DISTRICT OF COLUMBIA COMMUNITY HEALTH NEEDS ASSESSMENT, Volume 2

Prepared by

District of Columbia Department of Health

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ACKNOWLEDGMENTS

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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.

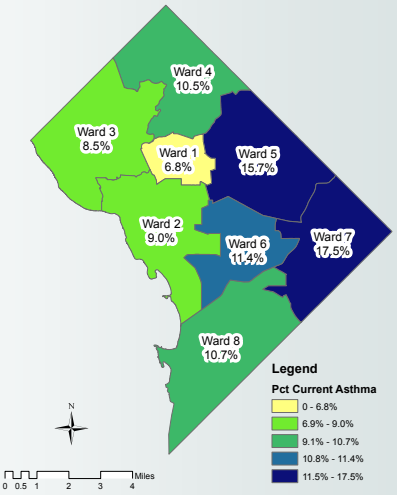
Goal Not Met: Reduce the overall asthma morbidity rate, as measured by a reduction in the asthma hospitalization rate, to 10 per 10,000 people.

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

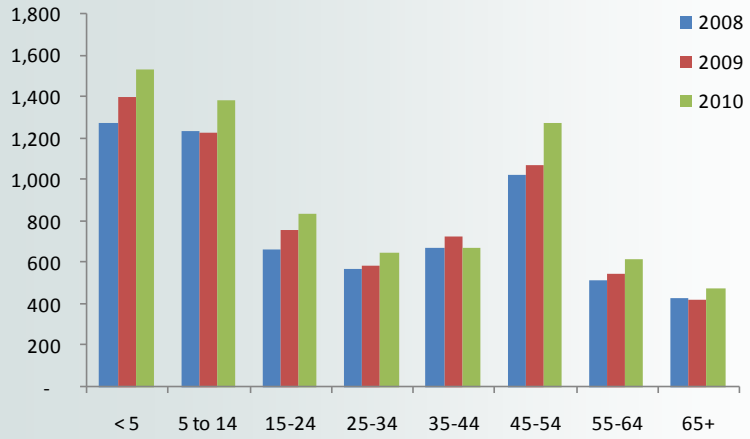


Figure 110. Adult Asthma Prevalence, National vs. District of Columbia (BRFSS Data), 2006-2010

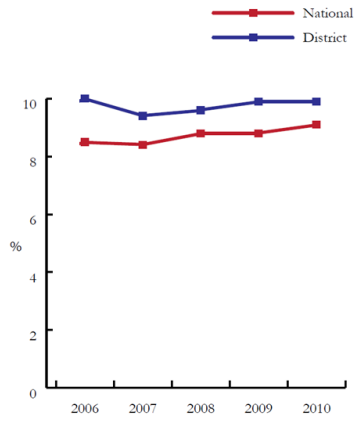


Figure 111. Hospitalizations due to Asthma, District of Columbia, 2008-2011

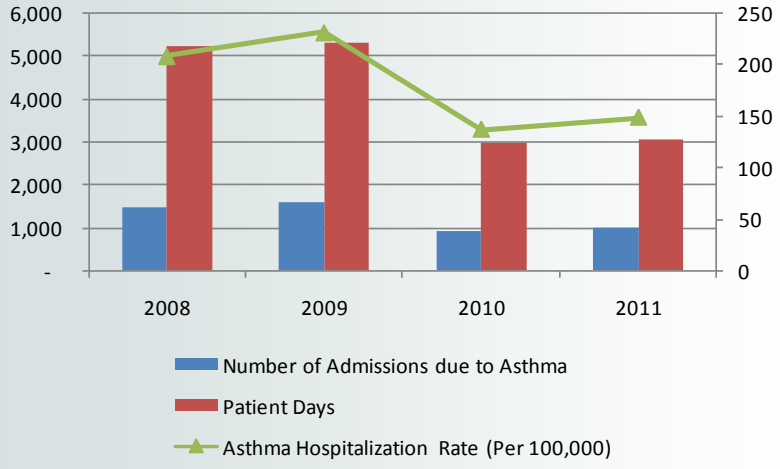
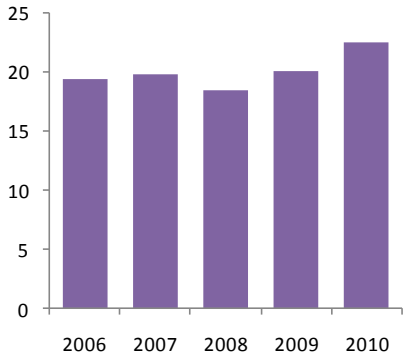


Figure 112. Child Asthma Prevalence Rate, District of Columbia, 2006-2010



- 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.

Source: District of Columbia Hospital Association

- 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.

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

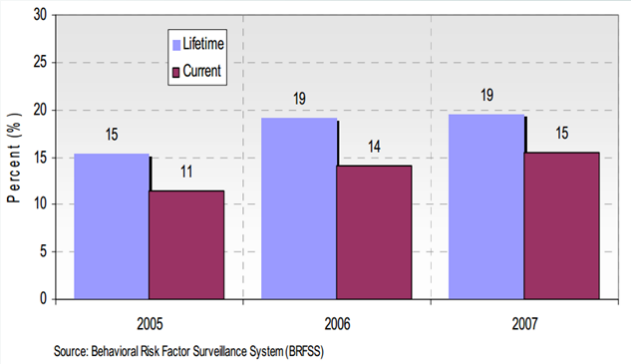


Figure 114. Asthma Prevalence among Children (0-17 yrs) by Age Group, District of Columbia, 2007

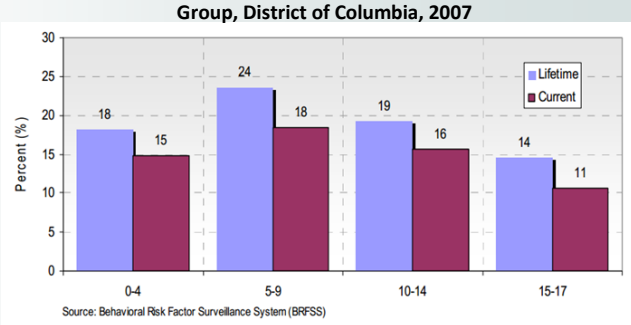


Figure 115. Asthma Prevalence among Children (0-17 yrs) by Race/ Ethnicity, District of Columbia, 2007

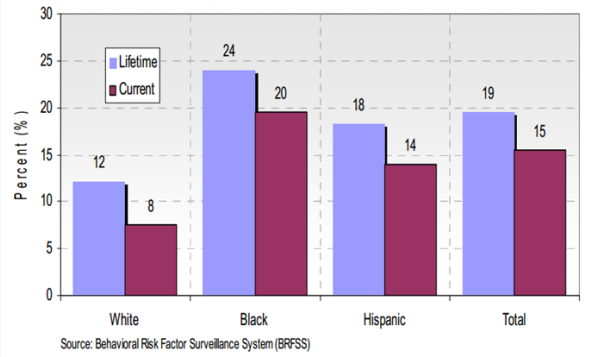
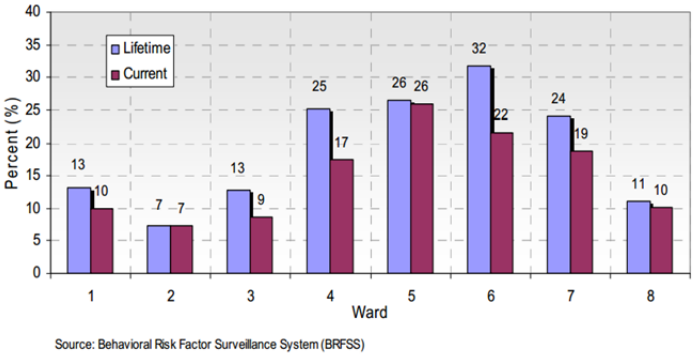


Figure 116. Asthma Prevalence among Children (0-17 yrs) by Ward, District of Columbia, 2007



