Chapter 6
Human Services

Page

Human Services

This chapter on human services consists of service elements provided by the District's Department of Human Services (DHS), Department of Health (DOH), Department of Mental Health (DMH) and other human services delivery agencies and administrations in the District of Columbia government. The mission of DHS is to coordinate and provide a range of services that collectively create the enabling conditions for economic and socially challenged residents of the District of Columbia to enhance their quality of life and achieve greater degrees of self-sufficiency. DHS achieves its mission through partnerships with community-based organizations and other local and federal government agencies. DOH is responsible for recognizing and serving the health needs of District residents. It sets the agenda for disease prevention and health promotion among local residents. The mission of DOH is to ensure a safe and healthy environment for city residents. The goal of DMH is to develop, support and oversee a comprehensive, community-based, consumer-driven, culturally competent, quality mental health system. This system should be responsive and accessible to children, youths, adults and their families. It should leverage continuous positive change through its ability to learn and to partner.

Clients in Human Services Programs

It is estimated that roughly 200,000 District residents received 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, AFDC), Supplemental Nutritional Assistance Program (SNAP, formerly Food Stamps) and Interim Disability Assistance. Medicaid continues to be the largest program, with an enrollment of over 140,000 individuals.

A comparison of participants over the nine-year period shows that the number of Medicaid recipients increased by 17 percent, SNAP recipients increased by three percent and TANF recipients decreased by 28 percent.

Table 6.1. Number of Participants by Program

(Fiscal Year)	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Medicaid	119,712	125,680	129,638	130,663	133,913	137,832	144,026	144,413	140,486	140,600
SNAP (formerly Food Stamps)	84,386	79,536	72,776	73,069	79,887	86,817	87,215	86,872	85,011	86,957
TANF	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272
Health Services Medical Charities	8,306	8,905	9,264	7,331	n/a	n/a	n/a	n/a	n/a	n/a
General Assistance for Children	571	546	548	555	525	512	463	411	384	360
Interim Disability Assistance	n/a	n/a	n/a	420	787	1,012	1,510	1973	2140	3481

Source: Department of Human Services

Income Assistance

Temporary Assistance for Needy Families (TANF)—formerly Aid to Families with Dependent Children (AFDC)

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 program to a cash assistance program limited to 60 months in a lifetime. The TANF program assists 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. As shown in the following table, the annual caseload for TANF has decreased by 28 percent from 51,535 recipients in 1999 to 37,272 in 2008. The total annual payment to all TANF households has decreased by 16.6 percent, from $80.3 million in 1999 to $67 million in 2008. In 2008, DHS implemented an increase in monthly cash benefits to families. Higher benefits resulted in a 4.46 percent increase in total TANF payments, from $64.14 million in 2007 to $67 million in 2008.

Table 6.2. Temporary Assistance for Needy Families (TANF)

(Fiscal Year)	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Monthly Average										
Recipients	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272
Children	37,481	34,271	32,056	32,050	32,638	33,501	32,780	30,379	28,768	28,078
Cases	19,062	17,312	16,210	16,390	16,804	17,329	17,066	16,012	15,171	14,892
Avg. Mthly Payment by Case	$351	$346	$340	$335	$335	$335	$331	$334	$352	$374
Family Size	2.7	2.7	2.7	2.7	2.6	2.6	2.6	2.49	2.48	2.5
Total TANF Payments (in millions)	$80.30	$71.80	$67.20	$66.80	$67.50	$69.60	$67.70	$64.11	$64.14	$67.00

Source: Department of Human Services

Services to the Elderly

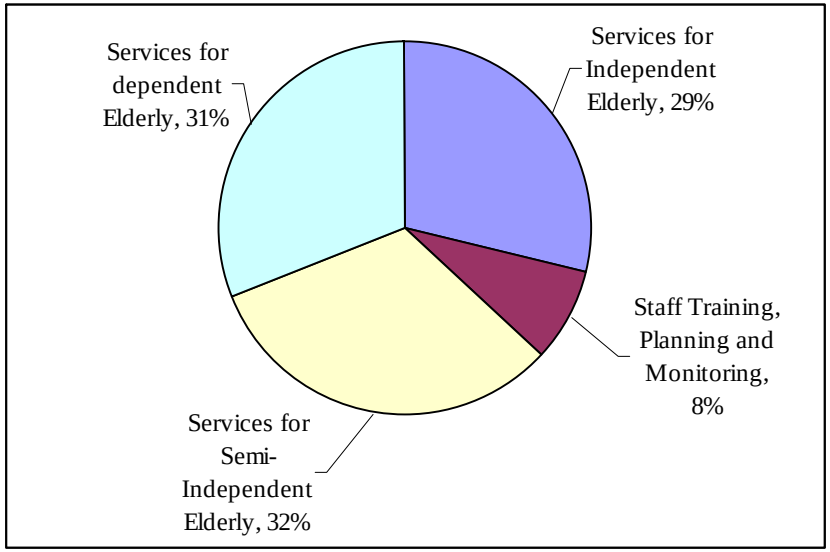
The District government provides a variety of comprehensive programs and services for senior citizens; many of these are funded through the D.C. Office on Aging (OoA), which administers funds under the federal Older Americans Act of 1965, as well as District-appropriated monies. These funds are distributed to 27 public and private non-profit community-based, educational and local government agencies that operate 37 programs for senior citizens (persons 60 years and older). These programs and services are crucial for allowing seniors to age in place in their communities. Services such as counseling, case management,

congregate and home delivered meals, in-home support, caregivers support, legal, advocacy, wellness centers, employment, group homes, one-stop resource center, group housing, senior center activities, long term care, transportation and geriatric day care. OoA has oversight of the two city-owned nursing homes (J.B Johnson and Washington Center for Aging Services) and a food service operation that prepares and delivers meals to seniors throughout the city. We have four senior wellness centers of which the latest opened in FY 2008 in Ward 4. In 2008, the Office on Aging, through an agreement with DOH, manages and operates the Aging and Disability Resource Center.

In FY 2006, the spending for services to the elderly under the auspices of OoA amounted to $21.8 million, which included $ 14.8 million in District funds and $7.1 million in federal funds. In 2007, spending for services amounted to $ 23.9 million, which included $16 million in District funds and $ 7.9 million in federal funds. By 2008, spending for services amounted to $ 23.8, which included $17.4 million in District funds and $6.4 million in federal funds. The elderly population has increased four percent since 2005.

In 2008, 32,722 clients were served by OoA and its grantee agencies. The most requested services by seniors were counseling, congregate and home delivered meals, transportation, wellness services and case management. By comparison, the most utilized services were congregate and home delivered meals, wellness programs and transportation.

Figure 6.1. Percentage of Dollars Spent FY 2008



Through the activities of the Commission on Aging, elderly residents can participate in promoting, planning and assessing services and programs for their peers. The Commission consists of 15 members appointed by the Mayor with the advice and consent of the D.C. Council. The members serve as a citizen advisory group to the Mayor, the Council and OoA. During FYs 2006- 2008, the Commission sponsored a citywide intergenerational poster contest and participated in OoA special events and forums. They also testified and lobbied on transportation, utilities, housing, crime prevention, fare increases, kinship care and nursing home reform legislation affecting the elderly, as well as the OoA budget.

Other agencies offering specific services to seniors include: DC Housing Authority, Metropolitan Police, Public Library, Housing and Community Development, Fire and Emergency Services, Health, Human Services, Tax and Revenue, Parks and Recreation, Arts and Humanities , Motor Vehicles and the University of the District of Columbia.

In FY 2008, the average age of the participants in OoA programs was 79. About 74 percent of participants were women and 18 percent lived alone.

Table 6.3. Number of Persons Receiving Services

	FY 2006	FY 2007	FY 2008*
Persons Served	50,664	50,827	32,722
Counseling	9,010	9,454	5,413
Congregate Meals	3,235	3,726	3,927
Transportation	3,837	3,565	3,831
Homemaker	535	532	490
Home-Delivered Meals	3,813	4,169	3,661
Wellness Services	789	1,584	1,476
Geriatric Day Care	206	182	274
Comprehensive Assessment and Case Management	1,962	2,195	1,396

Source: FY '08 D.C. Office on Aging Client Service Tracking and Reporting System (CSTARS)
FY '06 and '07 D.C. Office on Aging Client Service Information System (CSIS)

* The decline in the number of persons served is due to the implementation of the new Client Service Tracking And Reporting System (CSTARS) which has reduced the number of duplicated clients. In FY 2008, an assessment of home bound meals recipients identified clients who were no longer eligible for the service. Additionally, staff shortages and difficulties recruiting licensed social workers to perform counseling, case management and comprehensive assessment services impacted the number of clients served in FY 2008.

Table 6.4. Units of Services Provided			
	FY 2006	**FY 2007**	**FY 2008**
Counseling	161,817	165,800	153,139
Congregate Meals	265,595	317,206	368,700
Transportation	227,777	203,025	166,137
Homemaker	99,807	96,022	96,811
Home-Delivered Meals	562,510	552,560	601,139
Wellness Services	100,432	180,628	239,494
Geriatric Day Care	99,748	92,018	89,843
Comprehensive Assessment and Case Management	30,214	32,140	24,379

Source: FY '08 D.C. Office on Aging Client Service Tracking and Reporting System (CSTARS)
FY '06 and '07 D.C. Office on Aging Client Service Information System (CSIS)

Services for District Residents with Disabilities

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

Citizens with Developmental Disabilities

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

Figure 6.2.

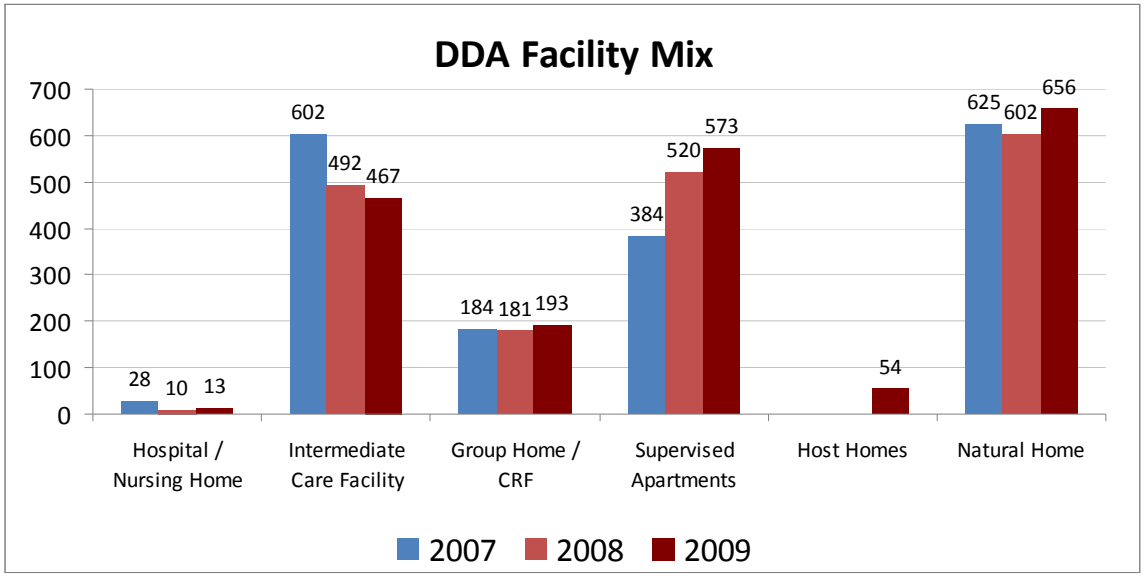

DDA Facility Mix
700
600
500
400
300
200
100
0
28
10
13
602
492
467
184
181
193
384
520
573
54
625
602
656
Hospital / Nursing Home
Intermediate Care Facility
Group Home / CRF
Supervised Apartments
Host Homes
Natural Home
2007
2008
2009

Figure 6.3.

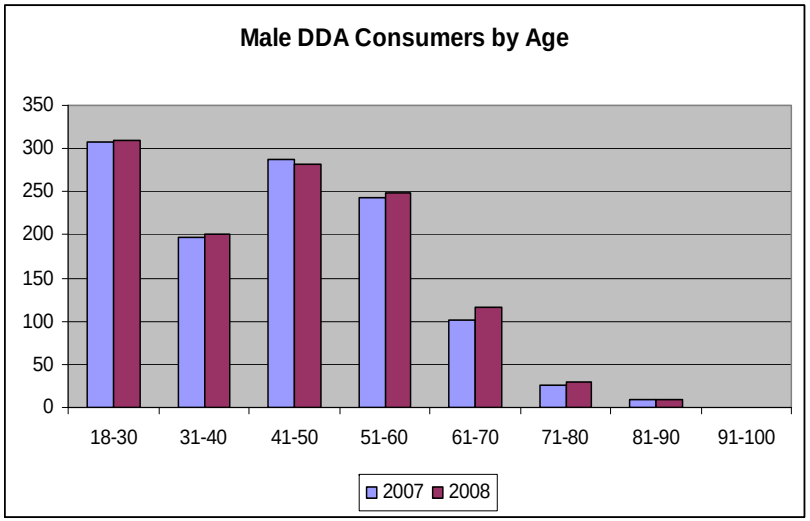
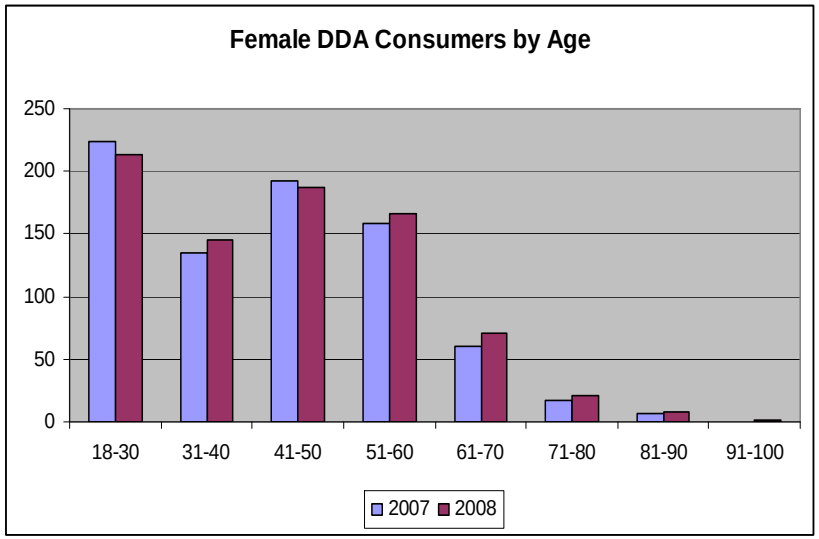


Figure 6.4.



