THE DISTRICT OF COLUMBIA

HEALTHY PEOPLE 2010

FINAL REPORT

Government of the District of Columbia
Vincent C. Gray, Mayor

Acknowledgements

This report would not have been possible if not for the contributions of many District of Columbia Government employees. These acknowledgements not only serve to show our appreciation for their work but also to identify contacts for future use of data and program planning.

Saul M. Levin, M.D., MPA
Acting Director

Fern Johnson-Clarke, PhD
Senior Deputy Director for Policy, Planning and Evaluation

Department of Health

Brian Amy, MD, *Senior Deputy Director for Health Emergency Preparedness and Response*
Robert Austin, *Emergency Medical Service Training Coordinator*
Robin Diggs, *Program Manager, Diabetes Prevention and Control*
Lawrence Frison, *Supervisory Public Health Analyst for HIV/AIDS, Hepatitis, STD and TB*
Denise Grant, *Manager for Tobacco Program*
LaVerne Jones, *Program Manager for Asthma Control*
Jennifer Kret, *CSTE/CDC Applied Epidemiology Fellow for Policy, Planning and Evaluation*
Doris Kuehn, *Project Coordinator for Women, Infant and Children Program*
Sylvia Luna-Lopez, *Program Coordinator for Vital Records*
Rosemarie McLaren, *CDC Public Health Advisor for Immunization Program*
Alina McClerkin, *Performance Manager for Addiction Prevention and Recovery*
Jenevieve Opoku, *Epidemiologist for HIV/AIDS, Hepatitis, STD and TB*
Charlissa Quick, *Chief of School Health Division*
Lauren Ratner, *Bureau Chief for Primary Care*
Joelle Robinson, *Public Health Analyst for Community Health*
Rowena Samala, *Statistician for State Center for Health Statistics*
Kim Seechuk, *Bureau Chief for HIV/AIDS, Hepatitis, STD and TB*
George Siaway, *GIS Coordinator for Policy, Planning and Evaluation*
Kimberley Turner, PhD, *Program Manager for Policy, Planning and Evaluation*
Karen Watts, *Bureau Chief for Perinatal and Infant Health*
Arturo Weldon, *Chief Information Technology Officer*

Department of the Environment

Keith Anderson, *Director*
Cecily Beall, *Associate Director, Air Quality Division*
Pierre Erville, *Associate Director, Lead and Healthy Homes Division*
Adriana Hochberg, *Special Assistant to the Director*

Department of Health Care Finance

Benjamin Finder, *Supervisory Program Manager*
Colleen Sononsky, *Associate Director for Children's Health Services*

Department of Mental Health

Juanita Reaves, *Manager for Planning and Performance*
Anne Sturtz, *Deputy Director*

Acknowledgements

Report Authors & Healthy People Workgroup Members:

Fern Johnson-Clarke, PhD, *Senior Deputy Director for Policy, Planning and Evaluation*
John Davies-Cole, PhD, *State Epidemiologist*
Tracy Garner, *Coordinator of Behavioral Risk Factor Surveillance System*
Emily Putzer, *Healthy People Coordinator*
Heather Reffett, *Performance Improvement Manager*
Amha Selassie, *Director for State Health Planning and Development*
Vanisa Verma, *Accreditation Coordinator*
Jill Woods, *Administrative Officer for Policy, Planning and Evaluation*

Acknowledgements for the support provided by college interns and Fellows

Ian Hedges, Intern, *Beloit College, Beloit, WI*
Stephanie Bland, *Capital City Fellow, Washington, DC*
Michael Clark, Intern, *Georgetown University, Washington, DC*
Spring Worth, *Capital City Fellow, Washington, DC*

VINCENT C. GRAY
MAYOR

Letter from the Mayor

It gives me great pleasure to release the District of Columbia Healthy People 2010 Final Report. The Report demonstrates the progress of our health system in improving the health outcomes of our residents over a ten year period. As I review the results of this report, I am encouraged by many of the great successes we have documented. However, our work is far from over. We know that improving the quality of life for our residents remains a priority.

I ask that community members and stakeholders take the results of this report, and see how your programs or contributions can address our city's common goals. Gone are the days of working in silos. Together, we can strengthen our partnerships by sharing this data and collaborating on projects that address our most pressing health challenges. Community members who are revamping neighborhoods must think of ways to promote healthy behaviors amongst their fellow residents. Health care professionals must hear from community advocates on how to improve cultural-competency in the services they provide. City officials must work with non-traditional partners so that we may better facilitate access to healthcare services within the District.

Now is the time for community members and stakeholders, as One City, to work together and improve our city's health. We cannot improve our total health and wellness without your participation.

Vincent C. Gray
Mayor

TABLE OF CONTENTS

District of Columbia Healthy People 2010 Final Report

Executive Summary

The Healthy People 2010 Plan set health improvement targets and priorities over the first decade of the century. This report details the incredible growth, both through the building of public health infrastructure, and the improvement of health for District of Columbia (DC) residents. The plan identified 21 focus areas and 116 indicators to guide health programming and services and assess progress in health outcomes in order to improve health and alleviate health disparities. The indicators focused on public health outcomes, access to health care, and public health infrastructure. The data indicate that from the baseline measure through 2010, DC was successful in lowering tobacco use among adults, reducing deaths from cancer and reducing infant and children deaths. An assessment of DC public health infrastructure illustrates the health system's improved capacity to meet the needs of District of Columbia residents through initiatives such as policy development, new clinics, and expansion of health education programs.

Much of the success over the last ten years can be attributed to the strengthening of DC's public health infrastructure. The creation of the DC Department of Health (DOH), which had, before 1998, existed as the Commission of Public Health within the Department of Human Services, provided a better opportunity to assess the strengths of the existing public health infrastructure and identify gaps in the city's ability to provide all 10 essential public health services. There are more health care providers working in underserved communities, emergency response planning has improved, and more residents who were eligible for Medicaid were enrolled over this time period. In these and other ways, the capacity to meet healthcare needs of DC residents was greatly improved. As a recently-established health department at the turn of the century, DOH was able to use Healthy People 2010 as a detailed blueprint to guide its development in and increase its capacity to serve the community.

The Healthy People 2010 indicators reported on here fall into four categories: Promote Healthy Behaviors; Promote Healthy and Safe Communities; Improve Access to Quality Healthcare Services; and Prevent and Reduce Diseases and Disorders. Key findings detailed in the report are summarized below:

Promote Healthy Behaviors

Nutrition and Overweight –Initiating breastfeeding postpartum increased by over 6 percentage points, nearing the targeted 55% of new mothers; however, to achieve targets for mothers breastfeeding through the first 6 months and iron levels in children and newborns, current trends must be reversed.

Tobacco Use – Three populations were targeted to improve smoking outcomes: Hispanic adults, youth grades 9-12, and pregnant women. The objective involving Hispanic adults who are current smokers was attained and surpassed during the 10-year period while the latter two populations saw a negative trend in their health outcome.

Promote Healthy and Safe Communities

Environmental Health and Food Safety – Strides were made to mitigate environmental health hazards such as exposure to pollution and lead poisoning, though food-borne illnesses were on the rise.

Injury/Violence Prevention – Steps were taken to create reliable data sources to better measure and evaluate these important indicators.

Pediatric Dental Health – Though more data sources may be needed to comprehensively track children suffering from tooth decay, the percent of school children who had received a dental check-up increased, exceeding the Healthy People 2010 target.

Improve Access to Quality Healthcare Services

This category includes measures related to **Primary Care**; **Emergency Medical Services**; **Health Care Finance**; **Maternal, Infant, and Child Health and Family Planning**; and **Public Health Infrastructure**.

Access to primary care saw a large improvement, with nearly all 2010 targets exceeded or met. Emergency Services Infrastructure was bolstered through the creation and updating of protocols and policies, but work is still needed in streamlining services. Medicaid enrollment increased over the measured decade and a new data reporting system was established to monitor utilization of services and quality outcomes. DOH was able to improve data access and efficiency by establishing electronic and online information systems, connecting all agencies to the internet, expanding data collection categories, and creating several planning documents.

One of the largest successes for the District over the plan years was the reduction in the infant mortality rate. The Healthy People 2010 goal was met (8.0 deaths per 1,000 live births), but DC still has a rate above the national average. This is a priority area that will continue to be aggressively targeted over the next decade. Child mortality (ages 1-14) also decreased over this time period, nearly meeting 2010 targets.

Prevent and Reduce Diseases and Disorders

The diseases and disorders included in this section include high-priority areas for District of Columbia residents. Below are listed the general trends noted over the 10-year period measured in Healthy People 2010:

Asthma – While hospitalizations decreased, asthma-related emergency department visits increased over the 10-year period.

Cancer – Cancer death rates were greatly reduced in the District, exceeding Healthy People 2010 targets for lung, breast, cervical, and colorectal cancers.

Diabetes – Diabetes mortality rates declined over the decade, but fell short of the 2010 target. Many patients with diabetes see providers and are regularly screened for potential complications, though some areas for growth include self-examinations and dilated eye exams from providers.

Disabilities – The Healthy People 2010 target of 100% hospital reporting for newborns at risk for developmental delays was met, though work is still needed to integrate persons with disabilities into core DOH surveillance instruments.

Cardiovascular Disease and Stroke – The heart disease mortality rate decreased over the measured decade; however, it remains the number one cause of death for DC residents, and will be aggressively targeted over the following decade as well. The mortality rate from stroke also decreased, but neither condition met their respective Healthy People 2010 target.

HIV/AIDS – The work to reduce HIV infections and improve linkage to care and quality of life for persons living with HIV/AIDS was substantial over the decade. In 2000, HIV/AIDS was the 3rd leading cause of death for District residents, dropping to the 7th leading cause of death by

2010[1]. Still, HIV/AIDS continues to disproportionally affect the District, and racial, ethnic, and geographic disparities need sustained attention over the next decade.

