

# STATE TITLE V BLOCK GRANT NARRATIVE

STATE: **DC**

APPLICATION YEAR: **2005**

---

## **I. General Requirements**

[A. Letter of Transmittal](#)

[B. Face Sheet](#)

[C. Assurances and Certifications](#)

[D. Table of Contents](#)

[E. Public Input](#)

## **II. Needs Assessment**

### **III. State Overview**

[A. Overview](#)

[B. Agency Capacity](#)

[C. Organizational Structure](#)

[D. Other MCH Capacity](#)

[E. State Agency Coordination](#)

[F. Health Systems Capacity Indicators](#)

### **IV. Priorities, Performance and Program Activities**

[A. Background and Overview](#)

[B. State Priorities](#)

[C. National Performance Measures](#)

[D. State Performance Measures](#)

[E. Other Program Activities](#)

[F. Technical Assistance](#)

### **V. Budget Narrative**

[A. Expenditures](#)

[B. Budget](#)

### **VI. Reporting Forms-General Information**

### **VII. Performance and Outcome Measure Detail Sheets**

### **VIII. Glossary**

### **IX. Technical Notes**

### **X. Appendices and State Supporting documents**

## **I. GENERAL REQUIREMENTS**

### **A. LETTER OF TRANSMITTAL**

The Letter of Transmittal is to be provided as an attachment to this section.

### **B. FACE SHEET**

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

### **C. ASSURANCES AND CERTIFICATIONS**

The District of Columbia's signed assurances and certifications are on file at the offices of the Maternal and Family Health Administration. To obtain a hard copy, call Vernetta Daniels 202 443 9334.

### **D. TABLE OF CONTENTS**

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

### **E. PUBLIC INPUT**

Hard copies of the application submitted July 15, 2003 were distributed to the central and branch libraries in August 2003, as will be done with the current application. An informational session on the federal requirements for the Title V block grant was presented at the annual maternal and child health coordination conference held February 24, 2003. Over 1000 persons attended the conference; about 25 attended the session on Title V Understanding the Title V Maternal and Child Health Block Grant. Presenters informed participants how to access the Title V information Web site. Following the session, several attendees requested hard copies, which staff later mailed.

## **II. NEEDS ASSESSMENT**

In application year 2005, the Needs Assessment may be provided as an attachment to this section.

### **III. STATE OVERVIEW**

#### **A. OVERVIEW**

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 has gradually returned control in many areas to the elected mayor, who took office in January 1999. Since the District has experienced 5 years of balanced budgets, the Authority is to be disbanded at the end of FY 2001, restoring power to elected governmental officials. However, the District's fiscal and legislative authority will continue to be subject to Congressional approval. District residents do not have voting representation in Congress.

A marked and steady decrease in the number of births to residents also continued--from 11,806 in 1990 to 7,513 in 1999, a 36 % reduction. The birth rate declined from 17.5 in 1994 to 14.7 in 1998, compared to the US rate of 14.6. 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.

DC is a predominately African-American city. In 2000, the population was estimated to be 60% African-American, 30.8% white and 2.8% Asian/Pacific Islander. Latinos officially constituted 7.9% . 68% of the total 1999 births (5080/7513) were to African-Americans, and nearly 12% of births on which ethnicity was recorded were to Latinas (810 Latinas and 594 missing data).

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. 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.

/2002/ As data from the US Census 2000 become available, changes in the DC population during the 1990s can be compared with shifts in the US population. Several changes have implications for planning for the maternal and child health population. Although the official, unadjusted population count declined from 606,900 in 1990 to 572,059 in 2000, this decrease was considerably less than anticipated in the annual estimates--most recently 519,000 in 1999. The District 10-year change of --6% occurred in a metropolitan region that grew 16%. As of May 2001, the State Planning Office has not corrected estimates of population and subpopulations for recent years; therefore denominators for health measures used in this application have not been adjusted accordingly.

During the 1990s, the Latino population increased 37.4% to 44,953 or 7.9% of the entire population. 10% of District children are Latino, compared to 1 in 16 in 1990. "The influx of Latino families helps explain why the population of children in the District declined only slightly after dropping sharply for decades." Latino leaders say that this number continues to represent a considerable undercount.

The Asian/Pacific Islander population increased 39.4%--from 1.8% of the total population in 1990 to 2.8% in 2000. The District remains a majority African-American city (60%), but the numbers of both African-Americans and nonHispanic whites have declined. Perhaps one of the most significant population shifts is the migration of African-American families to the Maryland suburbs, resulting in a

loss of population from the primarily African-American eastern wards of the city, areas of the city where many of the Department of Health and other public programs are located.

A recently published analysis of the Immigration and Naturalization Service data on immigration in the Washington metropolitan area revealed that the metropolitan area has become the 5th most common destination area for immigrants into the US--a considerable increase from the previous decade. Compared with other regions of high immigration, recent immigrants to Greater Washington were more diverse, coming from 193 countries during the period 1990 to 1998, and dispersing themselves throughout the region, rather than settling in ethnic enclaves. Although 87% of immigrants live in the Maryland and Virginia suburbs, 2 of the 10 top immigrant destination zip codes are located in the District. The Adams Morgan-Mt. Pleasant area of Ward 1 received over 6500 legal immigrants from 130 countries during this 8-year period. The Petworth Brightwood Park neighborhood of Ward 1 was the destination of nearly 4400. Leaders from immigrant communities generally believe that the real numbers of immigrants are much greater than the official estimates.

Little systematic data are available to describe the health status of immigrants. A health needs assessment of African-born residents in the Washington DC metropolitan area undertaken by the Ethiopian Community Development Council found numerous problems with access to health care particularly for the most recent and lowest income residents. While the survey methods limit the extent to which results can be generalized, the lack of other data is such that the survey results are worth noting: 29% of adults reported being uninsured, and 40% said someone in their household was uninsured. 24% did not have a primary care home. 27% had never visited a dentist and 34% of women had not received a Pap smear test.

Compared with other states and the US, the District has a high proportion of persons living in poverty--the 1997-99 3-year average was 19.7% (SE +/-1.65), compared to 12.6 for the nation. However, the median income for 4 person families is somewhat higher in the District than in the US--\$62,281 compared to \$59,981--indicating the great disparities that exist among residents' income. 56.6% (+/- 3.8) of District children under 19 years of age live at or below 200% of the poverty level. Of that group an average of 11.1% (+/-2.5) were uninsured for the years 1996-98.

/2003/ After 5 years of balanced budgets, the federally-appointed, 5-member Financial Responsibility and Management Assistance Authority was dissolved in 2001, restoring power to elected governmental officials.

As a result of population shifted revealed by the 2000 census, new ward boundaries were resolved. The State Center for Health Statistics will report 2002 health data using the new boundaries. As additional analyses of 2000 census data are published, the increasing diversity of the District's population is highlighted. The foreign born component of the Black population grew steadily from only 1% in 1970 to 7.8% in 2000, the same proportion as in the US population. Overall, 13% of the population is foreign born, and 17% of the population older than age 5 typically speaks languages other than English at home, an increase from 10% in 1990.

#### Public Benefit Corporation

In March 1998, principals of the DC Health and Hospitals Public Benefit Corporation (PBC) and the DC Department of Health (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 \$3.5 million of the FY 1999 Title V funds and \$1million in FY 2000. The PBC, which was created in October 1997, continued efforts throughout FY 2000 to integrate the 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).

/2002/ Over the past year, District and Congressional leaders became unwilling to tolerate the increasing costs and declining utilization of the PBC facilities. City officials examined several options for the future of DC General Hospital, which has operated with increasing deficits and declining occupancy over the past decade. After an impasse between the mayor and the city council, the federally-appointed, 5-member Financial Responsibility and Management Assistance Authority, mandated by Congress in 1995 to establish fiscal stability in the District of Columbia, decided to privatize public safety net medical services. In May 2001, the Authority supported the mayor, overriding a unanimous vote in opposition by the city council, and negotiated a 5-year contract with the owners of Greater Southeast Community Hospital, Doctors Community Healthcare Corporation, an Arizona-based for profit, to provide a comprehensive range of emergency care and safety net services emphasizing primary care. The legislation establishing the PBC has been repealed, and Doctors Community Healthcare Corporation will operate the remaining services of the former PBC facilities.

Doctors Community Healthcare Corporation, through 1 of its 2 DC hospitals, Greater Southeast Community Hospital, formed the DC Healthcare Alliance to purchase patient care services from private providers. Greater Southeast Community Hospital is receiving city funds to establish a trauma center at its main facility and will provide other hospital-based services, and operate the DC General Hospital-based emergency services and outpatient clinics. Greater Southeast Community Hospital is the prime contractor. Subcontractors include Chartered Health Plan, a Medicaid managed care contractor, which is to provide the system-wide MIS, care management and primary care. The Nonprofit Clinic Consortium, whose 13 members are freestanding, not-for-profit primary care facilities located in and/or serving underserved areas, is also a participant. George Washington University Hospital is a subcontractor for trauma and other hospital-based care, and Children's National Medical Center will be responsible for pediatric safety net services, including hospital-based specialty care and the operation of the public schools school nurse program.

Eligible for enrollment to receive services without charge are uninsured District residents with incomes less than 200% of the Federal Poverty Level (FPL). They are to have access to the same level of services previously obtained at the PBC. This will bring eligibility for persons without minor dependents to the same level as the SCHIP-Medicaid program. Insofar as the specifics of this arrangement are being worked out and the transition is occurring as this submission is being prepared, it is not possible to describe this system in great detail. Transition plans have been complicated by staff retention problems and termination of DC General Hospital residency programs. Among the issues on which consumers and other interest groups have sought clarification are the numbers of and meeting the needs of the uninsured and underinsured over 200% of the FPL who were receiving services through the PBC. Many concerns have been raised about care for persons who cannot document residency, provision of pharmacy services and contract monitoring and quality improvement. The DOH is establishing a new administration, called the Healthcare Safety Net Administration, to be responsible for all oversight.

/2003/ Approximately a year after the award of the Alliance contract, the DC Primary Care Association (DCPCA) convened a community forum on May 16, 2002 and issued a community check-up document that compared commitments made by District officials with currently available information on services provided by the Alliance partners. Representatives of community provider and consumer groups, including DCPCA, noted that reports on enrollment, utilization and costs have not been made available by DOH or the Alliance as promised, making accountability difficult.

/2004/ Before the kinks in the restructured safety net system--the Alliance--were worked out, arrangements began to deteriorate due to the financial instability of the prime contractor's parent corporation. In November 2002, the National Century Financial Enterprises--an Ohio lender that supplied virtually all of the Greater Southeast Community Hospital's (GSCH) cash--collapsed, causing the hospital to immediately close pediatric inpatient and other services, reduce staff and take other crisis measures, and the parent corporation, Doctors Community Healthcare Corp. which had purchased the GSCH when it was forced into bankruptcy several years ago, eventually filed for

bankruptcy itself.

In order to keep GSCH open the bankruptcy court required immediate measures to control losses, 1 of which was to close the emergency room operation at DC General, which had remained open under the management of GSCH when the inpatient services were shut down. GSCH was to open a trauma center at its own facility but this never happened. 4 city hospitals--CNMC, George Washington University Medical Center, Providence Hospital and Washington Hospital Center-- protested to the bankruptcy court, arguing that emergency room utilization at their hospitals had already increased significantly with the closure of DC General Hospital and created a crisis throughout the city. The closure of the DC General emergency room, it was argued, would further exacerbate the situation.

District officials then negotiated a letter of agreement in which the hospitals agreed to drop their complaint in bankruptcy court and allow the conversion of the DC General emergency room into an urgent care center in exchange for an extension of presumptive eligibility, convening a task force on ways to more efficiently enroll eligible persons into Medicaid and the Alliance and several other measures intended to alleviate concerns of area hospitals. The DC General emergency room closed May 2, 2003 and the opening of an urgent care center (not 24/7) was announced. The presumptive eligibility issue is an important one for participating hospitals insofar as many clients enter the system via hospital emergency rooms. But from the payor's perspective, presumptive eligibility contributes considerably to cost.

The GSCH, the only acute care and emergency facility located in the southeast quadrant of the city, remains open with reduced services as the courts deal with the bankruptcy proceedings, including the issue of the \$70 million annual contract with the District to provide charity care. (The Alliance has operated in deficit and total Alliance funding is \$85 million for FY03, \$88 million for FY04.) GSCH also is experiencing problems in maintaining JCAHHO accreditation.

While the bankruptcy is being litigated, the DOH has assumed management of the Alliance, stepping into the administrative role previously played by GSCH. The extent to which the restructuring of the safety net has benefited those who use the system has yet to be determined. According to an analysis by the DC Primary Care Association: As of April 30, 2003, there were 24,225 people enrolled, 3,499 were presumptive (one month eligibility, no proof of residency and income submitted). 30,000 adults are estimated to be eligible. In year1, June 01 through May 02, 37,614 different people were enrolled at one time or another. 27,608 got full enrollment. 21,679 people received at least one service, and 10,406 were presumptive. Some significant numbers of those enrolled were either eligible for or enrolled in Medicaid.

The current arrangements are considered to benefit members of (and their patients) the NonProfit Clinic Consortium, generally small not-for-profit, neighborhood based providers. These clinics provide culturally and linguistically appropriate care to many of the city's residents who are uninsured but not eligible for Medicaid/SCHIP. In particular, Latino residents have voiced their support for the Alliance at various community forums. More than 20 specialty clinics and health services remain available on the DC General Health campus, operated by Alliance subcontractors: such as: Ear, Nose, and Throat (ENT) Clinic, Cardiology Clinic, Pediatrics Clinic, Dental Clinic, Gastro-Intestinal (GI) Clinic, Obstetrics and Gynecology Clinic, Surgery Clinic, and Urology clinic.

In October 2002 the DC Office of the Inspector General released the report of an audit of the Alliance contract. In addition to faulting the DOH for inadequate staffing to provide oversight and contract monitoring, and delineating a number of deficiencies in ensuring recipients of services met eligibility criteria, the Office of the Inspector General examined trends in emergency room utilization prior to and following the closure of DC General Hospital. Utilization at area hospitals had increased approximately 5%. Noting that utilization had increased throughout the US during this period, the report concluded that an increase in emergency room visits was likely due in part to the closure of DC General Hospital.//2004//

***/2005/ The Greater Southeast Community Hospital has since regained its accreditation, and***

**emerged from bankruptcy in May 2004. A new board of directors was formed. Officials reportedly expect the 160-bed hospital to show a profit or at least break even by fall as occupancy increases and length of stays decrease. This year the District entered into a MOU with Howard University to begin work for a new full service Level 1 trauma center with 200-300 beds to be constructed on the campus of DC General.**

**In October 2003 The Henry J. Kaiser Family Foundation released the findings from the DC Health Care Access Survey, 2003 <http://www.kff.org/minorityhealth/minorityhealth103003pkg.cfm>, a telephone survey of a representative sample of 1581 adults. Findings confirmed that 2 characteristics shape access and health status in the District. The population is majority (72%) "minority" (African American, Latino, Asian/Pacific Islander and other). And 36% of the population is low income (less than 200% of the federal poverty level, \$30, 520 for a family of 3). Latinos (55%) and African Americans (38%) are much more likely to be poor than are whites (20%). The report concludes that the Latino population is particularly vulnerable to lack of access to health services.**

**Due to the expansion of public programs in recent years, the DC population now has 1 of the highest rates of having health insurance in the US. 91% of those age 18 -- 65 have some form of health coverage, 70% employer based insurance, 11% Medicaid-SCHIP, 5% other and 4% DC HealthCare Alliance. (Although the Alliance is not strictly speaking an insurance program, enrollment in the program enables beneficiaries to access Medicaid managed care-like services at no charge.) Only 5% of women in the 18-65 age group lack some coverage. But although a relatively low proportion of the overall population lacks health insurance, disparities are considerable. For example, 32% of Latino adults lack insurance, compared to 10% of African Americans. Other findings include:**

**9% of the population either relied on an emergency room or reported no regular source of care, with 24% of Latinos being in this situation.**

**36% of uninsured persons rely on emergency room (21%) or had no regular source of care (15%).**

**45% of the uninsured did not have a medical visit in the last 12 months.**

**38% of all Latinos had no medical visit in 12 months.**

**Residents (24%) believe HIV/AIDS is the most critical health issue in the District.**

**40% of Latinos report having a problem communicating with providers due to language barriers.**

**Although 79% of residents rate their overall experiences in the health care system as excellent or good, the elderly, white and higher income residents report more positive experiences than others.//2005//**

#### **Devolution and Welfare Repeal**

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 report 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.

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.

/2002/ According to the District's Income Maintenance Administration (IMA), in July 2000, 16,677 families received TANF; approximately 11,000 family recipients were subject to the 60-month limit for

federally funded case assistance. IMA estimated that 4,700 of those families, having received assistance since March 1997, were most at-risk for reaching time limits in 2002. Not unexpectedly, these families have older parents (59% over age 30), and larger families (41% 3 or more children), but also have young children (half include children under age 7). The families tend to have little experience in work force participation; hence job development strategies have been less productive with this population. The District has yet to declare policy for providing assistance once time limits are reached.

In October 2000, the court ruled in approval of a plan to relinquish federal control of the District's child welfare agency, which resulted from the *LaShawn v. Barry* in 1989, ending a receivership in existence since 1995. First, the District must establish Child and Family Services as a cabinet level agency, reporting to the mayor, and enact legislation to give responsibility to Child and Family Services for both child abuse and neglect, the former having been the responsibility of the police department. Officials expect that these requirements will be completed by summer 2001. A new director, Olivia Golden, has been appointed to head the agency.

### 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. Poverty affects children disproportionately: 35% of children under age 5, and 35.9% of children age 5 to 17, live in poverty. 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. The most recently available estimates place the uninsured population at 17% in 1998.

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. 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. 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 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. 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.

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.

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.

//2004/ See the needs assessment attachment for more recent information on concentration of poverty and other disparities.//2004//

#### 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-approved FY 2001 budget of \$1,015,282,000 included 1241 FTEs. Approximately 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.

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 Maternal and Family Health Administration (Administration) 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.

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.

//2002/ The DC Healthy People 2010 plan was released in September 2000. An annual implementation plan (2002) is being formed. Other planning efforts that are underway include a 5-year health systems plan to guide the certificate of need program. A contractor is expected to complete the plan before the end of FY 2001. The Administration management is providing comments at various stages of plan development. The Safe Passages plan is updated annually with monthly performance measure review conducted at the deputy mayor level. For information visit <http://neighborhoods.washingtondc.gov/strategicplan/safepassages.pdf>

In January 2002, a public forum was convened to receive comments on the draft 2002 Annual Implementation Plan, Healthy People 2010 prior to its finalization ([http://dchealth.dc.gov/information/healthy\\_people2010/pdf/annualimplan.shtm](http://dchealth.dc.gov/information/healthy_people2010/pdf/annualimplan.shtm)).

/2003/ The DOH, as well as the entire District and nation, was greatly affected by the events and aftermath of September 11. On October 20, 2001 the first diagnosis of anthrax in a worker at the Brentwood Road postal station was confirmed and subsequently a public health emergency was declared in the District. DOH nurses, outreach workers and some support staff were redeployed to various tasks pertaining to triage and treatment of thousands of postal workers at the DC General, the District's former public hospital, which was closed for inpatient services in June 2001 as a result of a decision to privatize the health care safety net (See Section 1.4.). The anthrax control work continued through November, disrupting or delaying many on-going Administration efforts. The department also initiated disaster plan development in response to September 11, and public health officials were involved in planning with other officials in the metropolitan region as well as federal officials. Administration management personnel reviewed and responded to draft plans.

While public health officials were still responding to the anthrax emergency, the District Board of Education announced that students who were not in compliance with immunization requirements would no longer be admitted to school after January 25, 2002. For some years, school officials had taken no action to enforce compliance and there was a backlog of approximately 29,000 (42%) of the total 68,449 students whose immunization records were incomplete.

The DOH organized a response to immunize these students. The recently privatized community health centers were asked to extend their hours. Express clinics were set up with the help of the private sector. A 24-hour clinic was opened at DC General, and services were provided at selected schools. Once again, Administration and other DOH staff were temporarily reassigned to this work.

In February 2002, Dr. Walks announced his resignation as DOH director effective May 1. On March 25, the mayor announced the appointment of James A. Buford, MPH as interim director. Since February 5, Buford had been serving as the chief operating officer for the DOH. On June 19, 2002, he was sworn in by the mayor as acting director and awaits city council confirmation hearings later this summer. From April 1980 through May 1983, Mr. Buford served as the director of the DC Department of Human Services. Since then, he has served the District in several consultant assignments.

