



# DISTRICT OF COLUMBIA COMMUNITY HEALTH NEEDS ASSESSMENT, Volume 1



Prepared by  
District of Columbia Department of Health  
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# EXECUTIVE SUMMARY

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

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

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

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



# EXECUTIVE SUMMARY

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

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

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

## I. District of Columbia Demographics

During the 1950 United States Census there were a reported 802,178 residents in the District of Columbia. For every decade after 1950, the population declined. According to the 2000 Census, the District's population had reached its lowest at 572,059. This marks a 29 percent reduction in population size occurring over the 50 year time period. In 2010, the Census showed a 5.2 percent increase in population size at 601,723. The most recent data records the District population size at 632,323 in 2012. For the CHNA, the DOH used 2010 data. This year was selected since all of the primary population health datasets and the majority of the program datasets have been closed and validated for this time period.

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

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

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

# EXECUTIVE SUMMARY

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

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

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

## II. Health Profile

### *Life Expectancy*

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

### *Infant Mortality*

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

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

# EXECUTIVE SUMMARY

## Health Care Coverage

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

## Top Ten Leading Causes of Death

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

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

## Heart Disease

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



# EXECUTIVE SUMMARY

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

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

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

## Cancer

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

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

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

## Diabetes

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

# EXECUTIVE SUMMARY

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

## HIV/AIDS

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

## Hospitalizations

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

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

## III. Community Priorities

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



# EXECUTIVE SUMMARY

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

Target# 1: By 2032, cut the citywide obesity rate by 50 percent;

Target# 2: By 2032, ensure 75 percent of District residents live within ¼ mile of a community garden, farmers' market or healthy corner store.

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

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

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

Action# 3.2.2: Reduce Infant Mortality;

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

Action# 3.4.1: Improve Access to Healthy Food;

Action# 3.4.2: Expand Nutrition Education

## IV. Summary

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

# SUMMARY HIGHLIGHTS

## Key Indicators

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

## Leading Causes of Death

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

## Diseases and Disorders

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

# SUMMARY HIGHLIGHTS

## Ward Level

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

## Access to Care

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

## Health Behaviors and Risk Factors

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

# SUMMARY HIGHLIGHTS

## Racial Disparities

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



# INTRODUCTION

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

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

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

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

# INTRODUCTION

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

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

# KEY INDICATORS AT-A-GLANCE

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

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

<b>Mortality and Life Expectancy</b>	<b>District of Columbia</b>		<b>United States</b>
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
<b>Maternal and Child Health Outcomes</b>			
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
<b>Access to Care</b>			
Health Care Coverage, Any Type (Percent Adults Aged 18-64)	92.2	👍	85.0
Enrollment in Medicaid Managed Care (Percent, 2009 Data)	66.0		71.2
Enrollment in Health Maintenance Organizations or HMOs (Percent, 2008 Data)	64.1	👍	24.8
Physician-to-Resident Ratio (Per 100,000 Population, 2009 Data)	817	👍	273
Nurse-to-Resident Ratio (Per 100,000 Population, 2009 Data)	1,483	👍	842


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

# KEY INDICATORS AT-A-GLANCE

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

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

## Health Behaviors







	District of Columbia		United States
<b>Tobacco Use</b>			
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
<b>Alcohol Consumption</b>			
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
<b>Physical Activity</b>			
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
<b>Fruit and Vegetable Consumption</b>			
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
<b>Screening and Immunization</b>			
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
<b>Oral Health</b>			
Dental Visit within Past Year (Percent Adults 18 and Older)	75.3		69.6
<b>Injury</b>			
Seatbelt Use (Percent Adults 18 and Older)	90.3		85.3
<b>High Risk Behavior</b>			
Marijuana Use During Lifetime (Percent High School Students, 2011 Data)	43.0		39.9
Marijuana Use in Last 30 Days (Percent High School Students, 2011 Data)	26.1		23.1
First Time Marijuana Use Before Age 13 (Percent High School Students, 2011 Data)	11.0		8.1
Drinking and Driving (Percent High School Students, 2011 Data)	5.4		8.2
Carried a Handgun (Percent High School Students, 2011 Data)	7.5		5.1

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

# KEY INDICATORS AT-A-GLANCE

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

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

Chronic Health Indicators	District of Columbia		United States
<b>Overweight and Obesity (BMI)</b>			
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
<b>Cardiovascular Diseases</b>			
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
<b>Diabetes</b>			
Diagnosed with Diabetes (Percent Adults 18 and Older)	8.3		8.7
<b>Asthma</b>			
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 Children 17 and Under)	22.4		12.4

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

# METHODOLOGY

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

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

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



# METHODOLOGY

## Data Sources

*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 should be interpreted with caution since they were derived from self-reported data which present potential sources of bias. This assessment also does not include the many programs and services that are currently implemented to address these health-related issues either by the DOH or by other stakeholders.



# Demographic Characteristics of the District of Columbia

## DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

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

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

**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.

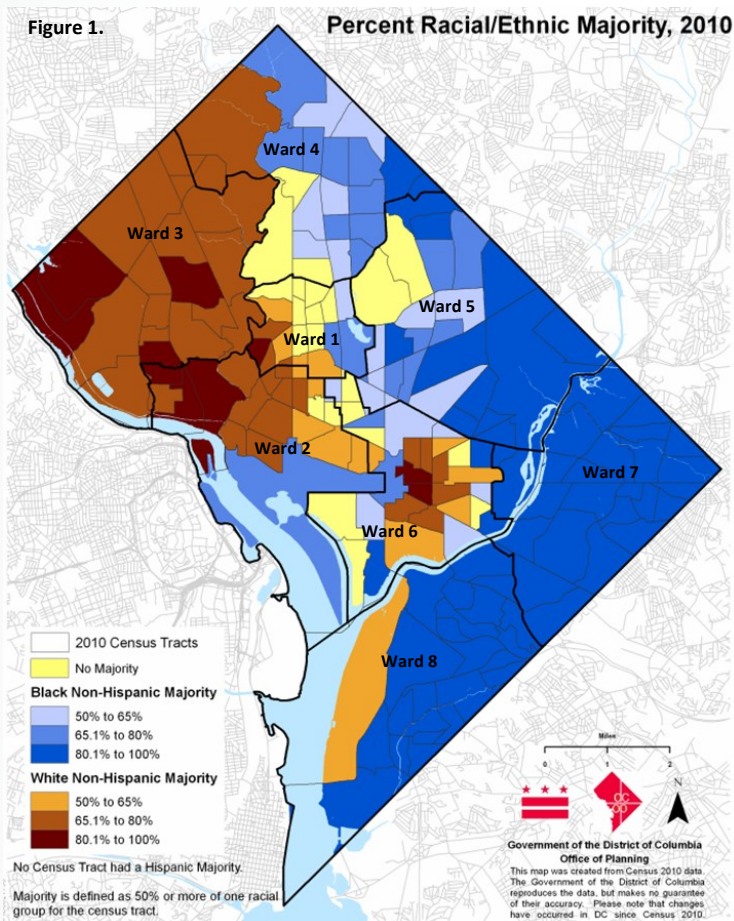
**Hispanics or Latinos.** Hispanics or Latinos may be of any race. In 2010, Hispanics or Latinos were the third fastest growing group in the District's population. Between 1990 and 2000, the Hispanic or Latino population grew by 37.4 percent. From 2000 and 2010, the Hispanic population increased again 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
<b>ALL AGES</b>						
<b>RACE</b>						
<b>Total Population</b>	<b>572,059</b>	<b>100.0%</b>	<b>601,723</b>	<b>100.0%</b>	<b>29,664</b>	<b>5.2%</b>
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%
<b>HISPANIC OR LATINO RACE</b>						
<b>Total Population</b>	<b>572,059</b>	<b>100.0%</b>	<b>601,723</b>	<b>100.0%</b>	<b>29,664</b>	<b>5.2%</b>
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
<b>District of Columbia</b>	<b>572,059</b>	<b>601,723</b>	<b>29,664</b>	<b>5.2%</b>
<b>WARD</b>				
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.



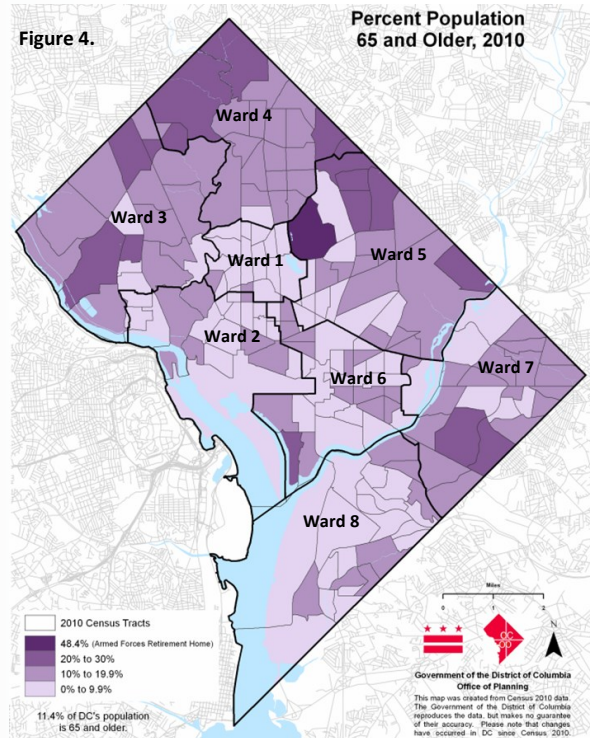
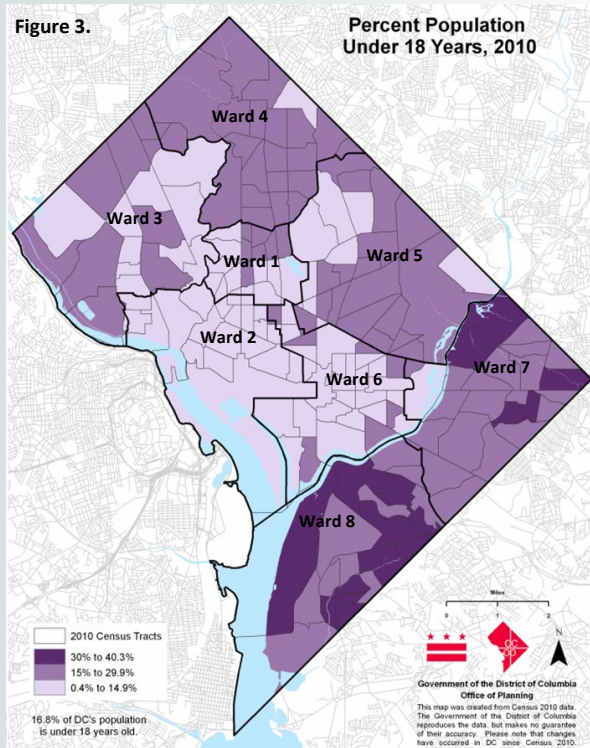
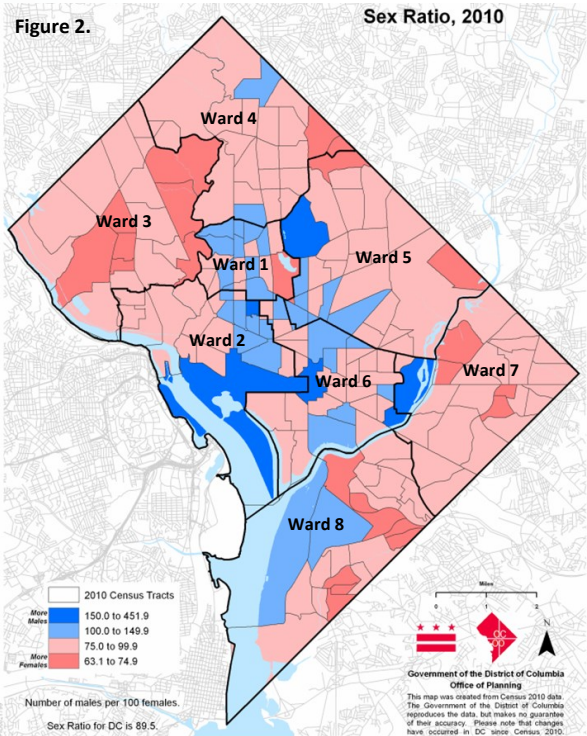
## Section III. Demographics

# 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.



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.

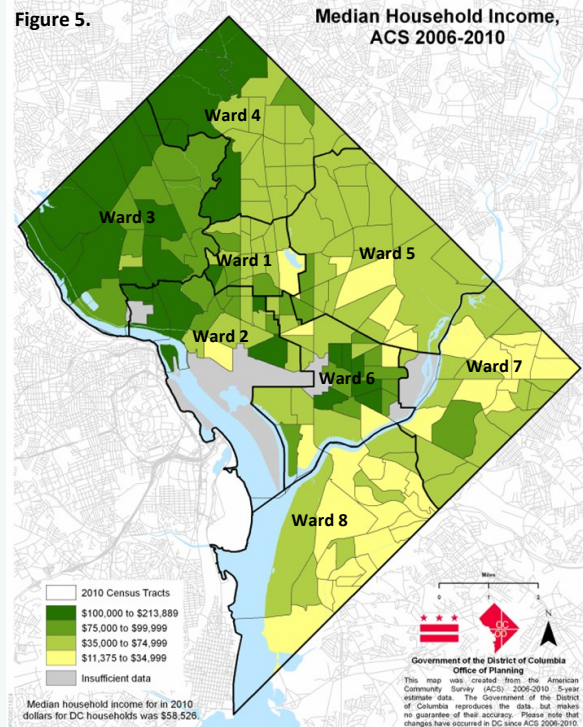
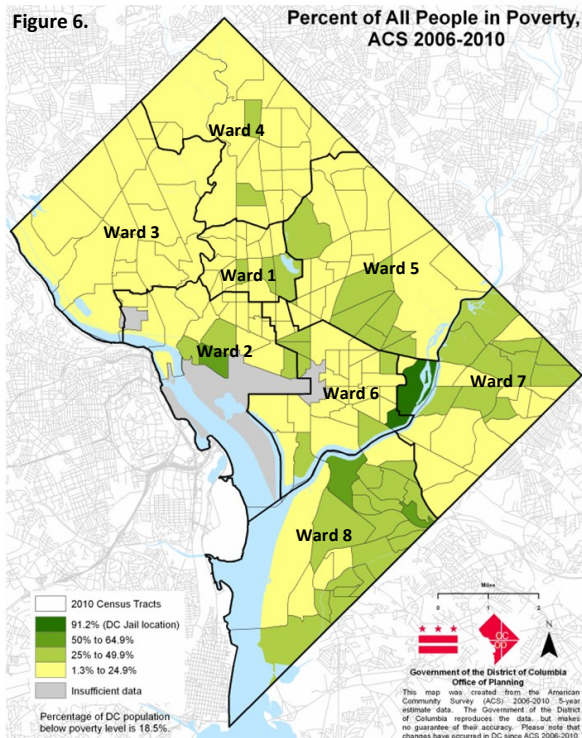
District of Columbia Government. *Senior Needs Assessment*. DC Office on Aging 2012.



## 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.



**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<sup>1</sup>. 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.

<sup>1</sup>US National Center for Health Statistics, National Vital Statistics Report (NVS), *Births, Marriages, Divorces, and Deaths: Preliminary Data for 2009*, Vol. 58, No. 25, August 2010, and prior reports.