Immunization – Immunization rates have increased over the decade, with coverage for children in pre-kindergarten classes at 96% in 2010.

Mental Health – The Healthy People 2010 goals related to expanding prevention-oriented services for special populations were met, though services still need to be improved in the District through expanded objectives to support all individuals experiencing a mental illness.

Sexually Transmitted Diseases (STDs) – This category measured incidence of gonorrhea, chlamydia, and syphilis in several populations. No Healthy People 2010 goal was met, though strides were made in reducing cases of gonorrhea in adults. Unfortunately, gonorrhea cases reported in adolescents ages 10-19 increased substantially over the decade, indicating much work still to be done in controlling STDs in District residents.

Substance Abuse – A large number of youth still have access to and are abusing substances in the District, and youth using marijuana has increased over the measured decade. Treatment facilities and prevention programs met Healthy People 2010 targets, but a more aggressive approach may be needed to affect health behaviors.

Tuberculosis (TB) – The Healthy People 2010 target for reducing TB incidence was exceeded, though many patients still do not complete the recommended treatment course.

[1] http://www.cdc.gov/nchs/data/dvs/LCWK9_2000.pdf

District of Columbia
HEALTHY PEOPLE 2010
SNAPSHOT

	2000 Baseline*	2010
Infant Mortality β	10.2	8
Child Mortality ages 5-14**	35	12
Tobacco Use among adults	20.4%	15.6%
Breast cancer mortality**	27	18.4
Lung cancer mortality**	60	42.4
Cervical cancer mortality**	4.3	1.1
Colon cancer mortality**	29.7	21.1
Prostate cancer mortality**	50.78	12.9
Asthma mortality**	2.8	1.1
Tuberculosis Incidents**	14.3	7.2
Established Trauma Registry	Did not exist	Exists
Maintaining 95% Child Immunization	95%	96%
Iron Deficiency among WIC infants	19.1%	26.7%
Emergency Department Asthma visits α	195	235.33

*2000 Baseline refers to the data used for the 2000 Report but data may be from a different year
β Rates are per 1,000 live births
α Rates are per 10,000 people
**Rates are per 100,000 people

District of Columbia Healthy People 2010 Final Report

Introduction

Healthy People is often referred to as 'the blueprint' for public health. It is a comprehensive plan that sets health improvement targets in a wide range of topic areas and monitors progress over a decade. Healthy People is an initiative of the U.S. Department of Health and Human Services and has been utilized by communities around the nation since 1979. With each decade, the ability to plan and coordinate service delivery, prevent poor health outcomes, promote good health and strengthen our public health infrastructure is streamlined and improved.

In 2000, the District of Columbia Department of Health (DOH) developed its first Healthy People plan. The plan described the state of the District's health system and the health of its residents, established baseline measures, and set 2010 health improvement targets. It was a collaborative effort involving government agencies, healthcare providers, community based organizations and residents. The original focus areas and indicators were chosen through established committees and advisory work groups and submitted for public comment.

The DC Department of Health was established in 1998 and data collection near the beginning of the decade was not uniform. Therefore, baseline data were collected between the years of 1997 and 2001, depending on availability. DOH obtained data related to the health outcome objectives from numerous programs and surveillance systems in different agencies and administrations. The two primary data sources were the Behavioral Risk Factor Surveillance System (BRFSS) and Vital Records' Birth and Mortality Data. BRFSS is an ongoing telephone survey that measures the health trends of all 50 states and the District of Columbia. Birth and mortality data were obtained through DOH Vital Records, which includes all District of Columbia resident infant births and deaths. The data were analyzed by the Department of Health.

Due to the differences in data collection methods over the decade, some 2010 reporting does not exactly reflect the original objective. Partial or related data are shared where available. As the decade progressed, changes were made to certain objectives and others were omitted altogether, accounting for the gaps in objective numbers.

The trends and 2010 data help us look to the future by establishing current benchmarks, recognizing disparities and gaps in services or health outcomes, and identifying possibilities for additional data collection and research. This report will help inform 2020 health topics and objectives as well as support existing and new community health collaborative efforts.

Community stakeholders can take advantage of this document to strategize with DOH ways to reduce health disparities and enhance the quality of health and healthcare for District of Columbia residents. These institutions, organizations, researchers, and others may use this report as a resource, employing it in ways such as:

- ✓ A data tool for measuring program performance;
- ✓ A framework for program planning and development;
- ✓ A map for goal-setting and agenda-building;
- ✓ A model for teaching public health courses;
- ✓ A set of benchmarks to compare national, state and local data and health status among or between populations; and
- ✓ A guide to developing non-traditional partnerships.

A color-coded system has been established with each objective's outcome to illustrate progress (or lack thereof) over the first decade of the century. A green dot indicates that the objective was

achieved; a yellow dot indicates the objective was not reached, but showed improvement; a red dot indicates the objective was not achieved; and a grey dot indicates the objective was unable to be measured.

Goal Attained	Goal Showed Progress	Goal Not Attained	Data Not Available

Promote Healthy Behaviors

1. NUTRITION AND OVERWEIGHT
2. TOBACCO USE

NUTRITION AND OVERWEIGHT

Overview

Nutrition has a profound impact on the health of Americans. Lack of proper nutrition is closely linked to the major causes of disease and disability. Overweight status and obesity lead to health problems such as diabetes, heart disease, high blood pressure and stroke. What often leads to being overweight or obese is not only the amount of food one consumes, but also about the quality of food. Many people suffer from nutrient imbalance, consuming too much fat and refined sugars and too few fruits, vegetables and whole grains. This often occurs in low-income communities.

Research shows that many low-income communities do not have access to fresh fruits and vegetables in their neighborhoods. As a result, they often times are not able to get nutrient-rich foods. The DC Healthy People 2010 measures evaluate nutrition through pregnant women and mothers who participate in the Women, Infants, and Children Program (WIC), a federally funded program that provides nutrition education; breastfeeding promotion and support; and supplemental food to low-income pregnant women, new mothers and infants and children up to five years old.

In an effort to improve the nutrition of WIC participants, the Department of Health focused on improving the nutrition of these participants in two specific areas: iron deficiency and breastfeeding.

FOCUS AREA 1: NUTRITION AND OVERWEIGHT CHART

2010 OBJECTIVE	BASELINE	2010 DATA
1-1. Reduce iron deficiency to 15% or less among infants and children up to the age of 5-years, and among women of childbearing age in the Women and Infant Children (WIC) population.	19.1% of WIC infants and children under the age of 5 years were iron deficient, according to the 2000 Centers for Disease Control and Prevention (CDC) data from the Pediatric Nutrition Surveillance Survey (PedNSS).	26.7 % of infants and children enrolled in WIC were iron deficient. (Source: CDC data/PedNSS, 2010)
1-2.1. Increase the breastfeeding initiation rate among WIC postpartum mothers to 55%.	44.7% of WIC participants initiated breastfeeding in the early postpartum period. (Source: CDC data/PedNSS, 2000)	51.0% of WIC enrollees initiated breastfeeding in the early postpartum period. (Source: CDC data/PedNSS, 2010)
1-2.2. Increase the percentage of WIC postpartum mothers' breastfeeding at least 6 months to 47%.	22% of WIC breastfeeding mothers continued to breast-feed at 6 months postpartum. (Source: CDC data/PedNSS, 2000)	20.2% of WIC breastfeeding mothers continued to breast-feed at 6 months postpartum. (Source: CDC data/PedNSS, 2010)

TOBACCO USE

Overview

Tobacco use is a major public health problem and is one of the most preventable causes of disease and death. The problem does not only affect the smoker but also those who are exposed to second- and third-hand smoke. Each year, thousands of people die because of problems associated with smoking and exposure to second-hand smoke. Apart from the economic burden associated with smoking, Tobacco use increases the risk for cancer, particularly of the lungs and oral cavities, as well as increases risks for cardiovascular and respiratory diseases and disorders.

Since regular smoking usually begins during early teenage years, the DC Department of Health (DOH) launched a smoking prevention campaign targeting children and adolescents in order to reduce the number of young smokers. DOH later broadened its outreach to include reducing tobacco use in Hispanics and pregnant women.

FOCUS AREA 2: TOBACCO USE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
2-1.1. Reduce to 18.5% the proportion of adults (18 years or older) who are current smokers.	20.4% of adults in the District were current smokers in 2002. (Source: Behavioral Risk Factor Surveillance System or BRFSS, 1997)	15.6% of adults were current smokers. (Source: BRFSS, 2010)
2-1.2. Reduce to 20% the proportion of adult Hispanics (18 years and older) who are current smokers.	28.0% in 2002 and 24.2 percent in 2003 of Hispanics were current smokers in the District. (Source: BRFSS, 1997)	16.8% of adult Hispanics were current smokers. (Source: BRFSS, 2010)
2-1.3. Reduce the proportion of young people in grades 9–12 who have ever smoked cigarettes to no more than 50%.	56.7% of young people in grades 9-12 had tried cigarettes in 2001. (Source: District of Columbia Youth Risk Behavior Survey or DC YRBS)	44% of male students and 41.2% of female students have smoked cigarettes. (Source: DC YRBS, 2010)
2-1.4. Reduce to no more than 16% the proportion of young people in grades 9–12 who report that they are current smokers.	16.9% of boys and 12.3% of girls were smokers in 2001. (Source: DC YRBS)	19.5% of male students and 19.1% of female students were current smokers. (Source: DC YRBS, 2010)
2-2. Increase abstinence from tobacco use by pregnant women to 98%.	94.5% of pregnant women reported not smoking in 1997. (Source: Hospital Records)	An average of 89.6% of women reported not smoking while pregnant. (Source: DC DOH, CPPE, Vital Statistics 2010)
2-3. Increase to 75% the proportion of patients who receive advice to quit smoking during the reporting year from a health care provider.	53.6% of the total population had received such advice, in 1996. (Source: BRFSS, 1997)	61.6% of the total population had received such advice. (Source: BRFSS, 2010)

Promote Healthy and Safe Communities

3. ENVIRONMENTAL HEALTH AND FOOD SAFETY
4. INJURY/VIOLENCE PREVENTION
5. PEDIATRIC DENTAL HEALTH

ENVIRONMENTAL HEALTH AND FOOD SAFETY

Overview

The environment plays a major role in the health and well-being of residents. The air quality and natural environment have a significant impact and it is critical that attention be given to the environmental causes of morbidity and mortality.

