

# Addressing the District of Columbia's Health Priorities

## STATE HEALTH PLAN



Government of the District of Columbia  
Adrian M. Fenty, Mayor



### ***Acknowledgements***

*The Department of Health would like to express its appreciation to Sanja Partalo and Amha Selassie for their tireless efforts in spearheading the development and approval of the State Health Plan. Special appreciation is extended to the staff of the Department of Health's Center for Policy, Planning and Epidemiology for their input and research.*

*The Department of Health would like to thank the Statewide Health Coordinating Council who gave their time generously and whose careful deliberations greatly enhanced the framework of the State Health Plan.*

## *Addressing the District of Columbia's Health Priorities*

Excerpt from *100 Days and Beyond Plan: 2007 Action Plan for District of Columbia*, Adrian M. Fenty, Mayor, District of Columbia, January 11, 2007

“..A new era for the District of Columbia stands before us – an era of transparency and accountability. Today, we envision the evolution toward a health city, a capital to lead our nation, to learn from proven success and to set the precedent for our residents and for our children.

A health city reflects every facet of our lives from our personal health to the health of our neighbors, our communities and our environment. In realizing a collective vision we understand that a health city ensures that all District residents have:

- Access to affordable, comprehensive and high-quality health care through established medical homes;
- Access to affordable health insurance that includes cost-effective preventative care and health maintenance;
- A strong health care safety net that fosters social inclusion by covering services for medical needs, mental illness, pharmacy services, substance abuse and oral health care, regardless of ability to pay;
- The tools necessary for residents to maintain, both individually and collectively, health and balanced lives.



The state of our health and well being is an indicator of the general condition of our city. For our city to continue to prosper we must enable our citizens to be productive by taking a more expansive view of the term “health care.” A health city relies not only on what the District does for its residents, but also on what the residents do as individuals and collectively as community to create the conditions under which people can be healthy.

In an era of accountability comes the accountability of each of us as well – a responsibility to take care of ourselves, to seek preventive care, to have a medical home base and to have our voices heard as citizens to foster needed change. Together we will realize the District of Columbia as a health city.”

GOVERNMENT OF THE DISTRICT OF COLUMBIA  
DEPARTMENT OF HEALTH



Office of the Director

November 14, 2007

Dear District Resident:

The Department of Health is pleased to present the *District of Columbia's State Health Plan*, our first such plan in nearly two decades. It will serve as a guide for the city's nearly \$2 billion investment to improve the health and wellbeing of every District resident.

For too long, DC has exhibited unacceptably high rates of prematurity and infant mortality as well as high rates for chronic conditions such as heart disease, diabetes, asthma, cancer, and HIV/AIDS. The Department of Health is charged with reversing this trend, and the *State Health Plan* is one tool for reaching this important goal. I want to thank the many partners from the health care, public health and advocacy communities that provided insights and contributed to the development of this document.

Included in the *State Health Plan* is a series of health indicators from the most recent data available regarding our population's life expectancy, leading causes of death, infant mortality rates, pregnancy rates and others, further broken down by race, gender, and geography. Using each of these measures as a baseline, the Department has established targets for improvement in an array of related health care and public health categories, including tobacco use, violence and injury prevention, chronic disease management, HIV/AIDS, oral health, maternal and infant health, and various aspects of departmental performance.

It is important to remember that, like the population's health status, this document is not static but rather ever-changing. It is structured to allow constant updating and tailoring to remain in line with the evolving health needs and goals of DC residents. To that end, the Department of Health is committed to regularly reviewing and analyzing our health indicators and releasing future versions of our *State Health Plan*.

There is much work to be done to improve the health of all DC residents, and the Department of Health is pleased to, at long-last, have an updated *State Health Plan* to guide us in these endeavors. We look forward to continued collaboration with all of our community partners as we strive to promote the health of our world class city.

Sincerely,

Carlos Cano, M.D.  
Interim Director

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*"To improve health outcomes for all residents of the District of Columbia"*

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# Executive Summary

Health planning embodies a systematic, consistent approach that ties activities to outcomes in measurable ways and thus, serves as a tool for guiding public resources and activities to improve health and health care services in the District.

In December 1989, the District of Columbia published a comprehensive health plan. *In contrast, the current State Health Plan is a strategic plan that sets out goals, identifies data-driven priorities for a specific time period, and institutes a process for managing and measuring progress.* The Plan is thus part of a framework for focusing public resources most productively and efficiently.

The key long-term goals and accountability measures of the Plan are those established under Healthy People 2010, Hospital Quality Measures developed by the Centers for Medicare and Medicaid Services (CMS), HEDIS<sup>®</sup> measures developed by the National Committee on Quality Assurance (NCQA), and Behavioral Risk Factor Surveillance System (BRFSS).

The Plan builds on the 1989 *Comprehensive Health Plan* and on *Healthy People 2010 Plan, Midcourse Revisions (2000-2005)*. It also incorporates work done at the Department of Health with the Healthcare Decisions Group in producing *Accomplishing the District of Columbia's Health Objectives: A Health System Plan for D.C.*

## ***New Approach for the Strategic Health Plan***

The Plan is a concise document that is intended to serve as a guidebook and an accountability tool for the Department of Health and other stakeholders in the District. It outlines a management process that generates goals and performance measures for accomplishing the overall vision. The process will bring together stakeholders and Department officials on a periodic basis through a public-private advisory committee to discuss current health needs data, develop health priorities and accountability measures based on health needs data, and target additional resources to address emerging priorities.

The Plan is a departure from traditional state health plans in that it is *not an end document*. Rather, the Plan will identify health priorities based on needs data for each year and a template for measuring progress towards established goals. In this way, the Plan will be specific enough to guide decisions but flexible enough to readily assimilate directives from new managers and respond to new city challenges. Its inclusive process represents a framework for accountability to traditional stakeholders and to District of Columbia leadership.

*The Plan directs the Department's focus to a manageable number of high-priority, achievable goals and related accountability measures. It functions as a tool not only for setting priorities for the short-term, but also for measuring progress toward goals over the long-term. In addition, it provides a framework for efficient budgeting and resource allocation on an ongoing basis.*

## *The Strategic Planning Process*

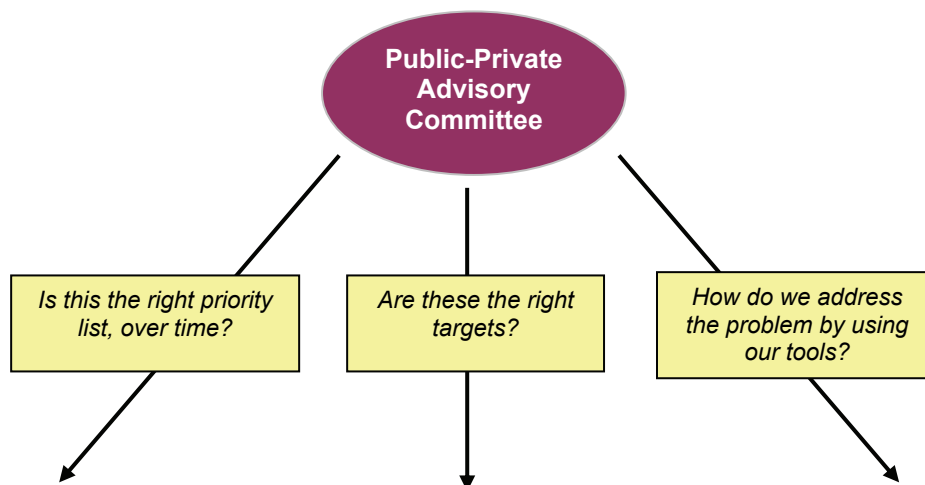
The management process is the critical difference between a comprehensive plan and a strategic plan. The process begins with identifying priorities based on the most current health needs data. In formal consultation with stakeholders through the public-private advisory committee, the Department of Health will establish priorities reflective of current health needs data and recommend actions to be undertaken utilizing the tools and resources the Department has at its disposal and resources available in the public sector.

The priorities will be accompanied by a set of nationally recognized performance measures derived from National Hospital Quality Measures developed by the federal Centers for Medicare and Medicaid Services (CMS), Healthy People 2010, HEDIS<sup>®</sup> measures developed by the National Committee on Quality Assurance (NCQA), and Behavioral Risk Factor Surveillance System (BRFSS). The measures will enable the Department to systematically track progress towards identified priorities.

The members and the Department will also decide how to utilize the available tools to address identified priorities and achieve stated goals. The tools Department of Health has at its disposal to effect change are Insurance Programs, Public Health Grants, Certificate of Need program, and Health Professional Boards/Health Regulation.



Figure 1: Strategic Planning Process Example



DATA-DRIVEN HEALTH PRIORITY	MEASURES*	TOOLS**
<p>Health Needs Data Indicates:</p> <ul style="list-style-type: none"> <li>8.3% of District residents diagnosed with diabetes as compared to national median of 7%</li> <li>African Americans (12.3%) are much more likely to be diagnosed with diabetes than Caucasians (2.3%)</li> <li>Direct correlation with poverty: just 3.5% of those with incomes of \$75,000 have been diagnosed with diabetes, compared to 14.1% of those with incomes of less than \$15,000</li> </ul> <p>Thus, Health Priority: <b>Prevent &amp; Control Diabetes</b></p>	<p><u>HEDIS Measures</u></p> <ul style="list-style-type: none"> <li>HbA1c (blood glucose) Testing</li> <li>Poor HbA1c Control</li> <li>Eye Exams</li> <li>Lipid Profile</li> <li>Lipid Control &lt;130</li> <li>Lipid Control &lt;100</li> <li>Monitoring Diabetic Nephropathy</li> </ul> <p><u>Healthy People 2010</u></p> <ul style="list-style-type: none"> <li>Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000</li> <li>Reduce the mortality rate due to diabetes as the primary cause of death among African-American residents to 30.0 per 100,000</li> <li>Increase to 75% of D.C. residents with diabetes report having their feet checked for sores or irritations</li> <li>Increase by 50% proportion of D.C. residents with diabetes who report at least one encounter with a health care professional regarding dietary counseling</li> </ul>	<ul style="list-style-type: none"> <li>Requiring <b>Insurance Programs</b> (Medicaid &amp; Alliance) to incorporate diabetes measures and report their performance; leveraging Pay-for-Performance; conduct diabetes and risk factor surveillance</li> <li>Engaging in partnerships and targeting <b>Public Health Grants</b>; asking the grantees to incorporate the diabetes measures and report the performance; conduct diabetes and risk factor surveillance</li> <li>Utilizing <b>Health Regulation/Health Professional Boards</b> in highlighting focus on improving and tracking diabetes and diabetes quality of care; establish standards of care reflective of the diabetes management and prevention activities</li> </ul>

*Accountability Measures
<ul style="list-style-type: none"> <li>Healthy People 2010</li> <li>CMS Hospital Quality Measures</li> <li>NCQA HEDIS® Measures</li> <li>BRFSS</li> </ul>

**Tools to Effect Change
<ul style="list-style-type: none"> <li>Insurance Programs (Medicaid &amp; Alliance)</li> <li>Public Health Grants</li> <li>Certificate of Need Program</li> <li>Health Professional Boards/Health Regulation</li> </ul>

## ***Statewide Health Coordinating Council***

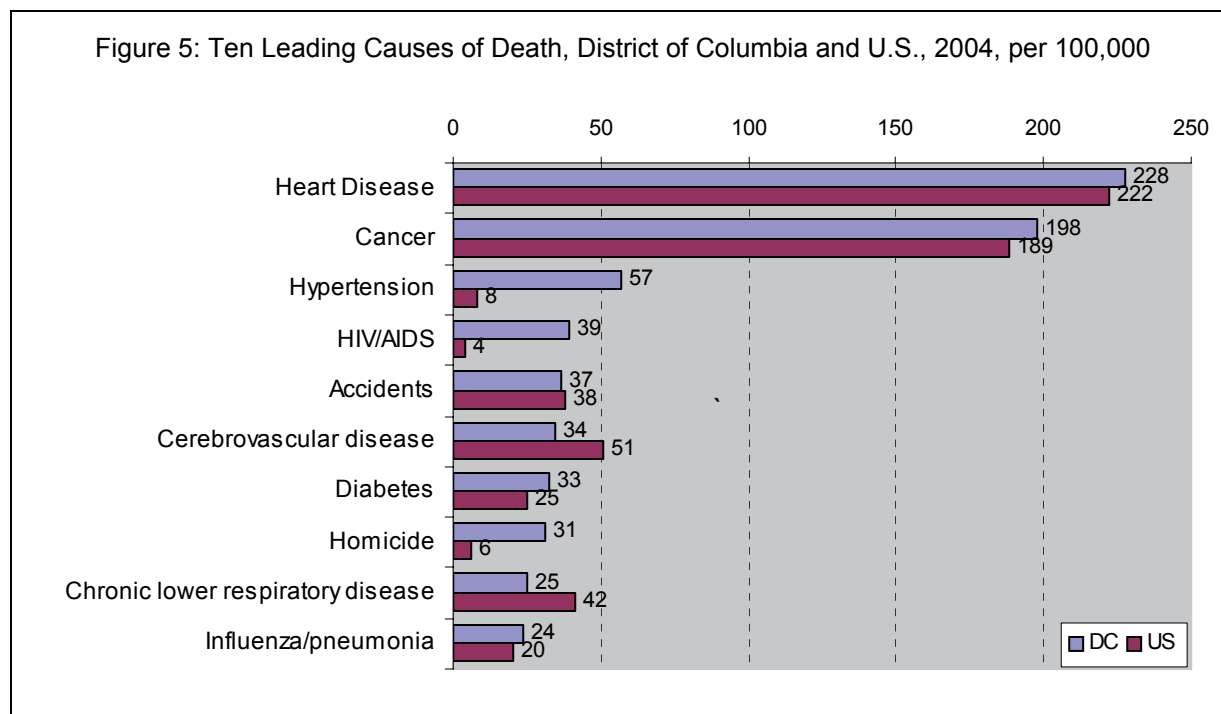
The Statewide Health Coordinating Council (SHCC), established by District law (D.C. Official Code § 44-403 and § 44-404), plays a major role in the plan development process. The members represent diverse stakeholders in the community and are appointed by the Mayor with the advice and consent of the Council of the District of Columbia. The SHCC will utilize the resources of the State Health Planning and Development Agency (SHPDA) in carrying out its responsibilities. The SHPDA will seek the advice and recommendation of the SHCC in developing facility and service plans. The facility and service plans will be a component of the State Health Plan. The SHCC will choose a few health priorities or services a year for implementation. Goals, objectives and recommended actions will be developed for specific health priorities and be accompanied by a set of benchmarks and nationally recognized accountability measures. In addition to the goals and objectives, the SHCC may provide recommended actions, the rationale for these actions, strategy statements and resource requirements. In addition to providing advice and guidance to the SHPDA, the SHCC can facilitate cooperation between the Department of Health and other public and private sector entities in addressing the public health needs of the residents.

The SHPDA, however, will continue to develop specific facility and service plans that will be utilized in reviewing certificate of need applications. The intent is to have a strong and sustainable health care delivery system to meet the needs of residents.

The certificate of need review framework is a conceptual approach for analyzing the health care system's facility and service needs and is used to analyze and make determinations on applications submitted for approval in accordance with DC Official Code §44-401. The health planning framework utilized by the SHPDA analyzes proposed new institutional health services and capital expenditures based on the proposals meeting the criteria, standards and need assessments. The certificate of need review framework addresses the following health system characteristics, as articulated in the State Health Plan:

- The availability of the proposed service based on a needs projection that identifies gaps and unmet need;
- The accessibility of the proposed services;
- The quality of the proposed services;
- The acceptability of the proposed services;
- The continuity of care for the proposed services; and
- The financial viability of the proposed services.

Essential to assessing the need for new institutional health services and capital expenditures are population-based need projections that quantify the availability of health resources – facilities and services – and identify gaps and unmet needs. The SHPDA will develop service-specific population-based need projections for each of the services subject to certificate of need review. The service-specific need projections will be used along with the criteria and standards outlined in the State Health Plan to evaluate proposals for certificates of need.



### *Health Status of District Residents*

The Plan presents leading health issues that affect the health status of District of Columbia residents by looking at mortality and morbidity data. Through analysis of burdens of mortalities and morbidities, the Plan presents an opportunity to allocate healthcare resources for prevention and treatment to areas where these resources are most needed and where they are most likely to have an effect. The health needs data will enable the Statewide Health Coordinating Council to decide upon a manageable number of high priorities and accompanying performance measures. In addition, the Plan devotes special attention to presenting health conditions affecting the uninsured, as well as outlining gender and geographical differences on causes of death.

Analysis of the distribution of the ten leading causes of death by Wards provides a high level indicator of the geographic location and severity of specific health conditions. The ward level analysis is a useful guide in targeting health policies and resources in the District of Columbia.

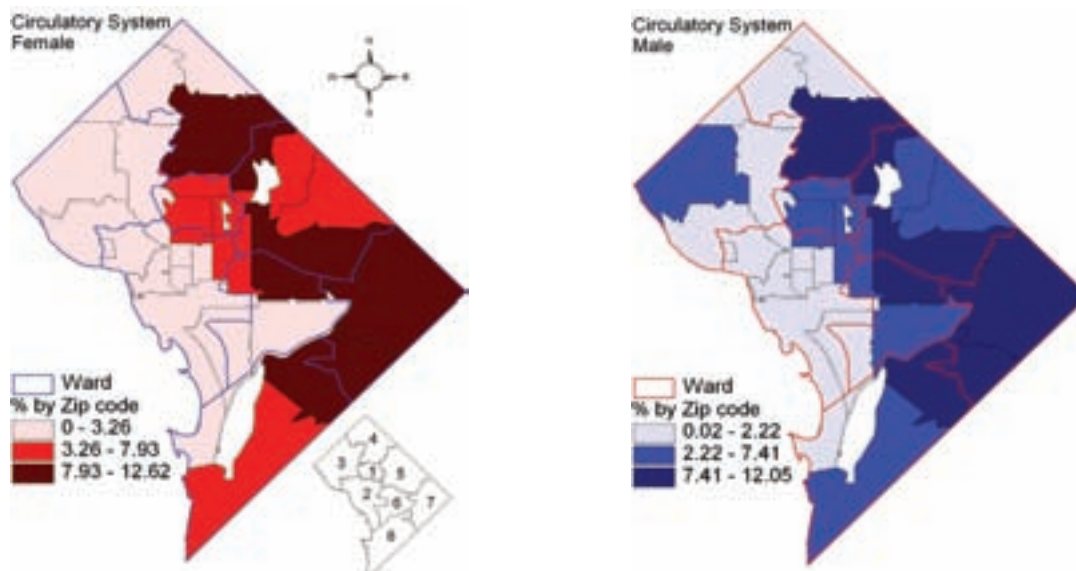
Ranking the leading prevalence of a disease in a population (morbidity) in concert with mortality data, provides an insight into those conditions that affect the population the most at any moment in time. An analysis of leading morbidities presents an opportunity to allocate healthcare resources for prevention and treatment to areas where these resources are most needed and where they are most likely to make a difference.

Table 5. Top Ten Leading Causes of Death by Ward, District Residents, 2004

CAUSE OF DEATH	Total	Wards of Residence							
		Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
POPULATION	572,059	80,014	82,845	79,566	71,393	66,548	65,457	64,704	61,532
HEART DISEASE Rates	1,301 227.4	105 131.2	142 171.4	178 223.7	218 305.4	202 303.5	138 210.8	194 299.8	115 186.9
CANCER Rates	1,132 197.9	114 142.5	140 169.0	135 169.7	207 289.9	167 250.9	115 175.7	164 253.5	82 133.3
ESSENTIAL HYPERTENSION Rates	326 57.0	34 42.5	45 54.3	32 40.2	45 63.0	56 84.1	34 51.9	43 66.5	37 60.1
HIV/AIDS Rates	223 39.0	34 42.5	25 30.2	2 2.5	16 22.4	44 66.1	23 35.1	34 52.5	42 68.3
ACCIDENTS Rates	210 36.7	18 22.5	20 24.1	17 21.4	32 44.8	33 49.6	23 35.1	32 49.5	32 52.0
CEREBROVASCULAR DISEASES Rates	196 34.3	13 16.2	16 19.3	25 31.4	38 53.2	29 43.6	20 30.6	30 46.4	22 35.8
DIABETES Rates	187 32.7	15 18.7	13 15.7	13 16.3	25 35.0	36 54.1	20 30.6	44 68.0	21 34.1
HOMICIDE Rates	178 31.1	8 10.0	4 4.8	1 1.3	21 29.4	34 51.1	31 47.4	36 55.6	41 66.6
CHRONIC LOWER RESPIRATORY Rates	145 25.3	10 12.5	23 27.8	19 23.9	30 42.0	20 30.1	15 22.9	20 30.9	8 13.0
INFLUENZA/PNEUMONIA Rates	136 23.8	12 15.0	16 19.3	13 16.3	25 35.0	25 37.6	8 12.2	25 38.6	10 16.3

\*Crude death rates are per 100,000 population. Numbers may not add to totals due to rounding and unknowns.

Figure 13: Leading Hospital Discharge Diagnosis by Gender, Spatial Distribution



### *Putting it All Together*

The results of the data analysis point to several key health concerns for District residents. Chronic non-infectious diseases including heart disease, cancer, cerebrovascular disease, diabetes and hypertension are the major cause of death and illness among persons over age 45. HIV is the chronic infectious disease exhibiting the heaviest impact on younger adults. Injury, both intentional and unintentional, has its largest impact on infants, children and youth. By identifying and examining the conditions and related risk factors that have the most significant impact on the health and welfare of the population, strategic planning can be targeted to primary prevention and intervention.

Considerable healthcare resources are used to address chronic diseases. Cancer has a major affect on the decreased life expectancy rate. Diabetes is a leading cause of death, particularly among person 65 and older. Hypertension is also a major source of concern as evidenced by the resources used to manage it in the clinic and hospital settings. HIV has emerged over the past ten years as the leading cause of death among persons 25-44 years old in the District. Intentional and unintentional injury is a leading cause of death for persons 1-24 years old. In addition to drawing conclusions related to specific illness or injury, special target populations require priority focus due to the nature and scope of the conditions affecting them. Tobacco is still the number one preventable cause of death in our society and smoking cessation programs should receive high priority in the District's prevention agenda.

This plan will seek to implement the vision of a healthier city reflecting every facet of our lives at the personal, and community and environmental levels. This vision seeks to ensure that all District residents have:

- Access to affordable, comprehensive and high quality care through traditional providers and new facilities such as medical homes;
- Access to affordable health insurance;
- Access to information and programs that promote prevention of disease and injury at every stage of life by adopting healthy behavior and lifestyle;
- A strong and effective healthcare safety net that provides healthcare services for the medically needy in all areas such as primary care, care for the mentally ill, pharmacy services, substance abuse treatment and support services, and oral health care.

This vision also seeks to promote greater involvement of the broad healthcare community and citizens in all health related issues.

### **Blueprint for Better Health Outcomes and Reduced Disparities**

Given this document's strategic focus, the Plan does not seek to detail future health program and facility needs, which are not precisely foreseeable. Rather, it outlines an approach to planning for how best to identify and respond to shifting needs, priorities, and resources. It does not attempt to list all health needs, nor all health resources or interventions. Rather, it sets out a workable framework for effective planning, powered by information, within an ongoing process of decision-making. It is a blueprint for systematically identifying priorities and monitoring needs, objectives, and performance. Its success will flow from its effectiveness in supporting a continuous process of improvement.

## ***Overarching Goals***

### **A. Health Disparities**

Health disparities refer to inequality in available opportunities to access high quality and affordable health care by varying racial, ethnic and socioeconomic groups. Lack of insurance coverage, lack of a regular source of care, cultural and language barriers, shortage of providers in neighborhoods where minorities live, lack of education and awareness are the main sources of health disparities.

The U.S. Surgeon General estimates that nearly 84,000 deaths can be prevented each year if gaps in mortality between blacks and whites were eliminated. Further, a study developed by the Institute of Medicine has found that:

- Members of minority groups are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery;
- Minorities are less likely than whites to receive kidney dialysis or kidney transplants;
- Minorities are less likely than whites to receive the best diagnostic tests or treatments for stroke or cancer;
- Minorities are less likely to receive state-of-the-art treatments or therapies that can forestall the onset of AIDS; and

- Minorities are more likely to receive less desirable treatments than whites.

The study also indicated that there are many possible reasons for racial and ethnic disparities in health care, including:

- Cultural and language barriers;
- Time limitations imposed by pressures of clinical practice;
- Distrust for health care establishments by many minority patients;
- A woeful lack of minority physicians who may be more culturally sensitive to the needs of their patients; and
- Conscious or subconscious biases, prejudices, and negative racial stereotypes or perceptions that affect the way providers deliver care.

One of the overarching goals of both the federal and District of Columbia Health People 2010 goals is the elimination of racial and ethnic health disparities. In 2003, the U.S. Surgeon General cited the following six areas of focus in order to accomplish this goal: infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, immunizations and HIV/AIDS. The U.S. Surgeon General's proposed solution was for public and private organizations to develop and implement the needed changes in the health care system (access to care, mental health, injury and violence, environmental quality, and immunization), and for individuals and groups to collaborate in adopting strategies to change unhealthy lifestyles (physical activity, overweight and obesity, tobacco use, substance abuse, and responsible behavior).

**Table 11: Ten Leading Causes of Death and Crude Death Rate by Race and Gender:  
District of Columbia, 2004**

Rank*	Cause of Death	White (Rate per 100,000)			Black (Rate per 100,000)		
		Male	Female	All	Male	Female	All
	All Causes	563.27	547.34	621.80	1341.6	1086.13	1223.4
01	Heart Disease	160.6	162.0	161.3	294.4	291.3	292.7
02	Cancer	152.6	137.1	144.8	282.9	224.2	250.8
03	Homicide			7.3	97.7		57.9
04	Essential Hypertension	39.9	43.0	36.2	84.2	70.8	68.4
05	HIV/AIDS	15.9		7.9	82.3	42.6	60.6
06	Accidents	38.7	19.3	25.9	68.8	25.7	44.6
07	Cerebrovascular Diseases		32.8	22.7	45.6	45.3	45.5
08	Diabetes	13.7	9.1	11.4	44.4	51.7	48.1
09	Influenza/Pneumonia	14.8	17.0	15.9	31.5	30.4	30.9
10	Chronic Lower Respiratory	23.9	27.2	25.5	31.5	26.6	29.1

\*Rank based on number of deaths from the list of 113 selected causes of death.

\*\* Rate per 100,000 population based on Census 2000.

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



The elimination of health disparities is a crucial step in improving health outcomes and quality of care. There is a need to identify gaps in health care services and their causes in order to design appropriate interventions. It is recommended that the Department of Health establish an advisory panel of experts from the public and private sectors to identify areas of health disparity and propose ways to reduce and, where possible, eliminate the gaps. The panel should include members from health providers, policy makers, teaching institutions, churches, advocacy organizations, insurance carriers, as well as community groups. The reduction and elimination of disparities will not only improve health outcomes but will have economic, social, and educational benefits. Among other things, the panel should:

- Review the existing health care delivery system and determine why racial and ethnic minorities are not receiving equitable care;
- Identify short-term and long-term solutions to the problems;
- Provide a road map on how resources can be more equitably allocated to address the problems;
- Identify bench marks to measure progress over time; and
- Make suggestions on how to improve health coverage to address disparities.

## **B. Preventive Health**

Currently, the leading causes of death in the District are mainly attributed to chronic illnesses. Prevention of such illnesses occurs in many arenas including: (1) maintaining healthy personal behaviors, (2) improving health treatments and interventions, (3) creating a healthy environment, and (4) actions taken through social and economic means to encourage healthy living.

The benefits of preventive health to society are enormous. Prevention:

1. Improves quality of life for patients;
2. Improves workforce and school productivity;
3. Decreases the financial burden to patients;
4. Educates the public about healthy lifestyle choices;
5. Detects or prevents major illnesses from occurring;
6. Decreases morbidity and mortality rates;
7. Promotes better use of health care resources;
8. Reduces emergency department use;
9. Reduces the economic and medical care burden to hospitals and health care facilities; and
10. Increases life expectancy.