Rehabilitative Services

The District of Columbia Rehabilitation Services Administration (DCRSA) focuses on employment and independent living related services, ensuring that individuals with disabilities achieve a greater quality of life by obtaining and sustaining employment consistent with their capability and informed choice, economic self-sufficiency and independence within their communities. DCRSA achieves this through offering an array of individualized services which include, but are not limited to, the following: counseling and guidance, employment and placement services, post-secondary education, vocational training, mental and physical restoration, assistive technology services, follow-up and inclusive business enterprises and support for the D.C. Center for Independent Living. Recent initiatives include increasing the number of persons with disabilities who receive the support necessary to obtain and maintain living wage employment in integrated settings, as well as expanding the opportunities available for youth with disabilities by ensuring that they have Individualized Plans for Employment in place prior to high school graduation. Additionally, the Social Security Disability Insurance Determinations Unit assists individuals in receiving social security supplemental income and social security disability income benefits.

Figure 6.5.

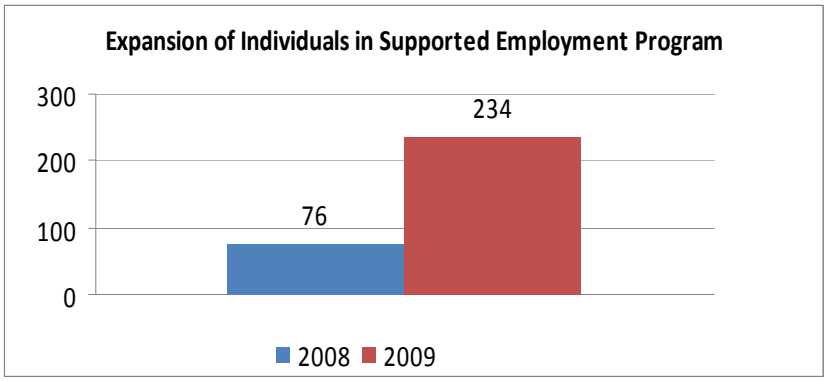
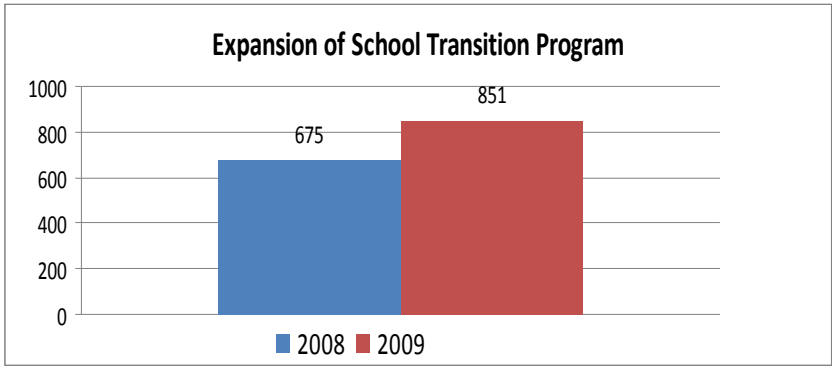


Figure 6.6.



Child and Family Services

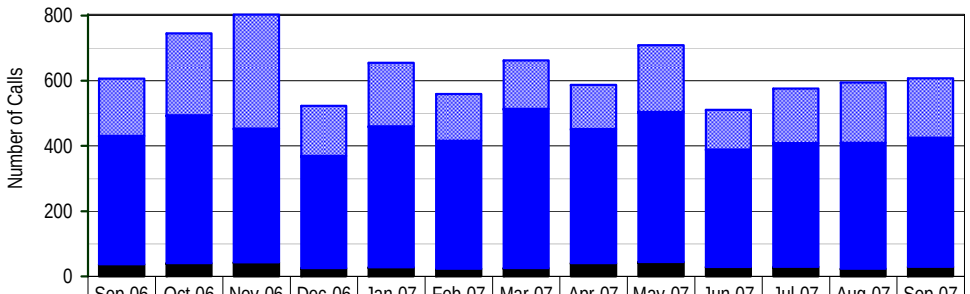
The D.C. Child and Family Services Agency (CFSA) investigates reports of child abuse and neglect, and provides child protection. CFSA services include foster care, adoption and supportive community-based services to enhance the safety, permanence and well-being of abused, neglected and at-risk children and their families in the District of Columbia. CFSA seeks to achieve the highest quality of community-based services, to increase the number of families who receive community-based preventive and support services and to expand the network of resources providing services to at-risk children and their families. The following data provide information on the core aspects of the Agency's operation and further insight into the CFSA population served. This data includes hotline calls, investigations and CFSA clients served, and is current as of May 31, 2009.

Hotline Calls

In FY 2006, the average number of hotline calls received per month was 671. Of the hotline calls received in September 2006, 431 were initially screened as potentially involving child maltreatment and 176 were related to information and/or referrals. Of the 431 Child Protective Services (CPS) calls received that month, 37 (8.5 percent) were screened out and 394 (91.4 percent) were accepted for investigation. Throughout FY 2006, the proportion of CPS calls screened out has ranged between eight and twelve percent.

Comparatively, in FY 2007 the average number of hotline calls per month was 630. In September 2007, CFSA received a total of 628 hotline reports. Of these, 182 (27 percent) were categorized as Information & Referral (I&R) and the remaining 446 reports (73 percent) were alleged child maltreatment. Twenty-nine (29) of the 446 CPS reports received in the month of September were subsequently screened out[1]. Of the remaining 417 reports, 396 were accepted for further investigation and 20 were linked to existing investigations.

Figure 6.7. Hotline Calls: September 2006-September 2007



	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	Sep-07
Total Calls	607	747	804	523	655	559	663	587	709	511	576	595	628
I&R Calls	176	252	349	153	195	143	149	135	205	122	167	185	182
CPS-Accepted	394	453	411	345	432	392	489	411	460	360	379	386	396
CPS-ScreenedOut	37	39	43	24	27	23	24	41	44	29	30	24	29
Pending*		2	0	1	1	1	1	0	0	0	0	0	1

Source: CFSA FACES Report INT003

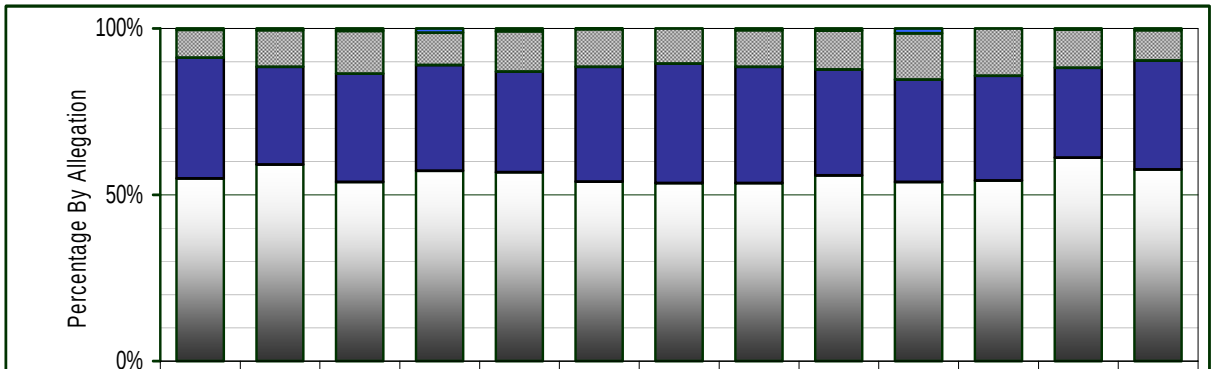
[1] All CPS reports are screened daily by a screening panel and the decision about whether or not an allegation should be investigated or screened out receives greater scrutiny by this panel.

The average number of hotline calls per month in FY 2008 was 901. Hotline calls between September 2007 (628) and September 2008 (940) increased by 49 percent. Of the 940 hotline calls received in September 2008, 283 (30 percent) were categorized as calls for I&R, 563 (60 percent) were accepted or linked to existing investigations and 94 (ten percent) were screened out. In September 2008, 483 new CPS investigations were opened, a 22 percent increase compared to September 2007 (396). Between FY 2006 and FY 2008, the average number of hotline calls received increased by 34 percent. In FY 2009 to date, the average number of hotline calls is 938 per month, higher than the FY 2008 monthly average.

Investigations

The average number of open investigations in FY 2006 was 589. Among the 394 accepted CPS calls received during the month of September, 227 (57.6 percent) were referrals involving neglect, 129 (32.7 percent) were referrals involving physical abuse and 36 (9.1 percent) were referrals involving sexual abuse. Additionally, there were two child fatality referrals received.

Figure 6.8. CPS Referrals Accepted by Allegation (September 2005 - September 2006)

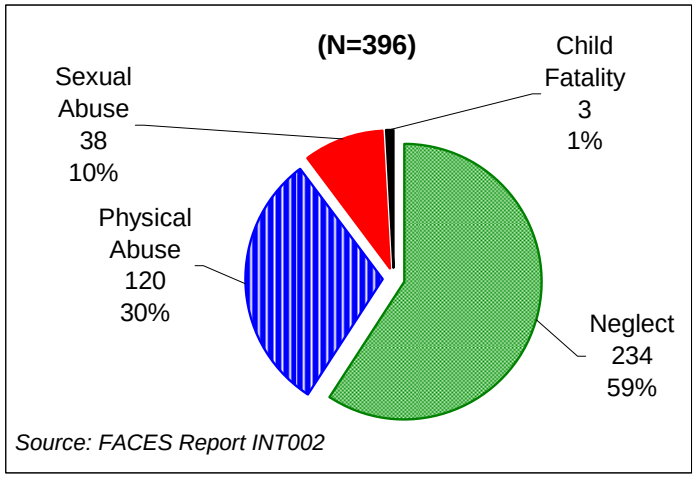


	Sep-05	Oct-05	Nov-05	Dec-05	Jan-06	Feb-06	Mar-06	Apr-06	May-06	Jun-06	July-06	Aug-06	Sep-06
Child Fatality	2	3	3	5	4	1	0	2	3	5	0	1	2
Sexual Abuse	38	57	52	39	57	55	60	42	60	46	40	40	36
Physical Abuse	165	154	131	128	142	168	204	134	162	102	89	94	129
Neglect	250	309	217	230	267	263	304	205	285	179	153	213	227

Source: CFSA FACES Report (INT002)

In comparison, of the hotline calls accepted for investigation in September 2007, three (one percent) were related to child fatality, 38 (ten percent) were related to sexual abuse, 120 (30 percent) were related to physical abuse and 234 (59 percent) were related to neglect. Compared to FY 2006, investigations related to child fatality increased by one, investigations related to sexual abuse increased by two, investigations related to physical abuse decreased by nine and investigations related to neglect increased by seven. The average number of open investigations in FY 2007 was 414, a 30 percent decrease compared to the FY 2006 open investigation average.