In 2000, when DC Healthy People 2010 was published, the District of Columbia's food safety program was combined with the DOH Environmental Health Program. Six years later, the Department of the Environment (DDOE) was created to focus primarily on environmental health issues. Since its inception, the DDOE has focused on protecting and enhancing the health of District of Columbia residents and the natural environment. The agency works to reduce hazards and contaminants in District of Columbia land, air, water and homes by certifying facilities and professional service providers, reviewing plans, issuing permits, and conducting inspections. DOH continues to work on reducing the number of food-borne illnesses.

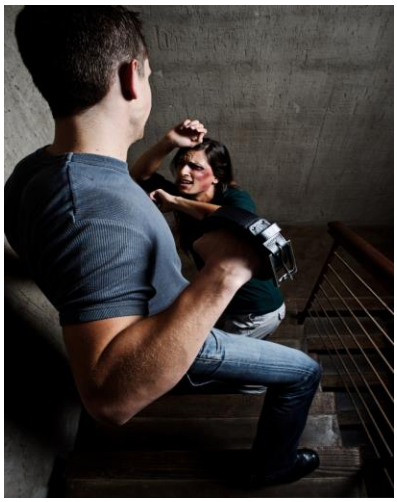
This report, which reflects the progress in the area of environmental health, is a combined effort of these two agencies.

FOCUS AREA 3: ENVIRONMENTAL HEALTH AND FOOD SAFETY CHART

2010 OBJECTIVE	BASELINE	2010 DATA
3-2 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 1997, 3% of District children screened had blood lead levels exceeding 15 µg/dL (count: 86). (Source: DC Public Health Laboratory Services)	○ In 2010, 35 children in the District between 6 months and 72 months of age (0.2% of those tested) were identified with a blood lead level of 15 µg/dL or greater, and 107 (0.7% of those tested) had a blood lead level of 10µg/dL or greater. (Source: DDOE LeadTrax database, 2011)

2010 OBJECTIVE	BASELINE	2010 DATA
3-3. Improve air quality to healthy levels for 100% of the people who reside in and visit the District.	Baseline not available.	The only criteria pollutant for which the District has attained acceptable levels is ground-level ozone (also known as smog). In 2010, the levels had decreased 21% from baseline. (Source: DDOE)
3-7. 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.	Remediation of the Washington Navy Yard began as part of a Corrective Action Order issued by the Environmental Protection Agency (EPA) in 1998.	The District has one NPL site at the Washington Navy Yard. According to the Environmental Protection Agency, the current health exposures at this site were under control. (Source: EPA, 2011)
3-9. Reduce infections caused by key foodborne pathogens to incidences per 100,000 of no more than those listed below: Salmonella species, rate of 0 Escherichia Coli 0157: H7, rate of 0 Listeria monocytes, rate of 0 Unknown etiology, rate of 1 (Figures are per 100,000 people.)	In 1998 infections in the District were as follows: Salmonella species, 2 Escherichia coli 0157: H7, 0 Listeria monocytes, 0 Unknown etiology, 3 (Figures are per 100,000 people) (EHA Database)	Campylobacteriosis, rate of 10.0 Listeriosis, rate of 0.2 Salmonella, rate of 15.0 E.Coli STEC, rate of 1.7 (Figures are per 100,000 people) (Source: National Electronic Disease Surveillance System, 2010)
3-10. Reduce outbreaks of Salmonella enteriditis to fewer than 25 outbreaks yearly.	In 1988, there were two outbreaks in the District.	There were no Salmonella enteriditis outbreaks in the District in 2010. (Source: National Electronic Disease Surveillance System, 2010).

INJURY AND VIOLENCE PREVENTION



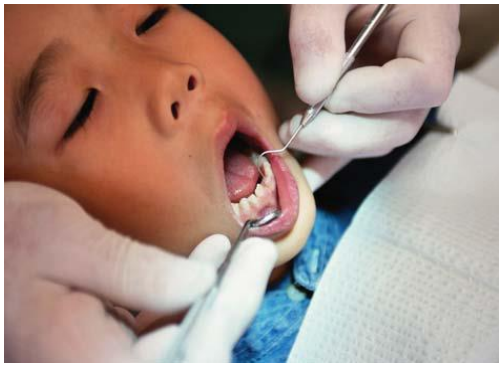
Overview

In 2000, many of the indicators and progress measures for the District of Columbia showed that violence and abusive behaviors constituted more of a problem for the city than the nation in general. Violence and abusive behavior can cause stress, injury, and death. Unintentional injuries and accidents also increase morbidity and mortality and affect all segments of society. Injuries continue to be the second leading cause of death for young people 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.

FOCUS AREA 4: INJURY AND VIOLENCE PREVENTION CHART

2010 OBJECTIVE	BASELINE	2010 DATA
4-1.1. Establish a Trauma/Injury Registry at DOH to monitor data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics.	In 2000, no Trauma/Injury Registry existed at DOH.	◯ In June of 2011, the DOH was able to acquire the trauma registry software. It has been installed on a server hosted by the District of Columbia's Office of the Chief Technology Officer (OCTO). (Source: DC DOH, HEPRA)
4-1.2. Increase to 90% the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data to the DOH Trauma/Injury Registry.	Baseline not available.	◯ Two trauma facilities (Washington Hospital Center and Children's National Medical Center) have submitted their data to the District of Columbia's Trauma Registry via voluntary reporting. (Source: DC DOH, HEPRA)

PEDIATRIC DENTAL HEALTH



Overview

Dental disease is one of the main health challenges affecting children. Up to 29% of children have cavities and dental related problems before they are ten years old. Oral health means much more than healthy teeth; it is integral to general health. However, there still continues to be profound disparities in the oral health of Americans even though safe and effective disease prevention measures exist. 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. Untreated dental disease adversely affects individuals of lower socioeconomic status, particularly African-Americans and Hispanics who cannot access dental services due to limited resources to pay for expensive dental treatment.

FOCUS AREA 5: PEDIATRIC DENTAL HEALTH CHART

2010 OBJECTIVE	BASELINE	2010 DATA
5-1. 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% among children ages 2–4, 45% among children ages 6–8, and 50% among adolescents age 15.	Baseline not available.	 DOH does not currently collect data on the number of cavities occurring within the entire pediatric population. In 2010, 4,585 (30%) out of 15,149 students ages 2-4 years had at least one cavity, (2010 CMS Form 416, Annual DC EPSDT Participation Reports). 359 (98.6%) out of 364 students ages 6-8 years had at least one cavity. (Source: DC DOH School Based Dental Program data-FY 2010-2011)
5-2. Increase to at least 35% the proportion of 2nd and 3rd grade children who have received protective sealants in at least one of their permanent molar teeth.	Nationally, between 1988 and 1994, 23% of 8-year olds and 24 % of 14- year olds received sealants in permanent molar teeth.	 In FY 2010, there were 33.3% (391) of sealants placed on the permanent teeth of 2nd and 3rd graders (6- 8 years) at seven (7) public elementary schools that participated in the DC DOH school based dental program. (Source: DC DOH School Based Dental Program FY 2010-2011 data)
5-3. Increase to at least 50% 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.	33% of students entering school programs have received an oral health screening in school year 2005-2006. (DC DOH School Based Nursing Program Oral Health Assessment Forms)	 In FY 2010, 67% (54,274) of students (Early Head Start to High School) out of 80,734 students received at least one dental assessment to determine the existence of dental decay or oral pathologies and/or deformities. (Source: 2010 CMS Form 416, Annual DC EPSDT Participation Reports)

IMPROVE ACCESS TO QUALITY HEALTHCARE SERVICES

6. PRIMARY CARE
7. EMERGENCY MEDICAL SERVICES
8. HEALTH CARE FINANCE
9. MATERNAL, INFANT, CHILD HEALTH AND FAMILY PLANNING
10. PUBLIC HEALTH INFRASTRUCTURE

PRIMARY CARE

Overview

Primary care is the gateway to the health care delivery system. Primary care is utilized by people with a variety of health challenges from all walks of life and focuses on prevention and early diagnoses. Therefore, it is important that primary care services are accessible and that providers have extensive knowledge in many areas. While the District of Columbia has one of the highest numbers of nurses and doctors, as well as hospitals and other health care facilities per capita, accessing primary care continues to be a challenge for many residents. A large percentage of District of Columbia residents live in neighborhoods that are designated by the Federal Government as Health Professional Shortage Areas (HPSAs), which indicates 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, supporting 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.

FOCUS AREA 6: PRIMARY CARE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
6-1. Increase access to care by increasing the number of National Health Service Corps Loan Replacement (NHSCLR) providers in the District of Columbia from 26 to 36.	There were 26 health care providers in District's Loan Repayment Program in 1999. Providers are defined as physicians, dentists, nurse practitioners, physician assistants, and nurse midwives.	There were 41 NHSCLR providers practicing in the District of Columbia in 2011. (Source: National Health Service Corps/HRSA, 2011)

2010 OBJECTIVE	BASELINE	2010 DATA
6-2. Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60.	There were 50 treatment sites in the District in 1999.	There were 12 new Certificates of Need (CON) issued for primary care facilities from 2000-2010 (Source: DC State Health Planning and Development Agency (SHPDA), 2011)[2], though there were 51 active treatment sites in the District in 2011. (DC DOH, CHA, Primary Care Bureau, 2011)
6-3. 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 two HPSA Facility Designations in 1999.	There were six HPSA Facility Designations at the end of 2010. (Source: DC DOH, CHA, Primary Care Bureau, 2011)
6-4. 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.	Baseline not available.	228,000 total participants have enrolled in the DC Healthy Families Program. (Source: Department of Health Care Finance (DHCF))
6-7. Retain 40% of National Health Service Corps and Conrad-30 program providers in Health Professional Shortage and Medically Underserved Areas after their commitment period.	The Fiscal Year 2004 Target was 33% retention rate, but the actual retention rate was 81%.	There was 100% retention rate among Conrad-30 providers that completed their service in the last three years of the decade; additional Conrad-30 and NHSC data not available. (Source: DC DOH, CHA, Primary Care Bureau, 2011)
6-8. 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.	Baseline not available.	Managed Care Organizations collect data from Consumer Assessment of Health Plans Survey (CAHPS) on an annual basis to determine patient satisfaction. (Source: DHCF)

[2] Indicates that 12 Certificates of Need were issued, but does not reflect whether the sites currently exist.

