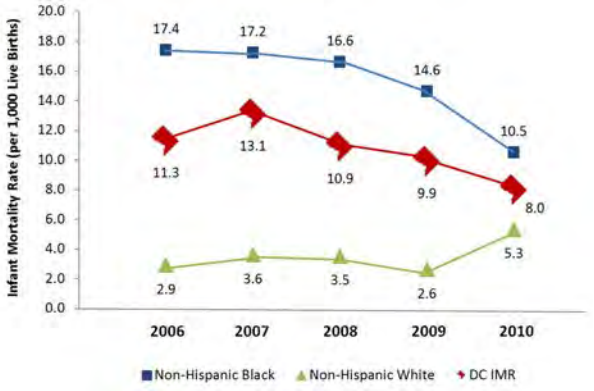
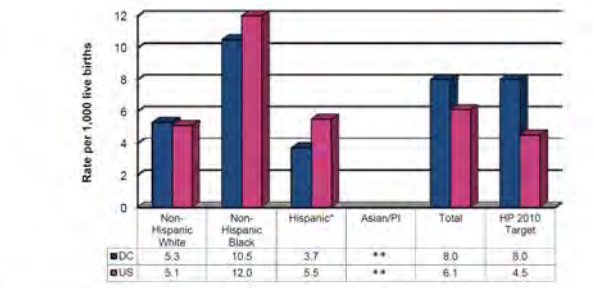


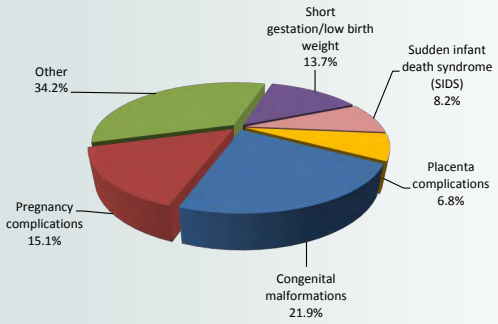
Figure 18. Infant Mortality Rate by Race/Ethnicity, DC and US, 2010



	Non-Hispanic White	Non-Hispanic Black	Hispanic*	Asian/PI	Total	HP 2010 Target
DC	5.3	10.5	3.7	**	8.0	8.0
US	5.1	12.0	5.5	**	6.1	4.5

*Hispanics include persons of all Hispanic origin of any race.
**Rates not computed due to small number of infant deaths and, therefore, are likely to be unstable.
Sources: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, DC Department of Health
National Center for Health Statistics: http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf

Figure 19. Infant Mortality by Cause of Death, 2010

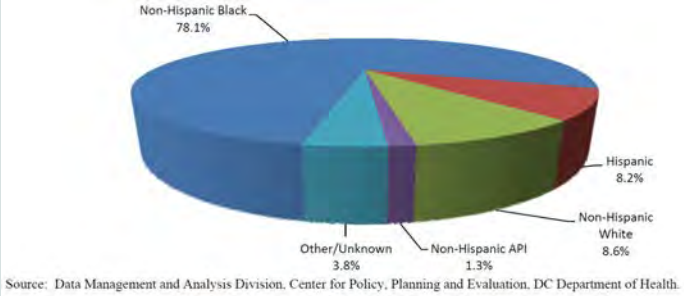


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Non-Hispanic black infants account for a disproportionate percentage of all infant deaths.

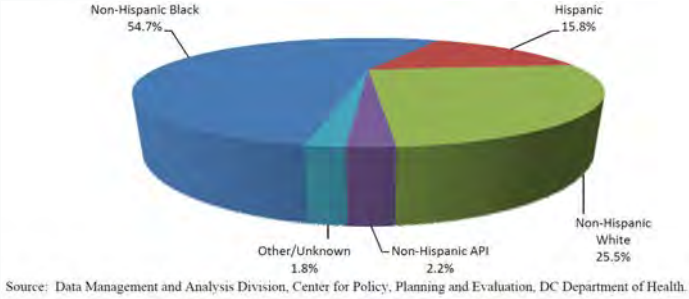
- In 2006-2010, the disparity ratio of non-Hispanic black to non-Hispanic white IMR was 4.3, which means an infant born to a non-Hispanic black mother was 4.3 times more likely to die before reaching its first birthday as an infant born to a non-Hispanic white mother. If non-Hispanic black IMR were reduced to the non-Hispanic white IMR level, 39 deaths would have been prevented.
- On average between 2006 to 2010, infants to non-Hispanic black mothers disproportionately died (78.1 percent) compared to their total number of births (54.7 percent).

Figure 20. Infant Deaths by Race/Ethnicity of Mother, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, DC Department of Health.

Figure 21. Births by Race/Ethnicity of Mother, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, DC Department of Health.

FACTORS CONTRIBUTING TO INFANT MORTALITY

Reduction in the District's teen births and the expansion and increased access to the District's primary care (prenatal) services have contributed to the declining trend in infant mortality.

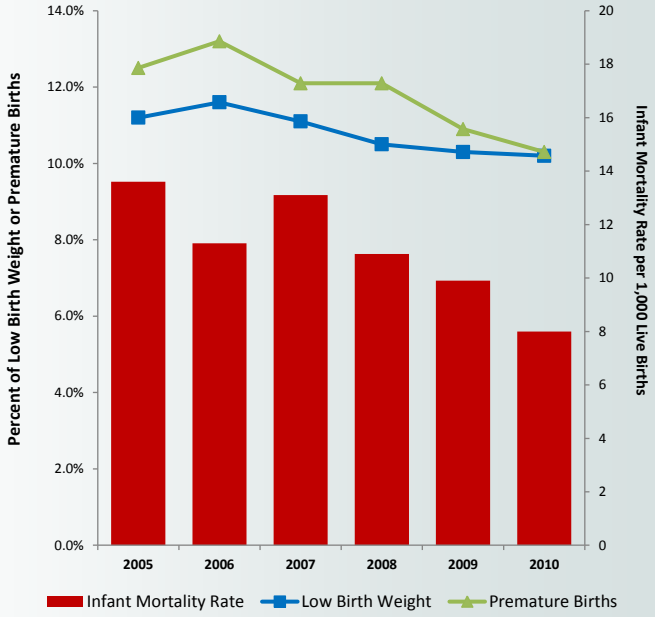
Vital statistics over the years have indicated that factors such as low birth weight (under 2,500 grams), prematurity (under 37 weeks of gestation), and lack of adequate prenatal care are associated with infant mortality. Other factors such as race/ethnicity, maternal age, and marital status may also be associated with infant mortality.

- Teen births (births to mothers under 20 years of age) have decreased in the last 5 years, after peaking in 2008.
- Pregnancy outcomes such as low birth weight and prematurity have also demonstrated a downward trend from 2005-2010.
- Early, high-quality prenatal care (PNC) is one of the cornerstones of a safe motherhood program, which begins before conception, continues with appropriate PNC and protection from pregnancy complications, and maximizes healthy outcomes for infants and mothers[1]. Women who receive late (third trimester of pregnancy[2]) or no PNC do not receive timely preventive care or education and are at risk for having undetected complications of pregnancy that can result in severe maternal morbidity and sometimes death.
- The Community Health Administration (CHA) of DC DOH has provided home visitation services to pregnant women and new mothers since 1991. Recipients of these services include mothers from Wards 5, 6, 7, and 8. Since the launch of the Infant Mortality Citywide Action Plan in 2008, the number of home visits performed by DOH have more than doubled in Wards 7 and 8.

Figure 22. Births to Teen Mothers, 2006-2010

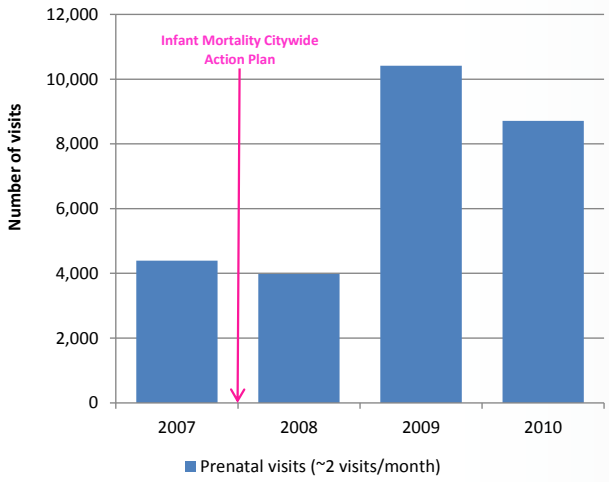
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 23. Infant Mortality, Low Birth Weight, and Premature Births, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 24. Home Visits to Mothers in Wards 7 and 8, 2007-2010



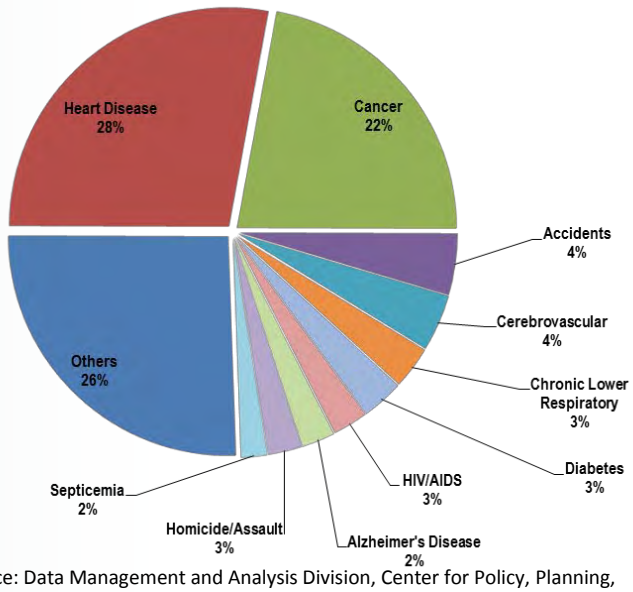
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

[1]Centers for Disease Control and Prevention. Entry Into Prenatal Care – United States, 1989-1997. MMWR 49(18):393–8. 2000.

[2]Osterman MJK, Martin JA, Mathews TJ, et al. Expanded data from the new birth certificate, 2008. National Vital Statistics Reports; vol 59 no 7. Hyattsville, MD: National Center for Health Statistics. 2011.

LEADING CAUSES OF DEATH

Figure 25. Leading Causes of Death for DC Residents, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

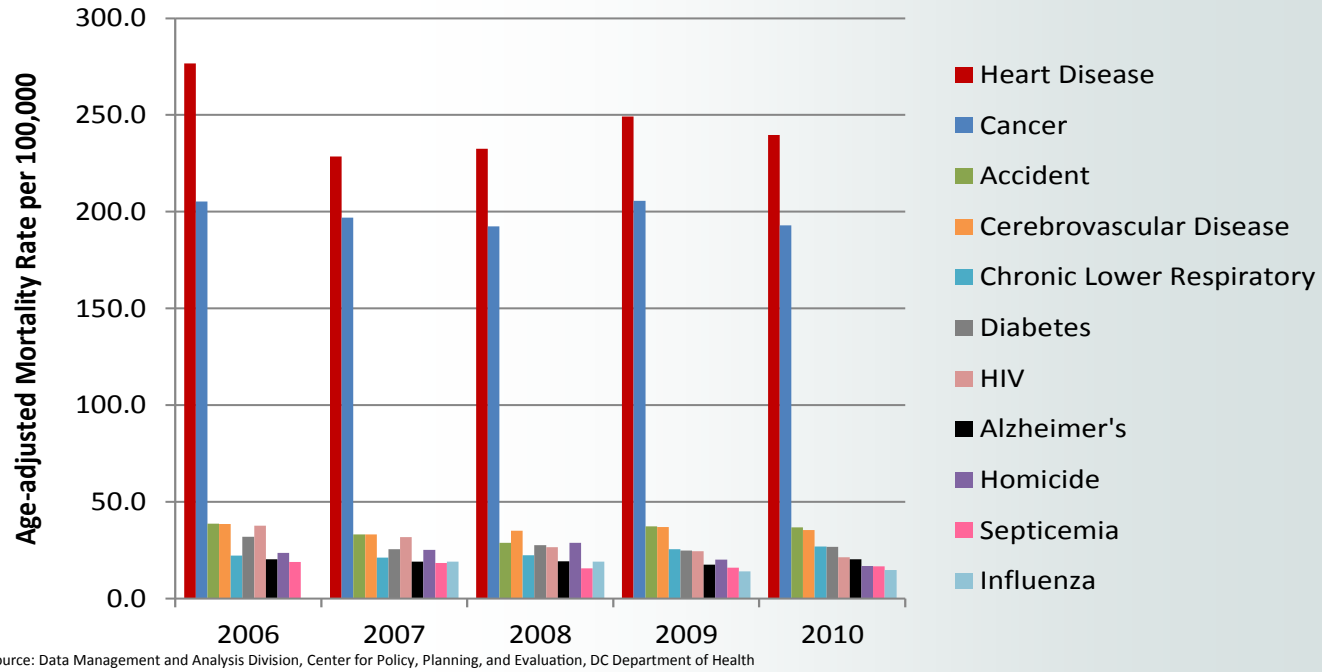
- In 2010, there were 4,670 deaths to residents of the District of Columbia. This represented a crude death rate of 776.1 per 100,000 population and an age-adjusted death rate of 793.5 per 100,000 US 2010 estimated population. The District's age-adjusted death rates are higher than the national rate but declining since 1994.
- In 2010, of the 4,670 resident deaths, 2,272 (48.6 percent) were males and 2,398 (51.4 percent) were females.
- Of the 4,670 DC resident deaths, 3,580 (76.7 percent) were blacks/African Americans and 1,016 (21.8 percent) were whites.
- In the District of Columbia, the 2010 crude death rate for males (799.4 per 100,000) remained higher than for females (755.3 per 100,000) and the 2010 rate for blacks/African Americans (1,173.3 per 100,000) was significantly higher than for whites (438.9 per 100,000).
- A disproportionate number of deaths occurred among blacks/African Americans (76.7 percent on average) in comparison to their share of the total population (approximately 50 percent). The top two leading causes of deaths for black/African American and white residents in 2010 were heart disease and cancer. Heart disease was the leading cause of death for men (221.7 per 100,000) and women (211.0 per 100,000 population).
- The average age among the leading causes of death reveals that decedents whose death was due to Alzheimer's Disease were the oldest, on average, and died at the median age of 89.2 while decedents who died as a result of Accidents or Homicide (Assault) were the youngest at under 1 year old.
- Among District residents in 2010, heart disease had the highest crude mortality rate (216.0 per 100,000 population) and age-adjusted mortality rate (221.4 per 100,000 population) killing 1,300 people or 27.8 percent of all resident deaths. Heart disease is the leading cause of death both for men (221.7 per 100,000) and women (211.0 per 100,000). The crude death rate for heart disease was the highest for Ward 5 (323.0 per 100,000), followed by Ward 7 (309.6 per 100,000), and the lowest crude death rate was in Ward 2 (87.6 per 100,000).
- In 2010, cancer was the second-ranked leading cause of death in both the United States and the District of Columbia. Of the 4,670 District resident deaths in 2010, 1,035 (22.2 percent) or a little more than one in five died from cancer with a crude death rate of 172.0 per 100,000 population and an age-adjusted rate of 177.1 per 100,000 population. Cancer affects residents in every ward, but Ward 5 (259.7 per 100,000 population) had the highest rate of deaths, followed by Ward 4 (213.8 per 100,000 population), and Ward 7 (212.5 per 100,000 population)
- In 2010, the age-adjusted rate for people dying in accidents was 34.9 per 100,000 population. In the District of Columbia deaths due to accidents ranked third. Males were more likely to die from accidents (47.5 per 100,000 population) as compared to females (23.9 per 100,000 population). Ward 5 (49.8 per 100,000 per population), followed by Ward 8 (46.7 per 100,000 population) and Ward 7 (45.0 per 100,000 population) had the highest mortality due to accidents in the city.
- Cerebrovascular diseases (age-adjusted rate of 32.4 per 100,000 population), which causes stroke, was the fourth leading cause of death in 2010 and also ranked fourth (age-adjusted rate of 39.0 per 100,000 population) in the United States. Wards 5 (51.1 per 100,000 population), Ward 7 (47.8 per 100,000 population), and Ward 4 (40.9 per 100,000 population) had the highest rates while Ward 2 had the lowest rate (10.0 per 100,000 population).
- Chronic Lower Respiratory Diseases (CLRD) such as chronic obstructive pulmonary disease (COPD) was ranked the fifth leading cause of death in the District of Columbia in 2010 (25.5 per 100,000 population age-adjusted death rate). Eighty-one percent of deaths due to CLRD were among the elderly (65 years and older). Ward 5 had the highest rate of 37.7 per 100,000 population while Ward 1 had the lowest mortality rate of 10.5 per 100,000 population.
- Diabetes (age-adjusted rate of 24.9 per 100,000 population) ranked as the sixth leading cause of death in the District of Columbia in 2010. In the District of Columbia, the crude death rate due to Diabetes for blacks/African Americans was 42.0 per 100,000 population which was seven times the rate for Whites, 6.0 per 100,000 population. Eighty-five percent of the deaths due to diabetes occurred to decedents 55 years or older. Ward 7 (43.6 per 100,000), Ward 8 (41.0 per 100,000), and Ward 5 (40.4 per 100,000) had the highest crude death rates while Ward 2 had the lowest mortality rate (6.3 per 100,000) in this category.
- Human Immunodeficiency Virus (HIV) ranked seventh leading cause of death in the District for 2010 with an age-adjusted death rate of 20.4 per 100,000 population. About 97 percent of decedents who died from HIV/AIDS were black; 78.5 percent were between the ages of 35 and 64. The rates in Ward 7 (42.2 per 100,000 population) and Ward 8 (31.1 per 100,000 population) were the highest. Ward 3 (0 per 100,000 population) had zero deaths due to HIV.
- Homicide was the eighth leading cause of death in the District of Columbia in 2010. The age-adjusted death rate in the District was 17.1 per 100,000 population. Most of the deaths due to homicide were (80.5 percent) were young in the age group 15 and 44; 89 percent of them were African Americans. Ward 8 (49.5 per 100,000) and Ward 7 (40.8 per 100,000) had the highest crude death rate of homicide while Ward 3 had the lowest (1.3 per 100,000 due to this cause.
- Alzheimer's disease ranked ninth leading cause in the District of Columbia in 2010 with an age-adjusted rate of 18.7 per 100,000 population. Ward 3 had the highest mortality rate of 35.0 per 100,000 compared to Ward 1 (3.9 per 100,000), which had the lowest mortality rate. As expected, the deaths due to Alzheimer's were the highest (75 percent) in decedents aged 85 or older.
- In 2010, septicemia was the 10th leading cause of death with an age-adjusted mortality rate of 15.3 per 100,000 population in the District of Columbia. Seventy-one percent of deaths due to septicemia were among the elderly (65 years and older); 88 percent were among African Americans. Ward 8 had the highest rate (31.1 per 100,000 population) whereas Ward 2 had the lowest rate (2.5 per 100,000 population).

MORTALITY TRENDS

The number of deaths to DC residents has dropped by 11.7 percent from 2006 to 2010.

Deaths due to Heart Disease and Cancer accounted for 50 percent of deaths in the District in the last 5 years.

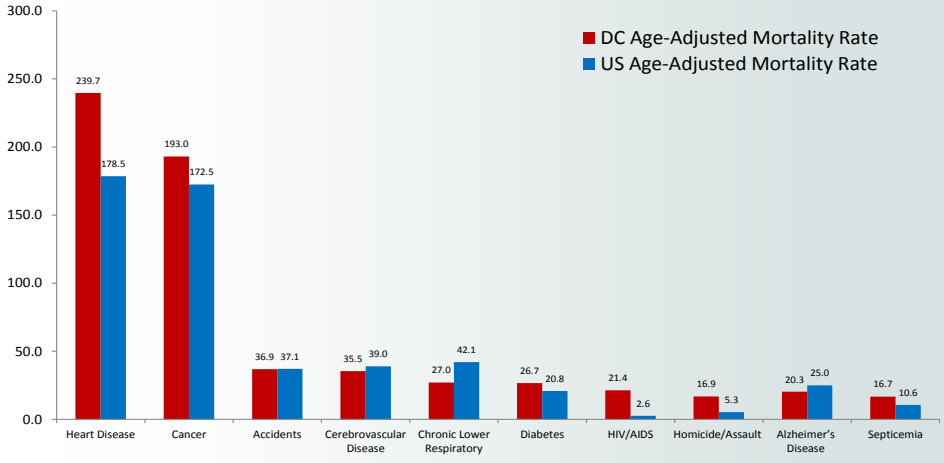
Figure 26. Leading Causes of Death, Age-adjusted Rates, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

- Heart Disease and Cancer have consistently ranked number 1 and 2 causes of death, respectively, in the District with fairly steady declines in the last 5 years.
- From 2006 to 2010, the age-adjusted mortality rates for Heart disease and Cancer decreased by 13.4 and 5.9 percent, respectively.
- The age-adjusted mortality rates for Heart Disease and Cancer in the District were higher than the national rates in 2010.
- Age-adjusted mortality rates for Accidents, Cerebrovascular Disease, Chronic Lower Respiratory Disease, and Alzheimer's Disease in the District were lower than the national rates in 2010.
- Despite a 43.2 percent drop in the HIV age-adjusted mortality rate from 2006 to 2010, the DC rate was 8.2 times higher than the national rate in 2010.
- The age-adjusted mortality rate for Homicide in the District decreased by 28.7 percent from 2006 to 2010; however, the DC rate was 3.2 times higher than the national rate in 2010.

Figure 27. Leading Causes of Death, Age-adjusted Rates, DC and US, 2010



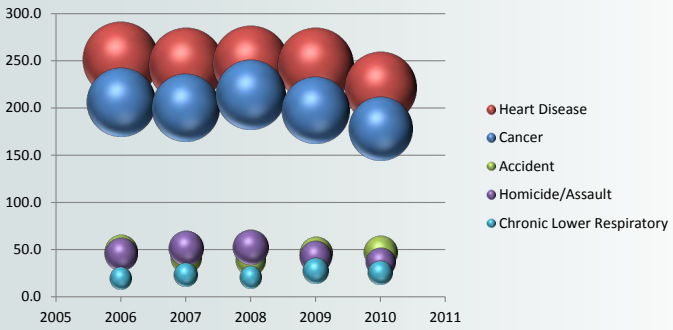
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

MORTALITY TRENDS

Heart disease and Cancer are the two leading causes of death among District residents, regardless of sex and race.

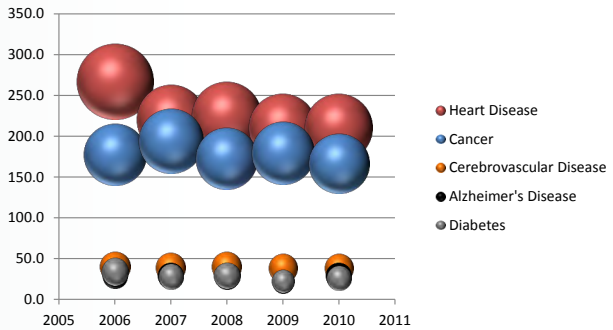
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both men and women in the District.
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both black and white DC residents.

Figure 28. Leading Causes of Death in Men, Age-adjusted Rates, 2006-2010



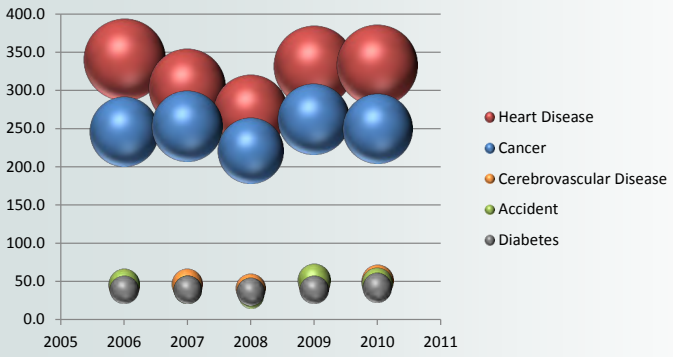
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 29. Leading Causes of Death in Women, Age-adjusted Rates, 2006-2010



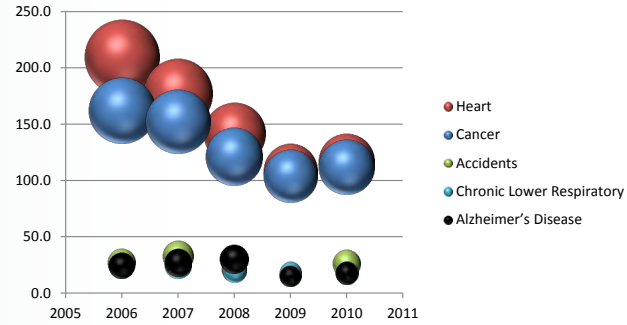
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 30. Leading Causes of Death in Blacks, Age-adjusted Rates, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 31. Leading Causes of Death in Whites, Age-adjusted Rates, 2006-2010

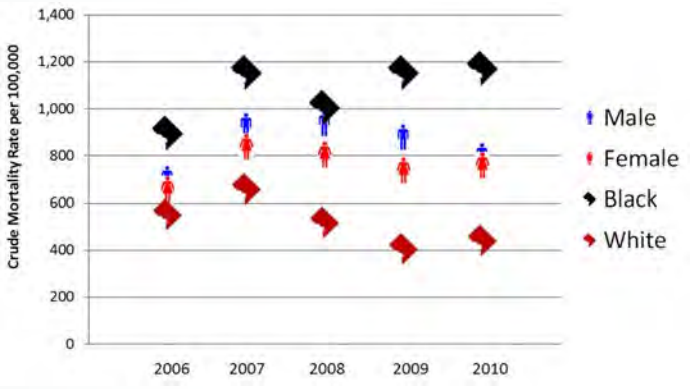


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

While overall death rates have declined in the last 5 years, disparities persist between gender and race.

- From 2006 to 2010, the overall death rate for DC residents had fallen by 14.1 percent (from 903.2 per 100,000 in 2006 to 776.1 per 100,000 in 2010).
- Male residents continued to have higher death rates than female residents in the District, with a 5.5 percent difference in 2010.
- In 2006, black residents in the District had a 38.6 percent higher death rate than their white counterparts (896.3 vs. 550.3 deaths per 100,000).
- By the end of 2010, the black/white gap widened to 62.6 percent (1,173.3 vs. 438.9 deaths per 100,000).
- Over a 5-year period, the death rate in blacks increased by 30.9 percent while the death rate in whites fell by 20.2 percent.

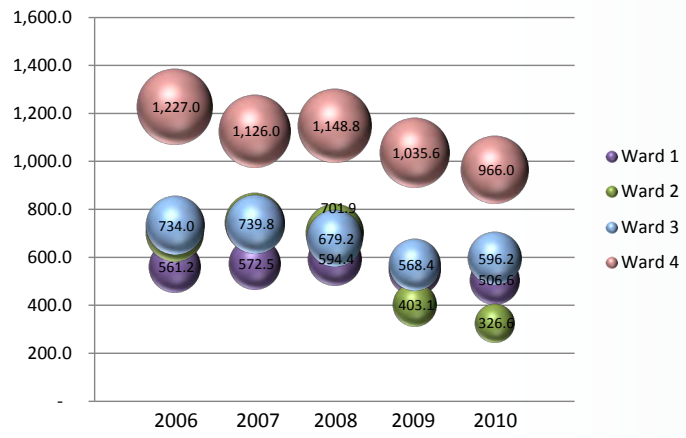
Figure 32. Crude Mortality Rates by Gender and Race, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

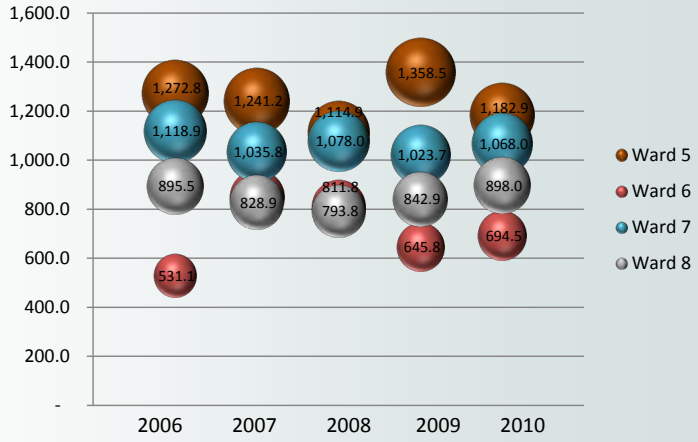
MORTALITY BY WARD

Figure 33. Crude Mortality Rates for Wards 1-4, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 34. Crude Mortality Rates for Wards 5-8, 2006-2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Death rates in all wards have declined in the last 5 years, except in Wards 6 and 8.

In 2010, 4 wards did better than the overall DC death rate; Wards 4, 5, 7, and 8 did worse.

Deaths due to Accidents, Diabetes, and Septicemia increased dramatically in Ward 8 from 2006 to 2010.

Deaths due to Alzheimer's Disease rose significantly in Ward 4.

Deaths due to Cancer, HIV, and Homicide revealed a downward trend in all wards from 2006 to 2010.

- In 2010, 4 wards exceeded the overall crude death rate in the District of 776.1 per 100,000. Wards 4, 5, 7, and 8 had crude death rates of 966.0, 1,182.9, 1,068.0, and 898.0 per 100,000, respectively.
- Wards 6 and 8 experienced a 30.8 and 0.3 percent increase, respectively, in crude death rates from 2006 to 2010.
- The largest decline was seen in Ward 2, where the death rate dropped by more than half (53.6 percent) over a 5-year period.
- Between 2006 and 2010, death rates in Wards 1, 3, 4, 5, and 7 decreased by 9.7, 18.8, 21.3, 7.1, and 4.5 percent, respectively.
- Deaths due to Heart Disease dropped in all wards except in Wards 6, 7, and 8, which increased by 15.1, 8.3, and 16.5 percent, respectively.
- Deaths due to Cancer decreased in all wards, with the largest drop occurring in Ward 2 (49.3 percent decrease).
- Deaths due to Accidents rose in Wards 1, 5, 7, and 8 by 20.2, 37.9, 38.5 and 104.7 percent, respectively.
- Deaths due to Cerebrovascular Disease rose in Wards 6, 7, and 8 by 30.6, 29.0 and 39.1 percent, respectively.
- Increases in deaths due to Chronic Lower Respiratory Disease occurred in Wards 1, 3, 5, and 7 by 5.0, 41.0, 67.5 and 39.1 percent, respectively.
- Only Wards 7 and 8 did not improve their diabetes death rates, with 28.3 and 129.1 percent increases, respectively.
- Deaths due to HIV plummeted in all wards, with Ward 3 winding down to zero HIV deaths in 2010.
- Homicide death rates fell in all wards, with the most significant drop in Ward 2 (80.5 percent).
- Increases in deaths due to Alzheimer's Disease were seen in Wards 4, 5, and 6 (81.3, 34.6, and 7.0 percent, respectively).
- Septicemia death rates rose by 21.7 and 139.3 percent in Wards 7 and 8, respectively.

HEART DISEASE

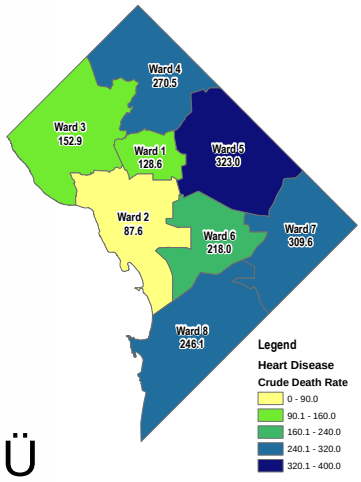
District of Columbia	Deaths due to Heart Disease
TOTAL	**1,300**
Gender	**Percentage**
Male	48.5
Female	51.5
Age	
0-4	0.0
5-14	0.0
15-24	0.4
25-34	0.8
35-44	1.4
45-54	7.7
55-64	15.8
65-74	17.3
75-84	25.5
85+	31.1
Race	
Black	78.2
White	20.8
Asian/Other	1.1
Ethnicity	
Hispanic	1.8
Non-Hispanic	96.8
Ward Comparison	
Ward 1	7.5
Ward 2	5.4
Ward 3	9.1
Ward 4	15.8
Ward 5	18.5
Ward 6	12.8
Ward 7	16.9
Ward 8	13.4

Healthy People 2010 Objectives

Goal Met: Reduce deaths from heart disease to no more than 230.2 per 100,000 people; the District's rate is 221.4 per 100,000.

- Heart disease was the leading cause of death both in the District of Columbia and the United States in 2010.
- Among District residents in 2010, heart disease had the highest crude mortality rate 216.0 per 100,000 and age-adjusted rate of 221.4 per 100,000 population killing 1,300 people or 27.8 percent of all resident deaths.
- Heart disease is the leading cause of death both for men (221.7 per 100,000) and women (211.0 per 100,000).
- The highest mortality rate was for blacks/African Americans (333.0 per 100,000), followed by whites (116.6 per 100,000).
- Most of the deaths due to heart disease were in the higher age groups with decedents aged 55 years and older accounting for 89.7 percent.
- The crude death rate for heart disease was the highest for Ward 5 (323.0 per 100,000), followed by Ward 7 (309.6 per 100,000), and the lowest crude death rate was in Ward 2 (87.6 per 100,000).
- This difference may also be a reflection of the age of the population living in Wards 5 and 7 which have older populations, while Ward 2 has a younger population. Better lifestyle habits can help reduce risk of heart attacks. Weight management through diet and exercise, smoking cessation and management of hypertension are examples suggested by the American Heart Association.

Figure 35. Map of Heart Disease Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

CANCER

District of Columbia	Deaths due to Cancer
TOTAL	**1,035**
Gender	**Percentage**
Male	48.9
Female	51.1
Age	
0-4	0.0
5-14	0.1
15-24	0.3
25-34	0.7
35-44	1.7
45-54	11.7
55-64	21.5
65-74	23.1
75-84	23.0
85+	17.9
Race	
Black	73.8
White	25.0
Asian/Other	1.2
Ethnicity	
Hispanic	2.4
Non-Hispanic	97.0
Ward Comparison	
Ward 1	9.6
Ward 2	6.2
Ward 3	11.5
Ward 4	15.7
Ward 5	18.6
Ward 6	11.1
Ward 7	14.6
Ward 8	12.2

Healthy People 2010 Objectives

Goal Met: Reduce the mortality rate for cancer of the lung and bronchus by 12 percent of the 2000 baseline rate; the District's rate dropped from 60 per 100,000 to 42.4 per 100,000.

Goal Met: Reduce the mortality rate for breast cancer by 10 percent of the 2000 baseline rate; the District's rate dropped from 27 per 100,000 to 18.4 per 100,000.

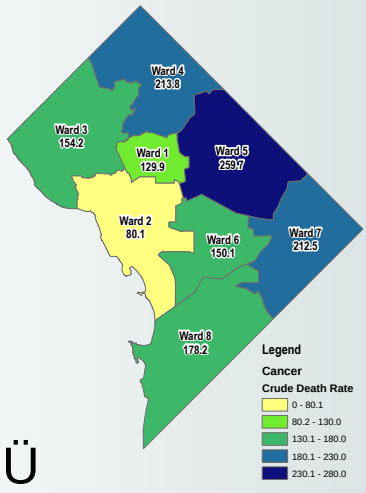
Goal Met: Reduce the mortality rate for cervical cancer by 15 percent of the 2000 baseline rate; the District's rate dropped from 4.3 per 100,000 to 1.1 per 100,000.

Goal Met: Reduce the mortality rate for colorectal cancer by 15 percent of the 2000 baseline rate; the District's rate dropped from 29.7 per 100,000 to 21.1 per 100,000.

Goal Met: Reduce the mortality rate for prostate cancer in African American men by 25 percent of the 2000 baseline rate; the District's rate dropped from 64.9 per 100,000 to 18 per 100,000.

- In 2010, cancer was the second-ranked leading cause of death in both the United States and the District of Columbia.
- Of the 4,670 District resident deaths in 2010, 1,035 (22.2 percent) or a little more than one in five died from cancer with a crude death rate of 172.0 per 100,000 and an age-adjusted rate of 177.1 per 100,000.
- Incidence and mortality rates are highest for blacks/African Americans who account for a majority of the District's residents.
- Blacks/African Americans had a mortality rate of 250.4 per 100,000, which was significantly higher than that of whites (111.9 per 100,000).
- Similarly, the mortality rates for males (178.0 per 100,000) were higher than the female (166.6 per 100,000).
- Like heart disease, cancer deaths were also concentrated in older age groups where 85.5 percent who died of this condition were of age 55 and older.
- Cancer affects residents in every ward, but Ward 5 (259.7 per 100,000) had the highest rate of deaths, followed by Ward 4 (213.8 per 100,000), and Ward 7 (212.5 per 100,000).
- Ward 2 had the lowest cancer mortality rate of 80.1 per 100,000, again likely a reflection of the young age of the population in this ward.

Figure 36. Map of Cancer Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

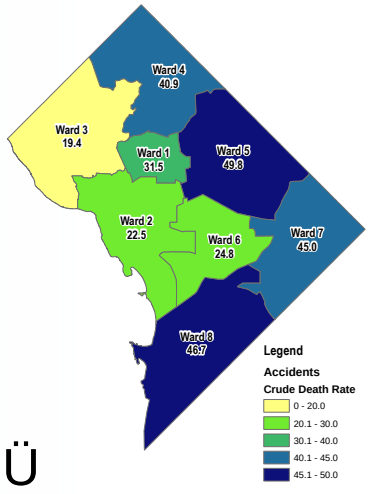
ACCIDENTS

District of Columbia	Deaths due to Accidents
TOTAL	**211**
Gender	**Percentage**
Male	64.0
Female	36.0
Age	
0-4	0.9
5-14	0.5
15-24	5.2
25-34	9.5
35-44	11.8
45-54	18.5
55-64	19.4
65-74	6.2
75-84	14.7
85+	13.3
Race	
Black	69.7
White	28.9
Asian/Other	1.4
Ethnicity	
Hispanic	2.4
Non-Hispanic	97.2
Ward Comparison	
Ward 1	11.4
Ward 2	8.5
Ward 3	7.1
Ward 4	14.7
Ward 5	17.5
Ward 6	9.0
Ward 7	15.2
Ward 8	15.6

- In 2010, the age-adjusted rate for people dying in accidents was 34.9 per 100,000 population.
- In the United States, deaths due to accidents ranked fifth while in the District of Columbia it ranked third in 2010.
- Males were more likely to die from accidents (47.5 per 100,000 population) as compared to females (23.9 per 100,000 population).
- Blacks/African Americans had a mortality rate of 48.2 per 100,000 population, also significantly higher compared to whites (26.4 per 100,000 population).
- Ward 5 (49.8 per 100,000), followed by Ward 8 (46.7 per 100,000) and Ward 7 (45.0 per 100,000) had the highest mortality due to accidents in the city.
- Ward 3 (19.4 per 100,000) had the lowest mortality rate due to accidents.

A local law firm suggests 10 tips to avoid motor vehicle accidents are: (1) Avoid drinking and driving. (2) Minimize distractions such as reading newspapers or talking on the cell phone when driving. (3) Properly maintain vehicles. (4) Do not encourage aggressive drivers. (5) Leave a safe distance between your cars and others. (6) Maintain a constant speed. (7) Adjust mirrors properly and check the side and rear-view mirrors every 15 seconds. (8) Take defensive driving classes to improve your ability to drive and be better prepared for the unpredictable behavior of other motorists. (9) Proceed with great caution through intersections. (10) Be sufficiently aware of road conditions and be more visible.

Figure 37. Map of Accident Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

CEREBROVASCULAR DISEASE

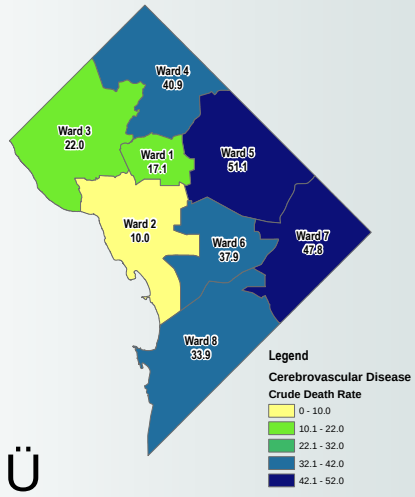
District of Columbia	Deaths due to Cerebrovascular Disease
TOTAL	**194**
Gender	**Percentage**
Male	37.1
Female	62.9
Age	
0-4	0.0
5-14	0.5
15-24	0.0
25-34	1.0
35-44	2.6
45-54	7.2
55-64	18.0
65-74	16.5
75-84	18.6
85+	35.6
Race	
Black	80.9
White	18.0
Asian/Other	1.0
Ethnicity	
Hispanic	2.6
Non-Hispanic	96.9
Ward Comparison	
Ward 1	6.7
Ward 2	4.1
Ward 3	8.8
Ward 4	16.0
Ward 5	19.6
Ward 6	14.9
Ward 7	17.5
Ward 8	12.4

Healthy People 2010 Objectives

Goal Met: Reduce the mortality rate from stroke to no more than 33.2 per 100,000 population; the District's rate is 32.4 per 100,000.

- Cerebrovascular disease which causes stroke, was the fourth leading cause of death in 2010, with an age-adjusted mortality rate of 32.4 per 100,000 population.
- It also ranked fourth (age-adjusted rate of 39.0 per 100,000 population) in the United States.
- Blacks/African Americans were over three times more likely to die from cerebrovascular diseases (51.5 per 100,000) compared to their white counterparts (15.1 per 100,000).
- The mortality rate was higher for females (38.4 per 100,000) as compared to males (25.3 per 100,000).
- The age group 65 or older accounted for 70.6 percent of deaths due to cerebrovascular diseases.
- In 2010, the crude death rate for cerebrovascular diseases by ward showed that Wards 5 (51.1 per 100,000), 7 (47.8 per 100,000), and 4 (40.9 per 100,000), had the highest rates in the District.
- Ward 2 had the lowest rate of 10 deaths due to cerebrovascular disease per 100,000 residents.
- According to the National Institute of Neurological Disorders and Cerebrovascular Diseases (2001), the majority of cerebrovascular diseases can be prevented by managing hypertension, heart disease, and diabetes, and by proper nutrition and smoking cessation. Transient ischemic attacks (TIAs), commonly referred to as "mini-strokes", are events lasting only a few minutes or hours and are warning signs of major cerebrovascular diseases and should not be ignored. Timely diagnosis of TIAs and other risk factors is needed to prevent cerebrovascular accidents (or stroke), and immediate treatment can minimize the long-term disabling effects of a cerebrovascular accident such as paralysis and speech deficits. The mortality data suggest that District residents in general and black/African American residents in particular, often lack access to or under-utilize available life-saving interventions.

Figure 38. Map of Cerebrovascular Disease Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

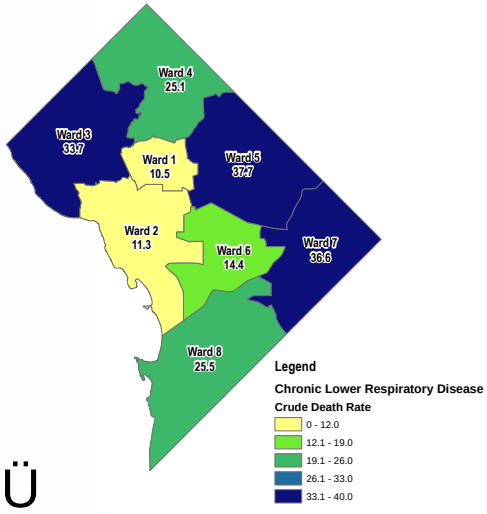
CHRONIC LOWER RESPIRATORY

District of Columbia	Deaths due to Chronic Lower Respiratory Disease
TOTAL	**146**
Gender	**Percentage**
Male	50.0
Female	50.0
Age	
0-4	0.7
5-14	0.0
15-24	0.7
25-34	0.7
35-44	2.1
45-54	5.5
55-64	9.6
65-74	19.2
75-84	30.1
85+	31.5
Race	
Black	68.5
White	28.8
Asian/Other	2.7
Ethnicity	
Hispanic	1.4
Non-Hispanic	96.6
Ward Comparison	
Ward 1	5.5
Ward 2	6.2
Ward 3	17.8
Ward 4	13.0
Ward 5	19.2
Ward 6	7.5
Ward 7	17.8
Ward 8	12.3

- Chronic Lower Respiratory Diseases (CLRD) such as chronic obstructive pulmonary disease (COPD) was ranked the fifth leading cause of death in the District of Columbia in 2010.
- The age-adjusted death rate was 25.5 per 100,000 compared to the third leading cause of death (age-adjusted mortality rate of 42.1) nationally.
- CLRD was the fourth leading cause of death for whites (18.1 per 100,000) but was the 8th leading cause of death for blacks/African Americans (32.8 per 100,000).
- Men had a higher CLRD crude death rate (25.7 per 100,000 population) as compared to women (23.0 per 100,000).
- The highest proportion (80.8 percent) of deaths due to CLRD were among the elderly (65 years and older).
- Ward 5 had the highest rate of 37.7 per 100,000 while Ward 1 had the lowest mortality rate of 10.5 per 100,000.
- According to the American Lung Association (2008), smoking is the leading risk factor for CLRD. Other risk factors include exposure to air pollution and second-hand smoke, occupational dust, chemicals, a history of childhood respiratory infections and heredity.

Figure 39. Map of Chronic Lower Respiratory Disease

Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

DIABETES

District of Columbia	Deaths due to Diabetes
TOTAL	**145**
Gender	**Percentage**
Male	42.1
Female	57.9
Age	
0-4	0.0
5-14	0.0
15-24	1.4
25-34	1.4
35-44	3.4
45-54	9.0
55-64	18.6
65-74	16.6
75-84	26.9
85+	22.8
Race	
Black	88.3
White	9.7
Asian/Other	2.1
Ethnicity	
Hispanic	2.1
Non-Hispanic	97.2
Ward Comparison	
Ward 1	3.4
Ward 2	3.4
Ward 3	4.1
Ward 4	15.2
Ward 5	20.7
Ward 6	11.7
Ward 7	21.4
Ward 8	20.0

Healthy People 2010 Objectives

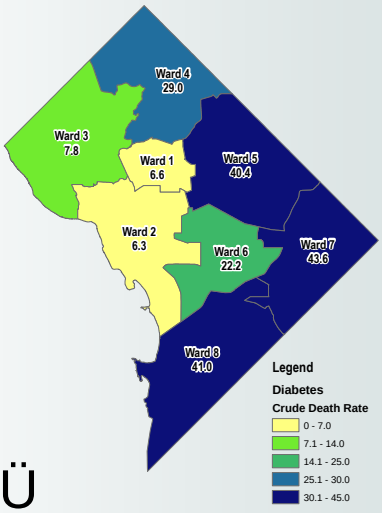
Goal Not Met: Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents; the District's rate is 24.9 per 100,000.

Goal Not Met: Reduce the mortality rate due to diabetes as the primary cause of death among African Americans to 30.9 per 100,000 residents; the District's rate is 42 per 100,000.

- Diabetes (age-adjusted rate of 24.9) ranked as sixth leading cause of death in the District of Columbia in 2010 but seventh (age-adjusted rate of 20.8) in the United States in 2010.
- The crude death rate for diabetes in 2010 was 24.1 per 100,000 population.
- In the District of Columbia, the crude death rate due to diabetes for blacks/African Americans was 42.0 per 100,000 population which was seven times the rate for Whites, 6.0 per 100,000 population.
- Eighty-five percent of deaths due to diabetes occurred to decedents 55 years or older.
- Ward 7 (43.6 per 100,000) , Ward 8 (41.0 per 100,000), and Ward 5 (40.4 per 100,000) had the highest crude death rates while Ward 2 had the lowest mortality rate (6.3 per 100,000) in this category.

Lack of timely, appropriate medical care may contribute to the complications of diabetes, such as lower extremity amputations, end stage renal disease, heart disease, cerebrovascular diseases, high blood pressure, and blindness. It also contributes to the number of premature deaths in the United States and the District. As many diabetics actually die from complications of diabetes, rather than the disease itself, diabetes deaths alone understate the extent to which diabetes contributes to mortality. According to the American Diabetes Association, a recently completed Diabetes Prevention Program (DPP) study conclusively showed that people with pre-diabetes can prevent the development of type 2 diabetes by making changes in their diet and increasing their level of physical activity. They may even be able to return their blood glucose levels to the normal range. While the DPP also showed that some medications may delay the development of diabetes, diet and exercise worked better. Moderate physical exercise of about 30 minutes a day, coupled with a 5-10 percent reduction in body weight, produced a 58 percent reduction in diabetes.

Figure 40. Map of Diabetes Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

HIV

District of Columbia	Deaths due to HIV
TOTAL	**121**
Gender	**Percentage**
Male	56.2
Female	43.8
Age	
0-4	0.0
5-14	0.0
15-24	1.7
25-34	9.1
35-44	18.2
45-54	43.8
55-64	16.5
65-74	7.4
75-84	2.5
85+	0.8
Race	
Black	96.7
White	3.3
Asian/Other	0.0
Ethnicity	
Hispanic	0.0
Non-Hispanic	99.2
Ward Comparison	
Ward 1	9.1
Ward 2	4.1
Ward 3	0.0
Ward 4	11.6
Ward 5	17.4
Ward 6	14.0
Ward 7	24.8
Ward 8	18.2

Healthy People 2010 Objectives

Goal Met: Increase by 5 percent annually the number of HIV+ individuals identified through HIV counseling and testing

Goal Not Met: Increase by 5 percent annually the number of newly reported AIDS cases as a result of active case finding

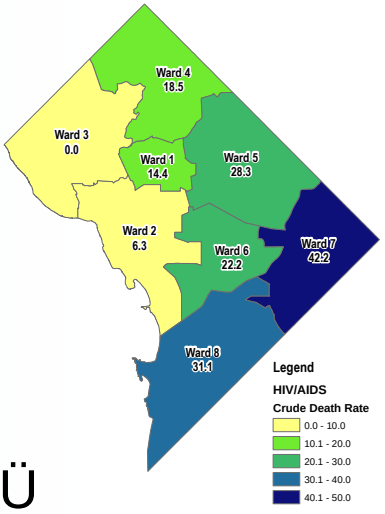
Goal Not Met: Increase by 10 percent annually the number of HIV+ individuals who received housing assistance services

Goat Met: Increase by 2.5 percent annually the number of HIV+ individuals who enroll in the AIDS Drug Assisted Program (ADAP)

- Acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV) and ranked as the seventh leading cause of death in the District for 2010.
- The age-adjusted death rate was 20.4 per 100,000 population, compared with 2.6 per 100,000 nationally.
- Although HIV disease was not among the 15 leading causes of death in 2010 for all ages combined in the United States, it remains a public health concern, especially for those between the ages of 15 and 64. About 78.5 percent of decedents who died from HIV in the District were between the ages of 35 and 64.
- Mortality rates for HIV in the District were higher in blacks/African Americans than in any other race or ethnic group. In 2010, the crude death rate for blacks/African Americans was 38.3 per 100,000 compared to white population crude death rate of about 1.7 per 100,000.
- The crude death rate is much higher in males who continue to be infected at considerably higher rates (23.9 per 100,000) as compared to females (16.7 per 100,000); however, it is noteworthy that the number of infected females is rapidly rising.
- The rates in Ward 7 (42.2 per 100,000) and Ward 8 (31.1 per 100,000) were the highest.
- There were no deaths due to HIV among residents in Ward 3.

