DISTRICT OF COLUMBIA

DEPARTMENT OF HEALTH

MATERNAL AND FAMILY HEALTH ADMINISTRATION

TITLE V BLOCK GRANT APPLICATION

5 YEAR NEEDS ASSESSMENT

Revised
October, 2005

Summary

The District of Columbia Department of Health Maternal and Family Health Administration completed a 5-year assessment of the needs of the maternal and child population, including children with special health care needs (CSHCN). The data collection and analysis division staff reviewed national and local data sources to analyze the health status and access to health services of pregnant women and infants, other women of childbearing age, children and youth, and CSHCN. Findings were summarized and presented in a series of stakeholder focus groups convened during the summer of 2005. Over 250 stakeholders were invited to participate in a series of 4 meetings (see Appendix I). Teens comprised 1 focus group and a parents' advisory group another. 2 groups included both representatives from community organizations and Administration staff. A technical assistance contractor funded through the federal Maternal and Child Health Bureau convened 10 focus groups sessions in wards 1, 2, 3, and 4 to determine perceived barriers to health care for the District's Hispanic/Latino community.

In addition to the long-recognized problems of high prevalence of late entry into prenatal care, low birthweight and premature births, and unintended pregnancies, issues around limited access to oral health services, lack of recognition of and limited mental health preventative services, especially for youth, and the need for improving the cultural and linguistic competency of providers surfaced among stakeholders and were supported by the quantitative findings as well.

Senior managers discussed the implications of these findings in setting the District's 5-year MCH priorities. They decided to retain 4 priorities delineated for the 2000-2005 period:

1. Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status (an overarching priority that connects all 4 level of services);
2. Population based services and infrastructure development: Improve oral health among children, youth and pregnant women.
3. Enabling services and direct services: Reduce unintended pregnancies and teen births.
4. Infrastructure development and enabling services: Increase the proportion of the population that is insured, and increase the comprehensiveness of the insurance to include primary preventative services and preconceptional services.

Senior managers agreed to formulate 5 new priorities:

1. Infrastructure development and enabling services: Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services.
2. Infrastructure development: Enhance nutrition and increase physical activity for children and youth.
3. Infrastructure development: Decrease violence toward children and youth.

4. Infrastructure development and direct services: Increase access to medical homes for CSHCN and support seamless systems of care and transitions across service systems.
5. Infrastructure development: Increase the cultural competency of the MCH workforce and service organizations.

Senior managers also decided to continue reporting on the 7 state performance measures delineated in previous years due to emphasis placed on issues of considerable importance to the District's maternal and child population such as:

1. Increase the % of women who receive adequate prenatal care;
2. Increase EPSDT participation;
3. Reduce the prevalence of lead levels exceeding 10ug/dl among children through age 6;
4. Reduce the prevalence of tobacco use among pregnant women;
5. Reduce the proportion of births resulting from unintended pregnancies;
6. Reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester; and
7. Reduce the incidence of repeat births for teens less than 19 years of age.

2.1 Needs Assessment of the Maternal and Child Health Population

The five-year needs assessment seeks to provide valuable information to help the District of Columbia Department of Health, Maternal and Family Health Administration as it works in partnership with community organizations and providers to identify actions that are effective in improving the health status of the District's maternal and child health (MCH) population. More specifically, the major objectives of the needs assessment were to:

- Describe the health status, problem health issues and available preventive and primary care services, including gaps in services, for pregnant women, women of child bearing age, infants, and children, including children with special health care needs in the District of Columbia;
- Make recommendations to the Title V Agency regarding effective intervention opportunities to improve the health of residents for incorporation into the FY 2006 plan; and
- Meet the requirements for the Title V application.

The needs assessment reflects more than a compilation of numbers or descriptions. It discusses health status and trends, gaps and discrepancies (i.e. age, gender, socio-economic and cultural groups and geographic groupings), and events and circumstances that impact the measures or indicators.

2.1.1 Needs Assessment Process

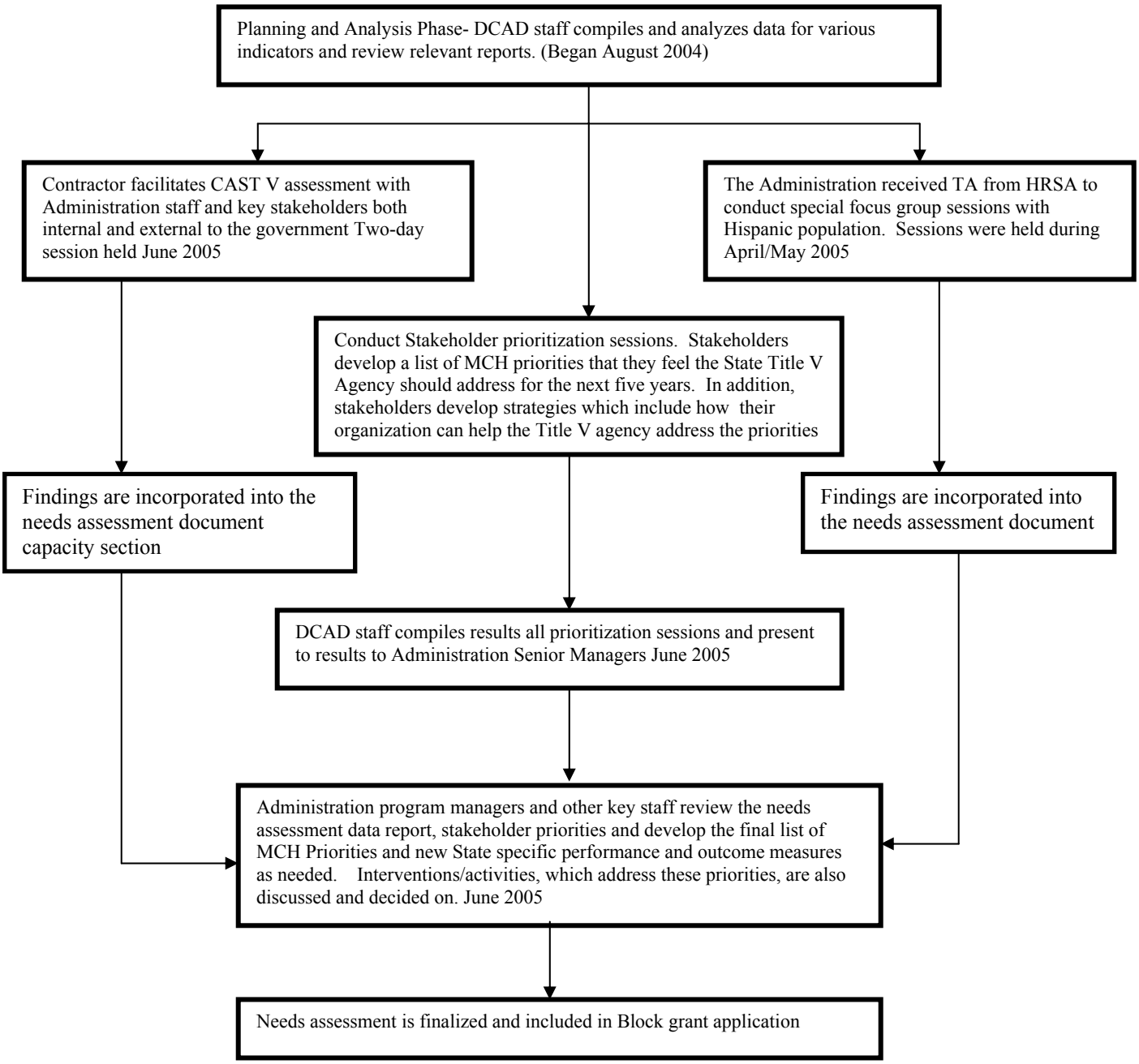
In the summer of 2004, Maternal and Family Health Administration (the Administration) staff began planning the five-year needs assessment process for the District's Title V Block grant submission. During the planning phase, staff from the Data Collection and Analysis Division (DCAD) within the Administration researched various methods of conducting needs assessments from across the country to obtain the most current methodologies available. Methodologies from the states of Washington, Rhode Island, New Mexico Oregon, Massachusetts and San Diego, California were among the sites examined. In addition, literature on the subject contributed by experts in the field including, those from the Maternal and Child Health Bureau (MCHB), Johns Hopkins University and the University of Illinois at Chicago School of Public Health were reviewed.

Statistical analysis techniques used included univariate, multivariate and logistical regression analysis. Associations between independent and outcome variables were assessed. To test for differences between means and percentages, *z* statistics were computed; tests were two-tailed, and

α was set at .05. Unknown values were excluded from computations. Chi-square test of association was also used to examine differences in various risk factors across populations and/or races.

Once a substantial amount of the indicator data was compiled, plans were made to invite community stakeholders to one of four all day retreats to discuss the data and develop a list of ten priorities. Stakeholders were defined as those individuals in the community (i.e. advocacy groups and activists, providers of care, parents, clients, other state agencies) who had a key interest in MCH issues in the District. A list of two hundred and fifty (250) potential stakeholders was compiled. In addition, the Adolescent Health Division held two special sessions. One group was comprised of sixteen persons between the ages of 18-24 years. The second group was comprised of six parents from the parent advisory group at Covenant House of Washington. All sessions were held between the May 2005 and June 2005.

The diagram below illustrates the process used to conduct the needs assessment.



Data Used and Sources of the Data: Because health status is an important factor driving the demand for health services in the District of Columbia, the first step in the assessment was to identify the specific health problems of the populations. To accomplish this, a broad spectrum of health-related data was collected, including all publicly available health (e.g. causes of death, birth outcomes, infant and child mortality and morbidity) and health care utilization data (e.g. EPSDT services used) as well as data on population characteristics and socioeconomic status. DCAD staff compiled over 100 health, social, and safety indicators, as well as indicators of health system capacity and adequacy, based on the list of model MCH indicators developed by the MCHB. Since the 2000 needs assessment, DCAD staff had put in place a monitoring/tracking system to annually collect data from various sources in order to facilitate a smoother 2005 needs assessment process. Data from the following sources were utilized:

- Title V Performance and Outcome Measures;
- Health Status Indicators;
- DC Healthy Residents 2010 Health Objectives;
- Vital Records;
- Juvenile Justice;
- Temporary Assistance for Needy Families (TANF);
- Child Abuse and Neglect;
- Hospital discharge file;
- WIC;
- Pregnancy Risk Assessment Monitoring System (PRAMS);
- Pregnancy Nutrition Surveillance System (PNSS);
- Youth Risk Behavioral Surveillance System (YRBSS) and other DC Public School data;
- Medicaid, including EPSDT;
- Children with Special Health Care Needs SLAITS Survey;
- DC Department of Employment Services;
- DC Housing Authority;
- Behavioral Risk Factor Surveillance System (BRFSS);
- Planned Parenthood of Metropolitan Washington, DC (Title X Agency);
- Infant Mortality and Child Fatality Reviews;
- Environmental Health Administration/ Lead Poising Prevention Program;
- DC Office of Planning, State Data Center; and

- The US Census Bureau.

Various reports, including *Primary Health Care Services Safety Net: Health Care Services for the Medically Vulnerable In the District of Columbia 2003 Update* by the District of Columbia Primary Care Association were also used as data resources.

2.1.1.2 **Data and Methodology Limitations:** Interpretation of the data from the various sources is dependent on an understanding of the limitations of the data collected and reported. When different sources provided differing values on an indicator, staff made a judgement about which source would be considered primary and the source was contacted directly to verify the methodology used to construct the indicator. In addition, Census Bureau population estimates were used to calculate the rates for the various indicators. These population estimates are in fact not absolute numbers but scientific "guesses" of the numbers derived from annual adjustments to the 2000 Census data, based on several parameters including telephone lists and automobile registration.

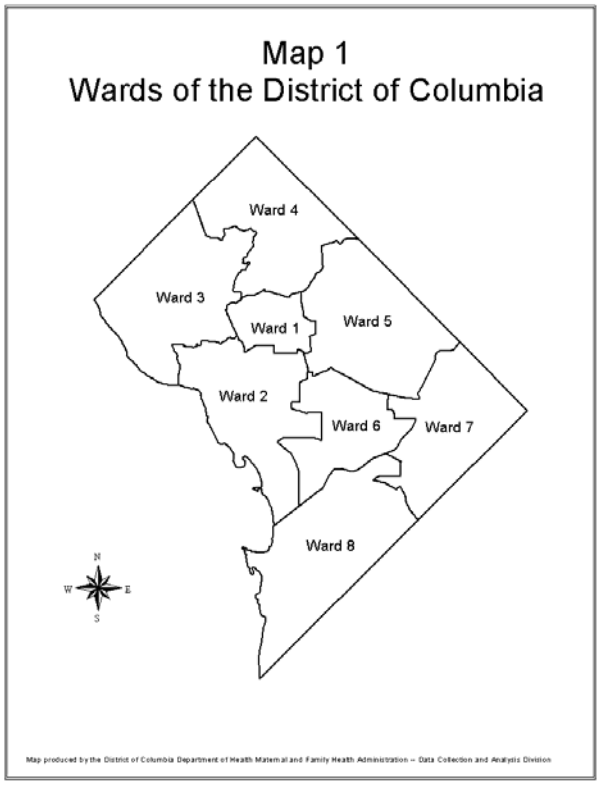
Caution must be used when interpreting the small number of occurrences for a particular indicator. Fluctuations easily occur when dealing with small numbers in small area analysis. In most cases, except in case of recent focus group sessions and a special immigrant study, for ease of comparability, only data up through 2002 was used for the needs assessment.

2.1.1 Needs Assessment Content

2.1.1.1 Overview of the Maternal and Child Health Population's Health Status

According to the 2000 United States Census, 572,059 people live in the District of Columbia.[1] The District's residents are racially and ethnically diverse. The sixty-nine square miles that make up the District are divided into eight Wards. Each Ward has roughly the same number of residents. The largest number of residents (74,937) is concentrated in Ward 4. Ward 6 has the smallest number (68,037) of residents. See Map 1 below for a visual layout of the District of Columbia by Ward.

1 The most recent population estimate for the District of Columbia is for the year 2004 in the amount of 553,523. However, Ward population breakdowns have not yet been made available. Therefore, for the purpose of this report census data from 2000 will be used.



The majority of residents, 60% (343,312) are African American, 30.8% (176,101) are White, 2.8% (15,537) Asian or other Pacific Islander, and 3.8% (21,950) are some other race. Hispanic/Latinos (who can be of any race) comprise 7.9% (44,953) of the total population. 57% of the District's African American population lives in Wards 5, 7 and 8. More than 90% of the total population of Wards 7 and 8 is African American. 60% of the District's white population lives in Wards 2 and 3. Hispanics/ Latinos are concentrated in Wards 1 and 4. More than 18% of the total population of Wards 1 and 4 is Hispanic/ Latino. 80% of the District's Asian/Native Pacific Islander population lives in Wards 1, 2 and 3.

By far, Ward 1 has the most "equally" diverse population in the District of Columbia. Within this Ward, 46% is Black/African American, 32% White, 25% Hispanic/Latino, 4% Asian/Pacific Islander, and 14% some other race. Ward 7 is the least diverse in the District with a population that is 97% Black/African American, 1% White, 1% Hispanic/Latino, 0.2% Asian/Pacific Islander, and 0.3% some other race. See Table 1 below for the census and racial/ethnic breakdown by Ward.

Table 1: District of Columbia: Demographics by Ward

Washington, DC	Population 2000 Census	Asian/ Pacific Islander	White/ Caucasian	Black/ African American	Hispanic/ Latino (any race)
Ward 1	73,364	3.6%	31.7%	45.7%	24.7%
Ward 2	68,869	7.9%	65.4%	19.9%	10.2%
Ward 3	73,718	5.8%	83.6%	5.8%	6.8%
Ward 4	74,092	1.0%	17.7%	70.7%	12.5%
Ward 5	72,527	0.8%	9.4%	86.7%	2.6%
Ward 6	68,035	2.1%	31.6%	62.7%	3.0%
Ward 7	70,540	0.2%	1.4%	96.8%	0.9%
Ward 8	70,914	0.5%	5.3%	92.4%	1.4%
Total	572,059	2.8%	30.8%	60.0%	7.9%

Source: DC Office of Planning, United States Census 2000.

According to the 2000 US Census, District residents reported the following ancestries: 44,953 are Latino/Hispanic, 15,189 from Asian countries, 16,010 are from sub-Saharan Africa, 7,861 are West Indian, 3,120 are from Arab countries, 1,713 are American Indian/ Alaska Native and 348 are other Pacific Islanders. In addition, the Census noted that there were 73,555 recent foreign-born District residents most of whom came during 1990 - 2000. Of this number, 37,079 came from Latin America, 12,909 came from Europe, 12,503 from Asia, and 9,208 from Africa.

In September 2005 the Council of Latino Agencies (http://www.consejo.org) released a report, ***The State of Latino Health in the District of Columbia***, based on a population based survey of Latino households conducted in 2004 in conjunction with the District of Columbia Department of Health and supported by a grant from the federal Centers for Medicare and Medicaid. Although the Department of Health has yet to release the more comprehensive companion report, the Maternal and Family Health Administration management believes it is important to incorporate the study findings into this needs assessment with the understanding that additional information on the representation of the findings will be available for inclusion in next year's block grant application submission.

The survey used questionnaire items from the National Health Interview Study and the Behavioral Risk Factor Survey. Therefore, results can be compared to other populations. The report presents findings in comparison to the U.S. Latino population (which is quite different in terms of country of origin, length of time in the U.S. and other demographics from the D.C. Latino population). Comparisons are also shown with the D.C. white population, the ethnic group that has the best general health indicators, but not with the majority African American population.

The District's Latino population is overwhelmingly of Central American ancestry, 61% from El Salvador. 69% of the population is age 40 and under. 60% have an 8th grade education or less. 2/3 have household incomes of $25,000 or less. Nearly 42% have been in the U.S for more than 10 years and over 1/3 for less than five years. 59% spoke only Spanish.

41% of adults reported having no health insurance, public or private with women (67.5%) more likely to be insured than men (46.2%).

53.5% had visited a doctor for a *routine check up* in the past year and they were more likely to use clinics or health centers than a doctor's office, HMO or hospital emergency department. The authors of the study point out that the underutilization and lack of access to health services has implications for disease prevalence rates based upon self report: Many Latinos likely have diseases that have not been diagnosed because they have not been seen by a health care provider.

A high proportion – 36% -- reported their health as only fair or poor although 86% reported no change in activity levels due to illness in the past 30 days. 81.5% reported that immigration-related problems interfered with their ability to maintain good health.

61% were overweight or obese based on self reported BMI. 38% did not engage in even moderate physical activity. More than 40% had not visited a dentist in over a year.

Rates of screening for breast and cervical cancer were relatively high in comparison to other groups given the high rate of uninsured: 81% of women age 40 and older had received a mammogram within the past two years and 89% of women had had a Pap test within the past three years. Likewise, a high proportion of respondents, nearly 2/3, reported having been tested for HIV, most within the past two years.

But only 1/3 reported condom use during the most recent sexual intercourse. Of those with multiple partners, nearly 2/3 had used condoms.

Of particular importance to identifying maternal and child health needs in the District is the finding that 12% of respondents reported having been diagnosed with gestational diabetes, a rate considerably higher than the U.S. Latino rate.

Questions (based on PRAMS) were asked of a subset of survey respondents to obtain information specific to maternal and child health. However, the sample size and selection process do not allow for generalization to the entire population. Nevertheless, the Council of Latino Agencies believes the information to be important in illuminating issues pertaining to this group. First of all, in comparison to adults children were much more likely to be insured and to have a health care provider, reflecting the greater eligibility of children for Medicaid-SCHIP. Parents relied upon community clinics for pediatric care and they tended to be satisfied with the care received. This finding was very much consistent with the results of focus groups of Latinas convened by a contractor in 2005 for the Maternal and Family Health Administration's five year needs assessment. Participating Latinas spoke of their greater comfort in seeking care from a

community or church-based clinic at which Spanish was spoken and where they encountered other persons known to them.

A very high proportion reported not smoking or drinking alcohol during pregnancy and a majority breast feed exclusively until at least three months. Most women reported having received education on breastfeeding, HIV, birth control and the importance of abstaining from tobacco, alcohol and other drugs during their prenatal care; but only a small proportion received information about seat best use, physical abuse or genetic screening.

In 2000, the median age of District residents was 35 years. About 20% (114,992) of the population was younger than 18 years of age; 12% (69,898) of the population was 65 or older. About 75% (85,818) of the District's youth are African American. In contrast, only 11% (19,381) of the white population, about 9% (4,067) of the Hispanic population, about 5% (5,720) of the mixed race persons, and 1.5% (240) of the Asian/Pacific Islander population are less than18 years of age. More than 50% (57,206) of the District's youth under 18 live in Wards 4, 7 and 8. Approximately 36% (25,529) of the total population of Ward 8 is under the age of 18, the highest percentage of youth in a ward. The proportion of females in the overall population was slightly higher than the proportion of males 53% (303,192) vs. 47% (268,867).

Annually, approximately 15,000 births occur in District hospitals. However, only about half are to residents of the District. In addition, between 1998-2002 approximately 650 to 730 births to District residents occurred outside of the District, mostly in the state of Maryland. During this time period, approximately 6% of District resident births occurred in Maryland.

During the five-year time period of 1998-2002, on average 66% of the annual births to District women were to African Americans. 21% were to Whites and 13% were to Other races. Births to women of Hispanic origin (of any race) comprise about 12% of the District resident births between 1998-2002.

The literature clearly documents that socioeconomic status is associated with health status. Thus, before the health status of the MCH population of the District can be discussed it is important to understand the socioeconomic conditions of the District.

Socioeconomic Factors and Poverty: Socio-economic factors such as marital status, age and sex, housing, income, poverty status and education are known to affect health conditions. Health

disparities almost always exist between the poor and those with higher incomes. The District has a very diverse population as a whole with distinct distribution patterns within its Wards. Economic indicators seem to follow intuitively on the demographics, with the lowest unemployment and the highest median and per capita income in the Wards with the largest White/Asian populations. Conversely, the highest unemployment and the lowest median and per capita income are in Wards most densely populated by African-Americans. Table 2 below illustrates the District of Columbia's employment and economic indicators by Ward.

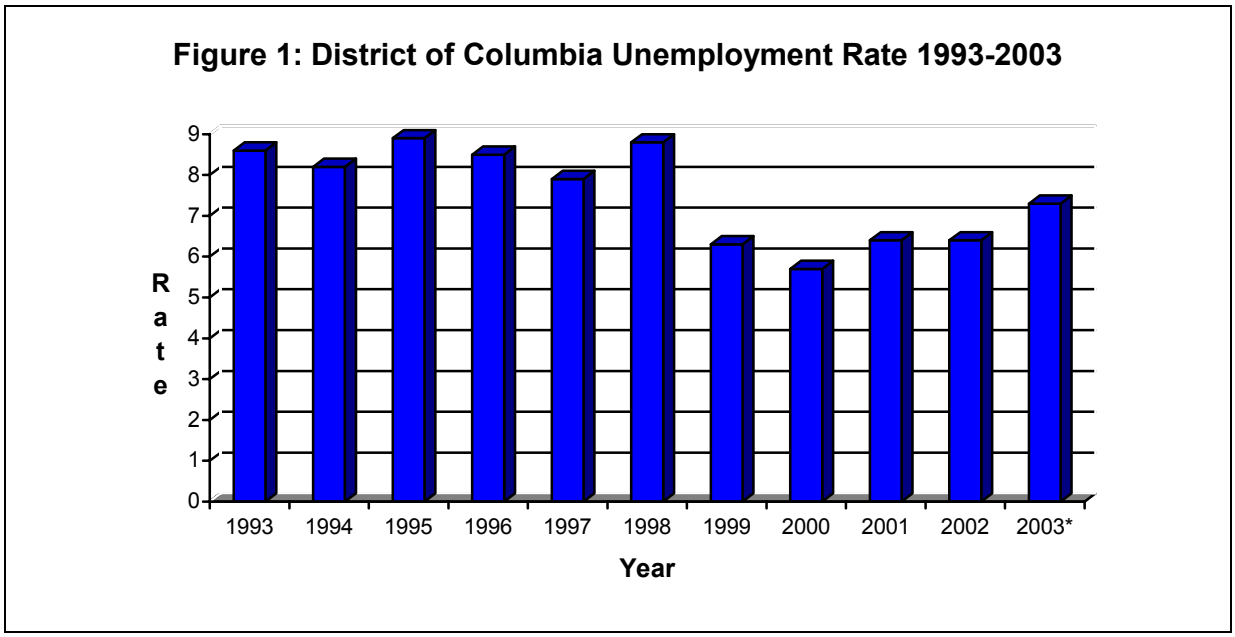
Table 2: Employment and Economic Indicators by Ward

Washington, DC	Population 2000 Census	Median Household Income	Per Capita Income	Percent Below poverty	Percent Below 200% of Poverty	Percent Unemployed
Ward 1	73,364	36,902	$23,760	22.0%	41.0%	6.1%
Ward 2	68,869	$44,472	$42,660	18.7%	31.0%	5.5%
Ward 3	73,718	$71,875	$58,584	7.4%	14.0%	2.2%
Ward 4	74,092	$46,408	$27,057	12.0%	21.0%	6.3%
Ward 5	72,527	$34,433	$19,173	20.0%	32.0%	8.6%
Ward 6	68,035	$41,554	$28,636	21.1%	33.0%	7.6%
Ward 7	70,540	$30,533	$16,959	24.9%	36.0%	7.6%
Ward 8	70,914	$25,017	$12,630	36.0%	49.0%	12.5%
Total	572,059	$41,399	$28,682	20.0%	32.0%	7.0%

Source: DC Office of Planning, United States Census 2000.

Between 1995 and 2001, the District's unemployment rate fell from 8.9% to 6.4%. However, with the economic downturn of 2001-2003, the unemployment rate increased to 7.3% as of August 2003. Unemployment in the District of Columbia's low-income minority communities remained consistently high with Ward 8 reporting over 10% unemployment throughout the late 1990's, and increased to 12.5% in 2002.

Like race and poverty, unemployment also varies by Ward and is concentrated in the eastern half of the District (Wards 5, 6, 7, and 8). In 2002, the highest unemployment was in Ward 8 (12.5%), Ward 5 (8.6%), and Ward 7 (7.6%). The lowest unemployment was in Ward 3 (2.2%), Ward 2 (5.5%) and Ward 1 (6.1%). Figure 1 illustrates rising unemployment over the last few years from a low of 5.7% in 2001 to 7.3% in August 2003.



Source U.S. Bureau of Labor Statistics and District of Columbia Primary Care Association, October 2003. *Through August 2003

Overall 20% (114,412), of Districts population live below the federal poverty level (FPL) up from 17% in 1990. 32% (36,612) of children ages 0-18 live below the FPL. 25% (28,603) of the African American population lives in poverty, representing 77% (88,097) of all DC residents living below FPL. Over 22% (3,341) of the Asian population and 20% (8,991) of the Latino population live in poverty. 8% (14,088) of the white (Non-Latino) population lives below the poverty line.

According to the Fiscal Policy Institute, since 1990, the number of people in poverty increased by more than 14% and the number of children living poverty increased by 24%. Although this increase in poverty occurred across all Wards and in all race and ethnic groups, the greatest increase was in the African American population, with an additional 6,747 individuals living below poverty. However, Asian and Latino populations in the District experienced the fastest growth in the percent of persons living in poverty, 104% and 39% respectively. The Wards that experienced the greatest growth in people living below the poverty level were Wards 7 and 8 (Fiscal Policy Institute, September 26, 2003).

As seen in Table 2 above, poverty rates vary substantially by Ward. In 2000, Ward 8 had the highest poverty rate of 36% compared to 27% in 1990. Ward 3 had the lowest poverty rate of 7.4% followed by Ward 4 with 12%. Less than an eighth of the population in Ward 3 and 4 lives

in poverty. Five wards have about one fifth of the population living in the poverty: Ward 7 (25%), Ward 1 (22%), Ward 6 (21%), Ward 5 (20%) and Ward 2 (19%).

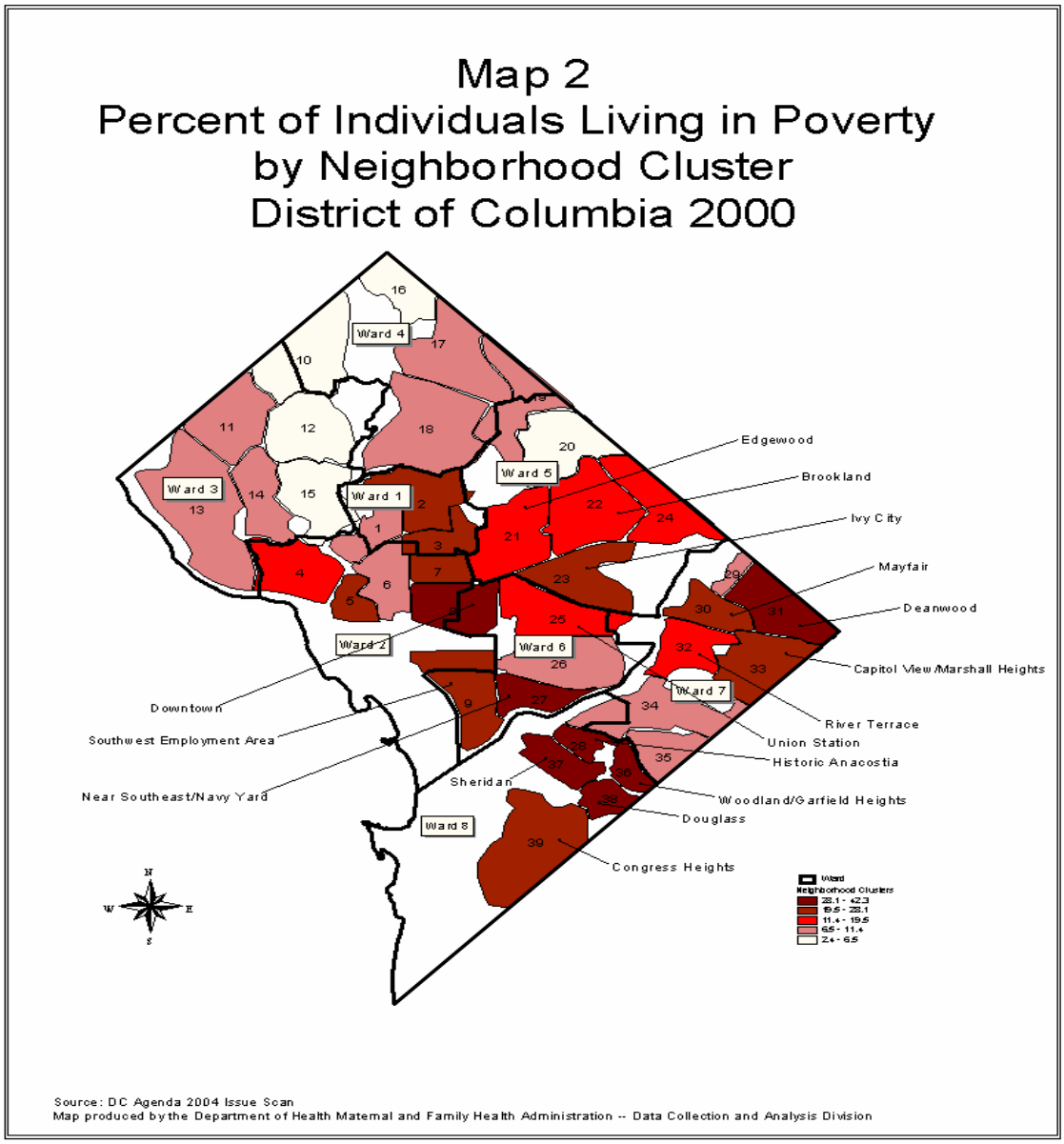
The highest proportion of persons living below the poverty level was between the ages of 25-44 years. A slightly higher percentage of males in the 25-44 year old age group were below the poverty level than females. In adults between the ages of 45 and 64 years old, slightly more women than men were below the poverty level. This was also true among older adults, aged 65 years and above; where 15.1 percent of women were below the poverty level versus 10.4 percent among men. (See Table 3 below)

Table 3: Percentage Distribution of Persons Living Below Poverty in 1999 by Gender and Age Group in the District of Columbia

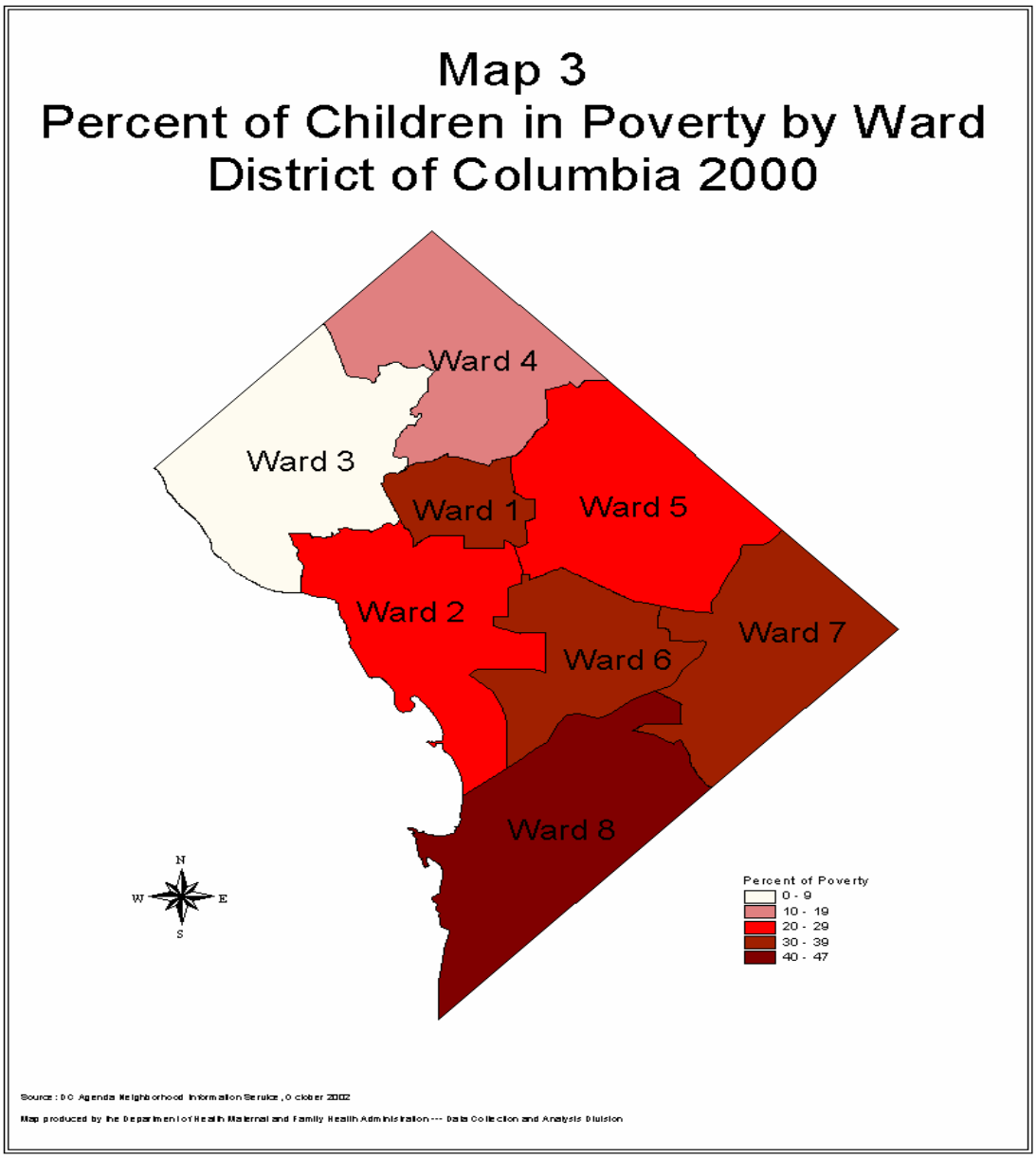
	Gender	
Age Group (Years)	Males, % (N=205,997)	Females, % (N=226,160)
Less than 25	27.0%	25.0%
25-44	38.8%	34.6%
45-64	23.8%	25.3%
65 and Over	10.4%	15.1%

Source: Census 2000, U.S. Bureau of the Census

Closer examination of the Wards reveals pockets of neighborhoods most affected by poverty within the Ward. As stated above, in 2000, Ward 8 had the highest percent of individuals living in poverty. Within Ward 8, neighborhood clusters Congress Heights (27.2%), Douglas (35.1%), Sheridan (34.3%), Woodland/Garfield Heights (35.3%) and Historic Anacostia (33.3%) had the highest percentage of individuals living in poverty. In Ward 7, which had the second highest percent of individuals living in poverty, the neighborhood cluster Deanwood (28.1%) had the highest percent of individuals living in poverty. In Ward 6, which had the fourth highest percent of individuals living in poverty, neighborhood clusters Downtown (35.6%) and Near Southeast/Navy Yard (42.3%) had the highest percent of individuals living in poverty within the Ward. In Ward 2, neighborhood cluster Shaw/Logan Circle (25.2%) had the highest percent of individuals living in poverty within that Ward. Overall, of the 39 District of Columbia neighborhood clusters, nine have 25% or more of the population living in poverty. Map 2 below provides a visual illustration of the percent of individuals living in poverty by neighborhood cluster.



The percent of children living in poverty varies among the Wards of the District. Ward 1 (35%) and Wards (6,7 and 8) have the highest percentage of children living in poverty. 47% of children in Ward 8 live in poverty. 37% of children in Ward 7 live in poverty followed by 36% in Ward 6. About a quarter of the children in Ward 2 (25%) and Ward 5 (28%) live in poverty. Ward 3 (3%) followed by Ward 4 (16%) have the least percent of children living in poverty. See Map 3 below.



