Revised 3/15/2013

DISTRICT OF COLUMBIA COMMUNITY HEALTH NEEDS ASSESSMENT, Volume 1

ONE CITY

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH
Promote. Prevent. Protect.

ACKNOWLEDGMENTS

The Community Health Needs Assessment (CHNA) was completed by the combined efforts of many individuals in the District of Columbia Department of Health. In addition, this report would not have been possible without the hard work, dedication, and contribution of health care providers, community groups, researchers, and members of the community.

Government of the District of Columbia

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The District of Columbia Department of Health (DC DOH) would like to express its appreciation to Domain 1 Workgroup of the DC DOH Accreditation Team for its efforts in spearheading the development and completion of the CHNA. Special appreciation is extended to the following staff who gave their time generously and whose careful deliberations greatly enhanced the framework of the CHNA:

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ACKNOWLEDGMENTS

The DC DOH would like to thank the many partners from health care, public health, and advocacy communities who contributed and provided insights to the development of this document.

American Academy of Pediatrics

American Medical Association

District of Columbia Board of Medicine

District of Columbia Cancer Consortium

District of Columbia Department of the Environment

District of Columbia Department of Transportation

District of Columbia Hospital Association

District of Columbia Office on Aging

District of Columbia Office on Gay, Lesbian, Bisexual, and Transgender Affairs

District of Columbia Office of Planning

District of Columbia Office of the State Superintendent of Education

Kaiser Family Foundation

National Center for Health Statistics

National Highway Traffic Safety Administration

United States Bureau of Labor Statistics

United States Census Bureau

United States Centers for Disease Control and Prevention

United States Centers for Medicare & Medicaid Services

United States Federal Bureau of Investigation

District of Columbia Department of Health

Addiction, Prevention, and Recovery Administration

Center for Policy, Planning, and Evaluation

Community Health Administration

Health Emergency Preparedness and Response Administration

Health Regulation and Licensing Administration

HIV/AIDS, Hepatitis, STD, and TB Administration

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EXECUTIVE SUMMARY

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

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

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

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

SUMMARY HIGHLIGHTS

Key Indicators

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

Leading Causes of Death

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

Diseases and Disorders

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

SUMMARY HIGHLIGHTS

Ward Level

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

Access to Care

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

Health Behaviors and Risk Factors

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

SUMMARY HIGHLIGHTS

Racial Disparities

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

INTRODUCTION

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

In April 2012, Mayor Vincent C. Gray released his vision for a Sustainable DC:

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

The DC DOH understands that maintaining good health and wellness for individuals and communities depends on quality health care for the sick, as well as providing opportunities to prevent health problems and improve the basic health and well-being of District residents. A measure of the relative health of the total population of a community is its health profile or health status. Together with demographic and socio-economic data, health status indicators provide the basic information for defining the community's health needs and assessing the manner in which the health care system can meet those needs. This community needs assessment provides an overview of selected health indicators in the District under the following categories: *Mortality and Life Expectancy, Promoting Healthy Behaviors, Promoting Healthy and Safe Communities, Improving Access to Quality Healthcare Services, Preventing and Reducing Diseases and Disorders, Special Populations, and Community Partnerships*. This information will be used to reduce health disparities, improve health outcomes, identify gaps, allocate resources and develop and implement policies to further strengthen the health care system to ensure that there is equitable access to quality healthcare services for all residents in the District.

KEY INDICATORS AT-A-GLANCE

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

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

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

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

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Health Behaviors

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

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

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

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

METHODOLOGY

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

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

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

METHODOLOGY

Data Sources

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

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

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

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

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

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

Limitations

While this state-wide assessment presents many important issues and topics, it does not present every possible health-related issue. The issues and indicators selected are intended to show the scope and complexity of population health. Further, some indicators were derived from self-reported data which present potential sources of bias and should therefore be considered as a caveat.

The assessment also does not include the many programs and services that are currently implemented to address these health-related issues either by the Department of Health or by other stakeholders.

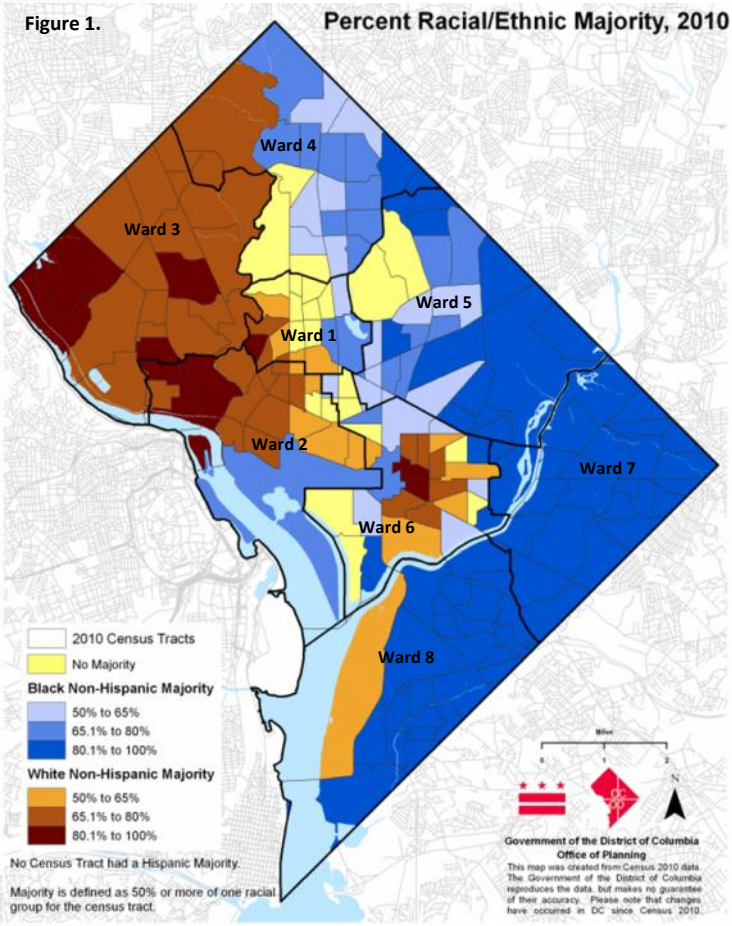
Demographic Characteristics of the District of Columbia

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

Figure 1. Percent Racial/Ethnic Majority, 2010



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

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

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

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

Source:

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

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

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

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

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

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

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

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

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

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

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

Figure 2.

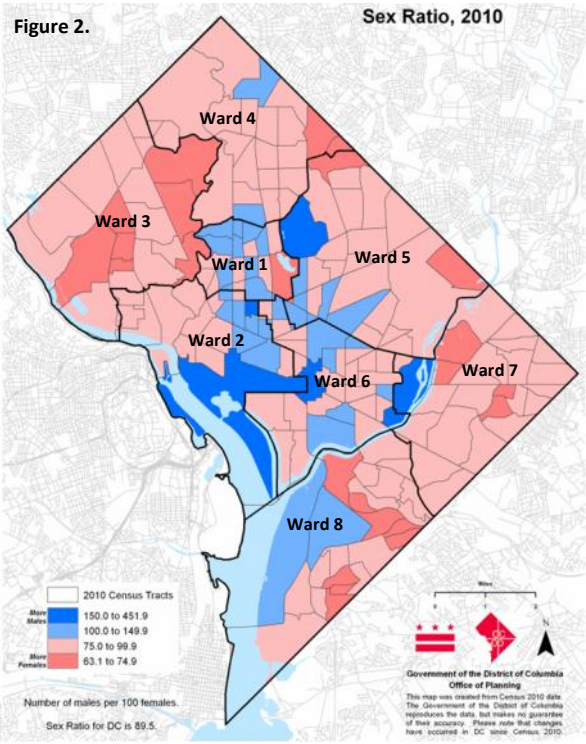


Figure 3.

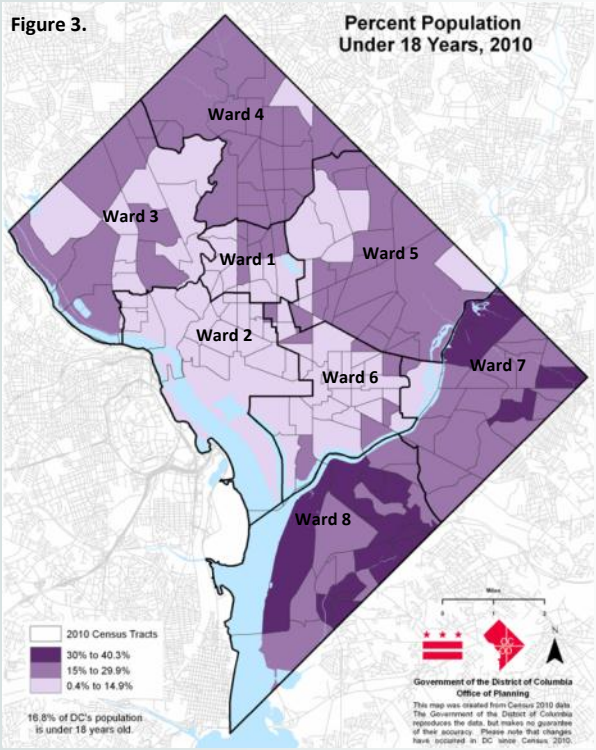
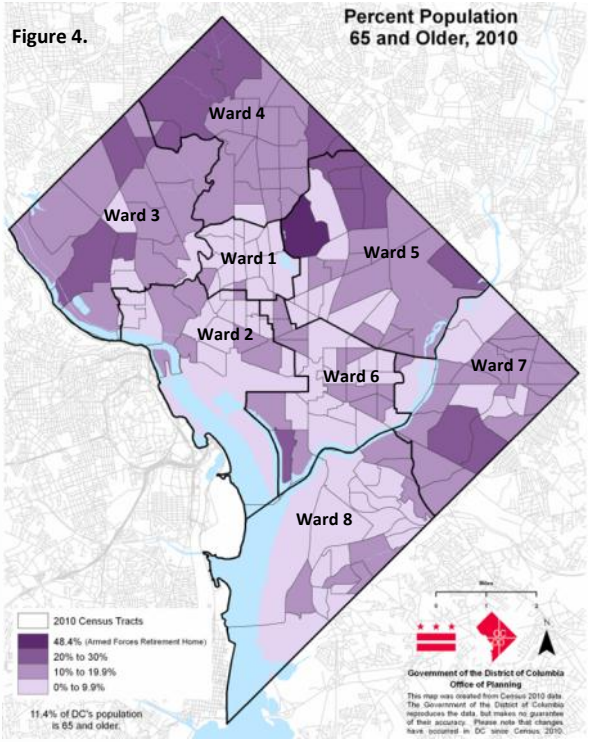


Figure 4.



Source:

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

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

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

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

Figure 5. Median Household Income, ACS 2006-2010

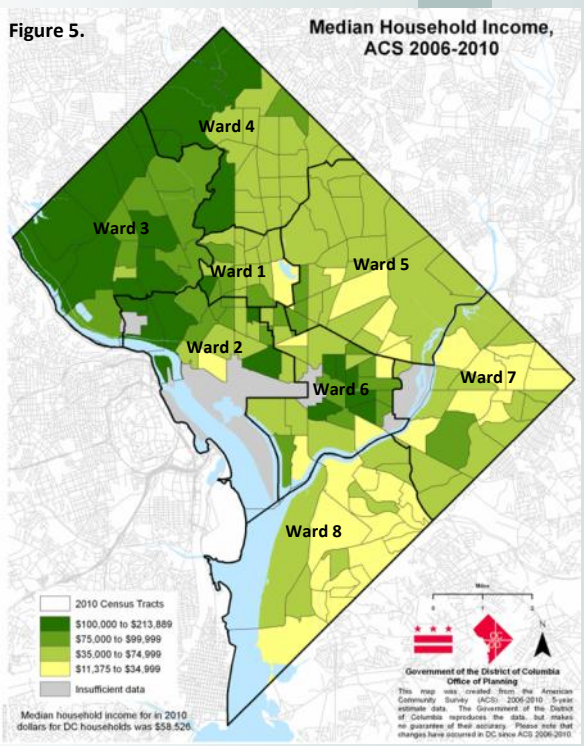
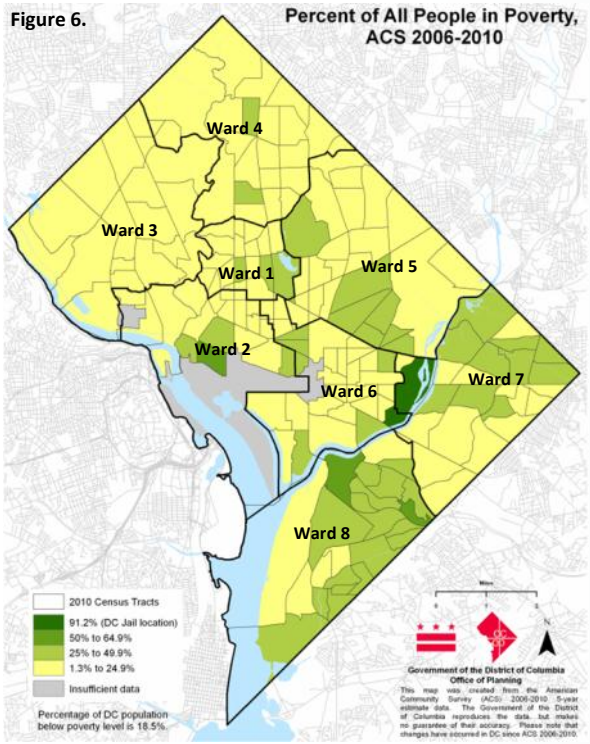


Figure 6. Percent of All People in Poverty, ACS 2006-2010



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

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

Source:

