Government of the District of Columbia DEPARTMENT OF HEALTH

The Child Health Action Plan

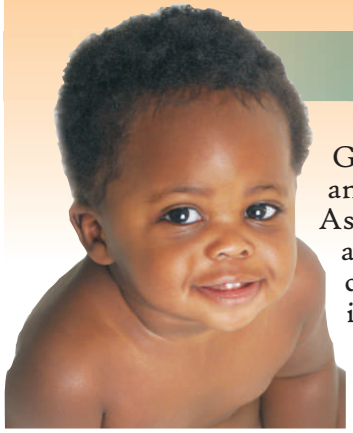
Improving Child Health in the District of Columbia

Government of the District of Columbia
Adrian M. Fenty, Mayor

2008

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DOH
DEPARTMENT OF HEALTH

Importance of Children Health Issues



Growing up healthy is every child's right and every parent's dream for their children. As a nation, we have made significant advances in improving child health and development over the past century by identifying the causes of many diseases by developing preventive measures, treatments, and cures and improving the overall health status of our children. Still, children today suffer high rates of asthma, developmental disorders, obesity, preventable injuries, and other health problems. However, the District of Columbia is committed to addressing children's health issues by drawing together various government agencies in an unprecedented collaboration.

The Child Health Action Plan for improving child health in the District of Columbia reaffirms the Mayor's commitment to the health and well-being of all children. The action plan is a public-private partnership with the Department of Health and multiple collaborating organizations and individuals. The purpose of the plan is to implement evidence-based practices and public health models focusing on system change and improve children's health outcomes within the District. Multiple District agencies, non-profit groups, and community health care providers stand poised to improve child health in the District of Columbia over the next three to five years. In addition, we will engage community and faith-based organizations in our neighborhoods to help build an improved child health system and advocacy network.

Through these partnerships we will develop and implement a unified approach to establish a common voice and a focused message leading to improvement of health and well-being of our children. This will also result in improvements in service coordination as well as cross-training across programs and departments. City leadership must maintain its commitment to deliver consistent and well-grounded messages that will educate residents in the District of Columbia and provide families with appropriate tools and resources to change the course of their children's life and enhance their well-being.

The District's Child Health Action Plan will use the following key strategies:

- Education
- Prevention
- Early Intervention
- Policy Development and Enforcement
- Capacity Building
- Community Mobilization
- Community Economic Development

In sum, the District will achieve better health outcomes for children and youth through greater cooperation among government agencies, stronger collaboration with community partners, implementation of innovative and evidence-based interventions to reach children and teens regardless of location, and collection of information with population-based surveys and other health utilization tools that effectively and efficiently measure efforts and inform the deployment of resources. This action plan is to be utilized as the blueprint, and with continued leadership and commitment of the city's leaders, we will make dramatic improvements in the lives of children, youth and families of the District of Columbia.

The next part of this document will outline the current state of health for children in the District of Columbia, followed by the targets for 2010 and some of the key strategies that will help reach these goals. This is followed by each individual action plan for all eight child health indicators (obesity, asthma, substance abuse, lead, well-child visits, infant mortality, oral health, and sexual health).

Indicator

Obesity

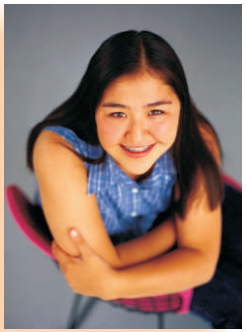
Baseline

- DC Medicaid Data: **25-45%** of 2-21 are overweight or obese.[1]
- *F as in Fat Report:* **23%** of 10-18 year olds are overweight or obese[2]

Target by 2010

- To reverse the trend in childhood obesity rates in DC by 2010

Strategies



- To increase the innovative programs improving the nutritional options available to children and families, through exceeding USDA standards in school, childcare, Head Start and after-school food programs and implementing Healthy Corner Store initiatives

- To increase the physical activity of children by utilizing the new Physical Education standards to establish required levels of physical activity in schools and increasing access to programs through the Department of Parks and Recreation

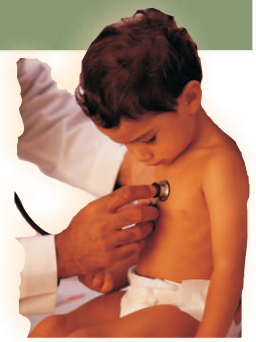
[1] The majority of the patients in the Early Periodic Screening Diagnosis and Treatment (EPSDT) data set are DC Medicaid. Some are Maryland and some are privately insured. 2007

[2] This is survey data; not taken from direct patient measurements but from reported measurements. F as in Fat Report, Trust For America's Health Foundation 2007.

[3] Asthma Impact Study from Children's National Medical Center 2005.

Indicator

Asthma[3]



Baseline

- 1-4 years 649
- 5-9 years 334
- 10-14 years 318
- 15-17 years 300

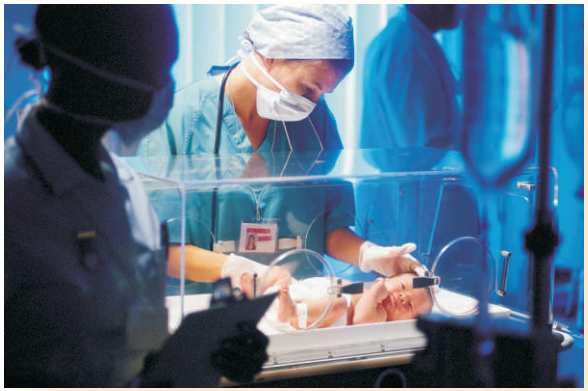
Annual ED visits per Per 10,000

Target by 2010

- To reduce Emergency Department visits for children by 10% by 2010

Strategies

- To implement a quality improvement initiative for health care providers to ensure consistent high quality care for children with asthma
    - Including an asthma registry and standardized asthma action plans and treatment records



Indicator

Substance Abuse

Baseline

Youth reporting[4]

- Current use of alcohol **(33%)**
- Episodic heavy drinking (bingeing) of alcohol **(12%)**
- Current use of marijuana **(21%)**
- Current use of cigarettes **(13%)**
- Accessing substance abuse services **(679)**

Target by 2010

- To reduce by 10% the number of youth reporting:
  - Current use of alcohol
  - Episodic heavy drinking (bingeing) of alcohol
  - Current use of marijuana
  - Current use of cigarettes
- To increase by 15% the number of youth accessing substance abuse services

Strategies

- To build the capacity of community-based and clinical organizations to provide prevention, intervention and substance abuse treatment services
- To implement a public information campaign to reinforce no-use and positive development messages and raise awareness of the availability of youth treatment services
- To conduct a minimum of 450 tobacco sales compliance inspections to reduce youth access to tobacco per year

[4] 2007 Youth Risk Behavior Survey (YRBS) and DOH/APRA Central Intake Division for Youth (CIDY), FY 2007 Intake Data

Indicator

Lead

Baseline

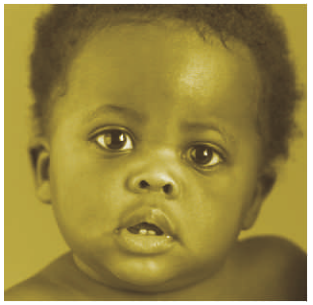
- 9.7 prevalence rate in CY06 of District children with a blood lead level 5 µg/dL, per CDC

Target by 2010

- To minimize the prevalence rate of children with a blood lead level equal to or greater than 5 µg/dL, to less than a 5% prevalence rate

Strategies

- To expand the capacity to provide risk reduction services in the homes of high-risk populations, including pre-1978 homes with:
  - Pregnant women
  - Low-income families
  - Foster care children
  - Children with blood lead levels under 10 µg/dL



Indicator

Well-child Visits

Baseline

- 77% of the District children ages 0-21 years old have recommended well-child visits

Target by 2010

- To increase wellness visits for children 0-21 year olds to 80% in order to vacate Salazar order

Strategies

- To have a *HealthCheck*[5] database that is fully functional in its capacity to receive data as well as to produce reports at the city, Medicaid managed care organization (MCO) and provider level

Indicator

Infant Mortality

Baseline

- Infant mortality rate of 13.6 deaths for every 1,000 live births (2005)

Target by 2010

- To reduce the infant mortality rate (IMR) to less than 10 per 1,000 live births

Strategies

- To recruit, train and deploy new Family Support Workers under the Healthy Start program to provide complementary support services that address psychosocial and medical risk factors affecting pregnant and parenting women and their children

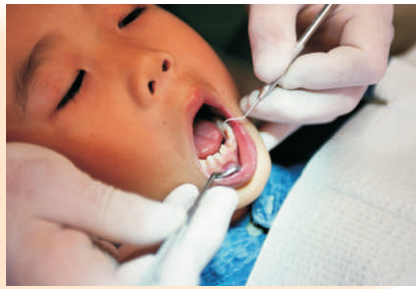
Indicator

Oral Health

Baseline

- 40% of children 0- 21 years old have at least one oral health assessment per year[6]
- No baseline data available on the rates of protective sealants in DC

Target by 2010



- To ensure that 55% of all children 0-21 will have at least one oral health visit (for any reason) documented

- To increase the rate of children aged 8 years old who have protective sealants on at least one of their permanent molar teeth by 5%

Strategies

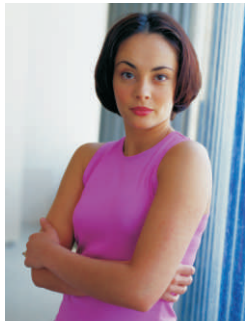
- To enhance DC DOH School-Based Dental Program's capacity to serve additional schools and re-visit schools to check the sealant retention rate of students previously treated

- To explore feasibility of pediatric primary care providers participating in caries risk reduction and anticipatory guidance practices as well as applying fluoride varnish

[5] HealthCheck database is the EPSDT database tracking and monitoring the well-child visits of Medicaid recipients.
[6] CMS 416 FY 06 Report; completed and submitted by DOH to Center for Medicaid and Medicare Services (CMS) on April 1, 2007.

