Health and Human Services

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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 260,000 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 Nutrition Assistance Program (SNAP, formerly Food Stamps), and Interim Disability Assistance (IDA). Medical assistance continues to be the largest program with an enrollment of nearly 250,000 individuals.

Over the last decade, there has been a steady increase in the number of individuals and families seeking assistance.

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. In response to the increasing demands, and the challenges facing TANF families, DHS has dramatically redesigned the TANF program and added both capacity as well as supportive services.

Table 7.1. Number of Participants by Program, Monthly Average by Fiscal Year

(Fiscal Year)	2010	2011	2012	2013	2014
Medicaid*	160,562	162,262	168,359	176,262	183,331
SNAP (formerly Food Stamps)	113,629	128,682	135,506	137,846	136,092
TANF	42,760	43,113	44,528	45,531	44,882
General Public Assistance for Children	329	285	306	257	244
Interim Disability Assistance	1,591	1,085	662	583	913
DC Healthcare Alliance**	48,082	23,705	20,543	14,496	14,208

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

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

(Fiscal Year)	2010	2011	2012	2013	2014
Recipients	40,554	43,113	44,528	45,531	44,882
Children	30,073	31,174	31,515	31,518	30,852
Cases	16,654	17,382	17,699	17,677	17,166
Avg. Mthly Payment by Case	$369	$358	$344	$349	$322
Family Size	2.4	2.5	2.5	2.6	2.6
Total TANF Payments (in millions)	$73.00	$74.7	$73.0	$74.0	$66.5

Source: Department of Human Services

Supplemental Nutrition Assistance Program (SNAP)

The SNAP (formerly food stamps) program is designed to provide supplemental nutrition assistance to individuals and families in need. Since 2007, the number of households receiving SNAP benefits has increased dramatically. 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 7.3. SNAP (Formerly Food Stamps), Monthly Average by Fiscal Year

(Fiscal Year)	2010	2011	2012	2013	2014
Recipients	113,629	128,682	135,506	137,848	136,072
Cases	63,720	73,438	77,717	79,240	78,069

Source: Department of Human Services

Table 7.4. Permanent Supportive Housing by Fiscal Year

(Fiscal Year)	2008	2009	2010	2011	2012	2013	2014
Individuals Housed	362	190	38	60	26	88	93
Families Housed	n/a	74	165	242	113	5	41
Total number of households	362	380	286	302	139	93	134

Source: Department of Human Services

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.

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.

Shelter Services

In addition to the Permanent Supportive Housing program, the District provides shelter and transitional housing programs for individuals and families experiencing homelessness.

- 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).

Table 7.5. Adult Protective Services by Fiscal Year

(Fiscal Year)	2008	2009	2010	2011	2012	2013	2014
Total number of cases	957	874	856	861	956	838	831

Source: Department of Human Services

Table 7.6. Strong Families by Fiscal Year

(Fiscal Year)	2008	2009	2010	2011	2012	2013	2014
Families Served	969	1,161	1,423	2,076	1,621	1,444	1,003

Source: Department of Human Services

Table 7.7. Shelter by Fiscal Year							
(Fiscal Year)	**2008**	**2009**	**2010**	**2011**	**2012**	**2013**	**2014**
Shelter*							
Individuals	11,631 persons	11,442 persons	10,427 persons	8,608 persons	9,289 persons	9,404 persons	9,870 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)	2,753 persons (830 families)	3,603 persons (1,095 families)
Transitional Housing							
Individuals	738 persons	702 persons	697 persons	1,252 persons	1,080 persons	1,475 persons	1,597 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)	1,738 persons (554 families)	1,129 persons (407 families)
** Includes hypothermia, seasonal, and overflow							
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 older District residents (age 60 plus), persons living with disabilities (age 18 to 59), and their caregivers.

Background

The District of Columbia Office on Aging was created by D.C. Law 1-24 in 1975 as the State Unit on Aging and the Area Agency on Aging. The agency is responsible for the development, implementation, and administration of a comprehensive and coordinated social services system for residents 60 years of age and older, persons living with disabilities, and their caregivers. The agency carries out its mission by funding over 40 programs operated by more than 30 community-based nonprofit organizations that comprise the Senior Service Network. The Senior Service Network provides a full range of home - and community - based supports and services, namely:

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

Additionally, DCOA provides a single, coordinated system of information and access for individuals seeking long-term care services and supports through the Aging and Disability Resource Center (ADRC). This is accomplished through the provision of unbiased reliable information, counseling, and service access to older adults, individuals living with disabilities, and caregivers. ADRC direct services include:

- Information and Referral/Assistance
- Alzheimer's Disease Initiative Grant
- Caregiver Assistance: Lifespan Respite Care Program
- Community Social Work
- Community Transition
- Hospital Discharge Planning Program
- Housing Coordinator
- Medicaid Waiver Enrollment
- Senior Employment and Training Program

Furthermore, 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 the Vital Management Team, Inc.

DCOA works closely with 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 D.C. 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.

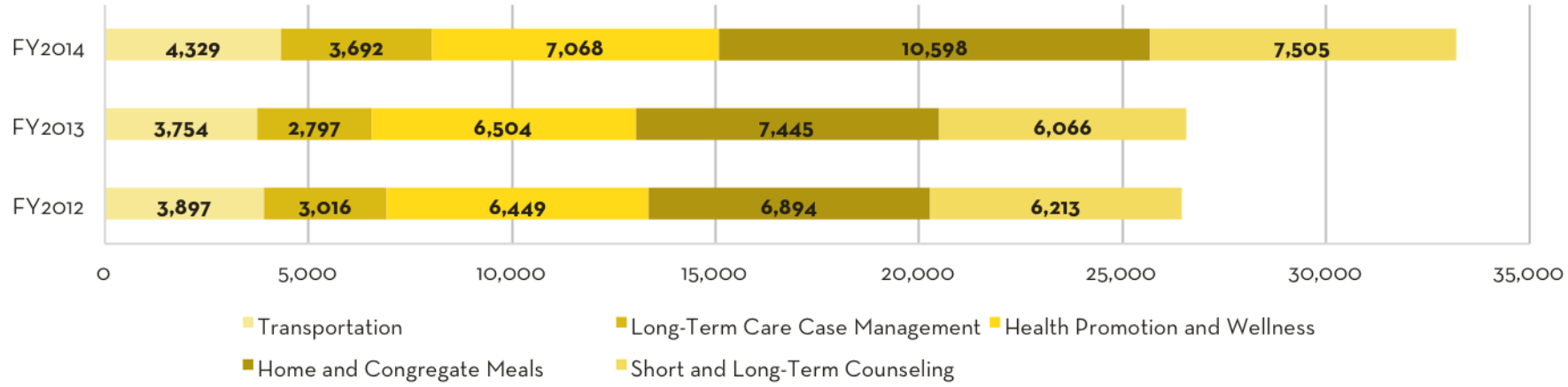
Community Supports and Services

From 2012 through 2014, more than 28,000 of the 105,487 seniors living in the District have received one or more core services funded by the DCOA. The top five most utilized services in 2014 were home-delivered and congregate meals, health promotion and wellness, short-term and long-term counseling, transportation, and long-term care case management.

Changing Demographics of an Aging Population

The District of Columbia has a growing population of 658,893 residents. From 2010 to 2014, the Census reported that the District's population increased by 57,126 persons. Based on the Census, 2013

Figure 7.1. Number of Persons Receiving Core Services



Source: DC Office on Aging Customer Services Tracking and Reporting System

Annual Estimates of the Resident Population, 105,487 persons are 60 years of age and older (16 percent of the DC population) with 20,428 persons 80 years of age or older. Overall, this is an increase of 2,007 older persons (2 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 on average 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).

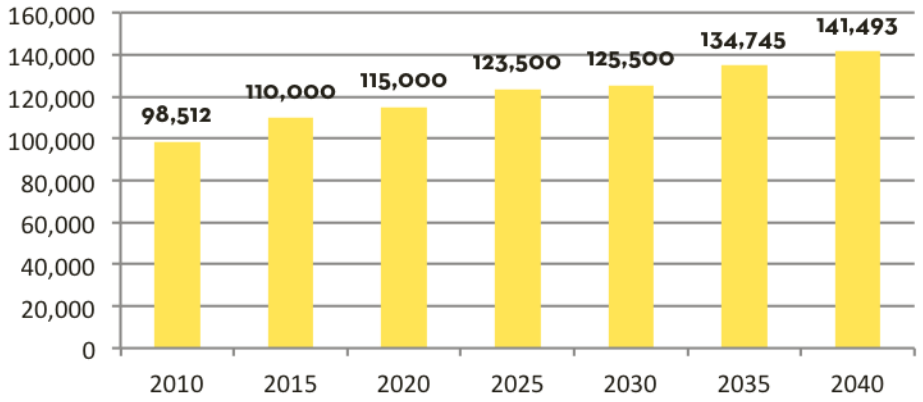
As the number of multicultural older adults with low-income increases, along with the surge in multiple chronic healthcare needs, DCOA is committed to expanding home- and community-based programs. The agency also has a keen interest in assisting the growing aging population stay active, remain healthy,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

New Programs and Initiatives

In FY 2013 and FY 2014, DCOA implemented the following new programs and services:

- DCOA acquired the Commodity Supplemental Food Program ("CSFP") and the Senior Farmers Market Nutrition Program ("SFNP") from the Department of Health in fiscal year 2013. This was a logical move as DCOA is responsible for promoting the well-being of seniors, including providing meals and food items that promote sound nutrition, and seniors comprise approximately 98% of CSFP beneficiaries in the District of Columbia. Thus, seniors in CSFP and SFNP are better able to access other DCOA services that will help them to live quality lives in the community.
- In fiscal year 2013, DCOA established the Nursing Home Transition Unit under the ADRC, which is comprised of nursing and social worker staff who transition willing and capable nursing home residents back into the community and assist them with securing cost effective home and community-based services. The team expanded in 2014 to include Money Follows the Person Specialists in order to streamline interagency procedures.
- In partnership with DCOA's Elder Abuse Prevention Committee (EAPC), DCOA experienced great success developing and piloting the Consumer Financial Protection Bureau's "Money Smart for Older Adults." The agency provided more than 10 trainings and reached over 500 older adults in fiscal year 2014. Additionally, DCOA produced a radio PSA campaign around elder abuse prevention and education.

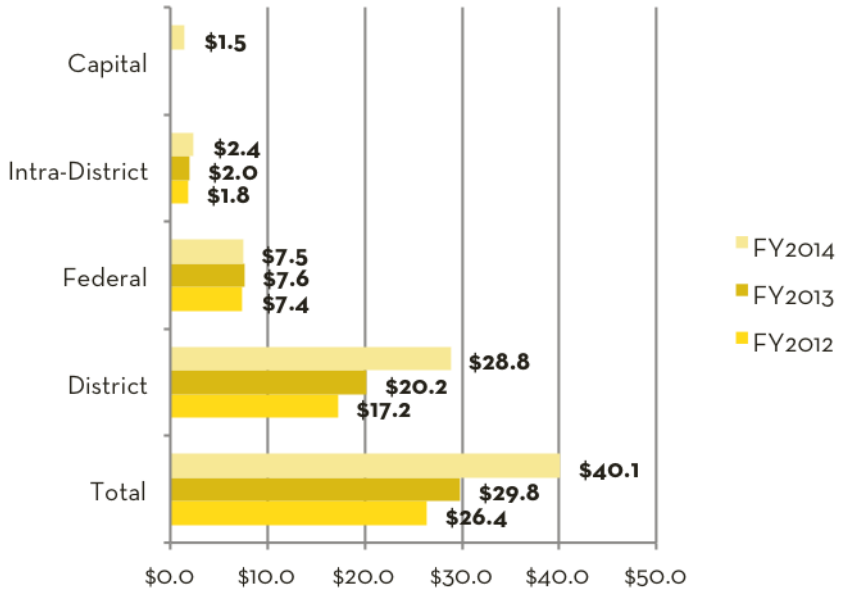
Figure 7.2. Persons 60 Years and Older by Actual and Projected Counts



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

- In fiscal year 2014, DCOA and the National Foundation to End Senior Hunger (NFESH) developed and began a pilot that measures, reduces, and composts the food waste from congregate meals sites. The program is known as the What-a-Waste Initiative. The goals are to increase consumption of nutritious foods, reduce food waste, and increase cost saving practices.
- Beginning in July 2014, DCOA started an organized, district-wide educational campaign around falls prevention. DCOA worked with volunteer Occupational Therapists (OT) to develop an education seminar that focused on the importance of balance and strength, and reducing risk factors at home. In conjunction with the education campaign, DCOA contracted for OT specialists to perform in-home falls risk screenings. OT specialists conducted a falls assessment, a comprehensive evaluation based off evidence-based programs in order to advise and recommend ways to eliminate fall hazards in seniors' homes. Additionally, the agency is working with key stakeholders in the community to rejuvenate the grassroots Falls Prevention Coalition.
- In fiscal year 2014, DCOA partnered with Sibley Hospital to establish the Club Memory Program on the East End of the City. Club Memory is a stigma-free social club for people with early-stage Alzheimer's, Mild Cognitive Impairment or other forms of dementia, and their spouses, partners and caregivers. At Club Memory, conversation, camaraderie and even laughter among peers who truly understand each other open the doorway to living life to its fullest in the face of a dementia diagnosis. In addition to the twice monthly meetings, social and cultural events are coordinated for Club Memory members as an optional weekly outing.
- In August 2014, DCOA began a pilot program with Common Good City Farm to bring intergenerational gardens to Model Cities and Washington Seniors Wellness Centers. High school students interning at Common Good City Farm attend each sionce a week to work with seniors in the garden then lead a nutrition education session. The program increases access and availability of fresh produce for seniors, enhances nutrition education at the wellness centers, and provides intergenerational opportunities with Common Good City Farm's students.

Figure 7.3. 2012-2014 DCOA Budget by Funding Source



Source: DC Office on Aging Budget, 2012-2014

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

In FY 2012, the budget for services to seniors under DCOA amounted to $26.4 million, which was comprised of $17.2 million in District funds, $1.8 million in Intra-District funds, and $7.4 million in federal funds. FY 2013, the budget for services to seniors under DCOA amounted to $29.8 million, comprised of $20.2 million in District funds, $2.0 million in Intra-District funds, and $7.6 million in federal funds. By FY 2014, there was a marked increase in the budget for services that amounted to a total of $40.1 million, which included $28.8 million in District funds, $2.4 million in Intra-District funds, $7.5 million in federal funds, and $1.5 million in Capital funds.

Agency Challenges

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.

Based on the data from DCOA's Senior Needs Assessment and research from the Age-Friendly City Initiative, along with the calls received by DCOA's call center on a daily bases, the most significant challenges faced by seniors living in the District are:

- Transportation and walking safety
- Affordable housing
- Employment
- Assistance remaining in their home
- Meals and nutrition counseling.

Accomplishments and Goals

In FY 2013 and FY 2014, DCOA's accomplishments included:

- DCOA collaborated with Legal Counsel for the Elderly to successfully advocate for the enactment of legislation to address abuses in the real property tax sales process that was resulting in the loss of their homes through foreclosure due to relatively small sums of unpaid real property taxes. Based on LCE's analysis of the tax sale lists provided by OTR, the number of tax sales of properties coded as "senior" fell from 26 in 2013 to just 9 in 2014, a reduction of over 70 percent.
- Starting in October 2013, DCOA began efforts to streamline, update, and expand our transportation program. By consolidating services and acquiring a new fleet of 21 vehicles, DCOA increased the capacity to provide rides to medical related appointments, and expanded services to include rides of personal business related to public benefits, such as Social Security, housing assistance, and the Supplemental Nutrition Assistance Program.
- To improve our efforts to combat food insecurity, DCOA eliminated the home-delivered meals wait list and further expanded this program to weekend services for non-frail customers. By the end of FY14, DCOA increased the number of home delivered meals by 129,122, or 31 percent when compared to FY13.
- DCOA successfully developed and published the District of Columbia Alzheimer's Disease State Plan. DCOA worked with a coalition of stakeholders to identify and coordinate city resources to ensure individuals with ADRD and their caregivers receive the support they need and reduce the burden that often accompanies ADRD. The five year State Plan outlines 33 short-, mid-, and long-term measureable goals within four major categories: Research and Data, Quality of Care, Public Outreach and Awareness, and Training and Workforce Development.

- In January 2014, the agency published a white paper that outlines needs for modernizing senior wellness centers. This research set the foundation for expanding utilization and capability as the older adult population continues to grow. DCOA has successfully expanded health promotion programs and services at senior wellness centers in order to raise awareness and promote healthier habits among older adults. DCOA introduced salad bars into six senior wellness centers to offer more fresh fruits and vegetables and more choice. Furthermore, DCOA successfully increased capacity and improved efficiency of home-delivered meal 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 DC Office of Disability Rights (ODR) is to ensure that the programs, services, benefits, activities and facilities operated or funded by the District of Columbia are fully accessible to, and useable by people with disabilities. ODR is committed to inclusion, community-based services, and self-determination for people with disabilities. ODR is responsible for overseeing the implementation of the City's obligations under the Americans with Disabilities Act (ADA), as well as other disability rights laws.

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.

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

Programs and Services

According to Cornell University 2012 Disability Statistics Report, 11.5% of persons living in the District of Columbia identified as a person with a disability. The report also indicates that 12.1% of

females of all ages and 10.7% of males of all ages in the District of Columbia identified as having a disability.

ODR provides technical assistance, training, informal dispute resolution, policy guidance, and expertise on disability rights issues to District agencies and the disability community. In FY 2015, ODR provided training to over 2400 District employees in areas of reasonable accommodation, emergency preparedness, and cultural sensitivity. ODR also hosted and collaborated on more than 20 community outreach events that aimed to educate people with disabilities about their rights, as well as resources provided by the District of Columbia. ODR hosted events included:

- Disability Awareness Exposition
- White Cane Celebration Day
- 25th Anniversary of the Americans with Disabilities Act
- Olmstead Conference
- Ward-by-Ward Emergency Preparation Trainings
- Accessible Housing Forum

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
- Centralized Sign Language Interpretation Program
- Centralized Reasonable Accommodation Program
- Braille Translation Services
- Close Captioning Assistance
- Video Relay Assistance
- Coordinating the efforts of District government agencies involved with providing services to people with disabilities in institutional and community-based settings, and developing and overseeing the District government's Olmstead Plan
- Providing technical assistance to the Public Service Commission, which is responsible for ensuring that companies offering telephone services to the general public comply with the ADA
- 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, a Mayoral-appointed body that advises the Mayor on issues of relevance to the Disability community
- Support to the D.C. Developmental Disabilities Council

Disabilities Services

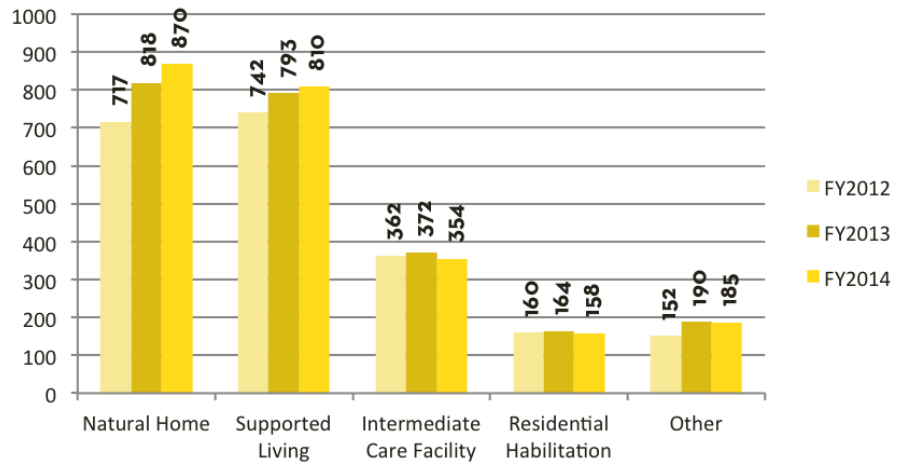
Mission

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.

The Department on Disability Services (DDS) is composed of two administrations that oversee and coordinate services for residents with disabilities through a network of private and not-for-profit providers.

The Developmental Disabilities Administration (DDA) ensures that residents with intellectual disabilities receive the services and supports they need to lead self-determined and valued lives in the community. DDA achieves this through the delivery of outreach and service coordination services; the development and management of a provider network delivering community residential, day, vocational, employment, and individual and family support services; and the operation of a comprehensive quality management program.

Figure 7.4. Developmental Disabilities Administration Facility Mix



Source: Department on Disability Services

Rehabilitation Services Administration

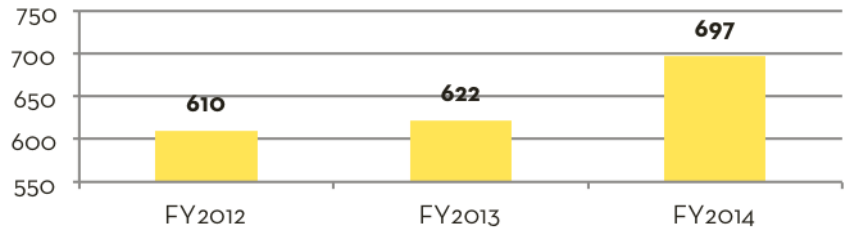
The Rehabilitation Services Administration (RSA) delivers vocational rehabilitation services focusing on employment and training activities that allow persons with disabilities to experience a greater quality of life by obtaining and sustaining employment, economic self-sufficiency, and independence. RSA provides employment marketing and placement services, vocational rehabilitation, inclusive business enterprises, and support for the D.C. Center for Independent Living. The Department on Disability Services also serves as the state agency for Social Security Disability Insurance determinations under the direction of the Social Security Administration.

Child and Family Services Agency

Mission and Functions

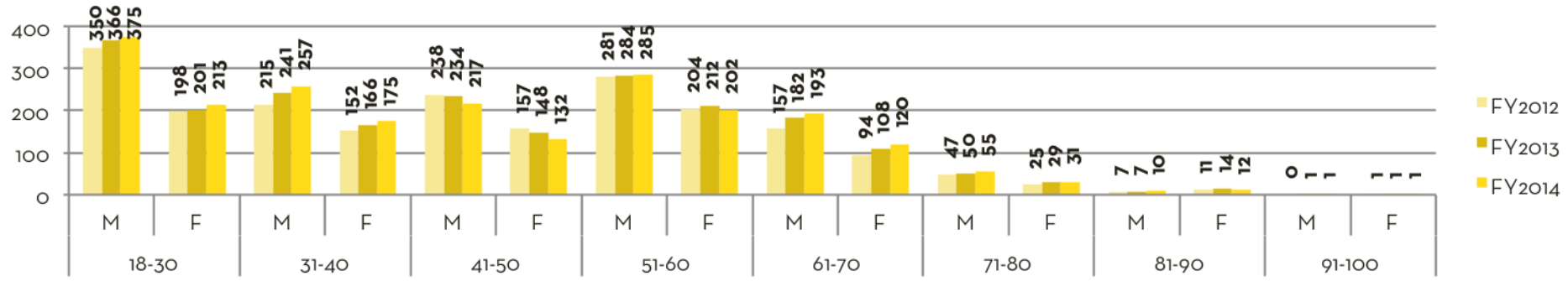
In the District of Columbia, the Child and Family Services Agency (CFSA) is the public child welfare agency with the legal authority and responsibility to protect child victims, and those at risk, of abuse

Figure 7.6. People in Supported Employment



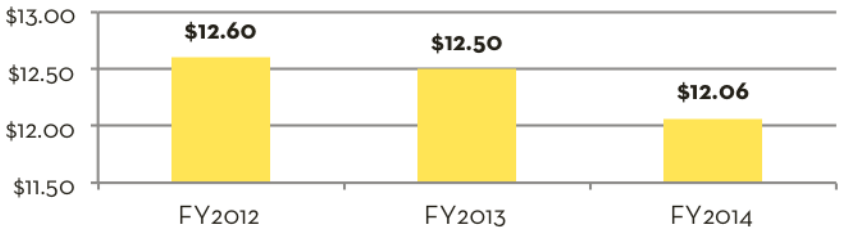
Source: Department on Disability Services

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



Source: Department on Disability Services

Figure 7.7. Average Hourly Wage for Individuals Who Achieve Competitive Employment through RSA



Source: Department on Disability Services

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 children and youth 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 an investigation to determine whether they are true and if so, to identify the maltreater. 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 well-being of children in their homes.

- 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. District residents interesting in becoming foster parents should call 202-671-LOVE.

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 children 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. People interested in adoption should call 202-671-LOVE. Legal guardianship is an alternative to adoption for relatives (or others) who want to provide a permanent home for children without legally terminating their parents' 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 50% of the caseload
- Federal Court oversight continues as a result of the LaShawn lawsuit filed in 1989, with A Better Childhood, LLC as Plaintiff. CFSA has completed 84% of requirements in the court-ordered Implementation and Exit Plan.
- Long-standing local statutes allow youth to remain in the system to age 21, if necessary (in contrast to age 18 in most states)
- Half 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

The District has diligently reformed child welfare for more than a decade. 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 essential aspect of child welfare 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-supported 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 www.cfsa.dc.gov.

Demand for Service

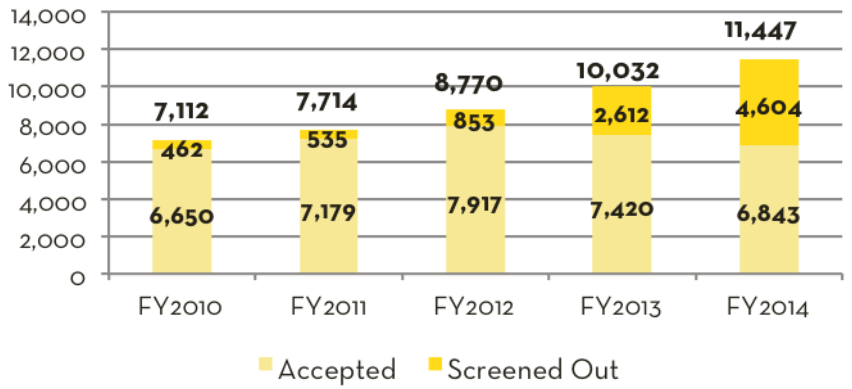
Child and youth victims, and those at risk, of abuse and neglect come to CFSA attention via calls to the District's 24-hour hotline at 202-671-SAFE. Under District law, numerous child-serving professionals designated as "mandated reporters" must call whenever they know or suspect that a child or youth 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). A major 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.

Child Welfare Population

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, and the gap between in-home and out-of-home cases continues to widen (Figure 7.9). This is an 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.

Figure 7.8. Hotline Calls



Source: DC Child and Family Services Agency

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 slightly

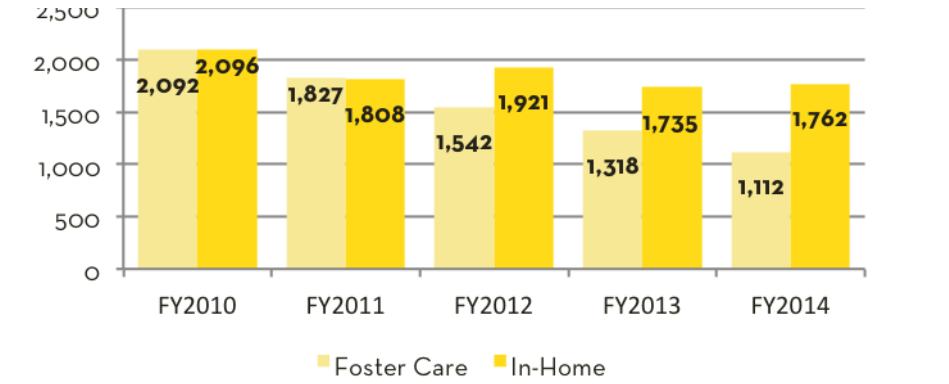
Table 7.8. Key Indicators of Demand for Services

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
FY2013	6,112	1,350	404	3,058
FY2014	3,863	1,024	394	2,878

Source: DC Child and Family Services Agency

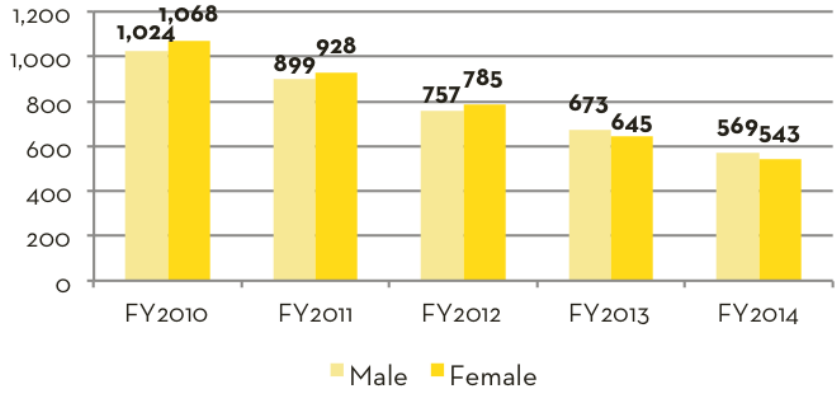
more than half the caseload is composed of youth age 13 or older (Figure 7.12).

Figure 7.9. DC Child Welfare Population Trend (Point in time: Last day of Fiscal Year)



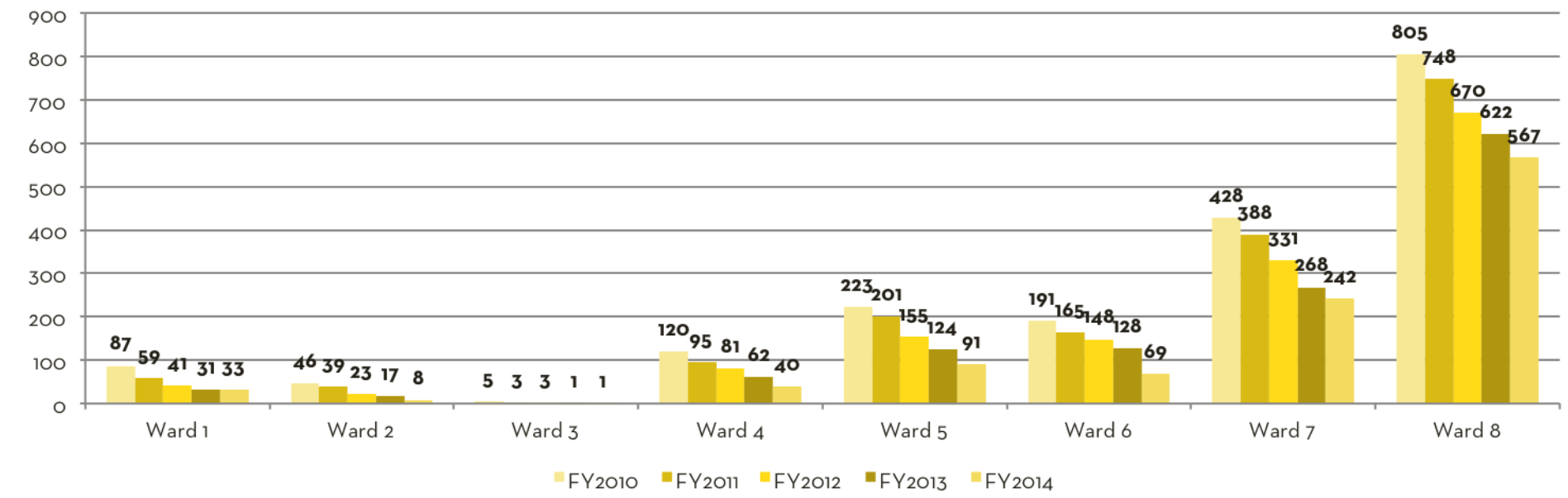
Source: CMT232

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



Source: Department on Disability Services

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

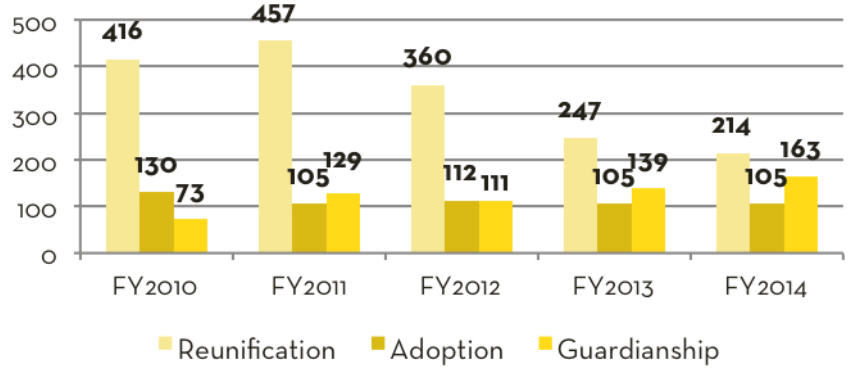


Source: PLC156

Exits from Foster Care

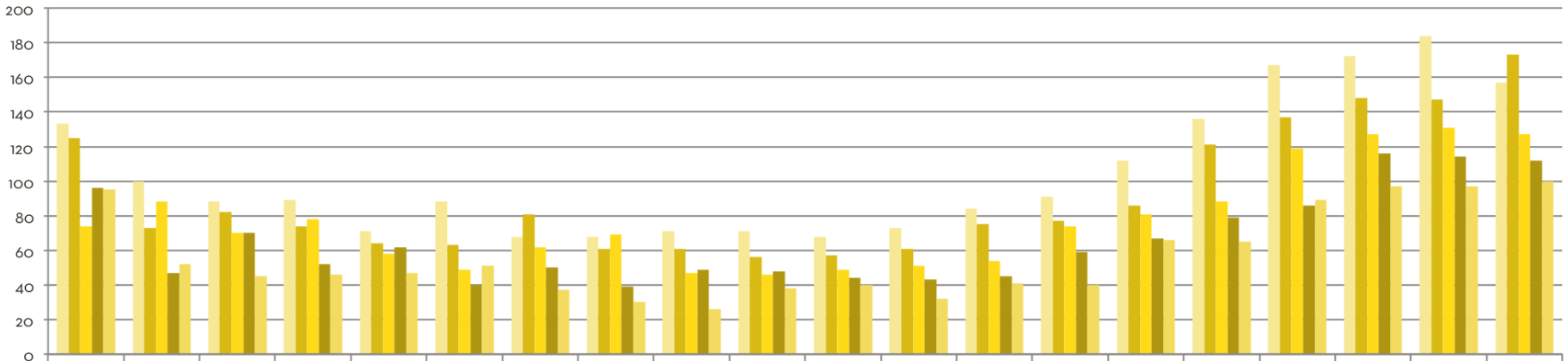
For many years, exits from foster care have exceeded entries. In FY14, 394 children and youth came into care and 482 left, for a ratio of 1:1.2. The outcome CFSA strives to achieve for every child or youth in care is an exit to a safe, nurturing, permanent home as quickly as possible. This can mean returning 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: PLC155

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

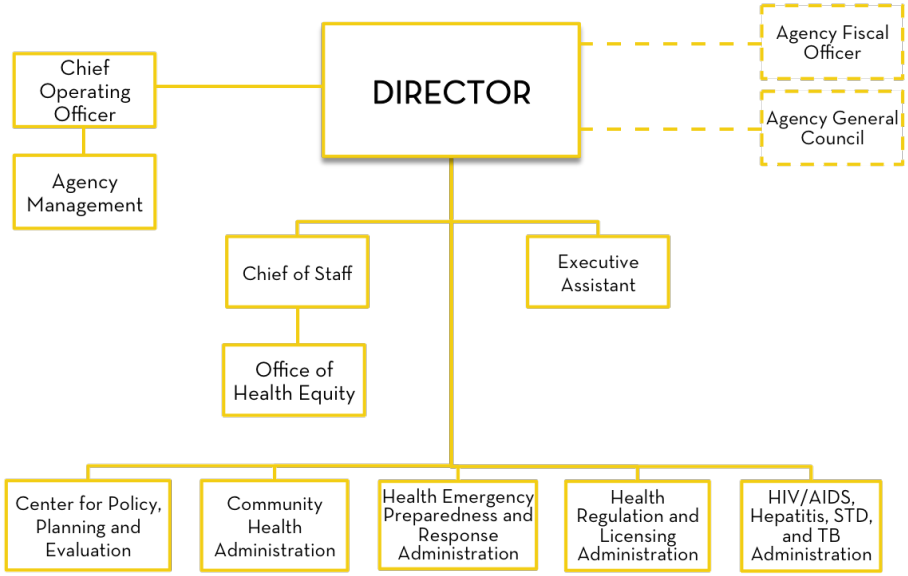


	1 year or less	2 years	3 years	4 years	5 years	6 years	7 years	8 years	9 years	10 years	11 years	12 years	13 years	14 years	15 years	16 years	17 years	18 years	19 years	20 years
FY2010	133	100	88	89	71	88	68	68	71	71	68	73	84	91	112	136	167	172	184	157
FY2011	125	73	82	74	64	63	81	61	61	56	57	61	75	77	86	121	137	148	147	173
FY2012	74	88	70	78	58	49	62	69	47	46	49	51	54	74	81	88	119	127	131	127
FY2013	96	47	70	52	62	40	50	39	49	48	44	43	45	59	67	79	86	116	114	112
FY2014	95	52	45	46	47	51	37	30	26	38	40	32	41	40	66	65	89	97	97	100

Source: PLC156

Department of Health

DC Department of Health Organizational Structure



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 five administrations and offices within the Office of the Director indicated in the organization structure below.

