Chapter 7
Health and Human Services

Health and Human Services

Department of Human Services

The mission of the Department of Human Services (DHS) is to coordinate and provide a range of services that collectively create the enabling conditions for economic and socially challenged residents of the District of Columbia to enhance their quality of life and achieve greater degrees of self-sufficiency. DHS achieves its mission through partnerships with community-based organizations and other local and federal government agencies.

Clients in Human Services Programs

It is estimated that roughly 200,000 District residents receive one or more services administered by the District's human services safety net. Recipients of these services include participants in income support programs, such as Temporary Assistance for Needy Families (TANF, formerly Aid to Families with Dependent Children), Supplemental Nutritional Assistance Program (SNAP, formerly Food Stamps), and Interim Disability Assistance (IDA). Medicaid continues to be the largest program with an enrollment of over 160,000 individuals.

A comparison of participants over the twelve-year period shows that the number of Medicaid recipients increased by 34 percent, SNAP recipients increased by 35 percent, and TANF recipients decreased by 17 percent.

Table 7.1. Number of Participants by Program (Monthly average)

(Fiscal Year)	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Medicaid*	119,712	125,680	129,638	130,663	133,913	137,832	144,026	144,413	140,486	140,600	133,905	160,562
SNAP (formerly Food Stamps)	84,386	79,536	72,776	73,069	79,887	86,817	87,215	86,872	85,011	86,957	99,203	113,629
TANF	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272	36,677	42,760
General Assistance for Children	571	546	548	555	525	512	463	411	384	360	334	329
Interim Disability Assistance	n/a	n/a	n/a	420	787	1,012	1,510	1973	2140	3481	2697	1591
DC Healthcare Alliance**	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	44,513	48,095	52,082	48,082

*DHS provides Eligibility only; benefits administered by Department of Health Care Finance (DHCF)
**DHS initiated DC Healthcare Alliance services in FY07

Temporary Assistance for Needy Families (TANF)

In 1996, Congress enacted the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), P.L. 104-193, which eliminated the Emergency Assistance Program and the Aid to Families with Dependent Children (AFDC) program shifting from an open-ended entitlement to a cash assistance program limited to 60-months in a lifetime. The TANF program is designed to assist individuals to become self-sufficient by requiring them to work or participate in certain work activities in order to receive benefits. Support services and employment related services are provided to enable the individual to seek, obtain and maintain employment. After a number of years of declining caseloads, the number of TANF cases has seen a significant increase since 2008. In response to the increasing demands, and the challenges facing TANF families, DHS is redesigning the TANF program. The first phase of the redesign is scheduled to rollout in the Fall of 2011.

Table 7.2. Temporary Assistance for Needy Families (TANF)												
Fiscal Year - Monthly Average	**1999**	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Recipients	51,535	46,764	43,702	43,600	43,137	44,985	43,576	39,859	37,613	37,272	39,588	40,554
Children	37,481	34,271	32,056	32,050	32,638	33,501	32,780	30,379	28,768	28,078	29,549	30,073
Cases	19,062	17,312	16,210	16,390	16,804	17,329	17,066	16,012	15,171	14,892	16,085	16,654
Avg. Mthly Payment by Case	$351	$346	$340	$335	$335	$335	$331	$334	$352	$374	$373	$369
Family Size	2.7	2.7	2.7	2.7	2.6	2.6	2.6	2.49	2.48	2.5	2.5	2.4
Total TANF Payments (in millions)	$80.30	$71.80	$67.20	$66.80	$67.50	$69.60	$67.70	$64.11	$64.14	$67.00	$72.00	$73.00

Food Stamps

The Food Stamp program is designed to provide supplemental nutrition assistance to individuals and families in need. Since 2007, the number of households receiving Food Stamp benefits has increased dramatically by nearly 42%. This has been the result of both the economic downturn, as well as expanded eligibility guidelines in the District.

Table 7.3. SNAP (Formerly Food Stamps)								
Fiscal Year - Monthly Average	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Recipients	79,887	86,817	87,215	86,872	85,011	86,957	99,203	113,629
Cases	37,910	41,977	43,273	44,058	44,028	46,132	54,299	63,720

Permanent Supportive Housing

In 2008, the District of Columbia adopted the Housing First Initiative, a revolutionary, yet tested, approach for addressing and bringing an end to chronic homelessness in the District of Columbia. As a result, DHS created the Permanent Supportive Housing (PSH) Program, which serves individuals, families and veterans. The PSH programs transformed the delivery of homeless services from an approach that simply meets the survival needs of individuals with blankets and shelter, to one that provides a subsidized housing unit paired with tightly linked supportive services. In its first three years, the PSH program has housed 1,028 of the most vulnerable homeless individuals and families in the District.

Table 7.4. Permanent Supportive Housing (PSH)			
(Fiscal Year)	**2008**	**2009**	**2010**
Individuals Housed	362	190	38
Families Housed	n/a	74	165
Total number of households	362	380	286

Shelter Services

In addition to the Permanent Supportive Housing programs, the District provides shelter and transitional housing programs for individuals and families experiencing homelessness.

- Hypothermia, low barrier and temporary shelters provide 12-24 hour daily shelter with access to supportive services.
- Transitional shelter aims to facilitate the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months)**.**
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In recent years, the number of persons that have utilized individual shelter beds decreased by approximately 10%; while family beds utilized have decreased by approximately 31%. Transitional housing beds for individuals have remained steady, while family bed usage experienced a 9% increase from 2008 to 2009, and a 3% decrease from 2009 to 2010.

Table 7.5. Shelter

(Fiscal Year)	2008	2009	2010
Shelter*			
Individuals	11,631 persons	11,442 persons	10,427 persons
Families	1,371 persons (433 families)	1,451 persons (464 families)	1,802 persons (564 families)
Transitional Housing			
Individuals	738 persons	702 persons	697 persons
Families	918 persons (281 families)	1,008 persons (304 families)	1,035 (310 families)

***Includes hypothermia, seasonal and overflow beds**

Adult Protective Services

Adult Protective Services (APS) investigates reports alleging abuse, neglect and exploitation of elderly, disabled and other vulnerable adults and intervenes to protect those adults who are at risk.

Table 7.6. Adult Protective Services (APS)

(Fiscal Year)	2008	2009	2010
Total number of cases	957	874	856

Strong Families

The Strong Families program aims to strengthen individuals and family units, foster healthy development, and help address the issues that create ongoing challenges by providing client needs assessments, case plan development, social work interventions and referral and coordination of services. Over the last three years, the total number of clients served has increased by approximately 31%.

Table 7.7. Strong Families

(Fiscal Year)	2008	2009	2010
Families Served	969	1,161	1,423

Office on Aging

Services to the Elderly

The District government provides a variety of comprehensive programs and services for senior citizens; many of these are funded through the DC Office on Aging (OoA), which administers funds under the federal Older Americans Act of 1965, as well as District appropriated monies. These funds are distributed to 27 public and private non-profit community-based, educational as well as local government agencies that operate 37 programs for senior citizens (persons 60 years and older). These programs and services are crucial to allowing seniors to age in place in their communities. Services such as counseling, case management, congregate and home delivered meals, in home support, caregivers support, legal, advocacy, health and wellness, employment, center programs and activities, long term care options counseling, respite care, transportation and geriatric day care are provided. DCOA provides managerial oversight for the food service contract that prepares and delivers congregate and home delivered meals to seniors throughout the city. DCOA provides funding for 6 senior wellness centers of which the latest will open in FY 2012 in Ward 6. Since 2008, the Office on Aging through an agreement with the Department of Health Care Finance manages and operates the Aging and Disability Resource Center (ADRC).

In FY 2009, the spending for services to the elderly under the auspices of the OoA amounted to $19,974,156 million, which included $14,815,604 million in District funds, $4,510,253 million in federal funds. By 2010, spending for services amounted to $19,598,370, which included $14,176,516 million in District funds and $4,759,816 million in federal funds. The elderly population has increased 8% since 2000.

In FY 2010, more than 35,107 senior citizens received one or more services funded by the DC Office on Aging. That translates into 36% of the senior population receiving one or more services from an Office on Aging sponsored program. The most requested service by seniors were counseling, congregate and home delivered meals, transportation, wellness services and case management. By comparison, the most utilized services were congregate and home delivered meals, wellness programs and transportation.

Through the activities of the Commission on Aging, elderly residents can participate in promoting, planning and assessing services and programs for their peers. The Commission consists of 15 members appointed by the mayor with the advice and consent of the DC Council. The members serve as a citizen's advisory group to the mayor, the Council and the DC Office on Aging. During FY 2009-2010, the Commission sponsored a citywide Intergenerational Poster contest and participated in Office on Aging special events and forums. They also testified and lobbied on transportation, utilities, housing, crime prevention, fare increases, kinship care, and nursing home reform legislation affecting the elderly, as well as the OoA budget.

Other agencies offering specific services to seniors include: DC Housing Authority, Metropolitan Police, Public Library, Housing and Community Development, Fire and Emergency Services, Health, Human Services, Tax and Revenue, Parks and Recreation, Motor Vehicles, Health Care Finance Agency and the University of the District of Columbia.

Figure 7.1. Dollars Spent in FY 2010 by Percent

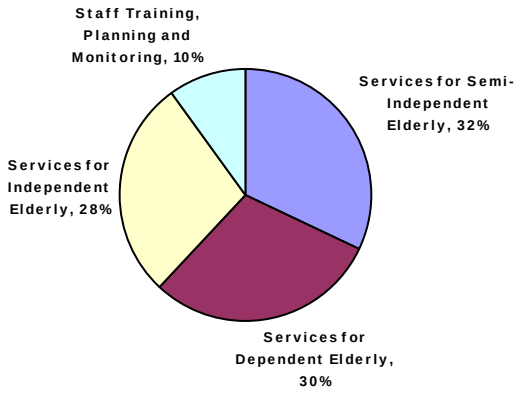


Table 7.8. Number Of Persons Receiving Services			
	FY 2008	**FY 2009**	**FY 2010**
Persons Served	32,722	29,003	35,107
Counseling	5,413	7,074	6,676
Congregate Meals	3,927	5,159	5,098
Transportation	3,831		
Homemaker	490	465	428
Home-Delivered Meals	3,661	3,926	2,661
Wellness Services	1,476	1,919	1,934
Geriatric Day Care	274	208	190
Comprehensive Assessment and Case Management	1,396	2,269	2,437
TransEscorts	n/a	2,006	2,003
TransSites	n/a	2,319	2,540
Source: FY'09-10 DC Office on Aging Client Service Tracking and Reporting System (CSTARS)			

Table 7.9. Units Of Services Provided			
	FY 2008	**FY 2009**	**FY 2010**
Counseling	153,139	120,845	97,315
Congregate Meals	368,700	439,133	389,462
Transportation	166,137	101,211	104,769
Homemaker	96,811	92,872	81,351
Home-Delivered Meals	601,139	508,739	501,324
Wellness Services	239,494	280,723	302,496
Geriatric Day Care	89,843	77,864	95,863
Comprehensive Assessment and Case Management	24,379	24,519	26,154
TransEscorts	n/a	84,659.00	80,447.00
TransSites	n/a	100,901.70	104,341.50
Source: FY'09-10 DC Office on Aging Client Service Tracking and Reporting System (CSTARS)			

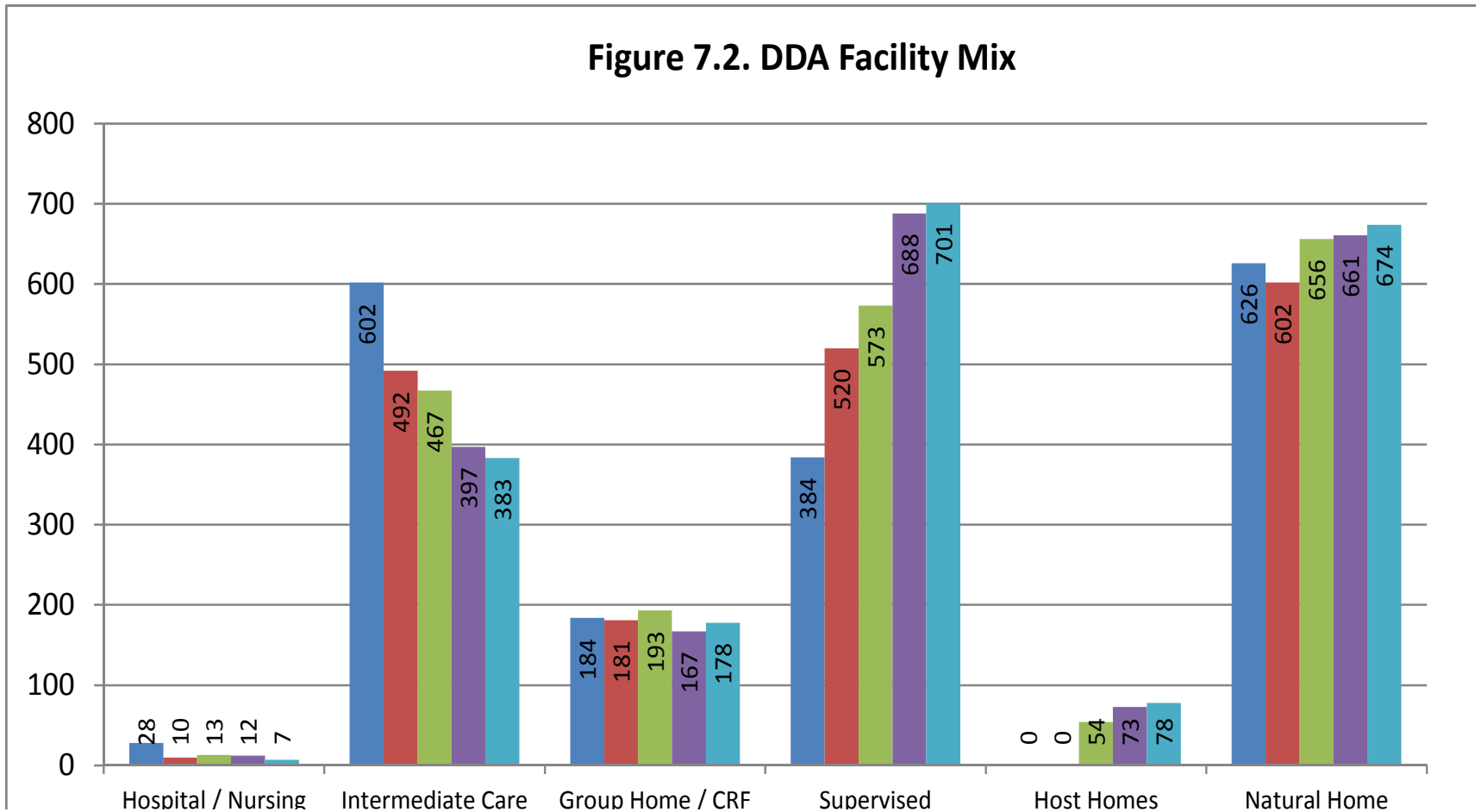
Disability Services

Services for District Residents with Disabilities

The mission of the Department on Disability Services (DDS) is to provide innovative high quality services that enable people with disabilities to lead meaningful and productive lives as vital members of their families, schools, workplaces and communities in every neighborhood in the District of Columbia. DDS is composed of two Administrations that oversee and coordinate services for residents with disabilities through a network of private and non-profit providers; The Developmental Disabilities Administration and the Rehabilitation Services Administration.

Citizens with Developmental Disabilities

The Developmental Disabilities Administration (DDA) ensures that residents with developmental disabilities receive the services and supports they need to lead self-determined and valued lives in the community. These services include needs assessment and evaluation, care coordination, transportation planning, community living services, quality assurance reviews, medical consultation and training, health monitoring and employment assistance Recent initiatives aim to ensure the successful transition of Home and Community based Services (HCBS) waiver eligible persons with developmental disabilities, to community based settings. The data provided demonstrate the move from more restrictive living situations such as intermediate care facilities to less restrictive settings such as natural homes.



Note that the Group Home / CRF category is now referred to as Residential Habilitation, and the Supervised Apartments category is referred to as Supported Living.

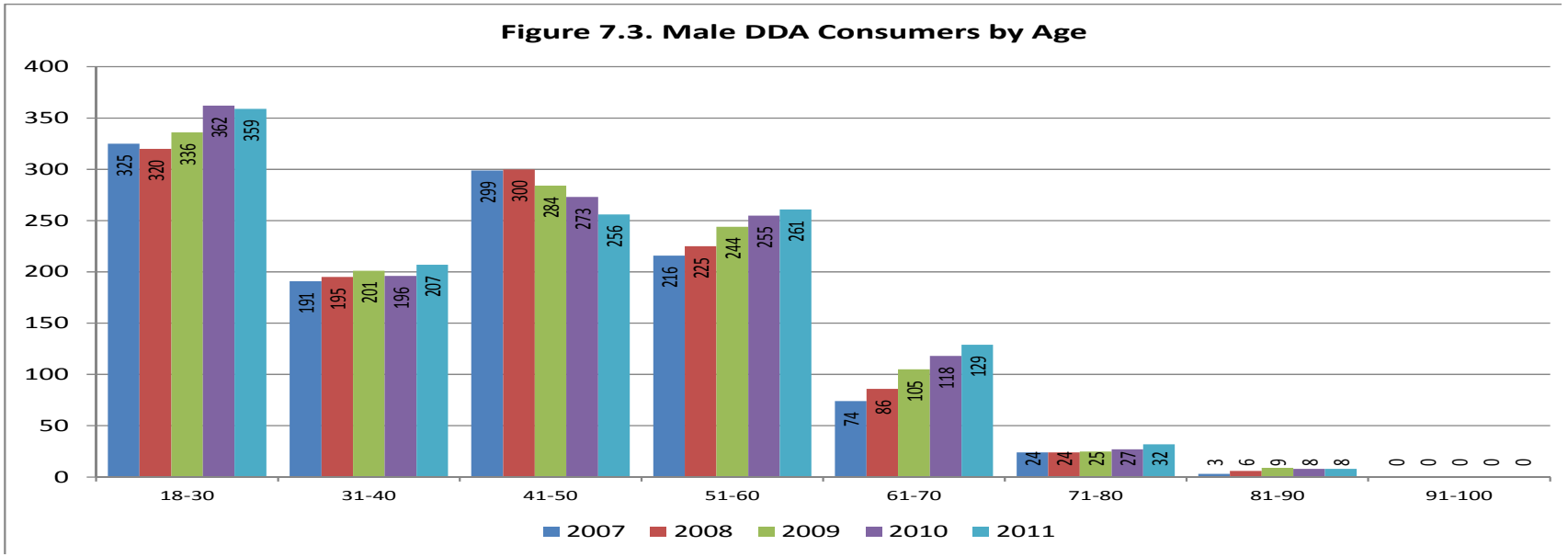


Figure 7.3. Male DDA Consumers by Age
400
350
300
250
200
150
100
50
0
325 320 336 362 359
191 195 201 196 207
299 300 284 273 256
216 225 244 255 261
74 86 105 118 129
24 24 25 27 32
3 6 9 8 8
0 0 0 0 0
18-30
31-40
41-50
51-60
61-70
71-80
81-90
91-100
2007 2008 2009 2010 2011

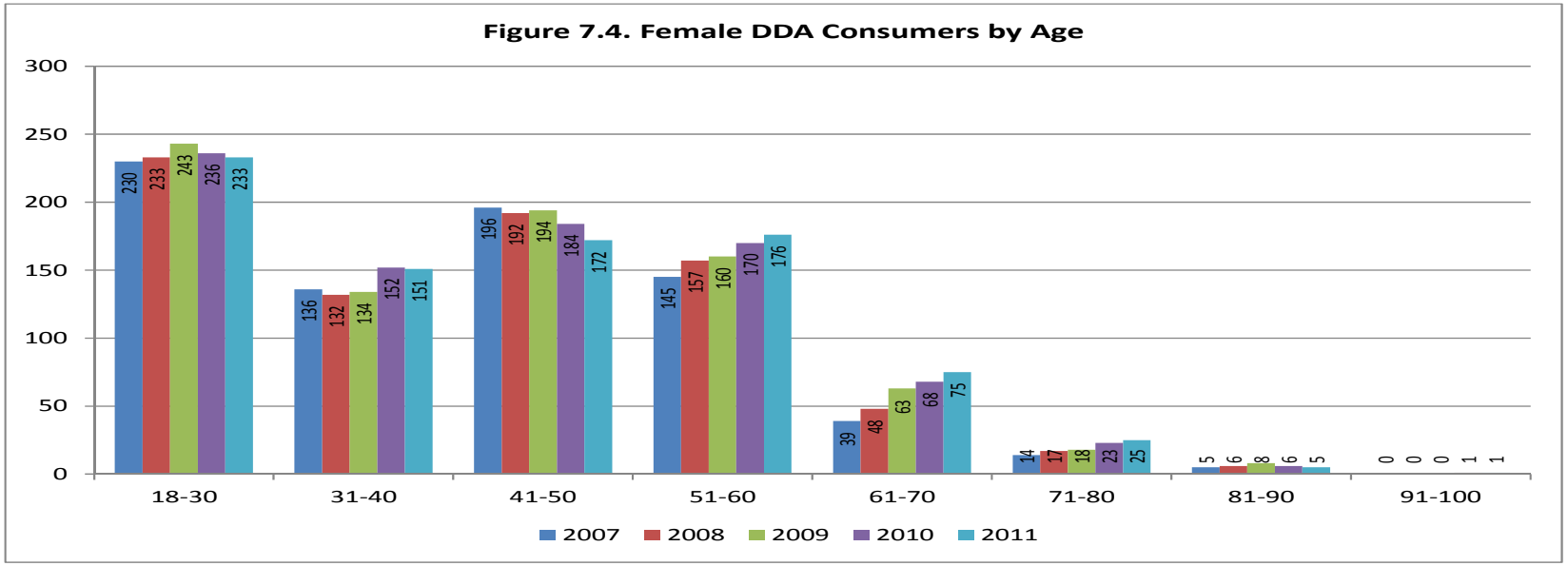


Figure 7.4. Female DDA Consumers by Age
300
250
200
150
100
50
0
230 233 243 236 233
136 132 134 152 151
196 192 194 184 172
145 157 160 170 176
39 48 63 68 75
14 17 18 23 25
5 6 8 6 5
0 0 0 1 1
18-30
31-40
41-50
51-60
61-70
71-80
81-90
91-100
2007 2008 2009 2010 2011

Rehabilitative Services

The District of Columbia Rehabilitation Services Administration (DCRSA) focuses on employment and independent living related services, ensuring that individuals with disabilities achieve a greater quality of life by obtaining and sustaining employment consistent with their capability and informed choice, economic self-sufficiency and independence within their communities. The DCRSA achieves this through offering an array of individualized services which include but not limited to the following: counseling and guidance, employment and placement services, post-secondary education, vocational training, mental and physical restoration, assistive technology services, follow-up and inclusive business enterprises and supports for the DC Center for Independent Living. Recent initiatives include increasing the number of persons with disabilities who receive the supports necessary to obtain and maintain living wage employment in integrated settings as well as expanding the opportunities available for youth with disabilities by ensuring that they have Individualized Plans for Employment in place prior to graduation. Additionally, the Social Security Disability Insurance Determinations Unit assists individuals in receiving social security supplemental income and social security disability income benefits

Figure 7.5.

