FY 10 PERFORMANCE PLAN
Department of Health

MISSION

The mission of the Department of Health (DOH) is to promote healthy lifestyles, prevent illness, protect the public from threats to their health, and provide equal access to quality healthcare services for all in the District of Columbia.

SUMMARY OF SERVICES

The Department of Health provides programs and services with the ultimate goal of reducing the burden of disease. We do this through a number of mechanisms that center around prevention, promotion of health, and expanding access to health care. The Department provides public health management and leadership through policy, planning, and evaluation; fiscal oversight; human resource management; grants and contracts management; information technology; government relations; risk management; communication and community relations; legal oversight; and facilities management. Our performance plan is based on three priority areas: 1) health and wellness promotion, 2) HIV/AIDS prevention and awareness, and 3) public health systems enhancement. Our success with these priorities will be measured in part by the performance measures in this document, but also by the many other measures of performance defined by the divisions within the agency.

PERFORMANCE PLAN DIVISIONS:

- Office of the Director
- Health Emergency Preparedness and Response Administration (HEPRA)
- Addiction Prevention and Rehabilitation Administration (APRA)
- Center for Policy, Planning, and Epidemiology (CPPE)
- HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)
- Health Regulation and Licensing Administration (HRLA)
- Community Health Administration (CHA)

Office of the Director

MISSION

Provide vision and leadership for the administrative functions of the health department to reach its primary goals of assessing and monitoring health and healthcare in DC, developing effective policies related to health, and assuring the public's health in general through education, regulation, and access to high quality, accessible, competent healthcare.

SUMMARY OF SERVICES

The Department of Health, Office of the Director, provides public health management and leadership through policy, planning, and evaluation; fiscal oversight; human resource management; grants and contracts management; information technology; government relations; risk management; communication and community relations; legal oversight; and facilities management.

OBJECTIVE 1: Develop and retain a competent workforce.

INITIATIVE 1.1: Ensure timely recruitment of a competent workforce by implementing workforce and succession planning across the department.

Workforce planning is a systematic, fully integrated organizational process that involves proactive planning to avoid talent surpluses or shortages, enabling managers to have the right people, with the right skills, in the right place, at the right time. The HR department will work closely with senior managers to develop the agency Workforce Plan to ensure that placements are available to do the following: 1) fill important vacancies; 2) determine how many and what types of jobs are needed in order to meet the performance objectives of the agency; 3) provide realistic projections for budget purposes; 4) and, as necessary, help administrations prepare for restructuring, reducing, or expanding its workforce. Senior managers will communicate their needs in standard monthly meetings with HR, OCFO and other leadership staff. The DOH Workforce Plan will be developed no later than November 30, 2009 and monitored/updated at the end of each month thereafter. In addition, the Workforce Plan will ensure the maintenance of an accurate and updated Schedule A, a roster of all department employees.

OBJECTIVE 2: Ensure effective administration and business practices across the Department.

INITIATIVE 2.1: Obtain delegated small procurement authority for DOH.

By mid-year FY10, the Project Manager for the DOH Contracts and Procurement Unit (CPU) will have received procurement training from OCP and, upon completion, obtained a warrant authorizing the manager to award purchases under $25,000. Current CPU staff will also be trained in processing small purchases. In FY 2009, DOH submitted to OCP approximately 400 small purchase requests valued at less that $25K. This number comprised roughly 75% of all DOH procurements in FY 09. By centralizing the procurement process, completing requests in-house should reduce turnaround time.

INITIATIVE 2.2: Increase the skill level of all DOH staff involved in the procurement process.
DOH experiences procurement difficulties at both the pre- and post-award stages due to insufficient planning, inadequate preparation of supporting documentation (such as statements of work, sole source justifications, and Project Initiation Forms), errors made in budget and accounting coding, and poor post-award administration at the program level. DOH will continue to expand current in-service training offerings, and establish advanced training to ensure that employees responsible for serving as contracting officers technical representatives (COTR) are competent and accountable contract administrators. By the end of FY 2010, approximately 20 current COTRs will receive advanced contract administration from DOH's ACO. This training will provide uniform tools and information to improve their skills in performance review and monitoring, indentifying performance problems, effective communication with contractors, and dispute resolution. Trained program staff will become procurement leads who will continue working under program supervision to effect proper procurement planning, early and ongoing communication with OD procurement staff and OCP, effective contract/purchase order management and timely vendor payment.

INITIATIVE 2.3: Improve the efficiency of grants management by implementing a risk-based monitoring system for all sub grants.
DOH will continue its integration of a risk-based monitoring framework to all grants management policy and procedure manuals. Each sub grant should have a monitoring plan based on assessment of the recipient's current fiscal/administrative capacity, history -of performance and specific needs of the funded program. The implementation of Risk-based monitoring has increased DOH's capacity to identify and target sub-grantee risk of failure and non-compliance while also increasing the value-added of corrective and supportive mechanisms delivered by DOH.

INITIATIVE 2.4: Reduce the number of DOH leased facilities to control fixed costs.
DOH will relocate operations from four facilities in FY 2010 to reduce leased space. Those facilities include: 3720 MLK Avenue SE; 2100 MLK Avenue SE; 3330 V Street NE; and 33 N Street NE.

OBJECTIVE 3: Effectively communicate with stakeholders and the community about public health assets and challenges.

INITIATIVE 3.1: Improve the usability of the DOH website and intranet.
Accurate and accessible information is critical to a robust public health infrastructure; and the current DOH website and intranet site contains outdated information that leaves both consumers and staff unaware of available resources. In FY 2010, DOH will have a fully dedicated webmaster responsible for upgrading the content and usability of its website and intranet site and for maintaining the necessary protocols to ensure continued accuracy and usability.

