FY 2011 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 (DOH) provides programs and services with the ultimate goal of reducing the burden of disease. DOH does 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. DOH's 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.

PERFORMANCE PLAN DIVISIONS:

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

AGENCY WORKLOAD MEASURES

Measures	FY2009 Actual	FY2010 YTD
Number of inquiries to the Department of Health (DOH) through the "Ask the Director" section of DOH's website.	240	160
Number of Supplemental Nutrition Program for Women, Infants, Children (WIC) participants	3,234	3,135
Number of Commodity Supplemental Food Program (CSFP) Participants	6,447	3,367
Number of DC Medicaid 1115 Waiver Reform Demonstration project clients receiving pharmaceutical services through the pharmaceutical procurement and distribution program	3,250	1,522
Number of DC Alliance clients receiving pharmaceutical services through the pharmaceutical procurement and distribution program	54,594	48,500
Number of Ryan White Service Visits	415,258	450,000
Number of individuals entering the APRA Assessment and Referral Center to seek substance abuse treatment services by quarter.	Not Available	Not Available
Number of new EMT certifications by DC DOH	1,210	1,023
Number of community based health centers involved in emergency preparedness activities with HEPRA	41	12
Number of clinics submitting request forms to the public health lab	30	33
Number of background checks conducted	Not Available	8,400
Number of complaint follow-ups	Not Available	25
Number of adverse events reported in nursing homes & hospitals	328	640
Number of additional health care professionals regulated by HRLA	Not Available	6,000
Number of Certificate of Need Application decisions	27	19
Number of comprehensive reports completed and posted on the DOH web site	10	5

Addiction Prevention and Recovery Administration (APRA)

SUMMARY OF SERVICES

The Addiction Prevention and Recovery Administration (APRA) promotes access to substance abuse prevention, treatment and recovery support services. Prevention services include preventing the onset of alcohol, tobacco, and other drug use by children and youth, reducing the progression of risk and increasing protective factors that increase the likelihood of healthy, drug-free youth and their families. 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 skill 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 reduce substance use by District children, youths, and families.

INITIATIVE 1.1: Fully implement the District of Columbia Substance Abuse Prevention Center Network throughout the District of Columbia.
APRA will collaborate with the newly established Prevention Centers in developing Ward level strategic prevention plans for substance abuse prevention by April 2011 that target District-wide priority risks and measurable outcomes.

INITIATIVE 1.2: Enhance the capacity to collect and utilize data for substance abuse prevention planning by January 2011.
APRA will develop the first comprehensive prevention database that provides District and Ward-level predictors and consequences of alcohol, tobacco, and other drug use by youths. This information, which will be continuously collected and updated, will drive APRA prevention planning, resource allocation and evaluation, and decision-making. Moreover, the data findings will be provided in easy to use formats and shared with District partners and DC Prevention Centers for dissemination.

INITIATIVE 1.3: Establish a District of Columbia Substance Abuse Prevention Leadership Center by January 2011.
APRA will support the development of a DC Prevention Leadership Center to support community capacity building. The center will provide an integrated mechanism for building local capacity for data collection and evaluation, training and technical assistance, and implementation of best practices. The Center will also strengthen APRA's capacity to implement the federal Strategic Prevention Framework State Incentive Grant from FY10 through FY14.

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 by June 2011.
In addition to existing intake locations at the D.C. Superior Court and APRA's Assessment and Referral Center, APRA will designate at least three substance abuse treatment providers as community-based intake locations. This approach, which is modeled on the youth treatment system, will allow adult clients to go directly to the provider of their choice for intake, assessment, and referral to treatment services.

INITIATIVE 2.2: Expand Medicaid reimbursement for substance abuse treatment services by September 2011.

APRA will collaborate with the Department of Health Care Finance to draft and submit an amendment to the District of Columbia Medicaid state plan. Once approved by the Centers for Medicaid and Medicare Services, this amendment will allow substance abuse treatment providers to seek Medicaid reimbursement for treatment services provided to Medicaid clients. In addition, APRA will work with the Department of Health Care Finance to ensure that at least 50% of the treatment provider network has the capacity to bill Medicaid for substance abuse treatment services.

INITIATIVE 2.3: Enhance the co-occurring capacity of the adolescent continuum of substance abuse treatment services by August 2011.
APRA will implement a mandatory protocol that will enhance the capacity of its adolescent treatment provider network to identify and treat co-occurring substance abuse and mental health disorders through onsite services or linkages to appropriate care.

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

INITIATIVE 3.1: Promote access to effective substance abuse recovery support services by January 2011.
APRA will identify recovery support services that have been demonstrated to complement and enhance sustained recovery from substance abuse. Once identified, APRA will integrate the recovery support services into the continuum of substance abuse services offered in the District of Columbia.

APRA PROPOSED KEY PERFORMANCE INDICATORS - Addiction Prevention and Recovery Administration

Measure	FY 2009 Actual	FY 2010 Target	FY10 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
# of Prevention Centers serving all 8 Wards of the District.	0	4	4	4	4	4
# of APRA-supported community capacity-building training and technical assistance opportunities provided to increase knowledge, skills and implementation of evidence-based prevention programs.	2	10	19	15	15	15
% of clients presenting at the Assessment and Referral Center that complete the assessment and referral process within 2 hours.	Not Available	95%	Not Available	100%	100%	100%
% of clients that are screened for mental health disorders during the assessment and referral process.	Not Available	100%	100%	100%	100%	100%
% of clients assessed and	Not	85%	Not	85%	85%	85%

Measure	FY 2009 Actual	FY 2010 Target	FY10 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
referred for service that are admitted to a community-based provider.	Available		Available			
% of clients that complete the detoxification and stabilization program within 3-5 days.	Baseline	95%	93.3%	95%	95%	95%
% of clients referred to outpatient or intensive outpatient services that complete 2 treatment sessions within the first 2 weeks of treatment.	Not Available	80%	Not Available	85%	90%	95%
% of clients referred to residential treatment services that remain in active treatment for at least 30 days.	Not Available	85%	Not Available	90%	95%	95%
# of District residents age 12 or older reporting cocaine use[1]	Not Available	Not Available	Not Available	Not Available	4.2%	4.2%

Center for Policy, Planning, and Evaluation (CPPE)

SUMMARY OF SERVICES

The Center for Policy, Planning, and Evaluation is responsible for developing an integrated public health information system to support heath policy decisions, state health planning activities, and 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 Evaluation and Health Risk Assessment program which involves federal, state, county and municipal functions.