Examination of child poverty by neighborhood cluster reveals a much different picture than overall poverty by neighborhood cluster. Of the 39 District of Columbia neighborhood clusters, 22 have 25% or more of children living in poverty. Table 4 below lists the 39 neighborhood clusters and the percent of child poverty for each cluster. The 22 neighborhoods are highlighted.

Table 4: Percent of Children in Poverty by Neighborhood Cluster, District of Columbia 2000

Neighborhood Cluster		Percent of Poverty
1	Kalorama Heights/Adams Morgan	26%
2	Columbia Heights/Mt. Pleasant	35%
3	Howard University/Le Droit Park	43%
4	Georgetown	7%
5	West End/Foggy Bottom	10%
6	Dupont Circle	17%
7	Shaw/Logan Circle	32%
8	Downtown	37%
9	Southwest Employment Area	42%
10	Hawthorne	1%
11	Friendship Heights/Tenleytown	1%
12	North Cleveland Park/Van Ness	4%
13	Spring Valley/Foxhall	2%
14	Cathedral Heights/Glover Park	10%
15	Cleveland Park/Woodley Park	0%
16	Colonial Village	7%
17	Takoma	17%
18	Brightwood Park	20%
19	Lamond Riggs	10%
20	North Michigan Park	11%
21	Edgewood	31%
22	Brookland	33%
23	Ivy City	45%
24	Woodridge	13%
25	Union Station	28%
26	Capitol Hill	21%
27	Near Southeast/Navy Yard	67%
28	Historic Anacostia	50%
29	Eastland Gardens	43%
30	Mayfair	35%
31	Deanwood	40%
32	River Terrace	36%
33	Capitol View/Marshall Heights	48%
34	Twining	20%
35	Fairfax Village	27%
36	Woodland/Garfield Heights	61%
37	Sheridan	59%
38	Douglass	56%
39	Congress Heights	46%
99	No cluster assigned	7%

Source: DC Agenda 2004 Issue Scan

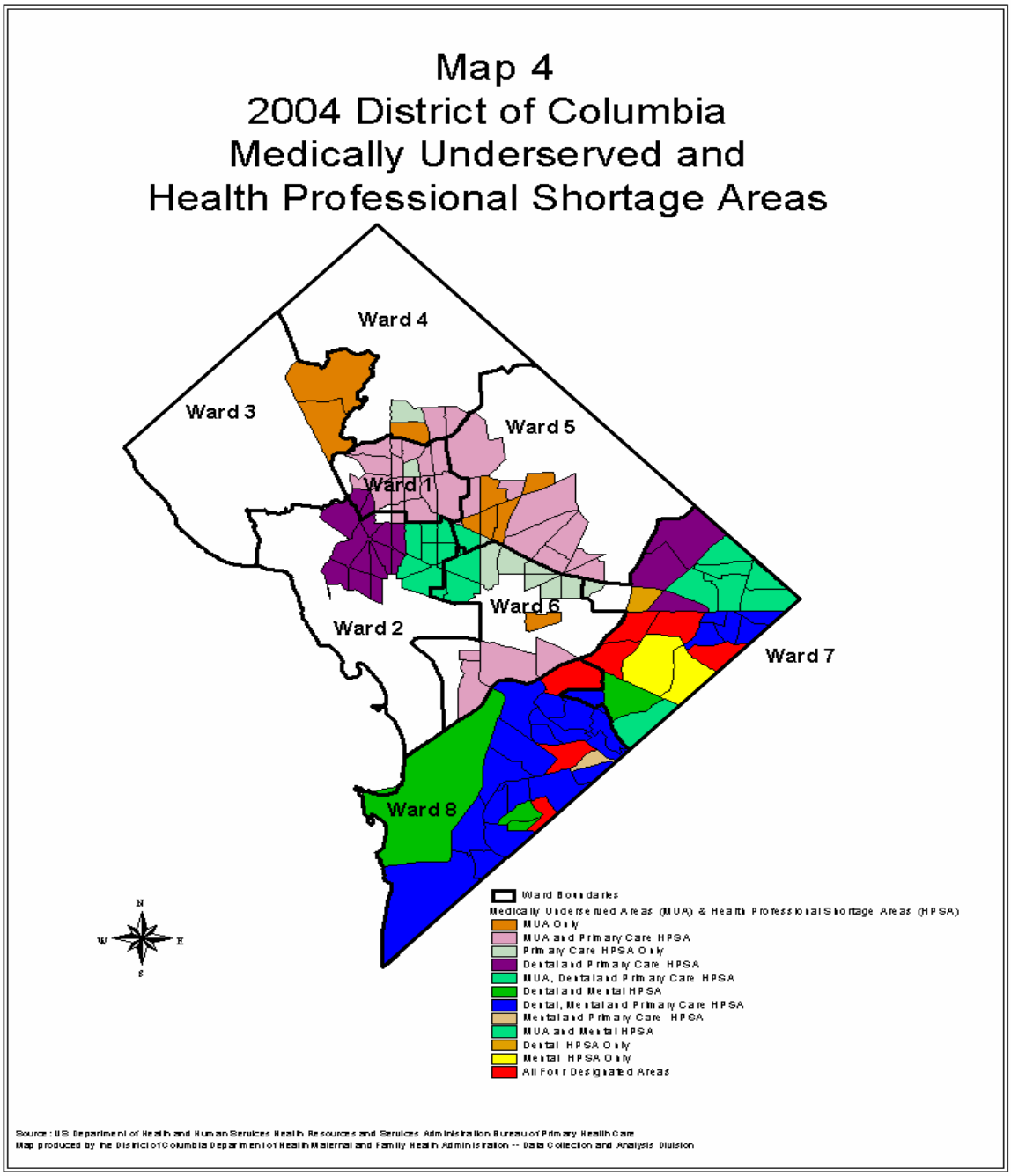
Educational Attainment: In the District of Columbia in 2000, about 73% of persons 25 years and over had graduated from high school and approximately 33% of these persons had graduated from college. Five Wards (1,5, 6, 7 and 8) had percentages of high school graduates lower than the District's average. (See Table 5 below) Ward 3 far exceeded the District's average percent of high school graduates with 94.1% of its population of persons 25 years or over having a high school degree. The same was true for the percent of persons with a college degree (70.1%). In addition, Ward 2 had a relatively high percentage of high school and college graduates, 81.4% and 52.3% respectively. The disparity in this area is seen in Ward 8, where only 61.3% percent of persons 25 years and older had high school degrees and only 8% had college degrees.

Table 5: Percentage Distribution of the Population 25 Years or Older Who Have Graduated from High School and College.

Ward	Persons 25 years and Over	% High School Graduates	% College Graduates
1	54,614	67.6%	35.6%
2	52,940	81.4%	52.3%
3	57,808	94.1%	70.1%
4	56,539	73.5%	24.8%
5	50,657	65.6%	19.4%
6	50,952	71.0%	31.8%
7	46,839	64.3%	11.6%
8	38,782	61.3%	8.0%
District	409,131	73.1%	33.3%

Source: Census 2000, U.S. Bureau of the Census & D.C. Office of Planning

Health Professional Shortage and Medically Underserved Areas: In the District of Columbia, a vast number of residents suffer from a lack of access to primary care providers. Of the 572,059 total District residents, 300,825 (52%) live in federally designated primary care Health professional Shortage Areas (HPSAs) and 173,228 (30%) residents live in federally designated Medically Underserved Areas (MUAs) Map 4 below illustrates how these designations closely parallel the distribution of persons living in poverty and areas where the population has a high percentage of minority residents as previously discussed.



Participation in Government Programs

WIC (Women, Infants, and Children) Program: The mission of the District's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) is to improve the lifelong health and nutrition of pregnant women, new mothers (breast-feeding and non-breast-feeding), infants, and children by providing nutrition education, nutrient-rich supplemental food,

and health and social service referrals. From 1999-2004, there was an overall increase of 38.5% in the total number of individuals served through the District's WIC Program. (See Table 6 below)

Table 6: District of Columbia Special Supplemental Nutrition Program for Women, Infant, and Children (WIC) Enrollment Data, Fiscal Year 1999-Fiscal Year 2004

Year	Infants Served	Children Served	Women Served	Total Served
1999	3964	9937	4381	18677
2000	4625	10318	4669	19711
2001	5817	11981	5793	23591
2002	4267	9943	4798	19822
2003	4201	9885	4815	18910
2004	5664	13274	6938	25876

Source: District of Columbia Department of Health, Nutrition Programs Administration

The greatest percent increase in the population served occurred among women. Between 1999 and 2004, there was a 58.4% increase in the number of women served, from 4,381 in 1999 to 6,938 in 2004. The number of children served by the WIC program outnumbered the number of women and infants combined in all years.

The vast majority of clients served by the District's WIC program are Black followed by Hispanics, and Asian Pacific Islander women and children. (See Table 7 below) As noted above, between 1999-2004, the District's WIC program experienced an overall increase in the number of clients served. This increase was seen among Asian Pacific Islanders (64%), Hispanic (29%), and White (12%) women and children. There has been an overall decrease (10%) in the number of Black women and children participating in WIC over the same six-year period.

Table 7: Average Annual Participation in the Special Supplemental Nutrition Program for Women, Infant, and Children (WIC), District of Columbia 1999-2004

Year	White	Black	Hispanic	American Indian	Asian Pacific Islander
1999	235	14,942	3,300	44	263
2000	256	13,951	3,577	53	295
2001	313	13518	3,628	38	327
2002	302	13461	3,770	34	354
2003	273	13,290	4,112	37	406
2004	264	13,427	4,261	34	431

Source: District of Columbia Department of Health, Nutrition Programs Administration

Free/Reduced Lunch Program: The District of Columbia Public Schools' free/reduced lunch program is part of a federally assisted meal program operating in public and non-profit private schools and residential care institutions. It provides nutritionally balanced, low cost or free lunches to children each school day. DCPS receives cash subsidies and donated commodities

from the U.S. Department of Agriculture for each meal they serve. Children from families with incomes at or below 130 percent of the poverty level are eligible for free meals. Table 8 below shows the break down of the average daily participation in the National School Lunch Program for the District of Columbia Public Schools for the last six years. Between 1999 and 2004, there was an overall 14.5% decrease in the percent of students participating in the school lunch program, from 40,575 in 1999 to 34,698 in 2004.

Table 8: The Average Daily Participation in the National School Lunch Program for the District of Columbia Public Schools, 1999-2004

Year	Number of School Participants
1999	40,575
2000	41,210
2001	42,303
2002	40,502
2003	37,610
2004	34,698

Source: District of Columbia Public Schools

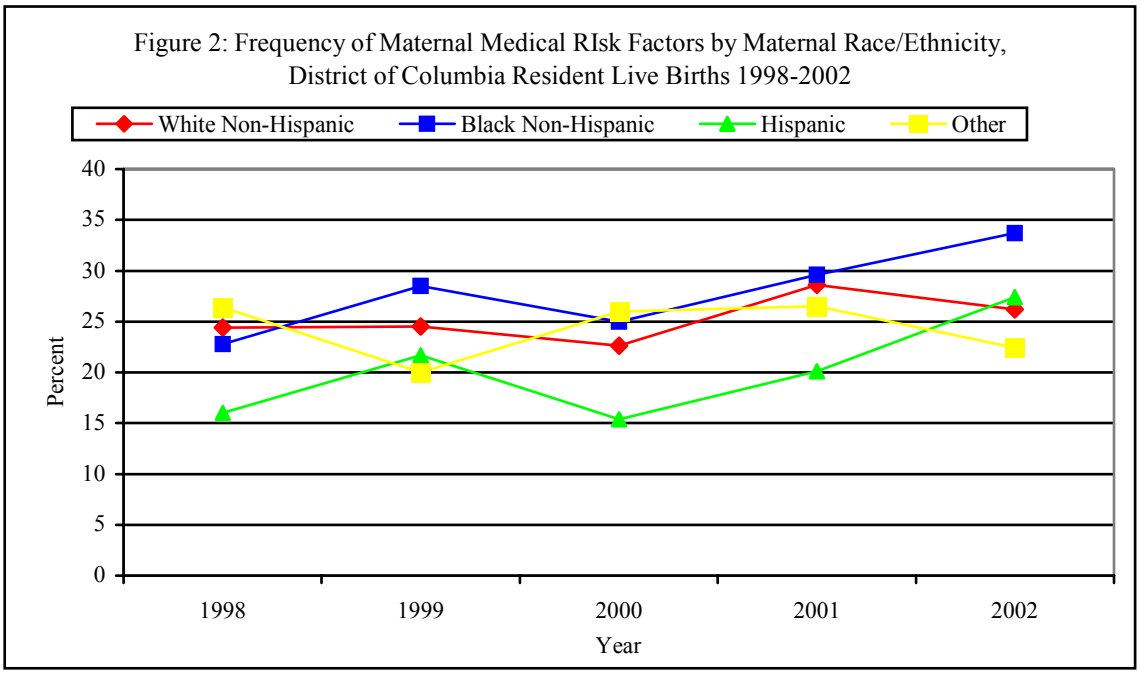
2.1.1.2 Assessment of the Needs of the Maternal and Child Health Population Groups

Several health and social indicators were analyzed during the needs assessment. As a result a comprehensive data report was completed. This report is in the process of being published and disseminated. The following narrative presents key findings from the report for each population covered under the Title V Block grant.

2.1.1.2a. Women

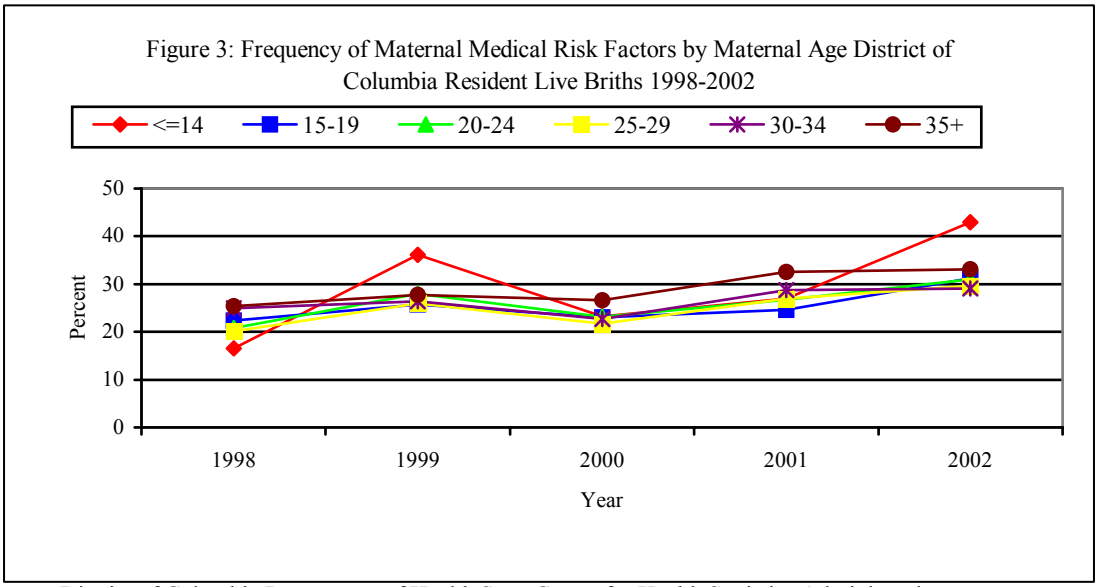
Pregnancy and Birth

Maternal Medical Risk Factors*:* Most women have a safe and healthy pregnancy and delivery a healthy infant, however this is not the experience of all women. Some women have an increased risk of pregnancy complications due to certain maternal risk factors. In addition, the racial/ethnic disparities that exist in most areas of health also apply to pregnancy and birth outcomes. In the District of Columbia, the frequency of reported medical risk factors experienced by mothers increased dramatically from 1998 to 2002. (See Figure 2 below) It is unclear whether this increase was a result of increased surveillance and reporting or an increase in incidence. The maternal medical risk factors captured in the District's birth file are as follows: anemia, cardiac disease, acute or chronic lung disease, diabetes, genital herpes, hydramnios/oligohydramnios, hemoglobinopathy, chronic hypertension, pregnancy hypertension, eclampsia, incompetent cervix, previous infant 4000+ grams, previous infant preterm or small for gestational age, renal disease, Rh sensitization, uterine bleeding, and other.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

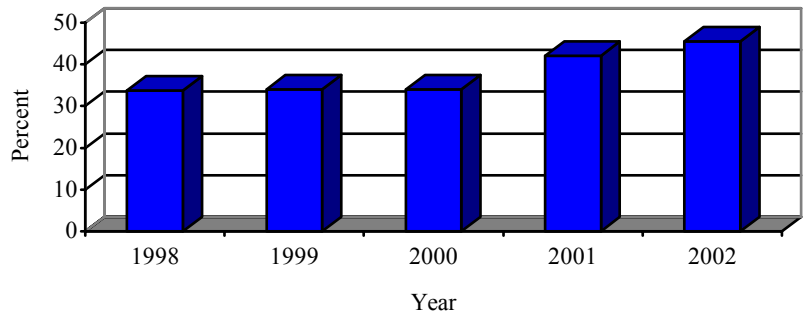
Overall, the proportion of deliveries involving maternal medical risk factors increased by approximately 10%. In 1999 and 2002, mothers aged 14 and younger had the highest proportion of deliveries with maternal medical risk factors. Mothers aged 35 and older had the highest proportion of deliveries with maternal medical risk factors in the remaining years. See Figure 3 below.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

Between 1998 and 2002, the proportion of preterm deliveries that included maternal medical risk factors increased by approximately 12%. See Figure 4 below.

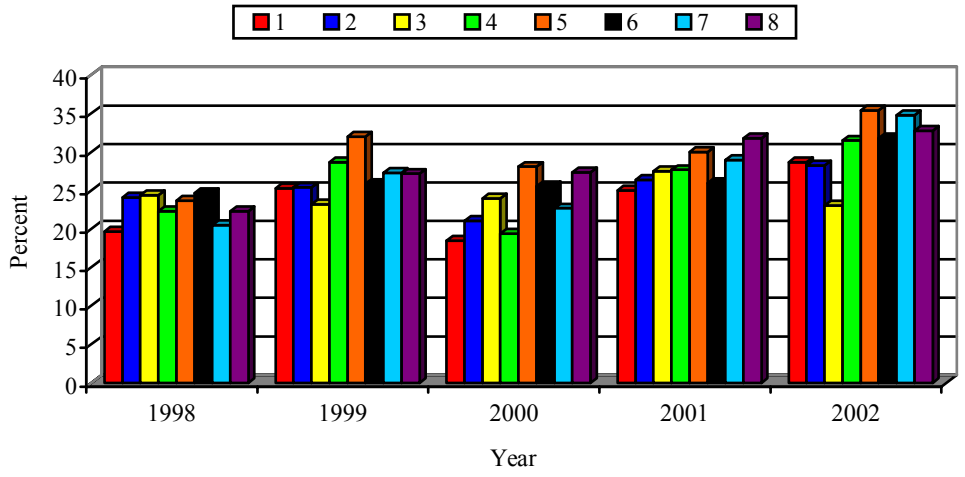
Figure 4: Percent of Preterm Deliveries with Maternal Medical Risk Factors, District of Columbia Resident Live Births 1998-2002



Source: District of Columbia Department of Health State Center for Health Statistics Administration

The frequency of maternal medical risk factors in each Ward was dependent on the racial/ethnic demographics and the number of births in the higher risk age groups. Wards with the greatest proportion of births to Black and Asian/Pacific Islander mothers, as well as mothers under age 14 or over age 35, were more likely to have a higher frequency of reported maternal medical risk factors. See Figure 5 below.

Figure 5: Frequency of Maternal Medical Risk Factors by Ward of Residence District of Columbia Resident Live Births 1998-2002



Source: District of Columbia Department of Health State Center for Health Statistics Administration

Table 9 below illustrates the top five reported maternal medical risk factors for each year, ordered from highest to lowest reported condition. Consistently anemia, diabetes and hypertension lead the list for the five-year period. The potential for a good pregnancy outcome is directly related to the severity of these maternal medical risks. The potential outcomes can be serious for both the

mother and infant including the risk for seizures and stroke in the mother, severe growth restriction, low birth weight, preterm birth, and macrosomia in the infant. Macrosomic or "big" babies face health issues of their own, including damage to the shoulders during delivery, being born with high glucose levels because their pancreas was used to releasing extra insulin while in utero, as well as being at higher risk for breathing problems. In addition, women who develop gestational diabetes are at higher risk for developing Type II diabetes later in life.

Table 9: The Top Five Maternal Medical Risks Among Resident Live Births, District of Columbia, 1998-2002

Rank	1998	1999	2000	2001	2002
1	Anemia	Anemia	Anemia	Anemia	Anemia
2	Diabetes	Hydramnios/ Oligohydramnios	Diabetes	Diabetes	Diabetes
3	Pregnancy Hypertension	Diabetes	Pregnancy Hypertension	Pregnancy Hypertension	Pregnancy Hypertension
4	Hydramnios/ Oligohydramnios	Pregnancy Hypertension	Hydramnios/ Oligohydramnios	Genital Herpes	Genital Herpes
5	Genital Herpes	Chronic Hypertension	Genital Herpes/ Eclampsia	Hydramnios/ Oligohydramnios	Chronic Hypertension

Source: District of Columbia Department of Health State Center for Health Statistics Administration

An analysis of hospitalization data for this time period revealed similar information. Between 1998-2002 key reasons for entry into the hospital during pregnancy, not counting reasons associated with childbirth or abortions, ectopic pregnancy, hypertension (including pre-eclampsia and eclampsia), infections of the genitourinary tract, and nutritional deficiencies.

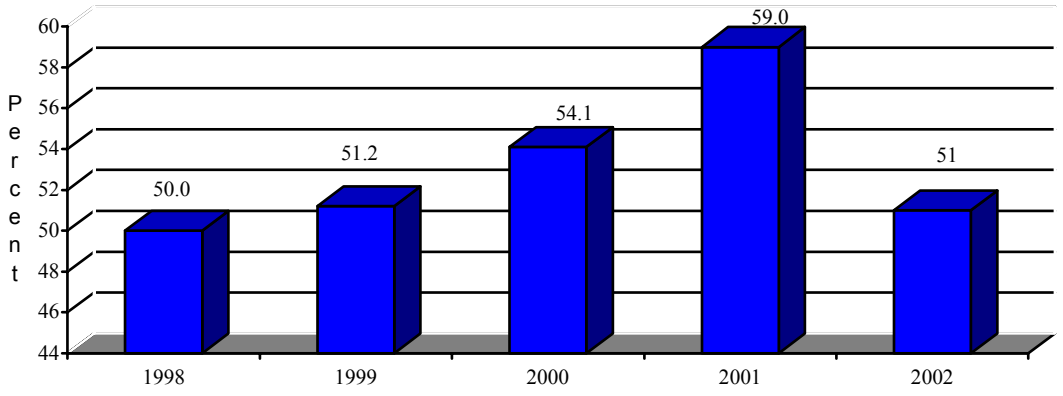
Out of Wed-lock Births*:* Between 1998 and 2002, births to unmarried women in the District of Columbia has decreased by 11% from 63% in 1998 to 56% in 2002. Unfortunately, racial disparities continue to exist in this area as well. During the five-year time period of 1998-2002, among African-American live births, approximately 78%, almost four out of five births, were to women who were not married compared to only 10% of the births to White residents and 49% to women of Other races.

Studies have shown that out of wedlock childbearing is related to increased risks for both mothers and children. These risks include (1) the mother being less likely to obtain adequate prenatal care; (2) more likely to engage in behavioral risks during pregnancy (e.g., greater use of alcohol, tobacco and narcotic drugs); and (3) the child is more likely to be abused. With the numerous risks associated with out-of-wedlock childbearing, addressing this issue must be a key component in the District of Columbia's efforts to deal effectively with the problems of poverty, crime, and poor education and health outcomes.

Unintended Pregnancy: *(State Performance Measure #7)* Unintended pregnancy, defined as a pregnancy that is unwanted or mistimed at the time of conception, has significant consequences for the health of women and children. These consequences include health (late or in adequate prenatal care, fetal exposure to alcohol, tobacco or drugs, low birthweight etc.), social (loss of education, career or financial opportunities for the mother, etc.) and economic consequences.

Nationally, approximately half of all pregnancies are unintended. Analysis of the 1998-2002 District of Columbia Pregnancy Risk Assessment Monitoring System (PRAMS) data revealed that between 50-59% of the women sampled had an unintended pregnancy. (See Figure 6 below) 46% of these women were receiving Medicaid at the time of their conception.

Figure 6: Percent Unintended Pregnancies Among Dsitrict of Columbia Resident Live Births 1998-2002



Source: District of Columbia Pregnancy Risk Assessment Monitoring System (PRAMS)

There is no one cause of unintended pregnancy and therefore, there is no one solution. Reductions will require a District-wide public and private partnership. Strategic opportunities must include increasing male involvement in preconception planning and increasing male awareness of the various methods available. Surprisingly, among the PRAMS women who reported that they were not using any contraceptive method at the time that they became pregnant, 1 in 5 said that their husband or partner did not want to use a method.

Providers of primary care services need to capitalize on the opportunities to improve contraceptive vigilance of adults and adolescents. These opportunities include catching clients when they present for services at STD clinics, pediatric visits, routine physical examinations, pregnancy tests, sports exams and other well child visits for adolescents.

Maternal Mortality: One of the District's Healthy Residents 2010 Health People Objectives is to reduce the overall maternal mortality rate (MMR). From the time period covering 1998-2002, the overall MMR for the District of Columbia was 5.3 per 100,000 live births, representing 2 deaths. (See Table 10 below)

Table 10: Number and Rate* of Maternal Deaths
District of Columbia Residents, 1998-2002.

	1998	1999	2000	2001	2002	Total
# Maternal Deaths	0	0	2	0	0	2
# Live Births	7,678	7,513	7,666	7,621	7,494	37,972
MMR*	0	0	26.1	0	0	5.3

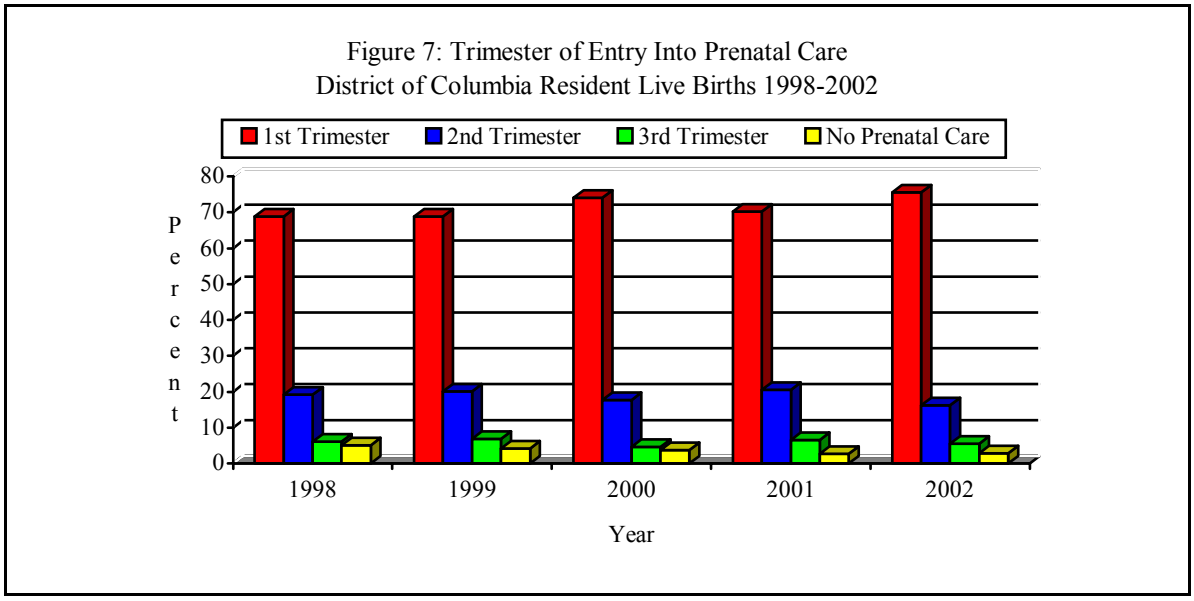
Source: District of Columbia Department of Health State Center for Health Statistics Administration
* Number of maternal deaths per 100,000 live births

The risk for maternal death among African-American women compared to White women continues to be one of the largest racial disparities among major public health indicators. Analysis of national data suggests that race and ethnicity are not risk factors for maternal mortality but instead may be markers of social, economic, cultural, health-care access and quality, and other related factors that may increase the risk for death among pregnant women in the District of Columbia. Factors, such as quality of prenatal, delivery, and postpartum care, and interaction between health-seeking behaviors and satisfaction with care, may also explain part of the difference.

To effectuate change in this area, review committees will need to examine factors that may have contributed to the maternal deaths, including the quality of medical care and problems in the health-care delivery system. Both public health surveillance and prevention research are needed to understand the underlying causes of maternal mortality and the disparity between black and white women and to guide appropriate interventions and improvements in maternal health care in the District of Columbia.

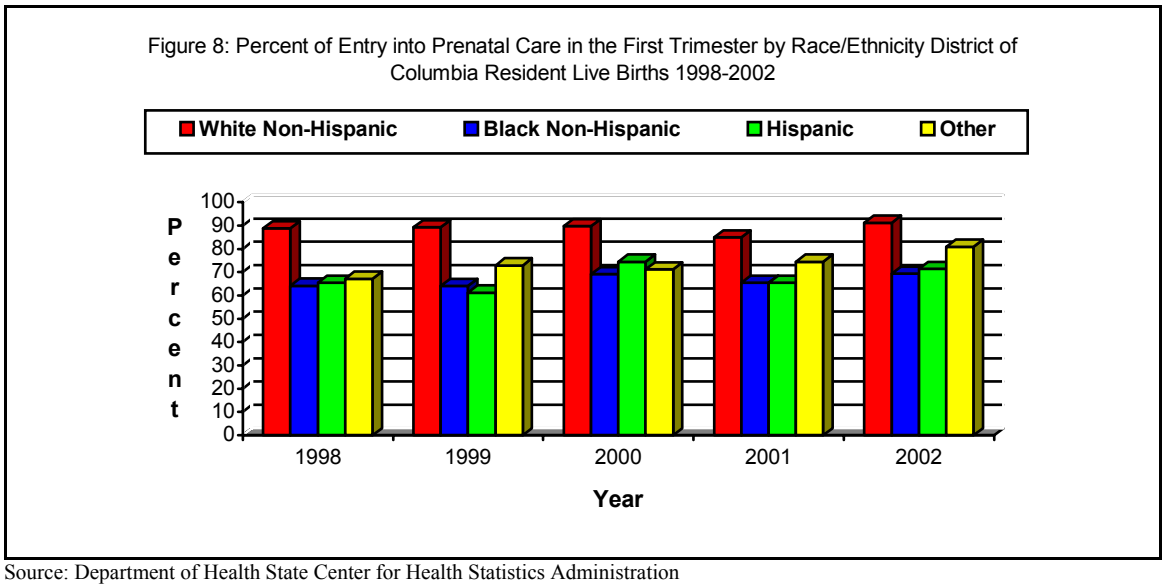
Entry Into Prenatal Care and Adequacy of Prenatal Care: *(National Performance Measure #18, State Performance Measure #1 & #8, Health Systems Capacity Measure #4, Health Systems Capacity Indicator#05c &d)* The District of Columbia health objective for 2010 to increase to at

least 80% the proportion of pregnant women who enter the first trimester of pregnancy is well within reach. Between 1998 and 2002 there was a 9.6 % increase in percent of births to women who initiated PNC in the first trimester from 68.9% in 1998 to 75.5% in 2002. (See Figure 7 below) During the same time period there was a 45.1% decrease in the percent of births to women receiving no prenatal care. However, despite the gains that have been achieved over the last ten years, District resident women continue to enter prenatal care in the first trimester at a lower rate than women nationally.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

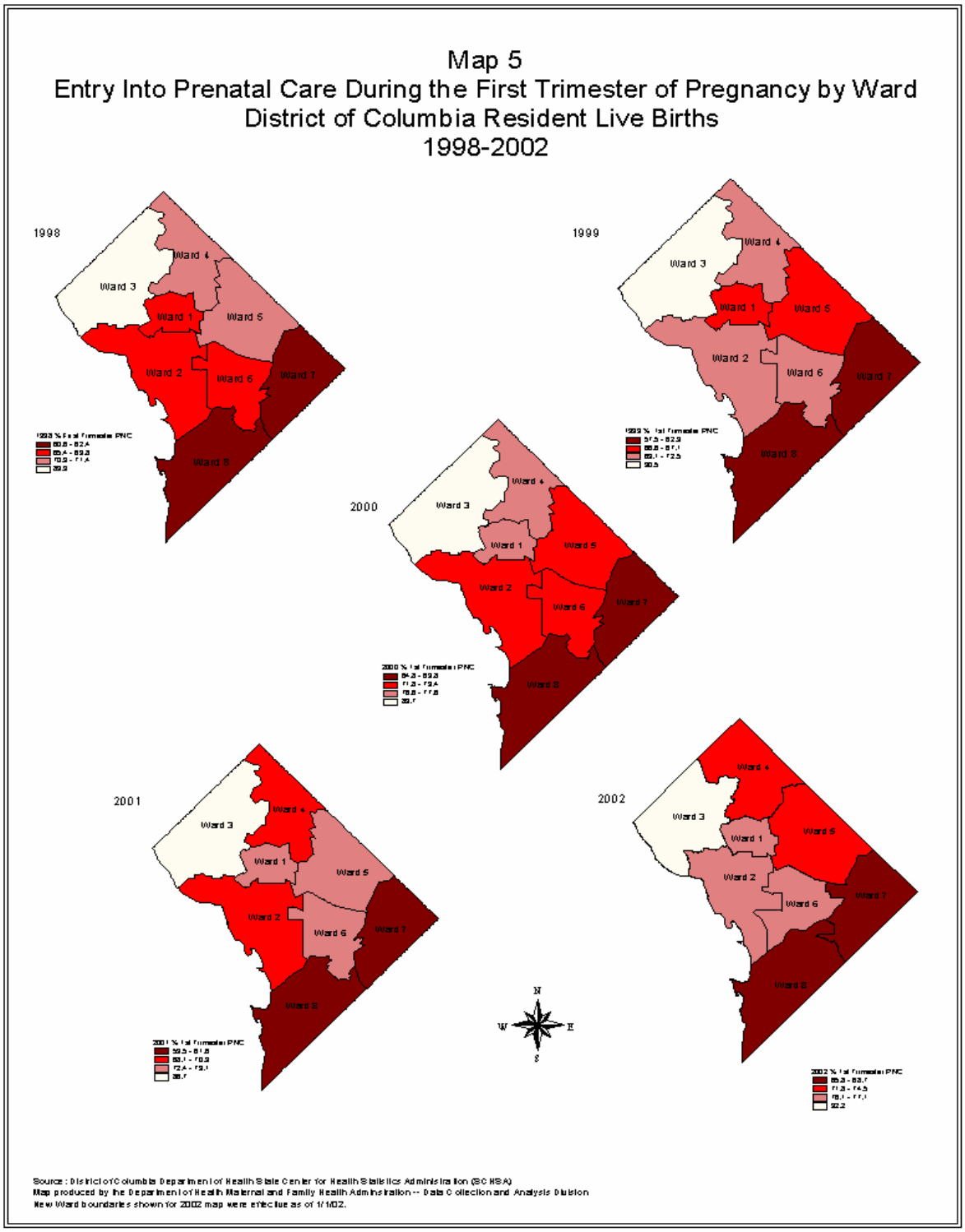
In addition, while increases were seen across racial/ethnic lines during the five year period between 1998-2002, White Non-Hispanic women were more likely to enter prenatal care in the first trimester than any other race/ethnic group. Moreover, except for in 1999, Black Non-Hispanic women were least likely to enter prenatal care in the first trimester than any other race/ethnic group. Overall during this same time period, women of Other races experienced the greatest percent increase in early entry into prenatal care, 20.4% compared to 9.2% for Hispanic women, 7.9% for Black Non-Hispanic women and 2.7% for White Non-Hispanic women. (See Figure 8 below)



Source: Department of Health State Center for Health Statistics Administration

Despite the overall gains in receiving prenatal care during the first trimester, Black Non-Hispanic women were more likely to receive no prenatal care than any other racial/ethnic group.

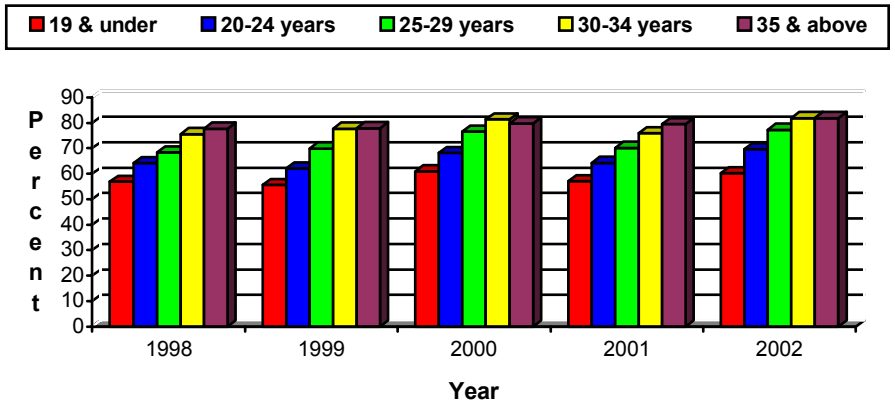
Disparities also exist geographically. During the five year time period between 1998-2002, Ward 3 consistently had the highest percentage of women who entered prenatal care during the first trimester than any other Ward, while Wards 7 and 8 had the lowest percentage of women entering prenatal care during the same period. Map 5 below graphically depicts the trends of entry into prenatal care by ward between 1998-2002.