//2004/The FY 2004 proposed DOH budget is \$1,510,608,815, a 4.3% increase from 2003, including 1,319 FTEs, a 4.1% decrease from the previous year. Local funds account for about 1/3 of the total budget, the remainder being federal funds. Federal Medicaid payments constitute 84% of the federal funds. In addition to the overall increase in the 2004 budget, increased expenditures for Medicaid program and the health care safety net program created decreased funds for remaining public health programs.//2004//

***/2005/ The FY 2005 proposed DOH budget is \$1,667,168,819, an increase of 11.1% over the FY 2004 approved budget of \$1,500,159,447. This supports 1459 FTEs, a decrease from the FY 2004 approved level of 1468 FTEs. Nearly 59% of budgeted revenues are federal Medicaid payments, and another 9% is made up of federal grants. Local/state funds represent an increase of 12.5% over 2004.***

***In 2004 the District passed legislation to increase language access to government services and benefits. It requires government agencies to provide oral language services to limited English proficient persons, meaning persons whose primary language is not English as well as English speakers with low literacy skills. Each agency is expected to determine what type of oral language service (i.e. telephone language line, bilingual front-line staff) to provide by considering a number of factors, including the agency's size and the type of services it provides. Agencies are also required to provide written translations of vital documents into those languages spoken by the larger language populations served. Medicaid clients are being informed of their right to an interpreter (not necessarily a medical interpreter apparently) in any native language and the translation of all vital documents in Spanish, Vietnamese, Mandarin, Amharic and/or Braille. Print materials are to be designed at a 5th grade reading level.***

**On March 26, 2004 during the response to the public outcry following disclosure of the elevated lead levels in the city's water supply, Herbert R. Tillery was appointed interim director of the department. Mr. Tillery has served as deputy major for operations since summer 2002. Prior to that appointment he was executive director for the Center for Excellence in Municipal Management at George Washington University after retiring from the US Army with the rank of colonel. As interim director, he is charged with stabilizing the organization by improving the department's basic infrastructure, administrative functions and employee morale, until the search for a permanent director is completed. His appointment as interim director follows an assessment of the department by a new city administrator, Robert C. Bobb, appointed September 2003.**

**Several other changes in DOH leadership occurred this year. Of the 6 senior deputy director positions as of July 9, 4 are currently interim appointments, including the deputy director of health promotion to which the Maternal and Family Health Administration reports. And the other 2 senior deputies--the Medicaid director and the director of the Addiction Prevention and Recovery Administration--were appointed in early FY 2004.**

**As of June 2004 a number of proposed changes are underway to consolidate various administrative and other support systems throughout the department. Changes affecting Maternal and Family Health Administration services include consolidation of staff and physical space of the 1-800-MOM-BABY HEALTHLINE with other department-wide call centers and hotlines. The department's aim is to reduce or eliminate many of the existing call centers and hotlines, and create a centralized call center through which clients can access the full range of information and services provided by the department. The firm Winbourne & Costas has been retained in this effort. It is also expected that client and staff transport functions will be consolidated within the department, resulting in a more efficient use of resources. More centralized communications, procurement and personnel functions are expected as well.**

**These efforts follow the installation of the Procurement Automation Support System (PASS) in November 2003. Designated administrative staff meets weekly to work out the kinks in this new system, which is expected to expedite small procurements. Other automations in the wings are a new personnel support system and budget preparation system, both scheduled to go live August 2004. These will be followed by a new payroll system in 2005.**

**Administration staff was involved with departmental and city-wide health planning efforts. The District of Columbia Healthy People 2010 Annual Implementation Plan (AIP) 2002 was distributed to the public March 2002. Included in the report was a review of the progress made in attaining year 2002 targets in each of the 2010 focus areas. In mid 2003 DOH management decided to move to a 2 year period for charting and reporting progress. In spring 2004 the Biennial Implementation Plan (BIP) 2003-2004 was published ([www.dchealth.dc.gov/information/healthy\\_people2010/pdf/2003\\_2004bipfinal.shtm](http://www.dchealth.dc.gov/information/healthy_people2010/pdf/2003_2004bipfinal.shtm)). In addition to the overarching objective of reducing the infant mortality rate, several focus area objectives are directly related to Title V capacity and performance measures: breastfeeding, childhood immunization, early entry into prenatal care, teen pregnancy prevention and asthma hospitalization.**

**After forming several strategic partnerships, the DOH engaged in efforts to expand understanding of health issues among Latinos. Supported in part with a grant from the Centers for Medicare and Medicaid Services and consultants from the George Washington University School of Public Health and Health Services, the Council of Latino Agencies is conducting a household survey in Wards 1, 2 and 4 where the Latino population is concentrated. The interview is based on the behavioral risk factor survey items but has been adapted for the target population with input from a community advisory group. In addition to the survey, the Council of Latino Agencies has recently published several reports based on analyses of secondary data to describe changes in the Latino population and to highlight disparities.**

**The entire department, including the Administration, was involved this year in responding to 2 environmental hazards--a mercury spill and elevated lead levels in the water supply. On October 2, 2003 there was a mercury spill at Ballou High School. Before hazmat responders were called and not knowing that the substance was poisonous, students had spread it throughout the school building and on their clothing and personal affects. It took several weeks for officials to determine the magnitude of the exposure. The school was closed for several months for decontamination, and approximately 100 homes were tested, some residents being evacuated.**

**The adolescent health division staff participated in sessions to inform and educate students about the exposure. Sessions were conducted at the convention center, which served as a school site during the period the building was being decontaminated. Sessions were conducted over a 2-day period with an estimated 90% of students in attendance.**

**The Ballou High School is located in the Healthy Start target area. Healthy Start health educators and nurses were enlisted in the response to the exposure as well, working to distribute information from the DOH to families and residents in the area. Outreach staff participated in assigned administrative talks such as locating families and monitoring the exposure in the building. Several pregnant women with potential exposure were contacted by Healthy Start and offered information and follow up services.**

**This year the District experienced an environmental hazard with elevated lead levels in the city's water supply. In accordance with the Environmental Protection Agency (EPA) requirement that water authorities test tap water in 10--100 residences annually for lead, in March 2003, DC Water and Sewer Authority (WASA) expanded its lead-in-water testing program to homes with lead service pipes extending from the water main to the house. In January 2004, the public became aware that the results of the expanded water testing indicated that the majority of homes tested had water lead levels above EPA's action level of 15 parts per billion (ppb). A flurry of water testing in private homes, schools and child care centers ensued, often with inconsistent findings.**

**On February 26, 2004 the DOH issued a health advisory recommending that pregnant and lactating women and children under age 6 who lived in homes with lead service lines not drink unfiltered tap water. Letters were sent to addresses with known lead service lines. Healthy Start and other direct services providers responded with calls and flyers to clients and the general community with warnings to pregnant women and parents of young children to avoid drinking tap water, and in some instances bottled water was provided. The advisory was also distributed by the 800 HEALTHLINE.**

**Express blood testing sites were set up on the campus of DC General and several neighborhood clinics. And testing of individuals at school and child care sites where water testing revealed elevated lead is continuing. Since it is necessary for school children to have parental consent, this is proceeding slowly.**

**Prior to the issuance of the health advisory, the DOH asked CDC for assistance in investigating the health effects of elevated levels in water. The investigation is on-going, but preliminary findings reported in MMWR, March 30, 2004 <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm53d330a1.htm>. indicated that although lead in tap water contributed to a small increase in blood lead levels in DC, no children were identified with levels >10?g/dL, even in homes with the highest water lead levels. The longitudinal surveillance data indicated a continued decline in the percentage of levels >10 ? g/dL. The authors concluded that their findings suggest that levels exceeding the EPA action level of 15 ppb can result in an increase in the percentage of blood lead levels >5 ?g/dL. Homes with lead service pipes are older, and persons living in these homes are more likely to be exposed to high-dose lead sources.**

**Although the cause of the elevated water lead levels continues to be studied, a change in the**

**disinfection process from chlorine to chloramines that occurred in November 2000 and contributed to the deterioration of lead service pipes is now considered the likely primary cause. The advisory continues in effect.**

**The media attention and public outcry about water safety and release of information to the public brought increased attention to the more general problem of lead poisoning and elevated lead levels. The CDC investigation was hampered by the lack of compliance with childhood lead screening requirements. That is, although District regulations require annual testing of children under age 6 and reporting the results to a central registry, providers and labs tend to report only elevated levels, if they test at all. Thus there is no way to know whether a child has not been tested or whether the child was tested and tested negative. District law gives officials authority to take criminal or civil action against physicians and labs, but the law has not been enforced. See SP#3. //2005//**

#### Medicaid

Medicaid participation is high in the District of Columbia: 1 of every 4 residents and 2 of every 3 children. In Ward 8 where participation is highest, 42% of the residents are recipients. 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.

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. The request for proposals was finally issued October 2000. Deadlines for responses were extended several times with the results that as of May 2001, the contracts have yet to be awarded.

The Medicaid agency originally 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. Later the intent became 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. 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.

/2002/ The District SCHIP expanded the Medicaid program to include children, their parents/caregivers and pregnant women up to 200% of the Federal Poverty Level, with presumptive eligibility for pregnant women. Awards of the new round of Medicaid MCO contracts are scheduled to be announced in summer 2001. The solicitation contains a number of requirements that reflect a concern with the maternal and child population and present considerable opportunity for the Administration's involvement.

Each high-risk (criteria are not delineated) newborn is to receive a home visit by a registered nurse within 48 hours of discharge. The nurse is to make any necessary referrals and to provide either in person or telephonic follow up to assure that the family is linked to referral sources. Contractors are to authorize mental health services according to level of care criteria that reflect standards promulgated by American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, AMBHA and others, and that reflect current evidence of treatment efficacy. Criteria are to be approved by the Dixon Transitional receiver, now the Commission of Mental Health.

/2003/ In summer 2001, the court rescinded the receivership, which had been in effect since 1997, after the District agreed to a series of reform, including creating a cabinet-level Department of Mental Health.

Awards of the new round of Medicaid MCO contracts, having been delayed for some time, were finally announced in April 2002 with a startup date in August. In February 2002, the Administration was asked to participate in an interagency policy subcommittee convened by the Medicaid agency to develop policies and procedures to integrate Medicaid-reimbursable services across systems--public schools, child welfare, TANF, juvenile justice and health department. In addition to resolving long-standing problems that have adversely impacted upon the District's Medicaid budget, the subcommittee's work is expected to contribute to a case management and systems approach that spans agency boundaries.

***//2005/ See Health Systems Capacity Indicators and Performance Measures Sections, Medicaid and EPSDT-related measures for additional information.//2005//***

## **B. AGENCY CAPACITY**

The State Title V Agency Capacity

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

/2002/ The Administration's position authority for fiscal year 2001 is 140 full-time positions, 59 of which are supported by federal Healthy Start funding and 81 by Title V monies. As of March 2001, 28 of the 140 positions were vacant. The position authority represents a decrease from 144 in FY 2000. The proposed position authority for FY 2002 is 145. The Maternal and Family Health Administration received notice of 2 new grants in FY 2001, the Infant Mortality Child Fatality Review Capacity Building Project and the Newborn Hearing Screening and Intervention Grant. The latter will require the hiring of an audiologist, an administrative assistant, a nurse abstractor and a project assistant. Staff is currently responding to conditions of the grant award.

The DOH is still experiencing problems in retaining staff and in hiring qualified candidates. Although the length of time required to advertise, recruit and fill positions has diminished, there is still a substantial time period between when a qualified candidate is identified and when an official offer of employment is made. During this interval, many candidates have accepted other positions. Most of the Administration staff with clinical training--primarily nursing and social work--work in the Healthy Start programs. Several recent Administration hires are MPH-prepared.

Since 1998, most DOH components, including the Administration, have been relocated to the same physical space, which has enhanced the opportunity for coordination of services. Administration 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 system. Certain components of the Administration, 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.

/2002/ As of May 2001, 98% of DOH workers had email and Internet access. In April 2001 the email system was upgraded and is now a part of the citywide system. Additional training is scheduled for June 2001 to address the changes to the system. The Healthy Start project is being relocated to

facilities with email and Internet access.

To improve the efficiency of existing services, several improvements are in process and will be completed by the end of the current fiscal year. An automated call distribution system and the implementation of a HEALTHLINE database on a client/server network will modernize the mandated telephone services. Additionally, the establishment of databases for the Teen Mothers Take Charge project, Infant Mortality Child Fatality Review, and the migration of the Healthy Start database to Oracle constitute much needed improvements to the information system.

In spring 2001, 5 additional Administration employees were relocated off-site. Connectivity is being established at the site.

/2003/ During 2002, the Administration operated with a position authority of 142, with 19 vacancies as of May 2002, representing a decrease in the proportion of vacancies from the previous year. 6 new positions were created and filled as a result of grants starting at the beginning of the fiscal year. A few of the new hires have completed MPH degrees; several others have health-related qualifications. Somewhat fewer difficulties were experienced with recruitment this year, in part because of the availability of former PBC employees who could be transferred into the DOH.

The Administration began to experience difficulties due to the restrictions on space at the central DOH offices. Additional Administration employees were relocated off-site; the community services division and the special initiatives division staff are now housed approximately 5 blocks from the DOH headquarters. Several special needs division staff have been relocated there as well. Employees in this space have Internet connectivity, but the installation of computers and telephones has lagged behind the relocation and hiring of employees. Plans described last year to modernize the mandated HEALTHLINE services with the installation of an automated call distribution system and the use of a client/server network for the HEALTHLINE database were revamped when an analysis by Advanced Resources Technology, Inc. found that an automated call distribution system would not be cost efficient given the relatively low number of calls received. The vendor is, however, developing an online database to assist staff in handling information requests.

/2002/ The District of Columbia Healthy Start project in Wards 7 and 8 was awarded a 4-year grant of \$2,350,000 annually, CFDA 93.926E, Eliminating Disparities in Perinatal Health, beginning July 1, 2001. The District of Columbia (DC) Healthy Start project in Wards 5 and 6 was awarded a 4-year grant of \$1,350,000 annually, CFDA 93.926E, Eliminating Disparities in Perinatal Health, also beginning July 1, 2001. During the period July 2001 through January 2002, case management intake was closed as project staff closed out the previous grant, incorporated new protocols and recruited staff for the newly funded projects. All patient record formats, data collection formats and consent forms were submitted to legal counsel for HIPAA compliance review. Requests for admissions in Wards 5 and 6 were referred to Healthy Babies, a subcontractor. Start up was also adversely affected by the aftermath of the events of September 11th and a citywide crisis in immunization compliance, both of which required the temporary deployment of Healthy Start staff.

/2003/ All Healthy Start employees were relocated to another building on St. Elizabeth's Hospital campus. The relocation resulted in more spacious office, meeting and storage space and brings all employees from both projects to a common site. Although not yet installed, it is expected that these employees will eventually have Internet connectivity.

Work supported by 4 new grants began in FY 2002: a 4-year Newborn Hearing Screening and Intervention grant; a 3-year Infant Mortality Child Fatality Review Capacity Building Project; Establishment of a Birth Defects Registry, and a 3-year Addressing Asthma from a Public Health Perspective grant. These grants support a total of 6 new positions, several of which involve specialties new to the Administration (audiologist, respiratory therapist, MPH-level epidemiologist).

/2004/ During FY 2003, the Administration operated with a position authority of 158, 64 of which were Healthy Start-funded positions. As of May 2003, 18 of the 158 positions were vacant, with active

recruitment underway for 4. 11 of the 158 positions are assigned external to the Administration.

In FY 2003 Administration employees petitioned to and eventually voted to form a bargaining unit. The budgetary implications are described in Section V. Approximately 145 of the Administration positions will become subject to union scale wages, resulting in a nearly 8% increase in labor costs for FY 2004.

Space limitations continued to be challenging. The CSHCN officer and staff relocated their offices to a building housing other District agencies. The building is adjacent to the building housing the HEALTHLINE staff. The Healthy Start staffs, located on the campus of St Elizabeth's Hospitals, were connected to the Internet January 2003.//2004//

***//2005/ In summer 2003 the Administration engaged a consultant recommended by MCHB to work with management to complete the CAST 5 analysis. Following the preliminary work, senior staff and other managers completed a 2-day training and retreat September 10 and 11, 2003. The consultant also drafted a work plan with assignmentS for getting started on a 5 year strategic plan. Initial work was also done to establish a high-level citywide maternal and child health advisory board. But due to several staff resignations and the need to deal with unanticipated events, work did not commence until June when another consultant was retained to work with staff in an on-going process to produce a strategic plan by the beginning of FY 2005. Management intends to incorporate aspects of the plan and recommendations into the upcoming work on the 5-year needs assessment and plan. //2005//***

#### 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.

*//2002/ As of June 2001, 9 FTEs are allocated to the Administration's Children with Special Needs Unit. In addition to the special needs officer, who directs the unit, staff is in place in 4 positions: a sickle cell coordinator, an asthma coordinator, a newborn screening administrative assistant and a secretary. The status of the vacancies is as follows. The newborn screening director resigned in 2000. Recruitment is focusing on a person with the capability to combine the new newborn hearing screening with the newborn metabolic screening. An audiologist will also be recruited to staff the hearing screening program. Also vacant are positions for SIDS, Fetal Alcohol Syndrome and folic acid coordinator and a parent involvement coordinator. Finally, a senior analyst is being recruited to take responsibility for unit planning and monitoring functions, as well as to coordinate adolescent transition activities.*

*//2003/ Beginning in the spring of 2001 and continuing through 2002, the Administration has made a concerted effort to expand its capacity in the area of children with special health care needs. These efforts focused on obtaining grants, building the organizational structure, staff training and*

development of an advisory board. Several new grants were received during this period--for newborn hearing screening, asthma control, genetics services and establishment of a birth defects registry. Although other applications--medical home initiative, ready to work transition, insurance innovations, and oral health--did not yield awards, the planning that was done in completing the applications resulted in the commitment of resources from the Title V block grant to dedicate staff to develop related projects.

A team of seasoned consultants was retained to review the functions of the program, examine the core public health functions of government and Title V agencies, review federal and local legislative mandates for CSHCN programs, and take into account the current health care environment in the District and findings from needs assessment of CSHCN conducted in summer 2000. Specifically, the Federal Maternal and Child Health Bureau 10-Year Action Plan for CSHCN to accompany Healthy People 2010, was reviewed and analyzed along with the Safe Passages District of Columbia Children and Youth FY Action Plan and the Healthy 2010 Plan. The consultants compared the current functions and structure of the Administration's CSHCN program with those in other states and recommended an organizational structure to bring about the best possible fit between the available resources and the needs of the District's CSHCN population. They also devoted time to position descriptions, and individual staff training and development, and compiled a staff orientation manual.

Results in part include 4 documents, which are now guiding the work of the division. A blueprint for restructuring the special needs division with a special services branch, a newborn screening and genetics services branch, care coordination and ambulatory health services branch, and an office of systems development, monitoring and outreach is being implemented. A genetic services plan has been delineated, and notification of an award to implement the plan was recently received. A plan to achieve community-based service systems for children and youth with special health care needs has been developed. Finally, a process for incorporating plans for CSHCN into area disaster or trauma plans was prepared. Disaster planning issues were the focus of a session at the annual citywide maternal and child health conference February 20, 2002; additional work on the plan is pending the identification of funds. During the same time period, recruitment for the new grant funded positions brought needed skills into the division--an MPH-level epidemiologist, audiologist and certified health educator to name a few.

As of June 2002 the CSHCN division is staffed with 17 positions, of which 11 are currently filled. The aforementioned hearing screening and asthma prevention grants provided support for new positions.

Division staff members are active in an array of inter- and 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 Administration 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 the Administration 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.

/2002/ The Administration staff is finalizing a MOU with the Office of Early Childhood Development (OECD), which includes the DCEIP in its scope of cooperative activities. In addition to the database linkage, the MOU will support 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. The Administration will engage OECD staff in training, and the 2 agencies will jointly offer training for Head Start and pre-kindergarten programs, mental health

providers, child care providers and early intervention programs. They will continue to work on a universal health form to be used by schools and all other District early care and education programs. A protocol for reciprocal referrals and for the provision of client specific information is being developed to increase the participation of eligible children in Part C and other programs for children with special health care needs. The protocols also provide for the construction and implementation of a management information system to enable the tracking of clients across various services and programs administered by the 2 agencies. To ensure coordination, the Administration and OEDC are jointly funding a staff position to be located in OEDC.

/2003/ Although OEDC has not yet signed the MOU, several of the planned coordination efforts have been accomplished. Since spring 2001, an Administration staff member with a degree in early childhood development has been on informal detail as a shared position with and liaison to OEDC; that position was recently assigned to the CSHCN division. In spring 2002 the incumbent organized orientation sessions to acquaint all OEDC staff with the Administration's functions, programs and personnel, following by a session for Administration staff on OEDC. OEDC offers periodic training to its subsidized child care providers to help them to meet licensure requirements. These training sessions are now incorporating the dissemination of information from the Administration. For example, providers have been given multiple copies of the child passports for distribution and explanation to their clients. The development of the universal health form continues.

/2004/ The MOU with OEDC was signed June 2002 and extends through September 2003. The CSHCN division staff is working with the advisory board and consultants to finalize a 5-year plan (2000 -- 2005). The plan is available upon request. Components and activities of the plan are incorporated into Section IV C, D and E of this application.//2004//

***/2005/ Staff is working to modify the OEDC MOU to better define the responsibilities of the shared position and to update areas of coordination in accordance with current activities. Administration and OEDC staff continued to meet quarterly. For additional information on coordination, see NP#3.//2005//***

## C. ORGANIZATIONAL STRUCTURE

Following legislation in 1997 that established the DOH, a mayoral administrative issuance, followed by a departmental organization order, designated the Administration as the Title V state agency for the District of Columbia. 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.

/2002/ In February 2001 the Office of Maternal and Child Health was elevated to the status of an administration within DOH. Now called the Maternal and Family Health Administration (Administration), it continues to be under the purview of the senior deputy director of health promotion--a position that is also responsible for the Office of Nutrition Programs and the Office of Medical Assistance to Social Services. Marilyn Seabrooks Myrdal, the interim director, was appointed director under the title chief maternal and child health officer and is responsible for the operation and oversight of the Administration. Ms. Joyce Brooks served as interim deputy director from 1998 through 2000. Following that period, a deputy chief maternal and child health officer was hired and served from January-June 2001. The Administration is actively recruiting to fill the position again.

/2004/ In May 2003, William Hunter was appointed deputy director of the Administration. He has served as a consultant with the Administration since September 2001, working on special projects involving public-private partnerships. He has extensive experience in public management, including serving as city manager and assistant city manager. Among his new responsibilities is that of liaison with the Medical Assistance Administration (Medicaid and SCHIP) and the Medical Safety Net Administration (the Alliance). He is also conducting an assessment of the Administration's organizational structure.//2004//

***/2005/ Mr. Hunter resigned February 2004. The position remains vacant.//2005//***

Recent additions to the leadership include the appointment of a senior DOH employee to develop the women's health program. Ms. Barbara Baldwin brings to this position considerable experience in directing the breast and cervical cancer screening program and other health promotion efforts. In May 2001, Ms Eleanor V. Padgett, MSW, LICSW, was appointed maternal and child health community services officer, bringing more than 20 years of human services experience, most recently in a management position with the Department of Human Services, Child and family Services Division, North Capitol Collaborative, to the Administration.

In order to simplify content for readers, the former name of the Title V agency "Office of Maternal and Child Health" has been replaced with the current name "Maternal and Family Health Administration" or "Administration" throughout this submission. The current name is used regardless of year of reference, that is, some sections refer to activities of the Maternal and Family Health Administration, although it was officially the Office of Maternal and Child Health at that specific time.