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

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

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

DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

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

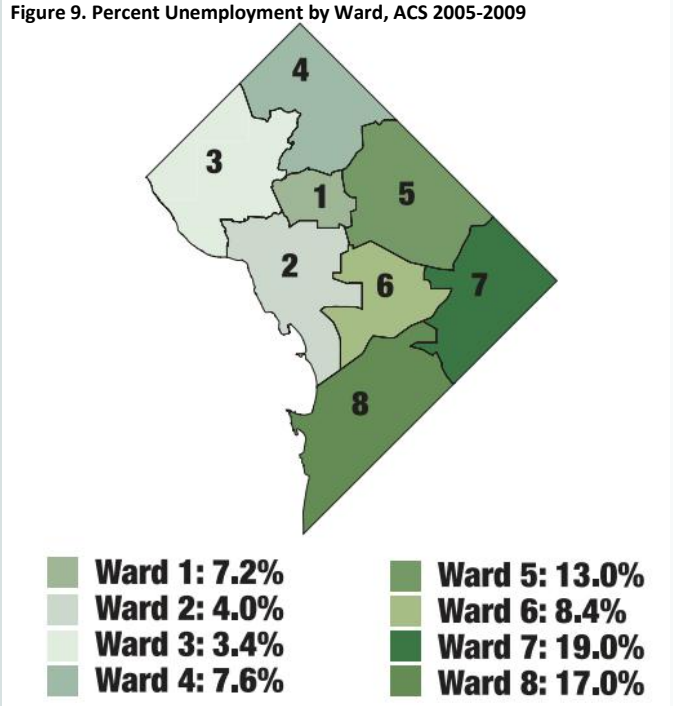


Figure 7. Percent Completed High School, ACS 2006-2010

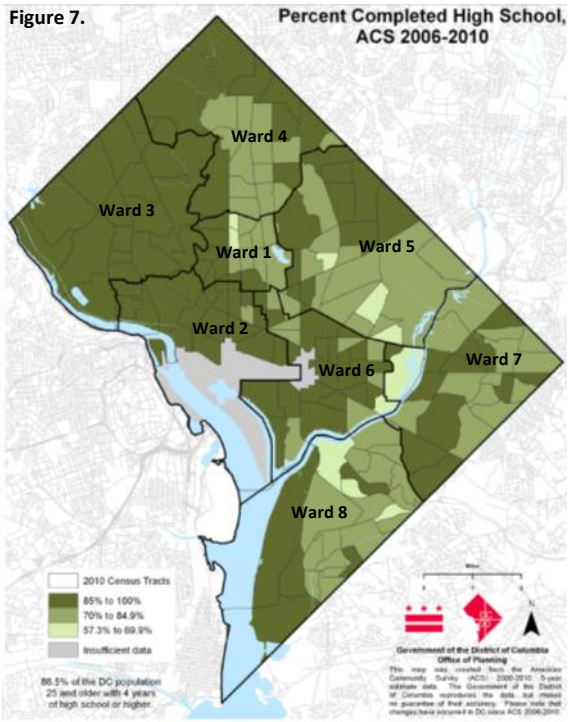
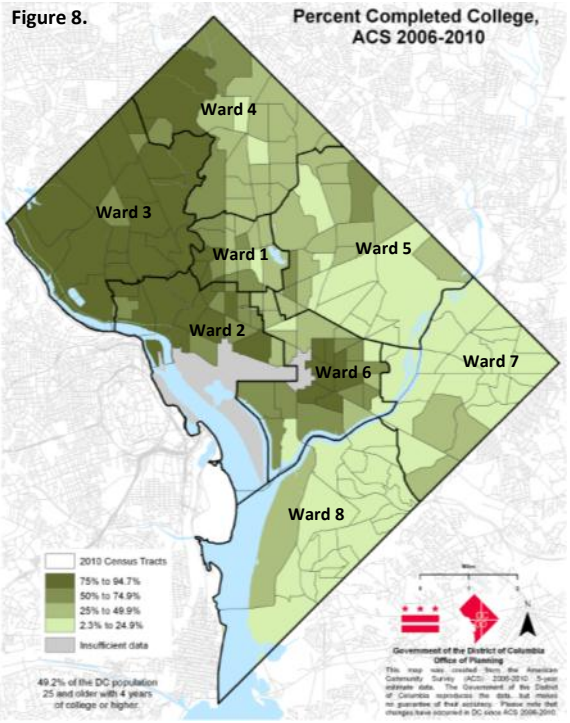


Figure 8. Percent Completed College, ACS 2006-2010

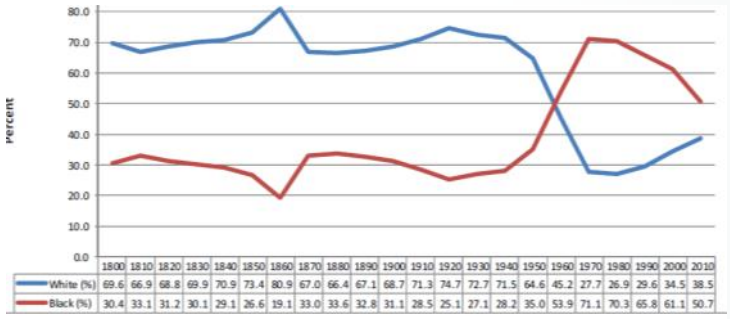


Source:
District of Columbia Government. *District of Columbia Census 2010 Atlas*. DC Office of Planning, July 2012.
Sustainable DC Plan, available at http://sustainable.dc.gov/sites/default/files/dc/sites/sustainable/page_content/attachments/SDC%20Final%20Plan_0.pdf

POPULATION TRENDS

Racial and ethnic composition in DC is constantly changing.

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



	1800	1810	1820	1830	1840	1850	1860	1870	1880	1890	1900	1910	1920	1930	1940	1950	1960	1970	1980	1990	2000	2010
White (%)	69.6	66.9	68.8	69.9	70.9	73.4	80.9	67.0	66.4	67.1	68.7	71.3	74.7	72.7	71.5	64.6	45.2	27.7	26.9	29.6	34.5	38.5
Black (%)	30.4	33.1	31.2	30.1	29.1	26.6	19.1	33.0	33.6	32.8	31.1	28.5	25.1	27.1	28.2	35.0	53.9	71.1	70.3	65.8	61.1	50.7

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

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

Source:

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

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

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

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

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

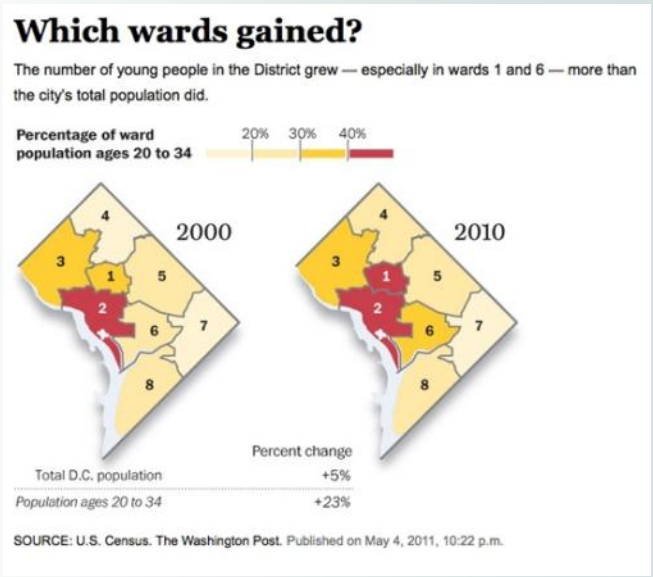
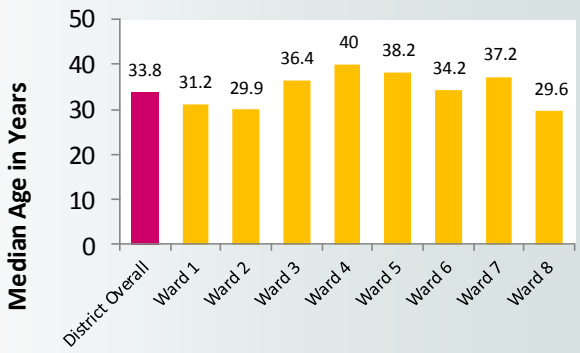


Figure 12. Median Age by District of Columbia Wards, 2010



Source: DC Office of Planning/State Data Center

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

MORTALITY AND LIFE EXPECTANCY

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

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

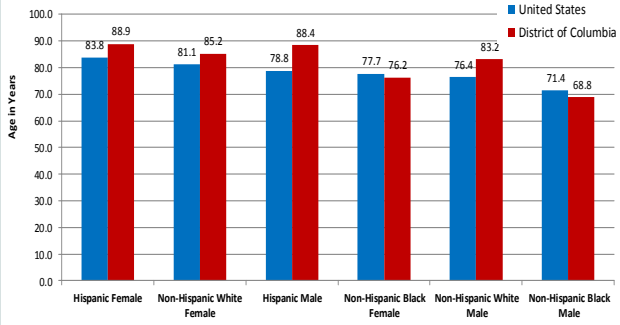
LIFE EXPECTANCY

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

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

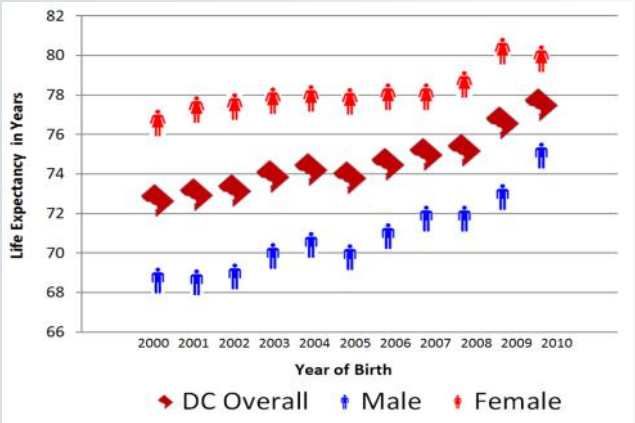
- In the District of Columbia, average life expectancy has climbed to a historic high of 77.5 years in 2010, a 10-year gain from the life expectancy in the early 1990's.
- District residents are expected to live 1 year shorter than the average United States resident. In 2010, life expectancy in the United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

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



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

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

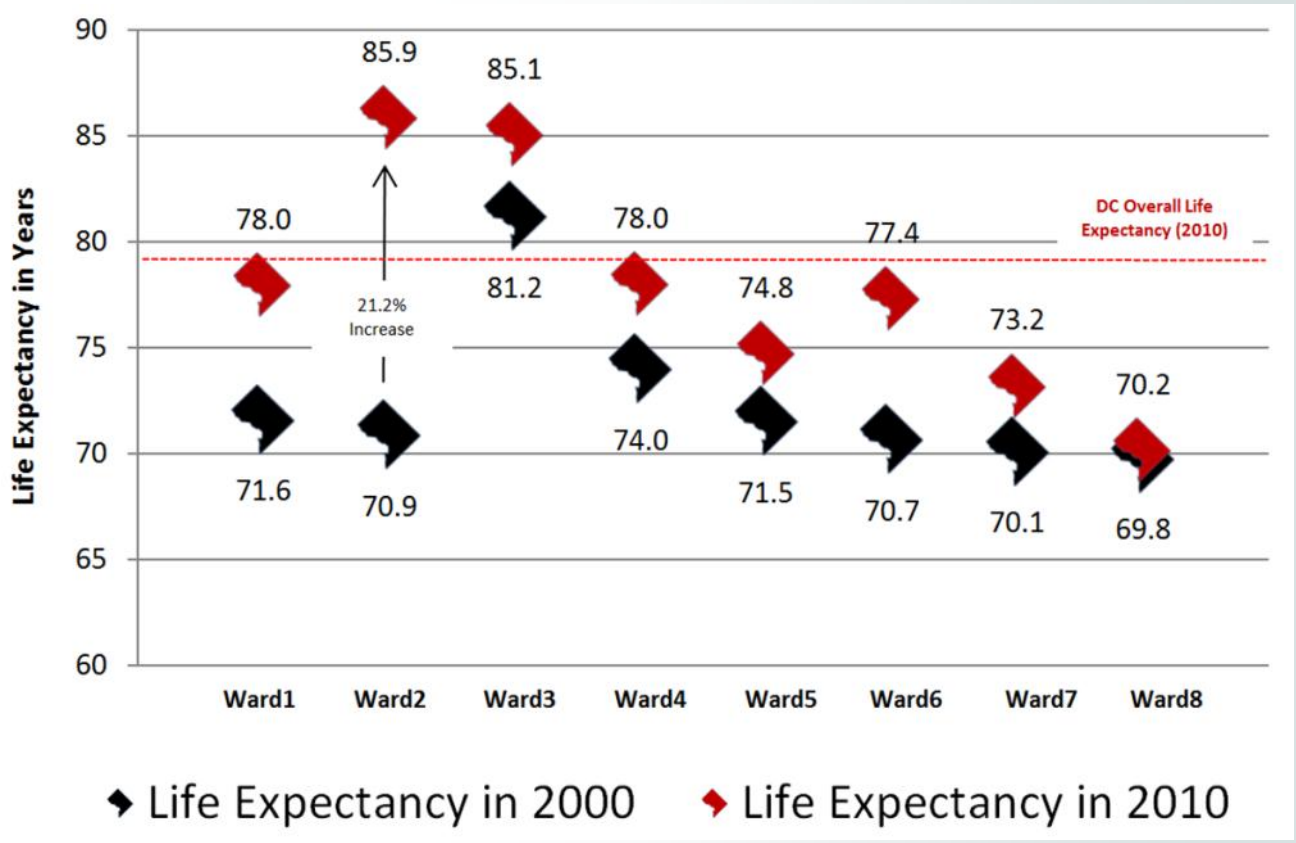


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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

LIFE EXPECTANCY BY WARD

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



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

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

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

Note:

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

INFANT MORTALITY

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

District of Columbia	Rate per 1,000 Live Births
Five-year Comparison	
2006	11.3
2007	13.1
2008	10.9
2009	9.9
2010	8.0
City Comparison	
Baltimore City, Maryland	11.0
Detroit City, Michigan	13.5
District of Columbia	8.0
Richmond, Virginia	12.8
Ward Comparison	
Ward 1	4.1
Ward 2	2.9
Ward 3	5.0
Ward 4	11.3
Ward 5	10.3
Ward 6	9.8
Ward 7	6.6
Ward 8	10.4
Total	8.0
Mother's Race/Ethnicity	
Race	
Black	10.7
White	4.9
Asian/Other	1.0
Ethnicity	
Non-Hispanic Black	10.5
Non-Hispanic White	5.3
Hispanic	3.7
Mother's Age	**Percentage of Total Infant Deaths**
< 20	5.5
20-24	16.4
25-29	17.8
30-34	28.8
35-39	26.0
40+	5.5

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

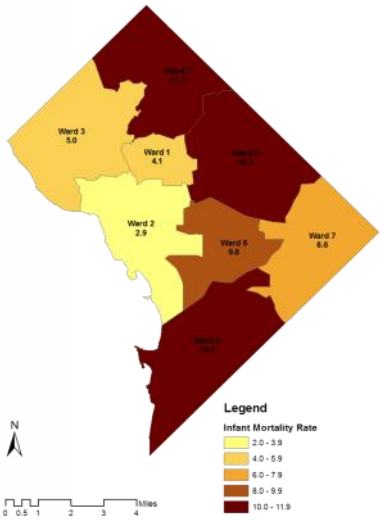
The infant mortality rate (IMR) is the most commonly used index for measuring the risk of dying during the first year of life. The rates presented in this report are calculated by dividing the number of infant deaths that occurred during 2010 by the number of live births for the same period and are presented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

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

Note:

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

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



INFANT MORTALITY TRENDS

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

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

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

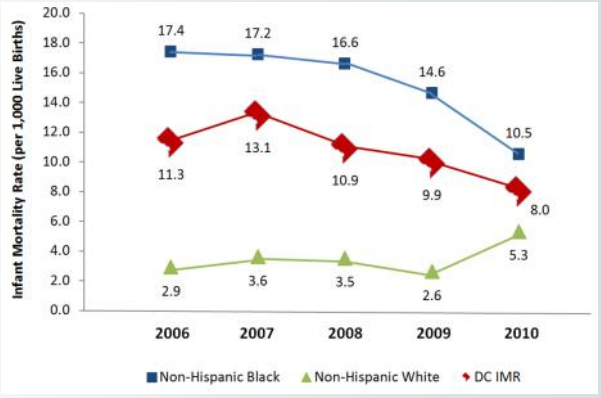
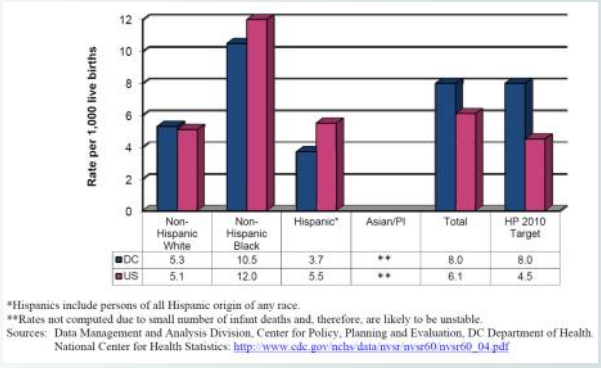


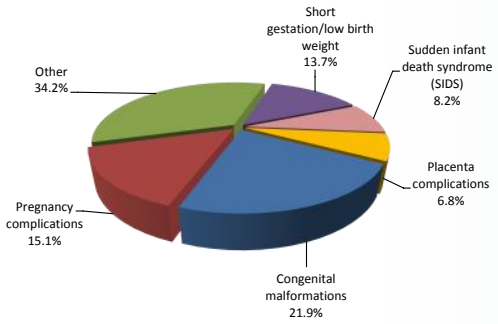
Figure 18. Infant Mortality Rate by Race/Ethnicity, DC and US, 2010



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

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

Figure 19. Infant Mortality by Cause of Death, 2010

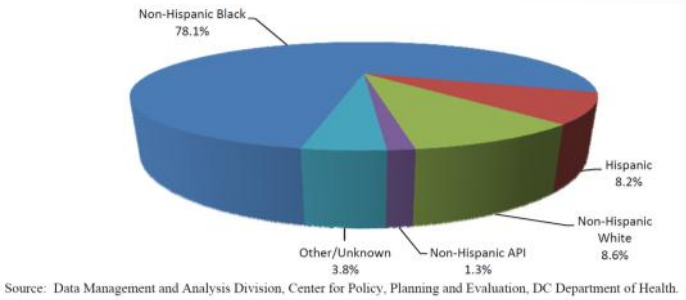


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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

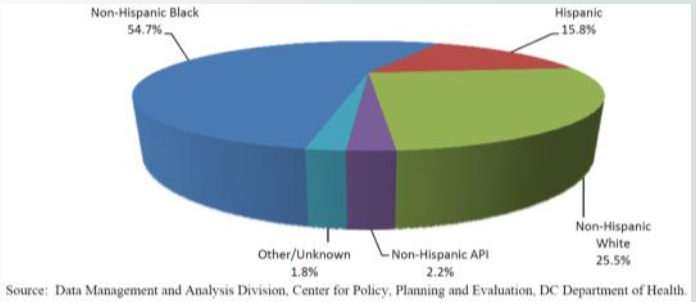
- In 2006-2010, the disparity ratio of non-Hispanic black to non-Hispanic white IMR was 4.3, which means an infant born to a non-Hispanic black mother was 4.3 times more likely to die before reaching its first birthday as an infant born to a non-Hispanic white mother. If non-Hispanic black IMR were reduced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

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



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

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



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

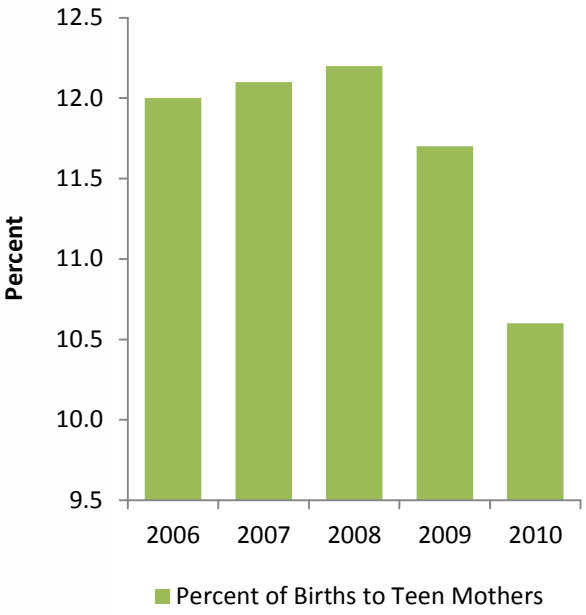
FACTORS CONTRIBUTING TO INFANT MORTALITY

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

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

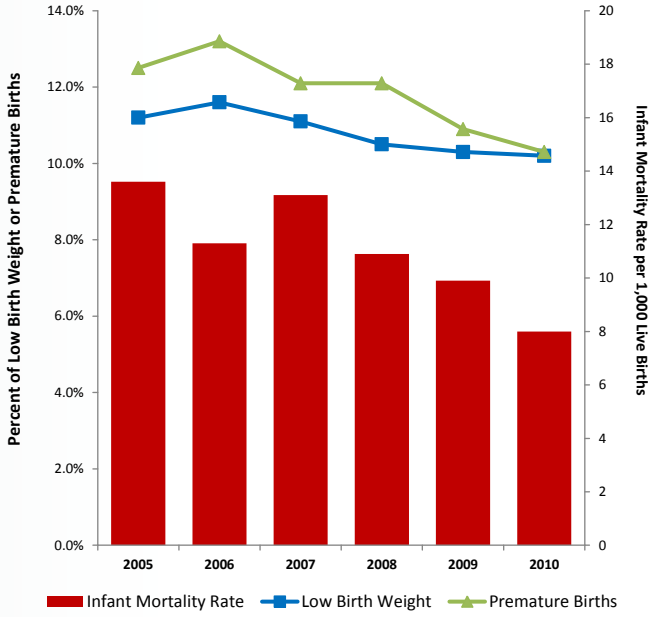
- Teen births (births to mothers under 20 years of age) have decreased in the last 5 years, after peaking in 2008.
- Pregnancy outcomes such as low birth weight and prematurity have also demonstrated a downward trend from 2005-2010.
- Early, high-quality prenatal care (PNC) is one of the cornerstones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

Figure 22. Births to Teen Mothers, 2006-2010



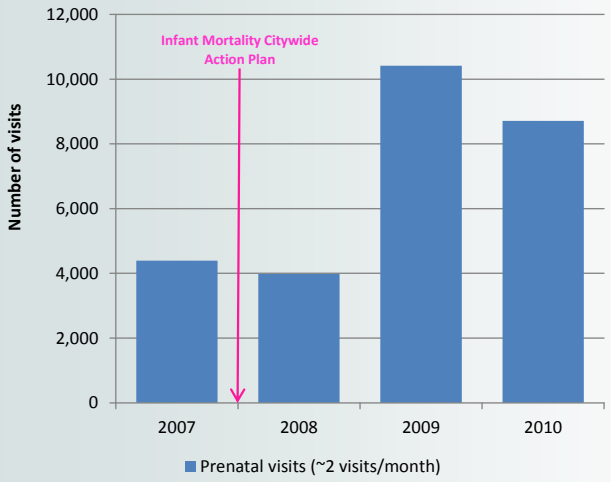
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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



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

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



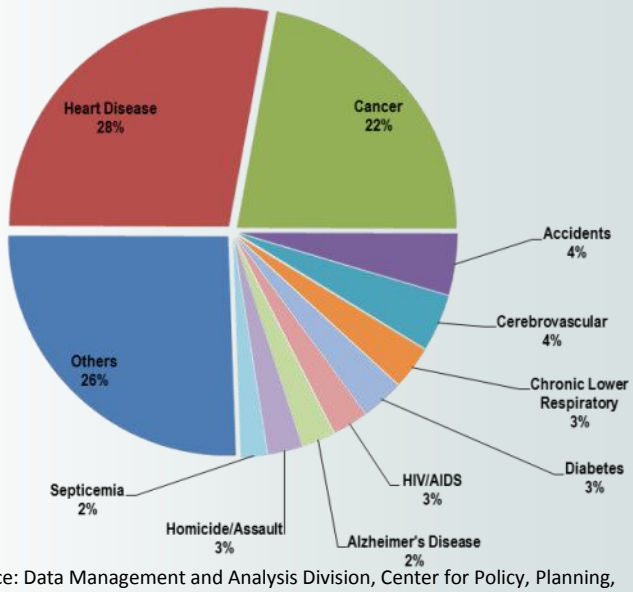
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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

