Department of Health
DDS *(HC)*

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.

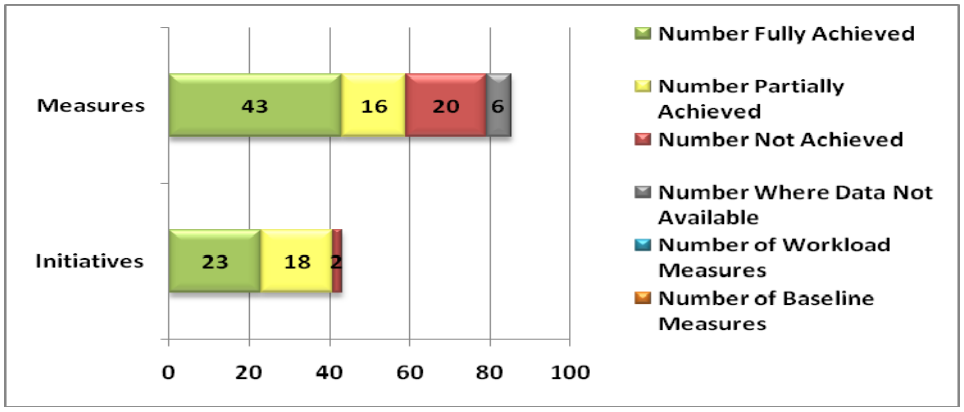
SUMMARY OF SERVICES

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.

ACCOMPLISHMENTS

- ✓ **HAHSTA doubled the number of District residents receiving free HIV medications from 1,200 to 2,500 between 2007 and 2009.** The DC AIDS Drug Assistance Program (DC ADAP) provides HIV-related prescription drugs to underinsured and uninsured individuals living with HIV/AIDS. During FY10 enrollment was increased to 3,439. This figure is among the highest enrollment numbers recorded in DC.
- ✓ **DOH HR has reduced vacancy posting time from 75 days to 60 days.** In the past the DOH recruitment process has run anywhere from 3 to 7 months. In FY 2010, DOH-HR division developed a recruitment timeline to attain a 75-day goal. We have exceeded this goal by reducing vacancy posting times from 75 to 60 days by streamlining the process and managing concurrently instead of sequentially.
- ✓ **The Health Regulation and Licensing Administration developed and implemented a comprehensive database for food facility inspections accessible to the public.** During FY 10, HRLA was provided a computerized tool for sanitarians to conduct food facility inspections that are consistent, clear, and concise and easy to understand. In 2010, the inspection forms were uploaded to the DOH web site for public review. This system will be accessible by the public to help foster informed decisions and to incentivize better health practices.

OVERVIEW OF AGENCY PERFORMANCE



Performance Initiatives – Assessment Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

OFFICE OF THE DIRECTOR

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.**
  Due to the specialized nature of many of the agency's positions, recruiting a qualified applicant pool has been challenging. To attract talented, qualified candidates, DOH advertises on health association websites, and targets students obtaining graduate degrees in health-related fields from local colleges and universities. DOH also recruits for vacancies internally, giving existing employees opportunity to advance their careers, and promoting employee retention. Additionally, Senior Deputy Directors across the agency re-prioritize vacancies annual to determine which positions are critical to the agency. Each administration also has a monthly meeting with OCFO and HR to ensure that budget and workforce development planning are closely linked. These changes have contributed to DOH's ability to reduce vacancy posting times from 75 to 60 days.

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

- **INITIATIVE 2.1: Obtain delegated small procurement authority for DOH.**
  DOH Contracts and Procurement Manager completed the Agency Contracting Officer training to obtain contracting authority from the Chief Procurement Officer for small purchases, including those under $25,000. This training last three months, and benefits the agency because 75% of purchases are under $25,000. This training was three months long. Small procurements are now done in-house at DOH allowing for a shorter turnaround time for processing, quicker response to emergency requests, and improved purchasing efficiency overall.

- **INITIATIVE 2.2: Increase the skill level of all DOH staff involved in the procurement process.**
  DOH acquired an Agency Contracting Officer (ACO) lead agency procurement and contracts management. The ACO has provided acquisition training to the DOH contract unit staff and other key staff with contracting responsibilities in the agency. One hundred percent of the Contracts and Procurement Unit staff were trained to make small purchases, which means that DOH now has the capability to respond quickly to the agency's needs. DOH did not complete Advanced COTR training across the agency as planned.

- **INITIATIVE 2.3: Improve the efficiency of grants management by implementing a risk-based monitoring system for all sub-grants.**
  DOH met its target of integrating three core elements of risk-based monitoring for at least 80% of DOH-issued Notice of Grant Award (NOGAs) into policy and procedures for grants management. FY10 targets included full implementation of three core elements of risk-based monitoring: completion of risk

assessments, and monitoring plans for all DOH-issued NOGAs within 30 days of award, and interim (optional) and annual (mandatory) performance ratings. Two of the three elements were documents for at least 80% of NOGAs issues. Performance ratings as a core element of risk-based monitoring needs to be further developed. Additional staff training and tools for managing data collection and reporting for this objective will be fully implemented in FY11. A uniform and centralized system of measuring, documenting and reporting performance will be established by the DOH Office of Grants Management.

