



State Title V Block Grant Narrative

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Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director



July 14, 2000

Peter C. van Dyck, M.D., M.P.H.
Associate Administrator
Maternal and Child Health Bureau
Health Resources and Services Administration
Room 18-31, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. van Dyck:

Re: Maternal and Child Health Services Block Grant
#00BIDCMCHS-Budget Period 10/1/2000-09/30/01

The **District of Columbia** Department of Health is pleased to submit the **FY 2001** Maternal and Child Health Services Block Grant Application Annual Report. This document will comply with the provisions of Title V of the Social Security Act, revised by P.L. 07-95, the Omnibus Budget Reconciliation Act of 1981, as amended by P.L. 101-239, the Omnibus Budget Reconciliation Act of 1989.

The proposed allotment of **\$7,031,721** is being requested to maintain a citywide system of family-centered, culturally competent, comprehensive quality health care and related services for women of childbearing age, mothers, infants, children and adolescents-including children with special health care needs. The Application/Annual Report also responds to the requirements delineated in your final review report of August 10, 1999.

Please contact Marilyn Seabrooks Myrdal, M.P.A., Interim Maternal and Child Health Officer. If you have any questions or need clarification regarding the **FY 2001** MCH Services Title V Block Grant Application Annual Report at (202) 442-5925.

Sincerely,

Ivan C.A. Walks, M.D.
Director

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1.4 Overview of the State

The District of Columbia (DC) consists of a land area of 63 square miles. 57% of the land base is tax-exempt, much of it owned by the federal government, and 41% of the assessed property value is exempt from property taxes. DC is unique among US cities in its multiple roles as the nation's capital, a state and a city. This status, combined with limitations of the local government's authority to tax federal and other property and incomes of commuters, severely limits the availability and allocation of resources.

The District is divided into 8 wards--governmental subdivisions on which political representation is based and public services are administered. Voters in each ward elect a city council representative, and 4 members are elected at-large. A federally-appointed, 5-member Financial Responsibility and Management Assistance Authority, established in 1995, continues to have official responsibility for city government operations, however, the Authority is gradually returning control to the elected mayor, who took office in January 1999. If FY 2000 yields a budget surplus, the Authority may be disbanded, restoring power to elected governmental officials. However, the District's fiscal and legislative authority will continue to be subject to Congressional vetoes. District residents do not have voting representation in Congress.

The 1999 population was estimated to be 519,000, a 15% decline from both natural change and net migration from the population of 606,900 reported in the 1990 US Census. A marked decrease in the number of births to residents also continued--from 11,650 in 1991 to 7678 in 1998, a 34 % reduction. The birth rate declined from 17.5 in 1994 to 14.7 in 1998, compared to the US rate of 14.6¹ The 1998 fertility rate was 60.9, compared to the US rate of 65.6. Although the teen birth rate declined sharply from 114.4 in 1991 to 65.4 in 1998, teen birth and pregnancy rates are among the highest in the US. And teen repeat birth rates are exceptionally high in comparison to other cities: *31% of teen births in 1997 were to women who were already mothers.*²

DC is a predominately African American city. In 1998, the population was estimated to be 61.7% African American, 34.9% white and 3% Asian American. Latinos are estimated to constitute

¹ National Vital Statistics Reports, Vol. 47, No. 26, October 25, 1999, Tables 2 and 3 and Vol. 47 No. 25, October 5, 1999.

² The Right Start: Conditions of Babies and Their Families in America's Largest Cities. Kids Count Special Report. Baltimore, Maryland, The Annie E. Casey Foundation, 1999.

proximately 7.4%³. 70% of the total 1998 births (5381/7678) were to African Americans, and nearly 10% to Latinas (762).

Economic, social and health status indicators vary considerably across the 8 city wards. For example, median household income ranges from \$26,300 in Ward 8 to \$64,800 in Ward 3.⁴ Racial/ethnic composition varies from 4.9% non-Hispanic African American in Ward 3 to 96.3% non-Hispanic African Americans in Ward 7. More than 40% of the Latino population is concentrated in Ward 1 where it represents 25.5% of the population.⁵

State Health Department

The Department of Health (DOH) became a cabinet-level department in January 1997 with a FY 2000 budget of \$1,004,295,919 and 1107 FTEs. The city council recently approved the FY 2001 budget of \$1,015,282,000, including 1241 FTEs. 85% of the total budget is allocated for the Medicaid and medical charities programs. More than 68% of the total annual budget derives from federal funding. The director of the DOH reports to the deputy mayor for children, youth and families, a position created by the current administration to give more visibility and attention to services affecting this population. The Department of Human Services also falls within the purview of that position.

Ivan C.A. Walks, MD was appointed director of the DOH September 1999. His appointment precipitated several changes in organization made to reflect the continuing change of the department's role from the delivery of direct services to public health functions. Although the organizational structure continues to evolve as personnel changes occur and new initiatives are undertaken, as of May 2000, the department is managed by a chief administrator, a legislative officer and 5 senior deputy directors. Senior deputy directors are responsible for programs of health assurance (which includes environmental health, food safety and state lab functions), health promotion, and Medicaid respectively. The other 2 senior deputy directors are responsible for health policy and evaluation, and quality, planning and external affairs.

According to documents submitted for the FY 2001 budget:

³ Population estimates were obtained from the DC Office of Planning, State Data Center. The Latino estimate includes both whites and African Americans.

⁴ DC Office of Planning, State Data Center. Median household income for the entire DC in 1997 was \$39,792.

⁵ 18,356/71,782 estimated in Ward 1, 1997. Total Hispanic population = 43,332.

The mission of the Department of Health is to forge public and private partnerships and collaborations; to assure safe and healthy environments through licensing and regulation; to establish a culture within the Department of Health based on the cornerstones of accountability, integrity, customer service and cultural quality; and to ensure culturally and linguistically competent delivery systems

The department delineated these priority goals:

- Establishing a strong Department of Health that treats our customers with respect and dignity, removes barriers to health care access, improves the environment and exacts the highest standards of health care practice for citizens;
- Establishing a health care environment that is based on cultural quality, maximizes external resources, and focused on customer satisfaction;
- Developing, implementing, and evaluating programs aimed at promoting, educating and empowering healthier families and communities;
- Protecting the health and ensuring the safety of all residents and visitors;
- Developing public health policy based on sound science that encourages creativity and innovation in developing programs and initiatives and that firmly establishes the District of Columbia as a national leader in public health;
- Ensuring that every eligible resident has health insurance and that every resident has access to a primary care home;
- Improving the quality of life for residents by planning with data input, creating work plans to address problems, and measuring and evaluating outcomes; and
- Improving its public image by exceeding the expectations of the populations we serve by providing seamless opportunities for service delivery through public/private partnerships

In the winter of 2000, under the leadership of the State Center for Health Statistics, DOH completed the 2010 planning process. The final plan, ready for release to the public pending mayoral approval, incorporates 20 maternal and child health objectives, 14 adolescent objectives, and 6 family planning objectives. The Office of Maternal and Child Health (OMCH) staff relied heavily on the performance measures required for Title V reporting, and consequently 13 of the 2010 objectives overlap with the Title V measures. The 2010 objectives have also been incorporated into the 5-year needs assessment process. (See section III.).

The DOH was involved in a number of other planning efforts during this period. Throughout the spring and summer of 1999, Mayor Anthony Williams held a series of retreats for the members of his cabinet, resulting in the establishment of a series of goals for citywide planning. Agencies were then directed to develop objectives for FY 2000 under each goal area. To maximize citizen participation, the mayor held a citizen's summit November 20, 1999 with over 3000 residents attending; at a second summit, held January 29, over 1500 attended. These events gave citizens an opportunity to respond to the 1st draft of the citywide strategic plan, as well as articulate their concerns and their hopes. Of 6 possible priorities presented, the citizens listed 3 as most important. Each related to the health and well being of children, youth, and families: building and sustaining healthy neighborhoods; investing in children and youth; and strengthening families.

In a parallel effort, the Office of the Deputy Mayor for Children, Youth, and Families issued the District of Columbia FY 2000 children and youth action plan, known as *Safe Passages*. The plan outlined specific strategic priorities for the year, several of which relate directly to OMCH initiatives. In addition, the plan will form the foundation for the section on investing in children and youth found in the citywide strategic plan. Priorities and strategies are summarized as follows:

Priority 1: children are ready to learn upon entering school.

- Improve and expand quality in childcare and early childhood development facilities and programs.
- Introduce legislation to the council of the District of Columbia to require universal newborn hearing screening.

Priority 2: children and youth are succeeding in school.

- Develop out-of-school time initiatives that assist and enable schools to be more effective in educating our children.
- Increase access to support services for at-risk students and families.

Priority 3: youth are developed into successful young adults.

- Establish a district youth council as an adjunct to the workforce investment board. the youth council will bring us fresh ideas about developing effective school-to-work programs.
- Launch a passport-to-work internship initiative for 12th grade students who are performing satisfactorily in school. This initiative will provide structured work experiences for youth.

Priority 4: children, youth, and families are healthy.

- Substantially increase enrollment in the DC Healthy Families expanded Medicaid health insurance program.
 - Increase the proportion of eligible women, infants, and children enrolled in the WIC nutrition program.

Priority 5: reduce youth-on-youth violence in school settings.

- Establish a roving leaders program to focus on working with at-risk adolescents, particularly those at risk of gang involvement.
- Expand successful violence prevention in 5th and 6th grade, high schools, and charter schools.

At the department level, the DOH director, working with his senior deputy directors, has developed a draft plan that is in keeping with the city plan. The DOH plan is currently under review by the mayor. Specific health objectives related to children and youth included in the DOH plan are identical to the health objectives outlined in *Safe Passages*. Also, the plan articulates the change from direct service delivery to a focus on the traditional public health functions of assessment, assurance and policy.

PBC

In March 1998, principals of the DC Health and Hospitals Public Benefit Corporation (PBC) and DOH signed a 3-year intra-district grant agreement wherein \$3.5 million of FY 1998 Title V funds were transferred to provide safety net, preventive and primary care for women, infants and children, including children with special health care needs. This agreement, with the annual amount to be renegotiated yearly, continued the longstanding relationship between the Title V program and the public community health centers, previously operated under the authority of the Commission of Public Health. According to the agreement, the PBC accepted responsibility for the 3 to 4 required match of the transferred funds. Subsequent agreements transferred \$3,500,000 of the FY 1999 Title V funds and \$1,000,000 in FY 2000.

The PBC, which was created in October 1997, continued the integration of 8 community health centers (CHCs), the Health Services for Children with Special Needs Clinic, the school health nurses program and the DC General Hospital (DCGH). In collaboration with other city agencies, a new primary care clinic was opened at Ballou High School November 1999 to serve students in an

impoverished and underserved area of the city. Ballou is the only high school in Ward 8. Operating during school hours, it is staffed by a full time RN and NP. A physician see patients 1 day weekly, with a social worker and other specialists on site for specific hours on a weekly basis.

The PBC executed a new contract for billing services June 1998, which included retroactive 3rd party billing for services provided during 1997. A number of billing claims through 1999 are currently under negotiation with the Medicaid agency. The same billing and collections contract has been maintained since 1998 for all clinical service reimbursement, including efforts to assign the eligible uninsured to Medicaid managed care. About 26% of CHC patients are currently covered by Medicaid managed care, 22% receive assistance under DC Medical charities, and more than 40% have no insurance.

Six of the 7 Medicaid managed care organization (MCO) contractors negotiated contracts, as required by law, with the PBC in 1999. They continue to be in place. Under the terms of the contracts, when the enrollment broker contractor enrolls beneficiaries in one of the MCOs, enrollees may designate the PBC as their primary care provider (PCP). Within the MCO networks, the PBC Health Services for Children with Special Needs Clinic is available to receive referrals from primary care providers for comprehensive developmental assessments, treatment and care coordination. As of May 2000, the PBC had 4925 MCO patients, the large majority of which selected CHC doctors as their primary care providers.

In 1999, the PBC negotiated a 5-year contract with the LaShawn Receivership to provide medical, mental health and behavioral health services to foster children in the District's custody. This program, called *Healthy Kids*, was implemented October 1999, with primary care provided at 3 CHCs (Congress Heights in Ward 8, Hunt Place in Ward 7, and Walker-Jones in Ward 2).

PBC officials say they expect their organization to be approved as an MCO for competition in future Medicaid managed care expansions. They have argued that exclusion from competition in bidding for Medicaid mandatory managed care provider contracts has affected their ability to compete effectively. The revenues retained from patients who elected to remain with their CHC providers were reduced by capitated payments from the MCO contractors, but payments would be higher if the PBC were a MCO contractor. Currently, capitated payments average about \$15 per patient per month for primary care.

The PBC is continuing with plans to improve physical plants. The DC capital budget includes funding for a new facility to replace the Anacostia CHC. Ground breaking is scheduled for September 2000. Expected to be ready to receive patients in CY 2001, the CHC will be open 7 days per week. Funds have also been allocated for a new center in Ward 7, which will combine the service areas of the old Benning Road and Hunt Place centers. A major renovation of the Walker Jones center will take place next year.

The PBC is proceeding with JCAHO accreditation—the labs are fully accredited—and DC licensure. Officials say they are also applying for 330 and/or federally qualified health center status.

Although the PBC has established a sliding fee scale and installed a system to maximize 3rd party billing, officials continue to maintain their longstanding commitment to provide care to residents regardless of ability to pay. PBC managers and staff have been trained to assist clients to enroll in Medicaid and the Title XXI-supported expansion. Usually, if an uninsured patient presents, a staff member is able to start the process of determining eligibility and enrollment on the spot. Calls are made in advance to patients with appointments to initiate the eligibility determination process and assist patients in bringing required information to their appointments.

Medical record purging and archiving at CHCs, initiated in FY 1998, was completed in 1999, and an ongoing purging process is in place. Uniform record forms and problem lists are used throughout the PBC system. A consistent, unified medical record format has been installed. All medical and dental services, including specialty services, are a part of the patient record. An on-line patient registration system is now being used in the Health Services for Children with Special Needs Clinic and 6 of the 8 CHCs. Bell Atlantic is completing wiring for the remaining facilities—Adams Morgan and Benning Heights—with a target date for full service in 2000. This computer system is fully integrated with DCGH, providing uniform pharmacy, lab orders, scheduling and appointments throughout the entire PBC system. PBC officials have repeatedly expressed confidence that the new MIS will generate reports containing required information for the Title V report and application in subsequent years. The new MIS is not yet fully operation because of difficulties in getting the CHCs connected. After the last 2 clinics are brought on-line in the summer of 2000, several months will be devoted to training and the final implementation steps.

Medicaid Managed Care

Medicaid participation is high in the District of Columbia: 1 of every 4 residents and 2 of every 3 children.⁶ In Ward 8 where participation is highest, 42% of the residents are recipients.⁷ HCFA approved the DC 1915(b) Medicaid waiver in March 1997 to move approximately 80,000 TANF and TANF-related Medicaid beneficiaries into mandatory managed care. Initial enrollment of eligible beneficiaries into 7 managed care organizations (MCOs) was completed in November 1998. Approximately 73% voluntarily selected their own MCO.

Since then, legal services and consumer advocacy groups have worked to strengthen requirements for grievances and appeals procedures, EPSDT compliance and timely appointment making, and to eliminate improper billing and lags in recertification. Although originally scheduled to begin the process of re-bidding the 3-year contracts in August 1999, with contractor selection projected for completion by December 1999, the Medicaid agency has postponed the re-bidding, with extension of the existing contracts through March 2001. In the late summer 1999, the specifications for the new solicitation were circulated throughout DOH. OMCH submitted a number of recommended changes in the text, particularly with regard to obligations of providers of services for children with special health care needs. Under the draft solicitation, the Medicaid agency planned to contract with 4 MCOs, 2 of which would include SSI children, a group that, to date, has had a choice between a dedicated MCO and fee-for-service. But recent interviews undertaken in preparation of this report revealed that the current intent is to select 1 dedicated special needs contractor and continue to allow beneficiaries to select fee for service or the dedicated MCO.

This decision was based upon several factors. In an analysis of enrollment patterns, MAA found that most of the children with serious disabilities were enrolled in the dedicated MCO, which provides care coordination, while many of the beneficiaries with less serious medical problems chose to remain in fee-for-service. Disenrollment rates have been consistently low--most recently 2.5% annually. An HCFA-sponsored evaluation conducted by Abt Associates was generally favorable, and other indicators, particularly client satisfaction surveys, are positive as well. Medicaid officials consider the program a success as indicated by enrollments--66% to 77%⁹ of the approximately 3000 eligible children have elected to enroll and have maintained their eligibility.

⁶ District of Columbia Medicaid Program: Turning the Corner Annual Report, 1998, Department of Health. Participation is high because of the high incidence of poverty.

⁷ Primary Health Care Services For the Medically Vulnerable In the District of Columbia: A 2000 Update, District of Columbia Primary Care Association, June 2000, p. 28.

⁸ District of Columbia Medicaid Program: Turning the Corner, 1998 Annual Report. DC Department of Health, Medical Assistance Administration, p. 16.

⁹ 2/3 is cited in the District of Columbia Medicaid Managed Care: Phase II Plan for Children with Special Health Care Needs--Concept Paper. DC Department of Health, Medical Assistance Administration, 5/3/99, p. 1. 77% is cited in District of Columbia Medicaid Program: Turning the Corner, 1998 Annual Report. DC Department of Health, Medical Assistance Administration, p. 18.

Officials are still considering what to do with Medicaid children who are not SSI recipients but who have more broadly defined special needs. The District continues to operate without an official definition of what constitutes special needs. In a 1st attempt to rectify this, MAA plans to hold a conference in the fall of 2000 to consider expanding the program beyond SSI beneficiaries to include some or all of various special health care needs categories: foster children, children in the custody of the Youth Services Administration, children in or at-risk of residential placements; many of which are located outside of the DC metropolitan area, and children under age 1 with rare and expensive diagnoses. DC has not established presumptive eligibility, therefore many of the latter group are eventually enrolled in SSI, but generally not during their 1st year of diagnosis.

MAA staff members recognize a number of barriers to improving care for the special needs population: diversity in primary languages, homes that are physically inadequate to support the care of a special needs child, and dysfunctional families.

As of June 16, 2000 the new solicitations have not been published, although officials have indicated that the process must begin soon in order to have new contracts in place for the transition in March. Existing contacts for all MCOs were extended for several reasons, including debate about carve in/out of mental health services and the extent to which substance abuse treatment should be covered. In addition, the MCO market is volatile and at the time of the extensions, several MCOs were experiencing bankruptcy and/or buy-outs. In addition, a new city administration installed in January 1999, pending waiver applications, and the possibility of expanding Medicaid coverage contributed to the decision to postpone changes in the scope of services. The recommendations of a high-profile commission on restructuring the health system, appointed in the fall of 1999, may be incorporated in the process.

The Medicaid agency was placed in the DOH 2 years ago. DOH officials' current policy views Medicaid as a component of public health, rather than simply a financing mechanism for medical services to the poor. As a result, there may be support for closer coordination of Medicaid contracted services and DOH public health functions.

Title XXI--Child Health Insurance Program--DC Healthy Families

On October 1, 1998 DC expanded its Medicaid eligibility rules to provide health insurance coverage to low-income children, their parents and pregnant women under a new program—DC Healthy

Families. The eligibility criteria are as follows: children under age 19 and the parents, legal guardians, and relative caretakers of eligible children who are (a) qualified immigrants; (b) residents of DC; and have family income at or below 200% of FPL. An outreach and enrollment services contractor worked with government agencies, community-based organizations, and the public to identify eligible children, parents and pregnant women and assist them with enrollment. The efficient enrollment of eligible persons and assisting them in obtaining services became a priority for the entire department, including the Office of Maternal and Child Health (OMCH).

As of May 1, 2000, Medicaid officials reported the following enrollments:

- 87.9% (3537/4023) of the targeted children eligible for Medicaid but not previously enrolled;
- 53% (2983/5601) of the targeted newly eligible children;
- 95.5% (6413/6714) of the targeted adults included in the expansion; and overall,
- 79.2% of the total target enrollment (12933/16338) has been met.

Community advocates and providers, however, have raised concerns about the reliability and validity of the targets, which are not equivalent to the original estimates of eligible persons, but rather upon projections of a subset of eligibles who would actually enroll, for example, that 64% of the targeted population would enroll in year 1 and 100% of the targeted population by the end of year 3. These estimates and projections were made by a contractor (Lewin) commissioned in 1998 and are subject to the usual limitations of estimating relatively small population subgroups. Regardless of the degree of accuracy, the discrepancies have become an issue with advocates.

However, the official enrollment rates compare favorably with those of other states, although as Medicaid officials recognize, the lower rates of enrollment for the newly eligible children and families compared to rates in other categories indicate a need for more innovative outreach strategies. Enrollment under the Medicaid program has increased markedly since the public information campaign for DC Healthy Families was launched.

Since its inception officials have worked to identify and overcome barriers to enrollment, for example, use of a 2-page application form, abbreviated from the 28-page Medicaid application is used. The English-Spanish form can be picked up at many retail establishments and service organizations, and mailed in by applicants, eliminating the barriers that arise from having to apply in person at a welfare office. Documentation of eligibility has been minimized to the extent required by

law. Community based organization staffers have been trained and enlisted in the effort. Focus group research was conducted to identify other ways to reduce barriers. As a result of findings, the visual appeal of informational material, as well as of the application itself, has been changed to reduce the perceived stigma of participation in a DC government program.

A number of barriers remain. Immigrants fear not being able to adjust to a permanent immigration status because of immigration and naturalization laws related to public charge. These fears have reportedly not been entirely alleviated by the promulgation of a federal regulation that officially removed this barrier. Long-standing systemic problems with eligibility determination have not been satisfactorily solved. Advocates continue to receive anecdotal reports about difficulties in obtaining and processing applications in a timely manner. For example, Income Maintenance Administration eligibility workers reportedly do not always understand the differences in the Medicaid and the DC Healthy Families eligibility requirements. Consequently, they sometimes misinform applicants and request unnecessary documentation.

Although considerable progress has been made in enrollment, the current challenge may be one of maintenance and continuity. Anecdotal evidence suggests that both recipients and workers continue to be unsure about the right to, and process for, continued Medicaid benefits for recipients as they transition out of, or are removed from, the TANF program. Staff representatives say that letters are sent to persons who have been terminated from Medicaid to inform them of the Title XXI program, however, past experience suggests the ineffectiveness of reliance on mailed notification.

It recently became obvious that the recertification process is a serious barrier to continued participation. Title XXI recertification/reenrollment currently requires the recipient to fill out the regular Medicaid recertification form. This form contains a financial assets section, not included in the 2-page Healthy Families application. Consequently, recertification applicants are being required to provide more information than in the original application, and, as a result, recipients are dropping off the rolls. DOH and the Income Maintenance Administration are working to correct this problem by reducing the amount of information requested to the extent allowed by law.

Over the past 2 years, OMCH and the MAA developed a strong partnership in order to successfully implement DC Healthy Families. Specifically, the OMCH Healthline serves as a cornerstone of the outreach efforts. To support this collaboration, MAA funded 2 FTEs through a contractor to expand

the telephone referral capacity and increase its bilingual capability. The positions were filled in November 1998. The MAA staff and the outreach contractor, Houston Associates, provide monthly in-service education and training for Healthline staff. Examples of training sessions include dealing with the difficult caller, cultural diversity, and telemarketing. The Healthline also maintains TDD/TTY capacity.

Multi-lingual Healthline workers have been trained to give information to callers. The English/Spanish bi-lingual capability of the Healthline has been in place for 10 years. With the addition of contractual staff, this linguistic capacity has been extended to include Vietnamese, Mandarin and, with somewhat less fluency, Korean. An average of 90 calls a month are being received from the Asian community. Arrangements for dealing with callers who need information in other languages can be made with the Children's National Medical Center translation center or through the DC government's contract with AT&T. A private sector collaborative—Community Voices—has provided funds to a nonprofit clinic—La Clinica—to provide Spanish translation services to other DC based health clinics. La Clinica has arranged with the Northern Virginia Health Education Center for *medical* interpretation services in other languages. The center employs 40 interpreters and offers services in 12 languages.¹⁰

During this reporting period, staff responded to 24,479 calls, 51% of which concerned health insurance. The Healthline number--1 800 MOM BABY--is on all printed outreach materials, and is used in all media opportunities, thus increasing awareness of the telephone number as a general public information resource as well as a specific source of information about enrollment in DC Healthy Families.

Other Medicaid Expansions

Serious discussions are ongoing to expand coverage for additional categories. An expansion in FY 2001 to cover childless adults with incomes less than 50% of FPL, for which a waiver application must be approved, was included in the budget request and could result in enrollment of an estimated 8000 poor adults.

Stemming from a legislative compromise during the action on the FY 2000 budget in which the mayor originally proposed increased coverage up to 200% of the FPL, legislation was eventually

¹⁰ Rx for Language Gap At the Doctor's Office, *The Washington Post*, April 27, 2000.

passed in spring 2000 to expand Medicaid-like coverage for up to 500 children ineligible for standard Medicaid coverage due to their immigration status. Children who have legal permanent resident status and who entered the US after August 22, 1996, children in “temporary protective status”, and children who have no immigration papers are potentially eligible. Funding was approved for 1 year.

Devolution and Welfare Repeal

OMCH staff is not aware of a formal analysis of the effects of welfare repeal, TANF policies and/or delinking of TANF and Medicaid on Medicaid enrollment or insurance rates, specific to the District of Columbia. The average number of children receiving welfare declined 19% from 1995 to 1998 (50,734 to 41,165). And the number of TANF recipients was significantly lower in January 1998 (56,128) than in the previous year (67,871). As indicators presented in other sections of this application show, insurance rates have not significantly declined in DC as has been the case nationally. DC TANF officials report¹¹ that the District has minimized the reductions in food stamp and Medicaid participation as a result of the decline in TANF caseloads that have characterized other states.

As shown in section III, Medicaid enrollment has increased substantially, due to the expansion through Title XXI, but enrollment through TANF has also been relatively stable. TANF requirements may be less restrictive in DC than in other places, nevertheless, as the maximum enrollment periods are reached, health advocates have expressed concern that eligible families that leave or are terminated from TANF are not being enrolled in transitional Medicaid. In addition to the recipients themselves not being aware of their rights, *eligibility workers* reportedly are not well versed in the requirements for participation. Consequently, much of the burden for client advocacy has fallen upon the safety net health care providers. Patients may present to these providers saying that they have lost their Medicaid benefits, when in fact they are eligible.

The Medicaid agency staff and the advocates engage in on-going efforts to address the training and support for eligibility and enrollment workers, as well as the process for and means of notifying beneficiaries of how to continue their benefits.

TANF work requirements may be affecting participation in health care programs and utilization of clinical services. For example, Healthy Start nurses report that home visits to pregnant women and

¹¹ June 7, 2000, DC Action for Children Forum, Kate Jesberg

new mothers are less likely to be completed than in the past because clients are not at home, due in part to work requirements. Keeping appointments for well-baby visits and other preventive care is also said to be more difficult for parents. The PBC has responded by providing after-work and Saturday hours at several CHCs.

The extent to which work requirements are impacting special needs children is also a concern, although no quantitative data on the magnitude of the impact are available. In particular, there is a dearth of services for special needs children as they age out of the public education system but continue to be dependent. While in the past a parent was able to remain home to care for the child, this alternative often is no longer available.

Disparities

The District population experiences high rates of poverty. Bureau of the Census estimates place 22.7% of DC residents below the official poverty level—a rate that has changed little over the decade.¹² Poverty affects children disproportionately: 35% of children under age 5, and 35.9% of children age 5 to 17, live in poverty.¹³ Furthermore, an average 60.2% of DC residents under age 19 lived at or below the 200% poverty level for the period 1996-98, making them eligible for the Title XXI DC Healthy Families.¹⁴ The most recently available estimates place the uninsured population at 17% in 1998.¹⁵

In a study commissioned by the Morino Institute, which argues for increased investment in children, the Brookings Institution found that 2/3 of DC public school students received free or subsidized school lunches in 1997.¹⁶ 62% of all DC families with children were living in single headed households in 1996, compared to 27% in the US. 58% of children lived in households with absent fathers, a change from 49% in 1990. Continuing a trend since 1994, child abuse cases increased 20% between 1997 and 1998, although neglect cases remained stable.¹⁷ Emphasizing the need for greater investment in education, the report goes on to point out that throughout the 1990s the DC high school graduation rate was less than 60%. Even more alarming, skill levels declined as children moved

¹² 3 year average 1996-98. (SE 1.72) US Bureau of the Census.

¹³ Poverty estimates are by the US Bureau of the Census, Small Area Income and Poverty Estimates Program, released November 1999 for 1996. 90% CI=30.4-39.7 and 90% CI=32.7-39.

¹⁴ SE=3.7% And 11.2 (SE=2.4) of this age group is without health insurance. US Bureau of the Census, Low Income Uninsured Children by State, February 1999.

¹⁵ US Bureau of the Census, Health Insurance Coverage: 1998.

¹⁶ The Value of Investing in Youth in the Washington Metropolitan Area, prepared for the Morino Institute by the Brookings Institution Center on Urban & Metropolitan Policy. Washington, DC. January 2000.

¹⁷ Brookings Institution report, p. 12.

through the grades. For example, in 1998, more than 2/3 of 3rd graders were tested as proficient in basic math skills; fewer than 20% of tenth graders had mastered basic math skills.

Although median household income in DC (in 1996 \$34,697, 90% CI \$32,976-\$39,418) is comparable to median US income (\$35,492), the national trend toward increasing income inequality is magnified in DC. Comparing pretax income data from the 1970s, 80s and 90s, the Center on Budget and Policy Priorities found that the income gap between the highest and the lowest income quintiles was not only great but also growing.¹⁸ The average annual income for the poorest 5th of DC families declined 17% from the late 1980s to the late 1990s, while families in the middle 5th experienced a decline of 14%. Yet the average income for the top 20%, families earning more than \$89,605, increased by 37%. That 20% of the population receives 62% of the income, while the bottom 20% gets 2%. The official DC unemployment rate declined from 8.8% to 5.6% in a 2-year period; nevertheless, the general prosperity of the Washington metropolitan area is much greater in the suburbs than in the District.¹⁹

The DC population is characterized by a high prevalence of poor health status--high infant, child and maternal mortality, as well as mortality rates due to leading causes of death that far exceed those of the general US population. Although the 1998 infant mortality rate (IMR) of 12.5 per 1000 births was the lowest in DC reporting history, it continues to be much higher than the national rate of 7.54.²⁰

The IMR for DC African Americans (15.0) far exceeds that of babies born to white residents (3.1). There is even greater variation across geographical areas of the city, as shown by 1998 ward-level IMRs ranging from 2.5 (2/792) in Ward 3 to 25.1 (22/878) in Ward 5. Additional descriptive measures presented in sections 2.4 and 2.5 and III provide a more complete picture of the health-related problems facing the maternal and child segments of the DC population.

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

¹⁸ The Rich, Still Different From Most, *The Washington Post*, January 24, 2000

¹⁹ Creation of New Jobs Slows in DC, *The Washington Post*, May 15, 2000.

²⁰ Provisional data, National Vital Statistics Reports, Vol. 47, No 25, October 5, 1999, Table 10.

As described in greater detail in section III, OMCH undertook extensive data acquisition and collection in conducting the required 5-year needs assessment. In the course of the needs assessment, various stakeholders and experts were invited to a meeting in May 2000 to discuss priorities, potential interventions, and availability and allocation of resources. On June 26, the interim chief then convened unit chiefs and other key staff to review the available needs assessment results, and to discuss on-going commitments and plans. After identifying priority outcomes, this group discussed how the available resources could be most effectively allocated to bring about the desired outcomes. Subsequent to that meeting, the interim director discussed the preliminary results of the assessment with DOH management and other city officials, focusing on congruence of needs and priorities identified by OMCH staff, stakeholders, empirical evidence and previously delineated department and city goals.

Finally, the interim director asked 2 maternal and child health experts, with long-term experience in, but not limited to, DC, to review the draft needs assessment and to make recommendations on short-term programmatic and administrative issues. Through this iterative process, priorities were delineated and the section IV plan finalized.

OMCH recognizes that the needs assessment and planning process is a continuing one: Some decisions had to be made before all needs assessment data had been analyzed and discussed. In September 2000, after a comprehensive needs assessment report has been completed, OMCH will reconvene stakeholders who were involved in the initial planning retreat in May 2000 to present the completed needs assessment and the plans reflected in this application. It is expected that the stakeholders will then be involved in further refinement of plans.

1.5 The State Title V Agency

The District of Columbia has designated the Department of Health (DOH) Office of Maternal and Child Health (OMCH) as the Title V state agency.

1.5.1. State Agency Capacity

A description of the current organizational structure and the program capacity of the OMCH follows.

1.5.1.1 Organizational Structure

Following legislation in 1997 that established the DOH, a mayoral administrative issuance, followed by a departmental organization order, designated the OMCH as the Title V state agency for the District of Columbia.²¹ OMCH now is under the purview of the senior deputy director of health promotion. In addition to OMCH, health promotion includes the Office of Nutrition Programs and the Office of Medical Assistance to Social Services. Michelle Davis, PhD, CDC MCH Epidemiologist, served as interim chief of the Office of Maternal and Child Health from January 1998 to May 2000. Marilyn Seabrooks Myrdal, MPA was appointed interim chief effective May 22, 2000. Prior to her appointment, she directed the DOH women’s health initiative and the CISS project. Joyce Brooks, MSW, is serving as interim deputy director.

OMCH is currently organized around 6 units or teams: data collection and analysis; family services; children with special needs; community services; policy, planning and evaluation; and adolescent health. The latter 2 units are newly constituted and personnel have yet to be assigned. The administrative officer and staff are responsible for procurement, personnel and budget issues, as well as training and staff development. (See p. NN for organizational table.) The unit managers and their dates of appointment are as follows:

Data Collection and Analysis	Deneen Long White	January 1998
Family Services	Diane Davis, RN	October 1998
Children with Special Needs	Joyce Brooks, MSW	
Community Services.	Linda Jenstrem, acting	May 2000
Policy, Planning and Evaluation	not yet appointed	
Adolescent Health	not yet appointed	
Administrative Officer	Bryan Cheseman	July 1999

See Appendix for CVs.

The 2 federally funded Healthy Start projects, which are the largest sources of funding other than Title V, along with the CISS project, constitute the family services unit. The community services unit includes abstinence education, the 800 information and referral telephone line, transportation services, the parent council, and public information and community education. The administrative

21 (87 Stat. 790; DC Code, sec. 1-242 (12)); DC Law 4-42; DC Code, sec 1-299.1 et seq.) DC Law 9-182; DC Code, sec. 6-131 et seq.) Res. 11-450; 43 DCR 3974; paragraph two of the DC Financial responsibility and Management Assistance Authority letter, dated December 18, 1996, Mayor’s Order 97-42; DOH Organization Order No. 23, 2-23-99

officer and his staff support program activities in the other units. The responsibilities of the special needs unit and the data unit are described in 1.5.1.2 (special needs) and 1.5.1.3 (data and planning).