Office of the Director - Office of Health Equity

The recently created Office of Health Equity, established in May 2015, works to address the root causes of health disparities, beyond healthcare and health behaviors, by supporting projects, policies, and research that will enable every resident to achieve their optimal level of health. The Office achieves its mission by informing, educating and empowering people about health issues; and facilitating multi-sector partnerships to identify and solve community health problems related to the social determinants of health.

Administrations

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; statistics on Occupational injuries, illnesses, and workplace fatalities; and hospital emergency department chief complaint data.

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 communicable 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.

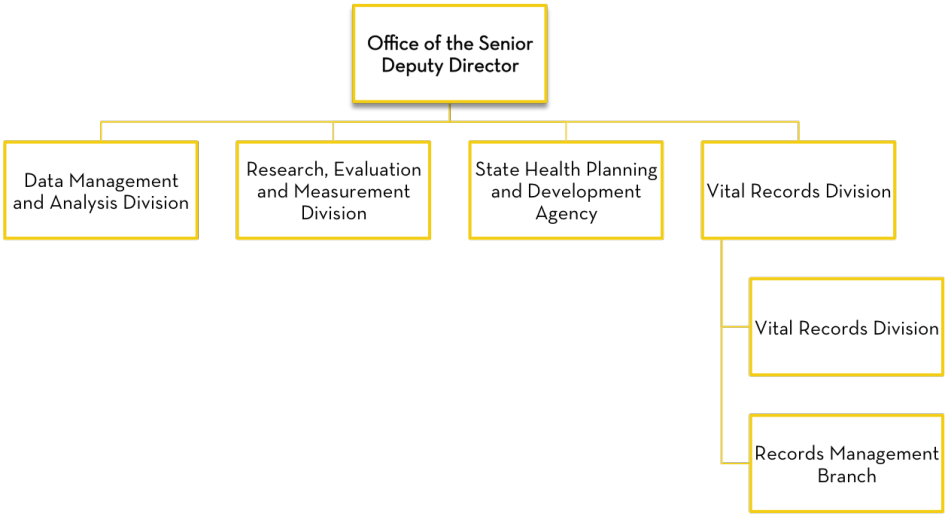
The Health Emergency Preparedness and Response Administration (HEPRA) provides accurate and timely information about the prevention and control of biological threats to the residents of the District of Columbia. HEPRA is responsible for the preparedness of the city, which includes Bioterrorism resources, 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 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.

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.

Center for Policy, Planning and Evaluation

CPPE Organizational Chart



Mission

The mission of the Center for Policy, Planning, and 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 and Vital Records Division

While the Vital Records Division is responsible for collecting, preserving, and administering the District's system of birth and death records, the Data Management and Analysis Division works very

closely with the Vital Records Division to collect, create vital statistics databases, analyze, and maintain statistical data for human service delivery program components of the Department of Health.

Census of Fatal Occupational Injuries, District of Columbia Workplace Fatalities, 2013

Program Background

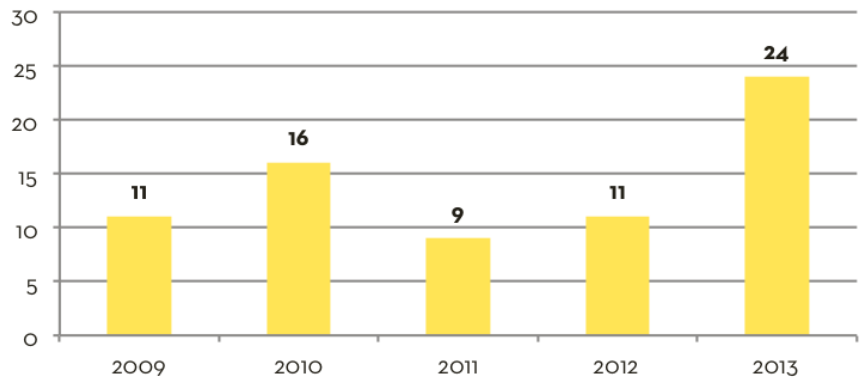
The Census of Fatal Occupational Injuries (CFOI), part of the BLS Occupational Safety and Health Statistics (OSHS) program, compiles a count of all fatal work injuries occurring in the U.S. during the calendar year. The CFOI program uses diverse state, federal, and independent data sources to identify, 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).

Fatal work injuries totaled 24 in 2013 (Figure 7.14) 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 2013 count represented the highest annual total since 1993, due in part to the Washington Navy Yard shooting, where 13 workers died. Violence and other injuries by persons or animals were the leading cause of on-the-job fatalities during 2013 in the District of Columbia, with 19 deaths or 79 percent. The service providing industry accounted for 67 percent of the total workplace fatalities in the District of Columbia.

Key Characteristics of Fatal Work Injuries in 2013 in the District of Columbia:

- Men (20) accounted for almost all of the work-related fatalities in the District, representing 83% of work-related fatalities in 2013. Violence and other injuries by persons or animals made up the majority of these fatalities. Four women were fatally injured on the job.
- Eighteen of the 19 fatalities were caused by violence and other injuries by persons or animals; 14 of these were homicides including 13 fatalities from the Washington Navy Yard shooting.
- Workers aged 45-64 years comprised of 14 fatalities in the District of Columbia, representing 58 percent of work-related fatalities in 2013; eight of the 24 fatal workplace injuries in the 45-54 age group occurred in violence and other injuries by persons or animals.
- Twenty-one of the workers who died on-the-job in the District of Columbia worked for wages and salaries. Service providing incidents (which include trade, transportation, and professional and technical services) and assaults and violent acts accounted for 19 of these deaths.
- Fifty percent of the workers who died on-the-job were White, non-Hispanic and 33 percent were Black, non-Hispanic.
- Three self-employed workers died in 2013.

Figure 7.14. Fatal Occupational Injuries in the District of Columbia: 2009-2013



Source: D.C. 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

Survey of Occupational Injuries and Illnesses, 2012

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).

The District of Columbia's Annual Survey of Occupational Injuries and Illnesses for 2012 showed that there were 2,770 work-related injury and illness cases reported in the private industry that required days away from work. Sprains and strains accounted for approximately 35 percent of these cases and was the leading type of injury or illness. Education and health services occupations had the most injury and illness days away from work cases and made up 1,030 or 37 percent of the cases; followed by leisure and hospitality with 550 or 20 percent of the cases (Figure 7.15).

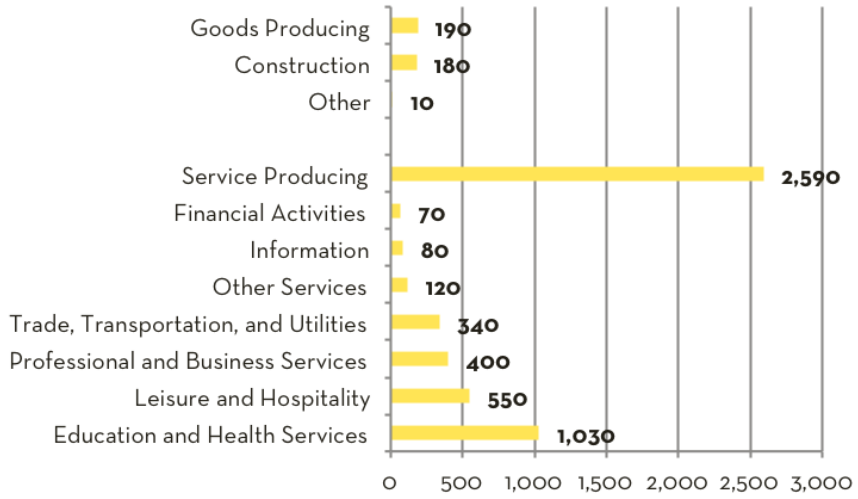
Case Characteristic Highlights

- The leading nature of the work-related injury or illness cases involving days away from work was sprains and strains (980 cases); other significant causes were soreness and pain (510 cases), cuts and lacerations (320 cases) and bruises and contusions (280 cases).
- The part of the body that was most frequently affected by injuries and illnesses was upper extremities (880 cases) which includes the shoulder, arm, wrist and hand which accounted for 32 percent of all days away from work cases. The trunk (710 cases) which includes the back accounted for 26 percent while lower extremities, including the knee, ankle foot, toe and toenail accounted for 22 percent of all days away from work cases.
- Floor and ground surfaces (560 cases) accounted for 20 percent of all sources of injury and illnesses cases.
- Cases involving overexertion and bodily reaction accounted for 29 percent or 800 cases, the majority of these cases were overexertion in lifting or lowering (300 cases). The next largest event category was cases which involved falls, slips and trips which accounted for 28 percent or 780 cases, the majority of these were cases involving falls on the same level which accounted for 500 cases.

Demographic Highlights

- Fifty-five percent of the occupational injuries and illnesses that resulted in days away from work involved women (1,510 cases)
- Workers in the age range of 45-54 years accounted for 27 percent or 750 cases
- Forty-two percent of the occupational injuries and illnesses that resulted in days away from work involved Black or African American workers (1,150 cases)
- Forty-one percent of the occupational injuries and illnesses that resulted in days away from work involved employees with more than five years of service with employer (1,140 cases)
- 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 28 percent or 770 cases that resulted in days away from work
- 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 540 cases
- Wednesday (520 cases), Thursday (500 cases) and Monday (470 cases) were the days of the week when most of the injuries and illnesses involving days away from work occurred

Figure 7.15. Injury and Illness Cases Involving Days Away From Work by Selected Occupational Group: Washington, DC Private Industry: 2012



Source: D.C. 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

DC Healthy People 2020

DC Healthy People 2020 (DC HP2020) strives to identify local health improvement priorities, provide relevant and measurable objectives and goals, and engage multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge. DC HP2020 forms an integral part of the Community Health Improvement Process, using DOH's Community Health Needs Assessment to set health goals and priorities and, along with stakeholders, determine community health objectives and targets.

Six working groups, with representation from over 25 stakeholder organizations and DOH, have been formed to finalize objectives, set targets, evaluate appropriate strategies, and create an action plan. Community input will be incorporated throughout and an advisory board will review and approve the plan. DC HP2020 will be shared in an online interactive platform that monitors progress toward key health objectives. Full implementation is slated for December 2015. Follow DC HP2020 progress or get involved at http://doh.dc.gov/page/dc-healthy-people-2020.

Additional Aims of the DC HP2020 Development Process

- Bring non-traditional stakeholders to the table to facilitate coordination and improve population health by focusing on social determinants of health and using a health equity lens.
- Improve coordination of planning, community engagement, and health programs/services provided in DC.

DC HP2020 Topic Areas

1. Access to Health Services
2. Asthma
3. Adolescent Health
4. Blood Disorders and Blood Safety
5. Cancer
6. Diabetes
7. Disability Services
8. Environmental Health
9. Food Safety
10. Foreign-Born Populations
11. Healthcare-Associated Infections
12. Heart Disease and Stroke
13. Hepatitis C
14. HIV/AIDS
15. Immunization and Infectious Diseases
16. Injury and Violence Prevention
17. Lesbian, Gay, Bisexual and Transgender Health

18. Maternal, Infant and Child Health
19. Mental Health and Mental Disorders
20. Nutrition, Weight Status and Physical Activity
21. Older Adults
22. Oral Health
23. Preparedness and Response
24. Public Health Infrastructure
25. Sexually Transmitted Diseases
26. Sleep Health
27. Social Determinants of Health
28. Substance Abuse
29. Tobacco Use

Vital Statistics—Births

Since 2004, the number of births showed an increasing trend and reached its highest in 2012 with 9,370 births, an 18 percent increase from 2004. In 2013, there were 9,264 births (preliminary) in the District. This figure represents a 1.1 percent decrease compared with 2012. The general fertility rate, a measure based on the number of women of child-bearing age, increased from 54.8 in 2005 to 61.4 in 2008, and then started declining from 2009, with a fertility rate of 59.7, and further declined to 53.2 in 2013. In 2013, births to women younger than 20 years of age accounted for 7.1 percent of all births, compared to 8.5 percent of all births in 2012. The proportion of births to single mothers decreased from 51.1 percent in 2012 to 50.6 percent in 2013. The percent of infants weighing less than 2,500 grams decreased from 9.7 percent in 2012 to 9.5 percent in 2013. The preliminary infant mortality rate in 2013 decreased to 6.8 per 1,000 live births, which was a historic low in the District of Columbia. This rate represents about 14 percent decrease from 2012 (Table 7.9), but the District rate remains higher than the national rate of 6.0 per 1,000 live births.

Table 7.9. Annual Live Births and Infant Deaths, District of Columbia: 2004-2013 by Calendar Year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*
Live Births Total**	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289	9,370	9,264
Married Women	3,495	3,492	3,613	3,679	3,846	3,950	4,093	4,290	4,537	4,523
Single Women	4,442	4,448	4,908	5,190	5,278	4,995	5,008	4,963	4,788	4,690
General Fertility Rate	55.2	54.8	58.3	60.0	61.4	59.7	56.4	55.9	55.1	53.2
Percent of Births to Women Younger than 20 Years	11.2	11.0	12.0	12.1	12.2	11.7	10.6	9.8	8.5	7.1
Percent of Low Birth Weight Infants	11.1	11.2	11.6	11.1	10.5	10.3	10.2	10.5	9.7	9.5
Infant Deaths	94	108	96	116	100	89	73	69	74	63
Infant Death Rate Per 1,000 Live Births	11.8	13.6	11.3	13.1	10.9	9.9	8.0	7.4	7.9	6.8

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

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

Births by Race/Ethnicity and Education of Mother and Prematurity

The number of births over this 10-year period showed an increasing trend. Births increased by 18 percent between 2004 and 2012, and then decreased 1.1 percent in 2013. During this same period, the proportion of births to black mothers declined by 11.5 percent. Since 2004, the proportion of births to white mothers showed a steady upward trend. Births to white mothers increased by about 29.0 percent, from 26.6 percent in 2004 to 32.4 percent in 2013. The proportion of births to Hispanic mothers also showed an increasing trend. Births to Hispanic mothers increased by 12.3 percent in 2012, from 13.0 percent in 2004 to 14.6 in 2012, but dropped to 13.4 percent in 2013. The number of births to Asian & Pacific Islanders also increased during the reporting period (Table 7.10).

Births to women with post-secondary education (i.e., some college or higher) increased by about 31.0 percent from 44.0 percent in 2004 to 57.5 percent in 2013 and births among women with primary & secondary education declined about 17.0 percent during the same period. Preterm birth was highest with 13.4 percent in 2005 and 2006 but the lowest in 2012 (9.9 percent) and again increased to 10.4 in 2013.

Births by Ward

As shown in Table 7.11, from 2004-2013, except the years 2005 and 2006, Ward 8 had the largest number of births. From 2005-2013, Ward 4 had the second highest number of births. Ward 2 had the fewest number of births followed by Ward 3 from 2007-2013.

Table 7.10. Annual Live Births by Race/Ethnicity, Education of Mother, and Preterm Birth, District of Columbia: 2004-2013 by Calendar Year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*
All Races Total**	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289	9,370	9,264
Black	4,684	4,575	4,848	4,926	5,031	4,847	4,940	4,903	4,816	4,840
White	2,115	2,171	2,312	2,370	2,494	2,655	2,635	2,843	2,974	2,997
Asian & Pacific Islander	199	165	182	215	220	276	342	402	410	434
Other/Unknown	939	1,029	1,180	1,359	1,389	1,230	1,239	1,141	1,170	993
Hispanic Origin***										
Hispanic	1,028	1,132	1,344	1,487	1,527	1,498	1,351	1,358	1,370	1,244
Non-Hispanic	6,909	6,806	7,175	7,383	7,596	7,305	7,721	7,828	7,966	7,976
Education of Mother (Percent)										
Primary & Secondary	48.0	47.8	48.2	50.0	50.0	46.3	46.5	45.5	43.7	41.1
Post-Secondary	44.0	43.0	42.9	42.8	45.6	51.2	51.8	53.1	55.2	57.5
Percent of Pre-Term Birth										
< 37 Weeks Gestational Age	12.5	13.4	13.4	12.2	12.2	11.0	10.4	11.0	9.9	10.4

*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

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 nine years, the number of reported abortions averaged 1,835 per year. The number of reported abortions for District residents fluctuated until 2011, the years after which declines in both the number and rate of abortions were reported. Abortion performed on women under the age of 20 declined from 12.3 percent in 2012 to 10.7 percent in 2013. In 2013, more than 61 percent of the procedures were performed on women in their twenties, while 25.0 percent were performed on women in their thirties and 2.8 percent on women in 40 years and older. The rate of abortion in 2013 was 9.3 per 1,000 women between the ages of 15 and 44 (Table 7.12), the lowest level in recent years. 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 – Assisted Reproductive Technology (ART) Conceived Births

The 2003 revision of the U.S. Standard Certificate of Live Birth was implemented in the District of Columbia in 2009. This certificate allowed for the collection of new information, which included Assisted Reproductive Technology (ART) information related to birth outcomes. ART-conceived births are increasing in the U.S. as well as in the District.

In 2009, ART births accounted for 1.4 percent of all births in D.C., which was equivalent to the proportion of ART births nationally. The percentage of ART births in D.C. doubled to 2.8 percent in 2013 from 2009. The overall percentage of births resulting from an ART procedure in D.C. from 2009 to 2013 was 2.3 percent (Table 7.13).

Table 7.11. Annual Live Births by Ward, District of Columbia 2004-2013 by Calendar Year

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013*
All Wards Total**	7,937	7,940	8,522	8,870	9,134	9,008	9,156	9,289	9,370	9,264
Ward 1	1,141	1,123	1,262	1,243	1,306	1,227	1,219	1,174	1,196	1,061
Ward 2	763	799	846	634	682	693	691	601	643	667
Ward 3	1,013	936	913	796	786	765	801	842	820	824
Ward 4	1,088	1,196	1,316	1,460	1,467	1,441	1,324	1,423	1,479	1,375
Ward 5	854	839	898	1,041	1,085	1,099	1,067	1,089	1,113	1,181
Ward 6	946	949	991	939	998	1,067	1,118	1,245	1,276	1,259
Ward 7	898	945	1,015	1,210	1,222	1,162	1,218	1,218	1,156	1,236
Ward 8	1,231	1,150	1,249	1,545	1,583	1,521	1,635	1,667	1,675	1,649

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

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

Table 7.12. Number and Rate* of Abortions Reported Performed on District Residents: 2005-2013 by Calendar Year

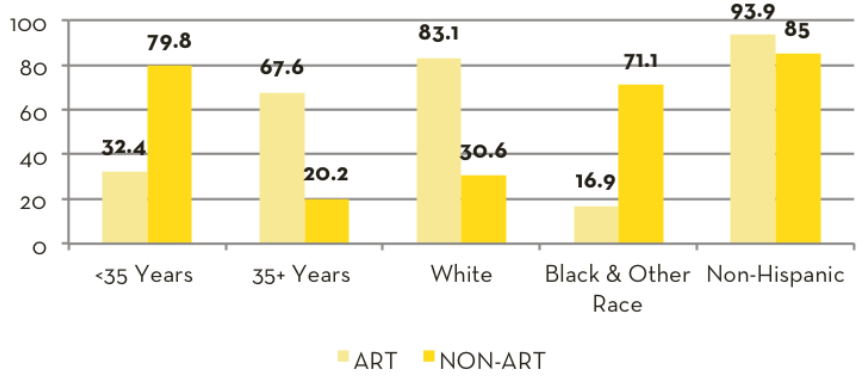
	2005		2006		2007		2008		2009		2010		2011		2012		2013	
Maternal Age	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**	**#**	**Rate**
Under 15 years**	27	1.7	9	0.6	8	0.6	7	0.5	14	1.0	19	1.5	10	0.8	15	1.2	6	0.5
15-19 years	444	21.9	204	9.9	178	8.4	208	9.8	240	11.1	275	13.1	232	11.3	215	10.5	168	8.5
20-24 years	830	30.5	504	18.0	464	16.2	414	14.2	594	21.9	593	16.8	612	18	579	17.7	545	17.2
25-29 years	679	22.7	498	16.6	447	14.7	385	12.2	483	15.0	507	13.5	519	13.1	507	12.3	458	10.9
30-34 years	407	16.3	269	10.9	282	11.3	221	8.9	288	10.7	302	10.6	345	11.2	314	9.5	282	7.9
35-39 years	219	9.9	158	7.1	160	7.2	118	5.4	137	5.9	163	7.6	168	7.7	189	8.3	118	4.8
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	45	2.3	45	2.2
Not Reported	0	-	4	-	1	-	0	-	0	-	1	-	5	-	-	-	1	-
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	1865	11.0	1623	9.3

*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

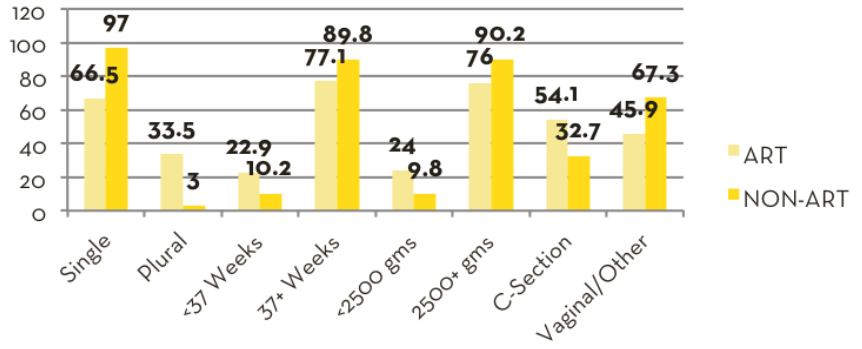
In Table 7.13, a significantly (p<0.01) higher proportion (~ 68%) of ART-achieved pregnancies occurred among women aged 35 years and older compared to 21% of their non-ART counterpart between 2009 and 2013 (Figure 7.16). A higher proportion of non-Hispanic white mothers (77.2%) had ART births compared to non–Hispanic black and other races (17.0%) and the difference was highly significant (p<0.001). Hispanic mothers were less likely to undergo ART procedure compared to non-Hispanic (Figure 7.16). The proportion of preterm (<37 weeks gestation) births was more than 2 times (22.9% vs. 10.3%) higher among mothers who had ART-conceived pregnancy than non-ART. A significantly (p<0.01) higher proportion of low birth weight babies were born among women who underwent ART procedure compared to the non-ART group (24% vs. 9.8%, respectively). C-section deliveries were higher among births conceived through ART procedure (54%) compared to non-ART (33%) and the difference was significant (p<0.01). Significantly (p<0.001) higher proportion of multiple births (33.5%) occurred among women who had ART-conceived pregnancies compare to non-ART women (3.1%) (Figure 7.17). A high incidence of multiple births among women using ART could be attributed to women receiving transfer of two or more embryos during ART procedure.

Figure 7.16. Percent Of Art And Non-Art Births By Maternal Characteristics, District Of Columbia: 2009-2013



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

Figure 7.17. Percent of ART and Non-ART Births by Pregnancy Characteristics, District of Columbia: 2009-2013



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

Table: 7.13. Percent Of Births Resulting From Assisted Reproductive Technology (Art) By Selected Mother's Demographic And Health Characteristics And By Birth Year, District Of Columbia: 2009-2013

	2009	2010	2011	2012	2013*	ART 2009-2013	Non-ART 2009-2013
	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)	N(%)
All Births	9,008	9,156	9,289	9,370	9,264	46087**	
ART	130(1.4)	222(2.4)	235(2.5)	227(2.4)	255(2.8)	1,069(2.3)	45,018(97.7)
Mother's Age							
<35 Years	42(32.3)	76(34.2)	70(29.8)	75(33.0)	83(32.5)	346(32.4)	35718(79.1)
35-39 Years	59(45.4)	93(41.9)	94(40.0)	79(34.8)	93(36.5)	418(39.2)	7373(16.4)
40 + Years	29(22.3)	53(23.9)	71(30.2)	73(32.2)	79(31.0)	303(28.4)	1921(4.4)
Race & Ethnicity							
Non-Hispanic White	108(84.4)	175(79.9)	185(81.1)	161(70.9)	185(73.4)	814(77.2)	12089(27.1)
Non-Hispanic Black	8(6.3)	21(9.6)	13(5.7)	26(11.5)	26(10.3)	94(8.9)	23738(53.3)
Non-Hispanic Others	6(4.7)	16(7.3)	22(9.7)	18(7.9)	20(7.9)	82(7.8)	1979(4.4)
Hispanic	6(4.7)	7(3.2)	8(3.5)	22(9.7)	21(8.3)	64(6.1)	6756(15.2)
Multiple Births							
Single	83(63.9)	123(55.4)	149(63.4)	167(73.6)	189(74.1)	711(66.5)	43563(96.9)
Plural	47(36.1)	99(44.6)	86(36.6)	60(26.4)	66(25.9)	358(33.5)	1414(3.1)
Gestational Age							
<37 Weeks	25(19.2)	70(31.5)	53(22.6)	44(19.4)	53(20.8)	245(22.9)	4589(10.3)
37+ Weeks	105(80.8)	152(68.5)	182(77.4)	183(80.6)	202(79.2)	824(77.1)	40202(89.7)
Birth Weight							
<2,500 Grams	35(26.9)	72(32.4)	51(21.7)	45(19.8)	53(20.8)	256(24.0)	4361(9.7)
2,500+ Grams	95(73.1)	150(67.6)	184(78.3)	182(80.2)	202(79.2)	813(76.0)	40598(90.3)
Method of Delivery							
C-Section	77(59.2)	132(59.5)	117(49.8)	113(49.8)	139(54.5)	578(54.1)	14699(32.7)
Vaginal/others	53(40.8)	90(40.5)	118(50.2)	114(50.2)	116(45.5)	491(45.9)	30262(67.3)

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

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

Vital Statistics – Deaths

In 2013, there were 4,696 District resident deaths recorded. Total District resident deaths have fluctuated over the past five years. In 2011, deaths decreased by 4.9 percent from 2009, and then there was a 2.5 percent increase from 2011 to 2013. When examined by race and gender, the 2009 to 2013 trends show a 4.3 percent decrease among black and other non-white males compared to a decrease of 1.9 percent among white males. For black and other non-white females, total deaths decreased 0.7 percent compared with a decrease of 2.8 percent among white females. When examined by Hispanic ethnicity and gender, the 2009 to 2013 trends show a 14.6 percent decrease among Hispanic males compared to a decrease of 4.1 percent among non-Hispanic males. For Hispanic females, deaths were steadily near 1 percent (Table 7.14).

Table 7.14. Deaths by Race, Ethnicity and Gender in the District of Columbia by Calendar Year

	2009	2010	2011 #	2011 %	2012 #	2012 %	2013* #	2013* %
Black & Other Non-White races								
Male	1,967	1,777	1,739	38.0	1,774	38.2	1,882	40.1
Female	1,868	1,877	1,907	41.6	1,894	40.7	1,855	39.5
Subtotal	3,835	3,654	3,646	79.6	3,668	78.9	3,738	79.6
White								
Male	520	495	488	10.7	486	10.5	510	10.9
Female	462	521	448	9.8	494	10.6	449	9.6
Subtotal	982	1,016	936	20.4	980	21.1	959	20.4
Total	**4,817**	**4,670**	**4,582**	**100**	**4,648**	**100**	**4,696**	**100**
Hispanic								
Male	82	52	59	1.3	72	1.5	70	1.5
Female	56	54	49	1.1	56	1.2	56	1.2
Subtotal	138	106	108	2.4	128	2.8	126	2.7
Non-Hispanic								
Male	2,363	2,182	2,134	46.6	2,161	46.5	2,267	48.3
Female	2,256	2,326	2,294	50.1	2,322	50.0	2,232	47.5
Subtotal	4,619	4,508	4,428	96.6	4,483	96.5	4,499	95.8
Unknown	**60**	**56**	**46**	**1.0**	**37**	**0.8**	**71**	**1.5**

*Preliminary data.

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

Table 7.15a. Leading Causes of Death in the District of Columbia: 2009-2013 (Age-Adjusted Rate per 100,000 Population)

DC Rank*	Cause of Death	2009	2010	2011	2012	2013**	Change 2009-2013
1	Heart Disease	231.4	221.4	193.9	212.5	213.1	-7.9%
2	Malignant Neoplasms (Cancer)	190.2	177.1	180.4	178.6	173.3	-8.9%
3	Unintentional Injuries (Accidents)	35.1	34.9	29.0	31.1	31.7	-9.7%
4	Cerebrovascular Diseases (Stroke)	34.3	32.4	34.1	33.7	30.2	-11.9%
5	Chronic Lower Respiratory Diseases	24.2	25.5	25.4	23.5	24.8	+2.7%
6	Alzheimer's Disease	16	18.7	19.6	20.5	20.7	+29.2%
7	Diabetes	23	24.9	25.6	23.9	17.5	-23.7%
8	Homicide/Assault	20.5	17.1	15.5	15.4	11.9	-41.9%
9	Influenza and Pneumonia	13	13.6	15.8	12.1	12.9	-0.9%
10	HIV/AIDS	23.6	20.4	14.7	11.6	12.0	-49.2%

* Rank based on number of District of Columbia resident deaths in 2013.
** Preliminary data.
Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, Data Mgmt & Analysis Division. U.S. Census Bureau, Population Division.

The percentage of deaths among black and other non-whites in 2013 was disproportionate to their fraction of the population. This group accounted for 79.6 percent of all deaths among residents, yet accounted for only 49.5 percent of the District's population.

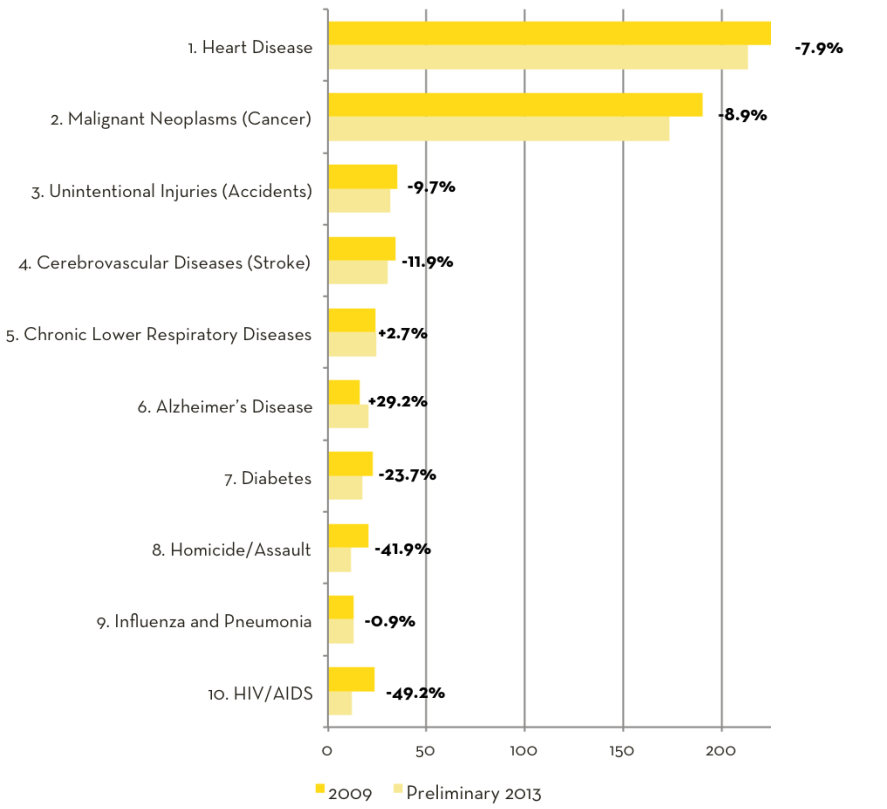
The leading cause of death in the District of Columbia and in the nation in 2013 was heart disease. In the District, the age-adjusted death rate from heart disease decreased the most from 2009 to 2011, by 16.1 percent, with an overall decline from 2009 to 2013 of 7.9 percent (Table 7.15a and Figure 7.18). Nationally, the age-adjusted death rate for heart disease has decreased by 7.1 percent during the same five-year period (Table 7.15b). The second highest cause of death in the District is cancer, which has decreased between 2009 and 2013 by 8.9 percent. In 2013 in the District, unintentional injuries or accidents surpassed cerebrovascular diseases (stroke) to rank the third leading

Table 7.15b. Leading Causes of Death in the United States: 2009-2013 (Age-Adjusted Rate per 100,000 Population)

US Rank*	Cause of Death	2009	2010	2011	2012	2013**	Change 2009-2013
1	Heart Disease	182.8	179.1	173.7	170.5	169.8	-7.1%
2	Malignant Neoplasms (Cancer)	173.5	172.8	169	166.5	163.2	-5.9%
3	Chronic Lower Respiratory Diseases	42.7	42.2	42.5	41.5	42.1	-1.4%
4	Unintentional Injuries (Accidents)	37.5	38	39.1	39.1	39.4	+5.1%
5	Cerebrovascular Diseases (Stroke)	39.6	39.1	37.9	36.9	36.2	-8.6%
6	Alzheimer's Disease	24.2	25.1	24.7	23.8	23.5	-2.9%
7	Diabetes	21	20.8	21.6	21.2	21.2	+1.0%
8	Influenza and Pneumonia	16.5	15.1	15.7	14.4	15.9	-3.6%
9	Nephritis, Nephrotic Syndrome and Nephrosis (Kidney disease)	15.1	15.3	13.4	13.1	13.2	-12.6%
10	Intentional Self-Harm (Suicide)	11.8	12.1	12.3	12.6	12.6	+6.8%

* Rank based on number of District of Columbia resident deaths in 2013.
** Preliminary data.
Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, Data Mgmt & Analysis Division. U.S. Census Bureau, Population Division.