The Administration is currently organized around 6 units or teams /2003/ now called divisions: data collection and analysis; family services; children with special needs; community services; policy, planning and evaluation; and adolescent health. Personnel have yet to be assigned to the 2 latter units. The administrative officer and staff are responsible for procurement, personnel and budget issues, as well as training and staff development. (See organizational table.) The division officers 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, 1993  
Administrative Officer, Bryan Cheseman, July 1999

/2002/ Adolescent Health, Colleen Whitmore, MSN, September 2001  
/2002/ Community Services, Eleanor Padgett, LICSW, May 2001

/2003/ Policy, Planning and Evaluation, Margaret Luck, SD, April 2002  
/2004/ Policy, Planning and Evaluation, vacant, February 2003

/2003/ Special Initiatives, Barbara Baldwin, MS, February 2002  
***/2005/ Special Initiatives, Felicia Buadoo-Adade, 2004 //2005//***

/2002/The organizational table (see attachment) shows the program responsibilities for the respective units. In addition to the 6 program units, the Administration contains various administrative and support functions, such as an administrative officer, public information officer and a human resources specialist. Both the Women's and Men's Health Initiative have dedicated directors and on-going programmatic activities. Active recruitment is underway to fill vacant positions. Administration managers meet weekly to report on the status of programs and to discuss any issue or program barriers. Information about the Administration and DOH is shared with management staff during these weekly meetings.

/2003/ FY 2002 saw several organizational changes, namely the establishment of a new division and the appointment of managers to 2 divisions. In February 2002, several initiatives in the Administration, men's health, women's health, perinatal HIV prevention, nutrition services and youth tobacco prevention, were merged to form a special initiatives division. The division's purpose is to conduct health promotion campaigns, implement special projects and provide technical assistance to agencies to improve the health and wellness of the maternal and family population of DC. Barbara Baldwin, formerly the director of the women's health program, was selected to head the special programs division. She also serves as the liaison to the DC Healthcare Alliance.

The 7 operational subdivisions of the Administration are now referred to as divisions, rather than

units. Colleen Whitmore, MSN brings experience as a nurse practitioner at Woodson High School Wellness Center and the project officer of the TANF-funded Teen Mothers Take Charge (TMTTC) to the position of adolescent health officer. She is responsible for school health, abstinence education and other health promotion and education efforts directed toward youth. The appointment of an officer to head this division represents an important step toward increasing program capacity.

Margaret Luck, SD was appointed MCH policy, planning and evaluation officer in March 2002. She brings extensive experience in planning and evaluation of international health and development programs to the position. As of June 2002, 2 key managerial positions remain vacant--the Title V officer and the deputy director.

/2004/ Dr. Luck resigned February 2003 and the position remains vacant. The Administration contracted with a consultant to conduct an assessment of, make recommendations on and prepare a work plan to further the development of the policy and planning division. The consultant will also identify stakeholder groups and organizations for inclusion in strategic planning and make recommendations on the establishment of a mayoral level advisory group. //2004//

***/2005/ Barbara Baldwin retired July 2003. Felicia Buadoo-Adade, RD was assigned in 2004 to lead the special initiatives division, which includes women's health, perinatal HIV and nutrition.***

***The Administration continued to participate in AMCHP, CityMatCH and APHA, sending staff to conferences and skills trainings sponsored by these professional organizations and making presentations on special projects. This year the maternal and family health officer was selected as the Region III representative to AMCHP and as an at-large representative to CityMatCH, thus expanding the Administration's involvement at the national level. //2005//***

The 2 federally funded Healthy Start projects, which are the largest sources of funding other than Title V, family planning and the home visiting initiative, 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 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 the section on special needs and other capacity respectively.

/2002/ During the current fiscal year until March 2001, the maternal and child health officer, the administrative officer and the data unit chief held monthly meetings with PBC managers to review required reports and coordinate efforts. The lack of a PBC distinct accounting attribute system for the intra-district funds from DOH continued to hinder efforts to track allocations and monitor utilization of services. The dissolution of the PBC and the privatization of safety net health services were described in the preceding section. Once the DOH was assigned to lead the restructuring process, there were rapid and numerous personnel changes in the PBC, and it became impossible to obtain cooperation with information requests.

## **D. OTHER MCH CAPACITY**

In addition to the staff capacity described in above, Title V funds support 10 of the 13 FTEs in the Administration data collection and analysis division. Officially formed in January 1998, the unit brought together staff from all surveillance systems under the auspices of the Administration, 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 division's capacity has continued to receive considerable attention. Beginning in FY 1999 and extending through FY 2000, on-going in-

service training was provided to ensure that staff has basic skills in the use of Microsoft ACCESS and related software. The unit chief continued to present in-service sessions 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 Use Institute and Data Speaks.

***/2005/ Several database linkages and integration efforts are underway in the Administration as well as throughout the DOH. They are described in various sections throughout this application.//2005//***

/2003/ Staff also used the University of North Carolina Data Skills Online, an interactive Web-based learning tool, to stay abreast of issues and resources to advance their skills.

Throughout the Administration, 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 Administration 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.

## **E. STATE AGENCY COORDINATION**

### **Intradepartmental Coordination**

During the reporting period, the Administration continued to work with the WIC and the immunization programs, both of which are located in the DOH.

/2004/ See annual report/annual plan NP# 11 and 7 for a description of activities. The Administration applies Title V funds to the support of the lead poisoning screening program, which is also supported by CDC and HUD grants. See annual report/annual plan section SP# 3. Coordination with the Addiction Prevention and Recovery Administration is described in the section below on HIV.

### **Coordination with Medicaid**

In addition to the coordination through the HEALTHLINE, 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. A 2nd and revised edition was printed and distributed in 2001.

/2003/ During fall 2001, Use Your Power! Parents leaders agreed to form an organization independent from the Administration and DOH.

/2004/ Other coordination activities are described in the annual report/annual plan section of this application.//2004//

***/2005/ Since August 2002 when the current Medicaid managed case contracts began, the Administration has been attempting to negotiate MOUs with the 4 MCOs. Draft language included sharing data, criteria for assigning clients to case management and protocols for prevention of HIV perinatal transmission, and assistance in locating noncompliant and lost to follow up clients. Administration management also attempted discussion with the Medicaid agency and the Medicaid MCOs about providing and being reimbursed for transportation for high-risk clients. Existing MCO transportation arrangements, largely dependent upon contracts with the private sector for van services and vouchers for taxis and Metro bus and rail, do not work well. Clients in underserved neighborhoods cannot get taxi service, and public transportation is often inconvenient especially for new mothers with several children in tow. The Healthy Start van service, however, has been popular with clients. Using drivers indigenous to the community and training them to provide information about basic health services to clients, as well as providing door-to-door services, has reportedly resulted in a high degree of client satisfaction. Attempts have yet to result in serious discussions.***

***Other areas in which the Administration attempted to pursue an agreement with 1 or more Medicaid MCOs to provide and be reimbursed for services included EPSDT screening at the 2 school clinics serving special needs children and Woodson Senior High School Wellness Center, and dental services at the special needs school clinics. //2005//***

#### Interagency Coordination

***/2005/Coordination with various agencies is discussed throughout this application-- in the overview as well as the annual report/annual plan sections. See performance measures dealing with CSHCN for description of activities with early intervention and child care agencies, and other agencies that serve children with special needs.//2005//***

#### Coordination with Public School System

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. Moreover, 10,560 (14.7%) had special needs, and 66% of special needs students were estimated to be eligible for Medicaid.

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. ? High schools have a registered nurse on duty at least 40 hours per week. The Administration has responsibility for monitoring compliance. During the reporting period, there was 100% compliance.

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 Administration 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.

/2002/ In FY 2000 the Administration school health liaison continued to have responsibility for the administration, policy development, evaluation and monitoring of the public health aspects of the school health program.

A memorandum of understanding, effective October 2000, was negotiated between the DC Public Schools and the DOH to establish 2 new school-based health centers for adolescents, one at a public school, and the other at a chartered school. Washington Behavior Health Care, Inc. was contracted to provide services consisting of health promotion, education, screening, social services assessment and limited referrals. No medical treatment is provided.

/2004/ Funding for the 2 school-based wellness centers was not sustained.//2004//

/2003/ The privatization of safety net health care in the District and the subsequent abolishment of the DC Health and Hospitals Public Benefit Corporation (PBC) in 2001, described in the state overview of this report, also affected the school nurse program, which had been operated by the PBC since 1996. Children's National Medical Center (CNMC) now has the contract for the school nurse program, and the Administration's role vis a vis the program has been altered. The DOH formed a new component, the Health Care Safety Net Administration, to support and monitor the new delivery system, and that administration is now responsible for contractual oversight of the school nurse services as well. A mayoral appointed commission is advisory to the Safety Net Administration. Although coordination between the Maternal and Family Health Administration and the Safety Net Administration is a responsibility of managers reporting directly to the director of DOH, the adolescent health officer has established a schedule of regular monthly meetings with CNMC management as well to ensure coordination at the operational level.

CNMC management has had to incorporate a new function and role--that of the school nurse-- which is very different from the roles of hospital and ambulatory clinic nurses, into its operation. New referral protocols and relationships with other departments of the medical center had to be established. Very few school health suites are equipped with computers, and nurses lack Internet access, making communication across schools and with service providers difficult. School principals were accustomed to decentralized decision making, which encouraged them to communicate directly with the nurses stationed in their schools. There have been impacts upon school budgets as well: Those schools that need or want nurse services in excess of the 20 mandated hours per week must pay from individual school budgets. The hourly amount charged by CNMC is greater than that previously paid to the PBC, contributing to difficulties in accepting the transition.

/2004/ The adolescent health officer continues to meet monthly with representatives of the school nurses program, operated under contract by the Children's National Medical Center. But since the contract is with another DOH entity, the Health Care Safety Net Administration, the Administration does not have oversight responsibility. In addition to the broad range of issues discussed, the adolescent health officer also participates in the immunization task force.//2004//

***/2005/ The relationship with the school system continues to evolve. The adolescent health officer is in daily contact with the school health nurses program regarding the reporting and resolution of urgent issues, for example, nurse coverage of schools to meet legal requirements, particularly at the beginning and end of the term. Schools have very different needs based upon location, enrollment, and socio-demographic characteristics of the***

**students and neighborhoods; the adolescent health officer is involved in working with school officials and the Children's National Medical Center in determining and meeting needs for special nursing skills.**

**Medically fragile children are increasingly mainstreamed. It is not uncommon for a child to transfer in without notice and the necessary resources in place to meet her/his needs for nursing support. Not all school nurses have recent training sufficient to meet specific, individual needs. It then becomes the responsibility of the adolescent health officer to work with those involved to find a solution. The adolescent health division is working with a group of experts and stakeholders to develop standards and protocols for the transition of medically fragile children into the DC Public School system.**

**See NP#3 for a description of grant-funded efforts to coordinate systems to promote early intervention.**

**The Administration is 1 of many government agencies participating in a private-public partnership to improve learning outcomes for young children through the alignment of programs for children ages 3-6 and transition between school and preschool. 10,000 of the 16,000 3-4 year olds are estimated to be enrolled in some type of early education programs, but fewer than 33% attend a program accredited by the National Association for the Education of Young Children. SPARKS (Supporting Partnership to Assure Ready Kids) is part of a national initiative of the W.K. Kellogg Foundation led by the National Black Child Development Institute. 3 large child development centers have been selected as anchor sites in each of Ward 1, 7 and 8. Each anchor is paired with an elementary school and staff and parents will adapt and implement preschool-school transition strategies affecting 1000 preschool children. The Administration's unique contribution to this effort will be to incorporate the 6 schools in the school health information automation pilot project. See NP# 7. //2005//**

#### HIV/AIDS Coordination

In March 2000, the Administration 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, Administration 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 2 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.

/2004/ The LCSW prevention case manager and 3 family service advocates conduct home visits to each new Healthy Start client to counsel and recommend HIV testing and to support initial and follow up testing, and if positive, treatment. The LCSW provides prevention case management to women who are positive.//2004//

/2003/ As a result of participation during 2001-2002 in a special CityMatCH project, the Perinatal Urban Learning Cluster, and later in the Association of Maternal and Child Health Programs (AMCHP)

Perinatal HIV Transmission Action Learning Lab, the Administration strengthened its relationship with its sister agency, the HIV-AIDS Administration (HAA), and the Ryan White Title IV grantee to develop a perinatal transmission policy for District providers and residents. To date, the District's official draft policy is based upon the 1995 US Public Health Service recommendations. The revised recommendations, issued in November 2001 have yet to be incorporated in District policy and practice. A Clinical Advisory Workgroup convened in March 2002 is expected to issue a report in June 2002. When the DOH director approves the report and recommendations, a mechanism is in place for distribution to and training of providers. Informational and marketing materials are also being designed for distribution to clients.

The Administration is also working on an agreement with its sister agency, the Addiction Prevention and Recovery Administration, (APRA) to use Healthy Start funds to provide pregnancy test kits for women who present for substance abuse services. To date, these clients have not been routinely tested for pregnancy and consequently their substance use related services are not well coordinated with reproductive health and/or HIV services. The extent to which these clients receive HIV counseling and testing has not been determined. (See Section 3.4 needs assessment for summary of Center for Substance Abuse Treatment's technical review of District substance abuse treatment services for pregnant and parenting women.)

/2004/ The agreement with the Department of Health Addiction Recovery and Prevention Administration (APRA) to supply pregnancy testing kits in order that women who present at APRA-operated facilities can be tested and if pregnant referred to Healthy Start or another case management program was signed March 17, 2003. Testing reportedly began in late June 2003. A similar arrangement with HIV-AIDS Administration for pregnancy testing at HIV testing sites has been submitted to the administrator to be finalized. Staff continued to work on the CityMatCH-supported project.

The DOH has yet to revise policy for control of perinatal transmission and the District's official draft policy is based upon the 1995 US Public Health Service recommendations! New draft policy recommendations expected to be acted upon by DOH officials in June 2002 were revised again to take into account the availability of rapid testing technology. In May 2003, a CDC representative met with the Clinical Advisory Workgroup and DOH staff to discuss the implications of rapid testing technology on perinatal HIV control. Following the discussions with the CDC representative, assigned staff from the Administration, the HIV/AIDS Administration, APRA and a panel of 6 District physicians prepared the March 2003 Final Draft Revised Recommendations for Universal HIV Screening of Pregnant Women. Recommendations include the incorporation of routine HIV testing as a normal part of prenatal care, including universal retesting in the 3rd trimester. Under the draft recommendations, providers can adopt "opt-in" or "opt-out" protocols. Clinical guidelines at [www.hivatis.org](http://www.hivatis.org) (currently [http://aidsinfo.nih.gov/guidelines/default\\_db2.asp?id=66](http://aidsinfo.nih.gov/guidelines/default_db2.asp?id=66)) are recommended. The March 2003 draft is being reviewed by the HIV/AIDS Administration prior to forwarding to the DOH director for action. //2004//

***/2005/ During FY 2003, the Administration and the Addiction Prevention and Recovery Administration (APRA) updated their MOU to better coordinate services for pregnant women needing or receiving substance abuse services. A jointly-funded coordinator position, located at the APRA Women's Clinic, is now responsible for carrying out action steps included in the MOU. She will be responsible for ensuring that reciprocal referrals across Administration-supported services and APRA services receive priority attention. According to this most recent arrangement, Healthy Start is no longer assigning a nurse case manager to the Women's Clinic. Healthy Start is continuing to provide pregnancy testing kits to the Clinic and to the Central Intake Registry so as to encourage women who present for services to be tested at admission and periodically thereafter. APRA has yet to supply information on the use of the kits, in particular the number of women who are aware of their pregnancy status because of the test. The MOU does not address HIV testing protocols.***

***DOH has not yet issued guidelines for the prevention of perinatal HIV transmission.***

**Administration staff continues to be involved with the CityMatCH Perinatal HIV Urban Learning Cluster. Coordination of policy across the several administrations appears to be problematic. In its most recent CDC Closeout Report 1999-2003 Perinatal Section, the HIV/AIDS Administration reported that 3 planning and coordinating bodies had been established for and continued to work on the perinatal HIV prevention: a DOH perinatal HIV workgroup, the perinatal HIV prevention clinical advisory group and the perinatal HIV prevention stakeholder committee, the latter including a subcommittee to represent the District in the CityMatch Learning Cluster and the AMCHP national capacity building project. In addition to their charge to address policy and planning priorities, these groups increased program linkages. //2005//**

#### Mental Health

/2002/ In March 2001, the Administration, through the Healthy Start program, set the stage for an important collaboration with the Commission on Mental Health (CMHS). The Parent and Infant Development Program (PIDP), located in the Children and Youth Services Administration, CMHS, provides outpatient evaluations, psychiatric, psychological and psychotherapeutic services to pregnant women, their families and children up to age 5. Its mission is to provide family centered, early intervention and treatment in order to prevent the development of emotional and psychiatric developmental problems, to provide social services and case management as needed to address developmental pediatric needs. Referrals come primarily from the community--child care centers and schools, teen mother programs, child protective services, substance abuse services and primary medical care providers. Children over 5 receive services at the adjoining Child and Family Therapy Center. The co-location of these services makes it possible to provide therapy to children in the same family at the same visit. PIDP has established teen parent groups in 3 schools.

PIDP has on-going referral relationships with many of the agencies with which Healthy Start also refers and with which the Administration has a relationship. Healthy Start and PIDP negotiated an agreement establishing a reciprocal referral arrangement, in-service trainings and, pending continued federal Healthy Start funding, co-location of a nurse case manager.

/2004/The MOU with the PIDP Department of Mental Health was signed February 2003 and Healthy Start funds were transferred to pay 2 LICSWs to case manage referrals of women with depression and/or related diagnoses. Healthy Start depression screening has been incorporated into on-going services. //2004//

**//2005/ The LICSWs were hired September and October 2003 respectively. 275 Healthy Start clients were screened for depression in FY 2003. 39% screened positive and 47% of the positives were referred for assessment and treatment. The Administration worked with Mary's Center for Maternal and Child Care to submit June 2, 2004 a grant application to MCHB for a 1-year program to introduce perinatal depression screening throughout the District of Columbia. //2005//**

**//2005/ The Administration collaborates with child welfare agencies and early intervention programs, through committees and task forces and as partners in grants. Such efforts are described under specific performance measures. See in particular NP# 3. In addition to the coordination with Child and Family Services Administration with regard to responding to hospital reporting of drug exposed infants, the District drafted protocols for the Child Safety Net Coordination System. Conceptualized in part to correct the situation found in cases reviewed by the Child Fatality Review Committee that the family was known to several agencies prior to the death of a child, the CSNCS is intended to systematize the coordination of various units of the DOH, the Child and Family Services Administration, Department of Mental Health and DC Public Schools in providing services to very high risk pregnant women, women with children, and families. The protocol sets out a process for determining the lead agency for a case family based in part on the presenting problem and eligibility, the roles of the lead and other agencies, and a sequential referral procedure. Funds have yet to be dedicated to this effort. //2005//**

## F. HEALTH SYSTEMS CAPACITY INDICATORS

This year the Administration was able to acquire and review these and other indicators data in a more timely way than has been the case in prior years. The MOU with the State Center for Health Statistics was signed in August 2003, and the data collection and analysis officer had access to the 2002 birth records and other data in April prior to block grant submission in July. Problems with quality data continue however. (See notes Form 11.)

Senior staff reviewed the most recent data and discussed implications in a meeting June 11, 2004. Examination of the 6 health systems capacity indicators shown on Form 17 suggests several limitations in capacity to serve women and children, especially low income children. In addition, limitations in the capability to obtain and interpret the data, combined with problems with the quality of the data pose barriers to the description and analysis of systemic issues.

1. asthma hospitalization rate -- The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 - 493.9) per 10,000 children less than five years of age - The most recent information reported is for 2003, with the rate 21.8. Since first reporting in 1998, the rate has varied widely from 91.2 (1999) to 21.8 (2003), considerably higher than the US rate.

The District has recently made considerable progress in describing asthma morbidity. Using funds from a cooperative agreement with CDC, Administration Control Asthma Now (DC CAN) staff completed a state asthma plan this year. Prior to finalization of the plan, an epidemiologic profile was compiled and published December 2003. The plan was distributed to stakeholders at a session of the citywide maternal and child health coordinating conference in February 2004. The profile presents data from 3 existing sources: the BRFSS, mortality files, and inpatient discharge data. Post 9/11, the District has been conducting an ongoing syndromic surveillance system on 7 syndromes, 1 of which is respiratory and includes asthma. 8 hospital emergency departments participate. Beginning in 2004, asthma is being coded as an additional syndrome. The DOH Bureau of Epidemiology and Health Risk Assessment (BEHRA) is responsible for this system. BEHRA also maintains a list of High Incidence Flag Day among emergency departments. A flag represents a higher incidence of a syndrome than normally would be expected. These days are reviewed for asthma as the primary diagnosis or chief complaint.

With the exception of the hospital discharge data, which are acquired by the DC Hospital Association from its member hospitals, the aforementioned components of the surveillance system are collected and maintained by the DOH. Maternal and Family Health Administration staff must access the data for analysis by going through sister agency managers.

The asthma epidemiologic profile examined asthma hospital discharges over the period, 1998 -- 2003 by 4 age categories (including children 1-4), gender, race, and zip code. Mortality data for the period 1995 -- 2000 were reported by ward and age category. BRFSS data from 1999 through 2002 were analyzed by gender, race, age category, income and education. In addition, DOH is developing an asthma data warehouse, which is expected eventually to include environmental surveillance and Medicaid cost and utilization data, emergency department visits, over the counter pharmaceutical use, school absenteeism, and workman's compensation data.

(See section Other Program Activities for more information on the state asthma plan.)

2. Medicaid enrollees < 1 year with at least 1 periodic screen -- The reported screening rate has increased from 34.8% in 1999 to 73.3% in 2003. Despite on-going litigation, attempts to install Internet based reporting systems and various efforts at provider education and enforcement of EPSDT requirements, the District has yet to reach mandated targets for EPSDT, although considerable improvement has been made. In all age categories, the participant ratio is much lower for the medically needy enrollees, who are fee-for-service, than for the categorically needy, most of whom are in managed care.

Compliance with EPSDT schedules is an important component of the Administration's Healthy Start and Teen Mothers Take Charge programs.