The OMCH interim chief is responsible for managing the intra-governmental transfer with the District of Columbia Health and Hospitals Public Benefit Corporation (PBC) for the use of Title V funds. Financial monitoring is coordinated through the financial officer, Bryan Cheseman, who has served in that position since July 1999. During the current fiscal year, the OMCH interim director and administrative officer held monthly meetings with PBC managers to agree on a reporting format. However, the PBC has not established a distinct accounting attribute for the intra-district funds from DOH, therefore tracking allocations and monitoring utilization of services is at best difficult.

Deneen Long White, chief of the data unit, is responsible for acquiring service utilization and program participants data from the PBC, to address in part the requirements delineated in the MCHB correspondence of November 23, 1998 and November 1999 recommendations. Monthly reporting on services rendered was agreed upon, effective October 1999 (See Appendix for report format.) and OMCH received the 1st report July 3, 2000.

1.5.1.2 Program Capacity

The OMCH position authority for fiscal year 2000 remained at 144 full-time positions. As of June 2000, there were 40 vacancies. 42 of the filled positions are funded by the Title V block grant, 58 by Healthy Start mentoring and replication projects, and 1 position is supported by appropriated funds. MCHB grants—SSDI, CISS and abstinence—each fund a position. Most of the OMCH staff with clinical training—primarily nursing and social work—work in the Healthy Start programs. Several recent OMCH hires are MPH-prepared.

Under the management of the mayor, most DOH direct services are to be contracted to the private sector. As a result, the position authority for OMCH may be reduced. During 2001, a new employee evaluation system based on performance goals will be installed throughout the government. The new procedure is designed to improve the performance of public employees.

Most DOH components, including OMCH, moved to new office space in March 1999. Remaining components, including environmental health, Medicaid, and the Addiction Recovery and Prevention

Administration, were also moved into the central space during the past 12 months. These changes brought together the various functions of DOH into the same physical space and continue to enhance coordination. OMCH employees located at the DOH space have Internet connectivity and email and have been trained to use the available technology.

As of May 2000, 75% of DOH workers had email and Internet access. Employees have been required to attend a minimum of 16 hours of training, provided by the contractor, to enable them to use the LAN. Classes on Microsoft Word, Excel, Access, PowerPoint and Project are freely available to all employees. Employees are paid while they attend training. Many DOH employees have upgraded computer equipment installed at their workstations. Systems were upgraded for Y2K compliance well in advance of 2000, and there have been no major breaks in service due to that transition or to viruses.

Certain components of OMCH, namely the Healthy Start programs, the information line and family resource center, are located at community sites that lack connectivity. This places a considerable number of employees at a disadvantage in communicating with and beyond the office.

PBC Capacity

Through its intra-district agreement with the PBC, the OMCH supports preventive and primary care services for pregnant women, mothers, infants, children and adolescents, including those with special health care needs. Services were provided during FY 1999 at 8 community health centers and the Health Services for Special Needs Children Clinic, located on the campus of DC General Hospital.(DCGH).

A senior vice president-chief operating officer who reports directly to the PBC CEO manages the PBC Community and School Health Program. The associate chief medical officer, Candace Mitchell, DDS, who is responsible for medical affairs, reports to the senior vice president and collaborates with the PBC chief medical officer. Each CHC has a dedicated administrator who reports directly to the chief operating officer. Each CHC also has a center chief who reports to the associate chief medical officer. CHCs lead nurses, who supervise school health nurses working in the respective neighborhoods, report to director of the school health program.

Each of the 8 CHCs has a full time OB-GYN on staff; 7 of the 9 physicians are board-certified, 2 board-eligible. Obstetric services were expanded with certified nurse midwives in June 1998. Since June 1999, each CHC has offered midwifery services for a minimum of 1 day per week. High-risk prenatal patients are referred to the hospital-based ambulatory clinic. Patients who receive prenatal care at the CHCs deliver at DCGH barring extraordinary circumstances. Although a few CHC physicians have applied for hospital privileges, hospital staff physicians typically delivers babies. Current policy dictates that newly hired obstetricians must be able to obtain privileges for delivery at DCGH.

As of June 2000, 11 pediatricians, 7 of whom are board certified, are distributed among 7 centers offering pediatric services. 7 centers offer general dentistry services, all of which may provide services to children. CHC dental providers accept children at age 2.

The CHCs typically see patients Monday through Friday, 8:15 to 4:45, with expanded hours for pediatric services at 4 centers. Southwest Community Health Center opens at 7:30 AM and 3 other centers offer Saturday morning hours and stay open until 7:30 (1 clinic) or 8:45 PM on 1 to 2 nights per week. The expanded hours make services more convenient for employed parents, in particular those who are transitioning from welfare to work, and reduce the need to take children out of school for routine care.

Special Needs Capacity

Joyce Brooks, MSW, continues to direct the special needs unit. Staffing of the special needs unit consists of 6.5 FTEs, 4 of which are new positions established in the past 12 months to increase capacity to respond to a broader range of functions: a position to manage and promote the unit and improve the unit's data capacity; a newborn screening program coordinator and 1.5 screening staff; a SIDS coordinator to develop and oversee an initiative directed toward the African American community; a newborn hearing screening coordinator to establish a universal screening program (vacant); and a public health analyst to coordinate health education to reduce the risks of life-threatening diseases, birth defects, and chronic disabling conditions (vacant).

To date, in addition to the data manager, 1 of the new positions has been filled with an MPH analyst, who has been assigned to coordinate SIDS, folic acid and sickle cell efforts. Recruitment for the 2 other new positions is well underway, although delayed from the November 1999 date projected in

the July 1999 Title V application. The 2nd position will have responsibility for coordinating with programs mandated to work with chronic conditions and youth who are aging out of special education, foster care and other programs. In addition to these recent additions, genetic services and newborn metabolic screening are located in the special needs unit. The coordinator, a full time assistant, and a half time RN staff newborn screening. The remainder of the RN's time is allocated to Healthy Start.

Unit staff members are active in an array of inter-, intra-agency and public-private partnerships that focus on a broadly defined special needs population. The newborn screening coordinator and the interim chief share responsibilities for serving on numerous city-wide committees and advisory groups, including the DC Intra-agency Coordinating Council (Part C) and Developmental Disabilities State Planning Council. An OMCH representative attended meetings of the MAA Joint Managed Care/Children's Health Subcommittee until the meetings were discontinued due to changes in leadership and staff turnover in the current budget period. The SIDS coordinator regularly meets with the DC Committee of the National Organization on Fetal Alcohol Syndrome (NOFAS).

The special needs unit has worked during the current budget period to strengthen coordination with the DC Early Intervention Program (DCEIP). Frequent meetings to exchange information keep OMCH apprised of DCEIP services and projects, such as a pilot project to change the Individual Family Service Plan process to increase the likelihood that MCOs will expedite approval services.

One recent collaboration is the development of a Memorandum of Understanding (MOU) between DCEIP and OMCH to share data on EIP clients with a database on special needs children, which is being designed by OMCH with support from the MCHB SSDI 2-year grant. In addition to the database, the MOU supports coordination of the training of Healthy Start and Healthline staff in Part C program guidelines and services, and of Healthy Start parents in daycare/parenting training by the Commission of Social Services. (See Appendix.)

OMCH is represented on the Mayor's Advisory Committee on Early Childhood Education, which over the past year has pursued differential child care reimbursement rates for children with disabilities. These rates have been working their way through the regulatory process and should go into effect by the end of 2000.

OMCH is a member of the Caring for Infants and Toddlers (CFIT) continuing education program for pediatricians and primary care physicians. Along with introducing the early intervention concept, a great deal of effort has gone into pulling a state leadership team together, holding train the trainer sessions, and adapting the original CFIT manual to the District's early intervention program.

Physician seminars are scheduled for spring and summer of 2000. During the past year, transition training was held on a regular basis for families, service providers, and therapists. DCEIP's transition specialists also began having more regular meetings with DCPS personnel during this period to seek improved transition for Part C children.

In May 1999, DC was one of 10 states selected by the US Administration on Children and Families to receive technical assistance under the auspices of the Map to Inclusive Child Care Project. DCEIP organized a team of parents, childcare providers, and public and private agencies to address child care service delivery for children with special needs. In addition to OMCH, participating public agencies include MAA, DC Public Schools (619 Program, Head Start), University of the District of Columbia (Cooperative Extension Program), Department of Human Services, Child and Family Services, and the Department of Parks and Recreation. The project developed 3 goals: (1) to infuse knowledge about inclusion into the child care community, (2) create a seamless, workable system for inclusive child care; and (3) develop policies and funding streams to support an inclusive child care system.

A major component of the agreement with the PBC is the direct provision of clinical and enabling services through the Health Services for Children with Special Needs Clinic. Title V funds are designated to support clinic staff, which includes physicians, registered nurses, audiologists, speech, occupational and physical therapists, and social workers. In addition to various other clinical and administrative positions, the clinic has access to a few volunteer specialists, as well as staff throughout the PBC system.

The clinic provides the following services.

- comprehensive health evaluations
- birth to 3 program
- juvenile amputee program
- ophthalmology program
- orthopedics program
- oro-facial defects program
- hearing testing, and hearing aid prescription and fitting

- speech pathology, including individual and group speech and language therapy
- care coordination services for children transitioning from high school into vocational training or jobs
- occupational therapy
- physical therapy
- hearing screening for newborns
- comprehensive, developmental screening, assessment and treatment for children referred by PBC primary care providers
- medical/developmental eligibility examinations for children applying for SSI benefits

Management reports describe delays and problems in obtaining and retaining clinic staff, and therefore the extent to which the complete array of above services was available throughout the entire reporting period has not been determined. The clinic medical director reported that 1297 children registered in FY 1999. Approximately a 3rd of the patients were 0-3, another 3rd age 6-12, 20% were 3-6 and the remainder were youth up to age 21.

The clinic acts as one of the city's developmental assessment centers for children ages 0-2 that may qualify for support under Part C of IDEA through EIP. The EIP Child Find conducts 150 assessments annually for the age 0 - 3 population. Approximately 130 of these patients later receive treatment and care coordination services.

Clinic staff members have lead responsibility for training school nurses to conduct hearing screening in the public schools. This program is described in section II. They also conduct newborn hearing screening at DCGH.

1.5.1.3 Other Capacity

In addition to the staff capacity described in 1.5.1.2, Title V funds support 10 of the 13 FTEs in the OMCH data unit. Officially formed in January 1998, the unit brought together staff from all surveillance systems under the auspices of OMCH, including Healthy Start, infant mortality and child fatality reviews, Pregnancy Nutrition Surveillance System (PNSS) and the Pregnancy Risk Assessment Monitoring System (PRAMS). Staff members have experience in database design and maintenance, data collection and acquisition, and in the use of SAS, SPSSPC, SUDAAN, Arcview GIS and HUD Community 2020.

Since it was identified as a priority in FY 1998, strengthening the unit's capacity has continued to receive considerable attention. Beginning in FY 1999 and extending through FY 2000, on-going in-service training is being provided to ensure that staff have basic skills in the use of Microsoft ACCESS and related software. The OMCH interim chief and the unit chief presented in-service sessions, often attended by staff from other units, on epidemiologic measures and analytic techniques, trend analysis, use of NCHS data user files, and small area analysis. Employees attend off-site training and conferences supported by CDC, HRSA and NIH. All staff members have participated in distance learning sessions, especially courses offered through the MCHB contract with University of Illinois at Chicago, Center for the Advancement of Distance Education, City MatCH Data Utility Institute and Data Speak.

In May 2000, an MPH-prepared individual with extensive experience in program evaluation joined the staff.

Throughout OMCH, staff members have participated in numerous national, regional, local and in-service trainings; examples include the annual AMCHP conference, American Public Health Association meetings, and a 2-day in-service on proposal writing and planning and evaluation. Members of the special needs unit increased their participation in regional and national training events as well.

In addition to their professional training and/or organizational experience, at least 10 OMCH staff members parent children with special needs. These staff members were not necessarily hired to advocate for the special needs population; their responsibilities are integrated throughout the functions of the office. Nevertheless, their ongoing experiences with accessing educational, social and medical services provide a valuable asset for the entire office staff. A dedicated parent coordinator is assigned to the *Use Your Power!* project and gives technical assistance to the special needs unit.

1.5.2. State Agency Coordination

Intradepartmental Coordination

During the current budget period, OMCH made significant accomplishments in working with the WIC and the immunization programs, both of which are located in the DOH. WIC staff identified several voucher redemption sites with low pick up and redemption rates, attributed to the unavailability of supermarkets in the area. Recognizing that WIC participation was a priority for OMCH as well, OMCH and WIC staffs developed a cooperative project to transport clients from a redemption site to their homes.

Beginning in July 2000, WIC clients residing in Wards 6, 7 and 8 will be offered transportation in OMCH vans to a supermarket serving the area. The service will be available at least 2 days a week, 3 times a day. To access the services, clients will make a transportation reservation at least 48 hours in advance through the Healthline.

This new partnership will meet a critical need: WIC clients often must travel long distances by inadequate public transportation to obtain the healthy foods pregnant women and infants require. Returning home, the client may be laden with several bags of groceries and may have one or more children in tow. It is expected that the new service will help clients use their WIC coupons more effectively. The project also opens a new avenue to work with WIC on nutrition education and buying skills. Plans to capitalize on these opportunities are described in section IV.

As a result of intradepartmental coordination between OMCH and the immunization program, Healthy Start staff is providing clients with an immunization information packet containing information about express clinics, and other locations and times for obtaining immunizations. In response to concerns that MCO providers are not giving parents individualized immunization records, the packet also contains a personal immunization record for parents to present to providers. Pending approval of the protocol by DOH administration, Healthy Start nurse case managers will do in-home immunizations for those clients who are hard to reach or previously lost to follow-up. The National Vaccine Program is providing vaccines and supplies.

Efforts are also underway to improve the exchange of information between the immunization registry and Healthy Start, institutionalized by an agreement to share and exchange client specific immunization records. In addition, Healthy Start nurse case managers will follow-up with pregnant women who have been exposed to Hepatitis B.

Coordination with Medicaid and Title XXI

In addition to the coordination through the Healthline described in section 1, The *Use Your Power!* project, supported by the MCHB SSDI grant through FY 1999, continued to engage in significant collaboration with the Medicaid agency. The project has focused on consumer-led strategies to train past or present Medicaid beneficiaries to become managed care educators and advocates. A *Use Your Power!* video was released in 1996, a parent council recruited and trained in 1997. In 1998, 10,000 copies of a 65-page pocket map, designed with considerable input from the parent council, were released, and used as a companion to the video.

However, once the Title XXI program—DC Healthy Families—was implemented, the pocket map needed to be revised to include the new program. The Medicaid agency agreed to provide most of the funding to print 35,000 full color copies of a 2nd edition. In June 1999 3 large meetings of parents, advocates, and government agency staff were held to obtain input on revisions. Medicaid officials were also involved in the meetings, reviewed subsequent drafts, and served as advisors for the publication prior to going to print.

The parent council also constituted a consumer focus group to MAA staff as plans for DC Healthy Families were being developed early in FY 1999. Members advised on issues including outreach strategies and simplifying the application process. Parent council members continue to serve on the Medical Care Advisory Committee, which advises the Medicaid director.

OMCH Healthy Start case managers, resource parents, and mobile unit and transport van staffs, have been trained to give clients information on DC Healthy Families and to encourage them to enroll. Mail-in applications are distributed, and workers assist with completing applications as needed.

Perhaps even more important has been the effort to inform and educate clients on the benefits of receiving preventive services *prior* to becoming ill and helping them to navigate the managed care system.

EPSDT Task Force

Since March 1997, the Medicaid agency has been under court order to comply with federal regulations concerning processing of enrollment applications and EPSDT. The current court monitor is Henry Ireys, MD, Johns Hopkins University School of Public Health and Hygiene, who was appointed in February 1999. A task force, formed in 1997 by the Medicaid agency and the General Counsel to coordinate the response of government agencies to the court decree, has continued to meet, and in 2000 was officially renamed the DC Healthy Tots Teens/EPSDT Program Task Force.

The school health liaison represents OMCH on the citywide EPSDT Task Force where her role is to coordinate and enhance existing linkages and/or create new ones in the administration of services for prevention and treatment programs for public school students. In FY 1999, she gave presentations to the task force to better acquaint the membership with school health services, characteristics of and services to students with severe chronic illness and/or disabilities, and findings and trends based on the Youth Risk Behavior Survey, 1997 and 1995.

The liaison staff worked with the task force to revise the periodicity schedule in accordance with current American Academy of Pediatrics and CDC recommendations, and Bright Futures guidelines for health supervision of infants, children and adolescents.

Task force forums have further provided OMCH the opportunity to inform, share and coordinate with other members on surveillance and population-based screening efforts such as Pregnancy Risk Assessment Monitoring Systems (PRAMS), Pregnancy Nutrition Surveillance System (PNSS), and newborn screening.

As described in the state negotiated performance measures section, the FY 1999 EPSDT participation ratio actually declined to 38% from 55% in the previous year! According to MAA staff, the court monitor and the MCO contractors are continuing to work on a universal reporting format—now expected to be installed by FY 2001—to not only measure compliance but to begin to build a client information system. Actions taken to increase compliance in addition to those discussed above

include the revision of a brochure, which is used by both parents and Income Maintenance Administration workers to better explain the benefits. The new brochure includes a focus on adolescents, added to deal with the lower participation ratio among this age group. (Participation ratio ranges from 22% for age 15-20 to 62% for age 6-9, and 35% for infants.)

As required by the court order, a 3rd party was contracted to conduct a record audit to determine the extent of MCO and individual provider compliance with EPSDT requirements. It was found that providers underreport, although Medicaid staff members were unable to say what actual compliance rates were in comparison to reported rates. From the providers' perspective barriers included capitation rates that do not take into account the effort involved in screening and reporting, lack of understanding of standards for vision, hearing and dental screening, and reluctance to screen in such areas in which the physician does not have specialized training. Some providers also reported liability concerns. Five MCO contractors were required to submit corrective action plans for bringing their providers into compliance.

Coordination with Public School System

In 1997 the DOH Office of School Health Services, which had responsibility for the school nurse program and its public health surveillance, testing and screening functions, was transferred to the PBC. A single employee, who served as school health liaison for a CDC comprehensive school health infrastructure grant, was subsequently transferred to OMCH. The school health liaison continues to have responsibility for the administrative, policy development, evaluation and monitoring of the public health aspects of the school health program.

71,889 students were enrolled in public schools in 1999. 86% were African American, 8.3% Latino and 11.5% were defined as not proficient in the English language. 10,560 (14.7%) had special needs, and 66% of special needs students were estimated to be eligible for Medicaid.²²

DC public schools are required by The District of Columbia Public School Nurse Assignment Act of 1987 to staff a minimum of 20 hours per week of nursing services in public schools.²³ High schools have a registered nurse on duty at least 40 hours per week.

²² District Schools Losing Millions In Medicaid, *The Washington Post*, June 5, 2000.

²³ DC Law 7-45' DC Code, Sec. 31-2421, effective October 16, 1987.

In the fall of 1999, a mayoral initiative involving the chief executive officers of the DOH, DC Public Schools, the PBC, the Commission on Mental Health Services and the Commission on Social Services, Child and Family Services Administration, was convened to address school health related concerns. Agency heads moved quickly to appoint persons with authority to make decisions. Since then the Consortium on School Health/Education and Community Awareness has been meeting weekly to develop an interagency structure for accomplishing specific goals. Memoranda of understanding have been developed to clarify respective roles and resource allocations. Staff completed a review of legislative authority pertaining to the schools and identified areas in which policy should be clarified and strengthened.

The consortium was instrumental in reopening the Ballou Senior High School wellness center, previously a school health clinic operated by a community hospital. In addition to Ballou, there are 2 schools with clinics or wellness centers, 1 of which—Woodson Senior High School Wellness Center—is operated with OMCH Healthy Start funds. The consortium has set a goal to establish 2 additional school based centers—at an elementary school and a middle school—in school year 2000-2001. In addition to the school health liaison, the OMCH data unit chief provides technical support to the consortium.

The OMCH school health liaison continued to work closely with the director of the PBC community and school health program to reinstate the school hearing screening program, which had been discontinued in 1996 due to lack of funds. A needs assessment was completed in 1999 on children in targeted grades (Pre K, K, 1st, 2nd, 4th and 6th grades), special education classes, and children referred as suspect of having a hearing loss. Upon completion of the needs assessment, funding was requested and received from the Department of Human Services to support the purchase of equipment for the hearing screening program.

Although school health nurses had been trained in 1998 to conduct hearing screening, the equipment available through the PBC was old and in disrepair. Finally 9 new audiometers and 9 sound level meters, for measuring the room noise prior to screening, were purchased and ready for use in September 1999. The new equipment is assigned to the 8 PBC community health centers, which are responsible for support and supervision of school nurses in respective neighborhoods, and the Health Services for Children with Special Needs Clinic, Department of Audiology, which is responsible for

training, monitoring and follow-up of screening. It is expected that in the 2000-2001 school year all children in targeted grades will be tested.

During school year 1998-1999, 21,067 school children (Pre K, K, 1st, 2nd, 4th and 6th grades, special education classes and referrals suspect of having hearing loss) in 86 of the 104 elementary schools were screened. (That is, an estimated 29% of students enrolled were screened.) Coverage was incomplete due to various factors. The new equipment was not yet in place during that school year. Screening was begun later in the year than intended. Some nurses were unable to attend the training sessions and thus were unable to perform the screening. In addition, there was a learning curve for those nurses who had been trained. Due to time constraints not all grades in the schools were tested. The results are shown below.

Results of School Hearing Screening, School Year 1998-99

GRADE	NUMBER TESTED	NUMBER PASSED1 ST SCREEN	NUMBER FAILED1 ST SCREEN	NUMBER FAILED2 nd SCREEN**	DNT CNT*
PRE - K	270	208	49	36	13
K	4097	3618	393	212	86
1	4602	4102	459	231	41
2	4670	4255	397	210	18
4	3628	3308	310	163	10
6	2515	2332	173	98	10
SPEC. ED.	1011	879	107	67	25
OTHER	274	250	24	12	
TOTAL	21067 100%	18952 90%	1912	1029 4.9%	203 .96%

Source: DOH, OMCH, Unpublished

*Did/could not test

**Students in this category were referred for follow up with a notice to parents. Includes students who failed 1st screen but did not complete 2nd screen. Since this category is a subset of number who failed 1st screen, column totals > 21,067.

Mechanisms have yet to be established to track follow up testing, diagnosis, treatment and/or rehabilitation. When a child is seen at a PBC hearing clinic--Health services for Children with Special Needs or Hunt Place, a report is sent back to the school nurse, however, many children go to private doctors, or may not have follow-up, and this information is not always conveyed to the school nurse.

Other population-based health services in the schools included:

Service	Number
• Vision screenings	38,895
• Scoliosis screenings	7,091
• Immunizations/health certificates surveillance	17,750

School nurses also conducted health education activities, summarized below.

• Students presented with substance abuse prevention education	2,621
• Students presented with HIV/AIDS STD prevention education	3,083
• Students presented with sexual assault prevention classes	1,763
• Students presented with smoking prevention classes	522
• Students in targeted grades provided prevention education classes	6,030
• Students provided HIV/AIDS education	4,095
• Students provided HIV/AIDS counseling	4,115

The school nurse program also provided direct and enabling services to pregnant and other special needs children. These services are summarized below.

Service	Number
• Health appraisals (surveyed)	511
• Special screenings	14
• Medications administered	11,151
• Nursing encounters	124,078
• Pregnant students identified	245
• Students provided prenatal and post partum education (individual and group)	2,541
• Referrals made: prenatal students monitored	245
• Encounters with students who have medical	

needs monitored	9,674
• Catheterizations administered	451
• Doses of medications	7,890
• Students with chronic illness and or with disabilities who are case managed	580

Facilities Regulation

OMCH is represented on the DOH Child Development Facility Licensing Regulation Task Force whose mission is to establish uniform health requirements and a standardized health form for all children in the District of Columbia. The task force, convened in the spring of 1998, includes representatives of the childcare community, parents, academic medical centers, DC Public Schools, PBC, Office of Insurance and Securities Regulations, DC Health Policy Council, DC Financial Control Authority, DC Medical Society, DC Nurses Association, etc. A uniform health form, to be used by all providers and in all schools and child care facilities, has been drafted. Final approval is expected this year. In spring 2000, responsibility for carrying out the task force mandate was transferred to the DOH senior deputy director for quality, planning and external affairs, and her lead appointee in OMCH. Since her resignation in March 2000, responsibilities have not been reassigned.

Coordination with TANF

This year OMCH worked with the DC Department of Human Services Commission of Social Services to design a program to prevent/postpone repeat pregnancies in first-time pregnant teens who live in households with incomes that are at or below 200% of the FPL. The program will be city-wide and target teens 18 years old and under. Intended to bring both health and social services to teens and their infants, the program incorporates the case management/care coordination model applied in Healthy Start. Scheduled for start up in fall 2000, services will include pregnancy prevention, academic enrichment, tutoring, development of school-to-work goals and personal development. ***Teen Moms Take Charge***, a TANF-funded program, is expected to be located in the OMCH Family Services Unit, parallel to Healthy Start. Actual services are to be provided through a contractual arrangement, which has yet to be put in place, and monitored by a 5-person team made up of OMCH employees. The personnel process for establishing the new positions has been initiated.

HIV/AIDS Coordination

In March 2000, the OMCH and Children's National Hospital Medical Center (CNMC) implemented a new collaboration between Healthy Start and the Title IV-funded Family Connections to enhance and expand HIV/AIDS-related perinatal activities to high-risk Healthy Start participants. In addition to universal counseling about HIV testing, all pregnant women are being referred to their prenatal care provider for testing. Although the PBC policy is reportedly to counsel and encourage all pregnant clients to be tested, other Medicaid MCO providers have not universally implemented a similar policy. Thus, a specific referral for testing is necessary.

In June 1999, OMCH staff partnered with the Administration on HIV/AIDS, DOH, to produce a winning proposal to the CDC for a perinatal transmission control project. In part, the proposal was designed to supplement the Title IV project, which is a multi-site network that includes CNMC, Howard University Hospital, DCGH, and the Healthy Start projects. With the new CDC funding, an LCSW has been added to Healthy Start case management staff to supervise two family advocates funded by Family Connections through Title IV of the Ryan White Care Act.

The new team serves pregnant women in Wards 5 through 8 who are HIV-infected or who do not know their HIV status. Services are designed to support pregnant women who are fearful of learning their HIV status, as well as to assist HIV-positive women to connect with the appropriate level of specialty care.

DC Campaign to Prevent Teen Pregnancy

In February 2000, the DC Campaign to Prevent Teen Pregnancy was formally launched as a private, non-profit corporation with foundation funding. Modeled after the National Campaign and organized campaigns in other states, it grew out of a 2-year effort of the Mayor's Committee to Reduce Teen Pregnancy and Out of Wedlock Births. A recent report, based on results from a scientific opinion survey combined with a series of focus groups, found that DC residents:

- Believe that children and teens are being left behind as the city moves ahead;
- Agree across racial and age groups that teen pregnancy is a major problem;

- Agree across racial and age groups that parents, schools, government and private organizations need to play a role in helping teens postpone pregnancy so that they will not have to face the difficult consequences that follow;
- Support broad-based sexuality education in the schools; and
- Differ in their opinion about what should happen if pregnancy occurs.

The campaign's mission is to reduce the teen pregnancy rate by 50% by 2005. OMCH, represented by the adolescent health coordinator, participates in the campaign, which defines its function as a catalyst and transfer agent. A major strategy is to mobilize teens to guide and lead the work. The campaign co-sponsored a teen town meeting with Children's Hospital and Teens Against the spread of AIDS on February 23, 2000. 75 teens voiced their opinions on effective ways to reach teens with prevention messages. Several teen town meetings have been scheduled, the first for July 26, 2000. The adolescent health coordinator has agreed to serve as a moderator.

Coordination with Academic Programs

The Healthy Start program is a clinical site for orientation and observation of community health nursing to Howard University senior nursing students. Each year 12 students participate in a 6-week rotation, during which they assist on the MOM unit and with home visits to high-risk pregnant women and infants. DOH has also arranged internships with the George Washington University School of Public Health.

The George Washington University School of Medicine received a \$2.3 million 3-year HRSA grant in September 1999 to establish an Area Health Education Center (AHEC) designed to build a bridge between local university health professions training programs and community sites serving the medically underserved. Recruitment is underway for a center director and a project director has been hired. It is expected that DOH coordination will occur from the director's office.

Coordination with Child Welfare and Family Preservation

A number of efforts for which OMCH has primary responsibility depend upon the successful establishment of public-private partnerships. The OMCH home visiting initiative, currently in the final year of a 5-year Community Integrated Service System (CISS) grant, was originally mandated

to expand the identification and recruitment of pregnant and postpartum substance abusing women and drug-exposed infants, and to set up a seamless system of community-based care for at-risk families by linking and extending home visiting initiatives citywide. Recognizing that substance use contributes both to poor pregnancy outcomes, and child abuse and neglect, the DC Home Visiting Advisory Council was formed following a request for technical assistance by the project coordinator, Jean Batts, and provided through a conference facilitated by Health Systems Research, Inc. and John Snow, Inc. December 17, 1999.

Council membership consists of more than 20 representatives from a wide range of providers and community-based organizations that provide home visiting. The council is expected to agree on standards of care and protocols that can be adapted by home visitation programs throughout the city. Its scope of work also includes policy, staffing, sustainability, information sharing, systems integration, capacity building and linkages.

Through the collaboration of the DC Home Visiting Advisory Council, DC Healthy Start, Healthy Families DC and DC Healthy Babies, the development of a universal intake/referral form was undertaken. The universal form is to address the goal of creating a single point of entry for families into the home visitation system and to provide a tool to use resources more efficiently to better serve families in need. It is described in section IV.

Mortality Review

The Infant Mortality Review Workgroup, supported in part by Healthy Start and Title V funds, continues to meet monthly to review infant deaths, particularly those of Healthy Start project area residents. Initiated as a requirement of the receipt of federal Healthy Start initiative funds, the work of this group has been institutionalized and its functions combined with those of the city wide Child Fatality Review Committee, staffed jointly by the OMCH and the Commission of Social Services. HRSA/MCHB Partnership Funds 99/00 were of considerable benefit to the workgroup in furthering collaborative efforts of the mortality reviews. The membership includes representatives from Child and Family Services, the Metropolitan Police Department, child advocacy groups, and others, depending on the nature of the death being reviewed.

The Infant Mortality Review meets and reports monthly, with recommendations based on membership discussion forwarded to relevant agencies. In 1999, 47 infant deaths were reviewed. Approximately 1/3 of the 1998 deaths were reviewed. (The number of deaths in 1999 has yet to be determined/released.) Both review groups frequently find that the family in which the death occurred is known to at least 1, and usually more, service systems. Reportedly the lack of follow up and action on the findings and recommendations resulting from the reviews continues to be a problem. Both bodies recognize the challenges involved in advocating to have recommendations implemented without having the authority to take action.

Women's Health Initiative and Men's Health/Fatherhood Initiative

Planning which began in 1999 resulted in the launching of two important citywide initiatives. The Women's Health Initiative kicked-off February 29, 2000. One of the few new DOH programs to be funded through DC appropriations, this \$238,000 initiative focuses upon advocacy for programs and policies to improve the health status of women throughout the life cycle. A broad based, 40-member advisory board was convened in June 2000. Members discussed draft mission statements, selected a 7-person coordinating committee and created a committee structure. This group will promote standards of care for women's services providers.

The Men's Health/Fatherhood Initiative is supported by several DOH components in addition to OMCH. Officially launched June 14, 2000 by a mayoral proclamation and a week of well-attended community events, the initiative is charged with encouraging and promoting a healthier lifestyle for men and strengthening families through the involvement of fathers in the lives of their children.

II REQUIREMENTS FOR THE ANNUAL REPORT

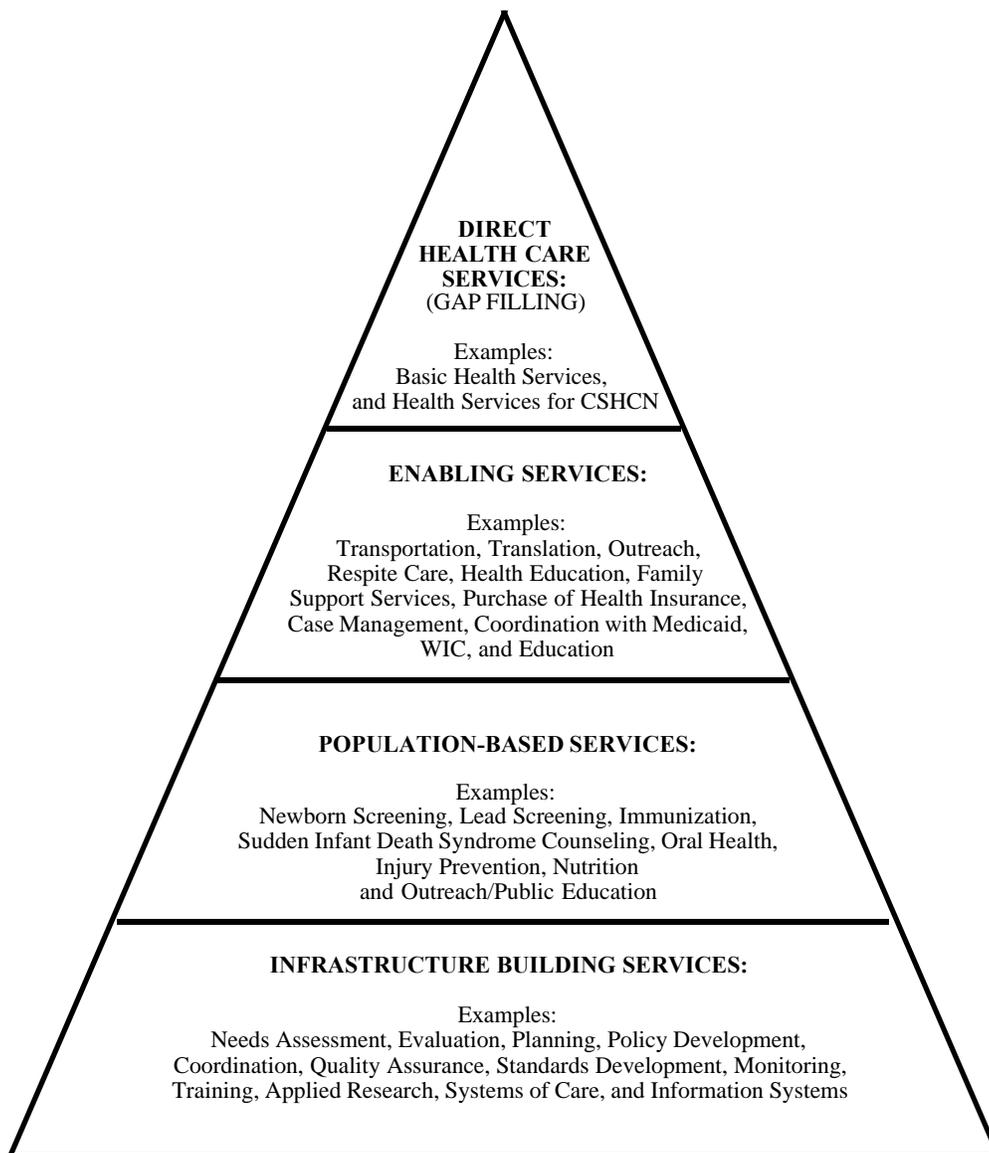
2.1 Annual Expenditures

Budgeted and expended funds have not varied during the period FY 1997-1999. The allocation of annual funds across types of individuals served varies somewhat based upon the availability of other grant funds. Budgeted funds for direct services have been reduced from 1997 to 1999, reflecting the expansion of coverage through Medicaid and, more recently, Title XXI. The enabling services budget has increased due in part to the DOH priority of enrolling eligible groups in public insurance

programs.