- **INITIATIVE 2.4: Reduce the number of DOH leased facilities to control fixed costs.**
DOH reduced 19,356 square feet from its fixed cost inventory at 2100 MLK, SE during FY10. DOH will further reduce the number of leased facilities in FY11 by vacating 33 N Street, NE 3720 MLK, SE, and 3330 V 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.**

In FY10, each DOH Administration identified outdated content for deletion or revisions. DOH also published Standard Operating Procedures for ongoing content revisions. DOH has begun reorganization and redesign of the website to improve usability and a new platform will be delivered in FY11.

- **Increase the number of DOH community outreach events.**
In FY10, DOH conducted 24 outreach events compared to four events in FY09. DOH convened 20 bedbug summits, participated in the Focused Improvement Area initiative, operated the Healthy MOM van, and held two ward walks during the fiscal year. DOH also engaged and mobilized residents from all wards to provide vaccinations for H1N1.

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.**
In FY10, DOH's Office of Risk Management analyzed more than 200 Unusual Incident Reports (UIR) and other sources, in search of patterns of recurring risk exposure. Two specific risk clusters were identified, and DOH is in the process of mitigating those issues. As a result, DOH has revised building access policies, and is working with sister agencies to improve fleet operations.

- **INITIATIVE 4.2: Improve disposition of incurred losses by training managers in DOH administrations to use unusual incident reports (UIR).**
During FY10, DOH's Office of Risk Management provided training on identifying and mitigating risk exposure to 23 managers in two DOH administrations. In FY10, 198 of 217 UIRs were completed correctly within the 30 day timeline, compared to 349 of 428 UIRs in FY09. In FY11, DOH plans to train managers in the remaining DOH administrations, and to provide refresher and post-incident response trainings.

HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION (HEPRA)

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.
Using test score data supplied by the National Registry of Emergency Medical Technicians, HEPRA compared pass/fail rates both within the District and against our counterparts nationwide. Nationally, 68% of first time test takers passed, while 76% of DC first time test takers passed. This is significantly better than the national average, and is reflective of the EMS curriculum and Instructor Certification standards, which are regulated by DOH-HEPRA.

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.**
DOH has been working diligently with the DC Emergency Healthcare Coalition (DC EHC) to ensure that all District hospitals are compliant with federal bed availability data standards and definitions. The two institutions that are not yet compliant will likely meet the standard in FY2011. DOH sub-granted Hospital Preparedness Program funding to the DC Emergency Healthcare Coalition to support the District's Skilled Nursing Facilities (SNF) / Long-Term Care Facilities (LTC) in developing their own evaluation plans and enhancing their emergency preparedness capabilities. While all LTC's have created their own evacuation plans, to-date, not all of the District's Community-Based Health Centers have fully developed or exercised their Plans. DOH will sub-grant Hospital Preparedness Program funds to the DC Emergency Healthcare Coalition in FY2011 for the purposes of testing Healthcare Facility Evacuation Plans; the remaining Community-Based Health Centers will begin updating their plans in FY2011.

- **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.**
To date over 493 DOH employees have completed one or more courses in National Incident Management System. However, the workforce is dynamic and many of these trained individuals have left DC Government and moved on to other careers. Currently 15% of DOH personnel are NIMS trained, but the rate more than triples, to over 50%, for HEPRA staff, which responds to all public health emergencies.

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.**
In FY10, the Public Health Lab moved from a paper and fax system to collecting and transmitting data through the Laboratory Information Management System (LIMS). This gives all DOH programs the ability to review results electronically through the web portal. In FY11, HEPRA expects to expand use of the web portal to external clients.

ADDICTION PREVENTION AND RECOVERY ADMINISTRATION

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 facilitated the development of four DC Prevention Centers, providing access to core prevention functions in all 8 Wards. The core functions - community education, community leadership, and

community change - are implemented in ways that address the unique populations and diverse geographic areas within the Wards each Prevention Center serves. Additionally, APRA continues to implement the $10.6 million Strategic Prevention Framework State Incentive Grant (SPF SIG). This grant supports planning and infrastructure building to strengthen the substance abuse prevention activities of the District. A major component created to support the grant was the creation of the Prevention Council, an advisory group composed of policy making representatives from DC government, local and national partners. This Council guides the development of the strategic prevention plan, which includes: assessment and evaluation; capacity building; strategic planning; and, evidenced based practices, strategies and programs. To fully achieve this initiative, APRA is working towards collecting and analyzing social indicator data at the District and Ward levels.

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

APRA has developed the data infrastructure to measure risk and protection for substance abuse among District adolescents. The infrastructure was validated by the National Institute on Drug Abuse and will be utilized by the new D.C. Prevention Centers for outcome-based planning.