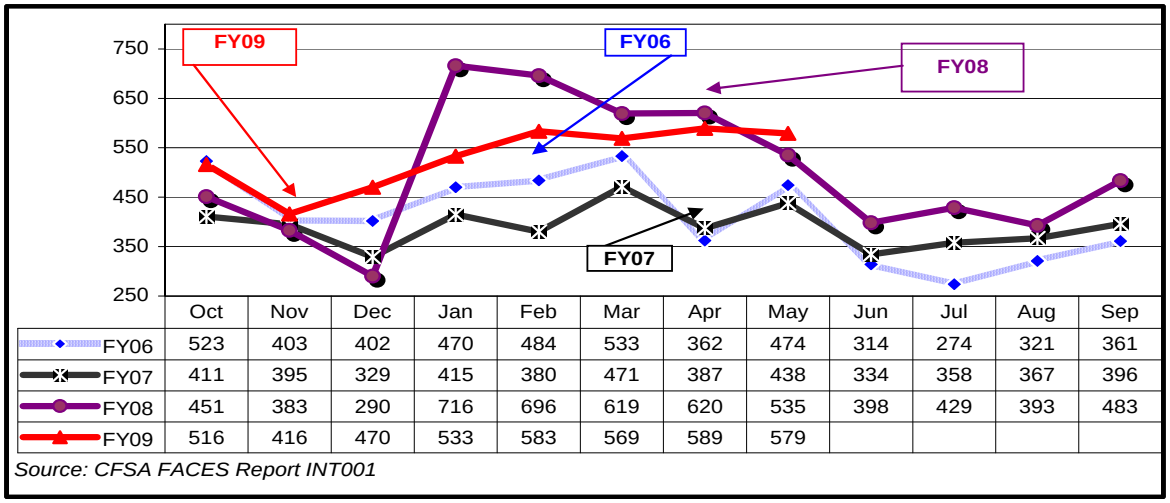
Figure 6.9. Hotline Calls Accepted for Investigations by Type: September 2007 (number and percent)



Source: FACES Report INT002

In September 2008, the majority of open child maltreatment investigations involved allegations of neglect. Of the 483 new investigations opened that month, 253 (52 percent) involved neglect, 199 (41 percent) involved physical or other types of abuse, 30 (six percent) involved sexual abuse and one (less than one percent) involved a child fatality. Compared to September 2007, there were eight percent (234) more investigations of neglect, 66 percent (120) more investigations of physical abuse and 21 percent fewer (38) investigations of sexual abuse in September 2008. The average number of open investigations in FY 2008 was 1,383, a 234 percent increase compared to the prior fiscal year average. In FY 2009 to date, the average number of open investigations is 626. Among new CPS investigations, the highest proportion of allegation type from FY 2006 to the present is neglect, comprising between 50 and 60 percent of the total each year.

Figure 6.10. Seasonal Trend in the Volume of New CPS Investigations (FY06 ~ FY09)



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY06	523	403	402	470	484	533	362	474	314	274	321	361
FY07	411	395	329	415	380	471	387	438	334	358	367	396
FY08	451	383	290	716	696	619	620	535	398	429	393	483
FY09	516	416	470	533	583	569	589	579				

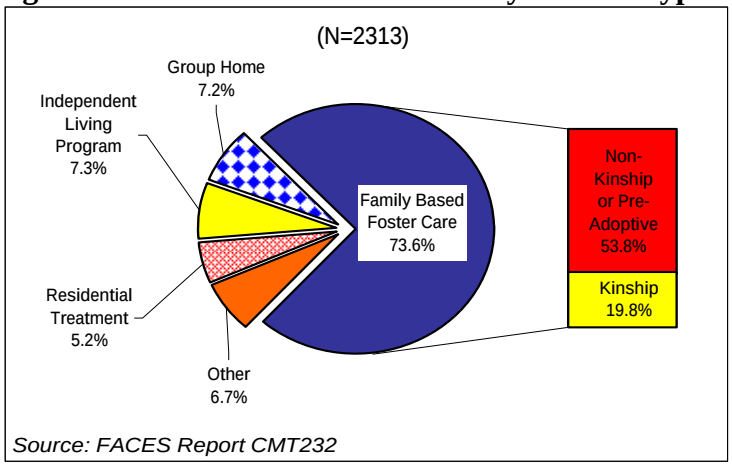
Source: CFSA FACES Report INT001

The hotline calls trend evidences seasonal peaks and dips. Typically, hotline calls surge at the opening and closing of the school year and remain flat throughout the summer months. The totals for FY 2008 and FY 2009 to date indicated the surge in new investigations when compared to trend in FY06 and FY07.

CFSA Population

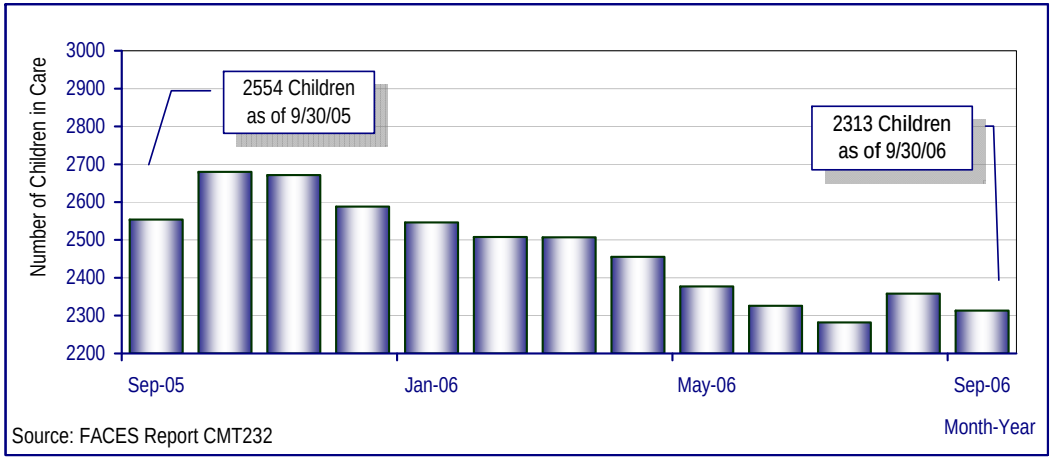
In September2006, CFSA served a total population of 4,464. Of these, 2,313 were children in out-of-home (foster) care. Of these children placed in foster care, 74 percent were in family-based foster care, seven percent in group homes, seven percent in independent living and five percent in residential treatment centers. Additionally, 2,102 children and their 717 families received in-home services.

Figure 6.11. CFSA Children Served by Service Type



Source: FACES Report CMT232

Figure 6.12. CFSA Foster Care Population: September 2005-September 2006



In comparison, CFSA served a total population of 4,278 in September 2007, a four-percent decrease compared to FY 2006. Of these, 2,243 were children placed in foster care, 39 were children placed in third-party placements and 301 were children who remained at home while their siblings were served in out-of-home-care. In addition, CFSA provided in-home services to 1,695 children (662 families) in-home. Of the 2,243 children in foster care as of September 30, 2007, 71 percent were in family-based foster care, seven percent were in group homes, seven percent were in independent living programs and seven percent were in residential treatment facilities.

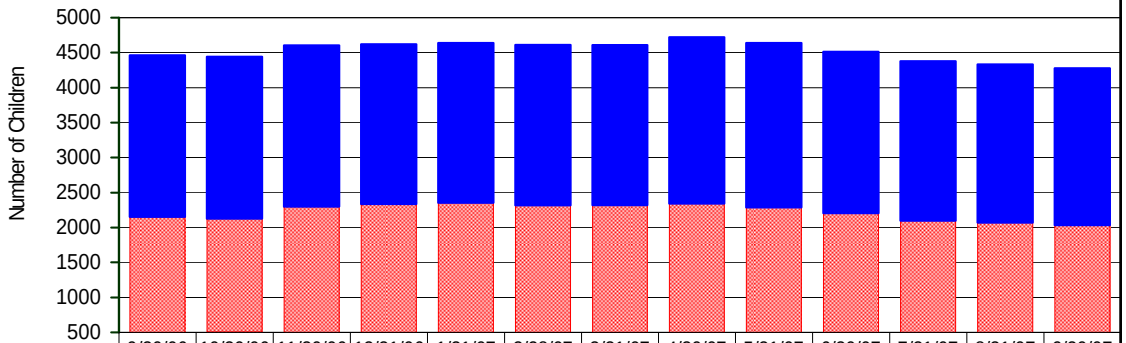
Table 6.5. Population Served by Placement Setting

Placement Setting		2006					2007								
		Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	
Family Setting	Kinship	19.80%	19.90%	19.30%	19.60%	18.70%	18.30%	17.60%	16.70%	16.60%	16.30%	16.30%	15.30%	**15.20%**	**341**
	Non-Kinship or Pre-Adoptive[1)]	53.80%	54.20%	53.50%	53.50%	54.20%	54.40%	54.70%	54.30%	54.40%	55.70%	55.70%	56.00%	**56.13%**	**1259**
	Sub-total	**73.60%**	**74.20%**	**72.80%**	**73.00%**	**72.50%**	**72.70%**	**72.30%**	**71.00%**	**71.00%**	**72.60%**	**72.60%**	**71.30%**	**71.33%**	**1600**
Group Homes		7.20%	7.70%	7.70%	7.90%	7.00%	7.00%	7.40%	7.70%	7.90%	7.40%	7.40%	7.20%	**7.45%**	**167**
ILP/Teen Program		7.30%	7.20%	7.20%	7.00%	7.30%	7.40%	7.40%	7.20%	7.00%	7.30%	7.30%	7.60%	**7.71%**	**173**
Residential Treatment		5.20%	5.40%	5.40%	5.20%	5.10%	5.30%	5.30%	5.70%	6.20%	6.40%	6.40%	6.60%	**6.60%**	**148**
Other[2)]		6.70%	6.90%	6.80%	6.80%	7.70%	7.60%	7.60%	8.30%	7.90%	6.90%	6.90%	7.40%	**6.91%**	**155**
Total in Foster Care		2313	2316	2311	2286	2285	2297	2292	2377	2352	2306	2281	2261	**100.00%**	**2243**

Source: CFSA

In addition, CFSA provided in-home services to 1,695 children (662 families) found to be victims of child maltreatment who were determined to be able to safely remain in their homes.

Figure 6.13. CFSA Total Population Served: September 2006-September 2007



	9/30/06	10/30/06	11/30/06	12/31/06	1/31/07	2/28/07	3/31/07	4/30/07	5/31/07	6/30/07	7/31/07	8/31/07	9/30/07
Total Children Served	4464	4443	4607	4620	4638	4614	4611	4719	4639	4511	4377	4332	4278
Children in Foster Care	2313	2316	2311	2286	2285	2297	2292	2377	2352	2306	2281	2261	2243
Children in Home	1681	1621	1826	1903	1924	1941	1976	1940	1914	1849	1747	1734	1695
Siblings of Out-of-home Children	421	458	425	389	391	335	306	366	339	323	319	303	301
Children in Third Party	49	48	45	42	38	41	37	36	34	33	30	34	39

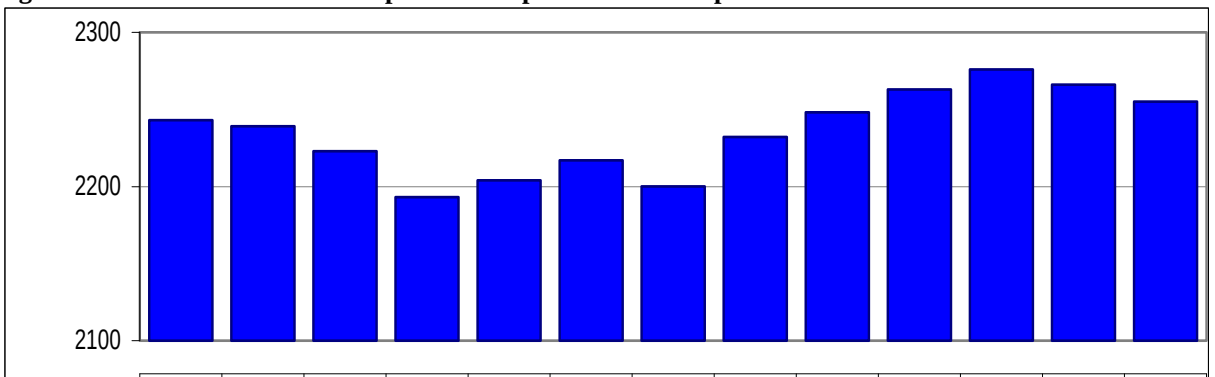
Source: CFSA FACES Report CMT232

In September 2008, CFSA served a total population of 4,379. Of these, 2,255 were children in foster care. CFSA out-of-home workers and private agency workers also provided support services to 325 children who remained at home while their siblings were served in out-of-home care. In addition, CFSA (and the private agencies to a lesser degree) provided in-home services to 1,782 children in 693 families.

Of the 2,255 children placed in foster care, 71 percent were in family-based foster care, eight percent in group homes, seven percent in independent living programs and five percent in residential treatment centers. Between the end of FY 2006 and end of FY 2008, the percentage of children in family-based foster care and congregate settings remained flat, with a slight increase between FY 2006 and FY 2007 and a decrease in the number of children placed in residential children centers at the end of FY 2008.

Overall, between the end of FY 2006 and the end of FY 2007, the foster care population decreased by four percent (30). Conversely, between the end of FY 2007 and FY 2008, the foster care population increased by 0.5 percent (12). Between FY 2008 and FY 2009 to date, the foster care population has decreased by 1.5 percent (34).

Figure 6.14. CFSA Foster Care Population: September 2007-September 2008



	9/30/07	10/31/07	11/30/07	12/31/07	1/31/08	2/29/08	3/31/08	4/30/08	5/31/08	6/30/08	7/31/08	08/30/08	9/30/08
FC Population	2243	2239	2223	2193	2204	2217	2200	2232	2248	2263	2276	2266	2255

Source: FACES Report CMT232

Population, Demographics and Trends

Of the children served by CFSA, over 90 percent are African American. An estimated six percent are Hispanic and two percent are Caucasian. There has been minor variance by race and ethnicity of clients served in recent fiscal years. With regard to the ages of children served, the District of Columbia's child welfare system is unique in that youth can remain until the age of 21. Most jurisdictions emancipate youth at the age of 18. Of the children served, the Agency has witnessed an increase in care entrance for two distinct populations – children three years old and younger and youth between the ages of 15 and 21.

