



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
District of Columbia**

**Application for 2009
Annual Report for 2007**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. Assurances and Certifications

These documents are available upon request.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; expires May 31, 2009.

E. Public Input

In past years MFHA has made the Title V block grant application available for review at the public libraries. Feedback on perceived needs and priorities was obtained at conferences and through focus groups. This year the senior deputy director presented the idea of establishing a maternal and child health advisory committee as a mechanism for institutionalizing public input for MFHA programming.

Nearly 50 stakeholders (local hospitals, the primary care association, community-based organizations, and members of the CSHCN advisory group) attended a three-hour open forum on June 14, 2006 to hear MFHA representatives describe sources of funding, current programs, and the requirements and opportunities of the Title V block grant. Various ideas for the structure, scope, and composition of an advisory group were discussed. Needs included: more information on how Title V and other grant funds are used, the proportion of funding allocated to personnel costs, and the effects of the Department of Health's programs and interventions.

Several next steps were agreed to, including making sections of the 2007 block grant report and application accessible to advocates, disseminating information on evidence-based practices, and investigating the feasibility of convening a meeting with stakeholders and government agencies that provide services to the maternal and child health population. MFHA management will continue to develop plans for convening an advisory group over the next 12 months.

/2008/ The former Maternal and Family Health Administration (realigned as the Maternal and Primary Care Administration -- MPCA) has conducted meetings with the following Advisory Groups during the reporting period: District's Healthy Family/Thriving Communities Collaboratives; the Children with Special Health Care Needs Advisory Board; the Men's Health Advisory Board; and the Women's Health Advisory Board. MPCA provided a draft of the 2008 Title V Application/ 2006 Annual Report to the advisory board members for their input. //

The groups raised critical health issues. Mental health was considered a critical issue. The groups agreed that major health problems included obesity, HIV/AIDS, nutrition, teen pregnancy, infant mortality, and preventive health care. When asked what the District Department of Health (DC DOH) can do to improve services for mothers, children, and families and children with

special health care needs, there were numerous responses, including increasing public knowledge of available services and providing clinics at more convenient times for families during the evening or on weekends. /2008//

/2009/ A Town Hall Meeting was conducted in May 2008 to solicit public input for the 2009 Title V Application. Participants validated proposed state priorities and provided testimony for additional needs for Children with SHCNs and provider education. An update of MCH efforts and utilization of grant funds was presented. Use of the existing Special Health Care Needs Advisory Board will help CHA: to review current state priorities; to identify gaps in services within the District's health care delivery systems; to identify who in the community can fill gaps; monitor state performance. // 2009//

An attachment is included in this section.

II. Needs Assessment

In application year 2009, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

//2008/ The 5-year needs assessment provides both recent and longer-term trends data on MCH topics. It also provides a snapshot of the District of Columbia's demographic and socioeconomic characteristics. The assessment is used to assist planners and program staff to prioritize program and population needs based upon the data available.

During 2008, MPCA plans to involve service providers, community groups and health planners in the development of the 2010 needs assessment report. Also, MPCA officials will have an opportunity to discuss needs, problems, and priorities of the MCH populations that are utilizing the District's health care delivery system. Ultimately, MPCA will develop priorities and recommendations to address the most pressing concerns and develop ways to reduce disparities and poor health indicators. The needs assessment report should be widely circulated among stakeholders and placed on the DC DOH website for public comment. At the end of the process, findings, results, and outcomes of activities conducted during the year would be incorporated into the final needs assessment report. //2008//

//2009// The Community Health Administration (CHA) recognizes the HRSA mandate to have a 5-year needs assessment in 2010. CHA also realizes that a needs assessment should be ongoing, and should not be confined to the constraints of only every 5 years. In order to best fulfill this federal mandate, CHA has recognized the need to outsource the work effort to conduct the 5-year Title V Needs Assessment. CHA is finalizing a scope of work for a Request for Proposal (RFP) to be issued in late fall 2008. The scope of work includes but is not limited to:

- 1) Development of a project work plan.***
- 2) Convene stakeholder meetings that include service providers, community groups, consumers and families and health planners in the development of the 2010 needs assessment report.***
- 3) Interviews with DOH and other District officials to discuss needs, problems, and priorities of the maternal and child and special health care needs populations that utilize or need to access the District's health care delivery system.***
- 4) Review historical data to support information collected during interviews and stakeholder meetings.***
- 5) In collaboration with CHA, the vendor will develop a list of priorities and proposed recommendations to address the critical success factors or imperative concerns.***
- 6) Identify and propose ways to reduce disparities and poor health indicators.***
- 7) Develop and implement an Assessment Report distribution plan that will foster public input.***
- 8) Submit a Public Input report.***
- 9) Submit a final Needs Assessment Report that includes the process, findings, results, and outcomes of activities conducted during the year. Hard copies and an electronic copy will be made available in accordance with Title V application requirements, including required timelines.***

CHA will assist with the circulation of the Needs Assessment Report through placement on the DC DoH web site for public comment as well as notification of its availability for review and comment in the weekly published Funding Alert.

Focus areas for the needs assessment should include addressing Homelessness in DC, Violence and Injury Prevention, Infant mortality, data collection problems especially mental health data, as well as assessing health disparities.

CHA seeks a vendor with the corporate qualifications that demonstrate, at a minimum, capabilities in health care, strategic planning, focus groups, and analysis and planning. The vendor staff is expected to have the experience, education and skills to effectively and efficiently perform the tasks required in the scope of work. CHA Grants Management staff will work in concert with the vendor to ensure compliance and completion of the scope of work within the proposed and approved timelines.//2009//

III. State Overview

A. Overview

The District of Columbia (DC) has a unique status as the nation's capital, and serves the multiple roles of a city, county and state. The District consists of an urban land area of 63 square miles. 57% of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes, factors that impact upon the resources available to the District government for services to residents. Although DC residents elect a mayor and city council, they do not have voting representation in the US Congress, which has exclusive authority over legislative acts, including those pertaining to the budget. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District is divided into 8 wards--subdivisions on which political representation is based and public services are administered. Voters in each ward elect a city council representative, and 4 members are elected at-large. As described in the needs assessment section of this application, socio-economic indicators, racial and ethnic composition and health outcomes vary widely across the 8 wards.

The US Census estimated the 2004 population at 553,523, down from the 572,059 count from the 2000 census. The District of Columbia is a majority (60%) African American city. Information from the 2003 American Community Survey indicates that 30% of the population is white, 3.5% is Asian/Pacific Islander and nearly 10% is Latino. Approximately 15% of the population is foreign-born, with 18% of the household population over age 5 speaking a language other than English at home.

/2007/ The District successfully challenged the 2005 Bureau of the Census estimate, which on July 21, 2006 was corrected to to 582,049. The revision marks the most significant increase in the District's population since it peaked in 1950 at 802,178. //2007//

The District is characterized by a high rate of poverty--nearly 20% of individuals and 18.5% of families. Median household income and median family income are \$42,118 and \$50,243 respectively, lower than the US medians of \$43,564 and \$52,273. And more than 1/3 (35%) of the District's children are members of families living below the federal poverty level (31.3 -- 39.1, 90% confidence intervals). The most recently compiled data on the District's public school population show 84% of the enrolled students are African American and 9.7% are Latino. 64% are low income and 19% are enrolled in special education.

In addition to the high poverty rate, inequality and the concentration of poverty have increased over the past decades. A comparison of pretax income data from the 1970s, 80s and 90s found that the income gap between the highest and the lowest income quintiles was not only great but also growing. The average income of the top 5th of the District's households -- \$186,830 in 1999 -- was 31 times higher than the average income of the bottom 5th of households --\$6,126. This gap is as great as or greater than any of the nation's 40 largest cities. During the boom years of the 1990s, average income for the highest quintile increased 36% (adjusted for inflation), but only 3% for the bottom quintile.

/2007/ Analyses by the DC Fiscal Policy Institute indicated that income inequality is great in the District and has increased over the past decades. Income among DC's poorest families remained virtually unchanged between the 1980 and the 2000 census when the average income of the bottom fifth increased 3% from \$12,300 to \$12,700. In contrast, the average income of the richest fifth of families increased 81%. As a result, the income gap between DC's high-income and low-income families widened significantly, as did the gap between wealthy and middle-income families. In 2000 the richest 20% of District families had incomes 12.4 times as large as the average income of the poorest 20%, up from a ratio of 7.1 in 1980. //2007//

Poverty in DC has increased over the past decade but had become more concentrated in certain census tracts. From 1990 to 2000, the number of residents living in extreme poverty tripled, reaching 66,000, and the number of high-poverty census tracts in the city rose from 36 to 43. The number of extreme-poverty tracts more than doubled, rising from 10 in 1990 to 23 in 2000. 24% of poor residents lived in high poverty tracts in 2000 compared to only 9% in 1990. The majority of these tracts are located east of the Anacostia River (www.fanniemaefoundation.org/programs/pdf/Housing_in_the_Nation_2003_ch7.pdf Accessed June 5, 2003).

The District, which currently ranks 31st among states in the nation for maximum TANF benefits, provides lower cash assistance to households with no other income than neighboring Maryland (21st) and Virginia (29th). Over the past 15 years, the maximum benefit level for TANF recipients with no other income has dropped by about 40%, after adjusting for inflation. The current maximum TANF benefit for a single mother of 2 children is \$379 per month, or \$4,548 per year-- only 29% of the federal poverty level! Considering additional income from food stamps, the annual income of a TANF family of 3 is just \$750 per month, or about 60% of the federal poverty level.

//2007/ TANF benefits increased 7.5% effective July 1, 2006. Approximately 45,000 persons in 15,614 households receive cash assistance benefits in the District. Payment for a family of three increased from \$379 to \$407. A comparable family would receive \$490 in Maryland and \$389 in Virginia. TANF participation in the District is at its lowest level since the 1996 welfare reform law went into effect. //2007//

The metropolitan region is experiencing economic growth and an increase in jobs, but the benefits are concentrated in the suburban jurisdictions. Even jobs generated in the District disproportionately benefit suburbanites. Unemployment has increased over the past year, with the most recent figures (preliminary February 2005) showing an official unemployment rate of 8.2%, varying from 2.8% in Ward 3 to a staggering 15.4% in Ward 8.

One manifestation of extreme socio-economic disparities is the increase in homelessness. According to a HUD report, the District ranked 1st among 13 jurisdictions in the prevalence of homelessness--defined as persons living in shelters--with a point prevalence of 1.4%, or 7% of poor persons. When estimates include persons living in or awaiting transitional housing, the prevalence increased to 2.2%. Average length of stay in shelters was 87.5 days. The number of homeless women with children also increased with more than 150 typically awaiting placement at any given time. Increases have been attributed to several trends: the decline of affordable housing and reduction in public housing units, breakdown in public services for substance abusers and mentally ill persons, and cuts in public assistance and welfare to work policies. The most recent survey conducted by the Metropolitan Washington Council of Governments found an increase of 8.8% (8977) in the number of homeless persons in DC from 2004.

//2007/ The 2006 point-prevalence survey of homeless persons conducted by the Metropolitan Washington Council of Governments found a 5.6% increase in the District from 2004, a current rate of 10.7/1,000. Slightly more than one-third is defined as chronically homeless. Approximately 33% of the District's homeless are persons living in families <http://www.mwcog.org/uploads/publicdocuments/8FpWXg20060615080733.pdf>. //2007//

Another analysis by the DC Fiscal Policy Institute found that the number of low income persons increased while the number of affordable housing units declined: In 1990, there were 47,000 renter households with income below \$20,000, and 43,000 apartments affordable to them (\$500 per month), a shortage of 4,000 units; by 2003, the number of low-income households had increased to 55,000 while the number of affordable rental units had fallen to 31,000 -- widening the affordable housing shortage to 24,000 units.

Of the District's population 35% spends 30% or more of household income on rent and utilities, a threshold at which families are considered likely to be deprived of other necessary goods such as food. Only 41% of District housing units are owner-occupied, ranging from 21% in Ward 8 to 62% in Ward 4. Furthermore, the most typical household composition is the 1-person household--44% of all households. 13% of households are female headed with related children. 13% are married couple households with no related children. The prevalence of female householders with related children varies from 2.1% in Ward 3 to 33% in Ward 8.

The extreme disparities in income and wealth overlaid with the long-term impact of racism, all concentrated in a small geographic area, without full political sovereignty, present formidable challenges to protecting and improving the public's health.

Since the mid 1990s, the way in which health services to the poor are financed and delivered has undergone many changes, not always in a linear fashion and generally without the inclusion of maternal and child health advocates in the planning process. First was the change from fee-for-service to mandatory managed care for the TANF Medicaid population, followed by an expansion of eligibility based on the SCHIP program. In 1999, the District consolidated its public hospital and network of ambulatory clinics into a single entity, the DC Health and Hospitals Public Benefits Corporation. 3 years later that entity was abolished.

In June 2001, the District, then operating under the authority of a federally-appointed, 5-member Financial Responsibility and Management Assistance Authority established in 1995, closed inpatient and emergency services at the city's sole public hospital, DC General Hospital, and transferred the management of the hospital's ambulatory clinics and community health centers, which along with the hospital were operated under the auspices of the DC Health and Hospitals Public Benefit Corporation, to the private sector. Another umbrella organization, the DC Health Care Alliance, was created to fund and manage the privatization of safety net health services. Before the kinks in the restructured safety net system--the Alliance--were worked out, arrangements began to deteriorate due to the financial instability of the prime contractor's parent corporation. In November 2002, the National Century Financial Enterprises--an Ohio lender that supplied virtually all of the Greater Southeast Community Hospital's (GSCH) cash--collapsed, causing the hospital to immediately close pediatric inpatient and other services, reduce staff and take other crisis measures, and the parent corporation, Doctors Community Healthcare Corp. which had purchased the GSCH when it was forced into bankruptcy several years ago, eventually filed for bankruptcy itself.

The GSCH, the only acute care and emergency facility located in the southeast quadrant of the city, has remained open despite financial and accreditation problems. The Department of Health (DOH) assumed management of the Alliance, stepping into the administrative role previously played by GSEH. The extent to which the restructuring of the safety net has benefited those who use the system is still being debated. The Alliance is considered to benefit small not-for-profit, neighborhood based clinics and their patients--clinics that are not part of the Medicaid MCOs' networks. These clinics provide culturally and linguistically appropriate care to many of the city's residents who are uninsured but not eligible for Medicaid/SCHIP. In particular, Latino residents have voiced their support for the Alliance at various community forums. More than 20 specialty clinics and health services remain available on the DC General campus, operated by Alliance subcontractors--Ear, Nose, and Throat (ENT) Clinic, Cardiology Clinic, Pediatrics Clinic, Dental Clinic, Gastro-Intestinal (GI) Clinic, Obstetrics and Gynecology Clinic, Surgery Clinic, and Urology clinic.

In October 2003 The Henry J. Kaiser Family Foundation released the findings from the DC Health Care Access Survey, 2003, a telephone survey of a representative sample of 1581 adults. Findings confirmed that 2 characteristics shape access and health status in the District. The population is majority (72%) "minority" (African American, Latino, Asian/Pacific Islander and other). And 36% of the entire population is low income (less than 200% of the federal poverty level, \$30,520 for a family of 3). Latinos (55%) and African Americans (38%) are much more

likely to be poor than are whites (20%). The report concludes that the Latino population is particularly vulnerable to lack of access to health services.

Due to the expansion of public programs in recent years, the DC population now has 1 of the highest rates of health insurance coverage in the US. 91% of those age 18 -- 65 have some form of health coverage, 70% employer based insurance, 11% Medicaid-SCHIP, 5% other and 4% DC Health Care Alliance. (Although the Alliance is not strictly speaking an insurance program, enrollment in the program enables beneficiaries access to Medicaid managed care-like services at no charge.) Only 5% of women in this age group lack some coverage. But although a relatively low proportion of the population lacks health insurance, the impacts vary. For example, 32% of Latino adults lack insurance, compared to 10% of African Americans. Other findings include:

- 9% of the population either relied on an emergency room or reported no regular source of care, with 24% of Latinos being in this situation.
- 36% of uninsured persons rely on emergency room (21%) or had no regular source of care (15%);
- 45% of the uninsured did not have a medical visit in the last 12 months;
- 38% of all Latinos had no medical visit in 12 months;
- Residents (24%) believe HIV/AIDS is the most critical health issue in the District;
- 40% of Latinos report having a problem communicating with providers due to language barriers;
- Although 79% of residents rate their overall experiences in the health care system as excellent or good, the elderly, white and higher income residents report more positive experiences than others.

Medicaid participation is high in the District, due to the high prevalence of poverty. Approximately 24% of the entire population receives Medicaid-SCHIP benefits. The District operates a combined Medicaid-SCHIP program, with eligibility covering up to 200% of the federal poverty level and including parents living with children under age 22. Presumptive eligibility for pregnant women provides coverage for this population, although many otherwise eligible persons are excluded due to their immigration and naturalization status. There are currently 3 managed care contractors that provide services to the TANF and TANF-related, and SCHIP beneficiaries. Another contractor provides carved-out services to children who qualify for SSI and Medicaid. Families may elect to receive fee-for-service Medicaid for these children.

//2007/ The recently adopted FY 2007 budget provides for expanding Medicaid for persons under 21 years of age from 200 to 300% of FPL. Pregnant women will be covered as well. It is estimated that up to 1,000 individuals will be newly eligible. The expansion must be approved by CMS.

In August 2005, the Department of Health announced it would incorporate performance-based payments into its contracts with managed care organizations (MCOs) serving Medicaid enrollees. The three Medicaid MCOs are now required to submit 41 Health Plan Employer Data and Information Set (HEDIS) measures with initial reports due July 2006. The District is currently developing its quality-based reimbursement system. It is expected that plans would be given capitated payments up front and, if they exceed performance measures, enhanced rates as bonuses. If a plan underperforms, it would be penalized. The current procedure in which beneficiaries who do not select an MCO are assigned randomly may change to one by which better performing plans received a greater proportion of assignees. //2007//

The DC Health Care Alliance provides health care services to approximately 26,400 uninsured District residents with incomes < 200% of the federal poverty level, and who are not eligible for any other health insurance coverage, including Medicaid. The Alliance is funded entirely by District funds.

The debate on how to finance and deliver health care safety net services in the District is far from over. It appears likely that within the next year, Alliance contracts will be aligned more closely with

Medicaid MCO contracts. Advocacy for a hospital to replace the DC General Hospital is very much alive. In 2004, the District entered into a MOU with Howard University Hospital to begin work for a new full service Level 1 trauma center with 200-300 beds to be constructed on the campus of DC General. Considerable debate about the feasibility of another hospital, and its effects upon other hospitals, particularly the floundering GSEH continues.

/2007/ The debate about the need for and how to finance a new hospital is continuing; the initial agreement with Howard University Hospital appears to have halted. A mayoral commission has been appointed to make recommendations. *//2007//*

In June 2005, the chair of the city council committee on health introduced legislation (B16-0348 Universal Healthcare Access Act of 2005) that would require the mayor to recommend within 6 months strategies to ensure universal access to health insurance by no later than December 2010. The bill, which is expected to be considered before the end of the 2005 session and is likely to be approved insofar as only 1 councilmember is not listed as a co-sponsor, lists strategies to include opt-in purchasing to the city's Medicaid program, insurance pools, medical savings accounts, or small employer buy-ins into the District's health insurance.

Mirroring the profound disparities in economic status and health indicators, the District's health care delivery system is 1 of extremes: 3 world class academic medical centers cluster in the northwest section of the city, yet 52% of the population resides in federally designated Health Professional Shortage Areas (HPSA). About 18% of the population lives in Medically Underserved Areas (MUA). Much of the HPSA has been designated as shortage areas for dental services and mental health services as well. According to an annual survey conducted by DC Primary Care Association, the primary care safety net consists of:

- 14 privately operated organizations, 4 of which are federally-funded section 330 community health centers. All together, the 14 entities operate 38 freestanding sites and 3 mobile units;
- 7 hospital affiliated clinics; and
- 3 school based clinics, 1 of which is operated by the Department of Health with federal Healthy Start funds and clinics operated by the Department of Mental Health (number not provided.)

The DC Primary Care Association analyzed the needs, capacity and demand for safety net services and concluded that the existing clinic system is not capable of meeting the demand for primary care services in accessible neighborhood-based settings. Often housed in inadequate physical space, with limited equipment and sometimes thin staffing, few offer the range of services required for adequate primary care. Additionally, linkages to secondary and tertiary care are too frequently tenuous. Moreover, the existing clinics are maldistributed across the city, with relatively few located in the lowest economic areas. DC Primary Care Association therefore embarked on a long term campaign to raise funds for the capital development of safety net clinics. Raising funds from federal, District and private grants and loans, and providing funds and technical assistance to safety net organizations are the initial steps. But assisting providers to expand and increase their own revenue streams is a primary strategy as well. Within the last year at least 4 private community based health centers have applied for and/or been granted federally qualified health center status and funding.

/2007/ In spring 2006, the DC Primary Care Association announced that Alvarez & Marsal and The Jair Lynch Companies were selected as development consultants to manage site selection and construction for its Medical Homes DC capital projects. To date, DCPCA -- through its Medical Homes DC initiative -- has awarded \$1 million in District capital planning and development grants to seven local nonprofit community health centers for nine projects as part of an effort to provide health care to over half of DC residents living in medically underserved neighborhoods. Another \$6 million in grants will be available later in 2006. Several health centers were awarded federally qualified health center status this year. *//2007//*

An analysis of the Behavioral Risk Factor Survey and hospital discharge data commissioned by the DC Primary Care Association and released in January 2005, confirmed that the adult chronic

disease burden is concentrated in low income zip codes of the city where there are fewer primary care providers. Furthermore, an examination of avoidable hospitalizations by age group and poverty rate of resident zip code during the period 2000 -- 2003 suggested to the researchers that due to the expansion of Medicaid and the establishment of the Alliance, the rate of avoidable hospital admissions declined to a greater extent in high poverty zip codes (43-59% below 200% of FPL) in comparison to zip codes with less concentration of poverty. The principal investigators, Nicole Lurie, RAND Corporation, and Martha Ross, Brookings Institution, also concluded from their review of these data that there was no evidence of an adverse effect of the closure of DC General Hospital in mid-2001.

/2007/ In 2006 legislation established the Office of African Affairs to assist immigrants with health, education, and job services. The District's African-born population increased approximately 40% in the 1990s, reaching 9,208 by the 2000 Census. Africans represent one-eighth of foreign-born residents, with Ethiopians constituting the largest group.

In September 2004 DOH published a report of a survey of the health status, risk behavior, and access to health care of the African, Latino, Asian and Pacific Islander and Caribbean immigrant populations in the District. Although it is not clear from the description of the sampling approach to what extent the results can be generalized, substantial numbers of immigrants were not obtaining basic preventative services. Of those sampled, 29% were uninsured. Nearly half of the women who responded had had a mammogram within the past 12 months, with higher rates among women from the Caribbean compared to Asian and Pacific Islander immigrants. About two-thirds of the women had had a PAP smear test in the past 12 months, with the lowest rates among Asian and Pacific Islanders. And 46% reported having an HIV test within the last 12 months, but 25% had never been tested at all. Among those not tested the most frequently given reasons were: lack of information about testing sites, no perceived need for testing, fear and cost. 79% were sexually active. Only 45.5% had seen or heard DOH prevention messages. //2007//

The District of Columbia Department of Health

The Department of Health (DOH), where the official Title V agency is located, became a cabinet-level department in January 1997. The FY 2005 operating budget of \$1,637,183,303 supports 1456 FTEs. 2/3rd of the budget total is based on federal Medicaid payments (\$951,289,000) and federal grants.

/2007/ The department operated in FY 2006 with an approved annual budget of more than \$1.7 billion and 1,370 FTEs; 66% of the budget is from federal sources. Due to the unique relationship between the District and the federal government, Congress has oversight of and must approve the District's budget. //2007//

The director of the DOH reports to the deputy mayor for children, youth, families, and elders, a position created by the current administration to give more visibility and attention to services affecting this population. The Department of Human Services and the Department of Mental Health also fall within the purview of that position.

Gregg A. Pane, MD, MPA, CPE, FACEP, was appointed director of DOH August 2004. Dr. Pane has more than 20 years of executive level public health experience. He joined the District from the Henry Ford Health System, where he served as System Vice President for Clinical Quality and Safety and Medical Director for Public Policy Initiatives for 2 years.

DOH is responsible for Medicaid (Medical Assistance Administration), contracting with the private sector to provide safety net health services and managing the Alliance (Health Care Safety Net Administration), substance abuse (Addiction Prevention and Recovery Administration), environmental health (Environmental Health Administration) and licensure and facilities regulation (Health Care Regulation and Licensing Administration). Other components are: Emergency Health and Medical Services Administration, HIV/AIDS Administration, Primary Care and

Prevention Administration, Health Promotion Administration, and Policy, Planning and Research Administration.

Following his appointment, Dr. Pane continued on-going efforts to centralize support functions and flatten the organizational table. He has delineated 3 principles and 5 strategies to guide DOH. The principles are innovation, measurable results and absolute fiscal and ethical integrity. The strategies are neighborhood outreach and prevention; quality, safe and coordinated system of care; community preparedness; healthy environment; and making government work. Included in the neighborhood outreach and prevention strategy is the consolidation of the Title V-mandated 800 information and referral line with other departmental information services and the establishment of a community outreach team to coordinate and integrate various grants and programs. Outreach and prevention efforts are to focus on language access, health literacy and community partnerships.

The Title V-mandated telephone information and referral operation was consolidated with other DOH information services call centers and hot lines in the communications office of the director of the department. Staff is trained to respond to a broad range of calls. Callers who request the information about maternal and child health services are being re-routed to the 1-800-MOM-BABY HEALTHLINE; however there are reportedly many callers who hang up because of the automated prompts in place before one connects with a live HEALTHLINE counselor. As a result, opportunities to engage women who call the 1-800-MOM-BABY HEALTHLINE and probe about status of prenatal care, health insurance, or child care issues and to intervene with referral services or brief counseling may have been affected. Because the 1-800-MOM-BABY HEALTHLINE is no longer the first responder for Title V services, call volume has been reduced by more than 50%. For Title V reporting (Form 9), the calls reported are those that are received via referral through the centralized call lines and calls made to the direct line.

In the winter of 2000, under the leadership of the State Center for Health Statistics Administration, DOH completed the 2010 planning process. The final plan, which was released in September 2000, incorporates 20 maternal and child health objectives, 14 adolescent objectives, and 6 family planning objectives. The Maternal and Family Health Administration staff relied heavily on the performance measures required for Title V reporting, and consequently 13 of the 2010 objectives overlap with the Title V measures (http://dchealth.dc.gov/information/healthy_people2010/pdf/2003_2004bipfinal.shtm). In addition to the overarching objective of reducing the infant mortality rate, several focus area objectives are directly related to Title V performance measures: breastfeeding, childhood immunization, early entry into prenatal care, and asthma hospitalization. A biennial implemental plan for 2003-2004 has been published and a community forum was held in the summer of 2005 to inform stakeholders of progress toward the objectives.

A 5-year health systems plan to guide the certificate of need program continues to be developed.

/2007/ MFHA continued to participate in the DC Healthy People 2010 process. DOH has published several reports--Healthy People 2010 Biennial Implementation Plan Year 2003-2005, Biennial Implementation Plan Progress Report Year 2003-2005, and Mid-Course Revisions 2000-2005. A public forum was held in May 2006. This year MFHA reduced the number of objectives it will report on from 23 to a more manageable subset of 8; selection was based on the availability of current data and relevancy to programming.

A draft of the District's long-awaited health systems plan was completed in May 2006. The plan is based on Healthy DC 2010 objectives.

The DC Cancer Control Plan 2005-2010, released in May 2006, revealed that the incidence of breast cancer in DC (143.3/100,000) is considerably higher than the national rate (132.2). Mortality is high as well. Screening rates are higher in DC than nationally among age groups, African Americans and women of low education. In addition to increased screening,

recommended strategies focus on linking women to cancer care services.

DC has the highest rate of cervical cancer among states in the US, and the proportion of cases diagnosed in advanced and unknown stages is higher in DC than in other states.

Recommendations include a public education campaign to increase awareness of symptoms of ovarian and endometrial cancers. //2007//

In 2004, the District passed legislation called the Language Access Act to increase access to government services and benefits. It requires government agencies to provide oral language services to limited English proficient persons, meaning persons whose primary language is not English as well as English speakers with low literacy skills. Each agency is expected to determine what type of oral language service (i.e. telephone language line, bilingual front-line staff) to provide by considering a number of factors, including the agency's size and the type of services it provides. Agencies are also required to provide written translations of vital documents into those languages spoken by the larger language populations served. Medicaid clients are being informed of their right to an interpreter (not necessarily a medical interpreter) in any native language, and translation of all vital documents in Spanish, Vietnamese, Mandarin, Amharic and/or Braille. Print materials are to be designed at a 5th grade reading level. The extent to which compliance with the law has been achieved has yet to be determined.

After forming several strategic partnerships, the DOH State Center for Health Statistics engaged in efforts to expand understanding of health issues among Latinos. Supported in part with a grant from the Centers for Medicare and Medicaid Services and consultants from the George Washington University School of Public Health and Health Services, the Council of Latino Agencies completed in 2004-2005 a household survey in Wards 1, 2 and 4 where the Latino population is concentrated. The interview was based on the Behavioral Risk Factor Survey items and adapted for the target population with input from a community advisory group, the Latino Health Care Collaborative, which continues to work on Latino health issues. In addition to the survey, the Council of Latino Agencies has recently published several reports based on analyses of secondary data to describe changes in the Latino population and to highlight disparities.

//2007/ In fall 2005, two committees--the Committee on Health and the Committee on Education--of the District Council (legislative branch) initiated hearings on the school health program. These hearings, combined with the work of advocacy groups, several of which were promoting the development of school-based health centers (SBHC), increased attention to the need to improve the school nurses program and has resulted in renewed interest, oversight, and funding for school health. In October 2005, the DOH was charged with developing a plan for a "coordinated school-based health service program". The project was assigned to the Maternal and Family Health Administration, Child, Adolescent and School Health Bureau. MFHA expended considerable resources on this effort throughout the 2006 fiscal year.

Staff conducted a needs assessment consisting of a review of existing reports of the DC Public Schools (DCPS) and the contractor for school nurse services, Children's National Medical Center; interviewed managers of various school-based mental health, substance abuse and health programs; and reviewed the literature on school health services. Service gaps and concerns were identified. A draft school health plan was published for public comment in January 2006. The following is a partial summary of the conclusions of the assessment.

There is no single document or collection of documents articulating the various statutes, rules and inter-agency agreements governing the funding and provision of health care services in public and charter schools. The complex governance and multiple institutional oversight of the school system including the Board of Education, DCPS administrators, the Council as well as the participation of other entities such as DOH, Child and Family Services Administration (CFSA), DMH, in the provision and oversight of health care services has resulted in an incomplete and at times inconsistent regulatory regime. The absence of a clearly articulated set of rules has created confusion and occasional controversy with respect to the provision of school-based services.

Since 2001, the Children's National Medical Center (CNMC) has operated the school nurse program under contract to the DOH. District law requires that all schools have a registered nurse available for a minimum of 20 hours per week. Among the 170 schools currently covered by the nursing program, 63.5% (108/170) receive 20 to 24 hours of registered nurse coverage per week while 36.5% (62/170) of the schools receive 40 hours of coverage each week. The average nurse-to-student ratio is roughly 700:1. Although this ratio meets the recommendation of the National Association of School Nurses and Healthy People 2010, it does not respond to variation in needs across schools. Consideration of needs includes: increased mainstreaming of medically fragile students; variation across schools in the numbers of medically fragile students--a factor not taken into account in calculating the nurse:student ratio; variation across schools in the prevalence of chronic diseases requiring attention from the school nurse; the lack of any school nurse coverage in more than 30 public charter schools; and the increasing demand for personnel to administer medication in the school setting.

The assessment concluded that much of what nurses perform during a typical school day does not require the level of a registered nurse. LPNs and other assistive personnel could generate letters, dispense medication, track down parents, and provide certain levels of care under the supervision of a registered nurse. The current staffing model based almost exclusively on RNs does not allow the flexibility to match the skills of caregivers with student needs. Although the authorizing statute prefers RNs, the law appears to allow the use of LPNs working under an RN to a much larger extent than presently utilized.

System-wide policies and procedures are not fully in place to a) alert the nurse services contractor about the expected case load of medically fragile children in a given school; or b) involve the nurse in the initial planning and coordination of care for these students; or c) ensure that a copy of the updated individualized health plan is maintained in the health suite or otherwise readily available to the school nurse.

CNMC hires a considerable proportion of contract personnel to staff its program with registered nurses. The fact that these practitioners are not employed by CNMC may affect continuity of care and adds complexity to program management and contract oversight.

In addition to the nurses' workload and staffing issues, the report noted problems with their work environment. No regulatory regime currently exists in the District to set and enforce minimum standards for equipping or operating these health care facilities. Currently, the space and quality of nursing suites vary widely from school to school. Some nursing suites lack running hot water and others have no phone. Many have no lockbox for the secure storage of student medication. Nearly half of the health suites are without routine online access to Web-based resources such as the DC Immunization Registry.

Another conclusion of the status report focused on the lack of standards or guidelines governing coordination among agencies and disciplines providing services in the schools. Proximity of nurses, school based health center (SBHC) practitioners, and mental health clinicians located in the same school would facilitate interdisciplinary collaboration, appropriate information sharing, and continuity of care. However, nursing suites, SBCH, and counseling rooms are not consistently co-located in the schools that provide these services. Additionally, the DMH operates programs in a number of schools, and a mobile dental services program circulates as well.

The degree of health information sharing among the different school-based clinicians (nurse, mental health counselor, nurse practitioner, dentist etc.) who may be seeing the same individual student varies from school to school and is often minimal. Forms to collect health information are not uniform system wide.

The level of coordination (e.g., follow up on referrals) between the school nurse and community-based specialty providers is reportedly limited. There is also need for clarity with respect to which

parties (school staff, nurses, or both) are responsible for updating and securely maintaining health care records in the school.

At present there is no formal coordination between CNMC nursing staff and the four SBHCs. A coordinated school health service program could in principle involve a single billing system for all school-based clinicians. Economies of scale could be achieved if all practitioners providing billable services could utilize the same system. Maximizing third-party reimbursement for services provided to the general student population would create a stable funding revenue stream available for continuing program improvement or expansion. Likewise, establishing a repository of electronic medical information accessible to the appropriate health personnel to facilitate continuity of care is more likely to occur under a unified governance structure for school health services than a fragmented system.

There is no formal relationship to date between school-based practitioners and Medicaid health plans covering a large proportion of the student body to coordinate services or for reimbursement of services. School-based Medicaid-covered services that qualify for federal funds include physical, occupational, and speech therapy, as well as diagnostic, preventive, and rehabilitative services. Presumably, school nurses could bill for providing certain services under the supervision of a physician or a nurse practitioner or when standing orders for certain Medicaid-covered services are on file. A clearly-stated and consistent policy has yet to be developed on this issue.

The poor oral health status of underserved children in the District was frequently raised in the course of assembling the school health plan report as an issue that requires immediate attention. SBHCs may provide dental care as part of an expanded scope of service or oral health assessments as routine care.

The nursing service program administered by CNMC has never undergone a comprehensive evaluation. The needs assessment, therefore, recommends an evaluation of the entire program, which should include an examination of the interface and linkages between SBHC and school nurses including questions such as whether SBHC staff could perform nursing program duties (thus easing registered nurse staffing requirements in the schools where health centers are established). The evaluation should fully explore sustainable financial models and, in particular, Medicaid reimbursement. The MFHA has drafted a RFP to identify a vendor to conduct an independent baseline assessment of the school nurse program and over the next fiscal year will conduct a process and outcome evaluation as the school nurse program implements new and evidenced-based strategies in the delivery of school-based services.

DOH proposed that it assume the lead responsibility for coordinating the financing and delivery and ensuring the quality of school health care services for the general student population in consultation with DC Public Schools (DCPS), DMH, CFSA, and other involved agencies.

The report recommended that although the mandates and authorities of each public agency differ somewhat, these interested parties must come together at the highest levels to develop a unified agenda to implement a school health plan and to develop unified policies with regard to:

- Responsibilities and commitments of each party
- Program models
- Mandatory and optional services
- Risk management
- Resource and expense sharing (including coordination of federal, local and philanthropic funding)
- Degree of flexibility for providers and principals to meet individual school needs
- Data management tools and evaluation process

Common decisions on these and other topics could be codified in a master memorandum of

understanding.

The school health plan delineated by MFHA proposed to concentrate first on improving essential structural and procedural aspects of a quality nursing program that are pre-requisites for establishing a student outcome measurement and evaluation system. These components include, for example, a) expanding the capacity to provide school health nursing services to all students in District public schools, b) ensuring that providers are well trained and qualified; c) generating the capacity to reliably collect valid data throughout the nursing program to drive the outcome indicator development process.

The DOH published a draft school health plan in January 2006, which proposed a timeframe and resource needs to deal with priority gaps and concerns. Comments from the public were solicited. The DOH key focus areas for FY 2007 include:

- Procurement and installation of wiring for Internet access for all DCPS health suites.
- Procurement of medical supplies and equipment for all DCPS and Charter schools with nursing services.
- Implement one to two pilot key initiatives focusing on STD education, counseling, testing, and treatment; and asthma or injury prevention.
- Equipping all health suites with computers and printers.
- Increasing by 30% the provision of full-time nursing coverage in schools
- Development of an electronic school health record and database.