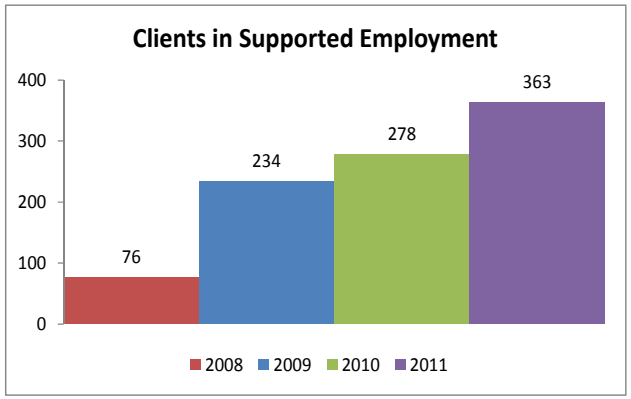
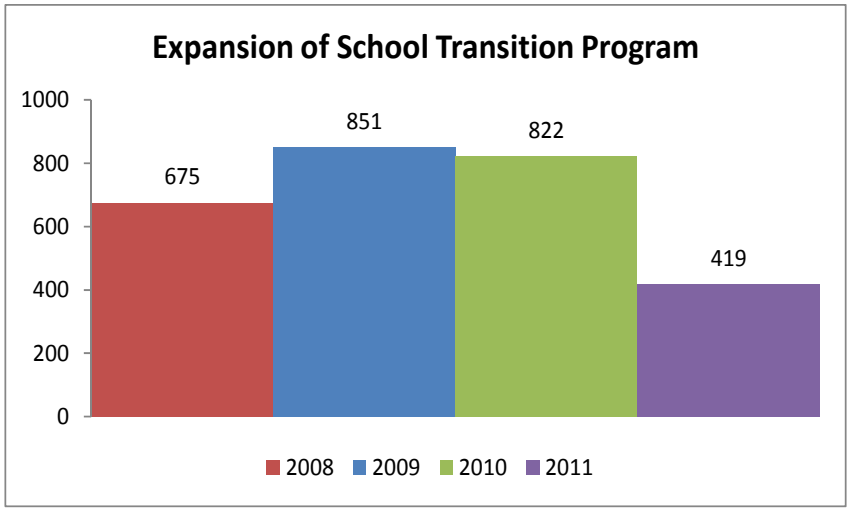


Figure 7.6.



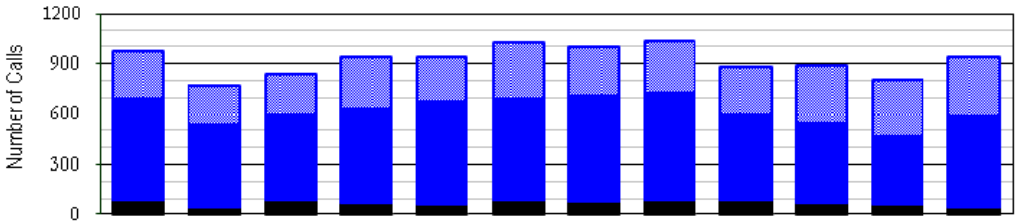
Child and Family Services

The DC Child and Family Services Agency (CFSA) investigates reports of child abuse and neglect, and provides child protection. CFSA services include foster care, adoption, and supportive community-based services to enhance the safety, permanence, and well-being of abused, neglected, and at-risk children and their families in the District of Columbia. CFSA seeks to achieve the highest quality of community-based services, to increase the number of families who receive community-based preventive and support services, and to expand the network of resources providing services to at-risk children and their families. The following data provide information on the core aspects of the Agency's operations, while providing further insight into the CFSA population served. Among data elements to provide and Agency overview are the following: hotline calls, investigations and the CFSA clients served. The window of time reporting the data is FY09 to FY10 and summary analysis of current data as of June 30, 2011.

Hotline Calls

In FY09, the average number of hotline calls received was 917, while the average number of calls accepted for investigation was 546. More specifically of the hotline calls received in September 2009, 534 (57%) were initially screened as potentially involving child maltreatment and 358 (38%) were related to information and/or referrals. Of the 938 CPS calls received in September, 46 (8.5%) were screened out. Throughout FY09, the proportion of CPS calls screened out has ranged between 5% and 9%.

Figure 7.7. CFSA Calls - FY 2009



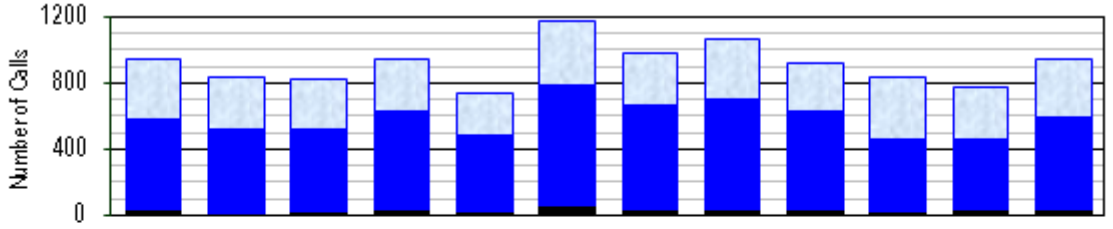
	Oct-08	Nov-08	Dec-08	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09
Total Calls	974	767	838	935	932	1024	1001	1032	877	883	804	938
I&R Calls	281	240	242	305	259	328	292	307	279	342	339	358
CPS-Accepted	601	480	508	555	614	608	626	640	512	473	404	534
CPS-ScreenedOut	92	46	86	74	59	87	82	85	86	68	61	46
Pending*	0	0	0	1	2	0	0	1	1	0	0	0

Source: CFSA FACES Report INT003

Comparatively in FY10 the average number of hotline calls was 920 and the average numbers of calls accepted for investigation was 554. More specifically as of September 30, 2010, CFSA received a total of 955 hotline reports. Of the 955 hotline reports, 560(59%) were accepted for investigation, 359 (38%) were categorized as I&R, and the remaining 46 reports (5%) were screened out. Between FY09 and FY10, the average number hotlines increased by 0.3% (n=3).

The most recent data report that comparatively, as of June 30, 2011, there were 1,040 total hotline calls. Of the 1,040 calls, 525 (50%) were accepted for investigation, 438 (42%) were information and referral and 36 (3%) were screened out.

Figure 7.8. CFSA Calls - FY 2010



	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Total Calls	948	837	829	949	746	1178	993	1068	925	837	780	955
I&R Calls	356	306	306	317	257	383	323	358	282	368	317	359
CPS-Accepted	550	508	491	595	455	727	624	671	604	441	424	560
CPS-ScreenedOut	40	23	32	37	34	67	46	39	37	28	39	36
Pending*	2	0	0	0	0	1	0	0	0	0	0	0

New Investigations

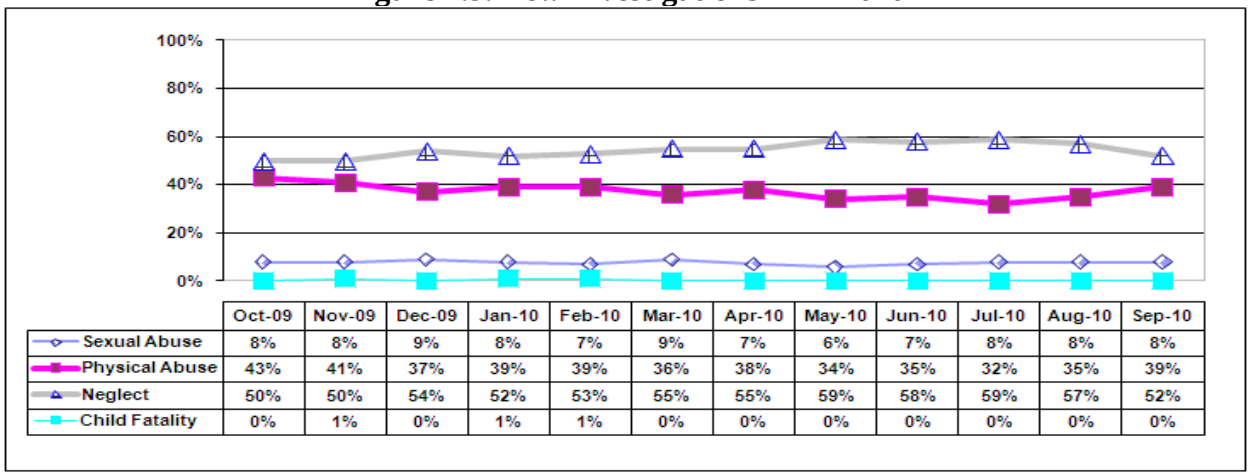
In FY09, the average number of new investigation was 506. In FY09, seven percent of new investigations were sexual abuse, thirty-two percent were physical abuse, and fifty-three percent neglect. The average number of new investigations in FY10 was 517. As of September 30, 2010 zero percent of new investigations were related to child fatality, eight percent were related to sexual abuse, thirty-nine percent were related to physical abuse and fifty-two percent were related to neglect.

Between FY09 and FY10 the average number of new investigations increased by 2% (n=11). The proportion of new investigations by allegation type remained consistent between FY09 and FY10 with neglect comprising the largest proportion ranging between 53-57%.

Physical abuse investigations comprised the second largest proportion with between 32-39% of new investigation types. Sexual abuse and child fatality investigations comprise the two lowest allegation types, with sexual abuse consistently comprising between 7-8% and child fatality comprising 0% of new investigations in both fiscal years.

As of June 30, 2011, there were 525 new investigations. Of the 525, there were no child fatalities, 41 sexual abuse investigation comprising 8%, 165 physical abuse investigations comprising 31% and 319 neglect investigations comprising 61% of new investigations as of June 30, 2011.

Figure 7.9. New Investigations – FY 2010



	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
Sexual Abuse	8%	8%	9%	8%	7%	9%	7%	6%	7%	8%	8%	8%
Physical Abuse	43%	41%	37%	39%	39%	36%	38%	34%	35%	32%	35%	39%
Neglect	50%	50%	54%	52%	53%	55%	55%	59%	58%	59%	57%	52%
Child Fatality	0%	1%	0%	1%	1%	0%	0%	0%	0%	0%	0%	0%

Figure 7.10. CFSA New Investigation - FY 2011 (June 2011)

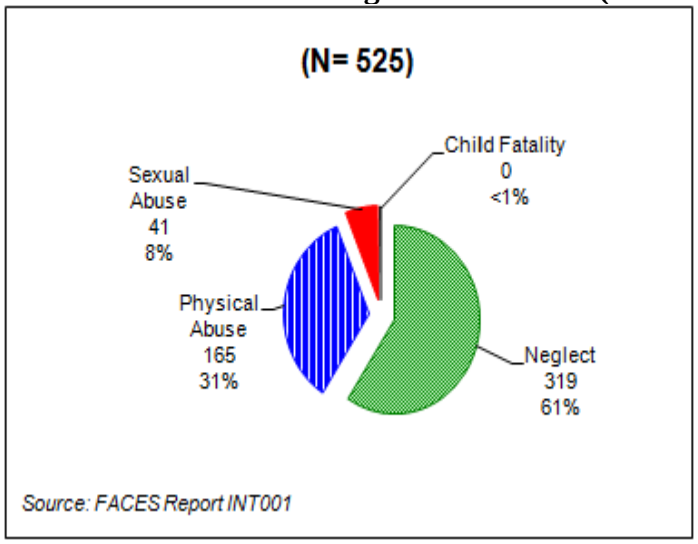
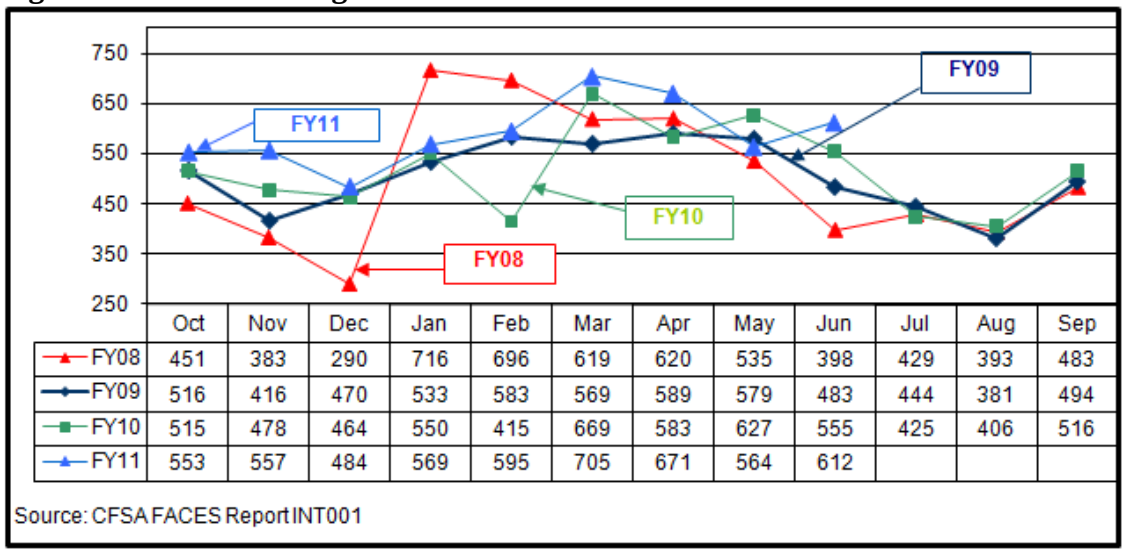


Figure 7.11. New Investigations - Seasonal



	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
FY08	451	383	290	716	696	619	620	535	398	429	393	483
FY09	516	416	470	533	583	569	589	579	483	444	381	494
FY10	515	478	464	550	415	669	583	627	555	425	406	516
FY11	553	557	484	569	595	705	671	564	612			

Source: CFSA FACES Report INT001

New Investigations Seasonal Trends

While the number of new investigations proportions by allegation type has evidenced slight increases but statistically remained flat with sexual abuse and child fatality comprising the lower percentage and neglect allegations comprising the largest, between FY08 to present, seasonal trends of new investigations indicate that the average number of new investigations has increased by 27% (n=129) between FY08 and FY11 to date. Seasonal new investigations trends find March as the heaviest month, followed by the end of the school recording the highest new investigation counts.

Open and Closed Investigations

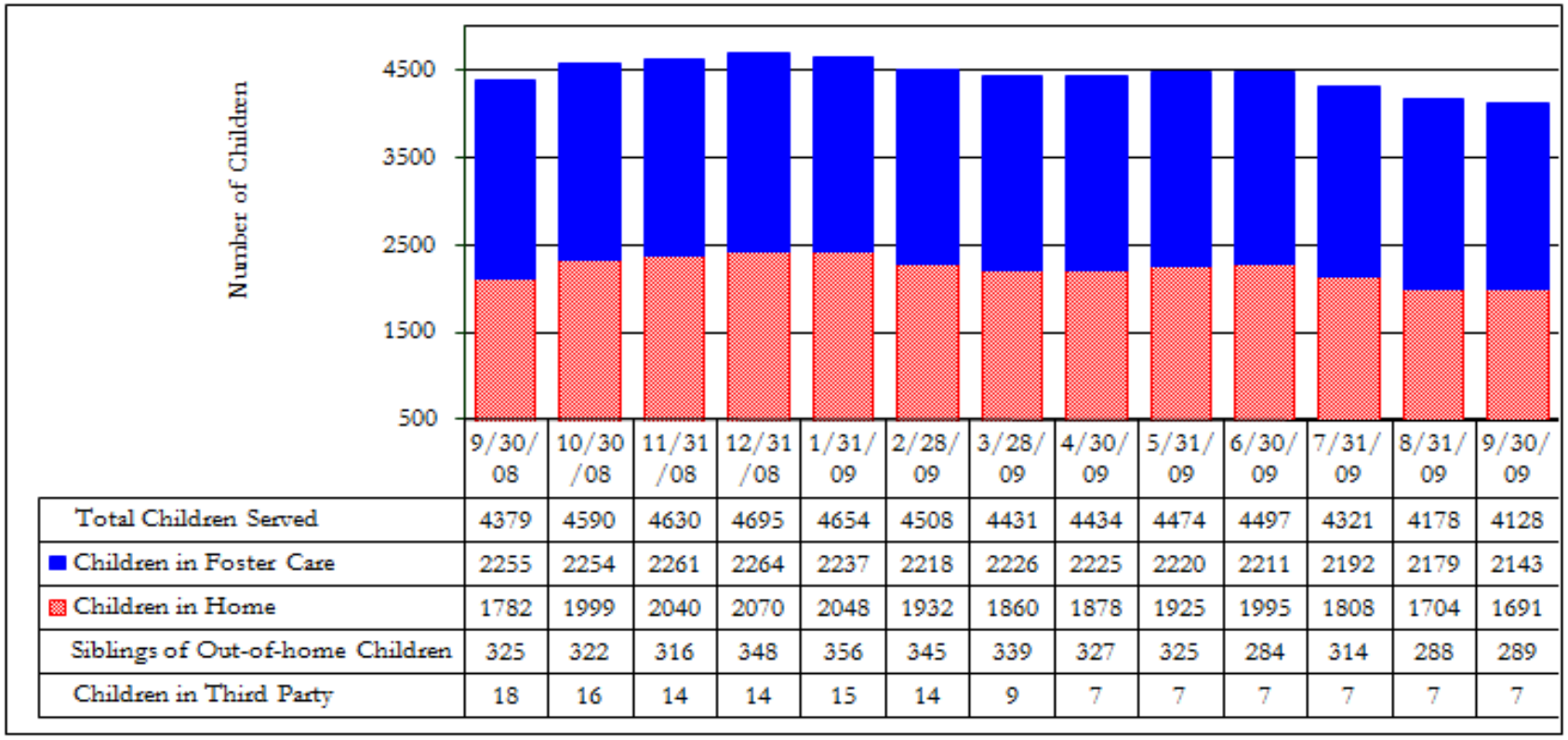
In FY09, the average number of open investigations was 553. In FY10, the average number of closed investigations was 585. In FY10, the average number of open investigations was 486 and the average number of closed investigation was 507. Between FY09 and FY10, the average number of open investigations decreased by 12% (n=67) and the average number of closed investigations decreased by 13% (n=78). Comparatively, as of June 30, 2011, there were 494 open investigations and 512 closed investigations.

CFSA Population

As of September 30, 2009, CFSA and private agencies served 2,143 children who were placed in foster care, seven children placed in third party placements and 289 children who remained at home as their siblings were served in out-of-home-care. In addition, CFSA (and the private agencies to a lesser degree) provided in-home services to 1,691 children (in 626 families) found to be victims of child maltreatment but who were able to safely remain in their homes or who were able to safely return to their homes. Overall, a total of 4,128 children were placed in out-of-home care or received in-home services from CFSA or private agencies, as of September 30, 2011.

Of the 2,143 children in foster care, 71% of children were in family-based settings, seven percent of children were in group settings, five percent in residential treatment centers and eight percent in independent living programs.