Figure 7.18. Change in Rates of Leading Causes of Death in the District of Columbia: 2009-2013 (Age-Adjusted Rate per 100,000 Population)



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

cause of death, while they were ranked 4th and 5th in the United States, respectively. From 2009 to 2013, the rate of deaths due to unintentional injuries decreased by 9.7 percent in the District, and the District's deaths due to unintentional injuries was consistently lower than national levels. Deaths due to HIV/AIDS in the District have been steadily declining; there was a decrease of 49.2 percent between 2009 and 2013. During this five-year period, the death rate due to homicide (assault) has also decreased by 41.9 percent in the District; however, the District's homicide (assault) death rate is still much higher than the national rate of 5.2. The rates of Alzheimer's disease and chronic lower respiratory disease deaths, however, increased 29.2 percent and 2.7 percent, respectively, from 2009 to 2013. Further, the District's mortality rates for four of the 10 leading causes of death were higher than the national rates: heart disease, cancer, homicide/assault, and HIV/AIDS. Stroke, unintentional injuries, chronic lower respiratory diseases, Alzheimer's disease, diabetes, and influenza/pneumonia death rates in the District were lower than in the nation.

Chronic, non-communicable diseases, including heart disease, cerebrovascular diseases (stroke), cancer, and diabetes, accounted for 57.4 percent of all deaths in the District in 2013. In addition, other chronic conditions, such as Chronic Lower Respiratory Diseases, Alzheimer's disease, and HIV/AIDS, contributed 3.2 percent, 2.8 percent, and 1.7 percent, respectively, of all deaths in 2013.

Deaths by Ward

As shown in Table 7.16a, from 2009 to 2013, Ward 5 and Ward 7 had the highest crude death rates among all wards, except in 2009, when Ward 4 had a higher rate than Ward 7. Ward 2 had the lowest crude death rate followed by Ward 1 and then Ward 3, from 2009 to 2013. Crude death rates have decreased in the last 5 years city-wide and in all wards, except in Wards 7 and 8, which increased by 12.7 and 3.2 percent, respectively. Although Ward 5 crude death rates were highest, on average, during these 5 years, the rate decreased 15.7 percent, more than any other ward.

Table 7.16a. Crude Death Rates by Ward, District of Columbia: 2009-2013 by Calendar Year

	2009	2010	2011	2012	2013*	% Change 2009-2013
City-wide Mortality Rate	803.3	776.1	741.4	735.1	726.4	-9.6
Ward 1	547.8	506.6	437.9	482.8	492.8	-10.0
Ward 2	403.1	326.6	360.8	358.1	357.8	-11.2
Ward 3	568.4	596.2	530.2	534.0	522.7	-8.0
Ward 4	1,035.6	966.0	895.2	926.5	901.3	-13.0
Ward 5	1,358.5	1,182.9	1,139.5	1,178.0	1,145.7	-15.7
Ward 6	645.8	694.5	661.0	709.1	619.2	-4.1
Ward 7	1,023.7	1,068.0	1,161.2	1,098.0	1,153.9	12.7
Ward 8	842.9	898.0	823.9	859.9	869.9	3.2

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

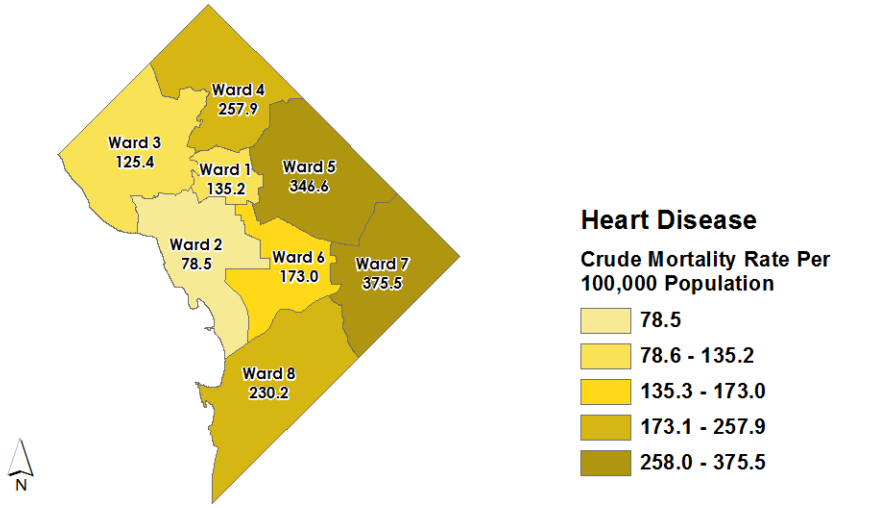
The distribution of the number of deaths and mortality rates for the 10 leading causes of death in DC in 2013 by Ward are displayed in Table 7.16b. The greatest number of total deaths occurred in Ward 5, but Ward 7 had the highest rate of deaths from all causes, 1,153.9 per 100,000 population. Conversely, Ward 2 had the fewest number of total deaths as well as the lowest rate of deaths from all causes, 269 deaths and 357.8 per 100,000 population, respectively. Further, Ward 7 had the highest rate of deaths for five out of ten of the leading causes of death in DC in 2013: heart disease, cancer, diabetes, homicide/assault, and HIV/AIDS. On the other hand, Ward 2 had the lowest rate of deaths for five out of ten of the leading causes of death, including heart disease, cancer, unintentional injuries, diabetes, and homicide/assault.

Table 7.16b. Number and Crude Rate of Deaths by Ward, District of Columbia Residents: Preliminary 2013*

Causes of Death**	All Causes	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
Total Deaths***	**4696**	**390**	**269**	**421**	**713**	**909**	**519**	**759**	**665**
Rate per 100,000 pop.	726.4	492.8	357.8	522.7	901.3	1,145.7	619.2	1,153.9	869.9
1. Heart Disease	**1329**	107	59	101	204	275	145	247	176
Rate per 100,000 pop.	205.6	135.2	78.5	125.4	257.9	346.6	173.0	375.5	230.2
2. Malignant Neoplasms (Cancer)	1072	105	71	100	153	194	131	161	149
Rate per 100,000 pop.	165.8	132.7	94.4	124.2	193.4	244.5	156.3	244.8	194.9
3. Unintentional Injuries (Accidents)	**204**	21	12	19	31	36	29	22	30
Rate per 100,000 pop.	31.6	26.5	16.0	23.6	39.2	45.4	34.6	33.4	39.2
4. Cerebrovascular Diseases (Stroke)	**187**	8	9	21	24	49	18	28	28
Rate per 100,000 pop.	28.9	10.1	12.0	26.1	30.3	61.8	21.5	42.6	36.6
5. Chronic Lower Respiratory Diseases	**150**	9	11	11	25	34	12	17	29
Rate per 100,000 pop.	23.2	11.4	14.6	13.7	31.6	42.9	14.3	25.8	37.9
6. Alzheimer's Disease	**131**	4	12	23	24	28	10	19	11
Rate per 100,000 pop.	20.3	5.1	16.0	28.6	30.3	35.3	11.9	28.9	14.4
7. Diabetes	**106**	14	3	5	13	20	6	24	21
Rate per 100,000 pop.	16.4	17.7	4.0	6.2	16.4	25.2	7.2	36.5	27.5
8. Homicide/Assault	**88**	5	0	0	7	11	7	28	29
Rate per 100,000 pop.	13.6	6.3	0.0	0.0	8.8	13.9	8.4	42.6	37.9
9. Influenza and Pneumonia	**80**	4	4	10	14	16	8	17	6
Rate per 100,000 pop.	12.4	5.1	5.3	12.4	17.7	20.2	9.5	25.8	7.8
10. HIV/AIDS	**79**	8	1	0	5	17	10	16	21
Rate per 100,000 pop.	12.2	10.1	1.3	0.0	6.3	21.4	11.9	24.3	27.5
All Other Causes	**1270**	**105**	**87**	**131**	**213**	**229**	**143**	**180**	**165**

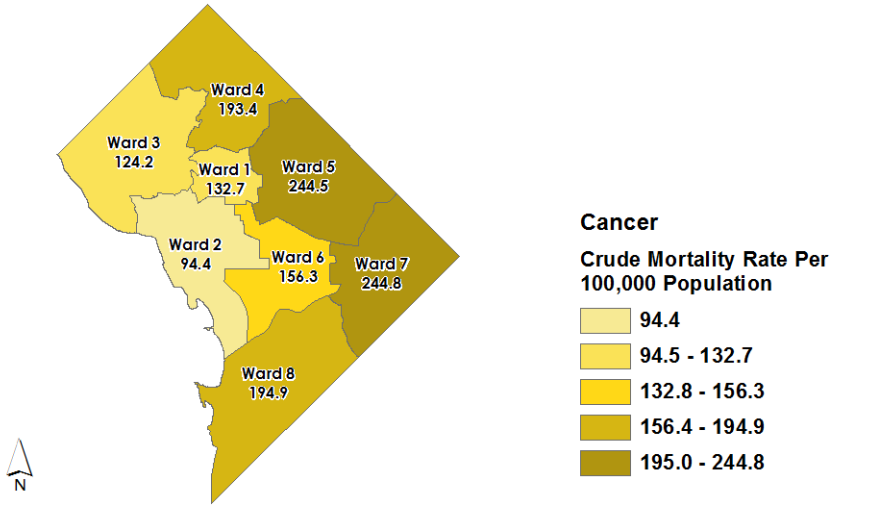
Note: Dark shaded areas show the highest death rates and light shaded areas show the lowest death rates by ward and disease.
* Crude death rates are per 100,000 population based on 2009-2013 ACS population estimate by ward.
** Rank based on number of deaths from the list of 113 Selected Causes of Death.
*** May not add to Total 4,696 deaths due to missing ward data.
Source: DC Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.1. Heart Disease Crude Mortality Rates by Ward, District of Columbia: 2013



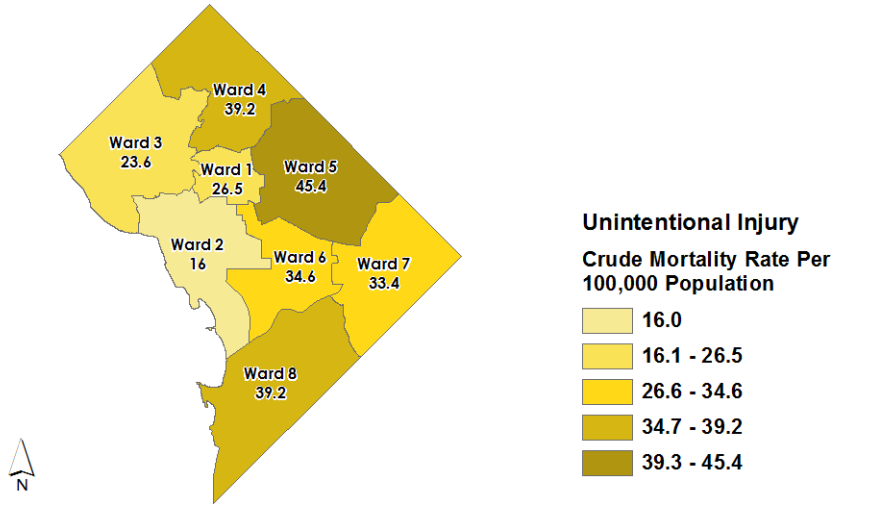
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.2. Cancer Crude Mortality Rates by Ward, District of Columbia: 2013



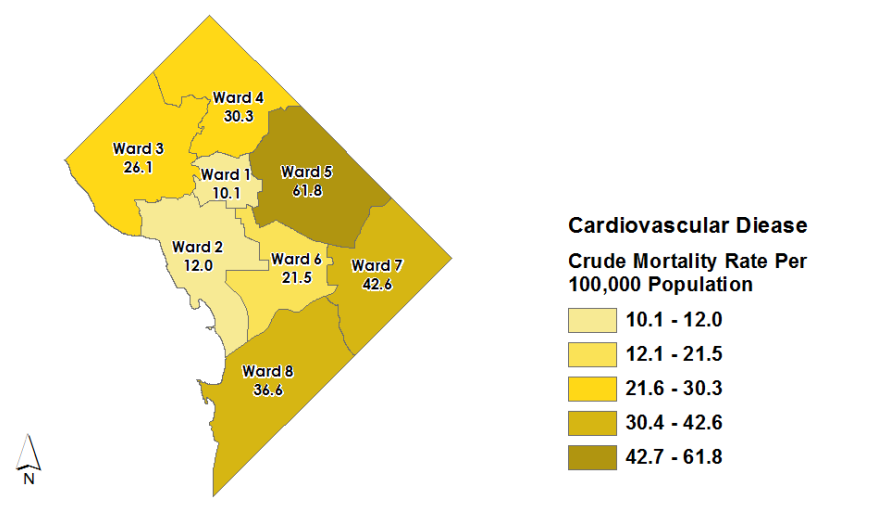
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.3. Unintentional Injuries Crude Mortality Rates by Ward, District of Columbia: 2013



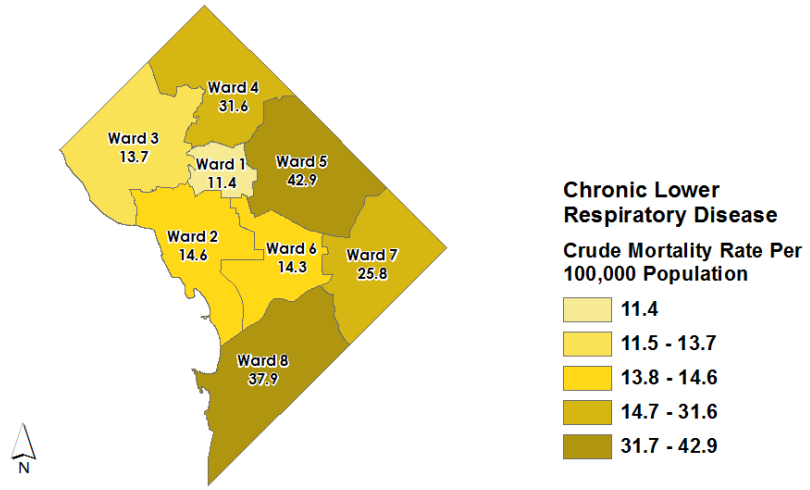
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.4. Cerebrovascular Disease Crude Mortality Rates by Ward, District of Columbia: 2013



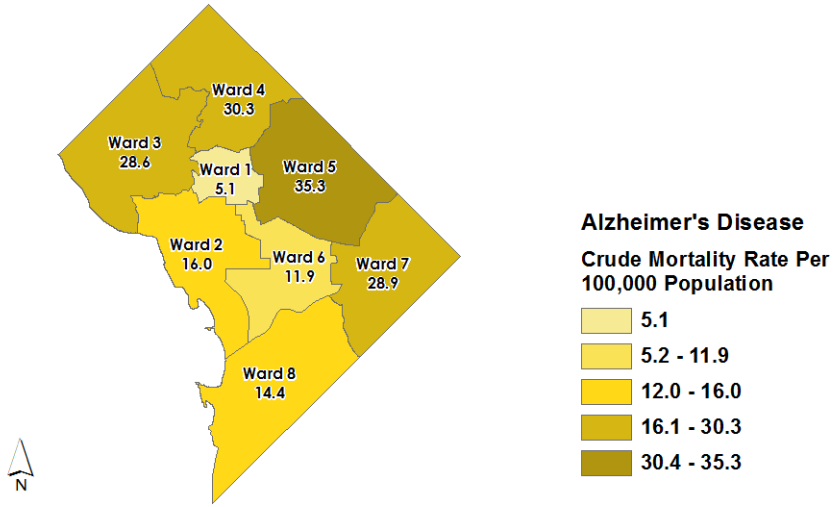
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.5. Chronic Lower Respiratory Disease Crude Mortality Rates by Ward, District of Columbia: 2013



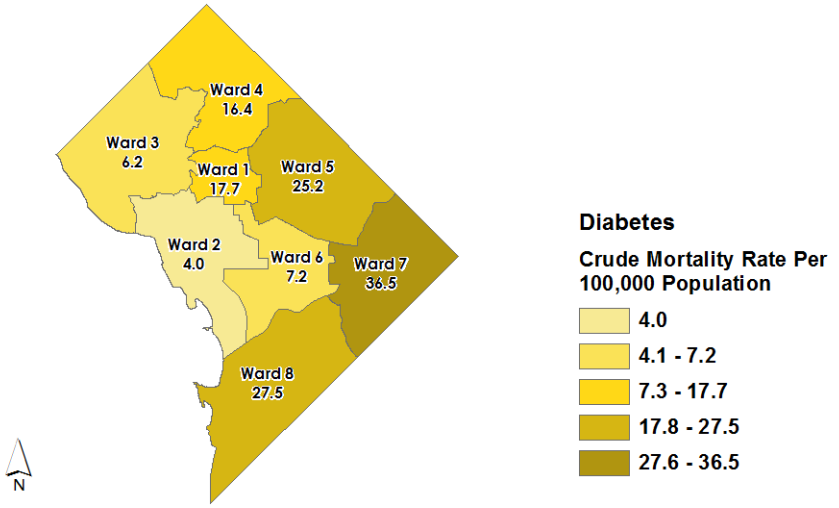
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.6. Alzheimer's Disease Crude Mortality Rates by Ward, District of Columbia: 2013



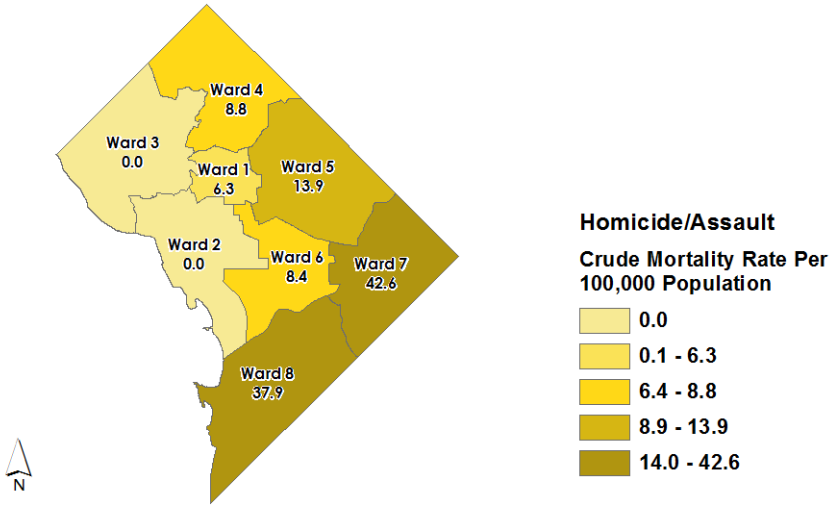
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.7. Diabetes Crude Mortality Rates by Ward, District of Columbia: 2013



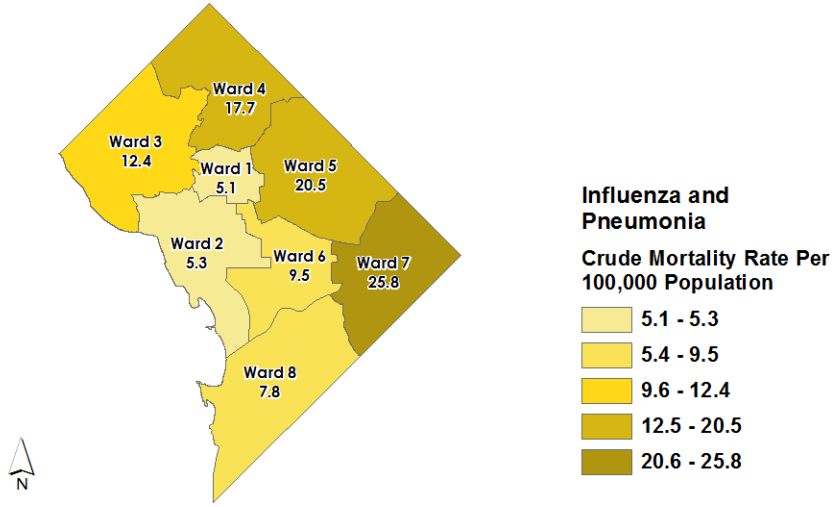
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.8. Homicide/Assault Crude Mortality Rates by Ward, District of Columbia: 2013



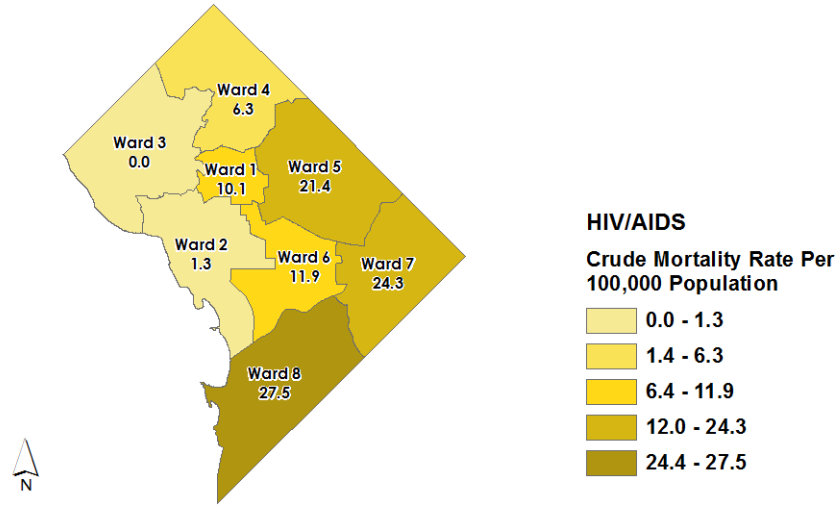
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Map 7.9. Influenza and Pneumonia Crude Mortality Rates by Ward, District of Columbia: 2013



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

Map 7.10. HIV/AIDS Crude Mortality Rates by Ward, District of Columbia: 2013

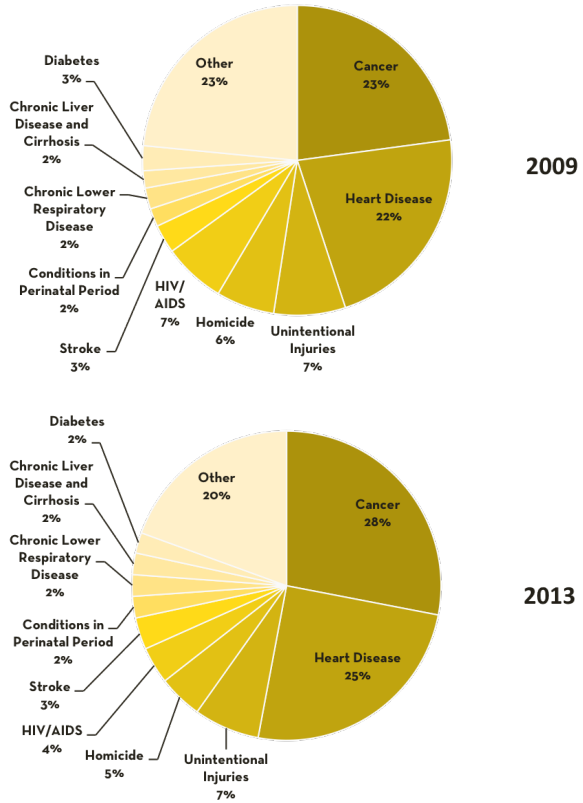


Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Data Management and Analysis Division.

Premature Deaths, Before Age 70 Years

Table 7.17 shows the leading causes of premature deaths, those which occurred before age 70 years, in the District from 2009 to 2013. Although many of the causes of premature death also appeared among the 10 leading causes of death, the rankings differed. The leading cause of premature death was cancer, and it increased from 22.9 percent of premature deaths in 2009 to 26.1 percent in 2012 and 2013 (Table 7.17 and Figure 7.19). Heart disease and unintentional injuries ranked in the top three causes on both lists. However, several diseases and

Figures 7.19. Percentages of the Most Common Causes of Premature Death in the District of Columbia: 2009 and 2013*



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

conditions were among the leading causes of premature death that did not appear among the leading causes for the entire District, including conditions originating in the perinatal period, chronic liver disease and cirrhosis, viral hepatitis, suicide, essential hypertension and hypertensive renal disease, and septicemia.

Table 7.17. Leading Causes of Premature Death in the District of Columbia

Percent of Premature Deaths, Before Age 70 Years

Rank*	Cause of Death	2009	2010	2011	2012	2013**
1	Cancer	22.9	23.5	24.9	26.1	26.1
2	Heart Disease	22.1	22.1	20.0	21.4	23.2
3	Unintentional injuries	7.5	6.9	7.1	7.1	6.4
4	Homicide/Assault	6.1	5.7	5.3	4.2	4.3
5	HIV/AIDS	6.5	5.5	4.5	4.6	3.6
6	Cerebrovascular diseases (Stroke)	3.0	3.6	3.7	3.1	3.1
7	Conditions originating in the Perinatal period	1.9	1.9	2.5	2.2	2.1
8	Chronic lower respiratory diseases	2.2	2.0	2.0	1.9	2.1
9	Chronic liver disease and cirrhosis	1.8	2.3	1.8	2.4	2.1
10	Diabetes	2.6	2.9	3.4	2.8	2.0
11	Viral hepatitis	1.4	0.9	1.8	1.2	1.7
12	Intentional self-harm (Suicide)	1.7	1.9	1.6	1.6	1.7
13	Influenza and pneumonia	1.0	0.8	1.5	1.1	1.2
14	Essential hypertension and hypertensive renal disease	0.8	0.8	0.8	1.1	1.0
15	Septicemia	1.4	1.6	1.3	1.3	0.9

* Rank based on number of District of Columbia resident deaths in 2013.
** Preliminary data.
Source: DC Dept of Health, Center for Policy, Planning, & Evaluation, Data Mgmt & Analysis Division. U.S. Census Bureau, Population Division.

Research, Evaluation and Measurement Division

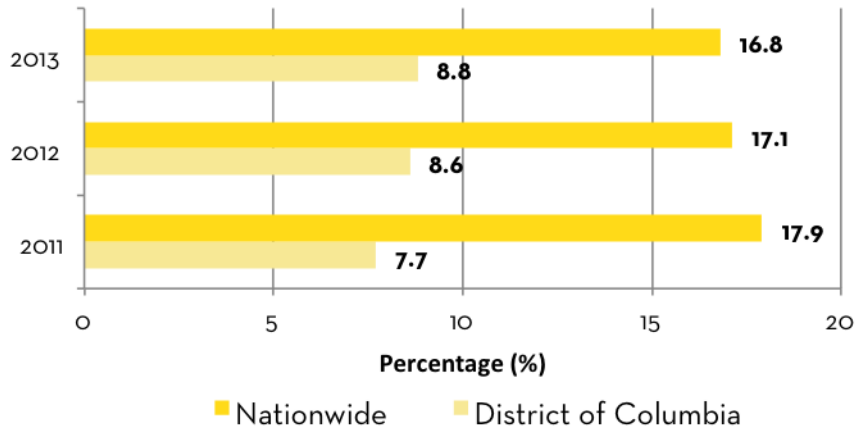
Behavioral Risk Factor Surveillance System

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 U.S. states, the District of Columbia, and three territories independently carry out this ongoing telephone survey, sponsored by the Centers for Disease Control and Prevention (CDC). Below are selected key indicators collected by BRFSS that can be used to plan interventions and monitor DC resident health.

Access to Health Services

From 2011-2013, adults who did not have health coverage increased slightly among District residents compared to nationwide where rates saw a slight but steady decrease (Figure 7.20).

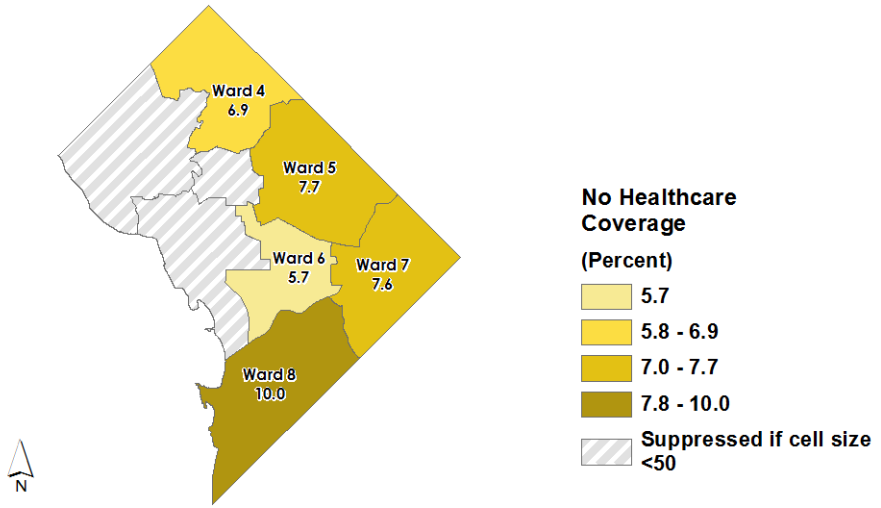
Figure 7.20. Adults Who Did Not Have Health Care Coverage, BRFSS 2011-2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.11 geographically displays health coverage by ward in 2013.

Map 7.11. Percentage of Adults Who Did Not Have Health Care Coverage by Ward: 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

District adults were asked if they had one person they thought of as their personal doctor or health care provider. Overall, 23.8% of District adults did not have their own personal health care provider (Figure 7.21). Map 7.12 shows adults who had no health care provider by ward.

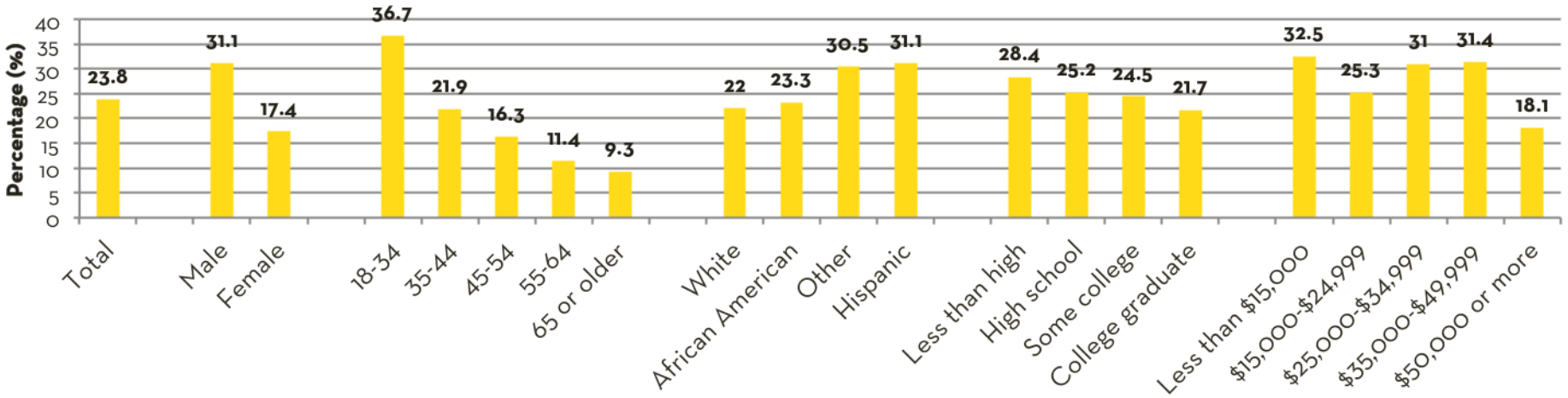
Chronic Disease and Risk Factors

Diabetes

District adults who were more likely to be diagnosed with diabetes (Figure 7.22 and Map 7.13) were:

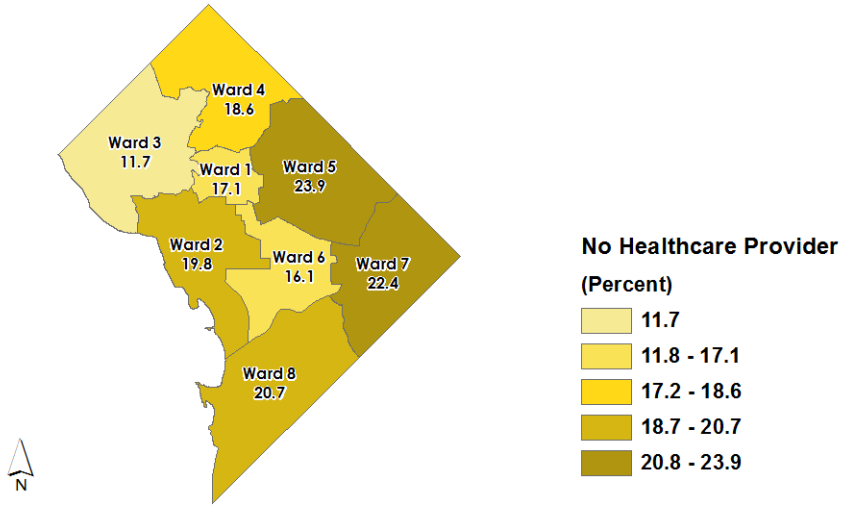
- Female
- Aged 65 or older
- African American
- Had less than a high school education
- Household income less than $15,000
- Resided in Ward 8

Figure 7.21. District Adults Who do not have one Person they Think of as Their Personal Health Care Provider by Demographics, BRFSS 2013



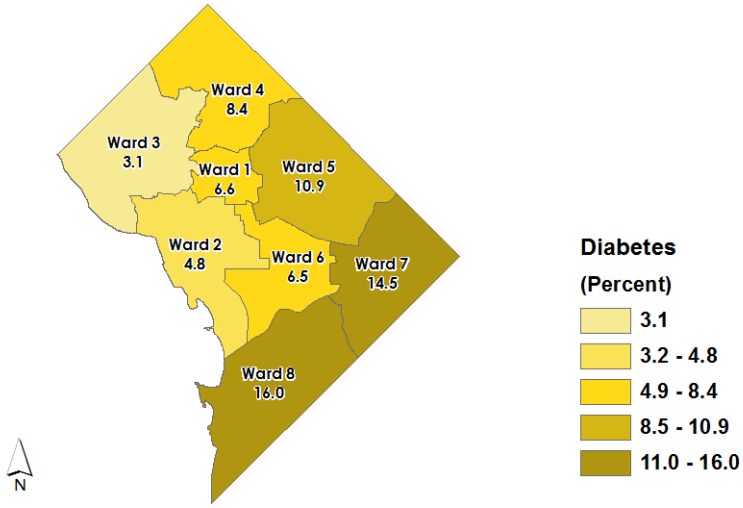
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.12. Percentage of Adults Who Did Not Have A Health Care Provider by Ward: 2013



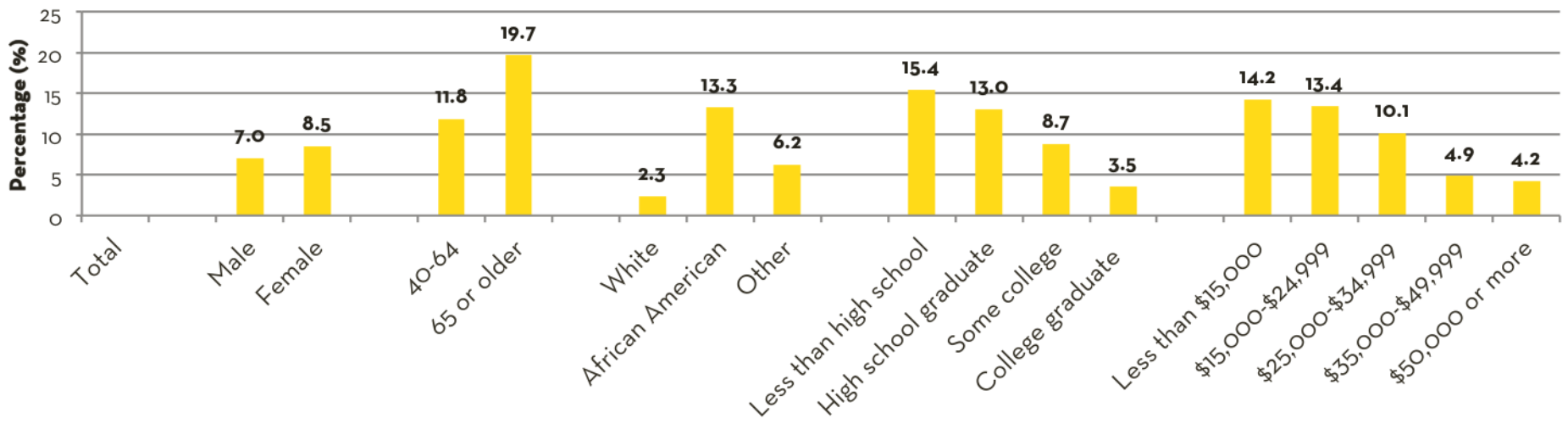
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.13. Percentage of Adults Diagnosed With Diabetes, by Ward, 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.22. District Adults Who were Diagnosed with Diabetes by Demographics, BRFSS 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

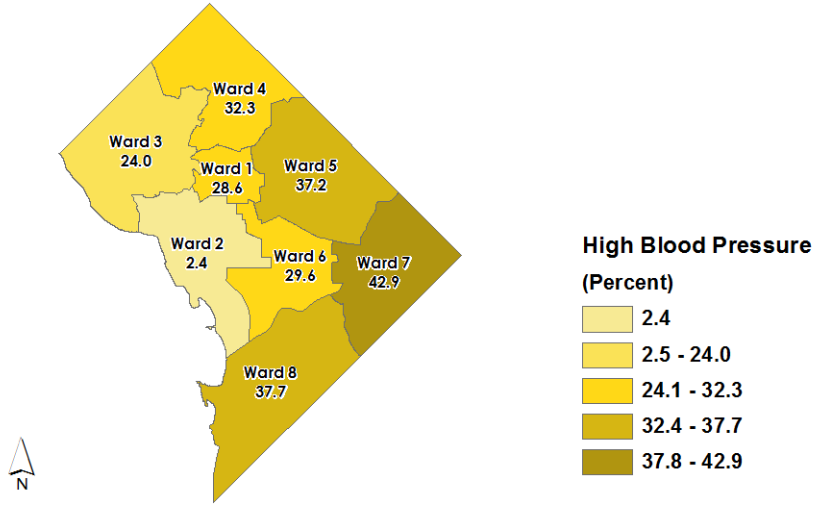
Blood Pressure

High blood pressure increases an individual's risk for heart disease and stroke, two of the leading causes of death for Americans. Figure 7.23 shows high blood pressure by demographics and Map 7.14 shows geographic distribution of residents with high blood pressure.

