Chapter 7

Health & Human Services

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Health & Human Services

Department of Human Services

The mission of the District of Columbia Department of Human Services (DHS), in collaboration with the community, is to assist low-income individuals and families to maximize their potential for economic security and self-sufficiency.

Clients in Human Services Programs

Over 220,000 District residents receive one or more services administered by the District's human services safety net. Recipients of these services include participants in income support programs, such as Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children), Supplemental Nutritional Assistance Program (SNAP, formerly Food Stamps), and Interim Disability Assistance (IDA). Medicaid continues to be the largest program with an enrollment of nearly 170,000 individuals.

A comparison of participants over the fourteen-year period shows that the number of Medicaid recipients increased by 34 percent, SNAP recipients increased by 41 percent, and TANF recipients have fluctuated, but have shown needed increase in recent years (Table 7.1).

Temporary Assistance for Needy Families (TANF)

In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), P.L. 104-193, which eliminated the Emergency Assistance Program and the Aid to Families with Dependent Children (AFDC) program, shifting from an open-ended entitlement to a cash assistance program limited to 60-months in a lifetime. The TANF program is designed to assist individuals to become self-sufficient by requiring them to work or participate in certain work activities in order to receive benefits. Support services and employment related services are provided to enable the individual to seek, obtain and maintain employment. After a number of years of declining caseloads, the number of TANF cases has seen a significant increase since 2008 (Table 7.2). In response to the increasing demands, and the challenges facing TANF families, DHS has dramatically redesigned the TANF program.

Table 7.1. Number of Participants by Program (Monthly average) by Fiscal Year

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Medicaid*	119,712	125,680	129,638	130,663	133,913	137,832	144,026	144,413	140,486	140,600	133,905	160,562	162,262	168,359
SNAP (formerly Food Stamps)	84,386	79,536	72,776	73,069	79,887	86,817	87,215	86,872	85,011	86,957	99,203	113,629	128682	135,506
TANF	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272	36,677	42,760	43,113	44,528
General Assistance for Children	571	546	548	555	525	512	463	411	384	360	334	329	285	306
Interim Disability Assistance	n/a	n/a	n/a	420	787	1,012	1,510	1973	2140	3481	2697	1591	1085	662
DC Healthcare Alliance**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	44,513	48,095	52,082	48,082	23,705	20,543

**DHS provides Eligibility only; benefits administered by Department of Health Care Finance (DHCF)*
***DHS initiated DC Healthcare Alliance services in FY07*

Source: Department of Human Services

Table 7.2. Temporary Assistance for Needy Families (TANF), Monthly Average by Fiscal Year

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Recipients	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272	39,588	40,554	43,113	44,528
Children	37,481	34,271	32,056	32,050	32,638	33,501	32,780	30,379	28,768	28,078	29,549	30,073	31,174	31,515
Cases	19,062	17,312	16,210	16,390	16,804	17,329	17,066	16,012	15,171	14,892	16,085	16,654	17,382	17,699
Avg. Mthly Payment by Case	$351	$346	$340	$335	$335	$335	$331	$334	$352	$374	$373	$369	$358	$344
Family Size	2.7	2.7	2.7	2.7	2.6	2.6	2.6	2.49	2.48	2.5	2.5	2.4	2.5	2.5
Total TANF Payments (in millions)	$80.30	$71.80	$67.20	$66.80	$67.50	$69.60	$67.70	$64.11	$64.14	$67.00	$72.00	$73.00	74.7	73.0

Source: Department of Human Services

Table 7.3. SNAP (Formerly Food Stamps), Monthly Average by Fiscal Year										
	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Recipients	79,887	86,817	87,215	86,872	85,011	86,957	99,203	113,629	128,682	135,506
Cases	37,910	41,977	43,273	44,058	44,028	46,132	54,299	63,720	73,438	77,717
Source: Department of Human Services										

Table 7.5. Shelter by Fiscal Year					
	2008	2009	2010	2011	2012
Shelter*					
Individuals	11,631 persons	11,442 persons	10,427 persons	8,608 persons	9,289 persons
Families	1,371 persons (433 families)	1,451 persons (464 families)	1,802 persons (564 families)	1,762 persons (579 families)	2,627 persons (791 families)
Transitional Housing					
Individuals	738 persons	702 persons	697 persons	1,252 persons	1,080 persons
Families	918 persons (281 families)	1,008 persons (304 families)	1,035 (310 families)	1,662 persons (512 families)	1,588 persons (475 families)
**Includes hypothermia, seasonal and overflow beds*					
Source: Department of Human Services					

SNAP/Food Stamps

The Food Stamp program is designed to provide supplemental nutrition assistance to individuals and families in need. Since 2007, the number of households receiving Food Stamp benefits has increased dramatically (Table 7.3). This has been the result of both the economic downturn, as well as expanded eligibility guidelines in the District.

Permanent Supportive Housing

In 2008, the District of Columbia adopted the Housing First Initiative, a revolutionary, yet tested, approach for addressing and bringing an end to chronic homelessness in the District of Columbia. As a result, DHS created the Permanent Supportive Housing (PSH) Program, which serves individuals, families and veterans. The PSH programs transformed the delivery of homeless services from an approach that simply meets the survival needs of individuals with blankets and shelter, to one that provides a subsidized housing unit paired with tightly linked supportive services.

Table 7.4. Permanent Supportive Housing by Fiscal Year					
	2008	2009	2010	2011	2012
Individuals Housed	362	190	38	60	26
Families Housed	n/a	74	165	242	113
Total number of households	362	380	286	302	139
Source: Department of Human Services					

Shelter Services

In addition to the Permanent Supportive Housing programs, the District provides shelter and transitional housing programs for individuals and families experiencing homelessness (Table 7.5). Hypothermia, low barrier and temporary shelters provide 12-24 hour daily shelter with access to supportive services. Transitional shelter aims to facilitate the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months).

Adult Protective Services

Adult Protective Services (APS) investigates reports alleging abuse, neglect and exploitation of elderly, disabled and other vulnerable adults and intervenes to protect those adults who are at risk.

Table 7.6. Adult Protective Services by Fiscal Year					
	2008	2009	2010	2011	2012
Total number of cases	957	874	856	861	956
Source: Department of Human Services					

Strong Families

The Strong Families program aims to strengthen individuals and family units, foster healthy development, and help address the issues that create ongoing challenges by providing client needs assessments, case plan development, social work interventions and referral and coordination of services (Table 7.7).

Table 7.7. Strong Families by Fiscal Year					
	2008	2009	2010	2011	2012
Families Served	969	1,161	1,423	2,076	1,621
Source: Department of Human Services					

Office on Aging

Mission

The mission of the District of Columbia Office on Aging (DCOA) is to advocate, plan, implement, and monitor programs in health, education, employment, and social services which promote longevity, independence, dignity and choice for our senior citizens.

Background

The District of Columbia Office on Aging was created by DC Law 1-24 in 1975 as the State and Area Agency on Aging. The agency is responsible for the development, implementation, and administration of a comprehensive and coordinated social services system which consists of over 30 programs (funded by federal and local dollars) for residents 60 years of age and older, persons living with disabilities and caregivers. The agency carries out its mission by funding its Senior Service Network comprised of 27 community-based nonprofit organizations that provide a full range of core home and community-based supportive services, namely:

- Adult Day Care
- Emergency Shelter
- Caregiver Support
- Congregate Meals
- Home Delivered Meals
- Elder Abuse Prevention
- Comprehensive Assessment
- Health Insurance Counseling
- Long-Term Care Case Management
- Respite Care
- Legal Support
- Transportation
- Recreation & Socialization
- Health Promotion & Wellness
- Short and Long-Term Counseling
- Nutrition Education & Counseling
- In-Home Care/Supportive Services

DCOA also offers information, assistance and referrals, employment and training programs, options counseling, nursing home transition and hospital discharge planning services through its Aging and Disability Resource Center (ADRC) for seniors, persons living with disabilities, and caregivers. In addition, DCOA owns two nursing facilities, the Washington Center for Aging Services and Unique Residential Care Facility, that are privately operated and managed by Stoddard Baptist Home Foundation and Vital Management Team.

Another component of the Office on Aging is the District of Columbia's Commission on Aging. This advisory board is comprised of 15 members appointed by the Mayor with the advice and consent of DC City Council and advocates on behalf of District seniors to ensure their concerns and needs are being met by DCOA and the District Government as a whole.

Community Supports and Services

From 2008 through 2012, more than 48,600 of the 103,483 seniors living in the District have received one or more core services funded by the DC Office on Aging. The top five most utilized services in 2012 were short and long-term counseling, home and congregate meals, transportation, long-term care case management, and health promotion and wellness (Figure 7.1).

Changing Demographics of an Aging Population

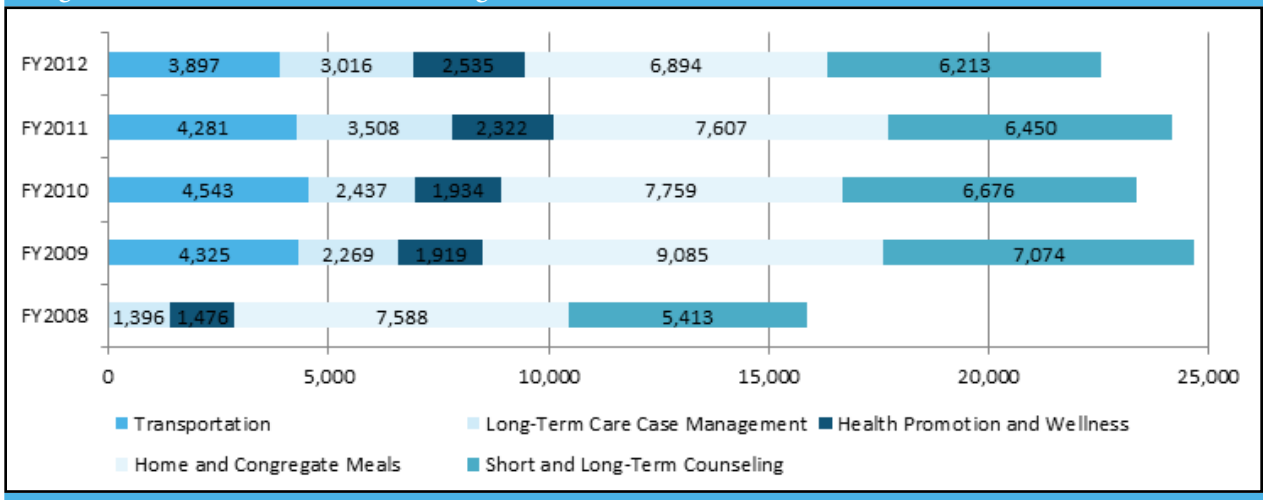
The District of Columbia has a growing population of 632,323 residents. From 2010 to 2012, the Census reported that the District's population increased by 17,000 persons. The population that is 60 years of age and older is

now 103,483, sixteen percent of the total population, with 11,003 persons 80 years of age. Overall, this is an increase of 1,696 older persons (1.5 percent increase) from the previous year.

Since 2006 (first year of the baby boomers turning 60), the population 60 years of age and older has increased by 1.6 percent each year. This trend is expected to continue over the next 15 years.

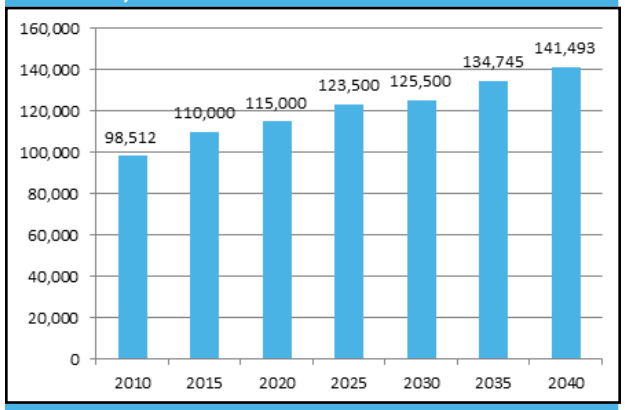
If current city demographic trends continue, the senior population will see the greatest growth from both ends of the age continuum; youngest seniors (60-69 years of age and older) and oldest seniors (85 years of age and older). It is projected by 2015, 110,000 persons (almost 17 per-

Figure 7.1. Number of Persons Receiving Core Services



Source: Office on Aging Customer Services Tracking and Reporting System, 2013

Figure 7.2. Persons 60 Years and Older by Actual and Projected Counts



Sources: Metropolitan Washington Council of Government Population Forecasts for Traffic Analysis Round 8.2, 35 Year Population forecasts at the traffic analysis zone (TAZ) level for the District of Columbia. Interim State Projections of Population for Five Year Age Groups and Selected Age Group: July 1, 2004 to 2030. US Census Bureau, Population Division, Interim State Population Projections, 2005

cent of the population) could be at least 60 years of age and older; this represents 1 out of every 7 residents in the District (Figure 7.2).

As the number of multicultural older adults with low-income increases, along with the surge in multiple chronic healthcare needs, DCOA is committed to expanding home and community-based programs. The agency also has a keen interest in the baby boomer population in helping them to stay active, remain healthy and live in the community for as long as possible.

New Programs and Initiatives

In FY 2011 and FY 2012, DCOA implemented the following new programs and services:

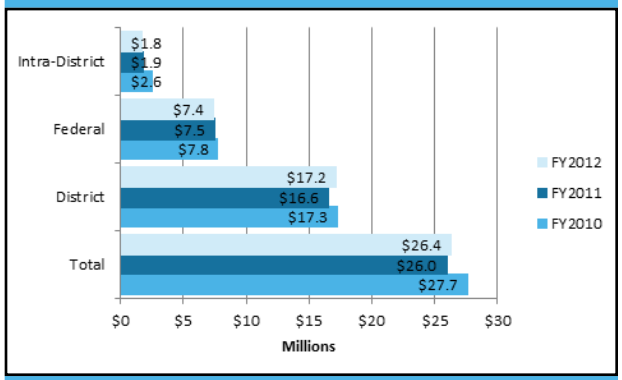
- ADRC launched a public awareness campaign entitled "Know Your Options Decide Your Future" to promote the importance of long-term care planning among DC residents. The campaign included advertisements on Metrobus, rail, and direct mail of more than 80,000 planning guides.
- The ADRC developed a user-friendly respite care database that is readily available on the DCOA's website and in print format to restore and strengthen caregivers' ability to continue providing care for their loved ones. The database assists in locating short-term relief to families and primary caregivers of children, persons living with disabilities and older adults by linking families to the online database of respite care providers.
- The ADRC conducted new Diabetes Self-Management Program (DSMP) workshops in senior housing buildings and senior wellness centers to promote healthy aging among residents. As a result, ADRC recruited and trained 18 Master Trainers for the DSMP and exceeded its goal of 52 workshops, with a total of 123 workshops.
- The ADRC formed the DC Healthy Aging Coalition (DCHAC), which is comprised of key leaders from organizations throughout the city with an interest in health promotion and/or aging. DCHAC's vision is that the District of Columbia will create and sustain programs, policies and environments to foster healthy aging and the health, well-being and independence of its citizens. The Coalition is a component of the Diabetes Self-Management Program in terms of the sustainability of the program and the promotion of a healthy living lifestyle beyond the grant period.
- The DCOA hosted the Mayor's First Annual Senior Symposium. It was a platform for our customers to express concerns and barriers while problem solve alongside government officials, health and human service providers and advocates. It was also an educational offering for participants to learn about issues such as the HIV/AIDS epidemic, Gay, Lesbians, Bisexual and Transgender (GLBT) issues, recreation and socialization, caregiver support, options counseling, and long-term care planning.
- The DC Long-Term Care Ombudsman Program succeeded in expanding the scope of its program. The program now includes monitoring the quality of care delivered in individual homes for residents receiving long-term care services through the DC Medicaid Elderly and Persons with Disabilities (EPD) Waiver. In addition, funding was secured for the program in the amount of $300,000 to carry out this new mandate.
- DCOA created the agency's first Ambassador Program. The goal of the program is to train volunteers as community representatives to educate and empower residents, particularly seniors, about the DCOA programs and services. As a result, there are currently 114 trained DCOA ambassadors throughout the city to educate seniors about our services.

Although DCOA has added new programs to its portfolio, seniors have also benefited from resources offered by other District agencies (DC Housing Authority, Metropolitan Police, DC Public Library, Department of Housing and Community Development, DC Fire and Emergency Services, Department of Human Services, Office of Tax and Revenue, Department of Parks and Recreation, Department of Motor Vehicles and the University of the District of Columbia).

Funding and Resources

In FY 2010, the spending for services to seniors under DCOA amounted to $27.7 million, which was comprised of $17.3 million in District funds, $2.6 million in Intra-District funds, and $7.8 million in federal funds. FY 2011, the spending for services to seniors under DCOA amounted to $26.0 million, comprised of $16.6 million in District funds, $1.9 million in Intra-District funds, and $7.5 million in federal funds. By 2012, spending for services amounted to $26.4, which included $17.2 million in District funds, $1.8 million in Intra-District funds and $7.4 million in federal funds (Figure 7.3).

Figure 7.3. DCOA Spending by Funding Source 2010-2012



Source: Office on Aging Budget, 2013

Agency Challenges

The federal cuts in spending due to sequestration pose a great risk to the District's economic and fiscal outlook, and could negatively impact funding for DCOA programs and services. In addition, there is a growing need for basic necessities of life such as food, healthcare, transportation and affordable housing for seniors, persons living with

disabilities and caregivers in the District of Columbia.

A very significant change in the senior population is rapidly approaching and will have a considerable impact on the ability of local and federal government agencies to provide services. In the District of Columbia, there is expected to be a sharper contrast between younger seniors, primarily baby boomers, who will have more education, more income in their work lives and larger pensions in their retirement as compared with older seniors (85+) who typically have less education and less income. Based on projected population growth, it is possible to have an entirely different set of needs identified for DCOA's customers in the next two decades as the number of baby boomers increases the pool of seniors, persons living with disabilities, and caregivers.

Accomplishments and Goals

In FY 2011 and FY 2012, DCOA's accomplishments included:

- The consolidation of the DCOA Headquarters and ADRC was the biggest accomplishment of the year. DCOA services needed to be centralized and this objective was realized. In addition, the agency saved an estimated $112,398 annually in rent payment for the ADRC location.
- DCOA worked with the Department of Real Estate Services (DRES) to transition the District's nursing home management contracts to long-term ground leases for the Washington Center for Aging Services and the JB Johnson Nursing Facility. For twenty years, the contracts presented a huge liability for the city and currently the facilities generate $2 million dollars of revenue annually and millions in savings from renovations and repairs.
- The Office on Aging administered the Senior Needs Assessment to better understand the needs of seniors in the District. This assessment helped the agency to recognize the needs of older adults, the current service delivery model and the gaps between the existing and necessary services. The results of the assessment shaped the development of Mayor Vincent Gray's New Community Living 5-Year Strategic Plan, providing a comprehensive framework for the agency to address various issues impacting the city seniors, persons living with disabilities, and their caregivers. The plan defines an overarching purpose and goals that will guide future work.
- The Office on Aging submitted and gained approval from the U.S. Administration on Aging for a new State Plan on Aging for Fiscal Years 2013-2015. The Plan outlines five goals and accompanying strategies to address the city's vision for modernizing the delivery of aging services.

DCOA strategic goals mirror those established by the U.S. Administration on Aging in its Strategic Action Plan for 2007-2013. The shared goals are listed below:

- Make it easier for older adults to access an integrated array of health, social supports and long-term care options.
- Promote home and community-based support services for older adults and caregivers.
- Empower older people to stay active and healthy through Older Americans Act services and the new prevention benefits under Medicare.
- Ensure the rights of older people and prevent their abuse, neglect and exploitation.
- Maintain effective and responsive management.

Through these goals, objectives, strategies and outcomes, DCOA and its Senior Service Network are moving towards a truly integrated system and is committed to meeting the new and existing demands of the senior population, including baby boomers, and keeping them in the communities that they know and love with the proper supports for as long as possible.

Office of Disability Rights

Mission

The mission of the Office of Disability Rights (ODR) is to ensure that every program, service, benefit, and activity operated or funded by the District of Columbia is fully accessible to, and usable by, people with disabilities.

Programs and Services

ODR is responsible for oversight of the District's obligations under the Americans with Disabilities Act (ADA) as well as other federal and local disability rights laws.

ODR provides technical assistance, training, informal dispute resolution, policy guidance, and expertise on disability rights issues to District agencies and the disability community.

ODR coordinates the ADA compliance efforts of all District agencies to ensure that the District is responsive to the needs of consumers, residents and employees with disabilities.

- Informal resolution of discrimination complaints
- Support District Government agencies to ensure ADA compliance
- Centralized Sign Language Interpretation Program
- Braille Translation Services
- Olmstead (community integration) planning
- Policy and budget recommendations to enhance District Government accessibility
- Training and technical assistance for District agencies, consumer and residents
- Support the DC Commission on Persons with Disabilities. Mayoral appointed body that advises the Mayor on issues of relevance to the disability community
- Other Local and Federal Civil Rights Laws; Fair Housing Act, Section 508 and more

The ADA is a civil rights law that protects people with different types of disabilities from discrimination in all aspects of social life. Title II of the ADA requires that all programs offered through the District of Columbia must be accessible to and usable by people with disabilities.

The ADA protects individuals with various kinds of disabilities. To be protected, a person must have a physical or mental impairment that substantially limits a major life activity. The person must also be qualified to participate in the job, program, or activity at issue.

The most notable rights under the ADA are…

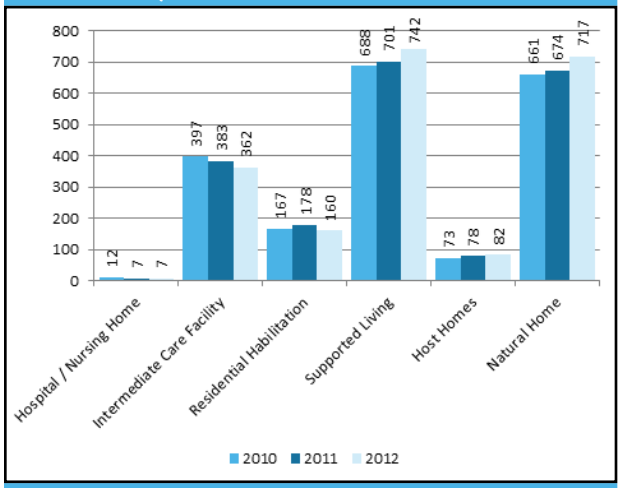
- No Exclusion
- Communications Access
- Programmatic Access
- Architectural Access
- Employment

To request training or file a disability rights complaint go to http://odr.dc.gov/ or call 202-724-5055.

Disabilty Services

The mission of the Department on Disability Services (DDS) is to provide innovative high quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces and communities in every neighborhood in the District of Columbia. DDS is composed of two Administrations that oversee and coordinate services for people with disabilities through a network of private and non-profit providers.