Figure 2

CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES



MCHB/DSCH 10/20/97

2.2 Annual Number of Individuals Served

(See Forms 7 – 9)

2.3 State Summary Profile

Form 10

2.4 Progress on Annual Performance Measures

Direct Health Care Service

During FY 1999, the DC Title V program continued to support direct safety net and gap filling services for the required population groups. Prenatal and other reproductive health services were provided to 1987 pregnant women at 8 PBC CHCs located in areas of underserved and underinsured populations. 7 centers also provided well-baby care, EPSDT, immunizations and other preventive and primary care services to 4425 infants and 17306 children up to age 22.

The Health Services for Children with Special Needs Clinic, located on the DCGH campus, provided a range of services including medical and surgical sub-specialty services, occupational and physical therapy, speech, hearing and language services, durable medical equipment and supplies, nutrition services, care coordination and early intervention to an estimated 1297 children. The direct clinical services were expected to contribute to achievement of the following performance measures SP# 1 - 6; NP# 1, 2, 3, 5, 6, 9, 10, 11, 13, 14, 15, 17 and 18.

Enabling Services

Enabling services consisting of information and referral, transportation, program coordination, and client education and support are described below.

Information and Referral

OMCH continued to provide enabling services, coordinated through the Healthline operation, which received 24,479 calls, a dramatic increase of 63% from the previous year, reflecting both the restored, full time operation after relocation to another site was completed and the expanded use of the information service. The Healthline serves all Title V-mandated populations as well as providers and the general public. During the reporting period, services expanded to include information on Title XXI eligibility and enrollment. Available in English and Spanish, and TTY/TTD accessible, it is a

24 hours, 365 days a year, 800 telephone number (1-800-MOM-Baby), staffed during regular business hours, for pregnant women, mothers, fathers, and teenagers seeking advice on maternal and child health questions, including special needs children. The Healthline is advertised through materials distributed at community events, health fairs, government offices and through *Use Your Power!* Parent Council activities, as well as on the transportation vans and the Healthy Start MOM unit. From time to time, PSAs are aired by area radio and TV stations.

During FY 1999, the Healthline continued to disseminate information on eligibility for and enrollment in Medicaid and DC Healthy Families, selection of MCO provider, where to obtain no-charge services, Healthy Start services, and a host of other health and social services programs. In FY 1999 the Healthline was staffed by 5 persons, including 1 registered nurse, who provided callers with information, counseling, and referrals.

As described in section 1.4, in FY 1999 OMCH and the Medicaid agency collaborated to use the Healthline as the primary telephonic means of informing the community and prospective enrollees of DC Healthy Families—the Title XXI program. Healthline workers also track and follow up with Healthy Start clients.

Service Coordination

The integration of Healthy Start services with the Healthline enables callers and/or transportation services users to be referred to Healthy Start case management outreach. Home visits are made to high-risk pregnant residents of target areas, and pregnant and parenting women are assisted in navigating the health care system. The Healthy Start programs conduct home visits in Wards 5, 6, 7 and 8. A nurse and 3 outreach workers provide coverage to Wards 1-4. In addition, arrangements can be made for home visits by nurses and/or paraprofessionals in conjunction with community-based organizations. Among the wide range of information and referral services available via the Healthline, staff refers callers to the PBC CHCs for medical appointments and responds to queries about obtaining health screenings and birth control services.

In FY 1999, OMCH continued to enable residents by coordinating program and service-specific information across programs—for example, ensuring that Healthy Start staff used current information in making referrals to the Ryan White Title IV-funded services, that lead screening was incorporated

into home visits made by outreach workers, and that special needs children were identified and entered into appropriate service networks.

Transportation

OMCH has assisted clients with transportation to and from health care services for many years. One of the most visible and highly-valued OMCH services, door-to-door van transportation for pregnant and post partum women and infants presents a unique opportunity to offer personalized health education and targeted referral services. Through in-service education sessions, van drivers are trained in community outreach techniques and current, important health topics. They are also prepared to provide information on community resources and services.

The transportation service has been underwritten by the DC Healthy Start grant funds (Wards 5 through 8) and Title V (Wards 1 through 4). In FY 1996, OMCH negotiated with the Medicaid agency to obtain reimbursement for transportation services; rates were established for roundtrips, 1-way trips, and “no shows.” With the advent of Medicaid managed care, each contractor provider was required to ensure transportation for patients to and from medical appointments. Concurrently, MAA began to disallow OMCH reimbursement requests for clients enrolled in managed care. In February 1999, OMCH staff conducted an analysis of billing and reimbursement data for the 1st quarter of FY 1999. The analysis showed that reimbursements were received for approximately half of the transports provided. Moreover, DOH was essentially paying for half of the transports twice – once under the capitated contracts and again by using scarce federal funds to operate the transport service.

Reluctantly, the decision was made to stop providing transportation to clients enrolled in Medicaid managed care or DC Healthy Families. Services were provided to all callers through June 1999. To ease the transition, clients received counseling and education regarding their rights as Medicaid beneficiaries to receive transportation assistance. Healthline operators used a script prepared by OMCH staff, as well as information provided by MAA, to educate clients about how to access the transportation through their MCO.

Transportation through Healthy Start continues to be offered to clients whose Medicaid or Healthy Families applications have yet to be processed or who have not selected a provider, as well as to those who are uninsured. 1885 trips (1-way) were provided in FY 1999.

In July 2000, OMCH began to offer transportation to WIC clients who reside in 2 city wards in which there is limited availability of supermarkets. This effort is described in section 1.

Client Education and Support in Navigation

The State Systems Development Initiative (SSDI) continued its focus on Medicaid managed care, and support of the *Use Your Power!* project through FY 1999. During this period, the project coordinator obtained several additional grants from private foundations to enhance the work of the parents council. Much of the reporting period was dedicated to revising the first edition of the *Use Your Power!* Pocket Map and creating a new 2nd edition. Funds were also obtained to develop a Spanish version of the picket map, and a collaboration was forged with the Council of Latino Agencies (COLA)—a coalition of approximately 40 community-based agencies serving the Latino community—to develop the Spanish version of the pamphlet. COLA coordinated community focus groups to determine the best translation for certain words and phrases.

Many changes were made in the 2nd edition, including: a new title--*Use Your Power: A Map to Help Parent Use Medicaid & DC Healthy Families*--and 8 additional pages with more information for immigrants, teens, and special needs children. The 2nd edition is also in full color, and changes had to be made to about half of the pages in the publication. Instead of the original 10,000 copies, enough funds were raised to print 35,000 pamphlets. It took approximately 9 months to complete the revisions, and the English language version of the new map was finally released in February 2000. The Spanish language version is slated for release in August 2000.

Use Your Power! continued to collaborate with other agencies and advocacy groups to improve access to care, working in coalitions with the DC Action for Children Covering Kids Initiative, the Alliance for Fairness in Reform to Medicaid (AFFIRM), and DC Health Care Now, a foundation supported project of the Center for Community Change. In June 1999 *Use Your Power!* co-sponsored with AFFIRM 2 focus groups aimed at examining the problems parents with special needs children were having in accessing care. AFFIRM staff used the results to make recommendations to the Medicaid agency on the solicitation for the special needs managed care contracts. (As described in section 1, the existing contracts have been extended and new solicitations are pending.)

Also in FY 1999 parent council members served as the central focus group for a study being conducted by the George Washington University Center for Health Services Research and Policy to

examine the DC EPSDT program. (As of June 2000, that study has yet to be released.) Parent Council members were also asked by the Infant Mortality Review Work Group to review SIDS public education materials. Their response resulted in the materials being sent back to the drawing board so that more culturally appropriate materials could be developed.

In June 1999 HCFA awarded the *Use Your Power!* project a *Beneficiary Services Certificate of Merit for partnering with consumers to educate and train beneficiaries on how to access the Medicaid managed care program.*

The enabling services mentioned above were expected to affect SP#1, 3, 4 and NP# 1, 5, 6, 12, 13, 14, 15, and 18.

Population-based Services

The DC newborn metabolic screening program continued to improve its services for all infants born in the District of Columbia. In March 2000, screening for G6PD Deficiency was implemented as part of the District's mandated panel, authorized by a Notice of Rulemaking. OMCH and Neo Gen Screening, Inc., the designated neonatal screening laboratory for the District since 1996, held in-services to educate staff at each participating hospital. A mass mailing provided information to 1500 D.C. metropolitan area pediatricians and family health care practitioners. Materials were developed for letter notification to parents of infants with abnormal test results, including a parent education sheet, *Parent Alert*, and a physician education sheet, *Physician Alert*, that the parent must take to the infant's pediatrician. Each *Alert* recommends further testing to confirm the diagnosis, and certain harmful medications, foods and other substances to be avoided to minimize the effects of the disorder. The OMCH newborn screening program assistant is responsible for sending the notification letters to parents upon receipt of the laboratory test results from Neo Gen.

Notification is also coordinated with Healthy Start. A Healthy Start nurse, supported in part with Title V funds, is assigned to receive contact information on project area infants with negative or inconclusive screens. The nurse follows up on the contacts, including making a home visit, to ensure that parents are aware of and understand the test results and assists them with medical appointments and services.

In March 2000, the D.C. Newborn Metabolic Screening Program established provider access to laboratory test results through two Neo Gen electronic systems: 1) Voice Response System and 2)

Internet Data Analysis Component. The Mayor's Committee on Metabolic Disorders and the DOH General Counsel resolved patient confidentiality issues.

The Genetic Services Program continues to serve clients at the PBS DC General Hospital OB-GYN Clinic, PBC Community Health Centers, and at Mary's Center and Children's National Medical Center Adams Morgan Clinic. The delivery system includes George Washington and Howard University Hospitals, and Children's National Medical Center. Foster care children were transitioned from Medlink Hospital to the PBC Community Health Centers where they are now seen. Otherwise the program remained unchanged. In FY 1999, 426 clients were seen for pediatric and prenatal genetics services, an increase of 75 clients from FY 1998.

The Infant Mortality Review Committee (IMRC) continued its work through FY 1999 with support from Healthy Start project funds as well as an additional \$100,000 of federal Healthy Start Initiative partnership funds received in January 1999. The review functions are now combined with those of the Child Fatality Review Committee. As a result of the additional funding, an annual report was published and a computerized integrated database installed with accessibility by partner agencies. 47 infant deaths were reviewed in 1999.

The Comprehensive Lead Poisoning Prevention Program (CLPPP) continued to conduct outreach, community and patient education, in-home testing and screening, and maintained the lead testing registry. Supported by HUD and CDC grants, and Title V funds, the program staff screened children in public schools, preschools, day care centers and Head Start programs. Door-to-door campaigns were conducted in selected neighborhoods to inform householders about lead safety and to offer free screening.

The school nurse program, administered by the PBC provided extensive hearing and other screenings, as well as education in the public schools, as described in section 1.5

These population-based services are expected to affect the following objectives: NP# 4, 5, 6, 9, 12, 13, 15, 18 and SP# 1, 2, 3, 4, 7.

Infrastructure Building

OMCH continued to support several surveillance systems, in addition to the lead poisoning registry. Pregnancy Nutrition Surveillance System (PNSS) data collection continued through 1999. Data collection for the Pregnancy Risk Assessment Monitoring System (PRAMS) resumed May 1998 with a different sampling design after being temporarily discontinued during FY 1997. Response rates range from 60 to 71%. The unit chief is currently negotiating with CDC to obtain technical assistance on how to weight the data. Acquiring this capability will enable OMCH to carry out the surveillance without the assistance of a contractor.

PNSS staff is cleaning the 1999 data file for submission to CDC. 1998 data were used to analyze access to prenatal care by comparing birth outcomes of Medicaid and non-Medicaid clients. Results were presented at the September 1999 CityMatCH conference and have also been used for the needs assessment. (See section III.) 1998 annual reports for both projects were distributed. 1999 reports are expected to be ready for distribution this fall.

During FY 1999 data unit staff began conducting monthly client satisfaction survey interviews with transportation service clients. Results are shared with senior managers, including the Healthy Start director, and the Healthline and transportation coordinators. Generally, about 90% of clients indicate a high satisfaction with services.

In addition to carrying out the Healthy Start data collection and reporting responsibilities, the data unit staff provided technical support on numerous program-specific and department-wide needs assessments, state plans, annual budget submissions and monitoring efforts. They worked with the State Center for Health Statistics to analyze and present maternal and child health data and on sections of the year 2010 plan.

As discussed in section 1.5.2, staff and managers participated in numerous intra- and interagency committees, task forces and forums convened to address maternal and child health policy and staged the annual coordinating conference.

The 13th Annual Maternal and Child Health Citywide Coordinating Conference--*Bridging the Gaps For Families*--convened Wednesday, February 24, 1999, at the George Washington University Marvin Center. Over 250 people attended, including the general public and key providers of health, education and social services. Both sponsorship and participation reflected OMCH efforts to establish partnerships, promote effective information sharing and coordination of citywide services.

Co-sponsors included the DOH Addiction, Prevention and Recovery Administration; the George Washington University School of Public Health and Health Services; and DC Action for Children. Participants were from diverse backgrounds/skills, ranging from social workers, educators, nurses, nurse practitioners, physicians, physician assistants, dentists, therapists, day care providers, public school counselors and members of the religious community.

Four workshops convened in the afternoon: MCH Surveillance and Monitoring; The Faith Community; Families Speak Out: Voice of the Community; and Public Information, which was set-up to include eleven roundtables. Exhibitors included organizations with which OMCH has worked over the past year: Project WISH (DOH breast and cervical cancer screening), Agency for HIV/AIDS, Early Childhood Development, DC Early Intervention, WIC, CSFP, Lead Poisoning Prevention, Medical Assistance Administration, State Center for Health Statistic, George Washington University School of Public Health and Health Services, 3 MCOs (Prudential Health Care, DC Chartered Health Plan, Capitol Community Health Plan), and 3 faith based service organizations (Community of Hope, One Church, One Child, Inc., and AHEAD, Inc. Infrastructure strategies contribute to achievement of all state and national performance measures.

This submission marks the 3rd Title V Application/Annual Report for the DC Title V agency using the MCHB revised format. This report presents information on the 18 mandated national core performance measures (NP) and the 6 mandated outcome (NO) measures as well as 8 state negotiated measures. 13 of the 32 measures reported here were incorporated into the 30 OMCH 2010 objectives. As was the case last year, OMCH does not have the capacity to collect or acquire the data to report on all measures. To comply with these reporting requirements, therefore, approximations have been used for a number of measures. The DC measures and sources of data in this submission are described on the required forms. Several of these deficiencies are being resolved by work supported by the current SSDI grant.

Managers undertook major revisions in measures, targets and the methods for delineating targets in conjunction with the year 2001-2006 needs assessment. They are described in section III.

Form 11 requests fiscal year information, but OMCH uses vital statistics data, which of course are compiled for the calendar, not fiscal, year for many measures. 1999 birth and other vital record data are expected to be released after September 2000, therefore, 1998 vital statistics data are reported in this submission.

Because of the relatively small DC population, small changes in numbers of cases may have a considerable impact on rates. Additionally, official estimates of population groupings by age are subject to substantial error and vary from year to year. Therefore, caution should be exercised in the interpretation of annual fluctuations of certain measures.

Setting DC Targets

In order to comply with the April 20, 1998 MCHB directive, numerical targets for performance and outcome measures were assigned through years 2001 based upon several considerations, including original targets for DC year 2000 objectives, Healthy People 2000 objectives for specific subpopulations, current data, and finally, directions from the MCHB review of the July 1998 submission. Some adjustments were made in conjunction with the July 1999 submission. Revisions in those measures for which the objective was achieved were postponed until all priorities, performance measures and outcomes could be considered in conjunction with the 5-year needs assessment. That process and the results are described in sections III and IV.

SP# 1 - By 2000, increase the % of women who receive adequate prenatal care (Kotelchuck) to 62. Despite various direct services, outreach and educational programs, this objective (1996-57.7%, 1997-58.5 % and 1998-59.2%) remains considerably below desirable levels. The accuracy of this measure is affected by the high number of records for which data on the variable trimester of entry are missing.

In CY 1997, information to calculate this variable was missing on 20.7% (1642) of births, in 1998 19% (1471). Therefore, whether one uses the proportion of all women who gave birth and received

adequate prenatal care, or the proportion of women who received adequate care among those for whom adequacy is known, that is, whether the missing cases are included in the denominator, has a considerable effect on the percent. While arguments can be made for either approach, the denominator reported on Form 11 excludes missing data. OMCH staff is working the State Center for Health Statistics to determine the extent to which the missing data are randomly distributed across hospitals and risk factors. There is no variation by ward of residence.

In FY 1999, OMCH continued the strategies used in previous years to support early and continuous prenatal care: door to door transportation to prenatal care for uninsured clients; home visiting and pregnancy registrations in Healthy Start target areas; and information and referrals through the Healthline, health fairs, community events, transportation vans and Maternity Outreach Mobile (MOM) unit. The OMCH and the Medicaid agency worked to inform and enroll eligible women in Medicaid or CHIP. PBC CHC staff provided prenatal care at 8 locations to 1967 patients.

SP# 2 - By 2000, reduce the prevalence of lead levels exceeding 10ug/dl among DC children through age 6 to no more than 2%. CLPPP staff reported that 20,009 children were tested in FY 1999, with elevated findings for 795 or 3.97%. This year staff members were able to provide the number of children screened, an improvement over previous years when only the number of screens were reported. In 1998, 28,159 blood lead *reports* were received by the registry. 858 or 3% were > 10 ug/dl in that year. Reported screens included an unknown number of multiple screens insofar as children with elevated levels are monitored with repeated testing over time. The CLPPP community outreach staff does approximately 12% of total screenings, and another significant proportion of all tests are conducted at WIC clinics.

Under reporting of blood lead tests continued to be a problem. Although labs are legally mandated to report test results to the registry, only 4 labs, including Children's Hospital National Medical Center, which provides lab services for CLPPP, report. Private labs only report results >9ug/dl, making it impossible to determine the extent to which the at-risk population has been screened. DOH has sent letters to all labs and to pediatric providers serving the area questioning compliance with reporting. The department is also seeking to strengthen statutory provisions for reporting.

In addition to policy development, assurance and surveillance activities, this program provides medical case management for children with confirmed blood lead levels > 15ug/dl. Employees

conduct home visits not only to locate children with elevated levels and assure compliance with referrals, but also to collect dust samples, arrange lead abatement, teach parents and caregivers about harm reduction, and perform in-home screening for resident children. Over a 3-year period, 500 children were placed in medical case management. In FY 1999 258 children were found living in housing with lead-based paint. CLPPP has been able to complete environmental risk assessments of the homes of only about 50% of the children with high blood lead levels. Reasons for the lack of completion include refusal of the occupant, inability to locate the occupant via telephone or home visit and insufficient staff. This year private certified contractors have been hired to reduce the backlog of investigations.

More than 45,000 lead poison prevention fact sheets were disseminated to parents of young children. Staff conducted provider education in 25 child care facilities and 3 public schools. They participated in 32 health fairs.

SP# 3 - By 2000, reduce the % of low birth weight (lbw) infants to 12.5. At the current level (1997 - 13.5% and 1998 – 13.2%) lbw, unfortunately, remains stable. And considering only singleton births, the rate is still high—11.7%. In addition to the strategies to reduce other adverse birth risks, OMCH efforts to reduce lbw included coordination of referrals with WIC and support of the Commodity Supplemental Food Program (CSFP) sites. OMCH provides support of \$100,000 for 4 staff positions in CSFP. These workers certify program participants at high utilization sites. In addition to food supplies, the program distributed printed materials on the role of nutrition and physical activity in protecting health.

Healthy Start continued to aggressively refer clients to WIC. In addition, nutritional services were available through the CHCs.

SP# 4 - By 2000, increase EPSDT participation to 60%. In FY 1998, 55% of enrollees received EPSDT screening, an increase from 49% in the preceding year. In FY 1999, it fell to 38%! The participation ratio means that only 38% of beneficiaries received at least one of the initial or periodic screening services for which they were eligible according to the periodicity schedule. Considering the total number of expected screens, based upon the number of enrollees, their period of eligibility, and the appropriate age-based periodicity schedule, 55% of the expected screenings actually

24 Annual EPSDT Participation Reports, 416 Report, DC MAA, March 31, 1999 and March 31, 2000.

occurred. As described in section 1.5.2, OMCH has partnered with the Medicaid agency to increase EPSDT participation, particularly to comply with conditions of the Salazar case.

In order to increase compliance with *Salazar v. District of Columbia*, in January 1999 the court ordered the Medicaid agency to ensure that its MCO contractors maintain a client-specific, by name and Medicaid identifier, tracking system to include all required screens, dates of and test results, immunizations, referrals for corrective treatment, results of the referrals, and all outreach efforts in conjunction with the above. The court is also requiring the MMA to ensure that MCOs contractors train all EPSDT providers, as well as to verify on a biannual basis that each EPSDT provider has the necessary equipment and knowledge to perform the required services.

The MCO contracts require that in 1998 the MCO meet a .75 participation ratio, and in 1999, .80 participation ratio. MCOs with ratios that vary more than .05 from the expected standard are to be required to implement a corrective action plan. The Medicaid agency is required to use an independent party to verify these data. As of June 2000, the contractor had reportedly completed the assessment audit, but results have yet to be published.

SP# 5 - By 2000, reduce the proportion of unintended pregnancies to 40%. In 1998, 50.1% of PRAMS respondents (unweighted data) reported their most recent births resulted from unintended pregnancies. The data unit chief is currently working with CDC to obtain assistance in assigning weights in order to derive an estimate for this indicator.

The CHCs provide family planning education and services. The contraception prescribed and/or dispensed at the CHCs consists of oral contraceptives, condoms, foam and Depo-provera. Healthy Start funds are used to make Depo provera, which Medicaid does not provide, available free of charge through the CHCs. Family planning information, counseling and referrals, as well as condoms, also are provided at the Healthy Start mobile sites. Healthy Start also facilitates several peer educator and/or skills building programs for young people, which are designed in part to reduce unplanned teen pregnancies. 21,281 condoms were made available to students through the school nurse program at all public senior high schools during school year 1998-99.

SP# 6 - By 2000, reduce the prevalence of tobacco use among pregnant women to 6%. The prevalence as measured by information provided on the birth certificate was 6.95% and 5.5% in 1996

and 1997 respectively. In 1998, it declined to 4.8%. Tobacco use data collected for the birth certificate is considered to be highly variable by hospital and provider and may be grossly under reported.

Healthy Start skill building sessions aimed toward youth emphasize reasons not to use tobacco as well as other substances. The CHCs distribute information to discourage the use of tobacco during pregnancy, as well as on the effects of secondary smoke on children.

SP# 7 - By 2000, reduce (maintain) the prevalence of alcohol use among pregnant women to below 2.5%. In 1998, the use of alcohol during pregnancy, as reported on birth certificates, was 1.76%, compared to 2.27% in 1997. As with tobacco use, this measure may be considerably under reported.

As one of its population-based services, during several months in FY 1999 OMCH continued distribution of *If you're pregnant, don't drink* signs to retail establishments selling alcoholic beverages in cooperation with the Alcohol Beverage Control (ABC) Board, which combined signage distribution and mandatory posting with liquor licensure and inspections. During that period, ABC Board employees distributed signs to Class A (liquor stores) establishments and convenience stores, restaurants and clubs. The signs prominently display the OMCH Healthline number. When the supply of signs was exhausted, they were not reprinted.

National Performance Measures

NP#1- Increase % of SSI beneficiaries under age 16 who receive rehabilitative services from the state CSHCN program to at least 9. During FY 1999, 254 SSI beneficiaries received services at the PBC Health Services for Special Needs Clinic—approximately 10% of the estimated SSI beneficiaries under 16. The numerator for this measure varies considerably across years due to changes in clinic volume, as well as accuracy of record keeping. Denominator estimates are also subject to substantial error, in particular because the SSA does not publish reports on the under age 16 category.

Although the measure reported here is based solely on clients seen at the PBC clinic, providers serve this population as well. Through the 1115 waiver, SSI Medicaid recipients under age 22 may enroll in a dedicated managed care organization (Health Services for Children with Special Needs, Inc.). Or they may elect fee for service. Some of the clients reported by the PBC clinic may have been Medicaid fee-for-service beneficiaries. Others may have been members of Health Services for Children with Special Needs, Inc., which contracts with the PBC. Or patients may be receiving services at the clinic because of its status as a traditional community provider. Insofar as the clinic plays a role in assisting clients with SSI applications, a measurement issue arises as to whether to use SSI status on the first visit in the fiscal year, last visit in the fiscal year, most frequent visit status or some combination of visit times.

NP# 2 -Maintain the degree to which state CSHCN program provides for specialty and sub-specialty services . . . not otherwise available . . .

As in prior years, the DC CSHCN program provides 7 of the 9 of the specialty and sub-specialty services delineated by MCHB (See Attachment - Performance Measure #02). Respiratory services and home health care are not provided through Title V. These services, as well as other specialty and subspecialty services, are available through Medicaid, for the SSI and the TANF/TANF-related populations, as well as children who qualify under the Title XXI program.

NP# 3 - Increase % of special health care needs children who have a medical home to at least 16. 100% of these children are estimated to have had a medical home in FY 1998. OMCH continues to grapple with this measure, currently estimating that 70% of special needs children have medical homes.

For the October 1998 application resubmission, MCHB directed OMCH to provide an estimate using the children in the state special needs program, that is, those patients served by the PBC Health Services for Children with Special Needs Clinic, as the denominator. At that time, PBC managers reviewed a sample of clinic administrative records but were unable to extract information to measure the prevalence of medical homes. Therefore, it was reported that 0% of children had a medical home in 1997.

After a discussion of operational definitions of medical home prior to the preparation of the 1999 report, and a record review conducted by clinic staff on a 15% simple random sample of patient

records, it was found that 100% of the children had a medical home. Children who are referred to the clinic by their Medicaid primary care provider have, by definition, a medical home. Uninsured children who are self-referrals or were first seen at a PBC CHC have a medical home at the PBC. If a child is seen on a continuing basis at the clinic, the clinic itself may serve as the medical home, with nonspecialty care provided at a CHC or in some cases by clinic staff. The change from zero in FY 1997 to 100% in 1998 does not indicate a change in the delivery system, but rather a change in interpretation of the definition of this measure.

For the 2000 report the denominator was changed. In conjunction with the 5-year needs assessment, a population-based estimate of special needs children was derived—approximately 16,000. Using current rates of Medicaid participation and uninsured, it is expected that 70% of these children have medical homes. Enrollment in Medicaid managed care is by definition assignment to a medical home.

NP# 4 - By 2000, 100% of newborns will be screened for each of . . .

In prior years an estimated 100% of newborns were screened, however, in 1997 an estimated 95% of babies delivered in DC hospitals were screened. The lower rate in 1997 was thought to be due to the submission of incomplete or incorrect information on the filter card screen by hospitals. Some newborns may have been discharged prior to screening. Fortunately rates increased in 1998 and 1999 to more than 99%--14989 of the 15078 births in 1998 (99.41%) and 14558 of the 14648 (99.38%) births in 1999.

NP# 5 - By 2000, 90% of DC 2-year-olds will have completed the 4:3:1:3 immunization series.

The National Immunization Survey produced the following coverage estimates for DC for children 19-35 months for the period July 1998-June 1999:

3 DTP/ DT % (95% CI)	94.3 (± 4.0)
4 DTP/ DT % (95% CI)	73.2 (± 7.3)
3 Poliovirus % (95% CI)	88.1 (± 5.2)
1 MCV % (95% CI)	91.8 (± 4.8)
3 Hib % (95% CI)	91.0 (± 4.7)
3 Hepatitis B % (95% CI)	79.2 (± 6.5)
1 Varicella % (95% CI)	53.9 (± 7.9)

It was estimated that 72% (CI= \pm 6.0) had completed the 4:3:1:3 series.²⁵ Estimated completion rates varied from 68.4% (\pm 7.7) for African Americans to 79.6(\pm 13.7) for Latinos and 89% (\pm 9.2) for whites. DC immunization coverage rates have not measurably improved over the past few years.

In addition to the coordination between Healthy Start and the immunization program described in section I, the OMCH school health liaison worked closely with the Preventive Health Services Administration Immunization Division in determining the need to bring school aged children into compliance for needed immunization. In 2000, the Consortium on School Health used immunization registry information and OMCH data to identify 14 schools with the highest rates for non-compliance of immunization. School nurses and their corresponding PBC CHCs participated in the effort, which involved dissemination of permission forms in 7 languages, establishment of a liaison to each school, visits and mass mailings to principals, attendance at principals' meetings, and parental and community outreach, emphasizing immunization for the entire family. The campaign will culminate in back to school outreach in August.

The MAA is using immunization coverage as one of the performance measures on which Medicaid contractors are required to report annually, however, there is little evidence that this is being enforced. Client-specific tracking is required by Salazar V. District of Columbia.

NP# 6 - By 2000, reduce the birth rate for teenagers aged 15 - 17 to 70.

In 1996, the birth rate for women aged 15 - 17 was estimated at 79.3 and for 1997, 65.8. That very significant reduction was sustained in 1998 (65.4). In addition to the strategies applied at the national level to change values and behaviors contributing to teen pregnancy, various local efforts have continued. HIV prevention education has resulted in increased condom use: In 1999 74.2% of sexually active students reported condom use before last sexual intercourse, a greater proportion than in the other US cities participating in the Youth Risk Behavior Surveys, as well as a change from 67.9% in 1997.²⁶

Contraception counseling and information are available through the CHCs as are condoms, Depo provera, foam and prescriptions for oral contraceptives. Male and female condoms, pregnancy testing, and information and referrals for reproductive health services are available on the OMCH-Healthy Start MOM unit. The Healthy Start programs supported several teen peer education efforts.

²⁵ http://www.cdc.gov/nip/coverage/tables/antigen_st.xls

The MCHB-supported abstinence education initiative grant assisted OMCH in finalizing an abstinence-based curriculum *I'm Worth the Wait*, designed for adolescents aged 9 – 14 living in Wards 5, 7 and 8. 25 peer educators and 10 service providers were trained to deliver the curriculum. Using the venue of a theater troupe, a new group of 10 peer educators from Shaed Elementary School is staging performances to expose at least 1000 youth to this message during FY 2000.

NP# 7 - By 2000, increase % of 3rd graders who have received protective sealants from an estimated 10 to at least 14. OMCH estimates that there has been no change from the previous year, and that prevalence remains at 10%. Since OMCH was not able to identify a data source for this measure, in 1998 MCHB Region III staff recommended an estimate based on prevalence data for Baltimore school children. In addition to its location in the same metropolitan area, the Baltimore population is demographically similar to the DC population. OMCH did not initiate nor identify additional activities in the area of oral health, therefore, it is estimated that prevalence remained the same through 1999.

DC does not have a school-linked sealant program nor has the DOH funded population-based oral health campaigns. Although resources have not been allocated to increase availability and access to services, oral health is receiving more attention as a DC health problem. Due to testimony at a June 1999 public hearing on the draft year 2010 health objectives by a PBC official, oral health services for children was added to the plan as a focal area. At least one advocacy group (AFFIRM) has raised the lack of dental services as an issue.

Sealants are reportedly available at the 7 PBC CHCs that offer dental services, although aggregate data on the numbers of children receiving sealants have not been compiled. DOH in collaboration with the PBC, will be implementing new school dental appraisal forms in September 2000, which will reflect the sealant status of school-aged children.

Dental services were provided at 2 school-based clinics (Sharpe Health School and Mamie D. Lee School) dedicated to children with special needs. An unknown number of children receive sealants through their dental services providers, including Medicaid providers. According to the FY 1999 EPSDT Participation Report, Form 416, 12,669, less than 16%, of eligible children under age 20

received preventive dental services. Less than 23% of EPSDT-eligible children age 6-9 years received any dental services.

OMCH has considered various approaches to collecting or acquiring the data to provide the estimates for this performance measure. At the suggestion of Region III MCHB staff, OMCH has decided to contract with the Association of State and Territorial Public Health Dental Directors to conduct a physical examination survey to identify gross dental and oral lesions in a sample of DC children. Data from the survey will be used to provide estimates for relevant national health objectives and performance measures, including prevalence of sealants. OMCH will use SSDI carry over funds with the expectation that the study will be completed by June 2001.

NP# 8 - By 2000, reduce the death rate of children aged 1 - 14 caused by motor vehicle crashes to 4.4. In 1997 the rate was 3.48 compared to 5.8 in 1996. The rate increased to 7.2 in 1998. Because of the small numbers (6 deaths in 1998), it is expected that the rate may vary considerably from year to year. Death by motor vehicle is a less significant component of the child mortality rate in DC than it may be in other areas. Nevertheless, the Child Fatality Review Committee has recommended that seat belt laws for children be more strongly enforced, but provided no suggestions as to how that should occur.

Infant car seats are available free of charge from the Department of Public Works and Project Safe Kids to Medicaid beneficiaries and at reduced rental rates for others. They are distributed through 16 locations, including community clinics and hospitals.

NP# 9 - By 2000, 46% of mothers will be breastfeeding at hospital discharge. OMCH estimates that in 1998, 36% of mothers breastfed at discharge, compared to an estimated 38% in both 1996 and 1997. The 1998 estimate is based upon birth certificates *for which data of this field were reported*. Data were missing on nearly 59% of the records. The estimates for 1996 and 1997 were based on a combination of WIC participation and US breastfeeding rates for Black women. The OMCH data unit chief is working with vital records staff to assess the causes and implications of the missing data.

Breastfeeding is a high priority for the WIC program, and WIC employees coordinate counseling and education efforts across sites, some of which are co-located with CHCs. Follow through on referrals to WIC is a priority for Healthy Start staff.

NP# 10 - By 2000, increase the % of newborns screened for hearing impairment before hospital discharge to at least 82.

During 1999 an estimated 17 % of newborns were screened. In FY 1997, city hospitals screened an estimated 48% of the newborns, compared to 20% in FY 1998. Three (Georgetown, Greater Southeast and Howard) of the 9 birthing hospitals in the District reported that universal hearing screening was conducted 1999. There were 2536 births at these hospitals.²⁷ In addition, 62 infants were screened at DC General Hospital, where, reportedly, it is hospital policy to screen all newborns, however, prior to the recent replacement of antiquated equipment, practice differed from policy. The other hospitals screen only high-risk infants as determined by the individual hospitals. At least 3 hospitals (Washington Hospital Center, Providence and DC General Hospital) are introducing screening in 2000. Children's National Medical Center is providing consultation and assistance to help start-up hearing screening programs at DC General Hospital and Providence hospitals.