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

APRA engaged in the following community capacity building activities:

- Developed concept and released RFA for new DC Prevention Leadership Center, which will function as the mechanism through which support for ongoing planning, technical assistance and training, social marketing, workforce development and the use of evidence-based strategies and practices is provided;
- Sponsored eight days of Community Mobilization and Community Changes training for APRA prevention staff and DC Prevention Center;
- Attended, with a Prevention Center representative, the National Association of State Alcohol and Drug Directors National Prevention Research Conference to learn about new prevention science, best practices and evidence-based programs.
- Continued partnership with the Justice Grants Administration's Enforcing Underage Drinking Laws (EUDL) Program including the development of ward-based conversations on underage drinking with youth and decision makers.

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.

In FY 10, APRA improved the assessment and referral processes improving access to the adult continuum of substance abuse treatment services. APRA has further standardized and systematized the process for completing substance abuse assessments, level of care determinations, facilitating choice of treatment providers, and making referrals with linkages to treatment. The implementation of the DATA system ensures that assessment information is as complete as possible, and gives the treatment provider to which the client is referred almost immediate access to assessment information. This efficient use of the DATA system has reduced the length of time from assessment to a client's first treatment appointment. APRA has also enhanced its public website to include a comprehensive provider directory which provides information on how to be assessed and referred. The hours of operation for the Assessment and Referral

Center have been extended from 8:30am to 4:30pm to 7:00 am to 6:00 pm.

- **INITIATIVE 2.2: Improve the efficiency and effectiveness of the APRA adult and adolescent substance abuse treatment system.**
  In FY 2010, APRA improved the efficiency and effectiveness of the adult and adolescent treatment systems by implementing an electronic voucher system, delivering numerous trainings to substance abuse treatment providers, conducting consistent oversight and monitoring of provider contracts, and conducting regular site visits to providers. In August 2010, APRA implemented a new electronic medical record system known as the DATA (District Automated Treatment Accounting) system, which APRA to provide an information technology system for its providers and clinicians to administer, manage, report, archive and share substance abuse treatment services data. These data elements are recorded in "real time," which also allows APRA to efficiently monitor a large treatment system, provide performance-based feedback to its providers, conduct regular quality assurance and quality control checks on the efficiency and effectiveness of interventions, and allows APRA to build automated rules in the system that prevent and detect potential fraud, waste, or abuse of public funds. This year APRA conducted more than 70 trainings on a range of management and clinical topics that directly address efficiency and effectiveness of treatment. Through the oversight of Contracting Officer Technical Representatives, APRA has enforced the stipulations set forth in the contracts established with adult and adolescent treatment providers. These agreements ensure that providers deliver services authorized by APRA in manners that are consistent with APRA's regulations. By ensuring that providers adhere to the Human Care Agreements and intervening when they have not, APRA has strengthened its ability to ensure the efficiency and effectiveness of the services it funds. Finally, the activities of APRA's Office of Certification and Regulation (OCR) have consistently focused on improving efficiency and effectiveness of the treatment system. In FY 2010, OCR conducted 32 site inspections of providers in the adult and youth treatment system. Thirty of the 32 providers who were visited received corrective action plans which targeted specific areas of inefficiency.

- **INITIATIVE 2.3: Increase access to the APRA adolescent continuum of substance abuse treatment services.**
  In FY 2010, APRA implemented the Adolescent Substance Abuse Treatment Expansion Program (ASTEP). Through ASTEP, APRA increased the points of adolescent client entry in DC's treatment system from one to five locations, geographically dispersed throughout the. Each provider conducts substance abuse assessments, referrals, and Intensive Outpatient/Outpatient treatment, including case management services, using evidence based approaches. APRA also lead the effort to ensure that the following partners could refer clients directly to the ASTEP network for assessment, referral, and treatment services: Department of Mental Health (DMH), Department of Youth Rehabilitative Services (DYRS), Child and Family Services Agency (CFSA), Core Services and Offender Supervision (CSOSA), Pre-Trial Services, the District of Columbia's Public School System, and the Metropolitan Police Department through the Mayor's Partnership for Success. These referral pathway developments combined with the implementation of the DATA system has allowed APRA to ensure that adolescents referred into the treatment system can be assessed and connected to the appropriate treatment services within 48 hours.

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.**
  APRA has used Access to Recovery grant funding from SAMSHA to establish a network of 28 providers each of which delivers recovery support services. These services are delivered to clients who are: in

substance abuse treatment, have completed treatment, or have not started treatment. APRA also initiative mobile recovery support services assessments and enrollments, and allowed providers to conduct intake at their locations. Both initiatives improved access to services.

CENTER FOR POLICY, PLANNING, AND EPIDEMIOLOGY

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.**
  The State Health Planning and Development Agency (SHPDA) has completed a draft of the regulations and submitted them to the Office of Attorney General (OAG). OAG will work to ensure that the regulations are consistent with requirements for publishing District rules. DOH anticipates these regulations being finalized by February 2011.