Several risk factors were found to be associated with late entry into prenatal care in the District of Columbia, including maternal age, education and marital status and Ward of residence (as seen above in Map 5). Between 1998 and 2002, women 30 years of age and older were more likely than any other age group to enter prenatal care during the first trimester. (See Figure 9 below)

While there was an overall 6% increase in the percent of teens entering prenatal care during the first trimester, teens were still least likely to enter prenatal care during the first trimester compared to other age groups. Women ages 25-29 experienced the greatest percent increase (13.2%) in entry into prenatal care in the first trimester from 68.3% in 1998 to 77.3% in 2002.

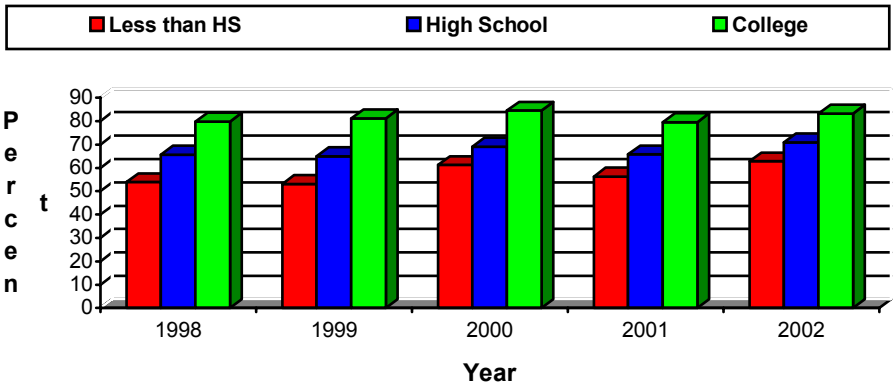
Figure 9: Percent of Entry into Prenatal Care in the First Trimester by Maternal Age District of Columbia Resident Live Births 1998-2002



Source: Department of Health State Center for Health Statistics Administration

Similar patterns were seen for maternal education. Women with a college education were more likely to enter prenatal care in the first trimester than women with a high school or less than high education. In addition, during the five year period of 1998-2002, women who had less than a high school education were least likely than any other group to enter prenatal care during the first trimester. (See Figure 10 below)

Figure 10: Percent of Entry into Prenatal Care in the First Trimester by Maternal Education District of Columbia Resident Live Births 1998-2002



Source: Department of Health State Center for Health Statistics Administration

Women who responded to the District's PRAMS survey provided some insight on key barriers to obtaining prenatal care. Between 1998-2002, while most women reported entering prenatal care as early as they wanted, those who wanted prenatal care earlier noted not knowing they were pregnant, not being able to get a prenatal care appointment earlier in their pregnancy and not having enough money or insurance as reasons for entering prenatal care later than desired.

Not only is obtaining early prenatal care critical but also receiving continued prenatal care plays a large role in ensuring healthy birth outcomes. During the five-year time period of 1998 –2002 the overall adequacy of prenatal care[2] has hovered between 60-64%. Increases have occurred for all racial and ethnic groups. However, the rate of increase has been slower for African-American women and in Wards 8, 7, 5, 2 and 1. The geographic finding is not surprising considering that large numbers of African-Americans and Latinos (Wards 1 and 2) reside in these Wards.

Breastfeeding: (*National Performance Measure #11)* The District of Columbia has three Healthy People 2010 goals for breastfeeding – (1) to increase to at least 40 percent the proportion of mothers who breast-feed their babies in the early postpartum period; (2) to increase to at least 70 percent the proportion of women whose infant are breast-fed exclusively; and (3) to increase to 65% the proportion of low-income mothers enrolled in WIC who breast-feed their babies in the early postpartum period and to at least 50% the proportion who breast-feed until their babies are 6 months old.

According to results from the 2003 National Immunization Survey, 65.5% of District mothers reported ever breastfeeding. Among all states, the District ranked 33rd in the percent of mothers who ever breastfed their infant. When compared to similar jurisdictions, the District fared much better. (See Figure 11 below)

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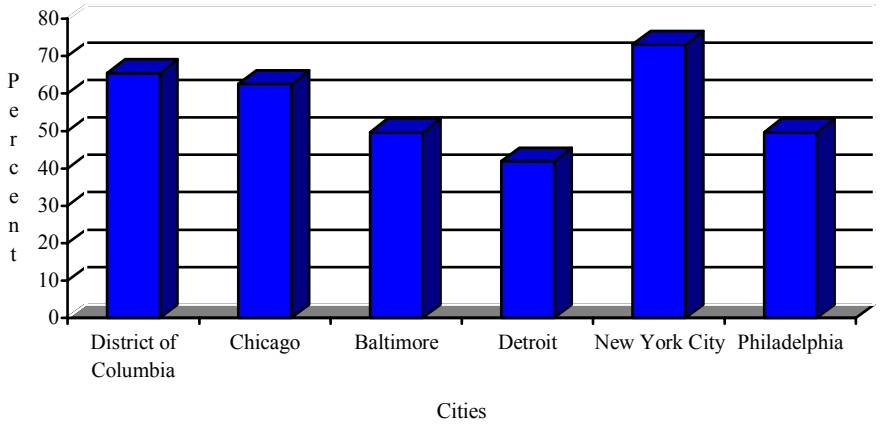
Figure 11: Percent of Women Reporting Ever Breastfeeding, District of Columbia and Select Cities 2003



Source: 2003 National Immunization Survey, Centers for Disease Control and Prevention, US Department of Health and Human Services

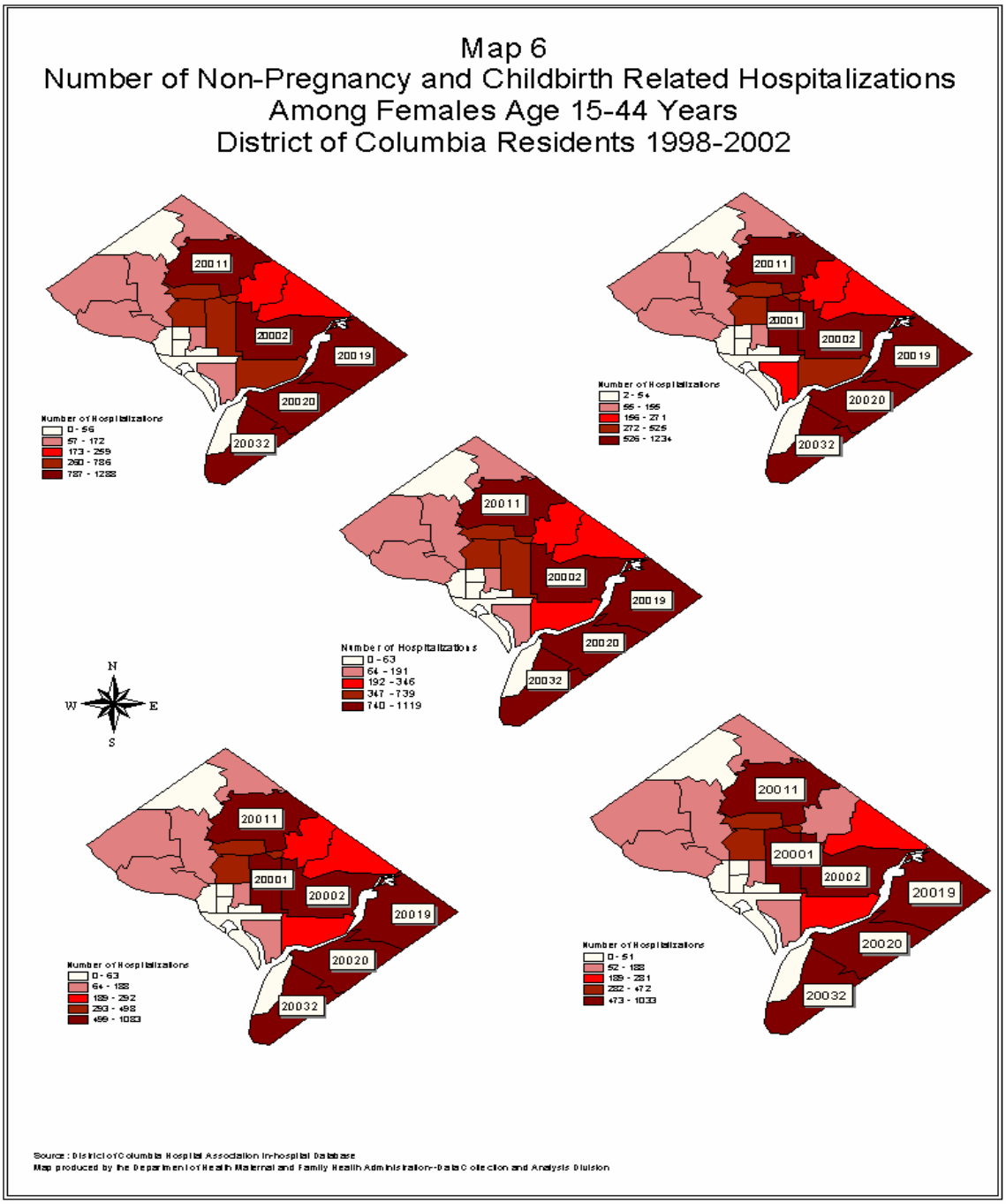
To assess duration and exclusivity for breastfeeding, women were asked about their breastfeeding practices at the 3, 6 and 12 month age of their infant. As to be expected, the older the infant became the lower the reported breastfeeding rates and exclusively breastfeeding rates.

Hospitalizations: Of the total number of hospital admissions to District hospitals by District residents between 1998-2002, approximately 21% were for females ages 15-44. Pregnancy and childbirth accounted for 50% of these hospitalizations. After childbirth, mental disorders and diseases related to the digestive system were the most common reasons for hospitalization among this population.

Primary causes of hospitalization among those with mental disorders were drug induced psychoses, schizophrenic disorders, substance use (dependent and non-dependent abuse), and affective psychoses including manic, major depressive and bipolar disorders. The most common diagnosis for diseases related to the digestive system were diseases of the esophagus, appendicitis, gallbladder disorders and diseases of the pancreas. For all years except for 2001 and 2002, diseases of the genitourinary system had the fifth highest number of admissions for women 15-44 years of age. The most common diagnosis for those admissions was kidney infections, inflammatory disease of the ovary, fallopian tube, pelvic cellular tissue, and peritoneum, and endometriosis.

Map 6 below provides a visual display of non-pregnancy and childbirth related hospitalizations by zip code for this population. Noticeably, zip codes with the highest number of hospitalizations

also correspond almost exactly to Wards (5, 6, 7 and 8) with the worst health indices in the District.

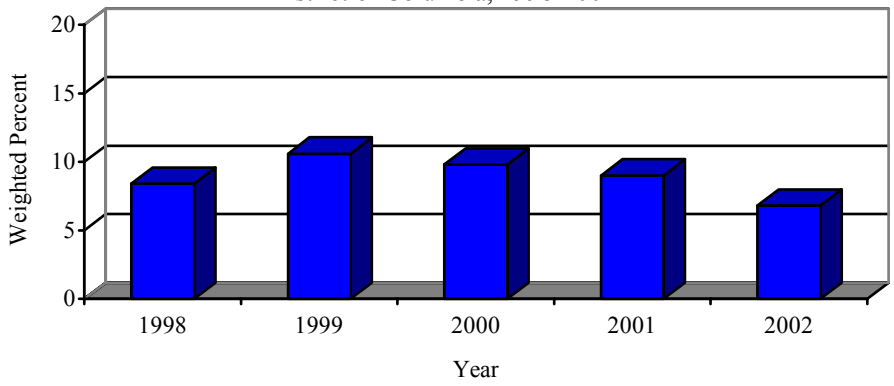


<u>Access and Utilization of Health Care Services</u>: In the District of Columbia the majority of residents are Black/African American. The Hispanic population is the fastest growing minority group. Residents of these racial/ethnic groups are more likely to lack insurance coverage, to be underinsured, and lack a consistent source of health care. Thus, many women in the District

underutilize critical preventive care services that can lead to early detection and treatment of many diseases and conditions.

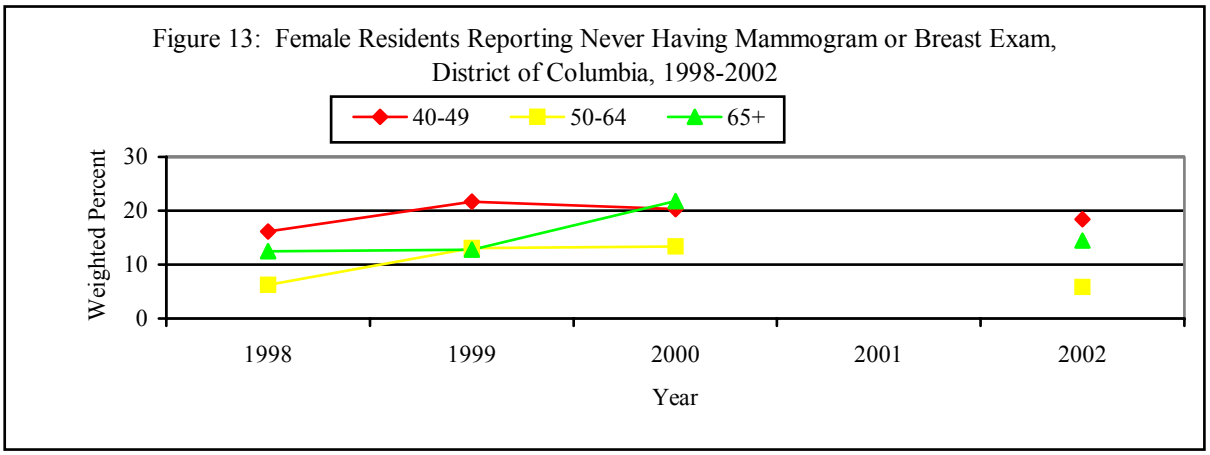
Figure 12 below illustrates the percentage of female residents over age 18 with no health insurance coverage. There was a 36 % overall decrease in the number of women reporting a lack of health insurance coverage during 1999 to 2002, from 10.6% to 6.8%, respectively.

Figure 12: Female Residents Aged 18+ Reporting No Health Insurance Coverage
District of Columbia, 1998-2002



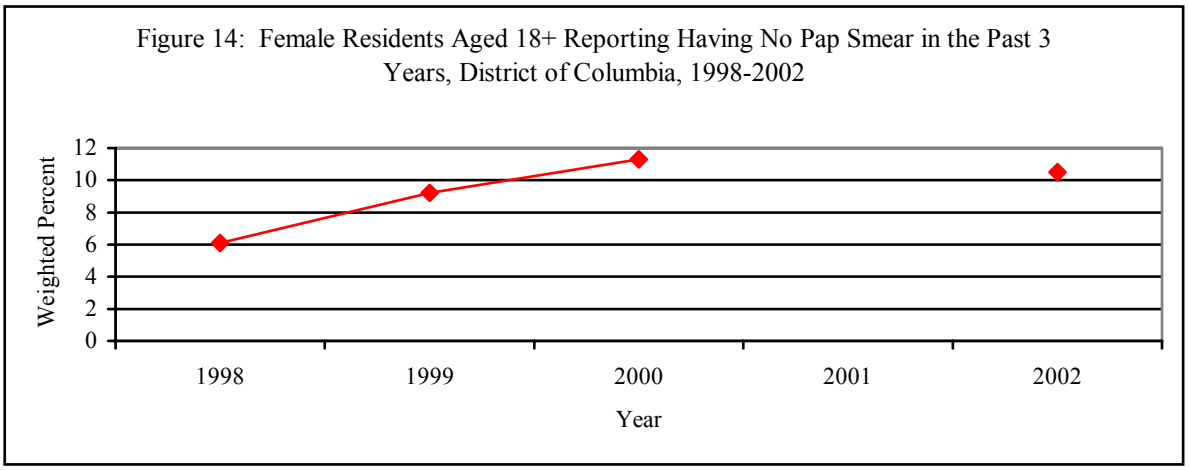
Source: District of Columbia Behavioral Risk Factor Surveillance System

According to the District of Columbia Behavioral Risk Factor Surveillance System (BRFSS) for 2002, 36 % of the female residents reported that they did not seek preventative care. Figure 13 below shows the weighted percentage of women who reported never having a mammogram or breast exam. The percentage of women age 50-64 who reported never having mammogram or breast exam increased from 6.2 % in 1998 to 13.4% in 2000. However, in 2002 there was a sharp decrease to 5.8 %. The percentage of women age 65 and over that reported never having a mammogram or breast exam has remained around 13% for the five-year period except for the year 2000 when there was an increase to 21.8%.



Source: District of Columbia Behavioral Risk Factor Surveillance System
* No data was reported for 2001

The national Healthy People objective for 2010 is to increase the proportion of women aged 18 years and older who received a Pap test within the preceding 3 years to 90%. Figure 14 below shows the percent of female residents age 18 and over who reported having no pap smear in the past three years from 1998-2002.



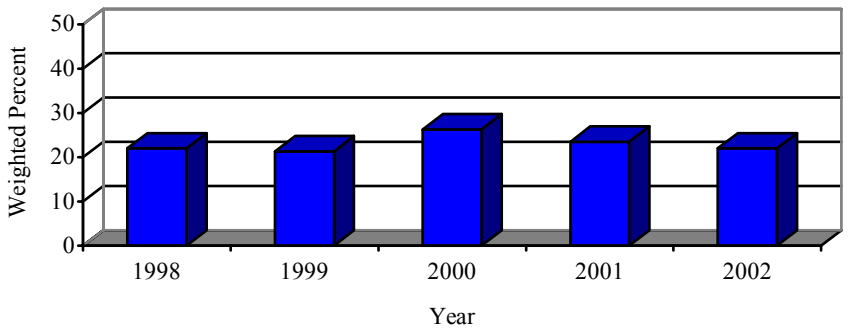
Source: District of Columbia Behavioral Risk Factor Surveillance System
*No data reported for 2001

Behavioral Risks

According to the Centers for Disease Control and Prevention, people who are overweight or obese increase their risk for cardiovascular disease, diabetes, high blood pressure, and some cancers. Lack of an adequate amount of exercise has been associated with needing more medication, visiting a physician more often, and being hospitalized more often. The direct medical costs associated with physical inactivity in the U.S. was determined to be approximately $76.6 billion in 2000, while the annual cost of obesity is about $117 billion.

Obesity, Nutrition and Physical Activity: Body Mass Index (BMI) measures body weight while adjusting for height. An adult with a BMI ranging between 25 and 29.9 is considered overweight. A BMI of 30 or higher is considered obese. In 2000, the percent of women reporting obesity was the highest over the five-year period of 1998-2002 at 26.3% Since that time there has been a steady decline. Figure 15 below shows the percent of female residents who reported being obese according to their body mass index (BMI).

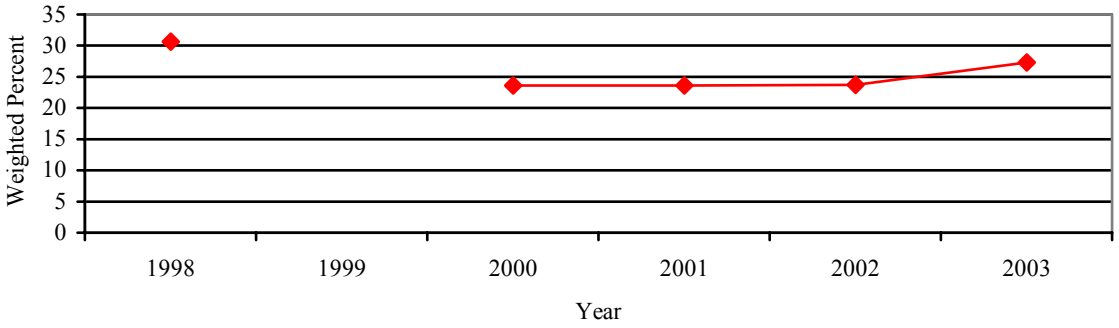
Figure 15: Female Residents Aged 18+ Reporting Obesity by BMI, District of Columbia, 1998-2002



Source: District of Columbia Behavioral Risk Factor Surveillance System

Leisure-time inactivity and improper nutrition are the main contributors to obesity. The Center of Disease and Prevention (CDC) recommends that individuals participate in moderate-intensity activities 30 minutes per day for 5 days a week. While the overall percent of women reporting no leisure time physical activity during the past month decreased by 10.8% between 1998-2003, there was a 15.2% increase between 2002 and 2003, from 23.6% to 27.3% respectively. (See Figure 16 below)

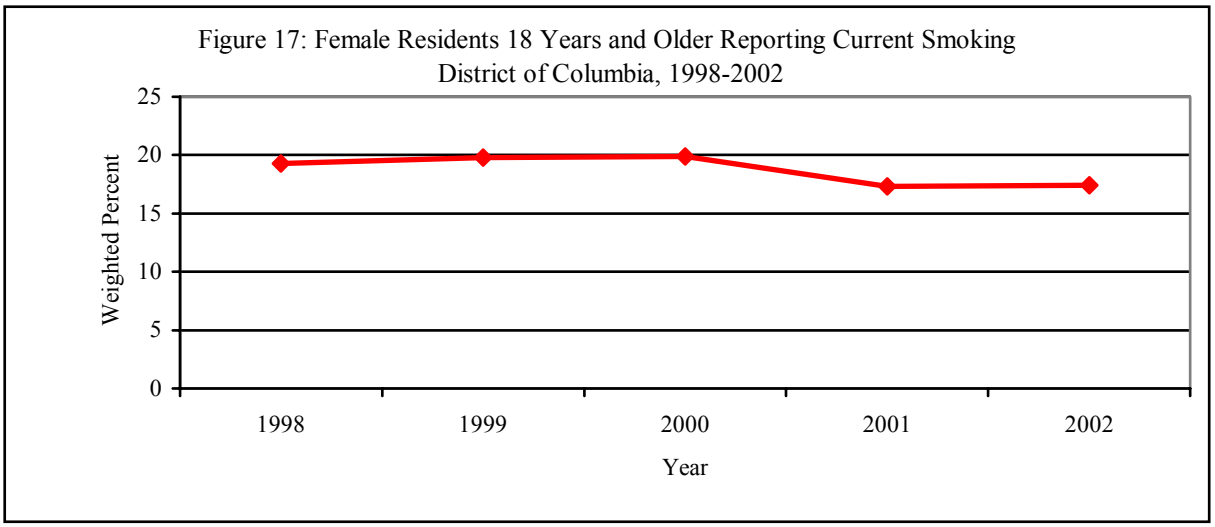
Figure 16: Female Residents 18 Years and Older Reporting No Leisure Time Physical Activity During the Past Month, District of Columbia, 1998-2003



Source: District of Columbia Behavioral Risk Factor Surveillance System
**No data reported for 1999

Substance Use (Tobacco, Alcohol, Illicit Drugs): In 2003, the Mayor's Interagency Task Force on Substance Abuse Prevention, Treatment and Control reported that nearly 15% of new mothers report having used illicit drugs during pregnancy. Approximately 85% of foster care placements are connected with substance abuse and 27% of the cumulative reported AIDS cases in the District are related to intravenous drug use. Clearly as the District looks to address health issues, substance use must be taken into account.

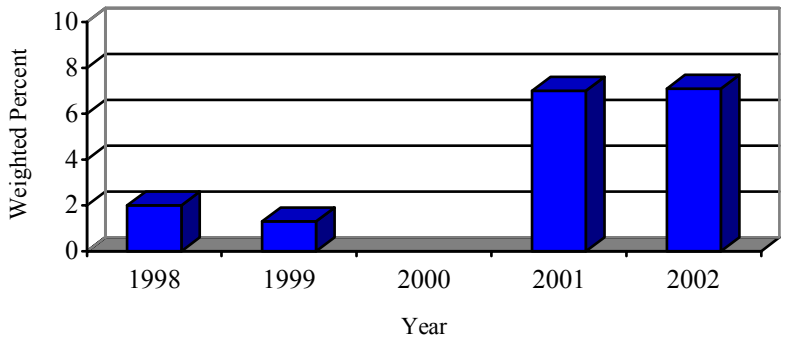
Figure 17 below illustrates the "current smoking" status of females aged 18 and older. Current smoking, defined as having ever smoked 100 cigarettes and reporting to smoke everyday or some days, among District of Columbia female residents reached a plateau between 1998 and 2000, but slightly decreased between 2000 and 2002.



Source: District of Columbia Behavioral Risk Factor Surveillance System

Figure 18 below illustrates the "chronic drinking" trends among District of Columbia females. The BRFSS defines chronic drinking as reporting consumption of 2 or more drinks per day, i.e. 60 or more drinks per month. The prevalence rate of chronic drinking among females more than doubled from 1998 to 2002, from 2.0% to 7.1% respectively.

Figure 18: Female Residents 18 and Older Reporting Chronic Drinking
District of Columbia, 1998-2002



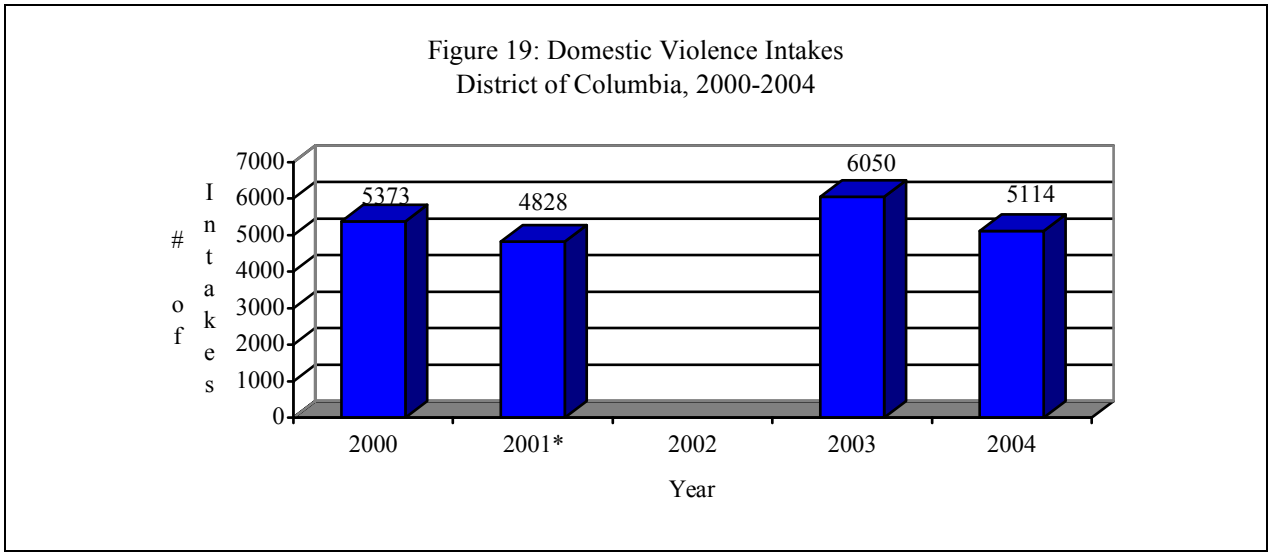
Source: District of Columbia Behavioral Risk Factor Surveillance System

Domestic Violence: Nationally, domestic violence causes an estimated $150 million in medical expenses annually. Businesses lose approximately $100 million annually in lost wages, sick leave, absenteeism and lowered productivity. An estimated 50% of all homelessness, among women and children, is due to domestic violence. Children living in homes where there is domestic violence are 15 times more likely to be abused.[3]

The Domestic Violence Intake Center (DVIC), a collaborative project of governmental and non-governmental agencies, was established to provide coordinated services to survivors of domestic violence in the District of Columbia. Specifically, the DVIC provides a single access point for victims of domestic violence by conducting intake evaluations, providing counseling, safety planning, assisting victims in drafting pleadings and other documents necessary for acquisition of protective orders and free legal representation. The agencies involved in the collaborative include the United States Attorney's Office (USAO), the Office of Corporation Counsel (OCC), the Metropolitan Police Department (MPD), Women Empowered Against Violence (WEAVE), Crime Victims Compensation Program (CVCP), Legal Aid Society, Ramona's Way, Center for Child Protection/Victim Service Center, DC Coalitions Against Domestic Violence (DCCADV) (Victim Advocacy), and the DC Superior Court Clerks Office. Although domestic violence is severely underreported, reports obtained from the Domestic Violence Intake Center provide great insight into the magnitude of the affect of domestic violence on the community.

3 District of Columbia Coalition Against Domestic Violence Center. "Who We Are," Http://www.dccadv.org. Accessed 2/18/2005.

Figure 19 illustrates the number of complaints that were filed at the two domestic violence centers operated by the District's Office of the Attorney General. Between 2000-2004, the overall volume of domestic complaints decreased slightly (5%).



Source: DC Office of the Attorney General, Domestic Violence Intake Center
*Only 11 months of data was available in 2001 and no data was available for 2002.

Studies have shown that most survivors of domestic violence do not share common characteristics although most victims are women and girls. One out of every four women will experience abuse during her life. For all years in which data was available for the District, females lead the group seeking services, averaging between 80%-83% of the total for each year. However, increasing reports are being received from men and boys who have been victims of domestic violence. Between 2000 and 2004, about 17% of the overall domestic violence reports were made by males. The data showed that only 4% of the complainants were for individuals over 55 and 1% were under the age of 18.

Disparities in the number of domestic violence reports were seen not only across gender and age but also geographically. For each year, Ward 8 lead in the number of domestic violence intake reports, followed by Wards 7, 4 and 5. Interestingly, these Wards also lead the District in having the worst health indices.

Leading Causes of Death/Mortality: Except for in 2000, HIV/AIDS has been the leading cause of death among District resident women 15-44. (See Table 11 below)

Table 11: Five Leading Causes of Death per 100,000 Women 15-44, District of Columbia Residents 1998-2002.

Cause	1998		1999		2000		2001		2002	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
HIV/AIDS	52	37.8	42	30.6	33	22.9	38	26.4	43	29.9
Cancer	40	29.1	31	22.6	35	24.4	37	25.7	24	16.7
Homicide	16	11.6	12	8.7	13	.9	18	12.5	21	14.6
Accidents	21	15.3	--	--	25	17.4	27	18.8	20	13.9
Heart	31	22.6	30	21.8	22	15.3	24	16.7	15	10.4
Cerebrovascular Diseases	--	--	9	6.6	--	--	--	--	--	--
Influenza/Pneumonia	--	--	9	6.6	--	--	--	--	--	--

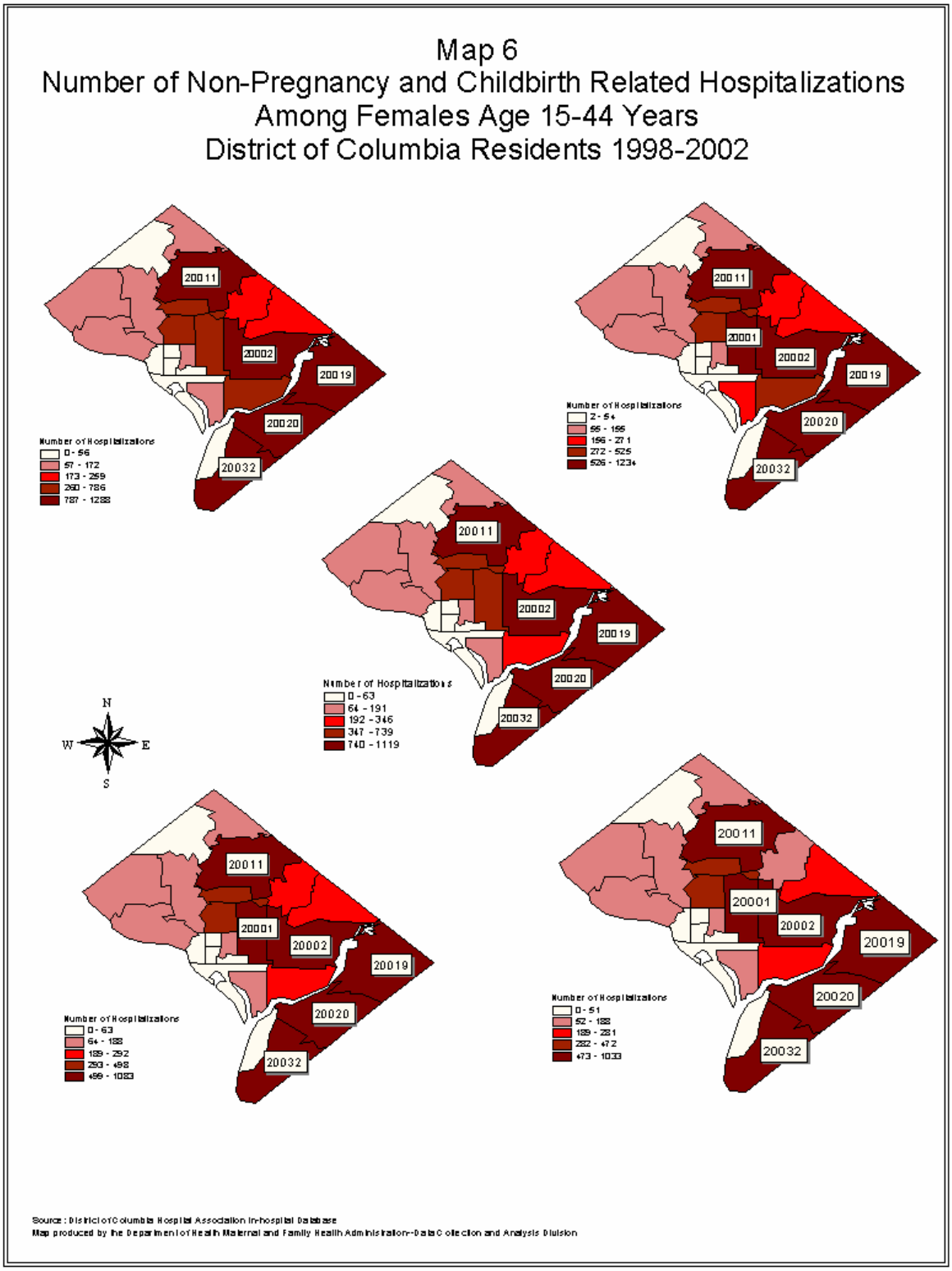
Source: District of Columbia Department of Health State Center for Health Statistics Administration
-- Not one of the leading causes of death for that year.

Geographical disparities were also seen in this area. Among the cases where HIV/AIDS was the cause of death, most women were residents of Wards 5,6,7,and 8. Similar patterns were seen for the other leading causes of death.

Hospitalizations: Of the total number of hospital admissions to District hospitals by District residents between 1998-2002, approximately 21% were for females ages 15-44. Pregnancy and childbirth accounted for 50% of these hospitalizations. After childbirth, mental disorders and diseases related to the digestive system were the most common reasons for hospitalization among this population.

Primary causes of hospitalization among those with mental disorders were drug induced psychoses, schizophrenic disorders, substance use (dependent and non-dependent abuse), and affective psychoses including manic, major depressive and bipolar disorders. The most common diagnosis for diseases related to the digestive system were diseases of the esophagus, appendicitis, gallbladder disorders and diseases of the pancreas. For all years except for 2001 and 2002, diseases of the genitourinary system had the fifth highest number of admissions for women 15-44 years of age. The most common diagnosis for those admissions was kidney infections, inflammatory disease of the ovary, fallopian tube, pelvic cellular tissue, and peritoneum, and endometriosis.

Map 6 below provides a visual display of non-pregnancy and childbirth related hospitalizations by zip code for this population. Noticeably, zip codes with the highest number of hospitalizations also correspond almost exactly to Wards (5, 6, 7 and 8) with the worst health indices in the District.



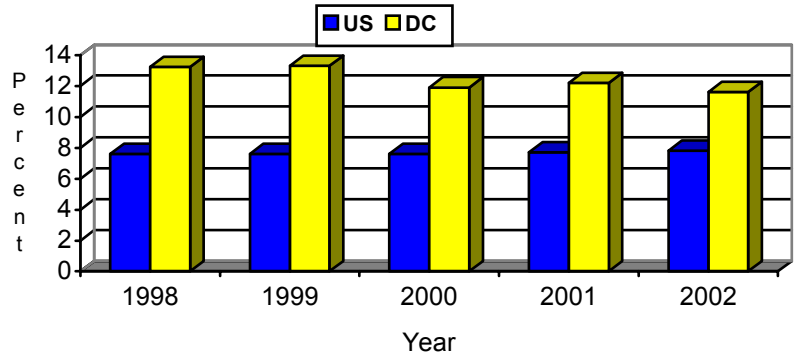
2.1.1.2.b Infants

<u>Low Birth Weight</u>: (*National Performance Measure #15, Health Systems Indicator #05a, Health Status Indicator Measure #01a & b and #02a & b)* Low birthweight (LBW) is defined as

weighing less than 2,500 grams or 5pound 5 ounces at birth. Very low birthweight (VLBW) infants are born weighing less than 1,500 grams or 3 pounds 5 ounces. Along with being a contributing factor for infant mortality, LBW and VLBW infants are at greater risk for developing serious health complications, such as respiratory tract disorders, neurological impairments, and developmental disabilities.

Nationally, between 1998-2002 low birth weight deliveries increased slightly from 7.6% in 1998 to 7.8% in 2002. During the same time period, the District of Columbia's incidence of LBW births decreased by 12.1% from 13.2% in 1998 to 11.6% in 2002. See Figure 20 below.