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

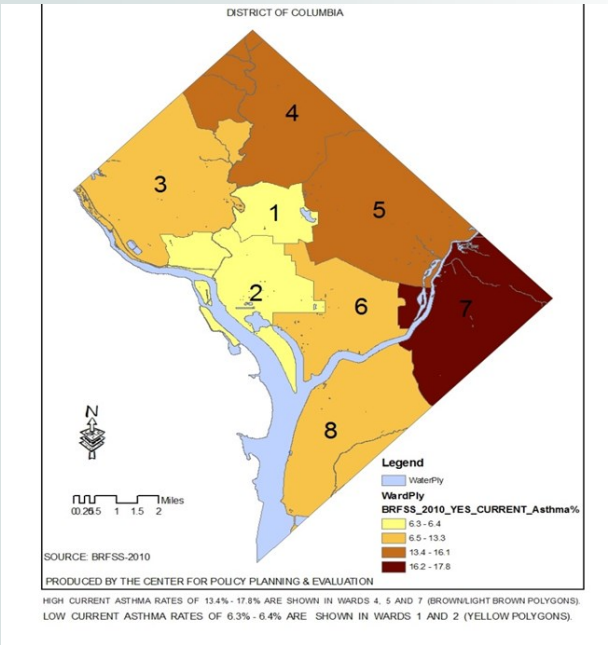


Figure 118. Distribution of Lifetime Asthma, 2010

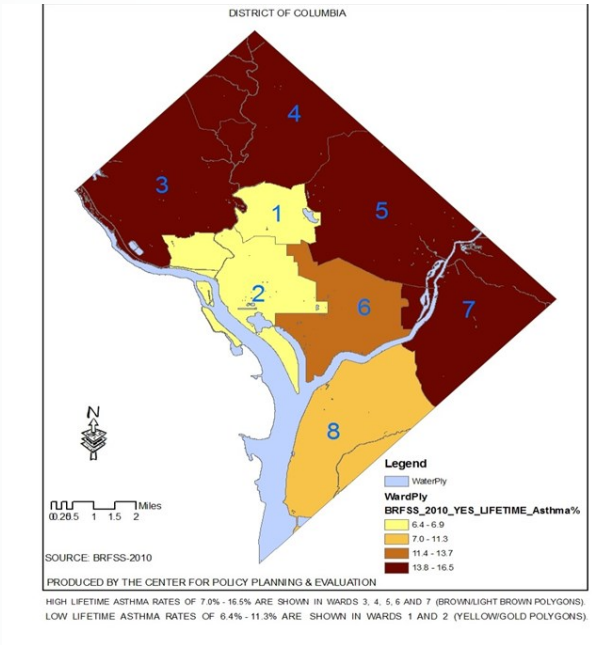


Figure 119. Distribution of Asthma Hospital Discharges, 2010

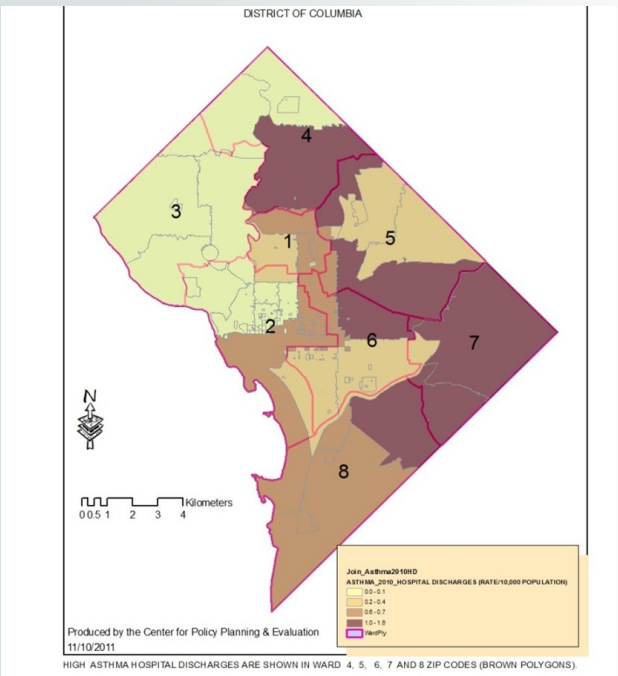
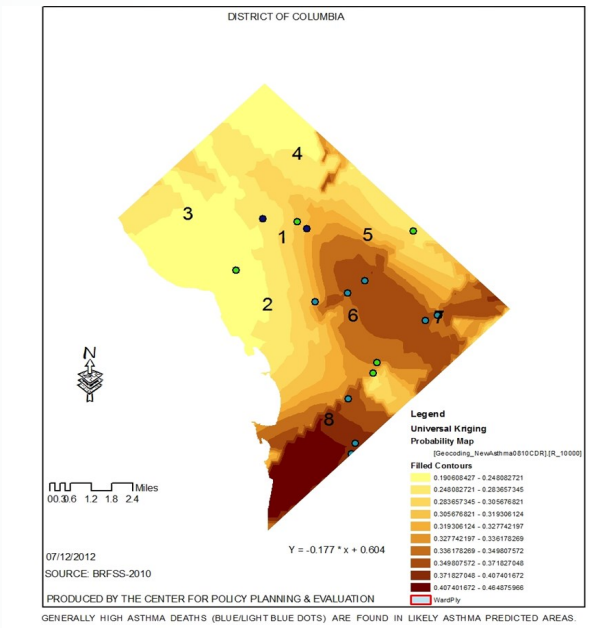


Figure 120. Comparison of Current Asthma Deaths and Probability of Asthma Deaths, 2010



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.

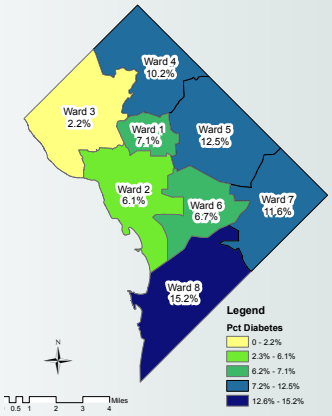
Goal Attained: Increase the proportion of persons with diabetes who have an annual dilated eye examination to 75 percent; the District's rate is 82.8 percent.

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

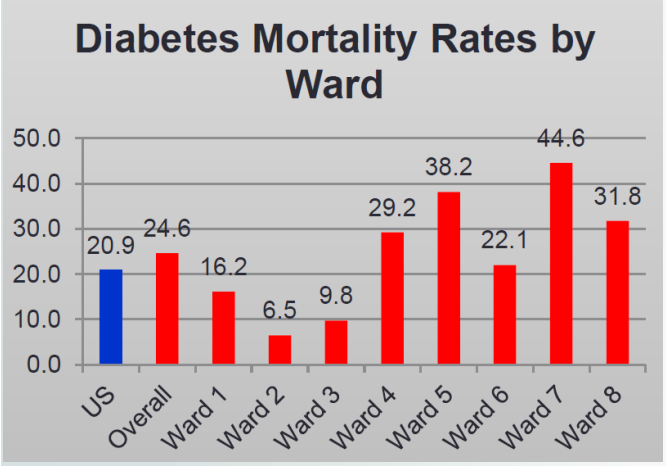
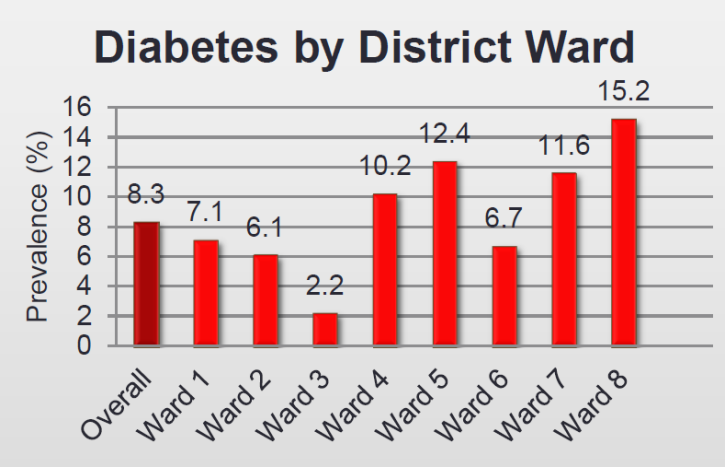
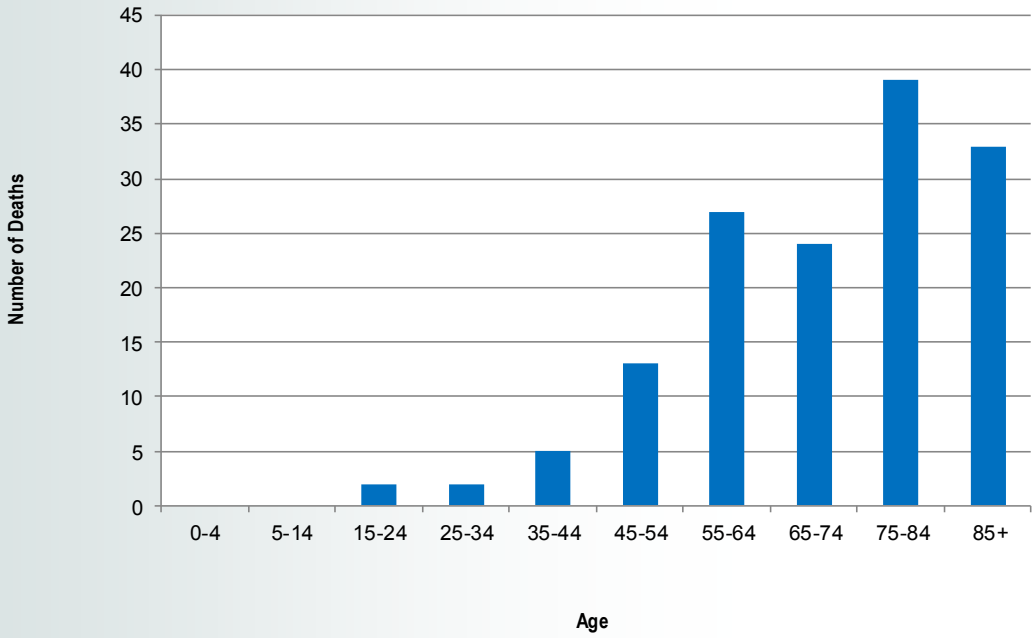


Figure 123. Prevalence of Diabetes by Ward, 2010



- 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

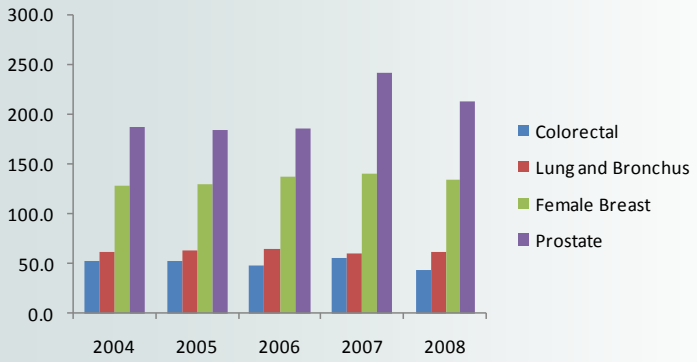
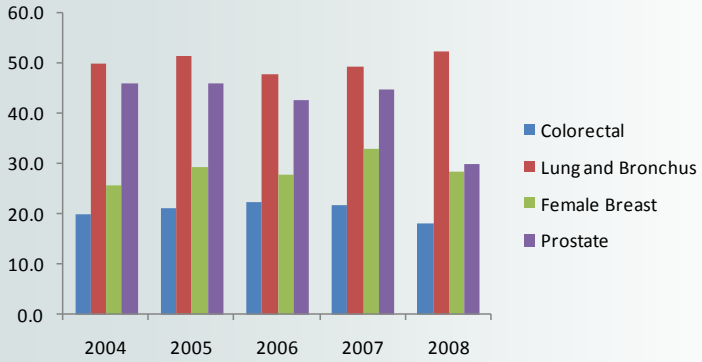


Figure 126. Age-adjusted Cancer Mortality Rate by Site, 2004-2008



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.

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.

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.

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 deaths from heart disease to no more than 230.2 per 100,000 people.

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.

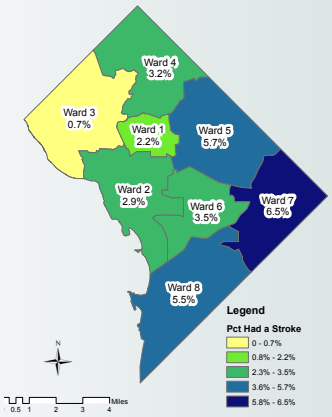
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have ever been told by a doctor, nurse or other health professional that they have heart disease.

- 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

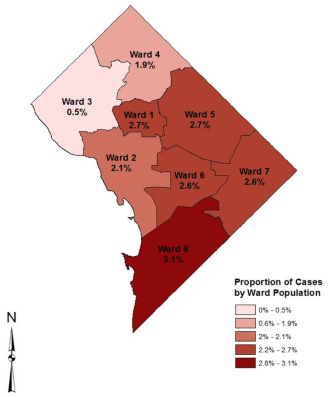
Goal Attained: Increase by 2.5 percent annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP); in 2010 ADAP enrollment was 2,638 (quarterly average).