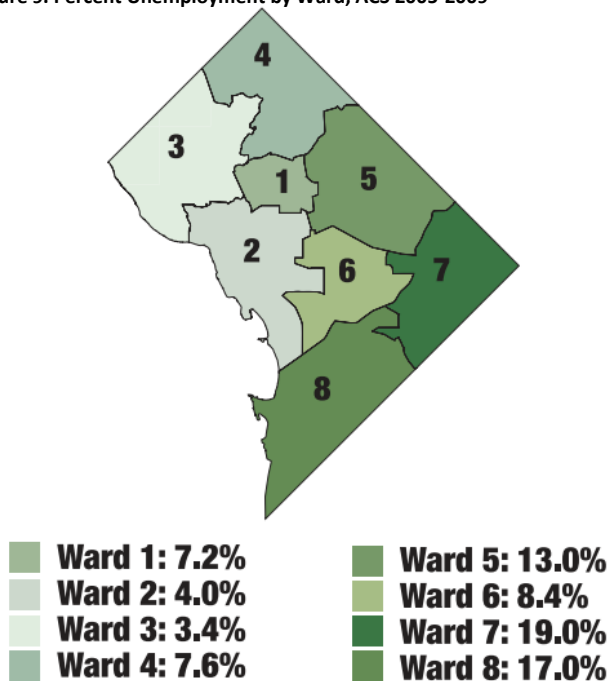


## DEMOGRAPHIC CHARACTERISTICS OF THE DISTRICT OF COLUMBIA

**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



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](http://sustainable.dc.gov/sites/default/files/dc/sites/sustainable/page_content/attachments/SDC%20Final%20Plan_0.pdf)

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

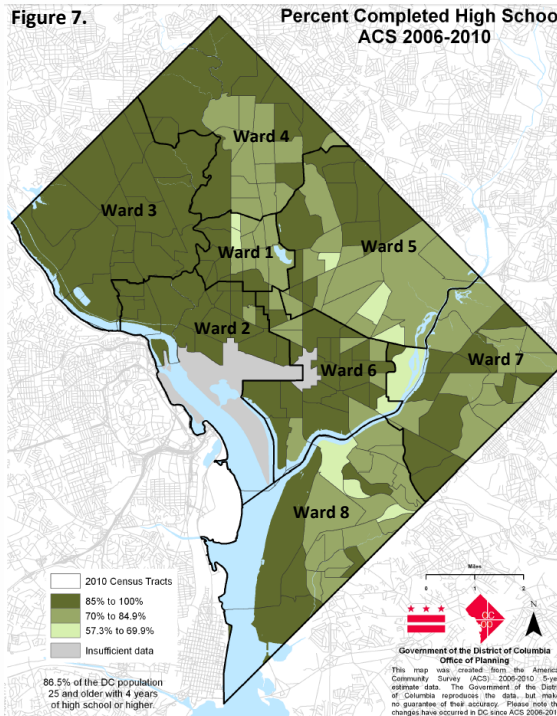
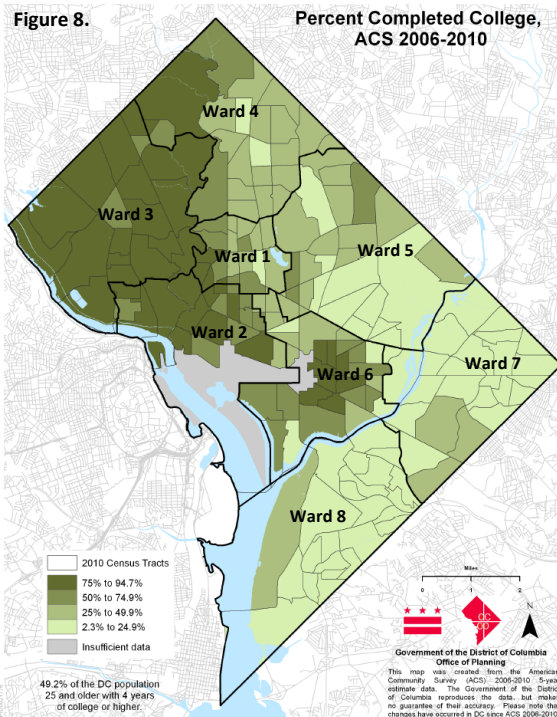


Figure 8. Percent Completed College, ACS 2006-2010

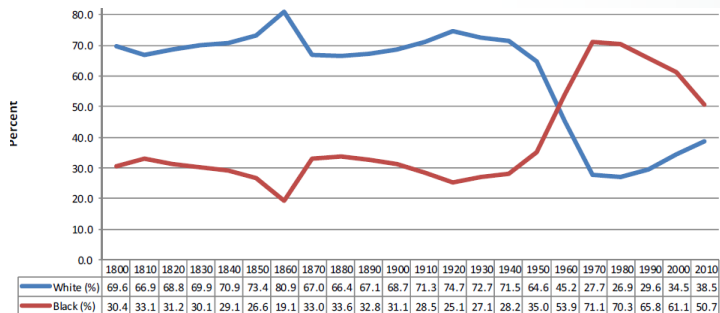


# POPULATION TRENDS



**Racial and ethnic composition in DC is constantly changing.**

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



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

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

Source:

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

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

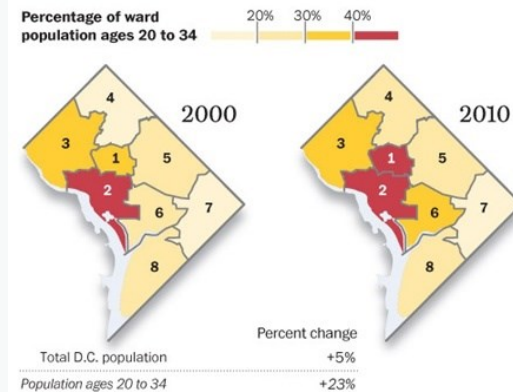
The fluctuations in the District's population since the 1800's have been influenced by many factors including the abolition of slavery (1865), the expansion of the Federal government during and after World Wars I and II, and the Civil Rights movement (peak 1955-1968). For Black residents in the District,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

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

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

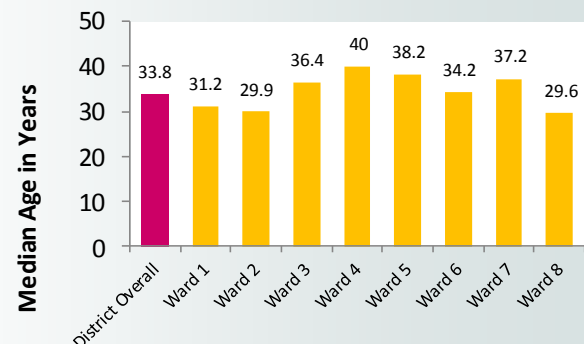
## Which wards gained?

The number of young people in the District grew — especially in wards 1 and 6 — more than the city's total population did.



SOURCE: U.S. Census. The Washington Post. Published on May 4, 2011, 10:22 p.m.

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

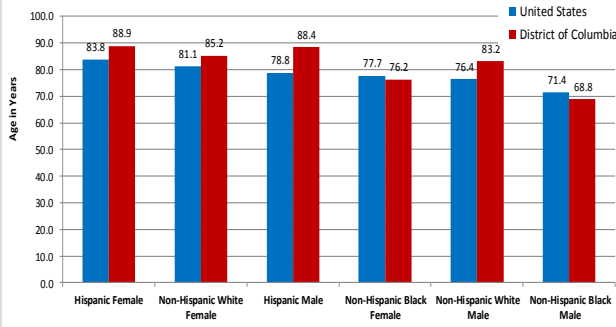
**Life expectancy has improved for all DC residents, regardless of sex and race.**

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.

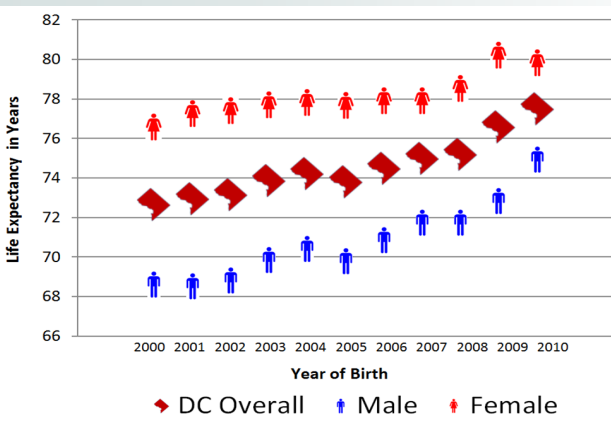


**Figure 13. Life Expectancy at Birth, by Hispanic Origin, Race, and Sex: District of Columbia and United States, Preliminary 2010**



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**



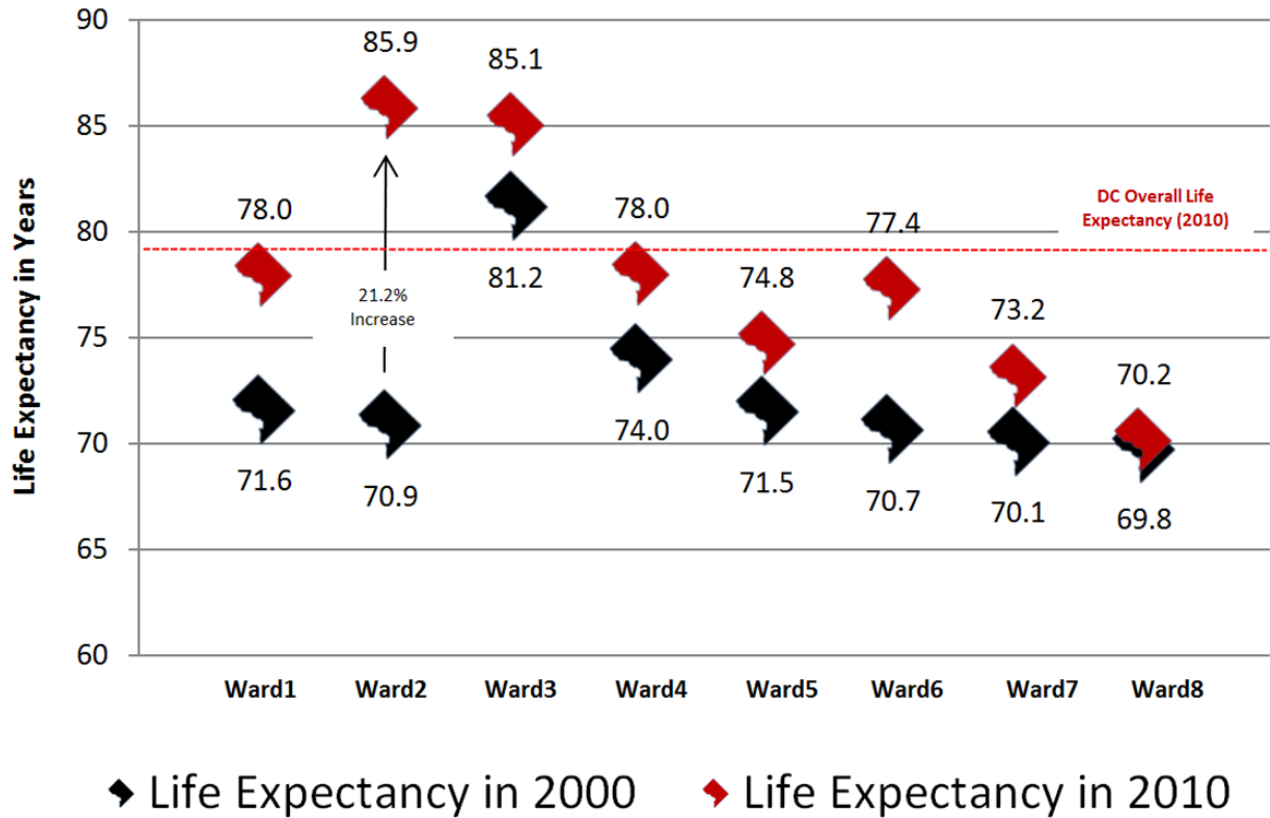
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

- 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

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

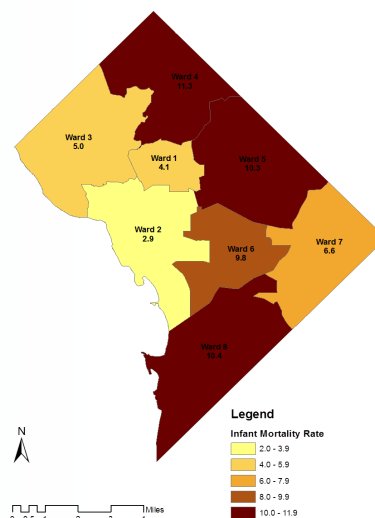
The infant mortality rate (IMR) is the most commonly used index for measuring the risk of dying during the first year of life. The rates presented in this report are calculated by dividing the number of infant deaths that occurred during 2010 by the number of live births for the same period and are presented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



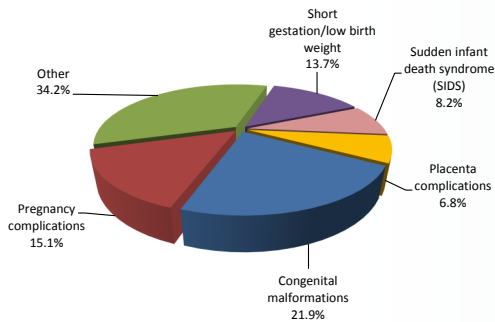
# INFANT MORTALITY TRENDS



**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 19. Infant Mortality by Cause of Death, 2010**



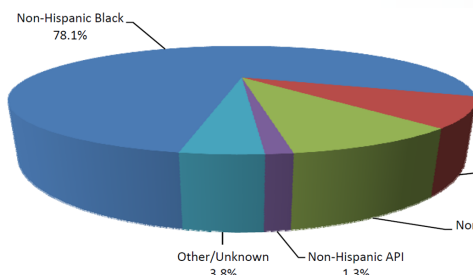
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health



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

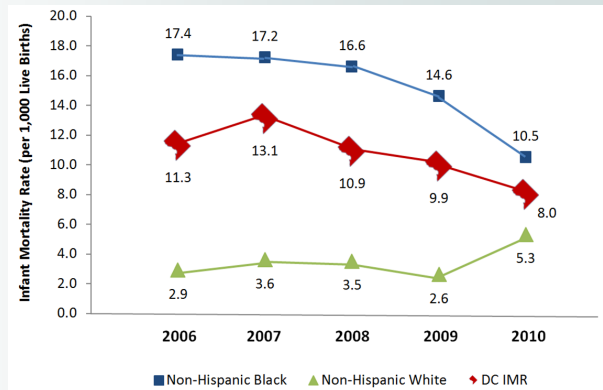
- In 2006-2010, the disparity ratio of non-Hispanic black to non-Hispanic white IMR was 4.3, which means an infant born to a non-Hispanic black mother was 4.3 times more likely to die before reaching its first birthday as an infant born to a non-Hispanic white mother. If non-Hispanic black IMR were reduced 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**

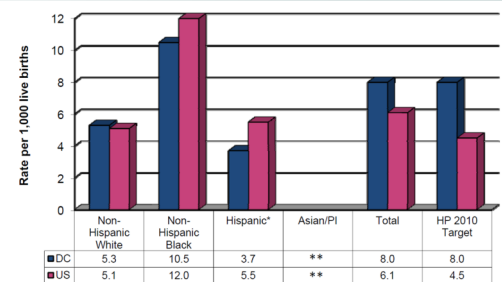


Source: Data Management and Analysis Division, Center for Policy, Planning and Evaluation, DC Department of Health.

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



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

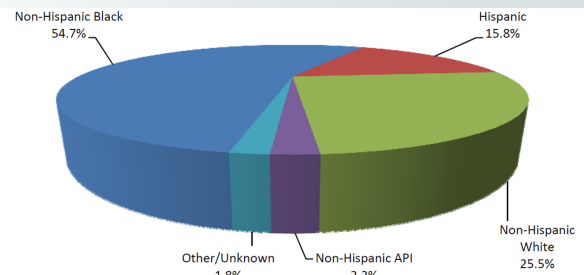


\*Hispanics include persons of all Hispanic origin of any race.

\*\*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](http://www.cdc.gov/nchs/data/nvsr/nvsr60/nvsr60_04.pdf)

**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.



## Section IV. Infant Mortality

# FACTORS CONTRIBUTING TO INFANT MORTALITY

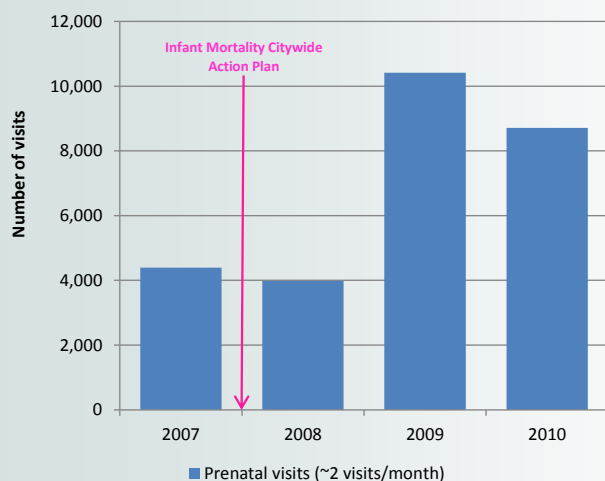


**Reduction in the District's teen births and the expansion and increased access to the District's primary care (prenatal) services have contributed to the declining trend in infant mortality.**

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.

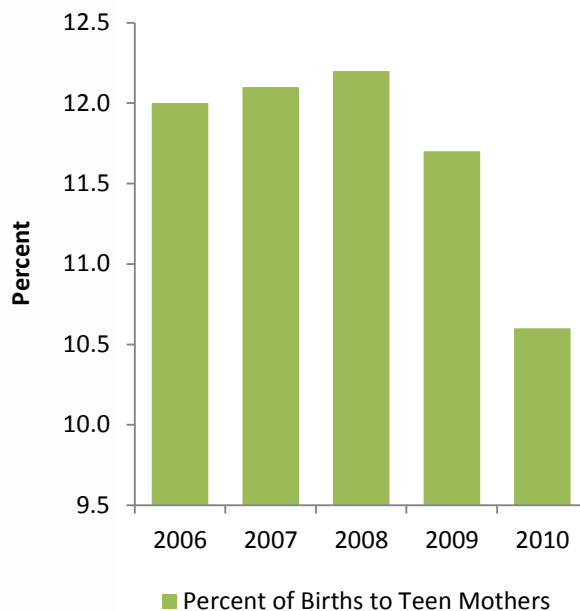
- Teen births (births to mothers under 20 years of age) have decreased in the last 5 years, after peaking in 2008.
- Pregnancy outcomes such as low birth weight and prematurity have also demonstrated a downward trend from 2005-2010.
- Early, high-quality prenatal care (PNC) is one of the cornerstones 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<sup>1</sup>. Women who receive late (third trimester of pregnancy<sup>2</sup>) 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 24. Home Visits to Mothers in Wards 7 and 8, 2007-2010**



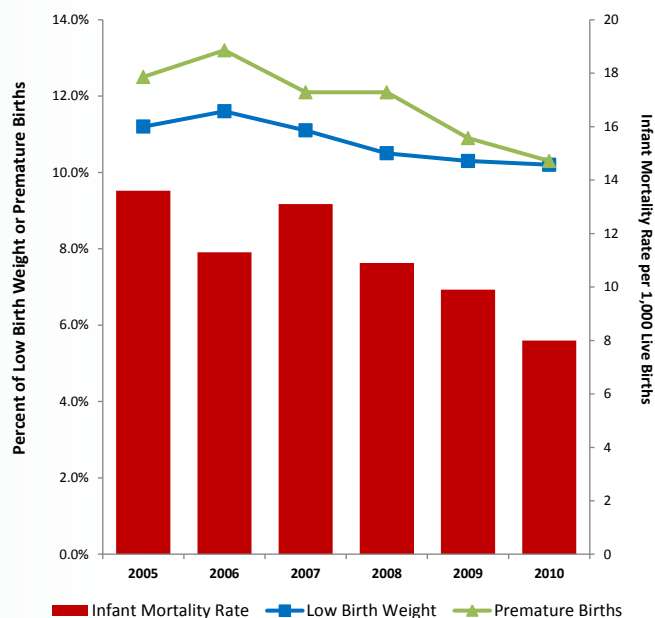
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

**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

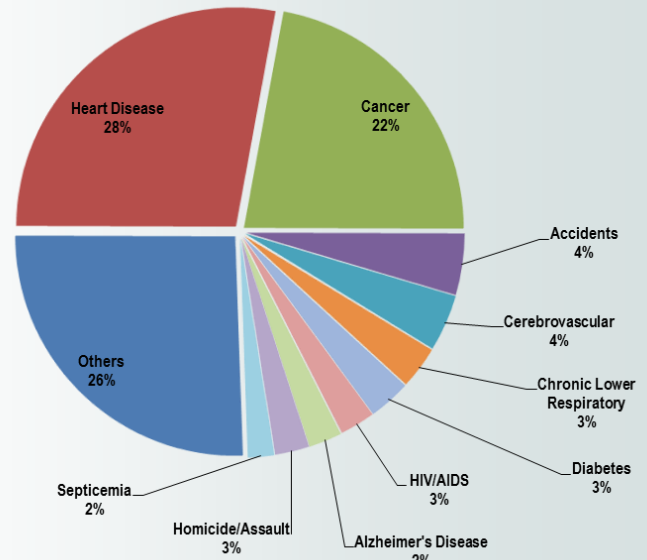
<sup>1</sup>Centers for Disease Control and Prevention. Entry Into Prenatal Care – United States, 1989-1997. MMWR 49(18):393-8. 2000.