Figure 7.4. Developmental Disabilities Administration Facility Mix



Source: Department on Disability Services

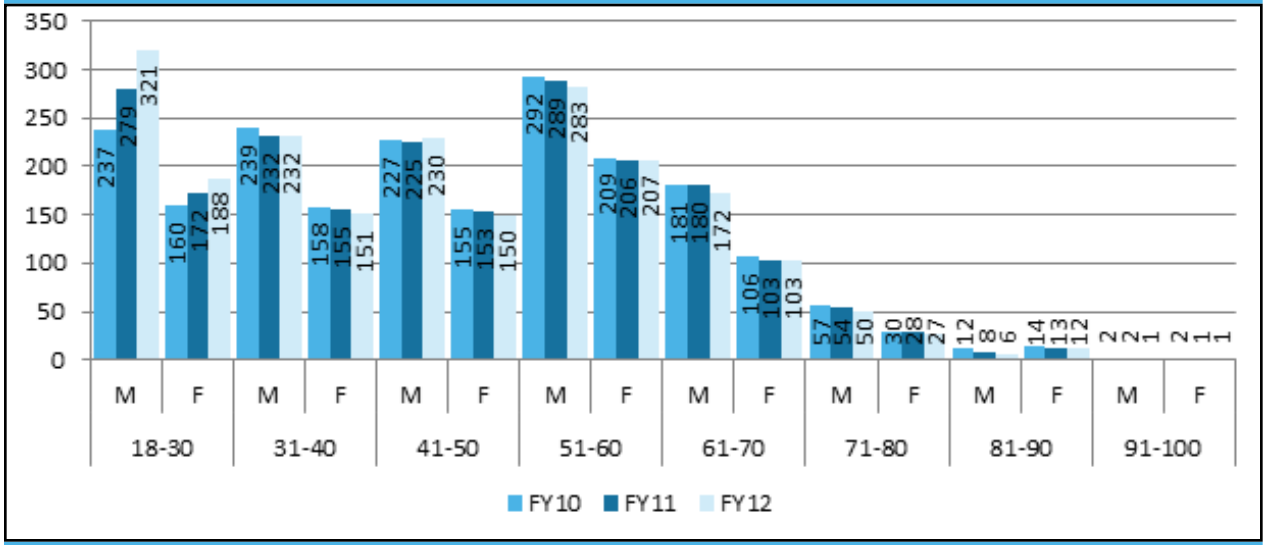
Developmental Disabilities Administration

The Developmental Disabilities Administration (DDA) ensures that people with intellectual and developmental disabilities receive the services and supports they need to lead self-determined and valued lives in the community. These services include needs assessment and evaluation, care coordination, transportation planning, community living services, quality assurance reviews, medical consultation and training, health monitoring and employment assistance. Recent initiatives aim to ensure the successful transition of Home and Community based Services (HCBS) waiver eligible persons with developmental disabilities, to community based settings. The data provided demonstrate the move from more restrictive living situations such as intermediate care facilities to less restrictive settings. (Figures 7.4 and 7.5)

Rehabilitation Services Administration

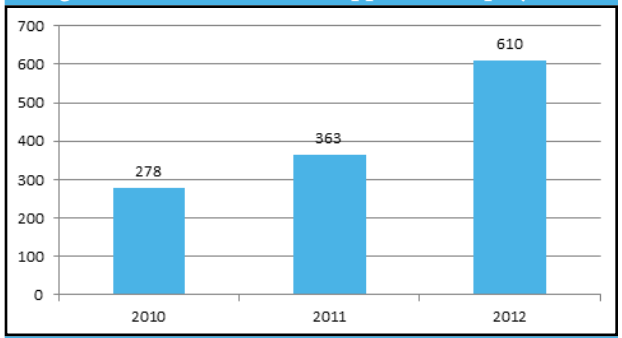
The Rehabilitation Services Administration (RSA) focuses on employment and independent living related services, ensuring people with disabilities achieve a greater quality of life by obtaining and sustaining employment consistent with their capability and informed choice, economic self-sufficiency and independence within their communities. RSA achieves this through offering an array of individualized services which include but are not limited to the following: counseling and guidance, employment and placement services, post-secondary education, vocational training, mental and physical restoration, assistive technology services, follow-up and inclusive business enterprises and supports for the DC Center for Independent Living. Recent initiatives include increasing the number of persons with disabilities who receive the supports necessary to obtain and maintain living wage employment in integrated settings as well as expanding the opportunities available for youth with disabilities by ensuring that they have Individualized Plans for Employment in place prior to graduation. (Figures 7.6 and 7.7)

Figure 7.5. Age and Sex of Individuals who Received DDA Services



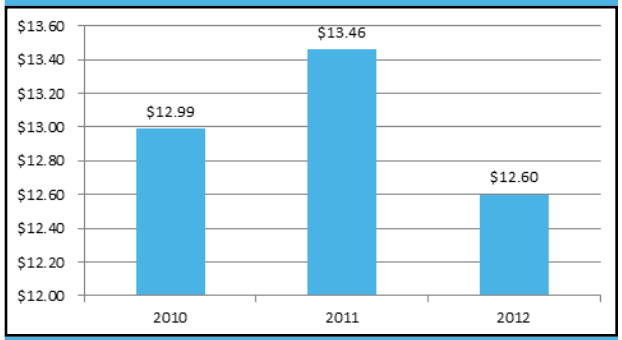
Source: Department on Disability Services

Figure 7.6. Individuals in Supported Employment



Source: Department on Disability Services

Figure 7.7. Average Hourly Wage for Individuals who achieve Competitive Employment through RSA



Source: Department on Disability Services

Child and Family Services Agency

Mission and Functions

In the District of Columbia, the Child and Family Services Agency (CFSA) is the public child welfare agency with the legal authority and responsibility to protect child victims, and those at risk, of abuse and neglect. Like public child welfare agencies across the nation, CFSA protects children through four core functions.

Take and Investigate Reports

CFSA Child Protective Services (CPS) is the gateway to the local public child protection system. CPS takes reports of known or suspected abuse and neglect of youngsters up to age 18 in the District 24 hours a day 365 days a year at 202-671-SAFE. When a report indicates a child has allegedly suffered abuse or neglect as defined in law at the hands of parents, guardians, or others acting in a parental capacity, CPS gets involved. (The Metropolitan Police Department investigates allegations of child abuse/neglect in the schools.)

Allegations of serious physical or sexual abuse get a full-blown investigation to determine whether they are true and if so, to identify the maltreated. However, the majority of reports are about child neglect. In instances where the risk to children is low, CFSA responds with a non-adversarial assessment that identifies family needs. When families agree to accept help, we connect them with other public or community-based services, safely diverting them from entering the child welfare system.

Strengthen Families

Child welfare is unique in that serving our primary clients—children—means helping their parents or caretakers. When CFSA identifies child victims of abuse or neglect, trained social workers from CFSA or private agencies under contract to CFSA step in to keep children safe by working with their families. We connect families to services that will help them overcome long-standing difficulties that endanger their children. About 60% of our cases involve social workers monitoring the safety and wellbeing of children in their homes. People interested in becoming foster or adoptive parents should call 202-671-LOVE.

Provide Safe, Temporary Homes for Children

When a child's home presents too much danger, CFSA has the authority to remove him/her to a safe setting. We must then gain agreement with our decision from the Family Court of the Superior Court of the District of Columbia. Our first choice is to keep families together by identifying a relative who will take the child and providing any support the relative needs. CFSA also recruits, trains, and licenses foster parents and also licenses, monitors, and maintains contracts with group homes (and other safe places) for children.

Children develop best within the bonds of a family. For that reason, removal of children from home is temporary. The goal is to help parents resolve crises and overcome difficulties so children can go home safely. However, when parents are unwilling or unable to protect their children, CFSA and Family Court must seek other permanent homes for them.

Ensure Children Have Permanent Homes

Everyone needs a family. CFSA recruits and trains people willing to adopt. Most local youngsters hoping to leave the child welfare system for an adoptive home are age 10 or older. Some want to be adopted with their brothers and sisters. People who adopt children from the public system are eligible for financial and other support. Legal guardianship is an alternative to adoption for relatives (or others) who want to provide a permanent home for children without legally terminating parental rights.

In addition to these standard child welfare functions, District child welfare has some distinguishing features.

- Both state-level and local child welfare functions are within CFSA.
- District child welfare is partially privatized, with private agencies under contract to CFSA managing about 60% of the caseload.
- Federal Court oversight continues as a result of the LaShawn lawsuit filed in 1989, with Children's Rights as plaintiff.
- Long-standing local statutes allow youth to remain in the system to age 21, if necessary (in contrast to age 18 in most states).
- More than half (52%) of the current foster care population is composed of youth age 13 or older.
- As with all social services agencies in the city, CFSA faces challenges associated with one of the highest percentages of children living in poverty—approximately 30% compared to 22% nationally.

Strategic Agenda

While the District has diligently reformed child welfare for more than a decade, recent events have dramatically accelerated progress. Under new leadership in 2012, CFSA and the local child-serving community developed and rallied around a strategic agenda known as the Four Pillars. It is a bold offensive to improve outcomes for children, youth, and families involved with District child welfare. Each pillar represents an area ripe for improvement and features a values-based foundation, set of evidence-based strategies, and series of specific outcome targets.

- Narrow the Front Door: Children have the opportunity to grow up with their families. We remove children from their families only when necessary to keep them safe.
- Temporary Safe Haven: Foster care is temporary. We start planning for a safe exit back to a permanent home from the moment a child enters care.
- Well Being: Every child is entitled to a nurturing environment that supports healthy growth and development, good physical and mental health, and academic achievement. Although the government can never be the optimal "parent," we take good care of children while they are in the system.
- Exit to Permanence: Every child and youth leaves foster care as quickly as possible for a safe, well-sup-

ported family environment or life-long connection. Older youth have the skills for successful adulthood.

A scorecard that tracks quarterly progress in achieving specific outcomes under the Four Pillars agenda is on the CFSA website at http://cfsa.dc.gov/.

Demand for Service

Child and youth victims and those at risk, of abuse and neglect come to CFSA attention via calls to the District's 24-hour hotline at 202-671-SAFE. Under District law, numerous child-serving professionals designated as "mandated reporters" must call whenever they know or suspect that a child or youth age 18 or younger is suffering maltreatment. Calls also come to the hotline from family members, neighbors, and other concerned citizens.

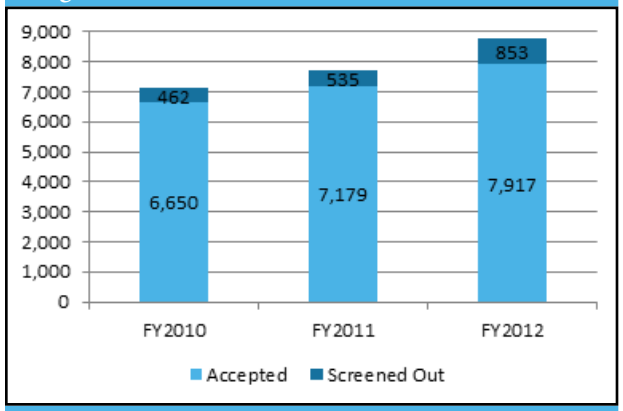
Over the last three years, calls to the hotline increased (Figure 7.8). One reason is that District law requires schools to report chronic truancy of children ages 5 to 13 to CFSA. As schools ramp up their compliance with this law, CFSA is receiving a rising volume of reports of educational neglect. At the same time, the total number of children and youth CFSA serves continued the steady decline that has been underway for a decade (Table 7.8). This reflects a national trend.

Table 7.8. Key Indicators of Demand for Services

Fiscal Year	New Investigations of Child Abuse/Neglect	Substantiations of Child Abuse/Neglect	Children Entering Foster Care	Total Children Served (Point in time: Last day of fiscal year)
FY2010	6,203	1,678	802	4,301
FY2011	6,653	1,498	604	3,753
FY2012	7,303	1,355	509	3,632

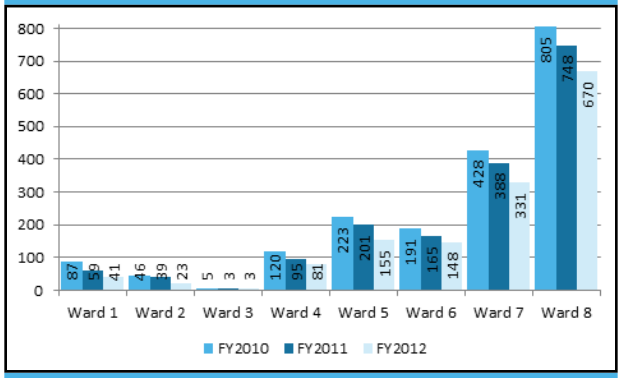
Source: DC Child and Family Services Agency

Figure 7.8. Hotline Calls



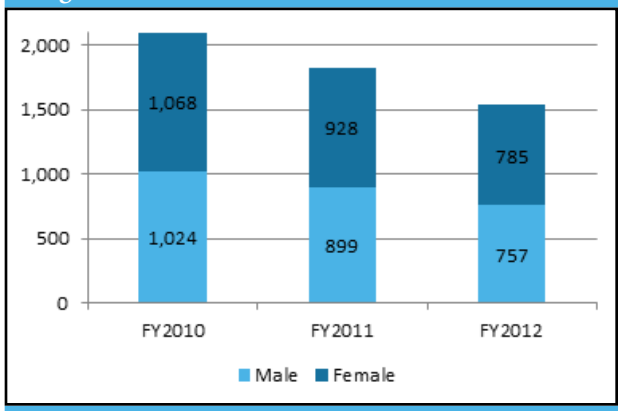
Source: DC Child and Family Services Agency

Figure 7.10. Home Ward of DC Children/Youth in Foster Care



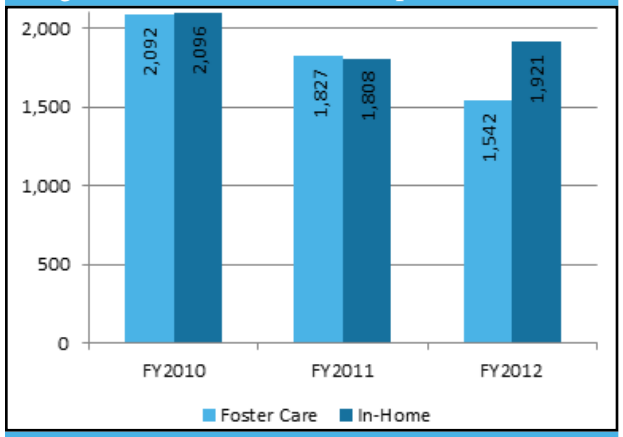
Source: DC Child and Family Services Agency

Figure 7.11. Gender of DC Children/Youth in Foster Care



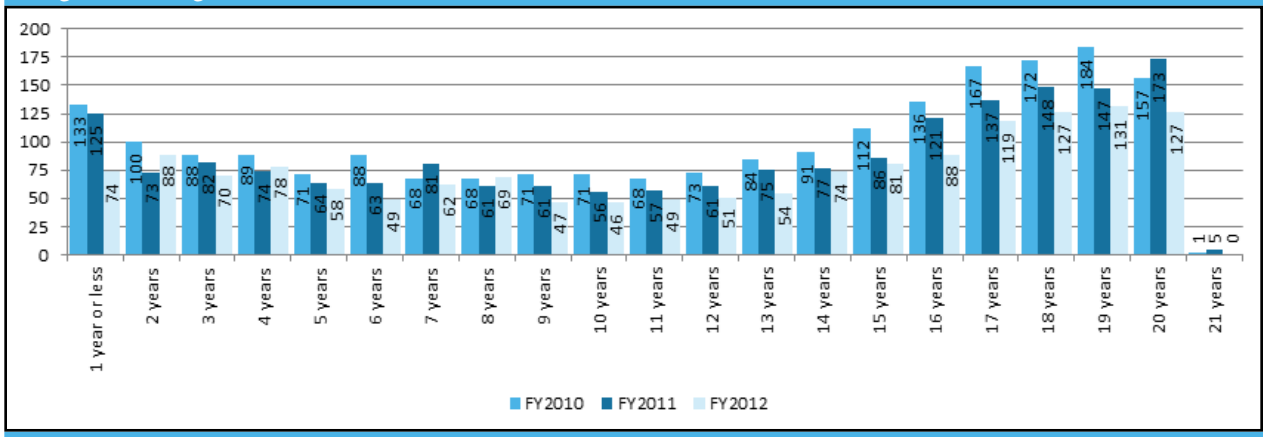
Source: DC Child and Family Services Agency

Figure 7.9. DC Child Welfare Population Trend



Source: DC Child and Family Services Agency

Figure 7.12. Age of DC Children/Youth in Foster Care



Source: DC Child and Family Services Agency

Child Welfare Population Trend

CFSA monitors children at home with their families (in-home cases) as well as children in foster care (out-of-home cases). In FY12, the number of in-home cases surpassed out-of-home (Figure 7.9). This is an early indication of success in pursuing the agency strategic agenda to "narrow the front door" safely. Whenever possible, children should grow up with their families. CFSA removes them only when they truly cannot be safe at home.

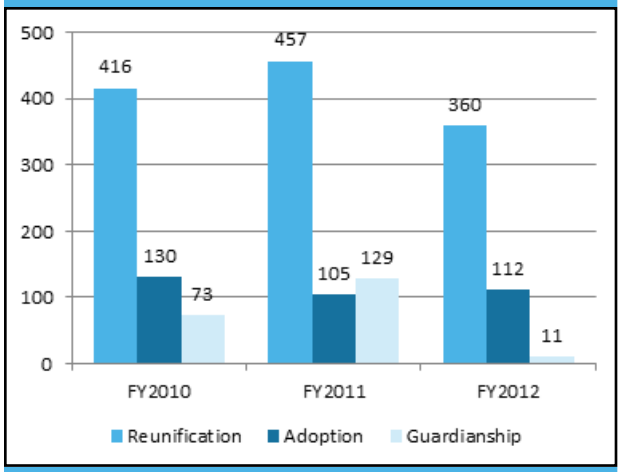
Demographics of Children and Youth in Foster Care

The majority of District children and youth entering foster care come from Wards 7 and 8 (Figure 7.10). The foster care population is about evenly divided between males and females (Figure 7.11), and more than half the caseload is composed of youth age 13 or older (Figure 7.12).

Exits from Foster Care

For many years, exits from foster care have exceeded entries. In FY12, 508 children and youth came into care and 767 left, for a ratio of 1:1.5. The outcome CFSA strives to achieve for every child or youth in care is an exit to a safe, nurturing, permanent home as quickly as possible. This can mean returning to parents (reunification), gaining a legal guardian (often a relative), or becoming part of new forever family via adoption (Figure 7.13).

Figure 7.13. Exits to Positive Permanence of DC Children/Youth in Foster Care



Source: DC Child and Family Services Agency

Department of Health

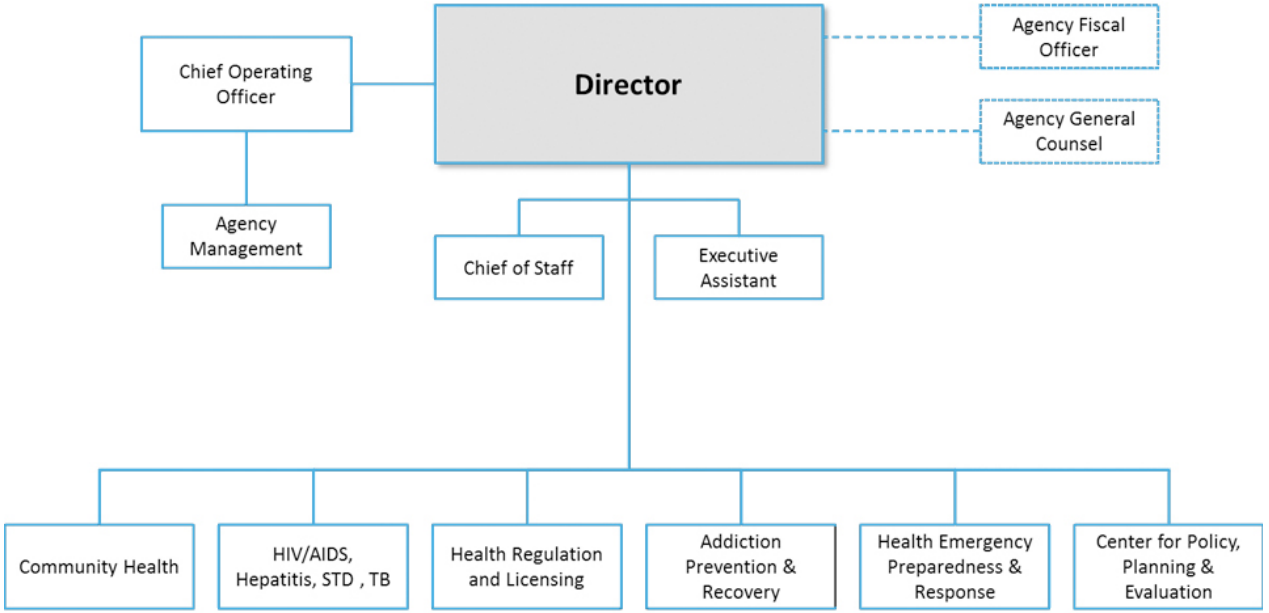
About the DC Department of Health

The Mission of the Department of Health is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. Our responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

The Department of Health is organized into six administrations and offices indicated in the organization structure below.

Administrations

- The Addiction Prevention and Recovery Administration (APRA) promotes access to substance abuse prevention, treatment and recovery support services. Prevention services include preventing the onset of alcohol, tobacco, and other drug use by children and youth, reducing the progression of risk and increasing protective factors that increase the likelihood of healthy, drug-free youth and their families. Treatment services include assessment and referrals for appropriate levels of care and maintenance of a comprehensive continuum of substance abuse treatment services including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy. Recovery support services include wrap-around services such as mentoring services, education skills building and job readiness training, to ensure a full continuum of care. APRA ensures the quality of these services through its regulation and certification authority as the Single State Authority for substance abuse treatment services.
- The Center for Policy, Planning, and Evaluation (CPPE) Administration's mission is to assess health issues, risks and outcomes through data collection, surveillance, analysis, research and evaluation; perform state health planning functions; and to assist programs in the design of strategies, interventions and policies to prevent or reduce disease, injury and disability in the District of Columbia. Services include birth and death certificates; Certificate of Need; Behavioral Risk Factor Surveillance (BRFSS) data; Occupational injuries, illnesses, and death statistics.
- The mission of the Community Health Administration (CHA) is to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members. The mission is also to provide chronic and communi-



cable disease prevention and control services, community-based forums and grants, expert medical advice, health assessment reports, and pharmaceutical procurement and distribution, disease investigations and disease control services to District residents, workers and visitors so that their health status is improved.

- The Health Emergency Preparedness and Response Administration (HEPRA) provides accurate and timely information about the prevention and control of biological threats to the residents of the District of Columbia. HEPRA is responsible for the preparedness of the city, which includes Bioterrorism resources, children and disease, Homeland Security Advisory Systems; resources for health care, for example, disaster preparedness providers and biological and chemical agents; and emerging infectious diseases like pandemic influenza.
- The HIV/AIDS, Hepatitis, STD and TB Administration (HAHSTA) is the core District government agency to prevent HIV/AIDS, STDs, Tuberculosis and Hepatitis, reduce transmission of the diseases and provide care and treatment to persons with the diseases. HAHSTA partners with health and community-based organizations to offer testing and counseling, prevention education and intervention, free condoms, medical support, free medication and insurance, housing, nutrition, personal care, emergency services, and direct services at its STD and TB Clinics and more for residents of the District and the metropolitan region. HAHSTA administers the District's budget for HIV/AIDS, STD, Tuberculosis, and Hepatitis programs, provides grants to service providers, monitors programs, and tracks the incidence of HIV, AIDS, STDs, Tuberculosis and Hepatitis in the District of Columbia.
- The mission of the Health Regulation and Licensing Administration (HRLA) is to administer all District and Federal laws and regulations governing the licensing, certification and registration of Health Professionals, Health Care Facilities, Food, Drug, Radiation and Community Hygiene Services. HRLA enforces all District and federal laws and regulations which govern licensure and regulations which protect the health, safety and environment District residents. Programs include: the Office of Compliance and Quality Assurance; Office of Health Professional Licensing Boards: Division of Medical Boards, Division of Nursing Boards, Division of Allied Health Board, Division of Pharmacy Boards; The Office of Health Care Facilities; Office of Food, Drug, Radiation and Community Hygiene: Division of Food, Division of Drug, Division of Radiation, The Division of Community Hygiene and The Branch of Animal Disease Control.

Community Health Administration

Children's National Medical Center School Health Nursing Program

Children's School Services, Health Suite Visits, School Year (SY) 2010 – 2011

Table 7.9. Children's School Services, Utilization data for all nursing suites, broken down by school, SY 2010-2011, Total–All Schools

	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Summer 2011	YTD Total
Student Encounters DCPS	27,145	14,048	17,837	11,063	15,189	16,588	23,117	14,434	22,123	10,796	9,437	181,777
Student Encounters PCS	6,321	4,529	6,009	3,603	5,330	6,178	8,334	5,697	7,150	2,781	2,264	58,196
Total Student Encounters	33,466	18,577	23,846	14,666	20,519	22,766	31,451	20,131	29,273	13,577	11,701	239,973

Source: DC Department of Health, Community Health Administration

Table 7.10. Public School Enrollment by Ward SY 2010-2011

	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Summer 2011	YTD Total
Ward 1	2,990	1,844	2,179	1,323	1,666	1,869	2,238	1,431	2,301	1,083	1,135	20,059
Ward 2	2,324	785	1,124	712	960	1,094	1,391	904	1,257	687	438	11,676
Ward 3	3,524	1,668	1,907	1,303	1,921	1,928	2,619	1,688	2,577	1,471	663	21,269
Ward 4	3,630	1,969	2,646	1,640	2,208	2,347	3,306	2,030	3,218	1,638	1,211	25,843
Ward 5	4,929	2,726	3,240	2,024	2,601	2,842	4,106	2,515	3,712	1,889	1,427	32,011
Ward 6	2,904	1,614	1,808	1,126	1,581	1,753	2,373	1,487	2,036	1,128	1,532	19,342
Ward 7	2,362	1,243	1,753	1,175	1,566	1,868	2,797	1,766	2,879	1,188	1,454	20,051
Ward 8	4,482	2,199	3,180	1,760	2,686	2,887	4,287	2,613	4,143	1,712	1,577	31,526
Elementary Schools	3,314	2,741	3,428	1,888	2,865	3,110	4,067	2,606	3,532	1,714	1,072	30,337
Secondary Schools	3,007	1,788	2,581	1,715	2,465	3,068	4,267	3,091	3,618	1,067	1,192	27,859

Source: DC Department of Health, Community Health Administration

The Children's School Health Nursing Program is responsible for the collection and submission of student health related data and statistics on a monthly and annual basis. This annual report has been compiled inclusive of information collected under the management and supervision of the Children's School Services leadership team. In FY10, Health Masters, a school-based electronic health records (EHR) system was implemented in DC public and public charter schools that participate in the DOH School Nursing Program.