EMERGENCY MEDICAL SERVICES

Overview

Emergency Medical Services (EMS) are an integral part of the health care delivery system. The mission of EMS is to promote the health and well-being of all residents by facilitating access to health care services, identifying risks that lead to illness and injury, understanding health monitoring activities and responding to disorders and calamities. Emergency services are provided by DC Fire and EMS, the Metropolitan Police Department, and the DC Department of Health's Emergency Preparedness and Response Administration (HEPRA), formerly known as the Emergency Health and Medical Services Administration (EHMSA).

FOCUS AREA 7: EMERGENCY MEDICAL SERVICES CHART

2010 OBJECTIVE	BASELINE	2010 DATA
7-1.1. Develop a document that describes in detail the qualifications, credentials, and duties of all emergency medical service (EMS) personnel, including medical directors, emergency medical technicians; paramedics (EMT/P), emergency medical technicians/ intermediates (EMT/I), emergency medical technicians; basic (EMT/B), and medical dispatchers.	Action on this objective had not commenced in 2000.	DC-DOH EMS Policy 2010-0009 identifies scope of practice for all EMS certification levels. DC-DOH EMS Policy 2010-0001 identifies the minimum qualifications now include NREMT certification. Qualifications for Medical Director are located in the Draft EMS Regulations – Title 29, Chapter 5, Sections 501 and 503. (Source: DC DOH EMS Policy 2010-0009 issued 15 Nov 2010, DC-DOH EMS Policy 2010-0001 issued 28 Jan 2010, Draft EMS Regulations-Title 29, Chapter 5, Sections 501 and 503 updated August 2, 2011)

2010 OBJECTIVE	BASELINE	2010 DATA
7-1.2. Ensure that all emergency 911 transport units have personnel with advanced life support capability as defined by DOH.	In 1999, 35% of transport units included advanced life support (ALS) capability.	In 2011, the DC Fire & EMS Department operated 14 ALS transport units (35%) and 25 basic life support (BLS) transport units (65%). This ratio has been determined to be appropriate to meet the need of DC emergency response. (Source: DC Fire and EMS Department (FEMS), 2011)
7-1.3. Ensure that response times (from the time the call is received by dispatch to the time EMS arrives at the scene) will meet the 90th percentile of 8 minutes for critical patients and 16 minutes for non-critical patients, based on the Medical Priority Dispatch System (MPDS).	In 1999, response times for 911 calls for critical patients in the 90th percentile equaled 10.21 minutes based on the MPDS. Non-critical patient data not available.	• 86.6% of critical medical calls with first EMT arriving within 6 minutes 30 seconds dispatch to scene. • 85.7% of critical medical calls with first paramedic arriving within 8 minutes, dispatch to scene. • 90.5% of critical medical calls with first transport unit arriving within 12 minutes, dispatch to scene. (Source: DC FEMS, FY2010)
7-1.4. Revise and update current District of Columbia Adult Pre-hospital Medical Protocols to meet and reflect current trends in pre-hospital care.	DC Adult Pre-hospital Medical Protocols not revised or updated in 2000. (Source: DC FEMS)	The DC Fire & EMS reviewed, updated and published their protocol on April 30, 2010. (Source: DC FEMS Pre-hospital Protocols)
7-1.5. Ensure proper medical direction of pre-hospital personnel in the District.	Baseline not available.	DOH drafted a regulation that requires all ambulance services to implement a Quality Assurance and Improvement program to address issues of medical direction and patient care. (Source: DC DOH EMS Policy 2010-0003 issued February 1, 2010, Draft EMS Regulations-Title 29, Chapter 5, Sections 556 and 557 updated August 2, 2011)
7-2.1. In conjunction with the EMS Advisory committee, the municipal and the commercial ambulance companies certified in the District, EHMSA will develop a comprehensive EMS dataset conforming to the national uniform dataset and linking to other DC agencies.	Dataset was not in existence in 2000.	The development of an EMS data set was transferred to the DOH as a result of the abolishing of the EMSAC. The DOH adopted the NEMSIS standard as the data collection standard for the District of Columbia. (Source: Draft EMS Regulations-Title 29, Chapter 5, sections 501, 508 and 557 updated August 2, 2011)

2010 OBJECTIVE	BASELINE	2010 DATA
7-2.2. Develop legislation requiring all licensed ambulance services to report the established comprehensive dataset to the Emergency Health and Medical Services Administration (EHMSA) in the DOH by January 1, 2002.	Dataset not in existence in 2000.	The requirement has been included in the draft regulations, section 508 (Draft EMS Regulations—Title 29, Chapter 5, Sections 501, 508 and 557 updated August 2, 2011).
7-2.3. Establish a District of Columbia Trauma Registry that captures all relevant data on utilization, levels of uncompensated trauma care, and indicators of the quality of trauma care.	As of July 2001, there was no Injury/Trauma Registry at DOH in which data were reported on a regular basis.	A successful application for funding a DC Trauma Registry was submitted to the CDC by EHMSA in July of 2005. In June of 2011, the DOH was able to acquire the trauma registry software. It has been installed on a server hosted by the District's Office of the Chief Technology Officer (OCTO) but has yet to become operational. (Source: DC DOH, HEPRA, January 2012)
7-4.1. Promote wellness, health, and injury prevention within the community through public education programs and other initiatives.	Baseline not applicable.	The Department of Health's (DOH) initiative, Live Well DC (LWDC) is intended to educate the public, and increase public awareness of the importance of making healthy lifestyle choices. Live Well DC is an interagency effort to create a holistic approach to health and wellness by targeting individual behaviors that result in poor health outcomes through encouraging residents to follow 10 Healthy Living Tips. (Source: 2010 EMS Annual Report, July 2011)
7-4.2. Define and expand the role of EMS in public health.	In 2002, the role of EHMSA did not include emergency preparedness.	After 2002, the role of EHMSA was expanded. The EMS organizations were made key components of the various emergency response plans developed by the DOH. (Source: 2010 EMS Annual Report, July 2011)
7-4.3. Support and promote EMS research on public health issues.	In 2000, EMS conducted no studies on public health issues.	Since 2003, EMHSA has been conducting statistical and epidemiological studies to examine the quality of pre-hospital medical care provided by the DCFEMS 1+1 Pilot Program, recommending additional research. DCFEMS declined the recommendation. Without the trauma registry and NEMSIS databases operational, there is little that can be done from an injury prevention research perspective. (Source: DC DOH, HEPRA, January 2012)

2010 OBJECTIVE	BASELINE	2010 DATA
7-5. Revise and update existing legislation regarding municipal and commercial ambulance services related to its delivery of effective EMS care and interfacility transports.	Existing legislation not revised or updated in 2000.	Interfacility transport protocols were developed in 2006. The EMS Act of 2008 (DC law 17-357) was passed by Council, signed by the Mayor and approved by Congress in March 2009. In June of 2009, Mayoral Order 2009-89 delegated the responsibility to the DOH. This placed the responsibility for all EMS activities in the DOH. (EMS Act of 2008 (DC law 17-357) passed January 16, 2009, Mayor's Order 2009-89 signed June 1, 2009)
7-6. Establish at DOH/EHMSA an Enforcement Division to ensure compliance with the DOH specified EMS rules and regulations.	This activity had not commenced in 2000.	The Enforcement Division was in place and staffed by 2003.The EMS Act of 2008 (DC Law 17-357) provides for criminal and civil penalties for violation of the Act (Section 25). Section 26 allows for criminal prosecutions and Section 27 allows for injunctions. The draft regulations contain a section on the enforcement of violations (Section 563).
7-7. Continue participation in the development and update of the District's Emergency Operations Plan for response to current and new threats to the District and surrounding jurisdictions.	In 2000, the District's Response Plan had not been updated.	The District's Response Plan, including the ESF #8: Health and Medical, was updated in May 2006. Following the events of September 11, 2001 and the Anthrax attacks of September 18, 2001, there has been a focus on emergency planning. HEPRA now has a medical planner and has developed several emergency plans. (Source: 2010 EMS Annual Report, July 2011)
7-8. Establish a Do Not Resuscitate (DNR) Registry at the DOH/EHMSA.	In 2000, no DNR Registry, protocols nor relevant trainings existed.	Legislation establishing a DNR Registry at the DOH/EHMSA was passed by the City Council in 2001. Protocols have been developed and were implemented on August 1, 2006. Training of hospital-based health care providers was conducted in August 2006. (Source: DC DOH, EHMSA)

HEALTH CARE FINANCE

Overview

The rate of uninsured adults in the District of Columbia is lower than the national average, even as the percentage of uninsured adults has increased nationally over the last three years. The District of Columbia has the second-highest rate of insurance coverage in the United States. It has reduced the rate of uninsured adults by creating the DC Alliance program, an insurance plan that covers individuals who are otherwise not covered by Medicaid or Medicare but earn below a certain income level.