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.**
  The State Health Planning and Development Agency (SHPDA) has compiled the uncompensated care data for FY2009, which includes data from 13 hospitals, 14 community health centers, 14 dialysis centers and nine nursing homes. Improvements initiated by SHPDA this performance year include:
  - All 13 hospitals are now using the same formula to calculate cost to charge ratios; and,
  - Community health centers are now reporting data in a manner that distinguishes uncompensated care costs from Alliance and grant reimbursements.

HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION

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.**
  HAHSTA, through community partners, conducted approximately 110,000 publicly supported HIV tests (preliminary numbers) in FY10, a nearly 20% increase from FY09. HAHSTA implemented HIV testing in seven out of eight DC hospital emergency departments, all seven labor and delivery suites and all Unity Health Care primary care clinics. HAHSTA is working towards an agreement with two MCO's to fully implement routine HIV testing. HAHSTA has launched a new public-private partnership through the Global Business Coalition with Pfizer to have sales representatives promote routine testing in regular sales calls and with George Washington University for medical students to promote testing in practicum placements with physicians. HAHSTA initiated a consumer-driven "Ask for the Test" and provider-driven "We offer the Test" social marketing program that has been widely distributed through media and directly to providers.

- **INITIATIVE 1.2*:* Expand Partner Services (PCRS).**
  HAHSTA fully integrated and combined HIV and STD partner service into one department, and has conducted regular monthly trainings with community partners on implementing partner services. The trainings were designed to increase provider participation in Partner Services, enhance the providers'

ability to secure client participation, elicit the needed partner information, and report to HAHSTA. HAHSTA developed new information material, including a handbook, information card, poster, electronic documents and a consumer brochure. HAHSTA also maintained its Internet Partner Notification on syphilis cases, and is planning to expand the service to HIV cases.

INITIATIVE 1.3: Enhance Services to Prevent Mother-to-Child Transmission of HIV.
While 2010 data is not yet available, preliminary data indicates that there were no peri-natal infections in the District in 2009. HAHSTA has implemented routine rapid testing in labor and delivery suites, developed an extensive handbook and other materials for providers on peri-natal HIV screening practices, and conducted extensive outreach to OB/GYNs and other medical providers. HAHSTA compared electronic birth records with peri-natal HIV data obtained from electronic birth records to identify previously unreported and new cases of HIV in order to improve peri-natal exposure surveillance. HAHSTA also participated in case record reviews to assess and improve the process of routine HIV testing and linkage to treatment.

INITIATIVE 1.4: Expand DC Needle Exchange Program (DC NEX).
HAHSTA continues to provide comprehensive syringe exchange/harm reduction services and capacity building activities for four NEX partners and training for direct service providers. HAHSTA has worked with providers on improving connections to detox and treatment. With the lifting of the ban of federal funds for needle exchange, HAHSTA briefed non-NEX providers on options for integrating NEX into current services, and issued an RFA with funding for NEX providers. HAHSTA continues to work on the Substance Abuse and HIV Prevention Strategic Plan, which DOH plans to release in FY11. 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.
HAHSTA surpassed the goal of tripling free condom distribution a year earlier than planned with 3.2 million condoms in FY09 and a projected 3.5 million in FY10. HAHSTA has engaged over 300 community partners of public health and non-public health community organizations and businesses to offer free condoms, and developed and distributed tens of thousands of informational and promotional materials for condom availability. HAHSTA introduced direct delivery of condoms to individual DC residents, and initiated new media components: Twitter, Facebook and text messaging for condoms. HAHSTA successfully formed a public-private partnership on education and utilization of the new FC2 female condom, and launched a new youth-targeted condom component of the program, working with youth community partners to distribute nearly 175,000 condoms.

INITIATIVE 1.6: Strengthen Community-level Capacity for HIV Care and Prevention Activities.
HAHSTA enrolled 12 new community organizations into the Effi Barry Year One Core Program, and expanded the opportunities for new capacity building support through the Effi Barry Program with the introduction of the Effi Accelerated – a single track focus on HIV competency and Linkages – supporting model integrated services among multiple organizations. HAHSTA provided funding to Metro TeenAIDS to provide capacity building assistance for non-HIV focused youth organizations and to Trinity Development Corporation for capacity building assistance to faith-based organizations. HAHSTA and the Places of Worship Advisory Board sponsored, with Trinity Development Corporation and the Black Leadership Commission on AIDS' DC Chapter, the One in the Spirit Faith and HIV symposium at the DC Convention Center.

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.**
  HAHSTA offered STD information and voluntary screening to students in all 20 DCPS high schools and several public charter schools. HAHSTA reached over 5,000 young people with STD screening, and increased the number of youth-serving community partners offering STD screening. DOH adopted a revised school condom availability policy allowing schools to designate other individuals to offer condoms to students. HAHSTA launched the Wrap M.C. condom education program to train adults and peers on condoms, HIV and STDs and certify them as condom educators. HAHSTA trained more than 130 Wrap M.C.s through its web-based training and certification program. HAHSTA funded Metro TeenAIDS to continue training of schools nurses, and continued support for the REALtalk youth social marketing program. HAHSTA is also collaborating with the Global Business Coalition on a new youth campaign initiative, engaging marketing experts to develop the program with a goal and theme of a HIV Free Generation in DC.