School nurses promote a healthy school environment and provide for the physical and emotional safety of the school community. School nurses are trained to assist students with asthma or other allergies. DC Public Schools collaborate with the Department of Health/Community Health Administration and Children's National Medical Center to ensure that each DCPS school has nursing coverage during the school year and during the summer if

Table 7.11. Type of Services broken down by School Year Period (School Year 2010-2011)

Nurse Services	Sept 10	Oct 10	Nov 10	Dec 10	Total
Catheterization	187	129	139	95	550
Diabetes Care	662	519	541	352	2,074
Gastrostomy: Tube Feeding	104	62	48	45	259
Medication Administration (Doses)	1,378	1,384	1,754	1,301	5,817
Ostomy Care	127	91	117	97	432
Tracheostomy: Suctioning	26	14	36	14	90
Total	**2,484**	**2,199**	**2,635**	**1,904**	**9,222**

Source: DC Department of Health, Community Health Administration

Table 7.12. FY2011 Nursing Services by Type

Nursing Services	Totals
Catheterization	16,308
Diabetes Care	60,809
Gastrostomy: Tube Feeding	3,280
Medication Administration (Doses)	5,037
Ostomy Care	1,954
Tracheostomy: Suctioning	31,478
Total	134,226

**Note: Children's School Services (CSS) data collection method changed over the last two school years due to both DCPS and charter school nurses are now using the electronic health record (Health Office). Last SY 2010-2011 CSS utilized 2 data systems and data from both were merged into one report. As such, CSS was limited to the field data fields that could be reported because the two systems were not congruent.*

Source: DC Department of Health, Community Health Administration

Table 7.13. Number of Health Education Sessions Attendees broken down by School Year Period (School Year 2010-2011)

Subject/Topic	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Total
Abuse Prevention	643	294	1,199	960	792	1,508	1,284	694	967	1,079	9,420
Asthma/Respiratory	1	0	27	0	28	1	255	42	176	6	536
Career Choices	170	0	142	0	30	0	85	0	47	15	489
Dental Care	103	163	231	497	981	1,198	1,272	87	1,850	641	7,023
Health Maintenance	215	109	432	281	587	571	676	177	1,958	109	5,115
HIV / STD Education/Family Planning	463	95	513	1,157	574	1,321	492	154	370	24	5,163
Human Anatomy	0	82	105	252	15	70	0	98	106	0	728
Human Growth and Development	3	123	100	263	509	103	207	147	735	155	2,345
Hygiene	897	523	560	292	937	919	446	434	597	75	5,680
Nutrition	623	385	729	189	676	570	546	856	351	158	5,083
Personal Choices/Decision Making	134	0	138	57	187	30	0	42	0	91	679
Pre/Post Natal Care	15	75	44	9	0	104	37	17	12	15	328
Safety	168	441	118	180	70	413	212	94	426	250	2,372
Substance Abuse Prevention Education (SAPE)	0	172	101	76	300	701	620	908	1,295	654	4,827
Total - All Education Session Attendees	3,435	2,462	4,439	4,213	5,686	7,509	6,132	3,750	8,890	3,272	49,788

Source: DC Department of Health, Community Health Administration

DCPS summer school is in operation at the school site. (Tables 7.9-13)

Immunization Services

The Immunization Program is located in the Department of Health's Community Health Administration (CHA). The Immunization Program was established to prevent and control vaccine-preventable diseases among District residents. The Immunization Program provides free immunization services to all medically uninsured and under-insured residents of the District. The mission of the program is to reduce and eliminate morbidity and mortality due to vaccine-preventable diseases in the District of Columbia. The goal of the program is to improve and maintain high immunization levels in children and adults, with particular emphasis on children less than two years of age.

Vaccines also provide great cost benefits by decreasing the economic impact associated with vaccine-preventable diseases, such as costs related to doctor's visits, hospitalizations, parent's loss of time from work and premature deaths. Since 1979, the District of Columbia has required children attending school and daycare to be fully immunized. Vaccination rates for children 19-35 months old have increased dramatically since 2003 (Table 7.14).

WIC, Special Supplemental Nutrition Program for Women, Infants and Children

WIC provides nutrition education and counseling, breastfeeding promotion and support, medical and social services referrals, and nutritious food. WIC food packages are designed to meet the nutritional needs of pregnant women, breastfeeding mothers, infants, and young children. WIC is a gateway to health care and social services. WIC promotes physical activities and plays an important role in achieving the national goals of improving maternal and child health, reducing infant mortality, ending childhood hunger by 2015, improving breastfeeding rates, reducing child abuse, and reducing obesity and chronic diseases.

To qualify for WIC, applicants must meet residential, categorical, income, and nutrition risk eligibility requirements to qualify for the program. Requirements include:

- Women to be pregnant or breastfeeding, a new mother, an infant, or a child up to age 5;
- Live in the District of Columbia (US Citizenship is not required);
- Have a nutritional or medical risk (determined by a health professional); and
- Fall within 185% of the Federal poverty guideline, or participate in Medicaid, DC Healthy Families, School Lunch Program, Temporary Assistance for Needy Families (TANF), or the Supplemental Nutrition Assistance program (SNAP).

A number of studies have found that WIC participation during pregnancy is associated with improved birth outcomes and reductions in maternal and newborn health care costs after birth. In contrast to the large body of literature examining the effects of WIC participation during pregnancy, fewer studies have focused on the effects of WIC participation on children. By far the most common birth outcome examined in the literature is newborn birth weight, and most studies find a significant effect of prenatal WIC participation on birth weight.

The mission of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which is funded and administered by the United States Department of Agriculture, is to improve the lifelong health and nutrition of pregnant women, new mothers (breastfeeding and non-breastfeeding), infants and children up to age 5 who are at nutritional risk by providing individualized nutrition education, breastfeeding promotion and support, tai-

Table 7.14. Immunization Compliance Levels in DC Using the Immunization Registry: Includes Routine, Catch-up, and Exemptions

				Non-Public Schools (Assessments start at the Beginning of the SY August through June)		
	Licensed Child Development Centers	Head Start Centers	Public Schools	Private	Charter	Parochial
2003	63.11%	59.35%	84.44%	79.58%	74.68%	55.81%
2004	67.33%	66.66%	90.88%	79.50%	84.76%	59.81%
2005	69.60%	74.78%	95.05%	84.10%	90.94%	74.70%
2006	71.73%	83.03%	96.32%	83.71%	91.32%	78.68%
2007	74.27%	81.42%	97.32%	85.04%	94.47%	78.67%
2008	93.03%	97.15%	97.94%	88.62%	96.25%	78.25%
2009	91.02%	91.75%	98.21%	88.77%	95.55%	79.74%
2010	90.84% (Dec 2010)	90.71% (June 2010)	89.97%	67.43%	83.11%	50.03%
2011	91.97% (Dec 2011)	89.06% (6/30/2011)	92.85% (6/30/2011)	79.39% (6/30/2011)	89.36% (6/30/2011)	67.14% (6/30/2011)
2012	91.64% (Dec. 2012)	91.09% (6/27/2012)	92.91% (6/28/2012)	80.65% (6/27/2012)	87.25% (6/28/2012)	73.23% (6/27/2012)

**1997-2008: Preschool - 4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella; School-Age - 5 DTaP, 4 Polio, 2 MMR, 3 Hep B, 2 Varicella, 1 10-year Td*
2009-2012: Preschool - 4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, 4 Pneumococcal Conjugate, 2 Hepatitis A.; School-Age - 5 DTaP, 4 Polio, 2 MMR, 3 Hep B, 2 Varicella, 1 Tdap, 1 Meningococcal, and HPV for girls entering the 6th grade

Source: DC Department of Health, Community Health Administration, Bureau of Child, Adolescent & School Health

lored nutrient-rich supplemental food packages that supply adequate levels of nutrients essential to prenatal and infant health, proper growth and development, and social service referrals and immunization screening for children less than two years of age. Comprehensive revisions to the WIC food packages, including adding fresh produce, were implemented by October 1, 2009.

Research shows that participation in the WIC program saves from $1.77 to $3.13 in health care costs for every infant within the first 60 days after birth and is responsible for the following improved health outcomes: improved birth outcomes, improved diet and diet-related outcomes, improved feeding practices, improved cognitive development, improved rates of childhood immunization due to having a regular source of medical care and improved preconception nutrition for women.

DC WIC served approximately 19,029 customers monthly at 20 clinics and four mobile unit sites in 2012 (Table 7.15).

Table 7.15. Average Monthly Enrollment of Women, Infants and Children

Year	Women	Infants	Children	Total
2003	4,820	4,178	9,775	18,773
2004	5,146	4,210	9,910	19,266
2005	5,279	4,285	9,795	19,359
2006	4,789	4,789	7,998	17,576
2007	4,845	5,310	7,034	17,189
2008	5,128	5,645	7,728	18,501
2009	5,157	5,657	8,782	19,596
2010	4,868	5,505	8,852	19,225
2011	4,719	5,404	8,949	19,072
2012	4,835	5,398	8,796	19,029

Source: DC Department of Health, Community Health Administration

Supplemental Nutrition Assistance Program-Education (SNAP-Ed)

The mission of the Supplemental Nutrition Assistance Program: Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed) is to provide nutrition education to residents of the District of Columbia that will help them make healthy food choices that are consistent with the Dietary Guidelines for Americans and My Pyramid and My Plate. The program is funded and administered by the United States Department of Agriculture.

Services

SNAP-Ed provides services where at least 50% of populations have gross incomes at or below 185% of poverty. Our services include interactive nutrition education classes, food/cooking demonstrations, and information booths at health fairs and farmers' markets. Our nutrition education topics include:

- Understanding the My Pyramid/My Plate
- Benefits of Physical Activity
- Obesity Prevention and Reduction
- Reading and Understanding Food Labels
- Meal planning and budgeting

SNAP-Ed Partners

Our DC partners include DC Public Schools, Public Chartered Schools, Day Care Centers, Senior Centers, Covenant House, Recreation Centers, churches and many other community outreach programs. They organize and promote SNAP-Ed activities within the community.

DC SNAP-Ed data collection started in 2004. The University of District of Columbia (UDC) and later, Capital Area Food Bank (CAFB) became sub-contractors. Tables 7.16-19 include both direct and indirect (e.g. health fairs) contacts.

SNAP-Ed Participants - Each individual counts as one participant, regardless of the number of times he or she has participated in direct education activities.

A **"SNAP-Ed contact"** is defined as an interaction in which a SNAP-Ed participant participates in a direct education activity. Each SNAP-Ed participant may have one or more SNAP-Ed contacts.

Table 7.16. Number of SNAP-Ed Contacts

Year	Agency	Total	Monthly Average
2004	DOH	4,480	373
2005	DOH+UDC	11,1132	9,261
2006	DOH+UDC	136,570	11,381
2007	DOH+UDC+CAFB	127,855	10,655
2008	DOH+UDC+CAFB	161,952	13,496

Source: DC Department of Health, Community Health Administration

Table 7.17. Number of SNAP-Ed Unduplicated participants

Year	Agency	Total	Monthly Average
2009	DOH+UDC+CAFB	15,276	1,273

Source: DC Department of Health, Community Health Administration

Table 7.18. Education and Administrative Reporting System (EARS) in FY 2010, Average Monthly number of SNAP-Ed participants (direct education)

Year	Less than 5 Years	5-17 Years Grades K-12	18-59 Years	60 Years or More	All Ages Combined
2010	292	478	1,032	525	2,327
2011	205	481	899	555	2140
2012	2,614	228	145	224	3,211

Source: DC Department of Health, Community Health Administration

Table 7.19. Education and Administrative Reporting System (EARS) in FY 2010, Average Monthly number of SNAP-Ed contacts (direct education)

Year	Less than 5 Years	5-17 Years Grades K-12	18-59 Years	60 Years or More	All Ages Combined
2010	3,337	4,297	11,380	4,642	23,656
2011	2,458	3,423	9,745	4,846	20,472
2012	27,964	912	145	400	29,421

Source: DC Department of Health, Community Health Administration

HIV/AIDS, Hepatitis, STD, & TB Administration

Mission

The HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA) within the District Department of Health holds primary responsibility for monitoring the occurrence of the infections/diseases referenced in the name of the agency, as well as responsibility for the coordination and implementation of related evidence-based prevention and treatment strategies.

Guided by multiple national and local strategic, program planning, and policy documents, the primary goals for HAHSTA focus on:

- Reducing the number of new HIV, Hepatitis, STD, and TB infections in the District;
- Increasing access to care and treatment services;
- Reducing health disparities and health inequities; and
- Achieving a more coordinated response to address local needs.

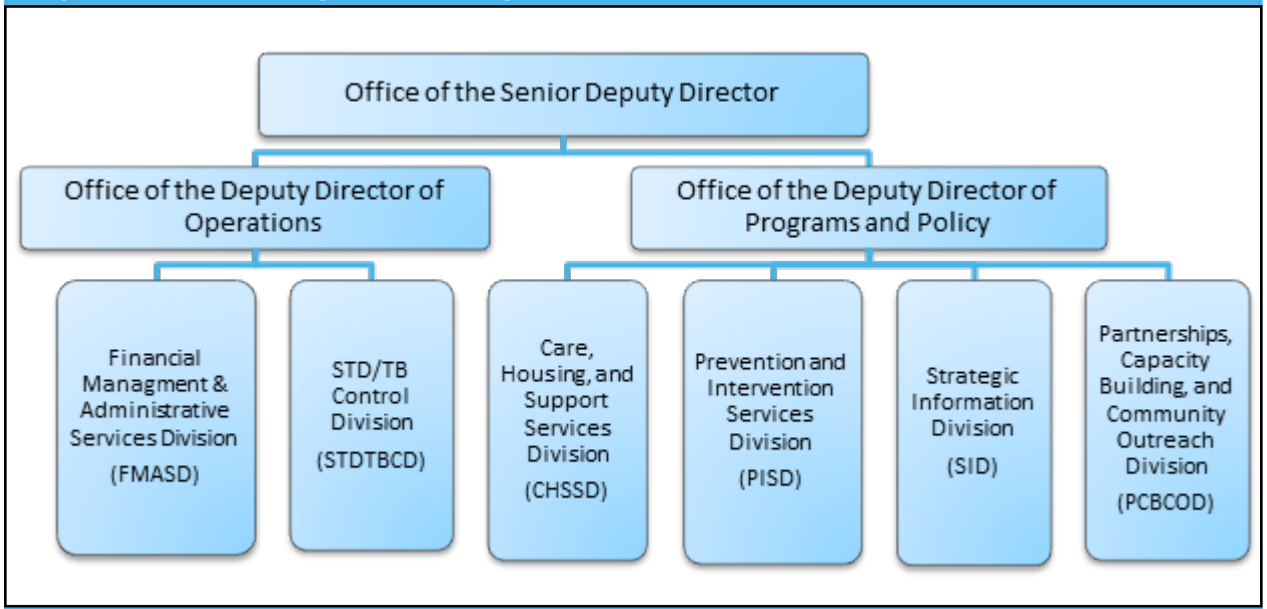
The multifaceted approach implemented by HAHSTA to achieve the stated goals incorporates activities directed toward increasing the efficacy within target populations to engage in preventive health behaviors, as well as in accessing needed testing, care, treatment, and ancillary support services. HAHSTA partners with a diverse range of clinical providers and community-based organizations throughout the District of Columbia metropolitan region to ensure that all segments of the population are reached through the programs and services funded by HAHSTA initiatives.

More information concerning the mission and goals for the HIV/AIDS, Hepatitis, STD, and TB Administration is outlined in the recent report, Ending the Epidemic: The District of Columbia HIV/AIDS Implementation Plan, available at http://doh.dc.gov/service/hivaids.

Organizational Structure

As represented by the red boxes in Figure 7.14, HAHSTA is comprised of the following five programmatic and service divisions: STD &TB Control; Prevention and Intervention Services; Care, Housing, and Support Services; Partnerships, Capacity Building, and Community Outreach; and Strategic Information. The alignment of these Divisions under one administration is designed to promote integrated surveillance, programmatic, and policy activities across disease areas, maximizing the effective coordination and utilization of resources in addressing HIV, STD, Hepatitis, and TB related syndemics within the District.

Figure 7.14. HAHSTA Organizational Diagram



Source: HAHSTA

Overview of HAHSTA Programs & Activities

As the administrative body providing oversight for the District's budget supporting HIV/AIDS, Hepatitis, STD, and TB related activities, HAHSTA manages a diverse portfolio of prevention, treatment, and care programs primarily implemented through strategic partnerships with community-based providers and organizations. Designed to address population needs identified through epidemiologic analysis, specialized studies and evaluations, and community input, funded programs include social marketing; condom distribution; testing and counseling services; subsidized medical and prescription services; emergency care; housing; and other ancillary support services. In addition, HAHSTA also provides direct services through agency run clinics supporting STD screening and treatment and TB control. While some activities are disease specific, considerable effort has been directed toward integrating prevention and treatment strategies to better reflect the syndemic nature of the infections targeted by HAHSTA supported programs and services.

Social Marketing & Condom Distribution

As a primary prevention strategy, HAHSTA has directed substantial resources towards increasing awareness concerning effective methods for preventing HIV and other sexually transmitted infections, and promoting the acceptability and accessibility of effective preventive measures. Social marketing campaigns such as "DC Takes on HIV", "Join the Rubber Revolution", and "DC's Doin' It" are based on multi-media approaches incorporating traditional advertising (e.g., print, radio, and television), social media (e.g., internet-based advertising, Facebook, and Twitter), and consumer/provider focused educational materials (e.g., brochures, posters, and palm cards). Through this mix of marketing, communication, and educational mediums, HAHSTA is able to maximize the reach of HIV and STD prevention messaging within the general population, as well as target sub-populations such as gay or bisexual men, older adults, and youth. Such campaigns also maximize population reach through the utilization of non-traditional advertising venues (e.g., bars, laundromats, and check cashing facilities), and through the devel-

opment of materials in multiple languages.

While some of the social marketing campaigns supported by HAHSTA direct attention toward testing and treatment, the promotion of condom utilization is a common focus among the campaigns previously mentioned. Complimenting efforts to promote the use of male condoms, the HAHSTA social marketing campaign "DC's Doin' It" represents the first campaign ever developed and implemented to educate and promote use of the FC2 female condom.

In order to ensure that individuals have access to effective methods for preventing HIV and STD infections, The Condom Distribution Program within HAHSTA supplies latex and non-latex male condoms, water-based lubricant, FC2 female condoms, and latex dental dams to over 530 community partners in the District for distribution at no costs to individuals. Additionally, individuals can order condoms directly from HAHSTA at no cost through the Department of Health website. The demand and distribution of condoms through this program has grown substantially in recent years in part due to the expansion in the number of community partners, as well as increased outreach through social marketing campaigns.

Table 7.20. HAHSTA Condom Distribution Program, District of Columbia Fiscal Year 2009-2012

	2009	2010	2011	2012
Total Number of Condoms Distributed	3,219,446	3,955,940	5,186,340	5,747,000

Source: Partnerships, Capacity Building, and Community Outreach Division, HAHSTA

HIV Counseling, Testing, & Referral

In order to increase the proportion of the population aware of their HIV status, HAHSTA has directed efforts towards expanding the provision of HIV testing in both clinical and non-clinical settings through educational, programmatic, and policy initiatives. Early diagnosis is not only important for optimizing health outcomes among infected individuals, but is also an essential component in disrupting transmission.

The number of publicly supported HIV test conducted in the District increased nearly 50% between fiscal years 2009 and 2012 (Table 7.21). During this time period, HAHSTA not only provided direct funding to multiple organizations to provide HIV counseling and testing services, but also distributed oral rapid HIV test kits to an expansive network of clinical and community-based providers in order to promote routine HIV testing. This network included multiple non-traditional testing sites including the District Department of Motor Vehicles and the District Department of Human Services. Supplementing this effort to expand accessibility to HIV testing services, HAHSTA also manages the "Ask for the Test" and the "We Offer the Test" campaigns designed to increase the demand for testing among consumers and the provision of testing services among providers.

Another cornerstone of the effort to increase the number of individuals receiving HIV testing services is the promotion of routine, opt-out HIV testing as a standard of care within clinical facilities through academic detailing and efforts to improve the sustainability of services by supporting the establishment of the needed mechanisms and structure for third party reimbursement of HIV testing services.

Table 7.21. HAHSTA Funded HIV Testing, District of Columbia Fiscal Year 2009-2012

	2009	2010	2011	2012
Total HIV Tests Completed	92,748	110,358	122,356	138,317

Source: Prevention and Intervention Services Division, HAHSTA

Ryan White HIV/AIDS Program

The Care, Housing, and Support Services Division (CHSSD) within HAHSTA serves as the grantee for Ryan White Part A, Part B and HOPWA services in the eligible metropolitan area (EMA). Programs within CHSSD include:

- *Part A* **(Grants to Eligible Metropolitan Areas and Transitional Grant Areas)** provides emergency assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely affected by the HIV/AIDS epidemic. Part A funds are used for persons living with HIV/AIDS (PLWHA) who are uninsured, underinsured, or underserved to ensure access to core medical and support health services that enhance access to care; maintain clients in care, particularly primary care services; and ensure continuity of care.
- *Part B* **(Grants to States and Territories)** provides a base grant to supplement core medical and support services, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, and grants to States for Emerging Communities.
- *Minority AIDS Initiative* (MAI) **(Grants for disproportionally impacted communities)** grants are provided to address the HIV/AIDS care needs of minority communities. In the DC metropolitan region, MAI funds are provided to the grantees under Parts A and B to DC, MD, and VA. The District also receives MAI funds through Part D.
- *AIDS Drug Assistance Program* (ADAP) in the District provides access to HIV related medications for low-income individuals with infected with HIV who have limited or no coverage from private insurance or Medicaid.
- *Housing Opportunities for Persons with AIDS* (HOPWA) funding provides housing assistance and related supportive services. HOPWA funds are used for a wide range of housing, social services, program planning, and development costs.

CHSSD is committed to ensuring that all clients across the EMA are provided equal, accessible, and quality HIV medical, treatment, housing, and health-related services. Sub-grantee performance is systematically measured and monitored to assess the extent to which service providers achieve key health outcomes for HIV-positive patients, and used to make data-driven decisions to enhance services provided to HIV-infected individuals. Sub-grantee performance data are collected through several reports, including the Ryan White Services Report (RSR) and Quality Management Report.

The RSR contains client-level data that include information on demographic status, HIV clinical information, and core medical and support services delivered with Ryan White funds. The RSR data presented provide a demographic profile of those utilizing Ryan White services in the District, including current age, gender, race, and risk factor/mode of transmission. Ryan White services are dependent on eligibility; therefore, it should not be expected that everyone living with HIV/AIDS in DC would be eligible for and/or receiving Ryan White services.

The number of clients utilizing Ryan White services varies year to year and is expected to continue to change due

to Medicaid expansion and the implementation of the Affordable Care Act. Persons between 45-64 years of age account for the most (54 percent) of those receiving services. Adolescents and young adults (ages 13–24) account for 6 percent of those receiving services (Table 7.22). The age distribution of those receiving services is similar to those living with HIV/AIDS in the District. Males comprise the majority of those utilizing Ryan White funded services, accounting for 62% percent of all services in 2012. Transgender persons make up 3 percent of those receiving services (Table 7.23). Blacks (includes African-born) account for 70 percent of those receiving services in the District (Table 7.24). Table 7.25 shows that heterosexual contact in the primary mode of transmission among those receiving Ryan White services, accounting for 22 percent of the service population. Additionally, MSM account for 17 percent of the service population.