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



# LEADING CAUSES OF DEATH

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



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

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

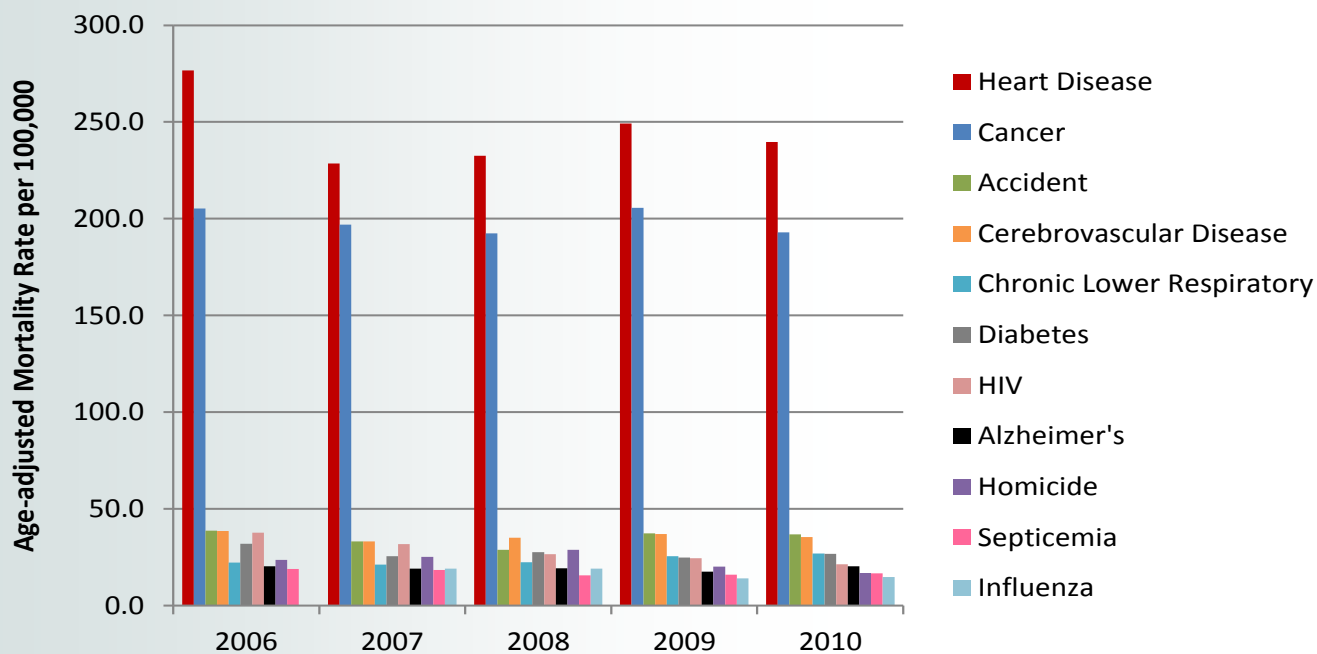
# MORTALITY TRENDS



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

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

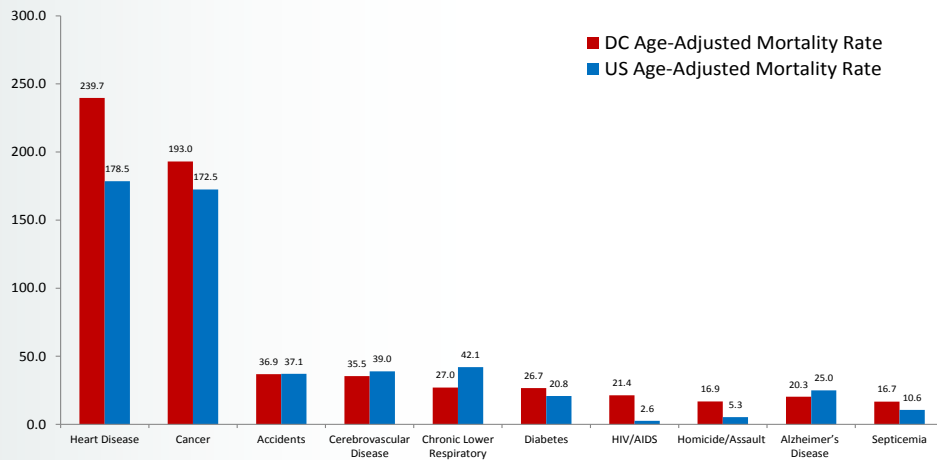
Figure 26. Leading Causes of Death, Age-adjusted Rates, 2006-2010



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

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

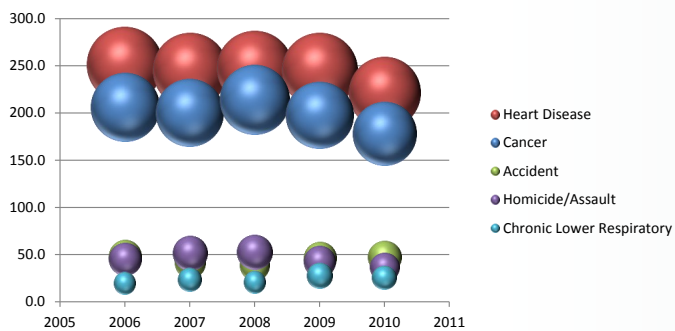
# MORTALITY TRENDS



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

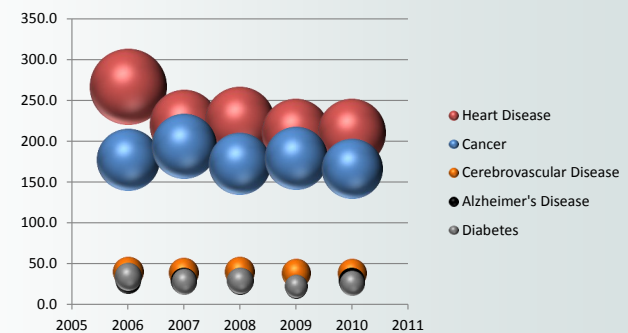
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both men and women in the District.
- From 2006 to 2010, Heart Disease and Cancer were the first and second leading causes of death, respectively, for both black and white DC residents.

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



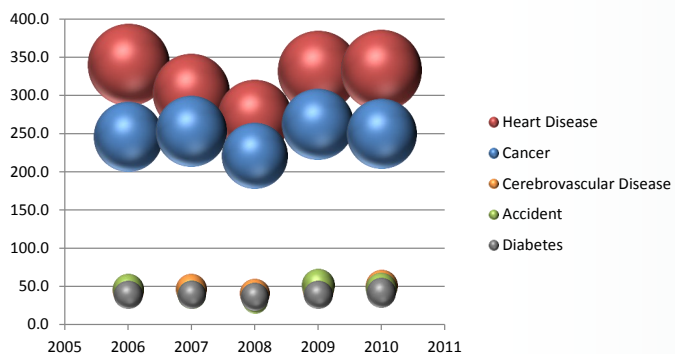
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

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



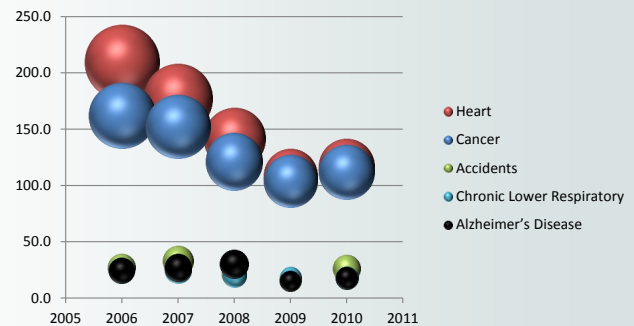
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

**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**



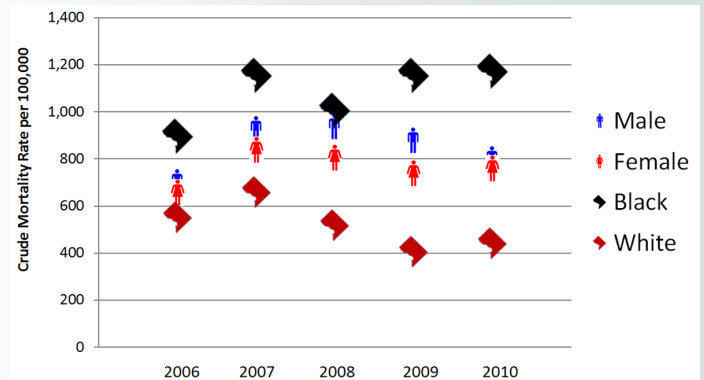
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health



**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**



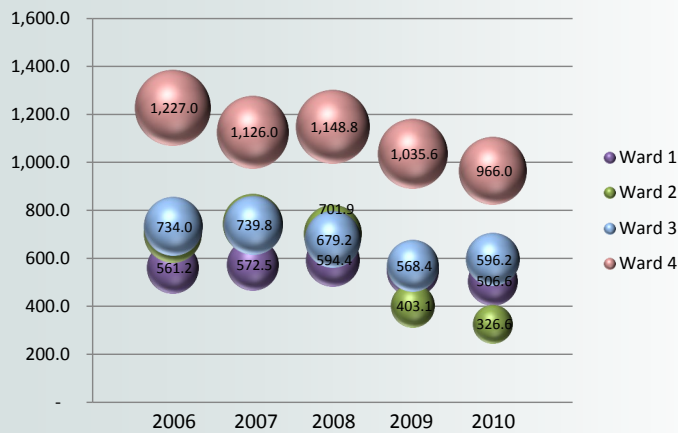
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health



## Section IV. Leading Causes of Death

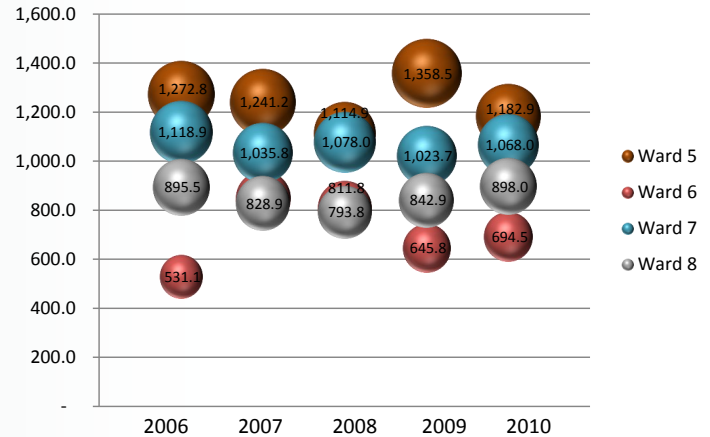
## MORTALITY BY WARD

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



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

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



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



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

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

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

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

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

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

# HEART DISEASE

## District of Columbia Deaths due to Heart Disease

**TOTAL** **1,300**

## Gender Percentage

Male 48.5

Female 51.5

## Age

0-4 0.0

5-14 0.0

15-24 0.4

25-34 0.8

35-44 1.4

45-54 7.7

55-64 15.8

65-74 17.3

75-84 25.5

85+ 31.1

## Race

Black 78.2

White 20.8

Asian/Other 1.1

## Ethnicity

Hispanic 1.8

Non-Hispanic 96.8

## Ward Comparison

Ward 1 7.5

Ward 2 5.4

Ward 3 9.1

Ward 4 15.8

Ward 5 18.5

Ward 6 12.8

Ward 7 16.9

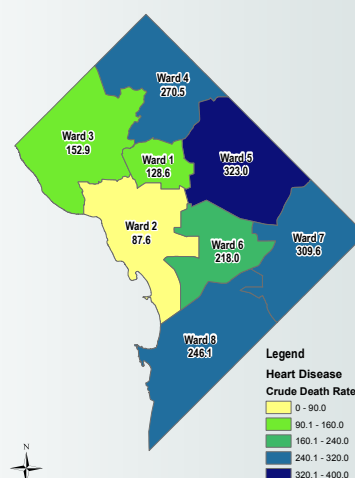
Ward 8 13.4

## Healthy People 2010 Objectives

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

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

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



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

# CANCER

## District of Columbia Deaths due to Cancer

**TOTAL** **1,035**

Gender	Percentage
Male	48.9
Female	51.1

Age	Percentage
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	Percentage
Black	73.8
White	25.0
Asian/Other	1.2

Ethnicity	Percentage
Hispanic	2.4
Non-Hispanic	97.0

### Ward Comparison

Ward 1	9.6
Ward 2	6.2
Ward 3	11.5
Ward 4	15.7
Ward 5	18.6
Ward 6	11.1
Ward 7	14.6
Ward 8	12.2

### Healthy People 2010 Objectives

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

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

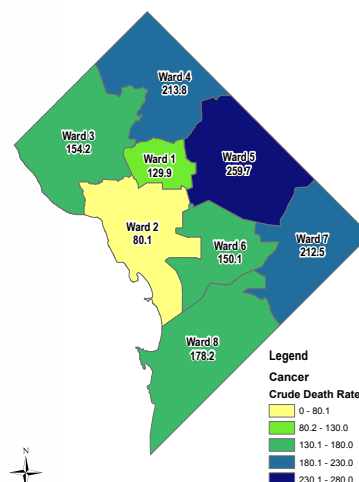
**Goal Met:** Reduce the mortality rate for cervical cancer by 15 percent of the 2000 baseline rate; the District's rate dropped from 4.3 per 100,000 to 1.1 per 100,000.

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

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

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

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



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

# ACCIDENTS

District of Columbia	Deaths due to Accidents
<b>TOTAL</b>	<b>211</b>

Gender	Percentage
Male	64.0
Female	36.0

Age	
0-4	0.9
5-14	0.5
15-24	5.2
25-34	9.5
35-44	11.8
45-54	18.5
55-64	19.4
65-74	6.2
75-84	14.7
85+	13.3

Race	
Black	69.7
White	28.9
Asian/Other	1.4

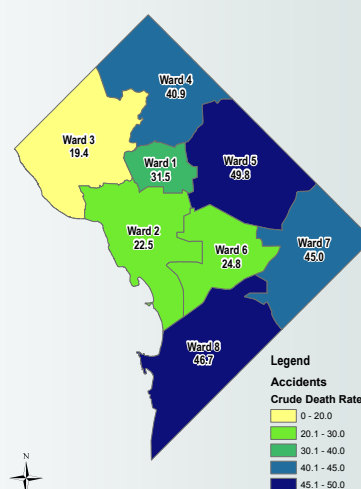
Ethnicity	
Hispanic	2.4
Non-Hispanic	97.2

Ward Comparison	
Ward 1	11.4
Ward 2	8.5
Ward 3	7.1
Ward 4	14.7
Ward 5	17.5
Ward 6	9.0
Ward 7	15.2
Ward 8	15.6

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

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

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



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

# CEREBROVASCULAR DISEASE

## District of Columbia Deaths due to Cerebrovascular Disease

**TOTAL** **194**

Gender	Percentage
Male	37.1
Female	62.9

Age	Percentage
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	Percentage
Black	80.9
White	18.0
Asian/Other	1.0

Ethnicity	Percentage
Hispanic	2.6
Non-Hispanic	96.9

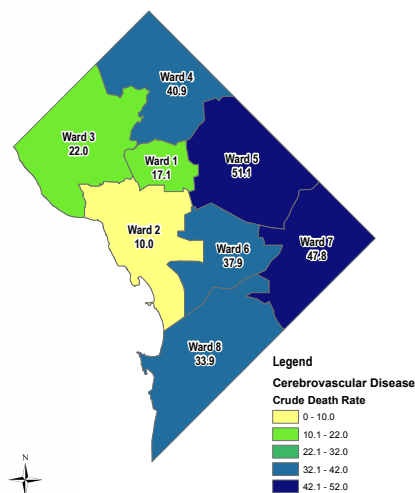
Ward Comparison	Rate
Ward 1	6.7
Ward 2	4.1
Ward 3	8.8
Ward 4	16.0
Ward 5	19.6
Ward 6	14.9
Ward 7	17.5
Ward 8	12.4