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

LEADING CAUSES OF DEATH

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



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

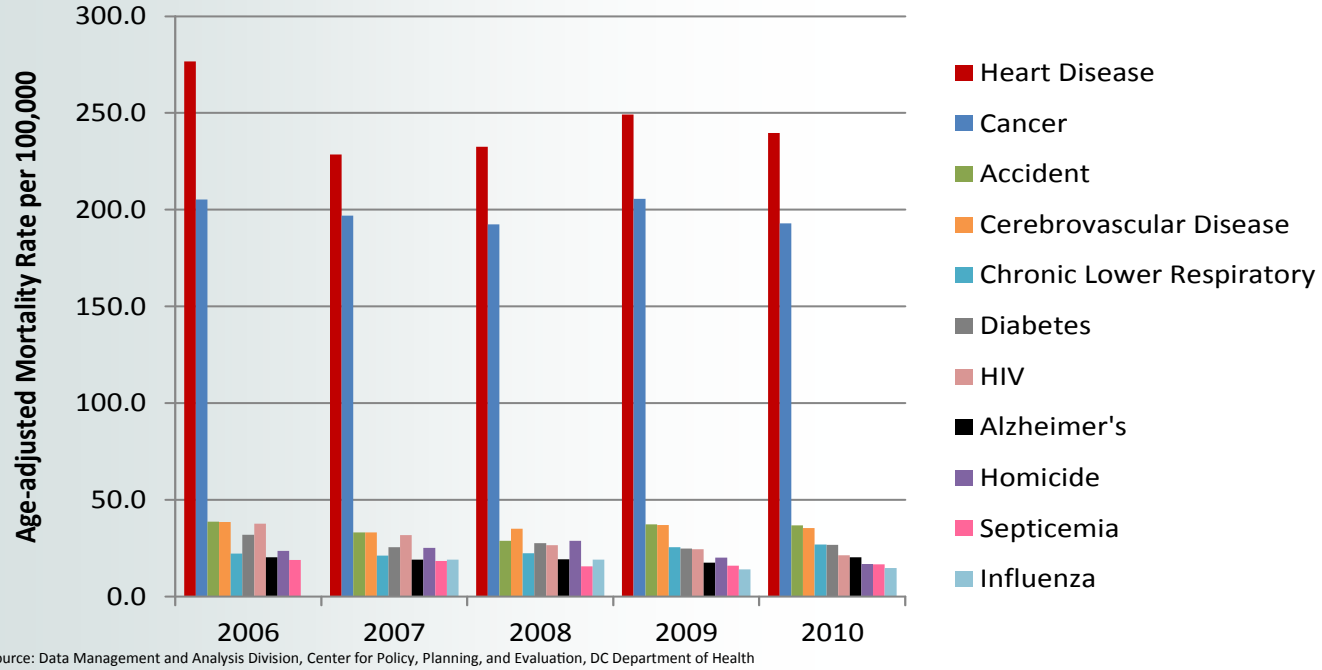
- In 2010, there were 4,670 deaths to residents of the District of Columbia. This represented a crude death rate of 776.1 per 100,000 population and an age-adjusted death rate of 853.3 per 100,000 US 2010 estimated population. The District's age-adjusted death rates are higher than the national rate but declining since 1994.
- In 2010, of the 4,670 resident deaths, 2,272 (48.6 percent) were males and 2,398 (51.4 percent) were females.
- Of the 4,670 DC resident deaths, 3,580 (76.7 percent) were blacks/African Americans and 1,016 (21.8 percent) were whites.
- In the District of Columbia, the 2010 crude death rate for males (799.4 per 100,000) remained higher than for females (755.3 per 100,000) and the 2010 rate for blacks/African Americans (1,173.3 per 100,000) was significantly higher than for whites (438.9 per 100,000).
- A disproportionate number of deaths occurred among blacks/African Americans (76.7 percent on average) in comparison to their share of the total population (approximately 50 percent). The top two leading causes of deaths for black/African American and white residents in 2010 were heart disease and cancer. Heart disease was the leading cause of death for men (221.7 per 100,000) and women (211.0 per 100,000 population).
- The average age among the leading causes of death reveals that decedents whose death was due to Alzheimer's Disease were the oldest, on average, and died at the median age of 89.2 while decedents who died as a result of Accidents or Homicide (Assault) were the youngest at under 1 year old.
- Among District residents in 2010, heart disease had the highest crude mortality rate (216.0 per 100,000 population) and age-adjusted mortality rate (239.7 per 100,000 population) killing 1,300 people or 27.8 percent of all resident deaths. Heart disease is the leading cause of death both for men (221.7 per 100,000) and women (211.0 per 100,000). The crude death rate for heart disease was the highest for Ward 5 (323.0 per 100,000), followed by Ward 7 (309.6 per 100,000), and the lowest crude death rate was in Ward 2 (87.6 per 100,000).
- In 2010, cancer was the second-ranked leading cause of death in both the United States and the District of Columbia. Of the 4,670 District resident deaths in 2010, 1,035 (22.2 percent) or a little more than one in five died from cancer with a crude death rate of 172.0 per 100,000 population and an age-adjusted rate of 193.0 per 100,000 population. Cancer affects residents in every ward, but Ward 5 (259.7 per 100,000 population) had the highest rate of deaths, followed by Ward 4 (213.8 per 100,000 population), and Ward 7 (212.5 per 100,000 population)
- In 2010, the age-adjusted rate for people dying in accidents was 36.9 per 100,000 population. In the District of Columbia deaths due to accidents ranked third. Males were more likely to die from accidents (47.5 per 100,000 population) as compared to females (23.9 per 100,000 population). Ward 5 (49.8 per 100,000 per population), followed by Ward 8 (46.7 per 100,000 population) and Ward 7 (45.0 per 100,000 population) had the highest mortality due to accidents in the city.
- Cerebrovascular diseases (age-adjusted rate of 35.5 per 100,000 population), which causes stroke, was the fourth leading cause of death in 2010 and also ranked fourth (age-adjusted rate of 39.0 per 100,000 population) in the United States. Wards 5 (51.1 per 100,000 population), Ward 7 (47.8 per 100,000 population), and Ward 4 (40.9 per 100,000 population) had the highest rates while Ward 2 had the lowest rate (10.0 per 100,000 population).
- Chronic Lower Respiratory Diseases (CLRD) such as chronic obstructive pulmonary disease (COPD) was ranked the fifth leading cause of death in the District of Columbia in 2010 (27.0 per 100,000 population age-adjusted death rate). Eighty-one percent of deaths due to CLRD were among the elderly (65 years and older). Ward 5 had the highest rate of 37.7 per 100,000 population while Ward 1 had the lowest mortality rate of 10.5 per 100,000 population.
- Diabetes (age-adjusted rate of 26.7 per 100,000 population) ranked as the sixth leading cause of death in the District of Columbia in 2010. In the District of Columbia, the crude death rate due to Diabetes for blacks/African Americans was 42.0 per 100,000 population which was seven times the rate for Whites, 6.0 per 100,000 population. Eighty-five percent of the deaths due to diabetes occurred to decedents 55 years or older. Ward 7 (43.6 per 100,000), Ward 8 (41.0 per 100,000), and Ward 5 (40.4 per 100,000) had the highest crude death rates while Ward 2 had the lowest mortality rate (6.3 per 100,000) in this category.
- Human Immunodeficiency Virus (HIV) ranked seventh leading cause of death in the District for 2010 with an age-adjusted death rate of 21.4 per 100,000 population. About 97 percent of decedents who died from HIV/AIDS were black; 78.5 percent were between the ages of 35 and 64. The rates in Ward 7 (42.2 per 100,000 population) and Ward 8 (31.1 per 100,000 population) were the highest. Ward 3 (0 per 100,000 population) had zero deaths due to HIV.
- Homicide was the eighth leading cause of death in the District of Columbia in 2010. The age-adjusted death rate in the District was 16.9 per 100,000 population. Most of the deaths due to homicide were (80.5 percent) were young in the age group 15 and 44; 89 percent of them were African Americans. Ward 8 (49.5 per 100,000) and Ward 7 (40.8 per 100,000) had the highest crude death rate of homicide while Ward 3 had the lowest (1.3 per 100,000 due to this cause.
- Alzheimer's disease ranked ninth leading cause in the District of Columbia in 2010 with an age-adjusted rate of 20.3 per 100,000 population. Ward 3 had the highest mortality rate of 35.0 per 100,000 compared to Ward 1 (3.9 per 100,000), which had the lowest mortality rate. As expected, the deaths due to Alzheimer's were the highest (75 percent) in decedents aged 85 or older.
- In 2010, septicemia was the 10th leading cause of death with an age-adjusted mortality rate of 16.7 per 100,000 population in the District of Columbia. Seventy-one percent of deaths due to septicemia were among the elderly (65 years and older); 88 percent were among African Americans. Ward 8 had the highest rate (31.1 per 100,000 population) whereas Ward 2 had the lowest rate (2.5 per 100,000 population).

MORTALITY TRENDS

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

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

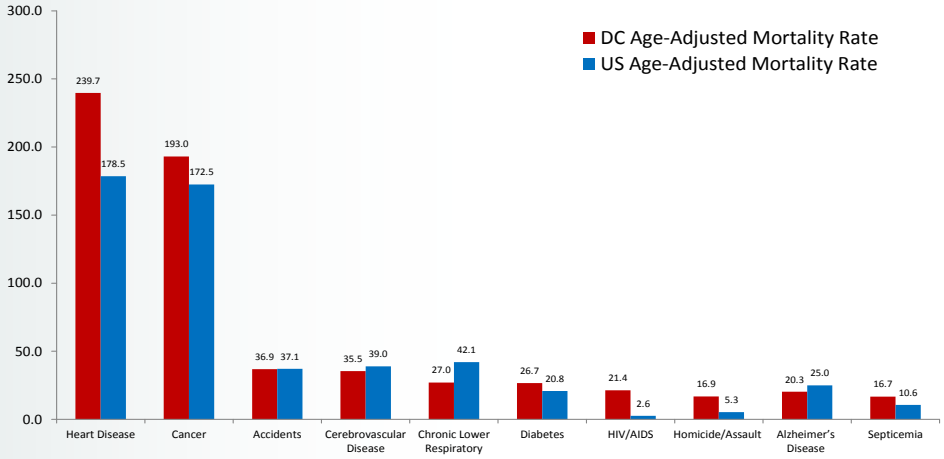
Figure 26. Leading Causes of Death, Age-adjusted Rates, 2006-2010



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

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

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



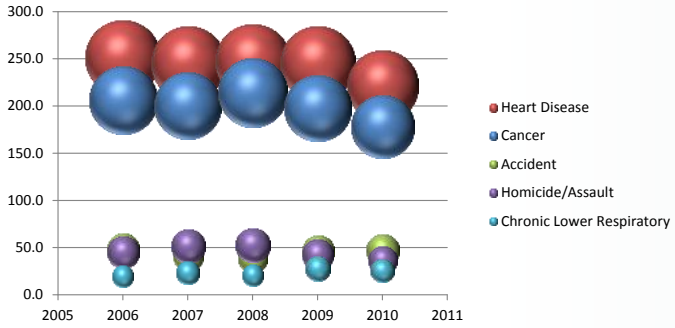
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

MORTALITY TRENDS

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

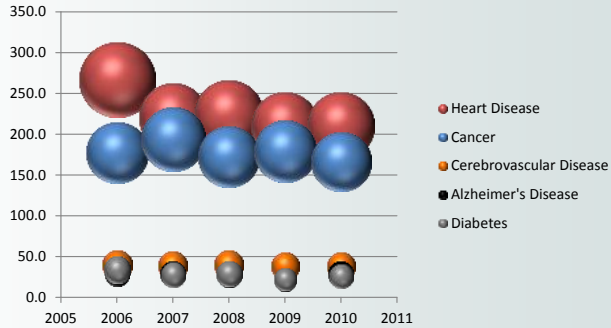
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both men and women in the District.
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both black and white DC residents.

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



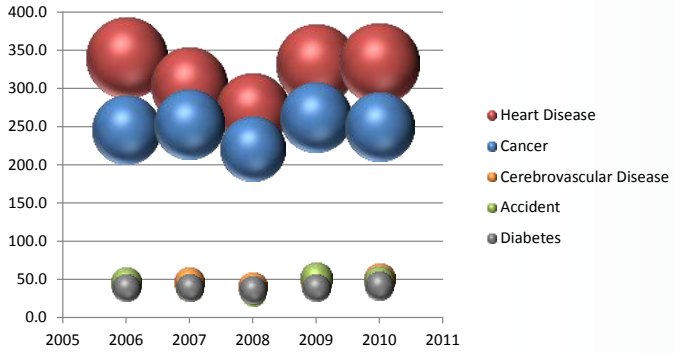
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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



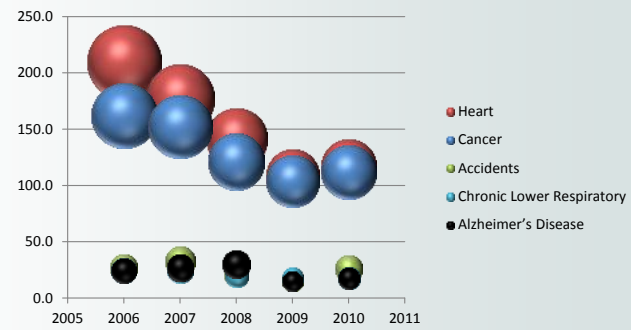
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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



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

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

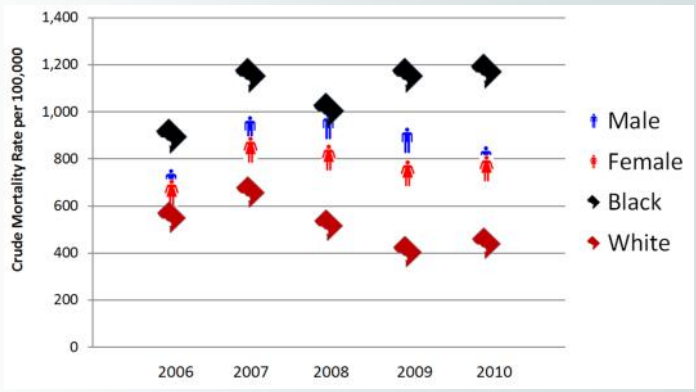


Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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

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

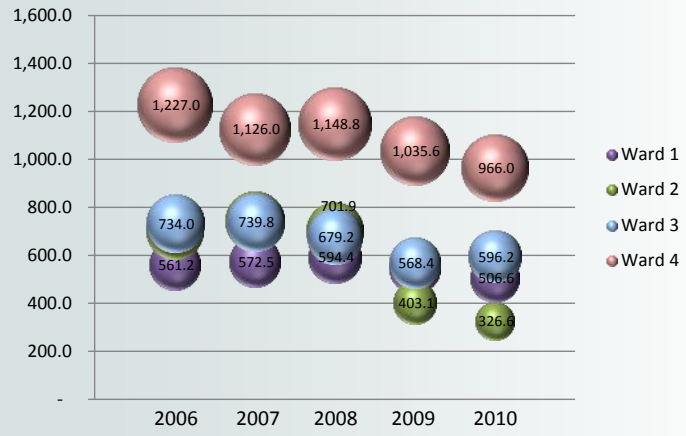
Figure 32. Crude Mortality Rates by Gender and Race, 2006-2010



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

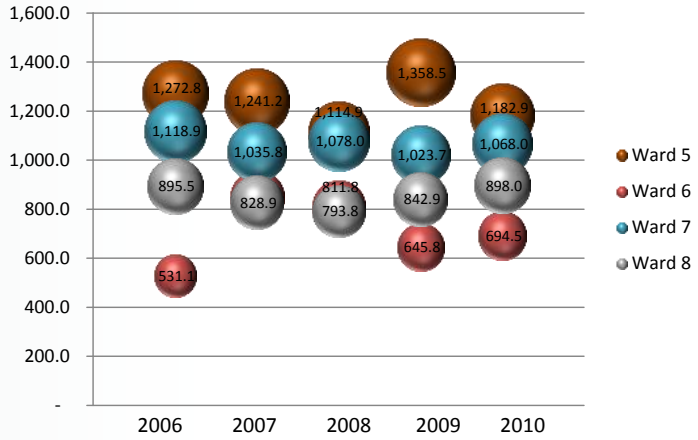
MORTALITY BY WARD

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



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

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



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

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

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

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

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

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

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

HEART DISEASE

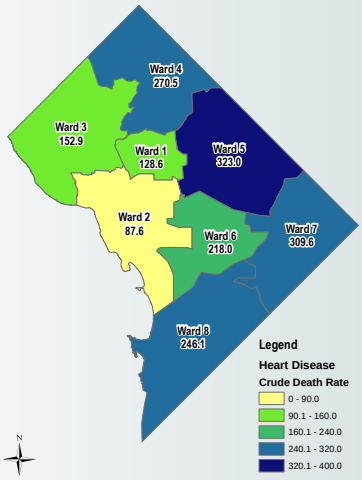
District of Columbia	Deaths due to Heart Disease
TOTAL	**1,300**
Gender	**Percentage**
Male	48.5
Female	51.5
Age	
0-4	0.0
5-14	0.0
15-24	0.4
25-34	0.8
35-44	1.4
45-54	7.7
55-64	15.8
65-74	17.3
75-84	25.5
85+	31.1
Race	
Black	78.2
White	20.8
Asian/Other	1.1
Ethnicity	
Hispanic	1.8
Non-Hispanic	96.8
Ward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

Healthy People 2010 Objectives

Goal Not Met: Reduce deaths from heart disease to no more than 230.2 per 100,000 people; the District's rate is 239.7 per 100,000.