FOCUS AREA 8: HEALTH CARE FINANCE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
8-1. Reduce to less than 5% the proportion of Medicaid-eligible pregnant women and children in families up to 200% of the poverty threshold who do not have health insurance coverage.	8.8% of this targeted population was eligible but not enrolled in 1996.	○ In 2010, the District covered Medicaid-eligible pregnant women and children in families at a higher threshold than 200% FPL (300% FPL). According to the Urban Institute, only about 6.2% of District residents report being uninsured. (Source: DC Medicaid State Plan, 2010)
8-2. Establish insurance coverage for adults without minor children up to 50% of the federal poverty level (FPL) who do not have health insurance. MAA has received approval from CMS for an 1115 Research and Demonstration Waiver to finance services for adults without minor children.	Childless adults were not covered in 2000.	In 2005, 1,208 adults without minor children were covered up to 50% of the FPL. (Source: Reports from the Income Maintenance Administration) ● The District implemented the 1115 waiver to cover childless adults up to 200% FPL in November 2010. (See 1115 waiver information on DHCF website)

2010 OBJECTIVE	BASELINE	2010 DATA
8-3. Establish a comprehensive data reporting system or data warehouse to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations, and provider types.	No such data reporting system existed in 2000.	The currently certified Medicare Management Information System (MMIS) was procured in 2002. A new MMIS, which collects data on visits to MCOs and fees-for-service, was procured in 2010. These data are reported to the District Actuary dashboard and reviewed with MCOs on a quarterly basis.
8-4. Increase to 95% the proportion of Temporary Assistance to Needy Families (TANF) related enrollees with a specified source of on-going primary care in collaboration with the MAA-contracted enrollment broker and managed care organizations (MCOs) to ensure that individuals are assigned to an MCO at enrollment and that the MCO contacts the individuals assigned to it.	In 1998 there were approximately 87% of all TANF enrollees who had a specified source of ongoing primary care (included being insured in one of the MAA contracted managed care organizations).	In 2010, MCOs assigned 100% of enrollees to a primary care physician (PCP) for management of care and services. (Source: Medicaid Managed Care Reporting System)
8-5. Increase to 80% the proportion of the Medicaid-eligible child population participating in EPSDT.	In 1998, 49% of the District's Medicaid-eligible child population participated in EPSDT.	Participation Ratio on the CMS-416 for FY 2010 was 83%. (Source: CMS-416, 2011)
8-6. Collaborate in the creation of an integrated services delivery system which ensures that Medicaid eligible persons have access to comprehensive behavioral health services consisting of mental health and substance abuse service.	In 2000, access to behavioral health services was limited.	Since 2004, MAA has been working with DOH on a State Plan Amendment (SPA) to finance substance abuse treatment rehab services. In 2010, the Department of Mental Health's Behavioral Health Services contracted with MCOs to provide services. (Source: DMH)
8-7. Ensure that Medicaid eligible persons with long-term care needs have access to a continuum of long-term care services, including but not limited to nursing home care, home health care, adult daycare, and assisted living services.	In 2000, there were limited services that allowed access to a continuum of long-term care.	In 2006, the number of people enrolled in the waiver was 1,207 and in nursing home care was 2,392. (Source; Medicaid Office of Disabilities and Aging) In 2010, the following programs provided these services: Developmental Disabilities Waiver; Elderly & Physically Disabled Waiver; and Money Follows the Person Program. (Source: DHCF, Waiver Descriptions)

MATERNAL, INFANT, AND CHILD HEALTH AND FAMILY PLANNING

Overview

The original focus area was revised to concentrate on infant and child mortality. Infant mortality is a leading health indicator that many states use to determine the current health status of their residents. In the District of Columbia, the 2010 infant mortality rate (IMR) was 8.0 per 1,000 live births. While this rate met the DC Healthy People 2010 goal, it was still above the national average of 6.14. The DOH's Healthy Start program has helped the IMR drop in DC by providing services to high-risk pregnant and postpartum women who have delivered an infant within three months prior to enrollment, though there is still work to be done in this area.

FOCUS AREA 9: MATERNAL, INFANT, AND CHILD HEALTH AND FAMILY PLANNING CHART

2010 OBJECTIVE	BASELINE	2010 DATA
9-1. Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births.	The infant mortality rate was 10.2 per 1,000 live births in 2003. (Source: SCHS)	In 2010, the infant mortality rate was 8.0 per 1,000 live births. (Source: DC DOH, CPPE, 2010 Infant Mortality Report)
9-3-1. Reduce the rate of child mortality to 30 per 100,000 children ages 1-4 years.	Overall, the child mortality rate in the District was 48 in 1997. (Source: SCHS)	In 2010, the child mortality rate for ages 1-4 was 35 per 100,000. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
9-3.2. Reduce the rate of child mortality to 25 per 100,000 children ages 5-14.	Overall, the child mortality rate in the District was 35 per 100,000 children ages 5-14 in 1997. (Source: SCHS)	In 2010, the child mortality rate for ages 5-14 was 12 per 100,000. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
9-11. Reduce the incidence of preterm births to 100 per 1,000 live births.	The pre-term birth incidence rate was 132.0 per 1,000 live births in 2000. (Source: SCHS)	In 2010, the pre-term birth incidence rate was 103 per 1,000 live births. (Source: DC DOH, CPPE, 2010 Infant Mortality Report)

PUBLIC HEALTH INFRASTRUCTURE

Overview

The city's public health infrastructure serves as the framework supporting a system better positioned to respond to the changing needs of public health in the District. Creating a strong network that continues to define shared data standards to support the exchange of key health information is critical for a more effective and proactive public health system. Currently, there are multiple systems in place that support communications for public health labs and the clinical community. Each has demonstrated the importance of being able to exchange health information. However, many of these systems operate in isolation, not capitalizing on the potential for a cross-fertilization of data exchange. A crosscutting and unifying framework is needed to better monitor these data streams for early detection of public health issues and emergencies.

FOCUS AREA 10: PUBLIC HEALTH INFRASTRUCTURE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
10-1.1. Increase to 90% the proportion of DOH agencies that provide on-site access to data via electronic systems and online information systems, such as the Internet.	No DOH agencies had access to the internet in 1997.	The goal was met in 2001. In 2010, All of the major sites at DOH – around 1200 employees – were connected via-electronic systems and online information systems and have Internet access. (Source: DC DOH, SCHSA)
10-1.2. *Revised in 2003*: Develop and implement a departmental intranet for DOH.	No intranet existed in 2000.	In December 2004, work on the DOH intranet was 50% complete. In 2011, DOH was working on moving to a new system platform; therefore, this objective is in the last step of development.

2010 OBJECTIVE	BASELINE	2010 DATA
10-1.3 *Revised in 2003:* Implement wireless communication capability for Bioterrorism Preparedness and other communications requirements.	In 1997, the process to implement wireless communication capability had yet to begin.	About 40% of the planned components were installed as of 2003.In 2010, DOH had several operational communication systems equipped for bioterrorism: The Hospital Mutual Aid Radio System (HMARS) was operational, allowing for acute care hospital emergency departments and skilled nursing facilities to receive alerts. The Health Alert Network (HAN) was operational, providing for notification of key health care responders through the use of pagers and other electronic devices. The DCResponds systems were also operational, allowing for the notification and activation of the Medical Reserve Corp (MRC) through the use of text messaging and e-mail. Finally the Healthcare Information System (HIS) was operational, providing alerts through text messaging, e-mail or other wireless devices.
10-3. *Revised in 2001 to*: Develop health baseline datasets on all resident racial/ethnic minority population groups in the District of Columbia (black/African American, white, Hispanic/Latino, Asian American/Pacific Islander, American Indian/ Alaska Native.	As of mid-1989, Vital Records data on race of residents were collected according to four broad categories: Black, White, Other, and Hispanic (ethnicity).	In 2010, Vital Records collected 20 racial/ethnic minority categories in the District of Columbia.(Source: DC DOH, CPPE)
10-4. *Revised in 2001*: Produce 2010 implementation plans with short-term targets to evaluate goal-seeking strategies for the District's Healthy People 2010 Objectives.	Baseline not applicable.	The 2001-2002 Annual Implementation Plan began a biennial process that tracked targets for over 60% of the 2010 Objectives. Based on these plans, goals and objectives were revised to reflect the abilities of DOH. (Source: DC DOH, SCHSA)
10-5. Increase to 50% the use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities.	About 10% of DOH agencies were using GIS in 1997.	67% of DOH agencies use geo-coding with the DOH data systems.
10-6. Increase to 20% the number of DOH agencies that ensure the provision of comprehensive epidemiology services to support essential public health services.	Baseline not available.	67% of DOH agencies use comprehensive epidemiology services to support essential public health services.