The Quality Report is comprised of a portfolio of nationally endorsed indicators. The measures are used to evaluate key aspects of care and support services that are optimally linked to better health outcomes. Data are used to doc-

Table 7.22. Age Breakdown for CARE Act Clients, 2010-2012

	2010		2011		2012	
Age group	**Number**	**%**	**Number**	**%**	**Number**	**%**
<2	22	0.3%	34	0.3%	86	0.9%
2 to 12	205	2.5%	292	2.4%	83	0.8%
13 - 24	833	10.2%	1287	10.5%	576	5.9%
25 - 44	3136	38.6%	4317	35.3%	3,459	35.3%
45 - 64	3666	45.1%	5871	48.1%	5,277	53.8%
65 & >	258	3.2%	412	3.4%	326	3.3%
Unknown	10	0.1%	35	0.3%	-	0.0%
Total	8130	100%	12215	100%	9,807	100.0%

Source: Ryan White Services Report

Table 7.23. Gender Breakdown for CARE Act Clients, 2010-2012

	2010		2011		2012	
	Number	**%**	**Number**	**%**	**Number**	**%**
Male	5,086	63%	7,469	61%	6,042	62%
Female	2,854	35%	4,496	37%	3,418	35%
Transgender	142	2%	170	1%	339	3%
Unknown/ Unreported	48	1%	80	1%	8	0%

Source: Ryan White Services Report

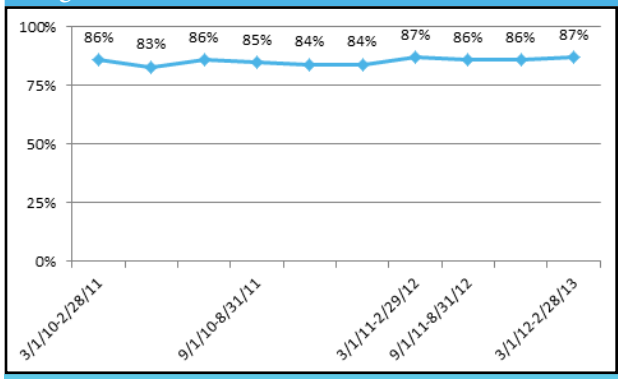
Table 7.24. Race* Breakdown for CARE Act Clients, 2010-2012

	2010		2011		2012	
	Number	**%**	**Number**	**%**	**Number**	**%**
White	907	11%	990	8%	620	6%
Black	6949	85%	9871	81%	7077	70%
Asian	34	0%	73	1%	1183	12%
Nat Hawaiian / PI	23	0%	25	0%	274	3%
American Indian / Alaska Native	38	0%	47	0%	226	2%
Unknown	179	2%	1209	10%	708	7%

**Multiple races can be reported on the same individual.*

Source: Ryan White Services Report

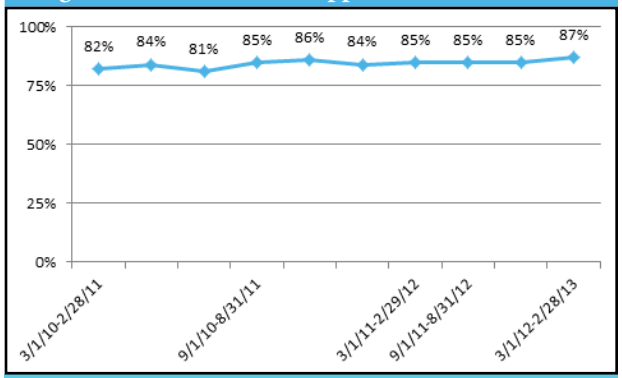
Figure 7.15. Medical Visits*



**Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.*

Source: Quality Management / DC Collaborative Data Reports

Figure 7.16. Viral Load Suppression*



**Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with viral load below limits of quantification (<200 copies/mL) at last test during the measurement year.*

Source: Quality Management / DC Collaborative Data Reports

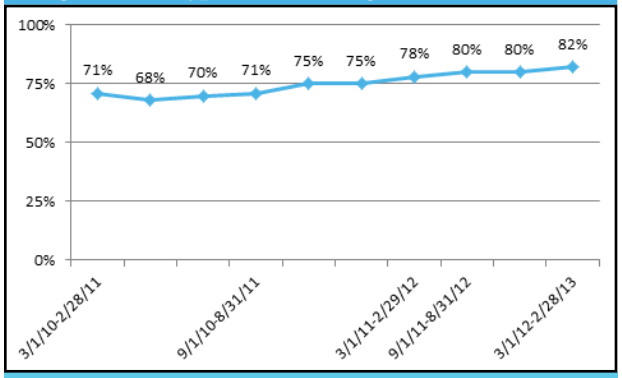
Table 7.25. Risk Factor* Breakdown for CARE Act Clients, 2010-2012

	2010		2011		2012	
	Number	%	Number	%	Number	%
MSM	667	8%	1,330	11%	1503	17%
IDU	238	3%	390	3%	465	5%
Hemophilia/Coag dis	6	0%	1	0%	17	0%
Hetero contact	1,175	14%	2,111	17%	1936	22%
Receipt of bld/bld prod	7	0%	22	0%	30	0%
Perinatal	19	0%	297	2%	200	2%
Other	49	1%	192	2%	437	5%
Unknown/unreported	5,970	73%	7,781	64%	4169	48%
Total	**8,131**	**100%**	**12,124**	**100%**	**8,757**	**100%**

**Multiple factors can be reported on the same individual.*

Source: Ryan White Services Report

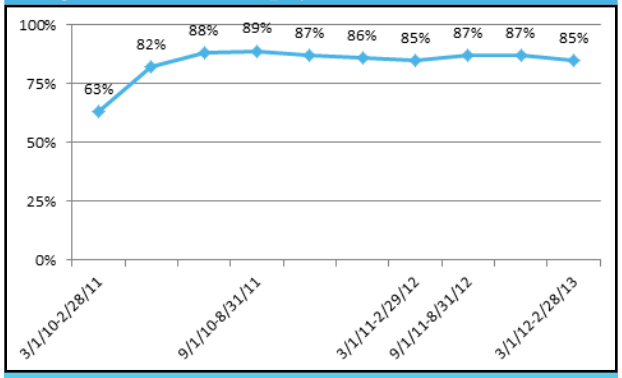
Figure 7.17. Syphilis Screening*



**Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement.*

Source: Quality Management / DC Collaborative Data Reports

Figure 7.18. PCP Prophylaxis*



**Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis.*

Source: Quality Management / DC Collaborative Data Reports

ument areas of strength, identify areas for improvement and help guide, shape, and enhance the delivery and quality of care. The performance indicators include: medical visits, as a measure of linkage and retention to care, and viral load suppression, which is the ultimate goal of treatment. Additional indicators vital to measuring progress on quality improvement projects and adherence to U.S. Public Health Service Guidelines include PCP Prophylaxis prescription rates and Syphilis screening rates.

CHSSD is dedicated to building capacity to provide the highest level of care to all persons living with HIV in the District of Columbia. Quality Improvement projects undertaken include an RPR Screening Project to test and treat for syphilis co-infection in HIV positive patients, and improving PCP Prophylaxis prescription rates in those with low CD4 T-cell counts infected with HIV.

Needle Exchange Program

The District Needle Exchange Program (NEX) targets reductions in the risks of HIV, hepatitis, and other infections among injection drug users by reducing the circulation of contaminated syringes and drug paraphernalia. Implemented as an integrated service program model, the NEX program also provides access to a full range of complimentary services such as HIV counseling and testing, HIV medical care linkages, hepatitis education and screening, HIV care and treatment, primary medical care services, residential and outpatient substance abuse treatment programs, methadone programs, mental health services, wound care services, overdose prevention, STD screening, and other social services. HAHSTA supported NEX programs offer a combination of fixed location and mobile outreach efforts. HAHSTA currently funds three needle exchange programs. Of the three programs, two provide mobile intervention services throughout Wards 1, 2, 4, 5, 6, 7, and 8 in the District. The remaining program operates as a stationary site in Ward 2.

As indicated in Table 7.26, the number of used syringes collected through the NEX program has increased substantially in recent years. Additionally, approximately 1,312 individuals were linked to HIV counseling, testing, and referral services during fiscal year 2012 through the District needle exchange program and 274 individuals were linked to substance abuse treatment services during the same time period.

Table 7.26. HAHSTA Needle Exchange Program, District of Columbia Fiscal Year 2009-2012

	2009	2010	2011	2012
Number of Used Syringes Collected from IDUs	279,707	302,997	341,879	549,464

Source: Prevention and Intervention Services Division, HAHSTA

Youth School-Based STD Screening Program

The District directs multiple efforts to support young people in developing awareness, skills, and behaviors that lead to a reduction in the risks for STDs and HIV throughout their lifetime. Activities to achieve this goal include: mainstreaming of STD/HIV information into youth activities; training all school nurses working in DC Public Schools (DCPS) to integrate routine STD and HIV prevention and screening; education for in-school and out-of-school youth to build skills that allow them to reduce their risks of infection; and expanding youth outreach and STD/HIV testing and treatment services.

The school-based STD health education and screening program is one of the strategies implemented by HAH-

STA in conjunction with DCPS to enhance the accessibility of age-appropriate sexual health information and services for youth in the District. HAHSTA maintains a successful partnership with twenty-five DCPS and select public charter schools to provide voluntary school-based STD screening during the school year. HAHSTA also has a partnership with youth-serving community based organizations to offer STD screening at their locations and in outreach activities. In order to ensure appropriate follow-up after screening, HAHSTA utilizes routine text message reminders to alert students of the need to call in for test results; and for those infected, text message reminders are also used to encourage partner testing and re-screening. Infected students are offered multiple options for treatment and follow-up including in-school services; the HAHSTA-managed Southeast STD Clinic; or their personal medical provider with close follow-up by a Disease Intervention Specialist (DIS).

During fiscal year 2012, 8,487 youth participated in the school-based STD health education and screening program. Of those students, 5,870 (69.2%) provided a urine specimen for STD testing (Table 7.27). Three hundred youth tested positive for chlamydia and/or gonorrhea, representing 5.1% of those screened. Approximately 91% of the students identified with an STD received appropriate treatment and counseling following testing.

Table 7.27. HAHSTA School-Based STD Screening Program, District of Columbia Fiscal Year 2009-2012

	2009	2010	2011	2012
Number of Youths, 15 to 19 years, Screened for STDs Through Outreach Programs	5,265	4,319	4,274	5,870

Source: Prevention and Intervention Services Division, HAHSTA

Clinic-Based STD Services

The Southeast (SE) STD Clinic is the only publicly funded STD clinic in the District. Operating five days per week, the SE STD Clinic provides STD and HIV screening, physical exams, laboratory testing, treatment, follow-up, disease intervention counseling, and referral services. In addition, clinic staff participates in multiple educational and screening outreach activities targeting high risk populations and geographic areas within the District.

Over 95% of those testing positive for an STD at the SE STD Clinic receive appropriate treatment and follow-up services. For those testing positive for HIV, appropriate mechanisms are in place to ensure linkage to medical care.

Table 7.28. Southeast STD Clinic, District of Columbia Fiscal Year 2011, 2012

	2011	2012
Number of Individual Clients Receiving Services	8,473	9,332
Number of Positive Diagnoses:		
Chlamydia	1,401	1,089
Gonorrhea	755	644
Syphilis*	51	27
HIV*	29	43

**New Diagnoses Only*

Source: STD & TB Control Division, HAHSTA

Tuberculosis Control Program

Through the Tuberculosis (TB) Control Program, HAHSTA provides the following prevention and control services for District residents:

- Screening, diagnosis, treatment, case management, and follow up of persons infected with or suspected of having TB;
- Contact investigations, including the evaluation and treatment of close contacts of TB cases;
- Screening and medical evaluation of individuals at high risk for TB infection and disease;
- Medical consultations, educational activities, and technical assistance for health care providers and others with an interest in TB prevention and control;
- Participation in TB Treatment Control Trials and Epidemiologic Studies sponsored by CDC;
- Training of nursing, medical and post-doctoral students and fellows in TB management; and
- Participation in national trainings such as grand round webinars on TB and contact investigation courses.

Health care providers and laboratories are required to report suspected cases of TB in District residents to the District Department of Health. All incoming reports are reviewed by TB Control Program staff. Reports with sputum smears showing acid-fast bacilli on microscopic examination are assigned immediately, as suspected cases of TB, and an investigation is initiated prior to diagnostic confirmation.

Table 7.29. TB Control Program, District of Columbia Fiscal Year 2011-2012

	2011	2012
Number of individuals receiving one or more clinic services*	5,700	4,379
Number of Preliminary Investigations Concerning Suspected TB Cases	118	26
Identification & Investigation of Confirmed TB Cases	53	37
Number of TB Contact Investigations	700	567

**Clinic services include tuberculin skin test, chest x-ray, medical evaluation and/or follow-up, and the dispensing of medication*

Source: STD & TB Control Division, HAHSTA

Epidemiology of HIV/AIDS, Hepatitis, STDs, and TB in the District

Key points from available 2011 HIV/AIDS, hepatitis, STD, and TB surveillance data include:

- 15,056 residents of the District of Columbia or 2.4% of the population are living with HIV. An estimated prevalence of 2.4% exceeds the World Health Organization definition of 1% as a generalized epidemic.
- Blacks, Hispanics, and whites with HIV exceed 1% of their respective populations, with blacks disproportionately impacted at 3.7%.
- Men who have sex with men (MSM) and heterosexual contact are the two leading transmission modes reported among newly diagnosed and identified HIV cases.
- The number of newly diagnosed HIV cases in the District decreased to 718 cases in 2011, a decline of 46% from 1,333 cases in 2007.
- There was an 80% decrease in the number of newly diagnosed HIV cases where reported mode of transmission was injection drug use. In 2007, prior to the scale up of DC's needle exchange program there were 149 cases compared to 30 in 2011.
- The number of reports of newly diagnosed AIDS

cases decreased 47% from 682 in 2007 to 363 in 2011.
- The number of deaths among persons with HIV decreased by 41% from 425 in 2007 to 251 in 2011.
- There were reports of 6,584 new cases of chlamydia, 2,572 new cases of gonorrhea, and 165 new cases of primary and secondary syphilis reported in 2011.
- There were reports of 2,924 cases of hepatitis B and 13,520 cases of hepatitis C diagnosed between 2007 and 2011.
- 55 new cases of TB were reported in 2011.

A detailed review of HIV/AIDS, hepatitis, STD, and TB trends and patterns within the District is provided in the Annual Epidemiology & Surveillance Report produced by HAHSTA, available at http://doh.dc.gov/service/hivaids.

Health Regulation and Licensing Administration

Mission Statement

The mission of the Health Regulation and Licensing Administration (HRLA) is to administer all District and Federal laws and regulations governing the licensing, certification and registration of Health Professionals, Health Care Facilities, Food, Drug, Radiation, and Community Hygiene Services. HRLA enforces all District and federal laws and regulations which govern licensure and regulations which protect the health, safety, and environment of District residents.

Program Activities

Office of Compliance and Quality Assurance: The Office has regulatory oversight to ensure the health, safety, and welfare of our most vulnerable population within community residential facilities and nursing homes. The Office also investigates complaints against health professionals and issues summary suspension notices and subpoenas. The Office aggressively investigates and provides timely and thorough investigations of incidents (self-reported by individual facilities) and complaints (from the public or family) that are triaged through the Office.

Office of Health Professional Licensing Boards: The objectives for the Office are to license and regulate health care professionals across 18 Boards and 35 licensee categories. The Office issues approximately 6,000 new licens-

Table 7.25. Risk Factor* Breakdown for CARE Act Clients, 2010-2012

Board	License Type	FY2009	FY2010	FY2011	FY2012	FY2013*
Medicine	Medicine & Surgery	9,072	9,697	9,489	1,041	10,413
	Osteopathy & Surgery	144	180	177	216	219
	Physician Assistants	461	550	549	639	668
	Anesthesiologist Assistants	19	23	24	31	34
	Acupuncturists	153	171	156	174	176
	Naturopathic Physicians	16	24	23	28	32
	Surgical Assistants	30	55	58	62	62
	Chiropractors	78	88	84	96	96
	Chiropractors – Ancillary Procedures	43	59	56	66	67
Nursing	Registered Nurse	20,400	19,861	22,365	24,370	19,553
	Licensed Practical Nurse	3,113	3,842	4,163	3,334	3,405
	Certified Nurse Midwives	92	82	93	89	89
	Clinical Nurse Specialists	48	46	49	47	48
	Nurse Practitioners	936	935	1,057	1,043	1,100
	Nurse Staffing Agencies	118	139	196	151	157
	Registered Nurse Anesthesiologist	156	138	155	152	152
	Trained Medication Employee	480	566	848	920	999
Audiology	Audiology	14	60	78	94	100
	Speech Language Pathology	59	285	396	506	550
Dance Therapy	Dance Therapist	3	2	3	2	3
Dentistry	Dentists	1,360	1,342	1,546	1,266	1,303
	Dental Hygienists	555	538	635	499	513
	Local Anesthesia	3	5	19	16	21
	Nitrous Oxide	0	0	1	1	1
	Local Anesthesia and Nitrous Oxide	8	28	31	17	18
Dietetics and Nutrition	Dieticians	448	408	451	379	402
	Nutritionists	70	72	72	55	55
Marriage & Family Therapy	Licensed Marriage and Family Therapist	117	136	131	141	139
Massage Therapist	Massage Therapist	702	863	713	859	844

Table 7.25 conti. Risk Factor* Breakdown for CARE Act Clients, 2010-2012						
Board	**License Type**	**FY2009**	**FY2010**	**FY2011**	**FY2012**	**FY2013***
Naturopathy	Naturopaths	788	No longer registering	No longer registering	No longer registering	N/A
Occupational Therapist	Occupational Therapist	477	562	611	533	578
	Occupational Therapist Assistants	16	25	44	27	33
Optometry	Optometrists	231	217	250	202	214
	DPA	144	151	170	164	176
	TPA	159	155	171	168	180
Pharmaceutical Control	Controlled Substance	5,983	6,713	6,597	7,456	7,671
	Controlled Substance – NP	578	591	695	708	749
	Controlled Substance – PA	143	206	218	278	297
Physical Therapy	Physical Therapists	877	989	691	816	1,024
	Physical Therapists Assistants	23	37	36	55	58
Podiatry	Podiatrists	156	147	168	132	132
Professional Counseling	Licensed Professional Counselors	1,014	836	929	1,032	1,044
	Addiction Counselors	501	505	112		109
Pharmacy	Pharmacists	1,512	1,679	1,591	1,747	1,790
	Pharmacists Interns	19	22	29	50	51
	Pharma Detailers	1921	1625	1845	1173	1261
	Vaccine and Immunization Authority	32	154	223	296	326
Psychology	Psychologists	1,207	1,211	1,307	1,156	1,171
	Supervised Practice Psychologist	1	1	1	2	2
Recreation Therapy	Recreational Therapists	63	46	50	45	50
Veterinary	Vet Examiners	198	200	223	224	230
Social Work	Graduate Social Workers	1,124	1,309	1,428	1,280	1,337
	Ind. Clinical Soc. Workers	2,697	2,919	3,006	2,836	2,905
	Independent Soc. Workers	88	88	88	78	79
	Social Work Associates	130	152	153	113	114
Nursing Home Administration	Nursing Home Administration	69	71	72	51	53

**Year to Date 6-10-2013*

Source: DC Department of Health, Health Regulation and Licensing Administration

es and renews biennially 61,000 licensed professionals in the District. The Office also provides administrative support to the Boards for meetings, disciplinary hearings, including investigation, legal and staff support.

- **Division of Medical Boards**: The Division of Medical Boards is the entity responsible for the licensing and regulatory oversight of medicine and surgery, chiropractors, ancillary procedures, osteopathy and surgery, physicians' assistants, acupuncturists, anesthesiologist assistants, naturopathic physicians, surgical assistants, postgraduate physicians, and polysomnographers.
- **Division of Nursing Boards**: The Division of Nursing Boards is the entity responsible for the licensing and regulatory oversight of registered nurses, licensed practical nurses, certified nurse midwives, clinical nurse specialists, nurse practitioners, nursing staffing agencies, nurse anesthetists, and trained medication employees.
- **Division of Allied and Behavioral Health Board:** The Division of Allied and Behavioral Health Board is the entity responsible for the licensing and regulatory oversight of addiction counselors, audiologist, dance therapists, dental hygienists, dentists, dieticians, licensed professional counselors, licensed marriage counselors, family therapist, nutritionists, occupational therapists, occupational therapist assistants, optometrists, physical therapists, physical therapist assistants, podiatrists, psychologists, recreational therapists, respiratory care practitioners, speech language pathologist, social workers, nursing home administrators and psychology associates.
- **Division of Veterinary Medical Boards**: The Division of Veterinary Medical Boards is the entity responsible for the licensing and regulatory oversight of Veterinarians in the District of Columbia.
- **Division of Pharmacy Boards:** The Division of Pharmacy Boards is the entity responsible for the licensing and regulatory oversight of pharmacists, pharmacists with the authority to immunize, pharmacy interns, controlled substances registrations for practitioners, and pharmaceutical detailer registrations.

The Office of Health Care Facilities

The Division of Health Care Facilities is the entity responsible for the inspection and certification of ambulatory surgical centers, certified home health agencies, end stage rental disease facilities, hospice care, hospitals, hos-

pital organ transplant, clinical laboratories, certificate of waivers, communicable disease labs, tissue banks, hospitals labs, nursing homes, outpatient physical therapy or speech pathology services, portable x-ray suppliers, DC detention center, DC youth services, and maternity centers.

The Division of Intermediate Care is the entity responsible for the inspection and certification of intermediate care facilities for persons with intellectual disabilities (IFC/ID), community residence facilities for persons with intellectual disabilities (CRF/ID), assisted living residences, child placing agencies, home care agencies, and community residence facilities.

Office of Food, Drug, Radiation, and Community Hygiene

Division of Food: The Division of Food Safety and Hygiene Inspection Services regulates food services that are provided in bakeries, delicatessens, food products, grocery stores, restaurants, caterers, marine, wholesalers, hotels, and vendors. The Division has the authority to inspect barbershops, beauty spas, massage establishments, and swimming pools.

Division of Drug: The Division of Drug Control is the entity that regulates local pharmacies, controlled substances, non-resident pharmacies, out of state controlled substances, out of state manufacturers, distributors/wholesalers, substance abuse facilities, researchers, hearing aid registrations, and medical marijuana.

Division of Radiation: The Division of Radiation Control is the entity that regulates dental x-ray equipment, medical x-ray equipment, health physicists, suppliers, and analytical x-ray tubes.

The Division of Community Hygiene: The Branch of Rodent Control within the Division of Community Hygiene is the entity responsible for providing public outreach and education, surveys and inspections, abatement, enforcement, and cooperation with private organizations to protect human health and the environment.

The Branch of Animal Disease Control: The Branch of Animal Disease Control is the entity responsible for the prevention and spread of communicable diseases transmitted from animals to humans through timely investigations, referrals, follow-up on cases, licensing, and enforcement and provides field inspection services throughout the District. The branch is also responsible for monitoring DC Animal Shelter.

Health Emergency Preparedness and Response Administration

The Health Emergency Preparedness and Response Administration (HEPRA) is responsible for protecting the public health and safety of the residents and visitors in the District of Columbia through public health emergency preparation and response, disease surveillance and investigation, regulatory oversight of Emergency Medical Services (including service providers, associated educational institutions, EMS agencies and their operations), and analysis of the health threat to First Responders and District residents. HEPRA and its partners are prepared to respond to city-wide medical and public health emergencies, such as those resulting from terrorist attacks or natural disasters.

There are a number of critical functions and activities performed by HEPRA:

- Bioterrorism and Response
- Community Resilience
- Emergency Medical Services
- Medical Planning
- Pharmaceutical Procurement and Distribution
- Special Operations
- Strategic National Stockpile

Bioterrorism and Response

Bioterrorism and Response conducts surveillance of biological agents which can be used in the deliberate release of viruses, bacteria, or other germs (agents) used to cause illness or death in people, animals, or plants. These agents are typically found in nature, but altering the natural composition increases their ability to cause disease, makes them resistant to current medicines, or increases their ability to be spread into the environment.

Community Resilience

Community Resilience is defined as the ability of communities to make it through and bounce back from natural and manmade disasters by assessing, strengthening and leveraging community connections, resources and relationships (e.g. neighbor to neighbor, organization to organization, and administration to administration). Resilient DC is a collaborative effort between government agencies, community based organizations and community members to build resilience in the District. Since January 2013, DOH/HEPRA has laid the groundwork for Resilient DC in collaboration with RAND Corporation. Accomplishments to-date include:

- Commissioning the Resilient DC Advisory Committee with leaders from the Mayor's office, business leaders, health care providers, etc.
- Facilitating a half-day Resilient DC Community Forum with a welcome from the Office of the Deputy Mayor for Health and Human Services that highlighted the connection between community resilience and community health
- Engaging approximately100 government and community based stakeholders from the business, media, cultural/faith, healthcare, housing, mental health, and senior services sectors
- Conducting focus groups with residents from all 8 Wards to get input on community resilience and preparedness strategies
- Organizing a community leaders roundtable to identify best practices in messaging resilience to the community

The next steps for Resilient DC include organizing a Steering Committee and sector based workgroups, develop and implement a strategic plan, and creating a communications plan.

Emergency Medical Services

The Emergency Medical Services (EMS) Division is the regulatory oversight authority for all EMS activities in the District of Columbia. This authority was placed in the Department of Health with the passage of "The EMA Act of 2008." The Division provides leadership to a comprehensive emergency care system of cooperative partnerships, certifies all emergency medical service providers, designates trauma centers and establishes and maintains the District-wide trauma system. In addition, the EMS Division may exercise its authority to deny, suspend or revoke the certification of an emergency medical service agency or provider who fails to meet set standards.