### Healthy People 2010 Objectives

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

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

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



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

# CHRONIC LOWER RESPIRATORY

## District of Columbia Deaths due to Chronic Lower Respiratory Disease

**TOTAL** **146**

### Gender Percentage

Male 50.0  
Female 50.0

### Age

0-4 0.7  
5-14 0.0  
15-24 0.7  
25-34 0.7  
35-44 2.1  
45-54 5.5  
55-64 9.6  
65-74 19.2  
75-84 30.1  
85+ 31.5

### Race

Black 68.5  
White 28.8  
Asian/Other 2.7

### Ethnicity

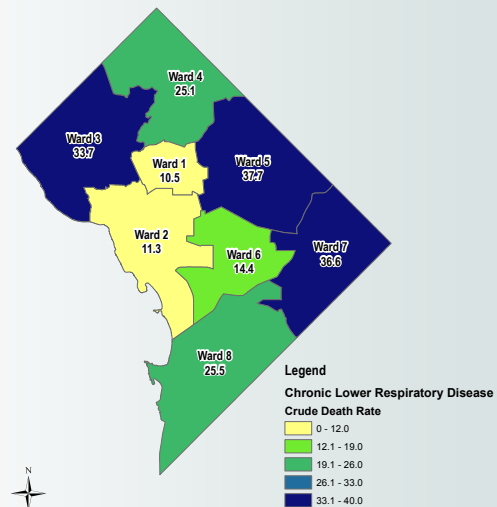
Hispanic 1.4  
Non-Hispanic 96.6

### Ward Comparison

Ward 1 5.5  
Ward 2 6.2  
Ward 3 17.8  
Ward 4 13.0  
Ward 5 19.2  
Ward 6 7.5  
Ward 7 17.8  
Ward 8 12.3

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

**Figure 39. Map of Chronic Lower Respiratory Disease**  
**Crude Death Rates by Ward, 2010**



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

# DIABETES

## District of Columbia Deaths due to Diabetes

**TOTAL** **145**

Gender	Percentage
Male	42.1
Female	57.9

Age	Percentage
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	Percentage
Black	88.3
White	9.7
Asian/Other	2.1

Ethnicity	Percentage
Hispanic	2.1
Non-Hispanic	97.2

Ward Comparison	Percentage
Ward 1	3.4
Ward 2	3.4
Ward 3	4.1
Ward 4	15.2
Ward 5	20.7
Ward 6	11.7
Ward 7	21.4
Ward 8	20.0

## Healthy People 2010 Objectives

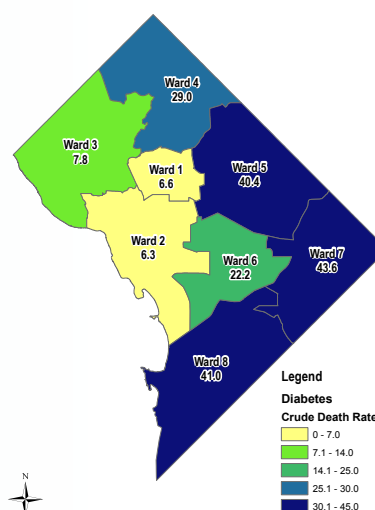
**Goal Not Met: Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents; the District's rate is 24.9 per 100,000.**

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

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

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

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



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

# HIV

## District of Columbia Deaths due to HIV

<b>TOTAL</b>	<b>121</b>
--------------	------------

### 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

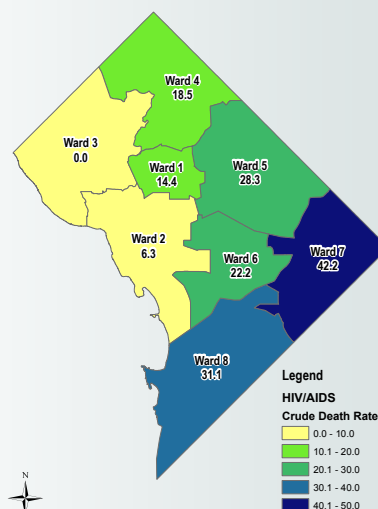
**Goal Not Met:** Increase by 10 percent annually the number of HIV+ individuals who received housing assistance services

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

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

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

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



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

# HOMICIDE/ASSAULT

## District of Columbia Deaths due to Homicide/Assault

**TOTAL 118**

### Gender Percentage

Male	89.0
Female	11.0

### Age

0-4	2.5
5-14	0.8
15-24	38.1
25-34	28.0
35-44	14.4
45-54	9.3
55-64	4.2
65-74	1.7
75-84	0.8
85+	0.0

### Race

Black	89.0
White	5.9
Asian/Other	5.1

### Ethnicity

Hispanic	4.2
Non-Hispanic	94.9

### Ward Comparison

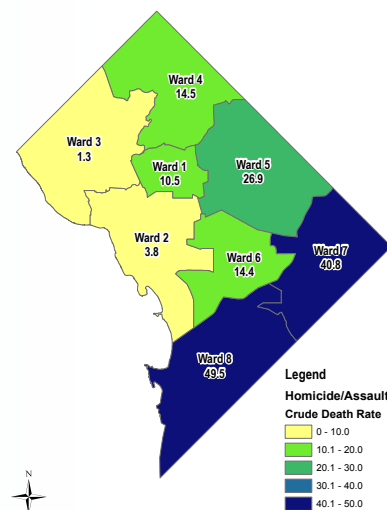
Ward 1	6.8
Ward 2	2.5
Ward 3	0.8
Ward 4	9.3
Ward 5	16.9
Ward 6	9.3
Ward 7	24.6
Ward 8	29.7

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

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

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

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



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

# ALZHEIMER'S DISEASE

## District of Columbia Deaths due to Alzheimer's Disease

**TOTAL 114**

## Gender Percentage

Male 17.5  
Female 82.5

## Age

0-4 0.0  
5-14 0.0  
15-24 0.0  
25-34 0.0  
35-44 0.0  
45-54 0.0  
55-64 0.0  
65-74 2.6  
75-84 21.9  
85+ 75.4

## Race

Black 60.5  
White 36.0  
Asian/Other 3.5

## Ethnicity

Hispanic 0.9  
Non-Hispanic 98.2

## Ward Comparison

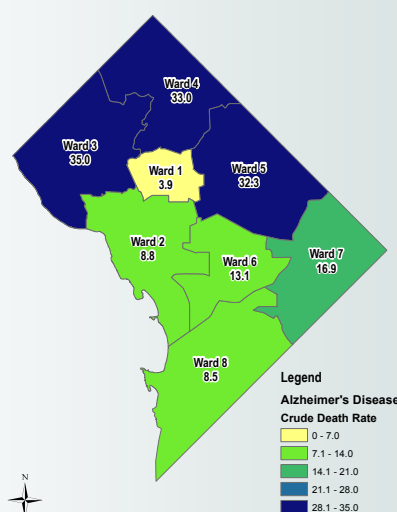
Ward 1 2.6  
Ward 2 6.1  
Ward 3 23.7  
Ward 4 21.9  
Ward 5 21.1  
Ward 6 8.8  
Ward 7 10.5  
Ward 8 5.3

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

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

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

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



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

# SEPTICEMIA

## District of Columbia Deaths due to Septicemia

**TOTAL** **90**

## Gender Percentage

Male 45.6  
Female 54.4

## Age

0-4 0.0  
5-14 0.0  
15-24 0.0  
25-34 2.2  
35-44 1.1  
45-54 6.7  
55-64 18.9  
65-74 28.9  
75-84 22.2  
85+ 20.0

## Race

Black 87.8  
White 8.9  
Asian/Other 3.3

## Ethnicity

Hispanic 3.3  
Non-Hispanic 96.7

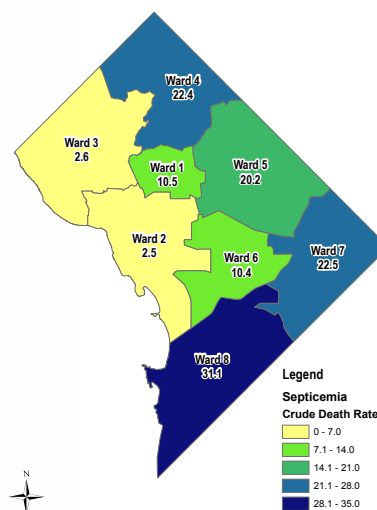
## Ward Comparison

Ward 1 8.9  
Ward 2 2.2  
Ward 3 2.2  
Ward 4 18.9  
Ward 5 16.7  
Ward 6 8.9  
Ward 7 17.8  
Ward 8 24.4

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

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

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



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

# PROMOTING HEALTHY BEHAVIORS

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

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



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

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

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

# OBEesity

District of Columbia	Percent Healthy Weight	Percent Obese
<b>TOTAL</b>	43.7	22.4
<b>Gender</b>		
Male	39.3	18.5
Female	47.7	26
<b>Age</b>		
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
<b>Race/Ethnicity</b>		
Caucasian	57.9	9.6
African American	30.1	34.9
Other	49.2	17.1
Hispanic	54.7	12
<b>Education</b>		
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
<b>Income</b>		
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

<b>Ward Comparison</b>		
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

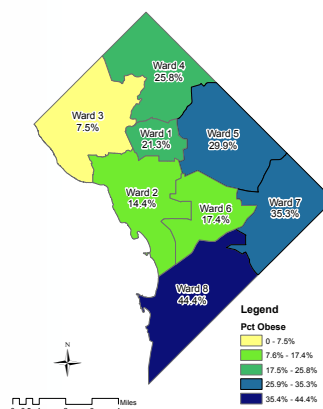
**Goal Not Met: Reduce the proportion of adults who are obese to 15 percent; the District's rate is 22.7 percent.**

**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 53.3 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



# OBESEITY TRENDS



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

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

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

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

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

**Access to Fruits and Vegetables: Policy and Environmental Indicators, 2009**

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

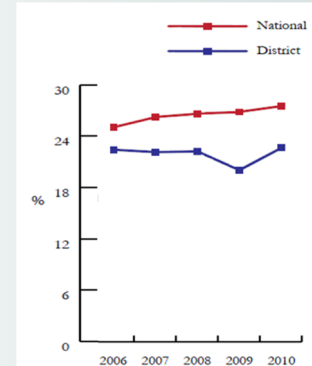
Source: Centers for Disease Control and Prevention, *State Indicator Report on Fruits and Vegetables, 2009*, available at: <http://www.fruitsandveggiesmatter.gov>

**State Laws Addressing Childhood Obesity, 2011**

	DC	US
Prohibits Sugar Sweetened Beverages in School Vending Machines	No	Yes
Requires Physical Education for All Grades (K-12)	No	Yes
Mandates BMI Screening in Schools	No	Yes

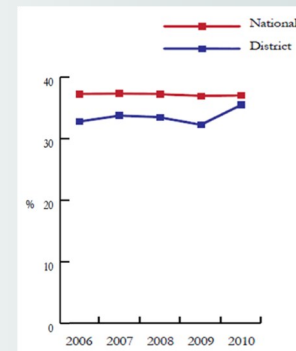
Source: Childhood Obesity Prevention, *2011 State Legislation Report, American Academy of Pediatrics*, (p. 38).

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



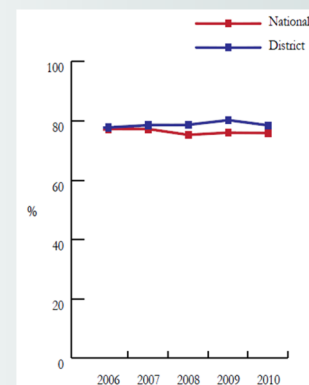
Source: 2010 District of Columbia BRFSS

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



Source: 2010 District of Columbia BRFSS

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

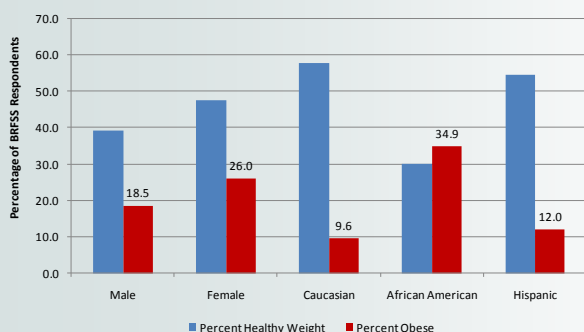


Source: 2010 District of Columbia BRFSS

# OBESITY TRENDS

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

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



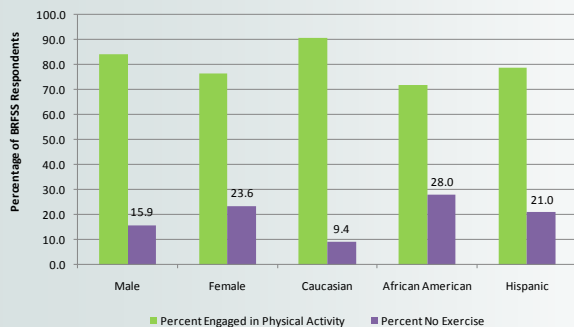
Source: 2010 District of Columbia BRFSS

**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

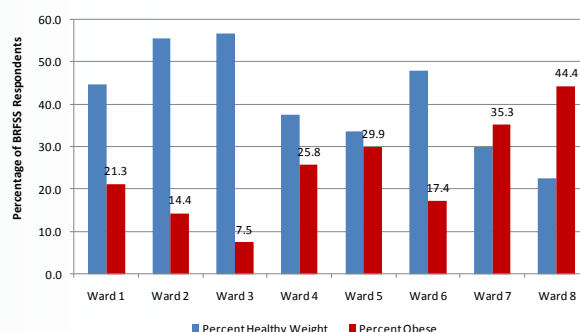
**Figure 53. Percent No Physical Activity in Past Month (in purple), by Gender and Race/Ethnicity, 2010**



Source: 2010 District of Columbia BRFSS

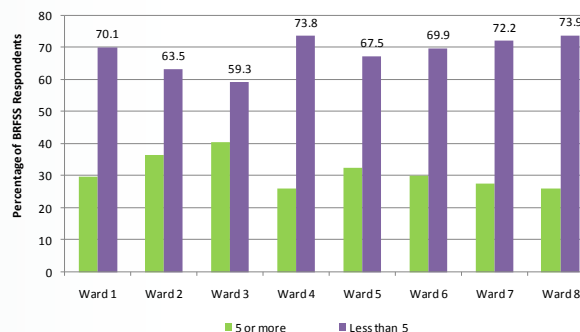
**Ward 8 residents have the highest obesity rates, and are least likely to exercise or consume the recommended serving of fruits and vegetables.**

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



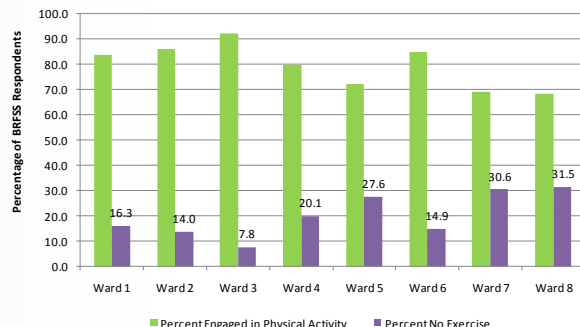
Source: 2010 District of Columbia BRFSS

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



Source: 2009 District of Columbia BRFSS

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

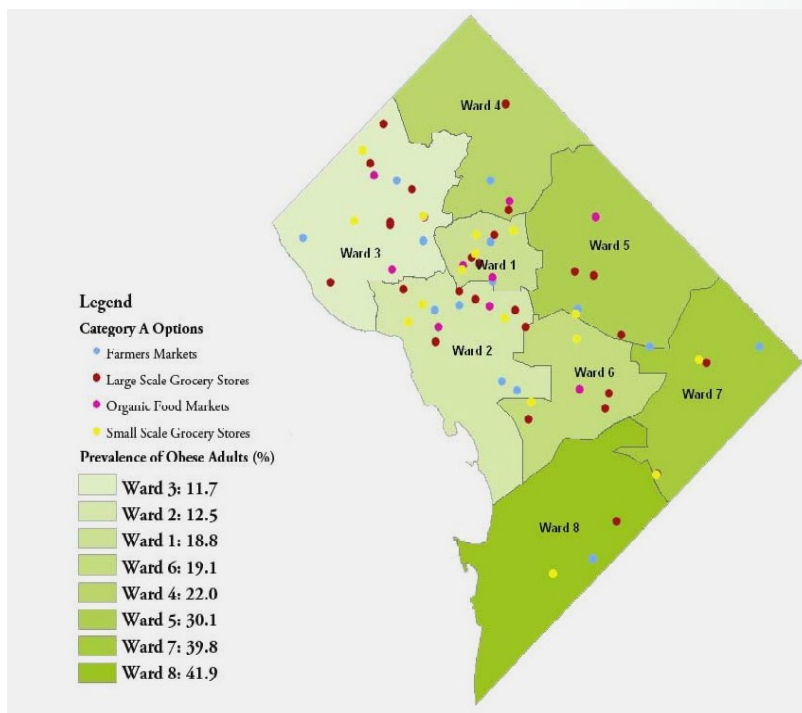


Source: 2010 District of Columbia BRFSS

# 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

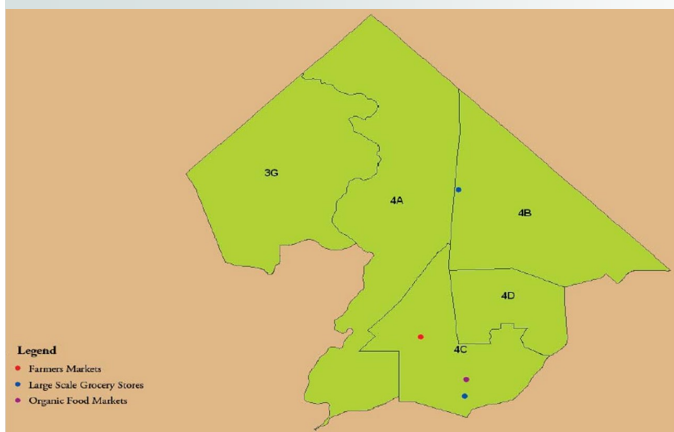
In 2010, the District of Columbia developed the five-year District of Columbia Overweight and Obesity Action Plan to engage community partners and government agencies and address clinical as well as broader social and community-based determinants related to weight status, overweight and obesity. The 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