Obesity

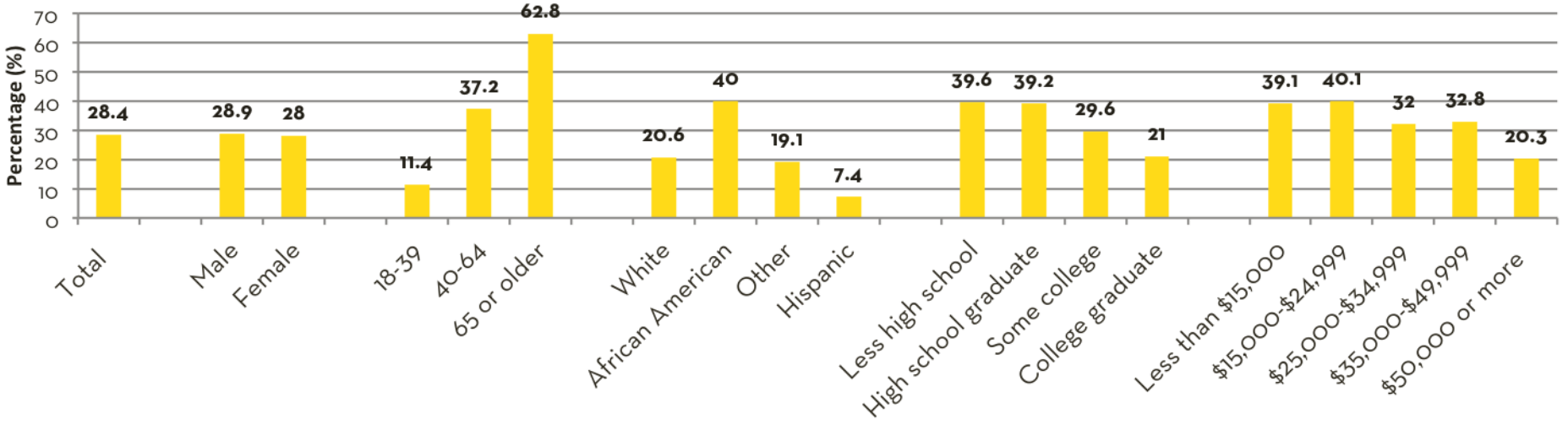
District adults were asked to provide their height and weight to determine weight status. Overall, 22.8% of District adults based on their height and weight were classified as obese. Figure 7.24 shows obesity by demographics and Map 7.15 shows the geographic distribution of the percent of residence who are obese by ward.

Map 7.14. Percentage of Adults with High Blood Pressure by Ward: 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.23. District Adults Who had High Blood Pressure by Demographics, BRFSS 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

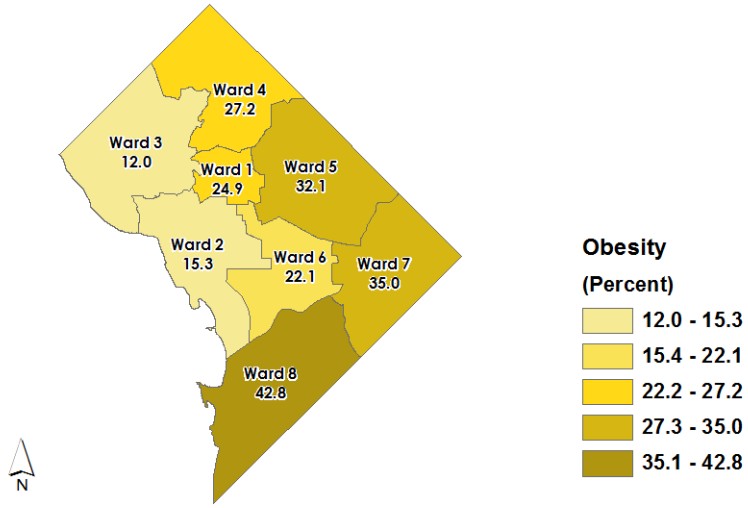
Physical Activity

Individuals who do not engage in regular physical activity increase their risk of chronic diseases associated with a sedentary lifestyle such as heart disease, type 2 diabetes, and some cancers. Figure 7.25 shows the demographics of adults who did not participate in any physical activities in the past 30 days. Map 7.16 shows where these adults resided.

Asthma

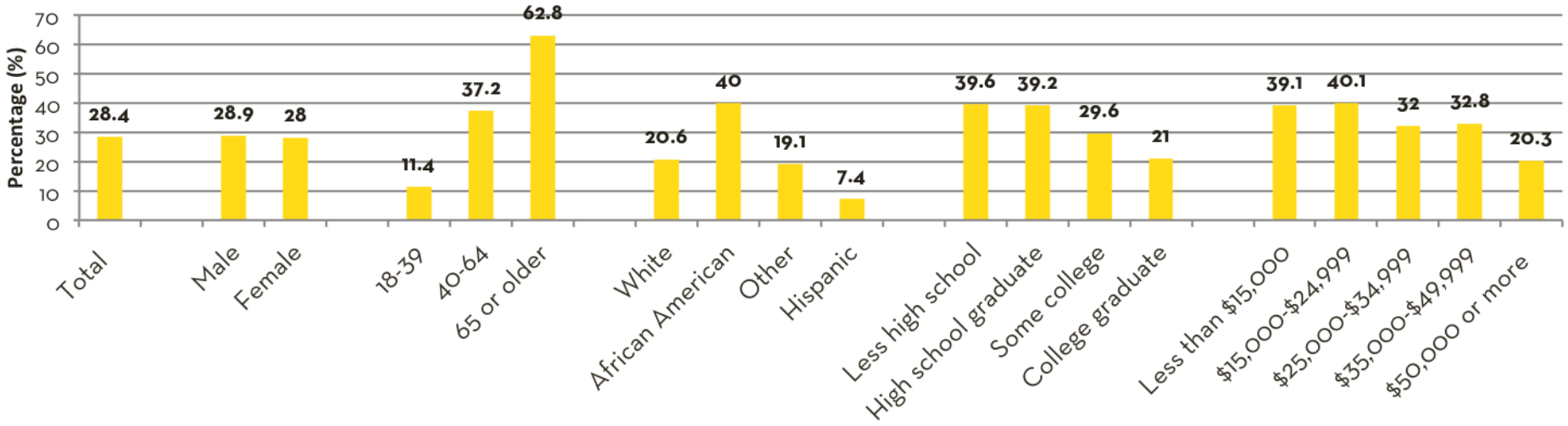
Nationwide, there was a slight but steady increase among individuals who have asthma compared to the District where asthma prevalence has shown no significant change from 2011-2013 (Figure 7.26). Map 7.17 shows where residents with current asthma reside.

Map 7.15. Percentage of Adults Classified as Obese Based on Body Mass Index by Ward: 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.24. District Adults Who were Classified as Obese Based on Body Mass Index by Demographics, BRFSS 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Immunization

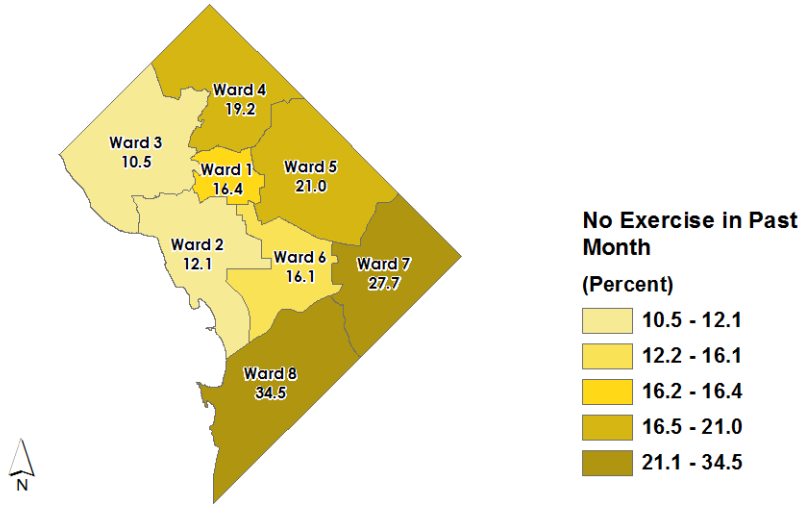
The flu vaccine protects against three or four influenza viruses that have been determined to be the most common during the upcoming season. During a regular flu season, about 90 percent of deaths occur in people aged 65 years or older. Figure 7.27 shows the comparison between the nation and District of adults who did not have a flu shot. Figure 7.28 and Map 7.18 show adults who did not have a flu shot/spray by demographics and ward, respectively.

Substance Use

Alcohol

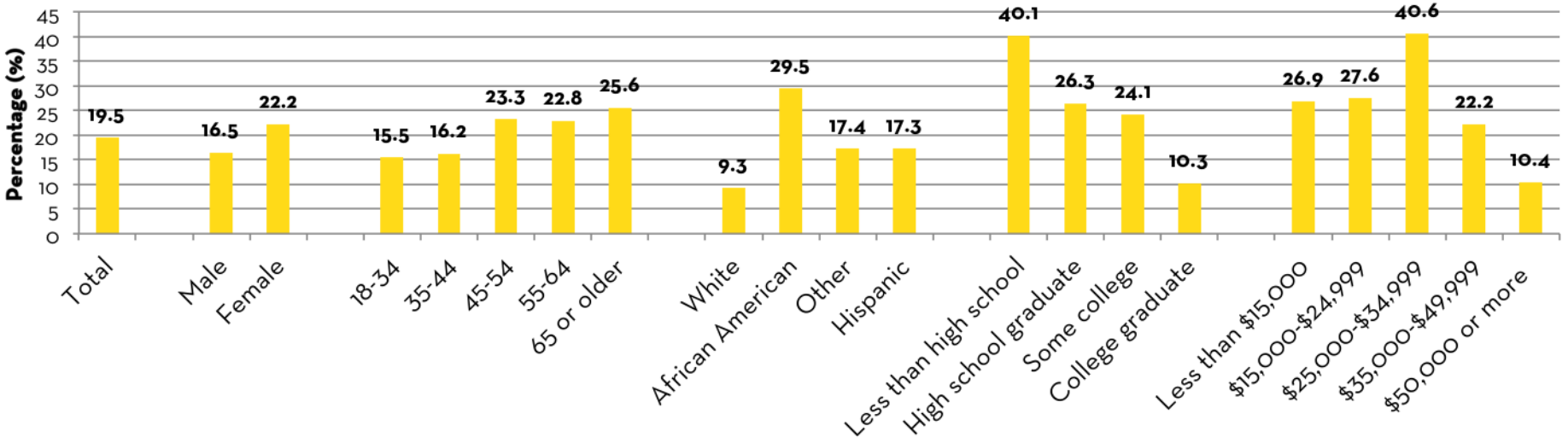
Binge drinking (defined as consuming 4 or more alcoholic beverages per occasion for women or 5 or more drinks per occasion for men) and excessive alcohol use has led to approximately 88,000 deaths,

Map 7.16. Percentage of Adults With No Exercise Within the Past 30 days by Ward, 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.25. District Adults Who Did Not Participate In Any Physical Activities Within the Past 30 Days by Demographics, BRFSS 2013



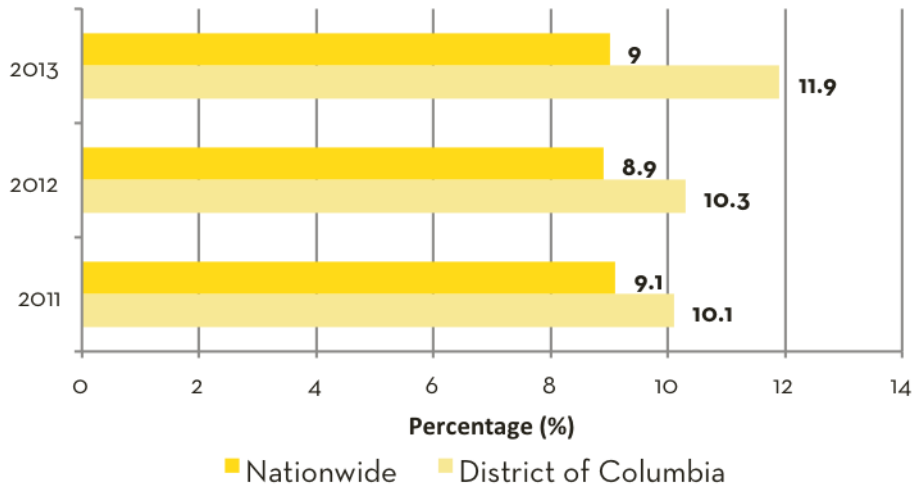
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

2006-2010. Excessive drinking contributes to over 54 different injuries and diseases, including car crashes, violence, and sexually transmitted diseases. Figure 7.29 and Map 7.19 show residents who binge drink by demographics and where they live, respectively.

Tobacco

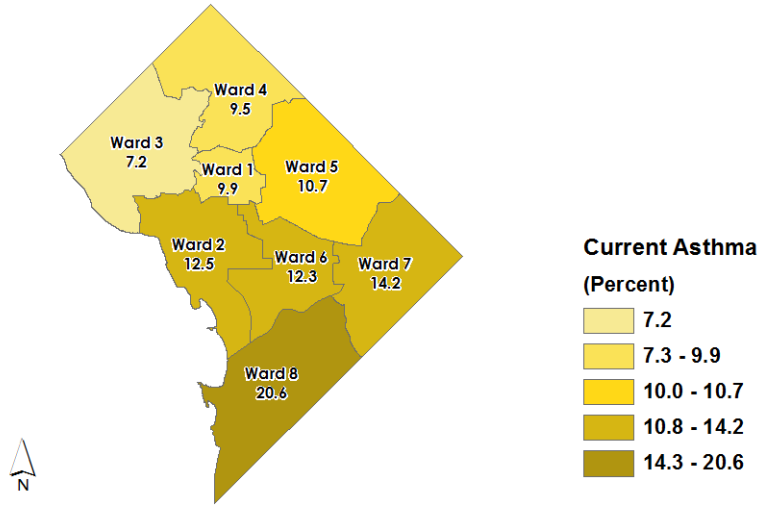
Smoking is the leading cause of preventable death in the United States. Cigarette smoking causes more than 480,000 deaths each year in the U.S., more than HIV, illegal drug use, alcohol use, motor vehicle injuries, and firearm-related incidents combined. Figure 7.30 and Map 7.20 show demographics and residence of adults who smokes, respectively.

Figure 7.26. Adults Who Were Told They Currently Have Asthma, Brfss 2011-2013



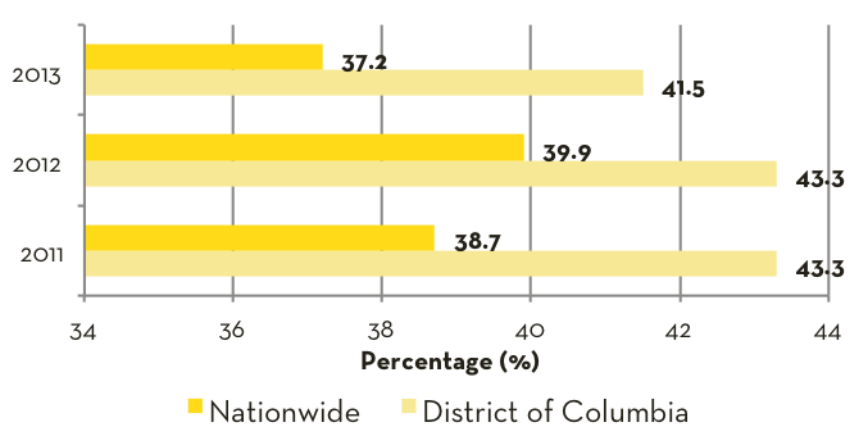
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.17. Percentage of Adults with Current Asthma by Ward: 2013



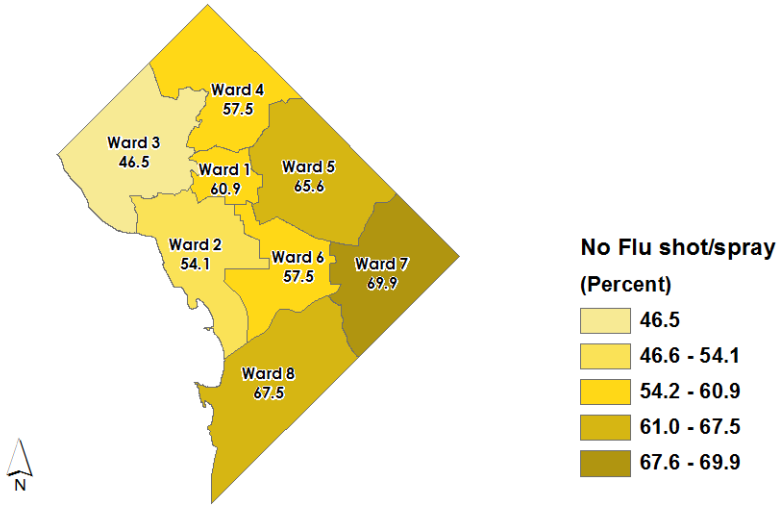
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.27. Adults Aged 65 And Older Who Did Not Have A Flu Shot Within The Past 12 Months, Brfss 2011-2013



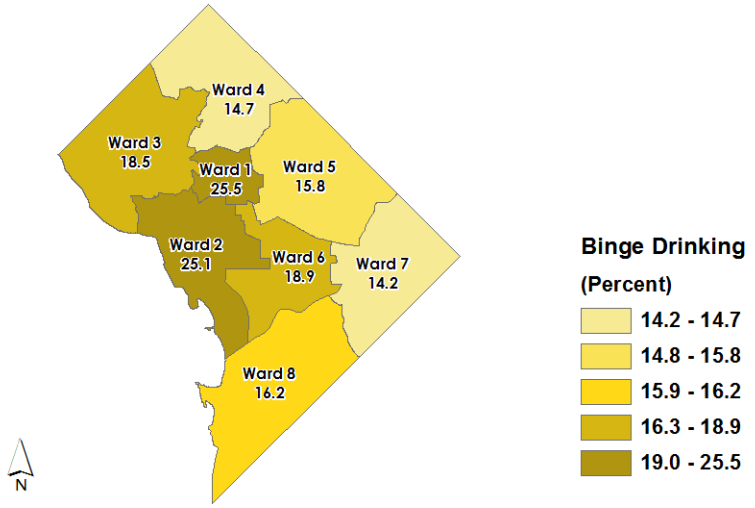
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.18. Percentage Of Adults With No Flu Shot/ Spray Within Past 12 Months By Ward: 2013



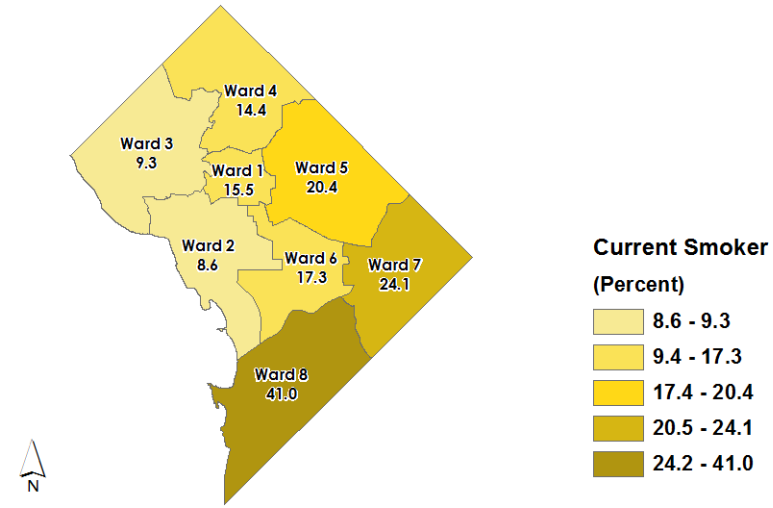
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.19. Percentage Of Adults Who Were Binge Drinkers By Ward: 2013



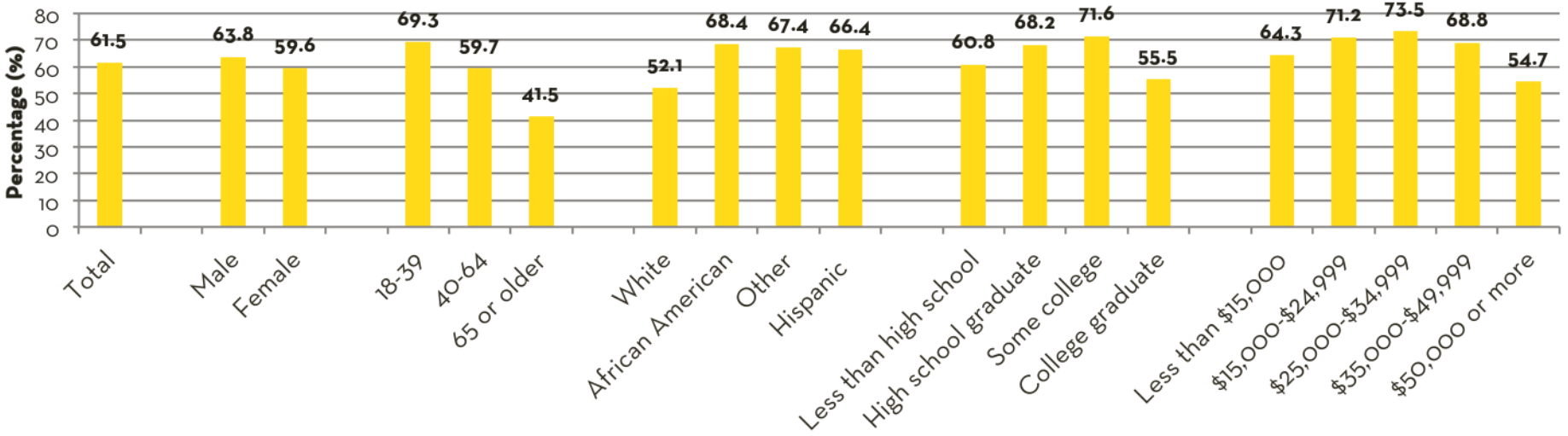
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Map 7.20. Percentage of Adults Who were Smokers by Ward: 2013



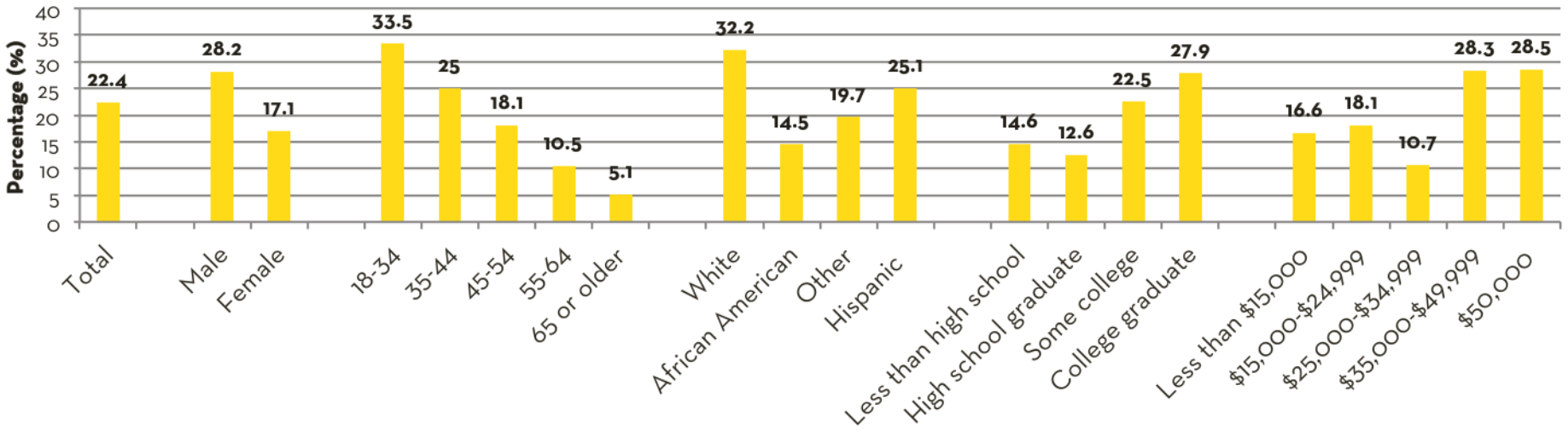
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.28. District Adults Who Did Not Have A Flu Shot/Spray Within The Past 12 Months By Demographics, Brfss 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

Figure 7.29. District Residents who are Binge Drinkers by Demographics, BRFSS 2013



Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

ESSENCE Surveillance System

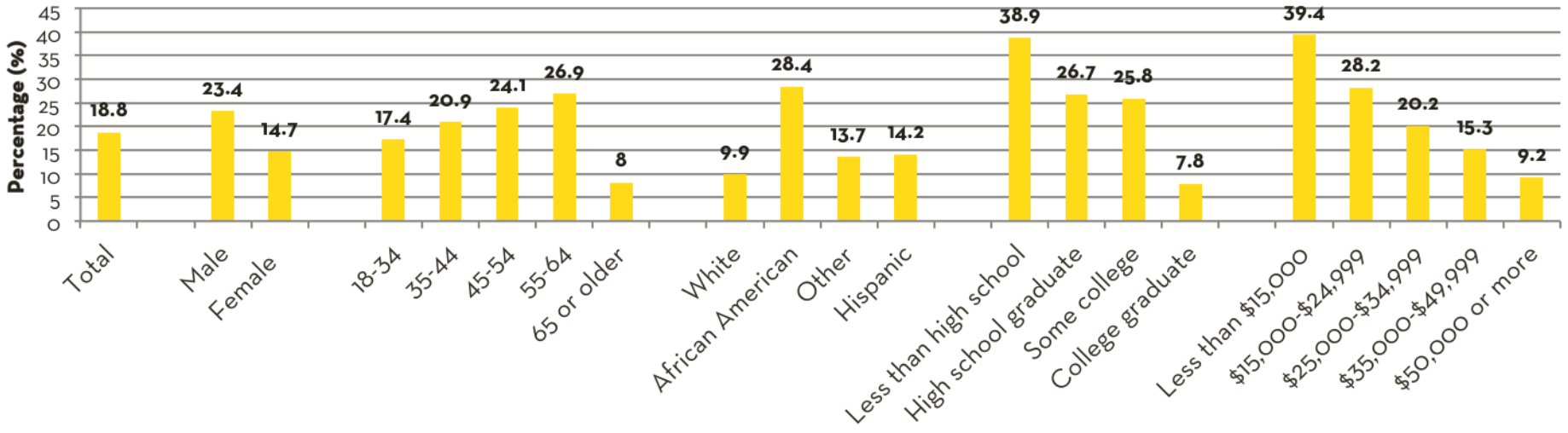
DC ESSENCE is a surveillance system that receives hospital emergency department (ED) chief complaint data in nearly real-time. It allows the Department of Health to detect, closely monitor and respond to potential outbreaks related to infectious disease, foodborne illness, and other emergencies. An example of how this system is used is shown in Figure 7.31 through a comparison of 2008-2009 and 2009-2010 influenza-like illness (ILI) ED visits. The latter years monitor the emergence of the H1N1 (also known as swine flu) outbreak between Week 12, 2009 to Week 12, 2010.

DC ESSENCE was able to detect significant changes in ILI activity during the outbreak period compared to normal ILI activity. The blue line represents the first confirmed case of H1N1 in the District during Week 18, 2009. The system was able to detect sharp increases in flu-like illness around week 16, before the first diagnosed case in the District. Figures 7.32 and 7.33 compare flu activity across age groups during the same two time periods as the first graph. In 2008-2009, the rates varied across age groups compared to the 2009-2010 pandemic where the younger age groups were disproportionately affected, a confirmed characteristic of the 2009 H1N1 outbreak. This demonstrates that not only is ESSENCE able to detect the outbreak, it is also able to accurately characterize it.

Figure 7.34 compares the 2012-2013, 2013-2014, and 2014-2015 flu seasons as seen by ESSENCE syndromic surveillance. ESSENCE was able to detect that the most recent flu season was significantly more severe than last year's 2013-2014 season in terms of raw number of visits to the ED for influenza like illness, and similar to the 2012-2013 flu season in terms of number of ED visits. The 2012-2013 season was also considered to be relatively severe.

Moving forward, DC ESSENCE data can be used to help public health policymakers and planners understand trends in emergency room chief complaints and potential corresponding environmental or social

Figure 7.30. District Adults Who Were Smokers By Demographics, Brfss 2013



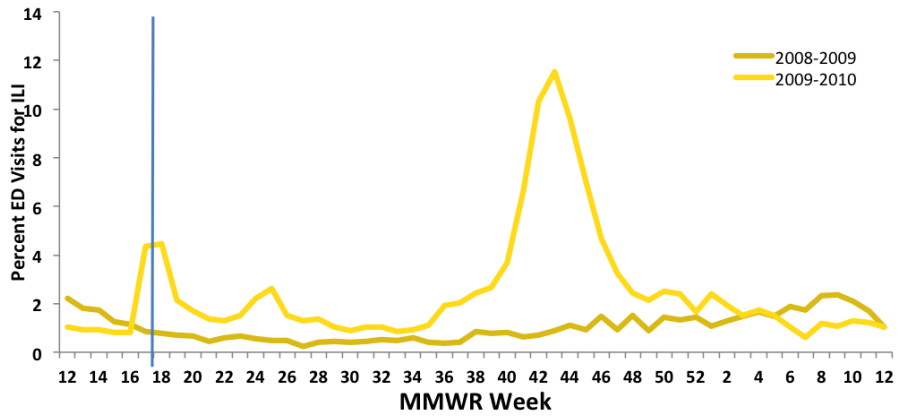
Source: D.C. Department of Health, Center for Policy, Planning, and Evaluation, Research, Evaluation and Measurement Division, BRFSS 2013.

factors not only in infectious and food-borne illnesses, but in areas such as chronic disease, oral health, asthma, traumatic injury, and more.

Healthcare-Associated Infection Reduction Task Force

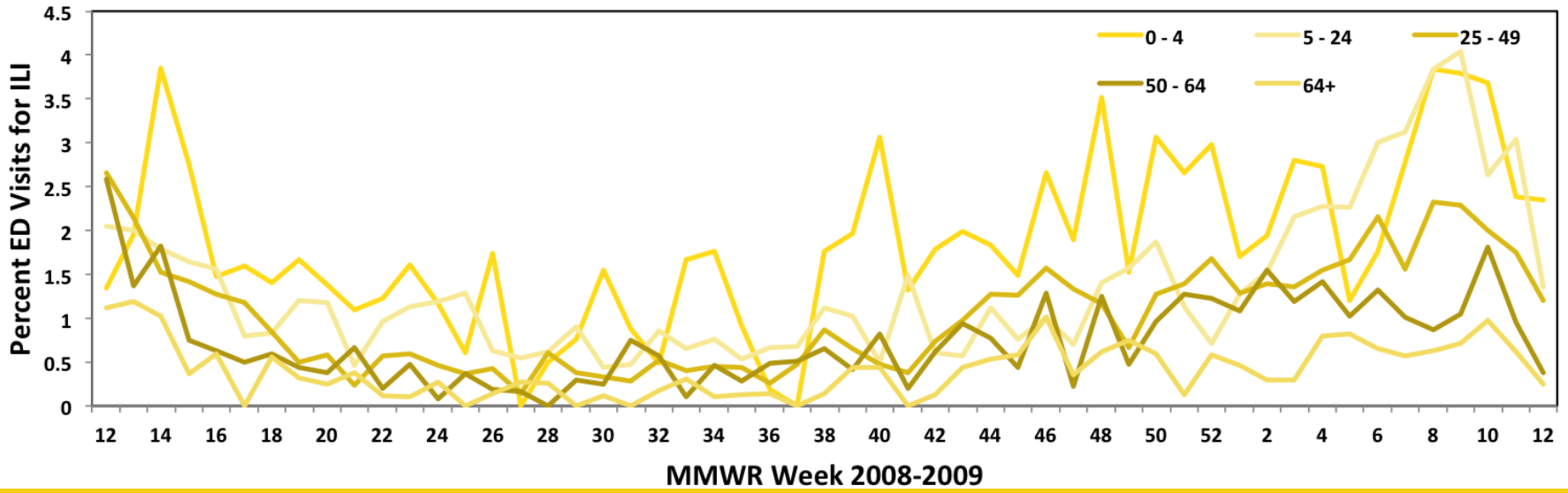
The District of Columbia Department of Health has partnered with the District of Columbia Hospital Association (DCHA), Delmarva Foundation for Medical Care, and the Metro DC Chapter of the Association for Professionals in Infection Control and Epidemiology (APIC) to create the Healthcare-Associated Infection (HAI) Reduction Task Force. HAIs include a variety of infections such as those associated with catheter placement and maintenance as well as transmission of multi-drug resistant bacterial infections. The goal of the task force is to reduce occurrences of HAIs by working collaboratively to develop a picture of where we are today, determine what we are doing well and what we can do better, identify key target areas for improvement, and design and implement initiatives to improve health care across District hospitals and healthcare facilities.