Table 6.6. Age Distribution of Children Entering Foster Care (FY 2005 - FY 2009 to date)

Age	FY06	FY07	FY08	FY09
<3	30%	22%	26%	27%
3~5	16%	13%	17%	18%
6~8	12%	14%	15%	14%
9~11	10%	12%	11%	11%
12~14	17%	15%	11%	14%
>=15	15%	24%	21%	16%
Total Entries	***554***	***592***	***755***	***442***
Monthly Average	***46***	***51***	***63***	***55***
**Of all children (entries + re-entries)*				
Source: Analysis of FACES Reports CMT331 & PLC208				

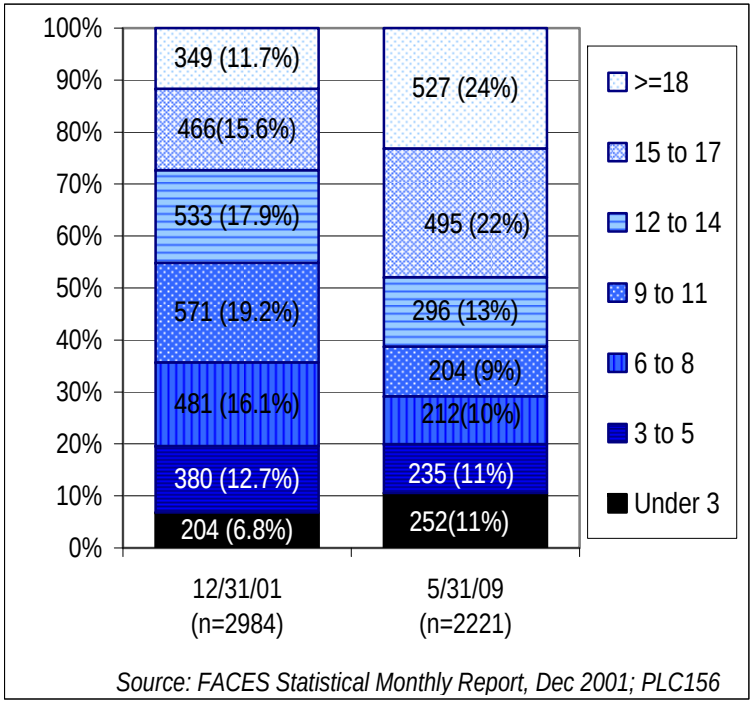
Currently, youth 15 years and older comprise nearly 50 percent of the population served. Youth 18 and older comprise 24 percent of the foster care population and youth between the ages of 15 and 17 comprise 22 percent.

Between the end of FY 2006 and May 31, 2009, the foster care population decreased by four percent (92). Throughout this period, the population has fluctuated with incremental increases. However, the overall trend indicates a decrease in the foster care population since FY 2006.

As of May 31, 2009, CFSA and private agencies served 2,221 children who were placed in foster care, seven children in third-party placements and 325 children who remained at home while their siblings were served in out-of-home-care. In addition, CFSA (and the private agencies to a lesser degree) provided in-home services to 1,925 children (in 715 families) found to be victims of child maltreatment, but still able to safely remain in or return to their homes. Overall, a total of 4,474 children were placed in out-of-home care or received in-home services from CFSA or private agencies during the month of May.

Over the past three fiscal years, the CFSA foster care population has declined. Recent trends indicate that as the out-of-home population has decreased, the in-home population has increased by 43 percent in the past year. As the foster care population has decreased, the total population served has fluctuated. Between FY 2006 and FY 2007, the total population served decreased by four percent (192). Conversely, between FY 2007 and FY 2008, the total population served increased by three percent (111). From FY 2008 to the present, the total population served has increased by two percent (95).

Figure 6.15. Population Served by Age Group



Source: FACES Statistical Monthly Report, Dec 2001; PLC156

Immunization Services

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

Vaccines also provide great cost benefits by decreasing the economic impact associated with vaccine-preventable diseases, such as costs related to doctor's visits, hospitalizations, parent's loss of time from work and premature deaths. Since 1979, the District of Columbia has required children attending school and Daycare to be fully immunized. Vaccination rates for children 19-35 months old have increased dramatically since 2002. Please see the table below:

Table 6.7. Immunization Compliance Levels in DC Using the Immunization Registry: Includes Routine, Catch-up and Exemptions
(Based on the DC School Immunization Requirements - DTaP, DT, Td, TdaP, Hib, Hep B, IPV, MMR, Me, Mu, Ru, Varicella, Pneumo Conj 7, Hep A, Meningococcal, HPV)

	Licensed Child Development Centers (LCDC's) *	**Head Start Centers**	**Public Schools**	**Non-Public Schools (Assessments start at the Beginning of the SY August through June)**		
				Private	**Charter**	**Parochial**
Year			40.0% as of Jan. 2002			
2002	52.57%	45.11%	72.90%	56.30%	56.67%	42.33%
2003	63.11%	59.35%	84.44%	79.58%	74.68%	55.81%
2004	67.33%	66.66%	90.88%	79.50%	84.76%	59.81%
2005	69.60%	74.78%	95.05%	84.10%	90.94%	74.70%
2006	71.73%	83.03%	96.32%	83.71%	91.32%	78.68%
2007	74.27%	81.42%	97.32%	85.04%	94.47%	78.67%
2008	93.03%	97.15%	97.94%	88.62%	96.25%	78.25%

* This represents 4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella and 4 Pneumococcal Conjugate
For all others this represents 5 DTaP, 4 Polio, 2 MMR, 3 Hib, 3 Hep B, 2 Varicella and 4 Pneumococcal Conjugate

Source: D.C. Department of Health, Community Health Administration, Bureau of Child, Adolescent & School Health

Children's National Medical Center:
Children's School Services School Health Nursing Program

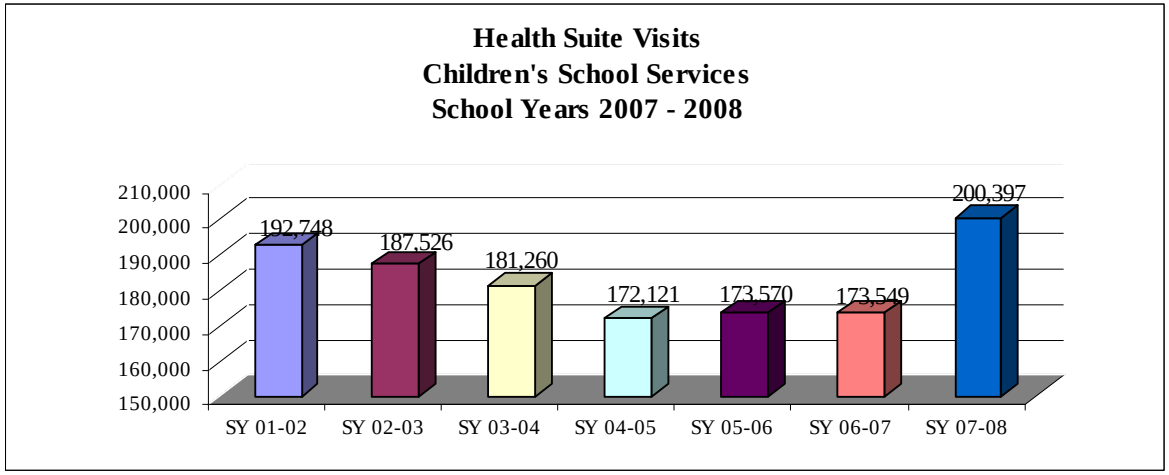
The Children's School Services School Health Nursing Program is responsible for the collection and submission of student health related data and statistics on a monthly and annual basis. This annual report has been compiled inclusive of information collected under the management and supervision of the Children's School Services leadership team.

Children's School Services, Health Suite Visits, SY 2007 - 2008

During SY 2007 – 2008 there were a total of 200,397 health suite visits, inclusive of visits by children with special needs. This represents an increase of approximately 21 percent over the previous school year. This increase is attributed to the following factors:

1. Increased staffing of nurses in health suites.
2. Extension of nurse staffing from part-time to full-time in 41 DC Public Schools. The increased presence of nurses for longer hours provides the opportunity for nurses to see more students during the school day.
3. The Children's School Services School Nurse Brochure was developed in December 2007, as a means of educating students, parents, school personnel and the general public about school nurses and their role in the provision of quality health care.

Figure 6.16.



From school year 2001 – 2002 to school year 2007 – 2008, school nurses have provided nursing care and services to students during an average of 184,000 health suite visits annually for a total of 1,281,171 health suite visits over the seven (7) year period.

Source: D.C. Department of Health, Community Health Administration

Table 6.8. Children's School Services
SY 2007 – 2008

DCPS and Public Charter Schools (Regular School Setting)

	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Total YTD
Cumulative Health Suite Visits	13,017	13,847	11,707	10,319	10,513	15,481	14,333	13,401	16,876	9,205	128,699
Injury Visits	4,866	6,497	5,186	4,814	4,540	6,222	6,525	6,517	8,606	6,170	59,943
Counseling Visits	259	255	362	222	242	340	395	425	480	413	3,393
Misc Visits	0	0	0	0	0	0	0	0	0	0	0
Total Health Suite Visits	**18,142**	**20,599**	**17,255**	**15,355**	**15,295**	**22,043**	**21,253**	**20,343**	**25,962**	**15,788**	**192,035**

Children with Special Needs (Sharpe Health and Mamie D. Lee)

	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Total YTD
Cumulative Health Suite Visits	717	749	817	675	618	938	641	744	730	353	6,982
Injury Visits	133	126	120	116	84	136	105	116	129	91	1,156
Counseling Visits	21	25	22	17	16	17	30	24	33	19	224
Misc Visits	0	0	0	0	0	0	0	0	0	0	0
Sub-total Health Suite Visits	**871**	**900**	**959**	**808**	**718**	**1,091**	**776**	**884**	**892**	**463**	**8,362**

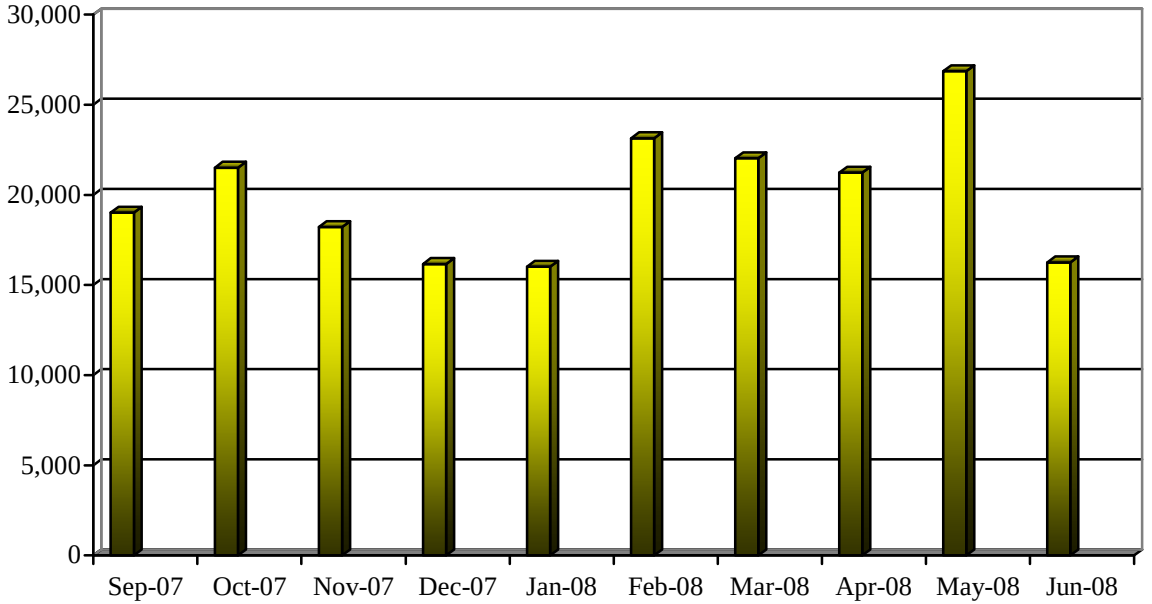
Total Health Suite Visits

	Sep-07	Oct-07	Nov-07	Dec-07	Jan-08	Feb-08	Mar-08	Apr-08	May-08	Jun-08	Total YTD
DCPS & PCS	18,142	20,599	17,255	15,355	15,295	22,043	21,253	20,343	25,962	15,788	192,035
Children with Special Needs*	871	900	959	808	718	1,091	776	884	892	463	8,362
Total Health Suite Visits	**19,013**	**21,499**	**18,214**	**16,163**	**16,013**	**23,134**	**22,029**	**21,227**	**26,854**	**16,251**	**200,397**

* Children with Special Needs include data from the following special needs designated schools: Ward 4: Sharpe Health; Ward 5: Hamilton, Mamie D. Lee, MM Washington and Taft Center; Ward 6: Prospect Learning Center.

Source: D.C. Department of Health, Community Health Administration

Figure 6.17. Number of Health Suite Visits by Month



Source: D.C. Department of Health, Community Health Administration

The number of health-related visits in School Year 2007-2008 ranged from 16,013 provided in January 2008, to 26,851 provided in May 2008, averaging 20,039 per month. Health suite services accounted for the majority (68 percent) of visits; visits due to injury accounted for about one-third (30 percent) of the total; and the remainder (two percent) were counseling visits.