CPPE includes the following Divisions:

- State Health Planning and Development Agency (SHPDA)
- Data Management and Analysis Division (DMA)
- Research, Evaluation and Measurement Division (REM)
- Vital Records Division (VRD)

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

INITIATIVE 1: Revise DCMR Title 22 Chapters 40-46 to streamline the review of Certificate of Need (CON) applications and reduce the timeframe for issuing a decision.

[1] **Industry Standard:** The National Survey on Drug Use and Health is conducted every 4-5 years. Nationally, it has reflected stable trends between 2002 and 2008 (4.2%).

A CON allows health care providers to establish new services, and make certain capital expenditures – providing additional options for District residents. This streamlining will make the application review process more user friendly and efficient. The regulations will be updated and posted on the DOH website by December 2010.

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

INITIATIVE 1: Evaluate financial data from private hospitals, nursing homes, primary care clinics, and home health care agencies and hospices to ensure compliance with legal requirements.
D.C. Official Code §44-405 requires health care facilities with an approved CON to report on their provision of a reasonable volume of uncompensated care through the annual compliance level of 3% of their operating costs minus the amount of reimbursement, if any, under Titles XVIII and XIX of the Social Security Act. The regulations that govern the provision of uncompensated care are contained in Title 22, Chapter 44 of the D.C. Municipal Regulations (DCMR), which directs the State Health Planning and Development Agency (SHPDA) to collect this information.

OBJECTIVE 3: Collect and analyze health care data to be in compliance with DC law.

INITIATIVE 1: D.C. Official Code § 44-405 requires the SHPDA to develop and maintain a health planning data system.
Accordingly, the SHPDA is developing a matrix to monitor and assess hospital performance, based on hospital discharge data and other sources.

OBJECTIVE 4: Provide vital statistics in a timely manner for monitoring the health of District residents.

INITIATIVE 1: Improve the timeliness of the publication and the posting to the website of 10 comprehensive statistical reports by September 30, 2011.
A major goal of this initiative is to make available comprehensive information on the health status of District residents through collaboration with other DOH programs. The re-engineering of the vital records systems will provide quality electronic data in a timely manner, and will provide policy-relevant data on vital events to DOH programs and policy makers.

INITIATIVE 2: Improve response time for requests for vital statistics data.
The initiative will facilitate data user access to vital statistics information to inform programmatic and policy decisions, to do research, and to apply for funding opportunities. Currently, CPPE responds to requests varies between 24 hours to 2 weeks. By September 30, 2011, CPPE will improve average response time to 72 hours.

OBJECTIVE 5: Design epidemiologic studies and reports to address issues and disparities in the District of Columbia.

INITIATIVE 1: Increase access to data on District health status and risk behaviors.
This initiative will facilitate improved data collection in the Behavioral Risk Factor Surveillance System, and the production of new reports on District health issues, especially studies on various minority populations, using BRFSS and other databases.

OBJECTIVE 6: Enhance project/program monitoring and evaluation within the Department of Health.

INITIATIVE 1: Improve program monitoring activities among public health programs.
Monitoring and evaluation (M&E) of project/program activities provides government officials, program managers and staff with better means for learning from past experience, improving service delivery, planning and allocating resources, and demonstrating results as part of accountability to key stakeholders. CPPE will coordinate all monitoring & evaluation activities within DOH and report annually on progress made.

OBJECTIVE 7: Conduct the Behavioral Risk Factor Surveillance System Survey (BRFSS)

INITIATIVE 1: Complete 4,150 interviews for the survey year implementing a landline and cell phone questionnaire.
Since its inception, the survey has been conducted using landlines, but a cell phone survey questionnaire will be added in FY11 by the CDC in order to maintain survey integrity and validity. Over the past several years data has shown that the 18 to 34 year old population is utilizing their cell phones as their primary source of communication. This new initiative will allow a representative sample of the District's population to participate in the BRBSS, increase response rates and improve data validity.

PROPOSED KEY PERFORMANCE INDICATORS - Center For Policy, Planning, and Evaluation

Measure	FY20 09 Actual	FY2010 Target	FY2010 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
Number of certificate of need application decisions	27	22	7	23	23	23
Length of time from submission of complete application to SHPDA decision	60-90 days	60-90 days	60-90 days	60-90 days	60-90 days	60-90 days
Percent of hospitals (13) submitting reports on uncompensated care	100%	100%	Not Available	100%	100%	100%

Measure	FY20 09 Actual	FY2010 Target	FY2010 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
Length of time from fiscal year to published uncompensated care report	Not Available	12 months	Not Available	12 months	12 months	12 months
Percent of hospitals (13) submitting data on health care facilities	100%	Not Available	Not Available	100%	100%	100%
Percent of vital records requests completed in 72 hours	319	300	59	300	300	300
Number of Epi studies/reports produced	Not Available	3	Not Available	5	6	7
Percent of program results indicating improved performance	Not Available	Not Available	Not Available	50%	60%	70%
Number of BRFSS surveys completed[2]	4150	4150	4150	4150	4150	4150

Community Health Administration (CHA)

SUMMARY OF SERVICES

The Community Health Administration (CHA) provides programs and services that promote coordination among the health care systems in the city and enhance access to effective prevention, primary and specialty medical care through collaborations with public and private organizations. The work of CHA is performed through its six bureaus:

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

OBJECTIVE 1: To support the promotion of chronic disease prevention, health and wellness initiatives and community programs that serve priority populations in the District.