The FY 2007 budget proposes an additional \$9.75 million of appropriated District funds dedicated to these key focus areas, as well as to the development of standards of care and regulations for the school health nursing program in addition to adopting best practice models in the provision of nursing care. The DOH will also launch a process outcome evaluation of the program.

In April 2006, the Board of Education approved a "comprehensive system-wide health and HIV/AIDS education program" that includes standards, testing and treatment policies for DCPS. A partial list of features affecting the school health program includes:

1. Creating a cabinet-level school health administrator who will oversee all DCPS health-related and health promotion activities and ensure coordination of HIV/AIDS services with the schools;
2. Convening an advisory committee that will include participation from a diverse group of stakeholders, including but not limited to, the DOH, Children's National Medical Center, other local hospitals, the Mayor's Office, the Council of the District of Columbia, representatives from community based organizations, the School-Based Health Coalition, school nurses, parents, religious leaders and students.
3. Reaching out to medical homes, whose mission is to strengthen and integrate the primary care safety net clinics for the uninsured and underinsured residents of the District for inclusion in the DCPS Strategic Health Plan;
4. Revising DCMR Title 5, Chapters 23 and 24 to comply and meet accepted DC and National Health Education Standards;
5. Approving comprehensive, pre-K through 12 evidence-based health education and evaluation standards;
6. Providing DCPS students with access to HIV/AIDS programs taught by trained professionals
7. Ensuring that DCPS HIV/AIDS education efforts follow the epidemiology of the epidemic; focusing the most resources on reaching those at highest risk for HIV infection;
8. Providing professional development and training for all person working toward meeting health

education standards;

9. Adopting standards and training, approved by the DOH and based on CDC guidelines, for partner community based organizations providing HIV/AIDS prevention programs in the schools;

12. Improving communications with the public about DCPS HIV/AIDS and students' sexual health programming including standards, curricula content, and related public policies, by creating a web-based venue for communicating vital information about their HIV/AIDS and health-related programs. //2007//

/2008/ The District of Columbia estimated population is currently 581,530 as compared to the 582,049 figure for the 2005 Bureau of the Census. Approximately 57% of the district's population is African American, 31% are White, 9% are Hispanic, and 3% are Asians, Native Hawaiian, and other Pacific Islanders.

The District's 63 square miles are divided into eight wards on which local political representation is based and services are administered. While the median household income is \$46,211, economic indicators vary widely across wards. Ward 3 in Northwest Washington, DC is the wealthiest with a median income of \$71,975. Ward 8 in Southeast is the poorest ward with a \$25,017 median income. Wards 6, 7, and 8 have the highest poverty rates in the District - 21, 25, and 36 percent respectively -- and the highest rates of children in poverty - 36, 37, and 47 percent respectively. These wards are overwhelmingly African American in population composition. Almost 20 percent of the population in the District lives below the poverty level.

In 2006, 9,369 individuals were homeless in the District, a 13.5 percent increase from 2004. There were 1,891 people identified as chronically homeless, meaning they had a disabling condition and had been either continuously homeless for a year or more or had at least four episodes of homelessness in the past three years. According to the District's organization Continuum of Care, about 15 percent of the homeless were severely mentally ill, about 18 percent had chronic substance abuse problems, and about 6 percent were victims of domestic violence.

The TANF population in the District has changed over the past ten years. Since DC implemented welfare reform policies in 1997, its TANF caseload has fallen by 38%. As TANF caseloads fall, the characteristics and service needs of welfare recipients have evolved as families near the five-year time limit for benefits. As of April of 2007, the average monthly TANF caseload in the District was 15,500 families and the estimated annual program cost was \$65,100,000.

Today, more than half of DC TANF recipients are either working or have worked recently. Working TANF recipients have jobs that pay about \$8.50 per hour on average, well above DC's minimum wage. About half of employed recipients have paid sick leave and health insurance from their employer. Overall, most recipients (86 percent) remain poor, and about one third are extremely poor, with incomes of less than 50 percent of the poverty line, low skills, and facing personal, family, and logistical challenges that make it hard for them to work.

The District of Columbia has a newly elected Mayor and City Council Chairman as well as newly elected Council members and Council Committee chairs. Mayor Adrian Fenty outlined a 2007 Action Plan for the District. His vision for a Healthy City would assure access to affordable, comprehensive, high quality health care through established medical homes; access to affordable health insurance (cost-effective preventive care and health maintenance); a strong health care safety net (including coverage for medical needs, mental illness, pharmacy services, substance abuse, and oral health needs regardless of ability to pay); and tools to enable residents to maintain healthy and balanced lives. During Mayor Fenty's first 100 days and beyond, he highlighted 25 action items in the area of health.

In light of the high incidence rates of a variety of cancers and chronic conditions, the city

government allocated during FY 2007 \$20 million of the tobacco settlement fund to the DC Cancer Consortium in order to implement over a three to five year period the previously developed 2005-2010 DC Cancer Control plan. An additional \$10 million was granted to the American Lung Association of DC to enhance tobacco cessation and control across the city. MPCA has the responsibility of overseeing these two significant grants.

The FY 2007 Budget for the DC DOH exceeds \$1.8 billion and includes 1,182 FTEs; 67% of the budget is from federal funding sources. The US Congress continues to have oversight and approval authority for the District's budget.

Shortly after the new city administration took office, the DC DOH instituted in January 2007 a realignment which consolidated the operational units within the Department into the following Administrations: Maternal and Primary Care Administration; Center for Policy Planning, and Epidemiology; Addiction Prevention and Recovery Administration, Medical Assistance and Health Care Safety Net Administration; Health Care Licensing and Regulation Administration; Emergency Medical Services Administration; HIV/AIDS Administration. However, these functional realignments could not be reflected in the FY 2007 budget and will be incorporated for the FY 2009 budget cycle. //2008//

//2009/ The District of Columbia estimated population in 2007 of 588,292 showed a 2.8% increase in population. In 2006, the population distribution was 55.5% African American, 34.5% Caucasian, 8.2% Hispanic, 5.1% including Native Americans, Alaskans, Hawaiians, and Pacific Islanders), 3.4% Asian, and 1.5% mixed (two or more races). Although the African American population is declining due to many middle class and professional African Americans leaving the city for suburbs, the District's white population has steadily increased, in part due to effects of gentrification in many of Washington's traditionally Black neighborhoods. The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average.

District residents live in one of the eight Wards. Economic disparities are event among the wards. For example, Wards 6, 7, and 8 comprise the majority of African American residents (79.2%) and more than 30% live below the Federal Poverty Level (FPL). Wards 4 and 1 comprise a significant proportion of the Latino population (20.8%) with expansion into Wards 5 and 6, due to rapid economic development.

The Rand Study (January 2008) reported that health outcomes in adult District residents varied significantly across wards. 1) Ward 7 had the highest rates of hypertension, diabetes, any chronic condition, and poor or fair self-reported health. These rates were statistically higher than the mean rate for all of DC. 2) Rates of hypertension, diabetes, and overweight/obesity were also higher in Ward 8 compared to the city-wide average. 3) Ward 5 had higher rates of hypertension and overweight/obesity compared to the citywide average. 4) The highest rate of obesity was in Ward 8. Rates of obesity were higher in Wards 4, 5, 7, and 8 compared to the city as a whole. Nearly three out of every four adult Ward 8 residents reported a height and weight that classifies them as overweight. Among key findings related to nutrition, physical activity and obesity for children in the District overall are the following: 1) Seven percent of children were reported to have a health issue that limits their ability to perform the activities of most children. 2) Across the city, 36 percent of children between ages 6 and 12 were overweight, while 17 percent of children between ages 13 and 17 were overweight. The Rand Study reported that 4.1% of District parents report that their children have poor or fair health and 12.1% believe that their children require more medical care than other children.

The Rand Study also cited several reasons for gaps in knowledge relative to children's health and access to care. Data is limited to National Survey of Children's Health. The most current is 2003. The Behavioral Risk Factor Surveillance System (BRFSS) asks if an individual has insurance but does not ask the type of insurance and therefore limits

specific data. Other gaps include: limited mental data, emergency care, differences in data formats and availability if Medicaid and Alliance data from managed care organizations and the lack of timely data analysis. As a result of the Study, the DOH has aggressively addressed the data collection needs and is currently collaborating with the Office of the Chief Technology Office (OCTO) to implement enterprise wide architecture that includes a master patient index and interfaces with each unique system application. The program is further described in Section B. Agency Capacity.

About one-third of Washington residents are functionally illiterate, compared to a national rate of about one in five. This is attributed in part to Hispanic, Ethiopian, and Eritrean immigrants that make up 12.7 percent of the District's population but are not proficient in English. It is also important to note that 45 percent of D.C. residents have at least a four-year college degree, the fourth-highest rate in the nation, illustrating the social divide present in the city. A 2000 study showed that 83.42% of Washington, D.C. residents age 5 and older speak only English at home and 9.18% speak Spanish. French is the third-most-spoken language at 1.67%.

The health and well being of women and children in shelters, transitional homes and on the street continue to be a major concern of the DOH. The Community Partnership for the Prevention of Homelessness (CPPH) reports on behalf of the District of Columbia the Annual Homeless Assessment Report (AHAR) for the Department of Housing and Urban Development (HUD). The purpose of the data reporting is to identify gaps in services, understand the nature of homelessness and analyze Continuum of Care effectiveness and utilizations. In January 2008 CPPH reported the age distribution of the 11,562 individuals in shelters for the period from October 2006 - September 2007 was: Ages 13-17 (.03%); 18-30 (8.0%); 31-50 (39.6%), 51-60 (18.8%) and 62 and older (3.8%). The District of Columbia Homeless Services Reform Act (2005) redefined Hypothermia and Emergency Shelter as Severe Weather and Low Barrier Shelter to ensure that the District's homeless population had access to shelter in the event of severe weather, such as extreme hot and cold temperatures, flooding and high winds.

The breakdown of single persons in the shelter system was 17 percent were women and 83 percent were men with a median length of stay at emergency shelters of 20 days. Twelve percent (12 %) of homeless women and eight percent (8 %) of homeless men stayed in shelter the entire year. One in ten persons in emergency shelter reported disabilities.

There were 1,618 single persons who used publicly funded transitional housing programs from October 2006 through September 2007. Twenty five percent (25 %) of persons served in transitional housing were also served in emergency shelter in FY07. Also, 91 percent of transitional housing beds were occupied on average throughout the year. And had a median length of stay in transitional housing was 172 days. Nearly one in ten clients in transitional housing were military veterans and over half of all transitional housing clients were disabled.

The number of families in the Emergency Shelter System was 1,661 persons in 507 families were served in publicly funded emergency shelters in FY07; 1,008 of the persons served were children, accounting for 61 percent of the population and 77 percent of adult persons in families were female. The median length of stay for adults in family emergency shelter was 160 days; 20 percent of families served in FY07 were in shelter for the entire year and 40 percent of the adults in families served were living with family or friends before entering shelter. Families in Transitional Housing accounted for 769 persons in 256 families were served in publicly funded transitional housing for families in FY07; 480 of the persons served were children, or 62 percent; 89 percent of the adult persons in families were female. The median length of stay for adults in family transitional housing was 361

days; 53 percent of families served in FY07 were in shelter for the entire year. On an average night during the period, 75 percent of family transitional housing beds were occupied.

DC's Mayor Fenty has a ten year plan to end homelessness. DC Village was closed in October 2007, which drastically changed the landscape of homeless services for families. Long-staying families already were placed in scattered site units of transitional housing through the District of Columbia's System Transformation Initiative. The changes to the District's continuum of care caused by the System Transformation Initiative are expected to be reported in the 2008 Report.

DOH has no direct services or medical care for the homeless or youth in DC. Unity Healthcare provides the medical services, and DHS contracts out for outreach services. \$125,00 to be given to oral health will affect this.

The DC Alliance continues to increase enrollment of residents ineligible for other private or public assistance with an estimated enrollment to reach 50,000 in late 2008. Although health coverage is significantly higher in the District than other states, District health disparities as described in the Rand Study, continues to rank among the highest in the United States.

The District working in collaboration with community providers, Federal and agency providers is actively addressing the disparities through a variety of efforts, including Cancer Coalition, Project WISH, Medical Homes; Hospital Discharge Program for Newborns; Child Health Action Plan and Interagency Collaborative Services Integration Commission (ICSIC). //2009//

B. Agency Capacity

The District of Columbia has designated the Department of Health (DOH) Maternal and Family Health Administration (MFHA) as the Title V state agency, with responsibility resting with the state maternal and child health officer. Formerly the Office of Maternal and Child Health, the agency was elevated to administration status in February 2001 and, along with several changes made in the DOH organizational table over the past year, is undergoing another proposed realignment as this application is being prepared. The senior deputy director of Maternal and Family Health Administration (or designee) will function as the state maternal and child health officer. That position is currently vacant, with a hire expected by October 1, 2005. Until that time, Marilyn Seabrooks Myrdal will continue to serve as the Title V officer.

/2007/ Carlos Cano, MD was appointed Senior Deputy Director of the Maternal and Family Health Administration in October 2005. Dr. Cano was trained as a psychiatrist and family therapist. As a health policy analyst and medical advisor with the Centers for Medicare and Medicaid Services, he focused in recent years on the synthesis of scientific evidence in support of policy development (such as approving use of new drugs and medical devices under the Medicare program only if proven effective). During that time he also became familiar with an array of medical, public health, and social interventions centered on infants, young children, and mothers which have produced significant and measurable improvements in life expectancy and other health measures in both advanced and developing countries.

Also effective October 2005, was a realignment of MFHA in which seven former divisions were reorganized into five primarily population-based bureaus. In announcing these changes in fall 2005, the DOH director wrote:

"The overarching goal for the administration in the next few years will be to reduce the rates of untimely deaths and preventable disease among babies, children, and mothers in our city. Taking into account the disparities in infant and child health status due to ethnicity, socioeconomic class, and geographic location, the initial emphasis throughout the organization

will be to reduce infant mortality to no more than 8 per thousand live births per year by 2010."

In implementing the changes in organizational structure described above, Dr. Cano convened meetings with staff and management to resolve personnel reassignments and other issues pertaining to the changes. He has established regular meetings with mid-level staff. One issue, still under consideration, pertains to the former data collection and analysis division. The DOH is considering centralizing the various surveillance, management information systems and data analysis functions now located throughout the department. Pending a final decision, the staff of the MFHA data collection and analysis division has been subsumed in the Adult and Family Health Services Bureau, which is also responsible for services to the other bureaus-- transportation, telephone information and referrals, advisory committee affairs, internal and external communications, and health promotion activities. //2007//

Several laws affect the responsibilities and authority of the Administration:

- Title III of the Child and Youth, Safety and Health Omnibus Amendment Act of 2003, DC Law B-15-607 directed the development and implementation of a universal health screening form, the child health certificate and oral health assessment form--the use of the form in services was implemented in 2005.
- DC Law 6-13 Newborn Screening Requirement Act of 1978, Amendments Act of 1985
- DC Law 3-33 Newborn Health Insurance Act of 1979, which mandates 3rd party payment of newborn metabolic and genetic screening
- DC Law 13-276 Universal Newborn Hearing Screening
- DC Law 7-45, Sec 31-2421, Public School Nurse Assignment Act of 1987, which requires a minimum of 20 hours of nurse coverage per school
- DC Law 10-55 The Administration of Medication by Public School Employees Act of 1993
- DC Law 3-20 The Immunization of School Students act of 1979
- DC Law 6-66 The Student Health Care Act of 1985, which requires pre-k, 1st, 3rd 5th, 7th, 9th, and 11th grade students to have had a comprehensive physical and dental examination and directs the school health division to review the records and notify schools of students who are out of compliance

MFHA's position authority for FY 2005 is 142 full-time positions, 50 of which are supported by federal Healthy Start funding and 57 by Title V monies. 35 are supported by other grants; none are funded by state-appropriated monies. Currently, only 9 positions are vacant, a lower rate than in past years. Since 2000, the position authority has varied from 140 to 158 FTEs. Many of the staff and managers are seasoned District employees. The staff consists of 17 registered nurses (several master's-prepared), 1 LPN, 2 masters of social work, 1 DDS, 1 RD, 1 MD, and 1 CHES. 5 hold MPH degrees. The majority of employees are of African American heritage, reflecting the composition of the District population. There is 1 bilingual (Spanish-English) nurse.

/2007/ MFHA operated in FY 2006 with an approved budget of \$36.6 million, approximately 73% of which comes from federal grants, and has position authority for approximately 192 FTEs. The increase over the previous year represents the transfer of WIC and other nutrition programs and the children's lead poisoning prevention program to MFHA. Of the total 192 FTEs, 73 are supported by the block grant. There are currently five vacancies. Disciplines represented on the staff are: nursing (15); physician (1); dentist (1); social work (2). Six staff members have completed the MPH.

The following are the major Title V (TV) organizational components of MFHA.

Adult and Family Health Bureau 20 TV FTEs
Child, Adolescent and School Health Bureau 10 TV FTEs
Children with Special Health Care Needs Bureau 17 TV FTEs
Nutrition and Physical Fitness Bureau 1 TV FTEs
Perinatal and Infant Health Bureau 6 TV FTEs
Office of the Senior Deputy Director 13 TV FTEs

MFHA staff have applied for several new grants this spring and summer; to date no additional awards have been received. //2007//

The DOH continues to experience difficulties in retaining staff and hiring qualified candidates. Although the length of time required to advertise, recruit and fill positions has diminished, there is still a substantial period between the time when a qualified candidate is identified and when an official offer of employment is made. In 2005, personnel functions and hiring decisions in the department were centralized at the director's level (previously at the administration level.)

MFHA received 2 new grants in FY 2005-- Accessing Health Care for Children and Youth with Epilepsy residing in Medically Underserved Areas in the District of Columbia, and Screening and Treatment for Perinatal Depression. A notice of award for a lead poisoning prevention grant has been received for FY 2006. The purpose of the grant is to conduct assessments and remediation of lead and water pipes, followed by comprehensive risk assessments of children in homes with lead exposure. The 2 federal Healthy Start grants were refunded following a competitive application process. The Healthy Start project in Wards 7 and 8 was awarded a 4-year grant of \$2,350,000 annually (CFDA 93.926E, Eliminating Disparities in Perinatal Health), beginning July 1, 2005. The Healthy Start project in Wards 5 and 6 was awarded a 4-year grant of \$1,350,000 annually, also beginning July 1, 2005. In anticipation of level funding, several services were adjusted, resulting in a change in staffing. 6 Healthy Start paraprofessional outreach positions and 1 driver will be transferred to the Nutrition and Physical Activity Bureau where the incumbents will be assigned similar outreach duties, allowing their knowledge of their communities to be retained in the Administration.

Several grants are ending this fiscal year--The MCHB-funded newborn hearing screening, and the CDC-supported birth defects registry. As this application is being prepared (July 8, 2005), MFHA officials are uncertain as to the possibility of refunding for the hearing screening grant. In the absence of federal funding, MFHA officials will consider the possibility of allocating block grant monies to fill the audiologist position and continuing the technical assistance provided to MCOs, hospitals and early childhood development programs.

An evaluation of the discharge program, which involves surveying mothers utilizing services from the program, is currently underway. The future of the birth defects registry is uncertain. Data collection is linked to maintaining the newborn hospital discharge program

/2007/ A new hearing screening grant was received for FY 2006. The audiologist position was not filled. The birth defects registry has been discontinued due to lack of funds. The hospital discharge planning program was discontinued as well, effective June 2006. A pilot "bridge" project targeted toward the population most at risk for potential social and medical complications will replace it and is being implemented as of this writing. //2007//

MFHA staff is housed in several locations: the central office of the DOH; Addiction Prevention and Recovery Administration office sites; the campus of St. Elizabeth's Hospital; the campus of DC General; sites throughout the city including clinics, WIC centers and labs.

/2007/ Healthy Start staff was relocated to offices of the former DC General Hospital in October 2006. Staff reports problems with Internet access and long distance fax capabilities. CSHCN Bureau staff was relocated to offices in the central DOH building where other MFHA bureaus are located with the exception of the Adult and Family Health Services Bureau, which is slated to move to the central DOH building this summer. //2007//

MFHA leases several vans for transport of clients and staff. From 1994 to June 2003, Healthy Start operated the Maternity Obstetric Mobile (MOM) unit, a 40 feet unit with 2 fully equipped examination rooms, audio-visual equipment, and health education materials. The unit serves the project area, providing a range of curbside services (depending upon available staff)--pregnancy tests, health screening, health education, immunizations and enrollment in case management.

The unit was retired in June 2003, and a replacement ordered. The new unit will have a dental chair and a dental hygienist will provide oral health screening to pregnant and postpartum women. It is expected to be available for operation by the beginning of FY 2006.

/2007/ The projected time for operation of the mobile unit is now October 2006. //2007//

MFHA maintains a Maternal and Child Health Resource Center at the central DOH office. A variety of print and video materials are available to DOH staff and staff of community based providers. The Healthy Start project maintains a library of training materials at its site.

In FY 2003 MFHA employees petitioned to and eventually voted to form a bargaining unit. Approximately 145 of the then-158 Administration positions became subject to union scale wages, resulting in a nearly 8% increase in labor costs for FY 2004.

In the summer of 2003, MFHA engaged a consultant recommended by MCHB to work with management to complete the CAST 5 analysis. Following the preliminary work, senior staff and other managers completed a 2-day training and retreat on September 10-11, 2003. The 2nd phase of the analysis took place June 29-30, 2005. The results have been used to define MFHA's technical assistance needs for this application. The report will be circulated to the senior deputy director for Maternal and Child Health Administration when the position has been filled. An orientation and strategic planning retreat for the Administration will be convened at that time.

MFHA participates in AMCHP, CityMatCH and APHA, sending staff to conferences and skills training sponsored by these professional organizations and making presentations on special projects.

Special Needs Capacity

Joyce Brooks, MSW, continued to direct the CSHCN division, which consists of 25 FTEs, funded by two federal grants in addition to Title V--newborn hearing screening and access to care for children with epilepsy. The childhood lead poisoning prevention program, which receives funding from the Department of Housing and Urban Development and the Centers for Disease Control and Prevention, is being moved from the DOH Environmental Health Administration to the Maternal and Family Health Administration, Child Health Services Bureau, which will replace the CSHCN division. Currently, 5 of the 25 positions are vacant. In addition, there is no audiologist on staff, a previously grant funded position that is key to the operation of the newborn hearing screening program. There is 1 RN and 1 LPN on the staff.

CSHCN division staff members are active in an array of inter- and intra-agency and public-private partnerships that focus on a broadly defined special needs population, including the DC Intra-agency Coordinating Council (Part C) and Developmental Disabilities State Planning Council, and coordination with the DC Early Intervention Program (DCEIP).

The division coordinates with a range of government agencies and private sector organizations, a few of which are described in this section of the application. Since June 2002, the Administration has had a MOU with the Office of Early Childhood Development (OECD), which includes the Early Intervention Program (DCEIP) in its scope of cooperative activities. The CSHCN division is responsible for coordination with OECD. The MOU covers database linkage and tracking of clients across various services and programs administered by the 2 agencies; training of Healthy Start and information and referral staff in Part C program guidelines and services; and jointly offering training for Head Start and pre-kindergarten program staff, mental health providers, child care providers and early intervention programs. The Administration, OECD and various other stakeholders developed a universal health form now being used by schools and all other District early care and education programs. A protocol for reciprocal referrals and for the provision of client specific information was developed to increase the participation of eligible children in Part C and other programs for children with special health care needs.

OECD offers periodic training to its subsidized child care providers to help them to meet licensure requirements. These training sessions are now incorporating the dissemination of information from the Administration. The MOU must be renewed periodically.

Coordinative activities with the OECD have been supported by a 3-year Early Childhood Comprehensive Systems grant from MCHB, now concluding its 2nd year. Focusing on development from the prenatal period through age 8, the grant is being used for environmental scanning and resource mapping, with the expected end result being a realistic plan for services integration. The CSHCN division participates with other city initiatives focusing on early childhood, such as the Early Learning Opportunities Act Grant (ELOA), addressing ages 3 and 4, the Kellogg Foundation SPARK grant for "Supporting Partnerships to Assure Ready Kids," addressing ages 3 to 5, and the DC Education Compact which is developing a Strategic Plan for DC Public Schools, to overlap age cohorts and build a system based on a developmental definition of childhood (0-8).

/2007/ The Early Childhood Comprehensive Systems grant was extended for another year to allow for completion of planned contractual services. Administration of the grant was transferred from the CSHCN Bureau to the Child, Adolescent and School Health Bureau.

The CSHCN division became a bureau effective October 2006. The bureau has been headed by interim chief Joyce Brooks. In June 2006 the position of chief was advertised with a closing date of July 10, 2006. //2007//

/2008/ The components of MPCA formerly constituting the Maternal and Family Health Administration operate in FY 2007 with an approved budget of \$38.9 million; approximately 73% of the budget is comprised of federal grants. MFHA counts 185.5 FTEs, of which 70.34 FTEs are funded by the Title V Block Grant. The following are the major organizational components of MFHA:

Adult and Family Health Bureau 20 TV FTEs
Child, Adolescent and School Health Bureau 10 TV FTEs
Children with Special Health Care Needs Bureau 17 TV FTEs
Nutrition and Physical Fitness Bureau 5 TV FTEs
Perinatal and Infant Health Bureau 6 TV FTEs
Office of the Senior Deputy Director 12.34 TV FTEs

Special Needs Capacity

In August 2006, Joyce Brooks, MSW, was selected as the Children with Special Health Care Needs (CSHCN) Bureau Chief. In 2006, the Childhood Lead Poisoning, Screening, and Education Program (CLPSEP) was transferred to MFHA and incorporated into the CSHCN Bureau. However, in the context of DC DOH's realignment and creation of MPCA and given the importance of abating lead poisoning in the city, CLPSEP has constituted the basis of a new Lead and Environmental Hazards Bureau.

The CSHCN Bureau is focused on strengthening established partnerships as well as establishing new partnerships and relationships with various stakeholders. The Bureau is working to strengthen and improve collaborative relationships with Medicaid to enhance the identification of children with special health care needs under the Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT) program.

In order to address the issues of pediatric mental health, the CSHCN Bureau has joined the Early Care and Education Administration Advisory group on Mental Health. Both Joyce Brooks, Bureau Chief, CSHCN, and Michelle Sermon, Newborn Screening Coordinator, serve on the Early Childhood Mental Health Committee that has been established to develop a comprehensive service delivery system for all children 0-5 in the District of Columbia. Ms. Brooks serves on the

Funding Subcommittee which is responsible for gathering all of the major child serving agencies in the District of Columbia to form a funding collaborative to establish a continuum of mental health related practices using evidence-based strategies. Ms. Sermon serves on the Public Information Subcommittee that has the primary responsibility for ensuring that all families are made aware of the new system being developed, how it works, the eligibility criteria, and the referral process.

The CSHCN Bureau is also an active participant with the Universal School Readiness Stakeholders group working to focus on and target children with special health care needs. This past year, the Bureau conducted a presentation to the students and participants of the Leadership Education in Neurodevelopmental and Related Disabilities (LEND) program. As a result, the Bureau has been invited to identify prospective applicants for the LEND program.

The CSHCN Bureau has continued its partnerships with the Howard University School of Social Work and Genetics Program. Two students from each program have interned with the Bureau working within the Newborn Metabolic and Hearing Screening Programs, the Woodson Wellness Center, and in other bureau initiatives Lead Screening Preventio Program and Child, Adolescent, and School Health programs.

While the various chronic disease programs within MPCA are currently primarily teen- and adult-focused, the CSHCN Bureau will seek to establish effective relationships and collaborations with these programs and the Birth-to-six program in an effort to raise the consciousness and awareness of children with chronic conditions.

The CSHCN Bureau was also invited to participate in the DC Partnerships to Improve Children's Healthcare Quality (PICHQ) Advisory Board. The Bureau will become a more active participant on the PICHQ Advisory Board.

The Senior Deputy Director for the Maternal and Primary Care Administration has an interest in exploring and perhaps replicating the Rhode Island Medical Home Project in the District. Rhode Island's Pediatric Practice Enhancement Project (PPEP) provides parent support personnel to primary care physician who serve a large percentage of CSHCN and their families. Parent consultants are placed in targeted primary pediatric offices and assist the physician in providing a comprehensive coordinated medical home to about 300 families annually. Parent consultants link families with necessary community resources, assist physicians and families in accessing specialty services, and identify and resolve with the PPEP Steering Committee systems barriers to coordinated care. The PPEP is a partnership between the Rhode Island Department of Health, Department of Human Service, and the Rhode Island Chapter of the American Academy of Pediatrics. The CSHCN Bureau and Dr. Cano plan to visit Rhode Island to better understand the project evaluate its appropriateness as a model in DC.

The MPCA has identified funds during the current fiscal year to provide direct services to the community. The CSHCN Bureau will award sub-grants to several community based organizations to provide services for children with special health care needs. The funding of these services is in keeping with the US Department of Health and Human Services, Maternal and Child Health Bureau's mission that calls for states to have service systems for children with special health care needs which encompass the implementation of a comprehensive, culturally sensitive, accessible, coordinated community based health partnership with numerous organizations and individuals and develop a model of family-centered care for children with special health care needs.

These services will also assist the Bureau in meeting the six core outcomes for children with special health care needs as part of the national action plan to achieve community-based service systems for CSHCN and their families. Sub-recipients are expected:

To provide scholarships for 31 campers and transitional youth to attend camps that serve children with Neurofibromatosis (NF-1), Tourette Syndrome, Epilepsy, and Teen leaders with chronic

health conditions and disabilities during the summer of 2007.

To provide technical assistance in conducting six summer workshops for parents of transitional youth to increase their knowledge of vocational rehabilitation, exploration of career options, disability awareness, and other topics related to transitional services for youth with special health care needs.

To enhance follow-up services for children identified with sickle cell disease, sickle cell trait and related disorders. These services include genetic counseling, care coordination and pediatric services.

To provide sickle cell disease education to school-aged children in DC Public Schools, recreation centers, and public events for the purpose of increasing knowledge of sickle cell disease and conveying the importance of knowing your sickle cell status.

To subsidize childcare services for families of children with special health care needs.

To establish a fund for insured families that have reached the maximum of their benefits to provide medications, medical supplies and equipment for children with special health care needs.

To provide early identification of children with developmental disabilities through timely and comprehensive assessments.

District Title V Capacity

The District's Title V program has the capacity to provide preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; services for CSHCN; and culturally competent care that is appropriate for the District's MCH population.

August 2006 marked the 15th year of operation for the District of Columbia Healthy Start I Project, which serves Wards 7 and 8. The project is coordinated with another federally funded Healthy Start Project II in Wards 5 and 6 that is funded under a separate application.

The Perinatal and Infant Health Bureau is currently looking at ways to expand home visitation and reach out to more women at social or medical risk for adverse perinatal outcomes. In the next few months, MPCA plans to start utilizing family support workers, who in conjunction with the nurse case manager will provide home visits to pregnant women. These duties will include providing support and guidance; reinforcing the importance of following up with medical appointments and referrals; and providing assistance with enrollment in Medicaid, WIC, and other entitlement programs. MPCA anticipates that the expansion will result in a net increase in capacity to serve an additional 80-100 pregnant woman in Wards 5, 6, 7, and 8.

In late September 2006, the new Healthy Start Maternity Outreach Mobile (MOM) unit was delivered. The unit replaces the MOM Unit that was originally launched in 1994. Following a three-year absence of mobile unit services, staff spent the first quarter of the program year involved in redeployment activities, including reevaluating old sites, identifying new sites, and building partnerships for the provision of services. The MOM unit serves in the adjacent Wards, 5, 6, 7, and 8.

The MOM unit services represent a major outreach strategy that focuses on the early identification and recruitment of pregnant women not yet enrolled in prenatal care. The new unit will target high-risk neighborhoods (for example, those with high infant mortality and HIV infection rates) and will include services that are equivalent to a first prenatal visit (including laboratory work-up) for pregnant women not yet enrolled in care and they will link women to traditional prenatal care and entitlement programs such as Medicaid, WIC and TANF. The MOM unit

promises to be an effective strategy to assure that high-risk pregnant women receive early prenatal care.

A nurse practitioner and an outreach technician provide services on the MOM unit. Women seen on the unit who have a positive pregnancy test receive a physical examination and are screened for a variety of risk factors (e.g., substance abuse, depression, and domestic violence). In addition, a full panel of laboratory tests are completed and sent to the city laboratory for processing. Each woman is strongly encouraged to participate in pre-test counseling, HIV/AIDS testing (using OraQuick Rapid Test), and post-test counseling. Recently, staff met with the Childhood Lead Prevention, Screening and Education program staff within MPCA to discuss strategies to screen pregnant women for lead levels and to educate them on the need for infant screening.

In 2006, the hiring of a Public Health Advisor expanded the staff in the new Child, Adolescent and School Health Bureau to provide additional school health services. The Public Health Advisor coordinates policy development for the Child, Adolescent, and School Health (CASH) Bureau. Her current responsibilities include developing and revising school health legislation and regulations, and researching and recommending policy initiatives in the areas of child, adolescent, and school health.

In FY 2008, CASH will finalize the overhaul of the school health policies and regulations and plans to establish an Advisory Committee on School Health to assist with research and policy development in this area.

New Program Capacities

The MPCA received a State Data and Assessment Technical Assistance (DATA) Mini-grant from the Association of Maternal and Child Health Programs to provide training in program evaluation to our staff. The training focused on the development of a framework for effective program evaluation of MPCA's program activities. MPCA provided a sub-grant to the School of Public Health Services at George Washington University to conduct a series of program evaluation workshops for staff in MPCA.

MPCA received a new five-year grant to continue funding for the State Systems Development Initiative (SSDI) which is designed to collaborate and improve partnerships for linking data systems, improve research and planning capacity, conduct needs assessments, prepare data analyses, and more effectively utilize performance measures. The SSDI grant is designed to complement the Title V Maternal and Child Health (MCH) Block Grant Program. In the FY 2007-FY 2011 cycle, MPCA will develop a comprehensive strategy that leads to better and more timely data, and then use data to stimulate more effective program planning, improve our monitoring capability, and begin using evaluation tools to provide timely feedback to program planners and stakeholders.

Specific SSDI Grant projects include (1) linking newborn screening data with birth, infant death, Medicaid Recipient, WIC, and social services benefits (ACEDS) files; (2) making data sets available to DOH data groups, and academic researchers interested in working on MCH issues and problems; (3) working with community stakeholders; (4) start a Phase II Perinatal Periods of Risk (PPOR) program to address infant mortality disparities; (5) building an interactive website to allow community groups and stakeholders to access MCH data; (6) working on other SSDI-related projects, including working on a two-year needs assessment process; and (7) assisting in developing an integrated MCH information system designed to tie together multiple activities within a single database, including the development of a school health information system.

MPCA received a new five-year grant from the Centers for Disease Control and Prevention to continue funding for the Rape Prevention and Education Program. This Program is designed to conduct surveillance of rape and sexual assault in the District and monitor trends; provide

education to and increase sexual awareness among students in DC public and charter schools; provide sexual assault prevention and education to increase community awareness; develop a comprehensive violence prevention plan; and conduct ongoing evaluation of rape and sexual assault prevention activities.

MPCA has sought technical assistance from the Children's Safety Network (CSN) in developing effective injury-related performance measures and evaluation strategies for injury and violence prevention programs. The Maternal and Child Health Bureau (MCHB) funds the CSN to support state MCH programs' injury and violence prevention activities, especially those related to each state's national and state-selected performance measures. CSN's services and resources include on-line workshops and presentations; resources such as fact sheets and case studies; helping with identifying best practices and finding relevant resources and research; and providing individualized technical assistance on both injury-specific topics and programmatic issues including data collection, strategic planning, and evaluation.

MPCA staff will participate in an evaluation webinar conducted by CSN to assist state MCH agencies and their partners with public health data sets that MCH agencies can use to address injury- and violence-related performance measures. CSN will provide assistance to enhance MPCA's capacity to analyze data and surveillance needs to better understand and address preventable injury in DC. CSN will conduct a data analysis webinar during which MPCA will review the strengths and weaknesses of state and local injury data sources, including the 11 data sets in the consensus recommendations for injury surveillance in State health agencies. CSN will also provide guidance to MPCA in the development of a sexual assault prevention plan.

Cultural Competency

In 2002, President Clinton signed a law to create minimum standard for Cultural and Linguistic Competency in health services based on the CLAS standard published in the Federal Register in December 22, 2000. In 2004, Mayor Anthony Williams signed specific legislation to facilitate access to service to all LEP individuals residing in the District of Columbia called the Language Access Act.

Achieving cultural competence is both a gradual process and a goal toward which professionals and organizations can strive. Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations. It implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by patients/consumers and their communities. Cultural competence is the ability and the will to respond to the unique needs of an individual patient/client that arise from the client's culture and the ability to use the person's culture as a resource or tool to assist with the intervention and help meet the person's needs.

MCPA is developing mechanisms to increase cultural competence.