3. SCHIP screening - The District SCHIP and Medicaid are a combined program. The Medicaid enrollee screening rates include SCHIP beneficiaries.

4. Women > 80% Kotelchuck Index -- The percent of women giving birth who met this standard decreased from 77.4 in 1999 to 60.2 in 2002, a troubling trend. The high proportion of missing data on trimester of entry into prenatal care and number of visits continues to make it difficult to use this measure to assess capacity of the District's health care system. What it does seem to suggest is the need for more attention to measurement issues, especially vital records reporting.

5. Comparison of Medicaid, nonMedicaid and total MCH populations -- Of the 4 measures listed on Form 18, the Administration is able to report only 1, the Medicaid and nonMedicaid IMR. Because of the relatively low number of deaths, annual differences between the 2 populations are likely unstable.

6. The District's combined Medicaid/SCHIP covers eligible families of minor children (to age 22) up to 200% of the federal poverty level. As a result of Medicaid/SCHIP and the DC HealthCare Alliance (see overview section), the District has 1 of the lowest levels of uninsuredness in the US. However, as the various EPSDT participation measures indicate, the extent to which Medicaid beneficiaries are receiving services to which they are entitled is an issue.

Medicaid reported nearly 90,000 children enrolled in 2003, including those covered under the State Child Health Insurance Program.

7. Medicaid enrollees age 6 -- 9 receiving dental service -- The percent of Medicaid and SCHIP enrollees reported to have received any dental service during a year increased from 22.9% in 1999 to 31.5% in 2002, but declined again to 23.1% in 2003. Although the EPSDT participant ratio is generally increasing, gains are not being made in dental services. Oral health status and access to oral health services continue as serious problems for DC children and their families. See section Priorities, Performance, and Program Activities, State Priorities, oral health and NP#9 for a description of problems and interventions expected to affect receipt of oral health services.

8. Percent of State SSI beneficiaries less than 16 years old receiving rehabilitation services from the State Children with Special Health Care Needs program -- The Administration continues to be unable to report this measure.

9(A). Ability to access policy and program relevant information and data - As indicated on Form 19, the Administration has access to all of the listed electronic databases, 2 of which (PRAMS and birth defects surveillance) are located in the Administration's data collection and analysis division. The birth defects surveillance system is being installed (see NP#3) but several years may be required before the system yields data for planning and policy development purposes.

Although several staff members have the training and skills to obtain data from birth records, discharge data and Medicaid claims files for program planning and policy purposes in a timely manner, limited resources and the need to respond to urgent issues constitute formidable barriers to the generation of analytic reports on a periodic basis. As a result, the Administration and its community partners often lack data to anticipate and address policy issues and to plan effective interventions. For example, the information to complete Form 18 comparing Medicaid/SCHIP and nonMedicaid/SCHIP outcomes is not readily available. Quality of the data also poses limitations to analysis, for example, the proportion of birth records with missing data on trimester of entry into prenatal care.

9(B). Ability to determine percent of adolescents in grades 9-12 who report use of tobacco - Although the District public school system participates in the YRBSS, in 2001 the school level participation was

insufficient to meet sampling criteria. The 2003 survey had 100% school participation <http://www.cdc.gov/mmwr/PDF/SS/SS5302.pdf> and comparisons can be made with 1999 and prior years data. As shown in the table below, prevalence of reported tobacco use by both DC male and female students has decreased significantly since 1999.

#### Reported tobacco use in past 30 days

2003, total 14.7 (?2.0); females 13.2 (?2.4); males 16.5 (?3.3)

1999, total 23.3 (?2.5); females 21.2 (?2.9); males 25.9 (?3.6)

Source: CDC YRBSS <http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=Ci&cat=2&quest=504&year=Trend&loc=DC>

Insofar as the District may have a relatively high proportion of out-of-school youth, YRBSS data do not include this segment of the youth population. Nor is the private school population included.

The Administration's adolescent health division will use YRBSS data in developing its needs assessment and 5 year plan, which will then be incorporated in the 2006 Title V block grant needs assessment; however to date there has been no analysis and presentation of the most recent survey data. And although the Administration has some access to Pediatric Nutrition Surveillance System and WIC program data (see Form 19), no comprehensive analysis of these data has been conducted. Staff is working to allocate staff resources to analyze and use data from these surveillance systems and administrative databases in the upcoming needs assessment.

The Administration data collection and analysis staff has worked with sister DOH agencies, other District government agencies and several private sector organizations to link and in some cases integrate administrative data bases to track individual clients across systems as well as to generate data sets for planning, policy development and assessment. These efforts are described in the section on performance measures.

9(C).Ability to determine prevalence of obese and overweight children -- As described above, the District public school system participates in the YRBSS and therefore DOH can obtain estimates of the prevalence of overweight among adolescents enrolled in public schools grades 9 -- 12. As shown below, there has been no change since 1999 in the proportion of public school children grades 9 -12 who describe themselves as overweight. In addition to the limitations of the YRBSS noted above (9 (B)), self reported overweight is subject to considerable variation due to factors in addition to BMI.

#### Describe themselves as overweight

2003, total 13.5 (?1.9); females 11.5 (?2.1); males 15.5 (?3.0)

1999, total 12.7 (?1.5); females 11.3 (?2.2); males 14.2 (?2.2)

Source: CDC YRBSS <http://apps.nccd.cdc.gov/yrbss/QuestYearTable.asp?path=byHT&ByVar=Ci&cat=2&quest=504&year=Trend&loc=DC>

The District does not currently have an estimate of the prevalence of overweight and obesity for children.

## **IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES**

### **A. BACKGROUND AND OVERVIEW**

The Maternal and Family Health Administration continues to focus on the priorities established as a result of the priority setting process in June 2000, working within the DC Department of Health and in an environment that has undergone significant change over the past 4 years. The continuing restructuring of the District's safety net for the provision of health care for the poor, hospital closures and financial crises, the aftermath of September 11, 2001 and the increasing emphasis in public health on responding to potential bioterrorism, coupled with diminished tax revenues have affected the Administration's resources and activities. Throughout this period of responding to immediate demands and crises, the Administration has continued to focus on its 5-year objectives and long term priorities. Several of the priorities delineated in 2000 have moved beyond "establish" to "continue" or "strengthen and institutionalize".

In summers of 2001 and 2002, following the priority setting in June 2000, senior Administration staff convened to review the most recent performance measure and outcome data and trends. They were asked to discuss and reconsider their programmatic efforts directed toward these measures. In addition, Administration staff was involved with DOH-wide Healthy People 2010 and annual implementation planning and the development of a 5-year state health systems plan to guide the District's certificate of need process. A number of drafts have been compiled for stakeholder review; as of July 2004, the process continues.

In preparation for the July 2003 block grant report and application submission, staff and consultants considered the findings from the MCHB-sponsored national survey of CSHCN. Reviewing the DC data in comparison to US data as well as information collected as a result of activity on categorical grants, targets for the performance measures specific to CSHCN were set. These targets and subsequent program planning have been incorporated into this application. See the 2004 updates to the needs assessment section.

Preparation for the July 2004 block grant submission included convening a 1-day meeting of senior staff (division heads) to present and explain Forms 17, 11 and 12 indicators data. Staff discussed how to interpret trends and the relationship between on-going programs and health outcomes.

### **B. STATE PRIORITIES**

In this section of the application, the status of priorities set in June 2000 is described by level of service. More detailed information can be found in the sections on the national and state performance measures. The order in which priorities are listed does not indicate rank in importance. Priorities are numbered only for purposes of reference in discussion.

Infrastructure building: Priority 1: Establish (and institutionalize) a coordinating committee to strengthen system links among health, social services, juvenile justice, public schools, mental health, protective services and developmental disabilities.

In summer 2000, clients, providers and agency officials agreed that programs and services directed toward the 3 MCH populations were not well coordinated. This applied both to services across systems, for example, special education and health services, and to programs within DOH and other agencies. Integration of the Administration-managed and supported programs was also a need. The need to improve coordination applied to all MCH mandated populations, but was particularly acute for the special needs population. It was agreed the Administration could stimulate improvements in coordination by convening and establishing a citywide coordinating committee for special needs.

The CSHCN Advisory Board was formed in 2001 and has continued to function with a stable leadership and membership comprised of representatives from the public and private sectors and across social service and health care systems. It provided leadership to the planning for CSHCN described in this application and reviewed the SLAITS Children With Special Health Care Needs Survey data and the integration of the new national performance measures. During the years in which

the advisory board has been working to strengthen intersystem linkages, the systems themselves were undergoing changes, often making it difficult to "establish links". As described in other sections of this application, the primary traditional provider of direct care to CSHCN closed in June 2001, and the extent to which the currently evolving safety net system adequately addresses this population continues to be an issue. Nevertheless, several federal grant-funded projects within the Administration continue to work to forge and institutionalize links across systems. In addition, the grant-supported efforts to link reporting systems and data bases across metabolic screening, newborn hearing screening, birth defects surveillance and others are slowly overcoming policy, technical and administrative barriers. See national performance measures 1 -- 6, 12, and state measure 7.

Priority 2: Assess needs and resources to improve oral health among children and youth. Another infrastructure priority delineated in June 2000 was to improve the oral health of children and youth. Several measures reported in this application suggest the seriousness of problems related to lack of oral health services (See NP# 9 and SP# 2). Although Medicaid reimbursement rates were adjusted in FY 2003, and increasing recognition of the lack of accessible services has resulted in mobile dental services offered in a few underserved neighborhoods, efforts have yet to result in observable improvements in access to and utilization of oral health services. The Administration's plan, described in the 2001 application, to support a physical examination survey to develop estimates on oral health status and morbidity has yet to be implemented due in part to competing resource demands and the restructuring of safety net and school health services described in this application.

In September 2002 the DOH was awarded a 3-year innovation grant of \$450,000 annually from the federal Department of Health and Human Services, Office of the Assistant Secretary for Policy, Planning and Evaluation, to provide oral health services to children with special health care needs in partnership with the Children's National Medical Center, Howard University School of Dentistry and the DC Public Schools. Beginning with 2 schools dedicated to special needs children--schools at which the Administration uses Title V funds to support health services, the grant funds were applied in 2004 to renovating the medical/dental health suites and installing telemedicine capabilities in order to serve the oral health needs of these students, many of whom have severe physical disabilities. Children will be digitally linked to dentists at Children's National Medical Center who will provide oral screenings, consultations, and referrals. The project is projected to provide at least 3000 dental health sessions annually.

400 children are enrolled in Mamie D. Lee Elementary School and Sharpe Health School. Virtually all are special education students. More than 95% are African American. Both schools are located in federally-designated health professional shortage areas. Renovating and expanding the dental suites at the 2 schools with federal grant funds exposed unanticipated problems with the physical structure that had to be addressed before the upgrading began. Both buildings are old, and the plumbing and electrical systems were inadequate to support the new equipment. Additional telephone lines were necessary to support the telemedicine function. Contracting for the work, which involved the DC Public Schools, the Department of Health and Children's National Medical Center, was challenging. In addition to 2 dental chairs at Sharpe, a panoramic x-ray machine was installed to make services more accessible for wheelchair bound students. 1 chair was installed at Mamie D. Lee.

Dental suites at the 2 schools are expected to reach full capacity summer 2004, depending in part upon the results of staff recruitment. Grant funds, in combination with Title V funds, are being used to support dental services staff at the schools. As of April 2004, 2 hygienist positions and 1 dental assistant position were vacant. Telemedicine services are scheduled to begin June 2004. Grant funds are being used to retain The Lewin Group to provide technical assistance and operational support, including to maximize 3rd party reimbursement. The Lewin Group will also design, collect data for and report on the process evaluation. As delineated in the grant work plan, arrangements are being finalized with the Howard University School of Dentistry for residents to serve clinical rotations at the schools, thereby supplementing the staff and providing services to more children.

Mobile oral health services are beginning May 2004 to 2 District schools with high numbers of special

needs children--Taft School in Ward 5 and Prospect in Ward 4. Grant funds have been allocated to the Children's National Medical Center mobile dental unit to expand to these 2 schools.

In the 3rd year of the grant, FY 2005, services will be expanded to additional schools with children with special health care needs. The project includes a strong health professional training and development component, linking dental students with pediatric sub-specialties. HSCSN, Inc., which is the managed care contractor for children who are both SSI and Medicaid recipients, is agreeable to including the school-based dental services providers in its provider network; however, contractual arrangements have yet to be finalized.

A pilot school based sealant project got underway in October 2003. See NP #9 for description and results.

Population based: Priority 3: Establish universal newborn hearing screening; changed to: Strengthen universal newborn hearing screening and ensure the provision of follow up diagnostic, treatment and early intervention services.

In June 2000 the Administration recognized the need to expand newborn screening to include universal hearing screening. In 2001, the award of a MCHB grant enabled the Administration to hire a coordinator and support birthing hospitals in installing systems to implement hearing screening. Legislation mandating universal screening was enacted.

See NP # 12 for current status and plans for ensuring follow up and enhancing early intervention.

Priority 4: Work through health services delivery systems and neighborhood organizational infrastructure to reduce incidence of SIDS and other infant deaths.

Since the recognition of this priority need in June 2000, the Administration has dedicated 1 FTE to SIDS education. The SIDS education and outreach coordinator is located in the family services division and activities are integrated with Healthy Start outreach. Focus groups were convened in FY 2003 to review draft community educational materials, and a brochure targeted at African American families with a reading level of grades 4 to 6 was designed. A curriculum on SIDS and back to sleep, consisting of a 15 minute power point presentation and a manual for community providers to use in a 90 minute session was finalized. Educational sessions have been presented to Healthy Start staff, other Administration employees and community partners. These sessions will continue to be offered throughout 2005.

The Administration will continue to integrate SIDS efforts into the operation of the Safe Cribs project so that families that receive crib vouchers also receive the back to sleep training. (See Section Other Program Activities.) In addition to SIDS specific risk reduction efforts, much of the Administration's work is directed toward factors related to infant mortality, which continues to be a major concern to District public health officials. See NP # 1, 3, 13, 15, 18 and SP # 1, 2, 4, 5, 6.

Enabling services: Priority 5: Reduce unintended pregnancies and teen births.

Recognizing the relationship between unwanted pregnancies and adverse outcomes and that late entry into prenatal care is more prevalent among women who are ambivalent about an unintended pregnancy, the Administration decided in 2000 to refocus some outreach efforts on pregnancy prevention/postponement. Since then the Administration has acted on 2 funding opportunities to advance this priority. The Teens Mothers Take Charge, originally funded by District TANF monies but now supported by Title V funds, currently supports 4 community based service organizations to provide care coordination and enrichment services to teen mothers with the objective of preventing unintended repeat pregnancies and assisting young mothers to become self sufficient.

In Fall 2001 the Healthy Start projects were refunded for a 4-year period with an extension in focus from perinatal case management to interconceptional care. More than 330 low income African

American clients are now receiving case management for 2 years following birth. In addition to ensuring early entry into and sustained prenatal care, the project supports women in avoiding unplanned repeat pregnancies within that time period. The Administration will continue to support these 2 programs, tracking numbers of clients served, types of services received and outcomes and use the assessment results in improving, expanding or replicating these programs as other opportunities arise. While the organizational structures are in place to operate these programs and the available data indicate progress locally as well as nationally, continuation of efforts remains a priority. See also NP # 8, SP# 5, 7.

Priority 6: Increase the proportion of the population that is insured.

Although the Administration does not have primary responsibility for informing and enrolling eligible persons in Medicaid, including the expansion through Title XXI, sustaining the progress made in enrollment in and using managed care since 1998 continues to be a priority, particularly in view of budget constraints. Since the setting of this priority in 2000, the restructuring of the District's safety net has resulted in enrolling additional residents into a type of managed care (the Alliance services), a change from the pattern of receiving medical services from a public hospital and affiliated neighborhood health centers. While Alliance clients are primarily adults (because children, youth and parents under 200% of poverty generally qualify for Medicaid-SCHIP), enrollment and processing procedures continue to result in increased case finding and enrollment into Medicaid.

For several years the 800 MOM BABY HEALTHLINE played a role in informing the public and assisting residents with Medicaid applications; however, that formal arrangement ended when the Medicaid information and outreach contractor decided to set up a dedicated telephone information service. The Administration has continued to disseminate information about Medicaid-SCHIP and the Alliance at conferences, health fairs and through Healthy Start case managers, as well as the HEALTHLINE itself. Assisting women with public insurance enrollment and use is an important part of case management services provided to Healthy Start and Teen Mothers Take Charge clients. See also NP# 4, 13, 14 and SP# 2.

Priority 7: Monitor and assess the effect of welfare repeal and mandatory managed care on health status.

In 2000 the Administration found that additional work was needed to make the health systems culturally competency and to ensure that standards of care are appropriate to the populations served. To affect this, the Administration needed to increase staff knowledge about health financing, managed care delivery systems, quality improvement, Medicaid-SCHIP and to incorporate staff liaison work with Medicaid into its organizational structure and work plan. Although not formally assessed, it is likely these needs still exist. Depending on other assignments, Administration staff participates on various DOH task forces and committees that work to coordinate with and across Medicaid managed care organizations. See NP# 1, 3, 4, 6, 7, 3, 12, 15, and SP# 1, 2, 3, 5, 7.

Direct services: Priority 8: Elimination of racial, ethnic, immigrant status and class disparities in birth outcomes and child health status.

This overarching priority connects all 4 levels of services. Although a number of District health status measures show improvement, profound disparities continue to exist. Most of the national and District performance measures are affected by disparities. In recent years Title V funds have supported a dentist and dental hygienist to rotate between 2 public schools dedicated to students with special health care needs. The Administration also funds 3 RNs, 2 LPNs, a nursing assistant and 1.2 physician FTEs for the 2 schools. In FY 2004, the dental positions were funded primarily through another grant.

## **C. NATIONAL PERFORMANCE MEASURES**

Performance Measure 01: *The percent of newborns who are screened and confirmed with*

*condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

#### a. Last Year's Accomplishments

The District's newborn screening program, operated through the CSHCN division, tests for 7 metabolic disorders. 100% of births in District hospitals were reported screened. Positive test results were returned weekly to the coordinator by the lab contractor. The coordinator contacted the parent by telephone and faxed the test results to the attending physician. She maintained contact until the infant had been seen for confirmatory testing and inquired about confirmatory test results and the need for referrals before officially closing the case. The Administration revised the parent's pamphlet on metabolic screening to make it less clinical and more "reader friendly".

In FY 2003 there were 249 confirmed cases of G-6-P, a considerable increase over the 100 confirmed in 2001. In addition, 31 other presumed positives for a condition were confirmed positive. According to records maintained by the coordinator, 12 infants presumed positive were lost to follow up -- 3.1% of all presumed positives and inconclusive screens.

The sickle cell program coordinator worked with Howard University Hospital colleagues to prepare and submit an application to MCHB in July 2003 to establish a sickle cell project coordinating center; the application was not funded. In August 2003 the sickle cell coordinator began a partnership with a new not-for-profit--Faces of our Children, Inc., which in conjunction with Howard University Center for Sickle Cell Disease engages in a variety of educational and advocacy activities. These organizations collaborated with the DOH to observe Sickle Cell Awareness Month in September with a community art project in which 140 children participated.

1399 students in 14 District schools participated in sickle cell health education sessions, an increase of over 100% from the previous year. The sessions were led by the staff coordinator and used art as a medium to teach children about the disease. Age and culturally appropriate presentation materials, such as a coloring book, give-away incentives and video, were used.

In March 2002 the Administration received funding through a CDC cooperative agreement to establish a birth defects surveillance and prevention program. Goals included the determination of prevalence and incidence of birth defects and the improvement of access to early intervention services for infants with birth defects. An active case ascertainment system was designed using the hospital based discharge planners described NP#3.

The Welligent Corporation was contracted to customize the AURIS reporting system to integrate databases for the birth defects program, newborn hearing screening and the metabolic screening program and to allow users at many different locations access to data for viewing, updating and generating reports. A Birth Defects Advisory Committee was convened October 2002 with representation from hospitals, perinatologists, OB/GYN, genetic counselors, March of Dimes, and NOFAS.

#### b. Current Activities

The CSHCN division continues to administer the newborn metabolic screening program with follow-up as described above. Fact sheets on each of the 7 disorders screened for were developed and tested and are being distributed. When families are notified of positive screens, the relevant fact sheet is enclosed in the mailing.

During the current fiscal year DOH officials sought to shift the cost of newborn metabolic screening from DC appropriated and Title V block grant funds to 3rd party insurance reimbursement. Management of the District's combined Medicaid/SCHIP program, DC

Families, agreed to pay for its beneficiaries, although the Medicaid MCO contracts were not readjusted to take into account an additional required service. The DC Hospital Association objected to this change in policy, saying that each hospital should do its lab work, making the contract for screening unnecessary. As of January 2004, the Administration is paying for metabolic testing for uninsured infants only. As of June 2004, the lab has informed the CSHCN director that several hospitals' payments are in arrears.

The Mayor's Advisory Board on Metabolic Disorders was reinstated with new leadership after a hiatus of several years. 2 meetings were convened during the first 6 months of the fiscal year. The board is working with the hospitals to resolve concerns about payment and expanding testing beyond the current 7 conditions. The board is structured with 6 committees: expansion, data, laboratory standards, policy, finance, and counseling and education.

The sickle cell coordinator continues to make telephone contact with families of infants identified with sickle cell disease and sickle cell trait to discuss the meaning of the test and to ensure that they are aware of appropriate follow up. An informational brochure is mailed to parents whose infant is positive for sickle cell disease, and a different brochure for parents whose infant has been found to carry the trait. Families are referred to the Administration's contractor Howard University Center for Sickle Cell Disease for medical services.

Staff completed the design of and is distributing a fact sheet on sickle cell. The fact sheet is intended to show prospective parents the probability of bearing a child with sickle cell disease under various scenarios, and recommends testing to know one's status. Sickle cell education sessions continued to be presented to students at 14 District schools. Included among the students exposed to education on sickle cell were preschoolers enrolled in the United Planning Organization child care centers. Staff uses the Bobby Blood Cell's Big Adventure coloring book to engage the children.

Data from the newborn screening program is being used as a central data source for linking data with other administrative data sets for DC Kids Link, which is supported by the MCHB SSDI grant; however, problems with receipt of lab reports have yet to be resolved.