Two bills have been introduced to implement Newborn Hearing Screening and Early Intervention in the District. Proposed legislation written by OMCH in cooperation with the DOH General Counsel is included in the Child and Youth Safety and Health Omnibus Amendment Act of 2000, Bill 13-672, a mayoral initiative. The other bill proposes to add hearing screening to the District of Columbia Newborn Screening Requirements Act of 1979, as amended in 1980 and 1999. As of May 2000, both bills have been sent to the Committee on Human Services and should be addressed in the fall of 2000.

Plans to hire a hearing screening program coordinator in fall 1999 to establish a program were not realized, however, recruitment is underway. In January 2000, OMCH submitted a proposal to MCHB for support to establish universal hearing screening for DC newborns, but the application was not funded.

NP# 11 -By 2000, increase the % of CSHCN in the state CSHCN program with a source of insurance for primary and specialty care to 75. More than 95% of the 1297 patients registered by the PBC special needs clinic were Medicaid managed care enrollees. In FY 1998, 69.6% of the children served by the PBC Health Services for Special Needs Clinic were insured. Only a few of these had a source of support other than Medicaid. Whether the increase from 47.5% in 1997 to over 95% in this reporting period represents a real change or is due to differences in record keeping is unknown. Among the possible causes of measurement error is whether the source of insurance is defined at the

²⁷ The total for 1998 was used because the 1999 births per hospital have not yet been released.
²⁸ Based upon a sample of 62% of records conducted by clinic staff.

time of the first visit, last visit in a fiscal year, or at some other point. Clinic staff said their records contain information reported by parents or caregivers, which may not be accurate or current.

NP# 12 - By 2000, reduce the % of children without health insurance to no more than 7. Bureau of the Census estimates indicate that 12.6% of DC children were uninsured in 1999. Estimates done in preparation for the Title XXI application placed the uninsured population under age 19 at 13.69% in mid 1997. An estimate of the number of uninsured children published July 16, 1998 indicated 13.10%. Enrollment in Title XXI began in October 1998. Although the absolute number estimated as uninsured declined from 1998 to 1999, the number of children in the city also declined, resulting in only a small change in the proportion of uninsured children. It is worth noting, however, that in many communities, the decline in private insurance rates and the decreased Medicaid participation due to TANF terminations may contribute to a net reduction in insuredness even as state Title XXI programs enroll children. As described in section I, DC ranks favorably among other states in enrollment.

OMCH and Healthy Start participated in the DC Action for Children application for RWJ Foundation Covering Kids Initiative, which was funded in 1999, and have since been involved in outreach and information campaigns to encourage persons to apply for the program. As described in section 1.4, the OMCH Healthline serves as the official Title XXI information number. Healthy Start outreach workers also played a role in telling community residents about the new insurance program, how to enroll, and, most important, how to use the preventive and primary services.

The DOH MAA reported to HCFA that during FY 1999 3029 persons were enrolled in CHIP.²⁹

NP# 13 - By 2000, increase % of potentially eligible children who have received a Medicaid service to 90. Using data source HCFA-2082 Report Table 22/Table 28, it is estimated that 87.1% (66693/76525) of Medicaid eligibles under age 21 received at least 1 service in 1998, compared to an estimated 90% in FY 1997. Because of the numerous data quality and measurement limitations inherent in this performance measure, caution in interpretation is warranted. For example, service received is measured by claims processed. In addition to other differences in receipt of a service and a claim for service processed, the differences in time periods may contribute further to measurement error.

²⁹ <http://www.hcfa.gov/init/enroll99.pdf>

The availability of pediatric services at the CHCs, Healthy Start case management, transportation for specific categories of clients, education of parents through the *Use Your Power!* materials, and Healthline information and referrals may contribute to the receipt of needed Medicaid services.

NP# 14 - By 2000, the degree to which the DC assures family participation in program and policy activities in the state CSHCN program will be rated "10". OMCH staff assigned a self-rating of "11" on the 18 point scale provided by MCHB. Family participation increased in 2000 due to successful efforts to include consumer families in the needs assessment. The PBC Health Services for Children with Special Needs Clinic also works with a parents' advisory group. The *Use Your Power!* parents council is also involved in effort to improve Medicaid policy regarding special needs children.

NP# 15 - By 2000, reduce the incidence of vlbw to 2.5%. The incidence in 1998 was 3.2%, compared to 3.51% in 1997. As with the incidence of lbw, this measure has changed very little; however, as indicated by changes in the IMR (NO#1), the survival rate of lbw and vlbw infants has improved, probably due to advances in neonatal intensive care. Nevertheless, through the Healthy Start program activities and the CHCs, OMCH continued efforts to inform women of the importance of early and consistent prenatal care, provided no-charge door-to-door van transportation to uninsured women, conducted home visits to high risk women in targeted neighborhoods, and made and followed up on referrals to social and medical services and WIC.

NP# 16 - Through 2000, maintain or reduce the average suicide rate among youths aged 15 - 19 at no more than 8.2 (the national year 2000 objective). In 1998 there were 4 suicides, and the rate was 15.52. In 1996, the DC youth suicide rate was 7.63. Only 2 deaths were coded as suicides. But there were 5 suicides in 1997, increasing the rate to 19.43. Because of the relatively small DC population, per 100,000 rates may be greatly affected by a few additional cases. In the past, suicide has not been a major problem for DC's majority African American population, for which the major manifestation of intended violence has been high homicide rates. In contrast to suicides, the homicide rate for persons aged 15-19 was 213.7 in 1997!

Again this year, Healthy Start education staff ran several peer education and skill building programs for youth to support a range of healthy behaviors, including conflict resolution and self esteem, however, OMCH is not aware of city programs intended specifically to address youth suicide.

NP# 17 - By 2000, 90% of vlbw deliveries will take place at facilities for high-risk deliveries and neonates. 9 hospitals provided obstetric services in 1998--6 offered tertiary care for deliveries and neonates: Georgetown University Hospital, George Washington University Hospital, Washington Hospital Center, DC General Hospital, Howard University Hospital and Columbia Hospital. 2 hospitals, Georgetown and Children's National Medical Center, accept very high risk neonate transports. The distribution of vlbw births across hospitals has not changed in recent years: In 1998 72.7% of vlbw babies were delivered at the 6 tertiary care institutions.

In FY 2000, the OMCH interim chief attempted unsuccessfully to place this specific issue, as well as the more general need to develop a citywide, integrated system of perinatal services, on the agenda of the mayoral task force on restructuring the health care system.

NP# 18 - By 2000, at least 70% of infants will be born to women who began prenatal care in the 1st trimester. Entry into prenatal care in the 1st trimester increased from 66.7% in CY 1997 to 72% in 1998. A high proportion, 15.5%, of the birth records lack information on the trimester of entry (!), and these cases were not included in the denominator. The OMCH data unit chief met with analysts at the State Center for Health Statistics to determine causes of the missing data. They agreed that hospital staffs need more on-going training in obtaining this information, including feedback on missing fields. To date, it has not been possible to dedicate staff time to this task.

Intensive efforts continue to be directed toward supporting women to enter prenatal care as early as possible and to sustain the care throughout their pregnancies. Each of the 8 CHCs offers pregnancy testing and prenatal care. Efforts have been made to simplify and expedite enrollment into the Title XXI DC Healthy Families. The Healthy Start programs target home visiting and counseling to low income, predominately African American neighborhoods to encourage women to obtain early and continuous prenatal care.

2.5 Progress on Outcome Measures

Progress on outcome measures is shown on Form 12.

NO# 1 Reduce IMR to 11. by 2000. The IMR continued a steady decline—in 1998 to 12.5 from 13.1 in 1997—although not in all areas of the city. While the IMR is declining, risk factors highly associated with infant mortality--v/lbw and late entry into prenatal care--remain relatively constant. In addition, racial and class gaps, as well as differences in comparable DC and US rates, have not been dramatically reduced. It is expected that the continuation of the Healthy Start program in 4 of the 8 city wards will result in a significant impact on the IMR by 2000.

NO# 2 - By 2000, eliminate the disparity between the African American and white IMRs. In 1996, infants born to white DC residents had an IMR of 3.8, while the rate for infants born to women of African American heritage was 17.2, a disparity ratio of 4.53. Although the African American rate and the white rate, as well as the overall IMR, declined in 1997, the disparity ratio actually increased to 5.32. The white IMR declined to 3.1, the African American to 16.5. In 1998, however, the disparity ratio was reduced to 4.8, as a result of the continuing decline of the African American IMR to 15.0. As described in the initial pages of this application, DC is a majority African American city, and 70% of births were to African American women.

NO# 3 - By 2000, reduce the neonatal mortality rate to at least 9. In DC, as elsewhere, most infant deaths occur in the neonatal period: In 1998 the rate was 7.0, down from 9.6 in 1997. The most frequently cited causes of death were disorders related to short gestation and unspecified lbw.

NO# 4 - By 2000, reduce the postneonatal mortality rate to at least 2. In 1997, the rate was 3.5 and it increased to 5.5 in 1998, suggesting that the distribution of infant deaths during the neo- and post-natal periods is changing.

NO# 5 - By 2000, reduce the perinatal mortality rate to at least 14. The 1998 perinatal mortality rate was 15.4, a decline from previous years.

NO# 6 - By 2000, reduce the child death rate to at least 40. In 1996, the child mortality rate was 60.47. The number of child deaths decreased from 52 in 1996 to 41 in 1997, bringing the mortality rate to 47.6. The 1998 rate, 47.9, indicates little change. Much remains to be done to reduce intentional injuries and lack of timely medical care for chronic conditions. Findings of the Child

Fatality Review Committee indicate that of deaths reviewed a high proportion occur in families known to 1 or more systems.

SO# 7 - By 2000, reduce fetal death rate to no more than 9/1000. The 1998 fetal death rate was 8.39 (65/7743),³¹ a continuing decline from 9.7 in 1996 and 9.14 in 1997. Nevertheless, it remains high and reflects the same social conditions as other birth outcomes.

III REQUIREMENTS FOR APPLICATION

3.1 Needs Assessment of the Maternal and Child Health Population

The five-year needs assessment seeks to provide valuable information to help the District of Columbia Department of Health, Office of Maternal and Child Health as it works in partnership with community organizations and providers to identify actions that are effective in improving the health status of the District's maternal and child health (MCH) population. More specifically, the major objectives of the needs assessment were to:

- Describe the health status, problem health issues and available preventive and primary care services, including gaps in services, for pregnant women, women of child bearing age, infants, and children, including children with special health care needs in the District of Columbia;
- Make recommendations to the Title V Agency regarding effective intervention opportunities to improve the health of these resident for incorporation into the FY 2001 plan; and
- Meet the requirements for the Title V application.

The needs assessment reflects more than a compilation of numbers or descriptions. It discusses health status and trends, gaps and discrepancies (i.e. age, gender, socio-economic and cultural groups and geographic groupings), and events and circumstances that impact the measures or indicators.

Maintenance of Effort

The District of Columbia will continue to provide the maintenance of effort amount of \$5,273,791 as outlined in Section 505(a)(4).

3.1.1 Needs Assessment Process

3.1.1.a. In the summer of 1999, Office of Maternal and Child Health (OMCH) staff began planning the five-year needs assessment process for the District's Title V Block grant submission. Prior to the

³¹ As of July 3, 2000 the 65 reported fetal deaths in 1999 were considered to be based on preliminary data.

initial full planning meeting, staff from the Data, Policy, Planning and Evaluation Unit within OMCH and the State MCH Epidemiologist researched various methods of conducting needs assessments from across the country. Methodologies from the states of Washington, Virginia, New Mexico and San Diego, California were among the sites examined. In addition, literature on the subject contributed by experts in the field including, those from the Maternal and Child Health Bureau (MCHB), Johns Hopkins University and the University of Illinois at Chicago School of Public Health were reviewed.

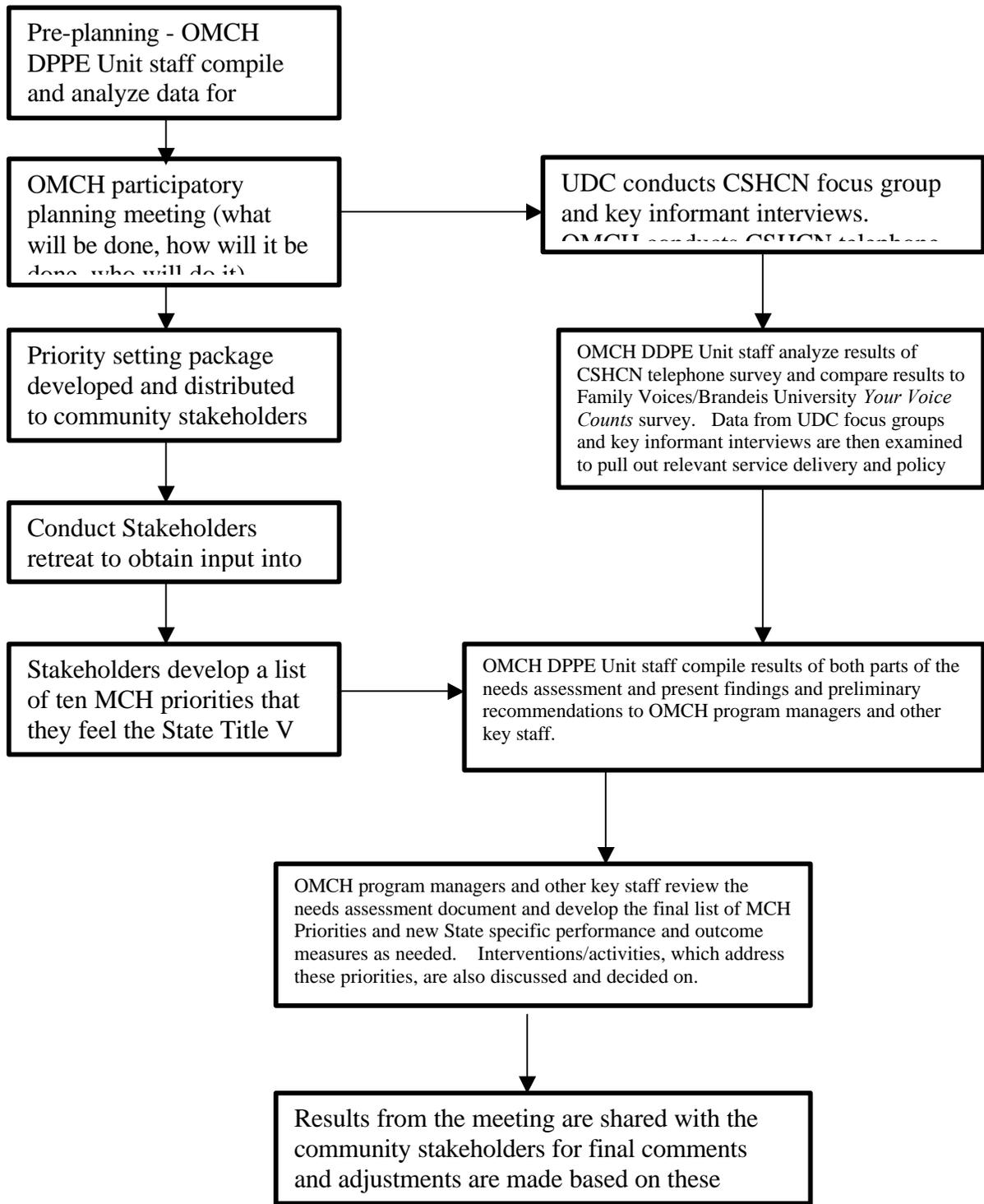
OMCH decided that secondary data and recently published reports would be used to assess the needs of two of the three populations covered under the Title V funding. Since little information was available about Children with Special Health Care Needs (CSHCN), a more extensive assessment, using both primary and secondary data, was planned for this population. The process for this portion of the needs assessment is discussed further in Section 3.1.1.b below.

Statistical analysis techniques used included univariate, multivariate and logistical regression analysis. Associations between independent and outcome variables were assessed. To test for differences between means and percentages z statistics were computed; tests were two-tailed, and α was set at .05. Unknown values were excluded from computations. Chi-square test of association was also used to examine differences in various risk factors across populations and/or races.

Once a substantial amount of the indicator data was compiled, plans were made to invite community stakeholders to an all day retreat to discuss the data and develop a list of seven to ten priorities. Stakeholders were defined as those individuals in the community (i.e. advocacy groups and activists, providers of care, parents, clients, and other state agencies) who had a key interest in MCH issues in the District. A list of fifty-five (55) potential stakeholders was compiled.

During a staff-planning meeting, the original list was cut to thirty-five (35). This list of individuals served as the primary stakeholder list. A second backup list was developed from the remaining names of the original list of stakeholders. See Appendix 5.3 for a list of the participating stakeholders. Eighteen stakeholders participated in the all-day retreat held on May 3, 2000.

The diagram below illustrates the process used to conduct the needs assessment.



3.1.1.b. Prior to beginning the CSHCN needs assessment, OMCH staff reached a consensus on a definition of the population of children with special needs. Staff recognized that there were various definitions in the field for this population based on the different purposes for defining the group. For

example, one definition is based on the diagnosis of the child, such as a developmental delay or the presence of a specific biologic risk factor.

OMCH chose to adapt the definition developed by Ruth Stein et al. in 1993. Specifically, children with special health care needs are defined as “those having disorders that have biologic, psychologic, or cognitive basis; have lasted or are expected to last at least 12 months and produce one or more of the following sequelae: (1) need for medical care related services, or educational services over and above the usual for the child’s age, or for special ongoing treatments, interventions, or accommodation at home or at school; (2) limitation in function, activities, or social role in comparison with healthy age peers in the general areas of physical, cognitive, emotional, and social growth and development; and (3) dependency on one of the following to compensate for or minimize limitation of function, activities, or social role: medications, special diet, medical technology, assistive devices, or personal assistance.”

After examining several models of needs assessments conducted for CSHCN, the District chose to follow the methodology of the State of Virginia as detailed in the document entitled *Virginia 1999 Needs Assessment and Recommendations: Services for Children with Special Health Care Needs & Their Families*. This model used focus groups, key informant interviews, and a special telephone survey to assess the systems of care for CSHCN and develop recommendations to improve these systems.

To collect parts of the primary data for this portion of the needs assessment, an Intra-District Agreement was established between the Office of Maternal and Child Health and the University of the District of Columbia, Center for Applied Research and Urban Policy (CARUP). CARUP staff led by Deborah Lyons, Ph.D. was charged with conducting focus groups with parents of special needs children, and key informant interviews with individuals involved with making policy, providing services, or advocating for this population. In total 7 key informant interviews and 4 focus group sessions have been held to date. See Appendix 5.3 for a list of questions asked in the focus groups and key informant interviews. Focus groups are being held in all eight Wards of the city to ensure that the results would be representative of residents living throughout the city. See Appendix 5.3 for a list of key informant participants.

In addition, during the first phase of assessing service needs of CSHCN, CARUP was responsible for estimating the size of the population of children with chronic health conditions in the District. The

approach used replicated the approach used by Virginia. The estimation was based on the work of Henry Irely, Ph.D. at Johns Hopkins University who developed the methodology to produce an estimate for the State of Virginia. See Appendix 5.3 for a complete report on the methodology used for estimating the population.

The CSHCN needs assessment is an ongoing activity for which the final report will not be available until August 2000. Results, from the telephone survey, and completed interviews and focus groups up to the time of this writing were included in this report. Once the final report is received OMCH staff will review the recommendations and revise the submitted plan if necessary.

3.1.1.1 Data Used and Sources of the Data: Because health status is an important factor driving the demand for health services in the District of Columbia, the first step in the assessment was to identify the specific health problems of the populations. To accomplish this, a broad spectrum of health-related data was collected, including all publicly available health (e.g. causes of death, birth outcomes, infant and child mortality and morbidity) and health care utilization data (e.g. EPSDT services used, Title X service utilization) as well as data on population characteristics and socioeconomic status. OMCH staff compiled over 90 health, social, and safety indicators, as well as indicators of health system capacity and adequacy, based on the list of model MCH indicators developed by the MCHB. (See Appendix 5.3 for a complete list of the indicators used) Data from the following sources were utilized:

- Title V Performance and Outcome Measures;
- Health Status Indicators;
- DC Healthy Residents 2010 Health Objectives;
- Vital Records;
- Juvenile Justice;
- Temporary Assistance for Needy Families (TANF);
- Child Abuse and Neglect;
- Hospital discharge file;
- WIC;
- Pregnancy Risk Assessment Monitoring System (PRAMS);
- Pregnancy Nutrition Surveillance System (PNSS);
- Youth Risk Behavioral Surveillance System (YRBSS) and other DC Public School data;

- Medicaid, including EPSDT;
- Head Start;
- Early Intervention;
- DC Department of Employment Services;
- DC Housing Authority;
- Behavioral Risk Factor Surveillance System (BRFSS);
- Planned Parenthood of Metropolitan Washington, DC (Title X Agency);
- Infant Mortality and Child Fatality Reviews;
- Environmental Health Administration/ Lead Poisoning Prevention Program;
- DC Office of Planning, State Data Center; and
- The US Census Bureau.

Various reports, including two recently completed, one by the Urban Institute, entitled *Capacity and Needs Assessments: Youth Activities in the District of Columbia*, and a second entitled *Primary Health Care Services for the Medically Needy In the District of Columbia A 2000 Update* by the District of Columbia Primary Care Association, and the *1999 Every Kid Counts in the District of Columbia: 6th Annual Fact Book* by the DC Children’s Trust Fund were also used as data resources. In addition the most recent version of the *1997-1998 Indices: District of Columbia Statistical Handbook Volume XII*, a book which provides a full range on data on the District of Columbia, was utilized.

3.1.1.2 Data and Methodology Limitations: Interpretation of the data from the various sources is dependent on an understanding of the limitations of the data collected and reported. When different sources provided differing values on an indicator, staff made a judgement about which source would be considered primary and the source was contacted directly to verify the methodology used to construct the indicator. In addition, Census Bureau population estimates were used to calculate the rates for the various indicators. These population estimates are in fact not absolute numbers but scientific “guesses” of the numbers derived from annual adjustments to the 1990 Census data, based on several parameters including telephone lists and automobile registration.

Also, caution must be used when interpreting the small number of occurrences for a particular indicator. Fluctuations easily occur when dealing with small numbers in small area analysis. Except

in the case of recent surveys for CSHCN, for ease of comparability, only data up through 1998 was used for the needs assessment.

3.1.2 Needs Assessment Content

3.1.2.1 Overview of the Maternal and Child Health Population's Health Status

Based on 1998 US Census population estimates, 523,124 people live in the District of Columbia.

While the total population size has decreased over the past ten years, the racial/ethnic composition of the city has remained stable. In 1998, the District's population consisted of 62.3% African-American, 34.3% White and 7.2% Hispanic. (Hispanic population estimate include both Whites and African-Americans)

Although the racial composition of the city has remained stable, the proportion of recent immigrants continues to grow. Currently, one in six residents in the Washington metropolitan area are immigrants, in the District of Columbia, the proportion has reached 10%. The dominant immigrant group in D.C. is El Salvadorian, followed by people from other countries in Central and South America. Immigrants from Africa, Vietnam, and the Caribbean comprise the next three most numerous groups. Connecting these diverse populations to the services they need in a culturally appropriate manner presents unique challenges

Clearly, public health interventions must assure that culturally appropriate activities/literature are available for this growing population. Women of childbearing age, infants and children make up approximately 47% (243,154) of the District's population. Of that number 8% are Hispanic, 60% are African-American, 30% are White 3% are Asian or Pacific Islander.

Annually, approximately 15,000 births occur in District hospitals. However, only about half are to residents of the District. On average, about 70% of the annual births to District women are to African-Americans, 16% are to Whites and 11% are to other races. Births to women of Hispanic origin make up about 9% of District resident births annually.

While pregnancy rates decreased for most age groups during the time period of 1996-1997, pregnancy rates for women between the ages of 25-29, 35-39 and 40 years and older have increased. The pregnancy rates of 15-19 year old women and 20-24 year old women decreased 7.5 % and 7.7%,

respectively. Conversely, the pregnancy rate of women 25-29 years of age increased 8% and the pregnancy rate of women 35-39 years of age increased 20% between the same time period.

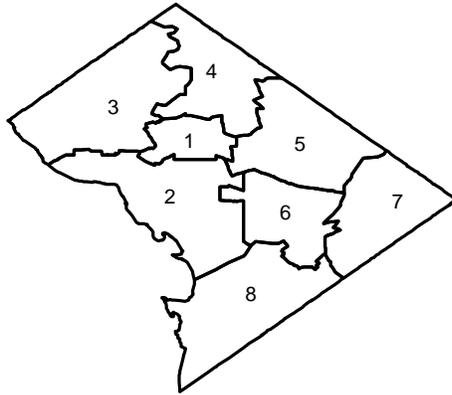
The literature clearly documents that socioeconomic status is associated with health status. Thus, before the health status of the MCH population can be discussed it is important to understand the socioeconomic conditions of the District. The story of the District of Columbia is a tale of two cities.

The city is divided into eight Wards. Economic, social and health status indicators vary considerably across these wards. The median household income for the District of Columbia in 1998 was \$43,011. However, the median household income ranged from \$27,937 in Ward 8, an area where many are living at or below the poverty level, to \$79,832 in Ward 3 an area where many wealthy residents reside. An even more striking statistic is the comparison of per capita income among these two wards. In Ward 3, the per capita income was \$63,340, a startling contrast to Ward 8's \$12,651, which is 68.8% below the national and 132.3% below the citywide average of \$21,350.

Racial/ethnic composition varies from 4.9% non-Hispanic African Americans in Ward 3 to 96.3% non-Hispanic African Americans in Ward 7. More than 43% of the District's Hispanic population is concentrated in Ward 1 where it represents about 25.5% of the Ward's population. Ward 3 has a predominantly White population, while Wards 6, 7 and 8 are predominantly African-American.

The Census Bureau estimates that 22% of the District's residents are living below the poverty level. Poverty affects District children disproportionately. Thirty-five (35) percent of children under age 5 and 36% of children age 5 to 17 live in poverty. According to Census estimates an average of 57.3% of the DC residents under age 19 lived at or below the 200% poverty level for the period 1995-97. While the Washington metropolitan area is considered to have a strong and sound economy with very low unemployment rates, this prosperity has had a lesser impact on the District where the official unemployment remains more than 6.3%. Using the receipt of cash assistance (TANF) as a marker for poverty, it was found that a large number of census tracts in Wards 6,7 and 8 had over 50% of their children living in families who received this benefit. Ward 3 had none. Moreover, less than 1% of child Medicaid recipients reside in Ward 3, compared to 24.4% in Ward 8. (See Map 1 below for a visual layout of the District of Columbia by Ward.)

Map 1
Wards of the
District of Columbia

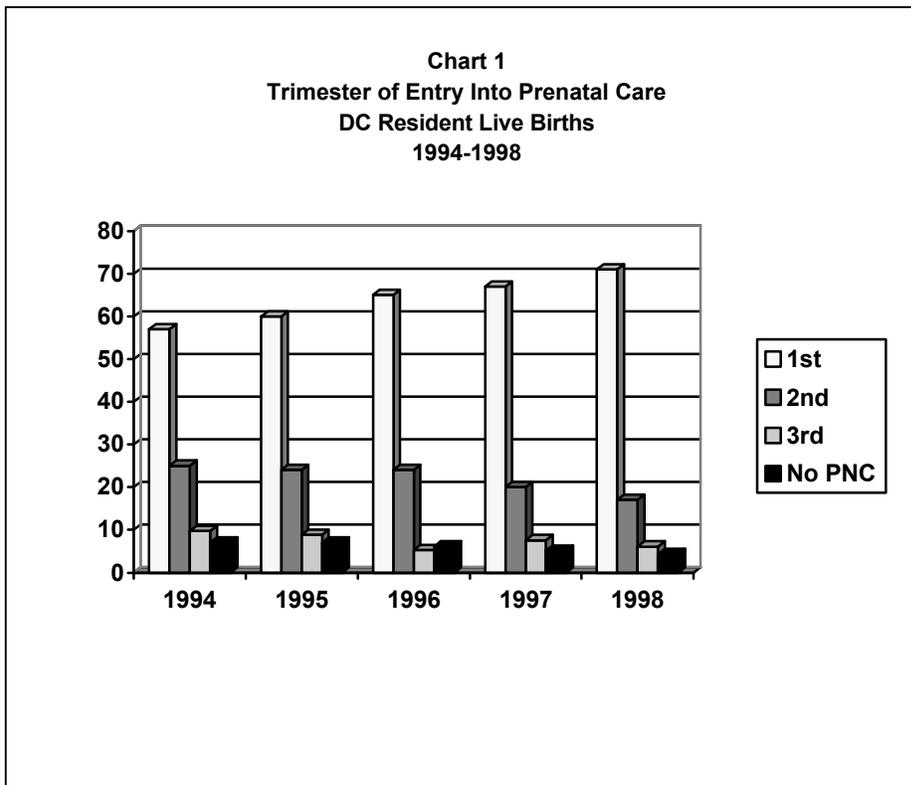


Health status indicators reflect these socioeconomic disparities. As will be seen, the District of Columbia's MCH population is characterized by some of the poorest health status indicators (i.e. infant, child and maternal mortality rates) in the nation.

LEADING MCH HEALTH AND SOCIAL INDICATORS

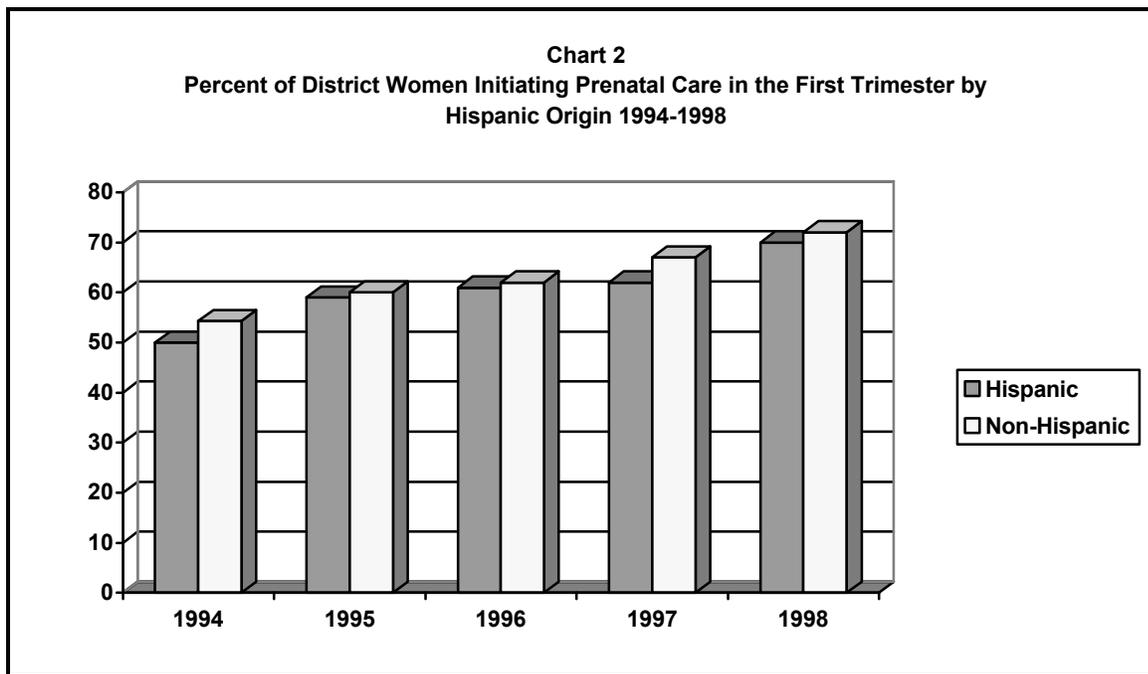
While several health and social indicators were analyzed during the needs assessment, the following narrative presents findings on some of the leading ("usual suspects") and emerging indicators.

Prenatal Care and Adequacy: Over the past five years, the District has seen a rise in the percent of women who initiated prenatal care in the first trimester from 57.3% in 1994 to 70% in 1998(See Chart 1 below).



Source: Department of Health, State Center for Health Statistics

While these increases have been seen across racial/ethnic lines, African-American women still lag behind White women when it comes to receiving prenatal care in the first trimester. Entry into prenatal care in the first trimester has markedly increased for both Hispanic and non-Hispanic women during the five year period examined. Women of Hispanic origin have increased prenatal care initiation in the first trimester from 50% in 1994 to 70% in 1998. This trend was similar for non-Hispanic women (See Chart 2 below).



Source: Department of Health, State Center for Health Statistics

Not only is obtaining early prenatal care critical but also receiving continued prenatal care plays a large role in ensuring healthy birth outcomes. During the five year time period of 1994 –1998 the overall adequacy of prenatal care increased from 51% in 1994 to 59.2% in 1998. Again, increases have occurred for all racial and ethnic groups. However, when examining the data available, the rate of increase has been slower for African-American women and in Wards 8, 7, 2 and 5. The geographic finding is not surprising considering that large numbers of African-Americans reside in these Wards.

Infant Mortality: The infant mortality rate is a reliable indicator of overall infant health and is frequently used as a reference point for defining a society’s quality of life. Defined as the number of infants who die between birth and one year of age per 1,000 live births, the overall infant mortality rate in the District of Columbia has continued to drop in recent years. In 1998, the rate, 12.5 per 1,000 live births, was an all time low for the District. This was a 5% decrease in the rate from 1997 (13.1 per 1,000 live births). In addition, it was the first time in the District’s history that the number of infant deaths fell below 100. Over the ten-year period, there were 171 fewer deaths representing a decline of 64%. (See Table 1 below) However, while efforts are being made to sustain and further improve on this reduction, the rate for the District remains significantly higher than the 7.1 rate for the United States as a whole.

Table 1: Ten-Year Infant Mortality Trends			
District of Columbia Residents, 1989-1998			
Year	# of Births	# of Infant Deaths	Infant Mortality Rate*
1989	11,567	267	23.1
1990	11,806	236	20.0
1991	11,650	235	20.2
1992	10,939	200	18.3
1993	10,614	177	16.7
1994	9,911	180	18.2
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5

*per 1,000 live births

Source: Department of Health, State Center for Health Statistics

Several Wards throughout the city also have experienced declines in it's infant mortality rate. Wards 1, 3, 4, 6, and 8 have seen consistent declines in the rates since 1994, while Wards 2 and 5 have fluctuated or risen in the past five years. Surprising, while most have taken notice of the rates in Wards 5,6,7 and 8 (Healthy Start sites), little has been noted of the steady rise in Ward 2's infant mortality rate over the past four years (See Table 2 below).

A preliminary analysis of the infant death data for 1998, revealed that 40.6% of the infant deaths were to mothers who were enrolled in the Medicaid program. In fact, records showed that some of the women had lost eligibility for Medicaid during their pregnancy or shortly afterwards. The loss of medical insurance may imply that the women lacked access to prenatal or well-child care because of financial barriers. While this won't be known until further analysis is conducted on the data, lack of money to pay for preventive care visits has been shown to be a barrier to seeking care when needed.