Indicator

Sexual Health-STD/HIV



Baseline

- Chlamydia rates among young people 15-24 years old of 5-9% in 2005
- 54% of young persons aged 18-24 years old who know their HIV status in 2004[7]
- Number of persons under 25 receiving Housing Opportunities for People With AIDS (HOPWA) housing assistance: 2 clients under 17 years old and 84 clients between 18-30 years old in FY07.
- Number of HIV+ persons under 25 receiving continuous HIV care: 60 enrolled clients and 41 clients receiving services from AIDS Drug Assistance Program (ADAP) as of September 2007
- HIV infections and new AIDS diagnosis among young persons aged 15-24: 252 newly reported AIDS cases 2001-2006

Target by 2010

- To reduce Chlamydia infections among 15-24 year olds to <3%
- To increase the proportion of youth aged 15-24 years who know their HIV status by 25%
- To increase the delivery of HIV care and support services by HIV+ youth by 10%
- To reduce the number of new HIV infections by 25%

Strategies

- To mainstream STD and HIV prevention services into existing programs that have ongoing contact with youth
- To reach in-school and out-of-school youth with services and skills-building programs that both reduce current STD rates and also reduce high risk behaviors

[7] Behavioral Risk Factor Surveillance System (BRFSS) 2007.
[8] DOH Policy Planning and Research Administration, State Center for Health Statistics 2007.

Indicator

Sexual Health-Teen Pregnancy

Baseline

- Pregnancy rate of women 15-19 year old: 64.4 per 1000 women[8] (2005)

Target by 2010

- To reduce the rate of pregnancy rate to 15-19 years olds by 10%

Strategies

- To work with community partners to implement evidence-based approaches to increase the age of sexual initiation
- To establish programs and procedures that support adolescent parents

Health Indicator 1: Obesity

Target: Reverse trend in childhood obesity rates in DC by 2010.

Baseline:
- **DC Medicaid Data: 25-45% of 2-21 year olds are overweight or obese.**[9]
- ***F as in Fat* Report: 23% of 10-18 year olds are overweight or obese.**[10]

Improvement Strategy I: Support improved nutrition and increased physical activity for DC children, youth, and families.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
Actions Involving Both Nutrition and Physical Activity				
1. Identify steps DC government and community will need to take to support the *Alliance for a Healthier Generation's* activities to create and sustain a *Healthy DC Schools Program*.	DCPS and OSSE in lead with core agencies and community stakeholders.[11]	*Alliance for a Healthier Generation* (via the Robert Wood Johnson and Clinton Foundations in collaboration with American Heart Association) to provide substantial resources for the implementation of this initiative over a four-year period.	Specifics will be available after contract is signed with District in 2008. All public schools (including charter schools) will be involved.	2008 through 2012. Program to be phased-in by schools
2. Implement child care center nutrition and physical activity policies and programs, utilizing evidence-based national models such as Head Start's *I Am Moving/ I Am Learning*.[12]	DHS Early Care and Education Administration (ECEA), DOH, community-based organizations (CBOs) such as SHIRE, CYITC	Model project to implement a child care "Train the Trainers" program for the *I am Moving, I am Learning* program to be funded in three wards via DOH's Preventive Health Block Grant, implemented by SHIRE.	Completion of this model obesity-prevention training program for child care centers will provide the city significant information for future planning.	Begin February 2008 through 2010

[9] The majority of the patients in the EPSDT data set are DC Medicaid. Some are Maryland and some are privately insured. 2007.
[10] This is survey data not taken from direct patient measurements but from reported measurements. Trust for America's Health Foundation 2007.
[11] **Core District agencies for obesity** are: DOH, DPR, DCPS, OSSE, EOM, CYITC, and OP. **Core non-governmental agencies** involved to date in many DC obesity activities in the community and with DOH include the DC AAP and SHIRE Early Childhood Obesity Collaborative.
[12] A proactive approach for addressing obesity in Head Start children.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
3. Encourage the implementation of worksite wellness programs for both private and public sector employers.	DOH with core agencies and key community partners, such as the American Heart Association.	Initiatives already underway in the private sector with the American Heart Association. OP is exploring the capacity of programming within the DC Government. DPR is willing to help coordinate physical activities and provide space.	This will require leadership to explicitly support programs and encourage participation. February 2008: DOH participation in Worksite Wellness regional event with American Heart Association. April 2008: Best practices from federal agencies on worksite wellness policies and programs presented for consideration.	January 2008 through September 2008.
4. Facilitate the utilization of evidenced-based educational tools to increase the awareness of healthy eating and increased physical activity needs within DCPS, child care facilities, and other appropriate locations.	Core agencies with OSSE, DCPS, ECEA, CYITC and CBOs	DOH-CHA staff coordinating the obesity work group and working with the appropriate staff at other agencies, such as the DCPS and OSSE health and food program staff	DOH/CHA/Bureau of Nutrition & Physical Fitness will explore an MOU with DCPS to implement the *Eat Smart/Move More* program.[13]	September 2008
Actions Involving Nutrition				
5. Implement policy to ensure that all meal programs operated in the District for children and adults exceed the current Federal nutrition standards (including school breakfast and lunch programs, afterschool programs, child care programs).	OSSE and DOH-CHA with other core agencies	US Department of Agriculture (USDA) is developing recommendations regarding increased access to whole grains and fresh produce at public schools	Public health professionals agree that to effectively combat childhood obesity, DC must insist that all federal meal programs exceed USDA nutritional standards. Monitor pending changes in federal requirements to ensure that DC can meet amended standards.	September 2008

[13] A program to increase the activity and improve the nutrition of the community with documented results in North Carolina.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
6. Increase neighborhood-based access to healthy food choices and nutrition education (via grocery stores, corner stores, street vendors, farmers' markets, possibly *Farmers' Markets on Wheels.*	Core agencies with DCRA and CBOs	Private foundation and government resources will be sought to implement these ideas. DCRA to assist with healthy street vendor concept. Community groups working with Farmers' Markets and will be collaborating with new Giant in Ward 8 to create educational opportunities onsite.	DC Hunger Solutions "Healthy Corner Store Initiative" will complete DOH-funded study in 2008. OP should consider tax incentives to encourage increases in access to healthy foods in underserved areas.	March 2008-2010
Actions Involving Physical Activity				
7. Increase opportunities for physical activity in schools, early childcare, Head Start and after-school programs with standards of physical activity.	Core agencies, specifically OSSE, DCPS, CYITC and DHS-ECEA.	New physical education standards have been accepted by the School Board. Many private entities are engaged in determining how to appropriately implement the standards.	The standards must be taken beyond individual skills to actual expectations of levels of physical activity that will aid in combating childhood obesity.	September 2008
8. Increase availability of safe spaces and green spaces in all communities for children and families to be active.	Metropolitan Police Department (MPD), Department of Transportation (DOT), with core agencies and community groups.	"Safe Routes to School" Program "Bicycle-Pedestrian Safety" Program[14]	OP has included these Action Steps in their Obesity Action Plan. National Urban League recently completed an "environmental scan" outlining obstacles to increased physical activity in Ward 8.	July 2008 through 2010
9. Increase the access to and diversity of DPR activities.	Core agencies with DPR leading and community groups	Staff Evaluation of DPR activities ongoing.	DPR staff actively engaged in the interagency obesity workgroup. Significant safety issues will need to be addressed at certain facilities.	June 2008

[14] The "Safe Routes to School" program empowers communities to make walking and bicycling to school a safe and routine activity. The "Bicycle- Pedestrian Safety" program promotes bicycle and pedestrian transportation accessibility, use, and safety.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
10. Expand programs, policies, and public-private partnerships that enable low-income families to participate in both public and private physical fitness activities.	Core agencies, including DOH-MAA, in collaboration with CBOs including sports teams.	Staff Private organizations very engaged in the desire to combat childhood obesity.	DOH-MAA to determine feasibility of providing "fitness prescriptions" for community-based fitness programs.	July 2008-January 2009

Evidence of Success / Criteria

- Increased availability of appropriate foods.
  - DCPS, Early childhood care programs, afterschool programs exceeding USDA nutritional standards.
  - Increased availability of fresh fruits and vegetables linked to nutrition education programs, particularly in wards 5, 7, and 8.
- Increased availability of exercise and activity programs.
  - Physical education programs in all DCPS and charter schools.
  - Physical activity as a part of all early childhood, Head Start and afterschool programs.
  - Increased utilization of DPR programs.
  - Improved built environment to encourage exercise
- Establishment of a citywide infra-structure to implement and monitor school wellness programs.
  - Implementation of citywide DC Healthy Schools program.
- Availability of community-based education programs on physical fitness and nutrition.
  - Children and families receiving more information about healthy choices and active lifestyles.

Evaluation Process / Targets

- Appropriate foods.
  - Comparison of all childhood nutrition programs to USDA standards.
  - Number of farmers markets in Ward 5, 7 and 8, with availability of systems allowing food stamp utilization.
  - Availability of fresh fruits and vegetables in corner store.
  - Availability of grocery stores in Ward 5, 7 and 8.
- Exercise and physical activity.
  - Number of schools with physical education programs on a regular basis. This does not include recess.
  - Number of childcare, Head Start and afterschool programs with regular, organized physical activities, not including free play.
  - Number of children utilizing DPR activities and the distribution across the city.