/2009/ The Community Health Administration (CHA) oversees the Bureaus responsible for the oversight, management, planning, and evaluation of the Maternal and Child Title V Block Grant. The Perinatal and Infant Health Bureau, Special Health Care Needs (SHCN) Bureau, and Child Adolescent School Health (CASH) Bureau along with the Oral Health Program, and Nutrition and Physical Fitness Bureau. The Lead Program, previously under the SHCN Bureau will be re-assigned to the District Department of Environment (DDOE) in Oct 2008.

The District's 2009 capacities are briefly described below:

The Special Health Care Needs Bureau continues to focus on strengthening partnerships with community organizations as evidenced by it sub grant awards to the Goldberg Center for Community and Pediatric Health, Epilepsy Foundation, and Easter Seals. SHCN 's

efforts are focused on addressing the six core performance measures of the state. The development of partnerships is our response to developing a community based system of care for families: 1) establish a DC Parent Information Network -- Planning and Implementation Phase; 2) increasing services for SHCN's families. Interventions considered in the future included transition care/coordination; family navigation to included financial assistance to families with specialty care expenses not covered by insurance or Medicaid.

The Bureau is an active participant in several committees e.g. DC Hears Advisory Board; The Metabolic Advisory Board is empowered to make recommendations regarding newborn screening policies; and Early Comprehensive Childhood Services (ECCS) that focuses on the critical components of access to comprehensive health services and medical homes.

Perinatal and Infant Health Care Bureau provides oversight of the Healthy Start Program as well as Infant Mortality Action Plan. Under the leadership of Karen P. Watts, RNC, FACHE, FAHM, PMP, the Bureau has implemented a variety the activities. In December 2007 the District published the "Addressing Infant Mortality in DC: Citywide Action Plan" to respond to the maternal and child health needs in the District and reduce infant mortality rates throughout the city. It also convened the year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices and provide recommendations to CHA based on existing data regarding infant mortality and perinatal outcome disparities.

Child, Adolescent School Health (CASH) Bureau responsibilities include the management and oversight of the following programs: 1) Health and Sexuality Classes presented to students in grade Pre-Kindergarten to 12 in the DC Public and Charter schools as well as two private schools. The goal of the classes to older students include: reduce teen pregnancies, reduce Sexually Transmitted Diseases, and reduce high risk behaviors by encouraging good health life styles. It will expand the sexual health program utilizing the CARRERA model. CASH has oversight for the school nurse program. 183 schools (28,258 children) receive school nurse services. The school nurses collaborate with the DOH to ensure that the children meet the immunization compliance requirements of 96.5 % compliance. The current compliance rate is 97%.

The Oral Health Program provides oral health education to DC PS children as well as dental exams and sealants to third graders in several schools. It works with MAA to promote dental services and identify dental providers to provide services.

The Nutrition and Physical Fitness Bureau with collaborative efforts between District agencies and private partners developed initiatives that will shift eating behaviors from foods with limited nutritional value to those with higher nutritional dietary value. Also \$600,000 in local funds made for FY 2009 have been made available for grants to fund grants to address childhood obesity.

The Lead Program continues to identify children at risk of exposure to lead through mandatory blood level screening for those < the age of six by each provider or facility and reporting of the results to the District. The Lead Poisoning Prevention Program focuses on surveillance, screening and home assessment of children with levels at or = to 5ug/dL. The Lead Program will move to DDOE in October. It collaborates with DCRA, MAA, SHCN Bureau and Perinatal and Infant Health Bureau to expand screening and MCO case management services as well as mitigate sources of lead in the home.

The District will develop a new Birth Certificate to be released January 2009 which will alleviate some of the District's data collection problems. It will include mothers age, sex, race, ethnicity, residence, education, prenatal care, alcohol and tobacco use before birth,

low birth weight, and other important health indicators.

Technical Assistance has been requested to increase cultural competence in DC.

The D.C. CSHCN Advisory Board was established in May 2001. The Board is composed of approximately 40 members including representatives from public/private organizations, parents of CSHCN, physicians, educators, advocates, citizens, and other interested individuals who are residents of the District of Columbia or represent agencies and organizations concerned with services and resources for children with special needs and their families in the District of Columbia. Subcommittee members do not have to be residents of the District of Columbia.

Currently the charge of the D.C. CSHCN Advisory Board is to advise the CHA on:

- 1. The health care needs of families and CSHCN;*
- 2. Program guidelines and criteria considered essential to providing effective, quality care programs for CSHCN and their families;*
- 3. Use of federal and local funds for CSHCN, administered through the CHA; and*
- 4. Development and implementation of a strategic agenda to ensure the delivery of comprehensive, continuous, coordinated, culturally competent, family-centered, community-based services for children and youth with special health care needs and their families in the District of Columbia.*

Technical assistance to enrich the advisory board was requested specifically to increase parent participation, increase cultural diversity on the board, include youth involvement.

//2009//

An attachment is included in this section.

C. Organizational Structure

Following legislation in 1997 that established the DOH, a mayoral administrative issuance, followed by a departmental organization order, designated the Administration as the Title V state agency for the District of Columbia. Marilyn Seabrooks Myrdal, MPA was appointed the state chief maternal and child health officer to direct the Administration (then the Office of Maternal and Child Health) May 2000. Until recently, the maternal and family health programs continued under the purview of the senior deputy director of health promotion, a position also responsible for the Office of Nutrition Programs. As this application is being prepared, the Administration is being realigned: DOH management is replacing the position of senior deputy director of health promotion with the senior deputy director of the Maternal and Family Health Administration, and bringing nutritional services into the Administration. The senior deputy director will report directly to the DOH director. Recruitment for the position is underway with a decision expected by October 1, 2005.

In this section of the application, the current organizational structure will first be described, followed by a description of the plans, as they are known to date (June 30, 2005) for the realignment.

For several years, maternal and family health programs and Title V functions were organized around 7 divisions. An administrative officer and staff-- responsible for procurement, personnel and budget issues, as well as training and staff development--who previously reported to the state chief maternal and child health officer were transferred to the chief of staff, office of the deputy director of health promotion in Fiscal Year 2005. (See organizational tables, appendix) The division officers and their dates of appointment are as follows:

Data Collection and Analysis	Deneen Long White	1/98-6/05
Family Services	Diane Davis, RN	10/98-present

Children with Special Needs	Joyce Brooks, MSW	1993-present
Community Services	Eleanor Padgett, LICSW	5/01-present
Policy, Planning and Evaluation	vacant except for 10 month period 02-03	
Adolescent Health	Colleen Whitmore, MSN	9/01-present
Special Initiatives	Felicia Buadoo-Adade, RD	10/03-present

Division directors meet weekly to report on the status of programs and to discuss any issues or program barriers requiring coordination across divisions. Information about the Administration and DOH is shared with management staff during these weekly meetings.

The 2 federally funded Healthy Start projects, which are the largest sources of funding other than Title V, family planning and the home visiting initiative, constitute the family services division. The community services unit includes information and referral, transportation services, and community education. The responsibilities of the special needs division and the data division are described in the section on special needs and other capacity respectively.

The Realignment

The Maternal and Family Health Administration, to be headed by a senior deputy director, is being realigned as 5 bureaus as this application is being prepared. The purpose is to align programs that are population based or service driven and to assure an integrated approach to service delivery. The mission of the Maternal and Family Health Administration continues to be to promote the development of an integrated community based health delivery system, to improve health outcomes, to foster public private partnerships for women, infants, children, CSHCN, adolescents, families (including fathers) and seniors. The realignment becomes effective October 1, 2005. The DOH director is preparing a transition plan.

The Perinatal and Infant Health Bureau is responsible for the federally funded Healthy Start projects, which provides nurse case management for at-risk pregnant women in Wards 5, 6, 7 and 8. Women and their infants are retained in case management for 24 months after delivery, with coordination of well baby care and special needs referrals, contraception and other interconceptional care of the women. This Bureau will also be responsible for the implementation of a newly awarded 1-year MCHB grant to promote perinatal depression screening and referrals for treatment. In addition, the Perinatal and Infant Health Bureau will operate a number of Title V-funded services and activities, namely the SIDS bereavement and education program and the newborn home visiting program, which includes distribution of free cribs to families that do not have safe sleep arrangements for newborns, and funding of discharge planners in local birthing hospitals. The bureau will also continue to be the liaison to the District's child and infant mortality review functions, currently located in the Office of the Medical Examiner, an office that reports directly to the mayor.

The Child Health Services Bureau /2007/ Children with Special Health Care Needs Bureau // 2007// is responsible for all CSHCN functions--the genetic and metabolic, and newborn hearing screening programs, sickle cell disease program, and the grant-funded awareness and access to care for children with epilepsy. The childhood lead poisoning prevention program, formerly a component of the Environmental Health Administration, will be a new responsibility for this bureau.

The Nutrition and Physical Activity Bureau /2007/ Nutrition and Physical Fitness Bureau//2007// is responsible for the Special Supplemental Program for Women, Infants and Children (WIC) and the administration of other grants funded by USDA--Loving Support Breastfeeding Program (a partnership with Howard University Hospital), Food Stamp Nutrition and Education Program, Commodity Supplemental Food Program, Farmers' Market Nutritional Program, Folic Acid Initiative and the Employee Wellness Program.

The School Health and Adolescent Health Bureau /2007/ Child, Adolescent and School Health

Bureau //2007// will be made up of 3 divisions--school health, adolescent health and oral health. The School Health Division, staffed with 1 FTE, is responsible for the school health nursing program (see section on interdepartmental coordination for description), the Woodson Senior High School Wellness Center (funded with Healthy Start grant monies), and the vision screening program, which was formerly conducted by the CHSCN division.

/2007/ The vision screening program remains in the CSHCN Bureau. See other activities section of this application. In addition to this program, the school nurse program includes periodic universal vision screening. //2007//

The Adolescent Health Division will have responsibility for the grant-funded abstinence education program, the TANF-funded teen pregnancy prevention program, and 2 programs that will continue to be supported by Title V monies--youth violence prevention, and the health and sexuality education initiative. Oral health activities are being placed in the Oral Health Division, staffed with a public health dentist. Division responsibilities include directing a federal grant--oral health integrated system development--to rebuild the structure for a state oral health function, including the formulation of standards for school based oral health services and child oral health assessment and the operation of a small school based dental sealants project. Another oral health grant, in its final year but with substantial funds available for carry over, has been used to work in conjunction with CNMC to establish oral health services at 2 public schools dedicated to CSHCN, and to use telemedicine to extend such services to other schools serving high numbers of CSHCN.

/2007/ The teen pregnancy prevention program (Teen Mothers Take Charge) is Title V-funded. Local funds have been appropriated to expand the program in FY 2007. //2007//

The 5th bureau, the Adult and Family Health Services Bureau, will be responsible for the men's health initiative, the women's health initiative and family planning, which are currently a part of the Administration's special initiatives division. The bureau will be responsible for transportation, as well as a sexual assault prevention program that is being transferred from the Primary Care and Prevention Administration.

The status of the MFHA Data Analysis and Program Evaluation Division is uncertain, pending further review at the departmental level and by the new Senior Deputy Director of the Maternal and Family Health Administration. Decisions about the assignment of nutritional services and lead poisoning prevention surveillance positions have yet to be announced.

/2007/ The surveillance positions remain in the respective bureaus. //2007//

Incumbent division directors have been informed that they must apply for the positions of bureau chiefs. However, the new positions are at a higher grade and therefore not all directors are eligible to apply for the positions in which they are currently functioning.

/2007/ The realignment described above officially became effective December 2005 with slight changes in the names of these bureaus. The following bureau chiefs have been appointed.

Perinatal and Infant Care Bureau	Vacant as of June 22, 2006
Child, Adolescent and School Health Bureau	Colleen Whitmore, MSN, CFPN
Nutrition and Physical Fitness Bureau	Michele Tingling-Clemmons
Adult and Family Health Services Bureau	Paula Marshall, MA, MHS, CPM
Children with Special Health Care Needs Bureau	Interim, Joyce Brooks, MSW //2007//

/2008/

The Realignment

The former Maternal and Family Health Administration and the Primary Care and Prevention

Administration were realigned as the Maternal and Primary Care Administration. Gregg Pane, M.D., Director D.C. Department of Health approved this realignment on January 17, 2007. Carlos Cano, M.D., was appointed as the Senior Deputy Director. This is a functional realignment that is not reflected in the FY 2007 budget and new budget structures will not occur until FY 2009. See the attached organizational chart.

The mission of the MPCA is to improve health outcomes for all residents of the District with an emphasis on women, infants, children (including CSHCN) and other vulnerable groups such as those with a disproportionate burden of chronic disease and disability. To this end MPCA provides programs and services to promote coordination among the health care systems of the city and enhance access to effective prevention, primary, and specialized medical care. MPCA also collaborates with public and private organizations to provide support services to ameliorate the social determinants of health status for these groups. MPCA embraces the values of accountability, collaboration, and initiative in the pursuit of our mission and foster public participation in the design and implementation of our programs.

The MPCA is part of the DC DOH, and is the District's Title V agency. As of May 2007, the MPCA consists of a Senior Deputy Director, a Chief of Staff, and three new offices under the Senior Deputy Director: Office of Program Support Services, Office of Grants Monitoring and Program Evaluation, and the Office of Health Care Access and Clinical Services. The Lead and Environmental Hazards Bureau is a new Bureau. The Adult and Family Health Bureau was eliminated and staff were reassigned to other Bureaus. The following eight Bureaus comprise the Administration:

Children with Special Health Care Needs Bureau, Joyce Brooks, MSW, Chief.
Child, Adolescent, and School Health Bureau, Colleen Whitmore, MSN, FNP, Chief.
Perinatal and Infant Health Bureau, Karen Morris, M.D., Chief.
Nutrition and Physical Fitness Bureau, Michele Tingling-Clemmons, Chief.
Lead and Environmental Hazards Bureau, Pierre Erville, Chief.
Cancer and Chronic Disease Prevention Bureau, Emanuel Nwokolo, PhD, Chief.
Communicable Disease Control Bureau, Karyn Berry, M.D., Chief.
Bureau of Pharmaceutical Services, Gisele Sidbury, Pharm.D, Chief.

The major priorities of the MPCA are to reduce infant mortality rates, enhance the MPCA's data gathering and analysis systems, and improve access to primary and specialty care (medical homes) for underserved populations including children with special health care needs. MPCA is focusing on developing programs that contribute to a lower infant mortality rate and enlarging public participation in the Title V program. MPCA also will work more closely with the District's community-based organizations to achieve these goals. The ultimate goal of the Title V program will be to improve national and District performance measures and reduce disparities with respect to resident health outcomes.

The DC DOH is responsible for the administration and supervision of programs carried out with allotments under Title V, Section 509 (b). This is done under the supervision and direction of the Senior Deputy Director. The following programs funded by the Federal-State Block Grant Partnership include:

Direct health care services (basic health services and health services for CSHCN).

Enabling services (transportation, translation, outreach, respite care, health education, family support services and purchase of health insurance, case management and coordination with Medicaid, WIC, and education).

Population-based services (newborn screening, lead screening, immunization, Sudden Infant Death syndrome counseling, oral health, injury prevention, nutrition, and outreach/public education).

Infrastructure building services (needs assessment, evaluation, planning, policy development, coordination, quality assurance standards development, monitoring, training, applied research, systems of care, and information systems).

This section includes an organizational chart for MPCA as an attachment. //2008//

/2009/ This year the DOH experienced two major organizational events. Under the direction of the Director of Health, Dr. Gregg Pane, DOH was realigned to form seven administrations. The realignment reduced the number of DOH administrations from 11 to seven, reallocated staff to a new procurement and grants management function, and created a new focus on performance accountability. The new DOH operational structure incorporates many of the recommendations from DC Mayor Adrian Fenty's Pre-Transition Health Team. The primary changes included 1) the integration of the Bureau of Epidemiology and Health Risk Assessment with the State Center for Health Statistics and the State Health Planning and Development Agency to create a Center for Policy, Planning and Epidemiology. 2) Changing the name of the Maternal and Primary Care Administration to the Community Health Administration (CHA). This Administration is responsible for the Office of Grants Management and Program Planning, Perinatal and Infant Health Bureau, CSHCN Bureau, CASH Bureau, and the Nutrition and Physical Fitness Bureau. A copy of CHA's organizational chart is enclosed as an attachment. In October 2008 the Lead Program moves to the District Department of the Environment.

In March 2008 Mayor Fenty named Pierre N.D. Vigilance, MD, MPH as Director of DOH. Dr. Viligance served as the director and health officer of the Baltimore County Department of Health since 2005.

Other significant staff changes within the Community Health Administration include assignment of Charles Nichols, MPP, Chief, Grants Monitoring and Evaluation and Nathaniel Beers, MD, Deputy Director of Policy and Planning. Brief biographical sketches of Mr. Nichols and Dr. Beers are enclosed as an attachment.

***Dr. Cano continues as the Senior Deputy Director of the CHA and fully supports and advocates CHA's overarching goal to improve the health and well being of residents by reporting, investigating and controlling communicable diseases, prevention of chronic diseases and their complication, and engaging in health care system planning to meet the service needs of the population. CHA focuses on carrying out the Mayor's initiatives to reorient the health care system toward community-based prevention, primary care, and keeping citizens healthy. //2009//
An attachment is included in this section.***

D. Other MCH Capacity

Title V funds the majority of the 10 - 11 FTEs assigned to the data collection and analysis division. 4 of the incumbents hold masters degrees. The project activities carried out in the division include Healthy Start MIS, Pregnancy Nutrition Surveillance System (PNSS), Pregnancy Risk Assessment Monitoring System (PRAMS), birth defects registry, ECCS grant data collection, and the SSDI grant, which supports various database linkages and integration efforts.

Because the Administration is undergoing a major realignment, and the centralization-decentralization of surveillance and management information systems is being reassessed throughout the department, a needs assessment process will be developed to evaluate existent data systems and staffing to meet the needs of the new organizational structure, fulfill state level data requirements and grant reporting functions, and monitor program and contractor activities.

The Administration is faced with several critical data related issues. 1 issue involves the costs and relevant benefits of existent and developing surveillance, tracking, and websites over time. PRAMS and PNNS have been in operation for over a decade. Healthy Start MIS captures client and case management services and has been expanded to capture data from a variety of outreach activities. DC Kids Link is a developing population-based system linking child related

data from a variety of sources. UNITS is a new system for tracking hospital and referral activities for the newborn screening programs, the newborn discharge program, and for the birth defects registry. Finally, the school health information system is a pilot project designed to gather school health data on approximately 16,000 of the District's school children. Data on each of the latter 2 systems are maintained by a private contractor.

/2007/ PRAMS, PNSS, and the birth defects registry were discontinued in 2006 due to the inability to obtain appropriated funds to replace federal funding. The pilot project in the schools was halted in anticipation of the development of a new MIS to link school and school health data with other information systems. See the overview section for recent developments in school health. //2007//

Currently, DOH surveillance functions are decentralized and scattered throughout the organization. At issue is whether to merge most of the data functions, or combine some of the data groups, or make no major changes. Finally, the organizations will assess existent and future staffing patterns. Web-based applications and data warehousing may require reeducating existent staff or require staffing with different skill sets.

/2007/ MFHA expects to hire a data unit coordinator this summer to complete a data needs assessment and to make recommendations on the most effective organizational structure for the data unit. In addition, MFHA management is holding discussions with CDC and MCHB to support the assignment of a senior epidemiologist to assist with this effort. See section of this application on technical assistance. //2007//

Aside from their professional training and/or organizational experience, at least 10 Administration staff members parent children with special needs. These staff were not necessarily hired to advocate for the special needs population; their responsibilities are integrated throughout the functions of the Administration. Nevertheless, their ongoing experiences with accessing education, social and medical services provide a valuable asset for the entire staff. Marilyn Seabrooks Myrdal, the Administration's representative to AMCHP, represents AMCHP on the Family Leadership Caucus, a group formed to advise and guide AMCHP and state Title V programs regarding the roles and responsibilities of families.

The grant to enhance access to services for children with epilepsy will fund a family advocate to be located with each of the 4 Medicaid MCOs.

In 2004, the MFHA dedicated a position for Hispanic Health Services. The individual who filled the position (now on extended leave) is a bilingual registered nurse and health educator. She organized an Hispanic Health Coalition of representatives from community based organizations in the Latino community. The coalition was instrumental in organizing focus groups to elicit data for the needs assessment described in this application and continues to advise Administration management on meeting the needs of the Latino MCH population.

/2007/ The Hispanic Health Services position and the Hispanic Health Coalition are no longer in place. //2007//

Another MFHA employee, hired as a liaison to the Asian and Pacific Islander community, speaks Mandarin, Cantonese and Vietnamese.

The DOH has formed an office of language and communications in order to comply with the recently passed language access law. This office arranges for translation of departmental materials.

/2008/ Below is a list of the number and locations of staff that work on Title V programs based upon the current budget structure that comprises the former Maternal and Family Health Administration. Recent staffing changes for the MPCA such as, the creation of the new Bureau of

Lead and Environmental Hazards and the reassignment of the Adult and Family Health Bureau staff, are not reflected:
Bureaus and Offices (Title V FTEs):

Adult and Family Health: 20
Child, Adolescent and Health Bureau: 10
Children with Special Health Care Needs: 17
Nutrition and Physical Fitness Bureau: 5
Perinatal and Infant Health Bureau: 6
Office of the Senior Deputy Director: 12.34

A biographical sketch of the key senior management level employees in the lead positions follows.

Carlos Cano, M.D. was appointed Senior Deputy Director of the Maternal and Family Health Administration in October 2005. Dr. Cano was trained as a psychiatrist and family therapist. As a health policy analyst and medical advisor with the Centers for Medicare and Medicaid Services, he focused on the synthesis of scientific evidence in support of policy development (such as approving use of new drugs and medical devices under the Medicare program if proven effective). During that time, he also became familiar with an array of medical, public health, and social interventions centered on infants, young children, and mothers which have produced significant and measurable improvements in life expectancy and other health measures in both advanced and developing countries.

Sandra Robinson is the Chief of Staff, MPCA. She started in this position in April of 2006. Previously, she was Director of the Center for Workforce Development, District of Columbia Office of Personnel; Program Manager of the District of Columbia Office of Contracting & Procurement; Project Director of TONYA, Inc.; and Manager, Division of Human Resource and Organization Development, District of Columbia Department of Housing and Community Development. She has a master's degree in Project Management from the School of Business and Public Management, The George Washington University.

The new Bureau Chief of Perinatal and Infant Health is Karen Morris, M.D. and the new Bureau Chief of Lead and Environmental Hazards is Pierre Erville.

In order to improve MPCA's capacity to collect, acquire, analyze and utilize program data and strengthen surveillance systems, Stephanie Alexander was hired as Chief of the Data Analysis and Program Evaluation Division. The Division is focusing on improving the Administration's capacity to develop uniform performance measures, establish data linkages, conduct data analysis, and perform program evaluations. Also, MPCA will coordinate efforts to rebuild PRAMS.

MPCA is collaborating with the city's Office of the Chief Technology Officer (OCTO) to develop an integrated data management system. OCTO will analyze the current business practices and the data linkages needed to support the system. The DC DOH has been awarded a Medicaid Transformation Grant for data integration. In time, MPCA plans to link its data-bases to the Medicaid Information System as well. The long-range goal will be to link MPCA to the Safe Passages System, which is a common database for human services agencies in the District of Columbia. As a result, case managers and other appropriate staff will be able to identify and improve the coordination of all services in which a child is enrolled.

The Center for Disease Control and Prevention assigned Dr. Genet Burka, a medical epidemiologist to assist in the investigation of the District's high infant mortality rate. Both Dr. Burka and Ms. Alexander will be conducting a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. They will be collaborating with a number of programs to assess the various data that are routinely captured for inclusion in trend analysis. In addition, MPCA is in the preliminary stages of developing a database on infant birth, morbidity, and mortality statistics for the District to assist public and

private programs with research, planning, and service coordination.

MPCA was selected to participate in a year-long Data Institute Initiative sponsored by City Match Urban Leadership Institute for Maternal and Child Health. Through participation with City Match, MPCA will continue to work to improve its capacity to evaluate the effectiveness of the Safe Start: Cribs for Newborns Program. The Safe Start: Cribs for Newborns Program provides cribs and safe sleeping education to low-income, high-risk families in the District of Columbia through Title V and a partnership with local community-based organizations providing pre-natal services. The aim is to assist in reducing the infant mortality rate by providing cribs, mattresses and education on safe sleeping practices to mothers, guardians and caregivers.

The CSHCN Bureau has sent two managers to the Maternal and Child Health Leadership Skills Training Institute. The MCH Training Institute offers continuing education and training to increase leadership skills for key management personnel in State Title V Maternal and Child Health and Children with Special Health Care Needs (CSHCN) programs in the United States. The Institute focuses on two curricula: (1) Planning, Implementing and Evaluating Programs (PIE) and (2) leadership skills required to address the growing need to coordinate and integrate with programs outside of the current Title V domain.

The MPCA has been an active participant in the Regional Conference Calls hosted by the Association of Maternal and Child Health Programs (AMCHP). A new Region III representative has been appointed. During the past year, the Maternal and Primary Care Administration has been an integral part of the strategic planning process with the other Region III states for the annual AMCHP conference. The conference was held March 3-7, 2007 in Washington, DC. The District participated in the Regional Roundtable at the Conference, wherein MCH and CSHCN leaders came together to provide updates on their respective state activities, and highlight programs that merit national attention. //2008//

/2009/ In March 2008 Mayor Fenty named Pierre N.D. Vigilance, MD, MPH as Director of the DOH. Dr. Vigilance, a veteran public health leader, leads a team of experts including Dr. Carlos Cano, who skillfully ran DOH during the interim period prior to the naming of the permanent director. His goal is to keep human service agencies focused on the target populations in greatest need. As the director and health officer of the Baltimore County he led an agency of 500 staff covering a jurisdiction of approximately 800,000 residents and a \$50 million annual budget. He established a quantitative management reporting system to improve performance management and was responsible for improving access to care for the medically uninsured by increasing the number of Kaiser Permanente "Bridge" program slots from 300 to 525 (75%) in just two years. He has been instrumental in local legislative changes aimed at reducing youth access to tobacco and has been a collaborator with the Johns Hopkins University Bloomberg School of Public Health to provide regular applied public health internship opportunities.

Charles Nichols, MPP, Chief, Grants Monitoring and Program Evaluation, has more than 14 years experience with the Department of Health. His major areas of responsibilities include: 1) Grants Monitoring and staff oversight related to approximately 40 federal grants and 20 awards made to local community partners to ensure compliance with all applicable federal and District grant circulars, laws, policies and regulations. 2) Program Administration management activities related to the program implementation of the Preventive Health Services Block Grant, the Maternal and Child Services Block Grant, State Systems Development Initiative Grant, and the Traumatic Brain Injury Grant through the supervision of the respective program coordinators. 3) Resource Development activities that include identifying funding opportunities, coordinating the development of grant proposals, and providing quality assurance through direct supervision of the process and internal approval. 4) Program Evaluation activities that include development of a system within the Administration to use program evaluation techniques including the analysis of data to improve the effectiveness of program initiatives. Responsibilities also

include supervision of Supervise a team of public health analysts. Mr. Nichols received is AB, Government and Economics from Georgetown University, and a Master of Public Policy from The University of Michigan.

Nathaniel Beers, MD, a board certified developmental behavioral pediatrician, is the Deputy Director of Policy and Planning. He previously served as the Medical Director of the Children's Health Center, Children's National Medical Center. Dr. Beers has more than 9 years of experience in the field of children with special health care needs with a strong interest in children with disabilities, obesity, behavioral disorders, immunizations, school health and public health and policy. He has also published a comprehensive analysis of Title V programs and the effects of different systems on funding. He is President of the DC Chapter of the American Academy of Pediatrics.

Dr. Beers received his B.S. from the University of Rochester; M.D. from The George Washington University, School of Medicine and Health Sciences; MPA from Harvard University, John F. Kennedy School of Government; Clinical Effectiveness Certificate Program, Harvard University, School of Public Health; and Certificate in Leadership in Human Resource Development from The George Washington University, School of Education and Human Development.

CHA is responsible for the management of the Title V Maternal and Child Health Block grant. The programs funded through the Title V Block Grant and discussed in the application are managed by the Perinatal and Infant Health Bureau, Child, Adolescent and School Health Bureau, Special Health Care Needs Bureau and Nutrition and Physical Activity Bureau.

*The full time equivalents (FTEs) positions supported by Title V funds include: Administration (includes Grants Management and Evaluation, Finance, Data Analysis, etc.) - 26 FTEs
Perinatal and Infant Health Bureau - 12.5 FTEs
Children Adolescent School Health Bureau (includes Oral Health Program)- 11 FTEs
Other Federal grants fund staff positions that support Title V.*

*The Lead Program will move to the District's Department of the Environment (DDOE) in October 2008. Funds previously utilized to fund staff positions will be used to support Title V programs. The Program will continue to provide lead screening and home assessments of children with blood lead levels = or > than 5 ug/dL. Funds will be allocated to support lead screening for uninsured District children. //2009//
An attachment is included in this section.*

E. State Agency Coordination

Intradepartmental Coordination

During the reporting period, the Administration continued to work with the WIC and the immunization programs, both of which are located in the DOH. See NP# 11 and 7 for a description of activities. The Administration applies Title V funds to the support of the lead poisoning prevention program, which is also supported by CDC and HUD grants. See SP# 3. WIC and other nutritional programs and the childhood lead poisoning prevention programs are being moved to a new component of the Administration--Nutrition and Physical Fitness Bureau. Lead screening will be located in the CSHCN Bureau.

Coordination with Medicaid-SCHIP

Administration efforts to establish formal relationships with its sister agency--the Medical Assistance Administration--and the Medicaid managed care organization (MCO) contractors, which have been underway since the initiation of Medicaid mandatory managed care in the mid

1990s, are finally coming to fruition. By December 2004 the 3 MCOs and the CSHCN carve-out MCO had signed MOUs outlining the respective responsibilities of the MCO, MAA and the Administration. The agreements focus on the care coordination and continuity of care for those MCO enrollees who are also Administration clients, including but not limited to Healthy Start participants. Representatives of MAA, the Administration and the MCOs have been meeting monthly since January 2005, the initial objective being to share information about programs, services and barriers. It is expected that in FY 2006, representatives will begin work on case management standards and protocols.

Prior to the MOU, Administration employees were trained on procedures for referring potentially eligible persons to Medicaid-SCHIP enrollment sites. Healthy Start nurse case managers work to enroll and maintain certification of their clients, and to assist them as necessary with the selection of a primary care provider. Clients are also instructed in how to use a managed care provider--medical home.

/2007/ See state performance measure 2. //2007//

Substance Abuse

The Administration negotiated an MOU with its sister agency, the Addiction Prevention and Recovery Administration (APRA), March 2003 to use Healthy Start funds to provide pregnancy test kits for women who present for substance abuse services at the Women's Services Clinic and other APRA-operated facilities. Pregnant women, as well as women up to 3 months postpartum, are referred to Healthy Start for case management. Prior to the agreement, APRA clients had not been routinely tested for pregnancy and consequently their substance use related services were not well coordinated with reproductive health and/or HIV services. The 2 agencies established a reciprocal referral system, and a jointly funded paraprofessional health education position is located at the Women's Services Clinic to coordinate referrals, joint case conferences and staff training. Staff report considerable demand for the testing kits.

HIV/AIDS Coordination

As a result of participation during 2001-2002 in a special CityMatCH project, the Perinatal Urban Learning Cluster, and later in the Association of Maternal and Child Health Programs (AMCHP) Perinatal HIV Transmission Action Learning Lab, the Administration strengthened its relationship with its sister agency, the HIV/AIDS Administration (HAA), and the Ryan White Title IV grantee to develop a policy statement on perinatal transmission. In 2003, a CDC representative met with the Clinical Advisory Workgroup and DOH staff to discuss the implications of rapid testing technology on perinatal HIV control. Following the discussions with the CDC representative, assigned staff from the Administration, the HIV/AIDS Administration, APRA and a panel of 6 District physicians prepared the March 2003 Final Draft Revised Recommendations for Universal HIV Screening of Pregnant Women. Recommendations included the incorporation of routine HIV testing as a normal part of prenatal care, including universal retesting in the 3rd trimester. Under the draft recommendations, providers can adopt "opt-in" or "opt-out" protocols. Clinical guidelines at www.hivatis.org (currently http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66) are recommended. The March 2003 draft was to have been reviewed by the HIV/AIDS Administration prior to forwarding to the DOH director for action. To date, the District's official draft policy is based upon the 1995 US Public Health Service recommendations.

/2007/ MFHA is working with a sister agency, the Administration for HIV Policy and Programs (AHPP), formerly named the HIV/AIDS Administration, on the implementation of a CDC perinatal HIV prevention grant. The prevention plan includes HIV testing for pregnant women; training for providers regarding perinatal and HIV prevention, pediatric care and treatment services; and access to medications through the AIDS Drug Assistance Program (ADAP).

Work is underway with an internal DOH workgroup to agree on and disseminate prenatal testing standards and policy. It is expected that standards for rapid testing in labor and delivery based on those in place in New Jersey will be adopted. The group is reviewing existing counseling, testing

and referral (CTR) policy to incorporate prenatal opt-out and HIV-exposure reporting for newborns. Pending a MOU, the perinatal prevention grant may also support co-location of CTR and case management with Healthy Start case management. Such an arrangement was funded in past years but then lapsed.

Also several District hospitals have participated in a CDC-sponsored study to determine prenatal HIV-testing rates through medical chart review. Findings will be used to provide a baseline for targeting provider and facility training on prenatal HIV testing standards.

On June 19, 2006 in commemoration of National HIV Testing Day, AHPP kicked-off a campaign to encourage all District residents, ages 14 to 84, to be screened for HIV and know their HIV status. Those who test positive are to be immediately referred to counseling, medical care, and treatment. DOH has purchased 80,000 rapid testing kits for distribution to hospitals, clinics, physicians, and community testing sites. The announcement of the campaign follows a period of considerable advocacy activity and public scrutiny of HIV programs in response to the high rate of AIDS cases in DC. In 2004 the rate was 179.2/100,000, the highest among cities with a population in excess of 500,000. //2007//

Interagency Coordination

Coordination with various agencies is discussed throughout this application-- in the overview as well as the annual report/annual plan sections. See performance measures dealing with CSHCN for a description of activities with early intervention and child care agencies, and other agencies that serve children with special needs.

Coordination with Public School System

DC public schools are required by the District of Columbia Public School Nurse Assignment Act of 1987 to staff a minimum of 20 hours per week of nursing services in public schools. High schools are to have a registered nurse or LPN on duty at least 40 hours per week. The operation of the school nurse program has undergone a number of changes over the past 10 years. For many years the Department of Health (then the Commission of Public Health) operated the program, with nurses employed directly by the commission. In the late 1990s the responsibilities were transferred to the DC Health and Hospitals Public Benefits Corporation (PBC), which was also responsible for the operation of the DC General Hospital and the public community health centers. When the PBC was abolished and the entire safety net system was privatized in 2001, the District contracted with the Children's National Medical Center, a regional tertiary care institution, to operate the school nurse program. The DOH Safety Net Administration was created to oversee the entire privatization effort and contracts, with the Maternal and Family Health Administration retaining some responsibilities for school nursing policy and standards development, evaluation and monitoring.

The Administration's relationship with the school system continues to evolve. The advent of charter schools during this period increased the cost burden insofar as charter schools are eligible to request school nurse services; but 36 of the 57 charter schools do not have the required nursing services. Additional local funds were requested in the FY 2006 budget to meet this demand, but only partial funding was approved.

In 2004, the Administration hired a masters-prepared registered nurse to support coordination with the schools and the school nurse program. This school health liaison is currently the sole staff person in the new Adolescent and School Health Bureau, School Health Division. The proposed FY 2006 budget includes funds to provide additional school health services.

The school health liaison also represents the Administration on the city wide Task Force on Immunization. In past years, DOH has had to redeploy staff at the beginning of the school year to staff express clinics and track down children whose immunization records were not up to date.

Schools have denied admission to students who were not in compliance with immunization requirements; however, it appears that the annual "immunization crisis" will be avoided this September: 90% of the schools have > 90% of students properly immunized.

The school health liaison is in daily contact with the school health nurses program regarding the reporting and resolution of incidents and urgent issues, for example, nurse coverage of schools to meet legal requirements, particularly at the beginning and end of the term. Schools have very different needs based upon location, enrollment, and socio-demographic characteristics of the students and neighborhoods, and the numbers and needs of medically fragile students who have been mainstreamed.

It is not uncommon for a medically fragile child to transfer in without notice and the necessary resources in place to meet her/his needs for nursing support. Not all school nurses have recent training sufficient to meet specific, individual needs. It then becomes the responsibility of the Adolescent and School Health Division staff to work with those involved to find a solution.

In spring 2005, the Adolescent and School Health Division implemented a systematic school health monitoring protocol, which supplements the monitoring of the physical facilities and equipment in the school nurse suite conducted by the Safety Net Administration. The inadequacy of the space, equipment and Internet access of many school nurse suites has been noted and efforts are proceeding to incorporate standards published by the National Association of School Nurses.