Consistent with the United States, deaths among people with HIV continue to decline in the District. In 2003, it was estimated that over one million people in the US had HIV and the CDC estimates that about 40,000 people get infected with HIV each year. HIV testing is important as those who do not know they are infected can infect others unknowingly and are unable to take advantage of the multitude of drugs available to keep them healthy and extend their lives.

Figure 41. Map of HIV Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

HOMICIDE/ASSAULT

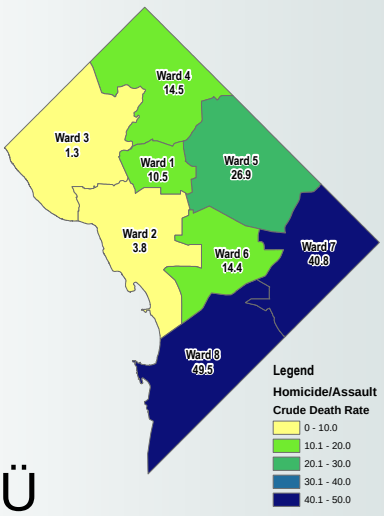
District of Columbia	Deaths due to Homicide/Assault
TOTAL	**118**
Gender	**Percentage**
Male	89.0
Female	11.0
Age	
0-4	2.5
5-14	0.8
15-24	38.1
25-34	28.0
35-44	14.4
45-54	9.3
55-64	4.2
65-74	1.7
75-84	0.8
85+	0.0
Race	
Black	89.0
White	5.9
Asian/Other	5.1
Ethnicity	
Hispanic	4.2
Non-Hispanic	94.9
Ward Comparison	
Ward 1	6.8
Ward 2	2.5
Ward 3	0.8
Ward 4	9.3
Ward 5	16.9
Ward 6	9.3
Ward 7	24.6
Ward 8	29.7

- Homicide was the 8th leading cause of death in the District of Columbia in 2010.
- The age-adjusted death rate in the District was 17.1 per 100,000 compared to age-adjusted death rate of 5.3 nationally.
- For men living in the District, homicide was the fourth leading cause of death (36.9 per 100,000 population) while it was not in the top 10 leading causes of death for women.
- Homicide was the 7th leading cause of death for blacks/African Americans (34.4 per 100,000 population) but was not in the top 10 causes of death for whites (3.0 per 100,000 population).
- Most of the deaths (66.1 percent) due to homicide were among the young who were between the ages of 15 and 34; 89 percent of them were African Americans.
- Ward 8 (49.5 per 100,000) and Ward 7 (40.8 per 100,000) had the highest crude death rate of homicide while Ward 3 had the lowest rate (1.3 per 100,000) in 2010.

According to the CDC, violence is a serious public health problem in the United States. From infants to the elderly, it affects people in all stages of life. In 2007, more than 18,000 people were victims of homicide and more than 33,000 took their own life. The number of violent deaths tells only part of the story. Many more survive violence and are left with permanent physical and emotional scars. Violence also erodes communities by reducing productivity, decreasing property values, and disrupting social services.

The CDC's Division of Violence Prevention is committed to stopping violence before it begins and has been working to develop strategic directions that guide our research and programmatic activities. A strategic direction is defined as a focused and compelling strategy for reducing rates of the various forms of violence (e.g., child maltreatment, intimate partner violence, sexual violence, suicidal behavior, and youth violence). The identified strategies are organized around multiple areas of public health research and practice and link back to the broader goals of the agency and the field of violence prevention. The CDC's key strategy in preventing child maltreatment is the promotion of safe, stable, and nurturing relationships between children and caregivers. Their key strategy in preventing intimate partner violence is the promotion of respectful, nonviolent intimate partner relationships through individual, community, and societal level change. And the CDC'S key strategy in preventing fatal and nonfatal suicidal behavior is promoting individual, family, and community connectedness.

Figure 42. Map of Homicide/Assault Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

ALZHEIMER'S DISEASE

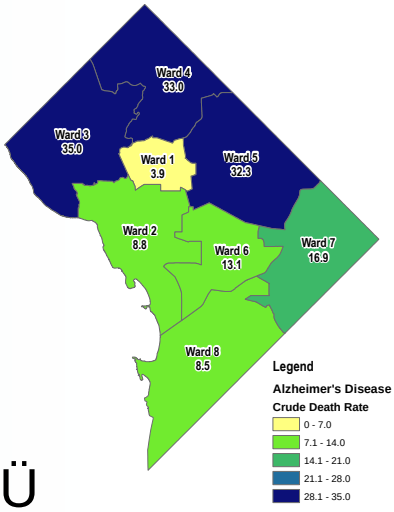
District of Columbia	Deaths due to Alzheimer's Disease
TOTAL	**114**
Gender	**Percentage**
Male	17.5
Female	82.5
Age	
0-4	0.0
5-14	0.0
15-24	0.0
25-34	0.0
35-44	0.0
45-54	0.0
55-64	0.0
65-74	2.6
75-84	21.9
85+	75.4
Race	
Black	60.5
White	36.0
Asian/Other	3.5
Ethnicity	
Hispanic	0.9
Non-Hispanic	98.2
Ward Comparison	
Ward 1	2.6
Ward 2	6.1
Ward 3	23.7
Ward 4	21.9
Ward 5	21.1
Ward 6	8.8
Ward 7	10.5
Ward 8	5.3

- Alzheimer's disease was ranked the 9th leading cause of death in the District of Columbia in 2010 with an age-adjusted rate of 18.7 per 100,000 population.
- In contrast, Alzheimer's ranked sixth nationally with an age-adjusted rate of 25.0 in 2010.
- Alzheimer's disease was the 5th leading cause of death among whites (crude rate 17.7 per 100,000) but was not in the top 10 causes of death for blacks.
- As expected, the deaths due to Alzheimer's were the highest (75 percent) in decedents aged 85 or older.
- Ward 3 had the highest mortality rate of 35.0 per 100,000 compared to Ward 1 (3.9 per 100,000), which had the lowest mortality rate.

According to the National Center for Health Statistics (NCHS, 2008), the mortality trend for Alzheimer's disease is one of rapid increase. From 1979 to 1998, the rate for Alzheimer's disease increased dramatically because of factors such as improvements in diagnosis and awareness of the condition within the medical community. The transition from ICD-9 to ICD-10 brought substantial changes to the coding and selection rules for this condition, which created a major disruption in the time series trend for Alzheimer's disease between 1998 and 1999. The large increase in the Alzheimer's disease mortality between 1998 and 1999 is partly due to the ICD transition (NCHS, 2001).

Although there are no magic solutions, new evidence suggests it *may* be possible to prevent or delay the onset of Alzheimer's disease through a combination of healthful habits. Scientists now suggest you can stimulate your mind, improve your mood, sharpen your memory, and reduce your Alzheimer's risks (HelpGuide, 2009). Although you cannot change your inherited genes, ethnicity, gender, or age, conditions and behaviors that leave you more likely to develop Alzheimer's disease such as diabetes, hypertension, high blood cholesterol, heart disease, obesity, chronic stress, poor quality or insufficient sleep, sedentary lifestyle, liver and kidney disease, smoking, alcohol and drug use, head injury, and toxic insults *have* been identified. disease, smoking, alcohol and drug use, head injury, and toxic insults *have* been identified.

Figure 43. Map of Alzheimer's Disease Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

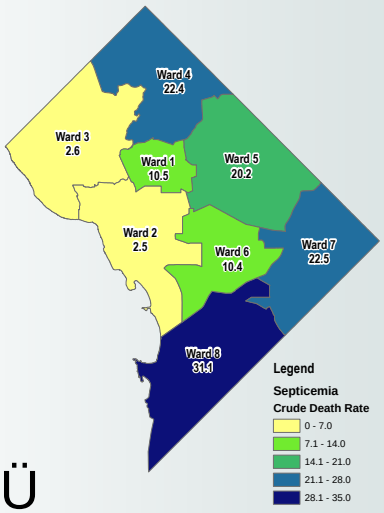
SEPTICEMIA

District of Columbia	Deaths due to Septicemia
TOTAL	**90**
Gender	**Percentage**
Male	45.6
Female	54.4
Age	
0-4	0.0
5-14	0.0
15-24	0.0
25-34	2.2
35-44	1.1
45-54	6.7
55-64	18.9
65-74	28.9
75-84	22.2
85+	20.0
Race	
Black	87.8
White	8.9
Asian/Other	3.3
Ethnicity	
Hispanic	3.3
Non-Hispanic	96.7
Ward Comparison	
Ward 1	8.9
Ward 2	2.2
Ward 3	2.2
Ward 4	18.9
Ward 5	16.7
Ward 6	8.9
Ward 7	17.8
Ward 8	24.4

- In 2010, Septicemia (bloodstream infection) causing failure of multiple vital organs was the 10th leading cause of death with an age-adjusted mortality rate of 15.3 per 100,000 population in the District of Columbia.
- Seventy-one percent of deaths due to Septicemia were among the elderly (65 years and older); 88 percent were among African Americans.
- Septicemia was the 9th leading cause of death for African Americans (25.9 per 100,000 population) but was not in the top 10 causes of death for whites (3.5 per 100,000).
- For male and female residents in the District, Septicemia was the 9th leading cause of death at 14.4 and 15.4 per 100,000 population, respectively.
- Ward 8 had the highest rate (31.1 per 100,000 population) followed by Wards 7 and 4 (22.5 and 22.4 per 100,000 population, respectively). Wards 2 and 3 had the lowest rate (2.5 and 2.6 per 100,000 population, respectively).

Septicemia and sepsis are serious bloodstream infections that can rapidly become life-threatening. Those who survive sepsis are more likely to have permanent organ damage, cognitive impairment, and physical disability.

Figure 44. Map of Septicemia Crude Death Rates by Ward, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

PROMOTING HEALTHY BEHAVIORS

Understanding determinants of health behavior and how to influence behavior change could improve the health of communities in the District and shape effective interventions. Several health behaviors where interventions could have a great impact health include nutrition, alcohol consumption, tobacco use, physical activity, sexual health, and oral health.

Poor nutrition is a major risk factor for disease and disability in the District and in the US. Consuming a diet high in fat and refined sugar (energy dense foods) and low in fruits, vegetables and whole grains (nutrient dense foods) has become a major public health concern because these dietary behaviors contribute to overweight and obesity. Diet quality is not the only factor to impact health, but the amount of food eaten and daily physical activity performed also determine weight status. Further, overweight and obesity are associated with increased risk for health problems such as diabetes, heart disease, high blood pressure, stroke and result in a major burden on healthcare costs.

Tobacco use is a major public health problem and is the most preventable cause of death and disease. The problem does not only affect the smoker but also those who are exposed to secondhand smoke. Each year thousands of deaths are attributable to smoking and tobacco smoke exposure. The economic burden associated with smoking is also very significant. Tobacco use increases the risk for cancers, particularly of the lung and oral cavity, cardiovascular and respiratory diseases and disorders.

In order to reduce the number of smokers, the Department of Health's Community Health Administration and Addiction, Prevention, and Recovery Administration focused on preventing smoking amongst children and adolescents, since regular smoking usually begins during the adolescent years. The department also extended its targeted focus area to include reducing tobacco rates for Hispanics and pregnant women.

Dental disease is also one of the main problems that affect children. Many suffer from tooth decay and about 50 percent of children are affected by cavities and dental related problems before they are even ten years old. Oral health means much more than healthy teeth, it is integral to general health. Even though safe and effective disease prevention measures exist that everyone can adopt to improve oral health and prevent disease, we still continue to see profound disparities in the oral health of Americans. According to the Centers for Disease Control and Prevention, untreated dental disease may result in pain and suffering that affect a child's ability to eat, attend school and communicate. This disease adversely affects individuals of lower socio-economic status, particularly African-Americans and Hispanics. Often they lack dental insurance, have limited resources to pay for expensive dental treatment, and cannot access dental services.

OBESITY

District of Columbia	Percent Healthy Weight	Percent Obese
TOTAL	43.7	22.4
Gender		
Male	39.3	18.5
Female	47.7	26
Age		
18-34	53.3	18.2
35-44	47.1	21.4
45-54	37.6	25.3
55-64	36.2	26
65+	41.9	22.6
Race/Ethnicity		
Caucasian	57.9	9.6
African American	30.1	34.9
Other	49.2	17.1
Hispanic	54.7	12
Education		
Less than High School	27.7	39.6
High School Graduate	30.6	33.4
Some College	32.3	33.4
College Graduate	52.5	14.4
Income		
Less than $15,000	35.6	37.2
$15,000-$24,999	37	31.7
$25,000-$34,999	34.4	32.1
$35,000-$49,999	38	26.8
$50,000-$74,999	40.8	27.6
$75,000 and over	50	14.3
Ward Comparison		
Ward 1	44.7	21.3
Ward 2	55.6	14.4
Ward 3	56.7	7.5
Ward 4	37.5	25.8
Ward 5	33.6	29.9
Ward 6	47.9	17.4
Ward 7	30.1	35.3
Ward 8	22.7	44.4

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

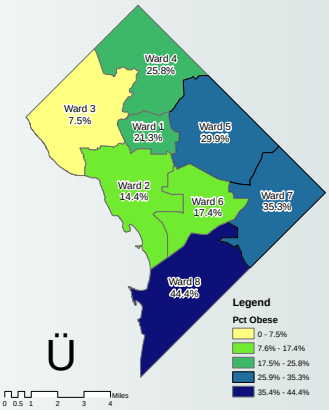
Goal Not Met: Reduce the proportion of adults who are obese to 15 percent; the District's rate is 22.7 percent.

Goal Not Met: Increase the proportion of adults who are at a healthy weight to 60 percent; the District's rate is 42.6 percent.

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked to provide their height and weight measurements. Body Mass Index (BMI) calculations were made and respondents were classified as: (1) neither overweight nor obese (BMI less than 24.9); (2) overweight (BMI 25.0-29.9); and (3) obese (BMI 30.0 and greater).

- Overall, 43.7 percent of respondents were of healthy weight (neither overweight nor obese) compared to 35.3 percent nationally. BRFSS data also revealed that 22.4 percent of District respondents were obese compared to 27.6 percent nationally.
- Females were more likely than males to have a healthy weight, at 47.7 percent.
- Adults aged 18-34 years were more likely than all other age groups to have a healthy weight, at 53 percent.
- Adults aged 55-64 years were more likely than all other age groups to be obese, at 26 percent.
- Caucasians were more likely than all other race/ethnic groups to have a healthy weight, at 58 percent.
- African Americans were more likely than all other race/ethnic groups to be obese, at 35 percent.
- Adults with less than a high school education were more likely than all other education subgroups to be obese, at 39.6 percent.
- Adult households with an income of less than $15,000 were more likely than all other income subgroups to be obese, at 37 percent.
- Adults who resided in Ward 8 were more likely than all other wards to be obese, at 44.4 percent.
- Adults who resided in Ward 3 were more likely than all other wards to be neither overweight nor obese, at 57 percent.

Figure 45. Map of Obesity Rate by Ward, 2010



OBESITY TRENDS

District residents have a healthier body mass index (BMI) compared to the rest of country.

The District provides greater access to healthy food options compared to nationally, except in school settings.

Currently, there are no state laws addressing childhood obesity in the District.

Obesity rate is one of the key indicators established and monitored by the One City Action Plan to improve the quality of life for all residents in the District. Obesity is a costly condition that can reduce quality of life and is related to numerous of health problems, some of which include high blood pressure, heart disease, diabetes, stroke, and premature death. Policy and environmental change initiatives that make healthy choices in nutrition and physical activity available, affordable, and easy will likely prove most effective in combating obesity.

- Overall, District residents are less likely to be obese than the average US resident. In 2010, 22.4 percent of District respondents (BRFSS) were obese compared to 27.6 percent nationally.
- District residents are less likely to be overweight than the average US resident. In 2010, 34.8 percent of District respondents (BRFSS) were overweight compared to 36.3 percent nationally.
- District residents are more physically active than the average US resident. In 2010, 80 percent of District respondents (BRFSS) participated in exercises such as running, calisthenics, golf, gardening, or walking compared to 76 percent nationally.
- According to the CDC State Indicator Report on Fruits and Vegetables (2009), the District has greater access to healthy food retailers and farmers markets compared to the rest of the US, but does not offer fruits and vegetables as competitive foods in middle and high schools.
- Currently, there are no state laws addressing childhood obesity in the District.

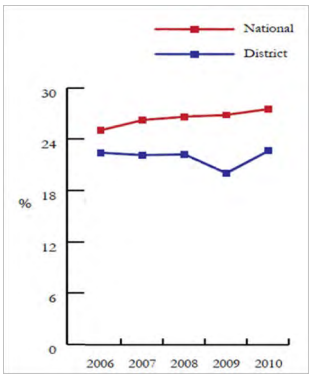
Access to Fruits and Vegetables: Policy and Environmental Indicators, 2009		
	DC	US
% of Census tracts with Healthy Food Retailers within 1/2 mile of boundary	82.4%	72.0%
Farmers Markets per 100,000 population	3.9	1.7
% of Farmers Markets that accept EBT	21.7%	7.6%
% of Farmers Markets that accept WIC FMNP Coupons	56.5%	28.2%
% of Middle and High Schools that offer Fruits & Vegetables as Competitive Foods	0.0%	20.9%
% of Cropland Acreage Harvested for Fruits & Vegetables	0.0%	2.5%
State-Level Healthier Food Retail Policies	Yes	Yes
State Food Policy Council	NA	Yes
State-Level Farm to School Policies	No	Yes
Number of Local Food Policy Councils	1	59

Source: Centers for Disease Control and Prevention, *State Indicator Report on Fruits and Vegetables, 2009*, available at: http://www.fruitsandveggiesmatter.gov

State Laws Addressing Childhood Obesity, 2011		
	DC	US
Prohibits Sugar Sweetened Beverages in School Vending Machines	No	Yes
Requires Physical Education for All Grades (K-12)	No	Yes
Mandates BMI Screening in Schools	No	Yes

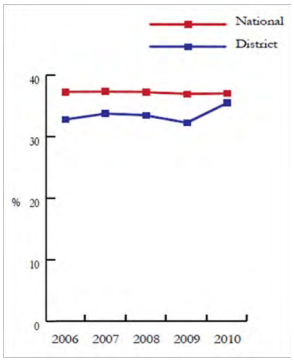
Source: Childhood Obesity Prevention, *2011 State Legislation Report*, American Academy of Pediatrics, (p. 38).

Figure 46. Percent Obese, DC and US, 2006-2010



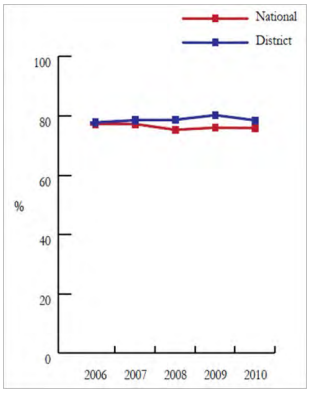
Source: 2010 District of Columbia BRFSS

Figure 47. Percent Overweight, DC and US, 2006-2010



Source: 2010 District of Columbia BRFSS

Figure 48. Percent Exercise, DC and US, 2006-2010

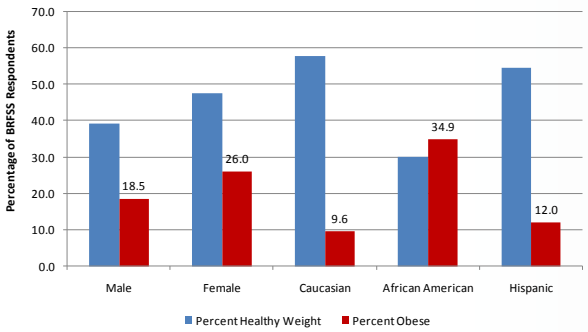


Source: 2010 District of Columbia BRFSS

OBESITY TRENDS

Blacks have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.

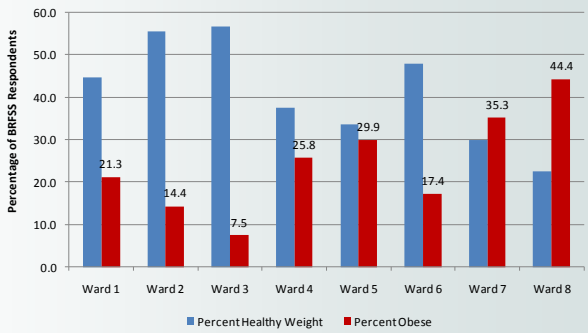
Figure 49. Percent Obese (in red), by Gender and Race/Ethnicity, 2010



Source: 2010 District of Columbia BRFSS

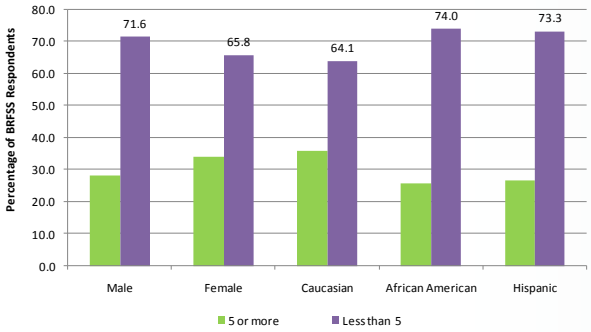
Ward 8 residents have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.

Figure 50. Percent Obese (in red), by Ward, 2010



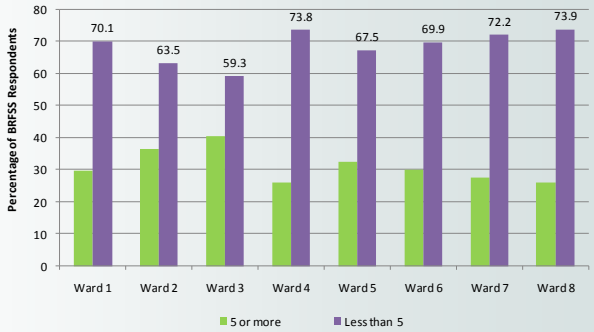
Source: 2010 District of Columbia BRFSS

Figure 51. Percent Consumed Less than 5 Servings of Fruits and Veggies (in purple), by Gender and Race/Ethnicity, 2009



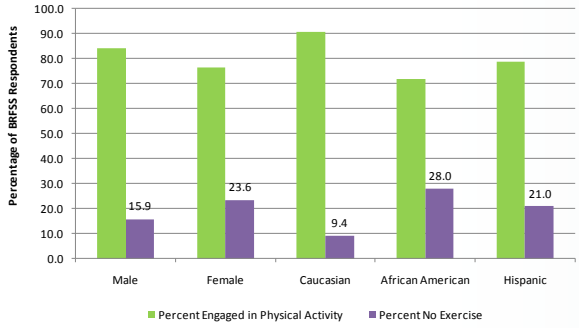
Source: 2009 District of Columbia BRFSS

Figure 52. Percent Consumed Less than 5 Servings of Fruits and Veggies (in purple), by Ward, 2009



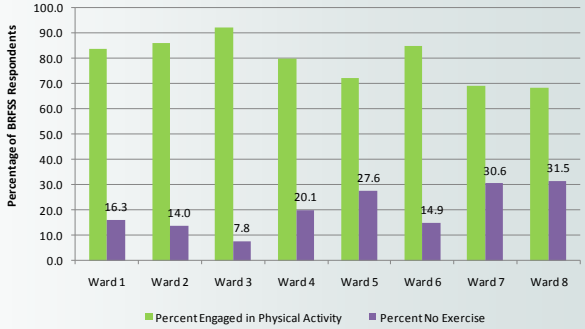
Source: 2009 District of Columbia BRFSS

Figure 53. Percent No Physical Activity in Past Month (in purple), by Gender and Race/Ethnicity, 2010



Source: 2010 District of Columbia BRFSS

Figure 54. Percent No Physical Activity in Past Month (in purple), by Ward, 2010

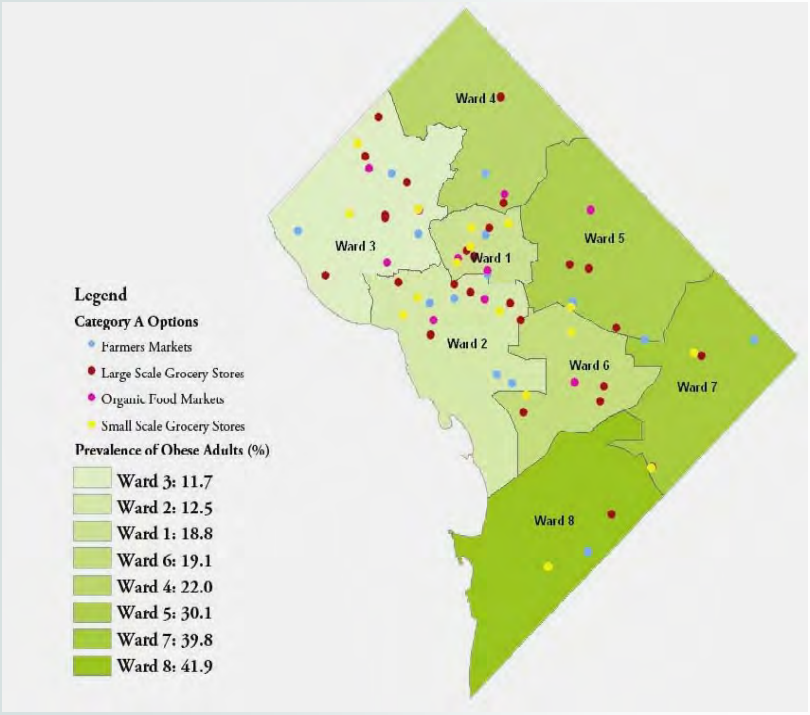


Source: 2010 District of Columbia BRFSS

FOOD OPTIONS IN DISTRICT

The availability of healthy food options varies widely across the wards in the District. The abundance of Category A options (Farmers Markets, Organic Food Markets, Large Scale and Small Scale Grocery Stores) corresponds with areas where adult obesity levels tend to be lower, whereas, Category B options (Convenience Stores, Carry-outs, and Traditional Fast Food Restaurants) are highly prevalent in wards with higher obesity levels. Increasing availability of healthy food options could reduce environmental barriers for District residents to choose healthy behaviors.

Figure 55. Category A* Food Options by Adult Obesity Prevalence in the District of Columbia



*Category A Food Options include Farmers Markets, Organic Food Markets, Large Scale and Small Scale Grocery Stores.

Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

The District of Columbia Overweight and Obesity Action Plan

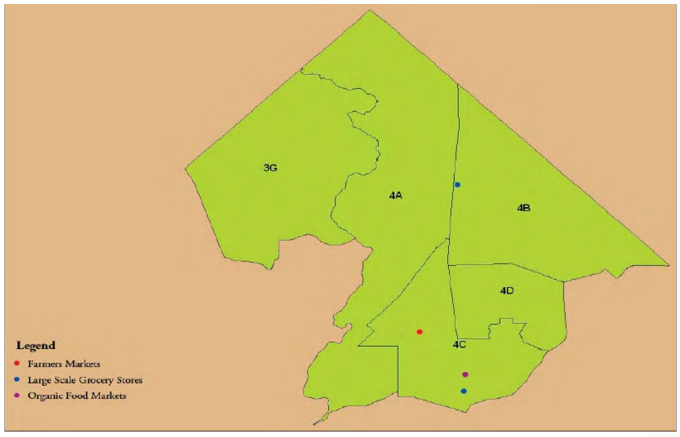
In 2010, the District of Columbia developed the five-year District of Columbia Overweight and Obesity Action Plan to engage community partners and government agencies and address clinical as well as broader social and community-based determinants related to weight status, overweight and obesity. The plan calls for the District community to adopt policies and inform interventions that improve availability of healthy foods and physical activity in neighborhoods, schools, worksites, and places of worship. The following are some of the goals and objectives of the Action Plan:

- District children and adults are able to maintain healthy eating and physical activity to support a healthy weight while in schools and child care facilities.
- District residents consume a diet consistent with the Dietary Guidelines for Americans.
- District residents are physically active on a regular basis consistent with the Physical Activity Guidelines for Americans.
- District residents are able to maintain healthy eating and physical activity at their place of employment to support a healthy weight.
- District of Columbia Government agencies and community and professional non-government agencies collaborate to ensure that residents at risk of overweight and obesity have access to healthy foods, opportunities to be physically active, and supportive policies combined with information to regularly make healthy choices.

FOOD OPTIONS IN WARDS 4 AND 5

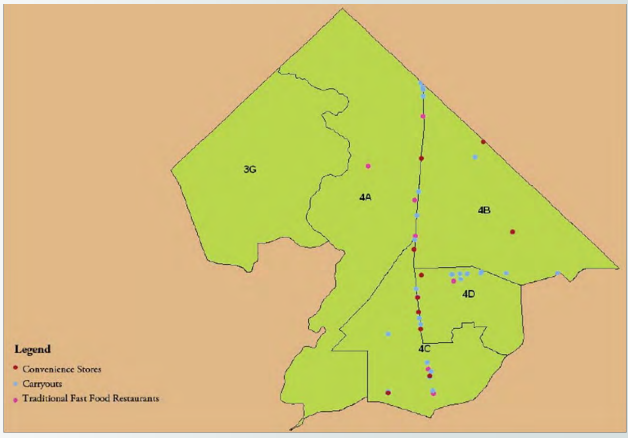
In Wards 4 and 5, obesity rates (25.8 and 29.9 percent, respectively) are higher than the city-wide average (22.4 percent), and residents are not likely to consume the recommended serving of fruits and vegetables when compared to wards with lower obesity rates. The following is an analysis of the geographic distribution and types of food options available in these wards. Food options are categorized into Category A (Farmers Markets, Organic Food Markets, Large Scale and Small Scale Grocery Stores), and Category B (Convenience Stores, Carry-outs, and Traditional Fast Food Restaurants). Figures 57and 59 display the distribution of Category B food options in Wards 4 and 5, respectively. Conversely, Figures 56 and 58 show limited Category A food options for Wards 4 and 5, respectively, compared to the abundance of Category B food options in these wards.

Figure 56. Distribution of Category A Food Options in Ward 4



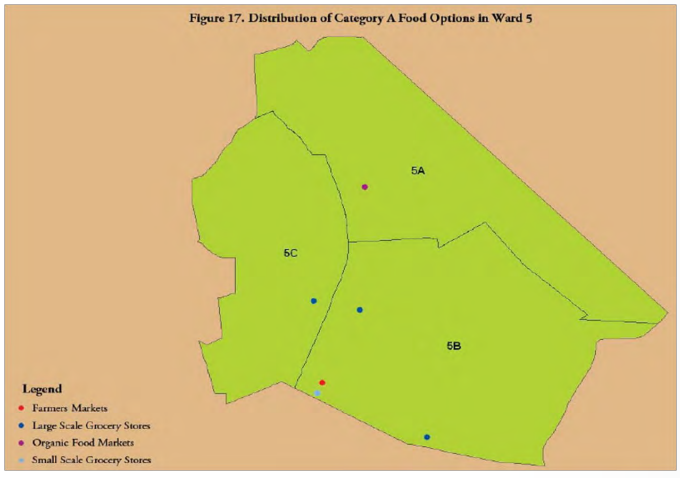
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 57. Distribution of Category B Food Options in Ward 4



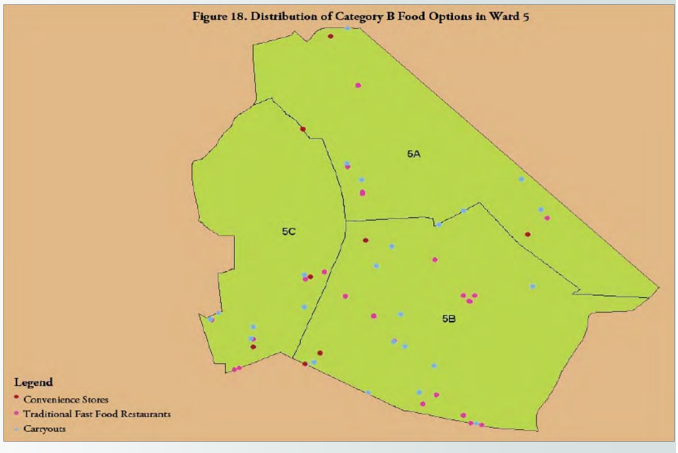
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 58. Distribution of Category A Food Options in Ward 5



Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 59. Distribution of Category B Food Options in Ward 5

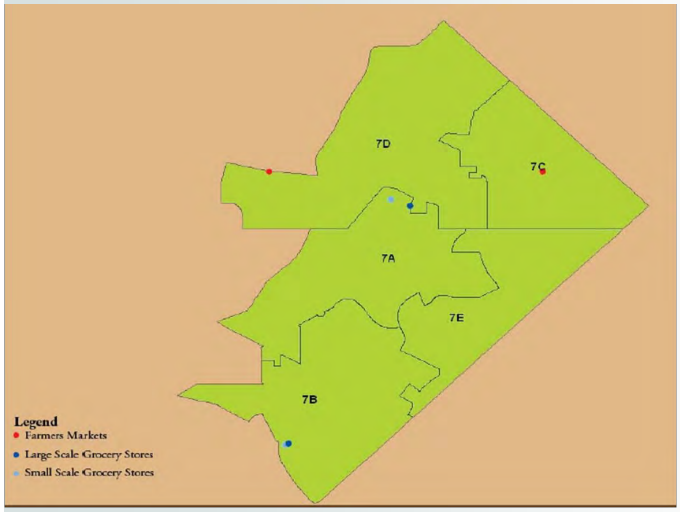


Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

FOOD OPTIONS IN WARDS 7 AND 8

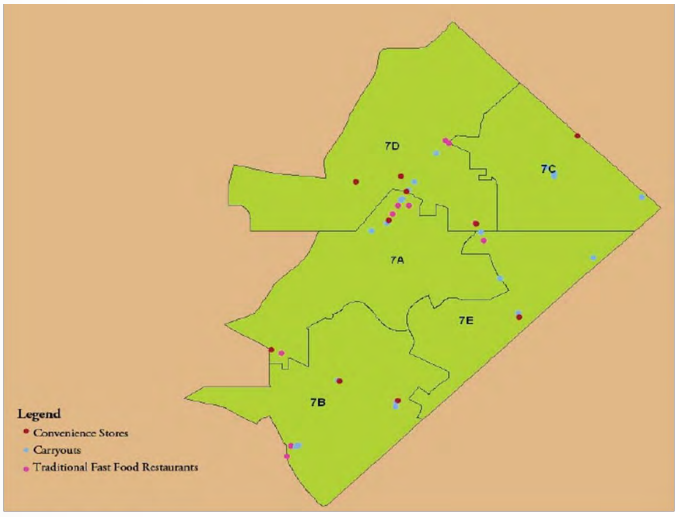
In Wards 7 and 8, obesity rates are highest in the District (35.3 and 44.4 percent, respectively), and residents are the least likely to consume the recommended serving of fruits and vegetables. The following is an analysis of the geographic distribution and types of food options available in these wards. Food options are categorized into Category A (Farmers Markets, Organic Food Markets, Large Scale and Small Scale Grocery Stores), and Category B (Convenience Stores, Carry-outs, and Traditional Fast Food Restaurants). Figures 61 and 63 display the distribution of Category B food options in Wards 7 and 8, respectively. Conversely, Figures 60 and 62 show limited Category A food options for Wards 7 and 8, respectively, compared to the abundance of Category B food options in these wards.

Figure 60. Distribution of Category A Food Options in Ward 7



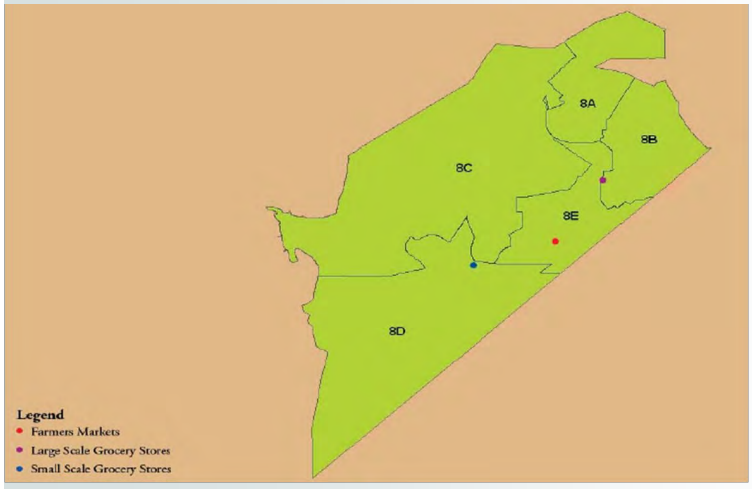
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 61. Distribution of Category B Food Options in Ward 7



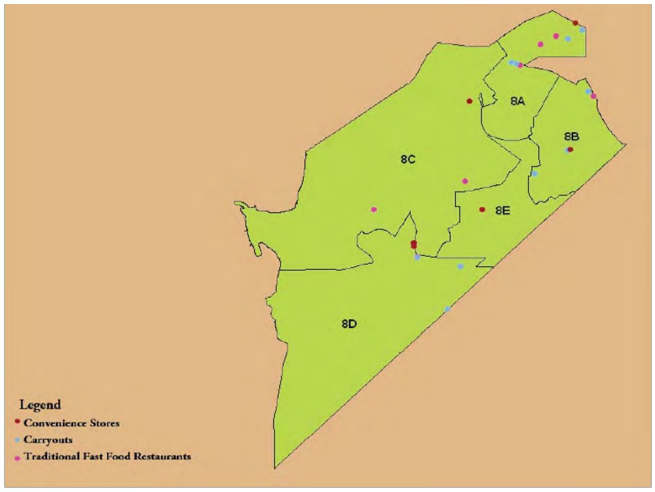
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 62. Distribution of Category A Food Options in Ward 8



Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

Figure 63. Distribution of Category B Food Options in Ward 8



Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

ALCOHOL CONSUMPTION

District of Columbia	Percent Heavy Drinker	Percent Binge Drinker
TOTAL	6.1	15.4
Gender		
Male	5.3	19.4
Female	6.7	12
Age		
18-34	8.8	73.8
35-44	4.8	81
45-54	5.8	86.3
55-64	6	92.6
65+	4.5	95.3
Race/Ethnicity		
Caucasian	10.3	76.8
African American	3.6	89.9
Other	3.1	85.2
Hispanic	5.2	86.2
Education		
Less than High School	6.2	9.3
High School Graduate	4.3	11.5
Some College	3.1	12.3
College Graduate	7.4	18.1
Income		
Less than $15,000	4	12.4
$15,000-$24,999	5.6	11.6
$25,000-$34,999	6.4	12
$35,000-$49,999	2.7	12
$50,000-$74,999	4.2	17.1
$75,000 and over	8.4	19.2
Ward Comparison		
Ward 1	5.2	17.9
Ward 2	6.4	18.8
Ward 3	8.6	16.7
Ward 4	4.1	14.6
Ward 5	3.4	10.4
Ward 6	7.8	20
Ward 7	2.4	6.2
Ward 8	5.5	11.9

Source: 2010 District of Columbia BRFSS

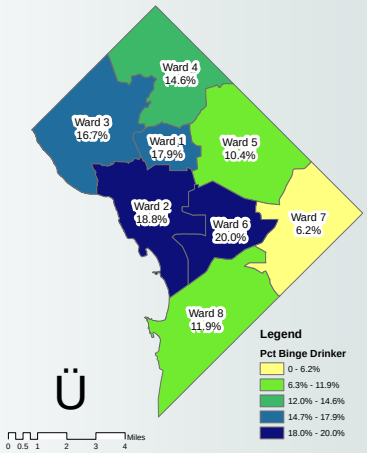
Healthy People 2010 Objectives

Goal Not Met: Reduce the proportion of adults engaging in binge drinking of alcoholic beverages to 6 percent; the District's rate is 15.4 percent.

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked a variety of questions about their alcohol intake during the past 30 days. This included whether or not they had at least one drink of any alcoholic beverage, how many days per week or per month they drank, how many alcoholic drinks they drank in a day on average, how many times they binge drank, and finally, the highest number of alcoholic drinks they consumed on any occasion.

- Binge drinking is defined as men drinking five or more and women drinking four or more alcoholic drinks within a two-hour time period. Overall, 15.4 percent of District respondents were considered to be binge drinkers compared to 15.1 percent nationally.
- Males were more likely than females to be binge drinkers, 19 percent and 12 percent, respectively.
- Adults aged 18-34 years were more likely than all other age groups to be binge drinkers, at 26.2 percent.
- Caucasians were more likely than all other race/ethnic subgroups to be binge drinkers, at 23.2 percent.
- College graduates were more likely than all other education subgroups to be binge drinkers, at 18 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to be binge drinkers, at 19.2 percent.
- Adults who resided in Ward 3 were more likely than all other wards to be binge drinkers, at 20 percent.
- Heavy drinking is defined as drinking two or more drinks per day for men and one or more drinks per day for women. The prevalence of heavy drinking for District adults is 6 percent compared to 5.1 percent nationally.

Figure 64. Map of Binge Drinking Status by Ward, 2010



TOBACCO USE

District of Columbia	Percent Current Smoker
TOTAL	15.6
Gender	
Male	18
Female	13.6
Age	
18-24	13.9
25-34	14.4
35-44	13.1
45-54	21.9
55-64	15.3
65+	10.3
Race/Ethnicity	
Caucasian	9.1
African American	21.5
Other	11.9
Hispanic	16.8
Education	
Less than High School	31.7
High School Graduate	28.3
Some College	19.7
College Graduate	8.9
Income	
Less than $15,000	38.5
$15,000-$24,999	26.2
$25,000-$34,999	18.2
$35,000-$49,999	13.4
$50,000-$74,999	18.9
$75,000 and over	9.3
Ward Comparison	
Ward 1	10.7
Ward 2	8.3
Ward 3	8.5
Ward 4	8.9
Ward 5	23
Ward 6	15.4
Ward 7	22.3
Ward 8	29.7

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

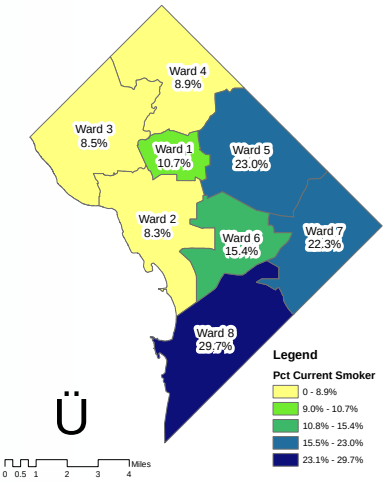
Goal Not Met: Reduce cigarette smoking by adults to 12 percent; the District rate is 15.6 percent.

Goal Not Met: Increase smoking cessation attempts by adult smoker to 75 percent (who stopped smoking for one day or longer in the past year because they were trying to quit); the District rate is 64.6 percent.

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they currently smoke (smoked at least 100 cigarettes in their entire life and now smoke every or some days).

- Overall, 15.6 percent of District respondents were current smokers compared to 17.3 percent nationally.
- Males were more likely than females to be current smokers, 18 percent and 13.6 percent, respectively.
- Adults aged 45-54 years were more likely than all other age groups to be current smokers, at 22 percent.
- African Americans were more likely than all other race/ethnic groups to be current smokers, at 21.5 percent.
- Adults with less than a high school education and high school graduates were more likely than all other education subgroups to be current smokers, at 31.7 percent.
- Adults with a household income of less than $15,000 we more likely than all other income subgroups to be current smokers, at 38.5 percent.
- Adults residing in Ward 8 were more likely than all other wards to be current smokers, at 29.7 percent.

Figure 65. Map of Current Smoking Status by Ward, 2010



PHYSICAL HEALTH

District of Columbia	Percent Engaged in Physical Activity
TOTAL	80
Gender	
Male	84.1
Female	76.4
Age	
18-24	82.8
25-34	86.5
35-44	83
45-54	78.5
55-64	78.1
65+	72
Race/Ethnicity	
Caucasian	90.6
African American	72
Asian	73.3
Other	78.1
Hispanic	79
Education	
Less than High School	61.8
High School Graduate	66.8
Some College	78.8
College Graduate	86.4
Income	
Less than $15,000	70.7
$15,000-$24,999	64.5
$25,000-$34,999	69.8
$35,000-$49,999	73.5
$50,000-$74,999	78
$75,000 and over	89.2
Ward Comparison	
Ward 1	83.7
Ward 2	86
Ward 3	92.2
Ward 4	79.9
Ward 5	72.4
Ward 6	85.1
Ward 7	69.4
Ward 8	68.5

Source: 2010 District of Columbia BRFSS

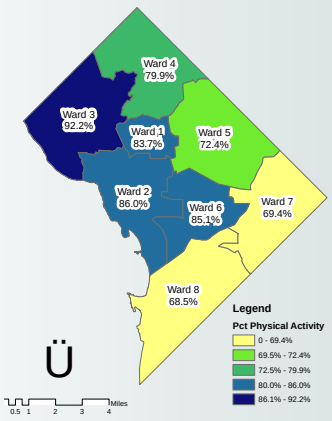
Healthy People 2010 Objectives

Goal Not Met: Reduce the proportion of adults who engage in no leisure-time physical activity to 20 percent; the District's rate is 21.4 percent.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if during the past month, other than their job, did they participate in any physical activities or exercise such as running, calisthenics, golf, gardening or walking for exercise.

- Overall, 80 percent indicated that during the past month, other than their job, they participated in physical activities or exercise such as running, calisthenics, golf, gardening or walking for exercise compared to 76 percent nationally.
- Males were more likely than females to participate in some form of physical activity within the past month, 84 percent and 76 percent, respectively.
- Adults aged 25-34 years were more likely than all other age groups to participate in some form of physical activity within the past month, at 86.5 percent.
- Caucasians were more likely than all other race/ethnic groups to participate in some form of physical activity within the past month, at 90 percent.
- College graduates were more likely than all other education subgroups to participate in some form of physical activity within the past month, at 86.4 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to participate in some form of physical activity within the past month, at 89 percent.
- Adults residing in Ward 3 were more likely than all other wards to participate in some form of physical activity within the past month, at 93 percent.

Figure 66. Map of Physical Activity by Ward, 2010



GENERAL HEALTH

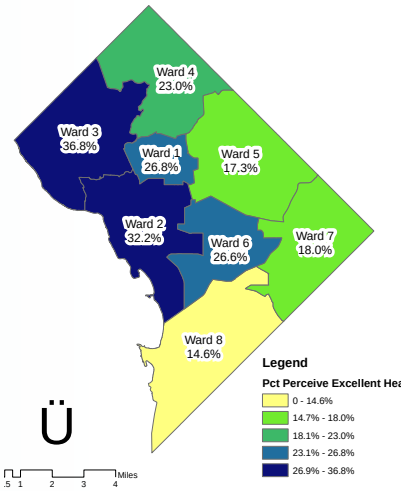
District of Columbia	Percent Excellent Health
TOTAL	25.2
Gender	
Male	26.3
Female	24.3
Age	
18-24	32.2
25-34	31.6
35-44	32.4
45-54	23.3
55-64	20.4
65 or older	13
Race/Ethnicity	
Caucasian	36.1
African American	16.9
Asian	27.3
Other	19.6
Hispanic	29.8
Education	
Less than High School	11.9
High School Graduate	17.2
Some College	18.2
College Graduate	30.9
Income	
Less than $15,000	14.7
$15,000-$24,999	12.5
$25,000-$34,999	18.9
$35,000-$49,999	21.4
$50,000-$74,999	17.7
$75,000 and over	34.9
Ward Comparison	
Ward 1	26.8
Ward 2	32.2
Ward 3	36.8
Ward 4	23
Ward 5	17.3
Ward 6	26.6
Ward 7	18
Ward 8	14.6

Source: 2010 District of Columbia BRFSS

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked how they rate their general health.

- Overall, 25 percent indicated that they rate their general health as excellent, 35.6 percent very good, 27.5 percent good, 9 percent fair, and 2.6 percent poor.
- Males were more likely than females to rate their general health as excellent, 26 percent and 24 percent, respectively.
- Adults aged 18-24 and 35-44 years were more likely than all other age groups to rate their general health as excellent, at 32 percent.
- Caucasians were more likely than all other race/ethnic groups to rate their general health as excellent, at 36 percent.
- College graduates were more likely than all other education subgroups to rate their general health as excellent, at 30.9 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to rate their general health as excellent, at 35 percent.
- Adults who resided in Ward 3 were more likely than all other wards to rate their general health as excellent, at 36.8 percent.