Preventive health strategies should include participation from a variety of stakeholders. Individuals should practice behaviors that promote good health. Healthcare professionals should identify at-risk patients and develop appropriate and effective intervention strategies. Governmental agencies should formulate policies, allocate financial resources and collect data in order to evaluate the effects of various interventions. Third party payers should work with government officials, businesses, and the community in making affordable health insurance a priority, and include prevention and wellness benefits into insurance policies. Community organizations should identify needs and resources, and assist in the implementation of health promotion activities. Businesses and employers should assist employees in obtaining health

insurance at a reasonable cost and develop policies that promote healthy behaviors. Churches should promote health related activities and develop support systems to assist congregants in coping with illnesses or modifying behavior. Schools should develop health education programs that focus on healthy behaviors, create healthy lunch and diet choices, design health education and disease management strategies for students with chronic illnesses, and develop physical activities programs.

A major component of preventive health is education and promotion. Health education is composed of activities and experiences which teach individuals and the collective community which behaviors and actions are conducive for good health. Health promotion not only encompasses education but looks at a broader framework of strategies which includes social, economic, and political components coupled with achievable health outcomes. Promotional campaigns and activities involve individuals and engage the community as a whole. A more balanced planning and implementation process can result in giving all stakeholders the opportunity to participate in health care decision making.

In general, health education and promotion should increase public awareness of behavioral and environmental risk factors, support behavioral change to reduce those risk factors, promote early diagnosis and treatment, and increase access to medical care and support services.

The Department of Health must work with different groups and organizations in order to improve the health status and well-being of the residents. Improving health-related behavior, instituting appropriate policies and regulations and providing the necessary support is critical to the success of preventive health.

Therefore, it is recommended that greater emphasis be given to providing disease prevention and health promotion education in the schools. Health habits are usually developed early and health education programs aimed at the adolescent population provide an excellent opportunity to encourage positive behaviors and support students in management of their health. The majority of adolescents are enrolled in school and the school setting is ideal for teaching students about physical activity, nutrition, healthy living, HIV/AIDS, substance abuse, obesity, environmental health, emergency response, dental care, reproductive health, counseling, wellness programs, and the like. It is also relatively easy to reach families and the community through the students. Adolescents can facilitate communication with their families and can be a conduit for the distribution of targeted educational programs and materials. For example, adolescents who are taught effective asthma management skills may influence the way a family member with asthma treats the condition.

A concerted effort should be made to persuade schools' administrations and teachers about the value of health education. It is important to encourage dialogue and promote education for school staff in order to foster and sustain health education programs. If school health programs are to succeed there is a need to establish and strengthen relationships with parents, hospitals, primary care facilities, professional organizations, government entities and community groups in conjunction with the full support and participation of the school community.

## **C. Health Care Financing**

The District of Columbia fares very well in terms of health coverage of its citizens. Given the large number of firms offering employer sponsored insurance, the number of residents employed by the public sector, city's large Medicaid program, and an average income above the national average, most people in the District have health insurance and receive good coverage. However, a number of residents still remain uninsured or underinsured. For some, the barrier to coverage is the cost of the health insurance that is available to them, and for others, it is the lack of appropriate coverage. In addition, some District residents may be eligible to receive health insurance through local and federal government but are not aware of these benefits.

The DC Healthcare Alliance is an additional public insurance program available to District residents, funded by local funds. Through the DC Healthcare Alliance members have access to an array of professional healthcare providers within a managed care network. Eligibility is open to those residents who have incomes under 200 percent of the federal poverty level (FPL) and who do not qualify for the Medicaid program. As of May 1, 2007, there were 45,807 District residents enrolled in the Alliance program.

Legislation passed by the City Council in 2006 will bring the District one step closer to providing universal coverage. Specific policy changes include: expansion of Medicaid to cover children up to 300% of the federal poverty level; the creation of Healthy DC, a new program allowing residents who are not eligible for Medicaid or the Healthcare Alliance to buy basic health care coverage; and increased coverage of Medicaid dental benefits.

In addition, in order to ensure that all eligible residents are covered, the District has streamlined the enrollment process for Medicaid and Alliance coverage. This effort has resulted in 20,000 new enrollees between June 2006 and June 2007. For those with incomes above 200% FPL, legislation was passed to expand SCHIP eligibility to 300% FPL, a change from the previous cap of 200% FPL.

The District should continue to explore different ways to provide coverage to all residents. This could be accomplished by an expansion of public coverage, by working with the private sector to encourage private coverage, by educating the public on available and affordable insurance options, and by using the tax system to provide incentive to individuals as well as employers.

Specifically, the District should:

1. Identify the characteristics of the population that is currently enrolled in the public programs;
2. Improve outreach for the Alliance and Medicaid programs in order to facilitate enrollment of eligible residents;
3. Develop an information clearinghouse on health insurance products offered by the private insurance plans that are available to individuals and small businesses; the information will help individuals and businesses to identify plans which meet their health and financial needs; and
4. Continue to streamline the reimbursement process for both Medicaid and Alliance in order to attract qualified and specialty providers and to facilitate access to services by those who are already covered.

## **D. Environmental Health**

Over the last 50 years, progress has been made in understanding the effects of the environment on health and wellbeing of the population. Environmental health covers those characteristics of human health, disease and injury that are affected by factors in the environment. The environmental conditions that affect physical, social and psychological health include microscopic and chemical agents, such as particulate matter and lead. While individuals have some control over the personal aspects of their own lives, such as drinking, smoking, or exercising, they have little control over environmental hazards like the quality of the air, soil or the water supply. The government has an important role to play in bringing together individuals and the community in seeking to preserve the ecosystem and prevent and control environmentally related diseases.

Even though environmental health awareness has increased over the years, there are still gaps in our knowledge and understanding of environmental related diseases. Therefore, it is very important to develop the tools to understand the relationship between human health and the environment. It is particularly important to develop surveillance systems to track environmental exposures and to monitor the health status of the residents.

It is recommended that the Department of Health in cooperation with the Department of the Environment establish a comprehensive environmental public health program.

## **E. Health Data**

A vital prerequisite for building an efficient public health delivery system is a) having access to complete and accurate health information, and b) having the ability to communicate such information to required users in a timely and secure manner. Comprehensive and accurate health data is the foundation for the development of good health policy. Traditionally, health data in the District have been collected by various health care providers based on their perceived needs and on requirements established by federal and local governments. The absence of standard collection instruments and guidelines for data has resulted in the creation of databases with different electronic storage and management systems, varying data definitions, dissimilar coding of the same variables and other various inconsistencies.

It is recommended that DOH establish citywide standards for the collection and reporting of health data and improve data systems integration and client monitoring/tracking. This can be accomplished through the establishment of a data workgroup that will examine federal and local standards relating to health data and make a recommendation for the implementation of a new policy regarding collection of health data.

In particular, DOH needs to establish a Web-based Interactive Health Data Query System (WIHDS). The system should provide an opportunity for end users to make online requests for multiple years of specific and customized health reports for a number of leading health indicators. Efforts must be made to make the system operational by September, 2008.

## **F. Quality of Care**

The Department of Health should work closely with public and private organizations to identify priority areas for quality improvement. To promote transparency in the health care delivery system and provide the public with reliable information on quality of health services and providers, the Department of Health will utilize quality performance measures. Such measures should be based on already established national standards. A subset of performance measures that the Department will utilize is included in the Appendix.

## Overview of the Plan

Health planning embodies a systematic, consistent approach that ties activities to outcomes in measurable ways and thus, serves as a tool for guiding public resources and activities to improve health and health care services in the District.

In December 1989, the District of Columbia published a Comprehensive Health Plan. In contrast, the current State Health Plan is a strategic plan that sets out goals, identifies data-driven priorities for a specific time period, and institutes a process for managing and measuring progress. The Plan is thus part of a framework for focusing public resources most productively and efficiently.

The key long-term goals and accountability measures of the Plan are those established under Healthy People 2010<sup>1</sup>, Hospital Quality Measures developed by the Centers for Medicare and Medicaid Services (CMS), HEDIS<sup>®</sup> measures developed by the National Committee on Quality Assurance (NCQA), and Behavioral Risk Factor Surveillance System (BRFSS).

The Plan builds on the 1989 *Comprehensive Plan* and on *Healthy People 2010 Plan, Midcourse Revisions (2000-2005)*. It also incorporates work done at the Department of Health with the Healthcare Decisions Group in producing *Accomplishing the District of Columbia's Health Objectives: A Health System Plan for D.C.*

### New Approach for the Strategic Health Plan

The Plan is a concise document that is intended to serve as a guidebook and an accountability tool for the Department of Health and other stakeholders in the District. It outlines a management process that generates goals and performance measures for accomplishing the overall vision. The process will bring together stakeholders and Department officials on a periodic basis through a public-private advisory committee to discuss current needs data, develop health priorities and accountability measures based on that needs data, and target additional resources to address emerging priorities.

The Plan is a departure from traditional state health plans in that it is *not an end document*. Rather, the Plan will identify health priorities based on needs data for each year and a template for measuring progress towards established goals. In this way, the Plan will be specific enough to guide decisions but flexible enough to readily assimilate directives from new managers and respond to new city challenges. Its inclusive process represents a framework for accountability to traditional stakeholders and to District of Columbia leadership.

*The Plan directs the Department's focus to a manageable number of high-priority, achievable goals and related accountability measures. It functions as a tool not only for setting priorities for the short-term, but also for measuring progress toward goals over the long-term. In addition, it provides a framework for efficient budgeting and resource allocation on an ongoing basis.*

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<sup>1</sup> Most of the District's *Healthy People 2010* objectives are linked to federal Centers for Disease Control and Prevention's new Health Protection Goals which are organized under four themes: Healthy People in Every Stage of Life; Healthy People in Healthy Places; People Preparing for Emerging Threats; Healthy People in a Healthy World.

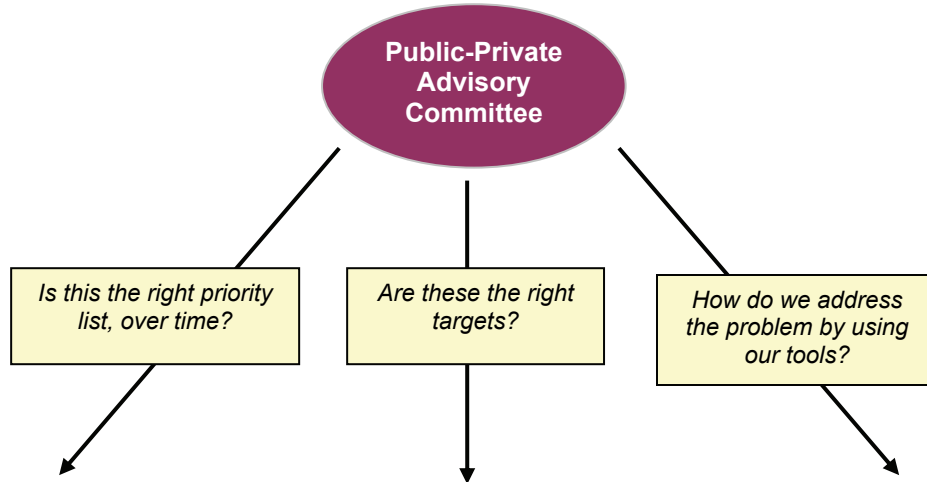
## *The Strategic Planning Process*

The management process is the critical difference between a comprehensive plan and a strategic plan. The process begins with identifying priorities based on the most current health needs data. In formal consultation with stakeholders, through the public-private advisory committee, the Department of Health will establish data-driven priorities for a given time period, and recommend actions to be undertaken utilizing the tools and resources the Department has at its disposal and resources available in the public sector. The priorities will be accompanied by a set of nationally recognized performance measures derived from National Hospital Quality Measures developed by the federal Centers for Medicare and Medicaid Services (CMS), Healthy People 2010, HEDIS<sup>®</sup> measures developed by the National Committee on Quality Assurance (NCQA), and Behavioral Risk Factor Surveillance System (BRFSS). The accountability measures will enable the Department to systematically track progress towards identified priorities.

The 1989 Plan included analyses of the recommended approaches for addressing problems and issues. Such analysis is incorporated in the current Plan in the form of public-private advisory committee made up of stakeholders, consumers, and experts, thus bringing together current practice and state-of-the-art in each area.



Figure 1: Strategic Planning Process *Example*



DATA-DRIVEN HEALTH PRIORITY	MEASURES*	TOOLS**
<p>Health Needs Data Indicates:</p> <ul style="list-style-type: none"> <li>8.3% of District residents diagnosed with diabetes as compared to national median of 7%</li> <li>African Americans (12.3%) are much more likely to be diagnosed with diabetes than Caucasians (2.3%)</li> <li>Direct correlation with poverty: just 3.5% of those with incomes of \$75,000 have been diagnosed with diabetes, compared to 14.1% of those with incomes of less than \$15,000</li> </ul> <p>Thus, Health Priority: <b>Prevent &amp; Control Diabetes</b></p>	<p><u>HEDIS Measures</u></p> <ul style="list-style-type: none"> <li>HbA1c (blood glucose) Testing</li> <li>Poor HbA1c Control</li> <li>Eye Exams</li> <li>Lipid Profile</li> <li>Lipid Control &lt;130</li> <li>Lipid Control &lt;100</li> <li>Monitoring Diabetic Nephropathy</li> </ul> <p><u>Healthy People 2010</u></p> <ul style="list-style-type: none"> <li>Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000</li> <li>Reduce the mortality rate due to diabetes as the primary cause of death among African-American residents to 30.0 per 100,000</li> <li>Increase to 75% of D.C. residents with diabetes report having their feet checked for sores or irritations</li> <li>Increase by 50% proportion of D.C. residents with diabetes who report at least one encounter with a health care professional regarding dietary counseling</li> </ul>	<ul style="list-style-type: none"> <li>Requiring <b>Insurance Programs</b> (Medicaid &amp; Alliance) to incorporate diabetes measures and report their performance; leveraging Pay-for-Performance; conduct diabetes and risk factor surveillance</li> <li>Engaging in partnerships and targeting <b>Public Health Grants</b>; asking the grantees to incorporate the diabetes measures and report the performance; conduct diabetes and risk factor surveillance</li> <li>Utilizing <b>Health Regulation/Health Professional Boards</b> in highlighting focus on improving and tracking diabetes and diabetes quality of care; establish standards of care reflective of the diabetes management and prevention activities</li> </ul>

Accountability Measures
<ul style="list-style-type: none"> <li>Healthy People 2010</li> <li>CMS Hospital Quality Measures</li> <li>NCQA HEDIS® Measures</li> <li>BRFSS</li> </ul>

Tools to Affect Change
<ul style="list-style-type: none"> <li>Insurance Programs (Medicaid &amp; Alliance)</li> <li>Public Health Grants</li> <li>Certificate of Need Program</li> <li>Health Professional Boards/Health Regulation</li> </ul>

## *A Vision for Better Health Planning*

Residents of the District of Columbia are healthier today than in earlier eras. Nonetheless, substantial improvement in health remains possible overall and particularly in reducing disparities, both in services and in outcomes. Too many residents die prematurely or live with avoidable impairments. Improving health is the key mission of the D.C. Department of Health, which works through its own programs, grants to private partners, and oversight of a number of private activities. The Department has broad responsibilities that in other jurisdictions are split between state and local health authorities. Given these broad responsibilities, effective planning and measurement of achievements are important to facilitate progress toward departmental and health system goals internally and in cooperation with others – in order to allocate resources effectively, account for its activities to its Federal grantors and to the District Council, and hold its grantees accountable.

Health services are an important factor in maintaining the health of District residents. Access depends both on ability to pay for useful services, as well as on having sufficient suppliers of service, both practitioners and institutions. Payment for personal health services mainly comes from insurance, but a significant share comes from patient out-of-pocket spending, even for insured people. In the District, a large share of spending on medical care is publicly financed through Medicaid and the D.C. Alliance.

Both Medicaid and the Alliance are administered by the Department of Health (DOH), as is the Certificate of Need program that oversees investments in health services and equipment, giving DOH a central role in the District's health care sector. The Department's interest in the distribution and right-sizing of health care facilities serves both the public at large and its own need to be a prudent purchaser of health care.

Despite the value of health services—and of insurance to pay for them and providers to supply them—health status and health outcomes are heavily influenced by other factors. Genetics, personal behavior, social circumstances, and environment are even more important determinants of residents' health status than is access to health care services. The Department's public health activities and preventive services are as important for keeping people healthy as curative services are to helping them get well if they get sick.

The Department's activities are organized into seven administrations, with separate but sometimes overlapping focus. Some are concerned with a particular population, others with a particular health condition. Still others provide core functions, such as data collection, that cut across all programs.

### **Blueprint for Better Health Outcomes and Reduced Disparities**

Given this document's strategic focus, the Plan does not seek to detail future health program and facility needs, which are not precisely foreseeable. Rather, it outlines an approach to planning for how best to identify and respond to shifting needs, priorities, and resources. It does not attempt to list all health needs, nor all health resources or interventions. Rather, it sets out a workable framework for effective planning, powered by information, within an ongoing process of decision-making. It is a blueprint for systematically identifying priorities and monitoring needs, objectives, and performance. Its success will flow from its effectiveness in supporting a continuous process of improvement.

## *Roadmap to the Strategic Plan*

The next section outlines the tools Department has at its disposal to effect change. The subsequent section provides an overview of the health status of District residents as an introduction to the most pressing health care needs facing the District and opportunities for action. The role of the Certificate of Need review process is discussed in greater detail in the third section. Finally, performance measures that will serve as accountability tools and a mechanism to track progress toward defined goals are listed in the Appendix.

## *Tools to Affect Change*

*Insurance Programs ▪ Grant-Making Policy  
Certificate of Need ▪ Health Professional Boards*

A key tool for advancing toward goals set by the planning process described above is to use **insurance programs** to generate information about participating health plans' performance and that of their participating health care providers. Once measurement is initiated and validated, incentives or controls will address how to improve performance. Such actions include providing performance information to existing and prospective enrollees, altering level of payment per enrollee based on performance, and disqualification of a participating insurance plan for sufficiently subpar performance. This process is already under way as part of implementing "pay for performance" for Medicaid managed care organizations (MCOs) within the Medical Assistance Administration of the Department. Medicaid and Alliance contracts with participating are to be modified to specify the operational details. The core of this effort is the HEDIS<sup>®</sup> measures widely used within the private sector (Figure 28). Other states have similarly modified sets of these measures already developed by National Committee on Quality Assurance.

Another available tool is **grant-making policy**. Both for population health and for individual-oriented services, the Department often operates through grants made to private recipients, from District own-source revenues and from federal grants. Through its grant making process, the Department of Health can direct funds toward priority projects and initiatives. Grantees include both medical services providers and non-governmental organizations. These partnerships allow the Department to work through diverse community organizations to reach a broad range of communities and constituencies.

Going forward, grant applicants will contribute to strategic planning by clarifying how their activities contribute to achieving goals and measures set by the planning process, and how best to track systematic progress toward those goals. New agreements with grantees will incorporate selected State Health Plan priority objectives and associated measures, and grantees will be held accountable for making progress toward those objectives. Similar efforts to incorporate measurable performance are under way for Medicaid agreements with participating MCOs, as noted.

The Department's State Health Planning and Development Agency (SHPDA), established by D.C. Official Code § 44-401, is responsible for the administration, operation and enforcement of the **Certificate of Need** (CON) review process. CON review process is another important tool the Department has at its disposal to direct healthcare resources toward data-driven health priorities, reflective of where the health needs are and where placement of healthcare resources is most likely be effective. The law requires that all persons proposing to offer or develop in the District a new institutional health service, or to obligate a capital expenditure to obtain an asset to be located in the District shall, prior to proceeding with that offering, development, or obligation, obtain from the SHPDA a CON that demonstrates a public need for the new service of expenditure. The CON review process, through public input and analysis of health data, can be used to improve the health of District of Columbia residents by increasing the accessibility, continuity, and quality of health services, restraining increases in health care costs, preventing unnecessary duplication of health resources, and maintaining and enhancing competition in the health service area.

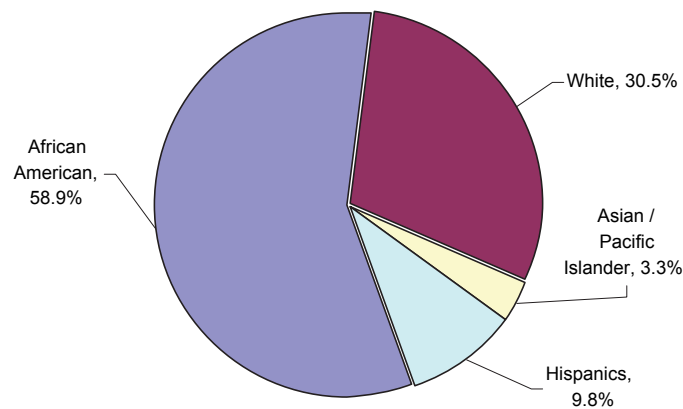
Utilizing **health professional boards** and **health regulation** is an additional tool the Department can employ in advancing toward goals set by the planning process. The Department currently provides administrative support to 18 health professional boards responsible for licensing, certification, registration and enforcement. As most U.S. health professionals are licensed, these boards have a large impact on the ongoing development of health professionals, particularly in the arena of continuing education. Licensure and certification can serve as a lever for ensuring that practicing health professionals meet specific standards reflective of current State Health Plan priorities, and are aware of Plan's goals and relevant measures. Boards can assist the Department in educating healthcare consumers by asking health professionals to incorporate public health messages and initiatives in their practices. In addition, boards can implore cooperation with private organizations in collecting epidemiological data that will further guide the development of data-driven health priorities and measures.

# Health Status of the District Residents

## Leading Health Indicators

This section provides an overview of the leading health issues that affect the health status of residents of the District of Columbia. The health status of the District of Columbia is a description of the health of its population. The information used to report health status comes from a variety of sources, including birth and death records; hospital discharge data; and health information collected from health care records, personal interviews, physical examinations, and telephone surveys.

Figure 2: Estimated Population by Race, District of Columbia, 2003



Source: \*US Census Bureau, <http://www.census.gov/acs/>,  
D.C. Department of Health, State Center for Health Statistics

Table 1: Health Status Indicators, District of Columbia, 2004	
1. Live births	7,937
2. Live birth rate per 1,000 population	13.9
3. Low weight live births/rate	881 / 11.1
4. Births to teenage mothers/rate	887 / 11.1
5. Births to unmarried women/rate	4,442 / 56.0
6. Total deaths	5,359
7. Crude death rate per 100,000 population	936.8
8. Infant deaths	94
9. Infant mortality rate per 100,000	11.8
10. Heart disease death rate per 100,000 population	227.6
11. Cancer death rate per 100,000 population	197.9
12. Hypertension death rate per 100,000 population	57.2
13. Cerebrovascular diseases death rate per 100,000 population	34.3
14. Homicide death rate per 100,000 population	31.1

Source: Department of Health, State Center for Health Statistics.

## Life Expectancy

As a health status indicator, life expectancy is a comparative measure of longevity and is often used to gauge the overall health of a population. Life expectancy is the average number of years remaining to be lived by those surviving to that age on the basis of a given set of age-specific rates of dying. Life expectancy at birth represents the average number of years that a group of infants would live if the infants were to experience throughout life the age-specific mortality rates in a given period (Anderson et al., NCHS, 2002). Life expectancy at birth is strongly influenced by infant and child mortality. According to census data, life expectancy at birth for the District of Columbia was 72.6 in 2000 compared to 77.0 for the U.S. This was the lowest compared to all states. Neighboring states such as Maryland (76.3) and Virginia (76.9) were slightly below the national average.

There are marked differences in life expectancy at birth by race and gender for the total population of the U.S., with females tending to live longer than males and Whites living longer than Black/African Americans. For the U.S. in 2000, life expectancy for females was 79.5 years, while life expectancy for males was 74.1 years. Therefore females, on the average, lived 5.4 years longer than males. In 2000, life expectancy for Whites was 77.4 years compared with the life expectancy for Black/African Americans which was 71.7 years, a difference of 5.7 years between the White and Black/African American populations.

Among the four major race-gender groups (Table 4), White females continued to have the highest life expectancy at birth (80.0 years), followed by Black/African American females (74.9 years), White males (74.8 years), and Black/African American males (68.2 years). Between 1999 and 2000, life expectancy increased 0.4 year for Black/African American males from 67.8 years in 1999 to 68.2 in 2000. Black/African American males experienced annual increases in 1990-1992 and 1994-2000 (NCHS, 2002). Life expectancy for Black/African American females climbed from 74.7 years in 1999 to 74.9 years in 2000, an increase of 0.2 year. From 1999 to 2000, life expectancy for White males increased 0.2 year from 74.6 years to 74.8 years. White female life expectancy increased during the same period by 0.1 year from 79.9 years to 80.0 years. Overall, the largest gain in life expectancy between 1980 and 2000 was for Black/African American males (4.4 years).

Table 2. Life Expectancy at Birth by Race and Gender:  
U.S., 2000 and D.C., 1989-1991

	All Races			White			Black/African American		
	Total	Male	Female	Total	Male	Female	Total	Male	Female
<b>U.S.</b>	76.7	73.9	79.4	77.3	74.6	79.9	71.4	67.8	74.7
<b>D.C.</b>	68.0	62.0	74.2	76.1	71.4	81.1	64.4	57.5	71.6

Source: Deaths: Final Data for 2000. National Vital Statistics Reports; vol 50 no 15. Hyattsville, Maryland: National Center for Health Statistics. 2002.

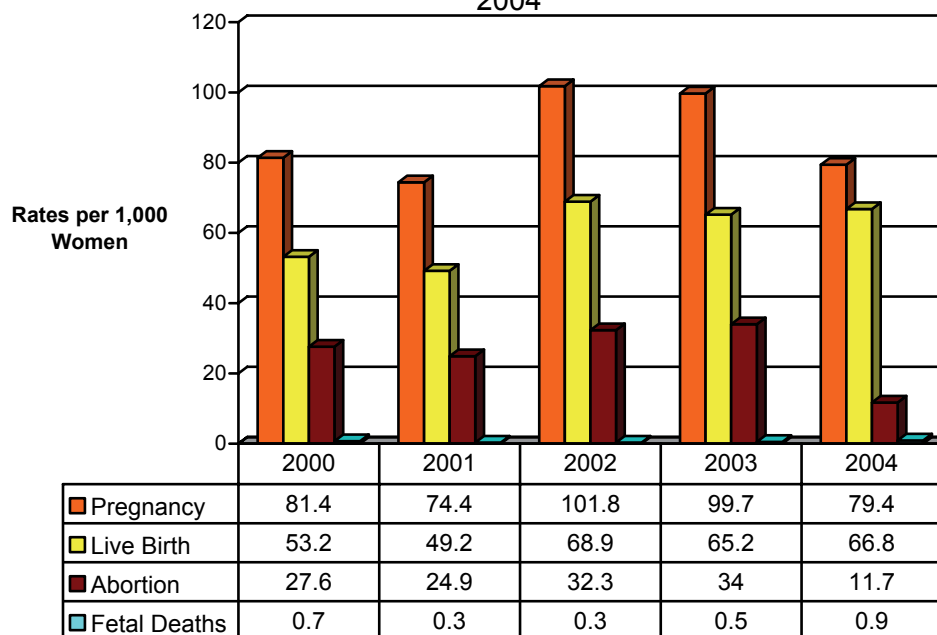


## Pregnancy and Pregnancy Rates

A pregnancy can have one of three outcomes: a live birth, an induced abortion, or a fetal death. The number of pregnancies is the sum of live births, legally induced abortions, and fetal deaths. Abortion reporting is voluntary in the District of Columbia. The Department of Health does not receive reports on abortions performed in private physicians' offices. Reported pregnancies decreased 16.9 percent and pregnancy rates decreased 12.2 percent between 2000 and 2004. Pregnancy rates decreased each year during the five-year period except for 2003, when the rate increased by 2.1 percent from 2002. The 9,118 pregnancies reported to the Department of Health in 2004 were 10.0 percent fewer than the 10,126 pregnancies reported in 2003. The pregnancy rate, which decreased by 8.5 percent between 2003 and 2004, decreased from 73.2 pregnancies per 1,000 women aged 15-44 years in 2003 to 67.0 in 2004. Pregnancy rates decreased between 2003 and 2004 for women 15-19 years, 20-24 years, 25-29 years, and 30-34 years of age. The pregnancy rate for 35-39 year old women and women 40 years and older increased almost equally, 7.1 percent and 0.5 percent, respectively between 2003 and 2004.