Improvement Strategy II: Increase prevention and treatment programs in the health care delivery system.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Develop training program for primary care providers to increase capacity to participate in prevention, identification and treatment of obesity.	DOH-MAA DC AAP DC PICHQ [15] MCOs	Proposal exists to do this type of training with primary care providers. Awaiting approval of funding from the MCOs.	Initial acceptance of proposal by MCOs obtained contracts are being developed to initiate this activity. Program will also include implementation of a quality improvement programs in primary care through the MCO contracts.	March 2008
2. Expansion of availability of comprehensive treatment programs of obese children, youth, and families a. Develop models to allow treatment programs to exist outside of current institutional walls. b. Increase recognition of the need for non-covered entities to participate in the successful treatment of obesity.	MAA DC AAP DC PICHQ MCOs	A cost model has been developed. It will require that a different funding structure be put in place to allow coverage for uncovered services or to allow bundling of services for these types of treatment programs.	MCO CEOs are evaluating the cost models to determine the appropriate method to pilot. Parents and caretakers must be engaged as a part of these treatment programs.	March 2008
3. Ensure adequate payment mechanisms for care related to obesity. a. Assure obesity is a recognized code by Medicaid and other payers. b. Develop payment policies to allow for the delivery of multidisciplinary treatment programs and allowing for coverage of currently uncovered services necessary to have successful treatment programs.	MAA, Council of the District of Columbia (Committee on Health), DC AAP, CBOs	Medicare has recognized Obesityas a billable condition. It is still not recognized by DC MAA and many private insurers. See notes above under 2 around reimbursement for treatment services. May need legislative action to make this viable.	MAA staff is working to amend the Medicaid State Plan so that obesity is included. Legislation may NOT be needed to allow Medicaid to include Obesity as a covered service under the State Plan options.	March 2008

[15] DC PICHQ is a collaboration between MAA, MCOs, DC AAP, and all academic institutions.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
4. Establish comprehensive program to measure and track BMI in multiple settings (primary care offices, schools, childcare providers, Head Start) with linkage of data to the HealthCheck database.	DOH-CHA DOH-MAA DC AAP DC PICHQ DCPS	Staff already engaged. DC HealthCheck database has the capacity to calculate the BMI and percentage for each child.	WIC already measuring BMI on clients. Universal health certificate has data to calculate BMI on children. Standardized Medical Record Forms for Medicaid have BMI as part of the measurements for each well-child check.	September 2008

Evidence of Success / Criteria

- Primary care service capacity expansion
  - o Primary care learning collaborative underway.
  - o QI measures being implemented in primary care practices using the American Medical Association recommendations.
- Treatment services
  - o Increased number of treatment programs available or increased number of days of service.
  - o Decreased wait time until initiation of treatment.
- Payment
  - o Obesity becomes a covered diagnosis under DC Medicaid.
  - o Obesity, a covered diagnosis by private insurance plans.
  - o Billing systems in place to allow bundling of services for comprehensive multidisciplinary treatment services.
- BMI measured and entered in the HealthCheck database by multiple entities interfacing with children.

Evaluation Process / Targets
SEE ABOVE.

- Primary care services
- Treatment services
- Payment

Improvement Strategy III: Engage government and community in citywide child-family obesity planning (Infrastructure building).				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Create structures to facilitate citywide communication, collaboration, and coordination on child-family obesity, as well as implementation of policies and programs.	DOH-CHA	DOH-CHA has new staff in place ready to lead the coordination of these efforts.	Need to define staff, organizational chart, responsibilities, budgetary needs to reflect obesity priority within DOH.	January-May 2008
2. Establish an obesity work group with inter-agency and community input to initiate long-term planning process.	Core agencies Community Partners.	Existing staff Community partners are already engaged in process.	Thoughtful consideration should be given to how an advisory vehicle could be structured so it is productive, creative, and representative, not unwieldy or bureaucratic.	Initiated in October 2007. Begin inviting community partners in April 2008.
3. Develop plan for community dialogue to allow grass-roots and community-based leaders to share information and obtain ideas and feedback on city's obesity activities.	Core agencies Community Partners.	Existing staff. Utilize DPR and/or other sites that can be obtained at no cost.	Thoughtful consideration should be given to how an sory vehicle could be structured so it is productive, creative, and representative, not unwieldy or bureaucratic.	Initiated in April 2008.
4. Develop targeted program to support community organizations conducting specific obesity-related activities via different categories of grants.	Core agencies with Obesity Workgroup	DOH Preventive Health Block grants earmarked $250,000 dollars for obesity prevention programs in 2008. Potential funding from the chronic disease management funding stream.	Additional dollars are needed to implement this goal. DOH will consider partnering with DPR and other government agencies to explore funding for this initiative.	2008 funds awarded. By September 2008 need plan for additional funds.
5. Identify current or planned child obesity public awareness activities in the District. Develop plan to address additional public awareness campaigns	Core agencies, with Obesity Workgroup.	Some obesity-related public awareness activities already underway, including efforts by Hospital for Sick Children Foundation and SHIRE.	Office of Planning is interested in pursing this type of messaging as well. Private and public campaigns must be coordinated to assure maximum impact.	By June 2008 draft plan for obesity-related public awareness.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
6. Enlist involvement from sports and entertainment celebrities as well as local officials to expand public awareness regarding obesity.	Core agencies with sports teams and private organizations serving children.	Solicit support from community groups to recruit local and national celebrities in obesity public awareness activities.	Additional resources for this task of involving local and national celebrities in local obesity campaigns and activities will be obtained from the private sector.	May 2008-September 2008

Evidence of Success / Criteria

- Clearly delineated Obesity Program within DOH/Community Health Administration including budget, staff, and responsibilities of Bureaus.
- Obesity Workgroup established; new structure (task force or Council) formed with interagency membership and public representation with focused goals and objectives.
- Public-private partnerships; citywide events, planned with specific outcomes and goals.
- Mini-grant process established, with sufficient budget to allow for both city-wide and neighborhood grants, supplemented by capacity-building and technical assistance to support grass-roots efforts.
- Local and national celebrities recruited to participate in obesity public awareness campaign.

Evaluation Process / Targets

- Evaluation from participants of Inter-agency Obesity Workgroup.
- Evaluation of community leadership events by participants.
- Structured process to obtain feedback from community groups on obesity activities.

Health Indicator 2: Asthma

Target: Decrease asthma-related Emergency Department visits for children by 10% of 2005 baseline by 2010.

2005 Baseline:
Annual Emergency Department visits:[16]

- **1-4 years 649 per 10,000**
- **5-9 years 334 per 10,000**
- **10-14 years 318 per 10,000**
- **15-17 years 300 per 10,000**

Improvement Strategy I: To improve the quality of care for children who suffer from asthma

TASKS/ACTION STEPS	RESPONSIBILITIES	RESOURCES	CONSIDERATIONS	TIMELINE
1. Develop and implement quality improvement initiatives on asthma with DC medical providers. a. Implement Standardized asthma medical record form for use by primary care providers.	DOH-CHA DOH-MAA, Asthma Steering Committee	Asthma Clinician's Workgroup [17] MAA MCOs	DC PICHQ already has experience in Well-child Care quality improvement. Asthma can be added to this ongoing project. A standard asthma medical record form is in development.	September 2009
2. Increase the number of volunteer certified medication administration staff in DCPS/Chartered Schools by offering incentive programs.	DOH, DCPS, OSSE	Certification classes are available to DCPS/chartered school staff and are taught by school nurses.	School staff reluctant to volunteer for fear of liability issues. May need to consider providing incentives for volunteers and ensuring volunteers of any liability. Currently 300 certified staff in DCPS. It is estimated that 10-15 schools need to recruit volunteer medication givers.	September 2010
3. Implement Act 17-226, the "*Student Access to Treatment Act of 2007*" allowing asthmatic children and children who have severe allergic reactions to self-carry and administer medications and requiring inclusion of asthma action plans in files of affected students.	DOH DCPS	Staff	Act 17-226 must undergo Congressional review. DOH is in the process of developing regulations.	September 2008

[16] Asthma Impact Study from Children's National Medical Center.
[17] DOH-CHA led group to lead to the development of appropriate tools and systems to improve care for children in DC.

Evidence of Success / Criteria

- Routine use of asthma action plans by Primary Care Physician in partnership with parent/caregiver.

Evaluation Process / Targets

- 50 percent increase of asthma action plans on file in student's school medical records as reported through the school nurse program.

Improvement Strategy II: Asthma Management Education for Children and their parents/caregivers

TASKS/ACTION STEPS	RESPONSIBILITIES	RESOURCES	CONSIDERATIONS	TIMELINE
1. Implement asthma education programs in the DC Schools for asthmatic children parents/caregivers.	DOH –CHA- DCPS- Charter Schools American Lung Association of DC	Current grants available through DOH to support programs for 2008.	Cooperation from DCPS/chartered schools is vital to implementing programs.	ongoing
2. Work with community partners to pilot environmental health education and training for daycare providers and parents.	DOH–CHA, ECEA DCPS, Children's Environmental Health Network	Current grants available until 2010.	Additional funding will be needed to sustain programs beyond current funding.	March 2008

Evidence of Success / Criteria

- Asthma education programs are implemented routinely in daycare sites, and schools.

Evaluation Process / Targets

- At least 20 educational programs conducted annually in both daycare and school settings.

Improvement Strategy III: Improve indoor air quality in school, daycare sites, and homes				
TASKS/ACTION STEPS	**RESPONSIBILITIES**	**RESOURCES**	**CONSIDERATIONS**	**TIMELINE**
1. Work with DCPS/Chartered Schools to increase the participation of schools implementing the Environmental Protection Agency's (EPA) Tools for Schools Environment Assessment Program and implement environmental assessment recommendations to improve indoor air quality.	DOH DCPS	"Tools for Schools" toolkits are needed for participating schools[18]	Forming the volunteer teams at each school participating in the "Tools for Schools" workgroups. Resources provided to the schools to take the necessary corrective actions on recommendations of the work groups.	September 2008
2. Work with Federal and local government and community based environmental group to implement "Healthy Homes" strategies.	DOH, US Department of Energy and Housing and Urban Development			September 2010
3. Provide technical assistance to educational programs and environmental assessments for 60 childcare sites (20 sites per year).	DOH, Early Care and Education Administration (ECEA), Department of Consumer and Regulatory Affairs, Children's Environmental Health Network, George Washington University	Funding is currently available for only 20 sites per year for three years. Additional funding is needed to: 1) build upon existing resources to expand the number of daycare sites 2) to sustain the programs.3) to assist with any necessary corrective repairs (remediation).	Once the assessments are completed funding and other resources are needed to implement recommendations for improvements.	September 2010
Evidence of Success / Criteria • Environmental assessments conducted annually for at least 20 daycare sites and schools.				
Evaluation Process / Targets • At least 10 or more schools and daycare sites report an improvement in indoor air quality as a result of the environmental assessments.				