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

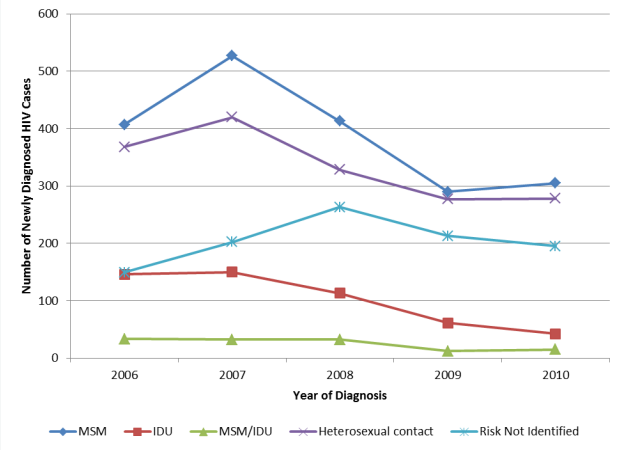


Figure 130. Time Between HIV Initial Diagnosis and Entry into Care as Evidenced by First CD4 Count, Percentage or Viral Load Test among HIV/AIDS Cases by Year of HIV Diagnosis, District of Columbia, 2006-2010

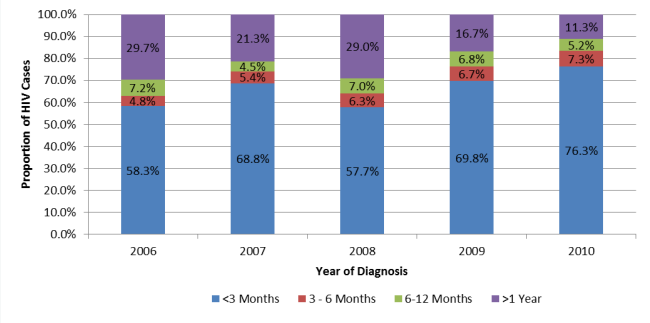
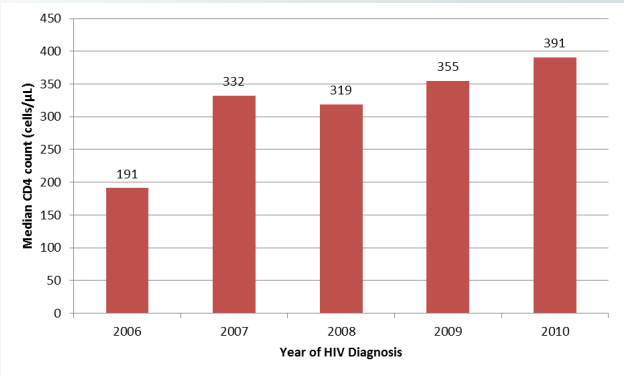


Figure 131. Median CD4 Cell Count at Diagnosis for HIV Cases by Year of HIV Diagnosis, District of Columbia, 2006-2010



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

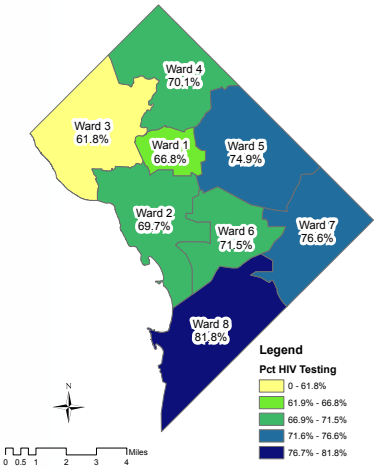
Healthy People 2010 Objectives

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

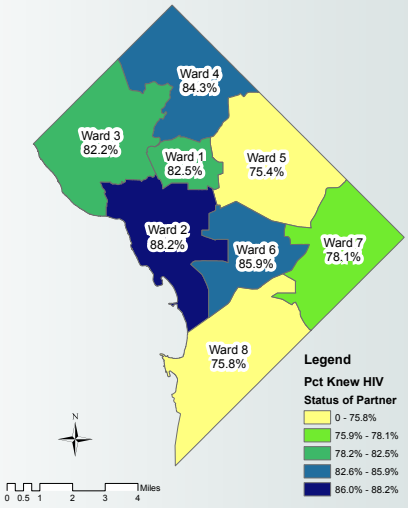
District of Columbia	Percent Knew Partner HIV Status
TOTAL	80.2
Gender	
Male	80.7
Female	79.8
Age	
18-24	71.8
25-34	85.7
35-44	84.5
45-54	80.1
55-64	70.6
Race/Ethnicity	
Caucasian	86.5
African American	74.8
Asian	86.3
Other	72.2
Hispanic	78.8
Education	
Less than High School	71.4
High School Graduate	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

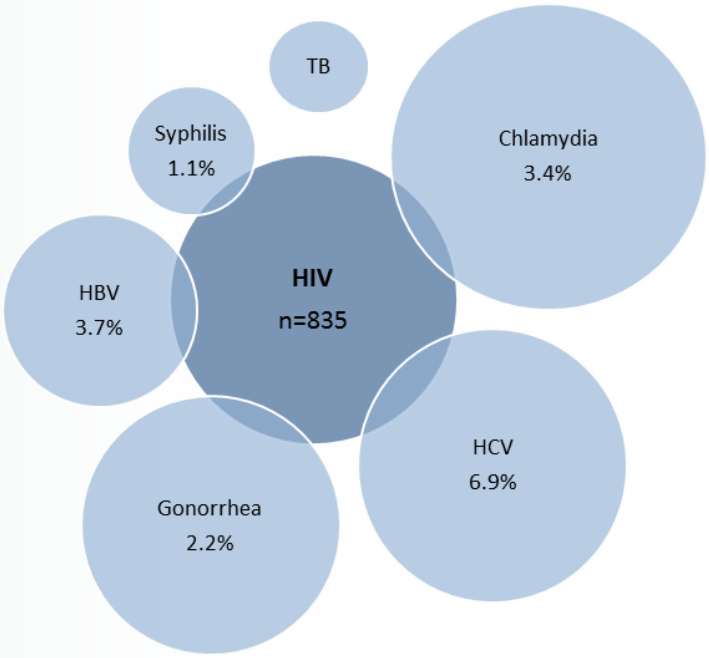
Source: HIV/AIDS, Hepatitis, STD and TB Administration (HASTA), DC Department of Health

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



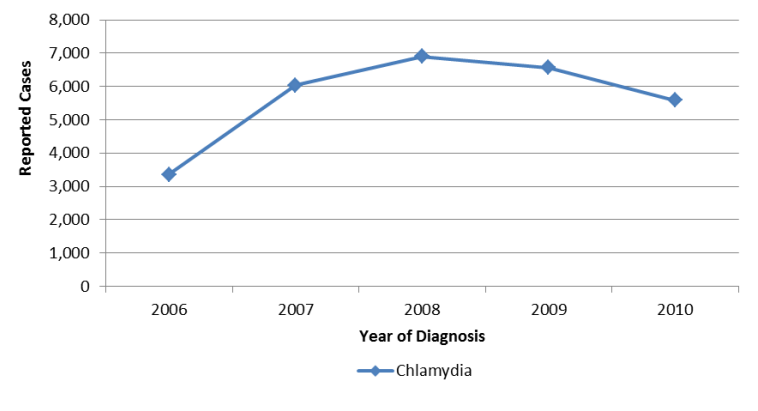
CHLAMYDIA

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

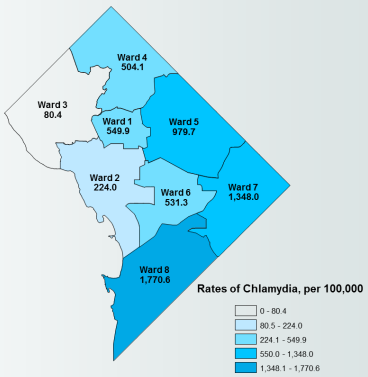
Goal Not Met: Reduce the prevalence of Chlamydia trachomatis infections among young persons (15 to 24 years old) to no more than 3 percent; the District's rate is 3.9 percent.

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

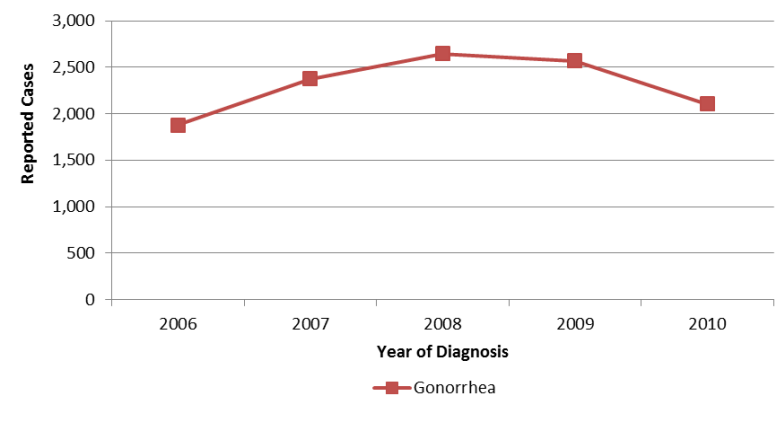
Healthy People 2010 Objectives

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.

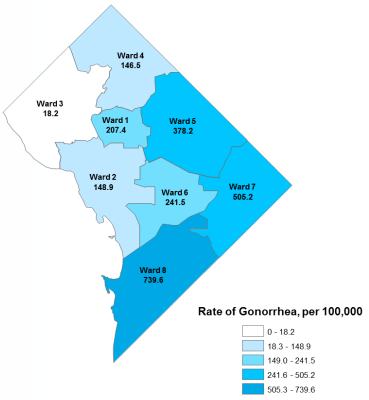
Goal Not Met: Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000; the District's rate is 397 cases per 100,000 women.

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

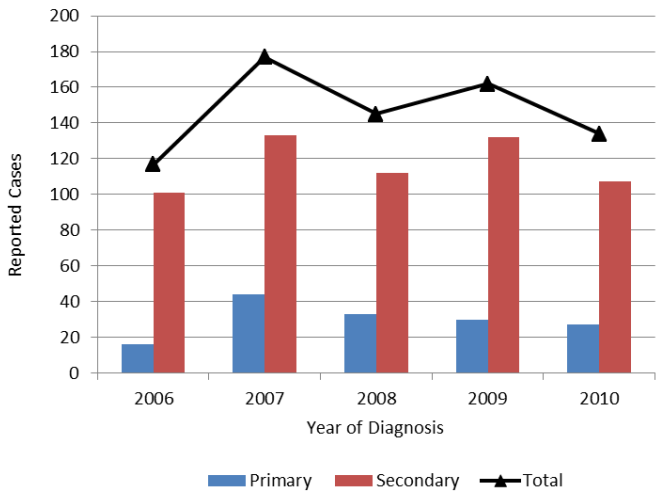
District of Columbia	Rate per 100,000 Population
TOTAL	22.3
Type	
Primary	4.5
Secondary	17.8
Gender	
Male	46.4
Female	-
Age	
0-14	-
15-19	17.5
20-24	31.2
25-29	34.5
30-39	37.7
40+	18.7
Race	
Black	23.3
White	20.3
Asian	28.1
AI/AN	-
Other	21.6
Ethnicity	
Hispanic	20.1
Non-Hispanic	22.1
Ward Comparison	
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

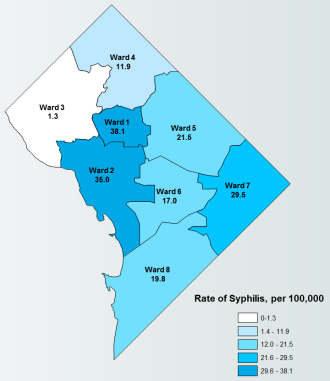
Goal Not Met: Reduce the incidence of primary and secondary syphilis to no more than three cases per100,000 people; the District's rate is 22 per 100,000.

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.