The teenage pregnancy rate for 2004 was 79.4 pregnancies per 1,000 women aged 15-19 years, slightly greater than the teen birth rate in that year (66.8). The teenage pregnancy rate decreased 20.4 percent from 2003 to 2004. This decrease in the 2004 teen pregnancy rate is consistent with the decrease in the reported number of abortions among teenagers. Live births and fetal deaths to teens increased in 2004 (Figure 6). The pregnancy rates for teenagers aged 15-17 years and 18-19 years were 67.9 per 1,000 women aged 15-17 years (19.1 percent decrease between 2003 and 2004) and 88 per 1,000 women aged 18-19 years (21.1 percent increase between 2003 and 2004), respectively.

Figure 3. Pregnancy, Live Birth, Abortion and Fetal Death Rates for Teenagers 15-19 years: District of Columbia, 2000-2004



Source: D.C. Department of Health, State Center for Health Statistics.

## Mortality

This section presents information on mortality from the District of Columbia vital records system. In 2004, there were 5,359 deaths to residents of the District of Columbia. This represented a crude death rate of about 933.3 per 100,000 and an age-adjusted rate of approximately 955.3 per 100,000. The age-adjusted death rate eliminates the effects of the aging of the population per 100,000 U.S. standard population.

The District's crude and age-adjusted death rates are higher than the national rate but have been declining since 1994. The crude death rate for the United States in 2004 was 816.7 per 100,000 and the age-adjusted death rate was 801.1 per 100,000. In the District, the 2004 crude rate for males (1,006.2 per 100,000) was considerably higher than for females (868.6 per 100,000), and the 2004 rate for Blacks/African Americans (1,220.2 per 100,000) was significantly higher than for Whites (1,088 per 100,000) (Table 6).

Table 3. Death Rate\* for All Causes by Race and Sex; District Residents, 2004

	All Races		White		Black		Other	
	Number	Rate*	Number	Rate*	Number	Rate*	Number	Rate*
<b>Both Sexes</b>	5,359	955.3	1,095	617.8	4,200	1,220.2	62	158.2
<b>Males</b>	2,719	1,006.2	559	629.7	2,128	1,362.9	32	164.1
<b>Females</b>	2,640	868.6	536	606.0	2,072	1,101.9	32	152.3

\*Crude Rate per 100,000 population.

Source: D.C. Department of Health, State Center for Health Statistics.

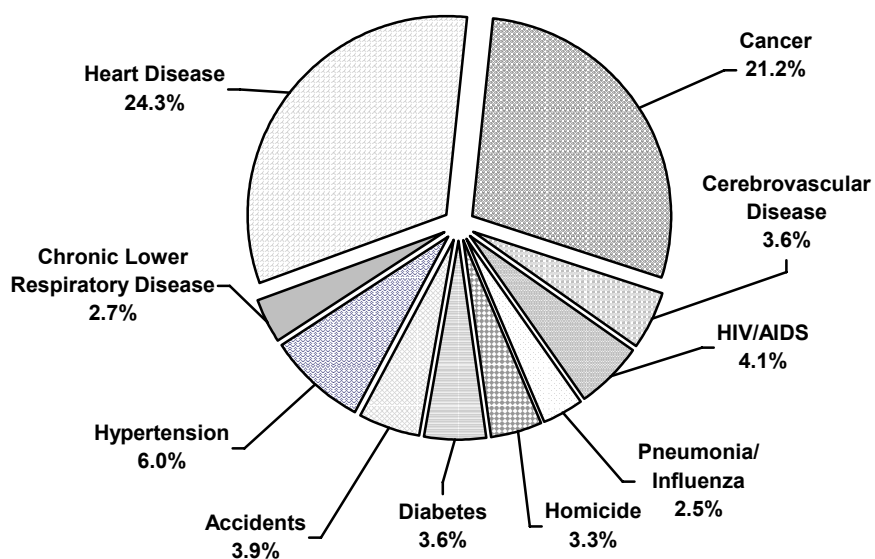
## Ten Leading Causes of Death

*In an era of consistently rising healthcare costs and limited healthcare budgets, the analysis of leading mortalities presents an opportunity to allocate healthcare resources for prevention and treatment to areas where these resources are most needed and where they are also most effective.*

Over time, with the advance of medicine and medical technology, populations are predominantly affected by varying types of illness and death. Ranking the leading causes of death is one way of keeping track of those conditions that affect the population the most at any moment in time. Even though causes-of-death is just one indicator of the health status of a given population, it is the most severe indicator and is deserving of its place in health priority.

Leading causes-of-death and leading morbidities may vary by factors such as age, race and ethnicity, gender, income, geographic location and access to healthcare resources.

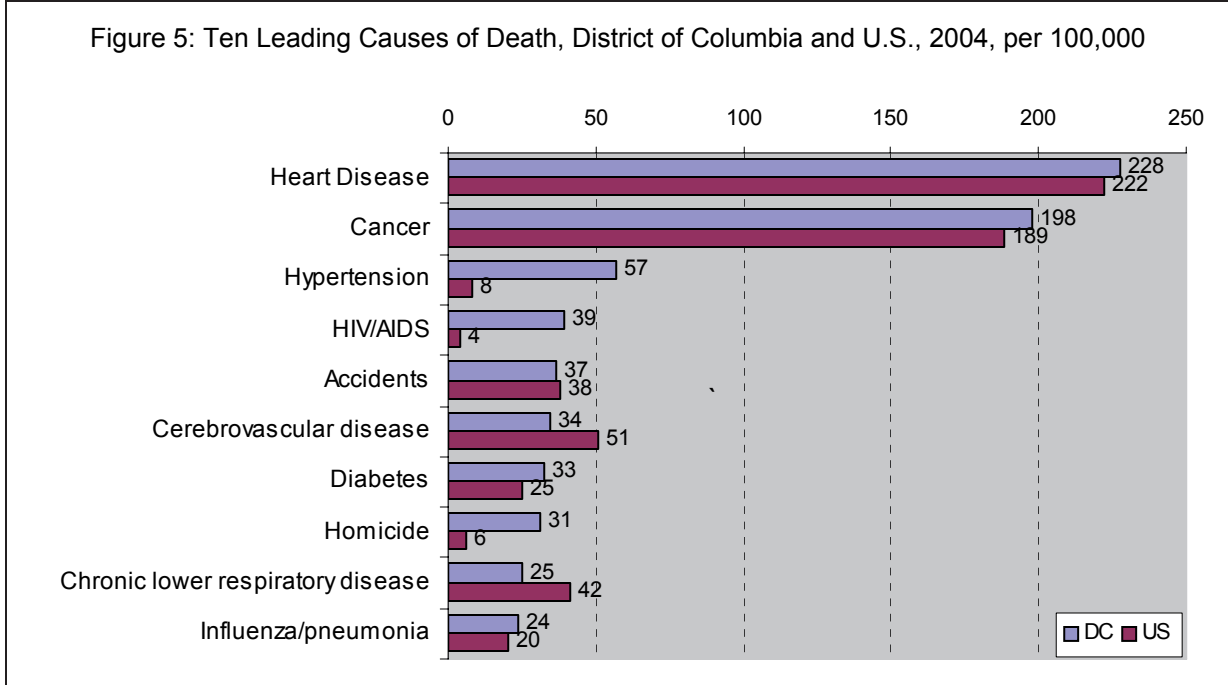
Figure 4: Ten Leading Causes of Death in the District of Columbia, 2004



Source: D.C. Department of Health: State Center for Health Statistics, 2004

Available data show that Heart Disease, Cancer (all sites), Hypertension, HIV/AIDS, Cerebrovascular Disease (Stroke), Injuries, Homicide, Diabetes, Influenza/ Pneumonia, and Chronic Respiratory Disease are the leading causes of death in the District. Infant mortality is another important indicator of the health status of District residents. For some of these conditions, such as Stroke and Chronic Lower Respiratory Disease, rates are lower in the District than in the nation as a whole. For others, such as HIV/AIDS and Hypertension, the rates are much higher. Within the District, mortality rates vary, sometimes widely, across wards, with some rates above the national level and others below.

For the District of Columbia, the ten leading causes of death account for over 70 percent of deaths for all causes in 2004. The two leading killers, Heart Disease and Cancer combined to account for 45.6 percent of all deaths in the District for 2004. However, it is important to note that District's Heart Disease and Cancer Rates are relatively close to national rates and are among the lowest when appropriately compared (see Figure 8, 9 and 10).



The main difference between the ten leading causes of death for the District of Columbia and the U.S. as a whole is the inclusion of HIV/AIDS as the fifth leading cause of death for the District and its exclusion from the top fifteen causes for the country. Another major difference between the District and the U.S. is that Hypertension ranks third among all causes for the District and is the thirteenth leading cause for the nation. Further, the District's homicide rates are drastically higher than those in the nation.

Two factors should be considered when comparing the District death rates for HIV/AIDS and Hypertension with the U.S. or other jurisdictions. First, the District is an urban jurisdiction with a minority population proportion of over 70 percent. Death rates tend to be higher for urban jurisdictions throughout the U.S. and it is well established that the death rates for African-Americans and other minorities significantly exceed the death rates for Whites in the U.S. for many of the leading causes of death. The national HIV/AIDS death rate for Whites in 2003 was 2.5 per 100,000 compared to that of African-Americans at 21.8 per 100,000. The death rate in the U.S., due to hypertension, was 7.6 per 100,000 in 2004. However the rate for African-Americans was almost three times the rate for Whites. Other leading causes of death for the District tend to exceed the national rates for similar reasons.

A more relevant comparison of death rates is between the District and other large cities. The Big Cities Health Inventory (compiled by the Chicago Health Department for the National Association of County and City Health Officials) shows mortality rates for the 47 largest cities in the country. Of these 47, eight including the District are majority African-American. Since race is correlated with the prevalence of many of these conditions, these cities represent an informative comparison group for the District.

Figure 6: Heart Disease Rates in Selected Big Cities, 2000

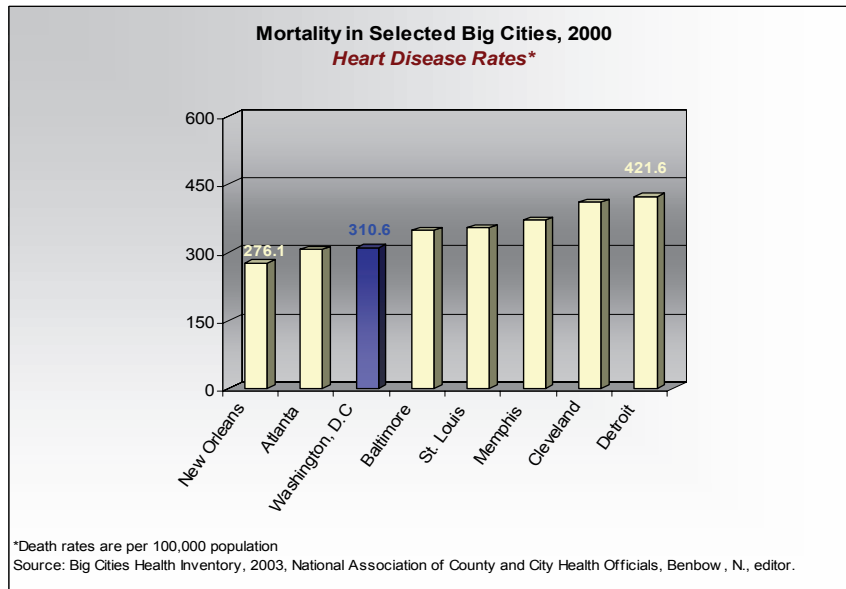


Figure 7: Cancer Rates in Selected Big Cities, 2000

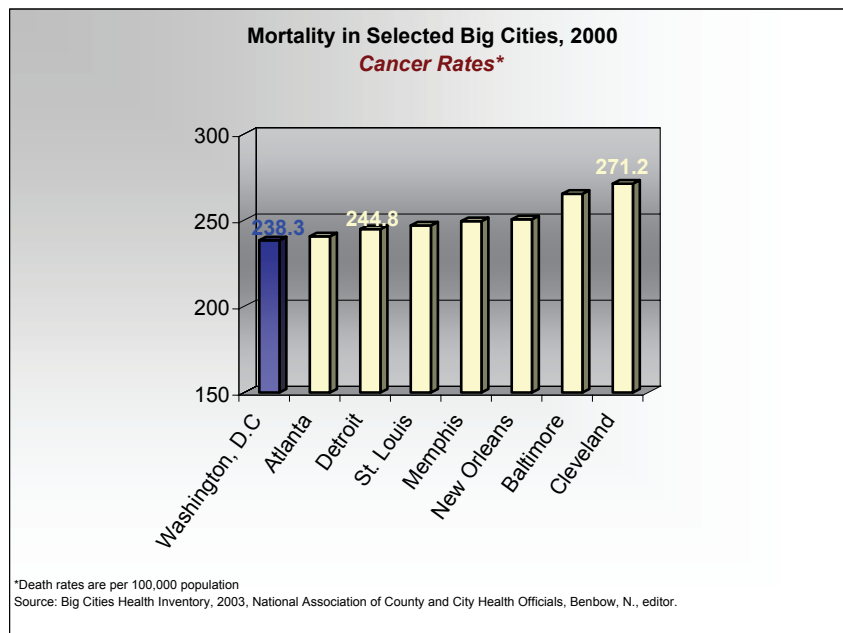


Figure 8: HIV/AIDS Rates in Selected Big Cities, 2000

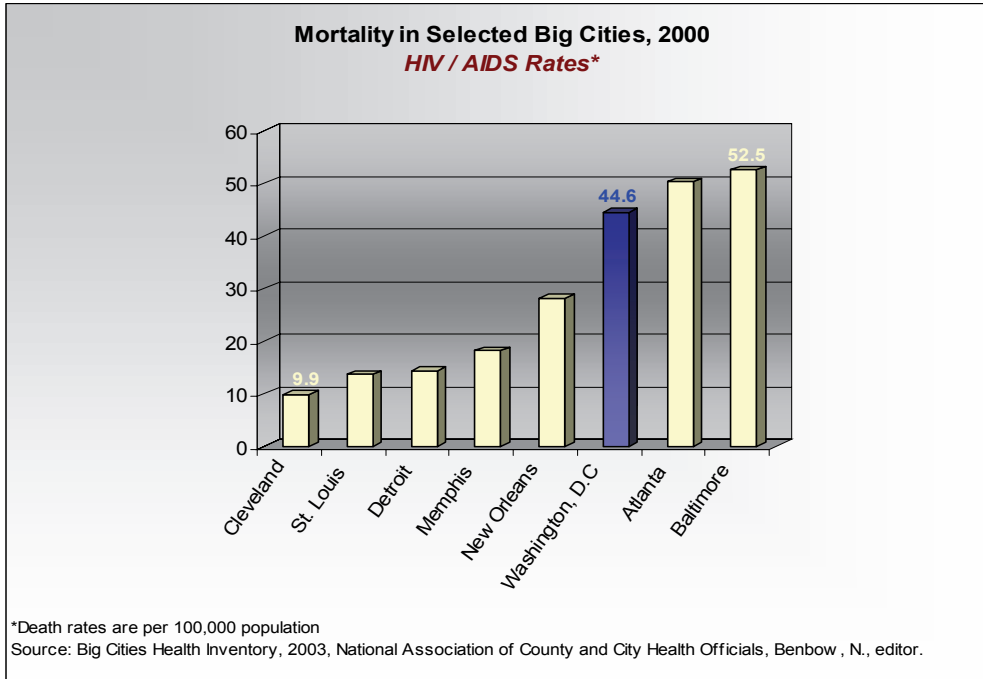
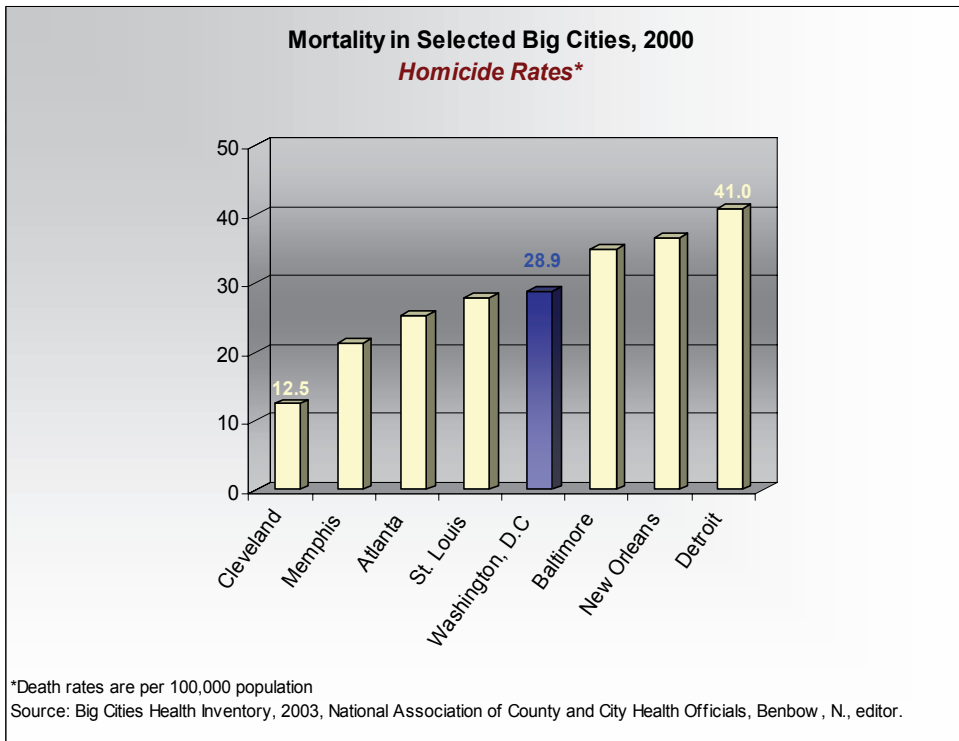


Figure 9: Homicide Rates in Selected Big Cities, 2000



## Gender and Geographical Differences on Causes of Death

Analysis of the ten leading causes of death for the District of Columbia by gender does not reveal substantial differences in the rates for heart disease. The heart disease death rate for males was 224.6 per 100,000 population and was only slightly higher for females at 229.9 per 100,000 (Table 12). Cancer death rates reflected greater variation by gender with the rate for males recorded at 216.1 per 100,000 while the rate for females was about 16 percent lower at 181.7 per 100,000. Another notable difference in death rates between men and women in the District was observed for HIV/AIDS where the male death rate was 53.1 per 100,000 and the female death rate at 26.4 per 100,000. Additionally, the death rates for males in the District exceeded those for females in seven out of the ten leading causes of death, with the rates for women exceeding those for men for Cerebrovascular Diseases, Diabetes and Influenza/Pneumonia.

Table 4. Ten Leading Causes of Death by Gender: District Residents, 2004

Cause of Death	Total		Male		Female	
	Number	Rate*	Number	Rate*	Number	Rate*
1. Heart Disease	1302	227.6	605	224.6	696	229.9
2. Cancer	1132	197.9	582	216.1	550	181.7
3. Hypertension	327	57.2	166	61.6	160	52.9
4. HIV/AIDS	224	39.2	143	53.1	80	26.4
5. Accidents	211	36.9	143	53.1	67	22.1
6. Cerebrovascular Diseases	196	34.3	82	30.4	114	37.7
7. Diabetes	187	32.7	81	30.1	106	35.0
8. Homicide	178	31.1	156	57.9	22	7.3
9. Chronic Lower Respiratory	145	25.3	70	26.0	75	24.8
10. Influenza/Pneumonia	137	23.8	64	23.4	72	23.8

\*Rates are per 100,000 population.

Source: D.C. Department of Health, State Center for Health Statistics, 2004



*Analysis of the distribution of the ten leading causes of death by Wards provides a high level indicator of the geographic location and severity of specific health conditions. The ward level analysis is a useful guide in targeting health policies and resources in the District of Columbia.*

Table 5. Top Ten Leading Causes of Death by Ward, District Residents, 2004

CAUSE OF DEATH	Total	Wards of Residence							
		Ward 1	Ward 2	Ward 3	Ward 4	Ward 5	Ward 6	Ward 7	Ward 8
POPULATION	572,059	80,014	82,845	79,566	71,393	66,548	65,457	64,704	61,532
HEART DISEASE Rates	1,301 227.4	105 131.2	142 171.4	178 223.7	218 305.4	202 303.5	138 210.8	194 299.8	115 186.9
CANCER Rates	1,132 197.9	114 142.5	140 169.0	135 169.7	207 289.9	167 250.9	115 175.7	164 253.5	82 133.3
ESSENTIAL HYPERTENSION Rates	326 57.0	34 42.5	45 54.3	32 40.2	45 63.0	56 84.1	34 51.9	43 66.5	37 60.1
HIV/AIDS Rates	223 39.0	34 42.5	25 30.2	2 2.5	16 22.4	44 66.1	23 35.1	34 52.5	42 68.3
ACCIDENTS Rates	210 36.7	18 22.5	20 24.1	17 21.4	32 44.8	33 49.6	23 35.1	32 49.5	32 52.0
CEREBROVASCULAR DISEASES Rates	196 34.3	13 16.2	16 19.3	25 31.4	38 53.2	29 43.6	20 30.6	30 46.4	22 35.8
DIABETES Rates	187 32.7	15 18.7	13 15.7	13 16.3	25 35.0	36 54.1	20 30.6	44 68.0	21 34.1
HOMICIDE Rates	178 31.1	8 10.0	4 4.8	1 1.3	21 29.4	34 51.1	31 47.4	36 55.6	41 66.6
CHRONIC LOWER RESPIRATORY Rates	145 25.3	10 12.5	23 27.8	19 23.9	30 42.0	20 30.1	15 22.9	20 30.9	8 13.0
INFLUENZA/PNEUMONIA Rates	136 23.8	12 15.0	16 19.3	13 16.3	25 35.0	25 37.6	8 12.2	25 38.6	10 16.3

\*Crude death rates are per 100,000 population. Numbers may not add to totals due to rounding and unknowns.  
Source: D.C. Department of Health, State Center for Health Statistics Administration, 2004.

## **Premature Deaths**

Chronic diseases, including Heart Disease, Stroke, Cancer, and Diabetes, account for more than 50 percent of all deaths in the District of Columbia. Today, Influenza and Pneumonia and HIV/AIDS are the only remaining infectious diseases accounting for a significant percentage of deaths in the District. In an analysis of the death certificate data in 2004, more than one-half of all deaths of District residents occur before the age of 75. In 2004, the average life expectancy at birth for the United States was 77.9 years; therefore, any death occurring before the age of 76 can be considered premature.

The average life expectancy for D.C. residents in 2004 was 72.0 years. In 2004, a total of 2,847 or 53 percent of all resident deaths occurred before age 75 years. Cardiovascular Diseases (i.e., heart disease and diseases of the arteries) and Cancer accounted for 40.0 percent of premature deaths in 2004. These two major causes combined with infant mortality, HIV/AIDS, accidents, homicide, Hypertension, and Diabetes account for 78.6 of all premature deaths.

The leading causes of premature mortality in the District of Columbia follows a slightly different pattern from the leading causes of death for all ages (Table 9, next page). In 2004, Cancer was the leading cause of premature mortality, followed by Heart Disease, HIV/AIDS, accidents, and homicide/assault. These five leading causes accounted for 60.1 percent of all premature deaths.

The leading causes of premature deaths in the 1-14 year age-group was accidents which accounted for 25.9 percent of deaths for the age group. Congenital Anomalies accounted for another 18.5 percent of deaths in this age group followed by HIV/AIDS at 14.8 percent and homicide/assault at 14.8 percent also. Nationally, accidents also accounted for most deaths (38 percent) in the 1-14 age group. In the 15-19 year age group, homicide accounted for about 77.5 percent of all deaths in this age group. This is followed by accidents (15 percent) and all other causes amounting to 7.5 percent. For the U.S., accidents accounted for the most deaths in this age group at 46 percent followed by assault (homicide) at 13 percent.

Homicide accounted for most deaths (68.5) in the 20-24 year age-group in 2004. Suicide followed with 9.6 percent and accidents account for 5.5 percent. In the 25-44 years age-group, HIV/AIDS is the leading cause of death with 19.90 percent, followed by homicide/assault at 12.7 percent, Cancer at 12.0 percent and 11.3 percent. At the national level, accidents were again the major cause at 22.7 percent, followed by Malignant Neoplasms at 14.6 percent and suicide at 12.6 percent.

For the 45-64 years age-group the leading cause of death for the District in 2004 was Cancer which accounted for 26.2 percent, followed by Heart Disease at 18.1 percent, HIV/AIDS at 7.4 percent and Accidents at 5.1 percent. The 65-74 year age-group featured Heart Disease as the leading cause at 33 percent of the total. Nationally, the 45-65 year old age group documented Malignant Neoplasms as the leading causes of death, and the 65 years and over age group listed Heart Disease as the leading cause of death.

Perhaps the most glaring example of premature deaths occurs to infants before their first birthday. These deaths receive special attention in the health field because of the innocence and the sensitivity to the tragic loss of life. Infant mortality is treated as a separate health topic when analyzing deaths and deservedly so.

**Table 6. Leading Causes of Premature Deaths Under 75 Years of Age:  
District of Columbia Residents, 2004**

<b>Cause and Rank</b>	<b>Number</b>	<b>Percent*</b>	<b>Cause and Rank</b>	<b>Number</b>	<b>Percent*</b>
<b>All Causes &lt;75 Years</b>	2,847	100.0	<b>All Causes 25-44 Yrs</b>	457	100.0
1. Cancer	652	22.9	1. HIV/AIDS	109	23.9
2. Heart Disease	486	17.1	2. Homicide/Assault	69	15.1
3. HIV/AIDS	223	7.8	3. Cancer	51	11.2
4. Homicide/Assault	172	6.0	4. Accidents	45	9.8
5. Accidents	162	5.7	5. Heart	36	7.9
Other causes	1,152	40.5	Other Causes	147	32.2
<b>All Causes 1-14 Yrs</b>	30	100.0	<b>All Causes 45-64 Yrs</b>		
1. Cancer	7	23.3	1. Cancer	1,290	100.0
2. Accidents	7	23.3	2. Heart	331	25.7
3. Homicide/Assault	4	13.3	3. HIV/AIDS	216	16.7
4. HIV/AIDS	2	6.7	4. Accidents	99	7.7
Other causes	10	33.3	5. Hypertension	79	6.1
<b>All Causes 15-19 Yrs</b>	48	100.0	Other Causes	79	6.1
1. Homicide (Assault)	37	77.1	<b>All Causes 65-74 Yrs</b>	486	37.7
2. Accidents	6	12.5	1. Cancer	871	100.0
3. Heart	2	4.2	2. Heart	261	30.0
Other Causes	3	6.3	3. Hypertension	229	26.3
<b>All Causes 20-24 Yrs</b>	66	100.0	4. Cerebrovascular Diseases	68	7.8
1. Homicide (Assault)	37	56.1	5. Diabetes	39	4.5
2. Accidents	11	16.7	Other causes	36	4.1
3. Heart	3	4.5		238	27.3
Other causes	15	22.7			

\*Does not add to 100% due to rounding.

Source: D.C. Department of Health, State Center for Health Statistics Administration.

Updated: August 1, 2006.

## Infant Mortality

There has been an overall declining trend in the infant mortality rate over the past ten years from 1995 to 2004. During this ten-year period, the number of infant deaths declined from 145 in 1995 to 94 in 2004 resulting in an overall decline in the District's infant mortality rate of 26.7 percent between 1995 and 2004. There were 51 fewer infant deaths in 2004 compared to 1995 and there were 1,056 fewer live births in 2004 compared to 1995. Table 15 presents a ten-year summary of these statistics.