Figure 7.12. Children Served – FY 2009



	9/30/08	10/30/08	11/31/08	12/31/08	1/31/09	2/28/09	3/28/09	4/30/09	5/31/09	6/30/09	7/31/09	8/31/09	9/30/09
Total Children Served	4379	4590	4630	4695	4654	4508	4431	4434	4474	4497	4321	4178	4128
Children in Foster Care	2255	2254	2261	2264	2237	2218	2226	2225	2220	2211	2192	2179	2143
Children in Home	1782	1999	2040	2070	2048	1932	1860	1878	1925	1995	1808	1704	1691
Siblings of Out-of-home Children	325	322	316	348	356	345	339	327	325	284	314	288	289
Children in Third Party	18	16	14	14	15	14	9	7	7	7	7	7	7

As of September 30, 2010, CFSA and private agencies served 2092 children who were placed in foster care, six children placed in third party placements and 317 children who remained at home as their siblings were served in out-of-home-care. In addition, CFSA (and the private agencies to a lesser degree) provided in-home services to 1,779 children (in 640 families) found to be victims of child maltreatment but who were able to safely remain in their homes or who were able to safely return to their homes. Overall, a total of 4,194 children were placed in out-of-home care or received in-home services from CFSA or private agencies during the month of September. Of the 2,092 children in out-of –home placement, 72% of children were in family-based placements, seven percent were in group homes, six percent in independent living program and two percent of children were placed in residential treatment centers.

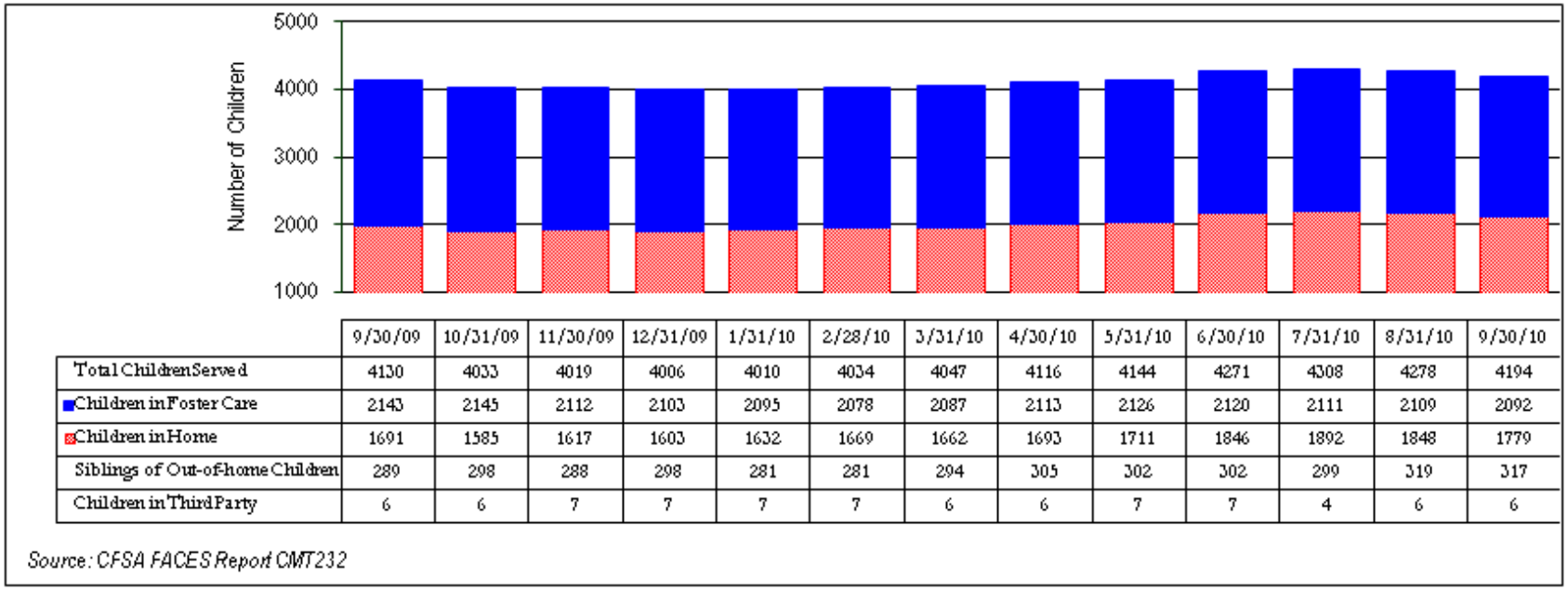
Table 7.10. Placement Setting – FY 2009

Placement Setting		2008			2009									
		31 Oct	30 Nov	31 Dec	31 Jan	28 Feb	31 Mar	30 Apr	31 May	30 Jun	31 Jul	31 Aug	30 Sep	
Family Setting	Kinship	16%	15%	15%	16%	16%	16%	16%	16%	16%	15%	15%	15%	322
	Non-Kinship or Pre-Adoptive[1]	56%	55%	55%	55%	54%	56%	57%	56%	56%	56%	57%	56%	1,208
	Sub-total	**71%**	**71%**	**70%**	**70%**	**71%**	**73%**	**73%**	**72%**	**72%**	**71%**	**72%**	**71%**	**1,530**
Group Homes		6%	6%	6%	6%	6%	7%	7%	6%	6%	7%	7%	7%	7%
ILP/Teen Program		7%	7%	7%	7%	7%	7%	7%	7%	7%	6%	7%	6%	6%
Residential Treatment		5%	5%	5%	5%	5%	5%	5%	6%	7%	5%	6%	5%	5%
Other[2]		%	5%	10%	10%	10%	5%	6%	6%	5%	5%	5%	5%	5%
Total Foster Care		**2,255**	**2,261**	**2,264**	**2,237**	**2,218**	**2,226**	**2,225**	**2,221**	**2,211**	**2,192**	**2,179**	**100%**	**2,143**

Between September 30, 2009 and September 30, 2010, the total population served increased by 2% (n=66). The number of children served in out-of-home decreased by 2% (n=51). In contrast CFSA has witnessed an increase in the children served in-home population served by 5% (n=88). The number of families served in-home increased by 2% (n=14)

As of June 30, 2010, CFSA and private agencies served 1931 children who were placed in foster care, 4 children placed in third party placements and 319 children who remained at home as their siblings were served in out-of-home-care. In addition, CFSA (and the private agencies to a lesser degree) provided in-home services to 1,684 children (in 603 families) found to be victims of child maltreatment but who were able to safely remain in their homes or who were able to safely return to their homes. Overall, a total of 3,938 children were placed in out-of-home care or received in-home services from CFSA or private agencies as of June 30, 2011. With regard to placement setting, as of June 30, 2011, 78% of children in out-of-home placements were in family-based placements, 15% were in group setting with 6% of children group homes, 6% in independent living placements and 2% in residential treatment facilities. Another 7% were in other placements, inclusive of children in abscondance, college, correctional facilities, hospitals and children with a grandparent subsidy.

Figure 7.13. Children Served – FY 2010



	9/30/09	10/31/09	11/30/09	12/31/09	1/31/10	2/28/10	3/31/10	4/30/10	5/31/10	6/30/10	7/31/10	8/31/10	9/30/10
Total Children Served	4130	4033	4019	4006	4010	4034	4047	4116	4144	4271	4308	4278	4194
Children in Foster Care	2143	2145	2112	2103	2095	2078	2087	2113	2126	2120	2111	2109	2092
Children in Home	1691	1585	1617	1603	1632	1669	1662	1693	1711	1846	1892	1848	1779
Siblings of Out-of-home Children	289	298	288	298	281	281	294	305	302	302	299	319	317
Children in Third Party	6	6	7	7	7	7	6	6	7	7	4	6	6

Source: CFSA FACES Report CMT232

Between September 30, 2010 and June 30, 2011, the total population served has decreased by 6% (n=256) and the out-of-home population has decreased by 8% (n=161). The number of in-home families served decreased by 5% (n=37) and the number of children served in-home increased by 8% (n=156). Between the end of FY09 and FY11 to date the total population served has decreased by 4% (n=190). The out-of-home population decreased by 9% (n=212). Conversely, the number of families served in-home decreased by 4% (n=23), while the number of children served in-home increased by 3% (n=56).

Table 7.11. Placement Setting – FY 2010

Placement Setting		Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	
Family Setting	Kinship	15%	15%	15%	15%	16%	16%	16%	16%	15%	15%	15%	322	15%
	Non-Kinship or Pre-Adoptive*	57%	56%	56%	58%	57%	58%	57%	58%	58%	58%	59%	1239	59%
	Sub-total	72%	72%	72%	73%	73%	73%	73%	73%	74%	74%	74%	1561	75%
Group Homes		8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	153	7%
ILP/Teen Program		7%	7%	8%	8%	7%	7%	7%	7%	7%	7%	6%	131	6%
Residential Treatment		4%	4%	4%	4%	4%	4%	4%	4%	3%	3%	3%	70	3%
Other**		9%	9%	9%	9%	8%	8%	8%	8%	8%	8%	9%	177	8%
Total in Foster Care		2145	2112	2103	2095	2078	2087	2113	2126	2120	2111	2109	2092	100%

Population, Demographics and Trends

Of the children served by CFSA, over 90% are African American. An estimated 9% are Hispanic and two percent Caucasian. There has been minor variance by race and ethnicity of clients served in recent fiscal years. With regard to the ages of children served, the District of Columbia's child welfare system is unique, in that, youth can remain until 21. Most jurisdictions emancipate youth at 18. Of the children served the CFSA has witnessed increased in care entrance in three distinct populations – children ages 0-3, children between the ages of 3-5 and children age 15 and older.

Table 7.12. Age Distribution of Children Entering Foster Care (FY2007 - FY2011 to date)

Age	FY07	FY08	FY09	FY10	FY11
<3	22%	26%	26%	22%	18%
3~5	13%	17%	18%	18%	19%
6~8	14%	15%	14%	16%	13%
9~11	12%	11%	10%	15%	15%
12~14	15%	11%	12%	14%	17%
>=15	24%	21%	19%	14%	18%
Total Entries	*592*	*755*	*643*	*780*	*142*
Monthly Average of Entries/Re-entries	*51*	*63*	*54*	*65*	*47*

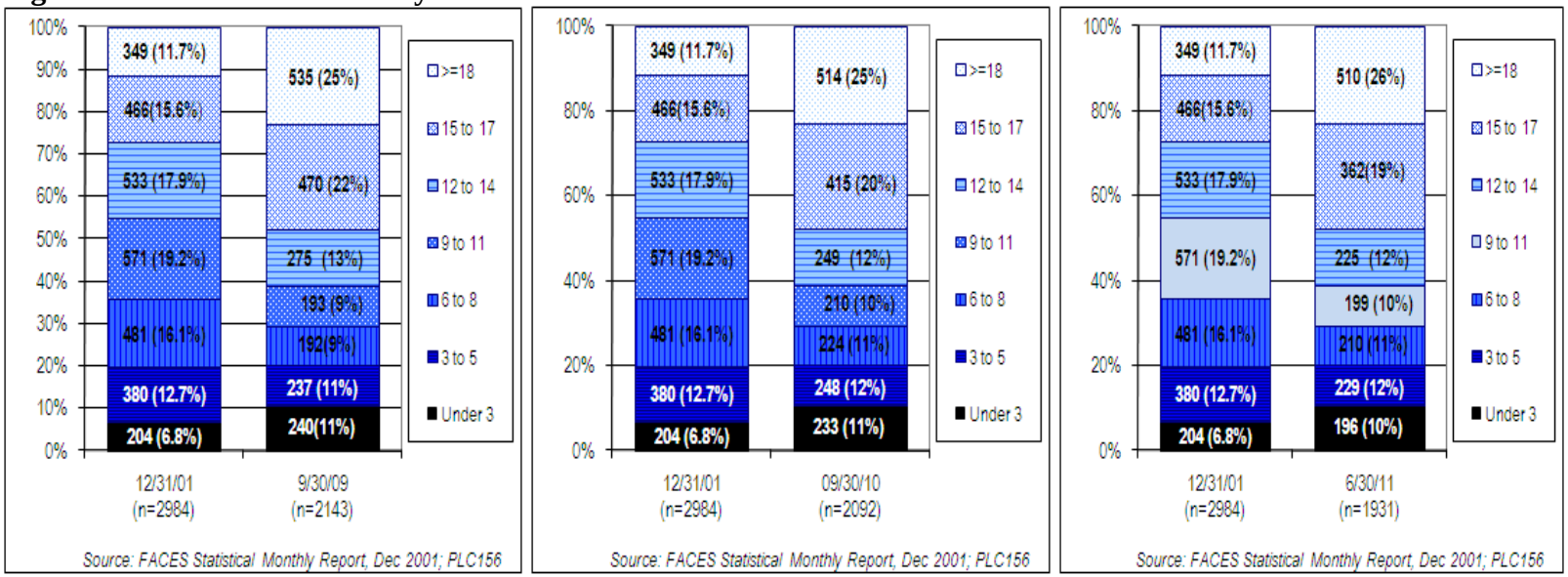
Source: Analysis of FACES Reports PLC208

Between FY09 and FY10, the number of children entering foster care increased by 21 % (n=137). By age distribution, the percentage of children entering care between the ages of 0-3, formerly the highest entering population, decreased by 4%. The largest group entering care during FY09 and FY10 was children between the ages of 3-5. The third largest group of children entering foster care between FY09 and FY10 are children ages 15 and older. In FY09 and FY10 combined, children between the ages of 0-3 comprised 3% of the population entering care. Children between the ages of 3-5 comprised 36% of children entering, and children ages 15 and older comprised 33% of children entering foster care. In FY11 the percent of children entering care between 0-3 has decreased by 4% three quarters into the FY11 fiscal period. Children between the ages of 3-5 entering care has increased by 1%. Children entering care ages 15 and older has increased by 4% three quarters into this fiscal period.

Age Distribution

As of the end of CY 2001 CFSA served 2,984 children in out-of home care. Of the children served, children ages 15 and older comprised 27% of the population. At the end of both FY09 and FY10, this population comprised 47% of the population served. Comparatively, as of June 30, 2011 children ages 15 and older comprised 45% of the children served in out-of-home care. Over two to three fiscal years, CFSA children ages 15 and older represent nearly 50% of the children served in foster care. Recent trends in children entering care reinforces this trend with the percentage of older youth entering care steadily increasing in FY09 and FY10. The second largest in-care populations are children between the ages of 12-14 and ages 3-5, both comprising 12-13% of the population served in FY09, FY10 and FY11 to date.

Figure 7.14. Children Served by Percent – 2001-2011



Health Regulation and Licensing Administration

Mission Statement

The mission of the Health Regulation and Licensing Administration (HRLA) is to administer all District and Federal laws and regulations governing the licensing, certification and registration of Health Professionals, Health Care Facilities, Food, Drug, Radiation and Community Hygiene Services. HRLA enforces all District and federal laws and regulations which govern licensure and regulations which protect the health, safety and environment District residents.

Programs:

- **Office of Compliance and Quality Assurance:** The Office has regulatory oversight to ensure that the health, safety, and welfare of our most vulnerable population within community residential facilities and nursing homes. The Office also investigates complaints against health professionals and issues summary suspension notices and subpoenas. The Office aggressively investigates and provides timely and thorough investigations of incidents (self-reported by individual facilities) and complaints (from the public or family) that are triaged through the Office.

- **Office of Health Professional Licensing Boards:** The objectives for the Office are to license and regulate health care professionals across 18 Boards and 35 licensee categories. The Office licenses approximately 6,000 new licenses and renews biennial 61,000 licensed professionals in the District. The Office also provides administrative support to the Boards for meetings, disciplinary hearings, including investigation, legal and staff support.

- **Division of Medical Boards:** The Division of Medical Boards is the entity responsible for the licensing and regulatory oversight of medicine and surgery, chiropractors, ancillary procedures, osteopathy & surgery, physicians' assistants, acupuncturists, anesthesiologist assistants, naturopathic physicians, surgical assistants, postgraduate physicians, dos and polysomnographers.

- **Division of Nursing Boards:** The Division of Nursing Boards is the entity responsible for the licensing and regulatory oversight of registered nurses, licensed practical nurses, certified nurse midwives, clinical nurse specialists, nurse practitioners, nursing staffing agencies, nurse anesthetists and trained medication employees.

- **Division of Allied Health Board:** The Division of Allied and Behavioral Boards is the entity responsible for the licensing and regulatory oversight of addiction counselors, audiologist, dance therapists, dental hygienists, dentists, dieticians, licensed professional counselors, licensed marriage counselors, family therapist, nutritionists, occupational therapists, occupational therapists assistants, optometrists, physical therapists, physical therapists assistants, podiatrists, psychologists, recreational therapists, respiratory care practitioners, speech language pathologist, social workers, nursing home administrators and psychology associates.

- **Division of Pharmacy Boards:** The Division of Pharmacy Boards is the entity responsible for the licensing and regulatory oversight of pharmacists, pharmacists with the authority to immunize, pharmacy interns, controlled substances registrations for practitioners and pharmaceutical detailer registrations.

- **The Office of Health Care Facilities:** The Division of Health Care Facilities is the entity responsible for the inspection and certification of ambulatory surgical centers, certified home health agencies, end stage rental disease facilities, hospice care, hospitals, hospital organ transplant, clinical laboratories, certificate of waivers, communicable disease labs, tissue banks, hospitals labs, nursing homes, outpatient physical therapy or speech pathology services, portable x-ray suppliers, dc detention center, dc youth services and maternity centers.

- **Division of Intermediate Care:** The Division of Intermediate Care is the entity responsible for the inspection and certification of intermediate care facilities for persons with intellectual disabilities (IFC/ID), community residence facilities for persons with intellectual disabilities (CRF/ID), assisted living residences, child placing agencies, home care agencies and community residence facilities.

Office of Food, Drug, Radiation and Community Hygiene

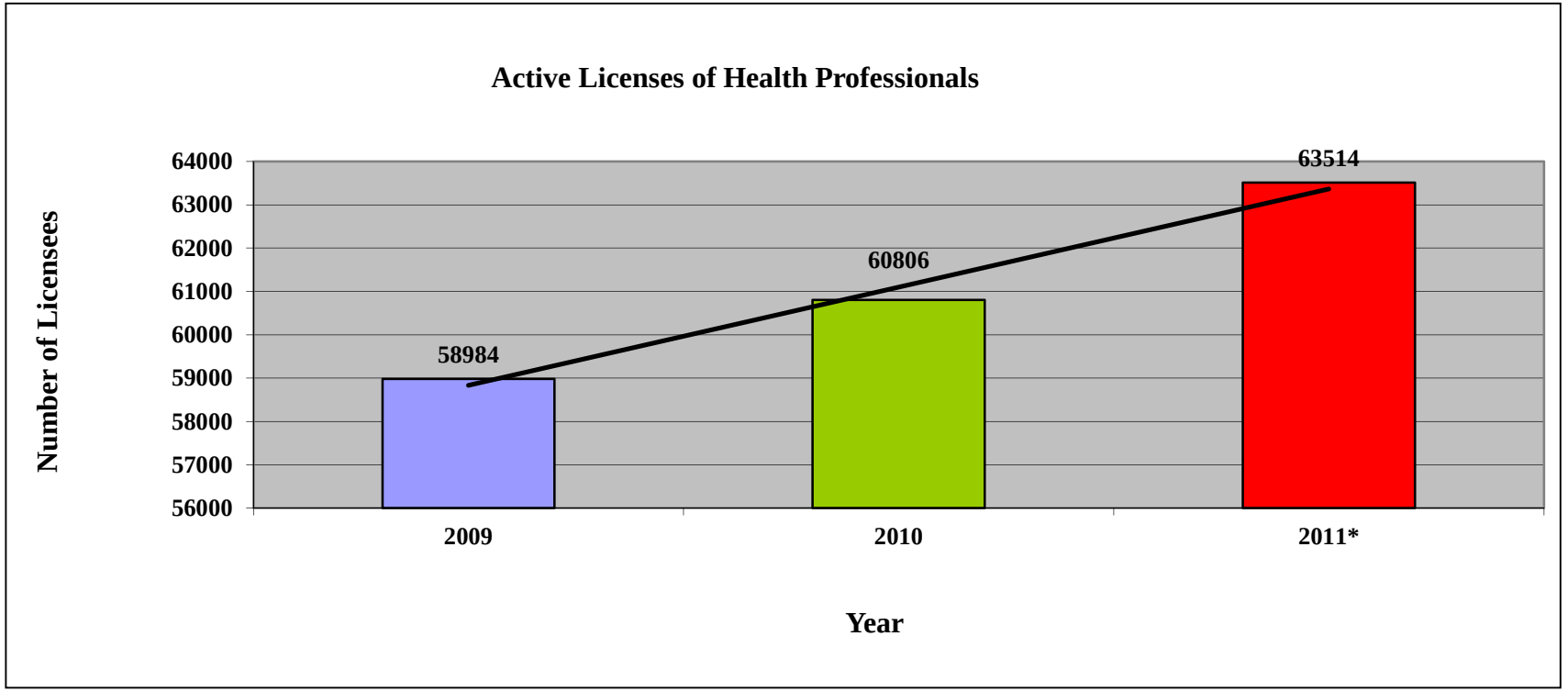
- **Division of Food:** The Division of Food Safety and Hygiene Inspection Services regulates food services that are provided in bakeries, delicatessens, food products, grocery stores, restaurants, caterers, marine, wholesalers, hotels and vendors. The Division has the authority to inspect barbershops, beauty spas, massage establishments and swimming pools.
- **Division of Drug:** The Division of Drug Control is the entity that regulates; local pharmacies, controlled substances, non-resident pharmacies, out of state controlled substances, out of state manufacturers, distributors/wholesalers substance abuse facilities, researchers, hearing aid registrations and medical marijuana.
- **Division of Radiation:** The Division of Radiation Control is the entity that regulates; dental x-ray equipment, medical x-ray equipment, health physicists, suppliers and analytical x-ray tubes.
- **The Division of Community Hygiene:** The Branch of Rodent Control is the entity responsible for providing public outreach and education, surveys and inspections, abatement, enforcement and cooperation with private organizations to protect human health and the environment.
- **The Branch of Animal Disease Control:** The Branch of Animal Disease Control is the entity responsible for the prevention and spread of communicable diseases transmitted from animals to human through timely investigations, referrals, follow-up on cases, licensing, and enforcement and provides field inspection services throughout the District. The branch is also responsible for monitoring DC Animal Shelter.