OBJECTIVE 4: Reduce Exposure to Potential and Incurred Losses Related to Risk Management.

INITIATIVE 4.1: Identify "risk clusters" in DOH operations and work to mitigate potential losses from this source.
Risk is spread unevenly across DOH activities and programs. Anecdotal analysis of Unusual Incident Reports suggests that certain activities and programs show increased risk exposure, either because of the nature of the tasks or because of current staffing or experience levels. This initiative will focus on analysis of incident reports to identify "risk clusters." That analysis will be shared with management of the affected activities and programs. An effort will be made to mitigate risk levels by making recommendations to management as to changes in policy, practice, training, or other interventions.

INITIATIVE 4.2: Improve disposition of incurred losses by training managers in DOH administrations to use unusual incident reports (UIR).
During FY09, this approach was field-tested with one DOH Administration. In FY10 this will become a formal initiative, with the goal of training managers at three DOH Administrations to use UIRs. As part of this training, an effort will be made to present incident reporting as part of the larger concept of risk mitigation and control, as well as to present risk management as an integral component of manager responsibilities.

PROPOSED KEY PERFORMANCE INDICATORS-Office of the Director

Metric	FY 2008 Actual	FY 2009 YTD	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2012 Target
Develop and retain a competent workforce						
# of FTEs	1067	911	911	835	835	835
Vacancy Rate	N/A	N/A	N/A	8%	7%	6%
% of new hires on board within 60 days after job posting	N/A	N/A	N/A	75%	80%	85%
Quality of new hires based on average quarterly probationary job performance rating	N/A	N/A	N/A	3	3.5	3.5
Turnover Rate	N/A	N/A	N/A	5%	4%	4%
Ensure effective business practices						
% of sub-grant invoices paid within 30 days of receipt	Pending	Pending	80%	85%	90%	95%
# of reported single audit findings that indicate material non-compliance or a	FY 06-12	Pending	≤ 8	≤6	≤4	<4

reportable condition						
% lapse of total dollar amount of federal grant budget.	3%	TBD	≤ 4%	< 4%	<3%	<3%
% of grants management specialists receiving inservice or a skills-based grants management training.	Pending	Pending	60%	70%	75%	75%
# of COTRs receiving advanced training	N/A	N/A	N/A	10	15	20
# of procurement related trainings held annually	6	4	4	4	4	4
Square footage of leased space	242,905	242,905	0	149,941	0	0
Facility Cost per DOH employee	$9,548	$9,548	0	$9,548	0	0
Effectively Communicate with Stakeholders about public health assets and challenges						
# of visitors to the DOH website	N/A	593,273	600,000	690,000	724,500	760,725
Average time spent on website per user	N/A	4:53	4:00	5:00	5:20	5:30
Reduce Exposure to Potential Losses Related to Risk Management.						
# of Safety Incidents	N/A	16	16	15	12	9
% of DOH Employees in Need of Safety Training	N/A	100%	99%	99%	70%	10%
# of Professional Educational and Training Activities Attended by ORM	N/A	6	8	10	12	14
# of Unusual Incident Reports Filed	N/A	272	290	180	150	130
# of Administrations Trained in the Use of Unusual Incident Reports (UIR)	N/A	0	0	1	3	5 (Also refresher & new staff)

STANDARD CITYWIDE OPERATIONAL MEASURES

Measure	FY09 YTD
Contracts	
KPI: % of sole-source contracts	
KPI: Average time from requisition to purchase order for small (under $100K) purchases	
KPI: # of ratifications	
KPI: % of invoices processed in 30 days or less	
Customer Service	
KPI: OUC customer service score	
Finance	
KPI: Variance between agency budget estimate and actual spending	
KPI: Overtime as percent of salary pay	
KPI: Travel/Conference spending per employee	
KPI: Operating expenditures "per capita" (adjusted: per client, per resident)	
People	
KPI: Ratio of non-supervisory staff to supervisory staff	
KPI: Vacancy Rate Total for Agency	
KPI: Admin leave and sick leave hours as percent of total hours worked	
KPI: Employee turnover rate	
KPI: % of workforce eligible to retire or will be within 2 years	
KPI: Average evaluation score for staff	
KPI: Operational support employees are percent of total employees	
Property	
KPI: Square feet of office space occupied per employee	
Risk	
KPI: # of worker comp and disability claims per 100 employees	

Health Emergency Preparedness and Response Administration (HEPRA)

SUMMARY OF SERVICES

The Health Emergency Preparedness and Response Administration (HEPRA) provides regulatory oversight of Emergency Medical Services including Emergency Medical Services providers, associated educational institutions, EMS agencies and their operations. HEPRA also ensures that DOH and its partners are prepared to respond to citywide medical and public health emergencies, such as those resulting from terrorist attacks or large accidents. The Public Health Laboratory (PHL) functions as a state and local laboratory providing analytical and diagnostic services for programs within the Department of Health (DOH) and various free and non-profit clinics within the District.

OBJECTIVE 1: Improve the quality and efficiency of Emergency Medical Services in the District of Columbia.

INITIATIVE 1.1: Improve the quality of education provided at Emergency Medical Services instructional institutions through comparison of local test scores with national test score averages not later than September 30, 2010.

An EMS provider is only as good as the instruction they receive. By monitoring instructional institutions National Registry test scores, we can ensure that DC instructional institutions are meeting or exceeding national standards. HEPRA will work with individual institutions that do not meet national standards to create an individualized improvement plan. HEPRA will monitor progress through continued comparison of test scores to ensure that all EMS students have an increased understanding of the nationally prescribed curriculum. National Registry testing became a District requirement on July 1, 2009. Reporting on instructional institution progress will begin once National Registry testing becomes mandatory and all training centers are compliant.