Table 2: Infant Mortality Rates* by Ward					
District of Columbia Residents, 1994-1998					
Ward	1994	1995	1996	1997	1998
1	13.0	11.5	14.3	13.2	9.9
2	11.1	9.0	9.2	12.4	14.6
3	7.0	4.0	4.1	2.8	2.5
4	16.7	14.0	13.0	13.5	10.6
5	20.2	29.3	15.9	13.5	25.1
6	19.4	14.5	15.5	16.0	8.5
7	27.2	21.6	20.6	14.2	17.3
8	22.0	19.1	17.4	15.8	11.6
Overall	18.2	16.1	14.4	13.1	12.5

*per 1,000 live births

Source: Department of Health, State Center for Health Statistics

The neonatal period (first 27 days of life) is important relative to efforts to reduce infant mortality. Many of the causes of infant deaths during this period could have been mitigated or prevented with good preconception and prenatal care. Of the 96 infant deaths in 1998, 56% occurred during the neonatal period (under 28 days of life). Although this shows a decline of about 27% from 9.6 per 1,000 live births in 1997 to 7.0 per 1,000 live births in 1998, the District still leads the country in this indicator category. Conversely, the postneonatal death rate increased by 57.1% in 1998, from 3.5 per 1,000 to 5.5 per 1,000. This may be attributed to the use of modern technology to prolong the survival of infants born prematurely.

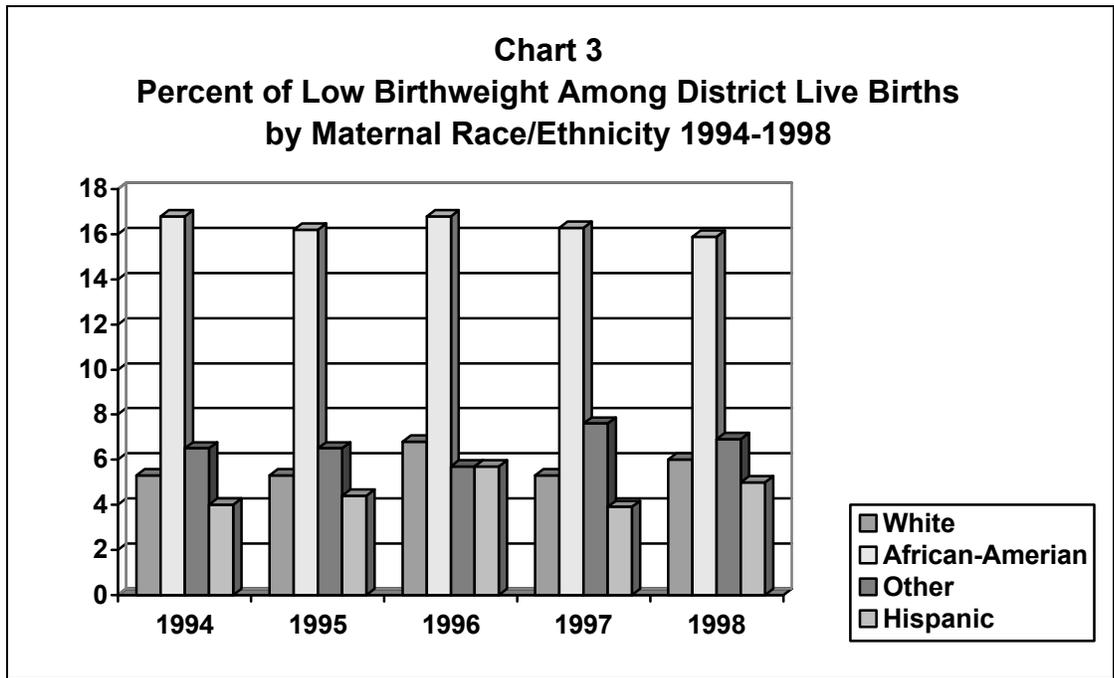
The Surgeon General has called for the elimination of health disparities. This is also a focus of the District's State Title V Agency. However, in examining the District's infant mortality rate over the past five years, while rates have declined, African Americans continue to have higher infant death rates than whites, 16.9 per 1,000 and a 3.1 per 1,000 respectively. The ratio of the black infant mortality to the white infant mortality rate has averaged 4.8 over the past three years. More specifically, the ratio has been 4.5 (1996), 5.3 (1997) and 4.9 (1998). Little has changed. In fact, the District's African American infant death rate even exceeds that of the US African American population (13.7%).

In order to effectively address this situation, more must be done than to rely on the kinds of advances in technology that have been responsible for much of the progress in the reduction of infant mortality

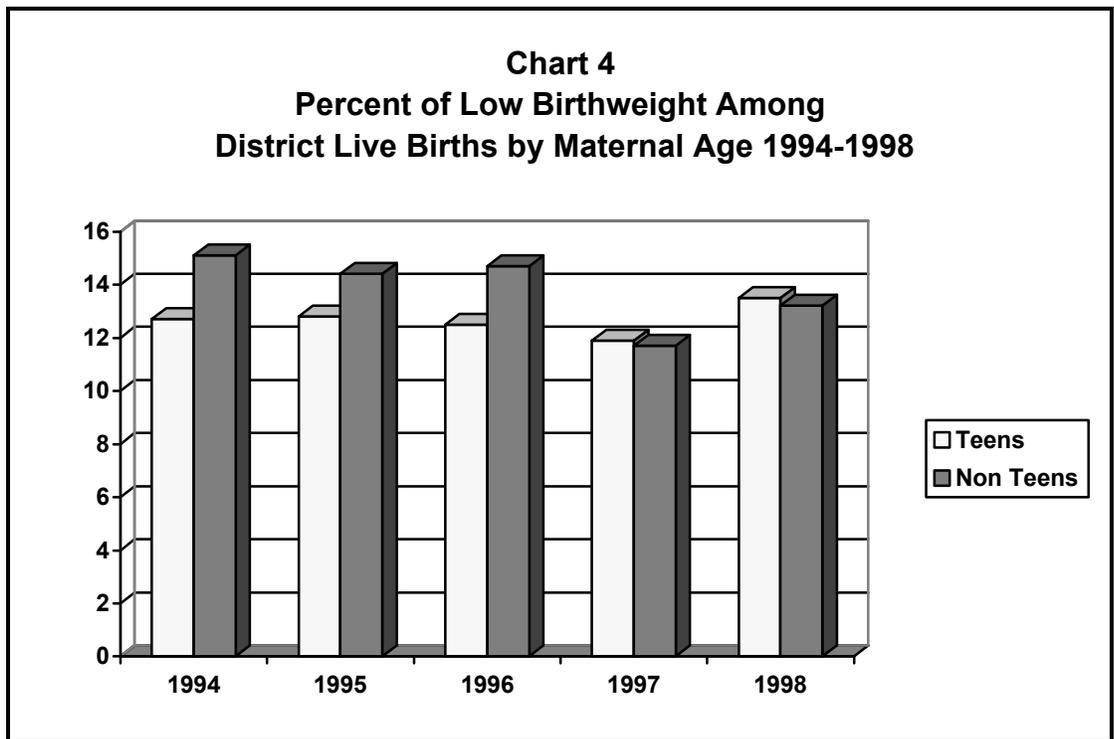
during the twentieth century. Continued gains will require the development of increasingly innovative health promotion programs which will involve affected constituencies and improved access to care for the most vulnerable members of the society. The District's programs will need to implement the recommendations of the Infant Mortality and Child Fatality reviews. These recommendations represent cross-cutting issues including: (1) strengthening Medicaid Health Maintenance Organization contracts to assure appropriate case management services, transportation, and other support services; (2) incorporating family planning counseling as part of routine case work practice within the child welfare program; (3) conducting a city-wide SIDS public education campaign; and (4) advocating for making parenting skills training available as a preventive measure to recipients of public assistance and other public services.

Low Birthweight: Low birth weight, infants weighing less than 2,500 grams or 5 ¹/₂ pounds at birth, is a major predictor of infant mortality. Many of these newborns, if they survive their first year of life, are highly susceptible to a wide range of disorders, including neuro - developmental disabilities, learning disorders, behavior problems and lower respiratory tract infections.

During the past several years little ground has been gained in respect to decreasing the number of resident births born weighing less than 2,500 grams. In fact, the overall percent of infants born weighing less than 2,500 grams has hovered at about 13.7% during the past five (5) years. This trend was mirrored across racial and ethnic lines (See Chart 3 below).



Source: Department of Health, State Center for Health Statistics
 Note: Hispanic includes all races.



Source: Department of Health, State Center for Health Statistics

The prevalence of low birth weight among teens (women 19 years and younger) has averaged about 12.7% annually over the five year period. (See Chart 4 above). Overall, teens births make up about

only 14.5% of all low birthweight births occurring in the District. This data suggests that if marked improvements are to be made in this area, interventions will need to be targeted to older women.

Disparities also existed across geographic areas. Ward 3 consistently had the least proportion of low birthweight births, while Ward 8, 5 and 7 posted the highest percentages. This pattern has persisted over the past 5 years. Map 2 on the next page shows consistent annual trends in where low birthweight births are occurring.

Reducing the low birth weight rate can result in significant savings in health care costs associated with medical conditions brought about by being born weighing too little. However, this reduction will necessitate an emphasis on prevention that focuses on early prenatal care and preconceptional care, including birth control.

Teen Pregnancy: The District's teen (women aged 15-19) pregnancy rate has been on a downward trend for many years, from 238.7 per 1,000 women in 1993 to 152.1 in 1997 (the most current pregnancy rate statistic). Furthermore, when examining 1997 pregnancy rates for teenage women age 15-19 and for age groups 15-17 and 18-19 years, vital records data showed that the pregnancy rate was higher for teens age 18-19, 210.2 per 1,000 women and twice the rate among women 15-17. This finding, which is consistent with nation data.

A review of the results from the 1999 YRBS for the District showed that 47.8% of the teens are currently sexually active. This number has decreased substantially from 61.2% in 1993 to the current rate. Although there has been a decrease in the percent of teens who reported that they were sexually active, a large number are still at risk for becoming pregnant or contracting a sexually transmitted disease.

The decrease in sexual activity may be due to increased STD education being taught in the schools. According to District YRBS data, in 1999 88.9% of the teens responding stated that they were taught about HIV/AIDS in school. In addition, in 1997 73% of the youths reported that they had talked about HIV/AIDS infection with a parent or other adult family member. While, the content of the education that was given is not fully known, DC public schools does provide age-appropriate information on STDs and sexual education, including condom use to prevent pregnancy and the spread of infections.

Mobilizing the community, increasing the number of school-based and school-linked clinics where adolescents will have increased access to counseling and reproductive health services as well as providing age appropriate abstinence and sex education classes in schools may help in further curbing adolescent pregnancy.

Out of Wedlock Births: Births to unmarried women in the District of Columbia accounted for more than 6 out of every 10 live births in 1998. While, the number of out-of-wedlock births has declined over the past five years, the rate of decline is minimal. Unfortunately, racial disparities continue to exist in this area also. Among African-American births, 79% were to women who were not married compared to only 11% of the births to White residents.

Studies have shown that out of wedlock childbearing is related to increased risks for both mothers and children. These risks include (1) the mother being less likely to obtain adequate prenatal care; (2) more likely to engage in behavioral risks during pregnancy (e.g., greater use of alcohol, tobacco and narcotic drugs); and (3) the child is more likely to be abused. With the numerous risks associated with out-of-wedlock childbearing, addressing this issue must be a key component in the District of Columbia's efforts to deal effectively with the problems of poverty, crime, and poor education and health outcomes.

Maternal Mortality: One of the District's Healthy Residents 2010 Health People Objectives is to reduce the overall maternal mortality ratio (MMR). From the time period covering 1987-1996, the overall MMR for the District of Columbia was 22.8. No major improvements in the rate have occurred. With the District leading, the District and eight other states have significantly higher MMRs than the national MMR.

The risk for maternal death among African-American women compared to White women continues to be one of the largest racial disparities among major public health indicators. Analysis of the data suggests that race and ethnicity are not risk factors for maternal mortality but instead may be markers of social, economic, cultural, health-care access and quality, and other related factors that may increase the risk for death among pregnant women in the District of Columbia. Factors, such as quality of prenatal, delivery, and postpartum care, and interaction between health-seeking behaviors and satisfaction with care, may also explain part of the difference.

To effectuate change in this area, further investigation, in the form of a review committee will need to be formed. This committee will review factors that may have contributed to the maternal deaths, including the quality of medical care and problems in the health-care delivery system. Both public health surveillance and prevention research are needed to understand the underlying causes of maternal mortality and the disparity between black and white women and to guide appropriate interventions and improvements in maternal health care in the District of Columbia.

Unintended Pregnancy: Family planning has long been appreciated as a woman's issue. However, public health professionals are now realizing that it is also important to men, children and the community. Unintended pregnancy, defined as a pregnancy that is unwanted or mistimed at the time of conception, has significant consequences for the health of women and children. These consequences include health (late or in adequate prenatal care, fetal exposure to alcohol, tobacco or drugs, low birthweight etc.), social (loss of education, career or financial opportunities for the mother, etc.) and economic consequences.

Analysis of the 1998 District of Columbia Pregnancy Risk Assessment Monitoring System (PRAMS) data revealed that 50% of the women sampled had an unintended pregnancy. 38% of these women were receiving Medicaid at the time of their conception.

On average, Medicaid each year pays for about 45% of the District resident births. The average annual cost to Medicaid for an uneventful pregnancy is \$5,370. Assuming that all of the Medicaid unintended pregnancies were uneventful (which in fact we know they were not), if these pregnancies were delayed until the mother was ready, the District would have realized a health care saving of \$7,050,810.

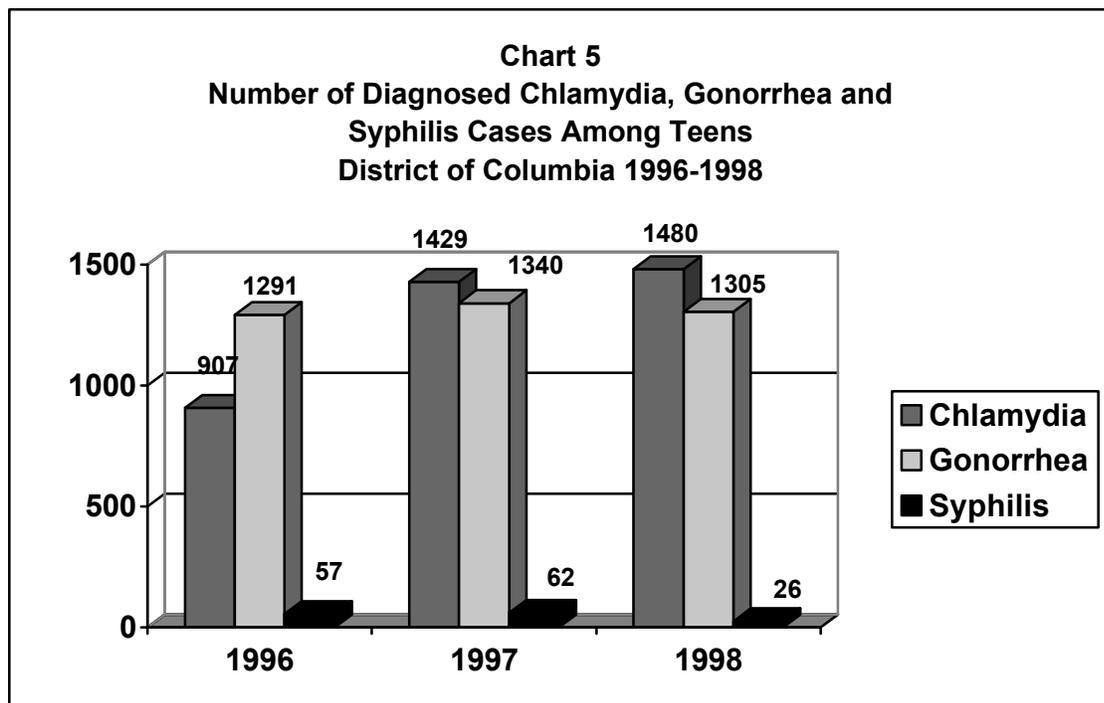
Gaps exist in many areas when it comes to the provision of family planning services. For example, Medicaid funding covers only the very poor or pregnant. While ten Title X subsidized clinics exist in the District, it fails to adequately cover all Wards of the District especially in many areas East of the River where the need is greatest.

There is no one cause of unintended pregnancy and therefore, there is no one solution. Reductions will require a District-wide public and private partnership. Strategic opportunities must include

providing emergency contraception via managed care organization services and increasing male involvement in preconception planning. Interesting enough this is one of the District's Healthy People 2010 Objectives. It must also include increasing male awareness of the various methods available. Surprisingly, among the PRAMS women who reported that they were not using any contraceptive method at the time that they became pregnant, 10% said that their husband or partner did not want to use a method.

Providers of primary care services need to capitalize on the opportunities to improve contraceptive vigilance of adults and adolescents. These opportunities include catching clients when they present for services at STD clinics, pediatric visits, routine physical examinations, pregnancy tests, sports exams and other well child visits for adolescents.

Sexually Transmitted Infections (STIs): Adolescent sexual activity often results in unintended pregnancies and sexually transmitted disease, which contribute, to poor health and developmental outcomes for the mother, child and the male sexual partner. Reported cases of gonorrhea and syphilis have declined over the past years, however, the number of chlamydia cases have continued to rise among adolescents, from 907 cases in 1996 to 1,480 cases in 1998. (See Chart 5 below) Chlamydia is now the most common STI and is increasing rapidly.

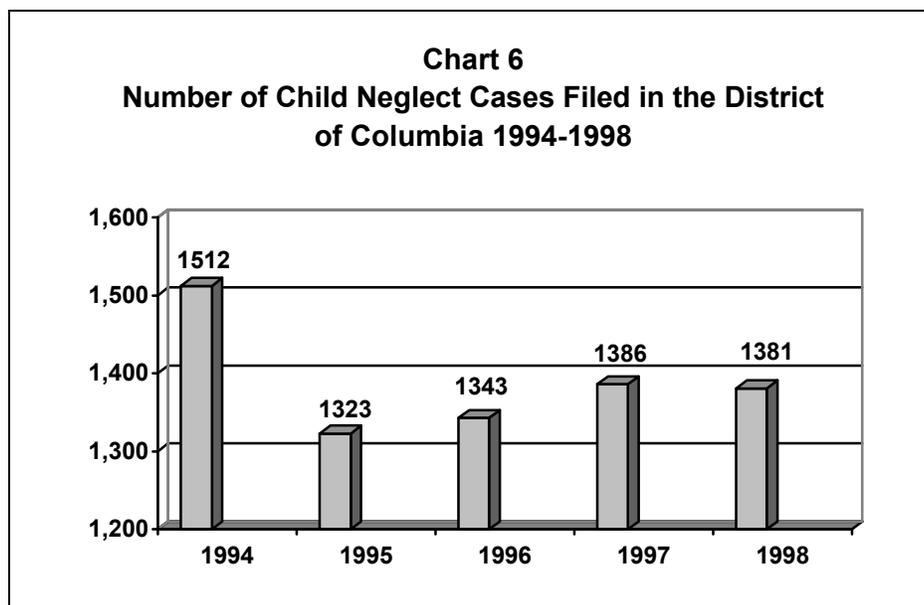


Source: District of Columbia, Department of Health, Preventive Health Services Administration, and Bureau of STD Control, Surveillance Unit

Total reported cases of syphilis, chlamydia, and gonorrhea among women of childbearing age (10-44 years) have remained about the same from 4,569 cases in 1997 to 4,589 in 1998. While, syphilis may be the most serious, both gonorrhea and chlamydia can cause problems if left untreated. In fact, chlamydia is the leading cause of sterility in women today.

While, the District experienced a decline in the number of deaths attributed to HIV/AIDS, decreasing 37 percent between 1996 and 1997, from 544 to 342 deaths, HIV/AIDS remained the fourth leading cause of death in the District for White males, black males and black women between the ages of 25 to 44. In addition, pediatric AIDS cases, children between the ages of 10-14, have decreased since 1994 from 22 to 9 in 1998.

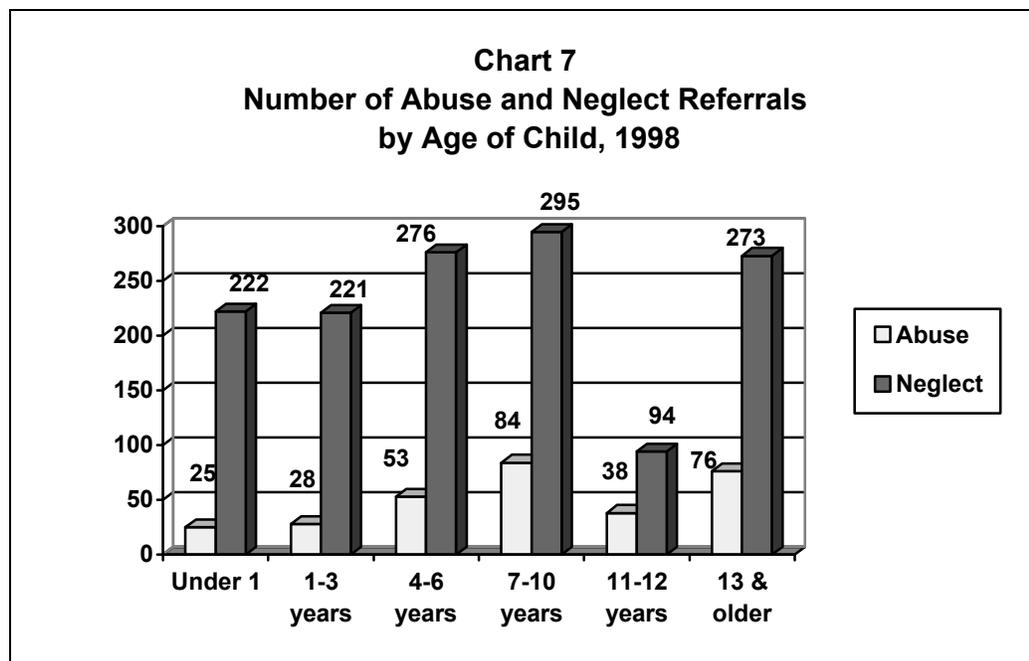
Child Abuse and Neglect: While the number of child abuse and neglect cases filed with DC Superior Court had increased to an all time high in 1994 (1,512), the numbers now seem to have leveled off (See Chart 6 below).



Source: District of Columbia Courts Annual Report

In 1998, 1,381 cases were filed an increase of 5 cases over the previous year. Children under the age of one are the most common victims of alleged abuse and neglect. Although the number of infants

alleged to be abused has come down slightly from 1996, 268 cases, in 1998, 222 infants were alleged to be neglected and 25 were alleged to be abused (See Chart 7 below).



Source: District of Columbia Courts unpublished data, Research and Development Division

Child Morbidity

Immunizations: Rates of childhood immunizations are one measure of the extent to which children are protected against serious preventable diseases. Nationally, 78% of children are up to date with their immunizations. In the District, the percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza and Hepatitis B has averaged about 76% during the five year time period.

Research has shown that children in families below the poverty level are less likely to receive the combined series of immunizations than children with family incomes at or above the poverty line. In addition, national data reveals that African-American children and Hispanics are more likely not to be up-to-date on their immunizations. Immunization data by race and ethnicity were not available during the analysis phase of the needs assessment. However, based on the pattern of other indicators broken down by race/ethnicity, the District can only assume that this racial disparity also occurs here. Since on average, 57% of the District’s children under age 19 are living at or below the 200% of the poverty level, the District Title V Agency needs to be vigilant in ensuring that these at risk populations receive appropriate and timely immunizations. This can easily be done through

continued support for and coordination of services with the Vaccines for Children (VFC) Program and the DC Healthy Families Program (the state Child Health Insurance Program). All opportunities, including well child, family planning and WIC visits, to increase immunization rates among children should be exhausted.

Asthma: Asthma is the most common chronic illness among children and the number one cause of school absenteeism. It hits the very young, minorities and the poor hardest. Nationally, asthma causes 5,000 deaths a year. From 1994 – 1997, 11 District children between the ages of 0-17 died from asthma attacks.

Data from the District's hospital discharge file, showed that the number of asthma inpatient discharges among 0-17 year olds decreased by 40% from 964 in 1996 to 581 in 1998. This may represent advances in preventive treatment for children in more affluent areas. However, caution must be taken when interpreting this decline, since hospital discharge data does not take into account people who present for treatment in the emergency room and are not admitted into the hospital. National studies have shown that the numbers of individuals visiting hospital emergency rooms due to asthma is on the rise.

To examine the possibility that geographic disparities exist, asthma discharges were mapped by zip code. Dramatic disparities were revealed. Zip codes 20032, 20020 and 20019 had the highest incidences of discharges due to asthma than any other zip code in the city. These zip codes are located in Wards 6,7 and 8 (See Map 3 on the next page). It is clear that more extensive outreach efforts focusing on asthma are needed in specific Wards of the city.

Child Mortality: The District's overall child mortality rate among 1-14 year olds for 1998 was 47.9 per 100,000. This number showed no change from the 1997 rate of 47.6 per 100,000.

Homicide: The number of deaths due to homicide has decreased. However, it continues to be the leading cause of death among District children between the ages of 0 and 19. In the District, deaths due to homicide disproportionately affect adolescent African-American males more than any other race or gender group. Firearms caused most of these deaths.

Data from the Youth Risk Behavior Survey (YRBS) showed a slight increase of the percent of high school students reporting that they had carried a weapon on one or more occasion during the past

thirty day, from 29.5% in 1995 to 33.5% in 1997. In addition, during this same time period 8.2% (in 1997) reported that they had been in a physical fight after which they had to be treated by a doctor. This was a slight increase over 1995 in which 5.7% reported they had to be treated by a doctor after a similar encounter.

Automobile Accidents: The rate of deaths to children 1-14 caused by motor vehicle accidents had declined during the period between 1996 and 1997, from 5.8 per 100,000, to 3.5 per 100,000 respectively. However, in 1998 the rate increased to 7.2 per 100,000. Among teens 15-19, the 1998 rate was 7.8 per 100,000, far below the national rate of 27.9.

The District's YRBS data provides a glimpse into the percent of adolescents at risk for dying in automobile crashes. During 1999, 10.4 % of the adolescents stated that they rarely wore seatbelts. This was a three-fold decrease in the 1997 data (31.9%). Males were at a higher risk for not wearing a seat belt.

Suicides Among Youth 15-19: The District experiences an average of five (5) suicides a year among 15-19 year olds. During 1997, the rate of suicide among this age group was 19.4 per 100,000. In 1998 the rate decreased to 15.1 per 100,000. While, these numbers are small, compared to other jurisdictions, public health professionals in the District would be remised if they overlooked 1999 YRBS data which showed that 13.5% of students responding stated that they had seriously considered attempting suicide during the past twelve months.

Children with Special Health Care Needs

Sudden Infant Death Syndrome (SIDS): Recent studies have shown that the prone sleep position is associated with an increased risk of sudden infant death syndrome (SIDS). In countries where the prevalence of prone sleep position has been reduced, the rates of SIDS have declined by more than 50%.

One of the District's 2010 Health Objectives is to increase the number of infants being put to sleep on their backs. While no trend data was available for analysis, 1998 PRAMS data revealed that 43% of the women reported placing their child on its back to sleep. 20% reported placing their child on it's stomach. African-American women and Hispanic women were two to three times more likely to place their child on their stomach. A recent study by Brenner et al. conducted as part of the National

Institute of Health's Initiative to Reduce Infant Mortality in Minority Populations in the District of Columbia, found similar results among a cohort of infants born to predominately low-income women living in the District.

Qualitative analysis of PRAMS comments shed further light on why these mothers were exhibiting this behavior. Several stated that they placed their infant on it's stomach for fear that the infant would choke. Others reported that their mother's had put them on their stomachs and that nothing had happened to them or their other children whom they had also put to sleep on their stomach. In fact, many acknowledged that the baby should be placed on it's back but that they felt more comfortable with the child on it's stomach or side. These comments suggest that to effectuate change among this population, cultural and familial beliefs will need to be taken into account when designing SIDS outreach activities.

Folic Acid: It is estimated that nationally approximately 50% of the cases of neural tube defect could be prevented with adequate levels of folic acid from the time of conception throughout pregnancy. Increasing the proportion of women of childbearing age who take folic acid is one of the District's health objectives for the year 2010. 1998 PRAMS data showed that 63%, or 6 out of 10 women responding to the questionnaire said that they had heard or read that taking the vitamin folic acid can help prevent some birth defects. Although no statistically significant difference was found, African-American women were less likely to answer "yes" than White women. Similar results were recorded in a recent March of Dimes survey in which 68% of the women stated that they were aware that folic acid prevents birth defects. Racial disparities were also noted in this study. If the District seeks to increase folic acid intake among women of childbearing age, interventions will need to be developed which address preconceptual planning and optimization of well women health visits to deliver the appropriate health message.

Population Estimate: In 1998, approximately 16,000 (or 14%) of the children, ages 0-18, living in the District of Columbia had a special health care need, based on a recent estimate by CARUP. Wards 8, 7, and 1 reported the highest number of CSHCN, 21%, 16% and 14% respectively. The State program serves about 1200 CSHCN each year or about 8% of the estimated number of CSHCN. In addition, data obtained from the District's Medicaid program showed that 4522 CSHCN are receiving SSI benefits. This number accounts for only 28% of the estimated number of CSHCN in the District.

Estimates of the percentage of this population who are poor or near poor were also calculated. Overall, 42% of the CSHCN are living below the federal poverty level. Table 3 below shows estimates of CSHCN in the District of Columbia by Ward and poverty level for 1998.

**TABLE 3
ESTIMATES OF CSHCN IN THE DISTRICT OF COLUMBIA BY
WARD AND POVERTY LEVEL
1998**

WARD	TOTAL	Est. # of CSHCN Below Poverty	Est. # of CSHCN between 100 and 199% Poverty	Est. # of CSHCN above 200% Poverty
1	2231	1084	462	685
2	1229	613	262	354
3	1244	47	21	1176
4	1737	306	130	1301
5	2005	675	288	1042
6	1687	701	291	695
7	2585	1339	571	675
8	3316	2028	865	423
Total	16,034	6793	2890	6351

Source: University of the District of Columbia, Center for Applied Research and Urban Policy (CARUP). Preliminary report on estimates of Children with Special Health Care Needs, 5/2000.

An estimated 34% of the children are receiving special education services, while 12% are receiving mental health services and another 21% require prescription medicines. Table 4 below shows estimates of specialized health services provided to children with chronic conditions by Ward.

**TABLE 4
ESTIMATES OF SPECIALIZED HEALTH SERVICES PROVIDED TO CHILDREN WITH
CHRONIC CONDITIONS BY WARD
DISTRICT OF COLUMBIA, 1998**

WARD	Prescription Medicines	Mental Health Services	Special Diets	Mobility Services	Breathing Equipment	Special Education
1	469	268	112	45	201	759
2	258	147	61	25	110	418
3	261	149	62	25	112	423
4	364	208	87	35	156	590

5	420	240	100	41	180	681
6	354	202	84	34	152	573
7	542	310	129	52	232	878
8	696	397	166	66	298	1127
Total	3364	1921	801	323	1441	5449

Source: University of the District of Columbia, Center for Applied Research and Urban Policy (CARUP). Preliminary report on estimates of Children with Special Health Care Needs, 5/2000.

The data, which provides a glimpse into where the CSHCN are located throughout the District of Columbia, reveals that many of these children live in Wards of the city that are impoverished and represent the highest number of health professional shortage areas (HPSAs),

Special Education: During the 1997-98 school year, the District’s public schools reported that a total of 7,676 children, or 48% of the estimate number of CSHCN, were served under Part B of the Individuals with Disabilities Act (IDEA). Most (6,731) of these children were between the ages of 6-17. Table 5 below shows the number of District children receiving special education services during 1997-1998 by age and type of disability.

TABLE 5
NUMBER OF CHILDREN SERVED UNDER IDEA, PART B
BY AGE GROUP AND DISABILITY
DISTRICT OF COLUMBIA SCHOOL YEAR 1997-1998

DISABILITY	AGES 6-11	AGES 12-17	AGES 18-21	TOTAL
Autism	43	22	2	77
Deaf-Blindness	6	5	0	11
Developmental Delay	0	0	0	0
Emotional Disturbance	360	608	111	1079
Hearing Impairments	14	9	1	24
Mental Retardation	467	560	157	1184
Multiple Disabilities	30	31	9	70
Orthopedic Impairments	90	45	14	149
Other Health Impairments	65	23	12	100
Specific Learning Disabilities	1630	2330	250	4210
Speech or Language Impairments	1491	61	2	1554
Traumatic Brain Injury	8	5	1	14
Visual Impairments	5	11	2	18

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS), 1998
 Note: Developmental Delay is applicable only to children 3-9.

Students who are eligible for special education may also be eligible for related services, such as therapies, counseling and interpreter services. Services provided are based on an Individual Education Program (IEP) that is developed by a team consisting of a representative of DC Public Schools, the child's teacher, and the child's parent(s). Provisions are available for a parent to appeal their child's IEP.

Findings from the focus groups and surveys revealed that many parents are dissatisfied with the support that DCPS provides for their special needs child. One major criticism of special education was the long wait times for evaluation and placement. Other complaints included lost files, inadequate training, unskilled and uncaring teachers, low level of instruction received in special education classes, over crowded special education classrooms, and unhealthy windowless environments in some open classrooms. The parents felt that open space classrooms were too distracting for special education students. Several parents felt that DC public schools did not act quick enough to respond to their child's needs. One parent who responded to the telephone survey stated "I applied for services through DCPS but nothing ever came through". Another stated "It took

so long to get services for my grandson. It took my daughter talking with someone who also had a special needs child at Slowe Elementary to find out what could be done”

Survey, Focus Group and Key Informant Results:

As discussed earlier, one method used to describe the needs (services, health etc.) of these children was to review the results of special surveys such as the Children with Special Health Care Needs Survey conducted by OMCH. In addition, the PBC Health Services for Children with Special Needs Clinic, the State program for CSHCN, participated in the 1998 “Your Voice Counts” survey, a collaborative effort between Family Voices, Brandeis University and 20 State Title V Agencies. The data from the surveys cannot be generalized to the entire special needs population, it does provide a snapshot into what is going on among some children with special needs who are also receiving Medicaid and/or Supplemental Security Income (SSI). OMCH staff are looking forward to the SLAITS telephone survey of CSHCN that will be conducted by the Maternal and Child Health Bureau. This survey will provide statewide estimates for many issues facing CSHCN.

In examining the data obtained from the surveys, focus group sessions and key informant interviews, OMCH sought answers to the following questions:

- What types of services are not available or accessible to CSHCN?
- What if any are the barriers to services that CSHCN and their families’ experience?
- What types of health or support services do CSHCN and their families need?
- What role can the Title V agency plays in assuring that the needs of CSHCN are met?

Primary Care: Systems of care for children with disabilities are greatly influenced by a number of federal funding sources including Medicaid, Social Security Administration, and the Department of Education (Part B and Part C). To a lesser extent, many local District of Columbia agencies influence service delivery as well including: the Department of Human Services, DC Public Schools, Public Benefits Corporation, and the Department of Health. In the private nonprofit sector organizations like March of Dimes and Easter Seals and health and educational facilities like Children National Medical Center and Gallaudet College also influence the type and quality of care through direct services and education. Finally, the private sector insurance carriers also have medical input on defining quality of care.