Figure 20: Percent of Low Birthweight Live Births in the United States and the District of Columbia 1998-2002

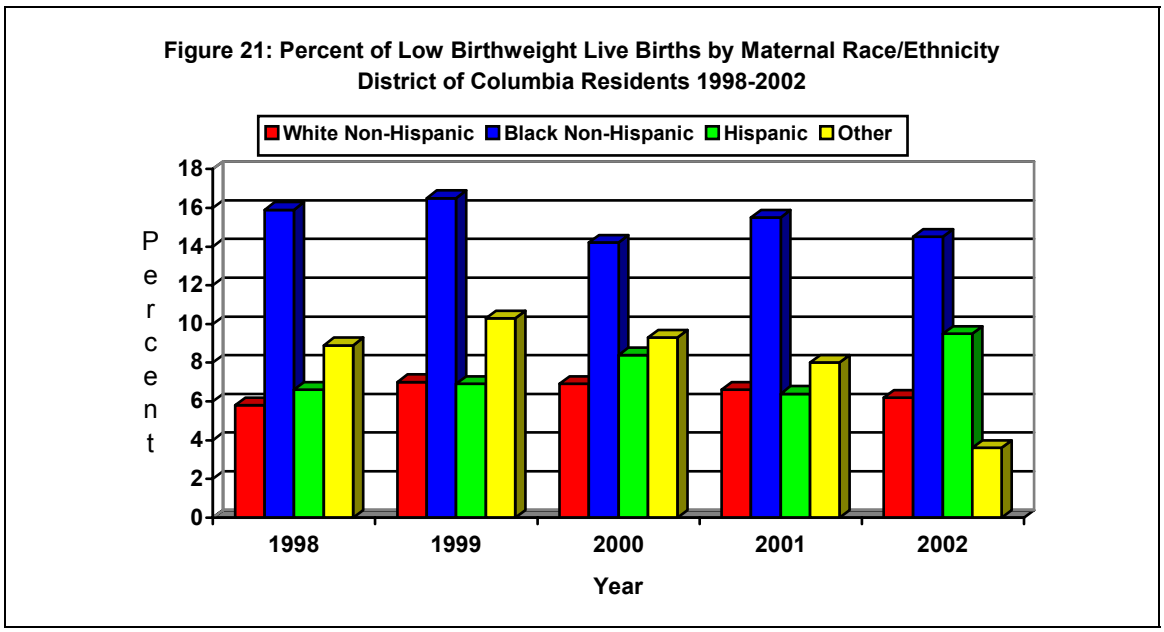


Source: Centers for Disease Control and Prevention (CDC) and the District of Columbia Department of Health State Center for Health Statistics Administration

Though there is no specific cause for low birth weight births there are several factors that can be considered, such as; age and health status of the mother, higher order multiple births, e.g., twins; triplets are at a greater risk for LBW, in many cases attributable to premature births. In the District, since 1997, the number of multiple order births classified as LBW has decreased from 2.7% to1.8% in 2002. Between 1997 and 2002, the incidence of VLBW in the District of Columbia, ranged from 2.7% - 3.5% compared nationally to 1.4%-1.5% respectively.

The Institute of Medicine had identified race as a risk factor for low birthweight. In the District of Columbia, the percentage of LBW births among Black, Non-Hispanic women continues to be significantly higher than that of other racial/ethnic group. Between 1998-2002, the percent of LBW births among Black Non-Hispanic women ranged from 14.2 to 16.5%. In contrast, the percent of LBW births among White Non-Hispanic women ranged from 5.8 to 7%. The percent of LBW births among women of Other racial/ethnic groups varied from 3.6 to 10.3% within the same timeframe. (See Figure 21 below) Over the five-year period, women of Other racial/ethnic

groups have experienced the greatest overall percent of decrease (59.6%) from 8.9% in 1998 (with a high of 10.3% in 1999) to 3.6% in 2002. Conversely, Hispanic women have experienced an overall 43.9% increase in the percent of low birthweight births from 6.6% in 1998 to 9.5% in 2002. However, although Hispanic women experienced this increase they still were more likely to have a better birth outcome than Black Non-Hispanic women. Suggesting that there may be protective factors for Hispanic women that need to be identified.

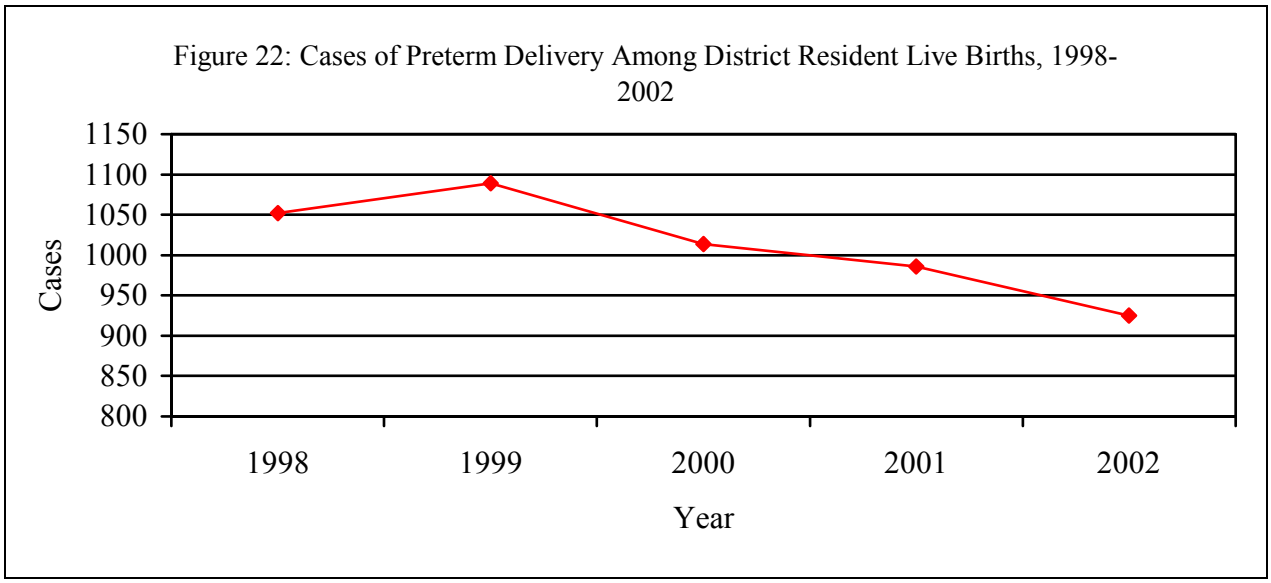


Source: District of Columbia Department of Health State Center for Health Statistics Administration

Geographical disparities for LBW also exist in the District of Columbia. The District is divided into eight geographical Wards, of equal size. However, within each Ward, racial and socio economic status varies greatly. Between 1998-2002, Wards 5, 7 and 8 had the highest proportions of LBW births while Wards 1,2,4 and 6 had slightly lower rates, Ward 3, consistently had a substantially lower rate than all other Wards.

Preterm Births: Preterm delivery, defined as a live birth occurring prior to 37 completed weeks gestation, is a primary predictor of low birth weight and is responsible for most neonatal deaths and approximately half of all congenital neuro-developmental disabilities. Though there is not an exact cause for preterm delivery, there are behaviors and risk factors that contribute to a having a preterm delivery including previous preterm delivery/or low birth weight delivery, multiple gestation, maternal tobacco and/or alcohol use during pregnancy, unplanned pregnancy, infections during pregnancy, lack in prenatal care and poor nutrition.

In the District of Columbia, over the five-year time period of 1998-2002, the number of cases of preterm delivery steadily declined from 1,052 in 1998 to 925 in 2002 for an overall decline of 12.1%. (See Figure 22 below)



Source: District of Columbia Department of Health State Center for Health Statistics Administration

However, the rates demonstrate a less dramatic decline as well as some inconsistency when stratified by age.

Black mothers continue to bear a disproportionate burden with an incidence twice the rate for white women. The racial gap in preterm delivery decreased from 2001-2002, however, it is mostly attributable to rate increases among White and Hispanic mothers. Black Non-Hispanic mothers had the highest rates of preterm delivery between 1998 to 1999 and 2001 to 2002. Hispanic and White Non-Hispanic mothers had the lowest rates of preterm delivery over the five-year period.

Women of Other races had the highest rate of preterm delivery in 2000, even though they have fewer births than Black, White, and Hispanic women.

Mothers aged 35 years and older, and mothers aged 14 years and younger, had higher incidence rates of preterm delivery than mothers of other age groups. In 2000 and 2002, preterm deliveries among mothers aged 14 years and younger peaked around 300 cases per 1,000 live births, which was more than two times the rate in 2001.

From 1998-2002, the proportion of preterm deliveries that yielded low birth weight (LBW) and very low birth weight (VLBW) infants remained consistent. Over 60% of infants who were born preterm, were also LBW or VLBW.

The Healthy People 2010 goal is to reduce preterm births to no more than 7.6% of live births. From 1998 to 2002 there has been only a slight reduction. In 1998 and 1999, 13.7% and 14.5% of live births were preterm, respectively. In 2000, the proportion of live births that were preterm reduced to 13.2%. From 2001-2002 the proportion of preterm births reduced from 12.9% to 12.3%.

Infant Mortality*:* (*National Outcome Measure #01, 02, 03, 04, 05, Health Systems capacity Indicator #05b)* Infant mortality is a reliable indicator of overall infant health and is frequently used as a reference point for defining a society's quality of life. Defined as the number of infants who die between birth and one year of age per 1,000 live births, infant mortality rate (IMR) is broken down into two sub categories, (1) neonatal mortality (0-27 days) and (2) post neonatal mortality (28-365 days).

Nationally, between 1998 and 2002, the IMR decreased from 7.2 per 1,000 live births, in 1998 to 7, per 1,000 live births in 2002. However, during the same 5-year period, the District's IMR decreased from 12.5 per 1,000 live births in 1998 to 11.5 per 1,000 live births in 2002, for an overall decline of 8%. Table 12 below presents a comparison of 10-year infant mortality trends among District of Columbia residents between 1993-2002. During this period, the District experienced an overall decrease of 31% in the infant mortality rate and 91 fewer infant deaths.

Table 12: Infant Mortality Trends
District of Columbia Residents
1993-2002

Year	Infant Births	Infant Deaths	Infant Mortality Rate*
1993	10614	177	16.7
1994	9911	180	18.2
1995	8993	145	16.1
1996	8377	121	14.4
1997	7916	177	16.7
1998	7678	96	12.5
1999	7513	113	15
2000	7666	91	11.9
2001	7621	81	10.6
2002	7494	86	11.5

*Per 1,000 live births Source: District of Columbia Department of Health State Center for Health Statistics Administration

Although the District's infant mortality rate is declining, it still has some ways to go to meet the District's Healthy People 2010 goal of 8.0 per 1,000 live births. Between 1998 and 2002, the infant mortality rate for African American women decreased from 15.0 to 14.1 for an overall decline of 6%. 2002 marked the first year the District's black infant mortality rate was below the National black infant mortality rate (14.3). White mothers experienced an increase of 112% between 1998 and 2002, from 3.1 to 6.6. The infant mortality rate for Hispanic mothers increased between 1998 and 2002, from 6.6 in 1998 to 9.0 in 2002.

Though the trends indicate the overall rate of infant mortality in the District is declining, there continues to exist great disparities geographically. Wards consistently experiencing the highest rates of infant mortality include Wards 2, 5, 7 and 8. In 2002, for the first time, the infant mortality rate in Ward 8 was not among the top four highest. In fact, between 2001 and 2002 the infant mortality rate for Ward 8 decreased by 54% from 23.1 to 10.6. Conversely, between 2001 and 2002, Ward 1 experienced the highest percent increase (130%) in its infant mortality rate from 5.4 in 2001 to 12.4 in 2002. The significant disparities among population groups as well as geographically warrant further investigation of this issue in the District of Columbia.

The neonatal period (first 27 days of life) is important relative to efforts to reduce infant mortality. Many of the causes of infant deaths during this period could have been mitigated or prevented with good preconception and prenatal care. Between 1998 and 2002, the District's neonatal mortality rate declined from 7.0 in 1998 to 7.7 per 1,000 live births in 2002. (See Table 13 below)

Table 13: Neonatal and Postneonatal Mortality Rates, District of Columbia Residents 1998-2002.

Age at Death	1998	1999	2000	2001	2002
Neonatal	7.0	11.7	8.7	7.7	7.7
Postneonatal	5.5	3.3	3.1	2.9	3.7

Source: District of Columbia Department of Health State Center for Health Statistics Administration

Between 1998-2002, all races experienced fluctuations in both the neonatal and postneonatal mortality rates. (See Table 14 below) Among African American women the neonatal mortality rate, during the same time period, increased from 7.6 in 1998 to 9.1 per 1,000 live births in 2002, while the postneonatal mortality rate decreased from 7.4 in 1998 to 5.1 in 2002. The neonatal mortality rate for infants of White mothers for the five-year period increased by 2½ fold from 2.2 in 1998 to 5.5 in 2002. The postneonatal mortality rate for infants of born to White women increased as well. The neonatal and post neonatal mortality rates for infants born to women of Other races decreased between 1998-2002. The neonatal mortality rate for infants of women of Other races decreased from 8.3 per 1,000 live births to in 1998 to 6.3 in 2002 for an overall decrease of 24%. The postneonatal mortality rate for this group decreased from 5.2 in 1998 to 1.0 in 2002 for an overall decrease of 62.5%. Between 1998-2002, Hispanic mothers, who can be of any race, experienced an overall increase in their neonatal mortality rate and decrease in the postneonatal mortality rate. The neonatal mortality rate for Hispanic women increased from 1.3 in 1998 to 8.0 in 2002. The overall postneonatal morality rate for Hispanic women decreased by 81% from 5.2 in 1998 to 1.0 in 2002.

Table 14: Neonatal and Postneonatal Mortality Rates*District of Columbia Residents 1998-2002

	Neonatal Mortality		Postneonatal Mortality	
1998	**Number**	**Rate**	**Number**	**Rate**
Maternal Race				
White	3	2.2	1	.7
Black	41	7.6	40	7.4
Other	7	8.3	4	4.8
Hispanic*	1	1.3	4	5.2
1999	**Number**	**Rate**	**Number**	**Rate**
Maternal Race				
White	8	5.5	3	2.1
Black	66	12.9	20	3.9
Other	3	3.1	2	2.1
Hispanic*	7	8.6	5	6.1
2000	**Number**	**Rate**	**Number**	**Rate**
Maternal Race				
White	2	1.3	0	---
Black	57	11.3	19	3.8
Other	6	5.9	5	4.9
Hispanic*	5	5.5	3	3.3
2001	**Number**	**Rate**	**Number**	**Rate**
Maternal Race				
White	4	2.3	1	.6
Black	51	10.7	18	3.8
Other	4	3.8	3	2.9
Hispanic*	2	1.9	2	1.9
2002	**Number**	**Rate**	**Number**	**Rate**
Maternal Race				
White	10	5.5	2	1.1
Black	41	9.1	23	5.1
Other	7	6.3	2	1.8
Hispanic*	8	8.0	1	1.0

Source: District of Columbia Department of Health State Center for Health Statistics Administration
*Hispanic can be of any race
**Rate per 1,000 live births

During the five–year period of 1998-2002, except for 1999, infants in the District of Columbia were more likely to die as a result of maternal complications of pregnancy or complications of the placenta, cord and membranes followed by congenital anomalies/birth defects. In fact congenital anomalies/birth defects has been the second leading cause of infant deaths in the District for the past four years (1999-2002). Further stressing the importance of surveillance and prevention activities in this area. In 1998, congenital anomalies/birth defects was the fourth leading cause of District infant deaths. Table 15 below, highlights the top five causes of infant deaths for 1998-2002 based on the number of deaths. As shown in the table, two causes tied for fifth place in 2002.

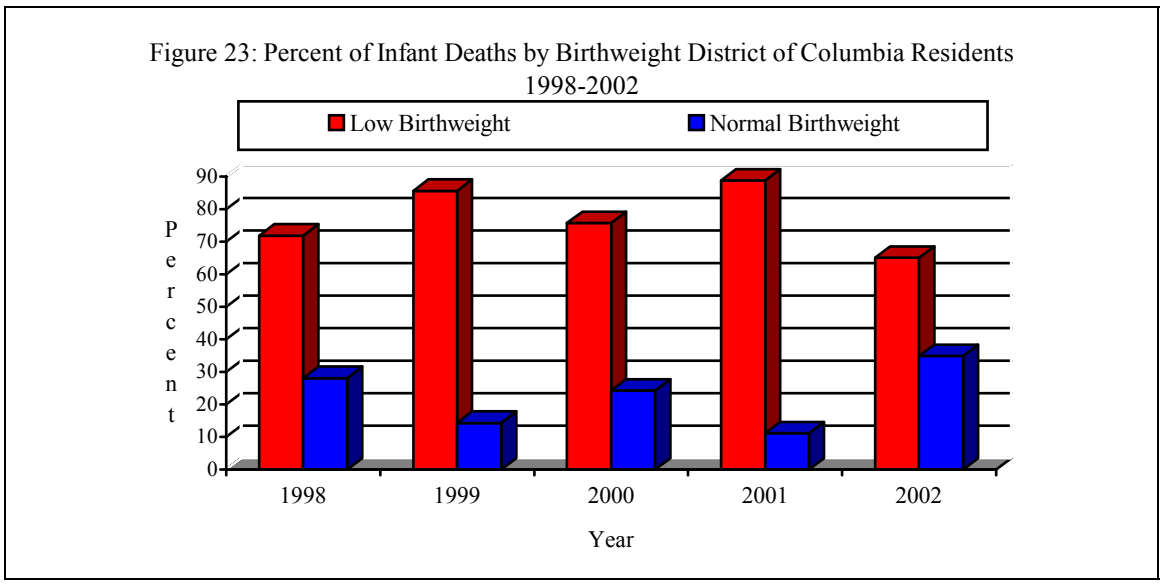
Table 15: Leading Causes of Infant Deaths District of Columbia Residents 1998-2002

Rank	1998	1999*	2000*	2001*	2002*
1	Other chronic respiratory conditions of the fetus and newborn	Newborn affected by complications of placenta, cord and membranes (P02)	Newborn affected by complications of placenta, cord and membranes (P02)	Newborn affected by maternal complications of pregnancy (P01) (includes premature rupture of membrane)	Newborn affected by maternal complications of pregnancy (P01) (includes premature rupture of membrane)
2	Disorders relating to short gestation and unspecified low birthweight	Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) (includes birth defects)	Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) (includes birth defects)	Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) (includes birth defects)	Congenital malformations, deformations and chromosomal abnormalities (Q00-Q99) (includes birth defects)
3	Sudden Infant Death Syndrome	Respiratory distress syndrome (P22)	Newborn affected by maternal complications of pregnancy (P01) (includes premature rupture of membrane)	Disorders related to short gestation and low birthweight not elsewhere classified (P07)	Newborn affected by complications of placenta, cord and membranes (P02)
4	Congenital anomalies (birth defects)	Newborn affected by maternal complications of pregnancy (P01) (includes premature rupture of membrane)	Sudden Infant Death Syndrome (R95)	Newborn affected by complications of placenta, cord and membranes (P02)	Disorders related to short gestation and low birthweight not elsewhere classified (P07)
5	Respiratory distress syndrome	Disorders related to short gestation and low birthweight not elsewhere classified (P07)	Disorders related to short gestation and low birthweight not elsewhere classified (P07)	Respiratory distress syndrome (P22)	Disease of the circulatory system (I00-I99)
					Respiratory distress syndrome (P22)

Source: District of Columbia, Department of Health State Center for Health Statistics Administration
*Causes of death for these years based on the Tenth Revision, International Classification of Disease

Although the factors contributing to infant deaths are complex, research has shown that several risk factors are associated with infant mortality. These include low birthweight, maternal race, maternal age, multiple births, poverty and maternal education.

An examination of birthweight and infant deaths for the period of 1998-2002 revealed that the vast majority of infants who died were born low birthweight. (See Figure 23 below) this data supports previous research, which identifies birthweight as a key predictor at birth of a child's survival.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

Sudden Infant Death Syndrome: *(State Outcome Measure #1)* Sudden Infant Death Syndrome (SIDS) is the diagnosis given to a sudden death of an infant under one year of age that remains unexplained after a thorough autopsy, crime scene investigation, and review of the infant's health status before dying. Nationally, SIDS is the leading cause of death of infants between one month and one year of age.

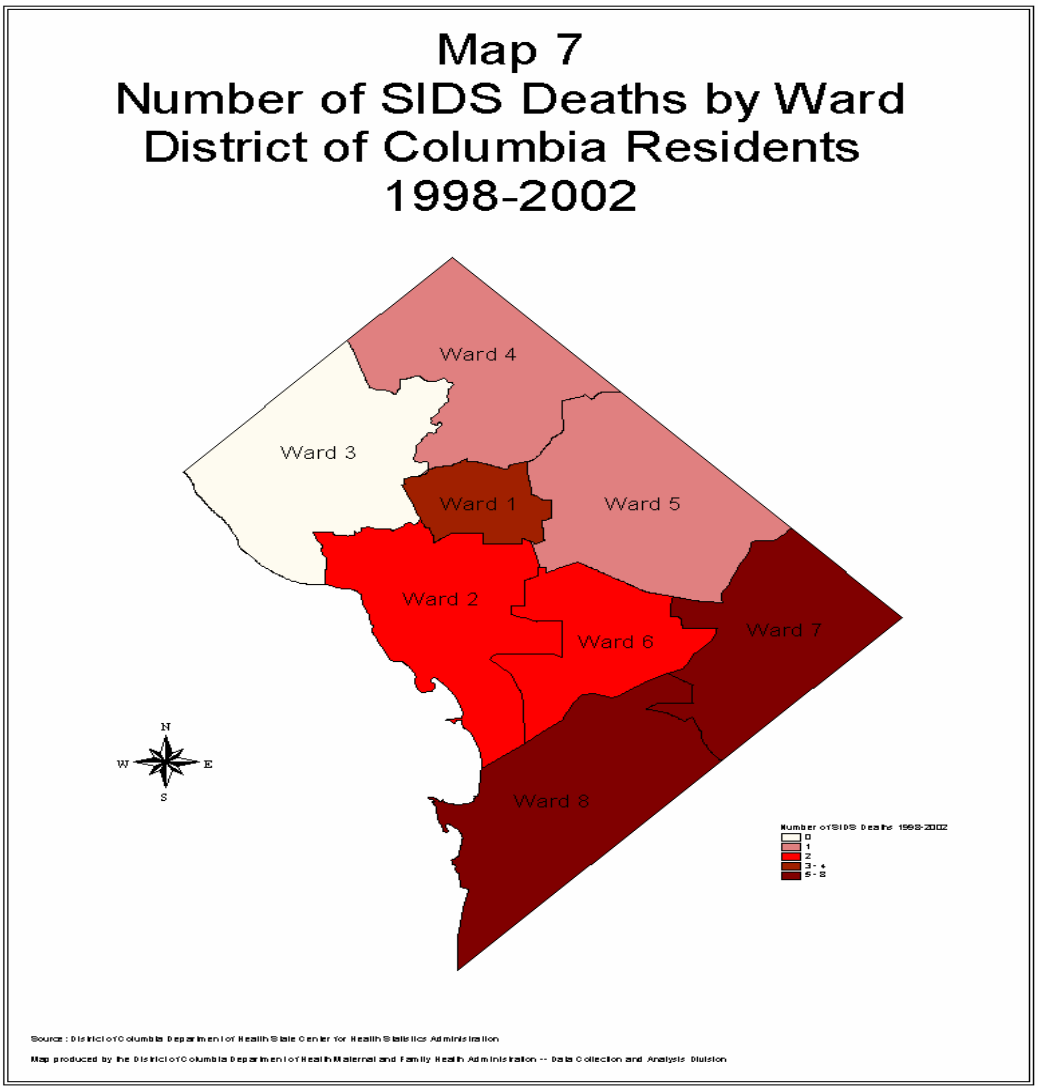
In the District of Columbia from 1994-2002 the number of SIDS related deaths has decreased by 77.8%, from 18 in 1998 to 4 in 2002. (See Table 16 below)

Table 16: Number of Sudden Infant Death Syndrome (SIDS) Deaths District of Columbia Residents 1994-2002

Year	Number of SIDS Deaths
1994	18
1995	10
1996	7
1997	5
1998	9
1999	2
2000	9
2001	5
2002	4

Source: District of Columbia, Department of Health State Center for Health Statistics Administration

For all years combined, 1998-2002, Wards 8,7 and 1 lead in the number of SIDS deaths. (See Map 7 below) In addition, during this time period, SIDS disproportionately affected infants of African American women.



One of the District's 2010 health objectives is to increase the number of infants being put to sleep on their backs. The District's PRAMS survey provides some insight to the progress being made in this area. Between 1998-2002, there was an overall 21% decrease in the percent of women reporting that they placed their child on its back, from 43% in 1998 to 34% in 2002. Conversely there was an overall 29.7% increase in the percent of women who reported placing their baby on its side, from 37% in 1998 to 48% in 2002. During the same five-year time period there was a slight overall decrease (10%) in the percent of women who reported placing their baby on their stomachs, from 20% in 1998 to 18% in 2002. African-American women were four times more likely than White women to place their child on their stomach. A study by Brenner et al. conducted as part of the National Institute of Health's Initiative to Reduce Infant Mortality in Minority Populations in the District of Columbia, found similar results among a cohort of infants born to predominately low-income women living in the District.

Qualitative analysis of PRAMS comments shed further light on why these mothers were exhibiting this behavior. Several stated that they placed their infant on its stomach for fear that the infant would choke. Others reported that their mother's had put them on their stomachs and that nothing had happened to them or their other children whom they had also put to sleep on their stomach. In fact, many acknowledged that the baby should be placed on it's back but that they felt more comfortable with the child on it's stomach or side. These comments suggest that to effectuate change among this population, cultural and familial beliefs will need to be taken into account when designing SIDS outreach activities.

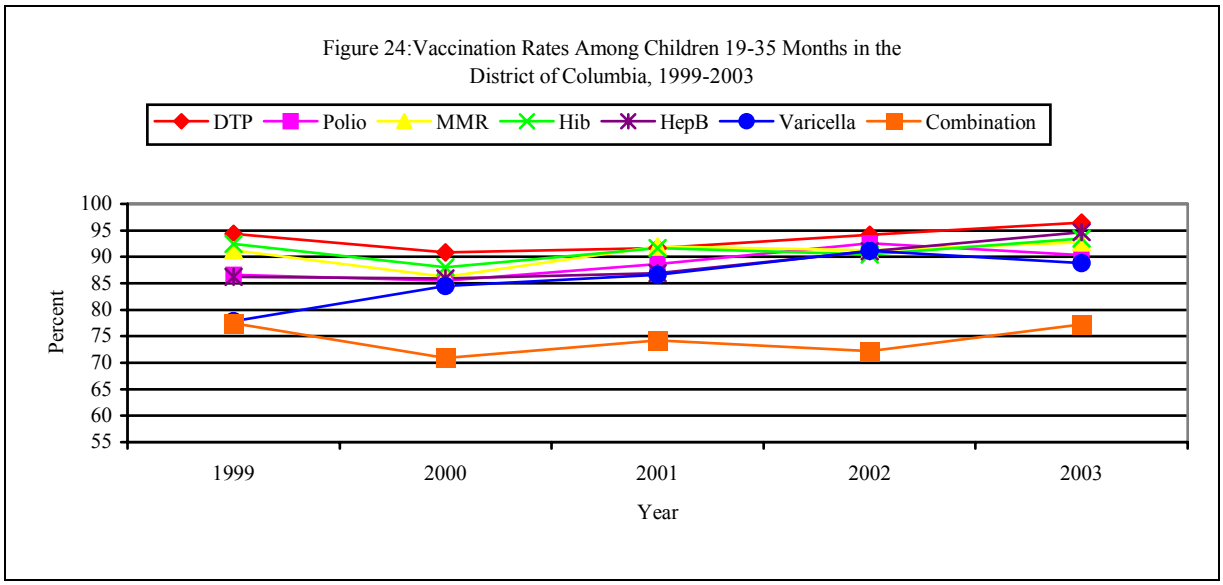
Hospitalizations: Between 1998-2002, admissions for children under 1 year of age comprised about 10% of the total number of hospital admissions to District hospitals by District residents. Diseases of the respiratory system accounted for 24.1%-29.2% of all admissions for this age group. After diseases of the respiratory system, conditions originating in the perinatal period, infectious and parasitic diseases, and ill-defined conditions were the most common reasons for hospitalization among this population. Between 1998 and 1999, there was a 25% overall increase in the number of hospitalizations children under 1, from 1,135 in 1998 to 1,419 in 1999. Coincidently, the infant mortality rate for the District between 1998 and 1999 increased as well. Since 1999 the number of hospitalization to children under one has steadily decreased.

Primary causes of hospitalization among children under one with diseases of the respiratory system were pneumonia, acute bronchitis and asthma. The most common diagnosis for conditions originating in the perinatal period were disorders related to short gestation, infections specific to the perinatal period (including neonatal conjunctivitis, herpes simplex and congenital rubella), other perinatal jaundice, and other respiratory conditions of the fetus and newborn. Common diagnosis for infants hospitalized for infectious and parasitic diseases were septicemia, viral infection in conditions classified elsewhere and intestinal infections due to other organisms. It should be noted that for this general classification during the years 2000-2002, there was an increase in the number of hospitalizations for meningitis due to enterovirus, 11, 26, and 8 respectively. Between 1998 and 2002, symptoms and ill-defined conditions fluctuated between the third and fourth top reason for hospitalizations for children under one year of age. The most common diagnosis for infants hospitalized with this condition were convulsions, symptoms involving the respiratory system and other chest symptoms, symptoms concerning nutrition, metabolism and development including feeding difficulties, failure to gain weight, and failure to thrive, and pyrexia.

2.1.1.2.c Children and Adolescents

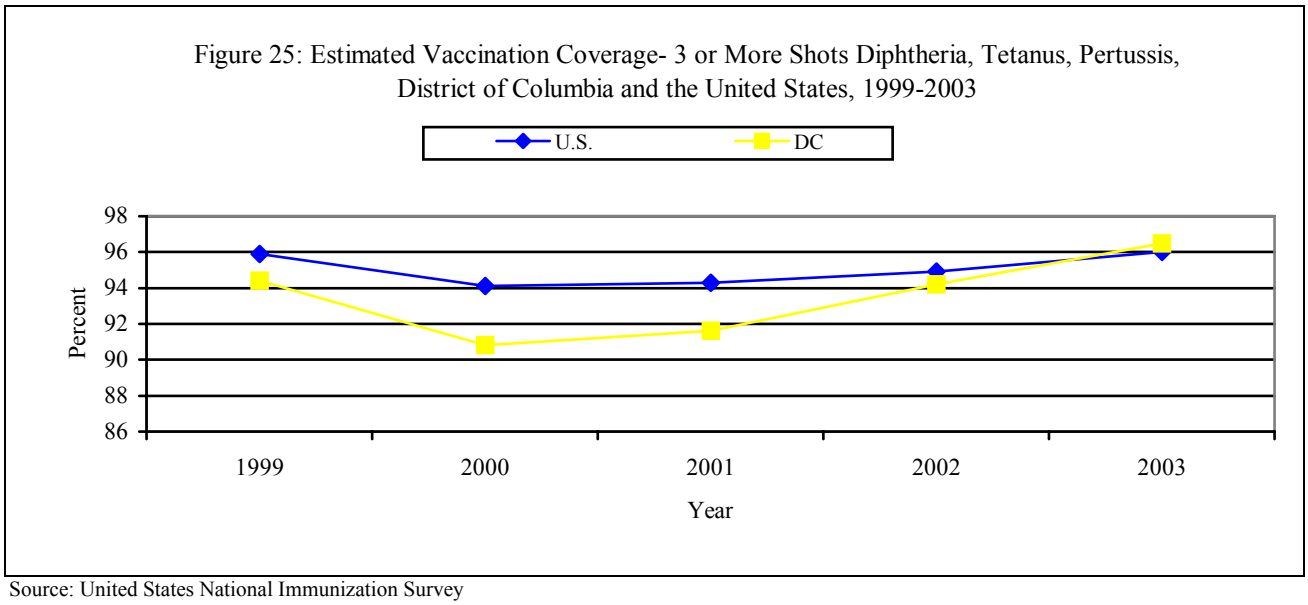
Immunizations: *(National Performance Measure #07)* The Centers for Disease Control and Prevention (CDC) recommends vaccinating children against most vaccine-preventable diseases by the time they are two years old. The District's Healthy People 2010 goal is for 90 percent of children aged 19-35 months to be immunized against DTP, polio, MMR, Hib, hepatitis B, and varicella. The CDC's immunization schedule for children recommends four doses of the diphtheria, tetanus, and pertussis (DTP) vaccine, three or more doses of polio vaccine, one or more doses of the measles-mumps-rubella (MMR) vaccine, three or more doses of the Haemophilus influenzae Type b (Hib) vaccine, the hepatitis B vaccine, and the varicella (chickenpox) vaccine. The DTP, polio, MMR, and Hib vaccines are collectively referred to as the combination series or 4:3:1:3 vaccine.

In 2003, the District of Columbia exceeded the 2010 goal for all these diseases except for varicella immunizations (89%). There was an increase in the proportion of children receiving the recommended doses of vaccines between 1999 and 2003. The increase in immunization rates ranged from 1.2 percent for the Haemophilus influenzae Type b (Hib) vaccine to a 14 percent increase for the varicella vaccine over the five-year period. Vaccination rates increased slightly (0.4 percent) from 1999 to 2003 for the proportion of children aged 19 to 35 months receiving the combined series of vaccines (4:3:1:3), however the rate increased almost 7 percent between 2002 and 2003. (See Figure 24 below)



Source: United States National Immunization Survey

3+DTP, the vaccination commonly given to children between the ages of 19 - 35 months, had lower immunization rates between 1999 and 2002 compared to national rates. However, in 2003, the District's rate increased above that of the US. The overall percent increase in 3+DTP immunization rates for the District increased by 2.2% between 1999 and 2003, compared to only .1% nationally for the same time period. (See Figure 25 below)



Source: United States National Immunization Survey

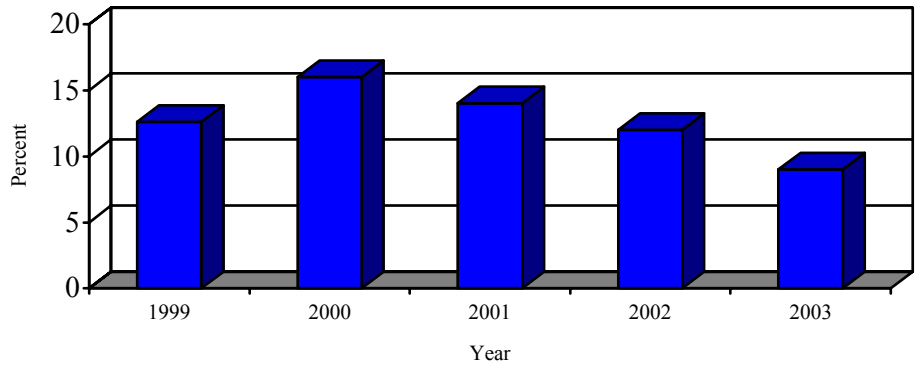
Oral Health: Approximately 33,000 children 5 to 17 years of age and 24,000 young adults 18 to 24 years of age lived in areas of the District of Columbia where there was a shortage of dental health professionals in 2003. See Map 4 above for a visual layout of Dental Health Professional Shortage Areas in the District of Columbia. Twenty-three percent of dentists in the District of Columbia were enrolled in Medicaid and SCHIP in 2003, and there were 15 community-based low-income dental clinics and 3 school-based dental clinics.

There is not much information pertaining to adolescents and oral health in the District of Columbia, but the District's Behavioral Risk Factor Surveillance System (BRFSS) provides a profile for adolescents 18 to 24 years old. In 2002, 15.6% had lost six or more teeth to decay or gum disease, a 6% decline from 1999. Additionally, 75.7% of adolescents had visited a dentist in the past year in 2002, 2.5% less than in 1999, and 72.6% had their teeth cleaned by a dentist or dental hygienist, 8.7% less than in 1999. For younger youth, there is some information from the Early and Periodic Screening, Diagnostic, and Treatment Services program. In 2001, 27.4% of adolescents between the ages of 10 and 20 who were eligible for services received any Dental

Services. The majority of these dental services were preventive. However, in 2003, only 16.7% of youth eligible for this program received dental services.

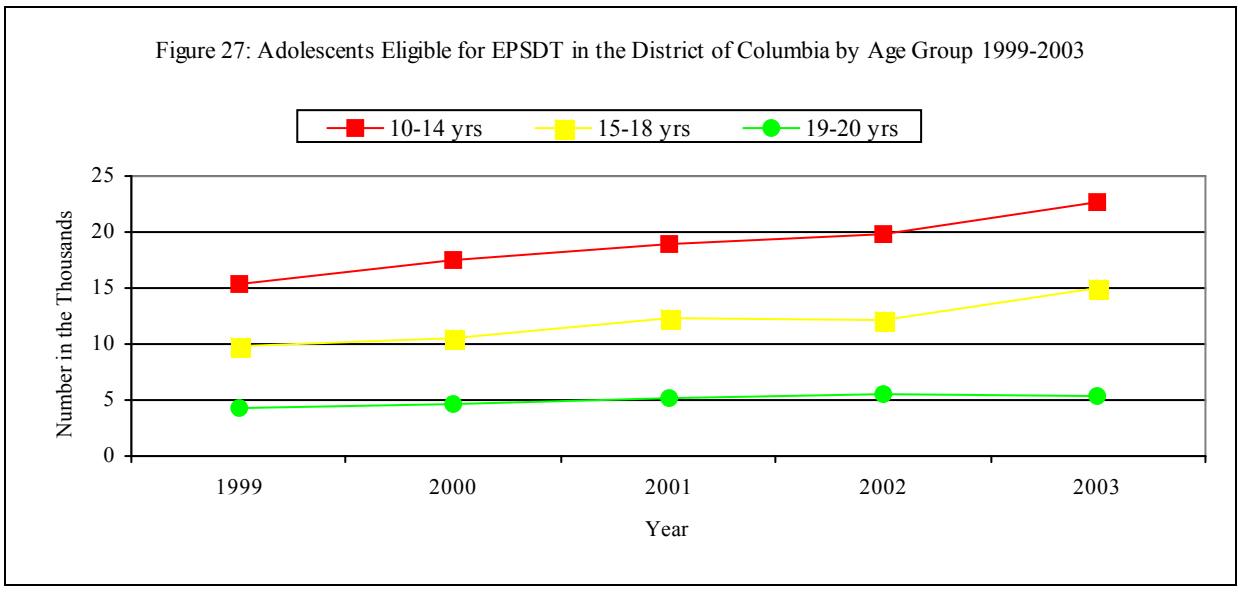
Health Care Coverage, Access/ EPSDT: Although adolescents are considered a healthy population; nevertheless, health care coverage and access are necessary for well being. In the District of Columbia, the percentage of children less than 18 years of age without health insurance coverage had decreased from 16.0% in 2000 to 9.0% in 2003. (See Figure 26 below) Results from the BRFSS in 2002 indicated that 15.1% of 18 to 24 year old youth did not have any kind of health care coverage, down 3.7% from 2001.