- Heart disease was the leading cause of death both in the District of Columbia and the United States in 2010.
- Among District residents in 2010, heart disease had the highest crude mortality rate 216.0 per 100,000 and age-adjusted rate of 239.7 per 100,000 population killing 1,300 people or 27.8 percent of all resident deaths.
- Heart disease is the leading cause of death both for men (221.7 per 100,000) and women (211.0 per 100,000).
- The highest mortality rate was for blacks/African Americans (333.0 per 100,000), followed by whites (116.6 per 100,000).
- Most of the deaths due to heart disease were in the higher age groups with decedents aged 55 years and older accounting for 89.7 percent.
- The crude death rate for heart disease was the highest for Ward 5 (323.0 per 100,000), followed by Ward 7 (309.6 per 100,000), and the lowest crude death rate was in Ward 2 (87.6 per 100,000).
- This difference may also be a reflection of the age of the population living in Wards 5 and 7 which have older populations, while Ward 2 has a younger population. Better lifestyle habits can help reduce risk of heart attacks. Weight management through diet and exercise, smoking cessation and management of hypertension are examples suggested by the American Heart Association.

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



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

CANCER

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

Healthy People 2010 Objectives

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

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

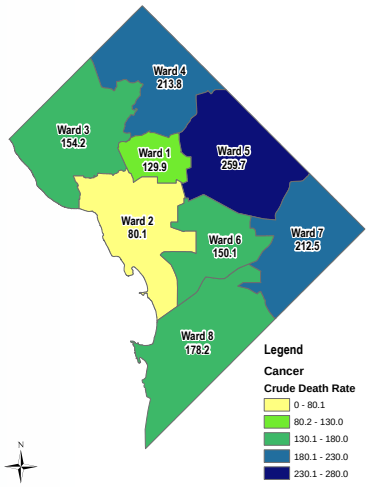
Goal Met: Reduce the mortality rate for cervical cancer by 15 percent of the 2000 baseline rate; the District's rate dropped from 4.3 per 100,000 to 1.1 per 100,000.

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

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

- In 2010, cancer was the second-ranked leading cause of death in both the United States and the District of Columbia.
- Of the 4,670 District resident deaths in 2010, 1,035 (22.2 percent) or a little more than one in five died from cancer with a crude death rate of 172.0 per 100,000 and an age-adjusted rate of 193.0 per 100,000.
- Incidence and mortality rates are highest for blacks/African Americans who account for a majority of the District's residents.
- Blacks/African Americans had a mortality rate of 250.4 per 100,000, which was significantly higher than that of whites (111.9 per 100,000).
- Similarly, the mortality rates for males (178.0 per 100,000) were higher than the female (166.6 per 100,000).
- Like heart disease, cancer deaths were also concentrated in older age groups where 85.5 percent who died of this condition were of age 55 and older.
- Cancer affects residents in every ward, but Ward 5 (259.7 per 100,000) had the highest rate of deaths, followed by Ward 4 (213.8 per 100,000), and Ward 7 (212.5 per 100,000).
- Ward 2 had the lowest cancer mortality rate of 80.1 per 100,000, again likely a reflection of the young age of the population in this ward.

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



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

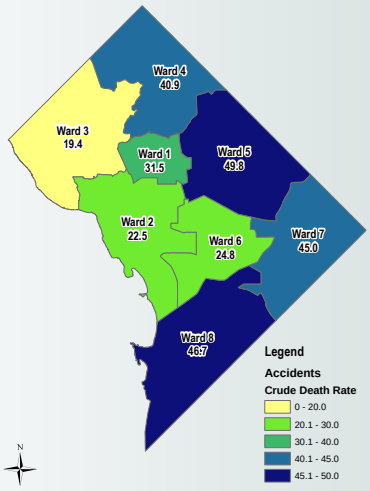
ACCIDENTS

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

- In 2010, the age-adjusted rate for people dying in accidents was 36.9 per 100,000 population.
- In the United States, deaths due to accidents ranked fifth while in the District of Columbia it ranked third in 2010.
- Males were more likely to die from accidents (47.5 per 100,000 population) as compared to females (23.9 per 100,000 population).
- Blacks/African Americans had a mortality rate of 48.2 per 100,000 population, also significantly higher compared to whites (26.4 per 100,000 population).
- Ward 5 (49.8 per 100,000), followed by Ward 8 (46.7 per 100,000) and Ward 7 (45.0 per 100,000) had the highest mortality due to accidents in the city.
- Ward 3 (19.4 per 100,000) had the lowest mortality rate due to accidents.

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

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



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

CEREBROVASCULAR DISEASE

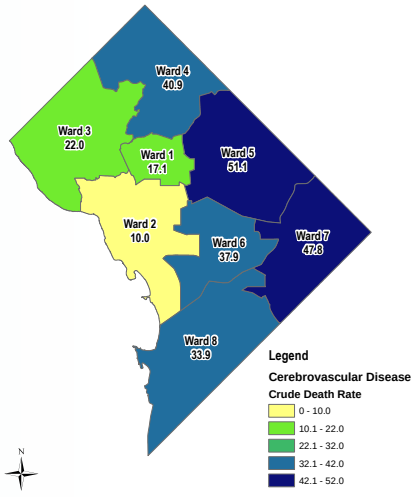
District of Columbia	Deaths due to Cerebrovascular Disease
TOTAL	**194**
Gender	**Percentage**
Male	37.1
Female	62.9
Age	
0-4	0.0
5-14	0.5
15-24	0.0
25-34	1.0
35-44	2.6
45-54	7.2
55-64	18.0
65-74	16.5
75-84	18.6
85+	35.6
Race	
Black	80.9
White	18.0
Asian/Other	1.0
Ethnicity	
Hispanic	2.6
Non-Hispanic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

Healthy People 2010 Objectives

Goal Not Met: Reduce the mortality rate from stroke to no more than 33.2 per 100,000 population; the District's rate is 35.5 per 100,000.

- Cerebrovascular disease which causes stroke, was the fourth leading cause of death in 2010, with an age-adjusted mortality rate of 35.5 per 100,000 population.
- It also ranked fourth (age-adjusted rate of 39.0 per 100,000 population) in the United States.
- Blacks/African Americans were over three times more likely to die from cerebrovascular diseases (51.5 per 100,000) compared to their white counterparts (15.1 per 100,000).
- The mortality rate was higher for females (38.4 per 100,000) as compared to males (25.3 per 100,000).
- The age group 65 or older accounted for 70.6 percent of deaths due to cerebrovascular diseases.
- In 2010, the crude death rate for cerebrovascular diseases by ward showed that Wards 5 (51.1 per 100,000), 7 (47.8 per 100,000), and 4 (40.9 per 100,000), had the highest rates in the District.
- Ward 2 had the lowest rate of 10 deaths due to cerebrovascular disease per 100,000 residents.
- According to the National Institute of Neurological Disorders and Cerebrovascular Diseases (2001), the majority of cerebrovascular diseases can be prevented by managing hypertension, heart disease, and diabetes, and by proper nutrition and smoking cessation. Transient ischemic attacks (TIAs), commonly referred to as "mini-strokes", are events lasting only a few minutes or hours and are warning signs of major cerebrovascular diseases and should not be ignored. Timely diagnosis of TIAs and other risk factors is needed to prevent cerebrovascular accidents (or stroke), and immediate treatment can minimize the long-term disabling effects of a cerebrovascular accident such as paralysis and speech deficits. The mortality data suggest that District residents in general and black/African American residents in particular, often lack access to or under-utilize available life-saving interventions.

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



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

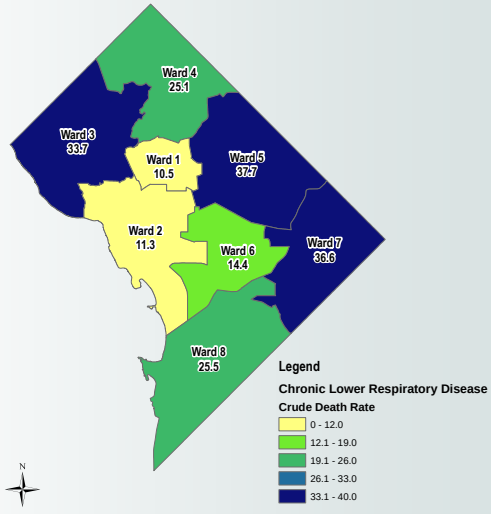
CHRONIC LOWER RESPIRATORY

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

- Chronic Lower Respiratory Diseases (CLRD) such as chronic obstructive pulmonary disease (COPD) was ranked the fifth leading cause of death in the District of Columbia in 2010.
- The age-adjusted death rate was 27.0 per 100,000 compared to the third leading cause of death (age-adjusted mortality rate of 42.1) nationally.
- CLRD was the fourth leading cause of death for whites (18.1 per 100,000) but was the 8th leading cause of death for blacks/African Americans (32.8 per 100,000).
- Men had a higher CLRD crude death rate (25.7 per 100,000 population) as compared to women (23.0 per 100,000).
- The highest proportion (80.8 percent) of deaths due to CLRD were among the elderly (65 years and older).
- Ward 5 had the highest rate of 37.7 per 100,000 while Ward 1 had the lowest mortality rate of 10.5 per 100,000.
- According to the American Lung Association (2008), smoking is the leading risk factor for CLRD. Other risk factors include exposure to air pollution and second-hand smoke, occupational dust, chemicals, a history of childhood respiratory infections and heredity.

Figure 39. Map of Chronic Lower Respiratory Disease

Crude Death Rates by Ward, 2010



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

DIABETES

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

Healthy People 2010 Objectives

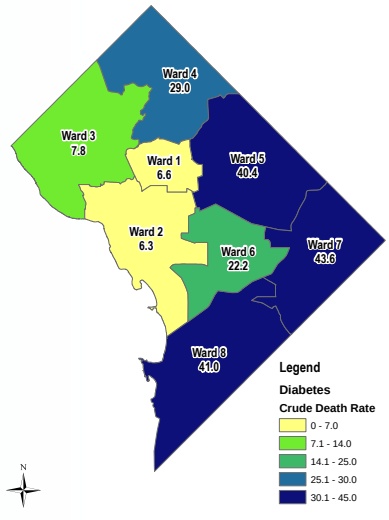
Goal Not Met: Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents; the District's rate is 26.7 per 100,000.

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

- Diabetes (age-adjusted rate of 26.7) ranked as sixth leading cause of death in the District of Columbia in 2010 but seventh (age-adjusted rate of 20.8) in the United States in 2010.
- The crude death rate for diabetes in 2010 was 24.1 per 100,000 population.
- In the District of Columbia, the crude death rate due to diabetes for blacks/African Americans was 42.0 per 100,000 population which was seven times the rate for Whites, 6.0 per 100,000 population.
- Eighty-five percent of deaths due to diabetes occurred to decedents 55 years or older.
- Ward 7 (43.6 per 100,000) , Ward 8 (41.0 per 100,000), and Ward 5 (40.4 per 100,000) had the highest crude death rates while Ward 2 had the lowest mortality rate (6.3 per 100,000) in this category.

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

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



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

HIV

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

Healthy People 2010 Objectives

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

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

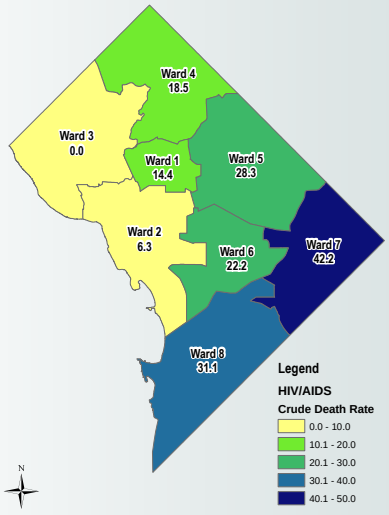
Goal Not Met: Increase by 10 percent annually the number of HIV+ individuals who received housing assistance services

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

- Acquired immune deficiency syndrome (AIDS) is caused by the human immunodeficiency virus (HIV) and ranked as the seventh leading cause of death in the District for 2010.
- The age-adjusted death rate was 21.4 per 100,000 population, compared with 2.6 per 100,000 nationally.
- Although HIV disease was not among the 15 leading causes of death in 2010 for all ages combined in the United States, it remains a public health concern, especially for those between the ages of 15 and 64. About 78.5 percent of decedents who died from HIV in the District were between the ages of 35 and 64.
- Mortality rates for HIV in the District were higher in blacks/African Americans than in any other race or ethnic group. In 2010, the crude death rate for blacks/African Americans was 38.3 per 100,000 compared to white population crude death rate of about 1.7 per 100,000.
- The crude death rate is much higher in males who continue to be infected at considerably higher rates (23.9 per 100,000) as compared to females (16.7 per 100,000); however, it is noteworthy that the number of infected females is rapidly rising.
- The rates in Ward 7 (42.2 per 100,000) and Ward 8 (31.1 per 100,000) were the highest.
- There were no deaths due to HIV among residents in Ward 3.