Figure 7.31. Percentage Of Emergency Department Visits For Influenza-Like Illness Complaints From DC Essence, 2008-2009 Vs. 2009-2010



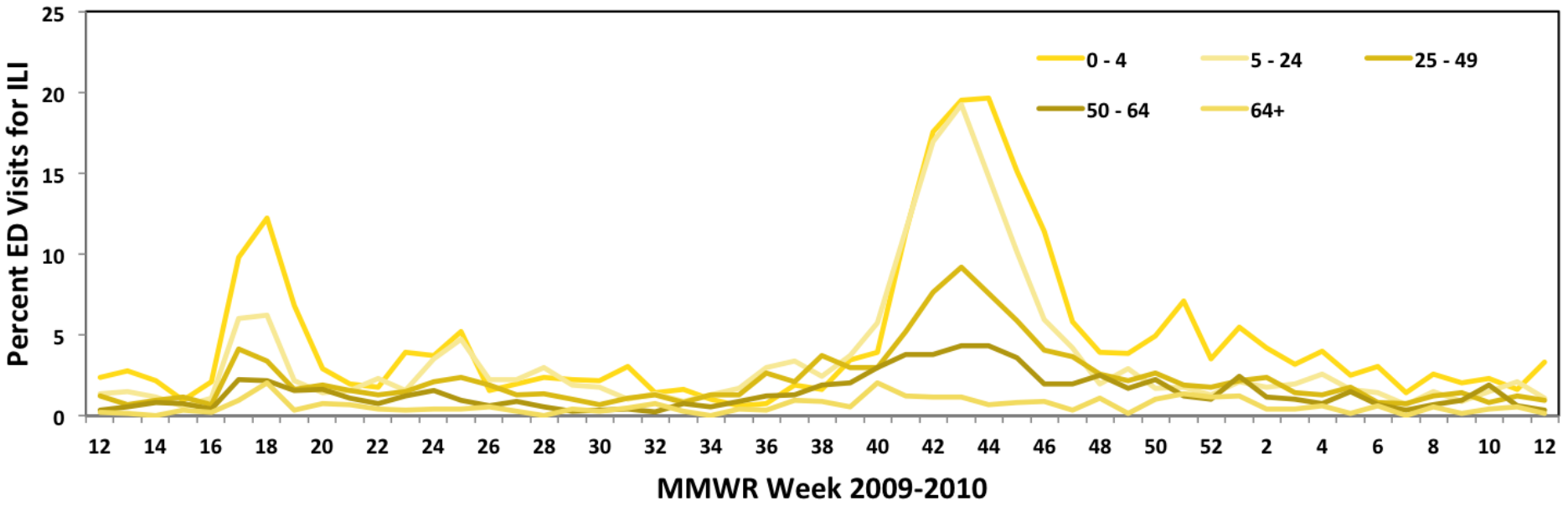
Clear differences in the percentage of ILI visits can be seen during the outbreak period 2009-2010 compared to the year before, especially during the peaks of the outbreak around weeks 17, 25, and 44. The blue line marks the day the first case of H1N1 was confirmed in the District on May 6th 2009. Source: DC ESSENCE, Center for Policy, Planning and Evaluation, District of Columbia Department of Health.

Figure 7.32. Breakdown Of Percent Visits For Influenza-Like Illness By Age Group: 2008-2009



Source: DC ESSENCE, Center for Policy, Planning and Evaluation, District of Columbia Department of Health.

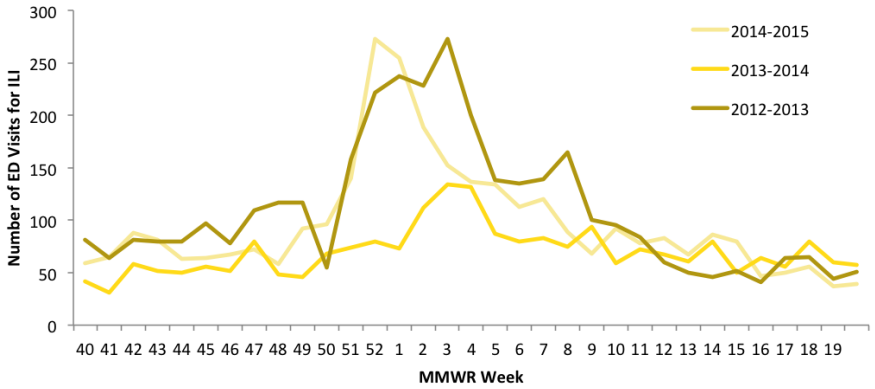
Figure 7.33. Breakdown Of Percent Visits For Influenza-Like Illness By Age Group: 2009-2010



Source: DC ESSENCE, Center for Policy, Planning and Evaluation, District of Columbia Department of Health.

First steps have been taken through the administration of a gap analysis survey of the eight acute care hospitals and two long-term acute care hospitals* in the District (Table 7.18). This survey was designed to assess infection prevention program infrastructure, program components, and defined HAI initiatives. Each hospital will receive a customized report of the results of the survey, identifying areas for improvement and providing guidelines for best practices. In 2015, DOH, in partnership with the Public Health Lab, will conduct a point prevalence study of acute care and skilled nursing facilities to determine the burden of Carbapenem-resistant Enterobacteriaceae, an emerging multi-drug resistant organism.

Figure 7.34. Number Of Emergency Department Visits For Influenza-Like Illness Over Three Flu Seasons (2012-2013, 2013-2014, And 2014-2015)



Source: DC ESSENCE, Center for Policy, Planning and Evaluation, District of Columbia Department of Health.

State Health Planning and Development Agency

State Health Planning and Development Agency (SHPDA) 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 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 (CON) program. 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 7.19 shows the CON applications by category.

Hospital Discharge Data

SHPDA collects hospital discharge data from eight acute care hospitals in the District (Table 7.18) thru the DC Hospital Association (DCHA). Since 2010, an average of 139,000 hospitalizations per year was reported, down from an average of 147,000 hospitalizations per year in the 2000-2009 period. Hospitalization of DC residents has remained stable over the past decade, averaging 77,000 discharges per year, or 53% of all discharges. Hospital discharge data are used in the analysis of population morbidity, hospital utilization patterns, and in the planning and evaluation of health programs and services. Table 7.20 summarizes the leading causes of hospitalization among District residents in 2012.

Table 7.18. Acute Care Hospitals In The District Of Columbia

Children's National Medical Center
George Washington University Hospital
Georgetown University Hospital
Howard University Hospital
Providence Hospital
Sibley Memorial Hospital
United Medical Center
Washington Hospital Center
Long-Term Acute Care Hospitals*
BridgePoint Hospital – Capitol Hill
BridgePoint Hospital – Hadley

*Long-Term Care Hospitals (LTCHs) are referred to as Long-Term Acute Care Hospitals in the National Healthcare Safety Network (NHSN). (Healthcare Facility HAI Reporting Requirements to CMS via NHSN, December 2014)
LTCHs are certified as acute-care hospitals, but LTCHs focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home. LTCHs typically give services like comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management (Centers for Medicare and Medicaid Services (CMS), August 2014).
Source: District of Columbia Hospital Association

Community Health Administration

Cancer and Chronic Disease Bureau

Chronic disease initiatives are designed to prevent, manage, and reduce risk factors associated with chronic disease; including asthma, childhood and adult obesity, diabetes, heart disease, stroke and tobacco control and prevention. The Department of Health, Bureau of Cancer and Chronic Disease's focus includes implementing environmental approaches to support healthy behaviors; health systems interventions to improve quality and efficiency of care delivery; community-clinical linkages to support prevention and management of diabetes and hypertension; and, collecting and analyzing data to guide work. From 2013-14, the Bureau has worked

with eight (8) health centers and eight (8) primary care practices reaching 36,439 patients to improve the management of chronic disease in the District.

Key health status indicators for the District are included in Table 7.21. The leading causes of death in the District are related to tobacco use, physical inactivity and poor nutrition. Tobacco use by adults in the District has been declining and remains below the national rates. In an effort to reverse the steady trend of obesity in the District, the Bureau employs strategies to improve the early care and education environment for children which directly impacts what children consume and levels of activity; workplace strategies which focuses on supporting healthy eating and active living in the workplace; and, implementing food service guidelines to create environments in which healthier choices are more available for residents.

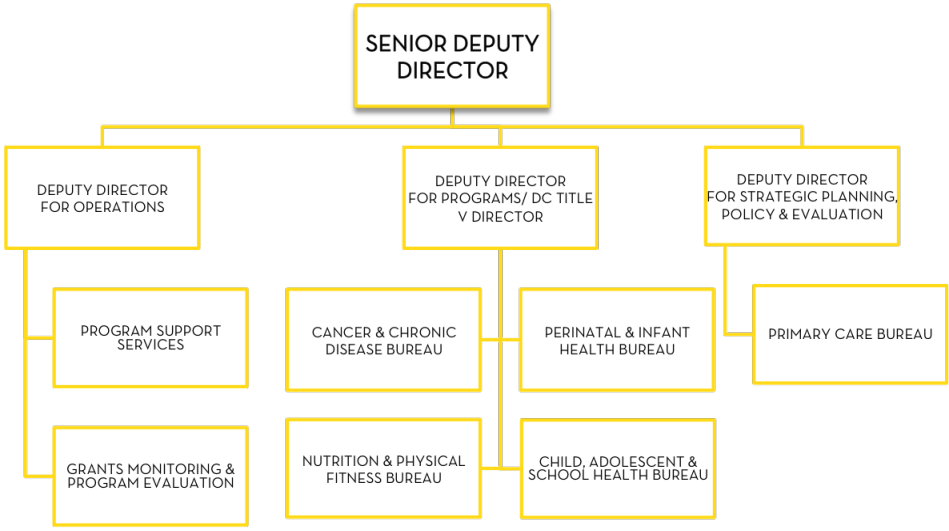


Table 7.19. Certificate of Need Applications By Category: 2005-2014

Calendar Year	Applications	Facilities and Services	Replacement and Renovation	Major Medical Equipment	Change of Ownership
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
2013	20	15	3	2	0
2014	30	22	4	0	4

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

Table 7.20. Leading Causes of Hospitalization for DC Residents: 2012

Percent of Premature Deaths, Before Age 70 Years

Rank*	Cause of Death	2009
1	Complications Related to Pregnancy, Childbirth and Puerperium	9,148
2	Heart Disease	7,251
3	Accidents and Poisoning	5,628
4	Psychoses	5,320
5	Chronic Lower Respiratory Disease	3,583
6	Pneumonia and Influenza	4,157
7	Cancers and Neoplasms	2,786
8	Diabetes Mellitus	1,699
9	Cerebrovascular Disease	1,483
10	HIV AIDS	370

Source: D.C. Hospital Association. Data prepared by D.C. Department of Health, Center for Policy, Planning, and Evaluation, State Health Planning and Development Agency.

An overview of cancer along with the top 10 cancer incidence rates in the District can be found in Figure7.35 and Table 7.22. Cancer initiatives provide low-income, uninsured, and underserved women access to timely breast and cervical cancer screening and diagnostic services as well as linkage to treatment. Through partnership with community health providers, Project WISH (Women Into Staying Healthy) continues to provide comprehensive breast and cervical cancer education and screening services to low income women who reside in DC. In FY 14, Project WISH provided 2,382 breast cancer screenings as compared to 1,422 in FY13, a 68 % increase, and 419 cervical cancer screenings and diagnostic services, up from 319 in FY13, representing a 31% increase. The Comprehensive Cancer Control initiative consists of a collaborative and strategic approach that allows the community and other stakeholders to combine, share, and coordinate resources to reduce the burden of cancer within the District of Columbia.

Child, Adolescent and School Health

The Department of Health, Child, Adolescent and School Health Bureau aims to improve and promote optimal health and quality of life for all District pre-school and school-age children and adolescents, including children and youth with special healthcare needs. The Bureau enhances access to preventive, dental, primary, and specialty care services for all children, provides education and support resources for families, and contributes to the development of a coordinated, culturally competent, family-centered health system.

Maternal, Infant and Early Childhood Home Visiting

The Maternal, Infant, and Early Childhood Home Visiting (MIECHV) supports parents of children from birth to five years of age develop the skills they need to raise children who are physically, socially and emotionally healthy and ready to learn. Through federal funds, the Department of Health funds three evidence-based home visiting models (Healthy Families America, Parents as Teachers and Home Instruction for Parents of Pre-School Youngsters), with focused enrollment of families in Wards 5, 7 and 8. These home visiting programs have been proven to help prevent child abuse and neglect, encourage positive parenting, and promote child development and school readiness. Home visiting is an early childhood intervention that supports pregnant women and parents/caregivers in their role of raising children by bringing services to them in their natural setting: their home. The models provide voluntary visits for families on a weekly, bi-weekly, or monthly schedule. Additionally, the home visitors screen families and link them to needed community resources. In FY13 192 families and 202 children were served; and, in FY14 176 families and 178 children were served.

Figures 7.36, 7.37a, and 7.37b provide an overview of program data.

School Nursing Program

The school nurse program works to ensure the health and wellness of District school children. School nurses are responsible for the provision and coordination of health services to students through active collaboration with students, families, school personnel and community based organizations.

Specific responsibilities include but are not limited to:

- Administration of medications, treatments and procedures
- Vision, hearing and BMI screenings
- Providing case management and referrals for identified students with special health care needs
- Promoting good health practices through health education
- Implementing the Adolescent Aids Prevention /Condom Availability Program

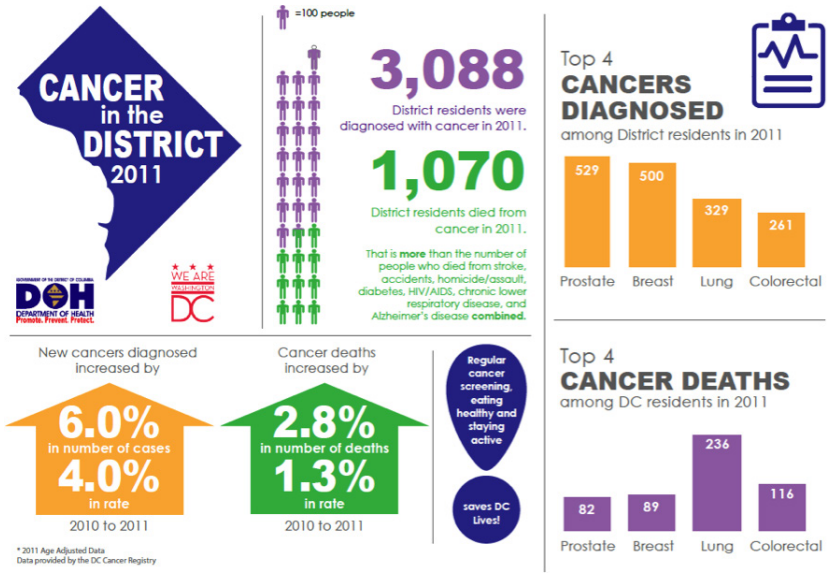
Table 7.23 details the number of District students served by the school health program.

Table 7.21. District of Columbia, City Health Status Indicators: 2011 - 2013

Subject/Topic	2011 (Prevalence %)	2012 (Prevalence %)	2013 (Prevalence %)
Arthritis Adult	20.9	18.2	19.5
Asthma Adult Current	10.1	10.3	11.9
Asthma Adult Lifetime	15.8	14.7	17.5
Cancer - Ever told you had any other types of cancer?	4.7	4.6	5.2
Cardiovascular Disease - Stroke Adult	3.7	3.2	3.2
Cardiovascular Disease - Coronary Heart Disease Adult	3.0	3.1	2.6
Cardiovascular Disease - Heart Attack Adult	3.4	3.2	4.1
Cardiovascular Disease - Diagnosed with High Cholesterol	34.3	N/A	34.0
Cardiovascular Disease - Adults who have been told they have high blood pressure	30.0	N/A	28.4
COPD - Ever told you have COPD? (Adult)	4.6	4.5	5.8
Diabetes (Adult)	9.1	8.2	7.8
Depression - Ever told you that you have a form of depression? (Adult)	16.0	16.3	20.9
Kidney Disease - Ever told you have kidney disease?	2.7	2.5	2.4
Obesity Adult (BMI>30)	23.8	21.9	22.9
Obesity Youth (High school students with a BMI greater than the 95th percentile for age and sex)	N/A	15.0	N/A
Overweight Adult (BMI 25.0-29.9)	29.1	30.0	30.9
Overweight Youth (High school students with a BMI at or above the 85th percentile for age and sex)	N/A	17.0	N/A
Healthy Weight Adult (BMI 18.5-24.9)	45.4	46.0	43.0
Physical Activity Adults (During the past month, did you participate in any physical activities?)	80.2	82.6	80.5
Physical Activity Youth (High school students with at least 60 minutes per day on five or more days)	N/A	28.1	N/A
Nutrition Adult (Consumed vegetables less than one time per day)	N/A	N/A	20.9
Nutrition Youth (High school students who did not eat vegetables (green salad) in past 7 days)	N/A	43.1	N/A
Nutrition Adult (Consumed fruit less than one time per day)	N/A	N/A	34.8
Nutrition Youth (High school students who did not eat fruit in past 7 days)	N/A	21.8	N/A
Tobacco - Smokers Adult Current	20.8	19.6	18.8
Tobacco - Smokers Youth (High school students who smoked a cigarette in past 30 days)	N/A	13.8	N/A

Source: Government of the District of Columbia, Department of Health, Center for Policy, Planning and Evaluation, Division of Epidemiology Disease Surveillance and Investigation, Behavioral Risk Factor Surveillance System, 2011-2013
Ost, Julie C. & Maurizi, Laura K. (2013). 2012 District of Columbia Youth Risk Behavior Survey Surveillance Report. Office of the State Superintendent of Education: Washington, DC.
Population 2014 estimate = 649,111 - U.S. Census Bureau: State and County QuickFacts. Data derived from Population Estimates, American Community Survey, Census of Population and Housing, State and County Housing Unit Estimates, County Business Patterns, Nonemployer Statistics, Economic Census, Survey of Business Owners, Building Permits. Last Revised: Thursday, 28-May-2015 14:58:18 EDT

Figure 7.35. District of Columbia Cancer Infographic: 2011



Source: DC Community Health Administration

Table 7.22. District of Columbia Top 10 Cancer Incidence Age-Adjusted Rates: 2009-2011

Cancer/Site	2009	2010	2011
Prostate	176.7	187.5	195.0
Breast	143.2	143.0	153.1
Lung & Bronchus	61.5	59.0	55.8
Colorectal	47.6	45.3	43.7
Corpus & Uterus	26.9	37.6	27.7
Kidney & Renal Pelvis	13.5	14.0	16.4
Pancreas	16.7	13.7	16.1
Liver & Intrahepatic Bile Duct	-	-	15.7
Urinary Bladder	16.0	16.5	15.3
Non-Hodgkin Lymphoma	17.8	16.6	15.3

Source: District of Columbia Cancer Registry, 2015.

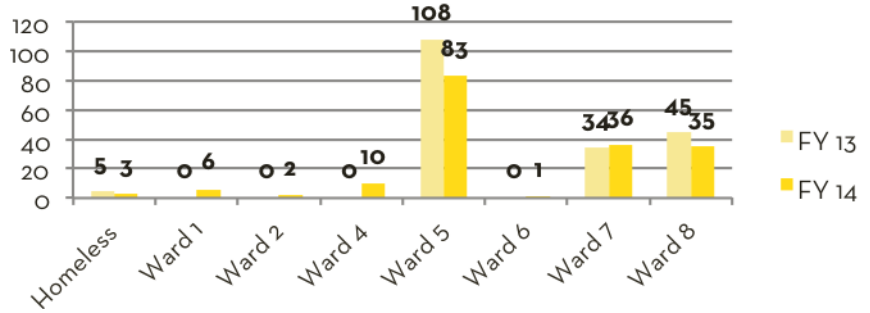
School Based Health Center Program

Located within the school building, the School-Based Health Center (SBHC) is designed to bring the medical home to the school, thus decreasing barriers to health care access. SBHCs complement and enhance the District's health care system by serving as many students' primary medical home or coordinating care with students' primary providers working outside of SBHCs. The key mission of SBHCs is to provide prevention, early identification and treatment of medical and behavioral health concerns, so students are ready and able to learn.

Services provided include:

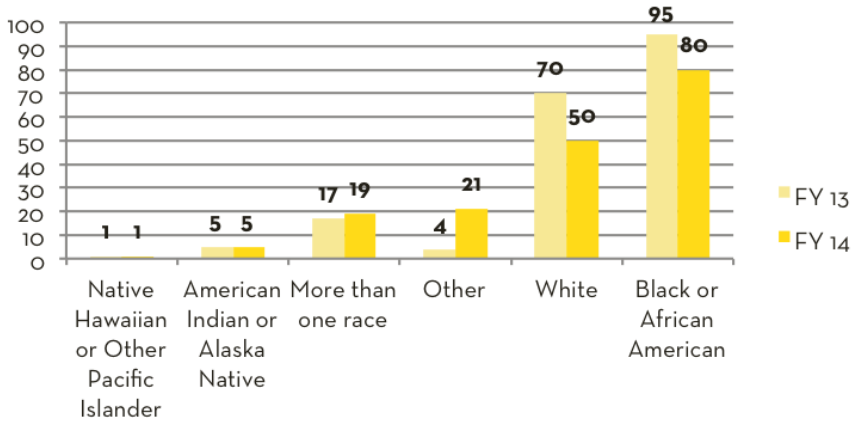
- Well child examinations (with immunizations)
- Gynecological examinations
- Pregnancy testing and contraceptive management
- STI and HIV testing
- Mental health screening and referral
- Social work and case management services and referrals
- Dental services
- Health promotion education
- Specialty health care referral and care coordination

Figure 7.36. Families Participating in Maternal, Infant, and Early Childhood Home Visiting by Ward



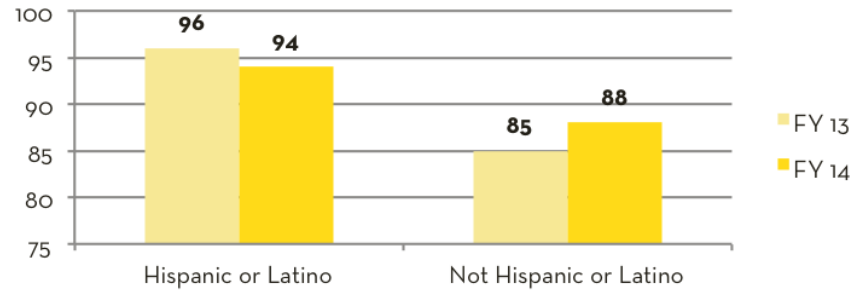
Source: DC Department of Health, Community Health Administration, MIECHV Data Collection Reporting System

Figure 7.37A. Families Participating In Miechv By Race



Source: DC Department of Health, Community Health Administration, MIECHV Data Collection Reporting System

Figure 7.37b. Families Participating in Maternal, Infant, and Early Childhood Home Visiting by Ethnicity



Source: DC Department of Health, Community Health Administration, MIECHV Data Collection Reporting System

The District of Columbia has seven school based health centers, with DOH providing oversight for six centers (Anacostia Senior High School, Ballou Senior High School, Cardozo Learning Center, Coolidge Senior High School, Dunbar Senior High School and Woodson Senior High School). An eighth center (Roosevelt High School) is scheduled to open in the 2015-16 school year. Table 7.24 details utilization of those SBHCs with DOH oversight.

Immunization Program

The mission of the Immunization Program is to reduce and eliminate illness and death related to vaccine-preventable diseases in the District of Columbia through promotion of recommended vaccines, surveillance and assessment. The goal of the program is to improve and maintain high immunization levels in children and adults. The program manages the District of Columbia Immunization Information System (DOCIIS), works to ensure the availability of vaccines to community-based providers through the federal Vaccines for Children (VFC) program, and operates an Immunization Express Clinic. The DC Vaccines for Children Program distributed over 200,000 doses of vaccines to 103 VFC providers in 2014. Since 1979, the District of Columbia has required children attending school and daycare to be fully immunized. Vaccination rates for children in DC schools are detailed in Table 7.25.

Oral Health Program

The mission of the Oral Health Program is to promote and improve the oral health of all District of Columbia residents. Good oral health has been proven to be a key component to achieving overall wellness. The program mission is accomplished through application of data-oriented insights, public and provider outreach and education, policy development, and oversight of school based dentistry. Major initiatives include: School-Based Oral Health, Perinatal Oral Health, Adult Oral Health and Oral Health Surveillance. Table 7.26 details utilization of oral health services in District schools.

Table 7.23. Participation in the School Health Program

	SY2011-2012	SY2012-2013	SY2013-2014	SY2014-2015
DCPS	179,208	179,249	177,514	163,032
PCS	50,336	60,634	61,218	32,534
Total	229,544	239,883	238,732	195,566

Source: DC Department of Health, Community Health Administration, School Nursing Program

Nutrition and Physical Fitness Bureau

The Nutrition and Physical Fitness Bureau administers programs that aim to improve the health and wellness of city residents by increasing access to healthy, locally sourced foods and nutrition education provided by trained professionals. The Bureau also couples nutritional support with programs fostering physical activity intended to decrease obesity and improve health outcomes.

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

Through funding from the United States Department of Agriculture, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) aims to improve the lifelong health and nutrition of pregnant women, new mothers, infants and children up to age five who are at nutritional risk. The program provides free health assessments, individualized nutrition education, breastfeeding promotion and support, tailored nutrient-rich supplemental food packages that supply adequate levels of nutrients essential to prenatal and infant health, proper growth and development, 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 in October 2010. Additional revisions occurred in 2014, including increasing the purchase benefit for fruits and vegetables. DC WIC served approximately 18,154 women, infants, and children monthly at 19 health care sites and four mobile unit sites during the first three quarters of fiscal year 2015. WIC participation over the last 14 years can be found in Table 7.27.

Not only do data related to breastfeeding highlight health benefits among WIC participants (Table 7.28), national research has also shown that WIC has had a significant impact on the well-being of its participants:

Table 7.24. Number of Students Utilizing School Based Health Centers

	SY2012-2013	SY2013-2014	SY2014-2015
Students Enrolled in SBHCs	2,226	2,713	2,061
Unique Visits*	7,371	7,731	4,529
Acute Care/Follow-up Visits	Not Reported	Not Reported	3,746
Social Service Appointments	1,818	1,596	1,272
STD/HIV Tests Provided	1,662	1,836	2,076

*A unique visit refers to the type of service provided. For example, if the student came in for four sexually transmitted infection (STI) screenings, it would count as one unique visit. If he/she came in for one physical, one STI screening, and one mental health visit, it would count as three unique visits.
Source: DC Department of Health, Community Health Administration, School Based Health Center Program

Table 7.25. District Immunization Compliance Levels (includes Routine, Catch-up and Exemptions)

Year	Head Start Centers	Public Schools	Private	Charter	Parochial
2003	59.4%	84.4%	79.6%	74.7%	55.8%
2004	66.7%	90.9%	79.5%	84.8%	59.8%
2005	74.8%	95.1%	84.1%	90.9%	74.7%
2006	83.0%	96.3%	83.7%	91.3%	78.7%
2007	81.4%	97.3%	85.0%	94.5%	78.7%
2008	97.2%	97.9%	88.6%	96.3%	78.3%
2009	91.8%	98.2%	88.8%	95.6%	79.7%
2010	90.7%	90.0%	67.4%	83.1%	50.0%
2011	89.1%	92.9%	79.4%	89.4%	67.1%
2012	91.1%	92.9%	80.7%	87.3%	73.2%
2013	90.1%	89.9%	75.9%	83.3%	72.7%
2014	86.5%	88.0%	73.3%	82.2%	72.6%

Source: DC Department of Health

- WIC reduces the likelihood of adverse birth outcomes, including very low birth weight babies and infant mortality rates.
- Medicaid recipients participating in WIC have on average 29% lower Medicaid costs for infant hospitalization compared with those not participating in WIC.
- Participation in WIC significantly increases the Healthy Eating Index scores for households.
- WIC infants are in better health than eligible infants not participating in WIC and have increased intakes of iron, potassium, and fiber.
- Women participating in WIC have been found to have longer pregnancies resulting in fewer premature deaths.

Table 7.26. Number of Students Utilizing School Based Oral Health Services

Fiscal Year	Number of Participating Schools	Number of Students That Received Preventive Oral Healthcare Services
2004	7	406
2005	4	260
2006	4	314
2007	6	700
2008	11	1,649
2009	11	1,115
2010	8	1,233
2011	9	1,271
2012	6	1,020
2013	3	796
2014	43	2,139

Source: DC Department of Health

Supplemental Nutrition Assistance Program-Education (SNAP-Ed)

The mission of the DC Supplemental Nutrition Assistance Program: Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed) is to improve the likelihood that persons eligible for SNAP in the District will make healthy food choices within a limited budget and choose physically active lifestyles consistent with the Dietary Guidelines for Americans and USDA food guidance. The SNAP-Ed Program is funded and administered by the United States Department of Agriculture. SNAP-Ed provides services in geographic areas where at least 50% of populations have gross incomes at or below 185% of the federal poverty line. Services include interactive nutrition and physical activity education classes, food/cooking demonstrations, information booths at health fairs and farmers' markets. Nutrition and physical activity education topics include: Understanding MyPlate Guidelines, Benefits of Physical Activity, Obesity Prevention and Reduction, Reading and Understanding Food Labels, and Meal Planning and Budgeting.
Along with participant contact data (Tables 7.29 and 7.30), listed below is a compilation of demographic SNAP- Data

- In fiscal year 2014, 143,000 District Residents participated in SNAP, or 22% of the state population (1 in 5 people)
- 61% of all SNAP participants in the District are in families with children
- 33% of all SNAP participants in the District are in families with elderly or disabled members
- 13.4% of households in the District were "food insecure" or struggled to afford a nutritionally adequate diet in 2011-20131
- 18.9% of the District population lived below the federal poverty line in 2013
- 26.7% of children in the District lived below the federal poverty line in 2013
- 17.5% of elderly in the District lived below the federal poverty line in 2013

Table 7.27. District of Columbia WIC Program Average Monthly Enrollment

Year	Women	Infants	Children	Total
2002	4,284	4,270	9,373	17,927
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	4,834	7,998	17,621
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
2013	4,578	4,787	8,399	17,764
2014	4,337	4,991	7,795	17,122
2015	4,493	4,841	8,820	18,154

Source: DC Department of Health

Table 7.28. District of Columbia WIC Program Breastfeeding: FY2010-FY2013

Participant Data (total number and percent of WIC participants)

Year	Fully Breastfed	Partially Breastfed	Total Breastfed	Fully Formula Fed	Total Infants
2010	162 (3.3%)	1,120 (22.8%)	1,282 (26.1%)	3,622 (73.9%)	4,904
2011	182 (3.8%)	773 (16.2%)	955 (20.1%)	3,804 (79.9%)	4,759
2012	263 (5.5%)	938 (19.6%)	1,201 (25.1%)	3,582 (74.9%)	4,783
2013	351 (7.6%)	1,119 (24.1%)	1,470 (31.7%)	3,169 (68.3%)	4,639

Source: DC Department of Health

Perinatal and Infant Health

The mission of the Perinatal and Infant Health Bureau is to improve perinatal outcomes for women of child bearing age, including pregnant and parenting women, and their infants into early childhood. The overarching goal is to reduce infant mortality and perinatal health disparities in the District.

District of Columbia Healthy Start

District of Columbia Healthy Start (DCHS) is the District's oldest perinatal program, working to reduce perinatal disparities and to improve the health status of women of reproductive age since its inception in 1991. Over the last two decades, the District has made tremendous progress in decreasing the overall infant mortality rate (IMR), however, disparities in IMR by ward and by race persist (Table 7.31 and Figure 7.38). Through community-based approaches DCHS provides case management and health education to pregnant and parenting women and fathers throughout the District, with an emphasis in areas at greatest risk for poor health outcomes (Wards 5, 7 and 8). DCHS aims to achieve optimal health for all reproductive aged women, promote high quality health care and coordination of care, and increase accountability through rigorous program evaluation and monitoring.

Safe Sleep Program

The Safe Sleep program was established in 2000 to assist in the reduction of infant deaths caused by unsafe sleep environments and serves families with infants from birth to 12 months. The Program holds educational workshops on Sudden Infant Death Syndrome (SIDS), Sudden Unexpected Infant Death (SUID) and safe sleep

environment for expecting parents. Parents who complete the workshop are offered Pack-n-Play cribs (Table 7.32). The Program also educates community based organizations, government agencies, daycares, and schools to enable wide dissemination of information about safe sleep practices.

Newborn Metabolic Screening Program is a federally funded program designed to ensure that all infants born in the District of Columbia are screened for more than 40 genetic and metabolic disorders at birth. The program helps families with abnormal screens (Table 7.33) receive follow up diagnostic procedures including laboratory testing, genetic counseling and education, and clinical evaluation and management.

DC Hears

The District of Columbia (DC or the District) Hears Program works to ensure all infants born in the District of Columbia receive a Newborn Hearing Screening; those who do not pass the initial screening receive a follow-up screening; those who do not pass the follow-up screening receive diagnostic testing; and those with identified hearing loss obtain the treatment and services they need, in accordance with nationally-recognized time frames and standards of care. For screening, results, and referrals, see Table 7.34.

Table 7.29. Annual Number of DC Supplemental Nutrition Assistance Program-Education Contacts

Year	Total Direct Contacts	Total Indirect Contacts
2010	283,867	38,285
2011	245,664	35,505
2012	353,052	33,708
2013	154,321	17,587
2014	83,402	430,530

Source: DC Department of Health

Table 7.30. Average Monthly Number of DC Supplemental Nutrition Assistance Program-Education Contacts by Age Group (Direct Education)

Year	Less than 5 Years	5-17 Years (Grades K-12)	18-59 Years	60 Years and over
2010	3,337	4,297	11,380	4,642
2011	2,458	3,423	9,745	4,846
2012	27,964	912	145	400
2013	11,070	568	570	652
2014	5743	460	441	306

Source: DC Department of Health

Primary Care Bureau

The Primary Care Bureau identifies health professional shortage areas for primary care, dental, and mental health care services and implements workforce and infrastructure development programs to increase access to primary and specialty care services for District residents regardless of their ability to pay for services.