INITIATIVE 1.1: By September 30, 2011, BCCD will assess 30 District businesses for worksite wellness program readiness using a web-based survey instrument. Data shows that worksite wellness programs can reduce healthcare costs from 20-55%. In order to assess District businesses for worksite wellness program readiness, the Cardiovascular Health Program (CHP) has developed a web-based worksite wellness survey instrument. This assessment tool will provide the CHP with valuable environment

[2] **Industry Standard:** The Center for Disease Control and Prevention requires a minimum of 4,000 surveys to be completed annually for the BRFSS. DOH's goal is to achieve 6,000.

and policy inventory information, and provide survey participants with "best practices" and evidence-based worksite wellness resources.

INIATIVE 1.2: By September 30, 2011, the BCCD will support training and technical assistance that will establish at least three effective, affordable and sustainable prevention interventions for people with pre-diabetes in the District.
The Diabetes Program will support community partners in developing and deploying the Lifestyle Balance Program in the District, which has demonstrated that a 5-7% loss of body weight can reduce a person's chance of developing Type 2 diabetes by up to 58% in people diagnosed with pre-diabetes. The prevention program, led by community-trained lay health educators, equips participants with coping, healthy eating and exercise skills. The program will be tested in one location, preliminary recommendations on the identification and treatment of people with pre-diabetes will be developed and, if funding permits, the program will scale to additional locations.

OBJECTIVE 2: To reduce the District's cancer burden by effectively manage data surveillance through the Central Cancer Registry, providing high quality screenings and treatment, and delivering health education programs and navigation services.

INITIATIVE 2.1: By September 30, 2011, BCCD will fund 1,300 cancer screenings for qualifying uninsured and underinsured District residents through provider contracts.
The purpose of this initiative is to provide 1,300 cancer screenings for qualifying uninsured and underinsured residents through provider contracts. The division will provide culturally appropriate community-based education workshop to decrease misconceptions about cancer screening. BCCD provides comprehensive services to eligible residents in the form of free colonoscopies, breast exams, mammograms, pelvic and/or cervical exams and PAP-tests.

OBJECTIVE 3: Reduce infant mortality and improve birth outcomes in the District.

INITIATIVE 3.1: Increase the number of participants in the DC Healthy Start program and the average number of visits per month by September 30, 2011.
By September 30, 2011, increase the number of participants in the DC Healthy Start program to 395 women and 150 men by targeted recruitment efforts, and increase the average number of prenatal home visits for clients to two visits per month by ensuring adherence to program protocols. The case management program strengthens the formal and informal healthcare and social support systems available to pregnant and postpartum women, infant and their families. This bond encourages learning, empowerment, and a forum for changing health and behavioral risk to improve birth outcomes.

INITIATIVE 3.2: Increase the number of women who enroll in the Healthy Start program during the prenatal period and deliver normal birth weight infants by September 2011.

The Healthy Start program has five major components: Outreach and Client Recruitment; Case Management; Health Education; Depression Screening; and Interconceptional Care. Within the Outreach and Client Recruitment component, Healthy Start has outreach workers working at identified sites (IMA offices and community sites) to engage District residents and identify women who may be pregnant. They also perform community canvassing activities, pregnancy testing and hold health related function to identify women early in their pregnancy. DOH will continue operation of the Maternal Outreach Mobile van and continue their public information campaign. DC Healthy Start also has a male case management component that allows us to reach out to the male population. Males are educated on the importance of pregnancy identification and supporting their partner to get care early.

INITIATIVE 3.3: By September 30, 2011, increase the number of cribs and pack-n-plays distributed annually through the Safe Crib program.
By September 30, 2011, increase the number of cribs and pack-n-plays distributed from 750 to 850 per year through the Safe Crib program through outreach efforts at community based settings, medical facilities and educational forums. The distribution of cribs and pack-n-plays is an effort to reduce sudden infant death syndrome (SIDS) from accidental suffocation, rollovers caused by co-sleeping and other preventable causes. The Safe Crib program offers health education for professionals and the general public, especially pregnant women and families of newborns, about reducing the risk of SIDS.

OBJECTIVE 4: To recruit and retain health care practitioners to provide services to the District's underserved and increase the number and types of health care facilities serving the underserved.

INITIATIVE 4.1: Conduct a minimum of 4 outreach activities to recruit providers to practice in the District by the end of FY11.
The Primary Care Bureau (PCB) coordinates three distinct programs aimed at recruiting and placing providers in underserved areas in the District: J-1 Visa Waiver, Health Professionals Loan Repayment Program (HPLRP) and the National Health Service Corps. In service to all of these programs, the Bureau is developing written, web-based and video recruitment materials to begin conducting outreach to local residency/health professional training programs. The Bureau will have these materials finalized and will conduct 4 outreach visits by the end of FY11.

INITIATIVE 4.2: Increase from 8 to 10 the number of health professional shortage area (HPSA) designations by the end of FY11.
The federal HPSA designation identifies an area or population as having a shortage of primary, dental, and/or mental health care providers. HPSA designations enable health care practices serving the underserved to access Federal resources that allow them to provide care to individuals regardless of their ability to pay. The District currently has eight geographic and population HPSAs (6 primary care, 1 dental and 1 mental health), and has not applied for a new area designated as a HPSA since 2001. In response, the Primary Care Bureau has initiated efforts to develop a comprehensive provider database

to be used in evaluating areas for potential designation, which includes surveying several thousand health and mental health providers. The Bureau will work with HRLA to incorporate the data required for HPSA designation applications into the health professional licensing process to make the renewal and new designation process less time-intensive. With these improvements, the Bureau will expect to be able to evaluate new areas for eligibility as HPSAs and submit applications to get eligible areas designated. The Bureau anticipates two new areas that will be approved as HPSAs FY11.