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

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



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

HOMICIDE/ASSAULT

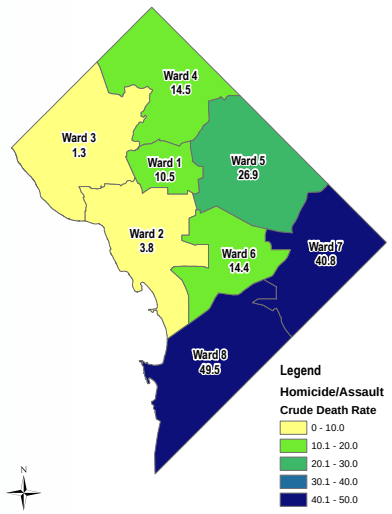
District of Columbia	Deaths due to Homicide/Assault
TOTAL	**118**
Gender	**Percentage**
Male	89.0
Female	11.0
Age	
0-4	2.5
5-14	0.8
15-24	38.1
25-34	28.0
35-44	14.4
45-54	9.3
55-64	4.2
65-74	1.7
75-84	0.8
85+	0.0
Race	
Black	89.0
White	5.9
Asian/Other	5.1
Ethnicity	
Hispanic	4.2
Non-Hispanic	94.9
Ward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

- Homicide was the 8th leading cause of death in the District of Columbia in 2010.
- The age-adjusted death rate in the District was 16.9 per 100,000 compared to age-adjusted death rate of 5.3 nationally.
- For men living in the District, homicide was the fourth leading cause of death (36.9 per 100,000 population) while it was not in the top 10 leading causes of death for women.
- Homicide was the 7th leading cause of death for blacks/African Americans (34.4 per 100,000 population) but was not in the top 10 causes of death for whites (3.0 per 100,000 population).
- Most of the deaths (66.1 percent) due to homicide were among the young who were between the ages of 15 and 34; 89 percent of them were African Americans.
- Ward 8 (49.5 per 100,000) and Ward 7 (40.8 per 100,000) had the highest crude death rate of homicide while Ward 3 had the lowest rate (1.3 per 100,000) in 2010.

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

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

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



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

ALZHEIMER'S DISEASE

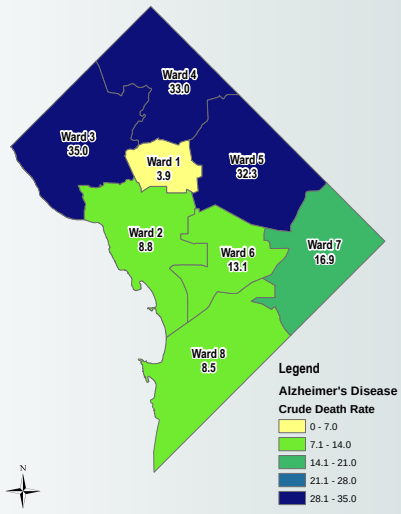
District of Columbia	Deaths due to Alzheimer's Disease
TOTAL	**114**
Gender	**Percentage**
Male	17.5
Female	82.5
Age	
0-4	0.0
5-14	0.0
15-24	0.0
25-34	0.0
35-44	0.0
45-54	0.0
55-64	0.0
65-74	2.6
75-84	21.9
85+	75.4
Race	
Black	60.5
White	36.0
Asian/Other	3.5
Ethnicity	
Hispanic	0.9
Non-Hispanic	98.2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

- Alzheimer's disease was ranked the 9th leading cause of death in the District of Columbia in 2010 with an age-adjusted rate of 20.3 per 100,000 population.
- In contrast, Alzheimer's ranked sixth nationally with an age-adjusted rate of 25.0 in 2010.
- Alzheimer's disease was the 5th leading cause of death among whites (crude rate 17.7 per 100,000) but was not in the top 10 causes of death for blacks.
- As expected, the deaths due to Alzheimer's were the highest (75 percent) in decedents aged 85 or older.
- Ward 3 had the highest mortality rate of 35.0 per 100,000 compared to Ward 1 (3.9 per 100,000), which had the lowest mortality rate.

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

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

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



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

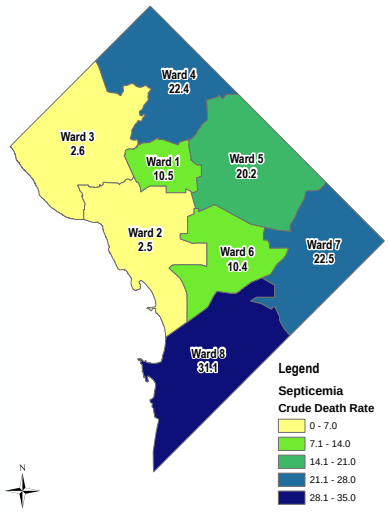
SEPTICEMIA

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

- In 2010, Septicemia (bloodstream infection) causing failure of multiple vital organs was the 10th leading cause of death with an age-adjusted mortality rate of 16.7 per 100,000 population in the District of Columbia.
- Seventy-one percent of deaths due to Septicemia were among the elderly (65 years and older); 88 percent were among African Americans.
- Septicemia was the 9th leading cause of death for African Americans (25.9 per 100,000 population) but was not in the top 10 causes of death for whites (3.5 per 100,000).
- For male and female residents in the District, Septicemia was the 9th leading cause of death at 14.4 and 15.4 per 100,000 population, respectively.
- Ward 8 had the highest rate (31.1 per 100,000 population) followed by Wards 7 and 4 (22.5 and 22.4 per 100,000 population, respectively). Wards 2 and 3 had the lowest rate (2.5 and 2.6 per 100,000 population, respectively).

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

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



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

PROMOTING HEALTHY BEHAVIORS

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

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

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

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

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

OBESITY

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

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

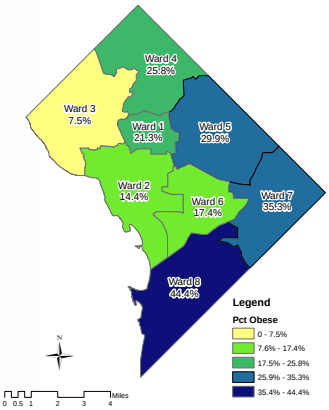
Goal Not Met: Reduce the proportion of adults who are obese to 15 percent; the District's rate is 22.7 percent.

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

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

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

Figure 45. Map of Obesity Rate by Ward, 2010



OBESITY TRENDS

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

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

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

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

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

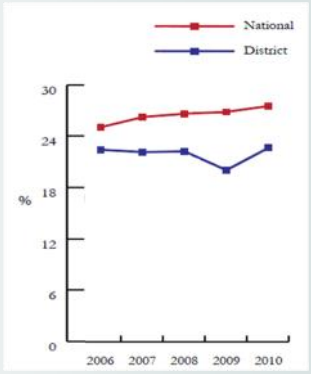
Access to Fruits and Vegetables: Policy and Environmental Indicators, 2009		
	DC	US
% of Census tracts with Healthy Food Retailers within 1/2 mile of boundary	82.4%	72.0%
Farmers Markets per 100,000 population	3.9	1.7
% of Farmers Markets that accept EBT	21.7%	7.6%
% of Farmers Markets that accept WIC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

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

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

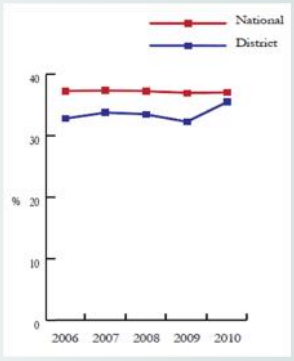
Source: Childhood Obesity Prevention, *2011 State Legislation Report*, American Academy of Pediatrics, (p. 38).

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



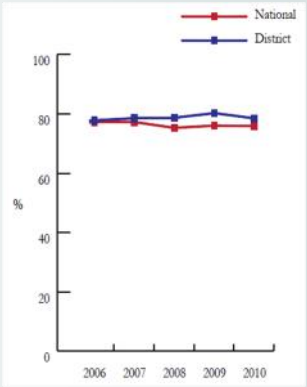
Source: 2010 District of Columbia BRFSS

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



Source: 2010 District of Columbia BRFSS

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



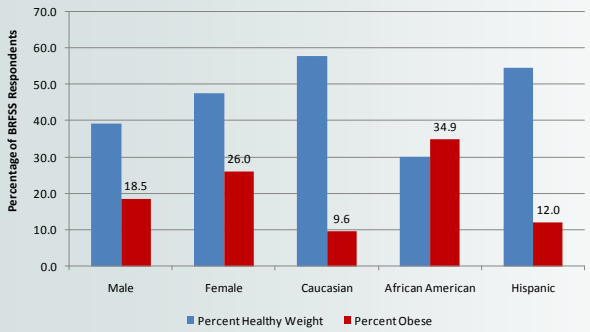
Source: 2010 District of Columbia BRFSS

OBESITY TRENDS

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

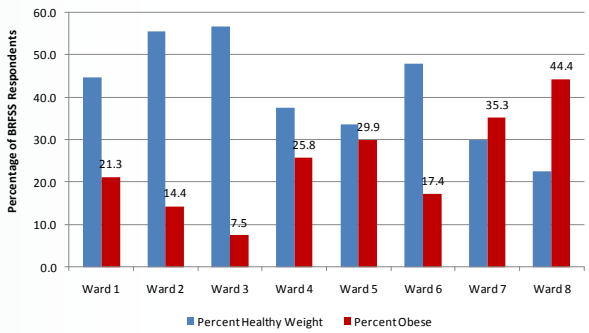
Ward 8 residents have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.

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



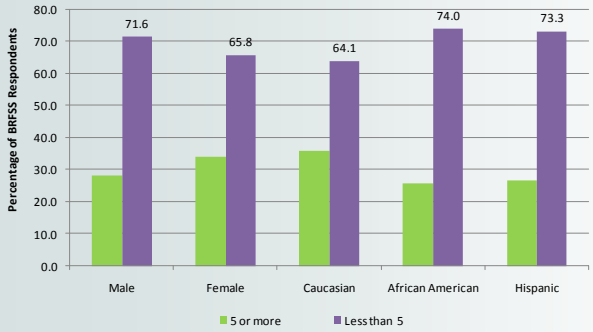
Source: 2010 District of Columbia BRFSS

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



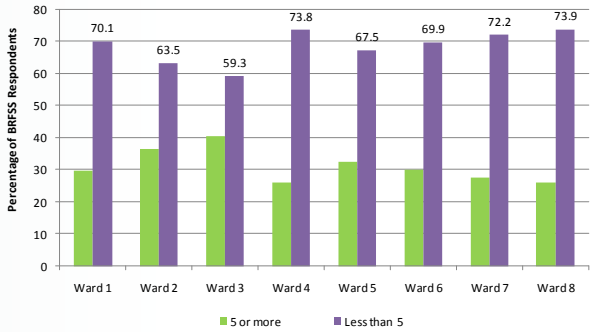
Source: 2010 District of Columbia BRFSS

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



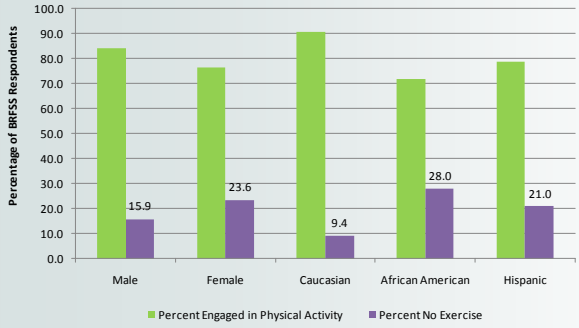
Source: 2009 District of Columbia BRFSS

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



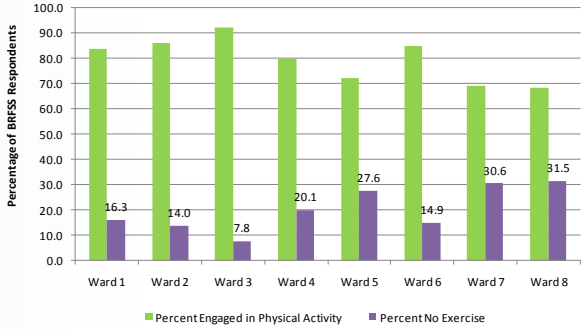
Source: 2009 District of Columbia BRFSS

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



Source: 2010 District of Columbia BRFSS

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

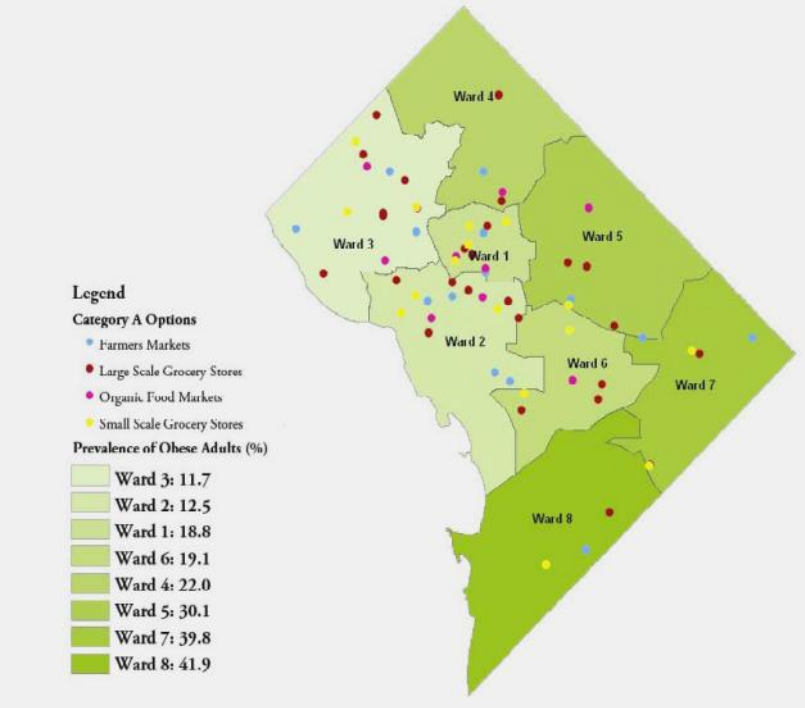


Source: 2010 District of Columbia BRFSS

FOOD OPTIONS IN DISTRICT

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

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



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

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

The District of Columbia Overweight and Obesity Action Plan

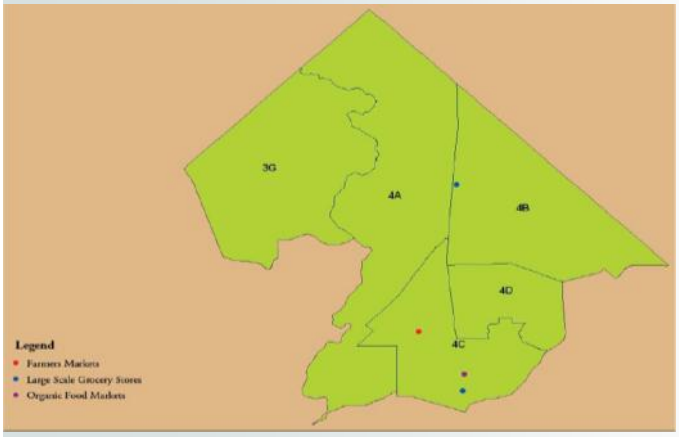
In 2010, the District of Columbia developed the five-year District of Columbia Overweight and Obesity Action Plan to engage community partners and government agencies and address clinical as well as broader social and community-based determinants related to weight status, overweight and obesity. The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