Figure 26: Percent of Children <18 Years Old with No Health Insurance
District of Columbia, 1999-2003



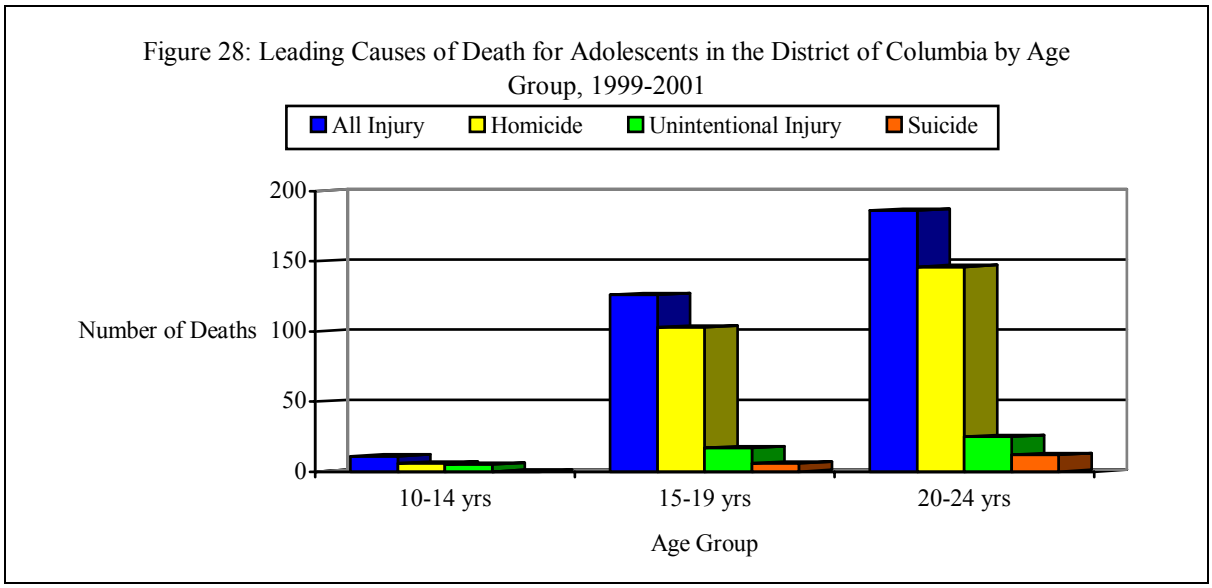
Source: MCH Title V Grant 2005

In 2001, about 10% of the individuals enrolled in Medicaid in the District of Columbia are adolescents between the ages of 15 and 20, and 42,943 adolescents 10 to 20 years old were eligible for the Early and Periodic Screening, Diagnostic, and Treatment Program (EPSDT) under Medicaid in 2003. The number of adolescents between the ages of 10 and 20 eligible for EPSDT has increased 45.4%. (See Figure 27 below) The percentage of eligible persons receiving at least one initial or periodic screen decreases with age among adolescents. For 10 to 14 year olds, 60.3% received at least one initial or periodic screen in 2003, while 49.6% of youth between 15 and 18 participated in this service. An even smaller percentage of 19 to 20 year olds, 33.1%, participated. These participation ratios are reduced compared to peak participation numbers in 2001, where 89.8% of eligible adolescents 10 to 14, 96.1% of youth 15 to 18, and 78.2% of young adults 19 to 20 received at least one initial or periodic screen. With regards to health care access, approximately, 49,000 youths 5 to 17 and 38,000 youths 18 to 24 live in areas where there is a shortage of primary care health professionals.



Source: District of Columbia Department of Health and Human Services. Health Care Financing Administration

Injury & Violence: Between 1999 and 2001, the two leading causes of death for adolescents 10 to 24 years old in the District of Columbia, were homicide and unintentional injury (see Figure 28 below). The majority of homicide deaths to youth were attributable to firearms, most unintentional injury deaths were due to motor vehicle accidents. The mortality rate for adolescent males in 2001 was 234 per 100,000 and the rate for adolescent females was 33 per 100,000 people.



Source: Centers for Disease Control and Prevention: Web-based Injury Statistics Query and Reporting System

Carrying a weapon significantly increases the risk that a violent argument will result in death, disability, or other serious injury. According to the District's Youth Risk Behavior Surveillance

System (YRBSS), there were decreasing trends for adolescents who reported carrying weapons from 34% in 1993 to 20% in 2001; and for carrying guns and from 13.7% in 1993 to 5.7% in 2001. These percentages however rose in 2003 to 25% for students carrying a weapon in the past thirty days and 8% for students carrying a gun in the past thirty days.

In 2003, about 11% of District high school students reported that they carried a weapon on school property in the past thirty days. The Department of Education reported 3 firearm-related expulsions from school during the 2001-2002 school year in the District of Columbia compared to zero in the previous school year. In 2003, about 12 percent of District high school students reported that they had been threatened or injured with a weapon on school property, while 15% engaged in physical fights at least once on school property. These combined dangerous risk behaviors resulted in 14% of students feeling too unsafe to go to school in 2003. A higher percentage of Hispanic students (20%) felt unsafe to go to school than Black students (13%).

Not all violence-related behavior involves weapons. Between 1997- 2003, the percent of District high school students who reported engaging in a physical fight in the past 12 months has had little change from 39.4% in 1997 to 38% in 2003. In 2003, 12% of female students and 18% of male students were involved in one or more physical fights. From 1997 –2003, there was a 34.4% increase in the percent of high school students reporting that they were injured in a physical fight, from 6.4% in 1997 to 8.6% in 2003. In addition, the percent of students who were in a physical fight on school property in the past 12 months decreased from 19% in 1997 to 15% in2003. Reduction in physical fighting among adolescents is a national Healthy People 2010 critical objective adolescent objective.

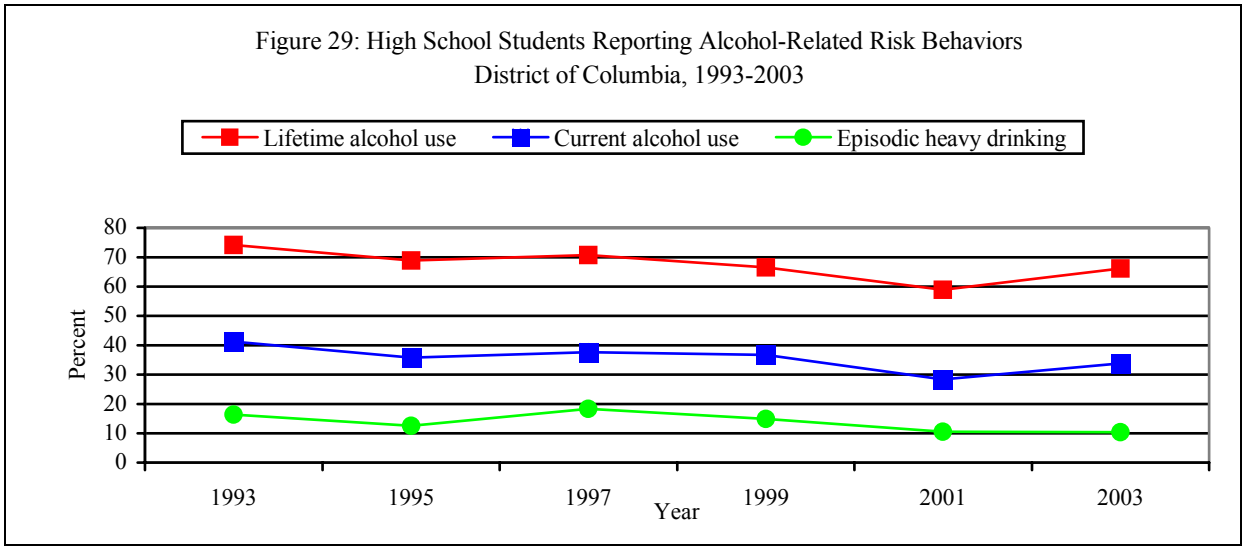
Dating violence is a newly emerging issue for adolescents. It can cause emotional and physical harm for both males and females. Youth who report being victims of dating violence are more likely to have lower self-esteem and to report poor emotional well-being, suicidal thoughts, and disordered eating. Nationally, one-out-of- every 11 high school students was a victim of dating violence in 2003 (CDC). The 2003 YRBSS indicated that 1 out of 10 adolescents in the District had been forced to have sexual intercourse. Sixteen percent of Black high school students reported dating violence in 2003 while only 7% of Hispanic students reported dating violence.

Abuse and Neglect*:* The number of adolescent maltreatment victims ages 12 to 15 in the District of Columbia increased 26.4% between 2000 and 2002. Adolescent victims between 16 and 17

increased minimally. There were approximately 800 victims of maltreatment (12 to 17 years old) in 2002.

In the District of Columbia Courts, for 2003, there were 310 cases filed for abused and neglected youth greater than 11 years old. A total of 853 cases were filed in 2003 for abused and neglected children and youth with an age range of under 1 year to 13 years and older, compared to 1,105 cases in 2002.

Alcohol and Drug Use: Alcohol and drug use are other risk behaviors that adversely affect or compromise adolescent well-being. The District's YRBSS showed a decreasing trend in the past decade for both lifetime and current alcohol use among the adolescent population. However, in 2003, there was an increase in these two risk behaviors where 66.1% of adolescents had ever used alcohol and 33.8% of the students had used alcohol in the past thirty days. (See Figure 29 below)



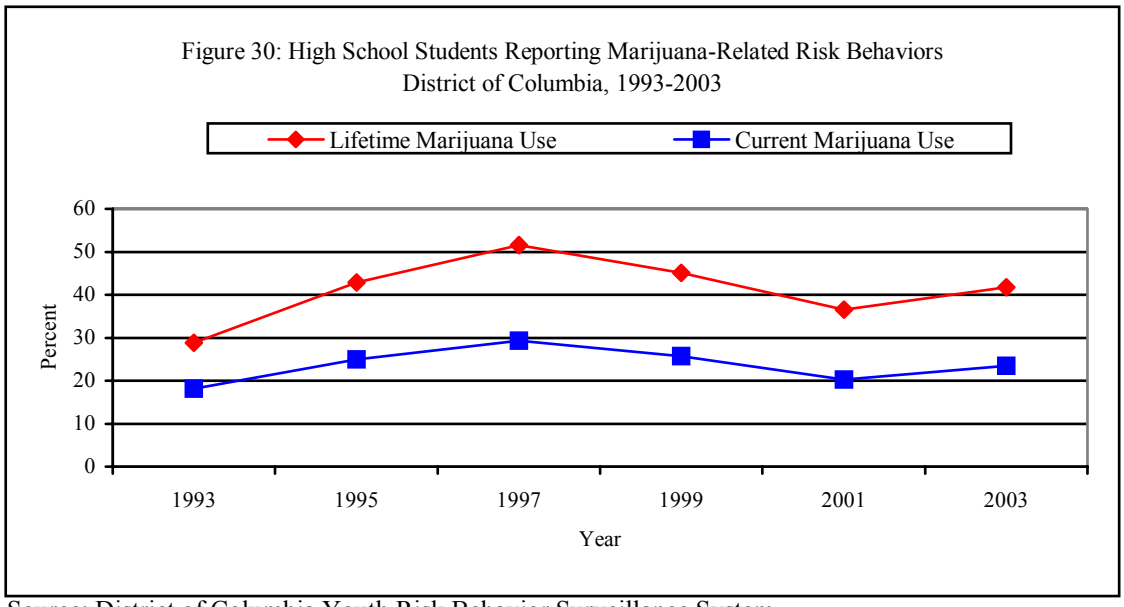
Source: District of Columbia Youth Risk Behavior Surveillance System

Before 2003, the percentage of female high school students in the District of Columbia who had ever drank alcohol was higher than for male high school students, but in 2003, 2% more males than females reported lifetime alcohol use.

The prevalence of episodic heavy drinking was lowest in 2003; 10.3% of high school students drank at least 5 or more drinks on one or more occasions in the past thirty days. This prevalence was much higher for 18 to 24 year olds in 2001; 52.9% drank heavily in the past month at least once, an increase from 1999. However, the risk of heavy drinking was higher in younger

adolescents. Of youth 12 to 17 years old, 50.5% reported the perception of great risk of drinking five or more drinks once or twice a week, while only 41.5% of 18 to 25 year olds reported that same risk. It was estimated that the average age at first alcohol use among persons reporting first use at age 25 or younger in the District of Columbia was 16.5. In 2000, in a study conducted by the District of Columbia Addiction Prevention and Recovery Administration, 2.0% of adolescents 12 to 17 reported alcohol dependence, while 14.0% of those 18 to 24 reported alcohol dependence.

In addition to alcohol use, a prevalent substance abuse-related risk behavior among adolescents is marijuana use. Like many of the risk behaviors covered in the YRBSS, both lifetime and current marijuana use increased in 2003 when there had been a decrease in past years. Of adolescents in grades 9 through 12, 41.7% had ever tried or used marijuana, while almost 1 out of 4 had used marijuana in the past thirty days in 2003. (See Figure 30 below)

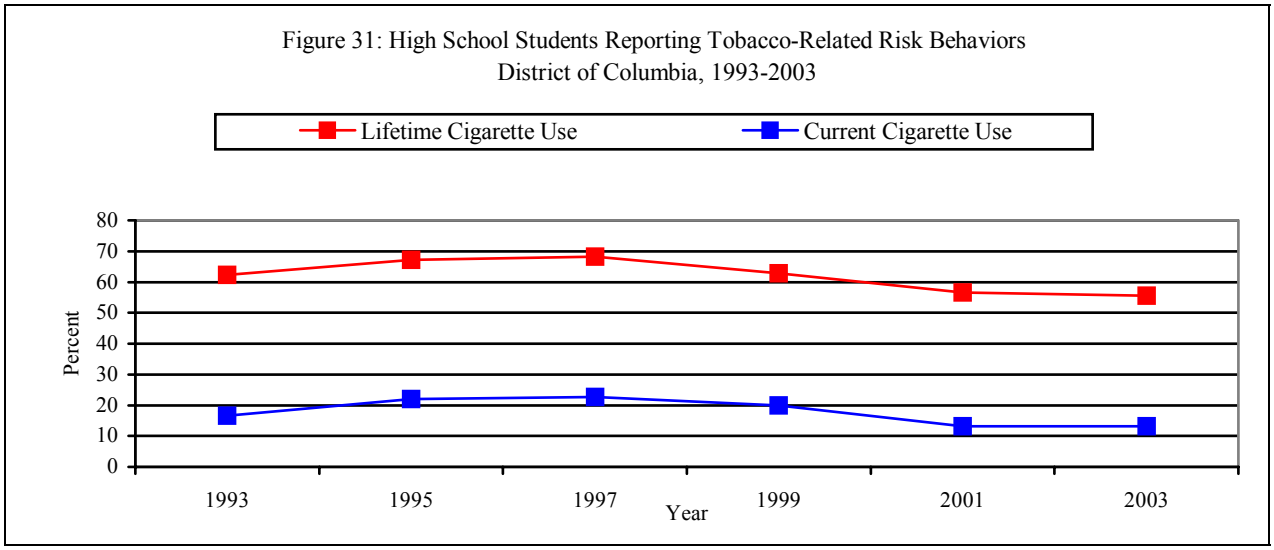


Source: District of Columbia Youth Risk Behavior Surveillance System

The perceived risk of marijuana use, like alcohol, was also greater in younger adolescents; for the 12 thru 17 age group, 33.8% reported the perception of great risk of smoking marijuana once a month, while only 23.1% of youth 18 to 25 reported this same risk. Data from 2000-2001 National Household Survey on Drug Abuse indicated that for 12 to 17 year olds, approximately 2,000 begin smoking marijuana each year, and for 18 to 25 year olds, an average of 4,000 try marijuana for the first time each year. It was also estimated that the average age of first marijuana use among persons reporting first use of marijuana at age 25 or younger was 16.4 years of age.

Tobacco Use: Although cigarette smoking has decreased for youths in high school as well as older adolescents, this trend is not true for other tobacco products. Beginning in 1997, the percentage of high school students who had ever smoked decreased from 68.2% to 55.5% in 2003. In previous years, lifetime cigarette use was higher in males than females, but in 2003, the percentages were equal.

Current cigarette smoking decreased from 22.7% to 13.2% between 1993 and 2003. In 2002, 15.1% of 18 to 24 year olds were current smokers, a decrease of 5% from 2000. (See Figure 31 below) Frequent cigarette use in high school students decreased 4.6% between 1997 and 2001. Lifetime and current cigarette smoking was higher among Hispanic students than Black students; 65.0% of Hispanic adolescents had ever smoked as opposed to 54.1% of Black adolescents. Additionally, 20.3% of Hispanic youth smoked in the past 30 days compared to 11.5% of Black youth.

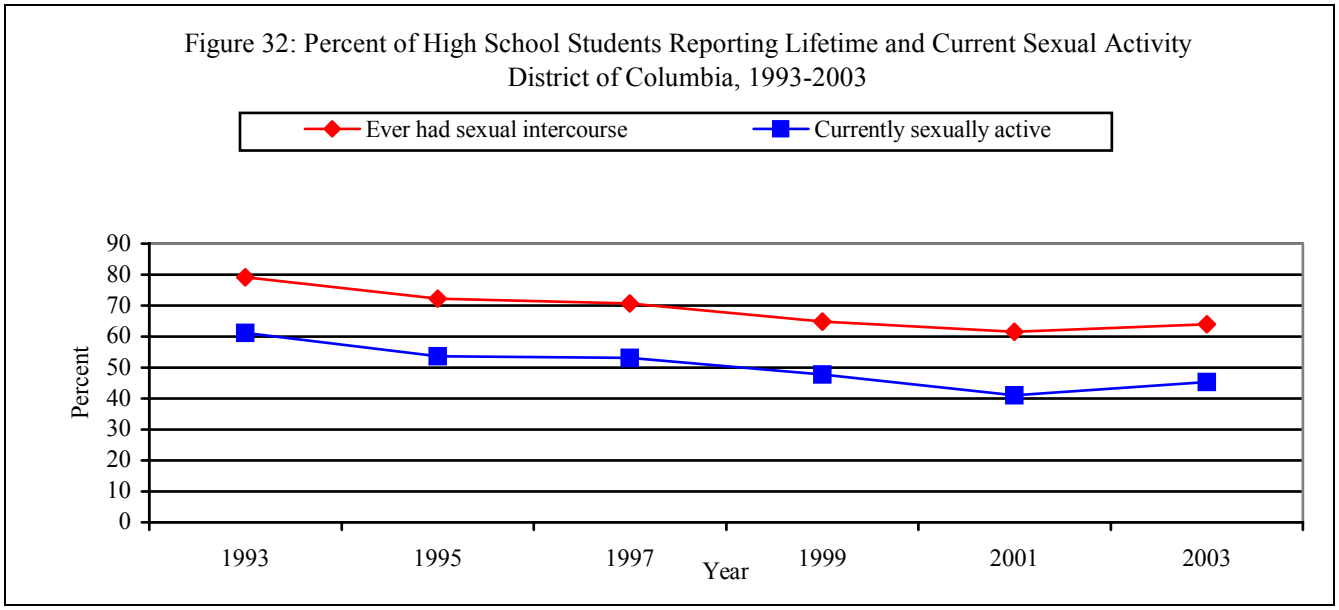


Source: District of Columbia Youth Risk Behavior Surveillance System

Among current smokers between ages 18 and 24, the number trying to quit has also decreased almost 30% between 2000 and 2002. For high school students, 59.5% attempted to quit smoking in 2003. It is estimated that there are 900 new youth smokers in the District of Columbia each year, and about 7,700 kids in the District of Columbia will die early from smoking. Of current smoking high school students less than 18 years of age, 27.6% had purchased cigarettes during the past thirty days.

Reproductive Health

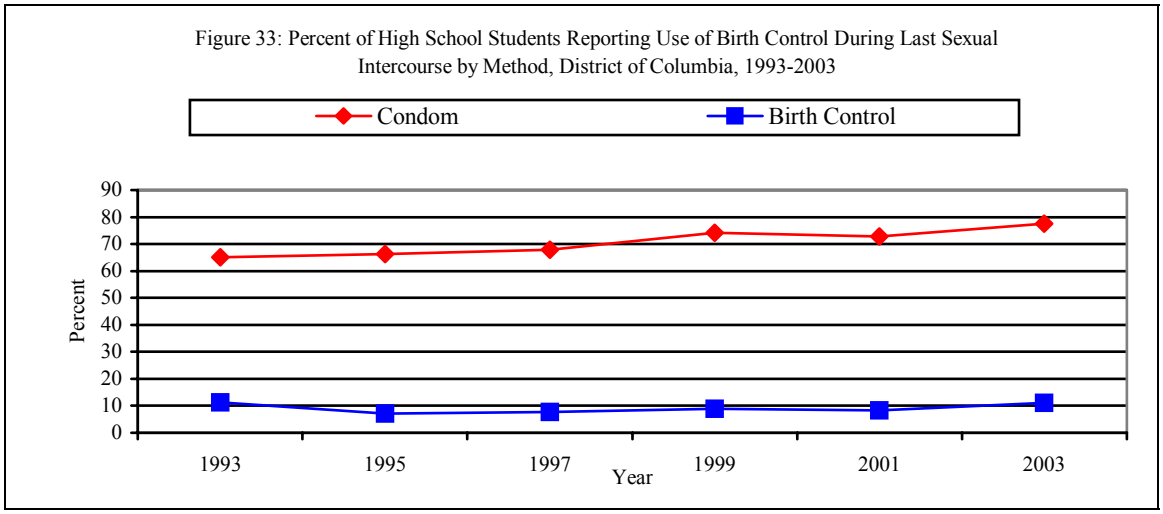
Reviewing adolescent sexual activity, teen pregnancy, and rates of STD's will provide a better understanding of adolescent reproductive health. Sexual activity among youth in the District of Columbia has decreased steadily, with a very small increase in 2003. In 1993, 79.2% of adolescents had ever had sexual intercourse, and 61.2% were sexually active within the past thirty days before the survey was given. A decade later these percentages decreased to 63.9% for lifetime sexual activity and 45.3% for current sexual activity. (See Figure 32 below)



Source: District of Columbia Youth Risk Behavior Surveillance System

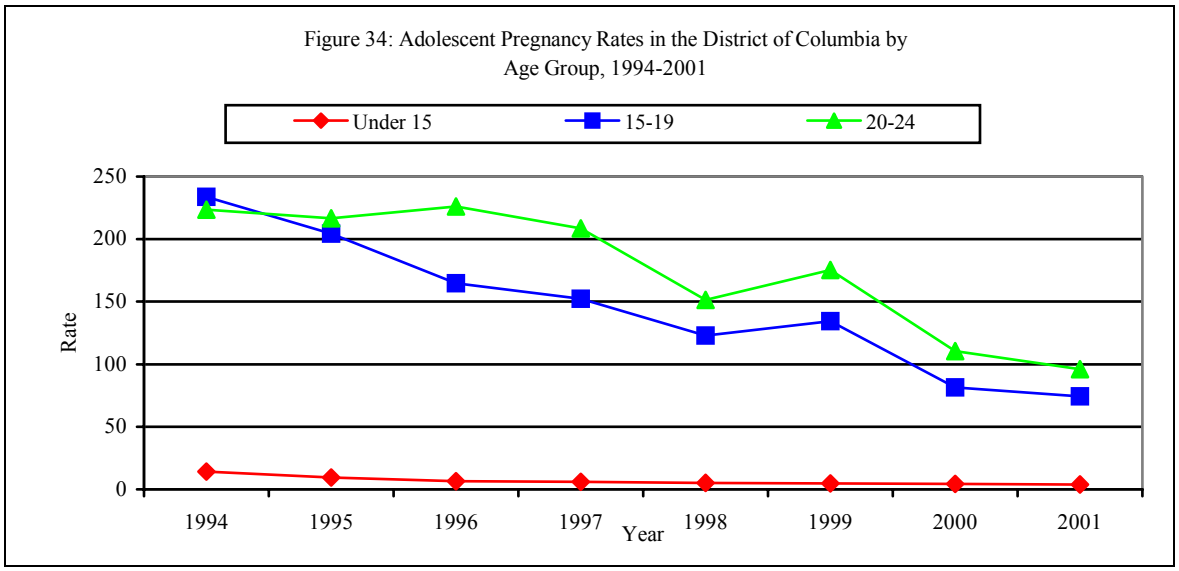
The number of students with four or more partners decreased approximately 20% between 1993 and 2003; a greater percentage of Black high school students- 26.3% reported having four or more partners than Hispanic students-16.3% in the District of Columbia.

Among District high school students, condom use has increased over the past ten years, from 65.0% to 77.5%. This percentage was higher than in similar cities like Detroit and Philadelphia where 70.9% and 70.2% of adolescents used condoms during their last intercourse. In 1993, 11.2% of adolescents in the District of Columbia were using birth control pills during their last sexual intercourse, this number decreased in 1995 and stayed low, but increased to 11.1% in 2003. (See Figure 33 below) Males in the District reported use of birth control during last intercourse more than females in 2003; this difference was approximately 3%.



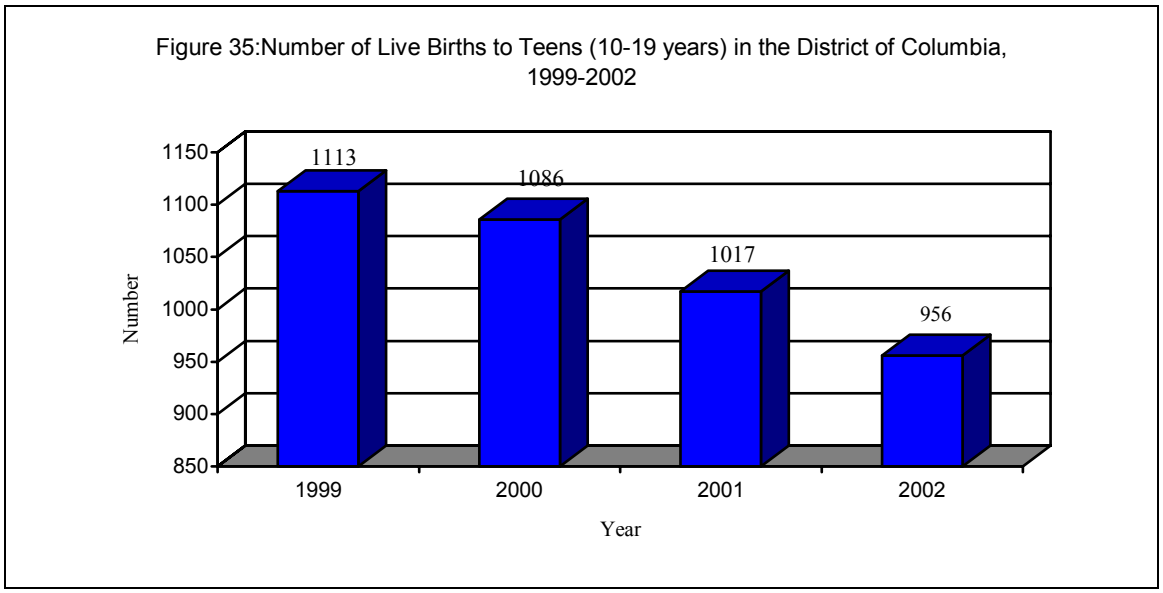
Source: District of Columbia Youth Risk Behavior Surveillance System

Teen Pregnancy and Births: (*National Performance Measure #08*) Adolescent pregnancy rates in the District of Columbia have also decreased steadily for all age groups. The rate in 2001 for teens less than 15 years of age was 3.7 per 1,000, 74.4 per 1,000 for 15 to 19 year olds, and 96.1 pregnancies per 1,000 for 20 to 24 year olds. (See Figure 34 below)



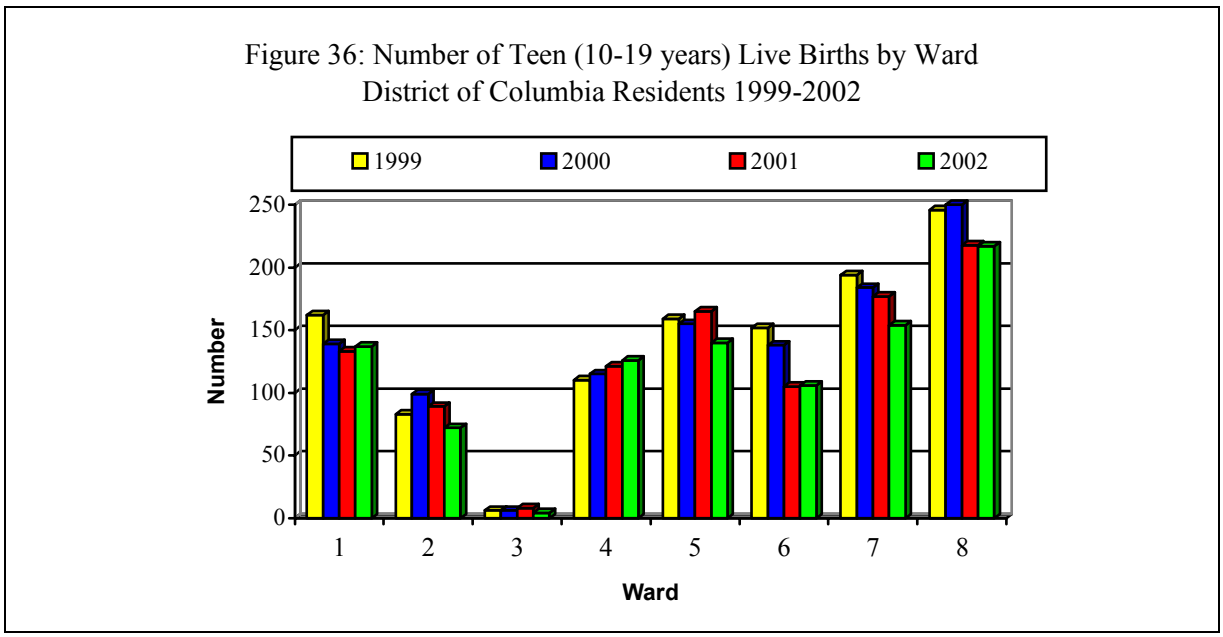
Source: District of Columbia Department of Health State Center for Health Statistics Administration

Teen births have also declined in the District of Columbia. (See Figure 35 below) In 1999, 14.9% of all births were births to teenage mothers, and in 2002, 12.8% of all births were teen births.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

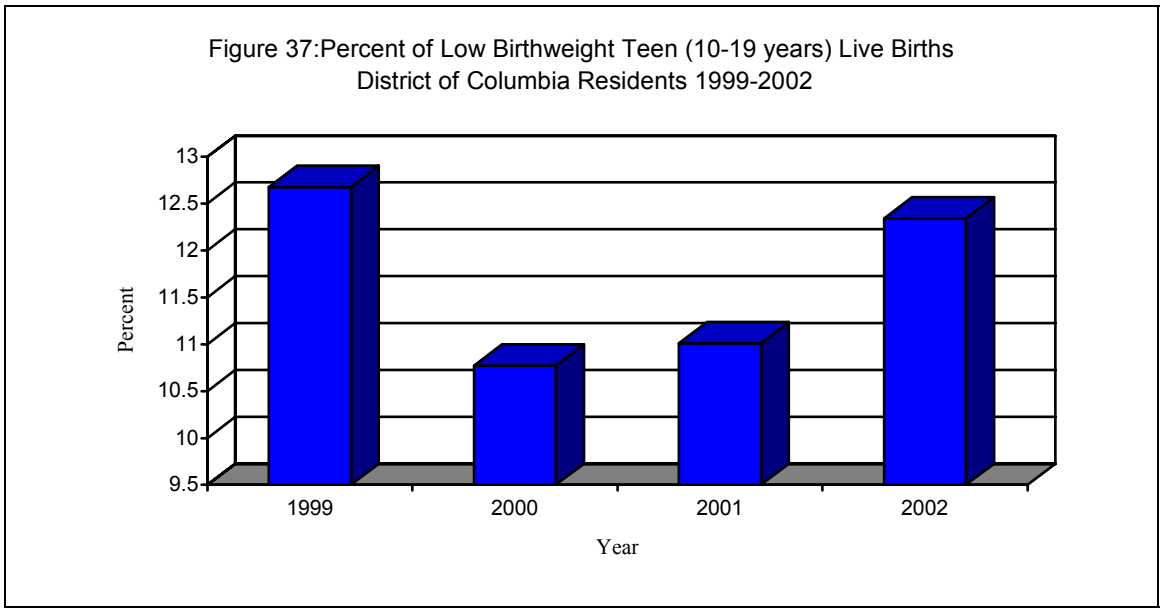
The number of teen births (10 to 19 years old) decreased 20.6% for Ward 7 between 1999 and 2002. Between 2000 and 2002, teen births decreased 13.2% for Ward 8 and 27.3% for Ward 2. Ward 4 experienced a 14.5% increase in the number of teen births between 1999 and 2002. (See Figure 36 below)



Source: District of Columbia Department of Health State Center for Health Statistics Administration

Approximately 12% of teen mothers in 2002 did not receive prenatal care or began prenatal care in the third trimester, and almost one third of teenage mothers received inadequate prenatal care.

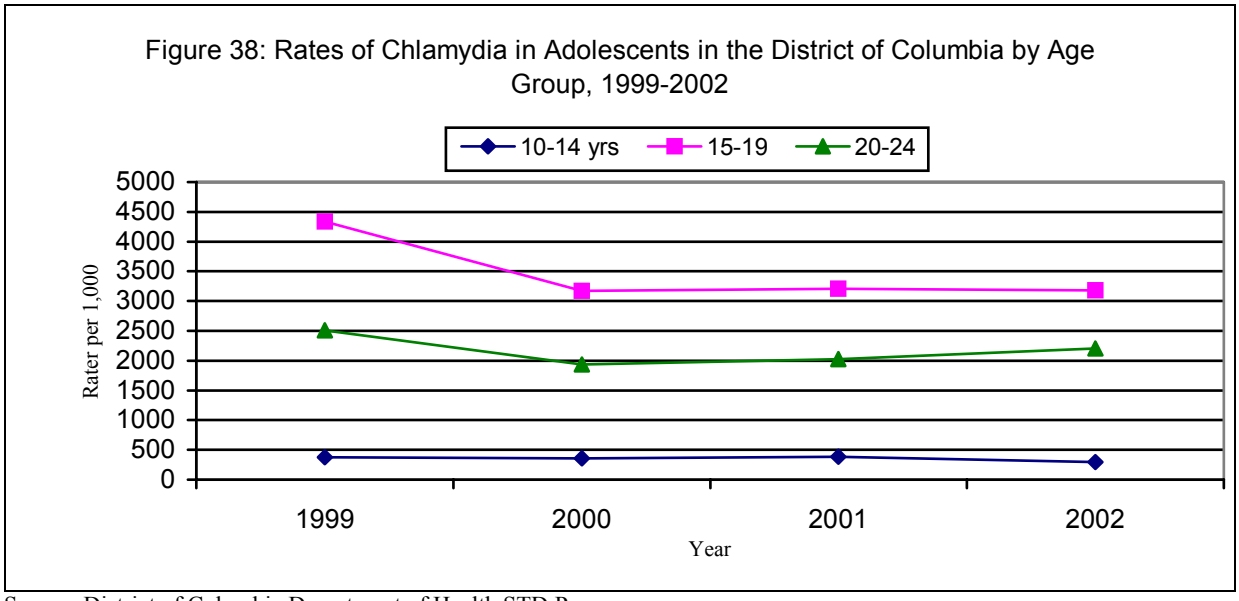
The number of low birth weight births among teens decreased almost 2% from 1999 to 2000, but there was an increase in the percentage of low birth weight births in 2001 and 2002. (See Figure 37 below) The number of teen births for black adolescents has declined 19.6% since 1999 while the number of births to White mothers has not changed significantly, and the number of births to Hispanic mothers increased 20.7%.