OBJECTIVE 2: Improve public health emergency preparedness within the District of Columbia.

INITIATIVE 2.1: Develop and provide emergency preparedness training to health care facility staff.

HEPRA in collaboration with the District of Columbia Healthcare Coalition will work with the District of Columbia Health Care Association (DCHCA) and the District of Columbia Primary Care Association (DCPCA) to develop and implement emergency preparedness training in the District's long term care facilities and community health centers. Training which will include basic Emergency Preparedness, Incident Command Training, NIMS, the National Response Framework, and understanding the District Response Plan. A major focus will be to develop templates for Emergency Operations Plans (EOP) and Evacuation Plans that will allow each facility to tailor the plans to their unique situations. By the end of FY09, at least 50% of the District's long-term care facilities will develop evacuation plans. By the end of FY10, at least 75% of the long-term Care facilities will develop evacuation plans. All of the District's long-term care facilities will develop evacuation plans by FY11.

INITIATIVE 2.2: Improve the ability of the Department of Health to respond to a crisis situation or long term public health emergency by training 100% of DOH staff in Incident Command System by December 31, 2009.
HEPRA will train 100% of Department of Health employees on the basics of the Incident Command System (ICS) to be capable of performing 24 hour operations in the Health Emergency Coordination Center during crises situations or long term public health emergencies. Training will incorporate ICS courses 700, 100 and 200, which are the basic training requirements.

OBJECTIVE 3: Improve the ability of the public health laboratory to provide quality healthcare support and emergency preparedness services within the District of Columbia.

INITIATIVE 3.1 - Improve procedures for submitting patient specimens and obtaining specimen results by June 30, 2010. Public Health Lab will develop an information system solution for submission of electronic specimen requests and chain of custody forms by June 30, 2010 in order to enhance specimen processing accuracy and timeliness. PHL will continue to provide training for proper specimen submissions and use of secure fax or web portal for patient test results to reduce specimen turnaround time by June 30, 2010.

PROPOSED KEY PERFORMANCE INDICATORS- Health Emergency Preparedness and Response Administration

Metric	FY 2008 Actual	FY 2009 YTD	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2012 Target
Objective I						
% of District of Columbia EMTs that meet or exceed National Registry test standard.	**Pass 1st Attempt** DC-71%	**Pass 1st Attempt** DC-64%	**Pass 1st Attempt** DC-64%	**1st Attempt** DC-70%	**1st Attempt** DC-75%	**1st Attempt** DC-80%
Certifications are rapidly issued to reduce downtime of uncertified providers	5 business days 95% of the time	5 business days 95% of the time	4 business days 95% of the time	2 business days 95% of the time	2 business days 95% of the time	2 business days 95% of the time
Objective II						
% of DOH staff trained in the National Incident Management System	20%	20%	30%	70%	75%	80%
% of hospitals compliant with National Incident			80%	90%	100%	100%

Management System training requirements						
% of hospitals that adopted bed availability data standards and definition	UNK	90%	100%	100%	100%	100%
% of Long-term Care facilities that develop Facility Evacuation Plans	N/A	0%	90%	100%	100%	100%
% of Community-based Health Centers that biannually update Emergency Operations Plans and Facility Evacuation Plans	N/A	0%	90%	100%	100%	100%
Objective III						
% of clients using the secure web portal to obtain lab results.	0	TBD	40%	60%	80%	79%
% of clinics submitting request forms electronically	0%	0%	60%	80%	90%	95%
% of clinics receiving specimen test results by secure fax or web portal	35%	35%	60%	80%	90%	95%
% of clinics reporting above average satisfaction with laboratory services.	TBD	TBD	70%	80%	90%	95%

Addiction Prevention and Recovery Administration

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SUMMARY OF SERVICES

The Addiction Prevention and Recovery Administration (APRA) promotes access to substance abuse prevention, treatment and recovery support services. Prevention services include raising public awareness about the consequences of substance abuse and providing evidence-based program resources to community and faith-based organizations to promote wellness and reduce substance use and abuse. Treatment services involve assessment and referrals for appropriate levels of care. Treatment services also include maintenance of a comprehensive continuum of substance abuse treatment services including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy. Recovery support services include wrap-around services, such as mentoring services, education skills building and job readiness training. APRA ensures the quality of these services through its regulation and certification authority as the Single State Agency for substance abuse.

OBJECTIVE 1: Implement an integrated prevention system to reduce priority risk factors and increase protective factors that reduces substance use and abuse by District children, youths and families.

INITIATIVE 1.1: Develop a culturally sensitive infrastructure and substance abuse prevention delivery system at District-wide and ward levels.

APRA will develop a strategic prevention plan by April 2010. For each ward, the strategic prevention plan will assess risk and protection factors, identify existing prevention resources, and determine prevention service gaps and capacity building needs. The development of this strategic plan reflects APRA's commitment to making data-driven decisions in its allocation of prevention resources.

INITIATIVE 1.2: Establish a data and evaluation system and increase the use of data for substance abuse prevention planning.

APRA will modify its client information system to include prevention specific outcome measures by September 2010. Modification of the client information system to collect prevention data will establish APRA's first comprehensive prevention database. APRA will continue to work in partnership with its epidemiological outcomes work group and community partners to assess and report the incidence and prevalence of risk and protective factors at District-wide and ward levels.

INITIATIVE 1.3: Develop community capacity to prevent the onset of, and reduce the progression of, substance abuse at the ward level.

In FY2010, APRA will establish 4 Prevention Centers to implement ward-level training and community capacity building strategies, monitor data to evaluate performance, and identify priority populations for resource allocation. The development of these Prevention Centers will enable APRA to educate, empower and partner with community stakeholders in a more focused, collaborative, and effective manner.