OBJECTIVE 5: Expand the District's medication distribution capabilities

INITIATIVE 5.1: Establish a Mail Order Pharmacy Service
Establish DOH Mail Order Pharmacy Service (MOPS) to provide a mechanism for the direct delivery of selected prescription medications to eligible District residents who currently receive medications from the ADAP, Alliance, 1115 Waiver or other District programs by September 30, 2011.

INITIATIVE 5.2: Establish a Medication Therapy Management Service

Establish a Medication Therapy Management (MTM) service for District residents for the purpose of counseling and otherwise assisting recipients with multiple chronic diseases (such as diabetes, asthma, hypertension and hyperlipidemia), HIV/AIDS, multiple medications/poly-pharmacy issues and high drug costs by September 30, 2011.

OBJECTIVE 6: Reverse the trend in obesity by increasing breastfeeding rates, empowering residents to make healthier food choices and promoting physical activity.

INITIATIVE 6.1: Partner with key stakeholders and market managers to expand access to fresh fruits and vegetables.
The Nutrition and Physical Fitness Bureau (NPFB) will work with key partners to recruit and train additional farmers to participate in the Farmers' Market Nutrition Program and increase the total number of farmer's market sites from 34 in FY10 to 36 in FY11. To expand access to fresh vegetables further, the Bureau will conduct outreach activities for WIC and CSFP to increase the voucher redemption rate amongst this population.

INITIATIVE 6.2: Increase breastfeeding preparation and initiation among pregnant women.
Expand breastfeeding promotion and education prior to delivery, emphasizing the resources NPFB provides, which include Breastfeeding Peer Counselors, Lactation Consultants, availability of breastfeeding pumps and working with hospital maternity wards to become "Baby-Friendly Hospitals" (as defined by World Health Organization/UNICEF global criteria). "Baby-Friendly Hospital" is an official designation, which means the hospital implements 10 steps shown to support breastfeeding initiation like not accepting formula, having rooming-in policies, encouraging breastfeeding within 30 minutes of delivery plus 7 or 8 other steps. Staff

will work with hospital maternity wards (provide TA, resources, etc.) to develop and implement these policies & practices to earn the "Baby-Friendly" designation.

INITIATIVE 6.3: Expand community-based nutrition education activities by hosting community education sessions.
NPFB is the local affiliate for the Supplemental Nutrition Assistance Program Education Program (SNAP-ED). USDA regulations require that 50% of audiences receiving nutrition education through this program be eligible to participate in the SNAP program administered by the DC Department of Human Services. In efforts to improve access to nutrition education services in the District, the program will expand its outreach efforts and service areas to residents throughout the District. The Bureau will continue to identify and establish partnerships with community organizations with a focus on individuals eligible for SNAP–ED benefits, as well as collaborate with sub-grantees to provide nutrition education activities for residents with a focus on individuals eligible for SNAP-ED benefits.

OBJECTIVE 7: Enhance efficiency and effectiveness of child health efforts in the District to improve child health outcomes

INITIATIVE 7.1: Improve immunization compliance for children.
By working closely with school health officials, health care providers, and Managed Care Organizations, and DOH will meet the immunization compliance goal of 98% by September 2011. DOH has launched a public information campaign to drive children and their caregivers to a primary care provider and will partner with community health centers to provide incentives for obtaining a well-child exam, including immunizations. This activity, along other training and enhancement measures, will continue to educate the public and providers, thereby resulting in 98% compliance by September 2011.

INITIATIVE 7.2: Improve quality of and access to child health data.
In FY10, the use of Health Masters as a school based EHR system was implemented in DC public and public charter schools that participate in the DOH School Nursing Program. In FY11, DOH will implement electronic health records in the school nursing program and school based health centers consistent with the National Coordinator for Health IT's definition of meaningful use. The agency will work with a contracting agency (currently Children's School Services) to extract aggregate data on BMI, immunization compliance rates, and children requiring case management and special services by September 30, 2011.

PROPOSED KEY PERFORMANCE INDICATORS - Community Health Administration

Measure	FY2009 Actual	FY2010 Target	FY2010 YTD[3]	FY2011 Projection	FY2012 Projection	FY2013 Projection
Number of businesses assessed	Not Available	10	6	30	50	75

[3] Data reported as of September 9, 2010.

Measure	FY2009 Actual	FY2010 Target	FY2010 YTD[3]	FY2011 Projection	FY2012 Projection	FY2013 Projection
Number of colonoscopies	Not Avaiable	25	Not Available	400	500	650
Number of mammograms and/or clinical breast exams	594	600	307	600	650	700
Number of pelvic/cervical exams and PAP test	234	300	80	300	350	400
Number of women participating in Healthy Start[4]	620	370	324	395	420	450
Number of men enrolled in Healthy Start	140	150	117	155	160	165
Average number of prenatal home visits provided to Healthy Start participants per month	1.6	2	0.85	2	2	2
Percentage of Healthy Start participants who enter the program during the prenatal period and deliver LBW babies	14.8%	10%	Not Available	5%	3%	2%
Number of HPSAs[5]	8	8	8	10	11	11
ADAP clients enrolled in MOP	Not Available	Not Available	Not Available	Baseline	50%	70%
Alliance clients enrolled in MOP	Not Available	Not Available	Not Available	Baseline	50%	70%
Number of clients receiving MTM services	Not Available	Not Available	Not Available	Baseline	50%	70%
Number of farmers' market sites accepting WIC	24	34	34	36	38	40
Farmers' market check redemption rate among WIC participants	68% (9,256/13,644)	70%	Not Available	72%	75%	80%
Farmers' market check redemption rate among CSFP participants	81% (5,267/6,535)	83%	Not Available	85%	87%	90%
Percent of postpartum WIC mothers who initiate breastfeeding[6]	51%	45%	47%	45%	46%	47%

[4] In FY09, this number includes participants in the Healthy Babies program. In subsequent years, this number represents DOH Healthy Start program participants only.