[18] "Tools for Schools" targets improving the indoor air quality for schools.

Improvement Strategy IV: Data Collection, Surveillance Reports				
TASKS/ACTION STEPS	**RESPONSIBILITIES**	**RESOURCES**	**CONSIDERATIONS**	**TIMELINE**
1. Revise the 2004 Strategic Plan to address the burden of asthma in the District. Copy of the report released and distributed citywide and available on DOH website.	DOH/CHA Asthma Steering Committee's Members	Community partners that are members of the DC Control Asthma Now (DC CAN) Steering Committee. Funds provided by the CDC grant.	Work has begun on the revision including the 2006 State of Asthma meeting.	September 2008
2. Expand dissemination of all DOH asthma data reports through citywide distribution and access on the DOH website.	DOH-Community Health Administration (CHA)	Funding for printing and dissemination.	Currently the DOH websites for specific program information is difficult to navigate. Direct links to programs should be created.	June 2008
3. Standardized asthma action plans distributed to providers citywide and used by providers for children with a diagnosis of asthma.	DOH-CHA	Continued funding is needed to print and reprint the plans.	The Student Access to Treatment Act 2007 requires a medical action plan for children to self-carry and administer asthma medication while attending school or school related activities.	Ongoing
4. Develop asthma related school health data collection system	DOH-CHA	Database system	DOH Community Health Administration is currently working towards this goal. School data will be collected on asthma.	September 2008
5. Implement an asthma registry within the HealthCheck Registry.	DOH-CHA- health provider community Medical Assistance Administration (MAA)	MAA Requires new funding source to support modifying the current database.	Work with MAA and Managed Care Organizations (MCOs) to make the necessary modifications to include asthma. MCOs have been willing partners in other initiatives.	September 2009
Evidence of Success / Criteria • Reports are published and are easily accessible on DOH website. • HealthCheck database is modified to include asthma data.				
Evaluation Process / Targets • All current reports including: 2003 Burden of Asthma Report, 2004 Asthma Strategic Plan, Asthma Fact Sheets accessible on DOH website by June 2008. • Updated Asthma Strategic Plan available on DOH's website by December 2008. Standard asthma visit tool developed and approved as data source for asthma registry.				

Health Indicator 3: Substance Abuse

Targets:

Reduce by 10% the number of youth reporting current use of Alcohol, Episodic heavy drinking (bingeing) of alcohol, use of marijuana, and cigarettes
Increase by 15% the number of youth accessing substance abuse services

Baseline:

- **Current use of alcohol (33%)**
- **Episodic heavy drinking (bingeing) of alcohol (12%)**
- **Current use of cigarettes (13%)**
- **Annual number of youth accessing APRA-sponsored substance abuse services (679)**

Improvement Strategy I: Provide substance abuse information, education and training to individuals who interact with youth to implement best practices in prevention, intervention and treatment, and advocacy for youth substance abuse services.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1.Establish training on Screening, Brief Intervention, Referral and Treatment (SBIRT) for School Nurses and School-based Mental Health Counselors.	DOH-APRA, DOH-CHA, DMH, Center for Workforce Development, CYITC, DCPS, Parent Teacher Associations, Family Advocacy Groups, HU, Children's Hospital, Consultants	Agency staff, contract trainers	Need support from DCPS and other government administrations to coordinate types of trainings, scheduling and making available continuing education units and/or contact hours for participants.	September 2008 Ongoing
		Through the Adolescent Treatment Coordination Grant, $400,000 is available to provide training.	Identify certified contractor to deliver SBIRT training. Contractor receptivity of additional work; time to devote for training. Target audiences: • DC government staff • Youth serving organizations • Parents and caregivers • Community and faith-based organizations	March 2008 - Ongoing

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
2. Conduct 50 workshops, five assemblies, 10 conferences and 25 health fairs for students, parents and residents.	DOH/APRA, DCPS, Howard University	Funding for staff, students, teachers, consultants, trainers, literature, curriculum, DVD and other substance abuse materials is available through Appropriated funds, the Substance Abuse Block Grant, Safe and Drug Free Schools, and the ATC grant. Staff is already engaged.	Competing priorities Key events: Underage Drinking Conference Alcohol Screening at five sites Recovery Month Conference and Health Fair	March 2008 April 2008 September 2008
3. Fund a citywide anti-drug coalition to provide training, develop ward-level strategies and eight sub-coalitions.	DOH/APRA, Children &Youth Investment Trust Corporation, Howard University	Howard University Center for Drug Abuse and Research (CDAR) was awarded $250,000 to coordinate and develop the infrastructure for a citywide coalition and eight ward level sub-coalitions to inform, educate organize and advocate for a healthy drug free community.	Penetration of wards by engaging key stakeholders, community leaders, residents and youth to identify ward specific substance abuse issues, develop a coordinated substance abuse implementation plan and evaluate the outcomes may be difficult.	December 2007
4. Implement Botvin's Life Skills Curricula for 5th thru 8th graders.[19]	DOH, DMH, DCPS	DMH administers a behavioral health prevention and early intervention program in 48 public and charter schools.	Buy-in from school officials and teachers is critical to the success of the adoption and expansion of a curriculum-based program. Continued training, monitoring and evaluation to determine the effectiveness of the program presents a challenge. Funding required for expansion to 40 schools is approximately $717,872 yearly. This estimate includes staffing, training, materials and evaluation.	Training: Summer 2008 Phased into schools Fall Semester 2008

[19] Program designed to enhance students' self-esteem, feelings of self-efficacy, ability to make decisions, and ability to resist peer and media pressure

Evidence of Success/Criteria

- Increased number of individuals and organizations receiving information and education on substance abuse.
- Improvement in sharing information and reviewing and developing proactive policies to address substance abuse.
- The number of citizens and community groups that join the city-wide coalition; establishment of the 8 ward-based coalitions and levels of training, planning and advocacy activities.

Evaluation Process/Targets

- The capacity of a cross section of individuals, community organizations, and parents to engage in substance abuse prevention, intervention and treatment activities and services.
- 2009 Youth Risk Behavior Survey results w ill indicate reduction in use in alcohol, binge drinking, marijuana and cigarette use among youth.
- The increase in advocacy activity relating to substance abuse.
- The increase in knowledge of substance abuse by agency staff, school workers, parents, and residents.

Improvement Strategy II: Develop and implement a range of outreach and information dissemination activities that will engage youth, parents, schools, community and government in substance abuse prevention, intervention and treatment services.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Implement a social marketing campaign to reinforce no use and positive development; raise awareness of the availability of youth treatment services; messages to include print, radio, and websites.	DOH-APRA DOH-OCCR	Funding has been identified. DOH-APRA and DOH-OCCR staff, and a public relations contractor.	Identifying a public relations contractor through the procurement process can cause considerable delay in designing, creating and implementing a social marketing campaign.	March 2008
2. Sponsor at least 50 community groups' participation in Prevention Blitz IV, an annual prevention awareness day targeting 5,000 children, youth and residents.	DOH-APRA CYITC	To support this annual event, $150,000 is available to provide small stipends to participating community and faith-based organizations. DOH-APRA staff and materials are available to support the activity.	Efforts are needed to ensure that prevention activities and events occur in all eight wards of the city and promote the collaboration and partnerships of community and faith-based organizations around alcohol, tobacco and other drugs efforts.	September 2008
3. Conduct a minimum of 450 tobacco sales compliance inspections to reduce youth access to tobacco.	DOH-APRA, MPD, DCRA Contractor	$75,000 is available through appropriated funds to conduct tobacco compliance checks. DOH-APRA staff transportation, and merchant education materials are available.	MOU with the MPD must be finalized. Need timely issuance of a contract with an organization to provide youth inspectors can and updated merchant list.	September 2008

Evidence of Success/Criteria

- Launching of a citywide substance abuse media campaign reaching all segments/populations of the community.
- The number and placement of marketing campaign materials.
- Decreased number of merchants selling tobacco products to minor.
- Increase number and location of prevention activities for targeted populations.

Evaluation Process/Targets

- Penetration and recognition/recall of campaign themes and messages.
- The District will maintain its tobacco compliance rate within the national standard.