OBJECTIVE 2: Maintain and support a comprehensive continuum of accessible substance abuse treatment services.

INITIATIVE 2.1: Increase access to the APRA adult continuum of substance abuse treatment services.
APRA will increase access to the adult continuum of substance treatment services by extending the operation of the Assessment and Referral Center to 10 hours daily. APRA will also establish a 24-hour helpline to direct residents to needed substance abuse treatment resources. Extended operating hours and the establishment of the 24-hour hotline will be implemented in January 2010.

INITIATIVE 2.2: Improve the efficiency and effectiveness of the APRA adult and adolescent substance abuse treatment system.
In FY2010, APRA will implement a comprehensive client information system and electronic medical record system to improve client engagement, retention in care, and treatment completion rates. The implementation of the client information system will facilitate client linkages to care, enable APRA to monitor the delivery of treatment services in real time, and provide APRA with a system-wide mechanism to identify quality care and address service deficiencies. The client information system will be fully implemented by February 2010.

INITIATIVE 2.3: Increase access to the APRA adolescent continuum of substance abuse treatment services.
APRA will expand its network of Medicaid certified adolescent substance abuse treatment providers by 100% in FY2010.

OBJECTIVE 3: Promote long-term recovery from substance use disorder through maintenance of a comprehensive continuum of accessible recovery support services.

INITIATIVE 3.1: Increase access to the APRA continuum of recovery support services.
In FY2010, APRA will expand its network of recovery support service providers to enhance services to the following target populations: adolescents, gay, lesbian, bisexual and transgendered individuals, veterans, and women with children. To better serve these populations, APRA will contract with 4 new recovery support service providers.

Proposed Key Performance Indicators- Addiction Prevention and Recovery Administration

Metric	FY 2008 Actual	FY 2009 Actual	FY 2009 Target	FY 2010 Projection	FY 2011 Projection	FY2012 Projection
# of community capacity-building training sessions and technical assistance efforts provided to organizations in support of evidence-based prevention programs implementation.	UNK	2	N/A	10	15	25
% of clients presenting at the Assessment and Referral Center that complete the assessment and referral process within 2 hours.	UNK	TBD	N/A	95%	100%	100%
% of clients that are screened for mental health disorders during the assessment and referral process.	UNK	TBD	N/A	100%	100%	100%
% of clients of clients assessed and referred for service that are admitted to a community-based provider.	UNK	TBD	N/A	85%	90%	90%
% of clients that complete the detoxification and stabilization program within 3-5 days.	UNK	TBD	N/A	95%	95%	95%
%of clients referred to outpatient or intensive outpatient services that complete 2 treatment sessions within the first 2 weeks of admission to	UNK	TBD	N/A	90%	90%	95%

Metric	FY 2008 Actual	FY 2009 Actual	FY 2009 Target	FY 2010 Projection	FY 2011 Projection	FY2012 Projection
treatment.						
% of clients referred to residential treatment services that remain engaged in active treatment for at least 30 days.	UNK	TBD	N/A	90%	90%	95%
% of clients referred to recovery support services that redeem service vouchers.	UNK	80%	N/A	85%	90%	N/A
% of recovery support clients that receive a 6-month post admission interview.	UNK	85%	N/A	90%	90%	N/A
% of recovery support clients that maintain abstinence from alcohol and drugs 6 months post admission.	UNK	40%	N/A	45%	50%	N/A

NOTE: Due to ongoing transition, APRA will begin reporting clinical outcomes in the 3rd quarter of FY2010.

Center for Policy, Planning, and Epidemiology

SUMMARY OF SERVICES

The Center for Policy, Planning, and Epidemiology is responsible for developing an integrated public health information system to support health policy decisions, state health planning activities, performance analysis, and direction setting for department programs; health policy, health planning and development; health research and analysis; vital records; and for planning, directing, coordinating, administering, and supervising a comprehensive Epidemiology and Health Risk Assessment program, which involves federal, state, county and municipal functions.

OBJECTIVE 1: Promote the availability of accessible, high quality and affordable healthcare services.

INTITIATIVE 1.1: Revise the regulations for the Certificate of Need (CON) process to reduce the timeframe for reviewing and issuing a decision on complete applications by January 2010.

Healthcare providers seek Certificate of Need approval, as required by law, prior to establishing new health care services or facilities within the city. State Health Planning and Development Agency (SHPDA) approves or denies projects based on what is needed to promote accessible, quality and affordable services. The review is done with the advice and guidance of the Statewide Health Coordinating Council (SHCC), a body appointed by the Mayor with the advice and consent of the D.C. Council. By revising regulations, DOH will reduce the time necessary to make decisions from 180 days to 90 days.

OBJECTIVE 2: Monitor health care facilities' compliance with the requirements that govern the provision of uncompensated care to needy residents.

INITIATIVE 2.1: Enhance compliance monitoring to ensure that the provision of uncompensated care is met by all health care facilities with a Certificate of Need by evaluating financial data and issuing an annual report.

To help ensure access to healthcare for the uninsured, District law requires health care facilities with an approved Certificate of Need (CON) to report on their provision of a reasonable volume of uncompensated care through the annual compliance level of 3% of their operating costs (total operating expenses of a facility as set forth in an audited financial statement or its equivalent) minus the amount of reimbursement, if any, under Titles XVIII and XIX of the Social Security Act. Currently there are 13 private hospitals, 18 nursing homes, 13 primary care clinics, and 30 home health care agencies and hospices required to comply with this legal requirement. By the end of FY 2010, CPPE will evaluate financial data on all of these providers and issue an FY09 annual report.