Table 7: Ten-Year Infant Mortality Trends District of Columbia Residents, 1995-2004			
Year	Births	Infant Deaths	Infant Mortality Rate*
1995	8,993	145	16.1
1996	8,377	121	14.4
1997	7,916	104	13.1
1998	7,678	96	12.5
1999	7,513	113	15.0
2000	7,666	91	11.9
2001	7,621	81	10.6
2002	7,494	86	11.5
2003	7,616	78	10.2
2004	7,937	94	11.8

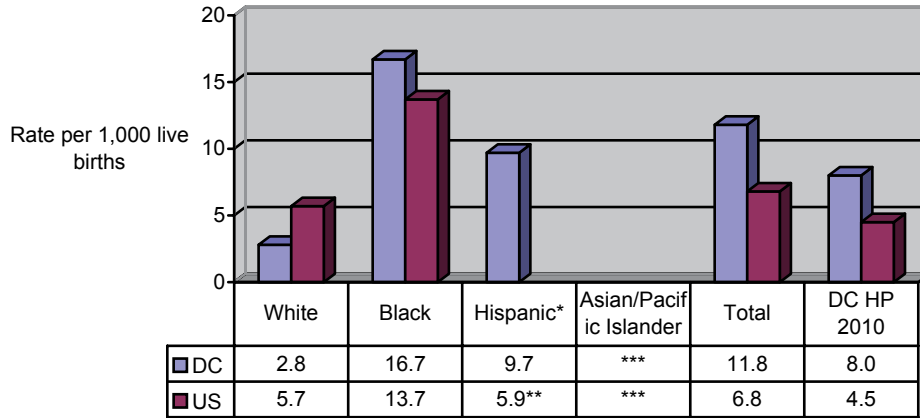
\* Per 1,000 live births

Source: D.C. Department of Health, State Center for Health Statistics.

In 2004, there were 7,937 live births and 94 infant deaths to District of Columbia residents. This resulted in an infant mortality rate of 11.8 deaths for every 1,000 live births. In 2003, there were 7,616 live births and 78 infant deaths. The infant mortality rate for 2003 was 10.2 deaths per 1,000 live births. There were 16 more infant deaths in 2004 than in 2003 and 321 more births to District women in 2004 as compared to 2003. Ward 3 had the lowest infant mortality rate at 1.0 death per 1,000 live births and Ward 7 had the highest infant mortality rate at 22.3 deaths per 1,000 live births.

Of the 94 infant deaths that occurred in 2004, 66 (or 70.2 percent) occurred during the neonatal period (under 28 days of life). The neonatal death rate increased by 22.1 percent from 6.8 per 1,000 live births in 2003 to 8.3 per 1,000 live births in 2004. The neonatal period is important relative to efforts to reduce infant mortality. Many of the causes of infant deaths during this period may have been mitigated or prevented with preconception and prenatal care.

Figure 10 : Infant Mortality Rates for the District of Columbia and the United States, 2004



Source: D.C. State Center for Health Statistics. National Center for Health Statistics.

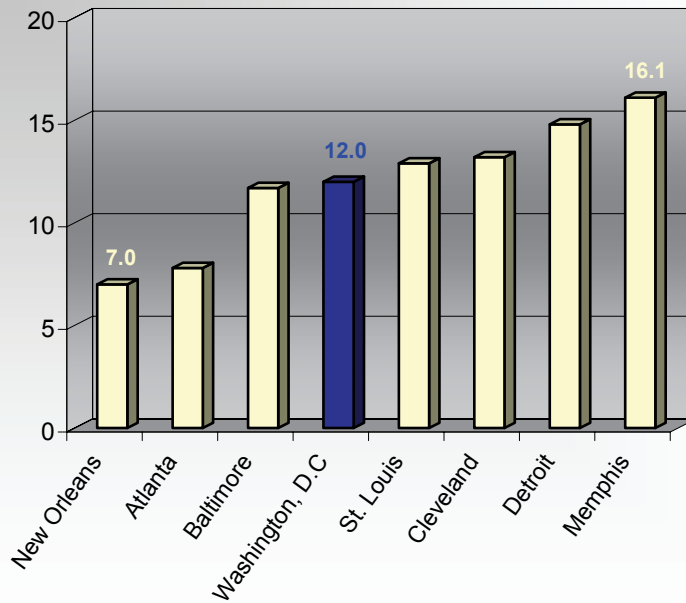
\*Hispanics include persons of all Hispanic origin of any race.

\*\* US rate based on 2003 data.

\*\*\*Rates not computed due to small number of infant deaths and, therefore, are likely to be unstable.

Figure 11: Infant Mortality in Selected Big Cities, 2000

Infant Mortality Rates\*



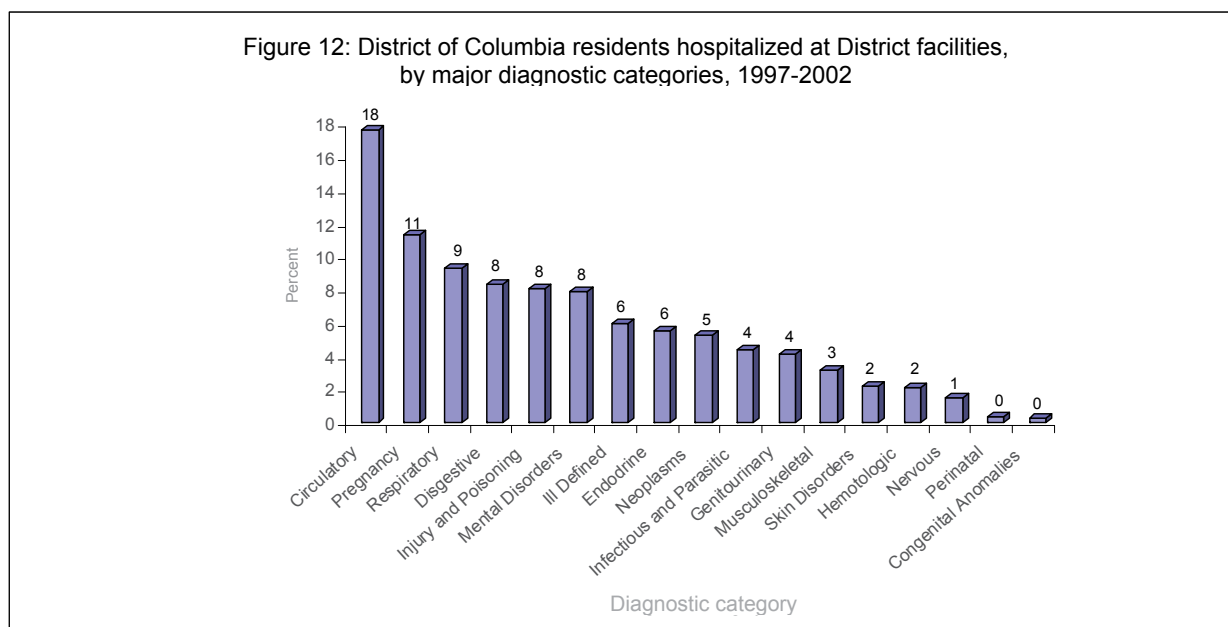
\*Death rates are per 100,000 population

Source: Big Cities Health Inventory, 2003, National Association of County and City Health Officials, Benbow, N., editor.

## Morbidity

*Ranking the leading prevalence of a disease in a population, in concert with mortality data, provides an insight into those conditions that affect the population the most at any moment in time. An analysis of leading morbidities presents an opportunity to allocate healthcare resources for prevention and treatment to areas where these resources are most needed and where they are most likely to make a difference.*

This section presents information on morbidity from the Department of Health, State Center for Policy, Planning and Epidemiology and Medical Assistance Administration.



Diseases of the circulatory system (18%) were consistently the leading causes of hospitalizations for District residents during the period from 1997-2002. With the exception of complications of pregnancy, childbirth and puerperium, diseases of the circulatory system hospitalizations occurred twice as often as any other category. Overall, the remainder of the top ten leading causes of hospitalizations among District residents were complications of pregnancy, childbirth and puerperium (11%), diseases of the respiratory system (9%), diseases of the digestive system (8%), injury and poisoning (8%), mental disorders (8%), symptoms, signs, and ill-defined conditions (6%), endocrine, nutritional, and metabolic and immunity disorders (6%), neoplasms (5%), and infectious and parasitic diseases (4%). Three percent (3%) of the major diagnostic categories were undefined.

When looking at women only, the pregnancy complications category was the leading cause of hospitalizations (20%), followed closely by diseases of the circulatory system (17%). Diseases of the respiratory and digestive systems consistently ranked third and fourth, but occurred at half the frequency of circulatory diseases. During the study period, the diagnostic categories ranked from 5-10 fluctuated. For example, injury and poisonings ranked fifth in 1997, 1998, 2000 and 2002; and sixth in 1999 and 2001. In a like manner, mental disorders rose from seventh in 1997

to sixth in 2002 with a peak of fifth in 1999. In contrast, neoplasms steadily decreased from sixth in 1997 to ninth in 2002.

Among men only, circulatory diseases consistently ranked highest for the 1997-2002 surveillance period. Injury and poisonings, the second overall leading cause of hospitalizations for men, rose from third in 1997 to second in 2002. The third ranked diagnostic category for men was diseases of the respiratory system, which dropped from second in rank in 1997 to fourth in rank in 2002. Hospitalizations due to mental disorders rose in rank from fifth to third within the surveillance period. Diseases of the digestive system have consistently ranked fifth as a cause of hospitalization from 1998 to 2002. Proportionately, ill-defined conditions rose from a rank of seventh in 1997 to sixth in 2000-2002. Endocrine, nutritional, metabolic, and immunity disorders rose in rank from eighth to seventh during the surveillance period. Infectious and parasitic diseases decreased in rank from sixth to eighth. Hospitalizations due to neoplasms for males, like their female counterparts, ranked ninth.

Figure 13: Leading Hospital Discharge Diagnosis by Gender, Spatial Distribution  
*Circulatory System*

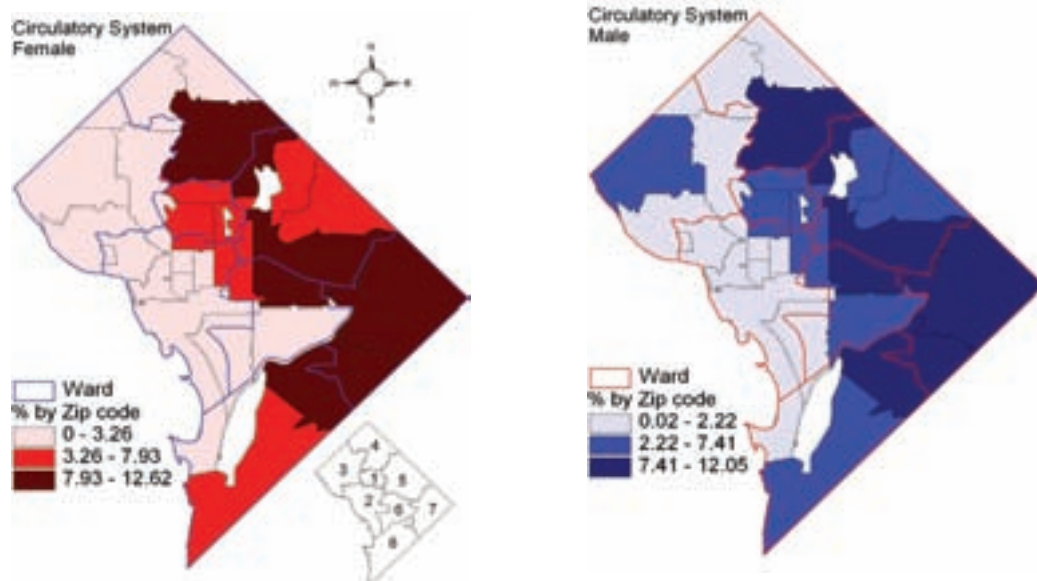




Figure 14: 2<sup>nd</sup> Leading Hospital Discharge Diagnosis  
by Gender, Spatial Distribution  
*Respiratory System/Injury & Poisoning*

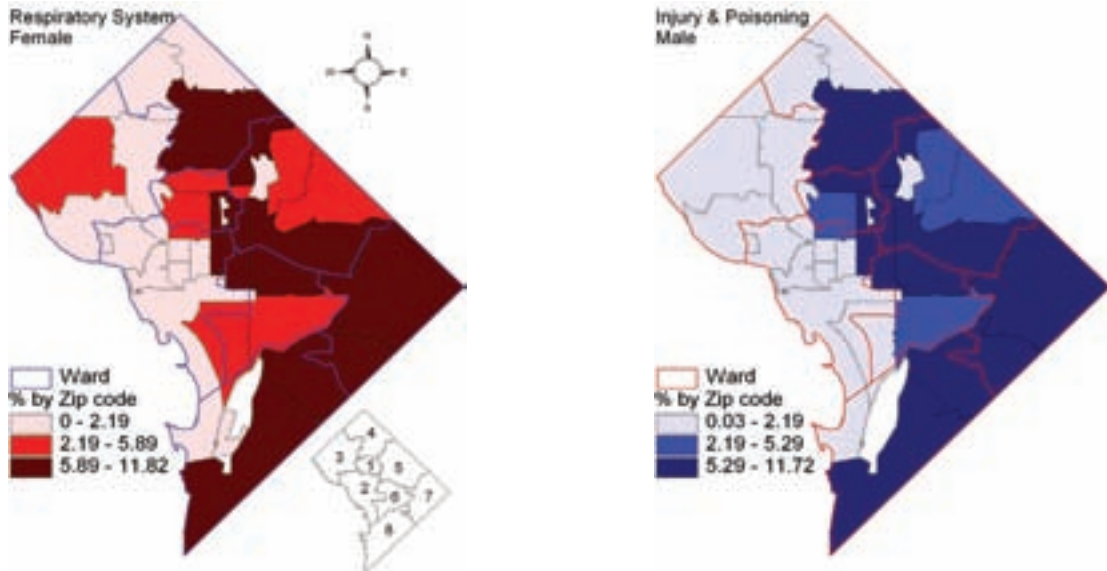


Figure 15: 3<sup>rd</sup> Leading Hospital Discharge Diagnosis  
by Gender, Spatial Distribution  
*Digestive System/Mental Health*

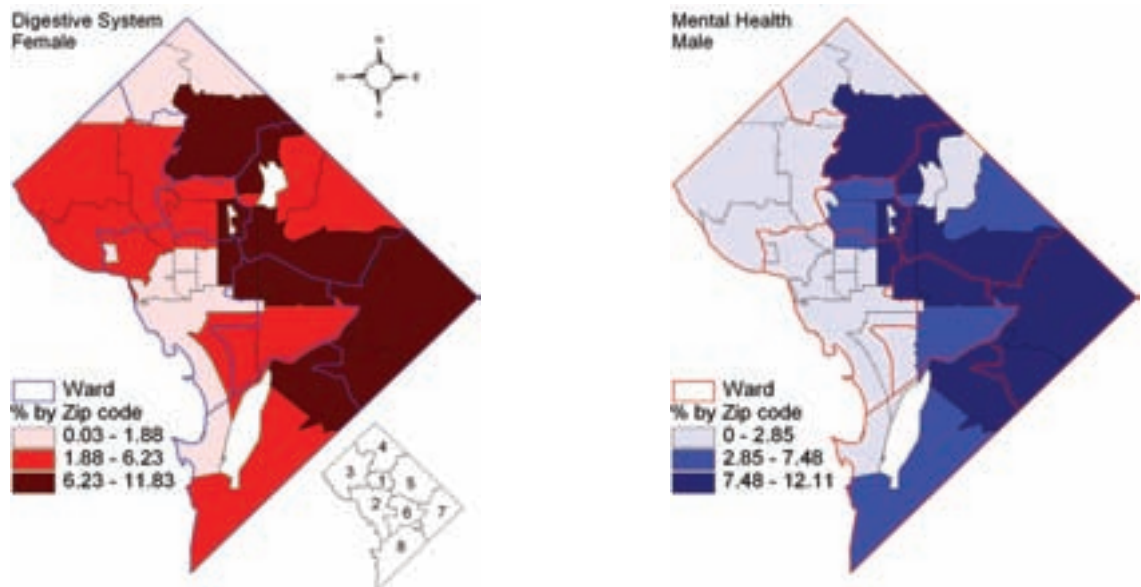




Figure 16: 4th Leading Hospital Discharge Diagnosis  
by Gender, Spatial Distribution  
*Injury & Poisoning/Respiratory System*

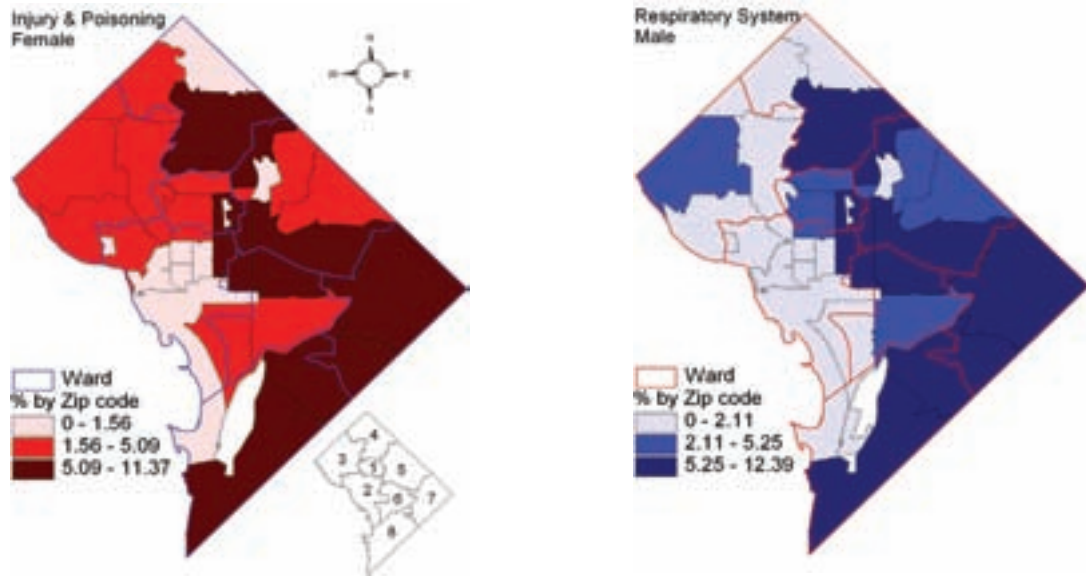


Figure 17: 5th Leading Hospital Discharge Diagnosis  
by Gender, Spatial Distribution  
*Mental Health/Digestive System*

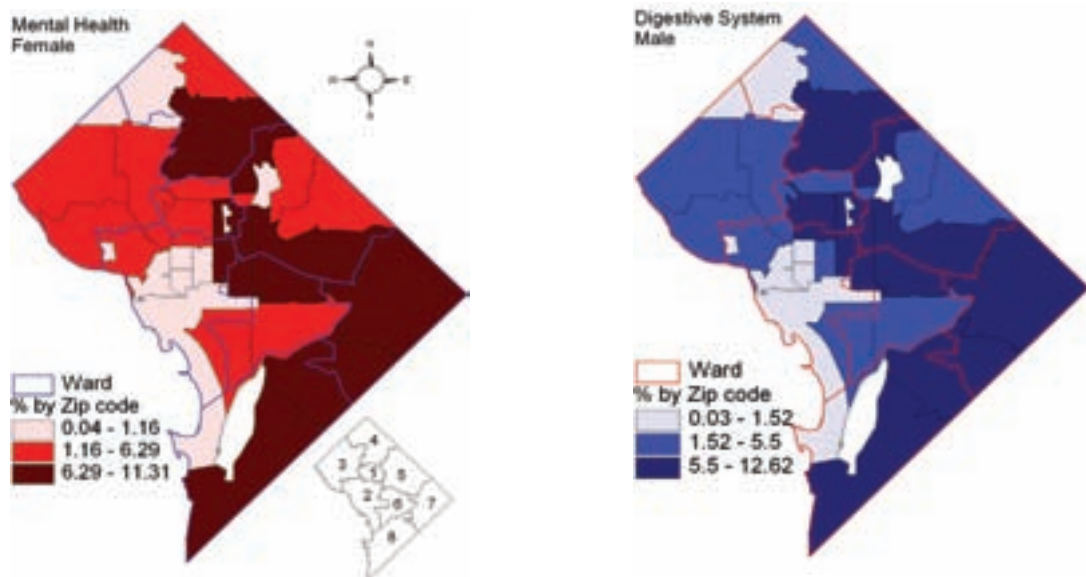
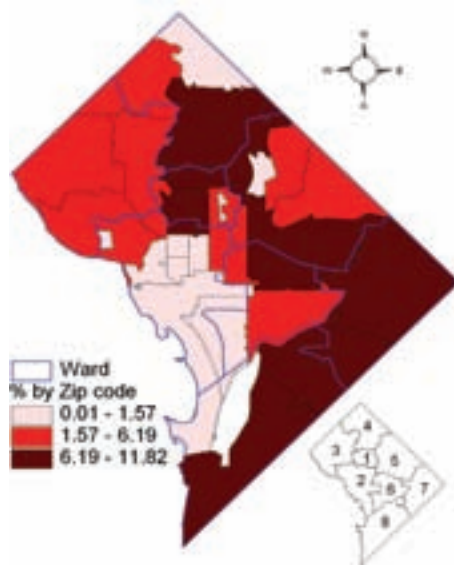


Figure 18: Distribution of Pregnancy Complications  
*The Most Common Reason for Female Hospital Discharge*



### Health Conditions Affecting the Uninsured

Examining the data from the D.C. Alliance provides an insight into severity and type of health conditions that affect District’s most vulnerable population, the uninsured. The leading reason for inpatient claims among the uninsured population covered by Alliance was Pneumonia, followed by Congestive Heart Failure, HIV, Chest Pain, and Acute Pancreatitis. Inpatient claims due to HIV rose from fourth to third rank from 2004 to 2005. Acute Pancreatitis emerged in 2005 as the fifth ranked for inpatient claims, a new diagnosis on the top five leading causes for inpatient claims list.

Table 8: D.C. Alliance Inpatient Claims, 2004-2005

FY 2004	FY 2005
Pneumonia	Pneumonia
Congestive Heart Failure, Unspecified	Congestive Heart Failure, Unspecified
Other Cellulitis and Abscess (Leg, Except foot)	HIV
HIV	Chest Pain, Other
Chest Pain, Other	Acute Pancreatitis

Source: D.C. Department of Health, Medical Assistance Administration, 2006.

Utilization of emergency rooms (ER) by D.C. Alliance members was driven by diagnosis of Pain in Limb, Essential Hypertension, Attention to Surgical Dressing and Sutures, Chest Pain and Headache. The top five leading causes for emergency room utilization remained unchanged from 2004 to 2005, with a slight shift in the rankings. Utilization of ER due to Headache and needed Attention to Surgical Dressing and Sutures declined in 2005, while Chest Pain and Essential Hypertension visits climbed.

Table 9: D.C. Alliance Emergency Department Claims, 2004-2005

FY 2004	FY 2005
Pain in Limb	Pain in Limb
Attention To Surgical Dressing and Sutures	Essential Hypertension, Unspecified
Headache	Attention To Surgical Dressing and Sutures
Essential Hypertension, Unspecified	Chest Pain, Other
Chest Pain, Unspecified	Headache

Source: D.C. Department of Health, Medical Assistance Administration, 2006.

Essential Hypertension and Diabetes are constant leading causes for physician visits for the uninsured, as is pregnancy.

Table 10: D.C. Alliance Physician Outpatient Claims, 2004-2005

FY 2004	FY 2005
Essential Hypertension, Unspecified	Essential Hypertension, Unspecified
Diabetes Mellitus Without Mention of Complication	Diabetes Mellitus Without Mention of Complication
Abdominal Tenderness	Attention To Surgical Dressing and Sutures
Supervision of other Normal Pregnancy	Pregnant state
Pregnant state	Supervision of other Normal Pregnancy

Source: D.C. Department of Health, Medical Assistance Administration, 2006.

## Morbidity Conclusions

- Diseases of the circulatory system including Cardiovascular Diseases (CVD) such as Heart Disease and Stroke account for the most hospitalizations (18 %) in the District of Columbia;
- The second leading reason for hospitalizations in the District was due to complications related to Pregnancy, Childbirth and Puerperium. While these hospitalizations accounted for 11 %, Respiratory Diseases accounted for about 9 %, diseases of the Digestive System for 8 %, Injury and Poisoning for 8 %, Mental Disorders for 8 %, and Neoplasms accounted for 5 %.
- The largest concentration of hospital discharge diagnoses for the leading morbidities were attributed to residents from the eastern section of the city - mainly Wards 4, 6, 7 and 8.
- Of great importance is the health status of the District's most vulnerable populations, including those who are uninsured. The leading inpatient claims among this group were for Pneumonia, followed by Conjestive Heart Failure, HIV, Chest Pain and Acute Pancreatitis.
- Hypertension and Diabetes are also among leading causes of physician visits among the uninsured.

## *Putting It All Together*

The results of the data analysis point to several key health concerns for District residents. Chronic non-infectious diseases including heart disease, cancer, cerebrovascular disease, diabetes and hypertension are the major cause of death and illness among persons over age 45. HIV is the chronic infectious disease exhibiting the heaviest impact on younger adults. Injury, both intentional and unintentional, has its largest impact on infants, children and youth. By identifying and examining the conditions and related risk factors that have the most significant impact on the health and welfare of the population, strategic planning can be targeted to primary prevention and intervention.

Considerable healthcare resources are used to address chronic diseases. Heart disease is the leading cause of death and hospitalization for District residents. Implementing primary prevention strategies that would avoid or delay the onset of heart disease could delay death and thus increase life expectancy. Preventing heart disease involves a combination of lifestyle changes and medical treatment of risk factors. Culturally appropriate health education on the benefits of smoking cessation, balanced nutrition, weight management and consistent exercise combine to combat the onset of heart disease. Regular screening and treatment for hypertension, diabetes and hypercholesterolemia would also prevent or at least delay onset of heart disease.

Likewise, cancer has a major affect on the decreased life expectancy rate. Preventing all types of cancer, especially lung, colorectal, cancer and prostate cancers, and treating it at early stages would greatly improve the overall health status of the citizenry. While some types of cancer have unique risk factors, most have a similar cluster of preventable risk factors. Use of tobacco products including cigarettes, cigars and smokeless tobacco has long been reported as a major cause of lung cancer. Dietary changes to maintain a low-fat diet high in fruit and vegetable consumption has been reported to prevent colorectal, breast and prostate cancers. Continuous exercise has also been associated with decreased risk for many types of cancer. Screening is the major secondary prevention strategy for several types of cancer. Initiatives to continue to make timely screening for colorectal, breast and prostate cancer readily available for all residents, including the uninsured and underinsured, can ensure prompt treatment and thus improve cancer treatment options and decrease the mortality rate.

Diabetes is also a leading cause of death, particularly among person 65 and older. It has been noted that persons residing in the District experience earlier onsets of conditions secondary to diabetes at an earlier age as compared to other parts of the U.S. Screening blood glucose levels to determine pre-diabetes status is a critical means to preventing or delaying type 2 diabetes onset. The recently completed Diabetes Prevention Program study conclusively showed that people with pre-diabetes can prevent the development of type 2 diabetes by making changes in their diet and increasing their level of physical activity.

Hypertension is also a major source of concern as evidenced by the resources used it manage it in the clinic and hospital settings. Each of these conditions are preventable. To do so, however, requires a comprehensive citywide effort involving public and private stakeholders along with the community. As with many chronic diseases, hypertension can be prevented with health education campaigns and specialized programs the promote maintaining a healthy body weight, eating a healthy diet that is low in salt and fat, participating in a consistent exercise program, stopping smoking and limiting alcohol.

HIV has emerged over the past ten years as the leading cause of death among persons 25-44 years old in the District. Overall, the District has one of the highest HIV mortality rates when compared to other big cities with comparable populations. By causing death at such early ages, HIV will continue to decrease the life expectancy for the District. HIV has also become one of the leading causes for inpatient claims among the city's uninsured as recorded in the D.C. Alliance outpatient patient claims data. Also a preventable and treatable condition, the city leaders must sustain efforts prevent HIV infection, detect it at early stages and treat it in a consistent and ongoing manner. Targeted health education programs to promote the ABCs (Abstinence, Being faithful in monogamous relationships and correct Condom use) of HIV prevention can decrease HIV infection rates. As a secondary prevention measure, increased screening at a community-wide level will lead to early treatment and disease management.

Intentional and unintentional injury is a leading cause of death for persons 1-24 years old. Homicide is leading cause of death among youth and young adults, 15-24 years old. Though relatively low in number, seven in 2004, motor vehicle crashes are the leading killer of children 1-14 years old. Evidenced-based health promotion programs to promote safe communities and alternatives to violence will reduce the violence related death and disability rate. Also, coordinated home and community safety programs will decrease death and injury related to vehicular crashes.