/2007/ See the overview section for recent advances in interagency coordination on school health. //2007//

Mental Health Coordination

In March 2001, the Administration, through the Healthy Start program, set the stage for an important collaboration with the Commission on Mental Health, now the Department of Mental Health (DMH). The Parent and Infant Development Program (PIDP), located in the Children and Youth Services Administration, DMH, provides outpatient evaluations, psychiatric, psychological and psychotherapeutic services to pregnant women, their families and children up to age 5. An MOU with the PIDP DMH was signed February 2003 and Healthy Start funds were transferred to pay 2 LICSWs to case manage referrals of Healthy Start clients who screen positive for depression and/or appear to have other mental health disorders. The Administration worked with Mary's Center for Maternal and Child Care (a 330 grantee) to submit on June 2, 2004 a grant application to MCHB for a 1-year program to introduce perinatal depression screening throughout the District of Columbia. Notice of an award for \$250,000 was received spring 2005. Implementation will begin October 2005.

The Maternal and Family Health Administration is among the many government agencies participating in a private-public partnership to improve learning outcome for young children through the alignment of programs for children ages 3 -- 6 and transition between preschool and school. 10,000 of the 16,000 3-4 year olds are estimated to be enrolled in some type of early education programs, but fewer than 33% attend a program accredited by the National Association for the Education of Young Children. SPARKS (Supporting Partnership to Assure Ready Kids) is part of a national initiative of the W.K. Kellogg Foundation led by the National Black Child Development Institute. 3 large child development centers have been selected as anchor sites in each of Ward 1, 7 and 8. Each anchor is paired with an elementary school and staff and parents will adapt and implement preschool-school transition strategies affecting 1000 preschool children. The Administration's unique contribution to this effort is to incorporate the 6 schools in the school health information automation pilot project. See NP# 7. In 2005, the partners worked to develop universal standards for school readiness for 4 year olds.

Family Services

The Administration and the Child and Family Services Administration (CFSA), Department of

Human Services, negotiated a memorandum of understanding (MOU) effective December 2002 through September 2004 (signed April 23, 2003) for joint case management of drug exposed infants. The MOU was developed in response to the varying practices in hospitals for reporting "substance-positive infants" and the Child Fatality Review Committee's long standing recommendation to improve and coordinate home visiting services to high risk families. Through the Administration's home visiting program, many substance using families are identified and targeted for continued assessment and treatment; however once the infant leaves the hospital, many refuse follow up services. The joint case management incorporates the Administration's skilled nursing assessment and related services by Healthy Start nurses and the CFSA's family focused case management. Law 14-206 Improved Child Abuse Investigations Amendment Act of 2002 strengthened the District's investigations of child abuse and neglect. Among other provisions, the law changes the definition of child neglect to include drug exposure and positive drug test in newborns and requires reporting of positive drug tests. But the language does not mandate a finding of neglect based on drug exposure alone. The legislation was not supported by dedicated funding for implementation.

During 2004-2005, due to the influx of these cases, Healthy Start nurses reached and exceeded their caseloads, reducing the resources for prenatal and interconception care coordination as required by the Healthy Start grant. Administration nurses funded through Title V also have high caseloads, and referrals to other case management programs in the city stretched private resources. A new MOU that requires CFSA to provide funding for 2 FTE Healthy Start nurse case managers to provide services to these cases is ready for signatures.

/2007/ The commitment to support these positions was not realized. In spring 2006, MFHA was informed that funds were not available to support the positions.

MFHA recently issued a subgrant to Mary's Center to develop a pilot program to screen high risk mothers, including those who use substances, and conduct assessments and nurse home visits after discharge from the hospitals. The agreement also includes training of MFHA staff to augment case management capacity in the community. //2007//

Other collaborations and coordination of activities are described in the performance measures sections of this application.

/2008/ MPCA has established many internal and external organizational relationships throughout the District that enhance the capacity of the Title V program. Instances of these collaborative efforts are described below.

Intradepartmental Coordination

The CSHCN Bureau is currently working in collaboration with the Child, Adolescent, and School Health Bureau's Oral Health Division and the managed care organization HSCSN to create a task force and action plan to improve the oral health of children and youth with special health care needs.

MPCA jointly participates with the Addiction Prevention and Recovery Administration's (APRA) in the Pregnancy Identification Intervention Strategy Program with the Addiction Prevention and Recovery Administration's (APRA) Central Intake Unit. Ultimately the goal is to improve the system of care for pregnant and post-partum substance abusing women and reduce infant mortality in the community by enrolling more women in the DC Healthy Start program.

The school health liaison represents the MPCA on the citywide Task Force on Immunization. The current immunization compliance rating for the District of Columbia Public Schools is almost 98%. MPCA also conducted bi-weekly meetings with the DC DOH immunization program to ensure higher compliance rates and increase vaccination coverage among school-aged and pre-school children.

Interagency Coordination

MOUs

The Perinatal and Infant Health Bureau has a multi-year Memorandum of Understanding with the Department of Mental Health's Parent Infant Development Program (PIDP) for the Healthy Start Project staff to provide mental health counseling and support to pregnant and parenting women who may be at-risk for depression. Interagency conferences are held bi-weekly between PIDP and Healthy Start staff to exchange information and plan care.

DC DOH will enter into an MOU with the State Education Office, Nutrition Services Department in order for MPCA to provide an intensive, comprehensive nutrition education and physical activity training program for District of Columbia child care providers. The Nutrition and Physical Fitness Bureau will facilitate this effort.

DC DOH and the DC Public Schools will enter an MOU in order for the DC Public Schools to allow the MPCA, Rape Prevention and Education Program's sub-grantee, Men Can Stop Rape, Inc. to provide sexual violence prevention education training sessions to male students attending DC public schools.

Programs

MPCA collaborates with the District of Columbia Public Schools on an ongoing basis to implement the District of Columbia Public School Nurse Assignment Act of 1987 in order to staff a minimum of 20 hours per week of nursing services in public schools. In FY 2006, there were 141,030 student visits to the health suites. To date in FY 2007, there are 103,897 student visits documented.

MPCA is in the process of ensuring that all health suites are provided with computers and wired for Internet connectivity. The Bureau plans to ensure that virtually all health suite have network connectivity by FY 2008.

The Perinatal and Infant Health Bureau/DC Healthy Start Project in FY 2008 plans to enter into a collaborative agreement with the Child and Family Services Administration to expand home visitation activities in targeted areas of the District of Columbia. Families with children ages 2-5 years old will receive referrals, home-visits, and monitoring and supportive services from a family support worker under the nationally recognized Healthy Families model.

MPCA staff serve as members of the Child Fatality Review Committee, a city-wide collaborative program authorized by the Child Fatality Review Committee Establishment Act of 2001. The committee was established for the purpose of conducting retrospective examinations of the circumstances that contributed to the deaths of infants, children, and youth who reside in the District.

The Perinatal and Infant Health Bureau/DC Healthy Start Project has a multi-year (through December 31, 2009) sub-grant agreement with the Healthy Babies Project, Inc. to expand case management/care coordination services to 105 high-risk pregnant and parenting women residing in Wards 5 and 6.

The District has made changes internally to develop and implement a vigorous enforcement program to ensure compliance on all lead-related legislation, regulation and standards.

The CASH Bureau plans to increase the number of schools receiving 40 hours of nursing coverage to 75% in FY 2008 with additional resources authorized by the Council of the District of Columbia. The Child Adolescent and School Health Bureau also plans to collaborate with the

Bureau of Communicable Disease's STD program to launch a school-based STD urine screening project in area high schools to contain and reduce the escalating rates of Chlamydia and gonorrhea in the adolescent population.

In July 2006, the Nutrition and Physical Fitness Bureau (NFPB), Food Stamp Nutrition Education Program staff provided nutrition education to the Department of Parks and Recreation's Healthy Kids Camp, one week at each of the two sites, where adolescents received both nutrition education and fitness instruction to guide them on a long-term program to improve their health. Starting in October 2006, NFPB has participated with Summit Health Institute for Research and Education on its development of a Childhood Obesity Collaborative for Ward 8, East of the River.

In 2006, between May and November, the Farmers' Market and Senior Farmers' Market Nutrition Programs engaged in a series of innovative activities to ensure that the maximum distribution, redemption, and use was made of the coupons provided to each Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and Commodity Supplemental Food Program participants.

The District of Columbia Metropolitan Police Department has a Sexual Assault Unit that partners with DOH on pursuing grants, as well as providing sexual assault data in the District.

External Partnerships

The MPCA funds three grants to the DC Primary Care Association to assist in the creation of medical homes for underserved populations in the District. One grant provides operating funds to support the overall Medical Homes Initiative.

The MPCA awarded \$125,000.00 to So Others Might Eat (SOME) and \$100,000 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents.

The CSHCN Bureau improved the ease with which families could utilize community-based service systems by entering into a collaborative agreement with the four Medicaid MCOs. The MCOs hired parent advocates to help families enrolled in their respective plans learn to effectively navigate the health care delivery system.

MPCA was selected among 18 other states to participate in the Assuring Better Child Health and Development Screening Academy project. Through this Academy, MPCA will receive technical assistance to integrate valid, standardized tools of children's development into preventive health care practice.

The Childhood Lead Poisoning, Screening, and Education Program (CLPSEP) has an on going subcontract with Lead Safe Babies of the National Nursing Center Consortium (NNCC) to provide in-home screening and education for 400 pregnant and new mothers in high-risk areas.

The CSHCN Bureau has established a Memorandum of Understanding with Howard University Hospital called the District of Columbia Greater Access to Pediatric Sickle Cell Services Project (DC GAPS). The goal of this partnership is to improve education and outreach to children with sickle cell disease and their families.

The Perinatal Infant Health Bureau, in collaboration with Healthy Families Thriving Community Collaborative Council (HFTCC) has implemented a neighborhood-based family support system to sustain a seamless network of community partners throughout the District of Columbia that builds strong families and supportive communities.

The University of the District of Columbia partners with the MPCA to deliver sexual violence prevention education to the UDC student and personnel population as well as staff and students of a university consortium including American University, Georgetown University, George

Washington University, the Catholic University of America, and Gallaudet University.

The District of Columbia Rape Crisis Center is also supported by MPCA to deliver sexual violence prevention information to various populations in the District of Columbia.

Family Support Services Division staff participates and provide expertise to the Family Shelter Collaboration on issues of homelessness and related housing and lack of employment opportunities.

The Vision Screening program collaborates with the Lions Club to provide services to children from one to six.

The DC Healthy Start Project and The DC American Lung Association formed a partnership in January 2007 to promote tobacco cessation.

MPCA also supports the DC Control Asthma Now (DC CAN), a public-private partnership to improve health outcomes and reduce the burden of asthma on residents of the District of Columbia.

The MPCA also collaborates with the National Capital Asthma Coalition, a major regional resource for asthma training for children, adults, and professionals, which includes an Asthma Friendly Schools Training and Awards program known as Everybody BREATHES (Breathe Right, Exercise, and Take to Heart Eating Smart).

//2008//

/2009/ The Community Health Administration (CHA) continued as well as established many internal and external organizational relationships throughout the District to enhance the capacity of the Title V program.

Within CHA, the coordination efforts are reflected in the Perinatal and Infant Health Bureau's partnering with sister Bureaus, such as SHCNs and CASH to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Healthy Start's nurse case managers and family support workers link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services.

APRA, HAA, DMH, DHS, CFSA

Bidirectional referrals of pregnant or parenting women occur between Perinatal and Infant Health Bureau.

Medical Assistance Administration (MAA)

The Bureaus work closely with MAA to identify opportunities to enroll women and children; improve the health of children and address the state priorities. Efforts include: lead screening and reporting of newborns lead blood level results and obesity in children projects.

Other State Agency coordination include:

HAA conducted sexually transmitted disease screening in several DCPS high schools. The screening was highly successfully and will be expanded to all high schools in 2009.

Department of Corrections (DOC)

The Perinatal and Infant Health Bureau is collaborating with DOC to facilitate access to prenatal care for women incarcerated in the DC Jail.

Child and Family Services Administration (CFSA)

The SHCN Bureau coordinates with the CFSA to identify children with disabilities and developmental delays and assist with access to care.

Obesity Interagency Work Group

CASH Bureau with support of the Nutrition and Physical Fitness Bureau convened the DC Obesity Inter-Agency Work Group in October 2007 and is comprised of DC government agencies and CBOs. Its purpose is to gather information about nutrition, physical activity and obesity prevention activities of DC government. Membership includes more than 15 inter and intra agencies, consumer groups, schools and community based organizations.

DC Public Schools (DCPS)

The CASH Bureau works in concert with the DCPS and Charter Schools: 1) oversight of the school nurse program; 2) father/son and mother/daughter programs; 3) health education sessions; 4) targeted oral health education, screening and sealant program.

DC Consumer and Regulations Authority

Lead Program partnered with DC Consumer and Regulatory Affairs to establish a home based lead assessment and mitigation program to decrease lead exposure in District residences.//2009//

F. Health Systems Capacity Indicators

Introduction

/2008/ The major priorities of the MPCA are to reduce infant mortality rates, enhance infant survival, enhance the MPCA's data gathering and analysis system, and improve its infrastructure. MPCA is focusing on developing programs that contribute to a lower infant mortality rate and enlarging public participation in the Title V program. MPCA also will work more closely with the District's community-based organizations to achieve these goals.

The ultimate goal of the Title V program will be to improve national and district performance measures. In addition, MPCA's realignment is expected to facilitate better communications and foster greater collaboration among Bureaus. This should have a positive impact on the Title V program. These are the factors that have influenced and will continue to influence the District's ability to maintain or improve the Health Systems Capacity Indicators.

The District's Title V program has the capacity to provide preventive and primary care services for pregnant women, mothers, and infants; preventive and primary care services for children; and services for CSHCN. Many of these program strategies already exist; others are being developed to meet the Health Systems Status Indicators. *//2008//*

/2009/ During this grant year DOH continued to focus on infant mortality; children with special health care needs; oral health; lead, asthma, youth injury/violence; administrative issues that improve program evaluation; data collection, analysis and integration. The Program staff are active participants in agency and community based coalitions focused on enhancement of maternal/child health issues. //2009//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	36.4	34.0	34.4	45.3	45.3
Numerator	122	119	121	161	161
Denominator	33513	35029	35175	35513	35513
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

Data for 2007 will be updated when made available.

Notes - 2006

This measure will be updated when the 2007 data becomes available.

Data includes all children less than 5, including those less than 1.

Notes - 2005

2005 Data not available. When the 2005 final data becomes available, it will be updated.

Denominator: Source Table 2. Estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2005. (SC-EST2005-02-11) Population Division, US Census Bureau

When updating the 2006 number it was found there was just a slight change in the 2005 number which was applied here.

Narrative:

/2008/ MPCA received the data from the District of Columbia Hospitals Association and from the staff of the CDC-funded asthma control grant. The rate for children hospitalized for asthma in the District has been declining since 2001.

MPCA is one of the many governmental agencies that is represented on the DC CAN Intergovernmental Agency Committee as well as the Steering Committee and includes representation from private sector organizations. The purpose of the committee is to make recommendations to decrease asthma related morbidity and mortality.

One asthma control issue in which MPCA continues to be involved in is that of the development of a school-based policy on self-medication. The Child and Adolescent Health Bureau (CASH) staff continues to work with DC Public Schools to finalize and implement a policy specifying under what conditions students will be permitted to carry medications and self-medicate. //2008//

/2009/ DOH assigned a full time epidemiologist to the DC Control Asthma Now program to assist in data analysis and identification of strategies to improve management of children with asthma. The program will help to advance legislation allowing a child's permission to carry medications and self medicate during the school day by ensuring that school nurses train volunteer certified medication administration staff in DCPS/Chartered schools.

Under the Child Health Action Plan DOH expects to decrease Emergency Department visits for children by 20% by 2010; implement a quality improvement initiative for health care providers to ensure consistent high quality care for children with asthma, including an asthma registry and standardized asthma action plans and treatment records. //2009//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	73.3	75.7	81.7	72.6	82.4
Numerator	3616	3828	4334	4114	4143
Denominator	4935	5059	5303	5668	5026
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data taken from national Form 426: Annual EPSDT Participation Report.

Numerator taken from Row 8: Total eligible who should receive at least one initial or periodic screen for children <1.

Denominator taken from Row 9: total eligible receiving at least one initial or periodic screening for children <1.

Barriers to achieve the objective will be addressed in the new partnership between DC Partnership to Improve Health care quality and MAA to create an EPSDT well child registry.

Notes - 2006

Source: District of Columbia Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration. This includes SCHIP recipients as well.

Notes - 2005

Source: District of Columbia Form 416 FY05 Annual EPSDT Participation Report provided by the Medical Assistance Administration. This include SCHIP recipients as well.

Narrative:

/2008/ There has been a steady increase in the percentage of Medicaid enrollees less than one year old who received at least one initial periodic screen, from 56.4 percent in 2002 to 72.6 percent in 2005. Unfortunately, there was a decline from 2005 to 2006. The increase can be attributed to the efforts of DC DOH and its partners, especially Managed Care Organizations that promote well-child visits. Reasons for the decline are not evident from the available data. However, MPCA staff will further explore this decline with the staff of the Medicaid Assistance Administration once 2007 data are available. //2008//

/2009/ The percentage of Medicaid enrollees less than one year old who received at least one initial periodic screen increased from 72.6% to 82.4%. The Medical Assistance Administration and the Perinatal and Infant Health Bureau actively promote newborn visits within the first 48 hours as well, outreach efforts encourage mothers to utilize primary care services. //2009//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0	0	0	0	0
Numerator					

Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The State has no breakout of SCHIP data within its EPSDT data.

Notes - 2006

The State has no breakout of SCHIP data within its EPSDT data.

Notes - 2005

The District Medicaid and SCHIP are fully integrated. According to the State Medicaid Office, SCHIP numbers are reported with Medicaid numbers on Form 416.

Narrative:

//2008/ SCHIP data is not reported separately from EPSDT data.

Medicaid and the District SCHIP are part of the same state program, and the Medical Assistance Administration does not publish numbers about SCHIP. Consequently, no data is available.

//2008//

//2009/ There has been no change in separating the report of SCHIP data from EPSDT data. Medicaid and the District SCHIP are part of the same state program, and the Medical Assistance Administration does not publish separate data about SCHIP. Consequently, no data is available. //2009//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	59.0	60.9	56.4	55.9	55.9
Numerator	3784	3779	4449	4727	4727
Denominator	6414	6210	7891	8461	8461
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 file becomes available.

Notes - 2005

Final data.

Narrative:

/2008/ The percentage of women with a live birth during the reporting year who had prenatal visits was consistent from 2002 to 2004 and then increased approximately 10 percent in 2005. In the past two decades, there has been a national decline in prenatal care by family physicians and general practitioners. These changes can be explained by increases in non-physician providers, changes in the specialist workforce, or poor access to prenatal services. //2008//

/2009/ The relative consistency in the percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index is a reflection of the active outreach of the Perinatal and Infant Health Bureau's MOM van; Healthy Start case management and family support worker program as well as efforts of the Primary Care Association's medical home initiatives.

Based on a service gap analysis, DOH identified potential holes in the safety net of services for residents of the District and established three strategies for improvement in perinatal and infant care over the course of the next year. The first was increasing capacity and impact of the DOH home visitation program for pregnancy women. The federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs administered by DOH and by Mary's Center for Maternal and Child Care, Inc. promote a healthier physical and social environment in the home and link families to needed care. In 2008, additional funds will be used to expand the capacity of the Healthy Start program, including an investment to recruit and train family support workers who will team up with nurse case managers to address major risk factors affecting the health of pregnant and parenting women and their children. The Bureau hired and is training Family Support Workers through Healthy Start funding. These workers will provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and children. The first goal also includes a public information campaign to educate women and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy and distribution of 15,000-18,000 cribs over the next seven years to prevent Sudden Infant Death Syndrome (SIDS). This program is funded through a grant from the Bill and Melinda Gates Foundation to First Candle.//2009//

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	72.6	72.6	58.9	55.8	57.3
Numerator	65357	65357	54062	53636	52259
Denominator	89993	89993	91734	96063	91236
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Final
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Notes - 2007

Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Denominator is line 1: total individuals eligible for EPSDT, while the numerator is line 9: Total eligible receiving at least one initial or periodic screen.

Notes - 2005

Data are not available.

Narrative:

/2008/ From 2002 through 2006, the percentage of Medicaid-eligible children who received a service paid by Medicaid declined from 84.1 percent to 55.8 percent. However, this is an estimate and the District currently does not have reliable data on the number of potential Medicaid-eligible children. Some of these children may be covered outside the Medicaid program by an alliance of commercial insurers. It is estimated that between 10-12% of potential children in the District are eligible for Medicaid. Currently, the Medical Assistance Administration is examining the number of additional children who might be eligible. //2008//

/2009/ Data related to services received and paid by the Medicaid program is obtained from the Form 416:Annual EPSDT Participation Report provided by the DC Medicaid program for FY 2007. A slight increase is noted from 2006 to 2007. This is an estimated number because the District currently does not have reliable data on the number of potential Medicaid-eligible children. Some of these children may be covered outside the Medicaid program by the alliance program or commercial insurers. It is estimated that between 10-12% of children in the District are potentially eligible for Medicaid but not enrolled. //2009//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	23.1	36.2	40.3	36.0	42.5
Numerator	4354	6533	7103	6523	7119
Denominator	18867	18045	17628	18125	16769
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2007

Data obtained from the Form 416:Annual EPSDT Participation Report provided by our Medicaid program for FY2007.

Numerator is taken from row 12A (Age Group 6-9), while the denominator is taken from Row 1 Total individuals eligible for EPSDT (Age group 6-9).

Notes - 2006

Source: District of Columbia Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration.

Notes - 2005

Source: District of Columbia Form 416 FY05 Annual EPSDT Participation Report provided by the Medical Assistance Administration

Narrative:

/2008/ The percentage of EPSDT-eligible children ages 6 through 9 who received dental services during the year increased from 2002 to 2005 and then declined in 2006. In 2006, the percent of EPSDT-eligible children ages 6 through 9 who have received any dental service during the year dropped to 36 %, a decline of 4% when compared with 2005, but matching the rate obtained in 2004.

MPCA recognizes that the provision of oral health services is a challenging problem in the District. Currently, the Oral Health Division's School Based Dental Program provides preventative dental services to DC Public Schools elementary school students who present their signed parental consent forms.

The Medical Assistance Administration does not receive school-based data. There may be more children receiving dental services than the statistics indicate. In other words, the number of children receiving dental services may be underreported.

The MPCA awarded a grant of \$125,000 to SO Others Might Eat (SOME) and \$100,000.00 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents. SOME will also provide clinical cultural competency training for senior dental and senior dental hygiene students.

The DC Healthy Start MOM unit began providing basic dental services in May 2007. Perhaps these programs will result in an increasing percentage in succeeding years. //2008//

/2009/ The increase in the percentage of EPSDT-eligible children ages 6 through 9 who received dental services during the year from 36.0 to 42.5 percent may be due to several factors: 1) increase in dental reimbursement rates; 2) oral health data is collected on Form 416.

Two major efforts for the upcoming year include a memorandum of understanding between DOH and DCPS/OSSE to expand scope of work of dentists in DC public school sites and Charter schools.

The Child Health Plan targets by 2010 that 55% of all children 0-21 will have at least one oral health visit (for any reason) documented and to increase the rate of children aged 8 years old who have protective sealants on at least one of their permanent molar teeth by 5%.

CHA is in the process of developing another initiative to permit primary care providers to apply fluoride varnish to children and document on the Form 416. //2009//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Indicator	0.0	0.0	0.0	NaN	NaN
Numerator	0	0	0	0	0
Denominator	3420	3420	3420	0	0
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	Yes
Is the Data Provisional or Final?				Final	Final

Notes - 2007

The District no longer has a clinical program for CSHCN rehab services. Therefore 0 is entered in all fields..

Notes - 2006

The District no longer has a clinical program for CSHCN rehab services. Zero was entered in all fields.

Notes - 2005

The District no longer has a clinical program for CSHCN.

Narrative:

2008/ The District no longer has a clinical program for CSHCN. //2008//

/2009/ Although the District no longer has a clinical program for beneficiaries less than 16 years old receiving rehabilitative services it is considering a Medicaid requirement for billing to allow multidisciplinary providers to serve children with SHCNs. //2009//

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2006	matching data files	13	10.3	11.2

Notes - 2009

2006 Birth file linked with Medicaid recipient file.

Narrative:

/2008/ Comparing the health system capacity indicators of Medicaid, non-Medicaid, and all MCH populations in the District was one of the principal objectives of the SSDI grant. MPCA staff is working closely with the Center for Policy, Planning, and Epidemiology to refine the data. Although the national upswing in multiple births has had an important influence on recent trends in pre-term birth rates, shorter gestations have also risen among singleton deliveries. Reasons for lower rates in the District are less clear since infant mortality has increased slightly, while low birth weight rates decreased in 2005. However, disparities exist when examining pre-term birth by race. African Americans have somewhat higher rates (14.9%) than white non-Hispanics

(9.0%) and Hispanics (10.1%). See National Performance Measure 17. //2008//

/2009/ In an initiative under the Infant Mortality Plan, the Perinatal and Infant Health Bureau will design and implement a public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy in efforts to decrease infant morbidity and mortality due to low birth weights.

//2009//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Infant deaths per 1,000 live births	2006	matching data files	11	11.5	11.3

Notes - 2009

There are 96 infant deaths in 2006. Of that group 45 or 46.9% are on Medicaid. To compute for Medicaid 45/4086 (Medicaid Births) * 1,000 and for non-Medicaid 51/4436 (Non-Medicaid births) * 1,000.

Narrative:

//2008/ The District has a high infant mortality rate in comparison to the rest of the country. Factors that account for more than half of the District's infant deaths include maternal complications of pregnancy, birth defects, complications of delivery, and disorders related to short gestation and low birth weight. Other factors associated with infant mortality are adequacy of prenatal care, reproductive tract infections, race, age, and ward of residence of the mother. Socioeconomic disadvantage, poverty and lack of health insurance are among obstacles to health and health care often cited. Many of the conditions and risk factors associated with maternal and infant mortality in the District of Columbia disproportionately affect women of color.

In 2008, a major priority of MPCA is to fund sub-grants to reduce infant mortality in the District. A new data chief and CDC epidemiologist have joined the MPCA. They will focus on evaluation, surveillance systems, and infant mortality by using Periodic Periods of Risk (PPOR) and rebuilding PRAMS. MPCA also plans to revitalize the Birth Defects program in order to capture, track and link families of children with birth defects to services. Identifying these children will support efforts of MPCA to reduce infant mortality and morbidity in the District.

MPCA will continue participating in the District-wide Infant Mortality Advisory Committee. The combination of the above-mentioned activities is intended to help reduce the number of infant deaths. //2008//

/2009/ The Infant Mortality Plan strategies include: recruit, train and deploy family support workers under the Healthy Start program to provide complementary support services that address psychological and medical risk factors affecting pregnant and parenting women and their children.

Facilitate the distribution of 15,000 to 18,000 free cribs over the next seven years to low-

*income mothers to prevent Sudden Infant Death Syndrome (SIDS), thanks to an \$11 million grant from the Bill & Melinda Gates Foundation to First Candle.
//2009//*

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2006	matching data files	68.6	80	75

Notes - 2009

2006 Birth file linked with Medicaid recipient file.

Narrative:

//2008/ The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester is much lower in Medicaid than in the non-Medicaid population. DC Healthy Start staff will continue identifying and recruiting pregnant women early and enroll them into prenatal care. Staff will continue to provide initial prenatal care visits on the MOM unit to pregnant women not yet enrolled in care. The capacity to provide case management services to high-risk pregnant women will be maintained in the coming year. The 1-800-MOM-BABY HEALTHLINE telephone number will continue to provide advice and information for pregnant women. The MPCA intends to use these programs to reach more pregnant women on Medicaid. See National Performance Measure 18. //2008//

//2009/ The percentage of pregnant women receiving Medicaid benefits entering the first trimester of pregnancy continues to be considerably lower than non Medicaid pregnant women. The Perinatal and Infant Health Bureau staff is aggressively continuing its outreach efforts through the Healthy Start, family support worker program and MOM unit program; enrolling women in prenatal care and in Medicaid programs, as needed. //2009//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate	2006	matching data files	43.7	67.1	55.9

prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])					
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Notes - 2009

2006 Birth file linked with Medicaid recipient file. Mothers between 18 and 44 are compared with Kotelchuck. Missing information is included in the analysis to determine adequacy.

Narrative:

/2008/ The percent of infants born to pregnant women receiving prenatal care beginning in the first trimester is much lower in Medicaid than in the non-Medicaid population.

DC Healthy Start I and II staff will continue identifying and recruiting pregnant women early and enroll them into prenatal care and will continue to provide initial prenatal care visits on the MOM unit to pregnant women not yet enrolled in care. The capacity to provide case management services to high-risk pregnant women will be maintained in the coming year and the 1-800-MOM-BABY HEALTHLINE telephone number will continue to provide advice and information for pregnant women. The MPCA will use these programs to reach more pregnant women on Medicaid. See National Performance Measure 18. //2008//

/2009/ The data presented for 2006 reflects the disparities between Medicaid and non Medicaid pregnant women with adequate prenatal care. Strategies to address this disparities include increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance and facilitate outreach and linkages to care for homeless pregnant women. The Bureau has implemented a collaborative project with the Department of Corrections to identify pregnant women in the criminal justice system.//2009//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2007	300
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2007	300

Narrative:

/2008/ Eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level as of June 1, 2007. //2008//

/2009// the Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2009//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's	YEAR	PERCENT OF POVERTY LEVEL
---	-------------	---------------------------------

Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.		Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	300 300
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2007	300 300

Narrative:

/2008/ As of June 1, 2007, eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level. //2008//

/2009/ Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300% of the Federal Poverty Level. //2009//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2007	300
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women	2007	300

Narrative:

/2008/ As of June 1, 2007, eligibility for Medicaid-SCHIP for children 18 years or younger increased from 200 percent to 300 percent of the federal poverty level. Eligibility included pregnant women. //2008//

/2009/ Eligibility for Medicaid-SCHIP for children 18 years or younger remains at 300 percent of the Federal Poverty Level. Eligibility included pregnant women. //2009//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death	3	Yes

certificates		
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	No
Annual birth defects surveillance system	1	No
Survey of recent mothers at least every two years (like PRAMS)	1	No

Notes - 2009

Dr. Genet Burka, a CDC appointee, is working on a PRAMS like survey on pregnancy and barriers to prenatal care. It is expected to be a population based risk factor surveillance system identify selected maternal behaviors that occur before and during pregnancy including access to prenatal care, use of alcohol and tobacco during pregnancy.

CHA has been able to both improve relationships to obtain timely data and increase its capacity to match and link data. Using SSDI funds, CHA has brokered formal and informal agreements on sharing data, procedures for requests for information, and some collaboration among partners. CHA for the first time is using a statistical package Link Plus for matching and linking. This software is a probabilistic record linkage program developed at CDC's Division of Cancer Prevention and Control.

The DC Medicaid program provides CHA with an annual recipient file, but is not always able to provide claims data in a timely fashion.

Narrative:

In 2006 the MCH program began linking data for the Title V submission, through SSDI funding. In 2007 newborn screening data (metabolic screening and newborn hearing) data was linked with the most recent birth file. In addition, a Medicaid file of newborns was linked with the birth file. In the previous two cycles the MCH program has used SQL code to match and link files using MS ACCESS. During the year program staff began experimenting with "Link Plus", a CDC-funded probability statistical linking software designed to work with cancer data. (Dan)

/2008/ Until recently, MPCA had limited access to electronic databases and had to formally request the data from the appropriate agency. Staff will be attending CDC/HRSA Maternal and Child Health epidemiology training in New Mexico to enhance skill sets in data trend analysis, needs assessment, and program evaluation. Moreover, MPCA was accepted into the CityMatch

Data Institute to obtain technical assistance for both data analysis and program evaluation on our Safe Start Crib Program to address sudden infant death syndrome and infant mortality within the District.

In 2006, the MCH program began linking data for the Title V submission, through SSDI funding. In 2007, newborn screening data (metabolic screening and newborn hearing) data was linked with the most recent birth file. In addition, a Medicaid file of newborns was linked with the birth file. In the previous two cycles, the MCH program has used SQL code to match and link files using MS ACCESS. During the year, program staff began experimenting with "Link Plus," a CDC-funded probability statistical linking software designed to work with cancer data.

Dr. Genet Burka and Stephanie Alexander will be conducting a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. They will be collaborating with a number of programs to assess the various data that are captured for inclusion in trend analysis. In addition, they will be developing a database on infant birth, morbidity and mortality statistics for the District to assist programs with planning and services. //2008//

//2009/ CHA proposes a pilot PRAMS-like survey in 2009. A request for proposal and scope of work will be developed and vendor solicited to provide the survey.

Dr. Genet Burka continues to lead a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. The process includes collaboration with a number of programs to assess the various data that are captured for inclusion in trend analysis and developing a database on infant birth, morbidity and mortality statistics for the District to assist programs with planning and services. The database will be a component of the Data Integration project. //2009//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No

Notes - 2009

Narrative:

//2008/ Since 1999, the reported use of tobacco has declined among male and female students. Out-of-school youth were not surveyed. See State Performance Measure 4. //2008//

//2009/ The Child Health Action Plan focuses on reducing youth tobacco product use by 10% by 2010. The strategies include conducting a minimum of 450 tobacco sales compliance inspections to reduce youth access to tobacco per year. The YRBS data is available through the collaboration with DC Public Schools. //2009//

IV. Priorities, Performance and Program Activities

A. Background and Overview

During this reporting period, MFHA continued to focus on the priorities delineated in June 2000, working within the Department of Health (DOH) in an environment that has undergone significant change over the past 5 years. The continuing restructuring of the District's safety net for the provision of health care for the poor, hospital closures and financial crises, the aftermath of September 11, 2001 with an increasing emphasis in public health on responding to potential bioterrorism, coupled with diminished tax revenues affected MFHA's resources and activities. Changes occurred within the DOH as well. Throughout the period 2000-2005, MFHA continued to focus on its 5-year objectives and long term priorities. Each year from 2000 to 2004 prior to the submission of the Title V block grant application, senior staff met to review and discuss annual performance measures. As a result, a few of the priorities were slightly modified, for example, changing "establish" to "institutionalize", but remained essentially the same.

In preparation for the July 2003 block grant report, application submission, and 5-year needs assessment, staff and consultants considered the findings from the MCHB-sponsored national survey of CSHCN. Reviewing the DC data in comparison to US data as well as information collected as a result of activity on categorical grants, targets for the performance measures specific to CSHCN were set.

In the spring of 2005 MFHA completed the collection of data for the 5-year needs assessment. As described in the needs assessment section of this application, the data collection and analysis staff compiled data from numerous sources to describe the District's maternal and child health populations. These data were presented to forums and focus groups, and the report was widely distributed. Several focus groups were convened to elicit input on residents' needs. The focus groups included groups dedicated to teens, parents and Latinas. On June 27, 2005, 9 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 experiences in administering programs. Also taken into account were the District's Healthy People 2010, an emerging state health plan to guide the certificate of need process, the state Medicaid plan, the developing state adolescent health plan, and planning for categorical grants.

The priority-setting exercise gave special attention to the issues that were unanimous across focus groups. Next, the staff reviewed the 2000 priorities and discussed whether any should be retained for the 2006-2010 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. A 4th priority, monitor the effects of welfare repeal on health status, had yet to receive much attention and now seemed beyond the scope of existing resources, and it too from removed from the priority list.

The staff then formulated 5 new priorities. In the next section of the application, the status of and plans for each of the priorities is described. First, the status of priorities set in June 2000 is described, including the 4 priorities that will not be continued into 2006-2010. Next, the status of 3 priorities established in 2000 and carried over into the 2006-2010 period is described. Then 5 new priorities are described. Priorities are numbered only for purposes of reference in discussion.

MFHA will continue to report on the same 7 state performance measures delineated in previous years due to their emphasis on issues of considerable importance to the District maternal and child population:

- 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.

MFHA recognizes that the needs assessment is an ongoing process of reviewing new information and reassessing priorities. Toward that end, the Maternal and Child Health Officer is recommending to the director of the Department of Health that a Maternal and Child Health Work Group be convened to review the findings of the recently submitted needs assessment and discuss the implications for the development of policy in the District. The Work Group would be charged with developing a short-term plan for approaching and informing local policy makers on ways to improve the health of women, children and families.

The recommended composition of the Work Group will include maternal and child health services providers, including CSHCN, advocates, and representatives of government agencies.

/2007/ The recommendation was sent forward to the DOH director in August 2005. It was not acted upon. In October 2006 there was a transition in leadership to a new senior deputy director. See the section on public input for current plans for a maternal and child health advisory group.

Following the realignment of MFHA (see agency capacity) and the appointment of a new senior deputy director, the priority needs delineated in July 2005 were reviewed. During May through June 2006, senior staff reviewed the priority needs, taking into account changes in the environment, new directives, recently available data on health measures, resource requirements, and information obtained from participation in the technical assistance workshop presented in May 2006 by MCHB. Extensive discussions resulted in several changes to the priority needs list.