[5] **Industry Standard:** The RAND report compares DC to six benchmark cities (Atlanta, Baltimore, Cleveland, Detroit, Philadelphia and Richmond) with four to nineteen HPSAs, and a mean of one HPSA per 65,000 residents.

[6] Breastfeeding data is currently only available for WIC participants.

Measure	FY2009 Actual	FY2010 Target	FY2010 YTD[3]	FY2011 Projection	FY2012 Projection	FY2013 Projection
Percentage of residents attending SNAP-ED sessions who are not eligible for SNAP	Not Available	Baseline	N/A	20%	30%	40%
Percent of children with up-to-date immunizations in: Public Schools	98.21%	98%	88.29%	98%	98%	98%
Percent of children with up-to-date immunizations in: Charter schools	95.55%	98%	77.97%	98%	98%	98%
Percent of children with up-to-date immunizations in: Licensed Child Development Centers	91.02%	98%	87.46%	98%	98%	98%
Percentage of students enrolled in schools with school nursing services that are overweight or obese (per BMI)	Not Available	Not Available	Not Available	Baseline	TBD	TBD

HIV/AIDS, Hepatitis, STD, and TB Administration (HAHSTA)

SUMMARY OF SERVICES

The HIV/AIDS, Hepatitis, STD and TB Administration's (HAHSTA) mission is to prevent primary infection of HIV/AIDS, STDs, Tuberculosis and Hepatitis, reduce transmission of the diseases and provide care and treatment to persons with the diseases. HAHSTA partners with health and community-based organizations to offer HIV and STD testing and counseling, prevention education and interventions, free condoms, as well as medical support, medication at no cost and other support services needed by clients living with HIV/AIDS. In addition, HAHSTA provides direct services at its STD and TB Clinics for residents of the District, administers the District's budget for HIV/AIDS, STD, Tuberculosis, and Hepatitis programs, and collects and manages data on disease-specific programs and services.

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: Increase efforts to identify individuals newly infected with HIV or STDs.

Routine, opt-out HIV testing is a key component of HAHSTA's strategy to prevent new infections. HAHSTA has worked to incorporate this policy as a standard of care in all facilities in the District. For FY11, HAHSTA will build toward full implementation of

routine testing by focusing in a number of areas: Managed Care provider network, unaffiliated physicians and practices (educate 400 physicians) and expanded partner services (community provider training). HAHSTA has proposed a new initiative, pending federal funding, to equip up to 25 hospitals and medical providers with new technology to provide confirmatory tests rapidly, which will improve immediate linkage into HIV medical care and identifying acute infection, which can be more easily transmitted.

INITIATIVE 1.2: Elimination of Mother-to-Child Transmission of HIV.
Peri-natal infection of HIV is nearly 100% preventable; therefore, HAHSTA's goal is to eliminate mother-to-child transmission of HIV in the District. HAHSTA has been specifically working with medical providers on routine peri-natal testing, standard first and third trimester testing as well as at the time of delivery with OB/GYNs and labor and delivery suites, awareness through intensive outreach with CHA's Healthy Start program, and incorporating peri-natal exposure surveillance through the Vital Records electronic birth record system. As the majority of HIV positive women are in child bearing years and most opinion from the public and providers is that HIV positive women should not or cannot have healthy babies, HAHSTA will add a new component on education and awareness that HIV positive women can safely have a healthy baby to increase testing and diagnosis of child-bearing age women and proper treatment by September FY11.

INITIATIVE 1.3: Reduce the Prevalence of STDs and HIV in Youth.
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 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 and STD/HIV testing and treatment services to venues other than the school. For FY11, HAHSTA will undertake several new initiatives: public/private partnership with Unity Health Care to expand STD treatment and HIV testing through school-based screening program, pilot HIV testing at schools with STD treatment, implementation of Wrap M.C. expanded condom education and distribution program, a new social marketing program (delay sexual activity, promote condom use and reduce overlapping partners) and pending federal funding, a targeted intervention on youth with repeat STD infections.

INITIATIVE 1.4: Implement Newly Developed Protocols for Hepatitis.
During FY10, HAHSTA has worked with NIH to set-up a Hepatitis sub-specialty clinic in the District. Now that this service exists, a new protocol has been developed to encourage screening of high risk clients and triage them for services. The Hepatitis coordinator will begin training providers in the District on Hepatitis during FY 2010, but will have the full protocol and system implemented during FY 2011. HAHSTA expects to see a higher number of individuals screened, immunized and treated for Hepatitis.

OBJECTIVE 2: 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 2.1: Increase the Number of People in quality HIV medical care.
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. For FY11, HAHSTA will implement the Red Carpet Entry program (expedited appointments for HIV medical care for newly diagnosed and returning to treatment), increase the number of providers and duration of recapture activities to identify and reenter individuals into HIV medical care, work with DHCF to accelerate and maximize the transition of eligible persons into expanded Medicaid coverage through Health Care Reform and realign the AIDS Drug Assistance Program to reach new persons ineligible for other coverage and meeting health care gaps through insurance. HAHSTA will measure increased linkage rates from testing positive to initiating HIV care, number of HIV primary care providers participating in recapture blitz activities, viral load suppression, CD4 counts, number of medical appointments per year and number of previously-positive persons linked to HIV care.

INITIATIVE 2.2: Expand Housing Options for persons living with HIV/AIDS.
HAHSTA continues to work to 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. HAHSTA is also working with its providers to ensure the HIV positive clients maintain the HIV care and work toward a more stable housing plan through the provision support and case management services. For FY11, HAHSTA will collaborate with DHS on a new self-sufficiency demonstration project to increase employment among HOPWA recipients and persons on the HOPWA waiting list through intensive job preparation and increased housing support to transition to non-subsidy housing.