Table 6.9. Children's School Services
SY 2007 – 2008
Performance Measures

Health Suite Activity	SEP 2007	OCT 2007	NOV 2007	DEC 2007	JAN 2008	FEB 2008	MAR 2008	APR 2008	MAY 2008	JUN 2008	Total
Total Visits	19,013	21,499	18,214	16,163	16,013	23,134	22,029	21,227	26,854	16,251	200,397
# of Children	14,050	10,214	6,801	5,586	4,754	6,078	6,135	5,413	6,524	3,749	69,304
DC Public Schools											
Total number of visits in health suite	14,561	15,784	14,027	12,476	12,665	18,294	16,756	16,796	20,280	12,917	154,556
Elementary	9,292	11,442	10,114	9,228	9,505	13,545	12,714	12,828	15,478	10,420	114,566
Secondary	5,269	4,342	3,913	3,248	3,160	4,749	4,042	3,968	4,802	2,497	39,990
Children with Special Health Care Needs (CSHCN)											
Total number of children seen in the health suite	871	900	959	808	718	1,091	776	884	892	463	8,362
Total Visits	871	900	959	808	718	1091	776	884	892	463	8362
Public Charter Schools											
Total number of children seen in the health suite	3,581	4,815	3,228	2,879	2,630	3,749	4,497	3,547	5,682	2,871	37,479
Total Visits	3581	4815	3228	2879	2630	3749	4497	3547	5682	2871	37479
Elementary	1,203	1,532	1,176	1,037	878	1,472	1,798	1,631	2,541	1,369	14,637
Secondary	2,378	3,283	2,052	1,842	1,752	2,277	2,699	1,916	3,141	1,502	22,842

Source: D.C. Department o Health, Community Health Administration, Children's School Health Nursing Program

In School Year 2007 – 2008, 69,304 children visited health suites, including students of DC Public Schools and Public Charter Schools, and Children with Special Health Care Needs (CSHCN). During the school year, 200,397 visits to a health suite occurred. Students averaged nearly three visits (2.89) during the school year. DC Public Schools represented 77.1 percent of the overall health suite visits, with 84.1 percent of these occurring in elementary schools and the remaining 25.9 percent in secondary schools. Public Charter Schools represented 18.7 percent of the visits, with 39.1 percent of these occurring in elementary schools and 60.9 percent in secondary schools. Special needs children accounted for 4.2 percent of all visits in the school year.

Table 6.10. Children's School Services
Hearing Screening SY 2007 – 2008

Ward	# Tested 1st Screen	# Passed 1st Screen	# Failed 1st Screen	# Tested 2nd Screen	# Passed 2nd Screen	# Failed 2nd Screen	No Test	Unknown
1	1,764	1,722	42	42	25	17	0	0
2	1,277	1,251	26	9	8	1	0	17
3	1,823	1,791	32	21	10	11	0	0
4	2,721	2,659	62	62	29	33	0	0
5	2,133	2,082	51	44	22	22	0	7
6	2,356	2,330	26	11	7	4	0	15
7	2,122	2,089	33	29	14	15	4	0
8	1,829	209	45	38	4	34	7	1,575
DC Public Schools	16,025	14,133	317	256	119	137	11	1,614
Public Charter Schools	3,765	3,694	71	71	27	44	0	0
CSHCN	426	406	20	20	5	15	0	0
Total	**20,216**	**18,233**	**408**	**347**	**151**	**196**	**11**	**1,614**

Source: D.C. Department of Health, Community Health Administration

In the District of Columbia, hearing screenings are conducted on children enrolled in Kindergarten, 1st, 2nd, 4th and 6th grades attending DC Public Schools (DCPS) (79.3 percent), Public Charter Schools (PCS) (18.6 percent), or for Children with Special Health Care Needs (CSHCN) (2.1 percent). Of this group, nearly nine out of ten children (89.3 percent) passed an initial hearing screening in School Year 2007-2008. Of the 408 children not passing the first screening, 85.0 percent were screened again. CSHCN (4.2 percent) are more likely to fail an initial screening, compared to DCPS (2.0 percent) and PCS students (1.9 percent).

Table 6.11. Cumulative Vision Screening Report SY 2007 - 2008												
	DC Public Schools									Public Charter Schools	CSHCN	Total
	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5A	Ward 5B	Ward 6	Ward 7	Ward 8			
Enrollment	822	619	765	488	785	602	976	432	503	2372	609	8,973
I. INITIAL SCREENING												
Total Screened	422	515	617	383	615	152	894	307	436	1896	423	6,660
# Screened without glasses	350	446	516	318	523	146	847	285	423	1575	383	5812
1. Passed	298	365	389	259	455	132	744	273	352	1332	313	4912
2. Failed	52	81	127	59	68	14	103	12	71	243	70	900
# Screened with Glasses	72	69	101	65	92	6	47	22	13	321	40	848
1. Passed	64	52	91	52	84	6	45	22	11	268	28	723
2. Failed	8	17	10	13	8	0	2	0	2	53	12	125
Total Failures	60	98	137	72	76	14	105	12	73	296	82	1,025
II. RE-SCREENINGS												
A. # Re-screened by Nurse	60	94	137	60	73	13	105	12	66	273	82	975
B. # Failed by Nurse	56	81	132	51	63	13	83	10	50	265	80	884
III. REFERRAL STATUS												
Not Referred (Under care/Previous corrected)	0	0	0	4	10	0	3	6	0	32	22	77
Referred	56	81	132	47	63	13	80	4	50	233	58	817
1. Failed This Year	22	64	132	37	50	13	36	5	14	208	24	605
2. Failed in Previous Year	34	17	0	10	13	0	44	4	36	25	34	217
IV. FOLLOW-UP STATUS												
# Under medical care	39	57	75	18	46	5	25	3	14	73	36	391
Glasses - recommended by doctor	0	1	37	0	1	0	0	0	0	2	4	45
Myopia	0	0	19	0	1	0	0	0	0	1	4	25
Astigmatism	0	0	16	0	0	0	0	0	0	1	0	17
Hyperopia	0	0	1	0	0	0	0	0	0	0	0	1
Amblyopia	0	0	1	0	0	0	0	0	0	0	0	1
Other (Specify)	0	1	0	0	0	0	0	0	0	0	0	1

(Cont…)

Glasses not recommended by doctor	35	40	34	13	44	5	24	3	14	62	32	306
Other Rx	0	0	0	0	0	0	0	0	0	4	0	4
Neg. (No Rx recommended)	4	16	4	5	1	0	1	0	0	5	0	36
# Not under medical care	17	11	49	22	14	7	37	0	34	20	15	226
Future appointment	0	12	8	2	2	0	11	0	1	125	2	163
Transferred out of DCPS	0	1	0	4	1	1	6	1	1	15	2	32
Transferred within DCPS	0	0	0	1	0	0	1	0	0	0	2	4

Source: D.C. Department of Health, Community Health Administration

Overall, approximately three-quarters (74.2 percent) of children enrolled in grades pre-K, K, 1, 2, 6, 8 and 10 in DCPS, PCS , and CSHCN, received preliminary vision screening in School Year 2007-2008. Screening levels were similar for each group: DCPS: 72.4 percent; PCS: 79.9 percent; CSHCN: 79.9 percent. Re-screening of students not passing the initial vision test was successful: Overall: 95.1 percent; DCPS: 95.8 percent; PCS: 92.2 percent; CSHCN: 100 percent.

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

Funded and administered by the United States Department of Agriculture, the mission of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is to improve the lifelong health and nutrition of pregnant women, new mothers (breastfeeding and non-breastfeeding), infants and children by providing nutrition education, nutrient-rich supplemental food, health and social service referrals and immunization screening for children less than two years of age. Comprehensive revisions to the WIC food packages, including adding fresh produce, will be made before October 2009.

WIC offers a nutritional prescription designed to provide adequate levels of nutrients essential to prenatal and infant health, proper growth and development, nutrition education, breastfeeding promotion and support, vouchers for nutritious food, and health and social service referrals to low-income pregnant women, new mothers (breastfeeding and non-breastfeeding), infants, and children up to age 5 who are at nutritional risk. Research shows that the WIC program saves $4.21 million in health care costs and improves the lifelong health and nutrition of WIC participants. DC WIC currently serves approximately 17,500 customers monthly at 24 clinics and two mobile unit sites.

Table 6.12. WIC Average Monthly Enrollment				
Year	**Women**	**Infants**	**Children**	**Total**
1999	4,378	4,512	10,289	**19,179**
2000	4,356	4,351	9,372	**18,079**
2001	4,341	4,380	9,216	**17,937**
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	4,789	7,998	**17,576**
2007	4,845	5,310	7,034	**17,189**
2008	5,128	5,645	7,728	**18,501**
2009*	5,131	5,706	8,612	**19,449**
* 2009 YTD Figures				

Source: D.C. Department of Health, Community Health Administration

Vital Statistics – Births

In 2006, there were 8,522 births in the District. This figure represents a 7.7 percent increase in births from 1997 and a 7.3 percent increase compared with 2005. The general fertility rate, a measure of fertility based on the number of women of child-bearing age, increased from 52.8 in 2002 to 58.4 in 2006. In 2006, births to women under 20 years of age accounted for 12.0 percent of all births, compared to 11.0 percent of all births in 2005. The proportion of births to single mothers increased from 56.0 percent in 2005 to 57.6 percent in 2006. The percent of infants weighing less than 2,500 grams decreased from 11.2 percent in 2005 to 11.6 percent in 2006. The infant mortality rate in 2006 was 11.3 deaths per 1,000 live births. This rate represents a 16.9 percent decrease from 2005.

Table 6.13. Annual Live Births And Infant Deaths

(*Calendar Year*)	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Live Births	7,916	7,678	7,513	7,666	7,621	7,494	7,616	7,937	7,940	8,522
Married Women	2,874	2,849	2,872	3,043	3,248	3,261	3,523	3,495	3,492	3,613
Single Women	5,042	4,829	4,641	4,623	4,373	4,233	4,093	4,442	4,448	4,908
Total	7,916	7,678	7,513	7,666	7,621	7,494	7,616	7,937	7,940	8,522
Percent to Women										
Under 20 Years	15.7	15.3	14.8	14.2	13.3	12.8	11.4	11.2	11.0	12.0
Percent Low										
Birth weight Infants	13.5	13.2	13.3	11.9	12.2	11.6	11.0	11.1	11.2	11.6
Infant Deaths	104	96	113	91	81	86	78	94	108	96
Infant Death Rate										
Per 1,000 Live Births	13.1	12.5	15	11.9	10.6	11.5	10.2	11.8	13.6	11.3

Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics

Vital Statistics – Termination of Pregnancies

Abortions performed in the District are reported to DOH on a voluntary basis by hospitals and free-standing clinics. 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 five years, the number of reported abortions averaged 2,109 per year. The number and rate of reported abortions for District residents decreased 36.8

percent and 37.3 percent, respectively, between 2005 and 2006. Of the 1,697 abortions reported in 2006, 12.6 percent were performed on women under the age of 20. Fifty-nine percent of the procedures were performed on women in their twenties, while 25.2 percent were performed on women in their thirties, and 3.0 percent on women in their forties. The rate of abortions in 2006 was 11.6 per 1,000 women between the ages of 15 and 44. 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.

Table 6.14 Number and Rate* of Abortions Reported Performed On District Residents

(*Calendar Year*)	**2002**		**2003**		**2004**		**2005**		**2006**	
	Number	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Under 15 years**	19	1.2	13	0.9	33	2.2	27	1.7	9	0.6
15-19 years	438	32.3	437	34	151	11.7	444	21.9	204	9.9
20-24 years	868	29.5	844	30.8	373	15	830	30.5	504	18
25-29 years	665	22.6	635	20.7	267	8.4	679	22.7	498	16.6
30-34 years	373	14.1	304	11.7	174	6.7	407	16.3	269	10.9
35-39 years	166	7.5	149	7	103	4.9	219	9.9	158	7.1
40 years and older**	61	2.9	59	2.9	26	1.3	80	3.9	51	2.5
Not Reported	2	-	1	-	0	-	0	-	4	-
Total****	2,592	18.3	2,442	17.7	1,127	8.3	2,686	18.5	1,697	11.6

* These are the rates per thousand women aged 15-44 years, using the Bureau of the Census July 2002-2006 population estimates. 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: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics

Vital Statistics – Deaths

In 2006, there were 5,289 District resident deaths recorded. Total District resident deaths have decreased in each of the past five years. In 2006, deaths decreased by 8.5 percent from 2002. When examined by race and gender, the trends show a 15.4 percent decrease among black and other non-white males in contrast to an increase of 13.2 percent increase for white males from 2002 to 2006. For black and other non-white females, total deaths decreased 8.3 percent compared with a negligible decrease of less than one percent (0.4) among white females during this same five-year period.

The number of deaths among black and other non-white males in 2006 was disproportionate to their numbers in the population. This group accounted for 39.0 percent of all deaths of residents, yet accounted for only 25.4 percent of the District's population.

Table 6.15. Deaths by Race and Gender in the District of Columbia						
Calendar Years	2002	2003	2004	2005	2006	2006 (Percent)
Black & Other Non-White Races						
Male	2,435	2,270	2,160	2,159	2,061	39.0
Female	2,243	2,144	2,104	2,124	2,056	38.9
Subtotal	4,678	4,114	4,264	4,283	4,117	77.9
White						
Male	552	537	559	643	625	11.8
Female	549	527	536	550	547	10.3
Subtotal	1,101	1,064	1,095	1,193	1,172	22.1
Total	5,779	5,478	5,359	5,476	5,289	100
Source: D.C. Department of Health, Center for Policy, Planning and Epidemiology/State Center for Health Statistics. Census Bureau Population Division, 2006 population estimate by race and gender (Table 3, SC-EST2008-03-11). Release date: May 14, 2009.						