Two state performance measures are being replaced with new measures. These changes are discussed in the next section of this application. //2007//

/2008/ During the reporting period, the former Maternal and Family Health Administration and the Primary Care and Prevention Administration were realigned (see Organizational Structure) as the Maternal and Primary Care Administration (MPCA). MPCA established a Maternal and Child Health Services Title V Block Grant Planning Team that was co-chaired by Joyce Brooks and Paula S.F. Marshall. The team guided the development of the Title V Application for FY 2008 and the Annual Report for FY 2006. The Team reviewed the state priorities delineated in July 2006 taking into account the public input received from the MPCA advisory committees and community collaboratives, Healthy People 2010 objectives, DC DOH Strategic Business Plan, program goals, performance measures, program activities, and resources. //2008//

/2009/ The Community Health Administration (CHA) is responsible for the oversight and management of the Title V Block Grant including the issuance and award of community based grants to support state priorities; grantee monitoring and evaluation of compliance with performance measures; data collection and analysis; program and staff progress in accomplishment of program goals and objectives; and identification of coordination activities with sister Bureaus.

During the past year CHA continued to focus on the 10 State Priorities discussed in the previous sections. The activities are described in the Health Care Indicators sections of the application. Each Bureau actively identifies opportunities to improve maternal and child health disparities for District residents. Staff utilize coalitions comprised of inter and intragency representatives, providers, community based organizations and families to identify strategies to develop policies, expand resources, facilitate access to services and knowledge.//2009//

B. State Priorities

Two priorities were discontinued in FY 2008.

Direct HealthCare Services (DHS), Infrastructure Building (IB), population-based services (PBS), enabling services (ES)

Increase awareness of the role of mental health in adolescent risk behaviors, school achievement and perinatal outcomes; and increase availability of preventive services. (IB, PBS, ES)

Universal depression screening of Healthy Start clients will continue through June 2009, supported by 2 federal grants. A 1-year grant to expand perinatal depression screening in all areas of the city will be underway in FY 2006. The Administration will continue to work within an MOU with the DC Department of Mental Health to fund and co-locate 2 FTE licensed therapist positions at the Parent and Infant Development Program to receive, assess, diagnose and treat Healthy Start clients who screen positive for depression or other mental health problems. MFHA will work with MCOs to incorporate more mental health services into physical care. This new priority is related to NP# 3, 5, 8, 16 and SP# 1, 5, 7.

/2008/ This priority is being discontinued. MPCA acknowledges that mental health is a major issue of concern for all populations in the District. The DC DOH will continue to collaborate with the DC Department of Mental Health to launch its Teen-screen Initiative, a suicide screening and counseling program. The DC Healthy Start Project will continue to screen all pregnant and parenting women for depression throughout the duration of their participation in the program (up to child's second birthday). However, due to inadequate staffing and resources it is not feasible to keep this as a priority. //2008//

Increase the proportion of the population that is insured, and increase the comprehensiveness of the coverage to include primary preventative services and preconceptional services. (ID, ES) MOUs were established with the 4 Medicaid MCOs in late 2004, opening the door for the development of standards of care to improve services to the maternal and child health populations, including more comprehensive and accessible preconception and interconception health care services.

/2007/ This priority is being revised to: Increase the proportion of the population that receives comprehensive primary preventative and preconceptional services. The restatement emphasizes utilization and receipt of services rather than availability. The District is increasing Medicaid-SCHIP eligibility from 200 to 300% of the FPL, making additional expansion of coverage less urgent. It will be, however, necessary to increase efforts to inform the public of the change in eligibility and how to access and use services, particularly preventive services. //2007//

The Administration has continued to disseminate information about Medicaid-SCHIP and the Alliance. See NP# 4, 13, 14 and SP# 2.

/2008/ This priority has been discontinued. It will be addressed in our efforts to decrease infant mortality//2008//

1. Improve oral health among children, youth, and pregnant women. (IB, PBS, DHS)

Although Medicaid reimbursement rates were slightly adjusted in FY 2003, with another increase in the proposed FY 2006 budget, and increasing recognition of the lack of accessible services has resulted in mobile dental services offered in a few underserved neighborhoods, efforts have yet to result in observable improvements in access to and utilization of oral health services. In September 2002 the Administration secured funds from the Office of the Assistant Secretary for Planning and Evaluation in the amount of \$450,000 to implement a school-based oral health program that would restructure the manner in which oral health services are delivered to CSHCN enrolled in the public schools. Beginning with 2 schools dedicated to special needs children, the

grant funds were applied in 2004 to renovate the medical/dental health suites and install telemedicine capabilities in order to serve the oral health needs of SHCN students. Children were digitally linked to dentists at CNMC who provided oral screenings, consultations, and referrals.

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. Anticipate carry-over monies for use in 2006.

The Healthy Start MOM unit, which is expected to be functioning by the beginning of FY 2006, /2007/ now expected in FY 2007 //2007// will add oral health screening for pregnant and interconceptional women. In addition to beginning to build an oral health infrastructure by establishing an oral health division, located in the Administration's Adolescent and School Health Bureau, an Oral Health Coalition, consisting of organizations representing oral health and dental services providers, was formed in 2004. This priority will continue through 2010. See NP# 9 and SP# 2.

/2008/ The Oral Health Division's School Based Dental Program provides preventive dental services to DCPS elementary school students of all grades who present their signed parental consent forms. MPCA awarded sub grants of \$125,000 to So Others Might Eat (SOME) and \$100,000.00 to Howard University College of Dentistry to treat and improve the oral health of vulnerable District residents. SOME will also provide clinical cultural competency training for senior dental and senior dental hygiene students. The DC MOM Unit began providing basic dental services in May 2007. //2008//

/2009/ Three oral health activities: the MOM van provides dental screening as part of prenatal services; MOU with DCPS and Chartered Schools to expand oral health services to provide screenings, fluoride treatment and sealants to children and oral health education programs. //2009//

2. Reduce unintended pregnancies and teen births. (ES)

The Teen Mothers Take Charge (TMTTC) program, originally funded by District TANF funds and later supported by Title V funds, originally provided monies to 4 community based organizations to provide care coordination and enrichment services to teen mothers with the objective of preventing unintended repeat pregnancies and assisting young mothers to become self sufficient. In FY 2005, due to budgetary reductions, the TMTTC program provided services to 75 clients at 1 community based organization. The program is expected to continue through FY 2006, with an expected client load of 95 young women.

In June 2005, the 2 Healthy Start projects were refunded for a 4-year period with a focus to include perinatal and interconceptional care case management. The case managers support the clients in avoiding unplanned repeat pregnancies within that time period. See also NP # 8, SP# 5, 7. This remains a priority for the period 2006-2010.

/2008/ The Health and Sexuality Education program provides comprehensive health and sexuality education to District youths, as well as providing training and technical assistance to community-based organizations. In FY 2006, a total of 16 elementary schools, 4 senior high schools, 3 middle schools, 2 public charter schools, and 2 faith-based organizations received program services. A total of 1,231 youth received health and sexuality education, with the highest concentration of program services occurring in Wards 5, 6, 7 and 8. In addition, the Abstinence Education Program educates District youths about the benefits of sexual abstinence until marriage. During FY 2006 the program conducted over 100 abstinence education sessions throughout the District of Columbia. A total of 1,000 youth in 30 DC Public Schools received abstinence education sessions. //2008//

/2009/ CASH Bureau expanded its sexual health program utilizing the CARRERA model in

DCPS and Charter Schools. //2009//

3. Enhance nutrition and increase physical activity for children and youth. (ES)

In FY 2006, as WIC and related nutrition programs are integrated into MFHA, managers will schedule planning sessions in order that staff and managers are well informed about all programs, activities and objectives across bureaus. Integration into the Administration's structure presents the opportunity for staff to exploit all opportunities for coordination and integration, not only linkage of databases.

MFHA will continue to participate in the Obesity Prevention Advisory Council, which was convened in June 2005 by the Medical Assistance Administration (state Medicaid agency).

The recently re-funded Healthy Start grant includes a component to enlist clients in a post partum nutrition and physical activity program, partnering with the WIC Eat Smart/Move More program to establish sites specifically for Healthy Start participants. /2007/ Healthy Start has abandoned this component. //2007//

In 2005, a MFHA staff member's time was allocated to coordinate with a local radio station, WPFW, campaign to establish "Movement Clubs". WPFW promotes the program through the Web site (www.wpfw.org), on-air announcements and public affairs programs. MFHA will assess the results to determine how best to support and/or expand this effort in 2006.

/2007/ Funding is being sought for a reunion of movement clubs, in which 1,500 persons participated, and production of a DVD featuring physical movement to promote sustainability of physical activities is planned for completion in 2006. See other activities section of this application. //2007//

MFHA will also use its relationships with the public school system to understand and influence policies pertaining to vending machine access and contents, school and summer feeding programs, and school event sponsorships and fundraising. This priority may be somewhat related to NP# 11, SP# 1, O#6 and 09C.

/2008/ The Nutrition and Physical Fitness Bureau provides nutrition and fitness classes to school children, parents, and seniors using USDA's Team Nutrition curriculum. The Bureau has been an active participant with the Ward 8 Childhood Obesity Collaborative, working to support an initiative providing assistance and training to Family Day Care Providers, as well as a range of policy initiatives on expanding fresh food access in that area of the city, the poorest ward in the District. //2008//

/2009/ The Nutrition and Physical Fitness Bureau's collaborative efforts developed initiatives to shift eating behaviors to foods with nutritional dietary value; Food Stamp Education Plan and awarded a TEAM Nutrition grant; furthered the DCPS nutrition policy; increase the level of physical activity in schools and health fair promotions.

Legislation was passed to increase breast feeding friendly workplaces in DC. DOH continues to support is Lactation Center and Resource Room.

DC Obeisty Work Group formed: obesity prevention and reduction, State Plan Development.//2009//

4. Decrease violence toward and by children and youth. (PBS)

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 to develop 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 seek funding opportunities to operationalize these plans.

The proposed realignment of the DOH includes the transfer of a violence prevention program (primarily focusing on sexual assault) to MFHA, increasing the opportunities for a more integrated violence prevention intervention strategy. Staff will be assisted to exploit opportunities to coordinate and integrate violence prevention programs. Efforts around this priority are expected to affect NP# 6, 8, 10 and O# 1, 2, 6.

/2008/ The MPCA Rape Prevention and Education Program collaborates with public and private providers to address violence toward and by children and youth in the District and targets schools, universities, and community members. //2008//

/2009/ CHA plans to solicity strategies from organizations currently addressing violence toward and by children and youth. Public and private partnership developed a poster campaign that will be distributed to DC schools.

Technical Assistance was requested. //2009//

5. Increase access to medical homes for CSHCN and support seamless systems of care. (IB, DS)

/2007/ This priority is being restated to emphasize utilization rather than access and availability: Educate consumer and providers to increase utilization of medical homes.

Due to the Medicaid carve-out for SSI beneficiaries, changes in the Medicaid MCO contracts, and the expansion of Medicaid-SCHIP, District residents increasingly have opportunities for obtaining care within a Medicaid home. //2007//

MFHA staff will continue to work to ensure that CSHCN services are well-integrated with Medicaid-SCHIP services. In Fiscal Year 2006, staff will work with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN, and support the training of staff in selected clinics to expand diagnostic and treatment skills for genetic disorders.

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 clinics to provide medical homes. Advocates for CSHCN have yet to be involved in these efforts. During FY 2006, Administration staff will attempt to coordinate their plans with those of the primary care "system".

Staff will continue to support the CSHCN Advisory Council in the identification of needs and opportunities for strengthening referral systems across systems of care. This priority is related to NP# 3, 4, 5, 6 and SP#3.

/2008/ This priority has been reworded as above. MPCA staff will continue working to ensure that CSHCN services are well-integrated with Medicaid-SCHIP services. Staff will work with Medicaid-SCHIP contractors and providers to adopt evidence-based standards of care for CSHCN, and support the training of staff in selected clinics to expand diagnostic and treatment skills for genetic disorders. //2008//

/2009/ CHA continues to work with DCPCA and MAA to ensure that children with SHCN are well integrated with Medicaid-SCHIP program. //2009//

6. Improve MPCA capacity to collect, acquire, analyze and utilize program data and strengthen surveillance systems. (IB)

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

health status.

The overarching priority delineated in 2000 will be carried over in the 2006-2010 period. This 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, in particular the outcome measures, are affected by disparities. The Administration will continue to operate the grant-funded Healthy Start projects, which are designed to eliminate disparities in perinatal outcomes among African American women.

/2007/ This priority is being changed to reflect the need to strengthen MFHA surveillance systems: Manage surveillance to eliminate disparities. The urgent need to improve MFHA capacity to collect, acquire, analyze and use program data has been evidenced throughout this application. Although data to describe disparities are available, few, if any, analytic efforts are underway to help to determine appropriate interventions. Making this an explicit priority is consistent with proposed SSDI grant activities.

/2008/The new data chief and CDC epidemiologist that joined the MPCA are focusing on evaluation, surveillance systems, and infant mortality by using PPOR and rebuilding PRAMS. DC DOH merged its epidemiologists with the Vital Records Division to create the Center for Policy, Planning, and Research Statistics (formerly the State Center for Health Statistics Administration). Also, DC DOH will link the newborn file with WIC, CLPSEP, and Healthy Start. DC DOH received a \$9.8 million Medicaid Transformation grant to improve health outcomes, and analyze Medicaid data with patients' medical histories. Client data from Medicaid, safety net clinics, and a hospital group will be placed on a data sharing hub relying on a central client index. Later, MCH data will be added. //2008//

/2009/ CHA initiated the data integration project that will support the timely and quality collection of disparate data across DOH administrations. Dr. Burka leads CHA's efforts focusing on evaluation, surveillance systems, and infant mortality tracking outcomes of Title V funded programs and not just a count of services. //2009//

7. Provide STD screening and prevention services for adolescents. (DHS)

/2008/ The incidence of STD infections in DC has steadily increased over the last five years and most cases of chlamydia and gonorrhea are reported among 15-19 years old, especially females. Adolescents do not usually seek medical attention, increasing the probability for those with untreated infections progressing to serious reproductive and other health problems. With CNMC, DCDOH and DCPS plans to implement annual chlamydia and gonorrhea screenings in two high risk DC senior HS in September 2007. See HSI # 05A. //2008//

/2009/ Implement its highly successful chlamydia and gonorrhea screenings in all DC Public high schools. //2009//

8. Decrease infant mortality. (ES)

This addition emphasizes the importance of infant mortality within District government and the Department of Health, and makes Title V priorities consistent with DC 2010 objectives. */2008/ The new MOM unit provides early identification of high-risk pregnant women who are not yet enrolled in prenatal care. The MOM unit provides women with preventive services such as screening for breast and cervical cancer, STDs, and chronic medical conditions. Women receive assistance with applying for benefits such as Medicaid, TANF, and SSI (if eligible) to remove any financial barriers that may prevent them from utilizing primary and preventive health services. See SPM # 4, 6, 7, 9 and SOM # 1. //2008//*

/2009/ 2008 programs will continue; development of the Infant Mortality Plan (part of the Child Health Action Plan) is major priority of Mayor Fenty. CHA will benefit from increased capacity of healthy babies program. //2009//

9. Improve school-based asthma management of children (ES)

/2008/ MPCA has an agreement with the National Capital Asthma Coalition. This is a major regional resource for asthma training for over 6,000 children, adults, and professionals at over 80 community workshops and health fairs each year. The Program involves an Asthma Friendly Schools Training and Awards Program known as Everybody BREATHEs (Breathe Right, Exercise, and Take to Heart Eating Smart). See HSCI # 07A and SPM # 2. //2008//

/2009/ Child Health Action Plan targets asthma management, decreased ED visits by 20% by 2010; implement QI plans and asthma protocols in school education initiatives. //2009//

10. Decrease lead poisoning for children under six years of age.(PBS)

/2008/ The Childhood Lead Poisoning, Screening, and Education Program (CLPSEP) served a total of 16,028 individuals in FY 2006.CLPSEP used the DC DOH Lead Mobile Health Unit to provide screening, outreach and educational activities. The program has improved service penetration into the Medicaid eligible population and by data sharing, improved the screening rates among the various Managed Care Organizations from 54% to 63.8%. See SPM # 3. //2008//

/2009/ Conducts home based assessment of children with blood lead levels at or equal to 5 ug/dl. //2009//

/2009/ DC Partnership to improve Health Care Quality is working with MAA to develop the EPSDT well child registry. There is city commitment to increase family support and home visit programs. In January DC will release a new Birth Certificate that will increase mother and child data collection at the person level.

**The CSHCN advisory board will increase membership, youth and citizen involvement. CHA will ad a parent advocate to AMCHP advisors. //2009//
An attachment is included in this section.**

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	NaN	100.0	100.0
Numerator	36	33	0	30	30
Denominator	36	33	0	30	30
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	98	98	98	98	98

Notes - 2007

2007 data is not available at this time and will be updated.

CHA discovered previously that the wrong information was being entered from Form 6. This is noted and will be corrected in the future.

Notes - 2006

CHA discovered during the 2009 application process that the wrong information was being entered from Form 6. Instead of reporting the % of positive screens, the table was reporting the % of total screens. This is being corrected.

Notes - 2005

CHA discovered during the 2009 application process that the wrong information was being entered from Form 6. Instead of reporting the % of positive screens, the table was reporting the % of total screens. This is being corrected.

When correcting for this problem it was found that there were 0 positive screens reported.

a. Last Year's Accomplishments

The Special Health Care Needs Bureau's activities for this year include the working with the Perinatal and Infant Health Bureau's newborn screening program that screens newborns for hearing loss and metabolic disorders prior to hospital discharge. In FY 2007 14,745 babies were born in DC of which an estimated 8,500 are DC residents. The District continued in 2007 to consistently follow-up on infants born with a definitive diagnosis and support clinical management in a timely manner. It continues its goal to achieve a 100% compliance. The District mandates a home visit for each newborn within 48 hours and one month. This program enhances DOH's ability to achieve its goals. The addition of family support workers in high risk Wards will further advance DOH's goals.

Follow-up services for children with special health care needs, including referrals for infants and children with positive screenings for hearing and metabolic disorders. Approximately 25 District newborns were born with positive metabolic screening disorders and 26 were born with hearing loss.

Each of the District's contracted Medicaid managed care providers offer case management services for newborns with special needs to ensure that newborns receive follow-up care and appropriate services. Infants and children meeting special needs eligibility requirements are enrolled in the HSCN managed care program.

FY 2007, DOH funding provided to three birthing hospitals with equipment and software that allowed newborn hearing screening results to be automatically downloaded into a data collection system which is made available in real time to the Care Coordinator. This has improved the service delivery, tracking and follow-up of newborns.

The Bureau is an active participant in several committees and coalitions to identify opportunities, support services and policies are available to facilitate children and families' newborns with definitive diagnoses have optimum access to needed or requested services. The staff provides support to the various coalitions, including but not limited to logistical and administrative support. The coalitions' mission and objectives are briefly described:

DC Hears Advisory Board: This group meets quarterly to review, modify and make recommendations on children with hearing loss

New York-Mid-Atlantic Consortium for Genetic and Newborn Screening Services (NYMAC): This group meets quarterly to ensure that a child with heritable disorders and their families have access to quality care and appropriate genetic services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospital newborn discharge program	X			
2. Mandatory newborn hearing screening	X		X	
3. Mandatory newborn metabolic screening	X		X	
4. Implement the Standardized Medical Record Form in additional primary care practices				X
5. Implement audits of data collect			X	
6. Enhance access to medical homes and collaboration with DCPCA			X	
7. Access to subspecialists			X	X
8. DC Linkages and Tracking System Program integrated into the hospital discharge and Healthy Start Programs.			X	X
9.				
10.				

b. Current Activities

The current activities for children with special health care needs include:

Hospital Newborn Discharge Program identifies high risk newborn District babies and coordinates case management services and access to care. The services are conducted by a vendor with a scope of work that requires the contractor to visit newborn District babies within two days of birth and their mothers in either the hospital and/or home setting. The services are available to newborns throughout the District. Nurses ensure that mandatory hearing and metabolic screenings are completed and reported. Mothers and infants meeting eligibility requirements are referred to appropriate providers and approved by their Medicaid plan. In addition, care coordination includes referral to support groups and other entitlement programs.

Through a public partnership collaborative effort the Child Health Action Plan was developed and implemented. The Plan focuses on eight health indicators including well child visits and infant mortality. Targets are defined.

The Bureau is an active participant in several committees and coalitions to identify opportunities, support services and policies are available to facilitate children and families newborns with definitive diagnoses have optimum access to needed or requested services.

The Bureau staff continue to actively participate in the committees and coalitions described in the previous section that relate to National Performance Measure 01.

c. Plan for the Coming Year

To address the National Performance Measure 01 the DOH will continue its Healthy Start Program and Hospital Newborn Discharge Program to ensure that each District newborn receives a follow-up visit within 48 hours of birth and within 1 month. As well, case managers assist patients in enrollment in a case management program either through the Medicaid managed care program or through the HCSN managed care program.

The Child Health Action Plan strategies to support the percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs include:

Well child visits for children 0-21 years old include:

- 1) continue implementation standard medical record form (SMRF) in all pediatric practices
- 2) conduct education of all pediatric primary care providers on HealthCheck Database regarding the SMRF
- 3) Conduct audits
- 4) Assure that every child with SHCN has a primary care provider
- 5) Increase access to subspecialty care

The reduction in infant mortality strategies included the previously presented and the training and deployment of family support workers to provide complementary support services that address medical, social, and psychological risk factors affecting pregnant and parenting women and their children.

Performance measure for 2009 include: Improve follow up for children with abnormal screens by enhancing case management. Every infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening currently receives short term follow from identification to specialty referral. These infants are followed to diagnosis. The NMS program is currently in the process of developing a long-term follow up protocol, allowing care-coordinators to provide enhanced follow up beyond disorder identification to ensure continued comprehensive, coordinated care and treatment for those infants affected. Early identification and appropriate and continuous treatment is vital to the addressing the morbidity and mortality of these infants.

Other projects include DC Linkages and Tracking System Program integrated into the hospital discharge and Healthy Start Programs.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	56	56.5	57	57.5	58
Annual Indicator	55.5	55.5	55.5	55.5	53.1
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	58	58	58	58	58

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

The accomplishments this year that involved participation of parents and families in the decision making relate to their children's special health care needs include:

1) Parent participation in the Town Hall Meeting - participants identified issue related to 1) access to specialty providers; 2) funding for parents who exceed income eligibility guidelines and struggle to meet their child's needs and 3) identification of providers to transition children from pediatric to adult services.

2) The Sickie Cell Program for newborns and children diagnosed with sickle cell receive follow-up care and services through a memorandum of understanding with Howard University Hospital and The DC Pediatric Sickie Cell Services (DC GAPS). It provides a well coordinated intensive case management system for infants with sickle cell disease to establish a medical home. Service delivery to parents with sickle cell trait of newborns by offering genetic counseling services. The Special Health Care Needs Bureau staff monitors the care coordination procedures and quality of care delivered.

3) The Epilepsy Program supported children living in medically underserved areas to attend Camp great Rock, a summer camp for children with epilepsy and seizure disorders. The program re-established the Metropolitan Epilepsy Affiliate which held a conference for parents and teens with epilepsy and seizure disorders. Of the 226 seminar participants, 70% (159) were parents and teens.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Case management services	X			
2. Pediatric Epilepsy Action Plan			X	
3. Working on Birth Defects and Screening Legislation				X
4. Parent Information Network project	X		X	
5. Parent education project through the community based organization grant	X			
6. Sickie Cell Program " Face of Our Children"			X	
7. Build Autism Service Capacity		X	X	
8. Partner with MAA to address insurance gaps for privately insured patients		X		X
9.				
10.				

b. Current Activities

The Bureau's activities this year include:

The Sickie Cell Program supports families' in decision making at each level of their child's care.

The "Faces of our Children" Program is a partnership with a local organization focusing on sickle cell disease education to conduct outreach and education activities. It supports teens understanding of the importance of genetic counseling services.

Award of a Parent Information Network grant that supports families' partner in decision making at all levels.

The Bureau's Epilepsy program established a partnership with the District's managed care organizations to ensure children with special healthcare needs such as those suffering from epilepsy and seizure disorders receive coordinated care within a medical home. The MCOs provide care coordination, support group meetings, educational sessions and mailings, service satisfaction/needs assessment, phone surveys, community forums, and support for children and youth to attend camps during the summer.

Award of a Parent Information Network grant that supports families' partner in decision making at all levels.

c. Plan for the Coming Year

The Special Health Care Needs Bureaus plans for the coming year include:

- 1) Contract with a vendor to provide transition case management services for children with special health care needs to facilitate their transition from pediatric to adult care. the scope of work will include working with families and children and actively seeking this support and direction in each phase of the transition process.
- 2) Implementation of the Family Development Center for children with special health care needs provides parent child classes. This program will enhance parents knowledge of entitlements, resources, policies and services available to optimize access to care and services.
- 3) Parent Infant Network will expand from the pilot phase to implementation phase. The scope of work will include expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs, etc.
- 4) Continue sickle cell and epilepsy programs.
- 5) Increase knowledge of parents by providing educational materials. In FY09, the Bureau will distribute new brochures to hospitals containing information about what it means when their child does not pass their initial hearing screening.
- 6) Autism - increase capacity of parents with children with autistic spectrum disorder to identify and access relevant resources. Also to assure the capacity for programs caring for children to provide the appropriate levels of care.
- 7) CHA will engage with Medical Assistance Administration (MAA) to look at funding streams for privately insured patients whose coverage does not adequately cover the necessary services.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	42	42.5	43	43.5	44
Annual Indicator	41.4	41.4	41.4	41.4	36.9
Numerator					
Denominator					

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	44	44	45	45	45

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

Notes - 2006

The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.

Notes - 2005

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

The Sickle cell program for newborns and children diagnosed with sickle cell receive follow-up care and services through a memorandum of understanding with Howard University Hospital and The DC Pediatric Sickle Cell Services (DC GAPS). It provides a well coordinated intensive case management system for infants with sickle cell disease to establish a medical home. Service delivery to parents with sickle cell trait of newborns by offering genetic counseling services. The Special Health Care Needs Bureau staff monitors the care coordination procedures and quality of care delivered.

The Bureau's Epilepsy program established a partnership with the District's managed care organizations to ensure children with special healthcare needs such as those suffering from epilepsy and seizure disorders receive coordinated care within a medical home. The MCOs provide care coordination, support group meetings, educational sessions and mailings, service satisfaction/needs assessment, phone surveys, community forums, and support for children and youth to attend camps during the summer.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote services of DC GAPS - sickle cell activities in Metro area			X	
2. Expand Medical homes in DC through DC Primary Care Association				X
3. Faces of our Children - increase awareness of hemoglobinopathies		X		
4. Home assessment of children with blood lead levels at or greater than 5ug/dL.	X		X	
5. Expand the number of available medical homes by increasing the funding for additional primary care, subspecialty and urgent care facilities and providers				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The Sickle cell program for newborns and children diagnosed with sickle cell receives a well coordinated intensive case management system for infants with sickle cell disease to establish a medical home. Service delivery to parents with sickle cell trait of newborns by offering genetic counseling services. The Special Health Care Needs Bureau staff monitors the care coordination procedures and quality of care delivered.

Coordination with Medical Assistance Administration (MAA) to identify opportunities to improve care coordination and identify medical home needs for families and children with special health care needs.

Revision of MCO contract language to increase access to medical homes.

c. Plan for the Coming Year

The SHCN Bureau will continue its support of the Sickle Cell and Epilepsy and Seizure Disorder Programs and work with the DC Primary Care Association's Medical Homes project.

The Bureau will continue to work with the Medical Assistance Administration (MAA) to monitor the MCO's care coordination practices and satisfaction survey results for families and children with special health care needs.

The Bureau's performance measures includes:

Increase integration with the medical home by identifying the Pediatrician/Primary Care Provider prior to discharge. In the current year, the Bureau will partner with the DC hospitals to identify and verify the newborn's primary care provider prior to discharge.

Improve follow up for children with abnormal screens by enhancing case management. Every infant born in a District hospital who receives an abnormal newborn genetic/metabolic screening currently receives short term follow from identification to specialty referral. These infants are followed to diagnosis. The NMS program is currently in the process of developing a long-term follow up protocol, allowing care-coordinators to provide enhanced follow up beyond disorder identification to ensure continued comprehensive, coordinated care and treatment for those infants affected. Early identification and appropriate and continuous treatment is vital to the addressing the morbidity and mortality of these infants.

Another plan for the coming year includes expansion of the number of available medical homes by increasing the funding for additional primary care, subspecialty and urgent care facilities and providers.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	60.5	61	61.5	62	62.5
Annual Indicator	55.9	55.9	55.9	55.9	62.7
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	62.5	63	63	63	

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

Notes - 2006

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

Notes - 2005

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

The District meets its performance objective. Working in concert with its sister bureau, the Perinatal and Infant Health Bureau to enroll infants identified with special health care needs in public and private insurance programs as well as refer the parents to various support groups and programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaboration with Medical Assistance Administration			X	
2. Healthy Start Case Management Program	X			
3. Family support worker program	X			
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Perinatal and Infant Health Bureau Healthy Start Program and family support workers; MOM unit and hospital newborn discharge program support the enrollment of special needs children into public or private health insurance.

c. Plan for the Coming Year

Continue the Healthy Start Program and MOM unit outreach efforts to enroll pregnant and parenting women in entitlement programs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	71	71.5	72	72.5	73
Annual Indicator	69.9	69.9	69.9	69.9	88.8
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	73	73	73	73	73

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006

The data reported in 2006 are pre-populated with the data from the 2001 CSHCN survey.

Notes - 2005

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

The SHCN Bureau has worked with the Medical Assistance Administration (MAA) to ensure that children with special health care needs age 0 to 18 whose families report that the community-based service systems are organized so they can use them easily. MAA conducts enrollee satisfaction surveys as a quality improvement activity to determine satisfaction with access and delivery of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Universal Call Center data collection project				X
2. Database linkages - data integration				X
3. Various advisory board/coalitions with family/consumer representation				X
4. Autism capacity planning project			X	X
5. Collaboration with OSSE related to special needs children			X	X
6.				
7.				
8.				
9.				

10.				
-----	--	--	--	--

b. Current Activities

The primary activity to determine satisfaction is through the MCOS.

Awarded a contract to implement a pilot family navigator program in 3 District health centers. Based on the Parent Consultant Program of the Rhode Island Parent Information Network (RIPIN). The outcomes include:

- 1) Provide navigation services to 100 families of special needs kids
- 2) Satisfaction survey of care and access to care
- 3) Decrease in emergency department visits as well as decrease in the number of school days missed

Review findings with Medical Assistance Administration and recommend implementation of successful strategies by MCOS serving children with special needs.

c. Plan for the Coming Year

The current year activities include working with the MCOs as well as

Expand the PARENT Information Network Program in additional health centers. The model is based on the Parent Consultant Program of the Rhode Island Parent Information Network (RIPIN). Review the outcomes from the pilot project and refine or adapt the program based on findings. At a minimum the outcomes will include:

- 1) Provide navigation services to more than 100 families of special needs children
- 2) Conduct and report the results of a satisfaction survey of care and access to care by families receiving navigation services.
- 3) Review the first years data related to emergency department visits as well as number of school days missed. Refine the program to improve performance and outcomes.

Autism - increase capacity of parents with children with autistic spectrum disorder to identify and access relevant resources. Also to assure the capacity for programs caring for children to provide the appropriate levels of care.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6.5	7	5.8	8	8.5
Annual Indicator	5.8	5.8	5.8	5.8	24
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	
	2008	2009	2010	2011	2012
Annual Performance Objective	9	9	9	9	

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

Notes - 2006

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

Notes - 2005

Data are prepopulated by federal MCHB with 2001 SLAITS CSHCN Survey.

a. Last Year's Accomplishments

The SHCN Bureau participated in the HRSA conference call related to Transition Strategies for children with special needs from pediatric to adult providers.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and issue the RFP for Transition Services for children with special needs		X	X	X
2. Work with Dr. Patience White to develop Transition Services proposal		X	X	X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau is currently developing a request for proposal and statement of work to develop and implement a Transition Plan for Families and Children with Special Health Care Needs. The statement of work will include a gap analysis; identification of providers serving the special health care needs population; recruitment and outreach strategies to health care and other service providers; implementation of DOH approved strategies.

c. Plan for the Coming Year

The Bureau will award a contract to develop and implement a Transition Plan for Families and Children with Special Health Care Needs. Dr. Patience White nationally known expert, will serve

as a mentor to develop the RFP. Also, utilize data from the Adolescent Employment Readiness Center to facilitate development of the RFA.

Convene stakeholder meetings to identify transition to adult service needs.

Monitor Parent Information Network activities.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	82	85	70	80	82
Annual Indicator	76.5	82.5	73.5	78.4	83.4
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes		
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	82	83	83	83	83

Notes - 2007

Estimates are based upon 2007 Q3-2006 to q2 007. Children were born between July 2003 and December 2005. ††† 4:3:1:3:3 plus 1 or more doses of varicella vaccine. http://www.cdc.gov/vaccines/stats-surv/nis/tables/0607/tab09_

Notes - 2006

Estimates are based upon 2006 NIS. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months - United States, 2006 Source: MMWR, September 15, 2007 / http://www2a.cdc.gov/nip/coverage/nis/nis_iap.asp?fmt=v&rpt=tab02_antigen_iap&qtr=Q1/2006-Q4/2006 The 2005 NIS survey cohort included Children in the Q1/2006-Q4/2006 National Immunization Survey were born between January 2003 and June 2005; Rate shown is for four or more doses of DTP, three or more doses of poliovirus vaccine, one or more doses of any MCV, three or more doses of Hib, three or more doses of HepB 4:3:1:3:3: series 95% CI +/- 6.

Notes - 2005

Estimates are based upon 2005 NIS. National, State, and Urban Area Vaccination Coverage Among Children Aged 19-35 Months - United States, 2005 Source: MMWR, September 15, 2006 / 55(36);988-993 <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5429a1.htm>.

The 2005 NIS survey cohort included children born during February 2002--July 2004; all of these children might have been affected by the shortages of PCV during February--September 2004, when recommendations to defer the 4th dose or the 3rd and 4th doses were in effect. Rate shown is for four or more doses of DTP, three or more doses of poliovirus vaccine, one or more

doses of any MCV, three or more doses of Hib, three or more doses of HepB 4:3:1:3:3: series 95% CI +/- 6.6

a. Last Year's Accomplishments

The Immunization Program conducts a wide array of activities including but limited to annual assessments for immunization compliance in Head Start, Licensed Child Care facilities and schools -- public, private, charter and parochial. The program monitors hepatitis B infections in pregnant women and ensure follow-up treatment for these women, infants, and contacts. In addition, the program administers immunizations to children and adults at five (5) express and special immunization clinics.

The program provides vaccines to medical practices and providers who serve high-risk adults. Vaccines are also distributed to healthcare providers enrolled in the Vaccine for Children Program (VFC) to ensure that children eligible for the VFC receive timely immunizations. Members of the VFC staff program conduct monitoring visits in the offices of VFC providers to ensure accountability for vaccines distributed to their practices, this includes assessment of vaccine usage, storage and handling. The Program manages the District-wide immunization registry which warehouses all the immunization data for the District. The Program conducts immunization trainings for healthcare providers. One component of the program monitors and tracks all vaccine-preventable diseases and outbreaks as well as adverse events in the District of Columbia. The Program supports efforts of the Immunization Coalition of Washington, D.C.

The result of these activities are reflected in the Percent of children with up-to-date immunizations in:

Licensed Child Development Centers increased from FY 2007 74.27% to 88.66% in FY 2008
 Headstart increased from FY 81.42% to 96.85% in FY 2008

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Hospital newborn discharge program	X			
2. Family support worker program		X		
3. Healthy Start Program	X			
4. Collaboration with Medical Assistance Administration				X
5. Head Start Program	X			
6. Development and implementation of the Child Health Action Plan			X	
7. Develop practice based improvement strategies for children 0-4 years of age			X	X
8.				
9.				
10.				

b. Current Activities

The Bureau staff works closely with the DC Public Schools and Charter Schools and school nurses to maintain immunization levels for children enrolled in Head Start programs as well as school aged children.

Healthy Start Program counsels pregnant and parenting women on the importance of childhood immunizations and assists them with access to pediatric services including transportation to and from provider offices.

Monitoring the Immunization Registry data collection and reporting to ensure that DOH will continue to meet its immunization performance measures.

Distributed Vaccines for Children to providers throughout the District.

Local funds for FY09 are allocated to develop practice based improvement strategies for immunization rates for children 0-4 years of age. The funds will be utilized in grant year FY 2008 and FY 2009.

c. Plan for the Coming Year

The activities related to this national performance measure for the coming year are focused on assuring access to and utilization of immunizations for residents of DC. The initiatives include:

1: Maintain levels of immunization compliance in Public and Charter schools as well as in licensed child development centers and Headstart centers and increase immunization compliance rates in Private and Parochial schools by working closely with school health officials and staff from the Health Regulations Administration

During FY09 and FY10, the DC Immunization Program will work with the School Nurses and Administrators of the Public, Charter, Parochial and Private schools to assure high immunization rates in the face of new regulations.

The Immunization Program staff will work with the Health Regulation Administration to provide data needed to enforce immunization compliance for licensed child development centers and Head Start centers and assure staff at these facilities are informed of the new regulations

2: Assure maintenance of the immunization registry by working with senior officials in the Department of Health.