See NP# 3 birth defects.

### c. Plan for the Coming Year

The sickle cell project coordinator will continue to work with Faces of Our Children, the National Organization for Wellness of Children and Families with Sickle Cell Disease, Inc. (NOW-CFSCD), SCANCA--a parents' support group, and Howard University Center for Sickle Cell Disease to disseminate educational materials, organize blood drives and engage in policy and legislative advocacy. The project coordinator will continue to identify and develop informational materials for various District populations. She will enlist the support of 1 of the partner organization to convene a focus group to assist in determining the appropriateness of a book for teens, part of an on-going effort to locate materials on the prevention of sickle cell disease that will appeal to youth.

Staff will continue to work with the Mayor's Advisory Board to determine the benefits and feasibility of expanding the number of disorders included in newborn screening. Committees are working on laboratory standards, and education and counseling as well. Other on-going screening activities described above will continue through 2005.

The DC Kids Link will continue. The 3-year grant for \$100,000 annually for the period October 2003 through September 2006 was awarded to continue the development of DC Kids Link, a Web-based information and reporting system intended to serve multiple purposes--planning, monitoring follow up services for individual cases, measuring program performance, and

research. Although the module for metabolic screening for the Web-based surveillance system, which is intended to link birth, infant death, metabolic screening, hearing screening and other infant and child administrative databases, is ready, as of May 2004 metabolic screening files for the period 2002 -2003 had not been received from the lab contractor. Files are expected to be received on an annual basis. The company, NeoGen, was acquired by another company, Pediatrics, and management has yet to agree to provide electronic records, citing HIPAA restrictions. The data collection and analysis officer is attempting to resolve this issue so that the project can complete FY 2005 objectives.

See NP# 3 birth defects.

*Performance Measure 02: The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

**a. Last Year's Accomplishments**

The CSHCN Advisory Board was formed in 2001 to include representatives of AAP, Family Voices, MAA (Medicaid), and MCOs, as well as unaffiliated parents. Input from parents and families was solicited in all phases of the CSHCN needs assessment and strategic planning process. Several parents have been involved in the work of the board. A committee structure and procedures were developed and agreed upon. Plans were made to recruit a parent advocate.

**b. Current Activities**

As of May 2004 the parent advocate position has not been filled due to budget constraints. Several parents continue to participate in monthly meetings of the Advisory Board. Recruitment of additional parents and training and support of current parent representatives has been somewhat constrained by the inability to process a contract with the UDC Center for Applied Urban Research for, in addition to the collection of needs assessment and capacity data, administrative support of the advisory board. The CSHCN division continues to try to establish a parent-run information and education resource center and drop-in facility; however, grant writing to obtain dedicated funding has yet to be successful. Space has been obtained at the same building in which the division staff is located and furniture and equipment have been ordered. Without dedicated funding and staff, efforts to organize the DC Special Needs Family Network (DCSNFN) to reach out to families with special needs children to provide information and education, support, referral and coordination have not progressed.

**c. Plan for the Coming Year**

CSHCN staff will continue to work in FY 2005 to recruit, retain and support family participation in the advisory board, and to complete setting up the parents resource center. Efforts will be made in cooperation with the adolescent health division to recruit and engage representatives of special needs adolescents in the work of the advisory board. Staff will continue to seek federal funds to maintain the parent information resource center. Parents will be represented among stakeholder groups in setting priorities for the 5 year needs assessment.

Staff will continue to work with the advisory board, and to strengthen family representation and participation.

*Performance Measure 03: The percent of children with special health care needs age 0 to 18 who*

#### a. Last Year's Accomplishments

In 2001 the Administration and the CSHCN Advisory Board formally adopted the AAP medical home concept as an essential component of the CSHCN system of care. A medical home coordinator staff position was identified; however, the incumbent resigned in 2002. A replacement was later obtained, but she resigned in August 2003.

The medical home concept has been integrated into the CSHCN division's categorical grant-funded projects, such as newborn hearing and metabolic screening, asthma prevention and control, birth defects registry, and genetic services. Each of these projects has as a component working with families and providers to establish a medical home for the infant.

The Every Child Deserves a Medical Home training conference, December 6, 2002, brought together parents, pediatricians, internists, specialists and other health professionals to focus on the issues surrounding the development and implementation of high quality systems of care for children with special needs. Although 125 people registered for the conference, attendance was approximately 20% lower due to bad weather and a competing marathon.

The Administration established a newborn discharge planning system, which may contribute to the establishment of a medical home for newborns. As of May 2003, 5 of the 7 District birthing hospitals had signed agreements whereby the Administration was to provide at least \$75,000 to each hospital (to be renegotiated annually) to support a full time discharge planner--an RN or MSW.

The hospital based discharge planners were to visit every mother and infant prior to discharge for an assessment of the infant's post-discharge needs. The discharge planners were expected to obtain the parent's consent to conduct a home visit within 48 hours of discharge. The purpose of the home visit, conducted by an Administration nurse, was to assess the infant's environment and to link the family with needed health and social services. If the patient was a client of a case management agency, she was referred back to that provider for the visit. Medicaid-SCHIP recipients were referred to their Medicaid MCOs, which are required by their contracts to conduct home visits to high risk infants. The discharge planner was expected to ensure that a primary care provider had been identified for the infant and to make the infant's initial appointment, thereby taking the 1st step toward the establishment of a medical home. For those women who agreed to the home visit, the nurse conducted an assessment of the home environment and the infant, and assisted the family with obtaining health and social services. If the family was interested, there was a need, and resources were available, the nurse referred the client to a case management provider.

The Administration and the Children and Family Services Administration negotiated an MOU for joint case management of drug exposed infants.

See attachment for legislation on drug exposed infants, birth defects and data set linkage.

#### b. Current Activities

The CSHCN division is working to contract with Georgetown University to present early in FY 2005 a training for providers on maintaining medical homes for special needs children. This session is planned as part of a series of trainings on recognizing genetic disorders and will be the 1st follow up to the medical home training of December 2002. The session is expected to focus on the relationship among the primary care physician, the specialists, and the medical social workers in maintaining a medical home.

The staff person assigned to medical home work resigned and has not been replaced due to

limited funds. 2 Howard University social work interns assigned to the CSHCN division participated in the planning for the District's medical home initiative led by the DC Primary Care Association. That initiative is focusing on raising funds to upgrade and expand the physical capacity of the community health centers.

The Administration continued to implement the hospital-based discharge planner project. As of May 2004, discharge planners are in place at 4 of the 7 birthing hospitals--Providence, Georgetown, George Washington and Washington Hospital Center. The Washington Hospital Center planner started January 2004; the others in 3rd quarter 2003. Although Howard University Hospital signed the agreement a year ago, a planner has yet to be hired. Arrangements with Greater Southeast Community Hospital were disrupted due to the situation described in the overview section of this application.

The Administration's community services officer meets with the discharge planners at least bimonthly. The protocol has been agreed upon across hospitals. The discharge planner reviews the new mother's chart and visits her at bedside to deliver a welcome baby gift basket. She opens the basket and reviews the enclosed information, which includes the video First Years Are Forever, information on SIDS, WIC, breastfeeding and the 800 HEALTHLINE. The planner talks to and counsels the patient about the importance of a home visit, and completes an assessment form. She determines if there are unresolved insurance coverage issues, identifies the primary care provider and makes an appointment for the baby's initial visit. If the patient gives informed consent for the home visit, the discharge planner schedules it, or if an appointment cannot be scheduled at that time, arranges for the HEALTHLINE to call the client and schedule at a later time. Contact information for Medicaid MCO patients who agree to a home visit is forwarded to a DOH Medicaid agency coordinator who contacts the respective MCO and makes a visit request. Although the disposition of these referrals is not reported back, informal reports indicate that the MCOs are generally following through on their commitments to conduct post-delivery home visits.

See attachment for information on discharge planning results, birth defects, drug exposed infants and data set linkage.

### c. Plan for the Coming Year

After completing the final year of the 3-year birth defects surveillance and prevention grant, staff expects to apply for the next round of funding in order to continue installation and institutionalization of the system in the District.

Staff will work with Welligent to develop entry screens for PDAs for the newborn discharge planners to enter data at bedside.

The continuing medical education sessions on genetic services described above will be offered to community providers, hopefully in their own clinical settings. The genetic services grant staff will contract with Children's National Medical Center for a pilot project to offer genetic education and clinical consultations via videoconferencing to 2 neighborhood health clinics in the 7 metabolic disorders for which newborn screening is mandatory.

The genetic services grant staff will contribute culturally competent materials to the parents information resource center, including establishing and maintaining a Web site and publishing a quarterly newsletter. They expect to organize a genetics committee under the auspices of the advisory board on metabolic disorders

Newborn discharge planning, receipt of referrals of drug exposed newborns, birth defects surveillance and the other projects described above will continue and efforts will be made to enlist those birth hospitals and other providers that have yet to participate.

The maternal and child health officer is seeking additional funds to handle the increased caseload resulting from hospital reporting of drug exposed infants. Healthy Start nurses have reached and exceeded their caseloads, reducing the resources that can be applied to prenatal and interconception care coordination as required by the Healthy Start grant. Administration nurses funded through Title V also have high caseloads, and referrals to other case management programs in the city have stretched private resources. Although no funds have been appropriated, the maternal and child health officer has made it clear in interdepartmental meetings that resources from the Child and Family Services Administration FY 2005 budget will be required to add a registered nurse for home visiting-case management to accommodate the increased demand.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

#### a. Last Year's Accomplishments

Due to the high poverty rates in the District, a large proportion of children are eligible for the Medicaid-SCHIP program, which can enroll children and their parents up to 200% of the federal poverty level. This program generally offers good coverage for children with special health care needs; therefore, Administration efforts to provide information on and assistance with enrollment may have contributed to the achievement of this measure. (See NP# 13.)

Community health advocates engaged in numerous efforts to increase availability of and access to oral health, mental health and substance abuse services through Medicaid-SCHIP with little measurable success. The Administration staff worked with the CSHCN Advisory Board to clarify and expand the services available to those Medicaid-SCHIP CSHCN beneficiaries who received services through the mandated MCOs. Unlike those children who are both Medicaid and SSI recipients and have access to expanded services through a dedicated MCO, the services needed by many special needs children were sometimes difficult to obtain.

For example, as a result of the newborn hearing screening grant and the vision screening that was directly provided at selected sites, Administration staff identified gaps in private insurance coverage for the provision of hearing aids and other devices. In addition, fee-for-service Medicaid beneficiaries, such as children in foster care, can not easily obtain these devices. Staff had to make arrangements for individual children to obtain the necessary services and devices through other resources. During FY 2003, 10 families of deaf and hard of hearing children accessed the hearing aid loaner bank, which serves children 0-5 years of age. Hearing aids were purchased for 5 children.

Although contacts were made to determine what steps could be taken to mandate insurance coverage in these areas, an advocacy plan has yet to be put in place.

#### b. Current Activities

As a result of follow up with newborn metabolic screening and newborn hearing screening, CSHCN staff continues to work to ensure that eligible newborns are enrolled in public insurance programs. In those situations in which the coverage is inadequate for needs, such as infant hearing aids, staff arranges the necessary services. The grant-supported newborn hearing screening program continues to provide a loaner service for persons whose insurance does not cover the necessary devices.

### c. Plan for the Coming Year

Staff and the CSHCN Advisory Board will revisit plans delineated several years ago to work with Medicaid officials to improve comprehensive benefits and services, including strengthening the financing and reimbursement of services for children with special needs. In FY 2005, the Administration will continue current efforts described above.

*Performance Measure 05: Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

### a. Last Year's Accomplishments

The CSHCN Advisory Board, a group formed in 2001, continued to draw new members and met monthly after April 2001. During 2003, a consultant worked with the CSHCN Advisory Board to develop a committee structure and bylaws, and to clarify the functions of an advisory group. Representation included a broad range of service sectors, which served to promote a system wide perspective to committee work. Since multiple service sectors were represented, the board was uniquely qualified to work toward the coordination and integration of services to make them more accessible to the population. The board reviewed during summer 2003 the CSHCN division strategic plan, including findings from the national CSHCN survey, and assisted with delineation of objectives.

The Administration was awarded an 18-month early childhood comprehensive systems grant for \$100,000 annually from the MCHB August 2003. Directed toward the goal of ensuring that all children enter school healthy and ready to learn, the grant funds will support the Administration and a group of public and private partners in conducting needs assessment and planning activities and produce a strategic plan for coordination and integration of health and medical homes, mental health and social-emotional development, early care and education, parent education and family support.

### b. Current Activities

Work commenced on the early childhood comprehensive systems grant when budget authority was received February 2004. The scope of the target population has been expanded to include the prenatal period through age 8. Staff is working with the Mayor's Committee on Early Childhood Development and the Office of Early Childhood Development on implementation. Stakeholder representatives have adopted a vision statement, the first ever agreed upon across District child development agencies, and a conceptual framework. Coordination with 2 related Department of Human Services grant efforts--SPARKS and Early Learning Opportunities Act grant (ELOA)--is underway. A workshop presentation on the vision and framework, and future activities was made at the annual maternal and child health conference February 2004. Braintree Solution Consulting has been contracted to work with committees to produce a systems map of the District's early childhood system. In addition, the firm is facilitating and coordinating all planning conducted under the auspices of the grant.

The CSHCN Advisory Board continues to meet monthly. The chair and the CSHCN officer meet monthly. An executive committee meets quarterly to coordinate committee work. As mentioned elsewhere, the board's work has been somewhat hampered by delays in letting a contract with the UDC Center for Applied Research and Urban Policy. The board is currently working to refine the CSHCN 2000 -- 2005 plan, concentrating on the expected activities of the board. The chair and several other members have attended several MCHB trainings and meetings.

### c. Plan for the Coming Year

Once a contract is let with the UDC CARUP, staff will work with the contractor to compile information on current capacity of community based service providers and to identify service gaps that may be filled by the establishment of partnerships to bring or link additional services to underserved communities. Findings will be used to fold into the Administration-wide 5 year needs assessment and priority setting process.

Staff will continue work on the early childhood comprehensive care systems grant, working with Braintree Solution Consulting to complete a more detailed mapping of resources, funding, program capacity, and outcome tracking. The mapping is expected to articulate the relationship between federal and DC resources and to promote greater efficiency and effectiveness of program and financial management, and finally a plan for systems integration.

*Performance Measure 06: The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

### a. Last Year's Accomplishments

The Administration allocated a dedicated position for improving the transition of adolescents from pediatric to adult health care, secondary school to employment, training or higher education, and dependent to independent living. The Healthy and Ready to Work coordinator organized an Interagency Transition Workgroup, which included representatives from DC Public Schools, vocational counselors from the Rehabilitation Service Administration, Marriott Bridges, Internal Revenue Service, Medicaid, and Mental Retardation Developmental Disability Administration among others. An Interagency Transition Workgroup was organized and had its 1st meeting June 28, 2002. The coordinator worked with staff at the Mamie D. Lee School and Sharpe Health School to develop informational resources for and to engage students in planning for their transition to independent adults, including the maintenance of a medical home until her resignation in August 2003.

### b. Current Activities

The dedicated staff position has been vacant since August 2003. In the absence of staff, it was not possible to continue activities.

### c. Plan for the Coming Year

Pending the availability of funds, the Administration will recruit to fill the Healthy and Ready to Work coordinator position and proceed to regroup with plans.

*Performance Measure 07: Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

### a. Last Year's Accomplishments

Immunization coverage has not improved in recent years. Although the District's 2010 objectives for childhood immunization target children enrolled in licensed childcare facilities, head start centers, and prekindergarten classes, the development of the central immunization registry is key to ensuring all childhood immunization goals. Each new birth cohort is to be enrolled in the registry. The State Center for Health Statistics Administration transmits a data

file of agreed upon fields for all new births to District residents to the registry on a monthly basis. This ensures that all infants born to DC residents are entered into the registry, and that the status of reporting on their subsequent immunizations can be tracked. According to the District's Healthy People 2010 Biennial Implementation Plan, 76% of 1999 births had been enrolled in the registry by the end of 2001. The target for 2004 is 78% of the year 2003 birth cohort.

Care coordination for Healthy Start and Teen Mothers Take Charge clients and their infants included informing and educating clients on the importance of adhering to immunization schedules, making appointments and arrangements for immunization as necessary and tracking compliance. Both programs followed infants to at least age 2.

See section on other activities for information on immunization of the school population.

In 2002 and 2003, the Administration provided \$168,000 to the DOH immunization program to contract nurses to staff express clinics and other targeted immunization efforts. The Administration extended this support through FY 2004.

General information about immunizations was available to the public through the 800 HEALTHLINE. The information and referral HEALTHLINE was staffed 8:00 AM to 8:00 PM, Monday through Friday, and took voice messages during other hours. Among other types of information and referral requests, staff responded to queries about immunization schedules and disseminated information on the availability of express and community clinics where immunizations could be obtained. The HEALTHLINE was staffed with 7 FTEs, one of which was a Spanish-English bi-cultural RN. She was located at the Cardoza Unity Health Care Center 40% time, where she conducted information and referral for patients. She was telephone accessible for urgent requests in Spanish 24/7.

A multilingual worker with considerable experience in the Chinese American community conducted outreach to Asian and Pacific Islanders communities in addition to staffing the telephone service. The Administration provided funding for the Howard University Intercultural Health Access Program, established in 2002 to reduce linguistic and cultural barriers for DC residents seeking better healthcare and to enhance the ability of the DC limited English proficiency communities to gain full access to the available healthcare and social services, including immunizations.

## b. Current Activities

Care coordination for Healthy Start and Teen Mothers Take Charge clients and their infants continues to include informing and educating clients on the importance of adhering to immunization schedules, making appointments and arrangements for immunization as necessary and tracking compliance. Both programs follow infants to at least age 2.

The Immunization Task Force recently agreed to begin looking at immunization rates in the preschool population among which the coverage rates are low.

The HEALTHLINE continues to be staffed and to provide information as described above.

## c. Plan for the Coming Year

Compliance with immunization schedules will continue to be an essential component of the care coordination provided to infants through the Healthy Start and Teen Mothers Take Charge projects. The Administration does not expect to be responsible for the contract to provide nurses for express clinics in FY 2005.

In FY 2005 the Administration adolescent health officer will continue to participate in the Immunization Task Force convened by public school system officials and Children's National Medical Center. Staff will be deployed as necessary to respond to needs to staff express clinics prior to the start of school.

Information dissemination through the HEALTHLINE will continue.

**Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.***

**a. Last Year's Accomplishments**

In addition to the strategies applied at the national level to change values and behaviors contributing to teen pregnancy, various local efforts continued. The MCHB-supported abstinence education initiative grant assisted the Administration in expanding the capacity of youth services providers to offer modules from an abstinence-based curriculum I'm Worth the Wait, designed for adolescents aged 9 -- 14, and then modified in 2003 for ages 8 - 12. Initially focusing on Wards 5, 7 and 8, which have the highest numbers of school age youth, since 2001 the training has been expanded to community-based youth services organizations in all city wards.

The curriculum, which has been used for several years, consists of user-friendly, stand-alone units of instruction. The curriculum is rarely delivered in its entirety. Short pre-post test instruments accompany each module and the modules can be used in sequence or selected as needed.

In FY 2003, the abstinence education grant- supported activities included a first-time focus on Latino youth. A bilingual health educator worked with 6 organizations serving primarily Latino youth and 41 public and charter schools located in predominately Latino neighborhoods. The number of participating schools and organizations greatly exceeded the annual goal and 500 Latino youth were exposed to the abstinence curriculum. Staff in 14 organizations that provided services in other neighborhoods, primarily African American, were trained to deliver the abstinence education curriculum, reaching more than 400 children. The abstinence education coordinator met weekly with 2 3rd grade classes for mentoring and counseling. In total, 2591 students were exposed to at least 1 educational session.

A peer educator-theater troupe of 9 to 12 year olds, the Shaed Players, continued to be a component of the program. Players were selected from auditions and directed by interns from the Duke Ellington High School for the Performing Arts. Peer educators and members of the theatre troupe functioned as role models and acquired skills enabling them to handle classroom instruction sessions and informal rap groups. The theatre troupe presented skits and role plays of situations that promoted abstinence as the only way to avoid out-of-wedlock pregnancies, sexually transmitted diseases, and associated health problems.

Administration staff participated in the work of the DC Campaign to Prevent Teen Pregnancy. A major strategy of the campaign was to mobilize teens to guide and lead the work.

**b. Current Activities**

During FY 2004, 2 health educators supported by the abstinence grant continue to work with community and faith based organizations and schools to deliver units of the I'm Worth the Wait curriculum. As in prior years, a health educator meets weekly with 2 3rd grade classes. Peer education using the 12 member Shaed Players troupe continued.

A research protocol for a longitudinal evaluation, which will compare outcomes of children that complete the I'm Worth the Wait program with a comparison group, was resubmitted to and subsequently approved by the Department of Health institutional review board. The division of data collection and analysis will be responsible for carrying out the sampling and data collection protocol. The intervention curriculum will be introduced in 10 transforming schools, the name given to underperforming schools in low income neighborhoods in which several government agencies are concentrating resources. The target is 3rd graders--20 children per school, for a total of 200 children reached. 3rd graders in 1 comparison school will receive a health education curriculum.

Additionally, a new programmatic effort will be introduced to provide abstinence education during the summer using a 6-week implementation of I'm Worth the Wait. The summer program targets youth 8-12 years old at 3 community sites--Covenant House, Metropolitan Washington Boys and Girls Club and DC Parks and Recreation. A target of 30 youth in total will be reached through twice weekly, hour-long abstinence education sessions (12 sessions in total). The summer program begins in July and ends in August.

The abstinence education project director continues to represent the Administration on the DC Campaign to Reduce Teen Pregnancy. She is working with Media Education Entertainment on identifying targets and developing messages consistent with the Campaign's objectives.

The bilingual (Spanish-English) abstinence educator continued to work (until her resignation in June 2004) in conjunction with a school, a church and 2 community based organizations, all serving a primarily Latino population, to train trainers and to deliver the Spanish version of I'm Worth the Wait. Through March 2004, 213 youth have completed units of the curriculum. At Bell Multicultural Middle School, she worked with parents in an ESL class to give them training in reinforcing abstinence messages with their children. Their children were enrolled in I'm Worth the Wait.