The sheer number of market forces involved in the special needs arena, the complexity of defining disabilities, and the varying goals of the institutions affect how this population receives treatment and services, who pays for the service, the level of services, and the length of time services are received.

Currently, CSHCN receive care and services through one of the following methods:

- (1) carved out managed care program for children who qualify for SSI;
- (2) managed care health maintenance organizations for children on Medicaid, but not qualifying for SSI;
- (3) traditional fee for services program for SSI children who elect not to participate in managed care;
- (4) Title V-funded Children with Special Health Care Needs clinic located on the grounds of DC General Hospital and run by the PBC; or
- (5) traditional fee for services program for children that do not qualify for Medicaid, SSI or other insurance funding sources other than private insurance.

Access to a routine source of primary care helps to assure continuity of care and consistency in following emerging health conditions. Emphasis on specialty care for CSHCN can lead to the neglect of primary care needs. Therefore, it is important to monitor and assure access to primary care services such as immunizations and dental services. Information about access to primary care for CSHCN can be found in both the telephone and Family Voices surveys. Only 4% of the respondents from the telephone survey and 9% from the Family Voices survey reported that their special needs child did not have a primary care provider.

Preliminary results from the focus groups sessions revealed that none of the participants felt that they needed, but were not able to obtain primary care, hospital care or medications for their child. Levels of satisfaction with their primary care provider was also high among Family Voices survey respondent. For example, 89% stated that they would recommend their primary health plan. Data from both surveys reported high levels of satisfaction with the primary care physician.

Receipt of dental services was not a problem for respondents in both of the surveys. The Family Voices survey showed that 76% had received dental care. Only 3% stated that dental services were needed but not received. Likewise, the telephone survey showed that 96% of the CSHCN had visited a dentist within the past year.

Specialty Services: Respondents from both surveys reported that they did not have any problems receiving the specialty care services that their child needed. Less than 2% reported that there were specialty services needed but did not receive them. Physical therapy, speech therapy, and occupational therapy were among the most specialty services used by the children of the survey respondents. Focus group participants, on the other, shared that mental health services, specialty care equipment, and early intervention services were needed services for their children.

Data from both surveys revealed that there may be problems associated with obtaining the medications the child needed. 10% of the respondents from the Family Voices survey and 8% from the telephone survey reported that they had problems obtaining prescription medicines for their child.

Care Coordination: Non-coordination of services among providers was a resounding cry among survey respondents, focus groups and key informant interviews. 41% of the respondents to the telephone survey stated that they felt that their child's needs were well coordinated by the case manager. During one of the telephone interview a parent stated "They need more and better services. The service providers have to work together". Results from focus group sessions supported this finding. When asked what they liked least about the services currently being received by their child parents stated that there was sense that "services are not organized".

In addition, key informants felt that OMCH should take the lead in organizing all the agencies in the District who provide services to CSHCN for the purpose of coordinating activities and maximizing resources.

Family Support Services: The focus group sessions and surveys provided further insight into the types of family support needs of families with CSHCN including respite care, transportation, transitional services and support groups.

Telephone survey respondents were asked for the three most serious difficulties they faced in getting care for their child and family. The three issues that stood out were (1) not knowing what services were available, (2) needed services were not available in their community and (3) lack of communication, coordination, or cooperation between service providers. In addition, when asked in what areas they would like to get more training the following areas stood out: (1) special education; (2) care coordination; (3) assistive learning; and (4) parenting skills.

Respite Care: 87% of the respondents to the telephone survey stated that they did not receive respite care. Among those respondents who did receive respite care, a relative provided the care. One respondent shared “the program is suppose to offer the it but the care provider doesn’t call”. Another stated “I need it and would like to receive it”. Interestingly, parents at one focus group session were skeptical of someone they did not know coming to their home to take care of their special needs child. This suggests that more education on respite care services to the parent of the special needs child and assisting with the identification of a care giver the parent feels comfortable with alleviate the underutilization of this service. In addition, working with providers to ensure that this service is available and “pushed” may help parents who want to make use of the services.

Transition Services: Approximately, 50% of the parents reported that their child was not receiving vocational services. Among those reporting that their child was receiving services most reported that they services were being received in through their child’s school. Several parents who participated in the focus groups stated that there were too few transition services for adolescent special education children.

Support Groups: 84% of the telephone respondents stated that they did not participate in support groups. However, many of these respondents added comments to the effect that they would if the service was available. Focus group participants mirrored this sentiment. One mother stated “the only person that can really understand what I am going through is another parent with a special needs child.” Focus group parents expressed a strong need for parent support groups where they could meet and discuss issues with their counter parts. Parents felt that these support groups and family support services should be available in the Wards where they lived.

Assessment of the Current System: Key informants identified several major weaknesses of the current system. These included:

- Lack of a multi-system approach to providing mental health services to the target population;
- Inability to monitor service providers because of a lack of staff (the quality of services being provided to the clients is unknown); and
- Lack of adequate resources;

A consistent weakness identified by all interviewees was that there was too much overlapping and duplication of services. Interviewees felt that there was a need for increased interagency planning and coordination.

On the other hand, many strengths were also identified including:

- Dedicated providers working with the population;
- Recent efforts by DC government agencies to address the issue of coordination and integration of services through bimonthly meetings to discuss issues of the CSHCN population; and
- Increased age coverage for after school care;

All of the interviewees felt that the system was ripe for change and that the District should take full advantage of this opportunity.

Recommendations by Key Informants and Parents for an idea System: Key informants and parents had varying ideas of what an ideal system for CSHCN in the District would assemble. Key informants recommendations focused on policy and systems change. This groups ideas included:

- Increasing the payment allotment for services;
- Appointing an ombudsman to represent the interest of CSHCN;
- Designing a website that identifies all of the agencies and services provided to CSHCN;
- Establishing a coordinating body of the sister agencies serving CSHCN to develop a workable plan to coordinate services; and
- Creating an integrative, electronic database and information retrieval system on the population of CSHCN;

Parents on the other hand focused on enabling services when answering what their ideal system would consist of. The following inclusions emerged from this group:

- Hiring compassionate and professional persons;
- Providing more support from interdisciplinary team and school personnel;
- Having resources available for all ages (seamless transition);
- Hiring parents with CSHCN to work within the system since they have the experience (parent partnership);
- Providing a building or space to conduct support groups;
- Providing hotline services; and
- Providing education for parents to help them understand their child's needs.

Summary of Needs of CSHCN and their Families: In summary, the greatest needs of CSHCN identified by the surveys, focus groups and key informant interviews were not primary care services but enabling services. Perceptions of insensitivity by the school system including the school bus

drivers, lack of coordination of services especially within the special education system, and lack of support services in the form of support groups and respite care, were among the unmet needs.

The District's Title V Agency should take the lead in coordinating service delivery efforts throughout the city on behalf of CSHCN. As the Agency seeks to develop the ideal system of care for CSHCN the input from the parents, key stakeholders and the children themselves should be taken into account.

3.1.2.2 Direct Health Care and 3.1.2.3 Enabling Services

One step in assessing health care resource coverage is to examine underserved geographic areas neighborhood health service assets. People living in these areas have limited access to primary care services due to financial, geographic, cultural and/or language barriers. The misdistribution of physicians, large distances to specialty care centers, and shortages of bilingual staff in certain city-wards all may have a negative effect on access to appropriate care. Eighty-five (85) census tracts make up eight-(8) health professional shortage areas (HPSAs) in the District. The most serious concentration of these shortage areas is in Ward 8. Thirty-six (36) census tracts in the District of Columbia are considered medically underserved areas (MUAs). Of these, most are located in Wards 2 and 7. In the District, approximately 47% (115,000) of the women of childbearing age, infants and children live in federally designated primary medical care health professional shortage areas. See Map 4 on the next page for a visual of the primary medical care health HPSAs in the District of Columbia.

Leading MCH indicators (i.e. infant mortality, low birthweight, prenatal care initiation etc.) were transposed against the mapped primary medical care HPSAs as well as clinics and hospitals in the District. Not surprisingly, many of the census tracts that experience the highest number of adverse health and social indicators fall in the HPSA census tracts. In addition, the residences mapped were not located in close proximity to a primary health care facility. The identification of these areas should serve to heighten the awareness of health professionals to potential health care or service delivery problems for the residents of these census tracts.

With nine hospitals providing obstetric services, six of which are tertiary care hospitals and a number of these hospitals have community-based primary care clinics, Washington, DC is considered the hub of the perinatal system for the Washington, DC metropolitan area. Five of the tertiary hospitals

contract with the Medicaid managed care organizations. Several other providers offer primary care services throughout the city. The locations of hospitals and clinics within the Wards highlight the disparities in health care access for the residents of the District (See Table 6 below and Map 5 on the next page).

Table 6: Number of Primary Health Care Providers by Ward								
District of Columbia								
Wards								
Provider Type	1	2	3	4	5	6	7	8
Safety Net	12	13	1		2	7	9	8
Hospital-based	5	3		3		1		
Total # of clinics	17	16	1	3	2	8	9	8

Source: DC Primary Care Association

Health insurance for most of the District’s residents is provided through private or public insurance. However, for many District residents, who are uninsured, few financial avenues are available to cover the cost of primary and preventive care. The District like other jurisdictions has tried to address this issue by using a combination of strategies including:

- Expansion of insurance coverage for children, prenatal and postpartum women, including the raising of Medicaid income levels for the uninsured children;
- Provision of enabling services, such as transportation, translation and extended outreach and follow up; and
- Assuring linkages between levels of care, especially with regard to perinatal services (DC Healthy Start and other projects);

However, even 100% enrollment does not assure that all children and pregnant women will get access to the care that they need. For example, in the area of dental treatment, although covered by EPSDT under Medicaid, children often have difficulty accessing needed oral health services due to the paucity of dentists that will accept Medicaid.

Four major systems serve the medically vulnerable in the District:

- The District of Columbia Health and Hospital Public Benefit Corporation (PBC)
- Unity Healthcare, Inc.
- The Non-Profit Clinic Consortium (NPCC)
- Hospital-Affiliated Clinics
- Hospital-based Clinics

These providers offer free primary care to an estimated 60,000 residents. Funding to cover the costs comes from a variety of sources, depending on whether the provider is integrated vertically or horizontally. For example PBC patients have access to care in either direction. This means that because the clinics are linked to one another (horizontal) as a system it's patients have access to the other services, including medications and specialty care (vertically). This does not hold true for the other safety net providers such as Unity Healthcare whose uninsured patients have difficulty receiving specialty care and have limited access to medications. Unity's patients are only horizontally linked. This is an important fact to note, since Unity Healthcare serves a large Hispanic population in the District. The same holds true for the NPCC whose providers are not linked either horizontally or vertically.

A recent provider survey, conducted by the DC Primary Care Association, revealed several barriers to care from the providers standpoint including:

- Lack of funding;
- Insufficient staffing;
- Lack of transportation;
- Lack of inpatient care;
- Patients seeking care only when care was needed; and
- Limited access to medication

The District's Title V Agency works closely with only a few of these organizations. No one organization has taken the lead to coordinate services provided by the agencies discussed above.

Expansion of Public Insurance: The expansion of Medicaid eligibility during the 1990s, and the District's implementation of Title XXI to insure children and families up to 200% of the federal poverty level through the Medicaid managed care program, increased insuredness among the Title V population and affected the financing of health care. The federal government's agreement to increase its Medicaid match to 70% in DC greatly increased the significance of expansions. The growth in public insurance in DC may have counterbalanced the general trend toward a decline in the proportion of the insured population, which has occurred throughout the US.

Medicaid participation is high in the District of Columbia: 1 of every 4 residents, including 2 of every 3 children.³² Participation is high, not due to generosity of coverage, but because of high poverty rates.

Although eligibility has been expanded significantly, other factors affecting enrollment and use of services are changing more slowly. New eligibles often are not enrolled until they have presented for emergency or acute care services, when it is in the financial interests of the medical facility to enroll them. It has reportedly been difficult to convince many residents of the benefits of scheduling well visits, rather than waiting until illness occurs. Many persons who are eligible for and/or enrolled in Medicaid continue to present to community health centers, the HRSA-funded Unity Healthcare facilities, or one of the nonprofit clinics offering no charge or reduced-fee services. Likewise, use of emergency room services continues to be an issue. The Medicaid program has been slow to support staffing of enrollment and eligibility workers in nongovernmental sites, forcing the provider organizations themselves to assume the cost of enrollment. Consequently, the District has yet to maximize the benefits of expanded Medicaid, although efforts are being made in that direction. A case in point is the failure to claim an estimated \$40 to \$80 million in services over the past 4 years for the 66% of the 10,560 special education students who are Medicaid eligible.³³ Additionally, Title XXI enrollment has yet to reach many eligible persons.

Recently, families have been dropped from the program because of failure to recertify. Although the application for the Title XXI program was abbreviated from 27 to 2 pages to make the process as client friendly as the law allows, the recertification requires completion of the traditional Medicaid application. MAA and IMA officials are in the process of negotiating a solution to this cumbersome process.

The shift in sources of public funding with the increased federal support through Medicaid is at the crux of the current crisis regarding the future of the District of Columbia Public Benefit Corporation (PBC), a quasi-public organization responsible for DC General Hospital (DCGH), 8 community health centers (CHC) and the school nurses program. Long before the advent of managed care, the role of the hospital and the extent to which it should be supported have been debated. As the provider of last resort, utilization has declined as public insurance programs have expanded, although

³² *District of Columbia Medicaid Program: Turning the Corner*, Annual Report, 1998, Department of Health, p. 3.

³³ *District Schools Losing Millions In Medicaid*, *The Washington Post*, June 5, 2000.

the PBC continues to provide services for at least 30% of the uninsured population.³⁴ And concurrently, in a system with excess beds, private nonprofit hospitals increasingly compete for Medicaid patients.

During the 1990s several commissions, committees and workgroups were charged with determining what to do with DCGH. In 1995 the PBC was formed, but restricted from full participation in the competition for managed care contracts. Increased subsidies have been required, deficits have mounted, charges of poor management have been made, and once again the question of what to do with the public hospital is at the forefront of local health policy debate. While some stakeholders believe that its very existence is unnecessary given current market conditions, others argue that its location, scope of services, role in serving the underclass, and its significance to the African American community demand increased support.

In view of increased Medicaid support of health services to mothers, infants and children, OMCH began gradually to shift Title V funds away from direct clinical services provided through the PBC to population based services, and to a lesser extent infrastructure development. Form 5 shows the change in allocations.

Other Access Issues in Transition to Managed Care: Whether services under managed care are more, or less, available, accessible, or of acceptable quality than previously is a question as difficult to answer in the District as it is in other jurisdictions. The disruption during the transition to Medicaid mandatory managed care was considerable and may never be completely resolved as new contracts are negotiated, and as new groups become eligible. The financial instability of several MCOs has contributed to problems as well.

Although they are insured, many beneficiaries continue to experience problems with transportation, appointments and selection of PCPs. Certain noncitizen categories are not eligible, placing stress on safety net providers.

As described in section II, despite considerable local and national attention, including a court order, EPSDT screening and immunization coverage have not measurably improved under managed care.

³⁴ *Primary Health Care Services For the Medically Vulnerable In the District of Columbia: A 2000 Update.* District of Columbia Primary Care Association, June 2000, p. 18.

There is considerable evidence that missed opportunities on the part of the provider, rather than parental nonadherence, are responsible.³⁵ Neither OMCH nor MAA has closely examined utilization data to determine whether expansion of eligibility and increase in enrollments have resulted in changes in utilization or health outcomes. But in the District as elsewhere, physicians argue that the capitation rates do not provide adequate reimbursement for counseling, screening and other forms of preventive care. Certainly the *declining* ratios of reported EPSDT participation do not argue well for improved quality of care.

District Medicaid officials have been challenged to award and monitor the Medicaid contracts, insofar as the transition to mandatory managed care and the expansions came during a period of budgetary and political crisis. Cost containment was the overriding issue, consequently contracts did not require compliance with standards, mandated public health surveillance, or coordination with public benefit programs, such as WIC and early intervention. Although consumer groups and provider associations have advocated for expanded benefits and various quality improvements, it is often difficult to see long-term effects. It is hoped that in the upcoming round of selection of new contractors can use the current experience to improve services, however, budget concerns will continue to be a primary focus.

A broad group of stakeholders brought together under the umbrella of the HRSA-funded DC Primary Care Association has been instrumental in drawing attention to continuing maldistribution of providers and the lack thereof in low-income communities, and in recognizing that financial access is only 1 link in the chain of obtaining services. The association is advocating for the certification of DC qualified health centers, which would provide a more advantageous rate of reimbursement, in keeping with their higher costs of treating poor, at risk patients. Also being sought are direct grants for capital improvements of health centers, as well as technical assistance to assist health centers with accreditations and qualifications. The DOH is supporting the use of tobacco settlement funds for these improvements.

Title XXI: As described in section I, within 18 months of implementation the Title XXI program reported that nearly 80% of the enrollment *target* has been achieved, providing Medicaid managed care benefits to 13,000 additional DC residents. But since the targets were set below the estimated numbers of eligible persons, efforts to reach eligible uninsured must continue.

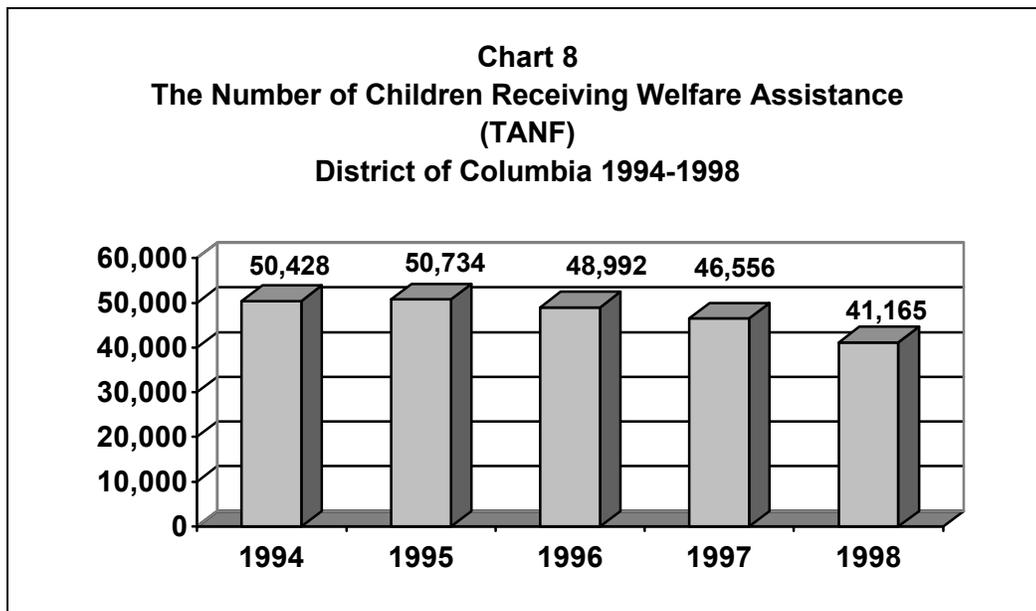
³⁵ Presentations, NIH-DC Initiative to Reduce Infant Mortality in Minority Populations in the DC, Community Forum:

The DC enrollment rates compare favorably to the experience in other states, although the enrollment of only 53% of the newly eligible children points to the need for increased outreach. This experience also suggests there is sufficient capacity to bring the recently legislated new categories into the system.

However, as described in section I, community advocates and providers have raised concerns about the reliability and validity of the target numbers, which are not equivalent to the estimates of persons eligible but rather upon projections of a subset of eligibles that would actually enroll, for example, that 64% of the targeted population would enroll in year 1 and 100% of the targeted population by the end of year 3. These estimates and projections by Lewin were commissioned in 1998 and are subject to the usual limitations of estimating relatively small population subgroups. Regardless of the degree of accuracy, potential discrepancies have become an issue with advocates.

TANF Issues: Welfare repeal appears to have had fewer short term adverse effects than in many jurisdictions, although the impact may have been postponed rather than prevented. The AFDC caseload had been decreasing prior to the introduction of TANF, due to declining birth rates, out-migration and a stronger economy. Welfare to work requirements have been less stringent in DC and officials have worked to minimize the reductions in food stamp and Medicaid participation as a result of the decline in TANF case loads that have occurred in other states.

OMCH employees are not aware of a formal analysis of the effects of welfare repeal, TANF policies and/or delinking of TANF and Medicaid on Medicaid enrollment or insurance rates, specific to the District of Columbia. The average number of children receiving welfare declined 19% from 1995 to 1998 (50,734 to 41,165). See Chart 8 below.



Source: District of Columbia, Department of Human Services, Income Maintenance Administration

And the number of TANF recipients was significantly lower in January 1998 (56,128) than in the previous year (67,871). As indicators presented in other sections of this application show, insurance rates have not significantly declined in DC, as has been the case nationally.

As shown below, Medicaid enrollment has increased substantially, due to the expansion through Title XXI. (included in the *other* category), but enrollment through TANF has been relatively stable.

Table 9

Mean Monthly Medicaid Participants in DC

FISCAL YEAR	TANF	SSI	OTHER	TOTAL
2000 thru 4/30	75,116 (61%)	30,354 (24%)	19,550 (16%)	125,020 (100%)
1999	74,945 (62%)	30,272 (26%)	14,496 (12%)	119,713 (100%)
1998	77,028 (66%)	29,908 (25%)	9,354 (9%)	116,290 (100%)
1997	81,155 (68%)	29,888 (25%)	7,781 (7%)	118,824 (100%)

Source: DC Income Maintenance Administration, May 2000.

DC Medicaid officials attribute their success in controlling unintended enrollment declines to several factors: a computer system that requires caseworkers to determine eligibility for all programs and that operates on both a family and an individual basis; training caseworkers to consider Medicaid eligibility as a priority; distribution of approval and denial notices to families rather than individuals;

and termination from Medicaid for specific reasons only, not automatic termination when cash assistance is terminated.³⁶

Nevertheless, as the maximum enrollment periods are reached, health advocates have expressed considerable concern that families who leave or are terminated from TANF are not being enrolled in transitional Medicaid. In addition to the recipients themselves not being aware of their rights, *eligibility workers* reportedly are not well versed in the requirements for participation. The Medicaid agency staff and the advocacy groups engage in on-going efforts to address the training and support for eligibility and enrollment workers, as well as the process for and means of notifying beneficiaries of how to continue their benefits.

Anecdotal evidence suggests that work requirements may be affecting utilization of health services, for example, Healthy Start nurses report that home visits to pregnant women and new mothers are less likely to be completed than in the past because clients are not at home, due in part to work requirements. Keeping appointments for well-baby visits and other preventive care is also said to be more difficult for parents. The extent to which work requirements are impacting special needs children is also a concern, although no quantitative data on the magnitude of the impact are available. In particular, there is a dearth of services for special needs children as they age out of the public education system but continue to be dependent. While in the past a parent was able to remain home to care for the child, this alternative is often no longer available.

OMCH Response: OMCH employees have attempted to follow the above issues and have participated in numerous conferences, forums and advisory groups convened to address issues of access, scope and quality of services. The multiplicity of interest groups and complexity of issues make it difficult to have an effective voice in decisions. Furthermore, OMCH has been hampered by limited staff expertise in Medicaid financing, managed care, and quality improvement, which would be necessary to carve out a role Vis a Vis the other actors.

According to an OMCH employee, who recently interviewed a MAA manager, the Medicaid agency sees a real need for OMCH to take a more active role in assessing and improving the city's health delivery system. That manager believes OMCH has been reluctant to get involved in managed care

³⁶ *The Findings of the Kaiser Commission on Medicaid and the Uninsured: Do Similar System Problems Exist in the District?* Distributed by the Income Maintenance Administration. No date.

issues. There is a sense that OMCH was advocating for support for special needs children without getting actively involved in the ongoing changes within the health delivery system. The perception is that under Title V funding, OMCH was locked into perpetuating an older system of care, rather than adapting to changes in delivery and financing.

On the other hand, OMCH officials sometimes believed they were locked out of the managed care development process. MCO development was clearly a Medicaid program and, as in other states, public health professionals were often excluded from decisions. A neutral party also might conclude that each organization was following a path mandated by funding streams. Clearly, work needs to be done to develop ways in which the agencies can provide more meaningful support to each other, since they now reside in the same department and within the same headquarters.

OMCH involvement in standard setting efforts includes the work of the school health liaison in revisions of EPSDT periodicity schedules, which incorporated current CDC, AAP and Bright Future guidelines into the requirements. The CISS coordinator is working with a broad-based advisory council to develop guidelines for home visiting.

3.1.2.4 Population-Based Services

As described in section II, OMCH operates the newborn screening program, supports the lead screening program, which is operated under another arm of the health department, and coordinates outreach and informational activities with the immunization program. In addition, through the Healthy Start projects, in-home immunizations will soon be provided in conjunction with other home visiting services. In 2001 SIDS counseling is planned through partnerships with other organizations. And the National SIDS Alliance will provide support for provider training and outreach. (See section IV for more detail.)

Plans to add a hearing screening coordinator to the staff to work with hospitals and provider organizations to institute newborn hearing screening have yet to materialize. OMCH needs to close that gap in 2001. Both the lead screening and the immunization registries have experienced only limited success due in part to issues of reporting as well as technical capacity. Legislation has been introduced to strengthen lead screening requirements. Renegotiation of Medicaid contracts could provide an opportunity for DOH program managers to convince officials to require contractors to participate in surveillance reporting and to coordinate with public programs

OMCH employees engage in numerous public education and awareness efforts, including, for example, the posting of *If you're pregnant, don't drink* signs, health fairs, participation in special events, and support for signage on metro rail and bus. But these efforts often seem to be sporadic, short term, dependent upon categorical funding and not always well-integrated into comprehensive strategies to improve health. Efforts tend to be focused on the majority African American community, in particular the low-income neighborhoods, which is where the poor health outcomes are manifested. They are infrequently evaluated; thus very little evidence is available for use in planning follow up efforts.

OMCH has attempted several partnerships with the Latino community and has adapted some informational efforts to that population. But in general, the Latino community has had to develop its own infrastructure to address health and social issues. OMCH has been able to do very little regarding partnerships with the Vietnamese community, or other small enclaves of immigrants, including acquiring data to describe this group, or other small populations.

OMCH efforts to participate in an oral health initiative have been described in section II. Only recently has there been citywide awareness of oral health as a public health issue. Injury prevention and nutrition have not been considered priorities, in part because of categorical funding streams, and the placement of responsibility for these programs in other components of the health department.

3.1.2.5 Infrastructure Building Services

For years the State Title V program has worked to establish a coordinated comprehensive system of care for the District's MCH population. Linkages have been made with various providers, advocacy groups and government agencies. Coordination efforts with the various agencies and providers are discussed below.

DC Healthy Families: On October 1, 1998, under the federal Children's Health Insurance Program (CHIP), the District government initiated an expanded Medicaid program of guaranteeing health insurance to all low and moderate income families with children. The Office of Maternal and Child Health serves as a primary link in the DC Healthy Families outreach activities. The Medical Assistance Administration (MAA), which administers the DC Healthy Families Program, funds two positions on the MCH Healthline. These individuals have been placed there to expand the

Healthline's bilingual capacity. In addition, the 1-800-MOM-BABY telephone number has been placed on all outreach materials and included in all public services announcements regarding the program. Currently, DC Healthy Families healthline staff speak 3 languages, Spanish, Vietnamese and Mandarin Chinese, and are assisting MCH with translating the written materials into these languages. During Fiscal Year 99, over 51% (12,545) of the calls to the Health line were related to DC Healthy Families.

Coordination efforts: In other sections of this application, the coordination with Medicaid, Title IV, early intervention, school health, WIC and social services is described. OMCH has been able to carve out defined roles with these programs or at least establish working relationships.

With the other programs listed in the guidance (special education, vocational rehabilitation, mental health, interagency transition programs, and SSI), there is only sporadic contact. In fact, employees are not always aware of the current emphases of these programs. Several (mental health, special education) programs are themselves experiencing severe problems (under receivership or other litigation) and require more than coordination with sister agencies.

OMCH has relationships with several hospitals and medical centers, primarily through programs operated by Children's Hospital Medical Center, and via representation on various councils and advisory groups. In addition to the *Use Your Power!* Parents Council, OMCH employees relate to several other consumer advocacy groups. OMCH has supported the PBC Health Services for Children with Special Needs Clinic parents group. There is some interaction with representatives of the local chapter of the American Academy of Pediatrics through the Children's Health Care Coalition.

Gaps and Needs in Coordination: OMCH has not had the capability to maximize functions of assessment, policy development and assurance. Over the next 5-year period, OMCH can be more deliberate and strategic as to how staff and other resources are allocated. OMCH management can dedicate staff time to form liaisons with specific government agencies—special education, mental health, protective services, for example. The continuity of interdepartmental liaison work may be even more important than intradepartmental coordination, insofar as there are more opportunities to communicate within the department. Relationships with other agencies require time to develop and mutual exchanges, such as funds and staff expertise.

Staff and leaders are often challenged by the need to change from a direct service to a population-based approach. Formal preparation in public health has not been a priority for recruitment, retention or advancement, although several recent hires are MPH-prepared. Efforts have been made to take advantage of the many conferences and events in the metropolitan area as an avenue of keeping abreast of changes in maternal and child health and public health. OMCH management could coordinate recruitment and training with other divisions of DOH, for example, splitting positions to obtain expertise in public health nutrition, health education, epidemiology, and statistics.

Future efforts for the Office of Maternal and Child Health should be in the areas of strengthening collaborations with the District's Title X Agency, monitoring and assessing the impact of welfare reform on women's health, monitoring the impact of welfare reform on undocumented women, infants and children.

3.2 Health Status Indicators

The core and developmental health status indicators were used extensively as the needs assessment was being conducted. The mandated collection of these measures helped to provide a better picture of the District's MCH population. Several indicators are reported in the narrative (i.e. asthma, low birthweight, and adequacy of prenatal care). In the future, these indicators will serve as the base for ongoing assessment for the MCH population in the District. OMCH staff will continue to work to establish linkages with primary sources of the data to obtain the information in the required format.

3.2.1. Priority Needs

In this section of the application, the result of the OMCH priority setting process is summarized.

Infrastructure building: Clients, providers and agency officials agree that programs and services directed toward the 3 MCH populations are not well coordinated. This applies both to services across systems, for example, special education and health services, and to programs within DOH other agencies. Integration of OMCH managed and supported programs is also a need. The need to improve coordination applies to all MCH mandated populations, but is particularly acute for the special needs population. It may not be possible to change directly the structural causes of disjointed systems, however, OMCH can stimulate improvements in coordination by convening and establishing a citywide coordinating committee for special needs.

Building upon OMCH efforts over the past 2 years to expand capacity in data collection and acquisition, and analysis, a continuation of efforts to link client information files across systems may be used as a wedge to improve coordination of services.

Priority: *Establish a coordinating committee to strengthen system links among health, social services, juvenile justice, public schools, mental health, protective services and developmental disabilities.*

OMCH also recognizes the need to organize a broad based maternal and child health advisory board, which can serve to identify emerging needs and community resources, share information and coordinate services and policies across public and private systems. The board would help to coalesce political power to address resource issues.

Oral health is a major need and must be approached from numerous perspectives: maldistribution of community-based providers; low Medicaid reimbursement rates; lack of recognition of the role of dentists in primary care; low rates of EPSDT screening; absence of school-based oral health preventive services; and lack of or insufficient dental insurance among the generally insured population. OMCH can play a role in the increasing recognition of DC's inadequate response to the oral health needs of children and youth. As an initial step, OMCH will support a physical examination survey to develop estimates on oral health status and morbidity. OMCH staffers also need to contribute to a better understanding of factors affecting the allocation of resources for oral health.

Priority: *Assess needs/resources to improve oral health among children and youth.*

Population based: OMCH will continue to provide and/or support services that meet the on-going need for newborn screening, lead poisoning screening and immunization. The expansion of newborn screening to include universal hearing screening is an unmet need that OMCH recognizes as a priority. Although OMCH is committed to working with birthing hospitals to put hearing screening in place, follow through is dependent upon hiring a dedicated coordinator. As a primary prevention strategy, this program is directed toward the special needs population.

Priority: *Establish universal newborn screening.*

Outreach and public education projects should be integrated into a more comprehensive communications strategy to better reach underserved and disengaged youth, parents and other caregivers. OMCH is doing this to some extent now, for example, using the provision of

transportation as a vehicle for disseminating information, and including parent education on a variety of subjects in Healthy Start home visits. Such integration should also include assuring that maternal and child health populations are included in prevention efforts spearheaded by other DOH agencies. A case in point is working with the tobacco control program to include a focus on pregnant women and to provide information in school health education classes on the effects of second hand smoke on children.

OMCH needs to take advantage of evidence-based strategies for improving pregnancy outcomes, for example, a SIDS prevention program needs to be introduced throughout DC.

Priority: *Work through health services delivery systems and neighborhood organizational infrastructure to reduce incidence of SIDS and other infant deaths.*

Enabling services: Unmet transportation needs affect the 3 MCH populations. Efforts to provide or subsidize transportation are often disjointed or the service is poor. There is a continuing need to provide transportation so that mothers and infants can access other services. While the need for OMCH to provide transportation to medical services has diminished, other needs continue, for example, to access WIC voucher redemption sites.

OMCH needs to expand linguistic and cultural competency; first, by assuring that its own print and video materials address the major underserved language groups in DC. This will require a greater awareness of and information about small immigrant communities.

Strategies to reduce the high proportion of women that give birth as a result of unintended pregnancy need to be incorporated into MCH programs. OMCH needs to increase the awareness among policy makers and medical and social service providers of the relationship between unwanted pregnancies and adverse outcomes. Since research findings suggest that late entry into prenatal care is more prevalent among women who are ambivalent about an unintended pregnancy, OMCH should refocus some outreach efforts on pregnancy prevention/postponement, beginning by incorporating client education on reproductive health with other service delivery, and dedicating OMCH staff resources to coordination with family planning and education providers.

Priority: *Reduce unintended pregnancies and teen births.*

Although OMCH does not have primary responsibility for informing and enrolling eligible persons in Medicaid, including the expansion through Title XXI, the progress made in enrollment in and using managed care over past 2 years must be sustained. The 800 Healthline plays an important role in informing the public and assisting residents with applications. In the next year, transition from TANF and DC Healthy Families recertification will require greater emphasis. Additional work is needed to make the health systems culturally competency and to ensure that standards of care are appropriate to the populations served. To affect this, OMCH needs to increase staff knowledge about health financing, managed care delivery systems, quality improvement, Medicaid and Title XXI. OMCH needs to incorporate staff liaison work with Medicaid (and other programs as well) into its organizational structure and work plan.

Priority: *Increase the proportion of the population that is insured.*

Priority: *Monitor/ assess the effect of welfare repeal and mandatory managed care on health status.*

Direct services: Although the expansion of public insurance has reduced the need to provide direct clinical services, OMCH must contribute toward meeting certain safety net needs. One is the need to support new oral health capacity at the PBC Health Services for Special Needs Children Clinic, which will also make services more available for other children.

The needs for preventive and primary care remains unmet for several groups: unqualified immigrants, uninsured persons over 200% of FPL or who otherwise do not qualify for public insurance, and persons who need expanded service(s) not covered by Medicaid.

Support for direct services addresses an overriding priority for improving health status in DC.