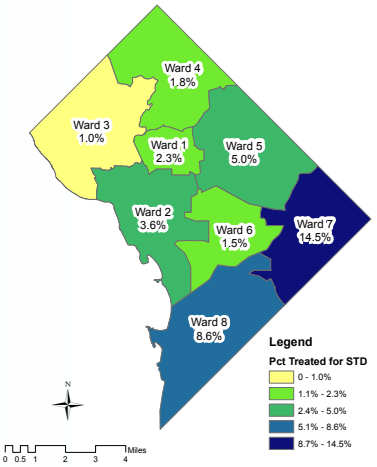
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they have ever been treated for an STD in the past 12 months.

- 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

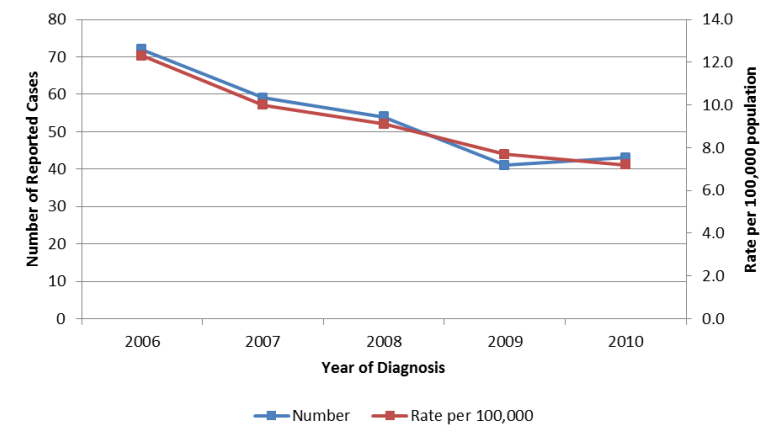
Healthy People 2010 Objectives

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.

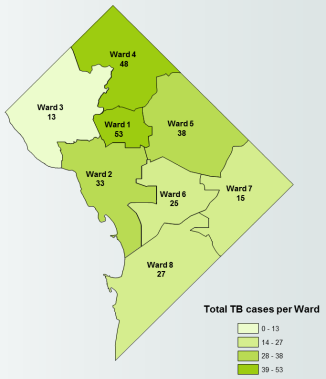
Goal Not Met: Increase to 90 percent the proportion of close contacts of persons infected with TB who complete the recommended courses in preventive therapy; the District's rate is 26 percent.

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.

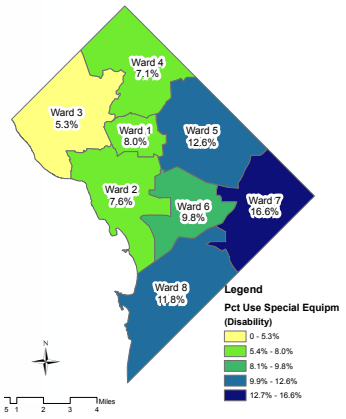
District residents who participated in the Behavioral Risk Factor Surveillance System (BRFSS) survey were asked if they were limited in any way in their activities because of physical, mental or emotional problems.

- 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).

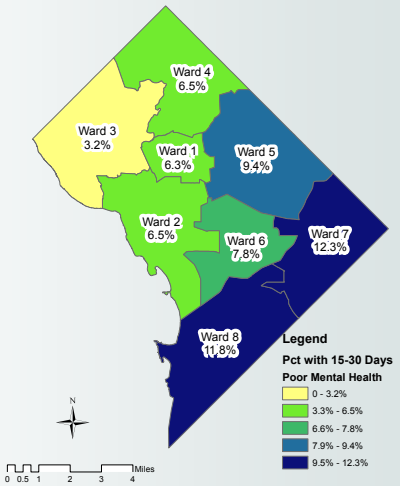
Goal Attained: Increase to 5 percent annually the services to persons age 18 and older who are homeless with serious mental illness.

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

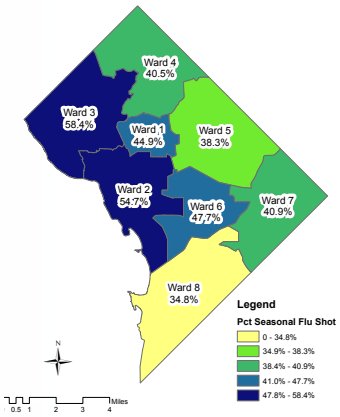
Goal Not Met: Increase the proportion of adult's age 65 and older who are vaccinated annually against influenza to 90 percent; the District's rate is 62 percent.

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



District of Columbia Community Health Needs Assessment

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

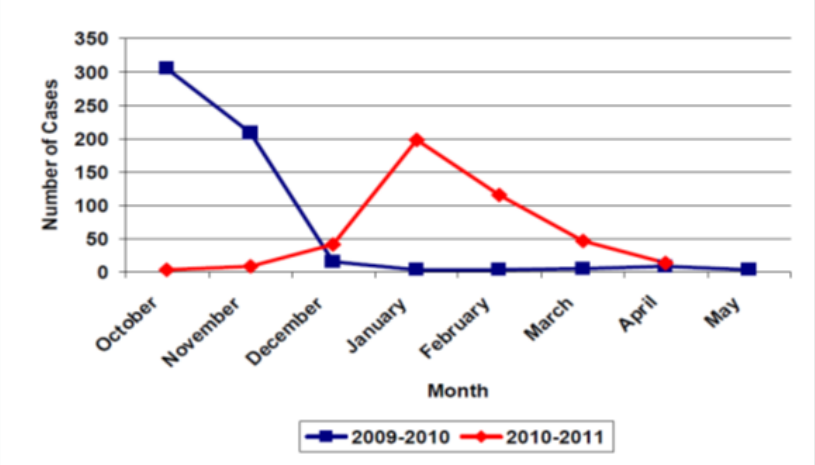


Figure 148. Time Trend Comparison of Influenza Cases among District Residents, 2009-2010 vs 2010-2011

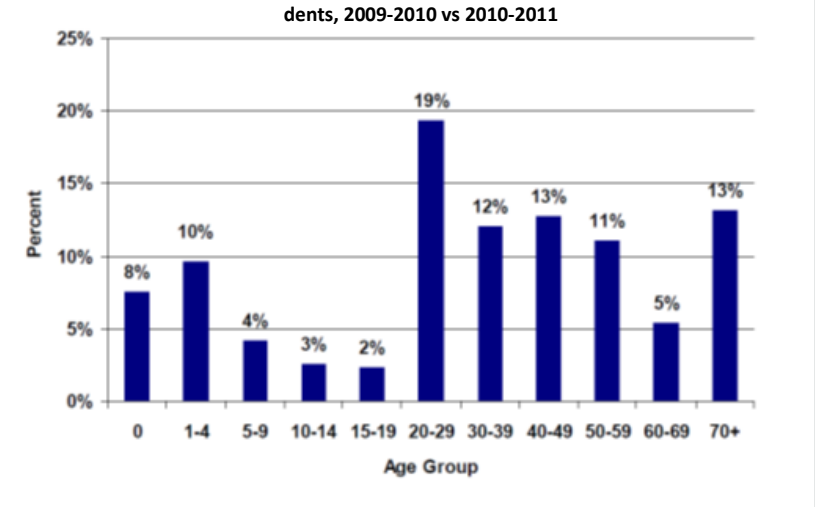
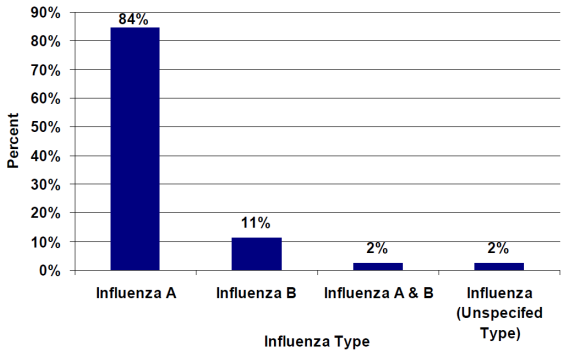


Figure 149. Distribution of Influenza Cases among District Residents, by Influenza Type, 2010-2011



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.

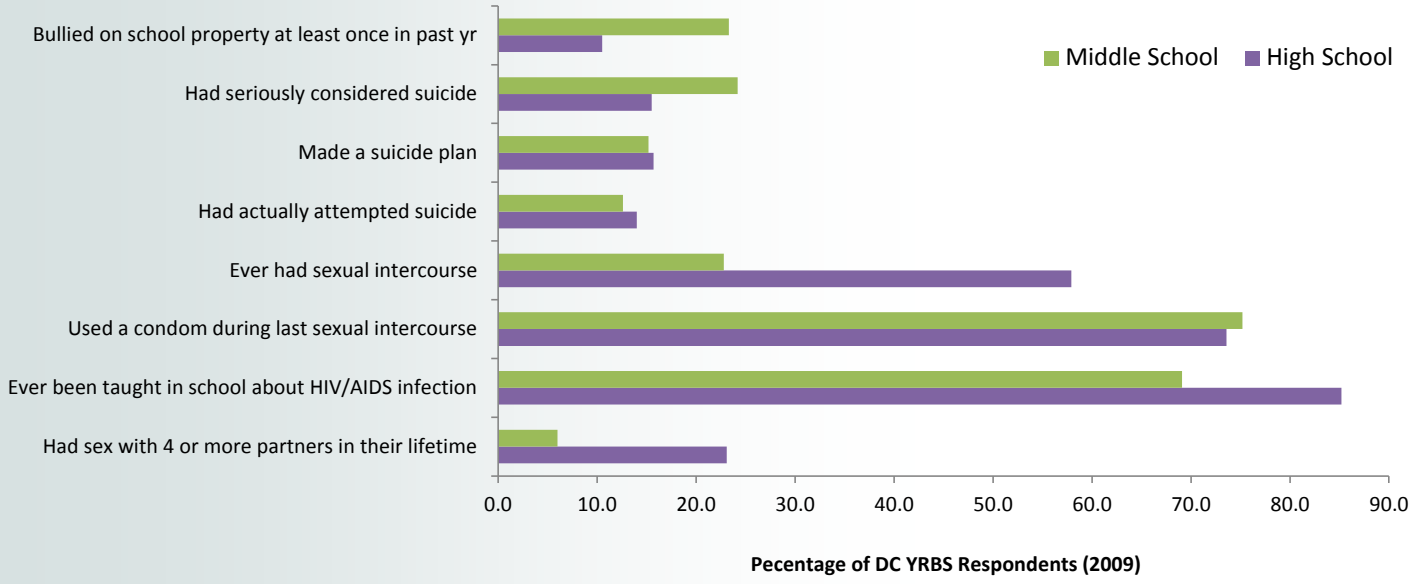
While 50 percent of youth live in Wards 7 and 8, less than 10 percent of the District's grocery stores are located there.

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).