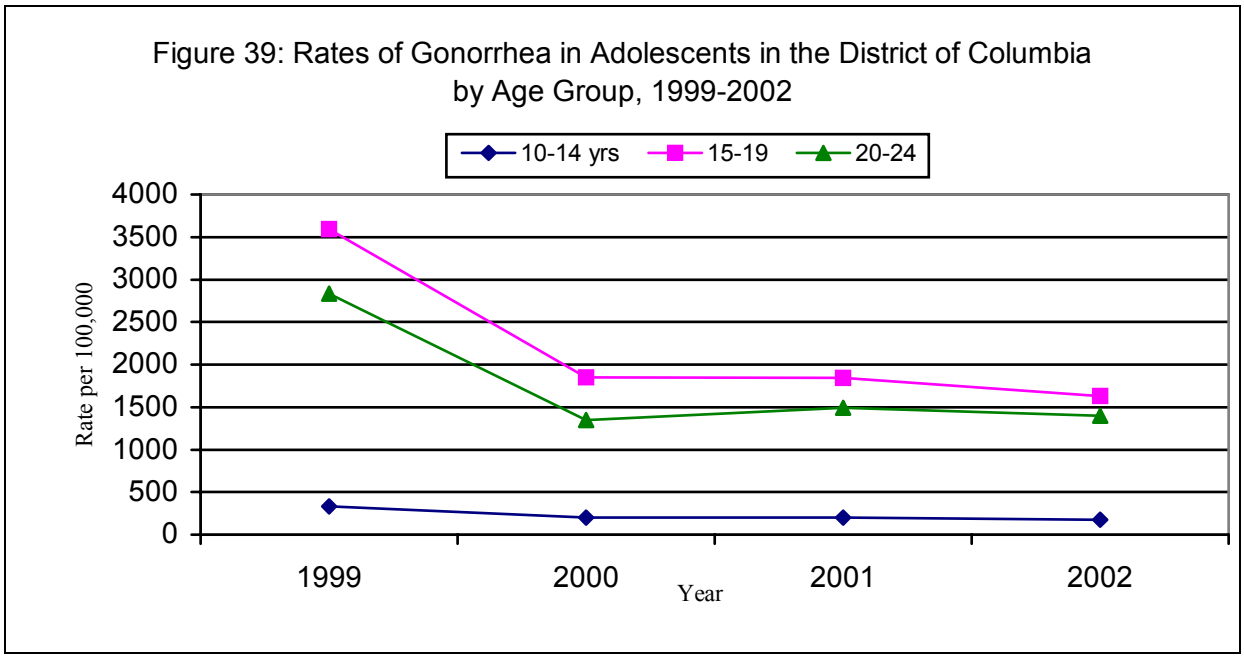
Source: District of Columbia Department of Health State Center for Health Statistics Administration

Between 1999 and 2001, the abortion rate for teens also declined. In 2001, the abortion rate for teens between the ages of 10 and 19 was 14.8 per 1,000, and 33.5% of teen pregnancies ended in an induced abortion.

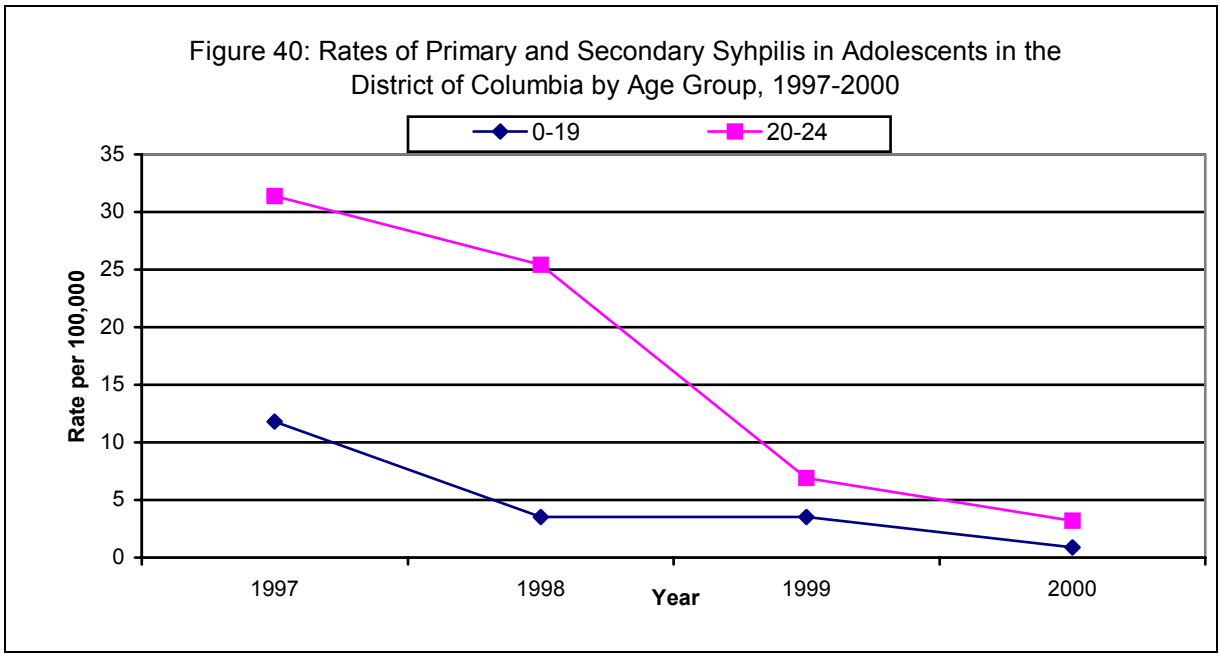
Sexually Transmitted Infections (STIs): (*Health Status Indicator Measure #05a & #05b*) Among adolescents, rates of primary and secondary syphilis and gonorrhea have decreased, but rates of Chlamydia have remained steady. Of all STD's, the highest number of adolescent cases were for Chlamydia, and there has been a significant decrease in primary and secondary syphilis. (See figures 38, 39 & 40) Generally, STD rates were higher in females than males, and the 15 to 19 age group is most vulnerable to Chlamydia and Gonorrhea infection.



Source: District of Columbia Department of Health STD Program

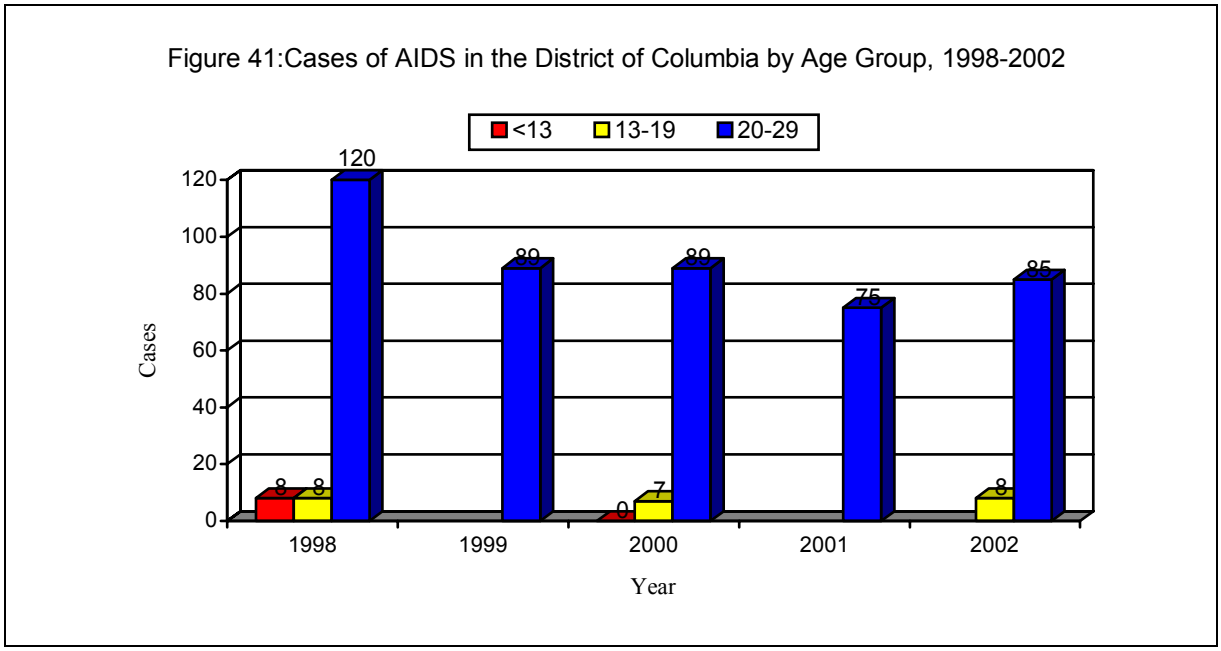


Source: District of Columbia Department of Health STD Program



Source: District of Columbia Department of Health STD Program

The number of HIV/AIDS cases diagnosed each year remains low for person less than 19 years of age, and there has been no significant change in the number of cases among 20 to 29 year olds. (See Figure 41) Between 1990 and 2002, for adolescents 13 to 19 years of age the primary mode of transmission was through heterosexual contact whereas the primary mode of transmission for 20 to 29 year olds was men having sexual intercourse with other men.



Source: Epidemiologic Profile for the District of Columbia 2004 HIV/AIDS

Physical Activity and Nutrition: Because physical activity and nutrition can affect the outcome of such health problems as obesity and Type II diabetes, these are two areas of relevance for adolescent well being. Over the past ten years, there has been no significant change in the percentage of adolescents participating in vigorous physical activity. In 2003, 44.4% of high school students in the District of Columbia participated in sufficient vigorous physical activity (exercised or participated in physical activities for at least 20 minutes that made them sweat and breathe hard on three or more of the past seven days). In 1999, there was a 17.6% decrease in the percentage of students participating in sufficient moderate physical activity. This decrease continued through 2001, and increased slightly in 2003 where only 15.5% of high school students were participating in moderate physical activity (participated in physical activities that did not make them sweat or breathe hard for at least thirty minutes on five or more of the past seven days). One in five adolescents in grades 9 through 12 did not participate in any vigorous or moderate physical activity in 2003.

The number of students enrolled in Physical Education fluctuated throughout the past decade with the lowest percentage in 1993 at 43.2% and the highest percentage in 1997 at 66.6%. In 2003, 53.3% of students were enrolled in P.E., and 18.8% of students participated in P.E. daily. There was, however, a decline in the percentage of students both male and female, watching T.V. for greater than 3 hours per day on an average school day from 63.9% to 56.7% between 1999 and 2003. In 2000, it was estimated that 66.8% of 18 to 24 year olds were at risk for health problems related to lack of exercise.

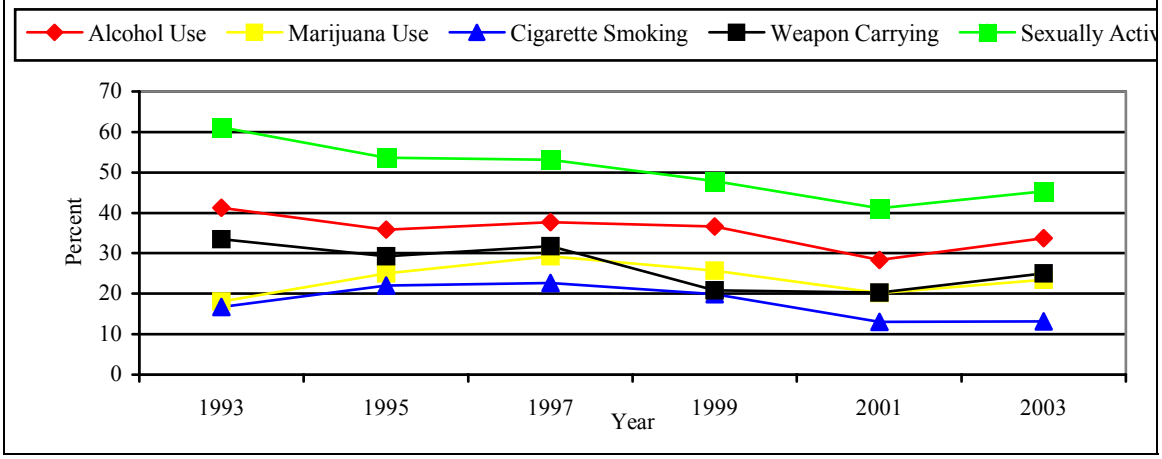
In the District of Columbia, 21.3% of high school students had five or more servings of fruits and vegetables per day for the past seven days. Of adolescents 18 to 24 years of age, 33.1% ate fruits and vegetables five or more times a day. Very few high schools students, 5.7%, had three or more glasses of milk per day for the past seven days.

Approximately 82% drank one hundred percent fruit juices at least once a day for the past seven days. Of District of Columbia schools, 100% sold soft drinks, sports drinks, or fruit drinks, and 81.8% offered 100% fruit juices. Only 23.8% of schools offered fruits or vegetables for students to buy. For adolescents between 18 and 24 years of age, the percentage reporting a diagnosis of high cholesterol increased from 5.9% in 1999 to 21.5% in 2002.

Risk Behaviors Before Age 13 and Current Risk Behaviors: The YRBSS surveys high school students to evaluate participation in certain risk behaviors before age 13 which include first sexual intercourse, alcohol use, smoking cigarettes, and marijuana use. Of possible risk behaviors, the highest percentage of District adolescents drank alcohol before age 13 for both females and males in 2003, but in previous years males reported engaging in sexual intercourse before age 13 more than drinking alcohol. Conversely, the percentage of females reporting first sexual intercourse before age 13 was low and became the least prevalent risk behavior before age 13 in 2003. Overall, the percentages of females reporting any risk behavior were lower than the percentages for corresponding risk behaviors in males.

Among the current risk behaviors (past thirty day) surveyed in YRBSS, the highest number of students were engaging in sexual activity for the years in which the survey was conducted followed by alcohol use. In 2001 and 2003, the percentage of high school students currently smoking marijuana was almost equal to the percentage currently carrying a weapon in the District of Columbia. Current cigarette smoking was the least prevalent risk behavior among high school students. (See Figure 42 below)

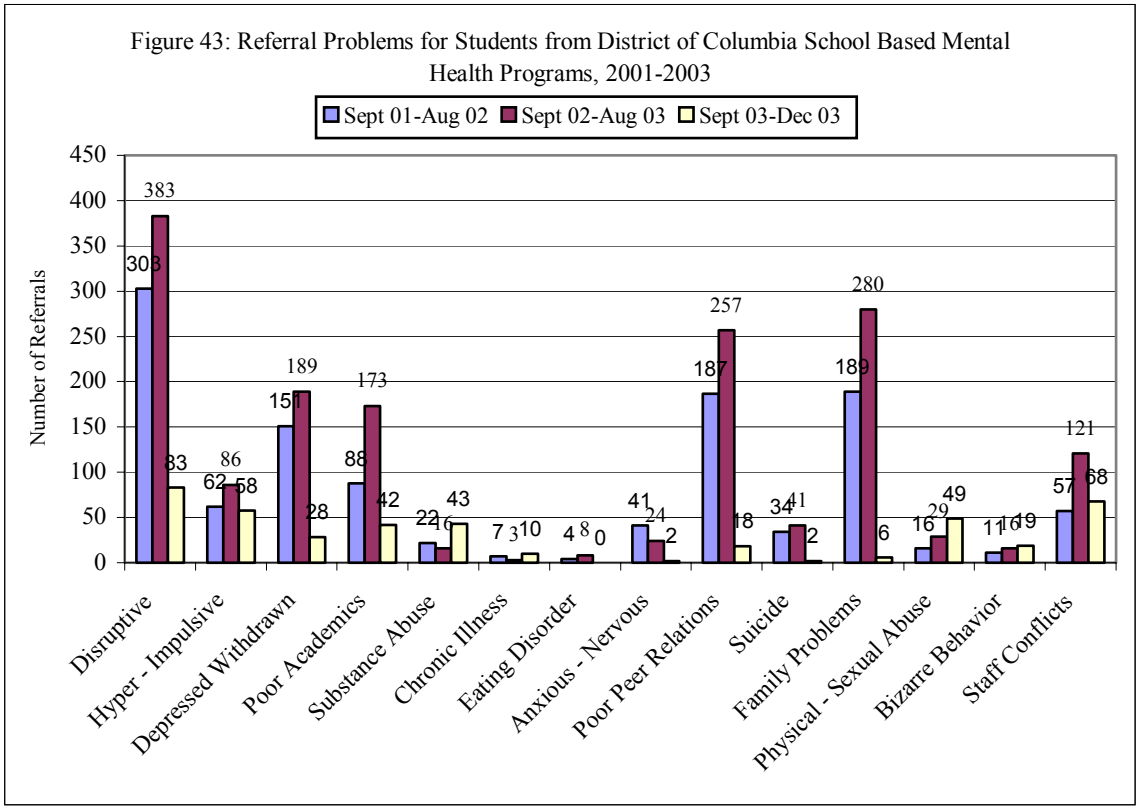
Figure 42: Current (Past 30 days) Risk Behaviors in High School Students
District of Columbia, 1993-2003



Source: District of Columbia Youth Risk Behavior Surveillance System

Mental Health: Approximately 10.0% of individuals between 18 and 25 years of age in the District of Columbia suffer from a serious mental illness. Wards 8 and 7 have mental health professional shortage areas, and roughly 25,000 people 5 to 24 years of age live in these areas. See Map 4 above for a visual layout of Mental Health Professional Shortage Areas in the District of Columbia. The District of Columbia Department of Mental Health has developed a

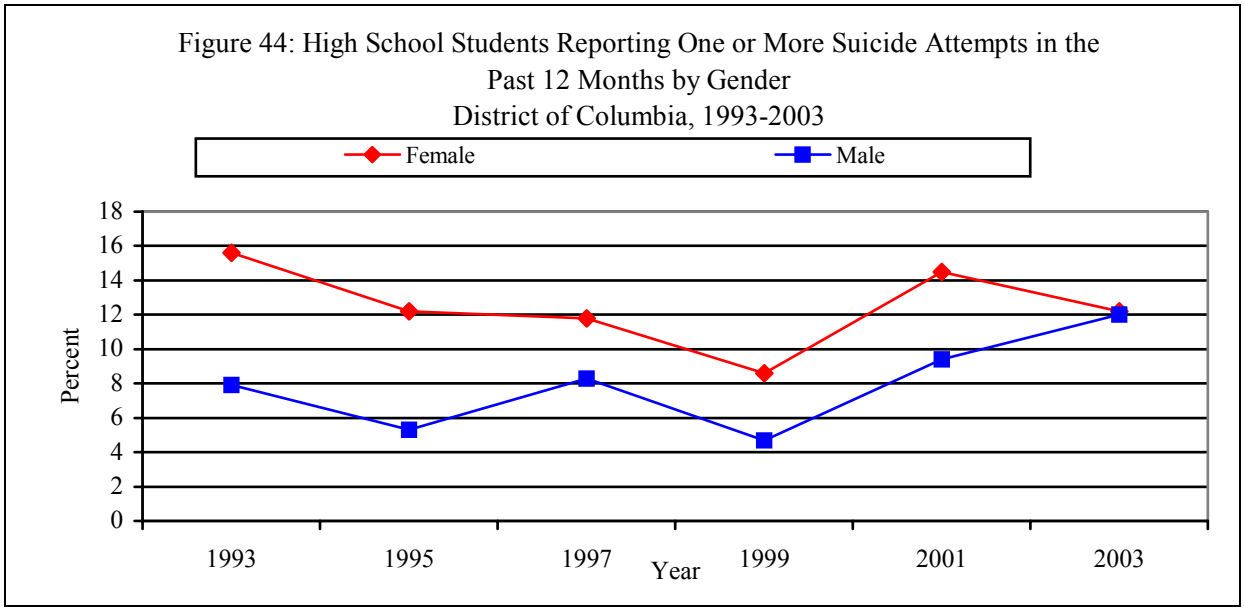
School-Based Mental Health Program. In each of the schools that partners with the Department, a clinician provides mental health care with three main components: primary prevention, secondary prevention, and clinical services. For the 2001-2002 and 2002-2003 school years, the top three problems in referrals for mental health services were disruptive behavior, family problems, and poor peer relations. (See Figure 43 below)



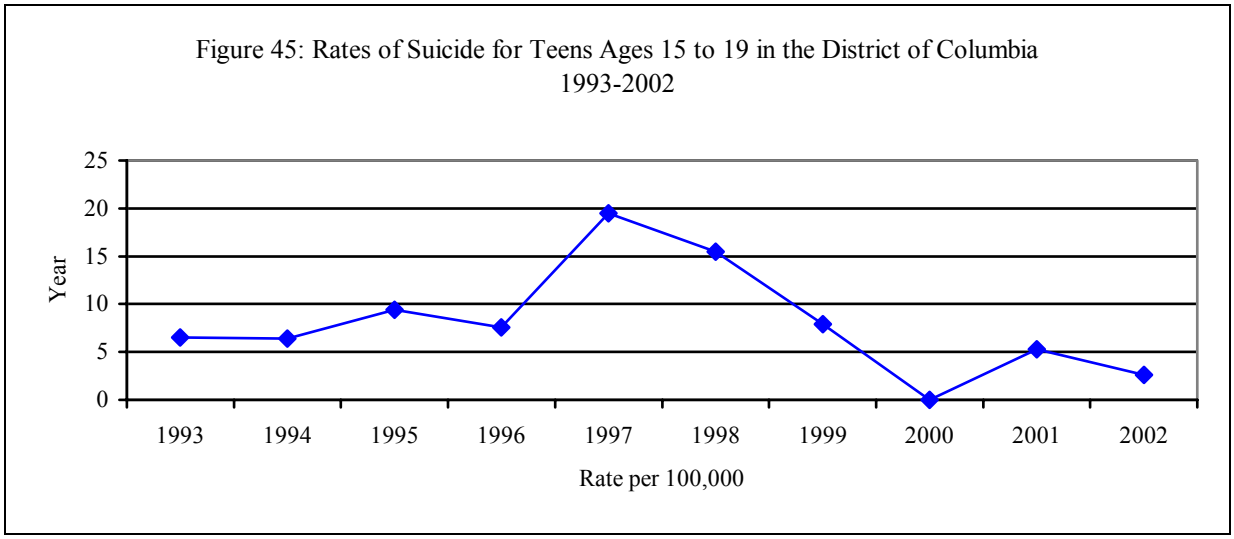
Source: Department of Mental Health

One mental health issue affecting adolescents in particular is suicide. From the School-Based Mental Health Program, the Department of Mental Health received thirty-four referrals for mental health services because of suicide in the 2001-2002 school year and forty-one referrals in the 2002-2003 school year. In the District, 14.2% of high school students had thought seriously about suicide in 2003, and the percentage of students attempting suicide in the past 12 months increased 5.4% from 1999 to 2001, remaining at about 12% in 2003. In past years, a smaller percentage of males than females reported suicide attempt each year, but over time, female suicide attempts decreased while male suicide attempts increased, and in 2003, these percentages were approximately equal between the sexes. (See Figure 44 below) For adolescents 10 to 19 years of age, deaths from suicides have fluctuated. There were no deaths in 2000, but 3 deaths in 2001. Between 1993 and 2001, male deaths from suicide outnumbered female deaths for all years except for 1996 and 1999 where the numbers of male and female deaths were equal. In

2002, the rate of suicide for teens between 15 and 19 years of age was 2.6 per 100,000. (See Figure 45 below)



Source: District of Columbia Youth Risk Behavior Surveillance System



Source: District of Columbia Department of Health State Center for Health Statistics Administration

Leading Causes of Death: In 2000, 49 percent of all deaths among US teens aged 15-19 years resulted from unintentional injuries, 14% were from homicides or assault and about 12% were attributed to suicides. Among District of Columbia males aged 15-24 the top three causes of death ranked similar to the nation while for females they ranked homicide, HIV and unintentional injury were the top three leading causes of mortality.

Suicide ranked eighth over the 4-year period for female adolescents and young adults in the District. The rates of homicides increase dramatically for males in the District throughout adolescence and young adulthood and adolescent males are more than ten times likely than females to be homicide victims.

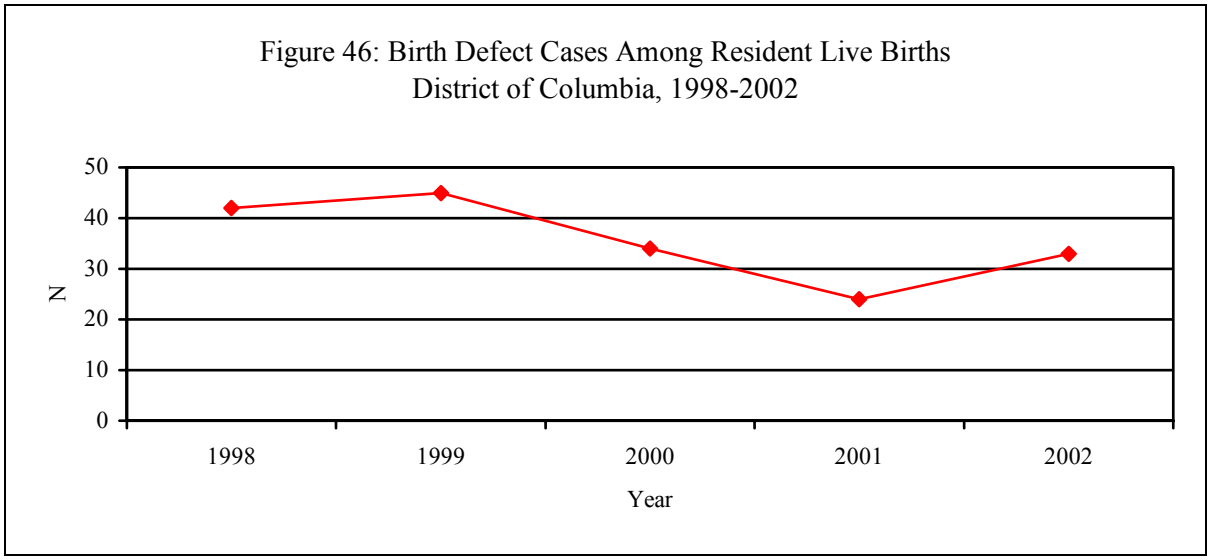
Hospitalizations*:* Between 1998-2002, admissions to the hospital for children 1-14 years of age comprised about 3% of the total hospital admissions to District hospitals by District residents. Diseases of the respiratory system accounted for 25%- 35% of all admissions for this age group. After diseases of the respiratory system, injury and poisoning, infectious and parasitic diseases, diseases of the blood and blood forming organs, and symptoms, signs and ill-defined conditions were the most common reasons for hospitalization among this population.

Between 1998 and 2002 there was an overall 10.6% decrease in the number of admissions to the hospital for this age group from 2,560 in 1998 to 2,288 in 2002. Primary causes of hospitalization among this age group with diseases of the respiratory system were pneumonia and influenza (primarily pneumonia), asthma, and acute bronchitis and bronchiolitis. Between 1998-2002, admissions for asthma accounted for 49-55% of all admissions for diseases of the respiratory system. The most common diagnosis for injury and poisoning were fractures, burns, intracranial injuries excluding skull fractures, poisoning, and complications of surgical and medical care not elsewhere classified. Common diagnosis for infectious and parasitic disease included HIV/AIDS, septicemia, viral infection in conditions classified elsewhere and of unspecified site, and intestinal infections due to other organisms. Primary diagnosis for hospitalizations due to symptoms, signs and ill-defined conditions were convulsions, and other symptoms involving abdomen and pelvis including abdominal pain. Overwhelmingly, sickle cell was the most common diagnosis for diseases of the blood and blood forming organs among this age group. Between 1998-2002 hospital admissions for sickle cell accounted for 74-82% of all admissions for diseases of the blood and blood forming organs.

2.1.1.2.d Children with Special Health Care Needs

Birth Defects*:* Birth Defects are referred to as a multitude of structural, functional, or metabolic abnormalities present at birth. The etiology of most birth defects has still yet to be determined. Children with birth defects account for 25-30 percent of all pediatric hospital admissions in the District of Columbia. Based on an estimated annual cost of $240,000 per case, the 33 cases of birth defects reported in 2002 for the District of Columbia would cost approximately $7.9 million.

Figure 46 below shows the number of birth defect cases reported in the District's live birth file for the period of 1998-2002.



Source: District of Columbia Department of Health State Center for Health Statistics Administration

In 1998 and 1999, Hispanic/Latino mothers were more likely to deliver an infant with a birth defect than Black and White Non-Hispanic mothers. However, from 2000-2002, the birth defect incidence rate for Hispanic/Latino mothers dropped below the rates for their Black and White Non-Hispanic counterparts. Between 1998 and 2002, the rates for Black Non-Hispanic women remained steady, while the rates for White Non-Hispanic women alternated between being higher and lower than Black Non-Hispanic women's rates. In 2002, the rates for Black and White Non-Hispanic women converged. From 1998 to 2000, "Other" mothers were more likely to deliver an infant with a birth defect than Black and White Non-Hispanic mothers. However, in 2001 and 2002, the birth defect incidence rate for "other" mothers dropped to zero below the rates for their White Non-Hispanic, Black Non-Hispanic, and Hispanic counterparts.

Table 17 below shows the number of presentations for each condition, if the number of presentations exceeded 1for the year.

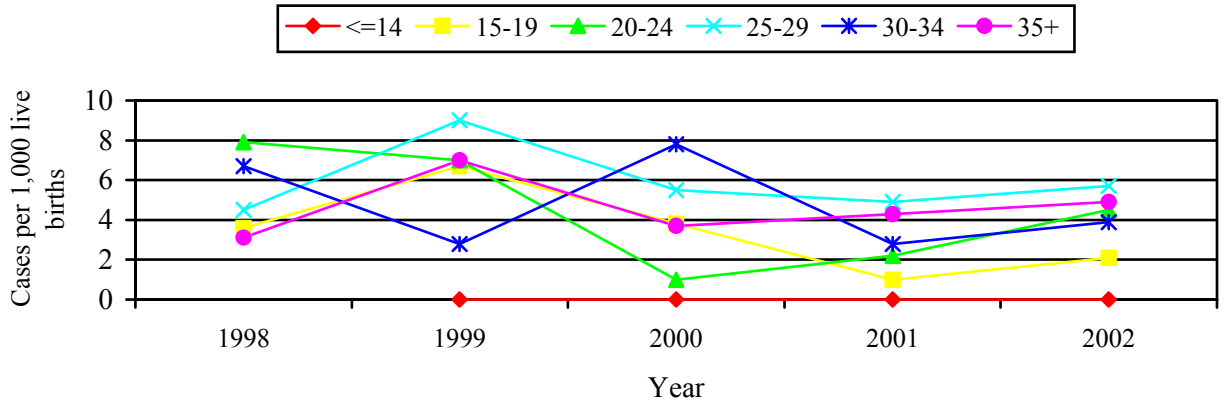
Table 17: Case Frequency of Congenital Anomalies Among District of Columbia Resident Live Births, 1998-2002

	1998	1999	2000	2001	2002
Anencephalus			6		
Other Musculoskeletal Anomalies				2	3
Hydrocephalus		3		2	2
Malformed Genitalia				3	2
Cleft Lip/Palate			2		
Heart Malformations	3	4			2
Other Circulatory/Respiratory Anomalies	4				
Omphalocele/Gastroschisis	2		5		2
Other Gastrointestinal Anomaly	2				
Renal Agenesis		2			
Polydactyly/Syndactyly/Adactyly		4	2		2
Club Foot	3			2	2
Down's Syndrome	2		3	2	
Other Urogenital Anomalies					3
Other Chromosomal Anomalies	2	2			
Other	22	30	11	12	17

Source: District of Columbia Department of Health State Center for Health Statistics Administration

In 1998, mothers between the ages of 20-24 and 30-34 had the highest incidence rates of delivering infants with births defects. However, in 1999, mothers between the ages of 25-29 demonstrated higher rates, followed by 30-34 year old mothers in 2000. In 2001 and 2002, 25-29 year old mothers, and mothers aged 35 and older, had the higher incidence rates. See Figure 48 below. Data for mothers aged 14 and younger in 1998 were not included due to there being one case among a very small number of births to this age group; thus, giving the incidence rate too much weight and appearing disproportionately large compared to the other age groups.

Figure 48: Birth Defect Incidence Among Resident Live Births by Maternal Age
District of Columbia 1998-2002



Source: District of Columbia Department of Health State Center for Health Statistic Administration

Table 18 below illustrates the number of cases in each ward for the years 1998-2002. With the exception of 1999, Ward 8 had the most cases of birth defects over the five- year period.

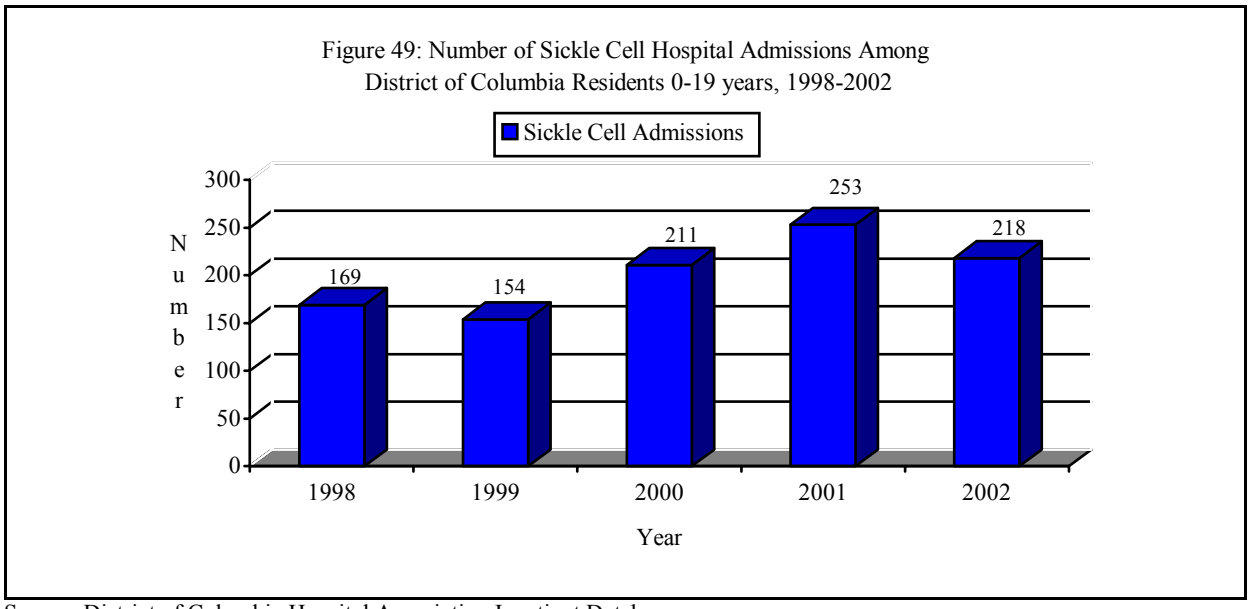
Table 18: Number of Birth Defect Cases Among Resident Live Births by Ward of Residence, District of Columbia 1998-2002.

Ward	1998	1999	2000	2001	2002
1	6	6	5	3	5
2	7	3	2	2	4
3	1	8	1	2	3
4	2	8	5	3	1
5	6	4	4	3	2
6	7	5	4	2	4
7	5	5	5	1	6
8	8	7	7	7	8

Source: District of Columbia Department of Health State Center for Health Statistic Administration

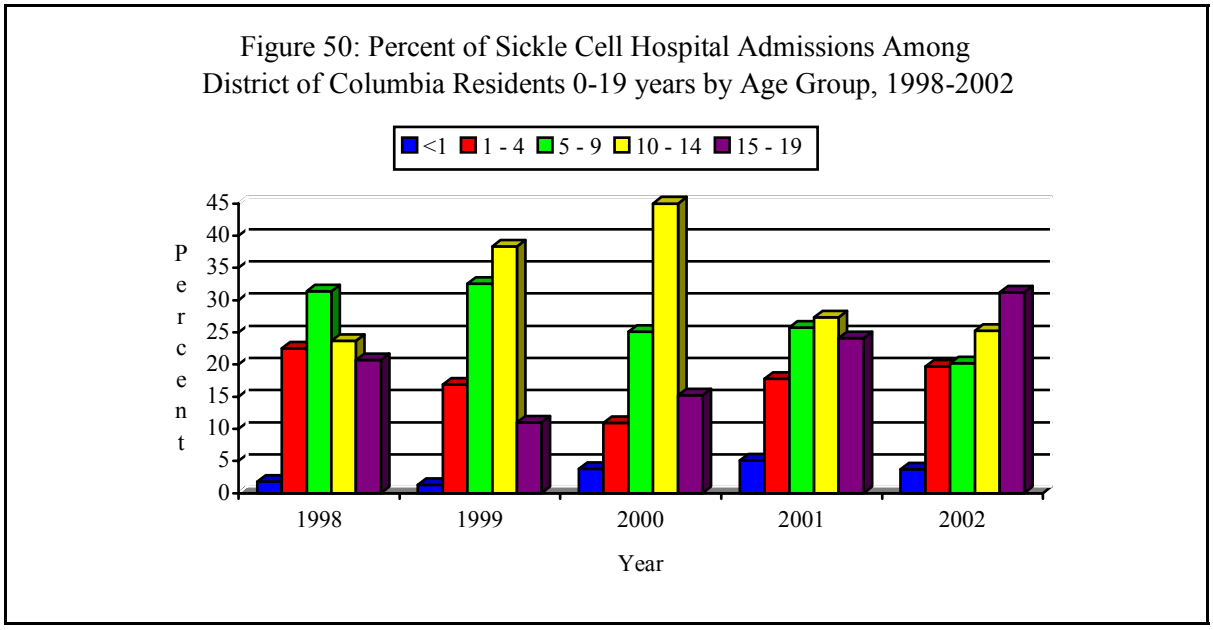
Folic Acid Knowledge: It is estimated that nationally approximately 50% of the cases of neural tube defect could be prevented with adequate levels of folic acid from the time of conception throughout pregnancy. Increasing the proportion of women of childbearing age who take folic acid is one of the District's health objectives for the year 2010. In 2002, 76% of women responding to the District's PRAMS survey said they had heard or read that taking the vitamin folic acid could prevent some birth defects. This was up from 63% in 1998, possibly indicating that the message is spreading regarding the importance of folic acid intake. Unlike in 1998, there was no difference in the response found when comparing racial groups.