Improvement Strategy III: CAPACITY BUILDING: To build the capacity of community-based and clinical organizations to provide prevention, intervention and substance abuse treatment services.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Fund at least 10 evidence-based prevention programs fostering school community partnerships.	DOH-APRA	Grants in the amount of $60,000 are available for 10 or more community and faith-based organizations to implement Alcohol Tobacco and Other Drugs evidence-based programs.		March 2008
2. Develop Underage Drinking Strategic Plan.	DOH-APRA, DCPS, MPD, Alcoholic Beverage Regulation Administration, National Capital Coalition to Prevent Underage Drinking	Funding is available for the design and printing of the plan.	A draft Underage Drinking Strategic Plan is being vetted to key government and community stakeholders to solicit recommendations and concurrence. DOH-APRA, DOH-OCCR staff, and a public relations contractor is required.	March 2008
3. Increase APRA network of youth treatment providers to establish a comprehensive continuum of substance use disorder treatment and care.	DOH-APRA	Funding for staff is available through the Adolescent Treatment Grant.	Trainings and technical assistance are available to guide prospective providers through the certification process. Readiness of providers may limit the number of agencies available to provide services.	September 2008

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
4.Enhance APRA link to birthing hospitals and case workers/outreach specialists that come in contact with expected mothers and mothers/infants who may be at risk due to a history of substance abuse. a. Identify and make available to health care providers a list of alcoholic and Narcotic Anonymous support groups. b. Provide coordinated outpatient services for at-risk women of child-bearing age in a location that is accessible to this population.	DOH/APRA; Mary Center; Hospitals DOH-APRA; Choice in Drug Treatment Providers; DMH	Through existing resources, DOH-APRA will improve coordination with DOH-CHA Programs like Healthy Start and the Nurse Home Visitation Program to improve the capacity of staff to identify and refer mothers suspected of substance use disorder to DOH-APRA programs and recovery support networks. Through existing resources, DOH-APRA will enhance the capacity of current community treatment providers to meet the needs of this population.	Active engagement and considerable training to enhance readiness of providers to identify and address these areas of need are key factors.	September 2008
5. Establish reimbursement strategy to allow federal drawdown of Medicaid funds for youth treatment.	D.C. Council, DOH-APRA, DOH-MAA, Center for Medicare and Medicaid Services (CMS)	Staff, consultants, intra-agency collaboration	There is currently no reimbursement methodology in place to leverage Medicaid funds to support treatment of youth with substance use disorders. DOH-APRA is engaged in the CMS approval process.	June 2008

6. Increase access to substance abuse treatment and support services for youth with co-occurring (substance abuse/mental health) disorders.	DOH-APRA, DMH, DOH-MAA, treatment providers, community health providers	Funds are available through the "Adolescent Treatment Coordination" grant. Staff is available to provide training and technical assistance to potential vendors to increase their ability to screen, refer and treat youth with co-occurring disorders	Provider readiness and limited information about the availability of co-occurring services and public awareness of the relationship between substance abuse and mental health disorders are challenges.	August 2008
7. Develop recovery support services for youth via the "Access to Recovery Grant."	DOH/APRA, DMH, treatment providers, community and faith-based organizations	Funding for recovery support services for youth will be available through the Access to Recovery Grant. Staff support and vouchers will be issued.		March 2008

Evidence of Success/Criteria

- Inventory the number of evidence-based prevention programs in each ward of the city. Increase in the number and availability of evidence-based prevention programs in each ward of the city.
- Increase number of youth treatment providers and increase capacity to provide community-based recovery support services in partnership with new and existing youth providers beyond the four youth treatment providers in the APRA network currently available.
- Expand access to treatment for youth with co-occurring disorders. Establish capacity to treat youth with co-occurring disorders within DMH and DOH-APRA provider networks.
- Establishment of a reimbursement strategy for Medicaid funds for youth treatment services.

Evaluation Process/Targets

- Increased availability of evidence-based prevention programs in each ward of the city.
- Increased number of youth treatment providers and youth recovery support services providers in the DOH-APRA network.
- Establish substance use disorder treatment capacity and treatment of youth with co-occurring disorders within DMH and DOH-APRA provider networks.
- Receive Medicaid reimbursement for substance use disorder treatment services for youth.

Health Indicator 4: Childhood Lead Exposure

DC Target: To minimize the prevalence rate of children with a blood lead level equal to or greater than 5 µg/dL, to less than a 5% prevalence rate.

Baseline:
- **9.7% prevalence rate in CY06 of District children with a blood lead level 5 µg/dL (per CDC).**

Improvement Strategy I: Primary Prevention Avoidance of Lead Expo sure, Reduction of Risk, and Identification and Removal of Lead Hazards

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Provide Lead-Safe Work Practices (LSWP) training to reduce risk of lead hazards being generated during any renovation, painting, maintenance or other activity disturbing pre-1978 painted surfaces.	DOH-CHA Lew Corp with Community Action Group (CAG) Training Network Inc	These are free trainings but some marketing costs, staff outreach work, and administrative staff work vis a vis registration is required.	Requires significant advance marketing to ensure a critical mass of participants. Language barrier is a potential challenge, with respect to providing training opportunities for all, in particular for Asian language speakers.	First training was held December 2007; second (in Spanish) is scheduled for March 2008; others to occur through end of fiscal year 2009.
2. Amend subcontract with CBO to: a. Add new primary prevention services benefiting at-risk families, namely dust testing followed by removal of any identified lead-contaminated dust. b. Expand list of at-risk recipients of such services, to include foster care homes and homes where a child was identified with a blood lead level between 5 µg/dL and 9.9 µg/dL	DOH-CHA NNCC CFSA	CDC grant pays for most NNCC activities; funding expected from DDOE for the foster care component. DOH Lead Program staff are responsible for oversight and to approve all written outreach materials to be distributed or otherwise relied on by NNCC. DOH legal staff to prepare liability waiver form stating lead dust removal does not constitute guarantee of lead safety.	Access to foster care homes is a potential challenge. Timely removal of any identified lead-contaminated dust is a potential challenge.	Subcontract partially amended in December 2007; DDOE funding expected by end of January, allowing rest of subcontract amendment to occur by March 2008.

Evidence of Success / Criteria:

- Benchmark for LSWP trainings is at least 20 individuals at each training; benchmarks for NNCC-related task are at least 25 homes where lead dust samples are taken per month, and where elevated lead dust levels are found, 100% of those homes receive dust removal services w/in 2 weeks of the elevated dust levels being identified.

Evaluation Process / Targets:

- This goal will have been reached if fewer lead hazards are generated as a result of work on older homes, and thus fewer cases of elevated blood lead levels resulting from renovation work will have been identified; if children with blood lead levels between 5 and 9 µg/dL do not have higher blood lead levels on their next blood lead test after NNCC work has been conducted at their homes.

Improvement Strategy II: Systematized Elimination of Lead-Based Paint Hazards

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Develop enforcement mechanisms related to new lead law.	DOH –CHA DDOE, DCRA, DHCD, DCHA, CFSA, and OAG	Coordination between DOH Lead Program Manager and other agencies' lead staff contacts.	Specifics hinge on nature of new legislation to be enacted in 2008, and which agency is given legal authority to do enforcement, other functions.	Continuing through FY10.
2. Provide outreach to legal services providers, to give them the knowledge and tools to incorporate in their standard procedures a step that specifically identifies among their clients those who live in rental housing who may be at particular risk of exposure to lead hazards, and to provide them with guidance as to how to proceed to ensure such housing does not contain lead hazards in violation of DC law.	DOH-CHA OAG Law school clinics (American, Howard, Georgetown, UDC and George Washington)	DOH-CHA will collaborate with staff from OAG to put together outreach materials for legal services providers and to help provide the on-site educational services to these providers.	Getting the legal services providers to collaborate on a special focus on lead poisoning prevention may be a challenge.	Initiate once new lead law is enacted; repeat periodically, as needed.
3. Engage rental property owners and property managers through their respective trade associations to encourage adoption of prudent property management practices and of lead safety measures at unit turnover.	DOH-CHA	DOH-CHA will take the lead in this task.	Associations may resist collaboration or may not want to promote DOH recommendations to their membership.	By May 2008.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
4. Ensure all District homes associated with a child under age 6 with an elevated blood lead level are promptly checked for presence of lead hazards and ensure any such hazards are abated in a timely manner.	DOH-CHA	DOH in-house risk assessment staff; DOH risk assessor contractor; labs to analyze environmental samples; and DOH case management procedures. Primarily CDC funding. Some costs potentially reimbursable through Medicaid.	Gaining access to all identified properties may be a challenge.	Effective immediately.

Evidence of Success / Criteria:

- Progress will be measured by the number of homes where lead hazard identification and abatement measures are being implemented, as evidenced by an increased demand for such certified contractors in DC.

Evaluation Process / Targets:

- We will strive to ensure that all kids under age 6 are being screened for lead, through increased collaboration with the managed care organizations that provide medical services to Medicaid-enrolled children and through increased outreach to key audiences. This will enable us to validate the data that will show that the prevalence rate has been lowered to below 1%, thereby confirming that these tasks have helped accomplish our overall goal.

Health Indicator 5: Well-child Visits for children 0 – 21 years old

DC Target: 80% of children 0-21 years old will have the appropriate well-child visits.

Baseline:

- **77% of children 0-21 years old have the appropriate well-child visits based on CMS 416 report for 2006.**

Improvement Strategy I: Develop and Implement a Standardized Medical Record Form (SMRF) to facilitate documentation

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Continue to implement SMRFs in all pediatric practices	DOH-MAA DC Partnership for Improving Child Healthcare Quality (DC PICHQ)	Staff Private partnership MCOs	Coordination of MAA MCOs and private partners requires ongoing attention	Ongoing
2. Conduct education of all pediatric primary care providers on HealthCheck Database, regarding the SMRF components and required Early Periodic, Screening Diagnosis and Treatment services (EPSDT).	DOH-MAA DC PICHQ MCOs	Staff Private partnership. MCOs.	Federal mandates Changes in the AAP periodicity schedule.	Ongoing
3. Monitor completion and submission of SMRFs to HealthCheck database.	DOH-MAA DC PICHQ	Staff		Ongoing
4. Conduct audit of documentation on SMRFs,	DOH-MAA DC PICHQ	Staff Funding	Court mandated audits.	Baseline study completed by August 2008
5. HealthCheck database fully functional with the capacity to produce city, plan and provider specific reports	DOH-MAA DC PICHQ	Staff Funding	Continued monitoring to assure adequate development of the database and appropriate reporting capacity. Must be prepared for conversion by providers to electronic medical records.	March 2008

Evidence of Success / Criteria
1. 98% of all pediatric PCPs are using SMRFs
2. 98% of all pediatric PCPs have received education on the elements of a well-child visit and use of the SMRFs
3. 100% of submitted SMRFs will be complete
4. DOH-MAA and PICHQ will be able to produce "report cards" for providers

Evaluation Process / Targets
See above.