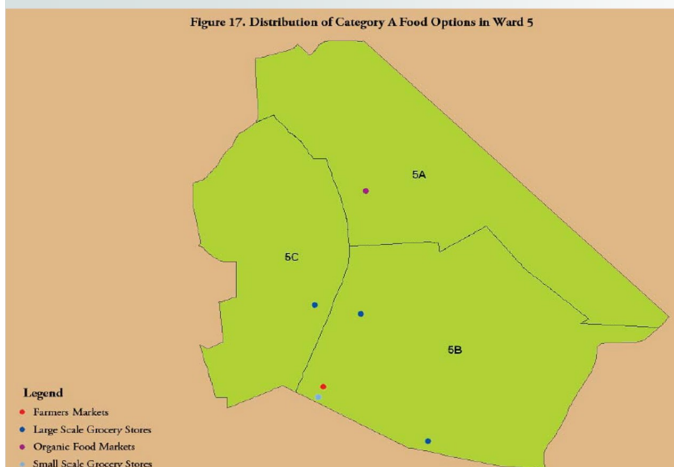
In Wards 4 and 5, obesity rates (25.8 and 29.9 percent, respectively) are higher than the city-wide average (22.4 percent), and residents are not likely to consume the recommended serving of fruits and vegetables when compared to wards with lower obesity rates. The following is an analysis of the geographic 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 57 and 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**



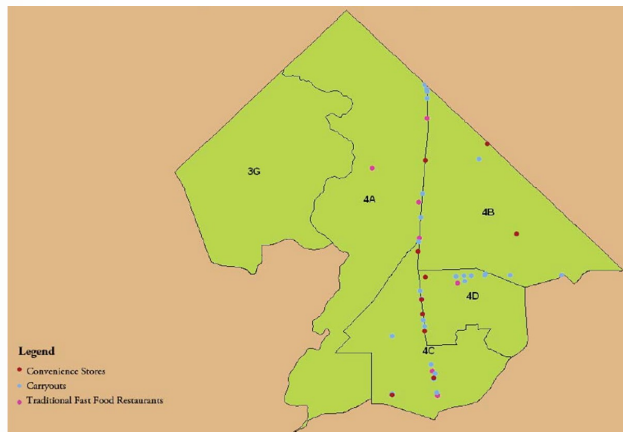
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



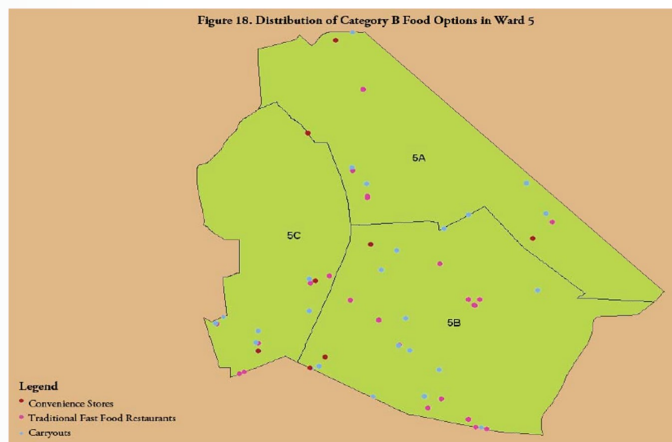
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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

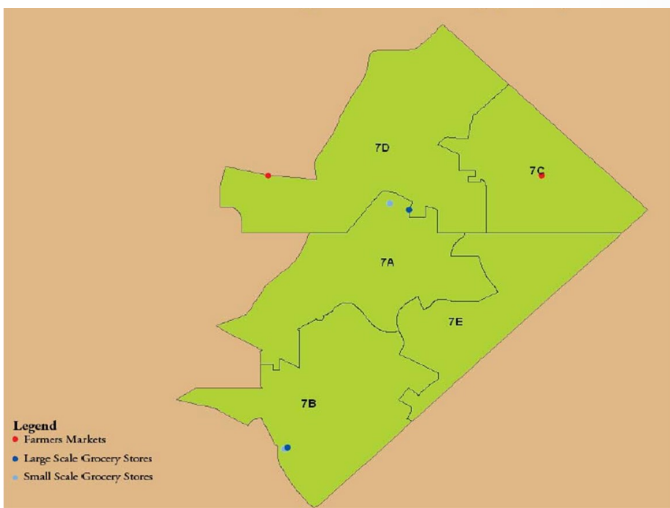


Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

# FOOD OPTIONS IN WARDS 7 AND 8

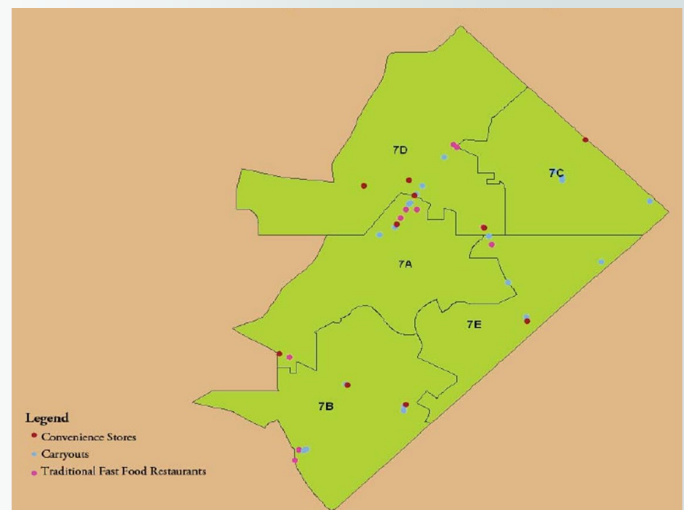
In Wards 7 and 8, obesity rates are highest in the District (35.3 and 44.4 percent, respectively), and residents are the least likely to consume the recommended serving of fruits and vegetables. The following is an analysis of the geographic distribution and types of food options available in these wards. 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**



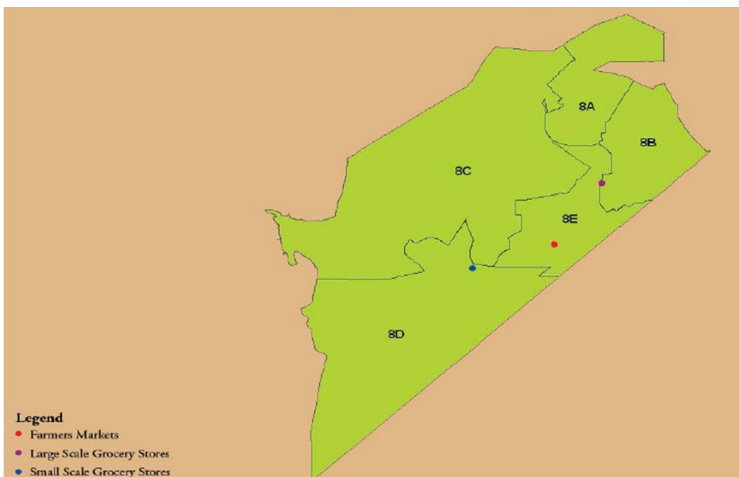
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

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



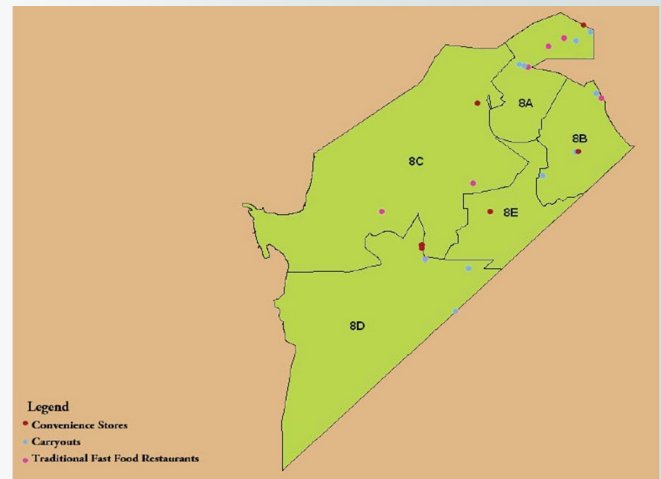
Source: Obesity in the District of Columbia, Center for Policy, Planning, and Evaluation, 2009

**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
<b>TOTAL</b>	6.1	15.4
<b>Gender</b>		
Male	5.3	19.4
Female	6.7	12
<b>Age</b>		
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
<b>Race/Ethnicity</b>		
Caucasian	10.3	76.8
African American	3.6	89.9
Other	3.1	85.2
Hispanic	5.2	86.2
<b>Education</b>		
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
<b>Income</b>		
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
<b>Ward Comparison</b>		
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

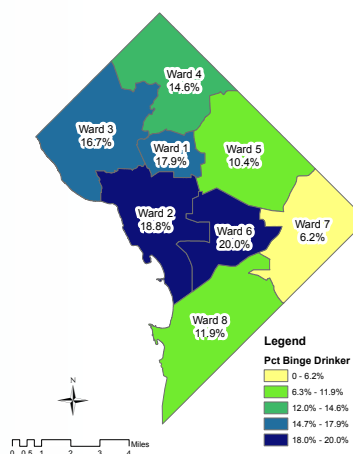
## Healthy People 2010 Objectives

**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 BRFS

## Healthy People 2010 Objectives

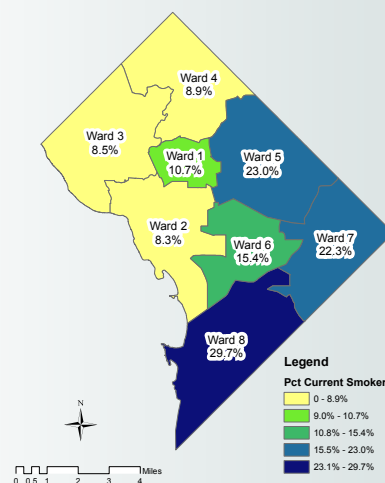
**Goal Not Met: Reduce cigarette smoking by adults to 12 percent; the District rate is 15.6 percent.**

**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 were 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

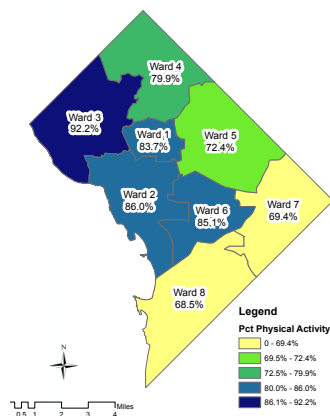
## Healthy People 2010 Objectives

**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

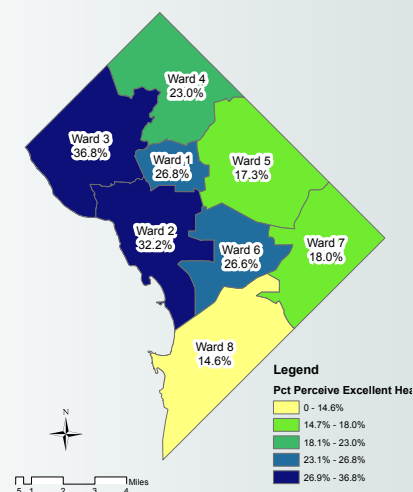
Ward 1 26.8  
Ward 2 32.2  
Ward 3 36.8  
Ward 4 23  
Ward 5 17.3  
Ward 6 26.6  
Ward 7 18  
Ward 8 14.6

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

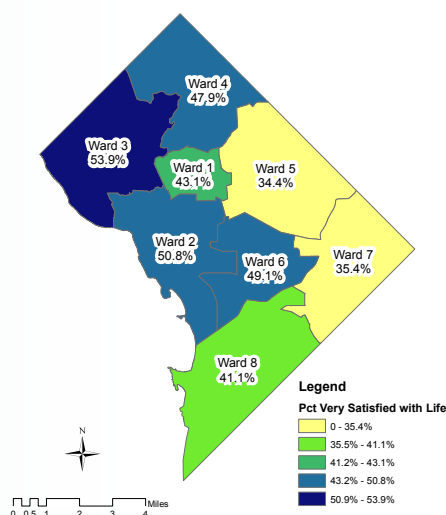
Ward 8 41.1

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

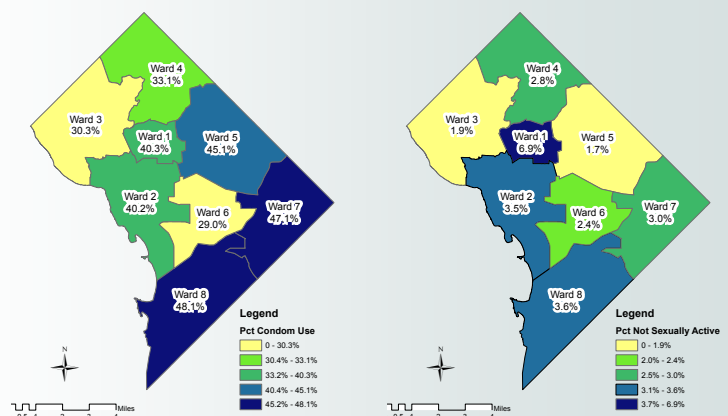
District of Columbia	Percent Condom Use	Not Sexually Active
<b>TOTAL</b>	38.2	3.1
<b>Gender</b>		
Male	42.9	1.8
Female	33.8	4.3
<b>Age</b>		
18-24	67.9	4.8
25-34	40.4	1.2
35-44	38.9	0.9
45-54	34.5	3.4
55-64	27.1	7.5
<b>Race/Ethnicity</b>		
Caucasian	30.3	1.8
African American	45.4	4.1
Other	39.7	4.5
Hispanic	*	2
<b>Education</b>		
Less than High School	*	*
High School Graduate	45.4	4
Some College	50.6	3.8
College Graduate	33.2	2.4
<b>Income</b>		
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
<b>Ward Comparison</b>		
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

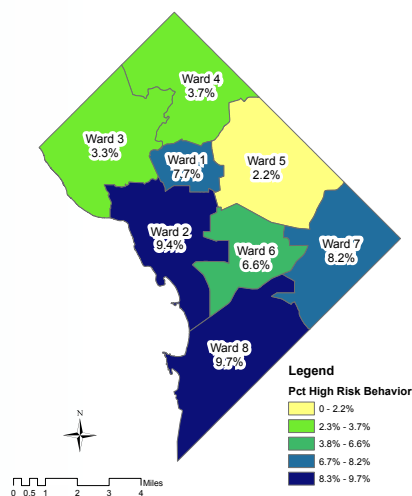
District of Columbia	Percent with High-Risk Behavior
<b>TOTAL</b>	6.4
<b>Gender</b>	
Male	8.8
Female	4.1
<b>Age</b>	
18-24	5.1
25-34	11.8
35-44	6.4
45-54	5.1
55-64	3.1
<b>Race/Ethnicity</b>	
Caucasian	6.4
African American	5.9
Asian	1.3
Other	10
Hispanic	11.9
<b>Education</b>	
Less than High School	16.1
High School Graduate	5.9
Some College	4.9
College Graduate	6.3
<b>Income</b>	
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
<b>Ward Comparison</b>	
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
<b>TOTAL</b>	73.7
<b>Gender</b>	
Male	71
Female	76.1
<b>Age</b>	
18-24	65.8
25-34	72.1
35-44	76.8
45-54	76.2
55-64	74.4
65+	69.6
<b>Race/Ethnicity</b>	
Caucasian	85.6
African American	63.4
Asian	74.8
Other	74.6
Hispanic	79.8
<b>Education</b>	
Less than High School	46
High School Graduate	64
Some College	65.1
College Graduate	82.1
<b>Income</b>	
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

<b>Ward Comparison</b>	
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.

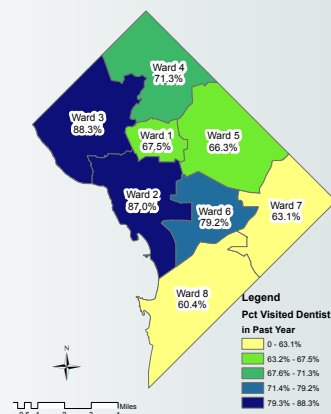
**Goal Attained:** Increase by at least 50 percent the number of children entering school programs who have received a dental assessment from a qualified health care professional to determine the existence of any decay or oral pathologies and/or deformities.

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.

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."

## 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.*

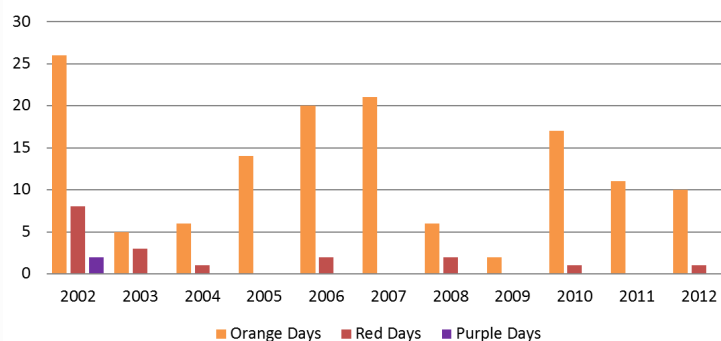
**Goal Not Met:** Eliminate significant health risks from the National Priority List (NPL) of hazardous waste sites, as measured by performing a level of site cleanup sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments.