Table 7.13. Health Professional Licenses By Type

Board	License Type	FY2009	FY2010	FY2011*
Medicine	Medicine & Surgery	9072	9697	9295
	Osteopathy & Surgery	144	180	171
	Physician Assistants	461	550	538
	Anesthesiologist Assistants	19	23	24
	Acupuncturists	153	171	153
	Naturopathic Physicians	16	24	23
	Surgical Assistants	30	55	57
	Chiropractors	78	88	84
	Chiropractors – Ancillary Procedures	43	59	56
Nursing	Registered Nurse	20400	19861	21837
	LPNs	3113	3842	4163
	Certified Nurse Midwives	92	82	91
	Clinical Nurse Specialists	48	46	48
	Nurse Practitioners	936	935	1031
	Nurse Staffing Agencies	118	139	196
	Registered Nurse Anesthesiologist	156	138	153
	Trained Medication Employee	480	566	848

Table 7.13. Health Professional Licenses By Type				
Board	**License Type**	**FY2009**	**FY2010**	**FY2011***
Audiology	Audiology	14	60	74
	Speech Language Pathology	59	285	378
Dance Therapy	Dance Therapist	3	2	3
Dentistry	Dentists	1360	1342	1546
	Dental Hygienists	555	538	635
	Local Anesthesia	3	5	17
	Nitrous Oxide	0	0	1
	Local Anesthesia and Nitrous Oxide	8	28	31
Dietetics and Nutrition	Dieticians	448	408	451
	Nutritionists	70	72	72
Marriage & Family Therapy	Licensed Marriage and Family Therapist	117	136	126
Massage Therapist	Massage Therapist	702	863	686
Naturopathy	Naturopaths	788	No longer registering	No longer registering
Occupational Therapist	Occupational Therapist	477	562	611
	Occupational Therapist Assistants	16	25	44
Optometry	Optometrists	231	217	250
	DPA	144	151	170
	TPA	159	155	165
Pharmaceutical Control	Controlled Substance	5983	6713	6597
	Controlled Substance – NP	578	591	675
	Controlled Substance – PA	143	206	215
Physical Therapy	Physical Therapists	877	989	876
	Physical Therapists Assistants	23	37	33
Podiatry	Podiatrists	156	147	168
Professional Counseling	Licensed Professional Counselors	1014	836	929
	Addiction Counselors	501	505	112
Pharmacy	Pharmacists	1512	1679	1556
	Pharmacists Interns	19	22	29
	Pharma Detailers	1921	1625	1786
	Vacc and Immun Authority	32	154	182
Psychology	Psychologists	1207	1211	1307
	Supervised Practice Psychologist	1	1	1
Recreation Therapy	Recreational Therapists	63	46	50
Veterinary	Vet Examiners	198	200	223
Social Work	Graduate Social Workers	1124	1309	1428
	Ind. Clinical Soc. Workers	2697	2919	3006
	Independent Soc. Workers	88	88	88
	Social Work Associates	130	152	153
Nursing Home Administration	Nursing Home Administration	69	71	72
***Year to Date 8-4-11**				
Source: DC Department of Health, Health Regulation and Licensing Administration				

Figure 7.15.



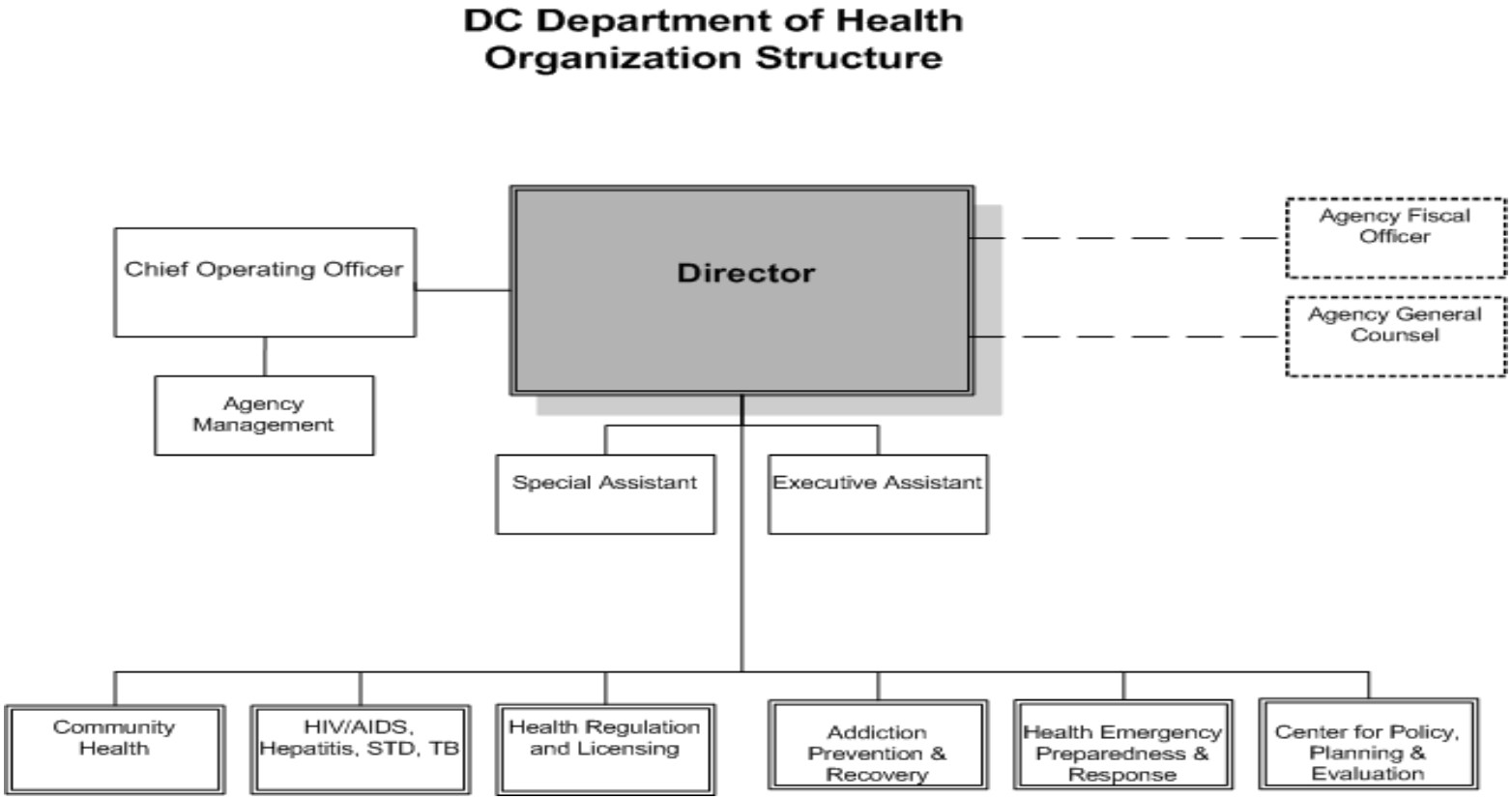
Source: DC Department of Health, Health Regulation and Licensing Administration

Department of Health

About the DC Department of Health

The Mission of the Department of Health is to promote and protect the health, safety and quality of life of residents, visitors and those doing business in the District of Columbia. Our responsibilities include identifying health risks; educating the public; preventing and controlling diseases, injuries and exposure to environmental hazards; promoting effective community collaborations; and optimizing equitable access to community resources.

The Department of Health is organized into six administrations and offices indicated in the organization structure below.



Administrations

- 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 include assessment and referrals for appropriate levels of care and maintenance of a comprehensive continuum of substance abuse treatment services including outpatient, intensive outpatient, residential, detoxification and stabilization, and medication assisted therapy. Recovery support services include wrap-around services such as mentoring services, education skills building and job readiness training, to ensure a full continuum of care. APRA ensures the quality of these services through its regulation and certification authority as the Single State Authority for substance abuse treatment services.
- The **Center for Policy, Planning, and Evaluation (CPPE) Administration's** mission is to assess health issues, risks and outcomes through data collection, surveillance, analysis, research and evaluation; perform state health planning functions; and to assist programs in the design of strategies, interventions and policies to prevent or reduce disease, injury and disability in the District of Columbia. Services include birth and death certificates; Certificate of Need; Behavioral Risk Factor Surveillance (BRFSS) data; Occupational injuries, illnesses, and death statistics.
- The mission of the **Community Health Administration** (CHA) is to improve health outcomes for targeted populations by promoting coordination within the health care system, by enhancing access to prevention, medical care and support services, and by fostering public participation in the design and implementation of programs for District of Columbia women, infants, children (including children with special health care needs) and other family members. The mission is also to provide chronic and communicable disease prevention and control services, community-based forums and grants, expert medical advice, health assessment reports, and pharmaceutical procurement and distribution, disease investigations and disease control services to District residents, workers and visitors so that their health status is improved.
- The **Health Emergency Preparedness and Response Administration** (HEPRA) provides accurate and timely information about the prevention and control of biological threats to the residents of the District of Columbia. HEPRA is responsible for the preparedness of the city, which includes Bioterrorism resources, children and disease, Homeland Security Advisory Systems; resources for health care, for example, disaster preparedness providers and biological and chemical agents; and emerging infectious diseases like pandemic influenza.
- The **HIV/AIDS, Hepatitis, STD and TB Administration** (HAHSTA) is the core District government agency to prevent 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 testing and counseling, prevention education and intervention, free condoms, medical support, free medication and insurance, housing, nutrition, personal care, emergency services, and direct services at its STD and TB Clinics and more for residents of the District and the metropolitan region. HAHSTA administers the District's budget for HIV/AIDS, STD, Tuberculosis, and Hepatitis programs, provides grants to service providers, monitors programs, and tracks the incidence of HIV, AIDS, STDs, Tuberculosis and Hepatitis in the District of Columbia.

The mission of the **Health Regulation and Licensing Administration** (HRLA) is to administer all District and Federal laws and regulations governing the licensing, certification and registration of Health Professionals, Health Care Facilities, Food, Drug, Radiation and Community Hygiene Services. HRLA enforces all District and federal laws and regulations which govern licensure and regulations which protect the health, safety and environment District residents. Programs include: the Office of Compliance and Quality Assurance; Office of Health Professional Licensing Boards: Division of Medical Boards, Division of Nursing Boards, Division of Allied Health Board, Division of Pharmacy Boards; The Office of Health Care Facilities; Office of Food, Drug, Radiation and Community Hygiene: Division of Food, Division of Drug, Division of Radiation, The Division of Community Hygiene and The Branch of Animal Disease Control.

Center for Policy, Planning and Evaluation

Vital Statistics – Births

In 2009, there were 9,008 births in the District. This figure represents a 17.5 percent increase in births from 2000 and a 1.4 percent decrease compared with 2008. The general fertility rate, a measure of fertility based on the number of women of child-bearing, increased from 54.8 in 2005 to 59.7 in 2009. In 2009, births to women under 20 years of age accounted for 11.7 percent of all births, compared to 12.2 percent of all births in 2008. The proportion of births to single mothers decreased from 57.8 percent in 2008 to 56.2 percent in 2009. The percent of infants weighing less than 2,500 grams decreased from 10.5 percent in 2008 to 10.3 percent in 2009. The infant mortality rate in 2009 was 9.9 deaths per 1,000 live births. This rate represents a 9.2 percent decrease from 2008.

Table 7.14. Annual Live Births And Infant Deaths

(*Calendar Year*)	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Live Births Married Women	3,043	3,248	3,261	3,523	3,495	3,492	3,613	3,679	3,846	3,950
Live Births Single Women	4,623	4,373	4,233	4,093	4,442	4,448	4,908	5,190	5,278	5,058
Live Births Total	**7,666**	**7,621**	**7,494**	**7,7616**	**7,937**	**7,940**	**8,522**	**8,870**	**9,134**	**9,008**
Percent of Women Under 20 Years	14.2	13.3	12.8	11.4	11.2	11.0	12.0	12.1	12.2	11.7
Percent Low Birth weight Infants	11.9	12.2	11.6	11.0	11.1	11.2	11.6	11.1	10.5	10.3
Infant Deaths	91	81	86	78	94	108	96	116	100	89
Infant Death Rate Per 1,000 Live Births	11.9	10.6	11.5	10.2	11.8	13.6	11.3	13.1	10.9	9.9

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, State Center for Health Statistics.

Vital Statistics – Termination of Pregnancies

Abortions performed in the District are reported to the DOH on a voluntary basis by hospitals and free-standing clinics. The DOH does not receive reports on abortions performed in private physician's offices. Abortions performed on District residents in other states are included in the reporting on a voluntary basis. During the past five years, the number of reported abortions averaged 1,811 per year. The number and rate of reported abortions for District residents increased 28.7 percent and 27.7 percent, respectively between 2008 and 2009. Of the 1,806 abortions reported in 2009, 14.1 percent were performed on women under the age of 20. Almost 60 percent of the procedures were performed on women in their twenties, while 23.5 percent were performed on women in their thirties and 2.8 percent on women in 40 years and older. The rate of abortions in 2009 was 12.0 per 1,000 women between the ages of 15 and 44. In 1988, Congress prohibited the District government from paying for abortions with federal or local funds, except in cases to save the life of the mother.

Table 7.15. Number and Rate* of Abortions Reported Performed on District Residents

(*Calendar Year*)	2005		2006		2007		2008		2009	
	Number	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**	**Number**	**Rate**
Under 15 years**	27	1.7	9	0.6	8	0.6	7	0.5	14	1.0
15-19 years	444	21.9	204	9.9	178	8.4	208	9.8	240	11.1
20-24 years	830	30.5	504	18.0	464	16.2	414	14.2	594	21.9
25-29 years	679	22.7	498	16.6	447	14.7	385	12.2	483	15.0
30-34 years	407	16.3	269	10.9	282	11.3	221	8.9	288	10.7
35-39 years	219	9.9	158	7.1	160	7.2	118	5.4	137	5.9
40 years and older***	80	3.9	51	2.5	47	2.3	50	2.5	50	2.5
Not Reported	0	-	4	-	1	-	0	-	0	-
Total**	**2,686**	**18.5**	**1,697**	**11.6**	**1,587**	**8.3**	**1,403**	**9.4**	**1,806**	**12.0**

*These are the rates per thousand women aged 15-44 years, using the Bureau of the Census July 2005-2009 population estimates.
**For "under 15 years," rate computed by relating the number of events to women under 15 years to women aged 10-14 years.
***For "40 years and older," rate computed by relating the number of events to women aged 40 years and over to women aged 40-44 years.
****For the total, rate computed by relating the number of events to women of all ages to women aged 15-44 years.

Source: DC Department of Health, Center for Policy, Planning, and Evaluation, State Center for Health Statistics.

Vital Statistics – Deaths

In 2009, there were 4,817 District resident deaths recorded. Total District resident deaths have decreased in each of the past five years. In 2009, deaths decreased by 12 percent from 2005. When examined by race and gender, the trends show an 8.9 percent decrease among black and other non-white males in contrast to a decrease of 19.1 percent among white males. For black and other non-white females, total deaths decreased 12.1 percent compared with a decrease of 16 percent among white females.

Table: 7.16 Deaths by Race And Gender in the District of Columbia

Calendar Years	2005	2006	2007	2008	2009	2009 Percent
Black & Other Non-White races						
Male	2,159	2,061	1,979	2,037	1,967	40.8
Female	2,124	2,056	2,030	2,028	1,868	38.8
Subtotal	**4,283**	**4,117**	**4,009**	**4,065**	**3,835**	**79.6**
White						
Male	643	625	599	573	520	10.8
Female	550	547	560	486	462	9.6
Subtotal	**1,193**	**1,172**	**1,159**	**1,059**	**982**	**20.4**
Total	**5,476**	**5,289**	**5,168**	**5,124**	**4,817**	**100.0**

Sources: DC Department of Health, Center for Policy, Planning, and Evaluation, State Center for Health Statistics.
U.S. Census Bureau Population Division, 2009 population estimate by race and gender (Table 2, SC-EST2009-02-11). Release date: June 2010.

The number of deaths among black and other non-white males in 2009 was disproportionate to their numbers in the population. This group accounted for 40.8 percent of all deaths of residents, yet accounted for only 31.7 percent of the District's population.

Vital Statistics – Leading Causes of Death

The leading cause of death in the District of Columbia and in the nation in 2009 was heart disease. The age-adjusted death rate from heart disease decreased by 17.8 percent from 2005 to 2009; however, from 2005 there has been no consistent downward trend. While the age-adjusted death rate due to heart disease has decreased in the District, the age-adjusted death rate for the country has decreased by 14.8 percent. The second highest cause of death is cancer, which has decreased 5.5 percent in the District between 2005 and 2009. As of 2009 in the District, Cerebrovascular Diseases (which leads to stroke) and Accidents were the third and fourth causes of death, while they were ranked 4th and 5th in the United States, respectively. From 2005 to 2009, the rate of deaths due to Accidents decreased by 34.1 percent in the District, which made the District's Accidents' death lower than the national levels. Deaths due to HIV/AIDS have been steadily declining from 2006; a decrease of 36.5 percent between 2005 and 2009. During this five-year period, the death rate due to homicide (assault) has significantly decreased by 37.2 in the District; however, the District's homicide (assault) death rate is still much higher than the national rate of 5.5. The District's mortality rates for six of the 10 leading causes of death were higher than the national rates: cerebrovascular diseases (which lead to stroke), accidents, chronic lower respiratory diseases, and Alzheimer's disease were the four categories where the death rates were lower in the District than in the nation.

Chronic disease, including heart disease, cerebrovascular diseases (stroke), cancer, and diabetes, account for 53.0 percent of all deaths in the District in 2009. If HIV/AIDS is included as a chronic disease, then these five causes of death account for 55.9 percent in 2009. Today, HIV/AIDS is the only remaining infectious disease accounting for significant percentage of deaths in the District.

Table 7.17. Leading Causes of Death in the District of Columbia and the United States Crude Rate Per 100,000 Population							
DC Rank[1]	**Cause of Death**	**2005**	**2006**	**2007**	**2008**	**2009**	**% Change 2005-2009**
1	Heart Disease	265.2	271.7	228.6	232.6	218.0	-17.8
2	Malignant Neoplasms (Cancer)	200.2	201.0	197.0	192.4	189.1	-5.5
3	Cerebrovascular Diseases	40.2	37.8	33.2	35.0	33.5	-16.7
4	Accidents	35.8	38.6	33.1	28.8	23.6	-34.1
5	HIV/AIDS	36.2	37.9	31.8	27.6	23.0	-36.5
6	Chronic Lower Respiratory Diseases	23.4	21.9	21.1	22.4	18.6	-20.5
7	Homicide/Assault	32.0	26.2	25.2	28.8	20.1	-37.2
8	Diabetes	33.2	31.5	25.6	27.6	21.6	-34.9
9	Alzheimer's Disease	19.8	20.3	19.1	19.1	15.9	-19.7
10	Septicemia	22.7	18.5	21.3	23.2	14.8	-34.8
US Rank[2]	**Cause of Death**	**2005**	**2006**	**2007**	**2008**	**Preliminary 2009**	**% Change 2005-2009**
1	Heart Disease	211.1	200.2	190.9	186.7	179.8	-14.8
2	Malignant Neoplasms (Cancer)	183.8	180.7	178.4	175.5	173.6	-5.5
3	Chronic Lower Respiratory Diseases	43.2	40.5	40.8	44.0	42.2	-2.3
4	Cerebrovascular Diseases	46.6	43.6	42.2	40.6	38.9	-16.5
5	Accidents	39.1	39.8	40.0	38.6	37.0	-5.4
6	Alzheimer's Disease	22.9	22.6	22.7	24.4	23.4	2.2
7	Diabetes	24.6	23.3	22.5	21.8	20.9	-15.0
8	Influenza and Pneumonia	20.3	17.8	16.2	17.0	16.2	-20.2
9	Nephritis, Nephronic Syndrome and Nephrosis	14.3	14.5	14.5	14.8	14.8	3.5
10	Intentional Self-Harm (Suicide)	10.9	10.9	11.3	11.6	11.7	7.3

[1]Rank based on number of District of Columbia resident deaths in 2009.
[2]Rank based on number of deaths in the United States in 2009.
Source: DC Department of Health, Center for Policy, Planning, and Evaluation, State Center for Health Statistics and U.S. Department of Health and Human Services, Center for Disease Control and Prevention, National Center for Health Statistics.