Improvement Strategy II: Provide Access to HealthCheck database to school nurses and appropriate childcare, Head Start and WIC personnel.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Identify and train appropriate personnel on to use the HealthCheck database.	DOH-MAA, DOH-CHA, DHS-ECEA	Staff Funding	Multiple agencies and providers with various skill sets.	September 2008
2. Develop & implement policies and procedures for personnel to enter data updates to system	DOH-MAA, DOH-CHA, DHS-ECEA	Staff Funding	Multiply agencies and providers to develop user agreements and set access levels.	September 2008

Evidence of Success / Criteria
- All school nurses have access to HealthCheck database and are able to identify children in need of well-child visit.
- More complete school health records.
- Evidence of Women, Infants and Children (WIC), Childcare Providers, and Head Start providers having access to *HealthCheck* database.

Evaluation Process / Targets
- School nurses, WIC, Head Start and Childcare providers enter data into the registry from Health Certificates.

Improvement Strategy III: Increase access to primary and specialty medical services for children with special health care needs.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Assure that every child with special health care needs has a primary care provider.	DOH-MAA DOH-CHA (Special Health Care Needs Bureau) MCOs	DOH staff MCOs	DOH-MAA can hold MCOs accountable for this task in the managed care contracts. MAA will have to work on fee-for-service patients to improve engagement.	September 2009
2. Improve access to subspecialty care. a. Decrease administrative burden of referral process. b. Lengthen time associated with authorizations.	DOH-MAA DC AAP MCOs	Staff Funding DC AAP MCOs	DC AAP has already developed a universal referral form for all 4 MCOs that has been accepted and is in pilot. MCOs are in discussions with MAA and DC AAP to pilot longer authorization periods for a specialized group of patients with special health care needs.	September 2008
Evidence of Success / Criteria • Implementation of a universal referral form for all MCOs for sub-specialty care. • Children with special health care needs with an indentified primary care medical provider. • Lengthening authorized coverage for all children with special health care needs for subspecialty referrals.				
Evaluation Process / Targets • Primary care providers identified by MCOs and parents. • Feedback from parents and providers about the referral process for children with special health care needs.				

Health Indicator 6: Infant Mortality

Target: To reduce the infant mortality rate (IMR) to no more than 10 per 1,000 live births.

Baseline:

- **Infant Mortality Rate 13.6 per 1,000 live births in 2005.**

	Year	
	2004	2005
• Number of low birth weight to mothers:	881	888
• Number of very low birth weight to mothers:	223	214
• Percentage of women initiating prenatal care in first trimester:	79.4%	70.4%
• Percentage of women receiving adequate care:	22.3%	19.6%

Improvement Strategy I: Increase capacity and effectiveness of DOH home visitation program for pregnant women :

Tasks / Action Steps	Responsibilites	Resources	Considerations	Timeline
1. Increase oversight and effectiveness of the Healthy Start program's nurse case management component through the establishment of the Bureau of Perinatal and Infant Health (PHIB).	DOH-CHA	PIHB Bureau Chief; Clinical Division Chief; Healthy Start Nurses	Need to strengthen Quality Assurance Unit; establish key process and outcome indicators	May 2007-ongoing
2. Recruit, train and deploy Family Support Workers (FSW) to provide complementary support services that address medical, social, and psychological risk factors affecting pregnant and parenting women and their children.	DOH-CHA (Healthy Start Program)	Baseline local funding available to hire FSWs in-house and to select vendor to expand capacity utilizing nurse-FSW hybrid home visitation model	Requisition and hiring processes underway. Need to work in concert with CBOs that perform home visitation/case management for this population, with hospitals and MCOs	January 2008-ongoing

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
3. Design and implement a public information campaign educating women, including those who are not yet pregnant, and their families about the critical role of comprehensive pre-conception and prenatal care in ensuring a healthy pregnancy, birth, and infancy.	DOH-CHA Community partners	One-time local funding available in FY 08 to secure contractor for this activity	Partnerships with community organizations to augment capacity to have message be sustained.	May 2008
4. Facilitate the distribution of 15,000 to 18,000 free cribs over the next seven years to low-income mothers to prevent Sudden Infant Death Syndrome (SIDS) and fatalities due to co-sleeping.	DOH and First Candle National Crib Campaign	DOH staff; First Candle Program Manager $11 million grant from the Bill and Melinda Gates Foundation to First Candle.	Evaluation is an important and also funded part of this effort that will be conducted by several nationally recognized SIDS researchers.	March 2008
5. Update the DOH website to include general educational information on SIDS/Safe Sleeping including a precautionary checklist.	DOH	DOH staff in collaboration with OCTO	DOH will work with OCTO's IT Specialist to ensure information is current.	March 2008

Evidence of Success / Criteria

- Implementation of all action steps.
- Establish baseline of the number of cribs given out monthly in CY 2007 and document variation in monthly distribution.
- Establish performance measures (process and outcome) for DOH/Healthy Start staff.

Evaluation Process / Targets

- Vendors secured for public information campaign and for Healthy Starts service expansion.
- First Candle providing cribs for distribution on a projected schedule. Eligible mothers identified for crib distribution.
- Evaluate effectiveness of DOH Healthy Start program against established performance measures.

Improvement Strategy II: Enhance collaboration between DOH Community Health Administration's initiatives and other sectors of government serving at-risk women and families				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Increase early identification of pregnancy and ensure timely enrollment in prenatal care for all women of child-bearing age under Medicaid and the DC HealthCare Alliance.	DOH and managed care organizations (MCOs)	Outreach workers in DOH. Managed Care Case Workers and Outreach staff; Providers	Locating pregnant women and encouraging them to see a provider are ongoing challenges. Need to evaluate the role and placement of outreach workers.	
2. Increase well-child pediatric visits throughout the first year of life for all newborns on Medicaid, in particular, the first two visits at 48 hours and 1 month post-discharge.	DOH and MCOs	Healthy Start case workers. Pediatricians/ Family Practitioners	MAA periodicity schedule encourages this visit pattern. *HealthCheck* database provides the capacity to measure outcome. Challenges with mothers facing barriers in bringing children to providers.	Ongoing
3. Implement routine prenatal HIV testing and treatment that prevents perinatal HIV transmission to the infant.	DOH-HAA DOH-CHA	Providers of obstetric care; Case Managers; Outreach Workers	Public perceptions around testing continue to be a barrier.	Ongoing
4. Enhance screening and linkage to education and treatment services for all women of child-bearing age at risk for mental illness and/or substance abuse.	DOH-APRA; DMH	Counselors; Social Workers; Case Managers; Outreach Workers	Convincing clients to follow through with appointments; Access to appropriate mental health resources that are timely is challenging.	Ongoing
5. Enhance community-based screening and prevention services for families and youth at risk for child abuse.	DOH CFSA	Counselors; Social Worker		Ongoing
6. Facilitate outreach and linkages to care for homeless pregnant women.	DOH DHS	Counselors; Social Workers	Contacting homeless women; having enough resources for them.	Ongoing

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
7. Provide adequate prenatal care for pregnant inmates during incarceration.	DOH DOC	DOC Contractor		Ongoing
Evidence of Success / Criteria • Evaluate the collaboration between agencies through establishment of points of contract and documentation of meetings to discuss processes and issues.				
Evaluation Process / Targets • Monitor effectiveness of collaborative efforts between agencies (e.g., document the number of incarcerated women who are identified as pregnant and receive prenatal care).				

Improvement Strategy III: Increase coordination between government and the community to ensure a comprehensive, citywide approach to improving infant survival and well-being.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Institutionalize and expand pilot program to ensure adequate discharge planning and linkage to appropriate medical and social services for women admitted to birthing hospitals with inadequate prenatal care and at risk for domestic violence, substance abuse or other factors that negatively affect infant development.	DOH and Mary's Center for Maternal and Child Care	Case Managers and Family Support Workers	Need engagement with birthing hospitals to overcome difficulties in obtaining timely access to patients or their data during hospital stay.	Ongoing
2. Facilitate linkage to tobacco cessation programs for all at-risk mothers.	DOH and American Lung Association-DC	ALA personnel, Case Managers and Family Support Workers	Need ongoing staff training on approaches to persuade mothers about the adverse effects of primary and secondary smoking	January 2008
3. Compile perinatal screening risk information into a perinatal data registry in order to increase utilization of risk data by clinicians and case managers caring for all newborns and their mothers.	DOH and prenatal clinics, community obstetricians and pediatricians, birthing hospitals and other health care providers	Program managers Birthing facilities Providers of obstetric and pediatric care.	Partnership needed with birthing facilities to obtain and collect individual patient data.	July 2008
4. Convene a year-long advisory group comprised of experts and stakeholders in perinatal and infant health to identify and compile best practices based on existing data regarding infant mortality and perinatal outcome disparities.	DOH, NICHD, health care providers, MCOs, and community-based organizations	Staff Appropriate venue and support services (e.g., transcription, language interpretation)	Identification of appropriate committee members (public and private representation). Request for nominations has been released.	March 2008

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
5. Commission a comprehensive study of factors associated with infant death and developmental disability for Medicaid beneficiaries in the District of Columbia and identify novel population-based preventive activities and individual health care interventions that will reduce infant mortality.	DOH and the George Washington University (GWU) School of Public Health and Health Services	GWU staff	Multiple data sources available of administrative and survey data need to be secured, analyzed for a comprehensive report.	December 2008
Evidence of Success / Criteria • Tobacco cessation program points of contact for referrals identified. • Development of operational data registry for perinatal data collection and analysis. • Receive final report of GW's comprehensive study findings.				
Evaluation Process / Targets • Develop process to link mothers using tobacco and a cessation program by the end of March 2008. • Establish an advisory committee by the end of April 2008. • Identify specific parameters for the GW Medicaid comprehensive study by the end of March 2008.				