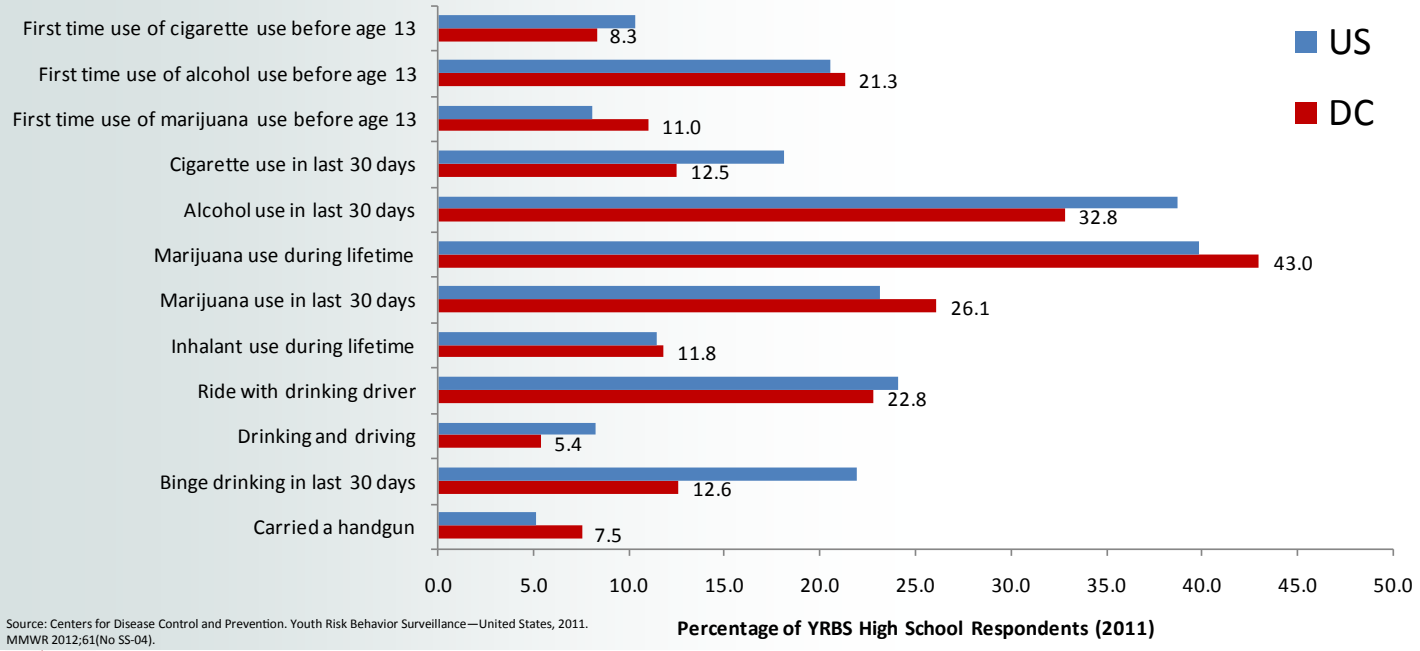
In 2007, an estimated 100 non-fatal traffic injuries in the District involved an underage driver that had been drinking.

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

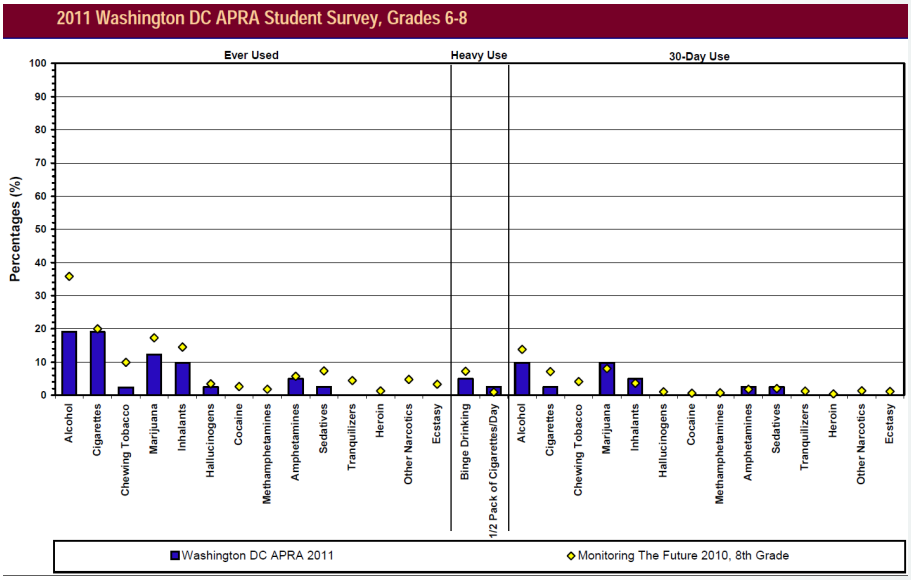
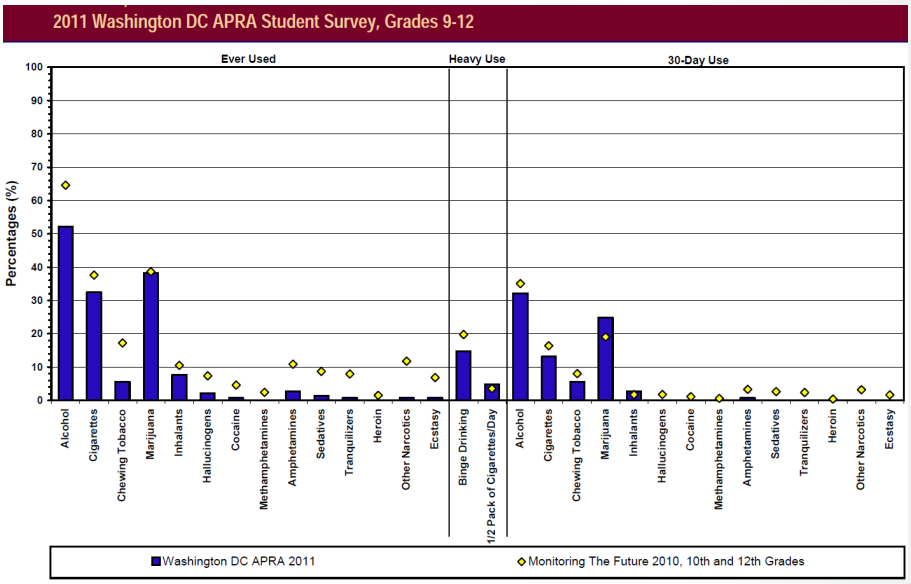


Figure 153. Lifetime, 30-Day, and Heavy Alcohol, Tobacco, and Other Drug Use, Grades 9-12



- 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.

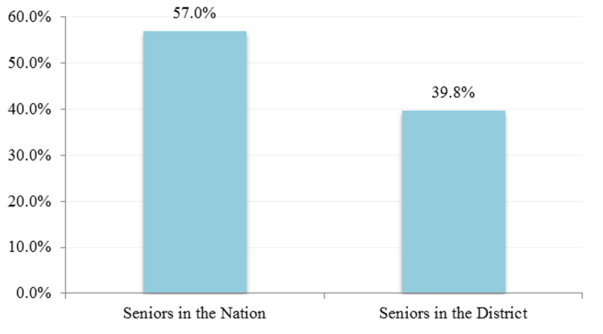
Community Leadership Input on Substance Use at the Ward Level

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

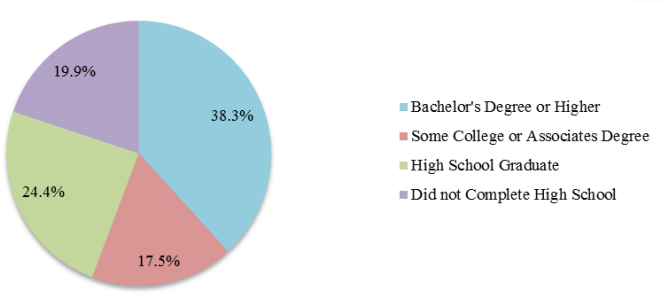
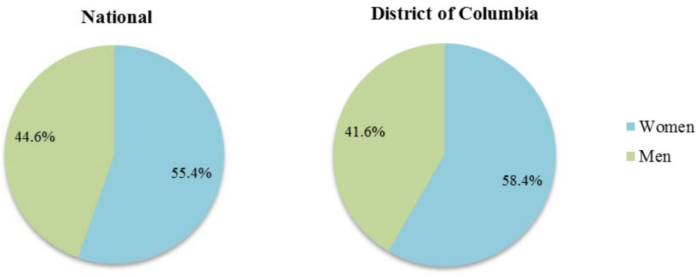


Figure 156. Senior Men and Women. National vs. District of Columbia

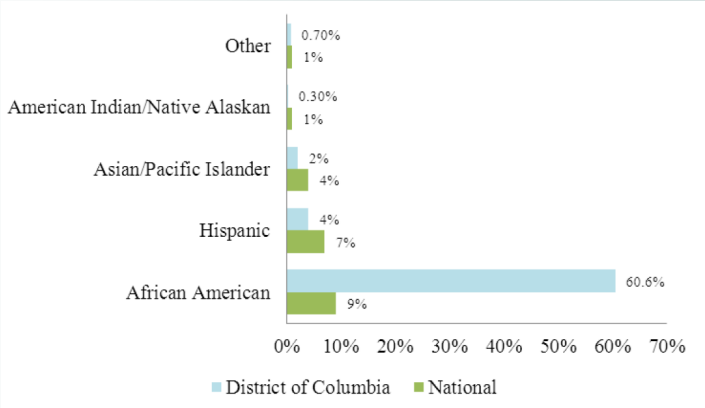


Medicare Facts At-a-Glance

	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

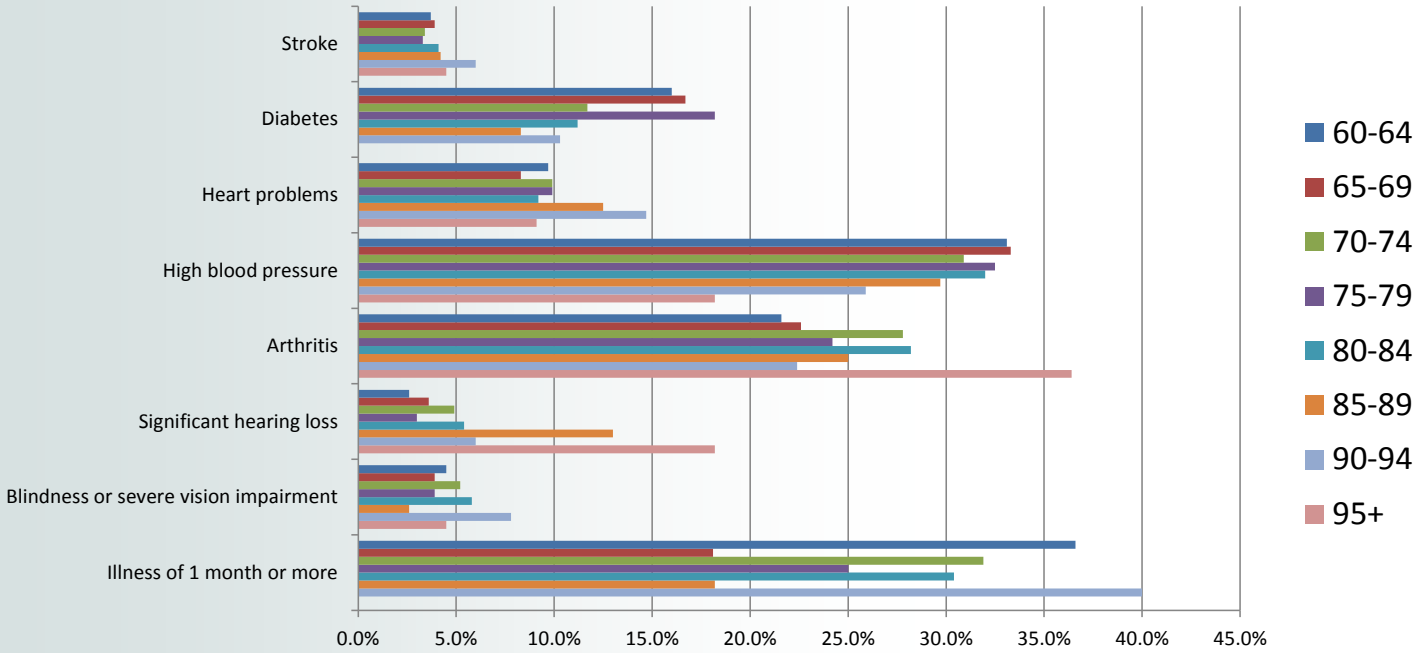
Figure 157. Distribution of Senior Minority, National vs. District of Columbia