Figure 67. Map of Health Perception by Ward, 2010



LIFE SATISFACTION

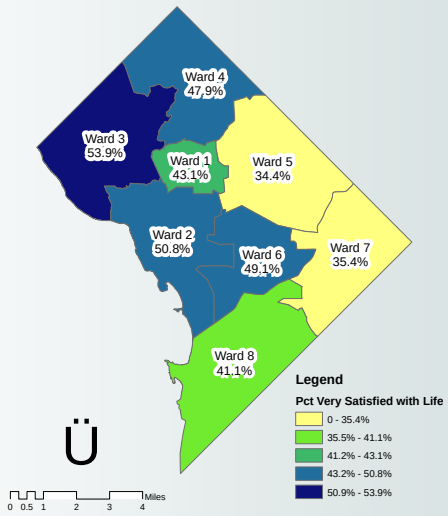
District of Columbia	Percent Very Satisfied
TOTAL	45.1
Gender	
Male	43.8
Female	46.3
Age	
18-24	37.4
25-34	45.7
35-44	46.4
45-54	43.4
55-64	46.8
65+	47.7
Race/Ethnicity	
Caucasian	53.4
African American	38
Asian	47.1
Other	42.9
Hispanic	48.7
Education	
Less than High School	35.1
High School Graduate	37.9
Some College	36.4
College Graduate	50.5
Income	
Less than $15,000	25.8
$15,000-$24,999	32.3
$25,000-$34,999	31.3
$35,000-$49,999	39.6
$50,000-$74,999	35.6
$75,000+	57.2
Ward Comparison	
Ward 1	43.1
Ward 2	50.8
Ward 3	53.9
Ward 4	47.9
Ward 5	34.4
Ward 6	49.1
Ward 7	35.4
Ward 8	41.1

Source: 2010 District of Columbia BRFSS

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked in general how satisfied they are with their life.

- Overall, 45 percent indicated that they were very satisfied with their life.
- Females were more likely than males to indicate that they were very satisfied with their life; 46 percent and 44 percent, respectively.
- Adults aged 65 years and older were more likely than all other age groups to be very satisfied with their life, at 47.7 percent.
- Caucasians were more likely than all other race/ethnic groups to be very satisfied with their life, at 53.4 percent.
- College graduates were more likely than all other education subgroups to be very satisfied with their life, at 50.5 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to be very satisfied with their life, at 57.2 percent.
- Adults who resided in Ward 3 were more likely than all other wards to be very satisfied with their life, at 53.9 percent.

Figure 68. Map of Life Satisfaction by Ward, 2010



SEXUAL HEALTH

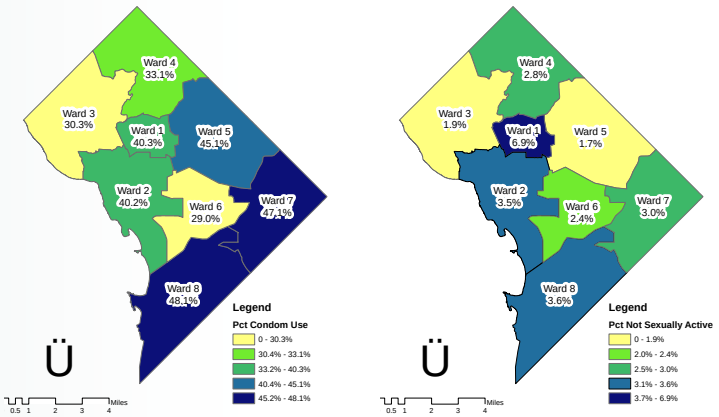
District of Columbia	Percent Condom Use	Not Sexually Active
TOTAL	38.2	3.1
Gender		
Male	42.9	1.8
Female	33.8	4.3
Age		
18-24	67.9	4.8
25-34	40.4	1.2
35-44	38.9	0.9
45-54	34.5	3.4
55-64	27.1	7.5
Race/Ethnicity		
Caucasian	30.3	1.8
African American	45.4	4.1
Other	39.7	4.5
Hispanic	*	2
Education		
Less than High School	*	*
High School Graduate	45.4	4
Some College	50.6	3.8
College Graduate	33.2	2.4
Income		
Less than $15,000	49.3	8.3
$15,000-$24,999	43.6	6.7
$25,000-$34,999	46.5	3.4
$35,000-$49,999	42	3.5
$50,000-$74,999	43	3.1
$75,000 and over	29.6	1.2
Ward Comparison		
Ward 1	40.3	6.9
Ward 2	40.2	3.5
Ward 3	30.3	1.9
Ward 4	33.1	2.8
Ward 5	45.1	1.7
Ward 6	29	2.4
Ward 7	47.1	3
Ward 8	48.1	3.6

Source: 2010 District of Columbia BRFSS

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they used a condom the last time they had sexual intercourse.

- Overall, 38 percent of District respondents indicated that they used a condom the last time they had sexual intercourse.
- Males were more likely than females to use a condom the last time they had sexual intercourse, 43 percent and 34 percent, respectively.
- Adults aged 18-24 years were more likely than all other age groups to use a condom the last time they had sexual intercourse, at 68 percent.
- African Americans were more likely than all other race/ethnic groups to use a condom the last time they had sexual intercourse, at 45 percent.
- Adults with some college education were more likely than all other education subgroups to use a condom the last time they had sexual intercourse, at 50.6 percent.
- Adults with a household income of less than $15,000 were more likely than all other income subgroups to use a condom the last time they had sexual intercourse, at 49 percent.
- Adults who resided in Ward 8 were more likely than all other wards to use a condom the last time they had sexual intercourse, at 48 percent.

Figure 69. Maps of Condom Use and Sexual Activity by Ward, 2010



HIGH-RISK BEHAVIOR

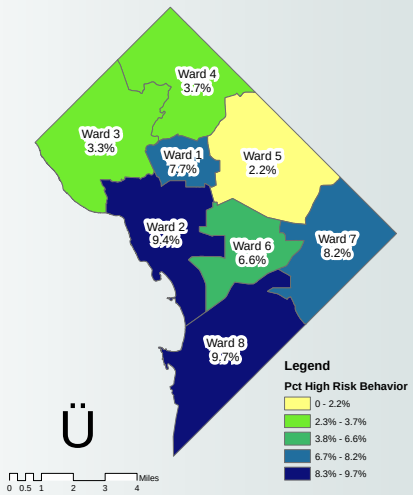
District of Columbia	Percent with High-Risk Behavior
TOTAL	6.4
Gender	
Male	8.8
Female	4.1
Age	
18-24	5.1
25-34	11.8
35-44	6.4
45-54	5.1
55-64	3.1
Race/Ethnicity	
Caucasian	6.4
African American	5.9
Asian	1.3
Other	10
Hispanic	11.9
Education	
Less than High School	16.1
High School Graduate	5.9
Some College	4.9
College Graduate	6.3
Income	
Less than $15,000	6.7
$15,000-$24,999	9.6
$25,000-$34,999	11.3
$35,000-$49,999	6.5
$50,000-$74,999	3.5
$75,000 and over	6.2
Ward Comparison	
Ward 1	7.7
Ward 2	9.4
Ward 3	3.3
Ward 4	3.7
Ward 5	2.2
Ward 6	6.6
Ward 7	8.2
Ward 8	9.7

Source: 2010 District of Columbia BRFSS

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were read a series of situations: Have they used intravenous drugs in the past year? Have they been treated for a sexually transmitted or venereal disease in the past year? Have they given or received money or drugs in exchange for sex in the past year? Have they had anal sex without a condom in the past year? Following, District residents were asked if any of the high-risk situations applied to them.

- Overall, 6 percent indicated that one or more of the high-risk situations applied to them.
- Males were more likely than females to participate in high-risk activities, 8.8 percent and 4 percent, respectively.
- Adults aged 25-34 years were more likely than all other age groups to participate in high-risk activities, at 12 percent.
- Hispanics were more likely than all other race/ethnic groups to participate in high-risk activities, at 12 percent.
- Adults with less than a high school education were more likely than all other education subgroups to participate in high-risk activities, at 16 percent.
- Adults with a household income of $25,000-$34,999 were more likely than all other income subgroups to participate in high-risk activities, at 11 percent.
- Adults who resided in Ward 8 were more likely than all other wards to participate in high-risk activities, at 10 percent.

Figure 70. Map of High Risk Behavior by Ward, 2010



ORAL HEALTH

District of Columbia	Percent Visited Dentist within Past Year
TOTAL	73.7
Gender	
Male	71
Female	76.1
Age	
18-24	65.8
25-34	72.1
35-44	76.8
45-54	76.2
55-64	74.4
65+	69.6
Race/Ethnicity	
Caucasian	85.6
African American	63.4
Asian	74.8
Other	74.6
Hispanic	79.8
Education	
Less than High School	46
High School Graduate	64
Some College	65.1
College Graduate	82.1
Income	
Less than $15,000	56.8
$15,000-$24,999	60.5
$25,000-$34,999	62.4
$35,000-$49,999	68.3
$50,000-$74,999	77
$75,000 and over	84.2
Ward Comparison	
Ward 1	67.5
Ward 2	87
Ward 3	88.3
Ward 4	71.3
Ward 5	66.3
Ward 6	79.2
Ward 7	63.1
Ward 8	60.4

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Not Met: Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the percentage of children who have had one or more cavities (filled or unfilled) is no more than 13 percent among children ages 2–4, 45 percent among children ages 6–8, and 50 percent among adolescents age 15.

Goal Not Met: Increase to at least 35 percent the proportion of 2nd and 3rd grade children who have received protective sealants in at least one of their permanent molar teeth.

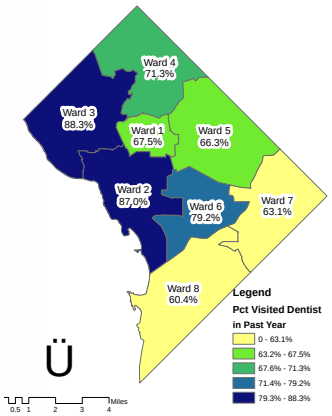
Goal Attained: Increase by at least 50 percent the number of children entering school programs who have received a dental assessment from a qualified health care professional to determine the existence of any decay or oral pathologies and/or deformities.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked how long has it been since they last visited a dentist or a dental clinic for any reason.

- Overall, 73.7 percent of District respondents visited a dentist or dental clinic within the past year compared to 69.8 percent nationally.
- Females were more likely than males to visit a dentist or a dental clinic within the past year, at 76 percent.
- Adults aged 35-44 years were more likely than all other age groups to visit a dentist or a dental clinic within the past year, at 77 percent.
- Caucasians were more likely than all other race/ethnic groups to visit a dentist or a dental clinic within the past year, at 85.6 percent.
- As education increased so did the likelihood that residents would visit a dentist or a dental clinic within the past year.
- Adult households with an income of $75,000 or more were more likely than all other income subgroups to visit a dentist or a dental clinic within the past year, at 84.2 percent.
- Adults who resided in Ward 3 were more likely than all other wards to visit a dentist or a dental clinic within the past year, at 88.3 percent.

District residents were asked how long it has been since they had their teeth cleaned by a dentist or dental hygienist. Overall, 73 percent of respondents had their teeth cleaned within the past year; 11 percent had their teeth cleaned within the past 2 years; 9 percent had their teeth cleaned within the past 5 years; 6.5 percent had their teeth cleaned 5 or more years ago and 0.9 percent never had their teeth cleaned by a dentist or dental hygienist.

Figure 71. Map of Dental Visit by Ward, 2010



PROMOTING HEALTHY AND SAFE COMMUNITIES

The environment plays a major role in the health and wellbeing of residents. The quality of the air, the natural environment, hazardous materials, food, water, housing and land use have health consequences. It is, therefore, important that public health pay attention to the environmental causes of morbidity and mortality.

Since its inception in 2006, the District Department of the Environment (DDOE) has focused on protecting and enhancing the health of District residents and the natural environment. DDOE's Environmental Services Administration works to reduce hazards and contaminants in District land, air, water and homes by certifying facilities and professional service providers, reviewing plans, issuing permits, and conducting inspections. The Department of Health's Health Regulation and Licensing Administration (HRLA) also focuses on reducing the number of food-borne illnesses.

In 2000, many of the indicators and progress measures for the District of Columbia indicated that violence and abusive behaviors constitute even more of a problem for this city than the nation in general. Nationally, violence and abusive behavior continue to be major causes of death, injury and stress. Unintentional injuries and accidents also cause morbidity and mortality, affecting all segments of society. Injuries continue to be the second leading cause of death for young persons ages 15 to 24 and the leading cause of death for African Americans in this age group. Understanding the incidence and prevalence of violence related injuries in the District of Columbia creates opportunities for the development and implementation of comprehensive and effective prevention measures.

It is vital that public and private agencies in the District continue to collaborate in addressing injury and violence prevention. Public, private, and community-based agencies throughout the District have traditionally approached violence and injury outreach from a judicial, educational, and/or environmental perspective. The focus of the Department of Health (DOH) is a holistic approach to address the public health problems associated with violence and injury prevention.

ENVIRONMENTAL HEALTH

Since its enactment over 30 years ago, the federal Clean Air Act has fostered significant progress toward improving the quality of the air we breathe. Emissions of many pollutants have substantially decreased due to the implementation of air pollution control measures. In the past 20 years, levels of the most common ambient air pollutants throughout the country—particulate matter, ground-level ozone, sulfur dioxide, nitrogen dioxide, carbon monoxide, and lead—have dropped. In spite of these successes, there is still room for air quality improvement in the District because levels of some pollutants continue to exceed the national health standards. Poor air quality can contribute to increased asthma rates in both children and adults, increased rates of respiratory disease, and even premature death.

- The Air Quality Index (AQI) is a color-coded guide to daily air quality information that rates the air on a spectrum from good to very unhealthy. AQI levels correspond with national health standards and are based on the concentration of pollutants in the air and corresponding potential health impacts.
- An orange rating signals standards that are unhealthy for children, the elderly, and those with heart or respiratory conditions.
- A red rating suggests unhealthy conditions for the entire population—sensitive groups should avoid outdoor activities, and everyone should limit outdoor physical exertion.
- A purple score suggests that conditions are very unhealthy for the entire population; everyone should avoid outdoor activities on these days. Comparisons of the number of purple, red, and orange alert days per year can help us understand how much air quality has improved over time and where improvement is still needed.

The quantity of purple, red, and orange alert days is highly dependent on weather (sunlight and hot weather help form ozone), motor vehicle emissions, and the quality of the air that is transported into the District and entire Washington metropolitan area from upwind sources. An increase in the stringency of the ozone standards (i.e., a lower numerical value) by the Environmental Protection Agency (EPA) may also cause an apparent increase in the number of air quality alert days - an ozone concentration that is below one standard and not trigger an alert day might be above a new, more stringent standard and so trigger an alert.

Healthy People 2010 Objectives

Goal Not Met: Reduce the prevalence of blood lead levels greater than or equal to 10 µg/dL in children 6 months to 6 years in age, and ensure that no District child in this age group has a blood lead level greater than or equal to 10µg/dL.

In the District in 2010, 107 children between 6 months and 72 months of age (0.7 percent of those tested) were identified with a blood lead level of 10 µg/dL or greater, of whom 35 (0.2 percent of those tested) had a blood lead level of 15µg/dL or greater. (DDOE LeadTrax database, verified and confirmed on June 28, 2011)

Goal Attained: Improve air quality to healthy levels for 100 percent of the people who reside in and visit the District.

The only criteria pollutant for which the District is not in nonattainment is ground-level ozone (also known as smog). In the year 2010, the smog levels showed a significant 21 percent decrease compared to the level in 1999.

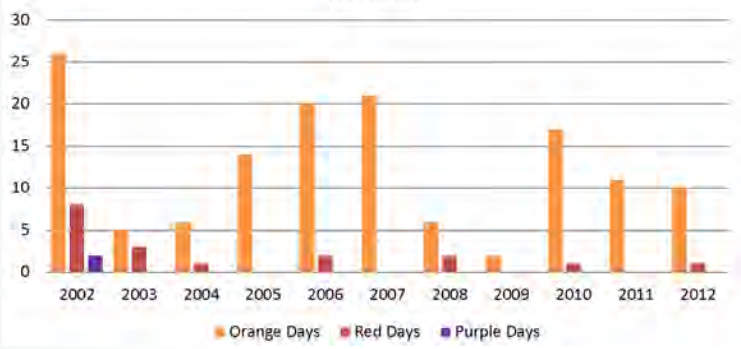
Goal Not Met: Eliminate significant health risks from the National Priority List (NPL) of hazardous waste sites, as measured by performing a level of site cleanup sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments.

Goal Not Met: National Poison Control Center to identify the total number of accidental pesticidal exposures, routes of exposure, and types of pesticides involved. Design an outreach and education program targeted to reduce the causes of the most frequent types of exposure.

Figure 72. Color-Coded Key to Interpretation of Air Quality Index Values

Air Quality Index (AQI) Values	Levels of Health Concern	Colors
When the AQI is in this range:	*..air quality conditions are:*	*...as symbolized by this color:*
0-50	Good	Green
51-100	Moderate	Yellow
101-150	Unhealthy for Sensitive Groups	Orange
151 to 200	Unhealthy	Red
201 to 300	Very Unhealthy	Purple
301 to 500	Hazardous	Maroon

Figure 73. Ten-Year Trends in Air Quality Alert Days by Air Quality Index Categories in the District of Columbia, 2002-2012



Source: http://airnow.gov/index.cfm?action=aqibasics.aqi "The U.S. EPA, NOAA, NPS, tribal, state, and local agencies developed the AIRNow Web site to provide the public with easy access to national air quality information. The Web site offers daily AQI forecasts as well as real-time AQI conditions for over 300 cities across the US, and provides links to more detailed State and local air quality Web sites."

FOOD SAFETY

There are a multitude of places where food safety can be compromised along the farm to table continuum: farms, transport companies, processing plants, groceries and retail stores, restaurants, institutional facilities, and other food service establishments. Foodborne disease surveillance is necessary for identifying trends that may signify an outbreak, identifying the source of disease, preventing outbreaks, and determining when control measures are needed. The DC DOH is authorized by law to investigate foodborne and other food-implicated communicable diseases of DC residents. Environmental investigations focus on inspecting suspected sites where foodborne illness originated—the temperature and sanitation of food storage, safe handling, health of food handlers, and details of preparation of implicated foods.

- From 2007-2010, the highest number of foodborne disease cases reported among District residents were attributed to ***Salmonella*** (30.5 percent), ***Giardia*** (27.8 percent), and ***Campylobacter*** (17.1 percent) (Figure 74.
- These pathogens are commonly transmitted through the ingestion of contaminated food or water. Symptoms of foodborne illness include diarrhea, abdominal pain, nausea, fever, or headache with varying severity.

The Food Safety and Hygiene Inspection Services Division (FSHISD) of HRLA within DC DOH inspects the District's approximately 5,100 food establishments. These include boarding homes, commission merchants, dairies, delicatessens, bakeries, candy manufacturers, grocery stores, retail markets, ice cream manufacturers, restaurants, wholesale markets, mobile vendors and hotels.

FSHISD conducts routine inspections of food establishments to prevent food-borne outbreaks, protect the food supply, and protect the public health and safety of residents and visitors in the District. It also offers educational, informational, and consultative sessions for community and industry groups.

- More than 3,000 inspections of new food establishments in the District are conducted annually (Figure 75).
- In addition to routine food safety inspections, the FSHISD reviews food establishment plans, issues and renews business licenses, and investigates and responds to consumer complaints.
- From October 2010 to September 2011 (Fiscal Year 2011-2012), there were 222 establishment closures in the District. Grounds for closure due to imminent public health risks may include but are not limited to fire, flood, extended interruption of electrical or water service, sewage backup, misuse of poisonous or toxic materials, onset of an apparent foodborne illness outbreak, gross insanitary occurrence or condition or other circumstance that may endanger the public health, such as rodent infestation.

Healthy People 2010 Objectives

Goal Met: Reduce outbreaks of *Salmonella enteriditis* to fewer than 25 outbreaks yearly.

There were no *Salmonella enteriditis* outbreaks in the District in 2010 (National Electronic Disease Surveillance System, 2010).

Goal Not Met: Reduce infections caused by key foodborne pathogens to incidences per 100,000 of no more than those listed below:

HP 2010 Goal	2010 Actual
(Per 100,000 people)	(Per 100,000 people)
Salmonella species, rate of 0	Salmonella, rate of 15.0
Escherichia coli 0157: H7, rate of 0	E.Coli STEC, rate of 1.7
Listeria monocytes, rate of 0	Listeriosis, rate of 0.2
Unknown etiology, rate of 1	Campylobacteriosis, rate of 10.0

Figure 74. Foodborne Disease Cases among District Residents, 2007-2010

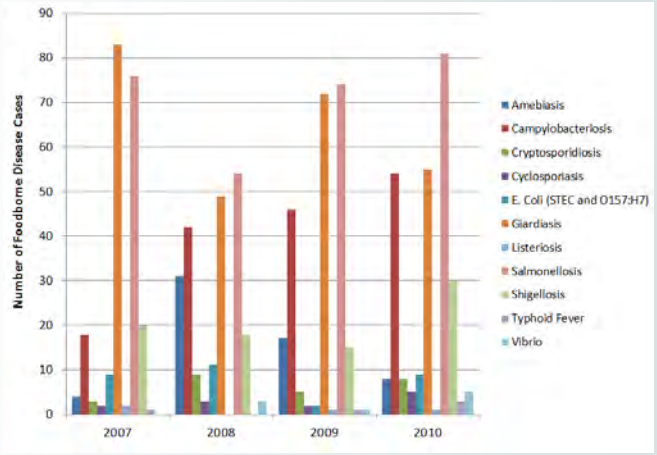
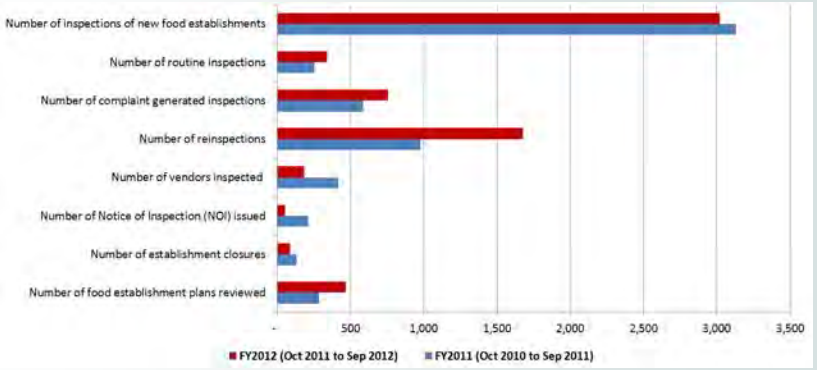


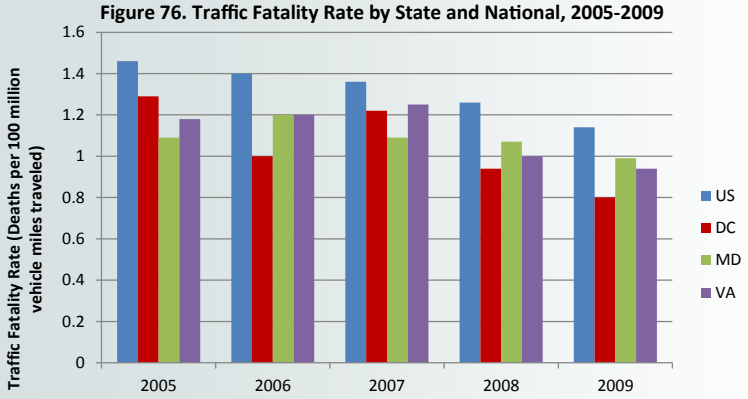
Figure 75. Food Establishment Inspections Conducted by DC DOH, FY 2011-2012



Source:
District of Columbia Disease Surveillance Bulletin, 2008-2010
Healthy People 2010 Final Report
Health Licensing and Regulation Administration, Outcome Measures for FY 2011 and FY 2012

PUBLIC SAFETY

Figure 76. Traffic Fatality Rate by State and National, 2005-2009



Source: U.S. National Highway Traffic Safety Administration, Traffic Safety Facts

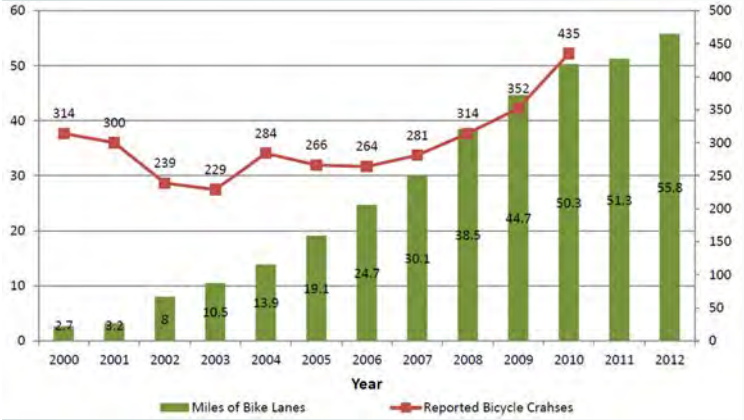
Transportation Facts in the District

- 41 percent (121,000) of District residents commuted by motor vehicle
- 38 percent (113,700 daily) of District residents commuted by public transportation
- 27 percent (79,100) of District households do not have access to a motor vehicle
- 12 percent (35,000 daily) of District residents walked to work
- 3 percent (9,300 daily) of District residents biked to work in 2010

Snapshot of Bicycle Facilities and Infrastructure in the District

- 56 miles of Bike Lanes (marked streets)
- 56 miles of Bike Trails (parkland)
- 3 miles of Cycle Tracks
- 2,300 Bike Racks installed since 2001
- 1,500 Capital Bikeshare Bikes (DC's premiere Bike Sharing Program
- 137 Capital Bikeshare Stations
- 84 miles of Signed Bike Routes
- 6.6 miles of Shared Lanes

Figure 77. Bicycle Crashes Relative to Miles of Bike Lanes



Source:
American Community Survey (ACS) 2010. Means of Travel to Work (Data is collected for workers 16 years old and over who reside in the District regardless of their place of work)
District of Columbia Department of Transportation. District of Columbia Bike Program Fact Sheet

Healthy People 2010 Objectives

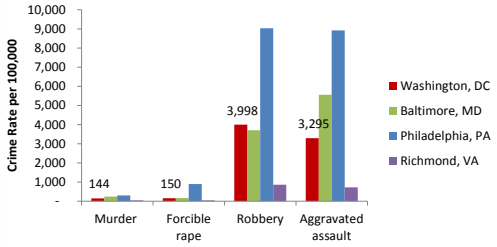
Goal Attained: Establish a Trauma/Injury Registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics; DOH is installing software to begin a Trauma Registry.

Goal Not Met: Increase to 90 percent the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data to the DOH Trauma/Injury Registry.

Two trauma facilities (Washington Hospital Center and Children's National Medical Center) have submitted their data to the District's Trauma Registry. (E-mail from Digital Innovations contractor on the current status of the District Trauma Registry, dated 22 February 2012).

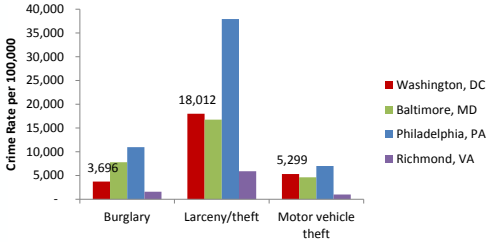
- According to the US National Highway Traffic Safety Administration, there were 192 traffic fatalities in the District (deaths within 30 days of accident) from 2005 to 2009.
- During this 5-year period, the traffic fatality rate in the District was lower than the national rate.
- In 2009, the traffic fatality rate in the District was 0.8 deaths per 100 million vehicle miles traveled, lower than Maryland and Virginia's rate (1.0 and 0.9 deaths per 100 million vehicle miles traveled, respectively).
- Violent crime in the District, which includes murder, forcible rape, robbery, and aggravated assault, was lower than in neighboring large cities Philadelphia and Baltimore in 2009. The crime rate due to robbery alone was higher in DC compared to Baltimore in 2009.
- Total property crime, which includes burglary, larceny/theft, and motor vehicle theft, was lower in the District than in Philadelphia and Baltimore in 2009. However larceny/theft alone or motor vehicle theft alone was higher in DC than in Baltimore in 2009.

Figure 78. Violent Crime in Select Large Cities, 2009



Data Source: Crime in the United States, FBI website: http://www.fbi.gov/stats-services/crimestats

Figure 79. Property Crime in Select Large Cities, 2009



Data Source: Crime in the United States, FBI website: http://www.fbi.gov/stats-services/crimestats

SEAT BELT USE

District of Columbia	Percent Always Use Seatbelt
TOTAL	90.4
Gender	
Male	89.2
Female	91.4
Age	
18-24	84.7
25-34	90
35-44	89.6
45-54	92
55-64	91.5
65+	90.6
Race/Ethnicity	
Caucasian	92.8
African American	89.3
Asian	86.7
Other	90.7
Hispanic	83.6
Education	
Less than High School	87.9
High School Graduate	89.4
Some College	88.8
College Graduate	91.3
Income	
Less than $15,000	88.5
$15,000-$24,999	91.9
$25,000-$34,999	89.5
$35,000-$49,999	87.4
$50,000-$74,999	90.6
$75,000 and over	90.3
Ward Comparison	
Ward 1	87.8
Ward 2	92.5
Ward 3	93.6
Ward 4	90.2
Ward 5	92.1
Ward 6	91.3
Ward 7	91
Ward 8	87.2

Source: 2010 District of Columbia BRFSS

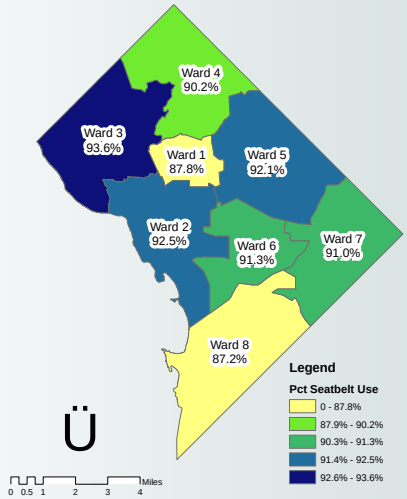
Healthy People 2010 Objectives

Goal Not Met: Increase the use of safety belts to 92 percent; the District's rate is 90.5 percent.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked how often they use seat belts when they drive or ride in a car.

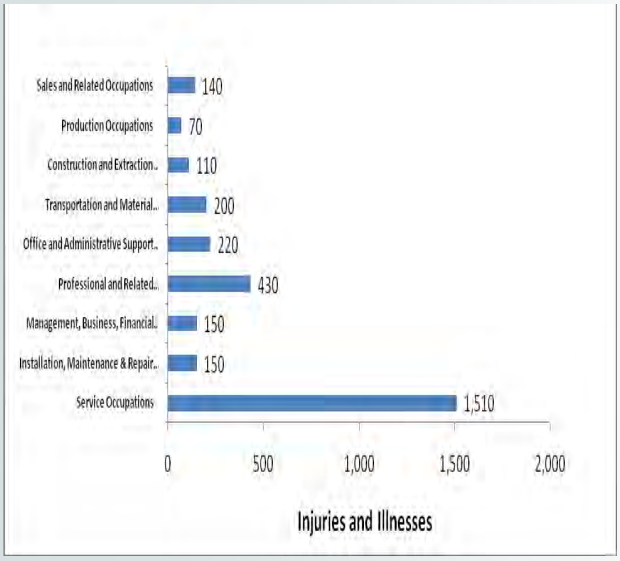
- Overall, 90.4 percent respondents reported always wearing their seat belts and 9.6 percent reported not always wearing their seat belt.
- Males were more likely than females to report they do not always wear their seat belt, at 10.8 percent.
- Adults aged 18-24 years were more likely than all other age groups to report they do not always wear their seat belt, at 15.3 percent.
- Hispanics were more likely than all other race/ethnic groups to report they do not always wear their seat belt, at 16.4 percent.
- Adults with less than a high school education were more likely than all other education sub-groups to report they do not always wear their seat belt, at 12 percent.
- Adult households with an income of $35,000-$49,000 were more likely than all other income subgroups to report they do not always wear their seat belt, at 12.6 percent.
- Adults who resided in Ward 8 were more likely than all other wards to report they do not always wear their seat belt, at 13 percent.

Figure 80. Map of Seatbelt Use by Ward, 2010



OCCUPATIONAL INJURY

Figure 81. Injury and Illness Cases Involving Days Away From Work by Selected Occupational Group and Industry Sector, 2010



Source: DOH, Characteristics for Injuries and Illnesses Requiring Days Away from Work in Private Industry 2010

Fatal Work Injuries in the District of Columbia

There were 16 fatal work injuries in 2010 for the District of Columbia, according to the DC DOH Census of Fatal Occupational Injuries (CFOI), in cooperation with the US Department of Labor, Bureau of Labor Statistics (BLS). The 2010 count of workplace fatalities increased 5 over the year and was 3 more than the highest total since 2006. Assaults and violent acts were the leading cause of on-the-job fatalities in 2010 (44 percent). The service providing industry accounted for 56 percent of the total workplace fatalities in the District.

Key Characteristics

- Men (15) accounted for almost all of the work-related fatalities in the District. Assaults and violent acts were the leading cause.
- Six of the seven fatalities caused by assaults and violent acts were shootings.
- Workers aged 35-54 years comprised of 10 fatalities in the District, representing 63 percent of work-related fatalities in 2010; three of the five fatal workplace injuries in the 35-44 age group occurred in falls and three of the five fatal workplace injuries in the 45-54 age group occurred in assaults and violent acts.
- Eleven of the workers who died on-the-job in the District worked for wages and salaries.
- Thirty-eight percent of the workers who died on-the-job were Black, non-Hispanic.
- Five self-employed workers died in 2010. Assaults and violent acts accounted for all of these.

The District of Columbia's Annual Survey of Occupational Injuries and Illnesses for 2010 showed that there were 2,980 work-related injury and illness cases reported in the private industry that required days away from work. Sprains and strains accounted for approximately 33 percent of these cases and was the leading type of injury or illness. Service occupations had the most injury and illness days away from work cases and made up 1,510 or 51 percent of the cases; followed by professional and related occupations with 430 or 14 percent of the cases.

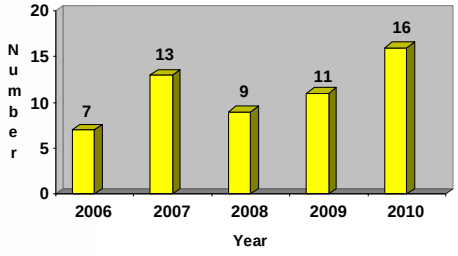
Case Characteristic Highlights

- The leading nature of the work-related injury or illness cases involving days away from work was sprains and strains (990 cases); other significant causes were soreness and pain (390), bruises and contusions (370) cases and cuts and lacerations (250 cases).
- The part of the body that was most frequently affected by injuries and illnesses was the trunk (850), which includes the back and shoulder, which accounted for 29 percent of all days away from work cases. Lower extremities, including the knee, ankle, foot and toe, accounted for 26 percent while upper extremities, including arm, wrist, hand, and finger, accounted for 23 percent of all days away from work cases.
- Floor and ground surfaces accounted for 28 percent of all sources of injury and illness cases.
- Cases involving contact with an object or equipment accounted for 740, the majority of these were cases involving being struck by an object which accounted for 490 cases. The next largest event categories involved cases with falls on the same level and overexertion which accounted for 580 cases each.

Demographic Highlights

- Fifty-four percent of the occupational injuries and illnesses that resulted in days away from work involved women (1,620 cases).
- Workers in the age range of 45-54 years accounted for 27 percent or 810 cases.
- Forty-seven percent of the occupational injuries and illnesses that resulted in days away from work involved Black or African American workers (1,400).
- Employees with a length of service with their employer from one to five years or more accounted for 2,330 of the injuries and illnesses.
- Of the injuries and illnesses with days away from work that reported the time of incident, the hours from 8:01 AM to 12:00 PM accounted for 890 incidents.
- Of the injuries and illnesses with days away from work that reported hours on the job before the event occurred, employees on the job for two to four hours made up 700 cases.
- Tuesday (600 cases) and Thursday (540 cases) were the days of the week when most of the injuries and illnesses involving days away from work occurred.

Figure 82. Number of Fatal Work Injuries in the District of Columbia, 2006-2010



Source: DOH, DC Workplace Fatalities 2010

IMPROVE ACCESS TO QUALITY AND HEALTHCARE SERVICES

As the District has long recognized, all residents deserve equal access to quality health care which can help reduce deaths due to preventable diseases and ultimately lower health care costs. Consistent with specific priorities identified in the One City Action Plan to improve the quality of life for all, the District has taken important steps to expanding health care services in its underserved areas. These include recent investments of more than $90 million for the construction of new primary health care clinics and approximately $3 million to the District's loan repayment program (HPLRP) that assists with recruiting and retaining primary care, mental health and dental providers to serve in underserved areas. The District's capital investments have funded a total of 16 projects over the last five years. These health centers are focused on expanding access to prevention and primary care.

Primary care is usually the gateway to the health care delivery system. Primary care is utilized by people of all walks of life, with all types of health problems. It is, therefore, important that the services be accessible and that providers have extensive knowledge in many areas. While the District has one of the highest numbers of nurses, doctors, hospitals and other health care facilities per capita, accessing primary care continues to be a challenge for many residents. A large percentage of District residents live in neighborhoods that are designated by the federal government as Health Professional Shortage Areas (HPSAs) indicating that there are not enough primary care doctors located in these areas and/or serving the populations in these areas. The Department of Health is responsible for identifying shortage areas, funding the establishment of new facilities in underserved areas, and recruiting and retaining primary care providers to work in shortage areas and at facilities that serve the residents of those areas and all residents at-risk for underservice.

While the percentage of uninsured adults has increased over the last three years, nationally, it has been going down in the District of Columbia. Uninsured persons are disproportionately low income. Even with persons who are in the workforce, many are not covered by employers or cannot afford to make the necessary contributions to get coverage. For those who are working and have insurance, the premiums have gone up so that insurance costs more to retain. The increase in the uninsured leads to an increase in Medicaid enrollment.

PRIMARY CARE

District of Columbia	Percent with Health Care Provider
TOTAL	83.3
Gender	
Male	78.1
Female	87.9
Age	
18-34	69.5
35-44	81.3
45-54	86.2
55-64	91.4
65+	94.4
Race/Ethnicity	
Caucasian	84.5
African American	84.3
Asian	70.2
Other	77.5
Hispanic	80.6
Education	
Less than High School	80.7
High School Graduate	81.9
Some College	83.0
College Graduate	84.2
Income	
Less than $15,000	73.8
$15,000-$24,999	75.6
$25,000-$34,999	86.8
$35,000-$49,999	83.3
$50,000-$74,999	84.5
$75,000 and over	87.3
Ward Comparison	
Ward 1	82.8
Ward 2	87.2
Ward 3	86.9
Ward 4	88.6
Ward 5	78.7
Ward 6	89.3
Ward 7	82.9
Ward 8	84.8

Source: 2010 District of Columbia BRFSS

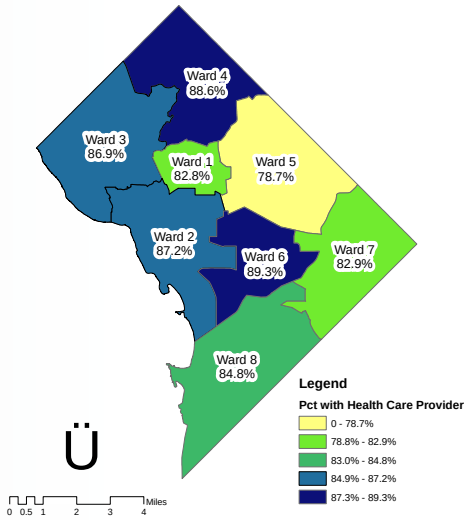
Healthy People 2010 Objectives

Goal Not Met: Increase the proportion of persons who have a regular primary care provider to 85 percent; the District's rate is 79.3 percent.

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have at least one person they thought of as their personal doctor or health care provider.

- Overall, 83.3 percent of District respondents stated that they had at least one person they thought of to be their personal doctor or health care provider.
- Females were more likely than males to have at least one person they think of as their personal doctor or healthcare provider, 87.9 percent and 78.1 percent, respectively.
- Adults aged 55-64 years and 65 or older were more likely than all other age groups to have at least one person they thought of as their personal doctor or health care provider, at 91.4 and 94.4 percent, respectively.
- Caucasians and African Americans were more likely than all other race/ethnic groups to have at least one person they thought of as their personal doctor or health care provider, at 84.5 percent. And 84.3 percent respectively.
- College graduates were more likely than all other education subgroups to have at least one person they thought of as their personal doctor or health care provider, at 84.2 percent.
- Adults with a household income of $75,000 and over were more likely than all other income subgroups to have at least one person they thought of as their personal doctor or health care provider, at 87.3 percent.
- Adults who resided in Ward 6 were more likely than all other wards to have at least one person they thought of as their personal doctor or health care provider, at 89.3 percent.

Figure 83. Map of Percent with Health Care Provider by Ward, 2010



ROUTINE CHECK-UP

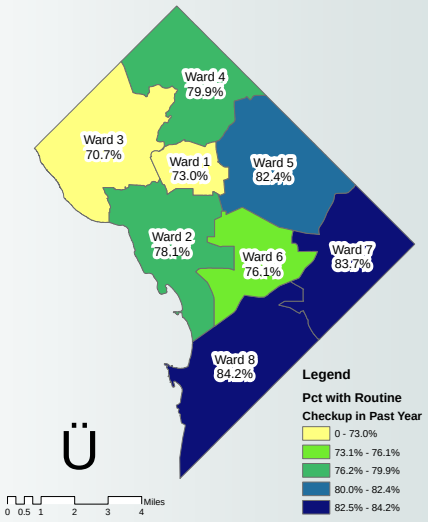
District of Columbia	Percent with Routine Check-up within Past Year
TOTAL	77.4
Gender	
Male	72.0
Female	82.2
Age	
18-34	69.9
35-44	72.4
45-54	78.6
55-64	80.4
65+	91.0
Race/Ethnicity	
Caucasian	69.4
African American	84.7
Asian	71.0
Other	75.9
Hispanic	77.7
Education	
Less than High School	90.6
High School Graduate	86.0
Some College	82.8
College Graduate	72.0
Income	
Less than $15,000	78.7
$15,000-$24,999	77.5
$25,000-$34,999	87.2
$35,000-$49,999	83.7
$50,000-$74,999	78.7
$75,000 and over	73.5
Ward Comparison	
Ward 1	73.0
Ward 2	78.1
Ward 3	70.7
Ward 4	79.9
Ward 5	82.4
Ward 6	76.1
Ward 7	83.7
Ward 8	84.2

Source: 2010 District of Columbia BRFSS

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked how long it has been since they last visited the doctor for a routine check-up.

- Overall, 77.4 percent of District respondents indicated that they had visited the doctor within the past year.
- Females were more likely than males to visit a doctor for a routine check up within the past year, 82.2 percent and 72 percent, respectively.
- Adults aged 65 years and older were more likely than all other age groups to visit a doctor for a routine check-up within the past year, at 91 percent.
- African Americans were more likely than all other race/ethnic groups to visit a doctor for a routine check-up within the past year, at 84.7 percent.
- Adults with less than a high school education were more likely than all other education sub-groups to visit a doctor for a routine check-up within the past year, at 90.6 percent.
- Adults with a household income of $25,000-$34,999 were more likely than all income sub-groups to visit a doctor for a routine check-up within the past year, at 87.2 percent.
- Adults who resided in Ward 8 were more likely than all other wards to visit a doctor for a routine check-up within the past year, at 84.2 percent.

Figure 84. Map of Routine Check-up by Ward, 2010



HEALTH CARE COVERAGE

District of Columbia	Percent Covered by Health Plan
TOTAL	93
Gender	
Male	91.1
Female	94.6
Age	
18-34	89.6
35-44	96
45-54	91.3
55-64	92.3
65+	96.7
Race/Ethnicity	
Caucasian	97.4
African American	90.4
Other	87.4
Hispanic	91
Education	
Less than High School	90.7
High School Graduate	88.1
Some College	88.7
College Graduate	95.9
Income	
Less than $15,000	81
$15,000-$24,999	86.6
$25,000-$34,999	90.2
$35,000-$49,999	88
$50,000-$74,999	91.2
$75,000 and over	98.9
Ward Comparison	
Ward 1	96.2
Ward 2	95
Ward 3	97.4
Ward 4	91.6
Ward 5	86.2
Ward 6	97.6
Ward 7	90.5
Ward 8	89.7

Source: 2010 District of Columbia BRFSS

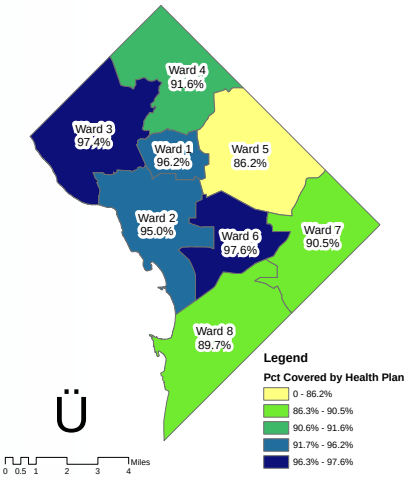
Healthy People 2010 Objectives

Goal Not Met: Increase the proportion of adults under age 65 years with health insurance to 100 percent; the District's rate is 93 percent.

District respondents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have any kind of health care coverage, including health insurance, prepaid plans such as Health Maintenance Organizations (HMO) or government plans such as Medicare.

- Overall, 93 percent of District respondents aged 18-64 years old indicated that they have health care coverage, compared to 85 percent nationally.
- Females were more likely than males to have health coverage; 94.6 percent and 91.1 percent respectively.
- Adults aged 65 years and older were more likely than all other age groups to have health coverage, at 96.7 percent.
- Caucasians were more likely than all other race/ethnic groups to have health coverage, at 97.4 percent.
- College graduates were more likely than all other education subgroups to have health coverage, at 96 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to have health coverage, at 98.9 percent.
- Adults who resided in Wards 3 and 6 were more likely than any other wards to have health coverage, 97.4 and 97.6 percent, respectively.

Figure 85. Map of Percent Covered by Health Plan by Ward, 2010



HOSPITAL UTILIZATION TRENDS

Emergency visits and ambulatory services increase steadily while patient days decline in the District.

Pregnancy–related and Heart Disease are the two leading causes of hospitalization for DC residents.

The source of the data is the District of Columbia Hospital Association's (DCHA) Monthly Utilization Survey and Quarterly Bed Capacity and Census Survey (self-reported by individual hospitals). The graphs in this section describe utilization trends in the aggregate for the following District acute care non-federal hospitals: Children's National Medical Center, George Washington University Hospital, Howard University Hospital, MedStar Georgetown University Hospital, MedStar Washington Hospital Center, Providence Hospital, Sibley Memorial Hospital, and United Medical Center.

- The number of ambulatory surgeries (scheduled surgical services provided to patients who do not remain in the hospital overnight) continues to increase steadily. Visits were up by over 3,800 visits, or 6.0 percent, over the past five years and up 11,500 visits, or 20.7 percent, over the last decade.
- District hospitals have seen an increase in emergency department visits of more than 85,300, or 20.9 percent, over the last five years. Over the last ten years, the increase was even greater at over 103,200, or 26.5 percent.
- After reaching the highest point in 2006 since the early nineties, the number of inpatient admissions and patient days has declined over the last five years, by 2.6 and 7.2 percent, respectively. As evident in the overall increase in ambulatory surgeries and the decrease in inpatient days of care, the hospitals continue to provide more and more care on an outpatient basis.

Figure 86. Hospital Utilization Trends, 2007-2011

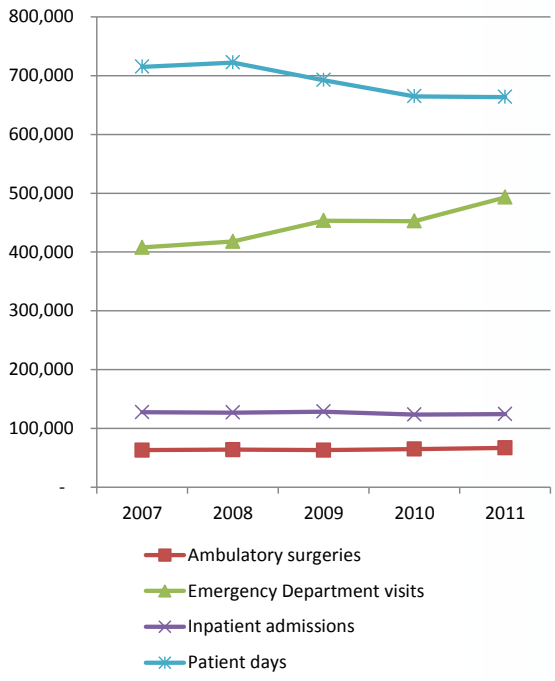
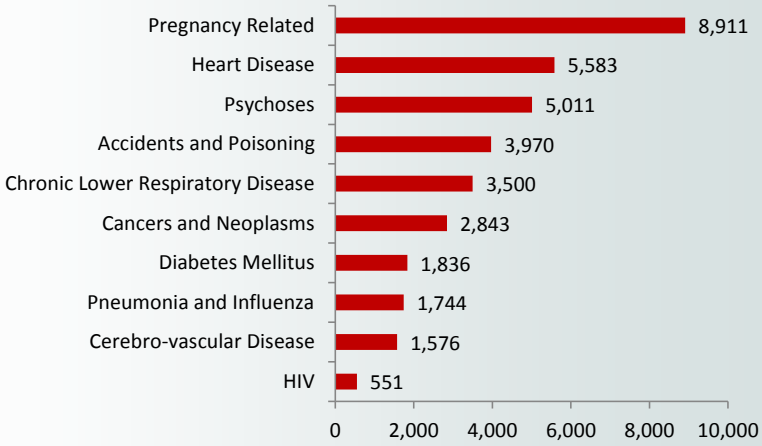
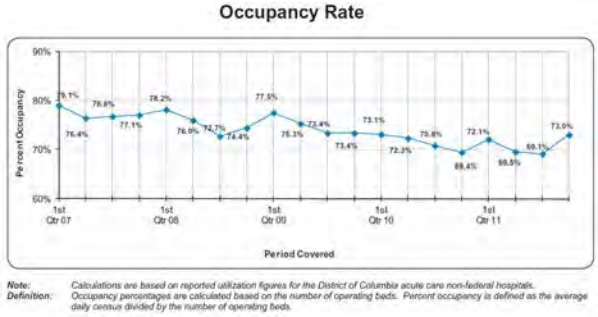


Figure 87. Leading Causes of Hospitalization for DC Residents, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 88. Hospital Occupancy Rate by Quarter, 2007-2011



- The 5 leading causes of hospitalization for DC residents in 2010 were pregnancy-related, heart disease, psychoses, accidents and poisoning, and chronic lower respiratory disease which accounted for 11.8, 7.4, 6.6, 5.3, and 4.6 percent of all hospitalizations, respectively.
- Hospital occupancy rates (average number of people served on an inpatient basis on a single day divided by the number of operating beds) in the District gradually decreased in the last 5 years.