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.**
  Since 2007, HAHSTA has doubled the number of District residents receiving free HIV medications from 1,200 to 2,500 under the AIDS Drug Assistance Program. Through the efforts of HAHSTA and its community providers, the number of people who were linked to care within 3 months of their diagnosis increased by more than one third. HAHSTA used surveillance data to initiate a recapture blitz. With providers HAHSTA re-enrolled 181 people who had dropped out of medical care. HAHSTA developed new HIV primary care standards and medical case management protocols and conducted trainings of all HIV case managers. HAHSTA launched the Red Carpet Entry program that enables newly diagnosed and those returning to care to obtain a full HIV medical evaluation within 48 hours. Eight medical providers have joined the program. HAHSTA worked with DHCF to identify and transfer individuals served under Ryan White CARE Act Funding, including ADAP, to Medicaid under Health Care Reform's expanded coverage.

- **INITIATIVE 3.2: Expand Housing Options for persons living with HIV/AIDS.**
  HAHSTA made significant improvements and efficiencies in the HOPWA program by consolidating rent support payments, making it easier for individuals to apply directly for housing support through a central provider, and redirected all funding to housing assistance. HAHSTA contacted individuals on the waiting list every six months and provided referrals to other housing assistance opportunities. HAHSTA provided long-term housing assistance to 313 households and short-term assistance to over 200 households. Despite these efforts, the HOPWA wait list continues to increase with more than 740 individuals seeking housing assistance.

Community Health Administration (CHA)

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.**
  The Advisory Committee on Perinatal, Infant and Inter-conceptional Health and Development was

developed is to assist the Community Health Administration in exploring strategies and interventions directed at:

- Reducing the District of Columbia's infant mortality rate;
- Improving the pre- and inter-conceptional care of women of child-bearing age;
- Deceasing the health disparities in identified residential areas; and
- Examining best practices from other jurisdictions.

The Committee shall review and analyze scientific studies and recommendations from medical, public health or other relevant experts in pre-conception, prenatal and postpartum care in order to recommend to DOH strategies and initiatives for perinatal programs citywide and to generally refine the DOH Child Health Action Plan to address infant mortality.

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.

DOH has provided $3,000,000 in grants to various health entities including community based organizations to address chronic disease in the District. Among those granted funding were Whitman - Walker Clinic, Spanish Catholic Center, Carl Vogel Center, Columbia Lighthouse for the Blind, Howard University Diabetes Treatment Center and a host of others, which ensures the District government commitment to fighting chronic disease.

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.

The following screenings have been provided for DC school children:

- 77% of students grades PK, K, 1, 2, 6, 6, 8, and 10 and in special education have been screened for vision;
- 79% of students in grades K, 1, 2 and 6, and in special education have been screened for hearing;
- 18.4% have been screened for scoliosis; and
- 71% of students have been screened for BMI.

INITIATIVE 2.2: Increase the capacity to measure the progress of the School Nurse Program by implementing a new data management system.

Phase I of the Health Master-Health Office, the school nursing data system, was implemented to provide a comprehensive picture of service provision in each school.

INITIATIVE 2.3: Monitor comprehensive physical examinations by providers by collaborating with DCPS and OSSE.

Annual comprehensive physical exams became a statutory requirement with the enactment of the Healthy Schools Act of 2010, which became effective on July 27, 2010. The annual exam provision was drafted by DOH with the support of the School Health Working Group, an interagency school health policy group. Previously, school exams were only required for students entering Pre-Kindergarten, Kindergarten, 1st grade, 3rd grade, 5th grade, 7th grade, 9th grade, and 11th grade. DOH has been collaborating with the DME, DCPS, OSSE, and the Public Charter School Board to identify schools in which

the previous health screening standards have not been met, and will strengthen efforts to monitor compliance with the new annual exam policy. Through Children's School Services, case managers routinely link students to insurance resources, medical homes, and other community resources.

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.**

  In FY10, the breastfeeding enrollment rates dropped from 51% in FY09 to 47% in FY10, as a new WIC food package was implemented at the beginning of the fiscal year. While the new food package better supports breastfeeding by giving larger packages to fully and mostly breastfeeding mothers, many states have experienced decreased breastfeeding enrollment for the following reasons:

  - The previous food package allowed minimally breastfeeding mothers to receive a breastfeeding food package and a full formula package for their infants throughout the infant's first year. In the new food package, breastfeeding infants may only receive one can of powdered infant formula during the first month. Formula is not routinely issued in order to protect the mothers' milk supplies. Some mothers report that they are not breastfeeding so that they will get formula.
  - Mothers of infants who receive a full formula package will get the same food package as that of a non-breastfeeding woman. They also will only receive this food package for the first 6 months of the infants' lives. For this reason, mothers are not re-certifying as breastfeeding mothers.