PREVENT AND REDUCE DISEASES AND DISORDERS

11. ASTHMA
12. CANCER
13. DIABETES
14. DISABILITIES
15. CARDIOVASCULAR DISEASE AND STROKE
16. HIV/ AIDS
17. IMMUNIZATION AND INFECTIOUS DISEASES
18. MENTAL HEALTH
19. SEXUALLY TRANSMITTED DISEASES
20. SUBSTANCE ABUSE
21. TUBERCULOSIS

ASTHMA

Overview

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

FOCUS AREA 11: ASTHMA CHART

2010 OBJECTIVE	BASELINE	2010 DATA
11-1 Reduce the asthma mortality rate to no more than 1.5 per 100,000 people.	Asthma death rate was 2.8 per 100,000 residents for all ages in 1997 (non-age adjusted figures).	The age adjusted asthma death rate was 1.1 deaths per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
11-2. Reduce the overall asthma morbidity rate, as measured by a reduction in the asthma hospitalization rate, to 10 per 10,000 people.	Asthma hospitalization rate was 176 per 10,000 in 2000.	The hospitalization rate in 2009 was 26.68 cases per 10,000 people. (Source: 2009 Crude Hospitalization Rate)
11-3. Reduce the annual rate of Emergency Department (ED) visits for all ages to no more than 150 per 10,000 population.	The estimated ED visit rate for people of all ages is 195 per 10,000 population in 2003.	The ED visit rate in 2009 was 235.33 per 10,000 people. (Source: 2009 Crude ED Visit Rate)

CANCER

Overview

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

FOCUS AREA 12: CANCER CHART

2010 OBJECTIVE	BASELINE	2010 DATA
12-1. Reduce the mortality rate for cancer of the lung and bronchus by 12% of the 2000 baseline rate (52.8 per 100,000 population).	The age-adjusted mortality rate for cancer of the lung and bronchus was 60 per 100,000 in 2000. (Source: DC DOH, CHA, Cancer Incidence and Mortality Report (CIMR) for 2000)	The age-adjusted death rate was 42.4 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)

2010 OBJECTIVE	BASELINE	2010 DATA
12-2.1. Reduce breast cancer mortality rate by 10% of the 2000 Rate (to 24.3 per 100,000).	The age-adjusted breast cancer mortality rate in the District was 27.0 per 100,000 residents in 2000. (Source: DC DOH, CHA, CIMR, 2000)	The age-adjusted death rate was 18.4 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
12-2.2. Reduce cervical cancer mortality rate by 15% of the 2000 Rate (to 3.7 per 100,000).	The age-adjusted mortality rate for cervical cancer in the District was 4.3 per 100,000 residents in in 2000. (Source: DC DOH, CHA, CIMR, 2000)	The age-adjusted rate was 1.1 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
12-3. Reduce colorectal cancer mortality rate by 15% of the 2000 Rate (to 25.2 per 100,000).	The age-adjusted mortality rate for colorectal cancer was 29.7 per 100,000 residents in the District in 2000. (Source: DC DOH, CHA, CIMR, 2000)	The age-adjusted death rate was 21.1 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
12-4. Reduce the prostate cancer mortality rate among African American men by 25% of the 2000 rate (to 48.7 per 100,000).	The overall mortality rate for prostate cancer in the District was 50.78 per 100,000 residents in 2000. For African-American men the prostate cancer mortality rate was 64.9 per 100,000 in 2000. (Source: DC DOH, CHA, CIMR, 2000)	The age-adjusted death rate was 12.9 per 100,000 residents. In African American men, the prostate cancer mortality rate was 18.0 per 100,000 in 2010. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)

DIABETES

Overview

More than 45,000 District residents have diabetes and that number is expected to increase significantly in the future. The Centers for Disease Control and Prevention estimates that African-Americans and Hispanic/Latinos born in the year 2000 will have a 1-in-2 chance of developing diabetes during their lifetime (2006 CDC Diabetes Fact sheet). Diabetes and its related co-morbid conditions will continue to have a significant impact on District residents and its economy.

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

FOCUS AREA 13: DIABETES CHART

2010 OBJECTIVE	BASELINE	2010 DATA
13-1. Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents.	The age-adjusted mortality rate due to diabetes as the primary cause of death was 37.5 per 100,000 residents in 2001.	● The age-adjusted mortality rate due to diabetes as the underlying cause of death was 26.7 per 100,000 residents in 2010. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)

2010 OBJECTIVE	BASELINE	2010 DATA
13-2. Reduce the mortality rate for diabetes as the primary cause of death among African-American residents of the District to 30.9 per 100,000 population.	The mortality rate with diabetes as the primary cause among African-American residents in the District was 55.05 (crude rate) per 100,000 in 2001.	The mortality rate with diabetes as the underlying cause among African-American residents in the District was 42.0 (crude rate) per 100,000 in 2010.(Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
13-3. Increase to 80% the proportion of District residents with diabetes who report having a yearly hemoglobin A1c measurement.	62.5% of diabetic residents in the District reported having hemoglobin A1c measurement yearly. (Source: BRFSS, 2001)	80.7% of District residents with diabetes reported having a yearly hemoglobin A1c measurement (Source: BRFSS, 2010)
13-5. Increase to 85% the percentage of District residents with diabetes who report having a dilated eye exam within the past year.	75.6% of diabetic residents in the District reported having a dilated eye exam within the past year. (Source: BRFSS, 2001)	73.4% of District residents with diabetes reported having a dilated eye exam within the past year (Source: BRFSS, 2010)
13-6. Increase to 75% the percentage of District residents with diabetes who report having their feet checked for sores or irritations by a health care professional within the past year.	72.5% of diabetic residents in the District reported having had their feet checked for sores or irritations by a health care professional within the past year. (Source: BRFSS, 2001)	77% of District residents with diabetes reported having their feet checked for sores or irritations by a health care professional within the past year. (Source: BRFSS, 2010)
13-7. Increase the proportion of District residents with diabetes who report having an oral health exam within the previous 12 months by 50%.	57.0% of diabetic residents in the District reported having had an oral health exam within the previous 12 months. (Source: BRFSS, 1999)	79.6%of District residents with diabetes had an oral health exam within the last 12 months. (Source: BRFSS, 2010)
13-8. Increase to 75% the proportion of District residents with diabetes who report participating within the previous 12 months in at least 1 health care provider encounter focusing on self-management strategies.	53.2% of diabetic residents reported having participated within the previous 12 months in at least 1 health care provider encounter focusing on self-management strategies in the 2001 BRFSS.	58.5% residents have ever taken a self-management course but the measure does not specify if the course was led by a health care provider (Source: BRFSS, 2010).

2010 OBJECTIVE	BASELINE	2010 DATA
13-9. Increase by 50% the proportion of District residents with diabetes who report self-examination of their feet at least once daily.	64.0% of diabetic residents in the District reported self-examination of their feet at least once daily. (Source: BRFSS, 2001)	60.4% of District residents who diabetes reported self-examining their feet at least once daily. (Source: BRFSS, 2010)
13-10. Increase by 50% the proportion of District residents with diabetes who report at least one encounter with a health care provider devoted to dietary counseling (consisting of eating *more* fruit and vegetables and *less* high fat/cholesterol foods).	54.9% of diabetic residents in the District reported at least one encounter with a health care provider devoted to dietary counseling. (Source: BRFSS, 2001)	*Data not available*

DISABILITIES

Overview

A disability is a physical or mental impairment that substantially limits one or more major life activities. There are millions of people in this country that have some level of disability, with varying types and levels of impairment. In addition to addressing the causes and everyday consequences of a disability, there is a need to find ways to empower persons with disabilities to lead more independent lives. People with disabilities require reasonable accommodations or assistive technology to lead healthy lives. The Department of Disability Services addresses some of these needs by coordinating services for disabled residents through a network of private and non-profit providers.

FOCUS AREA 14: DISABILITIES CHART

2010 OBJECTIVE	BASELINE	2010 DATA
14-1. Ensure that 100% of hospitals in the District of Columbia report data on children born at risk for developmental delay or disability to the Department of Health (DOH) agencies charged with collecting such information.	33% of hospitals provided DOH agencies with data on children born at risk for developmental delay or disability.	100% of hospitals provide DOH Vital Records division with data on children born at risk for developmental delay or disability. (Source: DC DOH, CPPE, Vital Records, Electronic Birth Registration System, 2010)
14-2. Ensure that 100% of the relevant DOH programs have a standardized set of parameters in their core surveillance instruments that include information on persons with disabilities.	20% of relevant DOH Health programs collected data on disability status in 2001.	There are no core DOH surveillance instruments that include persons with disabilities in their populations parameters. (Source: DC DOH, CPPE, 2011)

CARDIOVASCULAR DISEASE AND STROKE

Overview

Cardiovascular disease and stroke remain the top causes of mortality in the District, and can easily be prevented by behaviors, environments, and policies that facilitate early detection and treatment. The Cardiovascular Health Program (CHP) focuses on the aspirin therapy for appropriate populations, blood pressure control, cholesterol control, sodium reduction and smoking cessation with an emphasis on population-level strategies and policy and environmental changes. Additionally, the CHP has started several heart disease and stroke awareness campaigns and sponsored the Stroke Collaborative with seven acute care, adult-serving District hospitals to assist them in standardizing stroke treatment activities throughout the District.

FOCUS AREA 15: CARDIOVASCULAR DISEASE AND STROKE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
15-1. Reduce deaths from heart disease to no more than 230.2 per 100,000 people.	The age-adjusted mortality rate from heart disease was 273.7 per 100,000 population in 2000. (Source: DC DOH, CHA, CVD Program Epidemiologist)	The age-adjusted death rate is 238.3 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data)
15-2. Reduce the proportion of adult residents with high blood pressure to no more than 10%.	28.8% of District residents reported being diagnosed with high blood pressure. (Source: BRFSS, 2001)	26.1% of adult residents reported being diagnosed with high blood pressure. (Source: BRFSS, 2009)

2010 OBJECTIVE	BASELINE	2010 DATA
15-3. Increase to at least 50% the proportion of adult residents with high blood pressure whose pressure is under control.	In 2001, 73.8% of District residents reported taking blood pressure medication. (Source: BRFSS, 2001)	76.6% of District residents reported taking blood pressure medicine. (Source: BRFSS, 2009)
15-4. Increase to at least 95% the proportion of people with high blood pressure who are taking action to help control their blood pressure.	Nationally, 72% of people with high blood pressure ages 18 and older took measures to control their blood pressure, such as medication and diet modification. (Source: NHIS, 1998)	86% of people who have ever been diagnosed with high blood pressure reported taking steps to control their blood pressure to include; changing eating habits, reducing salt intake, reducing alcohol consumption, or exercising. (Source: BRFSS, 2009)
15-5. Increase to 100% the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.	97% of District residents reported having had their blood pressure checked within the past two years. (Source: BRFSS.1994)	*These data were no longer being collected in 2010.
15-6. Reduce the mean total blood cholesterol levels among District adults to no more than 193 mg/dL.	Nationally, adults, ages 20 and older, had blood cholesterol levels of 206 mg/dL in 1988-1994. (Source: NHANES)	*These data were not available through the District's Cardiovascular Program.
15-7. Reduce the prevalence of blood cholesterol levels of 240 mg/dL to no more than 13%.	28.8% of District residents reported being told they had high cholesterol. (Source: BRFSS, 2001) *These data capture residents who were ever told they have high blood cholesterol. However, the definition of "high" in terms of mg/dl is not specified.	34.4% of District residents reported being told they had high cholesterol. (Source: BRFSS, 2009) *These data capture residents who were ever told they have high blood cholesterol. However, the definition of "high" in terms of mg/dl is not specified with this measure.
15-8. Reduce the mortality rate from stroke to no more than 33.2 per 100,000 residents.	The age-adjusted mortality rate for stroke in the District was 39.5 per 100,000 residents in 2000. (Source: DC DOH, CHA, CVD Program)	The age-adjusted death rate was 35.4 per 100,000 residents. (Source: DC DOH, CPPE, Data Management and Analysis Division, 2010 preliminary data).