In addition to drawing conclusions related to specific illness or injury, special target populations require priority focus due to the nature and scope of the conditions affecting them. Though the infant mortality and teen pregnancy rates are declining, they still remain high; therefore, continued focus is needed on teens and pregnant women. Given the health disparities between Whites and African-Americans, as well as Latinos, health care resources should be focused on those populations that continue to be at risk for adverse health outcomes. Certain geographic sections of the city are experiencing illness and injury at excess levels and should receive special attention. In focusing on selected groups and geographic areas, the District can direct its efforts and resources to achieve maximum impact on the wellbeing of its residents.

Tobacco is still the number one preventable cause of death in our society and smoking cessation programs should receive high priority in the District's prevention agenda. Further, a new study released by the Centers for Disease Control (CDC) in March, 2004, revealed that deaths due to poor eating habits and physical inactivity rose by 33 percent over the past decade and may soon overtake tobacco as the leading preventable cause of death. The CDC study concluded that about half of all deaths in the U.S. in 2000 could be attributed to "a limited number of largely preventable behaviors". The study "Physical Inactivity & Poor Eating Habits Becoming Leading Causes of Preventable Deaths; Cuts Fitness For Men Providing An Effective & Popular Solution" is being published by the Journal of the American Medical Association. Health awareness programs will also emphasize good nutritional practices, weight control, various wellness check-ups and screenings and higher levels of testing among high risk groups.

This plan will seek to implement the vision of a healthier city reflecting every facet of our lives at the personal, and community and environmental levels. This vision seeks to ensure that all District residents have:

- Access to affordable, comprehensive and high quality care through traditional providers and new facilities such as medical homes
- Access to affordable health insurance
- Access to information and programs that promote prevention of disease and injury at every stage of life by adopting healthy behavior and lifestyle;

- A strong and effective healthcare safety net that provides healthcare services for the medically needy in all areas such as primary care, care for the mentally ill, pharmacy services, substance abuse treatment and support services, and oral health care.

This vision seeks also to promote greater involvement of the broad healthcare community and citizens in all health related issues.

## *Overarching Goals*

### **A. Health Disparities**

Health disparities refer to inequality in available opportunities to access high quality and affordable health care by varying racial, ethnic and socioeconomic groups. Lack of insurance coverage, lack of a regular source of care, cultural and language barriers, shortage of providers in neighborhoods where minorities live, lack of education and awareness are the main sources of health disparities.

The U.S. Surgeon General estimates that nearly 84,000 deaths can be prevented each year if gaps in mortality between blacks and whites were eliminated. Further, a study developed by the Institute of Medicine has found that:

- Members of minority groups are less likely than whites to be given appropriate cardiac medicines or undergo coronary bypass surgery;
- Minorities are less likely than whites to receive kidney dialysis or kidney transplants;
- Minorities are less likely than whites to receive the best diagnostic tests or treatments for stroke or cancer;
- Minorities are less likely to receive state-of-the-art treatments or therapies that can forestall the onset of AIDS; and
- Minorities are more likely to receive less desirable treatments than whites.

The study also indicated that there are many possible reasons for racial and ethnic disparities in health care, including:

- Cultural and language barriers;
- Time limitations imposed by pressures of clinical practice;
- Distrust for health care establishments by many minority patients;
- A woeful lack of minority physicians who may be more culturally sensitive to the needs of their patients; and
- Conscious or subconscious biases, prejudices, and negative racial stereotypes or perceptions that affect the way providers deliver care.

One of the overarching goals of both the federal and District of Columbia Health People 2010 goals is the elimination of racial and ethnic health disparities. In 2003, the U.S. Surgeon General cited the following six areas of focus in order to accomplish this goal: infant mortality, breast and cervical cancer, cardiovascular disease, diabetes, immunizations and HIV/AIDS. The U.S. Surgeon General's proposed solution was for public and private organizations to develop and



implement the needed changes in the health care system (access to care, mental health, injury and violence, environmental quality, and immunization), and for individuals and groups to collaborate in adopting strategies to change unhealthy lifestyles (physical activity, overweight and obesity, tobacco use, substance abuse, and responsible behavior).

**Table 11: Ten Leading Causes of Death and Crude Death Rate by Race and Gender: District of Columbia, 2004**

Rank *	Cause of Death	White (Rate per 100,000)			Black (Rate per 100,000)		
		Male	Female	All	Male	Female	All
	All Causes	563.27	547.34	621.80	1341.6	1086.13	1223.4
01	Heart Disease	160.6	162.0	161.3	294.4	291.3	292.7
02	Cancer	152.6	137.1	144.8	282.9	224.2	250.8
03	Homicide			7.3	97.7		57.9
04	Essential Hypertension	39.9	43.0	36.2	84.2	70.8	68.4
05	HIV/AIDS	15.9		7.9	82.3	42.6	60.6
06	Accidents	38.7	19.3	25.9	68.8	25.7	44.6
07	Cerebrovascular Diseases		32.8	22.7	45.6	45.3	45.5
08	Diabetes	13.7	9.1	11.4	44.4	51.7	48.1
09	Influenza/Pneumonia	14.8	17.0	15.9	31.5	30.4	30.9
10	Chronic Lower Respiratory	23.9	27.2	25.5	31.5	26.6	29.1

\*Rank based on number of deaths from the list of 113 selected causes of death.

\*\* Rate per 100,000 population based on Census 2000.

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

The elimination of health disparities is a crucial step in improving health outcomes and quality of care. There is a need to identify gaps in health care services and their causes in order to design appropriate interventions. It is recommended that the Department of Health establish an advisory panel of experts from the public and private sectors to identify areas of health disparity and propose ways to reduce and, where possible, eliminate the gaps. The panel should include members from health providers, policy makers, teaching institutions, churches, advocacy organizations, insurance carriers, as well as community groups. The reduction and elimination of disparities will not only improve health outcomes but will have economic, social, and educational benefits. Among other things, the panel should:

- Review the existing health care delivery system and determine why racial and ethnic minorities are not receiving equitable care;
- Identify short-term and long-term solutions to the problems;
- Provide a road map on how resources can be more equitably allocated to address the problems;
- Identify bench marks to measure progress over time; and
- Make suggestions on how to improve health coverage to address disparities.



## **B. Preventive Health**

Currently, the leading causes of death in the District are mainly attributed to chronic illnesses. Prevention of such illnesses occurs in many arenas including: (1) maintaining healthy personal behaviors, (2) improving health treatments and interventions, (3) creating a healthy environment, and (4) actions taken through social and economic means to encourage healthy living.

The benefits of preventive health to society are enormous. Prevention:

11. Improves quality of life for patients;
12. Improves workforce and school productivity;
13. Decreases the financial burden to patients;
14. Educates the public about healthy lifestyle choices;
15. Detects or prevents major illnesses from occurring;
16. Decreases morbidity and mortality rates;
17. Promotes better use of health care resources;
18. Reduces emergency department use;
19. Reduces the economic and medical care burden to hospitals and health care facilities; and
20. Increases life expectancy.

Preventive health strategies should include participation from a variety of stakeholders. Individuals should practice behaviors that promote good health. Healthcare professionals should identify at-risk patients and develop appropriate and effective intervention strategies. Governmental agencies should formulate policies, allocate financial resources and collect data in order to evaluate the effects of various interventions. Third party payers should work with government officials, businesses, and the community in making affordable health insurance a priority, and include prevention and wellness benefits into insurance policies. Community organizations should identify needs and resources, and assist in the implementation of health promotion activities. Businesses and employers should assist employees in obtaining health insurance at a reasonable cost and develop policies that promote healthy behaviors. Churches should promote health related activities and develop support systems to assist congregants in coping with illnesses or modifying behavior. Schools should develop health education programs that focus on healthy behaviors, create healthy lunch and diet choices, design health education and disease management strategies for students with chronic illnesses, and develop physical activities programs.

A major component of preventive health is education and promotion. Health education is composed of activities and experiences which teach individuals and the collective community which behaviors and actions are conducive for good health. Health promotion not only encompasses education but looks at a broader framework of strategies which includes social, economic, and political components coupled with achievable health outcomes. Promotional campaigns and activities involve individuals and engage the community as a whole. A more balanced planning and implementation process can result in giving all stakeholders the opportunity to participate in health care decision making.

In general, health education and promotion should increase public awareness of behavioral and environmental risk factors, support behavioral change to reduce those risk factors, promote early diagnosis and treatment, and increase access to medical care and support services.

The Department of Health must work with different groups and organizations in order to improve the health status and well-being of the residents. Improving health-related behavior, instituting appropriate policies and regulations and providing the necessary support is critical to the success of preventive health.

Therefore, it is recommended that greater emphasis be given to providing disease prevention and health promotion education in the schools. Health habits are usually developed early and health education programs aimed at the adolescent population provide an excellent opportunity to encourage positive behaviors and support students in management of their health. The majority of adolescents are enrolled in school and the school setting is ideal for teaching students about physical activity, nutrition, healthy living, HIV/AIDS, substance abuse, obesity, environmental health, emergency response, dental care, reproductive health, counseling, wellness programs, and the like. It is also relatively easy to reach families and the community through the students. Adolescents can facilitate communication with their families and can be a conduit for the distribution of targeted educational programs and materials. For example, adolescents who are taught effective asthma management skills may influence the way a family member with asthma treats the condition.

A concerted effort should be made to persuade schools' administrations and teachers about the value of health education. It is important to encourage dialogue and promote education for school staff in order to foster and sustain health education programs. If school health programs are to succeed there is a need to establish and strengthen relationships with parents, hospitals, primary care facilities, professional organizations, government entities and community groups in conjunction with the full support and participation of the school community.

## **C. Health Care Financing**

### Background

Lack of health insurance coverage contributes to adverse consequences and poor health outcomes. Data indicates that uninsured people are almost twice as likely to delay getting needed medical care. Estimates also indicate that thousands of deaths among those aged 25 to 64 could have been prevented if these individuals had health insurance. The growing number of uninsured has a negative financial consequence both on the individuals and the health care delivery system.

An individual who is *uninsured* can be simply defined as someone who lacks health insurance. However, lacking health insurance can be a temporary or a permanent state. Those who have health insurance today may lose it tomorrow. Minor changes in income or work status can cause an individual to drift between having and not having insurance. A new job may mean a new employer who does not offer health benefits or if health benefits are offered new employees may have to endure a waiting period before they become eligible.

An individual who is *underinsured* has health insurance that is inadequate to secure access to needed care. For example, individual health insurance policies often have substantial gaps, imposing high out of pocket costs and limiting access to benefits such as prescription drugs, mental health or maternity care.

## Health Insurance Coverage in the District

The District of Columbia fares very well, and much better than U.S. or other large urban jurisdictions, in terms of health coverage of its citizens. Given the large number of firms offering employer sponsored insurance, the number of residents employed by the public sector, city's large Medicaid program, and an average income above the national average, most people in the District have health insurance and receive good coverage. However, a number of residents still remain uninsured or underinsured. For some, the barrier to coverage is the cost of the health insurance that is available to them, and for others, it is the lack of appropriate coverage. In addition, some District resident's may be available to receive health insurance through local and federal government but are not aware of these benefits.

The DC Healthcare Alliance is an additional public insurance program available to District residents, funded by local funds. Through the DC Healthcare Alliance members have access to an array of professional healthcare providers within a managed care network. Eligibility is open to those residents who have incomes under 200 percent of the federal poverty level (FPL) and who do not qualify for the Medicaid program. As of May 1, 2007, there were 45,807 District residents enrolled in the Alliance program.

Legislation passed by the City Council in 2006 will bring the District one step closer to providing universal coverage. Specific policy changes include: expansion of Medicaid to cover children up to 300% of the federal poverty level; the creation of Healthy DC, a new program allowing residents who are not eligible for Medicaid or the Healthcare Alliance to buy basic health care coverage; and increased coverage of Medicaid dental benefits.

In addition, in order to ensure that all eligible residents are covered, the District has streamlined the enrollment process for Medicaid and Alliance coverage. This effort has resulted in 20,000 new enrollees between June 2006 and June 2007. For those with incomes above 200% FPL, legislation was passed to expand SCHIP eligibility to 300% FPL, a change from the previous cap of 200% FPL.

The District should continue to explore different ways to provide coverage to all residents. This could be accomplished by an expansion of public coverage, by working with the private sector to encourage private coverage, by educating the public on available and affordable insurance options, and by using the tax system to provide incentive to individuals as well as employers.

Specifically, the District should:

5. Identify the characteristics of the population that is currently enrolled in the public programs;
6. Improve outreach for the Alliance and Medicaid programs in order to facilitate enrollment of eligible residents;
7. Develop an information clearinghouse on health insurance products offered by the private insurance plans that are available to individuals and small businesses; the information will help individuals and businesses to identify plans which meet their health and financial needs; and
8. Continue to streamline the reimbursement process for both Medicaid and Alliance in order to attract qualified and specialty providers and to facilitate access to services by those who are already covered.

## **D. Environmental Health**

Over the last 50 years, progress has been made in understanding the effects of the environment on health and wellbeing of the population. Environmental health covers those characteristics of human health, disease and injury that are affected by factors in the environment. The environmental conditions that affect physical, social and psychological health include microscopic and chemical agents, such as particulate matter and lead. While individuals have some control over the personal aspects of their own lives, such as drinking, smoking, or exercising, they have little control over environmental hazards like the quality of the air, soil or the water supply. The government has an important role to play in bringing together individuals and the community in seeking to preserve the ecosystem and prevent and control environmentally related diseases.

The District government has put in place a number of programs and initiatives to promote environmental health. In the 1980s, the government established regulatory bodies to protect the environment and to oversee the enforcement of laws and regulations. Housed within the Department of Consumer and Regulatory affairs, most of these programs included regulation of facilities or organizations handling hazardous materials such as gas stations, dry cleaners, and other facilities. In mid 1990s, these environmental agencies were incorporated into Department of Health and combined with other regulatory programs focusing on community health, such as the rodent control and the restaurant inspection programs. Now a decade later, the District has established a newly created Department of the Environment.

Although this new Department gives environmental issues a much needed priority focus, there remains the need for effective coordination and collaboration among the various players throughout the District government. The enforcement of environmental regulations falls within the Department of the Environment but the responsibility to protect the public's health remains within the Department of Health. Additionally, other key agencies play a role in the development and enforcement of environmental health policies: Department of Consumer and Regulatory Affairs, Department of Public Works, Department of Transportation, and the Water and Sewer Administration. These agencies must come together in administering programs which educate the public, assess the conditions that affect the health of residents, and control those factors in the environment that are adversely affecting the health of the residents. It would be prudent for the District of Columbia government to create a task force to bring together all of the relevant government agencies playing a role in ensuring environmental health. In joining together these agencies, their shared responsibilities can be better organized through proper coordination of data sharing and collaborative enforcement efforts.

Even though environmental health awareness has increased over the years, there are still gaps in our knowledge and understanding of environmental related diseases. It is therefore very important to develop the tools to understand the relationship between human health and the environment. It is particularly important to develop surveillance systems to track environmental exposures and to monitor the health status of the residents. It is recommended that the Department of Health in cooperation with the Department of the Environment establish a comprehensive environmental public health program. This program should include:

- Public health surveillance systems for environmentally related diseases;
- Strategic education initiatives coordinated among the different agencies to promote services and educational programs; and
- Cooperation with local agencies and neighboring jurisdictions to address regional environmental issues and emergency response procedures.

### Public Health Surveillance System

Environmental hazards include chemicals, physical agents, and biological toxins in the environment that have a negative impact on health. Exposure to environmental hazards accounts for a significant percentage of many chronic diseases. Environmental health surveillance is the systematic, ongoing collection and analysis of information related to disease and the environment. Reliable surveillance information is the most basic tool for preventing chronic diseases. A surveillance system would track disease trends to understand if they are changing over time and inform the development and evaluation of disease prevention programs and policies. Investment in this system would greatly enable the city to improve health outcomes of its residents with regards to such diseases and disorders as cancer, lead poisoning and asthma.

### Education Efforts

Preventive health initiatives should include components that educate people on how to recognize, manage and prevent negative health effects from environmental exposure. The District should take a strategic approach for incorporating environmental health information into education of school age children, and practices of health care providers and community organizations. Information materials should be developed to educate people on basic knowledge of health effects related to exposure to hazardous materials, such as pesticides and lead, and effects related to exposure to poor air and water quality.

### Emergency Response Preparedness

In collaboration with other jurisdictions, the District government must work with its emergency response personnel, hospitals and other healthcare providers to provide immediate and effective healthcare to minimize morbidity and mortality in the event of a terrorist attack or other public health emergency. The health care system must enhance its ability to deliver coordinated and effective emergency care. Program priority areas include improving bed and personnel surge capacity, decontamination capabilities, isolation capacity, pharmaceutical supplies, and supporting training, in form of drills and exercises.

## **E. Health Data**

A vital prerequisite for building an efficient public health delivery system is a) having access to complete and accurate health information, and b) having the ability to communicate such information to required users in a timely and secure manner. Comprehensive and accurate health data is the foundation for the development of good health policy. Traditionally, health data in the District have been collected by various health care providers based on their perceived needs and on requirements established by federal and local governments. The absence of standard collection instruments and guidelines for data has resulted in the creation of databases with different electronic storage and management systems, varying data definitions, dissimilar coding of the same variables and other various inconsistencies.

Moreover, since many provider institutions have overlapping and/or complimentary functions in providing health related services to residents, there is substantial duplication of effort and redundancy in the collection and storage of basic client information, such as demographic and socioeconomic factors. Data sharing and information gathering is also negatively affected by lack of timely electronic reporting by the health care providers.

The factors discussed above make it difficult for health officials and program managers to fully assess the utilization and effect of health resources available in the District. They also present difficulties in estimating the extent to which residents lack access to needed health care services.

Looking forward, health systems and health data integration offer the potential of delivering more complete health information on clients and their health issues such as: access and health resource utilization, cost of care, quality of care, and health outcomes. Integrated health information systems offer significant advantages over systems that address only a limited health aspect. Integrated systems provide better support for the core functions of public health by providing more comprehensive health data and information as the basis for accurate needs analysis, astute planning, meaningful and relevant policy formulation, and efficient health interventions.

It is recommended that DOH establish citywide standards for the collection and reporting of health data and improve data systems integration and client monitoring/tracking. This can be accomplished through the establishment of a data workgroup that will examine federal and local standards relating to health data and make a recommendation for the implementation of a new policy regarding collection of health data.

Among other things, the workgroup should address health data integration among major health databases such as Vital Records, Medicaid recipients and claims data, and Hospital Discharge data. The integration of these major databases will provide basic health information on most health encounters in the District. In addition to the integration of the three major health databases, efforts must be made to include additional program databases from the Cancer Registry, Healthy Start and WIC, School Health and Chronic Disease Registry. DOH data integration efforts must proceed with the goal of merging with social services data under a

project currently managed by the Office of the Chief Technology Officer (OCTO). The integration of both health and social services data will enable comprehensive client monitoring and better case management.

In recognition of the overall health impact of the large (60+ %) minority percentage of the District's population and the associated magnitude of health disparities, new policies must be implemented to significantly improve the collection and reporting of more comprehensive race and ethnicity health data by all licensed healthcare providers in the District.

In particular, DOH needs to establish a Web-based Interactive Health Data Query System (WIHDS). The system should provide an opportunity for end users to make online requests for multiple years of specific and customized health reports for a number of leading health indicators

such as: causes of death; birth and prenatal care, leading morbidities and hospital visits, race and ethnicity health reports and health care quality indicators.

Efforts must be made to make the system operational by September, 2008.

## **F. Quality of Care**

Quality of care is usually defined as the level of excellence of health services that are provided to an individual. It is determined in terms of technical competency, appropriateness, and the need for the service provided to an individual. Quality of care is the degree to which the services provided are properly matched to the needs of the population, are technically correct, and result in a beneficial and desired outcome.

Outcome is the most important element of quality of services provided. However, it is also very difficult to measure. While one can make a general correlation between the degree of quality provided and the health outcome and health status of the residents, it is not easy to measure quality across the full spectrum of the health care delivery system. In addition to the quality of services, the health status of residents can also be affected by other issues such as the environment, genetic disposition, and personal behavior.

To this end, the Department of Health should work closely with public and private organizations to identify priority areas for quality improvement. To promote transparency in the health care delivery system and provide the public with reliable information on quality of health services and providers, the Department of Health will utilize quality performance measures. Such measures should be based on already established national standards. A subset of performance measures that the Department will utilize is included in the Appendix.

# *Certificate of Need Program*

## ***Legislative Provisions***

The State Health Planning and Development Agency (SHPDA), which is established by D.C. Official Code § 44-401, is responsible for (1) the administration of a Health Systems Plan which serves as a guide for the development of health care services by both the public and private sectors; (2) the administration, operation and enforcement of the Certificate of Need (CON) program; (3) the collection and analysis of health data; and (4) the monitoring of health care facilities for compliance with the requirements that govern the provision of uncompensated care to needy residents.

The SHPDA was originally established as part of a federal initiative to promote health planning in the nation. The overall goal was to ensure the availability of quality, affordable and accessible health care services to all residents.

The law requires that all persons proposing to offer or develop in the District a new institutional health service, or to obligate a capital expenditure to obtain an asset to be located in the District shall, prior to proceeding with that offering, development, or obligation, obtain from the SHPDA a certificate of need that demonstrates a public need for the new service or expenditure. Only those institutional health services or capital expenditures that are granted a certificate of need shall be offered, developed, or obligated within the District of Columbia.

The CON review process is a public process that involves input and participation by the general public. Members of the public are afforded the opportunity to comment on CON applications in support of or in opposition to proposed projects. Applicants are also required to inform the general public by publishing a notice in a newspaper of general circulation, and to write letters to the Advisory Neighborhood Commissions in their service area about the proposed project before they submit their CON applications. This way, members of the public are made aware of services that will be established in their neighborhood. The process gives the SHPDA the opportunity to consider the needs, interests, and concerns of stakeholders and the community at large.

The law also mandates the establishment of an advisory council, known as the Statewide Health Coordinating Council. The District of Columbia's SHCC is a council comprised of volunteer consumers and public and private sector health providers. In its dual role as both an advisory and policymaking body, the SHCC works closely with the SHPDA to plan and develop an orderly arrangement of health resources for the District's residents. The SHCC meetings essentially serve as a public forum by which wide-spread citizen participation is promoted and solicited for input into the planning process.

Working in collaboration, the SHPDA and the SHCC strive to:

- Improve the health of District of Columbia residents;
- Increase the accessibility, acceptability, continuity, and quality of health services;
- Restrain increases in health care costs;
- Prevent unnecessary duplication of health resources; and
- Maintain and enhance competition in the health service area.



To accomplish this, the SHPDA and the SHCC conduct a variety of activities through the interrelated mechanisms of plan development and project review.

### ***Use of the Plan***

The Plan sets priorities in the District's health delivery system and serves as a guidebook and an accountability tool for agencies and individuals responsible for making decisions in the following areas:

- Formulation of policies on health related issues;
- Education of residents on the status of the health care system and health needs and priorities;
- Identification of research and study needs;
- Formulation of proposals for legislation, rules, regulations and policies;
- Stimulation of innovations within the health care system;
- Allocation of resources in response to identified needs; and
- Promotion of citizen participation in health planning and awareness of health problems and issues.

### ***Planning Framework***

A health planning framework is a conceptual approach for analyzing the health care system and its component health care services parts, health care settings, and health care resources. The health planning framework utilized by the SHPDA will enable planners to analyze components of the health system by the following health system characteristics:

- the need for the proposed services;
- the accessibility of the proposed services;
- the quality of the proposed services;
- the acceptability of the proposed services;
- the continuity of care for the proposed services; and
- the financial viability of the proposed services.

### ***Definitions of Health Systems Characteristics***

The following are definitions of each of the six health system characteristics utilized by the SHCC and SHPDA in analyzing the health delivery system.

#### ***Availability***

Availability of health services is defined as the existence of health resources and services in relation to the needs or demands of a given individual or community. The definition components of availability include: 1) the supply of services – existing service capacity and utilized capacity; and 2) the supply of resources that comprise service – personnel, equipment, facilities, and financial resources. Simply stated, availability is the adequacy or inadequacy of the supply of services, as well as the comprehensiveness of the services that are provided.

A service or resource is considered adequately available, only if the supply meets the aggregate need. It can only be available to an individual or community when it can be obtained at the time and place that it is needed, and from appropriate personnel at affordable costs. For example, emergency care services are available if they can be obtained at any hour of the day, in a setting that is equipped to handle emergency situations, and performed by personnel who are trained to provide emergency care.

To determine the types, amounts, and levels of services that should be available to a given community, three different factors can be utilized: need, demand, and want. Need for health services are derived from an assessment of the health status of the community, or by utilization of population/service ratios. Once need has been determined, health experts decide what services, in their belief, ought to be consumed over a relevant period of time for the population to remain or become as healthy as possible, given existing medical knowledge. Demand for health services is that quantity of health services which the population is willing and able to purchase over a relevant period of time. Want is that quantity of health services which the members of the community believe that they ought to consume over a period of time, based on their perceptions of their health needs. Planning must be based primarily on need while taking into consideration demand and want.

### ***Accessibility***

Accessibility is the measure of an individual or group's ability to obtain needed services. Accessibility is characterized by factors that either enhance or inhibit the individual's ability to get to the site where care is provided, and to receive appropriate services once there. It is most often associated with hours of operation, location and distance factors. Measures of accessibility include financial, spatial, geographic, temporal, accommodative, and other associated factors which are defined as follows:

- Financial accessibility (affordability) is the relationship of prices and services, provider's insurance or deposit requirements and acceptability of public support medical assistance and existing health insurance.
- Spatial or location accessibility refers to the effect of distance between the patient's location and the location of available services or the ability of the patient to receive services. Factors include the geographic locations of available transportation resources – either public, the patient's own, or that made available by the provider to get to and from available services within a given period of time.
- Geographic or physical accessibility is ease in reaching available services, or the existence or nonexistence of physical barriers to available services, (for example, hills, railroad tracks, a highway or busy freeway, a body of water, and the like). This includes architectural accessibility or the existence of provisions for the handicapped (ramps, handrails, transportation, and the like), which aid the handicapped individual's ability to get to and receive services.
- Temporal accessibility is the amount of time required to travel between the patient's location and the location of services, taking into consideration the location of services from the patient's site of residence, travel routes, and modes of transportation, as well as the amount of time the patient must wait for services once reaching the site of care.

- Accommodative accessibility is the ease of entry into health care, or the relationship of the manner in which the health services are organized to accept the patient – that is, the appointment system, hours of operation, provisions for cultural and language differences, walk-in facilities, emergency facilities, telephone facilities, and the patient/provider relationship.

### ***Quality***

Quality is defined as the degree or grade of excellence which characterizes services received by an individual or group. It is measured by gradations or levels of existence, rather than by its presence or absence; and can be determined in terms of technical competency, need for the service provided, and appropriateness. In other words, quality is the degree to which the services provided are properly matched to the needs of the population, are technically correct, and achieve beneficial impact.

Quality can be considered in three dimensions: the structural aspects of resources and services, the process of producing and delivering services, the outcome of services on health status, environment and behavior. Structure includes factors as:

- 1) the qualifications of staff and other resources;
- 2) the existence and extent of review and quality assurance mechanisms, and
- 3) the provision of minimal volumes of specialized services.

Process includes such factors as:

- 1) accuracy of services provided;
- 2) appropriateness of services provided; and
- 3) documentation of treatment provided.

Technical correctness is also considered a factor of quality that falls under the dimension of process. Outcome includes:

- 1) health status;
- 2) behavior; and
- 3) environment.

Outcome is usually considered to be the most important dimension of quality; however, it is also the most difficult to measure. Theoretically, there is a direct correlation between the degree of quality in the health care system and the immediate outcome of the system on the health status of the population. As yet, a direct correlation between the two has not been determined. In addition, it is becoming more and more evident that health status is a function of several other variables in addition to health services. These are: 1) heredity; 2) behavior; and 3) environment.

Since the measurement of outcome is so difficult, most current measurement techniques emphasize the structure and process components of health delivery, although the relationship between structure and process and health has not yet been established unequivocally.