PROPOSED KEY PERFORMANCE INDICATORS- Center for Policy, Planning, and Epidemiology

Metric	FY 2008 Actual	FY 2009 YTD	FY 2009Target	FY2010 Projection	FY 2011 Projection	FY 2012 Projection
Objective I						
Number of decisions issued on certificate of need applications*	23	9	16	16	16	16
Objective II						
Percent of health care facilities submitting uncompensated care reports:						
Hospitals	100%	100%	0%	100%	100%	100%
Nursing Homes				75%	100%	100%

*The number of certificate of need applications is expected to decrease due to the impact of the global recession on capital investments and new business development.

HIV/AIDS, Hepatitis, STD, and TB Administration

SUMMARY OF SERVICES

The HIV/AIDS, Hepatitis, STD, and TB Administration partners with health and community-based organizations to provide HIV/AIDS, Hepatitis, STD, and TB prevention and care services. Services include prevention tools and interventions, medical care and supportive services, housing services for persons living with HIV/AIDS, HIV counseling and testing, data and information on disease-specific programs and services. Further, the administration provides information on the impact of these diseases on the community, education, information, referrals, and intervention services. The AIDS Drug Assistance Program (ADAP) provides drugs at no cost to eligible District residents who are HIV positive or have AIDS. The HIV/AIDS, Hepatitis, STD and TB Administration administers the District's budget for HIV/AIDS, Hepatitis, STD, and TB programs, provides grants to service providers, provides direct services for TB and STDs, monitors programs, and tracks the rates of HIV, Hepatitis, STDs, and TB in the District of Columbia.

OBJECTIVE 1: Reduce transmission/prevent new infections of HIV, STD, TB, and Hepatitis through early diagnosis and treatment, harm reduction, and behavior change interventions.

INITIATIVE 1.1: Expand Routine HIV Screening.
Routine, opt-out HIV testing is a key component of the strategy to prevent new infections. The expansion of opt-out HIV testing will focus on various medical settings, including 6 emergency departments, 7 labor and delivery sites, and primary care providers. By the end of 2010, the routine testing policy and practice will be adopted by three of Medicaid and Alliance MCOs and at least one DC government employee health insurance plan, as well as all of the medical settings that are receiving support and/or testing kits from HAHSTA. Ongoing access to community-based rapid HIV testing will be supported.

INITIATIVE 1.2*:* Expand Partner Services (PCRS).
Another key strategy in preventing new HIV and STD infections is to increase testing among persons at highest risk. HAHSTA and its community partners will target those individuals by standardizing the offering of partner services for both STD and HIV to persons testing positive for either. Although partner services have been available in the past, they have not been highly utilized. In FY 2010, HAHSTA will be integrating HIV and STD partner services into one program and will expand coverage to 80% or more of those persons newly testing positive for HIV, syphilis and other STDs through the publicly-supported testing programs.

INITIATIVE 1.3: Enhance Services to Prevent Mother-to-Child Transmission of HIV.
While peri-natal infection with HIV is nearly 100% preventable, children in the District have continued to be born with the virus since 2005. The District will eliminate peri-natal HIV transmission through rapid testing in labor & delivery sites, implementation of standard of care for routine opt-out HIV screening in prenatal and reproductive health

settings, intensive outreach through CHA's Healthy Start program, and application of peri-natal exposure surveillance through the Vital Records electronic birth record system. This initiative works within the context of the Mayor's city-wide Child Health Action Plan, with specific attention to the reduction of infant mortality and morbidity.

INITIATIVE 1.4: Expand DC Needle Exchange Program (DC NEX).
HAHSTA will increase access to comprehensive substance abuse and HIV prevention services, specifically through expansion of harm reduction and needle exchange services. This expansion will be guided by the Substance Abuse and HIV Prevention Strategic Plan, which will be completed early in FY 2010. A key focus will also be to connect clients of the DC NEX program to HIV testing as well as drug detoxification and treatment programs supported by APRA.

INITIATIVE 1.5: Expand Condom Distribution.
In FY08, Mayor Fenty pledged to triple the size of the public condom distribution program from approximately 1,000,000 condoms per year to 3,000,000 condoms per year in FY10. This 3,000,000 goal will place DC on par with New York City's program, the only other city-wide public condom program in the United States. Once achieving this 3,000,000 goal, additional needs assessment will be performed to inform any further scale up. HAHSTA has built internal capacity to scale-up and expects to provide 3 million condoms per year in FY10.

INITIATIVE 1.6: Strengthen Community-level Capacity for HIV Care and Prevention Activities.
HAHSTA will work to expand utilization of HIV care and prevention services by increasing capacity within community organizations that have not typically offered HIV services as part of their core mission (youth groups, faith-based groups, etc). The Effi Barry Initiative, the Faith-Based Leadership Initiative, and community-based health education/risk reduction programs provide training in organizational management, HIV technical competencies, and service delivery to reach District Residents with services and information about primary health care, disease prevention, testing and access to care, and prevention skills and strategies. HAHSTA will work to train 12 new community partners through Effi Barry each fiscal year, as well as continue to support the alumni of the program. The Faith-Based Leadership Initiative will work specifically with churches and other faith-based groups to begin or integrate HIV prevention and care service provision.

OBJECTIVE 2: Expand education, behavioral prevention, and STD/HIV diagnosis and treatment programs for young persons in the District of Columbia.