HIV/AIDS

Overview

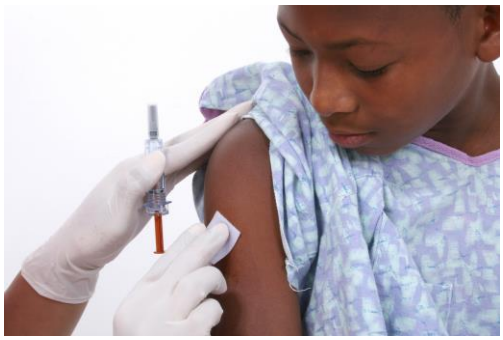
The District of Columbia continues to fight a severe HIV/AIDS epidemic. In 2009, the District reported its first ever HIV/AIDS rate decline since the epidemic began in the 1980s. In 2010, there was a 3.2% prevalence HIV/AIDS rate among adult and adolescent residents. The current rate of 2.7% shows a slight decrease from the 2010 rate. This epidemic has disproportionately affected African American adults ages 30-59 years, and is more prevalent in Wards 1, 5, and 8.

FOCUS AREA 16: HIV/AIDS CHART

2010 OBJECTIVE	BASELINE	2010 DATA
16-1. Increase by 5% annually the number of HIV+ individuals identified through HIV counseling and testing through programs funded by the HIV/AIDS Administration and the Centers for Disease Prevention and Control (CDC).	209 individuals were identified as HIV+ through counseling and testing services in FY 2003 (Source: Counseling and Testing database).	Over the course of the decade, identified HIV+ individuals increased by much more than 5% annually. A few years showed small decreases, but the overall trend increased. In 2004, 319 HIV+ individuals were identified through HIV testing and counseling (a 53% increase from FY2003). Diagnoses from 2009 (881 cases) to 2010 (867 cases) showed a decrease, but the average annual increase from baseline to 2010 was 22.5%. (Sources: Performance Evaluation and Monitoring System; DOH, HAHSTA, Annual Epidemiology and Surveillance Report)

2010 OBJECTIVE	BASELINE	2010 DATA
16-2. Increase by 5% annually the number of newly reported AIDS cases as a result of active case findings.	1,160 newly reported AIDS cases were recorded as a result of active case findings in FY 2003 (AIDS Surveillance database). 970 newly-reported AIDS cases were recorded as a result of active case findings during the January 2004 to December 2004 reporting year.	452 newly-reported AIDS cases were recorded in 2010, and no constant annual increase is seen through the data. However, this goal was not achieved because the overall prevalence rate of HIV has decreased in the District of Columbia over time. (Source: DC DOH, HAHSTA, 2011 Annual Report)
16-3. Increase by 10% annually the number of HIV+ individuals who receive Housing Assistance services (by programs funded through the HIV/AIDS Administration and HOPWA)	400 housing slots were occupied in FY 2003 (monthly reports). In FY 2004, housing assistance was provided for 760 individuals and families in the form of emergency shelter, short term supportive housing, and Tenant Based Rental Assistance (TBRA) and Short-Term Rental, Utility, and Mortgage (STRUM) Assistance.	712 individuals who were HIV + received Housing Assistance services, and no constant annual increase is seen through the data (Source: DC DOH, HAHSTA, 2011 Annual Report)
16-4. Increase by 2.5% annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP).	646 HIV+ individuals were newly enrolled in ADAP in FY 2003. (Source: ADAP Enrollment database)	In 2010, ADAP enrollment was 2,581 in the first quarter of the year, 2708 in the second quarter of the year, 2,710 in the third quarter of the year, and 2,551 in the last quarter of the year. (Source: ADAP, 2011)

IMMUNIZATION AND INFECTIOUS DISEASE



Overview

Disease prevention is key to many successes in public health. Vaccines help prevent infectious diseases such as polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps and tetanus. Vaccines prevent diseases in the people who receive them and protect those who come into contact with unvaccinated individuals. When the vaccination levels in a community are high, even the unvaccinated people in the community are protected, because of "herd" immunity. However, the organisms that cause vaccine preventable diseases have not disappeared. They have receded due to immunizations, but can quickly reemerge if vaccination coverage levels drop. Since 1979, the District of Columbia has required children attending school and childcare centers to be fully immunized.

FOCUS AREA 17: IMMUNIZATION AND INFECTIOUS DISEASE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
17-3. Maintain immunization coverage at 95% for children in licensed child care facilities, Head Start, and pre-kindergarten classes.	Coverage levels for licensed childcare facilities in 2001 were 4 DtaP 95%, 3 + Polio 97%t, 1 + MMR 97%, 3+ Hib 95%, and 1 Varicella/ history 97% according to survey data. Coverage levels for Head Start centers in 2001 were 4 DtaP 91%, 3 + Polio 95%, 1 + MMR 95%, 3+ Hib 91% and 1 Varicella/history 95% according to registry data. Coverage levels for PreK/K/1 grade students in 2001 were 4 DtaP 92%, 3+ Polio 94%, 1+ MMR 98%, Hib not age appropriate, and 1 Varicella/history 91% according to survey data.	Immunization coverage is at an average of 96% for the children in child care facilities, Head Start, and pre-kindergarten classes (Source: CDC Childcare Immunization Survey, DC Central Immunization Registry, 2010).

2010 OBJECTIVE	BASELINE	2010 DATA
17-7. Increase to 100% (minus any deaths) the proportion of each new birth cohort enrolled in the Center Immunization Registry.	This project began in 2001. Baseline data indicate that 76% (5,683 of 7,513 births, based on 1999 births to District women) of the cohort was enrolled in the Central Immunization Registry by the end of 2001. (Source: DC DOH Immunization Registry)	Since 2000 the Immunization Program has been receiving data for births to DC residents. Since 2008, DOH has received data for all births in the District (includes non-residents who deliver babies at hospitals in the District). (Source: DC DOH, CPPE, Vital Records Electronic Birth Registration System)
17-8. Increase to 90% the number of non-institutionalized adults ages 65 years and older immunized against influenza; and increase to 60% the number of non-institutionalized adults ages 65 years and older immunized against pneumococcal disease.	BRFSS coverage level data from 1999 indicated that 54% of non-institutionalized adults 65 years and older were immunized with influenza vaccine and 32% of non-institutionalized adults 65 years and older were immunized with pneumococcal vaccine. (Source: BRFSS, 1999)	As of 2010 the percentage of adults aged 65+ who have had a flu shot within the past year was 60.9%. As of 2010 the percentage of adults aged 65+ who have had a pneumococcal vaccination was 64.7%. (Source: BRFSS, 2010)

MENTAL HEALTH

Overview

The Department of Mental Health (DMH) primarily addresses issues related to mental health. The primary mission of DMH is to address the mental health service and support needs of District of Columbia residents. To accomplish this mission, DMH is responsible for the development of policy, certification of providers, quality oversight, administration of mental health rehabilitation services, and licensure of mental health facilities. The DMH also operates Saint Elizabeth's Hospital, a public provider of acute and chronic inpatient mental health services.

Mental health is as critical to public health as one's physical health. Mental illness has been linked to the onset and/or the progression of certain diseases. In some cases, persons with mental illness may be at greater risk for obesity, lack of physical activity, substance abuse, and tobacco use. Depression is considered one of the risk factors for several chronic diseases including hypertension, cardiovascular disease, and diabetes.

FOCUS AREA 18: MENTAL HEALTH CHART

2010 OBJECTIVE	BASELINE	2010 DATA
18-1.3. Expand the prevention-oriented services for children and adolescents (ages 5–18) in the mental health rehabilitation services (MHRS) programs by 10% annually.	In FY 2005, approximately 2,515 children were served in the MHRS program, of this number 1,409 were ages 5-12, and 1,106 were ages 13-18.	Prevention-oriented services included 3,934 children and adolescents.[3] (Source: e-CURA)

[3] Represents children enrolled in the MHRS program not necessarily only those who have a prevention-oriented service.

2010 OBJECTIVE	BASELINE	2010 DATA
18-1.4. Expand the prevention oriented services for children in D.C. Charter and Public Schools. (DCPS).	In school Year 2004-2005 the SMHP provided services in 19 DCPS and 10 Public Charter Schools serving 599 children in the treatment component.	The SMHP operated in 50 DCPS and 9 Public Charter Schools. 737 children were served in the treatment component[4] (Source: School Mental Health Program, 2011)
18-2. Increase to 5% annually the services to persons ages 18 and older who are homeless with serious mental illness.	The Dixon Exit Criterion required engaging 150 adults for 4 consecutive quarters. The number in FY 2006 was 139 as reported by the DMH Homeless Outreach Team.	155 adults who were homeless with serious mental illnesses received services through Pathways To Housing-DC.[5] (Source: Pathways To Housing Program-DC, 2011)
18-3. Increase to 5% annually the proportion of working-age individuals with SMI who are employed.	In FY 2005, 169 consumers were working through the supported employment program.	201 working-age individuals with SMI were working through supported employment. (Source: DC DMH Supported Employment Program, 2011)

[4] Unduplicated counts are not kept for children in the prevention and early intervention components.
[5] This Dixon Exit criterion was measured by the Pathways to Housing-DC home first homeless services program in FY 2010 as originally intended.