See the description of Teen Mothers Take Charge, SP # 7, which may also contribute to a decrease in teen birth rates.

### c. Plan for the Coming Year

The Administration will continue to administer the abstinence education grant with increased federal funding. Activities described above will continue. In addition, the abstinence and sexuality education project director has planned a health and sexuality education program to be introduced in FY 2005 with Title V funds. The approach focuses upon training and technical assistance to community based and faith based youth services groups and selected schools and training centers to introduce an integrated health and sexuality curriculum for youth age 10 to 24. Education will be accompanied by staging health-related events in target neighborhoods. It is expected that the project will engage youth service providers and teachers in advocating for comprehensive health and sexuality education in the public schools. Additionally, the project director is hoping to enlist Media Educational Entertainment is developing a video to accompany the program. A similar 8-week health education curriculum was delivered to homeless adolescents enrolled at Covent House in FY 2004.

Pending recruitment of a bilingual health educator, technical assistance to Latino organizations will be expanded, resulting in an increase in the number of Latino youth who have completed units of the abstinence curriculum.

Teen Mothers Take Charge will continue as well

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

a. Last Year's Accomplishments

Plans described in previous applications to conduct a survey to obtain estimates for this performance measure did not progress.

The Administration used Title V funds in FY 2002-2003 to support a dentist, dental hygienist and dental assistant to provide services at 2 public schools dedicated to students with special health care needs. 400 students received at least 1 service. The extent to which sealants were included was not reported. In September 2002 the DOH was awarded a 3-year innovation grant of \$450,000 annually from the federal Department of Health and Human Services, Office of the Assistant Secretary for Policy, Planning and Evaluation, to provide oral health services to children with special health care needs in partnership with the Children's National Medical Center, Howard University School of Dentistry and the DC Public Schools. See preceding section on state priorities -- oral health.

The underutilization of oral health services continued to be a serious problem. In June 2002, the plaintiffs for the Salazar Medicaid class action filed a motion asking the court to enforce EPSDT services of the Settlement Order based on the fact that the majority of children were not receiving appropriate lead blood screenings and dental services. According to the FY 2003 Form 416 Annual EPSDT Participation Report, fewer than 19% (16772/89993) of children under age 21 received any dental services whatsoever. Within the 6-9 age group, 23% (4345/18867) received at least 1 preventive dental service.

b. Current Activities

In FY 2004 the DOH began a pilot school-based sealant project. Using remaining funds from the Community Voices Kellogg Foundation grant and several smaller grants, DOH purchased portable equipment and retained a dentist and hygienist to do examinations, cleanings and to apply sealants. 7 elementary schools were identified based on need and a cooperative school administration. Parents of 2nd and 3rd graders who were interested in the program signed informed consent forms.

The number of 2nd and 3rd graders in the 7 schools totaled 827; 49% returned consent forms and were subsequently given an oral exam, prophylaxis and fluoride treatment. The percent of children participating by school ranged from 29% to 92%. In 5 schools over 90% of the participants were African American; in 2 schools there was a significant Latino population, 49 and 74% respectively.

Of the 406 children examined, 50% had decayed primary teeth and 19% had decayed permanent teeth. They were referred to their managed care provider or to a clinic that accepts Medicaid payments. The extent to which these children were able to obtain treatment is not known. Only 12% had sealants. Sealants were provided to 72% (260/359) of children without sealants. In total 988 sealants were placed.

The experience with the school based sealant project confirms that there is a considerable unmet need/demand for both preventive and restorative dental services among public school children, a need that can be met only in part by a school based program. The continuation of the program is dependent upon resources. The District has not committed funds to this service, and the existing grant funds will soon be exhausted. The director is working with Administration staff and others to determine to what extent the children who received services were Medicaid/SCHIP recipients. This information will be used to present a case for reimbursement or funding by the Medicaid MCO contractors.

On June 21, 2004 a motion was filed on behalf of the plaintiffs to enforce the Salazar Settlement Order to make the District take more concrete steps to improve dental health. The filing used the DC 416 reports to document that utilization of dental services had declined since the settlement order. The plaintiffs documented that DC reimbursement rates are below the 25th percentile for the South Atlantic region--for a prophylaxis \$9, and a topical fluoride treatment \$8. Evidence was presented that the supply of dentists was inadequate in underserved areas, as well as in MCO networks. The filing also pointed to inadequate outreach about dental services to families and the need for provider education. Plaintiffs requested the court to order increased reimbursement rates and streamlining of claims processing. As of July 6, the court had yet to announce a decision.

See state priorities - oral health for status of implementation of innovations grant.

### c. Plan for the Coming Year

As noted in Form 11, the Administration continues to be unable to provide estimates for performance measure #9. Plans for a visual survey of a statistical sample of 3rd graders to be conducted by students from Howard University School of Dentistry, supported in part by the MCHB SSDI grant, were put on hold once again for FY 2004: however, the Administration is currently working on the language for the MOU. It is expected that the MOU with Howard University School of Dentistry will be signed before the beginning of FY 2005, and that implementation will begin in 2005. Residents will be credentialed by HSCSN, Inc. (the managed care contractor for Medicaid-SSI children with special needs) so that services can be reimbursed by Medicaid. Children's National Medical Center has agreed that Medicaid reimbursements will be dedicated to continuing the oral health services at the schools.

Grant funds are expected to sustain the program into FY 2006. Although the grant ends in 2005, carry over funds can be used in 2006. The Children's National Medical Center mobile dental unit will expand services to additional schools. The Administration is currently considering whether to continue direct subsidy of the dental services at Mamie D Lee and Sharpe schools and is encouraging DCPS and Children's National Medical Center to maximize Medicaid reimbursements.

*Performance Measure 10: The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

### a. Last Year's Accomplishments

Although the Administration has not developed specific programs to decrease morbidity and mortality due to crashes, the staff continued to support and was well-represented on the Child Fatality Review Committee, which investigated a range of infant and child deaths under its purview. The MCHB infant mortality review grant supported activities of the infant mortality review function of the Child Fatality Review Committee.

Plans to post annual reports on the DOH Web site have yet to be accomplished.

In June 2001, the Administration implemented an internal review committee to respond to the Child Fatality Review Committee (CFRC) recommendations made to the DOH. This internal review committee was formed out of the realization that although the requests for responses to the recommendations were directed at the Administration as the lead agency responsible for the development and implementation of a comprehensive system of health care for women and children in DC, recommendations were often beyond the scope of the Administration's power to implement. This internal review committee, which is chaired by the Healthy Start director, has 2

major responsibilities: 1st, to conduct record searches to determine if decedents or families scheduled for review are known to a DOH program, and 2nd to respond to the Child Fatality Review Committee recommendations. In 2003, the DOH Medical Assistance Administration (Medicaid agency) and the Safety Net Administration (Alliance) began to participate in DOH reviews, greatly expanding access to information about decedents' medical conditions and utilization of medical services. The review of the review committee continued its work through 2003, formalizing its mandate with monthly meetings and written protocols. As a result, DOH was able to gather information and respond to the CFRC recommendations in a more timely manner than was previously the case. Consistent participation of DOH components continued to be a challenge.

#### b. Current Activities

The contract with a database developer to design a Web-based infant and child mortality review reporting system to support the review functions, which was described in previous block grant reports, is not yet in place. The Administration continues to work on the process. Administration staff continues to participate in the activities of the Child Fatality Review Committee. The committee's plans to implement a home visiting component, which will consist of maternal in-home interviews and grief counseling and other services, have yet to get underway.

In January 2004 the Child Fatality Review Committee released a combined 2001 and 2002 Annual Report. For the 1st time since its establishment in 1992, the committee released the report at a joint meeting of the DC City Council human services committee and judiciary committee. During 2001-2002, 278 fatalities were reviewed. The extent to which the reviews covered all deaths that occurred in that time period was not disclosed. 10 of the deaths reviewed were due to automobile vehicle crashes, the major cause of unintentional injury deaths but a small number in comparison to the 68 homicides that came under the purview of the committee. There were no pedestrian deaths reviewed. None of the 6 children and youth who died as a result of automobile crashes in 2001 was wearing seatbelts. Interestingly, seat belt use was not noted in the investigations of the 2002 deaths.

To help prevent injuries resulting from crashes, infant car seats continue to be available to Medicaid beneficiaries free of charge and at reduced rental rates for others from the Department of Public Works and Project Safe Kids. HEALTHLINE staff provides this information in response to callers' requests. Healthy Start and Teen Mothers Take Charge clients are informed of the importance of using car seats and are told how to obtain them; in some instances a case manager or other staff person makes the necessary arrangements for a client to obtain and install the car seat. Likewise, the CSHCN care coordinator arranges for car seats for those families with which she comes into contact through the infant screening and birth defects programs.

#### c. Plan for the Coming Year

In FY 2005, the Administration will continue to participate in all activities of the Child Fatality Review Committee, as well as to provide information on the availability of infant car seats through the HEALTHLINE, the hospital discharge planners, and the Healthy Start and Teen Moms Take Charge care coordination.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

## a. Last Year's Accomplishments

Follow through on referrals to WIC has been a priority for Healthy Start case management staff for many years. 7 case management staff received training in promoting breastfeeding, receiving 16 hours of training from WIC during June-July 2003. Several workers were subsequently certified as peer counselors by WIC. Refresher sessions were presented to 12 Healthy Start staff. Healthy Start case management staff continued to incorporate information about and counseling on breastfeeding to clients. Teen Mothers Take Charge clients were exposed to information on breastfeeding. WIC staff organized a breastfeeding support club in which several teen mothers participated.

The Administration formalized its coordination with WIC through the development of a MOU. Data sharing was included as well as other coordinative efforts, such as the staff training described above. The MOU was signed May 12, 2003 and extended through September 2003 with automatic renew for an additional 1-year term with optional periods.

In 2002, 40% of women enrolled in WIC initiated breastfeeding; 21% continued breastfeeding up to 6 months, but only 12% continued past six months postpartum. Strategies delineated by WIC management for the Healthy People 2010 Biennial Implementation Plan 2003-2004 were to:

- ? Use registered dietitians, lactation consultants, and peer counselors to educate WIC families about the importance of breastfeeding;
- ? Use creative, culturally appropriate education strategies that include computer-assisted learning units, such as kiosks;
- ? Train all WIC staff that has contact with clients in basic breastfeeding, knowledge and counseling skills.

## b. Current Activities

The now 4 contractors for Teen Mothers Take Charge are being encouraged to have staff trained to support clients' breastfeeding. Healthy Start case management staff continues to counsel clients on the benefits of breastfeeding and to refer clients to WIC for services.

The Administration staff formed a Breastfeeding Task Force in April 2004 to coordinate with citywide and national efforts around breastfeeding. The District WIC agency is a grantee of the WIC Loving Support initiative to promote breastfeeding. Other efforts have been organized under the auspices of the African American Breastfeeding Alliance and the Howard University Hospital BLESS initiative, funded in part by WIC and the US DHHS Office of Women's Health. Participants in these efforts are preparing for the launch of the national breast feeding campaign in summer 2004, which is now reportedly under attack from the formula makers industry.

The Administration is benefiting from several components of the BLESS initiative. Its employees were among the 106 participants in a citywide conference Recapturing the Breastfeeding Tradition: The State of Breastfeeding in the African-American Community sponsored by Howard University September 26-27, 2003. BLESS and the African American Breast Feeding Alliance presented a workshop at the annual maternal and child health coordinating conference February 2004. BLESS, the African-American Breastfeeding Alliance and WIC established the Howard University Hospital Breastfeeding Drop-in Clinic, which is staffed by lactation consultants and is open 2 days weekly. Healthy Start case managers are being informed of this referral resource.

In December 2003 Administration staff began to work with BLESS to engage prospective fathers and fathers in support of breastfeeding. A video is being shown by the Healthy Start male outreach workers to their clients. Designed to decrease 1 barrier to breastfeeding--male

attitudes and values, the video shows African American men discussing their concerns about breastfeeding.

The Administration's staff task force on breastfeeding is identifying opportunities for and coordinating activities across divisions, as well as with WIC. 2 staff in-service trainings focused on benefits of breastfeeding and reducing barriers in the African American community. Task force members expect to delineate a work plan for implementation beginning September 2004.

3 Administration HEALTHLINE staff, including the multilingual outreach worker to the Asian/Pacific Islander community, were trained and certified as WIC breastfeeding peer counselors in February 2004 in anticipation of providing telephone counseling via the HEALTHLINE.

The newborn discharge planners described in NP#3 offer mothers of newborns a home visit by a registered nurse to assess the infant and the home environment. Assistance with breastfeeding is a frequently given reason for wanting the visit.

### c. Plan for the Coming Year

Although breastfeeding is not currently included in the reporting required of the Teen Mothers Take Charge contractors, the adolescent health officer is preparing to add it in FY 2005. Staff is also planning training for contractor staff to promote breastfeeding among teens.

Plans to introduce a call-in breastfeeding information and education service via the HEALTHLINE described in last year's application as scheduled for September 2003 have been rescheduled for FY 2005. HEALTHLINE staff will query callers about their interest in breastfeeding and then provide information with the expectation that many callers who are pregnant do not understand the nutritional impact of breastfeeding and the effects of breastfeeding on infant development. They will attempt to change attitudes, in particular teen attitudes. The medical director of the Howard University Hospital Breastfeeding Drop-in Clinic is preparing a script to query callers about breastfeeding plans.

The breastfeeding task force members will implement their action plan, which is expected to include a review of the scientific literature for use in selection and design of any interventions, compilation of a resource guide on breastfeeding resources for HEALTHLINE staff and other Administration employees, review of the adequacy of and enhance as necessary the information on breastfeeding included in the newborn gift baskets, development of a consumer tool kit, and expansion of efforts to enlist men in the support of breastfeeding.

In FY 2005 information on breastfeeding will continue to be incorporated into Healthy Start and Teen Mothers Take Charge care coordination services. Teen Mother Take Charge contractors will be informed of the breastfeeding support services available at the Howard University Hospital Breast Feeding Drop In Center. Referrals to WIC will continue to be made and tracked.

*Performance Measure 12: Percentage of newborns who have been screened for hearing before hospital discharge.*

### a. Last Year's Accomplishments

Work commenced on an MCHB 4-year, \$195,000 annual newborn hearing screening grant--DC Hears--in October 2001. Law 13-276, mandating newborn hearing screening, went into effect in April 2002. As a result of deficiencies discovered during the project director's visits to hospitals November -- December 2001, rulemaking was amended in April 2002, and a notice of final

rulemaking was published requiring that an audiologist oversee newborn hearing screening in hospitals effective August 2003. Regulations state that an audiologist shall advise the hospital about all aspects of the hearing screening service, including screening and recommendations for follow up testing and treatment.

The project director worked with the 7 District birthing hospitals to install a surveillance system customized by the Welligent Corporation. The Web-based platform--UNITS--was designed to integrate newborn hearing screening, metabolic screening, birth defects registry and the newborn discharge planning (see NP#3 above) system and to enable DOH to track identified children from birth to age 5. The system went live in June 2003, with 6 hospital audiologists reporting screening results directly. In 2003 98% of births were reported screened. See Form 11, NP#12 notes for missed screens at 1 hospital.

In 2003 DC Hears provided 10 audiologic evaluations to uninsured infants, loaned hearing aids to 5 infants and 5 pre-school children whose insurance did not cover hearing aids, and purchased hearing aids for 5 children with fee-for-service Medicaid. 8 infants were identified with hearing loss, with 5 diagnosed and fit with amplification by 6 weeks of age. The remaining 3 were diagnosed and fit by 6 weeks. 4 additional cases were lost to follow up.

During the 1st year of the grant, staff became aware of the limited comprehensive pediatric diagnostic auditory brainstem response (ABR) capabilities in the community. Grant funds supported the purchase of diagnostic ABR equipment for Georgetown University Medical Center. To further fill the existing service gap, in FY 2003 the Administration entered into an MOU with Howard University Hospital Speech and Hearing Clinic. Grant funds were used to purchase diagnostic audiology equipment to enable the clinic to provide free newborn hearing screening and follow up services, and diagnostic and habilitative audiology services to infants and children. DC Public School audiologists were housed at this location. The clinic serves as an amplification safety net by housing the hearing aid loaner bank, another grant-supported service whereby hearing aids are provided for infants who are un-or under-insured for such devices.

Since its establishment in August 2001, the DC Hears Newborn Hearing Screening, Tracking and Intervention Advisory Board has met quarterly. The project director and audiologists from the Early Intervention Program and the DC Public Schools met monthly to discuss educational services for hard of hearing children

## b. Current Activities

As of March 2004, there are 4 tertiary care facilities in the District with comprehensive pediatric diagnostic auditory brainstem response (ABR) capabilities--Georgetown, Howard University Hospital, Children's National Medical Center and Hospital for Sick Children.

Staff continues to provide technical assistance on screening, including staff training and training in the use of the Web-based surveillance system, to birthing hospitals. The surveillance is now working as intended in 5 of the 7 birthing hospitals, although data from 1 of the 5 must be entered manually by Administration staff rather than by the hospital audiologist via the Web-based system. The extent to which the requirement for all birthing hospitals to have an audiologist to implement newborn screening has been incorporated into enforcement of licensure regulation is unknown.

1 hospital, Greater Southeast Community Hospital, withdrew its participation from hearing screening, and is reportedly referring newborns to Children's National Medical Center for screening. (See Overview, discussion of Alliance). Because the patients are primarily Medicaid managed care recipients, it has so far been possible for the DC Hears director and the Medicaid managed care project officer to coordinate with the respective MCO to arrange initial

hearing screening and any necessary follow up for the infants.

From October 2003 through March 2004, the CSHCN division care coordinator followed 7 children identified through newborn screening and 1 identified through birth defects surveillance. 5 of the 8 infants were eligible for the dedicated special needs Medicaid managed care program and were subsequently enrolled in Health Services for Children with Special Needs, Inc. The care coordinator also assisted with enrollment in the Early Intervention Program, arranged for cribs and car seats, and coordinated transportation to appointments.

The DC Hears Newborn Hearing Screening, Tracking and Intervention Advisory Board is continuing to meet quarterly. 3 committees meet more frequently. This year, the board examined hospital performance related to coverage, referral rates and the number of infants receiving diagnostic evaluation and timely early intervention services. Findings of inconsistent follow-up and reporting errors from 1 hospital were documented and discussed with the respective audiologist.

The project continues to offer continuing education, concentrating on providers with Medicaid/SCHIP patient loads. The 1st of a series of work shops presented with the DC Chapter of the American Academy of Pediatrics was held March 2004. The continuing education session focused on the importance of early hearing loss identification and intervention and the importance of establishing a medical home for CSHCN. Physicians and other health care professionals received CMEs.

See attachment for accomplishments in expanding early intervention options, and training of providers and parents.

### c. Plan for the Coming Year

Services and coordination initiated in previous years and described above will continue. Continuing medical education will be offered in conjunction with the DC Chapter of the American Academy of Pediatrics and the Alexander Graham Bell Association. In FY 2005, the final year of the DC Hears grant, staff will concentrate on sustaining grant-supported efforts when federal funding may no longer be available. Toward that end, staff participated in a MCHB sponsored workshop on sustainability in FY 2004 and will request information and assistance from colleagues in the state of Utah who have been able to sustain their program through funding from Head Start and Early Head Start. During the remaining period, funds will be used to condition loaner hearing aids and support the auditory oral program at Mazique Center.

## Performance Measure 13: *Percent of children without health insurance.*

### a. Last Year's Accomplishments

The Administration provided information on the availability of and how to apply for public insurance--DC Healthy Families, the combined Medicaid and SCHIP program. 24% of the 13,446 calls received on the Title V mandated HEALTHLINE during FY 2003 sought information on or were referred to DC Healthy Families, a decline from the 34% of the 14,135 calls in FY 2002 that were referred to DC Healthy Families.

Healthy Start outreach workers also continued to play a role in telling community residents about the insurance program, and explaining enrollment procedures and how to use the preventive and primary care services. Information was distributed via the mobile unit until it was retired August 2003. Case managers worked with individual clients on Medicaid enrollment and re-certification.

Enrolling the Teen Mothers Take Charge clients (see SP# 7) in Medicaid/SCHIP and working with them on how to access services was a major emphasis of the contractors' care coordination efforts.

#### b. Current Activities

Dissemination of information about eligibility for DC Healthy Families continues via the HEALTHLINE, DC Healthy Start and Teen Moms Take Charge. 13% of the 5848 HEALTHLINE calls during the 1st quarter of FY 2004 were referred to DC Healthy Families.

#### c. Plan for the Coming Year

During FY 2005, the HEALTHLINE, Healthy Start and Teen Mothers Take Charge activities to inform families about the availability and use of publicly supported health insurance will continue. Pending successful procurement, a new Healthy Start mobile unit will be in service and information about DC Healthy Families will again be disseminated via this venue.

*Performance Measure 14: Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

#### a. Last Year's Accomplishments

A number of the Administration's projects may have indirectly contributed to Medicaid utilization. See SP# 2 (increase EPSDT participation). Healthy Start workers were trained on eligibility criteria, application process and benefits of Medicaid, which enabled them to incorporate accurate information into home visits, case management services and community information dissemination. Case managers were expected to assist eligible clients with enrollment and recertification, as well as to comply with prenatal, postpartum, interconceptual care and infant care recommendations.

The 3 Teen Mothers Take Charge contractors provided care coordination to teen mothers, including assisting with enrollment in Medicaid and obtaining recommended health services for themselves and their children. The CSHCN grant-supported projects described in this and previous applications also contributed to the numbers of children who receive Medicaid services. These include newborn metabolic and hearing screening, school-based asthma education, school-based health services at Woodson, Sharpe and Mamie D. Lee schools, and birth defects surveillance. Deployment of staff for immunization clinics, the newborn discharge planning, and vision and hearing screening at selected sites may also have contributed to the utilization of Medicaid services insofar as children who were referred presented for and received services from their Medicaid provider.

The Administration's efforts to negotiate agreements with Medicaid MCO providers were described in the section on state agency coordination.