Indicator 7: Oral Health

Target: 55% of Medicaid children birth to 21 will have at least one oral Health visit (for any reason) documented

Baseline:
- **40% (CMS 416 FY 06 Report completed & submitted to CMS on April 1, 2007)**

Target: The rate of children aged 8 years old who have protective sealants on at least one of their permanent molar teeth is 35%.

Baseline:
- **There is currently no baseline data for this target.**

Improvement Strategy I: Increase access to oral health providers by utilizing and expanding existing resources

Tasks/Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Enhance DC DOH School-Based Dental Program's capacity to serve additional schools and re-visit schools to check the sealant retention rate of students previously treated.	DCPS DOH – CASH/Oral Health Division DC Head Start DC Chartered Schools	Staff Baseline funding available Partner with clinics and mobile units to enhance this effort.	Pursuant to D.C. Law 6-66, the "Student Health Act of 1985" all students attending public and private schools in the District of Columbia must receive oral health exams. Students are expected to have their completed oral health exams, on entry into grades Pre-Kindergarten, Kinder, 1, 3, 5, 7, 9 and 11.	September 2008
2. Explore feasibility of training pediatric primary care providers participating in caries risk reduction and anticipatory guidance practices as well as applying fluoride varnish.	DOH–MAA DOH–CASH/Oral Health Division DC Dental Society DC AAP	Staff DC AAP	Needs strong collaboration of all stakeholders (particularly DC Dental Society).	September 2008

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
3. Hire dental hygienists to provide preliminary dental examinations; complete prophylaxis; polishing of a tooth and application of pit and fissure sealants within the School Based Dental Program under the general supervision of a licensed dentist.	DC DOH – MAA DC DOH – CASH/Oral Health Division DC Dental Society	Staff	There is currently a shortage of dental hygienists in DC. Functions of dental hygienists are detailed in the DC Municipal Regulations for Dental Hygiene. Needs strong collaboration of all stakeholders (particularly DC Dental Society).	October 2009
4. Expand referral base for students in need of restorative dental treatment not offered by the School-Based Dental Program.	DOH–MAA MCOs DOH–CASH/Oral Health Division	Increased buy-in from MCOs. Community-based dental clinics. Clinicians willing to serve needs of this population. Funding	Need to partner with clinics and mobile units to serve more students throughout DC. This process needs significant buy-in from all stakeholders to ensure that an efficient mechanism is established to ensure that students receive the care they need.	September 2008

Evidence of Success / Criteria

- Increasing the rate of children who receive preventive dental services.
- Increasing the rate of children who have at least one dental visit annually.
- Increasing the rate of children aged 8 years old who have protective sealants on at least one of their permanent molar teeth.

Evaluation Process / Targets

- Both objectives are used as oral health measures nationally and also by the Association of State & Territorial Dental Directors (ASTDD).Baseline data will first be established/determined for these objectives. A mechanism to monitor this data will also be implemented.Preventive oral health services (including both clinical and educational) will be increased to enhance access to oral health services, ensuring that more children receive treatment and oral health education.

Improvement Strategy II: Develop and implement an outreach & education plan to encourage parents and caregivers to value their oral health.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Develop "Awareness Campaign" about the importance of good oral health with an emphasis on cultural sensitivity by targeting three sub-groups: a. Students – importance of good oral hygiene. b. Parents/Caregivers – importance of preventive dental services. c. Dental Providers – awareness of the challenges faced by low-income children in accessing dental services.	DOH-MAA Outreach Contractor CHA/Oral Health MCO DCPS DC Chartered School DC Head Start Program DC Dental Society Robert T. Freeman Dental Society	Funding Staff Oral health educational material (brochures, flyers etc.) Outreach contractor	Currently there are limited funds and resources (including staff) available for these tasks.	January 2009
2. Increase collaboration with MCOs to enhance their oral outreach efforts.	MAA CASH/Oral Health	Funding Staff		August 2008
3. Establish a multi-disciplinary oral health advisory committee	DCPS, Chartered Schools DC DOH, Head Start, Childcare providers, CFSA/ DC Family Courts Dental providers, Physicians, Community based advocates	Staff	Committee should assist in developing "Awareness Campaign" and to engage additional stakeholders that may contribute to oral health strategy implementation	March 2008
Evidence of Success / Criteria • Increasing the # of educational sessions for both children and caregivers. Increasing the rate of individuals (children and caregivers) who report an improvement of oral health knowledge.				
Evaluation Process / Targets • Baseline data will first be established/determined for all objectives. A mechanism to monitor this data will also be implemented to document that more children receive treatment and oral health education.				

Improvement Strategy III: Develop & implement an efficient surveillance method of collecting, analyzing, reporting and monitoring oral health data				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Explore feasibility of utilizing an existing database system for oral health data: a. Coordinate the flow of data from Oral Health Assessment (OHA) forms between DCPS (and charter schools) DOH-CHA & MAA. b. Increase partnership with other stakeholders collecting oral health data to establish baseline data and develop surveillance method.	DCPS DOH – CASH/Oral Health Division DC Head Start Childcare providers CFSA/ DC Family Courts DC Chartered Schools OCTO	Central oral health database that will allow stakeholders to update when needed. Staff Funding	Internet connectivity and deployment of electronic student health record software are scheduled for completion in FY08. All DCPS nursing suites are expected to be able to electronically record health information including items from the oral health assessment (OHA) form.	August 2008
Evidence of Success / Criteria • Improved the ability to capture, analyze & monitor data pertaining to children's dental caries experience in their primary and permanent Teeth.				
Evaluation Process / Targets • Baseline data will first be established/determined for all targets.				

Indicator 8a: Sexual Health - STD / HIV

Targets include:

- **Reduce Chlamydia rates among young persons 15-24 years old to no more than 3%.**
- **Increase the number of young persons aged 15-24 years old who know their HIV status by 25%.**
- **Increase the number of persons under 25 receiving Housing Opportunities for People with AIDS (HOPWA) housing assistance by 10%.**
- **Increase the number of HIV+ persons under 25 receiving continuous HIV care by 10%.**
- **Reduce the rates of new HIV infections and new AIDS diagnosis among young persons 15-24 yrs by 25%.**

Baseline:

- **Chlamydia rate 15-24 year olds 5-9% in 2005.**
- **Numbers of 18-24 year olds who know their HIV status 54% in 2004 (BRFSS 2007)**
- **2 HOPWA clients under 17 years old and 84 clients between 18 and 30 years old in FY07.**
- **60 enrolled clients receiving services from AIDS Drug Assistance Program (ADAP) as of September 2007.**
- **252 newly reported cases of AIDS 2001-2006.**

Indicator 8b: Sexual Health - Teen Births

Target - To reduce the pregnancy rate to 15-19 year olds by 10% by 2010.

Baseline: Pregnancy rate of women 15-19 years old: 64.4 per 1000 women. (2005)

Improvement Strategy I: Promote HIV and STD prevention skills and sexual health in DC youth, through evidence-based curricula in decision-making (Proud Choices), Parent-Child Communication (Parents Matter), and school-based health teaching.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1.Implement evidence-based curricula (e.g., "Proud Choices") for appropriate audiences	DOH-HAA Prevention Bureau staff; DOH-CHA CASH Bureau. DCPS; OSSE, Office of Deputy Mayor of Education (ODME)	DOH-HAA staff in collaboration with community or training partners. Expertise and technical assistance is available from CDC-funded organizations such as the national Minority AIDS Council.	Additional funding is needed to transition to using expert partners to routinely deliver trainings under the oversight of DOH-HAA.	Train 100 people by September 2008
2. Develop cost-analysis and strategy for rolling out Parents Matter in schools and faith-based organizations across at least 2 wards	DOH-HAA. Implementation would require collaboration with DCPS and Community-based/ faith-based organizations.	DOH-HAA staff in collaboration with CDC can provide planning resources. CDC can provide early trainings and materials.	This is an ideal initiative to identify public-private partnership for pilot implementation. Challenge will be bringing such a partnership to fruition and identifying sustainable funding.	Develop plan by September, 2008

3. Implementing an evidenced-based curriculum meeting the Health Education Standards for HIV and STD education	DCPS DOH-HAA and DOH-CHA	DCPS and DOH staff Community partners with local and national expertise	Selection of appropriate existing materials Community input Teacher training	By September 2009
Evidence of Success / Criteria • Benchmarks of success are those determined by DC or CDC 2010 Healthy People Goals as well as those developed and documented in the 2007 DC Youth HIV /AIDS Initiative. Specific goals/criteria for success are described in section above				
Evaluation Process / Targets • Process evidence of success includes having developed a cost-analysis and potential funding stream by FY09. Service indicators include number of children reached through evidence-based curriculum supported by DOH-HAA.				
Improvement Strategy II: Mobilize community partners to reach an increased number of in-school and out-of-school youth with quality STD/HIV prevention, care, and treatment services.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Work with funded partners to deliver prevention and care services and to build youth-friendly skills among general providers.	DOH-HAA Prevention bureau staff will oversee prevention services. DOH-HAA Care and Support Services will oversee care services.	HAA staff is available to train and coordinate trainings provided by Youth partners to non-youth service providers.	HAA Youth Coordinator job now vacant; timing of HR hiring process and/or ability to use TAPER hiring will determine timeframe.	Ongoing.
2. Reach non-funded community partners through the youth working group.	DOH-HAA staff will coordinate the working group.	No funding is needed to facilitate meetings. HAA Prevention bureau staff will serve as coordinator.	Success of working group dependent on participation of partners. HAA Youth Coordinator job now vacant; timing of HR hiring process and/or ability to use temporary hiring will determine timeframe.	Ongoing. Conduct four meetings of the youth working group by September 2008.
Evidence of Success / Criteria • Benchmarks of success are those determined by DC or CDC 2010 Healthy People Goals as well as those developed and documented in the 2007 DC Youth HIV /AIDS Initiative.				
Evaluation Process / Targets • Process-related evidence of success includes increasing the number of non-youth providers trained in youth issues to 50% of funded prevention service providers; meeting of youth prevention working group at least quarterly; service indicators include number of youth reached directly by youth providers.				