OBJECTIVE 3: Increase the District's Capacity to Respond to HIV, STD, TB and Hepatitis Effectively

INITIATIVE 3.1: 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 up to 10 new community partners through the Effi Barry Program 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.

INITIATIVE 3.2: Increase Capacity for Data Collection and Use for Program Planning and Improvement.

HAHSTA has put a focus on increased both the quality and use of data over the past few years. We have added additional data management staff and managers and are in the process of building a new integrated data management system. For FY11, HAHSTA will build new data capacity through two projects: implementation of the new MAVEN data system (integrated case and program data for HIV/AIDS, STD, TB and Hepatitis) with training of staff and providers and the first year of the DC Cohort Study which has the participation of the major HIV medical providers to collect real time data on health indicators of persons living with HIV. New for FY11, HAHSTA will be implementing a new project Program Collaboration and Service Integration (PCSI) to build capacity, consistent messages, high quality standards for program and personnel, accountability and efficiency for maximum results and impact all measured by data; and, HAHSTA, through MAVEN, will be able to start tracking clinical outcomes for persons living with HIV by comparing lab and program data to measure viral load suppression, CD4 counts and other indicators.

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

Measure	FY 2009 Actual	FY 2010 YTD	FY 2010 Target	FY 2011 Projection	FY 2012 Projection	FY 2013 Projection
# of new HIV (HIV/AIDS) cases diagnosed within the fiscal year[7]	714	193	1,500	1,500	1,500	1,300
#of publicly supported HIV tests performed	90,151	44,014	125,000	150,000	150,000	150,000
# of needles off the streets through DC NEX Program	279,707	158,803	300,000	350,000	400,000	425,000
# of condoms (female and male) distributed by DC DOH Condom Program	3,219,446	2,179,374	3,000,000	4,500,000	4,500,000	5,000,000
# of peri-natal HIV infections[8]	1	0	0	0	0	0

[7] **Industry Standard:** CDC reports 2005 data for Baltimore (1,001.3), Chicago (351.4), Detroit (291.1), Philadelphia (645.4), New York City (725.9) and Washington, DC (1,386.0). Due to increased testing, DOH expects that the number of newly diagnosed HIV cases will increase for several years.

[8] **Industry Standard:** NYC's DOHMH December 2008 Pediatric & Adolescent HIV Report reports six peri-natal infections in 2007.

# of youth (15-19 years) screened for STDs through youth outreach programs	5,265	3,050	10,000	12,000	12,000	12,000
Number of persons enrolled in ADAP	Not Available	2,832	2,650	3,350	2,000	2,000
Percent of HIV positive persons with viral load suppression (below 400)	Not Available	Not Available	TBD	TBD	TBD	TBD
Total number transitioning from HIV Housing Programs	11	0	Not Available	20	30	40
% of Effi Barry participants scoring in the high capacity group after at least one year of training	Not Available	Not Available	65	75	75	80

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 (EMS) 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 DOH and free and non-profit clinics within the District of Columbia.

OBJECTIVE 1: Improve the quality of Emergency Medical Services (EMS) in the District.

INITIATIVE 1.1: Develop and implement an unannounced ambulance inspection program.

In the District, there are currently 134 ambulances, both Basic Life Support and Advanced Life Support. All ambulances are inspected on an annual basis by our single inspector as part of their certification process. This is an announced inspection and an ambulance cannot be certified to operate in the District without first passing this inspection. Beginning in FY11, the EMS Division will perform unannounced inspections of ambulances to ensure continued compliance with the regulations. The equipment/supply listing is based on the recommendations of the American College of Surgeons, the American College of Emergency Physicians, the National Association of EMS Physicians, and the American Academy of Pediatrics.

INITIATIVE 1.2: Monitor the quality of the District's EMS training and education.

By monitoring EMS providers' first time National Registry of Emergency Medical Technicians test scores and comparing it with national average each July, we can advise DC instructional institutions as to whether or not they are meeting or exceeding national standards on September 30, 2011 annually.

OBJECTIVE 2: Improve the efficiency of the DOH response and recovery to public health and medical crisis.

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 and the District of Columbia Primary Care Association to develop and implement emergency preparedness training in the District's long term care facilities and community health centers. Training includes basic Emergency Preparedness, Incident Command Training, NIMS, the National Response Framework, and understanding the District Response Plan. A major focus is to develop templates for Emergency Operations Plans (EOP) and Evacuation Plans that will allow each facility to tailor the plans to their unique situations. All of the District's long-term care facilities will have developed evacuation plans by the end of FY11.

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 participation in Public Health Lab (PHL) information system for submitting patient specimens.**
The PHL has developed an information system solution for submission of electronic specimen requests and chain of custody forms to enhance specimen processing accuracy and timeliness. PHL also provides training for proper specimen submissions and use of secure fax or web portal for patient test results to reduce specimen turnaround time.

OBJECTIVE 4: Improve all-hazards preparedness and response in the District of Columbia's healthcare facilities.

INITIATIVE 4.1: **Improve utilization of and responsiveness to notification systems among District healthcare partners to improve emergency preparedness capabilities.**
The Bioterrorism (BT) Division utilizes the Health Alert Network (HAN) to notify, update, and alert healthcare partners in the District regarding public health emergencies. The BT Division will conduct quarterly contact drills utilizing the HAN in order to establish and maintain an up-to-date list of registered healthcare partners.