Certified Ambulances

The EMS Division inspected and certified a total of 189 ambulances in the District of Columbia in 2012. There

were 152 ambulances certified for Basic Life Support (BLS) level care, while the remaining 37 ambulances were certified at the Advanced Life Support (ALS) care level.

EMS Response Services

There are 12 EMS response agencies certified in the District of Columbia, categorized as:

- 9-1-1 Public Service Providers
  1. DC Fire & Emergency Medical Services Department
- College Based Emergency Ambulance Services
  2. GERMS (Georgetown Emergency Response Medical Service)
  3. EMeRG (Emergency Medical Response Group at George Washington University)
- Hospital-Based Service Providers
  4. Children's Medical Transport Services (Ground ambulance)
  5. STAT MedEvac (Air ambulance service for Children's National Medical Center)
  6. MedSTAR Transport Services (Ground and Air ambulances for MedSTAR Washington Hospital Center
- Commercial Ambulance Service Providers
  7. All American Ambulance (AAA)
  8. American Medical Response (AMR)
  9. Butler Medical Transport
  10. LifeStar Response
  11. Team Critical Care (TCC)
- Special Events Service Providers
  12. Special Events Medical Services

EMS Education

EMS Educational Institutions

The EMS education institutions within the District of Columbia provide high-quality educational programs for EMS providers. These institutions are required to follow the guidelines of the National Educational Standards for EMS certification as published by the National Highway Transportation Safety Administration (NHTSA). They also are required to meet the District standards for educational institutions, as well as the requirements of the National Registry of Emergency Medical Technicians (NREMT). There are currently seven certified EMS Educational Institutions in the District of Columbia who meet these standards:

- DC Fire & EMS Department
- East Coast EMS Higher Development Academy
- Georgetown University
- George Washington University Emergency Health Services Program
- National Institute for Emergency Medical Services
- Washington Hospital Center EMS Education
- Westlink Career Institute

Updates in EMS Education Requirements

The National Education Standards have replaced the older National Standard Curriculum (NSC). All EMS providers who were certified under the older NSC will be required to attend a transition course in order to maintain their NREMT certification. The District is following the transition timetable as published by the NREMT.

Emergency Medical Technician (EMT) Certification Courses

In the District there were a total of 13 EMT certification courses conducted during 2012. A total of 380 students enrolled and 296 students completed the course requirements (Figure 7.19). 287 students passed the psychomotor exam, 217 students passed both the cognitive and psychomotor exam, obtaining NREMT certification, becoming eligible for District certification.

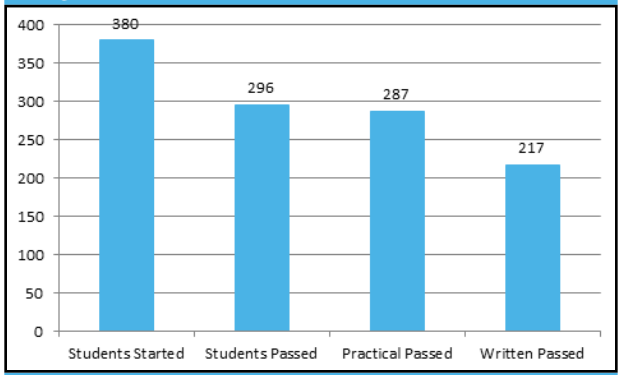
EMS Certification

District of Columbia Certified Providers

The District of Columbia has a dedicated group of EMS providers who administer pre-hospital healthcare services on a daily basis. In 2009, the District raised its certification standards by requiring all EMS providers to obtain NREMT certification for both initial certification and certification renewal. Today, all DC certified EMS providers have obtained their NREMT certification.

In 2012, the District had 2,498 certified EMS Providers (Figure 7.20), which included: (Table 7.31)

Figure 7.19. 2012 EMT Student Enrollment



Source: 2012 EMS Annual Report, Health Emergency Preparedness and Emergency Response Administration, DC Department of Health

Table 7.31. District of Columbia Certified EMS Providers, 2012

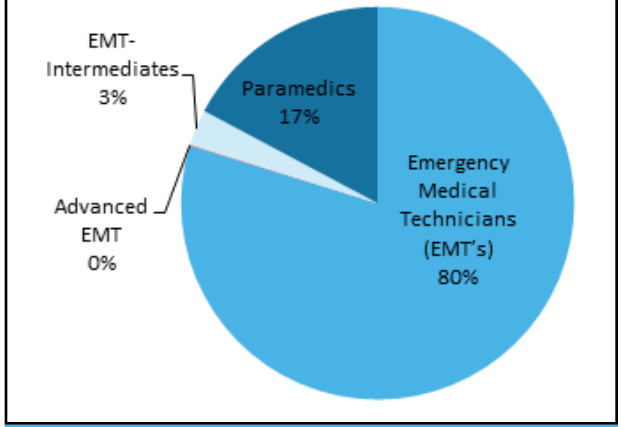
Certified Providers	Number	Percent
Emergency Medical Technicians (EMT's)	1,992	80%
Advanced EMT	2	0%
EMT-Intermediates	74	3%
Paramedics	430	17%

Source: 2012 EMS Annual Report, Health Emergency Preparedness and Emergency Response Administration, DC Department of Health

Medical Planning

Medical Planning partners with the DC Homeland Security and Emergency Management Agency (HSEMA) to assist special event organizers in the development of a health and safety plan. DOH in conjunction with DC HSEMA requires that all event coordinators submit a Health,

Figure 7.20. District of Columbia Certified EMS Providers



Source: 2012 EMS Annual Report, Health Emergency Preparedness and Emergency Response Administration, DC Department of Health

Medical and Safety Plan that is reviewed and approved by DOH before the event can begin. The DC Special Event Health and Safety Plan application includes a description of the event, location, date and hours of operation, medical provisions, types of medical aid to be offered, as well as the deployment of any aid stations or ambulances.

In 2012, DOH/HEPRA participated in three (3) disaster (incident response) and preparedness (planning) events in collaboration with DC HSEMA. In 2013, from January to May, there have been a total of four (4) events which currently represents a 25% increase above the total number of events in 2012. An increase in the total number of events in 2013 is expected with six (6) months remaining in the calendar year.

2012 Events:

- Derecheo (Incident Response) – June 2012
- July 4th Celebration (Planning/Response Coordination) – July 2012
- Hurricane Sandy (Incident Response) October 2012

2013 Events (January – May):

- 57th Presidential Inauguration (Planning/Response Coordination) – January 2013
- Presidential State of the Union Address (Planning/Response Coordination) – February 2013
- Snow Storm (Incident Response) – March 2013
- H7N9 Influenza (Intelligence Sharing) – May 2013

In 2012, HEPRA coordinated with HSEMA on three events. As of May 2013, the two agencies have coordinated on four events.

Pharmaceutical Procurement and Distribution

Pharmaceutical Procurement and Distribution maintains a timely and efficient drug delivery rate of greater that 99%, and assures that the Department of Health continues to maintain access to drug discount programs that will allow as many District residents as possible, access to life saving medications. It also provides clinical support formulary management and quality assurance monitoring sufficient to address the needs of all programs supported by Pharmaceutical Services, in addition to maintaining a state of the art inventory control system capable of supporting DOH needs and also supporting the Strategic National Stockpile (SNS) in the event of an emergency.

Special Operations

Special Operations monitors Special Events in the District of Columbia in conjunction with the DC Homeland Security and Emergency Management Agency and represents the Department of Health on the Mayor's Special Event Task Group. Special Operations supports the review, development, and implementation of health and safety plans for over 135 special events each year in the District of Columbia. Special Operations is involved in the planning of large scale special events in which the Department of Health plays a more active role to include personnel from the Medical Reserve Corps and the Department of Health in staffing aid stations and providing medical care.

Strategic National Stockpile

The Strategic National Stockpile (SNS) Program is an essential response component of the Centers for Disease Control (CDC) larger Bioterrorism Preparedness and Response Initiative. The SNS program ensures the availability and rapid deployment of life-saving pharmaceuticals, antidotes, other medical supplies, and equipment necessary to counter the effects of nerve agents, biological pathogens, and chemical agents. The SNS program stands ready for immediate deployment in the event of a terrorist attack using a biological toxin or chemical agent directed against a civilian population in the District of Columbia.

Center for Policy, Planning, & Evaluation

Mission

The mission of the Center for Policy, Planning, & Evaluation is to assess health issues, risks and outcomes through data collection, surveillance, analysis, research and evaluation; perform state health planning functions; and to assist programs in the design of strategies, interventions and policies to prevent or reduce disease, injury and disability in the District of Columbia.

Data Management and Analysis Division

Census of Fatal Occupational Injuries, District of Columbia Workplace Fatalities, 2010

Background of the Program

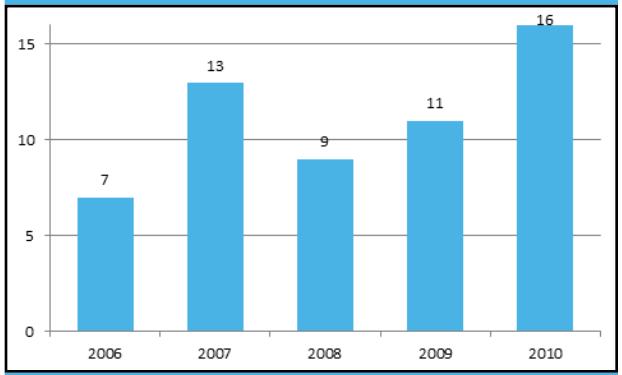
The Census of Fatal Occupational Injuries (CFOI), part of the BLS Occupational Safety and Health Statistics (OSHS) program, compiles a count of all fatal work injuries occurring in the U.S. during the calendar year. The CFOI program uses diverse state, federal, and independent data sources to identify, verify, and describe fatal work injuries. This assures counts are as complete and accurate as possible. Beginning with 2009 data, the CFOI program began classifying industry using the 2007 version of the North American Industry Classification System (NAICS 2007). Industry data from 2003 to 2008 were classified using the NAICS 2002. NAICS 2007 includes revisions across several sectors. The most significant revisions are in the information sector, particularly within telecommunications.

Fatal work injuries totaled 16 in 2010 for the District of Columbia, according to the District of Columbia Department of Health's Census of Fatal Occupational Injuries (CFOI), in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics (BLS). The 2010 count of workplace fatalities increased five over the year and was three more than the highest total since 2006 (Figure 7.21). Assaults and violent acts were the leading cause of on-the-job fatalities during 2010 in the District, with 7 deaths or 44 percent. The service providing industry accounted for 56 percent of the total workplace fatalities in the District of Columbia.

Key Characteristics of Fatal Work Injuries in 2010 in the District of Columbia:

- Men (15) accounted for almost all of the work-relat-

Figure 7.21. Fatal Occupational Injuries in the District of Columbia, 2006-2010



Source: DC Department of Health, Center for Policy, Planning, and Evaluation, Occupational Safety and Health Statistics Program and the U.S. Department of Labor, Bureau of Labor Statistics

ed fatalities in the District. Assaults and violent acts were the leading cause.

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

Survey of Occupational Injuries and Illnesses

Characteristics for Injuries and Illnesses Requiring Days Away From Work In Private Industry

The Washington, DC Survey of Occupational Injuries and Illnesses was conducted by the DC Department of Health in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics. Beginning with 2009 data, the Occupational Safety Health Statistics program began classifying industry using the 2007 version of the North American Industry Classification System (NAICS 2007). Industry data from 2003 to 2008 were classified using the NAICS 2002. NAICS 2007 includes revisions across several sectors. The most significant revisions are in the information sector, particularly within telecommunications.

Figure 7.22. Injury and Illness Cases Involving Days Away from Work by Selected Occupational Group and Industry Sector

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, Occupational Safety and Health Statistics Program and the U.S. Department of Labor, Bureau of Labor Statistics

The District of Columbia's Annual Survey of Occupational Injuries and Illnesses for 2010 showed that there were 2,980 work-related injury and illness cases reported in the private industry that required days away from work. Sprains and strains accounted for approximately 33 percent of these cases and was the leading type of injury or illness. Service occupations had the most injury and illness days away from work cases and made up 1,510 or 51 percent of the cases; followed by professional and related occupations with 430 or 14 percent of the cases (Figure 7.22).

Case Characteristic Highlights

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

Demographic Highlights

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

Research Evaluation and Measurement Division

Behavioral Risk Factor Surveillance System (BRFSS)

The Behavioral Risk Factor Surveillance System (BRFSS) is the largest health-risk behavior database in the world and provides the only nationwide health-risk data in the country. All 50 US states, the District of Columbia, and three territories carry out this ongoing telephone survey, sponsored by the Centers for Disease Control and Prevention (CDC), independently.

Traditionally the BRFSS has been a landline telephone health survey since 1984. During the 2011 survey period, two new changes in methodology and data collection were made to increase the integrity and validity of the BRFSS and to ensure the data represented the current population. These changes were 1) including cell phones and 2) adopting an advanced weighting method. With these new implementations, the BRFSS has been able to collect data that better represents the current health status of the nation's population.

Table 7.32. Having Health Care Coverage

"Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs or government plans such as Medicare or Indian Health Services?"

		#	Yes	No
Total		4,545	92.3	7.7
Sex	Male	1,737	90.3	9.7
	Female	2,808	93.9	6.1
Age	18 To 24	129	90.3	*
	25 To 34	457	91.9	8.1
	35 To 44	629	92.8	7.2
	45 To 54	781	90.0	10.0
	55 To 64	1,115	92.3	7.7
	65 Or Older	1,434	96.5	3.5
Race/Ethnicity	Caucasian/White	1,995	96.6	3.4
	African American/Black	2,023	89.4	10.6
	Other	247	89.4	10.6
	Hispanic	183	90.7	*
Education	Less than high school	291	88.1	11.9
	High school graduate	773	90.0	10.0
	Some college or tech sch	710	88.5	11.5
	College graduate	2,753	96.3	3.7
Income	Less than $15,000	486	90.1	9.9
	$15,000-$24,999	489	84.3	15.7
	$25,000-$34,999	283	87.3	12.7
	$35,000-$49,999	371	92.8	*
	$50,000-$74,999	484	92.1	*
	$75,000 or more	1,872	97.4	*
Ward	Ward 1	327	93.3	6.7
	Ward 2	362	96.2	3.8
	Ward 3	722	94.0	6.0
	Ward 4	594	90.2	9.8
	Ward 5	468	87.4	12.6
	Ward 6	496	91.7	8.3
	Ward 7	464	97.0	3.0
	Ward 8	375	93.2	6.8

**Suppressed if cell size is less than 50*

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), 2011

Table 7.33. Multiple Health Care Providers

"Do you have one person you think of as your personal doctor or health care provider?"

		#	Yes, only one	More than one	No
Total		454	73.0	7.7	19.3
Sex	Male	170	66.8	6.6	26.6
	Female	280	78.4	8.7	12.9
Age	18 To 24	129	64.6	6.1	29.3
	25 To 34	456	59.5	8.2	32.3
	35 To 44	629	75.0	6.9	18.1
	45 To 54	781	82.4	5.4	12.2
	55 To 64	111	81.5	7.5	11.0
	65 Or Older	143	80.9	12.2	6.8
Race/Ethnicity	Caucasian/White	199	71.3	9.0	19.7
	African American/Black	202	76.3	6.7	17.0
	Other	245	64.0	7.8	28.3
	Hispanic	184	66.8	8.0	25.2
Education	Less than high school	292	75.1	6.9	18.0
	High school graduate	777	74.5	5.9	19.6
	Some college or technical school	708	74.3	8.0	17.7
	College graduate	275	71.1	8.7	20.2
Income	Less than $15,000	487	72.3	6.5	21.1
	$15,000-$24,999	493	70.2	7.5	22.2
	$25,000-$34,999	282	81.1	5.1	13.8
	$35,000-$49,999	371	71.8	7.0	21.3
	$50,000-$74,999	483	71.0	8.2	20.8
	$75,000 or more	187	75.2	7.8	17.0
Ward	Ward 1	327	74.9	7.9	17.1
	Ward 2	361	75.1	11.3	13.7
	Ward 3	722	74.7	7.2	18.1
	Ward 4	594	80.6	5.2	14.2
	Ward 5	469	71.7	9.2	19.0
	Ward 6	495	74.5	9.0	16.6
	Ward 7	463	82.7	7.6	9.7
	Ward 8	377	74.8	5.3	19.8

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), 2011

Access to Health Care

Healthy People 2020 Objectives

- **Goal Not Met:** Increase the proportion of persons with medical insurance to 100%, the District of Columbia 92.3%.

An estimated 50 million adults aged 18-64 years had no health insurance at some point during the past 12 months. Individuals who do not have health care coverage do not receive many of the necessary screenings in a timely manner that would to detect many chronic diseases such as cancer at its early stages.

District residents were asked if they have any kind of health care coverage, including health insurance, prepaid plans such as Health Maintenance Organizations (HMO), or government plans such as Medicare. Overall, 92.3% of District residents have health care coverage (Table 7.32). District residents were asked if they had one person they thought of as their personal doctor or health care provider (Table 7.33). Overall, 73% of District residents have only one personal doctor or health care provider. District residents were asked how long it has been since they last visited a doctor for a routine check-up (Table 7.34). Overall, 74.6% of residents had a routine checkup within the past year.

Table 7.34. Time Since Last Check-up

"About how long has it been since you last visited a doctor for a routine checkup?" A routine checkup is a general physical exam, not an exam for a specific injury, illness or condition.

		#	Within past year	Within past 2 years	Within past 5 years	5 or more years ago	Never
Total		4,535	74.6	13.4	7.3	4.3	0.5
Sex	Male	1,730	69.1	14.9	9.1	6.3	0.6
	Female	2,805	79.3	12.1	5.7	2.5	0.4
Age	18 To 24	128	74.6	16.7	6.7	2.0	
	25 To 34	454	66.0	16.0	11.0	6.4	0.6
	35 To 44	625	67.7	14.4	10.2	7.3	0.4
	45 To 54	778	75.1	14.0	6.7	3.4	0.8
	55 To 64	1,115	81.0	11.2	3.8	3.0	1.0
	65 Or Older	1,435	89.0	6.8	2.5	1.6	0.2
Race/Ethnicity	Caucasian/White	1,988	65.9	17.4	9.4	6.9	0.4
	African American/Black	2,024	82.7	9.0	6.0	1.9	0.4
	Other	246	65.1	16.9	9.0	7.0	2.0
	Hispanic	182	72.5	19.4	4.2	3.6	0.3
Education	Less than high school	290	83.2	10.1	4.2	1.0	1.5
	High school graduate	775	83.3	10.7	3.6	2.0	0.4
	Some college or tech sch	708	75.9	11.2	7.7	5.1	0.1
	College graduate	2,743	67.4	16.7	9.7	5.9	0.4
Income	Less than $15,000	483	82.2	7.9	6.9	2.3	0.7
	$15,000-$24,999	490	78.1	12.7	6.6	2.5	0.1
	$25,000-$34,999	280	76.0	11.4	10.3	1.1	1.2
	$35,000-$49,999	371	75.6	11.0	7.4	6.0	
	$50,000-$74,999	484	72.3	16.5	5.0	5.8	0.4
	$75,000 or more	1,865	68.9	16.5	8.4	5.8	0.3
Ward	Ward 1	324	70.1	14.3	12.7	3.0	*
	Ward 2	362	68.0	18.3	7.8	6.0	*
	Ward 3	721	70.1	16.3	7.2	6.4	*
	Ward 4	591	75.3	14.2	7.3	2.9	0.3
	Ward 5	469	75.8	11.3	8.1	3.6	1.3
	Ward 6	493	71.1	13.1	7.7	7.2	0.8
	Ward 7	462	87.7	7.9	2.2	2.3	*
	Ward 8	374	86.0	7.4	6.1	.5	*

**Suppressed if cell size is less than 50*

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Alcohol Consumption

Healthy People 2020 Objectives

- **Goal Not Met:** Reduce the proportion of persons engaging in binge drinking during the past 30 days - adults aged 18 years or older to 24.4%; the District of Columbia rate is 25%.

The detrimental effect of alcohol use is a global problem resulting in millions of deaths, including hundreds of thousands of young lives lost. The widely used and legal substance is not only a contributing factor in many diseases, but also contributes to a variety of social problems. Its negative impact has spread throughout many communities. Excessive alcohol use, including underage drinking and binge drinking, can lead to increased risk of health problems such as injuries, violence, liver diseases, and cancer. Despite all these problems, the harmful use of alcohol remains a low priority in many health and public policies.

District residents were asked a variety of questions about their alcohol intake during the past 30 days. This included whether or not they had at least one drink of any alcoholic beverage, how many days per week or per month they drank, how many alcoholic drinks they drank in a day on average, how many times they binge drank, and finally, the highest number of alcoholic drinks they consumed on any occasion (Table 7.35). Overall, 25% of District residents were binge drinkers (5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women). Heavy drinking is defined as drinking two or more drinks per day for men and one or more drinks per day for women (Table 7.36). Overall, 9.6% of District residents were heavy drinkers.

Table 7.35. Binge Drinking

(Five or more drinks on an occasion for men or 4 or more drinks on an occasion for women)

		#	No	Yes
Total		258	75.0	25.0
Sex	Male	162	68.7	31.3
	Female	258	80.5	19.5
Age	18 To 24	116	59.9	40.1
	25 To 34	418	57.2	42.8
	35 To 44	590	74.3	25.7
	45 To 54	728	81.8	18.2
	55 To 64	103	89.7	10.3
	65 Or Older	132	94.6	5.4
Race/Ethnicity	Caucasian/White	190	67.1	32.9
	African American/Black	183	82.1	17.9
	Other	225	80.2	19.8
	Hispanic	170	66.7	33.3
Education	Less than high school	258	83.5	16.5
	High school graduate	680	80.2	19.8
	Some college or tech sch	642	76.2	23.8
	College graduate	261	69.8	30.2
Income	Less than $15,000	427	84.1	15.9
	$15,000-$24,999	449	80.8	19.2
	$25,000-$34,999	257	76.4	23.6
	$35,000-$49,999	349	70.7	29.3
	$50,000-$74,999	452	67.3	32.7
	$75,000 or more	178	70.2	29.8
Ward	Ward 1	306	65.4	34.6
	Ward 2	341	70.4	29.6
	Ward 3	681	73.7	26.3
	Ward 4	564	79.0	21.0
	Ward 5	440	80.8	19.2
	Ward 6	463	72.8	27.2
	Ward 7	409	82.7	17.3
	Ward 8	328	83.2	16.8

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), 2011

Table 7.36. Heavy Alcohol Consumption

Heavy drinking results are from responses to: One drink is equivalent to a 12 ounce beer, a 5 ounce glass of wine, or a drink with one shot of liquor. Heavy drinking is defined as drinking two or more drinks per day for men and one or more drinks per day for women.

		#	No	Yes
Total		4,216	90.4	9.6
Sex	Male	1,627	91.8	8.2
	Female	2,589	89.2	10.8
Age	18 To 24	116	86.9	13.1
	25 To 34	420	86.2	13.8
	35 To 44	589	92.1	7.9
	45 To 54	727	92.5	7.5
	55 To 64	1,036	91.8	8.2
	65 Or Older	1,328	94.4	5.6
Race/Ethnicity	Caucasian/White	1,904	87.5	12.5
	African American/Black	1,834	93.1	6.9
	Other	224	89.0	11.0
	Hispanic	172	90.2	*
Education	Less than high school	260	91.4	*
	High school graduate	679	92.4	7.6
	Some college or tech sch	645	90.9	9.1
	College graduate	2,618	89.1	10.9
Income	Less than $15,000	432	93.0	7.0
	$15,000-$24,999	446	92.6	7.4
	$25,000-$34,999	254	93.8	*
	$35,000-$49,999	350	88.6	11.4
	$50,000-$74,999	455	86.5	13.5
	$75,000 or more	1,786	88.1	11.9
Ward	Ward 1	305	87.8	12.2
	Ward 2	340	88.5	11.5
	Ward 3	684	90.0	10.0
	Ward 4	564	91.4	8.6
	Ward 5	439	95.4	4.6
	Ward 6	462	89.2	10.8
	Ward 7	411	90.7	9.3
	Ward 8	330	92.8	7.2

**Suppressed if cell size is less than 50*

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, District of Columbia Behavioral Risk Factor Surveillance System (BRFSS), 2011

Immunization

Healthy People 2020 Objectives

- **Goal Not Met:** Increase the proportion of adults aged 65 and older who are vaccinated annually against influenza to 90%; the District of Columbia rate is 56.7%.
- **Goal Not Met:** Increase the proportion of adults aged 65 or older who are vaccinated against pneumonia to 90%; the District of Columbia rate is 63.3%.