#### b. Current Activities

Healthy Start case managers follow clients for 2 years after birth, and nurses periodically screen infants using the Denver Developmental test; consequently, they encourage and support families in seeing that infants receive EPSDT and other services, thereby possibly increasing Medicaid utilization. The Teen Mothers Take Charge contractors are providing care coordination, including support of clients in the receipt of Medicaid services. Enrollment in the

program has been extended to up to 4 years, during which clients are informed about and assisted with how to use well-baby care and preventive health services for themselves. Over 70% of Teen Mothers Take Charge clients are receiving Medicaid. HEALTHLINE information and referrals may contribute to the receipt of needed Medicaid services as well.

Also see SP# 2 (increase EPSDT participation).

### c. Plan for the Coming Year

Staff expects to continue the efforts described above to encourage and support clients and the general public in utilization of Medicaid services. The maternal and child health officer will continue to pursue any opportunities for formal agreements with the Medicaid MCOs.

An increased number of students at 2 public schools dedicated to children with special health care needs are expected to receive oral health services. (See NP# 9.) These are children who would not otherwise receive the services, or would have been delayed in receiving them. Arrangements are being put in place to receive Medicaid reimbursement for the services. Insofar as the District does not have a sufficient supply of dentists who accept Medicaid patients, this is potentially a significant expansion of services.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

### a. Last Year's Accomplishments

During the period 2000 -- 2002, the rate remained stable at 2.7%. The Administration continued efforts through the Healthy Start program to inform women of the importance of early and consistent prenatal care, conducted home visits to high risk pregnant women in targeted neighborhoods, and made and followed-up on referrals to social and medical services, and WIC. 6.2% of the 210 births to Healthy Start clients reported in program year 2003 were very low birth weight.

A Healthy Start nurse case manager and outreach worker were stationed at the DOH Addiction Prevention and Recovery Administration (APRA) Women's Clinic 1-2 days per week to provide case management services to pregnant clients. As of June 2003, APRA and Healthy Start began to offer on-site pregnancy tests at the Women's Clinic and the Central Registry Division (intake) to all substance abuse clients in order to identify and provide intensive case management services to pregnant clients.

Nearly half (47%) of Teen Mothers Take Charge (see SP# 7) clients were enrolled before the birth of their baby. The care coordination services and the information and education about nutrition, reducing exposure to tobacco, alcohol and other drugs and how to use medical and social services may have helped to prevent very low birth weight. Because data were missing for more than 50% of Teen Mothers Take Charge clients, the incidence of very low birth weight among FY 2003 clients cannot be estimated with confidence.

Utilization of transportation increased in 2003 after a decline over the past few years, perhaps due to the work of the hospital based discharge planners and the subsequent home visits. In 2002, 165 of a total of 447 (37%) transports were to prenatal clients, compared to 43% of the total 600 transports in FY 2003. Transportation may help to reduce a barrier to receipt of prenatal care and subsequent adverse birth outcomes such as vlbw.

### b. Current Activities

Case management and other services to pregnant women provided through the 2 federally

funded Healthy Start projects and the Title V funded Teen Mothers Take Charge are continuing as described above and in other sections of this application. The HEALTHLINE coordinates transportation services and conducts home visits to high-risk pregnant women in non-Healthy Start target areas, Wards 1 through 4. Transportation resources consist of 3 drivers and 4 vans. Transportation via the HEALTHLINE continues to be provided to Medicaid beneficiaries only in special situations; Medicaid MCOs are responsible for transporting their clients. Transportation is being provided to Healthy Start clients to participate in health education group sessions.

Also see description of HIV/AIDS coordination activities in the state overview section of this application.

### c. Plan for the Coming Year

In 2005 the Administration intends to continue to offer transportation. Case management will continue to be offered to high risk pregnant women through the Healthy Start and Teen Mothers Take Charge programs. Arrangements will be made for home visits to high risk pregnant women in non Healthy Start target wards as necessary with subsequent referrals to other case management providers. Efforts to coordinate services for substance abuse and HIV-infected clients will continue as well.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

### a. Last Year's Accomplishments

Suicides continued to be rare among District youth. As described in NP# 10, the Administration supported and participated in the Child Health Fatality Committee, located in the Office of the Medical Examiner. 2 suicides were reviewed during 2001-2002. (There were 68 homicides reviewed.)

The Administration was awarded in FY 2003 a \$45,000 federal HHS Office of the Assistance Secretary for Policy, Planning and Evaluation grant to begin a 17-month violence prevention planning effort. Representatives from a broad array of youth services organizations and government agencies were brought together, along with young people age 14 -- 18. A mailed survey of 50 organizations and an initial meeting convened May 9, 2003 revealed providers' lack of information about the range of services available in the community and how to access them. Attendees also noted the need for increased advocacy on behalf of youth. The project--Youth Violence Prevention Architects Initiative--was expected to result in the establishment of a Web-based information exchange and communications clearinghouse providing stakeholders with expanded access to current data on core indicators and enabling network members to communicate electronically; however, that has yet to occur. Staff also expected participants to agree upon core standards based on youth development principles to guide programming across organizations.

### b. Current Activities

Under the auspices of the HHS grant funded project--Youth Violence Prevention Architects Initiative--3 citywide youth summits at which experienced youth facilitators worked with youth age 11 to 20 to discuss issues related to violence and injury prevention were convened in January, April and May 2004. Partners included the Department of Health Bureau of Injury Prevention and Violence. 64 youth and 25 adults attended the first summit. The youth were recruited by a variety of organizations including DC public schools, faith based groups, the juvenile justice system and community based youth-serving organization. The May event was

the culmination of the work with the youth, the outcome of which was a series of recommendations delivered to the mayor. The recommendations were not available as of July 13.

Staff submitted an application for an implementation grant but it was not funded. In June 2004, staff responded to a CDC grant announcement, requesting \$93,000 annually for a 2-year grant to plan interventions to reduce violence.

### c. Plan for the Coming Year

Staff will continue to support the activities of the Child Fatality Review Committee and will complete the HHS-funded violence prevention planning effort. Title V funds will be used to meet some needs identified from the completion of the grant funded Youth Violence Prevention Architects Initiative. Selected staff from city agencies and community based organizations will be trained in youth development in order to build capacity and skills for working with youth.

Pending the outcome of the CDC grant application, the adolescent health division staff will review the recommendations from the youth summits to determine which, if any, may be incorporated into existing activities and programs without additional funds.

## Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

### a. Last Year's Accomplishments

2 hospitals that historically cared for considerable numbers of high-risk deliveries (Columbia Hospital and DC General Hospital) closed in recent years, resulting in a redistribution of insurers' contractual relationships with birthing hospitals. In 2003, 4 hospitals offered tertiary care for deliveries and neonates, namely Georgetown University Hospital, George Washington University Medical Center, Washington Hospital Center and Howard University Hospital. 2 hospitals, Georgetown Medical Center and Children's National Medical Center, accepted very high risk neonate transports. No observable progress has been made on this measure since tracking was initiated in 1997. However, additional analysis of the birth records file by the data collection and analysis division resulted in correction of information reported in past years. In May 2004 staff examined the out-of-state vlbw deliveries; as a result of this analysis, it was found that 40 vlbw babies were delivered at level III hospitals in the Maryland and Virginia suburbs. This increased the proportion of 2001 vlbw deliveries at level III facilities from 59 to 78%. In the next few months staff hopes to be able to reexamine 1999 and 2000 births to determine if corrections in tracking data (Form 11) are warranted.

Through Healthy Start, the Administration began work with the March of Dimes to implement the Perinatal Periods Of Risk approach (PPOR). A preliminary analysis of perinatal data was compiled and presented to several stakeholder groups.

The Child Fatality Review Committee combined annual reports for 2001 -- 2002, released in January 2004, listed as 1 of its top 10 recommendations: Evaluate the availability of tertiary care for high-risk mothers and infants, including at a minimum, barriers such as the impact of lack of insurance, bed availability, staffing patters and MCO/HMO restrictions. To date, no steps have been reported toward the recommendation.

### b. Current Activities

Healthy Start management is continuing to work with March of Dimes representatives to

present PPOR to stakeholders, including the Healthy Start consortium. Administration management decided to take initial steps to form a DC perinatal association. Contacts were made with the National Perinatal Association, and the president participated in presentations to stakeholders. Potential founding members are being recruited and an invitational meeting is scheduled for July 28, 2004.

The maternal and child health officer is working with sister agencies involved with the development of a state health system plan in an attempt to obtain data on emergency transport services of high risk pregnant women, as well as emergency medical services protocols regarding pregnant clients.

### c. Plan for the Coming Year

Data collection and analysis staff will continue to analyze the birth records files to determine the extent to which births in hospitals outside the District are affecting this performance measure. Information will be included in presentations to the emerging perinatal association.

Other efforts described above will continue in 2005.

*Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

### a. Last Year's Accomplishments

Although this measure has shown some improvement since the mid 1990s (64.6% in 1996 compared to 75.5% in 2002), far too many District women did not enter prenatal care in the 1st trimester. In 2002, data on trimester of entry were missing on 13.7% of birth records, an improvement over the 23% missing in 1999. An analysis of the extent to which the missing data are randomly distributed has never been undertaken.

Efforts continued to be directed toward supporting women to enter prenatal care as early as possible and to sustain the care throughout their pregnancies. The Healthy Start projects have targeted home visiting and counseling to low income, predominately African-American neighborhoods to encourage women to obtain early and continuous prenatal care since 1994. However, many Healthy Start enrollees were women who came to the attention of the project via post delivery hospital referrals.

Information dissemination conducted through the HEALTHLINE stressed the importance of early prenatal care and where to go to receive it.

See also NP#15, SP#1 and 7.

### b. Current Activities

Activities described above are continuing throughout the current period.

See also NP#15, SP#1 and 7.

### c. Plan for the Coming Year

Healthy Start outreach staff will continue community activities to encourage early and sustained prenatal care, including working with males to support their roles as fathers and partners.

Also see SP#1.

HEALTHLINE will continue to disseminate information on the importance of and where to obtain prenatal care.

**FIGURE 4A, NATIONAL PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

**General Instructions/Notes:**

List major activities for your performance measures and identify the level of service for these activities. Activity descriptions have a limit of 100 characters.

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.				
1. develop and distribute parent information materials	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. follow up with positives to link with confirmatory testing, diagnosis, services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. establish Web based and integrated reporting systems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. make available tertiary level genetic services and counseling	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. disseminate sickle cell information and education to front line community based organization staf	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
6. integrate birth defects surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)				
1. CDC-funded asthma prevention and control planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. asthma information and education in selected schools	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. parent participation on advisory boards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)				
1. present provider training conference on medical home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. newborn discharge planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. establish birth defects surveillance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. organize birth defects advisory committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. obtain law to require birth defects registration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)				
1. identify gaps in coverage for vision and hearing aids and advocate to close gaps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. enlist Advisory Board in advocacy for Medicaid-SCHIP services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. continue HEALTHLINE and other information dissemination	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)				
1. complete systems planning grant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

2. strengthen policy and advocacy capacity of CSHCN Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. conduct survey to determine availability and accessibility of comprehensive services for CSHCN	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)				
1. recruit Ready to Work coordinator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. reactivate Interagency Transition Workgroup	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. assist Ready to Work teens exiting school	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.				
1. participate in school nurse immunization committee and integration of records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. redeploy staff for school immunization campaigns	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. counsel and follow up on client immunization status (Healthy Start and Teen Mothers Take Charge)	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. continue HEALTHLINE ? information on immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
8) The rate of birth (per 1,000) for teenagers aged 15 through 17 years.				
1. implemnt I?m Worth the Wait abstinence education curriculum	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. fund Teen Mothers Take Charge services, case management including family planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. participate in DC Campaign to Prevent Teen Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
9) Percent of third grade children who have received protective sealants on at least one permanent molar tooth.				
1. support HU dentistry students for sealant survey	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. provide oral health services to students at Sharpe and Mamie Lee schools for special needs students	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. implement oral health innovations grant to expand services in public schools	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
4. explore funding opportunities for school based sealant program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
10) The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.				
1. participate in and support Child Fatality Review Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. HEALTHLINE information on free infant and child car seats	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

3. Healthy Start and Teen Mothers Take Charge case managers assist with obtaining car seats	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. CSHCN coordinator assists with obtaining car seats	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
11) Percentage of mothers who breastfeed their infants at hospital discharge.				
1. Healthy Start case management - information and counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Teen Mothers Take Charge -- information and training of contractors	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. provide print materials on lactation at hospital discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. HEALTHLINE information for teens	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. continue staff Breastfeeding Task Force	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. stage video and discussions on breastfeeding for prospective fathers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
12) Percentage of newborns who have been screened for hearing before hospital discharge.				
1. convene and staff hearing screening advisory board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. support hospital screening and reporting, follow up with positives to ensure early intervention	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. MIS integration across hospitals and with other screening databases	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. educate/train providers and families	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. provide equipment for hospitals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. provide loaner infant hearing aids	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. continue to make arrangements to expand intervention options	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Pyramid Level of Service			
	DHC	ES	PBS	IB

NATIONAL PERFORMANCE MEASURE	DHC	ES	PBS	IB
13) Percent of children without health insurance.				
1. HEALTHLINE provides callers with information on eligibility for and enrolling in Medicaid-SCHIP	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Healthy Start -- case managers assist client with obtaining and retaining Medicaid and other insurance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Teen Mothers Take Charge -- case managers assist client with obtaining and retaining Medicaid and other insurance	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
14) Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.				
1. Healthy Start case management ? developmental screening and follow up until infant reaches age 2 with referrals and follow through	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Teen Mothers Take Charge -- case managers assist with accessing health services and screening	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. newborn metabolic and hearing screening follow up referrals	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4. hearing screening follow up referrals and early intervention	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. HEALTHLINE information dissemination and referrals	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
15) The percent of very low birth weight infants among all live births.				
1. Healthy Start outreach to identify pregnant women3. HEALTHLINE	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Healthy Start case management to support entry into and retention in prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Teen Mothers Take Charge -- case management assistance with prenatal care	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
16) The rate (per 100,000) of suicide deaths among youths aged 15 through 19.				
1. participate in and support Child Fatality Review Committee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. implement violence prevention planning recommendations to extent possible	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
17) Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				
1. Healthy Start to begin PPRO data compilation and obtain EMS transport data	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
2. participate in DOH health systems planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. form DC perinatal association	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

NATIONAL PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
18) Percent of infants born to pregnant women receiving prenatal				

care beginning in the first trimester.				
1. Healthy Start--identification of women early in pregnancy for risk assessment and enrollment in case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. HEALTHLINE callers receive information about benefits of early and consistent prenatal care	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3. Teen Mothers Take Charge case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**D. STATE PERFORMANCE MEASURES**

State Performance Measure 1: *By 2005, increase the % of women who receive adequate prenatal care (Kotelchuck) to 69.5.*

**a. Last Year's Accomplishments**

Planning and assessment efforts based on this measure, as well as a number of other national and state measures, were hampered by the quality of vital records data. From CY 1997 to 2001, the rate of missing data on this measure has ranged from 19 to 21%, improving to 16% missing data in 2002. 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. According to State Center for Health Statistics Administration staff, the DOH agency responsible for vital records functions, periodic meetings conducted with staff of birthing hospitals regarding reporting expectations, including the importance of complete data, have yielded little improvement.

The Administration and the State Center for Health Statistics Administration negotiated an MOU, delineating responsibilities for acquiring and sharing data. The Administration provided funds for data acquisition. The MOU also delineated rights and responsibilities for linkage and integration of the data systems described throughout this application. Birth records constitute the base for most of these systems. The MOU was signed August 2003.

The 2 federally funded Healthy Start projects operated by the Administration focused on locating low income, African American pregnant women in underserved areas of Ward 5, 6, 7 and 8 and providing nurse case management and home visits to ensure that clients received adequate prenatal care. The emphasis of the current Healthy Start grants is interconceptional as well as prenatal care. Staff attempted to retain women and their infants in case management for 2 years after birth; therefore the number of pregnant women served (penetration) was lower than in previous years when clients were typically discharged from case management within several months of birth and replaced with new pregnant enrollees. In FY 2003 Healthy Start added depression screening and referrals to mental health services with the expectation that treatment may contribute to better compliance with prenatal care among other effects.

Healthy Start staff worked with the Mary's Center for Maternal and Child Care to place ads promoting the importance of early prenatal care in metro buses. Designed pro bono by a

District media firm, the ads were placed on bus lines in the project areas in February 2003. Originally scheduled for 1-2 months, several remained through mid-June. 35 calls were received from pregnant women who were referred to a case management service, based on ward of residence and whether it was a 1st or other pregnancy.

Door-to-door transportation was provided to prenatal care for women not eligible for Medicaid transport. 261 trips were provided in FY 2003.

#### b. Current Activities

The MOU with the State Center for Health Statistics Administration was signed August 2003, enabling data acquisition for the purpose of this application to proceed more smoothly than in past years.

In addition to the continuation of Healthy Start, the Administration is continuing 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 client outreach to high risk cases identified through the HEALTHLINE, and information and referrals through the HEALTHLINE and health fairs.

Teen Mothers Take Charge (see SP #7) contractors continue to provide care coordination, education and enrichment services to pregnant and parenting teens. Although the overall budget was reduced 20%, a 4th contract was awarded (MELD/Even Start). Approximately 50% of the teens enroll prior to the birth of the infant. Enrollment in and adherence to prenatal care is an important component of the care coordination services offered by the contractors.

#### c. Plan for the Coming Year

Current Teen Moms Take Charge and Healthy Start activities will continue through FY 2005. Among their other objectives, both programs include case finding to support pregnant women's entry into and adherence to prenatal care.

### State Performance Measure 2: *By 2005, increase EPSDT participation to 85%.*

#### a. Last Year's Accomplishments

Since 1992 the participation ratio increased from 26% to 71% in 2003, exceeding the previously high of 70% in 1996 and 2000, but considerably short of the federal goal of 80%. 2003 also saw an increase in the number of children reported enrolled in Medicaid-SCHIP--- 89,993, compared to 85,160 in 2002. And as seen in Form 11, the number of children due for 1 or more EPSDT screen (denominator) has increased considerably over the past few years. 10% of children due in FY 2003 were medically needy and the participation ratio for this group was considerably lower than for the categorically needy, 20% and 80% respectively.

The Healthy Start projects and the Teen Mothers Take Charge contractors maintained clients in case management for 2 years after the birth of the baby. During this period, case managers tracked well-baby visits and worked with the mothers and their primary care providers to ensure that the appropriate immunizations, and health screens and follow-up were obtained. Healthy Start staff was trained to administer the Denver Development screens so that developmental delays could be referred directly for diagnosis and follow-up.

Children with special health care needs staff conducted, sometimes with Lions Club volunteers, vision screening during FY 2003 for:

- o 83 DCPS Head Start children for school entry

- o 117 pre-school/Head Start children
  - o 1206 school-age children, of which 37% were referred for further testing.
- Most of these children were Medicaid beneficiaries.

The Administration has used Healthy Start funds to operate an adolescent wellness center at H.D. Woodson Senior High School for nearly 8 years. The center is open 5 days per week year round. Students can obtain EPSDT services such as physical exams and immunizations. In addition, HIV, STD and pregnancy testing is available as are family planning and mental health services. In FY 2003 there were 1541 visits to the center. Due to the illness and death in July 2002 of the adolescent physician, the center operated without an on-site physician during this period.

Also see activities described for NP# 7, 13 and 14, and SP#3.

#### b. Current Activities

See NP# 9 on Salazar.

The District recently completed an audit by the Mercer Group on EPSDT outreach efforts by the MCOs.

Healthy Start contracted with Georgetown University Medical Center to provide an adolescent health physician(s) to staff the Woodson Senior High School Wellness Center 10 hours weekly beginning January 2004.

The 4 Teen Mothers Take Charge contractors extended their care coordination of clients up to 4 years after birth, although to a smaller number of clients due to budget reductions of 20%.

The oral health services provided to children (see NP# 9) may have contributed to EPSDT participation as well.

Other activities described and referenced above are continuing.

#### c. Plan for the Coming Year

In FY 2005, the Administration will continue the numerous efforts that may contribute to EPSDT utilization: Healthy Start, Teen Mothers Take Charge, vision screening in selected schools, MIS integration and linkage, and direct services to Woodson, Mamie B. Lee and Sharpe schools students

*State Performance Measure 3: By 2005, reduce the prevalence of lead levels exceeding 10ug/dl among DC children through age 6 to no more than 1.9%.*

#### a. Last Year's Accomplishments

For several years, Title V funds have been applied to the Comprehensive Lead Poisoning Prevention Program (CLPPP) to supplement CDC and HUD funding. Mutual responsibilities were delineated in an interagency memorandum of understanding between the Administration and the CLPPP, which is located in the DOH Environmental Health Division, signed in July 2002 to be renewed annually; however, renewal did not occur.

CLPPP staff reported that 22,138 screenings were conducted in FY 2003, compared to 22,830 in FY 2002, representing about 50% of children under 6 years of age. However, the number of reported screens may include duplicates or retests. A population-based prevalence estimate

has yet to be generated. In FY 2003, 1.8% of screenings were found to have lead levels exceeding 10 ug/dl (and .7% exceeded 15ug/dl), compared to 5.8% in FY 2002. 6.5% of the screenings were conducted by CLPPP staff.

The CLPPP continued to provide medical case management for children with confirmed blood lead levels > 15ug/dl. Employees conducted 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.

In May 2002, the Childhood Lead Poisoning Screening and Reporting Emergency Act of 2002, which contained strong provisions requiring providers to conduct tests of all infants at 6-9 months and again at 22-26 months, and labs to report all, not just positive, test results, was enacted by city council. The legislation assigned responsibility to the Medicaid program for environmental investigations and source control for any lead poisoned child who is a beneficiary. Responsibility in the case of children not receiving Medicaid was not mentioned.

In June 2002, the plaintiffs for the Salazar Medicaid class action filed a motion asking the court to enforce EPSDT services of the Settlement Order based on the fact that the majority of children on Medicaid are not receiving appropriate lead blood screenings and dental services. In FY 2003 only 12,369 screening blood lead tests were administered to 28,183 eligible children under age 6. Still, this was an increase from the 5454 screens for 24,735 eligible children in FY 2002.

Also see NP#9 Salazar.