Vital Statistics – Leading Causes of Death

The leading cause of death in the District of Columbia and in the nation in 2006 was heart disease. The age-adjusted death rate from heart disease increased by 10 percent from 2002 and 2006; however, from 2002 to 2004 the trend was moving downwards but began to increase in 2005 and continued in 2006. While the death rate due to heart disease has increased in the District, the age-adjusted death rate for the country has decreased by 16.9 percent. The second highest cause of death is cancer, which has decreased by 10.3 percent in the District between 2002 and 2006. As of 2006, in the District, Accidents and HIV/AIDS were the third and fourth causes of death, while they were ranked 5th and 18th in the United States, respectively. From 2002 to 2006, the rate of deaths due to Accidents increased by 8.1 percent in the District, which made the District's Accidents' death rate comparable to the national level. Deaths due to HIV/AIDS have remained almost constant and the rates for 2002 and 2006 are almost identical. During this five-year period, the death rate due to homicide (assault) has significantly decreased by 31.5 percent in the District; however, the District's homicide (assault) death rate was almost four times higher than the national rate. The District's mortality rates for six of the 10 leading causes of death were higher than the national rates: accidents, cerebrovascular diseases (which lead to stroke), chronic lower respiratory diseases, and Alzheimer's disease were the four categories where the death rates were lower in the District than in the nation.

Chronic diseases, including heart disease, cerebrovascular disease (which lead to stroke), cancer, diabetes, and chronic lower respiratory diseases, account for 61 percent of all deaths in the District in 2006. Today, HIV/AIDS is the only remaining infectious disease accounting for significant percentage of deaths in the District.

Table 6.16. Leading Causes of Death in the District of Columbia Age-Adjusted Rate Per 100,000 Population							
DC Rank[1]	**Cause of Death**	**2002**	**2003**	**2004**	**2005**	**2006**	**% Change 2002-2006**
1	Heart Disease	251.5	249.4	239.8	258.1	276.7	10.0
2	Malignant Neoplasms (Cancer)	228.8	196.6	205.3	197.1	205.2	-10.3
3	Accidents	35.8	37.5	38.4	34.6	38.7	8.1
4	HIV/AIDS	38.4	40.7	39.7	35.9	37.7	-1.8
5	Cerebrovascular Diseases	41.4	38.4	35.8	39.2	38.5	-7.0
6	Diabetes	31.4	27.6	34.1	32.9	31.9	1.6
7	Homicide/Assault	34.6	30.5	31.1	28.4	23.7	-31.5
8	Chronic Lower Respiratory Diseases	23.9	22.8	26.6	23.2	22.3	-6.7
9	Alzheimer's Disease	15.2	12.3	18.7	18.5	20.3	33.6
10	Septicemia	*	*	*	22.0	18.9	*

[1]Rank based on number of District of Columbia resident deaths in 2006. *Figure does not meet standards of reliability or precision (number of deaths fewer than 20).
Source: D.C. Department of Health, Center for Policy, Planning, and Epidemiology, State Center for Health Statistics.

Leading Causes of Death in the United States Age-Adjusted Rate Per 100,000 Population							
US Rank	**Cause of Death**	**2002**	**2003**	**2004**	**2005**	**2006**	**% Change 2002-2006**
1	Heart Disease	240.8	232.3	217.0	211.1	200.2	-16.9
2	Malignant Neoplasms (Cancer)	193.5	190.1	185.8	183.8	180.7	-6.6
3	Cerebrovascular Diseases	56.2	53.5	50.0	46.6	43.6	-22.4
4	Chronic Lower Respiratory Diseases	43.5	43.3	41.1	43.2	40.5	-6.9
5	Accidents	36.9	37.3	37.7	39.1	39.8	7.9
6	Diabetes	25.4	25.3	24.5	24.6	23.3	-8.3
7	Alzheimer's Disease	20.2	21.4	21.8	22.9	22.6	11.9
8	Influenza and Pneumonia	22.6	22.0	19.8	20.3	17.8	-21.2
9	Nephritis, Nephritic Syndrome and Nephrosis	14.2	14.4	14.2	14.3	14.5	2.1
10	Septicemia	11.7	11.6	11.2	11.2	11.0	-6.0

[1] Rank based on number of deaths in the United States in 2006.
Source: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics.

Human Immunodeficiency Virus (HIV) /Acquired Immunodeficiency Syndrome (AIDS) – Epidemiology

The District established the HIV/AIDS Administration (formerly the Office of AIDS Activities) in 1986, later incorporated within the DOH. Adult Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) programs were incorporated into this office in 2007. 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 living 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 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. HAHSTA is comprised of the Office of the Senior Deputy Director and eight Bureaus: Administrative Services; Prevention and Intervention Services (including Adult Hepatitis); Care, Housing and Support Services (including the AIDS Drug Assistance Program and Housing assistance); Strategic Information; Partnerships, Capacity Building and Community Outreach; Grants Management and Fiscal Control; STD Control and TB Control.

The *District of Columbia HIV/AIDS Epidemiology Update 2008* provided the most current statistics on the District's modern HIV/AIDS epidemic. Overall, 3 percent of all District residents are currently known to be living with HIV/AIDS. To put that in context, the U.S. Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) have historically defined an HIV epidemic as generalize severe when the overall percentage of disease among a population exceeds 1 percent. The numbers, however, reflect only the persons diagnosed with HIV/AIDS in the District. Other targeted studies show between one-third and one-half of residents who are already HIV-infected may be unaware of their infection. The true number of residents currently infected and living with HIV is certainly higher. In the District, nearly every population group, age and ward is experiencing a substantial epidemic. In 2007, 15,120 District residents are living with HIV/AIDS. Of all persons living with HIV/AIDS, men who have sex with men is the leading mode of transmission, followed by heterosexual contact and injection drug use. However, among new HIV cases, heterosexual contact is the leading mode of transmission. Over 70% of living HIV/AIDS cases are currently 40 or older. This number represents the combination of both people who are aging with HIV as well as those who are newly infected at older ages. In fact, we see nearly as many new diagnoses among persons who are 50 years old and older as among those who are under 30 years old. The number of new AIDS cases each year is decreasing substantially, likely due to earlier diagnosis and the availability and use of antiretroviral medications that can prevent and reverse progression of disease.

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Table 6.17. D.C. Newly Reported Aids Cases by Gender, Race/Ethnicity, Exposure and Vital Status by Year of Diagnosis and Reported through December 31, 2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1979-2007
GENDER											
Adult Male	657	494	452	457	718	623	561	444	474	453	14,133
Adult Female	269	179	208	213	297	254	249	217	220	195	4,019
Pediatric	7	4	1	3	3	4	1	0	0	0	181
Total	933	677	661	673	1,018	881	811	661	694	648	18,333
RACE/ETHNICITY											
White	102	81	63	57	81	80	56	56	62	55	3,183
Black	788	564	560	584	900	765	724	557	603	551	4,445
Hispanic	40	27	31	30	32	27	25	43	25	35	613
Other	3	5	5	2	5	9	3	5	4	7	1,984
Undisclosed/Unknown	0	0	2	0	0	0	3	0	0	0	8
Total	933	677	661	673	1,018	881	811	661	694	648	18,333
	1998	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**1979-2007**
MODE OF EXPOSURE											
Men having Sex with Men (MSM)	326	244	195	190	309	252	169	163	202	217	7,913
Injection Drug User (IDU) & MSM	25	16	14	23	20	17	24	23	29	21	852
Male IDU	173	100	99	74	114	97	120	113	71	70	2,919
Female IDU	117	53	62	59	79	67	74	72	64	47	1,679
Male Heterosexual Contact	74	69	66	65	111	110	106	84	112	73	1,321
Female Heterosexual Contact	114	98	99	86	151	113	100	116	135	110	1,746
Perinatal (Mother-to-Child)	7	5	0	3	3	3	1	0	0	0	176
Undisclosed/Unknown/Other	97	92	126	173	231	222	217	90	81	110	1,727
Total	933	677	661	673	1,018	881	811	661	694	648	18,333
VITAL STATUS											
Reported Deaths	272	248	216	199	158	129	92	294	224	*	*

*Data not available.

Source: D.C. Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration.

Counseling and Testing

HAHSTA supports community-based medical and outreach providers to conduct HIV testing, counseling and referral services. HAHSTA also provides oral rapid test kits to community partners. The District's HIV testing programs have greatly increased early diagnosis among residents and reduced the number of babies born with HIV. In 2005, ten babies were born with HIV. By 2007, only one baby was born with the infection. In 2008, there was a 70-percent increase in the number of people tested with publicly supported testing, from 40,000 in 2007 to over 70,000. The District was recognized by the U.S. Centers for Disease Control and Prevention (CDC) as one of the top three jurisdictions in the country in expanding HIV testing. DC nearly equaled New York City and the entire state of Florida in absolute numbers of persons tested and new HIV cases identified. DC is the first jurisdiction in the country to establish a policy of annual routine HIV screening in medical settings for residents ages 14 to 84 through an "opt-out" approach. Preliminary results from just the first 18 months of expanded testing suggest that this strategy has been successful in getting more people diagnosed with HIV while still healthy. CD4 counts are a measure of immune status—higher CD4 counts indicate that individuals are generally healthier and have not yet progressed to AIDS. A CD4 count below 200 is an AIDS diagnosis. In just the first 18 months of expanded HIV testing, the median first CD4 count had risen to 332, a 50-percent increase in CD4 counts since 2005. The District has also instituted a national model of routine voluntary screening for entering offenders into the DC Jail. The Mayor and City Council enacted a new groundbreaking law to require private and public insurance reimbursement to hospitals for routine HIV testing in emergency departments. HAA is now working with the District's major primary care providers to fully implement routine opt-out HIV as a standard of health care in the city.

Table 6.18. D. C. HIV Tests by Gender, Ethnicity, Location Tested and Positive Status Reported for the Years 1999-2007

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
TOTAL TESTS COMPLETED	15,630	16,842	18,706	18,555	17,355	19,766	24,352	34,876	43,271	72,864
TOTAL POSITIVE HIV TESTS	287	257	279	318	278	373	522	480	450	939
GENDER										
Male	10,189	10,626	12,053	12,145	11,140	12,331	14,145	21,077	26,735	41,134
Female	5,396	6,140	6,484	6,056	5,765	7,218	10,119	13,522	16,279	30,647
Transgender	*	*	*	*	*	*	*	*	*	1,083
Not Specified	45	76	169	354	450	217	88	277	257	*
Total	15,630	16,842	18,706	18,555	17,355	19,766	24,352	34,876	43,271	72,864
RACE/ETHNICITY										
White	3296	3,715	3,781	3,482	3,080	2,895	3,064	5,625	5,738	14,051
Black	10,409	10,779	12,064	11,738	10,440	13,618	18,100	28,469	36,562	55,177
American Indian/Native Amer.	0	0	0	0	0	0	0	0	0	0
Asian	0	0	0	0	0	0	0	247	307	1,133
Native Hawaiian/Pacific Islander	0	0	0	0	0	0	0	0	0	0
Multi-Race	0	0	0	0	0	0	0	186	202	646
Hispanic	1,403	1,664	2,082	2,432	2,800	2,392	2,347	1,889	2,344	4,504
TOTAL TESTED BY SITE										
STD Clinic	6,249	4,954	5,035	5,435	4,496	3,114	3,449	3,250	2,951	5,441
HIV CTS	4,311	6,657	6,589	5,947	5,959	6,265	6,412	10,005	7,517	17,192
CHC/PHC	1,840	1,650	1,711	2,167	2,185	2,151	5,251	8,794	10,080	35,352
Drug Treatment	1,120	639	1,254	1,166	938	1,478	1,166	814	740	135
Prison/Jail	1,369	1,486	1,287	1,483	861	2,222	2,832	9,667	9,761	7,634
Family Panning Clinic	0	0	0	0	0	0	0	0	0	0
Tuberculosis Clinic	0	0	0	0	0	0	0	36	31	168

Source: D.C. Department of Health, HIV/AIDS, Hepatitis, STD, and TB Administration.

Office of the Chief Medical Examiner (OCME)

OCME was established as a Medical Examiner's system from a Coroner system in 1971. At that time, the office had a single program, which was Death Investigation and Certification. OCME has grown into a cabinet-level agency that serves under the administrative authority of the Deputy Mayor for Public Safety and Justice. OCME's primary mission is to investigate all known or suspected homicides, suicides, accidents, drug-related and medically unattended deaths, all deaths in at-risk populations (e.g. children and intellectually and developmentally challenged individuals), deaths of those in custody and/or wards of the District of Columbia, as well as those deaths considered to be a threat to public health and safety. The agency has three programs: Death Investigations and Certifications, Agency Management and Fatality Review.

During the Calendar Year (CY) 2007, 3,049 cases were reported to and investigated by the Office of the Chief Medical Examiner (OCME). 1,477 of the cases were declined by OCME, 1,458 cases were accepted for further investigation and 117 were storage requests. Among the storage requests, nine were declined and 108 were accepted and approved as storage cases(of these, threebecame Medical Examiner cases). Of the cases accepted for further investigation, 949 were autopsied. OCME also had a total of 2,396 cremation requests submitted for approval.