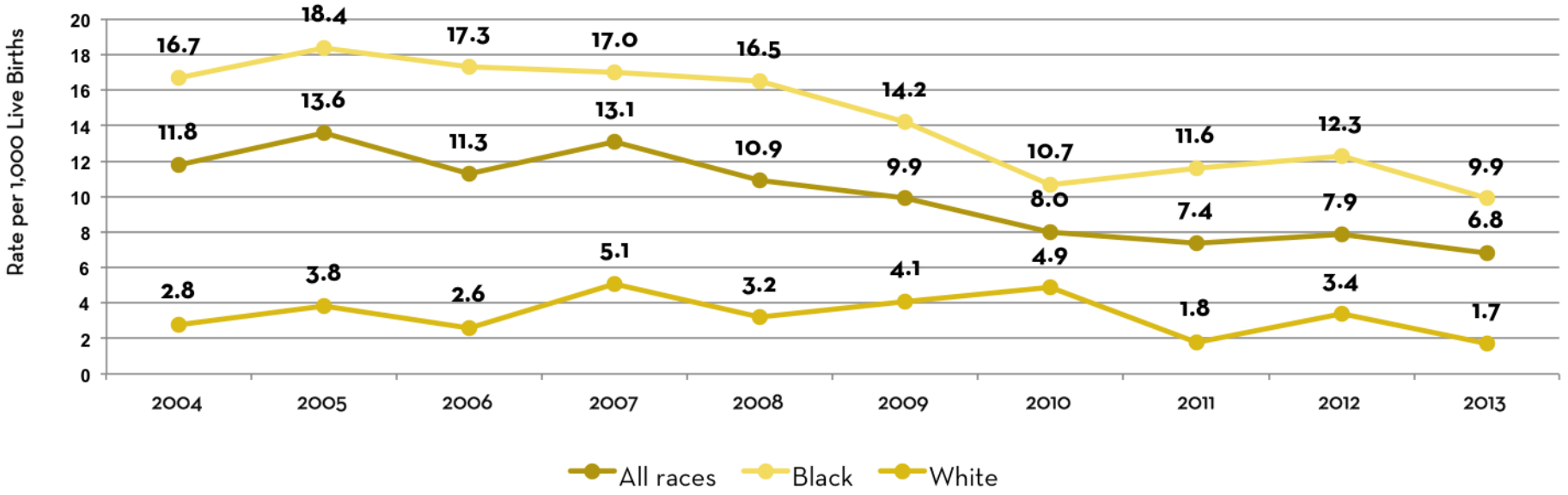
Capital Expansion Projects

The Capital Expansion Projects are part of Department of Health's Capital Health Project (CHP) initiative. Through this initiative more than $70 million of Tobacco Settlement/Community Health Care Financing funds were distributed through grants to expand projects at District health centers and hospitals, working to improve access to care for District residents. The Primary Care Bureau monitors utilization and provide technical assistance to the expansion sites, helping to fulfill the mission of expanded access to services. Grantees report each fiscal year on a variety of utilization measures, including the number of patients seen at the project sites. At the end of FY14, six new health centers were completed and operational: Mary's Center – Georgia Avenue, Bread for the City, Unity – Anacostia, Unity – Parkside, Community of Hope – Conway Health and Resource Center, and KidsSmiles

Table 7.31. Five-Year Infant Mortality* Trend by Ward, District of Columbia Residents: 2009-2013					
Ward	**2009**	**2010**	**2011**	**2012**	**2013**
1	8.1	4.1	3.4	5.9	5.7
2	5.8	2.9	6.7	1.6	0.0
3	2.6	5.0	0	1.2	1.2
4	10.4	11.3	8.4	3.4	5.1
5	11.8	10.3	12.9	11.7	11.9
6	1.9	9.8	5.6	8.6	4.0
7	12.9	6.6	6.6	9.5	9.7
8	18.4	10.4	12	14.9	10.9
Total	9.9	8.0	7.4	7.9	6.8

* Rates are Infant deaths per 1,000 live births. Note: Due to the small number of infant deaths, the above infant mortality rates are highly variable and should be interpreted cautiously.
Source: DC Department of Health, Center for Policy, Planning and Evaluation, Data Management and Analysis Division.

Figure 7.38. Infant Mortality Rates by Race of Mother, District of Columbia: 2004-2013



Note: Data for Hispanic and Asian/Pacific Islander were excluded due to rate variability and small numbers.
Source: DC Department of Health, Center for Policy, Planning and Evaluation, Data Management and Analysis Division.

Nonprofit Children's Dental Center. Table 7.35 contains aggregate data for the number of patients seen at these new health centers as of FY14. DOH expects the number of patients to steadily rise as all sites are completed and ramp up services and then to level out as the health centers reach capacity.

Health Professional Loan Repayment Program (HPLRP)

The District's Health Professional Loan Repayment Program (HPLRP) provides loan repayment to eligible District providers who commit to practicing for a minimum of two years in underserved areas of the District. Participants range from dental hygienists to physicians. The program is funded in part out of the District's local budget and in part through a grant from the Health Resources and Services Administration.

A total of 37 providers were active participants during FY14, including 23 primary medical providers, 9 dental providers, and 5 mental health providers. Participants were practicing at community health center and hospital outpatient clinics in the city's underserved areas as seen in Table 7.36.

Table 7.32. Pack-n-Play Distribution by Ward

Ward	FY2011	FY2012	FY2013	FY2014
1	27	97	41	74
2	34	43	18	19
3	22	7	19	4
4	149	142	103	157
5	117	130	118	167
6	159	57	94	77
7	199	158	193	169
8	187	233	221	239
Total	894	867	761	906

Source: DC Department of Health

Table 7.33. Annual Metabolic Newborn Screening Data: 2010-2014

Year	Abnormal Screens	Pre-sumptive Positive Screens	Confirmed Positive Screens	Referred and Treat-ed	Lost to Follow-up
2010	247	73	55	55	0
2011	515	48	36	36	0
2012	603	44	26	26	0
2013	618	44	26	26	0
2014	704	53	36	32	4

Source: DC Department of Health

HPLRP participants are required to submit an annual report of the number of patients they served over the course of the participation year. Table 7.37 is an aggregate calculation of the total number of patients served by HPLRP participants. Health Emergency Preparedness and Response Administration

Table 7.34. Annual Newborn Hearing Screening Data, 2013-2014

Year	Total Screens	Abnormal Screens	Referred	Positive Hear-ing Loss	Lost to Follow-up
2013	13,122	472	472	Not Available	Not Avail-able
2014	13,230	490	490	36	4

Source: DC Department of Health

Table 7.35. Number of New Patients Seen (Across All Sites)

Year	Number of Patients
FY12	20,541
FY13	24,850
FY14	35,766

Source: Department of Health, Community Health Administration, Primary Care Bureau

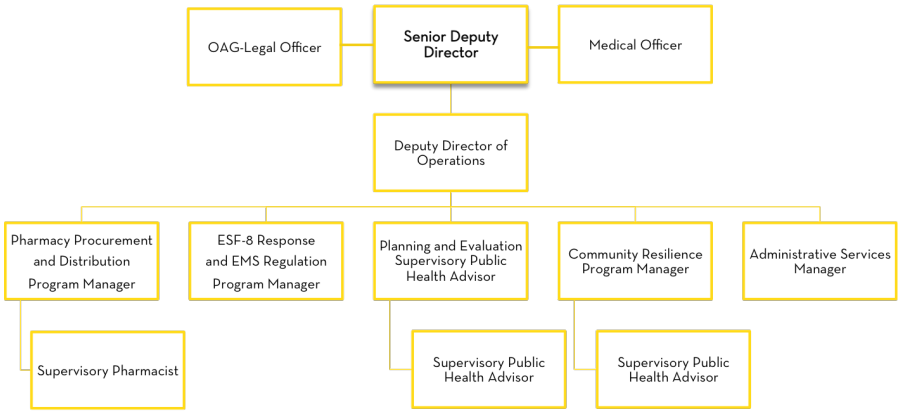
Table 7.36. Participants in the Health Professional Loan Program, FY 2014	
Ward	**# of Participants**
1	9
2	1
3	0
4	0
5	10
6	6
7	4
8	7

Source: Department of Health, Community Health Administration, Primary Care Bureau

Table 7.37. Number of Patients Served by HPLRP Providers	
Year	**Number of Patients**
FY13	39,744
FY14	38,224

Source: Department of Health, Community Health Administration, Primary Care Bureau

Health Emergency Preparedness and Response Administration



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, medical countermeasures planning, 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 coordinate a response to city-wide medical and public health emergencies, such as those resulting from man-made incidents, accidents and/or natural disasters.

HEPRA provides a number of critical functions and activities:

- Bioterrorism Surveillance
- Community Resilience
- Emergency Medical Services Compliance
- Medical Planning
- Pharmaceutical Procurement and Distribution

- Special Operations
- Strategic National Stockpile

Bioterrorism Surveillance

HEPRA 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 the ability of a community to withstand and bounce back from natural, man- made disasters and everyday emergencies. Resilient communities leverage community connections, relationships and resources, recover quickly and restore community functions and address those with access and functional needs. HEPRA staff conduct outreach and education, training, and planning for vulnerable populations to increase community resilience. HEPRA staff developed the Vulnerable Populations Community and Healthcare Coalition to address needs of vulnerable residents, or, those with access and functional needs and to reduce stress on the healthcare system. Empowered and connected communities are more self-reliant during disasters and emergencies.

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 EMS Act of 2008." The Division provides leadership to a comprehensive emergency care system of cooperative partnerships, certifies all emergency medical service providers, collaborates within the Department of Health on activities concerning 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

In 2013, the EMS Division inspected and certified a total of 189 ambulances in the District of Columbia in 2013. There were 152 ambulances certified at the Basic Life Support (BLS) level of care, while the remaining 37 ambulances were certified at the Advanced Life Support (ALS) level of care. The number of total inspections conducted in FY 2013 (certification inspections and unannounced inspections) totaled 523. This exceeded the previous year's inspection total of 464 ambulances. During FY 2013, there were 22 ambulances that failed inspection, a failure rate of 4 percent. All 22 of the units were re-inspected at later dates and passed their follow-up inspections.

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
  2. US Park Police Eagle Medevac (through a mutual aid agreement)
- University-based Emergency Ambulance Services
  3. Georgetown Emergency Response Medical Service (GERMS)
  4. Emergency Medical Response Group (EMeRG) at George Washington University

- Hospital-based Service Providers
  5. Children's National Medical Center Transport Services (Ground ambulance)
  6. STAT MedEvac (Air ambulance service for Children's National Medical Center)
  7. MedSTAR Transport Services (Ground and Air ambulances for MedSTAR Washington Hospital Center)
- Commercial Ambulance Service Providers
  8. All American Ambulance (AAA)
  9. American Medical Response (AMR)
  10. Butler Medical Transport
  11. LifeStar Response
- Special Events Service Providers
  12. Special Events Medical Services (SEMS)

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 five certified EMS Educational Institutions in the District of Columbia who meet these standards:

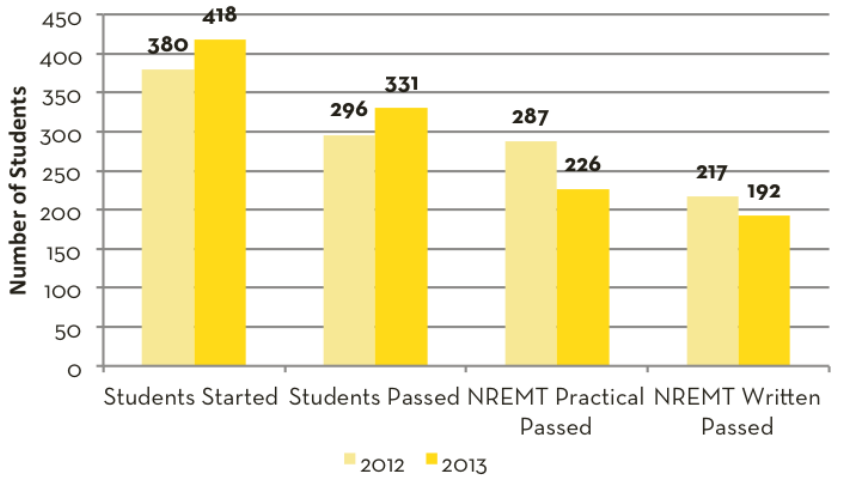
- DC Fire & EMS Department
- Georgetown University
- George Washington University Emergency Health Services Program
- Washington Hospital Center EMS Education
- Westlink Career Institute

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 are in the process of being updated on the new standards by attending 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 2013. A total of 418 students enrolled and 331 students completed the course requirements (Figure 7.39). Among that pool, 226 students went on and passed the psychomotor exam. From there, 192 students ultimately passed the cognitive and psychomotor exam, thereby obtaining NREMT certification and becoming eligible for District certification.

Figure 7.39. 2013 EMT Student Enrollment (Comparison to 2012)



Source: DC Department of Health, Health Emergency Preparedness and Emergency Response Administration, 2013 EMS Annual Report

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.

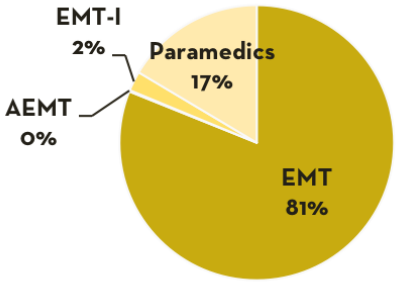
In 2013, the District had 2,515 certified EMS Providers (Table 7.38 and Figure 7.40).

Table 7.38. District of Columbia Certified EMS Providers, 2013

Certified Providers	Number	Percent
Emergency Medical Technicians (EMT's)	2039	81%
Advanced EMT	4	0%
EMT-Intermediates	58	2%
Paramedics	414	16%

Source: Department of Health, Community Health Administration, Primary Care Bureau

Figure 7.40. District of Columbia Certified EMS Providers



Source: DC Department of Health, Health Emergency Preparedness and Emergency Response Administration

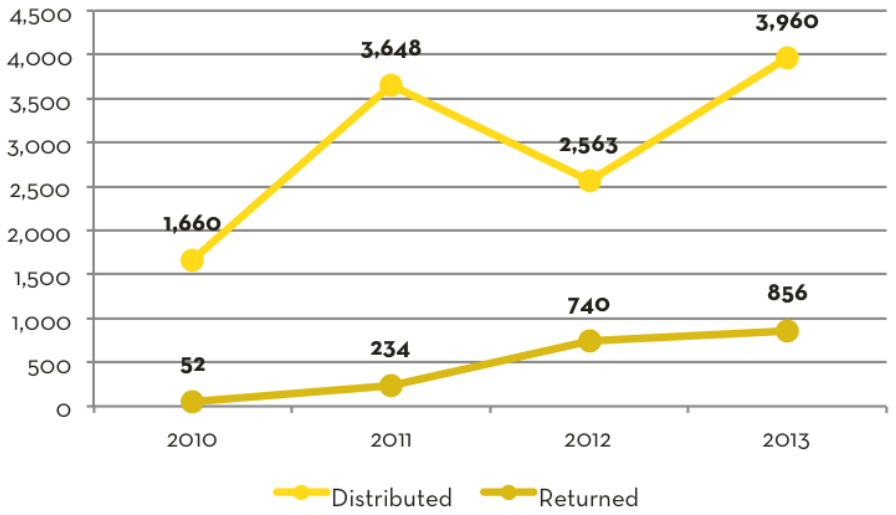
Comfort Care Order / Do Not Resuscitate Program

Comfort Care Orders allow patients diagnosed with specific medical conditions to express their wishes regarding end of life resuscitation in pre/post-hospital settings. Unless the order has been revoked, EMS personnel must honor the rights of a CCO patient when responding to calls for cardiac or respiratory arrest. In 2013, the Department of Health continued to see a steady increase in the number of CCO forms requested (3,960) and returned (856) to the department (Figure 7.41).

Medical Planning

HEPRA represents the Department of Health on the Mayor's Special Event Task Group in order to assist special event organizers in the development of a Health, Medical and Safety Plan for their concerts, parades, festivals, athletic events, conferences, conventions and fairs.

Figure 7. 41. Comfort Care Order Forms Requested and Returned



Source: DC Department of Health, Health Emergency Preparedness and Emergency Response Administration, 2013 EMS Annual Report

Special event organizers must submit a Health, Medical and Safety Plan for review and approval by DOH/HEPRA, in order to satisfy part of the requirements leading to the issuance of a permit by the DC Department of Consumer and Regulatory Affairs (DCRA). The DC Special Event Health, Medical and Safety Plan is the primary tool to ensure that the special event organizer has coordinated the specified medical support needed for their type event and estimated number of attendees. To that end, HEPRA reviewed and provided guidance and technical assistance to private, commercial and not-for-profit special event organizers on 134 special events in 2014. Additionally, as part of its ongoing efforts to improve customer service, HEPRA published on its website in 2014 the new DC DOH Special Events Health, Medical and Safety Planning Guide and added equipment inspection checklists for ground/air ambulances and Basic and Advanced Life Support-capable Medical Aid Stations.

Pharmaceutical Procurement and Distribution

Pharmaceutical Procurement and Distribution Warehouse (Warehouse) assures that the Department Of Health continues to maintain access to drug discount programs. The savings will allow District residents access to life saving medications. The Warehouse maintains a timely and efficient drug delivery rate of greater than 98% to the Pharmacies served. It also provides clinical support, formulary management and quality assurance monitoring to address the needs of all programs. In addition, Pharmaceutical Procurement and Distribution Warehouse facilitates the Strategic National Stockpile (SNS) medication for the Center of Disease Control (CDC) for the District residents in the event of an emergency.

Special Operations

HEPRA coordinates support to recurring National Security Special Events (NSSE) and Special Events (SE) in the District of Columbia primarily through its relationship with the DC Homeland Security Emergency Management Agency (HSEMA) and its participation in the National Security Special Events/Special Events (NSSE/SE) Health and Medical Subcommittee – National Capital Region, chaired by the US Department of Health & Human Services. HEPRA coordinates and plans those large-scale special events in which the Department of Health plays a more active role, to include providing regional public health coordination, near real-time patient tracking capability and the use of Medical Reserve Corps personnel.

In 2014, DOH-HEPRA participated in eight (8) incident response/special events – a 63 percent increase in participation compared to 2013. In 2015, from January to May, there have been a total of three (3) events. In addition to annually occurring special events such as the National Independence Day Celebration, a number of high-profile events are scheduled for 2015, including the 2015 World Police Fire Games Opening Ceremony, and a visit by Pope Francis before the end of the calendar year.

2014 Events:

- 2014 State of the Union Address (Planning/Response Coordination) - January 2014
- Winter Storm Response (Incident Response) – February 2014
- Rock'n'Roll Marathon (Planning/Response Coordination) – March 2014
- D.C. Emancipation Day (Planning/Response Coordination) - April 2014
- 2014 National Independence Day Celebration (Planning/Response Coordination) - July 2014
- US – Africa Leaders Summit – August 2014
- Ebola Response (Incident Response) - August 2014 (ongoing)
- HBO Concert for Valor – November 2014

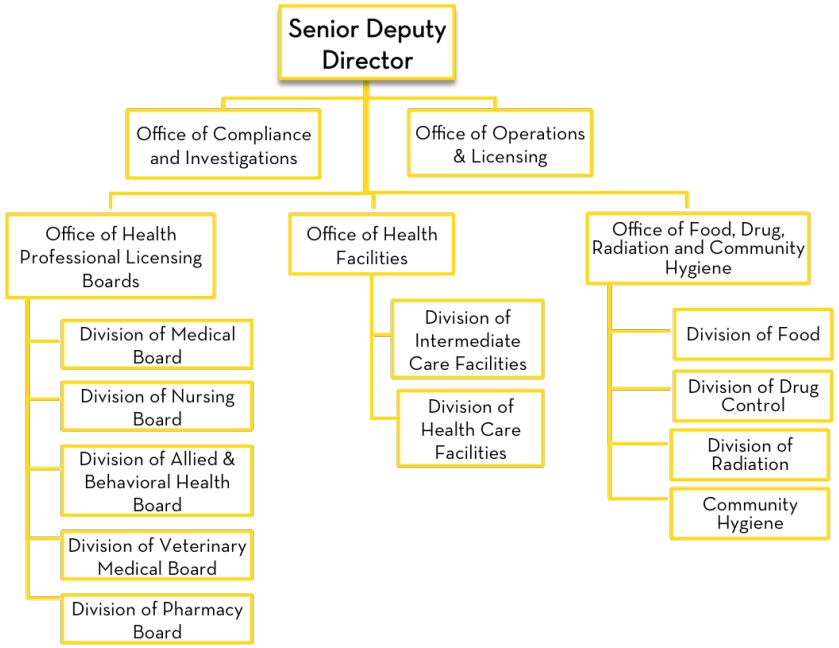
2015 Events (January – May):

- 2015 State of the Union Address (Planning/Response Coordination) – January 2015
- 2015 Earth Day (Planning/Response Coordination) – April 2015
- The Funk Parade (Planning/Response Coordination) – April 2015

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.

Health Regulation and Licensing Administration



Mission Statement

The mission of the Health Regulation and Licensing Administration (HRLA) is to protect the health of the residents and visitors of the District of Columbia and those that do business here by fostering excellence in health professional practice and building quality and safety in health-systems and facilities through an effective regulatory framework.

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 19 Boards (Table 7.39). The Office issues approximately 6,000 new licenses, annually, and biennially renews nearly 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 Board of Medicine - The Division of Board of Medicine 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 Board of Nursing - The Division of Board of Nursing 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 Boards - The Division of Allied and Behavioral Health Boards is the entity responsible for the licensing and regulatory oversight of addiction counselors, audiologist, dance therapists, 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 Board of Veterinary Medicine - The Division of Board of Veterinary Medicine is the entity responsible for the licensing and regulatory oversight of Veterinarians in the District of Columbia.
- Division of Board of Pharmacy - The Division of Board of Pharmacy 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.
- Division of Board of Dentistry - The Division of Board of Dentistry is the entity responsible for the licensing and regulatory oversight of dentists, dental hygienists and dental assistants.

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, hospital 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.

Table 7.39. Number of Active Health Professional Board Licensees by Type						
Board	**License Type**	**FY2010**	**FY2011**	**FY2012**	**FY2013**	**FY2014**
Chiropractic	Chiropractors	88	84	180	105	93
	Chiropractors – Ancillary Procedures	59	56	122	73	68
Dentistry	Dentists	1,342	1,546	1,266	1,418	1,521
	Dental Hygienists	538	635	499	548	586
	Local Anesthesia	5	19	16	43	62
	Nitrous Oxide	0	1	1	2	2
	Local Anesthesia and Nitrous Oxide	28	31	17	28	30
Medicine	Medicine & Surgery	9,697	9,489	10,530	11,289	10,346
	Osteopathy & Surgery	180	177	393	255	256
	Physician Assistants	550	549	1,188	748	677
	Anesthesiologist Assistants	23	24	55	36	40
	Acupuncturists	171	156	330	194	173
	Naturopathic Physicians	24	23	51	37	37
	Surgical Assistants	55	58	120	75	126
Nursing	Registered Nurses	19,861	22,365	24,370	22,446	25,543
	Licensed Practical Nurses	3,842	4,163	3,334	3,635	2,941
	Certified Nurse Midwives	82	93	89	94	105
	Clinical Nurse Specialists	46	49	47	54	57
	Nurse Practitioners	935	1,057	1,043	1,217	1,416
	Nurse Staffing Agencies	139	196	151	192	190
	Registered Nurse Anesthesiologists	138	155	152	181	196
	Trained Medication Employees	566	848	920	1,186	1,490
Pharmacy	Pharmacists	1,679	1,591	1,747	1,928	1,779
	Pharmacists Interns	22	29	50	76	226
	Pharma Detailers	1,625	1,845	1,173	1,522	1,743
	Vaccine and Immunization Authority	154	223	296	381	404
	Controlled Substance	6,713	6,597	7,456	8,301	8,236

Table 7.39. Number of Active Health Professional Board Licensees by Type, cont.

Board	License Type	FY2010	FY2011	FY2012	FY2013	FY2014
Pharmacy, cont.	Controlled Substance – NP	591	695	708	855	1,007
	Controlled Substance – PA	206	218	278	361	381
Veterinary	Vet Examiners	200	223	224	258	296
Audiology and Speech Pathology	Audiology	60	78	94	109	104
	Speech Language Pathology	285	396	506	630	625
Dietetics and Nutrition	Dieticians	408	451	379	445	513
	Nutritionists	72	72	55	56	59
Marriage & Family Therapy	Licensed Marriage and Family Therapist	136	131	141	147	146
Massage Therapist	Massage Therapist	863	713	859	982	822
Nursing Home Administration	Nursing Home Administration	71	72	51	66	71
Occupational Therapist	Occupational Therapists	562	611	533	642	616
	Occupational Therapist Assistants	25	44	27	39	35
	Recreational Therapists	46	50	45	54	60
	Dance Therapists	2	3	2	4	4
Optometry	Optometrists	217	250	202	225	246
	DPA	151	170	164	186	207
	TPA	155	171	168	193	214
Physical Therapy	Physical Therapists	989	691	816	1,140	1,071
	Physical Therapists Assistants	37	36	55	71	71
Podiatry	Podiatrists	147	168	132	136	145
Professional Counseling	Licensed Professional Counselors	836	929	1,032	1,121	1,032
	Addiction Counselors	505	112		295	289
Psychology	Psychologists	1,211	1,307	1,156	1,233	1,325
	Psychologist Associates	1	1	2	7	23
Respiratory Care	Respiratory Therapists	803	857	774	870	802

Table 7.39. Number of Active Health Professional Board Licensees by Type, cont.						
Board	**License Type**	**FY2010**	**FY2011**	**FY2012**	**FY2013**	**FY2014**
Social Work	Graduate Social Workers	1,309	1,428	1,280	1,704	1,494
	Ind. Clinical Soc. Workers	2,919	3,006	2,836	3,101	2,983
	Independent Soc. Workers	88	88	78	80	69
	Social Work Associates	152	153	113	118	90
Total		**61,609**	**65,183**	**68,306**	**71,192**	**73,143**

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

Office of Food, Drug, Radiation, and Community Hygiene

Division of Food Safety and Hygiene Inspection - 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.

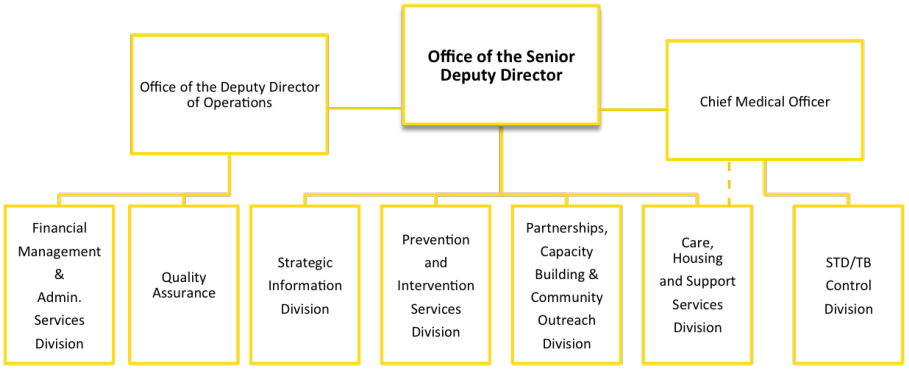
Division of Pharmaceutical Control - The Division of Pharmaceutical Control is the entity that regulates local pharmacies, controlled substances, non-resident pharmacies, out of state controlled substances, out of state manufacturers, distributors/wholesalers, substance abuse facilities, researchers,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

Division of Radiation Prevention - 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.

Division of Rodent Control - The Division of Rodent Control 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.

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.

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.

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 "You've Got This" (HIV treatment) 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, STD, and hepatitis 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 development 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. HAHSTA will be launching a new campaign promoting the new prevention intervention Pre-Exposure Prophylaxis (PrEP). PrEP works when a HIV negative person at high

risk takes a HIV medication to block infection. HAHSTA envisions PrEP as a major component of its HIV prevention strategy to reduce new infections.

In order to ensure that individuals have access to effective methods for preventing HIV and STD infections, The Condom Distribution Program (Table 7.40) 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.

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.

Table 7.40. HAHSTA Condom Distribution Program, District of Columbia: FY2009-FY2012

	FY2011	FY2012	FY2013	FY2014
Total Number of Condoms Distributed	5,186,340	5,747,000	6,941,760	6,081,900

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration, Partnerships, Capacity Building, and Community Outreach Division

For the past seven years, HAHSTA has promoted a municipal scale up of HIV testing across the District. During this time period, HAHSTA not only provided direct funding to multiple organizations to provide HIV counseling and testing services, but also distributed rapid HIV test kits to an expansive network of clinical and community-based providers in order to promote and normalize HIV testing. This network included multiple non-traditional testing sites including the District Department of Motor Vehicles and the District Economic Security Offices. Supplementing this effort to expand accessibility to HIV testing services, HAHSTA also developed 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. The result of the municipal scale up was in a dramatic increase in the number of publicly supported HIV tests conducted in the city between fiscal years 2009 and 2013 (Table 7.41).

Moving forward, HAHSTA continues to recommend the integration of routine HIV screening as a component of quality medical care and encourages providers to seek third party reimbursement where possible. The transition from supporting HIV testing exclusively through the use of public funds to the incorporation of the third party reimbursement system is a significant paradigm shift for District HIV testing providers. As such, HAHSTA facilitates the provision of intensive capacity building activities that enable providers to maximize third party billing opportunities for the testing they perform. In addition, HAHSTA uses academic detailers to expand its reach into

Table 7.41. HAHSTA Funded HIV Testing, District of Columbia: FY2009-FY2012

	2009	2010	2011	2012	2013	2014
Total HIV Tests Completed	92,748	110,358	122,356	138,317	157,958	126,029

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration, Prevention and Intervention Services Division

provider networks to educate clinicians and promote opt-out, routine HIV testing as a standard of care.

Despite the wide availability of HIV testing services throughout the District, there is a subset of District residents that are at risk for acquiring HIV/AIDS, but do not access medical care on a regular basis. In an effort to reduce missed opportunities for those that may be HIV infected and unaware of their status, HAHSTA continues to support HIV testing in community-based organizations. For testing in this setting, HAHSTA recommends the implementation of program models that utilize a highly targeted approach to HIV testing for those disproportionately affected populations with little or no history of HIV testing. These targeted, community-based testing programs are intended to complement the routine HIV testing programs in the District.

To date, HAHSTA's HIV Prevention strategy has yielded successful outcomes. In an effort to reduce providers' dependence on public funds to support HIV screening activities, HAHSTA worked to carefully transition providers to billable HIV testing models. For some, this meant a shift from models that used dedicated staff and rapid HIV testing supplies provided by HAHSTA to models that use existing staff and conventional testing technologies.

The impact of these structural changes is being realized. For the first time since FY2011, HAHSTA has reduced its annual spending for HIV testing supplies to less than $1 million for 2014. Clinical HIV testing providers are reducing their use of rapid tests and increasing their use of conventional testing technologies. In 2013, 83% of the HIV testing supported by HAHSTA was performed using rapid test technology. That number decreased to 67% for 2014.

Clinical providers represent about 80% of all HIV testing in the District. Reducing their need for public funds to support HIV testing affords HAHSTA the ability to reinvest those funds into highly targeted HIV testing programs that will identify hard to reach individuals that are unaware of their undiagnosed HIV infection.

Ryan White HIV/AIDS Program/Housing Opportunities for Persons with AIDS Program

HAHSTA's mission is to ensure that all persons diagnosed with HIV are in care and treatment and achieve viral load suppression. The Care, Housing and Support Services (CHSS) Division within HAHSTA serves as the grantee for Ryan White Part A, Part B and HOPWA services is the eligible metropolitan area (EMA). Programs within CHSS 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 people living with HIV and/or 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 grants including 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. DC also receives MAI funds through Part D.
- AIDS Drug Assistance Program (ADAP) in the District provides access to medications used to treat HIV and prevent the onset of related opportunistic infections to low-income individuals with HIV disease 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.

CHSS 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 (51%) of those receiving services. Adolescents and young adults (ages 13–24) account for 7% of those receiving services (Table 7.42). The age distribution of those receiving services is similar to those living with HIV/AIDS in the District. Men comprise the majority of those utilizing Ryan White funded services, accounting for 63% of all services in 2014. Transgender persons make up 4% of those receiving services (Table 7.43). Blacks (includes African-born) account for 77% of those receiving services in the District (Table 7.44). Table 7.45 shows that heterosexual contact in the primary mode of transmission among those receiving Ryan White services, accounting for 38% of the service population. Additionally, men who have sex with men account for 30% of the service population. (Source of Data: Ryan White Services Reports)

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 document 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.

A new data system was implemented in 2014. We continue to work collaboratively with our partners to improve the quality and completeness of the data.

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 document 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 (Figure 7.42), as a measure of linkage and retention to care, and viral load suppression (Figure 7.43), which is the ultimate goal of treatment. Additional indicators vital to measuring progress on quality

Table 7.42. Age Breakdown for Ryan White CARE Act Clients: 2011-2014

	2011		2012		2013		2014	
Age group	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
<2	34	0.3%	86	0.9%	49	0.6%	18	0.2%
2 to 12	292	2.4%	83	0.8%	71	0.8%	63	0.8%
13 - 24	1,287	10.5%	576	5.9%	514	6.1%	544	7.1%
25 - 44	4,317	35.3%	3,459	35.3%	3,011	35.6%	2,759	36.1%
45 - 64	5,871	48.1%	5,277	53.8%	4,439	52.5%	3,910	51.1%
65 & >	412	3.4%	326	3.3%	365	4.3%	363	4.7%
Unknown	35	0.3%	-	0.0%	-	0.0%	-	0.0%
Total	12,215	100%	9,807	100%	8,449	100%	7,657	100%

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Table 7.43. Gender Breakdown for Ryan White CARE Act Clients: 2011-2014

	2011		2012		2013		2014	
Gender	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
Male	7,469	61%	6,042	62%	5,306	63%	4,846	64%
Female	4,496	37%	3,418	35%	2,780	34%	2,493	33%
Transgender	170	1%	339	3%	277	3%	314	4%
Unknown/Unreported	80	1%	8	0%	86	1%	4	0%

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Table 7.44. Race Breakdown for Ryan White CARE Act Clients: 2011-2014*

	2011		2012		2013		2014	
Race	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
White	990	8%	620	6%	841	10%	918	12%
Black	9,871	81%	7,077	70%	7,082	81%	5,881	77%
Asian	73	1%	1,183	12%	59	1%	67	1%
Nat Hawaiian / PI	25	0%	274	3%	15	0%	8	0%
American Indian / Alaska Native	47	0%	226	2%	44	1%	24	1%
Unknown	1,209	10%	708	7%	679	8%	759	10%

*Multiple races can be reported on the same individual. Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Table 7.45. Risk Factor Breakdown for Ryan White CARE Act Clients: 2011-2014*

	2011		2012		2013		2014	
Risk Factor	**#**	**%**	**#**	**%**	**#**	**%**	**#**	**%**
MSM	1,330	11%	1,503	17%	2,108	23%	2,311	30%
IDU	390	3%	465	5%	284	3%	247	3%
Hemophilia/Coag dis	1	0%	17	0%	2	0%	1	0%
Heterosexual contact	2,111	17%	1,936	22%	2,598	38%	2,902	38%
Receipt of bld/bld prod	22	0%	30	0%	34	0%	45	1%
Perinatal	297	2%	200	2%	179	2%	254	3%
Other	192	2%	437	5%	839	9%	529	7%
Unknown/unreported	7,781	64%	4,169	48%	3,285	35%	1,368	18%

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

improvement projects and adherence to U.S. Public Health Service Guidelines include PCP Prophylaxis prescription rates (Figure 7.44) and Syphilis screening rates (Figure 7.45). CHSSD is dedicated to building capacity to provide the highest level of care to all persons living with HIV in the District of Columbia. (Source of Data: Quarterly Quality Data Reports).