#### b. Current Activities

In the overview section, the situation with elevated lead in the water supply was described. This brought about increased attention to the general lack of compliance with District law and EPSDT requirements for lead screening of young children.

The director of the CLPPP released a prevalence level estimate in an interview with The Washington Post--3700/45549 = 8%, something that Administration representatives have been requesting for several years. And as a result of public concern, government officials approved expenditures to enhance reporting: The DOH contracted with Welligent Corporation to design, install and support a Web-based lead registry--Lead Tracks, which went live April 2004. It is expected that data from the registry can be easily linked with the Administration's UNITS.

During the 1st quarter of FY 2004, 3362 screenings of children under 6 years were reported, 406 of them by CLPPP staff. (These screens occurred before the news about elevated lead in the water was released.) The CLPPP staff is continuing informational, educational and testing activities, including follow up of children found to have elevated levels. The Administration continued to fund 14 FTEs in the CLPPP.

#### c. Plan for the Coming Year

The Administration will continue to provide funds to support the operation of the CLPPP and participate in the activities described above. Efforts to link other data systems with the lead registry will continue.

*pregnant women to 2%.*

#### a. Last Year's Accomplishments

The prevalence as measured by information provided on the birth certificate was 2.6% in 2000, a steady decline from 6.95% in 1996. Since 2000, it has increased to 3.9. Tobacco use data collected for the birth certificate are considered to be highly variable by hospital and provider and may be grossly under reported. 6% of the 750 pregnant, post partum or interconceptional clients screened by Healthy Start in 2003 reported current cigarette smoking. In 2002, 17.4% (CIs 15.0-19.7) of District women reported current use of cigarettes, compared to the US state median of 20.8%

According to a report released in November 2003 by Tobacco Free Kids <http://tobaccofreekids.org/reports/settlements/2004/fullreport.pdf>, the District ranked last among states on the extent to which it funded tobacco control and prevention efforts. The District was among the last of the states to decide how to use its tobacco settlement funds. In 2001, after 3 years of budget debates with no spending decisions, the city council agreed to securitize most of the settlement funds by issuing bonds backed by the \$1 billion in expected receipts over the next 25 years. The money raised was transferred into a trust fund to pay the city's debt. Later, a Medicaid reserve fund was created. The legislation creating the fund sunset in 2005; however, once again in deliberation on the FY 2005 budget, decisions were made to use the monies to make up budget shortfalls.

A cigarette tax increase took effect January 1, 2003, increasing the cigarette tax by 35 cents to \$1 per pack. These revenues were not dedicated to tobacco control. In fiscal year 2003, the District's Synar Amendment noncompliance rate of 41.9% exceeded the 20% target rate set by federal standards.

An American Legacy Foundation grant, awarded in September 2001, made \$500,000 available annually for 3 years and required a 100% match. Grant activities were directed toward preventing the on-set of smoking among adolescents. DOH contracted with the DC Children and Youth Investment Trust Corporation (visit [www.cyitc.org](http://www.cyitc.org)) to build youth leadership and an anti-tobacco movement--Washington Area Youth (WAY) Too Cool to Smoke Youth Leadership Initiative. Grants were made to 8 ward- and community-based agencies to form youth teams to develop and present anti-tobacco messages. In 2003, additional organizations were awarded small grants to engage special populations such as Asian and Pacific Islander and Latino youth, teen parents, and the adjudicated in anti-tobacco work.

During the period they were funded, the teams organized activities for Kick Butts Day, developed and maintained a Web site, produced a documentary, and worked on the Smoke Free DC campaign. Strategies included developing leadership skills, mentoring and technical assistance to youth leaders who were charged with changing social norms about teen smoking. During FY 2003, an estimated 1000 youth received smoking prevention education through Way Too Cool.

#### b. Current Activities

Although the final year of the American Legacy grant was FY 2003, \$192,000 of carry over funds were used in FY 2004 for outreach and to finish some of the projects and activities initiated with the grant. The extent to which the community based organizations that started programs as a result of Legacy funds have been able to continue with other funding has yet to be determined.

The Healthy Start program continues to incorporate counseling about tobacco use into case management services. Health educators offered occasional multi-session cessation classes to the community.

### c. Plan for the Coming Year

Unfortunately, it will not be possible to continue the tobacco control work established with the American Legacy grant due to lack of funds. Healthy Start staff will continue to incorporate the dissemination of information and counseling about tobacco use into case management and health education efforts.

*State Performance Measure 5: By 2005, reduce the proportion of births resulting from unintended pregnancies to 37%.*

### a. Last Year's Accomplishments

3 Teen Mothers Take Charge community-based contractors provided care coordination and other services to 1st time pregnant and parenting teens to prevent repeat teen pregnancies. (See SP# 7.)

In conjunction with Healthy Start community outreach, condoms were distributed and birth control information made available at convenience neighborhood locations. Information and referrals for birth control services, and condoms were available curbside through the mobile unit until it was retired August 2003. Healthy Start staff attempted to maintain high risk women in case management for 2 years after delivery to coordinate interconceptional care, with an emphasis on maintaining family planning.

Title V funds supported the PRAMS, administered by the Administration's data collection and analysis division, which collects data from a sample of women post delivery, providing data to track this measure over time.

### b. Current Activities

The Healthy Start projects continue to work to maintain high risk women in case management for 2 years after birth to support their access to and utilization of health and other services, with family planning receiving major emphasis. Healthy Start staff receives periodic in-service continuing education on contraception, provided by Planned Parenthood and other providers. Healthy Start provides condoms and birth control information at 4 community office sites where outreach staff is stationed on a part-time basis. In addition to the incorporation of counseling concerning family planning services into case management and home visits, Healthy Start health educators offer informal education sessions on family planning at health clinics, housing developments and community centers.

4 Teen Mothers Take Charge contractors extended their period of care coordination to 4 years. During this period, teens, their partners and other family members receive a variety of support, mentoring and enrichment services intended to encourage them to continue their training and education and to avoid unplanned pregnancies.

The Administration continues to operate PRAMS.

### c. Plan for the Coming Year

Healthy Start, Teen Mothers Take Charge and PRAMS will continue in FY 2005 as described above

**State Performance Measure 6: *By 2005, reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester to 5.4%.***

**a. Last Year's Accomplishments**

In 2002, 534 women, 8.3% of births for which information was recorded, entered prenatal care in the 3rd trimester or had no care. The same percent was reported in 2000, with a decrease to 7.5% in 2001. These proportions represent a change from 12% in 1996. Unfortunately, quality of birth record data also affects reporting on this performance measure: data on trimester of birth was missing on nearly 14% of resident birth records.

See activities described for SP# 1, 5 and NP# 15, 18.

**b. Current Activities**

The 2 federally funded Healthy Start projects continue to work in low income African American neighborhoods. Healthy Start employees conduct community outreach and recruitment by door-to-door canvassing in neighborhoods and public housing communities, dissemination of flyers to patients and providers at community health centers, posting flyers and other materials at retail establishments such as hair and nail salons, laundries, supermarkets and corner stores, and contacting churches and community based organization. Outreach technicians also establish a presence at community events and meetings, and walk the commercial corridors in target areas. Information about services is also published in community newsletters and media directed toward African American audiences. Staff participates in community health fairs supported by the DOH, as well as in street fairs and festivals sponsored by churches and neighborhood groups.

Another outreach strategy involves pregnancy testing and pregnancy registrations. Healthy Start staff offer pregnancy testing at community sites and at health fairs and other special events. If the test is positive, the Healthy Start worker immediately assists the pregnant women in making a medical appointment, with her primary care provider if she has one, if not, at a community health center. The woman is assisted with completion of a pregnancy registration form. The Healthy Start worker encourages the woman to enroll in case management, and follows up within the next few weeks to encourage her to do so if she does not immediately enroll.

Through July 2003, the mobile obstetrics unit, which provided curbside services on a rotating basis, was both a mechanism for advertising services and an intake site. The mobile unit was retired in August and as this report is being written, procurement for a replacement is in process.

**c. Plan for the Coming Year**

To the extent that resources are available in 2005, Healthy Start will continue the effort described above to find pregnant women and maintain them in prenatal care; however, due to the federal grant requirement that women be maintained in case management for 24 months after delivery in combination with the need to allocate resources to joint case management of women reported under the auspices of Law 14-206 Improved Child Abuse Investigations Amendment Act of 2002, increasingly fewer resources will be available for case finding in early trimesters of pregnancy.

The provision of family planning services to Healthy Start and Teen Moms Take Charge clients will continue.

State Performance Measure 7: *By 2005, reduce the incidence of repeat births for teens less than 19 years of age to 19.3%.*

a. Last Year's Accomplishments

Beginning in 2001, the Administration received District TANF funds to develop the Teen Mothers Take Charge (TMTTC) program. 5 community based service providers were funded through a competitive process to recruit 1st-time pregnant or parenting teens and enroll them in a program to provide intensive care coordination and supports, as well as enrichment programs. 700 clients were expected to be served, with case management, social and employment services to be provided for up to 12 months after delivery or to a parenting teen up to the infant's 1st birthday. Interventions were intended to avoid repeat teen pregnancies and to maintain the clients in educational and/or work activities that fulfilled welfare to work requirements. Improved health outcomes for mothers and infants were implicit considerations.

An evaluation of year 1 conducted by the University of the District of Columbia Center for Applied Research and Urban Policy found that 79% of the enrollment goal of 485 was met. As of May 2003, of the 466 women ever enrolled, 29% (n=136) had been discharged, including 8% (39/466) who were lost to follow-up or moved without a forwarding address. Another 8% were discharged due to noncompliance. Other reasons for discharge included transfer to another agency, infant death or miscarriage, and graduation. The discontinuation of 2 of the 5 vendors probably contributed to the discharges due to reasons other than completion of the program although efforts were made to transfer clients to other programs. In FY 2003 after TANF support ended, Title V monies were applied to 3 grantees--Mary's Center for Maternal and Child Care, Shiloh Baptist Church Family Life Center and the Edward Mazique Parent Child Center--to provide mentoring and tutoring, GED preparation, skill building, comprehensive psychological assessments, parenting training, readiness workshops, abstinence workshops, career training workshops, home visits, family planning, home safety and crisis intervention. The services were changed to continue women in care coordination for up to 3 years, based on the experience that 2 years was not sufficient time for the teen to become self-sufficient. Services directed toward fathers and partners were incorporated into programming, and eligibility was expanded beyond the 1st pregnancy. Reciprocal referral arrangements were in effect with Healthy Start based upon the specific situation and needs of the teen client. For example, a client with a high medical risk may be referred to Healthy Start for nurse home visits and monitoring.

b. Current Activities

The TMTTC program continues to evolve. In FY 2004, 4 community based service organizations were contracted to provide services; the 4th and new contractor is MELD/EvenStart, which is providing care coordination to 50 African American teen mothers and their families. Contractors enroll young women up to age 19 who have no more than 3 children. Care coordination may continue up to 4 years or until the client is 19, whichever occurs first. In FY 2004 funding was reduced by approximately 20% and the number of women served was decreased accordingly. As of April 2004, 310 teens were receiving services (140 Shiloh, 50 Mary's Center, 70 Mazique and 50 MELD). Contract requirements this year included involving fathers in activities, such as health education classes in infant care.

The Administration encourages the grantees to counsel clients about voluntary HIV testing. Although the DOH HIV/AIDS Administration did not provide financial support to the program as described in last year's application, each grantee has a staff person who is trained and certified as an HIV testing counselor. The Administration has not advised or required the grantees as to the frequency of HIV testing for pregnant clients. (The DOH has not yet adopted a policy on prevention of perinatal transmission.) The contract reporting system does not request information on the extent to which clients have been counseled, tested and referred for HIV testing. Staff expects to add this for 2005 reporting.

The University of the District of Columbia Center for Applied Research and Urban Policy is the evaluation contractor for the program. The most recent evaluation report was submitted January 2004 and covered the 3 contracts for the time period 2001 -- 2003. Findings include: Retention over the past 2.5 years of TMTC operation has been in the vicinity of 62%. TMTC grantees reported only 2 cases of repeat pregnancy among the 582 teen mothers they served; however over a third of the clients were discharged over the course of the project, and for these clients repeat pregnancy data are not available. In addition, data on outcomes such as birth weight and gestational age were missing for up to 50%. 3 out of 4 teen mothers currently enrolled in TMTC are either enrolled in school or have a high school diploma/GED

**c. Plan for the Coming Year**

TMTC services will continue as in FY 2005. The Administration requested funding from the District Department of Human Services from the federal Bonus to Reward Decrease in Illegitimacy Ratio. However, no response has been received.

**FIGURE 4B, STATE PERFORMANCE MEASURES FROM THE ANNUAL REPORT YEAR SUMMARY SHEET**

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
1) By 2005, increase the % of women who receive adequate prenatal care (Kotelchuck) to 69.5.				
1. Healthy Start case management, outreach and health education	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Teen Mothers Take Charge case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. HEALTHLINE information dissemination	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
2) By 2005, increase EPSDT participation to 85%.				
1. Healthy Start case management and infant developmental screening	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Teen Mothers Take Charge case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. HEALTHLINE information to callers	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Support of lead screening program	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
5. MIS integration and linkage projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6.				

	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
3) By 2005, reduce the prevalence of lead levels exceeding 10ug/dl among DC children through age 6 to no more than 1.9%.				
1. Support DOH lead poisoning prevention and control program	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Form Childhood Lead Screening Prevention and Education Program Lead Advisory Board	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Inform Healthy Start and Teen Mothers Take Charge clients	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. MIS integration and linkage projects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
4) By 2005, reduce the prevalence of tobacco use among pregnant women to 2%.				
1. Disseminate print materials at health fairs and other events	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Teen Mothers Take Charge ? information and counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Healthy Start ? information and counseling	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
5) By 2005, reduce the proportion of births resulting from unintended pregnancies to 37%.				
1. Healthy Start interconceptional case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. I?m Worth the Wait abstinence education	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Participate in Campaign to Prevent Teen Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Surveillance - PRAMS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
6) By 2005, reduce the percent of women that give birth with no prenatal care or prenatal care initiated in 3rd trimester to 5.4%.				
1. Healthy Start outreach and case management	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. HEALTHLINE -- information to callers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

STATE PERFORMANCE MEASURE	Pyramid Level of Service			
	DHC	ES	PBS	IB
7) By 2005, reduce the incidence of repeat births for teens less than 19 years of age to 19.3%.				
1. Teen Mothers Take Charge case management, health education and enrichment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## E. OTHER PROGRAM ACTIVITIES

Asthma: The Administration will complete the 3rd and final year of a CDC cooperative agreement--addressing asthma from a public health perspective--September 2004. An application for another 3-year grant for \$350,000 annually to implement the state asthma control plan was submitted to CDC April 1, 2004. Project staff worked with a DOH sister agency, the Preventive Health Services Administration, to enlist 75 stakeholders in the DC Asthma Collaborative, and organized them around 5 committees--health education, health services and quality assurance, environmental and occupational health, policy, planning and evaluation, and surveillance and epidemiology. The project epidemiologist compiled a profile report (see discussion of health systems capacity measure #1). The report was released in conjunction with a workshop on the state asthma plan at the annual maternal and child health coordinating conference February 2004. The state strategic plan will be formally accepted by the Asthma Collaborative and then submitted for DOH internal review, which is subject to 4 critical approvals: public information officer, principal investigator, senior deputy director, and the office of communications and community relations. According to the DOH interim director, approval and publication is expected by September 2004.

As a result of the grant, the DOH is establishing an asthma data warehouse, which will eventually include data on hospitals stays, emergency department visits, BRFS, YRBS, Youth Tobacco Survey, SLAITS, PRAMS, mortality, workman's compensation, disability compensation, Medicaid claims and environmental surveillance. Additional asthma related items are being added to BRFS, YRBS, Youth Tobacco Survey and PRAMS. Asthma is being included in the ongoing syndromic surveillance system on 7 syndromes managed by the DOH Bureau of Epidemiology and Health Risk Assessment. The Bureau received daily emergency department logs from 8 hospitals. Respiratory illness is 1 of the syndromes, of which asthma is included. This process is currently being automated through the Washington Automated Disease Surveillance System (WADSS) and asthma will be coded as an additional syndrome to facilitate emergency department surveillance. WADSS includes data on over-the-counter pharmaceuticals and school absenteeism. This system is expected to interface with the DC Public Health Utility, expected to be piloted summer 2004 by the DC Asthma Coalition and its partners, an interoperable, electronic network for real-time data sharing.

Staff organized an Asthma Forum in December 2003. Staff worked with colleagues in the DOH Environmental Health Administration, the Office of Early Childhood Development and a private sector non profit, the Children's Environmental Network to apply for a grant from the Environmental Protection Agency to assess child care centers for asthma triggers and to train providers on working with children with asthma. Although the application was not funded, the preparatory work was helpful in further needs identification.

Grant funds were used to subcontract with the DC Asthma Coalition to provide Physicians Asthma Care Educational Program (PACE) training to 25 primary care providers. This training is expected in part to address a need identified through key informant interviews--that not all District providers were aware of and trained in the application of current asthma protocols and practices. Other training needs to be addressed in the future include coding to maximize Medicaid and other 3rd party reimbursement.

Pending funding of the implementation grant, staff will work with DOH staff and organizations represented in the Asthma Collaborative on implementation. Primary strategies will include:  
Child care facilities: Parents will be surveyed to determine asthma history, and home assessments and child care facility assessments will be conducted to identify triggers. Staff and parents will be trained on reduction of environmental triggers. Staff will work with parents to secure and submit asthma plans to the child care facility and provide technical assistance to facilities and parents.  
Schools in high prevalence wards: Staff will work with school nurses and parents to obtain asthma management plans from primary providers to be maintained in students' health files. Schools will implement the EPA's Tools for School Asthma Tool Kit and work with the American Lung Association of DC to implement the open airways program. The project will continue to apply funds to the support

of a summer camp program for asthmatic children. The Asthma Collaborative will continue to seek solutions to identified needs and problems, for example, to the DC Public School's policy guidelines regarding asthmatic self-management. Students are not allowed to have their inhalers or medications on their persons while in school. Nor are they allowed to give them to the school nurse. There is a lack of nurses or staff who have the authority to administer medication, and due to limited coverage, a nurse may not be available on site when a student requires treatment. A compounding problem is that parents do not always provide sufficient information to protect the child's health.

The reduction of asthma-related mortality and morbidity is a focus area tracked in the District's Healthy People 2010 Biennial Implementation Plan 2003-2004. A primary strategy is to promote adherence by providers to the national standard for diagnosis and treatment of asthma.

To kick-off World Asthma Day May 3, 2004, the University of South Carolina was contracted to tape a panel presentation on asthma, which was subsequently shown several times on cable TV. Viewers were referred to the HEALTHLINE for information and referral to services, and staff reported that several calls were received.

See the attachment for information on vision screening, annual MCH coordinating conference, contract monitoring, the state plan for adolescent health, safe cribs distribution, SIDS and FASD prevention education, immunization of public school students, introduction of the uniform health record and tracking the status of various MOUs.

## **F. TECHNICAL ASSISTANCE**

The Administration has a number of needs for technical assistance in the areas of data acquisition and analysis, staff training and development, Web site design and development, and in preparing for the upcoming needs assessment and strategic plan. However, managers have decided to wait until the end of the fiscal year to delineate and prioritize these needs. This decision is based in part on the need to wait until plans for changes in the organization of the Department of Health are announced. Decisions about centralizing functions such as planning, evaluation and surveillance will affect the Administration's specific needs.

## **V. BUDGET NARRATIVE**

### **A. EXPENDITURES**

The District of Columbia Department of Health Maternal and Family Health Administration has made every effort to adhere to the conceptual framework as envisioned by the four tier pyramid for the services provided by the Title V Maternal and Child Health Block Grant. The emphasis for the use of Title V dollars to address important issues facing the maternal and child health population are based upon identified unmet needs for services provided through the Title V Block Grant. The Maternal and Family Health Administration uses its annual coordinating conference to gather participant input to guide program development and resource allocations. The conference is used to establish a common and unified vision for the future direction of Maternal and Child Health Services in the District of Columbia. The conference ensures the involvement of health subject experts, scientist, the healthcare provider community, institutions of higher learning, community-based organizations, professional associations consumers and partners.

### **B. BUDGET**

The Maternal and Child Health Title V Block Grant funds continue to be used to address the most fundamental health issues faced by the maternal and child population in the District of Columbia. These include but are not limited to the elimination of health care disparities, the reduction in the infant mortality rate and the development and improvement of the Maternal and Child Health Infrastructure and Systems of Care.

#### **TITLE V FUNDED AND NON-TITLE V FUNDED POSITIONS**

During this budget period there were 89 filled Title V funded positions within the Department of Health Maternal and Family Health Administration and 51 non Title V funded positions.

#### **MATCH AND MAINTENANCE OF EFFORT**

The District of Columbia Department of Health Maternal and Family Health Administration through the local funding of the programs listed below met and exceeded its Match and Maintenance of Effort as required under Sec. 505 (a)(4).

- ? School Health Nursing Program
- ? Supplemental School Health Nursing Services
- ? Genetic and Metabolic Testing and Counseling Services -- Howard University Hospital
- ? Genetic and Metabolic Testing and Counseling Services -- George Washington University Hospital
- ? Genetic and Metabolic Testing and Counseling Services -- Children's National Medical Center
- ? Genetic and Metabolic Testing and Counseling Services -- Georgetown University Hospital

#### **NEW AND EXPANDED INITIATIVES FOR FISCAL-YEAR 2002 INCLUDED:**

- ? Early Childhood Comprehensive Systems
- ? SSDI-Needs Assessment addressing Adolescent Health

## **VI. REPORTING FORMS-GENERAL INFORMATION**

Please refer to Forms 2-21, completed by the state as part of its online application.

## **VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS**

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

## **VIII. GLOSSARY**

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

## **IX. TECHNICAL NOTE**

Please refer to Section IX of the Guidance.

## **X. APPENDICES AND STATE SUPPORTING DOCUMENTS**

### **A. NEEDS ASSESSMENT**

Please refer to Section II attachments, if provided.

### **B. ALL REPORTING FORMS**

Please refer to Forms 2-21 completed as part of the online application.

### **C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS**

Please refer to Section III, C "Organizational Structure".

### **D. ANNUAL REPORT DATA**

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.