SEXUALLY TRANSMITTED DISEASES

Overview

The District of Columbia is still experiencing multiple sexually transmitted disease (STD) epidemics – HIV, chlamydia, gonorrhea, and syphilis. Currently, chlamydia, gonorrhea and syphilis are the only non-HIV STDs for which surveillance data are routinely collected and analyzed in the District. Guided by surveillance data, DOH focuses prevention efforts on populations most at-risk. Prevention and intervention priority efforts include screening, diagnosing, treating and preventing infections, paying particular attention to the subpopulations most affected. The District supports these efforts by providing direct STD screening, diagnostic, treatment and partner services; distributing condoms; partnering with private and non-profit organizations to screen, treat (or refer for treatment), and educate communities about STD prevention; and, providing education and consultation to the private medical community about STDs in the District.

FOCUS AREA 19: SEXUALLY TRANSMITTED DISEASES CHART

2010 OBJECTIVE	BASELINE	2010 DATA
19-1. Reduce the prevalence of *Chlamydia trachomatis* infections among young persons (15 to 24 years old) to no more than 3%.	The proportion of District of Columbia women 15- 24 years old testing positive for Chlamydia trachomatis infections in the STD Clinic was 7% (176 of 2,613) and 3 % (106 of 3,636) in Family Planning clinics in 2002.	● There is a 3.9% prevalence of *Chlamydia trachomatis* infections with 364 positive results and 9,328 targeted tests. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)

2010 OBJECTIVE	BASELINE	2010 DATA
19-2.1. Reduce the incidence of gonorrhea among District residents to no more than 346 cases per 100,000 people.	The District's gonorrhea rate was 476 per 100,000 people (calculated 2,722 of 572,059 times 100,000) in 2002.	350 cases of gonorrhea per 100,000 people. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)
19-2.2 Reduce the incidence of gonorrhea in adolescents ages 10- 19 years in the District to no more than 580 cases per 100,000 people.	The gonorrhea rate among District adolescents ages 10-19 years was 991 per 100,000 people (calculated 673 of 67,885 times 100,000) in 2002.	1,165 cases per 100,000 population; actual number of cases reported: 783 cases reported out of 67,185. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)
19-2.3 Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000.	The gonorrhea rate in the District for women was 412 per 100,000 people (calculated 1,246 of 302,693 times 100,000) in 2002.	397 cases per 100,000 population; 1,073 cases reported from 270,112 females. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)
19-3. Reduce the incidence of primary and secondary syphilis to no more than three cases per 100,000 people.	The primary and secondary syphilis rate in the District was 10 per 100,000 people (calculated 59 of 572,059 times 100,000) in 2002	22 syphilis cases per 100,000 people; 134 cases reported From 601,723 persons. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)
19-4. Reduce the incidence of congenital syphilis to no more than 10 cases per 100,000 live births.	The congenital syphilis rate in the District was 13 per 100,000 live births in 2002.	11.3 per 100,000 live births; 1 case reported among 8,870 live births in 2007. (Source: DC DOH, HAHSTA, STD Control Program Annual Report, 2010)
19-5. Reduce the HIV positive rate to below 1% among newly tested patients at the Southeast Sexually Transmitted Diseases (STD) Clinic.	The HIV positive rate among patients tested at the Southeast STD Clinic was 1.6% (calculated 67 of 4,032) in 2002.	*Data not available.*

SUBSTANCE ABUSE

Overview

The Department of Health is responsible for providing programs for prevention, treatment, and recovery from alcohol and drug use. DOH strives to reduce substance abuse among youth and expand treatment services for persons with addiction. In 2000, the District of Columbia City Council passed The Choice in Drug Treatment Act, which mandated the implementation of the Drug Treatment Choice Program (DTCP). This law has greatly facilitated DOH's ability to increase community partnerships by entering into contractual agreements with over forty-four substance abuse treatment agencies that offer a wide range of treatment modalities and services that span across our continuum of care.

FOCUS AREA 20: SUBSTANCE ABUSE CHART

2010 OBJECTIVE	BASELINE	2010 DATA
20-1. Reduce to no more than 50% the proportion of youth who have ever tried cigarette smoking.	55.2% of boys and 55.7% of girls have tried smoking. (Source: 2003 District of Columbia Youth Risk Behavior Survey (YRBS))	44% boys and 41.3% of girls have tried smoking. 43.1% of all youth have tried smoking. (Source: 2010 DC YRBS-High School)
20-2. Reduce to 51% the proportion of youth reporting that they have ever drunk alcohol.	66.1% reported drinking alcohol. (Source:2003 DC YRBS)	60.3% of youth reported they had drunk alcohol. (Source: 2010 DC YRBS-High School)
20-3. Reduce to 20% the proportion of youth who have ever used marijuana.	41.7% of youth reported using marijuana.(Source: 2003 DC YRBS)	43% of youth reported that they had used marijuana. (Source: 2010 DC YRBS-High School)

2010 OBJECTIVE	BASELINE	2010 DATA
20-4. Reduce to 10% the proportion of youth who have been offered, sold, or given an illegal drug on school property during the past 12 months.	25% of youth reported obtaining an illegal drug on school property. (Source: 1997 YRBS)	22.6% of youth have been offered, sold, or given an illegal drug. (Source: 2010 DC YRBS-High School)
20-5 Expand treatment modalities to include 550 treatment slots for women and women with children to promote a better quality of life and decrease (drug-related) infant mortality.	There were 435 treatment slots in 2000.	64 beds in women-only residential facilities 569 beds in co-ed residential facilities 2700 outpatient treatment slots 3334 total treatment slots available to women (Source: DC DOH, APRA, 2011)
20-6. Establish coalitions and partnerships around quality prevention programs, and youth and adult treatment programs for the addicted.	There were more than 20 treatment and prevention partnerships in 2004.	In 2010, DOH contracted with: 23 Adult Substance Abuse Treatment Providers 7 Youth Treatment Providers 10 Access to Recovery Providers and 4 Prevention Centers that provided services to all 8 District Wards. (Source: DC DOH, APRA, 2011)

TUBERCULOSIS

Overview

It is important to maintain a strong tuberculosis (TB) control program because those who are affected must adhere to a consistent treatment regimen for months at a time. Those most affected by TB in the District are African-Americans and persons born in foreign countries where TB is endemic. Over the last five years, the District has experienced considerable success in reducing the number of TB cases and, consequently, the TB case rate for District residents. These recent decreases are moving the District closer to achieving its goals of eliminating TB.

FOCUS AREA 21: TUBERCULOSIS CHART

2010 OBJECTIVE	BASELINE	2010 DATA
21-1. Reduce the incidence of tuberculosis in the District of Columbia to no more than 9.9 cases per 100,000 people.	There were 14.3 cases of tuberculosis per 100,000 people in 2002.	7.2 cases per 100,000 in 2010. (Source: DC DOH, HAHSTA, Bureau of TB Control Annual Report, 2010, updated 2011)
21-2. Increase to 90% the proportion of TB patients who complete a recommended course of curative treatment.	88% of patients with newly diagnosed TB disease completed a prescribed course of curative treatment within 12 months of treatment initiation in 2002.	78.9% of TB patients completed a recommended course of curative treatment. (Source: DC DOH, HAHSTA, Bureau of TB Control Annual Report, 2010)
21-3 Increase to 90% the proportion of close contacts of persons infected with TB who complete the recommended courses in preventive therapy.	Less than 10% of close contacts of persons with active TB completed preventive therapy in 2002.	Approximately, 26 % of close contacts finished the prescribed preventative therapy. (Source: DC DOH, HAHSTA, Aggregate Report for TB Program Evaluation, 2010)

IMPORTANT ACRONYMS

ADAP: AIDS Drug Assistance Program

ALS: Advanced Life Support

APRA: Addition Prevention & Recovery Administration

BLS: Basic Life Support

BRFSS: Behavioral Risk Factor Surveillance System

CAHPS: Consumer Assessment of Health Plans Survey

CDC: Centers for Disease Control

CHA: Community Health Administration

CON: Certificate of Need

CPPE: Center for Policy, Planning & Evaluation

CVD: Cardiovascular Disease

DOH: Department of Health

DDOE: District Department of the Environment

DDS: Department of Disability Services

DHCF: Department of Health Care Finance

DMH: Department of Mental Health

EHMSA: Emergency Health and Medical Services Administration (currently HEPRA)

EMS: Emergency Medical Services

EMT: Emergency Medical Technician

EPSDT: Early Periodic Screening, Diagnosis, and Treatment

FPL: Federal Poverty Line

HEPRA: Health Emergency Preparedness and Response Administration (formerly EHMSA)

HPSA: Health Professional Shortage Area

HRLA: Health Regulation and Licensing Administration

HRSA: Health Resources and Services Administration

MCO: Managed Care Organization

MMIS: Medicare Management Information System

OCTO: Office of the Chief Technology Officer

PedNSS: Pediatric Nutrition Surveillance Survey

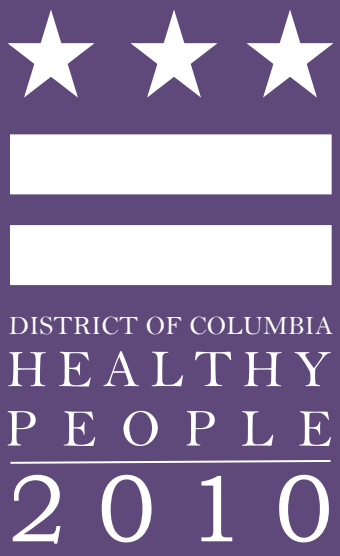
SCHS: State Center for Health Statistics

SCHSA: State Center for Health Statistics Administration

TANF: Temporary Assistance to Needy Families

WIC: Women, Infants, and Children Program

YRBSS: Youth Risk Behavioral Surveillance Survey



Saul M. Levin, M.D., MPA
Chief Health Officer of the District of Columbia
Acting Director, Department of Health