**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
<i>When the AQI is in this range:</i>	<i>...air quality conditions are:</i>	<i>...as symbolized by this color:</i>
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



## Section IV. Promoting Safe and Healthy Communities

# 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.

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

### Healthy People 2010 Objectives

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

There were no *Salmonella enteritidis* 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)
<i>Salmonella</i> species, rate of 0	<i>Salmonella</i> , rate of 15.0
<i>Escherichia coli</i> O157: H7, rate of 0	E.Coli STEC, rate of 1.7
<i>Listeria monocytogenes</i> , 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

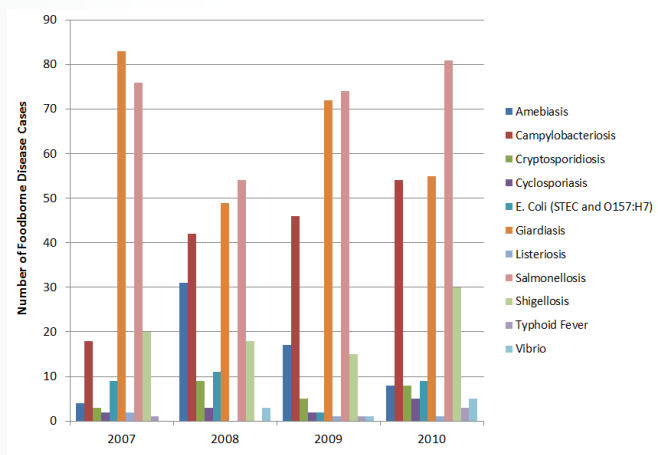
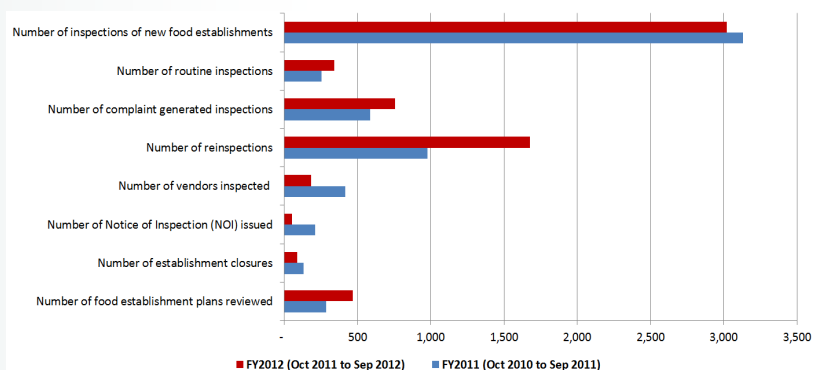
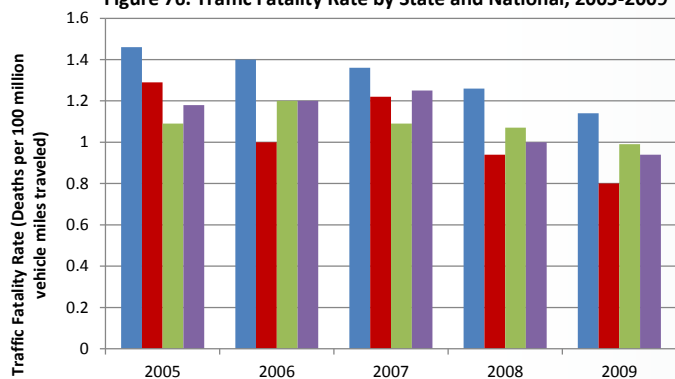


Figure 75. Food Establishment Inspections Conducted by DC DOH, FY 2011-2012



# PUBLIC SAFETY

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



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

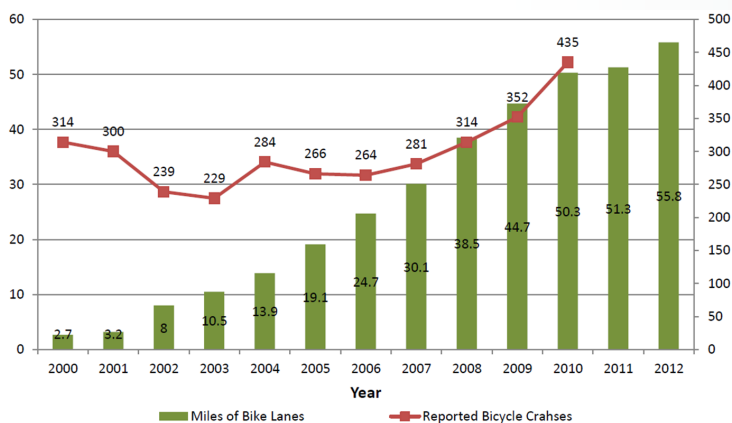
## Transportation Facts in the District

- 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

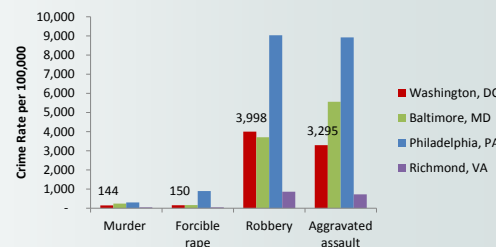
**Goal Attained:** Establish a Trauma/Injury Registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics; DOH is installing software to begin a Trauma Registry.

**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).*

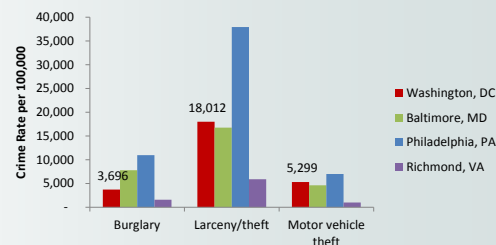
- According to the US National Highway Traffic Safety Administration, there were 192 traffic fatalities in the District (deaths within 30 days of accident) from 2005 to 2009.
- During this 5-year period, the traffic fatality rate in the District was lower than the national rate.
- In 2009, the traffic 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

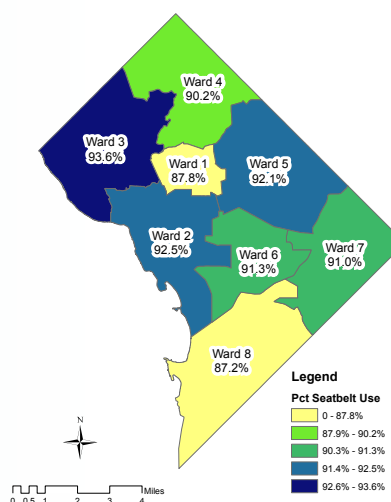
## Healthy People 2010 Objectives

**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.

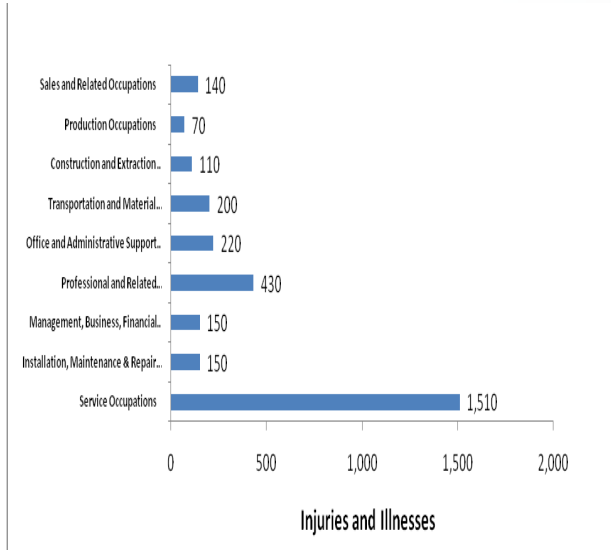
- Overall, 90.4 percent respondents reported always wearing their seat belts and 9.6 percent reported not always wearing their seat belt.
- Males were more likely than females to report they do not always wear their seat belt, at 10.8 percent.
- Adults aged 18-24 years were more likely than all other 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 subgroups to report they do not always wear their seat belt, at 12 percent.
- Adult households with an income of \$35,000-\$49,000 were more likely than all other income subgroups to report they do not always wear their seat belt, at 12.6 percent.
- Adults who resided in Ward 8 were more likely than all other wards to report they do not always wear their seat belt, at 13 percent.

Figure 80. Map of Seatbelt Use by Ward, 2010



# OCCUPATIONAL INJURY

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



Source: DOH, [Characteristics for Injuries and Illnesses Requiring Days Away from Work in Private Industry 2010](#)

## Fatal Work Injuries in the District of Columbia

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

### Key Characteristics

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

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

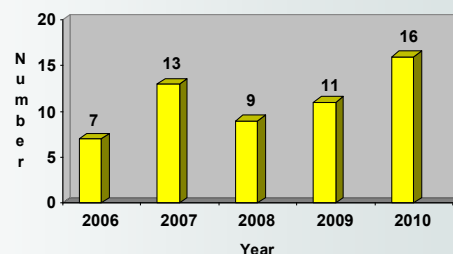
### Case Characteristic Highlights

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

### Demographic Highlights

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

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



Source: DOH, [DC Workplace Fatalities 2010](#)



## IMPROVE ACCESS TO QUALITY AND HEALTHCARE SERVICES

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



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

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

# PRIMARY CARE

## District of Columbia Percent with Health Care Provider

**TOTAL** 83.3

### Gender

Male 78.1

Female 87.9

### Age

18-34 69.5

35-44 81.3

45-54 86.2

55-64 91.4

65+ 94.4

### Race/Ethnicity

Caucasian 84.5

African American 84.3

Asian 70.2

Other 77.5

Hispanic 80.6

### Education

Less than High School 80.7

High School Graduate 81.9

Some College 83.0

College Graduate 84.2

### Income

Less than \$15,000 73.8

\$15,000-\$24,999 75.6

\$25,000-\$34,999 86.8

\$35,000-\$49,999 83.3

\$50,000-\$74,999 84.5

\$75,000 and over 87.3

### Ward Comparison

Ward 1 82.8

Ward 2 87.2

Ward 3 86.9

Ward 4 88.6

Ward 5 78.7

Ward 6 89.3

Ward 7 82.9

Ward 8 84.8

Source: 2010 District of Columbia BRFSS

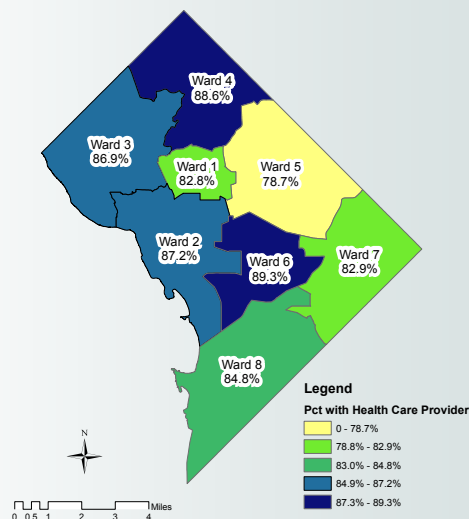
## Healthy People 2010 Objectives

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

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

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

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



# ROUTINE CHECK-UP

## District of Columbia Percent with Routine Check-up within Past Year

<b>TOTAL</b>	77.4
<b>Gender</b>	
Male	72.0
Female	82.2
<b>Age</b>	
18-34	69.9
35-44	72.4
45-54	78.6
55-64	80.4
65+	91.0
<b>Race/Ethnicity</b>	
Caucasian	69.4
African American	84.7
Asian	71.0
Other	75.9
Hispanic	77.7
<b>Education</b>	
Less than High School	90.6
High School Graduate	86.0
Some College	82.8
College Graduate	72.0
<b>Income</b>	
Less than \$15,000	78.7
\$15,000-\$24,999	77.5
\$25,000-\$34,999	87.2
\$35,000-\$49,999	83.7
\$50,000-\$74,999	78.7
\$75,000 and over	73.5

### Ward Comparison

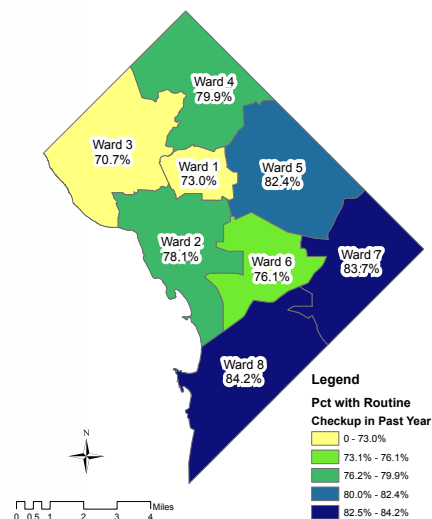
Ward 1	73.0
Ward 2	78.1
Ward 3	70.7
Ward 4	79.9
Ward 5	82.4
Ward 6	76.1
Ward 7	83.7
Ward 8	84.2

Source: 2010 District of Columbia BRFSS

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

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

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



# HEALTH CARE COVERAGE

## District of Columbia Percent Covered by Health Plan

**TOTAL** 93

### Gender

Male 91.1  
Female 94.6

### Age

18-34 89.6  
35-44 96  
45-54 91.3  
55-64 92.3  
65+ 96.7

### Race/Ethnicity

Caucasian 97.4  
African American 90.4  
Other 87.4  
Hispanic 91

### Education

Less than High School 90.7  
High School Graduate 88.1  
Some College 88.7  
College Graduate 95.9

### Income

Less than \$15,000 81  
\$15,000-\$24,999 86.6  
\$25,000-\$34,999 90.2  
\$35,000-\$49,999 88  
\$50,000-\$74,999 91.2  
\$75,000 and over 98.9

### Ward Comparison

Ward 1 96.2  
Ward 2 95  
Ward 3 97.4  
Ward 4 91.6  
Ward 5 86.2  
Ward 6 97.6  
Ward 7 90.5  
Ward 8 89.7

Source: 2010 District of Columbia BRFSS

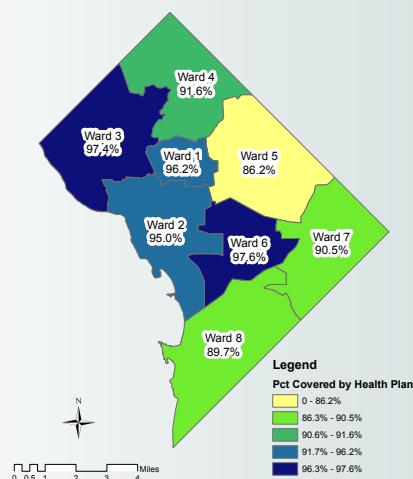
## Healthy People 2010 Objectives

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

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

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

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



## Section IV. Improving Access to Quality Health Care Services

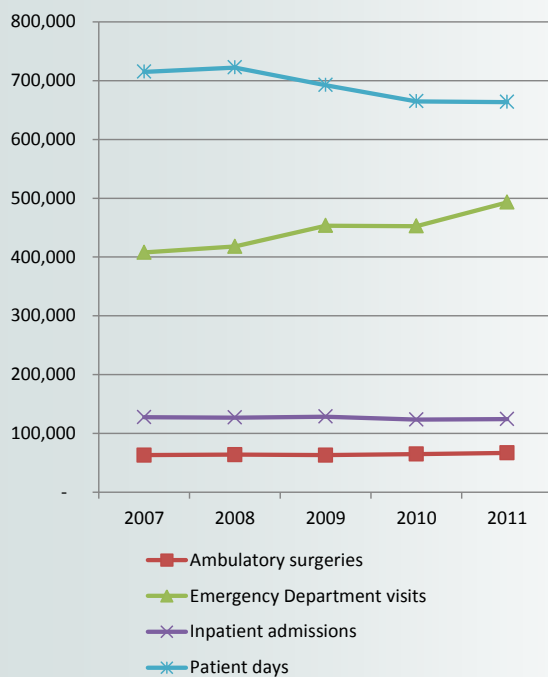
## HOSPITAL UTILIZATION TRENDS



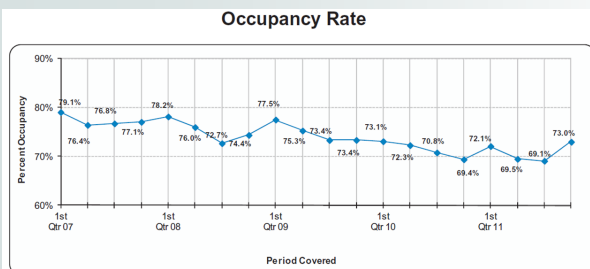
**Emergency visits and ambulatory services increase steadily while patient days decline in the District.**

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

**Figure 86. Hospital Utilization Trends, 2007-2011**



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



Note: Calculations are based on reported utilization figures for the District of Columbia acute care non-federal hospitals. Definition: Occupancy percentages are calculated based on the number of operating beds. Percent occupancy is defined as the average daily census divided by the number of operating beds.