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

FOOD OPTIONS IN WARDS 4 AND 5

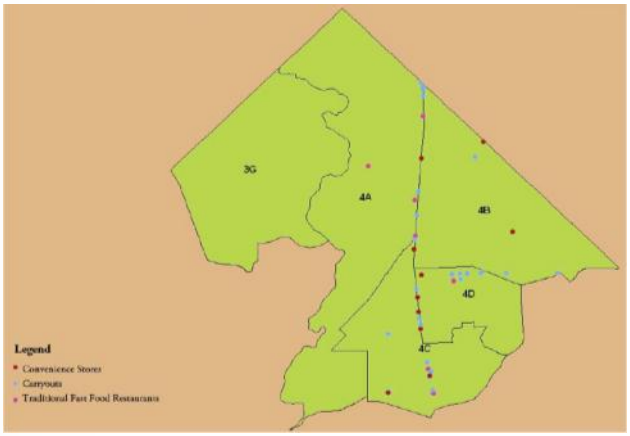
In Wards 4 and 5, obesity rates (25.8 and 29.9 percent, respectively) are higher than the city-wide average (22.4 percent), and residents are not likely to consume the recommended serving of fruits and vegetables when compared to wards with lower obesity rates. The following is an analysis of the geographic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

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



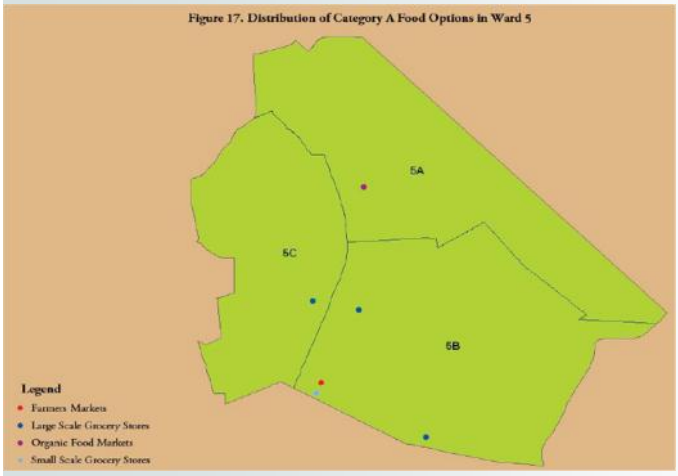
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



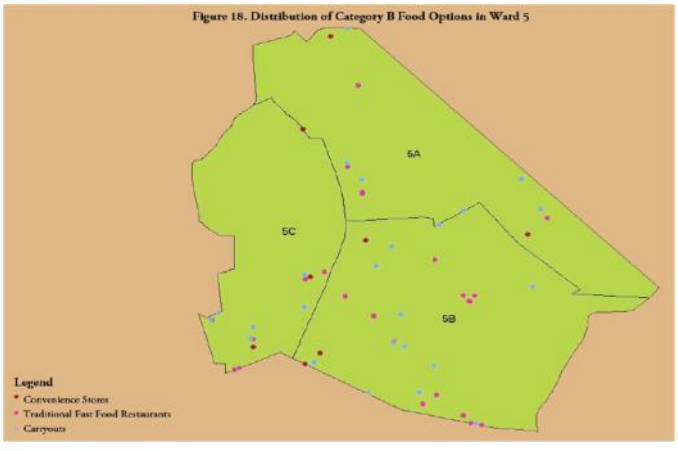
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



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

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

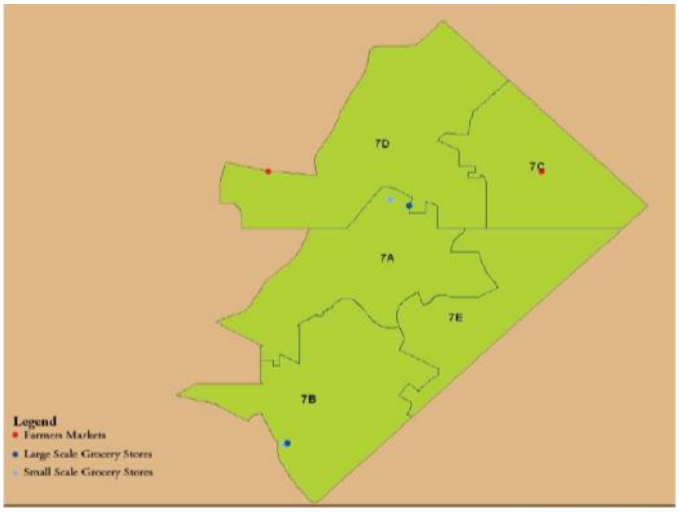


Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

FOOD OPTIONS IN WARDS 7 AND 8

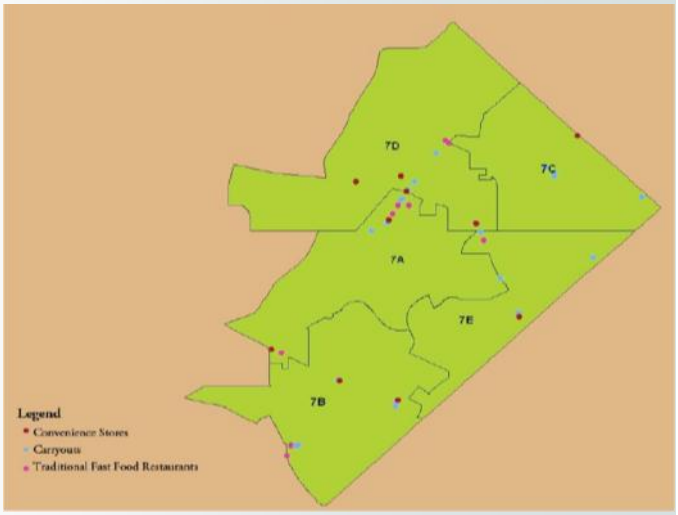
In Wards 7 and 8, obesity rates are highest in the District (35.3 and 44.4 percent, respectively), and residents are the least likely to consume the recommended serving of fruits and vegetables. The following is an analysis of the geographic distribution and types of food options available in these wards.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

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



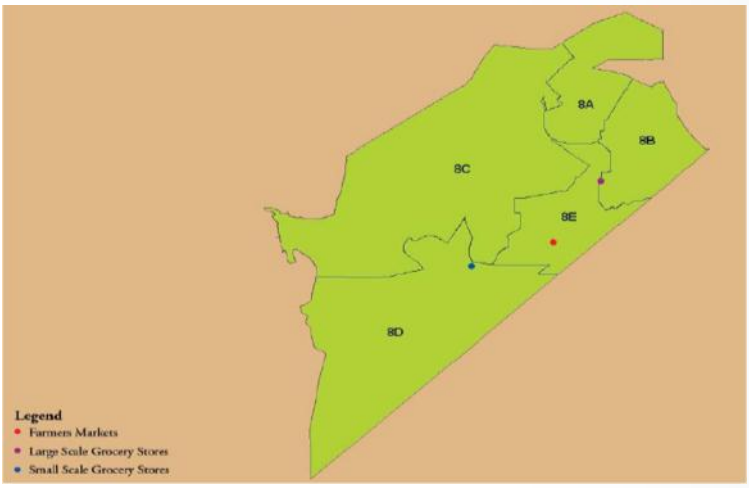
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



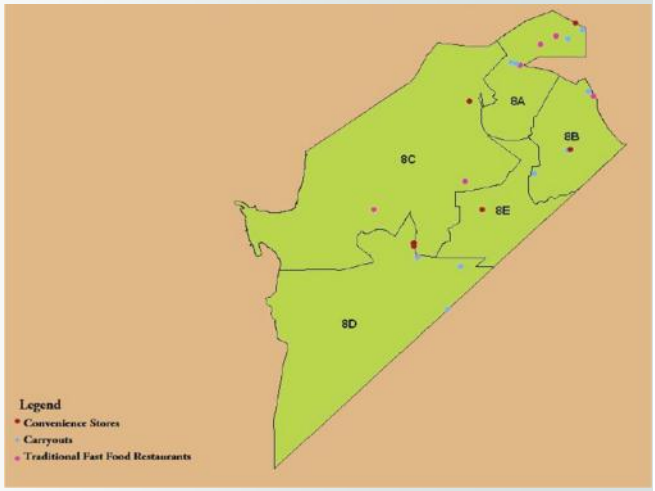
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



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

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



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

ALCOHOL CONSUMPTION

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

Source: 2010 District of Columbia BRFSS

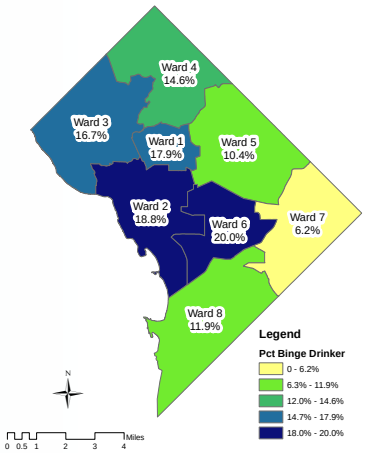
Healthy People 2010 Objectives

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

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

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

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



TOBACCO USE

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

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

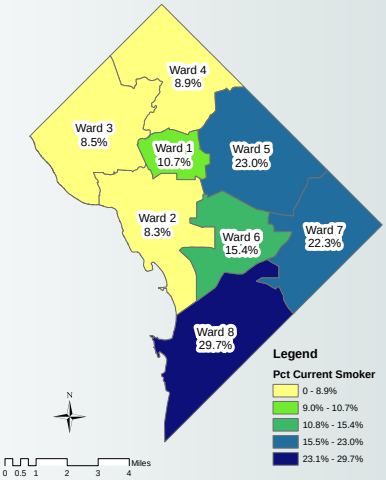
Goal Not Met: Reduce cigarette smoking by adults to 12 percent; the District rate is 15.6 percent.

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

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

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

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



PHYSICAL HEALTH

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

Source: 2010 District of Columbia BRFSS

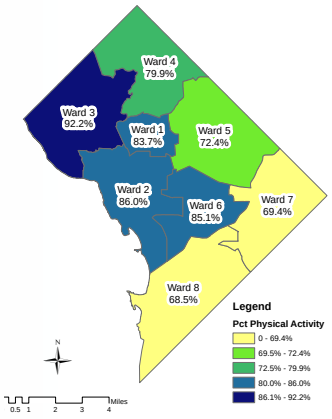
Healthy People 2010 Objectives

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

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

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

Figure 66. Map of Physical Activity by Ward, 2010



GENERAL HEALTH

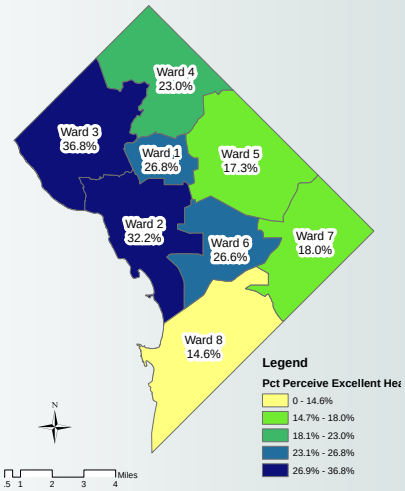
District of Columbia	Percent Excellent Health
TOTAL	25.2
Gender	
Male	26.3
Female	24.3
Age	
18-24	32.2
25-34	31.6
35-44	32.4
45-54	23.3
55-64	20.4
65 or older	13
Race/Ethnicity	
Caucasian	36.1
African American	16.9
Asian	27.3
Other	19.6
Hispanic	29.8
Education	
Less than High School	11.9
High School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

Source: 2010 District of Columbia BRFSS

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

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

Figure 67. Map of Health Perception by Ward, 2010



LIFE SATISFACTION

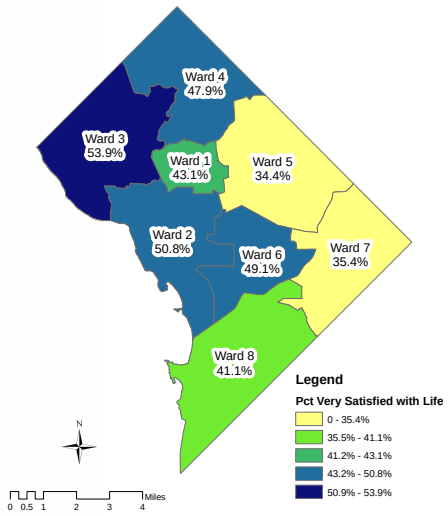
District of Columbia	Percent Very Satisfied
TOTAL	45.1
Gender	
Male	43.8
Female	46.3
Age	
18-24	37.4
25-34	45.7
35-44	46.4
45-54	43.4
55-64	46.8
65+	47.7
Race/Ethnicity	
Caucasian	53.4
African American	38
Asian	47.1
Other	42.9
Hispanic	48.7
Education	
Less than High School	35.1
High School Graduate	37.9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