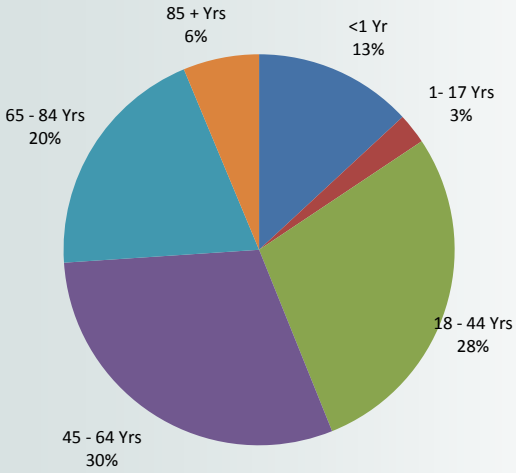
Source: District of Columbia Hospital Association Annual Report, 2011. Utilization Indicators.

Note: Figures 86 and 88 depict hospitalizations for both DC and non-DC residents served by the DC Hospitals aforementioned.

PATIENT DEMOGRAPHICS

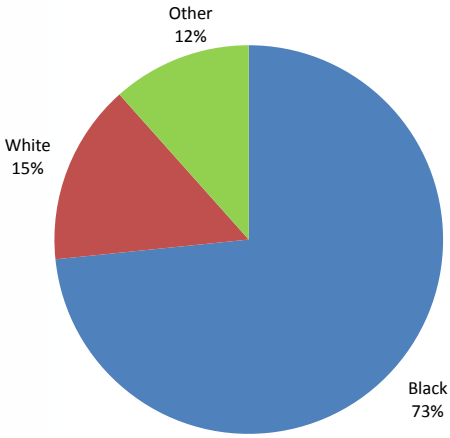
- There were 75,533 District residents hospitalized in 2010; 73 percent of whom were African-American and 15 percent were white.
- Majority of District residents hospitalized in 2010 were between 45 and 64 years old (30 percent), followed by residents aged 18 to 44 (28 percent).
- The elderly accounted for 26 percent of hospitalizations, while infants under 1 year accounted for 13 percent.
- Payment sources were Medicaid (34 percent), Medicare, (31 percent), Private (30 percent), and Other (5 percent).

Figure 89. Hospitalized DC Residents by Age Group, 2010



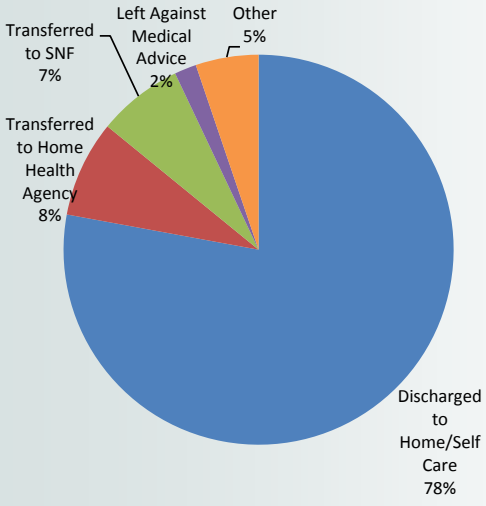
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 90. Hospitalized DC Residents by Race, 2010



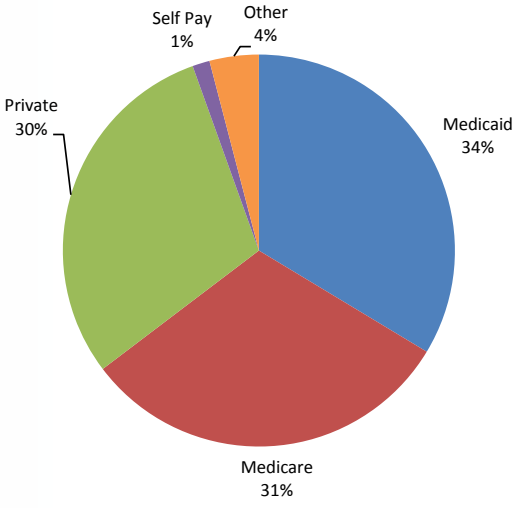
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 91. Hospitalized DC Residents by Discharge Disposition, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

Figure 92. Hospitalized DC Residents by Payment Source, 2010



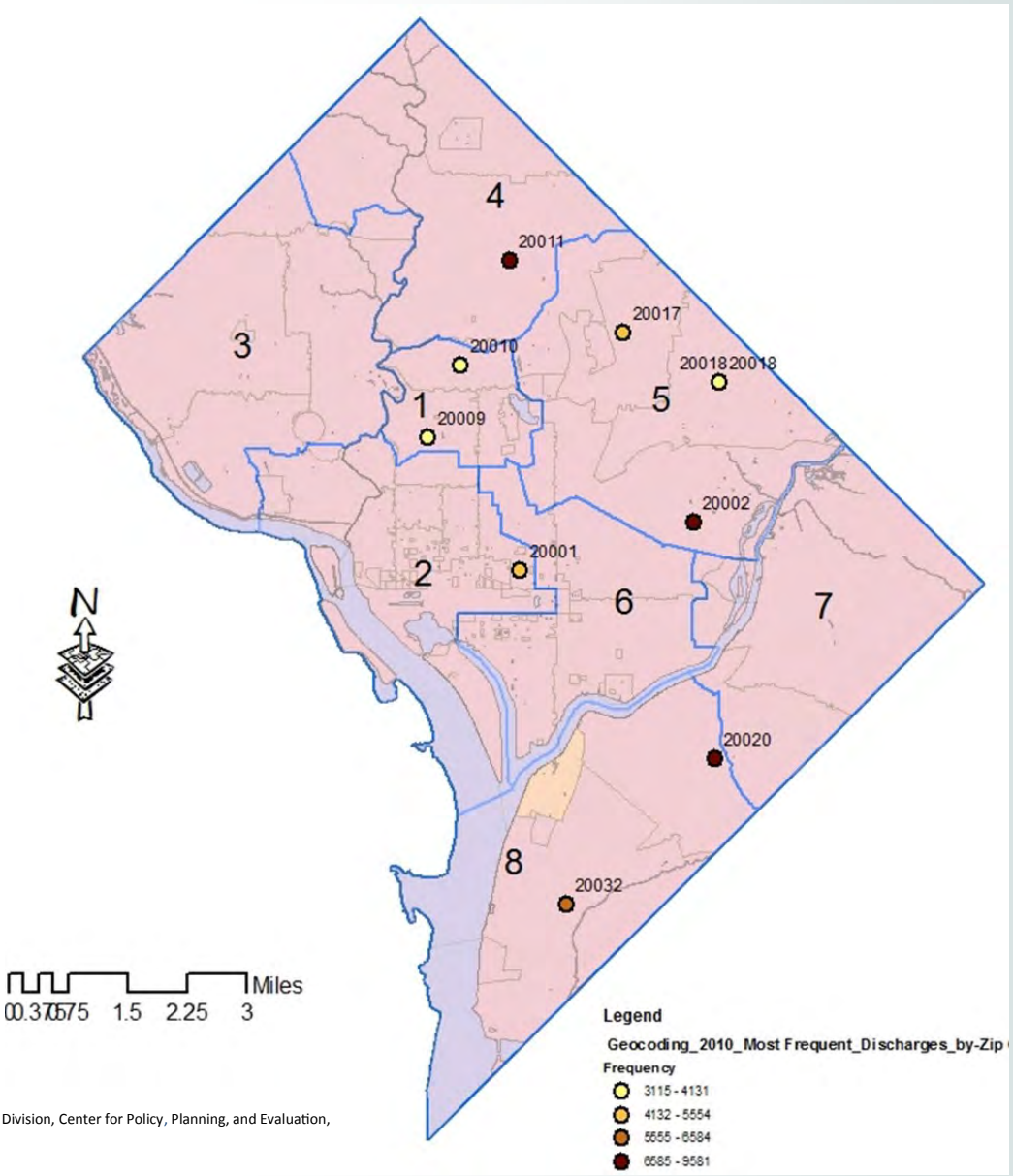
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

GEOGRAPHIC DISTRIBUTION

District residents in the top 10 zip codes accounted for 83 percent of total DC resident hospital discharges. They belong to Wards 1, 4, 5, and 8.

Rank	Zip Code	Number of Hospitalization	Ward
1	20018	9,581	5
2	20011	8,623	4
3	20020	8,420	8
4	20002	8,341	5
5	20032	6,584	8
6	20001	5,554	1, 5
7	20017	4,637	5
8	20009	4,131	1
9	20010	3,975	1
10	20019	3,115	5

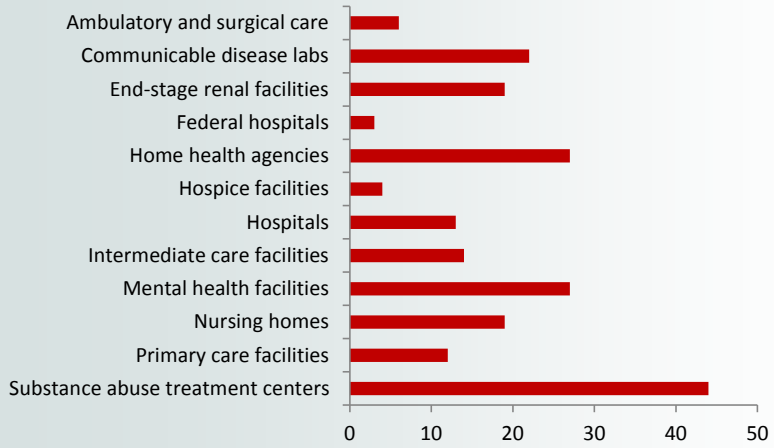
Figure 93. Geographic Distribution of Hospitalizations by Zip Code of Residence, 2010



Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

ACCESS TO CARE

Figure 94. Healthcare Facilities in the District, by Type

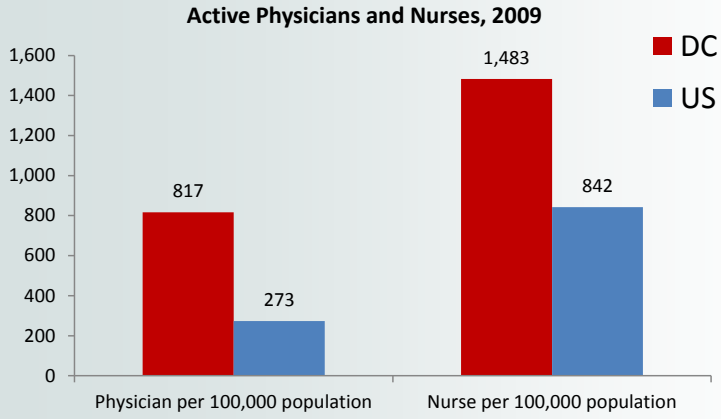


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

In 2009, the physician-to-resident ratio was higher in the District than the national rate.

There were more nurses per resident in the District compared to nationally.

Figure 95. Physician-to-Resident and Nurse-to-Resident Ratios, DC and US, 2009



Healthy People 2010 Objectives

Goal Not Attained: Increase access to care by increasing the number of National Health Service Corps Loan Replacement providers in the District of Columbia from 26 to 36.

There were 41 National Health Service Corps Loan Repayment providers practicing in DC (National Health Service Corps/HRSA, 2011).

Goal Not Met: Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60.

Goal Attained: Increase access to care for vulnerable populations by increasing the number of Health Professional Shortage Areas (HPSA) Facility Designations from two to five.

There were six HPSA Facility Designations at the end of 2010 (Primary Care Bureau, 2011).

Goal Not Met: Evaluate the impact (on participating children and their families) of the new health insurance programs implemented in October 1998 – Medicaid Managed Care expansion and Children's Health Insurance Programs (CHIP)/DC Healthy Families Program.

Goal Attained: Retain 40 percent of National Health Service Corps and Conrad-30 program providers in Health Professional Shortage Areas and Medically Underserved after their commitment period.

There was 100 percent retention rate among Conrad-30 providers that completed; there service in the last three years of the decade; additional Conrad-30 and NHSC data not available (Primary Care Bureau, 2011)

Goal Attained: Evaluate patients' satisfaction with the primary care services provided through the local and federal public health insurance programs in annual assessments with distribution of findings to primary care providers and the general public.

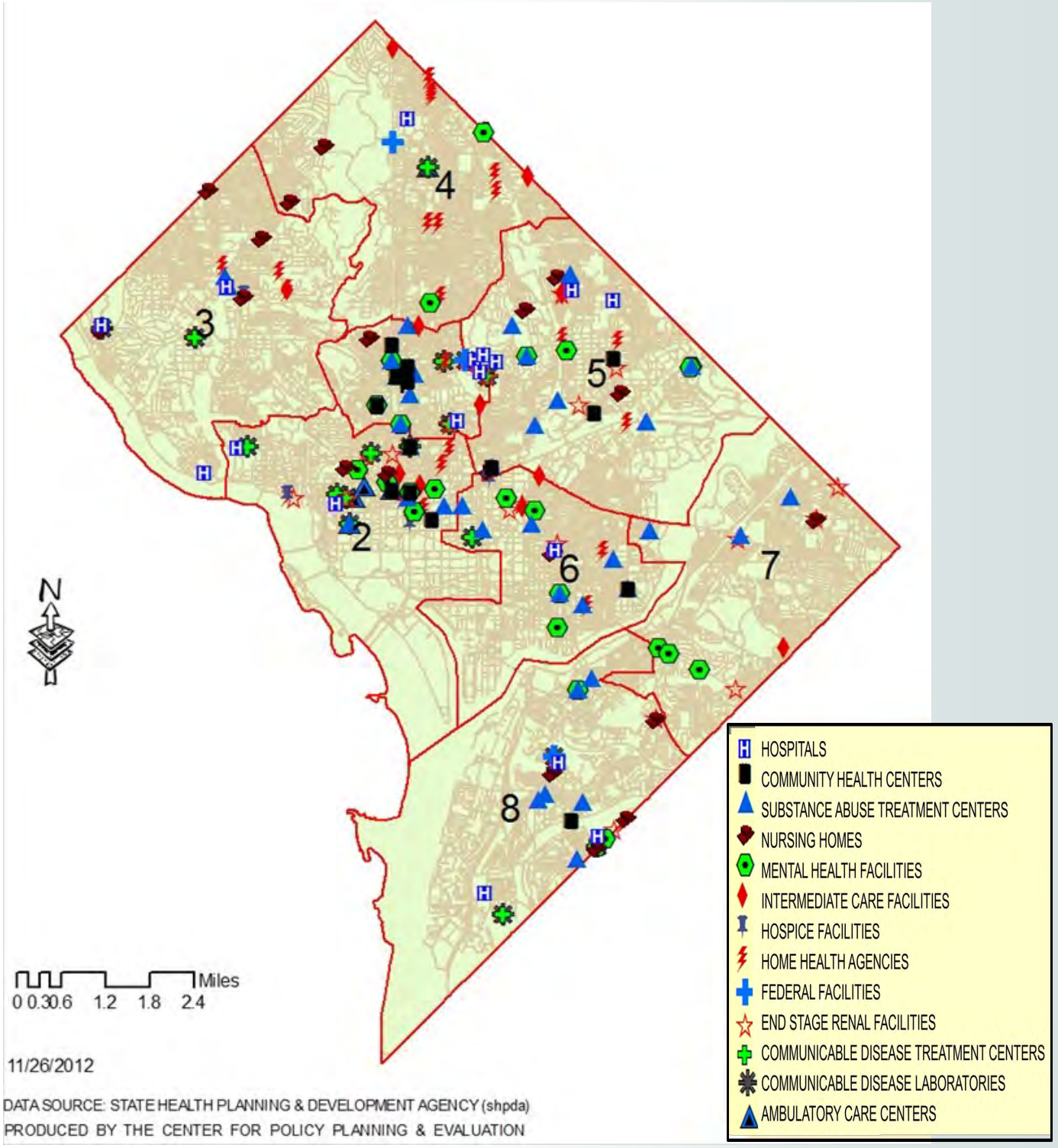
MCOs collect Data from Consumer Assessment of Health Plans Survey (CAHPS) on an annual basis (DHCF).

- Currently, there are over 200 health care facilities distributed throughout the District that are reviewed and monitored by the DOH to ensure health care services are available to all DC residents.
- More than 30 percent are substance abuse and mental health facilities; 16 percent hospitals and primary care; about 11 percent nursing home and hospice facilities.
- In 2009, the ratio of active physicians to residents in the District was 817, two-thirds higher than the national physician rate.
- In the same year, there were 1,483 nurses for every 100,000 DC residents, which was 43 percent higher than the national nurse rate.

Source: Physicians: American Medical Association, Chicago, IL, Physician Characteristics and Distribution in the US, annual (copyright); Nurses: Bureau of Labor Statistics, Occupational Employment Statistics, Occupational Employment and Wages, "May 2009 Wage and Employment Statistics."
For more information: http://www.ama-assn.org/
http://www.bls.gov/oes/home.htm#data

HEALTH CARE FACILITY MAP

Figure 96. Map of Healthcare Facilities in the District



TRENDS IN PROVIDER WORKFORCE

The national Patient Protection Affordable Care Act will extend health insurance coverage to 32 million people by 2019. As a result, there will be an increased demand on the healthcare workforce. Effective workforce planning within the District will require an accurate understanding of the practice characteristics and work behaviors, not just of the physicians and physician assistants that practice in the District, but of other essential non-physician healthcare providers as well.

All physicians and physician assistants licensed to practice medicine in the District are required to renew their license with the DC Board of Medicine on a biennial basis. The 2010 District of Columbia Board of Medicine Physician and Physician Assistant Workforce Survey (2010 DC Workforce Survey) was administered to eligible physicians and physician assistants who were renewing their license in the District from October 1, 2010 until December 31, 2010. Results of the survey will be used to initiate dialogue about the current capacity of the healthcare workforce in the District, and inform the DC Board of Medicine, policy makers, stakeholders, and the public about necessary steps that may need to be taken to protect the health and well-being of District residents.

Figure 97. District of Columbia Physicians by Place of Residence, 2010

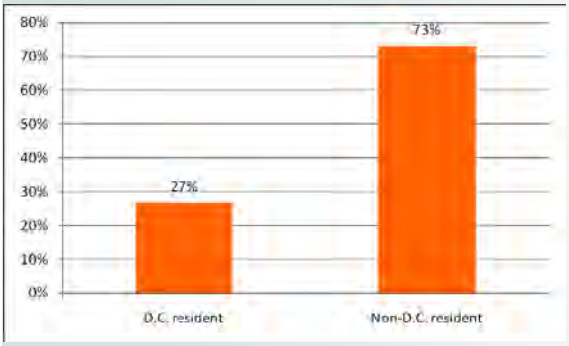
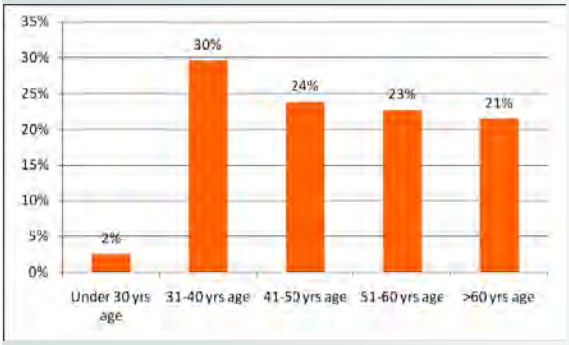


Figure 98. District of Columbia Practicing Physician Age Distribution, 2010



- Fifty-eight percent of physicians who responded to the 2010 DC Workforce Survey were practicing within the District. Forty-one percent of survey respondents spent more than 20 hours per week providing clinical care within the District (actively practicing).
- Only 27 percent of survey respondents were District residents. Seventy-five percent of practicing physicians commute to the District from neighboring states.
- Thirty percent of all practicing physicians within the District were between the ages of 31 and 40, while 21 percent were greater than 60 years of age.
- The racial and ethnic composition of physicians within the 2010 DC Workforce Survey was similar to national physician data. Black or African American physicians had a higher representation than national averages (19 percent in the District vs. 4 percent nationally).
- Forty-four percent of physicians did not speak a foreign language. Spanish was the most common foreign language (14 percent) among those that did speak a foreign language followed by French (6 percent), Arabic (2 percent), and German (2 percent).

Figure 99. District of Columbia Practicing Physician Race Compared to National Estimates

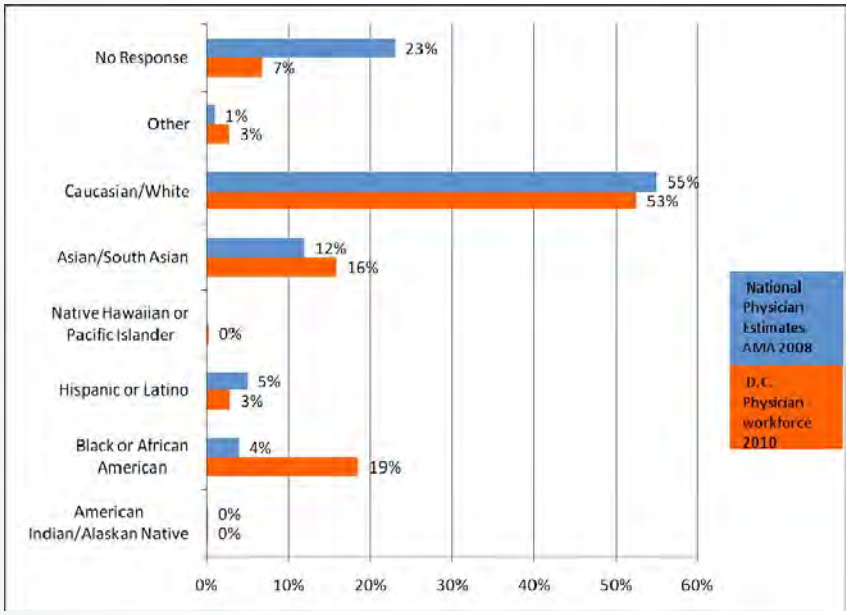
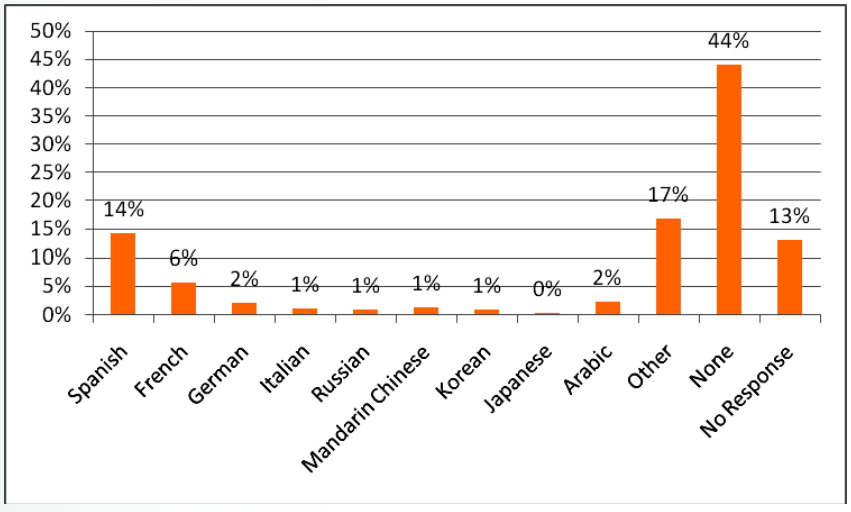


Figure 100. District of Columbia Practicing Physicians and Foreign Language Proficiency, 2010

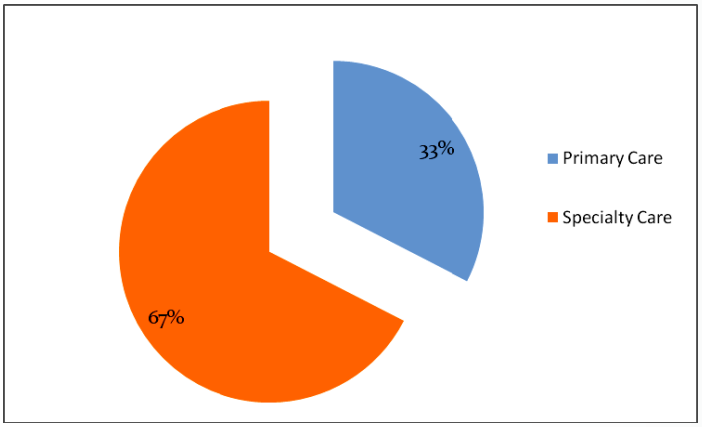


Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf

TRENDS IN PROVIDER WORKFORCE

The availability of primary care physicians has been a major concern among health policy makers. The Association of American Medical Colleges estimates that by 2015 there will be a national shortage of 29,800 primary care physicians. In the 2010 DC Workforce Survey, primary care physicians were defined as internal medicine, obstetrics and gynecology, pediatrics, and family medicine. Among all practicing physicians, 33 percent (n= 1,238) were engaged in primary care as their primary specialty and 67 percent (n= 2,487) were engaged in specialty care (Figure 101). Similar results were found among the actively practicing physician population (spent more than 20 hours per week providing clinical care within the District).

Figure 101. District of Columbia Practicing Physicians: Primary Care vs. Specialty Care, 2010



- The most common reported specialties among practicing physicians was internal medicine (15 percent). The next most common specialties were general pediatrics (11 percent) and psychiatry (10 percent). Three percent of practicing physicians were general surgeons. This was consistent with national estimates.
- Thirty-nine percent of practicing physicians were concentrated in hospital-based practices regardless of their specialty type.
- Overall, more than three quarters of practicing physicians were accepting new patients.
- Sixty-one percent of practicing physicians within the District were using some form of an electronic health record. Twenty-one percent of physicians use some form of social media.
- Most actively practicing physicians (78 percent) did not plan to change their clinical hours or locations of their practices over the next 2 years. Ten percent of physicians had plans to leave the workforce in some capacity (move practice out of the District, reduce patient hours, or retire from patient care). Internal medicine and cardiology were the most common specialties of actively practicing physicians with plans to leave the District workforce in some capacity.

Figure 102. District of Columbia Practicing Physicians by Specialty, 2010

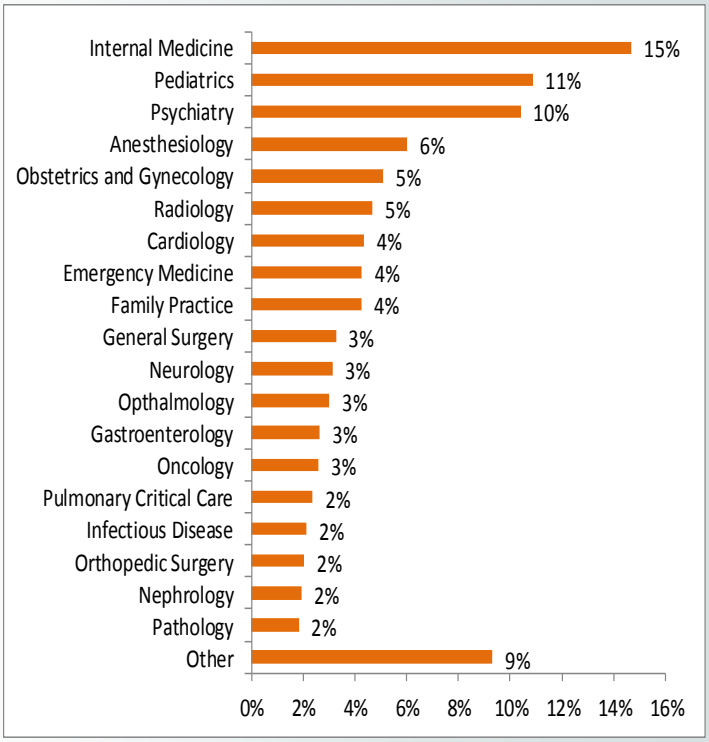
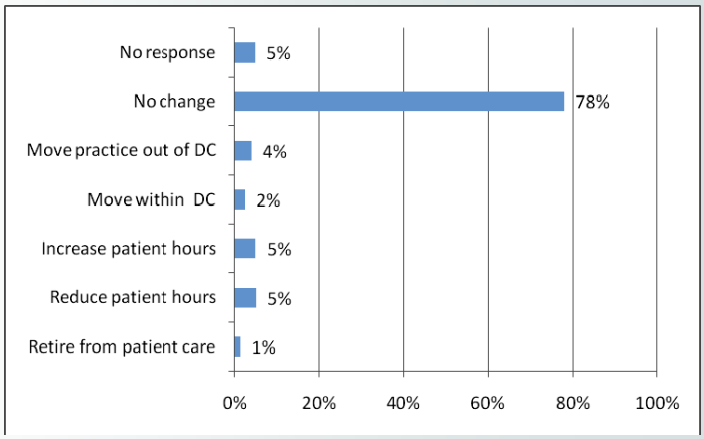


Figure 103. Future Plans of District of Columbia Actively Practicing Physicians within the Next 2 Years, 2010

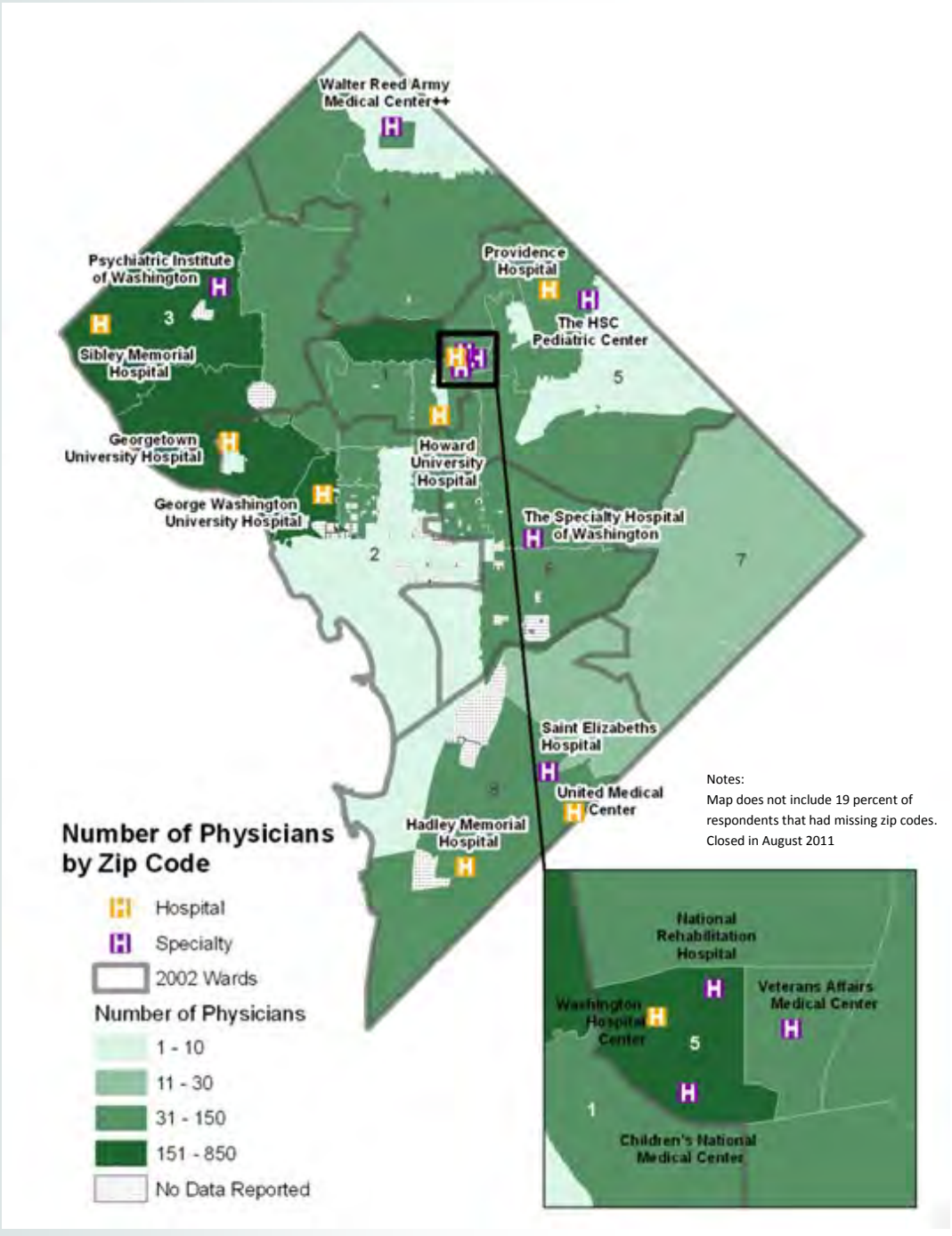


Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf

TRENDS IN PROVIDER WORKFORCE

Physician primary practice locations were mapped for available zip codes. The following map demonstrates the number of physicians per zip code. Among practicing physicians with available zip codes, wards 1, 2, 3, and 5 had the largest concentration of practicing physicians per zip code. Physicians were concentrated around hospitals.

Figure 104. Geographic Distribution of Practicing Physicians in the District of Columbia, 2010



Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf

UNDERSERVED AREAS

In 2012, the Federal government granted approval of the Department of Health's (DOH) applications for re-designation of 17 of the District's current and formerly expired Health Professional Shortage Area (HPSA) and Medically Underserved Area/Population (MUA/P) designations. The new designations include expansions to include areas that were previously excluded, higher scores that improve the District's ability to compete for Federal resources, and a sharper focus on the needs of the District's low-income populations.

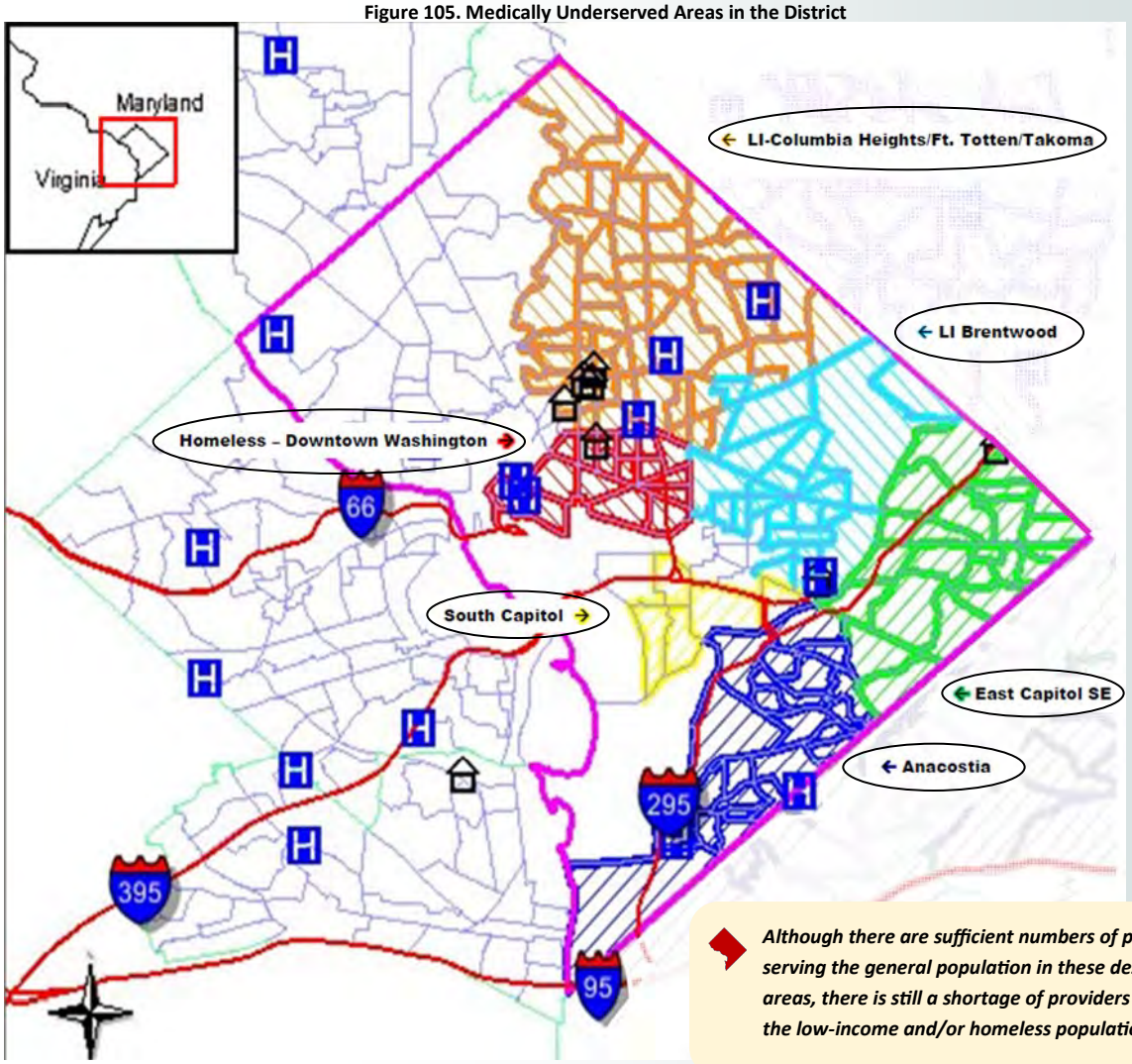
Data from the Health Professional Licensing Administration (HRLA), Medicaid claims data from the DC Department of Health Care Finance (DHCF), and data from detailed DOH surveys were linked and included in the analysis to identify these underserved areas.

HPSAs and MUA/Ps are used by the Federal government to recognize shortages of health care providers in geographic areas, populations or facilities and to prioritize the allocation of Federal resources to address these shortages. Whereas MUA/Ps refer only to Primary Care shortages, HPSAs can refer to shortages in any of three disciplines: Primary Care, Mental Health and Dental. A single area can be designated as a HPSA for one, two or all three of the disciplines.

HPSA determinations are based on population-to-provider ratios, demographic indicators associated with underservice (e.g. poverty rate, fertility rate, and infant mortality rate) and the accessibility of care in surrounding areas. MUA/P determinations are based on an Index of Medical Underservice (IMU) that uses a scale from 0 to 100, where 0 represents completely underserved and 100 represents the least underserved. The IMU involves four variables - ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with incomes below the poverty level, and percentage of the population age 65 or over.

The areas highlighted below are (clockwise): Low Income (LI) Columbia Heights./Ft.Totten/Takoma, Low Income (LI) Brentwood, East Capitol SE, Anacostia, South Capitol, and Homeless - Downtown Washington. These areas comprise Wards 1, 4, 5, 6, 7, and 8.

Figure 105. Medically Underserved Areas in the District



Although there are sufficient numbers of providers serving the general population in these designation areas, there is still a shortage of providers serving the low-income and/or homeless populations.

Source: Community Health Administration, Primary Care Bureau, DC DOH. For more information: Information Sheet on DC's Updated HPSAs and MUA/Ps Primary Care HPSA Maps 2012 http://doh.dc.gov/service/shortage-designation

HEALTH INSURANCE

How has the District implemented the Affordable Care Act?

The District of Columbia implemented early expansion of Medicaid eligibility under the Affordable Care Act that has led to insurance coverage for 93 percent of adults and 96 percent of children living in the District – the second highest insurance rate in the nation after Massachusetts.

Figure 106. Medicaid Enrollment in Selected States and National, 2008 and 2009

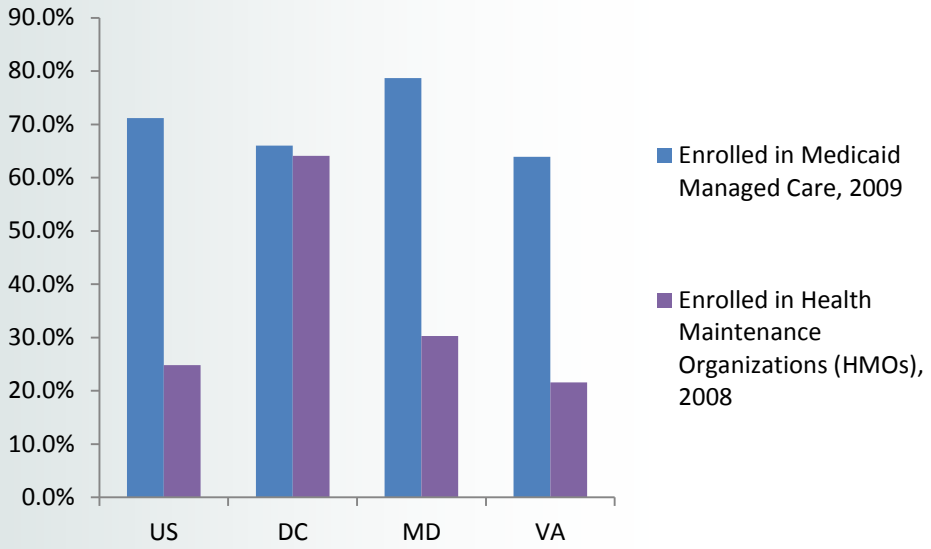
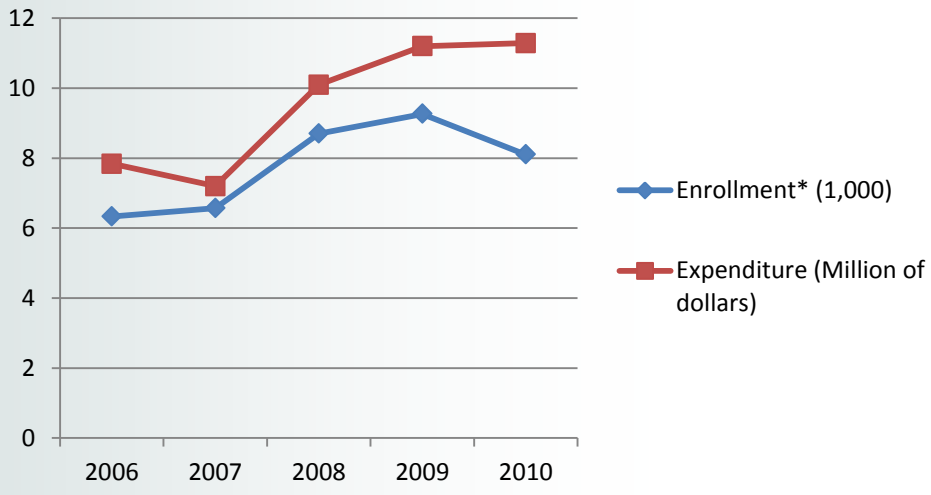


Figure 107. Children's Health Insurance Program, District of Columbia, 2006-2010



Source:

US Centers for Medicare and Medicaid Services, "2009 Medicaid Managed Care Enrollment Report," <http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrlRep.asp>.

HealthLeaders-InterStudy, Nashville, TN, The Competitive Edge (copyright). See also<http://www.interstudypublications.com/>.

US Centers for Medicare & Medicaid Services, The Children's Health Insurance Program (CHIP), Annual Enrollment Report and the Statement of Expenditures for the CHIP Program (CMS-21).

*For year ending September 30.

PREVENT AND REDUCE DISEASES AND DISORDERS

Asthma is a chronic disorder that inflames and constricts airways, making breathing difficult. Symptoms include recurrent coughing, wheezing, shortness of breath or rapid breathing, and chest tightness, which may be exacerbated by environmental factors (triggers), such as tobacco smoke, dust, pollen, pests, and stress. Asthma symptoms differ from person to person and could be triggered for various reasons. While it may not be cured, it can be managed successfully. Addressing risk factors and taking proper medication can help reduce the morbidity and mortality.

The District has one of the highest cancer mortality rates in the United States. Due to the prevalence of the disease, the DC Department of Health created the DC Cancer Coalition to serve as a resource in addressing comprehensive cancer control and prevention. In 2003, the Department of Health received initial funding from the Centers for Disease Control and Prevention to begin this process. The Coalition is a partnership of medical centers, health professionals, health care providers, community-based organizations, and others. The coalition has produced the state DC Cancer Control Plan of 2006. The Plan provides a strategic framework to address the various cancers of concern to District residents: to reduce the number of new cases of cancer and number of cancer-caused deaths, and to improve the quality of life for cancer survivors in the nation's capital.

Diabetes is a serious and costly disease. According to results obtained from the BRFSS, the overall prevalence rate in the District of Columbia has remained constant since 2004. More than 45,000 District residents have diabetes and the number of residents with diabetes is expected to increase at higher rates in the future. The Centers for Disease Control and Prevention estimates that African Americans and Hispanic/Latinos born in the year 2000 will have a 1-in-2 chance of developing diabetes during their lifetime (2006 CDC Diabetes Fact sheet). Diabetes and its related comorbid conditions will have a significant impact on District residents and the District's economy.

An assessment conducted by the DC Department of Health Diabetes Prevention and Control Program in 2005 showed that the District had less than 50 percent of the capacity needs to provide public health services. In some instances, the system's ability to conduct essential services such as mobilizing partnerships, developing policies and plans and enforcing laws and regulations met less than 35 percent of the needed system capacity.

Millions of people in the country have some level of disability. There are different types and levels of impairment. Impairment may be, among other things, visual, hearing, physical, mental, cognitive or language related. In addition to addressing the root causes and everyday consequences of a disability, there is a need to find ways to empower disabled persons to lead more independent lives. People with disabilities usually require special care and attention and need to get the help to support they need.

ASTHMA PREVALENCE

District of Columbia	Percent Current Asthma
TOTAL	10.4
Gender	
Male	8.3
Female	12.1
Age	
18-34	11.4
35-44	10.5
45-54	10.9
55-64	8.9
65+	8.7
Race/Ethnicity	
Caucasian	7.3
African American	12.3
Other	16.7
Hispanic	5.6
Education	
Less than High School	19.8
High School Graduate	12.3
Some College	11.4
College Graduate	8.5
Income	
Less than $15,000	14.6
$15,000-$24,999	13.5
$25,000-$34,999	13.6
$35,000-$49,999	8.4
$50,000-$74,999	10.5
$75,000 and over	7.3
Ward Comparison	
Ward 1	6.8
Ward 2	9
Ward 3	8.5
Ward 4	10.5
Ward 5	15.7
Ward 6	11.4
Ward 7	17.5
Ward 8	10.7

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Attained: Reduce the asthma mortality rate to no more than 1.5 per 100,000 people.

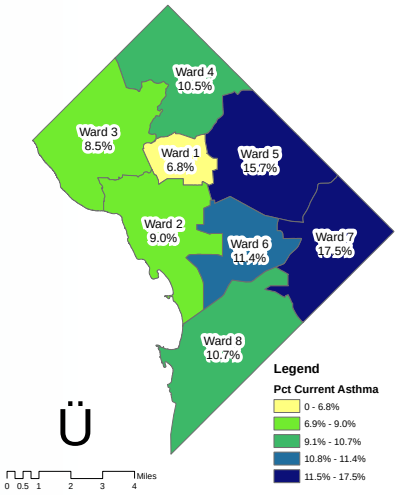
Goal Not Met: Reduce the overall asthma morbidity rate, as measured by a reduction in the asthma hospitalization rate, to 10 per 10,000 people.

Goal Not Met: Reduce the annual rate of Emergency Department (ED) visits for all ages to no more than 150 per 10,000 population.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked, if they have ever been told by a doctor, nurse or other health professional they had asthma.

- Overall, 10.4 percent of District respondents have asthma compared to 9.1 percent nationally; 5.2 percent formerly had asthma and 84.4 percent never had asthma.
- Females were more likely than males to currently have asthma, at 12 percent.
- Adults aged 18-34 years were more likely than all other age groups to currently have asthma, at 11.4 percent.
- District respondents of race/ethnic group "Other" were more likely than all other race/ethnic groups to currently have asthma, at 16.7 percent.
- Adults with less than a high school education were more likely than all other education subgroups to currently have asthma, at 19.8 percent.
- Adult households with less than $15,000 were more likely than all other income subgroups to currently have asthma, at 14.6 percent.
- Adults who resided in Ward 7 were more likely than all other wards to currently have asthma, at 17.5 percent.