HEALTH REGULATION AND LICENSING ADMINISTRATION (HRLA)

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.**
  Through an agreement with HRLA, MPD will conduct criminal background checks (CBC) for health care professionals applying for initial licensure. To prepare for implementation, HRLA conducted best practice research by looking at the states of Texas, Maryland and Arizona. Beginning in November 2010, HRLA will pilot CBCs with addiction counselors.

- **INITIATIVE 2.2: Implement a compliance office for follow-up on complaints/incidents.**
  HRLA's compliance office investigates complaints and incidents filed by citizens and healthcare establishments. During the past year, the Office of Compliance's primarily focused upon timely investigations of incidents and complaints concerning Intermediate Care Facilities for the Mental Retarded (ICF/MR), Community Resident Facilities for the Mental Retarded (CRF/MR) and Nursing Homes. In FY 2010, the Office of Compliance triaged over 700 nursing home incidents, over 932 ICF/MR incidents, and over 50 CRF/MRs incidents. The analytical data from the sources will be used this fiscal year to target professional development for facilities and improve reporting systems for nursing homes and emergency medical services.

- **INITIATIVE 2.3: Implement the Adverse Events reporting system**.
  In FY 2010, HRLA modified a contractor agreement to enable health care facilities, mostly hospitals and nursing homes, to report adverse events electronically through new software. The contractor has provided both technical assistance and an annual newsletter to hospitals on their adverse events.

  INITIATIVE 2.4: **Increase number of Licensed, Registered or Certified healthcare professionals regulated by DOH.** HRLA, in partnership with professional boards, has published final regulations for Speech-Language Pathology. Additionally, regulations in the following professions have been developed and are currently being reviewed by other district government agencies: audiologists, dental assistants, psychology associates, certified addiction counselors I and II, home health aide, dialysis technician, and pharmacy technicians. Finally, professional boards continue to work on licensure regulations for graduate professional counselors, licensed addiction counselors, nursing assistant/patient care technician, and medication aide.

- **INITIATIVE 2.5: Increase the ability of Boards to discipline health professionals.**
  The Health Occupations Revisions Act of 1985 Amendment Act of 1994 increases the number of categories for which a licensee, registrant, or certification holder may be disciplined from 29 to 45 and clarifies the language in some of the previous 29 - i.e. certification of addiction counselors; registration of home health and personal care aides.

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.**
  The Health Regulation and Licensing Administration developed and implemented a comprehensive database for food facility inspections accessible to the public. Previously, the inspector would inspect an establishment and provide the facility manager with the inspection report on the premises. During FY 10, HRLA was provided a computerized tool for sanitarians to conduct food facility inspections that are consistent, clear, and concise and easy to understand. In 2010, the inspection forms were uploaded to the DOH web site for public review. This system will be accessible by the public to help foster informed decisions and to incentivize better health practices.

Key Performance Indicators – Details

Performance Assessment Key:

Fully achieved | Partially achieved | Not achieved | Data not reported

	Measure Name	FY2009 YE Actual	FY2010 YE Target	FY2010 YE Actual	FY2010 YE Rating	Budget Program
1.1	Vacancy Rate	9	8	8%	100%	
1.2	# of FTEs	911	835	835	100%	
1.3	% of new hires on board within 75 days of job posting	0	75	80%	106.67%	
1.4	Turnover rate	0	5	7.07%	70.76%	
2.1	% of subgrant invoices paid within 30 days of receipt	80	85	N/A	N/A	
2.2	# of reported single audit findings that indicate material non-compliance or a reportable condition	8	6	7	85.71%	
2.3	% of lapse of total dollar amount of federal grant budget	4	3	N/A	N/A	
2.4	%of grant mgmt specialists receiving skill based training	60	75	78.57%	104.76%	
2.5	# of COTRs receiving advanced training	0	10	6	60%	
2.6	# of procurement related trainings held annually	4	4	2	50%	
2.7	Square footage of leased space	242905	149941	443920	33.78%	
2.8	Facility Cost per DOH employee	9548	9548	$9,548	100%	
2.9	# of visitors to the DOH website	593273	690000	1187244	172.06%	