Improvement Strategy III: Promote HIV and STD counseling, testing and referral among DC youth.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Conduct outreach STD/HIV education and testing through organizations that target youth	DOH-HAA staff will oversee HIV education and testing services. Community partners	FY08 Monies have been committed to multiple youth community partners for HIV testing, health education services at the youth detention facility, a youth social marketing campaign, and training of school health nurses.	Policy issues and practical barriers that impact the ability of DOH-HAA and providers to reach youth in the venues where they are clustered. Identifying continued funding in FY09 and FY10 to provide health education outreach services.	Implementation is ongoing.
2. Conduct HIV Education to high-risk youth at the juvenile detention facility	DOH-HAA and DYRS staff. "Steppin' Up, Movin' On" provides HIV education services at the youth detention facility. One HAA staff person is designated to serve as a technical advisor to project.	FY08 monies have been committed to provide health education services at the youth detention facility. If DYRS decides to utilize rapid testing technology to increase access to optional voluntary HIV testing, in context of prevention, linkage and support services, HAA will provide training and testing kits.	Identifying continued funding in FY09 and FY10 to provide health education outreach services.	Ongoing.
3. Identify HIV testing needs and develop implementation strategies for HIV screening of 13-18 year olds	DOH-HAA Prevention Bureau Community providers Government agencies	No additional funding needed to create report. Funding need to implement strategies will be identified in the report. Strategies are likely to include more data collection or new implementation pilots.	Lack of established best practices in this area. Lack of current youth coordinator. Additional original data collection and pilot studies may be needed to find implementable plan.	January 20 DC Youth HIV /AIDS Initiative. Specific goals/criteria for success are described in the Healthy People Objectives section above.

Evidence of Success / Criteria

- Benchmarks of success are those determined by DC or CDC 2010 Healthy People Goals as well as those developed and documented in the 2007 DC Youth HIV /AIDS Initiative. Specific goals/criteria for success are described above.

Evaluation Process / Targets

- Process-related evidence of success includes identification of strategies and minimization of policy barriers and policy misconceptions that limit delivery of testing services to 13-18 yr olds. Service data will provide process evidence of success in terms of number of youth reached for counseling and testing.

Improvement Strategy IV: Connect DC youth infected with and affected by HIV with care and support services

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Connect newly-diagnosed HIV-positive youth into care services, and treatment.	DOH-HAA Care and Support Services bureau will work with community providers of HOPWA services to ensure that they are available to youth. Case managers are supported through Ryan White funds. Care partners providing services to youth have specific adherence support programs.	DOH-HAA staff, HOPWA housing funding, existing partnerships with youth providers in the community. Additional funding needed to clear HOPWA waiting list. Resources to support treatment are currently available through ADAP program and Medicaid.	Need to engage fair housing supports. Need to establish options for and legality of prioritizing young persons on the waiting list. Need an adequate tracking mechanism; challenges to getting youth affected by any chronic diseases to be consistently compliant with care.	Ongoing. Enhanced outreach to youth providers between January-September 2008 to emphasize methods & importance of getting youth into stable housing and care earlier.

Evidence of Success / Criteria

- Benchmarks of success are those determined by DC or CDC 2010 Healthy People Goals as well as those developed and documented in the 2007 DC Youth HIV /AIDS Initiative. Specific goals/criteria for success are described above.

Evaluation Process / Targets

- Process evidence of success includes number of case workers exposed to youth-specific issues during routine HAA meetings/updates. Service data will provide process evidence of success in terms of number of youth reached with the specific housing and care interventions noted above.

Improvement Strategy V: Raise sexual health awareness and risk perception among DC youth.				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Work with funded Community partners use evidenced-based approaches and innovative strategies to reach youth with prevention and risk message and services.	DOH-HAA and DOH-CHA staff Funded community partners	FY08 Monies have been committed to partners for a youth-directed social marketing campaign and for internet-based text messaging awareness campaign. A general social marketing contract is being developed that will provide complementary social marketing services.	Identifying funds to continue services in FY09 and FY10.	The youth social marketing campaign and the internet-based text messaging project will be implemented by March 2008.
2. Provide training providers about Youth and STDs.	DOH-HAA STD Bureau	DOH-HAA STD Bureau has developed effective one-session sensitization meetings for providers to heighten awareness & skills regarding STD services for youth.		Complete 5 more trainings by September 2008 (ongoing--did 13 sessions in FY07)
Evidence of Success / Criteria • Number of trainings provided. • Funds available for innovative strategies and current evidenced-based approaches.				
Evaluation Process / Targets • Process evidence of success includes number of providers reached with STD updates/skills building and number of new evidence-based reached strategies implemented through HAA support. Service data will provide process with specific interventions. Evidence of success in terms of number of youth and parents.				

Improvement Strategy VI: Expand primary and secondary prevention of teen pregnancies (Prevention of subsequent pregnancies)				
Tasks / Action Steps	**Responsibilities**	**Resources**	**Considerations**	**Timeline**
1. Work with Community partners to implement evidence-based approaches to increase the age of sexual initiation. a. Support implementation and expansion of integrated school-based model of primary prevention of teen-age pregnancy (Carrera model)	DOH-CHA and DOH-HAA CYITC Community partners	CYITC has worked with DOH and others to implement Carrera model (middle school program to engage youth).	Need for identification of additional funding streams and partnerships in community.	Expansion by September 2008.
2. Review and implement evidence-based models for home visitation for teen parents.	DOH Healthy Start Program, community partners	Current home visitations programs. Community partners.	Secondary prevention: delaying or spacing out subsequent pregnancies for adolescent mothers has shown to improve outcomes	September 2008
3. Establish programs and procedures that support adolescent parents.	DOH CHA, DMH, DCPS, OSSE, Community partners	Space available. Need additional staff coverage and funding.	Expand school-based services such as daycare (expansion of hours till 5pm).	September 2008
4. Expand access to school-based health services with the capacity to distribute medications	DCPS, OSSE, DOH	Existing staff.	Need to engage DCPS and community partners to explore development of wellness centers and health services in DCPS and charter schools (e.g., teen parenting multidisciplinary support groups).	September 2008
5. Decrease the pregnancy rates of teen parents in foster care. a. Expand the services in the teen parent group homes to include more intensive mental health services and parenting support. b. Improve case management services	CFSA, DOH, Community partners	Existing funds. Existing staff.	Age-appropriate counseling on-site and reproductive health services referrals for all teens being tested for STDs.	October 2008

Evidence of Success / Criteria

- Capacity of teen parents to have a comprehensive array of services regardless of whether they are enrolled in school or not.
- Increase number of students served by integrated, school-based primary prevention program

Evaluation Process / Targets

- Number of services available to teen parents in unified locations. Clear plan for teen parents in the foster care system.
- Ongoing evaluation in place of primary prevention model assessing delay in pregnancy as well as related educational, health and other desirable outcomes.

Improvement Strategy VII: Leverage inter-agency cooperation for increased routine delivery of HIV/STD and teen pregnancy prevention services to DC youth.

Tasks / Action Steps	Responsibilities	Resources	Considerations	Timeline
1. Coordination of all agencies interfacing with teens around sexual health.	DOH-HAA co-leads with DOH-CHA	DOH-APRA, DCPS, OSSE, DPR Includes DOH-CHA, DOH-HAA, DOES, DYRS, DMH, CFSA, DHS		Ongoing

Evidence of Success / Criteria

- Benchmarks of success are those determined by DC or CDC 2010 Healthy People Goals as well as those developed and documented in the 2007 DC Youth HIV /AIDS Initiative. Specific goals/criteria for success are described above.

Abbreviations of Responsible Parties

DISTRICT GOVERNMENT AGENCIES

- Child and Family Services Administration (CFSA)
- Children's Youth Investment Trust Corporation (CYITC)
- Department of Consumer and Regulatory Affairs (DCRA)
- Department of Corrections (DOC)
- Department of Health (DOH)
  - Addiction Prevention and Recovery Administration (APRA)
  - Community Health Administration (CHA)
    - Children, Adolescent and School Health Bureau (CASH)
    - Perinatal and Infant Health Bureau (PIHB)
  - HIV/ AIDS Administration (HAA)
  - Medical Assistance Administration (MAA)
  - Office of Communications and Community Relation (OCCR)
- Department of Housing and Community Development (DHCD)
- Department of Human Services (DHS)
  - Early Care and Education Administration (ECEA)
- Department of Mental Health (DMH)
- Department of Parks and Recreation (DPR)
- Department of Youth and Rehabilitative Services (DYRS)
- DC Head Start (DCHS)
- DC Housing Authority (DCHA)
- DC Public Schools (DCPS)
- District Department of the Environment (DDOE)
- District Department of Transportation (DDOT)
- Executive Office of the Mayor (EOM)
- Metropolitan Police Department (MPD)
- Office of the Attorney General (OAG)
- Office of the Chief Technology Officer (OCTO)
- Office of Planning (OP)
- Office of the State Superintendent (OSSE)
- University of the District of Columbia (UDC)

COMMUNITY-BASED PARTNERS

- American Lung Association (ALA)
- DC Chapter of the American Academy of Pediatrics (DC AAP)
- DC Partnership to Improve Children's Healthcare Quality (DC PICHQ)
- George Washington University (GWU)
- Georgetown University (GU)
- Howard University (HU)
- Managed Care Organizations (MCOs)
- National Institute of Child Health and Human Development (NICHD)
- National Nursing Centers Consortium / NNCC
- Summit Health Institute for Research and Education (SHIRE)