Sickle Cell: Sickle cell disease is an inherited blood disorder that affects red blood cells. It is called sickle cell because sometimes the red blood cells of a person with sickle cell become crescent-shaped (sickle shaped) and have difficulty passing through small blood vessels. Between 1998-2002, inpatient hospital admission among District children 0-19 for sickle cell disease varied between 154 to 253 admissions per year. (See Figure 49 below)



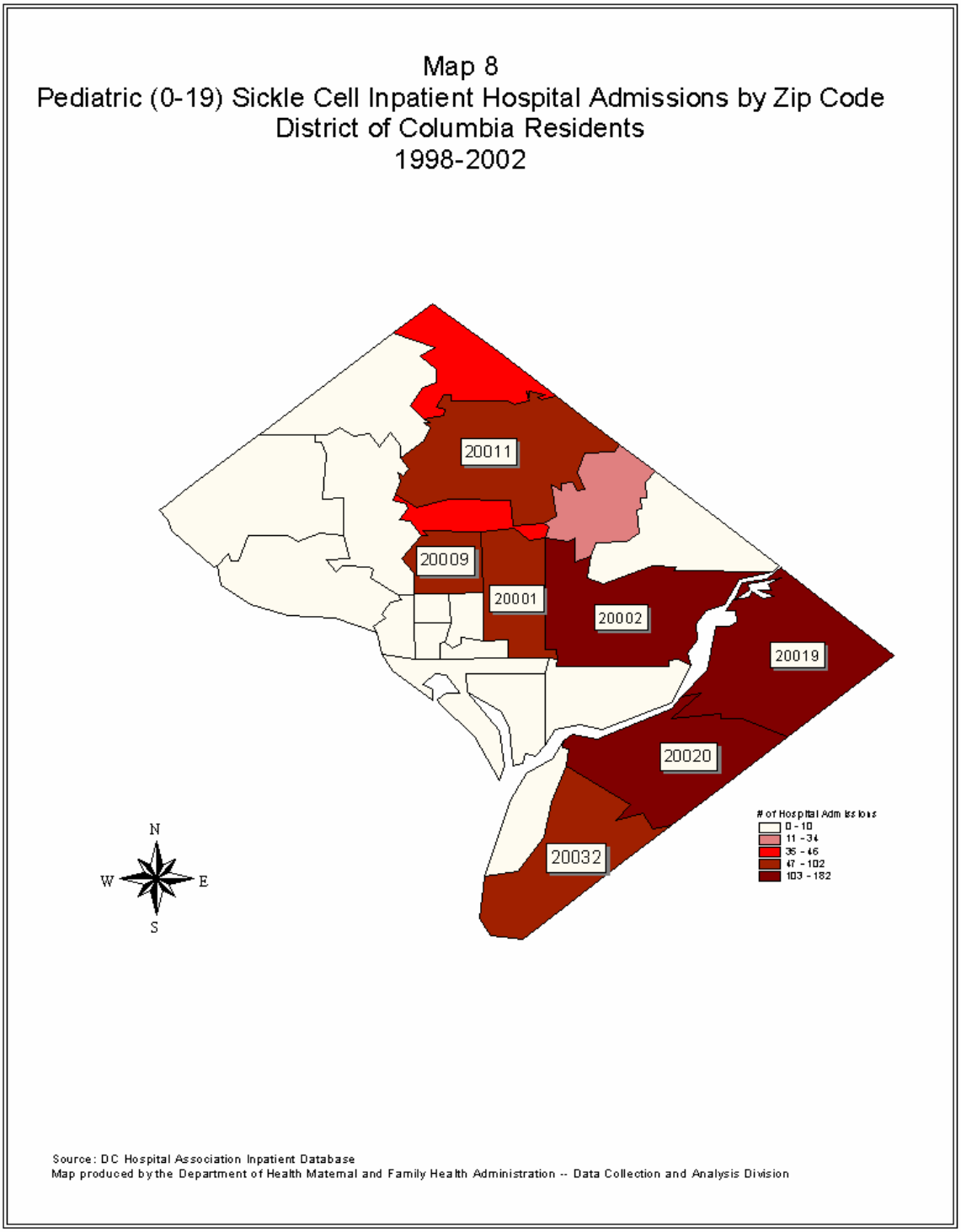
Source: District of Columbia Hospital Association Inpatient Database

For the same five-year time period, except for 2002, District children between the ages of 5 –14 accounted for the vast majority of hospital admissions for sickle cell. (See Figure 50 below)



Source: District of Columbia Hospital Association Inpatient Database

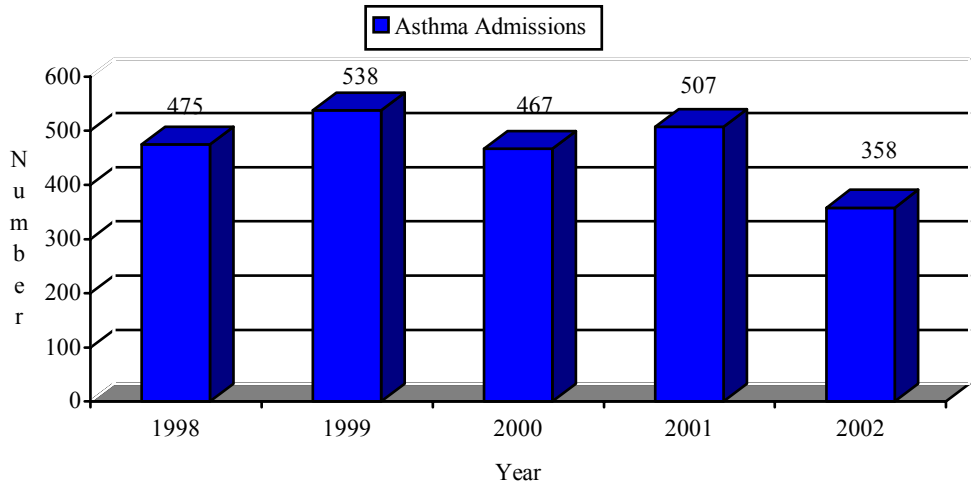
Between 1998-2002, zip codes 20020, 20019 and 20002 had the highest incidences of discharges due to sickle cell disease than any other zip codes in the city for children 0-19. (See Map 8 below) These zip codes are located in Wards 5, 6, 7 and 8.



Asthma: (*Health Systems Capacity Indicator #01*) Asthma is the most common chronic illness among children and the number one cause of school absenteeism. It hits the very young, minorities and the poor hardest. Nationally, asthma causes about 5,000 deaths a year. Data from the District's hospital discharge file showed that although there were increases in 1999 and 2001

the number of asthma hospital admissions among 0-19 year olds decreased by 24.6% from 475 in 1998 to 358 in 2002. (See Figure 51 below) Caution must be taken when interpreting this decline, since hospital discharge data does not take into account people who present for treatment in the emergency room and are not admitted into the hospital. National studies have shown that the numbers of individuals visiting hospital emergency rooms due to asthma is on the rise.

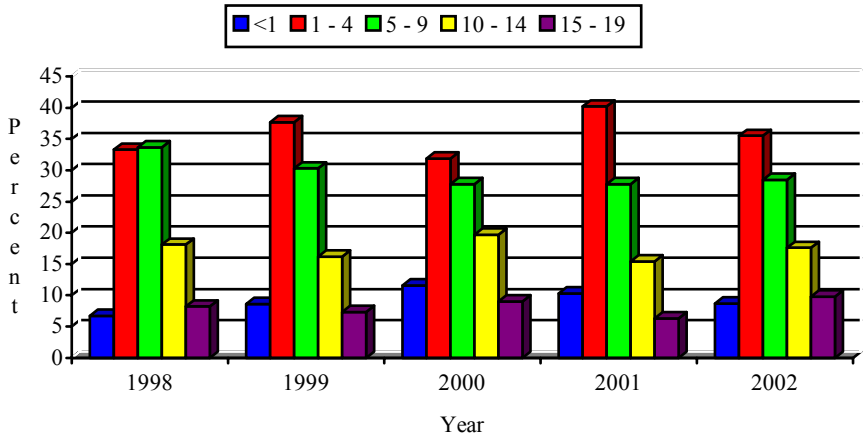
Figure 51: Number of Asthma Hospital Admissions Among District of Columbia Residents 0-19 years, 1998-2002



Source: District of Columbia Hospital Association Inpatient Database

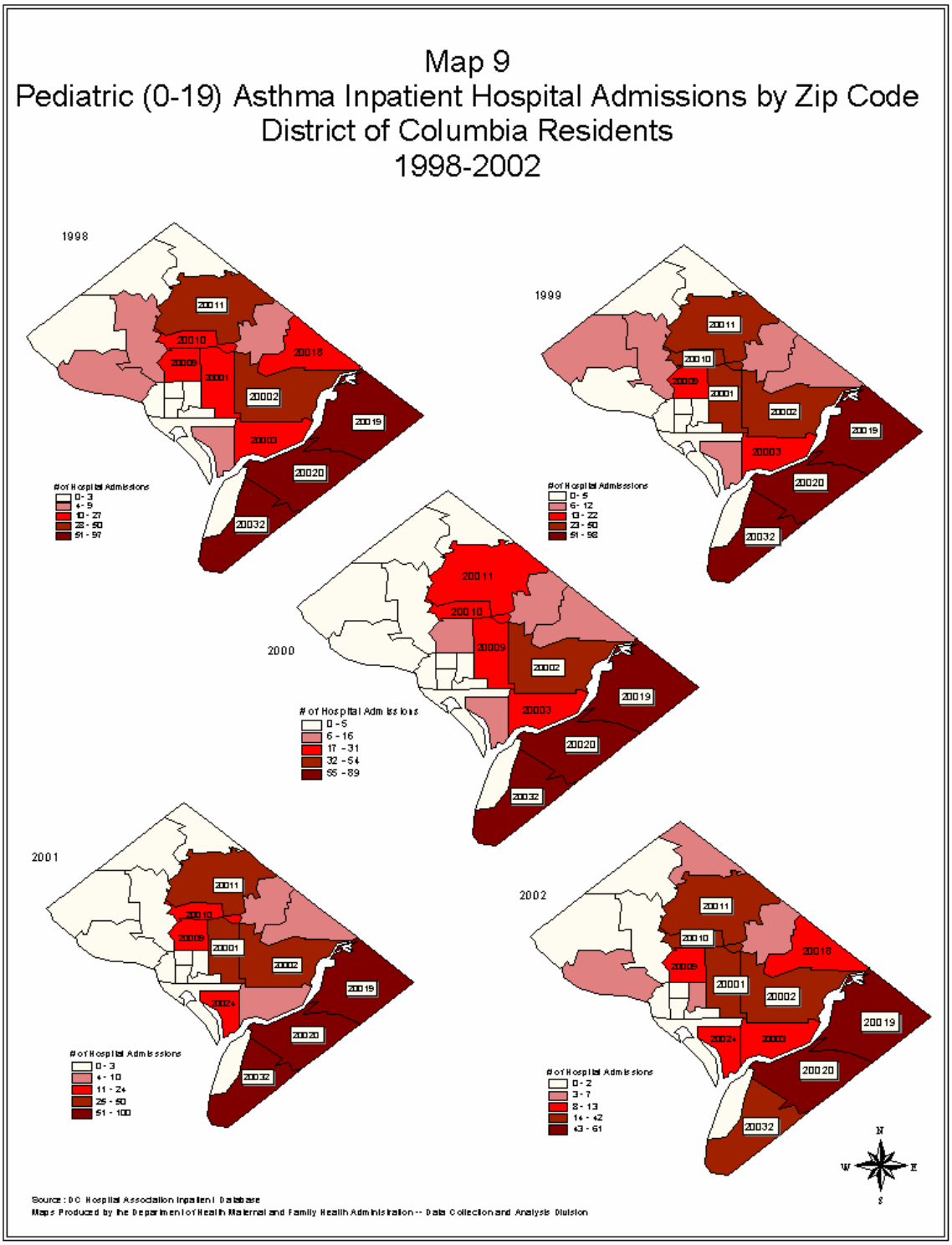
As noted previously, between 1998-2002, admissions for asthma accounted for 49-55% of all hospital admissions for disease of the respiratory system among children1-14. Further examination of hospital admission data for children 0-19 revealed that within this age group children 1-9 were most affected by asthma. (See Figure 52 below)

Figure 52: Percent of Asthma Hospital Admissions Among District of Columbia Residents 0-19 years by Age Group, 1998-2002



Source: District of Columbia Hospital Association Inpatient Database

To examine the possibility that geographic disparities may exist, asthma hospital admissions were mapped by zip code. Dramatic disparities were revealed. Zip codes 20032, 20020 and 20019 had the highest incidences of discharges due to asthma than any other zip code in the city for children 0-19. (See Map 9 below) These zip codes are located in Wards 6, 7 and 8. It is clear that more extensive outreach efforts focusing on asthma are needed in specific Wards of the city.



Epilepsy: Epilepsy and seizure disorders have become an emerging health issue in the District of Columbia. Between 1998-2002, there was an overall 13.1% decline in the number of hospital inpatient admissions among children 0-19 for epilepsy and seizure disorders, from 183 in 1998 to 159 in 2002. Although there was an overall decline during the five-year period, there was a 12%

increase between 2001 (142) and 2002 (159) possibly signally the beginning of an upward trend. Hospital inpatient admissions for seizure disorders among this age group far out numbered admissions for epilepsy. (See Table 19 below)

Table 19: Number of Epilepsy and Seizure Disorders Hospital Admissions Among Children 0-19 Years, District of Columbia Residents 1998-2002

Year	Epilepsy	Seizure Disorders	Total
1998	25	158	183
1999	25	168	193
2000	26	139	165
2001	29	113	142
2002	35	124	159

Source: District of Columbia Hospital Association Inpatient Database

During the five-year period, zip codes 20019, 20020, 20002 and 20011 had the highest incidences of hospital admissions due to epilepsy and seizure disorders than any other zip code in the city among children 0-19. These zip codes correspond to Wards 4, 5, 6, 7 and 8.

Metabolic Screening: *(National Performance Meausre #01)* To ensure that infants, who are potentially at risk, are identified, District of Columbia Law 3-65, the "District of Columbia Newborn Screening Requirement Act of 1979" amended 1985 and 1996, requires screening of all newborns delivered in the District. The program, which began in 1982, originally provided for testing of six genetic/metabolic disorders. This has now grown to seven with the addition of Glucose-6-Phosphate Dehyrogenase (G6PD) Deficiency screening in March of 2000. Table 20 below details the number of presumptive positive and confirmed cases of metabolic conditions identified in infants by the Newborn Metabolic Screening Program for the period covering 1999-2003.

Table 20: Number of Presumptive Positive and Confirmed Cases of Metabolic Conditions Among District of Columbia Live Birth Occurrences
District of Columbia Newborn Metabolic Screening Program 1999-2003

Type of Screening Test	Number of Presumptive Positive Screens	Number of Confirmed Cases
Phenylketonuria (PKU)	2	4
Congenital Hypothyroidism	57	36
Galactosemia	37	14
Sickle Cell Disease	151	94
Homocystinuria	3	3
Maple Syrup Urine Disease (MSUD)	1	1
Glucose-6-Phosphate Dehyrogenase (G-6-PD)	703	703

Source: District of Columbia Department of Health Maternal and Family Health Administration

As Table 20 illustrates, the most common positive newborn metabolic screen is sickle cell disease. In addition, on average, annually 800 District infants are born with the sickle cell trait. These findings are not unexpected given the racial makeup of the District.

Highlights from SLAITS Survey on Children with Special Health Care Needs

The National Survey of Children With Special Health Care Needs was developed to provide national and state-level data on the size and characteristics of the population of children with special health care needs. The survey, sponsored by the Maternal and Child Health Bureau of the Health Resources and Services Administration and carried out by the National Center for Health Statistics of the Centers for Disease Control and Prevention, was comprised of 15 sections. A total of 38,866 families of children with special health care needs were interviewed by telephone between October 2000 and April 2001. MCHB is currently preparing to conduct a new round of interviews to update its original findings. The following sections present results from the National Survey of Children With Special Health Care Needs for the District of Columbia based on parental reports provided during the interviews.

Prevalence of Children with Special Health Care Needs in the District of Columbia*:* Based on results of the survey, a total of 13.8% (15,625) of children under 18 in the District of Columbia are estimated to have special health care needs and represents approximately 21% of households in the District with children. The survey estimate of 15,625 is similar to the estimate (16,000) developed for the District in 1998 by the Center for Applied Research and Urban Policy (CARUP). Nationally 12.8% of children have special health care needs and 20% of households have children with special health care needs.

The prevalence of special health care needs varies by age, gender, race/ethnicity, and poverty level. In the District 17.1% (7,228) of children 6-11 years of age have special health care needs compared to 8.6% (3,304) of children age 0-5, and 15.5% (5,084) of children 12-17. As with national data, in the District, the prevalence of special health care needs is more prevalent in males (16.5%) than females (11.0%). The prevalence of children with special health care needs varied among poverty levels. Among children living 0-99% of the federal poverty level4, 16.9% had a special health care need. (See Figure 53 below)

4 2001 Federal poverty level guidelines

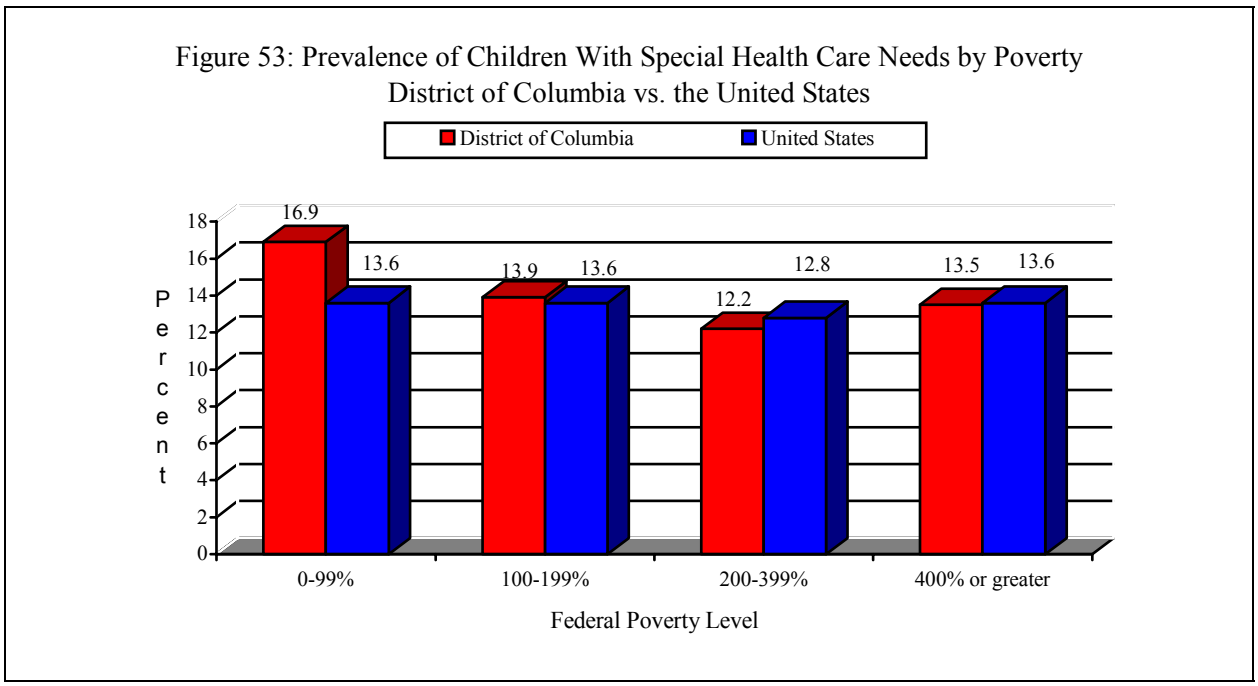


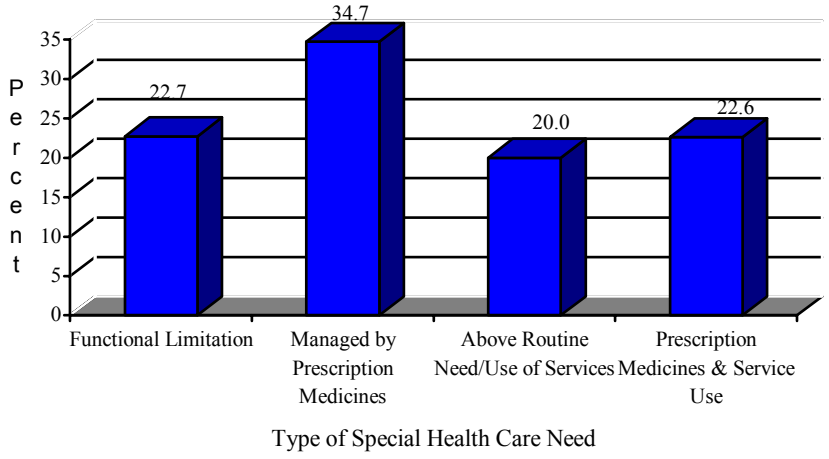
Figure 53: Prevalence of Children With Special Health Care Needs by Poverty District of Columbia vs. the United States

Source: The National Survey of Children With Special Health Care Needs 2001

Approximately 14.7% of Black Non-Hispanic children under 18 have a special health care need in the District of Columbia. The prevalence of special health care needs is highest among White Non-Hispanic children (15.6%) and lowest among Hispanic children (7%).

Health and Functional Status: The most common type of special need identified for children 0-17 years in the District of Columbia was conditions managed by prescription medicines (34.7%), followed by conditions that require prescription medicines and above routine use of services (22.6%) and functional limitations (22.7%). (See Figure 54 below)

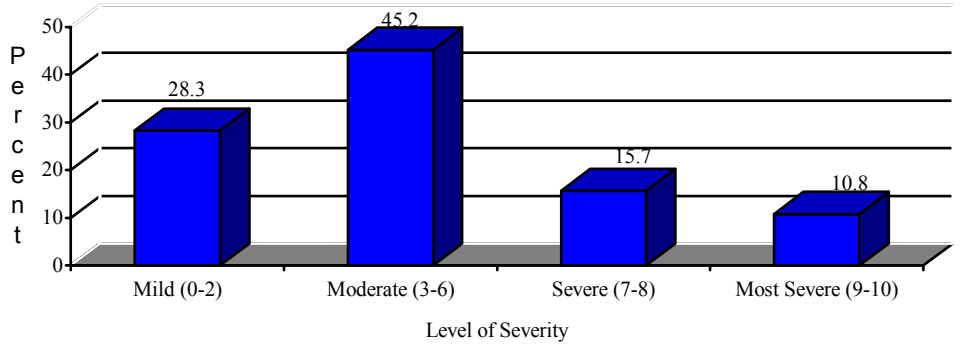
Figure 54: Percent of Special Health Care Needs by Type of Need
District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

District parents of CSHCN were asked to rank the severity of their child's health conditions on a scale of zero to ten where zero was the mildest and ten the most severe. 45.2% ranked their children's condition as moderate (3-6), followed by 28.3% as mild (0-2). (See Figure 55 below) 10.8% of parents ranked their children's health condition as severe.

Figure 55: Parent-ranked Severity of Children With Special Health Care Needs
Health Conditions, District of Columbia

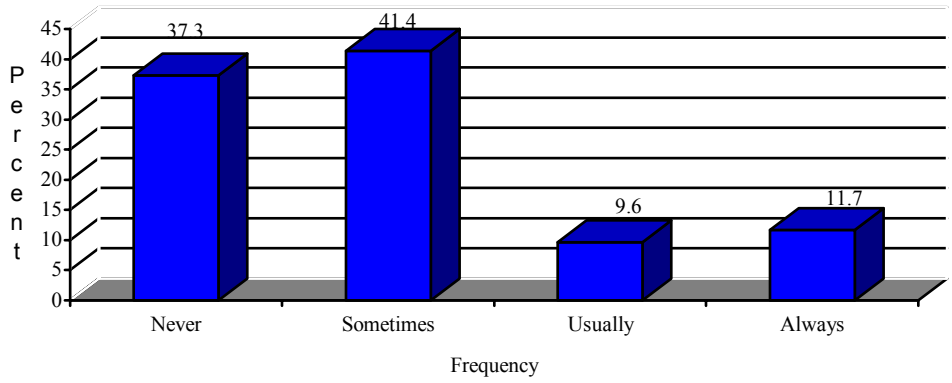


Source: The National Survey of Children With Special Health Care Needs 2001

To assess the impact of the child's special need on his/her daily life a series of questions were asked of parents. According to parental reports, 37.3% (5,799) of CSHCN are never affected in

their ability to do the things other children do, 41.4% (6,438) are sometimes affected in their abilities. (See Figure 56 below) CSHCN whose families had incomes below 200% of the federal poverty level were most often affected in their ability to do the things other children their age would do.

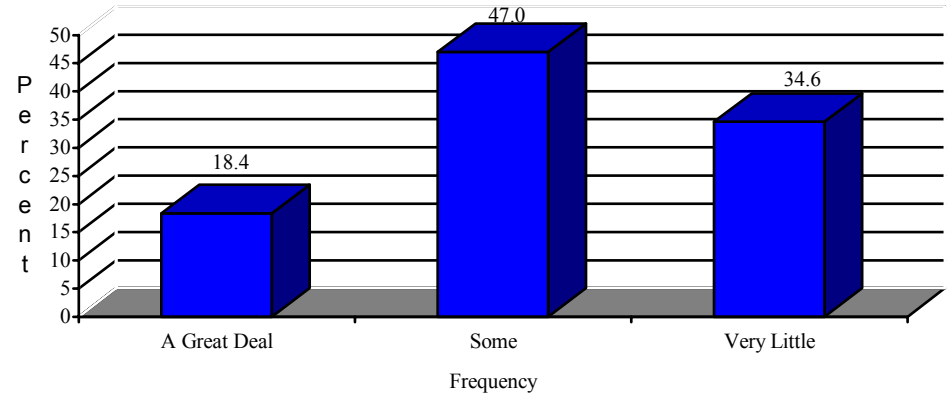
Figure 56: In the Past 12 Months, How Often Does Your CSHCN Health Conditions Affect Their Daily Life, District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

Children with functional special health needs were most affected in their abilities. Among those children who are affected in their abilities 18.4% (1,774) are affected a great deal. (See Figure 57 below)

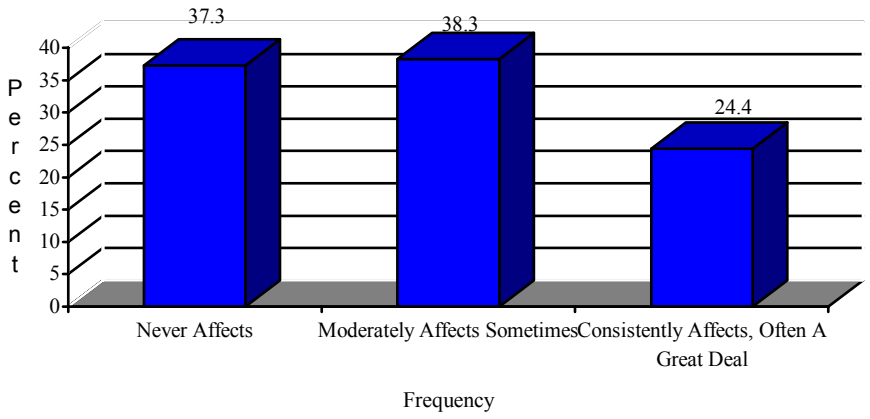
Figure 57: How Much CSHCN Health Conditions Affect Their Daily Activities District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

Closer examination of the extent to which the CSHCN health conditions affect or limited daily activities revealed that about 1 in 4 children are consistently affected often, a great deal. (See Figure 58 below)

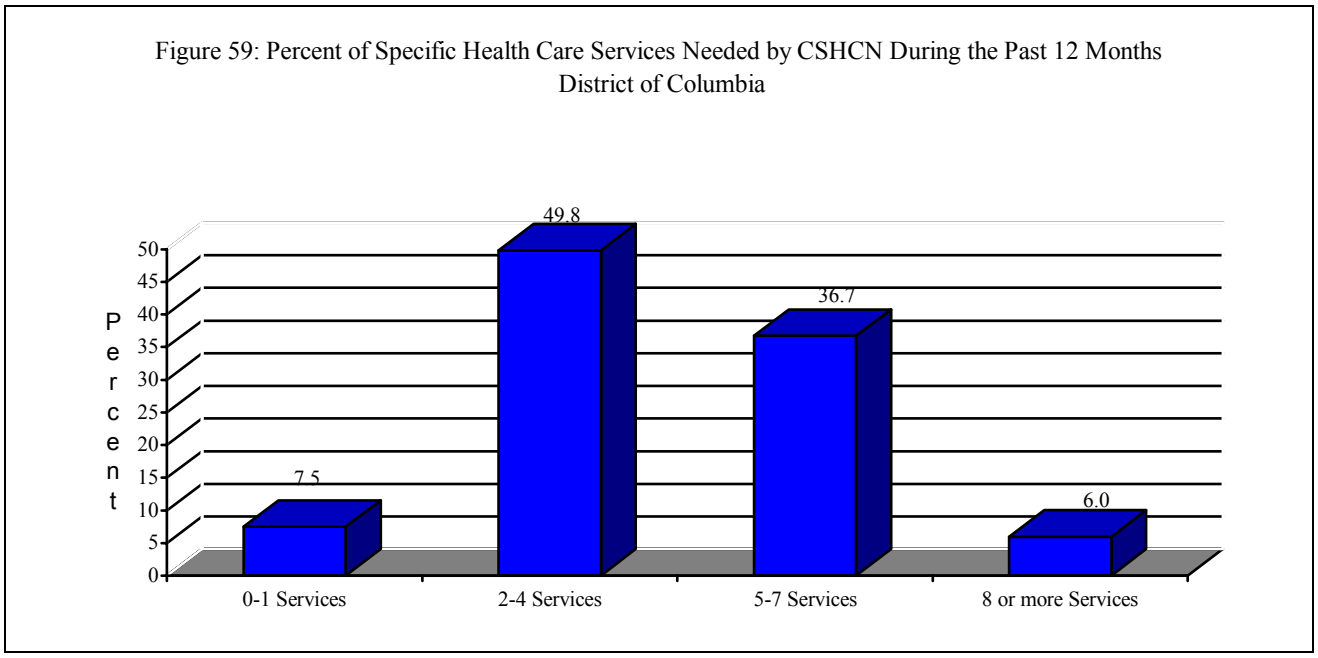
Figure 58: Extent to Which Health Conditions Affect or Limit CSHCN Daily Activities
District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

School absenteeism among CSHCN was also examined. Over half (55.8%) of CSHCN 0-17 years of age missed three or fewer days. 28.5% (3,530) of CSHCN missed 7 or more days of school due to illness.

Access to Care: Utilization and Unmet Need*:* CSHCN require many different types of services including primary and specialty medical care, respite care and therapies. Out of 14 specific types of health services, 49.8% of parents of CSHCN reported that their child needed 2-4 health services. (See Figure 59 below)



Source: The National Survey of Children With Special Health Care Needs 2001

Of the 14 specific types of health services that may have been needed in the last twelve months, 80.3% of CSHCN needed prescription medication followed by routine care (77.2%) and dental services (71.7%). (See Table 21 below)

Table 21: Percent of CSHCN Needing Health Services by Type of Service, District of Columbia

Type of Health Service	Percent
Routine Preventive Care	77.2%
Specialist	46.6%
Dental	71.7%
Prescription Medicines	80.3%
Physical, Occupational or Speech Therapy	30.5%
Mental Health Care or Counseling	29.5%
Substance Abuse	4.9%
Home Health Care	6.3%
Eyeglasses or Vision Care	34.4%
Hearing aid or Hearing Care	5.5%
Mobility aids or Devices	5.0%
Communication aids or Devices	1.5%
Disposable Medical Supplies	22.3%
Durable Medical Equipment	11.0%

Source: The National Survey of Children With Special Health Care Needs 2001

For each of the 14 specific health services, parents were asked if their child had received all of the care she/he needed. Overall, 26.1% of CSHCN had one or more unmet needs. As expected, CSHCN whose insurance was not adequate were more likely to have one or more unmet needs, 32.1% compared to 18.8%. The service most often reported as needed but not received was a

referral for specialty care (27.9%) followed by mental health care or counseling (24.1%) and dental care (16.5%). (See Table 22 below)

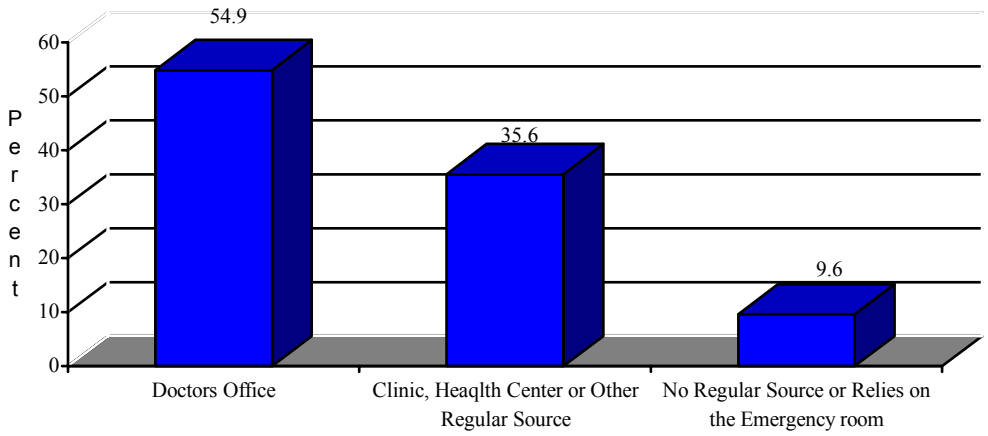
Table 22: Percent of Services Not Met by Specific Health Service, District of Columbia

Type of Health Service	Percent
Referral for Specialty Care	27.9%
Routine Preventive Care	5.3%*
Specialty Doctor	7.1%*
Dental Care	16.5%
Prescription Medications	3.0%*
Physical, Occupational or Speech Therapy	17.9%*
Mental Health Care or Counseling	24.1%
Substance Abuse Treatment or Counseling	13.3%*
Home Health Care	3.8%*
Eyeglasses or Vision Care	14.7%*
Hearing aid or Hearing Care	5.5%*
Communication aids or Devices	46.1%*
Disposable Medical Supplies	13.6%*

Source: The National Survey of Children With Special Health Care Needs 2001

Access to a usual source of care was also assessed. The survey asked parents if there was a place and what type of place their child with special needs usually went to when the child was sick. Overall, 9.6% of CSHCN did not have a regular place or relied on the emergency room. (See Figure 60 below)

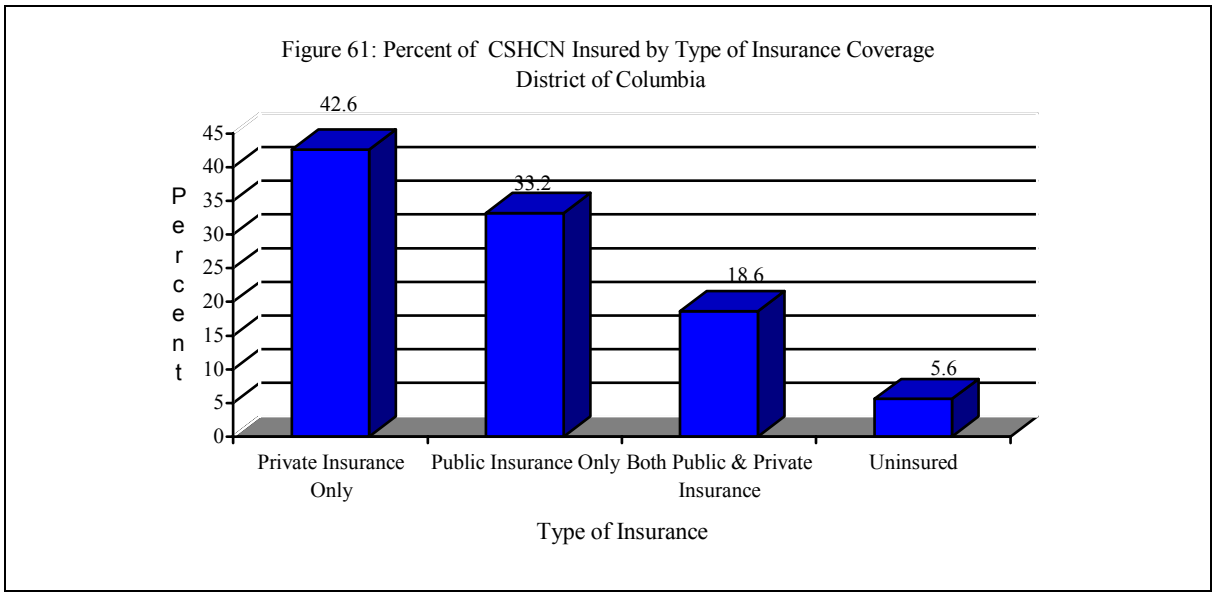
Figure60: Percent of CSHCN With a Usual Source of Care by Place/Source of Care
District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

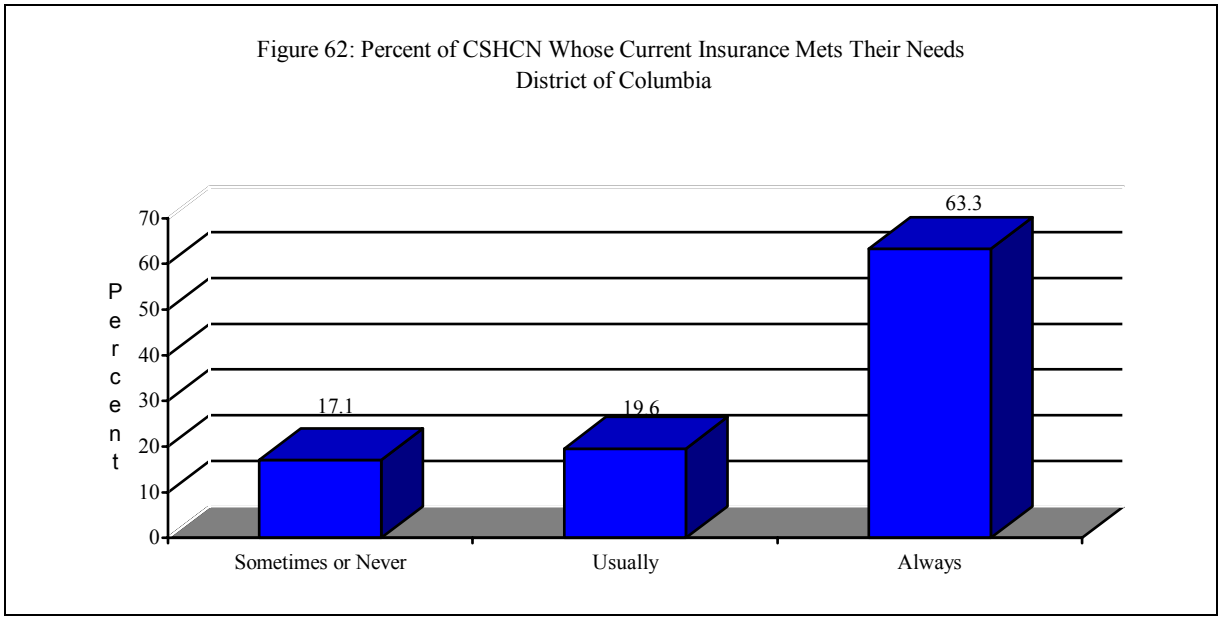
Consistency in health care for children with special health care needs is very important. Parents were asked whether their child with special needs had a person doctor or nurse who knows the child best. 82% of parents reported that their child had a personal doctor or nurse; only 18% of CSHCN did not have a personal doctor or nurse.