Figure 108. Map of Current Asthma by Ward, 2010



ASTHMA TRENDS

Figure 109. Number of Emergency Department Visits due to Asthma by Age Group, District of Columbia, 2008-2010

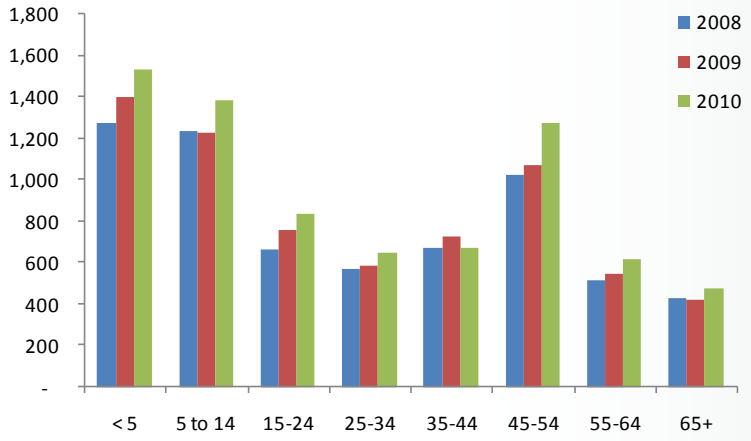


Figure 110. Adult Asthma Prevalence, National vs. District of Columbia (BRFSS Data), 2006-2010

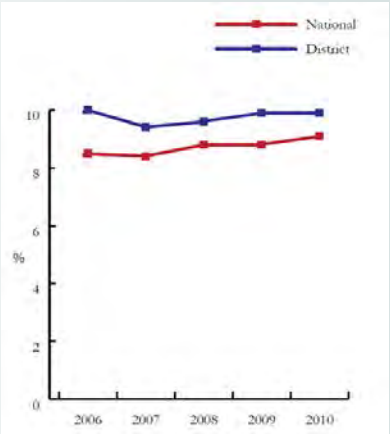


Figure 111. Hospitalizations due to Asthma, District of Columbia, 2008-2011

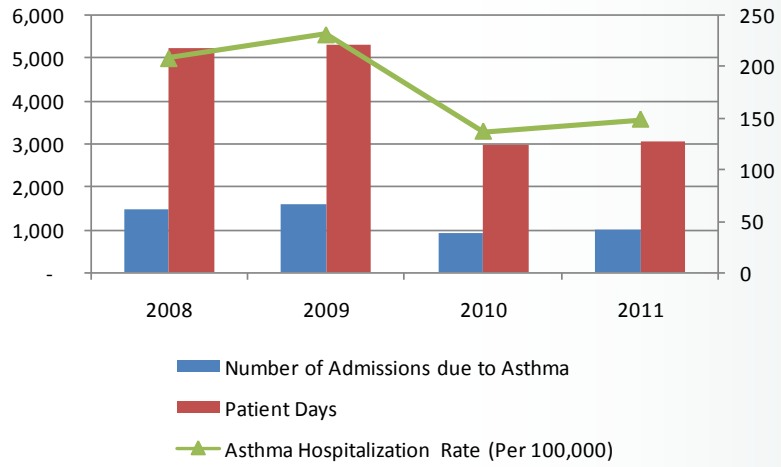
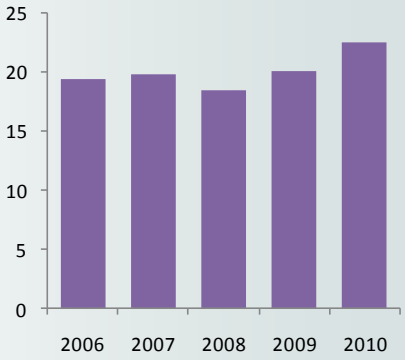


Figure 112. Child Asthma Prevalence Rate, District of Columbia, 2006-2010



- Children under 5 years account for the most number of emergency visits (20 percent) due to asthma from 2008 to 2010.
- As ER visits increase from year to year, the number of hospital admissions and patient days due to asthma decline.

- Lifetime and current asthma prevalence for children in the District were 22.4 and 18.0 percent, respectively.
- These rates were higher than the national medians, which were 12.4 and 8.4 percent respectively.
- Among District children, males were more likely to have a greater lifetime and current asthma prevalence than females.
- African-American children in the District have a higher prevalence of lifetime and current asthma compared to children within other racial groups.
- Current asthma for non-Hispanic black children in the District is higher than the national lifetime and current asthma prevalence rates.
- Asthma is one of the leading causes of school absenteeism. Asthma-related illnesses cause children to miss 13 million school days a year.

Source: District of Columbia Hospital Association

CHILDHOOD ASTHMA

Data on the proportion of District children who have asthma at a specific point in time (prevalence) was calculated using data from a standardized questionnaire, the Behavioral Risk Factor Surveillance System (BRFSS) survey. Asthma prevalence was grouped into lifetime and current asthma. Lifetime asthma estimates the proportion of the population who answered "yes" to the question, "Has a doctor, nurse or other health professional ever said that the child has asthma?" Current asthma is estimated by the proportion of the population who answered "yes" to the question, "Does the child still have asthma?" .

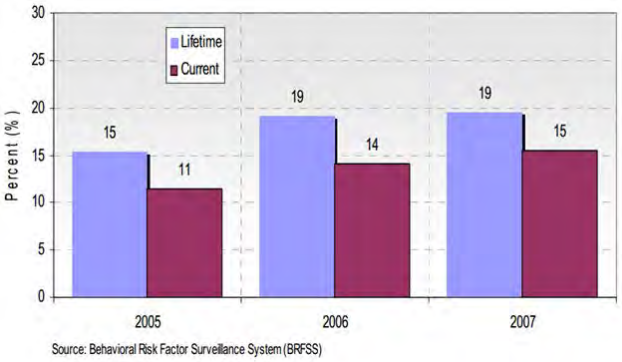
Lifetime Asthma

- In 2007, about 19% of District children under age 18 experienced asthma sometime during their life. The rate of lifetime asthma in children increased by about 27% from 2005 to 2007 among the District's children (Figure 113). In 2007, District children 5 to 9 years old had the highest lifetime asthma prevalence rate (24%) followed by children under 5 years old (18%) (Figure 114).
- In 2007, about 24% of non-Hispanic black, 18% of Hispanic and 12% of non-Hispanic white District children reported lifetime asthma. Twice as many non-Hispanic black District children had lifetime asthma as compared to non-Hispanic white children. About 50% more Hispanic children had lifetime asthma as compared to non-Hispanic white children (Figure 115).
- In 2007, children living in Ward 6 (32%) had the highest lifetime asthma prevalence rate, followed by Ward 5 (26%) and Ward 4 (24%). Ward 2 (7%) had the lowest lifetime asthma prevalence rate (Figure 116).

Current Asthma

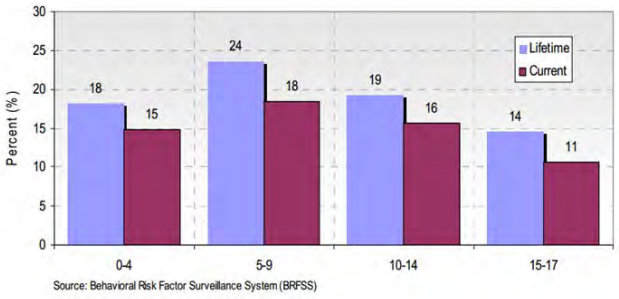
- In 2007, about 15% of District children under age 18 years were reported to have current asthma. The prevalence rate of current asthma among children increased by about 36% from 2005 to 2007 (Figure 113). In 2007, District children 5 to 9 years old had the highest current asthma prevalence rate (18%) followed by children 10 to 14 years old (16%) (Figure 114). In 2007, about 20% of non-Hispanic black, 14% of Hispanic and 8% of non-Hispanic white District children reported current asthma. More than twice as many non-Hispanic black District children experienced current asthma as compared to non-Hispanic white children. Almost twice as many Hispanic District children had current asthma as compared to non-Hispanic white children (Figure 115).
- In 2007, children living in Ward 5 (26%) had the highest current asthma prevalence rate, followed by Ward 6 (22%) and Ward 7 (19%). Ward 2 (7%) had the lowest current asthma prevalence rate (Figure 116).

Figure 113. Asthma Prevalence among Children (0-17 yrs) in the District of Columbia, 2005-2007



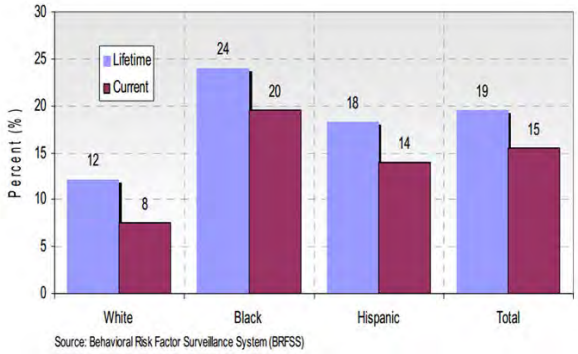
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 114. Asthma Prevalence among Children (0-17 yrs) by Age Group, District of Columbia, 2007



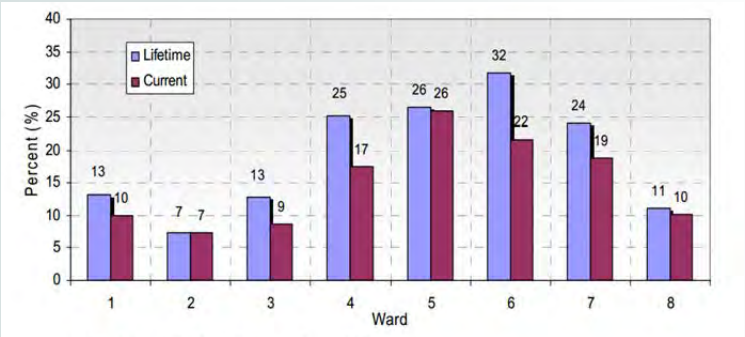
Source: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 115. Asthma Prevalence among Children (0-17 yrs) by Race/ Ethnicity, District of Columbia, 2007



Source: Behavioral Risk Factor Surveillance System (BRFSS)

Figure 116. Asthma Prevalence among Children (0-17 yrs) by Ward, District of Columbia, 2007

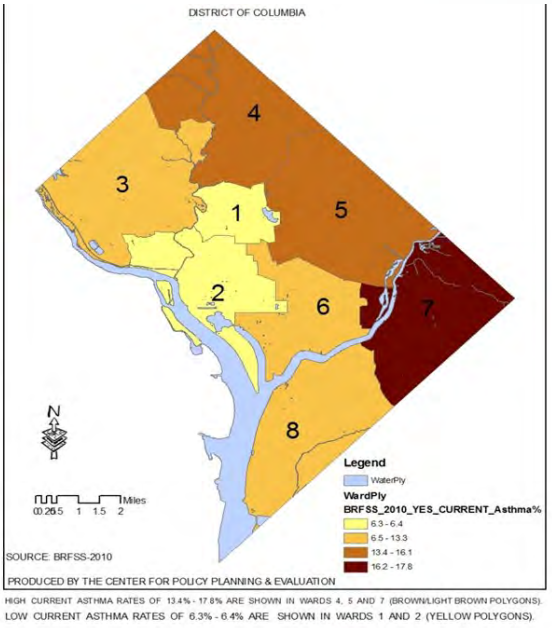


Source: Behavioral Risk Factor Surveillance System (BRFSS)

SPATIAL PATTERNS OF LIFETIME AND CURRENT ASTHMA AND SELECTED CO-FACTORS

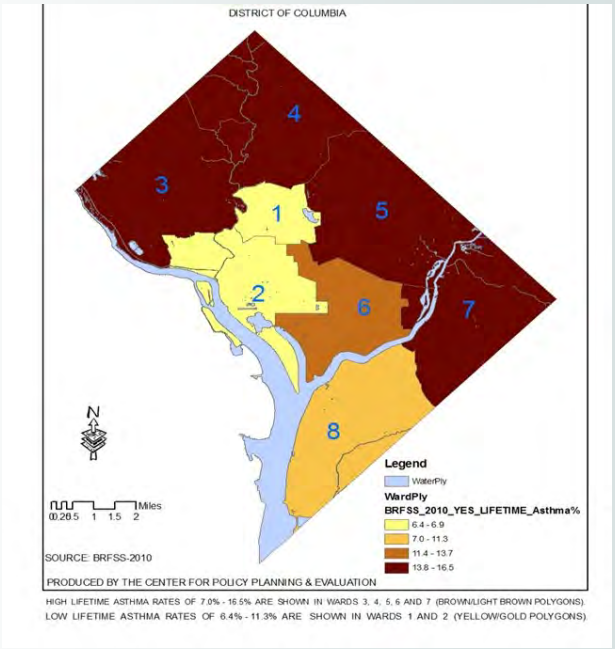
- High current and lifetime asthma rates and distribution patterns are similar for year 2010 in Wards 4, 5, 6, 7 and 8, while low rates and distribution patterns are consistent in Wards 1 and 2. A cluster analysis of asthma hospital discharges and asthma hospital discharge rates shows the distribution of high asthma hospital discharges and statistically significant clusters are co-located in Wards 5, 6, 7 and 8 (p = 0.01). That is, we are ninety nine percent certain the distribution of asthma hospital discharges does not occur by chance.

Figure 117. Distribution of Current Asthma, 2010



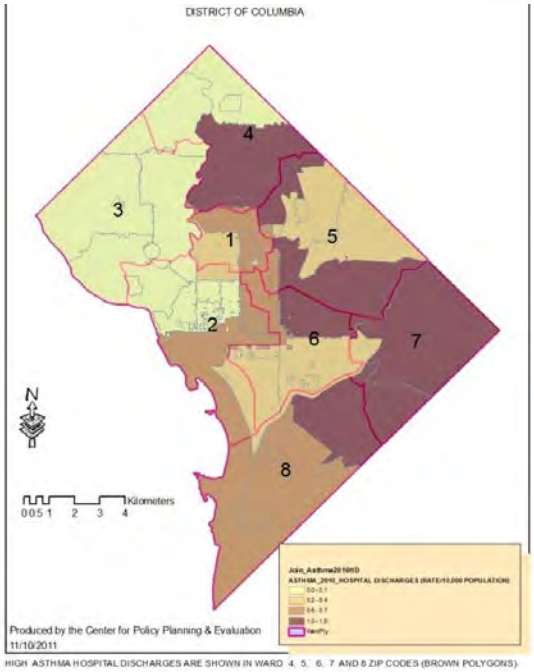
HIGH CURRENT ASTHMA RATES OF 13.4% - 17.8% ARE SHOWN IN WARDS 4, 5 AND 7 (BROWN/LIGHT BROWN POLYGONS).
LOW CURRENT ASTHMA RATES OF 6.3% - 6.4% ARE SHOWN IN WARDS 1 AND 2 (YELLOW POLYGONS).

Figure 118. Distribution of Lifetime Asthma, 2010



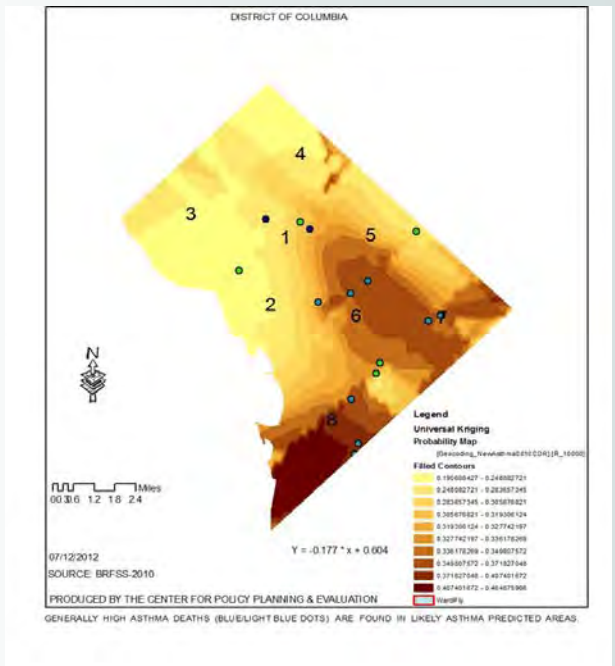
HIGH LIFETIME ASTHMA RATES OF 7.0% - 16.5% ARE SHOWN IN WARDS 3, 4, 5, 6 AND 7 (BROWN/LIGHT BROWN POLYGONS).
LOW LIFETIME ASTHMA RATES OF 6.4% - 11.3% ARE SHOWN IN WARDS 1 AND 2 (YELLOW/GOLD POLYGONS).

Figure 119. Distribution of Asthma Hospital Discharges, 2010



HIGH ASTHMA HOSPITAL DISCHARGES ARE SHOWN IN WARD 4, 5, 6, 7 AND 8 ZIP CODES (BROWN POLYGONS).

Figure 120. Comparison of Current Asthma Deaths and Probability of Asthma Deaths, 2010



GENERALLY HIGH ASTHMA DEATHS (BLUE/LIGHT BLUE DOTS) ARE FOUND IN LIKELY ASTHMA PREDICTED AREAS.

DIABETES PREVALENCE

District of Columbia	Percent Diabetes	Percent Pre-Diabetes
TOTAL	8.3	1
Gender		
Male	7.4	0.8
Female	9.1	1.1
Age		
18-34	1.5	0.4
35-44	5.2	0.2
45-54	6.8	0.9
55-64	13	2.5
65+	21.5	1.8
Race/Ethnicity		
Caucasian	2.5	0.4
African American	13.4	1.3
Other	7.3	2
Hispanic	5.5	0.6
Education		
Less than High School	20.6	1.4
High School Graduate	13.8	1.8
Some College	10.7	1
College Graduate	4.7	0.7
Income		
Less than $15,000	16.2	1.8
$15,000-$24,999	16.5	0.8
$25,000-$34,999	15.1	3
$35,000-$49,999	11.4	1.8
$50,000-$74,999	7.3	0.2
$75,000 and over	3.8	0.6
Ward Comparison		
Ward 1	7.1	0.4
Ward 2	6.1	0.5
Ward 3	2.2	0.1
Ward 4	10.2	1.4
Ward 5	12.5	1.4
Ward 6	6.7	1.5
Ward 7	11.6	1.6
Ward 8	15.2	1.2

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Not Met: Increase the proportion of person with diabetes who receive formal diabetes education to 60 percent; the District rate is 59.3 percent.

Goal Attained: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (A one C) at least once a year to 50 percent; the District's rate is 87.7 percent.

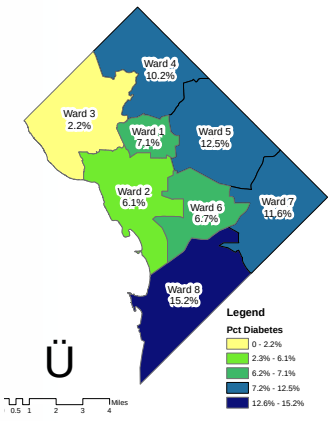
Goal Attained: Increase the proportion of persons with diabetes who have an annual dilated eye examination to 75 percent; the District's rate is 82.8 percent.

Goal Attained: Increase the proportion of adults with diabetes who have at least an annual foot examination to 75 percent; the District's rate is 82.3 percent.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have ever been told by a doctor, nurse or other health professional that they have diabetes.

- Overall, 8.3 percent of District respondents were told by a doctor, nurse or other health professional that they have diabetes compared to 8.7 percent nationally.
- Females were more likely than males to be told by a doctor that they have diabetes, at 9 percent.
- Adults aged 65 years and older were more likely than all other age groups to be told by a doctor that they have diabetes, at 21.5 percent.
- African Americans were more likely than all other race/ethnic groups to be told by a doctor that they have diabetes, at 13.4 percent.
- Adults with less than a high school education were more likely than all other education subgroups to be told by a doctor they have diabetes, at 20.6 percent.
- Adult households with an income of less than $15,000 and $15,000-$24,999 were more likely than all other income subgroups to be told by a doctor that they have diabetes, at 16.2-16.5 percent.
- Adults who resided in Ward 8 were more likely than all other wards to be told by a doctor that they have diabetes, at 15.2 percent.

Figure 121. Map of Diabetes by Ward, 2010



DIABETES DISPARITIES

Figure 122. Average Diabetes Mortality Rates by Ward, 2008-2009

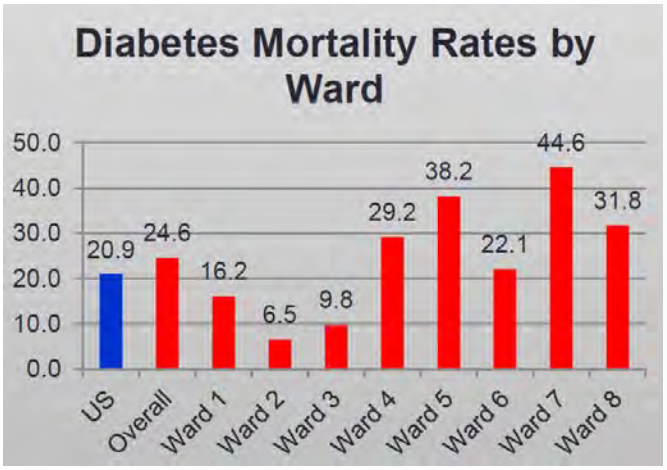
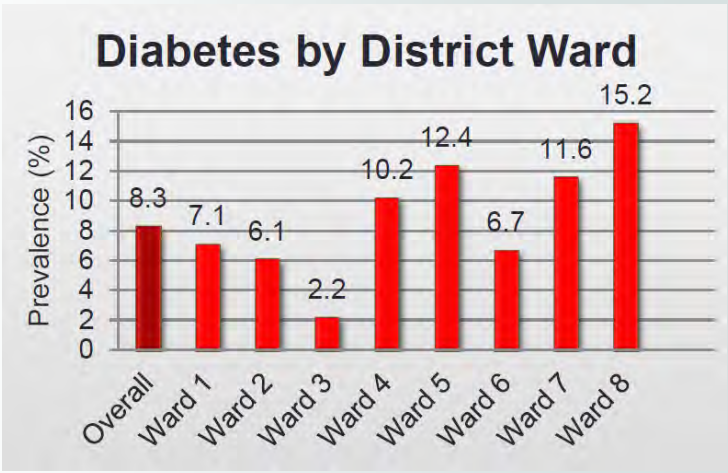
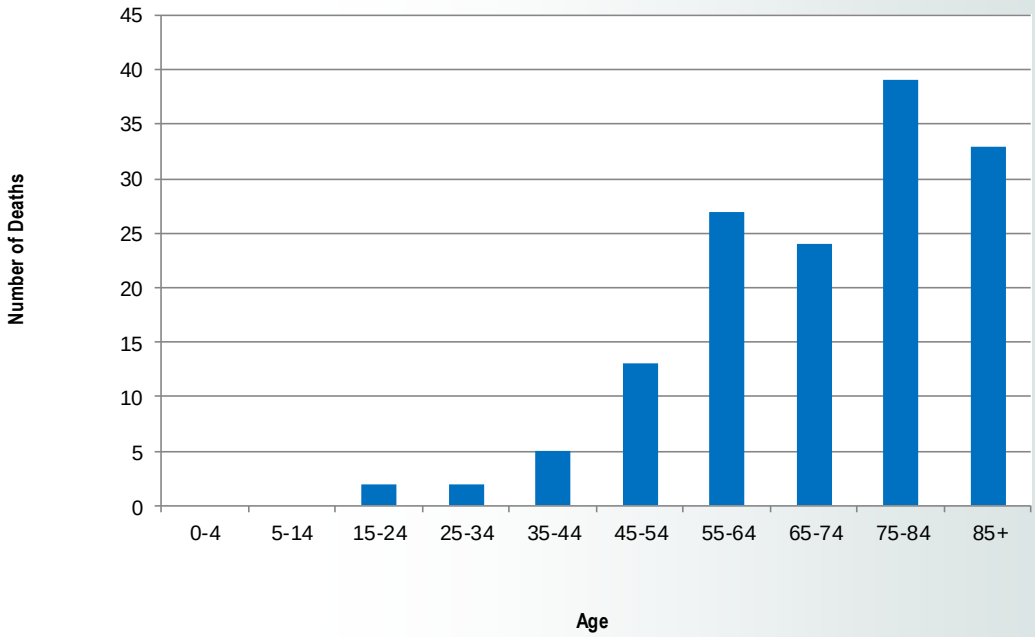


Figure 123. Prevalence of Diabetes by Ward, 2010



- The prevalence of diabetes is highest in District wards 4, 5, 7, and 8, exceeding the city-wide prevalence of 8.3 percent.
- Mortality associated with diabetes is highest in District wards 4, 5, 7, and 8, where the death rates for diabetes are higher than the city-wide rate.
- The crude death rate due to diabetes for blacks/African Americans was 42.0 per 100,000 population which was seven times the rate for Whites (6.0 per 100,000 population).
- Eighty-five percent of deaths due to diabetes occurred to decedents 55 years or older.

Figure 124. Number of Deaths due to Diabetes by Age Group, 2010



Source: Diabetes in the District of Columbia Fact Sheet 2012

CANCER

Cancer Incidence for All Sites Combined (Invasive)

2004-2008 Incidence and 2008 Patient Demographics

Five - Year Incidence		
	Age-adjusted rate	Number of cases
2004	490.7	2,757
2005	491.9	2,765
2006	486.6	2,731
2007	520.9	2,932
2008	487.8	2,741

2008

Gender		
	Age-adjusted rate	Number of cases
Male	605.3	1,422
Female	410.2	1,317

Ward Comparison		
	Age-adjusted rate	Number of cases
Ward 1	477.4	295
Ward 2	406.2	242
Ward 3	361.4	305
Ward 4	391.2	387
Ward 5	549.1	474
Ward 6	437.9	298
Ward 7	495.5	372
Ward 8	586.9	274

Race		
	Age-adjusted rate	Number of cases
Black	497.8	1,799
White	442.4	739

Age		
	Pct	Number of cases
15 - 24 years	1	27
25 - 34 years	3	82
35 - 44 years	6	165
45 - 54 Years	14.8	405
55 - 64 Years	26.2	716
> 65 Years	48.4	1,326

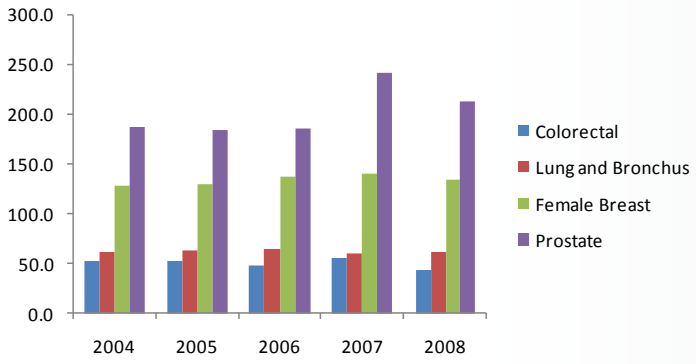
SEER Stage at Diagnosis		
	Pct	Number of cases
In Situ	6.5	192
Local	40.8	1,197
Regional	19.7	579
Distant	21.1	619
Unknown	11.8	346

Source: DC Cancer Registry

Rates are per 100,000 persons and are age-adjusted to the 2000 US standard.

INCIDENCE AND MORTALITY

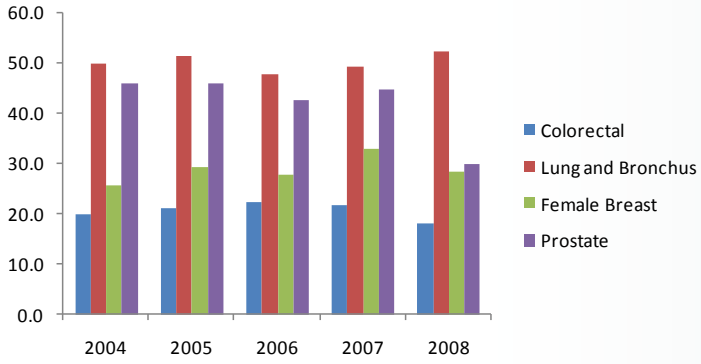
Figure 125. Age-adjusted Cancer Incidence Rate by Site, 2004-2008



Colorectal Cancer

- Significant decrease was seen in age-adjusted incidence rates for colorectal cancer (22.2 percent).
- 67 percent of colorectal cancer cases were diagnosed in patients between 55-84 years old.
- Colorectal cancer had significant decrease in age-adjusted mortality rates (17.7 percent).
- 72 percent of colorectal cancer deaths occurred in people over 60 years old.
- Colorectal cancer was more likely to be diagnosed at local stage (37.3 percent).
- There was a 7.3 percent difference in in situ SEER stage of diagnosis between white and black residents with colorectal cancer.

Figure 126. Age-adjusted Cancer Mortality Rate by Site, 2004-2008



Lung and Bronchus Cancer

- Lung and bronchus increased by 3 percent in the number of cancer cases and in age-adjusted incidence rates.
- Lung and bronchus cancer were the most likely to be diagnosed at advanced stage.
- 69 percent of lung and bronchus cancer cases were diagnosed in patients between 55-79 years old.
- 65 percent of lung and bronchus cancer deaths occurred in patients between 55-79 years old.
- Of the top 4 cancers diagnosed in the District, lung and bronchus cancer were more likely to be diagnosed in distant stage (47.8 percent).
- Lung and bronchus cancer showed a 2 percent difference in regional SEER stage of diagnosis between white and black residents.

Prostate Cancer

- Significant decrease was seen in age-adjusted incidence rates for prostate cancer (11.9 percent).
- 78 percent of prostate cancer cases were diagnosed in patients between 55-79 years old during 2008.
- Prostate cancer had significant decrease in age-adjusted mortality rates (32.9 percent).
- 72 percent of prostate cancer deaths occurred in patients over 75 years of age.
- 81 percent of prostate cancer cases were diagnosed at local stage.
- Prostate cancer was more likely to be diagnosed at local stage (81.3 percent).
- Prostate cancer showed the biggest difference between races in distant SEER stage, with 2.6 percent difference between black and white District residents.

Breast Cancer

- Breast cancer decreased by 5.2 percent in age-adjusted incidence rates.
- 61 percent of breast cancer cases were diagnosed in patients between 50-74 years old.
- Breast cancer had significant decrease in age-adjusted mortality rates (13.9 percent).
- 64 percent of breast cancer deaths occurred in patients between 55-84 years old.
- Breast cancer was more likely to be diagnosed at local stage (42 percent).
- There was a 14 percent difference in local SEER stage of diagnosis between white and black women in the District for breast cancer.
- Black women were more likely to be diagnosed at regional and distant stages, and were less likely to be diagnosed at local stage when compared to white women.

Source: DC Cancer Registry

Rates are per 100,000 persons and are age-adjusted to the 2000 US standard.

CEREBROVASCULAR DISEASE

District of Columbia	Percent Heart Disease	Percent Had a Stroke
TOTAL	2.6	3.4
Gender		
Male	3.5	3.3
Female	1.8	3.5
Age		
18-24	-	0.5
25-34	-	0.6
35-44	1	1.6
45-54	2.1	2.9
55-64	4.6	5.1
65+	7.9	9.7
Race/Ethnicity		
Caucasian	1.4	0.7
African American	3.7	5.8
Asian	1.4	2.1
Other	1.6	4.5
Hispanic	2	2.5
Education		
Less than High School	9.4	10.5
High School Graduate	3	6.1
Some College	2.8	4.6
College Graduate	1.7	1.5
Income		
Less than $15,000	7.7	12.3
$15,000-$24,999	3.4	6.1
$25,000-$34,999	5.3	6.1
$35,000-$49,999	1.4	3
$50,000-$74,999	0.8	2
$75,000 and over	1.4	0.8
Ward Comparison		
Ward 1	1.5	2.2
Ward 2	1.2	2.9
Ward 3	2	0.7
Ward 4	2.2	3.2
Ward 5	2.4	5.7
Ward 6	2.9	3.5
Ward 7	4.8	6.5
Ward 8	3.6	5.5

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Not Met: Reduce the proportion of adult residents with high blood pressure to no more than 10 percent.

Goal Attained: Increase to at least 50 percent the proportion of adult residents with high blood pressure whose pressure is under control.

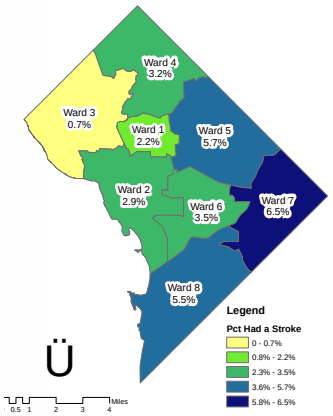
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have ever been told by a doctor, nurse or other health professional that they have heart disease.

- Overall, 2.6 percent of District respondents were told they have heart disease compared to 4.1 percent nationally.
- Males were more likely than females to have heart disease, at 3.5 percent.
- Adults aged 65 years or older were more likely than all other age groups to have heart disease, at 8 percent.
- African Americans were more likely than all other race/ethnic groups to have heart disease, at 4 percent.
- Adults who resided in Ward 7 were more likely than all other wards to have heart disease, at 5 percent.

District respondents were asked if they have been told by a doctor, nurse or other health professional that they had a stroke.

- Overall, 4.6 percent of District respondents were told they have had a stroke compared to 2.7 percent nationally.
- Males were more likely than females to have had a stroke, 4.8 percent and 4.4 percent, respectively.
- Adults aged 65 years or older were more likely than all other age groups to have had a stroke, at 9 percent.
- African Americans were more likely than all other race/ethnic groups to have had a stroke, at 7.5 percent.
- Adults who resided in Wards 5 and 8 were more likely than all other ward to have had a stroke, at 8 percent.

Figure 127. Map of Stroke by Ward, 2010



HIV PREVALENCE

With nearly 3 percent of its population diagnosed and reported with HIV, the District has a severe and generalized epidemic.

All race/ethnicities with HIV exceed 1 percent of their respective populations, with African Americans disproportionately impacted at 4.3 percent.

District of Columbia	Rate per 100,000 Population
TOTAL	2,739.0
Gender	
Male	4,238.8
Female	1,422.4
Age	
13-19	105.8
20-29	950.2
30-39	2,709.6
40-49	6,598.7
50-59	5,530.7
60+	1,523.7
Race/Ethnicity	
White	1,226.3
Black	4,264.6
Hispanic	1,836.4
Other	1,043.8
Ward Comparison	
Ward 1	2.7
Ward 2	2.1
Ward 3	0.5
Ward 4	1.9
Ward 5	2.7
Ward 6	2.6
Ward 7	2.6
Ward 8	3.1

Mode of Transmission	Percentage of Living HIV Cases
Men who have sex with men (MSM)	40.5
Injection drug use (IDU)	15.1
MSM/IDU	3.4
Heterosexual contact	28.0
Risk not identified	12.9
Other	0.2

Source: HAHSTA ANNUAL REPORT 2011

Healthy People 2010 Objectives

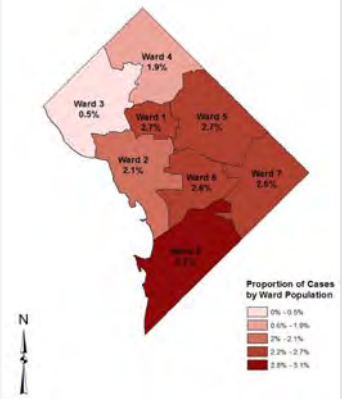
Goal Attained: Increase by 2.5 percent annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP); in 2010 ADAP enrollment was 2,638 (quarterly average).

Goal Not Met: Increase by 10 percent annually the number of HIV+ individuals who receive Housing Assistance services; in 2010, 712 individuals who were HIV + received Housing Assistance services, and no constant annual increase was seen through the data.

The District of Columbia continues to fight a severe HIV/AIDS epidemic. Among DC adult and adolescent residents, there is a 2.7 percent prevalence of HIV/AIDS. This surpasses the World Health Organization guideline which indicates that a generalized epidemic is a HIV/AIDS prevalence of 1 percent or more.

- At the end of 2010, 14,465 adults and adolescents were living with HIV in the District, accounting for 2.7 percent of District residents.
- Approximately 4.2 percent of men and 1.4 percent of women are diagnosed and living with HIV.
- Men accounted for less than half (46.7 percent) of District residents but almost three-quarters (72.3 percent) of living HIV cases.
- All race/ethnicities with HIV exceed 1 percent of their respective populations, with African Americans disproportionately impacted at 4.3 percent.
- Although blacks accounted for just under half (46.0 percent) of District residents over the age of 12, three quarters (75.4 percent) of District residents living with HIV were black.
- Among District women, black women accounted for the majority of living HIV cases (92.4 percent).
- District residents between 40-49 years of age and black men have the highest rates of HIV at 6,598.7 and 6,344.1 cases per 100,000 population respectively.
- Residence at diagnosis and ward information was available for 93.7 percent of living HIV cases. At the end of 2010, the highest rate of persons living with HIV was Ward 8 (3.1 percent) and the lowest rate of persons living with HIV was Ward 3 (0.5 percent).
- At the end of 2010, the highest number of persons living with HIV was reported in Ward 1 (n=1,913). The lowest number of persons living with HIV was reported in Ward 3 (n=322).
- In addition, 371 persons living with HIV were homeless at diagnosis and 931 persons living with HIV were diagnosed in jail.

Figure 128. Map of HIV Prevalence by Ward, 2010



HIV TRENDS, 2006-2010

As outlined in the One City Action Plan, the District is scaling up the National HIV/AIDS Strategy through a set of services that address targets set to be accomplished by 2015, including reducing HIV transmission, improving HIV/AIDS services, and reducing disparities associated with HIV/AIDS. Services include education, condom distribution and promotion of proper use, HIV testing, linkage to care, medical and social services for people living with HIV, and the needle exchange program. These strategies focus resources on high-risk populations and address disparities based on racial/ethnic groups, gender, sexual orientation, age, and ward.

Reducing New Infections

- The number of newly diagnosed HIV cases in the District decreased slightly from 853 cases in 2009 to 835 cases in 2010, however there has been a 24 percent reduction from 1,103 cases in 2006.
- The number of MSM cases diagnosed between 2006 and 2010 decreased by 45 percent. In 2006 there were 407 HIV cases diagnosed among MSM and in 2010 there were 305 cases diagnosed.
- HIV cases attributed to heterosexual contact declined from 368 cases in 2006 to 278 cases in 2010, a decrease of 24 percent.
- Overall the number of cases due to injection drug use has decreased by 70 percent since 2006. There was an even greater reduction after 2007 when the District expanded needle exchange services. In 2007 there were 150 newly diagnosed HIV cases attributed to injection drug use compared to 42 cases in 2010.
- New record of 122,000 publicly supported HIV tests, up from 110,000 in 2010 and triple the 43,000 tests in 2007.
- Distributed more than 5 million male and female condoms, a 10-fold increase from 2007.

Increasing Access to Care and Improving Health Outcomes

- The number of new AIDS cases decreased by 32 percent from 700 in 2006 to 477 in 2010.
- This declining trend may be attributed to expanded HIV testing, whereby people living with HIV are diagnosed and linked to care earlier which prevents the progression of disease.
- It is important that persons diagnosed with HIV enter care as soon as possible. Early entry into HIV care may improve health outcomes because immediate anti-retroviral therapy reduces the amount of virus in the body and slows progression to AIDS. According to the US Public Health Service Guidelines, CD4 cell counts and viral load tests are performed as part of routine HIV management. CD4 laboratory results reported to the surveillance system were used to assess whether District cases were accessing HIV primary medical care and how long after their initial HIV diagnosis they received services. Figure 130 shows the time from initial HIV diagnosis to first CD4 or viral load test.
- The majority (88.7 percent) of HIV cases diagnosed in 2010 entered care within 12 months of their initial diagnosis and three quarters (76.1 percent) entered care within 3 months. The proportion of cases entering care has steadily increased since 2006, when only 58.1 percent of cases entered care within 3 months of their initial diagnosis.
- After a person is diagnosed with HIV, their CD4 count is routinely measured, which indicates the state of their immune system. A CD4 count of less than 200 is considered an AIDS diagnosis, increasing the risk for severe illnesses such as opportunistic infections.
- There has been a steady increase in the median CD4 count at diagnosis since 2006 as well. In 2006 the median CD4 count among newly diagnosed cases was 191 cells/mL, while in 2010 the median CD4 count was 391 cells/mL, a 104 percent increase. This trend may be explained by the increased emphasis on routine HIV testing city-wide and thus earlier entry into care.

Figure 129. Newly Diagnosed HIV Cases by Year of Diagnosis and Mode of Transmission, District of Columbia, 2006-2010

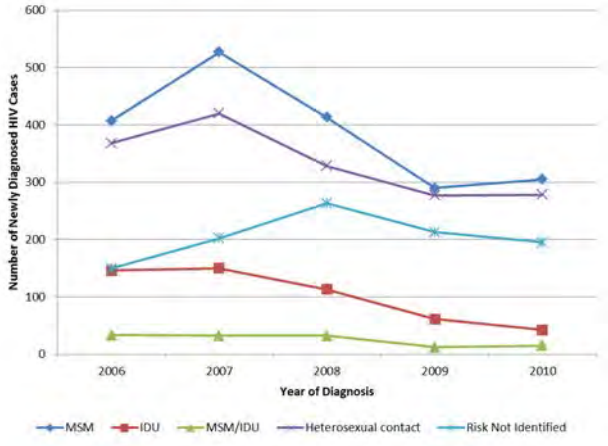
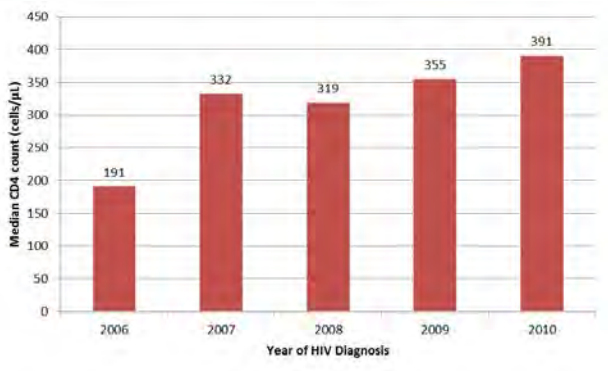


Figure 130. Time Between HIV Initial Diagnosis and Entry into Care as Evidenced by First CD4 Count, Percentage or Viral Load Test among HIV/AIDS Cases by Year of HIV Diagnosis, District of Columbia, 2006-2010

Figure 131. Median CD4 Cell Count at Diagnosis for HIV Cases by Year of HIV Diagnosis, District of Columbia, 2006-2010



Source: HAHSTA ANNUAL REPORT 2011

HIV TESTING

District of Columbia	Percent Tested for HIV
TOTAL	70.2
Gender	
Male	70.5
Female	70
Age	
18-24	65.5
25-34	72.9
35-44	79.2
45-54	70.3
55-64	55.2
Race/Ethnicity	
Caucasian	64.7
African American	78
Other	58.1
Hispanic	69.4
Education	
Less than High School	82.9
High School Graduate	74.2
Some College	70.6
College Graduate	68.3
Income	
Less than $15,000	80.7
$15,000-$24,999	76.1
$25,000-$34,999	79.7
$35,000-$49,999	70.7
$50,000-$74,999	69.2
$75,000 and over	68.6
Ward Comparison	
Ward 1	66.8
Ward 2	69.7
Ward 3	61.8
Ward 4	70.1
Ward 5	74.9
Ward 6	71.5
Ward 7	76.6
Ward 8	81.8

Source: 2010 District of Columbia BRFSS

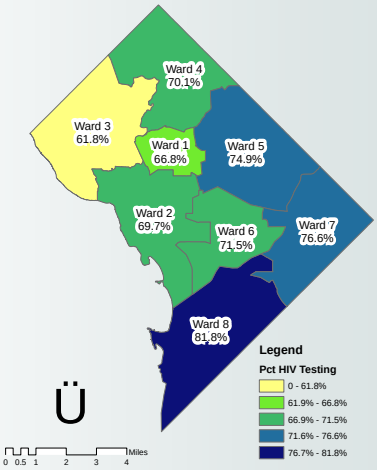
Healthy People 2010 Objectives

Goal Attained: Increase by 5 percent annually the number of HIV+ individuals identified through HIV counseling and testing; the District's rate was 7.3 percent from 2009 to 2010 (Program Evaluation and Monitoring System)

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they ever been tested for HIV (excluding blood donation).

- Overall, 70 percent District respondents have been tested for HIV.
- There were no differences in HIV testing for gender.
- Adults aged 35-44 years were more likely than all other age groups to have been tested for HIV, at 79 percent.
- African Americans were more likely than all other race/ethnic groups to have been tested for HIV, at 78 percent.
- Adults with less than a high school education were more likely than all other education subgroups to have been tested for HIV, at 83 percent.
- Adults with a household income of less than $15,000 were more likely than all other income subgroups to have been tested for HIV, at 80 percent.
- Adults residing in Ward 8 were more likely than all other wards to have been tested for HIV, at 82 percent.

Figure 132. Map of HIV Testing by Ward, 2010



HIV STATUS OF PARTNER

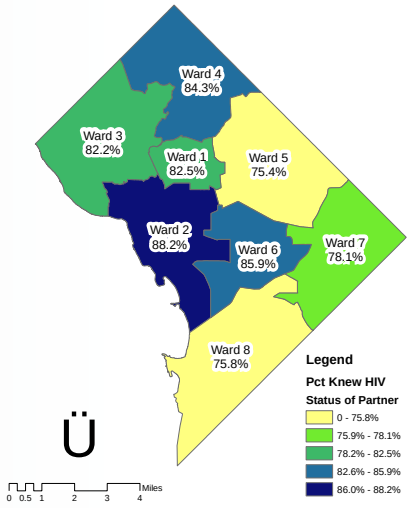
District of Columbia	Percent Knew Partner HIV Status
TOTAL	80.2
Gender	
Male	80.7
Female	79.8
Age	
18-24	71.8
25-34	85.7
35-44	84.5
45-54	80.1
55-64	70.6
Race/Ethnicity	
Caucasian	86.5
African American	74.8
Asian	86.3
Other	72.2
Hispanic	78.8
Education	
Less than High School	71.4
High School Graduate	71
Some College	71.9
College Graduate	85.2
Income	
Less than $15,000	69.2
$15,000-$24,999	71
$25,000-$34,999	69.5
$35,000-$49,999	71.9
$50,000-$74,999	75.4
$75,000 and over	89.1
Ward Comparison	
Ward 1	82.5
Ward 2	88.2
Ward 3	82.2
Ward 4	84.3
Ward 5	75.4
Ward 6	85.9
Ward 7	78.1
Ward 8	75.8

Source: 2010 District of Columbia BRFSS

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they know the HIV status of their primary partner.

- Overall, 80 percent indicated that they knew the HIV status of their primary partner.
- Males were more likely than females to know the HIV status of their primary partner, 81 percent and 80 percent, respectively.
- Adults aged 25-34 years were more likely than all other age groups to know the HIV status of their primary partner, at 86 percent.
- Caucasians and Asians were more likely than all other race/ethnic groups to know the HIV status of their primary partner, at 86.5 and 86.3 percent, respectively.
- College graduates were more likely than all other education subgroups to know the HIV status of their primary partner, at 85 percent.
- Adults with a household income of $75,000 or more were more likely than all other income subgroups to know the HIV status of their primary partner, at 89 percent.
- Adults residing in Ward 2 were more likely than all other wards to know the HIV status of their primary partner, at 88 percent.

Figure 133. Map of Known HIV Partner Status by Ward, 2010



HIV SYNDEMICS

District of Columbia	Percentage Co-Infected	Percentage HIV Only
Gender		
Male	74.6	71.1
Female	25.4	28.9
Age at HIV Diagnosis		
13-19	4.6	2.8
20-29	26.9	29.9
30-39	19.2	24.5
40-49	20.8	24.1
50-59	25.4	12.9
60+	3.1	5.7
Race/Ethnicity		
White	10.8	13.5
Black	85.4	76.2
Hispanic	3.8	7.2
Other	-	3.1
Mode of Transmission		
Men who have sex with men (MSM)	40.0	35.9
Injection drug use (IDU)	3.8	5.2
MSM/IDU	--	2.0
Heterosexual contact	33.1	33.3
Risk not identified	22.3	23.5

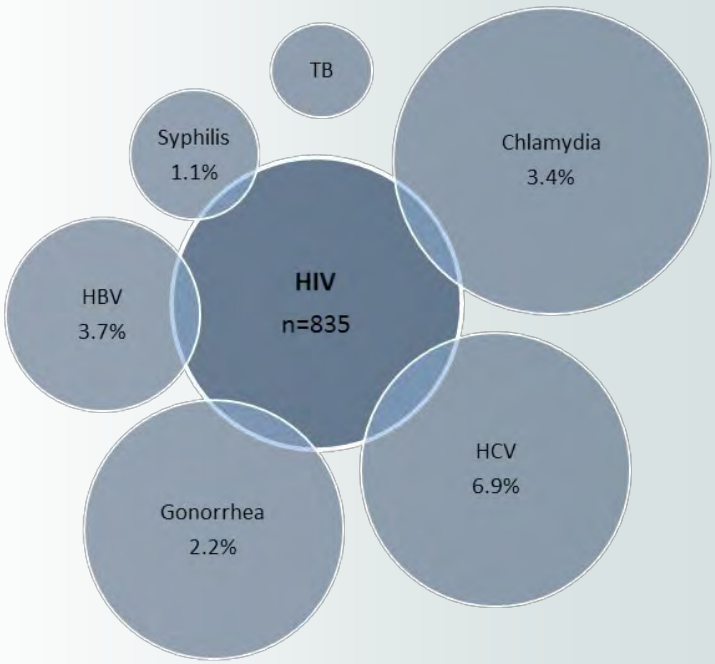
Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

HIV Syndemics

Syndemics can be defined as two or more diseases, or conditions, that interact to create an increase in transmissions or to worsen the health outcomes of people and communities. HAHSTA has examined HIV, STDs, viral hepatitis and TB to assess the prevalence of each disease as well as how they intersect in communities and populations. Syndemics are influenced not only by background prevalence but also by people, communities and environmental conditions. This syndemic analysis looks to describe focus populations and their risk factors as well as burden of disease.

- Persons diagnosed with HIV are often infected with other communicable diseases. Of the 835 HIV diagnoses in 2010, approximately 17 percent were identified as having a co-infection.
- Seven percent (7 percent) were co-infected with chronic hepatitis C, and approximately 4 percent were co-infected with chronic hepatitis B.
- Co-infections with sexually transmitted diseases (STD) were also present. Approximately 3 percent percent of the HIV diagnoses were co-infected with Chlamydia and 2.2 percent were co-infected with gonorrhea. Approximately 1 percent were infected with syphilis during 2010.
- There were slight differences among HIV diagnoses that were co-infected in comparison with those in infected with HIV only. Co-infected cases were more likely to be black (85.4 percent vs. 76.2 percent), MSM (40.0 percent vs. 35.9 percent) and over the age of 40 (49.3 percent vs. 42.7 percent).