Immunization is the process by which a person or animal becomes protected against a disease. This term is often used interchangeably with vaccination or inoculation. Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age 2, many under-immunized children remain, leaving the potential for outbreaks of disease. The District of Columbia Department of Health works closely with public health agencies and private partners to improve and sustain immunization coverage.

District residents were asked if they ever had a flu shot or spray (Table 7.37). Overall, 37.7% District residents had a flu shot/spray within the past 12 months. District residents were asked if they have ever received a pneumonia shot (Table 7.38). Overall, 32.5% of District residents had a pneumonia vaccination.

Table 7.37. Adult Influenza Vaccine

There are two ways to get the seasonal flu vaccine, one is a shot in the arm and the other is a spray, mist or drop in the nose called FluMist. "During the past 12 months, have you had either a seasonal flu shot or a seasonal flu vaccine that was sprayed in your nose?"

		#	Yes	No
Total		425	37.7	62.3
Sex	Male	164	37.9	62.1
	Female	261	37.5	62.5
Age	18 To 24	118	30.9	69.1
	25 To 34	424	26.7	73.3
	35 To 44	589	36.0	64.0
	45 To 54	733	36.3	63.7
	55 To 64	104	45.4	54.6
	65 Or Older	134	56.7	43.3
Race/Ethnicity	Caucasian/White	191	48.3	51.7
	African American/Black	185	30.3	69.7
	Other	229	35.8	64.2
	Hispanic	172	31.6	68.4
Education	Less than high school	265	29.7	70.3
	High school graduate	692	35.6	64.4
	Some college or tech sch	654	32.2	67.8
	College graduate	262	43.4	56.6
Income	Less than $15,000	442	29.6	70.4
	$15,000-$24,999	450	34.8	65.2
	$25,000-$34,999	259	30.9	69.1
	$35,000-$49,999	352	31.2	68.8
	$50,000-$74,999	454	35.4	64.6
	$75,000 or more	179	45.4	54.6
Ward	Ward 1	310	36.8	63.2
	Ward 2	343	45.2	54.8
	Ward 3	691	51.2	48.8
	Ward 4	566	37.6	62.4
	Ward 5	443	29.1	70.9
	Ward 6	465	40.3	59.7
	Ward 7	415	31.2	68.8
	Ward 8	337	35.3	64.7

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Table 7.38. Pneumococcal Immunization Rates

A pneumonia shot or pneumococcal vaccine is usually given only once or twice in a person's lifetime and is different from the flu shot. "Have you ever had a pneumonia shot?"

		#	Yes	No
Total		372	32.5	67.5
Sex	Male	137	34.6	65.4
	Female	235	30.9	69.1
Age	18 To 24	96	31.4	68.6
	25 To 34	323	22.3	77.7
	35 To 44	463	21.3	78.7
	45 To 54	636	29.8	70.2
	55 To 64	946	29.3	70.7
	65 Or Older	126	63.3	36.7
Race/Ethnicity	Caucasian/White	162	30.0	70.0
	African American/Black	170	35.6	64.4
	Other	188	30.8	69.2
	Hispanic	142	27.8	72.2
Education	Less than high school	251	42.0	58.0
	High school graduate	637	33.1	66.9
	Some college or tech sch	592	36.5	63.5
	College graduate	223	27.2	72.8
Income	Less than $15,000	414	35.7	64.3
	$15,000-$24,999	421	36.5	63.5
	$25,000-$34,999	241	30.8	69.2
	$35,000-$49,999	308	39.2	60.8
	$50,000-$74,999	399	31.6	68.4
	$75,000 or more	150	28.6	71.4
Ward	Ward 1	275	23.5	76.5
	Ward 2	292	33.5	66.5
	Ward 3	590	29.8	70.2
	Ward 4	512	30.2	69.8
	Ward 5	391	35.6	64.4
	Ward 6	408	30.9	69.1
	Ward 7	391	42.0	58.0
	Ward 8	307	32.7	67.3

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Overweight/Obesity

Healthy People 2020 Objectives

- **Goal Met:** Reduce the proportion of adults who are obese to 30.5%; the District of Columbia rate is 23.8%.
- **Goal Met:** Increase the proportion of adults who are at a healthy weight to 33.9%; the District of Columbia rate is 45.4%.

According to the 2011 BRFSS, District adults ranked 47th in obesity which is among the lowest in the nation. It is important to note that while the District of Columbia compared to national rates rank low in obesity, some of the District's wards rank higher than the national rate. More than one-third of U.S. adults (35.7%) are obese.

BMI is calculated from a person's weight and height (Table 7.39) and provides a reasonable indicator of body fatness and weight categories that may lead to health problems. District residents were asked about their height and weight to calculate their BMI (Table 7.40). Overall, 23.7% of District residents were obese.

Table 7.39. Body Mass Index

BMI between 25 and 29.9 is considered overweight and BMI of 30 or higher is considered obese.

Height	Weight Range	BMI	Considered
5'9"	124 lbs or less	Below 18.5	Underweight
	125 lbs to 168 lbs	18.5 to 24.9	Healthy weight
	169 lbs to 202 lbs	25.0 to 29.9	Overweight
	203 lbs or more	30 or higher	Obese

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Table 7.40. BMI

Calculated variable based on Body Mass Index (BMI). BMI is a function of respondent's reported height and weight. "Overweight" is equal to a BMI of 25 to 29 and "Obese" is equal to a BMI of 30 or higher.

		#	Under-weight	Normal Weight	Overweight	Obese
Total		4,368	1.7	45.4	29.1	23.7
Sex	Male	1,716	*	45.6	34.9	18.6
	Female	2,652	2.5	45.2	23.9	28.4
Age	18 To 24	123	*	65.7	22.3	*
	25 To 34	437	*	53.0	24.7	20.8
	35 To 44	599	*	43.3	33.4	22.0
	45 To 54	759	*	36.2	28.0	34.8
	55 To 64	1,064	*	35.1	33.2	30.6
	65 Or Older	1,386	2.4	36.7	34.6	26.3
Race/Ethnicity	Caucasian/White	1,938	1.9	58.5	28.9	10.7
	African American/Black	1,953	*	33.2	28.9	36.7
	Other	232	*	54.5	27.6	16.0
	Hispanic	167	*	51.3	31.6	13.3
Education	Less than high school	269	*	32.4	25.1	39.7
	High school graduate	750	*	35.7	29.5	33.0
	Some college or technical school	673	*	39.0	28.4	31.0
	College graduate	2,665	1.6	56.2	30.4	11.9
Income	Less than $15,000	464	*	31.6	25.1	41.6
	$15,000-$24,999	472	*	34.3	29.1	35.3
	$25,000-$34,999	277	*	40.1	28.9	30.0
	$35,000-$49,999	355	*	43.5	25.6	27.6
	$50,000-$74,999	475	*	46.5	31.4	20.3
	$75,000 or more	1,820	*	53.5	32.9	12.7
Ward	Ward 1	319	*	47.8	31.7	18.9
	Ward 2	352	*	61.6	26.9	11.1
	Ward 3	697	*	58.9	26.6	12.9
	Ward 4	568	*	45.6	29.1	23.2
	Ward 5	451	*	30.1	32.0	36.8
	Ward 6	480	*	43.8	33.6	20.6
	Ward 7	440	*	32.3	28.2	39.2
	Ward 8	361	*	32.9	22.0	42.0

**Suppressed if cell size is less than 50*

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Table 7.41. Exercise/Physical Activity

		Physical Activity Categories				
		#	Highly Active	Active	Insufficiently Active	Inactive
Total		415	34.4	23.0	20.5	22.1
Sex	Male	161	37.5	21.9	21.2	19.5
	Female	253	31.6	24.1	19.9	24.4
Age	18 To 24	115	45.4	24.6	19.2	10.8
	25 To 34	427	30.9	25.8	25.9	17.4
	35 To 44	592	31.1	26.3	22.9	19.7
	45 To 54	733	32.4	22.1	20.6	25.0
	55 To 64	992	33.0	19.7	18.7	28.5
	65 Or Older	129	37.2	17.4	11.9	33.4
Race/Ethnicity	Caucasian/White	189	39.0	31.2	19.8	10.1
	African American/Black	179	31.3	17.1	19.7	31.9
	Other	226	38.5	18.7	21.2	21.7
	Hispanic	171	24.8	20.9	28.8	25.5
Education	Less than high school	249	30.1	15.4	15.1	39.4
	High school graduate	681	33.5	12.9	21.2	32.5
	Some college or technical school	627	32.4	23.4	19.6	24.6
	College graduate	258	36.9	29.1	22.1	11.9
Income	Less than $15,000	423	26.4	18.5	18.8	36.4
	$15,000-$24,999	446	30.3	18.1	16.9	34.6
	$25,000-$34,999	261	30.9	20.9	25.8	22.4
	$35,000-$49,999	341	33.1	21.2	19.1	26.6
	$50,000-$74,999	443	36.6	26.5	17.7	19.1
	$75,000 or more	177	38.0	29.1	21.3	11.5
Ward	Ward 1	298	30.4	20.8	31.0	17.8
	Ward 2	337	41.6	28.7	19.5	10.2
	Ward 3	674	41.8	27.9	18.2	12.1
	Ward 4	551	33.2	22.1	19.1	25.7
	Ward 5	431	33.7	21.2	19.5	25.7
	Ward 6	459	31.2	27.2	23.0	18.5
	Ward 7	404	30.0	20.1	17.4	32.6
	Ward 8	330	30.1	14.0	15.9	40.0

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Physical Activity/Exercise

Healthy People 2020 Objectives

- **Goal Met:** Reduce the proportion of adults who engage in no leisure-time physical activity to 32.6%; the District of Columbia rate is 19.8%.

Regular physical activity is essential to good health, especially for individuals who are trying to lose weight or to maintain a healthy weight. Physical activity reduces risks of cardiovascular disease and diabetes beyond that produced by weight reduction alone. Physical activity can reduce high blood pressure, risk for type 2 diabetes, heart attack, stroke, and symptoms of anxiety, depression and several forms of cancer. Physical activity can also reduce arthritis pain associated with disability and reduce risk for osteoporosis and falls.

District residents were asked if during the past month, other than their job, if they participated in any physical activities or exercise such as running, calisthenics, golf, gardening or walking for exercise. Respondents who reported doing enough physical activity to meet the 300-minute (or vigorous equivalent) aerobic recommendation were classified as "Highly active"; respondents who reported doing 150-300 minutes (or vigorous equivalent) of physical activity as "Active"; respondents who reported doing insufficient physical activity (11-149 minutes) as "Insufficiently active"; and respondents who reported doing no physical activity as "Inactive" (Table 7.41).

Table 7.42. Prevalence of Diabetes

"Has a doctor, nurse or other health professional ever told you that you have diabetes?"

		#	Yes	Yes, but female told only during pregnancy	No	No, pre-diabetes or borderline diabetes
Total		4,551	9.1	0.7	89.0	1.2
Sex	Male	1,739	9.3	-	89.6	1.1
	Female	2,812	9.0	*	88.5	1.3
Age	18 To 24	129	-	*	96.9	2.2
	25 To 34	456	2.7	*	95.8	0.9
	35 To 44	628	5.3	*	93.8	0.1
	45 To 54	782	10.5	*	87.9	0.8
	55 To 64	1,116	17.6	*	80.8	1.5
	65 Or Older	1,440	22.6	*	74.5	2.2
Race/Ethnicity	Caucasian/White	1,997	2.8	*	96.4	0.4
	African American/Black	2,030	15.0	*	83.2	1.2
	Other	244	8.6	*	86.4	4.7
	Hispanic	184	5.4	*	89.8	2.6
Education	Less than high school	292	19.2	*	77.7	2.9
	High school graduate	777	13.4	*	85.1	1.1
	Some college or technical school	710	9.7	*	88.2	0.8
	College graduate	2,754	4.0	0.6	94.5	0.9
Income	Less than $15,000	485	15.4	*	82.5	1.1
	$15,000-$24,999	492	15.5	*	81.1	2.1
	$25,000-$34,999	282	11.3	*	86.6	2.0
	$35,000-$49,999	371	10.2	*	87.0	2.7
	$50,000-$74,999	485	7.1	*	90.6	2.0
	$75,000 or more	1,873	3.3	*	95.8	0.4
Ward	Ward 1	326	4.8	*	92.4	2.5
	Ward 2	362	4.0	*	95.5	0.4
	Ward 3	721	4.4	*	94.0	1.3
	Ward 4	594	9.6	*	87.7	0.4
	Ward 5	469	12.6	*	85.9	1.4
	Ward 6	495	8.4	*	90.2	0.7
	Ward 7	463	13.5	*	83.0	3.3
	Ward 8	377	20.4	*	78.6	0.5

**Suppressed if cell size is less than 50; - Zero response*

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, DC Behavioral Risk Factor Surveillance System (BRFSS), 2011

Diabetes

Healthy People 2020 Objectives

- **Goal Not Met:** Increase the proportion of persons with diabetes who receive formal diabetes education to 62.5%; the District of Columbia rate is 52.9%.
- **Goal Met:** Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (A1C) at least once a year to 71.1%; the District of Columbia rate is 84.3%.
- **Goal Met:** Increase the proportion of persons with diabetes who have an annual dilated eye examination to 58.7%; the District of Columbia rate is 81.9%.
- **Goal Met:** Increase the proportion of adults with diabetes who have at least an annual foot examination to 74.8%; the District of Columbia rate is 76.9%.

In the District of Columbia, diabetes is the sixth leading cause of death and the seventh leading cause of hospital admissions. Diabetes is the seventh leading cause of death in the United States. As of 2010, 25.8 million people—8.3% of the U.S. population—have diabetes; 1.9 million new cases of diabetes were diagnosed in people aged 20 years or older in 2010.

Diabetes is a disease in which blood glucose levels are above normal. Most of the food individuals eat is turned into glucose, or sugar, for our bodies to use for energy. The pancreas, an organ that lies near the stomach, makes a hormone called insulin to help glucose get into the cells of our bodies. When someone has diabetes, your body either does not make enough insulin or cannot use its own insulin as well as it should. Diabetes can cause serious health complications including heart disease, blindness, kidney failure, and lower-extremity amputations.

District residents were asked if they have ever been told by a doctor, nurse or other health professional that they have diabetes (Table 7.42). Overall, 9.1% of District residents have diabetes.

State Health Planning and Development Agency

State Health Planning and Development Agency is responsible for the administration of Health Systems Plan which serves as a guide for the development of health care services by both the public and private sectors; administration, operation, and enforcement of the Certificate of Need program; collection and analysis of health data; and the monitoring of health facilities for compliance with the

Table 7.43. Certificate of Need Applications By Category: 2003-2012

Calendar Year	Applications	Facilities and Services	Replacement and Renovation	Major Medical Equipment	Change of Ownership
2003	20	15	2	3	
2004	20	14	3	3	
2005	18	14	3	1	
2006	25	19	3	1	2
2007	29	19	2	3	5
2008	17	10	3	2	2
2009	25	21	3	0	1
2010	24	18	3	1	2
2011	43	26	6	7	4
2012	39	30	5	2	2

Source: DC Department of Health, Center for Policy, Planning and Evaluation, State Health Planning & Development Agency

requirements that govern the provision of uncompensated care to needy residents.

Certificate of Need Process

As a means of ensuring the availability of high quality, accessible and affordable health care services, the District has a Certificate of Need program (CON). Certificate of Need is essentially a mechanism that requires both public and private providers of health services to receive approval for capital improvements, equipment purchases or the establishment of new health services. District law (DC Official Code 44-401) requires that health care providers obtain a certificate of need when entering into an obligation for any new health care service, capital projects with a budget of $2.5 million or more, major medical equipment costing $1.5 million or more for facilities and $250,000 or more for physician's offices. Table 7.43 shows the CON applications by category.

Vital Records Division

Vital Records Division is responsible for collecting, preserving and administering the District's system of birth and death records.

Vital Statistics: Births

In 2011, there were 9,289 births in the District. This figure represents a 24.0 percent increase in births from 2002 and a 1.5 percent increase compared with 2010. The general fertility rate, a measure of fertility based on the number of women of child-bearing, increased from 54.8 in 2005 to 61.4 in 2008 and started a declining trend from 2009 with a fertility rate of 59.7. In 2011, births to women younger than 20 years of age accounted for 9.8 percent of all births, compared to 10.6 percent of all births in 2010. The proportion of births to single mothers decreased from 54.7 percent in 2010 to 53.4 percent in 2011. The percent of infants weighing less than 2,500 grams increased from 10.2 percent in 2010 to 10.5 percent in 2011. The infant mortality rate in 2011 was 7.4 per 1,000 live births, which was a historic low in the District of Columbia. This rate represents a 7.5 percent decrease from 2010 (Table 7.44).

Births by Race/Ethnicity

The number of births over this 10-year period showed an increasing trend. Births increased by 24 percent between

Table 7.44. Annual Live Births and Infant Deaths by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
Live Births Total**	7,494	7,616	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289
Married Women	3,261	3,523	3,495	3,492	3,613	3,679	3,846	3,950	4,093	4,290
Single Women	4,233	4,093	4,442	4,448	4,908	5,190	5,278	4,995	5,008	4,963
General Fertility Rate	52.1	53.1	55.2	54.8	58.3	60.0	61.4	59.7	56.4	55.9
Percent of births to Women Under 20 Years	12.8	11.4	11.2	11.0	12.0	12.1	12.2	11.7	10.6	9.8
Percent of Low Birth weight Infants	11.6	11.0	11.1	11.2	11.6	11.1	10.5	10.3	10.2	10.5
Infant Deaths	86	78	94	108	96	116	100	89	73	69
Infant Death Rate Per 1,000 Live Births	11.5	10.2	11.8	13.6	11.3	13.1	10.9	9.9	8.0	7.4

**Preliminary data.*
*** Numbers may not add up Total due to missing or unreported information.*

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

Table 7.45. Annual Live Births by Race/Ethnicity, Education of Mother, and Pre-Term Birth by Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
All Races Total**	7,494	7,616	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289
Black	4,532	4,566	4,684	4,575	4,848	4,926	5,031	4,847	4,940	4,903
White	1,808	1,925	2,115	2,171	2,312	2,370	2,494	2,655	2,638	2,843
Asian & Pacific Islander	193	225	225	165	182	215	220	298	365	420
Other	925	881	881	1,009	1,164	1,330	1,361	904	622	612
Hispanic Origin***										
Hispanic	1,000	975	1,028	1,132	1,344	1,487	1,527	1,498	1,351	1,358
Non-Hispanic	6,494	6,641	6,909	6,806	7,175	7,383	7,596	7,305	7,721	7,828
Education of Mother (Percent)										
Primary & Secondary	50.1	49.8	48.0	47.8	48.2	50.0	50.0	46.3	46.5	45.5
Post-Secondary	40.9	43.9	44.0	43.0	42.9	42.8	45.6	51.2	51.8	53.1
Percent of Pre-Term Birth										
< 37 Weeks Gestational Age	12.4	12.5	12.5	13.4	13.4	12.2	12.2	11.0	10.4	11.0

Preliminary data.* * Numbers may not add up Total due to missing or unreported information.* ****Persons of Hispanic origin may be of any race.*

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

2002-2011. During this same period, the proportion of births to black mothers declined by 12.7 percent. Since 2002, the proportion of births to white mothers showed a steady upward trend. Births to white mothers increased by 27 percent from 24.1 percent in 2002 to 30.6 percent in 2011. The proportion of births to Hispanic mothers also showed an increasing trend. Births to Hispanic mothers increased by 9.8 percent from 13.3 percent in 2002 to 14.6 in 2011. The number of birth to Asian & Pacific Islanders also increased during the reporting period (Table 7.45).

Births to women with post-secondary education (i.e., some college or higher) increased by 29.8 percent from 40.9 percent in 2002 to 53.1 percent in 2011 and births among women with primary & secondary education declined 9.2 percent during the same period. Preterm birth was highest with 13.4 percent in 2005 and 2006 but the lowest in 2010 (10.4 percent).

Births by Ward

As shown in Table 7.46, from 2002-2011, except the years 2005 and 2006, Ward 8 had the largest number of births. From 2005-2011, Ward 4 had the second highest number of births. Ward 2 had the fewest number of births followed by Ward 3 from 2002-2011.

Vital Statistics: Termination of Pregnancies

Abortions performed in the District are reported to the DOH on a voluntary basis by hospitals and free-standing clinics. The DOH does not receive reports on abortions performed in private physician's offices. Abortions performed on District residents in other states are included in the reporting on a voluntary basis. During the past seven years, the number of reported abortions averaged 1,861 per year. The number of reported abortions for District residents increased by 1.7 percent between 2010 and 2011, while the abortion rate decreased by less than 1 percent. Of the 1,941 abortions reported in 2011, 12.1 percent were performed on women under the age of 20. Almost 60 percent of the procedures were performed on women

Table 7.46. Annual Live Births by Ward, District of Columbia 2002-2011 Calendar Year

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011*
All Wards Total**	7,494	7,616	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289
Ward 1	1,126	1,053	1,141	1,123	1,262	1,243	1,306	1,227	1,219	1,174
Ward 2	757	759	763	799	846	634	682	693	691	601
Ward 3	921	956	1,013	936	913	796	786	765	801	842
Ward 4	1,001	1,034	1,088	1,196	1,316	1,460	1,467	1,441	1,324	1,423
Ward 5	787	791	854	839	898	1,041	1,085	1,099	1,067	1,089
Ward 6	850	834	946	949	991	939	998	1,067	1,118	1,245
Ward 7	822	932	898	945	1,015	1,210	1,222	1,162	1,218	1,218
Ward 8	1,221	1,252	1,231	1,150	1,249	1,545	1,583	1,521	1,635	1,667

Preliminary data.* * Numbers may not add up Total due to missing or unreported information.*

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

Table 7.47. Number and Rate* of Abortions Reported Performed on District Residents by Calendar Year

	2005		2006		2007		2008		2009		2010		2011	
Maternal Age	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**
Under 15 years**	27	1.7	9	0.6	8	0.6	7	0.5	14	1.0	19	1.5	10	0.8
15-19 years	444	21.9	204	9.9	178	8.4	208	9.8	240	11.1	275	13.1	232	11.3
20-24 years	830	30.5	504	18.0	464	16.2	414	14.2	594	21.9	593	16.8	612	18
25-29 years	679	22.7	498	16.6	447	14.7	385	12.2	483	15.0	507	13.5	519	13.1
30-34 years	407	16.3	269	10.9	282	11.3	221	8.9	288	10.7	302	10.6	345	11.2
35-39 years	219	9.9	158	7.1	160	7.2	118	5.4	137	5.9	163	7.6	168	7.7
40 years and older***	80	3.9	51	2.5	47	2.3	50	2.5	50	2.5	49	2.6	50	2.6
Not Reported	0	-	4	-	1	-	0	-	0	-	1	-	5	-
Total****	2,686	18.5	1,697	11.6	1,587	10.7	1,403	9.4	1,806	12.0	1,909	11.8	1,941	11.7

**These are the rates per thousand women aged 15-44 years, using the Bureau of the Census July 2005-2009 population estimates and 2010 census. Rates are calculated by dividing the number of abortions by the number of women in the age class being considered and multiplying by 1,000.*
***For "under 15 years," rate computed by relating the number of events to women under 15 years to women aged 10-14 years.*
****For "40 years and older," rate computed by relating the number of events to women aged 40 years and over to women aged 40-44 years.*
*****For the total, rate computed by relating the number of events to women of all ages to women aged 15-44 years.*

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

in their twenties, while 26.4 percent were performed on women in their thirties and 2.6 percent on women in 40 years and older. The rate of abortion in 2011 was 11.7 per 1,000 live women between the ages of 15 and 44 (Table 7.47). In 1988, Congress prohibited the District government from paying for abortions with federal or local funds, except in cases to save the life of the mother.

Vital Statistics: Deaths

In 2011, there were 4,582 District resident deaths recorded (Table 7.48). Total District resident deaths have decreased in each of the past five years. In 2011, deaths decreased by 11.3 percent from 2007. When examined by race and gender, the trends show a 12.1 percent decrease among black and other non-white males in contrast to a decrease of 18.5 percent among white males. For black and other non-white females, total deaths decreased 6.0 percent compared with a decrease of 20.2 percent among white females.

The number of deaths among black and other non-white females in 2011 was disproportionate to their numbers in the population. This group accounted for 41.6 percent of all deaths of residents, yet accounted for only 32.9 percent of the District's population.