INITIATIVE 2.1: Expand Youth HIV and STD Prevention.
It is critical that the District support young people to develop awareness, skills, and behaviors that lead to a reduction of risk for STDs and HIV throughout their lifetime. Activities to achieve this goal in FY2010 will include: mainstreaming of STD/HIV information into youth activities that do not currently address the issue; training all school nurses working in DC Public Schools to integrate routine STD and HIV prevention and screening; education for in-school and out-of-school youth to build skills

that allow them to reduce their risk of infection; and expanding youth outreach/school-based STD/HIV testing and treatment services. This initiative works within the context of the Mayor's Citywide Child Health Action Plan, and is directly aligned with the 2007-2010 Youth and HIV Prevention Initiative Plan. Over 2,000 youth were reached through these activities in FY 2008 and over 3,000 year-to-date in FY 2009. HAHSTA intends to substantially increase the coverage of these programs in FY 2010, working in all public schools (20 DCPS and 3 chartered) and reaching over 10,000 youth.

OBJECTIVE 3: Improve care and treatment outcomes, as well as quality of life, for HIV-infected individuals through increased access to, retention in, and quality of care and support services.

INITIATIVE 3.1: Expand Utilization of Quality Care and Treatment Services. HAHSTA will work to increase the utilization of HIV care services by DC residents and ensure the availability of critical and effective support services to maximize retention in care and health outcomes. HAHSTA will accomplish this by focusing on the four R's: recruitment, recapture, retention and results. This will be measured through increased linkage rates from testing positive to initiating HIV care, by the number of HIV primary care providers participating in recapture blitz activities, and by the number of previously-positive persons linked to HIV care. HAHSTA will work with DOH and DHCF to maximize combined coverage by Medicaid (including the Medicaid 1115 Waiver), DC Alliance, and DC ADAP. This will be measured through increased enrollment of HIV-infected persons in the DC AIDS Drug Assistance Program (DC ADAP), Medicaid 1115 waiver, and Medicaid/Medicare programs.

INITIATIVE 3.2: Expand Housing Options for persons living with HIV/AIDS. Stabilize and increase the number of persons living with HIV/AIDS receiving housing supports by building efficiencies in the HOPWA program, maximizing the proportion of HOPWA funding going to direct housing services, and expanding linkages of HIV-infected persons to non-HOPWA housing supports and solutions.

PROPOSED KEY PERFORMANCE INDICATORS- HIV/AIDS, Hepatitis, STD, and TB Administration

	FY 2008 Actual	FY 2009 YTD[13]	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2012 Target
Objective I						
# of new HIV (HIV/AIDS) cases diagnosed within the fiscal year[2]	975	498	1,400	1,500	1,500	1,500

[1] Year-to-date represents 3rd quarter (June 30, 2009) achievements.
[2] Due to increased testing, DOH expects that the number of newly diagnosed HIV cases will increase for several years. Indentifying these new cases is critical to increase survival of patients and decrease future transmissions. Reporting delays may lead to upward revision of actual numbers over time.

#of publically supported HIV tests performed	72,864	56,381	100,000	125,000	150,000	150,000
#of persons newly diagnosed with HIV through expanded partner services (PCRS)	19	24	40	80	150	200
#of needles off the streets through DC NEX Program	190,016	206,242	250,000	300,000	350,000	350,000
# of condoms distributed by DC DOH Condom Program	1.52 million	1.20 million	1.75 million	3 million	3 million	3 million
#of peri-natal HIV infections	3	0	0	0	0	0
Objective 2						
#of youth (15-19 years) screened for STDs through youth outreach programs (parks and recreation, summer employment, schools, etc)	2,091	2,807	5,000	10,000	12,000	12,000
Objective 3						
#of persons enrolled in ADAP	1,644	2,122	2,000	2,650	3,350	4,000
% of HIV positive persons with viral load suppression (below 400)[3]	TBD	TBD	TBD	TBD	TBD	TBD
# of families receiving long-term housing vouchers through HOPWA	331	313[4]	310	320	320	320
# of families receiving short-term (project-based and emergency) housing assistance through HOPWA[5]	109	337[6]	110	110	110	110
Number of families receiving HOPWA Short Term Rental and Mortgage Assistance (STRMU)	242	267[7]	260	260	260	260

[3] HAHSTA does not have current data for this measure, but has the preliminary systems in place to measure this indicator. We expect to have data by the end of FY 2009.
[4] Year-to-date for FY 2009 is for reports of services from October, 2008 through August 2009.
[5] The number of reported served through project-based transitional or emergency housing is not de-duplicated for the year to date, as families access these services more than once during the year. Final tallies and targets are duplicated
[6] Year-to-date for FY 2009 is for reports of services from October, 2008 through August 2009.
[7] Year-to-date for FY 2009 is for reports of services from October, 2008 through August 2009.

Health Regulation and Licensing Administration (HRLA)

SUMMARY OF SERVICES

HRLA is responsible for the inspection of restaurants and food establishments; massage parlors; barber and beauty shops; swimming pools; rodent control of public spaces; and the care, adoption and licensing of animals. The administration also manages the licensing of health care professionals; child care facilities, hospitals, nursing home facilities, intermediate care facilities, assistant living facilities, pharmacies, community residence facilities; and radiation emitting equipment.

OBJECTIVE 1: The Health Care Facilities Division (HCFD) will conduct on-site surveys to ensure health, safety, sanitation, fire, and quality of care requirements of facilities that are licensed and/or certified. HCFD will identify deficiencies that may affect state licensure and/or eligibility for federal compliance under the Medicare and Medicaid programs.

OBJECTIVE 2: Initiate, implement and/or revise licensing regulations for health care professionals.

INITIATIVE 2.1: Implement District Law regarding criminal background checks.
To meet the requirements of District law, new healthcare applicants will be required to undergo a background check. Jurisdictional applicants will be referred to the Metropolitan Police Department (MPD) for fingerprinting and other jurisdictions will be required to submit fingerprint cards from their local precinct. In each instance, fingerprints will be submitted by MPD to the Federal Bureau of Investigations. By 2011, new and renewing applicants will undergo a criminal background check.