Figure 134. Proportion of HIV Cases Diagnosed in the District of Columbia with a Co-infection, 2010



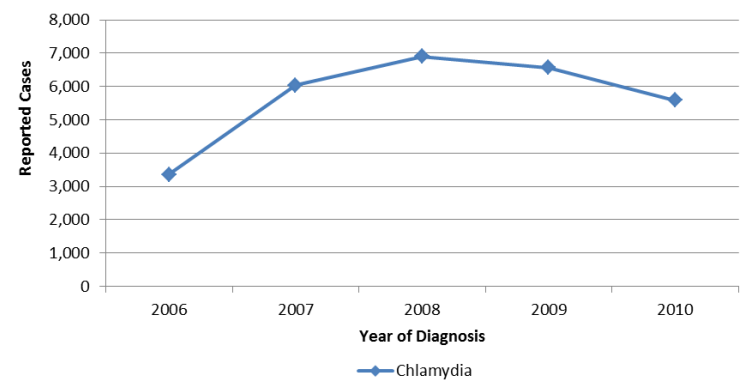
CHLAMYDIA

District of Columbia	Rate per 100,000 Population
TOTAL	929.3
Gender	
Male	628.7
Female	1,192.4
Age	
0-14	124.1
15-19	5,889.4
20-24	2,573.7
25-29	1,022.3
30-39	505.0
40+	113.7
Race	
Black	1,195.2
White	72.1
Asian	107.7
AI/AN	1,298.7
Other	57.6
Ethnicity	
Hispanic	248.4
Non-Hispanic	649.2
Ward Comparison	
Ward 1	549.9
Ward 2	224.0
Ward 3	80.4
Ward 4	504.1
Ward 5	979.7
Ward 6	531.3
Ward 7	1,348.0
Ward 8	1,770.6

Healthy People 2010 Objectives

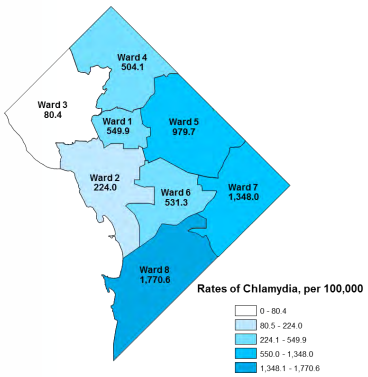
Goal Not Met: Reduce the prevalence of Chlamydia trachomatis infections among young persons (15 to 24 years old) to no more than 3 percent; the District's rate is 3.9 percent.

Figure 135. Reported Number of Chlamydia Cases, 2006-2010



- From 2006 to 2010 the District received 28,461 reports of chlamydia infections. Among those, more than two-thirds of cases were among women (67.1 percent), over half (60.4 percent) were black, and more than two-thirds (69.1 percent) were between 15-24 years of age.
- In addition, reported chlamydia cases more than doubled from 2006 (3,360) to 2008 (6,899) but have leveled off since then. This increase is likely due to expanded screening programs among high-risk populations and more sensitive diagnostic tests. These new tests can be performed on urine specimens that can be collected in non-traditional venues (such as high schools and non-clinical community programs) and are more effective at detecting infections.
- Because chlamydia is a "silent disease," the more "you look for it "(i.e. screen for it) the more "you find it" (asymptomatic infections).
- The highest rate for chlamydia cases was reported in Ward 8 (1,770.6 cases per 100,000 population) in 2010.
- The lowest rate for chlamydia cases was reported in Ward 3 (80.4 cases per 100,000 population) in 2010.

Figure 136. Map of Chlamydia Rates by Ward, 2010



Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

GONORRHEA

District of Columbia	Rate per 100,000 Population
TOTAL	349.7
Gender	
Male	361.7
Female	338.0
Age	
0-14	47.7
15-19	1,861.3
20-24	935.9
25-29	445.1
30-39	248.9
40+	67.8
Race	
Black	540.9
White	51.8
Asian	37.5
AI/AN	625.3
Other	9.6
Ethnicity	
Hispanic	82.2
Non-Hispanic	275.2
Ward Comparison	
Ward 1	207.4
Ward 2	148.9
Ward 3	18.2
Ward 4	146.5
Ward 5	378.2
Ward 6	241.5
Ward 7	505.2
Ward 8	739.6

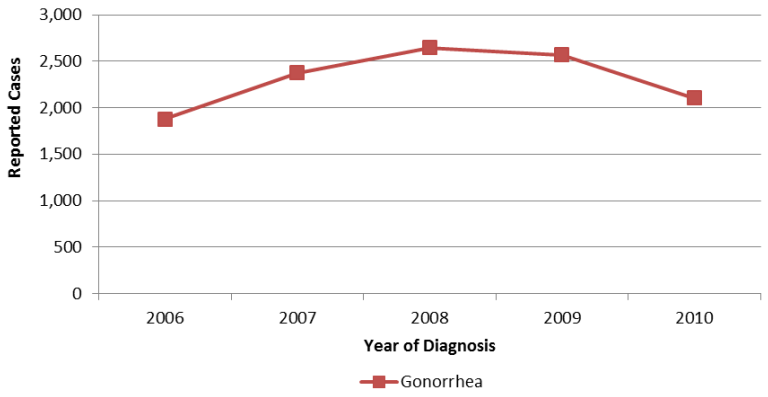
Healthy People 2010 Objectives

Goal Not Met: Reduce the incidence of gonorrhea among District residents to no more than 346 cases per 100,000 people; the District's rate is 350 per 100,000.

Goal Attained: Reduce the incidence of gonorrhea in adolescents ages 10- 19 years in the District to no more than 5800 cases per 100,000 people; the District's rate is 1,165 per 100,000.

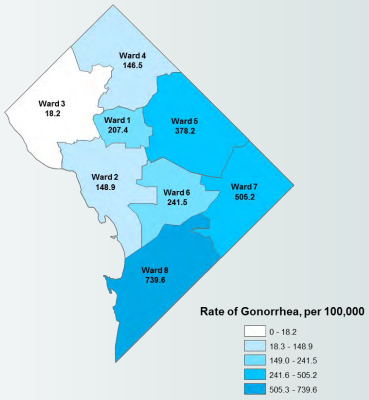
Goal Not Met: Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000; the District's rate is 397 cases per 100,000 women.

Figure 137. Reported Number of Gonorrhea Cases, 2006-2010



- From 2006 to 2010 the District received 11,569 reports of gonorrhea infections. Unlike chlamydia, the sex of reported cases was divided almost equally between men and women at 52.7 percent and 47.0 percent, respectively. Almost three-quarters of reported cases were among blacks (70.4 percent) and more than half (59.2 percent) were between 15-24 years of age.
- Unlike chlamydia cases, gonorrhea cases are usually symptomatic and often seek medical care for testing and treatment.
- In 2010, the highest rate of gonorrhea cases was reported in Ward 8 (739.6 cases per 100,000 population).
- In 2010, the lowest rate of gonorrhea cases was reported in Ward 3 (18.2 cases per 100,000 population).

Figure 138. Map of Gonorrhea Rates by Ward, 2010



Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

SYPHILIS

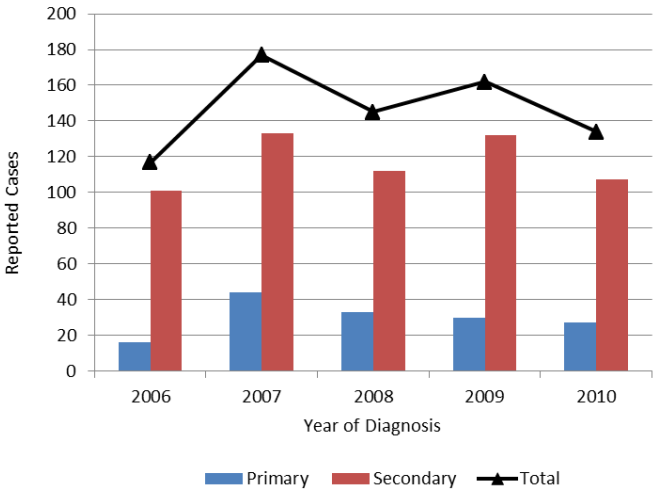
District of Columbia	Rate per 100,000 Population
TOTAL	22.3
Type	
Primary	4.5
Secondary	17.8
Gender	
Male	46.4
Female	-
Age	
0-14	-
15-19	17.5
20-24	31.2
25-29	34.5
30-39	37.7
40+	18.7
Race	
Black	23.3
White	20.3
Asian	28.1
AI/AN	-
Other	21.6
Ethnicity	
Hispanic	20.1
Non-Hispanic	22.1
Ward Comparison	
Ward 1	38.1
Ward 2	35.0
Ward 3	--
Ward 4	11.9
Ward 5	21.5
Ward 6	17.0
Ward 7	29.5
Ward 8	19.8

Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

Healthy People 2010 Objectives

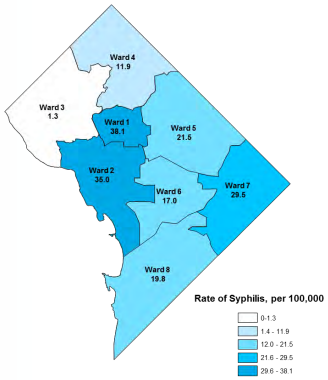
Goal Not Met: Reduce the incidence of primary and secondary syphilis to no more than three cases per100,000 people; the District's rate is 22 per 100,000.

Figure 139. Reported Number of Primary and Secondary Syphilis Cases, 2006-2010



- Primary syphilis is defined as the stage of syphilis characterized by a large painless lesion (chancre) where the bacteria entered the body. This lesion can be on or in the mouth, rectum, vagina, or penis. Secondary syphilis is characterized by rashes that can appear anywhere on the body, but typically involve the hands and feet.
- There were 735 cases of primary and secondary syphilis reported in the District between 2006 and 2010. Unlike chlamydia and gonorrhea, which predominately affected youth and young adults less than 24 years of age, almost two-thirds (65.3 percent) of infectious syphilis cases were 30 years of age or older. Slightly more than half (55.4 percent) of reported primary and secondary syphilis cases were among blacks and almost all cases (96.4 percent) were reported among men.
- In contrast to chlamydia and gonorrhea, the greatest number of primary and secondary syphilis cases was reported in Wards 1 and 2 (38.1 and 35.0 cases per 100,000 population, respectively).

Figure 140. Map of Syphilis Rates by Ward, 2010



STD TREATMENT

District of Columbia	Percent Treated for STD
TOTAL	4.6
Gender	
Male	4.6
Female	4.6
Age	
18-24	8.8
25-34	6.2
35-44	5.5
45-54	2.9
55-64	2.6
Race/Ethnicity	
Caucasian	1.5
African American	7.4
Other	2.9
Hispanic	8.5
Education	
Less than High School	*
High School Graduate	10.1
Some College	4.2
College Graduate	2
Income	
Less than $15,000	11.1
$15,000-$24,999	12.5
$25,000-$34,999	13.9
$35,000-$49,999	4.7
$50,000-$74,999	2.1
$75,000 and over	1.7
Ward Comparison	
Ward 1	2.3
Ward 2	3.6
Ward 3	1
Ward 4	1.8
Ward 5	5
Ward 6	1.5
Ward 7	14.5
Ward 8	8.6

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Not Met: Increase to at least 98 percent the proportion of major health providers managing STD patient care according to the most recent Centers for Disease Control and Prevention (CDC) guidelines for the treatment of Sexually Transmitted Diseases.

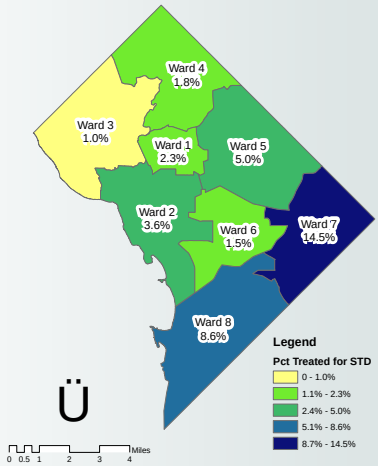
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have ever been treated for an STD in the past 12 months.

- Overall, 4.6 percent indicated in the past 12 months they have been treated for an STD.
- Males and females were equally as likely to have been treated for an STD in the past 12 months, at 4.6 percent.
- Adults aged 18-24 years were more likely than all other age groups to have been treated for an STD in the past 12 months, at 9 percent.
- Hispanics were more likely than all other race/ethnic groups to have been treated for an STD in the past 12 months, at 8.5 percent.
- High school graduates were more likely than all other education subgroups to have been treated for an STD in the past 12 months, at 10 percent.
- Adults with a household income of $25,000-$34,999 were more likely than all other income subgroups to have been treated for an STD in the past 12 months, at 14 percent.
- Adults residing in Ward 7 were more likely than all other wards to have been treated for an STD in the past 12 months, at 14.5 percent.

The highest rate for chlamydia and gonorrhea cases were reported in Ward 8.

Unlike chlamydia and gonorrhea, which predominately affect youth and young adults less than 24 years of age, majority of infectious syphilis cases were older and were reported in Wards 1 and 2.

Figure 141. Map of STD Treatment by Ward, 2010



TUBERCULOSIS

District of Columbia	Percentage of TB Cases in 2010
Disease Site	
Pulmonary	65.1
Extra Pulmonary	32.5
Gender	
Male	48.8
Female	51.2
Age	
0-14	-
15-19	-
20-24	-
25-44	41.9
45-64	27.9
65+	20.9
Race/Ethnicity	
Black non-Hispanic	65.1
Black Hispanic	-
White non-Hispanic	18.6
White Hispanic	9.3
Other	-
US Born vs. Foreign Born	
Foreign Born	62.7
US Born-Black	26.4
US Born-All Other Races	9.3

Ward Comparison	Number of Reported TB Cases, 2006-2010
Ward 1	53
Ward 2	33
Ward 3	13
Ward 4	48
Ward 5	38
Ward 6	25
Ward 7	15
Ward 8	27

Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

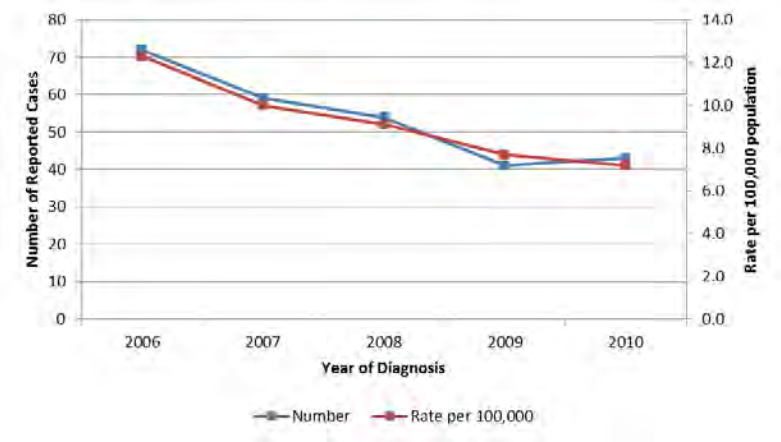
Healthy People 2010 Objectives

Goal Attained: Reduce the incidence of tuberculosis in the District of Columbia to no more than 9.9 cases per 100,000; the District's rate is 7.2 per 100,000.

Goal Not Met: Increase to 90 percent the proportion of TB patients who complete a recommended course of curative treatment; the District's rate is 78.9 percent.

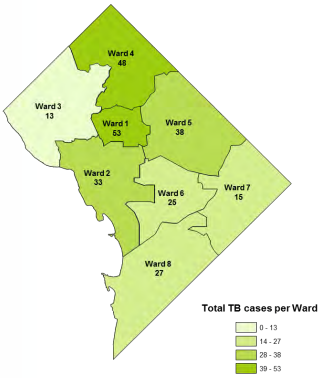
Goal Not Met: Increase to 90 percent the proportion of close contacts of persons infected with TB who complete the recommended courses in preventive therapy; the District's rate is 26 percent.

Figure 142. Reported Number and Rate of TB Cases, 2006-2010



- The District has experienced considerable success over the last five years in reducing the number of TB cases and consequently the TB case rate among District residents.
- In 2010, 43 cases of TB were reported, a 40 percent decrease from the 72 cases reported in 2006.
- During the report period, the TB case rate fell from 12.3 to 7.2 per 100,000 people. The number of cases from 2009 to 2010 has leveled off, at 41 and 43 respectively.
- Those most affected by TB in the District are US-born Blacks and persons born in foreign countries where TB is endemic.
- Overall 59.9 percent of reported TB cases were among men. In 2009 and 2010, however, this long standing trend was reversed somewhat, with more than half (54.8 percent) of cases being reported among women.

Figure 143. Map of TB Cases by Ward, 2010



DISABILITY

District of Columbia	Percent Limited by Health	Percent Use Special Equipment
TOTAL	16.5	8.8
Gender		
Male	15.1	7.8
Female	17.7	9.7
Age		
18-24	3.9	0.9
25-34	7.1	0.7
35-44	11.2	3.1
45-54	20	9.4
55-64	25.1	12.2
65+	25.4	24.9
Race/Ethnicity		
Caucasian	14.4	4.1
African American	18.4	12.9
Asian	13.8	2
Other	17.8	11.8
Hispanic	13.9	7.7
Education		
Less than High School	24.9	26.3
High School Graduate	19.4	12
Some College	18.5	13
College Graduate	14.2	4.9
Income		
Less than $15,000	38.1	29.2
$15,000-$24,999	23.3	13.1
$25,000-$34,999	14.2	12.5
$35,000-$49,999	15.8	7.8
$50,000-$74,999	12.7	6.2
$75,000 and over	11.7	3.2
Ward Comparison		
Ward 1	19.5	8
Ward 2	12.8	7.6
Ward 3	17.4	5.3
Ward 4	15.8	7.1
Ward 5	18.6	12.6
Ward 6	15.8	9.8
Ward 7	21.7	16.6
Ward 8	21.2	11.8

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Not Met: Ensure that 100 percent of relevant DOH programs have a standardized set of parameters in their core surveillance instruments that include information on persons with disabilities.

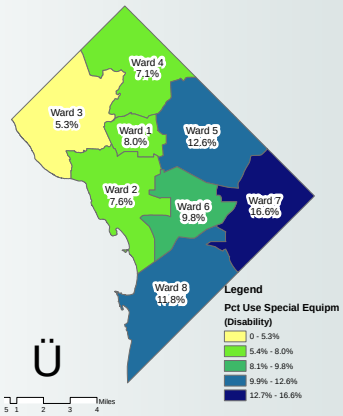
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they were limited in any way in their activities because of physical, mental or emotional problems.

- Overall, 16.5 percent indicated that they were limited in their activities because of physical, mental or emotional problems compared to 21.1 percent nationally.

District respondents were asked if they have any health problems that require them to use special equipment, such as a cane, wheelchair, special bed, or special telephone.

- Overall, 8.8 percent of respondents indicated that they have a health problem that requires them to use special equipment such as a cane, wheelchair, special bed, or special telephone compared to 7.5 percent nationally.
- Females were more than males to have health problems that require them to use special equipment, 9.7 percent and 7.8 percent, respectively.
- Adults aged 65 years or older were more likely than all other age groups to have health problems that require them to use special equipment, at 24.9 percent.
- African Americans were more likely than all other race/ethnic groups to have health problems that require them to use special equipment, at 12.9 percent.
- Adults with a household income of less than $15,000 were more likely than all other income subgroups to have health problems that require them to use special equipment, at 38.1 percent.
- Adults who resided in Wards 7 and 8 were more likely than all other wards to have health problem that require them to use special equipment, at 21.7-21.2 percent.

Figure 144. Map of Special Equipment Use by Ward, 2010



MENTAL HEALTH

District of Columbia	Percent with 15-30 Days Poor Mental Health	Percent with Zero Days Poor Mental Health
TOTAL	7.6	67.5
Gender		
Male	5.6	73.1
Female	9.3	62.6
Age		
18-34	5.5	63.5
35-44	8.8	63.4
45-54	8.5	66.6
55-64	8.7	70.3
65+	6.7	77.7
Race/Ethnicity		
Caucasian	4.6	69.6
African American	10.4	66.1
Other	4	65.7
Hispanic	6.7	67.4
Education		
Less than High School	16.4	61.9
High School Graduate	11.1	68.3
Some College	9.2	64.1
College Graduate	5.2	68.6
Income		
Less than $15,000	21.9	54.7
$15,000-$24,999	13.3	62.2
$25,000-$34,999	10.4	70.6
$35,000-$49,999	7.4	66.7
$50,000-$74,999	3.2	65.1
$75,000 and over	4.3	70.3
Ward Comparison		
Ward 1	6.3	65.5
Ward 2	6.5	74
Ward 3	3.2	69.9
Ward 4	6.5	71.3
Ward 5	9.4	66.2
Ward 6	7.8	69.8
Ward 7	12.3	62.9
Ward 8	11.8	60.6

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

Goal Attained: Expand the prevention-oriented services for children and adolescents (ages 5–18) in the mental health rehabilitation services (MHRS) programs by 10 percent annually.

Goal Attained: Expand the prevention oriented services for children in DC Charter and Public Schools. (DCPS).

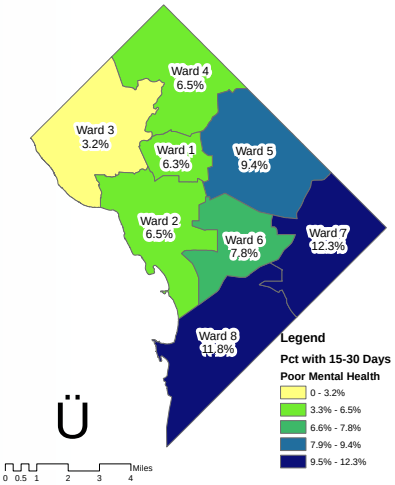
Goal Attained: Increase to 5 percent annually the services to persons age 18 and older who are homeless with serious mental illness.

155 adults who were homeless with serious mental illnesses receiving services through Pathways To Housing-DC. (Source: Pathways To Housing- DC)

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked how many days during the past 30 days their mental health was not good.

- Overall, 7.6 percent indicated in the past 15-30 days they had poor mental health.
- Females were more likely than males to indicate 15-30 days of poor mental health, 9 percent and 6 percent, respectively.
- Adults aged 35-44, 45-54 and 55-64 years were more likely than all other age groups to indicate 15-30 days of poor mental health, at 9 percent.
- African Americans were more likely than all other race/ethnic groups to indicate 15-30 days of poor mental health, at 10 percent.
- Adults with less than a high school education were more likely than all other education subgroups to indicated 15-30 days of poor mental health, at 16.4 percent.
- Adults with a household income of less than $15,000 were more likely than all other income subgroups to indicate 15-30 days of poor mental health, at 22 percent.
- Adults who resided in Ward 7 were more likely than all other wards to indicate 15-30 days of poor mental health, at 12 percent.

Figure 145. Map of Poor Mental Health by Ward, 2010



IMMUNIZATION

District of Columbia	Percent with Seasonal Flu Shot
TOTAL	44.3
Gender	
Male	43.1
Female	45.3
Age	
18-64	41.1
65 and Older	60.9
Race/Ethnicity	
Caucasian	55
African American	36.8
Other	44.4
Hispanic	35.6
Education	
Less than High School	42.9
High School Graduate	38
Some College	35.5
College Graduate	48.6
Income	
Less than $15,000	37.5
$15,000-$24,999	30.8
$25,000-$34,999	45.6
$35,000-$49,999	35.3
$50,000-$74,999	39.1
$75,000 and over	50.1
Ward Comparison	
Ward 1	44.9
Ward 2	54.7
Ward 3	58.4
Ward 4	40.5
Ward 5	38.3
Ward 6	47.7
Ward 7	40.9
Ward 8	34.8

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

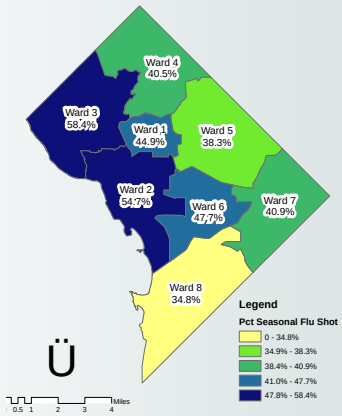
Goal Not Met: Increase the proportion of adult's age 65 and older who are vaccinated annually against influenza to 90 percent; the District's rate is 62 percent.

Goal Not Met: Increase the proportion of adult's age 65 and older who are vaccinated against pneumonia to 90 percent; the District's rate is 65 percent.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have had a seasonal flu shot.

- Overall, 44 percent of District residents received a seasonal flu shot; and 60.9 percent of adults 65 years and older received a seasonal flu shot compared to 68.8 percent nationally.
- Females were more likely than males receive a seasonal flu shot at, 45.3 percent and 43.1 percent, respectively.
- Adults aged 65 years and older were more likely than adults aged 18-64 years to receive a seasonal flu shot, at 60 percent.
- Caucasians were more likely than all other race/ethnic groups to receive a seasonal flu shot, at 55 percent.
- College graduates were more likely than all other education subgroups to receive a seasonal flu shot, at 48.6 percent.
- Adult households with an income of $75,000 or more were more likely than all other income subgroups to receive a seasonal flu shot, at 50 percent.
- Adults who resided in Ward 3 were more likely than all other wards to receive a seasonal flu shot, at 58.4 percent.

Figure 146. Map of Seasonal Flu Shot by Ward, 2010



INFLUENZA

The Division of Epidemiology-Disease Surveillance and Investigation (DE-DSI) of the DC DOH conducts surveillance of seasonal influenza and influenza-like illness (ILI) from October through May (influenza season). This effort helps DC DOH identify at-risk populations to focus vaccination efforts. Persons at high-risk for complications, hospitalizations, and death from flu include children less than two years, persons 65 or older, and individuals who are immune-compromised or have chronic medical conditions. The DE-DSI conducts influenza surveillance using 4 main sources: sentinel surveillance reporting, syndromic reporting, outbreak investigation and Public Health Laboratory (PHL) testing. Sentinel surveillance involves collecting reports of ILI from 4 select clinical settings in the District through a secure CDC website, as part of a national surveillance system. Syndromic surveillance involves collecting hospital emergency department cases with a chief complaint of ILI and diagnosed Influenza virus. Outbreaks of influenza and ILI are reported to DE-DSI for investigation as required by law. The DC PHL performs lab tests on human specimens to confirm influenza cases and reports to DE-DSI.

- During the 2010-2011 influenza season, a total of 554 influenza cases were identified through sentinel reporting and case reporting. Of these cases, 425 (76.7 percent) were attributable to District residents.
- The 2010-2011 totals represent a decrease from case totals in the previous season (2009-2010) (Figure 147).
- The 2010-2011 influenza season peaked during the winter months, which is consistent with past influenza seasons, unlike the 2009-2010 influenza season which peaked in late October.
- The unusual seasonal pattern of the 2009-2010 influenza season was due to the novelty of the 2009 H1N1 Influenza virus (known colloquially as "swine flu") and its introduction into the United States in April 2009.
- Although this new strain caused a pandemic during that influenza season, the illness it caused was mild for most individuals.
- Figure 148 shows the age distribution of influenza cases among District residents. The highest affected age group was adults aged 20-29 (19 percent), followed by the 40-49 (13 percent) and 70 years and older (13 percent). Children under 15 years of age accounted for 24 percent of flu cases.
- Majority of cases (84 percent) were confirmed as Influenza A, which includes 2009 H1N1 Influenza infections (Figure 149).

Figure 147. Time Trend Comparison of Influenza Cases among District Residents, 2009-2010 vs 2010-2011

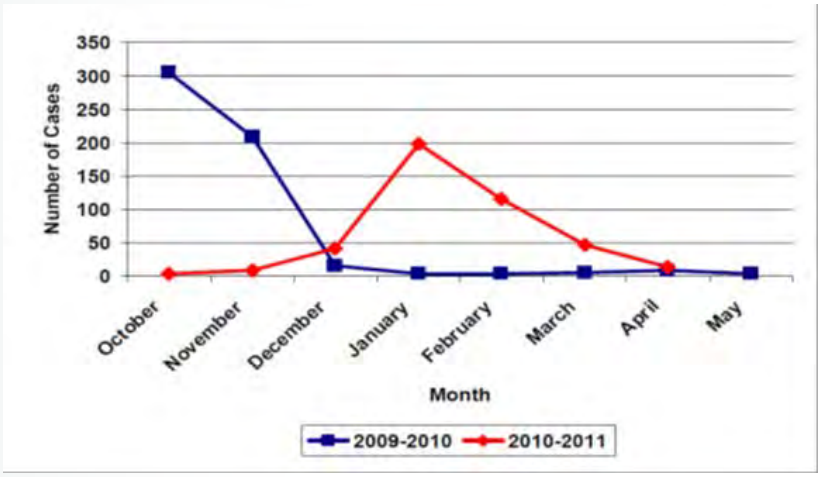


Figure 148. Time Trend Comparison of Influenza Cases among District Residents, 2009-2010 vs 2010-2011

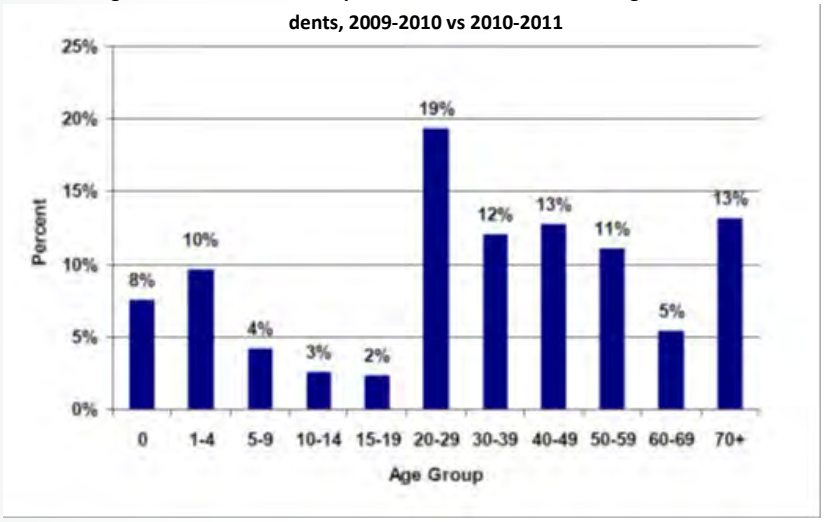
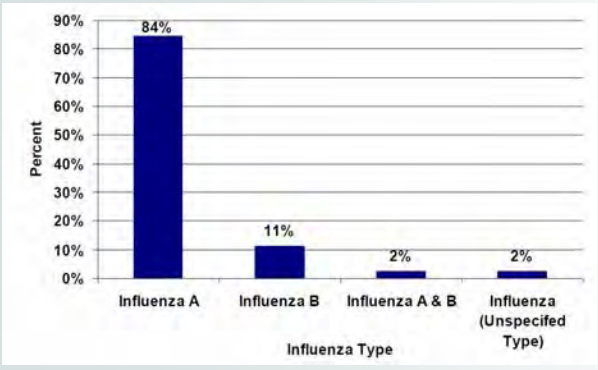


Figure 149. Distribution of Influenza Cases among District Residents, by Influenza Type, 2010-2011



Source:

DC DOH Annual Influenza Report, 2010-2011

Centers for Disease Control and Prevention (2011). People at High Risk of Developing Flu–Related Complications. Available at: http://www.cdc.gov/flu/about/disease/high_risk.htm.

SPECIAL POPULATION GROUPS

YOUTH AND YOUNG ADULTS

District of Columbia	Percent Middle School	Percent High School
TOTAL	3,314	2,094
Gender		
Male	48.2	44.7
Female	51.8	55.3
Age		
11 or younger	15.4	N/A
12	31.7	N/A
13	33.4	N/A
14 or older	19.4	N/A
15 or younger	N/A	37.3
16 or 17	N/A	48.8
18 or older	N/A	13.9
Grade		
6th	33.8	N/A
7th	39.2	N/A
8th	25.2	N/A
9th	N/A	29.1
10th	N/A	30.6
11th	N/A	22.7
12th	N/A	17.1
Race/Ethnicity		
Black	76.3	71.6
Hispanic	11.8	15.6
White	3.8	4.2
All other races	3.3	4.7
Multiple races	4.8	4.0

*Unweighted data.

Source: District of Columbia 2009 Youth Behavior Risk Survey (YRBS) Report

One in every 5 DC residents is an adolescent between the age of 10 and 24. In the past decade, the youth and young adult population in the District has grown by almost 8 percent, with the largest gains seen among the 20 to 24 subgroup. As the District continues to be a magnet for young people, it is important to examine the behaviors that jeopardize not only their current health status, but more importantly, risk factors that would impact the general population as they mature into adulthood.

The District of Columbia Youth Risk Behavior Survey (YRBS) monitors 7 categories of health risks and behaviors identified as most likely to negatively impact a young person's health and well-being. These include weight and dietary behaviors, physical activity, tobacco use, alcohol and illicit drug use, injury/violence, mental health, and sexual behavior. The YRBS was administered in grades 6-12 (Middle School and High School) in the District and was completed on a voluntary basis.

District of Columbia 2009 YRBS Highlights*

Weight, Diet, and Physical Activity

- 21 percent of middle school (MS) and 25.6 percent of HS students described themselves as slightly or very overweight.
- 79.9 percent of high school (HS) students ate at a fast food chain or carry out restaurant on one or more times in the past 7 days.
- 28.4 percent of HS students drank a can, or glass of soda one or more times per day in the last week.
- 22.3 percent of HS students ate fruit or vegetables 5 or more times per day in the last week.
- 74.8 percent of MS and 37.5 percent of HS students went to physical education (PF) classes on one or more days in an average week.

Tobacco, Alcohol, and Other Drug Use

- 25.4 percent of MS and 44.8 percent of HS students tried cigarette smoking.
- 38.2 percent of MS and 65.8 percent of HS students had at least 1 drink of alcohol one or more days in their life.
- 34.7 percent of HS students were offered, sold, or given an illegal drug by someone on school property.
- 11.2 percent of MS and 39.7 percent of HS students had used marijuana at least one or more times in their lifetime.

Unintentional Injuries and Violence

- 53 percent of MS and 61.5 percent of HS students responded that they or someone close to them has been wounded by a weapon or physically attacked.
- 15.2 percent of MS and 15.7 percent of HS students made a suicide plan.
- 27.1 percent of MS students had carried a weapon such as a gun, knife or club.
- 6.7 percent of HS students had carried a gun on one or more days in the past month.
- 10.8 percent of MS and 16.7 percent of HS students had been hit, slapped, or physically hurt on purpose by their significant other.

Sexual Behavior

- 13.7 percent of HS students had sexual intercourse before age 13.
- 39.5 percent of HS students had sexual intercourse with 1 or more people in the last 3 months (currently active).
- Among students who had sexual intercourse, 75.2 percent of MS and 73.6 percent of HS students used a condom during last sexual intercourse.

YOUTH TRENDS

Half of all cases of Chlamydia and gonorrhea in the District are among adolescents.

One in 100 youth in the District is HIV positive.

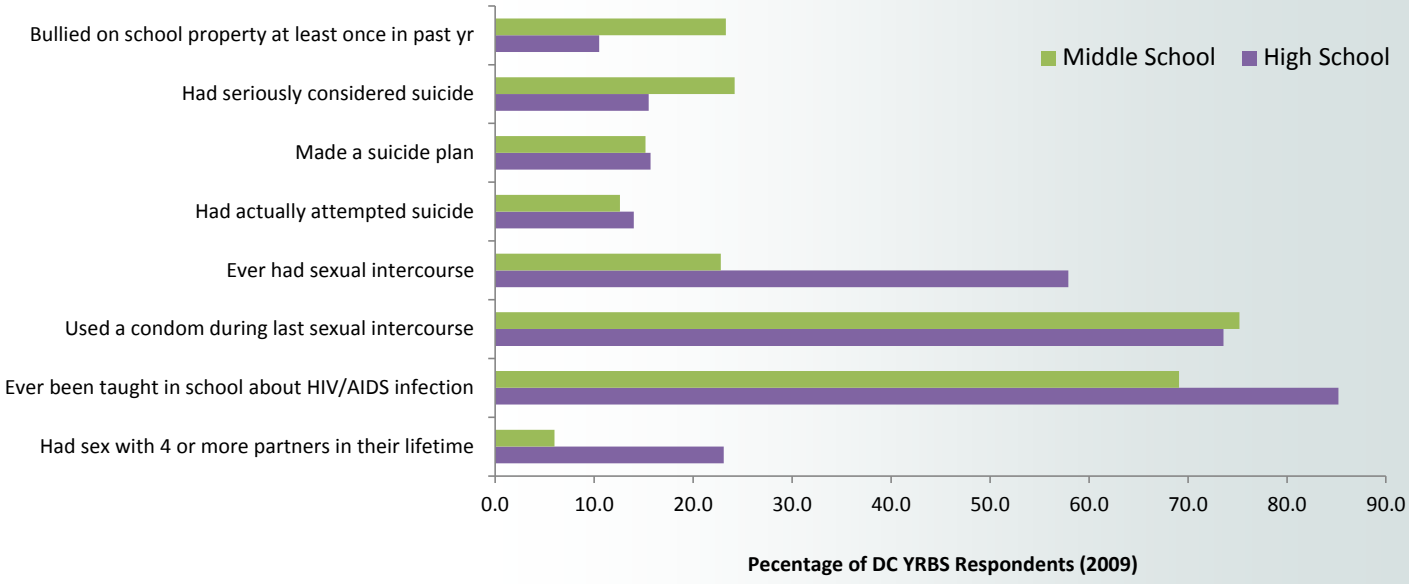
While 50 percent of youth live in Wards 7 and 8, less than 10 percent of the District's grocery stores are located there.

Self-reporting of attempted suicide by DC students has consistently been double the national average of 6.3 percent.

Among 10-24 year olds, homicide/assault is the leading cause of death (55 percent) followed by accidents (13 percent).

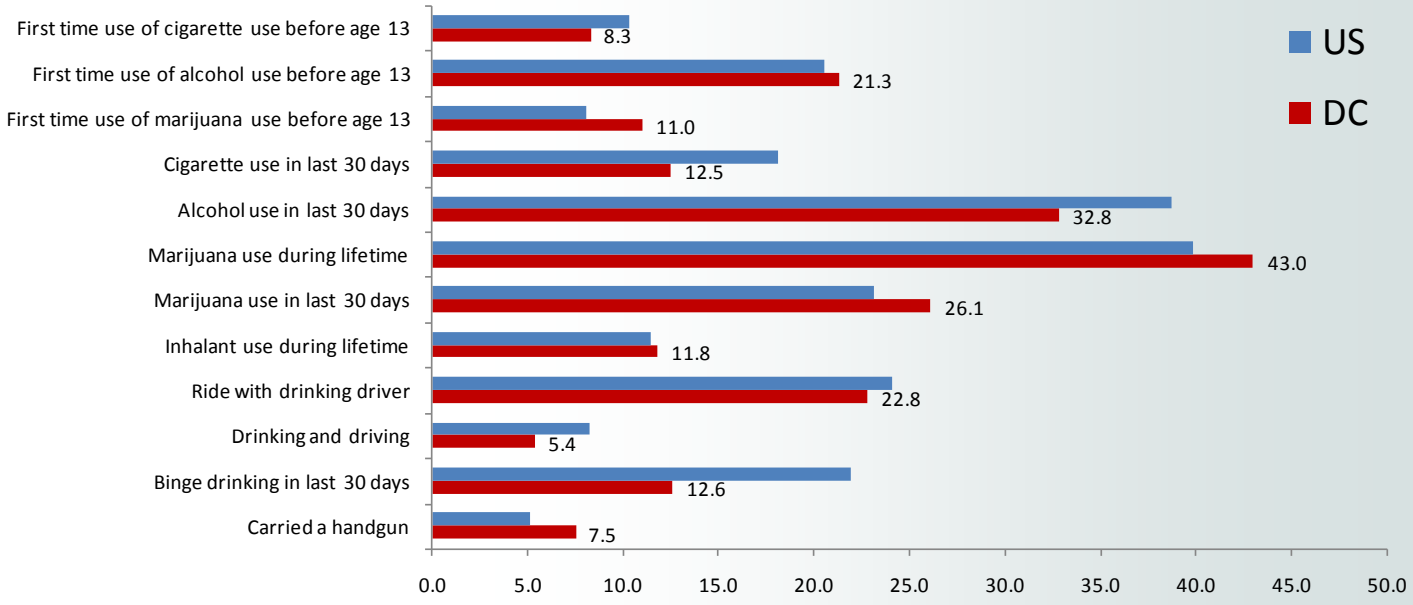
In 2007, an estimated 100 non-fatal traffic injuries in the District involved an underage driver that had been drinking.

Figure 150. Risk Behaviors among Middle and High School Students, DC YRBS 2009



Source: District of Columbia 2009 Youth Behavior Risk Survey (YRBS) Report

Figure 151. Risk Behaviors among High School Students, DC and National YRBS 2011



Source: Centers for Disease Control and Prevention. Youth Risk Behavior Surveillance—United States, 2011. MMWR 2012;61(No SS-04).

YOUTH SUBSTANCE ABUSE

In 2011, the Addiction Prevention and Recovery Administration (APRA) of DC DOH conducted a needs assessment survey to assess students' involvement in a specific set of problem behaviors, as well as their exposure to a set of scientifically validated risk and protective factors. The Community Prevention Assessment Pilot (CPAP) survey was a survey of youth in the areas served by four Prevention Centers. It was not designed to be a representative sample of the youth in the District and therefore applying these results beyond the youth who completed the survey should be done with caution. However, a comparison between the results from the Community Prevention Assessment Pilot and the results from Youth Risk Behavior Survey (YRBS) with a more random selection of youth from the District shows them to be quite similar. Thus, the results from the CPAP survey can be viewed as preliminary indicators of risk, protection, antisocial behavior, and alcohol and other drug (ATOD) use among youth in the District. A more comprehensive survey will need to be completed to confirm these initial findings.

Results are presented along with comparisons to national data sources such as the Monitoring the Future Survey (only grades 8, 10, and 12 are surveyed) and the Bach Harrison Norm (BH Norm), which consists of a large, weighted, nationwide sample.

Figure 152. Lifetime, 30-Day, and Heavy Alcohol, Tobacco, and Other Drug Use, Grades 6-8

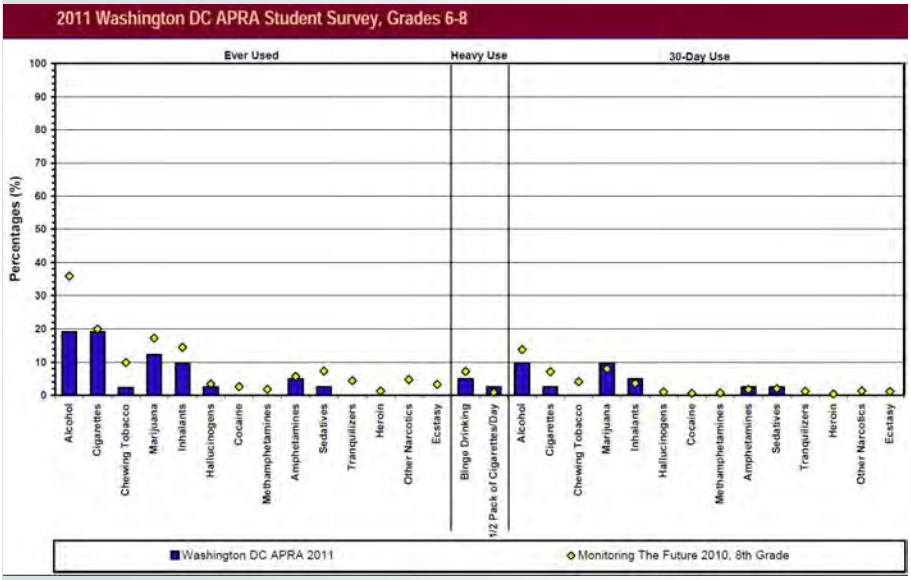
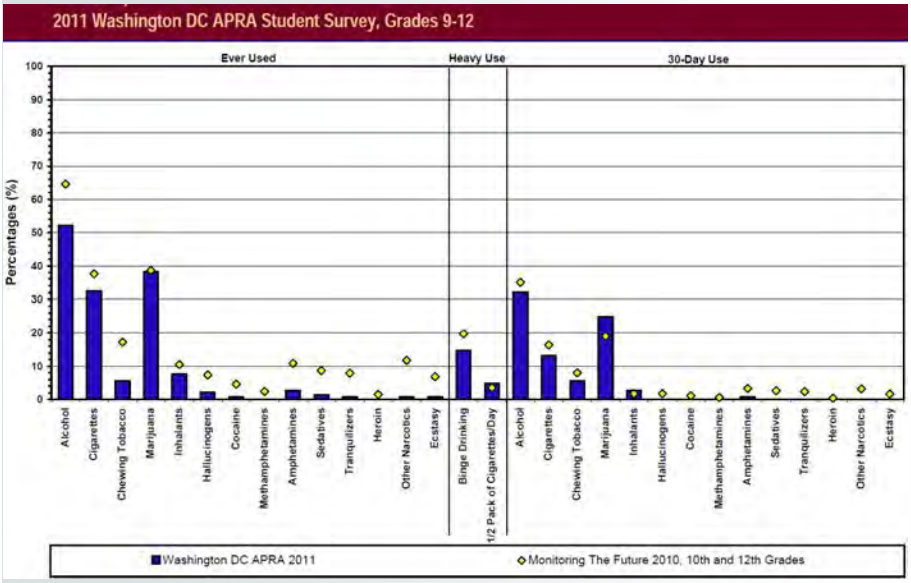


Figure 153. Lifetime, 30-Day, and Heavy Alcohol, Tobacco, and Other Drug Use, Grades 9-12



- The blue bars represent the percentage of students in that grade who reported a given behavior. The diamonds provide points of comparison to larger samples and represent national data from either the Monitoring the Future (MTF) Survey or the Bach Harrison Norm (BH Norm). The survey results provide considerable information for communities to use in planning prevention services.
- For Middle School students, use of most substances is lower than the national average for eight grade students. There is no national YRBS middle school data, therefore the MTF value for eighth grade was used to provide a national comparison even though there are also 6th and 7th grade youth in the middle school category. The percentage of youth ever using cigarettes (19.0 percent) and 30-day use of marijuana (9.8 percent), inhalants (4.9 percent), prescription stimulants (2.4 percent) and sedatives (2.4 percent) are near or above the national level for students in eighth grade.
- For High School students, only lifetime use of marijuana (38.2 percent) and 30-day use of marijuana (24.8 percent) and inhalants (2.8 percent) are at or above the national levels. Heavy use of cigarettes, defined as 1/2 pack per day or more at (4.8 percent), was slightly above the national average.
- Alcohol use in the 30 days prior to the survey by both middle school age youth (9.8 percent) and high school (32.2 percent) age youth is slightly less than the national average.
- Age of first use of cigarettes at 13.7 years, alcohol at 13.7 years, and Marijuana at 13.9 years is slightly higher than youth in other states resulting in the risk factor "Early Initiation of Drug Use" being lower for youth in grades 6-8 and similar to the norm for grades 9-12.

Source: Community Prevention Assessment Pilot, Office of Prevention Services, Addiction Prevention and Recovery Administration (APRA), July 2011.

YOUTH SUBSTANCE ABUSE

In addition, input was sought from Ward-level community leaders to assess local conditions and causes of underage drinking and youth marijuana use in the eight Wards. The table below provides a brief summary of some of this leadership input on priority substance use/abuse issues, critical causes of substance abuse, important local conditions and readiness to address the priority issues.

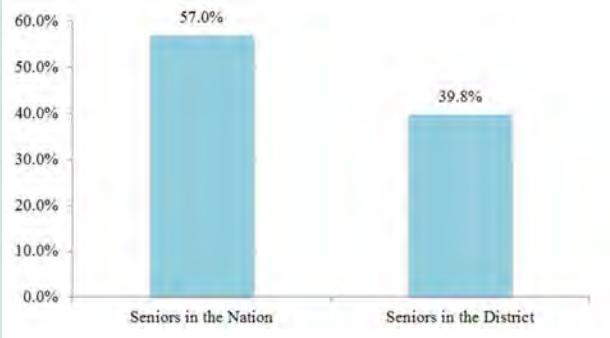
Community Leadership Input on Substance Use at the Ward Level

Input Area	Wards 1 and 2	Wards 3 and 4	Wards 5 and 6	Wards 7 and 8
Priority Issue	Alcohol, Marijuana	Marijuana	Alcohol	Alcohol, Marijuana
Critical causes	Retail availability Low perceived risk	Social, community norms	Early initiation Low perceived risk	Retail availability Social availability Social, community norms
Examples of key local conditions	High alcohol retailer density, proximity to schools; legalization of medical marijuana; low perception of harm	None identified	Participation in problem behaviors, low parental disapproval, peer use of alcohol	Underlying poverty, lack of opportunity, large number of liquor licenses, availability of synthetic marijuana, culture of getting high, lack of knowledge of health consequences
Readiness to address priority issues	Ready to conduct retailer education programs; social norms or social media campaigns	Lack of readiness related to low perception of any problems	Ready to support evidence-based programming by stakeholders, Prevention Centers	Lack of readiness due to focus on daily economic and health challenges

Source: 2011 Washington DC Addiction Prevention and Recovery Administration (APRA) Profile Report, DC Department of Health.

OLDER ADULTS

Figure 154. Seniors Living in Family Households, National vs. District of Columbia



According to the US Department of Health and Human Services Administration on Aging (AoA), the nation's senior population will grow faster than any other segment of the total population. Much of this growth is attributed to the baby boomer generation, individuals born between 1946 and 1964.

In 2010, the Census estimated 98,512 seniors residing in the District of Columbia, who accounted for 16.4 percent of the total estimated population. DC resident seniors are projected to grow by 17.4 percent in 2030. As the population continues to live longer and the estimated life expectancy in the District continues to rise, the need for health care among the elderly will likewise increase.

In 2012, the District of Columbia Office on Aging (DCOA) conducted a Senior Needs Assessment to better understand the needs of older adults in the District and to provide a glimpse of aging trends. Data were collected on 14 focus areas: wellness and quality of life, safety, socialization and recreation, case management and options counseling, health and mental health, home health/in-home support, nutrition, home delivered and congregate meals, transportation, employment, care giving and respite care, Medicaid/ Medicare, assisted living and housing placement, and legal services.