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

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

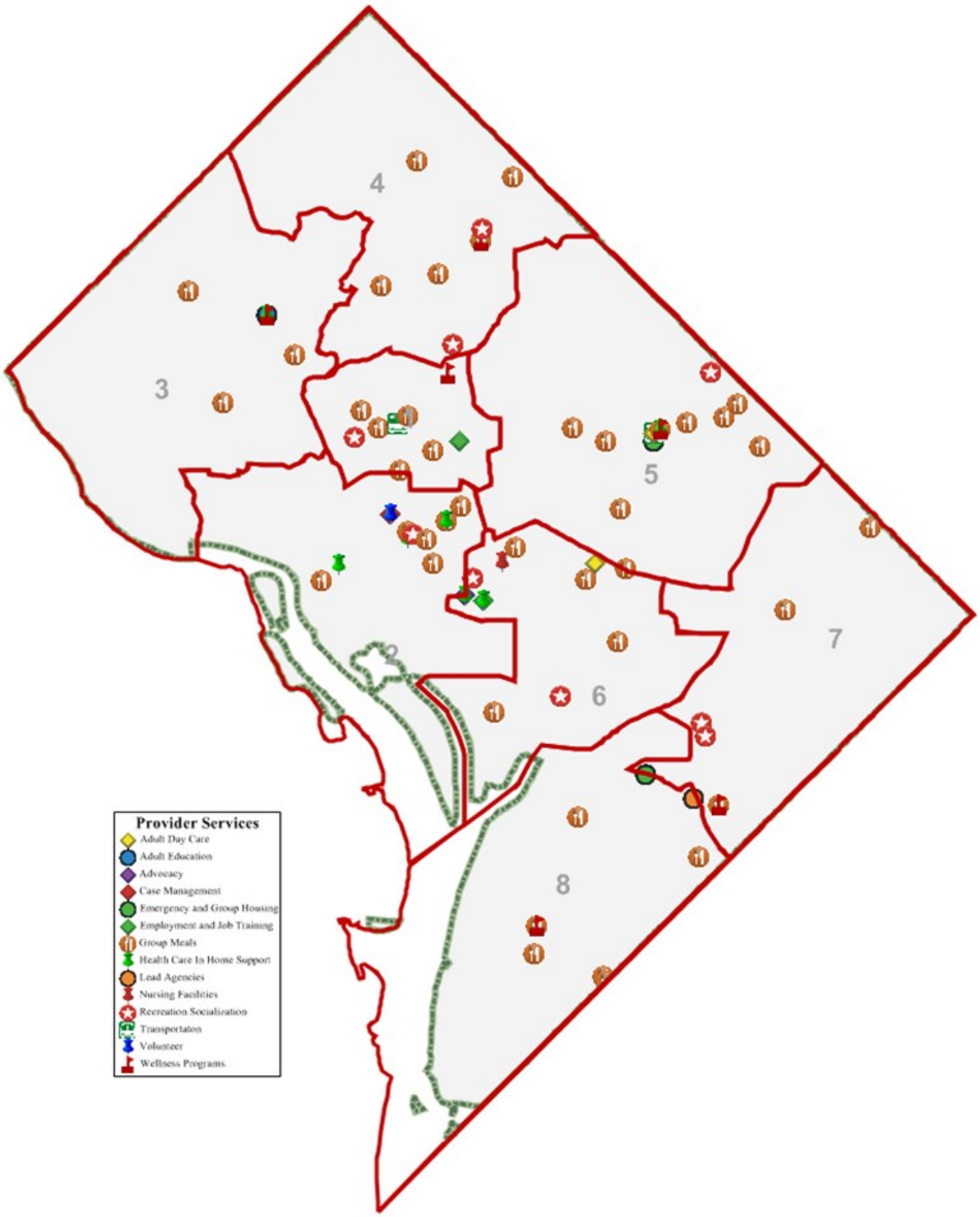
Chronic diseases, including heart disease and cancer, have caused most of the deaths among the elderly in the District.

- 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).

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

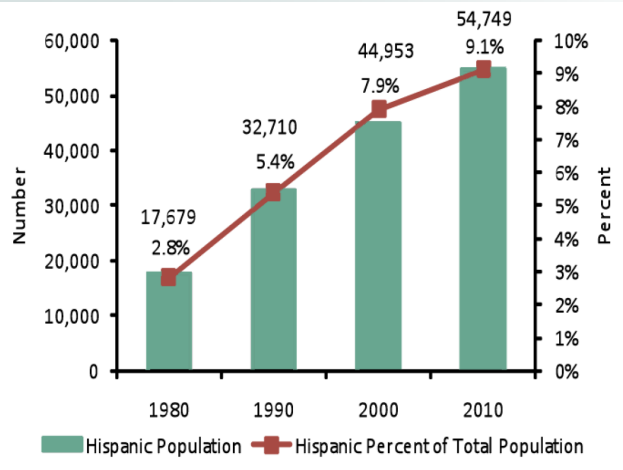
ACCESS TO CARE FOR SENIORS

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



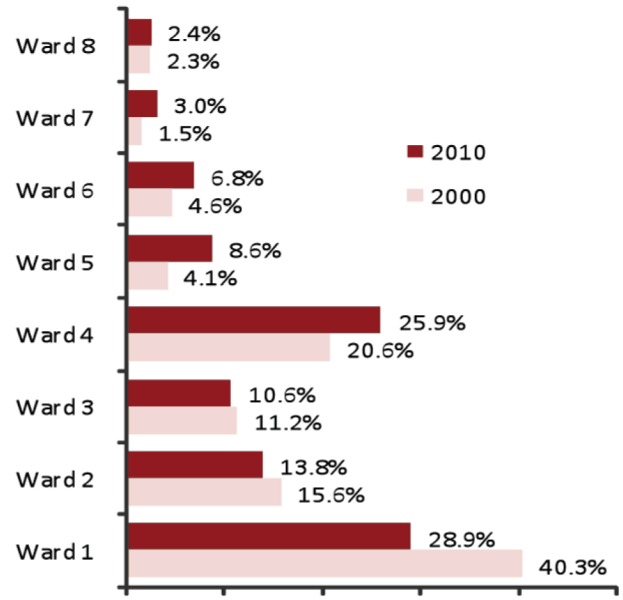
Source: U.S. Census Bureau, Census 2000 and Census 2010

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

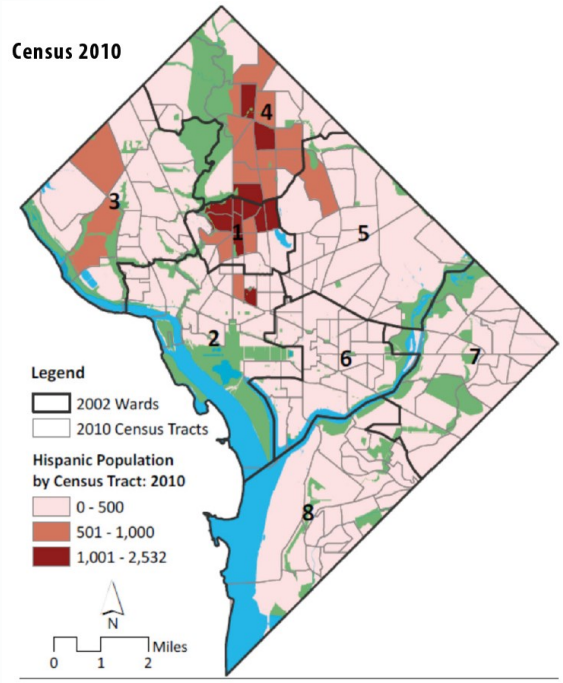
- Between 2000 and 2010, the Hispanic population in the District grew by 21.8 percent, rising from 44,953 in 2000 to 54,749 in 2010 and its share of the total population rose to 9.1 percent from 7.9 percent in 2000.
- Hispanic accounted for one-third of the District's total population growth between 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

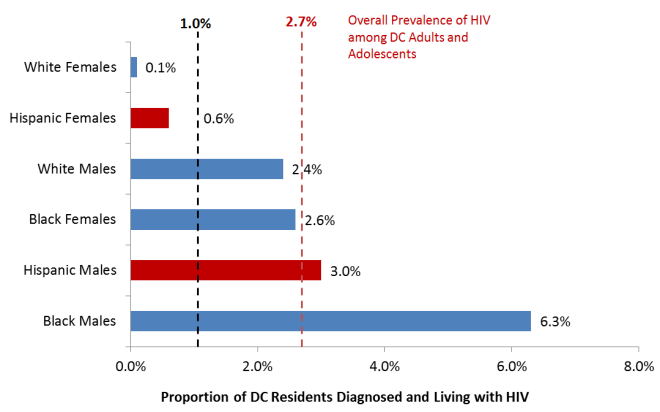
- Hispanic females were expected to live the longest in the District (88.9 years), followed closely by Hispanic males (88.4 years), non-Hispanic white females (85.2 years), and non-Hispanic white males (83.2 years).
- The largest differential is between Hispanics and non-Hispanic blacks, the former having 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. 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. GLBT face 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.[1]

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.
- Transgender is a term inclusive of transgender, transsexual, and gender variant identities of people who no longer express or identify their genders with their birth sex. Transgenders include Male-to-Females (MTFs), Female-to-Males (FTMs), and others who self-identify using over 100 identity terms[2].
- 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 transgenders 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]http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1070935/pdf/wjm17200403.pdf

[2]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.

[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.