2.10	Number of community based forums	4	6	24	400%	
2.11	Number of FIA doorknocks	4100	4100	1800	43.90%	
2.12	# of Safety Incidents	3	15	11	136.36%	
2.13	% of DOH Employees in Need of Safety Training	99	99	61.96%	159.78%	
2.14	# of Professional Educational and Training	2	10	13	130%	
2.15	Number of unusual incident reports filed	53	180	187	96.26%	
2.16	# of administrations trained in the use of unusual incident reports	1	1	3	300%	
HEALTH EMERGENCY PREPAREDNESS AND RESPONSE ADMINISTRATION (HEPRA)						
1.1	% of District of Columbia EMTs that meet or exceed National Registry test standard.	67	70	76.57%	109.39%	OFFICE EMERGENCY HEALTH&MED SERVICES
1.2	% of Certifications rapidly issued to reduce downtime of uncertified providers	4	2	92.48%	2.16%	PUBLIC HEALTH LABORATORY
2.1	% of DOH staff trained in the National Incident management system	38	70	21.37%	30.53%	OFFICE EMERGENCY HEALTH&MED SERVICES
2.2	% of hospitals compliant with National Incident Management System training requirements	84	90	93.33%	103.70%	OFFICE EMERGENCY HEALTH&MED SERVICES
2.3	% of hospitals that adopted bed availability data standards and definition	100	100	86.67%	86.67%	OFFICE EMERGENCY HEALTH&MED SERVICES
2.4	% of Long-term Care facilities that develop Facility Evacuation Plans	90	100	100%	100%	OFFICE EMERGENCY HEALTH&MED SERVICES
2.5	% of Community-based Health Centers that biannually update Emergency Operations Plans and Facility Evacuation Plans	85	100	100%	100%	OFFICE EMERGENCY HEALTH&MED SERVICES

	3.1	% of clients using the secure web portal to obtain lab results.	45	50	23.33%	46.67%	PUBLIC HEALTH LABORATORY
	3.2	% of clinics submitting request forms electronically	75	80	96.97%	121.21%	PUBLIC HEALTH LABORATORY
	3.3	% of clinics receiving specimen test results by secure fax or web portal	87	80	91.67%	114.58%	PUBLIC HEALTH LABORATORY
	3.4	% of clinics reporting above average satisfaction with laboratory services	0	80	66.67%	83.33%	PUBLIC HEALTH LABORATORY
	ADDICTION PREVENTION AND RECOVERY ADMINISTRATION						
	2.1	# of community capacity bldg training sessions and TA efforts provided to organizations in support of EVB prevention prgm implementation	0	10	25	250%	ACUTE DETOX & RESIDENTIAL TREATMENT
	2.2	% of clients presenting at the Assessment and referral ctr that complete the assessment and referral process within 2 hours	0	95	45.71%	48.12%	INTAKE ASSESSMENT & REFERRAL
	2.3	%of clients that are screened for mental health disorders during the assessment referral process	0	100	100%	100%	INTAKE ASSESSMENT & REFERRAL
	2.4	% of clients assessed and referred for service that are admitted to a community based provider	0	85	N/A	N/A	INTAKE ASSESSMENT & REFERRAL
	3.1	% of clients that complete the detox and stabilization program w/in 3-5 days	0	95	98.51%	103.69%	IMPLEMENTATION OF DRUG TREATMENT CHOICE

	3.2	% of clients referred to outpatient or intensive outpatient services that complete 2 treatment sessions w/in 1st 2 weeks of admission to tx	0	90	N/A	N/A	IMPLEMENTATION OF DRUG TREATMENT CHOICE
	3.3	% of clients referred to residential treatment services and remain engaged in active tx for at least 30 days	0	90	50.91%	56.56%	ACUTE DETOX & RESIDENTIAL TREATMENT
	3.4	% of clients referred to recovery support services that redeem service vouchers	80	90	100%	111.11%	INTAKE ASSESSMENT & REFERRAL
	3.5	% of recovery support clients that receive a 6month post admission interview	85	90	37.97%	42.19%	ACUTE DETOX & RESIDENTIAL TREATMENT
	3.6	% of recovery support clients that maintain abstinence from alcohol and drugs 6 months post admission	40	45	88.60%	216.50%	IMPLEMENTATION OF DRUG TREATMENT CHOICE
CENTER FOR POLICY, PLANNING, AND EPIDEMIOLOGY							
	1.1	Number of decisions issued on certificate of need applications	9	16	21	131.25%	POLICY,PLANNING AND RESEARCH
	2.1	Percent of hospitals submitting uncompensated care reports	100	100	100%	100%	POLICY,PLANNING AND RESEARCH
	2.2	Percent of nursing homes submitting uncompensated care reports	0	75	100%	133.33%	POLICY,PLANNING AND RESEARCH
HIV/AIDS, HEPATITIS, STD, AND TB ADMINISTRATION							
	1.1	# of new HIV/AIDS cases diagnosed in a fiscal year	714	1500	583	38.87%	HIV/AIDS ADMINISTRATION
	1.2	# of publically supported HIV tests performed	90151	125000	96299	77.04%	HIV/AIDS ADMINISTRATION