Health Insurance and Adequacy of Health Care Coverage: Although 9.8% of CSHCN were without insurance at some point during the past twelve months, at the time of the survey, only 5.6% of CSHCN were uninsured. A breakdown of type of insurance showed that 42.6% of CSHCN had private insurance only followed by 33.2% with public insurance only. (See Figure 61 below) Children whose family incomes fell within 100-199% of the federal poverty level were more likely to be insured.



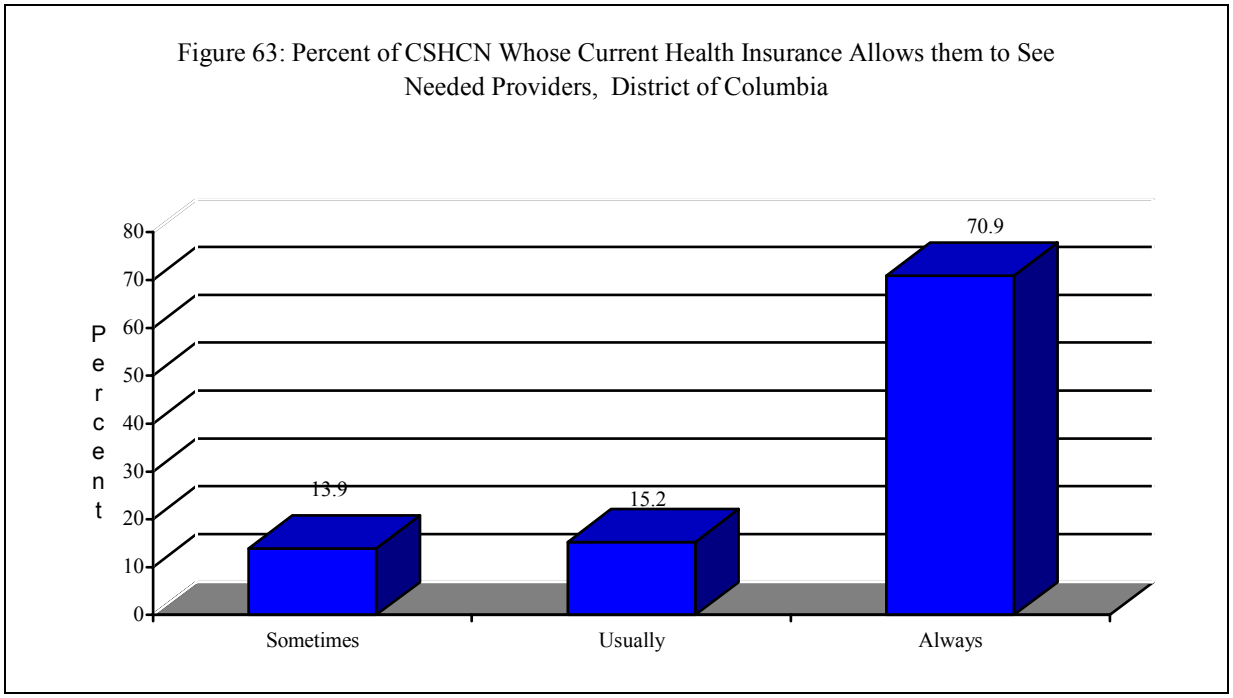
Source: The National Survey of Children With Special Health Care Needs 2001

Among children who were insured, 17.1% have insurance that sometimes or never offer benefits or cover services that meet the child's needs. (See Figure 62 below)



Source: The National Survey of Children With Special Health Care Needs 2001

Adequacy of insurance also involves having access to medical services and specialty providers. 70.9% of CSHCN health insurance always allows them to see needed providers. Only 13.9% of CSHCN insurance plans sometimes or never allows them to see needed providers. (See Figure 63 below)



Source: The National Survey of Children With Special Health Care Needs 2001

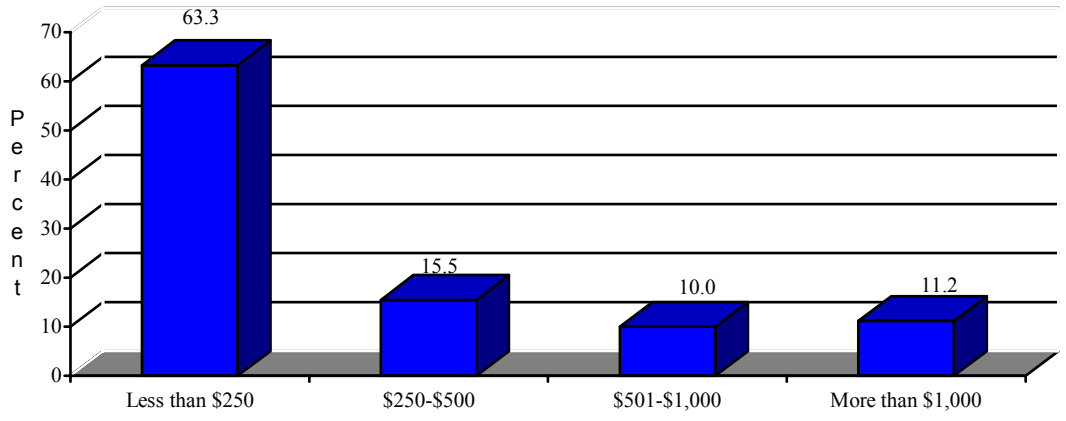
In addition, parents were asked about the reasonableness of charges not covered by the CSHCN insurance plan. 33.3% of parents with CSHCN reported that the charges covered by their current insurance plans were sometimes or never reasonable; 15.6% stated charges were usually reasonable. Overall, 51.1% stated that the charges were always reasonable.

Families often have other needs, which help them to cope with the issues facing their special health care needs child. Parents were asked about the need for support services. Overall, 33.7% of parents reported that they had one or more unmet needs.

Impact on the Family: Having a child with special health care needs impacts the family in many ways including financially and emotionally. To assess the impact that children with special health care needs have on their families, parents were asked questions about out-of-pocket expenses, time spent by family members providing and/or arranging for their child's care, and whether their children's needs have required them to cut back on work and/or stop working.

Annually 11.2% of families with CSHCN pay more than $1,000 in medical expenses for their child's care. (See Figure 64 below) These expenses include the cost of services that are not covered by their insurance plans including medical equipment, mental health care and various therapies.

Figure 64: Percent of Out-of-Pocket Medical Epenses Per Year for CSHCN
District of Columbia

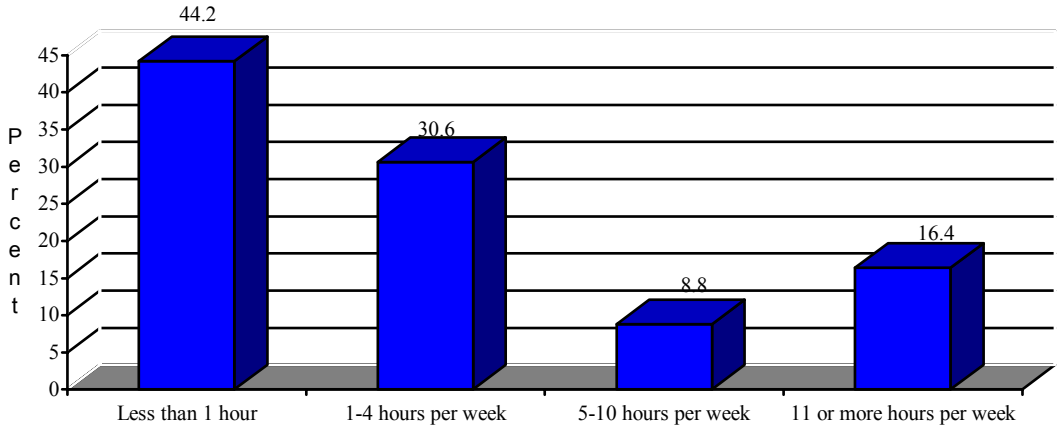


Source: The National Survey of Children With Special Health Care Needs 2001

Almost 18% of parents reported that their child's health condition has caused financial problems for the family. Children with special health care needs from lower incomes were more likely to be affected in this manner. To cover these costs many families need to obtain additional income. About 1 in 5 families of CSHCN reported that they needed additional income to cover their child's medical expenses.

To assure that their child with special health needs is getting proper care, many parents dedicate significant amounts of time to their child's care. These activities include making appointments, making sure that care providers exchange information, changing bandages and care of feeding or breathing equipment. 16.4% of parents reported spending 11 or more hours per week providing and/or coordinating their child's health care. (See Figure 65 below)

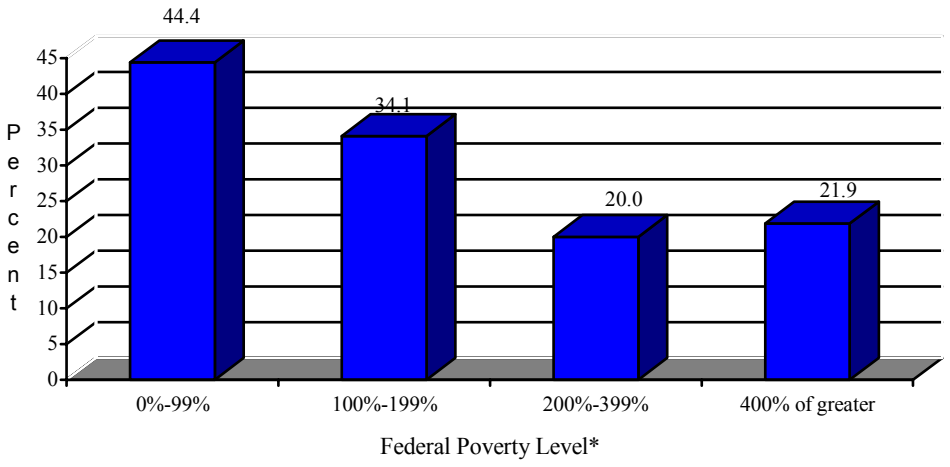
Figure 65: Percent of hour Spent Per Week by Families Providing and /or Coordinating Health Care for CSHCN, District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001

Naturally, the time spent on arranging and/or providing care to their special needs child may have some impact on the employment status of parents. 31.5% of parents reported that they had to cut back or stop working to care for their child with special needs. Of that number, 28.9% of CSHCN parents had to cut back on work while 16.7% reported they had to stop working to care for their child with special healthcare needs. Families with incomes 0-99% of the federal poverty level were more likely to report this occurrence. (See Figure 66 below)

Figure 66: Percent of Families Cutting Back or Stopping Work Because ot Their CSHCN Health Needs by Income Status, District of Columbia



Source: The National Survey of Children With Special Health Care Needs 2001
*2001 Federal Poverty Level guidelines

2.1.3 MCH Program Capacity by Pyramid Level

2.1.3a Direct Health Care and Enabling Services

One step in assessing health care resource coverage is to examine underserved geographic areas neighborhood health service assets. People living in these areas have limited access to primary care services due to financial, geographic, cultural and/or language barriers. The misdistribution of physicians, large distances to specialty care centers, and shortages of bilingual staff in certain city-wards all may have a negative effect on access to appropriate care. As discussed in section 2.1.1.1, approximately 52% (300,825) of the District's residents live in health professional shortage areas (HPSAs) and 30% (173,228) live in medically underserved areas (MUAs). Approximately 47% of women of childbearing age, infants and children live in federally designated primary medical care health professional shortage areas.

Leading MCH indicators (i.e. infant mortality, low birthweight, prenatal care initiation etc.) were transposed against the mapped primary medical care HPSAs as well as clinics and hospitals in the District. Not surprisingly, many of the census tracts that experience the highest number of adverse health and social indicators fall in the HPSA census tracts. In addition, the residences mapped were not located in close proximity to a primary health care facility. The identification of these areas should serve to heighten the awareness of health professionals to potential health care or service delivery problems for the residents of these census tracts.

Since the last needs assessment the District ahs gone from nine hospitals providing obstetric services to seven, three of which are tertiary care hospitals. A number of these hospitals have community-based primary care clinics. With these various resources, Washington, DC is considered the hub of the perinatal system for the Washington, DC metropolitan area. The locations of hospitals and clinics within the Wards highlight the disparities in health care access for the residents of the District. Since the closing of the District's public hospital, DC General, only one hospital (Greater Southeast Community Hospital) exists east of the river. This hospital has experienced many challenges over the past five years including loss and eventual gain of accreditation and limits on operating beds. It was not until June 2005 that the District's Department of Health lifted the operating bed cap.

Safety Net providers in the District can be classified in one of four categories: Private Non-Profit clinics, federally qualified health centers (FQHC), hospital affiliated and other. There are twelve private non-profit clinics (excluding the federally qualified health centers) that were affiliated with the former Non-Profit Clinic Consortium (NPCC). These clinics operate thirteen sites. (Since the fall of 2003, the District of Columbia Primary Care Association assumed the NPCC functions) The District has two FQHC. Table 23 below shows the provider type by Ward location.

Table 23: Number of Primary Health Care Providers by Ward, District of Columbia

Provider Type	Ward							
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Federally Qualified Health Center (FQHC)	5	7	3	1	5	3	4	7
Hospital Affiliated	4	2	1	0	2	3	2	3
Other	0	0	0	0	1	2	0	0
Private non-Profit (non-FQHC)	6	2	0	0	3	0	1	1
Total	15	11	4	1	11	8	7	11

Source: DC Primary Care Association

Health insurance for most of the District's residents is provided through private or public insurance. However, for many District residents, who are uninsured, few financial avenues are available to cover the cost of primary and preventive care. The District like other jurisdictions has tried to address this issue by using a combination of strategies including:

- Expansion of insurance coverage for children, prenatal and postpartum women, including the raising of Medicaid income levels for the uninsured children;

- Development of Medicaid-like health insurance called the Dc Healthcare Alliance for individuals that may not qualify for Medicaid or the SCHIP program (DC Healthy Families) such as non-pregnant women and immigrants;
- Provision of enabling services, such as transportation, translation and extended outreach and follow up; and
- Assuring linkages between levels of care, especially with regard to perinatal services (DC Healthy Start and other projects);

However, even 100% enrollment does not assure that all children and pregnant and parenting women will get access to the care that they need. For example, in the area of dental treatment, although covered by EPSDT under Medicaid, children often have difficulty accessing needed oral health services due to the paucity of dentists that will accept Medicaid.

Over the past five years, the District's Title V Agency, the Maternal and Family Health Administration, has worked closely with many of the safety net organizations to improve health care for women and their families. Administration employees have participated in numerous conferences, trainings and advisory groups convened to address issues of access, scope and quality of services. For example, for the past six months, the Medical Assistance Administration (MAA) and the Maternal and Family Health Administration have met once a month with the Medicaid managed care organizations to share information and coordinate activities. Several Administration staff are members of Medicaid (MAA) committees which address childhood obesity and obstetrical standards of care. To coordinate these activities the Administration has signed a memorandum of understanding with the MAA, which includes sharing of data, coordination of case management activities and development of new programs. Renegotiation of Medicaid contracts could provide an opportunity to require contractors to participate in surveillance reporting.

2.1.3b Population-Based Services

The Administration continues to operate the newborn screening and hearing programs, support the lead screening program, which in fiscal year 2006 will be directly operated by the Administration, and coordinates outreach and informational activities with the immunization program.

Administration employees engage in numerous public education and awareness efforts, including, for example, the distribution of folic Acid and fetal alcohol syndrome prevention literature and alcohol screening activities during National birth Defects Prevention Month. Birth Defects Surveillance staff are working with program managers to institutionalize awareness activities as a

year-round event rather than for only the month of January. Normally these efforts are sporadic, short term, dependent upon categorical funding and not always well integrated into comprehensive strategies to improve health. Efforts tend to be focused on the majority African American community, in particular the low-income neighborhoods, which is where the poor health outcomes are manifested. They are infrequently evaluated; thus very little evidence is available for use in planning follow up efforts.

The Administration has formed several partnerships with the Latino community and has adapted many informational efforts to that population. It has formed a Hispanic Coalition comprised of twenty organizations whose role is to provide guidance to the Administration in the development of programs and services for the Latino community. In addition, through the HEALTHLINE (1-800-MOM-BABY) outreach and education has been provided to both the Hispanic and Asian communities. During fiscal year 2004, 2,208 Hispanic and 2,467 Asian/Pacific Islander women were provided outreach and referral services through the HEALTHLINE.

2.1.3c Infrastructure Building Services

For years the State Title V program has worked to establish a coordinated comprehensive system of care for the District's MCH population. Linkages have been made with various providers, advocacy groups and government agencies. Coordination efforts with the various agencies and providers are discussed below.

DC Healthy Families: On October 1, 1998, under the federal Children's Health Insurance Program (CHIP), the District government initiated an expanded Medicaid program of guaranteeing health insurance to al low and moderate income families with children. The Administration's HEALTHLINE (1-800-MOM-BABY) has served as a link in the DC Healthy Families outreach activities. The telephone number has been placed on all outreach materials and included in all public services announcements regarding the program. During fiscal year 2004, 13.6% (2,962) of the calls to the HEALTHLINE were related to DC Healthy Families.

Coordination efforts:. The Administration has been able to carve out defined roles with many programs (i.e. WIC, Medicaid). With the other programs (special education, vocational rehabilitation, mental health, interagency transition programs, and SSI), there is only sporadic contact. In fact, employees are not always aware of the current emphases of these programs. Several (mental health, special education) programs are themselves experiencing severe problems

and require more than coordination with sister agencies. However, recently, the Administration has been invited to participate in the Child and Family Services Needs Assessment.

The Maternal and Family Health Administration has relationships with several hospitals and medical centers, primarily through programs operated by Children's Hospital Medical Center, and via representation on various councils and advisory groups. The formation of the Children with Special Health Care Needs Advisory Board has enabled the Administration to have an independent advocacy voice for this special population. In addition, recent efforts by the Administration to form a local Perinatal Association have strengthened many activities in this area.

Gaps and Needs in Coordination: While the Administration has made some advances in its ability to conduct the core public health functions of assessment, policy development and assurance, it still faces some challenges. Over the next 5-year period, the Administration can be more deliberate and strategic as to how staff and other resources are allocated. Administration management can dedicate staff time to form liaisons with specific government agencies—special education, mental health, protective services, for example. The continuity of interdepartmental liaison work may be even more important than intradepartmental coordination, insofar as there are more opportunities to communicate within the department. Relationships with other agencies require time to develop and mutual exchanges, such as funds and staff expertise. Future efforts for the Administration should be in the areas of strengthening collaborations with the District's Title X Agency and DC Health Care Alliance.

2.2 Health Status Indicators

The core and developmental health status indicators were used extensively as the needs assessment was being conducted. The mandated collection of these measures helped to provide a better picture of the District's MCH population. Several indicators are reported in the narrative (i.e. asthma, low birthweight, and adequacy of prenatal care). These indicators serve as the base for ongoing assessment for the MCH population in the District.

2.2.1 Priority Needs

In this section of the application, the result of the Maternal and Family Health Administration priority setting process is summarized.

The Maternal and Family Health Administration continued through FY 2005 to focus on the priorities established in June 2000, working within the DC Department of Health (DOH) and in an environment that changed considerably during those years. In the summers of 2001, 2002, and 2004, following the priority setting in June 2000, senior Administration staff convened to review the most recent performance measures and outcome data and trends. Senior Administration staff discussed and reconsidered their programmatic efforts directed toward these measures. Several priorities were modified as a result. In addition, Administration staff was involved with DOH-wide Healthy People 2010 annual implementation planning and the development of a 5-year state health systems plan to guide the District's certificate of need process, as well as planning supported by various categorical grants.

During FY 2005 the Administration's Data Collection and Analysis Division staff completed a comprehensive compilation and review of data describing the District's maternal and child health populations. A lengthy report was circulated to Administration and other DOH staff and stakeholders. The Administration's Adolescent Health Division, over the past two years, has been engaged in a comprehensive strategic planning process aimed at gaining greater information regarding the District's youth population—of which the Department had the least information. Major findings and trends revealed through this effort have been incorporated into the Title V – Five Years Needs Assessment. Summaries of the comprehensive data compilation were presented to participants in 4 focus groups convened during the summer of 2005. Teens comprised 1 focus group and a parents' advisory group another. The other 2 groups included both representatives from community organizations and Administration staff. A technical assistance contractor funded through the Maternal and Child Health Bureau convened 10 focus groups sessions in wards 1, 2, 3, and 4 to determine barriers to health care for the District's Hispanic/Latino community. In put was received from a total of 69 community residents. A written report was compiled summarizing the concerns, problems, recommended strategies and priorities of the focus group sessions.

On June 27, 2005, 9 Administration staff members met in a 3-hour priority-setting-exercise to discuss the needs assessment findings, both the trends outlined in the quantitative analysis and the comments from the focus groups, as well as their own experience in administering programs and new initiatives.

Special attention was given to the issues that surfaced across all of the focus groups. Next the staff reviewed the 2000 priorities and discussed whether any should be retained for the next 5-year period. It was generally agreed that considerable progress had been made toward 3 priorities; therefore, they were moved off the high priority list. It was noted that changing priorities did not mean work on these issues and programs would cease.

Establish (and institutionalize) a coordinating committee to strengthen system links among health, social services, juvenile justice, public schools, mental health, protective services and developmental disabilities.
Strengthen universal newborn hearing screening and ensure the provision of follow up diagnostic, treatment and early intervention services.
Work through health services delivery systems and neighborhood organizational infrastructure to reduce incidence of SIDS and other infant deaths.

Furthermore, it was agreed to remove a 4th priority insofar as few if any Administration resources had been allocated to it, although numerous local and national advocacy organizations continue to address these policy issues.
Monitor and assess the effect of welfare repeal and mandatory managed care on health status.

In this section of the application, the priorities for the period 2005 – 2010 are described by level of service. More detailed information can be found in the sections on the national and state performance measures. The order in which priorities are listed does not indicate rank in importance. Priorities are numbered only for purposes of reference in discussion.

Priorities continued from 2000-2005:

1.Population based services and infrastructure development: Improve oral health among children, youth and pregnant women.

This priority from 2000 will be retained through 2010. The needs assessment section, as well as several measures reported in this application, describes the challenges related to the lack of oral health services (NP# 9 and SP# 2). Although Medicaid reimbursement rates were slightly adjusted in FY 2003, with another increase slated for January 2006, and increasing recognition of the lack of accessible services has resulted in the expansion of mobile dental services offered in a few underserved neighborhoods, much remains to be done.

In June 2004, the Oral Health Coalition was formed to address increasing Medicaid dental provider rates, increasing funding for educational campaigns, conducting an oral health assessment in the District and supporting oral health promotion and outreach efforts. 3 subcommittees have been formed, and the local dental associations as well as the Howard University School of Dentistry are represented. The coalition continues to meet and formalize its structure. Coalition representatives have met with the DOH director and the chair of the city council committee on health to discuss the urgency of dealing with oral health issues. A periodicity schedule for oral health has also been developed

In September 2002, the DOH was awarded a 3-year innovation grant of $450,000 from the federal Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, to provide oral health services to Children with Special Health Care Needs (CSHCN) in partnership with the Children's National Medical Center, Howard University School of Dentistry and the DC Public Schools. Beginning with 2 school-based clinic sites dedicated to special needs children— the Administration has used Title V funds to support health services at each school. The grant funds were applied in 2004 to renovate the medical/dental health suites and installing telemedicine capabilities in order to serve the oral health needs of these students, many of whom have severe physical disabilities. In the 3rd year, FY 2005, services were expanded to additional schools with large numbers of CSHCN. But the project has not progressed as planned, due to infrastructure deficiencies within the school system that included the lack of readily available internet service, and difficulty in executing a contract to ensure connectivity to a water supply necessary for the proper operation of the dental chair. It is anticipated that the approval of requested carry-over monies will be received for use in 2006.

The project includes a strong health professional training and development component, linking dental students with pediatric sub-specialties. Health Services for Children with Special Health Care Needs, (HSCSN) Inc., which is the managed care contractor for children who are recipients of both Supplemental Security Income (SSI) and Medicaid, has agreed to include the school-based dental services provider in its provider network; however, contractual arrangements have yet to be finalized. (See NP # 9 for additional information.)

A pilot school-based sealant project got underway in October 2003. (See NP #9 for description and results.) DOH will continue this project through FY 2006 with state appropriated funds. The Healthy Start medical mobile unit, which is expected to be functioning by the beginning of FY 2006, will add oral health screening for pregnant and interconceptional women. However,

significant portions of the District are designated dental services shortage areas and obtaining treatment services continues to be extremely difficult for Medicaid-State Child Health Insurance Program (SCHIP) recipients. Additionally, an unknown number of insured persons lack dental services coverage.

2. Enabling services and direct services: Reduce unintended pregnancies and teen births.

Recognizing the relationship between unwanted pregnancies and adverse perinatal outcomes, the Administration decided in 2000 to make the reduction of unintended pregnancies a priority. Although the teen birth and pregnancy rates have decreased in recent years, the unintended pregnancy rate has changed very little. (See SP#7.) The Administration acted on 2 funding opportunities to advance this priority. The Teens Mothers Take Charge (TMTC) project, funded overtime with Title V and the District's Temporary Assistance for Needy Families (TANF) monies, supports a community-based organization to provide care coordination and enrichment services to pregnant and/or parenting teens. The goal of the program is to prevent unintended repeat pregnancies and assist young mothers to become self-sufficient. The program will serve 75 participants in 2005 and continue in 2006, serving up to 95 teens.

In spring 2005, the 2 Healthy Start projects were refunded at level funding for a 4-year period with a focus on the provision of case management services for 24 months after delivery. In addition to working toward early entry into and sustained prenatal care, the project supports women in avoiding unplanned repeat pregnancies within that 24-month interconceptional time period. The Administration will continue to support the Healthy Start and Teen Mothers Take Charge program by tracking numbers of clients served, types of services received and outcomes. See also NP # 8, SP# 5.

3. Infrastructure development and enabling services: Increase the proportion of the population that is insured, and increase the comprehensiveness of the insurance to include primary preventative services and preconceptional services.

Although the Administration does not have primary responsibility for informing and enrolling eligible persons in Medicaid-SCHIP, it has played a significant role in this effort, which continues to be a priority. Since the setting of this priority in 2000, the restructuring of the District's safety net has resulted in enrolling additional residents into a type of managed care (the DC Healthcare Alliance), a change from the pattern of receiving medical services from a public hospital and

affiliated neighborhood health centers. While Alliance clients are primarily adults (because children, youth and parents under 200% of poverty generally quality for Medicaid-SCHIP), enrollment and processing procedures continues to result in increased case finding and enrollment into Medicaid. Ensuring that Medicaid-SCHIP and Alliance services are comprehensive and incorporate evidence-based standards of preventive care will require coordination across components of the DOH and with private sector organizations. The Alliance also includes a special program to provide Medicaid-like coverage for immigrant children and pregnant women. Memoranda of Understanding (MOUs) were established with the Medicaid MCOs in late 2004, opening the door for the development of standards of outreach and care to, among other goals, increase the numbers of women who are aware of and avail themselves of preconceptional health care services.

The Administration disseminates information about Medicaid-SCHIP and the Alliance at conferences, health fairs and through Healthy Start case managers, outreach workers and Teen Mothers Take Charge care coordinators, Children with Special Health Care Needs Annual Service Round-ups, and the Newborn Initiative as well as the 800-mandated information and referral line. Assisting women with public insurance enrollment and use is an important part of case management services provided to Healthy Start and Teen Mothers Take Charge clients. See also NP# 4, 13, 14 and SP# 2.

New priorities for 2005-2010:

4. Infrastructure development and enabling services: Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services.

The Administration's experience with 3 years of depression screening in the Healthy Start program, combined with the analysis presented in the needs assessment section and reinforced by comments in the recently convened focus groups, led to agreement on this priority. Universal screening of Healthy Start clients will continue through June 2009, with the support of 2 federal grants. A 1-year grant to expand perinatal depression screening in all areas of the city was recently received.

The Administration has an MOU with the DC Department of Mental Health to fund and co-locate 2 FTE licensed therapist (clinical social worker) positions at the Parent and Infant Development

Program (PIDP) to receive, assess, diagnose and treat Healthy Start clients who screen positive for depression or other mental health problems. Although these therapists make home visits and Healthy Start staff nurse case managers assist with arrangements for and support clients in obtaining diagnostic and treatment services, the experience is that it is difficult to persuade women who screen positive for depression or other mental health problems to present for services, probably due in large part to the stigma attached to mental health services among the low income African American population.

Following decades of court-ordered monitors and receiverships, over the past few years public mental health services have been reorganized into a cabinet-level Department of Mental Health, with parallel status to the Department of Health. In August 2002, mental health services were integrated (carved-in) into all DC Medicaid managed care plans. The majority of mental health services previously paid by Medicaid fee-for-service are now coordinated and paid for by the managed care plans. The Medicaid MCOs are responsible for mental health assessments, outpatient crisis intervention, prescription and laboratory services, therapeutic nursery, inpatient services, alcohol/drug assessments, outpatient crisis intervention and inpatient services. MCO contracts negotiated in 2002 included a requirement for primary care providers to complete a mental health assessment, but Medicaid officials have yet to present information on the extent to which the requirement has been implemented

Although the Department of Mental Health has established some school based mental health services, teens and their parents, as well as youth advocate groups, cite the need for mental health services, and for primary prevention programs, as high priority.

The DC city council committee on health has oversight responsibility for both the DOH and the Department of Mental Health. The committee on health was formed in 2005; previously oversight was handled in the committee on human services. A narrower scope of responsibilities and a proactive chair may create opportunities for coordination and integration of mental and physical health services.

5. Infrastructure development: Enhance nutrition and increase physical activity for children and youth.

The nation's concern with the rapidly increasing prevalence of overweight and obesity among children is shared by District health officials and child advocates. The majority of District

children under age-8 are African American and Latino. Both groups are prone to high prevalence of obesity and chronic diseases such as diabetes and cardiovascular disease. Crime and deteriorating neighborhoods limit the availability of physical activity. Poorly funded schools have limited or eliminated sports programs, physical education and after school activities. School policies regarding access to vending machines (and the vending machine choices), sale of food products to and by students for fund raising purposes, and feeding programs are not uniform across the city.

A proposed realignment of the DOH now (June 28, 2005) in process will bring the Special Supplemental Program for Women, Infants and Children (WIC) and other USDA-funded programs into the Maternal and Family Health Administration as the Nutrition and Physical Activity Bureau as reflected in the 2006 Budget. This change presents considerable opportunity for increasing efforts toward city-wide policies that increase opportunities for improved nutrition and increased physical activity beyond the District's WIC eligible populations.

This year the Administration's nutritionist developed a curriculum—Nutrition Roadmap for Children—to encourage children age 7 – 18 to eat a balanced diet. It provides information of the amounts of fruits, vegetables, carbohydrates, and other foods included in the food guide pyramid, as well as recipes parents and caregivers can use for healthy eating. 3 staff persons were trained to use the curriculum in an after school program "Fields of Dreams". Staff expects to promote its use more widely in after school and in school classes.

6. Infrastructure development: Decrease violence toward children and youth.

As described in the needs assessment section, homicide is a leading cause of death for the 10-24 year old age group! Data on morbidity due to violence are not available. Periodic high profile cases, in particular homicides that occur on school premises, capture the attention of public officials and the media, but the attention is often short lived and does not lead to evidence-based public health interventions. The Office of the Deputy Mayor for Children, Youth, Families and Elders issued a report March 2005 entitled *Effective Youth Development: A strategy to Prevent Juvenile Homicides and Youth Violence: Funding and Operational Recommendations.* A city council special committee on the prevention of youth violent crime scheduled a hearing for July 11, 2005 to obtain public response to the plan. Although the Maternal and Family Health Administration was not asked to participate in the development of the recommendations, which reportedly emphasize a law enforcement approach, management is hopeful that opportunities for

broadening recommendations to include public health and youth development approaches will increase.

Over the past 2 years, the adolescent health division has sponsored several youth summits dealing with violence, and violence prevention was frequently raised as a priority issue during key informant interviews and focus groups convened in conjunction with the development of the adolescent state plan. Plans for FY 2006 include; establishment of a city-wide coalition for youth violence prevention that consists of government, community and faith-based organizations; partnering with developing the a youth violence prevention initiative for DC; and briefing city officials on the Department's stance and objectives relative to youth violence prevention in the District; Staff will also seek funding opportunities to operationalize these plans.

The Administration directs some Healthy Start resources to parenting skills development. The proposed FY'06 realignment of the DOH includes the transfer of a violence prevention program (primarily focusing on sexual assault) from the Primary Care Prevention and Planning Administration to the newly created Maternal and Family Health Administration, Adult and Family Health Services Bureau, increasing the opportunities for a more integrated violence prevention intervention strategy.

7. Infrastructure development and direct services: Increase access to medical homes for CSHCN and support seamless systems of care and transitions across service systems.

District children who quality for SSI and Medicaid have access to a special needs carve-out MCO, which provides a medical home and case management through age 21. Although families have the option of fee-for-service Medicaid for these CSHCN, participation in the MCO is high and satisfaction with and quality of services are reputed to be good. However, the situation is quite different for children who fall under the more inclusive definition of having special needs. Transitions from early childhood development services to school based special education services to adult vocational and rehabilitation services are fraught with difficulties. Accessing services across fragmented physical health, mental health, substance abuse, special education, juvenile justice, and foster care systems requires considerable parental resources.

Administration staff recognizes the need to continue to work to ensure that CSHCN services such as lead poisoning prevention, genetic/metabolic and newborn hearing screenings, as well as genetic counseling are well-integrated with Medicaid-SCHIP services. Staff also needs to work

with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN. Additionally, much remains to be done to work with managers in the above-mentioned systems to coordinate and integrate services.

As described in the introduction section of this application, a large-scale effort (Medical Homes DC) under the leadership of the DC Primary Care Association is underway to increase the supply and capacity of community-based to provide medical homes. The initial phase of this effort focuses on physical facilities and equipment, attempting to bring community clinics up to code and to construct facilities in underserved areas. Standards of care and continuum of services are to be developed in the future. To date, it appears that advocates for CSHCN have yet to be highly involved in these efforts, thus providing an opportunity for Administration staff to coordinate their plans with those of the primary care "system".

8. Infrastructure development: Increase the cultural competency of the MCH workforce and service organizations.

Racism, classism, sexism and agism constitute formidable barriers to access to services. Focus groups conducted in preparation for this year's needs assessment generated numerous comments from residents who believe they receive poor quality and delayed services due to being poor, a person of color, a Medicaid-SCHIP recipient, a single mom, not speaking English, not understanding medical terms, and/or receiving services from a facility located in a low income neighborhood. The effect of these barriers on access and quality of services, and health outcomes is well-documented. But establishing and adhering to standards of cultural competency require political will and resources.

Along with follow up to the June 29-30, 2005 CAST-V analysis, the Administration will develop a plan to increase staff skills and knowledge, including recruitment of Latinos and persons with Spanish-speaking skills. Cultural competency standards will be reviewed for incorporation into grants and contracts. And resources to assist with culturally competent and appealing print and video health education materials and public information campaigns will be identified and used. Because the numbers of Asian American/Pacific Islanders and African immigrants in the District are small in comparison to Latinos and African Americans, these minorities have relatively few resources dedicated to their needs. The Administration may be helpful in documenting the unique needs of such minorities and working with existing providers to accommodate those needs. Furthermore, the District's population is ever-changing; for example, Latinos are moving into

neighborhoods in Wards 7 and 8 where service organizations have historically served a more than 90% African American population. These Latinos are experiencing significant transportation barriers to accessing the parallel system of services for Latinos that has developed in Wards 1 and 2. The Administration will play a role in identifying and raising awareness of these needs.

Priority continued from 2000-2005:

9. Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status.

This overarching priority connects all 4 levels of services. Although a number of District health status measures show improvement, profound disparities continue to exist. Most of the national and District performance measures are affected by these disparities. Elimination of disparities is key to the improvement of these measures.

APPENDICES

Appendix I

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