ONE CITY Summit

ONE CITY, ONE FUTURE

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

Figure 165. Primary Care Physicians and Specialists Practicing in the District, by Ward and Count

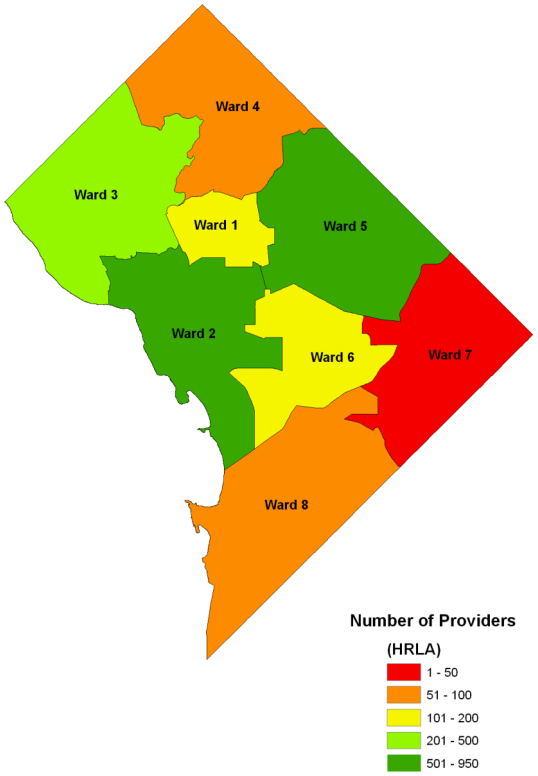
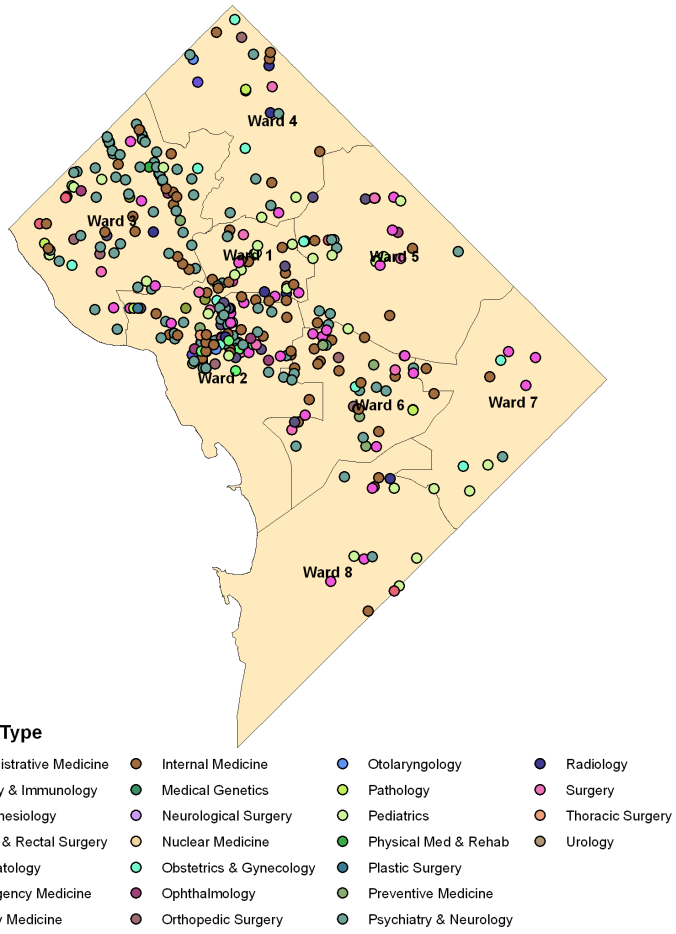


Figure 166. Primary Care Physicians and Specialists Practicing in the District, by Area of Expertise



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figure 167. Spatial Distribution of District of Columbia Hospitals

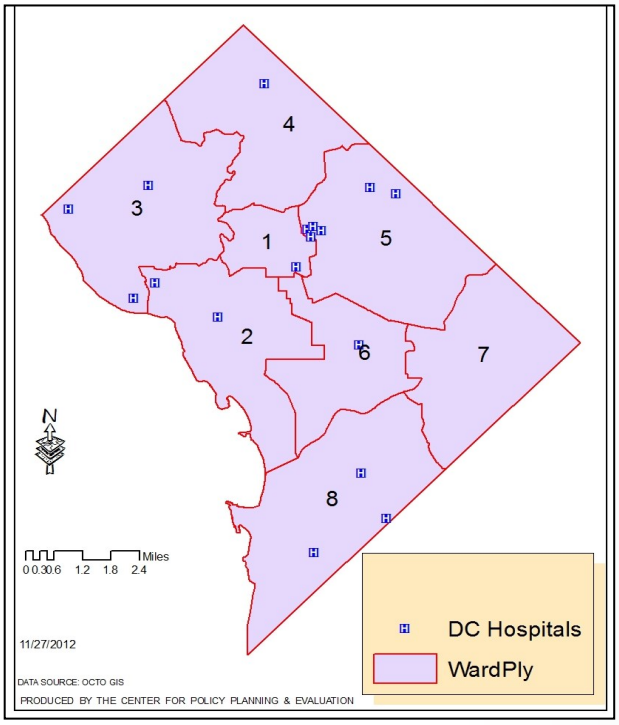


Figure 168. Spatial Distribution of Federal Facilities

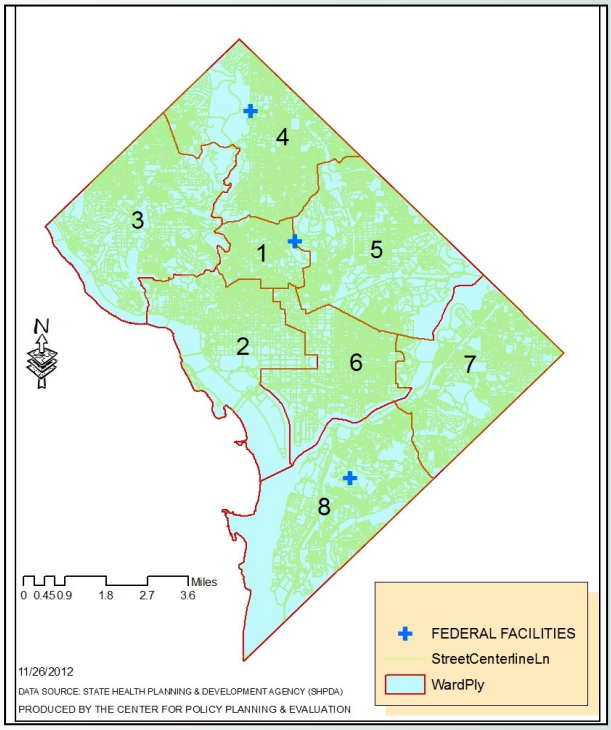


Figure 169. Spatial Distribution of Ambulatory Care Centers

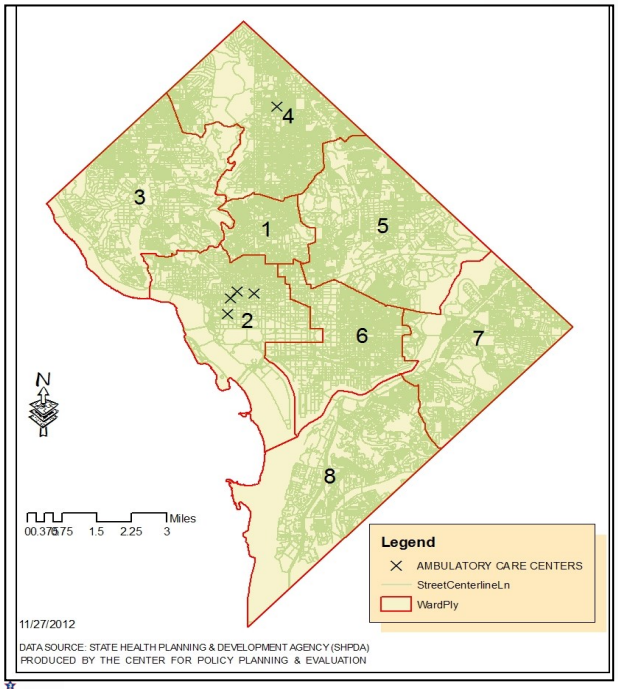
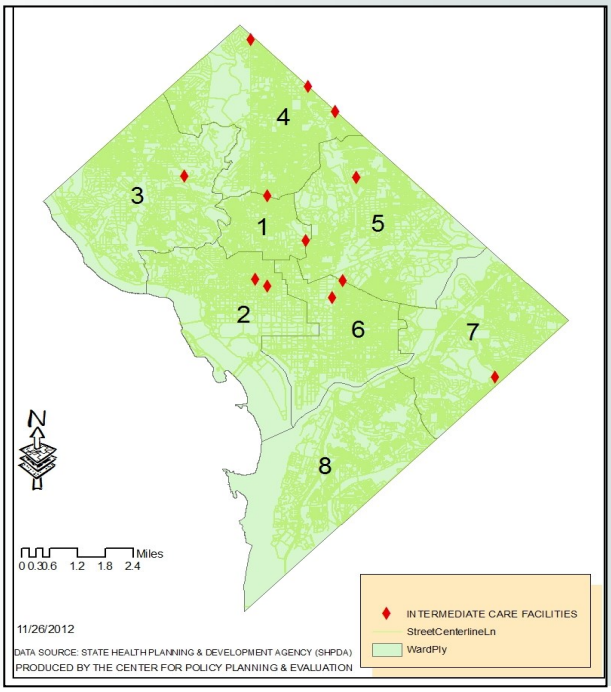


Figure 170. Spatial Distribution of Intermediate Care Facilities



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figure 171. Spatial Distribution of Home Health Agencies