Vital Statistics: Leading Causes of Death

The leading cause of death in the District of Columbia and in the nation in 2011 was heart disease. In the District, the age-adjusted death rate from heart disease decreased by 16.1 percent from 2007 to 2011, with a consistent downward trend beginning in 2008. Nationally, the age-adjusted death has decreased by 9 percent during the same five-year period. The second highest cause of death is cancer, which has decreased by 8.7 percent in the District between 2007 and 2011. As of 2011 in the District, Cerebrovascular Diseases (which leads to stroke) and Accidents were the third and fourth causes of death, while they were ranked 4th and 5th in the United States, respectively. From 2007 to 2011, the rate of deaths due to Accidents decreased by 19 percent in the District, which made the District's deaths due to Accidents lower than national levels. Deaths due to HIV/AIDS in the District have

Table 7.48. Deaths by Race and Gender in the District of Columbia by Calendar Year

	2007	2008	2009	2009 %	2010	2010 %	2011*	2011* %
Black & Other Non-White races								
Male	1,979	2,037	1,967	40.8	1,777	38.1	1,739	38.0
Female	2,030	2,028	1,868	38.8	1,877	40.2	1,908	41.6
Subtotal	4,009	4,065	3,835	79.6	3,654	78.2	3,647	79.6
White								
Male	599	573	520	10.8	495	10.6	488	10.7
Female	560	486	462	9.6	521	11.2	447	9.8
Subtotal	1,159	1,059	982	20.4	1,016	21.8	935	20.4
Total	**5,168**	**5,124**	**4,817**	**100.0**	**4,670**	**100.0**	**4,582**	**100.0**

**Preliminary data.*

Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, Data Mgmt & Analysis Division. U.S. Census Bureau, Population Division.

Table 7.49. Leading Causes of Death in The District of Columbia Age-Adjusted Rate Per 100,000 Population

DC Rank*	Cause of Death	2007	2008	2009	2010	Preliminary 2011	% Change 2007-2011
1	Heart Disease	228.6	232.6	231.4	221.4	191.9	-16.1
2	Malignant Neoplasms (Cancer)	197.0	192.4	190.2	177.1	179.8	-8.7
3	Cerebrovascular Diseases	33.2	35.0	34.3	32.4	34.1	2.7
4	Accidents	33.1	28.8	35.1	34.9	26.8	-19.0
5	Chronic Lower Respiratory Diseases	21.1	22.4	24.2	25.5	25.5	20.9
6	Diabetes	25.6	27.6	23.0	24.9	25.7	0.4
7	Alzheimer's Disease	19.1	19.1	16.0	18.7	19.7	3.1
8	Homicide/Assault	25.2	28.8	20.5	17.1	15.4	-38.9
9	Influenza and Pneumonia	19.1	19.0	13.0	13.6	15.4	-19.4
10	HIV/AIDS	31.8	27.6	23.6	20.4	14.4	-54.7
10	Septicemia	21.3	23.2	15.0	15.3	16.1	-24.4

**Rank based on number of District of Columbia resident deaths in 2011.*

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

been steadily declining from 2007; a decrease of 54.7 percent between 2007 and 2011. During this five-year period, the death rate due to homicide (assault) has also decreased by 38.9 percent in the District; however, the District's homicide (assault) death rate is still much higher than the national rate of 5.2. The District's mortality rates for six of the 10 leading causes of death were higher than the national rates: heart disease, cancer, diabetes, homicide/assault, HIV/AIDS, and septicemia. Cerebrovascular diseases (which leads to stroke), accidents, chronic lower respiratory diseases, Alzheimer's disease, and influenza/pneumonia death rates in the District were lower than in the nation.

Chronic disease, including heart disease, cerebrovascular diseases (stroke), cancer, and diabetes, account for 56.4 percent of all deaths in the District in 2011. If HIV/AIDS is included as a chronic disease, then these five causes of death account for 58.4 percent in 2011.

Deaths by Ward

As shown in Table 7.51, from 2007-2011, Ward 5 had the highest crude death rate among all wards, except in year 2008 when Ward 4 had the highest rate. Ward 4 had the second highest death rate in 2007 and 2009, while Ward 7 had the second highest death rate in 2010 and 2011. Ward 2 had the lowest crude death rate followed by Ward 1 from 2009-2011. Crude death rates in all wards have decreased in the last 5 years, except in Wards 7 and 8, which increased by 5.8 and 4.4 percent, respectively.

Table 7.50. Leading Causes of Death in The United States Age-Adjusted Rate Per 100,000 Population

U.S. Rank*	Cause of Death	2007	2008	2009	2010	Preliminary 2011	% Change 2007-2011
1	Heart Disease	190.9	186.5	180.1	179.1	173.7	-9.0
2	Malignant Neoplasms (Cancer)	178.4	175.3	173.2	172.8	168.6	-5.5
3	Chronic Lower Respiratory Diseases	40.8	44.0	42.3	42.2	42.7	4.7
4	Cerebrovascular Diseases	42.2	40.7	38.9	39.1	37.9	-10.2
5	Accidents	40.0	38.8	37.3	38.0	38.0	-5.0
6	Alzheimer's Disease	22.7	24.4	23.5	25.1	24.6	8.4
7	Diabetes	22.5	21.8	20.9	20.8	21.5	-4.4
8	Influenza and Pneumonia	16.2	16.9	16.2	15.1	15.7	-3.1
9	Nephritis, Nephrotic Syndrome and Nephrosis	14.5	14.8	14.9	15.3	13.4	-7.6
10	Intentional Self-Harm (Suicide)	11.3	11.6	11.8	12.1	12.0	6.2

**Rank based on number of deaths in the United States in 2011.*

Source: U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics.

Table 7.51. Crude Death Rates by Ward, District of Columbia, 2007-2011 Calendar Year

	2007	2008	2009	2010	Preliminary 2011	% Change 2007-2011
City-wide Mortality Rate	887.6	866.7	803.3	776.1	761.5	-14.2
Ward 1	572.5	594.4	547.8	506.6	429.2	-25.0
Ward 2	744.4	701.9	403.1	326.6	331.6	-55.5
Ward 3	739.8	679.2	568.4	596.2	537.9	-27.3
Ward 4	1,126.0	1,148.8	1,035.6	966.0	960.8	-14.7
Ward 5	1,241.2	1,114.9	1,358.5	1,182.9	1,139.9	-8.2
Ward 6	849.5	811.8	645.8	694.5	664.5	-21.8
Ward 7	1,035.8	1,078.0	1,023.7	1,068.0	1,096.1	5.8
Ward 8	828.9	793.8	842.9	898.0	865.5	4.4

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

Department of Mental Health

The mission of the Department of Mental Health (DMH) is to support prevention, resiliency and recovery for District residents in need of public mental health services. To fulfill its mission DMH develops, supports and oversees a comprehensive, community-based, consumer driven, culturally competent, quality mental health system that is responsive and accessible to children, youth, adults, and their families. DMH contracts with a network of community-based, private providers and also provides direct services through the Comprehensive Psychiatric Emergency Program, Mental Health Services Division, School-Based Mental Health Program, and Saint Elizabeths Hospital.

Transition to Dept of Behavioral Health

Effective October 1, 2013, the Department of Mental Health will merge with the Addiction Prevention and Recovery Administration in the Department of Health to integrate treatment and services for residents with mental health and substance use disorders. Mayor Vincent C. Gray formed the new Department of Behavioral Health to improve the health and well-being of residents who receive mental health and substance use treatment and supports. Research shows that integrated treatment produces better outcomes for individuals with co-occurring mental and substance use disorders. Without integrated treatment, one or both disorders may not be addressed properly. The overall vision of an integrated system is to effectively serve individuals with co-occurring disorders whether they are seeking help for substance use disorders or mental health conditions. It is estimated that annually about 22,000 adults and children receive mental health treatment while APRA serves about 12,000 residents. Over the next year, the new Department will merge separate clinical services and develop an infrastructure within the mental health and substance use systems to support integrated service delivery. Residents who only seek mental health treatment or only substance use treatment will continue to be served by the new Department.

Consumers in Department of Mental Health Programs

Tables 7.52-54 provide a profile of people receiving men-

Table 7.52. Number of Individuals Receiving Services in FY 2010

Age	Sex	Black	White	Hispanic	More than one race identified	Other	Total
Under17	Female	1,478	5	50	0	20	1,553
	Male	2121	10	103	0	29	2,263
	Unknown	0	0	1	0	0	1
	Total	3,599	15	154	0	49	3,817
18-64	Female	6,791	373	293	5	341	7,803
	Male	6,472	447	261	3	566	7,749
	Unknown	51	20	9	0	23	103
	Total	13,314	840	563	8	930	15,655
65+	Female	296	52	12	0	62	422
	Male	222	45	11	0	69	347
	Unknown	4	2	0	0	1	7
	Total	522	99	23	0	132	776
Total		**17,435**	**954**	**740**	**8**	**1,111**	**20,248**

Source: Department of Mental Health Uniform Reporting System Data submitted to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

Table 7.53. Number of Individuals Receiving Services in FY 2011

Age	Sex	Black	White	Hispanic	More than one race identified	Other	Total
Under17	Female	1,733	5	67	0	27	1,832
	Male	2,377	6	92	0	28	2,503
	Unknown	0	0	0	0	0	0
	Total	4,110	11	159	0	55	4,335
18-64	Female	7,322	425	316	6	353	8,422
	Male	7,227	493	310	5	552	8,587
	Unknown	7	8	1	1	5	22
	Total	14,556	926	627	12	910	17,031
65+	Female	282	60	17	0	64	423
	Male	214	54	12	0	67	347
	Unknown	1	0	0	0	0	1
	Total	497	114	29	0	131	771
Total		**19,163**	**1051**	**815**	**12**	**1,096**	**22,137**

Source: Department of Mental Health Uniform Reporting System Data submitted to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

Table 7.54. Number of Individuals Receiving Services in FY 2012

Age	Sex	Black	White	Hispanic	More than one race identified	Other	Total
Under17	Female	1,714	4	45	0	36	1,799
	Male	2,358	7	67	0	83	2,515
	Unknown	1	1	0	0	1	3
	Total	4,073	12	112	0	120	4,317
18-64	Female	7,845	415	295	4	671	9,230
	Male	7,996	465	278	6	839	9,584
	Unknown	25	18	1	4	7	55
	Total	15,866	898	574	14	1517	18,869
65+	Female	306	61	14	0	82	463
	Male	242	55	15	1	84	397
	Unknown	5	0	0	0	1	6
	Total	553	116	29	1	167	866
Total		**20,492**	**1,026**	**715**	**15**	**1,804**	**24,052**

Source: Department of Mental Health Uniform Reporting System Data submitted to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

tal health services by age, gender, and race for the period FY10, FY11, and FY12. The total number of persons served is 20,248; 22,137 and 24,052, respectively for the three fiscal years for an average of 22,146 served annually. These individuals received services from DMH either through its government operated mental health programs or through community based mental health providers. The majority of people who receive services are eligible for Supplemental Security Income, Medicaid or are uninsured.

Mental Health Services and Supports

DMH offers specialty services for adults and children/youth that include evidence-based and promising practices. These services include: assertive community treatment (ACT) for adults; and multi-systemic therapy (MST) and functional family therapy (FFT), and high fidelity wraparound (HFW) for children/youth. HFW is considered a promising practice, not an evidence-based practice. Table 7.55 shows the number of adults and children/youth who received these services in FY10-FY12.

Table 7.55. Adults and Children/Youth Receiving Evidenced-Based and Promising Practices

Services	Population	FY 2010	FY 2011	FY 2012
ACT	Adults	1020	1125	1300
MST	Children/Youth	122	129	120
FFT	Children/Youth	N/A	82	224
HFW	Children/Youth	171	211	282

Source: Department of Mental Health

Access HelpLine

DMH operates a 24/7 Access HelpLine (1-888-793-4357) for emergency psychiatric care and to enroll for ongoing mental health services. In April 2011, the Access HelpLine (AHL) was granted full certification as a Suicide Lifeline Network provider for the District of Columbia by the American Association of Suicidology. AHL provides Suicide Lifeline Network callers with 24-hour suicide prevention via telephone access. The activities include: 1) responding to callers who access the Suicide Lifeline Network; 2) providing suicide intervention; and 3) dispatching mobile crisis services when necessary.

In response to the increasing number of suicides at transit stations, during the latter part of FY11 in partnership with the Washington Metropolitan Area Transit Authority (WMATA), AHL began operating the WMATA Life Line. Also, in FY12 DMH began providing suicide prevention training to WMATA staff. Table 7.56 shows calls made to the AHL administrative, crisis and suicide lines.

Table 7.56. Access HelpLine Administrative, Crisis and Suicide Lines

	FY 2010	FY 2011	FY 2012
Administrative Line			
Inbound Calls	24,353	45,149	20,800
Outbound Calls	32,825	34,052	34,169
Total Admin. Line Calls	**57,178**	**79,201**	**54,969**
Crisis Line			
Inbound Calls Only	25,491	30,495	38,322
Suicide Life Line			
Inbound Calls Only	122	479	1,718
WMATA Life Line			
Inbound Calls Only	N/A	N/A	75
Total Other Calls	**25,613**	**30,974**	**40,115**

Source: Department of Mental Health

Crisis Emergency Services

DMH is responsible for providing emergency assistance to adults and children experiencing a psychiatric or emotional crisis. The Comprehensive Psychiatric Emergency Program (CPEP) is a 24-hour/7-day a week operation that provides immediate psychiatric evaluation, treatment and stabilization, and eight (8) extended observation beds if necessary for adults. There were 10,073 total admissions to CPEP during FY10-FY12, as shown in Table 7.57. This data represents total encounters not unduplicated counts.

During this 3-year period, a little more than half (55.4% or 4784) of admitted consumers were males, and the largest ethnic group (86.8% or 7498) was Black/African American (which includes individuals of African descent). The average age for consumers was 43 years for females, 42 years for males, and 38 years for transgendered individuals. The demographic profile of the adults who received emergency psychiatric services in FY10-FY12 is shown in Table 7.58.

Table 7.57. Number of Adults Receiving Emergency Psychiatric Services

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
FY10	341	337	332	333	288	326	276	330	321	357	380	322	3,941
FY11	305	305	304	319	318	382	352	350	314	313	331	328	3,921
FY12	340	332	318	294	315	365	339	312	340	331	334	305	3,925
Total	**986**	**974**	**954**	**946**	**921**	**1,073**	**967**	**992**	**975**	**1,001**	**1,045**	**955**	**10,073**

Source: Department of Mental Health

Table 7.58. Demographic Profile of Adults Receiving Emergency Psychiatric Services by Race/Ethnicity

Gender	American Indian	Asian/ Pacific Islander	Black/ African American	Caucasian/ White	Hispanic	Other	Total
Female	3	25	3,356	345	84	9	3,822 (44.2%)
Male	2	39	4,110	436	174	23	4,784 (55.4%)
Transgender	0	0	32	1	3	0	36 (0.4%)
Total	5 (0.06%)	64 (0.7%)	7,498 (86.8%)	782 (9%)	261 (3%)	32 (0.4%)	8,642 (100%)

Source: Department of Mental Health

CPEP also oversees mobile crisis teams that provide crisis intervention services for adults who are unable or unwilling to come to the facility. During FY10-FY12, the teams provided 7,200 face-to-face and phone engagements to 3,717 unique individuals as shown in Table 7.59.

In addition to on-site crisis stabilization, the mobile crisis services teams perform assessment for voluntary and involuntary hospitalizations and linkages to other services including ongoing mental health care and substance abuse detoxification and treatment. The mobile crisis services teams also provide follow-up care for consumers admitted to CPEP who are in need of further assistance (e.g., transport to their residence or to a core services agency intake appointment after discharge). Consumers in crisis may experience one or more mental health issues. The crisis teams reported that of the 3,306 crisis response episodes, 2,086 (63.1%) involved a consumer with mental illness who was decompensating; 1,062 (32.1%) were suicidal; 481(14.5%) were homicidal; 232 (7%) were using/abusing substances; 224 (6.8%) had self-neglect behaviors; 153(4.6%) also had medical issues; and 28 (0.8%) were hoarders.

Table 7.60. Children and Adolescent Mobile Psychiatric Service Calls and Deployments

Activity	FY2010	FY2011	FY2012
Total Calls	1,015	979	1,276
Total Deployable Calls	498	545	708
Total Deployments	581	482	644
Unduplicated Children Served	414	324	882

Source: ChAMPS Program Anchor Mental Health Catholic Charities of Washington DC

With regard to child and youth crisis services, DMH contracts with the Children and Adolescent Mobile Psychiatric Service known as ChAMPS, to provide rapid on the scene response to children facing an emotional or mental health crisis. This mobile crisis service team stabilizes the child, helps families manage the crisis, and in the case of foster parents, seeks to avoid placement disruption. Table 7.60 shows ChAMPS deployments during FY 10-FY12. In FY10, data for deployable calls was tracked beginning with the second through the fourth quarters.

Table 7.59. Mobile Crisis Service Engagements

Response Types	FY10	FY11	FY12	Total
Crisis Response – Face to Face	1,161	1,019	1,084	3,264 (45.3%)
Crisis Response – Phone Only	15	8	19	42 (0.6%)
Outreach – Face to Face	528	501	344	1,373 (19.1%)
Outreach – Phone Only	628	522	251	1,401 (19.5%)
Transportation Assistance - CPEP Discharge	421	342	357	1,120 (15.5%)
Total	2,753 (38.2%)	2,392 (33.2%)	2,055 (28.5%)	7,200 (100%)

Source: Department of Mental Health

Housing Services

To increase the supply of quality, affordable housing available to people with mental illness, DMH operates a rental housing subsidy program. In addition, to support community integration and recovery, DMH supports community residential facilities and supportive independent living. DMH has developed meaningful partnerships with the DC Housing Authority and Department of Housing and Community Development.

DMH awarded 133 new housing subsidies in FY12, which supported reaching the goal of 1,496 housing subsidies by the end of the fiscal year. Also, during FY12 DMH contracted with The Technical Assistance Partnership, Inc. to develop a housing strategic plan that was finalized in September 2012. This process involved evaluating DMH's current system of supported housing to identify strategies to ensure a continuum of community-based housing and

Table 7.61. Consumers Participating in Housing Programs			
Housing Program	**FY2010**	**FY2011**	**FY2012**
Home First	766	756	830
Supported Independent Living (SIL)	476	551	551
Local Rent Subsidy (LRSP)	43	80	93
Federal Vouchers (set asides)	368	368	368
Contract Community Residential Facilities (CRFs)	256	220	220
Independent Community Residential Facilities (ICRFs)	472	472	472
Total	**2,379**	**2,447**	**2,534**

Source: Department of Mental Health

support services that meet consumer needs, are built on best practices, consistent with DMH priority population needs, and cost-effective. The planning process included stakeholders, DMH staff, and other partners. The result of this work is the 5-year Supportive Housing Strategic Plan FY 2012- FY2017, which establishes guiding strategies for DMH's future activity in permanent supportive housing and specific actions to be implemented.

Supportive Housing Programs include services and supports to help individuals obtain and maintain appropriate housing. Table 7.61 shows the number of people who participated in the housing programs in FY10-FY12.

Homeless Services

The Homeless Outreach Program provides a wide variety of services for consumers with mental illness, providers and community members, and individuals initially identified as homeless. The primary services include: outreach and crisis services to individuals through regular visits to shelters; on the streets and in homes in the District; and coordination with other outreach program's social workers and community members to provide assessments, referrals, traveler's assistance, brief intervention services, and referrals to overnight shelter services.

Table 7.62. Unduplicated Consumers Served by Homeless Status					
Homeless Status	**Consumer Type**	**FY10**	**FY11**	**FY12**	**Total**
Homeless	Single-Adult	1141	909	841	2891 (75.1%)
	Family-Adult	109	111	110	330 (8.6%)
	Family-Child	56	111	109	276 (7.2%)
Not Homeless	Single-Adult	109	88	67	264 (6.9%)
	Family-Adult	43	9	4	56 (1.5%)
	Family-Child	2	0	1	3 (0.1%)
Unknown	Single-Adult	9	13	5	27 (0.7%)
Totals		**1,469**	**1,241**	**1,137**	**3,847 (100%)**

Source: Department of Mental Health

During FY10-FY12, the Homeless Outreach Program served 3,847 consumers. Of these, 3,497 (91%) were known homeless individuals; and the majority (2,891 or 75.1%) were single-adults (Table 7.62).

Also, during the reporting period consumers received a total of 9,824 face-to-face engagements with an average of three per consumer. The main services provided during these engagements included: 9,692 (98.7%) rapport building encounters; 2,012 (20.8%) assessments; 214 (2.2%) admissions to CPEP or a community hospital for psychiatric care; 36 (0.4%) admissions to an emergency room for health issues; and 217 (2.2%) encounters to assist with an existing or new core service agency linkage.

Mental Health Services Division

The Mental Health Services Division provides specialized mental health services that are not otherwise readily available within the DMH service system or the private sector. The programs and services include: 1) a same day urgent care clinic; 2) multicultural services; 3) intellectual/developmental disability and deaf /hard of hearing services; and 4) pharmacy services.

The Same Day Urgent Care Clinic services are intended to intervene to prevent relapse or full-blown crisis by alleviating presenting problems. Promotion of emotional health is enhanced beyond the services typically provided by a community clinic that serves individuals with major mental illnesses. This is achieved as follows: 1) adult and child consumers may walk-in unscheduled and be evaluated the same day; 2) same day access to a psychiatrist; 3) psychotherapy services are available on a scheduled basis through the Residents' Clinic; and 4) on-site pharmacy that serves individuals without insurance, all walk-in consumers who see a psychiatrist can also have their prescriptions filled that day. The number of consumers served by the Same Day Urgent Care Clinic in FY10-FY12 (Table 7.63).

Table 7.63. Unduplicated Consumers Served by Same Day Urgent Care Clinic			
Population	**FY2010**	**FY2011**	**FY2012**
Adults	2,080	2,825	3,083
Children/Youth	402	488	489
Totals	2,482	3,313	3,572

Source: Mental Health Services Division

School Mental Health Program

The School Mental Health Program promotes social and emotional development and addresses psychosocial and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom based interventions, psychoeducational groups, consultation with parents and teachers, crisis intervention, as well as individual, family and group treatment. The number of DC Public and Public Charter Schools that received services by school year include: 52 in SY 2009-2010; 59 in SY 2010-2011; and 53

in SY 2011-2012.

Table 7.64 shows the number of participants receiving various services during the three school years. Table 7.65 shows the number of participants in prevention and early intervention activities during the same period. The decrease in service utilization across years was likely due to the reduction in the number of full-time employees across the two academic years (i.e., loss of six contract positions and four vacancies during the 2011-2012 School Year).

Table 7.64. Treatment Services Provided by School Mental Health Program Clinicians

	SY 2009-2010	SY 2010-2011	SY 2011-2012
Referrals	1,715	1,538	1,453
Referrals Seen within the same month of referral	1,255	1,179	1,088
Students on Clinical Caseload	737	665	609
Individual Therapy Sessions	9,405	8,699	8,209
Family Therapy Sessions	539	629	544
Group Therapy Sessions	409	353	171

Source: Dept of Mental Health, School Mental Health Program

Table 7.65. Prevention and Early Intervention Services Provided by School Mental Health Program Clinicians

	SY 2009-2010	SY 2010-2011	SY 2011-2012
Prevention Sessions	1,868	1,792	1,098
Walk-ins	4,474	4,072	3,917
Conflict Resolution Sessions	1,906	15,50	1,428
Classroom Observations	2,233	2,284	1,875
Parent Consultations	2,385	2,249	2,202
Teacher Consultations	5,077	4,703	4,814
Other Staff Consultations	4,640	4,320	5,064
Referrals Made for Outside MH Services	152	131	132
Presentations, Workshops, and Conferences	206	217	194

Source: Dept of Mental Health, School Mental Health Program

Saint Elizabeths Hospital

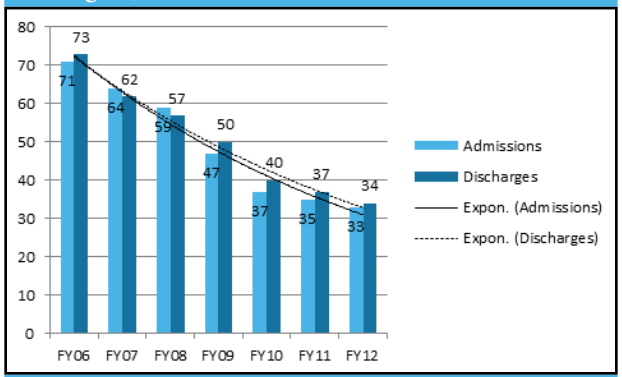
Saint Elizabeths Hospital (SEH) provides inpatient care for adults with serious and persistent mental illnesses, including those who have been civilly and forensically committed. Founded in 1855 at the urging of Dorothea Dix, Saint Elizabeths was the first large-scale, federally run mental health and psychiatric care facility in the United States. It was transferred to the District of Columbia in 1987. Working with community based mental health providers, Saint Elizabeths focuses on maximizing the potential for recovery so that people with mental illness will be able to integrate into the larger community with the appropriate level of support necessary for successful reintegration. In May 2010, a state-of-the-art, 448,190 square foot (10.3 acres) facility opened that features a number of strategies to lessen the building's environmental impact, including the use of natural light, bio-retention areas, and a 28,000 square foot green roof that is likely the largest on any mental health facility in the country.