Not to be overlooked is the trade-off between quality and the other characteristics of the health system, costs for improving quality in terms of adopting costly equipment, utilizing or implementing new techniques, and increased use of health manpower. These are examples of increasing costs, while at the same time attempting to improve the quality of care. On the other hand, quality may be increased by decreasing the overuse of technical equipment and certain medical procedures, for example, unneeded surgery. The impact of higher quality costs is therefore dependent on the nature of the action designed to improve quality. For instance, decreasing the incidence of unnecessary surgery would increase quality while decreasing total costs of surgical services.

### ***Acceptability***

Acceptability is an individual's or group's overall assessment of available health care in terms of such factors as cost, quality, outcome, convenience, and provider attributes. Acceptability is measured in terms of the degree to which health care consumers and providers are satisfied with the performance of the health system and the other health system factors and characteristics.

Unlike the other characteristics, acceptability focuses upon perceptions of the health system rather than upon the system itself. For instance, the difference between acceptability and cost is that actual expenses incurred by the community for health care services are a component of the cost characteristics, whereas acceptability addresses societal and consumer perceptions of whether these services are worth their costs, and whether costs are justly distributed. Because acceptability deals solely with attitudes and perceptions, it is difficult to conceptualize a measure.

From the consumer's perspective, acceptability can be defined as the consumer's overall assessment of available medical care. Consumers may assess providers in terms of age, sex, race and ethnicity, specialization, type of facility, size of facility, neighborhood, and location of facility. Religious preference, education, and income also influence the consumer when selecting a care site and assessing the acceptability of care.

Providers' attitudes and perceptions of the health care system and of the consumer also affect acceptability. The provider's view of the consumer in terms of race, sex, age, socioeconomic status, place of residence, payment source, and ethnicity may affect the way care is delivered. Acceptability deals with both consumer and provider perceptions of each other with regard to admission, utilization, and satisfaction with services.

The payers of health care must also be considered. Care may be rendered which is acceptable to consumers and providers, but not acceptable to third party payers for reasons ranging from type of service provided to the way in which payment forms are completed. The policy of payers can result in care that is acceptable to them, but unacceptable to consumers and providers.

### ***Continuity***

Continuity is the effective structuring, coordination and delivery of services on a continuous basis in one or more settings. Continuity of health care includes such factors as: 1) a regular source of care; 2) patient transfer; 3) medical information transfer; 4) lack of interruption or delays in service; and 5) follow-up procedures. It is measured by the ease in which individuals

move between required elements of the system and the degree to which the elements are integrated.

### ***Cost***

Cost is the total expense and economic consequences resulting from the provision of health care services and goods. A measure of cost includes consumer costs, direct provider costs, total program costs, indirect costs, capital costs, and operating costs. All associated expenses resulting from the need for and time required to obtain services and goods are factors.

The total cost system is subdivided into four characteristics: 1) direct costs of provider services; 2) costs of reserves and administrative expenses of service financing mechanisms; 3) opportunity costs; and 4) other societal costs. These cost characteristics are defined as:

- Direct costs of providing services include salaries, supplies, overhead, contributions to institutional reserves, and return on provider investments.
- Costs of reserves and administrative expenses of service financing mechanisms are the portions of health insurance premiums or enrollment fees attributable to reserve requirements and administrative expenses of commercial and governmental insurance plans, and prepaid group practices.
- Opportunity costs are the opportunities foregone when resources are used in a particular way. They may be incurred by consumers as well as by providers. An example of consumer-incurred opportunity costs can be illustrated by the lost value of devoting physician time to one type of care, for example, tertiary rather than primary or preventive care.
- Other societal costs are the undesirable effects of consuming health services. System-induced complications and unnecessary duplication of services are examples. Although the costs of providing services already include some aspects of these costs, the isolation of societal costs will highlight that portion of total system costs which are due to ineffective health system performance.

### ***Certificate of Need Requirements***

#### ***Availability***

The District of Columbia should have available adequate but not excessive services to be geographically located for ease of access by District residents. Additionally, availability of health services and health resources in the District should be based on the demonstrated health care needs of the population, not on economic demand or personal desire for potentially unnecessary or inappropriate care.

CON applicants for a Certificate of Need who propose to locate their services in underserved areas of the District should be given priority over other applicants.

CON applicants seeking to establish a new service must demonstrate an unmet need among the proposed target population.

- Describe the target population to be served.
- Identify the needs of the target population.
- Explain why current providers cannot meet the proposed need for service.
- Explain how the proposed service plans to meet the identified need.

CON applicants requesting expansion of services should demonstrate that existing utilization of such services system wide meets or exceeds minimum volume standards and that there is a need for additional capacity within the immediate service area.

CON applicants must demonstrate the impact of proposed services on existing providers and the health care delivery system. An applicant shall provide information and analysis with respect to the impact on geographic and demographic access to services, on occupancy, quality, on costs and charges of other providers, and on costs to the health care delivery system.

CON applicants are encouraged by the SHPDA to develop a consortia approach or other resource sharing arrangements in the provision of costly new services.

CON applicants shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the SHPDA with a written notice and explanation as to why the conditions or commitments were not met.

The burden of demonstrating need for services not covered by parts of the State Health Plan rests on the applicants.

### ***Accessibility***

CON applicants should not deny services because of age, sex, race, creed, religion, sexual orientation, color, national origin, socioeconomic status, legal status, disability, prior hospitalization, diagnosis, prognosis, organizational affiliation, ability to pay or payer source.

Financial eligibility requirements should not be a barrier to services for persons who are uninsured or underinsured.

CON applicants should meet Medicaid and Medicare standards for services that are reimbursable and secure and maintain Medicaid certification.

CON applicants should have written policies governing provision of services without charge for indigent patients in accordance with the uncompensated care obligation under D.C. Official Code § 44-405 (a).

CON applicants may establish sliding fee scales based on ability to pay and establish special payment plans for individuals unable to make lump sum payments for services rendered.

CON applicants should have available information about alternative sources of financial assistance and refer patients, as appropriate, to such resources.

CON applicants should make available to patients, at their request, information relating to charges of services provided.

Facilities must be architecturally designed to meet the needs of persons with disabilities.

Services should be geographically decentralized and available in neighborhoods throughout the District and should establish hours of operations that are convenient to the targeted population.

CON applicants must provide evidence that has adequately planned for any temporary move or relocation of any facility or service which may be necessary during any proposed construction period, and evidence that the applicant has planned adequately to assure patient protection from noise, dust, etc. and to the extent possible, continuation of services during any proposed construction period.

CON applicants must provide access to services free from all barriers. No barriers (architectural, communication, transportation, procedural, or financial) to the delivery of services shall exist.

CON applicants must describe arrangements to be developed to maximize accessibility (e.g., hours of operation, parking facilities, and transportation for related services, and reimbursement by Medicaid and other third party payers).

CON applicants should have translation, sign language interpretation, and/or interpreter capabilities for the major languages of non-English-speaking patient populations and ensure staff is aware of the cultural mores of the population.

CON applicants should provide health services in a timely manner.

CON applicants should ensure program design and administrative procedures should not discourage individuals in need from seeking and obtaining care.

### ***Quality***

CON applicants should have an individualized care plan for all patients that is reviewed and revised on a regular basis by all providers of care.

CON applicants should develop individualized care plans consistent with required licensure and certification to ensure the provision of an entire range of services, including services required after discharge from an inpatient facility.

CON applicants shall provide or formally arrange for any service deemed as a necessary component of the individualized care plan.

CON applicants should have a written policy providing for medical supervision of patients and the prescription of a planned regimen for total patient care. A medical director must oversee and coordinate the provision of medical care in the facility or service.

CON applicants should demonstrate development of a quality improvement plan that clearly indicates responsibilities and accountability and defines a process for ongoing evaluation and assessment.

CON applicants should implement a Continuous Quality Improvement (CQI) process into their organizational structure and service delivery system as follows:

1. Establish a quality improvement plan and staff to coordinate and implement the CQI process.

2. Involve interdisciplinary teams of treatment staff and management to monitor administrative and patient records to ensure compliance with key quality indicators of care and provide appropriate training of all personnel.
3. Monitor utilization of services and treatment outcomes.
4. Document all findings and corrective actions.

CON applicants should provide documentation of management efforts including problem identification, analysis, action plan, implementation, and re-evaluation.

CON applicants should be in compliance with all federal and District health and safety regulations, applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and other appropriate national accrediting organization standards, and applicable local certification standards.

Services should be delivered by professionals and paraprofessionals certified by the appropriate licensing authorities or professional bodies.

CON applicants must demonstrate and provide assurances that adequate qualified personnel are available at all times to meet the needs of patients.

CON applicants should develop and maintain training and continuing education programs for staff and volunteers.

Qualifications for practice should be continuously updated to keep pace with advancements in health care knowledge and techniques.

Care should be consistent with recognized standards of care.

CON applicants shall have malpractice insurance consistent with industry standards.

An application from an existing facility or services should identify any outstanding health care licensure deficiencies, citations or accreditation problems as may have been cited by the appropriate authority.

### ***Acceptability***

Upon admission, the patient and family/caregiver will be provided information necessary for an informed medical and financial consent.

CON applicants shall demonstrate how patients and family/caregivers are informed about the nature of their condition, the benefits and risks of available treatment, and the expected outcomes; they should be provided the opportunity to ask questions and discuss their medical record.

CON applicants shall demonstrate how patients and family/caregivers should be provided with simple understandable information about fees, billing procedures, scheduling of appointments, contacting the unit after hours, and grievance procedures.

CON applicants should have an adopted Patient's Bill of Rights, and should make these rights known to the patient and family/caregiver as part of an informed consent policy and procedure.



CON applicants should make available to the patient and family/caregiver an individual copy of the Patient's Bill of Rights which should also be posted in a visible location.

CON applicants should have written, publicized grievance procedures for patients, caregivers and staff that permit expression of concerns without fear of reprisal.

CON applicants should monitor the grievance procedure in order to maintain or improve its effectiveness and to ensure timely resolution of grievances.

CON applicants should demonstrate that services and facilities enhance the personal privacy and dignity of clients.

CON applicants should demonstrate that they have procedures to ensure patient confidentiality.

CON applicants should demonstrate that all patients and family/caregivers have the option to participate in care planning, review and evaluation of services.

CON applicants should demonstrate that the selection of treatment and the availability of support services should be conducive to patient cooperation and participation.

CON applicants to the extent possible should accommodate the cultural and/or religious needs of each patient and family/caregiver.

CON applicants should demonstrate efforts to encourage community participation including informing the Advisory Neighborhood Commissions in their service area.

CON applicants should establish procedures for the periodic assessment of their service acceptability as viewed by consumers, the community, and the health care industry and other health providers.

CON applicants should demonstrate they have internal mechanisms to assess the acceptability of the services provided to the patient.

### ***Continuity***

CON applicants should have formal referral agreements to ensure continuity of care and coordination of services with hospitals and other service providers in order to provide a full array of services necessary to give the most appropriate level and scope of health care services for the patient.

CON applicants should be able to demonstrate staffing patterns consistent with the Department of Health or national standards that ensure continuity of care for all patients at optimal levels.

Continuity of care should not be obstructed because of the source of care or method of payment.

Referral agreements should include a range of provisions covering primary, secondary, and tertiary levels of care. Services included may be: emergency, special diagnostic, medical-surgical inpatient care, social services, home care, and other support services.

CON applicants should have written policies and procedures for internal communication and service coordination.

CON applicants should have written policies and guidelines for referral of patients for different or additional services, including procedures for carrying out referrals.

Health services should be coordinated and interlinked with other human service delivery systems in the community, particularly the social services delivery system, to promote holistic care of the individual.

Hospitals should develop formal agreements with providers who see uninsured patients so that they have admitting privileges to hospitals.

CON applicants in referring patients, should include patient records to ensure that continuity of care is maintained. Records should include, at minimum, written summaries of care rendered as well as current patient care data.

The medical records and information system should enable ready transfer of health information, either physically or electronically, from one service provider to another.

CON applicants must demonstrate that they have adequate resources and procedures to provide for the monitoring of patient progress and as necessary, the ability to provide follow up medical and surgical services.

CON applicants should have written policies and procedures regarding discharge planning and follow-up care.

Patients and families should be educated prior to discharge regarding the practices to be followed for patients at home.

CON applicants should have an individualized care plan for all patients, which should include the diagnosis and assessment of the client's physical and mental health, and a determination of an appropriate treatment.

### ***Cost***

CON applicants should provide information on the financial viability of proposals.

CON applicants should demonstrate that less costly alternatives are not feasible or appropriate for the target population.

The costs of construction, equipment, expansion, or renovation of a facility should demonstrate an active intent to contain costs and should be consistent with costs for similar facilities and patient units in the Washington, D.C. metropolitan area.

In considering applications batched for review, the SHPDA may give favorable consideration to whichever of the applicants historically has provided the higher annual percentage of uncompensated care and the higher annual percentage of services to Medicare and Medicaid.

CON applicants shall demonstrate the availability of funds for capital expenditures and operating needs as well as the immediate and long-term financial projections of the costs of and charges for providing health services.

CON applicants must demonstrate the sources and amounts of funding for proposed projects including borrowing details; audited financial statements, lease and purchase arrangements, and other such financial indicators as may be requested by the SHPDA.

CON applicants must provide a written commitment that services for uncompensated care will be offered at a standard that meets or exceeds the District requirements.

CON applicants must provide a written commitment to participate in the Medicare and Medicaid programs.

Applicants should submit a projected manpower budget specifying the personnel required for the staffing of the proposed project and a plan for the recruitment and training of personnel.

CON applicants shall provide full disclosure of all entities, subsidiaries, or persons within a legal chain of control and such other relevant information as may be deemed necessary by the SHPDA for full disclosure.



# THE APPENDIX

*Performance Measures*  
Leading Accountability Tools

Hospital Quality Care Measures		No of Hospitals Reporting (out of seven) †	District of Columbia Average	United States Average
<b>Heart Attack Care Quality Measures</b>				
Percent of Heart Attack Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)*		3	81	81
Percent of Heart Attack Patients Given Aspirin at Arrival*		6	97	92
Percent of Heart Attack Patients Given Aspirin at Discharge*		5	88	89
Percent of Heart Attack Patients Given Beta Blocker at Arrival*		6	91	86
Percent of Heart Attack Patients Given Beta Blocker at Discharge*		5	88	89
Percent of Heart Attack Patients Given Percutaneous Coronary Interventions (PCI) Within 120 Minutes Of Arrival*		1	31	67
Percent of Heart Attack Patients Given Smoking Cessation Advice/Counseling*		3	51	85
Percent of Heart Attack Patients Given Thrombolytic Medication Within 30 Minutes Of Arrival*		0	5	30
<b>Heart Failure Care Quality Measures</b>				
Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)*		7	80	81
Percent of Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function*		7	89	82
Percent of Heart Failure Patients Given Discharge Instructions*		6	55	57
Percent of Heart Failure Patients Given Smoking Cessation Advice/Counseling*		5	71	79
<b>Pneumonia Care Quality Measures</b>				
Percent of Pneumonia Patients Assessed and Given Influenza Vaccination*		2	23	70
Percent of Pneumonia Patients Assessed and Given Pneumococcal Vaccination*		7	27	64
Percent of Pneumonia Patients Given Initial Antibiotic(s) within 4 Hours After Arrival*		7	55	78
Percent of Pneumonia Patients Given Oxygenation Assessment if appropriate*		7	99	99
Percent of Pneumonia Patients Given Smoking Cessation Advice/Counseling*		6	67	76
Percent of Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)*		7	82	81
Percent of Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics*		7	80	90
<b>Surgical Care Improvement/Surgical Infection Prevention Quality Measures + B12</b>				
Percent of Surgery Patients Who Received Preventative Antibiotic(s) One Hour Before Incision*		6	75	81
Percent of Surgery Patients Whose Preventative Antibiotic(s) are Stopped Within 24 hours After Surgery*		6	71	70

Source: US Dept of Health and Human Services

\* The percentage includes only patients whose history and condition indicate the treatment is appropriate.

† Total hospitals reporting = 7. Hospitals were excluded from some measure calculations for the following reasons:

The number of cases is too small (n<25) for purposes of reliably predicting hospital's performance.

No data is available from the hospital for this measure.

"0 patients" -- The hospital treated patients in this condition, but no patients met the criteria for inclusion in the measure calculation.

HEDIS Measures	Measure Description	DCMAA Average (3 Plans)	HEDIS Medicaid Mean†	75th %ile	90th %ile
<b>Effectiveness of Care</b>					
Childhood Immunization Status	Childhood Immunization Status-DTP	88.6%	75.6%	81.8%	85.8%
	Childhood Immunization Status-IPV	91.8%	84.8%	90.0%	92.8%
	Childhood Immunization Status-MMR	93.0%	88.1%	91.6%	94.1%
	Childhood Immunization Status-HIB	93.9%	78.9%	85.2%	88.3%
	Childhood Immunization Status-Hepatitis B	90.3%	81.9%	88.9%	91.2%
	Childhood Immunization Status-VZV	92.7%	84.7%	90.0%	92.2%
	Childhood Immunization Status-Combo 2	82.8%	62.9%	71.4%	75.7%
	Adolescent Immunization Status-MMR	83.8%	71.6%	82.2%	89.5%
	Adolescent Immunization Status-Hepatitis B	82.1%	61.0%	73.4%	80.6%
	Adolescent Immunization Status-VZV	75.1%	47.4%	63.8%	71.7%
Adolescent Immunization Status	Adolescent Immunization Status-Combo 2	73.6%	38.4%	53.8%	62.6%
	Appropriate Treatment for Children	89.5%	80.0%	85.5%	89.0%
	Appropriate Treatment for Children	41.1%	54.6%	67.5%	77.0%
	Breast Cancer Screening	52.2%	54.0%	59.4%	66.4%
	Cervical Cancer Screening	67.1%	64.5%	71.8%	76.6%
	Chlamydia Screening - Ages 16 to 20	62.7%	45.2%	54.0%	62.5%
	Chlamydia Screening - Ages 21 to 25	68.3%	48.2%	58.3%	64.5%
	Chlamydia Screening - Total	65.8%	46.4%	55.8%	62.9%
	Controlling High Blood Pressure	60.9%	61.5%	68.4%	71.0%
	Cholesterol Management After Acute Cardiovascular Events - Screening	68.6%	59.8%	70.8%	78.0%
Cholesterol Management After Acute Cardiovascular Event	Cholesterol Management After Acute Cardiovascular Events - Control LDL-C <130	55.3%	39.8%	51.1%	59.0%
	Cholesterol Management After Acute Cardiovascular Events - Control LDL-C <100	31.4%	27.7%	38.7%	42.9%
	Comprehensive Diabetes Care - HbA1c Testing	75.7%	75.0%	84.1%	88.8%
	Comprehensive Diabetes Care - Poor HbA1c Control	46.2%	49.4%	37.8%*	31.1%*
	Comprehensive Diabetes Care - Eye Exams	46.2%	44.1%	54.9%	60.9%
	Comprehensive Diabetes Care - Lipid Profile	81.5%	78.6%	86.6%	91.4%
	Comprehensive Diabetes Care - Lipid Control <130	58.6%	50.2%	59.4%	65.0%
	Comprehensive Diabetes Care - Lipid Control <100	35.2%	30.3%	36.4%	41.6%
	Comprehensive Diabetes Care -Monitoring Diabetic Nephropathy	59.5%	45.8%	54.7%	63.0%

HEDIS Measures	Measure Description	DCMAA Average (3 Plans)	HEDIS Medicaid Mean†	75th %ile	90th %ile
Use of Appropriate Medications for People With Asthma	Medications Use for Asthma - Ages 5 to 9	86.0%	62.8%	72.3%	76.6%
	Medications Use for Asthma - Ages 10 to 17	86.2%	61.8%	69.5%	73.6%
	Medications Use for Asthma - Ages 18 to 56	84.6%	64.4%	71.6%	75.1%
	Medications Use for Asthma -Combined	85.6%	63.8%	70.7%	74.1%
<b>Access/Availability of Care</b>					
Adults' Access to Preventive/ Ambulatory Health Services	Adults Access Preventive/Ambulatory Health Services Ages 20-44	74.5%	75.8%	83.5%	85.4%
	Adults Access Preventive/Ambulatory Health Services Ages 45-64	73.3%	81.1%	87.1%	88.7%
	Adults Access Preventive/Ambulatory Health Services Ages 65+	67.6%	79.8%	89.0%	91.5%
Children's and Adolescents' Access to Primary Care Practitioners	Children Access Primary Care Provider 12-24 Months	94.3%	91.8%	97.2%	98.3%
	Children Access Primary Care Provider 25 Months-6 Yrs	87.1%	81.6%	88.2%	91.4%
	Children Access Primary Care Provider 7-11 Yrs	89.8%	82.4%	89.7%	92.9%
	Children Access Primary Care Provider 12-19 Yrs	85.0%	79.0%	88.2%	90.6%
	Timeliness of Prenatal Care Postpartum Care	75.0%	78.3%	86.7%	89.5%
Prenatal and Postpartum Care	Annual Dental Visits - 4 to 6 Years Old	60.9%	55.9%	64.5%	69.7%
	Annual Dental Visits - 7 to 10 Years Old	48.0%	46.4%	58.1%	64.4%
Annual Dental Visit	Annual Dental Visits - 11 to 14 Years Old	44.3%	47.9%	56.9%	62.3%
	Annual Dental Visits - 15 to 18 Years Old	39.6%	43.4%	50.5%	57.2%
	Annual Dental Visits - 19 to 21 Years Old	31.8%	37.3%	46.8%	50.7%
	Annual Dental Visits - Combined	21.4%	28.7%	40.3%	43.3%
	Received <21% of expected prenatal care visits	37.7%	42.5%	50.9%	55.9%
<b>Use of Services</b>					
Frequency of Ongoing Prenatal Care	Received 21-40% of expected prenatal care visits	8.3%	19.3%	4.6%*	2.3%*
	Received 41-60% of expected prenatal care visits	9.8%	6.6%	8.1%	12.9%
	Received 61-80% of expected prenatal care visits	12.0%	7.8%	10.2%	13.3%
	Received over 81% of expected prenatal care visits	16.2%	13.8%	18.3%	21.3%
	Well Child Visits in the First 15 Months of Life	53.8%	50.9%	67.4%	79.0%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Well Child Visits in the First 15 Months of Life-6 or more visits	67.9%	46.8%	56.3%	65.7%
	Well Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	80.6%	61.9%	70.8%	76.7%
Adolescent Well-Care Visit	Adolescent Well-Care Visits	59.6%	40.3%	46.3%	53.9%



Other 2005 HEDIS Measures currently not being used by DOH-MAA	HEDIS Medicaid Mean†
Antidepressant Medication Management	Antidepressant Medication Management - Contacts Antidepressant Medication Management - Acute Phase Antidepressant Medication Management - Continuation Phase
Beta Blocker Treatment	Beta-Blocker Treatment After a Heart Attack
Childhood Immunization Status	Persistence of Beta-Blocker Treatment After a Heart Attack
DMARD Therapy	Childhood Immunization Status - Pneumococcal Conjugate DMARD Therapy in Rheumatoid Arthritis
Mental Illness	Follow-up After Hospitalization for Mental Illness Follow-up After Hospitalization for Mental Illness - 30 Days Follow-up for Children w/ADHD Medication - Initiation
Imaging Studies	Imaging Studies for Low Back Pain
Acute Bronchitis	Inappropriate Treatment for Adults with Acute Bronchitis
Alcohol/Drug Dep. Treatment	Init./Engagement Alcohol/Drug Dep. Treatment - Initiation Init./Engagement Alcohol/Drug Dep. Treatment - Engagement
COPD	Use of Spirometry in the Assessment and Diagnosis of COPD

**Summary**

- Total of **56** measures
- **44** exceeded HEDIS mean (79%)
- **17** were above 50th percentile
- **9** were above 75th percentile
- **18** were above 90th percentile
- **12** did not meet HEDIS mean (21%)

**District's Healthy People 2010 Measures  
Objectives, Baselines, 2005 Status and December 2007 Targets  
- 2006 Revisions -**

Focus Area 1: Nutrition and Overweight			
2010 Objective	Baseline	Status as of 2005	December 2007 Target
<p>1-1. Reduce iron deficiency to 15 percent or less among infants and children up to the age of 5 years, and among women of childbearing age in the Women, Infants, and Children (WIC) population.</p>	<p>19.1 percent of WIC infants and children under the age of 5 years were iron deficient according to the 2000 Centers for Disease Control and Prevention (CDC) data from the Pediatric Nutrition Surveillance Survey (PedNSS). Iron deficiency can result in anemia. Anemia rates vary substantially within race/ ethnicity groups with white non-Hispanic, as well as Asian/Pacific Islander children below the age of 5 years showing the lowest anemia rates in the District (11.8 percent and 11.7 percent, respectively). Anemia rates vary substantially within race/ethnicity groups with white non-Hispanic, as well as Asian/Pacific Islander children below the age of 5 years showing the lowest anemia rates in the District (11.8 percent and 11.7 percent, respectively) and black non-Hispanic children 15.5 percent showing the highest (20.4 percent). Of Hispanic children 15.5 percent were anemic. Data for 2003 show an increase in the anemia rate in the District by 2 percent, mostly due to a further increase in the anemia rate within the black non-Hispanic population to 24.1 percent.</p>	<p>According to FY 2004 Pediatric Nutrition Surveillance Survey data for the District of Columbia, the average percentage for low iron classification is 20.9 percent in children under the age of 5 years. There is a great deal of variation between race and ethnic groups; for instance, the prevalence of anemia in the Asian/Pacific Islander and Hispanic populations is 18.8 percent and 13.1 percent, respectively, while the rate of anemia for African American children is 23.9 percent.</p>	<p>By December 2007 (as proposed in the DC Healthy People 2010 Biennial Implementation 2006-2007), the proportion of infants and children under five years of age registering low iron levels in the blood will be decreased by 2 percent in African American infants and children 8 months to 5 years from 21 percent to 19 percent.</p>
<p>1-2.1. Increase the breastfeeding initiation rate among WIC postpartum mothers to 55 percent. Increase the duration rate among WIC postpartum mothers who breastfeed their infants until 6 months old to 30 percent.</p>	<p>44.7 percent of WIC participants initiated breastfeeding in the early postpartum period and 22 percent of WIC breast-feeding mothers continued to breast-feed at 6 months postpartum (2000 CDC data from the PedNSS).</p>	<p>Currently 47.5 percent of women enrolled in WIC initiate breastfeeding and 30 percent continue breastfeeding up to 6 months.</p>	<p>By December 2007, 50 percent of clients will breastfeed their babies in the early postpartum period and at least 32 percent will continue breastfeeding until the baby has reached 6 months of age.</p>

<p>1-2.2. Increase the breastfeeding duration rate at 1 year after birth to 25 percent.</p>	<p>In 2003, according to CDC data from the PedNSS, 19.5 percent of breastfeeding mothers breastfed for at least one year.</p>	<p>The December 2004 (BIP 2003-2004) targets stated that 20.3 percent of WIC mothers breastfed for at least one year. There has been a tremendous improvement in the breastfeeding rates by 146 percent compared to the FY 2000 baseline. Further efforts are needed to reach the 2010 national target of 25 percent.</p>	<p>By December 2007, 21 percent of infants will be breastfed for at least one year.</p>
<p>1-3. Reduce to less than 15 percent, the prevalence of overweight individuals among pediatric WIC participants.</p>	<p>11.3 percent of WIC infants and children under the age of 5 years were overweight (2000 CDC data from PedNSS).</p>	<p>The December 2004 target for Objective 1-3.1 was that a chapter on obesity will be integrated into the healthy eating core nutrition category of the WIC core curriculum. This target was not reached. The December 2004 target for Objective 1-3.2 was that clients would be counseled on well-balanced diets, the need to maintain a healthy weight, benefits of being physically active and ways of increasing physical activity, as well as proper diet in variety and quantity. This target was met. The Food Stamp Nutrition Education Program (FSNEP) reached a total of 4,480 contacts in the target audience in FY 2004.</p>	<p>By December 2007, new Motivational Interviewing techniques will be consistently used in some of the WIC local agency clinic sites to more effectively counsel children and their patients on eating health foods and being more physically active, which, consequently, should lead to healthier weights. Clients will be counseled on well-balanced diets, the need to maintain a healthy weight, benefits of being physically active and ways of increasing physical activity, as well as on proper diet variety and quantity.</p>
<p><b>Focus Area 2: Tobacco Use</b></p>			
<p><b>Objective</b></p> <p>2-1.1. Reduce to 18.5 percent the proportion of adults (18 years or older) who are current smokers.</p>	<p><b>Baseline</b></p> <p>20.4 percent of adults in the District were current smokers in 2002 (Behavioral Risk Factor Surveillance System or BRFSS).</p>	<p><b>Status as of 2005</b></p> <p>The first of the two December 2004 targets was to reach 11,000 of the adult population through anti-smoking education campaigns. This target was met. The second December 2004 was to reach licensed restaurant owners in the District of Columbia through anti-smoking educational campaigns and to encourage them to go smoke-free. This target was also met.</p>	<p><b>December 2007 Target</b></p> <p>By December 2007, smoking rates among District adult residents will be decreased to 20.5 percent (down from 22.0 percent in 2003).</p>

2-1.2. Reduce to 20 percent the proportion of adult Hispanics (18 years and older) who are current smokers.	28.0 percent in 2002 and 24.2 percent in 2003 of Hispanics were current smokers in the District (BRFSS).	Objective 2-1.2 was addressed in the BIP 2003-2004. Its December 2004 target of reaching 4,000 youth with educational anti-smoking campaigns, including workshops and youth-led activities was not attained; only 50 percent of the target was attained.	
2-1-3. Reduce the proportion of young people in grades 9-12 who have ever smoked cigarettes to no more than 50 percent.	56.7 percent of young people in grades 9-12 had tried cigarettes in 2001 (District of Columbia Youth Risk Behavior Survey or DC YRBS).		
2-1.4. Reduce to no more than 16 percent the proportion of young people in grades 9-12 reporting as current smokers.	16.9 percent of boys and 12.3 percent of girls were smokers in 2001 (DC YRBS).		
2-2. Increase abstinence from tobacco use by pregnant women to 98 percent.	94.5 percent of pregnant women abstained from smoking in 1997, according to hospital records.		
2-3. Increase to 75 percent the proportion of patients who receive advice to quit smoking from a health care provider during the reporting year.	53.6 percent of the total population had received such advice in 1996 (BRFSS).		
<b>Focus Area 3: Environmental Health and Food Safety</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status as of 2005</b>	<b>December 2007 Target</b>
3-1. Reduce outbreaks of waterborne diseases from infectious agents and chemical poisoning to no more than 11 per year with a decrease to zero.	According to the CDC, there are 900,000 cases of waterborne disease in the US each year, and possibly as many as 900 deaths each year.	There were zero waterborne diseases from infectious agents or chemical poisonings reported in 1997. Ongoing upgrades of the water supply system should ensure that the current status will be maintained and the 2010 goal of zero outbreaks achieved.	
3-2. Reduce the prevalence of blood lead levels in excess of 10 ug/dL in children 6 months to 6 years in age, and ensure that no District child in this age group has a blood lead level in excess of 10ug/dL.	In 1997, 86 or 3 percent of District children screened had blood lead levels exceeding 15 ug/dL (Source: Bureau of Labs).	The December 2002 target of 22,000 screenings of children in the 6 months to 6 years age group was met and exceeded by 839 bringing the total number of children in the targeted age range to 22,839.	