Priority: *Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status.*

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

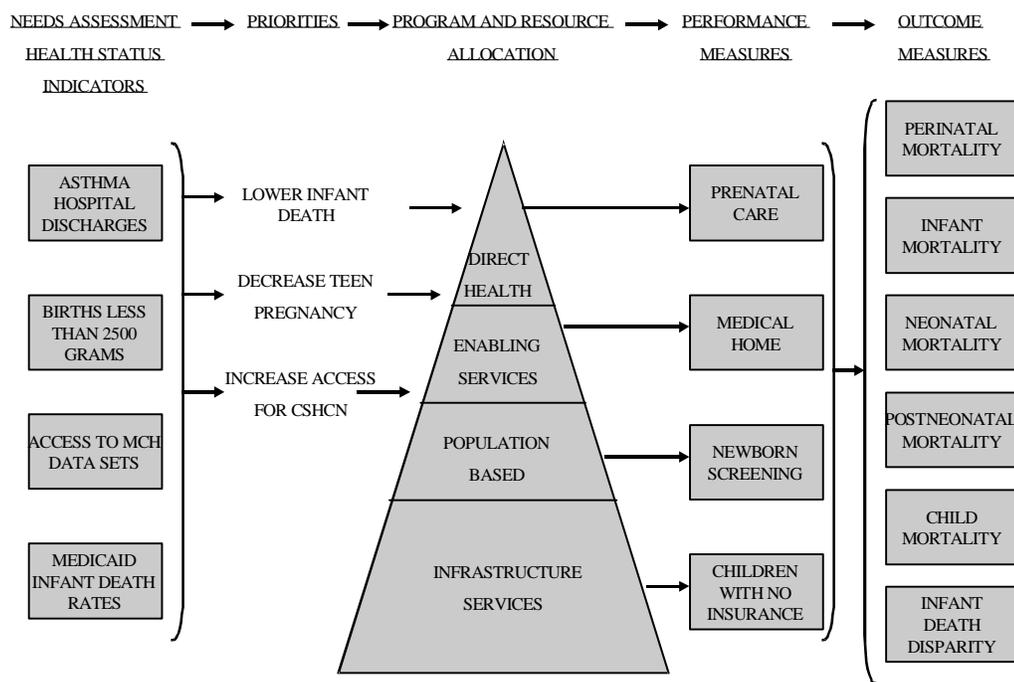
Forms 2 – 5 are included in the application.

3.3.2 Other Requirements

Form 2 shows the amount of MCHB funds received for SSDI, Abstinence Education and Healthy Start. The state match consists of DC appropriated funds, the majority of which are designated for newborn screening, school nurses program and women’s health.

3.4 Performance Measures

Figure 3
TITLE V BLOCK GRANT
PERFORMANCE MEASUREMENT SYSTEM



3.4.1 National Core Five Year Performance Measures

See figure 4.

Figure 4
PERFORMANCE MEASURES SUMMARY SHEET

Performance Measure	Pyramid Level of Service				Type of Service		
	DHC	ES	PBS	IB	C	P	RF
1) The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.	X				X		
2) The degree to which the State Children with Special Health Care Needs (CSHCN) Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.	X				X		
3) The percent of Children with Special Health Care Needs (CSHCN) in the State who have a “medical/health home”		X			X		
4) Percent of newborns in the State with at least one screening for each of PKU, hypothyroidism, galactosemia, hemoglobinopathies (e.g. the sickle cell diseases) (combined).			X				X
5) Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, Hepatitis B.			X				X
6) The birth rate (per 1,000) for teenagers aged 15 through 17 years.			X				X
7) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.			X				X
8) The rate of deaths to children aged 1-14 caused by motor vehicle crashes per 100,000 children.			X				X
9) Percentage of mothers who breastfeed their infants at hospital discharge.			X				X
10) Percentage of newborns who have been screened for hearing impairment before hospital discharge.			X				X
11) Percent of Children with Special Health Care Needs (CSHCN) in the State CSHCN program with a source of insurance for primary and specialty care.				X	X		
12) Percent of children without health insurance.				X	X		
13) Percent of potentially Medicaid eligible children who have received a service paid by the Medicaid Program				X		X	
14) The degree to which the State assures family participation in program and policy activities in the State CSHCN program				X		X	
15) Percent of very low birth weight live births				X			X
16) The rate (per 100,000) of suicide deaths among youths 15-19.				X			X
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates				X			X
18) Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester				X			X

NOTE: DHC = Direct Health Care ES = Enabling Services PBS = Population Based Services IB = Infrastructure Building C = Capacity P = Process RF = Risk Factor

SP# 1 - By 2005, increase the % of women who receive adequate prenatal care (Kotelchuck) to 69.5. (DHC, RF) Getting women into and sustaining prenatal care continues to be a necessary focus among DC African American women. OMCH also needs to work with the State Center for Health Statistics to improve completeness of birth certificate data to improve measurement of adequacy of prenatal care. SP# 1 may be key to an overarching priority: *Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status*. Adequacy of care and NO# 1-6 are strongly correlated.

SP# 2 - By 2005, reduce the prevalence of lead levels exceeding 10ug/dl among DC children through age 6 to no more than 2%. (PBS, P) Much more remains to be done to protect children from this environmental hazard. By continuing to track this measure, OMCH will enhance the efforts of sister agencies and programs, and achieve a significant result in preventing disabilities. This measure relates to priorities: *Strengthen policy and enforcement of standards of care (screening) to improve care of pregnant women, infants and children, including special needs children* and *Elimination of racial, ethnic, immigrant status and class disparities in ...child health status*. Activities measured may contribute to the achievement of NO# 1 and 6.

SP# 8 - New measure- By 2005, reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester to 5.4%. (E, C) Focusing exclusively on early entry (SP#1 and NP# 18) may contribute to overlooking a significant number of women who deliver with no or very late care, women predicted to experience the most adverse outcomes. They are prime candidates for HIV counseling and testing, substance use treatment, and child abuse and neglect prevention, and require labor-intensive outreach, including curbside mobile services and home visits. OMCH and several collaborators are developing capacity to identify and case manage these high-risk women. Participating organizations will use a universal intake and screening protocol to enroll and refer clients across programs and organizations. This new measure is related to priorities: *Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status* and *Strengthen systems links among health, social services, juvenile justice, public schools, mental health, child protective services, and developmental disabilities*. Timing of prenatal care is associated with NO# 1-6.

SP# 4 - By 2005, increase EPSDT participation to 60%. (PB, P) Inexplicably, EPSDT participation has not improved, despite litigation, task force activity and monitoring of MCOs. Yet the program has great potential for prevention of disabilities and chronic illnesses. This measure is related in part to several priorities: *Monitor/assess the impact of welfare repeal and mandatory managed care on health status; increase the proportion of the population that is insured; and assess needs/resources to improve oral health among children and youth*, and most importantly, *elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status*. The measure is related to NO# 1,2, 4 and 6.

SP# 5 - By 2005, reduce the proportion of births resulting from unintended pregnancies to 40%. (DHC and E, RF) Although considerable efforts have been made to address unintended pregnancies, much more remains to be done. SP# 5 measures priority: *Reduce unintended pregnancies and teen births*. Unintended pregnancies are correlated with late entry into prenatal care and may have a direct relationship as to NO# 1, 5 and 6 as well.

SP# 6 - By 2005, reduce the prevalence of tobacco use among pregnant women to 2%. (IB, RF, C) OMCH will retain this measure from the current period. Prevalence of tobacco use as measured by birth certificate data appears low, however, analysts question the reliability of the data. OMCH analysts will work within DOH to more accurately measure this risk factor, perhaps the single most preventable contributor to poor birth outcomes and child morbidity. DOH will introduce new tobacco control and prevention programs over the next few years as a result of tobacco settlement resources. It is important that pregnant women be targeted in such efforts, as well as included in new tobacco exposure surveillance systems. Also, any long-term change in tobacco use among adolescent women will eventually be observed in this measure. SP# 6 is related to priority: *Strengthen policy and enforcement of standards of care to improve care of pregnant women...* (by incorporating standards for tobacco use counseling and treatment into prenatal care). The measure is associated with NO# 1-6.

SP# 9 – New Measure: By 2005, reduce the incidence of repeat births for teens less than 19 years of age to 19%. (E, C) OMCH will be working with TANF to establish a system for case management of pregnant teens. Once the client is known to the system, through intensive care coordination and supports, unwanted, repeat pregnancies are expected to be reduced. This

addresses priority: *Reduce unintended pregnancies and teen births* and is associated with NO# 1, 2 and 6.

New State Outcome Measure: By 2005, reduce the incidence of confirmed SIDS cases (3-year to below .7 mean) by 50%. (P, RF) OMCH will undertake a major effort to reduce the incidence of SIDS. Based upon evidence of the success of Back to Sleep client, provider and community education efforts across the US, and the high proportion of African American infants who are not placed on their backs, OMCH has considerable opportunity to reduce the incidence of SIDS. This state outcome measure is intertwined with NP# 1 and 2.

3.4.2.3 Five Year Performance Objectives

See form 11.

3.4.2.4 Review of State Performance Measures

3.4.3 Outcome Measures

See forms 12 and 16.

IV REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

Direct Health Services – Pregnant Women, Mothers and Infants, and Children

Gaps in insurance coverage contribute to a continuing need to provide direct services: Expanded Medicaid eligibility extends to 200% of the FPL although many persons above that level cannot afford to purchase insurance. Unqualified immigrants rely on safety net services. Persons who have applied for Medicaid but are not yet certified or persons who fall off the rolls due to barriers to recertification require assistance. Patients may need more time with a provider or services in addition to those covered by Medicaid. In view of these needs, the DC Title V program will continue to provide safety net primary and preventive health services to pregnant women, mothers

and infants, children, including adolescents. OMCH will continue to support, but at a lesser level, services rendered by the PBC CHCs and the Ballou school clinic through FY 2001.

Through the Healthy Start mentoring and replication project, OMCH will work with a new, private sector community-based Healthy Start partner to expand and extend primary and preventive services. Mary's Center for Maternal and Child Health Care was recently awarded a Federal Healthy Start grant to serve Wards 1, 2 and 4, an area with a high prevalence of poverty and a concentration of Latino and other immigrant groups. The IMR for the project area was 12.4 for the period 1995-1997. The grant will enable Mary's Center to work with the PBC CHCs and a consortium of small nonprofit clinics to identify women, children and adolescents without health care homes and/or not receiving services. The project will utilize a universal intake and assessment protocol and refer participants to the most appropriate source of services. Mary's Center itself provides a comprehensive range of perinatal, ob-gyn and pediatric services, including home visits and social services.

Representatives from the new project target area will join the Healthy Start Consortium, extending the geographical and cultural mandate of that policy advisory group. OMCH expects the results of this new project to be significant both in improving accessibility to culturally competent care and to enhancing coordination of services throughout the city.

Direct clinical services provided by the PBC and community-based organizations are expected to contribute to achievement of important performance and outcomes objectives (SP# 1 - 7; NP# 1, 2, 5, 6, 9, 13, 15, 17, 18; O# 1-6).

Direct Health Services – Special Needs Children

The PBC Health Services for Children with Special Needs Clinic will continue to provide specialty services. The clinic receives referrals for specialized testing and services from the CHCs as well as other providers. The OMCH HEALTHLINE, Healthy Start, and the school nurses program refer clients to the clinic. The clinic will also continue to assist families with SSI applications and eligibility issues.

The clinic is reconstituting its dental services component to meet a need for physically accessible and medically appropriate oral treatment services for special needs children, those served not only in the PBC network but also throughout the city. Special needs children often require sedation and other specialized oral health services, which can be most efficiently delivered in a hospital-based clinic setting. Although pediatric dental services are available at 7 CHCs, not all are fully equipped to handle special needs children without disruption to patient flow. In view of the very low utilization of dental services among Medicaid beneficiaries, reportedly due in part to the lack of available services, this additional dental service within the PBC system will increase the number of children served throughout the city.

Provision of direct clinical services by the clinic will affect these performance and outcome measures: NP# 1, 2, 3, 7, 10, 13, and 14. and O# 6.

Enabling Services

Through FY 2001, OMCH will provide an array of enabling services to pregnant women, mothers and infants, and children, including adolescents and children with special health needs. Enabling services will include the following: information and referral through the HEALTHLINE; door to door van transportation to WIC voucher redemption sites and to medical services for pregnant women and infants who are not yet enrolled in MCOs; outreach in selected neighborhoods; home visits to at-risk families; case management; consumer health education; and coordination with other programs. Although these services have been offered in past years, OMCH expects to make several changes and improvements in order to more specifically meet identified needs.

The HEALTHLINE will continue to provide information and referral. As described in sections I and II, the HEALTHLINE serves a major role in the expanded Medicaid outreach and enrollment. A nurse case manager, a Latino community outreach specialist, and an outreach worker will conduct a variety of community outreach activities, concentrating in Wards 1, 2 and 4, an area that has not been covered by the more intensive Healthy Start-supported efforts. Since a new Healthy Start program will be starting up in FY 2001, OMCH will meet with the project management to agree on mutual referral protocols. The nurse case manager will make home visits to high risk pregnant women and/or to arrange services through community-based providers. Although the

position is currently vacant, a candidate has been identified. The position has cleared the DC government-wide review of all hiring actions. It is expected that the community health nurse will be on board within a month and that the resource center will re-open in a new location by the beginning of FY 2001.

Transportation

As in past years, OMCH will continue to provide door-to-door transportation to pregnant women, mothers and infants not otherwise covered by Medicaid managed care transportation benefits. Transportation capacity consists of a fleet of 4 leased 9-passenger vans, staffed by 4 drivers and a supervisor. Since 2 of the drivers are new to the OMCH staff, and 1 has been employed for less than a year, an intensive in-service education program for the drivers is scheduled for the last quarter of FY 2000. Additional training in education and counseling techniques and current MCH health issues will further prepare van drivers to be important members of the OMCH outreach team. The transport of these clients to medical care is expected to address several measures: NP# 3, 5, 13, 15 and 18.

Also during the last quarter of the current fiscal year and extending through 2001, OMCH will begin to offer transportation to WIC clients living in Wards 6, 7, or 8 to assist them in returning home with groceries purchased with WIC vouchers at the sole remaining supermarket in a 2-ward service area. Initially, the service will be provided twice a week, with 3 fixed pick-up times on the scheduled days.

WIC employees will distribute flyers that describe the new service when clients either enroll in the program or pick up their food vouchers. Clients will make transportation reservations through the OMCH HEALTHLINE. As described in section II, this pilot program is being launched at the request of WIC managers after an analysis revealed that redemption rates for vouchers had dropped in neighborhoods formerly served by now defunct stores. Lack of affordable, and accessible, public transportation has been identified as a major barrier to use of WIC vouchers.

A 3-month test of the new service will begin in mid-July 2000. After the pilot test period, the program may be expanded to include additional pick-up hours. A further expansion to a 2nd

supermarket location and/or a farmers market serving the target area may be made during the latter half of FY 2001, depending on an assessment of utilization and costs. Better access to voucher redemption sites will affect NP#9 and 15.

OMCH will use this cooperative effort with WIC to incorporate health education into the transportation service. Culturally appealing messages on nutrition, maternal and child health services, family planning, and health education will be distributed on the van. Audiotapes will be played. OMCH will negotiate with the pilot test supermarket site to secure space for a staffed outreach display near the entrance of the store or within the store. The OMCH outreach worker will staff the display, and it is hoped that the WIC program also will provide a worker. Information on and assistance with enrollment in DC Healthy Families (the expanded Medicaid managed care program) will be available. Several community-based groups will be invited to participate in information dissemination. One organization has offered to accompany clients on shopping trips to teach them how to purchase economical and nutritious food. Health education is directed toward SP# 4, 5, NP# 6, 7 and 13.

Consumer Navigation and Empowerment

Use Your Power! parents council will continue to educate, train, develop and empower parents to advocate for family-centered services. The council will be staffed by 2 FTEs, funded by OMCH, however, the coordinator has raised foundation funds to support all operational and program activities. In 2001 the council will conduct 25 community workshops on navigating the health care system, using the video and revised pocket map produced in past years. Several workshops will be held in and for the Latino community. In conjunction with the workshops and DC Covering Kids, residents will be encouraged to enroll in the Title XXI program. Now that enrollment outreach is going into the 3rd year, training and information will focus on issues around recertification and transitional Medicaid, in addition to informing new categories of eligible persons.

The council will continue to work with AFFIRM, DC Action for Children, the DC NonProfit Clinic Consortium, the DC Primary Care Association and other advocacy organizations in seeking better access to and improvement in the quality of health services. In the past, the council, although concentrating its activities in low-income neighborhoods, has worked primarily on citywide issues.

In 2001, a neighborhood focus will begin in Ward 5. Many of the more than 20 council members reside in Ward 5, where an increase in infant mortality and other adverse health outcomes has recently been observed.

As in past years, training and other supports will be used to enhance leadership skills of council members. The pocket map materials will be updated for additional printings as necessary. Council activities focus on the reduction of financial, administrative and social barriers to the utilization of prenatal and pediatric services and are expected, in combination with other OMCH programs and efforts of other organizations, to affect SP# 1,2,3, 4, 6, NP# 3, 5, 8, 1, 12, 13 and 14.

Coordination

OMCH will continue its partnership with 3 hospital-based providers as anchor partners in the Ryan White Title IV-funded Family Connections. A 3-person team consisting of a LCSW and 2 indigenous family advocates will work with Healthy Start case management staff to provide HIV counseling, to encourage all clients to be tested, and to assure that all HIV-positive clients are connecting with specialty medical care and social services. All pregnant clients are being referred to their PCP for HIV testing. Through the Family Connections partnership, OMCH participates in other HIV/AIDS provider networks, which allows staff members to have access to current information on recommended treatment protocols, sources of medical and social services, and financial assistance for clients. This information is used in scheduling in-service education and training and updating resource directories. The HEALTHLINE operators are kept informed of HIV-related service resources. Work with Family Connections will contribute to SP# 1, 5, NP# 3, 11, 13 and NO # 6.

The Healthy Start mentoring project and the Healthy Start replication project will provide nurse case management to approximately 1000 pregnant women and/or infants in FY 2001. Case management, which includes home visits, is directed toward encouraging and supporting pregnant women to present for prenatal care. As the pregnancy continues, case management workers assist with health care and social service referrals, and later in ensuring follow up with 6-week post partum visits and infant care. As described in sections I and II, OMCH will implement a new project to provide case management to TANF teen moms. These strategies contribute to many measures: SP# 1-6, NP# 3, 5, 6, 9, 11, 12, 13, 14, 15, 17, and 18.

Consumer Education and Public Information

In January 2000, 2 OMCH Healthy Start staff members collaborated with 2 nonprofit organizations and successfully applied for a mini March of Dimes grant to promote breast feeding among low income, pregnant Latinas and African American women. In addition to education and the provision of breastfeeding peer counselor support, the project will supply up to 10 women with breast pumps, the expense of which was identified as a barrier to breastfeeding for welfare to work participants. La Leche League is providing training to selected Healthy Start staff so enhance their skills in support of breastfeeding clients. This project is directed toward improvement of NP#9.

OMCH and MAA, as well as the DHS Office of Early Childhood Development (OECD) will collaboratively support a campaign to distribute and use a portable medical record, called a passport, for children and youth in FY 2001. Development of the passport prototype was funded by The Carter Center in Georgia. Collaborators included the Georgia Department of Medical Assistance, CDC, and the American Academy of Pediatrics. Since then, the states of Alabama, Idaho, North Dakota, and Kansas have adapted and distributed the document to their residents. The New York City Police Department has also used it in annual community outreach campaigns.

Locally, Capitol Community Health Plan (CCHP), one of the Medicaid managed care providers, uses the passport. CCHP is owned by 5 local hospitals, and each hospital distributes it to its respective CCHP client families through their physicians, clinics, and in hospital settings. CCHP reports that requests exceed by a factor of 4 to 5 their current MCO enrollment.

Available in both Spanish and English, the passport is a 32-page booklet approximately 4" by 5 ½" contained in a durable plastic pouch. Written at the Grade 4.2 reading level, the booklet is designed as a portable medical record and parental guidance tool. Healthy growth and development topics include: immunization schedule, with space for recording the child's personal immunization record; developmental milestones, with space for recording the child's progress; nutritional advice and feeding tips; advice on physical activity; space for recording the child's medical history, including chronic diseases and allergies; and parenting tips suitable for various developmental stages.

It also provides information on child abuse prevention, child safety and injury prevention, and child-care and babysitting. Finally, the booklet serves as an identification tool, with space provided for: the infant footprint; a full-face, recent photo of the child; and sequenced photos and growth information. The back cover of the passport will be customized for the District of Columbia and include the number 1-800-MOM-BABY.

OMCH will be the lead agency for designing and implementing the passport distribution, as well as for developing the template for the text to be printed on the back cover of each booklet. OMCH and MAA are sharing the cost of an initial printing of 100,000 passports in English and 10,000 in Spanish, more than enough to cover every child in the District who is ages 0 to 14. OECD has been asked to partner the project by providing funding for some staff support within OMCH (a .5 FTE coordinator), as well as funding for a public information campaign.

The distribution plan will be finalized by October 2000, with the target date for launching the campaign November 1, 2000. Pending funding, distribution will be accompanied by a major public information campaign. Target outlets include: all birthing hospitals; all public, non-profit, and managed care clinics; day care centers and the Head Start program. The accompanying public information campaign will emphasize the use of the passport as a parent education tool to enable social services workers, as well as health care providers, to assist parents and guardians in establishing a medical home for the children in their care. For those families that routinely rotate between medical care providers, the medical passport will provide a permanent, portable record for the child. A protocol, including counseling instructions for client education regarding its use, will be developed by and included with all bulk distributions. The OMCH community service unit employees will contact the outlet organizations and arrange staff training on the presentation and use of the passport. The introduction of the passport is expected to address, in part, SP# 2, 4, NP# 3, 5, 13.

OMCH will again participate in the DC Asthma Coalition, a public private partnership organized by the DOH, Preventive Health Services Administration. During the 1999-2000 school year, 12 nurses in Ward 6 schools were trained by the American Lung Association and the Environmental Protection Agency to teach asthma management to students, parents and faculty, using the *Open Airways* curriculum. Ward 6 was selected because of the high incidence of asthma mortality,

compared to other wards. School nurses in Wards 7 and 8 are currently being trained. During the 2000-2001 school year, training will be expanded to Wards 4 and 5. The continuing education effort directed toward schools nurses is used in combination with other program supports—distribution of peak flow meters, summer camp for asthmatic children, training of child care staffs, public information and dissemination of parent educational print materials.

Parent educational materials are being translated in Vietnamese, Somali, Mandarin and Tagalog. English and Spanish versions have been available. These materials are distributed at health fairs, public events, such as World Asthma Day, the Camp Happy Lungs and by school nurses. OMCH will also distribute them through existing networks—the transportation vans, mobile unit, Healthy Start home visits and the HEALTHLINE. Participation in the asthma program is expected to contribute to NO# 6.

Population-based Services

Newborn Screening

The newborn screening coordinator has made preliminary plans for consideration of expanding metabolic screening from 7 to approximately 30 inherited genetic disorders. This additional screening would identify the following disorders: 11 organic acidemia disorders; 6 fatty acid oxidation disorders; 2 amino acid disorders; Biotinidase Deficiency; Congenital Adrenal Hyperplasia; and Cystic Fibrosis.

Genetic Services

OMCH will execute a contract beginning August 2000 to enhance the genetic services program. District families will be able to obtain services at the 8 PBC CHCs and the DCGH OB-GYN and Pediatric ambulatory clinics. In addition, services will be provided at 4 private sites: Children's National Medical Center Comp Clinics at Shaw, Adams Morgan and Good Hope, and Mary's Center for Maternal and Child Care. While services primarily focus on inherited genetic disease and related birth defects, counseling and referral will be offered on the genetic implications of common, chronic conditions. To expedite the referral of infants found with abnormal test results by the Newborn Screening Metabolic Program, a site will be created for infants with sickle cell trait and their families that require counseling and confirmatory testing. In addition, an increased

number of referrals of metabolic disorders is anticipated if the mandated panel of disorders is expanded for the District's Neonatal Screening Program.

Staffs of participating health centers will be trained in emerging issues, such as the role of genetics in common, chronic conditions, e.g. cancer, heart disease, asthma and diabetes. Provider education will also include the impact of the Human Genome Project on individuals, families and society, as well as on expanded supplemental newborn metabolic screening. Genetics services and counseling is expected to reduce the prevalence of special needs and disabilities and to directly affect NO# 1-6.

SIDS

In coordination with the Infant Mortality Review Workgroup, the OMCH special needs unit will conduct SIDS prevention education, focusing on dissemination of Back to Sleep brochures and other materials. Health care professionals and service providers, birthing hospital personnel, Healthy Start and WIC workers, as well as leaders in the African American and faith communities, will be targeted. National SIDS month will be observed.

Building upon the groundwork laid in 2000, the OMCH special needs unit will work with other organizations to develop a unified approach to the reduction of SIDS and other infant deaths. (9 of the 96 infants deaths in 1998 were attributed to SIDS.) The significant disparity in SIDS rates between African American and white infants in the District and nationwide indicates the need for a more comprehensive and effective community-based risk reduction program.

Within the African American community, there is often considerable resistance to discussing SIDS and other infant deaths due to the stigma associated with them. A dedicated SIDS coordinator is working with the SIDS Alliance, the DC Infant Mortality Review Workgroup and an array of community based organizations to design an information project to address the attitudes and behaviors affecting SIDS in DC African American communities. The National SIDS and Infant Death Program Support Center, in collaboration with NIH and the DOH, will develop a media campaign involving distribution of culturally appropriate and appealing brochures and other publications, and an educational program for EMS and other medical professionals.

As part of the risk reduction activities, new parents will be provided with cribs that comply with product safety standards, and literature on Back to Sleep and infant safety will be disseminated through organizations such as Healthy Start, WIC and the transportation vans.

The coordinator will collaborate with other DOH programs, such as the immunization and asthma programs, to deliver the risk reduction message throughout the target community. She is currently forming an advisory group, which will determine whether to conduct a broad outreach program on general infant and childcare or a SIDS-specific program. Preliminary plans are ambitious and include training and dissemination of information to health care providers, hospital chaplains and MCOs, childcare providers, community-based service organizations, parents, grandparents and other informal caregivers. In addition to training and education, the project will include bereavement and grief/loss counseling in cooperation with the William Wendt Center Recovery Program. Work on SIDS is designed to address SO# 1 and NO# 1, 2, 4.

Hearing Screening

Pending the successful recruitment of a coordinator, preparation for the universal newborn hearing-screening program will begin. Plans to establish hearing screenings call for the same strategies as delineated in last year's application: establishment of an advisory committee of representatives of neonatology, audiology, speech, language and learning specialists, school systems, hearing associations, and consumers; obtaining cooperation from all DC hospital nurseries staff to set up screening protocols, clinical parameters, guidelines, data collection and reporting; development of a tri-state referral system of early intervention specialists in cooperation with Maryland and Virginia; collaboration with special needs services of public and private schools; development of legislative policy to mandate screening, and implementation of a fiscal system that supports the entire program. Management of the DC Early Intervention Program indicated interest in providing follow-up services for the hearing-screening program. The hearing screening is an initial effort to systematically address NP# 10.

Lead Screening

The Comprehensive Lead Poisoning Prevention Program, which operates primarily with CDC and HUD grant funds, will continue screening and lead abatement. Program strategies will again focus on door-to-door outreach and education, in-home testing and screening, and screening and testing in

schools, preschools and child care facilities. This year a ward-by-ward inspection of public housing dwellings and in-home screening of children is scheduled, beginning in Ward 8. Case management is available to ensure that children with elevated blood lead levels obtain medical care. Upgrading and improving compliance with reporting for the lead registry, and coordinating with MAA are also expected to receive emphasis.

DOH management will work to strengthen city policy regarding lead abatement and screening: A bill (13-721) has been introduced to regulate exposure in property built prior to 1978 and in use as a rental dwelling, foster care home, school or other facility, to establish a fund and tax credit for specific lead hazard reduction activities, to establish lead-safe work practice requirements, to authorize the use of market share liability theory in civil actions for damages due to lead-based paint, and to establish universal standards for screening children under the age of 6. Lead program activities will impact primarily upon SP# 2 and possibly NP# 3 and 13.

School Based Screening

OMCH will continue to work with the PBC school health nurses program to carry out hearing, vision and scoliosis screening, immunization compliance and other on-going supports described in section I. In school year 2000-01, OMCH expects the PBC to move beyond screening, with protocols and resources allocated to follow up on positive screens. Deliverables have been delineated in the MOU for the next year. In addition to tracking student follow up with testing and treatment, OMCH will work with the school central administration and selected schools to assure that children requiring follow up, as well as other eligible children, are enrolled in public insurance programs. In-service trainings are being held for nurses to inform them of eligibility criteria and enrollment procedures for the expanded Medicaid program.

Through Healthy Start and, when in effect, the TANF-supported *Teen Moms Take Charge*, OMCH will assure that protocols are in place for school nurses to refer pregnant students to appropriate services and programs. Coordination with school health may affect many measures: SP# 1, 3, 4, 5, 6, 7 and NP# 3, 6, 11, 12, 13, 16 and 18.

Abstinence

The abstinence education project will expand from 3 to 8 wards in 2001. Targeting youth ages 9-14, the *I'm Worth the Wait* curriculum has been designed, tested and revised to consist of stand-alone, user-friendly units of instruction. Short pre-post-test instruments accompany each module and the modules can be used in sequence or selected by need. Training of community-based youth service provider staffs will continue to add to the base of available trainers in the community in order that at least 1800 youth complete the curriculum. Additional troupes will be formed to perform in the theatre component of the curriculum, which is expected to reach at least 3000 youth through 32 performances.

Due to the success of the peer educator theatre troupe, training in how to start a theatre troupe will be given to interested youth service provider groups throughout the city. The original troupe will continue to perform at schools, churches and community centers. The project coordinator will also organize a parent advisory board and a youth advisory board.

Working with sister DOH agencies serving youth i.e., the Agency for HIV/AIDS, the Addiction Prevention and Rehabilitation Administration, and the Preventive Health Services Administration, as well as the DC Public Schools, the Metropolitan Washington Policy Boys and Girls Clubs, the Commission on Social Services Family Services Administration and the juvenile court system, the abstinence project coordinator will distribute abstinence information and education print and video materials. Abstinence education should contribute to the achievement of SP#5 and NP#6.

Infrastructure Building Services

The needs assessment findings suggest several critical factors that impact on the special needs population: First, systems of care are not integrated, nor are services comprehensive. Service providers find it difficult to coordinate services both within and across systems. As a consequence, families of children with disabilities have a difficult time gaining access to and navigating the service delivery systems.

Second, while numerous government entities collect information on children with special needs, no single organization has the capability to describe and track services to special needs children across

systems. Better information on this population would be a step toward improved coordination. In FY 2001, The OMCH special needs unit will undertake efforts to address the above issues.

Coordination

With the support of DOH and other DC government entities, and in collaboration with stakeholders, OMCH will convene a coordinating committee of representatives from agencies that provide services to special needs children and youth. The next stage of the OMCH needs assessment, described in part in section III of this application, presents an opportunity to reconvene stakeholders to discuss the needs assessment findings and recommendations, and to delineate actions that agencies will take collectively to address service gaps. Due to the urgency of issues, the special needs unit chief will take an incremental approach to organizing the coordinating committee, meeting initially with those organizations, agencies and programs that are linked to OMCH by funding agreements (PBC, CLPPP, DOH asthma program ...). Next, OMCH will request that Washington metropolitan area MCHB grantees participate in the coordination committee. Additional governmental agencies and private organizations will be incorporated into the committee over time and as issues are considered. While information sharing and resource identification will be among the functions of the committee, OMCH expects the coordinating committee to be "movers and shakers" for special needs children.

As part of the efforts of the special needs unit to enhance coordination with the DC Public Schools, the interim unit chief will participate in the monthly meetings of the Special Needs Think Tank, as well as meet periodically with the transition unit staff. Likewise, representatives of these groups will be invited to join the new OMCH coordinating committee. An initial task will be to develop a curriculum for MCOs. The work of the coordinating committee may over time have an impact on SP# 2, 4, NP# 1, 2, 3, 6,11, 12, 13, 14 and 16.

Linkages

OMCH, with support in part by a SSDI grant, is building a special needs population database. The information system will link with other administrative systems to identify, describe, and monitor children with special needs. The database is being designed to serve the following functions:

- Identify, describe, and monitor children with special needs and disabilities;

- Collaborate with other stakeholders in finding appropriate levels of services for these populations.

Participants include:

- Medical Assistance Administration (Medicaid)
- Office of Early Intervention Programs
- Automated Client Eligibility Determination System “ACEDS” (Social Services data)
- Health Services for Children with Special Needs Clinic, PBC
- DC Public Schools (Special Education)

These administrative data sets will be linked with several DOH databases, including:

- Newborn Genetics Screening
- Immunization Registry
- Vital Records
- Hospital Discharge data

The OMCH SSDI project coordinator is forming the database by using newborn screening data sets. Four years of data will be acquired from the contractor that conducts newborn testing. These data sets will serve as the foundation for the database in that nearly all children born in the District received newborn screening. Over the course of 2001 each of the other data sets will be added to the database. Since there are no universal unique identifiers, OMCH will use matching technology to link individual-specific data across datasets. All identifiers will be maintained and could be made available to the partners involved in the process.

Development of this database will take some time, because of the necessity of developing memoranda of agreement between participating agencies. Each agreement has to be reviewed by the legal counsels of the appropriate organizations. DOH guidelines will also be developed on sharing data and confidentiality. The project coordinator is drafting standard definitions, and procedures for accessing via the Internet and periodic updating. The SSDI project results may have an impact on NP# 1, 2, and 3.

Other Information Dissemination

In FY 2001, the OMCH special needs unit will engage in information dissemination programs to reduce mortality and disabilities, in addition to the SIDS prevention described under population based services. Information dissemination will be directed toward parents and caregivers, the general public and providers. Together with the DC Committee of the National Organization on Fetal Alcohol Syndrome and the PBC Department of Pediatrics, OMCH will sponsor workshops for PBC practitioners and distribute public information on the maternal effects of alcohol ingestion during pregnancy. In conjunction with the Childrens Fatality Review Committee, the DC Metropolitan Area March of Dimes and the Healthy Mothers/Healthy Babies Coalition, OMCH will initiate a public information campaign to promote folic acid intake. The information dissemination may impact upon NP# 15 and directly upon NO# 1, 2 and 6.

The special needs unit also plans to become more involved in training managed care providers on various aspects of special needs children. Ideas currently being explored include the following:

- Collaborate with Georgetown University, Maternal and Child Health Training Program to provide training to MCOs as regards to the special needs population
- Develop a training guide through the Institute for Child Health Policy to do distance learning on the special health care needs population.
- Utilize HRSA Managed Care Technical Assistance Center to provide training to the providers of services to special needs children, including the Medicaid MCOs.
- Provide sensitivity training to DC Public Schools staff, including teachers, bus drivers, counselors, and other administrators to sensitize them to needs special needs children

MCH Advisory Board

In 2001, the OMCH chief will work with DOH officials to organize a maternal and child health advisory board. Experts in public health approaches to maternal and child health will be invited to join the board, in addition to representative of stakeholder groups. The board will scan emerging issues, identify resources and opportunities for interventions, and develop and support city wide

policy change. The advisory board provides a mechanism for translating evidence-based research to programs in DC.