Figure 155. Education Level of Seniors in the District of Columbia

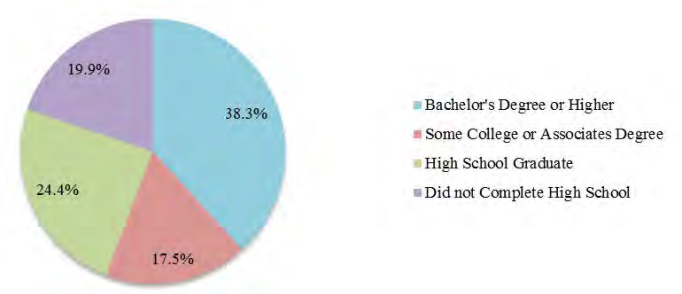
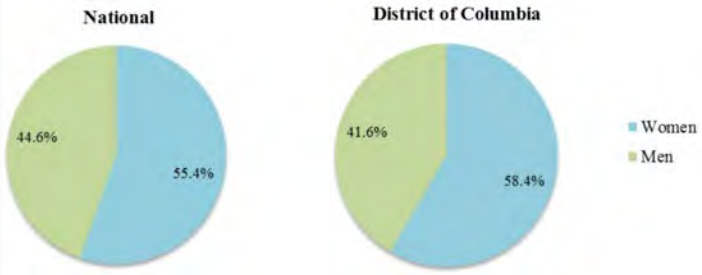


Figure 156. Senior Men and Women. National vs. District of Columbia

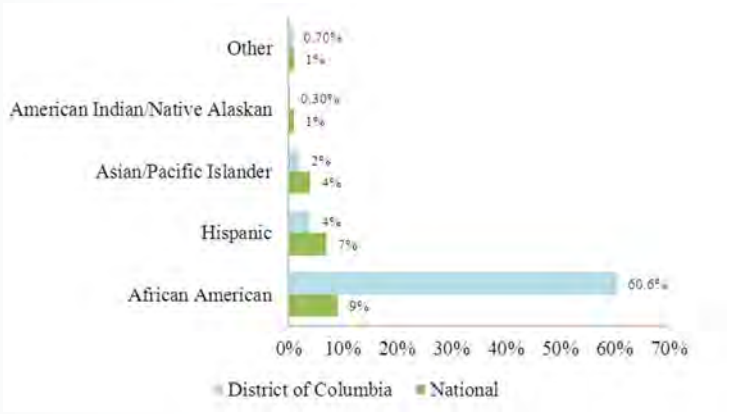


Medicare Facts At-a-Glance

	DC	%	US	%
Medicare Beneficiaries	-	-	-	-
Adults 19-64	11,100	15	7,232,800	16
Elderly 65-74	30,900	42	19,251,500	43
Elderly 75-84	20,100	27	12,394,800	28
Elderly 85+	10,400	14	4,810,600	11
Medicare Beneficiaries by Race/Ethnicity	-	-	-	-
White	16,700	23	34,353,400	77
Black	50,500	69	4,423,400	10
Hispanic	4,200	6	3,502,900	8
Other	NSD	NSD	2,047,600	5
Duals as a % of Medicare Beneficiaries	29	-	21	-
Medicare Spending by Residence	-	-	-	-
Total Spending (in millions)	$856	-	$471,260	-
Per Enrollee Medicare Spending	$11,157	-	$10,365	-
Medicare Advantage Penetration	-	9.7	-	25.6

Source: Henry J. Kaiser Family Foundation, 2010

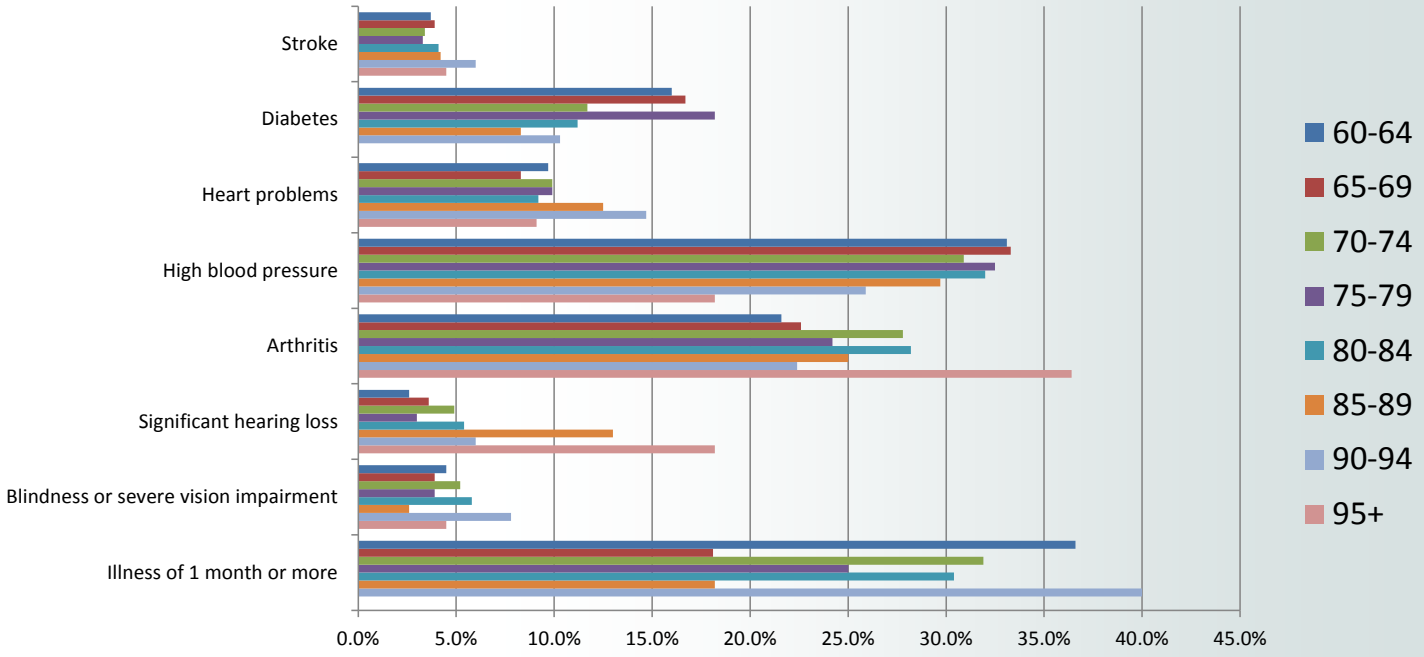
Figure 157. Distribution of Senior Minority, National vs. District of Columbia



Source: District of Columbia Office on Aging Senior Needs Assessment 2012

MORBIDITY AND MORTALITY OF OLDER ADULTS

Figure 158. Reported Illness and Physical Disorders among Older Adults, by Age Group



Source: District of Columbia Office on Aging Senior Needs Assessment 2012

Health Indicators in Adults 65 and Older, District of Columbia

(Percentage and National Ranking)

Preventive Care	Findings	District of Columbia Ranked Nationally	Grade
Flu Vaccine in Past Year	67.1%	43	◒
Ever Had Pneumonia Vaccine	62.1%	50	○
Mammogram Within Past 2 Years	86.3%	1	●
Colorectal Cancer Screening	70.2%	10	●
Cholesterol Checked in Past 5 Years	94%	30	◒
Health Status	**Findings**	**District of Columbia Ranked Nationally**	**Grade**
Physically Unhealthy Days (in months)	4.5	4	●
Frequent Mental Distress	4.9%	7	●
Oral Health: Complete Tooth Loss	15.9%	13	●
Disability	38.8%	42	○
No Leisure Time – Physical Activity	27.8%	9	●
Eating ≥ 5 Fruits & Vegetables Daily	35.6%	1	●
Obesity	22.2 %	16	◒
Current Smoking	8.9%	31	◒

● = Upper Third Nationally (top 33%)
◒ = Middle Third Nationally (middle 33%)
○ = Lower Third Nationally (lowest 33%)

Source: CDC, 2010

The State of Aging and Health in America Report, 2008-2009 DC Report Card

Chronic diseases, including heart disease and cancer, have caused most of the deaths among the elderly in the District.

Source: (Leading Causes of Death) Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

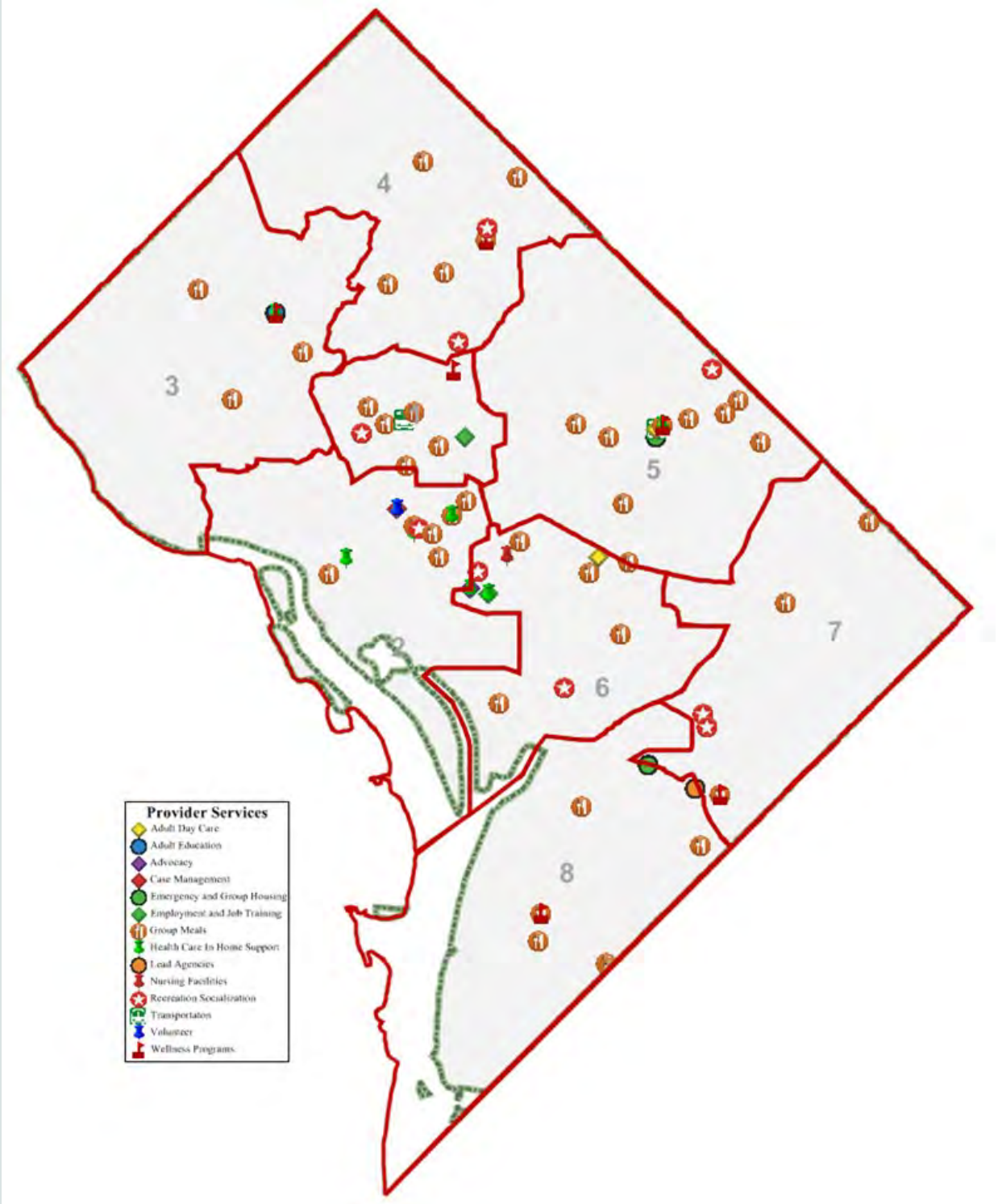
Leading Causes of Death in Adults 65 and Older, District of Columbia, 2010

Cause and Rank	Number	Percent
All Causes	2,971	100.0
1. Heart Disease	961	32.3
2. Cancer	662	22.3
3. Cerebrovascular Disease	137	4.6
4. Chronic Lower Respiratory	118	4.0
5. Alzheimer's Disease	114	3.8
6. Diabetes	96	3.2
7. Nephritis, nephrotic syndrome, nephrosis	75	2.5
8. Accident	72	2.4
9. Influenza and Pneumonia	66	2.2
10. Septicemia	64	2.2
Other causes	606	20.4

- A total of 2,971 (63.6 percent) District residents who died in 2010 were 65 years of age and older. Chronic diseases have caused most of the deaths among the elderly.
- The leading cause of death among the elderly aged 65 years and older was heart disease, accounting for 32.3 percent of all deaths in this age range.
- The second leading cause of death for this age range was cancer (22.3 percent).

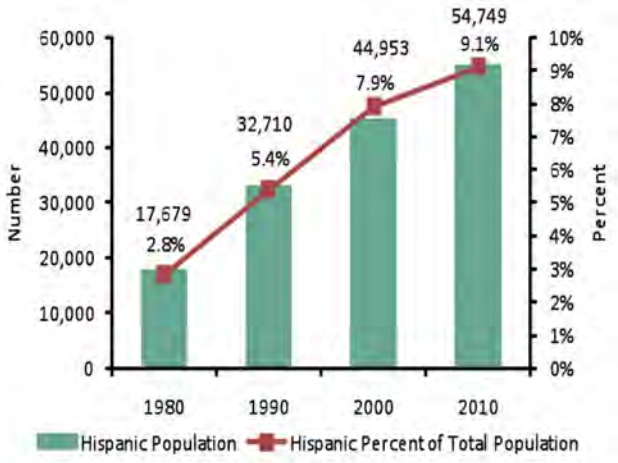
ACCESS TO CARE FOR SENIORS

Figure 159. Map of District of Columbia Office on Aging Provider Services In-Network



HISPANIC POPULATION

Figure 160. District of Columbia Hispanic Population: 1980-2010



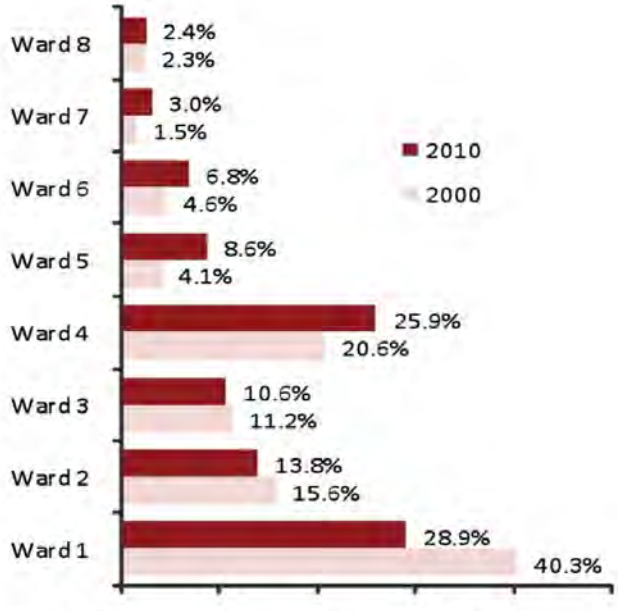
Source: U.S. Census Bureau, Census 2000 and Census 2010

The Office of Management and Budget (OMB) defines "Hispanic or Latino" as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Hispanic origin can be viewed as the heritage, nationality group, lineage, or country of birth of the person or the person's parents or ancestors before their arrival in the United States. People who identified their origin as Hispanic, Latino, or Spanish may be of any race.

Hispanic Population Trends

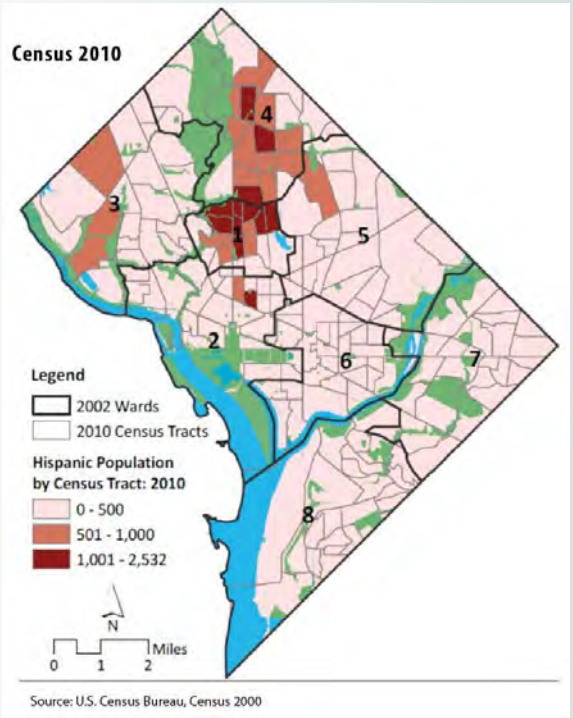
- Between 2000 and 2010, the Hispanic population in the District grew by 21.8 percent, rising from 44,953 in 2000 to 54,749 in 2010 and its share of the total population rose to 9.1 percent from 7.9 percent in 2000.
- Hispanic accounted for one-third of the District's total population growth between 2000 and 2010.
- In 2010, Hispanics of Salvadoran origin and Mexican origin were the two largest Hispanic groups in the District, representing 30.3 percent and 15.5 percent of the total Hispanics, respectively.
- While Hispanics live throughout all wards of the District, they resided predominantly in Wards 1 and 4.
- Except in Ward 1, the Hispanic population increased in all Wards of the District between 2000 and 2010. The largest numerical growth occurred in Ward 4, where the Hispanic population increased by 4,923 people (half of the total Hispanic population growth over the decade).
- The Hispanic population in Ward 1 declined by 12.6 percent, from 18,109 in 2000 to 15,827 in 2010. Census tract 28.02 in Ward 1 had the highest percentage of Hispanics (43.1 percent) among all census tracts in the District.

Figure 161. Percent Distribution of Hispanic Population by Ward: 2000 and 2010



Source: U.S. Census Bureau, Census 2000 and Census 2010

Figure 162. District of Columbia Hispanic Population, 2010



Source: U.S. Census Bureau, Census 2000

THE HISPANIC PARADOX

Popularly known as the "Hispanic Paradox", this phenomenon of healthier outcomes and longevity among Latinos despite a disproportionate burden of poverty, limited health insurance and low education has been the subject of extensive research and in recent years, substantiated by national estimates of life expectancy by Hispanic origin.

Hispanic Advantage

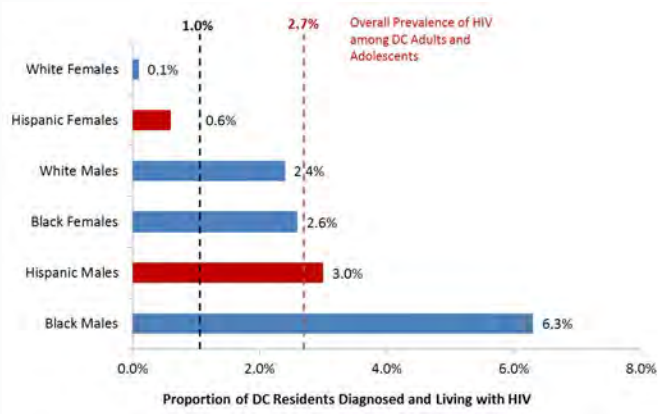
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years), non-Hispanic white females (85.2 years), and non-Hispanic white males (83.2 years).
- The largest differential is between Hispanics and non-Hispanic blacks, the former having an advantage of 19.6 years in men and 12.7 years in women.
- Infant mortality was significantly lower in Hispanics (3.7 deaths per 1,000 births) compared to their non-Hispanic black and white counterparts (10.5 and 5.3 deaths per 1,000 births, respectively).
- The Hispanic age-adjusted mortality rate (410.8 per 100,000) was lower than non-Hispanic whites (558.0 per 100,000) and more than doubled by non-Hispanic blacks (1,086.4 per 100,000).
- Data from the 2010 Behavioral Risk Factor Surveillance System (BRFSS) revealed a greater likelihood of being diagnosed with diabetes, asthma, stroke, and heart disease among non-Hispanic blacks compared to Hispanics in the District (Disparity Ratio: 2.4, 2.2, 2.3, and 1.9, respectively)
- Non-Hispanic blacks were also more likely to be obese and current smokers than Hispanics (Disparity Ratio: 2.9 and 1.3, respectively).

Leading Causes of Death among Hispanic Residents

- A total of 106 (2.3 percent) District residents who died in 2010 were of Hispanic ethnicity.
- Cancer and heart disease have caused most of the deaths in this ethnic group.
- The leading cause of death among Hispanics was Cancer, accounting for 23.6 percent of all deaths in this ethnic group.
- The second leading cause of death for Hispanics was heart disease (22.6 percent), followed by accidents, cerebrovascular disease, and homicide/assault, which all tied for third leading cause of death.

Cause and Rank	Number	Percent*
All Causes	106	100.0
1. Cancer	25	23.6
2. Heart Disease	24	22.6
3. Accident	5	4.7
4. Cerebrovascular Disease	5	4.7
5. Homicide/Assault	5	4.7
6. Diabetes	3	2.8
7. Influenza & Pneumonia	3	2.8
8. Septicemia	3	2.8
9. Chronic Lower Respiratory	2	1.9
10. Chronic liver disease and cirrhosis	2	1.9
11. Suicide	2	1.9
Other causes	27	25.5

Figure 163. HIV Prevalence by Race/Ethnicity and Gender, 2010



HIV and Risk Factors among Hispanics

- Hispanics newly diagnosed with HIV (not AIDS) were more likely to be younger than other racial groups. Approximately 63 percent of Hispanics were diagnosed between 20-39 years of age, while 51.7 percent of whites, 49.3 percent of blacks, and 58.2 percent of those classified as other race were between 20-39 years of age.
- The proportion of Hispanic s living with HIV diagnosed between 20-39 years of age (70.2 percent) is substantially larger than all other racial groups (56.6 percent of white cases, 53.9 percent of black cases, and 60.8 percent of cases classified as other race).
- The leading mode of HIV transmission among Hispanics newly diagnosed with HIV was men who have sex with men or MSM (55.5 percent).
- Among new AIDS cases, MSM was the leading mode of transmission among Hispanic men (46.9 percent), followed by heterosexual contact (27.0 percent). Seventy percent (70.4 percent) of newly diagnosed AIDS cases among Hispanic women were due to heterosexual contact.

District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were read a series of situations: Have they used intravenous drugs in the past year? Have they been treated for a sexually transmitted or venereal disease in the past year? Have they given or received money or drugs in exchange for sex in the past year? Have they had anal sex without a condom in the past year? Following, District residents were asked if any of the high-risk situations applied to them.

- Hispanics were more likely than all other race/ethnic groups to participate in high-risk activities, at 12 percent.
- Hispanics were second to African Americans, in the proportion of having been tested for HIV, at 69.4 percent and 78 percent, respectively.
- Hispanics were more likely than all other race/ethnic groups to have been treated for an STD in the past 12 months, at 8.5 percent.

Hispanics newly diagnosed with HIV were more likely to be younger than other racial groups.

Cancer was the leading cause of death for Hispanics in 2010.

Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

GAY, LESBIAN, BISEXUAL, AND TRANSGENDER

District of Columbia	Percent Homosexual	Percent Bisexual
TOTAL	7.0	1.8
Gender		
Male	12.8	1.7
Female	2.0	1.9
Age		
18-24	2.8	5.2
25-34	7.4	1.5
35-44	9.6	1.7
45-54	11.4	2.0
55-64	5.3	1.5
65+	2.2	0.6
Race/Ethnicity		
Caucasian	10.9	1.9
African American	3.0	2.0
Asian	4.5	0.0
Other	3.3	3.2
Hispanic	8.1	0.0
Education		
Less than High School	1.7	2.7
High School Graduate	3.6	0.2
Some College	6.4	4.0
College Graduate	8.6	1.6
Income		
Less than $15,000	4.7	3.6
$15,000-$24,999	5.6	1.1
$25,000-$34,999	3.5	2.0
$35,000-$49,999	3.4	3.5
$50,000-$74,999	6.6	2.9
$75,000 and over	10.1	1.2
Ward Comparison		
Ward 1	13.1	3.0
Ward 2	20.5	0.8
Ward 3	3.2	1.4
Ward 4	6.2	1.6
Ward 5	4.6	1.6
Ward 6	8.3	1.6
Ward 7	3.6	1.2
Ward 8	1.8	2.1

Sexual orientation is defined as one's natural preference in sexual partners. Transgender is a term inclusive of transgender, transsexual, and gender variant identities of people who do not or no longer express or identify their genders with their assigned birth sex. Transgender includes Male-to-Female (MTFs), Female-to-Male (FTMs), and others who self-identify using over 100 identity terms[1].

Gay, lesbian, bisexual and transgender (GLBT) adults are at increased risk for suicide, eating disorders, substance abuse, sexual violence, sexual assault, sexually transmitted diseases and breast and anal cancer. The GLBT community faces health care risks that are often not addressed because of lack of knowledge of the patient's sexual orientation, ignorance of specific health care issues, or because the patient feels that the health care professional is homophobic or anti-trans.[2]

District residents who participated in the 2009 Behavioral Risk Factor Surveillance System (BRFSS) survey were asked about their sexual orientation and whether they identify themselves as heterosexual, homosexual, bisexual or other. Overall 91 percent of respondents identify themselves as heterosexual, 7 percent homosexual, 2 percent bisexual and 0.7 percent as other.

Demographics of GLBT

- Males were more likely to identify themselves as homosexual (12.8 percent) compared to females (2 percent).
- Respondents aged 45-54 were more likely to identify themselves as homosexual (11.4 percent) while the 18-24 age subgroup was more likely to be bisexual (5.2 percent).
- Caucasians were more likely to identify themselves as homosexual or bisexual, at 12.8 percent, followed by Hispanics, at 8.1 percent.
- College graduates (10.2 percent) and persons with some college (10.4 percent) were more likely to identify themselves as homosexual or bisexual than other education subgroups.
- Adult households with an income of $75,000 and over were more likely than all other income subgroups to identify themselves as homosexual or bisexual, at 11.3 percent.
- Ward 1 and 2 residents were more likely to identify themselves as homosexual, at 13.1 and 20.5 percent, respectively.
- In a 2005 needs assessment of transgendered people of color living in the District[3], results indicated a need for increased medical and social services specific to transgender residents living in the District.

The Office of Gay, Lesbian, Bisexual and Transgender Affairs (GLBT) is a permanent, cabinet-level office within the Executive Office of the Mayor established by statute in 2006 to address the important concerns of the District's lesbian, gay, bisexual, and transgender residents. The Office of GLBT Affairs works in collaboration with an Advisory Committee appointed by the Mayor, to define issues of concern to the GLBT community and find innovative ways of utilizing government resources to help address these issues. Services offered include capacity building, community outreach, public education, and public policy development and advocacy.

Source:

2010 District of Columbia BRFSS

[1]Mayer KH, Bradford JB, Makadon HJ, et al. Sexual and gender minority health: What we know and what needs to be done. Am J Public Health. 2008;98(6):989-95.

[2]http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070935/pdf/wjm17200403.pdf

[3]Xavier J, Bobbin M, Singer B, et al. A needs assessment of transgendered people of color living in Washington, DC. Int J Transgenderism, 2005;8(2/3):31-47.

GLBT HEALTH

Major health issues for the GLBT community are sexually transmitted infections including HIV, depression, tobacco use, as well as alcohol and substance abuse.[1] Factors that contribute to these outcomes include the impact of homophobia, stigma and the absence of culturally relevant prevention and treatment public health initiatives.

In 2005 and 2007, a combined 6,218 residents in the District participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey. Approximately 4.5 percent of the respondents identified as gay or lesbian and 2.3 percent identified as bisexual or other. Data yielded from the survey provides insight into the general health of the GLBT community.

General Health

- Gay, lesbian, and bisexual respondents were more likely to rate their health as good, very good or excellent.
- 93.4 percent gay and lesbian respondents rated their health as good, very good or excellent compared to 86.9 percent of heterosexual and 86.3 percent bisexual respondents.
- In the 30 days leading up to the survey, 68.1 percent of gay and lesbians and 64.3 percent of bisexual/others respondents reported having no days where their physical health was not good compared to 65.5 percent of heterosexual respondents.
- 39.5 percent of gay and lesbian and 37.9 percent of bisexual/other respondents have had the flu shot in the past year compared to 32.4 percent of heterosexual respondents.

Access to Care

- Gay and lesbian respondents were less likely to report having a routine check up in the past year.
- 68.6 percent of gay and lesbian respondents reported having a routine check up in the past year as compared to 85.2 percent of bisexual/other and 73.6 percent of heterosexual respondents.
- 93.3 percent of gay and lesbian respondents reported having health care coverage as compared to 90.0 percent of bisexual/other and 91.1 percent of heterosexual respondents.

Mental Health

- Gay, lesbian and bisexual respondents were more likely to report one or more days of bad mental health in the month leading up to the survey.
- Bisexual/Other respondents were more likely to report being very dissatisfied with their lives.
- 39.8 percent of gay and lesbian and 45.7 percent of bisexual/other respondents reported having one or more days of bad mental health days in the 30 days prior to the survey compared to 31.3 percent of heterosexual respondents.
- 94.3 percent of gay and lesbian and 94.1 percent of heterosexual respondents report being satisfied or very satisfied with their lives compared to 88.9 percent of bisexual/other respondents.
- 2.8 percent of bisexual/other respondents reported being very dissatisfied with their lives compared to .2 percent of gay and lesbian and .9 percent of

Obesity/Exercise

- Gay and lesbian respondents were more likely to report being neither overweight or obese and more likely to report meeting requirements for moderate and vigorous physical activity..
- 51.4 percent of gay and lesbian and 46.2 percent of bisexual/other respondents reported that they are neither overweight nor obese compared to 44.4 percent of heterosexual respondents, 52.1 percent of gay and lesbian respondents, and 46.6 percent of bisexual/other respondents reported meeting the recommendations for moderate physical activity compared to 38.6 percent of heterosexual respondents.
- 54.5 percent of gay and lesbian respondents and 33.7 percent of bisexual respondents reported meeting recommendations for vigorous physical activity compared to 30.0 percent of heterosexual respondents.

Blood Pressure/Cholesterol

- Gay, lesbian and bisexual/other respondents were less likely to report having high blood pressure.
- 16.7 percent of gay and lesbian and 22.7 percent of bisexual/other respondents have been told they had high blood pressure compared to 28.8 percent of heterosexual respondents.
- 91.8 percent of gay and lesbian respondents reported having their blood cholesterol levels checked compared to 86.2 percent of bisexual/other and 85.4 percent of heterosexual respondents.
- 69.9 percent of gay and lesbian respondents, reported having their cholesterol levels checked within the past year compared to 72.9 percent of bisexual/other respondents and 74.3 percent of heterosexual respondents.
- 33.9 percent of gay and lesbian respondents and 33.6 percent of heterosexual respondents had been told they have high cholesterol.

Alcohol/Tobacco Use

- Gay and lesbian respondents were more likely to report smoking some days and smoking every day. Bisexual/other respondents were more likely to report being heavy drinkers. Gay, lesbian, and bisexual/other respondents were more likely to report being binge drinkers.
- 15.1 percent of gay and lesbian respondents reported smoking everyday compared to 11.0 percent of heterosexual respondents.
- 7.6 percent of gay and lesbian respondents report smoking some days compared to 6.8 percent of heterosexual.
- 7.6 percent of bisexual/other respondents reported being heavy drinkers compared to 5.2 percent of heterosexual and 4.3 percent of gay and lesbian respondents.
- 28.6 percent of bisexual/other respondents reported binge drinking compared to 16.3 percent of gay and lesbian and 15.8 percent of heterosexual respondents.

HIV Testing/Risk Behavior

- Gay and lesbian respondents were more likely to report having an HIV test and much more likely to answer yes to questions that indicated they engage in risky behavior for contracting HIV.
- 90.8 percent of gay and lesbian respondents reported being tested for HIV compared to 64.9 percent of heterosexual respondents.
- 23.6 percent of gay and lesbian, 12.6 percent of bisexual/other respondents and 5.1 percent of heterosexual respondents answered yes to having engaged

In a 2008 DC behavior study[2] of men who have sex with men (MSM), HIV is impacting MSM nearly 5 times that of the entire city's adults and adolescents and men of color nearly 3 times that of white men.

Source:

A REPORT OF LESBIAN, GAY AND BISEXUAL HEALTH IN THE DISTRICT OF COLUMBIA. Mayor's Office of Gay, Lesbian, Bisexual and Transgender Affairs, Government of the District of Columbia, June 30, 2010.

[1]Centers for Disease Control and Prevention, Lesbian, Gay, Bisexual and Transgender Health webpage.

[2]DC HIV Behavior Study Series #2. MSM in DC: A Life Long Commitment to Stay HIV Free. HAHSTA, DC DOH, 2008.

COMMUNITY PARTNERSHIPS

ONE CITY

One City Summit

On February 11, 2012, about 1,700 District of Columbia residents joined Mayor Vincent C. Gray and other city leadership at the Walter E. Washington Convention Center. Participants at the Summit spent the day discussing what it means to be One City and how to overcome challenges and build on the District's strengths to improve the quality of life for all residents. Throughout the day, participants discussed how we: 1) Create a more diverse and growing economy, 2) Ensure greater early success for all infants and toddlers, 3) Educate our youth for the economy of tomorrow, and 4) Align residents' job skills with our growing economy. Mayor Gray opened the day by outlining what the vision of One City means to him. For their discussions on the day's topics, the Mayor asked participants to think beyond themselves, their families, and their friends to ensure that we create a progressive, prosperous, inclusive, vibrant city for everyone. Throughout the meeting, participants used keypad polling to register their views and engaged in facilitated group discussions about being One City. The One City Summit utilized methodology from AmericaSpeaks, a nonprofit, non-partisan organization that engages citizens in the public decision-making that affects their lives.

Who Attended the One City Summit?

Summit demographics are compared with the demographics of DC.

Gender	One City Summit	Census Data
Female	61%	52.8%
Male	39%	47.2%

Age	One City Summit	Census Data
15 to 19	8%	6.6%
20 to 24	6%	10.7%
25 to 34	15%	20.7%
35 to 44	11%	13.4%
45 to 54	19%	12.5%
55 to 64	22%	10.6%
65 and better	19%	11.4%

Race/Ethnicity	One City Summit	Census Data
Asian American	8%	3.5%
Black/African American	44%	52.6%
Latino/Hispanic	19%	9.1%
Native American/Indian	1%	0.3%
White or Caucasian	22%	35%
More than one race	5%	3.2%
Other	1%	N/A

Ward Live In	One City Summit	Census Data
Ward 1	18%	12.7%
Ward 2	9%	13.3%
Ward 3	8%	12.8%
Ward 4	13%	12.6%
Ward 5	13%	12.3%
Ward 6	13%	12.7%
Ward 7	9%	11.8%
Ward 8	10%	11.8%
Work, but don't live in DC	7%	
None of the above	1%	

Household Income	One City Summit	Census Data
Under $25,000	27%	24%
$25,000 to $50,000	20%	18%
$50,000 to $75,000	15%	16%
Over $75,000	30%	42%
Not Sure	8%	

Length Lived in District	One City Summit	Census Data
Less than 5 years	17%	N/A
5 to 10 years	11%	
10 to 20 years	20%	
20 to 30 years	13%	
More than 30 years	34%	
None of the above	6%	

ONE CITY

One City Action Plan

The purpose of the "One City Action Plan" is to provide District residents with one document to show how we can move toward the One City vision and measure its progress along the way. Most importantly, it will provide a high degree of accountability by documenting outcomes. For each goal there are clear strategies and specific actions the Gray administration is taking to achieve results. Key indicators were outlined, based on citizen input from the One City Summit, to add accountability and to demonstrate how the District will move toward the One City vision.

Reasons Participants Attended the One City Summit

- Make my voice and our collective voices heard
- Speak for others who are not always heard - youth, seniors, homeless, immigrants, people with disabilities
- Speak up for education and affordable housing
- Learn more about what is happening across the District and where we are going
- Learn about the Mayor's vision
- Learn more about what is happening in different Wards/neighborhoods
- Learn more about available opportunities – jobs, education, housing

Ideas from Online Engagement:

- Enable all income levels to live and work in D.C. by using the city budget process to restore funding to key resources that allow all to thrive
- Annual "Guitars not Guns" festival to get at-risk youth for music education
- Create transitional living for disconnected youth
- Pursue D.C. statehood to enfranchise residents and end taxation with representation
- Create ways for non profits to share space and resources

Exciting Opportunities for Becoming One City as We Grow

- Improving opportunities for education in DCPS, charter schools, UDC- Community College, more choices 24%
- Our diversity is an asset 7%
- Creating more jobs and access to jobs 23%
- Growing awareness & support for self-determination 6%
- Increasingly rich & diverse cultural offerings (ie, zoo, museums, galleries, performing arts) 4%
- Access to lots of public transportation options (Capital Bikeshare, Circulator, Metro) 6%
- Decreasing crime rates & increase safety 13%
- Growing business development (i.e., green economy, growing retail, supporting small business development, revitalized neighborhoods) 14%
- Increasing access to health-care services 9%

Biggest Challenges to Becoming One City as We Grow

- Income inequality 14%
- Uneven economic development opportunities 12%
- Uneven access to quality education 14%
- Insufficient services for growing immigrant communities in jobs, education 9%
- Lack of affordable housing/gentrification 17%
- "Corruption and perceived corruption within city government undermines public trust" 15%
- Historic racial divides and discrimination persist 11%
- Difficulty accessing city services – health care, jobs, housing, etc. 11%
- Lack of access and options for transportation 4%

SUSTAINABLE DC

Sustainable DC

In July 2011, Mayor Gray announced a plan to make DC the greenest, healthiest, and most livable city in the nation when he tasked the Office of Planning (OP) and the District Department of the Environment (DDOE) with leading the Sustainable DC project. Covering the next 20 years, the Sustainable DC initiative is crafted for and by the city's diverse and knowledgeable community with the ultimate goal of making DC more socially equitable, environmentally responsible and economically competitive.

From its beginning, Sustainable DC has engaged people across the city by raising awareness, gathering public input, and tapping into the industry and business leaders the District is fortunate to headquarter. Even with extensive public participation and community input, the District will continue to reach out to an even broader audience until the Sustainable DC project has reached all people across all Wards.

Following the start of the Sustainable DC initiative, the Mayor took quick action to develop the plan and take the first steps to making the city more sustainable. In November 2011, Mayor Gray launched nine different public working groups that examined best practices, existing conditions, and public comments in order to develop key recommendations for the District's first sustainability plan. Over 700 people participated in the working groups throughout the winter of 2011 and 2012 by prioritizing innovative city goals and creating ambitious visions of what the District needs to do over the next 20 years to be sustainable.

In April 2012, the hard work of the working groups, with input from agency leaders and industry professionals, culminated in "A Vision for a Sustainable DC," which accomplishes two things: 1) sets the vision for the city as a whole and 2) provides the framework for a detailed strategy to achieve the vision, released in the fall of 2012.

So far, the Vision is the product of extensive public effort and engagement:

Outreach Data	
125	Public Meetings and Events
1,600	Registered email followers
1,100	Active website users
400+	Unique suggestions submitted online
440	Attendees for the Mayor's kick-off meeting
9	Public working groups
700	Working group participants
900	Working group goals and actions

SUSTAINABLE DC

The Sustainable DC process has consisted of several key groups who continue to influence the District's sustainability plan by contributing to meaningful conversations, offering insightful ideas, and investing countless hours for the sake of city's future.

Working Groups: Working groups were open to the public and facilitated by District agency staff and experienced community members. Over the winter of 2011-2012, hundreds of dedicated volunteers in nine working groups **met every other week** to identify and prioritize potential goals and actions within the topics of built environment, climate, energy, food, nature, transportation, waste, water, and the green economy.

Green Ribbon Committee: The Mayor convened this committee of civic leaders from the public, private, and non-profit sectors, in order to take a big picture view of plan development, as they review the plan from a broad range of community perspectives.

Green Cabinet: Convened by the Mayor, and led by the City Administrator, the Green Cabinet is composed of agency directors and key government officials and tasked with determining how District agencies can incorporate sustainable practices while advancing their core missions.

Plan Topics

The District's sustainability plan focuses on nine major categories. So far, working groups have invested incredible time and effort crafting visions, goals and actions for each topic. During the summer of 2012, recommendations from the working groups were analyzed by consultants to determine the feasibility, and benefits and costs of associated action. The result of this analysis combined with the Mayor's Vision were used in the implementation plan released in the fall of 2012.

Built Environment: Building and infrastructure relationships to transportation, energy, and water
Climate: Gas emissions reductions and adaptation to a changing climate
Energy: Energy use, generation, efficiency, providers, and financing issues
Food: Local food production, distribution, access, security, and community benefits
Nature: Natural systems, parks, habitat, biodiversity, and wildlife
Transportation: Transportation systems, infrastructure, modes, efficiencies, access, and delivery
Waste: Waste recycling, reuse, hauling and collection, composting, and waste to energy
Water: Watershed protection, storm water management, water quality and reuse, and sewers
Green Economy: Job creation, economic development, and local business development

Cross cutting issues transcend each of the plan's nine topics. Each working group consistently mentioned the need to provide particular focus on community health and education, social equity between all Wards and economic opportunity to create green and sustainable jobs.

DOH PARTNERSHIPS

APRA Partnerships

The Department of Health, Addiction Prevention and Recovery Administration greatly appreciates the members of the Prevention Policy Consortium for their time and input on the most comprehensive substance abuse prevention strategic plan in the District of Columbia's history. The strategic plan is the focus of The Strategic Prevention Enhancement Grant funded through the Federal Substance Abuse and Mental Health Services Administration. The process engaged new District agency partners, strengthened existing partnerships and created a drug-free vision for District youth, families, and communities.

Participating agencies and local organizations include:

Child and Family Services Agency (CFSA)

Community Anti-Drug Coalitions of America (CADCA)

DC Children and Youth Investment Trust Corporation (DCCYITC)

DC National Guard

DC Public Charter School Board (DCPCSB)

Department of Health (DOH), HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

Department of Mental Health (DMH)

Department of Parks and Recreation (DPR)

Department of Youth Rehabilitation Services (DYRS)

Justice Grants Administration and Victim Services (JGA/VS)

Metropolitan Police Department (MPD)

Office of the Deputy Mayor for Education (DME)

Office of the Deputy Mayor for Health and Human Services (DMHHS)

Office of the State Superintendent of Education (OSSE)

Participating Community Leaders include:

Wards 1 & 2:

1) Hubbard Place Social Services Residence Program- Cindy Rozon, Resident Services Coordinator & Betel Negash, Social Services Coordinator

2) La Clinica del Pueblo- Molly Goggin-Kehm, Counselor/Case Manager

3) Latin American Youth Center Treatment Services- Dora Guevara, Substance Abuse Counselor

4) Andromeda Transcultural Health Center- Mercy Cruz, Substance Abuse Counselor

5) Hands on Greater DC Cares- Adam Castle, Community Organizer

6) Columbia Heights/Shaw Family Support Collaborative- German Vigil, Community Capacity Director

7) State Board of Education- Patrick Mara, Ward 1 Representative

8) Hillcrest Children's Center- Andre Ruth-El, Substance Abuse Counselor

Wards 3 & 4:

1) Lamond/Riggs Community Prevention Network (Darice Stevens)

2) Ward 3 Civic Associations Community Prevention Network (ANC Commissioner Phillip Thomas)

3) Ward 4 Civic Associations Community Prevention Network (TBD)

4) Ward 3 Community Based Organizations (Pauline Hamlette)

5) Ward 4 Community Based Organizations (Shakira Gantt)

6) Ward 3 Faith Based Organizations (Denise Terry)

7) Ward 4 Faith Based Organizations (Pastor Gerald Elston)

8) Ward 3 DC Youth Serving Agencies Network (Rodney Weaver?)

9) Ward 4 DC Youth Serving Agencies Network (Dr. Stephanie Hill)

10) Ward 3 & 4 College/University Network (TBD)

Wards 5 & 6:

1) Chris Bryant, Executive Director - Streetwize Foundation (Ward 5)

2) Gigi Ranson, ANC Commissioner – ANC 5C12 (Ward 5)

3) Pat Fisher, Community Resource Coordinator – Edgewood/Brookland Resident Council (Ward 5)

4) Monica Veney, 5 D Community Outreach Specialist – US Attorney's Office-DC (Ward 5)

5) Beverly Sanders, Youth Minster – Mount Lebanon (Ward 5)

6) Dwayne Lawson-Brown, Community Outreach Coordinator – Metro Teen AIDS (Ward 6)

7) George Kerr, Executive Director – Start DC (Ward 6)

8) Alphonso Cole, Fatherhood Initiative – St. Augustine (Ward 6)

9) Gloria Matthews, President – Hopkins Resident Council (Ward 6)

10) Paul Taylor, Executive Director – Southwest Community Forum (Ward 6)

Wards 7 & 8:

1) Aisha Moore: r.e.e.l. (River East Emerging Leaders) Ward 8

2) Saleem Hylton: East River Family Strengthening Collaborative (ERFSC) Ward 7

3) Mable Carter: Far Southeast Family Strengthening Collaborative (FSFSC) Ward 8

4) Darryl Sanders: Ward 8 Drug Free Coalition (Ward 8)

5) William Commodore: DCPNI DC Promise Neighborhood Initiative (Ward 7)

6) Canary Giradeau: Ward 8 Tobacco Free Network (Ward 8)

7) Brian Rodgers, Ophelia Egypt Youth Health Messengers (Washington Parks and People) Ward 7

8) Dennis Chestnut, Marshall Heights Community (Anacostia Groundwork)

9) Reverend E. Jones, Deanwood Community

10) Phil Pannell, Anacostia Coordinating Council

DOH PARTNERSHIPS

HAHSTA Partnerships

The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) of the DOH prepared the DC HIV Implementation Plan by drawing upon the important work the community had already done to promote a more coordinated response to the HIV epidemic. The sources of the Implementation Plan include the HIV Comprehensive Care Plan, the Comprehensive HIV Prevention Plan, the DC Program Collaboration and Service Integration (PCSI) Plan, and DOH federal grant application plans, which are deeply rooted in the community and have strong community participation in the process.

Planning in the District of Columbia is city-wide, multi-sectoral, and community-based. The planning process brings together key stakeholders, with participation from wide expertise and representation including Behavioral Scientists, Community Based Organizations, Community Health Care Centers, DC HIV Prevention Planning Group Members, Faith Community, HIV Clinical Care Providers, Homeless Services, Local Education Agency, Mental Health, Metropolitan Washington Ryan White Planning Council, Persons Living with HIV/AIDS (PLWHA), Ryan White Funded Organizations, Social Services, and Substance Abuse services.

DC Partners:

AIDS Healthcare Foundation: Blair Underwood

Andromeda Transcultural Health

Bread for the City

Building Futures

Carl Vogel Foundation

Center for Minority Studies, Inc.

Children's National Medical Center

Christ House

Community Connections

Community Education Group

Community Family Life

Community of Hope

Consortium for Child Welfare

Cornerstone Community

Damien Ministries

DC Care Consortium

Deaf Reach

Echelon Community Services, Inc.

Extended Care

Family & Medical Counseling Services

Food and Friends

George Washington University Hospital

Georgetown University Medical Center

HIPS

Homes for Hope

Housing Counseling Services

Howard University Hospital Healthcare

Joseph's House

La Clinica del Pueblo

Mary's Center for Maternal and Child Care

Metro TeenAIDS

Miriam's House

National Community Advisory

Our Place, DC

Planned Parenthood

Regional Addictions Prevention

Sacha Bruce

Samaritan Ministry

Serenity, Inc.

Spanish Catholic Center

Terrific, Inc.

The Women's Collective

Transgender Health Empowerment

Union Temple Baptists Church

Unity Health Care, Inc.

Us Helping Us

Whitman Walker Health-Elizabeth Taylor Medical Center and Max Robinson Center

Maryland Partners:

Anchor of Walden Sierra

Another Way

Calvert County Health Department, Mental Health Clinic

Calvert Memorial Hospital, Behavioral Health Unit

Capital Hospice

Charles County Health Department

Chinese Culture and Community Service Center, Pan Asian Volunteer Health Clinic

Community Clinic, Inc.

Community Ministries of Rockville, Mansfield Kaseman Clinic

Dimensions Healthcare System (Glenridge Medical Center)

Frederick County Health Department

Frederick Institute

Gaudenzia at Landover

Greater Baden Medical Services, Inc.

Heart to Hand

Holy Cross Hospital Health Centers

Housing Authority of the City of Fredrick

Identity

Maryland Department of Health and Mental Hygiene

Mercy Health Clinic

Mobile Medical Care, Inc.

Montgomery County Department of Health and Human Services – Dennis Avenue Clinic

MRB Counseling Services Inc

Muslim Community Center Medical Clinic

Open ARMMS, Inc.

Planned Parenthood at Frederick

Planned Parenthood at Waldorf

Prince Frederick Family Planning Clinic

Prince George County Housing Authority

Prince George's County Health Department

Proyecto Salud

Psychotherapeutic Rehabilitation Services, Inc.

Southern Maryland Hospital Center Behavioral Health Services

Spanish Catholic Center

The People's Community Wellness Center

Vesta, Inc. Forestville Region

Washington Pastoral Counseling Service

VA Partners

AIDS Response Effort, Inc.

Alexandria Health Department, Casey Health Center – Subcontractor is

Alexandria Neighborhood Health Services, Inc.

Arlington County Department of Human Services /VA Department of Health

Homestretch

K.I. Services

Legal Services of Northern Virginia

Northern Virginia AIDS Ministry

Northern Virginia Family Service

Prince William Office of Housing and Community Development

Wesley Housing Development Corporation – Agape House

Wesley Housing Development Corporation – Agape House

Wholistic Family Agape Ministries Institute

WV Partners

Community Networks, Inc

HOPE Living Center

Loaves and Fishes

Telamon Corporation

VA Medical Center

DOH PARTNERSHIPS

Community Health Administration (CHA) Partners:

DC Cancer Consortium (70 members)

DC Primary Care Association

Chronic Care Coalition (35 organizations)

American Heart Association

American Diabetes Association

DC Department of Healthcare Finance

DC Department of Public Housing

DC Asthma Partnerships

DC Tobacco Free Coalition (40 members)

Live Well DC Community Coalition

State Health Planning and Development Agency (SHPDA) Partnerships

The State Health Planning and Development Agency (SHPDA) is responsible for planning, policy development, as well as data collection and analysis of the health care delivery system in the District of Columbia. The SHPDA is established by D.C. Official Code § 44-401. The law requires that anyone proposing to offer a new health service, acquire major medical equipment or obligate a health care related capital expenditure shall obtain a certificate of need from SHPDA that demonstrates public need. In addition, the SHPDA is responsible for developing a Health Systems Plan. The Plan is designed to articulate issues with respect to maintaining and improving the health of District of Columbia residents and identifying needs of the health care delivery system.