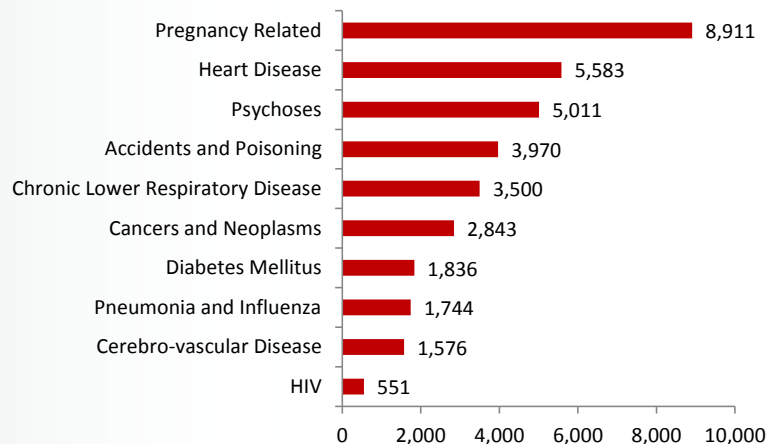
Source: [District of Columbia Hospital Association Annual Report, 2011. Utilization Indicators.](#)

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

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

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

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



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

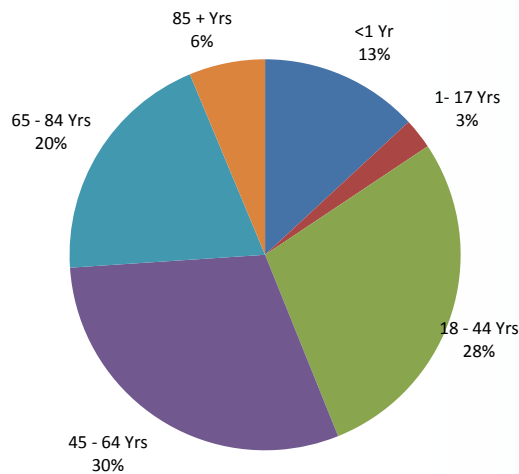
- The 5 leading causes of hospitalization for DC residents in 2010 were pregnancy-related, heart disease, psychoses, accidents and poisoning, and chronic lower respiratory disease which accounted for 11.8, 7.4, 6.6, 5.3, and 4.6 percent of all hospitalizations, respectively.
- Hospital occupancy rates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



# PATIENT DEMOGRAPHICS

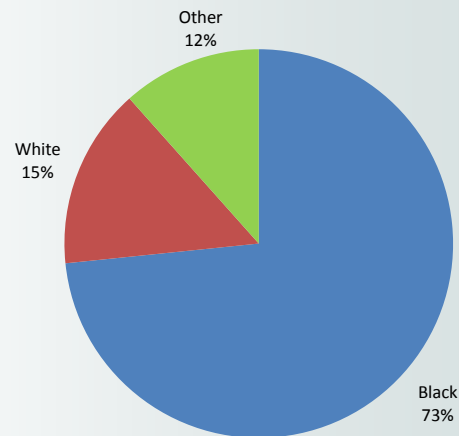
- There were 75,533 District residents hospitalized in 2010; 73 percent of whom were African-American and 15 percent were white.
- Majority of District residents hospitalized in 2010 were between 45 and 64 years old (30 percent), followed by residents aged 18 to 44 (28 percent).
- The elderly accounted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

**Figure 89. Hospitalized DC Residents by Age Group, 2010**



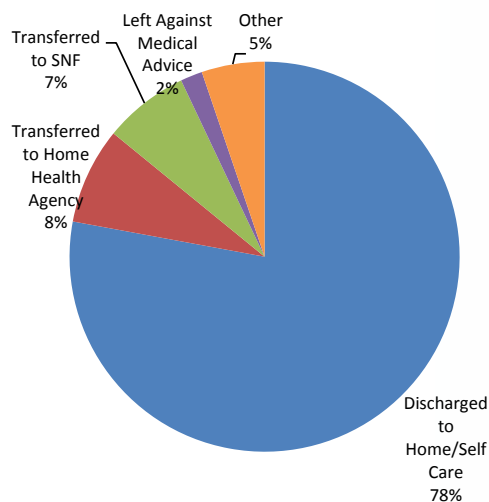
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

**Figure 90. Hospitalized DC Residents by Race, 2010**



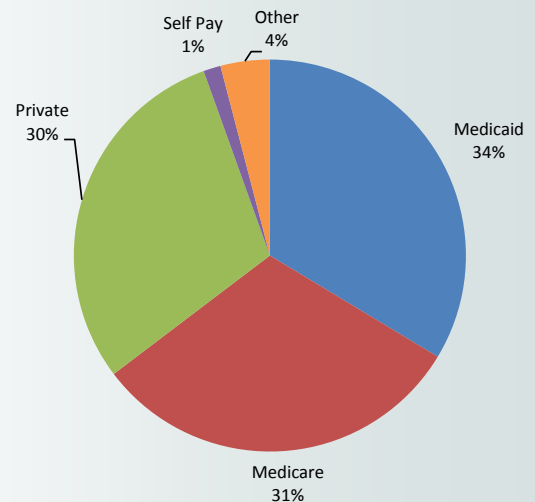
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health

**Figure 91. Hospitalized DC Residents by Discharge Disposition, 2010**



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

**Figure 92. Hospitalized DC Residents by Payment Source, 2010**



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

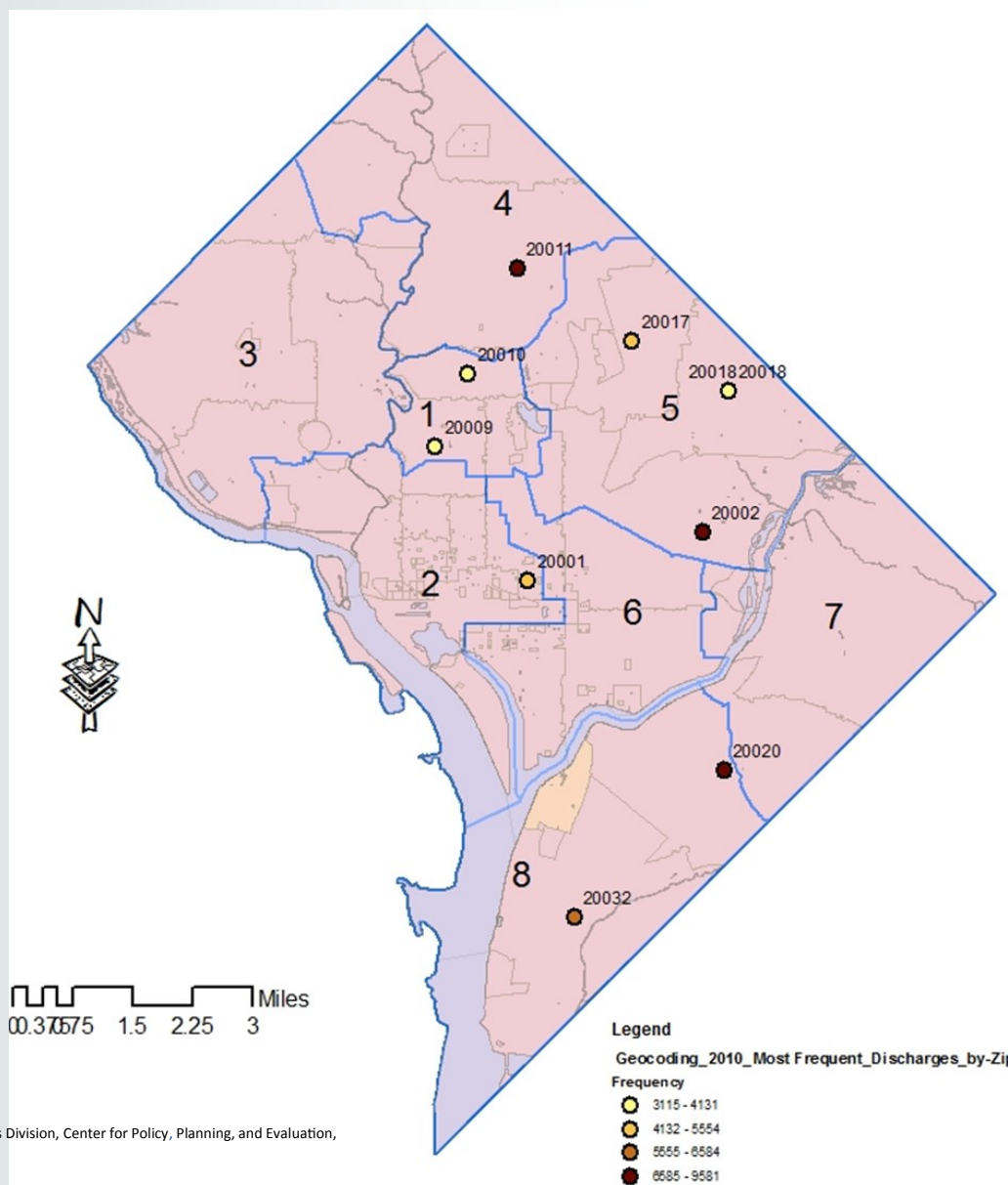
# GEOGRAPHIC DISTRIBUTION



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

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

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



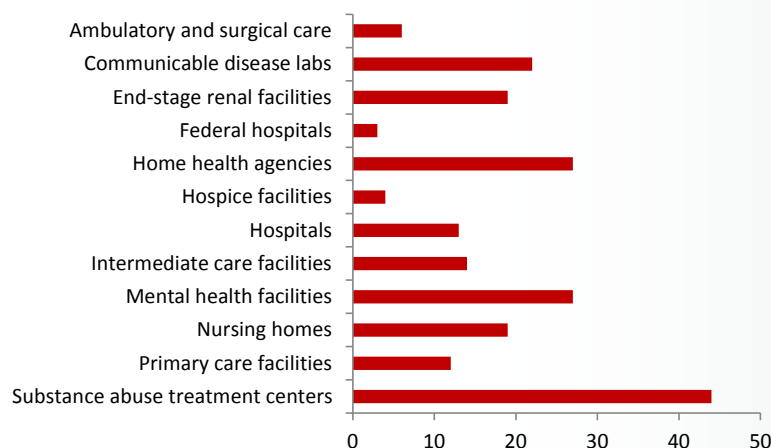
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation,

DC Department of Health



# ACCESS TO CARE

Figure 94. Healthcare Facilities in the District, by Type



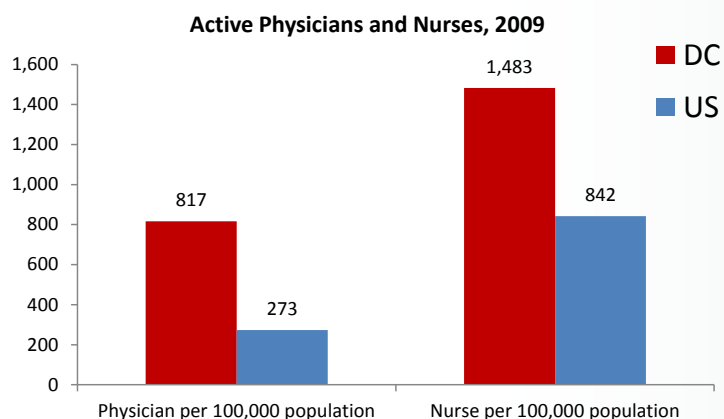
Source: Data Management and Analysis Division, Center for Policy, Planning, and Evaluation, DC Department of Health



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

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

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



Source: Physicians: American Medical Association, Chicago, IL, Physician Characteristics and Distribution in the US, annual (copyright); Nurses: Bureau of Labor Statistics, Occupational Employment Statistics, Occupational Employment and Wages, "May 2009 Wage and Employment Statistics."

For more information: <http://www.ama-assn.org/>  
<http://www.bls.gov/oes/home.htm#data>

## Healthy People 2010 Objectives

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

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

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

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

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

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

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

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

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

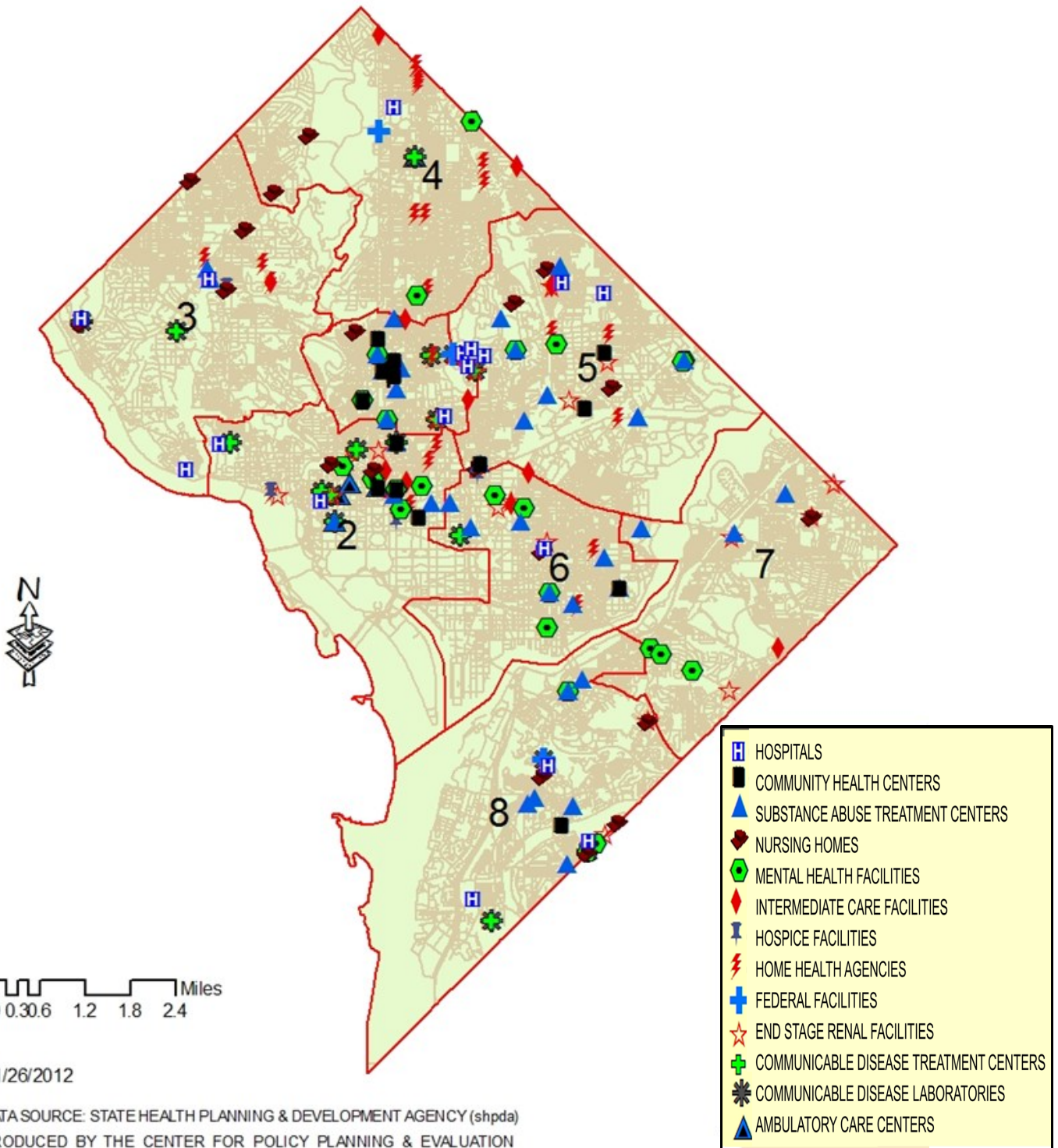
*MCOs collect Data from Consumer Assessment of Health Plans Survey (CAHPS) on an annual basis (DHCF).*

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



# HEALTH CARE FACILITY MAP

Figure 96. Map of Healthcare Facilities in the District



# TRENDS IN PROVIDER WORKFORCE

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

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

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

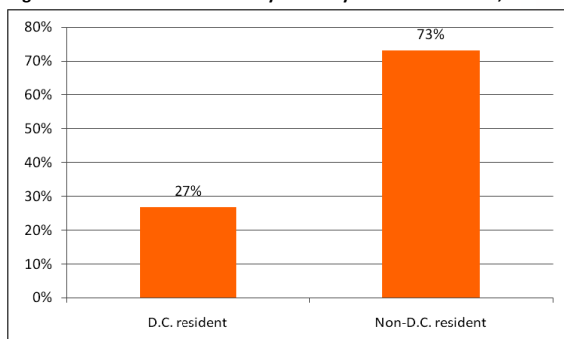
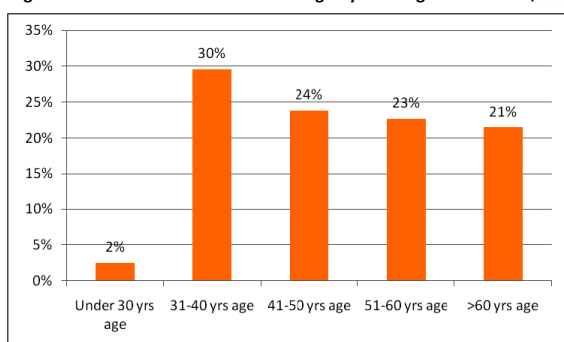