Source: 2010 District of Columbia BRFSS

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

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

Figure 68. Map of Life Satisfaction by Ward, 2010



SEXUAL HEALTH

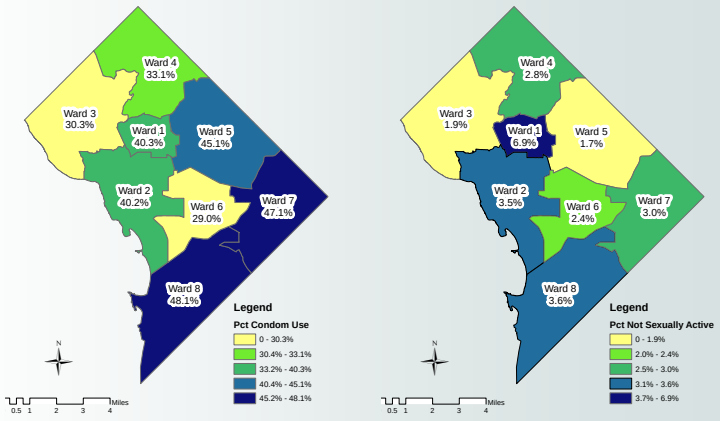
District of Columbia	Percent Condom Use	Not Sexually Active
TOTAL	38.2	3.1
Gender		
Male	42.9	1.8
Female	33.8	4.3
Age		
18-24	67.9	4.8
25-34	40.4	1.2
35-44	38.9	0.9
45-54	34.5	3.4
55-64	27.1	7.5
Race/Ethnicity		
Caucasian	30.3	1.8
African American	45.4	4.1
Other	39.7	4.5
Hispanic	*	2
Education		
Less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

Source: 2010 District of Columbia BRFSS

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

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

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



HIGH-RISK BEHAVIOR

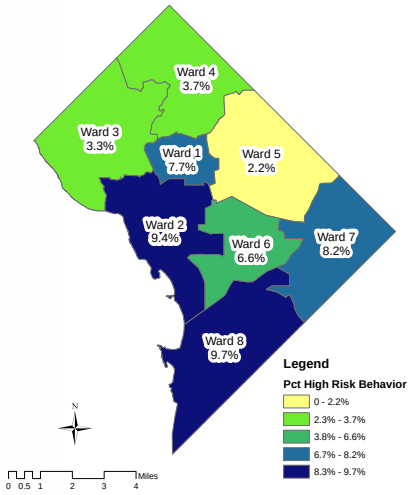
District of Columbia	Percent with High-Risk Behavior
TOTAL	6.4
Gender	
Male	8.8
Female	4.1
Age	
18-24	5.1
25-34	11.8
35-44	6.4
45-54	5.1
55-64	3.1
Race/Ethnicity	
Caucasian	6.4
African American	5.9
Asian	1.3
Other	10
Hispanic	11.9
Education	
Less than High School	16.1
High School Graduate	5.9
Some College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

Source: 2010 District of Columbia BRFSS

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

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

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



ORAL HEALTH

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

Source: 2010 District of Columbia BRFSS

Healthy People 2010 Objectives

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

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

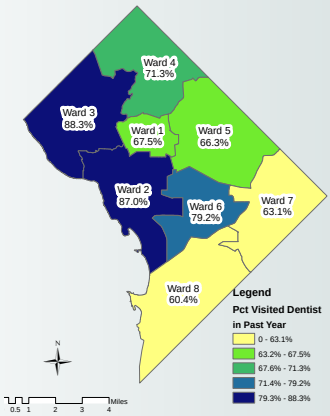
Goal Attained: Increase by at least 50 percent the number of children entering school programs who have received a dental assessment from a qualified health care professional to determine the existence of any decay or oral pathologies and/or deformities.

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

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

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

Figure 71. Map of Dental Visit by Ward, 2010



PROMOTING HEALTHY AND SAFE COMMUNITIES

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

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

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

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

ENVIRONMENTAL HEALTH

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

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

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

Healthy People 2010 Objectives

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

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

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

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

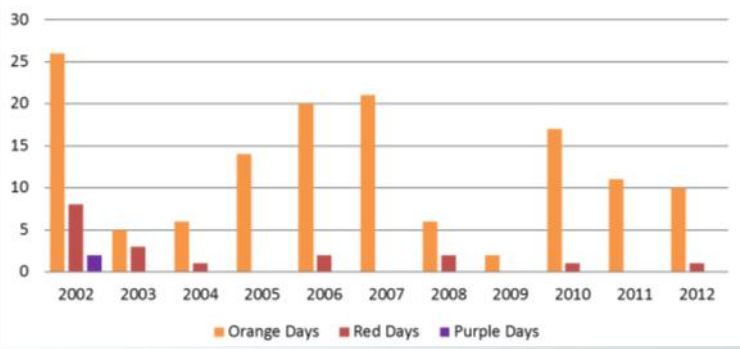
Goal Not Met: Eliminate significant health risks from the National Priority List (NPL) of hazardous waste sites, as measured by performing a level of site cleanup sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments.

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

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

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

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



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

FOOD SAFETY

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

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

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

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

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

Healthy People 2010 Objectives

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

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

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

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

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

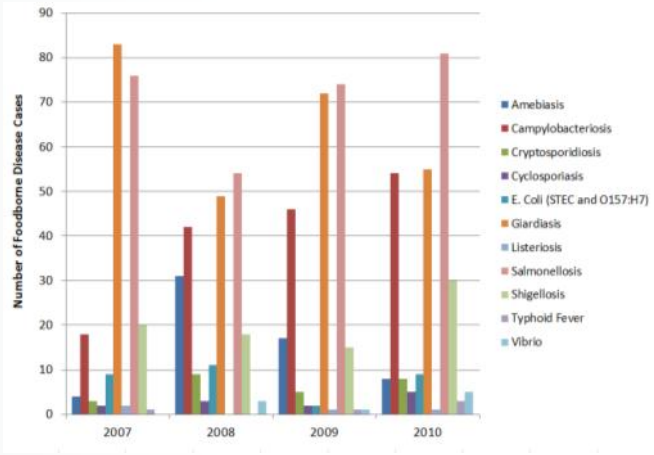
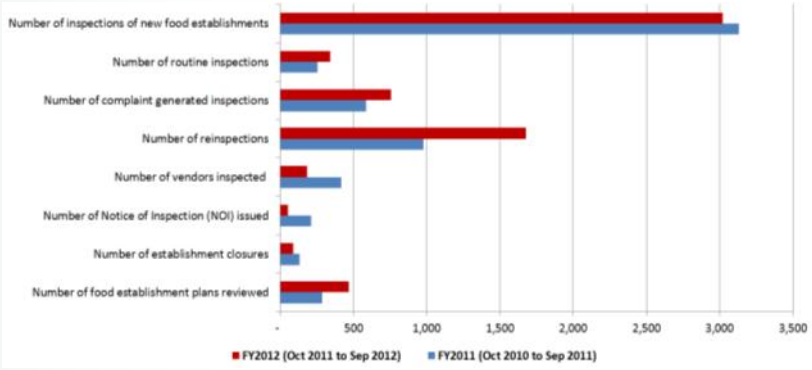


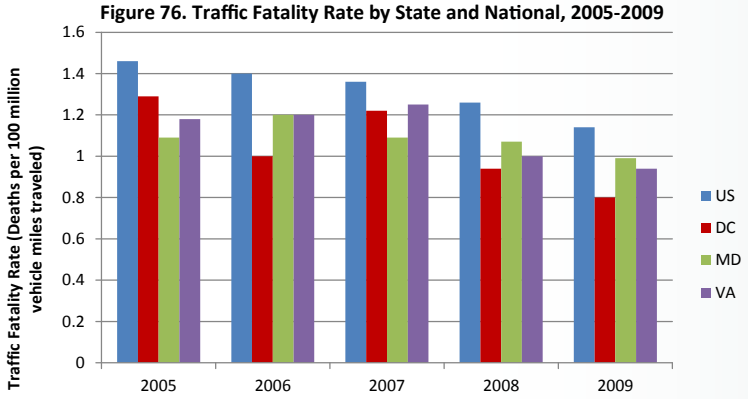
Figure 75. Food Establishment Inspections Conducted by DC DOH, FY 2011-2012



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

PUBLIC SAFETY

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



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

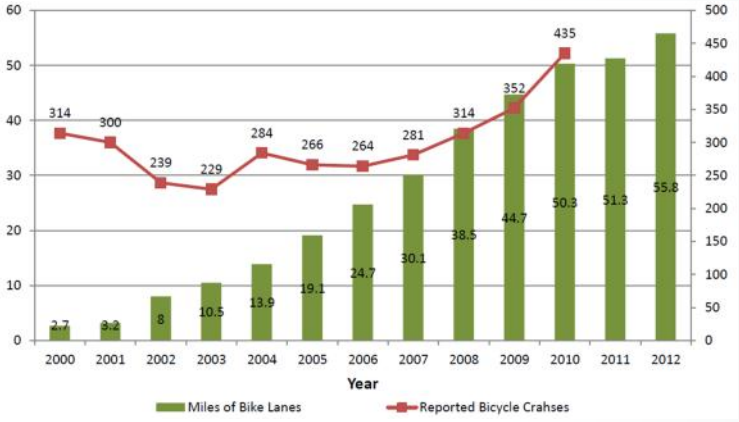
Transportation Facts in the District

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

Snapshot of Bicycle Facilities and Infrastructure in the District

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

Figure 77. Bicycle Crashes Relative to Miles of Bike Lanes



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

Healthy People 2010 Objectives

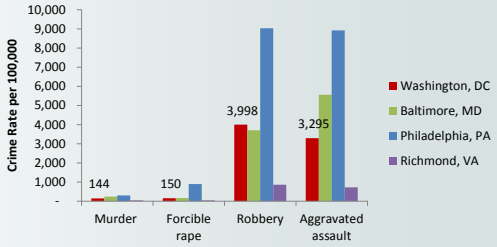
Goal Attained: Establish a Trauma/Injury Registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics; DOH is installing software to begin a Trauma Registry.

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

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

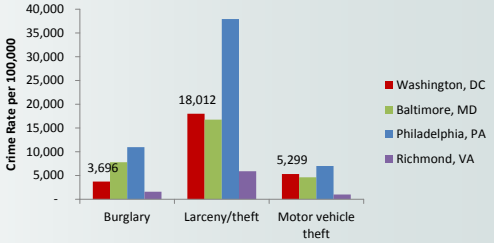
- According to the US National Highway Traffic Safety Administration, there were 192 traffic fatalities in the District (deaths within 30 days of accident) from 2005 to 2009.
- During this 5-year period, the traffic fatality rate in the District was lower than the national rate.
- In 2009, the traffic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

Figure 78. Violent Crime in Select Large Cities, 2009



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

Figure 79. Property Crime in Select Large Cities, 2009



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

SEAT BELT USE

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

Source: 2010 District of Columbia BRFSS

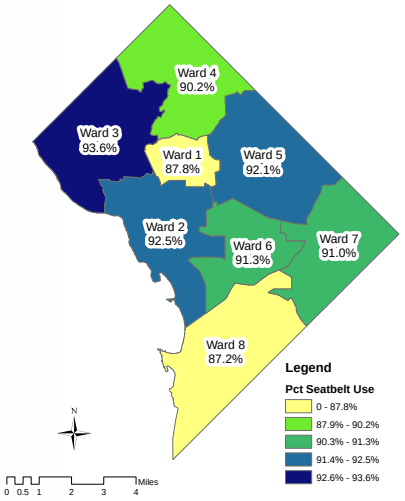
Healthy People 2010 Objectives

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

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

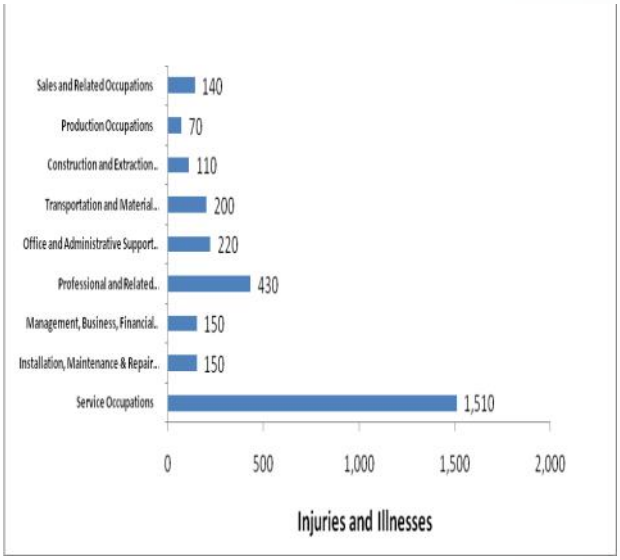
- Overall, 90.4 percent respondents reported always wearing their seat belts and 9.6 percent reported not always wearing their seat belt.
- Males were more likely than females to report they do not always wear their seat belt, at 10.8 percent.
- Adults aged 18-24 years were more likely than all other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

Figure 80. Map of Seatbelt Use by Ward, 2010



OCCUPATIONAL INJURY

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



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

Fatal Work Injuries in the District of Columbia

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

Key Characteristics

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

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

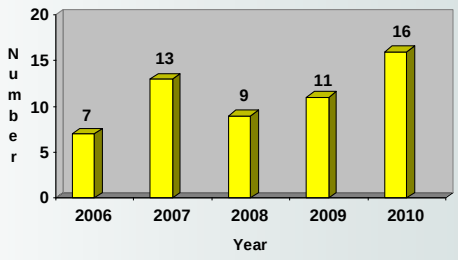
Case Characteristic Highlights

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

Demographic Highlights

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

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



Source: DOH, DC Workplace Fatalities 2010

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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.

Revised 3/15/2013

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