Immunization Services

The Immunization Program is located in the Department of Health's Community Health Administration (CHA). The Immunization Program was established to prevent and control vaccine-preventable diseases among District residents. The Immunization Program provides free immunization services to all medically uninsured and under insured residents of the District. The mission of the program is to reduce and eliminate morbidity and mortality due to vaccine-preventable diseases in the District of Columbia. The goal of the Program is to improve and maintain high immunization levels in children and adults, with particular emphasis on children less than two years of age.

Vaccines also provide great cost benefits by decreasing the economic impact associated with vaccine-preventable diseases, such as costs related to doctor's visits, hospitalizations, parent's loss of time from work and premature deaths. Since 1979, the District of Columbia has required children attending school and daycare to be fully immunized. Vaccination rates for children 19-35 months old have increased dramatically since 2002. Please see the table below:

Table 7.18. Immunization Compliance Levels in DC Using the Immunization Registry: Includes Routine, Catch-up and Exemptions

(Based on the DC School Immunization Requirements - DTaP, DT, Td, TdaP, Hib, Hep B, IPV, MMR, Me, Mu, Ru, Varicella, Pneumo Conj 7, Hep A, Meningococcal, HPV)*

	Licensed Child Development Centers	Head Start Centers	Public Schools	Non-Public Schools (Assessments start at the Beginning of the SY August through June)		
Year				**Private**	**Charter**	**Parochial**
2002	52.57%	45.11%	72.90%	56.30%	56.67%	42.33%
2003	63.11%	59.35%	84.44%	79.58%	74.68%	55.81%
2004	67.33%	66.66%	90.88%	79.50%	84.76%	59.81%
2005	69.60%	74.78%	95.05%	84.10%	90.94%	74.70%
2006	71.73%	83.03%	96.32%	83.71%	91.32%	78.68%
2007	74.27%	81.42%	97.32%	85.04%	94.47%	78.67%
2008	93.03%	97.15%	97.94%	88.62%	96.25%	78.25%
2009	91.02%	91.75%	98.21%	88.77%	95.55%	79.74%
2010	90.84% (12/2010)	90.71% (6/30/2010)	89.97%	67.43%	83.11%	50.03%
2011	92.33% (Ave of the first 2 quarters)	89.06% (6/30/2011)	92.85% (6/30/2011)	79.39% (6/30/2011)	89.36% (6/30/2011)	67.14% (6/30/2011)

*1997-2008: Preschool - 4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella
School-Age - 5 DTaP, 4 Polio, 2 MMR, 3 Hep B, 2 Varicella, 1 10-year Td

*2009-2011: Preschool - 4 DTP, 3 Polio, 1 MMR, 3 Hib, 3 Hep B, 1 Varicella, 4 Pneumococcal Conjugate, 2 Hepatitis A.
School-Age - 5 DTaP, 4 Polio, 2 MMR, 3 Hep B, 2 Varicella, 1 Tdap, 1 Meningococcal, and HPV for girls entering the 6th grade

Source: DC Department of Health, Community Health Administration, Bureau of Child, Adolescent & School Health

State Health Planning & Development Agency

Certificate of Need Process

As a means of ensuring the availability of high quality, accessible and affordable health care services, the District has a certificate of need program. Certificate of need is essentially a mechanism that requires both public and private providers of health services to receive approval for capital improvements, equipment purchases or the establishment of new health services. District law (DC Official Code 44-401) requires that health care providers obtain a certificate of need when entering into an obligation for any new health care service, capital projects with a budget of $2.5 million or more, major medical equipment costing $1.5 million or more for facilities and $250,000 or more for physician's offices.

Table 7.19. Certificate of Need Applications by Category (2001-2008)

Calendar Year	Applications	Facilities and Services	Replacement and Renovation	Major Medical Equipment	Change of Ownership
2001	12	5	3	4	
2002	11	10	0	1	
2003	20	15	2	3	
2004	20	14	3	3	
2005	18	14	3	1	
2006	25	19	3	1	2
2007	29	19	2	3	5
2008	17	10	3	2	2
2009	25	21	3	0	1
2010	24	18	3	1	2

Source: DC Department of Health, Center for Policy, Planning & Evaluation, State Health Planning & Development Agency

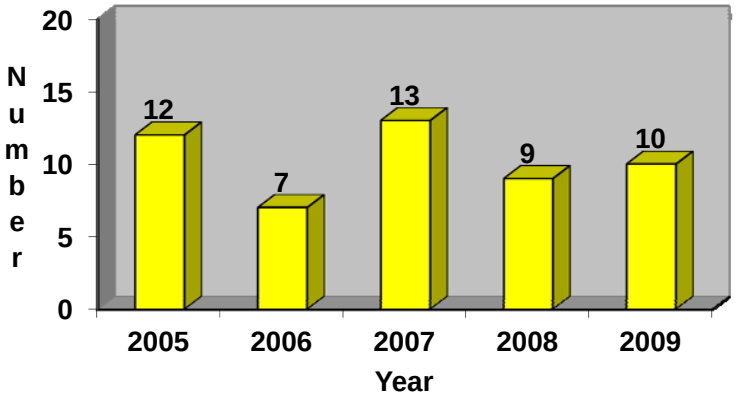
Census of Fatal Occupational Injuries - District of Columbia Workplace Fatalities, 2009

Background of the Program

The Census of Fatal Occupational Injuries (CFOI), part of the BLS Occupational Safety and Health Statistics (OSHS) program, compiles a count of all fatal work injuries occurring in the District of Columbia during the calendar year. The CFOI program uses diverse state, federal, and independent data sources to identify, verify, and describe fatal work injuries. This assures counts are as complete and accurate as possible. Beginning with 2009 data, the CFOI program began classifying industry using the 2007 version of the North American Industry Classification System (NAICS 2007). Industry data from 2003 to 2008 were classified using the NAICS 2002. NAICS 2007 includes revisions across several sectors.

Fatal work injuries totaled 10 in 2009 for the District of Columbia, according to the District of Columbia Department of Health's Census of Fatal Occupational Injuries (CFOI), in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics (BLS). The 2009 count of workplace fatalities was approximately one fourth less than the number recorded in 2007. Assaults and violent acts were the leading cause of on-the-job fatalities during 2009 in the District, with 6 deaths or 60 percent. The service providing industry accounted for 60 percent of the total workplace fatalities in the District of Columbia.

Figure 7.16. Fatal Occupational Injuries in the District of Columbia, 2005-2009



Key Characteristics of Fatal Work Injuries in 2009 in the District of Columbia:

- Men (7) accounted for most of the work-related fatalities in the District. Assaults and violent acts made up the majority of these fatalities. Three women were fatally injured on the job.
- Three of the six fatalities caused by assaults and violent acts were shootings.
- Workers 35-54 years old comprised 8 of the 10 fatalities in the District, representing 80 percent of work-related fatalities in 2009; three of the four fatal workplace injuries in the 35-44 age group occurred in assaults and violent acts.
- Seven of the workers who died on-the-job in the District worked for wages and salaries.
- Transportation incidents (which include highway, non-highway, pedestrian, air, water, and rail fatalities) and assaults and violent acts accounted for six of these deaths.
- Forty percent of the workers who died on-the-job were Black, non-Hispanic.
- Three self-employed workers died as a result of assaults and violent acts.

(Source: DC Department of Health, Center for Policy, Planning and Evaluation, Occupational Safety Health Statistics Program and the U.S.; Department of Labor, Bureau of Labor Statistics)

Survey of Occupational Injuries and Illnesses

Characteristics for Injuries and Illnesses Requiring Days Away From Work in Private Industry, Washington, DC 2009

The Washington, DC Survey of Occupational Injuries and Illnesses is conducted annually by the DC Department of Health in cooperation with the U.S. Department of Labor, Bureau of Labor Statistics. Beginning with 2009 data, the Occupational Safety Health Statistics program began classifying industry using the 2007 version of the North American Industry Classification System (NAICS 2007). Industry data from 2003 to 2008 were classified using the NAICS 2002. NAICS 2007 includes revisions across several sectors. The most significant revisions are in the information sector, particularly within telecommunications.

The District of Columbia's Survey of Occupational Injuries and Illnesses for 2009 showed that there were 3,090 work-related injury and illness cases reported in the private industry that required days away from work. Sprains and strains accounted for approximately 33 percent of these cases and was the leading type of injury or illness. Service occupations had the most injury and illness days away from work cases and made up 1,290 or 42 percent of the cases; followed by professional and related occupations with 630 or 20 percent of the cases (Figure 7.17).

Case Characteristic Highlights

- The leading nature of the work-related injury or illness cases involving days away from work was sprains and strains (1,010 cases); other significant causes were soreness and pain (710), cuts and lacerations (370 cases) and bruises and contusions (300 cases).
- The part of the body that was most frequently affected by injuries and an illness was the trunk (840), including the back and shoulder, which accounted for 27 percent of all days away from work cases. Upper extremities, including arm, wrist, hand, and finger, accounted for 23 percent of all days away from work cases, while lower extremities, including the knee, ankle, foot and toe, accounted for 21 percent.
- Floor, ground surfaces accounted for 26 percent of all sources of injury and illness cases.
- Cases involving contact with an object or equipment accounted for 930, the majority of these were cases involving being struck by an object which accounted for 640 cases. The next largest event category involved cases with falls on the same level which accounted for 610 cases, followed by cases involving overexertion that accounted for 600.

Demographic Highlights

- Fifty-one percent of the occupational injuries and illnesses that resulted in days away from work involved women (1,580 cases).
- Workers in the age range 45-54 accounted for 28 percent or 860 cases.
- Forty percent of the occupational injuries and illnesses that resulted in days away from work involved Black workers (1,230).
- Employees with a length of service with their employer from one to five years accounted for 1,300 of the injuries and illnesses.
- Of the injuries and illnesses with days away from work that reported the time of incident, the hours from 12:01 PM to 4:00 PM accounted for 810 incidents.
- Of the injuries and illnesses with days away from work that reported hours on the job before the event occurred, employees on the job from two to less than four hours made up 680 cases.
- Wednesday (630 cases) and Monday (520cases) were the days of the week when most of the injuries and illnesses involving days away from work occurred.

Figure 7.17.

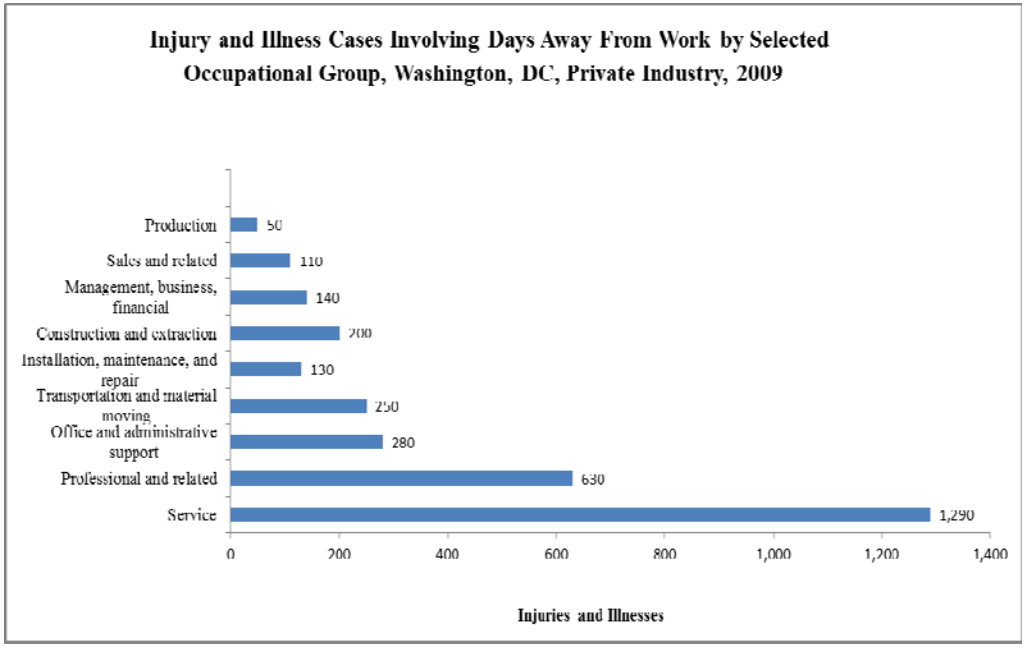
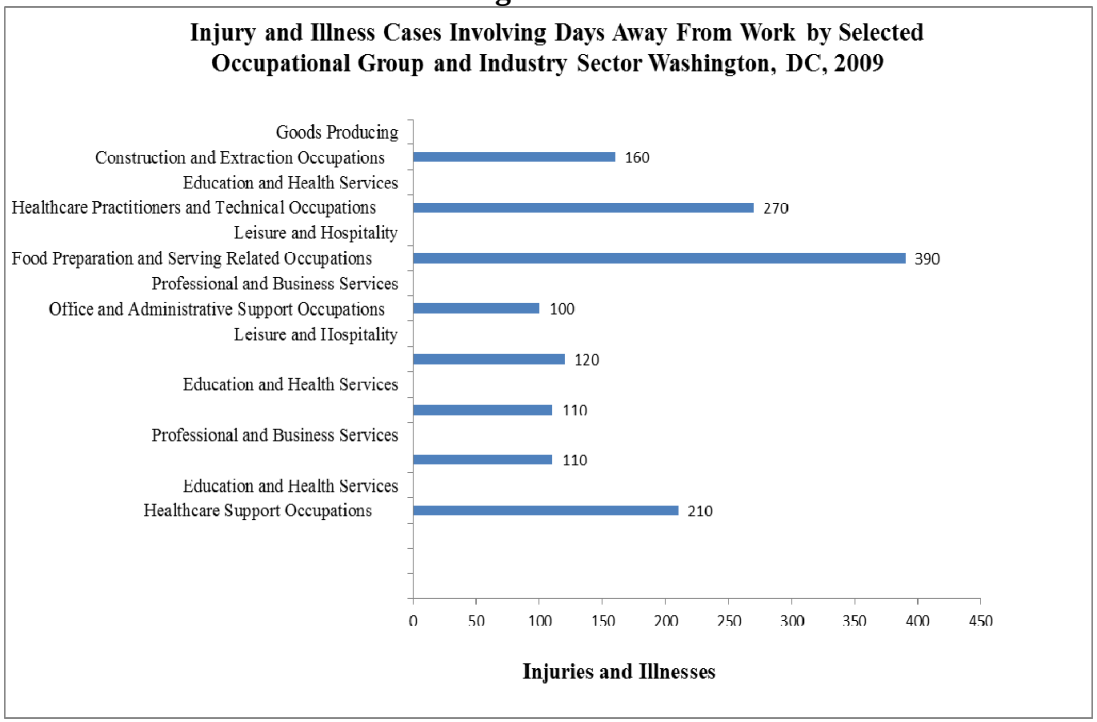


Figure 7.18.



Source: DC Department of Health, Center for Policy, Planning and Evaluation, Occupational Safety Health Statistics Program and the U.S. Department of Labor, Bureau of Labor Statistics

Children's National Medical Center School Health Nursing Program

Children's School Services, Health Suite Visits, School Year (SY) 2009 – 2010

The Children's School Health Nursing Program is responsible for the collection and submission of student health related data and statistics on a monthly and annual basis. This annual report has been compiled inclusive of information collected under the management and supervision of the Children's School Services leadership team. In FY10, Health Masters, a school-based EHR system was implemented in DC public and public charter schools that participate in the DOH School Nursing Program.

School nurses promote a healthy school environment and provide for the physical and emotional safety of the school community. School nurses are trained to assist students with asthma or other allergies. DC Public Schools collaborate with the Department of Health/Community Health Administration and Children's National Medical Center to ensure that each DCPS school has nursing coverage during the school year and during the summer if DCPS summer school is in operation at the school site.

Table 7.20. Children's School Services Utilization Data for all Nursing Suites SY 2009 – 2010 (Total – All Schools)

	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Summer 2010	YTD Total
Student Encounters DCPS	20,219	14,831	15,519	10,338	12,937	9,823	16,144	17,236	17,655	10,537	1,614	146,853
Student Encounters PCS	5,632	3,955	3,985	2,581	4,167	4,277	4,060	4,027	4,249	2,094	515	39,542
Total Student Encounters	25,851	18,786	19,504	12,919	17,104	14,100	20,204	21,263	21,904	12,631	2,129	178,558

Tables 7.21. Type of Services by School Year (SY 2009 – 2010)

Nurse Services	Sept 09	Oct 09	Nov 09	Dec 09	Jan 10	Feb 10	Mar 10	Apr 10	May 10	Jun 10	Summer 10	TOTAL
Catheterization	146	124	114	76	106	76	75	121	131	99	85	1,153
Diabetes Care	631	560	606	420	621	480	648	692	751	481	79	5,969
Gastrostomy: Tube Feeding	41	36	32	24	38	35	67	60	75	62	36	506
Medication Administration (Doses)	828	860	1,001	777	1,181	964	1,459	1,824	2,088	1,379	497	12,858
Ostomy Care	-	65	114	85	100	81	104	99	112	84	63	907
Tracheostomy: Suctioning	28	23	19	19	16	5	26	50	47	53	43	329
Total	**1,674**	**1,668**	**1,886**	**1,401**	**2,062**	**1,641**	**2,379**	**2,846**	**3,204**	**2,158**	**803**	**21,722**

Table 7.22. Number of Health Education Services Attendees by School Year (SY 2009 – 2010)																	
	ATTENDEES																
SUBJECT/Topic	**Sep-09**	**Oct-09**	**Nov-09**	**Dec-09**	**Jan-10**	**Feb-10**	**Mar-10**	**Apr-10**	**May-10**	**Jun-10**	**Sum 10**	**SY 09-10 Total**	**Sep-10**	**Oct-10**	**Nov-10**	**Dec-10**	**SY 10-11 YTD**
Abuse Prevention	15	800	354	226	643	642	640	698	2,323	633	0	**6,974**	643	15	1,125	627	**2,410**
Asthma/Respiratory	0	8	8	0	23	52	169	38	193	0	0	**491**	1	0	27	0	**28**
Career Choices	20	0	0	0	0	0	14	0	184	0	0	**218**	0	0	0	0	**0**
CPR	0	0	0	0	16	0	0	0	50	0	0	**66**	0	0	0	0	**0**
Dental Care	21	439	120	163	388	693	957	162	261	69	0	**3,273**	103	163	172	398	**836**
Disease Prevention	0	155	0	0	0	0	0	18	34	6	0	**213**	0	0	0	0	**0**
Health Maintenance	0	153	82	0	661	151	68	620	852	80	7	**2,674**	124	83	13	193	**413**
HIV / STD Education/Family Planning	0	454	191	250	645	637	987	1,000	1,769	227	28	**6,188**	463	95	423	1,152	**2,133**
Human Anatomy	0	185	32	0	2	6	13	36	179	0	0	**453**	0	82	105	55	**242**
Human Growth and Development	0	161	70	65	59	225	148	472	558	99	0	**1,857**	3	123	70	163	**359**
Hygiene	1,911	3,561	991	360	102	330	620	381	1,361	396	11	**10,024**	877	501	560	292	**2,230**
Nutrition	299	601	375	0	152	174	856	445	772	211	0	**3,885**	623	385	286	189	**1,483**
Personal Choices/Decision Making	0	0	0	0	130	16	270	23	703	177	0	**1,319**	0	0	0	0	**0**
Pre/Post Natal Care	0	41	15	15	15	4	5	20	20	5	0	**140**	15	68	44	9	**136**
Safety	20	264	85	17	947	391	474	379	1,243	1,018	21	**4,859**	168	441	118	180	**907**
Substance Abuse Prevention Education (SAPE)	0	111	90	27	657	316	1,516	874	1,791	1,083	0	**6,465**	0	42	101	26	**169**
TOTAL - All Education Session Attendees	**2,286**	**6,933**	**2,413**	**1,123**	**4,440**	**3,637**	**6,737**	**5,166**	**12,293**	**4,004**	**67**	**49,099**	**3,020**	**1,998**	**3,044**	**3,284**	**11,346**
Source: DC Department of Health, Community Health Administration																	

WIC, Special Supplemental Nutrition Program for Women, Infants and Children

The mission of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which is funded and administered by the United States Department of Agriculture, is to improve the lifelong health and nutrition of pregnant women, new mothers (breastfeeding and non-breastfeeding), infants and children up to age 5 who are at nutritional risk by providing individualized nutrition education, breastfeeding promotion and support, tailored nutrient-rich supplemental food packages that supply adequate levels of nutrients essential to prenatal and infant health, proper growth and development, and social service referrals and immunization screening for children less than two years of age. Comprehensive revisions to the WIC food packages, including adding fresh produce, were implemented by October 1, 2009.