During FY09, the Immunization Program will seek to secure funding streams to maintain the Immunization Registry. Key staff will work to assure implementation of a contract for registry. Key staff will update the registry algorithms to ensure that the new regulations are incorporated in the system.

3. Continue to develop practice based improvement strategies for immunization rates for children 0-4 years of age.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	41.1	37.4	34.1	34.1	34.1
Annual Indicator	39.7	42.2	37.8	38.8	38.8
Numerator	293	326	327	376	376
Denominator	7384	7717	8648	9681	9681
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	32	32	32	32	32

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 birth file becomes available.

Notes - 2005

Final data. Denominator is based on the 2005 Census Bureau estimate for the District of Columbia.

a. Last Year's Accomplishments

Performance Measure 08: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.

The Health and Sexuality Education Program is an effective component of the Department of Health's approach for achieving reduced incidences of high risk behaviors and improved health outcomes for District youth. The Health and Sexuality Education Program seeks to reduce the incidences of unintentional teen pregnancies, increase knowledge of sexually transmitted disease (including HIV/AIDS), increase knowledge of reproductive health, increase the number of parents participating in "How to talk to your child about sex" workshops and increase services to Latino youth, increase knowledge of healthy relationships and relationship building. The program focuses on seven categories of behavior: behaviors that lead to unintended pregnancies; intended and unintended injuries, smoking; alcohol and other drug use; sexually transmitted diseases including HIV infection; poor nutrition and obesity.

The primary focus of the Health and Sexuality Education program is to provide comprehensive health and sexuality education to District youths, as well as providing training and technical assistance to community-based organizations. The Center services include a comprehensive array of physical and mental health services as well as health education and support services.

The Carrera Teen Prevention Program model provides another opportunity to address and mitigate factors that lead to pregnancy in adolescent girls.

Worked with the Woodson Adolescent Wellness Center is support their mission to promote health maintenance among the Woodson adolescent population, motivate students to adopt healthy lifestyles and avoid risky behaviors; to provide convenient health services, and to educate students on utilization of the District of Columbia's health care delivery system.

The projected pregnancy rate among DC girls age 15-19 in FY 2007 is 69 per 1,000 girls
The Projected rate for FY 2008 is 66.6 per 1,000 girls age (15 -19)

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School Nurse Program	X			
2. Healthy Life Style and sexuality health classes at DCPS		X	X	
3. Carrera Pregnancy Prevention Model		X	X	
4. Development and implementation of Child Health Action Plan incorporates the infant mortality plan			X	
5. Family Support Worker Program		X	X	
6. DCPS to implement "Making Proud Choices Curriculum"				

7.				
8.				
9.				
10.				

b. Current Activities

The activities include:

- 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance;
- 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge;
- 3) Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant;
- 4) Enhance linkage to substance abuse education and treatment services;
- 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency;
- 6) Reduce STD and HIV rates in the District of Columbia by partnering with HAA. In FY09, CHA will increase classroom and community group sessions with HAA at District of Columbia schools and community youth service organizations, support condom distribution in schools by school nurses and provide referral information to youth friendly testing sites during every education session and forum.
- 7) Continued to support the Center services including a comprehensive array of physical and mental health services as well as health education and support services.
- 8) Carrera Pregnancy Prevention Program expansion.

c. Plan for the Coming Year

The primary goal for coming year is to reduce the rate of pregnancy rate to 15-19 year olds by 10%. The strategies included: 1) to work with community partners to implement evidenced based approaches to increase the age of sexual initiation. 2) establish programs and procedures that support adolescent parents. The initiatives include but are not limited to the following:

INITIATIVE 1: Increase the number of pregnancy prevention education and awareness sessions with in District of Columbia schools by increasing outreach efforts to additional schools to provide pregnancy prevention education and awareness to students grades K-12. In FY09, this will be accomplished by enhancing existing partnerships with District youth service agencies and organizations to conduct educational services to a minimum of fifty District schools and ten youth service agencies and organizations.

INITIATIVE 2: Reduce sexual initiation by empowering youth by expanding the Carrera program or a similar teen pregnancy prevention program.

The Carrera program is an Adolescent Pregnancy Prevention Program that uses a holistic approach to empower youth. To help them develop personal goals and the desire for a productive future, in addition to developing their sexual literacy and educating them about the consequences of sexual activity. Currently, it is implemented in one Public Charter School with plans in development for expansion and will be expanded in 2009.

Planning to utilize funds to expand primary and secondary pregnancy prevention strategies. The DCPS will be implementing the "Making Proud Choices Curriculum" for all high school students.

This will allow realignment of staff in CHA and resources. CHA will be assessing best practices on reducing teen pregnancy to allow for funding impact.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	55	60	65	65	65
Annual Indicator	10.0	10	13.3	3.0	57.6
Numerator	744		108	67	49
Denominator	7437		812	2259	85
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	65	65	65	65	65

Notes - 2007

This reporting period, 6 District of Columbia Public Schools were targeted to receive oral health services (2 more than last year). These schools met the criteria that at least one-half of the student enrollment were eligible for the free or reduced lunch program. Therefore, the number of eligible students (including those who returned permission slips) and including those who used the service remained low. In addition, the schools served had overall small enrollment numbers for third grade classes. The denominator reflects the number of eligible 3rd graders; the numerator reflects the number 3rd graders who received a sealant.

In 2006 the denominator was the number of all eligible children. This caused the annual indicator to be much lower, and therefore was not used again in this reporting year.

It can be noted that DC's oral health program is expanding to provide services in all grades in participating elementary schools.

Notes - 2006

This reporting period, only 4 District of Columbia Public Schools were targeted to receive oral health services. These schools met the criteria of at least one-half of the student enrollment were eligible for the free or reduced lunch program. Therefore, the number of eligible students (including those who returned permission slips) including those who used the service remained low.

Notes - 2005

This is an "estimate" based upon students examined under the auspices of the school-based sealant project, not a population-based estimate. Over a three-year period from 2004 through 2006, 812 second and third graders in 14 schools were screened. The students screened (those for whom parental consent was received) represented 46% of the total enrollment in the 14 participating schools.

a. Last Year's Accomplishments

In order to begin to address this issue, the District of Columbia (DC) Department of Health (DOH,) Community Health Administration (CHA), Oral Health Division (Division) implemented a School-Based Dental Program. This Program aims to reduce the incidence and prevalence of oral disease that affect vulnerable, low-income students. The Program targets students enrolled in DC Public Schools (DCPS), DC Head Start Programs and DC Chartered Schools. Since its inception, the Program captured data indicating that an alarming number of children within these educational institutions are in need of a continued source of preventive dental care. The Program utilizes portable dental equipment which is transported to different school sites where clinical dental services are offered. All city and federal infection control rules and recommendations will be strictly followed. Dental instruments that can be autoclaved will be heat-sterilized all others will be disposed immediately after use. The Division will also partner with the DC DOH Medical Assistance Administration to develop strategies aimed at increasing access to oral health services for low-income children and adolescents.

The Oral Health Division (Division) aims to reach its mission by developing public policies and strengthening collaborations with programs that emphasize and perform data collection, surveillance and analysis, early detection, disease prevention and treatment programs targeting high risk populations. Special emphasis is placed on school based school-linked programs. The Division uses as its guidelines the Healthy People 2010 plan, Surgeon General's Report on Oral Health in America and A National Call to Action to Promote Oral Health in implementing its priority programs.

Activities accomplished included:

- 1) Developed, published and distributed necessary oral health forms to participating DCPS schools and HS centers
- 2) Collected signed parental consent forms to be analyzed by dental provider to permit oral health screening and applications of fluorides.
- 3) Provided oral health education to DC children in schools and for caregivers and parents at Head Start and other community programs
- 4) Hired an Oral Health Educator
- 5) Provided dental treatment to DC children with signed parental consent form
- 6) Developed process to successfully refer students in need of more restorative dental treatment which can not be offered by the School-Based Dental Program

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Oral health exam and sealant program	X		X	
2. Oral health education program		X	X	
3. Development and implementation of Child Health Action Plan - oral health goals			X	
4. Collaboration with MAA to increase reimbursement for dental services			X	X
5. Change policy to permit dental hygienist to practice independently in schools and public health centers			X	X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The oral health program activities this grant year included:

- 1) Collaborating with DCPS schools and Head Start Centers to identify locations for and offer School-Based Dental Program
- 2) Continuing oral health education programs in DC Public and Chartered Schools.
- 3) Apply oral health screening and applications of fluorides in children with parental approval.
- 4) Actively seek dental school graduates to work in DC under the loan-forgiveness program.

c. Plan for the Coming Year

The Initiatives this year to ensure access to oral health care for children in DC.

Initiative 1: Increase the capacity to have more children receive oral health care by enhancing partnerships.

Dental caries is the most prevalent disease in low socio-economic and minority children. To address this epidemic, DOH will implement an educational campaign to increase the percentage of positive oral health consent forms returned to the school and will increase the scope of oral health services currently offered. DOH will also enhance partnerships with dental providers to increase the percentage of students referred for additional services in a timely manner by fall 2009.

Initiative 2: Increase knowledge of students by providing Oral Health Education and Promotion. The DOH will increase the percentage of students who report greater oral health and nutrition literacy by conducting more age appropriate oral health seminars and age appropriate pre and post tests by fall of 2009.

Objective 2: Provide access to oral health care for high risk pregnant women in DC.

Initiative 1: Expand access by providing direct oral health care. Ensuring that mothers have good oral health hygiene has been proven to decrease dental caries in their infants. Maternal periodontal (gum) disease has been associated with an increased risk of preterm and low birth weight. DOH will increase by fifty (50 %) percent the parentage of Healthy Start women who receive an oral health exam, teeth and gum cleaning and dental anticipatory guidance during and after pregnancy by fall of 2009 DOH will increase by fifty (50 %) percent the parentage of Healthy Start women who receive an oral health exam, teeth and gum cleaning and dental anticipatory guidance during and after pregnancy by fall of 2009.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	4	4	3	2	2
Annual Indicator	3.2	2.1	0.0	4.2	4.2
Numerator	3	2	0	4	4
Denominator	93747	93747	96217	95176	95176
Check this box if you cannot report the numerator because			Yes	Yes	

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	2	2	2	2	2

Notes - 2007

Data not available for 2007. When data becomes available, this measure will be updated.

Notes - 2006

Numerator,: 2006 District of Columbia provisional death file.. Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles.

Denominator: Source Table 2. Estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2006. (SC-EST2005-02-11) Population Division, US Census Bureau.

Notes - 2005

Numerator,: 2005 District of Columbia death file.. Number of deaths to children aged 14 years and younger caused by motor vehicle crashes. This includes all occupant, pedestrian, motorcycle, bicycle, etc. deaths caused by motor vehicles.

Denominator: Source Table 2. Estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2005. (SC-EST2005-02-11) Population Division, US Census Bureau

a. Last Year's Accomplishments

This national priority is not a high priority for CHA to focus resources to create or implement strategies to address the performance measure. Therefore, CHA did not participate in specific activities that address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analysis of appropriate policies and programs for violence and injury prevention including motor vehicles crashes				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CHA is currently analyzing the appropriate policy and programs for violence and injury including but not limited to motor vehicle crashes.

c. Plan for the Coming Year

CHA address the rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children through an analysis of policy and programs currently in place.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				40	41
Annual Indicator			34.6	28.8	20.9
Numerator				1352	428
Denominator				4695	2043
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	42	43	44	44	44

Notes - 2007

Source: FY 2007 DC Cares-WIC Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age.

In the previous year the numbers were an estimate based upon the Pediatric Nutrition Surveillance Program national phone survey on breastfeeding. Reporting actual numbers of serviced clients was deemed to be preferred over numbers taken from a phone survey.

Notes - 2006

Source: FY 2006 DC Cares-WIC Data base. This data reflects the breastfeeding rates for the District of Columbia's WIC population of women with infants who report breastfeeding at six months of age.

Notes - 2005

The estimate for 2005 is based on the 2005 NIS
http://www.cdc.gov/breastfeeding/data/NIS_data/data_2005.htm. 95% C.I. = +/- 5.2

TVIS does not allow entry in the 2004 column. The 2004 rate was 34.6±5.2 as well.

a. Last Year's Accomplishments

DOH opened a Lactation Unit to counsel breast feeding mothers.

The DC WIC Program has a breastfeeding program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level. Qualified WIC participants receive breast pumps, education, and support either one-on-one, or as

a group during our monthly Breastfeeding Beautiful Beginning Club meetings.

In 2007 the Nutrition Intervention Project was completed and is now being rolled out to the local WIC agencies. This project provides a healthy cooking curriculum along with videos and recipe cards for use at the local agencies to assist the staff in promoting optimal nutrition for WIC participants. The Breastfeeding Peer Counselor Program has continued to maintain a high level of breastfeeding efforts and activities.

A 32-page revised breastfeeding resource guide available in English and Spanish were distributed within the DC WIC program as well as to breastfeeding partners in the community to hand out to their respective clients (lactation consultants, physicians, nurse managers, etc.).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. WIC Program supports breastfeeding	X			
2. Hospital newborn discharge program	X		X	
3. Healthy Start Program with family support workers	X		X	
4. Breastfeeding Peer Counselor Program		X	X	
5. Representation on the DC Breastfeeding Coalition			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Legislation for creating breastfeeding friendly workplaces was passed in DC. The Lactation Unit and Resource room continues.

The DC WIC Program has a breastfeeding program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

Qualified WIC participants receive breast pumps, education, and support either one-on-one, or as a group.

Convene monthly Breastfeeding Beautiful Beginning Club meetings.

Collaborating with the DC Breastfeeding Coalition working to establish breastfeeding friendly hospitals. Karen Watts Director of Perinatal and Infant Health Bureau is the CHA representative on the Coalition.

c. Plan for the Coming Year

Plans for the coming year include:

The Lactation Unit and Resource Center will continue to operate and collect data on breastfeeding mothers. The unit will be evaluated to include more sharing opportunities for mothers to bond.

Continue breastfeeding program through the WIC Program that includes a breastfeeding coordinator at the State level, and a lactation consultant and breastfeeding peer counselors at the Local level.

Qualified WIC participants receive breast pumps, education, and support either one-on-one, or as a group.

Convene monthly Breastfeeding Beautiful Beginning Club meetings.

Continue collaboration with DC Breastfeeding Coalition to establish breastfeeding friendly hospitals.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	50	60	100	75	75
Annual Indicator	93.8	66.7	25.5	22.6	25.3
Numerator	14477	10417	3871	3175	3737
Denominator	15431	15617	15179	14065	14745
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80	85	90	90	90

Notes - 2007

2007 newborn hearing data was obtained from the AURIS database and compared with the 2007 birth file. Not all birthing facilities have the resources to input directly into the information system. 2007 birth file data is provisional.

The program obtains data directly from the hospitals and indicates that 14,995 tests were taken of children born in 2007.

Notes - 2006

2006 newborn hearing data has not been linked with the 2006 birth file yet.

Notes - 2005

2005 newborn hearing data was obtained from the AURIS database and compared with the 2005 birth file. Not all birthing facilities are able to input directly into the information system.

a. Last Year's Accomplishments

Data for 2007 does not accurately reflect practice of screening because of the data collection process. The number of screenings reflect the primary screening and a follow-up of an abnormal

result.

The SHCN Bureau serves children birth to 21 years of age and offers a variety of population-based and enabling services. These services are provided through the Newborn Metabolic Screening, Newborn Hearing Screening and the Sickle Cell Disease Programs.

The Bureau provides care coordination services to children with diagnosed disorders and/or special health care needs. Health education and outreach is provided to community partners to increase awareness of diseases and disorders that lead to chronic disabling conditions.

Developed performance metrics for 2009. A summary follows:

Objective 1: Ensure at minimum 95% of newborns are screened for hearing loss.

Percent of newborns screened for hearing loss reported in the Welligent/AURIS database system
20.4% FY 07 25.3% FY 08 50.0% FY 09 75.0%

Objective 2: Maintain the percent of newborns identified by the program with a failed hearing screening who receive timely and appropriate follow-up at 100%.

Percent of newborns identified with a failed hearing screening that are known to the program and referred to diagnostic centers for follow-up.

FY 07 100.0% FY 08 100.0% FY 09 100.0%

Percent of newborns confirmed with hearing loss that are in specialty care.

FY 07 100.0% FY 08 100.0% FY 09 100.0%

Percent of parents of newborns with hearing loss identified by the program receiving education from audiologist.

FY 07 N/A FY 08 TBD FY 09 TBD

Objective 3: Increase the percent of newborns with hearing loss identified by the program that have age appropriate communication and language skills.

Percent of newborns confirmed with a hearing loss by the newborn hearing screening who receive speech, language and audiological services per year.

FY 07 TBD FY 08 TBD FY 09 TBD FY 10 100%

Percent of parents of children with hearing loss identified through newborn hearing screening who are aware of developmental milestones for speech and language.

FY 07 NA FY 08 TBD FY 09 TBD FY 10 90.0%

Percent of 0-3 year olds identified with a hearing loss through newborn hearing screening referred to ITDD.

FY 07 100.0% FY 08 100.0% FY 09 100.0% FY 10 100.0%

Percent of children with hearing loss requesting hearing aids who receive them.

FY 07 100.0% FY 08 100.0% FY 09 100.0% FY 10 100.0%

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Mandatory hearing screening	X		X	
2. Hospital newborn discharge program and family support workers	X			
3. Vital Records revision to capture data			X	X
4.				
5.				

6.				
7.				
8.				
9.				
10.				

b. Current Activities

The SHCN Bureau activities included:

The Newborn Screening Coordinator trains hospital staff in the use the hearing screening equipment. The equipment downloads the results into the Welligent/AURIS system. Thereby improving data collection and reporting.

Continued working with Vital Records to ensure collection of data in birth records. Title V funds will be used to update the Vital Records data collection requirements.

Practitioners actually report much higher rates for newborns screened for hearing. DOH continues to work to improve data collection. DOH is working to find other mechanisms to obtain data by buying equipment for low reporting hospitals and changing reporting mechanisms.

c. Plan for the Coming Year

Identification of newborn hearing loss:

1) data collection by providing equipment to Hospitals to submit Newborn Hearing Screening test results.

In FY 09, the Bureau will provide two additional hospitals, Greater Southeast Community Hospital and Georgetown University Hospital, with equipment that will automatically download newborn hearing test results into the Welligent/AURIS system. The Newborn Screening Coordinator will also train staff to use the new equipment.

2) Increase verification of screenings by partnering with Vital Records. In FY09, the Bureau in collaboration with the Vital Records Division will establish a process of review of birth certificate data from the hospitals to ensure that newborn hearing screen has been performed and reported to DOH.

Ensure adequate final diagnosis of hearing loss in newborns.

1): Increase knowledge of parents by providing educational materials. In FY09, the Bureau will distribute new brochures to hospitals containing information about what it means when their child does not pass their initial hearing screening.

2): Increase integration with the medical home by identifying the Pediatrician/Primary Care Provider post discharge. In the current year, the Bureau will partner with the DC hospitals to identify and verify the newborn's primary care provider prior to discharge.

Ensure appropriate developmental progress for children with hearing loss.

1): Increase knowledge of parents and childcare providers by providing education on developmental milestones.

In FY09, an Audiologist will educate and conduct training sessions for parents and early child care providers regarding age-appropriate milestones for speech and language development.

2): Increase coordination of care by partnering with the Infants and Toddlers with Disability Division (ITDD).

The Bureau, in collaboration with ITDD and the Special Education units at DCPS and OSSE, will

monitor and co-manage children 0 to 3 years of age referred with hearing loss. The collaboration will commence during FY09.

3) Continue to working with Vital Records to ensure collection of data in birth records. Title V funds will be used to update the Vital Records data collection requirements.

Data collection issues with the AURIS database will be eliminated with introduction of the new DC birth certificate.

Performance Measure 13: Percent of children without health insurance.

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	7	6	6	6	6
Annual Indicator	9	10	6.9	7.8	7.8
Numerator			7697	9221	9221
Denominator			111967	118104	118104
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	6	6	6	6	6

Notes - 2007

Data for 2007 is not available, when it becomes available, this measure will be updated.

Notes - 2006

<http://www.statehealthfacts.org/profileind.jsp?ind=203&cat=4&rgn=10>.

Notes - 2005

Source: US Census Bureau, Current Population Survey 2005. Defined as coverage at point in time. CIs not available. www.census.gov/cgi-bin/broker

a. Last Year's Accomplishments

The Healthy Start and MOM unit Programs actively assist pregnant and parenting women in enrolling in health insurance programs to ensure health coverage of newborns. In addition to the Medicaid and SCHIP programs, the DC Healthcare Alliance also provide coverage to eligible children.

The Alliance conducts active enrollment activities of the District's uninsured through community forums in various ethnic communities, such as the Latino, Asian Pacific Islander and other communities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Medicaid and SCHIP enrollment through MOM unit	X		X	
2. Early identification of pregnant women by Medicaid and Alliance			X	
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

- 1) Healthy Start and MOM unit programs
- 2) Family support worker program that conducts outreach to pregnant and parenting women and assists with enrollment to entitlement programs.

c. Plan for the Coming Year

Continue Healthy Start, MOM unit and other outreach programs to enroll eligible pregnant and parenting women in insurance and other entitlement programs.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				13	13
Annual Indicator			12.8	14.6	14.6
Numerator				812	812
Denominator				5563	5563
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	12	12	12	12	12

Notes - 2007

The data indicated here is for 2005. Because this represents the first year that The Districts' WIC program has collected this data. When 2006 data becomes available, this measure will be updated

Notes - 2006

The data indicated here is for 2005. Because this represents the first year that The Districts' WIC program has collected this data. When 2006 data becomes available, this measure will be updated.

Notes - 2005

2004 - 2005 data are not yet available. 12.8% applies to 2002 WIC Program data, cited in DC Healthy People 2010 reports.

a. Last Year's Accomplishments

The DOH Medical Assistance Administration 2007 Weight and Obesity Initiatives Report stated that "In 2004 the Office of Managed Care reviewed more recent research outcomes and implemented recommendations from the EQRO study findings on childhood obesity and found that childhood overweight and obesity levels had nearly tripled since 1970. The prevalence of the most severe cases (a body mass index (BMI) for age over the 95th percentile) had virtually doubled over the past 20 years, while the prevalence of standard cases (BMI for age over the 85th percentile had increased about 50 percent).

During the past year three national organizations conducted a month long study to identify environmental factors that contribute to obesity. Robert Wood Johnson Foundation (RWJF) funded a month-long study with the assistance of the National Urban League for the Center for Applied Behavioral and Evaluation Research (CABER) and Academy for Educational Development (AED). The study focused on 45 distinct Ward 8 neighborhoods in the District of Columbia and African-American children who are at risk for obesity surveying dozens of food and deli markets, stores, gas stations and carryout restaurants using the census method. Surveyors witnessed children buying candies, chips and sodas and stated that this was their dinner.

There has been a dramatic shift in the Mayor and City Council's support of cooperative efforts involving parents, schools, businesses, and relevant government agencies to empower the District's children with appropriate information, access and choice to good nutrition. The roles of RWJF and CABER will be to use the data collected by AED to assist stakeholders, the National Urban League (NUL), AED, RWJF, and District of Columbia residents in developing a community action plan that can be used to advocate for the modification or repeal of trends, policies and practices that negatively impact childhood obesity.

The partnering of the Women, Infant and Children (WIC) Program and the Income Maintenance Administration (responsible for the food stamp program), yielded the District's Food Stamp Nutrition Education Program (FSNEP) which offers nutrition education to persons potentially eligible for Food Stamps. A multiparty approach recently united the Office of the State Superintendent of Education (OSSE) with the Cooperative Extension Service, WIC, Commodity Supplemental Foods Program, the Capital Area Food Bank, and other stakeholders to develop and implement a TEAM Nutrition grant. The CHA partnered with the DC Public Schools to further nutritional information and education and increase the level of physical activity among DC school children, through programs such as Food Stamp Nutrition Education Program, which offers four, six week sessions to school children, among others; school-based fitness and community health fair promotions.

Comprehensive state nutrition planning is underway in conjunction with the District's Healthy People 2010 Plan and Annual Implementation Plan (AIP). Planning coalitions were formed with community-based organizations and advocates who developed nutrition based priority targets. The plan focused on WIC initiatives, which include strategies for increasing the rates and duration of breastfeeding among women enrolled in WIC and the inclusion of obesity awareness in its core curriculum. The AIP also addressed the need for development and institution of standard baseline indicators for conducting nutrition and physical activity related assessments.

The DC Chapter of the American Academy of Pediatrics (AAP) hosted the DC City-Wide Childhood Obesity Summit on September, 19, 2007 funded by DOH through Title V funds. The Summit was co-sponsored by the DC Partnership to Improve Healthcare Quality (DC-PICHQ), the DOH CHA, Diana L. and Stephen A. Goldberg Center for Community Pediatric Health at the CNMC.

- In FY07 WIC implemented the revised nutrition risk code policy. The major impetus for the consolidation and revision of the dietary risk criteria was the 2002 report by the Institute of Medicine (IOM), "Dietary Risk Assessment in the WIC Program". The 2005 Special Projects Grant (SPG), "Impact of Motivational Interviewing Counseling Techniques on Health and Nutrition Behaviors among Urban Multi-Ethnic Populations" is a Train the Trainers program that will continue through FY08.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Nutrition and Physical Fitness Bureau Team Nutrition grant			X	
2. Partnerships with DCPS and OSSE to increase physical activities in schools	X		X	
3. Improved nutritional value of school meal programs			X	
4. Preventive Service Block Grant to expand the "I'm Moving I'm Learning" program to Child Development Centers		X	X	
5. Local funds to support grants for childhood obesity		X	X	
6. Develop state obesity plan.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Continue the DC Obesity Inter-Agency Work Group -- was initiated to gather information about obesity prevention activities of DC government. Membership includes: CHA and several of its Bureaus, MAA, DC Office of Planning, DC Department of Parks & Recreation, Executive Office of the Mayor (EOM) staff liaisons, Executive Office of the Mayor's DC Youth Advisory Council, DC Public Schools, Office of the State Superintendent of Education, DC Children & Youth Investment Trust Corporation (quasi public) and DC Child and Family Services Administration.

First year accomplishments include: 1) Creation of an informal work group on work site wellness and 2) Review and validation of the District's Child Obesity Plan

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - In FY 2007 the WIC Program organized an Infant Formula Committee to better determine the needs for types of infant formula within the District of Columbia. As a result of this committee, DC WIC generated a new formulary of infant formulas available to WIC participants, based on the needs of the community.

DC Action for Healthy Kids - is a volunteer-based group of local stakeholders committed to creating a healthier school environment for youth and children in D.C. by engaging schools in actions that foster sound nutrition.

Preventive Service Block Grant support expansion of "I'm Moving I'm Learning" Program to the Child Development Centers.

c. Plan for the Coming Year

Improve Nutrition and Physical Activity through several initiatives that include:

- (1) a training program for early childcare staff and parents in Wards 1,7, and 8, known as the I

am Moving I am Learning curriculum, a nationally recognized and tested system of physical activity and nutrition services improvement;

(2) the Healthy Corner Store Initiative, researching ways and developing social marketing materials to increase access to healthy foods in Ward 8 corner stores;

(3) Sister Circles, piloted in Wards 5,6,7, and 8 as a vehicle for supporting African American women 40-70 years of age to reduce stress, improve eating habits, and exercise more. Additional initiatives will be funded and implemented in FY09, and succeeding years.

Improve Nutrition and Physical Activity by encouraging implementation of Worksite Wellness policies and programs for both public and private sector employees.

A model Worksite Wellness policy and program will be developed at the Department of Health (DOH) in FY2008, utilizing best practices from across the nation, to serve as a pilot for ongoing adaptation in both government and private worksites throughout the District of Columbia. Policies and programs will aim to facilitate, support, and document employee improvement in nutrition, physical activity, and stress reduction

Assure adequate access to care for individuals with obesity or at-risk for obesity.

1): Improve quality of primary care services for identification, treatment and prevention of obesity by implementing a quality improvement initiative.
DOH will partner with Medicaid in the development and conduction of Obesity Primary Care Quality Improvement Training Program during FY 09.

2): Ensure adequate payment mechanisms for care related to obesity by implementing regulatory changes.

The payment for obesity related services is hindered by several major barriers. Obesity as a diagnostic code needs to be established as a billable diagnosis by Medicaid. Treatment programs need to be multidisciplinary to be more effective. However, current Medicaid rules do not permit billing by multiple subspecialists on the same day. Additionally, Medicaid does not recognize or adequately reimburse for nutrition, physical activity and psychological services. CHA is working with Medicaid to rectify these issues by FY 2009.

Increase collaboration by expanding the Obesity Work Group -. The Work Group will continue to meet in FY09 and beyond, creating specific committees and other mechanisms to accomplish short and long term goals.

DOH will develop a State Plan on Obesity Prevention and Reduction, in collaboration with the citywide Obesity Work Group.

Establish a comprehensive program to measure and track BMI in multiple settings with linkages to the HealthCheck database.

Preventive Service Block Grant support expansion of "I'm Moving I'm Learning" Program to the Child Development Centers.

The District budgeted \$600,000 in FY09 local funds for obesity grants in kids.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective					

Annual Indicator					
Numerator					
Denominator					
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?					
	2008	2009	2010	2011	2012
Annual Performance Objective					

Notes - 2007

We do not collect smoking data per trimester of pregnancy.

Notes - 2006

This information is not captured on the Vital Statistics Birth record. We are unable to provide information.

Notes - 2005

The District has yet to implement the 2003 revisions of the U.S. Standard Birth Certificate. See state performance measure #4. Also see performance measure discussion in narrative.

a. Last Year's Accomplishments

DOH does not collect data on the percentage of women who smoke in the last three months of pregnancy. The Healthy Start Program with family support workers and the MOM unit counsel pregnant and parenting women on the health effects of smoking on the fetus, newborns and personal health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start Program and Family Support Workers counsel pregnant women to stop or not to smoke	X			
2. Vital Records forms updated to capture data			X	
3. PRAMS-Like survey to capture the data			X	X
4. ICSIC's goals is to stay in school and identify children at risk for behavioral health issues.			X	X
5.				
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b. Current Activities

Continued to provide counseling pregnant and parenting women on health effects of cigarette smoking by Healthy Start case managers and new family support workers.

Continue to work with community agencies, American Lung Association of DC and APRA in support of smoking cessation.

Vital Records forms are updated to capture data.

c. Plan for the Coming Year

Continue counseling pregnant and parenting women on health effects of cigarette smoking.

Continue to work with community agencies, DC Lung Association and APRA in support of smoking cessation.

Vital Records forms revised to accurately capture data.

The new birth certificate will be available in January 2009 and will collect smoking as well as alcohol consumption in the last trimester of pregnancy.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	8	7	6	6	5
Annual Indicator	15.4	3.9	2.6	0.0	0.0
Numerator	4	1	1	0	0
Denominator	25929	25929	38600	39628	39628
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.			Yes	Yes	
Is the Data Provisional or Final?				Final	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	5	5	5	5	5

Notes - 2007

2007 data are not available and the measure will be updated when the data becomes available.

Notes - 2006

Source: 2006 District of Columbia death file

There were 0 suicide deaths in 2006 for the 15-19 year olds.

Notes - 2005

Numerator: District of Columbia 2005 death file. Denominator: Source Table 2. Estimates of the Population by Sex and Age for the District of Columbia: April 1, 2000 to July 1, 2005. (SC-EST2005-02-11) Population Division, US Census Bureau

a. Last Year's Accomplishments

CASH Bureau staff supported the Department of Mental Health in the development and implementation of their teen suicide prevention project -- Teen Screen -- through active participation on the project's advisory board.

The Woodson Adolescent Wellness Center promotes the health maintenance among the Woodson adolescent population, motivate students to adopt healthy lifestyles and avoid risky behaviors; to provide convenient health services, and to educate students on utilization of the District of Columbia's health care delivery system. Center services include a comprehensive array of physical and mental health services as well as health education and support services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ICSIC goals to include stay in school strategies		X	X	
2. Full service middle school pilot project	X	X		
3. Carrera Program that increases self efficacy and reduce mental health issues		X	X	
4. ICSIC's goals is to stay in school and identify children at risk for behavioral health issues.			X	X
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b. Current Activities

CASH Bureau staff participated in Teen Screen through the project's advisory board.

Provided three sessions to Senior High School students on suicide prevention

Provided 30 child safety sessions on Good Touch/Bad Touch.

One of the ICSIC's goals is to stay in school and identify children at risk for behavioral health issues.

Full service middle school pilot program to include preventive and mental health services. Staff includes a school nurse, psychologist, and detention specialist.

Carrera Program focuses in increased self efficacy and decrease mental health issues.

c. Plan for the Coming Year

CASH Bureau staff will continue to support Teen Screen, which will collaborate with the School Nurse Program to establish screening protocols.

One of the ICSIC goals is to stay in school and identify children at risk for behavioral health issues.

Full service middle school pilot program to include preventive and mental health services. Staff includes a school nurse, psychologist, and detention specialist.

Carrera Program focuses in increased self efficacy and decrease mental health issues.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	78	79	80	80	80
Annual Indicator	79.2	76.8	79.0	81.6	74.7
Numerator	137	169	169	177	177
Denominator	173	220	214	217	237
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	80	80	80	80	85

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 birth file becomes available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

Development of the Infant Mortality Plan, an expansion of strategies and initiatives of the Child Health Action Plan.

Other efforts included the Healthy Start Program; MOM van and Family Support Workers Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MOM unit visits to Ward 5, 6, 7, 8	X			
2. Hospital newborn discharge program	X			
3. Healthy Start program and family support workers	X		X	
4. Infant Mortality Plan strategies and initiatives		X	X	
5.				
6.				
7.				
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9.				

10.				
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b. Current Activities

The activities related to the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates include:

Development of the Infant Mortality Plan, an expansion of strategies and initiatives of the Child Health Action Plan.

Other efforts included the Healthy Start Program; MOM van and Family Support Workers Program.

c. Plan for the Coming Year

The plans this coming year related to the percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates include:

- 1) MOM unit will continue to conduct outreach activities to pregnant women and link women at risk to facilities for high risk deliveries and neonates.
- 2) Call center will continue to provide pregnant women information related to high risk facilities when requested. DOH plans to fund adaptation of the call center software to capture specific maternal and child health data.
- 3) Continued implementation of the Infant Mortality Plan.
- 4) One of the ICSIC's goals is to stay in school and identify children at risk for behavioral health issues.
- 5) Full service middle school pilot program to include preventive and mental health services. Staff includes a school nurse, psychologist, and detention specialist.
- 6) Carrera Program focuses in increased self efficacy and decrease mental health issues.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	87.9	91.5	75	77	78
Annual Indicator	75.3	77.4	77.0	75.0	75.0
Numerator	5206	5453	5409	5503	5503
Denominator	6918	7048	7025	7339	7339
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	78	80	80	80	80

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 data is available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

The District's most recent epidemiological report for infant mortality revealed slight changes in infant deaths from 1996 to 2005. In response to this steady trend, the Department of Health (DOH) has developed a citywide action plan to respond to the maternal and child health needs in the District and reduce infant mortality rates throughout the city. A service gap analysis conducted by the DOH identified potential holes in the safety net of services for residents of the District. DOH will focus on three strategies for improvement over the course of the next year, some of which are already in operation:

- I. Increase capacity and impact of DOH home visitation program for pregnant women
The federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs administered by DOH and by Mary's Center for Maternal and Child Care, Inc. promote a healthier physical and social environment in the home and link families to needed care. In 2008, additional funds will be used to expand the capacity of the Healthy Start program, including an investment to recruit and train family support workers who will team up with nurse case managers to address major risk factors affecting the health of pregnant and parenting women and their children.

- II. Enhance collaboration between DOH Community Health Administration's initiatives and other sectors of government serving at-risk women and families. The Community Health Administration will partner with sister administrations within DOH and other government agencies to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Specifically, Healthy Start's nurse case managers and family support workers will link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services.

- III. Increase coordination between government and the community to ensure a comprehensive, citywide approach to reducing infant mortality. The District will strengthen its partnership with healthcare providers, community-based organizations, and patient advocacy groups to identify opportunities for collaboration and mutual support in the effort to prevent mortality, lifelong disabling conditions, and other threats to infant health.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. MOM unit prenatal services to underserved mothers in Wards 5, 6, 7, 8	X			
2. Family Support Workers	X			
3. School Nurse support for pregnant teens	X			
4. Infant Mortality Plan strategies and initiatives		X	X	

5.				
6.				
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10.				

b. Current Activities

Increase oversight and effectiveness of the Healthy Start program's nurse case management component

Recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

Design and implement a public information campaign educating women,

Facilitate the distribution of 15,000 to 18,000 free cribs over the next seven years to low-income mothers to prevent Sudden Infant Death Syndrome (SIDS)

Increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.

c. Plan for the Coming Year

The Infant Mortality Plan details the plans for the coming year including but not limited to:

Increase oversight and effectiveness of the Healthy Start program's nurse case management component through the establishment of the Bureau of Perinatal Infant Health.

Recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psycho-social risk factors affecting pregnant and parenting women and their children.

Design and implement a public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.

Facilitate the distribution of 15,000 to 18,000 free cribs over the next seven years to low-income mothers to prevent Sudden Infant Death Syndrome (SIDS), thanks to an \$11 million grant from the Bill & Melinda Gates Foundation to First Candle.

Increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.

Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.

Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.

Enhance linkage to substance abuse education and treatment services.

Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency.

Facilitate outreach and linkages to care for homeless pregnant women.

Improve screening practices for all women and youth at risk for mental illness.

Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.

Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities and individual health care interventions that will reduce infant mortality

D. State Performance Measures

State Performance Measure 2: *Percent of Medicaid enrollees receiving EPSDT screening*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	75	80	75	75	78
Annual Indicator	71.0	71.3	76.8	77.4	73.6
Numerator	46382	49951	54062	53636	52259
Denominator	65357	70102	70427	69320	71013
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	78	80	80	80	80

Notes - 2007

Data obtained from national Medicaid Report Form 416: Annual EPSDT Participation Report.

Numberator is row 8: Total eligible who should receive at least one initial or periodic screen.

The denominaor is row 9: Total eligible receiving at least one initial or periodic screen.

DC and MAA are collaborating on the EPSDT well child registry and this should help achieve the annual performance objectivel.

Notes - 2006

Form 416 FY06 Annual EPSDT Participation Report provided by the Medical Assistance Administration

Notes - 2005

Form 416 FY05 Annual EPSDT Participation Report provided by the Medical Assistance Administration

a. Last Year's Accomplishments

State Performance Measure 2: Percent of Medicaid enrollees receiving EPSDT screening.

Woodson High School continue to provide comprehensive age appropriate health care and health education to students in a school setting; increase clinic staff to provide adequate health care; evaluate the nutrition program and present findings at local or national conferences; replicate Nutrition and Pregnancy Prevention Programs; repeat lunchtime sessions; and implement a data collection and evaluation system. Along with routine health care and health education provided, the Woodson Wellness Center collaborated with the DC Department of Mental Health to provide screenings for the students at Woodson High School.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide health education in school settings to students		X		
2. Provide school nurse program	X	X	X	
3. Family support worker program	X	X		
4.				
5.				
6.				
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9.				
10.				

b. Current Activities

CHA staff attended a presentation of an overview of the District's Medicaid and Alliance health benefits programs: 1) defined each of the programs and specific benefits that apply; and 2) data source of EPSDT.

The Perinatal and Infant Health Bureaus continued to work with sister Bureaus to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO)

The CASH Bureau continues to provide comprehensive age appropriate health care and health education to students in a school setting; continue oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles.

A partnership with the DCPS Early Childhood Special Education established a community hearing and vision assessment center at Shaw Junior High School. The site provides: The site provides the following services: 1) Hearing evaluations; 2) Oto-acoustic Emission screening; 3) Follow-up newborn hearing screening; 4) Vision screening; 5) Statewide 0-3 years of age child find services; 6) Newborn Hearing Screening (EHDI); 7) Early Intervention consultation/collaboration; 8) Head Start consultation; and, 9) Medical Home consultation. In support SHCN Bureau purchased the equipment and furniture

Nutrition and physical fitness expanded through the collaborative efforts of multiple agencies.

c. Plan for the Coming Year

The CASH Bureau will continue to provide comprehensive age appropriate health care and health education to students in a school setting; continue oversight of the school nurse program including identification of additional health education programs that will promote healthy life styles. Plans also include evaluation of the nutrition program and implement a data collection and evaluation system.

The Perinatal and Infant Health Bureaus will continue to work with sister Bureaus to increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, including the first two visits at 48 hours and 1 month post-discharge with the participating managed care organizations (MCO) and implementation of the Family Support Worker program.

Data collection from Shaw Junior High School Hearing and Vision Center will be utilized to support the District's success in meeting national and state performance requirements related to EPDST reporting requirements and special health care needs.

Rewrite regulations to the Universal Health Certificate requiring annual physicals prior to attending school.

State Performance Measure 3: Prevalence of lead levels > 10 ug/dL among children through age 6

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.4	2.2	1.9	1.9	1.9
Annual Indicator	1.8	1.3	1.3	1.8	1.3
Numerator	400	329	200	294	178
Denominator	22138	26311	15121	15958	13851
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	1.9	1.9	1.9	1.9	1.9

Notes - 2007

Data is obtained from the Lead Trax information system.

Notes - 2006

Source: Information taken from the program's LeadTrax system.

Notes - 2005

Source: Program date. According to information from the program epidemiologist (July 6, 2006), the denominator is number of children screened (unduplicated) , not number of screens as in prior years.

a. Last Year's Accomplishments

According to CDC the District children's prevalence of blood lead level 5 µg/dL is 9.7% for the Calendar Year 2006. The District's data integrity has been a challenge; as a result DOH contracted with Office of Computers and Technology (OCTO) to review and validate the data. In addition, the data collection was transferred from the Medical Assistance Administration (MAA) -- LEAD Trax application, a traditional CDC database. According to the Lead Trax Information System the 2007 rate of blood levels that exceed 10ug/dL is 1.3, down from 1.8 in FY 2006.

It is estimated that as many as 10,000 District children could have exposure to high lead levels.

The estimate is based on the housing stock, higher than average poverty and low education rates and screening the wrong cohort of children. The Department is working with the Medicaid MCOs to identify children who have not received the two required blood tests between the ages of 26 -- 72 months. Children testing with positive with elevated blood levels (EBL) of Lead are considered children with special health care needs. Approximately 1,000 of the 9,000 children served by the MCO managing children with special needs have not been tested for elevated Lead levels. Efforts are in process to have levels tested in the provider's offices.

CLPSEP staff conducted prevention educational activities, including screening of children under the age of six years, pregnant and lactating women. CLPSEP staff worked with the Medicaid EPSDT program to ensure that recipients are screened on schedule. Monthly matches of the Medicaid MCO screening activities with Lead Trax data are conducted, followed by reporting to MAA on compliance. Work on Lead Trax is continuing. The database does not yet have the capability for individual physicians to access information as to the screening status of a patient.

Staff also continues to contact and make presentation to community organizations on the dangers of lead exposure and resources for control and remediation. GIS resources are used to identify communities of greatest risk.

CLPSEP successfully submitted and was awarded two grants: (1) the CDC continuation Grant for \$781,620; and (2) the CDC Congressional Earmark Grant for \$198,400. Efforts are focused on involving prenatal care providers, churches, schools, day care centers, and community organizations in neighborhoods with older housing stock to ensure that personnel are knowledgeable about risks, hazard reduction and resources for remediation.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with MCOs to promote 2 Blood Lead Level screening for children 6 years and younger			X	
2. Utilization of Lead Trax for data collection and reporting. Link to data integration project.			X	
3. Community education programs			X	
4. Case management of children with blood lead levels >5ug/dL	X			
5. Coordinate with SHCN Bureau for children with blood level levels > 10 ug/dL		X	X	
6. Home assessment of children with positive blood lead levels			X	
7.				
8.				
9.				
10.				

b. Current Activities

There have been significant changes within the Lead Program, initiating in September 2007 with the hiring of a new Bureau Chief, Pierre Erville. This Program is responsible for conducting primary lead prevention, training, lead safe practice, renovation -- workers and occupants and clean up. DOH focuses on screening, education, outreach, and case management of elevated blood levels. Residents with test results of 10 mg or greater +EBL triggers case management. The case management activities include a home visit, risk assessment, education, and completion of a questionnaire as well as a property reviewed. The case management work load is 1 case manager to 30 cases. Data is collected and analysis performed by a newly hired epidemiologist.

The Lead Program offers Lead trainings in coordination with Community Action Group. Forty people attended the December 2007 program. Additional training was conducted in March 2008 and a Latino focused program is scheduled for December.

The Lead Program outreach activities include outreach to the Ethiopian Community and through a subgrant to the National Nursing Center Consortium. The "Lead Safe DC" conducts primary prevention in District homes with a focus on low income, pregnant women with border line blood levels (5-9 mg/EBL). In addition to lead education, case managers visualize the premises for sources of lead, including toys, peeling paint and dust collection. They also measure for elevated lead levels.

c. Plan for the Coming Year

The Lead Program continues its objective to identify at risk of exposure to lead through mandatory universal blood level screening of children under the age of six by each health care provider or facility and reporting of all blood results to the District. It focuses on surveillance, screening and case management program as well as working in collaboration with the Medical Assistance Administration, Department of Consumer and Regulatory Affairs, SHCN Bureau and Perinatal and Infant Health Bureau to expand screening and case management services as well as mitigate sources of lead in the home. In The Lead Program offers Lead trainings in coordination with Community Action Group. Forty people attended the December 2007 program. Additional training that is Latino focused program is scheduled for December 2008.

To minimize the prevalence rate of children with a blood lead level equal to or greater than 5 µg/dL, to less than a 5% prevalence rate. To expand the capacity to provide risk reduction services in the homes of high-risk populations, including pre-1978 homes with: Pregnant women; Low-income families; Foster care children and Children with blood lead levels under 10 µg/dL.

Continue working in concert with each of the Bureaus to identify women and children at risk for lead exposure and the Medicaid managed care companies to increase blood level screening and reporting in children less than six years of age.

Continue lead education and case managers visualize the premises for sources of lead, including toys, peeling paint and dust collection. They will measure for elevated lead levels. If the home tests positive, high -- specialized vacuum equipment is ordered to remove dust. Residents are requested to sign a form stating the agency's attempt to remove dust. The form explains that the vacuum reduces the exposure but does not clear it.

The Lead Department is working with the DC Department of Housing and City Council to put legislation in place to make major changes to the District's lead laws, such as authority for proactive Lead inspections.

The Lead Program is moving to the District Department of Environment (DDOE) in October 2008. The Lead Program will continue to work with the DOH to decrease blood levels to less than 5 µg/dL and ensure the validity of the data collection. It will expand the capacity to provide risk reduction services in the homes of high risk populations, including pre-1973 homes with: pregnant women, low income families, foster care children and children with blood levels under 10 µg/dL.

State Performance Measure 4: *Prevalence of tobacco use among pregnant women*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	2.3	1.9	1.7	1.7	1.7
Annual Indicator	3.7	3.4	4.3	3.7	3.7
Numerator	284	270	340	315	315
Denominator	7615	7918	7940	8522	8522
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	1.7	1.7	1.7	1.7	1.7

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final data for 2006 is available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

2008/ State Performance Measure 4: Prevalence of tobacco use among pregnant women.

As part of the case management protocols, Teen Mothers Take Charge care managers counseled clients about the effect of smoking during pregnancy and referred clients to smoking cessation programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start Program counsels pregnant women and new mothers on no use tobacco and smoking cessation	X		X	
2. School health program focus on tobacco cessation	X		X	
3. Disseminate print materials at health fairs and other events			X	
4. Continued to collaborate with American Lung Association of DC			X	
5. Update of Vital Records forms to enhance data collection			X	X
6. PRAMS Like Survey			X	X
7.				
8.				
9.				
10.				

b. Current Activities

The DC Healthy Start Project Health Education staff continues its partnership with the American Lung Association of DC to support no use and stop smoking programs for pregnant women and mothers. The DC Lung Association provides workbooks, tobacco replacement therapy (patches, lozenges), exercise tapes and CDs, and stress kits (squeeze ball, rubber bands, sugar free gum etc.) free of cost to participants of the group. Status of smoking cessation classes.

Family Support Workers and MOM unit also provides counseling to pregnant women on the effects of smoking on the health of the fetus, newborn and mother's health.

Unified call center provides smoking cessation information to callers requesting assistance. There is no data on the number of calls the unified call center receives from pregnant women.

c. Plan for the Coming Year

The Cancer and Chronic Disease Bureau will continue to incorporate counseling about the harmful effects of tobacco use. Also, the Tobacco Program will continue collaboration with The American Lung Association of DC and expand smoking cessation services in Wards 5-8.

The DC Healthy Start Project Health Education staff will continue its partnership with the DC American Lung Association. Health Educators will be trained and certified as Tobacco Cessation Specialists on the Tobacco Free Families Curriculum. The DC Lung Association will provide workbooks, tobacco replacement therapy (patches, lozenges), exercise tapes and CDs, and stress kits (squeeze ball, rubber bands, sugar free gum, etc.) free of cost to participants of the group. Trained staff will host several series of smoking cessation clinics throughout the project area, including APRA clinics, Community Action Group Drug Treatment Center, and the United Planning Organization's Family Strengthening Program.

The family support workers and MOM unit will continue to counsel pregnant women.

Unified call center will continue to refer callers seeking smoking session information.

Another tobacco initiative includes: Reduce smoking among adults and youth in the District by 1) reduce exposure at schools by promoting Smoke Free DCPS campuses and 2) reduce exposure at hospitals promoting Smoke Free Hospital campuses.

State Performance Measure 6: *Percent of resident women who give birth with no prenatal care or entry into prenatal care in 3rd trimester*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	6.2	5.8	5.4	5.3	5
Annual Indicator	7.3	6.4	5.6	6.4	6.4
Numerator	508	453	392	471	471
Denominator	6918	7048	7025	7339	7339
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	5	5	5	5	5

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 birth file becomes available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

2008/ State Performance Measure 6: Percent of resident women who give birth with no prenatal care or entry into prenatal care in 3rd trimester.

The DC Healthy Start Program goal is to decrease the number of women who enter into the third

trimester without prenatal care. Maternity Outreach Mobile (MOM) unit offers prenatal services to women in Wards, 5, 6, 7 and 8.

In 2008, additional funds allowed the capacity of the Healthy Start program, including an investment to recruit and train family support workers who will team up with nurse case managers to address major risk factors affecting the health of pregnant and postpartum women and their children.

Established a collaboration with the Department of Corrections to identify and support pregnant women in the criminal justice system.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start case managers and family support worker program	X			
2. Data Integration Project to link Kids Indirect application				X
3. MOM unit to provide prenatal services and linkages to care	X			
4. Provide transportation to services for uninsured pregnant women	X			
5. Coordinate outreach with MAA's managed care contracts				X
6. Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities				X
7. Collaboration with the DC Department of Corrections		X	X	
8. HAA and APRA for bidirectional referrals		X	X	
9. Child and Family Services Administration collaboration			X	
10. DHS Partnership with DC Village for Families in Transitional Housing		X	X	

b. Current Activities

Perinatal and Infant Health Care Bureau provides oversight of the Healthy Start Program as well as the Infant Mortality Action Plan. Under the leadership of Karen P. Watts, RNC, FACHE, FAHM, PMP, the Bureau has implemented a new course to abate infant mortality in the District. In December 2007 the District published the "Addressing Infant Mortality in DC: Citywide Action Plan". Due to the continuing and minimum changes in infant mortality from 1996 to 2005, the Department of Health (DOH) developed a citywide action plan to respond to the maternal and child health needs in the District and reduce infant mortality rates throughout the city. Based on a service gap analysis, DOH identified potential holes in the safety net of services for residents of the District and established three strategies for improvement in perinatal and infant care over the course of the next year.

Current activities include:

- 1) Healthy Start case managers and family support worker program
- 2) Data Integration Project to link Kids Indirect application
- 3) MOM unit to provide prenatal services and linkages to care
- 4) Provide transportation to services for uninsured pregnant women
- 5) Coordinate outreach with MAA's managed care contracts
- 6) Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.

c. Plan for the Coming Year

The Community Health Administration will partner with sister administrations within DOH and other government agencies to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Specifically, Healthy Start's nurse case managers and family support workers will link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services.

The strategy will increase the capacity and impact of the DOH home visitation program for pregnancy and postpartum pregnant women and their children. The Federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs promote a healthier physical and social environment in the home and link families to needed care.

The Healthy Start case managers and family support worker program is to increase the capacity and impact of the DOH home visitation program for pregnancy and postpartumpregnant women and their children. The federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs administered by DOH and by Mary's Center for Maternal and Child Care, Inc. promote a healthier physical and social environment in the home and link families to needed care.

- 2) Data Integration Project to link Kids Indirect application
- 3) MOM unit to provide prenatal services and linkages to prenatal care and access to services and entitlements.
- 4) Provide transportation to services for uninsured pregnant women
- 5) Continue to coordinate outreach with MAA's managed care contracts
- 6) Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.
- 7) An \$11 million grant from Bill and Melinda Gates Foundation supports the First Candle program. The District's Safe Crib program is one of three programs selected to receive bassinets from this grant. It is expected that the District will receive and distributed 15,000-18,000 cribs over the next seven years to prevent Sudden Infant Death Syndrome (SIDS).

State Performance Measure 7: *Incidence of repeat births for teens less than 19 years of age*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective	19.9	19.6	19.3	19	18.5
Annual Indicator	16.1	16.8	14.0	12.1	12.1
Numerator	87	95	81	84	84
Denominator	539	566	580	693	693
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	18.5	18.5	18.5	18.5	18

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 birth file becomes available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

2008/ State Performance Measure 7: Incidence of repeat births for teens less than 19 years of age.

The primary focus of the Health and Sexuality Education program is to provide comprehensive health and sexuality education to District youths, as well as providing training and technical assistance to community-based organizations. In FY 2006, a total of 16 elementary schools, 4 senior high schools, 3 middle schools, 2 public charter schools, and 2 faith-based organizations received program services. A total of 1,231 youth received health and sexuality education, with the highest concentration of program services occurring in Wards 5, 6, 7 and 8.

The Woodson Adolescent Wellness Center is a collaborative program between CHA and the DC Public Schools. Established in 1994, its goal is to provide comprehensive healthcare services, pregnancy prevention programs, and health education to adolescents in a safe, accessible, and convenient location. It is housed in the H.D. Woodson Senior high School in Ward 7, which is predominantly African American and is the second most impoverished of the District's eight Wards. The Center provides information and services about pregnancy and teen births.

Expansion of the Carrera Pregnancy Prevention Program to decrease births for teens less than 19 years of age.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. School nurse program				X
2. Support Woodson HS Wellness Center	X			
3. Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities				X
4. Continue with Child and Family Services Administration collaboration			X	X
5. Primary and secondary pregnancy prevention programs		X	X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Health and Sexuality Program and the Woodson Adolescent Wellness Center continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.

CHA CASH Bureau will continue its oversight and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.

Other activities include: 1) early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance utilizing Healthy Start case managers and family support workers; 2) expand well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) conduct routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhance linkage to APRA and other community based substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Work with the Department of Corrections to provide adequate prenatal care for pregnant inmates during incarceration.

c. Plan for the Coming Year

The 1-800-MOM-BABY HEALTHLINE or 311 number will continue providing information about pregnancies. The automated call distribution software will be adapted to permit the capture of calls related to maternal and child services and support the data collection requirements of the Title V Block Grant.

The Health and Sexuality Program and the Woodson Adolescent Wellness Center continue to provide health and sexuality education, comprehensive health services, and pregnancy prevention programs.

CHA CASH Bureau will continue its oversight and collaboration with school nurses to provide health education services in the DC Public Schools and selected Charter Schools.

The Perinatal and Infant Health Bureau initiatives include 1) increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance; 2) Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge; 3) Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant; 4) Enhance linkage to substance abuse education and treatment services; 5) Enhance community-based screening and prevention services for at risk families and youth served by child protective service agency; 6) Facilitate outreach and linkages to care for homeless pregnant women; 7) Improve screening practices for all women and youth at risk for mental illness; and 8) Provide adequate prenatal care for pregnant inmates during incarceration.

State Performance Measure 8: *Percentage of high school students who were in a physical fight one or more times during the past 12 months*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				33	30
Annual Indicator	38		36.3	36.3	19.8
Numerator					

Denominator					
Is the Data Provisional or Final?				Final	Final
	2008	2009	2010	2011	2012
Annual Performance Objective	28	26	25	25	25

Notes - 2007

Source:

<http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?ByVar=CI&cat=1&quest=Q20&loc=DC&year=2007> 95% confidence interval.

Technical Assistance was requested to address Violence Prevention in DC.

Notes - 2006

Source: YRBS

<http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2005&Year2=2003> . 2003 Survey 95% confidence intervals 38%± 3.2; 2005 Survey 36.3% ± 2.5

Notes - 2005

Source: YRBS

<http://apps.nccd.cdc.gov/yrbss/CompTableoneLoc.asp?X=1&Loc=DC&Year1=2005&Year2=2003> . 2003 Survey 95% confidence intervals 38%± 3.2; 2005 Survey 36.3% ± 2.5

a. Last Year's Accomplishments

The DC PS Youth Risk Behavior Survey (YRBS) reported that in 2007, 43% of 9-12th graders reported fighting; 19.8% reported fighting on school property. Other findings of the YRBS include: 1) middle school students were more seriously injured in a fight than senior high school students; 2) 10.9% of those injured in a fight required treatment by a nurse or doctor.

The CHA, DC Public Schools, and other youth-related programs implemented a school health plan that included school violence prevention programs at selected schools with a high incidence of youth violence. DC DOH also cooperated with the DC Public Schools nurse program implemented a screening and referral systems for mental health and other issues that may lead to school violence.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborative with public and private sector to develop strategies to decrease youth violence and injury			X	
2. Support and coordinate school nurses collaboration with Dept of Mental Health		X		X
3. Coordinate with the Rape Prevention and Education Program		X		X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The CHA and the DC Public Schools along with other youth-related programs continue to implement a school health plan that includes school violence prevention programs at selected

schools with a high incidence of youth violence. DC DOH also continues to cooperate with the DC Public Schools nurse program to monitor the screening and referral systems for mental health and other issues that may lead to school violence. Full service middle school wellness teams detect behavioral problems and address them before they become clinically significant.

The Rape Prevention and Education (RPE) Program collaborates with other CHA components and several other DC DOH administrations to provide sexual violence and dating violence prevention in DC Public Schools.

Currently analyzing the appropriate policy and programs that address rate of deaths due to violence and injury.

c. Plan for the Coming Year

These programs and school-based activities will continue. The RPE will continue to collaborate with other CHA components and several DC DOH administrations concerning violence prevention to provide sexual violence and dating violence prevention in DC Public Schools.

CHA will also evaluate the best practices to mitigate youth violence and injury among District middle and high school students.

Continue to analyze the appropriate policy and programs that address rate of deaths due to violence and injury and develop strategies to mitigate physical fights in schools and neighborhoods.

Technical Assistance was requested to address youth violence in DC.

State Performance Measure 9: *Percent of preterm births*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2003	2004	2005	2006	2007
Annual Performance Objective				12	11.5
Annual Indicator		12.5	12.5	13.4	13.4
Numerator		980	989	1135	1135
Denominator		7869	7897	8464	8464
Is the Data Provisional or Final?				Provisional	Provisional
	2008	2009	2010	2011	2012
Annual Performance Objective	11	10.5	10	10	10

Notes - 2007

There is a 2-year lag period in the District for reporting birth and death data. Data for 2007 will be available in 2009.

Notes - 2006

Data will be updated when final 2006 birth file data becomes available.

Notes - 2005

Final data.

a. Last Year's Accomplishments

2008/ State Performance Measure 9: Percent of preterm births.

Preterm birth is defined as the delivery of a live born infant prior to a 37-week gestational period.

In 2005, the most recent data available, 12.5 percent of District of Columbia newborns are born prematurely. The percent of preterm newborns increased to 13.4 percent in 2006. Previous years remained consistent at 12.5 percent. The 2008 report stated that lower rates in the District are less clear since infant mortality has increased slightly, while low birth weight rates decreased in 2005. However, disparities exist when examining preterm birth by race: African Americans have somewhat higher rates (14.9%) than white non-Hispanics (9.0%) and Hispanics (10.1%).

Last year, the Data Analysis and Program Evaluation Division developed a Data Set, Survey Instrument, and Best Practices Index to assist CHA in obtaining information on national data sets, collection tools and evidence based best practice models for both internal/external maternal and child health programs. This information will be included on our website to assist the Administration as well as local non-governmental organizations in program planning program and implementation within the District.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Dr. Genet Burka leads data collection, surveillance and analysis efforts				X
2. Data integration project to support linkages, timely collection and validation of data				X
3. Continue analysis of incidence of preterm births				X
4. Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities				X
5. Infant Mortality Plan strategies and initiatives			X	X
6. Family Support Workers Program		X	X	
7. Health Start Program		X	X	
8.				
9.				
10.				

b. Current Activities

Dr. Genet Burka and Stephanie Alexander initiated plans to conduct a 10-year trend analysis to determine patterns and the identification of programs/services that impact infant morbidity and mortality. CHA will be collaborating with a number of programs to assess the various data that are captured for inclusion in trend analysis. In addition, CHA will be developing a database on infant birth, morbidity and mortality statistics for the State to assist programs with planning and services.

c. Plan for the Coming Year

Increase coordination between government and the community to ensure a comprehensive, citywide approach to reducing infant mortality. DOH expects to strengthen its partnership with healthcare providers, community-based organizations, and patient advocacy groups to identify opportunities for collaboration and mutual support in the effort to prevent mortality, lifelong disabling conditions, and other threats to infant health. The activities include: 1) Institutionalize and expand pilot program to improve discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development; 2) Facilitate linkage to tobacco cessation programs for all at-risk mothers; 3) Compile perinatal screening risk information into a perinatal data registry in order to increase utilization of risk data by clinicians and case managers caring for all newborns and their mothers; 3) Convene a year-

long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities. Membership includes DOH and National Institute of Child Health and Human Development (NICHD), health care providers, managed care companies, and community-based organizations; and 4) Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities

The Data Analysis and Program Evaluation Division will be coordinating efforts to contract with a vendor to the PRAMS for the Maternal Child Program. and individual health care interventions that will reduce infant mortality.

E. Health Status Indicators

The Department of Health publishes annually the proportion of low and very low birthweight births in conjunction with the release of the infant mortality rate, which is followed closely by elected officials and the news media. These indicators have remained relatively stable in recent years, compared to an increase seen nationally.

MFHA staff reviews the injury mortality rates reported in this application, which are assembled primarily for purposes of Title V reporting. Due to the District's small population and the low number of injury-related deaths, annual variation in these rates is not particularly meaningful.

The District has yet to establish an injury reporting and surveillance system; therefore MFHA is unable to report on the injury indicators. Were these data collected, the information would likely be useful in targeting prevention efforts. A sister agency, the Bureau of Epidemiology, Health and Risk Assessment is working to develop a surveillance system that would allow for the linking of individual diagnoses across hospital inpatient and emergency department data systems. Staff is not able to project a date for when data may be available to report on indicators 04A, B and C.

MFHA staff work with colleagues in the Division of Sexually Transmitted Disease Control (DSTDC) to note changes in Chlamydia and other STD rates. High rates (likely under-reported) among residents are of concern to health officials. A joint project with MFHA and the DSTDC to institute testing in public high schools has been proposed based upon the alarming increase over the past few years.

Inter-census estimates of the demographics of the District's population are published infrequently by the Office of Planning. Again, because of the small population, changes in estimates of demographic characteristics over time are often unstable. MFHA uses these estimates in denominators when reporting rates; otherwise, they receive little attention.

Data on participation in public programs by race and ethnicity would be useful for describing the District's population and comparing changes over time. However, District agencies do not have a common data set or reporting format, making it very difficult to acquire summary reports with the requested information. Poverty rates remain high in the District.

/2008/ The MPCA is dedicated to ameliorate the health of District residents. By monitoring health trends throughout the District, MPCA can identify community health issues and impart qualitative/quantitative data which address the limitations of the services MPCA provides thus bridging the gap between health services and morbidities. MPCA recognizes the importance of how indicators can provide the foundation for overall public health expansion. Hence it is imperative to create surveillance systems in order to assess gaps in services for prevention of erroneous assessments.

In an effort to assess services, MPCA is collaborating with various nongovernmental organizations to have access to data sets with the hopes of using an integrated data system to determine the health status of our residents. While States are expected to concentrate SSDI resources on the Title V Block Grant HSCI #9(A), with first priority on data linkages, they may continue to address ongoing needs assessment and improve the data capacity for the performance/outcome measures of the Title V Block Grant Program.

Any activity regarding needs assessment or performance/outcome measures should focus on deficiencies and specifics for improvement. In 2006 the MCH program began linking data for the Title V submission, through SSDI funding. In 2007, newborn screening data (metabolic screening and newborn hearing) data was linked with the most recent birth file. In addition, a Medicaid file of newborns was linked with the birth file. In the previous two cycles, the MCH program has used SQL code to match and link files using MS ACCESS. During the year program staff began experimenting with Link Plus, a CDC-funded probability statistical linking software designed to work with cancer data. //2008//

//2009/ The District of Columbia estimated population in 2007 of 588,292 showed a 2.8% increase in population. In 2006, the population distribution was 55.5% African American, 34.5% Caucasian, 8.2% Hispanic, 5.1% including Native Americans, Alaskans, Hawaiians, and Pacific Islanders), 3.4% Asian, and 1.5% mixed (two or more races). Although the African American population is declining due to many middle class and professional African Americans leaving the city for suburbs, the District's white population has steadily increased, in part due to effects of gentrification in many of Washington's traditionally Black neighborhoods. The 2006 American Community Survey found that only 40% of current D.C. residents were born in the District, 16% below the national average.

This year the District produced several important action plans and studies that will impact the current and future health policies and public health initiatives.

As a result of the recent settlement of tobacco litigation, the District has more than \$200 million available to invest in the health of the city's residents. In 2006 the former mayor, Anthony Williams convened a task force with a charter to identify alternative ways to invest the available funds. The Health Care Task Force crafted several options that included investment in additional or improved hospital capacity, ambulatory care, and health care system improvement, but agreed that research was needed before final investment decisions could be made. Prior to final decision, the District contracted with the RAND Corporation to perform a study of health and the health care delivery system in the District. The goals of RAND's evaluation included:

- (1) Conduct a comprehensive health needs assessment for Washington DC;***
- (2) Assess the quality and accessibility of the District's health care delivery system for individuals with urgent or emergent medical needs; and***
- (3) Use information from those assessments to identify and assess various policy options for improving the health care delivery system.***

The City Council passed legislation in December 2006 allocating some of the tobacco settlement funds, including \$20 million for cancer prevention, \$10 million for anti-smoking efforts, \$10 million for chronic disease treatment, \$6 million for establishing a regional health information exchange, and \$2 million to buy new ambulances. The 2007 Legislation authorized the use of \$79 million for a public/private partnership between the District and Specialty Hospitals of America for the revitalization of Greater Southeast Community Hospital.

Allocation of the remaining funds, to be invested in hospital and/or ambulatory care improvements, was reserved until this study was completed.

A summary of findings that relate to the Title V Block Grant with its focus on Maternal and Child services; including children with special health care needs included:

The socio-demographic characteristics of the District for key geographical constructs used throughout the report--the District's eight wards and five Public Use Microdata Areas (PUMAs). (PUMAs are created by the U.S. Census Bureau and comprise areas that contain at least 100,000 people and are wholly enclosed within a state or territory). This demographic profile is helpful in understanding the results of the Rand analysis. A map of the PUMAs is enclosed as an attachment.

Findings from the Rand Study (Spring 2008) of health, health care, and the emergency care system in the District of Columbia include:

"(1) Among adult District residents, more than one in four adults reported having hypertension, making it the most common among the chronic diseases reported.
• Following hypertension, in order of prevalence, are asthma (10 percent), diabetes (8 percent), heart disease (5 percent), and cerebrovascular disease (3 percent).
• Over half of adult District residents qualify as overweight or obese, and nearly one quarter qualify as obese.

(2) District-wide, mortality rates from heart disease and cancer were higher than those from other causes, although cancer and HIV/AIDS contribute the most to rates of premature mortality.

(3) Measured health outcomes among District residents are comparable to those among residents of other "benchmark" cities that are socio-demographically similar to D.C. (such as Baltimore, Maryland and Atlanta, Georgia); although rates of mortality from diabetes are higher in the District compared to those in other cities.

(4) Among District children, 36 percent between ages 6 and 12 were overweight, based on reported height and weight, while 17 percent between ages 13 and 17 were overweight. Twelve percent were reported to have asthma; 9 percent of DC children were reported to have a dental health problem. 11 percent of parents reported that their children require services for a behavioral health issue. 8 percent of children in DC were estimated to have a serious emotional disturbance (in 2000).

(5) Among adults, residents of Wards 7 and 8 had generally higher rates of chronic disease, poor health status, and premature mortality. - However, other areas of the city also have poor health outcomes. Among adults, Ward 5 had rates of hypertension and overweight/obesity that exceeded the city-wide average. - Breast and prostate cancer incidence rates among adults were highest in Wards 4 and 8. The cervical cancer incidence rate was highest in Ward 7 and for colon cancer, Ward 6.

(6) Among children, health outcomes were better among those in Ward 3 than in other wards.
- Asthma prevalence among children was highest in Ward 7, with 18 percent of children reported to have asthma of any severity.

(7) Rates of health insurance coverage among adults were higher in the District than in comparable cities, probably largely as a result of the Alliance.

(8) Despite a relatively high rate of insurance coverage, about 20 percent of District residents--children and adults--reported no usual source of care. • Lack of a usual source of care was greater among uninsured compared to insured adults. • Among adults, PUMA C (which includes Wards 5 and 6) was associated with having a relatively low probability of having a usual source of care among adults. • Among children, those with public insurance were less likely to report having a usual source of care compared to those with

private insurance. • Among children, PUMAs D (which includes Wards 7 and 8) and B (which includes most of Ward 4 and some of Wards 1 and 5) were associated with relatively low rates of having a usual source of care, compared to other PUMAs.

(9) Rising rates of admissions for ambulatory care sensitive conditions¹ over time among youth and adults aged 40-64 suggest worsening access to non-hospital-based care in recent years. Similarly, rates of emergency department visits for conditions that are primary care sensitive have risen for adults 18-64.

(10) Admissions for ambulatory care sensitive conditions were highest in 2006 among adults in PUMA D (which includes Wards 7 and 8) and among children in PUMA B (which includes most of Ward 4 and some of Wards 1 and 5). • Among children, PUMA D (which includes Wards 7 and 8) was associated with a low probability of having a well child visit or dental care. PUMA C (which includes Wards 1 - These are conditions, such as asthma or heart failure, which can usually be treated by timely access to high quality outpatient care, thereby preventing the need for hospitalization; Wards 5 and 6) was associated with having a low probability of any well child visit, any acute care visit, or any dental care. • Among adults, the probability of having a check-up in the last two years was relatively low among residents of PUMA B (which includes most of Ward 4 and some of Wards 1 and 5) compared to those in other locations.

(11) Rates of primary care use among individuals enrolled in public insurance programs are low, as are rates of specialty use among those with chronic conditions. Rates of inpatient hospital stays and ED visits are relatively high. • Among children enrolled in Medicaid managed care, rates of primary care use ranged from about one third among older children to just over half among children 0-5 years old. Between 2 and 4 percent had an inpatient stay during the course of a year. Among children 0-5 years who are covered by Medicaid, 42 percent had an ED visit during the year. Approximately one-quarter of children 6-17 years old who are enrolled in Medicaid had an ED visit during the year. • Among adults covered by Medicaid, 40 percent had an ED visit during a year period. Approximately 14 percent of adult Medicaid enrollees had an inpatient stay during a one-year period. • While the majority of individuals with chronic conditions who are enrolled by Medicaid or the Alliance have at least one visit to a primary care provider, few see a specialist with expertise in treating their condition. Between about half and three fourths of these individuals use the ED at least once. Rates of inpatient hospital use among with those with selected chronic conditions (such as heart disease, HIV/AIDS, asthma or diabetes) ranged from 23 to 34 percent.

(12) From 2000-2006, rates of inpatient hospital use by DC residents remained fairly steady, while rates of ED use by District residents increased 7 percent between 2004 and 2006, with most of the increase driven by greater use among District residents ages 40-64.

(13) Overall primary and specialty care supply measures are not appreciably different from benchmark rates, but the distribution of providers does not appear commensurate with population need, and the availability of providers for vulnerable populations was difficult to measure.

(14) The average occupancy rate was at or below 70 percent at four hospitals in 2006, and was between 73 and 85 percent for three other hospitals. Only one hospital, Children's National Medical Center, had occupancy rates at or near 100 percent. • In all areas of the city, residents appear to have a choice in which hospital they go to, as residents from every zip code (or ward) used a variety of hospitals. • The supply of hospitals and hospital beds in the District was in the range of other benchmark cities.

(15) About one-fourth of inpatient admissions among children and among adults 40-64 are

ambulatory care sensitive. More than half of ED visits (that did not result in an inpatient admission) are classified as primary care sensitive across all age groups, and the percentage of ED visits that are PCS is highest among children.

(16) The overall demand for District emergency services has increased only modestly in recent years. • The volume of EMS runs was approximately eight percent greater in 2006 than 2000. • The number of ED visits appears to have increased between 2000 and 2001, although data from DC General, which are included in ED visit estimates, may be incomplete for these years. Since 2004, ED utilization at District hospitals increased 6.5 percent. • We were unable to fully explain the increase in diversion, which nearly doubled between 2000 and 2006.

(17) Patients with serious, acute conditions, such as heart conditions, strokes, and major trauma, are sometimes transported to hospitals that are not best suited to meet their needs. • This is a particular problem for residents in Wards 7 and 8 transported to Greater Southeast.

(18) There is little evidence of a single, unified vision of high quality pre-hospital and hospital emergency services and there are few available measures of the quality of emergency care in the District. • Hospital and DC Fire and Emergency Medical Services leaders appear to know little of each other's challenges." (Rand Study, Spring 2008)

These knowledge gaps relevant to Title V Block are largely due to gaps in data.