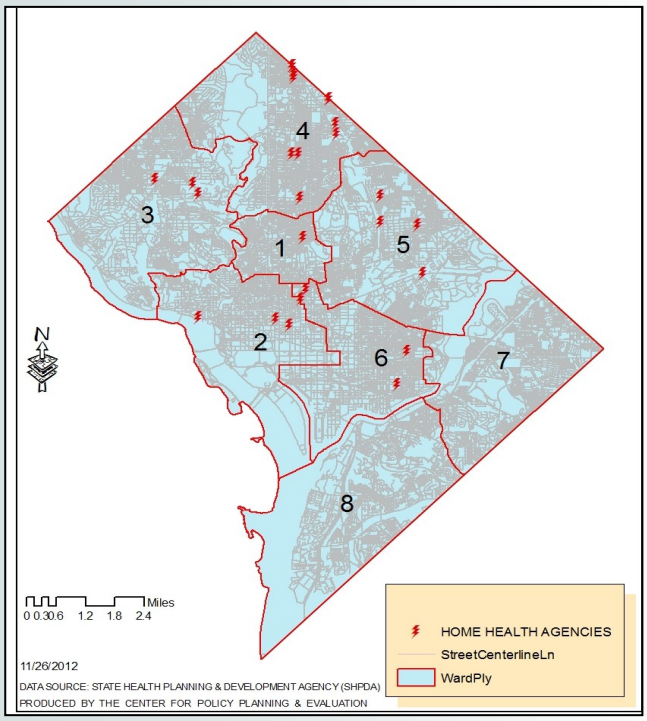


Figure 172. Spatial Distribution of Community Health Centers

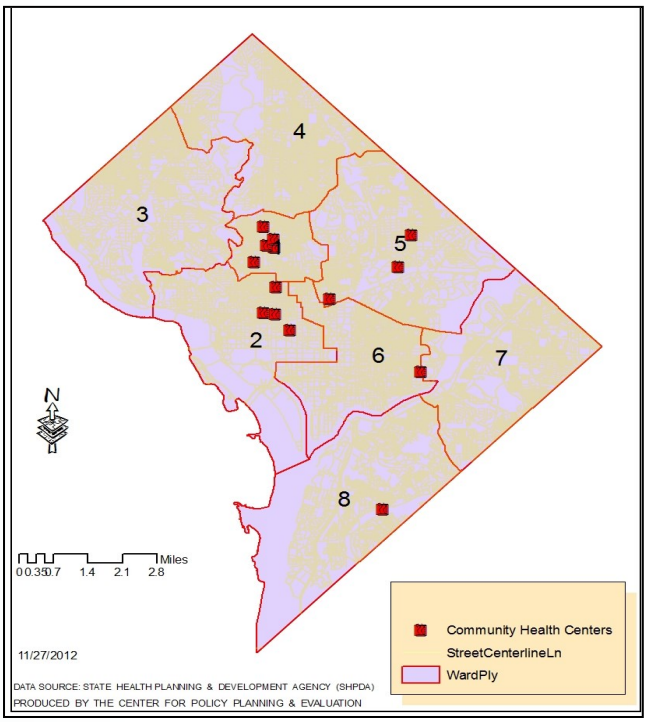


Figure 173. Spatial Distribution of Nursing Homes

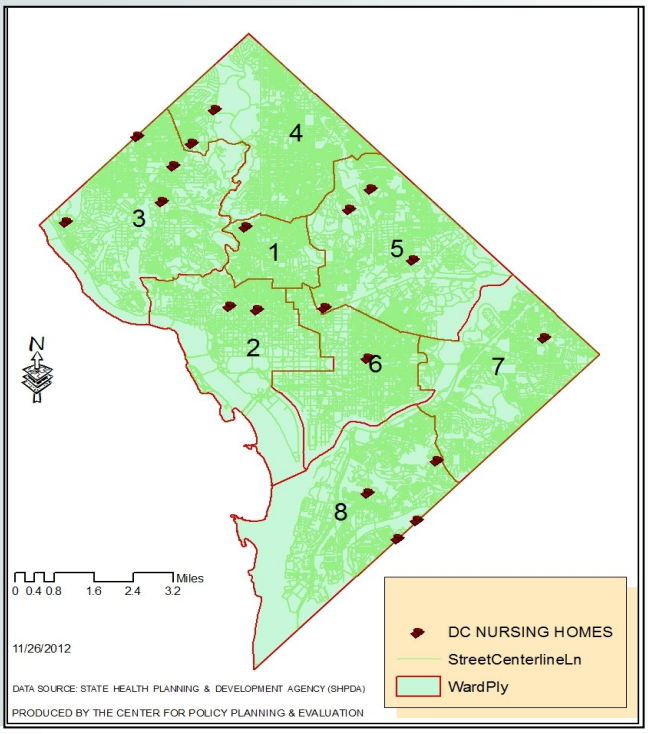
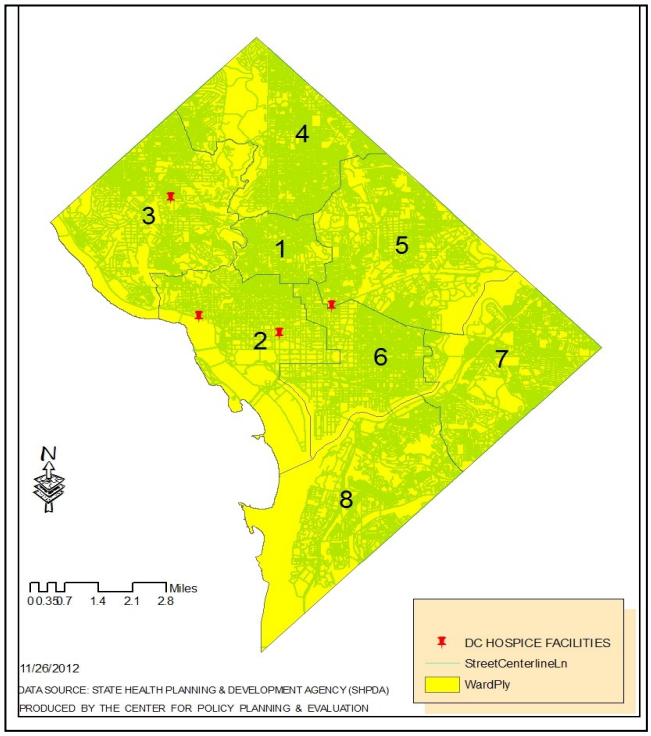


Figure 174. Spatial Distribution of Hospice Facilities



GEOGRAPHIC DISTRIBUTION OF HEALTH CARE FACILITIES IN THE DISTRICT

Figure 175. Spatial Distribution of Mental Health Facilities

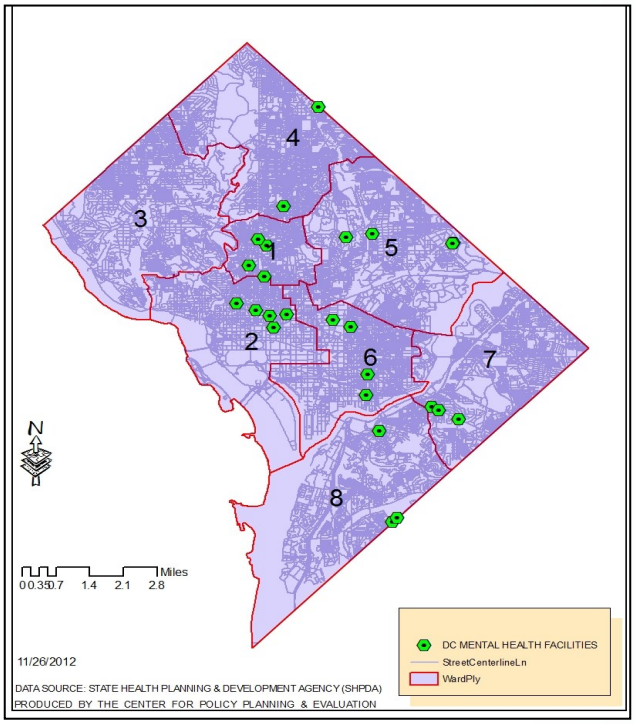


Figure 176. Spatial Distribution of Substance Abuse Treatment Centers

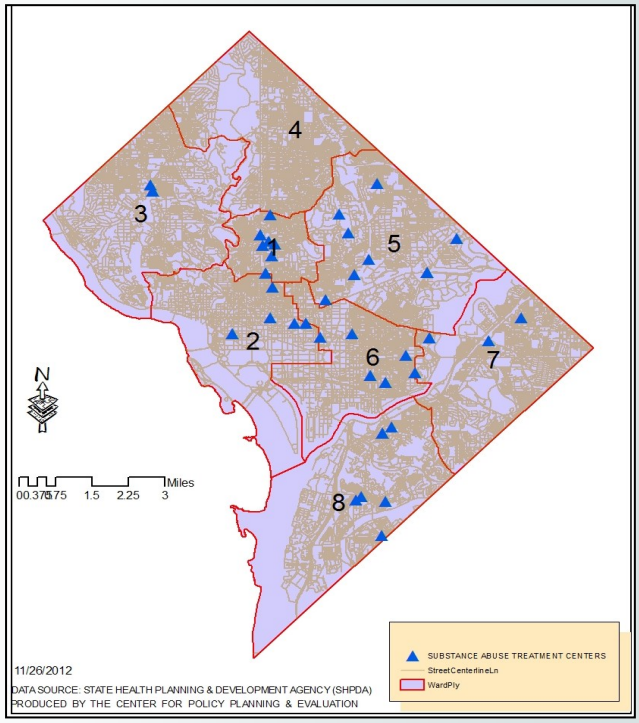


Figure 177. Spatial Distribution of End-Stage Renal Disease Facilities

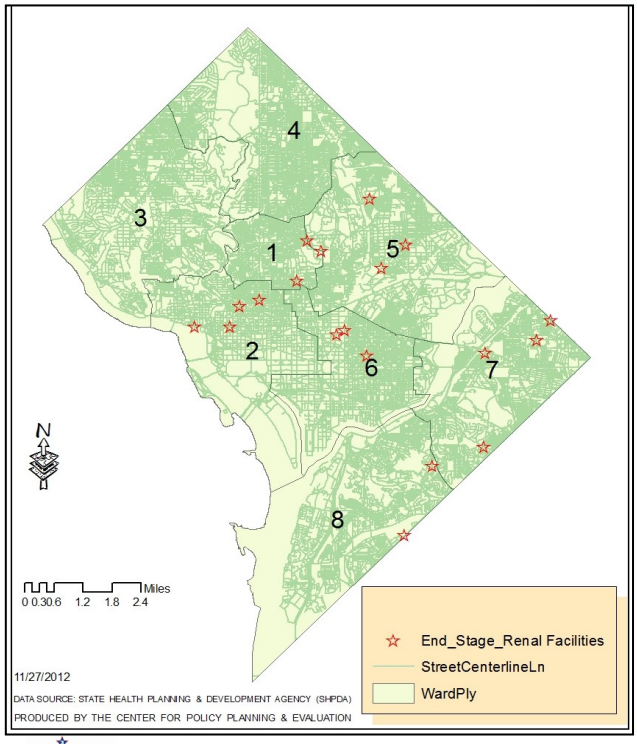
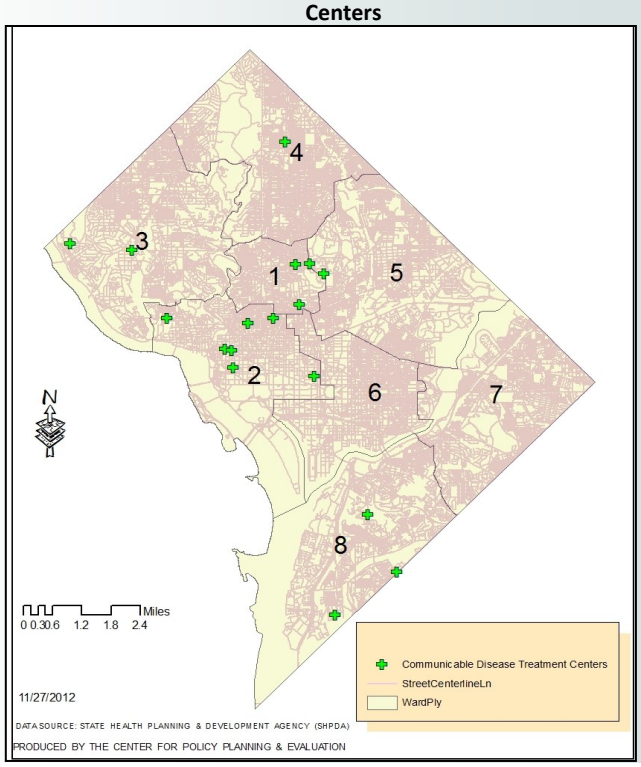


Figure 178. Spatial Distribution of Communicable Disease Treatment Centers



CONCLUSION AND RECOMMENDATION

CONCLUSION AND RECOMMENDATION

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.

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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.

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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.

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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

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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

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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

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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*

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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).

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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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