<p>3-3. Improve air quality to healthy levels for 100 percent of the people who reside in and visit the District.</p>	<p>In 2001, air quality in the District did not meet the new national standards for fine particles or the 8-hour ozone standard.</p>	<p>The District did not meet the new national standards for fine particles or the 8-hour ozone standard in 2001, and despite efforts in regional collaboration to institute adequate control and regulation measures, air pollution has continued to adversely affect residents of and visitors to the District of Columbia.</p>	<p>By December 2007, the District will have adopted new regulations and engaged in regional and interstate partnerships to reduce the number of days during which it is not in compliance with the new national standards for fine particles and the 8-hour ozone standard.</p>
<p>3-4 through 3-6 were dropped.</p>			
<p>3-7. Eliminate significant health risks from the National Priority List (NPL) of hazardous wastes sites, as measured by the level of site cleanup performance sufficient to eliminate the immediate and significant health threats as specified in the sites' health assessments. The Washington Navy Yard is the only site in the District that is on the NPL.</p>	<p>Remediation of the Washington Navy Yard was begun as part of a Corrective Action Order issued by the EPA in 1998.</p>	<p>Active participation continues in the Federal Facilities partnership that provides direction, technical review, and oversight for site remediation.</p>	<p>By December 2007, the remediation project will have met all the scheduled milestones for completion of the project by 2015.</p>
<p>3-8. Work with the National Capital Poison Control Center to identify the total number of accidental pesticidal exposures, routes of exposure, and types of pesticides involved. Design an outreach and education program targeted to reduce the causes of the most frequent types of exposures.</p>	<p>Baseline: to be determined.</p>	<p>This objective is being addressed for the first time in the BIP 2006-2007.</p>	<p>By 2007, the District will have implemented new pesticide control regulations, retained additional staff with expertise in toxicology and risk communication, and will have improved and expanded its public outreach and education initiatives.</p>
<p>3-9. Reduce infections caused by key foodborne pathogens to incidences per 100,000 of no more than those listed below:</p> <ul style="list-style-type: none"> <li>o Salmonella species 0</li> <li>o Escherichia coli 0157:H7 0</li> <li>o Listeria monocytetes 0</li> <li>o Unknown etiology. 1</li> </ul>	<p>In 1998 in the District there were the following infections:</p> <ul style="list-style-type: none"> <li>o Salmonella species 2</li> <li>o Escherichia coli 0157:H7 0</li> <li>o Listeria monocytetes 0</li> <li>o Unknown etiology. 3</li> </ul> <p>(Figures are per 100,000 people.) (EHA Database).</p>	<p>By 2005, all of the here and below-listed 2010 objectives for Food Safety in the District had been attained.</p>	
<p>3-10. Reduce outbreaks of Salmonella enteritidis to fewer than 25 outbreaks yearly.</p>	<p>Nationally in 1989, there were 77 outbreaks. In 1988 in the District, there were two outbreaks.</p>		

<p>3-1.1. Adopt and implement the 1999 Food Code for institutional food operations and the new Uniform Food Protection Code that sets recommended standards for regulation of all District food operations.</p>	<p>Twenty-one states and territories had implemented the 1999 Food Code for institutional food operations by March 2005. The 1999 Food Code was adopted in the District in 2003 and implementation is in progress.</p>	<p>The 1999 Food Code for institutional operations was adopted in the District of Columbia in 2003.</p>	
<b>Focus Area 4: Injury/Violence Prevention</b>			
<b>Objective</b>			
<p>4-1.1. Establish a Trauma/Injury Registry at the DOH to which data on injury cases seen at hospital emergency rooms, trauma centers, and ambulatory clinics regularly reported.</p>	<p><b>Baseline</b> No Trauma/Injury Registry has been yet established at the DOH as of 2006. A reliable source of funding was being sought.</p>	<p><b>Status as of 2005</b> No reliable source of funding had been identified.</p>	<p><b>December 2007 Target</b></p>
<p>4-1.2. Increase to 90 percent the proportion of emergency rooms, trauma centers, and ambulatory clinics reporting data to the DOH Trauma/Injury Registry.</p>	<p><b>Baseline</b> Baseline to be determined. All four level one trauma centers have registries that collect data on the external causes of injury, but are not mandated to report this information to the DOH. The number of treatment sites voluntarily reporting data to the DOH on intentional and unintentional injuries seen on-site can be considered as a baseline to which more sites can be added after reporting becomes mandatory.</p>	<p><b>Status as of 2005</b> Funding for the establishment of the DOH Injury/Trauma Registry appeared to have been identified and ensured. But by 2006, the search for funding had resumed.</p>	<p><b>December 2007 Target</b> By December 2007, the Injury/Trauma Registry will be funded and operational.</p>
<b>Focus Area 5: Pediatric Dental Health</b>			
<b>Objective</b>			
<p>5-1. Reduce dental caries (cavities) in primary and permanent teeth (mixed dentition) so that the proportion of children with one or more cavities (filled or unfilled) is no more than 10 percent among those 2–4 years of age, 35 percent among children 6–8 years of age, and 45 percent among adolescents 15 years in age.</p>	<p><b>Baseline</b> Nationally, between 1988 and 1994, 18 percent of children ages 2–4 years, 52 percent of those ages 6–8 years, and 61 percent of adolescents 15 years of age had experienced dental caries. (Local baseline to be established based on expansion of the Oral Health Program and the amalgamation of all data sources within DC DOH.)</p>	<p><b>Status as of 2005</b></p>	<p><b>December 2007 Target</b></p>

<p>5-2. Reduce untreated cavities in primary and permanent teeth (mixed dentition) so that the percentage of children with unfilled, decayed teeth is no more than 10 percent among children 2-4 years of age, 20 percent among children 6-8 years of age and 12 percent among adolescents 15 years in age.</p>	<p>Nationally, between 1988 and 16 1994, 16 percent of children ages 2-4 years, 29 percent of children ages 6-8 years, and 20 percent of adolescents 15 years in age had one or more decayed teeth. (Local baseline to be determined based on expansion of the Oral Health Program and the amalgamation of all data sources within D.C. DOH)</p>	<p>Nationally, between 1988 and 1994, 23 percent of 8- year olds and children and 24 percent of 14- year- year olds received sealants in permanent molar teeth.</p>	<p>By December 2007, increase to at least 35 percent the proportion of 2<sup>nd</sup> and 3<sup>rd</sup> grade children who have received protective sealants in at least one of their permanent molar teeth.</p>
<p>5-3. Increase to at least 10 percent the proportion of 2<sup>nd</sup> and 3<sup>rd</sup> grade children have received protective sealants in at least one of their permanent molar teeth.</p>	<p>Nationally, between 1995 and 1998, 15 percent of eligible 1-5 year-olds received dental assessments.</p>	<p>Nationally, between 1988 and 1994, 23 percent of 8- year olds and children and 24 percent of 14- year- year olds received sealants in permanent molar teeth.</p>	<p>Nationally, between 1995 and 1998, 15 percent of eligible 1-5 year-olds received dental assessments.</p>
<p>5-4. Increase to at least 15 percent, (the Early Periodic Screening, Diagnosis and Treatment rate) the proportion of 1 - 5 year olds who receive caries screening by a qualified health care professional to determine the existence of any observable decay and for counseling on the need to increase the source of fluoride or decrease potentially excessive sources of fluoride.</p>	<p>Locally, 33 percent of students entering school programs received an oral health screening in school year 2005-2006.</p>	<p>Baseline is to be determined.* *To begin establishing a baseline, the Oral Health Division will hire an Oral Health Educator to track the percentage of children who are referred for additional services.</p>	<p>Locally, 33 percent of students entering school programs received an oral health screening in school year 2005-2006.</p>
<p>5-5.1. Increase to at least 50 percent the percentage of all children entering school programs for the first time, who have received an oral health screening.</p>	<p>Baseline is to be determined.* *To begin establishing a baseline, the Oral Health Division will hire an Oral Health Educator to track the percentage of children who are referred for additional services.</p>	<p>Baseline is to be determined.* *To begin establishing a baseline, the Oral Health Division will hire an Oral Health Educator to track the percentage of children who are referred for additional services.</p>	<p>Baseline is to be determined.* *To begin establishing a baseline, the Oral Health Division will hire an Oral Health Educator to track the percentage of children who are referred for additional services.</p>
<p>5-5.2. Of those children screened and needing referral, increase to at least 20 percent the proportion of children receiving a referral for necessary diagnostic, preventive, and treatment services.</p>	<p>This objective has already been achieved and is included as a status indicator.</p>	<p>As of 2004, at least 25 percent of school-based health centers maintain an oral health component.</p>	<p>As of 2004, at least 25 percent of school-based health centers maintain an oral health component.</p>
<p>5-6. Increase to 10 percent the proportion of school-based health centers (pre-kindergarten through 12th grade) with an oral health component.</p>	<p>As of 2004, at least 25 percent of school-based health centers maintain an oral health component.</p>	<p>As of 2004, at least 25 percent of school-based health centers maintain an oral health component.</p>	<p>As of 2004, at least 25 percent of school-based health centers maintain an oral health component.</p>

Focus Area 6: Primary Care			
Objective	Baseline	Status as of 2005	December 2007 Target
6-6-1. Increase access to care by increasing the number of National Health Service Corps Loan Repayment providers in the District of Columbia from 26 to 36.	There were 26 health care providers in the District in 1999. Providers are defined as allopathic physicians, dentists, nurse practitioners, physician assistants, nurse midwives.	The December 2004 Target for this objective was achieved by 100 percent.	By December 2007, 30 providers will be placed in the District of Columbia.
6-6-2. Increase access to care for vulnerable populations in underserved areas by increasing the number of primary care treatment sites from 50 to 60.	There were 50 treatment sites in the District in 1999.		
6-6-3. Increase access to care for vulnerable populations by increasing the number of Health Professional Shortage Areas (HPSA) Facility Designations from 2 to 5.	There were 2 HPSA Facility Designations in 1999.		As of December 2004, 1 additional dental care services area and 1 mental health services area will be established. Target achievement was 50 percent; a mental health facility was designated.
6-6-4. Evaluate the impact (on participating children and their families) of the new health insurance programs implemented in October 1998 – Medicaid Managed Care expansion and Children’s Health Insurance Programs (CHIP)/D.C. Healthy Families Program.	10,500 children and their families have been enrolled in the DC Healthy Families Program since its implementation in October 1998.		
6-6-5 and 6.6 were dropped.			
6-7. Retain 40 percent of National Health Service Corps. and Conrad-30 program providers in Health Professional Shortage Areas and Medically Underserved Areas after their commitment period.	FY 04 Target 33 percent; actual 81 percent.	Staff, funding to increase training opportunities for providers who work with medically vulnerable populations needed.	By December 2007, 37 percent of providers will be retained.
6-8. Evaluate patients’ satisfaction with the primary care services provided through the local and federal public health insurance programs in annual assessments with distribution of findings to primary care providers and the general public.	Currently there are no data for collective, quantitative benchmarks. Data to be added when available.		



Focus Area 7: Emergency Health and Medical Services			
Objective	Baseline	Status as of 2005	December 2007 Target
<p>7-7-1.1: Develop a document that describes in detail the qualifications, credentials, and duties of all emergency medical service (EMS) personnel, including medical directors, emergency medical technicians, paramedics (EMP/P), emergency medical technicians/intermediates (EMP/IP), emergency medical technicians; basic (EMP/B), and medical dispatchers.</p>	<p>Action on this objective has been ongoing, since October of 2004. As of November 2006, policies and procedures for all levels of EMS providers are being developed.</p>	<p>As of November 2006, policies and procedures for all levels of EMS providers are being developed.</p>	
<p>7-1.2: Ensure that all emergency 911 transport units have personnel with advanced life support capability as defined by the DOH.</p>	<p>As of 1999, 35 percent of transport units include advanced life support capability.</p>		
<p>7-1.3: Ensure that response times (from the time the call was received by dispatch to the time EMS arrives at the scene) will meet the 90<sup>th</sup> percentile of 8 minutes for critical patients and 16 minutes for noncritical patients, based on the Medical Priority Dispatch System (MPDS).</p>	<p>As of 1999, response times for 911 calls for critical patients in the 90<sup>th</sup> percentile equal 10.21 minutes based on the MPDS.</p>		
<p>7-1.4: Revise and update current District of Columbia Adult Pre-hospital Medical Protocols to meet and reflect current trends in pre-hospital care.</p>	<p>Activities began after 2000. The DC Adult Pre-Hospital Medical Protocols were revised and updated in 2002. Additionally, protocols for "SARS," Near Drowning Continuous Positive Airway Pressure, D.C. General Urgent Care Center Transport Pilot Program, Cyanide Antidote Package and Sodium Thiosulfate have been adopted. A protocol for "Cessation of Medical Cardiorespiratory Resuscitation Efforts" will go into effect in December 2006.</p>	<p>Additionally, protocols for "SARS", Near Drowning, Continuous Positive Airway Pressure, DC General Urgent Care Center Transport Pilot Program, Cyanide Antidote Package and Sodium Thiosulfate have been adopted. A protocol for "Cessation of Medical Cardiorespiratory Resuscitation Efforts" will go into effect in December of 2006.</p>	
<p>7-1.5: Ensure proper medical direction of pre-hospital personnel in the District.</p>	<p>This objective has been met; every ambulance company has its own medical director who ensures compliance with the state pre-hospital protocols.</p>		

<p>7-2.1: In conjunction with the EMS Advisory committee, the municipal and the commercial ambulance companies certified in the District, EHMSA will develop a comprehensive EMS dataset conforming to the national uniform dataset and linking to other D.C. agencies.</p>	<p>While the U.S. Department of Transportation and the National Emergency Medical Services Information Systems (NEMSIS) finalize the national EMS comprehensive dataset, the DCFEMS Department, has developed a dataset for the 911 EMS system that is NEMSIS compliant.</p>		
<p>7-2.2: Develop legislation requiring all licensed ambulance services to report the established comprehensive dataset to the Emergency Health and Medical Services Administration (EHMSA) in the DOH by January 1, 2002.</p>	<p>This objective is awaiting the development of a standard dataset.</p>		
<p>7-2.3: In collaboration with the DOH Injury Prevention and Disabilities Health Program, establish a District of Columbia Injury/Trauma (Trauma/Injury) Registry that captures all relevant data on levels of uncompensated trauma care, and indicators of the quality of trauma care.</p>	<p>As of July 2001, there was no Injury/Trauma Registry at DOH to which data were reported on a regular basis. (A successful application for funding the Injury/Trauma Registry was submitted to the CDC by EHMSA in July of 2005.)</p>	<p>Funding was obtained in a successful application to CDC in July of 2006.</p>	<p>By December 2007, the Injury/Trauma Registry will be up and running.</p>
<p>7-3.1 and 7-3.2 have been dropped.</p>			
<p>7-4.1: Promote wellness, health and injury prevention within the community through public education programs and other initiatives.</p>	<p>This reflects ongoing activity. EHMSA is promoting injury prevention through collaboration with DOH Injury Prevention and Disability Health Program by participating in the Health Information Response (HIRT). The HIRT's goal is to decrease the incidence of child and adolescent injury by the provision of accurate and timely data to injury and violence prevention initiatives.</p>		
<p>7-4.2: Define and expand the role off EHMSA in Public Health.</p>	<p>Since 2002, the role of EHMSA has been expanded to include emergency preparedness.</p>		
<p>7-4.3: Support and promote EMS research on Public Health issues.</p>	<p>Since 2003, EMHSA has been conducting statistical and epidemiological studies to examine the quality of pre-hospital medical care provided by the D.C.FEMS 1+1 Pilot Program. Since the results were inconclusive, the DOH epidemiologists recommended additional studies. D.C.FEMS declined the recommendation.</p>		

7-5: Revise and update existing legislation regarding municipal and commercial ambulance services related to its delivery of effective EMS care and interfacility transports.	Interfacility Transport Protocols have been developed and will be in effect by January 1, 2007.	Interfacility Transport Protocols have been developed and will be in effect by January 1, 2007.	Interfacility Transport Protocols have been developed and will be in effect by January 1, 2007.
7-6: Establish at DOH/EHMSA an Enforcement Division to ensure compliance with the DOH specified EMS rules and regulations.	This activity began after 2000 and was in place and staffed by 2003.		
7-7: Continue participation in the development and update of the District's Response Plan (DRP) – particularly on the Emergency Support Function (ESF) # 8: Health and Medical, for which DOH is the lead agency for response to current and new threats to the District and surrounding jurisdictions.	This objective has been met. The District's Response Plan, including the ESF #8: Health and Medical, was updated in May 2006.		Not applicable. The DRP is current and all plans are current and all requirements have been met. Target has been met as of May 2006.
7-8: Establish a Do Not Resuscitate (DNR) Registry at the DOH/EHMSA.	Legislation establishing a DNR Registry at the DOH/EHMSA has been passed by the City Council in 2001. Protocols have been developed and were implemented on August 1, 2006. Training of hospital-based health care providers was conducted in August 2006. The objective has been met.		Not applicable. The DNR is fully implemented in the District of Columbia. Target has been met as of August 2006.
<b>Focus Area 8: Health Care Finance</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status as of 2005</b>	<b>December 2007 Target</b>
8-1. Reduce to less than 5 percent the proportion of Medicaid-eligible pregnant women and children in families up to 200 percent of the poverty threshold that do not have health insurance coverage.	8.8 percent of this targeted population was eligible but not enrolled in 1996.		Reduce to less than 4%.
8-2. Establish insurance coverage for adults without minor children up to 50 percent of the federal poverty level (FPL) who do not have health insurance. MAA has received approval from CMS for an 1115 Research and Demonstration Waiver to finance services for adults without minor children.	In 2005, 1,208 adults without minor children are covered up to 50 percent of the FPL. <i>(Plans to modify the Waiver to include persons up to 100 percent of FPL are on hold, because of funding constraints.)</i> Source: Reports from the Income Maintenance Administration	Target met – Waiver is in place and fully enrolled at the waiver cap.	Not applicable.

<p>8-3. Establish a comprehensive data reporting system or data warehouse to monitor the utilization of services and quality outcomes by contracted health plan, enrolled populations, and provider types.</p>	<p>The currently certified MMIS was procured in 2002. MAA will be procuring a new MMIS in 2008. The new MMIS will do much more than just pay bills. It is an MAA expectation that the new MMIS will be modular and flexible with case management and reporting capabilities. After the new MMIS is implemented, MAA is planning to procure a data warehouse to better use the data generated by the new system.</p>	<p>The current MMIS system was procured in 2002. The new system will provide additional capabilities.</p>	<p>By December 2007, a procurement path for a separate data warehouse will be established.</p>
<p>8-4. Increase to 95 percent the proportion of all Temporary Assistance to New Families (TANF) related enrollees with a specified source on ongoing primary care in collaboration with the MAA-contracted enrollment broker and managed care organizations (MCOs) to ensure that individuals are assigned to an MCO at enrollment and that the MCO contacts the individuals assigned to it.</p>	<p>In 1998 there were approximately 87 percent of all TANF enrollees who had a specified source of ongoing primary care (e.g., being insured in one of the MAA-contracted managed care organizations). Source: Medicaid Managed Care Reporting System</p>	<p>The goal of 95 percent for all TANF related enrollees with a specified source of ongoing primary care was attained in 2002.</p>	<p>By December 2007, MAA will have a finished managed care contract that includes pay-for-performance incentives.</p>
<p>8-5. Increase to 80 percent the proportion of the Medicaid-eligible child population participating in the EPSDT Program.</p>	<p>Baseline: Of the District's Medicaid-eligible child population, 40 percent participated in the EPSDT Program in 1998.</p>		
<p>8-6. Collaborate in the creation of an integrated services delivery system which ensures that Medicaid eligible persons have access to comprehensive behavioral health services consisting of mental health and substance abuse service. In 2001, MAA received approval from CMS to finance mental health rehabilitation services for Medicaid eligible.</p>	<p>Since 2004, MAA has been working with APRA on a State Plan Amendment (SPA) to finance substance abuse treatment rehab services. We expect this second SPA to move forward this year, so that ultimately both mental health and substance abuse rehab services will be available to Medicaid eligible.</p>	<p>In 2001, MAA received approval from CMS to finance mental health rehabilitation for Medicaid eligible enrollees. Since 2004, MAA has worked with APRA on a State Plan Amendment (SPA) to finance substance abuse treatment services. The SPA has been developed and submitted to CMS for review and approval.</p>	<p>By December 2007, MAA has participated in the development of coordinated behavioral health system of care that includes services provided across MCOs, DMH providers, and APRA providers for Medicaid recipients having either a mental health or a substance abuse diagnosis or both (dually diagnosed).</p>
<p>8-7. Ensure that Medicaid eligible persons with long-term care needs have access to a continuum of long-term care services, including but not limited to nursing home care, home health care, adult daycare, and assisted living services.</p>	<p>The current (2006) numbers for persons enrolled in the waiver is 1,207 and in nursing home care is 2,392. (Source: Medicaid Office of Disabilities and Aging)</p>		

Focus Area 9: Maternal, Infant and Child Health and Family Planning			
Objective	Baseline	Status as of 2005	December 2007 Target
9-1. Reduce the infant mortality rate to no more than 8 deaths per 1,000 live births.	The infant mortality rate was 10.2 per 1,000 live births in 2003. (SCHS)	The 2004 infant mortality rate of 11.8 per 1,000 live births for DC is the latest currently available.	As of December 2007, the reported infant mortality rate for 2006 will have decreased from 10.6 in 2001 to 9 per 1,000 live births.
9-3. Reduce the rate of child mortality to 30 per 100,000 children ages 1-4 and 20 per 100,000 children ages 5-14 per 100,000 children..	Overall, the child mortality rate in the District was 58.3 per 100,000 children ages 1-4; and 18.3 per 100,000 children ages 5-14 in 2000. (SCHS).	This is the first year in which this objective has been addressed in the DC Healthy People 2010 Implementation Plan series that began in 2001.	As of December 2007, the child mortality rate of 25 per 100,000 in 2003 will not increase above 25 per 100,000 children ages 1-4 years. As of December 2007, the child mortality rate will be reduced from 46.5 per 100,000 in 2003 to 40 per 100,000 children ages 5-14 years.
9-11. Reduce the incidence of preterm births to 100 per 1,000 births.	The preterm birth incidence rate was 132.0 per 1,000 live births in 2000 (Source: SCHS).	In 1997, the incidence rate for preterm birth was 131.6 per 1,000 live births. This objective had not been addressed prior to the BIP 2006-2007.	As of December 2007, the incidence of preterm births will have been reduced from 124 per 1,000 live births in 2004 to 120 per 1,000 live births.
Focus Area 10: Public Health Infrastructure			
Objective	Baseline	Status as of 2005	December 2007 Target
10-1.1. Increase to 90 percent the proportion of DOH agencies that provide onsite access to data via electronic systems and online information systems, such as the Internet.	Zero in 1997. DOH agencies had no access to the Internet at this time. By 2001, this goal had been met. All of the major sites at DOH – around 1200 employees - are connected via electronic systems and online information systems and have internet access.  (Source: SCHSA)	By 2001, this goal had been met.	
10-1.2. (Revised in 2003) Develop and implement a departmental intranet for the DOH.	Components of the departmental intranet for DOH were 10 percent complete in 2001. As of December 2004, work on the DOH intranet will be 50 percent complete.	As of 2004, an intranet website was established in a test environment. (As of May 1, 2006, 50 percent of the requirement has been met.)	
10-1.3 Revised in 2003: Implement wireless communication capability for Bioterrorism Preparedness and other communications requirements.	The process was begun in 1997 and about 40 percent of the planned components were installed as of 2003.		