1) Little is known about children's health status and access to care. The only available data are from the 2003 National Survey of Children's Health (NSCH), for which we needed to conduct analysis at the secure Research Data Center in Hyattsville, Maryland. While the 2007 wave of the NSCH is nearly complete, the District should consider a more regularly collected and accessible mechanism to gather information on access to care and health status for children.

2) Available information about insurance status among adults in the District is inadequate. The Behavioral Risk Factor Surveillance System (BRFSS) only asks about whether an individual has insurance but about not type of insurance. Further, the failure to ask about specific insurance sources by program name likely results in some misreporting by Alliance enrollees.

3) Little is known about the quality of emergency medical services in DC. Response times have been an important metric historically. But quality in health care has moved beyond just a question of timeliness. Quality is now thought to include six domains: safety, timeliness, efficiency, effectiveness, equity and patient-centeredness. Currently, some data exist on EMS timeliness and a little is known about hospital emergency care effectiveness. Not much in the way of quality of emergency services is measured in the District, and we have seen no imminent plans to do so, despite the District government's major role in financing these services.

4) Available data on mental health prevalence and mental health and substance abuse service use are extremely limited. Data from the National Survey of Drug Use and Health provide sub-city estimates of the prevalence of substance abuse disorders, but no comparable data exist for mental health. As a result, we had to rely on indirect estimates of mental health prevalence from outdated sources. Given the importance of these problems for the District's population and their implications for health care and for quality of life, productivity, employability and safety, the District would benefit from developing mechanisms to regularly monitor mental health needs and access to mental health and substance abuse services.

5) Provider supply could be measured with more precision if reliable data on practice time

in the District and population served by type of insurance were available.

6) Differences in data formats and availability of Medicaid and Alliance data from managed care organizations make it less useful than it could be. The District should, as part of its managed care organization (MCO) contracting process, work with MCOs to ensure that progress is made towards standardization of data in the future.

7) The lack of timely analysis of data with which to monitor the health of the District should be addressed. Such data clearly exist (e.g., vital statistics, cancer statistics and BRFSS), but analysis of them are often several years out of date." (Rand Study, Spring 2008)

The DOH has clearly identified and addressed the issues related to collection, validity and timeliness of data with the Data Integration Project. The goal of the project is to link the disparate data systems using a master patient index to collect, validate and report data in a timely manner.

Phase II of the Rand Study was published in June 2008. Recommendations include the use of tobacco funds:

1.To expand to expand the capacity and improve the physical space of community health centers: (a) target expanding primary care capacity in CHCs by 200,000 visits; invest in high need locations; and establish and commit to urgent care capacity

2.To support greater adoption of health information technology: subsidize the adoption of the electronic health records by hospitals and providers who serve a substantial number of individuals enrolled in Medicaid or the Alliance; invest in sustaining the regional health information organization; and consider investment in other promising health technologies.

3.To invest in establishing an information clearinghouse for provider availability.

4.To implement and evaluate programs to improve the accessibility and quality of care; planning and implementation of new data collection; and for evaluations of health and health care in the District

5.To pay for projects that move ambulatory health care facilities closer to evidence based design.

6.In diversion reduction strategies including a collaborative and a "dashboard" with real time information about diversion status and bed availability across hospitals.

7.Delay allocation of a portion of tobacco settlement until an assessment of needs for mental health and dental care is complete and to pay for ongoing investments in health care service delivery improvement.

Other recommendations includes: modifications to Medicaid and Alliance reimbursement for primary care and outpatient specialty care providers; enhance financial incentives for primary and specialty care providers who serve the underserved; and ensure the availability and affordability of medical malpractice coverage for specialties serving the Medicaid/Alliance enrollees and uninsured. Similar recommendations were made for improving ambulatory care and emergency services.

The Rand Study noted that the health of the District's population is the product of many factors. Systemic factors other than access to health care that give root to poor health outcomes in the city require additional, ongoing, and concentrated attention. These include the social environment (family structure, education, employment, crime), physical

environment (air quality, water quality, access to healthy food, safe environment for physical activity), and the prosperity of District residents.

The Rand study and report will provide valuable information and serve as a baseline for development of the Title V Needs Assessment.

The Child Health Action Plan was created for improving child health in the District of Columbia. The action plan is a public private partnership with DOH and multiple collaborating organizations and individuals. The purpose of the plan is to implement evidenced based practices and public health models focusing on systems change and improved children's health outcomes within the District over the next 3-5 years. The Plan utilizes 7 key strategies: education, prevention, early intervention, policy development and enforcement, capacity building, community mobilization and community economic development. The Plan focuses on eight child health indicators: obesity, asthma, substance abuse, lead, well child visits, infant mortality, oral health and sexual health.

The Plan sets a clear strategy, goals and outcome, tasks, etc. for each defined indicator. The Plan is consistent with the National Performance Measures and the District priorities related to the Title V grant.

The Infant Mortality Plan further expands the infant mortality indicator presented in the Child Health Action Plan. The DC Citywide Action Plan December 2007 - The District's most recent epidemiological report for infant mortality revealed slight changes in infant deaths from 1996 to 2005. In response to this steady trend, the Department of Health (DOH) has developed a citywide action plan to respond to the maternal and child health needs in the District and reduce infant mortality rates throughout the city. A service gap analysis conducted by the DOH identified potential holes in the safety net of services for residents of the District. DOH will focus on three strategies for improvement of infant mortality statistics over the course of the next year, some of which are already in operation:

1. Increase capacity and impact of DOH home visitation program for pregnant women
The federally funded Healthy Start programs constitute the city's primary initiative serving low-income expectant mothers and infants at risk for adverse perinatal health outcomes. These home visitation programs administered by DOH and by Mary's Center for Maternal and Child Care, Inc. promote a healthier physical and social environment in the home and link families to needed care. In 2008, additional funds will be used to expand the capacity of the Healthy Start program, including an investment to recruit and train family support workers who will team up with nurse case managers to address major risk factors affecting the health of pregnant and parenting women and their children.

2. Enhance collaboration between DOH Community Health Administration's initiatives and other sectors of government serving at-risk women and families - The Community Health Administration will partner with sister administrations within DOH and other government agencies to ensure that screening and identification of at-risk families is widespread to increase enrollment in prenatal care and home visitation programs. Specifically, Healthy Start's nurse case managers and family support workers will link high-risk women to needed care provided by sister agencies, including tobacco cessation, substance abuse treatment, HIV screening and care, and other services.

3. Increase coordination between government and the community to ensure a comprehensive, citywide approach to reducing infant mortality. The District will strengthen its partnership with healthcare providers, community-based organizations, and patient advocacy groups to identify opportunities for collaboration and mutual support in the effort to prevent mortality, lifelong disabling conditions, and other threats to infant health.

The Plan states the services or initiatives for each strategy, participating agencies and timeline.

The Nutrition and Physical Fitness Bureau is actively addressing the childhood obesity crisis in the District. The partnering of the Women, Infant and Children (WIC) Program and the Income Maintenance Administration (responsible for the food stamp program), yielded the District's Food Stamp Nutrition Education Program (FSNEP) which offers nutrition education to persons potentially eligible for Food Stamps. A multiparty approach recently united the Office of the State Superintendent of Education (OSSE) with the Cooperative Extension Service, WIC, Commodity Supplemental Foods Program, the Capital Area Food Bank, and other stakeholders to develop and implement a TEAM Nutrition grant. The CHA partnered with the DC Public Schools to further nutritional information and education and increase the level of physical activity among DC school children, through programs such as Food Stamp Nutrition Education Program, which offers four, six week sessions to school children, among others; school-based fitness and community health fair promotions.

Comprehensive state nutrition planning is underway in conjunction with the District's Healthy People 2010 Plan and Annual Implementation Plan (AIP). Planning coalitions were formed with community-based organizations and advocates who developed nutrition based priority targets. The plan focused on WIC initiatives, which include strategies for increasing the rates and duration of breastfeeding among women enrolled in WIC and the inclusion of obesity awareness in its core curriculum. The AIP also addressed the need for development and institution of standard baseline indicators for conducting nutrition and physical activity related assessments.

The surveillance of health indicators play a critical role in determining the effectiveness of health policies and health care services to District residents. The data analysis combined with surveys and studies assists the District in 1) collaborating with inter and intra District agencies to define and collect relevant data in a timely manner; 2) developing the strategies that will optimize the health of District residents; 3) identifying socio demographic areas that continue to demonstrate health disparities; and 4) collaboratively implement culturally effective strategies.

Other activities include:

CHA has contracted with Rand to assess the school nurse program to develop strategies and outcome measures relative to the school based program. Title V will fund this effort.

Infrastructure Building:

During the FY'08 grant cycle, the Community Health Administration (CHA), previously known as the Maternal and Primary Care Administration (CHA), earmarked federal funding to support three infrastructure building themes:

- 1) Improved data linking processes lead to more timely and meaningful data for planning, program monitoring, and program evaluation.**
- 2) Management has initiated more proactive planning to define program performance measures, tie measures to outcomes, and establish a framework to evaluate programs and systems.**
- 3) Data systems, at all levels of government, are being evaluated, linked with other program activities, and new ones are being implemented to address and define population needs, monitor activities, and link activities to outcomes.**

Following this cycle's guidance theme, the plan for FY2009 is to continue using a comprehensive strategy that leads to improve data linking techniques, provide, better and

more timely data, and to systematically use data in the planning, monitoring, and evaluation cycle. The SSDI grant monies will be utilized to foster a more direct relationship in using data to set Title V priorities for CHA, including MCH groups like children with special health care needs.

The Administration continues to use SSDI funding to assist CHA and its CSHCN programs in the building of District and community infrastructure that results in comprehensive, community-based systems of care for all children and their families. We will continue to focus grant resources on the Title V Block Grant Health Systems Capacity Indicator (HSCI) #9(A): the ability of States to assure that the Title V, as well as, the maternal and child program have access to policy and program relevant information and data.

The department has a number of major data-related projects in development that will affect the operations of each of the administrations. The Center for Policy Planning and Epidemiology (CPPE) initiated a Data Integration Workgroup to provide advice in developing a DOH-wide website. As an initial step they developed a common DOH Data Sharing Agreement (DSA). This DSA will provide a uniform framework for the secure exchange of private health information (data files, databases and health reports) across agencies within DOH and will also provide a standard instrument for the exchange of private health data and information between DOH agencies and entities outside the health department.

The major activity of the group is planning the development of a website to allow the community and stakeholders to access data on DC populations. The website called the District of Columbia Community Health Information System (DC-CHIS) is directly modeled from the Utah IBIS-PH system, an innovative user interface solution for web-based Data query systems. DC-CHIS will provide users with multiple years of selected health data through the internet. The web-based system allows users to prepare their own queries from the available data sets and to generate printable reports in tabular and graphical formats. Query results may also be saved in spreadsheets such as excel. The SSDI coordinator and the MCH epidemiologist both serve on the workgroup. Over time DOH will continue to add more data and expand the capabilities of the system. CPPE is actively seeking feedback from the workgroup to suggest how this system could be improved to better serve the users. The following datasets will be available for query in the first version of the system: births, deaths, cancer incidence, hospital discharges by diagnosis, hospital discharges by procedure, and District of Columbia population estimates.

Another major development project in the District of Columbia is the Safe Passages Information System (SPIS) which is being developed by the Office of Chief Technologies Officer (OCTO). A number of District agencies have placed their information systems onto SPIS platform. OCTO is able to link the various databases so that one user can have access to relevant data about their client activities with other DC agencies. OCTO seems ready to assimilate key databases from DOH into the SPIS system. This offers an opportunity for the selected DOH databases to be hosted in an integrated environment, maintained by OCTO, where the presence of other health and social services databases in that system will provide opportunity for linkages and client tracking across programs and other data systems. This arrangement also provides opportunity for data integration between selected databases and at certain levels.

Our Vital Records office began using the "2003 revised death certificate" in October 2005. They plan to implement the "2003 revised birth certificate" January 1, 2009. The revised birth certificate will mean new data on areas like prenatal care and tobacco use. More accurate and comprehensive reporting of data would assist in many important public health activities like tobacco cessation, including surveillance, identification of populations at risk, program development and evaluation, and analytic epidemiologic

research.

DC Regional Health Information Organization (DC RHIO)

Health care leaders have come to recognize that sharing health data can significantly improve quality, increase access to services, and reduce cost of care -- especially for low-income and vulnerable individuals. Treatment is often sporadic and spread across multiple sites, including emergency rooms, community health centers, and specialty visits. Seldom does any one clinician see a complete set of medical records.

The DC Regional Health Information Organization (DC RHIO) will allow multiple hospitals, clinics, and other health care institutions to access patient medical data in emergency rooms and health centers. The DC RHIO will connect electronic medical records (EMR) across participating facilities to allow health care professionals to view complete medical histories of clients they share in common at the click of a mouse.

In the fall of 2006, the District government funded a project to implement EMRs in six DC safety net health centers. DCPCA is providing management of this 3 year project, as a key component of its Medical Homes initiative. Software for the first six health centers is expected to be deployed by September, 2008. Expansion to four additional community health centers is contemplated. This creates an opportunity to link this network of deployed EMR to hospitals to create the core of the DC regional health information exchange. The overall goal of this project is to create a regional health information exchange framework, infrastructure, and system to enable multiple hospitals, clinics, and other health care institutions to rapidly and securely access medical history information about patients at the time care is provided, yielding improvements in quality and cost effectiveness. Successful development of a RHIO in the District will lead to further opportunities to collaborate and develop interoperability with related efforts in Maryland and Virginia.

CHA has also established performance measures for each Bureau for 2009. The performance measures are consistent with Title V National and State Performance Measures and includes responsibilities, outcomes and timelines.

The Early Childhood Comprehensive Systems (ECCS) initiative focuses on several goals and objectives for FY 09 including: 1) develop a cross trained integrated workforce in order to provide quality services and supports that will have the best outcome for children and families by initiating the use of childhood consultants to provide multidisciplinary training and onsite supports

Interagency Collaboration and Services Integration Commission (ICSIC) is Mayor Fenty's initiative to set priorities for young people District wide. It is an interagency collaboration and accountability efforts in relation to District children. The DOH responsibilities are under Goal #3 related to Children and Youth Health and Practice Healthy Behaviors.

//2009//

An attachment is included in this section.

F. Other Program Activities

Epilepsy

In 2004, MFHA received a federal grant, Awareness and Access to Care for Children and Youth with Epilepsy in the amount of \$250,000.00 from September 1, 2004-August 31, 2007. The purpose of this initiative is to improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs. This initiative aims to establish links between families and MCOs while integrating community resources by employing family advocates at each of the four managed care organizations located in the District. DOH

executed sub-grant agreements with three of the MCOs outlining specifications for the hiring and utilization of the family advocate. The MCOs include AmeriGroup, Chartered Health Plan, and HSCSHN, Inc. The mission is to ensure that each health plans' programs and services have input from caregivers and are responsive to the needs of this population. Caregivers will act as member-advocates, seeking and coordinating creative solutions to members' concerns. Family advocates will be employed by the respective health plans with salaries subsidized by DOH. Year 1 funds have been utilized to support community partnerships to allow early detection and treatment by improving access to ongoing care, addressing shortages in subspecialty care, identifying cultural and language barriers, and developing strategies for improving current systems of treatment. DOH anticipates the demonstration project will improve access to comprehensive, coordinated health care and related services for children and youth with epilepsy residing in MUAs throughout the District.

Vision Screening

In cooperation with the Lions Club, the CSHCN staff has conducted a vision screening program for several years, offering free screening for early detection of amblyopia in children from ages one to six years old. In addition to the screening at child care and pre-school facilities, vision screening was also conducted at many of the District's middle and junior high schools. Lions Club volunteers worked with parents to ensure that children who screened positive were seen for services and were provided with eye glasses. There are typically more requests from schools than can be met, in part because the program has better equipment than available at the school sites, and children are assured of being fitted with glasses. Many uninsured or underinsured children do not have access to being fitted with eye glasses.

In FY 2005 1,526 children were screened with 358 referred for eye glasses. The number actually fitted is not known. The work with the Lions Club is expected to continue in FY 2007 with screening to be focused on charter schools. In addition to this project, schools nurses conduct vision screening in conjunction with the contract with Children's National Medical Center.

Physical Activity and Nutrition

In FY 2007, staff is planning to create, implement, support and enhance pilot initiatives in collaboration with community and government partners to address obesity and wellness amongst families, women, and men that have the potential for duplication in communities and worksites throughout the District. These include:

Worksite efforts supporting DOH employees to participate in regular on-site physical exercise in a minimum of two DOH building sites, with the goal of using the experience as a pilot for potential duplication within other large District worksites;

Support men by promoting wellness via increased exercise, improved nutrition, stress reduction, and routine check-ups;

Support women by promoting wellness via increased exercise, improved nutrition, and stress reduction, and routine check-ups;

Convene one to three community-based forums to solicit and encourage community involvement in the development of citywide programs to enhance nutrition and increase physical activity; and

Partner with community media supporting and encouraging residents to participate in exercise and other wellness activities, utilizing and expanding upon "lessons learned" from the 2005 "Listening4yourhealth" initiative with WPFW-Pacific Radio.

/2008/ To ensure community-based service systems are organized so they can be used easily, and specifically to improve upon the health system for children with epilepsy and/or seizure disorders, the MPCA is collaborating with the National Epilepsy Foundation of America to establish a Metropolitan Chapter for Epilepsy in the District of Columbia. The chapter will be

established through grant funds and matching dollars from the National Epilepsy Foundation of America. The Epilepsy Foundation will take the lead on this effort.

The Nutrition and Physical Fitness Bureau has collaborated with DOH Communications, the former Adult and Family Services Bureau and WPFW-FM Pacifica Radio to develop a concept paper for a multi-year nutrition and fitness initiative entitled MOVE DC. Once fully initiated, it will develop and support a number of innovative programs, building on a successful 2005 collaboration where DC DOH partnered with WPFW radio promoting and on-air personalities contributed their personal interest and expertise, leading a series of "Movement Clubs."

NPFB is proceeding with plans for a citywide conference on nutrition and fitness, "The Path to Wellness: A Lifelong Journey" to be held in 2007. In addition to being located in the community, this conference will engage community leaders and health activists both as participants and as presenters. DC DOH Move DC kick-off event will be in the spring.

NPFB's Food Stamp Nutrition Education Program continues to provide nutrition and fitness classes to school children, parents and seniors using USDA's Team Nutrition curriculum. Meanwhile, NPFB has been an active participant with the Ward 8 Childhood Obesity Collaborative, working to support an initiative providing assistance and training to Family Day Care Providers, as well as a range of policy initiatives on expanding fresh food access in that area of the city, one of its poorest.

The Rape Prevention and Education Program (RPE) addresses violence toward and by children and youth in the District of Columbia. In addition, the RPE program targets universities and community members, because of the obvious maternal and child link with adult students/community members who (1) are survivors or of or at risk for sexual violence perpetration or victimization; and/or (2) have children who are survivors of or at risk for sexual violence perpetration or victimization.

Continued collaboration with the Lions Club for vision screening programs for several years, offering free screening for early detection of amblyopia in children from ages one to six years old. In addition to the screening at child care and pre-school facilities, vision screening was also conducted at many of the District's Public Charter Schools. In FY 2006, 2,035 children were screened with 240 referred for eye glasses. The number actually fitted for glasses is not known. In FY 2008, the collaboration between CSHCN staff and the Lions Club is expected to continue, with screening to be focused more on charter schools. //2008//

//2009/ Other Program activities during this grant year included:

Perinatal and Infant Health Bureau convened a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.

Special Health Care Needs Bureau continued Lions Club activities; developed the Parent Information Network Request for Proposals; and champions family access to services for children with special health care needs.

Child Health Action Plan focus on Asthma includes strategies to develop and implement quality improvement initiatives on asthma with DC medical providers and implement the Standardized asthma medical record form for use by primary care providers. //2009//

An attachment is included in this section.

G. Technical Assistance

In the July 2005 grant application, MFHA described two technical assistance needs--one, for an analysis to ensure that any centralization and/or warehousing of surveillance functions in DOH results in the capability to generate and analyze data required for MCHB grant reporting, and, two, assistance from an MCH epidemiologist or health statistician experienced in working with mortality data to assist in the design of an analysis to identify trends in and contributing factors to mortality in the population aged 1 to 21. But MFHA did not follow up with a formal request to MCHB for technical assistance.

This year MFHA plans to request technical assistance to help with two issues. First, MFHA needs a CDC MCH epidemiologist for at least a one-year period to work with surveillance and data analysis staff to review, update and possibly design surveillance systems to enable the tracking and analysis of data on infant mortality and morbidity. This level of assistance will provide analytic reports to inform planning to interventions to decrease infant mortality. Toward that end, the MFHA senior deputy director has initiated discussions with CDC and MCHB.

Second, MFHA needs assistance to organize a maternal and child health advisory committee. As described in the public input section of this application, MFHA has taken the initial step of gauging public interest in such a body. Now there is a need for a political scientist or a person knowledgeable about the development of civil society to assist with this effort.

During the grant review in August 2006, a third need was identified--assistance with file linkage, for example, in linking Medicaid eligibility and/or claims files with annual birth files.

//2008/ MPCA will seek technical assistance to explore the establishment of a MPCA Advisory Committee that may be composed of representation from existing advisory committees and other stakeholders. This committee will assist the Administration in identifying priorities and associated activities, allocating resources, identifying state performance measures, and monitoring progress. The primary role of the Committee will be to guide the Agency with appropriate information and guidance to meet the needs of mothers, infants, and children, including children with special health care needs; identify gaps in services within the District's health care delivery systems; and ensure that Title V funds are spent appropriately and support evidence-based programs that benefit families and improve the overall health of families within the District of Columbia. Technical assistance is being requested to help to establish the composition of the Committee; identify the ratio of consumers and professionals; determine mission and vision statements; and to develop by-laws to include terms of members, officers needed, voting requirements, executive board members, quorum delineation, and compensation of members.

The MPCA will seek technical assistance from Georgetown University to assist in strengthening culturally competent practices. Technical assistance is requested to enhance the capacity of MPCA to reach the culturally and linguistically diverse individuals in the underserved communities. MPCA plans to utilize the expertise of Georgetown University's National Center for Cultural Competence to develop a conceptual framework and definition for cultural and linguistic competence, identify the need for cultural and linguistic competence, develop policies to promote and sustain cultural and linguistic competence, and develop tools to assess the cultural and linguistic competence of MPCA and its community partners. //2008//

//2009/ Mary Frances Kornak, MPH, will be responsible for the day to day management of Title V activities. Reporting to the Title V Program Coordinator, Ms. Kornak will assist the Program Coordinator in the Title V grant implementation and monitoring of compliance; respond to queries from HRSA related to DOH Title V activities; responding to program staff and grantees related to Title V performance measures and proposed activities; assist with development of reports and presentations.

Ms. Kornak has more than 15 years experience in public health and medical field including

protocol design and survey development; project analysis, management and evaluation; clinical and scientific writing and technical knowledge in computers. She earned her Bachelor of Arts from the College of Notre Dame of Maryland and Masters in Public Health from George Washington University.

Refer to Form 15.

MS Kornak is the lead contact person for additional information related to CHA request for technical assistance in the following areas:

1) To establish a Title V Maternal and Child Program Advisory Committee. CHA will no longer be creating a new advisory board. CHA has decided to utilize the existing structure of the CSHCN Advisory Board. In the next few months the CSHCN-AB will be retooled to make full use of their expertise such as: 1) to review current state priorities, 2) to identify gaps in services within the District's health care delivery systems, 3) to identify who in the community can best fill those gaps, 4) to monitor state performance measures and program progress and 5) and to ensure that Title V funds are spent appropriately and guide DOH to meet the needs of mothers, infants, and children, including children with special health care needs.

However, it would be prudent to get a facilitator to expand the composition of the CSHCN-AB; identify the ratio of consumers and professionals; evaluate mission and vision statements, review by-laws to include (terms of members, officers needed, voting requirements, executive board members, quorum delineation, and compensation of members). This person would facilitate growth; increasing parent participation. Increasing active members including youths will help the board thrive beyond what exists today, and also helps CHA immensely to monitor our response to the cities problems. CHa will look to HRSA to name a vendor/identify resources.

2) To assist in strengthening culturally competent practices. Technical assistance is requested to enhance the capacity of CHA to reach the culturally and linguistically diverse individuals in the underserved communities. A suggested vendor is Georgetown University's National Center for Cultural Competence who has the expertise to develop a conceptual framework and definition for cultural and linguistic competence, identify the need for cultural and linguistic competence, develop policies to promote and sustain cultural and linguistic competence, and develop tools to assess the cultural and linguistic competence of CHA and its community partners.

3) To assist CHA to build population based strategies for implementing Maternal and Child programs.

The District's health disparities are higher in specific wards however, infant mortality, childhood obesity, asthma, youth violence, lead issues and oral health affect significant numbers of District residents in variouis wards. DOH seeks assistance in identifying population based strategies that meet the needs of the District as a whole. DOH requests that HRSA make a recommendation on who would be the best technical advisor/identify resources.

4) To assist CHA build evaluation capacity within the DOH. As DOH moves toward increased program funding and oversight and management of awarded community based grants and contracts it seeks assistance in developing capacity within DOH to effectively monitor awards. Bureau staff work closely with grantees and need tools to guide and counsel awardees to ensure compliance with the scope of work, performance measures and expected outcomes. CHA will look to HRSA to identify a vendor/resources.

5) To assist in the development of performance measures for evaluation tools as a component of the grants management process, specific to Maternal and Child programs.

DOH is focused on increased program focused allocation of funds with DOH oversight and management of awarded grants and contracts. Therefore it seeks assistance in developing performance measures that support proposed outcomes and ensures appropriate distribution of funds. CHA requests HRSA make a recommendation/identify resources.

6) To assist CHA with a review of the District's strategies that focus on decreasing youth violence and injury and assist DOH in selecting evidence based strategies that serve the District's targeted population as well as assist with defining the processes required for implementation and performance based evaluation methodologies CHA will look to local resources such as American Academy of Pediatrics and other existing youth violence programs.

//2009//

An attachment is included in this section.

V. Budget Narrative

A. Expenditures

V. Budget Narrative

A. Expenditures

/2008/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The percentage of Maternal and Primary Care Administration funds expended on the core services depicted by the four tiers of the MCH pyramid is as follows:

1. Direct Health Care Services (Basic Health Services and Health Services for CSHCN - 16%.
2. Enabling Services - 18%.
3. Population Based Services - 46%.
4. Infrastructure Building Services - 20%.

Maintenance of Effort/State Match

The District of Columbia expended \$8,849,391 in state funds in providing services to the Title V population. This amount is \$3,561,391 in excess of the \$5,288,000 MOE requirement and \$3,352,915 in excess of the \$5,552,915 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools.
//2009//

The District of Columbia will continue to expend Title V funding to support the following efforts:

- | | |
|--|--|
| <i>-Adolescent Health Initiative</i> | <i>-Genetics Program</i> |
| <i>-Community-Based Teen Pregnancy Prevention</i> | <i>-Newborn Metabolic Program</i> |
| <i>-Newborn Hearing Program</i> | <i>-Lead Poisoning Prevention Program</i> |
| <i>-Transportation Services</i> | <i>-Immunization Initiative</i> |
| <i>-Health Education</i> | <i>-SIDS and Infant Death</i> |
| <i>-Oral Health Services</i> | <i>-Dental Sealant Initiative</i> |
| <i>-Infant and Child Mortality Review</i> | <i>-School-Based Health Centers</i> |
| <i>-Early Intervention Programs</i> | <i>-Breastfeeding</i> |
| <i>-Case Management and Care Coordination</i> | <i>-Medical Homes Initiative</i> |
| <i>-Men's Health Initiative</i> | <i>-Women's Health Initiative</i> |
| <i>-Sickle Cell Initiative</i> | <i>-Vision Screening</i> |

Other sources of Federal MCH dollars include:

- Eliminating Disparities in Perinatal Health***
- Universal Newborn Hearing Screening***
- District of Columbia State Systems Development Initiative***
- Awareness and Access to Care for Children and Youths with Epilepsy***
- Rape Prevention and Education***
- Early Childhood Comprehensive Systems***

Methodology: The State makes every effort to use the data collected by the Department of Health and other entities to direct MCH funds to address

unmet needs. On a quarterly basis the Maternal and Family Health Administration proportions program expenditures to reflect percentage of effort in direct health care services, infrastructure-building, population-based services and enabling services. Program expenditures are also proportioned based on the "30-30-10" earmarking requirement of Title V. //2008//

/2009/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

The FY2007 Award \$7,583,387.46

The percentage of FY07 earmarking requirements included:

30% children with special health care needs: \$2,275.016.24

YTD Personnel Services	\$1,401,890.31
YTD Non personnel services	\$ 888,103.64
Total expenditures	\$2,289,993.95

Earmarking requirements 100.66%

30% FY2007 Preventive and Primary Care Earmarking \$2,275.016.24

YTD Personnel Services	\$1,208,428.08
YTD Non personnel services	\$1,106,576.40
Total expenditures	\$2,315,004.48

Earmarking requirements 101.76%

10% Administrative threshold \$758,338.75

YTD FY07 expenditures on administration \$283,663.63

% of FY07 Administrative threshold 37.41%

//2009//

B. Budget

V. Budget Narrative

A. Budget

/2008/ Completion of Budget Forms: Please refer to forms 2, 3, 4, and 5 for a summary of how MCH funds were budgeted and expended.

EARMARKING REQUIREMENT

I. Preventive and Primary Care Services

The District of Columbia will continue to expend Title V funding earmarked for preventive and primary care on immunization, SIDS and infant death counseling, lead poisoning prevention, case management and care coordination, school-based wellness center, hearing screenings and genetic testing and counseling.

II. Services to Children with Special Health Care Needs

Title V funding is used to support the Children with Special Health Care Needs Bureau activities and programs and services through sub-grants. These programs and services address newborn hearing and metabolic screening, genetic services, sickle cell and medical and dental services to students attending two District of Columbia schools specifically for children with special healthcare needs.

III. Administrative

Administrative costs in the Department of Health and the Maternal and Primary Care Administration include administrative overhead, internal accounting and information system charges, budgeting, and other charges generated from the operations and management units of the operating division.

IV. Maintenance of Effort/State Match

The District of Columbia has allocated \$10,758,179 in state funds to provide MCH services to the Title V population. This amount is \$5,470,179 in excess of the \$5,288,000 MOE requirement and \$5,439,917 in excess of the \$5,318,262 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools, teen pregnancy prevention, Women Infants & Children / Commodity Supplemental Food Program and Immunization Campaign. //2008//

/2009/ The DOH allocates Title V funding according to the defined categories described in the Application Guidance: 30% for preventive and primary care services for children; 30% for services for children with Special Health Care Needs; 30% for planning, administration, evaluation and education; and 10% for grant administration. The following presents the budget narrative to support personnel; programmatic and other related expenses.

Personnel Budget Narrative

\$3,453,123.58

The proposed personnel budget includes program, administrative and support staff positions described below. The total salary costs are \$2,928,858 plus fringe benefits (.1794) in the amount of \$524,265.58. The total personnel budget is \$3,453,123.58. Title V funding supports 49.5 FTEs.

Title V fund allocation for staff is limited to the Administration (30%), Primary Care and Prevention (30%) Child Adolescent and School Health Bureau and (30%) for Special Health Care Needs Bureau.

***Bureau Chief
Epidemiologist
Executive Assistant
Grants Management Specialist
Investigator
Program Analyst
Program Specialist
Project Coordinator
Public Health Advisor
Public Health Analyst
Receptionist
Research Analyst
Statistical Assistant***

Non Personnel Budget Narrative -

\$3,262,750.00

DOH proposes the following funding allocations for the various maternal child programs. CHA will earmark funds in accordance with the Title V Block Grant allocations

requirements: Primary Care and Prevention Funds (30%); Children with Special Health Care Needs (30%); Other (Planning, Administration, Education and Evaluation) and 10% for Grant Administration.

Health Babies Project Program was awarded in 2008 and is focused on health risk prevention in targeted Wards 5, 6, 7 and 8. The Project will collect, monitor and report health risks and mitigation strategies. CHA expects to exercise Option 1 year funding in the amount of \$248,000.

MOM Call Center is a Title V reporting requirement. Due to centralization of all District call centers, the 1-800-MOMs call has been absorbed into the central call center. Residents call either the 1-800-MOM number or the 311 number to obtain needed information. In order to track the specific calls related newborns and mothers software adaptation is required. Funds in the amount of an estimated \$45,000 will be allocated to the call center vendor to track data that meets the Title V reporting requirements.

PRAMS Like Survey will focus on capturing data on pregnancy and barriers to prenatal care based on the Pregnancy Risk Assessment Monitoring System (PRAMS) model. It is expected to be a population-based risk factor surveillance system designed to identify and monitor selected maternal behaviors that occur before and during pregnancy and the child's early infancy. CHA will issue a Request for Proposals to a vendor to provide the survey services in the amount of \$30,000.

Advisory Board comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities. Membership includes DOH and National Institute of Child Health and Human Development (NICHD), health care providers, managed care companies, and community-based organizations. Funds will be used to support the organization, logistics and facilitation of Advisory Board meetings. CHA will issue a Request for Proposals to a vendor to provide the services in an estimated amount of \$15,000.

Youth Violence and Injury Program will focus on identification and implementation of strategies to mitigate youth violence and injury among high risk youth. A Request for Proposal will be issued and program fund allocation in the amount of \$250,000.

Rand Study -- Assessment of the School Nurse Program to focus outcomes of school based health activities. An estimated \$250,000 is allocated for this effort.

Expansion of the Pregnancy Prevention Program to decrease teen pregnancy and support health life styles. CHA allocates an estimated \$100,000 for this program.

Transition Case Management Program is expected to support the transition of children with special health care needs to adult services through a case management program. A Request for Proposal will be developed and issued for a qualified community based organizations. An estimated award in the amount of \$500,000 will be awarded to a qualified vendor.

Family Development Center for children with special health care needs provides parent child classes. CHA may exercise Option 1 year of the two year grant in July 2009. The estimated award of the Option 1 year funding is \$38,000.

Oral Health Program -- funding to support oral health education in the DC Public Schools and Charter Schools; pregnant women's oral health, school nurse oral health education as well as efforts to enhance provider participation in Medicaid management care programs and oral health policy development. An estimated \$125,000 will be allocated to support expansion of the oral health initiatives in DC Public and Charter Schools.

CHA will continue to support the efforts of the Epilepsy and Seizure Disorders program including development of treatment protocols and primary care provider notification for use by emergency room staff when a child presents with a seizure. An estimated funding in the amount of \$30,000 will be allocated to the Epilepsy Learning Collaborative.

Autism Program to enhance capacity to improve parents and caregivers access to autistic spectrum disorder services. An estimated \$100,000 is allocated for this project.

Parent Information Network project expansion from a family navigator pilot project to implementation phase. The scope of work will include expansion of navigation services to families with children with special needs; help desk, or resource directory of state and regional services for children with special health care needs. The option year under the current contract may be exercised in an estimated \$500,000.

The Lead Program will provide blood lead level screening for uninsured children. A proposed budget of up to \$50,000 is allocated to support laboratory and related expenses.

To support the Child Health Action Plan target to enhance the care and services to children with asthma, it allocates an estimated \$100,000 to development of the Quality Improvement Initiative and best practice and evidence based protocols for children with asthma.

Block Grant Meetings staff expenses in the amount of \$3,000 as required in the Application Guidance. The funds will be used for staff expenses related to travel and lodging to attend HRSA and other MCH meetings.

Title V Staff Training in the amount of \$30,000 will be used to support the professional development of program staff.

Town Hall Public Input meeting logistics and facilitation to enhance public input opportunities related to the goals and objectives of the Title V Maternal and Child Health Block grant. A vendor will be identified to provide facilitation and logistical services. Proposed allocation of funds is \$5,000.

Professional development sub grant to a qualified a vendor to provide continuing education programs related to MCH services, data collection, analysis and integration and other relevant programs. An estimated \$30,000 is allocated for the grant.

Need Assessment -- a Request for Proposals will be issued to develop the Title V Block grant requirement to conduct a needs assessment every five years. The scope of work will include but not be limited to a gap analysis; strengths and weaknesses of current MCH programs and services; community focus groups; development of the state priorities for future years. An estimated \$300,000 will be allocated for this effort.

Grant writers to support development of grants to support maternal child health activities as well as assist with the development of the Needs Assessment. The proposed allocation of fund is \$100,000.

Data Integration Project is a critical program to facilitate the linkages of health and surveillance data from disparate applications. Utilizing an enterprise architecture approach and a master patient index CHA will integrate eight program applications. Cost per program implementation is \$120,000 each. Project estimated cost is \$960,000.

OCTO Contract for information technology maintenance services includes help desk support and trouble shooting for technology issues. Costs are estimated at \$750 per year

time for an estimated 50 personal computers = \$33,750.

Maintenance of Effort/State Match

The District of Columbia expended \$8,849,391 in state funds in providing services to the Title V population. This amount is \$3,561,391 in excess of the \$5,288,000 MOE requirement and \$3,352,915 in excess of the \$5,552,915 state match requirement. The MOE and matching funds are used to provide nursing services to all students attending District of Columbia public and public charter schools. //2009//

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.