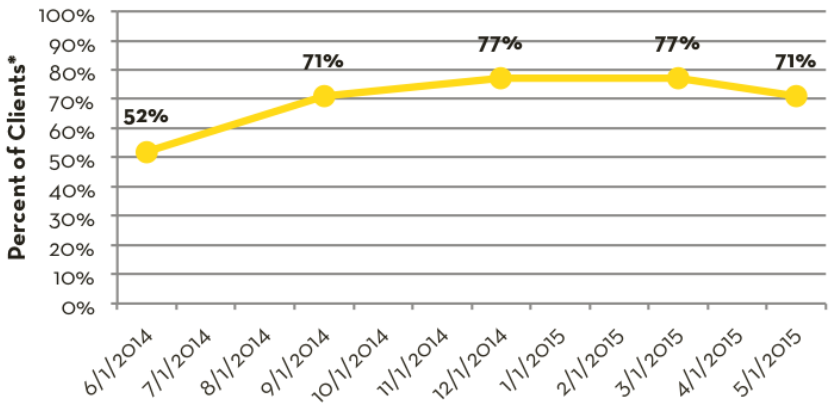
Needle Exchange Program

The District's 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. The NEX program also provides access to a full range of complementary 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, Narcan distribution, STD screening, and other social services. In the latest funding announcement, HAHSTA expanded its reach by targeting women and young injectors under the age of 30. Also, new for this funding period, HAHSTA is developing an initiative to train and certify community members to administer Narcan. Three District providers are funded to implement NEX services. HAHSTA selected two providers that offer a combination of fixed location and mobile outreach efforts throughout Wards 1, 2, 4, 5, 6, 7, and 8 in the District. The remaining program operates as a stationary site in Ward 2.

The overall goals of the programs are:

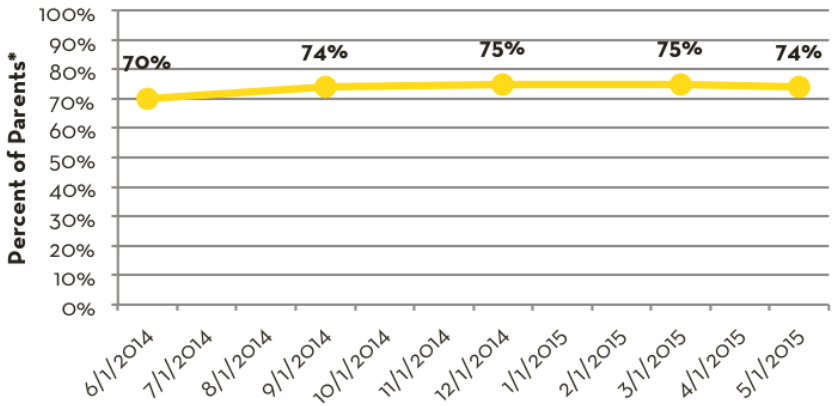
- Delivery of comprehensive HIV prevention and education services to the District's injection drug users utilizing the NEX model
- Improvement of relationships with community residents (i.e., community clean-ups, education sessions, etc.)
- Delivery of complementary services, such as linkage to HIV Counseling and Testing, linkage to viral hepatitis vaccination and screening, linkage to substance abuse detox and treatment, linkage to primary medical care, linkage to overdose prevention services, linkages to and/or direct access to wound care and overdose prevention/treatment (i.e., Naloxone also known as Narcan).

Figure 7.42. Ryan White Clients - Medical Visits



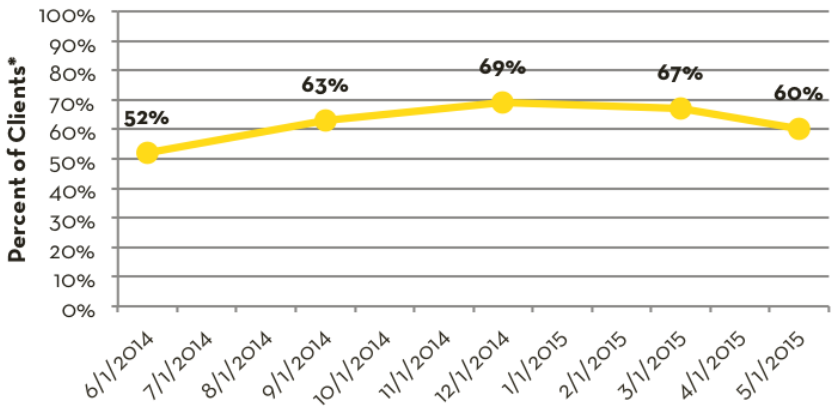
*Percentage of clients with HIV infection who had two or more medical visits in an HIV care setting in the measurement year.
Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Figure 7. 43. Ryan White Clients - Viral Load Suppression



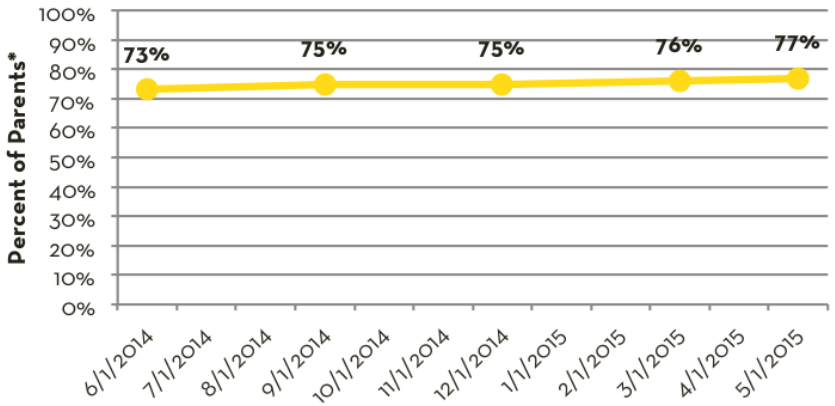
*Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with viral load below limits of quantification (<200 copies/mL) at last test during the measurement year.
Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Figure 7.44. Ryan White Clients - Syphilis Screen



*Percentage of adult clients with HIV infection who had a test for syphilis performed within the measurement.
Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

Figure 7.45. Ryan White Clients - PCP Prophylaxis



*Percentage of clients with HIV infection and a CD4 T-cell count below 200 cells/mm who were prescribed PCP prophylaxis
Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration

In FY12, HAHSTA added two new service areas to support the three existing needle exchange programs. One area was intended to offer needle exchange services to the transgender population. The other service area was Enhanced Harm Reduction (EHR) to support linkages to HCV and HIV screening among injection drug users. The scope of the program was expanded in 2014 to not only include injection drug users, but also foreign born individuals and adults born between 1945 and 1965.

As indicated in Table 7.46, the number of used syringes collected through the NEX program has increased substantially in recent years. Additionally, approximately 798 individuals were linked to HIV counseling, testing, and referral services during fiscal year 2013 through the District needle exchange program and 97 individuals were linked to substance abuse treatment services during the same time period.

Table 7.46. HAHSTA Needle Exchange Program, District of Columbia: FY2012-FY2014

	2012	2013	2014
Number of Used Syringes Collected from IDUs	549,464	647,838	699,807

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration, Prevention and Intervention Services Division

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 (Table 7.47) is one of the strategies implemented by HAHSTA 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 (Table 7.47). 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). HAHSTA continues to have a high treatment verification rate at more than 90% of all students diagnosed as positive. HAHSTA also introduced HIV testing into its school-based program. More than 700 young people received HIV testing in school year 2013-2014 with no students diagnosed as positive.

The Southeast (SE) STD Clinic (Table 7.48) is the only publicly funded STD clinic in the District. Operating five days per week, the SE STD Clinic provides STD, HIV and hepatitis C 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.

Table 7.47. HAHSTA School/Community-Based STD Screening Program, District of Columbia: FY2011-FY2014

	2011	2012	2013	2014
Number of Youths, 15 to 19 years, Screened for STDs Through Outreach Programs	4,274	5,870	4,449	3,825

Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration, Prevention and Intervention Services Division

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.

Tuberculosis Control Program

Through the Tuberculosis (TB) Control Program, (Table 7.49) HAHS-TA 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
- 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.

Key points from available HIV/AIDS, hepatitis, STD, and TB surveillance data through 2013 include:

- 16,423 residents of the District of Columbia or 2.5% of the population are living with HIV. An estimated prevalence of 2.5% exceeds the World Health Organization definition of 1% as a generalized epidemic.

Table 7.48. Southeast STD Clinic, District of Columbia: FY2010-FY2013

	2010	2011	2012	2013
Number of Individual Clients Receiving Services	5,219	8,473	9,332	10,945
Number of Positive Diagnoses:				
Chlamydia	1452	1,401	1,089	729
Gonorrhea	841	755	644	533
Syphilis*	46	51	27	67
HIV*	42	29	43	31

*New Diagnoses Only
Source: DC Department of Health, HIV/AIDS, Hepatitis, STDs, and TB Administration, STD & TB Control Division

Table 7.49. TB Control Program, District of Columbia: FY2012-FY2013

	2012	2013
Number of individuals receiving one or more clinic services*	4,379	2,043
Number of Preliminary Investigations Concerning Suspected TB Cases	26	11
Identification & Investigation of Confirmed TB Cases	37	38
Number of TB Contact Investigations	567	274

Number of TB Contact Investigations

- Blacks, Hispanics, and whites with HIV exceed 1% of their respective populations, with blacks disproportionately impacted at 3.9%
- African-American men who have sex with men (MSM) at 25% and African-American heterosexual women at 18% are the two leading newly diagnosed and identified HIV cases
- The number of newly diagnosed HIV cases in the District decreased to 553 cases in 2013, a decline of 59% from 1,333 cases in 2007
- There was an 87% 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 19 in 2013.
- There were reports of 6,647 new cases of chlamydia, 2,626 new cases of gonorrhea, and 154 new cases of primary and secondary syphilis reported in 2013
- There were reports of 2,241 cases of hepatitis B and 8,933 cases of hepatitis C diagnosed between 2009 and 2013
- 37 new cases of TB were reported in 2013

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/hahsta.

Department of Mental Health

The Department Behavioral Health (DBH) is the oversight and regulatory agency for mental health and substance use services for eligible District of Columbia residents. To fulfill its mission DBH develops, supports and oversees a comprehensive, community-based, consumer driven, culturally competent, quality behavioral health system created to support the needs of eligible citizens and their families. DBH contracts with a network of certified private providers to provide treatment and supports. DBH also operates an emergency care facility, adult and children's mental health clinics that provide immediate walk in service, and an assessment center for substance use referrals. Saint Elizabeths Hospital, the District's inpatient psychiatric facility, is managed by DBH.

Figure 7.46 shows the total number of people receiving outpatient mental health services, substance use services, and the subset receiving both mental health and substance use services.

Demographics for Individuals Receiving Services through Department of Behavioral Health Programs

Figure 7.46 illustrates the comparison between males and females receiving mental health and substance use services. Also shown is the gender breakout for the subset of consumers receiving both mental health and substance use services. For comparison, the gender breakout for Medicaid beneficiaries is included. In all categories, the proportion of males receiving services is higher than the Medicaid population. It should be noted that included in the consumers served is a small group of consumers who are uninsured.

Figure 7.47 shows that the majority of the individuals served within the public behavioral health system continue to be African American. DBH collects data on race and ethnicity separately, so the category of "other" includes consumers who identify their ethnicity as Latino.

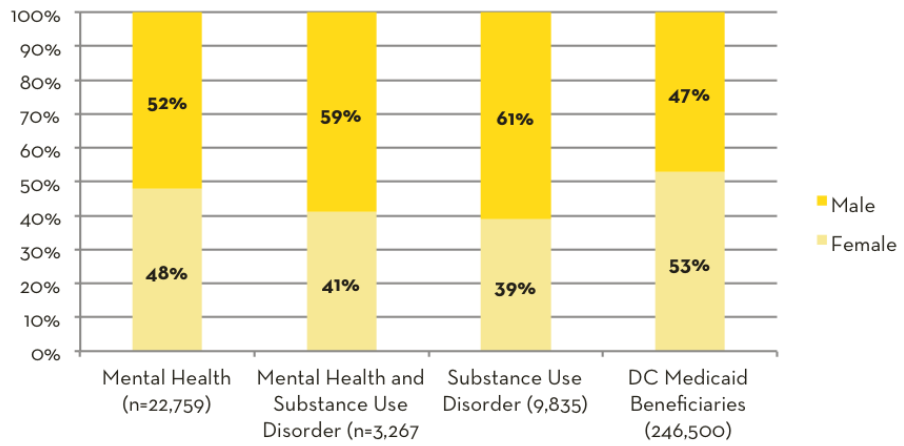
Mental Health Services

DBH provides an array of mental health services and supports through Mental Health Rehabilitation Services (MHRS). This includes: (1) Diagnostic and Assessment, (2) Medication/Somatic treatment, (3) Counseling, (4) Community Support, (5) Crisis/Emergency, (6) Rehabilitation/Day Services, (7) Intensive Day Treatment, (8)

Community Based Intervention, (9) Assertive Community Treatment, (10) Transition Support Services. In addition, there are a variety of evidence based services and promising practices. This includes wraparound support, trauma informed care, school mental health services, early childhood services, suicide prevention, forensic services and supported employment.

Figure 7.48 provides the numbers for the overall population of consumers both children/youth and adults receiving outpatient mental health services in the District. The total numbers of persons served were 22,929; 23,107 and 22,903, for the period FY12, FY13, and FY14 respectively; for an average of 22,979 served annually. The numbers include consumers who have received services from DBH 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.

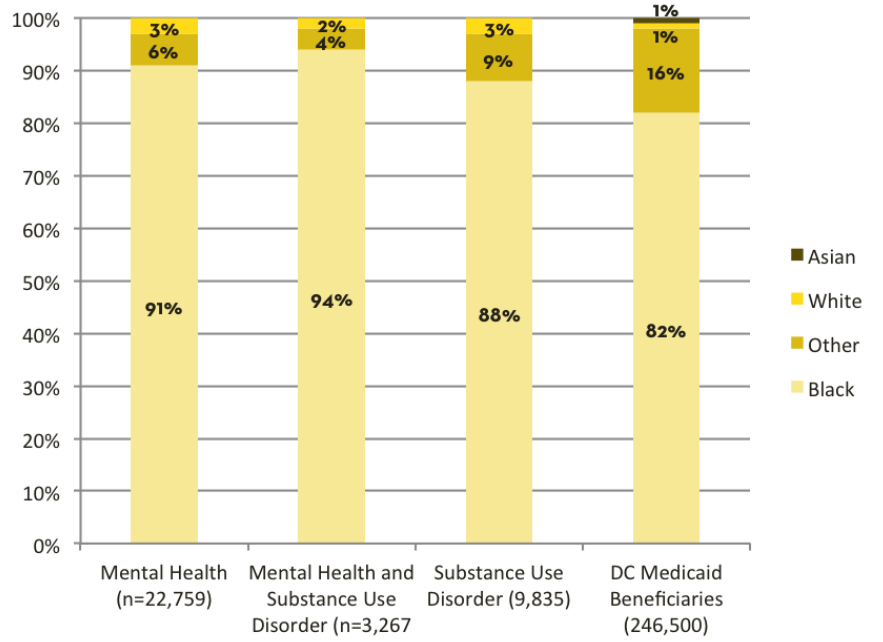
Figure 7.46. Percent of People Receiving Mental Health and Substance Use Services by Sex



Sources:PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Behavioral Health, eCura, DATA, Department of Health Care Finance

A broad range of services are offered through across DBH and certified community-based providers. These services can be broken out into clusters that show utilization across various levels of intensity and specialization. Initial and Ongoing Services are Counseling, Community Support, Diagnostic Assessment and Medication Somatic. Intensive Community Based Services are Assertive Community Treatment, Community Based Intervention, Multi-Systemic Therapy & Family Functional Therapy. Specialty Services are Day, Integrated Care Community Project, Supported Employment, Team Meeting and Jail Diversion. Crisis Services are Non Authorized Crisis Beds, Psych Beds and Emergency Services. Transition Support Services are Inpatient Discharge Planning, Continuity of Care Treatment Planning and Community Psych Supportive Treatment Program.

Figure 7.47. Percent of People Receiving Mental Health and Substance Use Services by Race



Sources:PRISM and Trend Analysis published by Office of Statistics and Reporting, Saint Elizabeths Hospital, Department of Behavioral Health, eCura, DATA, Department of Health Care Finance

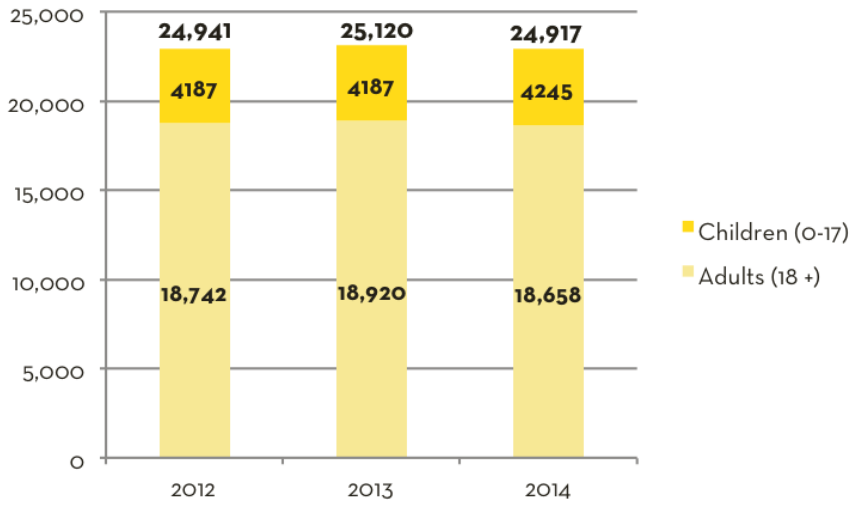
Figure 7.49 shows total consumers who have used services across these five clusters over the past three fiscal years. Numbers of consumers are unduplicated within each service cluster, but may be duplicated across clusters (the same consumer may have received services within multiple clusters). Specialty services and transition support services have had a significant increase over the past three years.

ACCESS HelpLine

DBH operates a 24/7 Access HelpLine (1-888-793-4357) for emergency psychiatric care through the mobile crisis service and to enroll in mental health services. It also authorizes ongoing treatment, enrollment in unique treatment practices and support services and processes transfers between providers. Access Helpline is certified as a Suicide Lifeline Network provider for the District of Columbia by the American Association of Suicidology. Access Helpline 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 partnership with the Washington Metropolitan Area Transit Authority (WMATA), Access HelpLine operates the WMATA Life Line. It also trains WMATA staff in suicide prevention. Table 7.50 shows calls made to the Access HelpLine administrative, crisis and suicide lines.

Figure 7.48. Number of People Receiving Mental Health Services by Age Group



Source: Mental Health Expenditures and Utilization Report (MHEASURE), January 2015

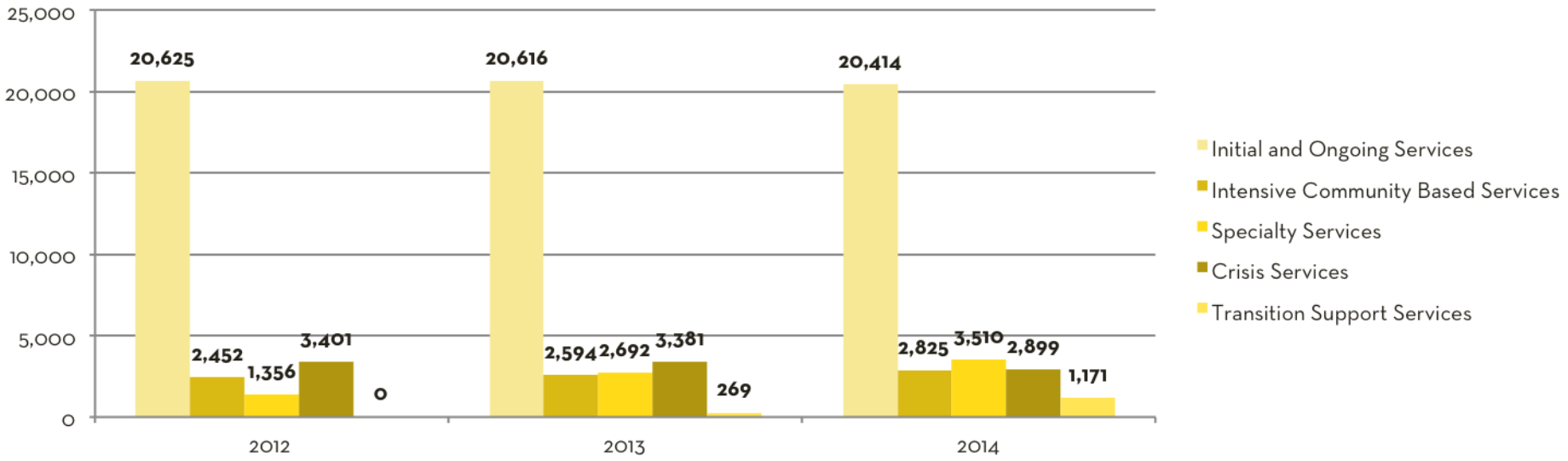
Evidence Based Practices

DBH offers specialty services for adults and children/youth that include evidence-based and promising practices. Evidence based practices (EBPs) are approaches to intervention or treatment that are based in theory, have undergone scientific evaluation, and are proven to make a difference. DBH has trained hundreds of clinicians in evidence based practices. Promising practices are defined as programs and strategies that have some scientific research or data showing positive outcomes but do not have enough evidence to support generalizable conclusions.

In FY 14, DBH offered ten evidence-based practices for children and youth, including treatment for co-occurring mental health and substance use disorders. DBH also offers specialized support for children and adolescents who experience significant emotional and behavioral difficulties related to traumatic life events. DBH also offers evidence based treatment and support services for adults with the most complex needs. Below are brief descriptions of each evidence based practice:

- Assertive Community Treatment (ACT) - intensive, integrated service for adults who have histories of multiple psychiatric hospitalizations, repeated emergency room use and/or frequent arrests
- Supported Employment - assists adults to obtain and keep employment

Figure 7.49. Number of People Receiving Mental Health Services by Service Clusterv



Source: Mental Health Expenditures and Utilization Report (MHEASURE), January 2015

- Multi-systemic Therapy (MST) - intensive, family-focused and community-based treatment program for chronic and violent youth
- Multi-systemic Therapy-Problem Sexual Behaviors (MST-PSB) - designed for youth ages 10-17 years who are at risk of or are exhibiting sexual offending behaviors
- Multi-systemic Therapy – Emerging Adults (MST-EA) - helps young adults with mental health and justice system involvement to decrease offending and increase their involvement in prosocial behaviors
- Functional Family Therapy (FFT) - is a short-term, family-based therapeutic intervention for delinquent youth at risk for institutionalization and their families
- High Fidelity Wraparound (HFW) - a process that involves implementing services to meet youth and families' complex needs; it is frequently used for youth at risk of residential placement
- Child Parent Psychotherapy for Family Violence (CPP-FV) - counseling service for parents with infants, toddlers, and pre-school children who have experienced a violent traumatic event
- Parent-Child Interactive Therapy (PCIT) - designed to provide training and support to parents and caregivers using positive behavior approaches and child development strategies to address behavior

Table 7.50. Access HelpLine Administrative, Crisis and Suicide Lines – Calls Received

	FY2012	FY2013	FY2014
Authorizations	20,800	20,203	13,723
Enrollments	38,322	43,971	50,297
Suicide Life Line	1,718	1,541	2,466
WMATA Life Line	75	1,062	698

Source: Department of Behavioral Health – Access HelpLine

- Trauma Focused-Cognitive Behavior Therapy (TF-CBT) - conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.
- Transition to Independence (TIP) - prepares youth and young adults with emotional and behavioral difficulties for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally-appropriate services and supports
- Adolescent Community Reinforcement Approach (A-CRA) - behavioral intervention that seeks to replace environmental influences that have supported alcohol or drug use with prosocial activities and behaviors that support recovery

DBH provides evidence based practices at a higher rate than the national average. For example, the national average for adult consumers receiving Assertive Community Treatment (ACT) services is 2% compared to, 9.5% in the District. The national average for consumers receiving Multi systemic Therapy (MST) is 1%, while 3% of DBH child/youth consumers received MST in FY14. Two percent (2 %) is the national average for consumers receiving Functional Family Therapy (FFT) compared to 6% of DBH child/youth consumers who received this service in FY14 (MHEASURE, January 2015).

As an illustration of the range of approaches, Table 7.51 shows those EBPs utilized for children and families in various therapeutic settings.

Crisis Services

DBH is responsible for providing emergency assistance to adults and children experiencing a psychiatric or emotional crisis. There are four components to these services. Three are administered through the Comprehensive Psychiatric Emergency Program (CPEP): an onsite psychiatric emergency facility, a homeless outreach program, and mobile crisis outreach. The fourth is a mobile crisis program for children, which is provided through a community based provider.

The onsite CPEP program 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 11,673 total admissions to CPEP during a 3 year period FY12- FY14, as shown in Figure 7.50. These data represents total encounters not unduplicated consumers.

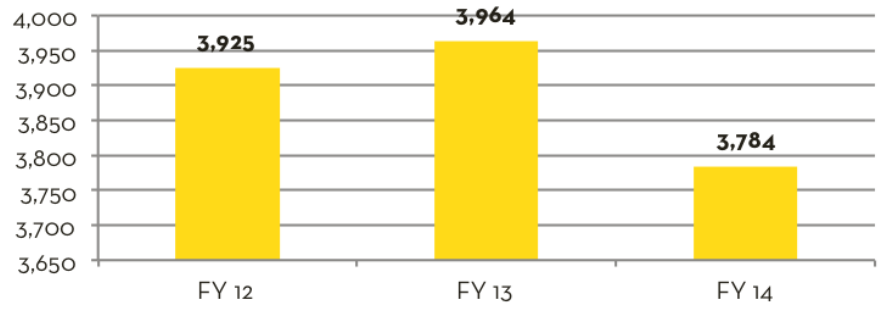
CPEP also includes mobile crisis teams who provide crisis intervention services for adults who are unable or unwilling to come to the facility. In addition to on-site crisis stabilization, the mobile crisis services teams perform assessment for voluntary and involuntary hospitalizations and linkages to other services including ongoing mental

Table 7.51. Number of Adults, Children and Youth Enrolled in Evidenced-Based and Promising Practices

Services	Population	FY 2012	FY 2013	FY 2014
ACT	Adults	1300	1513	1784
Supported Employment	Adults	552	732	689
MST	Children/Youth	120	122	100
MST-PSB	Children/Youth	NA	8	15
MST-EA	Children/Youth	NA	NA	9
FFT	Children/Youth	224	323	350
HFW	Children/Youth	282	337	355
PCIT	Children/Youth	NA	73	55
TF-CBT	Children/Youth	NA	72	127
CPP-FV	Children/Youth	NA	66	31
TIP	Children/Youth	NA	NA	393
A-CRA	Children/Youth	NA	NA	37

Source: Department of Behavioral Health

Figure 7.50. Number of Comprehensive Psychiatric Emergency Program Encounters



Source: Department of Behavioral Health - CPEP

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 community provider appointment after discharge). During FY12 through FY14, the teams provided 5,924 face-to-face and phone engagements, as shown in Table 7.52.

The purpose of the children's mobile crisis service is to provide immediate access to mental health services for children and youth in psychiatric distress. The goal is to stabilize youth within their homes and/or the community and avert inpatient hospitalization and placement disruptions. The mobile team provides on-site crisis assessments to determine the mental health stability of youth and their ability to remain safe in the community. The crisis team assists in the coordination of acute care assessments and hospitalizations when appropriate. Crisis teams also facilitate urgent care psychiatric assessments within 24-48 hours through a community provider or the DBH Physicians Practice Group (PPG). Post crisis follow up interventions are also conducted up to 30 days after the initial crisis intervention to ensure linkage to DBH mental health provider for ongoing treatment. The population of focus is children and youth 6-21 years of age (youth served ages 18-21 are those in the care of the District Child and Family Service Agency (CFSA).

The Homeless Outreach Program (HOP) works closely with the mobile crisis teams and provides a variety of services for individuals with mental illness identified as homeless. The primary services include: outreach and crisis services to individuals through regular visits to shelters and on the streets, and coordination with to provide assessments, referrals to support services. Homeless outreach teams provide support throughout the transition to temporary or permanent housing for homeless individuals and/or families. During hypothermia season, Homeless outreach and mobile crisis teams work to ensure individuals are safe. There were 2,734 people served between FY12 and FY14, as shown in Figure 7.51.

Mental Health Services Division

The Mental Health Services Division provides specialized mental health services that are not otherwise readily available within the DBH service system. There is a site dedicated to serving adults, and another site for children. The programs and services for adults are: 1) a same day urgent care clinic; 2) multicultural services; 3) intellectual/developmental disability services; 4) deaf/hard of

Table 7.52 Mobile Crisis Service Engagements

Response Types	Number of Engagements			
	FY12	FY13	FY14	TOTALS
Crisis Response – Face to Face	1,094	1,339	1,309	3,742
Crisis Response – Phone Only	19	28	13	60
Outreach – Face to Face	344	298	208	850
Outreach – Phone Only	251	150	53	454
Transportation Assistance - CPEP Discharge	357	250	211	818
TOTALS	2,065	2,065	1,794	5,924

Source: Department of Behavioral Health

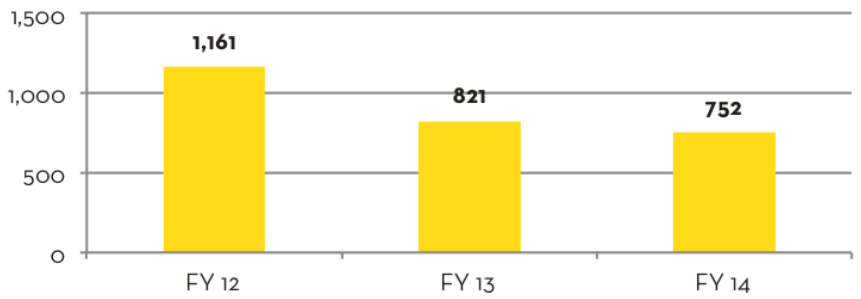
hearing services; 5) pharmacy services; 6) a physicians' practice group; 7) competency restoration; and 8) outpatient forensic services. The programs for children are: 1) early interventions; 2) pharmacy services; 3) same day urgent care clinic; 4) school-based and child care interventions.

School Mental Health Program

In partnership with DC Public School and the Public Charter Schools, the School Mental Health Program locates clinicians in public schools to promote 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 includes 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.

Tables 7.54 and 7.55 compare utilization data from SY 11-12, SY 12-13, and SY 13-14. The number of children referred across the three academic years is similar; however, there were more walk-ins and students receiving treatment services during SY 12-14. While the number of family therapy sessions remained relatively consistent, there was a decrease in the number of group therapy sessions in SY 13-14 and the increase of prevention and early intervention activities such as consultations with parents, teachers, collaboration with school staff, and observations.

Figure 7.51. Homeless Outreach Consumers Served



Source: Department of Behavioral Health – Homeless Outreach

Table 7.53 Children and Adolescent Mobile Psychiatric Service Calls and Deployments

Activity	FY12	FY13	FY14
Total Calls	1276	1226	1339
Total Deployable Calls	708	632	748
Total Deployments	644	608	717

Source: ChAMPS Program Anchor Mental Health Catholic Charities of Washington D.C.

Housing Services

DBH provides a range of housing supports from rental subsidies to community residential facilities and supportive independent living. Supportive Housing Programs include services and supports to help individuals obtain and maintain appropriate housing. Home First provides housing supports and subsidies to people with mental illness. The DBH Supported Housing program uses local funding (non-Federal) for housing subsidies for those with mental illness. Consumers pay thirty percent (30%) of their household income toward their rent and the Home First Program subsidizes the balance of the rental amount. DBH provides a comprehensive system of supports and clinical services and assigns a community support worker for each consumer/tenant. Table 7.56 shows the number of people who participated in the housing programs in FY12-FY14. DBH participates in the District-wide Coordinated Assessment and Housing Placement initiative.

Substance Use Services Prevention

DBH supports four Prevention Centers that conducts prevention activities across all eight wards. Hundreds of young people have been trained to support the Prevention Centers efforts to strengthen the community's capacity to prevent and curtail the use of drugs. Each center focuses on outreach to young people, building collaborations and partnership within the wards and promoting healthy drug -free living. APRA developed the Prevention Policy Consortium made up of more than 15 District agencies and national leaders to bolster the substance use prevention infrastructure and system.

In 2015, DBH received the Community Anti-Drug Coalitions of America (CADCA) Outstanding State Member Award for its support of local anti-drug coalitions and substance abuse prevention programs. In announcing the award, the CADCA said DBH has "greatly improved the prevention infrastructure in the District of Columbia."

Table 7.54. Treatment Services Provided by School Mental Health Program Clinicians

	SY 2011-2012	SY 2012-2013	SY 2013-2014
Referrals	1453	1659	1644
Students on Clinical Caseload	609	629	646
Individual Therapy Sessions	8209	9037	8500
Family Therapy Sessions	544	526	532
Group Therapy Sessions	171	184	68

Source: Department of Behavioral Health, School Mental Health Program

Table 7.55. Prevention and Early Intervention Services Provided by School Mental Health Program Clinicians

	SY 2011-2012	SY 2012-2013	SY 2013-2014
Prevention Sessions	1098	1223	1452
Walk-ins	3917	3228	3467
Conflict Resolution Sessions	1428	1019	985
Classroom Observations	1875	1580	2388
Parent Consultations	2202	2084	2242
Teacher Consultations	4814	4468	4986
Other Staff Consultations	5064	4132	5291
Referrals Made for Outside MH Services	132	202	179
Presentations, Workshops, and Conferences	194	161	206

Source: Department of Behavioral Health, School Mental Health Program

Treatment and Recovery

DBH contracts with approximately 30 treatment programs that provide services for adolescents and adults with substance use disorders. Individuals that want to obtain services go through the Assessment and Referral Center (ARC) administered by DBH or one of the contracted providers authorized to conduct assessments.