Figure 98. District of Columbia Practicing Physician Age Distribution, 2010



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

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

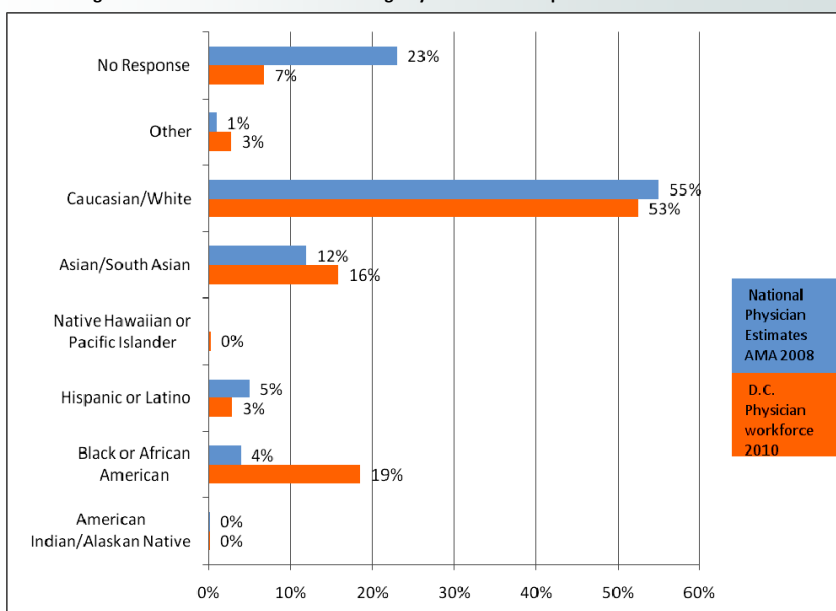
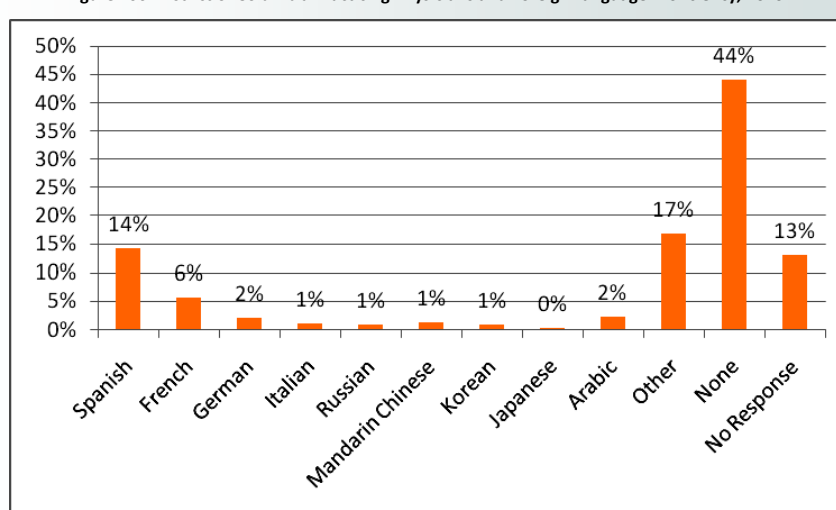


Figure 100. District of Columbia Practicing Physicians and Foreign Language Proficiency, 2010

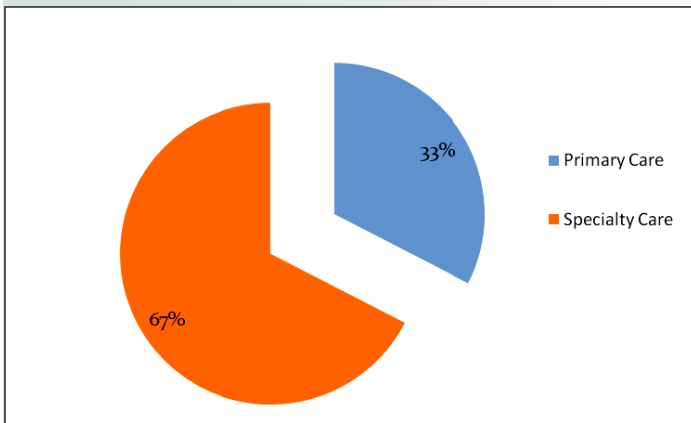


Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: [http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed\\_workforce\\_survey\\_report-final.pdf](http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf)

# TRENDS IN PROVIDER WORKFORCE

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

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



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

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

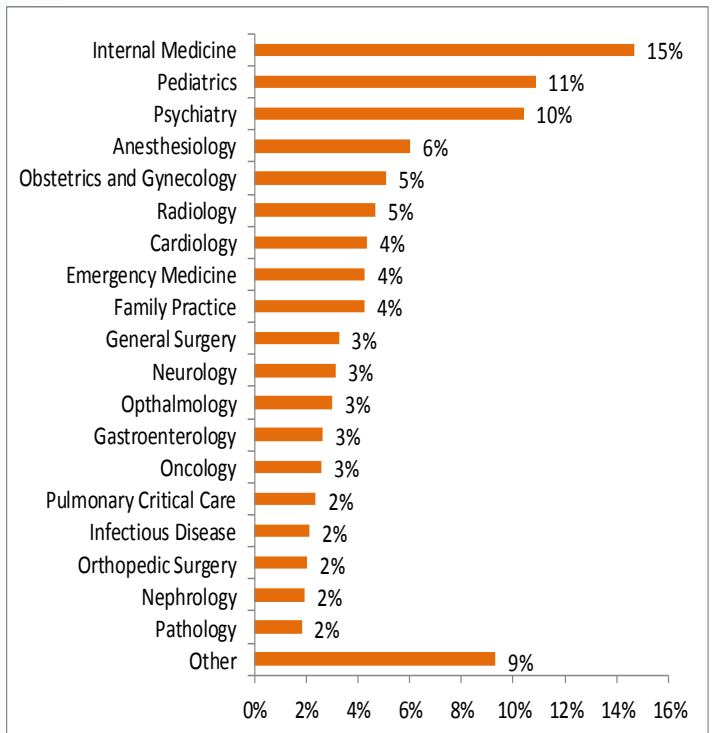
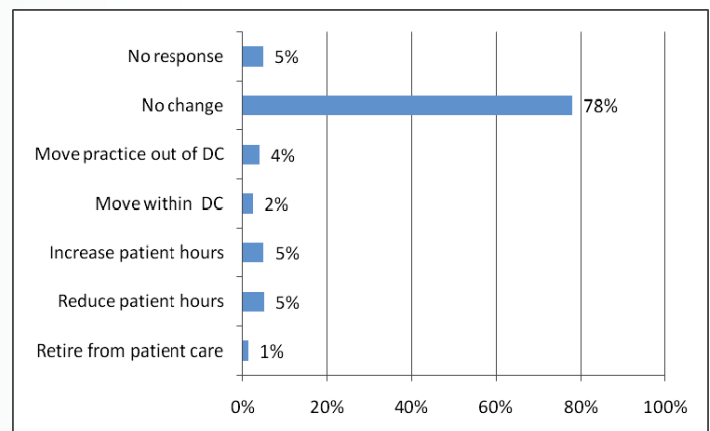


Figure 103. Future Plans of District of Columbia Actively Practicing Physicians within the Next 2 Years, 2010

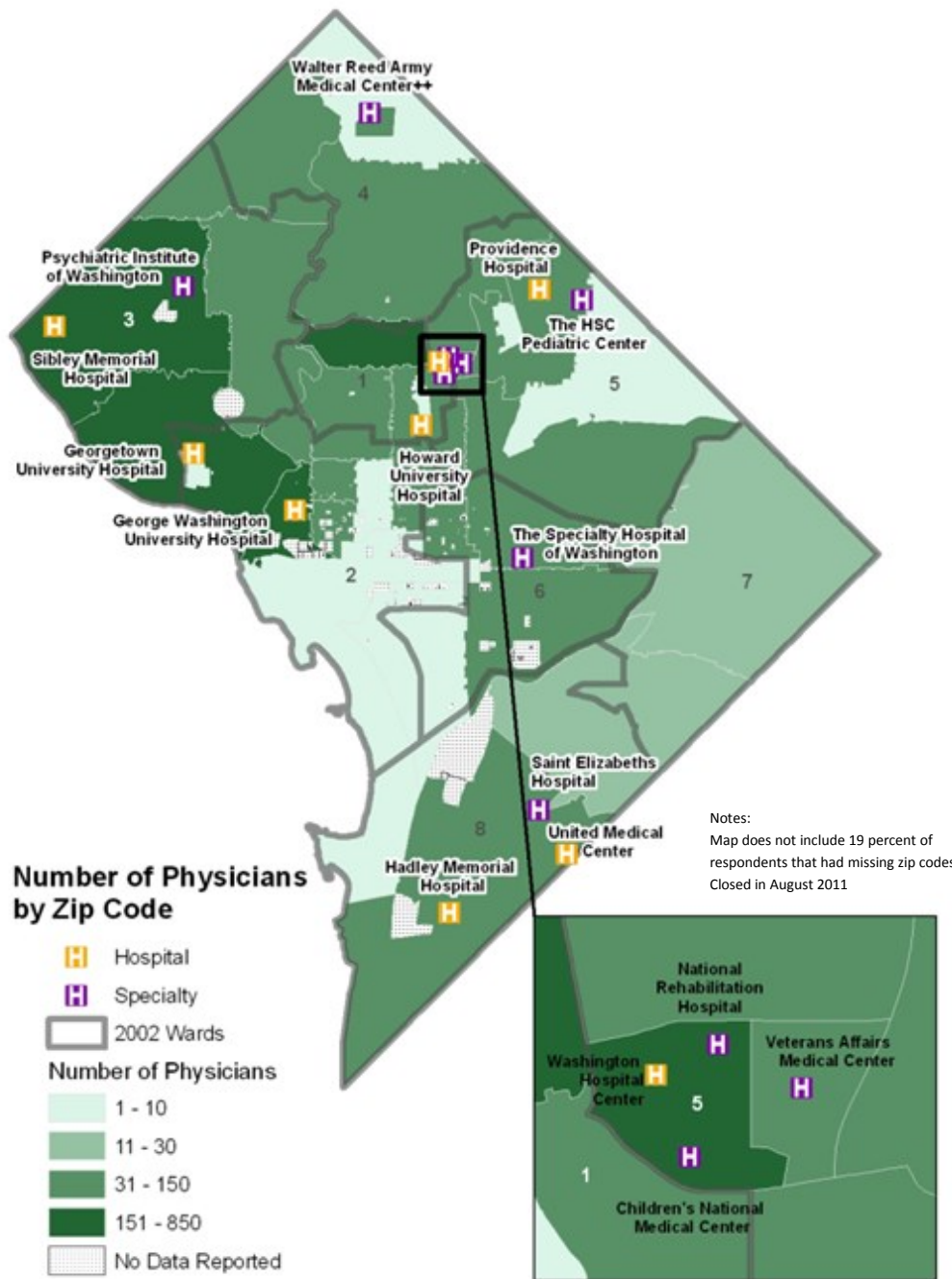


Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: [http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed\\_workforce\\_survey\\_report-final.pdf](http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf)

# TRENDS IN PROVIDER WORKFORCE

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

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



Source: District of Columbia Board of Medicine Physician and Physician Assistant Workforce Capacity Report. For more information: [http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed\\_workforce\\_survey\\_report-final.pdf](http://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/bomed_workforce_survey_report-final.pdf)



# UNDERSERVED AREAS

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

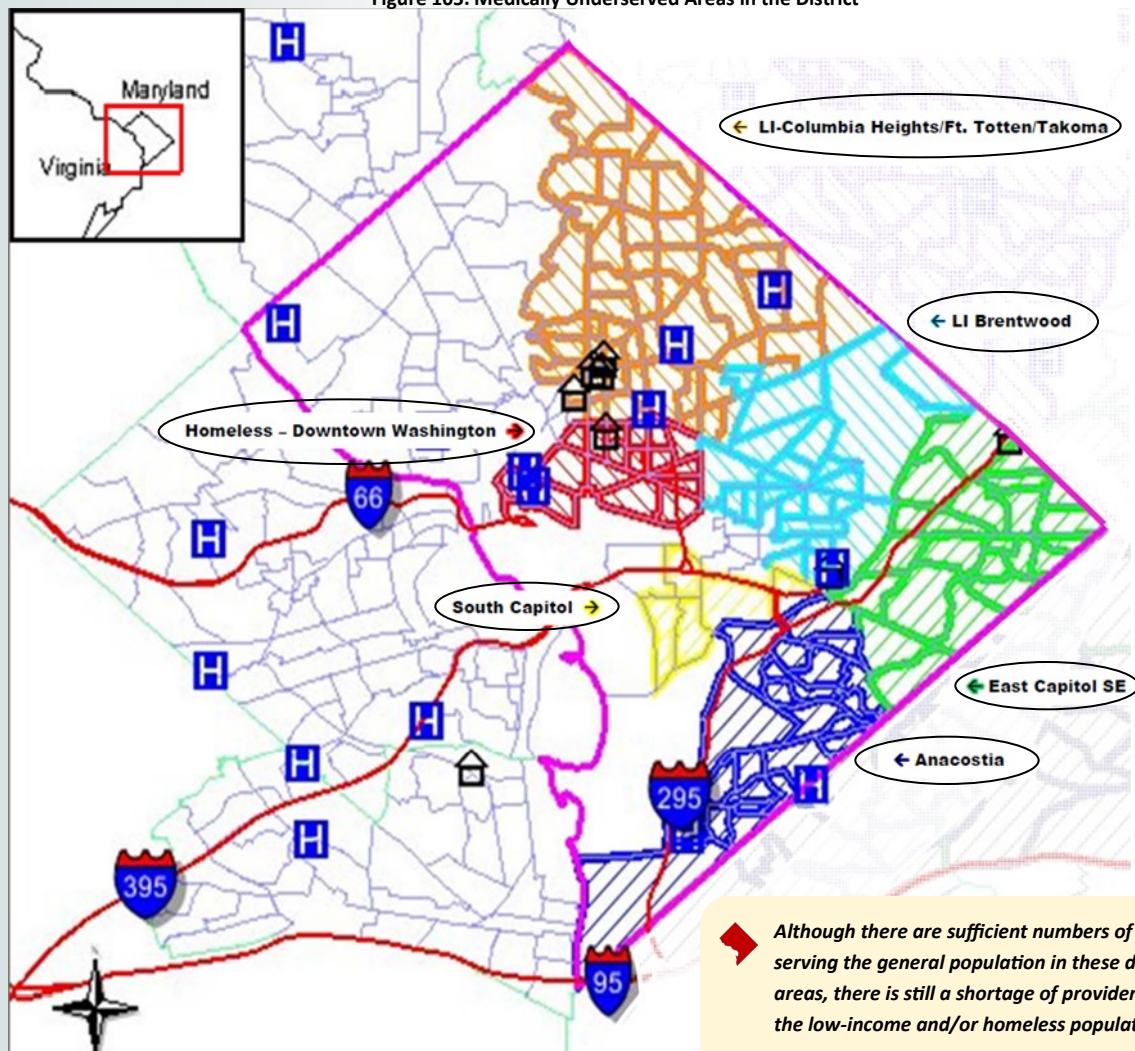
Data from the Health Professional Licensing Administration (HRLA), Medicaid claims data from the DC Department of Health Care Finance (DHCF), and data from detailed DOH surveys were linked and included in the analysis to identify these underserved areas.

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

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

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

Figure 105. Medically Underserved Areas in the District



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

# HEALTH INSURANCE



## How has the District implemented the Affordable Care Act?

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

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

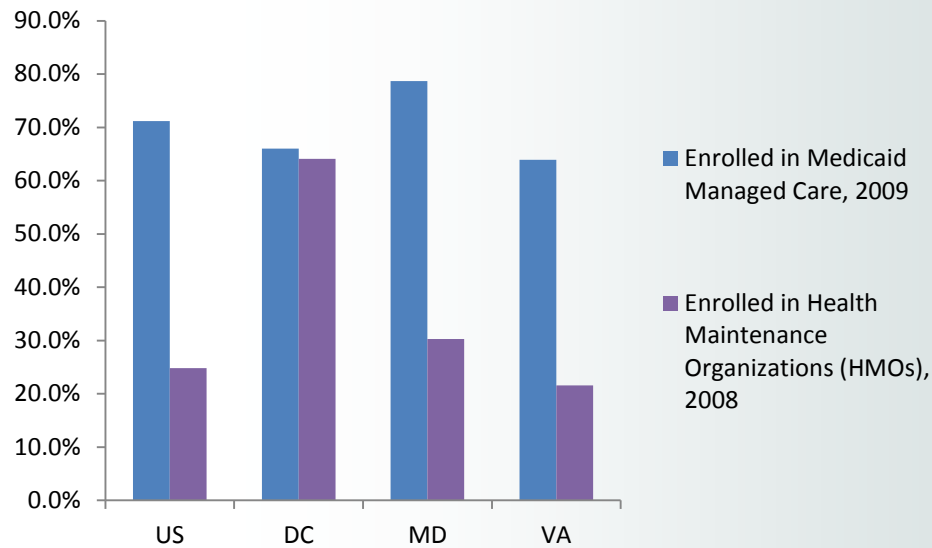
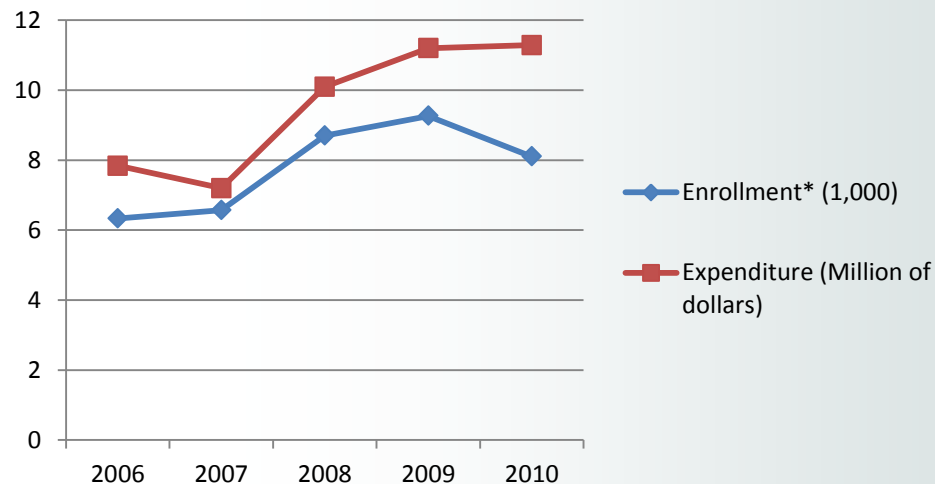


Figure 107. Children's Health Insurance Program, District of Columbia, 2006-2010



Source:

US Centers for Medicare and Medicaid Services, "2009 Medicaid Managed Care Enrollment Report," <[http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04\\_MdManCrEnrllRep.asp](http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/04_MdManCrEnrllRep.asp)>.

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

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

\*For year ending September 30.





TO OBTAIN A FREE COPY OF THIS REPORT OR TO REQUEST ADDITIONAL INFORMATION, PLEASE CONTACT:

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