<p>10-2: <b>Dropped</b></p>	<p>10-3. <i>(Revised in 2001)</i> Develop health baseline datasets on all resident racial/ethnic minority population groups in the District of Columbia (black/African American, white, Hispanic/Latino, Asian American/Pacific Islander, American Indian/ Alaska Native. Objectives</p>	<p>As of mid 1989, Vital Records data on race of residents were collected according to three broad categories (black, white, and other, as well as Hispanic ethnicity) and cited in reports produced by the SCHSA. Since 2005, preliminary data on the health status of the resident Latino community are available. Weighted data will be forthcoming.</p>	<p>In 2004, in a randomized household survey of a representative sample of the resident Latino community, health baseline data on this resident population group were collected in a community partnered research study by a team of researchers from the SCHSA in collaboration with the George Washington University Center for Global Health and the Council of Latino Agencies as the lead agency on a two-year grant from the Centers for Medicare and Medicaid. The Data Analysis and Final Report are in progress. This study, entitled the “Latino Health Care Collaborative,” represents the first application of a model for community health assessment and data-driven community health education that was developed by the DOH State Center for Health Statistics Administration (SCHSA) for application in resident minority populations, such as the Latino population of the District.</p>	<p>By December 2007, in community-partnered research, apply the health education model developed by the SCHS and piloted in the resident Latino community to obtain health baseline data on the resident AAPIO community.</p>
<p>10-4. <i>(Revised in 2001)</i> Produce 2010 implementation plans with short-term targets to evaluate goal-seeking strategies for the District’s 2010 Objectives.</p>	<p>This process began in 2001, with the development of the Annual Implementation Plan for 2001-2002. Progress in attaining targets has been tracked and reported annually or biennially in Progress Reports for over 80 percent of the 2010 Objectives.</p>	<p>As of August 2006, there have been two sets of Implementation Plans and Progress Reports developed: Annual Implementation Plan and Progress Report 2002, Biennial Implementation Plan and Progress Report 2003-2004. The third in this series, Biennial Implementation Plan 2006-2007 will soon be completed and online at the DOH website.</p>	<p>By December 2007, data and information collection for the production of the companion 2006-2007 Progress Report will be underway.</p>	
<p>10-5. Increase to 50 percent the use of geocoding in all DOH data systems to promote the development of Geographic Information Systems (GIS) capabilities.</p>	<p>About 10 percent of DOH agencies were using GIS in 1997.</p>	<p>Since 2003, this goal has been attained.</p>		
<p>10-6. Increase to 20 percent the number of DOH agencies that ensure the provision of comprehensive epidemiology services to support essential public health services.</p>	<p>Approximately 10 percent of DOH agencies were using GIS in 1999.</p>			

10-7. (Revised in 2004) Increase to 80 percent the proportion of DOH agencies that use summary population health measures for each of focus areas in the District's Healthy People 2010 Plan to monitor progress in residential communities and for planning purposes.	50 percent of agencies were providing summary population measures for the District's Healthy People 2010 Plan by 1997.	Since 2002, this goal has been attained.	
<b>Focus Area 11: Asthma</b>			
<b>Objective</b>			
11-1. Reduce the asthma mortality rate to no more than 1.5 per 100,000 residents.	Asthma mortality rate was 2.8 per 100,000 population in the District for all ages in 1997. (non-age adjusted figures)(Data Collection and Analysis Division of MFHA and SCHSA)	Status as of 2005	December 2007 Target
11-2. Reduce the overall asthma morbidity, as measured by a reduction in the asthma hospitalization rate to 10 per 10,000 people.	Asthma hospitalization rate was 27 per 10,000 for all ages in 1998; 22 per 10,000 in 2000. (D.C. Hospital Association provided data; calculation by D.C. CAN)		
11-3. Reduce the annual rate of Emergency Department (ED) visits to no more than 80 per 10,000 DC ages 0-4 children (CDC 2010 goal).	The ED rate for children ages 0-4 years was 745.7 visits per 10,000 children in 2003. (Source: Improving Pediatric Asthma care in the District of Columbia or IMPACT D.C.)		
<b>Focus Area 12: Cancer</b>			
<b>Objective</b>			
12-1. Reduce the mortality rate for cancer of the lung and bronchus by 12 percent of the 2000 baseline rate. <i>This objective has not been addressed.</i>	The age-adjusted mortality rate for cancer of the lung and bronchus was 60 per 100,000 in 2000. (DOH Cancer Incidence and Mortality Report for 2000)	Status as of 2005	December 2007 Target
12-2.1. Reduce breast cancer mortality rate by 10 percent of the 2000 rate.	The age-adjusted breast cancer mortality rate in D.C. was 27.0 per 100,000 residents in 2000. (Cancer Incidence and Mortality Report, 2000)	The December 2004 target of providing breast cancer education to 15,000 District women and free breast cancer detection services to 1,500 uninsured and underinsured District women - a repeat of last year's target which was 100 percent attained - was met. Last year Project WISH scheduled 1,503 appointments that resulted in 1,066 free mammograms to uninsured or underinsured women in the District.	By December 2007, at least 15,000 women will receive information about breast cancer screening and access to free services for eligible uninsured women. At least 600 District women will receive free breast cancer detection services under the D.C. Breast and Cervical Cancer Early Detection Program (D.C. BCCEDP).

12-2.2 Reduce cervical cancer mortality rate by 15 percent of the 2000 rate.	The age-adjusted mortality rate for cervical cancer was 4.3 per 100,000 residents in the District in 2000. (Cancer Incidence and Mortality Report, 2000)	The District of Columbia 2010 Goal is to attain an age-adjusted cervical cancer death rate reduction by 15 percent of the 2000 baseline rate. The year 2000 mortality rate for cervical cancer in the District was 4.3 per 100,000 population (U.S. 2000 Census).	By December 2007, at least 15,000 women will receive information about cervical cancer screening and about access to free services for eligible uninsured women. At least 300 District women will receive free cancer screening under the DC Breast and Cervical Cancer Early Detection Program (D.C. BCCEDP).
12-3. Reduce colorectal cancer mortality rate by 15 percent of the 2000 rate. <i>This objective has not been addressed</i>	The age-adjusted mortality rate for colorectal cancer was 29.7 per 100,000 residents in the District in 2000.	This is a new project that is targeting colorectal cancer.	By December 2007, fully implement a well coordinated Colorectal Cancer Control Program in the Department of Health.
12-4. Reduce the prostate cancer mortality rate among African American men by 25 percent of the 2000 rate.	The overall mortality rate for prostate cancer in the District was 50.78 per 100,000 residents in 2000. For African American men the prostate cancer mortality rate was 64.9 per 100,000 in 2000. (Cancer Incidence and Mortality Report, 2000)	In 2002, for African American residents, the prostate cancer mortality rate had decreased to 58.4 per 100,000 population.	By December 2007, DOH is to fully implement a citywide, well coordinated prostate cancer control program.
<b>Focus Area 13: Diabetes</b>			
	<b>Objective</b>	<b>Baseline</b>	<b>December 2007 Target</b>
13-1. Reduce the mortality rate due to diabetes as the primary cause of death to 22.9 per 100,000 residents.	The age-adjusted mortality rate due to diabetes as the primary cause of death was 37.5 per 100,000 residents in 2001	Status as of 2005	
13-2. Reduce the mortality rate for diabetes as the primary cause of death among African American residents of the District to 30.9 per 100,000 population.	The mortality rate with diabetes as the primary cause among African American residents in the District was 55.05 (crude rate) per 100,000 in 2001.		



<p>13-3. Increase to 80 percent the proportion of District residents with diabetes who report having a yearly hemoglobin A1c measurement.</p>	<p>62.5 percent of diabetic residents in the District reported having hemoglobin A1c measurement yearly in 2001 according to the Behavioral Risk Factor Surveillance Survey (BRFSS).</p>	<p>As of December 2004, standards of care guidelines were developed and approved. Funding constraints limited the establishment of registries to 25 percent accomplishment. Attainment of the standards target has allowed system partners to develop core data reporting requirements. These requirements will lead to system partners needing registries or other IT solutions to report data. The availability of data will fulfill a key requirement for meeting 2010 Objectives, since system partners will be able to develop performance improvement strategies based on their own data. System partners may set their performance targets based on system (District) level targets.</p>	<p>By December 2007, the D.C. Department of Health will work with health centers involved in the Collaborative to increase their A1c testing rates to the overall District average of 60 percent.</p>
<p>13-4 Deleted</p>			
<p>13-5. Increase to 85 percent the proportion of District residents with diabetes who report having a dilated eye exam within the past year.</p>	<p>75.6 percent of diabetic residents in the District reported having a dilated eye exam within the past year in the 2001 BRFSS.</p>	<p>The standards of care have been developed and approved. Of the system registries, 25 percent have been established.</p>	<p>As of December 2007, the D.C. Department of Health will work with health centers to increase their rate of dilated eye exams to the District average of 75 percent.</p>
<p>13-6. Increase to 75 percent the proportion of District residents with diabetes who report having their feet checked for sores or irritations by a health care professional within the past year.</p>	<p>72.5 percent of diabetic residents in the District reported having had their feet checked for sores or irritations by a health care professional within the past year in the 2001 BRFSS.</p>	<p>The Standards of Care Guidelines have been approved for implementation.</p>	<p>This objective was not targeted for 2007.</p>
<p>13-7. Increase the proportion of District residents with diabetes who report having an oral health exam within the previous 12 months to 30 percent or by 50 percent, whichever is greater.</p>	<p>57.0 percent of diabetic residents in the District reported having had an oral health exam within the previous 12 months in the 1999 BRFSS.</p>		
<p>13-8. Increase by 50 percent the proportion of District residents with diabetes who report participating within the previous 12 months in at least 1 health care provider encounter focusing on self-management strategies.</p>	<p>53.2 percent of diabetic residents in the District reported having participated within the previous 12 months in at least 1 health care provider encounter focusing on self-management strategies in the 2001 BRFSS.</p>	<p>In the 2001 BRFSS, only 53.0 percent of diabetic residents report a provider encounter on self-management techniques.</p>	<p>By December 2007, DOH will train 26 master trainers in the Stanford Model of Chronic Disease Self Management and these trainers will service key health disparity sections of the city.</p>

<p>13-9. Increase by 50 percent the proportion of District residents with diabetes who report self-examination of their feet at least once daily.</p>	<p>64.0 percent of diabetic residents in the District reported self-examination of their feet at least once daily in the 2001 BRFSS.</p>		
<p>13-10. Increase by 50 percent the proportion of District residents with diabetes who report at least one encounter with a health care provider devoted to dietary counseling (consisting of eating <i>more</i> fruit and vegetables and <i>less</i> high fat/cholesterol foods).</p>	<p>54.9 percent of diabetic residents in the District reported at least one encounter with a health care provider devoted to dietary counseling in the 2001 BRFSS.</p>		
<p>13-11. Deleted</p>			
<p>13-12. Decrease the percentage of D.C. residents who have an A1c measurement in the past 12 months with a value of 9 percent or above. Interim target: By September of 2006, develop a white paper which describes the rational, system capacity needs, and model programs from decreasing the percent of residents with an A1c measurement below 9 percent.</p>	<p>Baseline to be established.</p>		

<b>Focus Area 14: Disabilities</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status as of 2005</b>	<b>December 2007 Target</b>
14-1 Ensure that 100 percent of hospitals in the District of Columbia report data on children born at risk for developmental delay or disability to the Department of Health (DOH) agencies charged with collecting such information.	33 percent of hospitals provided DOH agencies with data on children born at risk for developmental delay or disability in 2001.	There are an estimated fifty-seven programs within the DOH that collect data on the health status of residents and environmental factors in the District of Columbia. Six of those programs, which are located in the Office of Environmental Health Sciences and Regulations, collect data on environmental factors. Over 13 percent of these programs are known to collect data related to the health status of District residents with disabilities. The December 2000 Target was that 20 percent of DOH data collection instruments will include questions pertaining to persons with disabilities. This target was partially met by December 2000.	By December 2007, DOH will invest concentrated efforts to add two additional birthing hospitals to its current two reporting sites for a total of 57 percent.
14-2 Ensure that 100 percent of the relevant DOH programs have a standardized set of parameters in their core surveillance instruments that include information on persons with disabilities.	20 percent of relevant DOH Health programs collected data on disability status in 2001.		
<b>Focus Area 15: Cardiovascular Disease</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status by 2005</b>	<b>December 2007 Target</b>
15-1. Reduce deaths from heart disease to no more than 230.2 per 100,000 people.	The age-adjusted mortality rate from heart disease was 273.7 per 100,000 population in 2000. (Source: DOH CVD Program epidemiologist)	The Assessment tool for the December 2004 targeted survey was created, and was to become web-based with the assistance of the DOH IT Department. The completion of the assessment would permit the CHP to construct its 5-year State Plan for cardiovascular disease prevention in the District of Columbia. The CHP has engaged its Forum members to assist in the creation of a State Plan to consist of policy amendments, as well as best practices for cardiovascular disease prevention.	

15-2. Reduce the proportion of adult residents with high blood pressure to no more than 10 percent.	19.3 percent of adult residents reported being diagnosed with high blood pressure in 1997. (CDC/NCHS, National Health and Nutrition Examination Survey or NHANES).		
15-3. Increase to at least 50 percent the proportion of adult residents with high blood pressure whose pressure is under control.	Nationally 18 percent of persons 18 years and older with high blood pressure had it under control (19 percent of African Americans) in 1988-1994 (NHANES).	According to the BRFSS, the percentage of District of Columbia residents who were ever told by a health care professional that they had high blood pressure decreased from 29 percent in 2001 to 25.2 percent in 2003, with a three year average of 26.6 percent.	By December 2007, at least 35 percent of adult residents with high blood pressure will have it under control.
15-4. Increase to at least 95 percent the proportion of people with high blood pressure who are taking action to help control their blood pressure.	Nationally, 72 percent of people with high blood pressure ages 18 and above took measures to control their blood pressure, such as medication and diet modification in 1998. (National Health Interview Survey or NHIS) District baseline to be established.		
15-5. Increase to 100 percent the proportion of adults who have had their blood pressure measured within the preceding two years and can state whether their blood pressure was normal or high.	97 percent of District residents reported having had their blood pressure checked within the past two years in 1994 (BRFSS).		By December 2007, 99 percent of District residents report having their blood pressure checked within the past two years.
15-6. Reduce the mean total blood cholesterol levels among District adults to no more than 193 mg/dL.	Nationally, adult Americans ages 20 and above had blood cholesterol levels of 206 mg/dL in 1988-1994 (NHANES). District baseline to be established.		
15-7. Reduce the prevalence of blood cholesterol levels of 240 mg/dL to no more than 13 percent.	Nationally, 21 percent of adult Americans ages 20 and above had blood cholesterol levels of 240 mg/dL or greater (1988-1994 NHANES).		
15-8. Reduce the mortality rate from stroke to no more than 33.2 per 100,000 residents.	The age-adjusted mortality rate for stroke in the District was 39.5 per 100,000 residents in 2000 (DOH CVD Program).	The crude death rate for cerebrovascular disease (stroke) has been following a consistently fluctuating pattern each year 1998. In 1998, the cerebrovascular death rate was 57.9 per 100,000 population, while in 2002, it was 40.2 per 100,000. The 2001 death rate of 39.2 per 100,000 was the lowest over this five-year period.	By December 2007, the mortality rate for stroke is not more than 38 per 100,000 residents.

Objective	Baseline	Status by 2005	December 2007 Target
16-1. Increase the number of HIV+ individuals identified through HIV counseling and testing (by programs funded by the Administration for HIV Policy and Programs (AHPP) and the Centers for Disease Prevention and Control (CDC)) annually by at least 5 percent.	209 individuals were identified as HIV+ through counseling and testing services as FY 2003 (Counseling and Testing database).	The December 2004 target of identifying 219 HIV+ individuals through HIV counseling and testing was exceeded; 278 HIV+ individuals were identified. Also in 2004, Objectives 16-1 through 16-4 were reworded and 16-5 through 16-7 were deleted.	By December 2007, there will be 422 newly identified HIV+ individuals.
16-2. Increase by 5 percent annually the number of newly reported AIDS cases as a result of active case findings.	1,160 newly reported AIDS cases were recorded as a result of active case findings in FY 2003 (AIDS Surveillance database).	By December 2004, 940 newly-reported AIDS cases were entered in the AIDS database for the January 2004 to December 2004 reporting period.	By December 2007, there will be 900 newly reported AIDS cases.
16-3. Increase by 10 percent annually the number of HIV+ individuals who receive Housing Assistance services (by programs funded through the AHPP and HOPWA)	400 housing slots were occupied in FY 2003 (Monthly reports)	Housing assistance for 760 individuals and families in the form of emergency shelter, short term supportive housing, and Tenant Based Rental Assistance (TBRA) and STRUM.	
16-3.1. Dropped			
16-4. Increase by 2.5 percent annually the number of HIV+ individuals who enroll in AIDS Drug Assisted Program (ADAP).	646 HIV+ individuals were newly enrolled in ADAP in FY 2003 (ADAP Enrollment database).	The December 2004 target of increasing the number of HIV+ individuals newly enrolled in ADAP to 662 was met and surpassed by a total of 768.	By December 2007, there will be 1600 clients enrolled.

<b>Focus Area 17: Immunization</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status as of 2005</b>	<b>December 2007 Target</b>
17-3. Maintain immunization coverage at 95 percent for children in licensed childcare facilities, Head Start, and prekindergarten classes.	Coverage levels for licensed childcare facilities in 2001 were 4 DtaP 95%, 3 + Polio 97%, 1 + MMR 97%, 3+ Hib 95%, and 1 Varicella/ history 97% according to survey data. Coverage levels for Head Start centers in 2001 were 4 DtaP 91%, 3 + Polio 95%, 1 + MMR 95%, 3+ Hib 91% and 1 Varicella/history 95% according to survey data. Coverage levels for PreK/K/1 grade students in 2001 were 4 DtaP 92%, 3+ Polio 94%, 1+ MMR 98%, Hib not age appropriate, and 1 Varicella/history 91% according to survey data.	Coverage level for licensed childcare facilities in 2002 for the complete immunization series was 52.57% (63.11 % in 2003; 67.33% in 2004; and 69.605 in 2005). Coverage at Head Start Centers in 2002 for the complete immunization series was 45.11% (59.35% in 2003; 66.66% in 2004; 77.32% in 2005). Coverage for PreK/K/1 grade students in 2001 for the complete immunization series was 57.93% (69.52% in 2003; 73.45% in 2004; 91.04% in 2005).	As of December 2007, 95 percent of children attending licensed child-care facilities, Head Start Centers, and Pre-K classes will have complete specific coverage rates for selected antigens.
17-1 through 17-6 were dropped.			
17-7. Increase to 100 percent (minus any deaths) the proportion of each new birth cohort enrolled in the Central Immunization Registry.	Baseline: This project began in 2001. Baseline data indicate that 76 percent (5,683 of 7,513 births, based on 1999 births to District women) of the cohort was enrolled in the Central Immunization Registry by the end of 2001.	This project started in 2001 and by the end of that year, 76 percent of 2000 births to District of Columbia residents had been enrolled. By December 2005, 79.29% (55,957 of an estimated 7,513 births) of the 2004 births to District of Columbia residents had been enrolled.	By December 2007, 80 percent of the year 2006 birth cohort will be enrolled in the Central Immunization Registry.
17-8 and 17-9 were revised and combined.			
17-8. Increase to 90 percent the number of non-institutionalized adults ages 65 years and older immunized against influenza; and increase to 60 percent the number of non-institutionalized adults ages 65 years and older immunized against pneumococcal disease.	BRFSS coverage level data from 1999 indicated that 54 percent of non-institutionalized adults 65 years and older were immunized with influenza vaccine and 32 percent of non-institutionalized adults 65 and older were immunized with pneumococcal vaccine.	The 2005 BRFSS data indicate that 54.7 percent of non-institutionalized adults 65 and older received an influenza vaccination; 51.6 percent of non-institutionalized adults 65 and older received a pneumococcal vaccination.	As of December 2007, 65 percent of high-risk adults or those 65 years and older will be vaccinated annually with influenza vaccine and 55 percent of high-risk adults or those 65 years and older will be up-to-date with pneumococcal vaccination.
<b>Focus Area 18: Mental Health and Mental Disorders</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status by 2005</b>	<b>December 2007 Target</b>
18-1.3. Expand the prevention-oriented services for children and adolescents (ages 5-18) in community programs by 10 percent annually.	In FY 2004, approximately 2,254 children were served in the MHRS program, of this number 1,802 were ages 0-12, and 1,101 were ages 13-18.	In FY 2005, approximately 2,416 children were served in the MHRS programs; of this number 1,208 were ages 0-12 years and 1,208 were ages 13-18 years.	By December 2007, demonstrate a 10 percent annual increase in the number of children served by community programs such as the MHRS.

18-1.4. Expand the prevention-oriented services for children in D.C. Charter and Public Schools (DCPS).	In FY 2002, the SMHPP provided mental health services to 1,722 children/youth.	From FY 2002 to FY 2005, the number of children/youth receiving services provided through the School Mental Health Program increased from 1,722 to 5,131.	By December 2007, demonstrate a 20 percent increase in the number of children/youth provided mental health services through the SMHPP.
18-2. Increase to 5 percent annually the services to persons age 18 and older who are homeless with serious mental illness (SMI).	IFY 2006 will be the baseline year.	The focus of this program was changed in 2005 and the baseline moved to 2006.	
18-3. Increase to 5 percent annually the proportion of working-age individuals with SMI who are employed.	In FY 2004, 209 individuals were employed through the IPS model implementation.	In 2005, 369 working-age individuals with SMI were employed.	By December 2007, demonstrate that the proportion of working-age individuals with SMI who are employed has increased by 5 percent.
<b>Focus Area 19: Sexually Transmitted Diseases</b>			
<b>Objective</b>	<b>Baseline</b>	<b>Status by 2005</b>	<b>December 2007 Target</b>
19-1. Reduce the prevalence of Chlamydia trachomatis infections among young persons 15-24 years old in the District to no more than 3 percent.	The proportion of District of Columbia women testing positive for Chlamydia trachomatis infections in the STD Clinic was 7 percent (176 of 2,613) in the STD clinic and 3 percent (106 of 3,636) in Family Planning clinics in 2002.	The proportion of women in the District testing positive for Chlamydia trachomatis infections has increased from 2000 to 2005. In the STD Clinic the proportion testing positive was 6.0 percent (146 of 2,428) and in Family Planning Clinics it was 3.8 (108 of 2,801) in 2000. In 2005, the proportion of women testing positive for Chlamydia trachomatis infections in the STD Clinic was 9.1 percent (100 or 1,097) and in Family Planning Clinics 5.8 percent (77 of 1,310).	By December 2007, the proportion of women 15-24 testing positive for Chlamydia trachomatis in the District's Southeast STD Clinic is reduced by at least 1 percent resulting in no more than 8.0 percent positivity, and in the Family Planning Clinics by at least 3 percent resulting in no more than 2.8 percent positivity.
19-2.1. Reduce the incidence of gonorrhea among District residents to no more than 346 cases per 100,000 people.	The District's gonorrhea rate was 476 per 100,000 people (calculated 2,722 of 572,059 times 100,000) in 2002.		
19-2.2. Reduce the incidence of gonorrhea in adolescents ages 10-19 years in the District to no more than 580 cases per 100,000 people.	The gonorrhea rate among District adolescents ages 10-19 years was 991 per 100,000 people (calculated 673 of 67,885 times 100,000) in 2002.		
19-2.3. Reduce the incidence of gonorrhea in women in the District to no more than 264 cases in 100,000 people.	The gonorrhea rate in the District for women was 412 per 100,000 people (calculated 1,246 of 302,693 times 100,000) in 2002.		

19-3. Reduce the incidence of primary and secondary syphilis in the District to no more than 3 cases per 100,000 people.	The primary and secondary syphilis rate in the District was 10 per 100,000 people (calculated 59 of 572,059 times 100,000) in 2002.	The primary and secondary syphilis rate in the District increased from 7.1 per 100,000 population in 2000 to 18 per 100,000 in 2005. increases in primary and secondary syphilis reports from 2003 to 2005 may contribute to congenital syphilis increases in 2007).	By December 2007, the incidence of primary and secondary syphilis has been reduced to no more than 37 cases per 100,000 population. (Incremental increases in primary and secondary syphilis reports from 2003 to 2005 may contribute to congenital syphilis increases in 2007).
19-4. Reduce the incidence of congenital syphilis among District residents to no more than 10 cases per 100,000 live births.	The congenital syphilis rate in the District was 13 per 1,000 live births (calculated of 7,666 times 1,000) in 2002.	In 2000 in the District, the incidence rate for congenital syphilis was 52.0 per 100,000 live births. In 2005 in the District, the incidence rate for congenital syphilis had decreased to zero per 100,000 live births.	By December 2007, congenital syphilis is reduced to no more than 26 cases per 100,000 population.
19-5. Reduce the human immunodeficiency virus (HIV)-positive rate to below 1 percent among newly tested patients at the Southeast sexually transmitted diseases (STD) clinic.	The HIV-positive rate among patients tested at the Southeast STD clinic was 1.6 percent (calculated 67 of 4,032) in 2002.		
19-6. Increase to at least 98 percent the proportion of major health providers managing STD patient care according to the most recent screening Centers for Disease Control and Prevention (CDC) guidelines for the treatment of Sexually Transmitted Diseases.	In 2002, 97 percent (3,315 of 3,419) of major health providers managed STD patient care according to the most recent CDC guidelines for the Treatment of Sexually Transmitted Diseases.		
<b>Focus Area 20: Substance Abuse</b>			
	<b>Objective</b>	<b>Baseline</b>	<b>Status by 2005</b>
	20-1. Reduce to no more than 50 percent the proportion of youth who have ever tried cigarette smoking.	55.2 percent of boys and 55.7 percent of girls have tried smoking, according to the 2003 District of Columbia Youth Risk Behavior Survey (YRBS).	56.7 percent of boys and girls reported trying smoking in 2001 (YRBS); 55.2 percent of boys and 55.7 percent of girls so reported in 2003 (YRBS).
	20-2. Reduce to 51 percent the proportion of youth reporting that they have ever drunk alcohol.	66.1 percent reported drinking alcohol, according to the 2003 DC YRBS.	The percent of youth indulging in binge drinking has declined from 10.3 in 2003 to 9.2 in 2005, according to the YRBS.
	20-3. Reduce to 20 percent the proportion of youth who have ever used marijuana.	41.7 percent of youth reported using marijuana according to the 2003 YRBS.	First time use of marijuana by children below age 11 has increased from 3.7 in 2003 to 5.9 percent in 2005, according to the YRBS.
			<b>December 2007 Target</b>
			By December 2007, no more than 35.8 percent of youth report smoking.
			By December 2007, no more than 44.9 percent of youth report consumption of alcoholic beverages.
			By December 2007, no more than 27.2 percent of youth will report engaging in the use of marijuana.



20-4. Reduce the demand for alcohol and other drugs by reducing the number of residents addicted to drugs and alcohol in the District of Columbia by 25,000 by the year 2010.	There are 60,000 addicted residents in 2004.			
20-5. Create a variable length-of-stay social detoxification program to address patients who show frequent relapse patterns and do not require medical intervention.	There is minimal funding to support the use of other detox facilities in the District to enhance patient readiness for substance abuse treatment and to reduce the rate of recidivism.			
20-6. Establish coalitions and partnerships around quality prevention programs, and youth and adult treatment programs for the addicted.	There were more than 20 treatment and prevention partnerships in 2004.			
<b>Focus Area 21: Tuberculosis</b>				
<b>Objective</b>	<b>Baseline</b>	<b>Status by 2005</b>	<b>December 2007 Target</b>	
21-1. Reduce the incidence of tuberculosis in all residents of the District of Columbia to no more than 9.9 cases per 100,000 population; reduce the incidence of TB in resident minority racial/ethnic groups to the following (cases per 100,000 population): - Asian/Pacific Islanders: 0.18 - African Americans: 10 -Hispanics: 2.3 -American Indians/ Alaska natives: 0.18	There were 14.3 cases of tuberculosis per 100,000 people in the District of Columbia in 2002, and for resident racial and ethnic minority population groups, the incidence of TB was the following (cases per 100,000 population in 2002): Asian/Pacific Islanders: 0.18; African Americans: 10.5 Hispanics: 2.7 American Indians/ Alaska Natives: 0.18	In 2004, 81 cases of TB were reported for the District of Columbia, a case rate of 14.2 cases per 100,000. For 2005, preliminary data, show 55 cases of TB were reported, a case rate of 10.0 cases per 100,000 population which is significantly lower than the case rate of 14.2 per 100,000 for 2004. However, it is still substantially higher than the 2004 national average of 4.9 cases per 100,000 population.		
21-2. Increase to 90 percent the proportion of TB patients who complete a recommended course of curative treatment.	Eighty-eight percent (88%) of patients with newly diagnosed TB disease completed a prescribed course of curative treatment within 12 months of treatment initiation in 2002.		By December 2007, the incidence of tuberculosis in the District of Columbia will have been reduced to 10.0 cases per 100,000 population.	
21-3. Increase to 90 percent the proportion of close contacts of persons infected with TB who complete the recommended courses in preventive therapy.	Less than 10 percent of close contacts of persons with active TB completed preventive therapy in 2002.	The proportion of close contacts completing therapy remained at less than 10 percent from 1999 through 2002.		By December 2007, 50 percent of close contacts have completed the recommended preventive therapy.

## Resources

The following documents are available on Department of Health's website at [www.doh.dc.gov](http://www.doh.dc.gov):

- *Healthy People 2010 Plan, Midcourse Revisions (2000-2005)*
- *Accomplishing the District of Columbia's Health Objectives: A Health System Plan for D.C.*

NCQA HEDIS measures <http://web.ncqa.org/>

Behavioral Risk Factor Surveillance System measures <http://www.cdc.gov/brfss/>

CMS Measures of Hospital Quality <http://www.hospitalcompare.hhs.gov>