Research shows that participation in the WIC program saves from $1.77 to $3.13 in health care costs for every infant within the first 60 days after birth and is responsible for the following improved health outcomes: improved birth outcomes, improved diet and diet-related outcomes, improved feeding practices, improved cognitive development, improved rates of childhood immunization due to having a regular source of medical care and improved preconception nutrition for women.

DC WIC serves approximately 19,180 customers monthly at 18 clinics and five mobile unit sites in 2010.

Table 7.23. Average Monthly Enrollment of Women, Infants and Children

Year	Women	Infants	Children	Total
1999	4,378	4,512	10,289	19,179
2000	4,356	4,351	9,372	18,079
2001	4,341	4,380	9,216	17,937
2002	4,284	4,270	9,373	17,927
2003	4,820	4,178	9,775	18,773
2004	5,146	4,210	9,910	19,266
2005	5,279	4,285	9,795	19,359
2006	4,789	4,789	7,998	17,576
2007	4,845	5,310	7,034	17,189
2008	5,128	5,645	7,728	18,501
2009	5,157	5,657	8,782	19,596
2010	4,868	5,505	8,852	19,225

Source: DC Department of Health, Community Health Administration

Office of the Chief Medical Examiner

The OCME serves the citizens of the District of Columbia and the Metropolitan DC area in their most difficult moments by providing timely removal of decedents from homes and public areas; thorough death investigation; prompt provision of death certificates and proofs of death to family members allowing for rapid funeral arrangements and access to insurance and other death benefits. The agency provides services to the public seven days per week during core business hours. However, deaths are reported to the agency 24 hours a day, 7 days per week, which includes weekends and holidays, and the investigations are conducted during the same time frame. Autopsies are performed every day of the year as well, and on occasion it is necessary for the Medical Examiner to perform them at night. The agency has three programs: Death Investigations and Certifications, Agency Management, and Fatality Review.

Death Investigation and Certification

Death Investigation and Certification program encompasses following areas within OCME: Forensic Pathology; Death Investigations; Toxicology, Mortuary Services and Communications. During the Calendar Year (CY) 2009, 3,000 deaths were reported and investigated by the OCME. Forty-five (**45)** of the reported cases were Storage requests only. 1,664 were declined, and 1,291 cases were accepted for further investigation. Of the accepted cases, 890 were autopsied (Full and Partials). The OCME also processed 2,426 cremation requests that were submitted for approval. Table 7.24 illustrates the number of death investigations by examination type and by "Manner of Death".

Table 7.24. 2009 Medical Examiner Cases by Manner of Death

Manner	Full Autopsy Examinations	Partial Autopsy Examination	External Examinations	Medical Record Reviews	Total	Toxicology Findings Drugs were Present
Accident	219	3	87	17	**326**	160
Homicide	139	0	0	1	**140**	79
Natural	360	75	250	7	**692**	178
Stillbirth	8	1	0	0	**9**	5
Suicide	50	0	2	0	**52**	32
Undetermined	47	1	0	1	**49**	30
Total	**823**	**80**	**339**	**27**	**1268**	**484**

Note: Data for the following cases are not included in this table: One (1) case was released to the Office of the Armed Forces Medical Examiner: 15 were **"***Non-Human Remains*"; and 7 cases were "Anatomical Specimens

Homicides

The OCME investigated 140 homicides in CY 2009. Table 7.25 and Figure 7.19 show a distribution by cause of death. Homicides were more prevalent in black males and in the age group 20 to 29 years. Most homicides were the result of gunshot wounds. The majority of incidents occurred in October.

Table 7.25. Homicides by Cause of Death

Cause	Number of Homicides	Percent of Total Homicides
Firearms	100	**72%**
Sharp Force	23	**16%**
Blunt Impact	12	**9%**
Other	3	**2%**
Asphyxia	2	**1%**
Total	**140**	**100%**

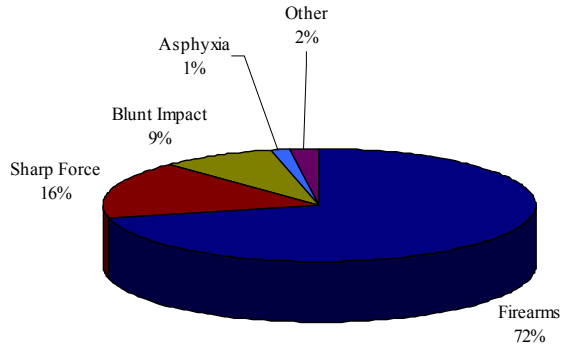


Figure 7.19. Homicides by Cause of Death

Suicides

The OCME investigated 52 suicides in CY 2009, which represents a 17% decrease from CY 2008 (n = 62). Suicides were more prevalent in white males and in persons between the ages of 50-59 years. Also, suicides decreased by 50% for those in the age group 30-39 years. As illustrated in Table 7.26, hangings were the leading cause of death. The majority of incidents occurred in September and November.

Table 7.26. Suicides by Cause of Death

Cause	Number of Suicides	% of Total Suicides
Hanging	20	38%
Blunt Impact Trauma	10	19%
Intoxication	7	13%
Firearms	5	10%
Other	5	10%
Thermal Injury	3	6%
Poisoning	1	2%
Sharp Object	1	2%
Total	**52**	**100%**

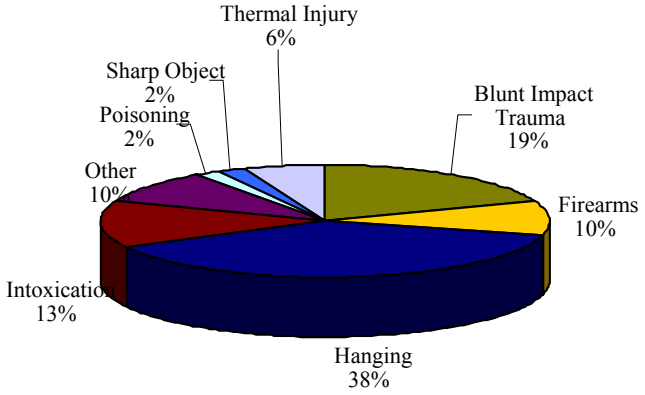


Figure 7.20. Suicides by Cause of Death

Accidents

OCME investigated 326 accident cases in CY 2009. Of the 326 cases investigated, 67 were related to motor vehicle accidents. 105 of the Accidental deaths were the direct result of illicit drug use. The majority of incidents occurred in May.

Table 7.27. Accidents by Cause of Death

Cause	Number of Deaths	Percent of Total Accidents
Intoxication	105	32%
Blunt Injury - Fall	101	31%
Blunt Injury – Traffic	67	21%
Thermal	24	2%
Asphyxia	7	2%
Drowning	7	2%
Therapeutic Complications	6	2%
Hypothermia	4	1%
Blunt Injury - Other	2	1%
Other	2	1%
Electrocution	1	0%
Total	**326**	**100%**

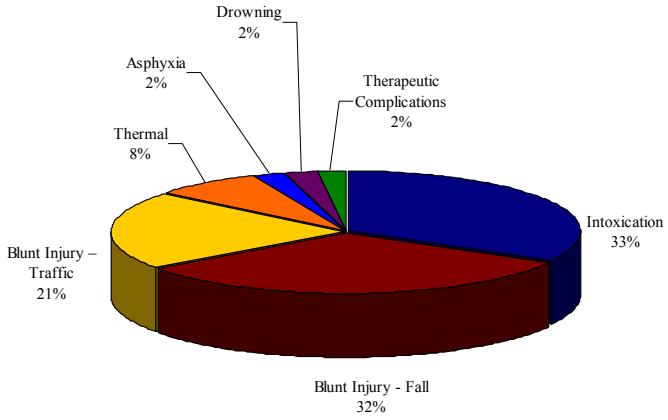


Figure 7.21. Accidents by Cause of Death

This figure does not include causes of death that are 1% or less of the total number of deaths.

Traffic-related Accidents: Of the 67 traffic-related deaths certified by the OCME in Calendar Year 2009; the majority of deaths occurred in the following categories: Pedestrian, Driver, and those within the age group of 20 to 29. The majority of traffic fatalities occurred in June.

Table 7.28. Traffic-related Accidents by Role		
Role	**Traffic Deaths**	**Percent of Traffic Deaths**
Driver *- Motor Vehicle(17)* *- Motorcycle (5)* *- Metro Train (1)*	23	34%
Pedestrian	29	43%
Passenger - *Motorvehicle (5)* - *Metro Train(8)*	13	19%
Bicyclist	1	1%
Other *- Parked Vehicle (1)*	1	1%
Total	**67**	100%

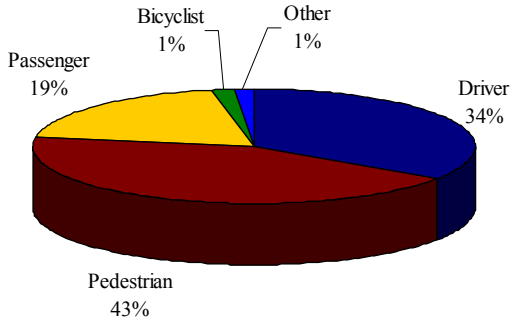


Figure 7.22. Traffic-related Accidents by the Role of the Decedent

Toxicology findings for Traffic-related accidents: Of the 67 Traffic-related deaths investigated by OCME toxicology analysis was performed in 55 cases. Drugs were absent in 27 of the traffic accident cases. Of the 28 cases that were positive for drugs, 28.5% had more than one drug present. Table 7.29 depicts the most commonly detected drugs in traffic accident cases.

Table 7.29. Most Commonly Detected Drugs in Traffic-related Accidents		
Name of Drug	**Number of Cases**	**% of Traffic Cases**
Ethanol	16	29.0%
Cocaine	5	9.0 %
PCP	4	7.2 %
Marijuana	4	7.2 %

In the 16 traffic deaths positive for ethanol, the average Blood Alcohol Concentration was 0.18% (range 0.02 – 0.41 %). The legal limit for Blood Alcohol Concentration in the District of Columbia is 0.08% while driving.

Toxicology finding for Accidental Drug Overdoses: There were 105[42] OCME cases where death was directly related to drug use, and toxicology analysis was performed in 103 of these cases. The most prevalent drug in the population was cocaine alone or in combination with other drugs. Drugs were present in all 103 overdose cases. Of the positive cases, 67.9% had more than one drug present. Table 7.30 depicts the most commonly detected drugs found.

[42] The Medical Examiner did not request Toxicology testing for two of the overdose cases because the testing was performed at the hospital.

Table 7.30. Most Commonly Detected Drugs in Overdose Cases		
Contributing Drugs	**Number of Cases**	**% of Cases**
Cocaine	55	53.3 %
Morphine	44	42.7 %
Ethanol	32	31.0 %
Methadone	12	11.6 %
Oxycodone	6	5.8 %

Naturals

In calendar year 2009, "Cardiovascular Disease" was the leading Natural cause of death in OCME cases followed by Alcoholism. Blacks represented 75% of these deaths. More Natural deaths occurred in September than in any other month.

Figure 7. 23. Natural Deaths by Cause of Death

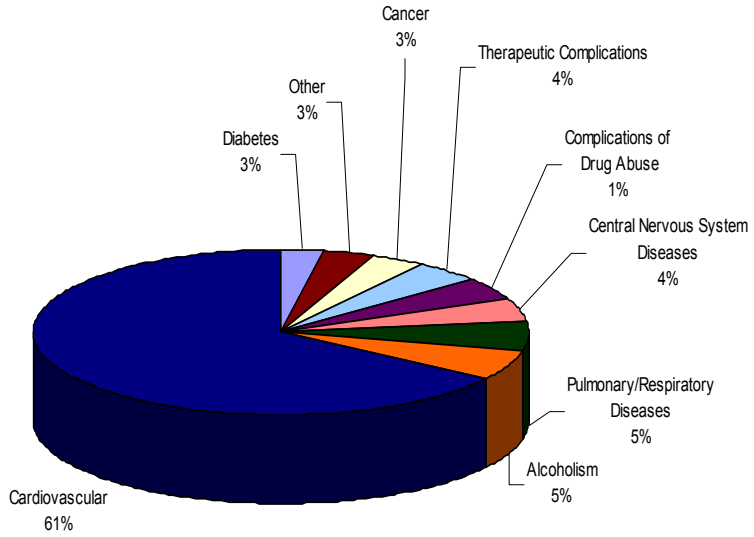


Table 7.31. Natural Deaths by Cause of Death		
Cause	**Number of Deaths**	**% of Total Natural Deaths**
Cardiovascular Disease	423	61%
Alcoholism	38	5%
Pulmonary/Respiratory Diseases	36	5%
Central Nervous System Diseases	31	4%
Infectious Disease	28	4%
Therapeutic Complications	27	4%
Cancer	24	3%
Other	21	3%
Diabetes	18	3%
Gastrointestinal Disease	11	2%
Obesity or Complications of Obesity	11	2%
Complications of Drug Abuse	9	1%
Blood Disease/Hemopoietic System	5	1%
Immune System Disease	5	1%
Genetic Disorder	4	1%
Connective Tissue Disease	1	0%
Total	**692**	**100%**

Undetermined

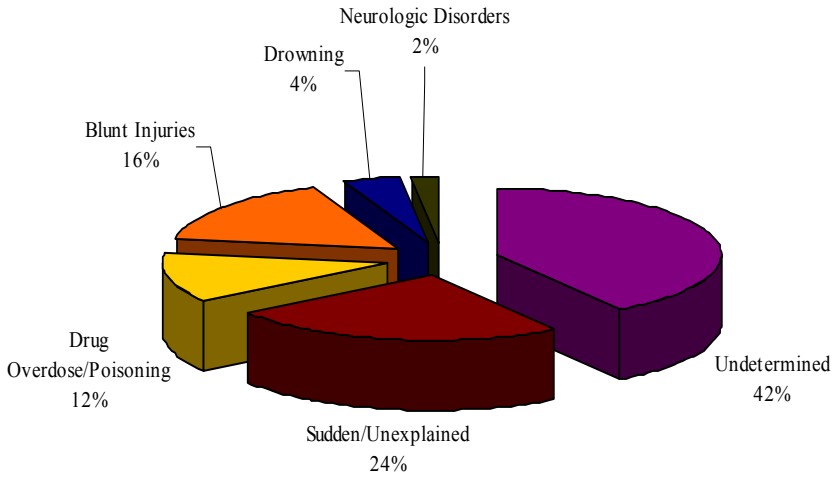
The OCME investigated 49 cases in which the manner of death was "Undetermined," and of these 20 cases also had an "Undetermined" cause of death.

These deaths are also comprised of skeletonized and severely decomposed remains.

Table 7.32. Undetermined

Cause of Death	Number of Deaths	% of Total Accepted Cases
Undetermined	20	42%
Sudden and Unexplained	12	24%
Drug Overdose/Poisoning	6	12%
Blunt Injuries	8	16%
Drowning	2	4%
Neurologic Disorders	1	2%
Total	**49**	**100%**

Figure 7.24. Undetermined Deaths by Cause of Death



Agency Management

The Agency Management program is responsible for all administrative programs within the agency and for providing required reports to the mayor, the City Council and the general public including the press.

Fatality Review Unit Programs

The Fatality Review Unit was established in October of 2005 to consolidate the administrative functions of the Fatality Review Committee. The purpose of the fatality review process is to conduct retrospective reviews of deaths of specific populations as identified by DC law and/ or Mayor's Order to reduce the number of preventable deaths and/or to improve the quality of life for DC residents. Each death review process is intended to assist in identifying systemic and community strengths, as well as improvements needed in service delivery systems in order to better address the needs of the residents of the District of Columbia. It is an opportunity for self-evaluation through a multi-agency and multi-disciplinary approach. This process provides a wealth of information regarding ways to enhance services and systems.

Currently there are three fatality review processes that operate within the FRU: the Child Fatality Review Committee (CFRC); Mental Retardation and Developmental Disabilities Fatality Review Committee (MRDD FRC); and the Domestic Violence Fatality Review Board (DVFRB).

Department of Mental Health

The mission of the Department of Mental Health (DMH) is to support prevention, resiliency and recovery for District residents in need of public mental health services. To fulfill its mission, DMH offers a range of community based services, including crisis emergency services programs and operates Saint Elizabeth's Hospital, the District's inpatient psychiatric facility

Consumers in Department of Mental Health Programs

In FY 2010, more than 20,000 individuals received services from the DMH either through its government operated mental health clinics or through community based mental health providers. The majority of people who received services are eligible for Supplemental Security Income, Medicaid or are uninsured. Table 7.33 describes individuals based on age, race and gender.

Table 7.33. Number of Individuals Receiving Services in FY 2010

Age	Sex	Race					Total
		Black/African American	White	Hispanic	More than one race identified	Other	
Under17	Female	1478	5	50	0	20	1553
	Male	2121	10	103	0	29	2263
	Unknown	0	0	1	0	0	1
	Total	**3599**	**15**	**154**	**0**	**49**	**3817**
18-64	Female	6791	373	293	5	341	7803
	Male	6472	447	261	3	566	7749
	Unknown	51	20	9	0	23	103
	Total	**13,314**	**840**	**563**	**8**	**930**	**15,655**
65+	Female	296	52	12	0	62	422
	Male	222	45	11	0	69	347
	Unknown	4	2	0	0	1	7
	Total	**522**	**99**	**23**	**0**	**132**	**776**
Total		17,435	954	740	8	1111	20,248

Source: Department of Mental Health Uniform Reporting System Data submitted to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration

Mental Health Services and Support

DMH offers several specialty services, including assertive community treatment for adults and multi-systemic therapy for children and youth. In FY 2010, 1020 adults received assertive community treatment services and 118 children/youth received multi-systemic therapy.

ACCESS Helpline

DMH operates a 24/7 Access Helpline (1-888-793-4357) for emergency psychiatric care and to enroll for ongoing mental health services. In 2009, the Access HelpLine (AHL) became a provisionally certified Suicide Lifeline Network provider for the District. Full certification was granted by the American Association of Suicidology in April 2011. AHL provides Suicide Lifeline Network callers with 24-hour suicide prevention via telephone access. The activities include: 1) responding to callers who access the Suicide Lifeline Network; 2) providing suicide intervention; and 3) dispatching mobile crisis services when necessary.

In FY 2010, the Access Helpline received over 50,000 incoming calls. For the period from March 2010 through September 2010, during the provisional certification period, there were 122 Suicide Lifeline calls.

Crisis Emergency Services

DMH is responsible for providing emergency assistance to adults and children experiencing a psychiatric or emotional crisis. The Comprehensive Emergency Psychiatric Program is a twenty-four hour/seven day a week operation that provides immediate psychiatric evaluation, treatment and stabilization, and eight extended observation beds if necessary for adults. There were 3,941 total admissions to the Comprehensive Psychiatric Emergency Program in FY 2010, as shown in Table 7.34. There were 2,657 unduplicated consumers, approximately 25% of whom were admitted more than once.

Table 7.34. Number of Adults who received Emergency Psychiatric Service

FY10	October	November	December	January	February	March	April	May	June	July	August	September	Total
	341	337	332	333	288	326	276	330	321	357	380	322	3,941

Source: Department of Mental Health

Approximately half (54.9% or 2162) of admitted consumers were males, and the largest ethnic group (85.6% or 3372) was Black/African American (which includes individuals of African descent). Consumers tended to be in their early 40's with the average age of female consumers being 42 years and the median 43 years, for males the average age was 41 years and the median 42 years. However, transgendered individuals tended to be younger with an average of 34 years and median 30 years. The demographic profile of the adults who received emergency psychiatric services is shown in Table 7.35.

Table 7.35. Demographic Profile of Adults who received Emergency Psychiatric Service							
	Race/Ethnicity						
Gender	American Indian	Asian/ Pacific Islander	Black/ African American	Caucasian/ White	Hispanic	Other	Totals
Female	0	21	1545	142	53	10	1771 (44.9%)
Male	0	21	1824	211	80	26	2162 (54.9%)
Transgender	0	0	3	4	1	0	8 (0.2%)
TOTALS	**0**	**42 (1.1%)**	**3372 (85.6%)**	**357 (9.1%)**	**134 (3.4%)**	**36 (0.9%)**	**3941 (100%)**
Source: Department of Mental Health							

As part of the Comprehensive Emergency Psychiatric Program, mobile crisis teams provide crisis intervention services for adults who are unable or unwilling to come to the facility. In addition to onsite crisis stabilization including dispensing medication, the mobile crisis services teams perform assessment for voluntary and involuntary hospitalizations and linkages to other services, including ongoing mental health care and substance abuse detoxification and treatment. Mobile crisis services teams also provide support in the aftermath of individual or mass tragedies to groups or families affected by the incident. The mobile crisis services team also provides follow-up care for consumers admitted to the Comprehensive Psychiatric Emergency Program who are in need of further assistance (e.g., transportation to their residence or to a CSA intake appointment) after discharge.

- **Individuals Served:** 1,693 unduplicated consumers in FY10, a 15% increase from FY09.
- **Groups Served:** 37 unduplicated groups/families in FY10, a 76% increase from FY09.