INITIATIVE 2.2: Implement a compliance office for follow-up on complaints/incidents.
The purpose of HRLA's new compliance office is to have a one-stop point of entry to receive complaints and incidents from citizens and healthcare establishments. The Office will log, track and analyze data received, and identify complaint/incident trends, and conduct follow-up investigations on facilities' correction action plans.

INITIATIVE 2.3: Implement the Adverse Events reporting system.
The organization is moving from a paper-oriented process to a real time Web-based reporting system. This will allow reporting entities to receive immediate feedback on the quality of their submission, to amend reports as required, and to ask questions of trained consultants so that all issues are addressed properly in initial reports. The results of the report will enable HRLA to provide technical assistance on preventive measures.

INITIATIVE 2.4: **Increase number of Licensed, Registered or Certified healthcare professionals regulated by DOH.**
Per the Health Occupation Revision Act 2009 (HORA), HRLA will be regulating new categories of health care professionals including psychology associates, graduate professional counselors, three (3) levels of addictions counselors, pharmacy technicians, five (5) different nursing assistant personnel, polysomnographic technicians, speech language pathologist, audiologist and dental technicians.

INITIATIVE 2.5: Increase the ability of Boards to discipline health professionals.
HRLA will improve the ability of the Boards to discipline health professionals by increasing the number of disciplinary categories and methods to provide discipline. The amendment to the HORA 2009 expands the number of laws that the boards can use to discipline healthcare professionals.

OBJECTIVE 3: Promote transparency and simplification of the food facility inspection system.

INITIATIVE 3.1: To develop and implement a comprehensive database for food facility inspections accessible by the public.
HRLA will provide a computerized tool for sanitarians to conduct food facility inspections that are consistent, clear and concise and easy to understand. The inspector would have access to previous inspections and provide the facility manager with the inspection report on the premises. In 2010, the inspection forms would be uploaded to the DOH web site for public view. This system will be accessible by the public to help foster informed decisions and to incentivize better health practices.

PROPOSED KEY PERFORMANCE INDICATORS- Health Regulation and Licensing Administration

Metric	FY 2008 Actual	FY 2009 YTD	FY2009 Projection	FY2010 Projection	FY2011 Projection	FY2012 Projection
Initiate, implement and/or revise licensing regulations for health care professionals.						
# of background checks conducted	N/A	N/A	N/A	8,400	22,000	24,000
# of complaint follow-ups conducted in compliance office	N/A	N/A	N/A	25	200	300
# of adverse events reported in nursing homes & hospitals	524	328	594	640	620	585
# of additional health care professionals regulated by HRLA	N/A	N/A	N/A	6,000	6,600	6,600
Promote transparency and simplification of the food facility inspection system.						
Number of food facility inspections.	9,322	5,564	9,500	10,000	10,250	10,500
# of food samples tested from food facilities throughout the District.	444	357	450	550	600	600

Community Health Administration (CHA)

SUMMARY OF SERVICES

The Community Health Administration provides chronic and communicable disease prevention and control services, community-based forums and grants, expert medical advice, health assessment reports, and pharmaceutical procurement and distribution, disease investigations and disease control services to District residents, workers and visitors so that their health status is improved. This work is performed through its bureaus:

- Nutrition and Physical Fitness Bureau
- Perinatal and Infant Health Bureau
- Child, Adolescent and School Health Bureau
- Cancer and Chronic Disease Prevention Bureau
- Primary Care Bureau
- Pharmaceutical and Procurement Distribution Bureau

OBJECTIVE 1: Improve the quality, access, and outcomes of health care services for children, families and adults in the District.

INITIATIVE 1.1: By September 2010 complete implementation of the DOH components of the Child Health Action Plan which targets the reduction of infant mortality and morbidity in the District of Columbia.

In February 2008, the District's Child Health Action Plan was released prescribing specific goals to improve infant health in the District by 2010. DOH is implementing a variety of action steps over the next 12 months to improve infant health. Those include efforts to:

- Evaluate the productivity and potential continuation of the Advisory Committee on Perinatal, Infant and Inter-conceptual Health and Development by April 2010
- Develop a DC Perinatal Risk Screening protocol for prenatal providers in collaboration with Department of Health Care Finance by January 2010
- Collaborate with the Center of Policy, Planning and Epidemiology to receive a weekly electronic birth record report that will enable the identification of at-risk infants and mothers by September 2001

INITIATIVE 1.2: Improve the District of Columbia's population-based monitors of quality of care for individuals, population health, and per capita costs concerning services for persons living with chronic conditions.

By September 2010 DOH will create a web-based dashboard to integrate claims and encounters data with data drawn from Vital Records, BRFSS, and the Cancer Registry for DC residents who rely on Medicaid and Alliance (40% of population). Analysis of this data will provide indicators of how to direct investments in chronic care.

OBJECTIVE 2: Ensure preventative services for children in DC.

INITIATIVE 2.1: Provide and monitor the recommended screenings received by DC school children for hearing, vision, scoliosis and BMI by improving data collection mechanisms.

Health screenings in schools enable early detection and referral for treatment of commonly occurring abnormalities that affect children's abilities to learn. However, except in very limited cases (less than 10%) such screenings are not routinely provided. Therefore, the proportion of school-aged children in grades Pre-K, K, 2, 4, 6, 8 and 10 who receive vision, hearing and scoliosis screenings will be increased to 90%. Additionally, the screening requirements will include BMI on students in grades 2, 4 and 6, which heretofore were not provided until grade 9. School nurses will provide evidence of testing on monitoring site visits conducted by the administration and submit screening results annually for review.

INITIATIVE 2.2: Increase the capacity to measure the progress of the School Nurse Program by implementing a new data management system.
During FY 10, the School Nurse Program will implement a data management system that provides a comprehensive picture of services provided by school nurses. The system will help determine the impact on the quality of screenings and referral services being provided to students and the impact of those services over a 3-5 year period on child health.