Table 6.19. 2007 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examination	External Examinations	Medical Record Reviews	Total	Toxicology Findings Drugs were Present
Accident	204	5	112	3	324	139
Homicide	200	0	0	0	200	104
Natural	370	74	370	7	821	157
Other	0	0	1	0	1	
Stillbirth	6	0	4	1	11	3
Suicide	44	0	2	0	46	31
Undetermined	46	0	2	0	48	15
Total	870	79	491	11	1451	449

Note: This table does not include data for *"Non-Human Remains"* (7).

Toxicology Laboratory

Depending on the specimens received and the degree of decomposition, routine toxicological testing includes analysis for alcohols (ethanol and other volatiles), an initial screen for major classes of illicit and prescription medications, and an additional screen for various illicit, prescription and "over-the-counter" medications. All drugs of significance are then confirmed by further testing. Typically, specimens received include blood, urine, bile, vitreous, liver, brain and gastric content.

Toxicology Findings

Overall, drugs were present in 104 of the homicides investigated, 31 suicides, 139 accidents, 157 natural deaths, 15 undetermined cases and 3 still births. In the 13 traffic deaths that tested positive for ethanol, the average Blood Alcohol Concentration was 0.16 percent (range 0.02 – 0.33 percent). The legal limit for Blood Alcohol Concentration on the District of Columbia is 0.08 percent while driving.

Table 6.20. Role of Decedent in Traffic Accident Deaths: 2007	
Role	**Traffic Deaths**
Driver	27
Pedestrian	31
Passenger	11
Motorcycle Rider	5
Role Unknown	3
Total	**77**
Source: Office of the Chief Medical Examiner	

Table 6.21. Traffic Deaths by Gender		
Gender	**Number of Traffic Deaths**	**% of Traffic Deaths**
Male	54	70%
Female	23	30%
Total	**77**	**100%**
Source: Office of the Chief Medical Examiner		

Table 6.22. Traffic Deaths by Month		
Month	**Number of Traffic Deaths**	**% of Traffic Deaths**
January	4	5%
February	14	18%
March	9	12%
April	5	6%
May	2	3%
June	6	8%
July	8	10%
August	10	13%
September	3	4%
October	6	8%
November	5	6%
December	5	6%
Total	**77**	**100%**
Source: Office of the Chief Medical Examiner		

Table 6.23. Traffic Deaths by Age		
Age	**Number of Traffic Deaths**	**% of Traffic Deaths**
1 to 5	3	4%
6 to 12	3	4%
13 to 15	3	4%
16 to 19	2	3%
20 to 29	16	21%
30 to 39	12	16%
40 to 49	10	13%
50 to 59	11	14%
60 to 69	3	4%
70 to 79	9	12%
80 to 89	5	6%
Total	**77**	**100%**
Source: Office of the Chief Medical Examiner		

Note: There were no traffic deaths for decedents under one year old or over 89 years old.

Fatality Review Unit Programs

The Fatality Review Unit was established under the auspices of OCME in October of 2005 as a means of centralizing all District-based fatality review functions. The purpose of the fatality review process is to conduct retrospective reviews of deaths of specific populations as identified by DC law and/ or Mayor's Order to reduce the number of preventable deaths and/or to improve the quality of life for DC residents. Each death review process is intended to assist in identifying systemic and community strengths, as well as improvements needed in service delivery systems in order to better address the needs of the residents of the District. It is an opportunity for self-evaluation through a multi-agency and multi-disciplinary approach. This process provides a wealth of information regarding ways to enhance services and systems.

Considering that each fatality review process is similar in purpose, goals, objectives and basic operating processes, the centralization of the fatality review office will create a congruent and collaborative operating structure while maintaining the unique features of the individual components. The objectives of the fatality review process are as follows:

- dentify trends and patterns related to the deaths of specific populations through collecting, reviewing and analyzing standardized data and to use such information to improve understanding of the causes and factors that may contribute to the fatalities
- work to ensure that all systems, both public and private, which are responsible for serving, assisting and protecting District residents, are effective, efficient and accountable
- improve and optimize systemic responses to violence/abuse/neglect of vulnerable populations by evaluating existing statues, policies and procedures
- recommend appropriate modifications to existing systems and develop new mechanisms to reduce the incidence of unexpected and preventable fatalities
- encourage inter and intra-agency and interdisciplinary education, communications, coordination and collaboration in the prevention of fatalities

Currently there are three fatality review processes that operate within the FRU: the Child Fatality Review Committee (CFRC); Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC); and the Domestic Violence Fatality Review Board (DVFRB).

Table 6.24. Decedent Demographic Data Decedent's Age and Gender – DC OCME Population *(CFRC)*		
Age/Gender	**Subtotal**	**Total Deaths**
Under 1 Year		**14**
Female	10	
Male	4	
1 thru 4 Years		**6**
Female	4	
Male	2	
5 thru 10 Years		**6**
Female	3	
Male	3	
11 thru 14 Years		**2**
Female	0	
Male	2	
15 thru 20 Years		**27**
Female	6	
Male	21	
Over 20		**4**
Female	0	
Male	4	

Table 6.25. Manner of Death – DC OCME Population *(CFRC)*		
Manner	**Number**	**% of Total**
Homicide	32	54%
Natural	9	15%
Accident	8	14%
Undetermined	9	15%
Suicide	1	2%

Table 6.26. Race of Decedents – DC OCME Population *(CFRC)*		
Race	**Number**	**% of Total**
Black	55	93%
White	1	2%
Hispanic	3	5%
Asian	0	0
Other	0	0

Table 6.27. Ward of Residence – DC OCME Populations *(CFRC)*	
Ward of Residence	**Number**
Ward One	4
Ward Two	3
Ward Three	1
Ward Four	4
Ward Five	9
Ward Six	8
Ward Seven	15
Ward Eight	14
Maryland	1

Table 6.28. Accidents *(CFRC)*		
Cause	**Subtotal**	**Total**
Motor Vehicle/ Subway		**4**
Pedestrian	2	
Passenger	1	
Drier (1 motorbike)	1	
Smoke Inhalation/ Asphyxia		**1**
Asphyxia (Choking)		**2**
Electrocution		**1**

Table 6.29. Natural Deaths *(CFRC)*	
Cause	**Number**
Complication of Pregnancy	1
Infectious Disease	3
Respiratory	1
Cardiovascular	2
Central Nervous System	1
Gastrointestinal	1

Table 6.30. Undetermined Deaths *(CFRC)*	
Cause	**Number**
Sudden Unexplained Death in Infancy	8
Undetermined	1

Table 6.31. – Status of Deaths Identified and Reviewed by Calendar Year *(MRDD FRC)*			
Year	**# Deaths Identified By Year**	**# Deaths Reviewed By Year**	**# Deaths Pending Review**
2007	30	21	9
2006	30	19	11
2005	34	24	10
2004	36	26	10
2003	31	23	8
2002	26	21	5
2001	32	32	0
Total	**219**	**166**	**53**

Table 6.32. Age and Gender by Year of Death (N=18 Cases Reviewed) *(MRDDA FRC)*				
	2006 Male	**(N = 16) Female**	**2007 Male**	**(N = 2) Female**
Under 41	**0**	**1**	**1**	**0**
41 – 50	**1**	**1**	**1**	**0**
51 – 60	**2**	**4**	**0**	**0**
61 & Over	**4**	**3**	**0**	**0**

Certificate of Need Process

As a means of ensuring the availability of high quality, accessible and affordable health care services, the District has a certificate of need program. Certificate of need is essentially a mechanism that requires both public and private providers of health services to receive approval to spend money 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 andmajor medical equipment costing $1.5 million or more for facilities and $250,000 or more for physician's offices.

Table 6.33. Certificate of Need Applications by Category
(2001-2008)

Calendar Year	*Applications*	*Facilities and Services*	*Replacement and Renovation*	*Major Medical Equipment*	*Change of Ownership*
2001	12	5	3	4	
2002	11	10	0	1	
2003	20	15	2	3	
2004	20	14	3	3	
2005	18	14	3	1	
2006	25	19	3	1	2
2007	29	19	2	3	5
2008	17	10	3	2	2

Source: D.C. Department of Health, Center for Policy, Planning & Epidemiology, State Health Planning & Development Agency

Health Regulations and Licensing Administration

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 and Radiation Services. HRLA enforces all District and federal laws and regulations governing licensures and regulation to ensure the protection of the health, safety and environment of residents of the District of Columbia who receive these services.

The Health Care Facilities Division (HCFD) is responsible for the licensure and certification of health care facilities to determine compliance with state and federal health and safety standards. The facilities that come under the purview of HCFD include nursing homes, hospitals, home health agencies, dialysis centers, ambulatory surgical centers, laboratories (communicable disease, tissue banks and CLIA), outpatient rehabilitation facilities, end stage renal disease centers, rehabilitation and psychiatric perspective units and District of Columbia Correctional facilities. HCFD conducts regular on-site surveys to ensure health, safety, sanitation, fire and quality of care requirements. HCFD identifies deficiencies that may affect state licensure or eligibility for federal reimbursements under the Medicare and Medicaid programs.

The Office of Professional Licensing administers all District and Federal laws and regulations governing the licensing, certification and registration of health care related professionals and provides administrative support to the health professional Boards and Advisory Committees that regulate the practice of their respective health professions.

Division of Medical Boards
The Division of Medical Boards is the entity responsible for the licensing and regulatory oversight of: post graduate physicians in training, acupuncturists, anesthesiologists, chiropractors, naturopathic physicians, surgical assistants, physician assistants and osteopathic physicians in the District of Columbia.

Division of Nursing Boards
The Division of Nursing Boards is the entity responsible for the licensing and regulatory oversight of: APRNs, LPNs, RNs, CNAs, Nursing Schools, Clinical Nurse Specialists, Nurse Staffing Agencies, TME, Certified Nurse Midwives and Certified Registered Nurse Anesthetics in the District of Columbia.

Division of Allied Health Boards
The Division of Nursing Boards is the entity responsible for the licensing and regulatory oversight of: Dentists, Massage Therapists, Nursing Home Administrators, Podiatrists, Dietetics, Dental Hygienists, Nutritionists, Respiratory Care, Naturopaths, Optometrists, Audiologists and Speech Pathologists in the District of Columbia.

Division of Behavioral Health Boards
The Division of Behavioral Health is the responsible entity for licensing and regulatory oversight of: addiction counselors, dance therapists, marriage and family therapists, occupational therapists, occupational therapist assistants, physical therapists, physical therapist assistants, professional counselors, psychologists and social workers in the District of Columbia.

Table 6.34. Nursing Facilities by Ward by Beds in the District of Columbia, 2008					
Ward	**Facility Name**	**SNF Beds**	**NF (Intermediate)**	**Dual Beds**	**Total Beds**
5	Carroll Manor Nursing & Rehabilitation Center	0	0	120	120
7	Grant Park Care Center	0	0	296	296
8	Hadley Hospital Skilled Nursing Units	0	0	62	62
8	Health Care Institute	0	0	183	183
3	Ingleside at Rock Creek	7	0	66	73
2	J.B. Johnson Nursing Center	0	205	25	230
5	Jeanne Jugan Residence	0	40	0	40
3	Knollwood – Health Services Center	0	0	69	69
3	Lisner Louise Home	0	0	60	60
3	Methodist Home	0	0	50	50
2	Rock Creek Manor	0	0	180	180
3	Sibley Memorial Hospital – The Renaissance Unit	0	0	45	45
6	Specialty Hospital of Washington Nursing Center	0	12	105	117
1	Stoddard Baptist Home	0	0	164	164
2	Sunrise at Thomas Circle	0	0	27	27
5	Washington Center for the Aging Services	0	0	259	259
6	Washington Home	33	0	155	188
8	Washington Nursing Facility	0	0	350	350
	Total:	**40**	**257**	**2,216**	**2,513**
Source: Health Regulation and Licensing Administration.					