The mobile crisis services team makes contact with both consumers and collateral sources (e.g., case workers, family members) in an effort to coordinate care. In FY 2010, the mobile crisis team made a total of 4868 service responses, of these 2123 (43.6%) were in person with consumers and 646 (13.3%) were telephone contacts with consumers as shown in Table 7.36.

Table 7.36. Mobile Crisis Service Contacts by Type			
		Number/Percent	
Consumer Type	Engagement Type	FY09	FY10
Individual Consumers	By Phone-Consumer	653 (21.9%)	646 (13.3%)
	In Person-Consumer	2,029 (68.2%)	2,123 (43.6%)
	In Person-Other	294 (9.9%)	329 (6.8%)
	By Phone-Other	NA	1,688 (34.7%)
Group/Family Responses	In Person	NA	37 (0.8%)
	By Phone	NA	45 (0.9%)
	TOTALS	**2,976 (100%)**	**4,868 (100%)**
Source: Department of Mental Health			

DMH also supports a mobile crisis service, known as CHAMPS, to provide rapid, on the scene response to children facing an emotional or mental health crisis. The mobile crisis service team will stabilize the child, help families manage the crisis, and in the case of foster parents, seek to avoid placement disruption. In FY 2010, CHAMPS received 1015 total calls and deployed 558 times. Data for FY 2010 in the aggregate and quarterly are shown in Table 7.37.

Table 7.37. CHAMPS Total calls and Deployments

	1st Quarter		2nd Quarter		3rd Quarter		4th Quarter		FY 2010 Total	
Calls	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Deployable			154	57%	151	48%	122	63%	**427**	
Non-deployable			114	43%	161	51%	71	37%	**346**	
Total Calls	**241**		**268**	**100%**	**313**	**100%**	**193**	**100%**	**1015**	
Total Deployments (Percentage represents the number of deployments on deployable calls only)	**168**		**141**	**92%**	**135**	**89%**	**114**	**93%**	**558**	**55%**
Total Unduplicated Children Served	**121**	**50%**	**108**	**40%**	**102**	**33%**	**83**	**43%**	**414**	

Source: Department of Mental Health

DMH in partnership with the DC Superior Court supports an urgent care clinic at Moultrie Courthouse to provide easy access to persons who come in contact with the courts who may need mental health services. During the second year of operation (June 2009 – May 2010), the urgent care clinic saw a total of 364 referrals and provided a total of 2,603 service units – including case management, medication management, and follow-up clinical appointments. The Pre-trial Services Agency is the largest source of referrals.

Housing and Homeless Services

To help increase the supply of quality affordable housing available to people with mental illness, DMH operates a rental housing subsidy program. In addition, to support community integration and recovery, DMH supports community residential facilities and supportive independent living. In partnership with the Department of Housing and Community Development (DHCD) that began in 2008, DMH is funding the creation and renovation of 300 units of housing that are set aside for mental health consumers. As of January 31, 2011, ninety (90) units were complete and sixty-eight (68) people had moved in. Table 7.38 shows the number of people who participated in the housing programs in FY 10. Supportive Housing Programs include services and supports to help individuals obtain and maintain appropriate housing. Since some people may leave or change housing during the year, the number served in some cases exceeds the capacity.

Table 7.38. Housing Programs

Program	FY10 Capacity	Consumers Served in FY10
Home First	750	766
Supported Independent Living (SIL)	461	476
Local Rent Subsidy (LRSP)	67	43
Federal Vouchers (set asides)	384	368
Contract Community Residential Facilities (CRFs)	225	256
Independent Community Residential Facilities (ICRFs)	442	472
Total	**2,329**	**2,379**

Source: Department of Mental Health

Homeless Services

The Homeless Outreach Program provides a wide variety of services to consumers with mental illness, providers and community members. The primary services provided include outreach and crisis services to individuals through regular visits to shelters, streets and homes in the District, coordination with other outreach programs, social workers and community members to provide assessments, referrals, travelers assistance, brief intervention services, and referrals to overnight shelter services.

In FY 2010, the Homeless Outreach Program served 1498 unduplicated consumers. Of these, 1337 (89.2%) were known homeless individuals; and the majority (1292 or 86.2%) were single-adults as shown in Table 7.39.

Table 7.39.
Unduplicated Consumers Served by Housing Status

Homeless Status	Consumer Type	Number/Percent
Homeless	Single-Adult	1176 (78.5%)
	Family-Adult	107 (7.1%)
	Family-Child	54 (3.6%)
Not Homeless	Single-Adult	106 (7.1%)
	Family-Adult	43 (2.9%)
	Family-Child	2 (0.1%)
Unknown	Single-Adult	10 (0.7%)
TOTALS		**1498 (100%)**
Source: Department of Mental Health		

Frequency counts of unduplicated consumers show that most consumers only had one face-to-face encounter with the Homeless Outreach Program. For example, 27.6% (414) of all consumers needed two or more contacts with the Homeless Outreach Program unit; and 16.2% (242) of consumers needed more than two face-to-face encounters. 129 consumers required 5 or more face-to-face contacts (max=26), and 38 required 10 or more encounters. This reflects the nature of homeless outreach and the level of disengagement of the population served.

On average, the Homeless Outreach Program responded and made contact (by phone or face-to-face) with 241 consumers per month, with a high of 304 (or 10.5% of contacts) in October and a low of 165 (or 5.7% of contacts) in July.

School Mental Health Program

The School Mental Health Program in the Department of Mental Health promotes social and emotional development and addresses psycho-social and mental health problems that become barriers to learning by providing prevention, early intervention, and treatment services to youth, families, teachers and school staff. Services are individualized to the needs of the school and may include screening, behavioral and emotional assessments, school-wide or classroom based interventions, psycho-educational groups, consultation with parents and teachers, crisis intervention, as well as individual, family and group treatment. During the 2010 – 2011 school year, the School Mental Health Program provided services to 59 DC Public Schools including 9 DC Public Charter Schools. Table 7.40 shows the number of participants receiving various services during the 2009 – 2010 school year. Table 7.41 shows the number of participants in prevention and early intervention activities during the 2009-2010 school year.

Table 7.40. Treatment Services Provided by School Mental Health Program Clinicians During the 2009 – 2010 School Year	
Referrals	1,715
Referrals Seen	1,255
Students on Clinical Caseload	737
Individual Therapy Sessions	9,405
Family Therapy Sessions	539
Group Therapy Sessions	409
Source: Department of Mental Health, School Mental Health Program	

Table 7.41. Prevention and Early Intervention Services Provided by School Mental Health Program Clinicians During the 2009 – 2010 School Year	
Prevention Sessions	1,868
Walk-ins	4,474
Conflict Resolution Sessions	1,906
Classroom Observations	2,233
Parent Consultations	2,385
Teacher Consultations	5,077
Other Staff Consultations	4,640
Referrals Made for Outside MH Services	152
Presentations, Workshops, and Conferences	206
Source: Department of Mental Health, School Mental Health Program	

Saint Elizabeth's Hospital

Saint Elizabeth's Hospital provides inpatient care for adults with serious and persistent mental illnesses, including those who have been committed by the criminal courts. Founded in 1855 at the urging of Dorothea Dix, Saint Elizabeth's was the first large-scale, federally run mental health and psychiatric care facility in the United States. It was transferred to the District of Columbia in 1987. Working with community based mental health providers, Saint Elizabeth's focuses on maximizing the potential for recovery so that people with mental illness will be able to integrate into the larger community with the level of support needed and wanted. A new state of the art facility opened in May 2010. The 448,000 square foot facility integrates a number of strategies to lessen the building's environmental impact, including the use of natural light, bio-retention areas, and a 28,000 square foot green roof that is likely the largest on any mental health facility in the country.

In FY 2010, the average daily census was 316.9. The total number of admissions during FY10 was 442: 237 in a civil legal status (Civil) and 205 in a forensic legal status (Forensic). The average number of monthly admissions was about 37 (20 in Civil and 17 in Forensic). This is a 21% reduction from FY09. Table 7.42 shows the total admissions per month.

Table 7.42. FY 2010 Monthly Admissions

	October	November	December	January	February	March	April	May	June	July	August	September	Total
Civil	17	20	34	20	16	17	20	13	14	25	21	20	237
Forensic	19	14	13	13	18	17	21	21	18	22	11	11	205
Total	**36**	**34**	**47**	**33**	**34**	**34**	**41**	**34**	**32**	**47**	**39**	**31**	**442**

Source: Department of Mental Health, Saint Elizabeth's Hospital FY 2010 Trend Analysis

A majority of admissions were either transfers from another psychiatric unit of a community hospital or pre-trial defendants admitted by court order. As of September 30, 2010, a total of 102 or 33% of the total individuals in care were those adjudicated to be not guilty by reason of insanity (NGBRI) and 52 or 17% were those court-ordered for inpatient pre-trial examination. Table 7.43 shows the source of admissions.

Table 7.43. FY 2010 Admissions by Source

Source	Number	Percent
Comprehensive Psychiatric Emergency Program	67	15%
Community Hospital – Medical Unit	19	4%
Community Hospital – Psychiatric unit	151	34%
Court/Law Enforcement	189	43%
Transfer from Forensic Outpatient to Inpatient	10	2%
Other	6	1%
Total	**442**	**100%**

Source: Department of Mental Health, Saint Elizabeth's Hospital FY 2010 Trend Analysis

Department of Health Care Finance

About DHCF

The Department of Health Care Finance (DHCF), formerly the Medical Assistance Administration under the Department of Health, is the District of Columbia's state Medicaid agency. The mission of DHCF is to improve health outcomes by providing access to comprehensive, cost-effective and quality healthcare services for residents of the District of Columbia. DHCF provides health care services to low-income children, adults, the elderly and persons with disabilities. In addition to the Medicaid program, DHCF also administers insurance programs for immigrant children, the State Child Health Insurance Program, which is an expansion of the Medicaid program and the Alliance Program, which is a publicly funded insurance program for eligible uninsured. Over 200,000 District of Columbia residents (nearly one third of all residents) receive health care services through DHCF's Medicaid and Alliance programs. Only 6.2% of District residents report being uninsured, which is among the lowest rates nationally. [43]

In addition to administering Medicaid, DHCF has responsibility for key Health Information Technology and Health Insurance Exchange activities within the District of Columbia. DHCF received a Statewide Health Insurance Exchange Planning Cooperative Agreement on behalf of the District of Columbia to develop a health insurance exchange for District residents, in association with partners in the public and private sectors. DHCF received funding from the Office of National Coordinator for Health Information Technology to support the development of a health information exchange. As the single state agency responsible for the administration of the Medicaid program for the District, DHCF received funding from the Centers for Medicare and Medicaid Services to develop a Statewide Medicaid Health Information Technology Plan to administer the federally-sponsored incentive program to foster the adoption of electronic health records (EHR) by eligible providers and hospitals. DHCF was awarded a Medicaid Transformation Grant to develop a Medicaid Patient Data Hub to support electronic health record technology and health information exchange for Medicaid enrollees. These programs were funded with the goals of reducing health care costs, improving health outcomes and improving the quality of health care.

Table 7.44. Medicaid and Alliance Enrollment

SERVICES	FY09 ACTUAL	FY10 ACTUAL	FY11[44]
Total Fee-For-Service	56,803	67,458	63,089
Total Medicaid Managed Care	104,212	134,886	146,033
Alliance Managed Care	56,517	25,642	24,067
TOTAL ENROLLMENT	**217,532**	**227,986**	**233,189**
Source: Department of Health Care Finance			

Table 7.45. Uninsured District Residents

MEASURE	FY09 ACTUAL	FY10 TARGET	FY10 ACTUAL	FY11 PROJECTION
% Uninsured DC residents	6.2%	6.2%	6.2%	6.2%
Source: Department of Health Care Finance FY 2011 Performance Plan				

[43] Health Insurance Coverage in the District of Columbia: Estimates from the 2009 DC Health Insurance Survey
[44] FY11 – October 2010 thru March 2011

MEDICAID

DC Medicaid is a healthcare program that pays for medical services for qualified people. It helps pay for medical services for low-income and disabled people. Anyone who meets the Medicaid eligibility requirements can receive Medicaid. For those eligible for full services, Medicaid pays healthcare providers (doctors, hospitals and pharmacies) who are enrolled with DC Medicaid.

Medicaid offers federally mandated services. Its benefit package includes doctor visits, hospitalization, eye care, ambulatory surgical center, medically necessary transportation, dental services and related treatment, dialysis services, durable medical equipment, emergency ambulance services, hospice services, laboratory services, radiology, medical supplies, mental health services, nurse practitioner services, home and community based services, transplants.

Under Medicaid, DC Healthy Families provides free health insurance for District residents and their children. DC Healthy Families provides free coverage for working families who live in the District of Columbia, do not have health insurance, income up to 200 percent of the Federal Poverty Level (FPL), and income up to 300 percent covering children only under the Children's Health Insurance Program expansion of Medicaid eligibility. Passage of Federal Health Care Reform Legislation allowed DC to implement two Medicaid Expansions. Effective July 1, 2010, eligibility was extended to childless adult citizens and legal residents up to 133% of the federal poverty level. Effective December 1, 2010, eligibility was extended to cover childless adult citizens and legal residents from 134% to 200% of the federal poverty level. Health insurance is offered through one of our two excellent health plans: DC Chartered Health Plan and Unison Health Plan.

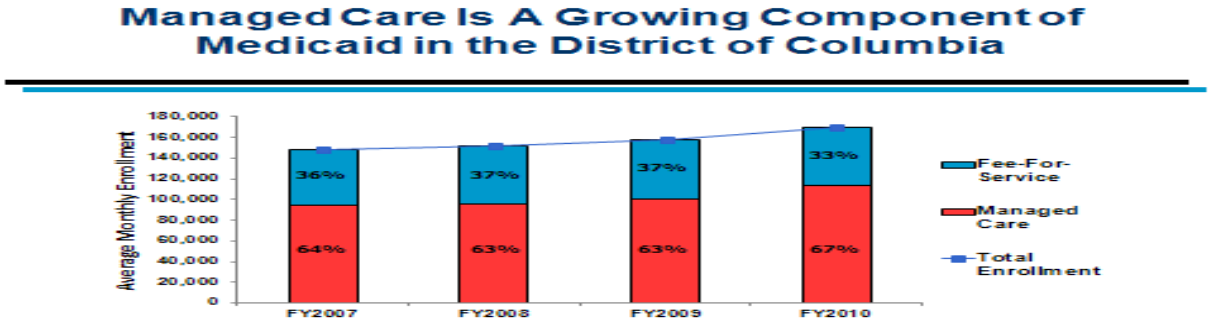
Prior to FY2009, Managed Care included the enrollment of children and families, children only, Immigrant Kids program, Health Services for Children with Special Needs, and the 50/64 waiver. In FY2009, the 0-133% FPL (federal poverty level) Expansion SPA was included, increasing enrollment by 4% in FY1010. At the same time, Fee-For-Service decreased by 4% as a result of individuals being moved from Alliance into the Medicaid program.

Table 7.46. Medicaid Income Requirements

HOUSEHOLD SIZE	300% FPL (Children Only)	200% FPL (Families)
1	31,200.00	20,420.00
2	42,000.00	27,380.00
3	52,800.00	34,340.00
4	63,600.00	41,300.00
5	74,400.00	48,260.00
6	85,200.00	55,220.00
7	96,000.00	62,180.00
8	106,800.00	69,140.00
Each additional person, add:	10,800.00	6,960.00

Source: Department of Health Care Finance

Figure 7.25.



Source: Department of Health Care Finance FY12 Budget Review

Major beneficiaries of the Medicaid program include children and adults, with the blind and disabled, and aged comprising of only 29% of total enrollment. While they make up a small percentage of total enrollment, they consume the greatest spending in Medicaid.

Figure 7.26.

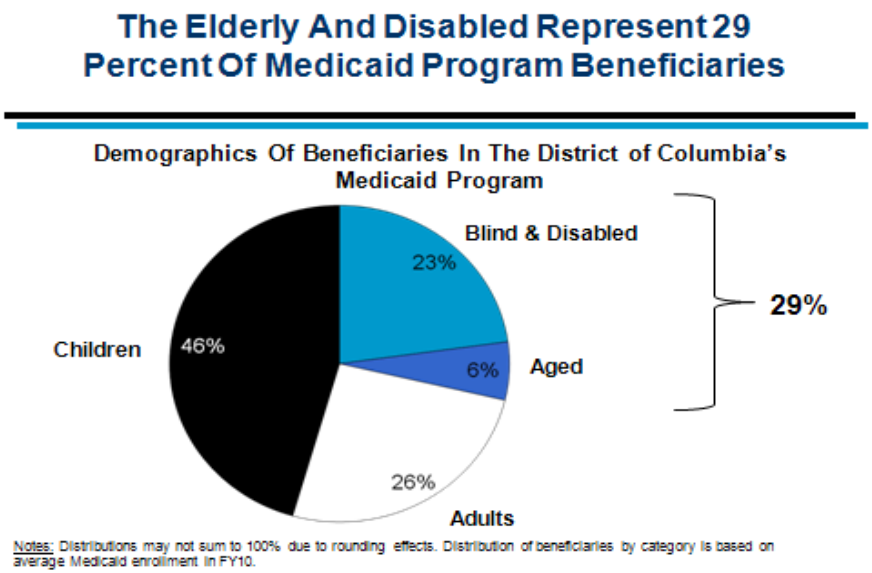


Figure 7.27.

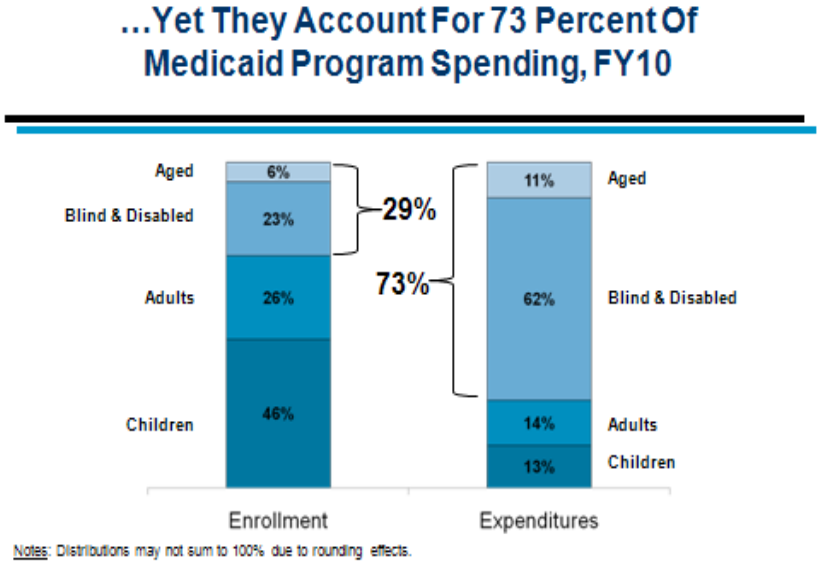
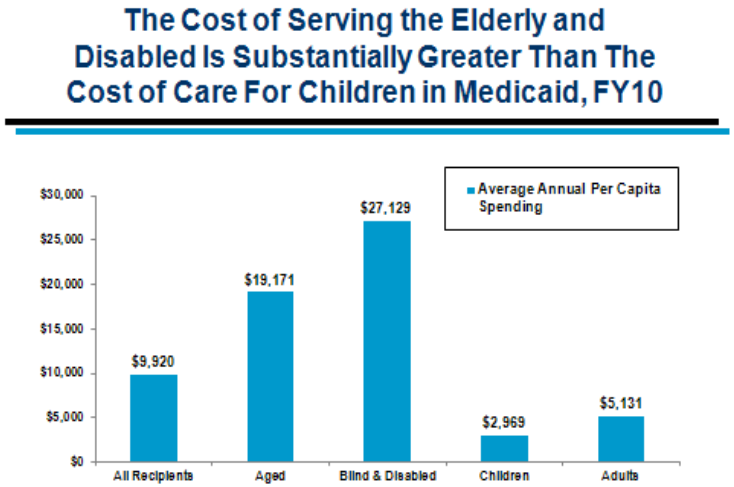


Figure 7.28



Spending for the elderly and disabled can be contributed to such services as inpatient hospital, physicians, nursing facilities, pharmacy, residential treatment centers, intermediate care facilities for persons with mental retardation, mental retardation/developmental disability waivers, elderly and physically disabled waivers, home health/personal care assistance.

ALLIANCE

The DC Healthcare Alliance is locally funded and offers a full range of health care services for its members. Those eligible must live in the District of Columbia, have no health insurance, including Medicare and Medicaid, and meet income limits. The Alliance program offers preventive care (checkups, diet and nutrition), health screenings (tests), prescription drugs, dental services (cleanings, fillings, dentures, and extractions), family planning services (birth control), urgent and emergency care (emergency room), immunizations (shots), prenatal care (pregnancy), wellness programs (eating well and staying healthy), and hospital care (medical, surgical, and GYN).

Enrollment was averaged from October to September to create average monthly enrollment. The Alliance program in its current form began enrolling beneficiaries in March of 2006. In July of 2010, the DHCF moved over 30,000 from the Alliance to the Medicaid program while implementing a new coverage option state plan amendment. Data shown for 2010 reflect October-June monthly average (pre-SPA) and July-September average (post-SPA). The Department transitioned over 2,700 people in December of 2010 while implementing a 1,115 waiver for childless adult beneficiaries with incomes between 133 and 200 percent of the Federal Poverty Level.