For the past several years, SEH saw a consistent and significant census reduction as a result of decreased admissions and concerted efforts to appropriately discharge individuals in care to the community. As a result, discharges have exceeded admissions. In FY06, there were 846 admissions and 872 discharges, 71 admissions and 73 discharges per month on average. FY12 data show admissions (400 in total or 33 per month) and discharges (411 in total or 34 per month) represent only 47% of the FY06 level. The number of discharges has exceeded the number of admissions every year since FY09, contributing to the steady reduction of census. The number of individuals served by the Hospital has continued to decline for the 4th consecutive year, falling 32% from September 2008 to September 2012. During September 2012, on average, a total of 273 individuals were in care per day, which is a 6% reduction from September 2011, when SEH served 290 individuals on a given day.

A majority of admissions at SEH were either transfers from another psychiatric unit of a community hospital or pre-trial defendants admitted by court order (Table 7.68). The forensic admissions include those who were adjudicated to be not guilty by reason of insanity (NGBRI) and have been residing in the community but are re-admitted to the Hospital.

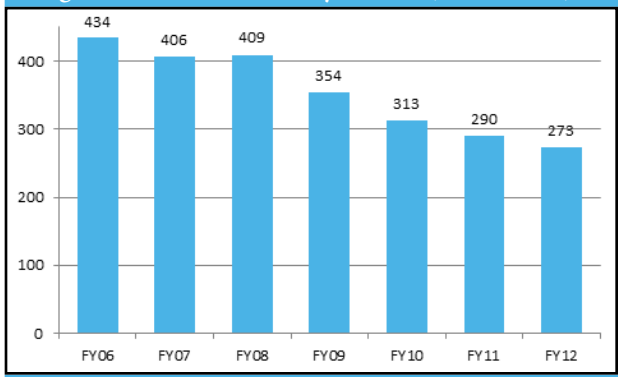
In the past few years, individuals admitted as pre-trial defendants increased while those admitted for emergency or with a civil commitment legal status significantly declined. SEH had a total of 237 admissions with a civil legal status in FY10 but only 171 and 173 civil admissions in FY11 and FY12, respectively, whereas pre-trial admissions increased from 184 in FY10 to 228 in FY11 and

Figure 7.23. Monthly Average Admissions vs. Discharges (FY06-FY12)



Source: PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Mental Health

Figure 7.24. Trend of Daily Census (FY06-FY12)



Source: PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Mental Health

declined a little bit to 204 in FY12.

As of September 30, 2012, a total of 105 or 38% of the 279 total individuals in care were those adjudicated to be not guilty by reason of insanity (NGBRI) and 64 or 23% were those court-ordered for inpatient pre-trial examination.

Table 7.66. Monthly Admissions (Civil vs. Forensic)

		Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Total
FY10	Civil	17	20	34	20	16	17	20	13	14	25	21	20	237
	Forensic	19	14	13	13	18	17	21	21	18	22	11	11	205
	Total	**36**	**34**	**47**	**33**	**34**	**34**	**41**	**34**	**32**	**47**	**39**	**31**	**442**
FY11	Civil	13	17	16	11	12	19	16	18	8	11	14	16	171
	Forensic	21	15	19	22	17	17	22	19	17	23	31	29	252
	Total	**34**	**32**	**35**	**33**	**29**	**36**	**38**	**37**	**25**	**34**	**45**	**45**	**423**
FY12	Civil	19	9	19	13	18	14	13	13	12	16	12	15	173
	Forensic	19	22	19	16	17	23	16	22	22	18	14	19	227
	Total	**38**	**31**	**38**	**29**	**35**	**37**	**29**	**35**	**34**	**34**	**26**	**34**	**400**

Source: PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Mental Health

Table 7.67. Legal Status (9/30/10, 9/30/11, 9/30/12)

	Legal Status	9/30/10	9/30/11	9/30/12
Civil	Committed Inpatient	35	31	24
	Committed Outpatient	31	28	21
	Emergency	36	15	22
	Voluntary	43	41	43
	Non Protesting	1	0	0
	Civil Sub-total	146 (47%)	115 (40%)	110 (39%)
Forensic Pre-trial	DC Examination	52	61	59
	DC Mentally Incompetent	5	3	5
	Forensic Pre-trial Sub-total	57 (18%)	64 (22%)	64 (23%)
Forensic Post-trial	Dual (NGBRI/Criminal Convict.)	1	1	1
	NGBRI - DC	91	94	92
	NGBRI - US	10	12	9
	NGBRI - USVI	2	1	1
	Sexual Psychopath (Miller Act)	4	3	2
	Forensic Post-trial Sub-total	108 (35%)	111 (38%)	105 (38%)
Grand Totals		**311**	**290**	**279**

Source: PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Mental Health

Table 7.68. Admission by Source, FY 2010-FY 2012

	FY 2010		FY 2011		FY 2012	
Admission Source	**#**	**%**	**#**	**%**	**#**	**%**
CPEP	67	15%	18	4%	22	6%
Community Hospital - Medical Unit	19	4%	6	1%	2	1%
Community Hospital - Psychiatric Unit	151	34%	149	35%	149	37%
Court/Law Enforcement	189	43%	226	53%	204	51%
Transfer from Forensic Outpatient (CL) to Inpatient	10	2%	16	4%	15	4%
Other or Not Identified*	6	1%	8	2%	8	2%
Total	442	100%	423	100%	400	100%

**This includes those whose admission source information is missing, unverifiable or categorized in inactive values in Avatar.*

Source: PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Mental Health

Health Care Finance

About

The mission of Department of Health Care Finance (DHCF) is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia. DHCF provides health care coverage for nearly one third (or more than 230,000) of District residents, including low-income children, adults, the elderly and persons with disabilities. DHCF is the District of Columbia's state Medicaid agency. In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children, the State Child Health Insurance Program (CHIP), and the DC Healthcare Alliance program, which is a locally funded insurance program for eligible, uninsured District residents. Historically, the District of Columbia has been a leader in health care coverage and in recent years only 6.2% of District residents reported being uninsured, which is among the lowest rates nationally. Health Insurance Coverage in the District of Columbia is estimated from the 2009 DC Health Insurance Survey.

The District of Columbia has made considerable progress toward implementation of the Patient Protection and Affordable Care Act (ACA), including two recent eligibility expansions: (1) Effective July 1, 2010, eligibility was extended to childless adult citizens and legal residents up to 133% of the federal poverty limit (FPL); and (2) effective December 1, 2010, eligibility was extended to cover childless adult citizens and legal residents from above 133% to 200% of the FPL. As an early expansion state, the District of Columbia added over 44,000 childless adults to the Medicaid program in 2010.

Section 2 of the District of Columbia Medicaid State Plan, which addresses eligibility, is currently under revision to incorporate all of the changes to Medicaid eligibility that are required by the ACA, including the implementation of Modified Adjusted Gross Income (MAGI) eligibility rules (to be effective October 1, 2013). DHCF is also currently working with the DC Health Benefit Exchange Authority and the Department of Human Services to launch a new eligibility website that will make it easier for individuals and families to apply for and maintain Medicaid benefits or purchase insurance on the Exchange.

Table 7.69. Medicaid & Alliance Enrollment, Monthly Averages

Services	FY11	FY12	FY13
Total Fee-For-Service	65,066	67,047	67,196
Total Medicaid Managed Care	143,817	151,072	154,897
Alliance Managed Care	24,304	19,357	15,653
Total DHCF Monthly Average	233,188	237,505	238,400

**FY13 is from April 3, 2013 Enrollment Report, Only includes October 2012 and November 2012.*

Source: Department of Health Care Finance, Medical Care Advisory Committee (MCAC), Rolling Monthly Enrollment Reports

Medicaid

Medicaid is a health insurance program that pays for medical services for low-income and disabled people. For those eligible for full services, Medicaid reimburses their doctors, hospitals and pharmacies that are enrolled as DC Medicaid providers. The Medicaid benefit package, which offers federally mandated services, includes doctor visits; hospitalization; eye care; dental services and related treatment; dialysis services; durable medical equipment; emergency ambulance services; hospice services; laboratory services; radiology; medical supplies; mental health services; nurse practitioner services; home and community based services; and other services as approved by the Centers for Medicare and Medicaid Services (CMS) in the State Plan.

Table 7.70. DC Medicaid Income Requirements

Household Size	2013 Federal Poverty Guidelines	300% FPL (Children Only)	200% FPL (Families)
1	$11,490.00	$ 34,470.00	$22,980.00
2	$15,510.00	$ 46,530.00	$31,020.00
3	$19,530.00	$ 58,590.00	$39,060.00
4	$23,550.00	$ 70,650.00	$47,100.00
5	$27,570.00	$ 82,710.00	$55,140.00
6	$31,590.00	$ 94,770.00	$63,180.00
7	$35,610.00	$106,830.00	$71,220.00
8	$39,630.00	$118,890.00	$79,260.00

For families/households with more than 8 persons, add $4,020 for each additional person.

Source: Annual Update of the HHS Poverty Guidelines Published in the Federal Register 1/24/13 https://www.federalregister.gov/articles/2013/01/24

The State Children's Health Insurance Program (CHIP), is a Medicaid program for the children of parents whose incomes are too high for Medicaid, but still too low to pay for their children's health insurance. The program covers doctor's visits, vision, dental care, prescription medication, hospitalization and more. Those who may be eligible include children; adolescents under the age of 19 who live alone; parents and guardians of children; and pregnant women. The program provides health insurance coverage for working families who: (1) live in the District of Columbia; (2) do not have health insurance; and (3) earn income up to 200 percent of the Federal Poverty Level (FPL), or up to 300 percent of the FPL (when covering children only).

Beginning July 2013, health insurance will be offered through one of the three managed care plans for the Medicaid Managed Care and Alliance programs: Thrive Health Plan, AmeriHealth Mercy Family of Cos., and MedStar Family Choice.

Long Term Care

Spending in the Medicaid program is organized across two major types of care: (1) primary and acute care services ($1.2 billion); and (2) long term care ($688.7 million). On the primary and acute care side, essentially 80 percent of all payments are made to the District's managed care plans (53 percent) or directly to the hospitals for inpatient care provided to beneficiaries who are not enrolled in managed care (27 percent). Medicaid funding for long-term care is allocated to providers who deliver services in either institutions or through community-based State Plan and waiver programs. The purpose of the waiver programs is to allow individuals who would normally require institutionalization due to their mental or physical disabilities to receive care in the community. The District of Columbia has two community based waiver programs: the DD waiver for qualifying individuals with developmental disabilities and the EPD waiver for qualifying individuals who are elderly or have physical disabilities. An

Table 7.71. Overall And Per Recipient Cost For Waiver, Personal Care And Institutional LTC Programs, FY2012			
Program Service	**Total Number of Recipients**	**Total Cost for Services**	**Average Cost Per Recipient**
DD Waiver*	1,591	$148,853,889	$93,560
ICF/DD	395	$69,778,061	$176,653
EPD Waiver	3,679	$84,544,759	$22,980
State Plan Personal Care	8,736	$162,448,495	$18,595
Nursing Facilities	3,724	$216,988,015	$58,268
**DD Waiver costs do not include DDS local funds for the waiver.*			
Source: Department of Health Care Finance			

important caveat to the use of community-based care is the federal requirement that the cost of these services, in the aggregate, must be less expensive than institutional care. Tables 7.71-72, taken from DHCF's FY 2014 Budget Briefing, present details on the scope and cost of the District's long-term care programs. As shown, while the waiver programs have high average per-participant cost, they are considerably less expensive than their institutional counterparts.

The Mayor has budgeted $338 million for FY 2014 to cover the inpatient hospital cost of Medicaid beneficiaries who are not in managed care – the so called fee-for-service population. There is a "high cost" group of Medicaid beneficiaries who comprise about 11 percent of the fee-for-service population. Compared to their "lower cost" counterparts, beneficiaries in this group are nearly five times more likely to visit an emergency room; are admitted for inpatient care at five times the rate of the "low cost" group; have hospital stays that are twice as long; average 10 more prescriptions, and are more likely to suffer from multiple chronic conditions. DHCF expects this population to exert continued upward pressure on inpatient hospital costs in FY 2014.

State Plan Personal Care Program

Over the next two years, DHCF will pay special attention to the services provided through DHCF's State Plan Option Personal Care program. The projected growth of over 80 percent from the FY 2013 to the FY 2014 budgets (Table 7.72). A large portion of this amount, however, can be attributed to an agency policy change which now requires that the first eight hours of personal care for individuals in the Elderly and Persons with Disabilities (EPD) waiver be charged to the State Plan Option program.

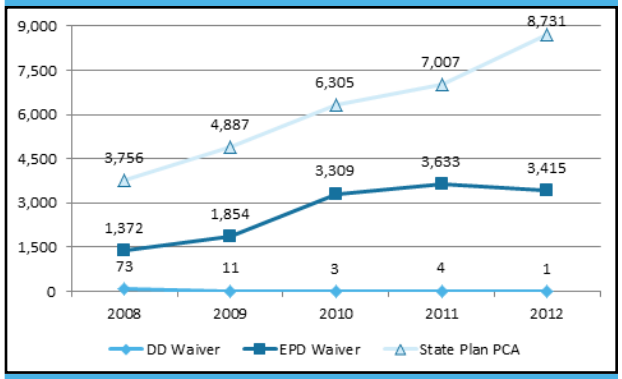
Table 7.72. Budget Request For Select Medicaid Mandatory Services			
Provider Type	**FY 2013 Budget**	**FY 2014 Budget**	**% Growth**
Managed Care	$701.5	$851.9	21.44%
Inpatient Hospital*	$349.9	$338.8	-3.17%
Nursing Facilities	$251.2	$274.3	9.20%
EPD Waiver	$123.6	$51.8	-58.09%
ICF/DD	$78.8	$96.9	22.97%
DD Waiver	$156.9	$180.3	14.91%
Personal Care	$100.7	$182.3	81.03%
**FY 2013 budget includes funding for emergency hospital care for Alliance beneficiaries. In FY 2014, the cost for this service is shown as a separate line.*			
Source: Department of Health Care Finance			

Administrations

The Health Care Delivery Management Administration (HCDMA) ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, CHIP and Alliance programs. HCDMA accomplishes this through informed benefit design; use of prospective, concurrent and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers.

The Health Care Policy and Research Administration (HCRPRA) has responsibility for maintaining the Medicaid and CHIP State Plan which governs eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP programs; developing policy for the administration of the Alliance and other health care programs for publicly funded enrollees that are administered or monitored by DCHF based on sound analysis of local and national healthcare and reimbursement policies and strategies; and ensuring coordination and consistency among healthcare and reimbursement policies developed by the various Administrations within DCHF. The administration is also responsible for designing and conducting research and evaluations of health care programs.

Figure 7.25. Number Of Medicaid Recipients Using Personal Care Benefits



Source: Department of Health Care Finance

The Health Care Operations Administration (HCOA) is responsible for the administration of programs that pertain to the payment of claims; management of the fiscal agent contract; management of the administrative contracts; management of the Medicaid Management Information Systems (MMIS); and provider enrollment and requirements. The office provides management of the Non-Emergency Transportation contract, the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the MMIS Fiscal Intermediary contract as well as additional administrative contracts.

The Health Care Reform and Innovation Administration (HCRIA) is responsible for identifying, validating and disseminating information about new care models and payment approaches to serve Medicaid beneficiaries while seeking to enhance the quality of health and health care and reducing cost through improvement. This office creates and tests new models in clinical care, integrated care and community health, and creates and tests innovative payment and service delivery models, building collaborative learning networks to facilitate the collection and analysis of innovation, as well as the implementation of effective practices, and developing necessary technology to support these activities; including HIT and HIE.

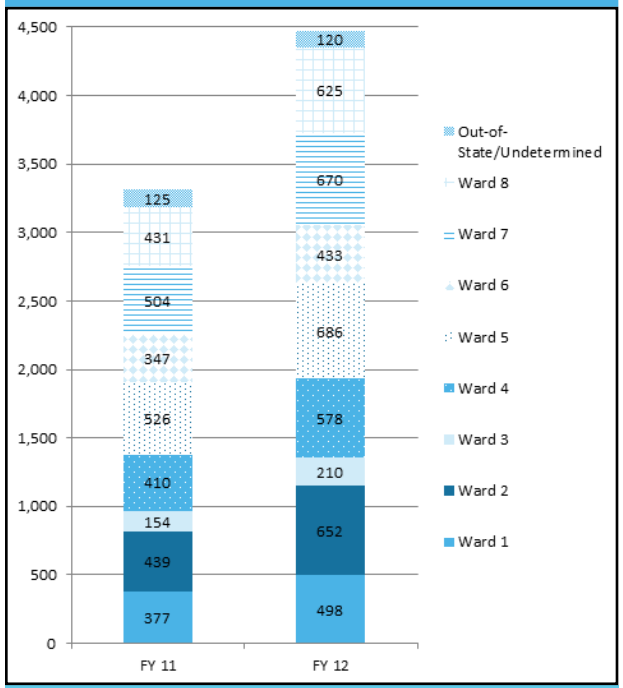
The Long Term Care Administration (LTCA) is responsible for developing, implementing and overseeing programming for elders and for persons with physical and developmental disabilities. Through program development and day-to-day operations, the LTCA also ensures access to needed cost-effective, high quality extended and long-term care services for Medicaid beneficiaries residing in home and community-based or institutional settings

Office of Health Care Ombudsman and Bill Of Rights

The Health Care Ombudsman and Bill of Rights (OHCOBR) is an independent office located in the Department of Health Care Finance (DHCF), Health Care Delivery Management Administration. The OHCOBR operates independently of all other government and non-government entities, and is a neutral body dedicated to advocating on behalf of the District's uninsured and underinsured residents, and insurance consumers. The Office maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health care service, health benefits plan or provider of a health benefits plan.

The OHCOBR provides varied assistance with respect to matters pertaining to the health care of individuals covered by insurance licensed in the District, as well as uninsured and underinsured District residents. At times, to assist consumers in the resolution of their health care issues, the OHCOBR collaborates with other DC agencies and organizations in the remediation of consumer disputes in an effort to ensure a timely and efficient resolution.

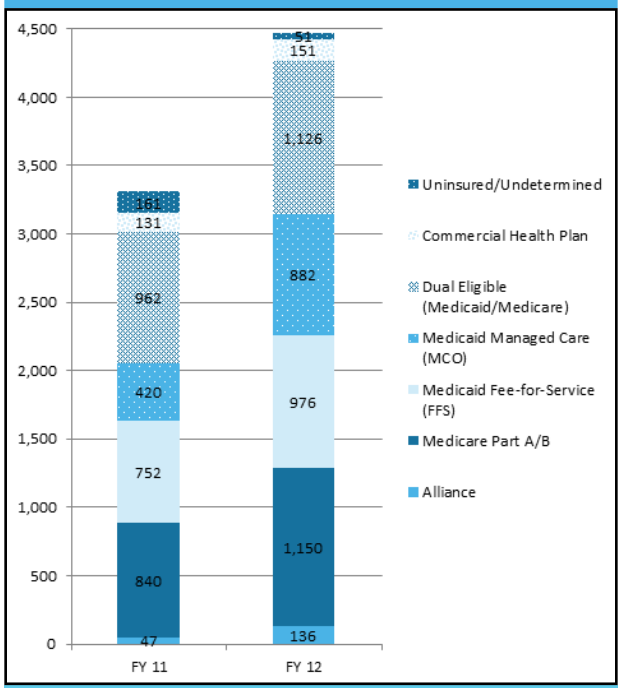
Figure 7.26. OHCOBR Contacts by Ward, FY11 and FY12



Data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

Source: Health Care Ombudsman and Bill of Rights

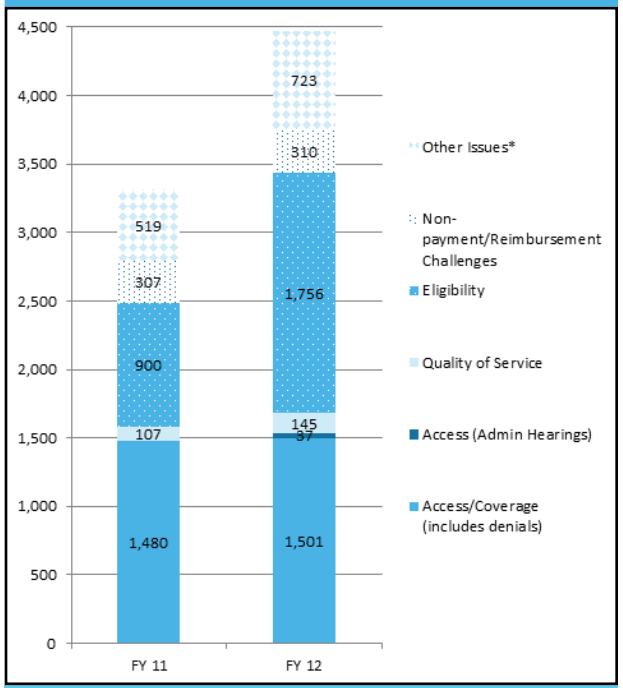
Figure 7.27. OHCOBR Contacts by Insurance Type, FY11 and FY12



Data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012

Source: Health Care Ombudsman and Bill of Rights

Figure 7.28. Categories of Issues Encountered by Consumers, FY11 and FY12



Data captured between October 1, 2010 through September 30, 2011 and October 1, 2011 through September 30, 2012.

Source: Health Care Ombudsman and Bill of Rights

The OHCOBR provides a considerable amount of direct assistance with Medicaid/CHIP and a limited amount to Medicare cases. While the OHCOBR mostly refers Medicare cases to the GW/HICP, OHCOBR is still involved in resolving matters for dual eligible beneficiaries (Medicare and Medicaid) where more than half of its contacts are derived.

OHCOBR Fiscal Year 2012 Activities

During Fiscal Year 2012, the OHCOBR has tracked all communications, or contacts, received (Figures 7.26-28). The OHCOBR classified all contacts as "cases" which the Office investigated and strived to bring closure. The OHCOBR staff recorded all contacts in a standardized Health Care Ombudsman In-Take Tracking Log that has specific categories for classifying different cases. These findings summarize data from the In-Take Tracking Log for the Fiscal Year 2012 (October 1, 2011 through September 30, 2012). During Fiscal Year 2012, the OHCOBR received a total of 4,472 contacts by individuals (consumers), of which 308 individuals were repeat callers. The category of issue "Other Issues" refers to anomalous and generic complaints such as auto repairs; banking issues; burial assistance; death certificates; duplicate QMB ID cards; food stamps; fraud-Medicaid/Medicare; housing assistance; legal services; name/address change; names misspelled on QMB ID cards; non-receipt-QMB cards; replacement of Medicaid/Medicare/MCO/QMB ID cards; and responses to Department of Health Care Finance's (DHCF) correspondence mailed to DC Medicaid beneficiaries regarding issues that affected their coverage; etc.

Initiatives

DHCF spends more than $2.5 billion every year to provide health insurance to lower-income District residents. DHCF's programs are critical to the health of District residents, because research has proven that people without health insurance are: sicker than people who have health insurance; get poorer quality health care when they do receive it; and have worse health outcomes even when they receive health care. In response, DHCF efforts are guided by four major priorities established at the beginning of Mayor Gray's Administration: (1) Improve patient outcomes; (2) Strengthen DHCF's program integrity operations; (3) Resolve Medicaid billing issues with our partner agencies; and (4) Successfully implement health care reform. Several key initiatives are outlined in Table 7.73.

Table 7.73. DHCF Initiatives

Initiative	Description	Goal of Project
Improve Patient Outcomes, Reform MCO Program	Build a program using health plans with innovative solutions to improving health outcomes for program beneficiaries, while mitigating the impact of those factors which have created growing cost pressures in the program.	Establish a managed care program that focuses on greater care coordination, improved services to children, and documented improvements in patient outcomes
Implement Health Care Reform, Develop New Medicaid Eligibility System for Health Care Reform	Work with an IT vendor to develop and implement a new eligibility, enrollment, integrated case management system, and HBX for the District of Columbia.	Provide seamless access to District health insurance options and other services to meet the requirements of the Affordable Care Act
Enhance Program Integrity, Reform Medicaid Long-Term Care System	Develop an improved system of long term care with a single "front door" for program entry, conflict-free, comprehensive, and automated assessments of patient need, and alignment of eligibility criteria with assessments, and improved program monitoring and oversight.	Eliminate fragmentation in the long-term care system, reduce inappropriate growth, and strengthen program oversight
Redesign The Hospital Outpatient Payment System	Develop a plan to shift hospitals to the ICD-10-CM system used to classify and code all diagnoses. Update the grouper used to calculate in-patient payment rates, and modernize the hospital outpatient payment methodology.	Modernize the outpatient payment methodology to establish diagnosis specific rather than flat rate payments for patient care

Source: Department of Health Care Finance