Table 6.35.Long Term Care Beds in Operation			
2005	**2006**	**2007**	**2008**
3,114	3,036	3,025	2,513

Table 6.36. Ward Distribution of Long Term Care Beds		
Ward	**Number of Facilities**	**Number of Beds**
1	3	929
2	5	1,237
3	7	720
4	2	1,063
5	5	957
6	3	365
7	1	296
8	8	911

Table 6.37. Professional Licenses by Board and Type: District of Columbia FY 2006-08				
Board	**License Type**	**FY 2006**	**FY 2007**	**FY 2008**
Medicine	Medicine & Surgery	9,529	8,929	8,731
	Chiropractors	84	80	89
	Osteopathy & Surgery	139	130	157
	Physician Assistants	430	401	457
	Acupuncturists	181	150	167
	Anesthesiologist Assistants	7	9	16
	Naturopath Physicians	0	4	11
	Surgical Assistants	0	0	19
	Post Graduate Physician Trainees	1,169	1,181	875
Nursing	Registered Nurses	15,089	18,308	**17,978**
	Licensed Practical Nurses	3,260	2,812	**3,473**
	Certified Nurse Midwives	83	90	**84**
	Clinical Nurse Specialists	39	44	**48**
	Nurse Practitioners	825	933	**856**
	Registered Nurse Anesthesiologists	164	179	**156**
	Trained Medication Employees	144	230	**238**
Dance Therapy	Dance Therapists	3	4	2

(Cont…)

Dentistry	Dentists	1,318	1,413	1,340
	Dental Hygienists	403	444	476
Dieticians and Nutritionists	Dieticians	**279**	**198**	**246**
	Nutritionists	**46**	**28**	**44**
Marriage and Family Therapy	Licensed Marriage and Family Therapists	**14**	**19**	**42**
Massage Therapy	Massage Therapists	**685**	**653**	**792**
Naturopathy	Naturopaths	**700**	**747**	**713**
Nursing Home Administration	Nursing Home Administrators	**68**	**73**	**64**
Occupational Therapy	Occupational Therapists	486	418	489
	Occupational Therapist Assistants	15	13	18
Optometry	Optometrists	206	235	253
	Diagnostic Pharmacy Agents	119	145	160
	Therapeutic Pharmacy Agents	134	151	168
Pharmacy	Pharmacists	1,364	1,352	1,426
	Pharmacist Interns	7	8	7
Physical Therapy	Physical Therapists	958	782	898
Podiatry	Podiatrists	153	159	149
Professional Counseling	Licensed Professional Counselors	1,121	1,053	1,123
	Registered Addiction Counselors	514	454	513
Psychology	Psychologists	1,061	1,133	1,114
Recreation Therapy	Recreation Therapists	59	61	51
Respiratory Care	Respiratory Care Practitioners	715	775	840
Social Work	Graduate Social Workers	1,314	1,132	1,374
	Independent Clinical Social Workers	2,772	2,586	2,788
	Independent Social Workers	103	98	105
	Social Work Associates	131	153	227
Total		**45,891**	**47,767**	**48,779**
Source: Health Regulations and Licensing Administration				

Table 6.38. Hospital Beds Licensed in the District of Columbia											
Ward	Hospital Name	Medical Surgical	Intensive Coronary Care	Obstetrics / Gynecology	Pediatrics	Psychiatric	Substance Abuse	Neonatal	Rehab	Nursery	**Total**
1	Children's National Medical Center	0	36	0	177	26	0	44	0	0	**283**
2	George Washington University Hospital	218	48	37	0	20	0	12	16	20	**371**
2	Georgetown University Hospital	339	74	62	46	14	0	50	0	24	**609**
8	SHW/ Hadley Memorial Hospital	82	0	0	0	0	0	0	0	0	**82**
5	Hospital for Sick Children	0	0	0	130	0	0	0	0	0	**130**
1	Howard University Hospital	249	77	53	40	26	0	25	0	12	**482**
6	The Specialty Hospital of Washington	60	0	0	0	0	0	0	0	0	**60**
4	National Rehabilitation Hospital	0	0	0	9	0	0	0	128	0	**137**
5	Providence Hospital	257	17	48	0	29	31	9	0	17	**408**
3	Psychiatric Institute of Washington	0	0	0	0	104	0	0	0	0	**104**
3	Sibley Memorial Hospital	246	18	36	0	28	0	0	0	41	**369**
4	Washington Hospital Center	642	75	41	0	57	22	20	17	52	**926**
8	United Medical Center	95	16	15	0	34	0	0	0	24	**184**
8	SHW/Greater Southeast Holdings	50	0	0	0	0	0	0	0	0	**50**
	Total:	**2,238**	**361**	**292**	**402**	**338**	**53**	**160**	**161**	**190**	**4,195**
Source: Health Regulations and Licensing Administration											

Mental Health

The mission of the Department of Mental Health (DMH) is to support prevention, resiliency and recovery for District residents in need of public mental health services. To fulfill its mission, DMH offers a range of community-based services and operates Saint Elizabeths Hospital, the District's inpatient psychiatric facility.

Consumers in Department of Mental Health Programs

In FY 2008, more than 15,000 individuals received services from DMH, either through its government-operated mental health clinics or through community-based mental health providers. The majority of people who receive services are eligible for Supplemental Security Income or Medicaid or are uninsured. Table 6.39 describes individuals based on age, race and gender.

Table 6.39. Number of Individuals Receiving Services

FY 08		Race					
Age	**Sex**	**Black/African American**	**White**	**Hispanic**	**More than one race identified**	**Other**	**Total**
Under17	F	858	4	51	1	245	1,159
	M	1,125	5	54	1	464	1,649
	UKN	99	0	6	0	52	157
	Total	**2,082**	**9**	**111**	**2**	**761**	**2,965**
18-64	F	4,123	233	205	11	1,111	5,683
	M	3,721	288	133	6	1,111	5,259
	UKN	262	31	19	0	197	509
	Total	**8,106**	**552**	**357**	**17**	**2,419**	**11,451**
65+	F	175	56	7	1	114	353
	M	129	28	5	0	90	252
	UKN	8	0	0	0	5	13
	Total	**312**	**84**	**12**	**1**	**209**	**618**
Total		10,500	645	480	20	3,389	15,034

Source: Department of Mental Health

DMH is responsible for providing emergency assistance to adults and children experiencing a psychiatric or emotional crisis. The Comprehensive Emergency Psychiatric Program is a twenty-four hour/seven day a week operation that provides immediate psychiatric evaluation, treatment and stabilization, and eight extended observation beds if necessary. 3,621 individuals were admitted to emergency psychiatric services in FY 2008 as shown in Table 6.40.

As part of the Comprehensive Emergency Psychiatric Program, mobile crisis teams provide crisis intervention services for adults who are unable or unwilling to come to the facility. In addition to onsite crisis stabilization, including dispensing medication, the mobile crisis services teams perform assessment for voluntary and involuntary hospitalizations and linkages to other services, including ongoing mental health care and substance abuse detoxification and treatment. Mobile crisis services teams also provide support in the aftermath of individual or mass tragedies.

DMH also supports a mobile crisis service to provide rapid, on-the-scene response to children facing an emotional or mental health crisis. The mobile crisis service team will stabilize the child, help families manage the crisis, and in the case of foster parents, seek to avoid placement disruption. Along with mobile crisis services, crisis beds for youth ages six to 21 are available for up to 14 days as an alternative to a psychiatric inpatient hospitalization.

DMH in partnership with the DC Superior Court supports an urgent care clinic at Moultrie Courthouse to provide easy assess to persons who come in contact with the courts who may need mental health services.

Table 6.40. Number of Individuals who received Emergency Psychiatric Service

FY 08	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	317	260	247	305	318	302	335	283	306	332	308	308

Source: Department of Mental Health

ACCESS Helpline

DMH operates a twenty-four hour/seven day a week Access Helpline (1-888-793-4357) for emergency psychiatric care and to enroll in ongoing mental health services. A total of 18,843 individuals sought information or services through theAccess Helpline in FY 2008.

DMH administers a range of community-based services to support people with mental illness, including housing supports, homeless outreach services and supportive employment. In addition, DMH operates a mental health program in the District public schools. In FY 2008, DHM mental health counselors provided services in 48 District public schools, including 11 public charter schools.

Housing and Homeless Services

To help increase the supply of quality affordable housing available to people with mental illness, DMH operates a rental housing subsidy program. In addition, to support community integration and recovery, DMH supports community residential facilities and supportive independent living. In partnership with the Department of Housing and Community Development (DHCD), DMH is funding the creation and renovation of 300 units of housing by 2011 that are set aside for mental health consumers.

Table 6.41 shows the number of people who participated in the housing programs in FY 2008. The Supportive Housing Program includes services and support to help individuals get and maintain appropriate housing.

DMH supports the operation of 24-hour supervised residential facilities where about 700 consumers live. All of the facilities are licensed and monitored by DMH. Table 6.42 shows the number of community residential facilities by ward. In addition, DMH provides supportive services to about 400 individuals who live independently.

Table 6.41. Housing Services

FY 08	**Persons Housed**
Rental Subsidies	750
Federal Vouchers	354
Supported Independent Living	401
Community Residential Facilities	702
Totals	**2,207**
Source: Department of Mental Health	

Table 6.42. Number of Licensed Community Residential Facilities by Ward

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
FY 08 Community Residential Facilities	7	2	0	17	21	16	18	27

Source: Department of Mental Health

Table 6.43. Number of Supported Independent Living Facilities by Ward

	Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
FY 08 Supportive Independent Living Facilities	12	4	2	15	351	7	22	21

Source: Department of Mental Health

Homeless Services

The Homeless Outreach Program provides a wide variety of services to consumers with mental illness, providers and community members. The primary services provided include outreach and crisis services to individuals through regular visits to shelters, streets and homes in the District, and coordination with other outreach programs, social workers and community members to provide assessments, referrals, travelers assistance, brief intervention services and referrals to overnight shelter services. Table 6.44 shows the number of participants in the homeless services program.

Table 6.44. Number of Participants in Homeless Services in FY 08

Programs	Homeless Outreach	Hermano Pedro Drop In Center	Psychiatry Residency Training	Sobering Station	Franklin Shelter Outreach
Unduplicated Count	1317	397	100*	186	191
Face to Face/Duplicated	2664	1319	720*	381	2483

*This represents an unduplicated count of the number of individual seen each week.
Source: Department of Mental Health

Supportive Employment

The Supported Employment Program offers job opportunities for individuals who have been unable to secure or have lost competitive employment or have worked intermittently as a result of a significant mental health illness. Through this service, individuals receive assistance to help them gain the employment skills and abilities required for a part-time or full-time job in a competitive employment setting that pays at least the minimum wage. The supports and services received include ongoing work-based vocational assessments, job development, job placement, job coaching, crisis intervention, development of natural supports and follow-up for each consumer, including offering job options that are diverse and permanent. Table 6.45 shows the number of consumers who participated in the supportive employment program along with the average number of hours worked and average salary.

Table 6.45. Supported Employment Consumer Outcome Data

Supported Employment Program	Number of Consumers Enrolled in Service	Number of Consumers Placed in Competitive Employment	Average Number of Hours Worked Per Week	Average Hourly Wage
D.C. Community Service Agency	110	32	24.0	$8.00
Green Door, Inc.	118	70	25.5	$9.79
Anchor Mental Health	64	35	24.0	$9.42
Psychiatric Center Chartered	65	47	38.4	$9.55
Community Connections	50	25	23.0	$9.00
Pathways To Housing	41	4	17.0	$7.66
Deaf Reach, Inc.*	29	11	28.0	$9.00
Total:	**477**	**224**	**25.70**	**$8.92**

* Deaf Reach, Inc. provides services to individuals who are deaf with a mental illness
Source: Department of Mental Health

School Mental Health Program

The School Mental Health Program (SMHP) in the Department of Mental Health promotes social and emotional development and addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom based interventions, psycho-educational groups, consultation with parents and teachers andcrisis intervention, as well as individual, family and group treatment. During SY 2007-2008 SMHP serviced 48 DC Public Schools including 11 DC Public Charter Schools. Table 6.46 shows the number of participants receiving various services. Table 6.47 shows the number of participants in prevention and early intervention activities. Table 6.48 is a demographic chart of the participants.

Table 6.46. Utilization Data		
	SY 2006-2007	**SY 2007-2008**
	Total for All SMHP Schools N=42	**Total for All SMHP Schools N=48**
Student Referrals	1,017	1,173
Student Referrals Seen	753	968
Student Involved Outside Agency	78	58
Students on Clinical Caseload	577	592
Individual Therapy Sessions	5,691	5,106
Group Therapy Sessions	636	514
Family Therapy Sessions	358	442
Source: Department of Mental Health, School Mental Health SY07-08 Report		

Table 6.47. Prevention and Early Intervention Data	
	SY 2007-2008
Prevention Sessions	2,524
Walk-ins	3,366
Conflict Resolution Sessions	1,885
Classroom Observations	1,823
Parent Consultations	1,878
Teacher Consultations	3,834
Other Staff Consultations	3,691
Referrals Made for Outside MH Services	219
Presentations, Workshop, and Conferences	365
Source: Department of Mental Health, School Mental Health SY07-08 Report	

Table 6.48. Demographic Characteristics of the Sample of Students in Treatment SY 2007-2008

N=458	Number	Percent
Grade Level of Student		
PK-2nd Grade	84	18.7%
Grades 3-4	67	14.9%
Grades 5-6	93	20.7%
Grades 7-8	129	28.7%
Grades 9-12	77	17.1%
Total	450	100.0%
Sex		
Male	212	46.2%
Female	245	53.8%
Total	457	100.0%
Age (mean, SD)	11.4	3.2
Age Range (Min/Max)	4	21
Age		
4-5 years	23	5.00%
6-10 years	151	33.2%
11-13 years	155	34.1%
14+ years	126	27.7%
Total	455	100.0%
Race/Ethnicity		
Black	409	89.9%
Hispanic	40	8.8%
Other	6	1.30%
Total	455	100.0%

Note: All data reflect numbers and percent except were specified.
Source: Department of Mental Health, School Mental Health SY07-08 Report

Saint Elizabeths Hospital

Saint Elizabeths Hospital provides inpatient care for adults with serious and persistent mental illnesses, including those who have been committed by the criminal courts. Founded in 1855 at the urging of Dorothea Dix, Saint Elizabeths was the first large-scale, federally run mental health and psychiatric care facility in the United States. It was transferred to the District of Columbia in 1987. Working with community-based mental health providers, Saint Elizabeths focuses on maximizing the potential for recovery so that people with mental illness will be able to integrate into the larger community with the level of support needed and wanted.

With the newest buildings dating back to the 1950s and no longer suitable for modern inpatient care, a new state-of-the-art facility is scheduled to be occupied in early 2010. The 448,000 square foot facility integrates a number of strategies to lessen the building's environmental impact, including the use of natural light, bioretention areas and a 28,000 square foot green roof that is likely the largest on any mental health facility in the country.