INITIATIVE 2.3: Monitor comprehensive physical examinations by providers by collaborating with DCPS and OSSE.
Annual assessments of students' health records in the District of Columbia public schools indicated that a small percentage of students received comprehensive physical examinations and oral health screenings as mandated by DOH and DCPS health standards. As such, the administration will actively collaborate with the Office of the Deputy Mayor for Education, Chancellor for DCPS, OSSE and the HCFA to identify schools where standards are not being met, link students to insurance resources, and establish medical home.

OBJECTIVE 3: Improve the quality of nutrition-related care delivery to customers at 4 CSFP local agency sites, 23 WIC clinics, one mobile unit, and 26 Farmers' Markets to improve health, increase breastfeeding, reduce obesity and support healthier food choices.

INITIATIVE 3.1: Increase breastfeeding initiation among postpartum WIC mothers by 1% annually through partnerships with community-based lactation advocacy organizations.

PROPOSED KEY PERFORMANCE INDICATORS-Community Health Administration

Metric	FY 2008 Actual	FY 2009 YTD	FY 2009 Target	FY 2010 Target	FY 2011 Target	FY 2012 Target
# of prenatal home visits per client per month.	2.5	2.1	2	2	2.5	3
# of women enrolled in Healthy Start case management per year.	496	656	600	690	700	725
# of men enrolled in Healthy Start case management per year.	69	130	150	150	160	170
% of newly enrolled Healthy Start pregnant women who report entering prenatal care in first trimester per ***calendar year***.	34.5%	40%	40%	45%	50%	55%
% of Healthy Start prenatally enrolled pregnant women who deliver vlbw (<1500 g) babies per ***calendar year***.	<1,500 – 1.3%	<1,500 – 2%	<1,500 – 2%	<1,500 – 2%	<1,500 – 2%	<1,500 – 2%
% of Healthy Start prenatally enrolled pregnant women who deliver lbw (<2500 g) babies per ***calendar year***.	<2,500g – 10%	<2,500g – 8%	<2,500g – 8%	<2,500g – 5%	<2,500g – 4%	<2,500g – 3%
Percent of school aged children in grades Pre-K, K, 2, 4, 6, 8 and 10 who receive screenings such as: • Vision	86%	86.5%	90%	95%	95%	98%
• Hearing	97%	91%	91%	95%	95%	98%
• Scoliosis	32%	28%	60%	90%	95%	96%
• BMI on students in grades 2, 4 and 6.	NA	NA	Baseline 25%	30%	45%	60%
% of students who receive comprehensive physical examinations	43%	46%	55%	65%	75%	80%

by providers.						
% of students who receive oral health screenings.	27%	36.6%	40%	45%	70%	80%
% of DCPS with full-time nursing coverage	40%	88%	92%	98%	100%	100%
# of Public Charter Schools with nursing coverage		44	43 (One declined)	50	55	60%
% of identified school aged children with chronic diseases who have Individualized Health Plans (IHPs) developed by school nurses	NA	NA	Baseline 80%	100%	100%	100%
% of postpartum WIC mothers who initiate breastfeeding.	49%	45%	45%	49%	50%	60%
% of WIC participants who receive a primary non-high risk or high-risk nutrition education contact during a 6-month certification period	96%	96%TBD [8]	97%	98%	99%	100%
# of sites funded by DOH adopting evidence-based care management programs [9]	2	10	10	7	2	2
# of residents with diabetes enrolled in DOH funded evidence-based care management projects[10]	600 (1.5%)	549 (1.5%)	5000 (14%)	7000 (20%)	600 (1.5%)	600 (1.5%)
% of residents with diabetes enrolled in DOH funded care	39	40	40	41	42	43

[8] FMNP year to date voucher redemption data is not yet available for FY 2009

[9] The number of funded projects in this KPI represents Budget Support Act and Chronic Care Initiative funded projects. In 2009 Community Health Administration funded there diabetes-related Budget Support Act projects and seven Chronic Care Initiative projects. In 2011 Chronic Care Initiative funding will expire. Our estimate for the number of funded sites in 2011 is based upon historical diabetes-related BSA funding

[10] Total number of residents with diabetes enrolled in DOH funded evidence-based care management programs. The number in parenthesis indicates the percentage of residents enrolled within the entire diabetes population. 2007 CDC BRFSS estimates indicate that 36,000 residents have diabetes

programs achieving ideal blood glucose levels (A1c ≤7) [11]						
% reach of DC tobacco users through the DC Tobacco Quitline (1.800.QUITNOW)	2.381%	2.708%	3.025%	1.907%	1.907%	1.907%
# of calls to the DC Tobacco Quitline (1.800.QUITNOW)[12]	2,248	2,556	2,856	1,800	1,800	1,800
Number of clinics making improvements and monitoring progress by participating in the Asthma Quality Improvement Collaborative	0	8	10	15	20	25

WIC will continue to utilize the newly expanded Nutrition and Physical Fitness Advocacy Board to strengthen promotion and messaging regarding the benefits of breast-feeding to WIC-eligible mothers.

[11] The numerator in this calculation represents the total number of enrollees with diabetes achieving an A1c ≤7. The denominator represents the total number of patients with diabetes enrolled in BSA and CCI programs. Routine monitoring of a patient's A1C is viewed as the "standard" for measuring blood sugar, or glucose, control over a two-month period. Extensive clinical research shows that holding A1C levels under 7 percent helps prevent many serious complications, including blindness, amputation, heart disease, stroke, and kidney damage.

[12] Number goes down in out years as the number of people who choose to smoke and need quit line services goes down.