PROPOSED KEY PERFORMANCE INDICATORS - Health Emergency Preparedness and Response Administration

Measure	FY2009 Actual	FY 2010 Target	FY 2010 YTD	FY 2011 Projection	FY 2012 Projection	FY 2013 Projection
% of District ambulances that pass	Not	50%	TBD	50%	75%	90%

Measure	FY2009 Actual	FY 2010 Target	FY 2010 YTD	FY 2011 Projection	FY 2012 Projection	FY 2013 Projection
an unannounced inspection for compliance	Available					
% of DC EMTs that pass National Registry Exam on 1st attempt[9]	64%	Not Available	80%	85%	90%	95%
% of Community Based Health Centers that bi-annually update their EOPS and evacuation plans	Not Available	75%	75%	83%	91%	100%
% of clinics submitting request forms electronically to PHL	60%	70%	80%	85%	90%	93%
% of clinics reporting above average satisfaction with PHL services	70%	75%	80%	85%	90%	93%
% of staff recalls which have at least a 70% response rate within one hour.	Not Available	Not Available	25%	>75%	>75%	>75%

Health Regulation and Licensing Administration (HRLA)

SUMMARY OF SERVICES
The Health Regulation and Licensing Administration is responsible for the inspection, licensure and certification of health care facilities, pharmacies, licensure and regulation of health care professionals involving disciplinary hearings, inspection food establishments serving/ processing food items, animal, rodent control and non-food health business establishments such as spas, pools, beauty/barber shops, radiation emitting equipment.

OBJECTIVE 1: Conduct annual licensure inspections of health care facilities as required by Centers for Medicare and Medicaid Services (CMS) and District Laws.

INITIATIVE 1: Improving Quality Indicator Survey by June 2011.
Healthcare Facilities Division (HCFD) will implement the CMS Quality Indicator Survey (QIS). The QIS is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the Federal requirements. A more structured process would improve consistency and accuracy of quality of care and quality of life problem identified.

INITIATIVE 2: Trend Common Health Care Deficiencies by September 2011.
Train Health Care Facilities personnel. Based on the annual surveys of nursing homes, hospitals, ESRDs and home health agencies, categorize the most commonly cited deficiencies to develop a training program for health care personnel i.e., documentation issues - omissions and facility acquired pressure ulcers. This initiative will do curtail the

[9] Industry Standard: The 2010 YTD National Registry of EMTs' reports the average as 68%.

number of incidents of this kind while improving the quality of care received by the residents, thus impacting the cost of care negatively.

INITIATIVE 3: Revise Home Care Regulations by July 2011.
Patient care being of upmost importance, revise regulations that meets today's changing environment and comply with recent changes to Medicaid; research surrounding jurisdiction practices; look at home care practices; and develop best practices in the revised regulations, for example administering home care medication; documentation of care provided by personal care aides; and the separation of skilled and non-skilled practices. The enabling legislation would prevent a reprimanded PCA from rotating from one facility to another; a facility would be exposed to proven methods of treatment based upon best practice; home care medication practices would be addressed; and specific skilled practices detailed versus non-skilled.

INITIATIVE 4: Revise Group Home Regulations by July 2011.
Past surveys within these facilities indicate that the regulations should be updated to capture repeated deficiencies specifically, Chapter XXXIV that addresses the elderly. New regulations would provide the inspectors to ability to cite deficiencies that are not covered by current statutes. Improving the physical as well as the atmospheric conditions of the facility, safeguards the residents' stay.

OBJECTIVE 2: Update Health Occupational Revisions Act (HORA) to reflect "best practices" for health care professionals.

INITIATIVE 1: Promote "best practices" for medical professionals licensed by the Boards of Allied and Behavioral Health by April 2011.
The Boards of Allied and Behavioral Health will replace all paper and pencil exams administered by HPLA with computerized examinations administered in established testing sites throughout the District of Columbia.

The Board of Psychology will revise its Jurisprudence Examination to include the use of the Association of State and Provincial Psychology Boards' *Practice Analysis* to validate the content for the District of Columbia Exam. The examinations will be administered by the Professional Examination Service, consistent with the process used by other state Boards.

The Board of Professional Counseling will implement an online Jurisprudence Exam for Addiction Counselors, utilizing existing testing centers located in the District of Columbia.

INITIATIVE 2: Establish Impaired Practitioners' Program by August 2011.
As an alternative to definitive discipline, develop an impaired program for substance abusers who are licensed by the Board of Allied and Behavioral Health. The Boards will implement a rehabilitation program for impaired healthcare professionals who are unable to perform their professional duties due to drug or alcohol dependency or mental illness.

The Boards will establish a committee to oversee the implementation and execution of a rehabilitation program for impaired healthcare professionals by the end of 2011.

OBJECTIVE 3: **Maintain safety of food supply, pharmacies and public facilities such as swimming pools, spas, barber/beauty parlors.**

INITIATIVE 1: Notify public notice of food establishment inspections by October 2010.
Provide the public with relevant information on the results of food inspections. Electronically record all food inspections on Department of Health's website within five days of inspection. Currently, the timeline is ten to thirteen days.

INITIATIVE 2: Automate pharmacy licensure renewal process by March 2011.
Automate renewal of pharmacy licensure. The current process is for pharmacies to renew licenses through a mail-in process. The automation of the renewal process will include the redesign of application forms to accommodate on-line renewal capability.

PROPOSED KEY PERFORMANCE INDICATORS - Health Regulation And Licensing Administration

Measure	FY2009 Actual	FY2009 Target	FY2010 Target	FY2010 YTD	FY2011 Projection	FY2012 Projection	FY2013 Projection
% of complaints close for nursing homes, ICF/MR and CRFs within 45 days	Not Available	Not Available	Not Available	Baseline	100	100	100
% of adverse events reported by nursing homes & hospitals	Not Available	Not Available	Not Available	Baseline	90	100	100
% of food facility inspected annually	Not Available	Not Available	Not Available	Baseline	93	95	**96**
% of food samples tested from food facilities throughout the District	Not Available	Not Available	Not Available	Baseline	10	12	**14**
% of food inspections completed and posted within designated timeline of five days	Not Available	Not Available	Not Available	Baseline	85	88	90

Office of the Director (OD)

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: Ensure the development and retention of a competent workforce.