1.3	#of persons newly diagnosed with HIV through expanded partner services (PCRS)	42	80	61	76.25%	HIV/AIDS ADMINISTRATION
1.4	#of needles off the streets through DC NEX Program	279707	300000	305385	101.79%	HIV/AIDS ADMINISTRATION
1.5	# of condoms distributed by DC DOH Condom Program	3219446	3000000	3300374	110.01%	HIV/AIDS ADMINISTRATION
1.6	#of peri-natal HIV infections	1	0	0	100%	HIV/AIDS ADMINISTRATION
2.1	# of youth screened for STDs through youth outreach programs	5265	10000	4974	49.74%	HIV/AIDS ADMINISTRATION
3.1	# of persons enrolled in ADAP	2060	2650	3439	77.06%	HIV/AIDS ADMINISTRATION
3.2	% of HIV positive persons w, viral load suppression below 400	0	0	N/A	N/A	HIV/AIDS ADMINISTRATION
3.3	# of families receiving long-term housing vouchers through HOPWA	385	320	314	98.13%	HIV/AIDS ADMINISTRATION
3.4	# of families receiving short-term HOPWA	337	110	270	40.74%	HIV/AIDS ADMINISTRATION
3.5	# of families receiving HOPWA short term rental and mortgage assistance	167	200	249	124.50%	HIV/AIDS ADMINISTRATION
Community Health Administration (CHA)						
1.1	# of prenatal home visits per client per month.	2.1	3	4.4	146.67%	MATERNAL AND CHILD HEALTH SERVICES
1.2	# of women enrolled in Healthy Start case management per year	656	690	1390	201.45%	PERINATAL & INFANT CARE
1.3	# of men enrolled in Healthy Start case management per year	130	150	500	333.33%	MATERNAL AND CHILD HEALTH SERVICES

1.4	% of newly enrolled Healthy Start pregnant women who report entering prenatal care in first trimester per calendar year.	40	45	45.5	101.11%	MATERNAL AND CHILD HEALTH SERVICES
1.5	% of healthy start prenatally enrolled pregnant women who deliver LBW	0	2	1.8	111.11%	MATERNAL AND CHILD HEALTH SERVICES
1.6	%of health start prenatally enrolled pregnant women who deliver LBW	0	5	14.8	33.78%	MATERNAL AND CHILD HEALTH SERVICES
1.7	% of students who receive comprehensive physical exams by providers	46	65	48.91%	75.24%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
1.8	% reach of DC tobacco users through the DC Tobacco Quitline	2.7	1.9	0.79%	41.71%	SUPPORT SERIVES
1.9	#of calls to the DC tobacco quitline	2556	1800	2270	79.30%	SUPPORT SERIVES
1.1	# of clinics making improvements and monitoring progress by participating in the asthma quality improvement collaborative	8	15	37	246.67%	HEALTH SERVICES MANAGEMENT
1.11	# of sites funded by DOH adopting evidence-based care mgmt programs	10	7	12	40.74%	HEALTH SERVICES MANAGEMENT
1.12	# of residents with Diabetes enrolled in DOH funded evidence based care mgmt projects	549	7000	858	12.26%	CHRONIC DISEASE
1.13	% of residents with Diabetes enrolled in DOH funded care programs achieving ideal blood glucose levels	40	41	30.93%	75.43%	CHRONIC DISEASE

2.1	% of students who receive oral health screenings	36.6	45	51.07%	113.48%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.2	% DCPS with full time nursing coverage	88	98	95.12%	97.06%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.3	#of public charter schools w, full time nursing coverage	44	50	141	282%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.4	% of identified school aged children with chronic diseases who have IHP developed by school nurses	80	100	3.46%	3.46%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.5	% of school aged children in grades 2, 4, and 6 who are screened for BMI	25	30	70.62%	235.40%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.6	% of school aged children in grades PreK-10 that receive hearing screenings	91	95	78.99%	83.15%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.7	% of school aged children in grades PreK-10 screened for vision	86.5	95	77.08%	81.13%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
2.8	% of school aged children in grades PreK-10 screened for scoliosis	28	90	18.39%	20.43%	CHILDREN, ADOLESCENT AND SCHOOL HEALTH
3.1	% of postpartum WIC mothers who initiate breastfeeding	45	49	46.57%	95.05%	MATERNAL AND PRIMARY CARE ADMINISTRATION
3.2	% of WIC participants who receive primary high risk nutrition education during a 6month cert period	96	98	97.99%	99.99%	MATERNAL AND CHILD HEALTH SERVICES
HEALTH REGULATION AND LICENSING ADMINISTRATION (HRLA)						
2.1	# of background checks conducted	0	8400	N/A	N/A	HEALTH REGULATION ADMINISTRATION
2.2	# of complaint follow-up conducted in compliance office	0	110	125	113.64%	HEALTH CARE REGULATION & LICENSING ADMIN

2.3	# of adverse events reported in nursing homes & hospitals	328	640	744	116.25%	HEALTH CARE REGULATION & LICENSING ADMIN
2.4	# of additional health care professionals regulated by HRLA	0	6000	N/A	N/A	HEALTH CARE REGULATION & LICENSING ADMIN
3.1	# of food facility inspections	5564	10000	11659	116.59%	HEALTH CARE REGULATION & LICENSING ADMIN
3.2	# of food samples tested from food facilities in District	357	550	1320	240%	HEALTH CARE REGULATION & LICENSING ADMIN