In July of 2010, the Department of Health Care Finance moved over 30,000 from the Alliance to the Medicaid program while implementing a new coverage option state plan amendment. Pre-SPA enrollment above reflects October-June monthly average, and post-SPA reflects July-September monthly average. Demographics by Ward reflect the highest post-SPA in Wards 1 and 4, which represents Wards where the most recipients were moved to Medicaid.

As a result of the transition from Alliance to the Medicaid program while implementing a new coverage option state plan amendment, the reduction in expenditures between FY09 and FY10 reflect this eligibility and coverage change.

Figure 7.29.

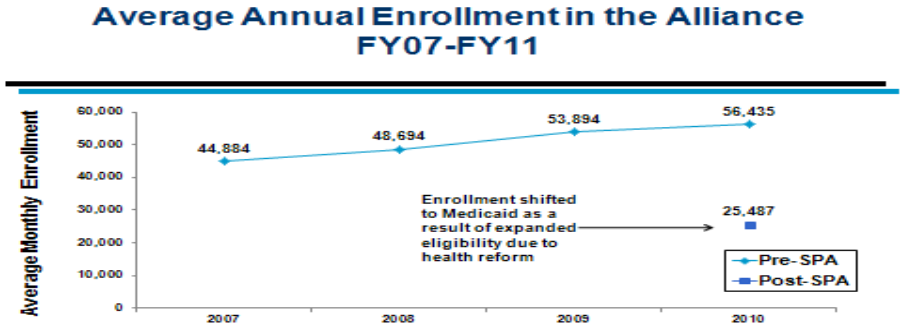


Figure 7.30.

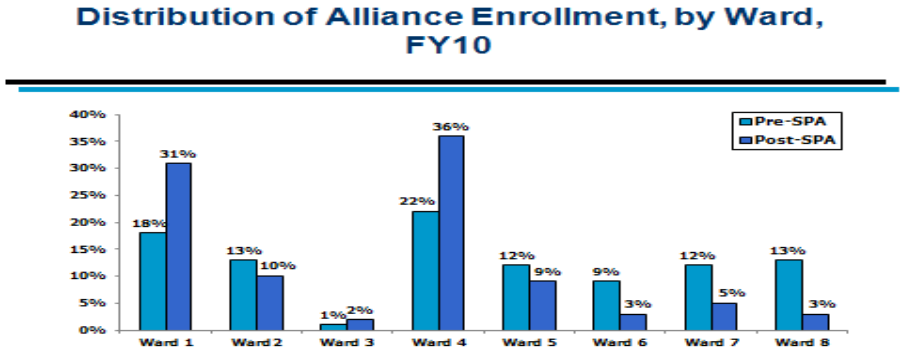
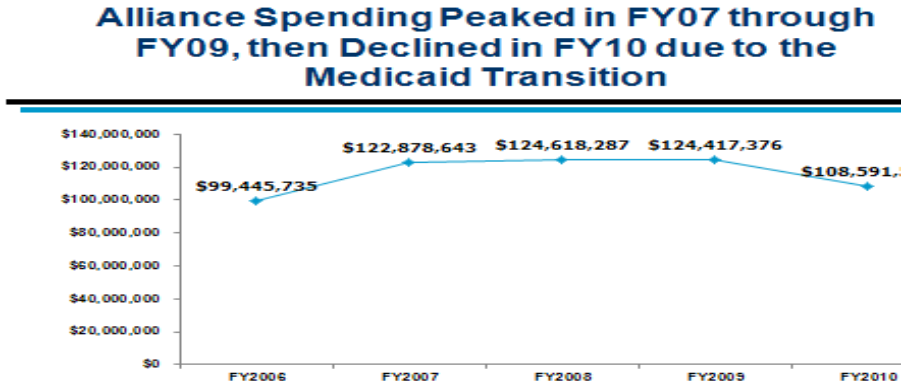


Figure 7.31.



Source: Department of Health Care Finance FY12 Budget Review

ADMINISTRATIONS

The Health Care Delivery Management Administration (HCDMA) ensures that quality services and practices pervade all activities that affect the delivery of health care to beneficiaries served by the District's Medicaid, CHIP and Alliance programs. HCDMA accomplishes through informed benefit design; use of prospective, concurrent and retrospective utilization management; ongoing program evaluation; and the application of continuous quality measurement and improvement practices in furnishing preventive, acute, and chronic/long-term care services to children and adults through DHCF's managed care contractors and institutional and ambulatory fee-for-service providers.

The Health Care Policy and Research Administration has responsibility for maintaining the Medicaid and CHIP State Plan which governs eligibility, scope of benefits, and reimbursement policies for the District's Medicaid and CHIP Programs; developing policy for the administration of the Alliance and other health care programs for publicly funded enrollees that are administered or monitored by DCHF based on sound analysis of local and national healthcare and reimbursement policies and strategies; and ensuring coordination and consistency among healthcare and reimbursement policies developed by the various Administrations within DCHF. The administration is also responsible for designing and conducting research and evaluations of health care programs.

The Health Care Operations Administration is responsible for the administration of programs that pertain to the payment of claims; management of the fiscal agent contract, management of the administrative contracts, management of the systems and provider enrollment and requirements. The office provides contract management of the Non-Emergency Transportation contract, the Pharmacy Benefits Manager, the Quality Improvement Organization contract, and the MMIS Fiscal Intermediary contract as well as additional administrative contracts.

T
he Health Care Innovations and Reform Administration is responsible for identifying, validating and disseminating information about new care models and payment approaches to serve Medicaid beneficiaries seeking to enhance the quality of health and health care and reducing cost through improvement. Creates and tests new models in clinical care, integrated care and community health, and creates and tests innovative payment and service delivery models, building collaborative learning networks to facilitate the collection and analysis of innovation, as well as the implementation of effective practices, and developing necessary technology to support this activity.

OFFICE OF HEALTH CARE OMBUDSMAN AND BILL OF RIGHTS (OHCOBR)

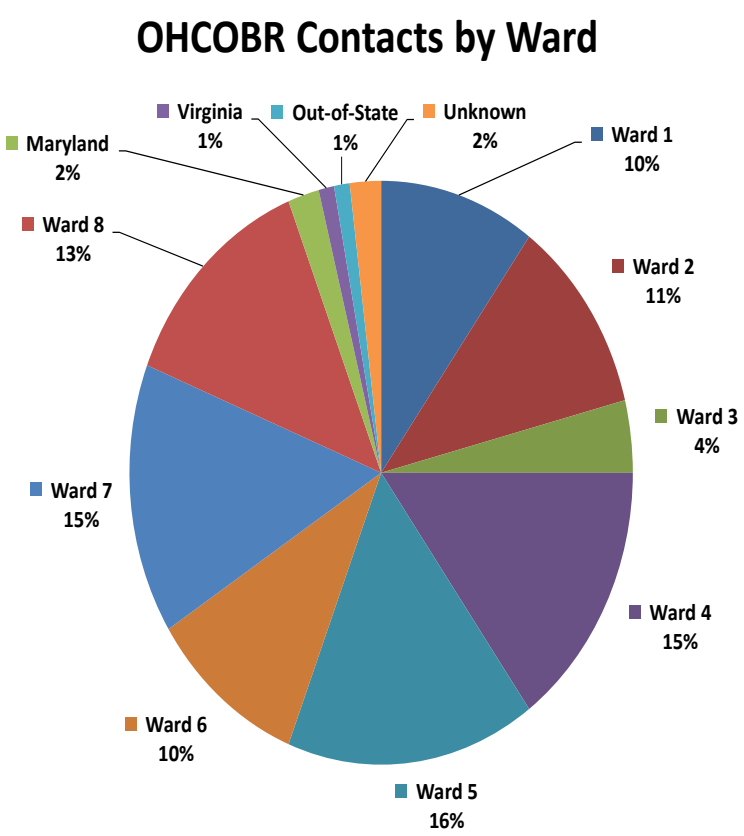
The Health Care Ombudsman and Bill of Rights (OHCOBR) is an independent office located in the Department of Health Care Finance (DHCF), Health Care Delivery Management Administration. The OHCOBR operates independently of all other government and non-government entities, and is a neutral body dedicated to advocating on behalf of the District's uninsured and underinsured residents, and insurance consumers. The Office maintains its independence by having no direct involvement, participation, investment, interest or ownership in a health care facility, health care service, health benefits plan or provider of a health benefits plan.

The OHCOBR provides varied assistance with respect to matters pertaining to the health care of individuals covered by insurance licensed in the District, as well as uninsured and underinsured District residents. At times, to assist consumers in the resolution of their health care issues, the OHCOBR collaborates with other DC agencies and organizations in the remediation of consumer disputes in an effort to ensure a timely and efficient resolution. The OHCOBR provides a considerable amount of direct assistance with Medicaid/CHIP and a limited amount to Medicare cases. While the OHCOBR mostly refers Medicare cases to the GW/HICP, OHCOBR is still involved in resolving matters for dual eligible beneficiaries (Medicare and Medicaid) where more than half of its contacts are derived.

During Fiscal Year 2010, the OHCOBR received a total of 3,727 contacts by individuals (consumers) and 1,603 were unique individuals. OHCOBR closed/resolved 90% (3,355 cases) out of 3,727 cases in FY 2010. The top three Wards in terms of contacts were Ward 5 (573 contacts or 16%), Ward 7 (569 contacts) and Ward 4 (568 contacts), each accounting for 15% of total contacts. These Wards were followed by Ward 8 (494 or 13%), Ward 2 (396 or 11%), Ward 1 (387 contacts) and Ward 6 (384 contacts), each accounting for (10%) of total contacts, and Ward 3 (166 contacts or 4%), Unknown (64 contacts or 2%), Maryland (64 contacts or 2%), Out-of-State (35 contacts or 1%), and Virginia (27 contacts or 1%).

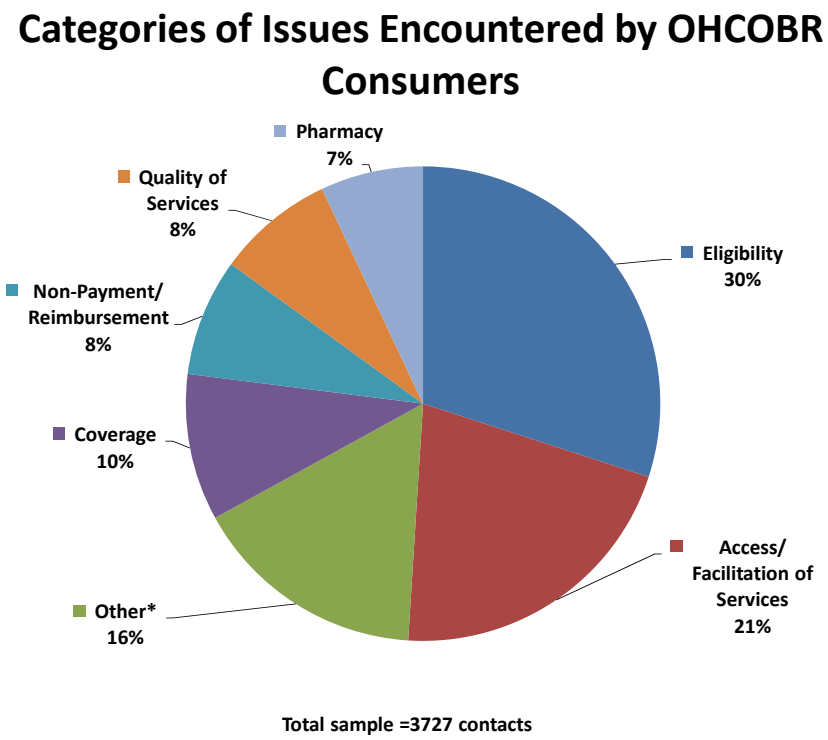
OHCOBR classified issues into the following categories: *Access/Facilitation of Services* - Prior authorization for health services, access to health care benefits (uninsured); assisting beneficiaries in securing medical, dental, durable medical equipment (DME) services or appointments, non-emergency transportation services, etc. *Eligibility* - Determining eligibility, status of eligibility, assistance with enrollment/ recertification in health care programs, explanation of Qualified Medicare Beneficiary (QMB) benefits, etc. *Coverage* - Appeals and grievances, denial of services, premiums, QMB co-payments, unpaid Medicare Part B premiums (Buy-In), etc. *Quality of Services* - Medical, dental, durable medical equipment (DME), inpatient/outpatient services, home health services, optical services, long-term care, etc. *Pharmacy* - Assistance in securing medications, methods of co-payments, filling prescriptions, etc. *Non-Payment/Reimbursement* - Non-payment of medical and dental bills, reimbursement of out-of-pocket expenses, etc. *Other* - Anomalous and generic complaints such as banking issues; death certificates; duplicate QMB cards; food stamps; fraud-Medicare/Medicare; termination of Home Health agencies; housing assistance; legal services; names misspelled on QMB cards; non-receipt-QMB cards; and replacement-Medicaid/Medicare/QMB cards; etc. The most frequent category of issues encountered by consumers was Eligibility, representing 30% of total contacts (3727 contacts).

Figure 7.32.



Source: OHCOBR FY10 Annual Report

Figure 7.33.



Source: OHCOBR FY10 Annual Report

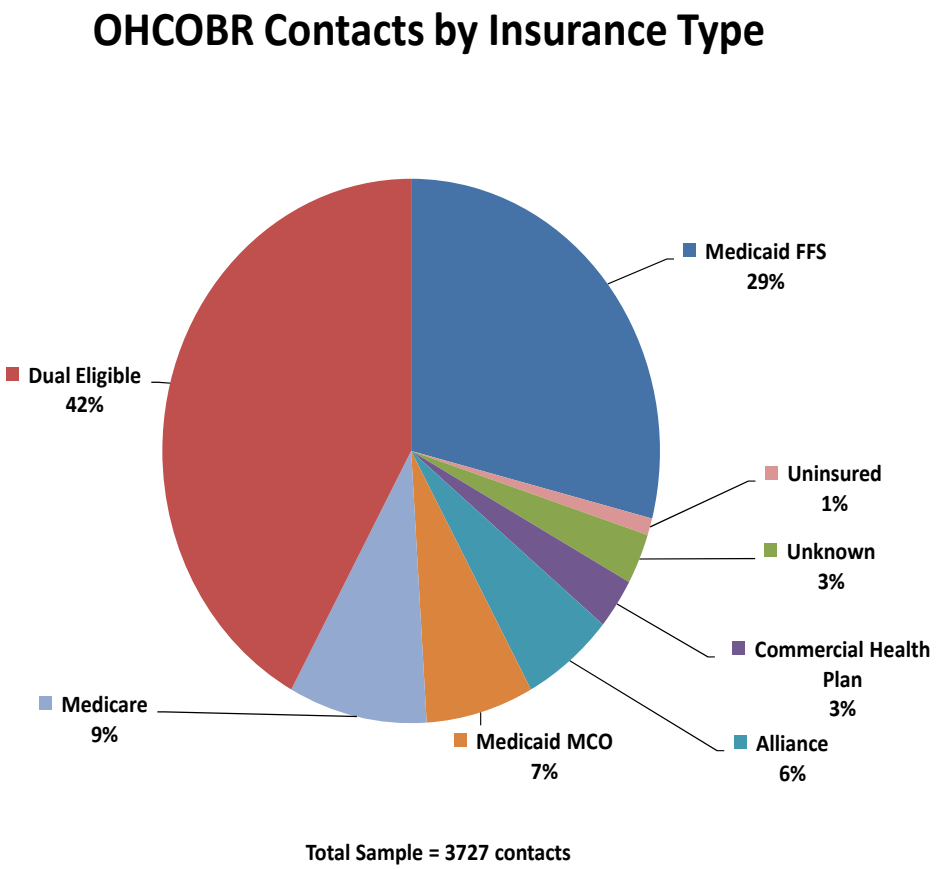
About half of OHCOBR contacts by insurance types during FY10 were by Dual Eligible (Medicare/Medicaid) beneficiaries (1,547 contacts, representing 42%). Contacts by those enrolled in Medicaid FFS represented the next most common insurance category (1,073 contacts, representing 29%), followed by Medicare Part A and/or Part B (336 contacts, representing 9%), Medicaid Managed Care (MCO) (233 contacts, representing 7%), Alliance (226 contacts, representing 6%), Unknown (142 contacts, representing 3%), Commercial Health Plan members (137 contacts, representing 3%), and Uninsured (33 contacts, representing 1%).

INITIATIVES

Design and Implement Health Information Exchange (HIE) initiatives:

Develop and Implement District-wide Health Information Exchange. In January 2010, the Office of the National Coordinator for Health Information Technology (ONC) at the U.S. Department of Health and Human Services awarded the District $5.1 million to facilitate the planning and implementation of a District-wide Health Information Exchange (HIE). HIE is the electronic sharing of health-related clinical, financial, and administrative health care information across care settings (such as physician offices, hospitals, pharmacies, and payers). The grant requires DHCF to conduct planning initiatives in FY 2010 and begin development in FY 2011. DHCF will focus FY 2011 initiatives on developing five key infrastructure components: governance; architecture; technical infrastructure; business and technical operations; and legal/policy. In FY 2011, DHCF will develop a roll out plan for HIE in the District, establish a governance mechanism for the provision of HIE services, and develop and deploy core HIE services. Services to be established during FY 2010 include: a baseline HIE architecture, implementation of core HIE services such as e-prescribing; structured lab reporting; and continuity of care reporting. These HIE components will be operational at the end of FY 2011.

Figure 7.34.



Source: OHCOBR FY10 Annual Report

Develop and Implement Medicaid Electronic Health Record Incentive Payments Program. Under American Recovery and Reinvestment Act funding, states are awarded funds to manage a multi-year program providing incentive payments to Medicaid providers for adoption, implementation and meaningful use of certified electronic health records (EHRs). The program requires states to develop a State Medicaid HIT (Health Information Technology) Plan (SMHP) which sets out the baseline environment, the objectives for EHR adoption and the processes and policies by which incentive payment will be made. This development of the SMHP is currently underway. During FY 2011, DHCF will develop and manage processes for verifying and authorizing incentive payments to eligible

Medicaid providers (including physicians, nurse practitioners, certified nurse midwives, dentists, physician assistants, acute care hospitals, and children's hospitals) who have successfully adopted certified EHRs and initiated their meaningful use. Payments will be phased over multiple years, with an initial payment for adoption, implementation and/or upgrade of an EHR to meet certification requirements. Subsequent payments will be tied to meaningful use of the EHR for functions such as e-prescribing, health information exchange and submission of clinical quality measures. Over six years, eligible providers may receive as much as $63,750 each in incentive payments. Incentive payments will begin during FY 2011.

Develop Planning and Implementation Activities for Health Insurance Exchange Implementation. The Patient Protection and Affordable Care Act enables states to establish a Health Insurance Exchange through which uninsured residents may purchase insurance and receive subsidies depending on income. The U.S. Department of Health and Human Services (HHS) is providing $1 million grants to states and the District to conduct planning purposes during FY 2011. The District will use these funds to coordinate background research, capacity, systems, and infrastructure assessments, and preliminary budget forecasting. Quarterly and Final reports will be developed and submitted to HHS, and will form recommendations to guide the District's plans for implementation of an Exchange by the 2014 federal deadline. The Health Insurance Exchange will give individuals and small businesses access to affordable coverage through a new competitive private health insurance market – state-based Affordable Insurance Exchanges.

The U.S. Department of Health and Human Services has recently awarded the District a Level One Exchange Establishment grant of $8.2M to continue with its planning and implementation of a Health Insurance Exchange for District residents. The funding from this grant will leverage the data, information and indicators gathered in the preliminary effort into a comprehensive project design document. DHCF is a member of the Health Reform Implementation Committee that will be providing recommendations to the mayor on the design of a health insurance exchange that is representative of the unique health insurance needs of District residents and that reflects the preferences of stakeholders.

Integrate and operate Patient Data Hub. In FY 2010, DHCF implemented the Patient Data Hub (PDH), funded through a Medicaid Transformation Grant from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The grant is intended to foster the adoption of innovative methods to improve effectiveness and efficiency in providing medical assistance under Medicaid. The PDH is a pilot implementation of technologies designed to enable real-time exchange of clinical and administrative medical data within the District, with better access to data informing clinical and program management decisions. In FY 2011, DHCF will focus on using the PDH to share clinical data from hospitals and clinics, and use PDH data to improve DHCF operations. Specifically, by the end of FY 2011, the PDH will be built out to include interfaces with the DC Regional Health Information Organization (DC RHIO) for hospital and clinic data and Children's National Medical Center for pediatric data.

ACCOMPLISHMENTS

Led the District to becoming the 2nd lowest in the nation in percent of uninsured residents, with only 6.2% of all District residents and 3.2% of District children lacking health insurance coverage in 2010 through implementation of Medicaid expansion under the Patient Protection and Affordable Care Act, thus providing more expansive health insurance coverage to 30,000+ low-income District residents and saving District taxpayers millions of dollars annually.
DHCF significantly improved management of the Medicaid program and operations from "material weakness" status in 2006 District's Comprehensive Annual Financial Report.