STATEWIDE HEALTH COORDINATING COUNCIL

The Statewide Health Coordinating Council (SHCC), established by District law (D.C. Official Code § 44-403), plays a major role in the review of certificate of need applications and the Health System Plan development process. The members represent diverse stakeholders in the community, such as health care consumers, providers, advocates and payors, and are appointed by the Mayor with the advice and consent of the Council of the District of Columbia.

The SHCC meetings serve as a forum, where the general public can express its views, issues and concerns on certificate of need applications and the planning process. The SHCC makes recommendations on whether a certificate of need application should be approved or denied. The following are examples of recent CON applications reviewed:

- Kids Smiles, Establishment of Dental Services
- George Washington University Hospital, Expansion and Renovation of the Surgery Department
- Children's National Medical Center, Establishment of a Satellite Pediatric Emergency Department at United Medical Center

According to the law, members of the SHCC should receive no compensation, but may be reimbursed for actual expenses incurred in the performance of official duties. In carrying out its responsibilities, the SHCC utilizes the resources of the SHPDA. The SHCC meets once a month, usually on the second Thursday at 6:00 pm. The meetings are open to the general public.

Those who are interested in serving on the SHCC are requested to complete an application form (OBC Form 8) which is available at www.obc.dc.gov. Those desiring additional information may contact the SHPDA at (202) 442 – 5852.

ASSETS

PUBLIC HEALTH SYSTEM ASSESSMENT

The National Public Health Performance Standards Program (NPHPSP) provides assessment tools and support services to evaluate and improve public health systems. The Program is a joint effort of 7 national partners who collaboratively produced **10 Essential Public Health Services (EPHS)** as a model standard to improve the practice and performance of public health systems. The Centers for Disease Control and Prevention is a leading contributor in this partnership.

Assessment results for the District's public health system were calculated by the DC DOH and the Association of State Territorial Health Officers (ASTHO) using stakeholder responses to the NPHPSP Performance Standards Program questionnaire.

Figure 164. Performance Scores for the 10 Essential Public Health Services in the District of Columbia

10 Essential Public Health Services		% Score
EPHS #1	Monitor Health Status To Identify Community Health Problems	43%
EPHS #2	Diagnose and Investigate Health Problems and Health Hazards	52%
EPHS #3	Inform, Educate, and Empower People about Health Issues	51%
EPHS #4	Mobilize Community Partnerships to Identify and Solve Health Problems	50%
EPHS #5	Develop Policies and Plans that Support Individual and Community Health Efforts	61%
EPHS #6	Enforce Laws and Regulations that Protect Health and Ensure Safety	54%
EPHS #7	Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable	52%
EPHS #8	Assure a Competent Public and Personal Health Care Workforce	34%
EPHS #9	Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services	36%
EPHS #10	Research for New Insights and Innovative Solutions to Health problems	35%
Overall Performance Score		**47%**

Table Scale:

0%	= No activity
1 – 25%	= Minimal activity
26 – 50%	= Moderate activity
50 – 75%	= Significant activity
75% -100%	= Optimal activity

Rows highlighted in red had the lowest scores and were deemed the top 3 priorities for improvement. Two EPHS categories (highlighted in yellow) were less than or equal to 50 percent, and need to be improved as well. The EPHS categories with scores of more than 50 percent need to be maintained.

Note on Performance Scores: No single domain attained an optimal performance of 75 percent. Therefore, it is important to maintain efforts in all areas of the EPHS to preserve and improve all of the 10 EPHS.

GEOGRAPHIC DISTRIBUTION OF PROVIDERS PRACTICING IN THE DISTRICT

The Department of Health's Primary Care Bureau is responsible for assessing and ensuring designation of areas of DC that have a shortage of health care providers. Areas with evidence of shortages are designated by the federal government as Health Professional Shortage Areas and/or Medically Underserved Areas/Populations.

HPSAs and MUA/Ps are used by the Federal government to recognize shortages of health care providers for geographic areas, populations or facilities and to prioritize the allocation of Federal and local resources to address these shortages. A shortage designation can refer to a gross shortage of providers available to the overall population in an area (i.e. a "geographic" HPSA or MUA) or a net shortage of providers available to a specific population that faces economic, cultural or linguistic barriers to health care in an area (i.e. a "population" HPSA or MUP).

DC has nine designated Health Professional Shortage Areas (HPSAs) and eight Medically Underserved Areas\Populations (MUA\P). Six areas of the District are designated as primary care HPSAs, two areas are designated as dental HPSAs and one area is designated as a mental health HPSA.

In Figure 165, the number of providers in each ward is shown. In Figure 166, providers are mapped and pinpointed according to area of expertise.

Figure 165. Primary Care Physicians and Specialists Practicing in the District, by Ward and Count

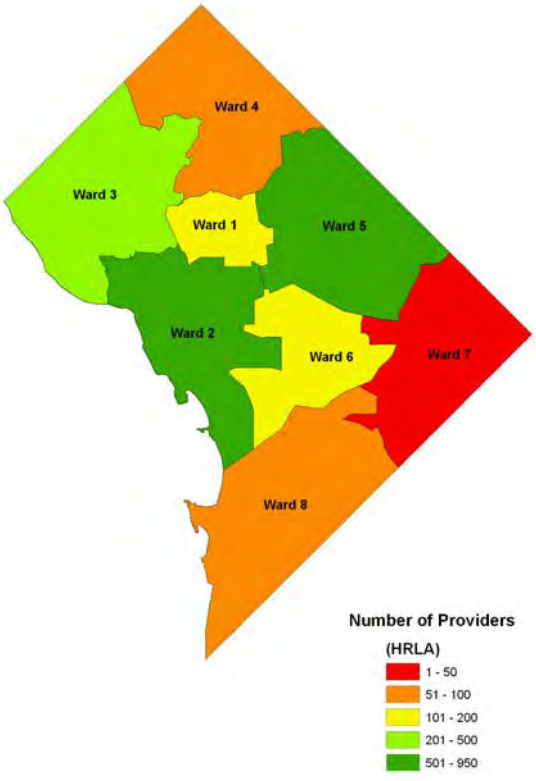
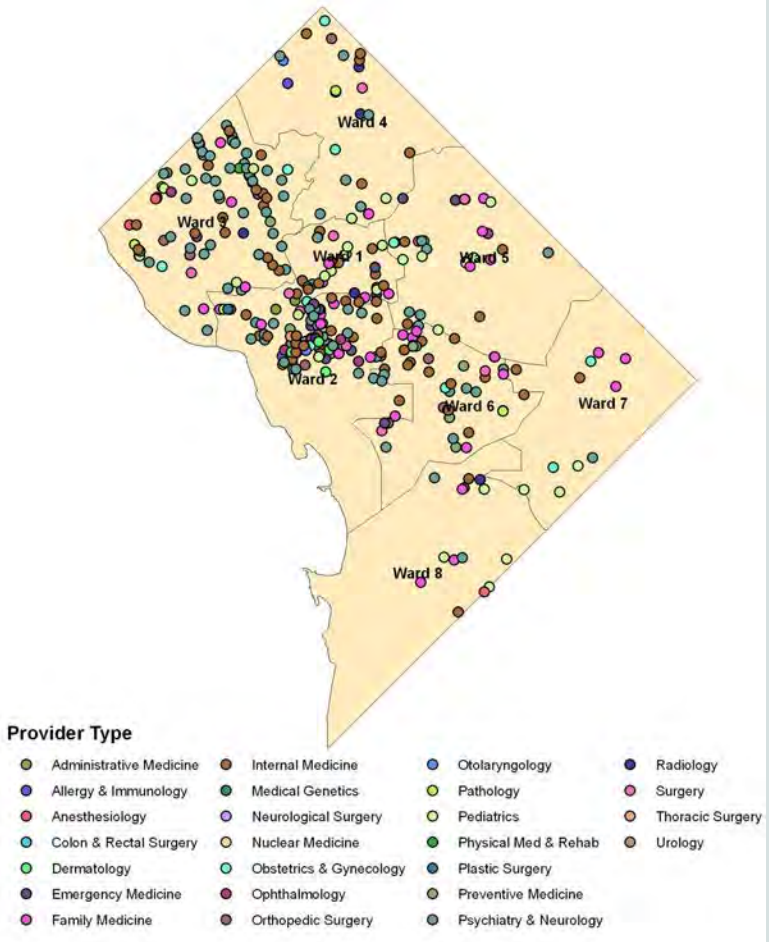


Figure 166. Primary Care Physicians and Specialists Practicing in the District, by Area of Expertise



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figures 167-178 map the number and location of DC Hospitals, Federal Facilities, Ambulatory Care Centers and Intermediate Care Facilities, Home Health Agencies, Community Health Centers, Nursing Homes, Hospice Facilities, Mental Health Facilities, Substance Abuse Treatment Centers, End-Stage Renal Disease Facilities, and Communicable Disease Treatment Centers, respectively.

Figure 167. Spatial Distribution of District of Columbia Hospitals

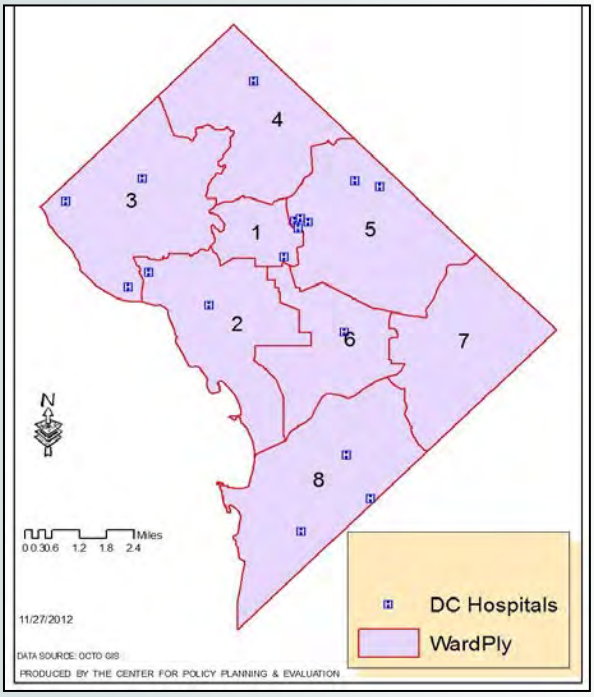


Figure 168. Spatial Distribution of Federal Facilities

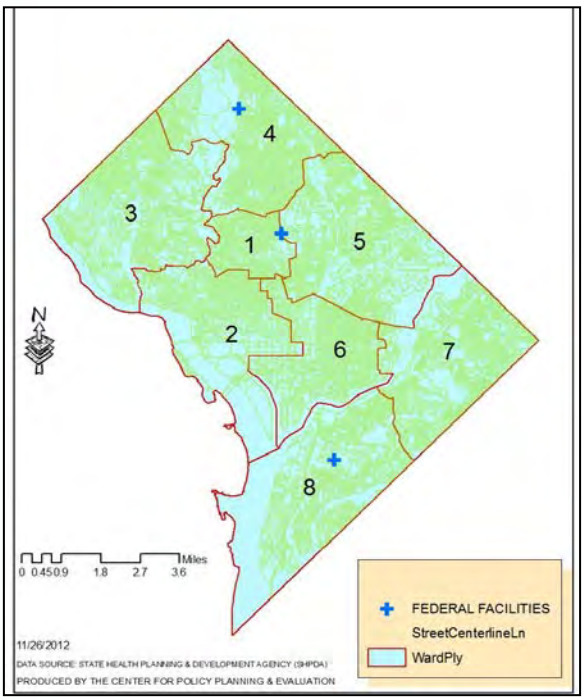


Figure 169. Spatial Distribution of Ambulatory Care Centers

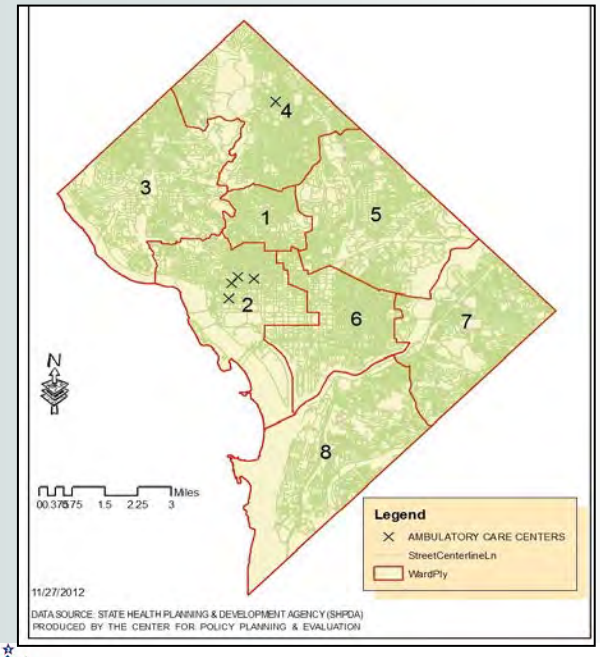
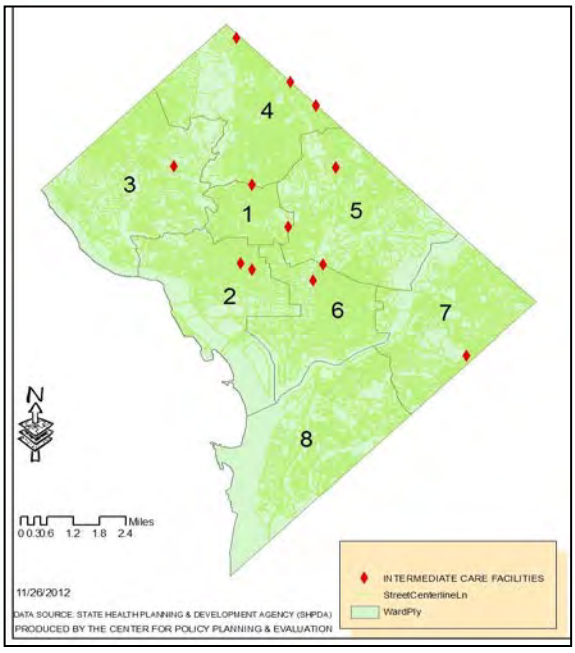


Figure 170. Spatial Distribution of Intermediate Care Facilities



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figure 171. Spatial Distribution of Home Health Agencies

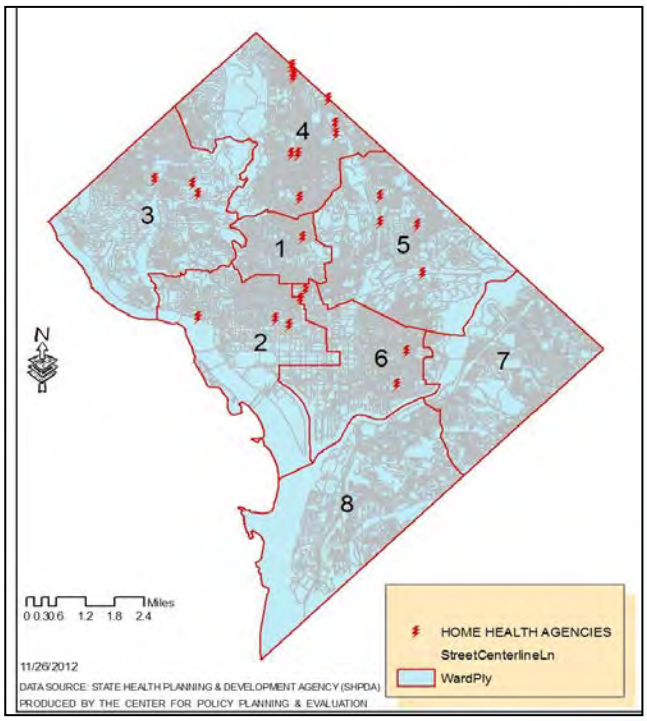


Figure 172. Spatial Distribution of Community Health Centers

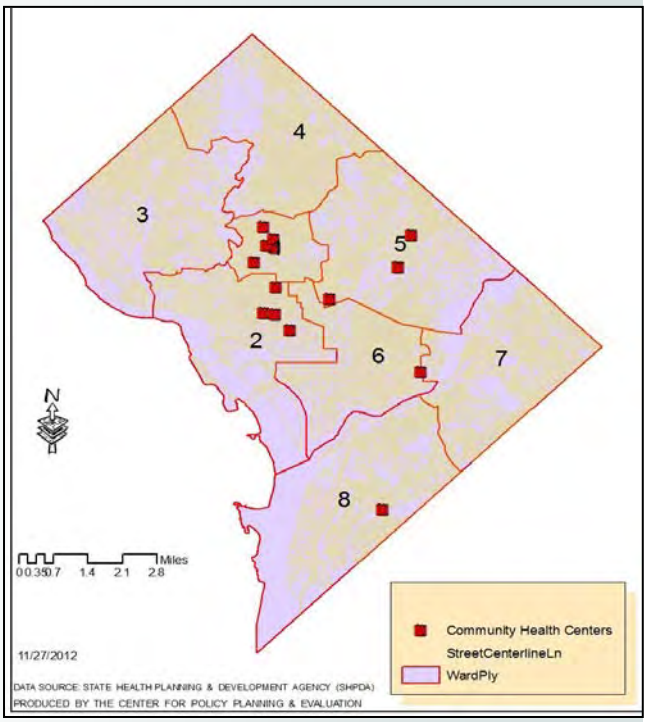


Figure 173. Spatial Distribution of Nursing Homes

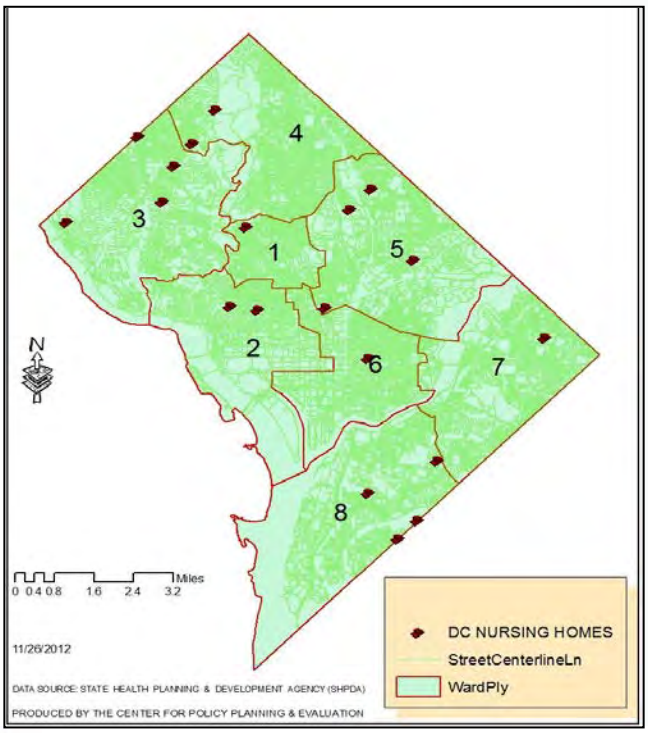
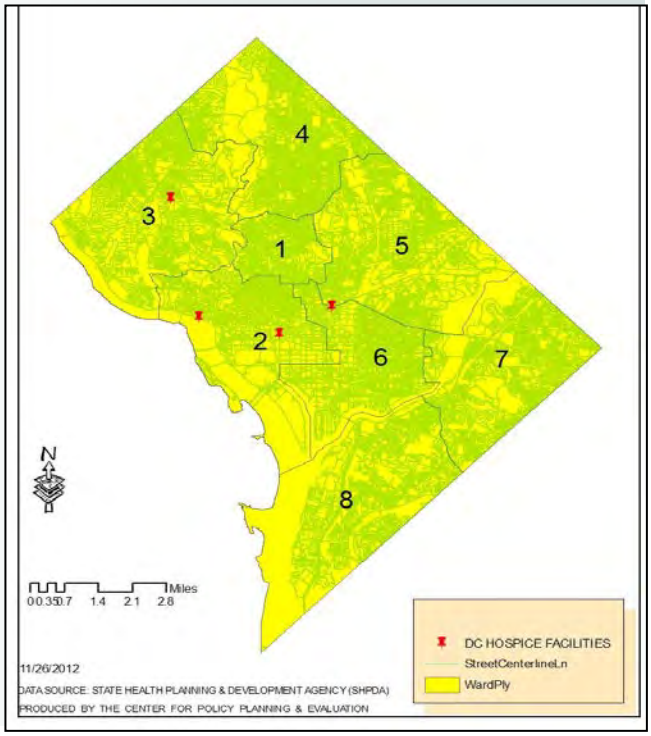


Figure 174. Spatial Distribution of Hospice Facilities



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figure 175. Spatial Distribution of Mental Health Facilities

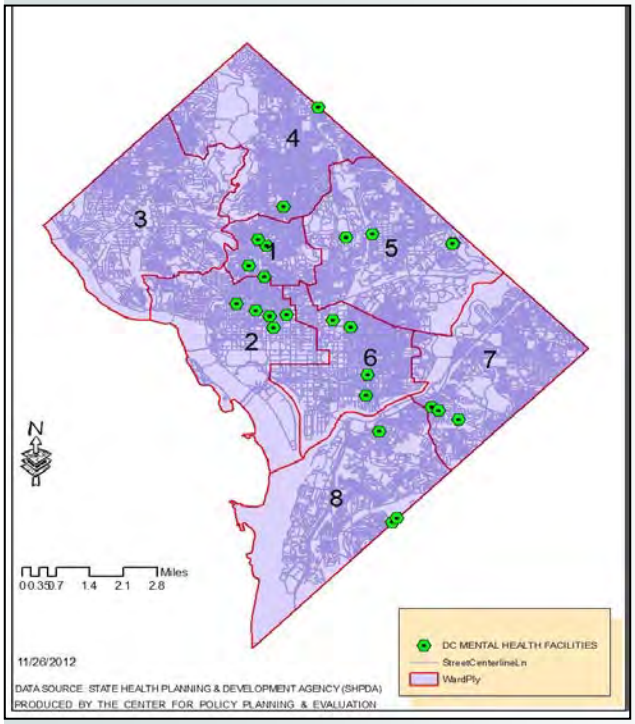


Figure 176. Spatial Distribution of Substance Abuse Treatment Centers

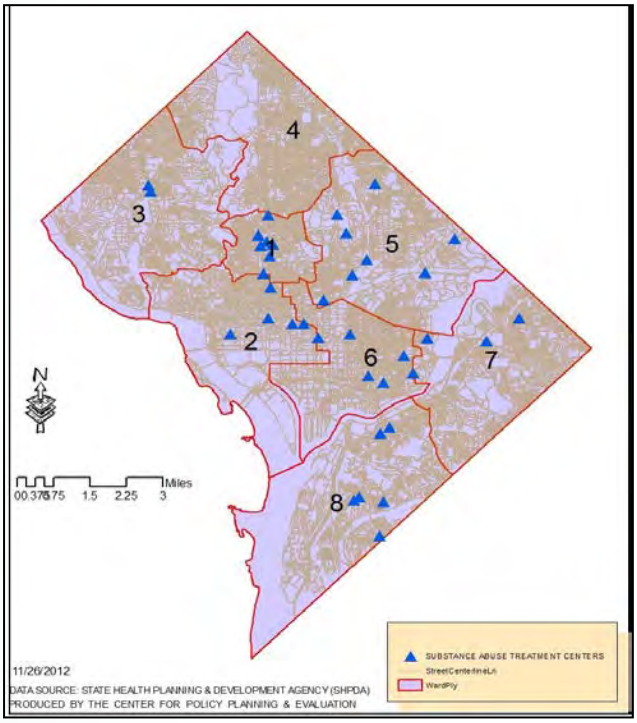


Figure 177. Spatial Distribution of End-Stage Renal Disease Facilities

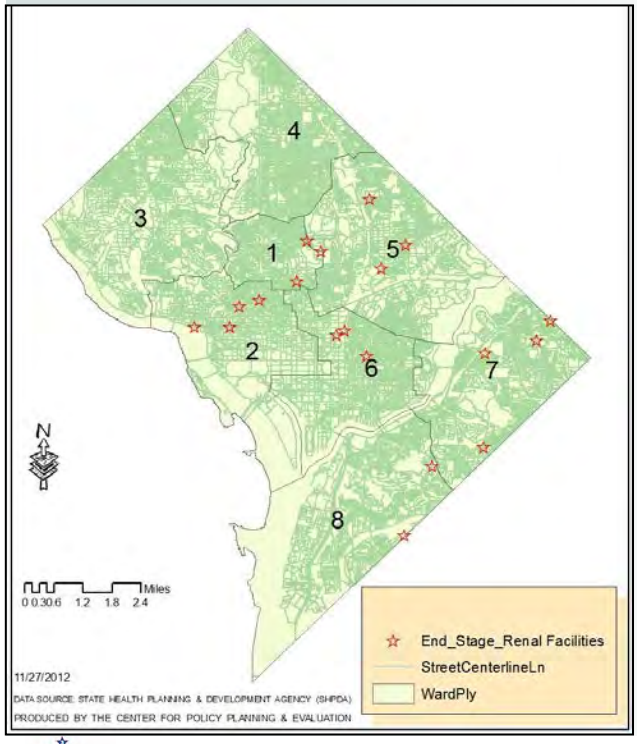
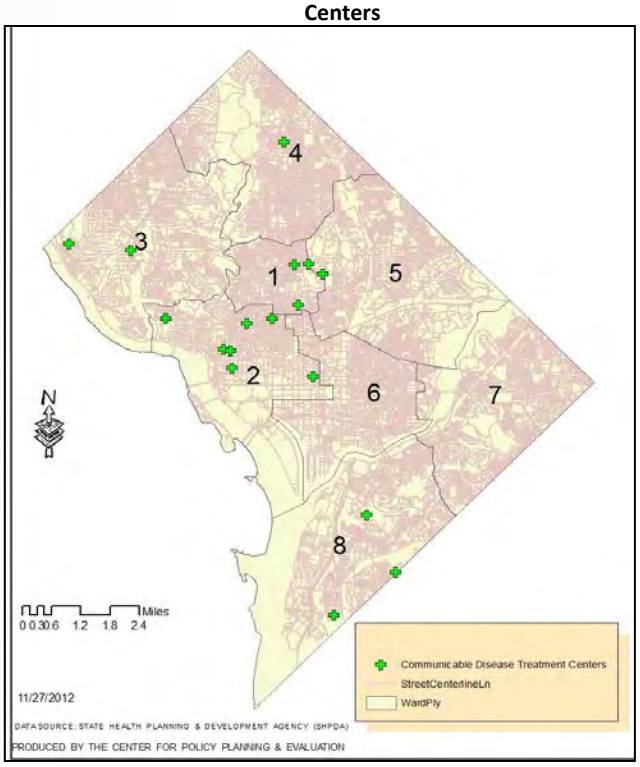


Figure 178. Spatial Distribution of Communicable Disease Treatment Centers



CONCLUSION AND RECOMMENDATION

CONCLUSION AND RECOMMENDATION

Racial Disparities

Residents of the District of Columbia are healthier today than they were before. The average District resident is expected to live longer, have greater access to care, benefit from the District's wealth of resources, and be able to make educated decisions to improve the quality of life. However, research studies demonstrate that disparities in health status are related to race, ethnicity, and various measures of socio-economic position. Health disparities refer to inequalities in health outcomes or determinants of health between groups of people. These disparities influence how frequently a disease affects a group, how many people get sick, or how often the disease causes death. Although mortality and morbidity rates have gone down in recent years, this assessment has demonstrated disparities persisting in the health status of racial and ethnic groups, particularly among African Americans who make up more than half of the District's population.

Life expectancy continues to be lower for black than for white DC residents, with an 11-year disadvantage for the former. Non-Hispanic black infants still account for a disproportionate percentage of all infant deaths, but for the first time in history, the DC rate for infant mortality in black mothers was lower than national. Black residents in the District remain disproportionately affected by chronic illness and deaths resulting from them. Compared to white residents, Blacks were twice more likely to die from cancer, three times more likely from heart disease and CVD, and seven times more likely from diabetes. Of all racial/ethnic groups, Blacks have the highest obesity rates in the District and are least likely to exercise or consume the recommended serving of fruit and vegetables. Non-Hispanic black children in the District have higher asthma rates than national. While homicide rates plunge in the District, Blacks were 10 times more likely to be victims of homicide compared to their white counterparts. Lastly, as the District continues to make progress in the fight against the HIV epidemic, the highest burden of disease is among black males who comprise almost half of all adults living with HIV in DC.

CONCLUSION AND RECOMMENDATION

Disparity Ratios were calculated to better understand the severity of health problems and the table below is a summary of the disparities for various indicators by race/ethnicity. A disparity ratio was calculated by first determining a comparison or reference group, the group with the lowest disease prevalence or death rate, and then dividing each group rate by the reference group rate. The grades shown below are meant to offer a broad understanding of disparities in the District for planning purposes, and not as a comparison across other states, counties or cities. Grade A means very good or no disparity; B is good but requires monitoring; C and D are fair and poor respectively, and requiring intervention; F is a failing grade that requires major intervention. For a detailed explanation of the methodology used to calculate these grades, please refer to the District of Columbia Health Disparities Report Card (http://doh.dc.gov/service/data-and-statistics).

	Mortality					Prevalence						
	Cancer	Cardiovascular disease	Homicide	Injury	Infant Mortality	Diabetes	HIV/AIDS	Overweight	Obesity	Tobacco Use	Alcohol use	Influenza Vaccination
Race/Ethnicity												
African-American/Black	D	F	F	C	F	F	F	B	F	D	A	B
Asian	-	-	-	-	A	-	C	-	-	-	-	-
Hispanic	-	-	-	-	F	D	B	B	B	C	B	B
White	A	A	A	A	F	A	A	A	A	A	D	A

To address racial health disparities means to begin identifying the underlying reasons that drive inequalities between racial groups which are often complex and socially intrinsic. In addition to the current expansion of health care services and public health infrastructure, there is a need for innovative behavioral research that will shed light on the formation of unhealthy habits and how small positive changes can be incorporated into everyday routine. More data is needed to understand the roles of gentrification, socio-economic status, age, and population dynamics in a city as transient as the District. Only then can interventions be effective in reducing deaths, preventing diseases, and ultimately lowering the cost of healthcare and achieving health equity for all.

CONCLUSION AND RECOMMENDATION

Unmet Need by Ward

Another common theme in this health assessment, in addition to racial disparity, is disparity of health outcome by geographic location, or in the District of Columbia, by ward of residence. Table 4 summarizes the health indicators covered in this report and provides a comparison by ward to the city-wide rate. Data included are of 2010 or the most recent available. Wards with rates that correspond to an unfavorable outcome compared to the city-wide rate are marked with an X. In 2010, 4 wards did better than the overall DC death rate; Wards 4, 5, 7, and 8 did worse. These wards had higher mortality rates for the top 10 leading causes of death, including heart disease, cancer, and accidents. Wards 4, 5, 6, 7, and 8 had higher rates for deaths due to chronic illness, such as cerebrovascular disease and diabetes. These deaths correspond to higher rates of obesity, lack of exercise, and poor nutrition in these wards. Residents in Wards 7 and 8 were more likely to smoke. Wards 5, 7, and 8 also had the highest rates of disease prevalence for asthma, diabetes, cancer, heart disease and stroke. Ward 8 had the highest prevalence for HIV. Sexually transmitted diseases (STDs) were highest in Wards 5, 7, and 8, except for syphilis which was highest in Wards 1 and 2. Residents in Wards 1 and 2 were more likely to binge drink and engage in risky behavior. On the other hand, Ward 3 residents were more likely to die from illnesses among the elderly, particularly chronic lower respiratory and Alzheimer's disease.

Inequalities in community health status by geographic location reflect the interplay of social, economic, and environmental factors that differentiate the quality of life of residents from one Metro stop to another. Residents from each ward have needs that are unique to their community cluster, demographics, and availability of resources in their area of residence. Monitoring and evaluation of health outcomes by smaller units of geography, in addition to ward-level analyses, may prove to be useful in the planning and development of intervention campaigns and health messages.

CONCLUSION AND RECOMMENDATION

Note: Wards with rates that correspond to an unfavorable outcome compared to the city-wide rate are marked with an X.

Table 4. Health Indicator by Ward	City-wide	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Mortality and Life Expectancy					x	x		x	x
Crude Mortality Rate (per 100,000)	776.1				x	x		x	x
Deaths due to Heart Disease	216.0				x	x	x	x	x
Deaths due to Cancer	172.0				x	x		x	x
Deaths due to Accidents	35.1				x	x		x	x
Deaths due to Cerebrovascular Disease	32.2				x	x	x	x	x
Deaths due to Chronic Lower Respiratory Disease	24.3			x	x	x		x	x
Deaths due to Diabetes	24.1				x	x	x	x	x
Deaths due to HIV	20.1					x		x	x
Deaths due to Homicide/Assault	19.6					x		x	x
Deaths due to Alzheimer's Disease	18.9			x	x	x		x	
Deaths due to Septicemia	15.0				x	x		x	x
Life Expectancy (in years)	77.5					x	x	x	x
Infant Mortality Rate (per 1,000 live births)	8.0				x	x	x		x
Promoting Healthy Behaviors					x	x		x	x
Obesity (percent)	22.4				x	x		x	x
No physical activity (percent)	20.0				x	x		x	x
Less than 5 serving of fruits and vegetables (percent)	68.5	x			x		x	x	x
Binge drinking (percent)	15.4	x	x	x					
Tobacco use (percent)	15.6							x	x
Condom use (percent)	38.2						x		
High-risk behavior (percent)	6.4	x	x				x	x	x
Oral health (percent)	73.7	x			x	x		x	x
Seat belt use (percent)	90.4	x			x				x
Primary care (percent)	83.3	x				x		x	
Routine check-up (percent)	77.4	x		x			x		
Healthcare coverage (percent)	93.0				x	x		x	x
Preventing and Reducing Disease and Disorder									
Current asthma (percent)	10.4				x	x	x	x	x
Diabetes (percent)	8.3				x	x		x	x
Cancer (all-site, incidence rate per 100,000)	487.8					x		x	x
Heart Disease (percent)	2.6					x	x	x	x
Stroke (percent)	3.4					x	x	x	x
HIV Prevalence (prevalence rate per 100,000)	2739.0								x
Knew HIV partner status (percent)	80.2					x		x	x
Chlamydia (rate per 100,000)	929.3					x		x	x
Gonorrhea (rate per 100,000)	349.7					x		x	x
Syphilis (rate per 100,000)	22.3	x	x					x	
Health limited by disability (percent)	16.5	x		x		x		x	x
Poor mental health (percent)	7.6					x	x	x	x

CONCLUSION AND RECOMMENDATION

Data Gaps

No comprehensive data sources were available to conduct an assessment on the following topics:

Health literacy in the District

Health literacy is the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions. Health literacy affects every aspect of health including prevention, access to care and treatment. It is still difficult to assess how health literacy impacts health outcomes in the District. The only available data comes from the 2003 National Assessment of Adult Literacy, which found that almost 19 percent of District residents lack basic prose literacy skills. These skills are necessary to follow written directions from a physician, instructions on medication bottles or basic medical brochures. However, other skills that are missing from the 2003 assessment are document literacy and numeracy. These skills are important measures to understand health literacy because they determine how well a population can measure their medications and interpret graphics and maps.

End-Stage Renal Disease

In the Washington MedStar Hospital's Community Health Needs Assessment, residents of Ward 5 stated that issues related to end-stage renal disease were affecting their community. However, data related to mortality and morbidity rates for end-stage renal disease are difficult to obtain. Many physicians are unable to initially recognize or document signs of end-stage renal disease or chronic kidney disease because it is usually results from another chronic condition.

Homeless and currently incarcerated populations

Local homeless and incarcerated health-related data is difficult to obtain because these demographic details are not usually collected in population survey assessments. Many homeless individuals in the District of Columbia are not able to access care or treatment services, which make it harder to assess what health conditions are most prevalent in homeless individuals. In addition, little research in the District is available about the health status of currently incarcerated individuals.

Source:

U.S. Department of Education, Institute of Education Sciences, National Center for Education Statistics, 2003 National Assessment of Adult Literacy

Washington MedStar Hospital Center, 2012, Community Health Assessment, Appendix: Community Input Results

CONCLUSION AND RECOMMENDATION

Transgender population

Many population assessment tools in the District do not include a transgender demographic question. The only assessment tool available for this population is the 2000 Washington Transgender Needs Assessment, which informed the District that mental health, substance use, HIV, housing, and access to hormone treatments are major health issues for transgender individuals. Another transgender needs assessment by community stakeholders is currently being conducted, but the results from the most recent assessment have not yet been released.

Foreign-Born Population

There are currently no localized, population sample data to assess the current status of health for foreign-born populations. According to the Agency for Healthcare Research & Quality, many reasons why these data are not collected stem from both patient and provider challenges. Many providers do not believe that response categories are sufficient for local populations, and could possibly create privacy concerns and discomfort between a patient and provider if such data were collected.

While the data is unavailable, the Department of Health is still interested in collecting data for these five areas to better inform our programs and meet the needs of our city's most vulnerable residents. Collaboration with stakeholders to collect and analyze such data is necessary in order to have a more comprehensive understanding of the District of Columbia's health status.

Source:

Simmons, Ron and Xavier, Jessica, Washington Transgender Needs Assessment, 2000

U.S. Department of Health & Human Services, Agency for Healthcare Research and Quality, Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement, 2010

CONCLUSION AND RECOMMENDATION

Recommendation

As previously noted, the District of Columbia has significantly improved the city's health status within the last ten years. This assessment shows that many of these improvements occurred because of the collaborative work made by District residents, community based organizations, and the District government. Many of the focus areas discussed in this assessment are currently being addressed with detailed action plans by the One City Action Plan and Sustainable DC Implementation Plan. As we move into Department of Health's community health improvement process, the Department of Health hopes that community partners and residents inform us of what strategies they would like to see in their communities.

This assessment has generated concrete areas of focus that we hope the District government, community partners and stakeholders consider for the future:

- *Expanding Access to Care*
- *Reducing Cardiovascular Disease & Stroke*
- *Reducing Cancer*
- *Reducing Diabetes*
- *Reducing HIV/AIDS*
- *Reducing Obesity*
- *Reducing the Use of Tobacco, Alcohol, and Other Drugs*
- *Reducing Infant Mortality & Improving Maternal Health*
- *Improving Public Safety*
- *Improving Social Determinants of Health*
- *Addressing Health Inequities*
- *Strengthening the District's Access to Data*

CONCLUSION AND RECOMMENDATION

Next Steps

As in the case of population health, this community health needs assessment (CHNA) is not static; it is expected to evolve and adapt to the changing health needs and health outcomes among District residents and the city overall. The Department of Health (DOH) understands that monitoring and evaluation of specific health indicators in the District are fundamental components of measuring progress towards key health targets. Hence, DOH will be releasing an updated version of the CHNA every 5 years. The CHNA provides the general public and policy leaders with information on the characteristics of the population served by the health department; it communicates health issues of importance to District residents and the contributing factors to these health issues. The CHNA examines disparities in health status among sub-population groups and sheds light on geographic segments of the population experiencing morbidity and mortality at excess levels; it also documents the distribution of current assets, healthcare facilities, and numerous community partnerships mobilized to address these health areas of concern.

Although the CHNA serves as a great resource document and guide for resources and services in the District, the main purpose of conducting the health needs assessment is to provide a foundation for efforts to improve population health. It is intended to facilitate goal-setting, planning, program development, and coordination of resources through data-driven priorities and collaboration among public health partners and community stakeholders in the District. For instance, the analysis of the prevalence of chronic diseases in the District presents an opportunity to not only understand disease severity and the demand for specific programs and services, but also enables the District to strategize the placement of healthcare resources for treatment and prevention efforts in underserved areas. Findings from the CHNA will be used to inform and support health improvement planning initiatives in conjunction with two notable plans that received extensive community input (i.e., the One City Action Plan and the Sustainable DC Implementation Plan).

CONCLUSION AND RECOMMENDATION

The DOH will be releasing the District of Columbia Community Health Improvement Plan (CHIP), a centralized planning document that will serve as a framework for goals and performance measures established in parallel with Healthy People goals and those based on critical health issues impacting District residents as identified in the CHNA. This plan includes nine focus areas and objectives that measure the District's continuing successes in improving the health of residents and includes current and proposed strategies for implementation within the next 5 years. The DOH recognizes that many community stakeholders can benefit from this document as:

- A data tool for measuring program performance
- A framework for program planning and development
- A map for goal setting and agenda building
- A way for teaching public health courses
- A set of benchmarks to compare national, state, and local data and health among populations
- A guide to developing non-traditional partnerships

For more information about the District of Columbia CHIP, please contact:

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TECHNICAL NOTES

Definition of Race Categories Used in the 2010 Census

"White or Caucasian" refers to a person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicated their race(s) as "White" or reported entries such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian.

"Black or African American" refers to a person having origins in any of the Black racial groups of Africa. It includes people who indicated their race(s) as "Black, African Am., or Negro" or reported entries such as African American, Kenyan, Nigerian, or Haitian.

"American Indian or Alaska Native" refers to a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment. This category includes people who indicated their race(s) as "American Indian or Alaska Native" or reported their enrolled or principal tribe, such as Navajo, Blackfeet, Inupiat, Yup'ik, or Central American Indian groups or South American Indian groups.

"Asian" refers to a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam. It includes people who indicated their race(s) as "Asian" or reported entries such as "Asian Indian," "Chinese," "Filipino," "Korean," "Japanese," "Vietnamese," and "Other Asian" or provided other detailed Asian responses.

"Native Hawaiian or Other Pacific Islander" refers to a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands. It includes people who indicated their race(s) as "Pacific Islander" or reported entries such as "Native Hawaiian," "Guamanian or Chamorro," "Samoan," and "Other Pacific Islander" or provided other detailed Pacific Islander responses.

"Some Other Race" includes all other responses not included in the White, Black or African American, American Indian or Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander race categories described above. Respondents reporting entries such as multiracial, mixed, interracial, or a Hispanic or Latino group (for example, Mexican, Puerto Rican, Cuban, or Spanish) in response to the race question are included in this category.

Definition of Hispanic or Latino Origin Used in the 2010 Census

"Hispanic or Latino" refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.

GLOSSARY OF TERMS

GLOSSARY OF TERMS, A to G

Accidents/Injuries	Accidents and unintentional injuries refer to external causes of injury, usually in the context of a cause of death including deaths from unintentional falls, motor vehicle traffic, and unintentional poisonings.
Alzheimer's Disease	The most common form of dementia in older adults, involving parts of the brain that control thought, memory, and language (CDC).
Ambulatory Services	Healthcare services delivered in the outpatient setting (hospital-based outpatient clinics, nonhospital-based clinics and physicians offices, ambulatory surgical centers and other specialized settings (CDC).
American Community Survey	An ongoing survey by the United States Census Bureau that generates demographic and socioeconomic data intended for use by communities, state governments, and federal programs (ACS).
Body Mass Index	Calculated using height and weight (weight (lbs)/height (in) squared x 703), is a fairly reliable indicator of body fat or weight status. A BMI between less than 18.5 is considered underweight, 18.5 to 24.5 is healthy, 25 to 29.9 is considered overweight, and 30 or above indicates obesity.
BRFSS	Behavioral Risk Factor Surveillance Survey is an on-going telephone health survey system that tracks health conditions and risk behaviors in adults in the United States (BRFSS).
Cancer	A disease of more than 100 different types, in which abnormal cells divide without control and are able to invade other tissues and can be spread through the blood and lymph systems (CDC).
Census, United States	The United States Census counts every resident in the U.S. every 10 years, as mandated by the Constitution (http://www.census.gov/2010census/about/).
Cerebrovascular Disease	Cerebrovascular disease is better known as stroke; occurs when a clot blocks blood supply to the brain or when a blood vessel in the brain bursts (CDC).
Chlamydia	A common sexually transmitted disease (STD) caused by a bacterium, *Chlamydia trachomatis* that infects men and women, but can cause serious and permanent damage to female reproductive organs (CDC).
Chronic Disease	Diseases or disorders that show little changes in symptoms from day to day, but the disease process continues and causes progressive deterioration.
Chronic Lower Respiratory Disease	Diseases of the lower respiratory tract including bronchitis, emphysema, chronic obstructive pulmonary disease (COPD) and asthma.
Communicable Disease	Also known as infectious diseases are illnesses that are caused by infection, presence and growth of pathogens (e.g., viruses, bacteria, fungi, and parasites) in humans or host animals.
Diabetes	Diabetes is a disease where blood glucose (sugar) levels are above normal resulting from either the pancreas no longer making insulin (Type 1) or the pancreas not making enough insulin (Type 2; CDC).
Disability	There are many types of disabilities: hearing, vision, movement, thinking, remembering, learning, communicating, mental health, and social relationships. Disabilities can result in functional limitations, activity limitations, and/or participation restrictions (CDC).
GLBT	Gay, lesbian, bi-sexual, and transgender
Gonorrhea	An STD caused by a bacterium, *Neisseria gonorrhoeae*, that infects reproductive tracts in women and the urethra in women and men. *N. gonorrhoeae* can also infect mucous membranes of the mouth, throat, eyes and anus.

GLOSSARY OF TERMS, H to M

Health Care Coverage — Any plan that covers health care costs such as health insurance, prepaid Health Maintenance Organizations (HMOs) or government plans (Medicare or Medicaid).

Health Disparities — Health disparities refer to inequalities in health outcomes or determinants of health between groups of people. These disparities influence how frequently a disease affects a group, how many people get sick, or how often the disease causes death. Most often health disparities are observed among: racial and ethnic minorities; women, children, and the elderly; and persons with disabilities.

Health Practitioners — Includes, but not limited to, physicians, dentists, pharmacists, physician assistants, nurses, midwives, dietitians, therapists, psychologists, chiropractors, physical therapists, emergency medical technicians, social workers, public health workers, and medical laboratory scientists.

Healthy People 2010 — Ten-year science-based, national goals and objectives for health promotion and disease prevention efforts in the US (CDC).

Heart Disease — Refers to several types of heart conditions including coronary artery disease, heart attack, angina, heart failure and arrhythmias (CDC).

High-Risk Behavior — Health Risk Behaviors that are monitored by the BRFSS and YRBS incorporate intravenous drug use, treatment for STDs, exchanging money or drugs for sex, and having sex without a condom.

HIV/AIDS — The Human Immunodeficiency virus (HIV) is a virus that can lead to acquired immune deficiency syndrome (AIDS). The virus destroys blood cells called CD4+ T cells that are essential to the body's ability to fight diseases (CDC).

Hospice — A nursing home for the care of the dying or the incurably ill.

Hospital Discharge — Release from inpatient care from a hospital.

Immunization — Also known as a vaccination, contain germs that cause diseases but that have been killed or weakened so that your immune system is stimulated to produce agents that kill germs and develop immunity to prevent diseases (CDC).

Incidence — The frequency or proportion of newly developed (incident) health or disease related events.

Infant Mortality Rate — The number of infant deaths that occurred in a given time period and population divided by the number of live births for the same period and in the same population. Rates are presented per 1,000 live births.

Life Expectancy — The average age to which a newborn is expected to live.

Low Birth Weight — Newborn weighing under 2,500 grams or 5 lbs. 8 oz.

Mental Health — Not necessarily the same as mental illness (diagnosable mental disorders associated with distress and/or impaired function). Rather, a state of well-being where a person realizes their own abilities, can cope with stress, works productively, and can contribute to their community (CDC).

Morbidity — The quality of being morbid or the rate of incidence of a disease.

Mortality — Death or reference to death rates.

Mortality Rate — The number of deaths per total population during a given period. For example, rates are commonly presented per 100,000 persons per year.

GLOSSARY OF TERMS, O to Z

Obesity	A label for a range of weight that is greater than what is generally considered healthy for a given height. For adults, a body mass index of 30 or above is commonly used to determine obese ranges.
Older Adults	Adults aged 65 and older.
Poverty Rate	A percentage of people or families who are below poverty.
Premature Birth	A live birth weighing 2,500 grams (5-1/2 pounds) or less. If birth weight is not stated, length of gestation (under 37 weeks) is used.
Prevalence	A measure of the frequency of an existing outcome at one point in time or during a given period of time.
Primary Care	Care provided by physicians to promote health, prevent disease, maintain health, and to provide counseling, education, diagnosis, and treatment of illnesses (AAFP).
Risk Factors	Any attribute, characteristic or exposure of an individual that increases their likelihood for disease or injury (WHO).
Routine Check-up	Health services like screening, exams and tests intended to monitor health status, prevent disease, and ensure early detection of diseases.
Septicemia	Infection of the bloodstream.
Socio-economic Status	A measure of social standing of an individual or group, often considering a combination of factors including education, income, occupation, marital status, and place of residence.
STD	Sexually Transmitted Diseases
Substance Abuse	Includes alcohol dependence or abuse, illicit drug use, underage drinking, and non-medical use of prescription and over-the-counter medications (SAMHSA).
Syndemic	Combination of two or more diseases in a population where the conditions interact in a way that exacerbates negative health effects.
Syphilis	An STD caused by a bacterium, *Treponema pallidum*. Long-term complications or even death can result if not adequately treated.
Tuberculosis	A disease caused by bacterium, Mycobacterium tuberculosis, that usually attacks the lungs, but can affect the kidneys, spine, and brain.
Ward	Geographical-political divisions of the District of Columbia. There are 8 Wards in DC.
Youth and Young Adults	Persons between the ages of 10 and 24 years.
YRBS	The Youth Risk Behavior Survey monitors priority health-risk behaviors (unintentional injuries and violence, STDs, alcohol and drug use, tobacco use, dietary behavior, and physical activity) and prevalence of obesity and asthma in youth and young adults.

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