Table 7.56. Consumers Participating in Housing Programs

Housing Program	FY2012	FY2013	FY2014
Home First	830	842	863
Supported Independent Living (SIL)	551	409	403
Local Rent Subsidy (LRSP)	93	60	56
Federal Vouchers (set asides)	368	548	569
Contract Community Residential Facilities (CRFs)	220	220	220
Independent Community Residential Facilities (ICRFs)	472	431	463

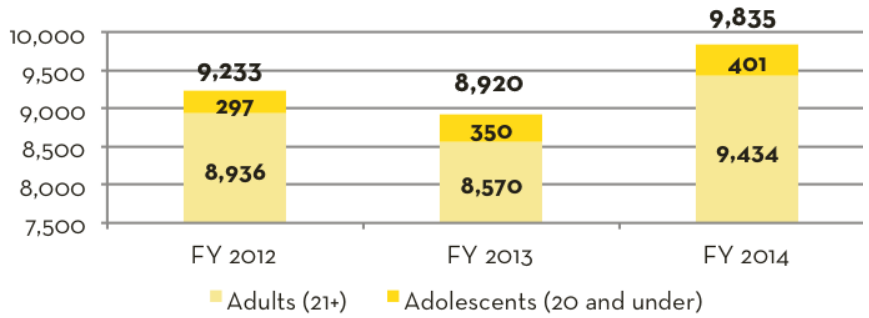
Source: Department of Behavioral Health, School Mental Health Program

SUD services for adolescents are provided through the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Four certified substance use disorder treatment providers specialize in providing these services. Adolescents in need of treatment may either self-refer or be referred by a parent/guardian or significant person in their life to any of the ASTEP providers. A youth can go directly to one of the four providers. Parental consent is required for youth under age of 16. Screening, assessment, out-patient and in-patient treatment and recovery services and supports are provided.

In addition to prevention and treatment, APRA also provides recovery services. In FY 2014, APRA provided recovery services to 3,001 consumers through the Access to Recovery (ATR) grant. Any resident of the District of Columbia may receive free Recovery Support services by visiting the ARC. Individuals are assessed to determine which Recovery Support services are appropriate to support recovery/sobriety needs. Recovery supports include, care coordination services, recovery coaching/mentoring, education support services, transportation and limited housing (up to 6 months) to help foster a stable recovery environment.

Figure 7.52 delineates the numbers of adults and children served from FY 2012 through FY 2014. For both children/adolescents and adults, there has been an increasing enrollment in the various programs. In FY 2014, DBH served 7,652 substance use clients in treatment programs.

Figure 7.52. Substance Use Services by Age Group



Source: Department of Behavioral Health

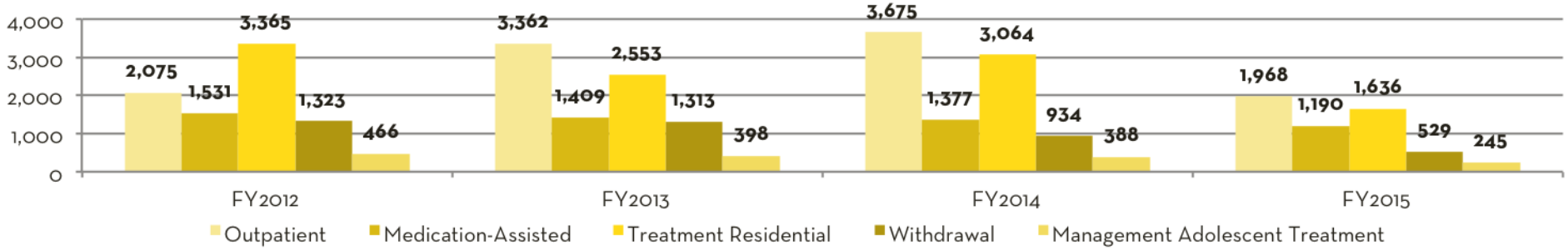
Once clients are assessed, the appropriate referrals are made to the network of SUD providers. Depending on the required level of care, a consumer can be admitted to multiple providers (i.e. a client is admitted to withdrawal management and then sent to residential treatment and upon completing that program is sent to intensive outpatient).

DBH provides a continuum of levels of care for substance use clients including detoxification, residential treatment (inpatient), and intensive outpatient services. These services are designed to be short-term. Some clients need longer-term services to maintain their abstinence from illegal substances; Medication-Assisted Treatment involves the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. There is a similar continuum for adolescents as adults. Figure 7.53 shows the number of admissions at each level. As previously stated, one client can enter multiple levels of care which explains the higher number of admissions than clients.

The drug of choice for those who entered substance use treatment with DBH providers in FY 14 differed from the national population. Figure 7.54 shows the comparison for FY 14. DBH consumers were less likely to use alcohol and marijuana than nationwide but were more likely to use PCP, crack/cocaine, and heroin.

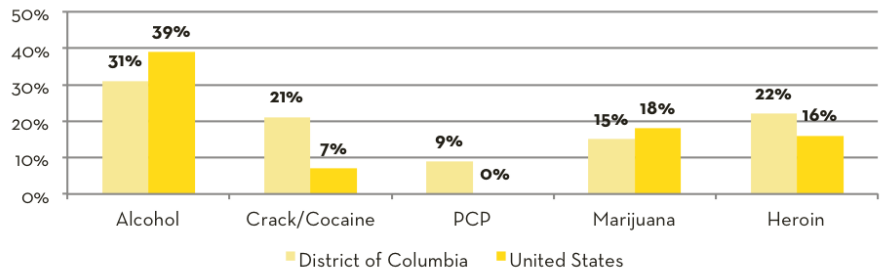
Figure 7.55 shows the top five primary substances used by consumers. The category of "other" includes Benzodiazepine, methamphetamines, no-prescription methadone, other hallucinogens, other opiates and synthetics, and other stimulants.

Figure 7.53. Level of Care for Substance Use Clients



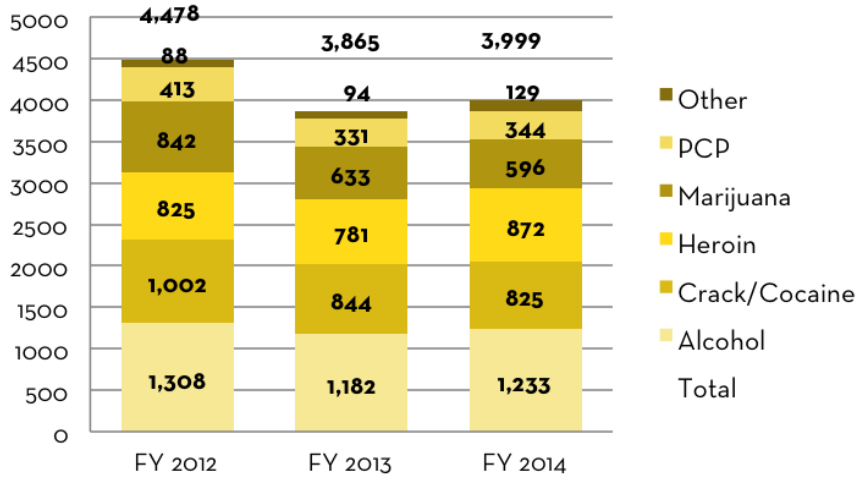
Source: Department of Behavioral Health, DATA

Figure 7.54. Primary Drug Of Choice Comparison Between Us And District Of Columbia, Fy 2014



Sources: Addiction Prevention and Recovery Administration, Department of Behavioral Health, Treatment Assessment Protocol (TAP). Data Received through 10.1.2014, Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Treatment Episode Data Set (TEDS). Data Received through 10.17.13.

Figure 7.55. Primary Drug of Choice for Substance Use Consumers: FY2012-FY2014



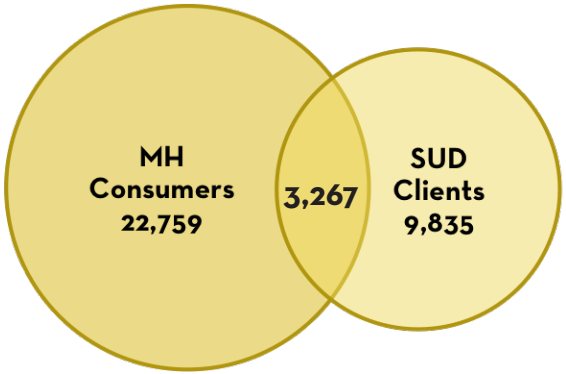
Source: Department of Behavioral Health

Co-Occurring Disorders

Approximately 8.9 million adults have co-occurring mental and substance use disorders. Only 7.4 percent of individuals receive treatment for both conditions, with 55.8 percent receiving no treatment at all (SAMSHA, 2015). This approach to care, integrated treatment which addresses mental and substance use conditions at the same time, is associated with lower costs and better outcomes. DBH has approached the process of serving co-occurring mental health and substance use disorder clients by first implementing a universal screening tool to identify clients that are experiencing needs in both areas. In FY14, DBH implemented activities at access points including the ARC, Urgent Care Clinic at Superior Court, Access Help Line, and several community partners to ensure all individuals entering into the DBH system are screened for co-occurring disorders by using an evidence based co-occurring screening tool called the Global Appraisal of Individual Needs-Short Screener (GAIN-SS).

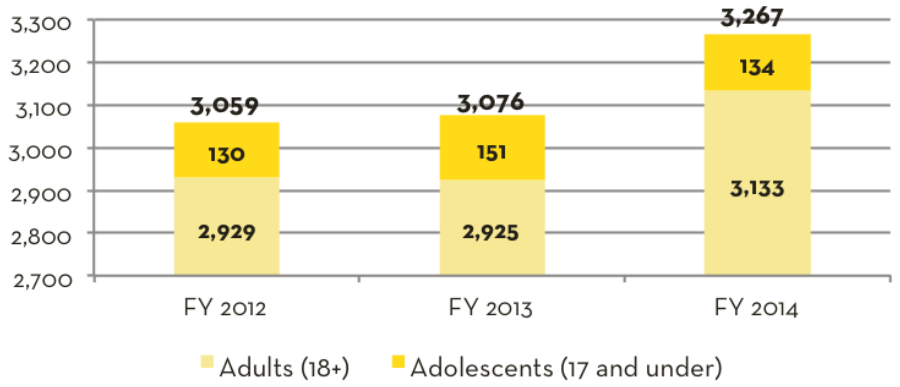
Figure 7.56 shows the number and proportion of individuals receiving services from both mental health and substance use providers in FY14.

Figure 7.56. Number and Proportion of People Receiving Mental Health and Substance Use Services



Sources: Department of Behavioral Health: DATA, eCura

Figure 7.57 Mental Health and Substance Use Services by Age Group



Source: Department of Behavioral Health

Figure 7.57 shows the number of consumers, by age group, who receive both mental health and substance use treatment within DBH.

Saint Elizabeths Hospital

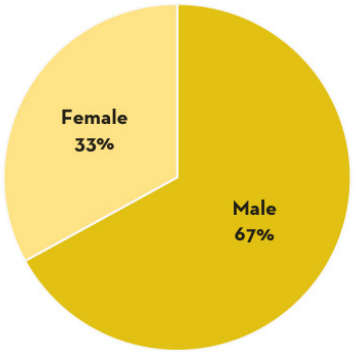
Saint Elizabeths Hospital is the District's inpatient psychiatric facility. Founded in 1855 at the urging of Dorothea Dix, Saint Elizabeths was a pioneer in humane treatment of people with mental illness. Working with community based mental health providers, Saint Elizabeths provides person centered treatment to maximize the potential for recovery so that individuals in care can reintegrate into the community with the appropriate level of support. Figures 7.58 and 7.59 show the gender and race proportions for FY14. The population for gender is the total number of individuals served by St. Elizabeths in FY14. The population for race/ethnicity is the number of people residing at St. Elizabeths on the last day of FY14, and it only includes those whose race data was available.

For the past several years, Saint Elizabeths Hospital 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. The number of discharges exceeded the number of admissions every year from FY09 until FY13, leading to the steady reduction of census. In FY14, admissions exceeded discharges by five, as shown in Figure 7.60 .This is still only 51% of the FY06 admissions. In FY14, on average, a total of 283 individuals were in care per day. Figure 7.61 shows the census as of the last day of the fiscal year for FY12-FY14. Table 7.57 shows the median and average length of stay for civil and forensic consumers for FY12-FY14. Forensic status is broken out by pre-trial and post-trial. Those committed post-trial (individuals found not guilty by reason of insanity) have the longest stays. The table also shows the number of individuals in care discharged after two or more years.

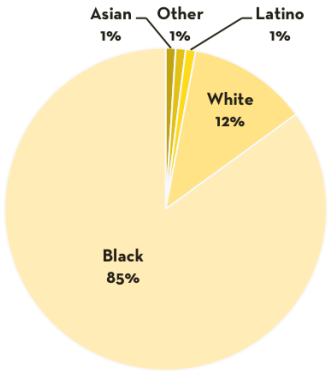
Saint Elizabeths manages five fully accredited training programs in Psychiatry, Psychology, Chaplaincy, Dentistry, and Creative Arts

Figure 7.58. Gender of People Served in FY 2014



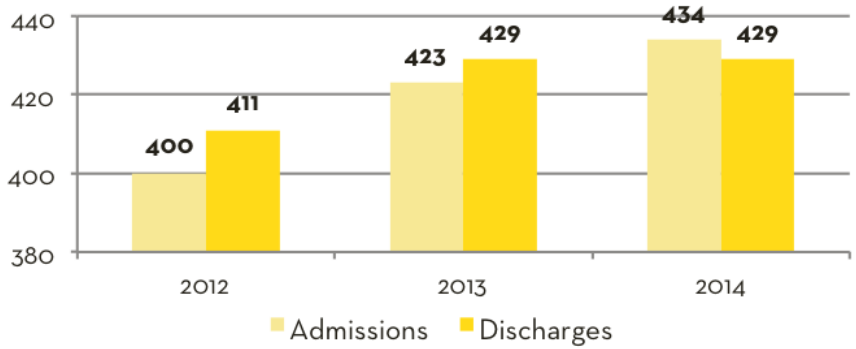
Source: Department of Behavioral Health

Figure 7.59. Race of People Residing at St. Elizabeths on the last day of FY 2014



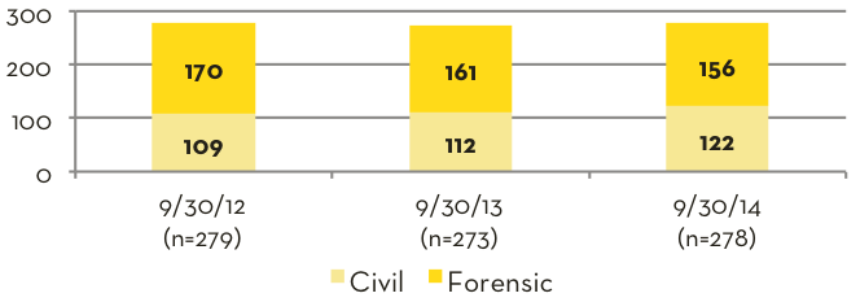
Source: Department of Behavioral Health

Figure 7.60. Saint Elizabeths Admissions and Discharges



Source: Department of Behavioral Health

Figure 7.61. Saint Elizabeths Trend of Daily Census by Legal Status



Source: Department of Behavioral Health

Table 7.57. Length of Stay at Discharge by Legal Status, Number of Discharges: FY2012-FY2014

	# of Discharges			Median LOS (Days)			Average LOS (Days)			# Discharged >=2 Years		
	FY12	FY13	FY14	FY12	FY13	FY14	FY12	FY13	FY14	FY12	FY13	FY14
Civil	186	223	213	40 days	38 days	50 days	189 days	254 days	322 days	10	19	13
Pre-Trial	194	179	178	69 days	61 days	51 days	83 days	84 days	67 days	0	0	0
Post-Trial	31	27	38	315 days	432 days	918 days	2159 days	2255 days	3317 days	11	10	22
Combined	411	429	429	63 days	55 days	58 days	287 days	309 days	483 days	21 (5.1%)	29 (6.8%)	35 (8.2%)

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

Therapies. The state-of-the-art, 448,190 square feet facility features 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.

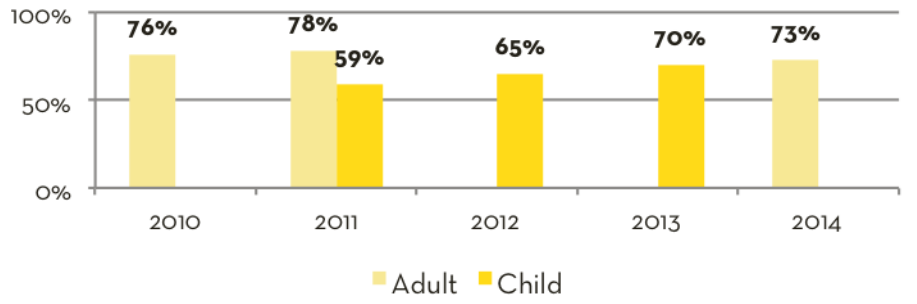
Community Services Reviews

The Community Services Review (CSR) is a case-based, quality assessment process which helps practitioners, supervisors and system leadership to understand how services are working at the system and practice levels. The CSR process seeks to identify both strengths and areas for improving practice to help consumers succeed in reaching their treatment goals and in life.

A team of reviewers examine records and meet with the consumer, family and service providers. The reviewers assess all perspectives of the consumer's status and how the service providers are working to improve the consumer's daily functioning. Based on the information obtained during the interviews the review team will evaluate the consumer's current status and the support received from the treating provider. Using standardized protocols, the review team assesses the consumer's current wellbeing, progress in treatment, and system performance. A feedback session to present initial findings is also conducted in which the reviewers meet with the front line staff, supervisors, and other team members involved with the case to discuss overall practice.

The targets for overall system performance are 80% for the adult system and 70% for the child system. Figure 7.62 shows the overall system performance from 2010 to 2014. Because the goal for the Dixon lawsuit was achieved for the adult system in 2011, DBH focused on the child system until 2013, when the Dixon benchmark was met. Moving forward, reviews will alternate between child and adult each year.

Figure 7.62. Community Services Review Overall System Performance



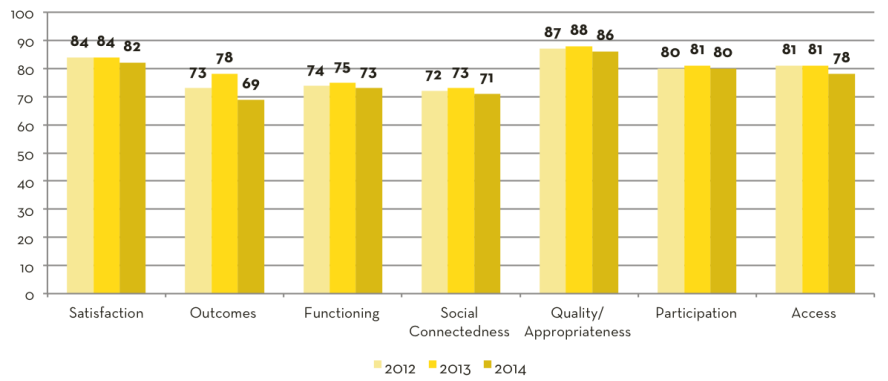
Source: Department of Behavioral Health

Mental Health Statistics Improvement Program

The Mental Health Statistics Improvement Program (MHSIP) is a national effort that was developed in 1996 by the Substance Abuse and Mental Health Services Administration (SAMHSA) to assess the quality of outcomes conceptualized as: psychosocial functioning, consumer satisfaction, and psychiatric symptoms (Jerrell, 2006). DBH administers the MHSIP Consumer Survey annually to meet the requirements of the SAMHSA-funded State Mental Health Block and State Data Infrastructure Grants. The Youth Satisfaction Survey for Families (YSS-F) is administered to the parents of children receiving mental health services.

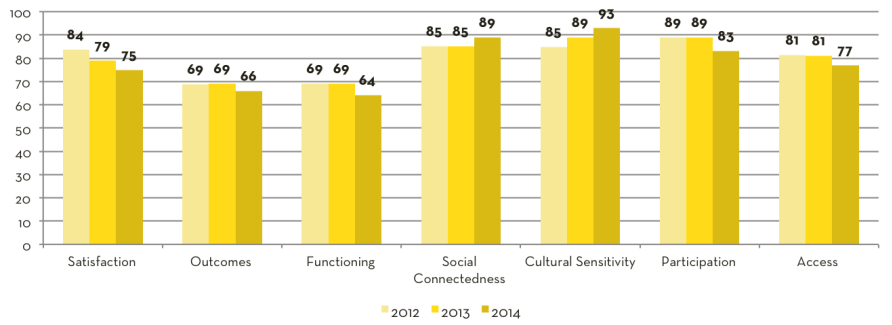
The items are divided into seven categories: access to care, participation in treatment planning, quality and appropriateness of services, social connectedness with family and friends, level of functioning, outcomes, and general satisfaction. Consumers rate the items on a 5-point scale that ranges from strongly agree to strongly disagree. Responses for each statement are aggregated and averaged for each domain to determine whether the consumer agreed or strongly agreed with the majority of the statements in the domain. Figures 7.63 and 7.64 show the percentage of consumers satisfied with each domain for the MHSIP and YSS-F for FY 12- FY 14.

Figure 7.63. Mental Health Statistics Improvement Program, Percentage of Consumers Satisfied



Source: Department of Behavioral Health

Figure 7.64. Youth Satisfaction Survey for Families, Percentage of Parents Satisfied



Source: Department of Behavioral Health

Health Care Finance

About DHCF

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 240,000) 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 2013, approximately 8% of District

residents reported being uninsured, which is among the lowest rates nationally.

Medicaid & Alliance Enrollment

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 (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 7.58. Department of Health Care Finance Enrollment

Services	FY13 Monthly Average	FY14 Monthly Average	FY15*
Total Fee-For-Service	65,897	68,313	66,123
Total Medicaid Managed Care	158,608	165,562	179,538
Alliance Managed Care	15,080	14,668	15,285
Total DHCF Monthly Average	239,380	248,466	260,946

* FY15 – From June 2015 Enrollment Report, only includes October 2014 through February 2015
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 people with disabilities.. 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 federal Centers for Medicare and Medicaid Services (CMS) in the State Plan.

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). See Table 7.59 for a breakdown of income requirements.

Health insurance is offered through one of the three managed care plans for the Medicaid Managed Care and Alliance programs: Trusted Health Plan, AmeriHealth District of Columbia., and MedStar Family Choice.

Table7.59. DC Medicaid Income Requirements			
Household Size	**2014 Federal Poverty Guidelines**	**300% FPL (Children Only)**	**200% FPL (Families)**
1	$11,670.00	$35,010.00	$23,340.00
2	$15,730.00	$47,190.00	$31,460.00
3	$19,790.00	$59,370.00	$39,580.00
4	$23,850.00	$71,550.00	$47,700.00
5	$27,910.00	$83,730.00	$55,820.00
6	$31,970.00	$95,910.00	$63,940.00
7	$36,030.00	$108,090.00	$72,060.00
8	$40,090.00	$120,270.00	$80,180.00

For families/households with more than 8 persons, add $4,060 for each additional person.
Source: Department of Health Care Finance

Long Term Care

Spending in the Medicaid program is organized across two major types of care: (1) primary and acute care services ($1.5 billion); and (2) long term care ($769.1 million). On the primary and acute care side, approximately 72 percent of all payments are made to the District's managed care plans (54 percent) or directly to the hospitals for inpatient care provided to beneficiaries who are not enrolled in managed care (18 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 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. In addition to the two waivers, DHCF also provides home health and personal care assistance services. DHCF is also implementing a new Adult Day Health program and is in the process of designing a Program for All Inclusive Care for the Elderly (PACE). The three tables below, taken from DHCF's FY 2016 Budget Briefing, present details on the scope and cost of the District's long-term care programs. As shown in Table 7.60, while the waiver programs have high average per-participant cost, they are considerably less expensive than their institutional counterparts.

Table7.60. FY 2014 Cost of Waiver and State Plan Personal Care Aide Services			
	Total Number of Unique Recipients	**Total Cost**	**Average Cost Per Recipient**
DD Waiver*	1,822	$165,331,140	$90,742
ICF/IDD	354	$96,619,321	$272,936
EPD Waiver	2,941	$24,006,181	$8,163
State Plan PCA	9,326	$212,823,944	$22,820
Nursing Facilities	3,231	$249,249,435	$77,143

*DD Waiver costs do not include local funds for the waiver
DD Waiver = Home and community-based services for individuals with intellectual or developmental disabilities
ICF/IDD = Intermediate Care Facilities for individuals with developmental disabilities
EPD Waiver = Elderly & persons with physical disabilities waiver
Source: Department of Health Care Finance

The Mayor has budgeted $310 million for FY 2016 to cover the inpatient hospital cost of Medicaid beneficiaries who are not in managed care – the so called fee-for-service population (Table 7.61). There is a "high cost" group of Medicaid beneficiaries who comprise about 15 percent of the fee-for-service population. Compared to their "lower cost" counterparts, beneficiaries in this group visit the emergency room 61 percent more than their counterparts;

Table 7.61. Budget by Provider Type			
Provider Type	**FY 2015 Budget**	**FY 2016 Budget**	**% Growth**
Managed Care	930,392,568.35	1,165,993,304.94	25.32%
Inpatient Hospital	377,236,061.77	309,673,271.77	-17.91%
Nursing Facilities	264,391,794.71	303,512,934.45	14.80%
EPD Waiver	39,157,838.80	73,647,353.60	88.08%
ICF/DD	103,750,182.28	101,279,167.46	-2.38%
DD Waiver	224,108,260.12	199,333,333.00	-11.05%
Personal Care	246,621,582.27	191,814,520.52	-22.22%

Source: Department of Health Care Finance

are admitted for inpatient care at a higher rate compared to the "low cost" group; have hospital stays that are nearly twice as long; have three times the number of 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 FY2016.

State Plan Personal Care Program

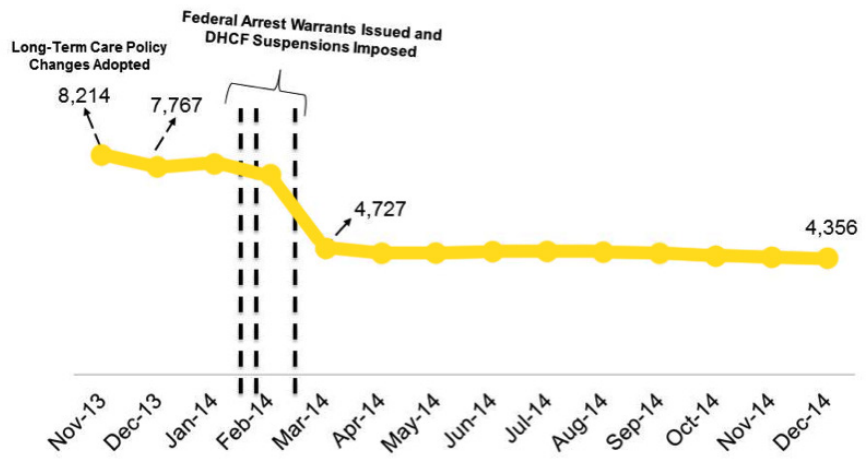
DHCF took several steps to reform the agency's personal care aide (PCA) program in FY 2014, in an effort to improve patient wellness and reduce inappropriate care. The agency established an independent patient assessment process, implementing a new, conflict-free assessment tool through an independent vendor to more accurately determine the number of hours of PCA a beneficiary needed (Figure 7.65). In addition, DHCF created a temporary DHCF Home Health Agency in order to maintain continuity of care for hundreds of beneficiaries whose PCA services were in jeopardy due to the closure of several providers for fraudulent practices. These initiatives helped to right-size the PCA program and ensure beneficiaries who truly need the benefit continue to receive it.

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

Figure 7.65. Monthly Enrollment Levels for Medicaid Personal Care Services



Source: Data reflects final claims, including adjustments, paid during FY13. Claims are identified via procedure code and categorized by progrma according to modifiers. Unique benefit counts indicate total number of individuals with non-zero claims paid during FY13.

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.

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.

In Fiscal Year 2014, DHCF created the Office of Rates, Reimbursement and Financial Analysis (ORRFA), which is led by the Deputy Director for Finance. The primary scope of ORRFA's duties is to serve as a central hub for ensuring compliance with Medicaid reimbursement principles of efficiency, economy, and quality of care. ORRFA staff work to understand each assigned program's regulatory requirements (both state and federal), business processes and financial management methodologies, to aid in conducting rate analyses, evaluating reimbursement methodologies and assessing programmatic expenditures.

Office of Health Care Ombudsman and Bill of Rights (OHCOBR)

The Health Care Ombudsman and Bill of Rights (OHCOBR) is an independent office located in the Department of Health Care Finance (DHCF). The OHCOBR operates independently of all other government and non-government entities, and is a neutral body dedicated to advocating on behalf of District consumers regarding access to health benefits, and to ensure those benefits meet their needs. The Office maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health care services, health benefits plan or provider of a health benefits plan.

The OHCOBR works to solve consumer complaints, facilitates the appeal and grievance process, and intervenes on behalf of consumers to reach a quick and satisfactory resolution. OHCOBR educates consumers about their rights and responsibilities concerning their health benefits, and they facilitate consumer enrollment in health plans and private and public insurance programs.

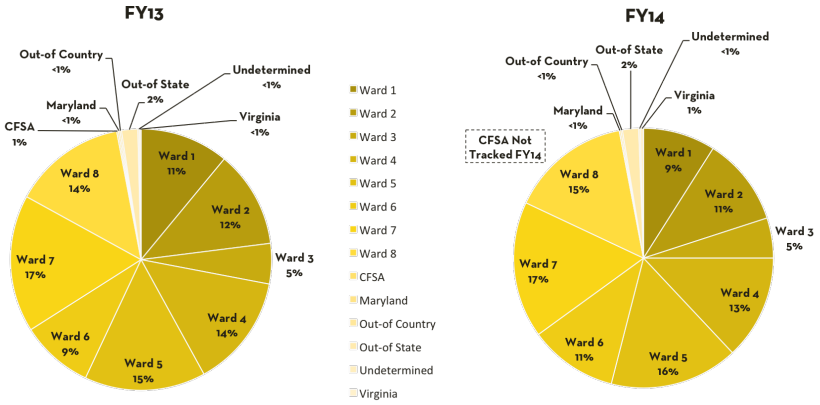
OHCOBR Fiscal Years 2013 and 2014 Activities

During Fiscal Years 2013 and 2014, the OHCOBR tracked all communications (contacts) received (Figure 7.66). The OHCOBR classified all contacts as "cases" which were investigated and brought to closure. During Fiscal Year 2013, OHCOBR opened 6,507 cases, of which 608 contacts were repeat users of OHCOBR's services; and during Fiscal Year 2014, OHCOBR opened 7,904 cases, of which 556 contacts were repeat users of OHCOBR's services. See figures 7.67 and 7.68.

Initiatives

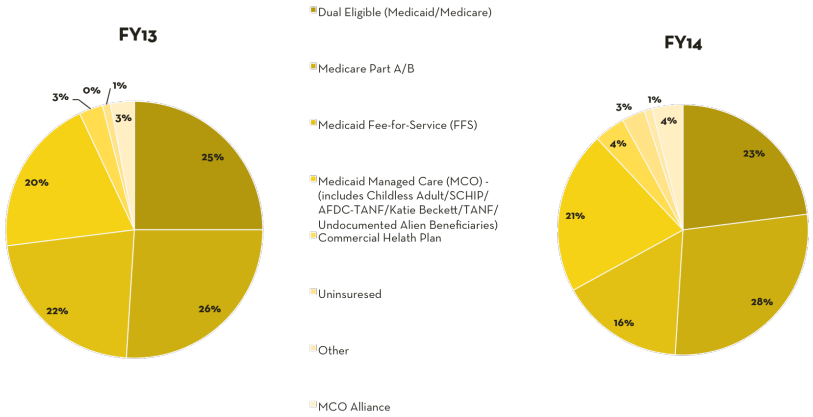
DHCF spends nearly $3 billion every year to provide health insurance to lower-income District residents. DHCF's programs are critical to the health of District residents, because research has proven that people without health insurance are sicker than people who have health insurance; get poorer quality 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 Bowser's Administration: (1) Improve patient outcomes through the use of care

Figures 7.66. Contacts by Wards and States Located Within the DC Metropolitan Area and States Located Outside of the DC Metropolitan Area



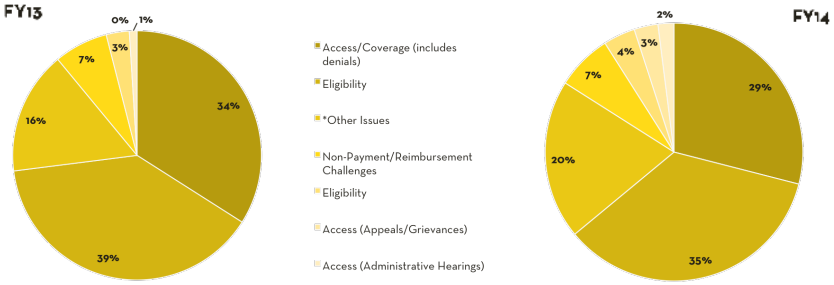
FY13 Total Sample = 6,507 contacted. FY14 Total Sample = 7,904 contacted
Source: Health Care Ombudsman and Bill of Rights

Figures 7.67. Categories of Contacts by Insurance Type FY13 and FY14



FY13 Total Sample = 6,507 contacted. FY14 Total Sample = 7,904 contacted
Source: Health Care Ombudsman and Bill of Rights

Figures 7.68. Breakdown of Types of Issues Encountered by All Contacts FY13 and FY14



*Other Issues: 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./ Source:Health Care Ombudsman and Bill of Rights

coordination; (2) Strengthen DHCF's program integrity operations; (3) reform DHCFs long-term care program; and (4) Support the District's public safety net hospitals and the related efforts to build an integrated health care network in Wards 7 and 8. Several key initiatives are outlined in Table 7.62.

Table 7.62. Department of Health Care Finance Initiatives

Initiative	Description	Goal of Project
Pay For Performance Program for Managed Care Plans	Establish a program that requires the three full risk-based health plans to meet performance thresholds or lose a portion of their capitated payments	Improve care coordination outcomes
Health Homes Care Coordination Program for Fee-For-Service Population	Develop a pilot program to test the efficacy of care coordination for the fee-for-service population	Establish a care coordination model using the Core Service Agencies to improve patient outcomes and reduce health care spending for 20,000 fee-for-service members.
Medicaid Long-Term Care Reform	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, alignment of eligibility criteria with assessments, and improved program monitoring and oversight	Improve the timeliness of the application process, eliminate fragmentation in the long-term care system, reduce inappropriate growth, and strengthen program oversight
Development of The PACE Program	PACE programs are designed to employ a comprehensive range of health care professionals to provide community-based health care to frail older Medicaid beneficiaries. PACE providers are required to develop contracts with community providers to ensure participants have access to a full range of services	Provide the necessary services to PACE members in a community-based setting to help beneficiaries avoid institutionalization
Rate-Setting for Several Provider Groups	Through the recently established Office of Rates, Reimbursement and Financial Analysis, DHCF will implement cost report audits on several major providers to more accurately identify their Medicaid allowable cost in support of the development of updated rate methodologies	Establish or refine the rate methodologies for the personal care program, ICF/IDD providers, and Federal Qualified Health Centers.
Development of the DCAS Eligibility System	In conjunction with DHS, develop and implement a new health and human services eligibility system for Medicaid and other public assistance programs	Establish an automated eligibility system that allows applicants to Medicaid and other assistance programs to apply for benefits through an online automated process.