Universal Assessment

Under the auspices of the CISS-supported Home Visiting Advisory Council, a universal intake and referral protocol for home visiting programs has been developed. The CISS project, now completing its 5th and final grant year, has focused on facilitating home visiting initiatives citywide that target substance abusing pregnant/postpartum women and drug-exposed infants. This is a critical need since substance use is considered a major contributing factor not only to poor pregnancy outcomes but also to child abuse and neglect.

During summer 2000, the protocol is being pilot tested in 3 programs. OMCH Healthy Start and 2 private organizations—Healthy Babies and Mary’s Center for Maternal and Child Care—will test the intake and referral procedures for a single point of entry for families in several areas of the city to enroll in Healthy Families DC, a nationwide service model to prevent child abuse and neglect through home visits and intensive supports to first time parents. This collaboration, which also includes cross training of staff and development of a comprehensive resource directory, will enable outreach and assessment workers to refer and enroll families in the most appropriate, available program.

In partnership with the PBC and new Healthy Start funding, Mary’s Center will begin using a mobile unit, patterned on the Healthy Start MOM clinical unit, for outreach and initial intake and screening in Wards 1, 2 and 4. The expansion of mobile services to this area of the city makes it imperative for maternal and child health service providers to improve coordination of intake and referrals across programs and providers.

Healthy Families is a national, primarily foundation-funded model that screens and assesses new parents for risk factors related to child abuse and neglect, and provides intensive support services to strengthen family bonds and improve parenting skills. The grantee, Mary’s Center, is expanding the program from the initial service area consisting of Wards 1,2, and 4 to Wards 5 and 8. Healthy Start is partnering with Mary’s Center to supplement services in Ward 8 and to provide the same type of services in ward 7.

Mary's Center and Healthy Start case management staffs are adopting common screening, assessment and intake protocols, which can be used at various locations, including the Healthy Start mobile unit. Client needs can then be matched with available services. Healthy Start staff will be trained to incorporate Healthy Family-type screening, based on the Kemp Family Stress Checklist, into their assessments, as well as to incorporate some of the Healthy Families protocols for managing families with high risk for domestic abuse. Staff training is being integrated across the organizations, and the expanded services are expected to be in place by September 2000.

Based on the results of the pilot test in the 3 organizations, it is expected other members of the Home Visitation Advisory Council will adopt it for use, and perhaps, move to develop standards of care for home visits. The establishment of universal screening and intake protocols across programs and organizations would be a major step toward better access to services for at-risk populations. This project is expected to contribute to many measures: SP# 1, 3, 4, 5, 7, NP# 3, 5, 9, 11, 12, 13, 15, and 18.

New Moms Letter and Home Visits

OMCH will also reinstitute an information letter to new mothers. Signed by the mayor and handed to the mother at the time of hospital discharge, the letter includes tips on accessing a variety of newborn services via the HEALTHLINE. An information packet will accompany the letter, including but not restricted to materials on Back to Sleep, nutrition and family planning.

Over the past several years, the Infant Mortality Review Workgroup has reviewed several infant deaths that might have been prevented if a nurse home visit assessment could have been made. In some instances, hospital discharge nurses were so uneasy about discharging the infant that they called the DHS Child and Family Services Administration (CFSA) only to be informed that reports of *potential* abuse or neglect would not be accepted.

In response, OMCH will establish a newborn urgent response system (NURS) that can be accessed by any birthing hospital or center nurse through I-800-MOM-BABY. Following receipt of a call, an OMCH community health nurse will make a home visit within 48 to 76 hours of hospital discharge. The visiting nurse will assess the home environment; enroll the mother in case management

services, if appropriate; and/or make an immediate referral to CFSA, if necessary. It is expected that NURS will be in place at the beginning of FY 2001. During the pilot phase, home visit requests will be filled by Healthy Start staff in Wards 5 through 8 and by the HEALTHLINE staff for Wards 1 through 4. The home visit service will address SP# 2, 4, NP# 3, 11, 12, 13, and directly, NO# 1.

Mortality Review

OMCH will continue to support mortality reviews. In May 2000, the deputy mayor for children, youth and families transferred the functions and staff of the Child Fatality Review Committee from the Department of Human Services, Commission on Social Services to the DOH. In 1998 a mayoral organizational order expanded the purview of the CFRC to include the Infant Mortality Review Workgroup, initially formed as a requirement of the MCHB-funded Healthy Start project and staffed by Healthy Start. Now that the full committee also is a responsibility of DOH, management is determining the relationship of the committee to other departmental functions and operations.

Surveillance

OMCH expects to work with the committee and the Infant Mortality Review Workgroup on the following, previously described activities to reduce infant and child mortality.

- Collaboration with many organizations to carry out a SIDS campaign;
- Establishment of a uniform risk assessment/case management tool to be used by providers to increase coordination across agencies and organizations;
- Advocate for allocation of resources to the CFRC;
- Development of strategies to encourage specific agencies, including the DOH, to act on recommendations; and
- Expansion of newborn screening and genetic counseling services.

The OMCH data unit will continue to operate the PRAMS and PNNS surveillance systems. Unit employees will complete the neighborhood health surveys currently being conducted with indigenous leadership in 7 public housing developments. Findings are to be used by the DOH director in planning department-wide strategies to improve health conditions in underserved neighborhoods.

The data unit recently submitted an application for Data Utilization and Enhancement: Cooperative Agreement Program for State Information System to lead a District-wide effort in compiling and disseminating information on maternal and child health and social indicators for various audiences, and at different geo-administrative levels. A multi-agency work group, with representatives from DC Public Schools, Medicaid, Commission on Social Services, Commission on Mental Health, other DOH components, DC Primary Care Association and other private organizations, will be convened to agree on the most relevant indicators and a process for intra- and inter-agency data set acquisition. A Web-based information system for querying data is to be the final product.

The OMCH database linkage activities will coincide with a major DOH undertaking to create a Medicaid data warehouse, with integration and validation links across public health surveillance and performance monitoring systems. Initial warehousing of the Medicaid eligibility system, provider payment disbursement system, provider audit and quality control system, fraud prevention system, client complaint tracking system and the financial management system will eventually be linked with vital records, cancer registry, immunization, STD reporting and other programs.

Oral Health

OMCH will use SSDI funds to conduct a direct observation survey to identify gross dental and oral lesions in a sample of DC children. An advisory committee, consisting of dental health experts, will design the study and train surveyors to conduct the exams. OMCH will assist with data collection and preparation of data for analysis. An oral health epidemiologist will direct analysis. Data from the survey will be used to provide estimates for relevant national health objectives and performance measures, including prevalence of sealants. The DOH director will use the survey results to organize a citywide response to meet children's oral health needs. Although this is an epidemiologic survey and is not directed toward the development of client treatment plans, the DOH will work with participating organizations to have a system in place for referrals to dental services. The survey may affect SP# 4, NP# 7, 12 and 13.

Men's Health

OMCH will continue to lead the city wide Men's Health Initiative (see Appendix). Plans include establishing a men's clinic that operates 1 evening a week in a CHC. Once the OMCH mobile health unit has been replaced, the unit will periodically be dedicated to men's outreach, information

and screening. The initiative will also undertake a range of policy development activities and conduct media campaigns promoting responsible father involvement in the lives of children. To the extent that the host of variables included in the concept of male involvement contribute to avoidance of unintended pregnancies, positive birth outcome and children's health status, this initiative may have an indirect effect NP# 6, 8, 9, 12, 13, 16 and 18.

OMCH Structure

In order to carry out the activities described above, OMCH is modifying its organizational structure to strengthen internal management. As shown on the organizational table, the 4 program units have been expanded to 6 to give more attention to policy, planning and evaluation and to adolescent and child health. Once personnel have been reassigned, the policy, planning and evaluation unit will begin to monitor and evaluate OMCH programs. The emerging structure, with specific liaison responsibilities delineated for each unit, is expected to support individual staff members in developing expertise in specific program areas. The liaisons will enhance coordination with relevant programs, such as violence prevention and traffic safety, which are not under the direct management of OMCH. In 2001, OMCH will assign specific responsibility for a staff training and development plan to the administrative officer. Responsibilities for all liaison functions will be delineated in the to-be-developed operating procedure manual.

4.2 Other Program Activities

OMCH will continue to participate in the DC Healthy Tots Teens/EPSTD Program Task Force and the other committees and consortiums mentioned throughout this application. Most of the program work described in section 4.1 involves other partners, therefore, plans for that coordination are not repeated in section 4.2.

OMCH will continue to have responsibility for the Women's Health Initiative, under the leadership of an advisory board and coordinating committee. The board will continue to expand awareness of women's health issues, implement recent advances in prevention and promote coordination of health programs in DOH. Dedicated staffers will expand the Web page, develop and distribute fact sheets and brochures, and stage continuing education events. The expansion of the DOH breast and cervical cancer screening to include modified ovarian cancer screening for symptomatic women

will continue. During FY 2001, the advisory board will begin to examine issues related to standards of care for women.

4.3 Public Input

Members of the public provided input into several components of the needs assessment. In May 2000, a group of key providers and health advocates convened to review a set of quantitative indicators and to discuss overall maternal and child health needs. In June and continuing through July 2000, focus groups were convened, including providers and parents. In September 2000, the key providers and advocates will be reconvened for a discussion of the needs assessment findings and their implications for policy development and programming.

The complete needs assessment and application will be made available at the main public library, on the DOH Web site and distributed at conferences and advisory group meetings.

4.4 Technical Assistance

OMCH is requesting assistance on a plan for maternal and child health externally and internally.

V SUPPORTING DOCUMENTS

5.1 Glossary

GLOSSARY

Adequate prenatal care - Prenatal care were the observed to expected prenatal visits is greater than or equal to 80% (the Kotelchuck Index).

Administration of Title V Funds - The amount of funds the State uses for the management of the Title V allocation. It is limited by statute to 10 percent of the Federal Title V allotment.

Assessment - (see “Needs Assessment”)

Capacity - Program capacity includes delivery systems, workforce, policies, and support systems (e.g., training, research, technical assistance, and information systems) and other infrastructure needed to maintain service delivery and policy making activities. Program capacity results measure the strength of the human and material resources necessary to meet public health obligations. As program capacity sets the stage for other activities, program capacity results are closely related to the results for process, health outcome, and risk factors. Program capacity results should answer the question, “What does the State need to achieve the results we want?”

Capacity Objectives - Objectives that describe an improvement in the ability of the program to deliver services or affect the delivery of services.

Care Coordination Services for Children With Special Health Care Needs (CSHCN, see definition below) - those services that promote the effective and efficient organization and utilization of resources to assure access to necessary comprehensive services for children with special health care needs and their families. [*Title V Sec. 501(b)(3)*]

Carryover (as used in Forms 2 and 3) - The unobligated balance from the previous years MCH Block Grant Federal Allocation.

Case Management Services - For pregnant women - those services that assure access to quality prenatal, delivery and postpartum care. For infants up to age one - those services that assure access to quality preventive and primary care services. (*Title V Sec. 501(b)(4)*)

Children -A child from 1st birthday through the 21st year, who is not otherwise included in any other class of individuals.

Children With Special Health Care Needs (CSHCN) - (*For budgetary purposes*) Infants or children from birth through the 21st year with special health care needs who the State has elected to provide with services funded through Title V. CSHCN are children who have health problems requiring more than routine and basic care including children with or at risk of disabilities, chronic illnesses and conditions and health-related education and behavioral problems. (*For planning and systems development*) - Those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.

Children With Special Health Care Needs (CSHCN) - Constructs of a Service System

1. **State Program Collaboration with Other State Agencies and Private Organizations.** States establish and maintain ongoing interagency collaborative processes for the assessment of needs with respect to the development of community-based systems of services for CSHCN. State programs collaborate with other agencies and organizations in the formulation of coordinated policies, standards, data collection and analysis, financing of services, and program monitoring to assure comprehensive, coordinated services for CSHCN and their families.

2. **State Support for Communities.** State programs emphasize the development of community-based programs by establishing and maintaining a process for facilitating community systems building through mechanisms such as technical assistance and consultation, education and training, common data protocols, and financial resources for communities engaged in systems development to assure that the unique needs of CSHCN are met.

3. **Coordination of Health Components of Community-Based Systems.** A mechanism exists in communities across the State for coordination of health services with one another. This includes coordination among providers of primary care, habilitative and rehabilitative services, other specialty medical treatment services, mental health services, and home health care.

4. **Coordination of Health Services with Other Services at the Community Level.** A mechanism exists in communities across the State for coordination and service integration among programs serving CSHCN, including early intervention and special education, social services, and family support services.

Classes of Individuals - authorized persons to be served with Title V funds. See individual definitions under “Pregnant Women,” “Infants,” “Children with Special Health Care Needs,” “Children,” and “Others.”

Community - a group of individuals living as a smaller social unit within the confines of a larger one due to common geographic boundaries, cultural identity, a common work environment, common interests, etc.

Community-based Care - services provided within the context of a defined community.

Community-based Service System - an organized network of services that are grounded in a plan developed by a community and that is based upon needs assessments.

Coordination (see Care Coordination Services)

Culturally Sensitive - the recognition and understanding that different cultures may have different concepts and practices with regard to health care; the respect of those differences and the development of approaches to health care with those differences in mind.

Culturally Competent - the ability to provide services to clients that honor different cultural beliefs, interpersonal styles, attitudes and behaviors and the use of multicultural staff in the policy development, administration and provision of those services.

Deliveries - women who received a medical care procedure (were provided prenatal, delivery or postpartum care) associated with the delivery or expulsion of a live birth or fetal death.

Direct Health Care Services - those services generally delivered one-on-one between a health professional and a patient in an office, clinic or emergency room which may include primary care physicians, registered dietitians, public health or visiting nurses, nurses certified for obstetric and pediatric primary care, medical social workers, nutritionists, dentists, sub-specialty physicians who serve children with special health care needs, audiologists, occupational therapists, physical therapists, speech and language therapists, specialty registered dietitians. Basic services include what most consider ordinary medical care, inpatient and outpatient medical services, allied health services, drugs, laboratory testing, x-ray services, dental care, and pharmaceutical products and services. State Title V programs support - by directly operating programs or by funding local providers - services such as prenatal care, child health including immunizations and treatment or referrals, school health and family planning. For CSHCN, these services include specialty and subspecialty care for those with HIV/AIDS, hemophilia, birth defects, chronic illness, and other conditions requiring sophisticated technology, access to highly trained specialists, or an array of services not generally available in most communities.

Enabling Services - Services that allow or provide for access to and the derivation of benefits from, the array of basic health care services and include such things as transportation, translation services, outreach, respite care, health education, family support services, purchase of health insurance, case management, coordination of with Medicaid, WIC and educations. These services are especially required for the low income, disadvantaged, geographically or culturally isolated, and those with special and complicated health needs. For many of these individuals, the enabling services are essential - for without them access is not possible. Enabling services most commonly provided by agencies for CSHCN include transportation, care coordination, translation services, home visiting, and family outreach. Family support activities include parent support groups, family training workshops, advocacy, nutrition and social work.

EPSDT - Early and Periodic Screening, Diagnosis and Treatment - a program for medical assistance recipients under the age of 21, including those who are parents. The program has a Medical Protocol and Periodicity Schedule for well-child screening that provides for regular health check-ups, vision/hearing/dental screenings, immunizations and treatment for health problems.

Family-centered Care - a system or philosophy of care that incorporates the family as an integral component of the health care system.

Federal (Allocation) (as it applies specifically to the Application Face Sheet [SF 424] and Forms 2 and 3) -The monies provided to the States under the Federal Title V Block Grant in any given year.

Government Performance and Results Act (GPRA) - Federal legislation enacted in 1993 that requires Federal agencies to develop strategic plans, prepare annual plans setting performance goals, and report annually on actual performance.

Health Care System - the entirety of the agencies, services, and providers involved or potentially involved in the health care of community members and the interactions among those agencies, services and providers.

Infants - Children under one year of age not included in any other class of individuals.

Infrastructure Building Services - The services that are the base of the MCH pyramid of health services and form its foundation are activities directed at improving and maintaining the health status of all women and children by providing support for development and maintenance of comprehensive health services systems including development and maintenance of health services standards/guidelines, training, data and planning systems. Examples include needs assessment, evaluation, planning, policy development, coordination, quality assurance, standards development, monitoring, training, applied research, information systems and systems of care. In the development of systems of care it should be assured that the systems are family centered, community based and culturally competent.

Jurisdictions - As used in the Maternal and Child Health block grant program: the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau.

Kotelchuck Index - An indicator of the adequacy of prenatal care. See *Adequate Prenatal Care*.

Local Funding (as used in Forms 2 and 3) - Those monies deriving from local jurisdictions within the State that are used for MCH program activities.

Low Income - an individual or family with an income determined to be below the income official poverty line defined by the Office of Management and Budget and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.[Title V, Sec. 501 (b)(2)]

MCH Pyramid of Health Services - (see “Types of Services”)

Measures - (see “Performance Measures”)

Needs Assessment - a study undertaken to determine the service requirements within a jurisdiction. For maternal and child health purposes, the study is aimed at determining: 1) What is essential in terms of the provision of health services; 2) What is available; and, 3) What is missing

Objectives - The yardsticks by which an agency can measure its efforts to accomplish a goal. (See also “Performance Objectives”)

Other Federal Funds (Forms 2 and 3) - Federal funds other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program. These may include, but are not limited to: WIC, EMSC, Healthy Start, SPRANS, HIV/AIDS monies, CISS funds, MCH targeted funds from CDC and MCH Education funds.

Others (as in Forms 4, 7, and 10) - Women of childbearing age, over age 21, and any others defined by the State and not otherwise included in any of the other listed classes of individuals.

Outcome Objectives - Objectives that describe the eventual result sought, the target date, the target population, and the desired level of achievement for the result. Outcome objectives are related to health outcome and are usually expressed in terms of morbidity and mortality.

Outcome Measure - The ultimate focus and desired result of any set of public health program activities and interventions is an improved health outcome. Morbidity and mortality statistics are indicators of achievement of health outcome. Health outcomes results are usually longer term and tied to the ultimate program goal. Outcome measures should answer the question, “Why does the State do our program?”

Performance Indicator - The statistical or quantitative value that expresses the result of a performance objective.

Performance Measure - a narrative statement that describes a specific maternal and child health need, or requirement, that, when successfully addressed, will lead to, or will assist in leading to, a specific health outcome within a community or jurisdiction and generally within a specified time frame. (Example: “The rate of women in [State] who receive early prenatal care in 19__.” This performance measure will assist in leading to [the health outcome measure of] reducing the rate of infant mortality in the State).

Performance Measurement - The collection of data on, recording of, or tabulation of results or achievements, usually for comparing with a benchmark.

Performance Objectives - A statement of intention with which actual achievement and results can be measured and compared. Performance objective statements clearly describe what is to be achieved, when it is to be achieved, the extent of the achievement, and target populations.

Population Based Services - Preventive interventions and personal health services, developed and available for the entire MCH population of the State rather than for individuals in a one-on-one situation. Disease prevention, health promotion, and statewide outreach are major components. Common among these services are newborn screening, lead screening, immunization, Sudden Infant Death Syndrome counseling, oral health, injury prevention, nutrition and outreach/public education. These services are generally available whether the mother or child receives care in the private or public system, in a rural clinic or an HMO, and whether insured or not.

PRAMS - Pregnancy Risk Assessment Monitoring System - a surveillance project of the Centers for Disease Control and Prevention (CDC) and State health departments to collect State- specific, population-based data on maternal attitudes and experiences prior to, during, and immediately following pregnancy.

Pregnant Woman - A female from the time that she conceives to 60 days after birth, delivery, or expulsion of fetus.

Preventive Services - activities aimed at reducing the incidence of health problems or disease prevalence in the community, or the personal risk factors for such diseases or conditions.

Primary Care - the provision of comprehensive personal health services that include health maintenance and preventive services, initial assessment of health problems, treatment of

uncomplicated and diagnosed chronic health problems, and the overall management of an individual's or family's health care services.

Process - Process results are indicators of activities, methods, and interventions that support the achievement of outcomes (e.g., improved health status or reduction in risk factors). A focus on process results can lead to an understanding of how practices and procedures can be improved to reach successful outcomes. Process results are a mechanism for review and accountability, and as such, tend to be shorter term than results focused on health outcomes or risk factors. The utility of process results often depends on the strength of the relationship between the process and the outcome. Process results should answer the question, "Why should this process be undertaken and measured (i.e., what is its relationship to achievement of a health outcome or risk factor result)?"

Process Objectives - The objectives for activities and interventions that drive the achievement of higher-level objectives.

Program Income (as used in the Application Face Sheet [SF 424] and Forms 2 and 3) - Funds collected by State MCH agencies from sources generated by the State's MCH program to include insurance payments, MEDICAID reimbursements, HMO payments, etc.

Risk Factor Objectives - Objectives that describe an improvement in risk factors (usually behavioral or physiological) that cause morbidity and mortality.

Risk Factors - Public health activities and programs that focus on reduction of scientifically established direct causes of, and contributors to, morbidity and mortality (i.e., risk factors) are essential steps toward achieving health outcomes. Changes in behavior or physiological conditions are the indicators of achievement of risk factor results. Results focused on risk factors tend to be intermediate term. Risk factor results should answer the question, "Why should the State address this risk factor (i.e., what health outcome will this result support)?"

State - as used in this guidance, includes the 50 States and the 9 jurisdictions. (See also, Jurisdictions)

State Funds (as used in Forms 2 and 3) - The State's required matching funds (including overmatch) in any given year.

Systems Development - activities involving the creation or enhancement of organizational infrastructures at the community level for the delivery of health services and other needed ancillary services to individuals in the community by improving the service capacity of health care service providers.

Technical Assistance (TA) - the process of providing recipients with expert assistance of specific health related or administrative services that include; systems review planning, policy options analysis, coordination coalition building/training, data system development, needs assessment, performance indicators, health care reform wrap around services, CSHCN program development/evaluation, public health managed care quality standards development, public and private interagency integration and, identification of core public health issues.

Title XIX, number of infants entitled to - The unduplicated count of infants who were eligible for the State's Title XIX (MEDICAID) program at any time during the reporting period.

Title XIX, number of pregnant women entitled to - The number of pregnant women who delivered during the reporting period who were eligible for the State's Title XIX (MEDICAID) program

Title V, number of deliveries to pregnant women served under - Unduplicated number of deliveries to pregnant women who were provided prenatal, delivery, or post-partum services through the Title V program during the reporting period.

Title V, number of infants enrolled under - The unduplicated count of infants provided a direct service by the State's Title V program during the reporting period.

Total MCH Funding - All the MCH funds administered by a State MCH program which is made up of the sum of the *Federal* Title V Block grant allocation, the *Applicant's* funds (carryover from the previous year's MCH Block Grant allocation - the unobligated balance), the *State* funds (the total matching funds for the Title V allocation - match and overmatch), *Local* funds (total of MCH dedicated funds from local jurisdictions within the state), *Other* federal funds (monies other than the Title V Block Grant that are under the control of the person responsible for administration of the Title V program), and *Program Income* (those collected by state MCH agencies from insurance payments, MEDICAID, HMO's, etc.).

Types of Services - The major kinds or levels of health care services covered under Title V activities. See individual definitions under "Infrastructure Building", "Population Based Services", "Enabling Services" and "Direct Medical Services".

YRBS - Youth Risk Behavior Survey - A national school-based survey conducted annually by CDC and State health departments to assess the prevalence of health risk behaviors among high school students.

5.2 Assurances and Certifications

ASSURANCES -- NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have any questions, please contact the Awarding Agency. Further, certain federal assistance awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified. As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the assistance; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.
3. Will establish safeguards to prohibit employees from using their position for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. Sects. 4728-2763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to non-discrimination. These include but are not limited to (a) Title VI of the Civil Rights Act of 1964 (P.L. 88 Sect. 352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. Sects. 1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. Sect. 794), which prohibits discrimination on the basis of handicaps; (d) The Age Discrimination Act of 1975, as amended (42 U.S.C. Sects 6101 6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office of Treatment Act of 1972 (P.L. 92-255), as amended, relating to non-discrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to non-discrimination on the basis of alcohol abuse or alcoholism; (g) Sects. 523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. Sect. 3601 et seq.), as amended, relating to non-discrimination in the sale, rental, or financing of housing; (i) any other non-discrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other non-discrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. Sects 1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. Sects. 276a to 276a-7), the Copeland Act (40 U.S.C. Sect 276c and 18 U.S.C. Sect. 874), the Contract Work Hours and Safety Standards Act (40 U.S.C. Sects. 327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in flood plains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. Sects. 1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. 7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. Sects 1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers systems
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. Sect. 470), EO 11593 (identification and preservation of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. Sects. 469a-1 et seq.)
14. Will comply with P.L.93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. 2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by the award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. Sects. 4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply will all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

CERTIFICATIONS

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

By signing and submitting this proposal, the applicant, defined as the primary participant in accordance with 45 CFR Part 76, certifies to the best of its knowledge and belief that it and its principals:

- (a) are not presently debarred, suspended proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission or fraud or criminal judgment in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission or any of the offenses enumerated in paragraph (b) of the certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause, titled "Certification Regarding Debarment, Suspension, In-eligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions" in all lower tier covered transactions (i.e. transactions with sub-grantees and/or contractors) in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about-
 - (1) The dangers of drug abuse in the workplace;
 - (2) The grantee's policy of maintaining a drug-free workplace,
 - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
 - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a) above, that, as a condition of employment under the grant, the employee will-
 - (1) Abide by the terms of the statement; and
 - (2) Notify the employer in writing of his or her conviction for violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notify the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d)(2), with respect to any employee who is so convicted-
 - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended, or
 - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Division of Grants Policy and Oversight
 Office of Management and Acquisition
 Department of Health and Human Services
 Room 517-D
 200 Independence Avenue, S.W.
 Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant

or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. The requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also know as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18 if the services are funded by

Federal programs either directly or through State or local governments by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable Federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of American people.

5.3 Other Supporting Documents

MARILYN SEABROOKS MYRDAL
9805 Forest Grove Drive, Silver Spring, Maryland 20902
(301) 593-9610/593-9614 (Fax) mseabrooks@dchealth.com

QUALIFICATIONS SUMMARY

More than 20 years experience managing program development and service delivery in a local government setting. Expert knowledge of the Federal legislative and administrative grant review process and public policy issues affecting children and families, including health, education, and social services. Areas of special expertise include problem-solving, organizational development, interpersonal communications, special events programming and coordination, budget development and monitoring, applied research, capacity building, neighborhood revitalization, community development, technical writing, strategic planning, advocacy, collaboration and team building, social marketing, staff supervision, and conference planning and logistics coordination, and public policy analysis.

Interim Chief

Department of Health, Office of Maternal and Child Health
Washington, D.C. (May – Present)

Title V Coordinator/Director Women's Health Initiative

Department of Health, Office of Maternal and Child Health
Washington, D.C. (August 1999 – Present)

Program Analyst/Project Coordinator

Department of Health, Office of Maternal and Child Health
Department of human Services/Lashawn General Receivership, Child and Family Services,
Family Preservation and Support Services Program, Washington, D.C. (March 1995 – August 1999)

Patient Service Representative

Washington Clinic, Chartered, Washington, D.C. (July 1993 – March 1995)

Local Store Marketing Director

Morrison Corporation, Mobile, Alabama (October 1992 – September 1993)

EDUCATION

Master of Public Administration

Bernard M. Baruch College/City University of New York (1984)

Candidate, Masters of Arts

(Joint degree in Business Administration and History/Thesis Pending)
Georgia Southern College, Statesboro, Georgia (1977-1979)

Bachelor of Arts

Major: History; Minor: American Studies (special emphasis on historic preservation)
Georgia Southern College, Statesboro, Georgia (1977)

LINDA L. JENSTROM
1811 Biltmore Street, N.W.
Washington, D.C. 20009
(202) 234-0764

FIELDS:	Child Advocacy Public Health	HIV/AIDS Adolescence	Public Policy Human Sexuality
SKILLS:	Administrator Writer	Planner Editor	Advocate Conference Coordinator

EXPERIENCE:

Department of Health, Washington, DC, 1997 - Present.

Public Health Analyst for the Office of Maternal and Child Health (OMCH), Department of Health (DOH): Responsible for the development of policies and procedures governing the operations of the single state agency; responsible for administering portions of the Title V state Maternal and Child Health Block Grant, as well as related discretionary, categorical grants for improving maternal and child health. Participates in interagency negotiations, drafting the agreements and providing background documentation. Responsible for seeking new funding opportunities for maternal and child health initiatives, informing management staff when appropriate opportunities are identified. As needed, provides technical assistance in the areas of program development and grant writing. Develops position papers on current public issues related to family health, as well as monitors pending legislation. Represents OMCH on community planning and advisory bodies, including the Metropolitan Washington HIV Health Services Planning Council. Prepares relevant sections of the annual Title V Block Grant and Annual Report.

Appointed Acting Team Leader of the Community Services (CS) Unit April 27, 2000. In that capacity, provides administrative oversight and staff supervision for the OMCH Healthline, OMCH Client Transportation service, Use Your Power/Parent Council, Abstinence Education program, Adolescent Health Initiative, Home Visiting Initiative, and the Reduction of Perinatal HIV Transmission Initiative.

DHS/Commission of Public Health, Washington, DC, 1991 - 1997.

Director, Comprehensive HIV Intervention and Prevention Services (CHIPS) for Families, Office of Maternal and Child Health: Planned, promoted and coordinated all project activities, as well as provided administrative management. Conducted all contract negotiations, staff training, and budgetary review and monitoring. Evaluated service delivery and conducted community liaison activities. Provided consultation and technical assistance to other offices and administrations in the Commission of Public Health with respect to the development of policies related to families affected by HIV/AIDS. Provided direct supervision of the Health Care Coordinator, Program Assistant, and the Case Management Supervisor. Monitored service utilization patterns and client demographic and epidemiological information through a computerized multi-site, case management data retrieval system. Prepared funding proposals to assure the continuation of services.

DHS/Commission of Public Health, Washington, DC, 1988-1990.

Public Health Advisor, Office of AIDS Activities: Under the aegis of the Acting Chief, Office of AIDS Activities (OAA), and the Administrator, Preventive Health Services Administration (PHSA), assumed responsibility for the 1990 AIDS Prevention and Surveillance Cooperative Agreement between the D.C. Department of Human Services and the Centers for Disease Control (CDC) in the amount of \$4.8 million. Provided Coordination and liaison among four OAA divisions and between Commission of Public Health staff and CDC Project Officers and Grants Management Specialists.

Children's Hospital National Medical Center, Washington, DC, 1974-1988.

Associate Director for Program Development, Office of Child Health Advocacy: Planned and designed new child health care programs to meet hospital objectives. Guided working project development teams and prepared funding proposals. Monitored and analyzed local and national health care legislation as well as demographic and epidemiological trends related to health care service delivery and financing. Prepared background reports, position

Latroyal Smith
9701 Courthouse Rd.
Vienna, VA. 22181
(202) 442-9368

EXPERIENCE:

District of Columbia Government, Department of Health, 825 N. Capitol Str. NE,
Washington D.C. 20002

Research Analyst (10/99 to Present)

- Provide technical skill and expertise to develop the capacity of DOH to analyze and interpret data
- Develop, implement, and evaluate programs to reduce infant mortality
- Plan, formulate and conduct the research of DCHS
- Select groups to be studied from analysis of data
- Determine the availability of adequate data to support studies of particular target groups
- Coordinates the work of other departmental analysts
- Develops new analytic methods and/or modify existing ones to support studies
- Develops, in conjunction with other professionals, technical papers for presentation at conferences, use in the development of research proposals

Chesterfield Employment Services, 7325 Whitepine Rd., Richmond VA. 23237

Employment Specialist (6/96-8/99)

- Administer intensive employment training to small groups at job sites
- Measure the quality and quantity of job performance
- Develop and market employment programs based on individual assessments

University of Akron, Department of Public Administration and Urban Studies, 434 Main str. Akron, OH

Graduate Assistant (1/95-5/96)

- Provided administrative support for the Department of Urban Studies
- Duties included writing letters and memoranda utilizing personal computer software
- Conducted library research
- Formulated facilitation groups and organized workshops
- Trained incoming graduate assistants

EDUCATION:

University of Akron, 434 Main str., Akron, OH.

Master of Public Administration (1/95-5/96)

Virginia State University, Department of Public Administration, P.O. box 9062,
Petersburg, VA. 23806

Bachelors of Science in Public Administration

Petersburg High School, Petersburg, VA. 23805

Academic Diploma

Joyce Elizabeth Brooks
7829 12th Street, N.W.
Washington, D.C. 20012
Jbrooks@DCHealth.Com

CURRICULUM VITAE

EXPERIENCE:

Over thirty years of experience working in public health, including administration, program management, program development and service delivery. Skilled in supervision, public relations, public policy analysis, contracts and grant monitoring, training, evaluation, budget development and fiscal management.

PROFESSIONAL EXPERIENCE

Social Work Program Specialist

D.C. Department of Public Health, Office of Maternal and Child Health (January 1998 – present)

Serve as Interim Deputy Maternal Health Officer, and currently hold the position as Chief, Special Needs Unit. Provide expert senior advice to the Chief of the Office of maternal and Child Health.

Create and structure policies and procedures, and other pertinent administrative and policy matters on behalf of the Office. Direct, guide, and assist in the implementation of maternal and child health programs and services. Provide leadership, guidance and oversight in the implementation of maternal and child health programs and services. Provide leadership, guidance and oversight in the development of the Maternal and Child Health Strategic and Annual State Plans. Exercise managerial oversight and responsibility for the daily operation of the Office and staff of approximately one hundred and forty employees.

Coordinate and monitor the Maternal and Child Health State Title V Block Grant. Provide program oversight and direction to Public Benefit Liaison staff that manage and operate the Health Services for Child with Special Health Care Needs Clinical Program housed at the Public Benefit Corporation. Supervise seven professionals, as well as administrative staff within the Office of Maternal and Child Health's Special Needs Unit, including staff assigned to Genetic and Newborn Screening Services, Sickle Cell Initiative, Sudden Infant Death Syndrome Initiative, Hearing Screening, and Asthma Project.

Provide direction and expert advice in the development of new service programs and memorandums of agreement. Establish state/public/private partnerships. Work collaboratively with federal agencies, external agencies, national programs, District agencies, managed care organizations (MCOs), health maintenance organizations (HMOs), and community-based organizations in support of services for mothers, infants, children and families.

Serve as Interim Deputy Maternal Health Officer

Serve as Chief, Special Needs Unit

- 5.4 Core Health Status Indicator Forms**
- 5.5 Core Health Status Indicator Detail Sheets**
- 5.6 Developmental Health Status Indicator Detail Forms**
- 5.7 Developmental Health Status Indicator Detail Sheets**
- 5.8 All Other Forms**
- 5.9 National “Core” Performance Measure Detail Sheets**
- 5.10 State “Negotiated” Performance Measure Detail Sheets**
- 5.11 Outcome Measure Detail Sheets**