INITIATIVE 1.1: Improve DOH's employee performance management system.
Employee performance management consists of employee performance plans and employee evaluations, and allows the employee to have direct input in developing performance objectives; allows the supervisor to convey their expectations of the employee; and offers a baseline for assessing job performance and growth. DOH will increase the number of on-time performance plans and evaluations completed; and increase the number of employees who adhere to their Individual Development Plans (IDP). This will be tracked by human resources and the Chief Operating Officer. All DOH managers will receive targeted training on how to monitor IDPs and assist with their subordinates completing them. Senior Deputy Directors and select managers will receive 360-degreee performance assessments in order to begin the process of planning targeted leadership and management enhancement by December 2010.

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

INITIATIVE 2.1: Implement standardized policies and procedures for Departmental administrative and operational processes.
Standardized policies and procedures play an important role in providing consistency for the internal and external functions of the Department. These procedures will take the form of a written guide outlining standardized administrative and operational processes, aligned with District guidelines that take into account the nuances of DOH operations. Currently, several Administrations have developed individual policies and procedures manuals and separate operational-specific policies exist within the Department. DOH will use these policies to develop Standard Operating Procedures to be applied across the board at DOH by January 2011.

INITIATIVE 2.2: Increase monitoring, compliance and performance for all local grants issued by DOH.
While the federally-funded sub-grants administered by DOH have prescribed federal reporting requirements and evaluation protocol systems in place to report on monitoring activities and performance, our local grants do not have a uniform and integrated system of reporting results. DOH will expand a 1-year pilot of bi-annual reporting for local grants to include local grants authorized by other legislation or requirements for federal

match. This will allow DOH to assess efficiency of monitoring as determined by 6 control areas: site visits, desk reviews, and responsiveness to performance indicators, spending, modifications and unusual incidents. DOH expects this process to improve the performance of grantees by September 2011.

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 in all grants management policy and procedure manuals. Each sub-grant has a monitoring plan based on assessment of the recipient's current fiscal/administrative capacity, history of performance and specific needs of the 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-add of corrective and supportive mechanisms delivered by DOH. Enhancements include a uniform risk assessment system and uniform rating system to be completed by September 2011.

INITIATIVE 2.3: Develop and implement a Department-wide online storage and retrieval system.
To improve the timeliness of and accessibility of records to the public, DOH has begun to develop an online storage and retrieval system for paper and electronic records and will migrate 20% of records by December 2011. This process is also important as DOH will reduce its physical footprint by consolidating the agency's space in January 2011. Online storage of records will increase both internal and external responsiveness and will be completed by January 2011.

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

INITIATIVE 3.1: Enhance DOH website through its re-design, migration, and re-launch
DOH's website is a critical communication channel to the public, stakeholders, and partners, and accessibility to accurate information is critical to a robust public health infrastructure. In its current state, the DOH website lacks a service-based platform and has a dated look and feel. Working with OCTO and as a part of a District-wide initiative, DOH will migrate the website to a new system, reorganize the site, and update the content. DOH's site will be re-launched in February 2011. The new site will be more citizen-centered and offer enhanced access to information and services.

INITIATIVE 3.2: Improve DOH customer service ratings.
DOH provides a number of services to customers inside and outside of the District. Historically, DOH has not met the customer services expectations, as defined by the Office of Unified Communications (OUC). DOH will increase its scores to the "meets expectations" category by September 2011. DOH will institute randomized tests modeled after the OUCs Customer Service tests. In FY11, the Director will address the importance of customer service at agency-wide meetings and trainings. The Director will address:

written, telephone and face-to-face customer service. An intra-agency committee will convene to identify opportunities to train staff on proper procedures and protocol. In addition, all Senior Deputy Directors will be engaged in the process.

PROPOSED KEY PERFORMANCE INDICATORS – Office of the Director

Measure	FY 2009 Actual	FY 2010 Target	FY 2010 YTD	FY 2011 Projected	FY 2012 Projected	FY 2013 Projected
Percent of Employee Reviews Completed on Time[10]	65%	Not Available	85%	90%	95%	100%
Number of single audit findings that indicate non-compliance or a reportable condition	2	Not Available	Not Available	<2	< 02	<02
Percent lapse of total dollar amount of federal grant budget	4%	3.70%	< 4%	<3%	< 3%	< 3%
Percent of grants management specialists receiving skills-based grants management training	Not Available	64%	84.6%	95%	90%	95%
Percent of total carryover funds requested	2%	<5%	10.28%	<5%	<5%	<5%
Percent of DOH grantees who received a satisfactory performance rating	Not Available	Not Available	Not Available	85%	90%	95%
# of visitors to the DOH website	Not Available	Not Available	690,000	724,500	760,725	785,500
Office of Unified Communication's Customer Service Rating	63%	85%	73%	85%	90%	95%
% of subgrantee's budget spent on programmatic costs 11	Not Available	Not Available	Not Available	65%	65%	65%
% of scheduled monitoring reports as defined in agency monitoring plan completed for each grant award12	Not Available	Not Available	Not Available	100%	100%	100%

[10] Industry Standard: The International City/County Management Association for Performance Management's Center for Performance Management's median for "Percentage of Employee Reviews Completed on Time" is 85% in 2008.

[11] The Wise Giving Alliance of the Better Business Bureau identifies 65% to be an industry standard for this measure http://www.bbb.org/us/Charity-Standards/. This metric measures all subgrantees' programmatic costs as a percentage of their overall costs.

[12] Pursuant to 11.4 of the Grants Manual and Source Book all District agencies must complete monitoring reports. All District agencies should be in compliance with this standard. The standard is 100%.